Medication Assisted Treatment in Primary Care - Planning List

1. Identify overall vision and philosophy for the program (for example: harm reduction)
   a. Who will be your champion/s?
   b. Will you require patients receiving MAT services at your site to identify your site as PCP?

2. Identify overall model that will be used (for example, will MAT clinic be co-located with primary care, integrated into primary care, hybrid model, etc) Examples (not exhaustive):
   a. Co-located Model: MAT sessions are completely separate from primary care schedules; only MAT-related issues are addressed at time of visit (in this model, PCP may not be within same organization. In this case care coordination should be planned)
   b. Integrated Model: Primary care and MAT-related concerns are addressed in same visit. Visits may be intermixed throughout clinic or may have particular sessions with focused MAT session (often for BH staffing purposes)
   c. Hybrid model- induction and stabilization done in MAT clinic (or even outside the system), and once stabilized, patients are referred to PCP for maintenance

3. Staffing Plan: There will need to be some central organization around the MAT program depending on the size of the program. Most models have at least one additional person in addition to a prescriber who serves as the “glue person” - could be a nurse, case manager, etc.
   a. Identify Prescribers
      i. Currently MD/DO need to complete an 8 hour training to be able to prescribe
      ii. APN and PA need to complete 24 hours of training to be able to prescribe
         1) In Illinois, APN collaborating physician does need have to have a waiver to prescribe until January 2018. APN’s can have two collaborating physicians. In January 2018, APNs who have full practice authority will not need to meet this requirement.
      iii. Ensure backup coverage in the case of unexpected leave or time off (never have just one prescriber!)
   b. Identify behavioral health support (on-site or external referral)
      i. If on-site, what background of staff and what will job duties entail?
         1) LCSW
         2) CADC/AODC
         3) Recovery Coach
      ii. If off-site, how will collaboration and coordination of care be managed and documented?
         1) Is formal MOU or other process needed?
         2) How you will document ongoing behavioral health engagement?
            (Meeting sheet, will records be shared, etc?)
   c. Additional Staff
      i. Nurse care manager
      ii. Care coordinator/case manager
      iii. MA’s specifically assigned to OBOT
      iv. Role identification- how do the roles of the various team members differ? How do different people person support overall clinic flow?

4. Training of entire staff on OUD and OUD treatment
   a. Important that all staff members understanding what medication is and the relapsing nature of OUD
   b. Importance of trauma-informed care
   c. Use of non-stigmatizing language
   d. Review of current organizational policies around opioid and benzodiazepine prescribing

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e. Important that all staff understand implications of someone missing an appointment/missing Rx for medication

5. Support of multi-disciplinary teams and team based care
   a. Outlining each team members’ role (examples: substance use counseling; mental health counseling/treatment; case management; coordination of care with outside facilities-i.e. OP, IOP, residential; checking of PMP, assistance with prior authorizations; development of resources for 12 step meetings; recovery-supportive churches, spiritual resources when appropriate; check-in calls and follow up if someone misses appointment, coordination with pharmacies, etc.)
   b. Supporting team based care: examples could be daily huddle, weekly team meetings, etc

6. Partnerships/Linkage Agreements
   a. Identify local/accessible resources for patients who are identified as needing a higher level of care:
      i. Inpatient detox (often needed for safe alcohol detox)
      ii. Residential program
      iii. Intensive Outpatient (IOP) and outpatient (OP) programs
      iv. Opioid treatment program (methadone) provides daily observed dosing for patients who need increased structure
      v. Recovery homes
      vi. Psychiatric services if not available on-site
   b. Identify local agencies, hospitals or other organizations as partners as sources for patient referrals to your program. Examples:
      i. Local ERs (Yale has published several papers on a model where the buprenorphine induction is done in the ER and then patients are referred to community clinics for ongoing care)
      ii. Detox Programs (particularly if you are using injectable naltrexone as part of your program)
   c. Partnerships with pharmacies
      i. Ensuring that partnering pharmacies will carry various doses of medications being prescribed
      ii. Identifying a pharmacy that will work with you when PA’s are needed
      iii. Ensuring partnering pharmacies are carrying naloxone formulations
      iv. 340B programs for uninsured

7. Clinical Tool Identification/Development:
   a. Identify how to order/use urine drug screens
      i. Rapid urine drug screens
         1) Which drugs to include and which to not include
         2) When to use/what is reimbursable
         3) CLIA waived
      ii. Send out urine drug screens
         1) Which drugs to include and which to not include
         2) When to use/what is covered by insurance
   b. Intake assessment tool
   c. Inclusion and exclusion criteria for the program & any priority patient groups (ie pregnant women)
   d. EMR decision support and tools (ie quicktexts, internal referral system for MAT, custom forms)
e. Development of after-hours and prescriber vacation/away coverage since not all who cover call will be familiar

8. Work flows
   a. Workflow from the point of patient requesting services until first visit
   b. Intake assessment- which tool and who completes it
   c. Medication induction work flows (office induction or home induction)
   d. Standardized workflow for reviewing IL PMP regularly
   e. Workflow to ensure that overdose prevention done with each patient and naloxone is distributed or prescribed
   f. Process to support outreach when patients are lost to care
   g. Process to assure regular updating of MAT patient list (must ensure that prescribers do not exceed federal patient limit)
   h. Workflow for “emergency prescriptions” (when a provider is out unexpectedly or a patient has missed a visit)

9. Development of Patient Materials:
   a. Patient agreement (expectations of patient and of prescriber)
   b. Patient identification card (to be shown in other appointments and/or in case police see patients with medication)
   c. Overdose prevention education materials and naloxone distribution
   d. Local Resources:
      i. Support groups (NA, AA, Smart Recovery, etc)
      ii. Legal Aid
      iii. Housing Support
      iv. Counseling
      v. Job training

Resources:

- Providers Clinical Support System- Medication Assisted Treatment (PCSS-MAT): online resource with many free CME webinars, many archived sessions as well: https://pcssmat.org/
- Buppractice.com- Has a variety of tools and resources for providers and patients: https://www.buppractice.com/
- Prescribe to Prevent: Has a variety of overdose prevention and naloxone educational materials, including patient videos: http://prescribetoprevent.org/
- Telehealth training through Project ECHO: https://echo.unm.edu/
- SAMHSA TIP 40: https://store.samhsa.gov/shin/content/SMA05-4003/SMA05-4003.pdf