Inclusion of Medications in SUD Care: Paving the Way to Uncover Opportunities and Challenges

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Executive Summary

The depth and breadth of the latest opioid epidemic has focused attention on and highlighted the gaps in accessing substance use treatment services. In light of this epidemic, the Community Health Resources Commission (CHRC) has prioritized support of innovative and sustainable projects that increase access and help remove the stigma associated with accessing substance use treatment services. The CHRC has provided $3.7 million to support Substance Use Disorder (SUD) projects, and these programs have collectively served more than 5,200 individuals in nine Maryland jurisdictions. CHRC grant funding helps behavioral health care providers to grow, innovate, and scale services to provide a wide range of treatment options for people with SUD. These options include psychiatric services, peer support recovery services, medication-assisted treatment, and wrap-around social services.

Medication-assisted treatment, an evidence-based service for the treatment of SUD, has been available since the 1970s, though many programs never used, insurers have not covered, and government has not required the use of these services. Now, in light of the current epidemic, policymakers and others finally wish to support access to medications. There are not, however, enough community providers with the capacity to deliver these services. Providers must build this capacity by hiring new staff that can prescribe these medications and/or obtaining a new federal status to provide methadone. There is little financial support for the administrative and cultural changes needed to support such capacity building. Fortunately, models exist that can help overcome some of the barriers. Some areas of the state had experienced high rates of opiate use before this epidemic and were already working to expand access to SUD services with medications. CHRC's long-standing support provided many sites with the capacity resources even before the current opioid epidemic and these, as well as other projects, can be used as models.

CHRC funding ultimately supported grantees in these ways:

- Providing leadership the time, planning assistance, and cultural adjustments needed to add or expand a lifesaving but stigmatized evidence-based service to their continuum
- Funding to support critical up-front costs until providers could develop service and reimbursement mechanisms
- Supporting grantees' work to destigmatize medications as they worked with other health care partners in both somatic and behavioral health systems of care

This white paper is the second of three white papers highlighting the efforts and successes of the Commission's behavioral health grant-funded programs. The first of these white papers, "Building a Base for Integrated Care," was published in 2017 and can be found on the CHRC website. This paper focuses on CHRC's efforts to increase access to medication-assisted treatment (MAT) in outpatient, short-term inpatient, and telehealth settings throughout Maryland.

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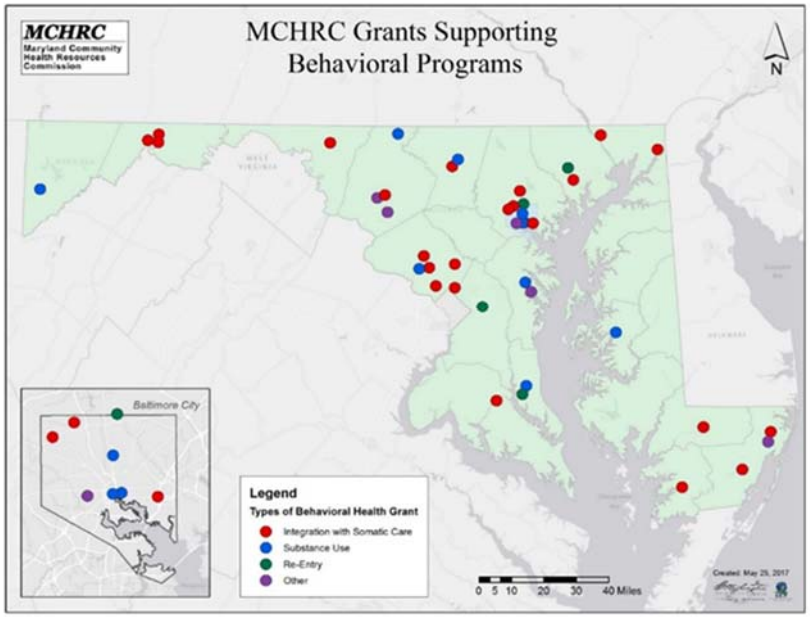
Introduction

Behavioral and somatic health care providers, policymakers, and the public have traditionally viewed individuals with Substance Use Disorder, especially those in poor communities and communities of color, as the responsibility of the justice system. Addiction was thought to be a lifestyle choice, and those afflicted with addiction were thought undeserving of evidence-based or evidence-informed prevention, secondary prevention, formal treatment, relapse treatment, or recovery services. Only recently have state and federal policymakers started to recognize addiction as a disease and tried to develop policies that treat it as such with community-based evidence-informed services. While federal legislators passed mental health and substance use disorders parity legislation and the Affordable Care Act included comprehensive SUD services as an essential benefit, it is truly the severity of the current opioid overdose epidemic that has forced policymakers to rethink strategies. The epidemic is challenging available resources and policies and creating a new sense of urgency, as there are not enough high-quality, culturally effective behavioral health programs to care for all those afflicted with SUD. Furthermore, the previous views of SUD often mean that policymakers lack the knowledge and understanding of best practices in this arena.

Similar to other health conditions, there are a number of effective treatments for SUD, yet no single treatment works for all patients. Fitting treatment options to an individual patient's realities and needs makes improved health, and even long-term recovery, more likely. Patients and providers should know about, and have access to, all evidence-based services as part of a service continuum, and policymakers should develop systems that support access to these services. Medication-Assisted Treatment, an evidence-based approach to SUD, has been around since the 1960s, but has been stigmatized and criticized as "simply replacing one addiction with another." As the current opioid epidemic has become a public health emergency, medications have been recognized as an important tool for comprehensive opioid treatment services, and providers can prescribe MAT in different health care settings including community clinics, hospitals, urgent care centers, and via telehealth settings. The CHRC has recognized the importance of medication as a component of treatment since 2007, and its grantees could serve as models of systemic and service change as the state and local governments try to respond to the opioid epidemic.

Organizational Background

The Maryland General Assembly created the Maryland Community Health Resources Commission in 2005 to expand access to health care services in underserved communities in Maryland. The CHRC is an independent commission, operating within the Maryland Department of Health, and is led by 11 Commissioners who are appointed by the Governor. Since its inception, the CHRC has prioritized expanding access to behavioral health services for underserved communities with a particular emphasis on the integration of behavioral health and primary care services. The CHRC has awarded 48 grants totaling $12.7 million to support behavioral health programs. The awardees have collectively served 67,810 residents, many of whom face complex medical issues and comorbidities. The overall goals of CHRC grants have been to: (1) increase access to critical addiction and mental health services for at-risk residents and underserved communities; (2) support the functional integration of behavioral health



services with primary care, community-based settings; and (3) work with many stakeholders at the state and local levels to address the heroin and opioid epidemic. The Commission looks to accomplish these goals in a way that leads to models of care that are replicable and sustainable. CHRC grants have supported a variety of programs focused on: (1) integration of behavioral health services into primary care programs in community health settings such as federally qualified health centers; (2) addition of primary care services in Assertive Care Teams and outpatient mental health programs; (3) implementation of SBIRT (Screening, Brief Intervention, and Referral to Treatment); (4) promotion of re-entry programs which link individuals with primary care and behavioral health services; (5) promotion of community programs that reduce the number of individuals presenting at hospital EDs with behavioral health needs; and (6) increasing access to Medication-Assisted Therapy. This paper will focus on the increasing access to Medication-Assisted Treatment.

The CHRC issues a Call for Proposals (RFP) approximately once each year. The RFP prioritizes integration planning as part of its selection criteria to grow the number of innovative, cost-effective, and sustainable integration models that would improve access to and provision of care for hard to reach populations. Within the focus area of behavioral health, the Commission prioritizes proposals in which primary care providers, behavioral health providers, hospitals, and social services providers agree to collaborate. Joint proposals allow diverse partners to identify shared goals and recognize that solutions require working outside of existing silos. The CHRC's population health focus requires systems to develop a sustainable safety net for the most vulnerable while also building systems for all population groups. CHRC grants can be used for building capacity by increasing staffing levels, improving performance through staff training, increasing the depth and breadth of program services, and purchasing the materials necessary for program implementation. Funds have also been used for bringing in representatives from successful integration programs outside of Maryland to inform, train, and/or evaluate the work being done in state (the overall aim is to ensure that programs will ultimately become sustainable after grant funds have been expended). The RFP also aims to identify qualified programs from all areas of the state which are designed for their community's specific needs, local populations, and capacity.

Impact of CHRC-funded programs

CHRC grants have supported programs to increase access to SUD treatment, with $4.1 million of funding going towards addiction treatment across the state. Since 2007, these programs have worked to decrease the harm caused by drug use for both individuals and the communities in which they reside. CHRC funding has supported outpatient and short-term inpatient SUD treatment programs as well as telehealth programs which provide MAT in isolated communities. These grants have:

- Increased access to and awareness of MAT across the state within existing SUD service systems
- Helped decrease stigma against medications by using thoughtful integration processes
- Allowed sites to purchase medications until providers could establish a system of reimbursement
- Demonstrated different ways to provide these services depending on capacity and patient population
- Improved the program's ability to collect data and evaluate service provision, thereby allowing for changes as needed to improve outcomes
- Enabled conversations that begin to decrease the stigma of using medications for opioid use disorder patients

The following are two examples of how CHRC funding supported new infrastructure development and increased capacity through implementation of integrated care. A full list of grantees and an overview of these programs are available on the CHRC website, https://health.maryland.gov/mchrc/Pages/home.aspx.

Strategies adopted by CHRC grantees to integrate medications into their service provision

The CHRC prioritized the treatment of substance use disorders in its first annual Call for Proposals, issued in 2007. The Commission realized that, as opposed to traditional mental health and SUD counseling, the treatment of SUD with MAT required additional training for providers and a dedication by clinic staff, integration partners, families, and the clients themselves, to overcome the stigma associated with using medications as part of the treatment plan. CHRC funding provided the opportunity to **explore partnerships, build capacity** and begin to **provide MAT**, even if clinics were unable or unwilling to offer a full spectrum of MAT options.

Outpatient SUD treatment

Union Memorial Hospital received funds from CHRC in 2007 to expand the capacity of its program to link inpatient clients with SUD to its existing outpatient buprenorphine program. CHRC funding supported staff salaries, data collection, patient medication costs, and training for case managers and social workers to improve their effectiveness working with patients receiving buprenorphine. Over the course of the grant, the clinic saw 902 individuals, with a total of 9,061 patient visits. The program addressed many of the unique challenges of their patients. In addition to heroin addiction, many patients were unemployed and had frequent hospitalizations and significant legal difficulties. The

program emphasized that medications were an adjunct to counseling, as treatment of the mental and emotional aspects of heroin addiction were as important as the treatment of the chemical dependence.

By 2015, opioid use became epidemic. The CHRC provided funding to the **Calvert County Health Department** for "Project Phoenix," which aimed to provide SUD treatment, including medications, and address social determinants of health facing individuals with substance use disorders. The program works with the drug court to provide services for those already involved with the criminal justice system and with the county school system to provide services to adolescents suffering from SUD. In the first year of the program, 446 individuals have received services offered by the program's psychiatrist and care coordinator on site at Project Phoenix, and the program has provided more than 9,000 behavioral health care visits for adolescents in the Calvert County Schools.

The **Calvert County Health Department** received another CHRC grant in 2014 to support "Healthy Beginnings," a program which provides a comprehensive range of health care, behavioral health, and social supports for pregnant and post-partum women with substance use disorders. The Calvert County Health Department has a MAT program in place that provides buprenorphine to this patient population (not supported by CHRC funds), and the Healthy Beginnings program provides a range of additional supports including intensive case management, prenatal care, family planning, insurance enrollment, and linkage to employment and educational opportunities. In the first year, the program demonstrated that 65% of women attended at least 7 prenatal visits, 87% delivered normal weight babies, and only 17% of infants required Neonatal Intensive Care Unit (NICU) services, with no neonatal deaths. The program has estimated that it has prevented 19-37 cases of neonatal abstinence syndrome and six low-birth weight babies that require NICU services, prevented over 100 unintended pregnancies in women with active substance use, and ultimately saved $4.6 million dollars. [1]

Short-term inpatient treatment

Unfortunately, SUD patients often lack the social supports necessary for full engagement in comprehensive treatment. In response, the **Potomac Healthcare Foundation** utilized CHRC funding in 2016 to establish a residential treatment center in West Baltimore to provide a structured, supportive short- to medium-term recovery environment and case management to facilitate SUD treatment. The center targets those who present to the emergency department because of overdose or other medical crises. Potomac Healthcare partners with an on-campus community treatment program to provide a full continuum of behavioral health treatment for opioid addiction and co-occurring disorders. These include: partial hospital program, ambulatory detox, intensive outpatient, buprenorphine treatment, extended release naltrexone treatment, and an outpatient mental health clinic delivering Integrated Dual Disorders Treatment (an evidence-based specialty program for integrated treatment of co-occurring SUDs and psychiatric disorders). This program served 331 patients in its first year, with two-thirds of patients completing the prescribed short-term residential stay.

[1] http://www.co.cal.md.us/DocumentCenter/View/13648

Telehealth services

In 2016, **Garrett County Health Department** received CHRC funding to increase access to MAT through telehealth services in a sparsely populated rural corner of the state. In partnership with the University of Maryland Medical School Department of Psychiatry, the program provides telehealth treatment for those who would otherwise have had no access to care, as the nearest MAT providers were located in Allegany County. The program also aims to increase the number of providers in the County who are licensed to prescribe buprenorphine to patients with SUD. This work is in its infancy, but other such telehealth programs have been successful and have been able to expand access to care in rural and urban areas.

Critical Success Factors in Provision of Medication-Assisted Therapy

As with the CHRC grantees that are integrating somatic and behavioral health services (the focus of the first white paper in this series), the key factor for program success was visionary, committed leadership within the organization. Leadership often had to change the systems of their organizations and the belief patterns of their employees and needed added strength to withstand decades of bias against medications, often within their own health systems and communities.

Successful grantees sought to develop programs based on their patients' needs and realities. They were willing to withstand the stigma because they recognized that the patients needed access to lifesaving medications. Services were developed in ways to decrease barriers. Organizations used data to assess success and, if new barriers arose, they had to change course.

Finally, all the leaders praised the commitment and dedication of staff to work in new ways, but also to embrace the patient-centric caregiving perspective.

Challenges

As with many attempts to improve systems of care, CHRC-funded programs aimed at increasing access to MAT have themselves faced challenges.

Hiring and retaining key trained staff

A dearth of qualified professionals has made hiring and retaining providers difficult and slowed the ability to launch MAT programs. This is especially true in rural areas, where organizations regularly face challenges in recruiting all categories of health care professionals. SUD patients can have complex needs that require staff who are culturally sensitive, non-judgmental, and do not convey disapproval for patients in need of SUD, including MAT services. These providers are in high demand as the need for opioid treatment services expands.

Federal regulations can also be burdensome for MAT prescribers, as they place special requirements and restrictions on those who seek to prescribe certain medications. For example, providers must receive specialized training and obtain a federal waiver to prescribe buprenorphine. Federal legislation limits the number of buprenorphine patients a provider can treat to 275 at a time, but the strain this puts on providers may be partially alleviated as new regulations allow for Nurse Practitioners and Physician Assistants to become licensed prescribers. Licensing requirements and training necessary to obtain a

license, however, could remain a hurdle for some. Organizations must pay for the cost of training as well as cover the costs of the provider's time away from seeing patients. Public and private payers could provide incentives for providers to not only become licensed, but be able to treat patients with SUD within their clinics.

Offering a full range of MAT services

There is no single medication that is a magic bullet for all patients with SUD. Different patients respond best to different medications (buprenorphine, methadone, or naltrexone), yet most providers offer only a single option. Buprenorphine is often the chosen MAT because providers can prescribe it within their clinical offices. Methadone treatment can only be provided in a strictly structured clinic, and few providers choose to set up facilities that meet these stringent requirements. Stigma and misconceptions about methadone make providers less likely to refer their patients to outside clinics to receive the medication. A number of providers have chosen to prescribe injectable naltrexone. Unfortunately, few clinics have the ability to offer all three medications. Therefore, patients with SUD may be not be able to access a treatment best suited for them.

There is a recognition that even after being informed of the options for and the effectiveness of MAT, some patients may choose a treatment regime that does not include medication. This option should be a free choice by patients in consultation with their provider and not driven by a lack of access to MAT treatment services.

Sustaining MAT programs through reimbursement

Another major stumbling block to providing SUD treatment services is the limitation in a provider's ability to provide non-reimbursable services. Working with individuals with SUD requires care coordination and case management to promote positive patient outcomes. Case managers often ensure that patients are linked to and engaged in health and social services. While the case manager is an essential team member, there is no guaranteed reimbursement for case management services. A lack of reimbursement for care coordination and case management services hinders a holistic approach to patient care. In the long term, reimbursement for case management and wrap-around services can save money by caring fully for patients with these complex needs.

Conclusion

Results from CHRC-funded programs demonstrate that medication-assisted treatment can be successfully integrated with other behavioral and somatic care services, but integration requires initial investment in both financial and human resources. CHRC provides the funding to overcome challenges, build capacity, and ultimately bring evidence-based services to the SUD service continuum. CHRC grants provide time for training, planning, and cross-clinic and cross-partner education to help implement programs that produce positive health outcomes. Challenges remain, however, in finding trained staff, providing a full range of MAT services, filling post-grant funding gaps, and attaining post-grant sustainability. The results of the pilot programs funded by CHRC will provide the background necessary to implement the changes in state and local health care systems, leading to increased access to MAT, improved lives of those with SUD, and fewer overdose deaths.