MeHAF
MAINE HEALTH ACCESS FOUNDATION

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MeHAF Addiction Care Program:
Medication Assisted Treatment Self Assessment Survey
May 2017

Project Name: _____ Date: _____

Name of person completing the SSA form: _____ Your role: _____

Did you discuss these ratings with other members of your team? Yes: ☐ No: ☐

Grantee Organization: _____

The purpose of this assessment is to show your current status along several dimensions of care and to stimulate conversations among your team members about where you would like to be along the continuum of care for Opioid Use Disorder (OUD) diagnosis and treatment. Please work with your team to select the description that best fits your current level of progress. There are no right or wrong answers as this is a tool that is meant to provide an honest assessment of current strengths and highlight potential areas of opportunity. Repeated administrations of the self-assessment form will help to show changes your organization is making over time. The answers are rated from 0-3 where:

- 0 indicates little to no progress has been made in this area.
- 1 indicates that early progress has been made.
- 2 indicates that moderate progress has been made.
- 3 indicates that this is a regular part of care.

Self-Assessment Questions				
0 - No Progress	**1 - Early Progress**	**2 - Moderate Progress**	**3 - Regular Part of Care**	**Your Assessment (#)**
I. Organizational Leadership				
We have not identified an executive champion/project sponsor.	We have identified an executive champion/project sponsor but the role is informal or they are not yet actively engaged with project team members. They are not part of the leadership team for our organization.	We have identified an executive champion/project sponsor. The role is filled by a senior administrator(s) as one of a number of on-going quality improvement initiatives. They do not play an active role in project activities (attend team meetings, etc.) but have made a commitment to implementing our project.	We have identified an executive champion/project sponsor who visibly champions a commitment to our project, is part of our organization's leadership team and plays an active role in all aspects of the project.	
Comments/Notes:				

Self-Assessment Questions				
0 - No Progress	**1 - Early Progress**	**2 - Moderate Progress**	**3 - Regular Part of Care**	**Your Assessment (#)**
II. Team-based Approach to Care				
We do not have a patient care team(s) for implementing integrated team-based care. No teams, roles or responsibilities have been identified.	We are planning opportunities and/or testing models to optimize roles and move toward a more team-based approach to care.	Patient care teams exist, but have little cohesiveness among team members or are not central to care delivery.	We have implemented a team-based approach to care delivery that includes expanded roles of non-physician providers and staff (e.g. nurse practitioners, physician assistants, nurses, medical assistants) to improve clinical workflows. (Examples: scripts, front desk / MA's providing higher level of support, etc.). All members identify as part of the team and can identify their specific role/responsibilities within the team.	
Comments/Notes:				
III. Integrated Care Management (CM)				
We have not identified CM roles and responsibilities, nor integrated CM into team(s). No clinical or care team meetings have been held.	We are in the process of planning for or designing a care management process. Clinical or care team meetings are held occasionally.	Care management processes are defined and include identified roles and responsibilities. Care management staff has been identified and is being integrated with the team. Clinical or care team meetings are held regularly, but less than monthly.	Care management processes are well-defined and the concept is embraced, supported and rewarded by teams and organizational leadership. There are documented workflows, roles and responsibilities and methods for tracking outcomes. Care management staff is fully integrated into the team. Clinical or care team meetings are held at least monthly.	
Comments/Notes:				

Self-Assessment Questions				
0 - No Progress	**1 - Early Progress**	**2 - Moderate Progress**	**3 - Regular Part of Care**	**Your Assessment (#)**
IV. Addiction Care Integration				
We do not currently screen for Opioid Use Disorder (OUD) or provide treatment/referrals for patients who may have an opioid use disorder.	We are planning/implementing a program to provide Medication Assisted Treatment (MAT) for our existing primary care patients who have been induced and are stable/currently receiving MAT elsewhere. We are aware of resources for inductions or higher levels of care and provide patients with information, but do not provide formal referrals for care or follow-up.	We provide MAT for our existing primary care patients who have been induced and are stable. We may do inductions on-site or refer patients for induction elsewhere but are not currently taking on new MAT patients. We have informal relationships with referral organizations for specialty care or higher levels of treatment, but do not share data, treatment plans or have formal communication mechanisms for shared patients.	We are part of an established "Hub and Spoke" model of treatment or have fully integrated addiction treatment on site. We have established formal Memoranda of Understanding (MOU) with referral organizations, frequent team communication for shared patients, consents for data and information sharing, and documented pathways for patients to move from induction to maintenance. There are established, routine workflows for referral and follow-up in case of relapse or patients in need of higher levels of care.	
Comments/Notes:				
V. Behavioral/Physical Health Integration				
Behavioral/Physical Health Integration is minimal or does not exist. Patients must go to separate sites for services and are typically responsible for their own coordination. There is no mechanism for information sharing or follow-up for shared patients.	We are planning or designing a program for integration. Resources are being coordinated, though patients typically go to separate sites and systems. Relationships and workflows are being defined and documented.	Services may be co-located. If separate, there are established communication channels and integration is achieved through the use of a care manager or other strategy for coordinating needed care. This may be for a specific population, or a pilot program for available only to a specific group of patients.	There is a system in place to ensure continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled and follow-up maintained. Services are fully integrated including health records and shared treatment plans. There are frequent team meetings and warm hand-offs occur regularly.	
Comments/Notes:				

Self-Assessment Questions				
0 - No Progress	**1 - Early Progress**	**2 - Moderate Progress**	**3 - Regular Part of Care**	**Your Assessment (#)**
VI. Inclusion of Patients, Families and Caregivers				
A. Advisory Groups				
There is currently no mechanism to involve patients, their families or caregivers, or peers in our improvement efforts.	We are in the process of identifying members to be included in leadership, improvement or advisory activities.	We have a plan to involve patients/family members/caregivers in our activities and have identified potential participants but they do not routinely meet.	We actively seek input from patients and families on how well their needs are being met and incorporate this feedback into improvement processes. Patients, families and care-givers participate in some sort of leadership meeting or advisory process to help identify needs and develop solutions.	
Comments/Notes:				
B. Peer Recovery Coaching for Patients				
We do not currently have peer recovery coaches available to patients.	We are planning to incorporate peer recovery coaches into our program or are actively recruiting coaches.	We have some volunteer coaches available to patients, but it is up to the patient and/or the clinician to request a coach.	We have a team of volunteer peer recovery coaches or have peer recovery coaches on staff. They are an integrated part of the care team and access to peer recovery coaches is a standard part of the treatment plan.	
Comments/Notes:				
C. Educational Resources and Training				
There are few resources available to patients or their families/caregivers to improve patient education, self-management, harm reduction, etc.	We are testing, designing or compiling some tools, training and or materials that promote patient education, self-management and harm reduction.	We are working to implement standardized use of training and educational materials for patient education, harm reduction and self-management resources.	We have a standardized set of materials and training resources and access to these is incorporated into our workflows and processes.	
Comments/Notes:				
D. Involvement in Care Plan				
Patient/family/caregiver involvement in care plan does not occur	Patient/family/caregiver involvement is passive. Clinicians or educators direct care with occasional input from the patient/family/caregiver.	Patients/families/caregivers are sometimes included in decisions about care and treatment and/or this process is done collaboratively with some patients.	Patient/family/caregiver involvement is an integral part of the system of care. Collaboration occurs routinely and team members take into account family, work, community barriers and resources.	
Comments/Notes:				

Self-Assessment Questions				
0 - No Progress	**1 - Early Progress**	**2 - Moderate Progress**	**3 - Regular Part of Care**	**Your Assessment (#)**
VII. Connection to Community Recovery Resources and Social Support Services for Patients with Substance Use Disorder				
A. Community Recovery Resources and Supports				
We do not have a working list of local resources and social services to help patients/families meet recovery goals.	We are compiling local community resources and social supports.	We have identified resources in our community and are making some referrals but we are still refining the process.	We can identify and routinely make referrals to local community recovery resources and social support services that provide support to individuals and their families and/or to help them overcome barriers to care so they can meet health goals.	
Comments/Notes:				
B. Social Supports for Patients to Implement Recommended Treatment				
These are not typically addressed.	This is discussed in general terms, not based on an assessment of patient's individual needs or resources.	This is encouraged through collaborative exploration of resources available (e.g., significant others, education groups, support groups) to meet individual needs.	This is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources	
Comments/Notes:				
VIII. Harm Reduction				
A. Naloxone Prescribing				
Patients are not screened for overdose risk and naloxone is not discussed.	Naloxone is prescribed for patients that request it or that have previously experienced an overdose.	Patients receiving Medication Assisted Treatment (MAT) are offered naloxone and some education is provided.	All patients on high dose opioids or receiving MAT (or their families/caregivers) are prescribed naloxone. Education on the risks of overdose and how to use naloxone is standardized and a routine part of care.	
Comments/Notes:				
B. Harm Reduction / Health Improvement				
Harm reduction methods (safer routes of administration, alternative/safer substances, methods to reduce harmful consequences) are not discussed with patients.	Discussion of harm reduction is left up to the individual clinician's/educator's discretion.	We make some educational materials and resources available to patients, but this is not routinely discussed during patient visits.	We have standardized educational materials and referral resources available. This is a routine part of care.	
Comments/Notes:				

Self-Assessment Questions				
0 - No Progress	**1 - Early Progress**	**2 - Moderate Progress**	**3 - Regular Part of Care**	**Your Assessment (#)**
IX. Incorporation of Evidence-based Guidelines and Best Practices				
A. Incorporation of Chapter 21 Recommendations (use of written agreements, regular urine tox screening, pill counts, etc.)				
We are not aware of the Chapter 21 recommendations or they do not apply to us.	We are aware of these requirements and it is up to each individual clinician to ensure that they are in compliance.	We have some policies and procedures in place to ensure that these recommendations are followed. We provide some amount of provider education on these topics and have circulated information on currently available tools, templates and resources to all prescribers within our organization.	We have standardized workflows and templates for compliance with all recommended standards of care included in Ch. 21 and there is a mechanism for tracking compliance to ensure that all patients on controlled substances have a written agreement and get regular urine tox screenings and pill counts. This is a routine part of care and is included in regular provider education/new provider orientation.	
Comments/Notes:				
B. Policies & Procedures for Opioid Prescribing and MAT				
We do not have any written policies or procedures for patients receiving controlled substances or on MAT.	We are working towards compliance with Maine Public Law. Ch. 488 (mandatory PMP checks, MME dosing and durational limitations, etc.) and/or are in the process of writing or updating our policies and procedures accordingly. Providers are expected to comply with Ch. 488 requirements but there is no formal tracking or reporting mechanism in place. We provide some amount of provider education on these topics and have circulated information on currently available tools, templates and resources to all prescribers within our organization.	We have documented policies and procedures in place that include standardized workflows and templates for all Ch. 488 requirements. There are tracking mechanisms in place to ensure compliance with our policies or we are in the process of designing/implementing a tracking mechanism. We provide regular provider education and updates on Ch. 488 and related topics.	We have documented policies and procedures in place that include standardized workflows and templates for all patients on controlled substances or receiving MAT. These policies and procedures incorporate all relevant Maine prescribing laws as well as additional evidence-based guidelines and best practices (US CDC Opioid Prescribing Guidelines, SAMHSA's Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction, etc.) We routinely provide education on related topics for providers and practice teams and have a standardized mechanism for tracking compliance across our organization.	
Comments/Notes:				

Self-Assessment Questions				
0 - No Progress	**1 - Early Progress**	**2 - Moderate Progress**	**3 - Regular Part of Care**	**Your Assessment (#)**
X. Incorporating MAT and Safe Prescribing into Provider/Team Education and Training				
Physician, team and staff education and training does not occur or does not include MAT core competencies and/or safe prescribing practices.	Physician, team and staff education and training on MAT and safe prescribing occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic.	Physician, team and staff education and training on MAT and safe prescribing is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation.	Physician, team and staff education and training for MAT and safe prescribing is supported and incentivized; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration	
Comments/Notes:				
XI. Provider Mentoring				
There is no peer mentoring or orientation for providers who have recently received their x-waiver and would like to begin prescribing buprenorphine.	After x-waiver training, providers receive some mentoring and support from other providers who are currently providing MAT.	Providers receive consistent mentoring from peers while offering MAT and there is an established mechanism available to them to request assistance or guidance. There is some form of orientation for bringing new providers into the MAT program.	Providers are able to receive on-site mentoring for the provision of MAT or can access it within the organization's network/parent organization/system. Providers are connected to a network of providers and can receive timely support and guidance. There are established support mechanisms for providers to request assistance if they run into issues.	
Comments/Notes:				
XII. Leveraging Health Information Technology				
A. Patient Information and Communication				
We do not have either an electronic medical record OR a registry to support improved communication for patient care. We don't have a way to communicate patient/care management information electronically with anyone outside the organization.	We are exploring integrated Health IT systems to support improved communication with and for patients, to assure they get care when and where they need and want it in a culturally and linguistically appropriate manner.	We are currently implementing integrated Health IT systems to support improved communication with and for patients, to assure they get care when and where they need and want it in a culturally and linguistically appropriate manner.	We use integrated Health IT to support improved communication with and for patients, and to assure patients get care when and where they need it in a culturally and linguistically appropriate manner, (e.g. registry, electronic medical record, personal health records, health information exchange, provider-patient secure messaging).	
Comments/Notes:				

Self-Assessment Questions				
0 - No Progress	**1 - Early Progress**	**2 - Moderate Progress**	**3 - Regular Part of Care**	**Your Assessment (#)**
B. Integrated Behavioral Health and Addiction Resources				
Our behavioral health and/or addiction care resources are completely separate entities. Each organization maintains its own electronic medical record (EMR) system. All communication is by phone, fax, and/or letters. There is little to no data sharing.	We are planning or in the process of creating integrated IT resources to facilitate communication and patient data sharing between primary care, addiction specialist and behavioral health providers.	We have some electronic communication in place between primary care, addiction specialist and behavioral health providers, for example secure email exchange and/or able to view shared patient information via an electronic Health Information Exchange (HIE).	We have a fully integrated system that allows for electronic patient information/electronic medical record sharing across primary care, addiction specialists and behavioral health providers. Data sharing consents are documented and workflows exist to ensure that those who have proper levels of viewing authority can access data across the organization(s).	
Comments/Notes:				
XIII. Culture and Engagement				
We do not currently provide MAT because it is not consistent with our treatment philosophy; or we do not provide MAT because of a lack of support for MAT in our organizational leadership or provider community.	Some providers/teams are interested in providing MAT or have started to implement MAT in their own practices, but there are many concerns within the organization at all levels due to one or more of the following: the cost of treatment, the efficacy (or lack thereof) in treating OUD, the potential for patient relapse, the need for significant resources in order to be successful, concern for the safety of providers and front office staff, concern it may increase provider/staff burnout, or the lack of available resources to support induction and/or higher levels of care.	Providers and leadership are moderately enthusiastic, and some members of the organization are volunteering to participate and working to help build engagement and buy-in amongst their peers.	Our organization recognizes the need for more MAT in our community and our role in expanding access to this treatment. Many, if not all, of our providers/staff enthusiastically support our MAT program/plans. We have an active culture of mentorship and training where experienced staff provide leadership and mentoring to staff that are new to the organization or this topic or have questions/concerns and we provide training for providers and staff that includes not just core competencies but also addresses bias and stigma associated with OUD and MAT.	
Comments/Notes:				

Self-Assessment Questions				
0 - No Progress	**1 - Early Progress**	**2 - Moderate Progress**	**3 - Regular Part of Care**	**Your Assessment (#)**
XIV. Billing and Reimbursement				
All work and/or treatment related to our MAT program (or planning) is supported by external grant funding with minimal internal funding resources or reimbursement revenue.	There is some amount of cost sharing across revenue streams and funding sources, e.g., for some staffing or infrastructure; available billing codes are used for insured patients; organization/team members contribute some resources to support planning or implementation, such as in-kind staff or expenses of provider training. We are not currently maximizing reimbursement strategies and are frequently not being reimbursed for the full cost of treatment, e.g. behavioral health and/or care management functions or are struggling with formulary or pre-approval requirements for medication.	We are in the process of developing or implementing a plan to maximize reimbursements and ensure appropriate billing for the full cost of treatments. We are have some external/grant funding, but are working on a plan for sustainability of our program after the end of grant funding.	We have a fully operational strategy for maximizing reimbursement and documented workflows for billing that include formulary management and pre-authorization of medication. Funding sources are fully integrated, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly.	
Comments/Notes:				