EXPANDING THE USE OF MEDICATIONS TO TREAT INDIVIDUALS WITH SUBSTANCE USE DISORDERS IN SAFETY-NET SETTINGS

Creating Change on the Ground: Opportunities and Lessons Learned from the Field

SAMHSA-HRSA

Center for Integrated Health Solutions

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SUMMARY

Given the dramatic increase in heroin- and opioid-related overdoses, and the continued negative health outcomes stemming from nicotine and alcohol use, the need for greater access to substance use treatment medications is significant. While people with substance use disorders are able to access services for the first time in many states because of Medicaid expansion and parity reforms, many do not receive medication assisted treatment (MAT).[1,2] While MAT for substance use disorders have been around many years, numerous studies have shown that they are underused and access remains limited.[3]

To help facilitate the use of substance use treatment medications, the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) created the yearlong *Health Networks Learning Collaborative on Expanding the Use of Medications to Treat Individuals with Substance Use Disorders in Safety-Net Settings.* This pilot project focused on building understanding among providers on how to best implement MAT to increase adoption of medications in the treatment of substance use disorders in primary care, substance use, and community mental health programs, with the long-term goals of helping people achieve and sustain recovery and improving health across safety-net settings. The project also enlisted the support of state and local leadership to help facilitate implementation.

This project yielded several opportunities and lessons learned at the provider, state, and federal level that may help the larger field as community providers and federal and local officials continue to develop opportunities to expand MAT's use. Those opportunities include:

- Increasing use of local pilot/demonstration projects
- Disseminating results to spread promising practices
- Fostering greater cross-collaboration between federal agencies invested in MAT
- Encouraging multiple organizations to "share" MAT providers
- Creating incentives for clinicians to adopt MAT

During the yearlong project, CIHS staff and consultants provided focused technical assistance (TA) to health networks that consisted of mental health, substance use, and primary health care providers, as well as state leadership in three states (California, Maryland, and Ohio) to help providers build their networks and increasing capacity for the use of medications. The project yielded positive results for the participants, including:

- Increased working relationships among diverse community providers
- Development of relationships with new payers and other community-based partners (e.g., managed care organizations, drug courts, child welfare)
- Increased workforce capacity to provide MAT
  - More than 200 training and webinar participants
  - Twenty-one physicians trained on buprenorphine (17 applied for a DEA waiver)
- Organizational and state regulatory policy changes (e.g., use of buprenorphine for pregnant women)

1. Medication assisted treatment (MAT) is the use of pharmacological medications, in combination with counseling and behavioral therapies, to provide a 'whole patient' approach to the treatment of substance use disorders.
2. Knusden, Roman, & Oser, 2010; Abraham, Knudsen, & Roman, 2011
3. Ibid.

BARRIERS TO MAT ACCESS

MAT for substance use disorders has proven to be clinically effective, cost effective, and to significantly reduce the use of inpatient and detoxification services.[4] However, it is greatly underutilized. A 2011 study found that less than 30 percent of contemporary substance use treatment programs offer medications; and less than half of eligible patients in those programs actually receive medications.[5] Further research has identified a number of factors that contribute to the low uptake of these evidence-based treatment options, such as:

- Lack of available prescribers
- Lack of support for existing prescribers
- Agency regulatory policy that restricts or forbids MAT use
- Workforce attitudes and misunderstandings about the nature and use of medications
- Limits on dosages prescribed (i.e., annual or lifetime medication limits for MAT)
- Initial authorization and reauthorization requirements
- Minimal counseling coverage
- "Fail first" criteria requiring other therapies be tried first[6]

Participants in the MAT learning community reported similar barriers. These barriers fell into three major categories:

1. Financing and reimbursement barriers
2. Regulatory issues
3. Workforce challenges

Financing and Reimbursement Barriers

A recent study conducted for the American Society for Addiction Medicine (ASAM), in conjunction with the Treatment Research Institute and the Avisa Group, noted that although progress has been made in increasing access to medications approved for the treatment of opioid use disorders, significant barriers exist on the state level with regard to benefits and coverage of medications that can be used as part of comprehensive treatment to treat addictions.[7] For example, many state Medicaid authorities require prior authorization for the use of any medication to treat addictions, and others limit the length of time during treatment in which medications can be used. Still other states simply do not reimburse for any medications used to treat addictions.[8]

Although all states now reimburse for at least one of the three more widely-used addiction treatment medications (methadone, naltrexone, and buprenorphine), in most states, Medicaid still does not reimburse for all three, and medications for nicotine use disorders face similar reimbursement challenges. The process to gain reimbursement for these medications can be cumbersome and confusing, and the process varies from state to state.[9] Clinicians' and administrators' lack of understanding about obtaining reimbursement for office-based medication management has also been identified as a barrier to the use of medications in addictions treatment.[10]

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4. Baser, Chalk, Fiellin, & Gastfriend, 2011
5. Knudsen, Abraham, & Roman, 2011
6. Roman, Abraham, & Knudsen, 2011
7. Rinaldo & Rinaldo 2013
8. Rinaldo & Rinaldo 2013
9. Ibid.
10. Chalk, Dilonardo, Rinaldo & Oehlman, 2010

Regulatory Issues

Several layers of regulatory issues affect the accessibility of MAT.

On a state level, there are several regulatory issues at play. In many states, health, mental health, and addiction treatment providers are accountable to different county and state-based agencies. This leads to confusion and complicates efforts to address substance use in a collaborative way. These various state level regulations can serve to impede implementation of MAT among community-based networks. For example, in some states, regulations do not permit specialty substance use treatment programs to hire physicians. In other states, even community mental health centers cannot hire physicians unless they are psychiatrists due to corporate practice of medicine definitions. In other states, treatment programs can contract with individual physicians and physician groups, but they cannot bill for services through the treatment programs. Conversely, in some states, regulations prevent medical staff in non-specialty settings from billing for substance use treatment services, including MAT.

On the community level, there may be county-level or city-level restrictions on where MAT dispensing sites can be located. To effectively use MAT, individuals with addictions should receive an integrated care approach where health, mental health, and addictions providers collaborate together. However, in many communities, integrated care does not exist.

At the individual provider level, a substance use or mental health provider may have an internal regulation in place to not provide MAT based on philosophical beliefs about the role of medications in addiction treatment and recovery. Despite science-based evidence regarding the effective use of MAT, some providers do not believe there is a role for medications in the treatment of addiction disorders.

Workforce Challenges

In addition to financing and regulatory barriers, research indicates that there are also significant workforce related challenges to the implementation of MAT services in safety-net settings.[11] The major workforce challenges identified through research include:

- Scarcity of medical providers trained to administer MAT services
- Workforce attitudes and misunderstandings about the nature and use of the medications used for MAT
- Lack of support staff for providers currently administering MAT services

These workforce challenges are significant, and were experienced by many of our project participants. To address them, there is a need for trainings for a variety of clinicians (prescribers, nurses, social workers, therapists, counselors, peer recovery coaches, etc.) as well as a sustained investment in developing the appropriate infrastructure and supports for staff all at levels.

From working with our project participants, we found an additional workforce-related barrier — inconsistency with counseling credential or licensure staff members must have in order to be reimbursed for MAT-related services in certain settings. This barrier looms large as more diverse payers and funding mechanisms continue to gain traction and as shortages in the addiction and psychiatric workforce continue to grow. For example, despite being trained in addiction, recovery, and behavior health counseling, certified addiction counselors working for health centers in many municipalities cannot bill and be reimbursed for services provided because their degree or specific counseling credential is not recognized by payers in that area. Barriers such as this are particularly problematic as many medical providers are averse to providing MAT services without addictions-related counseling supports being available.

11. Roman, Abraham, & Knudsen 2011

PROJECT OVERVIEW

The Health Networks Learning Collaborative on Expanding the Use of Medications to Treat Individuals with Substance Use Disorders in Safety-Net Settings project was a pilot project based on the knowledge that medications are an essential, evidence-based, and effective component of treatment that can support and facilitate recovery from addictions such as alcohol, opioid, or nicotine dependence. The primary goal of this project was to work with state substance abuse authorities (SSAs) and community safety-net providers to increase the adoption of MAT in primary care, substance use treatment, and community mental health programs as a means to encourage the sustained recovery and improved health for people with addictions across safety-net settings.

The project's secondary goals regarding MAT included:

- Create sustainable health networks consisting of community health centers, specialty substance use treatment settings, and community mental health treatment programs
- Improve communication, collaboration, and coordination among the health networks' treatment providers
- Improve selected states' capacity to provide MAT

To achieve these goals and address the cited barriers, CIHS offered selected state SSAs the opportunity to form health networks consisting of community health centers, community mental health centers, and addiction treatment programs to participate in a CIHS-led learning collaborative that provided significant support and TA to state leadership and the selected health networks.

CIHS believed partnerships between state agencies and health networks in local communities could help build infrastructure for the expansion of MAT by facilitating the sharing of resources and expertise. Increasing the capacity of treatment providers to use medications as part of treatment for addictive disorders could improve care across safety-net settings and in the larger community.

Prior to starting the learning collaborative, CIHS conducted an environmental scan to assess the regulatory framework in which MAT services are being provided in each state plus the District of Columbia, Puerto Rico, and the US Virgin Islands. The review answered a number of key questions related to state MAT efforts such as:

- Does Medicaid pay for the medications?
- Do states use the substance abuse block grant to pay for MAT medications?
- Do they use block grant funds to pay for MAT-related clinical services?
- Does the state use non-Medicaid, non-block grant funding to pay for MAT medications?
- Does the state pay for ambulatory medical withdrawal (detoxification)?
- Does the state pay for case management through block grant or other funds?
- Are addiction treatment medications purchased by community mental health centers?
- Does the state have a combined mental health and substance abuse SSA?
- Has the state conducted other initiatives around MAT?
- Does the state have a Primary Behavioral Health Care Integration (PBHCI) grantee?

Based on the analysis, 22 states had a regulatory environment suitable for participation in the project. Three states were selected for participation in the project. The states were selected based on their responses to a number of questions related to their regulatory environment and their interest in participating in this type of system change activity.

California

Developed health networks in Alameda County and Sutter/Yuba County
Medication of focus: Buprenorphine/naloxone

California focused on increasing the use of buprenorphine/naloxone in office-based treatment settings (both rural and urban) as an adjunct to traditional opioid addiction treatment. In addition to the development of networks within these two counties, the California Department of Alcohol and Drug Programs (ADP) also focused on increasing workforce capacity to offer MAT services. A portion of their activities focused on training prescribers and engaging of other primary care, addiction treatment and mental health staff within the counties on the use and benefits of buprenorphine/naloxone.

Maryland

Developed health networks in Baltimore City and Carroll County
Medication of focus: Tobacco cessation medications

The Maryland Alcohol and Drug Abuse Administration (ADAA) developed MAT health networks in Baltimore City and Carroll County with a focus on increasing the use of medications for tobacco cessation. In addition to developing the health networks in both areas, ADAA also focused on the development of model policies and procedures that would eventually be used to support a statewide tobacco initiative.

Ohio

Developed health networks in Cuyahoga County and Richland County
Medication of focus: Buprenorphine/naloxone

The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) implemented MAT health networks in Cuyahoga and Richland counties as a part of this learning collaborative with a focus on increasing the use of buprenorphine/naloxone as an adjunct to traditional opioid addiction treatment. ODADAS focused on building workforce capacity to offer MAT services, and a portion of their activities focused on training prescribers and engaging other primary care, addiction treatment, and mental health staff within the counties on the use and benefits of buprenorphine/naloxone. They also developed policies and procedures to address some of the financial and regulatory barriers around the provision of MAT that existed in these counties.

Technical Assistance Activities

Based on responses to an initial needs assessment with the participants, CIHS conducted a number of activities for the health networks, including:

- **Two meetings (Kickoff/Close-out)**
- **Two site visits**
- **Development of a resource web page devoted to MAT**
- **Nine webinars** (including two webinars done in conjunction with the SAMHSA/CSAT funded Addiction Technology Transfer Center) with more than 200 total webinar participants. Webinar topics included:
  - Building Partnerships and Capacity for MAT
  - Use of MAT in Health Centers
  - Engagement of Staff in the Use of MAT
  - Developing a Public Policy Framework for the use of MAT
  - MAT: A Psychiatric and Primary Care Perspective
- **Creation of a listserv to foster communication and collaboration among the project participants**
- **Six quarterly/special topic calls,** on topics such as financing of MAT, sustainability of medication services, and working with health centers
- **Distribution of resources from federal partners** (SAMHSA, NIDA, NIAAA, HRSA)

OUTCOMES

While this three state, six site pilot project was not large enough in scope or long enough in duration to achieve all of the goals proposed, positive results were achieved, including:

- Increased working relationships among diverse community providers
- Development of relationships with new payers and other community based-partners (MCOs, drug courts, child welfare, etc.)
- Increased workforce capacity to provide MAT
  - More than 200 training and webinar participants
  - 21 doctors trained on Buprenorphine (17 applied for DEA waiver)
- Regulatory policy changes (e.g. use of buprenorphine with pregnant women)

SOLUTIONS AND OPPORTUNITIES

As the participants moved forward with their projects and navigated their regulatory environments, a number of solutions and policy opportunities emerged that could be useful for other providers and state officials considering initiatives to increase access to MAT. These include:

- **Increased investment and use of local pilot/demonstration projects**
  The creation of smaller pilot/demonstration projects in communities or between providers could be instrumental in providing valuable information to policymakers and other stakeholders before larger projects are developed or sweeping policy changes are made. As a way to facilitate these "demonstration projects," state or local officials could consider relaxing certain rules or regulations to allow providers to work together and provide MAT services for a defined period of time. At the end of this demonstration period, information would be shared with stakeholders about the results and possible ways to move forward.

- **Dissemination of results to create spread of promising practices**
  In many states, projects related to increasing the use of MAT may be taking place, but finding information or contacting these projects was difficult and time consuming. Dialogue and collaboration between providers working on similar issues is critical to the spread of any innovation. A key role for government could be helping to identify and create opportunities for providers in different locations to communicate and share information and lessons learned. In addition, the development of a centralized system to catalog information about related projects could help facilitate this level of communication and dialogue.

- **Greater cross-collaboration between federal agencies invested in MAT**
  One specific recommendation that came out of this project was the development of a centralized training calendar for all national MAT-related trainings and workshops that are sponsored by the various government agencies working on MAT issues.

- **"Sharing" of MAT Providers**

  In many parts of the country, the demand for medical services outstrips the availability of providers. This is particularly true for MAT services. One of the potential solutions focused on during this project was the idea of sharing a medical provider. If several programs need the services of a medical provider within a given community, the county or the agency with oversight control could hire a provider and dedicate portions of their time to various organizations within the community. The prescriber would then provide medical and psychiatric services (including MAT) for various organizations as needed.[12] Alameda County, one of the participants in the learning collaborative, is exploring this opportunity as they are in the process of hiring a psychiatrist with MAT expertise whose services can be used by a number of community providers. This approach allows more flexibility in how and where prescribers are deployed. Additionally, it removes the burden from providers of having to find, hire, and pay for the services of a prescriber.

- **Creation of incentives for clinicians to adopt MAT**

  As policymakers think about how to address the shortage of MAT prescribers, one of the opportunities for consideration is the development of incentive programs for prescribers to provide MAT services. In many rural parts of the country, providers of medical services, especially those with the ability to provide MAT services, are scarce. To begin addressing this, policymakers may want to consider adjusting or adding provisions for MAT services to existing incentive programs for medical professionals. Across the country, there are a number of programs for medical providers, such as the National Health Service Corps, that incentivize medical professionals through loan repayments and housing subsidies to work in certain areas of the country or with a particular underserved community. These programs could be amended to allow the provision of MAT services in various settings as a component of participation.

LESSONS LEARNED

In addition to the concrete opportunities for improvement, the project resulted in several lessons learned. These include:

Increase Focus on Workforce Development Issues

While financing and regulation of MAT services remain significant challenges to overcome, progress is being made. All states provide some level of access and financing for at least one of the medications used for addiction treatment, and many states cover most of the medications needed. However, workforce issues such as lack of prescribers, harmful staff attitudes, and lack of education must be addressed to ensure appropriate utilization of the medications.

These issues can hinder access to providers and leave clients with limited information on the benefits of using medications as part of comprehensive treatment.

Since the workforce is key to any sustained improvement in MAT access, workforce issues may be the most important area to focus on going forward. Concerted efforts at the local, state, and federal level will need to be made to further address these issues.

Use of data to decision making about MAT services

While not an initial focus of the project, the use of data quickly became an important topic of consideration. Population level data to determine the MAT needs of the community is an issue of critical importance. A community needs assessment is recommended before the start of any new MAT-related initiative to determine the most appropriate medication intervention to meet the needs of the population being served.

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12. For those physicians providing buprenorphine/naloxone MAT, it is important to assure that patient limits are observed and that a list of all patients being treated under the physician's DEA registration is kept at the site of the address listed on the physician's DEA registration. This is undertaken as part of the preparation for any DEA inspection visit to the physician since the DEA is charged with monitoring office-based treatment of opioid addiction

Given the number of medications available, their efficacy, and the continued development of new medications to treat addiction, it is important for providers to use client level data to identify which medications may be most useful given the disease profiles of their clients and the regulatory environment in which they are providing services.

Development of community partnerships and infrastructure for MAT services requires sustained effort and resources across multiple levels and systems

To effectively spread the use of medications or any innovation, the community needs to be engaged. The importance of partnership building within the community cannot be overestimated, nor can the resources and time it takes to build these relationships successfully. In addition to the providers participating in the project, other community stakeholders and funders became engaged with the health networks. All of these stakeholders, while invested in the concept of increasing use of MAT, have different needs and may seek different outcomes from the partnerships. Community stakeholders will also engage in the partnerships differently based on the needs of particular groups they serve. Indeed, this was the case in California, Ohio, and Maryland. In each instance, the local organizations had different roles in their respective communities and engaged in the network differently. Particular attention must be paid to these relationships to ensure that the partnerships are meeting the needs of all the various stakeholders involved. Future projects must consider the time and resource investments necessary to create fully functional partnerships.

Leadership at every level is key to improving access to MAT services

Leadership plays a vital role in facilitating change and creating a healthy environment for change to occur. The issues involved in moving MAT forward are complex and multifaceted, requiring sustained effort and engagement of leadership at all levels. Significant progress in this area will not be made without the buy-in and support of leadership.

Efforts to expand access to MAT fit well with integrated primary and behavioral health-care efforts

Given the need for prescribers and other medical staff to provide MAT services, programs that are engaged in these integration efforts may be well positioned to consider integrating medications for addiction treatment into routine care. In addition to the availability of prescribers, these relationships have the added benefit of making the necessary adjunct behavioral health services more readily available. When developing primary care and behavioral health integration projects, the incorporation of MAT-related services should be strongly considered.

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APPENDIX I. FDA-Approved Medications for Substance Abuse Treatment and Tobacco Cessation

Medications for Alcohol Dependence	Naltrexone (ReVia®, Vivitrol®, Depade®) Disulfiram (Antabuse®) Acamprosate Calcium (Campral®)
Medications for Opioid Dependence	Methadone Buprenorphine (Suboxone®, Subutex®, and Zubsolv®) Naltrexone (ReVia®, Vivitrol®, Depade®)
Medications for Smoking Cessation	Varenicline(Chantix®) Bupropion (Zyban® and Wellbutrin®) Nicotine Replacement Therapy (NRT)

APPENDIX II. Medication Assisted Treatment Implementation Checklist

This checklist provides policymakers, state and local officials, and other community stakeholders key questions to consider before engaging in efforts to increase access to medication assisted treatment (MAT) for addictions in their communities.

Assess Economic Environment

- Are all the medications approved for addiction treatment (see box) on the Medicaid formulary in your state? If not, who specifically will provide the leadership to get these medications on the Medicaid formulary? Who specifically will talk with health plans and pharmacy benefit managers to get these medications on their formularies?
- Are these medications available through the 340B program administered through HRSA and the health centers in your state? This is particularly important for individuals without insurance.
- Are these medications used in the private sector in your state? Check with state psychiatric associations, state ASAM chapters, and associations of family practice and internal medicine.

Assess The Treatment Environment

- Which treatment programs in your state/area currently use medications in the treatment of addictions?
- If there are no programs in your state/area using medications in addiction treatment, why not?
  - Are there attitudinal problems?
  - Are there Medication cost concerns?
  - Are there Implementation cost concerns?
  - Are there state regulations and policy barriers?
- Who will provide the leadership to address these barriers?
  - How do you plan to assess which treatment programs are most likely to work with you (i.e., early adopters) to adopt medication assisted treatment?
- For treatment programs that use medications, how do you access physicians? Are they:
  - Full or part-time staff members?
  - Contracted?
  - Affiliated with a primary care clinic?
  - Affiliated with or embedded in a health center/FQHC?
- Do health centers and other providers have an appropriately trained integrated care team available?
- Are any treatment programs co-located with health centers? If so, where are they specifically located? If there are none, what do you need to do to have medical care and behavioral health care provided on the same site?
- What can you do to support the development of networks of treatment providers that include both primary care providers and addiction treatment programs?
- Are there any comprehensive treatment programs in your state that include primary care within an addictions treatment program? Is the primary care program co-located and under different management or part of the addictions treatment program? How can these different organizational structures serve as models for other addictions treatment programs?
- How will you work with medical and non-medical clinicians to assure that counseling services accompany use of medications in addictions treatment?

Assess Workforce Issues

- Are there enough trained physicians and nurses to work with treatment programs on MAT? If not, what is your plan for assuring physicians are trained?
- What is the level of acceptance of "medical models" of addiction by treatment programs and clinicians in your state? How do specialty addictions treatment clinicians view the use of medications to assist patients in treatment?
- What are the attitudes of boards of directors of addiction treatment programs toward use of medications in treatment? How will you work with boards of directors that need assistance in understanding the role of medications in treatment?
- Are clinicians in specialty treatment eligible to receive Medicaid reimbursement? If not, what can you do to help prepare clinicians to be able to be reimbursed for clinical services necessary as an adjunct to medications during treatment?
- How will you work with clinicians toward the goals of making MAT available?

Assess Regulatory Issues

- What is the strength of regulatory efforts at the state level related to distribution and use of medications in addiction treatment?
- Is the state legislature educated about the use of medications in addiction treatment? Has the legislature in your state intervened in any way to regulate the use of medications (in statute or otherwise)? If so, how does state regulatory action affect the availability and utilization of medications as part of comprehensive addiction treatment?
- What are the attitudes of state legislators about increased spending on addiction treatment related to the introduction of medications? How will you inform legislators about advances in addictions treatment? How will you work with legislators to improve the financing and regulatory environment for implementation of medication-assisted treatments?

Assess Attitudes

- How will you identify the specific groups outside of the addictions treatment field in your state that may oppose the use of medications in treatment? What is your plan for working with these groups to reduce potential barriers to implementation?
- How will you work with consumer groups and advocates to increase demand for MAT?