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Challenges and Strategies to Expanding MAT within Primary Care: Provider Perspectives. Issue Brief

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Maine Health Access Foundation (MeHAF): Addiction Care Program

Issue Brief: Provider Perspectives

Challenges & Strategies to Expanding MAT within Primary Care

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INTRODUCTION

The high rate of opioid misuse and subsequent addiction is an ongoing national and local public health crisis. Despite numerous statewide efforts to reduce rates of opioid prescribing, prevent diversion, and increase access to treatment for opioid use disorder (OUD), rates of opioid-related overdoses and deaths remain high. MeHAF's *Addiction Care Program* focuses on addressing opioid-related morbidity and mortality by supporting capacity building efforts to increase Medication-Assisted Treatment (MAT) in primary care settings. Ten grantee projects throughout Maine were selected in 2017 to plan and implement the integration of MAT into health system practices, workflows, and networks. While each grantee organization has specific strategies aimed at addressing the unique needs of their community, the overarching goal of the *Addiction Care Program* is to **create new or expand capacity for MAT in primary care for people with OUD.**

Medication-Assisted Treatment (MAT)
What is MAT?
MAT is an evidence-based path of recovery from substance use disorders (SUD) facilitated by medically monitored pharmacological agents approved by the FDA. For opioid use disorder (OUD), these medications include methadone, naltrexone, and buprenorphine (common brand names: Suboxone and Subutex). MAT is the combination of behavioral therapy with medication that is effective for many, but not all individuals.
Who can provide MAT?
In Maine, physicians (MD, DO), nurse practitioners (NP), and physician assistants (PA) can prescribe the medication(s) associated with MAT for opioid use disorder. To prescribe buprenorphine, providers must take additional training and receive a waiver from the federal government (X-waiver). The provider works collaboratively with the patient and with behavioral health professionals to provide comprehensive care for the person receiving MAT.
What type of training is required to provide MAT?
Physicians are required to complete an eight-hour training to qualify for an X-waiver to prescribe and dispense buprenorphine. Nurse practitioners and physician assistants are required to complete 24 hours of training, including the initial eight-hour MAT training for physicians.
Who is a good candidate for MAT?
Per guidance from the U.S. Substance Abuse and Mental Health Services Agency (SAMHSA), a good candidate for MAT for opioid use disorder: • Has an official diagnosis of an opioid use disorder. • Is willing to fully comply with prescribing instructions. • Lacks physical health issues that the medication could possibly exacerbate. • Is fully educated on alternative options.
For more information on MAT: https://www.samhsa.gov/medication-assisted-treatment

DATA COLLECTION

The Muskie School of Public Service at the University of Southern Maine (Muskie) was contracted by MeHAF to conduct an independent evaluation of the implementation and effectiveness of the *Addiction Care Program*. As a part of the evaluation, data was collected from participating *Addiction Care Program* sites between May of 2017 and May of 2019 via provider focus groups and surveys as well as programmatic data dashboards.

> **Providers:** Prescribers and anyone with direct interactions with MAT participants/patients. This staff includes but is not limited to: MD/DOs, PAs, RNs, LPNs, CMA/MAs, managers, LCSWs, and other behavioral health staff.

Focus groups were conducted using a semi-structured protocol in the last two quarters of Year One (N=36) and in Year Two (N=66). The focus groups in Year Two not only included providers, but also members of **change teams**. Change teams are comprised of individuals who are involved in the day-to-day collaborative and operational aspects of project implementation. Each grantee project has a change team specific to the work of the *Addiction Care Program*. Providers on change teams are dedicated champions working towards the implementation of MAT within their primary care setting. All focus groups were recorded and transcribed verbatim for analysis. Qualitative data analysis was done iteratively to identify reoccurring themes.

Surveys were deployed to providers at the beginning of Year One (N=92) and at the end of Year Two (N=31). Quantitative survey data were analyzed using appropriate descriptive statistics such as means and frequencies.

Data dashboards were created in Microsoft Excel for each grantee to record de-identified continuous quality improvement data (ie. number of individuals screened for OUD, number of individuals receiving MAT) and administrative data including: education and training sessions, stakeholder engagement, and individualized grantee-specific data. This issue brief provides a summary of provider perspectives obtained via these three data collection methods.

PROVIDER-IDENTIFIED CHALLENGES

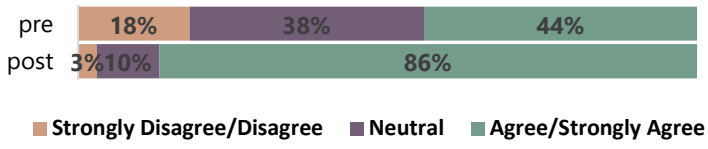
Organizational Supports

Providers working within grantee organizations frequently mentioned the need for resources to support their MAT implementation and expansion efforts. Internally, the key organizational supports identified by providers that are necessary to support the provision of MAT in primary care settings include: support for personnel at all levels; support and resources for prescribers (i.e. opportunities for peer-to-peer mentoring); communication infrastructure within and across organizations to support comprehensive integrated care; and stakeholder engagement, particularly of individuals with OUD to inform program policies and procedures. Providers indicated that they are reluctant to deliver MAT if they do not feel they have these necessary organizational supports. One focus group participant stated that, "The practice has to be ready right from the receptionist. It's a whole team. It's a pretty massive undertaking and a cultural shift." Grantees continue to use various strategies to strengthen organizational support and ensure practices are well-prepared for successfully delivering MAT (See table on next page).

Organizational cultures shifted as grantees implemented MAT, completed more MAT-related training, and included stakeholders in the process. One focus group participant stated at the end of Year Two, ***"People were scared of it [implementing MAT]. They didn't know what was going to happen. [It's] really just blossomed and it's really been a beautiful transition."***

By setting up supports for prescribers, including the infrastructure for communication, providers became more confident in their organization's ability to integrate MAT into clinical work with patients. One survey question asked, "*On a scale of 1 to 10, where 1 is "not confident" and 10 is "extremely confident," how confident are you in your organization's ability to integrate MAT into clinical work with patients?*" The mean score for this question significantly increased from 6.8 in the first year to 8.3 in the second year. One driver of this shift was the incorporation of data sharing agreements (sometimes called a Universal Agreement) which allows for shared patient information between primary care physicians, specialists, and behavioral health staff.

Figure 1. ***My colleagues have had success in dealing with OUD-related problems.***
(provider survey, all respondents)



Grantee Reponses: Key Components to Implementing MAT in Primary Care

Organizational Support at All Levels

Support and Resources for Prescribers

Infrastructure to Support Communication between Providers

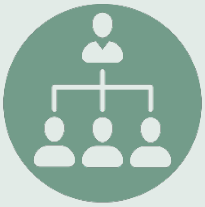
Stakeholder Engagement

Strategies for Successful Implementation

- Training providers and staff on OUD, stigma, and trauma
- Modeling behavior towards patients for staff

- Connecting patients with internal and external Suboxone subsidies or cost waivers
- Creating/linking to robust peer recovery networks
- Cataloging resources on how to respond to clinical situations
- Setting up opportunities for peer-to-peer support
- Educating and training

- Centralizing care in one location
- Utilizing release forms to facilitate rapid access to treatment
- Scheduling regular team meetings or case reviews



- Engaging stakeholders in the planning process through workgroups and committees
- Building off of existing collaborations and networks

Additionally, providers in the second year were significantly less likely to say they experienced conflicts in their decision on whether or not to address OUD in their practice and also felt their colleagues were having more success in dealing with OUD-related problems (Figure 1).

Workforce

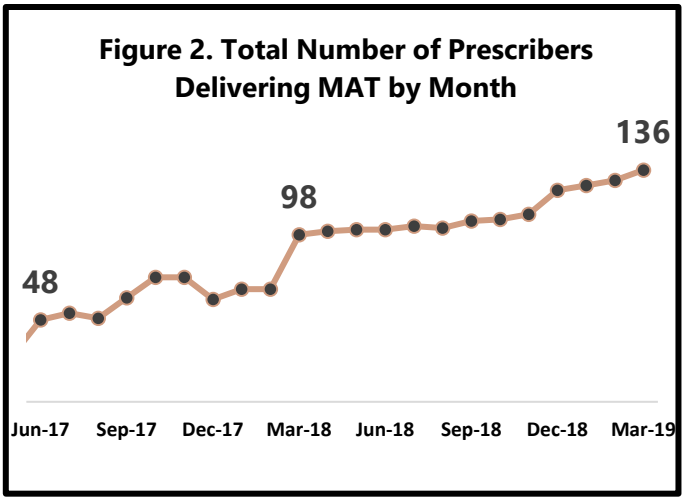
The ability of organizations to expand access to MAT is constrained by workforce shortages and staff turnover. During the first year of the program, providers frequently mentioned that their ability to provide services to address OUD in their communities was significantly impacted by the lack of waivered providers and behavioral health counselors. Moreover, providers indicated that the lack of available and trained staff to help with scheduling and managing care coordination for MAT patients often forced them to limit the size of their MAT patient panel.

In order to address the workforce capacity issues identified by providers, grantee organizations leveraged resources provided by the *Addiction Care Program* to employ additional staff. These employees support care integration, patient navigation, and connections to community supports.

> ***"I feel some of our greatest success has been the continuous addition of providers to our team."***
>
> ***-Provider, Year Two***

Additionally, education and training sessions on numerous topics, including the federal X-waiver training required to deliver MAT, as well as trainings for specific roles and workflows, led to increased capacity for grantees to deliver MAT. Ongoing MAT trainings ultimately increased the number of prescribers from 48 at the start of the program to 136 by the end of the second year of the *Addiction Care Program*, representing a nearly three-fold increase in the number of providers delivering MAT at grantee organizations (Figure 2). In the same time frame, grantee organizations were able to increase the number of patients in their MAT programs. Data collected via the data dashboards shows grantees collectively enrolled twelve times as many patients in their MAT programs at the end of the second year compared to the start of the first year.

Figure 2. Total Number of Prescribers Delivering MAT by Month



Payment and Reimbursement for Services

In the first year of the *Addiction Care Program*, providers indicated that reimbursement for services was the number one barrier to expanding access to MAT. Individuals with private or public insurance face cost barriers as many insurance companies do not fully cover or pay for the costs of patients' buprenorphine prescriptions and their treatment. Some insurance companies have placed limits and regulations on who can be prescribed MAT and for what duration. Practices lacked the necessary financial resources to implement and/or expand MAT programs without external funding (e.g. reimbursement for supportive services and funding for training).

The expansion of MaineCare, Maine's Medicaid program, will address some of these financial barriers. MaineCare expansion is expected to lead to increased coverage of low-income adults who have SUD. The expansion has already led to increased

reimbursement rates for treatment and support services.[1] Currently, some practices are striving to overcome this barrier by working to meet the eligibility requirements for Maine's Opioid Health Home programs, which are specifically designed to provide financial resources to support MAT and care coordination for complex uninsured and under-insured patients.

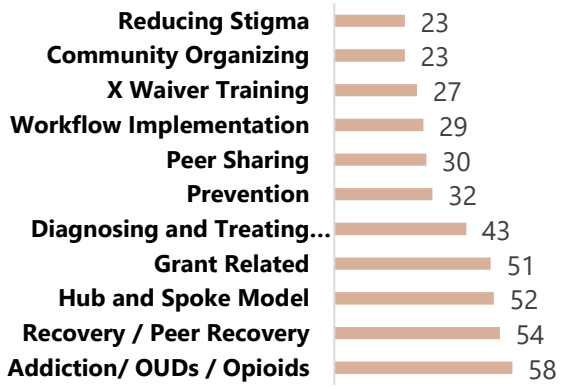
Training and Education

Providers regularly mentioned the lack of proper training and education for both providers and staff as barriers to expanding access to MAT. Respondents expressed the need for trainings for a variety of providers including, but not limited to: prescribers, nurses, social workers, therapists, counselors, and peer recovery coaches. Additionally, providers noted that current and future MAT prescribers could benefit from professional mentoring, especially for providers that have newly completed the federal X-waiver training required to deliver MAT. Most providers agreed that a more formal MAT provider-to-provider network within their own system and/ or perhaps a statewide clearinghouse would be beneficial for further training, consultation, and information sharing.

Throughout the grant period, grantee organizations made significant investments in training and education. By the end of the second year of the program, 116 healthcare staff completed trainings focused on MAT, and an additional 558 training/education sessions were conducted by grantee sites.[2] The most frequent training and education topics are shown in Figure 3. Grantee organizations have also focused on supporting providers by setting up opportunities for and encouraging peer-to-peer support. As a provider within a large health system explained, ***"A lot of the education has been provider to provider, which makes a big difference. Speaking to a colleague is very different than sitting in a meeting. One of our walk-in care providers has started doing MAT and does a fabulous job. Now the other walk-in care providers are starting to ask questions and are interested in it. So seeing people do it, more providers are like 'I can do that.' It makes sense."***

Treatment Program Policies

Figure 3.
Most Frequent Training and Education Topics



During the first year of the *Addiction Care Program*, providers frequently reported that inflexible MAT program policies as well as external policies, such as insurers' cumbersome prior authorization processes and barriers around sharing protected health information, made it difficult to have continuity of care in treatment and recovery. Inflexible program policies were often cited as impediments to successful treatment and often "set patients up for failure" by penalizing patients if they missed an appointment or group therapy session, experienced a reoccurrence, or had a change in insurance. Providers' concerns were echoed by program participants who indicated that while they appreciated the accountability the MAT programs were offering, they felt that the treatment programs could benefit from more flexibility to "meet the patient where they are."

[1] Clemans-Cope, Lisa, et al. *The Urban Institute. Leveraging Medicaid to Address Opioid and Substance Use Disorders in Maine: Ten State Policy Options from an Expedited Review*. 2019, www.urban.org/sites/default/files/publication/100443/2019.06.20_mainecare_report_final_7.pdf.

[2] Training and Education sessions recorded in grantees' data dashboards in the first two years of the grant.

In an effort to provide more patient-centered care and promote long-term patient engagement in treatment and recovery services, grantee organizations devoted resources in the second year of the *Addiction Care Program* to developing policies and procedures that offer greater flexibility to participants. For example, several grantee organizations responded to feedback from providers and patients by adjusting some of the stringent Intensive Outpatient (IOP) requirements (i.e. attending IOP 3-4 hours a day, 5 days a week) that were part of their first phase of the MAT program. In some cases, grantees reduced the length of time needed to complete IOP, or adjusted the number of group sessions needed to remain enrolled in the IOP.

"I think meeting patients where they're at when they come into our services is critically important because there's a lot of places that just say 'oh, you're new to treatment, you need an IOP,' which discourages patients from entering treatment because they may be like 'I'm not going to quit my job. I need Suboxone but I'm not going to quit my job' or whatever the situation is, or 'I can't get there five days a week.' So the fact is that we're here to help you and we're here to meet whatever your individual needs are, it's not a one-size-fits-all operation. It's a continuum of care, which I think should be the model that people are striving toward."

-Provider, Year Two

In addition, during the second year of the *Addiction Care Program*, grantee organizations offered more therapeutic options by varying group therapy sessions by size, time, and/or gender, and in some cases allowed patients who were unable to attend group therapy in a certain week the option to check in one-on-one with their prescriber or group leader. Ensuring treatment program policies are adaptive and flexible leads to greater continuity of care.

Stigma

Throughout the grant, providers reported that stigma among medical providers and staff often underlies or compounds the challenges associated with many of the barriers to MAT expansion. Stigma related to perceived work burden, around MAT treatment in primary care, and the nature of OUD as a disease contributes to a lack of providers willing to prescribe medications for OUD treatment.

"One of the most challenging things I've learned about is the strength of the stigma. I don't even mean on the streets or the neighborhood, I mean here [within the health organization]."

-Provider, Year Two

To address stigma at the provider level, grantees focused on utilizing educational opportunities as a mechanism to reduce stigma related to OUDs, offering trainings on stigma reduction for all providers, not just prescribers, as well as office staff. Over the course of the grant, 23 "reducing stigma" educational sessions took place.[3]

Additionally, prescribers discussed the importance of behavior modeling for other providers and co-workers. Grantee organizations have made a conscious effort to continually discuss mechanisms to address and reduce stigma through regular

[3] Training and education sessions recorded in grantees' data dashboards in the first two years of the grant.

conversations at project or staff meetings and by providing both organizational and peer support aimed at reducing stigma within the health care system.

By the end of the second year of the *Addiction Care Program*, survey results indicated that providers who were certified to prescribe were significantly more likely to feel that OUD-related problems were given equal priority as other chronic conditions within their organization. This indicates a shift in provider-based stigma and a change in organizational readiness to incorporate and address MAT within their practices. One provider stated, ***"I think differently now about my recovery patients and how I deal with them than I did when we started a year and a half, two years ago. I have different expectations of them and myself in the way I treat them."***

In addition to working on reducing stigma within their organizations, *Addiction Care Program* grantees have leveraged the comprehensive cross-sector partnerships they have built between health care, first responders, law enforcement, business, peer recovery and social service agencies to provide education and training across these stakeholder groups aimed at changing individuals' beliefs and attitudes about OUD and the use of MAT to address OUD. Promoting stigma reduction among community partners is critical to fostering clinical-community linkages and building the infrastructure necessary to creating sustainable community systems of care for individuals in treatment and recovery.

SUMMARY

Grantees have made great progress integrating MAT into health system practices, workflows, and networks. While challenges have been met throughout this process, grantees have been strategic in alleviating internal and external resource barriers (i.e. organizational supports, workforce, payment and reimbursement), providing training and educational opportunities, ensuring treatment program policies are patient-centered, and addressing stigma. As a result of these efforts, primary care practices are undergoing organizational shifts. Resources from the *Addiction Care Program* have enabled grantees to address challenges they met at the beginning of the grant, subsequently ensuring more individuals with OUD are able to access treatment. The strategies utilized by grantee organizations as part of the *Addiction Care Program* are addressing crucial access gaps in treatment infrastructure, provider training/education, and organizational capacity to deliver MAT in primary care settings.

"My dream is someday that opioid use disorder will be actually seen the same as COPD, diabetes, hypertension. I think it will come."

-Provider, Year One

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