MEDICATION-ASSISTED TREATMENT AND RECOVERY BEST PRACTICE GUIDE

PREPARED FOR THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

August 30, 2019

ALTARUM

SOLUTIONS THAT MATTER. HEALTH CARE THAT WORKS.

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Acknowledgments

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Introduction

BACKGROUND AND UNDERSTANDING

Medication-Assisted Treatment (MAT) and subsequent recovery is one part of a comprehensive approach used to treat opioid use disorder (OUD). The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies full recovery as the main objective of Medication-Assisted Treatment.[1] The effective practice of MAT consists of medications and behavioral therapies to provide a "whole-person" approach to treating substance use disorders (SUDs). The benefits of MAT include: decreased numbers of opioid overdose deaths; increased patient retention in treatment; decreased illicit usage of opioids; and increased ability to obtain and maintain employment.[1]

The medication prescribed during MAT allows people that are struggling with addiction to regain their normal lives by relieving withdrawal symptoms and cravings.[1] Methadone, buprenorphine, and injectable naltrexone are three medications prescribed in MAT for opioid use disorder. These three medications stabilize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions. Numerous studies have shown that the aforementioned medications reduce illicit drug use, disease rates, and criminal activity among patients with OUD.

Federal law requires patients engaging in MAT to enroll in some form of counseling, which may vary depending on the patient's individual needs.[1] Examples of commonly adopted MAT behavioral intervention practices include Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), and Mindfulness-Based Relapse Prevention (MBRP).

SAMHSA recommends six steps for providing effective MAT services:

1. Assess the need for treatment;
2. Educate the patient about how the medication works and the associated risks and benefits; obtain informed consent; and educate on overdose prevention;
3. Evaluate the need for medically managed withdrawal from opioid;
4. Address co-occurring disorders;
5. Integrate pharmacologic and nonpharmacologic therapies; and
6. Refer patients for higher levels of care, if necessary.

[1] https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat

It is important to keep in mind that there is no single medical or behavioral intervention that always works or that works best. However, there are a handful of medical and behavioral evidence-based practices (EBPs) that research supports as highly effective, when combined, to treat SUDs.

Despite what we know about the success rate of treating OUD with MAT, this life saving practice is not widely available. According to SAMHSA, roughly 80% of individuals with an OUD do not receive treatment.[2] Even though MAT is widely regarded and evidenced within the annals of addiction science research as the gold standard for OUD care, according to the White House Opioid Commission's 2017 report, a clear majority of physicians are not engaged in MAT. Specifically, 47% of U.S. counties and 72% of U.S. rural counties have no physicians practicing MAT. Further, only 5% of U.S. physicians are certified with a Drug Enforcement Administration (DEA) waiver for practicing MAT. Federal regulations impose special rules for practicing MAT — requiring 8 hours of training for physicians, and 24 hours of training for physician assistants and nurse practitioners, to obtain waivers.[3]

Applied research indicates that Michigan ranks sixth worst in the nation in the ratio of MAT providers to opioid deaths[4]. Per Larry Scott, who directs Recovery Services for the Michigan Department of Health and Human Services (MDHHS), there is a scarcity of physicians who are authorized to practice MAT, particularly in the Upper Peninsula of Michigan.[5]

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[2] Medication-Assisted Treatment of Opioid Use Disorder Pocket Guide. (2016, February 25). Retrieved from https://store.samhsa.gov/product/Medication-Assisted-Treatment-of-Opioid-Use-Disorder-Pocket-Guide/SMA16-4892PG

[3] Lopez, G. (2018, July 31). America's doctors can beat the opioid epidemic. Here's how to get them on board. Retrieved from https://www.vox.com/science-and-health/2018/7/31/17398914/opioid-epidemic-project-echo-new-mexico-addiction

[4] Michigan Roulette: The rise of a deadly street opioid. (2018, May 16). Retrieved from https://www.bridgemi.com/children-families/michigan-roulette-rise-deadly-street-opioid

[5] Michigan Roulette: The rise of a deadly street opioid. (2018, May 16). Retrieved from https://www.bridgemi.com/children-families/michigan-roulette-rise-deadly-street-opioid

EXECUTIVE SUMMARY

REPORT BACKGROUND

In response to the need for additional MAT services in the state of Michigan, MDHHS, in partnership with Altarum, sought to understand current best practices in MAT services in the state, as well as what conditions could help other providers achieve success in offering MAT services. This report contains three parts:

- Qualitative Interview Best Practices Information
- Michigan Primary Care Association MAT Provider Resource Appendix
- Altarum MAT Implementation Support Resource Appendix

The purpose of this guide is to add to the body of knowledge around the scope of MAT services in Michigan. We also highlight the voices and expertise of the providers, as the medical and public health workforces aim to increase access to behavioral health services. This report is intended for primary care clinicians who prescribe opioids and who wish to further the availability of MAT services.

METHODOLOGY

In August 2019, Altarum conducted interviews with 10 key provider stakeholders across Michigan to gain input around best practices for offering MAT. We inquired about successes in currently offered MAT services, barriers to prescribing and treating patients with OUD, challenges the provider community is facing around insurance reimbursement and in the health system, and key stakeholder recommendations for new and interested MAT prescribers. The following provided input through one-on-one interviews:

- Substance use treatment and recovery service providers
- Medical providers, including clinic staff and individual providers
- Provider professional organization staff
- Social services/provider technical assistance organization staff

To facilitate each discussion, the Altarum team developed a structured moderator's guide for consistent and systematic data collection. We identified interview participants through the SAMHSA MAT locator, physician referrals, and with the assistance of MDHHS. At the beginning of each discussion, the moderator provided each participant with a description of the study. Participants were informed that their participation was voluntary, each person's identity would remain private, and there were no known risks related to participating in the study.

In total, 10 interviews were conducted over the course of 3 weeks. All interviews were conducted over the phone and were scheduled for 45 minutes, moderated by a project analyst, and supported by research staff who took extensive notes. The team digitally recorded all interviews to

ensure the accuracy of notes and all quotations. The researchers then reviewed interview recordings, transcriptions and notes, and analyzed them for themes.

Report Limitations

Although the research team interviewed a variety of different providers and provider support staff, the material in this report represents a small sample size. Therefore, we acknowledge that the information presented in this guide is not exhaustive in representing providers' viewpoints on this issue throughout the state of Michigan.

FINDINGS

Upon completing this analysis, six major themes emerged from the provider and provider support groups interviewed. Providers stated that these issues define the current MAT service landscape in the state of Michigan.

The themes are:

- Setting Clear Expectations for Patients and Providers
- Institutionalized Stigma
- Integrating Substance Use Disorder Treatment into Medical Education
- Treating Substance Use Disorder Is a Team Effort
- Poor Coordination Between Government, Public Health, and Provider Entities
- Reimbursement Policy: Billing and Coding, Regulations, Prior Authorization

A thorough discussion of each theme, as well as best practice information, is provided in the subsequent full report.

ANALYSIS

Upon completing this analysis, six major themes emerged from the provider and provider support groups interviewed. Providers stated that these issues define the current MAT service landscape in the state of Michigan. This section of the guide expands upon provider views of each of the thematic areas and presents their solutions/advice for achieving best practice in each.

The themes are:

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- Institutionalized Stigma
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SETTING CLEAR EXPECTATIONS FOR PATIENTS AND PROVIDERS

Best Practice

- Immediately define rules and expectations for both the patient and the provider
- Develop clear policies and procedures for the organization
- Create "welcome" packets or toolkits to set clear expectations for patients receiving MAT services and their families

Among these successful providers, a common theme is to immediately define rules and expectations for both the patient and the provider. This practice is especially helpful with the patient population seeking MAT services. Providers state that patients are more likely to be happy with the recovery process and motivated to continue treatment when the patient clearly understands the impact that MAT will have on their lives. Additionally, providers find that initially defining the expectations and rules helps to prevent overdose and accidental death or injury from overdosing.

One interviewee stated that having clearly defined policies and procedures was the most important factor in guaranteeing success, and new prescribers should not move forward until policies and procedures and a comprehensive intake packet/process are finalized. This individual also felt that strict procedures help treatment staff be accountable to a firm process, and they can help mitigate frustrations when deviations are made that impact patients' outcomes.

Some providers have opted to create a welcome packet or toolkit, which includes information from all the providers involved in the patient's MAT care, for both the patient and the family. The welcome packet sets a consistent message, at the very beginning, of what to expect during treatment. This information also helps to reduce fear and anxiety about the process, as well as

realistically manage everyone's expectations about the outcome of receiving MAT services. Providers also found that clearly discussing and documenting expectations from the first meeting helps to build trust and transparency.

One provider noted success with tasking the in-clinic therapy team with the new patient intake process. Allowing the therapy team to complete the intake for MAT patients will help to emphasize the importance of counseling and therapy in addiction treatment to the overall medical treatment. This ensures that the patient sees the value of behavioral approaches before they even have the opportunity to meet with a provider about medication.

Interviewees noted that, as important as it is to manage patient expectations about receiving MAT services, it is equally important for MAT providers to understand the process of offering them. Providers must also realistically manage their own expectations when it comes to MAT services. In the words of one provider:

> *"Rewards come a year later, when they are finally recovering and see their lives coming back together"*
>
> *Provider*

Yet in the words of that same provider:

> *"There is nothing about managing blood pressure and cholesterol that can give you the satisfaction of turning somebody's life around like somebody following a treatment plan that makes sense to get them out of the disease of addiction. It is very rewarding."*
>
> *Provider*

Providers should enter addiction recovery work prepared for an ongoing investment. While achieving sustained recovery may take time, providers should prepare for the overwhelming satisfaction that comes with addiction medicine after their first year of practicing and for many more years down the road. Interviewed providers all spoke to the truly lifesaving nature of this work and said that the rewards and return on investment are different from those in other areas of medicine.

INSTITUTIONALIZED STIGMA

Institutionalized stigma is a predominant contributor to many of the myths around MAT

prescribing, according to interviewees. Some providers said they fear that others will view them as a legal drug dealer or that MAT prescribing will be viewed as enabling. Other providers who do not pursue waiver training may not end up actively prescribing because their employer is reluctant to provide MAT services. Providers also face resistance from many hospitals and practices that do not want to serve people who suffer from substance use disorders. When asked, almost all of the interviewees cited institutionalized stigma as a main reason that providers who have been waivered are not currently prescribing and/or the main reason many providers are not interested in pursuing waiver training.

When addressing challenges in offering MAT services, all respondents discussed the stigma around offering these services and treating MAT patients. Providers discussed the influence of stigma in all areas of the medical community, including among fellow providers, hospitals, and academic institutions, as well as within the patient's lives. One provider spoke about their patients' experiences with stigma extending beyond the medical community, to their own families and other close relationships. When addressing stigma, providers advised that new MAT providers should not only visualize the effects of stigma within their practices, but in the patients' lives as well.

Stigma also contributes to some of the myths around the workflow/effort it takes to work with substance use disorder patients. Many providers assume that working with addiction medicine is very time consuming. Others feel that the work is too complicated, so they would rather not be involved with this specialty. Interview participants shared different theories for why waiver trained providers do not prescribe; they suggested that providers may be reluctant to prescribe because they fear that they are not prepared to begin prescribing and working with a substance use disorder population. Some waiver trained providers fear the complications of the state prescribing regulations; they do not want to be under constant scrutiny for making possible mistakes.

Aversion of the Patient Population

A major manifestation of institutionalized stigma is the medical community's historic aversion of teaching students how to work with people living with substance use disorder. Moreover, many institutions, including hospitals and academic institutions, continue to prefer not to work with people living with substance use disorder. Providers stated that for physicians trained 20 or more years ago, medical education and training was inadequate for working with patients with a substance use disorder and led to poor communication with patients and a lack of understanding among providers about how to bring out honest responses from their patients. Also, as major institutions such as hospitals and universities were identified as unwilling to work with and support this population, these institutions were also not developing programs and/or resources to help support providers who offered MAT services. This is another example where MAT providers told us that they have been left on their own to navigate challenges.

Many providers stated that characteristics of patients who are seeking recovery from an OUD keep physicians from engaging with the population. Specifically, patients requiring MAT may be involved with the criminal justice system, and many providers are hesitant to work with re-entry and justice involved patients.

> *"The patients that you cherish, because you changed their lives, admittedly are difficult patients, whose lives are in chaos…and often cross back and forth in and out of criminal justice. The ordinary, primary care provider is very uncomfortable with that kind of patient. Stigma is presented [projected] on that patient."*
>
> *Provider*

The stigmatizing of, and provider discomfort with, this patient population, in addition to other institutional factors, leave the impression that addressing this crisis and treating addiction is optional or at least more difficult to manage than other chronic diseases.

> *"Because of regulations and bad press, people hold back, but like any disease that kills many people, just start trying and you will figure it out."*
>
> *Technical Assistance Provider*

Best Practice

- Break down stigma in organizations through changing one's language and by building trust in patient relationships

Be a Champion in Your Practice/Organization

Providers currently providing successful MAT services see this work as an opportunity to break down this stigma. One of the ways that providers approach this is to take personal responsibility for correcting instances of stigma or stigmatizing language. They recommended the following practical steps: Take responsibility for the word choices that your organization uses; stop conversations and meetings that are not embodying best practice language choices; ask your colleagues to use the APA Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) language guidelines and push your practice/ team to use safe and respectful language choices. This will have a direct impact on the care that a patient receives. The providers interviewed not only recommended being a champion of language use and choices in your own

organization, but also to remind other clinicians that language and words have a direct correlation to improved patient care. Reinforcing why these choices are important and linking the improved outcomes with the work is critical to successfully changing stigmatizing language norms. As described by a prescriber:

> *"It's a really big thing for me, the words that we use…If you diagnose a patient with a substance use versus a substance abuse disorder, we provide different care for the individual."*
>
> *Provider*

Respondents also recommended that providers seek out resources/tools if they were not familiar with best practices in this area. Community Catalyst stresses the importance of language when advocating with and for individuals with substance use disorders, and developed the following guide for non-stigmatizing language use (Figure 1):[6]

Figure 1:

Instead of using the term…	Consider using the following term
Addict; Abuser; Junkie	Person/Someone with Addiction; Individual in recovery or individual seeking recovery; Person with a substance use disorder
Clean i.e. "She has been clean for 10 years or She is finally clean and off drugs"	She has been in recovery for 10 years or She is currently in recovery
Dirty i.e. "The drug test came back dirty"	The drug test came back positive for drugs
User or Abuser	Individuals with addiction or substance use disorder
Drug problem; Drug Habit	Problematic use of drugs and alcohol
Reformed Addict or Reformed Alcoholic	Person in recovery
Experimental User; Recreational User	Person starting to use drugs
Substitution Therapy/Replacement Therapy	Medication-Assisted Treatment or Medication-Assisted Recovery

[6] Figure 1, Community Catalyst: Using Person-Centered Language to Avoid Stigmatizing Individuals with Substance Use Disorders, accessed from: https://www.communitycatalyst.org/resources/2017-alerts/6-22/Guide-to-non-stigmatizing-languageFINAL.pdf

These resources can not only help individual providers to implement correct language usage, but to act more easily as champions in their organization to reduce stigma. In addition to promoting DSM-V language use, providers can check patient communication materials, as well as posters and handouts available in all public waiting areas, to ensure that all communication with the patient is respectful and non-stigmatizing. A basic checklist for reviewing messaging/word choices for stigmatizing language includes asking:

- Are you speaking about a patient using person-first language? (a patient living with a substance use disorder versus "drug abuser")
- Are you using "substance use disorder" only when the clinical diagnosis has been made?
- Are you using technical language (e.g. there were detectable levels of cocaine in your body, could we talk about your recovery support system?) when speaking with patients instead of colloquialisms (e.g., negative urine drug screen versus clean urine)

Providers also observed that the first visit with each patient is crucial to establishing their role as a trusted provider. Patients have often been in previously hostile settings, including emergency rooms, or in the care of a family member, where they have been identified as a "drug addict" and the first visit can be intimidating. Providers can help reduce stigma by accepting and validating the fear and mistrust their patients typically feel, and they can build stronger relationships by working to discuss the difficult nature of recovery success and emphasize the partnership of the patient, therapist and medical team.

In addition to breaking down stigma in one's organization through changing one's language and building patient relationships, providers can also champion this issue among their colleagues. Due to the segregated nature of addiction treatment, many other family/primary care providers do not have as much information about MAT as they do for other chronic disease treatments. Providers currently prescribing MAT can help bridge this information gap. Interviewees say they have been able to correct misinformation around the patient population, the purpose of MAT, and many other myths in their conversations with other providers.

"They take care of people with diabetes on insulin, that's much more complicated than taking care of somebody with an opioid use disorder."

Provider

When asked, one interviewee said that it was through individual conversations with their colleagues that they have made the most difference in increasing the number of MAT prescribers at their organization:

> *"Just talking to them about how powerful and amazing it can be working with the [SUD] population…What a wonderful population of people it is to work with. That generally has been the most helpful. Then they hear me get all excited about it and then they are like, that sounds fun. I could get in on this"*
>
> *FQHC Program Manager*

Best Practice

- Be committed and believe in your work
- Be self-driven and wiling to learn

Provider Characteristics and Intrinsic Motivation

Interview participants stressed the importance of being committed and believing in the work. As with any profession, no day is easy; therefore, it is important to be passionate about this work and have the desire to help people. Providers shared that their medical education program did not prepare them to work in addiction recovery or with substance use disorder, so it was crucial that they were self-driven and willing to learn.

> *"I would really discourage people from looking at this as a money-making job because this is sacred work and it's life-(changing)… it cannot be done by just handing out prescriptions, you can do more harm than good that way".*
>
> *Provider*

INTEGRATING SUBSTANCE USE DISORDER TREATMENT INTO MEDICAL EDUCATION

Interview participants also shared the importance of following the Medical Education Model. Some interviewees suggested the need to increase education around addiction in medical school and residency programs. Providers suggested that the state's medical schools should be required to include addiction medicine in the curriculum. Those who are interested in providing MAT services should study to learn about different types of addiction recovery and various substances that are used. Participants who received addiction training either in their residency program or earlier in their career felt more comfortable initially providing MAT services than participants who took the waiver training afterward on their own. One interviewee also shared that opioid management was

discussed in medical school but said that the information would be more accurate if a provider that works in addiction was asked to teach the subject.

Lack of Addiction Specialists in Leadership Positions/Medical Board Review

Some participants who were MAT certified identified a lack of addiction specialists in leadership positions. They saw value in creating relationships with providers who were already established and successful in the field, but at times that was difficult. Providers stated that they would like to see an assembly of experienced addiction specialists collaboratively working as a team to provide guidance and resources to new and seasoned MAT certified prescribers.

A few interviewees also suggested that more addiction specialists should be in leadership positions to help with advocacy. Having providers involved in advocacy will help to drive policy while positively shaping the narrative of being a MAT prescriber. This would also allow MAT providers to offer guidance during the development of rules and regulations regarding addiction with the underlying goal of increasing patients' access to care.

Best Practice

- Form a robust care team to assist with caring for patients receiving MAT services

TREATING SUBSTANCE USE DISORDER IS A TEAM EFFORT

Providers indicated that using a team-based approach in treatment is key to providing MAT services. The idea of teamwork arose throughout many interviews:

- Have a team in your practice who treats MAT patients, whenever possible
- If you cannot operate with a team onsite, co-locate your office around other behavioral health/addiction treatment providers
- If you are a MAT waivered provider, create your own team/network and support other MAT prescribers and newly waivered providers

One of the most commonly highlighted/recommended approaches was the importance of having a care team at the MAT practice site. Members of the care team could include the following positions: provider, care manager, champion, medical assistant, peer-recovery coach, community health worker, and behavioral health provider. Interviewees stated that it is not always necessary to have all these team members, and they recommended building a team that works best for your practice and your patients. Providers recommend maintaining the prescriber role and tasking others on the care team to provide support to the provider and patient. Other team members could be of help by organizing the drug screenings, helping patients fill out their forms correctly, connecting patients with community resources and primary care providers, assisting patients with signing up for insurance, and even facilitating transportation. Preparing for patient visits in

advance also ensures time in the patient exam room is used efficiently.

When establishing a new care team, it is imperative that the team functions collaboratively and as one unit. According to one of our participants, the MAT team begins with the first person the patient sees walking through the door, and it includes all team members who are involved throughout the visit and beyond, including medical records staff. Each of these individuals has an opportunity to offer support to patients, so it is important to properly train and outline expectations to all staff. In the interviewee's organization, they begin to build this team during the employee interviewing process. Prospective employees are told that MAT is a priority of the organization, and if they do not want to work with MAT patients, this is not the job for them. Team members are continuously supported after hiring with trainings, lunch and learns, and other team exercises. Interviewees also stressed the importance of having team members be physically located together, so not only do they feel they are part of a team, but the rest of the organization begins to view SUD treatment teams as a core function of the practice.

In addition to co-location and a passion for the work, constant and effective communication among the team is vital to success. Some practices choose to have either daily huddles for 5 to 10 minutes or weekly meetings that last about an hour. While this is time that providers cannot be reimbursed for, interview participants stressed the value and effectiveness of using that time to prepare for seeing patients and noted that there is a corresponding improvement in patient care. Providers who take this time to coordinate and organize as a team universally felt that the return on investment in improving patient care and achieving successful MAT services was of high value.

Integrate with Other Behavioral Health Service Offerings

Providers we spoke with also stressed that MAT prescribers should be able to offer, at minimum, one best practice therapeutic support for their MAT patients. If they are unable to offer behavioral health services at their location, they recommend co-locating the practice in the same building or on the same block as behavioral health service providers. One provider told us that this step is more important than any other in ensuring that MAT patients have successful treatment outcomes:

> *"We needed to get more people therapy because, it's behavioral change that changes these people, not a little pill…Our number one sin in America, and in Michigan, is doctors that are prescribing buprenorphine and do not connect*

> *those patients to cognitive behavioral therapy, and legitimate group therapy, and psycho-social intervention."*
>
> *Provider*

The value of creating a robust care team/network goes beyond increasing the number of successful MAT patients.

In addition to implementing this best practice for the patient population, creating a network of services when you are an independent provider can also help your business model. If an individual provider is unable to offer therapy and other treatment services within their practice, integrating into a self-made network with these providers, and others in the recovery field, can help generate patient referrals to the practice. For some of the individual MAT prescribers interviewed, these referrals have helped to create a stable and profitable practice offering MAT services where it had not existed before.

Some providers have also found success in offering other addiction services in the office/clinic location, including Narcotics Anonymous and Alcoholics Anonymous meetings. Providers have learned that if their physical location is already a place of safety and comfort for people living with addiction, it is easier for them to seek out MAT services in that same location. Normalizing MAT as a regular aspect of addiction treatment also creates another source of patient referral.

Best Practice

- Develop a strong provider network to discuss complex MAT patient cases
- Enroll for same day consultation for patients with OUD
  Email interest to: **moc-administration@umich.edu**

Network/Build Fellowship with Other MAT Prescribers

An observation that most interviewees made was that, at this time, there is no substitute for connecting with other providers who are doing this important work. Each interviewee mentioned that expanding the fellowship and community among MAT providers is invaluable in achieving best practice for every prescriber.

One of the benefits from an increased community among MAT prescribers is the ability to consult with other providers around complex patient cases. Since many providers feel that both the training and education around MAT services are inadequate, especially for difficult cases, they strive to build their connections as a support system for themselves and their patients. Interviewees valued the advantages of connecting with other providers over any resource or other print/textbooks that are currently available.

A small portion of providers that were interviewed felt that in addition to there being a lack of

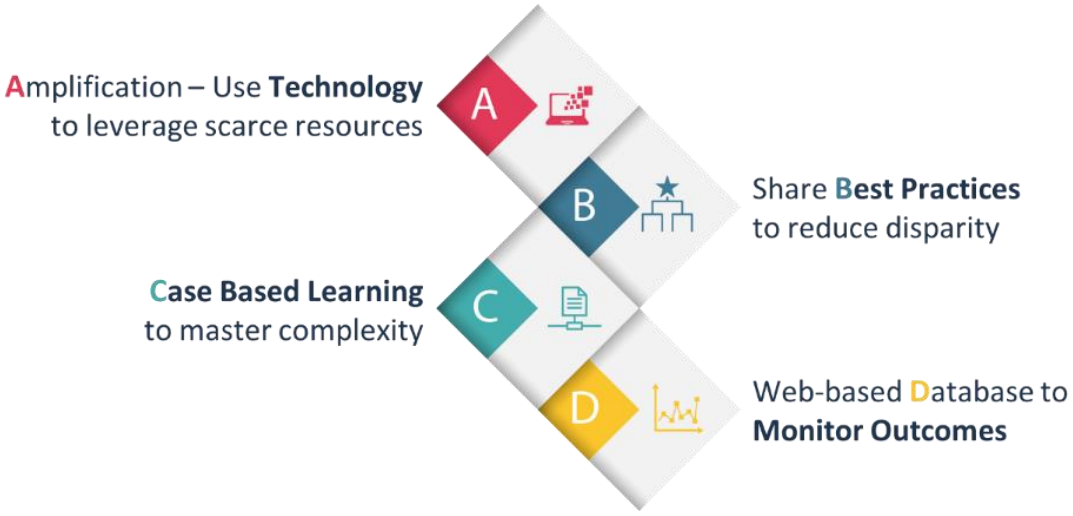
support among MAT prescribers in some areas, they noted that there are MAT providers who actively challenged the establishment of new MAT practices in their surrounding area. One provider we interviewed encouraged new MAT prescribers to continue to reach out and ask for help, because she initially faced many "no's," but she was finally able to secure 40 hours of physician shadowing that greatly helped her in her own practice.

Finally, although interviewees stated that they did not know of any active models in the state, the majority of those interviewed said that they believe Michigan should follow other states and create collaborative models to treat addiction such as Project ECHO (Figure 2)[7] and/or Hub and Spoke (Figure 3)[8].

ECHO Model

Project ECHO, pioneered by the University of New Mexico School of Medicine, links specialized groups at an academic hub with "spokes" that become a learning community. The "spokes" in the model are primary care clinicians from local communities. Through participating in the learning community, primary care clinicians receive feedback and mentoring from the specialists. Thus, the Project ECHO model enables a group that manages patient cases to ensure patients receive the high-quality care that they need.[9] ECHO has four main elements:

Figure 2:



[7] Figure 2, ©2019 Project ECHO, The University of New Mexico, downloaded from: https://echo.unm.edu/join-the-movement/need-to-know

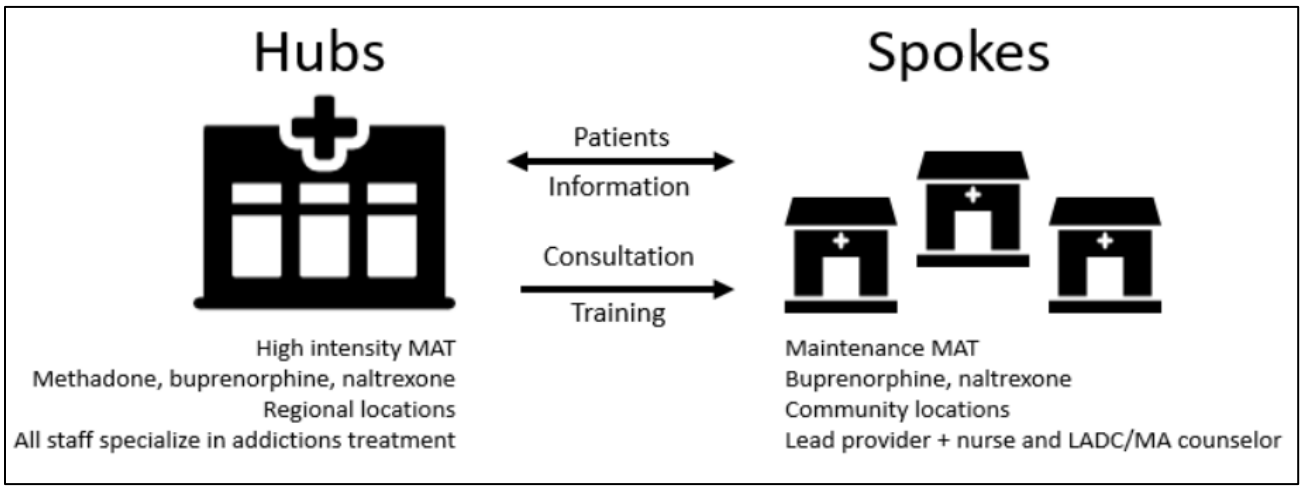
[8] Figure 3, State Of Vermont: Blueprint for Health, downloaded from: https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke

[9] 2019 Project ECHO, University of New Mexico School of Medicine, https://echo.unm.edu/

Hub and Spoke Model

The Hub and Spoke model of MAT service delivery was first created and implemented in the state of Vermont. In this model, Opioid Treatment Programs serve as the Hub, and they also include expanded services. Hubs are strongly connected with community Spokes; Spokes are office-based opioid treatment settings located in communities across Vermont. Within several Spokes, opioid use disorder care is integrated into general medical care, including treatment for co-occurring chronic diseases.[10] The Hub and Spoke model is pictured below:

Figure 3:



**LADC- licensed alcohol drug abuse counselor*

POOR COORDINATION BETWEEN GOVERNMENT, PUBLIC HEALTH, AND PROVIDER ENTITIES

Some providers state that poor communication between them and federal and state governments, public health organizations, and other providers is a barrier while providing MAT services. They note the difficulties they and patients experience while seeking guidance from insurance companies and the state in navigating medication-assisted treatment. Providers also indicate that communication with the government feels like a bottom-up effort, yet they expect these conversations to flow from the top down. Providers state that this obstacle causes them to feel as if they are alone while trying to provide MAT services.

Leadership Vacuum

Prescribers who have been offering these services for the past 10 years or more state that one of the defining obstacles while providing MAT services is that the provider community feels forced to

[10] Hub and Spoke, State of Vermont Blueprint for Health, accessed August 29, 2019 at: https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke

take leadership in responding to the opioid crisis.

> *"This is bottom-up and it should be top-down. This is a huge epidemic—it's a public health crisis—which is managed by public health entities…and at this point it is just starting to get on their radar. People have been taking a look at it, creating strategic plans…But for those of us in the field, it hasn't made one bit of difference in the quality of care or even the accessibility to care. We need action. This is bigger than what I can do as a provider."*
>
> *Provider*

Some providers said they feel the burden of caring for this patient population while also locating resources and support for themselves and other MAT providers. Many MAT providers struggle to gain access to help and report feeling that no one is listening to them, which adds to provider frustration in adopting MAT services.

It was not until local communities and community organizations started acting on this issue, after seeing so many struggles with opioid addiction, that physicians and other MAT providers found a way to engage on this issue. Several interviewees identified this not only as a challenge for existing prescribers but as a major barrier for any clinician choosing to take up MAT services or seeking a DEA waiver. Participants also observed that the perceived lack of leadership on this issue has allowed the media/media coverage of the opioid crisis to inform prescribers' opinions on this matter and has increased their fear and apprehension around offering MAT services.

To address the challenges of the perceived lack of communication and leadership within the public health community, providers voiced the ways that they have taken the initiative to be successful and make changes in the field, beyond the patient exam and treatment room. Participants noted their willingness to be engaged in the public health and education community by spearheading community support groups, developing continuing medical education opportunities, writing editorials, delivering presentations, and advocating for policies on TV and the radio. Prescribers also emphasized the need to stay current in the addiction field by participating in learning opportunities beyond the waiver training, such as pursuing CMEs, attending conferences, and joining committees and/or task forces.

REIMBURSEMENT POLICY: BILLING AND CODING, REGULATIONS, PRIOR AUTHORIZATION

At the top of providers' minds when it comes to the day-to-day operations of offering efficient and high-quality MAT services are the challenges associated with reimbursement for these

services. Issues with provider payment exist in both public and private insurance programs, and these issues are further complicated by state/federal regulations and policies. Since the population receiving MAT services is disproportionately comprised of Medicaid enrollees[11], interviewees voiced major concerns about structural issues around Medicaid compensation.

Offering MAT Services to Medicaid Patients

A major challenge that providers told us that they face in their MAT practices is receiving payment under Medicaid—from successfully coding for MAT services to successfully receiving reimbursement. They reported using more than a dozen different codes for treating opioid-related medical care under Medicaid, with as few as one of the codes reimbursed reliably. It took one of the interviewed providers over two years of filing for reimbursement with Medicaid to determine which codes result in payment for MAT services. Not only does Medicaid reimbursement take a lot of office staff effort and time to navigate, delayed payments can be especially harmful in the first years of offering MAT services, when many providers stated that they had operated at a deficit.

Another aspect of Medicaid billing and coding that providers say is problematic is that the reimbursement provided for these services does not cover the entirety of the patient need. One MAT provider said that she receives $47 per visit under Medicaid. And because Medicaid does not cover drug screening, she personally pays $25 of the $47 for urine screening. Additionally, her patients quite often also need help outside of the doctor's office; this requires that she spend time speaking with a patient on the phone. However, she is not allowed to bill for any additional reimbursement for time spent on the phone outside of the office visit. She reports that by the end of some of patient visits, she is paying out-of-pocket to provide appropriate patient services.

Most of the interviewees said that Medicaid reimbursement does not enable high quality MAT treatment without an investment from the provider. All the addiction specialists we interviewed recommended that MAT services should be part of a team approach (discussed later in this report), but Medicaid does not provide reimbursement for care team members, such as a care manager. In addition, the billing codes available for MAT do not cover any therapeutic or case management services. Nor do these codes cover any MAT services offered for other SUD, including alcohol use disorder (AUD), even though MAT is also an evidence-based treatment for AUD.

Offering MAT Services to Private or Uninsured Patients

Many providers also reported difficulties in treating MAT patients with private or no insurance. Both providing and receiving MAT services is expensive. Many patients must pay for services out

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[11] MACPAC (Medicaid and CHIP Payment and Access Commission). 2017. "Medicaid and the Opioid Epidemic." In *Report to Congress on Medicaid and CHIP*. Washington, DC: Medicaid and CHIP Payment and Access Commission.

of pocket, because their insurance does not cover substance use disorder treatment, or they have extremely high copays and/or deductibles. There are times when patients are motivated to seek treatment for their substance use disorder, but they simply cannot afford the treatment. Interview participants stated that some medical practices can provide patients with payment assistance.

Providers state that they have mixed success in submitting for and successfully obtaining reimbursement for MAT services from private insurance companies. In the words of one provider:

> *"Even with protection from legal contracts signed by both parties, it is not unusual for the payor not to fulfill the contract obligations and force me to make a decision to continue working without pay; to leave (me), having lost a month or two of pay; or to sue for the monies owed me."*
>
> *Provider*

Best Practice

- Bring in navigators and other support staff during open enrollment to help patients change their insurance to one better suited for receiving MAT services
- Provide guidance to patients about insurance companies that will better meet the patients' needs

To help new prescribers successfully navigate billing and coding for MAT services, providers shared their creative solutions. In the case of private insurance, if after initial efforts to communicate with an insurance company, a provider cannot work out reimbursement for services, they reported that they have ceased working with the problematic company. Rather than discontinue providing MAT to patients enrolled in this insurance, the practice brings navigators and other support staff in during open enrollment to help patients change their insurance to one better suited for receiving MAT services. They also use this opportunity to provide guidance to patients about insurance companies that will better meet the patients' needs.

Regulations/Policies that Contribute to Payment Challenges

In addition to billing, coding, and reimbursement issues impacting MAT services, our providers identified regulatory and policy barriers in implementing these services. The top regulatory barrier named in our interviews is the prior authorization process for Medicaid patients. Providers report that they cannot prescribe MAT to a patient, and have that patient pick up their prescription, without prior authorization from Medicaid. The prior authorization requirement creates difficulty for providers both in their relationship with their patients as well as in their clinical workflow. This

often creates a scenario in the critical first patient appointment where the provider is working to build a relationship with the patient and cannot get the medication into the patient's hands that day. In the words of a provider:

> *"You have someone in front of you that used heroin to get to the office, and they are in withdrawal, and you write them a prescription for medicine, and Medicaid won't pay for it—for a day, or two, or three."*
>
> *Provider*

This critical opportunity, when a patient is receptive to beginning MAT services, can be lost during the time spent navigating the prior authorization process. In addition to affecting the patient/provider relationship, the prior authorization process creates an administrative burden on providers. In the words of one provider:

> *"Every single time I write a prescription, [pharmacy] sends me back a prior authorization form because their system automatically sends it to the HMO and that gets booted back to my clinic. So, then my nursing staff has to check on every single patient if their prior authorization was done. That takes 5-7 minutes…for no reason."*
>
> *Provider*

Best Practice

- Utilize partnerships with different organizations to gain access to coupons that patients can use to pick up their MAT prescription free of (or very little) charge
- Build relationships with local pharmacies to avoid prior authorization complications

One practice uses an inventive way to deal with the delays by leveraging partnerships to get medication into the patients' hands on the same day the prescriptions are written. This practice utilizes partnerships with different organizations to gain access to coupons that patients can use to pick up their MAT prescription free of (or for very little) charge, before the prior authorization is processed and Medicaid begins to pay. Another provider also stresses the importance of building relationships with local pharmacies to avoid prior authorization complications.

The last administrative barrier we learned more about from the interviewees is related to the

limitation imposed for patient prescribing cap under the DEA waiver. Under current regulations, providers may obtain a waiver to prescribe buprenorphine to 30 patients in the first year, 100 patients in the second year and then 275 patients in all subsequent years[12]. Over half of the interviewees shared passionate objections to the waiver cap, one reason being the potential financial consequences for new MAT prescribers:

> *"My first year in doing it with the DEA X waiver of 30 patients, I made $5000 gross…I was paying out of pocket for all the office expenses. The second year when it goes to 100, I didn't have 100 patients. I made $15000 gross. Because of the limitations of the X waiver, which are necessary, I paid out of pocket to take care of those patients for two years."*
>
> *Provider*

Because of the financial model of the patient caps of the first two years of MAT services, it is hard to attract recent medical graduates who are paying off high levels of medical debt.

The second reason that providers shared passionate objections to the waiver prescribing maximums was the firm belief that the caps contribute to the institutionalized stigma around addiction treatment. Providers can prescribe as many opioids for pain as they see fit, but they are not allowed to prescribe as much MAT as they deem necessary.

Best Practice

- Ask for help

Expect to Ask for Help:

No matter the obstacle, one best practice tip that resonated among many interviews is to ask for help. As previously outlined, addiction medicine has yet to be integrated into the chronic disease curriculum for primary care and other providers. As a result, it is possible for a newly waivered provider to interact with their first MAT patient in their very first appointment, as opposed to in residency or another training position. These providers, as well as any other MAT providers, whether newly waivered or not, should expect to be in consultation with other MAT prescribers. One interviewee offered a final piece of advice:

[12] American Society of Addiction Medicine, Buprenorphine Waiver Management, https://www.asam.org/resources/practice-resources/buprenorphine-waiver-management

> *"Don't be scared to reach out for help. You didn't learn this in medical school, residency, fellowship. You didn't learn this anywhere. We don't expect you to have all the answers. There are people out here that are happy to help."*
>
> *Provider*

Each of the successful MAT prescribers interviewed for this guide attributed shadowing or a strong provider network to a key piece of their success. From asking basic questions initially to grappling with complex questions years down the road, asking for input from other providers results in successful MAT services. In addition to the best practice information and feedback provided in the report to help new providers understand the MAT landscape, our interviewees collectively recommended the following Provider Recommended Resources list that has aided them in becoming successful MAT prescribers.

Provider Recommended Resources

Organization	Short Description	Website
AAAP	AAAP. We are psychiatrists, faculty, medical students, residents and fellows, and related health professionals committed to evidence-based clinical practices and research in the prevention, identification, and treatment of substance use disorders and co-occurring mental disorders.	https://www.aaap.org/
ACEs	Adverse Childhood Experiences (ACEs) have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. Working together, we can help create neighborhoods, communities, and a world in which every child can thrive. Learn more about preventing ACEs in your community by assuring safe, stable, nurturing relationships and environments.	https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html
AMERSA	AMERSA (The Association for Multidisciplinary Education and Research in Substance use and Addiction), founded in 1976, is a non-profit professional organization whose mission is to improve health and well-being through interdisciplinary leadership in substance use education, research, clinical care and policy.	https://amersa.org/
ASAM	ASAM, founded in 1954, is a professional medical society representing over 6,000 physicians, clinicians and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.	https://www.asam.org/
MOC	In partnership with Michigan Department of Health and Human Services (MDHHS), the Department of Psychiatry and the Injury Prevention Center of the University of Michigan is working to build a statewide network to help Michigan prescribers ("providers") to use Medication Assisted Treatment (MAT) for patients with an Opioid Use Disorder (OUD). The resulting project, called the Michigan Opioid Collaborative (MOC), provides same day consultation from physicians with specialty addiction training to support enrolled providers. To enroll as a provider, contact MOC using the 'contact us' page on the website or email: moc-administration@umich.edu.	https://medicine.umich.edu/dept/psychiatry/programs/michigan-opioid-collaborative-moc

Narcan.com	Narcan.com was published by AdaptPharma. The website provides various resources regarding Narcan (naloxone) such as information explaining what Narcan is, how to get Narcan, how to use Narcan, and when to use Narcan.	https://www.narcan.com/
NIAAA	The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is one of the 27 institutes and centers that comprise the National Institutes of Health (NIH). NIAAA supports and conducts research on the impact of alcohol use on human health and well-being. It is the largest funder of alcohol research in the world. NIAAA leads the national effort to reduce alcohol-related problems by: ▲ Conducting and supporting alcohol-related research in a wide range of scientific areas including genetics, neuroscience, epidemiology, prevention, and treatment. ▲ Coordinating and collaborating with other research institutes and federal programs on alcohol-related issues. ▲ Collaborating with international, national, state, and local institutions, organizations, agencies, and programs engaged in alcohol-related work. ▲ Translating and disseminating research findings to health care providers, researchers, policymakers, and the public.	https://www.niaaa.nih.gov/
OBAT	Boston Medical Center's (BMC) Office Based Addiction Treatment (OBAT) Training and Technical Assistance (TTA) provides education, support and capacity building to community health centers and other health care and social service providers on best practices caring for patients with substance use disorders.	https://www.bmcobat.org/
PCSS	PCSS is a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) created in response to the opioid overdose epidemic to train primary care providers in the evidence-based prevention and treatment of opioid use disorders (OUD) and treatment of chronic pain. The project is geared toward primary care providers who wish to treat OUD. PCSS is made up of a coalition, led by American Academy of Addiction Psychiatry (AAAP), of major healthcare organizations all dedicated to addressing this healthcare crisis. Through a variety of trainings and a clinical mentoring program, PCSS's mission is to increase healthcare providers' knowledge and skills in the prevention, identification, and treatment of substance use disorders with a focus on opioid use disorders.	https://pcssnow.org/

PRAPARE	The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help health centers and other providers collect the data needed to better understand and act on their patients' social determinants of health. As providers are increasingly held accountable for reaching population health goals while reducing costs, it is important that they have tools and strategies to identify the upstream socioeconomic drivers of poor outcomes and higher costs. With data on the social determinants of health, health centers and other providers can define and document the increased complexity of their patients, transform care with integrated services and community partnerships to meet the needs of their patients, advocate for change in their communities, and demonstrate the value they bring to patients, communities, and payers.	http://www.nachc.org/research-and-data/prapare/about-the-prapare-assessment-tool/
Project ECHO	Project ECHO (Extension for Community Healthcare Outcomes) is a collaborative model of medical education and care management that empowers clinicians everywhere to provide better care to more people, right where they live. The ECHO model™ does not actually "provide" care to patients. Instead, it dramatically increases access to specialty treatment in rural and underserved areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions such as: hepatitis C, HIV, tuberculosis, chronic pain, endocrinology, behavioral health disorders, and many others. It does this by engaging clinicians in a continuous learning system and partnering them with specialist mentors at an academic medical center or hub. As the ECHO model expands, it is helping to address some of the healthcare system's most intractable problems, including inadequate or disparities in access to care, rising costs, systemic inefficiencies, and unequal or slow diffusion of best practices. Across the United States and globally, policymakers are recognizing the potential of ECHO to exponentially expand workforce capacity to treat more patients sooner, using existing resources. At a time when the health care system is under mounting pressure to do more without spending more, this is critical.	https://echo.unm.edu/

Trauma Informed Care	The ACE Study (Felitti & Anda, 1997) and subsequent research has generated a growing awareness that trauma is frequently at the root of social, emotional, and psychological difficulties. Consequently, many individuals, systems and institutions across various human service sectors are seeking and/or providing training in trauma-informed service delivery. This section aims to draw on existing literature and resources, as well as the experience and expertise of individuals involved in this project, to provide an overview of trauma and its impact on youth.	https://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_69588_80204_80360---,00.html