DEPARTMENT OF HEALTH

Tackling Overdose with Networks (TOWN) Evaluation- Model Implementation and Best Practices

SUMMER 2021 QUALITATIVE INTERVIEW SUMMARY

1/20/2022

TOWN Evaluation Qualitative Interview Summary

Minnesota Department of Health Injury and Violence Prevention Section
85 7th Place East
PO Box 64882
St. Paul, MN 55164-0882
651-201-5443
health.drugodprev@state.mn.us
https://www.health.state.mn.us/communities/opioids/index.html

To obtain this information in a different format, call: 651-201-5443.

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Introduction

Tackling Overdose with Networks (TOWN) is a clinic-based model advocating a multi-strategy approach to reduce opioid overdose through efforts to 1) decrease chronic opioid prescriptions; 2) increase access to Medication for Opioid Use Disorder (MOUD), otherwise referred to as Medicated-Assisted Treatment (MAT); and 3) increase community coordination and prevention efforts. The TOWN grant provides funding and technical assistance to twelve rural clinics across Minnesota. Funding for this work was provided by the Bureau of Justice Assistance Comprehensive Opioid, Stimulant, and Substance Abuse Program (BJA COSSAP), award number 2019-AR-BX-K050 and the Center for Disease Control and Prevention, Overdose Data to Action (OD2A), award number 5NU17CE924985-02-00.

Prior evaluation efforts have documented the success of clinics adopting the TOWN model in decreasing prescription opioid use, increasing the availability of evidence-based treatment for opioid use disorder (OUD), and improving community collaboration to monitor and decrease opioid use and misuse. The current evaluation seeks to continue that work by 1) documenting the impact of the TOWN model on people who misuse opioids, clinic systems, and communities; 2) describing the model as implemented; and 3) identifying resources needed for sustainability. This report describes how clinics implemented the TOWN model, lessons learned for best practices and implications for sustainability, as surfaced through reflective interviews conducted with clinic staff during July and August 2021. Across the twelve TOWN sites, 22 staff participated in an interview, including ten MOUD-waivered physicians/prescribers, ten nurse coordinators, one clinic director, and one pharmacist. At least one person participated from each site. Additional reports in this series describe emergent program outcomes. Future evaluation reports will synthesize data across multiple timepoints.

Key Findings

Nurse coordinators are essential to the initial implementation and ongoing sustainability of the TOWN model. They are the key touchpoint between opioid use disorder (OUD) patients and the clinic, providing patient-centered care and adapting clinic processes to best meet the needs of patients. Clinics that were not able to fill this position or a parallel role struggled with implementing the model.

Building buy-in within the clinic, administration, physicians/prescribers, nursing, and the emergency department is essential for successful implementation of opioid prescription tapering and MOUD efforts. Specific best practices for building buy-in are identified within this report.

Technical assistance provided through individual site visits, sample protocols, and site-specific suggested best practices by Dr. Heather Bell and Dr. Kurt Devine supported implementation. Initial site visits with clinic leadership were critical to building clinic and physician enthusiasm for tapering and MOUD efforts. Staff recommended a technical assistance site visit with facilitating staff (i.e. members of the substance review team, nurse coordinator, waivered physicians/prescribers) to go over the details related to tapering and MOUD best practices early in project implementation. Ongoing annual site visits support troubleshooting

ongoing efforts and provide encouragement, mentorship, education or brainstorming to support clinics into next steps as appropriate for their situation and context. Bimonthly facilitated meetings convene nurse care coordinators across sites to discuss current situations, successes, challenges, and specific cases to build cross-site staff connections.

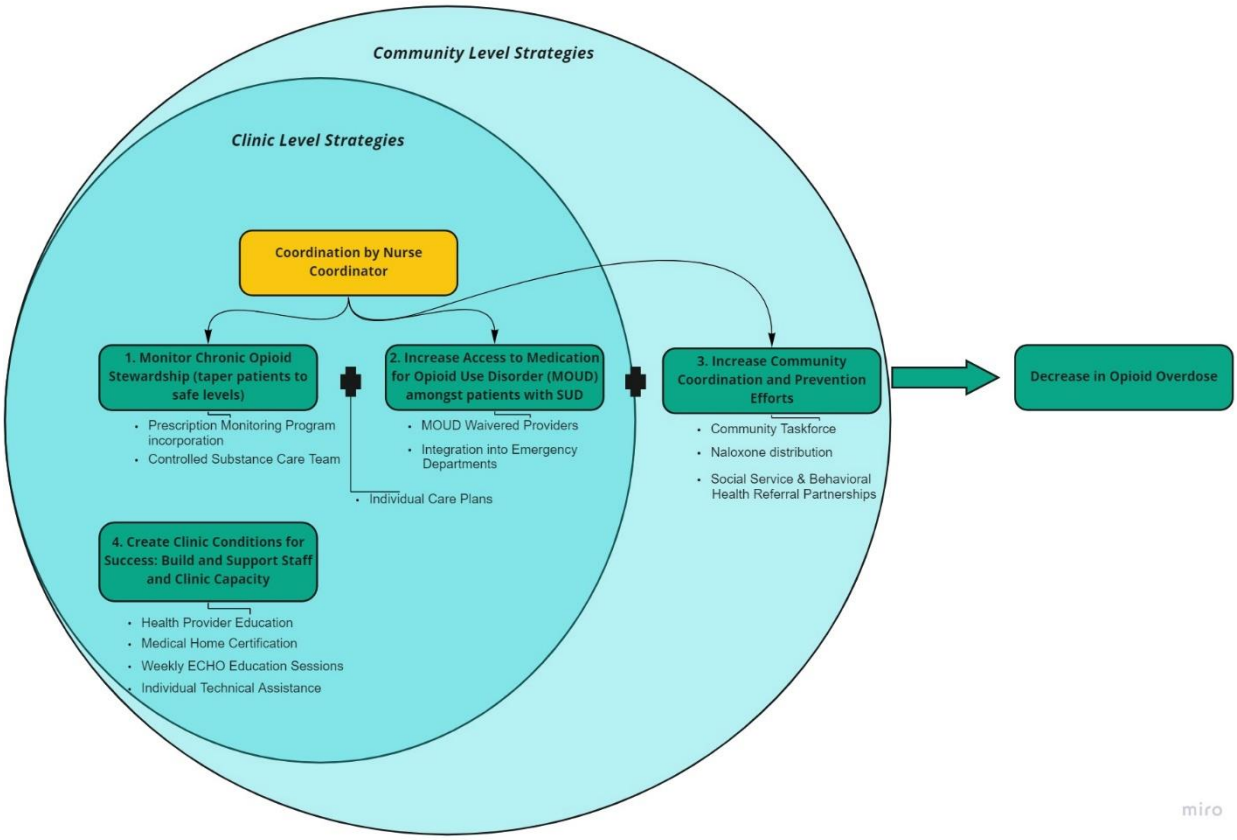
Most clinics **began implementation by encouraging physician MOUD-waivers alongside tapering efforts**. Moving forward, TOWN clinics are largely focused on efforts to integrate MOUD into the ER and expand on community outreach and system coordination in the coming months.

Many of the efforts to implement opioid tapering and MOUD that involve updates to protocols and integration into standard care were described as sustainable without additional funding once implemented. However, the nurse coordinator position and allocated time for physician champions to lead internal education and coaching activities requires ongoing and sustained funding.

Model Description and Implementation

The key strategies recommended in the TOWN model can be organized by their primary objectives: 1. Monitor chronic opioid stewardship by tapering those who have diagnosis appropriate for chronic opioid prescriptions to safe levels, 2. Increase access to Medication for Opioid Use Disorder (MOUD), and 3. Increase community prevention efforts and coordination to respond to people experiencing substance use disorder and/or those who have experienced an overdose. In addition to objectives 1 and 2 that focus on the clinic level, this model also includes specific strategies to 4. Build and support staff and clinic capacity. The strategies related to each objective are described in more detail below.

TOWN Model Strategies



To decrease chronic opioid prescriptions, the TOWN model advocates for the creation of a controlled substance care team and regular utilization of the prescription monitoring program (PMP). To increase access to MOUD, the TOWN model recommends efforts to increase MOUD-waivered providers and integration of MOUD into emergency departments (ED). Individual care plans are an integral component of both key objectives. To increase community coordination and prevention efforts, sites implement community taskforces and establish partnerships with social service and behavioral health providers. Additional intentional efforts build and sustain clinic and staff capacity through individual technical assistance and cross-site Extension for Community Healthcare Outcomes (ECHOs) led by Drs. Bell and Devine alongside encouragement to obtain medical home certification.

In practice, nurse coordinators and 'physician champions' - MOUD-waivered physicians/prescribers within each clinic who are seen as local experts and advocate internally for adoption of best practices - are crucial to the implementation of all objectives and ensure continuity of efforts. Many of the core strategies could not be successfully implemented without a nurse coordinator or parallel role to lead the work. While sites had some variation in the exact job title and background requirements for this position, a dedicated role is necessary to coordinate the components, provide non-judgmental client-centered care, and build community partnerships.

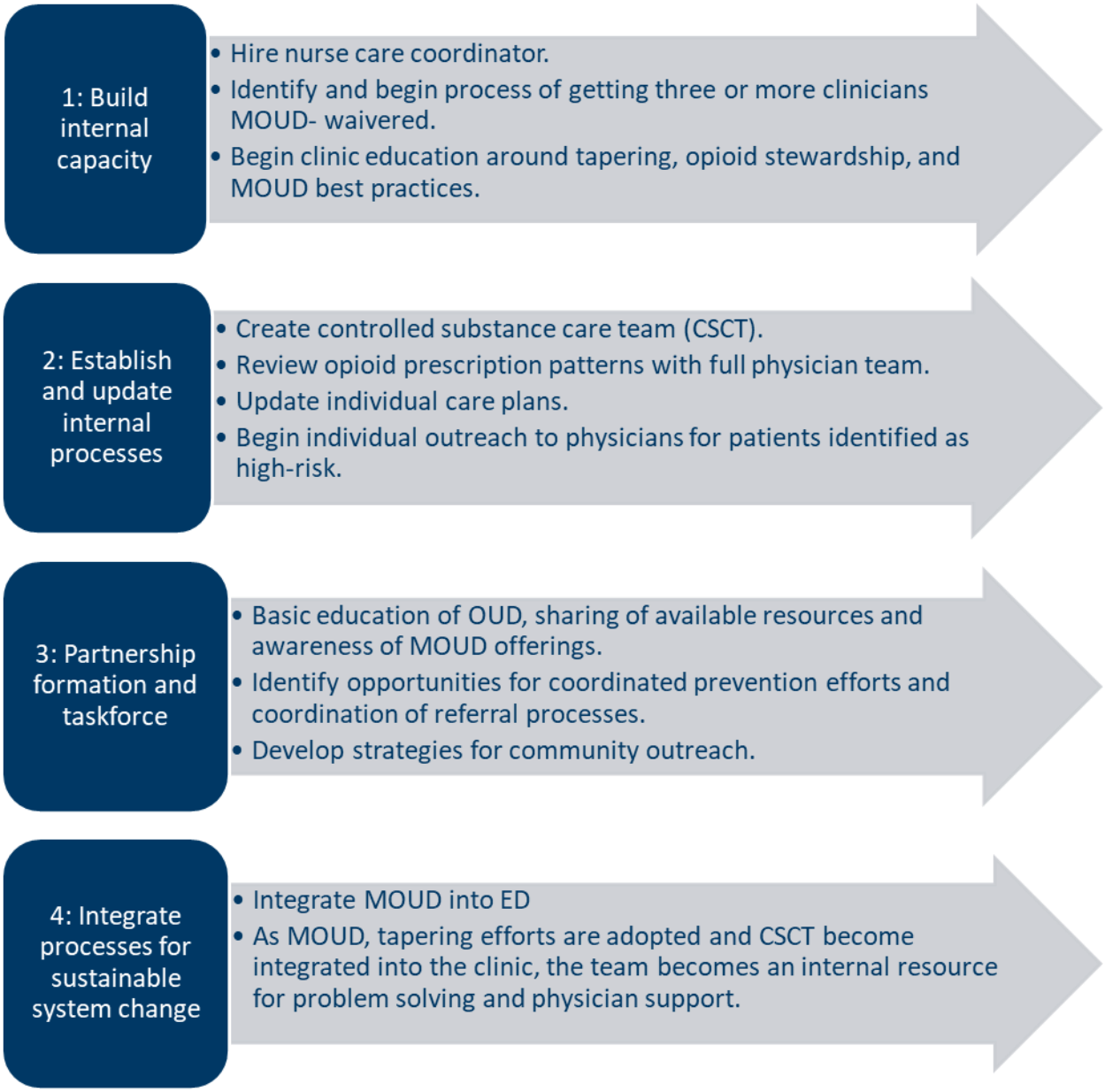
Clinics reported spending the majority of their initial implementation time on internal education to build buy-in for MOUD, promote critical reflection of current opioid prescribing habits, and garner physician commitment to opioid stewardship, appropriate prescribing, and

tapering opioid prescriptions for patients with chronic opioid prescriptions. Both nurse coordinators and physician champions spent significant time providing individual and collective training and support within the clinic team to recognize OUD and build interest in and capacity to utilize MOUD as a resource, as well as the ability to assess for dangerous prescriptions of opioids. Without collective buy-in from leadership, administration, and all roles of the medical team, further implementation of strategies is challenging or impossible.

The Controlled Substance Care Teams, use of Individual Care Plans, and MOUD-waivered physicians/prescribers were highlighted as key TOWN model components to improve actual patient care for chronic opioid prescribed patients and patients with OUD. By beginning immediately with building MOUD capacity, clinics have an internal resource- something concrete to provide- when someone is identified with OUD during tapering efforts. Implementation of the Community Taskforce and Social Service and Behavioral Health partnerships were dependent on clinic and community capacity; however, when implemented they resulted in exciting improvements in community coordination of prevention efforts and continuation of MOUD services during times of patient transition across systems (i.e. beginning or leaving a treatment facility or incarceration). ED integration additionally was described as a critical component, but in most cases, clinics had not yet been able to make significant progress. The PMP and Medical Home Certification, while important, had largely been integrated into clinic practice or achieved previously and was not described as a priority for clinics.

The image below outlines how clinics prioritized implementation of the multi-tiered strategies.

TOWN Model Order of Implementation



Clinics with greater staff capacity implemented priority 2 and priority 3 activities in parallel. Lessons learned and challenges sites encountered to date in enacting each core strategy are summarized below.

MOUD Capacity

Medication for Opioid Use Disorder (MOUD) is the standard of care for treatment of opioid use disorder over abstinence-based treatment as recommended by SAMHSA. MOUD, otherwise known as Medication-Assisted-Therapy (MAT) (https://www.samhsa.gov/medication-assisted-treatment), is a proven method to decrease death, increase retention in treatment, improve birth outcomes for pregnant women with OUD, and increase patient's ability to gain and maintain employment. The FDA has approved buprenorphine, methadone, and naltrexone

based products for the treatment of OUD. The TOWN model recommends buprenorphine (Subutex) or buprenorphine/naloxone (Suboxone) as an available option for patients identified as having OUD and should be initiated immediately upon diagnosis, in response to patient requests, when a patient is found to be in withdrawal or after naloxone administration. While the TOWN model recommends buprenorphine, in compliance with CFR42, patients are informed of all forms of MOUD. At the start of this project, all clinicians were required to complete specialized training and apply for a waiver to be able to prescribe buprenorphine, if the clinician would be prescribing to more than 30 patients. While that is no longer federally required for physicians, training is still recommended for education alongside additional technical assistance on implementation. Methadone distribution can only be done through an authorized treatment clinic (Federally Qualified Opioid Treatment Programs) which is a separate process from a clinician becoming waivered to prescribe buprenorphine; naltrexone can be administered by any provider licensed to prescribe medications.

At the onset of adopting the TOWN model, the physician champion(s) at all sites underwent the process of becoming MOUD-waivered and worked to encourage additional clinicians to also become MOUD-waivered. Additional clinicians varied in their willingness to participate. In most cases, physician champions had to address some form of resistance to encourage additional providers to participate.

As of October 2021, all clinics have at least one MOUD provider; nine sites have three or more. As of the last reporting period, clinics had 44 MOUD-waivered providers, providing MOUD to 516 patients in the last quarter alone (July-September 2021).

In addition to working to encourage clinicians to become MOUD-waived, the nurse coordinator implemented protocols for MOUD patient visits. This includes the more intensive first visit to induce MOUD which takes approximately three hours (time varies based on intensity of withdraw) and utilizes the individual care plan as described below in more detail as well as determining and implementing the process for coordinating ongoing visits within the clinic including onsite drug testing, scheduling, and follow-up. Nurse coordinators are part of most follow up visits with the patient before or after the doctor to maintain care coordination and reinforce trust in the relationship with patients. Nurse coordinators remain connected to patients in between visits through follow-up phone calls and are responsive to patient-initiated requests.

Best Practices & Lessons Learned for Building MOUD Capacity

Three or more waivered clinicians lends stability to the program, even if at small clinics. When many providers are waivered, clinicians can more easily distribute OUD patients across the team. Staff are noticing that with fewer than three waivered providers, the MOUD program is unstable, requiring calls outside of work hours for the waivered clinicians. With fewer than three providers, it is challenging to schedule patients when one provider is on vacation or on leave, and the provider who is waivered is more likely to experience burnout. Staff reported that most waivered clinicians do not want addiction medicine as their primary focus; when MOUD-capacity is shared across providers, each individual clinician is only treating OUD as a portion of their patient population. If there is only a single MOUD provider, the proportion of OUD patients takes up significantly more of their overall time. This in turn poses an additional barrier to other providers becoming waivered as they do not want to take on that level of work.

MOUD integration into clinics requires effort to build buy-in and address misconceptions. Physician champions and nurse coordinators confronted initial resistance to MOUD. Clinicians expressed unwillingness to become waivered or prescribe MOUD based on concerns that prescribing buprenorphine is the same as prescribing opioids, not wanting to recreate the initial problem they contributed to when prescribing opioids in the first place by replacing one drug with another and believing abstinence is the only way. Clinicians expressed concern that patients with OUD are harder to work with and more time intensive than other patients. Physicians/prescribers with more established practices were not interested in expanding their patient list and overall clinicians had concern that MOUD would take over their practice and their time was already limited. Physician champions generally had an easier time convincing newer clinicians who had received MOUD education during residency to integrate MOUD into their practice. Despite these initial hesitancies to become waivered, most sites reported that general education about MOUD was effective at building buy-in and gaining participation.

Staff recommended the following strategies to build buy-in for MOUD:

Encourage standard adoption of OUD screening and showcase MOUD as a best practice to support existing patients.

Staff commonly reported that providers who did not want to become MOUD-waivered expressed concerns that they did not want to start serving the/a OUD patient population, framing patients with OUD as distinctly different than their current patient population. Upon implementing MOUD, many of the first patients were not new patients but rather existing patients who were identified as having OUD. Seeing this helped resistant clinicians recognize the need for MOUD as part of care for their current patients.

Encourage getting a waiver as additional education and not as commitment to regular prescribing.

Some sites found success in encouraging clinicians to pursue getting waivered as a form of additional education without the expectation that they would then have to actively prescribe MOUD. Not all waivered physicians/prescribers at each site are actively prescribing; however, this approach was successful at convincing some physicians/prescribers who were hesitant to eventually prescribe after they understood the science and medicine behind MOUD through the education process.

Demonstrate impact of MOUD on patients and clinician interactions.

Highlighting preliminary data on early patient successes (i.e., ongoing participation in MOUD, reduced recidivism, family reunification or gaining employment), as well as sharing experiences of how patient/clinician interactions became more productive, positive, and less time consuming were identified as key ways to build greater physician buy-in. In this way, clinicians see for themselves how MOUD adds value to the practice.

Frame MOUD as proactive option to prevent overdose and highlight similarities to other diseases.

Staff reported that encouraging the mindset that MOUD was something to offer versus providing nothing and contributing to a potential death was an effective argument for many

providers to at least make a referral to a MAT-waivered physician, if not get waivered themselves.

Clearly articulate administrative or leadership support of this effort.

In the limited cases where physician champions reported not gaining any traction on encouraging participation in MOUD, staff advocated for greater administrative or leadership pressure to support full clinic participation in the TOWN model.

Alongside encouraging providers to become waivered, sites identified the following best practices for the visit itself to **streamline the patient experience and provide non-judgmental patient-centered care**:

Utilize a unique phone number for direct access to nurse coordinator.

Instead of requiring MOUD patients to be routed through a general clinic line to schedule appointments, many sites created a line so patients could access the nurse coordinator directly. This allowed for more personalized care and ensured a positive experience, reinforcing the relationship between the nurse coordinator and the patient. Additionally, as patients in some cases required additional scheduling flexibility and immediate responsiveness than other types of clinic visits, the nurse coordinator was able to fit patients into provider schedules directly and build ongoing trust through responsiveness to patient requests. The direct line also makes patients more comfortable due to their previous experiences being treated poorly when seeking care for substance use and minimizes the potential for stigmatizing treatment.

Utilize texting for patient reminders and follow up.

Likewise, one site in particular noted that gaining patient permission for text-based communication was effective for sending personalized reminders and follow-up in a relational, accessible way.

Integrate MOUD patients into clinic location.

Sites noted that visits were less stigmatizing when MOUD patients were distributed throughout the week, as opposed to trying to schedule all MOUD patients for set apart days or times. This makes identification while waiting for a visit less likely and accommodates the work and life commitments of OUD patients. Having a variety of patients reduces the stigma in the clinic waiting room when OUD patients await their appointment. Flexibility in scheduling within overall clinic hours also reduces barriers for patients to fit an appointment into their work schedule.

Less requirement-based, more optional treatment options.

As compared to other treatment options, MOUD as practiced in the TOWN clinics was noted as unique in that sobriety from all substances was not required for ongoing treatment and program engagement; likewise, a Rule 25 assessment was encouraged but not required. A Rule 25 is a clinical assessment conducted by a Licensed Alcohol and Drug Counselor to determine if a patient is recommended for alcohol or drug treatment and the intensity of treatment. Completing a Rule 25 is often a requirement for beginning various forms of SUD treatment. This flexibility based in a harm-reduction approach was identified by staff as both

a good fit for patients who were not interested in other treatment options or who were not seeking sobriety as well as for patients who had previously completed treatment at more intensive programs and wanted to continue MOUD long term. An accessible care coordinated clinic program is recommended by SAMHSA as equally if not more beneficial than in-patient treatment, as once stabilized, patients do not require the same level of intensity of treatment while enabling patients to re-engage with families, employment, and other community supports (www.samhsa.gov/section-223/care-coordination).

Staff shared the observation that many MOUD patients are used to being treated criminally and have responded positively to the non-judgmental care being provided. While sites do have basic expectations such as not allowing patients to sell medication, multiple sites shared examples of compassionately responding to learning that patients were sharing medication with loved ones by using that as an opportunity to encourage additional people to begin MOUD-treatment versus responding punitively.

Highlighted Challenge

Insurance coverage and medication cost

Multiple sites expressed concern over the costs associated with MOUD, challenges when an insurance provider denies coverage, or costs for patients who are uninsured. In particular, multiple clinics reported running into issues when patients transition out of jail, consequently lose their health insurance and therefore suspend MOUD or are forced to wait to begin MOUD because of not having insurance.

> *"Losing insurance right after you get out of jail has been a problem for some people. They won't come back until they actually have insurance and then they end up using. So we have one guy that will end up, it's happened to him a couple times, then he'll end up back in treatment, then you'll end up back in jail. It's just this cycle." – Nurse Coordinator*

To address this challenge, one clinic worked closely with their primary insurance provider representatives to support quick responsiveness and identify work-arounds when issues arose with medication coverage of medication.

> *"When we've had patients whose insurance has declined suboxone (…) and they can't afford the cost so we've got a direct number to (the insurance representative) and we can call in and she can literally approve it by the push of a button and then it's ready at the pharmacy. I can tell you at least five different times where that's played out where we just needed someone to approve a medicine. Literally just a phone call. 10 minutes later the patient can pick it up and not worry about going through withdrawal or heading back out to the street to buy some more." – Physician*

Controlled Substance Care Teams

The Controlled Substance Care Team (CSCT) is the mechanism to determine if current clinic opioid prescription practices are appropriate. The CSCT is intended to review the chart of each patient that was prescribed a controlled substance. The review includes evaluating the reason

for the initial prescription of opioids or controlled substances, the amount of medication prescribed including morphine milligram equivalents (MME), and other health conditions or prescribed medications that put the patient at higher risk for adverse health outcomes or death related to their opioid prescription. The physician champion's role on the CSCT is to determine the appropriateness of the prescriptions by evaluating previous steps taken to address the underlying health issue, assessing for alternative solutions, reviewing dosages, and making recommendations for next steps for patient treatment, including a tapering plan, if needed. The role of the nurse coordinator on the CSCT is to gather all necessary information needed to complete this review and support creation of a tapering plan if determined necessary.

In practice, all sites described implementing some version of a CSCT, naming the CSCT as the main mechanism for identifying and responding to patients at higher risk for adverse outcomes due to chronic opioid prescription. However, how often the team met and participating roles varied across sites and was mostly dependent on staffing capacity and organizational buy-in. At minimum, waivered physicians/prescribers and nurse coordinators constituted the CSCT; where available, pharmacists, clinic social workers, and physical therapists and practitioners of alternative pain management techniques were also present. Most commonly teams met weekly or monthly, however multiple sites reported that while the CSCT was prioritized in the beginning to launch tapering efforts, overtime the ongoing meetings were substituted with ad-hoc convenings in response to specific requestions or issues. This was especially true if the CSCT team was small and only consisted of the nurse coordinator and waivered physicians/prescribers.

One site reported already having a pain management team within their clinic who then took on the role of the CSCT. While this was reported as effective at supporting tapering and alternative pain management techniques within the clinic, it siloed tapering efforts from the MOUD work. Additional efforts had to then be made to integrate MOUD waivered physicians/prescribers into the pain management team or situate MOUD as a resource to clinic providers working on tapering.

Best Practices & Lessons Learned for implementing CSCT

While the CSCT was described as effective at identifying patients at risk and creating alternative treatment or tapering plans, those plans will not be implemented without the buy-in from the primary care doctor. **Physician champions identified the need to provide follow-up with individual clinicians to encourage adoption of tapering plans and pre-emptively build buy-in for tapering.** Physician champions were described as best suited to follow-up with primary care physicians/prescribers after a patient was identified as benefiting from tapering. In addition to priming the entire clinic through general education around the role and benefits of MOUD, at some sites, physician champions met individually with each provider to explain program expectations, how the CSCT could be a resource for clinic providers, and asked how each physician would want to receive information about their patients. Framing as a resource and coming from the angle of sharing experiences was described as more successful than authoritarian approaches to suggesting alternative care plans. Additionally, multiple physician champions reported using the opioid report cards and communal sharing of other data to encourage healthy competition between providers and facilitate self-reflection to lower their

opioid prescriptions. This groundwork to build physician buy-in as well as individual follow-up with providers to present tapering plans took significant time for physician champions.

A few sites indicated they knew their CSCT was successful when providers across their medical clinic and, in some cases, their organization, began reaching out and specifically requesting the team to review particular patients. This was more commonly reported among clinics with a CSCT that was comprised of colleagues from a wide array of fields (e.g., social work, pharmacy, physician therapy) who had established respect within the clinic before formation of the CSCT. **Presenting the CSCT as a resource for clinic providers as opposed to a requirement, audit or other authoritarian role encouraged adoption of tapering plans.** Similarly, including administrative staff, medical, or clinic director early on in TOWN model implementation efforts helped ensure that there was leadership support and participation in clinic policy recommendations.

Highlighted Challenge

In most cases, physician champions reported that once they reviewed the data on prescribing rates with their colleagues and discussed the dangers of high MME in combination with certain other prescriptions, most colleagues were on-board with tapering efforts. However, **some resistance was continually encountered, particularly as physicians/prescribers, while theoretically in favor of tapering, struggled with implementing it in practice with their patients.** One clinic described having more success with physician commitment to lessen opioid prescriptions for new patients but little success with tapering of current patients. For sites with limited CSCT participation, the key challenge identified was lack of staff resources (ie. no social worker on the team) and lack of organizational leadership support reinforcing the effort. In many cases, ongoing convening of the CSCT lost emphasis or support when competing priorities emerged in response to the COVID-19 pandemic.

Individual Care Plans

Individual Care Plans, formerly described as pain contracts or controlled substance contracts, as described in the TOWN model are agreements between the prescribing provider and all patients currently prescribed any controlled substance. Care plans are intended to be updated at minimum on a yearly basis or when a new controlled substance is prescribed and are utilized for MOUD patients as well as patients being prescribed opioids for chronic pain and other purposes. In this overlap, Individual Care Plans are intended as a strategy to increase MOUD access as well as decrease opioid prescriptions.

In practice, most sites described their Individual Care Plan as an expanded, more detailed version of a standard controlled substance contract. Unlike their previous versions, the template TOWN encourages included more education for the patient on harms and risks associated with opioids, shared expectations of the patient such as how to dispose of unused medication, agreement to not sell medication and the process of routine and random urine drug testing, contact information for the nurse coordinator, and compiled community resources that could further support the patient outside of the clinic setting. Physicians/prescribers reported also using the care plan as an opportunity to talk with their patients about the role of physicians/prescribers in creating chronic opioid dependence so as not to place undue blame on patients when suggesting tapering. The Minnesota Opioid Prescribing Work Group

(mn.gov/dhs/opip/about/opioid-work-group) now recommends care plans be updated annually for patients on chronic opioids.

While many sites had a prior practice of using pain contracts, sites reported inconsistent prior use and this put additional emphasis on ensuring this process was completed with existing and new patients. Additionally, this version emphasized a conversation between the provider and patient, moving beyond a signed form that was done as a formality to a deeper discussion about how this medication was being used and what it was being used for.

Best Practices & Lessons Learned for Individual Care Plans

Clinics identified the Individual Care Plan as **an opportunity to integrate questions to explore and discuss social determinants of heath as well as prior experiences with treatment and/or pain management.** Some clinics expanded the standard conversation to include additional questions to ascertain housing stability, access to medical insurance, employment status, and childcare and transportation needs and worked with the patient to determine a care plan that included these different components. This provides patients and prescribers an opportunity to reflect on why patients are on the controlled substances in the first place, including the original diagnosis as well as patient goals, with the intention of empowering the patient through motivational interviewing strategies.

As the care plan was implemented across MOUD and chronic opioid prescribed patients, some sites also integrated OUD assessment into this process as their mechanism to consistently identify chronic opioid prescribed patients who would be eligible for MOUD, identifying the Individual Care Plan as an opportunity to **consistently screen all opioid prescribed patients for opioid use disorder.**

Highlighted Challenge

While Individual Care Plans in most cases were directly implemented by each prescribing physician, nurse coordinators played a crucial role in this strategy preparing the materials, identifying patients for whom updated plans were needed, identifying available community resources, and in some cases, and following up on implementing portions of the care plan if connection to external resources was needed. Staff identified implementing Individual Care Plans as a time intensive process dependent on the role of nurse coordinators for successful implementation; the few sites who did not have the nurse coordinator position or a parallel position playing this specific role reported struggling to make progress on implementation of this strategy. In an effort to distribute the time burden across the team, one site is working to update nursing staff job descriptions and training all nursing staff to integrate this responsibility into ongoing patient care outside of the role of the nurse coordinator.

Community Taskforce

In the TOWN model, monthly community taskforce meetings are recommended as the vehicle to build partnerships in the community, increase community education and leverage collective assets, skills, knowledge and resources. Taskforces provide an avenue for community stakeholders to discuss the patterns, trends, and issues observed in the community and identify opportunities to address substance use issues.

Most sites were not previously involved in a community taskforce and began their taskforce from scratch, although less frequently sites joined onto existing taskforces already established in their communities. Nurse coordinators took the lead on recruiting and facilitating meetings. Cross-sector participants most often included representatives from local schools, pharmacists, law enforcement, criminal justice entities (jails, drug court if present, probation), and treatment providers (county mental health providers, inpatient treatment, mental health providers).

Sites identified the following main purposes of their taskforces:

- Basic education of substance use disorder and harm reduction; sharing of available resources and identifying community issues or trends in substance use.
- Raising awareness specifically of clinic MOUD offerings and process for getting patients started. Coordinated referral process between taskforce members.
- Coordination of naloxone distribution.
- Coordination of prevention efforts, most commonly community education or awareness-raising strategies; in some cases coordinated policy or system changes to promote prevention (i.e., changing employment policies to encourage hiring of someone with prior substance-related charges; strategizing to address community transportation and barriers to treatment access).
- Active community outreach (i.e., creation and dissemination of business cards to promote accessing treatment).

While more challenging to start, sites reported that community partners were excited to learn about expanded MOUD clinic offerings and for the opportunity to work collectively to address opioid misuse.

> *"Up to this point, I didn't have the time to do this. Having the nurse coordinator here who can foster relationships with people who I haven't had time, so it's taken a while to get that going. So the first meeting will be who we are, what we do, what we treat. Asking what are you seeing in the community and how can we help? Moving towards how do we coordinate referrals and particularly the connections between police and the clinic, so the more folks know what we do they can better refer people to us. That's the goal. I'm very excited it's finally coming to life. I think the community has been waiting for this." -Physician*

Best Practices & Lessons Learned for implementing Community Taskforces

Many sites reported that to get their taskforce up and running **relied on the prior personal and professional networks staff had created**. In the absence of existing relationships, staff devoted time to doing individual outreach to explain the MOUD program and how people could access MOUD services.

Like initial resistance from physicians/prescribers to becoming MOUD waivered, law enforcement, criminal justice, and abstinence-based treatment facilities all had initial resistance to MOUD, seeing it as further introduction of suboxone onto the streets and replacing one drug with another. Clinics addressed this by **demonstrating initial patient successes of MOUD and explaining the science behind MOUD**.

Some taskforces were successful by prioritizing efforts to **identify opportunities for policy, system, and environmental change.** Multiple clinics reported being surprised by the impact of the taskforce and the ability to implement coordinated cross-system referral pathways, policy changes, or pilot entirely new interventions to address community-identified issues.

Highlighted Challenge

While many clinics were excited by the successes in coordination and building community partnership brought on by the taskforce, in all cases, taskforce meetings were put on hold during the height of the Covid-19 pandemic and had to be re-ignited after a year hiatus. Some sites attempted to continue via remote gatherings but described that format as unsuccessful. As planning and facilitating new taskforces required a significant time investment, in sites without a nurse coordinator, this strategy was deprioritized. Additionally, some sites requested technical assistance (training, guidance and support) specific to convening a taskforce, especially for clinic staff who were newer to this type of facilitation as part of their role.

Social Services and Behavioral Health Provider Partnerships

The TOWN model recommends the development of partnerships with social workers or behavioral health providers who can connect patients with services they qualify for, suggest referrals to mental health treatments or assess for chemical dependency. In this way, patients are more likely to have their holistic needs met.

There was high variability of how sites were able to address this, mostly based on the availability or absence of internal or community resources. For some clinics with social workers, peer specialists, or behavioral health providers embedded within their medical system, social workers were present on the CSCT and could work in collaboration with nurse coordinators to connect with patients as needed. Other sites without this internal capacity relied on creating partnerships with county-based Licensed Alcohol and Drug Counselors (LADCs) to provide Rule 25 assessments and other local treatment or mental health options, if available in the community.

Best Practices & Lessons Learned for implementing Referral Partnerships

Clinics identified the need to prioritize building relationships **and coordination of MOUD prior to and after incarceration and inpatient treatment** as transition points where coordinated referrals and continuation of care are critical to prevent overdose and relapse. Multiple sites focused their attention on streamlining care coordination at transition points for patients entering or leaving jail and inpatient treatment. The use of MOUD as part of jail or inpatient treatment varies by facilities. In both cases, if inpatient treatment or jail requires abstinence and does not offer MOUD services, clinic-based MOUD can play an integral role in tapering patients in a safe way to prepare for entering into facilities. Likewise, exiting from jail or inpatient facilities is a key time of risk for many patients to resume substance use as there may be lapses in medical coverage, discontinuation of MOUD if started in-facility, or other conditions to instigate use. Some sites were able to coordinate with facility-based nursing staff to offer continuation of MOUD if started while in the facility or offer it to patients immediately upon transition. Staff reported these partnerships were established through persistence, prior relational trust, and active education about MOUD on the part of nurse coordinators. In one

case, willingness to coordinate with clinic-based MOUD programs only occurred after a patient experienced an overdose after leaving a facility. Grant-funded technical assistance helped to facilitate collaboration across TOWN sites.

Highlighted Challenge

Most sites noted the limited local capacity and availability of behavioral health staff and treatment services and highlighted the unmet need of supportive services for patients beginning MOUD. To address this challenge, one site who was working to integrate MOUD alongside clinic-based behavioral health services identified the **success of utilizing peer specialists** in this program to provide ongoing patient support and connections. However, the lack of available peer specialists is a barrier in rural areas. Other clinics recommended **telehealth options** to be able to meet the referral needs in rural locations and to **co-locate or share office space with local mental or behavioral health providers when possible**. One clinic was pursuing Behavioral Health Home certification as an avenue to increase availability of behavioral health services.

Emergency Department (ED) Integration

The TOWN model recognizes that the emergency room is a critical point of first interaction with OUD patients, as patients may seek care after an overdose. In the absence of continuation of care following an overdose, patients are routinely discharged while experiencing withdraw, which can lead to high risk of repeated overdose. To address this, the TOWN model recommends beginning a patient on buprenorphine in the emergency room with a direct referral to a clinic-based MOUD program. If not waivered, emergency room providers can administer, but not prescribe, buprenorphine for up to three days for a patient with OUD.

In practice, ED integration was identified as a key area of focus for future work with most staff expressing concern that currently their hospital system was largely missing patients at this critical juncture. However, a few sites identified the following best practices in making inroads with emergency departments.

Best Practices & Lessons Learned for integration of MOUD into ED

Nurse coordinators and physician champions worked to provide **simple, clear induction protocols** as well as **continuous education opportunities with ED staff** through individual meetings and group presentations to highlight the impact of ED inductions on patients, explain protocols, and build familiarity. While not a requirement for starting buprenorphine in the ED, a few sites reported success in **identifying waivered physicians/prescribers who worked in both the clinic and in the ED who became ED-specific champions and promoted MOUD in the ED context**. Clinics reported success coordinating with the pharmacy associated with the ED to ensure medications are stocked and available and **clarifying the handoff process** to connect ED patients with clinic-based MOUD. At one site, the nurse coordinator was able to encourage new patients wanting weekend access to MOUD to utilize the ED for induction which eased MOUD scheduling tensions while supporting continued clinic-based follow-up after a patient is induced in the ED. Lastly, one clinic observed that **having the nurse coordinator position housed within the social work team eased coordination with ED** as social workers are accustomed to navigating across the medical system.

Highlighted Challenge

Most sites had not yet consistently implemented buprenorphine into EDs. This was described mostly as a workflow issue, in that other components of the TOWN model had been prioritized for implementation thus far with ED described as a priority for the next year. Additional challenges that sites faced in implementing ED use of buprenorphine were general unfamiliarity with the process, concern about fentanyl precipitated withdrawal, insufficient ED space for long inductions, and the need for clinician education.

Health Provider Education

To support staff and clinic capacity, Drs. Bell and Devine provide individual technical assistance to all sites as well as protocol templates where applicable for all the strategies described above. Drs. Bell and Devine, as TA providers, complete their own ongoing education, including becoming boarded in addiction medicine, to offer the most up-to-date guidance. Site staff are encouraged to participate in weekly ECHO calls which is a remote based platform to provide continuing education and offer an opportunity for practitioners to share challenges and best practices. Continuing medical education credits are offered at no cost.

In practice, sites reported overall positive experiences with the coaching and resources provided by Drs. Bell and Devine as well as with the ECHOs. Individualized technical assistance and site visits were reported as particularly crucial at program onset to build buy-in across medical team and provide preliminary tools and templates for clinics to customize without recreating the wheel, as well as to problem-solve around more challenging patients or community situations throughout the duration of implementation. Drs. Bell and Devine were described as accessible and responsive to questions. Both nurse coordinators and physicians/prescribers reported participating in the ECHOs as available, with the biggest barrier to participating being time and scheduling constraints. ECHO participants reported that they made warm handoffs directly to other clinics providing MOUD services that might be a better fit due to a closer location for a particular patient because of the relationships built through the ECHOs and the trust in consistency in clinic services across sites. ECHO participants in turn utilized the information shared to provide education within their clinics.

Best Practices & Lessons Learned for Health Provider Education

Many staff reported that they utilize information shared in the ECHOs to then lead presentations and one-to-one conversations within their clinic. This could intentionally be amplified by **considering ECHO as a train the trainer model and providing resources, PowerPoints and other materials to make the further dissemination of information learned in ECHOs easier**.

In terms of individual technical assistance, **clinics recommended ensuring all sites are offered two site visits prior to and soon after project implementation, annual site visits, as well as additional support when issues arise on an as needed basis.** For those who were able to connect individually with Drs. Bell and Devine early on in implementation, staff found it helpful to have the Drs. meet with clinic administration and leadership staff, ED director, and physician providers to discussion the TOWN model. This helped build clinic and physician buy-in and set up conditions for success once the program began and was recommended as a standardized

technical assistance offering to set model expectations. Additionally, staff recommended a follow up site visit with facilitating staff (ie. members of the substance review team, nurse coordinator, waivered physicians/prescribers) to go over more of the nuts and bolts of tapering and MOUD best practices early in project implementation. While this occurred with most sites, some did not have a site visit until one year into implementation. Moving forward with the current set of TOWN sites, clinics recommended **emphasizing technical assistance related to integrating MOUD into EDs, establishing and continuing effective taskforces, and strategies for community outreach.**

Highlighted Challenge

Some physicians/prescribers reported that while ECHO topics are responsive to participant requests and interests, that responsiveness has led to veering away from the core skills of substance abuse management, and recommended reassesses ECHO topics for specificity to substance abuse management.

Prescription Monitoring Program (PMP) Incorporation

The PMP (https://pmp.pharmacy.state.mn.us/) is an online database used by prescribers, pharmacists and nurse coordinators to assist in managing patient care, detecting diversion, and preventing the abuse/misuse of controlled substance prescriptions. Best practice suggests that physicians/prescribers check the PMP for each patient before prescribing a controlled substance. TOWN sites reported routine and ongoing PMP use. Most sites reported utilizing Epic as their electronic medical record system, although there are options for how clinics handle their electronic medical record system. Epic has integrated the PMP within their system and does not require physicians/prescribers to separately access the PMP system through a different browser or software system. At many sites, nurse care coordinators look up the PMP and print ahead of time to save time for providers. Utilizing the PMP was more difficult for sites without a one-click integrated electronic medical record system, however, even sites who were not using Epic and had to access the PMP separately from their electronic medical record system felt the PMP was being readily utilized by providers. One site reported that PMP use had been communicated as an expectation by leadership, which supported integration.

Implications for Sustainability

Many of the efforts to implement opioid tapering and MOUD, as well as the strategies that involve updates to protocols and integration into standard care were described as being sustainable without additional funding once implemented. However, the following components were identified as requiring ongoing and sustained funding:

- Nurse coordinator position, crucial to patient and overall program success.
- Portion of time for physician champions to participate in and lead internal education and coaching activities.
- Taskforce leadership and participation.
- Ongoing technical assistance as opioid epidemic changes and evolves and as other substances such as methamphetamines add complexity to patient and clinic needs.

Strategy and Implications for Sustainability

Core Strategy	Implications for Sustainability
CSCT	CSCT was described as sustainable when tapering was generally adopted by the full physician team and the CSCT was considered an internal resource for physicians/prescribers wanting additional support to review specific cases. However, funding for time spent by physician champions providing individual provider education and support for follow-up was identified as a continuous and ongoing need for sustainability.
PMP Incorporation	Moving forward, sites reported that ongoing PMP integration required minimal to no additional attention to upkeep as it had become standard practice.
MOUD Capacity	Sites with less than three providers are focused on continuing to expand MOUD waivered physicians/prescribers, which is necessary to maintain sustainability of MOUD at clinic should the current provider team leave. Sites who have successfully encouraged three to five clinicians to be waivered identified next steps as exploring and expanding available MOUD treatment options as well as additional focus on outreach efforts to encourage more people to utilize now available MOUD services. One site, who had developed substantial referral pathways with local treatment centers, reported having to turn away or limit patient eligibility because demand exceeded internal provider availability. Other sites reported that additional care coordinator positions were needed to expand the limited time of the nurse coordinator. All sites identified the value of the nurse coordinator and the need for funding to support the continuation of this position as a necessary component for MOUD provision beyond the grant cycle.
ED Integration	ED integration had not yet been implemented enough to determine sustainability. ER integration was identified as an area for implementation focus in the coming year.
Individual Care Plans	While updates to forms and protocols constitutes sustainable change, currently this strategy still requires the active management and implementation by nurse coordinators, who would be required for ongoing sustainability until fully adopted by general nursing staff.
Taskforce	The taskforce was one of the first strategies to be put on pause in response to competing priorities, such as the pressures caused by the pandemic. Ongoing facilitation and participation requires committed time by nurse coordinator for sustainability.
Partnerships	Sustainability is dependent on clinic-based mental/behavioral health resources and the extent to which partnerships with external agencies have been established. Investment in building internal mental and behavioral health capacity (i.e. social workers, peer recovery specialists, etc.) is needed for sustainability. Partnership requires active and ongoing partnership management and coordination by nurse coordinator.
Health Provider Education	Ongoing participation in and leadership of internal education efforts was noted as requiring continued funding to cover staff time and effort.
Medical Home Certification	Once attained, no effort was reported as necessary to sustain medical home certification.

Additional challenges and requests to MDH

Multiple sites expressed concern that the biggest drug use issue facing their communities was **methamphetamine use**. While there are no parallel treatment options for methamphetamine use, sites expressed the need for additional attention and resources to address this underserved population. Additional funding and specific efforts are needed to address methamphetamine as a co-occurring part of the opioid epidemic.

As medical providers working in rural communities, clinics consistently reported **transportation and the lack of local behavioral health service providers** as barriers to consistent care. The lack of transportation is a barrier for community members to access necessary treatment. Likewise multiple sites noted as a gap the lack of available mental and behavior services, and specifically efforts to build positive social relationships when managing addiction. **Investment in peer specialists is crucial** to address this service gap across Minnesota.

Health insurance providers vary in their coverage of MOUD, requiring nurse coordinators or pharmacists to work with individual providers to address issues or workarounds when coverage is denied. Similarly, patients existing incarceration experience a lapse in health insurance that hinders access to MOUD. **Multiple clinics requested to be able to use grant funding to cover the first month of MOUD medications for patients in these situations.**

The core strategies cannot be successfully implemented without a nurse coordinator to implement and lead the work. While sites had some variation in the exact job title and background requirements for this position, a dedicated role is necessary to coordinate the components, provide non-judgmental client-centered care, and build community partnerships. **A few sites reported difficulty in hiring and filling the nurse coordinator position- both due to lack of emphasis and priority from administrative leadership and challenges in finding qualified interested people to fill open positions in rural areas**. Additionally, some sites utilize the nurse coordinator position to fill multiple roles in their facilities greatly reducing their ability to fully invest in this program. Clinics recommended additional emphasis from MDH that this position is necessary for program success and must be prioritized accordingly with allocated funding as a full-time position to ensure prioritization from clinic leadership. Likewise, this position is most at risk for sustainability issues if funding is discontinued. Additional technical assistance to provide sample job descriptions and recommended requirements encouraging flexibility in backgrounds (i.e. nursing background not necessarily required, peer specialists, care coordination, service provision experience) may expand applicant pool.

Lastly, as multiple clinics struggled with ED integration yet were partnering with law enforcement for naloxone distribution as part of their taskforce, there is an opportunity for MDH to foster integration across MDH-supported overdose prevention efforts, such as intentionally connecting TOWN clinics with EMS linkage to care effort and statewide naloxone distribution.

Conclusion

While each clinic implements TOWN in ways that are best suited for that site and their local resources and needs, there are patterns of how clinics approached implementation as well as identified best practices identified by one clinic that can be adopted by others. Building buy-in

within the clinic, administration, physicians/prescribers, nursing, and the ED is essential for successful implementation of opioid prescription tapering and MOUD efforts, as is the nurse coordinator role. Moving forward, TOWN clinics are largely focused on efforts to integrate MOUD into the ED and expand on community outreach and system coordination in the coming months. Future evaluation efforts will work to expand the monitoring of additional measurable outcomes.