Implementation Support for MOUD Implementation Guide

Practice Innovation Program

UNIVERSITY OF COLORADO

ANSCHUTZ MEDICAL CAMPUS

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Background

Implementation Support for Medication for Opioid Use Disorder (ISM) will help practices increase access to Medication for Opioid Use Disorder (MOUD) for patients and build the confidence of physicians to successfully support patients eligible for MOUD in primary care.

The project is organized into core aims. Each core aim is broken down into milestones with associated action items and practice resources. This guide provides further details on:

- Action items: Steps necessary for a practice to take in order to achieve the milestones for the core aims.

- Resources: Wide variety of websites, articles, screenings, etc. for practice facilitators and practices to utilize to achieve the objectives of the core aims.

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Core Aim 1: Build Your Team

Milestone 1.1: The leadership in this clinic is committed to providing Medications for Opioid Use Disorder (MOUD) and communicates consistently its aims within meetings, case conferences, emails, internal communications, and celebrations of success.

Action Items:

1. Practice leadership understands clinical approaches to providing MOUD
2. MOUD leadership creates a vision and aims to meet MOUD needs of patients that is refined by MOUD team and communicated to staff
3. Leadership recognizes and rewards innovation and improvement related to providing MOUD.

Resources:

California Improvement Network Webinar — Engaging Providers in Substance Use Disorder Treatment

California Improvement Network Toolkit – Three Strategies to Help Primary Care Teams Treat Substance Use Disorder

National Council for Mental Wellbeing - Medications for Addiction Treatment (MAT) Readiness and Implementation Checklist

Core Aim 1: Build Your Team

Milestone 1.2: Practice identifies champions (ie. RN, Provider, MA, etc.) responsible for practice change related to MOUD. Practice has dedicated resources (protected time, EHR, functionality, etc.) to meet and engage in practice change.

Action Items:

1. Identify MOUD practice champions; individuals that will lead process change to support MOUD.
2. Develop quality improvement (QI) capability within the practice and empower staff/providers to participate in MOUD related QI activities, including:
    a. Identify multidisciplinary MOUD quality improvement team.
    b. Protect time for MOUD team meetings by blocking patient care responsibilities where necessary.
    c. Consider what time and resources may be required for MOUD team work outside of regular meetings.
3. Champions regularly update clinic leadership and the care team about progress made on MOUD priorities

Resources:

Institute for Healthcare Improvement – Science of Improvement: Forming the Team

AHRQ Primary Care Practice Facilitation Curriculum - Creating Quality Improvement Teams and QI Plans

Core Aim 1: Build Your Team

Milestone 1.3: The practice identifies and maintains a list of providers interested in prescribing buprenorphine to current or new patients.

Action Items:

1. Compile a list of all prescribers in the practice.
2. MOUD training for new providers and/or those who would like more education around prescribing buprenorphine

Resources:

ASAM e-learning Center

Practice Innovation Program at CU Provider Training Opportunities

Core Aim 1: Build Your Team

Milestone 1.4: Providers and staff have received training in the last two years on patient-centered, empathic communication emphasizing patient safety, de-stigmatization, disease mitigation, and overdose prevention and response.

Action Items:

1. Identify and prioritize staff knowledge gaps and prioritize areas for training.
2. Pick resources that address knowledge gaps.
3. Participate in monthly ISM calls with addiction specialist.
4. Develop processes for new providers and staff to be trained on MOUD, emphasizing patient safety, de-stigmatization, disease mitigation, and overdose prevention and response during their onboarding.

Resources:

MOUD Learning Forum

March of Dimes Beyond Labels Stigma Training

Philosophy of Harm Reduction (National Harm Reduction Coalition)

Harm Reduction Action Center

Comparisons to Medications Used to Treat Opioid Use Disorder: Appendix XI (Page 143)

MOUD Training Video - By David Mendez, MD

Core Aim 1: Build Your Team

Milestone 1.4: Providers and staff have received training in the last two years on patient-centered, empathic communication emphasizing patient safety, de-stigmatization, disease mitigation, and overdose prevention and response.

Trainings:

DESCRIPTION	TARGET AUDIENCE	TIME REQUIREMENT
Colorado Consortium for Prescription Drug Abuse Prevention: Opioid Use and Pain Management CME Learning Modules	Patients, medical providers, care managers, social workers, clinic staff, public health, pharmacy, community coalitions, LEO	Hours of pre-recorded content. Learn at your own pace.
Primary care and behavioral health practices play a key role in increasing access to medication assisted treatment (MAT) for opioid dependence and use disorder (OUD). The IT MATTTRs TM Practice Team Training helps create a cohesive, supportive clinical environment where the entire team plays a role. Make sure your team is ready! IT MATTTRs Team Training Sign-Up	Clinic Practice Teams	Five 45-minute modules - details available on the IT MATTTRs Team Training web-page

Core Aim 1: Build Your Team

Milestone 1.5: Comprehensive policies regarding MOUD that reflect evidence-based guidelines exist, have been recently updated, and have been discussed with all clinicians and staff.

Action Items:

1. Create/edit/update policies regarding MOUD and build consensus across team about important aspects of MOUD care, such as establishing diagnosis, labs, urine drug testing, establishing routine follow up, routinely checking PDMP, and managing refills. Document and distribute policies to staff.
2. Establish or review current workflow to support implementation of practice established policies.

Resources:

Urine drug screening: A guide to monitoring Treatment with controlled substances (requires free Medscape login)

VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders – modules A and B provide good workflow examples

SAMSHA Buprenorphine Quick Start Guide

Comparisons to Medications Used to Treat Opioid Use Disorder: Appendix XI (Page 143)

Core Aim 1: Build Your Team

Milestone 1.6: Formal signed patient agreements regarding MOUD exist, align with current policies, and are consistently used with all patients on MOUD.

Action Items:

1. Develop or revise current patient agreement identifying areas of improvement with emphasis on patient centered versus punitive language.

Resources:

National Alliance of Advocates for Buprenorphine Treatment – The Words We Use Matter. Reducing Stigma through Language

ITMATTTRs Patient Consent Form

Sample Patient Agreement

Core Aim 1: Build Your Team

Milestone 1.7: Practice uses a registry or other system to proactively track & monitor patients prescribed MOUD to ensure their safety.

Action Items:

1. Practice maintains a registry of patients eligible for MOUD that tracks newly prescribed MOUD, maintenance refills of medications, patients lost to follow up, patients referred out of the practice, and patients that have stopped MOUD.
2. Practice creates a strategy to follow up and outreach to newly induced patients and/or patients lost to follow up.

Resources:

MOUD registry example

ISM MOUD Data Collection Table

Core Aim 2: Engage and Support Patients

Milestone 2.1: Care plan documentation templates align with current policies and are consistently used for people on MOUD.

Action Items:

1. Practice identifies documentation templates for MOUD patients.
2. Practice staff is trained on where to find and how to use MOUD documentation templates.

Resources:

CU College of Nursing and ITMATTTRs Induction Note Example

History of Present Illness (HPI) Assessment and Plan Template

ITMATTTRs Induction Day Care Plan

ITMATTTRs Maintenance Care Plan

Core Aim 2: Engage and Support Patients

Milestone 2.2: Practice communicates to its patients about the benefits of MOUD through flyers, posters and other appropriate outreach.

Action Items:

1. Practice identifies and circulates patient-facing materials demonstrating MOUD treatment options and outlining benefits of MOUD.

Resources:

Practice Innovation Program at CU Resources for your Practice and Patients

Prescription Drug Safety Starts With You | Take Meds Seriously

National Harm Reduction Coalition

Providers Clinical Support System, Common Questions and Concerns about Medications for Opioid Use Disorder (MOUD): A Handout for Ambivalent Patients

Have you Met MAT? - ITMATTTRs

MAT for OUD in SLV – ITMATTTRs

Core Aim 2: Engage and Support Patients

Milestone 2.3 Practice consistently uses screening tools and other workflows to identify opioid misuse, diversion, and addiction.

Action Items:

1. Identify patients meeting DSM-V criteria for opioid use disorder.
2. If the patient meets criteria for OUD, offer MOUD.
3. Providers should check PDMP prior to every visit or refill.
4. Practice implements universal screening to identify patients at risk for SUD (opioids, stimulants, benzodiazepines, alcohol, etc).
5. Establish frequency of urine drug testing – may vary depending on stability of use disorder. Consider referral to higher level of care for continued positive urine drug tests.

Resources:

ITMATTTRs DSM-V criteria for diagnosis of opioid use disorder

Opioid Risk Tool (ORT): patients on chronic opioid pain medications at risk for developing a use disorder

CRAFFT Screening Interview

AUDIT-C for Alcohol Use Screening

Example MOUD Workflow

Core Aim 2: Engage and Support Patients

Milestone 2.4: Workflows exist and are used to provide prompt access to patients for MOUD inductions and routine maintenance appointments.

Action Items:

1. MOUD team creates/tests/modifies workflow to support MOUD induction in practice.
2. Identify patients using illicitly manufactured fentanyl, as this will change the home induction process. Consider a slower buprenorphine induction to avoid precipitated withdrawal.

Resources:

ITMATTTRs Side Effect Management Protocol
Example MOUD Workflow
ITMATTTRs Buprenorphine Initiation Checklist for Clinics
ITMATTTRs Office Induction Protocol
Clinical Opioid Withdrawal Scale (COWS)
ITMATTTRs Patient Drug Relapse Flowchart
SAMSHA Buprenorphine Quick Start Guide (The last page has home induction protocol)
Patients using fentanyl (Start from section titled “the fourth wave” about 29 minutes into the video)
Home Induction Protocol (from Dr. Mendez)
ITMATTTRs Home induction patient guide
National Clinical Consultation Warm Line - Clinically supported advice warm line on substance use management for healthcare providers

Core Aim 2: Engage and Support Patients

Milestone 2.5: Strategies for disease mitigation and overdose prevention and response are identified, implemented and tracked as a part of the routine care for patients with an Opioid Use Disorder.

Action Items:

1. Routinely check infectious disease labs:
    a. Consider annual recheck: HIV, Hep C, Hep B/A.
    b. As needed depending on risks identified (every 3-6 months): Treponema ab, GC/CT.
2. Prescribe Narcan with all patients prescribed buprenorphine/opioids.
3. Identify resources for disease mitigation and overdose prevention and response (e.g. Naloxone distribution, syringe exchanges) in your community and compile hand out for patients.
4. Provide information about and access to fentanyl test strips.

Resources:

Syringe access sites in CO flyer

HRAC

Core Aim 2: Engage and Support Patients

Milestone 2.5: Strategies for disease mitigation and overdose prevention and response are identified, implemented and tracked as a part of the routine care for patients with an Opioid Use Disorder.

DESCRIPTION	TARGET AUDIENCE
Reducing health-related stigma among moms and babies https://beyondlabels.marchofdimes.org/	Designed for people who work in health-related fields, this interactive site will help you learn how stigma can impact the healthcare and support women need, seek and receive.
Committed to Public Health: The HRAC promotes public health by ensuring that people who inject drugs are educated and equipped with the tools to reduce the spread of communicable diseases such as HIV and Hepatitis C and to eliminate the proliferation of fatal overdoses.	Patients, medical providers, care managers, social workers, other clinic staff. *Located in Denver

Core Aim 3: Connect with Recovery Support Services

Milestone 3.1 Practice communicates with at least 3 local professional organizations about the availability of MOUD services in the clinic.

Action Items:

1. Identify and reach out to local professional organizations to raise awareness and visibility of available services.

Resources:

MAT Communications Guide from the Practice Innovation Program

Core Aim 3: Connect with Recovery Support Services

Milestone 3.2: Policies and workflows are implemented to identify people who may benefit from higher levels of care for their Opioid Use Disorder or other mental and behavioral health needs. Hand offs to appropriate specialists and treatment facilities are coordinated and tracked.

Action Items:

1. Identify co-morbid diagnoses that would trigger an automatic referral, including significant mental health illness, HIV+, Hep C+, and suicidal ideation.
2. Consider referral for ongoing benzodiazepine and/or alcohol use.
3. Identify nearby treatment facilities and addiction specialists that can provide care for diagnoses above.

Resources:

OpiRescue's treatment locator

SAMHSA's treatment locators

ITMATTTRs Drug Screening Treatment Referral Form

Medical Management Strategies for Patients Taking OUD Medications in Office-Based Settings

Core Aim 3: Connect with Recovery Support Services

Milestone 3.3: Patients are provided information about community resources for recovery services, including both in-person or virtual, where available,

Action Items:

1. Practice identifies community resources for recovery services.
2. Practice maintains up to date list of community recovery services for patient referral.

Resources:

Colorado Community Recovery Organizations

ITMATTTRs blank local resources log

Regional Health Connectors - can make introductions to community organizations that provide recovery support services as well as organizations to address social needs

Core Aim 3: Connect with Recovery Support Services

Milestone 3.4: Practice defines and implements workflows to assess social needs of those on MOUD (housing, transportation, food insecurity, etc.) and to refer patients to appropriate resources to address identified needs.

Action Items:

1. Choose and implement a method for initial assessment of patient population's social needs, including screening patients for existing social needs screening and speaking with social workers, care managers, or other personnel at practice or in community who are currently assisting patients with social needs.
2. Practice maintains, or has access to, up to date list of community services and resources for patient referral.

Resources:

AF Williams Social Determinants of Health Screening Tool

Three tools for screening for social determinants of health from the AAFP

A Practical Approach to Screening for Social Determinants of Health

The Feasibility of Screening for Social Determinants of Health: Seven Lessons Learned