Office-Based Opioid Treatment (OBOT) Planning List

The purpose of this planning list is to provide Nevada's Federally Qualified Health Centers (FQHCs) with a framework to assist in planning, developing, and implementing effective medication for addiction treatment (MAT) programs. The planning list identifies specific areas of consideration for clinic administrators and clinical champions; provides background information on each of these points of consideration; and, when applicable, links to relevant resources that can be utilized or adapted. Understanding that each FQHC is at a different stage of program implementation and will have different resources and staffing compositions, this tool identifies critical decision points and describes an array of approaches and strategies from which FQHCs can choose to best suit their individual needs and resources.

This tool is divided into the following sections:

Look for this icon to find relevant resources available to you on the SharePoint site: Nevada Medications for Addiction Treatment (MAT) FQHC Resource Site. The number next to the star can be used to locate the resource by folder and document number.

Section A. Leadership Buy-In and Staff Support

Whether you are just getting started or have an initiative already in place, it is ideal to obtain leadership buy-in prior to initiation of services. In addition, it is critical that front-line staff understand the decision around offering these services and recognize that buy-in must be obtained early.

 2.02 MAT Implementation Checklist

- **Administration and leadership:**
  - Identify opportunities for offering education to organizational leadership and/or the board of directors so that they understand the need for opioid use disorder (OUD) treatment services among the FQHC population, MAT services that will be offered, the evidence base for MAT services, and the financial and human resources needed to develop an evidence-based, sustainable program.
    - » FQHC leaders may need to consider giving clinical leaders and champions additional time to complete further training and develop the program. It is important that FQHC leadership give champions sufficient time to develop and implement the program; for example, by providing a temporary reduction in clinical duties.
  - Determine how decisions will be made and communicated to the board of directors.
  - Ensure that leadership supports the delivery of these services prior to their implementation.
  - Ensure that the board of directors supports the delivery of these services prior to their implementation.
- **Front line staff:**
  - Identify opportunities for offering education to medical providers, behavioral health (BH) clinicians, and all support staff to describe the need for OUD treatment services among the FQHC population, the MAT services that will be offered, the evidence base for MAT services, and the potential broader benefit to the community.
  - Give providers, BH clinicians, and all support staff the opportunity to ask questions and raise concerns.
  - Determine additional staff educational needs prior to rolling out services.
  - Identify the implementation champion(s) early, and engage these champions throughout the planning process.
  - Determine how decisions will be made and communicated to the clinicians and staff as the program is implemented.

Section B. Program Model

A variety of primary care-based MAT program models have been implemented and studied. FQHCs will need to consider existing staffing models, clinic structures and workflows, and payer requirements when determining the program model they will implement. Often, the program model will evolve over time as volume and demand increase.

1.04 Primary Care Based Models for OUD

Health Home Versus Open Access

- **Health home model:** Patients receive all services through one organization (primary care, psychiatry, MAT). Patients seeking to receive MAT services at your organization will be asked to reassign their primary care to your site.
- **Open access**: Patients maintain primary care/psychiatry/BH at outside facilities, and care is coordinated with those entities.

Primary Care Integration Versus Separate MAT Clinics

- **Primary care integration:** Services are integrated within the existing primary care clinic. For example, a medical provider will have general primary care visits and MAT visits during the same clinic session, and the typical expectation is that both primary care and addiction treatment will be offered during the same visit.
- **Separate MAT clinics:** MAT clinic visits are offered on certain days/times so that primary care providers have dedicated slots or sessions specifically for MAT services. This model is sometimes utilized when BH staffing is available only on certain days/times to allow for more integrated services.
- **Hybrid model:** Dedicated MAT clinic sessions are utilized for patient intakes and early stabilization on medication. As patients are stabilized on dose and visit frequency is reduced, patients transition to “normal” primary care sessions. The general concept with the hybrid model is that there are more comprehensive wrap-around services available in the MAT clinic sessions, and as patients need fewer services, they can be transitioned into the general primary care sessions. This type of model is sometimes referred to as a “hub and spoke.” If a patient destabilizes, then they are able to be referred back to the MAT clinic sessions, where they can receive additional supports and resources.
- **Important considerations:**
  - U.S. Health Resources and Services Administration (HRSA) reporting requirements for Uniform Data System (UDS)—For example, if blood pressure and diabetes metrics are reported for all patients, how will using an open-access model impact these measures?

- Payer requirements for billing—Will your health center be able to bill for MAT services if a patient is not assigned to your practice for primary care services?
- Provider panel size and ability to absorb new MAT patients within existing primary care sessions.
- Space/staffing needs to accommodate intake, medication initiation, and integrated BH support (if available) within existing primary care sessions.
- Productivity associated with primary care and MAT sessions.

Section C. Behavioral Health Services

Most patients with OUD will benefit from having access to behavioral counseling services. Not all patients will be ready or willing to engage in counseling; but when possible, services should be recommended and facilitated. While patients should be offered BH services, those services must not be mandated in order to receive medication for addiction treatment. BH services can be offered either on-site or through external referrals. Options for BH service delivery are described below.

1.01 Medications for Opioid Use Disorder Save Lives

1.03 Medications for Opioid Use Disorder (SAMHSA TIP 63)

3.05 SAMHSA Sample Decision Tree for Behavioral Health Referrals

On-Site Behavioral Health: Integration Versus Co-Location

- **Integrated model of care:** BH support (individual or group services) is delivered within a team-based model of care, and services are billed and documented as part of a shared record. In practice, this model often includes regular BH-primary care huddles, and patients often see the BH provider and medical provider sequentially in the same day.
- **Co-located model of care:** Services are offered within the same space; however documentation may not be integrated, and communication about patient care and treatment planning is less formalized.

1.05 Standard Framework for Levels of Integrated Care

Formal Referral for Counseling Services *or Access to Higher Levels of Care*

- External referral for counseling services should be utilized when:
  - The organization does not have BH staffing or when the demand for services is higher than the internal capacity.

  - Patients need more frequent visits, greater structure, or more support than your health center can provide. When available, primary-care based MAT programs should work to develop partnerships for referrals with opioid treatment programs (programs that dispense methadone) or with licensed addiction treatment programs that offer outpatient, intensive outpatient, and residential treatment services.

- When identifying partnerships for external counselling services or higher levels of care, the following should be considered:
  - The mission of the external partner and its alignment with the mission of your organization.
  - Awareness of any program requirements for patient intake and treatment initiation. For example, is a state ID required? Does the partner accept uninsured patients? Are there costs associated with any treatment services?
  - Development of 42 CFR-compliant release forms to allow for bi-directional sharing of relevant health information.
- Creation of a formal relationship through a memorandum of understanding/business associates agreement.
  - Establishment of processes at both organizations to develop and maintain collaboration and coordination of care across the two organizations.

5.01 Sharing information Across Physical and Behavioral Health

5.02 Disclosures of Substance Use Disorder Patient Records

Psychiatry Access

- Many patients with OUD have co-occurring mental illnesses. While depression and anxiety can often be managed in primary care settings, individuals with bipolar disorder, schizophrenia, or refractory major depressive disorder and anxiety may benefit from psychiatric assessment and management. When possible, it is important to consider psychiatry access for patients engaged in the MAT program. See Section D below for more details.

Section D. Workforce

MAT programs in FQHCs can have different staffing mixes to effectively meet the needs of their patients. Think about your organization and what key staff need to be involved. You may also need to consider which positions are able to provide billable services when considering the program's long-term sustainability. The sub-sections below outline the credentials of staff who may be involved in OBOT programs.

Medical Prescribers

- Currently, physicians, nurse practitioners (NPs), physician assistants (PAs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and certified nurse-midwifes (CNMs) can obtain a waiver to prescribe buprenorphine. Physicians need eight hours of training, and NPs, PAs, CNSs, CRNAs, and CNMs need 24 hours of training to be eligible to apply for the DATA2000 treatment waiver. When identifying prescribers, remember to:
  - Check whether your state has additional requirements with regard to NP and PA prescribing of buprenorphine. Examples of additional state requirements for NPs and PAs could include a requirement that the collaborating physician also must hold a DATA waiver.
  - Ensure the organization has at least two prescribers with waivers to guarantee back-up coverage for vacations or unexpected leave.
  - Consider anticipated demand for services. Most waivered prescribers start with a 30-patient limit, although if they work in a setting that meets all requirements, they may be able to qualify for a 100-patient limit.

     1.06 Waiver Application Information
  - Consider provider-level mix to maximize patient care and long-term financial feasibility.

     6.12 Provider Clinical Support System (PCSS)

Psychiatric Services

- Establish external referral partnerships if needed. Identify who will coordinate ongoing communication and collaborative treatment planning with external partners.
- If staff psychiatrists/psychiatric advanced practice nurses (psych APNs) are not waivered, consider how care delivery will be shared between the psychiatric provider and the waivered clinician.
- If appropriate and available, create a role for waivered psychiatrists or psych APNs to treat patients with co-occurring disorders. Because psychiatric services often are limited in these settings, consider which patients should see a psychiatric provider for MAT maintenance.

Behavioral Health Support

- Potential BH staff can include:
  - Licensed clinical social worker (LCSW)/ licensed clinical professional counselor (LCPC)/ psychologist (PsyD)—Can provide counseling on mental health conditions. Some, but not all, have specific training in addiction. It is important to consider whether existing

LCSW/LCPC/PsyDs will need additional/ongoing training in addiction before delivering services.

- Licensed social worker (LSW)/ License professional counselor (LPC)—Can provide the same services as their clinically licensed counterparts but must bill under a clinically licensed preceptor.
  - Not all states allow for this. Consider the financial implications of a mix of qualified/clinically licensed mental health professionals and other licensed staff.
  - If choosing a mixed clinically licensed staff and other licensed staff model, consider the implications relative to administrative needs for precepting of notes and required supervision of staff.
- Certified Alcohol and Drug Counselor (CADC)/Alcohol and Other Drug Counselor (AODC)—Can provide counseling specific to addiction but not to mental health conditions.

- Off-site counseling—If BH counseling services will be provided off-site, consider how collaboration and coordination of care will be managed. See Section C, Formal Referral Relationships for Counseling Services, for more information.

3.05 SAMHSA Sample Decision Tree for Behavioral Health Referrals

Additional Support Services:

- Recovery support/peer support specialists with personal histories of substance use disorder can provide peer support. In many systems, these individuals also provide case management services.
  - These services are typically non-revenue generating under an FQHC model.
  - Consider whether your state has alternative licensing that will allow for revenue generation associated with these services.

Case Management and Care Coordination:

- Most programs have at least one additional staff member who acts as a central point of contact and serves to support the administrative functioning and psychoeducation needs of the program by providing prior authorizations, overdose education, care coordination with outside facilities, and follow-up and check-in calls. These roles also can be divided among team members. As a program expands, this role will be critical to help support the program and provider. Often, this role is filled by a registered nurse and/or LSW care manager, care coordinator/case manager, or medical assistant.

Section E. External Collaboration and Partnerships

There are several key external partnerships that can improve care delivery and efficiency. Below, we list key partners with whom to consider establishing formal collaborations.

Pharmacy Partnerships

- Local pharmacy partnerships can reduce the likelihood that there are medication dispensing delays (for example, due to inadequate stocking or insurance barriers) and help ensure that your patients have positive experiences when interacting with pharmacy staff. Before you begin to see patients:
  - Identify trusted pharmacy partners who will work with you and your patients when prior authorizations are needed or when other challenges arise (e.g., pharmacy benefit lock-ins).
  - Ask the pharmacy to stock commonly prescribed doses/formulations of buprenorphine, XR naltrexone, and naloxone. This will help the pharmacies become familiar with medications and prescribing requirements.
  - Offer education to the partner pharmacies to help them understand that patients can go into withdrawal if they must wait several days for medication to be available.
- If your system participates in a 340B drug pricing program, work to ensure that low-income patients without insurance have access to medications through this program. In states with Medicaid Managed Care Organizations, participating in this program also can provide the health center's long-term financial viability.

Laboratory Services

- Most OBOT programs will utilize both in-house rapid (Clinical Laboratory Improvement Amendments [CLIA]-certified) urine toxicology testing in addition to confirmatory toxicology testing that is typically sent out through a lab vendor. In addition, blood work is recommended early in treatment and intermittently thereafter. It is important to identify which labs are available through existing supply and lab relationships.

  

  6.05 Use of Drug Testing

- **In-house testing:** Keep in mind the following factors when identifying a CLIA-certified rapid urine toxicology test that can be interpreted in the office:
  - Determine which drugs are commonly used in your area and ensure those are captured on the toxicology test.
  - Ensure buprenorphine is included.

  - Note that for FQHCs or other clinics being paid a set rate per visit, rapid drug screening provided by the health center will probably be a non-reimbursable cost. When feasible and appropriate, work with the onsite lab to utilize its rapid screening options. If none exist, determine the operational cost of offering rapid testing on-site and factor this into decisions around when and how the rapid tests are utilized.

- **Confirmatory and quantification testing:** Identify a lab vendor for send-out toxicology testing that will be able to offer confirmatory testing as well as quantification testing (often urine, but could also include saliva testing). Confirmatory testing is typically utilized for buprenorphine and will usually include a quantitative value and confirm the presence of the breakdown product of norbuprenorphine. Additional testing for other substances may be ordered for confirmatory testing when the rapid drug screen is inconsistent with the patient report (for example, the patient reports no other substance use, but the test is positive and the provider must determine if the test represents a false positive). Key considerations when selecting a test include:
  - Determining which drugs are commonly used in your area and ensuring those are captured on the toxicology test selected.
  - Ensuring buprenorphine quantification with confirmatory breakdown product norbuprenorphine is included and/or available as a separate test.
  - Determining which tests are covered by common payers (some are very expensive, so it is important to talk to a lab vendor to ensure that the test you are selecting is typically covered by your most common payers—i.e., Medicaid)

    
    6.06 ASAM Drug Testing Pocket Guide

Hospitals and Other Non-Clinical Partners

- As health systems increase access to MAT, it is important to identify community partners who may come into contact with individuals with OUD who would be good candidates for MAT. Partnerships and referral mechanisms can be developed to help ensure that patients who qualify for services are referred and can efficiently receive the MAT services. Below are examples of potential community partners:
  - **Emergency departments:** Ideally, providers in an emergency department will initiate buprenorphine and offer a prescription that lasts until the patient visit in your clinic, but referrals can be made without medication initiation. Information on emergency department-initiated treatment can be found here.

    
    6.13 ED Bridge-Emergency Department Initiation of MOUD
  - **Homeless shelters:** Approximately 50% of people experiencing homelessness have a substance use disorder, and homeless shelters can be good referral sources and partners.

- **Local addiction treatment providers:** Many treatment providers offer counseling services but do not have capacity to offer medication for OUD treatment.

Local Community Mental Health Providers

- Many community mental health programs work with patients with co-occurring OUD but do not have capacity to offer medication for OUD treatment.
  - **Drug courts:** Drug courts work with people who have opioid and other substance use disorders who are being referred to treatment in lieu of incarceration. In cases in which drug courts refer patients, be careful to ensure that clinical findings are not shared with the drug court unless you have explicit patient consent.
  - **Community partners:** Long-term recovery relies on the stabilization of other social factors including housing, food access, employment/income stability, and criminal legal involvement. Consider establishing partnerships with community-based organizations that:
    - Help train and place individuals in recovery—particularly those with previous criminal legal involvement—into employment services
    - Provide recovery homes, long-term housing supports, and resources
    - Assist with disability applications when appropriate
    - Assist with applications for various entitlement programs
    - Serve as area food pantries or urban farms that access Supplemental Nutrition Assistance Program (SNAP) and other benefits
    - Act as medical legal partners, including those that can help expunge criminal or drug offense records

Section F. Workflows, Policies, and Protocols

Organizations should create workflows, policies, and procedures to provide guidance to staff during care delivery. Workflows should describe the process from the point of initial request for services through initiation of treatment and long-term maintenance, including each team member's responsibility for each component of the process. Development of policies and protocols will ensure compliance with applicable regulations and will help provide staff with clear guidance in the course of daily operations.

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3.03 MSHC MAT Sample Workflow Program Design-patient phases

Workflows

- A non-comprehensive list of suggested workflows is described below.
  - **MAT referral workflow:** Describes how internal and external referrals for MAT will be managed to ensure efficient access to care.

    3.02 MSHC Sample MAT Workflow for Referral
  - **Intake assessment workflow:** Describes the specific staff members responsible for conducting different parts of the intake assessment and the tool(s) they will use.
  - **Medication initiation workflow:** Describes the process for initiating buprenorphine (in office or at home).

    3.04 Buprenorphine Home Initiation Versus Office Initiation Considerations
  - **State prescription drug monitoring program workflow:** Ensures that a process is in place to support the regular use of the state's prescription drug monitoring program by providers.
  - **Overdose prevention education and naloxone prescription/distribution workflow:** This also may include any on-site safety measures your organization has implemented to prevent on-site overdoses (e.g., Naloxone in emergency boxes or Naloxone emergency kits in high trafficked restrooms)

    6.07 Naloxone Distribution in Nevada

    8.06 Opioid Safety and How to Use Naloxone

    8.05 Naloxone Prescribing Resources

Policies, Protocols, and Consents:

- A non-comprehensive list of policies and protocols that are useful for a new OBOT program to consider follows.
  - **Program eligibility:**
    - Inclusion and exclusion criteria for program (note: very few medical exclusion criteria exist for buprenorphine; primarily only documented allergy to the medication).

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    - Identification of any priority patient groups (e.g., pregnant women or people leaving incarceration).
  - **Consent for treatment:** A form that is signed at the point of initiating care at the health center and renewed annually, this document should outline the patient's consent to care (as applicable, would include consent to primary care, mental health, and addiction

treatment services). In integrated care settings, it is particularly important to review the patient consent forms for treatment to ensure that the patient understands and agrees to receive primary care, that BH charts notes are combined, and that the primary care team can review substance use disorder treatment notes and vice versa.

5.04 Elica Sample Combined Intake and Consent Form

- **Patient treatment agreement** (also sometimes called informed consent): This document is reviewed with a patient at the time of initiating MAT services and focuses on the expectations of the patient and the clinic around medication management. This form is typically signed by the patient and a staff member at the time of treatment initiation.

  4.06 MSHC Sample MAT Treatment Agreement Buprenorphine

  4.04 Heartland Sample Treatment Agreement Buprenorphine

- **Policy for management of late and missed appointments,** including how bridge prescriptions will be managed.

  7.02 Heartland Sample Late Arrival Policy

- **Policy for after-hours coverage:** Since not all who cover a call will be familiar with buprenorphine treatment.
- **Policy for cross-coverage** when the primary prescriber is out of the office and/or when the patient misses a visit and must see another prescriber.
- **Treatment adherence policies**
  - Policies for addressing situations where patients report lost or stolen medications.

    7.06 BMC Sample Lost, Stolen, or Destroyed Buprenorphine Policy

  - Urine drug screening policies.

    7.03 ASAM Sample Office-Based OUD Policy

    7.01 Heartland Sample Urine Drug Testing

    7.05 BMC Sample Urine Toxicology Policy

  - Medication refill policies.
- **Medication storage policies** if medications will be kept on-site.

  7A.04 How to Prepare for a DEA Inspection

- **Outreach and engagement protocol** for when patients have missed visits or are lost to care.

- **DATA waiver patient limit monitoring protocol** to allow the clinic to monitor the number of active patients each prescriber is treating *(each prescriber will have a limit to the number of patients they can treat at one time—30, 100, or 275).* Typically, these systems can be set up in the electronic health record (EHR), but they should be tracked on a regular basis to ensure that no one goes above limit.
- **Patient Identification Card:** This is optional but can be helpful, as patients can show this to ER providers, dental providers, and other providers to advise that they are on buprenorphine (which is a partial agonist). Some patients also must show a patient identification card if they are stopped by police and are carrying medication.

Section G. Patient Education Materials

Patient education should be integrated into all patient-provider communications. Standardized patient education materials can help to ensure that all patients receive consistent information.

- **Treatment options for OUD:** It is important that clinical teams describe the available treatment options and answer any patient questions about treatment options. If a patient chooses another treatment not offered at your health center (e.g., methadone), clinic staff should support linkage to that treatment program when possible.

  8.01 Three Medication Comparison Guide

- **Buprenorphine administration description:** Comparison Information regarding the medication options available; instructions on how to take the medication being prescribed; overdose recognition and response information; and information to help patients understand treatment options, how to take medications, where to find supports and services, and harm-reduction strategies including overdose identification, response, and naloxone administration.

  8.02 Guide to Taking Suboxone

  8.03 Starting Buprenorphine Outside of Clinic

- **Overdose recognition and response:** All patients with OUD should receive information on overdose recognition and response. When possible, naloxone should be dispensed from the clinic or, at a minimum, a prescription should be written. Friends and family of the patient should be encouraged to obtain and carry naloxone as well.

  8.04 Prescribe to Prevent Patient Education Videos

  8.06 Opioid Safety and How to Use Naloxone

Section H. EHR Consideration and Supports

The EHR can be leveraged to support standardized documentation, program development, and quality assurance processes. Below, we suggest several tools that can be built into the EHR to promote efficient care delivery.

- **Standardized documentation tools** can ensure that the appropriate information is collected at each visit and that there is consistency in documentation across clinicians. Examples include:
  - Standardized fields for intake assessment.
  - Quick texts (sometimes called "dot phrases") to standardize documentation for history of present illness, assessment and plan, and patient education provided at visit.
  - A fillable template with DSM 5 criteria and automated scoring system.
    - » Ensure that problem list has DSM 5 diagnosis of OUD (mild, moderate, severe).
  - If the EHR includes medication "favorites," add buprenorphine/naloxone, extended release naltrexone, and naloxone to these lists to simplify the prescribing process.
  - When possible, add patient treatment agreements as forms that can be printed from the EHR.
  - When possible, add any patient education materials to be printable from the EHR

    

    9.01 Heartland Sample Medical Visit Quick Texts

    9.02 Sample Behavioral Health Quick Texts

    6.01 DSM-5 Criteria for Diagnosis of OUD

- **Monitoring and quality assurance processes**:
  - Create queries that will allow the organization to regularly assess how many active patients each provider has, and ensure that this monitor is monitored regularly.
  - Develop and test any queries that will be necessary for monitoring care quantity or quality that may be required for internal or external (grant) purposes.
- **Locked notes:** Work with compliance to determine which BH notes (if any) need to be "locked" based on the type of consent forms created and whether your organization qualifies as a licensed addiction treatment organization.

Section I. Staff Training

Many clinicians (medical providers, nurses, and BH providers) will have received no formal training in addiction or addiction treatment services. It will be important to acknowledge and support necessary training for clinical teams. In addition, the societal stigma held against people who use drugs also is present in medical settings. To ensure respectful, trauma-informed care, all-staff trainings often are necessary prior to the initiation of services.

- **Buprenorphine waiver training for clinicians:** All medical providers who are planning to prescribe buprenorphine will need to complete an approved course.
  - The 8-hour training is available fully online, via "half and half" training (half in-person and half online), or fully in-person. Many trainings are free, although some in-person trainings do assess fees. Physicians only need to complete the 8-hour training.
  - The remaining 16 hours of training for NPs and PAs is available online and at no charge.
  - Many health systems have nurses and other clinical staff attend the first four hours of the physician waiver training to provide consistent training across all staff.

6.12 Provider Clinical Support Systems (PCSS)

- **Addiction treatment continuing education opportunities:** Various local, regional, national, and web-based educational opportunities specific to addiction treatment are available.
  - Provider Clinical Support Systems (PCSS) is a federally funded education dissemination project that has a variety of free and helpful online resources.
  - MAT providers should be encouraged to use some of their CME time and funding to attend addiction-specific trainings.
- **Health center staff training:** As described in Section A, it is important to provide baseline training for any staff who will be in contact with patients with OUD. Examples of useful trainings include:
  - Introductory training on mental illness and substance use disorders, including prevalence among the local patient population.
  - Training on OUD as a chronic medical condition (including stigma reduction).
  - Information about why the clinic is offering treatment as part of its community response to the opioid epidemic and how these services will benefit the community.
  - Trauma-informed care training.
  - De-escalation training.
  - Workflow-specific trainings for relevant staff.

- **Training and support of interdisciplinary teams:** It is critical that all clinical team members have a clear understanding of individual roles, have time to build a cohesive team structure, and have supported time to work together in developing treatment plans.
- When possible, it can be helpful to offer interdisciplinary trainings for the team.
  - It is important to ensure time for the clinical team to meet and discuss the patient panel regularly. Typically, this is done through a daily huddle or a weekly care management meeting.

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