STATE OPIOID RESPONSE 2 GRANT:

Medication Assisted Treatment Implementation Lessons Learned and Recommendations

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The Substance Abuse and Mental Health Services Administration (SAMHSA) funded a fiscal year (FY) 2020 cohort of the State Opioid Response grant program (referred to here as SOR2). The purpose of SOR2 was to address the opioid crisis by providing resources for increasing access to FDA-approved medication for the treatment of opioid use disorder and supporting the continuum of prevention, harm reduction, treatment, and recovery support services for opioid use disorder (OUD) and other substance use disorders (SUD).

The Oregon Health Authority (OHA) contracted with Portland State University (PSU) to conduct an impact evaluation of SOR2. As part of the evaluation, PSU conducted a sub-study focused on MAT program implementation, and whether SOR2 funding expanded access to and utilization of MAT services in Oregon (complete findings are available in the full report: *State Opioid Response 2 Grant: Medication Assisted Treatment Expansion Evaluation**). This brief is a summary of implementation lessons learned and recommendations for future expansion of MAT services.

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Description of MAT Grantees

SOR2 funds were distributed to agencies providing MAT services in eight counties (see Figure 1). The seven agencies included in the evaluation were newly providing MAT or expanding MAT to new locations. As such, most locations had been providing MAT services for less than one year at the time of their first interview. Six agencies were office-based opioid treatment (OBOT) programs, which allow primary care or general care providers with an X waiver (created by the Drug Addiction Treatment Act, or DATA) to prescribe MAT medications (e.g., buprenorphine, buprenorphine/naloxone, naltrexone).[1] One agency was an opioid treatment program (OTP). OTPs integrate SUD treatment with various recovery support services and are certified to dispense methadone as well as buprenorphine.[2]

Most SOR2 expansion agencies adopted a MAT-first model, where clients receive medication as quickly as possible prior to lengthy assessments. Two agencies were bridge clinics, providing short-term services to increase speed of access to medications and then working to connect clients with long-term access. Agencies were located in a mix of rural and urban settings.

Data Collection

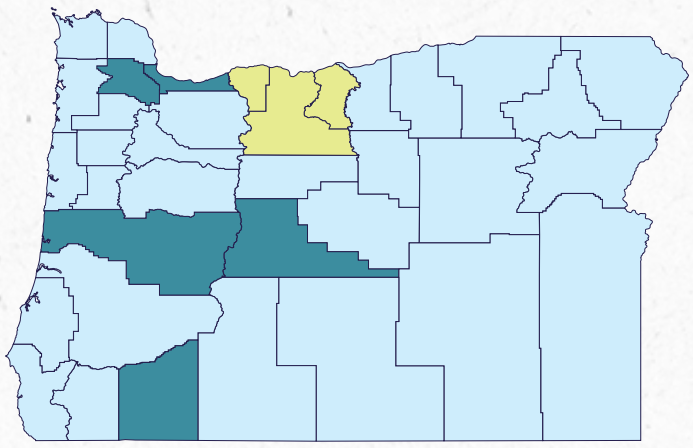
Data collection took place between June 2021 and July 2022. In consultation with OHA, PSU conducted two rounds of semi-structured interviews with MAT grantees to learn about their implementation successes and barriers, approach to health equity, and collaboration efforts. Among the seven agencies, 10 key staff participated in the first round, and 9 in the second round, of interviews.

Figure 1

Oregon counties with SOR2-funded grantees

Multnomah	Hood River*
Lane	Wasco*
Deschutes	Sherman*
Washington	
Jackson	

*New MAT service areas



1 Indian Health Services. (n.d.) *Office Based Opioid treatment* (*OBOT*). Retrieved from https://www.ihs.gov/opioids/recovery/obot/

2 Center for Substance Abuse Treatment. (2005). *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK64168/

Implementation Lessons Learned

The information summarized here reflects grantees' experiences as they worked to implement MAT services and navigate healthcare system regulations and policies, as well as issues specific to their agencies. Although these grantees' experiences may not fully represent all agencies implementing MAT services in Oregon or in other geographical locations, their lessons learned can help support organizations as they begin implementing MAT services.

MAT implementation lessons learned are as follows:

Include key agency staff and diverse, knowledgeable informants in implementation planning. Implementation committees should include key agency staff; community partners, especially culturally-specific organizations working with communities most affected by OUD; and individuals with lived experience with SUD (i.e., peers). Additionally, establish early connections with other organizations providing MAT and seek guidance and planning support from expert consultants if possible.

Assess staff readiness to implement MAT and design strategies to improve buy-in. Some treatment providers have reservations about MAT. It might be necessary to promote organizational culture shifts from a drug-free orientation toward a harm reduction/MAT-first approach.

Assess community readiness for MAT services and design strategies to increase awareness and understanding. Community members and clients with OUD often have misconceptions about MAT. Community outreach efforts (e.g., distributing materials, meeting with community leaders, public service announcements) can help educate people about MAT and approaches to harm reduction. These efforts should be linguistically and culturally inclusive (e.g., materials translated into multiple languages, working with culturally-specific community organizations). Examine community OUD treatment needs and possible utilization rates, especially when looking to provide MAT in rural areas (i.e., larger catchment area with fewer people).

Develop infrastructure to support service provision and regulatory compliance. Update and create workflow protocols and practices to support staff in having a consistent approach to MAT service provision. It is important for agencies to align their internal processes with state and federal regulations and continuously monitor for compliance. Additionally, it is critical to collaborate with Coordinated Care Organizations (CCOs, which deliver care to Medicaid members) and private insurers to set up billing procedures that comply with their policies and regulations as soon as possible.

Develop data systems and an organizational culture that supports continuous quality improvement. A system for tracking and analyzing data is a critical part of quality improvement - it can illuminate gaps in service, barriers to access, and other aspects of service provision in need of improvement. An organizational culture that values learning, flexibility, and adaptation will help agencies improve conditions for employees, and promote equitable outcomes for clients and communities.

Integrate peer support services with MAT service provision. Peers can play a vital role in MAT service provision. Agencies should work to establish sustainable funding for the peer workforce and develop clear MAT-specific peer job descriptions. Once hired, agencies should provide MAT-specific training and support for peers, which will in turn enhance their ability to support clients.

Adapt MAT services to a telehealth model. Establish a telehealth (or hybrid) option for MAT services to create a low-barrier pathway to treatment. Telehealth can help address the shortage of prescribers, overcome geographical barriers, offer flexibility to clients, and provide long-term continuity of care. It is especially important to have protocols designed to meet confidentiality requirements for telehealth appointments.

Plan for staffing shortages. Anticipate and develop strategies for managing staffing challenges, including a shortage of X waivered providers, pay discrepancies, and credentialing requirements. Strategies will likely need to address internal policies (e.g., restrictive policies that make it difficult to hire peers), upskill existing staff, manage state and federal regulations (e.g., credentialing requirements), and be proactive (e.g., create a talent pipeline by partnering with local community colleges).

Recommendations

Based on findings from the SOR2 MAT Evaluation, we offer the following recommendations to support the future expansion of MAT services in Oregon:

Allocate more resources for implementation. Implementing MAT services requires funding, staff time, technical assistance, and infrastructure investments (e.g., data systems). Future expansion efforts should allocate a proportion of funding specifically for implementation, and support agencies in connecting with technical assistance, expert consultants, and learning communities with other MAT providers. A longer grant funding period would also provide more time and resources for implementation. The two-year SOR2 funding period essentially required agencies to fully implement MAT services without time for thorough planning and installation.

Continue funding work in priority populations. Intentionally identifying and funding services for priority populations can promote equitable access to services. SOR2 funding, for example, intentionally expanded access to MAT services in rural communities. Future funding could use the same approach to expand access to other populations experiencing the disproportionate impact of OUD. Funding should also incentivize agencies to adopt and strive toward goals for providing equitable access to MAT services. Last, fund culturally-specific organizations to create more opportunities for culturally- and linguistically-relevant MAT services and promote health equity.

Encourage agencies to involve people with lived experience. In alignment with SAMHSA's *Participation Guidelines for Individuals with Lived Experience* and Family, encourage agencies to involve peers/people with lived experience in designing their programs, including client outreach, engagement, and retention.[3] Agencies should also be incentivized to collect client feedback on their experiences with MAT services to better assess whether they are culturally-responsive, trauma-informed, and client-centered, and to identify areas for improvement.

Invest in the SUD workforce. Hiring and retaining high quality staff was one of the main challenges grantees faced. State and federal investments in the SUD workforce could help increase wages, expand training opportunities, increase the number of credentialed providers, and develop a career ladder in the field (e.g., support paid internships for CADC-Rs). Removing financial barriers (e.g., scholarship programs) would encourage more people to enter the SUD field, and offering financial incentives for priority provider populations (e.g., Spanish-speaking) would create more equitable workforce opportunities. Importantly, workforce efforts should also focus on removing barriers to accessing higher education that disproportionately affect certain communities (e.g., ethnic/racial minority groups, low-income students),[4,5,6] resulting in a less culturally and linguistically diverse healthcare workforce.

Support grantees' understanding of state and federal policies and advocate for any needed changes. As MAT expands across Oregon, it will be important for agencies to fully understand and navigate state and federal policies pertaining to MAT service provision. Some examples of regulations that grantees found challenging to navigate or would like to see changed are the Suboxone certification process, MAT location restrictions, and rules that do not allow methadone admissions over telehealth (for OTPs). Additional support developing cost calculators, negotiating fees with CCOs and private insurance providers, and finding ways to get reimbursed for outreach activities would support agencies' financial sustainability. Another area for advocacy is credentialing, which can place limits on who can provide services (e.g., restrictive background checks for peers) and create gaps in funding if there is staff turnover (e.g., processing time when CCO's credential providers).

Acknowledgement

We would like to thank the program staff who work each day to provide life-saving MAT services. We appreciate the time you spent sharing your experiences with us for this evaluation.

3 Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). *Participation Guidelines for People with Lived Experience and Family*, Retrieved from https://www.samhsa.gov/grants/applying/guidelines-lived-experience

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5 Wyse, R., Hwang, W.-T., Ahmed, A. A., Richards, E., & Deville, C. (2020). Diversity by race, ethnicity, and sex within the US Psychiatry Physician Workforce. *Academic Psychiatry, 44*(5), 523–530. https://doi.org/10.1007/s40596-020-01276-z

6 Iglehart, J. K. (2014). Diversity dynamics — challenges to a representative U.S. medical workforce. *New England Journal of Medicine, 371*(16), 1471–1474. https://doi.org/10.1056/nejmp1408647