
Medication Assisted Treatment (MAT) Workflow

Entry into services:

- A patient is seen in the **ER, discharged from the hospital, referred from another treatment facility, or self-referred** with **documented opioid use disorder** and a **desire to receive medication assisted treatment (MAT)**.
 - If patient is seen in JH ER/Hospital the HUC, ER provider or hospitalist will send an EPIC message “high priority” to Krystal Brock-Farrington and Colleen Rodrigues (MAT Care Navigator once hired) regarding the need for an evaluation by a MAT waived provider.
 - If the patient is a self-referral or referred from another treatment facility, the phone team will enter an EPIC message “high priority” to Krystal Brock-Farrington and Colleen Rodrigues (MAT Care Navigator once hired) regarding the need for an evaluation by a MAT waived provider.
 - If patient has a PCP at JHC that is waived for MAT, a “high priority” message will be sent to the PCP.
 - If patient does not have a PCP at JH, patient will be assigned a MAT Star Doc.
 - If patient does have a PCP at JH, but their PCP does not provide MAT services, the patient will be assigned a MAT Star Doc. Send an Epic message to the patient’s PCP.
- The MAT Care Navigator/LICSW/Colleen or Krystal will call the patient to discuss the program and set up an intake appointment.
- The Star Doc spreadsheet will be used to assign the patient to the correct provider based on the rotation for MAT (taking the place of a normal Star Doc). The goal is to assign the patient at the clinic most convenient for the patient to establish care, OR if already established with JH PCP, within their current clinic and pod. Tracker will be updated when the patient is assigned.
- If a JH patient with documented opioid use disorder sees a **PCP that does not provide MAT services**:
 - PCP has a discussion with the patient regarding their diagnosis and **desire to receive MAT treatment** and an overview of the program
 - PCP contacts MAT-waivered provider (ideally within same pod/clinic) to request their patient be consulted for MAT services (NOTE: this service is NOT intended to be a chronic pain consultation)
 - If patient is felt currently appropriate for MAT evaluation by waived provider, appointment is made for intake*

* Original PCP will remain the PCP for the patient; MAT-waivered provider would consult for MAT services.

Before the initial intake appointment:

1. Schedule the patient ASAP, as they are indicating they are ready to begin treatment. This should be for a long visit (30-40 minutes), unless it is a Star Doc or the provider gives permission for a short visit. Whoever is scheduling the appointment asks the patient to arrive 20 minutes early to complete urine drug screen (UDS) and paperwork.
2. If the patient is physically in the clinic at time of scheduling, give the patient a MAT patient folder (stocked in clinic)

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Owner: Clinical Manager
Department: Jefferson Healthcare Medical Group
Reference (Policy, Procedure, Other): Procedure
Details: Quality Control



3. During chart prep, roomer uses dot phrase **.JHPCCHARTPREPMAT** to prepare for visit and enters a note (**MAT/UDS **) in the Appointment Notes for the front desk to give the patient a MAT folder and a card informing them they will need to give a urine sample. The roomer can also enter **MAT Intake** into the notes if the provider requests the paper MAT intake form – optional).

Day of the initial intake appointment:

1. During daily huddle: provider and roomer review needs for the visit, insure that chart prep tasks were completed
2. At check-in, patient receives a MAT patient folder and a urine sample card telling them that they will need to give a urine specimen (and that they should notify front desk if they need to use the rest room before taken back to the exam room). Patient also receives longer MAT intake form, if provider requests this (optional).
3. Roomer instructs patient on how to collect urine specimen, directs patient to restroom (and collects completed MAT intake questionnaire to give to provider, if provider had requested)
4. Roomer collects urine specimen, performs point of care UDS (and urine hCG if female) and rooms patient, pulling up note template: **.JHPCNOTEBUPINITIAL**
5. Roomer gives patient MAT agreement and informed consent (available as paper handouts in clinic) to review before provider enters exam room
6. Provider collects information asked in the note template (including the DSM-V Opioid Use Disorder Checklist) to guide conversation and to confirm the diagnosis and its severity
7. If the patient is a good candidate for MAT, the provider discusses how it works, why the patient has to be in withdrawal when starting treatment, and what's expected of them during induction, stabilization, and long term maintenance phases of treatment. This visit is typically billed on time (Long visit: 30 or 40 minutes, depending on provider scheduling template).
8. If the decision is made to proceed, the provider reviews the agreement and informed consent documents. The patient signs these or takes them home to read and bring back signed.
9. The provider discusses the importance of counseling in conjunction with MAT and orders a referral to a local program of the patient's choice. Patient completes the multi-party consent for release of information with the drug rehab counseling organization.
10. The standard recommendation is to get a CMP before starting treatment. Roomer will pend these labs before visit. If stigmata of severe liver disease present at first visit, order CMP lab before starting induction, but in most cases, this can wait until after induction to reduce any barriers to getting started. If drawing labs and patient has been an IV drug user, also order HIV, Hep B and Hep C labs.
11. **If patient will do home induction:**
 - Patient is given:
 - Buprenorphine/naloxone prescription (use outpatient "MAT Meds" preference list in Epic)
 - If needed, prescriptions for medications for withdrawal symptom relief (e.g., tizanidine, clonidine, hydroxyzine, ibuprofen - see "MAT Meds" preference list)
 - Home induction handout (paper handouts stocked in clinic), depending on medication or drug the patient is currently taking (both options contain home titration instructions and patient flow for home induction):
 - **Home Induction – Short-Acting Opioids** – if patient has been taking short-acting opioids (heroin, oxycodone, hydrocodone, morphine, codeine, fentanyl)

- **Home Induction – Long-Acting Opioids** – if patient has been taking long-acting opioids (extended release oxycodone/morphine – Oxycontin, MS-Contin, or methadone)
 - Tactical nurse or provider reviews the instructions with the patient
 - Patient is scheduled for:
 - Follow-up phone call from tactical nurse for afternoon of patient’s home induction day (put on nurse schedule)
 - Follow-up appointment with the provider for 2-5 days after home induction day
- 12. If the patient will do clinic induction:**
- Patient is given:
 - Patient handout: Patient Flow - Clinic Induction
 - Buprenorphine/naloxone prescription (patient will pick up medication before clinic induction appointment)
 - Patient is scheduled for an appointment with the provider for clinic induction (timeframe per provider’s instructions)

Induction

Home induction:

1. Patient fills prescription for buprenorphine/naloxone at pharmacy
2. Patient follows home induction instructions received in their After Visit Summary (AVS)
3. Check-in call:
 - a. The tactical nurse calls the patient in the afternoon after starting home induction to give an update on how things are going
 - b. If the patient reports any problems:
 - i. The tactical nurse will triage patient
 - ii. The provider may change dose and schedule additional phone follow up, if necessary

Clinic induction:

Prep work:

- The clinic induction appointment is scheduled for early in the morning (the appointment is usually scheduled as a double-booked appointment around 9:00 a.m.)
- There needs to be an exam room dedicated to this patient for the duration of the induction.
- Induction should ideally be on a day when the provider will also be in clinic the following day, to avoid problems/calls on provider’s day off or the weekend.
- Obtaining the medication:
 - Preferred method: the patient receives a paper prescription and fills the prescription at the pharmacy before coming to the appointment
 - Alternate possibility: JH pharmacy is notified and will prepare a packet of buprenorphine/naloxone strips (8 strips of the 2/0.5 mg dose or 2 strips of the 4/1 mg dose), which will be delivered first thing in the morning to tactical nurse or roomer

Induction Day 1:

1. Place order using Epic In Clinic “MAT” preference list for buprenorphine/naloxone 4-16 mg titrated. Select appropriate order for Day 1 (short-acting or long-acting opioid induction).
2. Roomer rooms patient per standard rooming workflow. Also:
 - a. Pulls up note template: **.JHPCNOTEBUPINDUCTION**

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- b. Confirms patient's last opioid use
3. The provider sees the patient:
 - a. Confirms last opioid use
 - b. Administers COWS scale to confirm adequate withdrawal
 - c. Directly administers buprenorphine/naloxone dose
4. Either the provider or the tactical nurse repeats the COWS score every 30-60 minutes.
 - If COWS > 4, repeat dose every 1-2 hours up to a max dose of 16 mg on Day 1
 - The provider will typically visit patient between other scheduled patients, each time spending 2-5 minutes with the patient
5. The patient is scheduled for follow up in the clinic the next day for Induction Day 2
6. If patient brought in buprenorphine/naloxone from outside pharmacy, patient takes home medication and will bring it back the next day for Day 2 induction.
7. If buprenorphine/naloxone was from JH pharmacy, any excess medication is returned to the pharmacy. Provider or tactical nurse notifies pharmacy of dose needed for Day 2 (usually 4mg higher than previous day's dose, in case it proves inadequate).
8. Induction visits are billed as office visits, plus prolonged outpatient observation codes (99354 – 1st hour, 99355 – every 30 minutes after).

Induction Day 2:

1. Induction Day 2 proceeds similarly to Day 1. When the provider is feeling confident about the correct dose, patient is informed of maintenance dose. If JH pharmacy supplied induction medication, provider writes a prescription for the patient to fill at the outside pharmacy.
2. With each new induction, the patient is added to the provider's log of MAT patients. This should be created in Epic (see Creating Epic Patient Lists guide: <X:\Departments\Medical Group\MAT>) The DEA requires that a list of active patients be kept, and it will be important to track if a provider is getting close to their 30 patient limit. Access to list should include provider, tactical nurse for pod or clinic, all roomers in pod or clinic, clinic manager and clinical manager.

Follow-up

The patient will have subsequent office visits during the stabilization phase (every week or two). These are the best visits! The patient is usually very happy with the results, optimistic about their future, wanting to refer friends, etc.

1. Standard 20-minute visits—billed as standard office visit- typically 99213
2. Note template: use Epic dot phrase **.JHPCNOTEBUPFOLLOWUP**
3. Review any side effects, craving control, relapses, participation in some form of psychotherapy, etc.
4. Roomer will get UDS and PMP prior to every visit.
5. During this phase, the provider will order CMP (if not previously done), HIV test, chronic hepatitis panel, and start to discuss other needed preventive care.

Maintenance

The maintenance phase typically starts about a month after the initial induction.

- At this point, the provider can start writing refills - buprenorphine is C-III, so the maximum supply is 30 days with 5 refills.
- Collect random UDSs, but not required at every visit
- In the long term, the provider may bring up a gradual wean off MAT if patient motivated, but the best evidence seems to favor long-term continuation for most people.

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