INTEGRATING MEDICATIONS FOR ADDICTION TREATMENT IN PRIMARY CARE – *Opioid Use Disorder Version* [IMAT-PC-OUD]

An Index of Capability at the Organizational/Clinic Level

IMAT-PC INDEX

Use this document if you'd like to *print out* the assessment and have team members complete drafts separately before completing the final version together as a group. **The final submission of your assessment should be the excel worksheet.**

DIMENSION 1: INFRASTRUCTURE						
		1 NI	2	3 PI	4	5 FI
1	**Senior organizational and clinic leadership, including CEO, CMO, board and medical directors strongly support providers prescribing medications for OUD in this clinic site**	No overt strong leadership support demonstrated at either the agency or clinic site level		Strong clinic level leadership support for prescribing medications for OUD but not from senior agency leadership		Strong and overt support for prescribing medications for OUD at the agency and clinic levels
2	**Medical record and releases of information are privacy compliant with HIPAA and 42CFR regulations**	Our clinic has either not resolved or does not fully understand HIPAA and 42CFR regulations		Our clinic has developed some workarounds to address 42CFR regulations		Our clinic has clear policies to access, exchange and release patient information within HIPAA and 42CFR compliance
3	**Insurers cover medical consultations and visits for medication management of OUD or medical services are covered by bundled contractual rates**	No provider services are covered by any insurance		Some provider services are covered, or all provider services are covered by some insurers		All reasonable provider services are covered for insured patients
4	**Insurers cover medications for OUD (buprenorphine and naltrexone IM) or medications are covered by bundled contractual rates**	No OUD medications are covered by any insurance		One OUD medication is covered, or both OUD medications are covered by some insurers		Both OUD medications are covered for insured patients
5	**Insurers cover behavioral health services**	No behavioral health services are covered by any insurance		Some behavioral health services are covered, or all behavioral health services are covered by some insurers		All behavioral health services are covered for insured patients

DIMENSION 2: CLINIC CULTURE AND ENVIRONMENT						
		1 NI	2	3 PI	4	5 FI
1	**All clinic staff accept and welcome equally persons with OUD—no evidence for stigma or discrimination**	Most clinic staff, both clinical and non-clinical, negatively perceive persons with OUD and are reluctant to accept and welcome them		There is variation in clinic staff members' acceptance and empathy for persons with OUD but overall there is acceptance and welcome		Clinic-wide, there is broad-based acceptance and welcome of patients with OUD and for providing medication services to them
2	**Open display and distribution of patient informational materials about OUD and medications for OUD in common areas and exam rooms**	No OUD informational materials for patients are visible in common spaces		OUD informational materials exist and are distributed to patients and family members as needed		OUD informational materials are visible in common areas (waiting and exam rooms)
3	**Patients and services are visibly integrated in general clinic spaces and in routine operations**	Patients receiving medications for OUD are not typically permitted in the clinic		Patients receiving medications for OUD obtain these services on designated days and times where patients without OUD are not scheduled, or in a location separate from general clinic practice		Patients receiving medications for OUD are scheduled for and receive services at times when patients without OUD are scheduled, and in spaces available in the general clinic practice
4	**All clinic staff believe offering medications for OUD to patients in this clinic setting is appropriate**	Most clinic staff believe that offering medications for OUD in this clinic site is inappropriate		There is variability among staff in their beliefs about the appropriateness of offering medications for OUD in this clinic site		Clinic-wide, there is broad staff consensus that offering medications for OUD is appropriate at this clinic site
DIMENSION 3: PATIENT IDENTIFICATION AND INITIATING CARE						
		1 NI	2	3 PI	4	5 FI
1	**All new and existing patients are screened using a standardized universal measure for opioid use risk**	No standardized measure or set of questions is used		A set of questions about substance use issues is routinely used		A standardized and validated universal screen (e.g. TAPS, NIDA Quick Screen, DAST) is used with all new and annual visits
2	**All patients who screen positive receive a standardized indicated assessment and, if positive, an OUD diagnosis is made and documented**	No standardized measure is used, and documentation of OUD diagnosis varies		No formal standardized measure is used but OUD diagnosis is routinely documented		A standardized indicated screen (e.g. DSM5 checklist) is used to support documentation of an OUD diagnosis

DIMENSION 3: PATIENT IDENTIFICATION AND INITIATING CARE (Continued)						
		1 NI	2	3 PI	4	5 FI
3	**All patients seen at this clinic site on dosages of >90 mg of morphine equivalents (MMEs) for >3 months to manage chronic non-cancer pain, are reviewed and evaluated for potential OUD diagnosis and appropriateness for buprenorphine**	No review or audit of patients on >90 MMEs occurs in our site		Review of >90 MME doses is performed by individual providers and medications for OUD are offered in some cases		There is a policy for pain management that addresses MME dosing; It articulates options for tapering and alternative treatments that include medications for OUD
4	**A protocol for identification, diagnosis and treatment initiation exists for conditions commonly comorbid with OUD including other *substance use disorders***	No protocol exists for addressing other substance use disorders (e.g. alcohol, stimulants, cannabis, benzodiazepines)		Patients with OUD are assessed for other substance use problems upon initiating care and/or throughout the course of treatment		A protocol exists for screening, diagnosis, treatment planning and monitoring for other substance use disorders in addition to OUD
5	**A protocol for identification, diagnosis and treatment initiation exists for conditions commonly comorbid with OUD including *other psychiatric disorders* such as depression, anxiety, PTSD or other mental health problems**	No protocol exists for addressing other psychiatric disorders (e.g. depression, anxiety, PTSD, bipolar disorder)		Patients with OUD and in MAT are assessed for other mental health problems upon initiating care and/or throughout the course of treatment		A protocol exists for screening, diagnosis, treatment planning and monitoring for other psychiatric disorders in addition to OUD
6	**A protocol for identification, diagnosis and treatment initiation exists for conditions commonly comorbid with OUD including *HIV and HCV***	No protocol exists for addressing risk of presence of infectious disease (e.g. HIV, HCV, STD)		Patients with OUD and in MAT are assessed for infectious disease upon initiating care and/or throughout the course of treatment		A protocol exists for screening, risk assessment & patient education, diagnosis, treatment planning and monitoring for infectious disease
7	**For patients diagnosed with OUD, the prescription drug monitoring program (PDMP) is queried**	PDMP is not routinely queried		PDMP is queried but variably		PDMP is queried on all new OUD cases before initiating medications for OUD
8	**For patients diagnosed with OUD, a point-of-care toxicology test is performed, i.e. urine drug screen (UDS) with built-in and/or rapid on-site immunoassay testing**	Toxicology tests are not routinely performed		Toxicology test are inconsistently performed		Point-of-care toxicology tests are consistently performed with all new OUD cases before initiating medications for OUD

DIMENSION 3: PATIENT IDENTIFICATION AND INITIATING CARE (Continued)						
		1 NI	2	3 PI	4	5 FI
9	**Patients with OUD are presented with clear treatment options, patient preferences are discussed, and a shared decision-making approach used**	Patients with OUD have no options for medications for OUD within this clinic site		Patients with OUD have 2 options (1 medication or no medication), and these are carefully reviewed		Patients with OUD have options for 2 medications within the clinic and other medications outside (methadone) or no medication. The pros, cons and preferences are reviewed, and a collaborative care plan chosen.
10	**Criteria for offering medications for OUD in the clinic are clear, they are documented in policy, patient information sheets/brochures and consent forms, and they are highly inclusive**	Patients with OUD have no options for medications for OUD within this clinic site		Criteria for offering medications for OUD are individual, provider driven and exclude patients with other substance use, history of diversion or non-adherence or other perceived risks		Criteria for offering medications for OUD are documented and transparent; Criteria are focused on initiating care to reduce risk of overdose death and engage patients in care
11	**Three components are performed for all patients using medications for OUD: Withdrawal symptoms are evaluated, side effects are discussed, and comfort medications to treat opioid withdrawal are made available**	None of the 3 components (withdrawal symptom evaluation, medications for OUD side effect review, comfort medications offered) are performed		2 of the 3 components (withdrawal symptom evaluation, medications for OUD side effect review, medications to treat opioid withdrawal offered) are routinely performed		All 3 components are performed (withdrawal symptom evaluation, medications for OUD side effect review, medications to treat opioid withdrawal offered) by protocol and include standardized measures and procedures (e.g. COWS; SOWs; patient informational materials; standard withdrawal medications)
12	**Patients choosing medications for OUD, either buprenorphine or naltrexone long acting injection, can be started on medication within 72 hours**	No patients typically are started on medications for OUD within 72 hours		The care process and review of all clinical information may take longer for some patients; Most are started within 72 hours		Protocol to initiate medications for OUD at first visit is in place
13	**Clinic has a patient treatment agreement document that describes expectations for clinic and patients on medications for OUD**	No formal document exists		No clinic-wide documents exists but individual providers use their own		The clinic has a standard patient treatment agreement document

14	**Using a protocol clear to both staff and patients, eligible patients can start the medication either in-home or in-office**	No provision exists for patients to start medications for OUD in-home or in-office; patients are started elsewhere and referred to us once stabilized		Protocol exists for starting medication in-office only		Protocol exists for starting medication either in-home or in-office and the approach is clear to staff and transparent to patients
DIMENSION 4: CARE DELIVERY AND TREATMENT RESPONSE MONITORING						
		1 NI	**2**	**3 PI**	**4**	**5 FI**
1	**Patients started on medications for OUD have at least 1 follow-up visit within 14 days (2 weeks)**	Follow-up visit after patients are started on medications for OUD are individually determined		Some patients are scheduled and/or attend first follow-up visit beyond 2 weeks; but most make this visit within 2 weeks		All patients are scheduled for at least 1 follow-up visit after starting medications for OUD; those who do not attend receive outreach
2	**Patients started on MAT have at least 2 follow-up visits within 30 days (1 month)**	Follow-up visits after patients are started on medications for OUD are individually determined		Some patients are scheduled or attend 2 follow-up visits beyond 1 month; but most make these visits within the 1st month		All patients are scheduled for at least 4 follow-up visits after starting MAT; those who do not attend receive outreach
3	**Ongoing toxicology testing, i.e. urine drug screen (UDS), is performed at least monthly, at random, and observed**	Toxicology testing is not performed once patients have started medications for OUD		Toxicology testing is performed at least monthly, but not at random or observed		Toxicology testing is performed at least monthly and at random; procedures for direct observation exist
4	**The prescription drug monitoring program (PDMP) is queried at least bi-monthly**	PDMP is not queried once patients have started medications for OUD		PDMP is queried at least bi-monthly at time of visit in many but not all cases		PDMP is queried at least bi-monthly at time of visit in all cases by protocol
5	**A protocol exists for random pill or film counts for patients prescribed buprenorphine**	Pill or film counts do not occur once patients are prescribed buprenorphine		Medication counts occur variably or "for cause" once patients are prescribed buprenorphine		PMDP is queried at least bi-monthly at time of visit in all cases by protocol
6	**A protocol exists, based on treatment response—including toxicology results and patient report of functioning—to adjust dose, frequency of visits and toxicological monitoring**	There is no standard protocol to adjust medications for OUD based on response		Clinical judgment is used to adjust dose, frequency of visits, and toxicology testing approach		A systematic and protocol-driven approach (e.g. OBOT Stability Index) is used to adjust dose, frequency of visits and toxicology testing approach

DIMENSION 4: CARE DELIVERY AND TREATMENT RESPONSE MONITORING (Continued)						
		1 NI	2	3 PI	4	5 FI
7	**A systematic approach (e.g. ASAM criteria), is used to assess patient functioning and social determinants; this approach supports treatment planning which may include additional physical or behavioral health services either within this clinic site or offered in another setting**	No specific approach is used to evaluate patient functioning and social risk factors; No specific approach is used to guide linkage to additional services		Clinical judgment is used to evaluate patient functioning and social risk factors, and to guide linkage to additional services		A systematic and protocol-driven approach (e.g. ASAM criteria) is used to evaluate patient functioning and social risk factors, and to guide linkage to additional services
8	**A systematic approach, such as the ASAM criteria or Treatment Needs Questionnaire, is used to determine need for a more intensive level of care (residential, hospital) or setting (methadone clinic)**	No specific approach is used to determine need for a more intensive level of care or setting		Clinical judgment is used to determine need for a more intensive level of care or setting		A systematic and protocol-driven approach (e.g. Treatment Needs Questionnaire) is used to determine need for a more intensive level of care or setting
9	**Patients are neither encouraged nor required to taper or discontinue the medication after a certain period of time or once stabilized or with improved functioning**	Once patients are detoxified from opioids and stable on medications for OUD we initiate the process of tapering		Patients who are stable on medications for OUD for at least 6 months and are functioning well are encouraged to consider tapering from medication		Medications for OUD are used as a stabilization and maintenance approach; patients continue on medications with positive response, including those who are stable and with improving functioning
10	**Six-month retention rates of patient panel on medications for OUD are tracked to examine this clinic site's processes**	No retention data are tracked		Informally the clinic examines retention and attrition rates and refines clinical processes based on perceived trends		Six-month retention data are routinely gathered and used to refine clinical protocols and processes

DIMENSION 5: CARE COORDINATION						
		1 NI	2	3 PI	4	5 FI
1	**The practice uses a team-based care approach to manage patients treated with medications for OUD; team members may include providers, nursing, behavioral health, and pharmacist; and with clearly defined, written roles and responsibilities for each member of the team**	No elements of a team-based care approach; provider delivers most aspects of treatment using medications for OUD with some nursing support		Some elements of a team-based care approach with prescribers and clinical staff working collaboratively; meetings, huddles, role-specific workflow for new and established patient visits		Many elements of a team-based care approach with an egalitarian model, individuals working to top of scope, and cohesive collaboration on patient care; meetings, huddles, role-specific workflow for new and established patient visits; and written roles and responsibilities for each member of the team
2	**A registry of patients on medications for OUD is used to track patient attendance, visit planning and treatment response**	No registry of patients on medications for OUD		Some aspects of tracking panel of patients on medications for OUD are in place: Patient list, set of tasks per visit, outreach criteria; not integrated in electronic health record or population health dashboard		Registry of patients on OUD medications used to systematically track patient attendance, visit planning and measuring treatment response; integrated with electronic health record and population health dashboard
3	**With the most common health care and social service partners, the practice has memoranda of understanding, agreements or clear understanding of methods to coordinate care, accept referrals (e.g. ED), refer or link patients with specialists (e.g. addiction, psychiatry, ID) or services (e.g. DCFS, probation and parole)**	No formal relationships with other health and social service agencies commonly involved in supporting patients with OUD		Some formal and some informal relationships with health and social service agencies commonly involved in supporting patients with OUD		Well-coordinated network of agreements, shared documentation, and practical definitions for referral appropriateness and care coordination
4	**The clinic has a HIPAA and 42CFR compliant set of forms to exchange or release clinical information with patient consent**	Clinic focuses on HIPAA compliance only		Clinic has policy to manage 42CFR information along with HIPAA rules		Clinic and organization has legal counsel documentation supporting clear policy on HIPAA and 42CFR regulations
5	**An outreach procedure exists for patients who have not made appointments or about whom there is clinical concern (phone or home visit)**	No outreach procedure exists		Some effort to contact patients of concern occurs but not standardized		Standard protocol for outreach to specific patients based on agreed upon criteria

DIMENSION 5: CARE COORDINATION (Continued)						
		1 NI	2	3 PI	4	5 FI
6	**Clinic leadership engages in regular meetings with other organizations in the geographic region (patient centered medical neighborhood) to troubleshoot, improve communication and strengthen the network of care**	No regular meetings with community coalition or other health and social service agencies		Some formal and informal meetings with other health and social service agencies commonly involved with patients in the medications for OUD practice; some sense of shared mission across patients and organizational boundaries		Well-coordinated network of organizations represented by leadership and key frontline personnel, with shared mission of improving communication and strengthening the network in the community
DIMENSION 6: WORKFORCE						
		1 NI	2	3 PI	4	5 FI
1	**X-waivered prescriber(s) onsite to prescribe medications for OUD**	No x-waivered prescribers on site		X-waivered prescribers are on site and prescribing to a few patients in total (<10)		X-waivered prescribers are on site and prescribing to a larger number of patients (>30)
2	**Nursing or pharmacist personnel are onsite to manage medications for OUD and nursing related needs of patients; a nurse or pharmacist care manager model is used to perform activities during patient visits either in individual or group formats; there is coordination of care with other health care providers; patient and family education is provided**	No nursing or pharmacist personnel involved in the medications for OUD program		Nursing and/or pharmacist personnel perform some activities during patient visits but they are not key team members		Nurse or pharmacist care manager model—nurse and/or pharmacist conduct visits, coordinate care in and outside the clinic, manage registry, educate patients and families, and are key team members
3	**Licensed behavioral health clinician(s) with credentials in both mental health AND addiction assessment and treatment are onsite; have expertise to conduct evaluations, individual, group and family/couples therapies; there is expertise in integrated behavioral health and in team based primary care; either individual behavioral health clinicians have expertise in both mental health and addiction OR two or more clinicians have combined expertise**	No onsite behavioral health clinician(s) are involved in the medications for OUD program		Onsite behavioral health clinician(s) perform some activities but is/are not a key team member(s); expert in mental health OR addiction assessment and treatment but not both; some expertise in primary care settings		Integrated behavioral health clinician(s) with expertise in primary care settings, expertise in both mental health AND addiction assessment and treatment approaches, and evidence-based understanding of medications for OUD

DIMENSION 6: WORKFORCE (Continued)						
		1 NI	2	3 PI	4	5 FI
4	**Staff or volunteer affiliation with peer recovery support group network (e.g. NA, AA, MA, Al-Anon) to educate and connect patients on medications for OUD and their support persons to these resources**	No connections with peer recovery support groups in the community		Informal efforts by some clinical staff to link patients on medications for OUD with peer recovery support groups in the community; some interventions focused on locating and preparing patients for meetings		Purposeful effort, including by key clinical staff or volunteers in recovery, to connect patients and their support persons to, and affiliation with, peer recovery support groups in the community
5	**Administrative support to manage registry, coordination of care, liaison with other agencies, and funders**	No non-clinical administrative support for the medications for OUD program		Administrative non-clinical support for financial activities including billing, budget monitoring and grant management		Administrative non-clinical support for financial activities plus patient registry maintenance, coordination of care, and liaison with other agencies
DIMENSION 7: STAFF TRAINING AND DEVELOPMENT						
		1 NI	2	3 PI	4	5 FI
1	**X-waivered providers/prescribers and other clinicians are actively involved in CME or equivalent continuing education and other advanced learning opportunities focused on medications for OUD, addiction and integrated behavioral health care**	X-waivered providers/prescribers and other clinicians are minimally active in advanced learning opportunities, and hide x-waiver listing from SAMHSA directory		X-waivered providers/prescribers and other clinicians are active in advanced learning opportunities, maintaining good clinical practice		X-waivered prescribers and other clinicians are active and sometimes lead advanced learning opportunities; on mission to scale up medications for OUD in their organization and field
2	**All non-clinical staff, including administrative and support personnel, have basic training in substance use disorders and their treatment**	No organized training program for non-clinical staff members on substance use		Optional and/or informal program to train non-clinical staff about substance use disorders and their treatment		Systematic and required onboarding and/or annual training program for non-clinical staff about substance use disorders and their treatment
3	**All staff (clinical and non-clinical) have completed training in empathy and stigma reduction for persons with substance use disorders**	No organized training program for all staff members in empathy and stigma reduction for persons with substance use disorders		Optional and/or informal training for all staff members in empathy and stigma reduction for persons with substance use disorders		Systematic and required onboarding and/or annual training program for all staff members in empathy and stigma reduction for persons with substance use disorders