Increasing Access To Evidence-Based Treatment

A NACo Opioid Solutions Strategy Brief

"Medication for opioid use disorder is evidence-based care."

—U.S. Centers for Disease Control and Prevention[1]

What can be done to increase access to evidence-based treatment?

The Food and Drug Administration has approved three medications that safely and effectively treat opioid use disorder (OUD): methadone, buprenorphine and naltrexone. However, our healthcare system's capacity to provide medications for opioid use disorder (MOUD) falls far below the current demand for care.[2] Only 1 in 4 people who need MOUD are able to access them.[3]

A multi-pronged approach is needed to build up the treatment workforce, create effective pathways to care and save lives. Counties can reach these goals by:

Expanding treatment capacity: Even the very best referral and diversion systems cannot link people to treatment that doesn't exist.

- The substance use treatment workforce can be expanded by connecting more healthcare institutions and practitioners with the training, support and incentives to prescribe buprenorphine.[4,5]
- Existing clinics can expand treatment capacity by expanding nursing staff,[6,7] encouraging group medical visits,[8] building collaborative care networks with mental health and social services[4,5] and hiring nurse care managers and behavioral health professionals at the county level to coordinate care across local clinics.[9]

Access NACo's Opioid Solutions Strategy Brief on MOUD

Maximizing pathways for treatment engagement: Effective referral systems are guided by the principle that there is "no wrong door" to enter treatment.[10]

- Emergency departments, primary care clinics, jails, harm reduction programs and resource centers can all serve as effective points of contact with treatment services.
- Telehealth options and mobile methadone programs can reduce common barriers to care and reach people in need across larger distances.[11,12]

What evidence supports these strategies for increasing access to evidence-based treatment?

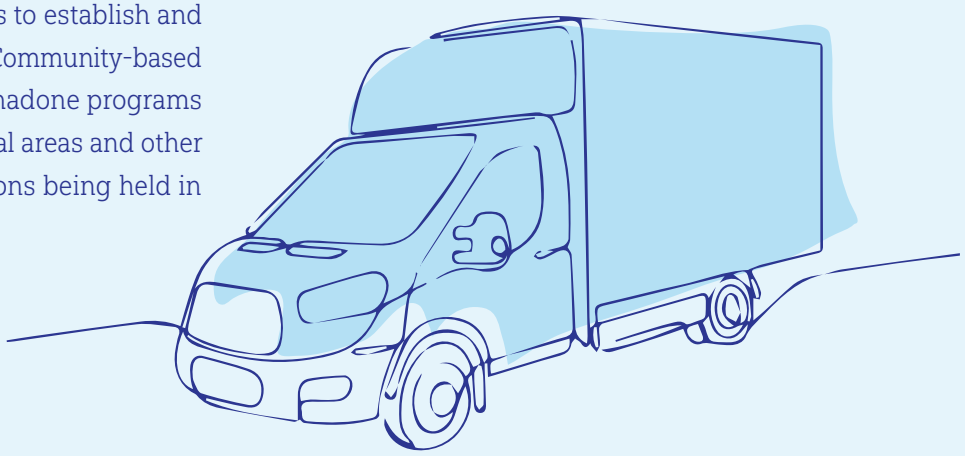
TREATMENT PROVIDERS NEED NURSING SUPPORT: Clinicians are more likely to prescribe buprenorphine if they have sufficient staff support and resources for managing OUD care.[6,13] Adding a nurse care manager to the clinical care team is one of the most impactful facilitators of buprenorphine availability in any healthcare practice;[6,7] it also improves patient engagement and satisfaction with care.[14] In primary care settings, academic detailing has also been proven effective at supporting evidence-based prescribing practices and boosting prescriber confidence.[15–17]

CREATIVE SOLUTIONS BENEFIT PATIENTS AND PROVIDERS: Group visits, also called shared medical appointments, are a long-standing strategy to meet growing demand for healthcare services.[18] Group visits allow clinicians to deliver health care, medication support, peer-to-peer support and group psychotherapy to multiple patients in one setting.[8]

TECHNOLOGY CAN OPEN DOORS: Telehealth options, such as phone or video-based medical appointments, dramatically improve access to MOUD and to mental healthcare. Patients who have access to telehealth tools are more engaged in treatment[12] and are less likely to drop out of treatment early.[19]

PROVIDE CARE WHERE PEOPLE ALREADY ARE: Effective recovery support "meets people where they are at."[20] Telehealth has allowed many syringe service programs (SSPs) across the United States to provide participants with immediate access to buprenorphine, HIV treatment and Hepatitis C treatment.[21–27]

TAKE TREATMENT ON THE ROAD: As of June 2021, DEA rules allow methadone clinics to establish and operate mobile methadone programs.[28] Community-based methadone clinics can use mobile methadone programs to deliver medication to residents of rural areas and other under-resourced settings[29] and to persons being held in prisons and jails.[30]



Are there risks to my community if we don't increase access to evidence-based care?

Yes.

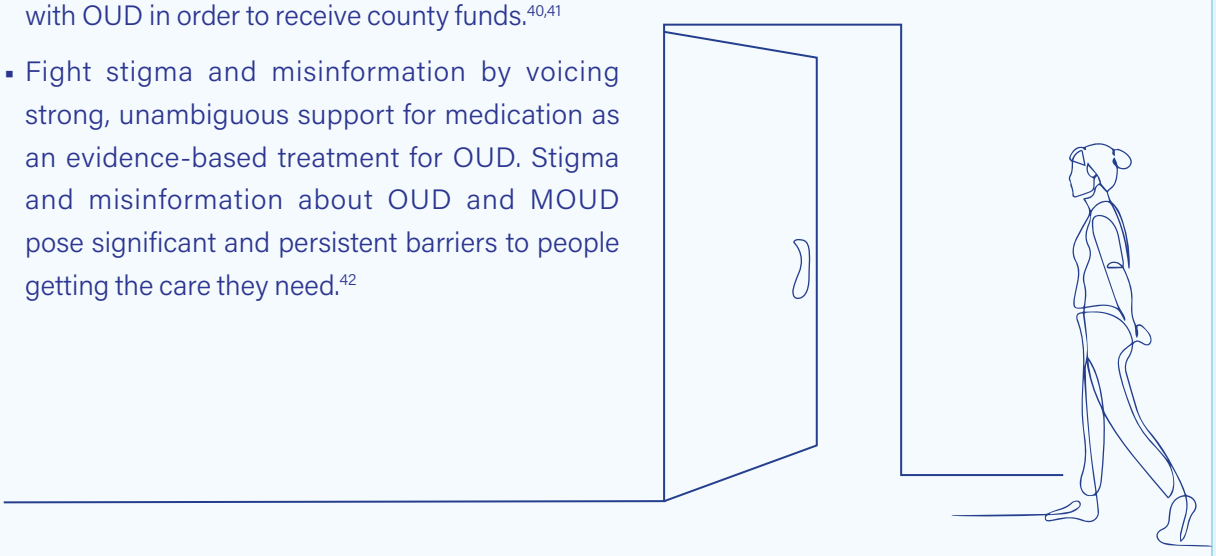
Regions with lower access to evidence-based treatment have the highest rates of OUD and opioid overdose in the country.[31,32]

In 2020, an estimated 2.7 million people over the age of 12 were living with OUD in the U.S.[33] This estimate does not include the approximately 2 million people who are incarcerated[34] (the majority of whom are living with a substance use disorder[35,36]) or the nearly 600,000 people experiencing homelessness.[37]

The greatest unmet need for MOUD is in rural and under-resourced settings. The average American lives 22.7 miles from an MOUD treatment provider.[38] Nearly 40% of rural counties have no local buprenorphine prescriber at all.[31]

What are best practices for increasing access to evidence-based treatment?

- Provide support for programs to implement telehealth services to expand MOUD access or add MOUD treatment to existing telehealth services.[12,19]
- Support local methadone clinics in going mobile by assisting with the costs of vehicles, equipment and staff.[11]
- Support the establishment of "health hubs" at community-based SSPs where clinics offering MOUD can be reached through telehealth and other cooperative arrangements.[39]
- Consider requiring substance use treatment providers to dispense or facilitate access to MOUD for patients with OUD in order to receive county funds.[40,41]
- Fight stigma and misinformation by voicing strong, unambiguous support for medication as an evidence-based treatment for OUD. Stigma and misinformation about OUD and MOUD pose significant and persistent barriers to people getting the care they need.[42]



What are some examples of successful efforts to increase access to evidence-based treatment?

In 2020, the state of Rhode Island created a "buprenorphine hotline" that residents could reach by phone to be connected with a qualified clinician for initial assessment and, if appropriate, an initial buprenorphine prescription and a referral to a community clinic for continued MOUD treatment.[12,43]

In April 2019, the Caroline County Health Department, located on Maryland's eastern Delmarva Peninsula, launched a Mobile Care Unit to provide evidence-based treatment with MOUD to residents in rural and underserved areas of the county.[44,45] The Mobile Care Unit is telehealth equipped to connect with addiction medicine specialists at the University of Maryland School of Medicine in Baltimore in order to provide point-of-care diagnosis, medication initiation and follow-up care.[44]

These and many other model programs are described online at the Brandeis Opioid Resource Connector

The North Carolina Harm Reduction Coalition and Queen City Harm Reduction recently partnered with Duke University's regional healthcare system to provide telehealth access to HIV prevention medication (PrEP), Hepatitis C treatment and OUD treatment (buprenorphine) to SSP participants in North Carolina's New Hanover County and Mecklenburg County, respectively. More than 80% of the patients enrolled in the telehealth clinic were actively seeking MOUD access to reduce their drug use.[46]

Atlantic County Justice Facility, the local jail in Atlantic County, N.J., was among the first in the nation to utilize a mobile methadone program. The facility partnered with John Brooks Recovery Center, a community-based treatment facility and methadone clinic, to provide persons incarcerated in the jail with daily methadone treatment through the Center's mobile methadone van.[47]

ADDITIONAL RESOURCES:

Please visit the Opioid Solutions Center for a curated list of resources, technical assistance opportunities and the sources referenced in this brief.

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