



**U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy**

PSYCHOSOCIAL SUPPORTS IN MEDICATION-ASSISTED TREATMENT:

SITE VISIT FINDINGS AND CONCLUSIONS

July 2019

Office of the Assistant Secretary for Planning and Evaluation

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Psychosocial Supports in Medication-Assisted Treatment: Site Visit Findings and Conclusions

Final Report on Site Visits

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ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

AA	Alcoholics Anonymous
ACT	Acceptance and Commitment Therapy
AIDS	Acquired Immune Deficiency Syndrome
ASAM	American Society of Addiction Medicine
ASAP	New Mexico Addictions and Substance Abuse Program
AUDIT	Alcohol Use Disorders Identification Tool
BAM	Brief Addiction Monitor instrument
BASIS-24	Behavior and Symptom Identification Scale
CBT	Cognitive Behavioral Therapy
CBT-IC	Cognitive Behavioral Therapy of Internal Cues
CFR	Code of Federal Regulations
CHARM	CHildren And Recovery Mothers collaborative
Co-OP	Collaborative Opioid Prescribing model
COAT	Comprehensive Opiate Addiction Treatment
CRA	Community Reinforcement Approach
CRAFFT	Car, Relax, Alone, Forget, Friends, Trouble screen
CRS	Certified Recovery Specialist
DAST-20	Drug Abuse Screening Test 20-item scale
DATA 2000	Drug Addiction Treatment of 2000
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSM-V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
EBP	Evidence-Based Practices
ECHO	Extension for Community Healthcare Outcomes project
EHR	Electronic Health Record
EMR	Electronic Medical Record
FDA	HHS Food and Drug Administration
FQHC	Federally Qualified Health Center
GAD-7	Generalized Anxiety Disorder 7-item scale
GME-SNC	Graduate Medical Education Safety-Net Consortium
HHS	U.S. Department of Health and Human Services
HIV	Human Immunodeficiency Viruses
HRSA	HHS Health Resources and Services Administration
IOP	Intensive Outpatient Program

LEC-5	Life Events Checklist for DSM-V
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer (or Questioning)
MARC	Maternal Addiction and Recovery Center
MAT	Medication-Assisted Treatment
MCO	Managed Care Organization
MET	Motivational Enhancement Therapy
N-DATSS	National Drug Abuse Treatment System Survey
NA	Narcotics Anonymous
NIDA	HHS National Institute on Drug Abuse
NSSATS	National Survey of Substance Abuse Treatment Services
OBOT	Office-Based Opioid Treatment
OBOT-B	Office-Based Opioid Treatment with Buprenorphine
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PacMAT	Pennsylvania Coordinated Medication-Assisted Treatment
PCL-5	Post-traumatic Stress Disorder Checklist for DSM-V
PCMH	Patient-Centered Medical Home
PCSS-MAT	Providers' Clinical Support System for Medication-Assisted Treatment
PDSA	Plan-Do-Study-Act cycle
PHQ-2	Patient Health Questionnaire 2-item scale
PHQ-9	Patient Health Questionnaire 9-item scale
PPS	Prospective Payment System
PROACT	Provider Response Organization for Addiction Care and Treatment
PS	Psychosocial Service
PTSD	Post-Traumatic Stress Disorder
SAMHSA	HHS Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SNAP	Strengths, Needs, Abilities, and Preferences assessment
STR	State-Targeted Response
SUD	Substance Use Disorder
TES	Therapeutic Education System
UNMH	University of New Mexico Hospital
USC	United States Code
WHO	World Health Organization
WHODAS	World Health Organization Disability Assessment Schedule
WVU	West Virginia University

EXECUTIVE SUMMARY

This report was produced under contract to the Office for the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services. The purpose of this report is to gain a better understanding of the role and range of different models of psychosocial support in medication-assisted treatment (MAT) for opioid use disorder (OUD).

Site Visits. This report presents findings from five site visits during which qualitative interviews were conducted with key staff to collect data on how psychosocial supports are implemented in their MAT program. While the sites were selected to represent diverse models of practice, the varying programmatic approaches to psychosocial supports in MAT were notable. Two sites were relatively new programs, and one long-standing program had radically re-designed its approach within recent months. Each program was in an integrated setting that offered both medical and behavioral health care. All recognized the need for a phased or stepped approach that adjusts treatment intensity over time. Programs varied in the types of psychosocial supports offered, use of evidence-based practices (EBPs), data collection and quality improvement initiatives, attention to comorbidities, specialty tracks for subgroups, and clinical response to continued substance use.

Research Questions. These site visits, as well as an environmental scan that included a literature review and key informant interviews, provided evidence to address the following research questions. **According to the best available evidence, what psychosocial components of MAT are the most important to support positive patient outcomes in OUD treatment?** The available literature on the value of psychosocial supports in MAT is limited. Research findings are mixed, though recent systematic reviews have been supportive of the value of psychosocial supports. In general, the literature is inadequate to draw conclusions about the types or levels of psychosocial services that should be provided, or how to adapt psychosocial supports across settings or patient groups. Yet, professionals in the field, including professional organizations, key informants interviewed, and staff in the visited sites all strongly agreed there is great value in psychosocial supports. **What types of psychosocial support are providers currently using in practice?** The findings of these case studies demonstrate great diversity in approaches and the general lack of a standard model for psychosocial supports for MAT. Programs employ a range of psychosocial supports that vary in content and intensity, including individual counseling, group counseling, self-help groups, case management, peer specialists, medication management, and skills learning groups. While EBPs are frequently evaluated in research, they are used less frequently or in an unstructured manner in practice. **What factors facilitate or impede medical providers' implementation of psychosocial support in MAT?** Most notably, programs experience challenges related to the hiring and retention of qualified, knowledgeable behavioral health clinicians, which has constrained capacity more than shortages of prescribers. They reported the need for additional workforce and support specific to MAT. Further, programs identified other barriers related to coordination of physical and behavioral health care, information sharing, and reimbursement. Stigma surrounding addiction and MAT continues to pose significant challenges to the expansion of these services.

Limitations, Policy Implications, and Future Research. The lack of comparable outcomes data and the small sample size of this study prevent us from comparing the effectiveness of these programs or generalizing the findings. However, this study highlighted important policy considerations related to the need to support the workforce, ensure sustainability, and standardize performance measures. Without improvements in data collection and analysis, there remain significant gaps in the knowledge related to the effectiveness of psychosocial supports in MAT.

1. INTRODUCTION

As the opioid epidemic has evolved into a national crisis, the need for treatment has increased greatly. Approximately 2.1 million people had an opioid use disorder (OUD) in the previous year according to the 2016 National Survey of Drug Use and Health.¹ Medication-assisted treatment (MAT) is a “whole-patient” approach to the treatment of OUD that combines the use of medications and psychosocial supports, such as counseling. Studies have demonstrated that MAT can effectively treat OUD by decreasing opioid use and opioid-related overdose deaths.² The U.S. Department of Health and Human Services (HHS), Food and Drug Administration has approved three medications to treat OUD: methadone, buprenorphine, and naltrexone.

Purpose

The purpose of this report is to highlight different models of psychosocial supports in MAT for OUD. The aim of these case studies is not to evaluate the practices of a program but rather to better understand their different approaches to psychosocial supports, the challenges they face implementing psychosocial supports, and the strategies they use to overcome those challenges. This report also builds upon the findings from the environmental scan conducted in the first phase of this study, *Psychosocial Supports in Medication-Assisted Treatment: Recent Evidence and Current Practice*, which reflects the results of a literature review and interviews with key informants that included researchers, health care providers, administrators of MAT programs, and policymakers (see Appendix 2).

For the purposes of this paper, psychosocial supports are defined to include formal or informal counseling by the prescribing physician or others, individual or group counseling or therapies, formal manual guided psychotherapies, participation in structured peer counseling, and identification of and attempts to address social determinants of health.

Psychosocial Supports and MAT

Psychosocial interventions in MAT aim to serve three important functions: engagement of patients in treatment, behavioral modification, and treatment of co-occurring mental health disorders. While much research has been devoted to the efficacy of the pharmacotherapy of MAT, less attention has been given to the psychosocial components of this treatment. Yet, by definition, psychosocial supports are meant to be a standard component of MAT per clinical practice guidelines set forth by the World Health Organization (WHO) and the American Society of Addiction Medicine. For example, Opioid Treatment Programs (OTPs) are required by the Code of Federal Regulations (CFR) to provide “adequate substance abuse counseling.”³ The *Federal Guidelines for Opioid Treatment Programs* further details the importance of other support services, such as peer recovery coaches, 12-step programs, and family counseling.⁴ Similarly, the Drug Addiction Treatment Act of 2000, which allows qualified providers to obtain waivers to prescribe buprenorphine in treatment settings other than OTPs, requires prescribers to have the capacity to directly provide or refer patients for counseling and other appropriate services.⁵

However, while legislation and regulations require psychosocial supports to be offered along with pharmacotherapy in MAT, there remains some debate as to the value of these services. In 2016, Dugosh and colleagues conducted a systematic review of the role of psychosocial supports in MAT and notes that, while they found some support for the efficacy of psychosocial interventions in combination with medication to treat OUD, the “incremental utility varied across studies, outcomes, medications, and interventions.”⁶ After reviewing the available literature, the current research in this field is largely inadequate to draw clear conclusions about the impact and value of psychosocial services in real-world, clinical settings. Many of the current studies face significant limitations, including analysis of relatively short-term outcomes that often fail to capture some of the impacts of psychosocial interventions on functional measures or quality of life.

As the environmental scan indicated, there is no well-defined standard model of psychosocial supports in MAT for OUD. The rapid expansion of MAT into a range of health care settings has in turn varied the psychosocial supports offered. Frequently, MAT programs must design the psychosocial support services themselves or rely on the local resources that are available to them.

Methodology

This study for the HHS Office of the Assistant Secretary for Planning and Evaluation, is designed to address three core research questions:

- Q1.** According to the best available evidence, what psychosocial components of MAT are the most important in terms of supporting positive patient outcomes in OUD treatment?
- Q2.** What types of psychosocial support are providers currently using in practice?
- Q3.** What factors facilitate or impede medical provider’s implementation of psychosocial support in MAT?

While the first question was largely addressed in the environmental scan, the second and third questions are the focus of this report, which draws upon data collected during site visits.

Recruitment and Selection. To ensure a diverse array of programs, the selection criteria incorporated key dimensions across which psychosocial services may vary, based on the results of the environmental scan. For example, factors under consideration included, but were not limited to type of pharmacotherapy offered, type of psychosocial supports, type of providers of psychosocial supports, setting of the MAT program, phased approaches to treatment, adaptations for specific patient populations, geographic diversity, and magnitude of the opioid epidemic in the state.

Seven programs delivering MAT for OUD were identified as possible candidates for the case studies, as suggested by key informants and experts in the field. Upon further discussion, five programs that represent diverse models of practice were selected for site visits: APT Foundation (New Haven, Connecticut), Cabin Creek Health Systems (Charleston, West Virginia), the Wright Center (Jermyn, Pennsylvania), University of New Mexico Addictions and Substance Abuse

Program (ASAP) (Albuquerque, New Mexico), and Valley Health Systems (Huntington, West Virginia).

Site Visits. One-day site visits were conducted at these five different organizations to collect data on how organizations implement psychosocial supports in their MAT program. Semi-structured interviews were conducted with key staff, including (as applicable) administrators, medical prescribers of MAT, providers of psychosocial supports (social workers, counselors, etc.), case managers, peer support specialists, and others. Discussion questions were developed to guide the site visit and addressed: (1) practices related to providing psychosocial support services to patients; (2) personnel involved in these services; (3) the role of psychosocial services as part of the treatment of patients with OUD; and (4) challenges related to providing these services, and strategies that are used to overcome those challenges.

2. CASE STUDIES

APT Foundation New Haven, Connecticut

The APT Foundation, which is a federally licensed OTP, provides outpatient substance use disorder (SUD) treatment, including MAT for OUD, mental health care, and primary care services. The program endorses the philosophy that addiction is a disease of the mind, body, and spirit that affects a person's social and emotional functioning and, therefore, requires a holistic approach to treatment.

The APT Foundation has a main access center that provides intake, MAT, other SUD treatment, and primary care services as well as three other clinics throughout New Haven County. Residency in New Haven County is not required as the program draws patients from the entire State of Connecticut.

Since July 2007, the APT Foundation has adopted an "open-access" model to treatment, which serves patients on a walk-in basis for assessment and intake and allows them to receive their first dose of medication on the same day as intake. Walk-in intakes are available on weekday mornings, and the program conducts approximately 15-25 intakes per day. In addition, this "open-access" model encourages patients to choose from a menu of psychosocial supports that are offered on varying days and times; appointments are not required to participate in these services.

This model has allowed the APT Foundation to greatly increase patient capacity, with the number of patients treated with methadone nearly tripling since the implementation of the open-access model in 2007. The program treats an estimated 8,000 patients per year, with approximately 56 percent receiving methadone and 12 percent receiving buprenorphine-naloxone (Suboxone®). About 2,500 of the APT Foundation's 8,000 patients are receiving treatment for a condition other than OUD, have a primary mental health condition, or have tapered off of MAT and now receive only psychosocial services for their OUD. While it is available, very few patients opt to use naltrexone.

Psychosocial Supports

Group Therapy and Group Activities: Group sessions are the primary form of psychosocial treatment offered by the APT Foundation. To accommodate patient's schedules, groups are

AT A GLANCE...

- SETTING**
Specialty Substance Abuse Treatment Program, Licensed Opioid Treatment Program
- PROGRAM AGE***
11 years
- SIZE**
8,000 Patients
- MEDICATIONS**
Methadone
Buprenorphine-naloxone
Naltrexone
- PSYCHOSOCIAL SUPPORTS**
Group Sessions
Individual Counseling
Case Management
Medication Management

*age of MAT program's current service model

available as early as 6 a.m. Group programming schedules are developed weekly and are designed to offer a variety of groups that address patient interests and needs. These schedules are posted on the program’s website so that patients can attend groups that align most closely with their interests.

In general, the APT Foundation prefers to design programming around patient interest and engagement rather than strictly adhering to manuals of evidence-based practices (EBPs). However, clinicians draw upon elements of EBPs as appropriate, such as using motivational interviewing or including content from the Seeking Safety intervention and the Trauma Recovery and Empowerment Model in trauma-related groups. They try to play to the strengths and interests of staff members when assigning facilitators to groups and add new groups to the rotation when clinical staff have ideas for activities that patients may find engaging.

Patients are requested to attend at least one group per month though an ad-hoc individual encounter or a treatment planning meeting can satisfy the contact requirement as well. Patients receiving methadone are required to have a minimum of one contact per month, and those using buprenorphine have to make a contact at the point of medication refill or at least once per month. Participation is tracked by patients through forms that are signed off during groups and used to record patients’ status or progress in their own words. These forms are also used to update the electronic medical record (EMR) and to generate billing.

A menu of services

On a weekly basis, the program publishes a schedule of all groups available and who will serve as the facilitators, so patients may choose to attend as many groups as they wish from the menu of services. At the access center, there are typically 11-15 group sessions available each weekday. Counselors and clinicians typically only facilitate one group per day, so the rest of their time is unscheduled, allowing them to provide therapy on a walk-in basis. Examples of groups include:

- **Skills Learning and Psychoeducation Groups:** Managing Money; Relapse-Prevention; Anger Management; Relaxation Techniques; Action not Reaction; Skill Building for Parents; Job-Seeking Skills; Emotional Regulation; Biology of Addiction; Prioritizing Self-Care; Getting Motivated to Change; Roadblocks to Recovery; Grief and Loss; Stress Management.
- **Activities and Interest Groups:** Acupuncture; Dancing Mindfulness; Walking Group; Guided Meditation; Art Journaling; Gardening; Crocheting.
- **Gender-Based Groups:** Men’s Recovery Group; Women’s Recovery Group; Men’s Trauma and Recovery.

Individual Counseling: Counselors and clinicians are available on a walk-in basis to provide individual therapy based on a patient’s needs as an adjunct to the group therapy. Typically, this would occur during the “unscheduled” time of the day when these staff members are not serving as facilitators of group sessions. If there are co-occurring mental health concerns that warrant further attention, the APT Foundation can also provide more-intensive, structured psychiatric services delivered by psychiatrists, psychologists, or licensed clinicians.

Case Management: While case management is not the primary emphasis of the psychosocial supports offered, staff do their best to assist patients in meeting their social and economic needs. For example, if patients are experiencing housing instability, staff will help connect patients with

potential resources in the community. There is also a dedicated team for benefits exploration, with each location having at least one point of contact to help people obtain health insurance, particularly through the state's Medicaid program. Also, the APT Foundation provides vocational services to help community residents obtain and maintain employment.

Medication Management: When patients come to the clinic for a refill of their medication, they initially meet with a behavioral health clinician. The clinician will observe the patient's affect and discuss any cravings, withdrawal symptoms, mental health challenges, comfort with the dosage, and any positive steps the patient has made in their recovery. Then, the behavioral health clinician provides the prescriber with an update on the patient's status based on their observations and clinical notes.

Clinical Response to Continued Substance Use: In general, the APT Foundation emphasizes a self-management rather than punitive approach when it comes to continued substance use. They perform urine drug screens, the results of which provide more information to the clinicians and prescribers about the patient's health and drug use status. While staff may offer psychoeducation and support to these patients, they do not discharge patients based on substance use. The team may recommend that patients who are struggling move to the Intensive Outpatient Program (IOP), though they do not require it. The IOP requires patients' attendance at three groups for 3 days a week, for a total of 9 hours, and may also include individual therapy.

Staffing and Staff Training

To address the shortage of experienced, qualified behavioral health providers in the local community, the APT Foundation has created a pathway to grow and train their staff and support their career advancement. The Foundation encourages formal training and provides tuition reimbursement for staff who seek additional educational credentials and training. Many staff members are hired initially as patient care associates, who are responsible for tasks such as checking patients in and administering urine screens. The patient care associates are required to become certified alcohol and drug counselors within 18 months of hire. After serving as a counselor, staff can go on to obtain their master's degree to be promoted to the clinician role, with tuition support from APT Foundation for the required classes.

Collaboration and Coordination

To coordinate care for patients and provide staff supervision, the program holds a monthly case presentation with half of the clinical staff. In addition, the team will identify patients who are struggling and discuss the plan to manage that patient and set next steps at the weekly staff meeting.

Financing

Medicaid is the primary payer of services for the APT Foundation, though the percentage of patients with private insurance is growing. APT Foundation will begin treatment even if the patient is currently uninsured because they have staff who are able to work with the patient to then enroll in Medicaid. Services for methadone patients are reimbursed by Medicaid using a daily bundled rate, which includes the costs of the medication itself, drug testing, case management, and individual or

group therapy. Buprenorphine services are billed on a fee-for-service basis. Additional medical or mental health services are billed separately.

The APT Foundation’s open-access model is financially viable because it maximizes efficiency, it has increased patient volume, and it is not driven by traditional productivity standards. Since shifting to the open-access model, APT has been able to nearly triple the number of methadone patients whom they serve. In traditional appointment-based treatment services, missed appointments lead to lost revenue. The open-access model allows for the more efficient use of counselors’ and clinicians’ time in that they can serve patients on a walk-in basis, resulting in more hours where clinicians are actually delivering services in a given day. The program maintains flexibility by canceling groups with poor attendance. Further, because there are no individual caseloads, clinical staff are not solely accountable for treatment planning, which allows them to spend more time with patients providing billable services.

HIGHLIGHTED BARRIER-	State Medicaid Policies
	Despite the need to increase resources for OTPs, financial support for substance use treatment services continues to be a challenge. Recently, the state of Connecticut moved from a weekly bundled rate for methadone patients to a daily bundled rate. This change has reduced the overall funding received for treating these patients because revenue is not received for days when a patient does not present for services. It remains to be seen whether the other efficiencies of the open-access model are enough to offset the financial impact of this policy change. Medicaid policies may also have an impact on other key aspects of treatment. For example, state Medicaid agencies set rules and pick vendors for non-emergency medical transportation for Medicaid members. Access to these transportation services may be critical for patients in order to engage in treatment and for programs to receive reimbursement, particularly in light of the recent change to a daily bundled rate.

Data Collection and Quality Improvement

The APT Foundation conducts robust data collection and analysis. Information collected at intake includes BASIS-24 (for behavior and symptoms), the LEC-5 (for life events), Smoking History, and a Pain and Physical Activity screen. As part of the psychiatric evaluation that is conducted by a master’s-level clinician at intake, they also create a SNAP (Strengths, Needs, Abilities, and Preferences) Assessment.

The program is also committed to evaluating the open-access no-appointment model in order to disseminate their findings and to support quality improvement, for which they use the NIATx approach to rapid-cycle process improvement. For example, they have studied the impact of the open-access model on admission wait time, patient census, retention, illicit opioid use, patient mortality, and financial sustainability. The abstract of their published article concludes that the open-access model, “appears to improve treatment access, capacity, and financial sustainability without evidence of deleterious effects on treatment outcomes.”⁷

Lessons Learned

As an OTP, the APT Foundation presents a unique case of innovative psychosocial services within an integrated medical and behavioral health treatment setting. Overall, the program's approach places a strong emphasis on self-management and patient-centered care. The model allows patients to determine their own care team by building relationships with a preferred cadre of staff. The shared responsibility of these patients appears to help prevent staff turnover and burnout because they can function as a team and share the burden of treatment planning and patient care. Additionally, staff report the unstructured day (i.e., the absence of scheduled patient appointments) keeps the work interesting.

Another core tenet of this program is its commitment to understanding and eliminating barriers to care. The organization's leadership concluded that delay in treatment admission is one of the most significant barriers for patients seeking treatment. Therefore, they designed a model to facilitate access for the underserved populations in their community. With its emphasis on efficiency, the APT Foundation is able to serve a very high volume of patients. Given the public health crisis the opioid epidemic poses, it may represent a promising approach to allow communities to scale up access to MAT.

Next Steps

The APT Foundation's future plans include further integration of the treatment of infectious diseases and SUDs as well as the introduction of some of the recently approved medications for OUDs. They also intend to continue their focus on patient self-management.

Cabin Creek Health Systems Charleston, West Virginia

Cabin Creek Health Systems, a Federally Qualified Health Center (FQHC), offers outpatient MAT for individuals with OUDs in a primary care setting at the Kanawha City Health Center--one of the five clinic locations in Kanawha County, home of West Virginia's state capitol and largest city, Charleston. All patients are tested for infectious diseases and offered comprehensive primary care services, in addition to their treatment for opioid use. Since its creation in January 2016, the MAT program has followed the Comprehensive Opiate Addiction Treatment (COAT) model developed by faculty from the Department of Behavioral Medicine and Psychiatry at the West Virginia University (WVU) School of Medicine. While Cabin Creek Health Systems is located in Kanawha County, it also serves patients from neighboring counties.

Currently, Cabin Creek's MAT program at Kanawha City Health Center has approximately 40 patients who are receiving buprenorphine-naloxone (Suboxone®) from a single prescriber and accompanying psychosocial supports. Cabin Creek currently receives about ten referrals a week, although many either choose not to enter the program once they are oriented to the structure, or they appear to need a higher level of care than the program can provide. In either case, those who do not enter are referred to other, more appropriate programs in the community. While there is currently a waitlist of approximately 5-6 people, staff work hard to get those who are ready to make a commitment to treatment into the program.

Psychosocial Supports

The psychosocial supports provided as part of the Cabin Creek program in the COAT model, including group therapy, individual counseling, and group medication management, are combined into a phased approach. The frequency of therapy sessions and medication management visits decreases over time if a patient continues to abstain from substance use and actively engages in treatment. Initially, these visits are required on a weekly basis. After 90 days of continuous non-use of all substances, as measured by urine drug screens, the program requires biweekly attendance to group therapy and medication management. After a year of continuous non-use, patients shift to monthly visits.

Individual Counseling: Addiction counselors see patients for individual therapy sessions at least once a month, with the frequency adjusted depending on a patient's needs and progress in recovery. Sessions are more frequent during the early phase of treatment. Individual counseling takes a trauma-informed approach because most patients have experienced trauma during childhood, as a



result of their addiction, or both. The goal of the one-on-one sessions is to address the specific needs of a person in their life and their recovery. Counselors draw upon evidence-based techniques, such as motivational interviewing, cognitive behavioral therapy (CBT), dialectical behavior therapy, or health realization, depending on the patient. In addition to counselors delivering individual therapy, a care coordinator also serves as a recovery coach to provide additional support. The care coordinator aims to form strong relationships with the patients and makes herself available 24 hours a day by cell phone if patients need help or someone to talk to.

Group Therapy: Group therapy tends to be psychoeducational in nature rather than process or therapeutic. The counselor uses a wide range of resources for the group sessions, choosing topics based on themes that have emerged among the group or individual sessions. She often draws upon programming from the Hazelden Foundation, the Cleveland Clinic, and EBPs featured on the HHS Substance Abuse and Mental Health Services Administration (SAMHSA) website.

Self-Help Groups: The program places a strong emphasis on the importance of 12-step meetings and requires participation. In the first year of treatment, patients are required to attend four 12-step meetings per week, in accordance with the WVU COAT model. Adherence is monitored by sheets that patients have signed at local 12-step meetings. Non-attendance may result in additional treatment requirements, such as more frequent office visits and reduced prescription length. Before a patient is able to move to the second phase of treatment with its less frequent biweekly group and medication management sessions, they must have a sponsor within their 12-step group. After a year in treatment, attendance at 12-step meetings becomes voluntary; however, the team noted most patients choose to continue to attend. [<http://www.hsc.wvu.edu/substance-abuse-prevention/patient-care-initiatives/comprehensive-opioid-addiction-treatment-provides-group-based-treatment-program-using-medication-assisted-therapy-mat/>]

A supportive relationship with WVU

The team at Cabin Creek receives ongoing continuing education and support through MAT ECHO and Psych ECHO with the WVU COAT program. These biweekly, hour-long videoconference sessions allow the team to consult with specialists on patient care and program issues. Leadership at Cabin Creek characterizes these ECHO sessions as being very helpful as they have developed the MAT program and prepared provider staff to assume new roles.

Case Management: The program's care coordinator assesses case management needs during intake by discussing a patient's financial, transportation, housing, and medical needs. The vast majority of patients use public transportation, so the program provides bus passes. The team will try to coordinate carpooling between patients to ensure everyone is able to attend treatment sessions and medication management visits. If needed, staff will also write letters on a patient's behalf describing their progress and adherence to treatment for housing, employment, or probationary purposes.

Medication Management: To increase efficiency, patients are seen by the physician for medication management in a group setting before group therapy. Before the group session begins, the physician receives a brief report about patient progress, including recent urine drug testing results regarding opioids and other substances, length of time since the patient's last opioid-positive urine test, current dose, recent 12-step group attendance, and therapy attendance. Using this

information, the physician briefly addresses each patient during the group medication management session, focusing on positive affirmations for those who are adhering to their treatment plans. For patients whose urines show continuing substance use or those who are not meeting the requirements of their treatment plans, the physician may intensify treatment (e.g., decrease the number of days of medication per prescription, increasing the number of required 12-step meetings per week).

Clinical Response to Continued Substance Use: Patients are required to submit to urine drug screens at each medication management visit as well as random screens every 30 days. Continued substance use triggers an increase in required psychosocial supports, in that patients with ongoing substance use are required to attend more 12-step meetings per week and/or more frequent visits to the Cabin Creek facility for medication refills.

Patients who are struggling may be recommended for increased treatment intensity. In “probationary MAT,” patients are required to submit to drug screenings twice a week as well as attend biweekly meetings with counselors. These patients may include those who are not honest when asked about their substance use before a screen, those who test positive for illicit substance use, or those in long-term treatment who fail to show for a random drug screen. Patients with “advanced probationary” status have often relapsed and must come in three times a week for drug screenings and once a week to meet with a counselor. A small number of patients in intensive outpatient MAT come to Cabin Creek every day for a drug screen and to see the prescribing physician; these IOP patients also meet with a counselor once per week (or more often if necessary).

Staffing and Staff Training

Cabin Creek has experienced significant behavioral health workforce issues, specifically related to psychiatrists and qualified master’s-level licensed counseling professionals. Relatively few of these professionals have comprehensive training in addiction treatment and are willing to work with this patient population. These workforce issues have posed challenges for increasing the number of MAT providers in this setting. The manager of substance abuse treatment services provides informal supervision to other members of the clinical staff.

Collaboration and Coordination

Before every group medication management and subsequent group therapy session, the prescriber, medical assistant, scribe, care coordinator, and behavioral health counselor all participate in a “team huddle.” During this time, they discuss the results of patients’ drug screens, self-disclosures of substance use, 12-step attendance, and any other relevant issues the patient is experiencing. These discussions inform changes to treatment plans that are made by the provider during the group medication management session, particularly in terms of increasing the intensity of treatment.

Financing

The majority of MAT patients, approximately three-quarters of the total patients served, are insured by Medicaid. In addition, relatively small numbers of patients have private insurance or are uninsured. Reimbursement for the group medication management visits adequately covers the physicians’ time and helps offset costs from other services that are not reimbursable. For example,

the care coordinator's services (while highly valuable) are not currently reimbursable by Medicaid. Similarly, the reimbursement for the addiction therapist's time for group and individual sessions is insufficient to cover the costs of these services.

While the program is primarily funded by billing Medicaid for services, it has received some support through federal grant funding from the SAMHSA and the HHS Health Resources and Services Administration (HRSA). State-Targeted Response (STR) funding from SAMHSA has been distributed to WVU, which has supported the Extension for Community Healthcare Outcomes (ECHO)-style training for Cabin Creek and other FQHCs. In addition, Cabin Creek is the recipient of STR funding to help train other FQHCs working to implement the COAT model.

HIGHLIGHTED BARRIER.	State Regulations
	In 2016, West Virginia passed a law that aimed to reduce abuse of opioids by tightly regulating clinics offering MAT in office-based settings. The regulations were modeled after those imposed on OTPs, and in effect made it more difficult to provide buprenorphine in an office-based setting. The regulations have created significant concern among some physicians that failure to comply will lead to professional or programmatic sanctions. When the new regulations were enacted, Cabin Creek consulted a lawyer about how to ensure they remained in compliance with the rules. These regulations pose challenges for MAT offered in integrated settings, such as Cabin Creek. For example, the initial program survey process was very burdensome, ill-suited to an integrated medical setting, and sometimes in conflict with other licensing or accreditation requirements. State officials have been responsive to feedback about these problems and are currently working to prepare a less burdensome version.

Data Collection and Quality Improvement

The program tracks specific measures of interest through Excel spreadsheets, including retention, relapses, dosages, results of urine screens, and attendance at 12-step meetings. While these data are used to adjust individual's treatment plans, it is not clear that the data are readily aggregated to assess program effectiveness or to identify areas for improvement.

Lessons Learned

The Cabin Creek Health Systems MAT program at the Kanawha City Health Center is a relatively young program that initially experienced some challenges related to community acceptance and uptake. In large part, this is due to the broader context of MAT in West Virginia and the approach the legislature has taken in regulating it. The WVU COAT model includes requirements for 12-step participation and employs contingency management measures to incentivize abstinence. The psychosocial supports that are offered are very structured and standardized, with treatment intensity driven by time in treatment and urine drug screening results. The program also places an emphasis on efficiency by using the group visits for medication management and therapy. Though they were aided by grant funding as they started implementation, this efficiency will be key to financial sustainability moving forward.

Further, staff report that this group medication management and group therapy model has allowed patients to form connections and support networks. Patients sometimes provide transportation to

other patients from their groups who need assistance in attending treatment sessions or 12-step meetings, and they communicate with each other when they suspect someone is struggling. Some patients who are advanced in their recovery are also becoming involved as advocates outside of the program, with some patients joining program staff to advocate for the benefits of MAT to the state legislature, doing presentations for child protective services, and planning to start their own 12-step groups that are more receptive to patients receiving MAT.

Next Steps

To address the ongoing need for greater access to MAT in the Charleston, West Virginia area, Cabin Creek intends to expand their MAT program to four of the five health system sites. They are seeking additional HRSA grant funding to assist them in these efforts, and are actively recruiting physicians and counselors who will agree to prescribe MAT. They have also hired a second care manager who will provide additional support to the patients with OUD. With these changes, they hope to double the number of patients enrolled in MAT services within the Cabin Creek Health System.

The Wright Center Jermyn, Pennsylvania

The Wright Center is a Patient-Centered Medical Home (PCMH) and Graduate Medical Education Safety-Net Consortium (GME-SNC) that serves Luzerne and Lackawanna counties in Pennsylvania, which include the cities of Scranton, Wilkes Barre, Clarks Summit, and Jermyn. The services offered by the Wright Center include primary care, maternal and child health care, behavioral health care, and dental care. As a GME-SNC, they aim to train culturally competent doctors on a whole-patient approach to care in an integrated setting. They offer residency and fellowship programs as well as research opportunities for graduate students.

In September 2016, the State of Pennsylvania created the Centers of Excellence program to increase access to treatment for individuals with OUDs and to keep them engaged in their care. The Wright Center was one of the 45 sites across Pennsylvania selected to serve as a Center of Excellence to provide treatment to individuals with OUDs. The Centers of Excellence emphasize a “whole-person” team-based approach with the aim of integrating behavioral health and primary care.

Since beginning to treat OUD patients with MAT in January 2017, the Wright Center has quickly developed and staffed a program that offers several forms of OUD pharmacotherapy, including buprenorphine-naloxone and naltrexone (both oral and extended-release). The Wright Center currently has 159 active MAT patients, 118 of whom receive buprenorphine-naloxone (Suboxone®) and 29 receive naltrexone. The program primarily receives referrals from other providers within the Wright Center, though many individuals seek treatment on their own.

Psychosocial Supports

Individual Mental Health Counseling: The mental health counseling offered on site by the Wright Center is provided by a licensed clinical social worker and psychiatric nurse practitioner, both of whom emphasize resilience, social connectedness, self-regulation, and self-care. They also use skills development, such as teaching patients about healthy routines, nutrition, or mindfulness. These behavioral health providers may use evidence-based techniques, such as CBT or motivational interviewing, if it fits the patient’s behavioral health needs. They always try to meet the patient where they are because of the Wright Center’s commitment to patient-centered care. If they feel a patient would benefit from a specific psychosocial intervention and no one on staff is trained in it, they will coordinate with a therapist who works in the community and specializes in that specific model.

AT A GLANCE...

- SETTING**
Patient Centered Medical Home,
Graduate Medical Education
Consortium
- PROGRAM AGE***
1.5 years
- SIZE**
159 Patients
- MEDICATIONS**
Buprenorphine-naloxone
Naltrexone
- PSYCHOSOCIAL SUPPORTS**
Individual Counseling
Self-Help Groups
Case Management
Peer Services
Medication Management

**age of MAT program's current service model*

Drug and Alcohol Counseling: While the Wright Center offers mental health counseling onsite, they refer patients to an outside organization that is licensed by the State of Pennsylvania to provide outpatient drug and alcohol counseling. This organization, Drug and Alcohol Treatment Service, Inc., offers a range of levels of care, including traditional outpatient services, IOP, and partial hospitalization. The traditional outpatient program includes 2-hour long groups twice per week as well as a session of individual counseling once per week. They use a systematic level of care assessment to determine the appropriate treatment plan for the patient, and aim to meet the client where they are by asking for client input as to his or her availability for treatment.

Self-Help Groups: Staff at the Wright Center encourage and recommend use of self-help groups, though self-help group attendance is not required as part of the MAT program. They do not specify which group to attend, but do encourage use of Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or SMART Recovery depending on the patient's preferences. However, if a self-help group is part of the patient's desired treatment plan, the team may ask that forms be completed to verify the patient's attendance.

Case Management: When patients enter the MAT program, they are assessed for relevant social and economic determinants of health using a comprehensive screening questionnaire. Critical needs that require immediate attention are highlighted and addressed first (e.g., victim of domestic violence, food instability, housing status). Notably, the Wright Center's policy is that critical needs must be addressed by staff within 24 hours. Over the course of treatment, patients see the case manager every other week to discuss ongoing needs. Case managers perform a variety of functions, including conducting intake interviews, developing treatment plans, and coordinating with MAT prescribers. Case managers also provide "mobile" case management services, in which staff may conduct home visits or meet patients out in the community. While community resources are limited, the case managers have developed connections with local agencies that help them to connect patients to supports such as housing, employment, and inpatient treatment.

Peer Services: The program has two certified recovery specialists (CRSs) who work with patients, primarily out in the community, to help patients work toward recovery in ways that are meaningful to them. The CRSs aim to connect with patients by speaking a language they can understand, decreasing the shame and guilt they feel about their disorder, and helping them to meet their individualized goals. Notably, the CRSs will provide transportation when needed to help patients attend self-help groups or to access other local services.

Medication Management: Prior to induction on MAT, the patient, case manager, and prescribing physician meet to develop an initial care plan. This discussion allows staff to review the options of medications, discuss the patient's history, and identify current needs. After induction, patients see physicians for medication management appointments every other week (on alternate weeks than their appointments with case managers). To maximize efficiency, all medication refills are on Mondays, though medication management appointments can be any day of the week. Case managers help triage who should receive refills.

As one physician described it, the medication is a "hook" that helps engage the patients in treatment so providers can work with patients on their other mental and physical needs as part of the larger recovery process. During medication management visits, prescribers take a holistic approach when assessing the patient's needs and clinical progress. For example, they may discuss cravings, family and spousal relationships, financial stress, or ways of finding meaning and purpose in life.

Clinical Response to Continued Substance Use: If a patient submits a urine specimen that tests positive for illicit drugs, the team will discuss the best approach to take with the individual patient. They may recommend increasing the intensity of treatment such as additional treatment sessions, visits with the CRSs, or greater participation in self-help groups. They may also refer patients to an external IOP based on clinical need. They rarely discharge patients, and would only do so with patients who were verbally abusive toward staff or other patients, were diverting their medications, or posed a safety risk to others. In the rare event that they discharge a patient, they always do their best to refer them to other MAT treatment options.

Nobody says, “Here’s the manual on how to do it.”

The Wright Center has successfully implemented a program within 18 months, requiring a rapid expansion and increase in staff. When they received state funding, they began their program with 1 behavioral health staff member and have since hired an additional 13 staff. They have also quickly recruited 10 of their providers to obtain their buprenorphine waivers and begin prescribing MAT. To rapidly scale up the program, the team worked diligently to build the infrastructure needed to support patients with OUD. However, they do not view their implementation of MAT as a static model. Rather, the team has applied continuous quality improvement practices to develop better processes and protocols to solve problems or address inefficiencies. Staff place a strong emphasis on creating efficient workflows while maintaining high-quality care. For example, the workflow for patient intake was designed to ensure physician time is used only as needed for prescribing and dose adjustments while leveraging the skills of other team members such as the case managers. Notably, many of the initial steps in the intake workflow are performed by case managers so that the time burden on physicians is lessened. The workflow is formalized in a color-coded flowchart that denotes which staff are responsible for the various steps of intake. The team continues to examine processes, such as this intake workflow, to ensure efficiency while providing patient-centered care.

Staffing and Staff Training

Given the challenging yet important nature of this work, leadership within the MAT program recognizes the need to be intentional, deliberate, and disciplined in how the workforce is trained and supported. With that approach in mind, there is a strong emphasis on staff training and continuing education. Leadership recognizes the need to take a holistic approach to recovery and encourages behavioral health staff to seek out trainings that reflect this, such as trainings on nutrition, mindfulness, etc. After staff members attend external trainings, those staff will hold a team meeting to share their experience so that others can benefit from what they have learned. In addition, the Wright Center leadership encourages and supports physicians who are trained in primary care specialties to obtain more education on addiction and its treatment. Of note, three primary care physicians so far have become board certified in addiction medicine since the establishment of the MAT program.

As a graduate medical education consortium, the Wright Center also makes an effort to grow the workforce by offering a residency program in psychiatry and free clinical supervision to social workers pursuing their clinical licensure. Other efforts to grow the clinical workforce include a summit held in April 2018 for physician assistants to gain continuing medical education credits that could be applied toward obtaining their waivers to prescribe buprenorphine.

Collaboration and Coordination

To enhance collaboration between physicians and behavioral health staff, each prescriber team is assigned a case manager with whom they often speak daily about their patients. Prescribers and behavioral health staff also meet together as a team when there are concerns about or needed changes in workflow or program policies.

Both the Wright Center and the external Drug and Alcohol Treatment Service, Inc., place a great value on the ongoing collaboration and strong relationship between their two organizations to deliver quality care. To coordinate care, staff from both organizations hold face-to-face, biweekly meetings to perform a clinical staffing on each shared patient. They discuss issues related to clinical progress, counseling attendance, and adherence to the treatment plan. While they are limited in what they can share to ensure compliance with any state or federal confidentiality regulations, there have not been any significant barriers to information sharing thus far that have challenged or jeopardized the delivery of treatment.

Financing

The Wright Center serves patients with Medicaid, Medicare, and private insurance. Individuals who are uninsured are never denied services based on inability to pay. The Wright Center is working with the state's Medicaid physical health managed care organizations (MCOs) to set up value-based contracts for patients with OUD. With the behavioral health MCO, they have a fee-for-service model to reimburse for services provided by the case managers and CRSs. However, not all of the work that a case manager performs for a patient is considered a billable service. In the long-term, staff expressed concern that fee-for-service is not a sustainable model with this population of patients because there are high no-show rates for appointments and engagement challenges, particularly in the early phase of treatment.

HIGHLIGHTED BARRIER.	Medicaid Carve-Outs
	Though many states have moved away from this financing model, the State of Pennsylvania maintains a Medicaid behavioral health carve-out in which behavioral health benefits are separately administered. This creates an added administrative burden when reimbursing for services in an integrated setting, such as the Wright Center, in which someone might be seen in 1 day for 3 services (i.e., substance abuse, mental health, and physical health). This necessitates duplicated efforts, such as clinical notes and billing, and complicates requirements on chart management to ensure there is no double dipping. Rather, they would prefer 1 bundled payment to take care of all a MAT patient's needs.

Data Collection and Quality Improvement

The Wright Center uses a sophisticated yet relatively user-friendly EMR system that allows them to systematically track patient progress. An in-house EMR specialist is critically important to quickly implement changes within the EMR. Currently the EMR includes collection of data on engagement

with the program, relevant physical health indicators (e.g., laboratory test results, hepatitis C), social determinants of health (e.g., housing status), and mental health (e.g., depression, anxiety, or trauma history). They continually work with the organization's EMR specialist to improve the functionality of the system and to improve their ability to generate data reports that can inform clinical care and guide process improvements. As a Center of Excellence, the state also requires regular reporting on measures such as referrals to counseling, engagement and retention, patient use of benzodiazepines, referrals to pain management, housing status, and self-reported quality of life.

As an organization, the Wright Center places a strong emphasis on quality improvement for all staff. All staff, including those working within the MAT program, are required to participate in six PDSA (Plan-Do-Study-Act) cycles per year to test potential improvements and changes.

Lessons Learned

The Wright Center has a history of strong care coordination within the PCMH model and broad experience fostering relationships between primary care and subspecialties. Behavioral health services are fully integrated into the organization's operations and workflows, with physicians transitioning between treating patients for primary care or OUD throughout the day. The program's strong emphasis on case management and wrap-around services to address the social determinants of health demonstrates a recovery-oriented, holistic approach individualized to the patient's needs. The Wright Center is a mission-driven organization with a clear commitment to delivering comprehensive health care. In a reflection of leadership commitment, the Chief Executive Officer is one of the waived MAT prescribers who obtained her board certification in addiction medicine after realizing she needed more training about addiction treatment. The staff not only welcome opportunities for improvement but also seek out ways in which they can improve the efficiency or quality of care. While the program has been implemented and scaled up in a relatively brief amount of time, it has been done in a thoughtful manner and continues to be refined.

Next Steps

In July 2018, the Pennsylvania Department of Health awarded the Wright Center a Pennsylvania Coordinated Medication-Assisted Treatment (PacMAT) grant to recruit and support ten or more physicians from rural FQHCs and private practices in its service area to develop MAT programs using a Hub-and-Spoke Model. They will train practices on the administration of Vivitrol® and Suboxone® to patients with OUD, workflows for MAT programs, the importance of psychosocial supports in MAT, and more. The Wright Center plans to build telemedicine infrastructure to support this PacMAT Hub-and-Spoke Model so it can effectively partner with the collaborating rural practices and further increase access to MAT.

University of New Mexico Hospital Addictions and Substance Abuse Program (ASAP)

Albuquerque, New Mexico

ASAP is a substance use treatment program embedded within the University of New Mexico Hospital (UNMH) system that provides treatment for opioid and other SUDs. The program is located in Albuquerque, the county seat of Bernalillo County, New Mexico; however, patients travel from all over the state to receive services. It is a certified PCMH and federally licensed OTP. The recovery-oriented, integrated program takes a team-based approach to offer substance use treatment to adults, transition-age youth, and pregnant women. The program offers primary care services, including treatment for hepatitis C, through a walk-in medical clinic. They also have a dedicated dual-diagnosis team for those with co-occurring psychiatric conditions and a dedicated post-traumatic stress disorder (PTSD) “track.” The program offers three forms of MAT: methadone, buprenorphine-naloxone (Suboxone®), and extended-release injectable naltrexone. Methadone and buprenorphine are both dispensed at a dispensing window, but some patients receive buprenorphine prescriptions under an office-based model that does not require daily dosing. Currently, ASAP serves 800-850 patients. Of the patients with OUD, there are 200-300 on methadone, 100-200 on Suboxone®, 1-5 patients on injectable naltrexone, and 1-5 patients not receiving medication. The program has not identified its maximum capacity because they are still working to determine the appropriate caseload for the counselors after recently implementing a major organizational change to their treatment model.

The program receives referrals through a number of pathways, including corrections, other programs within UNMH, other substance use treatment programs, the community, and psychiatric emergency services. There is a waitlist for entry into the program that fluctuates from less than ten to nearly 40 people and takes approximately 6-7 weeks to get into treatment; however, priority for treatment entry is given to pregnant women and individuals who inject drugs. For patients on the waitlist, group sessions are available during which nurses deliver psychoeducation on substance use, harm reduction, hepatitis C, and motivational exercises. Individuals who attend three of these group sessions are also given priority for intake, as they have demonstrated their motivation to receive treatment, and can get in as soon as 3 weeks.

AT A GLANCE...



SETTING
Specialty Substance Abuse Treatment Program, Licensed Opioid Treatment Program, Academic Medical Center



PROGRAM AGE*
< 1 year



SIZE
800 to 850 Patients



MEDICATIONS
Methadone
Buprenorphine-naloxone
Naltrexone



PSYCHOSOCIAL SUPPORTS
Individual Counseling
Group Therapy
Family and Couples Therapy
Self-Help Groups
Case Management
Medication Management
Skills Academy

*age of MAT program's current service model

Specialty tracks to meet patients' needs

Youth: The STAR program offers intensive substance use treatment for transitional age youth, up to age 21. The dedicated team may see patients several times a week and will include the parents or family of the patient in the treatment process.

Pregnant Women: Roughly 40% of new admissions to the program are pregnant women from all over the state. ASAP works closely with other programs to coordinate care for these women. The Milagro Program provides comprehensive services for pregnant women, including prenatal care, outpatient counseling, and case management support. Mariposa is a residential program that provides safe and stable housing during pregnancy. Finally, the FOCUS program provides ongoing primary care services for families of children through 3 years of age.

Dual Diagnosis: This clinic serves patients with co-occurring mental health disorders, such as PTSD, depression, psychotic disorders, and obsessive compulsive disorders that require intensive psychiatric medication management and follow-up.

PTSD: This track, with a dedicated treatment team, requires patients to complete an 8-session psychoeducation group before beginning evidence-based treatment for PTSD, specifically cognitive processing therapy or prolonged exposure therapy. Then, they participate in a monthly aftercare group for 14-24 months to practice skills and maintain progress for long-term recovery of PTSD.

Psychosocial Supports

While the ASAP program has a long-standing history delivering substance use treatment services to their community, they recently re-designed their approach to the psychosocial supports offered, launching the new model on April 30, 2018. The model is based on the trauma recovery work of Judith Herman, MD, which emphasizes that there are stages of recovery, that recovery is not linear, and that therapeutic approaches should be tailored to the stages. The stages are not time-limited, and patients move between stages based on their own individual needs and progress.

Stage 1: The primary goal for patients in Stage 1 is safety and stability. During this stage, providers focus on decreasing patient's substance use or self-harm behaviors, if applicable, and treating any critical psychiatric needs as patients begin MAT. Stage 1 emphasizes skills acquisition through the Skills Academy, a curriculum of classes that address topics such as life skills, relapse-prevention, psychological health, interpersonal health, and physical wellness. Classes are held every day, and patients can choose when and which classes to attend. Stage 1 does not include process groups or psychotherapy, as providers feel that intensive therapy and the group therapy milieu may be too overwhelming for patients at this stage and may actually discourage treatment engagement. However, there is a walk-in clinic in which counselors are "on call" to meet with patients about harm reduction, crisis management, or treatment planning. Engagement specialists monitor and track patients' progress, including Skills Academy attendance, urine drug testing results, medication dosages, and treatment plans. EBPs or techniques used during the Skills Academy or walk-in counseling appointments in Stage 1 include: motivational interviewing, motivational enhancement therapy (MET), cognitive behavioral skills training, harm reduction and relapse-prevention, 12-step facilitation, and Seeking Safety.

Stage 2: To transition to this stage, patients must be stable enough to engage in more-intensive psychotherapy and to maintain scheduled counseling appointments. Psychosocial supports offered

in this stage include individual, group, family, and couples therapy that aim to address the underlying drivers of their SUD. EBPs or techniques used during Stage 2 include motivational interviewing, MET, CBT, structured family and couples therapy, community reinforcement approach, cognitive processing therapy and prolonged exposure therapy for PTSD, interpersonal psychotherapy for depression, acceptance and commitment therapy (ACT), response prevention and exposure therapy, and dialectical behavior therapy skills.

Stage 3: Psychosocial supports during this stage serve as maintenance for patients who have experienced a remission in SUD symptoms and emphasize long-term stability. This phase of treatment includes peer-led aftercare groups and intensive process groups like a women's group. The ultimate goal of Stage 3 is for patients to graduate from the program and transition to other less-intensive, community-based services. Patients are encouraged to start thinking about what long-term recovery means to them and how to connect with the community in meaningful and joyful ways. For those patients who want to remain involved in ASAP, they may serve in a peer support capacity.

Self-Help Groups: Because addiction can be isolating, providers encourage patients to build social networks to help support them in their recovery outside of ASAP, including 12-step groups such as AA and NA or religious institutions. However, general participation in social networks is emphasized rather than a particular self-help group. Attendance is not a requirement of the program.

Case Management: The ASAP team tries to address critical case management needs as soon as possible, such as housing instability, lack of food, or domestic violence. There is a significant shortage of housing, lengthy wait times, and arduous requirements for those applying to subsidized housing. Case management needs are addressed by the community support worker and other members of the team, including counselors and engagement specialists, as needed.

Medication Management: When choosing which medications to prescribe, physicians in the program aim to take a patient-centered approach, which considers patient preferences, lifestyle, age, side effects, and medical history. Ongoing medication management is held primarily on an individual basis and employs motivational interviewing techniques. Patients receiving methadone receive their medication at the dosing window, beginning with daily dosing and, over time, are able to receive take-home doses. Some buprenorphine patients, particularly those needing more structure or who have unstable living arrangements (where a multiday supply of medication may raise the risk of diversion), receive their medication at the dosing window on a daily to weekly basis depending on the order written. Other patients receive buprenorphine through prescriptions from their provider.

Clinical Response to Continued Substance Use: The community has high rates of marijuana use, in part because medical marijuana is legal in the state. There is also an emerging issue with methamphetamine use. ASAP takes a true harm reduction approach regarding continued substance use among their patients that emphasizes engagement over enforcement. Providers engage patients in ongoing discussions using motivational interviewing techniques and aim to provide education around the benefits of discontinuing use of all substances. The team will try to keep patients in treatment at all costs given that discharge may increase the patient's risk of death. However, prescribers will stop providing MAT or offer alternatives should the patient's high use of benzodiazepines present a medical risk.

Staffing and Staff Training

The team reported relatively low staff turnover in part because of careful selection of staff during hiring. It is important to ASAP leadership that they have team members who want to work with this population and who are dedicated to their work. ASAP staff do a lot of engagement work with each other and team-building outside of work, including social activities and other projects to help bring joy to the workplace. The only staff shortage reported by the ASAP team is with psychiatrists. While they have tried to make use of nurse practitioners as much as possible, there are some hindrances from both federal regulations and laws and credentialing with the UNMH system that have made it difficult to engage nurse practitioners in the MAT program.

With the emphasis on EBPs, program staff are expected to engage in ongoing training. There is a weekly didactic series on EBPs. All new clinical staff and students on rotations at ASAP are required to attend a full series of didactic sessions. There is a strong emphasis on training, including all-staff trainings for PTSD, trauma-informed care, safe zone training (LGBTQ), and motivational interviewing. To ensure EBPs are implemented to fidelity, the team leadership provides clinical supervision. If staff are learning a new intervention, they are required to meet with the clinical program manager and provide taped sessions as well as complete two full cases to demonstrate they can maintain fidelity to the model. In addition, the clinical program manager has consultation hours during which members of the clinical team can seek feedback or support.

Collaboration and Coordination

The clinical team has a “huddle” every morning to staff patients and to discuss any urgent issues. To coordinate care between teams, ASAP holds a weekly meeting with members of medical, nursing, and clinical staff to review complicated cases.

Engagement specialists collate the information they are responsible for collecting about patient progress in Stage 1 and coordinate with other team members. They attend multidisciplinary staff meetings, during which they discuss patients about whom they are concerned, and they attend dose change meetings to give insight on what patients are saying about the dosage to the provider. The work of the engagement specialists is facilitated by EMR data as well as tracking patient progress through an Excel spreadsheet.

Financing

UNMH is a safety-net hospital, providing care to patients regardless of their ability to pay, so Medicaid is the primary payer for these services. The financial impact of the new model of care, has yet to be determined. Under the previous structure for psychosocial supports, ASAP experienced high no-show rates, which resulted in lost revenue. However, they are anticipating that the new service model, with a greater emphasis on walk-in appointments and the didactic Skills Academy in the early phase of treatment, will be more cost efficient and financially sustainable because only more stable patients will receive scheduled appointments. The team also anticipates that the new model will allow them to support a larger caseload of patients because they may share patients between counselors rather than pre-determining provider capacity with individual caseloads. Currently, the services provided by the community support worker and engagement specialists

cannot be directly billed; however, the team plans to explore possible ways to bill for these services once they have completed the transition to the new model.

HIGHLIGHTED BARRIER.	Community Resources
	Given the very rural nature of most of the state, community resources for substance use are often scarce and spread out. Specifically, specialty substance use treatment programs that deliver higher levels of care are difficult to access for safety-net patients. ASAP's outpatient program frequently serves complicated patients with severe SUDs because there are not enough inpatient beds available. There is also limited access to well-managed, monitored sober living or halfway houses. Further, MAT remains stigmatized in the community, with ASAP reporting resistance from community members as well as other community organizations providing substance use treatment. Even when a residential facility or IOP will accept ASAP's safety-net patients, those providers will not continue patients on MAT and will discharge them for substance use, raising the risk of relapse and mortality.

Data Collection and Quality Improvement

Approximately a year and a half ago, ASAP began collecting baseline data upon intake such as DAST-20 (for drug abuse), GAD-7 (for anxiety disorders), AUDIT (for alcohol use disorders), PHQ-9 (for depression), Pain Assessment, ACE Questionnaire (for adverse childhood experiences), Patient Stress Questionnaire, PCL-5 (for PTSD), Quality of Life, and WHODAS 2.0 (for functional disability). They are currently building the capacity to track these measures in the EMR longitudinally, which in the future will be used in clinical decision making, and to track patient progress and outcomes.

ASAP endorses a culture of continuous quality improvement. For example, the intake and induction process had become lengthy in order to meet regulatory requirements from several entities. A Fellow led a process analysis to identify elements that were duplicative, had little value added, or were not legally required. A new, streamlined intake and induction process has been developed that is more patient-centered and will ease the burden on staff.

Lessons Learned

The new program model is flexible, patient-centered, and recovery-oriented with psychosocial services tailored to the individual's stage of recovery. UNMH ASAP also presents an interesting study of radical organizational change that was planned over the course of a year. To facilitate this transition, leadership used a comprehensive communication strategy during which they solicited input from staff and patients. The communication strategy included posters throughout the site, patient handouts, and personal communication with patients, as well as an email that allowed staff to ask questions and disseminate answers to all staff.

While counselors were initially reluctant to give up their individual caseloads, counselors are now seeing the benefit of using scheduled appointments only for patients who are ready to do the work. Because the engagement specialists are now responsible for patient outreach, monitoring, and case

management, counselors now work at the top of their license rather than spending significant time on those non-billable non-clinical tasks. Counselors are also now volunteering themselves for the walk-in clinic when they have extra time due to a no-show, which capitalizes on previously lost revenue. In large part, their success in transitioning to a new program model has been attributed to the background and expertise of their clinical program manager. As a clinical psychologist with extensive training in EBPs, she has brought experience and knowledge of program development. The team combined her knowledge of systems change and the nursing staff's understanding of how to operationalize and implement the changes.

As part of an academic medical center, the ASAP team is dedicated to training a workforce that provides the best substance use treatment possible. ASAP serves as a rotation site for physicians, physician's assistants, nurse practitioners, psychiatric residents, family practice residents, preventive medicine residents, fellows in addiction psychiatry, psychiatric interns, psychiatric post-doc fellows, and master's-level social work and counseling students. Members of the ASAP team are also involved in various ECHO trainings, serve as clinical consultants for the state STR grant, advise the HHS Indian Health Service, have trained the Albuquerque police on naloxone, and delivered trainings for responsible chronic pain management. The ASAP team is trying to set a higher standard of care within the community for substance use treatment services, including MAT for OUD.

Next Steps

UNMH ASAP has a number of initiatives they plan to implement soon, including an IOP that uses the Matrix Model to address methamphetamine use. Additionally, they are hoping stable long-term patients may be able to participate in the hospital's volunteer peer services program. They are also continuing to modify elements of the new treatment model. They are in the process of implementing contingency management to help engage Stage 1 patients by providing a tangible incentive, like a UNMH notebook or stress ball, after accumulating points based on attendance and urine test results. The team also hopes to offer structured family psychoeducation groups in the evening for Stage 1 patients. For Stage 2, they plan to soon offer Matrix Model family and individual sessions, cognitive remediation, social skills training, and Assertive Community Treatment. Finally, for Stage 3 patients, they plan to implement a Matrix relapse-prevention group.

Valley Health Systems Huntington, West Virginia

This FQHC offers MAT for OUD at both the Highlawn and Hurricane health centers. From its location on the Ohio River in West Virginia, the program also serves individuals from the neighboring states of Ohio and Kentucky. As an integrated setting, there is a strong emphasis on the need to treat co-occurring physical and mental health conditions as well as the patient's OUD. Additionally, they have a maternal care program that provides MAT for pregnant and postpartum women.

Since its implementation in 2009, the program has grown to meet the ever-expanding need of the community. Currently, the Highlawn health center program treats about 250 patients, approximately 88 percent of patients receive buprenorphine-naloxone (Suboxone®), 10 percent receive buprenorphine, and 2 percent receive extended-release naltrexone (Vivitrol®). The program receives about ten referrals a week and is usually able to admit around five, largely due to no-shows. Referrals primarily originate internally from within Valley Health System, though many also come from community partners such as the local quick-response team that is working to address the opioid crisis and the local syringe exchange program. Similarly, they receive a number of referrals of postpartum women from the Maternal Addiction and Recovery Center (MARC) Program at the Marshall University Medical Center, coordinating with MARC when postpartum women are nearing discharge. Given the demand for services, there is a waitlist of approximately 200 people, and there is not a clear estimate as to how long it takes to get into the program from the waitlist. They report experiencing challenges with loss to follow up for individuals on the waitlist, and have created an inactive waitlist to which people are added if they cannot be contacted. However, they prioritize referrals of active Valley Health patients as well as pregnant women, postpartum women, and their spouses/partners.

AT A GLANCE...

-  **SETTING**
Federally Qualified Health Center
-  **PROGRAM AGE***
9 years
-  **SIZE**
250 Patients
-  **MEDICATIONS**
Buprenorphine-naloxone
Buprenorphine
Naltrexone
-  **PSYCHOSOCIAL SUPPORTS**
Individual Counseling
Group Therapy
Self-Help Groups
Case Management
Medication Management

*age of MAT program's current service model

Psychosocial Supports

Psychosocial supports are titrated based on three treatment phases. During Phase 1, patients are required to attend weekly group therapy and individual medication management appointments as well as biweekly individual therapy. After at least 12 months and at the discretion of the team, patients may be eligible to move to Phase 2, which decreases the frequency of medication management and group therapy sessions to every other week. To move to this less-intensive phase of treatment, the team requires a history of at least 6 months of opioid-negative drug screens. In

Phase 3, patients are only required to attend group therapy, individual counseling, and medication management sessions on a monthly basis. In contrast, patients who are pregnant are required to be seen weekly for the duration of their pregnancy, regardless of their length of time in the program.

Individual Counseling: Originally, Valley Health Systems contracted counseling services to an external organization; however, in 2015 they moved counseling services for the MAT program in-house. Individual therapy sessions initially occur twice a month for 30 minutes, and emphasize the development of coping skills and relapse-prevention. Topics of discussion may include life stressors, triggers or cravings, issues with family or a partner, and education or employment goals. Therapists often employ CBT or motivational interviewing techniques, and some incorporate elements of ACT.

Group Therapy: Patients in Phase 1 are required to attend weekly hour-long group sessions that focus on rotating topics related to addiction, with an emphasis on psychoeducation and building skills. All groups are separated by gender to increase patient's comfort and to allow providers to tailor the groups to relevant topics. As needed, providers may use specific EBPs during group sessions, such as Seeking Safety, SAMHSA's "Anger Management for Substance Abuse and Mental Health Clients," or curricula from the Hazelden Foundation.

Self-Help Groups: Initially, the Valley Health program required patients to attend three meetings (NA or AA) per week. However, they found it difficult to verify whether patients were attending their meetings, and patients reported challenges finding meetings that were MAT-friendly and easy to attend. Instead, they added homework to group sessions to encourage reflection and engagement in the recovery process outside of the program. While they still always encourage participation in self-help groups, such participation is no longer required.

A community mobilizing against a crisis

Valley Health Systems is working with a number of resources in Huntington that are all trying to combat the opioid epidemic. Some of these community resources include:

- **Quick-Response Team:** This community-based partnership of medical professionals, behavioral health professionals, and law enforcement seeks to identify individuals who have experienced a recent overdose and encourages them to seek treatment services.
- **Cabell-Huntington Health Department Harm Reduction Program:** This program aims to minimize harm and morbidity among individuals with OUD through a syringe exchange program to reduce the acquisition and transmission of infectious diseases, such as HIV and hepatitis C.
- **HER Place:** This women's addictions recovery outreach center offers free access to peer support services and educational programs as well as a safe and nurturing environment for women, children, and families.
- **Healthy Connections:** This local coalition of organizations, spearheaded by Marshall University and Marshall Health, helps individuals with SUDs navigate treatment options and provides support services with trained recovery coaches.
- **PROACT (Provider Response Organization for Addiction Care and Treatment):** This organization brings together resources from the community to serve as a hub of comprehensive assessment, education, intervention, and treatment solutions.

Case Management: During initial discussions with patients, the MAT patient advocate seeks to build a relationship with the individual, determine their needs, identify potential barriers to treatment, and then works to address these issues. For example, given the rurality of the area, transportation poses a significant issue for many patients. Patients often have to travel across state lines (Huntington is on the border with both Ohio and Kentucky) or drive an hour or longer to attend appointments. Consequently, the MAT patient advocate has to understand and work within the requirements of Medicaid-sponsored transportation services from three different state Medicaid entities. Similarly, childcare poses a significant logistical barrier for many patients. Although patients are allowed to bring children under the age of 2 to medical appointments and counseling sessions, reliable and affordable childcare remains a challenge. Additionally, the MAT patient advocate's case management responsibilities may include communicating with Child Protective Services to vouch for patients' progress and adherence to their treatment plans.

Medication Management: Medication management occurs in brief 5-minute to 15-minute individual sessions with a medical provider after the weekly group therapy sessions. Patients submit urine specimens for drug screens and have their vitals taken before they see the medical provider. During these medication management sessions, the provider reviews how the patient is responding to medication, discusses any issues related to the individual's health, and provides feedback on the results of recent drug screens. Medication management visits may also involve discussions about family functioning, employment challenges, and similar topics.

Clinical Response to Continued Substance Use: Valley Health has adopted a harm reduction approach to continued substance use among its patients within the MAT program. Currently, results of urine drug screens indicate that a significant proportion of MAT patients use methamphetamine and marijuana. Staff continue to address this substance use, probing why the patient is continuing to use and whether it is interfering with their quality of life. Rather than discharge a patient for continued substance use, they may recommend the patient be referred to a higher level of care--typically an IOP at another community agency--for failing to engage in treatment by missing appointments or continuing to use substances.

Staffing and Staff Training

The program has experienced challenges hiring additional well-trained, experienced counselors, which has proven to be a significant barrier to scaling up the program to meet the level of demand in the community. Given workforce shortages of behavioral health providers, the program has begun to take on more specialized training themselves. Most providers shadow for a minimum of 2 weeks prior to starting to see patients on their own. Any unlicensed providers receive a minimum of 1 hour of supervision per week for every 20 hours of direct service. Additionally, all licensed providers are required to complete continuing education in the field of addiction.

Collaboration and Coordination

Within the team, communication about patients may occur through the electronic health record or ad-hoc discussions between providers. Treatment team meetings between the providers, therapists, and case managers are held every 90 days.

The program has experienced some challenges with communication with the external IOP operated by the local comprehensive community mental health center to which they refer patients. While they use consent forms and processes that are intended to comply with the requirements of federal privacy regulations (including 42 CFR Part 2), they report that at times it can be difficult to obtain releases of information and the external provider cannot send provider notes on the patient to Valley Health staff.

Financing

As a FQHC, the majority of Valley Health System’s MAT patients (an estimated 95 percent) are enrolled in Medicaid. Most reimbursement is received on the prospective payment system (PPS) rate for Medicaid and Medicare. However, in July 2016 the state moved reimbursements for group therapy sessions from PPS to fee-for-service. The program reported that, while they can still cover their costs, this unexpected policy change has created a barrier to reinvesting in their program and in their ability to expand non-billable services, such as the MAT patient advocate position that provides case management services to help address psychosocial issues.

HIGHLIGHTED BARRIER.	Ability to Scale
	<p>There are two main limiting factors of Valley Health’s ability to provide treatment to more patients: a lack of physical space and the availability of behavioral health providers. While they have recently moved into a new location in the Highlawn Health Center with additional space, they would need another individual therapy office to take on more patients unless they expanded service into evenings or weekends. Additionally, they have experienced challenges finding qualified behavioral health providers who are willing to work with this population. While the physicians are under the federal limits in terms of patient caseload, there simply are not enough therapy providers or clinical space to expand MAT to serve more patients.</p>

Data Collection and Quality Improvement

The primary measures that are tracked to assess patient outcomes are retention and results of urine drug tests. They also look at other factors such as employment status, education, etc., but those are not used as a standardized measure due to variation of needs and goals between patients. Screening and assessments to collect data on patient status include the CAGE-AID (for SUDs), CRAFFT (for SUDs in adolescents), PHQ-2 and PHQ-9 (for depression), the Edinburgh Postnatal Depression Scale, and the GAD-7 (for anxiety).

Overall, Valley Health Systems has a structured quality improvement program with specified quality health metrics. Within the MAT program, they are working on quality initiatives related to specific target areas, including improved management of infectious diseases and increasing contraceptive use.

Lessons Learned

The MAT program at Valley Health demonstrates how MAT, including psychosocial supports, can successfully be integrated into a busy primary care setting within a FQHC. This type of behavioral health integration has resulted in the employment of behavioral health specialists, such as psychologists, counselors, and patient advocates who typically would not be working in the primary care environment were it not for the presence of the MAT program. However, Valley Health's experience also highlights that further expansion of MAT is constrained by practical limitations, such as limited physical space and difficulty hiring trained behavioral health clinicians, which precludes the delivery of more psychosocial supports (e.g., additional group therapy sessions) and the treatment of a greater number of MAT patients.

Given the rurality of the surrounding area and that some patients are even traveling from other states to receive treatment, the program takes a patient-centered approach by scheduling medication management and group therapy sessions sequentially on the same day. If desired, patients can also schedule their individual counseling sessions on the same day. This approach reduces some of the burdens of arranging transportation that are commonly experienced by patients.

Next Steps

Valley Health recently added a Peer Recovery Coach to the program to work with pregnant and postpartum women, and they hope to expand the role of peer recovery coaches to work with their general population. Also, several local physicians have expressed interest in becoming waived MAT prescribers and either moonlighting or contracting part of their time with Valley Health. However, to increase patient capacity with the addition of these prescribers, Valley Health would need more therapists to provide counseling. In addition to the current program at Highlawn, they are collaborating with the two local hospitals and Marshall Health to expand the MAT program to another nearby location where they hope to serve around 700 participants.

3. CONCLUSION

While this report largely focused on specific models of psychosocial supports in MAT programs, the broader study began with a review of the relevant literature, analysis of previously collected quantitative survey data, and a series of the key informant interviews. In this concluding chapter, we begin by summarizing the characteristics of the sites visited, and then draw upon findings from each portion of this qualitative study to address the original research questions and policy implications.

Summary of Site Visit Observations

The five MAT programs visited were selected for diversity in geography, clinical setting, and programmatic structure, as well as their strong emphasis on psychosocial services. Several sites had implemented their programs relatively recently in response to the emergence of the opioid epidemic, and thus had limited experience in providing MAT. Two sites began providing MAT in the past 2 years, and a third dramatically re-designed their treatment model within the past year. Only two programs had delivered MAT services using a consistent programmatic approach for 8 years or more. While we must be cautious about generalizing from observations of this small number of programs that were selected for their commitment to psychosocial services, they do illustrate a broad range of approaches in how psychosocial issues are currently being addressed by MAT providers.

Each program recognizes the need for a **phased or stepped approach** as patients moved through initial engagement and progressed toward longer-term recovery, although the timing, manner, and clinical strategies employed differed widely across the five programs. While each program was built on the **recognition of addiction as a chronic disorder** and all took steps to retain patients in treatment, there was again very little consistency in approach. While all programs had client-level data, none could provide ready analyses of **standard longer-term measures on patient retention in treatment**, and none had readily available data on other clinical outcomes, such as engagement in psychosocial supports, remission of OUD symptoms, or quality of life. One of the programs has recently published findings on a number of relevant programmatic indicators; however, the retention measure was only for 90 days--not a long enough period to provide a solid indication of progress toward long-term recovery. Some programs professed a strong commitment to **continuous quality improvement**, while other programs seemed to be struggling with the daily realities of treatment implementation and were less well-prepared to focus on refining procedures and practices based on patient data.

Every program visited reported making use of **EBPs** such as CBT and motivational interviewing, and some used standardized curricula, such as those developed by the Hazelden Foundation. Only one program implemented these practices in a highly structured fashion; others instead integrated key principles and components into group and individual sessions. Nearly all of the programs employed some form of contingency management in response to program participation and urine test results, making changes in areas such as visit frequency and prescription length. One program was in the process of implementing a more standard points-based contingency management system, although none of the programs were using contingency management in a manner consistent with a research-based approach at the time they were visited, citing cost and other barriers.

Four of the five sites provided all psychosocial supports on site, while one program provided medical and mental health services on site and collaborated very closely with a community-based substance use counseling agency. There was considerable variability across programs in the degree to which they were **flexible and patient-centered**. Some programs accommodated patient circumstances and tailored services to unique patient characteristics, while others provided a more standardized, fixed programmatic approach. Each program identified **psychosocial needs** and included some level of case management to address **social determinants of health** such as transportation, housing, or employment. However, programs differed in the number and type of staff dedicated to assisting patients, and programs faced challenges regarding the local resources available to meet these needs. Case manager to patient ratios varied from roughly one to 50 in the best case to as high as one to 250.

All five programs recognized the high rate of co-occurring medical and behavioral health comorbidities but varied in how they were addressed. **All five programs were located in integrated settings**, offering both medical and behavioral health care in the same facility. Two programs had begun as specialty substance use treatment facilities, and these two sites were also the only programs to provide all three forms of pharmacotherapy for OUD--methadone, buprenorphine, and naltrexone. The other three programs began as medical settings, including two FQHCs and a combination PCMH and graduate medical education program. The programs differed in their approach to identifying and treating **behavioral health comorbidities**. Some programs included routine screening for a range of mental health conditions and biopsychosocial measures to facilitate treatment planning and monitor progress. Other programs appeared to take a less systematic approach to identification of comorbid disorders. The use of **“specialty tracks” for patient subgroups** also varied. Two programs offered tracks for pregnant and postpartum women, and one also included specific tracks for transition-aged youth, patients with PTSD, and patients with more complex psychiatric disorders. There was a range of policies related to mixed versus gender-specific treatment groups. All of these programs incorporated urine testing, although there was considerable variation in protocols and the clinical response to positive findings of substance use, particularly to marijuana use.

Conclusions Related to the Research Questions

As noted above, findings are drawn from each portion of this qualitative study--the literature review, analysis of survey data, key informant interviews, and the site visits--to address the original research questions. A discussion of each of those three research questions follows.

What psychosocial components of MAT are the most important in terms of supporting positive patient outcomes in OUD treatment?

The available literature on the impact of psychosocial supports on patient outcomes in MAT is significantly limited both in quantity and quality. Few studies have sufficient duration, adequate size, or statistical power to draw clear conclusions. Findings related to the incremental benefit of psychosocial supports were mixed; however, the most comprehensive and current reviews were generally supportive of the value of psychosocial supports in MAT. Yet, current research is

inadequate to provide clear guidance on the types or levels of psychosocial services that should be provided or how psychosocial supports should be adapted across clinical settings or patient groups.

There is widespread agreement across professional organizations that psychosocial treatment is an essential component of MAT. For example, the WHO guidelines contend that, “providing medications without offering any psychosocial assistance fails to recognize the complex nature of opioid dependence.”⁸ The limited number of site visits makes clear that current practices in psychosocial services vary widely across programs but illustrates that many programs recognize the importance of psychosocial supports for patient engagement, behavior modification, and treatment of co-occurring mental disorders. Research suggests that longer-term retention in treatment increases the likelihood of recovery and presumably other associated positive outcomes, though, unfortunately, the lack of comparable outcome data from the site visits make it impossible to draw conclusions about differential effectiveness of these models. Future research to better understand how psychosocial supports contribute to longer-term retention and recovery is needed.

What types of psychosocial support are providers currently using in practice?

The published literature suggests, and the site visits confirm, that the psychosocial services offered differ widely across treatment settings such as smaller primary care practices, FQHCs, OTPs, and other specialty SUD care settings. Treatment provided may include individual counseling, group therapy, medication management, peer services, self-help groups, family therapy, and skills-based learning sessions. Some programs required specified levels of participation in these psychosocial supports, while others allowed patients to choose their level of participation. In the site visits, the most commonly reported EBPs were CBT, motivational interviewing/enhancement, and contingency management, although they reported integrating components of these approaches rather than implementing them in a standardized methodology. Each of the programs encouraged patient participation in self-help groups (e.g., AA, NA); only one program required self-help attendance.

The literature and site visits confirmed that interventions are commonly adapted for different patient groups, including youth, pregnant and postpartum women, persons who have experienced trauma, individuals with chronic pain, or co-occurring medical or psychiatric disorders. However, there is little data to suggest how best to align treatment models to specific populations, or how to adapt treatment models to different settings. Programs visited also differed in the extent to which they tailored supports to these groups or to individual patients’ unique needs.

What factors facilitate or impede medical provider’s implementation of psychosocial support in MAT?

Throughout this study, we have identified an array of factors that can challenge the implementation of psychosocial supports in MAT. Perhaps the most common barrier noted during the site visits was the challenge in hiring and retaining qualified and knowledgeable behavioral health clinicians with experience in SUD treatment, including counselors and psychiatrists. While people often focus on increasing the number of prescribers of MAT to increase capacity, several programs indicated that workforce shortages of behavioral health professionals were even more likely to be a limiting factor.

Programs identified a need for the dissemination of trainings on addiction as a chronic disorder and the benefits of MAT. There is clearly an important role for systemic models, such as hub-and-spoke

and Project ECHO, that provide valuable education and consultation to support individual MAT programs, but they are not always readily available. Multiple programs also reported that their ability to “scale up” to meet the need in their area was constrained by the lack of available space for professional offices and therapy rooms.

Other impediments included the traditionally siloed nature of our medical, mental health, and substance use treatment systems, and the relatively poor communication between silos. Federal privacy regulations (i.e., the 42 CFR Part 2 substance use privacy regulations) were often mentioned as challenges to patient safety and continuity of care. Inadequate payment and failure to reimburse for essential clinical and care management services were repeatedly noted as being problematic.

Social stigma about addiction impedes progress toward implementing MAT in multiple ways. Too often, OUD is seen as a self-inflicted condition caused by a moral failing or character weakness, rather than as a chronic, relapsing brain disease.^{9,10} Negative public opinions may influence the views of family members and friends of patients receiving MAT, and thus impact engagement and retention. Stigma may lead to a lack of respect for professionals treating SUDs, which discourages people from practicing in the field.¹¹ These stigmatizing perceptions of SUDs influence other areas of society, such as criminal justice policies, political opposition to adequate funding for treatment, zoning laws for treatment facilities, and acceptance of harm reduction programs.⁹

Limitations and Future Research

Limitations. In summary, the programs visited shared a commitment to psychosocial treatment of the patients they serve but differed widely in programmatic approach. Despite the value of the lessons learned from these case studies, there remain significant limitations to this study. First, the five purposively selected programs visited can in no way be considered representative of the “typical” MAT program. These sites were chosen for setting and geographic diversity as well as a commitment to psychosocial services. Much remains unknown about what psychosocial supports are routinely incorporated into MAT across the diverse range of organizations that now deliver this form of treatment. None were able to readily provide analyses of standard longer-term retention or other patient outcomes, so we are limited to illustrating the diversity and unable to compare the effectiveness of the various programs. Several programs were committed to continuous quality improvement and were early in the implementation process of collecting data that should enable evaluation of effectiveness in the future.

Future Research. There are a number of areas that warrant further exploration. More systematic evidence on the relative effectiveness of programmatic approaches, including their effectiveness in serving differing subgroups of patients with OUD, would be valuable to the field as it seeks to improve the quality of care and improve long-term outcomes for patients with OUD. There is a lack of data about the use of psychosocial supports from a national sample of MAT programs representing the full array of organizational settings (e.g., FQHCs, individual and group practice, specialty treatment centers), limiting the ability to comprehensively describe the current landscape and to estimate the associations between these program models and patient outcomes. Development of a consistent set of performance measures and definitions for major outcomes from treatment

would facilitate cross-program comparisons and research on effectiveness of varying models. In particular, a key question is the extent to which a patient's use of different types of psychosocial supports is associated with treatment retention, remission of OUD symptoms, and improvements in quality of life. Furthermore, studies of the impact of varying intensities of psychosocial supports may be a fruitful area for future exploration.

ENDNOTES

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APPENDIX A.

**CURRENT TEAM COMPOSITION OF THE
MEDICATION-ASSISTED TREATMENT PROGRAM**

Team Members	APT Foundation	Cabin Creek Health Systems Kanawha City Health Center	The Wright Center	University of New Mexico Hospital ASAP	Valley Health Systems Highlawn Health Center
<i>Number of MAT Patients (total patients, if applicable)</i>	~5,500 (8,000 total patients)	40	159	~300 to 500 (800-850 total patients)	250
Waivered Physicians	11	2**	7	4	4
Family Medicine	2	1	2	1	4
Internal Medicine	3	1	5	---	---
Psychiatry	6	---	---	3	---
Addiction Medicine	---	---	3***	3***	---
Advanced Practice Professionals	6	-	9	2	4
Waivered	6	---	3	2	4
Non-waivered	---	---	6	---	---
Nurses	33	—	—	8	—
Social Workers and Licensed Counselors	43	2	3	9	6
Non-licensed Counselors	31	—	3	—	—
Clinical Psychologists (master's or doctoral level)	10	—	—	2	4
Peer Specialists/ Recovery Coaches	0	1	3	—	1
Other Roles	Patient Care Associates	MAT Care Coordinator	—	Engagement Specialists	MAT Patient Advocate
<p>NOTE: “—” in this table indicates there are currently no staff members who fit this description at this time. However, many of these programs are expanding and may hire additional staff after the publication of this report.</p> <p>* The staff detailed in this table for the Wright Center only include the MAT staff on site, but they also refer patients to external drug and alcohol counseling services.</p> <p>** The medical director is a waivered physician who serves as a backup but does not carry a routine patient caseload.</p> <p>*** These physicians are dually board certified in addiction medicine and another discipline, and are already reflected in the cells above.</p>					

APPENDIX B.

**PSYCHOSOCIAL SUPPORTS IN
MEDICATION-ASSISTED TREATMENT: RECENT
EVIDENCE AND CURRENT PRACTICE**

Available separately at:

<https://aspe.hhs.gov/basic-report/psychosocial-supports-medication-assisted-treatment-recent-evidence-and-current-practice>

OPTIMAL UTILIZATION OF PSYCHOSOCIAL SUPPORT IN MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDER

Reports Available

OPTIMAL UTILIZATION OF PSYCHOSOCIAL SUPPORTS IN MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDER ISSUE BRIEF

HTML <https://aspe.hhs.gov/basic-report/optimal-utilization-psychosocial-supports-medication-assisted-treatment-opioid-use-disorder-issue-brief>

PDF <https://aspe.hhs.gov/pdf-report/optimal-utilization-psychosocial-supports-medication-assisted-treatment-opioid-use-disorder-issue-brief>

PSYCHOSOCIAL SUPPORTS IN MEDICATION-ASSISTED TREATMENT: SITE VISIT FINDINGS AND CONCLUSIONS

HTML <https://aspe.hhs.gov/basic-report/psychosocial-supports-medication-assisted-treatment-site-visit-findings-and-conclusions>

PDF <https://aspe.hhs.gov/pdf-report/psychosocial-supports-medication-assisted-treatment-site-visit-findings-and-conclusions>

APPENDIX B. PSYCHOSOCIAL SUPPORTS IN MEDICATION-ASSISTED TREATMENT: RECENT EVIDENCE AND CURRENT PRACTICE

HTML <https://aspe.hhs.gov/basic-report/psychosocial-supports-medication-assisted-treatment-recent-evidence-and-current-practice>

PDF <https://aspe.hhs.gov/pdf-report/psychosocial-supports-medication-assisted-treatment-recent-evidence-and-current-practice>