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Expanding Low Barrier Access to Medication Assisted Treatment: Issue Brief

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Maine Health Access Foundation: Addiction Care Program

Issue Brief: Expanding Low Barrier Access to Medication Assisted Treatment

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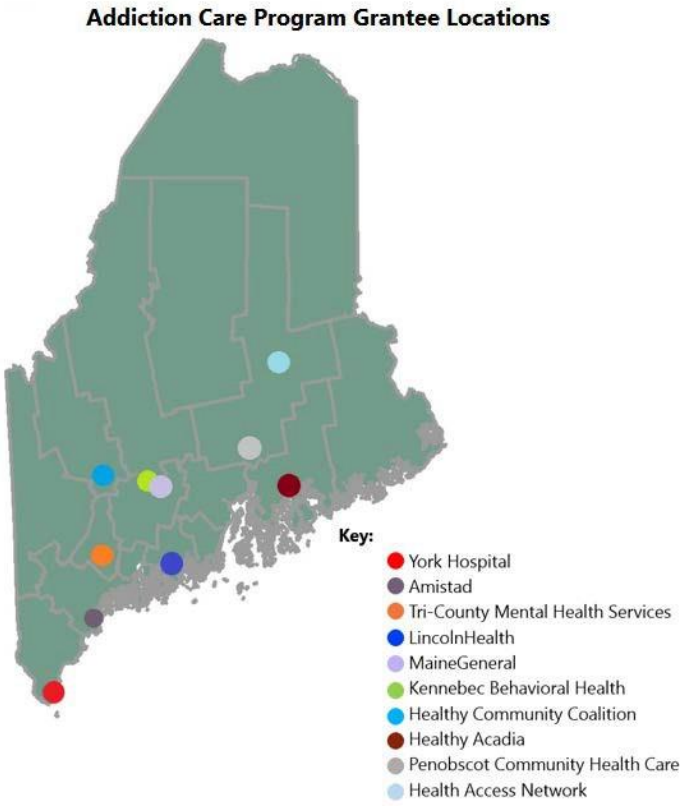
THE OPIOID PROBLEM IN MAINE

The misuse of opioids and subsequent addiction continues to be a public health crisis in the United States. In Maine, there were 354 overdoses involving opioids (pharmaceutical or non-pharmaceutical) in 2018 – this accounts for 80% of all drug-related deaths in the state.[1] Data from 2017 indicates Maine had the 6th highest rate of opioid-related overdose deaths.[2]

ADDRESSING THE PROBLEM

While the statistics are alarming, this public health crisis can be successfully addressed through comprehensive initiatives, policies, and strategies. Within primary care, one evidence-based strategy to address opioid use disorder (OUD) is **Medication Assisted Treatment** (MAT). MAT combines the use of behavioral therapy with medication – for OUD the medication is buprenorphine. Primary care providers are uniquely situated to deliver MAT as they are at the front line of the health care system and provide therapy for chronic pain, which often involves prescribing opioids. However, implementation of MAT within the primary care setting is challenging due to barriers at the patient, provider, and practice levels.

Understanding the existence of these barriers, the Maine Health Access Foundation (MeHAF) is supporting capacity-building efforts to expand access to patient-centered addiction care for people with OUD through their *Addiction Care Program*. This program, which started in April of 2017, is supporting ten grantees across the state of Maine. One of the primary goals of the program is to increase rapid access to MAT services.



EVALUATING THE PROGRAM

With funding from MeHAF, the Muskie School of Public Service at the University of Southern Maine is conducting an evaluation of the *Addiction Care Program*. Using quantitative data (clinical and site-level data, surveys) and qualitative data (patient focus groups, semi-structured provider interviews), the evaluation aims to (1) document practice and provider experience initiating and delivering MAT in primary care; (2) examine facilitators and barriers to expanding access to patient-centered addiction care; (3) evaluate implementation strategies; (4) assess the demand, utilization, and reach of efforts among grantee organizations; and (5) assess programmatic and patient outcomes.

[1] Sorg, Marcella. *Expanded Maine Drug Death Report for 2018.* Updated 4/19/19. Margaret Chase Smith Policy Center, University of Maine.

[2] National Institute on Drug Abuse. https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state. Accessed 11 April 2018.

LOW BARRIER ACCESS TO MAT

Creating low barrier access to MAT is a critical component to ensuring treatment initiation and engagement for high-risk patients.[3] To be effective, systems must ensure that individuals with OUD needing treatment will be identified, assessed, and receive treatment either directly or through referral, regardless of their pathway into the treatment system.[4] Establishing clinical-community linkages is essential for programs and policies that are consistent with a "no wrong door" policy.

Systems-level Barriers to Treatment Engagement

In surveys and interviews, MeHAF *Addiction Care Program* grantee organization program implementation teams, providers, and persons in recovery cited a number of barriers to initiating and accessing MAT and related recovery services, including: prescriber shortage, stigma, scarce access to comprehensive community-based services for those receiving MAT, financial challenges (i.e. low services reimbursement rates, lack of insurance coverage, and high medication and treatment costs), and transportation. The barriers to care are often intertwined and compounding.

Patients frequently cited the lack of available MAT providers in their community as a barrier to accessing care. Workforce shortages and staff turnover continue to constrain the ability of organizations to expand access to MAT. In our discussions with providers, they continually mentioned lacking the number of providers and counselors needed to effectively address the demand for services in their communities. Additionally, providers are faced with limited staff to help with scheduling and managing care coordination for MAT patients. A lack of staff to oversee these activities has forced prescribers to limit the size of their MAT patient panels.

As one prescribing provider noted, ***"the irony of that stigma [perceived work burden] is if we could spread this out over more people, it wouldn't be so onerous."***

In addition, particularly in rural areas, patients are faced with limited access to detoxification and MAT treatment programs because of the state's limited treatment infrastructure.

This brief highlights two MeHAF grantees that have employed unique strategies to remove barriers for individuals with OUD who wish to access MAT assessment and treatment services in their community.

GRANTEE HIGHLIGHT: TRI-COUNTY MENTAL HEALTH SERVICES

As part of the *Addiction Care Program*, Tri-County Mental Health Services (TCMHS) has engaged a group of key stakeholders in the planning of their MAT pilot program, named **CommUNITY Recovery**. To facilitate participation from a diverse group of stakeholders, CommUNITY Recovery established a Steering Committee and five subcommittees: Community Resources; Clinical and Treatment; Recovery Community; Law Enforcement; and Policy and Procedure.

One of the main goals of CommUNITY Recovery is to decrease barriers to accessing MAT by providing traditional MAT resources in tandem with counseling and wraparound services, (i.e. social services, recovery supports, housing and employment assistance) that ensure the hierarchy of individual needs are met for each person receiving MAT. Steering and subcommittee members reported that addressing social determinants of health and building partnerships with appropriate providers has been a primary aim of the project's planning process.

To that end, the CommUNITY Recovery project has built strong relationships across community organizations, with thirteen community organizations — including two hospital systems, police/sheriff departments, and city officials — directly involved in the planning of this project through their participation in the project Steering

[3] SAMHSA. Medication-Assisted Treatment of Opioid Use Disorder. Accessed May 26, 2017 from https://store.samhsa.gov/system/files/sma16- 4892pg.pdf.

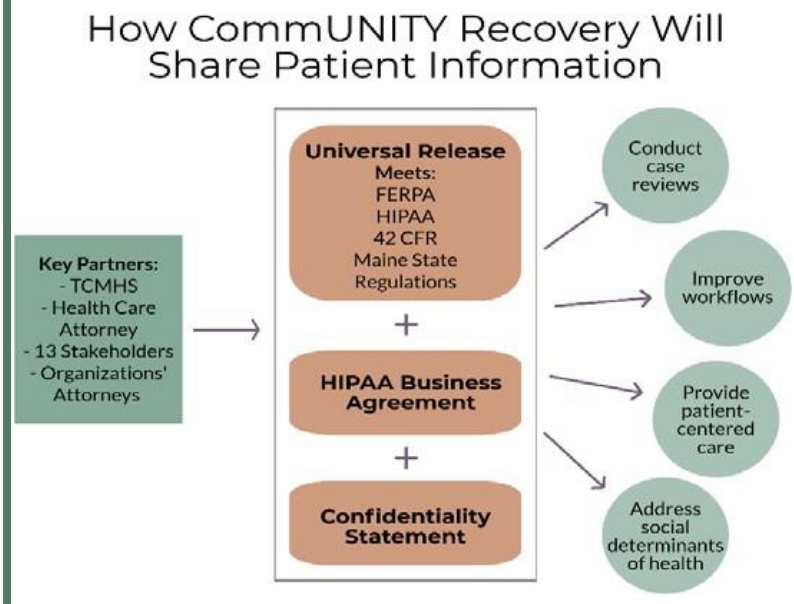
[4] Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons With Co-Occurring Disorders. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment Improvement Protocol (TIP) Series, No. 42.) 3 Keys to Successful Programming. Available from: https://www.ncbi.nlm.nih.gov/books/NBK64185/.

Committee. These strong clinical-community linkages established as part of the CommUNITY Recovery project planning process helped TCMHS establish a pilot model that is well positioned for providing low barrier access to both treatment and recovery support services for individuals with OUD.

To ensure that MAT is conducted in an environment that provides adequate support and services, CommUNITY Recovery created and adopted a **universal release form** (universal release) that allows all thirteen project partner agencies in the area to share information with each other about patients in the pilot program. Each stakeholder must sign a HIPAA business agreement and confidentiality statement. To enter the pilot MAT program, each patient must sign the universal release.

> ***The ultimate goal of the universal release is "to reduce as many barriers as possible to increase retention and the effectiveness of treatment."***
>
> ***- Project Director***

The universal release was created with input from all stakeholders as well as a health care attorney, in accordance with national and state health care privacy laws and regulations. The universal release allows the stakeholder steering committee to act as a case review



committee that will be able to work together to serve a patient's hierarchy of needs—not just for access to MAT, but for employment, shelter, food, family counseling, etc. It will support the flow of referrals between primary care, specialists and other key stakeholders, while ensuring there is "no wrong door" for accessing those services.

Stakeholders reported in focus groups that the commitment of partner organizations and their regular participation is a unique strength of the CommUNITY Recovery project. Ongoing engagement from stakeholders throughout the planning process has been instrumental in facilitating program design and successful implementation of the MAT pilot project. Since the roll-out of the pilot program in September of 2019, TCMHS has enrolled nearly 50 individuals into their MAT pilot program. Moreover, multiple projects have resulted from relationships formed out of the committee structure, and stakeholders described the process as a learning experience.

GRANTEE HIGHLIGHT: PENOBSCOT COMMUNITY HEALTH CENTER

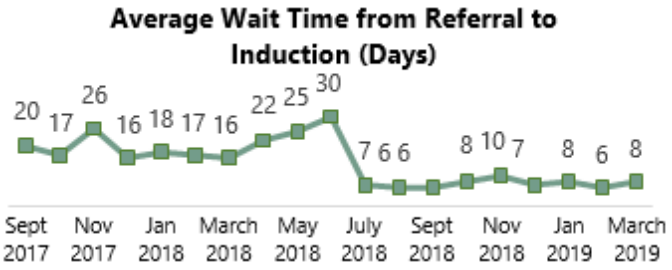
Penobscot Community Health Center's (PCHC) *Addiction Care Program* project, **A Regional, Rapid-Access Approach to MAT**, also aims to provide low barrier access to MAT services for their patients. To achieve this, PCHC has implemented practice-level strategies to capitalize on the narrow window of time when individuals are most motivated to commit to MAT.

In order to ensure rapid access to MAT, PCHC implemented a number of strategies to reduce barriers to accessing treatment services, from both the provider and patient perspective. PCHC has focused on increasing provider capacity to treat MAT by hiring experienced prescribers and encouraging existing prescribers to expand the size of their MAT patient panels, hiring a full-time clinical social worker to conduct intake evaluations and individual and group counseling sessions, and adding a care coordinator position specifically for

MAT patients. PCHC staff described the care coordinator position as an essential resource that allows providers to spend more time treating patients. Additionally, community partners and non-PCHC providers are encouraged to join trainings so they can acquire waivers to be able to prescribe buprenorphine.

PCHC holds weekly meetings for MAT providers to discuss programmatic- and patient-level challenges. By discussing complex patient cases, providers can address organizational barriers while fostering peer support. These meetings led to changes in patient scheduling processes to allow for day-of intake and initial review appointments. In addition, establishing workflows for Patient Service Representatives to assist patients with intake paperwork, processing paperwork, coordinating referrals, and data collection have helped to reduce provider workload.

PCHC's strategies to build workforce capacity, enhance organizational resources and infrastructure, update workflows, and provide prescriber peer-supports have led to a substantial decrease in wait time between initial referral to treatment and induction. As of October 2019, PCHC had 486 patients enrolled in their MAT program. The average wait time from referral to first induction was eight days in October of 2019, representing a 60% decrease in average wait time between referral and treatment initiation since the start of the program.



In addition to providing timely access to treatment services, PCHC reduced barriers to treatment engagement by providing MAT services in a co-located facility that has physical and behavioral health care as well as pharmaceutical services. This environment greatly reduces patient-level barriers to access, increases provider communication, promotes care coordination, and facilitates a holistic approach to addressing the complex physical and behavioral health care needs of individuals with OUD.

PCHC implemented other strategies to address patient-level barriers to maintaining treatment, including implementing a sliding fee scale for MAT services, providing patients transportation to medical appointments through a vendor, and implementing more flexible program policies to encourage treatment initiation and ongoing engagement (i.e. reducing the number of required counseling sessions in treatment).

In addition to building provider capacity internally, PCHC established relationships with community organizations to eliminate gaps in care as patients transition between programs. PCHC established referral processes from a social detox program, the Penobscot County Jail, and other legal channels that mitigate patient barriers to finding new prescribers, reducing the risk of relapse. PCHC is also able to refer patients with complex needs to specialty programs through a standing referral agreement with Acadia Hospital.

SUMMARY

Given the chronic nature of OUD, creating low barrier access to MAT is a critical component to ensuring treatment initiation and ongoing engagement. Both Tri-County Mental Health Services and Penobscot Community Health Center exemplify efforts to establish the infrastructure necessary to provide low barrier access to MAT and recovery support services to meet the needs of their patients. Both programs have used the resources provided from the *Addiction Care Program* to engage in thorough planning processes, which has helped them to establish the systems necessary to provide a broad range of MAT services, share information across agencies to promote care coordination, and create the clinical-community linkages necessary to provide wrap-around services to individuals with OUD.