



# **Foundation *for*** **Opioid Response** **Efforts**

**Program Advisory Meeting Summary**

**ACCESS TO TREATMENT**

**May 14, 2019**



# Foundation *for* Opioid Response Efforts

## Program Advisory Meeting: Access to Treatment

*Note: This summary is not intended to be a consensus document, but instead represents the breadth of discussion and guidance provided to FORE during the meeting. The use of the term “participants” does not imply majority agreement.*

### Executive Summary

On May 14, 2019, the Foundation for Opioid Response Efforts (FORE) convened a program advisory meeting at their offices in New York, NY, to address challenges that patients with opioid use disorder (OUD) face in accessing appropriate treatment.

Attendees were asked to highlight barriers that limit access to appropriate care for individuals with OUD. These included the stigma of addiction, a shortage of physicians who offer medication-based treatment (MBT), a lack of wraparound social services, inadequate health insurance coverage, regulatory and legal complications, inadequate measurement of treatment quality, and employers not understanding the importance of providing addiction treatment options for their employees, among others.<sup>1</sup>

Participants then identified patient-centered strategies FORE could employ to address these barriers, such as grantmaking, educational activities, convening meetings with experts and stakeholders, and issuing white papers that establish FORE as a thought leader in the field. They emphasized the importance of taking a patient-centered approach and focusing on certain underserved and high-risk populations, including people in urban, minority, and rural communities, children and adolescents, pregnant and parenting women, those involved in the family law system, justice-involved individuals, veterans, and tribal communities.

Recognizing that partnership is key to success, participants identified additional key individuals and organizations that are leaders in the field which FORE may want to partner with. Organizations included medical, dental, and behavioral health societies, health foundations and non-profits, community and faith-based organizations, civil rights and legal organizations, technology companies, and federal, state, and local government.

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<sup>1</sup> While the term medication-assisted treatment (MAT) is widely used to describe the combination of FDA-approved medication and behavioral health supports, participants recommended using the term medication-based treatment (MBT) to reflect the significance of medication in a patient’s treatment plan. For the purposes of this document and discussion, we will use MBT

## **Introduction**

To launch the meeting, foundation staff provided a brief presentation on the origins, vision, and mission of FORE, as well as some data on access to treatment, specifically among underserved populations. This included an overview of substance use disorder (SUD) facilities and the availability of MBT around the United States. Only a handful of states have any requirements around MBT, and it was highlighted that in states like Louisiana, only one in 20 people who suffer from a SUD undergo MBT. At a national level, only one in nine people who have a SUD undergo MBT. There are racial, gender, and social disparities around SUDs and MBT as well, as white youth are more likely to receive treatment for their SUD than youth of color. Furthermore, opioid use among pregnant women has quadrupled over the last two decades. Additionally, those involved in the criminal justice system are disproportionately affected by a lack of treatment options and are over 40 times more likely to die from an opioid overdose.

### **I. BARRIERS TO ACCESS**

While much of government efforts have focused on generally improving access to all forms of OUD treatment, quality of care is often overlooked, leading to inappropriate care, attendees said. They note that care would be considered “appropriate” if it is tailored to the patient’s individualized needs, treats the whole patient, and is evidence-based with respect to effectiveness, treatment time period, and setting.

#### **A. Early Intervention and Referral to Treatment**

Attendees identified the lack of early intervention and referral to treatment as a significant challenge for individuals with OUD. Long-standing methods of detecting and diagnosing OUD, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), may be inadequate to successfully get a patient into appropriate treatment. Some attendees felt that SBIRT may be ineffective because they believed practitioners often do not move past the brief intervention step. They felt that SBIRT may be more effective for alcohol use disorder and should not be used for OUD. They advocated for a “see, treat, and refer” model instead. This model has been described as “(1) using a standard screening process to identify patients with OUD in a hospital or emergency room setting, (2) initiating treatment, and (3) referring for follow up in a community setting”; however, this process could potentially be used in other non-hospital settings as well.<sup>2</sup>

To successfully intervene and refer patients to treatment early on, attendees recommended that providers “meet patients where they are” and promptly connect them to treatment. This sentiment acknowledges that individuals facing transitions or life course changes are often vulnerable and may be neglected but may also present critical opportunities if the right interventions are available. Places of transition ripe for seeing, treating, and referring individuals with OUD to care include, for example, ob-gyn clinics, the criminal justice system (drug courts, family courts, jails, and prisons), sterile syringe access programs (SSAPs), high schools, and emergency departments (EDs).

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<sup>2</sup> <https://www.bettercareplaybook.org/plays/screen-treat-and-refer-patients-substance-use-disorder-hospital-setting>

## **B. Treatment and Appropriate Level of Care**

Attendees noted that matching the patient to the appropriate level of care is a challenge for several reasons, chiefly the lack of consistency among levels of care. Treatment facilities may not meet all the requirements of a particular level of care consistent with the American Society of Addiction Medicine (ASAM) continuum, and states may have different regulations and licensing requirements. As a result, patients may end up with sub-par treatment or in a less than reputable treatment program. To counter this, attendees recommended the adoption of national standards for facilities and programs across the continuum of care.

Attendees also noted that some states encourage most patients to enter residential treatment programs, assuming a one-size-fits-all approach. Residential treatment may not be appropriate for all patients, yet individuals may still need long-term care. In addition, insurers often impose limitations on the number of days that they will cover.

Instead, attendees recommended that states offer individualized care tailored to each patients' needs and suggested educating insurers to remove such restrictions, looking specifically to eating disorders as a compatible model. Long-term care is covered for eating disorders because insurers recognize that patients need time to return to a healthy weight and stabilize their emotional wellbeing. Alternatively, the attendees recommended that patients could be referred to a different level of care if they are discharged from a residential treatment program earlier than needed based on insurance constraints.

Attendees pointed out that patients who may be most suited for MBT have difficulty obtaining it because many programs and communities are biased against this approach. These programs and communities may view the use of MBT, such as buprenorphine and methadone, as substituting one drug for another. As an example, in Kentucky, federally qualified health centers (FQHCs) still prohibit the use of buprenorphine. Attendees noted that these closely held beliefs are rooted in culture rather than data or science and, therefore, require a shift in the cultural belief system. Attendees recommended educational efforts to promote this cultural shift.

Attendees also identified a shortage of physicians who offer MBT as a barrier to treatment. Factors contributing to the shortage include bias against OUD among treatment providers and stigma around the practice of addiction medicine. Bias and stigma stem from a lack of understanding about addiction as a chronic disease of the brain. Additionally, attendees identified legal limits on the prescribing and dispensing of both methadone and buprenorphine as a contributing factor to the physician shortage and a perpetuation of stigma. For example, the Drug Addiction Treatment Act of 2000 (DATA 2000) imposes licensure requirements and limits the number of patients that waived practitioners can treat with buprenorphine in an office-based setting, resulting in a call to "X the X waiver." Attendees recommended educating practitioners on addiction to reduce stigma and bias, as many primary care providers do not understand the difference between dependence and addiction, and on effective treatment options that can lead to recovery. They also recommended changes to federal legal requirements governing the practice of MBT as a means of expanding the MBT workforce. This could be accomplished by supporting mid-level providers (i.e., nurse practitioners and physician assistants), particularly in geographic areas with few physicians.

### **C. Telehealth**

Attendees identified telehealth as a promising method to deliver care, especially in rural areas and those with physician shortages. They noted several barriers to accessing telehealth services though. First, one attendee noted that there is a lack of evidence regarding telehealth's efficacy. Others pointed out that insurers often do not provide coverage for telehealth services. Another attendee highlighted that the Ryan Haight Act serves as a deterrent to telehealth utilization because it requires providers to meet with patients in person during the first encounter, which may not always be feasible, especially in rural areas. As such, attendees recommended that health insurers be encouraged to cover telehealth and collect data on its effectiveness, and that the Ryan Haight Act be amended.

### **D. Treating the Whole Patient**

Attendees felt that regardless of a patient's level of care, the treatment program or provider must "treat the whole patient." They expressed concern that many, if not most, treatment programs and providers only provide medical services with no behavioral or social services. Missing services include counseling, certified peer recovery support, assistance with transportation, childcare, employment, stable housing, and other supports. Attendees recommended that states with enough capacity be encouraged to study and replicate Vermont's "hub and spoke" model, which incorporates many of these additional services with the caution that some of its success was based on the state's preexisting systems of care infrastructures, its culture of health, and community approach to care. Those seeking to replicate Vermont's model may need to establish similar roots before the model can be successfully implemented.

Health care systems should be considered "viable partners" in this approach, as they are working on related goals such as reducing expensive ED utilization and developing more efficient systems of care for high utilizers. Projects supported by the Center for Medicare and Medicaid Innovation (CMMI), as well as state Medicaid waivers, have helped some states and health care systems develop models to support OUD treatment; however, more work on payment strategies is needed.

### **E. Recovery**

Individuals with OUD who complete a physician-directed treatment plan may still require recovery support services. However, attendees noted that recovery services and centers are not well studied, and their role is still unclear. Additionally, attendees were concerned that many peer recovery coaches lack proper training, and in such circumstances, may cause more harm than good. For example, one attendee noted that some coaches encourage patients not to take medications that are FDA-approved for OUD treatment. Attendees recommended that the role of recovery services be studied further to establish their effectiveness. They also identified Missouri and Kansas' joint recovery city program as a model that could be studied and replicated.

## **F. Housing**

Attendees noted that, whether individuals with OUD are receiving active treatment, are in the recovery phase, or are reentering society from the criminal justice system, they require stable housing yet many — including those who have completed residential treatment programs and those who are reentering society from the criminal justice system, lack it. While recovery houses are a good solution, there is a shortage of such housing. Additionally, some recovery houses do not accept individuals receiving MBT, pregnant women, or new mothers who also require housing for their children.

One attendee noted that Michigan offers a recovery housing program to those who graduate from drug court programs.<sup>3</sup> The program provides treatment, support groups, and childcare onsite. It receives private and public funding through the U.S. Department of Housing and Urban Development (HUD) and the state. This program could be used as a model. Attendees also referred to Google's Verily Life Sciences, which has built a tech-focused rehab campus in Dayton, Ohio.

## **G. Health Insurers and Employers**

Attendees expressed concern that health insurers are not providing adequate coverage of addiction treatment services. For example, one attendee noted that some insurers are only covering OUD treatment provided by primary care providers (PCPs) or psychiatrists and not addiction treatment specialists. As a result, many addiction treatment providers must run self-pay programs that do not accept insurance. One example of a policy that supports access is Connecticut Medicaid's coverage model, which allows providers, including addiction treatment specialists, to bill for addiction treatment under both medical codes and behavioral health codes. This arrangement facilitates treatment integration.

Attendees were also concerned that employers do not understand the importance of OUD treatment for their employees and may be hesitant to provide information about treatment options to employees out of concern about health data sharing (primarily due to regulatory and privacy concerns). Similarly, insurers may seek to institute programs to expand access to OUD treatment, but they do not know which employees need such services. Attendees recommended educating employers on OUD and the importance and effectiveness of appropriate treatment.

## **H. Lack of Quality Data Metrics**

Attendees noted that health care systems offering OUD treatment often lack quality metrics. Metrics used to assess OUD treatment, collected across federal agencies, such as the Department of Health and Human Services (HHS), the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC), are inconsistent and not fully validated. They identified the need for a set of consistent quality metrics but acknowledged that creating a new metrics system could be time consuming. Attendees suggested adapting the

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<sup>3</sup> <https://wwmt.com/news/local/proposed-kalamazoo-housing-project-seeks-to-aid-recovering-opioid-addicts>

metrics used to assess depression as a potential short-term solution. They also recommended that HRSA, in partnership with the National Association of Community Health Centers (NACHC), the National Quality Forum (NQF), and the National Academies of Medicine (NAM), test a set of OUD quality metrics with FQHCs.

## II. SPECIFIC UNDERSERVED AND HIGH-RISK POPULATIONS

The attendees acknowledged that there are many underserved and high-risk populations of individuals with OUD that deserve additional attention or resources to ensure they receive appropriate care.

### A. Rural

Individuals in rural areas were identified as an underserved population due to a lack of providers who can offer quality care. One solution is to engage PCPs in providing MBT, an approach that could be promoted by Project ECHO (Extension for Community Healthcare Outcomes) or similar guided-practice programs.<sup>4</sup> Project ECHO is a distance education model that connects specialists with numerous PCPs via video to facilitate case-based learning.<sup>5</sup> Through these programs, specialists and PCPs train and mentor other PCPs in the care of patients with complex conditions, such as OUD.<sup>6</sup> One attendee suggested this program as a model for rural areas throughout the country. PCPs could be encouraged to participate in the project and become drivers of change in their communities.

Attendees also identified telehealth as an option to overcome the shortage of providers in rural areas. They expressed concern that state laws may restrict the ability of providers to offer telehealth services across borders. Attendees noted that Virginia Medicaid reimburses office-based opioid treatment providers in Tennessee who offer treatment to Virginia residents near the Virginia-Tennessee border. Other states could use as a model or enter into compacts to allow the practice of telehealth across state lines.

Coalition building in rural communities is also effective, attendees said. Creating a toolkit for communities that want to bring agencies and services together would be a valuable resource. The Pew Charitable Trusts is currently evaluating six communities. Additionally, recent HRSA *Rural Communities Opioid Response Program* grants are facilitating this type of coalition building in several other communities across the United States.

Additionally, attendees pointed to the need to educate rural communities about federal funding opportunities and provide support to communities that lack the ability to write grants or hire someone to do so. They recommended providing support to such communities for these purposes.

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<sup>4</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4873719/>

<sup>5</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4873719/>

<sup>6</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4873719/>

## **B. Urban and Minority**

Attendees noted that urban and rural communities have different needs and many states are still struggling with how to best tailor approaches so they are culturally and linguistically informed and responsive to local conditions. They noted, for example, that in the District of Columbia and Baltimore, heroin users are more likely to be African American men over the age of 40. In tribal communities, black tar heroin is more common. Attendees suggested that providers need to meet people where they are and need support from specialty outreach models, such as mobile clinics. One attendee suggested looking into whether barbershops could be leveraged to educate men about OUD, given that a similar model was used successfully to educate men about prostate cancer.

Attendees also recommended engaging the religious community in educating communities about OUD and encouraging treatment. One attendee highlighted a church in Baltimore that has implemented a program to teach the congregation about heart health. The community and its members, as well as several other churches, adopted heart-healthy eating and exercise. Could such a model be used for OUD educational efforts as well?

## **C. Children and Adolescents**

Attendees identified children and adolescents with OUD as an underserved population, perhaps due to their vulnerability during transitions. While the American Academy of Pediatrics (AAP) has guidelines addressing obstetrics and newborns, attendees noted that the AAP does not appear to take a position on the needs of adolescents with OUD. Additionally, attendees identified a lack of providers who treat adolescents with OUD as well as little research on utilizing MBT in the under-16 population. Attendees also pointed out that diagnosis and treatment typically do not occur in schools, and juvenile drug courts are the least successful drug courts. Adolescents processed through the drug court system are often sent to group therapy, which reportedly perpetuates use.

Attendees recommended encouraging earlier interventions and treatment referrals for juveniles. In particular, one attendee recommended engaging with a Florida judge who wrote a book on family dependency. Attendees also encouraged states to adopt Vermont's model integrating child welfare and drug treatment. Attendees also stated that it may be useful to meet with the AAP to encourage the organization to take up the issue. They also suggested the development of a curriculum for the National Council of Juvenile Law Judges.

## **D. Pregnant and Parenting Women**

Attendees identified pregnant and parenting women as high-risk populations. Laws in some states, such as Tennessee, make it a crime to use illicit substances when pregnant. These laws have reportedly caused the rates of prenatal care for women who use substances to decrease in the state and the numbers of births of drug-exposed newborns across state lines to increase. Attendees also noted significant confusion around mandatory reporting to child protective services (CPS) of substance use among pregnant or parenting women. They noted that there is no nationwide protocol or best practice for notification when a newborn is drug exposed. They



stated that the default is toward reporting, and there is inadequate understanding among practitioners of what the child welfare system does and the consequences of reporting. Attendees also identified an inadequate understanding of patient-provider privilege or confidentiality. Adding to these complications, every hospital has its own standards. Attendees recommended educating providers and nurses on reporting requirements and confidentiality standards. They suggested that model legislation on reporting child drug exposure and the conditions under which a child should be removed would be helpful.

Attendees also highlighted the lack of treatment among pregnant women not only with OUD, but also with chronic pain. They noted that once women in pain become pregnant, they are taken off their opioid medications, and their pain is not managed effectively. Such inadequate treatment can potentially lead to OUD or overdose. Attendees also stated that, in addition to an obstetrician and neonatologist, pregnant women need counselors, social workers, and a team of providers, but typically do not receive such care. Attendees noted the value in distributing existing educational materials, such as SAMHSA's guidelines on MBT for pregnant and breastfeeding women, and ASAM's document on OUD among pregnant women and following pregnancy, to pregnant and breastfeeding women, midwives, pediatricians, drug and family court staff, and child and family service workers. They encourage the adoption of the Developmental Understanding and Legal Collaboration for Everyone (DULCE) model, which incorporates social services and legal prevention.

Attendees stated that women are often ignored during the postpartum period even though the risk of overdose is highest six to 12 months postpartum, contributing to higher maternal mortality rates. Effective practices include models of care that can support both the mother and infant, as well as developing plans of safe care and standardizing reporting to child protective services. However, these practices lack reimbursement and proper training. Attendees noted that educational efforts to support policies and systems that improve health outcomes could help. They also recommended providing home-based visiting nurses services but cautioned that these nurses must be properly educated and trained. Otherwise, they could potentially cause more harm than good.

They also encouraged the adoption of Virginia Medicaid's Behavioral Health Home model. Under this model, prenatal care is unbundled, which provides coverage and payment for addiction treatment, as well as prenatal care. They also highlighted the need for infectious disease services and trauma survivor services, including in the courtroom.

## **E. Family Law System**

Attendees identified the family law system as an area in need of reform. They noted that when a parent with OUD is processed through the court system, children are often removed from their families and placed into foster care. They can get stuck in the foster care system when there is no adequate reunification plan. Often, CPS workers are not adequately trained on issues related to OUD, and social workers' recommendations may not include medication or appropriate treatment. Attendees suggested educating social workers, CPS workers, judges, and others within the child welfare system on OUD and appropriate treatment as well as on the

integration of child welfare and addiction treatment. They also suggested putting systems in place to encourage reunification of families sooner.

#### **F. Justice-Involved Individuals**

Attendees identified justice-involved individuals as an underserved, high-risk community. They noted that such individuals lack access to treatment upon entry into the correctional system; others may receive treatment during incarceration but may not be connected to health care when they are released. When individuals with OUD enter the justice system, they are usually tapered off their medication and do not receive ongoing treatment. Many jails and prisons do not provide access to MBT due to cultural barriers, stigma, and prejudice. Some only provide access to naltrexone, another form of MBT, which may not be appropriate for all individuals. Attendees recommended that states withhold funding from jails that refuse to provide access to MBT. They also recommended that states withhold contracts from private prisons unless they allow MBT.

Attendees also expressed concern about justice-involved individuals' loss of health insurance. They noted that Medicaid coverage is often terminated, rather than suspended, upon entry into jails and prisons. Upon reentry, individuals typically lack access to health coverage. In facilities that do offer access to OUD treatment, individuals may lose access to that treatment upon reentry. They suggested that states suspend, rather than terminate, Medicaid and identified the need for services to help individuals reentering society to access Medicaid coverage.

#### **G. Additional High-Risk Populations**

Participants were asked to suggest additional populations facing particularly high barriers to treatment. Additional high-risk populations briefly discussed at the meeting included the LGBT community, American Indians/Alaska Natives, and veterans. Attendees stated that the LGBT community experiences significant discrimination, and fatalities have increased significantly. Attendees noted that cultural sensitivity and resources were needed for the American Indian/Alaska Native populations. They also stated that the tribal justice system can be very punitive and is not very informed about substance use issues. For veterans, attendees suggested that states adopt a model like the one in place in Florida. Florida currently has 31 veterans' courts, which are designed to assist justice-involved defendants with complex treatment needs associated with substance use, mental health, and other issues unique to the traumatic experience of war.

### **III. POTENTIAL OPPORTUNITIES AND ACTIONS FOR FORE TO CONSIDER**

FORE asked each attendee to identify one or two projects that FORE could consider supporting or undertaking to address the issues discussed at this meeting. Attendees identified the following:

## **A. Overall Foundation Funding Principles**

- Develop and disseminate white papers to establish FORE as a leader in the community; these can be relatively short-term projects and products that provide valuable information. Potential topics are listed in next section;
- Engage in projects that are conceptually oriented. For example, focus on the general concept of “transitions” and meeting people where they are.

## **B. Overall Access to Treatment**

- Identify how to mobilize communities for successfully treating OUD, including all dimensions of the disease from diagnosis to recovery;
- Educate PCPs about the PCP-focused Minnesota MBT Project ECHO and encourage them to get involved and become leaders in communities; explore supporting primary care to primary care model of ECHO;
- Educate employers and their executives about the need for appropriate OUD treatment and encourage them to become drivers of change;
- Encourage communities to adopt the concept of “treating the whole patient.” In addition to providing OUD treatment, programs and practitioners should ensure that mental health and social determinants of health issues are addressed. The patient’s care team should work together rather than in silos;
- A synthesis of currently available recovery materials and a paper outlining gaps in research on recovery that need to be addressed, as well as a description of what recovery is;
- Work with insurers to change payment policies;
- Evaluate and grade state payment models, highlighting successes and calling attention to deficiencies; create a report card and score insurers by state.

## **C. Pregnant and Parenting Women**

- Distribute existing educational materials for pregnant and postpartum women with OUD to such women, midwives, emergency department clinicians, ob-gyn providers, pediatricians, social workers, CPS, and others, such as the SAMHSA toolkit;
- Provide funding for programs that offer treatment on the periphery of the health care system (e.g., during the first year postpartum);
- Offer programs to provide pregnant women with best possible care and establish what optimal care looks like (e.g., care that is multidisciplinary and cross-generational).

## **D. Justice System**

- Work with the criminal justice system to implement policies that allow individuals to remain on FDA-approved medications when they are in detention;
- Partner with the American Correctional Association to distribute educational materials on the importance of MBT;
- Host a conference for CPS and judges on how to properly deal with family law and justice-involved individuals in instances when an OUD is present. Include the

- National League of Cities, the National Sheriffs' Association, the National Association of Chiefs of Police, the United States Conference of Mayors, Huntington Mayor Stephen Williams (a well-known speaker), the American Civil Liberties Union, the Legal Action Center, the American Academy of Correctional Physicians, the American Correctional Association (working on keeping patients on MBT), the Coalition of Correctional Health Authorities, Betty Gondles (who organized a meeting with the National Governors Association), the National Commission on Correctional Health Care, the Arnold Foundation (which gave seven grants to jails in eight counties), the National Council of Juvenile and Family Court Judges, the National Council for Family State Courts, and Children and Family Futures.
- Disseminate the *Bench Book on Substance Abuse and Addiction for Family Courts* by the University of Baltimore School of Law Center for Families, Children and the Courts to judges at the conference;
  - Create a justice advisory group made up of criminal justice professionals (e.g., probation and parole officers, judges, district attorneys, and police departments), dependency courts, co-occurring disorders and specialty courts, the Buffalo Opioid Treatment Court, the National Judicial Opioid Task Force, the National Center for State Courts, a health researcher, and someone from the Veterans Justice Program;
  - Work with the criminal justice system to ensure that individuals do not lose access to MBT when they enter jail or prison.

#### **IV. ADDITIONAL PROJECT IDEAS**

Throughout the day, FORE attendees suggested various projects that FORE could support or undertake, including the following:

##### **A. White Papers and Other Educational Materials**

Attendees suggested developing white papers on the following topics:

- The use of telehealth in the courtroom using a Montana drug court judge's program as a model with distribution to other judges;
- The legal right to MBT in the criminal justice system pursuant to *Smith v. Aroostook County*:
  - Include a study of Rhode Island's program through which inmates may receive MBT;
  - Explain the need for informed consent to treatment, including the possible outcomes of each type of treatment;
  - Distribute the white paper to every prison, jail, and court across the country;
- Plans of safe care and the unintended consequences of such plans for mothers and children;
- A synthesis of currently available recovery materials and gaps in research on recovery that need to be addressed; and
- An evaluation of state payment models, highlighting successes and calling attention to deficiencies; a report card that scores insurers by state.

The Foundation could also play a role in broadly disseminating important materials to key stakeholders, as well as supporting development of new educational materials. Examples include:

- SAMHSA toolkit on pregnant and postpartum care;
- A curriculum for the National Council of Juvenile Law Judges;
- An employer toolkit or other educational materials on OUD as a treatable illness, the importance of appropriate access to OUD treatment, and data-sharing. Distribute it to the executives of Fortune 100 companies. The toolkit created by Kelly Clark, M.D. for Kentucky employers can be used as a model;<sup>7</sup>
- A website or app to help patients and families determine what good treatment entails and whether a treatment program can provide quality care (note: Shatterproof is currently building a report card for treatment facilities);
- A model law on reporting child drug exposure and the conditions under which a child should be removed; and
- A protocol for CPS workers to hold them accountable and make reasonable efforts to reunify the family.

## **B. Meetings or Conferences**

The attendees recommended that FORE convene the following meetings and host the following conferences:

- A series of meetings to develop a set of consistent, quality metrics. Rather than creating a new metrics system, which can be time consuming, the metrics used to assess depression could potentially be adapted for OUD;
- A conference or meeting for both employers and private insurers; and
- A conference for judges. The *Bench Book on Substance Abuse and Addiction for Family Courts* by the University of Baltimore School of Law Center for Families, Children and the Courts should be disseminated to judges. Offer a tribal court track at the conference.

## **C. Funding Opportunities**

The attendees suggested that FORE consider funding the following programs and services:

- Programs that offer counseling, certified peer recovery support, and social services, such as assistance with transportation, childcare, employment, stable housing, and other supports in addition to MBT;
- Projects based on the Virginia Medicaid's Health Home program, which offers coordinated care for individuals with chronic conditions like OUD and operates under a "whole-person" philosophy;<sup>8</sup>

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<sup>7</sup> <https://www.khcollaborative.org/employer-toolkit-roundtable/>

<sup>8</sup> <https://www.medicaid.gov/medicaid/ltss/health-homes/index.html>

- Projects that address mental health issues and social determinants of health;
- Programs that “meet patients where they are” and promptly connect them to treatment. For example, there are three SSAPs in Virginia that could be used as models. St. Luke’s Church, a Baltimore church, has set up an SSAP, which could also be used as a model;<sup>9</sup>
- Initiatives for practitioners to “see, treat, and refer” patients;
- Pilot programs like the Michigan recovery housing program, which offers housing to those who graduate from drug court programs.<sup>10</sup> Treatment, support groups, and childcare are all provided onsite. The program receives private and public funding through the HUD and the state;
- Technical assistance for people in rural areas to assist in applying for grants; and
- Child development specialists to evaluate children and conduct interventions if needed when the mother is receiving care.

#### **D. Educational Efforts**

The attendees recommended that FORE offer or fund educational courses or initiatives on the following topics:

- Courses for undergraduate and medical students and CME courses for practitioners. Customize education for ob-gyn, family, and emergency department (ED) physicians, as well as those in other specialty practice areas;
- Initiatives to “X the X waiver,” (i.e., amend DATA 2000 to remove the restrictions on access to treatment with buprenorphine for OUD);
- Initiative to educate patients and their families on the types of treatments available to them so they can secure the treatment to which they are entitled;
- Distribution of SAMHSA’s “Five Signs of Quality Treatment” to patients and their families;<sup>11</sup>
- Training for individuals who work in the criminal justice system to administer naloxone and provide inmates with naloxone upon release;
- Efforts to loosen the restrictions set forth in the Ryan Haight Act;
- Use of barbershops to educate men on OUD, employing as a model the educational effort around prostate cancer; and
- Trainings for nurses to score newborns appropriately using the Eat, Sleep, Console model or the Brazelton Newborn Test.

#### **E. Programs, Models, and Standards**

The attendees recommended that FORE offer or fund the following programs, models, and standards:

<sup>9</sup> <https://health.baltimorecity.gov/hiv-std-services/community-risk-reduction>

<sup>10</sup> <https://wwmt.com/news/local/proposed-kalamazoo-housing-project-seeks-to-aid-recovering-opioid-addicts>

<sup>11</sup> <https://store.samhsa.gov/system/files/pep18-treatment-loc.pdf>

- A program to encourage a referral to effective outpatient treatment for individuals who complete residential treatment;
- A model for insurance coverage for long-term residential treatment programs based on the model used for long-term treatment of eating disorders, which can also be a brain disease. Long-term care is covered for eating disorders because insurers recognize that patients need time to return to a healthy weight;
- Recovery city programs, which can be modeled after Missouri and Kansas' joint programs;
- Infectious disease services and trauma survivor services. Provide training for trauma survivors in the courtroom;
- Data collection to determine the percentage of providers with DATA 2000 waivers who utilize their authority and provide OUD treatment with buprenorphine. This would establish the nation's capacity to offer MAT to new patients, and identify providers who have a DATA 2000 waiver but do not provide OUD treatment with buprenorphine;
- Home-based visiting nurses' services, with training to support in serving patients with OUD;
- Telehealth services before inmates are discharged from jail or prison to ensure continuity of care. Encourage prisons to seek high-tech funding from states for telehealth, which provides a 90/10 match;
- A linkage program that connects inmates with care coordinators from Medicaid managed care organizations prior to release; and
- A justice advisory group made up of criminal justice professionals (e.g., probation and parole officers, judges, district attorneys, and police departments), dependency courts, co-occurring disorders and specialty courts, Buffalo Opioid Treatment Court, National Judicial Opioid Task Force, National Center for State Courts, a researcher, and someone from the Veterans Justice Program.

## V. ORGANIZATIONS OF INTEREST

Throughout the day, attendees identified various organizations with which FORE may want to collaborate and/or investigate in order to identify model programs and educational opportunities. For example:

- American Academy of Pediatrics, American Academy of Family Practice, and Children and Family Futures could help expand access to OUD treatment for children and adolescents;
- American Legislative Exchange Council (ALEC), the National Council of State Legislators, and the National Governors Association could assist with educational efforts to pass legislation;
- ASAM, which is developing program certification criteria jointly with the Commission on Accreditation of Rehabilitation Facilities (CARF); additionally, ASAM, the Joint Commission, CARF, and the National Association of Addiction Treatment Providers (NAATP) could also assist with resolving the lack of consistency as it relates to levels of care;

- Blueprint Health and Google’s Verily Life Sciences, which has partnered with Alexandria Real Estate Equities to build a tech-focused rehab campus in Dayton, Ohio;<sup>12</sup>
- CDC, HHS, HRSA, National Academy of Medicine, and SAMHSA, all of which could help develop quality standards and collect such data;
- Cigna, which has shown interest in telehealth;
- CPS and judges, National League of Cities, National Sheriffs’ Association, National Association of Chiefs of Police, United States Conference of Mayors, Huntington Mayor Stephen Williams, ACLU, Legal Action Center, American Academy of Correctional Physicians, American Correctional Association (working on keeping patients on MBT), Coalition of Correctional Health Authorities, Betty Gondles, National Commission on Correctional Health Care, Arnold Foundation (which gave seven grants for jails in eight counties), National Council of Juvenile and Family Court Judges, National Council for Family State Courts, and Children and Family Futures, which could be involved in a criminal justice–related conference;
- Corey Waller, M.D., who is building a continuum of care treatment structure for rural communities;
- Fortune 100 companies, which could be targets of an educational campaign to create awareness of OUD among employers;
- HUSKY Health, Connecticut’s Medicaid program, which can serve as a model for coverage and payment;
- Indian Health Service, which could assist in expanding access to treatment among American Indians/Alaska Natives;
- National Center for State Courts, which has made recommendations for trauma-sensitive individuals;
- National Governors Association, National Council of State Legislators, and Florida Veterans Courts, which could assist in reforming veterans’ courts;
- Michigan State Housing Development Authority and Virginia’s Department of Medical Assistance Services (DMAS), the state Medicaid program, which can serve as models for housing programs;
- Montana Healthcare Foundation and Montana Supreme Court, which have called for the use of telehealth;<sup>13</sup>
- National Council of Juvenile and Family Court Judges, National Council for Family State Courts, and Children and Family Futures, which could be approached to reform the family law system;
- Pew Charitable Trusts, which is working to build a relationship between an evaluator and six rural communities to assess metrics;
- Robert Wood Johnson Foundation, which is promoting a culture of health;
- Shatterproof, which is developing a system to determine whether a program is reputable;
- South Carolina and Mississippi Telehealth Centers for Excellence, which are gathering evidence on the efficacy of telehealth;

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<sup>12</sup> <https://www.cnn.com/2019/02/06/alphabets-verily-building-a-rehab-campus-to-combat-opioid-addiction.html>

<sup>13</sup> <https://www.greatfallstribune.com/story/news/2019/01/07/montana-drug-treatment-courts/2486221002/>



- Southeast ATTC (Pam Lee), which has been offering faith-based manuals with guidance on how to talk to community organizations about OUD;
- St. Luke’s Church in Baltimore, Md., which could be used as a model since it has set up an SSP with warm handoff to treatment;
- Tennessee’s Department of Health, which has created a faith-based recovery network<sup>14</sup>;
- United States Conference of Mayors, National League of Cities, National Association of Chiefs of Police, and Professional Black Barbers’ Association, which could assist in expanding access to treatment for OUD for individuals in urban and rural areas;
- Vermont’s Opioid Coordinating Council and the Substance Misuse Prevention Council, which could consult on developing a program to “treat the whole patient”;
- and
- Volunteers of America, which provides housing to pregnant women with OUD.

## VI. ATTENDEES

The following individuals attended the program advisory meeting. FORE is grateful for their time and contributions. Their participation in the meeting does not constitute their endorsement of this document.

Attendees:

- Mary Wakefield, Ph.D., R.N., Former HRSA Administrator and HHS Deputy Secretary (Meeting Chair)
- Kelly J. Clark, M.D., M.B.A., Founder of Addiction Crisis Solutions; Immediate Past President of ASAM;
- Jennifer Clarke, M.D., M.P.H., Medical Programs Director, Rhode Island Department of Corrections;
- Elizabeth Connolly, Director of Pew’s Substance Use Prevention and Treatment Initiative; Former Commissioner of NJ Department of Human Services;
- Loretta Finnegan, M.D., Executive Officer, College on Problems of Drug Dependence, Inc.;
- Judge Peggy Fulton Hora (retired), President of the Justice Speakers Institute, LLC; Retired California Superior Court;
- Hendree Jones, Ph.D., Executive Director of UNC Horizons; Professor, UNC Department of Obstetrics and Gynecology;
- Mark Levine, M.D., Commissioner, Vermont Department of Health;
- Douglas Olson, M.D., Vice President of Clinical Affairs, Fair Haven Community Health Center;
- Nisha Patel, Senior Advisor and Associate Director, HRSA, Office of Rural Health Policy; and

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<sup>14</sup> <https://www.tn.gov/behavioral-health/substance-abuse-services/faith-based-initiatives.html>

- Mishka Terplan, M.D., M.P.H., Associate Director of Addiction Medicine and Professor, Departments of Obstetrics & Gynecology and Psychiatry, Virginia Commonwealth University; Addiction Medicine Consultant for Virginia Medicaid.

FORE Board Members:

- Andrea Barthwell, M.D., Founder of Encounter Medical Group, P.C.; Director at Two Dreams; Former President of ASAM; Former Deputy Director for Demand Reduction, ONDCP;
- Adrienne Brown, M.S.W., L.M.S.W., Former Senior Administrator, Alcoholics Anonymous World Services and Administration for Children Services; and
- Pete Slone, Senior Vice President of Corporate Public Affairs, McKesson Corporation.

FORE Staff and Consultant:

- Karen Scott, M.D., M.P.H., President of FORE;
- Shibani Gambhir, M.P.A., Chief Operating Officer at FORE;
- Ken Shatzkes, Ph.D., Senior Program Officer at FORE;
- Lydia Tschoe, M.H.A., Program Assistant at FORE; and
- Stacey L. Worthy, Esq., Partner with DCBA Law & Policy.