The ‘Medication-First’ Model & Barriers in Accessing Treatment

Bureau of Justice Assistance (BJA)
Residential Substance Abuse Treatment (RSAT)
Program for State Prisoners
Training and Technical Assistance Resource
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The ‘Medication-First’ Model & Barriers in Accessing Treatment

David Lucas, MSW, Center for Court Innovation
Tamara Beetham, Yale University
Dawn Patrick, Affinia Healthcare
Rachel Winograd, Ph.D, Missouri Institute of Mental Health
Learning Objectives

- Identify and describe the range of barriers individuals face in accessing opioid agonist therapies
- Explain how these barriers reproduce existing racial disparities in healthcare and treatment access
- Recognize how the Medication-First model of care is responsive to these challenges
Some additional questions:

- What are some of the less visible MOUD treatment barriers we see in our own field or practice?
- How does ‘medical mistrust’ impact MOUD access?
- Why is promoting equal access to MOUD treatment so critical?
- Why do patients divert MOUD?
What we already know about MOUD:

- Increases treatment retention
- Extends period of non-use, less risky use
- Reduces overall use of unpredictable, street-acquired drugs
- Reduces overdose risk, especially post-release from jail, prison, treatment or hospital
- Associated with reductions in illegal income-generating activity, recidivism

...yet stigma and barriers persist


Selected readings on MOUD effectiveness (CDC, 2018), continued…
When are people at highest risk of overdose?

- Using alone, unpredictable supply
- Forced withdrawal or ‘dopesick’
- Re-entry / release from jail/prison (Binswanger, 2007; Joudrey, 2019)
- Release from hospital (Brady, 2015)
- Release from abstinence-based tx (Strang, 2003)
- After a housing eviction (BCSSU, 2019)
- After a destabilizing or traumatic life event
- Disrupted use of street supply
- Disrupted use of methadone/bupe
- Post-acute withdrawal syndrome
- Naltrexone (Vivitrol) treatment completion
- Notable change in street supply
- Notable change in MOUD prescription
- Restricted access to Naloxone, sterile supplies
- Experiencing intimate partner violence (Collins, 2020)
When are people at highest risk of overdose?

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Overdose Prevention: Sanctioned Practices (US)

- Naloxone distribution
- Good Samaritan Laws
- Drug testing strips
- Medications for Opioid Use Disorder
- ‘Medication-First’ model of care
- Community-based outreach programs (SSPs)
- Police or prosecutor-led diversion programs (LEAD, PAARI)
- Problem-solving courts (drug, opioid, mental health)
Our guest speakers:

• **Tamara Beetham** is conducting her doctoral studies at Yale University. She is earning her PhD in Health Policy and is a Teaching Fellow in Health Economics. She received her Master of Public Health from Harvard University, and has cared for patients in the inpatient psychiatric unit of her community hospital for 8 years. Her research is on mental health policy with a focus on barriers and disparities in accessing opioid agonist therapy for opioid use disorder.

• **Dawn Patrick** currently works at Affinia Healthcare in St. Louis Missouri. She obtained her Associates of Nursing from Jewish Hospital College and went on to obtain her Bachelor of Science and Masters of Science in Nursing from the University of Missouri – St. Louis. Dawn is a board certified Family Nurse Practitioner and licensed to practice in Missouri and Illinois. Dawn currently provides primary care to adult and pediatric patients; as well as provide outpatient Medication Assisted Treatment (MAT) services to patients suffering with addictions.

• **Rachel Winograd, PhD**, is an Associate Research Professor at University of Missouri St. Louis – Missouri Institute of Mental Health. She received her doctorate in clinical psychology from the University of Missouri, Columbia, and completed her doctoral internship with the VA St. Louis Healthcare System. Her clinical, research, and program development interests revolve around interventions designed to save and improve the lives of people who use drugs.
Tamara Beetham
Yale University
Health Policy and Management
Admission Practices, Cost, and Therapies Offered at Residential Treatment Programs

Tamara Beetham, MPH
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September 30, 2020
Background

- Residential treatment programs are frequently highlighted in policy proposals to improve access
- Clinical effectiveness compared to outpatient care is uncertain
- Concerns have been raised about high costs, substandard quality and patient exploitation
- Further assessment is needed, but little data is available
- We assess admission practices, costs, and treatments offered by residential programs nationally
**Study Design: “Secret Shopper”**

<table>
<thead>
<tr>
<th>Population</th>
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<tbody>
<tr>
<td>- 613 randomly sampled residential treatment programs</td>
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<td>- Identified from federal listings and search engine advertisements</td>
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<thead>
<tr>
<th>Profile</th>
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<tbody>
<tr>
<td>- Actively using heroin</td>
</tr>
<tr>
<td>- 27 years old</td>
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<tr>
<td>- Uninsured</td>
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<tr>
<td>- Seeking care</td>
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<tr>
<th>Main Outcomes</th>
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<tr>
<td>- Admission acceptance &amp; wait</td>
</tr>
<tr>
<td>- Recruitment techniques</td>
</tr>
<tr>
<td>- Treatment cost</td>
</tr>
<tr>
<td>- OAT availability and messaging</td>
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<th>Outcome Stratification</th>
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<tr>
<td>- Ownership (nonprofit vs for-profit)</td>
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<tr>
<td>- Presence of accreditation (state licensure, CARF, JCAHO)</td>
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Findings

Sample

1/4 US Facilities Surveyed

81% Response Rate

Admission

2/3 Have Immediate Bed Availability

Recruitment by Profit Status

Encouraged Debt-Based Financing

e.g. credit cards

For-profits 37%

Nonprofits 15%

Used Recruitment Techniques

e.g. paid transportation

For-profits 65%

Nonprofits 9%

Cost

3/4 Require Upfront Payments

Cost For-profit Nonprofit

Daily $758 $357

Upfront $17,434 $5,712

Opioid Agonist Therapy (OAT)

29% Offer OAT Maintenance

31% Offer Detoxification-Only OAT

21% Actively Discourage OAT

Results did not differ by State Licensure, Accreditation, or Ownership Status

12 Step

92% Offer 12-Step
Conclusions

Admissions
- Most Offer Rapid Access
- Frequent Use of Inducements
- Substantial Upfront Costs
- Especially For-Profit Programs

Opioid Agonist Therapy
- Few Offered OAT
- Many Discouraged OAT
- Not Associated with Licensure, Accreditation, or Ownership Status

Implications
- Regulatory Oversight and Transparency is Needed for Accountability
Admission Practices and Cost of Care for Opioid Use Disorder at Residential Addiction Treatment Programs in the US

Forthcoming in Health Affairs
Thank You!

Tamara Beetham, MPH
Yale University, Health Policy and Management
Email: tamara.beetham@yale.edu
Twitter: @tamarabeetham
Dawn Patrick

Affinia Healthcare
INVISIBLE/VISIBLE BARRIERS

• Continued shortage of Physicians, NP’s and PA's with Buprenorphine Waivers

• Limited inpatient and outpatient treatment facilities
  – Low treatment availability & affordability
  – Lack of direct links to care for providers

• Cost of Treatment
  – Inconsistent – treatment and medication expenses
  – Dependent on Treatment Facilities

• Lack of Recovery Housing
INVISIBLE/VISIBLE BARRIERS

• Lack of mental health services

• Privatized distribution of federal, state and local funding to private treatment facilities
  – lack of oversight of spending of funds
  – little funding provided to FQHC's & Methadone Clinics to help alleviate treatment gaps.
Rachel Winograd
Missouri Institute of Mental Health
Prior Approach to OUD Treatment

- Detox
- Residential and group therapy
- Acute care rather than chronic care
- Buprenorphine and Methadone as last resort
Prior Approach to OUD Treatment

- Detox
- Residential and group therapy
- Acute care rather than chronic
- Buprenorphine and Methadone as last resort
Missouri’s Medication First Approach

1) People with OUD receive medical treatment as quickly as possible, prior to lengthy assessments or treatment planning sessions;

2) Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;

3) Individualized psychosocial services are offered but not required as a condition of pharmacotherapy;

4) Do not discontinue medical treatment unless it is clearly worsening the patient’s condition.

Winograd et al., 2019, AJDAA
Individuals enrolled in STR were more likely to...

1. receive medication
2. get medication sooner
3. be engaged in treatment at 1, 3, 6, & 9 months
4. Cost the State 21% less per month, on average

The take-aways

Winograd et al., 2019, JSAT
Obstacles Remain

- Financial feasibility and sustainability in specialty addiction treatment settings
- Adjusting to a “sicker” client base… which comes with burnout, compassion fatigue, vicarious trauma
- Continued struggles to address all clients’ needs
- Lack of reliable, fast, and long-term access to care throughout the state
- Racial disparities in overdose deaths keep growing…
OPIOID OVERDOSE DEATHS BY GENDER AND RACE

Source: Bureau of Health Care Analysis and Data Dissemination, Missouri Department of Health and Senior Services
Questions and Discussion

Visit [www.noM0deaths.org](http://www.noM0deaths.org) to learn more and sign up for our statewide email listserv
Discussion Panelists

Tamara Beetham
Yale University

Dawn Patrick
Affinia Healthcare

Rachel Winograd
Missouri Institute of Mental Health
Question #1

For structurally marginalized populations – what changes are needed at the provider-level to better engage and retain patients? (e.g. more wraparound services; housing; legal advocacy; culturally-responsive/safe treatment options)
Question #2

Thinking about the harrowing overdose numbers, particularly since March, and in relation to recovery month – what system level changes are needed to ensure that opioid users survive this crisis and have a chance at recovery?
QUESTIONS

Type your questions in the Q&A box on your screen.

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CERTIFICATE OF ATTENDANCE

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CERTIFICATE OF CONTINUING EDUCATION

1 Continuing Education Hour (CEH) approved by NAADAC, the Association of Addiction Professionals

Pass 10-question quiz with 7 correct answers

Download certificate upon completion of the quiz

SEPTEMBER 30, 2020 RSAT webinar CEH quiz link:

http://www.rsat-tta.com/Home

Stephen Keller
RSAT TTA Coordinator | skeller@ahpnet.com