A Framework for Systems Transformation as a Facilitator to Overcome Barriers Related to the Implementation of Medication-Assisted Treatment within Rural Primary Care Practices

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Acknowledgements

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Rural Access to MAT in Pennsylvania

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Objectives

1. Review an **implementation framework (IF)** that can be used to implement medications for opioid use disorder (MOUD) within rural primary care practices;

2. Discuss **common barriers** to recruiting providers and implementing MOUD;

3. Review how the IF was applied to barriers and present **preliminary qualitative and quantitative findings** related to the use of the IF in implementation; and

4. Discuss **lessons learned** that can be applied by initiatives with similar goals and aims as Project RAMP.

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Objective 1.

Project RAMP Implementation Framework

Supportive Methods: Six MOUD Implementation Facilitators

- **Designated implementation team** to provide on-site and remote concierge technical assistance, training and education, and continuous quality improvement.
- **Individualized education and training** provided via live in-person formats, web-based presentations, and an online curriculum continuously updated with new content based on requests and/or needs of sites/providers.
- **Peer-to-peer teleconsultation** with a physician team to provide one-on-one clinical guidance.
- **Partnerships with local treatment and service providers** to provide care/case management, peer and recovery support, and substance use disorder (SUD)/mental health (MH) services for patients.
- **Partnerships with Pennsylvania Managed Care Organizations (MCOs)** to provide reimbursement-related implementation support.
- **Telepsychiatry coordination** to provide direct-to-consumer (DTC) MH treatment.

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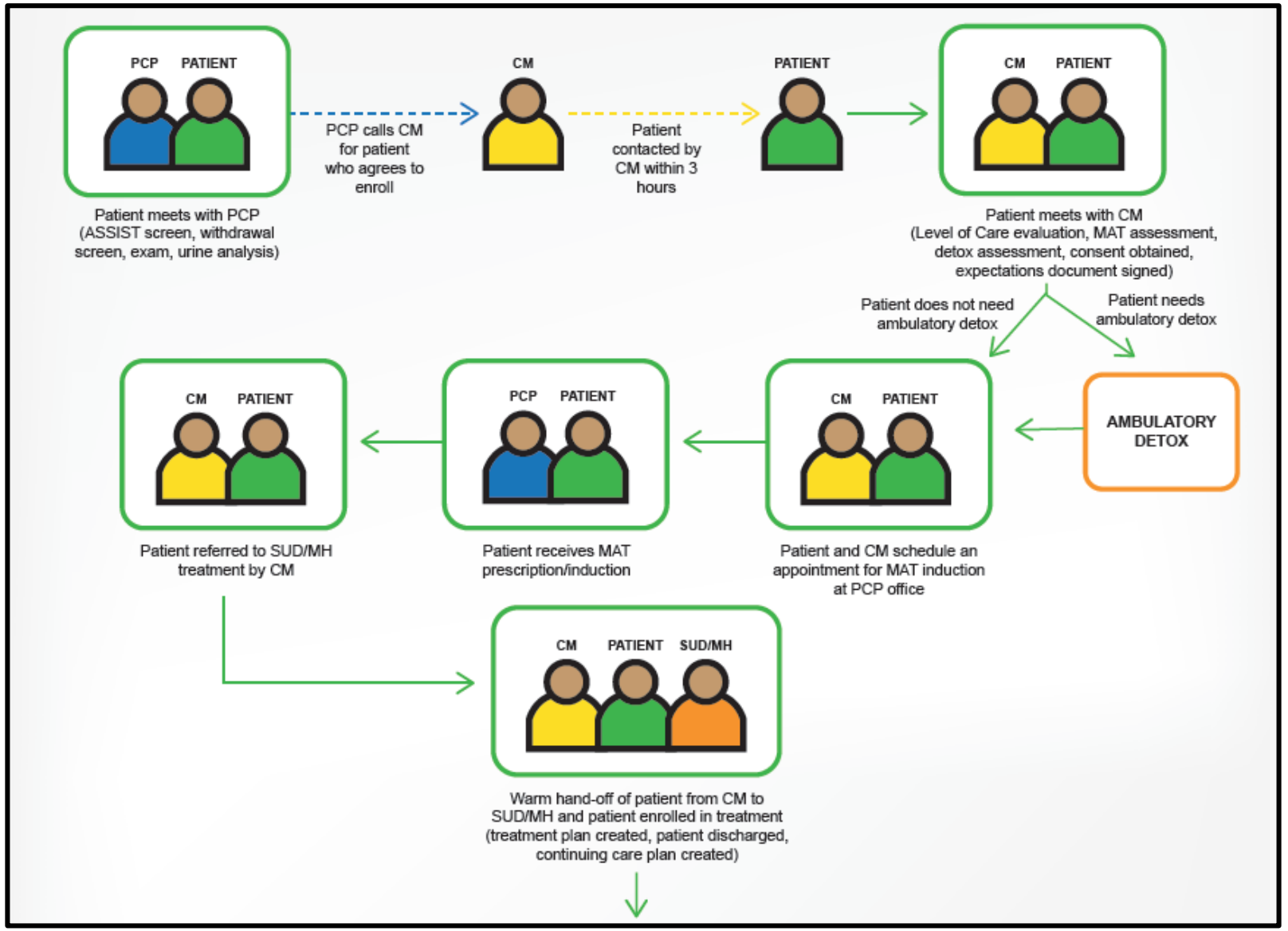
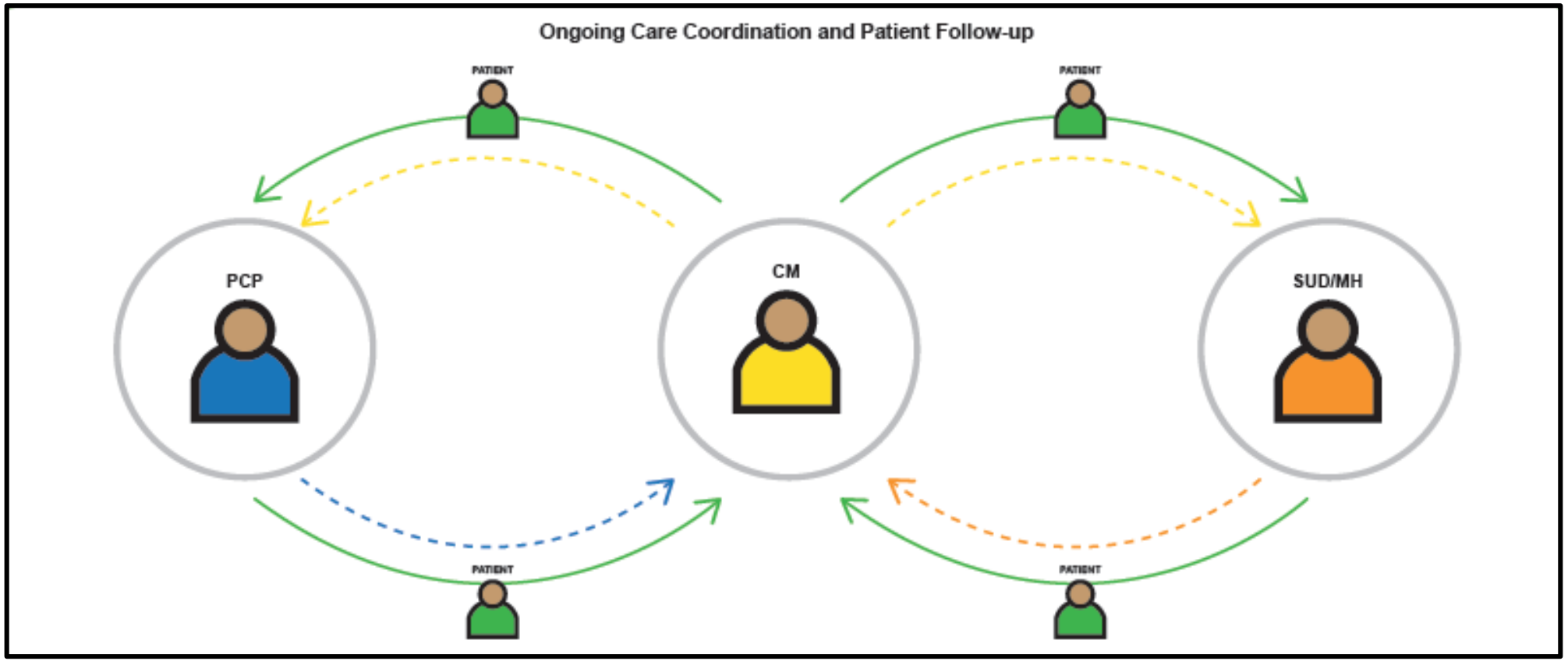
Patient Process Flow: Patient Screened, Assessed, and Referred by PCP



Patient Process Flow: Ongoing Care Coordination and Follow-up



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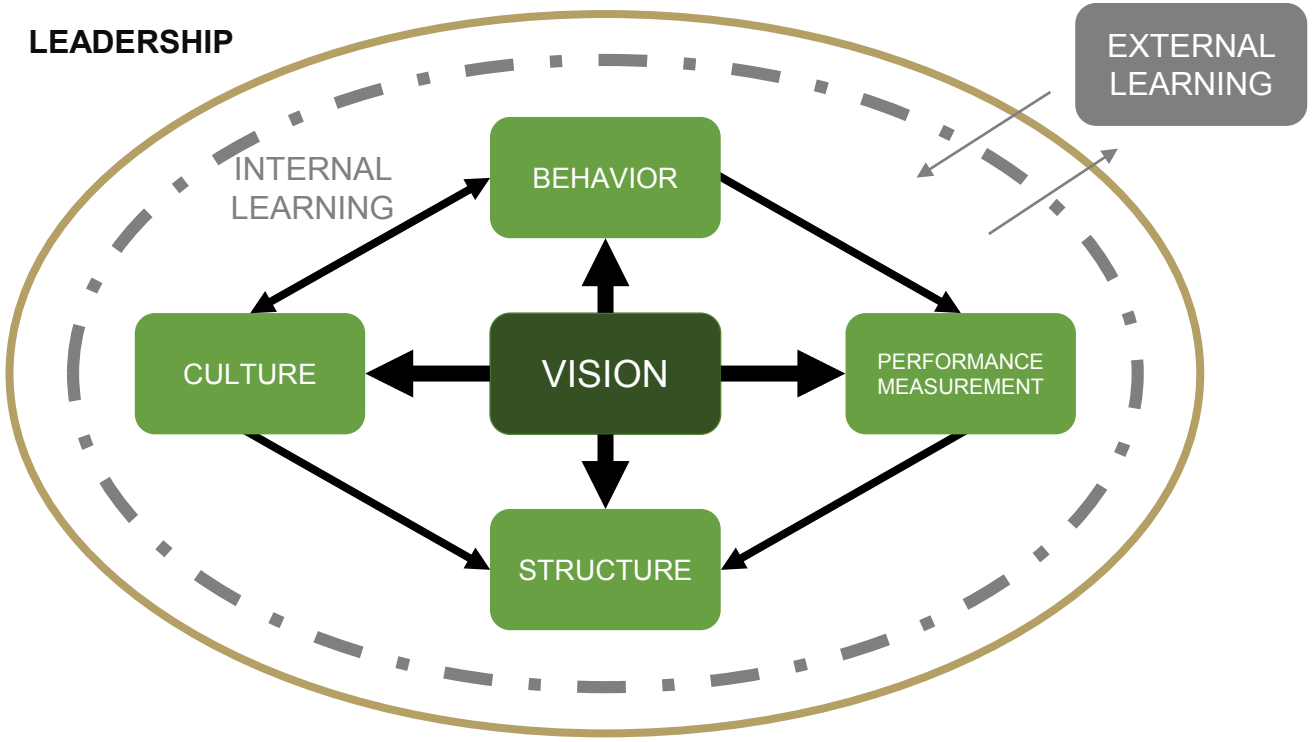
Framework for MOUD Implementation

Project RAMP uses a systematic method to guide implementation and address barriers called the **Systems Transformation Framework (STF)**.



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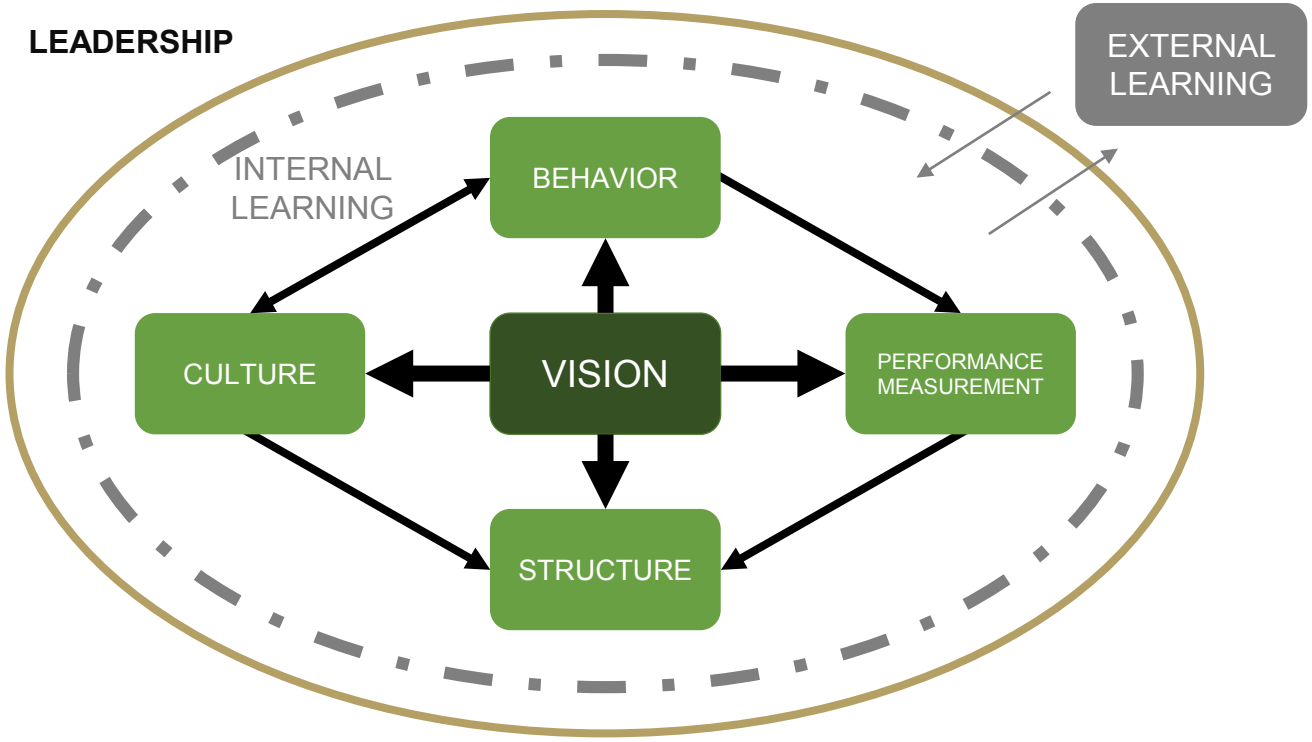
Framework for MOUD Implementation

Under the **STF**, MOUD implementation is centered around a common **vision**. **The organization or practice is assessed across four domains** and **strengths are leveraged** to guide the implementation process.



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Objective 2.

Barriers to Implementing MOUD in Rural Pennsylvania Primary Care Practices

Methods

Barriers were identified and assessed throughout implementation via:

1. **Demographic, Technical Assistance Needs, and Organizational Health Questionnaires**
   - Collection Timepoint(s): Prior to implementation

2. **Qualitative Interviews with Providers and Staff Champions**
   - Collection Timepoint(s): Quarterly

3. **Implementation/Technical Assistance Surveys**
   - Collection Timepoint(s): Quarterly

4. **MOUD Implementation Checklists**
   - Collection Timepoint(s): Quarterly and as-needed

5. **Training and Education Surveys**
   - Collection Timepoint(s): Following each training

6. **Ongoing/Routine Communication via telephone and email**

Barriers Encountered During Recruitment and Implementation

Stigma: Some providers and staff have had personal experiences that have negatively shaped their views towards individuals who use or misuse substances.

Administrative burdens: Unfamiliar administrative policies, procedures, and requirements can make it challenging for providers and practice administrators to implement MOUD without external support or expertise.

Time requirements: Rural PCPs are tasked with managing numerous chronic illnesses and have time constraints on training for and implementing new practices.

Access to support services and behavioral health: Low access to support services in rural communities creates challenges for practice sites to perform treatment.

Communication between providers: Communication between SUD/MH, MOUD, and other service providers can be challenging due to a lack of integration and confidentiality rules and regulations.

Barriers Encountered (cont.)

Comfort with and readiness to implement MOUD: Providers and staff have varying levels of experience and knowledge treating substance use disorders or managing co-occurring MH conditions.

Legal concerns: Many providers are hesitant to adopt MOUD due to legal concerns about buprenorphine treatment and misuse/diversion.

Staff turnover: High staff turnover in rural primary care practices creates challenges during implementation especially if the champion is lost and a new champion needs to be re-identified and trained.

Sustained provider engagement with MOUD: Providers often obtain a DATA Waiver, complete training and education, and begin prescribing but do not continue prescribing or treating patients long-term without follow-up from external supports.

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Objective 3.

Overcoming Barriers Using the Systems Transformation Framework

Vision: Use a Vision to Guide MOUD Implementation

"[Name of Primary Care Practice] will increase patient access to MOUD and addiction specialty services in [the community] by providing the highest quality MOUD services to our patients who suffer from opioid use disorder."

Leadership: Identify Health System and Practice Site Leadership

Map Key

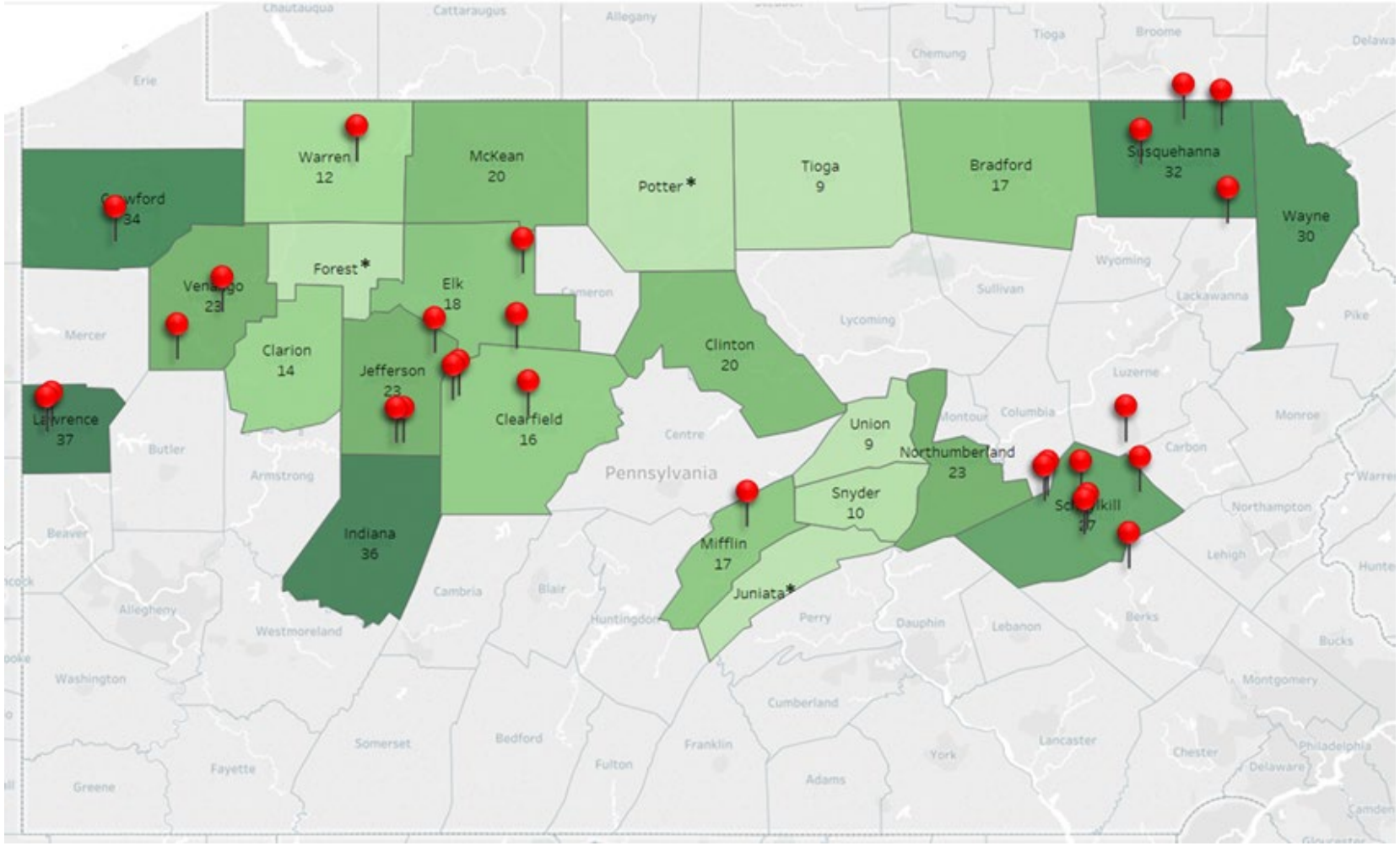
Project RAMP County

RAMP Primary Care MOUD Implementation Site

Map Color Scale

9 — 37

2018 Drug-Related Overdose Death Rate (per 100,000)



Recruitment: 27 practice sites within 13 unique health systems and provider groups across 13 Pennsylvania Counties.

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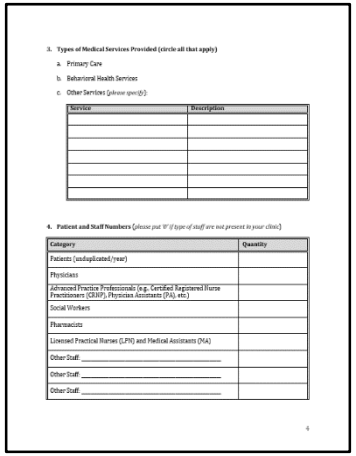
Organizational Culture/Behavior: Perform Site Assessments



3. **Types of Medical Services Provided (circle all that apply)**

a. Primary Care

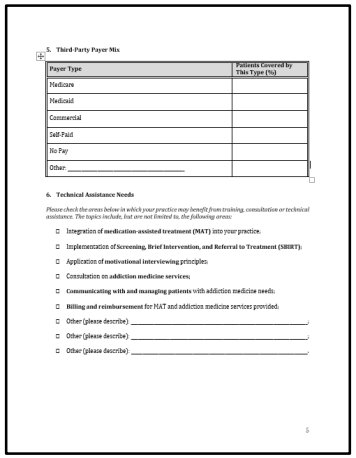
b. Behavioral Health Services

c. Other Services (*please specify*):

Service	Description

4. **Patient and Staff Numbers** (*please put '0' if type of staff are not present in your clinic*)

Category	Quantity
Patients (unduplicated/year)	
Physicians	
Advanced Practice Professionals (e.g., Certified Registered Nurse Practitioners (CRNP), Physician Assistants (PA), etc.)	
Social Workers	
Pharmacists	
Licensed Practical Nurses (LPN) and Medical Assistants (MA)	
Other Staff: _____	
Other Staff: _____	
Other Staff: _____	



5. **Third-Party Payer Mix**

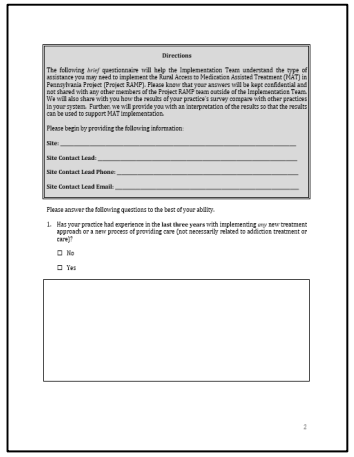
Payer Type	Patients Covered by This Type (%)
Medicare	
Medicaid	
Commercial	
Self-Paid	
No Pay	
Other: _____	

6. **Technical Assistance Needs**

Please check the areas below in which your practice may benefit from training, consultation or technical assistance. The topics include, but are not limited to, the following areas:

- ☐ Integration of **medication-assisted treatment (MAT)** into your practice.
- ☐ Implementation of **Screening, Brief Intervention, and Referral to Treatment (SBIRT).**
- ☐ Application of **motivational interviewing** principles.
- ☐ Consultation on **addiction medicine services;**
- ☐ **Communicating with and managing patients** with addiction medicine needs;
- ☐ **Billing and reimbursement** for MAT and addiction medicine services provided.
- ☐ Other (please describe) _____.
- ☐ Other (please describe) _____.
- ☐ Other (please describe) _____.

Demographic and Technical Assistance Needs Questionnaire



Directions

The following *brief* questionnaire will help the Implementation Team understand the type of assistance you may need to implement the Rural Access to Medication Assisted Treatment (MAT) in Pennsylvania Project (Project RAMP). Please know that your answers will be kept confidential and not shared with any other members of the Project RAMP team outside of the Implementation Team. We will also share with you how the results of your practice's survey compare with other practices in your system. Further, we will provide you with an interpretation of the results so that the results can be used to support MAT implementation.

Please begin by providing the following information:

Site: _____

Site Contact Lead: _____

Site Contact Lead Phone: _____

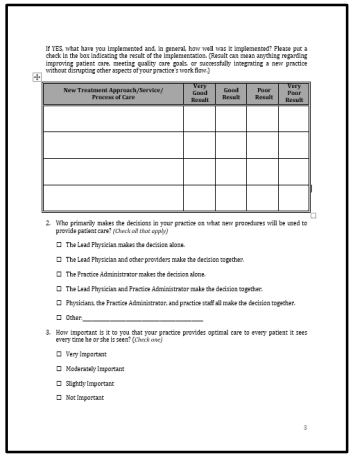
Site Contact Lead Email: _____

Please answer the following questions to the best of your ability.

1. Has your practice had experience in the **last three years** with implementing *any* new treatment approach or a new process of providing care (not necessarily related to addiction treatment or care)?

☐ No

☐ Yes



If YES, what have you implemented and, in general, how well was it implemented? Please put a check in the box indicating the result of the implementation. (Result can mean anything regarding improving patient care, meeting quality care goals, or successfully integrating a new practice without disrupting other aspects of your practice's work flow.)

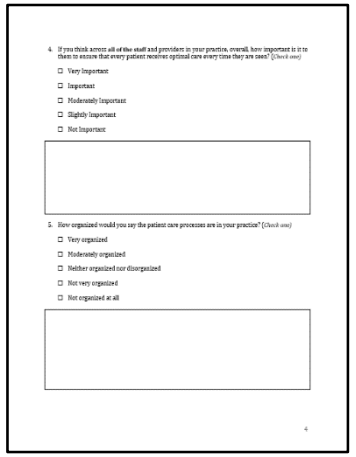
New Treatment Approach/Service/ Process of Care	Very Good Result	Good Result	Poor Result	Very Poor Result

2. Who primarily makes the decisions in your practice on what new procedures will be used to provide patient care? *(Check all that apply)*

- ☐ The Lead Physician makes the decision alone.
- ☐ The Lead Physician and other providers make the decision together.
- ☐ The Practice Administrator makes the decision alone.
- ☐ The Lead Physician and Practice Administrator make the decision together.
- ☐ Physicians, the Practice Administrator, and practice staff all make the decision together.
- ☐ Other _____

3. How important is it to you that your practice provides optimal care to every patient it sees every time he or she is seen? *(Check one)*

- ☐ Very Important
- ☐ Moderately Important
- ☐ Slightly Important
- ☐ Not Important

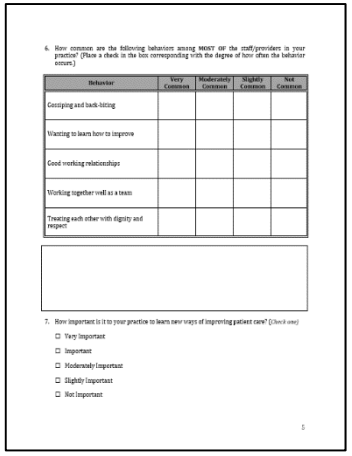


4. If you think across all of the staff and providers in your practice, overall, how important is it to them to ensure that every patient receives optimal care every time they are seen? *(Check one)*

- ☐ Very Important
- ☐ Important
- ☐ Moderately Important
- ☐ Slightly Important
- ☐ Not Important

5. How organized would you say the patient care processes are in your practice? *(Check one)*

- ☐ Very organized
- ☐ Moderately organized
- ☐ Neither organized nor disorganized
- ☐ Not very organized
- ☐ Not organized at all

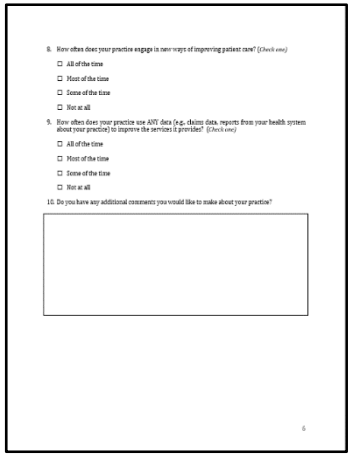


6. How common are the following behaviors among **MOST OF** the staff/providers in your practice? (Place a check in the box corresponding with the degree of how often the behavior occurs.)

Behavior	Very Common	Moderately Common	Slightly Common	Not Common
Gossiping and back-biting				
Wanting to learn how to improve				
Good working relationships				
Working together well as a team				
Treating each other with dignity and respect				

7. How important is it to your practice to learn new ways of improving patient care? *(Check one)*

- ☐ Very Important
- ☐ Important
- ☐ Moderately Important
- ☐ Slightly Important
- ☐ Not Important



8. How often does your practice engage in new ways of improving patient care? *(Check one)*

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Not at all

9. How often does your practice use ANY data (e.g., claims data, reports from your health system about your practice) to improve the services it provides? *(Check one)*

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Not at all

10. Do you have any additional comments you would like to make about your practice?

Organizational Health Questionnaire

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Organizational Structure: Present Options During Implementation

Recruited practice sites can participate in one of four ways:

1. Site performs **all aspects of MOUD and patient monitoring**;

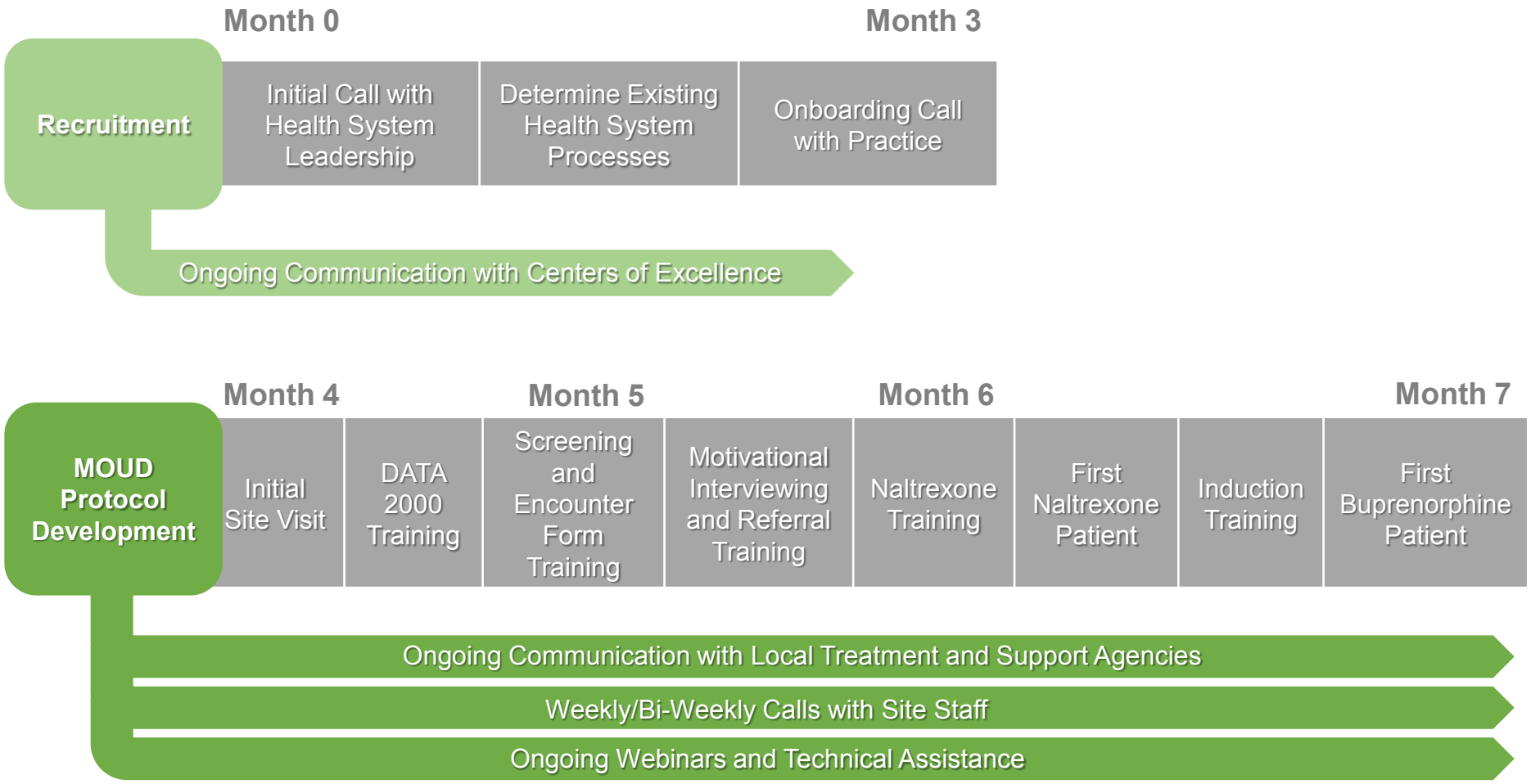
2. Site performs all aspects of MOUD, and **patient monitoring is referred to community partners**;

3. Site screens and assesses patients for MOUD need and **refers patients to "hubs" for induction and monitoring** while **accepting patients back for maintenance**; and

4. Site screens and assesses patient for MOUD need **and refers to "hub" for induction, monitoring, and maintenance.**

External Learning: Tailor Training Plans and Protocols

Example Timeline for Provider Implementing SBIRT, Naltrexone, and Buprenorphine Treatment:



As of **September 2019**, the following groups have been trained on MOUD:

- **36** Physicians;
- **17** Advanced Practice Providers; and
- **121** Clinical and Administrative Staff.

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External Learning: Obtain Quantitative Feedback

Sites provide feedback throughout the protocol development and training implementation process.

All trainings are evaluated using a 5-point Likert scale.
Scale values range from Strongly Disagree (1) to Strongly Agree (5).

Trainee Level of Agreement (n = 115)		
Statement about the training	**Mean**	**Mode**
Trainer was knowledgeable in subject	4.59	5
Trainer was prepared for the session	4.57	5
Information was presented in an engaging way	4.54	5
Training content was relevant to your job	4.64	5
Training enhanced your knowledge of the subject	4.57	5
This sample of evaluation data includes trainee ratings from nine trainings at six sites. These trainings were on topics related to MOUD and SBIRT.		

External Learning: Obtain Qualitative Feedback

Qualitative data is gathered throughout the training implementation process.

Data sources include **training evaluations**, **formal evaluation interviews**, and **feedback during the TA process.**

1. **Trainers**
   - "Trainers were very knowledgeable, and the training was very informative. I am new to this field and it was very helpful."
   - "Trainer was very knowledgeable and presented the information well. This is my first MI training and feel I learned a lot."
   - "They are enthusiastic, and you can tell they enjoy their work."

2. **Training Content & Delivery**
   - "I am new to this field, so this training was very informative and engaging. I learned a lot and this training helped to make terminology clearer to me and gain a better understanding of MAT."
   - "The overview was concise and informative, particularly regarding understanding of types of MAT."

3. **Resources**
   - "Good visuals & pocket reference was a great addition."
   - "POLAR*S tool was helpful and I can use as a guide."
   - "[I liked the] sample screening forms."

Internal Learning: Develop Site-Specific Protocols Using Lean Rules in Use

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Medication Assisted Treatment Protocol

University of Pittsburgh
School of Pharmacy
Program Evaluation and Research Unit
Updated: December 2018

University of Pittsburgh

Table of Contents

A. Assessment and Diagnosis of Opioid Use Disorder

A.1 Screening Patients for Harmful Drug and Alcohol Use

The following are directions for how to screen patients for drug and alcohol use, score screens to assess risk level, and diagnose Opioid Use Disorder (OUD).

A Note on Who Should Be Screened

The following patients should be screened for hazardous and harmful drug and alcohol use.

1. ***NEW PATIENTS***
2. ***PATIENTS WHO HAVE NOT BEEN SCREENED IN A YEAR***
3. ***PATIENTS SUSPECTED OF DRUG OR ALCOHOL MISUSE***

A.1.1 Administering the Drug Use Questionnaire/Alcohol Use Questionnaire

1. The office or medical assistant (OA/MA) will provide the patient with the *Drug Use Questionnaire/Alcohol Use Questionnaire* at check-in with any other documentation.
2. The OA will explain the following:

   "We are integrating a new process into the practice where we screen all patients at least once a year. This is just so that we can provide better healthcare. Your answers to these questions will remain confidential."
3. The patient will complete the questionnaire while waiting for his/her appointment.
4. Proceed to **A.2.**

A.1.2 Scoring the Drug Use Questionnaire/Alcohol Use Questionnaire

1. The Licensed Practical Nurse or Registered Nurse (LPN/RN) will collect the questionnaires when she/he brings the patient back to the exam room.
2. The LPN/RN will record the responses to the initial questionnaire in the patient's EHR.
3. The LPN/RN will note the scores calculated through the EHR.
   a. If the patient answered YES for the drug use question and is at a low risk for alcohol use **OR** answered YES for the drug use question and is at a hazardous, harmful, or dependent risk level for alcohol use, proceed to **A.1.3.**
   b. If the patient answered NO for the drug use question and is at a low risk for alcohol use **OR** answered NO for the drug use question and is at a hazardous, harmful, or dependent risk level for alcohol use, proceed to **A.1.5.**

   b. If the patient has at least three withdrawal symptoms at moderate to strong levels, proceed to step 2.
2. The patient takes the dose they ended the day prior with + 2 mg (e.g., 10 mg + 2 mg = 12 mg).
3. The patient determines if they are in withdrawal 1-2 hours later.
   a. If the patient is not experiencing at least three withdrawal symptoms at moderate to strong levels, they should not take any more buprenorphine on Day 3. Proceed to step 5.
   b. If the patient is experiencing at least three withdrawal symptoms at moderate to strong levels, they record these symptoms and take 2 mg of buprenorphine.
4. The patient records the final stabilized dose on the *Home Induction Worksheet.*
5. The patient calls the office. The provider writes a prescription for the stabilized dose that will last until the next in-office follow-up appointment.
6. Proceed to E.3 Stabilization and Maintenance

A Note on Dosing

Most patients will experience relief from withdrawal symptoms without sedation when taking between 4 and 24 mg of buprenorphine. Studies show little added benefit for doses above 24 mg. Many insurances limit dose to no more than 16 mg daily and require prior authorization for higher doses.

Many patients will be stabilized by day two.

E.3 Stabilization and Maintenance

1. Once the patient is stabilized, the provider writes a prescription for two or three days' worth of buprenorphine medication at the stable dose.
2. The provider/nurse conducts routine laboratory testing according to the following chart:

	Pre-Treatment	One-Month Post Treatment Initiation	3-Months Post	6-Months Post	Annually	Special Circumstances
Urine Drug and Alcohol Test	X					At each office appt during first month of treatment and random tests after
Pregnancy Test	X					Before induction and as clinically indicated
Liver Function Test	X	X	X	X	X	
Hepatitis B & C Tests	X				X	
HIV Tests	X				X	Every 6-months for at risk groups
CBC Test	X				X	
Chem 14 Panel	X				X	
RPR	X					

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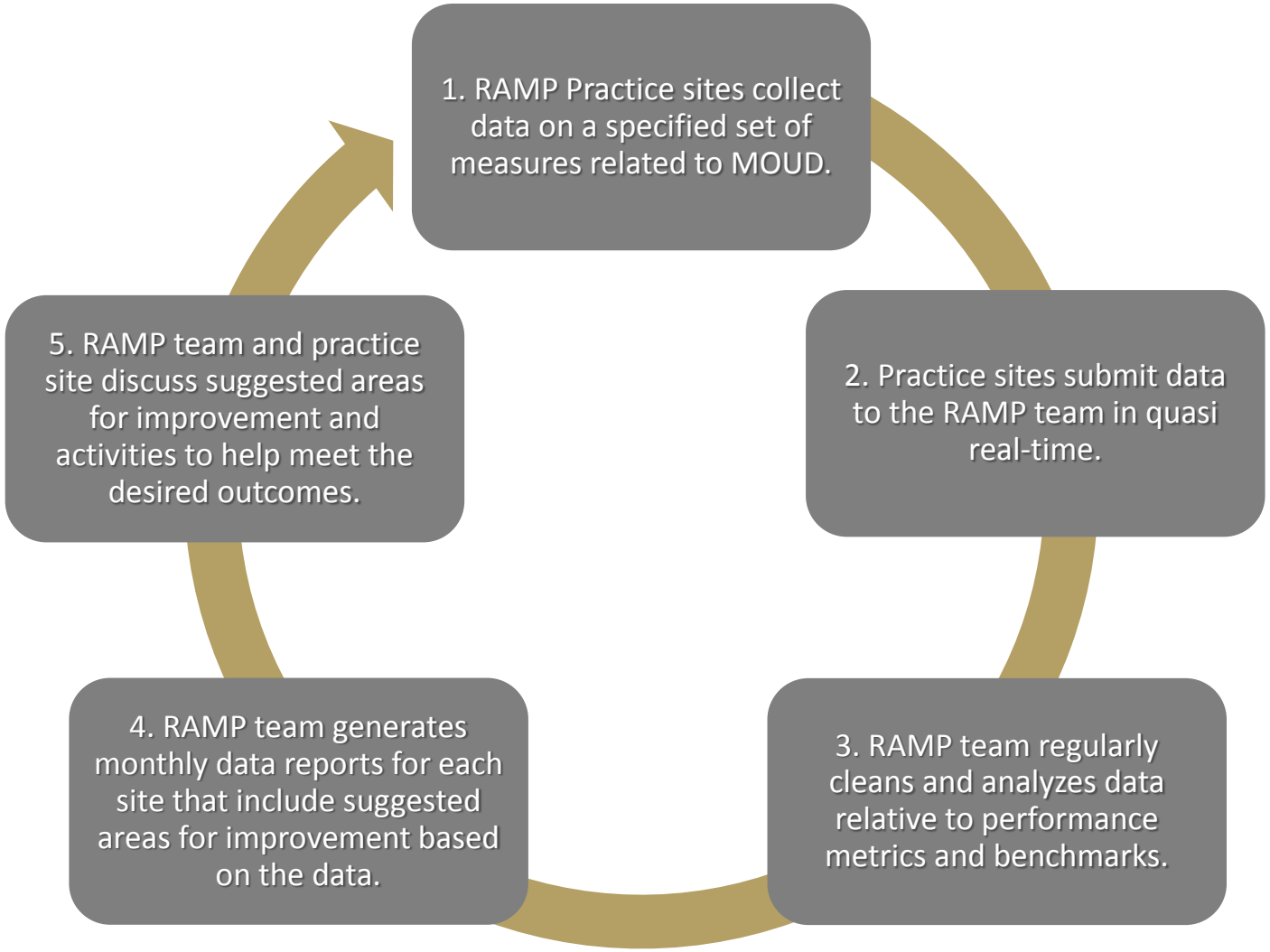
Performance Measurement: Perform Continuous Quality Improvement (CQI) Cycles



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Performance Measurement: Develop Audience-Specific Monthly Data Reports

RAMP DATA REPORT: JULY 2019

REPORT SUMMARY

- Net **increase of three active patients** from previous month;
- **75%** of June patients returned for treatment in July;
- ***Health System 2*** **"went live" with MAT** and reported initiating treatment with two patients (Table 1);
- *Health System 1* fell short of patient engagement with SUD Treatment benchmark but **improved from the previous month** (Figure 1);
- *Health System 3* and *Health System 4* providers **exceeded all RAMP monthly benchmarks** (Figures 3 & 5);
- All buprenorphine patients were prescribed daily maintenance doses **within clinically recommended ranges**, with the majority between 8-12 mg per day (Figure 7);
- **22% of naltrexone patients** active since 1/1/19 have had **continuous treatment** through 7/31/19 (i.e., received injections without any gaps) (Figure 8); and
- **Two of five discharges** during the month were due to **patient choice** (Figure 10).

PATIENT PANEL

27 Total active patients
15 Naltrexone
12 Buprenorphine
18 Patients returning from last month (18/24; 75%)
13 Practices reporting treatment data

RAMP HEALTH SYSTEM MONTHLY UPDATES

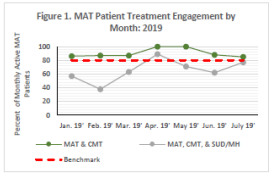
Table 1. MAT Continuous Quality Improvement (CQI) Phase Health Systems

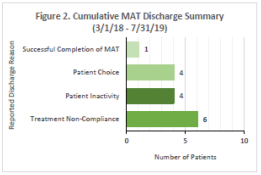
Health System	MAT Patient Count		Days between Patient Contact	Recent Achievements
	Active	Returning		
Health System 1	9	6/8 (75%)	27 days	• Mailed naltrexone treatment brochures for the waiting room to help increase the number of patients initiating MAT. • Mailed copies of screening tools and screening interpretation guidance to improve screening rate.
Health System 2	2	--	--	• Practices "went live" with MAT this month and have reported two patients thus far. • Developed data collection tools/protocol for conducting CQI efforts moving forward and provided on-site training to leadership and key personnel.
Health System 3	12	8/12 (67%)	12 days	• Developed and implemented new internal MAT tracking system to collect performance data on additional outcomes and further CQI efforts. • Conducted remote webinar training on MAT protocol and CQI for new staff.
Health System 4	6	4/4 (100%)	26.5 days	• Conducted conference call to introduce new staff at local drug and alcohol commission to Project RAMP and scheduled in-person training on RAMP protocol and processes to help improve coordination of care with case management and drug and alcohol counseling.

1

PATIENT ENGAGEMENT WITH TREATMENT

HEALTH SYSTEM 1





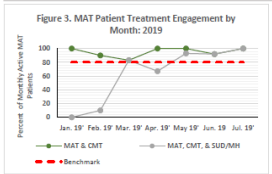
Monthly Benchmarks: Patient SUD treatment engagement benchmark was not met this month; however, patient CMT and MAT benchmarks were met.

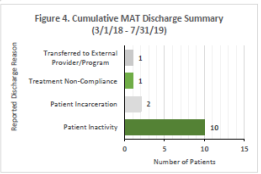
Areas for Improvement: SUD treatment engagement rate and non-compliance and inactivity discharge rates.

Monthly QI Goal: Exceed 80% CMT/SUD engagement benchmark in August.

Actions: The RAMP Team will liaise with the local drug and alcohol commission to follow up more frequently with patients who have not consistently engaged with SUD counseling.

HEALTH SYSTEM 3





Monthly Benchmarks: All monthly benchmarks were met this month.

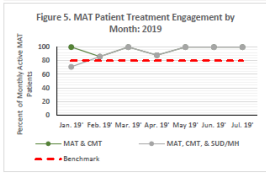
Areas for Improvement: Month-to-month retention, long-term retention, and inactivity discharge rate.

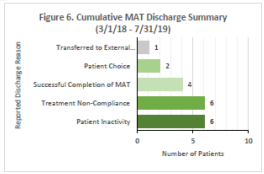
Monthly QI Goal: Increase month-to-month retention rate so at least 75% of July MAT patients return for treatment in August.

Actions: The RAMP Team will increase contact with the providers and case manager by providing a weekly update of patients who have not returned for MAT so they can focus their follow-up efforts on these patients.

2

HEALTH SYSTEM 4





Monthly Benchmarks: All monthly benchmarks were met.

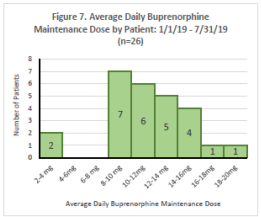
Areas for Improvement: Small and stagnant number of MAT patients, high non-compliance and inactivity discharge rates.

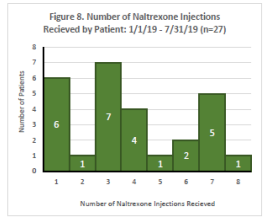
Monthly QI Goal: Increase number of patients accessing MAT with these providers.

Actions: The RAMP team will work with the local drug and alcohol commission to discuss increasing referrals to these providers.

The RAMP team will also continue to engage participating practices about buprenorphine implementation strategies and available support including RAMP online and in-person trainings.

PHARMACOTHERAPY



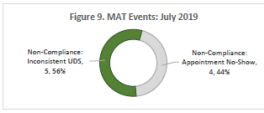


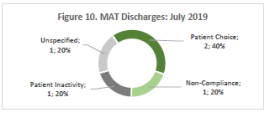
NOTES:

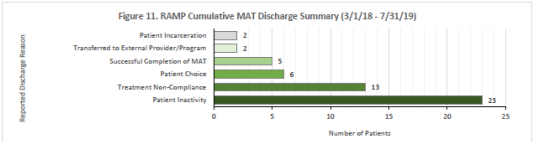
- The figures above utilize treatment data from distinct patients (have an assigned RAMP ID) within the timeframe. The total number of distinct patients is represented by "n".
- The majority of RAMP buprenorphine patients are prescribed a daily maintenance dose between 8-16 mg, consistent with current literature and ASAM prescribing guidelines. The largest sub-group of buprenorphine patients are prescribed 8-10 mg daily (7 patients, 27%).
- For naltrexone patients active from 1/1/19 – 7/31/19, 22% (6 patients) have received 7 injections or more. These patients have had "continuous" treatment since 1/1/19 as defined by clinical guidelines of administering injections every 28-30 days.

3

MAT EVENTS AND DISCHARGES







NOTES:

- Of the nine MAT events who were active in July, one patient had an inconsistent UDS and two appointment no-shows, possibly indicating the patient is at risk for discontinuing treatment.
- Of the five MAT discharges in July, two were patient choice discharges (40%).
- Patient inactivity discharges (>60 days without any services or contact) and treatment non-compliance discharges comprise most of the reported RAMP MAT discharges.

ACTIONS:

- The RAMP team will increase feedback to MAT sites regarding monthly MAT events and discharges to ensure every patient is connected with the appropriate treatment and services.
- The RAMP team will review patient engagement strategies for engaging patients who are at risk of treatment discontinuation (e.g., those with multiple missed appointments or consecutive inconsistent urine drug screen results) with MAT providers and case management teams.

4

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Objective 4.

Conclusions and Discussion: Lessons Learned During Recruitment and Implementation of Project RAMP

Implementation Summary

The STF and Project RAMP IF may be useful to other programs with similar goals to Project RAMP to overcome recruitment and implementation barriers.

Project RAMP Implementation Summary	
Total Number of Recruited Practices:	**27**
Total Number of Primary Care Practices with Naltrexone and/or Buprenorphine Implemented Through Project RAMP:	**24**
Number of Practices In-Training with RAMP for Naltrexone and/or Buprenorphine implementation:	**3**
Number of RAMP Practices with Naltrexone Implemented:	**24**
Number of RAMP Providers Administering Naltrexone:	**27**
Number of RAMP Practices with Buprenorphine Implemented:	**19**

Patient Treatment Summary

The STF and Project RAMP IF may be useful to other programs with similar goals to Project RAMP to overcome recruitment and implementation barriers.

Project RAMP Treatment Data Summary: March 2018 – September 2019	
Patient Type	**Number of Patients**
Total Naltrexone Patients	**98**
Total Buprenorphine Patients	**273**
Total MAT Patients	**371***
*Total patient counts likely underreported due to limitations of provider-collected encounter-based data collection.	

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Lessons Learned and Conclusions

Utilize the Systems Transformation Framework: Utilize the levers of the STF to align stakeholders towards a common vision and guide MOUD implementation planning, execution, and evaluation.

Provide concierge technical assistance: Provide ongoing and data-informed individualized assistance to sites both telephonically and via site visits.

Perform real-time data collection and CQI: Teach practice sites how to collect data in quasi-real-time and develop individualized data reports that include progress towards benchmarks with suggested areas of improvement.

Develop individualized training and education: Tailor training and education to the needs and structure of each individual practice site.

Lessons Learned and Conclusions (Cont.)

Provide ample time for training and implementation: Time requirements for recruitment, training, and implementation of MOUD vary drastically between health systems, practice sites, and communities.

Provide access to tele-consultation: Provide a “warm line” to an expert in MOUD and/or MH to offer treatment support to each practice site.

Offer various models of MOUD: Provide various models of MOUD to increase the probability that providers and practice staff will engage in MOUD service provision.

Identify and link practice sites to community supports to assist providers and their patients: Identify local community supports to increase long-term engagement in MOUD service provision by decreasing administrative and clinical burdens on the practice site.

Questions?

Thank You!

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