Assessment of Medications for Opioid Use Disorder (MOUD) Treatment and Related Services in Marion County, Indiana

Commissioned by the Richard M. Fairbanks Foundation

FINAL REPORT: JANUARY 2020

Marla Clayman | Elizabeth Salisbury-Afshar | Holly DePatie | Maliha Ali | Jessica Arnold

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Introduction

Opioid use disorder (OUD) is a serious concern both nationally and in Marion County, Indiana. In 2017, 365 Marion County residents experienced fatal drug overdoses, with an age-adjusted rate of 38.9 per 100,000 people, as compared with a state rate of 29.4 per 100,000 people.[1] A recent report found that 81% of all overdose deaths in Marion County involved opioids and that opioid-related overdose deaths were often undercounted because many death certificates in Indiana did not identify the specific drugs responsible for drug overdoses.[2] Literature suggests that people with OUD are not able to access timely, appropriate, evidence-based treatment for OUD when they need it.[3]

Specifically, individuals with OUD who receive one of three Food and Drug Administration (FDA)-approved medications long term (methadone, buprenorphine, and extended-release naltrexone) have better treatment outcomes than do individuals who receive only counseling. When used long term, each of the three medications has been shown to increase retention in treatment and reduce illicit drug use. Long-term use of methadone and buprenorphine has been shown to reduce risk of overdose death and reduce HIV-risk behaviors.[4,5]

Historically, use of these medications was often referred to as "Medication Assisted Treatment," or MAT, because each of the medications is recommended for use in conjunction with counseling. However, *Medication for Opioid Use Disorder* (MOUD) has emerged as the preferred terminology because evidence supports that the medications are effective even when used without counseling, or in other words, the medications themselves are treatment.[5] Current guidelines suggest that counseling should be recommended when individuals are using MOUD, but medications should not be withheld if an individual is not willing or able to engage in counseling services.[4,5]

Each medication has a different pharmacology, route of administration, cost, and regulation around prescribing and dispensing. When used for treatment of OUD, methadone can only be dispensed by licensed opioid treatment programs. During the early weeks and months of treatment, individuals go to the opioid treatment program daily for observed dosing (meaning they take the medication on-site). Buprenorphine (trade names are Suboxone, Subutex, Bunavail, Zubsolv, Probuphine implant, and Sublocade injection) can be prescribed from an office-based setting by a provider who has completed additional education and has obtained a waiver from the Drug Enforcement Agency. In most cases, buprenorphine is prescribed in an office setting and picked up at a pharmacy. Extended-release naltrexone (trade name Vivitrol) is an injectable formulation and is also administered by a medical provider, although no additional training or licensing is required to prescribe and administer extended-release

naltrexone. Throughout this document, we will refer to the generic names when describing each medication.[5]

Although methadone and buprenorphine can also be used as part of medically managed withdrawal (sometimes referred to as "detox"), this practice has been associated with relapse rates as high as 65% to 91% and has been associated with high risk of overdose following detox because of reduced tolerance.[5] Therefore, it is the long-term use of MOUD that is considered first-line treatment, and that is what we will focus on throughout this report.

Report Purpose, Methods, and Limitations

Understanding the current MOUD treatment capacity and ease of accessing MOUD services in Marion County is critical to ensuring adequate access to treatment, which will in turn lead to reductions in opioid-related morbidity and mortality. The goal of the work was to explore Marion County's MOUD treatment capacity, as well as the ease of navigating the treatment system. This report provides an in-depth analysis of treatment capacity and access and barriers to treatment for people with OUD. Areas of inquiry, by data collection method, are shown in Exhibit ES-1, below.

Exhibit ES-1. Areas of Research Inquiry, by Data Collection Method

Area of inquiry	Data collection method
1. Availability of medications for opioid use disorder (MOUD) treatment services in licensed substance use disorder treatment providers	1a. Administrative interviews with licensed addiction treatment providers (*n* = 8) 1b. "Mystery shopper" calls to licensed addiction treatment providers (*n* = 12)
2. Access to medications, including buprenorphine and extended-release naltrexone, in primary care settings	2. Phone survey of primary care practices (*n* = 33)
3. Barriers and facilitators to accessing MOUD treatment services	3. Interviews with service providers that assist with treatment referrals (*n* = 15 interviews with 23 individuals)

Data collection methods included interviews with providers, phone surveys with primary care practices, and mystery shopper calls. Mystery shopper calls are a widely used technique to gain insight into the experience of people attempting to access services. Mystery shoppers have been used in health care for decades,[6] including by the Centers for Medicare and Medicaid Services.[7] We have included mystery shopping here as one method of data collection because of the discrepancy between the findings of a prior report[8] that was commissioned by the Richard M. Fairbanks Foundation (the Foundation) and what we heard from the Foundation and its stakeholders in terms of people's experiences when trying to access treatment.

There are several limitations to this work. Namely, we did not speak with all MOUD treatment providers (Area of Inquiry 1), primary care practices that offer buprenorphine (Area of

Inquiry 2), or service providers who see clients with OUD (Area of Inquiry 3). However, in each case AIR worked closely with the Foundation and the project advisors to identify providers that serve larger patient populations with MOUD. Also, we did not speak directly with individuals or family members who had tried to access MOUD in Marion County. The mystery shopper calls were used to emulate what an individual or family member might experience, although they might not be representative of an individual's experience in accessing services. For further limitations please see the full report.

Key Findings

Overall, this study found that, while MOUD treatment and associated services were available in Marion County, accessing them could be confusing and complicated. For example, identifying a treatment provider could be challenging, as online information about services offered often conflicted with the treatment that organizations shared on the phone when a potential client or family member called. In addition, the process for accessing services once a provider had been identified could be a challenge, with restrictive availability, locations, and intake procedures. Further, barriers to maintaining treatment were identified, including lack of transportation, lack of stable recovery housing, and conflicts between treatment hours and work schedules. Finally, lack of insurance repeatedly came up as an initial barrier that could delay care, particularly for individuals without ability to pay. In short, identifying a provider, and accessing and maintaining treatment services, could be difficult to navigate and was not client-centered.

- **The systems for MOUD treatment are difficult to navigate.** People trying to find MOUD are subject to conflicting and difficult-to-find information. For instance, there were many discrepancies between administrative interviews and mystery shopper calls conducted at the same organizations, ranging from differences in wait times for intake appointments to discrepancies in which MOUD treatments were available. Similarly, while some organizations' administrators reported offering MOUD, some of the mystery shopper calls found that the medications were only offered as part of medically managed withdrawal, or detox, as opposed to long-term use, which is the current evidence-based recommendation. In-depth interviews with service providers who help people navigate the treatment system found that they often rely on their personal and institutional relationships, rather than more formal processes, in linking their clients to services, indicating that the system might be hard for individuals without knowledge or established relationships to navigate on their own.

- **MOUD treatment is generally available within a few days of request, but it is not consistently available when someone is ready for it.** Findings related to several of the activities that we undertook indicated various ways in which treatment was difficult for people to access. During in-depth interviews, several service providers discussed the need

to "strike while the iron is hot." That is, there was a desire to link clients to treatment as soon as they voiced interest in such services, but the providers were not always able to get people into treatment in a timely fashion. During the administrative interviews, mystery shopper calls, and primary care calls, it became clear that intake for initiating treatment was available during limited hours at many organizations. In addition, some organizations had specific and potentially difficult intake procedures. For example, three of the 12 organizations we called as a mystery shopper said that clients would need to call at 5 a.m. (one organization) or 6 a.m. (two organizations) to get appointments. Finally, multiple organizations reported a multistep process before a client could initiate MOUD. Restricted hours and difficult intake procedures may limit treatment initiation.

- **Cost remains a barrier for individuals who have never been enrolled in Medicaid/Healthy Indiana Plan (HIP) or those who are waiting for Medicaid/HIP to be reinstated.** All administrators we interviewed or organizations that received mystery shopper calls reported that they accepted Medicaid/HIP. Similarly, in-depth interviewees reported that MOUD services were generally available to individuals with Medicaid/HIP. However, if someone was Medicaid-eligible without being enrolled, organizations differed in their ability to provide care before enrollment was complete. Many organizations reported fee structures for individuals without insurance, and these fees were cost-prohibitive for many individuals. Finally, in-depth interviews found that private insurance was highly variable in terms of coverage of various services and co-pay structures, which could serve as barriers to receiving services.

- **There is limited MOUD access in primary care settings.** Buprenorphine and extended-release naltrexone can be prescribed in primary care settings, and people may prefer primary care settings for receiving such services. This may be for a variety of reasons, including a more holistic treatment model (ability to receive primary care services in the same setting) and because of the lack of stigma in visiting a primary care office. We identified and called 33 clinics listed as offering buprenorphine treatment through the Substance Abuse and Mental Health Administration (SAMHSA) Substance Use Treatment Locator, although we found that most of the sites were not able to answer our questions and/or calls were directed and redirected with no resolution. In the end, only seven of the 33 (21%) primary care practices we attempted to reach reported offering buprenorphine, with three of the seven also offering extended-release naltrexone.

- **Treatment and recovery support services need strengthening.** During in-depth interviews, service providers described barriers to treatment initiation and sustained recovery, including lack of sober housing/recovery homes, clients' difficulty obtaining or maintaining employment because of treatment requirements, and lack of transportation to and from the treatment providers. One interviewee felt that clients engaging in intensive outpatient

treatment several days a week might have difficulty finding and keeping a job that allowed them to attend treatment at that frequency.

- **People with co-occurring mental health conditions and OUD lack recovery support options.** Some service providers explained during the in-depth interviews that having a co-occurring mental health diagnosis often prevented clients from entering recovery housing. Specifically, some recovery homes did not accept individuals with specific mental health diagnoses such as schizophrenia.

- **Stigma against MOUD exists among many treatment and recovery service providers.** In-depth interviews found that some treatment providers did not offer MOUD or did not allow people using MOUD to receive counseling or other services in their agencies. These organizations are often referred to as "abstinence-based." Service providers described stigma against MOUD as having improved somewhat in recent years, although this stigma was still present in some places. These providers reported that this stigma could have a negative impact on the clients trying to obtain services while taking MOUD.

Recommendations

On the basis of the findings described above, we developed the following recommendations for next steps in improving MOUD access and continued treatment in Marion County, Indiana:

- **Develop a centralized substance use disorder intake and assessment process for Marion County.** While this report focuses on MOUD access, a centralized substance use disorder intake and assessment process will need to include information about treatment options for all substance use disorders, as many people with OUD also use other substances, and many treatment providers offer multiple levels of care and treatment services. This service could provide a basic assessment over the phone or on the Internet to help identify appropriate level of care, provide information on all types of medication and treatment services, and maintain a central repository of all treatment programs and related information (insurances accepted, days of operation, intake processes). Such a service could also receive daily updates on availability at each treatment program and be able to link individuals to the desired service and geographic location with the shortest possible wait time. A service like this would also allow Marion County stakeholders to understand which services are in highest demand and provide a real-time picture of access and wait times.

- **Provide more flexible treatment access.** This could include expanded hours and days of operation for both intake assessments and ongoing clinical services. Expanded hours would reduce barriers to initiating treatment and allow people to remain engaged in treatment while still meeting work and family demands. Similarly, treatment access could be improved through increased outreach efforts and provision of MOUD in settings where people with OUD may be found (e.g., homeless shelters, harm reduction agencies, syringe service

programs, emergency departments, inpatient hospital units, correctional facilities, and post-incarceration re-entry programs).

- **Reduce barriers to initiating MOUD.** It is important for individuals seeking methadone or buprenorphine to be able to start medication as soon as possible to reduce risk of loss to care and opioid-related overdose. Ideally, clients should be able to receive methadone or buprenorphine on the first visit. (Use of extended-release naltrexone does require a client to first go through medically managed withdrawal and have a 7-day wait period before medication can be initiated.) When discussed in the context of buprenorphine, this approach is sometimes referred to as a "medication first" model of care.[9,10] Clients interested in MOUD should be offered counseling, but counseling engagement should not be a requirement to start or maintain MOUD.[4]

- **Increase capacity for MOUD in primary care settings.** Settings such as Federally Qualified Health Centers, which accept Medicaid and are able to provide low-cost services to uninsured individuals, are well positioned to fill this gap in care. A variety of training models—ranging from in-person trainings and technical assistance to web-based educational training and mentoring—have been implemented nationally to support treatment expansion.[11,12,13] As capacity for MOUD in primary care settings increases, it will be critical to ensure that publicly available treatment lists (such as the Indiana treatment finder, INconnect) include information about how to identify primary care providers offering these services.

- **Train call-center, front-desk, and other front-line staff in services for MOUD.** It is critical for individuals answering calls to be knowledgeable about what services are offered and available, and the process for initiating care. This particularly relates to larger health systems that use centralized call centers.

- **Identify solutions to address transportation challenges.** Models to address transportation barriers to getting to and from treatment could include increasing transportation funds that support ride sharing (e.g., Uber or Lyft) or other transit.

- **Increase capacity of recovery home/sober living services, specifically for people on MOUD and with co-occurring mental illness.** Recovery home services are not considered treatment and therefore are not reimbursable through Medicaid. Individuals using MOUD can face additional challenges because many recovery homes do not allow individuals on MOUD to stay there. Similarly, individuals with certain mental health diagnoses (e.g., schizophrenia) may not be accepted into recovery homes. Access to low-cost (or no-cost) recovery housing is a critical component, especially early in recovery, for many individuals with unstable housing situations. Further, recovery housing needs to be accessible to individuals with co-occurring mental illness. A lack of access to affordable long-term

housing, while likely a larger systemic issue, was repeatedly identified as a barrier to long-term recovery.

- **Address stigma against MOUD among abstinence-based treatment providers and the recovery community more broadly.** Since MOUD is recognized as first-line treatment that reduces morbidity and mortality, it is crucial that all treatment providers understand the evidence base and work with clients who choose to use medication as part of their recovery path. If providers are not able to offer MOUD because of staffing, licensing, or other financial challenges, they should, at a minimum, counsel patients on available MOUD and the evidence behind this treatment while supporting linkage to programs that offer it. Education and tailored technical assistance could be provided to treatment agencies, ideally including individuals who use MOUD and are in recovery to share their personal experiences with medication.

- **Convene a multisectoral meeting of service providers, mental health providers, local government, employers, and funders to problem-solve and identify funds to support specific gaps in services.** Many service providers reported relying on their relationships with others to link their clients to services, while potential barriers and solutions were systemic and multisectoral in nature. These relationships and Marion County's size represent an opportunity to bring together many key players for a focused discussion on systemic barriers including transportation, employment opportunities, and recovery home access.

Introduction

Opioid use disorder (OUD) is a serious concern both nationally and in Marion County, Indiana. In 2017, 365 Marion County residents experienced fatal drug overdoses, with an age-adjusted rate of 38.9 per 100,000 people, as compared with a state rate of 29.4 per 100,000 people.[1] A recent report found that 81% of all overdose deaths in Marion County involved opioids and that opioid-related overdose deaths were often undercounted because many death certificates in Indiana did not identify the specific drugs responsible for drug overdose.[2] Current literature suggests that people with OUD are not able to access timely, appropriate, evidence-based treatment when they need it.[3]

In 2018, the City of Indianapolis' Office of Public Health and Safety, the Richard M. Fairbanks Foundation (the Foundation), and Community Solutions, Inc.,[8] led an effort to assess community capacity for mental health and substance use disorder treatment services in Marion County, Indiana.[8] The goal of the study was to help support community leaders in making decisions about where to invest resources in overall mental health and substance use disorder treatment services. Findings indicated that there was sufficient capacity (or at least an existing capacity within the programs that responded to the survey) to treat people with substance use disorder. However, the report did not specifically describe availability of medications for opioid use disorder (MOUD). These findings diverged from a prior Foundation-funded report, "The Changing Landscape of the Opioid Epidemic in Marion County and Evidence for Action," led by Dr. Dennis Watson and colleagues,[2] which found that many stakeholders who were interviewed felt that there was a need for better quality OUD treatment services, with a focus on increasing access to evidence-based treatment, specifically MOUD. The discrepancy between these two reports' findings warrants a closer look at the availability of MOUD treatment services and any access barriers at systemic, provider, and individual levels. A deeper understanding of the MOUD treatment landscape in Marion County is necessary to ensure adequate access to initial and ongoing treatment, which will in turn lead to reductions in morbidity and mortality related to opioid use.

This report focuses on MOUD access because individuals with OUD who receive one of three FDA-approved medications long term (methadone, buprenorphine, and extended-release naltrexone) have better treatment outcomes than do individuals who receive only counseling.

Historically, use of these medications was often referred to as "Medication Assisted Treatment," or MAT, because each of the medications is recommended to be used in conjunction with counseling. In 2019, the National Academy of Medicine, in its report "Medications for Opioid Use Disorder Save Lives," explained that MOUD is the preferred terminology over MAT because evidence supports that the medications are effective even when used without counseling; in other words, the medications themselves are treatment.[5]

Current guidelines suggest that counseling should be recommended when individuals are using MOUD, but medications should not be withheld if an individual is not willing or able to engage in counseling services.[4,5]

Each of the three FDA-approved MOUD (methadone, buprenorphine, and injectable extended-release naltrexone) has a different pharmacology, route of administration, cost, and regulation around prescribing and dispensing. When used for treatment of OUD, methadone can only be dispensed by licensed opioid treatment programs. During the early weeks and months of treatment, individuals go to an opioid treatment program daily for observed dosing (meaning that they ingest the medication on-site). Buprenorphine can be prescribed from an office-based setting by a provider who has completed additional education and has obtained a waiver from the Drug Enforcement Agency (DEA). In most cases, buprenorphine is prescribed in an office setting and picked up at a pharmacy. Some of the tablet and film formulations are a combination of buprenorphine and naloxone. The naloxone in these formulations was added solely as an abuse deterrent. When taken as prescribed (dissolved under the tongue or on inside of cheek), the naloxone has no activity; if it is injected, then the naloxone becomes active and reduces any effect of the buprenorphine. There are also implantable and injectable formulations of buprenorphine; each must be placed or administered by a medical provider. Extended-release naltrexone is an injectable formulation and is also administered by a medical provider, although no additional training or licensing is required to prescribe and administer it. Oral naltrexone is available, but it is not recommended for treatment of OUD because studies have not found it to be effective.[4] Therefore, it will not be discussed further in this document. The trade names, formulations, and dosing regimens are listed in Exhibit 1, below. Throughout this document, we will refer to the generic names when describing each medication.

Exhibit 1. Medications for Opioid Use Disorder (MOUD)

Generic name	Trade name(s)	Formulation	Dosing regimen
Methadone		Liquid	Daily
		Dispersible tablet	Daily
Buprenorphine	Suboxone (buprenorphine/naloxone)	Sublingual film	Daily
	Subutex (buprenorphine)	Sublingual tablet	Daily
	Zubsolv (buprenorphine/naloxone)	Sublingual tablet	Daily
	Bunavail (buprenorphine/naloxone)	Buccal film	Daily
	Sublocade (buprenorphine)	Injection	Monthly
	Probuphine (buprenorphine)	Implant	Every 6 months
XR naltrexone	Vivitrol	Injection	Monthly

Note. XR = extended-release

People with OUD who receive FDA-approved medications long term (methadone, buprenorphine, and naltrexone) as part of their treatment plan have better treatment outcomes than do individuals who receive only counseling. When used long term, each of the three medications has been shown to increase retention in treatment and reduce illicit drug use. Long-term use of methadone and buprenorphine has been shown to reduce risk of overdose death and also of HIV-risk behaviors. Although methadone and buprenorphine can also be used as part of medically managed withdrawal (sometimes referred to as "detox"), this practice has been associated with relapse rates as high as 65% to 91% and has been associated with high risk of overdose because of reduced tolerance.[5] Therefore, it is the long-term use of MOUD that is considered first-line treatment, and that is what we will focus on throughout this report.[5]

Methods and Results

General Overview of Methods

There were three areas of inquiry addressed through four data collection methods, which are outlined in Exhibit 2, below. Data collection activities were conducted from September through November 2019. This work was reviewed by the AIR Institutional Review Board (IRB) for adherence to standards for protection of research subjects and was considered not to be research and was therefore exempt from further IRB review. The following sections provide further information on the methods and results for each area of inquiry.

Exhibit 2. Areas of Research Inquiry, by Data Collection Method

Area of inquiry	Data collection method
1. Availability of medications for opioid use disorder (MOUD) treatment services among licensed substance use disorder treatment providers	1a. Administrative Interviews with licensed addiction treatment providers (n = 8) 1b. Mystery shopper calls to licensed addiction treatment providers (n = 12)
2. Access to medications, including buprenorphine and extended-release naltrexone, in primary care settings	2. Phone survey of primary care practices (n = 33)
3. Barriers to accessing MOUD treatment services	3. Interviews with service providers that assist with treatment referrals (n = 15 interviews with 23 individuals)

We assessed the availability of MOUD in licensed substance use disorder treatment organizations and in primary care clinics through telephone calls, while we conducted in-person in-depth interviews to assess service providers' views of treatment capacity. The methods for each of these activities are described further below.

Area of Inquiry 1. Availability of Medications for Opioid Use Disorder Treatment Services in Licensed Substance Use Disorder Treatment Providers

Methods for Area of Inquiry 1: Availability of Medications for Opioid Use Disorder Treatment Services in Licensed Substance Use Disorder Treatment Providers

To understand MOUD treatment capacity, accessibility, timeliness of service availability, and types of medications offered at substance use disorder treatment organizations, we worked with the Foundation to identify treatment providers that had indicated offering MOUD in the Community Solutions report.[8] The Community Solutions report identified 13 organizations that reported offering buprenorphine and/or naltrexone, and an additional three sites that reported they were licensed Opioid Treatment Programs (OTPs) offering methadone. We worked with the Foundation and the project advisors to identify which of these 16 licensed treatment entities were known to be high volume and in which we felt reasonably confident that we could identify respondents for the administrative interviews. In total, on the basis of the volume of population served and likelihood of response, we reduced the list to 12 of the 16 (75%) organizations that reported offering at least one form of MOUD in the Community Solutions report. Once we identified these organizations, we did the following:

1. Contacted administrators at each of the 12 substance use disorder treatment organizations. The advisors and the Foundation assisted in identifying the appropriate administrative contacts in each of the organizations. We e-mailed each treatment administrator to set a time to conduct a phone interview. Interviews lasted 15 minutes on average. During the phone interviews, we asked questions about MOUD treatment at each organization, including the levels of care, MOUD offered, types of payment accepted, and average number of days until an intake appointment. The "Licensed Treatment Provider Administrative Interview Guide" can be found in Appendix B. This activity was conducted specifically as a follow-up to the Community Solutions report[8] as a way to collect more detailed information that was specific to OUD treatment, including type(s) of medication offered. This activity also allowed us to validate information about access specifically to MOUD (in case the agency offered multiple types of services or levels of care). Although we attempted to conduct interviews with administrators at all 12 organizations, we were only able to reach eight. AIR worked with the Foundation and the advisors to try to identify alternate points of contact, and at least two attempts were made to reach alternate points of contact at each of the four nonresponsive organizations.

2. Conducted mystery shopper calls to each of the 12 identified organizations in order to gain an understanding of what a patient or family member might experience when trying to access services. Mystery shoppers have been used in health care for decades,[6] including by the Centers for Medicare and Medicaid Services.[7] We have included mystery shopping here

as one method of data collection because of the discrepancy between the findings of a prior report[8] that was commissioned by the Richard M. Fairbanks Foundation (the Foundation) and what we heard from the Foundation and its stakeholders in terms of people's experiences when trying to access treatment. An AIR research assistant called the main intake phone line of each of the 12 substance use disorder treatment organizations, posing as a family member seeking treatment services for a loved one. The caller inquired about services, insurance/self-pay options, wait times until the first available appointment, and whether MOUD would be initiated at the first visit. To ensure that these activities did not compromise the availability of appointments for patients, the caller did not complete scheduling of the appointment. The calls lasted 10 minutes on average. This activity helped give a snapshot understanding of treatment capacity and also helped improve our understanding of the process for patients and family members looking for treatment access. The script for the mystery shopper calls can be found in Appendix C.

We attempted to contact the same 12 organizations for both the administrative interview and the mystery shopper calls, to allow comparisons between the information provided by the administration and the information provided by the person taking the mystery shopper call. As we stated above, although 12 substance use disorder treatment organizations were identified to participate in both activities, only eight of the administrative calls were able to be scheduled and/or completed because of lack of response at four of the organizations. Organization names are not included in this report. Instead, we randomly assigned each organization to a letter of the alphabet and maintain that randomized letter throughout the first two activities.

To measure MOUD availability among licensed substance use disorder treatment providers, we asked questions in five separate content areas. We formally asked, in the administrative interviews only, about the levels of care the organization was licensed to provide. Levels of care are designated by the American Society of Addiction Medicine (ASAM), and include outpatient, intensive outpatient, and residential services.[14] We asked in both the administrative interviews and the mystery shopper calls about accepted payment methods, time until intake appointment, and type of MOUD offered. Finally, in the mystery shopper calls only, we asked specific questions about when MOUD would be initiated. Exhibit 3 compares the areas of inquiry that were covered, by type of call.

Exhibit 3. Content Areas for Administrative Interviews and Mystery Shopper Calls

Through these calls, we assessed	Administrative interviews (*n* = 8)	Mystery Shopper Survey (*n* = 12)
American Society of Addiction Medicine (ASAM) levels of care	●	
Type of MOUD offered	●	●
Accepted payment methods (insurances and self-pay)	●	●
Time until first intake appointment	●	●
Wait period between intake appointment and initiation of medication		●

Results for Area of Inquiry 1: Availability of Medications for Opioid Use Disorder Treatment Services in Licensed Substance Use Disorder Treatment Providers

The results are presented in three ways:

1. Results from the administrative interviews (*n* = 8)

2. Results from the mystery shopper calls (*n* = 12)

3. Comparison of data collected in the administrative interviews and the mystery shopper calls.

The labeling system for each of the 12 organizations is used consistently throughout all three sections.

Results for 1a: Administrative Interviews

Levels of care and type of medications offered

Of the eight completed administrative interviews, all were licensed to provide substance use disorder treatment and all reported offering at least one form of MOUD. All of the organizations offered at least two ASAM levels of care, including outpatient; intensive outpatient; residential; and residential, medically managed withdrawal services. Information was not collected from the other four organizations because of lack of response, as detailed above.

One organization reported offering all three forms of MOUD. Five of eight organizations reported offering both buprenorphine and extended-release naltrexone, one reported offering only extended-release naltrexone, and one reported offering buprenorphine only in its medically managed withdrawal program and referring clients seeking outpatient MOUD to other organizations. See Exhibit 4, which shows how many of the eight organizations interviewed reporting offering each form of medication.

Exhibit 4. Medications Offered, as Reported During Administrative Interviews (*n* = 8)
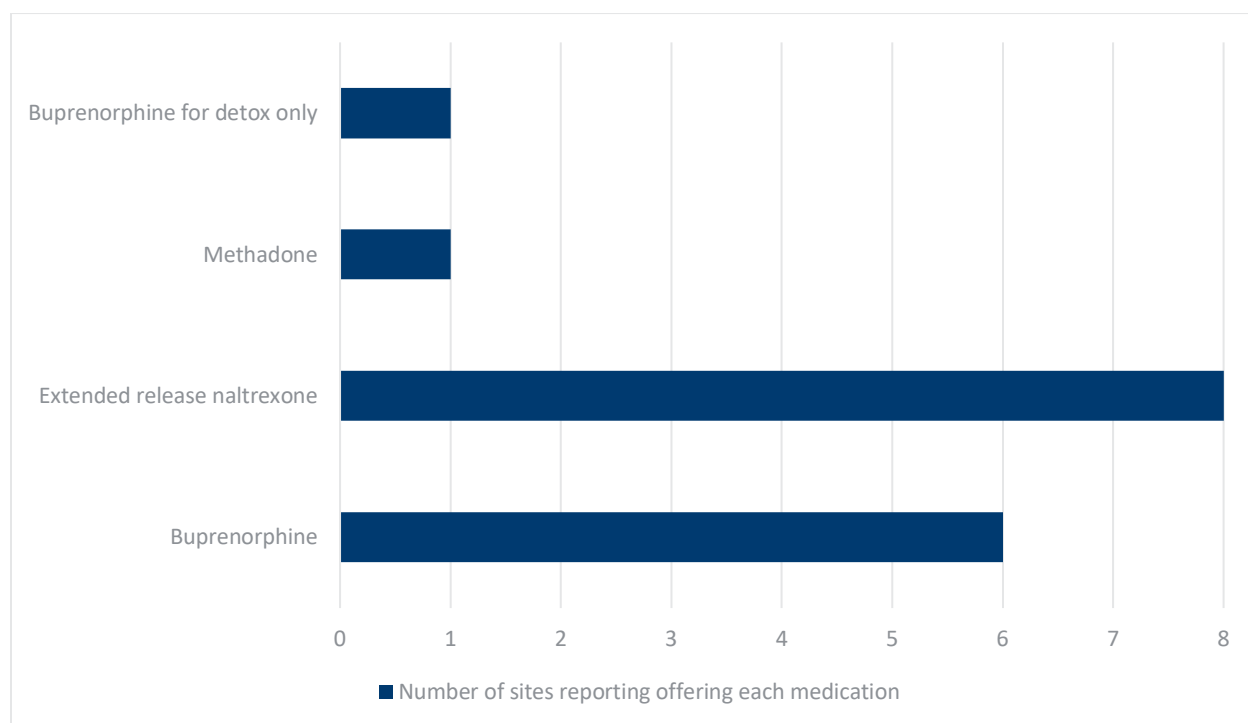
Note: Organizations that reported offering more than one form of medication are included in both categories

Accepted payment methods

All eight responding organizations reported that they accepted Medicaid/Healthy Indiana Plan (HIP) and that there was no limit or cap on the number of patients they would accept with public insurance. All eight organizations also reported that they accepted patients without insurance and had a structure in place to allow for self-pay. In addition to the questions that we asked, four of the eight organizations offered additional information, saying that their organizations had patient navigators to assist patients with applying for insurance coverage. One also explained that it had a limited availability for "charity care" cases each year (meaning care at no cost for uninsured individuals). As we did not specifically ask about insurance navigators or charity care in our interviews, we cannot conclude that the other organizations are without these services.

Time until first intake appointment

The reported average time to the first intake appointment ranged from immediate access (same-day walk-in) to a range of one to five days. See Exhibit 7 for more detailed information.

Results for 1b: Mystery Shopper Calls

Twelve mystery shopper calls were conducted to the preidentified organizations. Of the 12 calls, six organizations answered immediately with no wait and were able to answer the

questions posed by the caller. Two organizations required three separate attempts because of dropped calls and/or the caller's being transferred to a dead telephone line. One organization left the caller on hold for more than 10 minutes, so a second call was placed a few days later and was answered immediately.

Medications offered

All 12 organizations reported accepting new patients, and 10 of the organizations reported that they offered at least one form of MOUD. The remaining two reported that they did not offer MOUD, but because the Foundation and project advisors had previously reported that all 12 organizations did offer MOUD, a second mystery shopper call was conducted for these two sites. The subsequent calls were conducted on different days to confirm the original responses. On the second calls, one site reported it did offer MOUD, and the other maintained that it did not offer MOUD treatment services and only offered a 7-day "detox program" for alcohol and benzodiazepine misuse. No further information was collected from the organization that reported not offering any MOUD (Organization K).

Of the 11 organizations that reported offering MOUD, seven reported offering those medications as long-term (maintenance) treatment and four reported using medication only as part of opioid detox, which as we noted above, is against recommended standards based on clinical evidence and has been demonstrated to lead to additional harms.[5] Long-term use of MOUD is considered first-line treatment, and only seven organizations reported offering ongoing MOUD. See Exhibit 5 for a breakdown of the medications that each organization reported as being offered.

Accepted methods of payment and cost

Of the 11 organizations that reported offering at least one MOUD in some capacity, all reported accepting Medicaid/HIP and nine of the 11 organizations reported accepting out-of-pocket payment from patients with no insurance. The remaining two organizations were unable to answer questions about payment structure for uninsured clients. Of the organizations that reported on cost, the units of payment varied across organizations—from a set cost per visit to weekly and monthly rates. Exhibit 5 shows the costs quoted during the mystery shopper calls.

Time until first intake appointment

When we inquired about the first available appointment, six of the organizations said that individuals seeking treatment could walk in or call in for a same-day appointment. One organization reported requiring a walk-in orientation before an appointment could be scheduled. The other five organizations reported having availability ranging from within one day to approximately one week. It is also important to note that, although these organizations gave number of days until the next available appointment, three of the 11 organizations

required prospective patients to call by either 5 a.m. (one organization) or 6 a.m. (two organizations) to be able to schedule an appointment. Another organization informed the caller that, to be able to schedule an appointment, he or she had to call first thing on Monday morning, when the schedule would open. See Exhibit 7 for additional information and a comparison of responses collected about next appointment availability during the mystery shopper calls and the administrative interviews.

Wait period between initial appointment and medication initiation

The mystery shopper asked whether someone would receive medication on the first visit and received a variety of responses. Of the seven organizations that reported offering ongoing MOUD treatment, only one (Organization E) reported prescribing MOUD on the same day of intake. Two organizations reported requiring therapy sessions prior to medication referral, and three organizations indicated that they evaluated MOUD use on the basis of the patient's condition and the doctor's suggestion. One organization was unsure of when or how medication was prescribed to new patients.

Of the four organizations that described offering medication for detox only, two (C and D) reported that they offered only outpatient detox and medication would begin the day following intake. Organization F reported offering both inpatient and outpatient detox, and medication would begin according to the client's condition and doctor's suggestion. Organization J reported offering only inpatient detox and indicated that referrals for medication would be made once the client engaged in substance use counseling.

Exhibit 5. Medications Offered, Medication Initiation, and Costs of Services, as Reported During Mystery Shopper Survey

Organization	Medication(s) offered	When medication initiated	Self-pay cost reported
A	Buprenorphine	Requires therapy sessions first; referral to medication made afterward.	Intake assessment $120; sliding scale based on income for treatment
B	XR naltrexone	Requires therapy sessions first; referral to medication made afterward.	Intake assessment $130; sliding scale based on income for treatment
C	*(Buprenorphine for outpatient detox only)*	Detox begins the day after intake visit.	$800–$1,000 for initial labs; $200/month detox
D	*(Buprenorphine for outpatient detox only)*	Detox begins the day after intake visit.	Sliding scale based on income
E	Methadone	Begins day of intake.	$113/week
F	*(Buprenorphine for inpatient and outpatient detox only)*	Depends on patient's severity and doctor's suggestion.	$2,000–$4,000 total depending on level of care
G	Buprenorphine, XR naltrexone	Depends on patient's severity and doctor's suggestion.	$305 assessment, $77 per visit
H	XR naltrexone	Depends on patient's severity and doctor's suggestion.	Does not accept self-pay.
I	Methadone, buprenorphine	Depends on patient's severity and doctor's suggestion.	Methadone—initial $76 and $16/day; buprenorphine—initial $84 and $24/day; Subutex—$80 and $20/day
J	*(Buprenorphine for inpatient detox only)*	Requires therapy sessions first; referral to medication made afterward.	Respondent not able to provide information.
K	Does not offer MOUD.	Not collected.	Not collected.
L	Methadone, buprenorphine	Respondent not able to provide information.	Respondent not able to provide information.

Note. XR = extended-release

Comparisons Between Administrative Interviews and Mystery Shopper Calls

When comparing the responses collected from the administrative interviews and the mystery shopper calls, several discrepancies were identified, and they are described below. Although we attempted to contact the same 12 organizations for both data collection methods, eight administrative interviews were completed and four were not completed because of nonresponse. Of the 12 mystery shopper calls completed, one organization reported that it did not offer MOUD, so no further questions were asked. Therefore, our ability to draw comparisons across all organizations is limited.

Among the eight organizations for which we collected data in both the administrative interview and the mystery shopper calls, only two organizations (G, H) had responses that were completely consistent with regard to the type of medications being offered. This, along with inconsistencies noted across the other organizations, are displayed in Exhibit 6.

Exhibit 6. Type of MOUD Offered, as Reported in Administrative Interviews and Mystery Shopper Calls

Organization	Administrative response to type of MOUD offered (*n* = 8)	Mystery shopper response to type of MOUD offered (*n* = 12)
A	Buprenorphine and XR naltrexone	Buprenorphine
B	NA	XR naltrexone
C	NA	*Buprenorphine (for outpatient detox only)*
D	Buprenorphine, XR naltrexone	*Buprenorphine (for outpatient detox only)*
E	Methadone, buprenorphine, XR naltrexone	Methadone
F	Buprenorphine, XR naltrexone	*Buprenorphine (for inpatient and outpatient detox only)*
G	Buprenorphine, XR naltrexone	Buprenorphine, XR naltrexone
H	XR naltrexone	XR naltrexone
I	NA	Methadone, buprenorphine
J	NA	*Buprenorphine (for inpatient detox only)*
K	Buprenorphine and XR naltrexone	Does not offer MOUD.
L	*Buprenorphine (for detox only),* XR naltrexone	Methadone, buprenorphine

Note. NA = nonresponsive to our requests for interview. Organizations G and H were the only two that had consistent findings across both data collection methods. XR = extended-release

Accepted methods of payment

There was consistency in the responses collected regarding the accepted methods of payment. All respondents in the administrative interviews (*n* = 8) and mystery shopper calls (*n* = 11) reported that their organizations accepted Medicaid/HIP. All but Organization H reported that they accepted out-of-pocket payment for individuals without insurance.

Time until intake appointment

To assess availability of intake appointments and potential wait times, administrators were asked about the average wait time when a new client was requesting an intake appointment. During the mystery shopper calls, the caller specifically asked about the first available appointment. Generally speaking, administrators were more conservative in their time estimates than the staff who responded to mystery shopper calls. More than 50% of the mystery shopper respondents reported their organizations had availability for same-day

appointments. It is notable that some of the mystery shopper calls revealed strict time constraints for their appointment availability (such as calling only certain days of the week or at certain times of the day), which could serve as additional barriers to new clients.

Exhibit 7. Wait Time Until Next Intake Appointment, as Reported in Administrative Interviews and Mystery Shopper Calls

Organization	First available intake	
	Administrative interview	Mystery shopper call
A	1–4 days	Present in-person for same-day appointment.
B	NA	Present in-person for same-day appointment.
C	NA	Present in-person for same-day appointment.
D	1–5 days	Call for same-day appointment.
E	1–2 days	Call 5 a.m. Monday morning for an appointment that week.
F	1–2 days	1–3 days
G	1–5 days	Must complete orientation in-person before scheduling appointment.
H	1–2 days	Call before 6 a.m. for same-day appointment.
I	NA	Call before 6 a.m. for same-day appointment.
J	NA	Present in-person for same-day appointment.
K	24/7 walk-in access	Not collected because reported not offering MOUD.
L	24/7 walk-in access	Present in-person for same-day appointment.

Note. NA = nonresponsive organizations.

Area of Inquiry 2. Access to Medications, Including Buprenorphine and Extended-Release Naltrexone, in Primary Care Settings

Two of the three FDA-approved MOUD—buprenorphine and injectable extended-release naltrexone—can be prescribed in office-based settings, including primary care practices. Primary care practices are often seen as important MOUD treatment access points for a variety of reasons, including reduced stigma because people do not associate these settings with substance use disorder treatment; they provide comprehensive primary care services in addition to MOUD in the same setting; and they are an alternative treatment delivery model. Because the original Community Solutions report[8] did not explore access to MOUD treatment in primary care settings, this study attempted to evaluate access to MOUD in these settings.

Any medical provider (physician, nurse practitioner, or physician assistant) with prescribing privileges is able to prescribe extended-release naltrexone. However, to be able to prescribe buprenorphine, additional education and a special DEA license (called the DATA [Drug Addiction Treatment Act of 2000] waiver) is required. We were not able to identify a list of primary care settings that were offering MOUD through the online Indiana Treatment Finder, INconnect.[15] Therefore, we used the national SAMHSA Substance Use Treatment Locator.[16] Upon obtaining a DATA waiver, providers must opt in to be listed on the SAMHSA Substance Use Treatment Locator website. Therefore, this list only includes the providers who obtained a DATA waiver and have agreed to be listed. In addition, opting to be included on the publicly available list does not mean that the provider is actually prescribing buprenorphine. Despite these limitations, this list is the most comprehensive resource available.

Methods for Area of Inquiry 2: Access to Medications, Including Buprenorphine and Extended-Release Naltrexone, in Primary Care Settings

In June of 2019, 173 medical providers with a DATA waiver were listed in the SAMHSA Substance Use Treatment Locator as having office locations in Marion County. Providers working for licensed substance use disorder treatment organizations or pain specialty offices were then excluded. Of the remaining clinics/organizations, we reviewed office locations and merged clinic locations where multiple providers were listed as being able to prescribe buprenorphine. After this process, 80 total clinics remained on the list. Primary care clinics that had at least one DATA-waivered provider listed (*n* = 29) were identified as high priority, and an additional four clinics that seemed to have specialty services (e.g., sports medicine, allergy) with multiple DATA-waivered providers were identified as medium priority. The advisors reviewed the total list and made suggestions on which clinics should be included. The Foundation approved our final list of 33 clinics (41%) to call for phone interviews.

Each of the 33 identified practices received a phone call and were asked if they would be willing to complete a brief phone survey as part of a treatment capacity evaluation. Survey questions were developed with the expectation that the individual answering the phone in a typical primary care practice could provide the requested information. The caller inquired about types of MOUD offered, whether the clinic was accepting new patients, if the clinic accepted Medicaid/HIP, and when the first available new patient intake appointment would be. The full script can be found in Appendix D. The survey took approximately 10 minutes to complete.

Results for Area of Inquiry 2: Access to Medications, Including Buprenorphine and Extended-Release Naltrexone, in Primary Care Settings

Of the 33 phone calls made to primary care offices, nine surveys were completed on the first attempt and one additional survey was completed after a voicemail was left and the call was returned. Of the remaining 23 practices called, the survey was not completed for a variety of reasons, including not answering the call and not returning voicemails.

When calling larger health systems to inquire about MOUD services in primary care offices, calls were directed to a central switchboard, where the caller then asked to be connected with a specific primary care clinic to conduct the survey, but when inquiring about buprenorphine treatment, the clinic would transfer the caller back to the central switchboard, which could not answer questions about treatment. This kind of transfer loop occurred when calling four different health systems, and in each case the survey could not be conducted with any of the primary care clinics.

Although the survey questions were created with the intention that the individual answering the phone would be able to provide the information, often the person who answered the phone transferred the caller to someone else—a nurse or behavioral health provider. In these cases, there was a prompt to leave a message and only one of these calls was returned. Telephone call results appear below, in Exhibit 8.

Of the 10 clinics that answered survey questions, three clinics reported that they did not offer either form of medication, so no additional questions were asked. Of the seven clinics that reported offering MOUD, four prescribed buprenorphine only and three prescribed buprenorphine and extended-release naltrexone. Five of the seven clinics said they were accepting new patients and had availability to schedule an intake appointment. The three clinics that reported prescribing both medications were the only offices that reported accepting Medicaid/HIP. Five of the seven clinics provided us with the out-of-pocket costs, which ranged from $75 to $200 per visit. Exhibit 9 shows clinic responses to acceptance of Medicaid/HIP and cost structures reported.

Exhibit 8. Attempted Calls Made to Primary Care Clinics (*n* = 33)
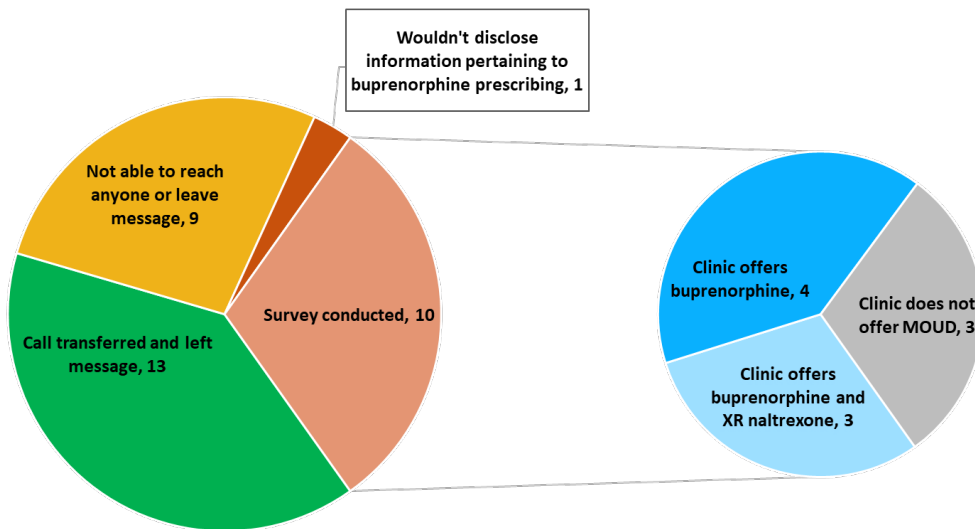
Note. XR = extended-release

Federal law limits the number of active clients to whom the DATA-waivered prescribers can prescribe buprenorphine at any given time. During the first year after obtaining the waiver, medical providers are limited to prescribing to no more than 30 clients at one time. Providers with certain board certifications or in qualified practice settings can have that limit increased to 100 clients in Year 1 and 275 clients in Year 2.[17] Because of these restrictions on the number of clients, clinics were also asked about the number of medical providers with a waiver to prescribe, as this gives a sense of the maximum capacity in that setting. Three clinics did not know how many medical providers prescribed buprenorphine, and among the remaining four clinics, the responses ranged from one to four providers. See Exhibit 9 for more information.

Exhibit 9. Primary Care Survey Responses

Clinic	Prescribe buprenorphine (Suboxone)	Prescribe XR naltrexone (Vivitrol)	Accepting new clients	Number of prescribers	Accept Medicaid/ HIP	Cost per visit (if not accepting insurance or for uninsured)
1	●	●	●*	"More than one"	●	NA (doesn't accept uninsured)
2	●	●	●	4	●	$75 per visit
3	●			2		$210 per visit
4	●		●	1		$250 initial, $200 per visit
5	●	●		2	●	$92 per visit
6	●		●	"At least one"		$150 per visit
7	●		●	"At least one"		Unsure

Note. XR = extended-release

* Clinic will initiate MOUD with someone who is an established primary care client.

Area of Inquiry 3. Barriers to and Facilitators of Access to OUD Treatment Services

To better understand the barriers to, facilitators of, and potential solutions to MOUD treatment access, we conducted in-depth interviews with service providers who commonly facilitated links to treatment for people with OUD. The service providers we interviewed worked for different agencies from those represented in the administrative interviews, mystery shopper calls, and primary care practices. Most service providers worked with specific populations (for example, people experiencing homelessness, pregnant women, or people leaving incarceration), and their responses to our questions may be somewhat specific to the special populations that they serve.

The rationale behind interviewing these service providers is that they frequently help individuals with OUD navigate the treatment system, and we hypothesized that they would have a good understanding of access and any possible barriers to MOUD. The Foundation and the advisory group helped identify service providers from a range of organizations and programs, including patient navigators working in emergency departments, individuals working in recovery homes, service providers offering post-incarceration service links, agencies offering services specifically for individuals experiencing homelessness, and individuals working in various aspects of the criminal justice system. The information collected during these interviews drew from a diverse group of service providers with varied experiences in helping clients navigate MOUD treatment services.

Methods for Area of Inquiry 3: Barriers to and Facilitators of Access to OUD Treatment Services

In total, we conducted 15 in-depth interviews, with 23 total participants (in some cases, more than one individual participated in an in-depth interview). The interviewees included peer recovery coaches/peer support specialists, social workers, social service referral coordinators, criminal justice teams, and mental health specialists. The Foundation and advisors to this project identified agencies that they felt would provide valuable information for understanding the treatment landscape in Marion County.

An experienced AIR qualitative interviewer conducted the in-person 60-minute interviews, using a formal interview guide. We ensured that our initial outreach and consent documents clearly stated that confidentiality of individuals and the organizations would be maintained. Interviews were audio-recorded and transcribed. Transcripts were coded using a qualitative software program.

Two qualitative analysts coded the transcripts to conduct content analysis. This process identified preliminary codes for performing a qualitative description of the themes discussed by service providers. After receiving feedback from the AIR team and reaching consensus on the codes, analysts applied codes to the transcripts in an iterative process of coding, analysis, review to achieve consistency in extracting, and cataloguing themes that emerged from the interview data. Content analysis focused on identifying overarching themes, as well as specific areas of similarities and differences among data sources. Analysts documented emerging themes and relationships among the codes in memos that were supported by pertinent quotes. The thematic memos were then analyzed separately and collectively. The interview guide is attached as Appendix E.

Any quotations used in this report have been deidentified. The numbers at the end of each quotation refer to the interview study number.

Results for Area of Inquiry 3: Barriers to and Facilitators of Access to OUD Treatment Services

Results are described under the following sections on the key themes that emerged from the analysis:

1. Overview of service needs

2. Barriers to OUD treatment access

3. Facilitators of OUD treatment services

4. Potential solutions suggested by service providers

After the overview, each section below has a text summary of major themes, followed by a table with illustrative quotes. A full list of quotes, by theme, including additional minor themes, can be found in Appendix F.

Overview of Service Needs—Available Services and Preferred Services

Service providers were asked about the types of OUD treatment and referral services offered by their organizations, as well as the services preferred by their clients. We assessed alignment between treatment availability and treatment service preferences to examine whether client needs were being met. In terms of treatment and service availability, most organizations interviewed offered referrals to treatment. Some organizations also offered behavioral health services, peer recovery support, and support for social services.

Many service providers reported that clients preferred and requested medication for OUD treatment, including buprenorphine and methadone. In addition to preferences for MOUD, some interviewees mentioned client requests for intensive outpatient treatment, inpatient

services, co-located services in residential homes, and rehabilitation services. Clients also showed interest in receiving services and support for housing and employment. Client preferences varied according to the client base of the organization where the service provider worked. For instance, service providers working for recovery housing noted client preferences for more housing support, and interviewees working in re-entry programs for clients with felony charges noted a greater client interest in employment services, recovery housing, and longer-term follow-up for OUD.

Barriers to OUD Treatment

Service providers were asked about the barriers to treatment and recovery services at the client level, as well as at the provider and system levels. We highlight these barriers in Exhibit 10 and further explain them in the section that follows.

Exhibit 10. Major Themes Among Barriers to OUD Treatment

A. Client-level barriers to OUD treatment

1. Lack of services for specific populations of clients: clients with dual diagnosis (mental illness and substance use disorder), people experiencing homelessness, and people with convictions
2. Lack of insurance and/or lack of documentation to get insurance
3. Social needs such as homelessness, lack of transportation, and unemployment that affect the ability to access MOUD

B. Provider-level and systemic barriers to OUD treatment

1. Stigma against MOUD
2. Care that is not client-centered:
   - Requirement for positive urine toxicology at time of admission
   - Impractical/unrealistic treatment schedules for clients
   - Lack of immediate capacity
3. Programming restrictions for eligibility based on grant and pilot funding
4. Lack of housing support
5. Insurance challenges related to authorization and billing
6. Inadequate reimbursement rates for OUD treatment providers

Client-Level Barriers to OUD Treatment

Service providers highlighted that barriers to accessing treatment are exacerbated for clients facing socially and financially challenging circumstances such as homelessness, unemployment, a co-occurring mental health diagnosis (especially in residential settings), or a criminal record. A frequent response to questions about needs for people with OUD pointed to broader socioeconomic challenges. Lack of stable housing prior to treatment, as well as lack of recovery and sober housing, were named as barriers to successful treatment.

Service providers had a variety of opinions related to insurance. Some felt that clients without insurance, as well as those unable to provide documentation to determine eligibility for insurance, had a difficult time accessing or maintaining MOUD treatment. Other service providers felt that "presumptive eligibility" for Medicaid was enough to get people into treatment. There was also a difference in capacity for people who had private insurance, compared with those with Medicaid.

Below is a list of key client-level barriers and illustrative quotes taken directly from interview transcripts.

Exhibit 11. Client-Level Barriers and Illustrative Quotes

Barriers	Illustrative quotes
Lack of services for specific populations of clients	*"If their mental health is out of our scope and we can't treat them here, there's really nowhere to send them to treat them for that. Like some of the things that we can't handle, like I said, eating disorders, schizophrenia, stuff like that, we just—that's out of our scope of practice. But when I'm trying to find somewhere to refer them to, there's nowhere. I give them referrals and we, we try to help them out, but I mean, a lot of the times there's just nowhere for them to go."* 0027_28 *". . . connecting them to kind of that mental health services, kind of health care in general, it's usually longer wait times to get them connected into. And they have a hard time navigating the systems. When they're here, we're here to assist them. We do some hand-holding to get them connected. But when they're out, we hear that, it's a barrier for them. . . ."* 0025
Lack of insurance or lack of documentation to get insurance	*"If they have insurance, typically we can get them in for Methadone treatment within a couple weeks. Within 2 weeks honestly, typically. But anything else, that's harder, Suboxone, Vivitrol, those are harder to get people into. There's only certain doctors that prescribe it. Their wait list is very long. Getting somebody in for medication, especially treatment for mental health, or addiction is hard."* 0024 *"We have no way to verify if they have insurance or not. . . . Sometimes a day or so waiting, and then by the time the piece we do hear is the initial application that they would do, and so then that's submitted and can take 30 days to get approved, and then they have 30 days to start turning in the other documents. . . . And if you're denied, you have to go through the appeal process. And we can get them an ID while they're here, but then to get an ID, then they got to go get a social security card, and those both take mailing addresses, which is a big barrier as far as just not having a stable mailing address."* 0025
Social needs such as homelessness, lack of transportation, and unemployment that affect the ability to access OUD treatment	*"[T]here's so many, in addition to the actual addiction, the social barriers surrounding that, whether it's transportation or insurance or you know, an underlying mental illness."* 0031 *"And a lot of my people are homeless. And they're really asking for a safe place. 'You know, I wouldn't be using if I wasn't staying on so-and-so's couch.'"* 0021

Provider-Level and Systemic Barriers to OUD Treatment

Service providers described the way certain organizational policies and processes of delivering care can impede access to MOUD treatment. For instance, some treatment providers that provide counseling services may not accept clients who are on MOUD. Moreover, access to certain treatment providers may be difficult if clients are unable to show "proof" that they need treatment, specifically in the form of urine toxicology being positive for opioids at the time of entry into treatment. In addition, service providers described difficulty in finding treatment for clients that ensures holistic care that addresses physical and emotional needs during withdrawal and MOUD treatment.

Interviewees noted that systemic difficulties arise as a result of insurance policies or procedures. For example, insurance denials, pre-authorizations, and co-pays and other out-of-pocket costs, even with insurance, all contribute to difficulties in accessing care and maintaining recovery. In addition, reimbursement rates to clinicians are low, which contributes to a shortage of providers willing to work in the field.

Below, in Exhibit 12, is a list of key provider- and system-level barriers with illustrative quotes. A full list of quotes, by theme, including additional minor themes, can be found in Appendix F.

Exhibit 12. Provider-Level and Systemic Barriers and Illustrative Quotes

Barriers	Illustrative quotes
Stigma against MOUD	*"I don't think a lot of other places accept clients that are doing the MAT treatments like Suboxone. . . . That's kind of got a bad rap. So a lot of people don't accept people on Suboxone. I know Methadone's a really, like, nobody really wants to accept anybody on Methadone, Vivitrol, you know." 0027_28*
Care that is not client-centered: requirement for positive urine toxicology at time of admission	*"They're like, 'I want to go now, I'm ready to go now.' You have to be like, 'I'm sorry I can't take you now.' Which [name of treatment provider] even, I think, [clients] have to have used within 72 hours. So if it's been over 72 hours and they have no money . . . where are you going to go?" 0021*
Care that is not client-centered: impractical treatment schedules	*"Sometimes the ask is really big for our clients, and I don't think we always recognize how big that is. 'You don't have a job, you don't have a house, you don't have a lot of supports in your life, but come to my clinic every day . . .' you know, like, even in this clinic, it's an intensive level of care. Eighty-five percent of our clients are dually diagnosed, so they've got some kind of mental health issue and an addiction issue, lots of trauma. Even in this clinic we're saying, 'We need you to be here three days a week because that's what you need.' Sometimes I don't think we appreciate enough what it takes to actually follow through and get here." 0030*

Barriers	Illustrative quotes
Care that is not client-centered: lack of immediate capacity	*"There's not enough beds. It's horrible to have to explain that to a patient you're going to have to call every four hours and find out if somebody left. There's nowhere, you know, and then we have the other issue, too, where we have patients who come in who maybe used three or four hours ago and they're not in active withdrawal. They want help, they don't want to be sick, they're going to go into active withdrawal, and they want help. Nobody will take them. There's nowhere for them to go at all. You got to go home and get sick and come back. Rarely do we see those patients again until they overdose the next time." 0022*
	"Sometimes our systems set up barriers because I think they want people to be more motivated than where people are at on the spectrum of usage, which is challenging. So they say, 'Oh well, you can't come back for 30 days,' or 'you can't come back for six months.' That's frustrating on the provider side, on the service side, because if they were there two weeks ago, they're ready now. So can we have a resource to be able to get them in right now? Sometimes we're not able to do that, so that's frustrating." 0021
Programming restrictions for eligibility based on grant and pilot funding	*"Also, lots of the money that is coming to us to provide treatment is through these pilot programs or grants, and it's never a sustainable pot of money. There's always different hoops that you have to jump through to access the money and then different assessments and tools and things that they require for you to draw down the money." 0030*
Lack of housing support	*"I would say, for housing is the biggest part because, once they're connected to insurance, they can get treatment through IOP [intensive outpatient program] or whatever, usually through Medicaid, and that's kind of the way the state's making everybody go to. But the housing piece is the hardest part that some of these smaller recovery homes that people are doing good and start programs that take people that are self-pay basically just to try to pay back the mortgage on it. The housing piece, that's where there's not really a lot of funding. . . ." 0025*
Insurance challenges related to authorization and billing	*"Sometimes they can't get started right away because the treatment providers are waiting on insurance to give the go-ahead and things like that. And so now you have another delay of a week or waiting two for prior authorizations and things of that nature." 0033*
	"For our population, sometimes staying on their health insurance benefits has been a bit of a challenge, so we will sign them up while they're in here, but that isn't always ready to go and be billable by the time they leave, so it is something that has to be continuously followed up on. . . ." 0025
Inadequate reimbursement rates for OUD treatment providers	*"Reimbursement rates are really bad for treatment, and so a lot of programs need to make a decision on, 'Am I going to provide this service because there's no profit margin and I can't pay my staff and I can't find staff and I can't pay them what they want and what they deserve because the profit margin is just not there. We're going to opt out on providing this service' or 'We're going to contract with somebody or we're going to refer somebody to another program that does it.'" 0030*

Facilitators of OUD Treatment Services

The analysis revealed seven types of facilitators of OUD treatment access that emerged through service providers' descriptions of their roles and the services they provided. Several of these facilitators had subthemes, as well. Examples of all themes and subthemes appear in Appendix F. Exhibit 13 describes the different facilitators and details are provided in the following section.

Exhibit 13. Facilitators of OUD Treatment Services

1. **Comprehensive, client-centered approach to OUD treatment**   • Tailored treatment approach   • Strong relationship with the client   • Close follow-up and monitoring   • Empowering clients through education and employment
2. **Partnerships and affiliations**   • Relationships among different treatment provider entities: health care systems, recovery housing, community resources, re-entry programs
3. **Easy access to services**   • Easy scheduling and appointments   • Provider networks   • Transportation   • Co-location of services
4. **Insurance**

Overall, service providers described facilitators as being systemic, holistic, respectful, and feasible for clients. The providers recognized the importance of comprehensive service provision that covered behavioral health, housing, employment, and other social needs. In some cases, service providers identified OUD treatment services that would be a good fit for clients and were prepared to follow clients long term. Service providers described approaching their clients with respect and taking time to get to know everything about the clients to build close and trusted relationships with them. Providers also relied on their own relationships with other organizations or service providers to access trusted services and provide referrals.

Exhibit 14. Facilitators of OUD Treatment and Illustrative Quotes

Facilitators	Illustrative quotes
Comprehensive, client-centered approach to OUD treatment	*"We work with a recovery wellness plan, and we help people to break their life up into smaller pieces. And first of all, 'How do you want to be connected to this recovery community that exists here in Indianapolis, in Indiana? What do you want to do to better your health? What do you want to do about your employment? About schooling? What do you want to do about your family? What do you want to do about your spiritual life? Your emotional life?' We want to break that up into small pieces so it doesn't seem so overwhelming for a person."* 0020 *"They may not be able to meet the demands physically or whatever that program is. I'm kind of working to just break down all those barriers. We do a little bit of follow up; a lot of our clients will call back. Even maybe after they've transitioned on, they may still need help with the barrier or something. Some people still kind of work with them over the phone or outside. We stop by a lot of the recovery facilities and just check on clients from time to time, see how they're doing if they're still in treatment."* 0024
Partnerships and affiliations	*"And that's actually really fortunate because the community is so large. We can refer people to stuff right near them. So that would just. . . . Through working with people and through referring them, you end up making a lot of contacts. So I don't know necessarily the regimented processes for everything, but I always know a person at this agency. So I'll call and say, 'Hey, what does this person need to do to get in?' And we'll get them referred that way."* 0019
Easy access to services	*"Let's figure out what kind of placement options you're looking at, what side of town you're going to be on. Let's connect you to that MAT provider, and not one across town so you're driving or trying to catch a bus from [one end of town to the other]."* 0025 *"Giving a person a fighting chance in that moment of clarity, trust me, one that's using, there's a moment of clarity that says, 'I don't want to do this anymore. I want to change my life.' And I believe that it's incumbent on us that are providing that treatment and providing those services to really capitalize on that moment, because it goes away very quickly."* 0020
Insurance	*"If someone's pregnant, getting them treatment does not seem to be a problem. . . . Mainly because they get insurance immediately, there's the presumptive eligibility. They get treatment right then and there, anywhere they walk into."* 0024

Gaps and Potential Solutions in OUD Treatment Service Delivery, as Described by Service Providers

We asked service providers about gaps in and potential solutions for increasing access to MOUD. They described gaps in MOUD treatment service delivery, mentioned social determinants that must be managed while treating clients for OUD, and proposed ways to provide clients with comprehensive care.

Service providers spoke to us about the need for streamlined, easy-to-navigate treatment and recovery support. When clients do not have a consistent advocate, they are likely to miss appointments, overlook opportunities for recovery, and relapse. Connecting treatment and

recovery support and/or providing comprehensive care are two ways in which recovery programming in Marion County may become more effective.

Based on findings from interviews conducted for this area of inquiry, it seems that many clients seeking MOUD in Marion County are in need of recovery supports such as housing and employment. It is a challenge for those in OUD treatment to find safe, affordable, recovery-supportive housing in Marion County. Several service providers identified housing as a gap and suggested that increased access to permanent, affordable housing in Marion County would improve OUD treatment outcomes.

Exhibit 15. Potential Solutions Identified by Service Providers

Potential solutions	Illustrative quotes
Streamline and improve navigability of treatment.	*"If we connected our treatment and recovery support and they worked together hand in hand, then we could probably do outpatient really well and see some greater successes. So that's probably my greatest concern with outpatient services. There are plenty of outpatient programs, plenty. It's not that we have . . . lack of them." 0020*
Improve the timeliness, standards, and processes of MOUD outpatient treatment.	*"You've got to get them in quickly, you got to provide them with services quickly, you got to engage them or they're going to leave. . . . If I get a call Sunday morning at 10 a.m., I need to be able to find a way to get that client into care because, by Monday morning at 9 a.m., that client may not be ready for treatment anymore for a lot of great reasons, a lot of understandable reasons. Quick access to care is critically important." 0030*
Improve comprehensiveness and continuity of care.	*"Moving forward, our plan is to offer that comprehensive whole health, every aspect, because everything's interconnected. If they've got pain in their back, that's before they would just go out and use. How do we address that now without even maybe medication? So moving forward . . . our plan is to offer more services than they have been getting and having it offered here in house. And if it's not here on-site, being able to just streamline that." 0032* *"More compassionate doctors. More educated doctors on addiction. Recovery coaches. Fill in the gaps in services because they're released from treatment and that's why I get with them. . . . They're released from detox and they just let them go without making any plans or getting them to think forward, 'Okay, now what are you going to do? You should go into transitional housing,' duh, duh, duh. They just let them go, and they're going to do what they always do. That's a hard question. Continuum of care." 0022_23*
Increase opportunities for safe, affordable recovery housing and stable employment.	*"I wish there was something more accessible, safe, affordable, supportive, for people who need stable housing. Even if it's a dorm setting. Even if it's a group setting. That's fine. They don't need their own apartment right at first. They can live in a recovery-based place. But those are hard to come by covered by the Recovery Works dollars or by insurance." 0019*
Provide education on MOUD for staff.	*"I think that some more education, too, about MAT because there's a lot of people, a lot of recovery homes, a lot of people within recovery that are really against it. 'If you're on this, you're not really sober, you're not really clean.' Well, this person is taking medication that's prescribed by a doctor that's being monitored by a doctor that's keeping them from [committing crimes]." 0022_23*

Service providers also had suggestions for aiding specific populations, including clients coming from the criminal justice system, those with co-occurring mental health and substance use disorders, and clients who are experiencing homelessness. All are in need of trauma-informed care and safe and affordable housing. In addition, these clients may lack insurance, employment, and transportation, and this negatively affects their ability to engage in treatment services and maintain recovery.

By conducting these in-depth interviews, we observe a nuanced picture of treatment capacity in Marion County. According to our sample, MOUD and some ancillary services (peer counseling, social supports) seem to be available in Marion County. However, the timeliness and accessibility of services may not match client needs. Access to MOUD is complicated by barriers that include a complex health care system and insurance requirements, lack of transportation, and unstable housing, which are at odds with the time-sensitive needs of clients with OUD and their motivation to seek treatment.

Summary of Findings

Overall, this study found that, while MOUD treatment and associated services were available in Marion County, accessing them could be confusing and complicated. For example, identifying a treatment provider could be challenging, as online information about services offered often conflicted with what treatment organizations shared on the phone when a potential client or family member called. In addition, the process for accessing services once a provider had been identified could be a challenge, with restrictive availability, locations, and intake procedures. Further, barriers were identified as related to maintaining treatment because of lack of transportation, lack of stable recovery housing, and conflicts between treatment hours and work schedules. Finally, lack of insurance repeatedly came up as an initial barrier that could delay care, particularly for individuals without ability to pay. In short, identifying a provider, and accessing and maintaining treatment services, could be difficult to navigate. The process as a whole was typically not client-centered.

- **The systems for MOUD treatment are difficult to navigate.** People trying to find MOUD are subject to conflicting and difficult-to-find information. For instance, there were many discrepancies between administrative interviews and mystery shopper calls conducted at the same organizations, ranging from differences in wait times for intake appointments to discrepancies in which MOUD treatments were available. Similarly, while some organizations' administrators reported offering MOUD, some of the mystery shopper calls found that the medications were only offered as part of medically managed withdrawal, or detox, as opposed to long-term use, which is the current evidence-based recommendation. In-depth interviews with service providers who help people navigate the treatment system

found that they often rely on their personal and institutional relationships, rather than more formal processes, in linking their clients to services, indicating that the system might be hard for individuals without knowledge or established relationships to navigate on their own.

- **MOUD treatment is generally available within a few days of request, but it is not consistently available when someone is ready for it.** Findings related to several of the activities that we undertook indicated various ways in which treatment was difficult for people to access. During in-depth interviews, several service providers discussed the need to "strike while the iron is hot." That is, there was a desire to link clients to treatment as soon as they voiced interest in such services, but the providers were not always able to get people into treatment in a timely fashion. During the administrative interviews, mystery shopper calls, and primary care calls, it became clear that intake for initiating treatment was available during limited hours at many organizations. In addition, some organizations had specific and potentially difficult intake procedures. For example, three of the 12 organizations we called as a mystery shopper said that clients would need to call at 5 a.m. (one organization) or 6 a.m. (two organizations) to get appointments. Finally, multiple organizations reported a multistep process before a client could initiate MOUD. Restricted hours and difficult intake procedures may limit treatment initiation.

- **Cost remains a barrier for individuals who have never been enrolled in Medicaid/HIP or those who are waiting for Medicaid/HIP to be reinstated.** All administrators we interviewed or organizations that received mystery shopper calls reported that they accepted Medicaid/HIP. Similarly, in-depth interviewees reported that MOUD services were generally available to individuals with Medicaid/HIP. However, if someone was Medicaid-eligible without being enrolled, organizations differed in their ability to provide care before enrollment was complete. Many organizations reported fee structures for individuals without insurance, and these fees were cost-prohibitive for many individuals. Finally, in-depth interviews found that private insurance was highly variable in terms of coverage of various services and co-pay structures, which could serve as barriers to receiving services.

- **There is limited MOUD access in primary care settings.** Buprenorphine and extended-release naltrexone can be prescribed in primary care settings, and people may prefer primary care settings for receiving such services. This may be for a variety of reasons, including a more holistic treatment model (ability to receive primary care services in the same setting) and because of the lack of stigma in visiting a primary care office. We identified and called 33 clinics listed as offering buprenorphine treatment through the Substance Abuse and Mental Health Administration (SAMHSA) Substance Use Treatment Locator, although we found that most of the sites were not able to answer our questions and/or calls were directed and redirected with no resolution. In the end, only seven of the

33 (21%) primary care practices we attempted to reach reported offering buprenorphine, with three of the seven also offering extended-release naltrexone.

- **Treatment and recovery support services need strengthening.** During in-depth interviews, service providers described barriers to treatment initiation and sustained recovery, including lack of sober housing/recovery homes, clients' difficulty obtaining or maintaining employment because of treatment requirements, and lack of transportation to and from the treatment providers. One interviewee felt that clients engaging in intensive outpatient treatment several days a week might have difficulty finding and keeping a job that allowed them to attend treatment at that frequency.

- **People with co-occurring mental health conditions and OUD lack recovery support options.** Some service providers explained during the in-depth interviews that having a co-occurring mental health diagnosis often prevented clients from entering recovery housing. Specifically, some recovery homes did not accept individuals with specific mental health diagnoses such as schizophrenia.

- **Stigma against MOUD exists among many treatment and recovery service providers.** In-depth interviews found that some treatment providers did not offer MOUD or did not allow people using MOUD to receive counseling or other services in their agencies. These organizations are often referred to as "abstinence-based." Service providers described stigma against MOUD as having improved somewhat in recent years, although this stigma was still present in some places. These providers reported that this stigma could have a negative impact on the clients trying to obtain services while taking MOUD.

Limitations

There are several limitations to this study. First, we did not speak with all MOUD treatment providers, primary care practices that offered buprenorphine and extended-release naltrexone, or service providers who help clients with OUD navigate treatment services in Marion County. However, in each case AIR worked closely with the Foundation and the project advisors to identify providers with higher volumes of patients being treated with MOUD.

Second, when assessing availability of MOUD services in licensed substance use disorder treatment organizations (Area of Inquiry 1), we were not able to contact all 12 organizations with the mystery shopper calls or the administrative interviews, and this limited our ability to make comparisons within sites. However, the eight sites for which we could make comparisons included many of the larger treatment organizations within Marion County.

A third limitation of the study is that we did not speak directly with individuals or family members who have tried to access MOUD in Marion County. The mystery shopper calls were used to emulate what an individual or family member might experience, although they might

not be representative of typical experiences in accessing services since the caller had background information on what they were looking for and a script to follow with regard to the questions to ask. In addition, it is possible that the mystery shopper calls, made at one point in time, were not representative of the average service availability of an organization. For example, it is possible that access to treatment is more or less available than on the day we called.

A fourth limitation is that the SAMHSA Substance Use Treatment Locator list used to identify primary care settings that offer MOUD (Area of Inquiry 2) is known to be incomplete. As we described above, upon obtaining a DATA waiver, providers must "opt in" to be listed on the SAMHSA Substance Use Treatment Locator website. Therefore, this list only includes providers who obtained a DATA waiver and have agreed to be listed. However, this list was the most comprehensive resource available. Unfortunately, there is no available listing of primary care providers who are willing to prescribe and administer extended-release naltrexone, so the same list was used to assess access to this medication in primary care settings.

A final limitation is that the service providers we interviewed (Area of Inquiry 3) might not have been representative of all service providers assisting people seeking MOUD in Marion County. Some service providers we interviewed work with specific populations (for example, pregnant women, people experiencing homelessness, or people who have been incarcerated), and their responses to our questions might have been more specific to the populations that they serve. However, there were some emergent themes across interviews, and we have tried to reflect that in our analysis.

Recommendations

On the basis of the findings described above, we developed the following recommendations for next steps in improving MOUD access and continued treatment in Marion County, Indiana:

- **Develop a centralized substance use disorder intake and assessment process for Marion County.** While this report focuses on MOUD access, a centralized substance use disorder intake and assessment process will need to include information about treatment options for all substance use disorders, as many people with OUD also use other substances, and many treatment providers offer multiple levels of care and treatment services. This service could provide a basic assessment over the phone or on the Internet to help identify appropriate level of care, provide information on all types of medication and treatment services, and maintain a central repository of all treatment programs and related information (insurances accepted, days of operation, intake processes). Such a service could also receive daily updates on availability at each treatment program and be able to link individuals to the desired service and geographic location with the shortest possible wait time. A service like

this would also allow Marion County stakeholders to understand which services are in highest demand and provide a real-time picture of access and wait times.

- **Provide more flexible treatment access.** This could include expanded hours and days of operation for both intake assessments and ongoing clinical services. Expanded hours would reduce barriers to initiating treatment and allow people to remain engaged in treatment while still meeting work and family demands. Similarly, treatment access could be improved through increased outreach efforts and provision of MOUD in settings where people with OUD may be found (e.g., homeless shelters, harm reduction agencies, syringe service programs, emergency departments, inpatient hospital units, correctional facilities, and post-incarceration re-entry programs).

- **Reduce barriers to initiating MOUD.** It is important for individuals seeking methadone or buprenorphine to be able to start medication as soon as possible to reduce risk of loss to care and opioid-related overdose. Ideally, clients should be able to receive methadone or buprenorphine on the first visit. (Use of extended-release naltrexone does require a client to first go through medically managed withdrawal and have a 7-day wait period before medication can be initiated.) When discussed in the context of buprenorphine, this approach is sometimes referred to as a "medication first" model of care. [9,10] Clients interested in MOUD should be offered counseling, but counseling engagement should not be a requirement to start or maintain MOUD.[4]

- **Increase capacity for MOUD in primary care settings.** Settings such as Federally Qualified Health Centers, which accept Medicaid and are able to provide low-cost services to uninsured individuals are well positioned to fill this gap in care. A variety of training models—ranging from in-person trainings and technical assistance to web-based educational training and mentoring—have been implemented nationally to support treatment expansion.[11,12,13] As capacity for MOUD in primary care settings increases, it will be critical to ensure that publicly available treatment lists (such as the Indiana treatment finder, INconnect) include information about how to identify primary care providers offering these services.

- **Train call-center, front-desk, and other front-line staff in services for MOUD.** It is critical for individuals answering calls to be knowledgeable about what services are offered and available, and the process for initiating care. This particularly relates to larger health systems that use centralized call centers.

- **Identify solutions to address transportation challenges.** Models to address transportation barriers to getting to and from treatment could include increasing transportation funds that support ride sharing (e.g., Uber or Lyft) or other transit.

- **Increase capacity of recovery home/sober living services, specifically for people on MOUD and with co-occurring mental illness.** Recovery home services are not considered treatment and therefore are not reimbursable through Medicaid. Individuals using MOUD can face additional challenges because many recovery homes do not allow individuals on MOUD to stay there. Similarly, individuals with certain mental health diagnoses (e.g., schizophrenia) may not be accepted into recovery homes. Access to low-cost (or no-cost) recovery housing is a critical component, especially early in recovery, for many individuals with unstable housing situations. Further, recovery housing needs to be accessible to individuals with co-occurring mental illness. A lack of access to affordable long-term housing, while likely a larger systemic issue, was repeatedly identified as a barrier to long-term recovery.

- **Address stigma against MOUD among abstinence-based treatment providers and the recovery community more broadly.** Since MOUD is recognized as first-line treatment that reduces morbidity and mortality, it is crucial that all treatment providers understand the evidence base and work with clients who choose to use medication as part of their recovery path. If providers are not able to offer MOUD because of staffing, licensing, or other financial challenges, they should, at a minimum, counsel patients on available MOUD and the evidence behind this treatment while supporting linkage to programs that offer it. Education and tailored technical assistance could be provided to treatment agencies, ideally including individuals who use MOUD and are in recovery to share their personal experiences with medication.

- **Convene a multisectoral meeting of service providers, mental health providers, local government, employers, and funders to problem-solve and identify funds to support specific gaps in services.** Many service providers reported relying on their relationships with others to link their clients to services, while potential barriers and solutions were systemic and multisectoral in nature. These relationships and Marion County's size represent an opportunity to bring together many key players for a focused discussion on systemic barriers including transportation, employment opportunities, and recovery home access.

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Appendices

Appendix A. Advisors

Justin Phillips, MA—Licensed clinical addictions counselor and experienced public health professional who founded Overdose Lifeline, which designs and implements programs to reduce opioid use deaths from OUD

Bradley Ray, PhD—Director of Center for Behavioral Health and Justice at Wayne State University, with prior experience on opioid-related challenges and solutions in Marion County

Ross Silverman, JD, MPH—Attorney and health policy expert at Indiana University, with experience leading work on overdose fatality reviews in Indiana

Dennis Watson, PhD, MA, MS—Associate director for community engagement at the Center for Dissemination and Implementation Science within the College of Medicine at the University of Illinois at Chicago, with prior experience on opioid-related challenges and solutions in Marion County as well as other regions of the country

Appendix B. Licensed Treatment Provider Administrative Interview Guide

Setting: These are organizations that responded to the Community Solutions survey "How does this facility treat opioid addiction?" We will only call the organizations that responded with one of these:

This facility accepts clients who are on methadone, buprenorphine, and/or naltrexone (Vivitrol) maintenance or treatment, but these medications originate from or are prescribed by another entity. (The medications may or may not be stored/delivered/monitored on-site.)

This facility administers and/or dispenses methadone, buprenorphine, and/or naltrexone (Vivitrol) as a federally certified Opioid Treatment Program (OTP). A DATA 2000–waivered physician may or may not also be on-site. (While most OTPs use methadone, some only use buprenorphine.)

This facility prescribes and/or administers buprenorphine and/or naltrexone (Vivitrol). This facility is NOT a federally certified Opioid Treatment Program (OTP). Buprenorphine is authorized through a DATA 2000–waivered physician.

Procedure

These questions will be asked by telephone. **We aim for this to be quite short**.

Good morning.

My name is [caller name], and I am calling from the American Institutes for Research. I am calling you about the Community Solutions survey that your facility completed in 2017.

The American Institutes for Research has partnered with the Richard M. Fairbanks Foundation to conduct brief, follow-up surveys to further understand the services available to those seeking opioid use disorder treatment in Marion County.

1. What levels of care does your facility offer?

    a. Level 1 = outpatient

    b. Level 2 = intensive outpatient

    c. Level 3 = residential

    d. Recovery home

    e. OTP (opioid treatment program)

    f. Other: (list here)

2. Is your facility licensed to provide treatment for mental illness (sometimes called dual diagnosis program)?

   a. Yes

   b. No

   c. Unsure

3. Does your facility either prescribe or dispense medication(s) for treatment of opioid use disorder? (examples would be methadone, suboxone or vivitrol) Y/N

   a. IF YES, go to Q4.

   b. IF NO, go to Q5.

4. IF YES,

   a. **Which medication**(s) does your facility offer for treatment of OUD? (ask about all 3 here):

      i. Methadone:

      ii. Suboxone/buprenorphine (also called Suboxone, Subutex, Sublocade, Probuphine, Zubsolv)

      iii. Vivitrol/naltrexone injection:

   b. **Are these just offered for detox?** (Note- if they say they only offer medication for detox, please clarify whether they offer these medications on an ongoing basis ("maintenance"). If they say "no" then the answer is "no" for buprenorphine or methadone. If they offer detox and then naltrexone on an ongoing basis, then it would "count" for naltrexone. In this circumstance, ask if they do the 2nd and 3rd injections or if they refer to other locations for that.

   c. Is there a **limit on how long your program will continue to prescribe/dispense** the medication to a patient?

   d. **Can patients get medications at all levels of care?** [If NO] At which level of care can patients get medications?

5. IF NO,

   a. Will your organization still offer treatment services to people who are on medication obtained elsewhere? (Note: Document if only certain medications are "allowed.")

   b. Does your facility refer patients to other providers who do offer these medications? (clarify whether in addition to the services you offer or instead of the services you offer)

For ALL:

6. Do you accept patients with Medicaid/HIP?

    a. Are there fees someone with Medicaid would pay?
    (Note: Ask this for all levels of care.)

    b. Are there limits on the number of patients you will accept with Medicaid/HIP? If so, how many will you accept?

        i. Similarly, do you accept patients without insurance who have limited means to pay?

            (a) Are there fees someone without insurance and limited means would pay? (Note: Ask this for all levels of care.)

            (b) Are there limits on the number of patients you will accept with Medicaid/HIP? If so, how many will you accept?

7. How is intake regulated/prioritized?

8. Hypothetically, if a patient with Medicaid/HIP called in today, when would be the soonest that they could get their intake visit for medication assisted treatment?

9. Hypothetically, if a patient without insurance called in today, when would be the soonest that they could get their intake visit for medication assisted treatment?

That was my last question. Thank you so much for your time! Do you have any questions or additional thoughts that you would like to share?

Again, we thank you so much for your time. Have a great day.

Appendix C. Mystery Shopper Survey Protocol

SCRIPT

The caller will simulate a woman calling on behalf of her 28-year-old brother, who is injecting heroin daily.

Hi, I'm calling because my brother is having some problems with drugs and I'm trying to find him some help. He lives at home with my parents. He's been using heroin for a while, and I'm very worried about him. We've talked a lot and he doesn't know how to get help so I thought I would call around to see what I can find for him.

1. Am I at the right place? Do you treat heroin addiction?

2. What kinds of treatment do you offer?

   (Record the type of treatment. If treatment includes medication, ask which medicine is offered. Record the response.)

3. He might not have insurance right now, but I think he can get HIP. What do you do if he doesn't have insurance? If he has HIP, can he get in?

   (If yes, continue to Q6. If no, continue to Q4.)

4. Can we pay out of pocket?

   (If yes, continue to Q5.)

5. How much does it cost?

   (Record the answer, and charges for each type of treatment per visits.)

6. Are you accepting new patients?

   (If yes, continue to Q7. If no, end call.)

7. How soon can he come in for an appointment?

   (If they say they have same-day appointments but need to call back the next morning or if no appointment is available, continue to Q8.)

   (If the wait is longer than 24 hours, say, "He really needs help now. Why does it take so long to get an appointment?" and go to Q8.)

(If there is an appointment available, record the date for the soonest available appointment with any provider at the location. Continue to Q9.)

8. Can he get on a waiting list?

    (Record answer and go to Q9.)

9. I know some people who got something called Suboxone and that helped them. Will he get that medicine on the day of the appointment?

    (If yes, record the response. Go to next section. If no, ask when he will get Suboxone. Record the date.)

10. "I really appreciate all this information. Is there anything else I should know or be thinking about that I didn't ask?"

    a. Oh, I meant to ask, do you offer transportation?

    (End call.) Great. Thanks so much for your time. I'll check with my brother to make sure we can get him there and we will call back together to confirm the appointment.

Appendix D. Primary Care Survey Protocol

SURVEY GUIDE

Introduction:

"Hi, I am calling from the American Institutes for Research. As part of an evaluation funded by the Richard M. Fairbanks Foundation, we are trying to find out about buprenorphine treatment availability in Marion County. Would you be willing to answer a few questions? The questions should not take more than 5 minutes to answer."

If the person is unavailable to take part at the time, ask about an alternative time to schedule the conversation. Make sure the practice is eligible by noting if they currently offer buprenorphine treatment, before rescheduling.

Survey questions:

1. Does your office/practice currently prescribe buprenorphine (Suboxone) to treat opioid use disorder (OUD)? (If yes, go to Q2. If no, end call.)

2. Can you tell me how many medical providers at your practice are able to prescribe buprenorphine?

3. Are you accepting new patients with OUD for buprenorphine treatment?

    a. If no: Can you tell me why new patients are not being accepted? Is there a waiting list?

    b. If yes: When is the next available appointment for a new patient who needs buprenorphine treatment?

4. Do you also offer naltrexone (Vivitrol) injection for opioid use disorder treatment?

5. Do you accept HIP?

6. Do you accept patients who don't have insurance? What is the cost of each visit for self-pay patients?

Appendix E. In-Depth Interviews With Service Providers Guide

Objectives

- Identify barriers that people seeking OUD treatment services may face in accessing treatment, using information obtained from key informant interviews with OUD treatment referral providers such as peer recovery coaches/specialists, social workers, and/or referral coordinators working for social service agencies, criminal justice teams, or health providers.

- Identify any gaps/discrepancies between the services that are available and the needs/preferences of the people seeking services.

Interview Questions

Section 1: Background

The purpose of this section is to gather information about the role of the interviewee, the population that requests services, and the referral process. The questions will also set the stage for Section 2.

Interviewer: I first want to know a little more about your organization and the work that you do related to opioid use disorder treatment. I would like to discuss who you serve and how these individuals receive the care that they need in your community, including the referral process.

[Role and Organization]

1. Can you begin by telling me about the organization/facility you work for?

   - *Probe: What types of services does your organization offer?*

2. Can you describe your work and how long you have been in this role?

   - *Probe: What is your job title? How long have you worked in this field, even if in a different role?*

[Information about people requesting referrals]

1. Tell me about the referral or treatment entry process, and where you/your organization fits in with that process.

   - *Probe: How do people find out about you/your organization? How do they typically contact you (e.g., in person, by telephone)?*

2. Tell me about the people who contact you/your organization?

   • *Probe: Are the people who call primarily patients, or family members, or representatives of other organizations? Can you give a rough estimate of the different people who call— who are the majority of your callers? Do you get calls from other providers seeking OUD treatment for their patients, such as primary care providers or mental health providers?*

3. Can you describe the people who request the services?

   • *Probe: Are people asking for services for specific age groups, young adults, older adults, pregnant women, people who are justice-involved? Do you know what part of the county/state people are usually coming from?*

4. On average, how many different referral requests does your facility receive in a day? (If they say less than one a day can ask average in a week?)

[Referral process]

1. Can you walk us through what happens when you receive a request for opioid addiction treatment? (Alternate question: Can you describe the process and procedures you follow when you receive an inquiry for opioid treatment services?)

   • *Probe: Do most people calling already know what kind of service (level of care or type of medication) they are looking for? Do you have to share information with them about the different types of treatment?*

   • *Probe: Do they ask for services directly related to getting treatment- transportation, insurance/HIP sign up. In addition to OUD treatment services, what other information do you provide over the call? What resources do you use to locate services for the callers? Where does this information come from? How regularly is this updated?*

2. What kinds of information about the treatment services do you provide?

   • *Probe: Do you provide the name and contact information of the service? What percent of the time do you actually call the provider and make the appointment for the patient for an intake appointment? Do you collect any information about the people requesting treatment services?*

Section 2. Gaps in Care

The purpose of this section is to collect information that will help us assess any gap between patients' needs and available services. In this section we will ask about the specific services that people request, the preferences of people asking for services, and the perceptions of the interviewee regarding: the reasons behind people's preferences for specific services, perceptions of the interviewee regarding gaps in care and barriers that exist to accessing care.

Interviewer: Thank you so much for sharing this information. I want to ask you more about the different types of services that are requested, available, or accessible in your community.

[Types of OUD services]

1. In your experience, what are the services that are in high demand/most preferred by the people who are looking for OUD treatment?

   - *Probe: What services do people most often ask for? (Do they ask for a specific level of care [residential, outpatient, etc.]). Do they ask for specific medications (e.g., methadone, suboxone/buprenorphine or naltrexone/vivitrol)? Do they ask for programs for "special populations"- adolescents, pregnant women, etc.?*

2. Can you tell us about the programs that you typically refer people to?

   - *Probe: Can you tell us why you refer people to these programs? (Look for if the person mentions objective reasons—information about these programs, cost/accepts insurance, or subjective reasons—he/she feels or has heard good things about these programs. Observe if referrals are to MAT, vs abstinence-only type of programs)*

[Demand for OUD treatment services]

1. To what extent are the services that are in high demand/most preferred available in your community?

   - *Probe: Why? In your experience, why are these services not available? (Probe for mention of resources, staffing)*

2. What do you think are the reasons for that (XX service) being in high demand?

   - *Probe: Do you think people like that service more? Do you think people don't know much about other services? Do you think people think that (XX service) is better?*

3. Which medications for OUD treatment (methadone, suboxone or vivitrol) are most commonly requested?

   - *Probe: Approximately how many (most/few/ two-thirds etc.) people seeking OUD treatment want/are interested in: Methadone, Buprenorphine, Naltrexone.*

   - What could be the reasons for people's preferences for this (XX MAT medication)?

[Availability of OUD Treatment services]

1. To what extent are the services that exist in the community readily accessible to people who contact you for information/referral services?

   - *Probe: Is it easy for people to go to those services? Why or why not? Probe on the potential barriers for access despite availability.*

- *Why do you think certain services are harder to find? Are there other factors that may affect accessibility such as time of year, location of facility, requirements for intake, etc.?*

Section 3. Barriers to meeting the care needs/preferences of people seeking treatment and perceived solutions

The purpose of this section is to identify the specific problems that can contribute to gaps in care noted or discussed in the previous sections. Questions will assess barriers relating to staffing capacity, resources, and ask about the interviewee's perceptions on potential solutions to barriers that are mentioned.

Interviewer: Again, thank you so much for providing such valuable information. Next, I would like to discuss in more detail with you what you think could be some of the reasons that people [may be] experiencing the gaps in care we heard about or may not be getting the services that they need. I want to know more about barriers that you think people face accessing treatment when you refer them for OUD treatment services.

[Provider-related challenges/barriers]

1. Can you tell me about certain treatment types (levels of care or types of medications) that you usually have a harder time getting people into?

    - *Probe: Which ones? Why do you think that is the case? (Ask for reasons such as funding, special populations [e.g., pregnant women], resources—e.g., not enough beds for a residential treatment facility, not enough treatment providers, whether the provider won't accept Medicaid or HIP, or out-of-pocket costs are high.)*

2. What do you estimate is the average time it takes from the initial request for treatment until someone actually starts treatment or medication? *(Ask about each type of service or fill in the information for the services noted by the interviewee. Be sure to ask about how long it takes until they are actually admitted to the program/get the first dose of medication for the MAT programs.)*

Service	Duration between referral request and appointment.
Residential services	2 days
Intensive outpatient services	
Outpatient services	
Inpatient detox (withdrawal management)	
Methadone maintenance	
Suboxone/buprenorphine maintenance	
Vivitrol injection	
Other:	
Other:	
Other:	

[Patient-related challenges/barriers]

1. Can you tell me about any challenges you know that people face to find the medication assisted opioid use disorder treatment services they are looking for?

   - *Probe: What types of barriers do you think they face to receiving OUD treatment services? (Ask about length of time until intake visit, availability of preferred service, wait lists, stigma at treatment locations, insurance acceptance/cost of services)*

2. Are there other factors, like location, that make it harder to link people to treatment that will work for them?

[Patient-related challenges—costs and payment]

1. Tell me how insurance and ability to pay affects treatment options.

   - *Probe: If someone has HIP, which services are available without having to pay out of pocket?*

   - *If someone doesn't have HIP, what are the options? Are there places you refer that people will generally pay out-of-pocket? Do you know about how much it costs? What if someone is not able to pay for services? Are there any programs that can accept people without insurance or payment? Are there places people can go to be enrolled in Medicaid or HIP?*

   - *Does losing eligibility for Medicaid and becoming "locked out" for 6 months (e.g., due to nonpayment of monthly premium or work requirements) pose problems for individuals you work with?*

   - *Is it difficult to find certain types of treatment for people with HIP (Medicaid)?*

   - *What about someone who is uninsured and not eligible for HIP?*

2. If someone with HIP calls today and wants to start buprenorphine (Suboxone) treatment right away, what is the soonest that they could find a provider and start on the medication?

   - *Follow up this question with: What about methadone? What about vivitrol?*

   - *Follow up with probing about the role of insurance: Is the availability of MAT services the same if they are uninsured?*

3. Are there programs that only take pay out-of-pocket? Do you know how much they typically cost?

[Referral-provider perceived challenges and solutions]

Section 4. Solutions offered to overcome barriers

The purpose of this section is to capture information on potential ways of addressing the challenges discussed. Ideally, a question asking about solutions should immediately follow the question related to a specific challenge. These questions have been noted in the previous section with the comment "solution."

In this last section, I would like to know more about your thoughts on potential solutions to the challenges that we have discussed. I want to remind you that we are looking for your opinion, that there are no right or wrong answers to these questions.

1. Based on your experience, what do you think is needed to meet the needs of people seeking services?

    *   *Probe: expanding the number of providers offering MAT; reducing administrative hurdles to Medicaid/HIP enrollment; ensuring access to all forms of MAT; training more medical and behavioral specialists focused on substance use disorder.*

Closing

Thank you for your time and participation in this interview. You have answered many questions and shared your experiences with us, and we really appreciate it.

Is there anything else that you would like to add about any of the topics that we've discussed today?

Again, thank you. If you have any questions about this interview, you can reach out to the project director, Marla Clayman, at 312-288-7607 or mclayman@air.org.

Appendix F: Barriers to and Facilitators of Access to OUD Treatment Services

Theme: Barriers to OUD Treatment

A. Client-Level Barriers to OUD Treatment

A1. Lack of services for specific populations of clients
"If their mental health is out of our scope and we can't treat them here, there's really nowhere to send them to treat them for that. Like some of the things that we can't handle, like I said, eating disorders, schizophrenia, stuff like that, we just, that's out of our scope of practice. But when I'm trying to find somewhere to refer them to, there's nowhere, I give them referrals and we, we try to help them out, but I mean, a lot of the times there's just nowhere for them to go."
0027_28

"Connecting them to kind of that mental health services, kind of health care in general, it's usually longer wait times to get them connected into. And they have a hard time navigating the systems. When they're here, we're here to assist them. We do some hand-holding to get them connected. But when they're out, we hear that, it's a barrier for them because they can't." 0025

"The downfall is that all the clients that participate in this are Recovery Works eligible. Because of that grant money, we could only work with felonies. So, we exclude a huge population of opiate addicted individuals that are simply on for a misdemeanor are excluded as well. So, we can't work with them at this point." 0019

A2. Lack of insurance and/or lack of documentation to get insurance
"If they have insurance, typically we can get them in for Methadone treatment within a couple weeks. Within two weeks honestly, typically. But anything else, that's harder, Suboxone, Vivitrol, those are harder to get people into. There are only certain doctors that prescribe it. Their wait list is very long. Getting somebody in for medication, especially treatment for mental health, or addiction is hard." 0024

"We have no way to verify if they have insurance or not. Sometimes a day or so waiting, and then by the time the piece we do hear is the initial application that they would do, and so then that's submitted and can take 30 days to get approved, and then they have 30 days to start turning in the other documents, and if they haven't had that . And if you're denied, you have to go through the appeal process, and we can get them an ID while they're here, but then to get an ID, then they got to go get a social security card, and those both take mailing addresses which is a big barrier as far as just not having a stable mailing address." 0025

"We probably still have about 400 clients of the 1,200 that are open at any given time in my programs who don't have insurance coverage. There's still an enormous number of people who kind of fall within that gap of, 'Maybe I have some level of employment so I don't qualify for Medicaid but I'm not working for an organization or I'm not working for enough hours to where I can get covered commercially' or 'My commercial insurance doesn't pay for the treatment that I need.'" 0030

A3. Social needs such as homelessness, lack of transportation, and unemployment that affect the ability to access MOUD

"There's so many, in addition to the actual addiction, the social barriers surrounding that, whether it's transportation or insurance or you know, an underlying mental illness." 0031

"The biggest barrier then is to help them sustain the housing." 0021

"And a lot of my people are homeless. And they're really asking for a safe place. 'You know, I wouldn't be using if I wasn't staying on so-and-so's couch.'" 0021

"All of those non-billables are often big barriers and so transportation is probably the number one barrier." 0030

"[The barriers to people getting the treatment are] employment, housing. It is a lack of resources." 0026

"Childcare is a huge barrier. Right now, the state for the past two years, we have not been able to get anybody approved for CCDF, they've been on a wait list, out of funds. We have a lot less children here than we have ever had. Because they can't pay for childcare. Childcare is extremely expensive. They have to leave their children with a family member, because they don't make enough." 0024

A4. Cost of treatment

"The only issue is that you have to have really good insurance or the ability to pay." 0019

"[Without insurance the cost is] for Methadone, the last time I checked, it was around $16 a day. The initial startup is like $150 to $175, then it's $16 a day. Vivitrol is completely different. Vivitrol is $1,000 for the month, for that month shot. That's just what that is. Then Suboxone of course it's a little bit different, there's a prescription. There's a doctor's office visit that costs money, all of that." 0024

"We try to make sure everybody's on insurance right away when they get in here, but the out-of-pocket costs can get super expensive with it." 0027_28

"[Names of treatment providers] and that costs a lot of money. There's not a lot of resources for that. There's not a lot of resources for treatment period. You've got to have money in your pocket going in for detox. So, we try to get really creative and try to, okay, are they eligible for Recovery Works. So are there Street Reach dollars, so first it's finding the funding." 0021

"But I want it to just really off the bat say that a great issue for this whole opioid piece is actually the access to treatment, whether that be inpatient treatment, outpatient treatment, or the MAT treatment however that is. That's sometimes where we can't even get people started. [The barriers to people starting] . . . just the dollars. Actual dollars to be able to get there. . . . Can't afford to go to treatment . . . can't afford to even pay to get in." 0020

"And that may be part of the reason why we don't see as many self-pay or walk-ins, because it's just they can't afford it." 0032

A5. Lack of motivation

"It all comes down to how motivated they are to get to those appointments. It's completely accessible if you follow through. But follow-through is so hard. When you are losing your appointment cards. When your phone's always shut off. When you don't . . . when you're not doing what you're supposed to." 0019

"Most of the folks aren't motivated to make the call [to schedule an appointment for treatment]. Most of the folks maybe make the call but miss their first appointment. Then they have to make the call again." 0019

"It's probably going to be an 80% chance that person's not going to show up if they're not excited themselves." 0027_28

"Some of that delay, it could be because the client is being forced into treatment and doesn't really have that motivation to go." 0033

A6. Fear and stigma

"Not only is it hard practically, but mentally, there's often a big block. 'I don't want to go. I'm scared that they're going to judge me.'" 0019

"One chooses the MAT treatment but also chooses to support themselves with some regular recovery supports like meetings, 12-step programs, and they're not received there positively because they chose the MAT treatment. So, they're told that they're not clean. You're not sober. And without a doubt that can be a barrier to someone's success." 0020

"We have a couple of physicians who have voiced that they are interested in caring for these moms, but I think they also are a little bit shy because, unfortunately, one of them did say,

'That's just a population that I don't really feel comfortable caring for and having them in my office all the time isn't something I want.'" 0029

"The judgment that they feel and the fear that they have. That, I think, is the biggest fear that a mom has. And that's why she doesn't access help or treatment or prenatal care because she just thinks immediately that there's going to be judgment and this baby's going to be taken from her as soon as she delivers." 0029

"There's a lot of judgment when clients fail their appointments." 0030

"I don't think a lot of other places accept clients that are doing the MAT treatments like Suboxone. . . . That's kind of got a bad rap. So, a lot of people don't accept people on Suboxone. I know Methadone's a really like, nobody really wants to accept anybody on Methadone, Vivitrol, you know." 0027_28

"You've got a patient, yes this patient is not cooperating with you and is guarded. They're terrified. It's all self-centered fear. . . . The drug they use takes away the fear. They're insecure and they have, their whole life is insecure, and their head is chaotic. They just kind of need you to be just a little bit more understanding." 0022

B. Provider-Level and Systemic Barriers to OUD Treatment

B1. Stigma against MOUD

"the issue with them, is they do not. . . . They are an abstinence-only. It's part of their [faith-based] regimen, whatever they call it. I don't know. But we can't send people there that want medicine. Not even Methadone. They won't let them go dose and come back." 0019

"I don't think a lot of other places accept clients that are doing the MAT treatments like Suboxone. . . . That's kind of got a bad rap. So a lot of people don't accept people on Suboxone. I know Methadone's a really like, nobody really wants to accept anybody on Methadone, Vivitrol, you know." 0027_28

"That's another thing that we often have to kind of work through with our clients and the people that we partner with is because some of the people who are providing the services don't support medication assisted treatment. . . . That's a barrier for our clients. We'll have clients who can't go there because it's not going to be okay for you to be on Methadone or Buprenorphine or something like that. I understand it but it makes it difficult for our clients, so I don't like it." 0030

B2. Care that is not client-centered

Requirement for positive urine toxicology at time of admission

"They're like I want to go now, I'm ready to go now. You have to be like I'm sorry I can't take you now. Which [name of treatment provider] even, I think, [clients] must have used within 72 hours. So if it's been over 72 hours and they have no money . . . . Where are you going to go?" 0021

"You can't get too clean because you still have to have a dirty drop. As crazy as that sounds, or you have to blow numbers. So it's like, okay, well I guess we're going to stop at the liquor store. You have to get creative and play these games just to get somebody into treatment. We joke about that as a community, but some of these systems are set up that way." 0021

"[Inpatient is hard because of] I guess their strict guidelines—their strict guidelines." 0018

"Let's take specifically [name of an organization], [the clients] have to be in withdrawal. It has to be 24 hours since their last use and they drop them. They have to have used for more than three months consistently. They have to have used more than a gram a day consistently for those three months. It's just like is it really that deep? Man, they want help, but that's what they do. It sometimes creates a barrier." 0023

Impractical treatment schedules

"Sometimes the ask is really big for our clients and I don't think we always recognize how big that is. 'You don't have a job, you don't have a house, you don't have a lot of supports in your life but come to my clinic every day' or 'Come to my clinic . . .' you know like even in this clinic it's an intensive level of care. 85% of our clients are dually diagnosed so they've got some kind of mental health issue and an addiction issue, lots of trauma. Even in this clinic we're saying, 'We need you to be here three days a week because that's what you need.' Sometimes I don't think we appreciate enough what it takes to actually follow through and get here." 0030

"I think also it's really hard for moms to work when they're doing an intensive outpatient program that sometimes can be three, four, and five days a week, and just to continue to stay compliant, have a job and just to function every single day." 0029

"And you miss a screen, you're in trouble with us. So, a lot of our men are unwilling to reduce their hours or adjust their work schedule. They already are lucky to have this job, so my boss isn't going to let me take all this time off. We lose a lot of people that way." 0019

Lack of immediate capacity

"Sometimes our systems set up barriers because I think they want people to be more motivated than where people are at on the spectrum of usage, which is challenging. So, they say, 'Oh well,

you can't come back for 30 days,' or 'you can't come back for six months.' That's frustrating on the provider side, on the service side because if they were there two weeks ago, they're ready now. So, can we have a resource to be able to get them in right now. Sometimes we're not able to do that, so that's frustrating." 0021

"There's not enough beds. It's horrible to have to explain that to a patient you're going to have to call every four hours and find out if somebody left. There's nowhere, you know, and then we have the other issue too where we have patients who come in who may be used three or four hours ago and they're not in active withdrawal, they want help, they don't want to be sick, they're going to go into active withdrawal, and they want help. Nobody will take them. There's nowhere for them to go at all. You got to go home and get sick and come back. Rarely do we see those patients again until they overdose the next time." 0022

"We could always use more beds. I mean, we're always full. Sometimes we have a wait list, sometimes we don't. But we're . . . yeah, I think that we could always use more beds, especially across the state more. There's just not a lot of, there's not very many [name of specific recovery housing service] across the state." 0032

"This [accessing MAT] is the biggest problem that we are having. If they have insurance, typically we can get them in for Methadone treatment within a couple weeks. Within two weeks honestly, typically. But anything else, that's harder, Suboxone, Vivitrol, those are harder to get people into. There are only certain doctors that prescribe it. Their wait list is very long. Getting somebody in for medication, especially treatment for mental health, or addiction is hard." 0024

"There's no detox facilities in [name of county] that I can get people into and stuff. And then if I want to get you into [name of specific organization], it has to be for one of three substances, you know? And then you're hoping insurance covers that and stuff and just affordable inpatient and programming as well. There are no inpatient facilities. I mean, we have great detox houses or recovery houses, I should say, [names of two organizations], but they're always full, yeah. Their list of like over six months." 0033

"About the recovery home aspect of it, because there's, I won't say lack of resources there, it's just availability is the biggest one." 0025

<u>Inadequate treatment duration</u>
"Medical protocols for detox changed up. And so, instead of a seven- or eight-day detox where you really get a chance to clean out, it may be 24, 48 hours and we're out of there, and figure out what you're going to do once you're gone." 0020

"The length of treatment. Again, which is attached to dollars. So the length of treatment and seven days is nothing. Person's been using seven years, [so] seven days is nothing. It's not even a drop in the bucket." 0020

"I think that the length of time that a person really needs to get that grounding, it's not there [in] outpatient. And I can only say this is just what I read and feel from my experiences. Outpatient services are sometimes walked into too quickly. Because what they're saying is that we're going to take care of you during the day and then you're on your own." 0020

"I guess maybe more [inpatient services] so the people that are struggling with like actually being able to follow through. So [the clients] want to, but the outpatient's not working. [It's] not enough for them." 0033

<u>Outpatient services are not integrated with behavioral health and recovery support.</u>
"Final barrier for me is that some are offered that treatment without any supports to it. So, it's not suggested that you see a therapist. It's not suggested that you backed us up with any meetings stuff, or any group stuff. Just come get your pills." 0020

<u>Quality concerns</u>
"We could get into the quality of them, and that's a whole other 2-day topic you don't really want to get into. There's definitely a variance in quality of these residential programs. Some are held very accountable, some are not held accountable, some offer programming, some don't." 0025

"The medication is there. I just think it's difficult to access. Even at the inpatient level, you have to be crazy patient. And sit there while you're throwing up. And while you're missing your family. And experiencing emotions for the first time in 10 years because you're not high. I wish there was a quicker way to do it [receive buprenorphine]." 0019

<u>Lack of resources (staff and funding)</u>
"I think capacity is a problem in the state of Indiana and I think from what I read and the people that I talk to I think across the country there is a capacity issue. I think that's driven by a lot of different things, so I think part of it is you just don't have enough providers and I think the other thing is you don't have a big enough pool to draw from in terms of experienced staff who want to do this work." 0030

"So, if it is a physician who really has a heart and a passion for it and he gets to his or she gets to their capacity and someone else shows up and they have to turn them away, empathy and sympathy burnout are really, really hard to deal with every single day." 0029

"To get more providers, I will say this, mental health treatment and substance abuse treatment, there are so many barriers and it is very hard. It is very hard for me to be a small mental health treatment provider. Extremely hard. Because of all the barriers in place through the state, through insurance companies. A lot of people get out of it. If they try, it doesn't work, and they get out of it. Because of the pressure put on providers to be the fix all, and you have courts hold us accountable and blame us of things go wrong. You have DCS blame us if things go wrong. You have everybody pointing the fingers at us. People transition out of this, because so much is expected of us too. They go into private practice, or they burn out and go work somewhere else. There needs to be more providers other than the big mental health clinics. I mean they are over capacity." 0024

"I think that a lot of facilities had trouble because there really needs to be some sort of social worker involved with, like a primary care, so there's a shortage of social workers, I think is the big problem. It's great, I can go, and I can get, so, and I can provide this, but I can't provide the counseling services that have to go with it." 0022

"There are so many demands on peer recovery coaches . . . that there aren't enough of them right now." 0018

B3. Programming restrictions for eligibility based on grant and pilot funding
"With our folks funding is always an issue. So again, going back to just trying to figure out the systems' funding. Because you may have someone, you're able to get them in, but then they're not connected to a resource. So how are you supposed to pay for that? I think that's the biggest barrier because you can't do anything without money." 0021

"Also, lots of the money that is coming to us to provide treatment is through these pilot programs or grants and it's never a sustainable pot of money. There's always different hoops that you have to jump through to access the money and then different assessments and tools and things that they require for you to draw down the money." 0030

"Again, you have to build that into, 'Okay I can hire two people to do this work,' knowing that a third of their time is going to have to be filling out whatever form this grant needs and then it goes away in two years. These are all the things that I have to kind of work through operationally to make sure that our staff can kind of do the work." 0030

"I think one of our biggest barriers is finding funding for them, if it's a place that isn't yet taking insurance as payment, so some of the recovery homes, I think probably funding for the individual is the biggest barrier as far as the recovery housing." 0025

"A lot of those community engagement services that really help us bring the client in and engage them and get them to come back, they're not funded." 0030

"But bus fare and all of those kinds of things to get the client into the program. Often that's not going to be a reimbursable expense." 0030

"One barrier that I thought of is [re-entry program] and then another [grant] that we get for guys for treatment [where] criminal history has to be part, like they have to qualify by felony or being on probation or parole, house arrest, anybody else would qualify for any kind of financial help. And, that's a huge barrier for a lot of guys who, they feel like they have to go out and commit a crime to pay for treatment. So, this Medicaid thing will be good for those guys, hopefully, but for whatever reason the grants that are set up for this kind of treatment are pretty much set up by the criminal justice system and not always fair." 0032

B4. Lack of housing support

"I would say, for housing is the biggest part because once they're connected to insurance, they can get treatment through IOP or whatever, usually through Medicaid and that's kind of the way the state's making everybody go to. But the housing piece is the hardest part that some of these smaller recovery homes that people are doing good and start programs that take people that are self-pay basically just to try to pay back the mortgage on it. The housing piece, that's where there's not really a lot of funding for." 0025

"Housing is also another challenge. We're calling everybody and fighting to get them in. Hoping it's a safe place. Or they go back with their families, or they you know, things like that. Or sober living homes. I'm a big proponent for sober living homes. I want them to go. I think it's a perfect transition, step down transition. But a lot of them have been incarcerated for so long that they don't want to go to another place that has another set of rules over their head telling them what to do." 0024

"More than half of brand-new clients are living couch to couch. I've got clients literally sleeping on the street because they don't have people to sleep couch to couch. And they refuse to go to the homeless shelter. I think homeless shelters have a bad rap period, but the ones down here are known for like, 'Oh, you just go out back and get high. And then you go in and then you go to bed.' And that's exactly where we're not trying to send our people." 0019

"Housing . . . we're having a little trouble with helping with housing . . . ladies trying to find housing that's at or has, you know, bad credit comes along with all this too. And so felonies, bad credit, so it's been a little bit of a struggle trying to partner with people for housing. So we're really trying to help ladies find that. But it's been an issue." 0027_28

B5. Insurance challenges related to authorization and billing

"Lots of those kinds of things are not currently reimbursable and commercial insurance is the worst. Even Medicaid . . . a lot of that stuff is not reimbursable, and it really impacts our ability to engage clients." 0030

"Issues with Medicaid prescription limits, that's one thing, because if someone has a history of opiate addiction, they're very limited on how many they can get and what quantity and how many days. So we've had our psychiatrist prescribe so much Subutex, like say 16 milligrams or something of Subutex a day, but their insurance will only pay for like 12 or will only pay for like two pills and they're supposed to get it four or three times, but insurance will only give you two. Those issues come up and we try to just work around it. I know that that was an issue a few times with some of our moms trying to leave." 0029

"[Insurance is] something that they're really struggling with. They're trying to get people in for a detox, an inpatient detox, and they keep getting denied." 0030

"Sometimes they can't get started right away because the treatment providers are waiting on insurance to give the go ahead and things like that. And so now you have another delay of a week or waiting two for prior authorizations and things of that nature." 0033

"Lots of money is being poured into this problem but you still have commercial insurances that really restrict what you can get, when you can get it and how much of it you can get. Even Medicaid and Medicare are the same way. I mean, they have all kinds of restrictions. My staff spend as much time filling out paperwork, following up on prior authorizations trying to get the coverage, working through denials to be able to get clients." 0030

". . . downstairs where they sign them up for insurance, but it's only good for 30 days and they have to initiate and give the rest of the . . . or, I mean, they have to give the rest of the paperwork within 30 days; however, last weekend they dropped the ball and they did not sign the person up for insurance. For it to be paid for, they have to sign them up within 24 hours of being in the ED for insurance." 0023

"The problem is that a lot of insurance requires, 'Well you've got to fill out this form' and 'You've got to do this assessment and then you've got to submit it to us and then we will get back with you within a week to let you know if the client.'" 0030

"My staff spend as much time filling out paperwork, following up on prior authorizations trying to get the coverage, working through denials to be able to get clients. If you could make that process easier, then my staff would, instead of spending 50% of my time working with clients and then 50% trying to justify and get reimbursed and all that kind of stuff, you know, maybe

they could have 75% of their time working with the client. You have to think about that when you're hiring and when you're staffing your program because you can only carry so many clients when you know that there's all this administrative stuff that you have to work through." 0030

"For our population, sometimes staying on their health insurance benefits has been a bit of a challenge, so we will sign them up while they're in here, but that isn't always ready to go and be billable by the time they leave, so it is something that has to be continuously followed up on." 0025

"Insurance is always an issue. . . . I had one person come in and he said that he's trying to get his medication and CVS says that his insurance won't pay for this. He called the insurance company and they said his insurance was good. He came up here for our help. I stood down with him in the lobby. We called the automated line, which says his insurance is active, we talked to a human being who said that the insurance was active, and we called CVS who said it's inactive and then we called back again. She put us in touch with a prescription expert. Come to find out that they upgraded the system and when they did that, certain patients' prescription benefits were shut off. Now, it took me two hours to get this information and somebody who is, you know, can't, it's really hard to navigate." 0022

"So, one of the things that a lot of, and we don't do inpatient drug treatment but some of my colleagues at other places who do that, one of the things that they're finding is that they will have a client present who needs inpatient services. They will get them in, they will admit them, they will fill out all the paperwork, they will send it over to get reimbursed and then they'll get denied." 0030

"All that time that that client was getting services, that's denied. Well you can appeal [insurance denial] and go through that whole process but I think the managed care entities, you know, they have really created lots of barriers that really get in the way of what we know works, you know, for clients who have a substance abuse disorder." 0030

B6. Inadequate reimbursement rates for OUD treatment providers

"Reimbursement rates are really bad for treatment and so a lot of programs need to make a decision on, 'Am I going to provide this service because there's no profit margin and I can't pay my staff and I can't find staff and I can't pay them what they want and what they deserve because the profit margin is just not there. We're going to opt out on providing this service' or 'We're going to contract with somebody or we're going to refer somebody to another program that does it.'" 0030

"I think the number of resources that we can kind of access and leverage is much higher than maybe other people who don't have those kinds of resources. They have to make tough choices because reimbursement rates are just not great." 0030

"I think, to me, the biggest change that would really transform my ability to help our clients seek and access care would be to have a reimbursement or an insurance system with very, very few barriers. There are just so many barriers." 0030

"I don't think the reimbursement rates for addiction group therapy have changed in 15 years." 0030

"But bus fare and all of those kinds of things to get the client into the program. Often that's not going to be a reimbursable expense." 0030

"I think there's still a lot more work to be done to attract people to the field and then pay them a livable wage so that they can make a living." 0030

Theme: Facilitators of OUD Treatment Services

A. Comprehensive, Client-Centered Approach to OUD Treatment

"We have an integrated approach to care so any client who comes in we're going to assess them for both their mental health needs and their addiction needs. We're not [siloing] care, we're not saying, 'Well you know, we can treat this, but you've got to get this over there.' We have an integrated approach to care, and we have a comprehensive approach to care. We don't have a one-size-fits-all curriculum." 0030

"We work with a recovery wellness plan, and we help people to break their life up into smaller pieces. And first of all, how do you want to be connected to this recovery community that exists here in Indianapolis, in Indiana? What do you want to do to better your health? What do you want to do about your employment? About schooling? What do you want to do about your family? What do you want to do about your spiritual life? Your emotional life? We want to break that up into small pieces, so it doesn't seem so overwhelming for a person." 0020

"I don't spit [out] treatment plans, which is a lot different from what we used to do at [name of an organization]. The DSM IV told us exactly where we were going to set you, where your recovery started, where you fit in, and then now it's going to spit out the treatment plan? Well, we operate in a little bit of different plan. We let that person tell us where they want to go." 0020

"Being prepared . . . I think, is really important, being prepared to be with that person through that whole process." 0020

"We're not tied to just sending referrals to one facility or anything, we can send them wherever the client really wants to go. And then we look at that too, on barriers of, okay, are they going to be able to get back to those appointments." 0025

"They may not be able to meet the demands physically or whatever that program is. I'm kind of working to just break down all those barriers. We do a little bit of follow up; a lot of our clients will call back even maybe after they've transitioned on, they may still need help with the barrier or something. Some people still kind of work with them over the phone or outside. We stop by a lot of the recovery facilities and just check on clients from time to time, see how they're doing if they're still in treatment." 0024

"We might pull out a map and say, 'Hey, this bus route would be easy for you,' or 'You could get a ride here.' I try to make it personalized . . . to the person to make it fit for them." 0019

"Because we have that relationship with them, we're always like, 'Hey, we will always open the door, we can't force you to walk through, but we will walk through it with you.' So, based on that relationship they're like, 'Okay, I'm ready to go back.'" 0021

B. Partnerships and Affiliations

"And that's actually really fortunate because the community is so large. We can refer people to stuff right near them. So that would just. . . . Through working with people and through referring them, you end up making a lot of contacts. So, I don't know necessarily the regimented processes for everything, but I always know a person at this agency. So, I'll call and say, 'Hey, what does this person need to do to get in?' And we'll get them referred that way." 0019

 "They've worked in this field for so long that I feel like they've made a lot of connections. So, I feel like pretty much anything that any of the [clients] are needing or asking for, we have the resources to like direct them to where they need to go." 0027_28

"We have the relationships with the recovery houses that we can get them in pretty quickly." 0025

"We meet with those providers, yeah, we meet with those agencies just like we meet with the recovery houses and stuff. I bring them in and let them know, and made the relationships to kind of have a direct number we can call and kind of get somebody an appointment within a couple of days. . . . We've got that relationship, they've built that relationship." 0025

"We have a relationship with a couple of different factories that actually pay very well. Where [clients] can afford childcare. The [name of organization] is continually working to build

relationships with different types of employers that will employ women and that will actually pay them a decent wage." 0024

"Now, we have a relationship with [name of organization]. If they come in the ED Monday . . . addiction does not do a Monday through Friday, 8:00 to 5:00, job, but then I can call right away and get them an appointment set up when they're open, and they can possibly go straight over and be seen." 0023

"Our partnership is with [name of Organization1]. Because in fact they have a partnership with [name of Organization 2] because everybody's not going to be able to get to a [name of Organization 3]. So, they [Organization 1] have a partnership with [Organization 2] where their entire funding stream is about getting people through treatment. And so, we work with [Organization 1] that if we find that someone is in need of treatment, we try to make the referral there first so that they can do their assessment and we can leverage those dollars as that person's coming back around, then we have some dollars here that we can help them address." 0020

C. Easy Access to Services

"All the stuff's right down here. . . . The bus, literally, the terminal's right outside that window." 0019

"The state has done a good job of really trying to address [transportation] and so there was a great or a contract set up with Lyft where clients who are seeking addiction treatment can get free Lyft rides to treatment and it was a fairly easy process to get. I think their initial pilot, I think they used the money very, very quickly and then really worked. I'm not sure if it's currently funded but that was awesome." 0030

"Let's figure out what kind of placement options you're looking at, what side of town you're going to be on, lets connect you to that MAT provider, and not one across town so you're driving or trying to catch a bus from [one end of town to the other]." 0025

"I think I feel very lucky to be a part of the [large Health System] because . . . I think the number of resources that we can kind of access and leverage is much higher than maybe other people who don't have those kinds of resources." 0030

"We've really been trying to get better at getting our intakes linked up with a psychiatrist much quicker and much sooner and so ideally we're trying to make that happen within the first week. If we have cancellations, no shows, we're going to do it the same day." 0030

"Open orientations across the street, so they can walk in." 0018

"We intake 24/7." 0025

"We have a Suboxone clinic here [referral provider organization], which has helped me a lot." 0021

"Like a warm handoff, so when they get placed into a recovery home, or that recovery residence however they define themselves, they either come and take our client there or we will physically take our client there and make sure that they get into the facility." 0025

"They're trying to combat the long wait times for behavioral health, they're offering those open to all orientation sessions, which allows someone to get in that week." 0029

"We have same-day access and then we have walk-in access. For anybody who calls and wants to get into care we will schedule you an appointment the same day. A client calls and says, 'Hey, I want to get into care,' we'll say, 'Okay, we can get you in at 3:00 today with a clinician,' and they say, 'Okay that's great.'" 0030

"The great thing about the way that an opiate treatment program is set up is that when we do an intake, on a [new] client in our opiate treatment program, you are seeing the clinician, you're seeing a nurse and you're seeing the physician the same day. After that four-hour assessment . . . and all the things that we have to do to make sure we have a pretty good sense of who you are and the nature of your illness we will medicate you that day. . . . That's for Methadone. Well the nice thing about that, and I think one of the reasons why we do it so quickly is because we're dispensing it and so you're getting your medication there by a nurse, we're watching you, we're observing you and then the next day you got to come back and you're going to get your dose from us again. There's some safety built into that because we can monitor, and we can make changes in the moment if we need to." 0030

"We've really been trying to get better at getting our intakes linked up with a psychiatrist much quicker and much sooner and so ideally we're trying to make that happen within the first week. If we have cancellations, no-shows, we're going to do it the same day." 0030

D. Insurance

"If someone's pregnant, getting them treatment does not seem to be a problem. . . . Mainly because they get insurance immediately, there's the presumptive eligibility. They get treatment right then and there, anywhere they walk into." 0024

"We have two different insurance screeners that come each week. And I don't know how we formed these partnerships. . . . So, on Wednesdays, the [Insurance Company 1] will come in the afternoon. And that's when we have [services]. So, if there's a male right there, we let him see

the judge for their court appearance, and you need to go see the insurance rep right now. And they'll screen him and get him eligible." 0019

"People with great insurance have flexibility." 0019

Additional Themes: Facilitators of OUD Treatment Services

A. Recovery Support

"[Peer recovery coach program] has really taken off. It's a great program. It's really helping people. That connection with somebody who's used, in the past. It's like a certified recovery specialist in mental health. They kind of identify with someone who's been through some of the things they've been through. And more willing to be open with them. More willing to take their suggestions, to be offered help." 0018

"It's great to have peer recovery specialists or clinicians who can go out into the field and knock on doors and say, 'Hey you were just in the ED. You were given a referral to [name of organization]. We'd love to get you into care. Can we drive you? Can we give you some bus fare? Can we follow up with you? Can you call me when you're struggling?'" 0030

"We do employment coaching and that is inclusive of readiness. Then helping with access to potential employers, and then retention once employed. And so, following that financial coaching and income support work. Something that would help an income stretch a little bit further. As well as then we have Mental Health and Recovery Support Programming. And that's a wide range of things, but including relapse preventions. We host recovery support meetings, MRT [Moral Recognition Therapy], TBI [Traumatic Brain Injury] support groups. We work with a peer-to-peer model inside of our Recovery Resource Center. So, peer-to-peer coaches will do one-on-one appointments, and goal setting, and follow up. We do lots of referrals to recovery community services. We partner with a lots of recovery community services." 0020

"One of the things that I learned as my journey started, was to stay attached to recovery support. And so, I did." 0020

"I just keep reminding them of the plan they wrote. And how do I support you in achieving the goals that you said you wanted to reach. And that it doesn't happen if you're using. And it doesn't happen if you're committing crime. And it doesn't happen if you're not supported in any way by any type of support. It could be your faith-based support. It could be friends that can support you in this. It can be us. It can be the recovery coach here. It could be an educator. It could be a mentor that you have. And if we need to do that because there are many different pathways to recovery. It's not just all one 12-step way to get here. So many different pathways. But you can't do it without some support. You can't." 0020

"Recovery coaches fill in the gaps in services because they [clients] are released from treatment and they [providers] just let them go without making any plans or getting them to think forward." 0023

B. Leadership

"The [leaders] in all their wisdom, thought MAT and peer recovery coaching, and dealing with substance abuse issues, were really important. So, they devoted a lot of funds to, they operated under the grant the first year and then we got a second year of the grant, but they already put me in the hospital budget to keep me on staff. . . . So, they were committed to keeping me." 0018

C. Supplemental Funding

"We get city dollars for our housing team now, but most of it is private funds. We do fundraising, we just had our big fundraising event a couple weeks ago. So, most of it's grants, a lot of it is grants, private dollars, private funders." 0021

"If they need recovery housing, this week we've placed two patients in recovery houses that we've been able to fund for a month." 0022

"When you already have a razor-thin profit margin and then we've got to buy bus tickets and there's some great grant money out there to help with these kinds of things. . . . Now there's grant money out there for it and we've benefited from some of that grant money and it's awesome." 0030

"We're just very blessed with the foundation. So that's a little bit different than what you'll see in public hospitals." 0029

"I always know that I have some barrier funds back here, which not all programs have. So, I always know I have some barrier funds back here if I need to give myself some backup." 0020

"We've learned to do with our recovery support is to get really, really smart, and to build in dollars into program budgets that can address barriers to success." 0020

"[Name of treatment provider organization] our first go-to, because it's free. Which we're super excited that they're here now." 0021

"As long as we know about it, because we have a connection with another church who will pay for that. But the financial counselor, I think, does a really good job of getting people connected to resources to pay that." 0021

"With the [name of program], it is a nonissue here because we can pay for their treatment through the [name of program]. So, if we have a [client] that is interested in inpatient treatment, wants to go directly from the hospital to somewhere, it's just a nonissue . . . we would just private pay for it from the [name of program]." 0029

D. Navigation and Coordination/Case Management Services to Connect Clients With Community Resources, Insurance, Housing, and Employment

"We can reconnect them to services, we can get them started connected with services, we can hook . . . we can get them connected even if they don't have an ID, we can get them to the license branch and get a photo ID if they have no identification. We work with insurance navigators and get them connected with insurance if they don't have that. It's just about trying to break down the barriers." 0025

"We meet with almost every recovery house before, and we go and see the recovery programs and houses, so that when we're referring to them we know exactly what's going there so that we're hopefully referring appropriate candidates to each program, and what they're going to be best so that we're not referring someone to a program because they heard about it and heard it's great. If we kind of feel that's probably not going to be a successful program for them because of some of their needs." 0025

"Especially with women, safe housing is essential to their recovery." 0024

"Next door, we have our housing team, which is a new addition we did last year, so that's all next door. So, what they do, they are receiving the coordinated entry vouchers with the IHA vouchers through coordinated entry. So, they're providing . . . for anybody that comes up on the referral through coordinated entry. They have housed, I think, 104 families now. It's well over 150 individuals, which is really exciting. So, they're the IHA vouchers. They're working with the people with the highest VI's, the longest chronicity, the hardest to house, really rooted in the housing first and harm reduction model." 0021

"Having some employment along with the treatment . . . improves your chances." 0026

"[Name of organization] has supportive housing. I've had people live there and do so well." 0019

"We do our best to get them connected and make sure that they're self-sustaining prior to them exiting." 0025

"Community engagement of clients with a substance use disorder I think is such a critical piece because you'll see a client [referred from various places]. . . . If we can't get out to the client to provide care or get the client here to receive the care, we've lost the client." 0030

Theme: Gaps in Potential Solutions to OUD Treatment Service Delivery, as Described by Service Providers

A. Potential Solutions Identified by Service Providers

A1. Streamline and improve navigability of treatment

"What's the support? There's no follow-up. So, what about the person that literally misuses their meds? Again, you have treatment, which is that MAT treatment, but you put the supports along with that, the recovery supports along with it. We minimize that." 0020

"If we connected our treatment and recovery support and they worked together [inaudible 00:20:17] . . . hand in hand, then we could probably do outpatient really well and see some greater successes. So that's probably my greatest concern with outpatient services. There are plenty of outpatient programs, plenty. It's not that we have for lack of them." 0020

A2. Improve the timeliness, standards and processes of oud outpatient treatment

"You've got to get them in quickly, you got to provide them with services quickly, you got to engage them or they're going to leave. . . . If I get a call Sunday morning at 10 a.m., I need to be able to find a way to get that client into care because, by Monday morning at 9 a.m., that client may not be ready for treatment anymore for a lot of great reasons, a lot of understandable reasons. Quick access to care is critically important." 0030

"Giving a person a fighting chance in that moment of clarity, trust me, one that's using, there's a moment of clarity that says, 'I don't want to do this anymore. I want to change my life.' And I believe that it's incumbent on us that are providing that treatment and providing those services to really capitalize on that moment, because it goes away very quickly." 0020

"I wouldn't say we need more prescribers necessarily, but I would say we could beef up the way in which it's already happening. Because just to tell someone, 'Well it's as easy as this, just go do it.' If they could do that, then they wouldn't have gotten [into trouble]." 0019

"So, on the outpatient level, I wish it was still held to a high standard, but quicker." 0019

"You've got to get them in quickly, you got to provide them services quickly, you got to engage them or they're going to leave. This is the tension that we're often facing which is, 'How much can we provide without all that stuff [insurance related barriers] in place?' " 0030

A.3 Improve comprehensiveness and continuity of care

"More compassionate doctors. More educated doctors on addiction. Recovery coaches. Fill in the gaps in services because they're released from treatment and that's why I get with them . . . they're released from detox and they just let them go without making any plans or getting them

to think forward, 'Okay, now what are you going to do? You should go into transitional housing,' duh, duh, duh. They just let them go and they're going to do what they always do. That's a hard question. Continuum of care." 0022_23

"Moving forward, our plan is to offer that comprehensive whole health, every aspect, because everything's interconnected. If they've got pain in their back, that's before they would just go out and use. How do we address that now without even maybe medication? So, moving forward, that's our plan is to offer more services than they have been getting and having it offered here in-house. And, if it's not here on-site, being able to just streamline that." 0032

"If it's outpatient treatment, let's put the supports behind the treatment. So, it's kind of making it one, it just really like flows together because they don't work separately. They don't work opposing and they don't work separately. They work fabulously when we blend them together. So, I think that's just number one. And this is unfortunate because across the field, no matter what issue we're trying to address, we've got to get out of silos." 0020

"If we connected our treatment and recovery support and they worked [inaudible 00:20:17] . . . together hand in hand, then we could probably do outpatient really well. And see some greater successes. So that's probably my greatest concern with outpatient services. There are plenty of outpatient programs, plenty. It's not that we have for lack of them." 0020

"And it's kind of just catching those folks that really are looking at the world very pessimistically. . . . And makes it okay to re-offend, or to continue your bad behavior. . . . There are curriculums, I now know, that can address that. That can at least try, if the offender's willing to receive the curriculum, address their way of thinking . . . until [we] address the errors going on in their [clients'] brain, they're not going to stay clean. They might white-knuckle it to graduate the [re-entry] program, but I didn't do anything for those people. When they leave, they're still going to run into a cop and run their mouth and get in trouble. That's something I don't think agencies necessarily view that as substance abuse-related. And I didn't used to, but I see it now." 0019

"I almost wish that there was some element of a peer recovery coach, or some type of person. . . . A guiding light through that intake process with agencies. Because to a lot of our folks, they've never been to a therapist before." 0019

"The problem is so complex and different people are going to need different interventions at different times and their ability to engage is also going to be individualized. If a client can engage what I offer, wonderful, but if a client needs to be engaged in the jail and provided good treatment with good linkage once they get out that's wonderful. If employers can start having programs and support and linkage to give people, the help that they need I think more and more it's important to look at a comprehensive approach to care and make it easy for people to

access it at the level that they need. I think that's how you're really going to combat the illness." 0030

A4. Increase opportunities for safe, affordable recovery housing and stable employment
"Housing is always an issue for one reason or another. Egos are high and tensions are high. Keeping jobs, you know, a lot of our patients have felony convictions." 0022

"I wish there was something more accessible, safe, affordable, supportive, for people who need stable housing. Even if it's a dorm setting. Even if it's a group setting. That's fine. They don't need their own apartment right at first. They can live in a recovery-based place. But those are hard to come by covered by the Recovery Works dollars or by insurance." 0019

"We've got all these services here, so they don't feel like it's as much of an issue. But . . . safe, sober housing is certainly an issue that they come to their capacity." 0033

"So really also trying to push towards more permanent housing though to increase our housing stock because shelters isn't always the answer. We need more permanent, supportive housing." 0021

"Of a location to place individuals with a substance abuse disorder, especially with the population we serve here. It's kind of going above of, they don't have a safe place to go, or they have no place to go, so we need to find, [Name of persons] have to find them a residence along with substance abuse treatment and program and things like that." 0025

"With the outreach, it can be a little bit more challenging just because they may not be at their camp or it's trying to coordinate. . . . So, we would love it to be quicker, but obviously there's challenges on our end and challenges on their end if they're not home. A lot of people are transient, so they may not have an established camp, so it's trying to catch them to find out where they're at." 0021

A5. Provide education on MOUD for staff
"We definitely need more education both for staff and for clients. . . . Education on safe usage, harm reduction, on suboxone and then also on the medical impacts. I guess that could go to safe usage, but I think that just education on opiates, what that looks like. I don't think there's ever enough education that we can have." 0021

"I think that some more education too about MAT because there's a lot of people, a lot of recovery homes, a lot of people within recovery that are really against it. If you're on this you're not sober, you're not clean. Well, this person is taking medication that's prescribed by a doctor that's being monitored by a doctor that's keeping them from [committing crimes]." 0022_23

"We need a little more understanding. I don't know how we can address the idea of that addiction is a disease. I firmly believe in that but it's important for people to understand that when you're in this cloud, in this fog, you can't respond appropriately. I think especially in the health care system that needs to be discussed more. There needs to be more education . . . you've got a patient, yes, this patient is not cooperating with you and is guarded. They're terrified. It's all self-centered fear. . . . The drug they use takes away the fear. They're insecure and they have, their whole life is insecure, and their head is chaotic. They just kind of need you to be just a little bit more understanding." 0022

"[As for] figuring out where to put resources, I really think it's that non stigma, nonjudgmental first impression that people get, that kind of make or break your relationship with them. So somehow offering to someone that they can come and talk to whenever, nonjudgmental. If you're not ready, you're not ready, but we'll still be here to support you emotionally and mentally, is what really develops that relationship. And then either creates them to a time when they're ready or doesn't, but you've chipped away at that block." 0029

"I think . . . there needs to be more education around what are the risks? What are the benefits? How is that going to help the client access care? [Education for] Professionals. Physicians. Nurse practitioners." 0030

"Medication assisted treatment. . . . But I know that it's, there's some controversy with it, but some more education when it comes to that and just being able to provide a good policy on like this is how you do it in a program like this, safely." 0032

A6. Clients with felony convictions and misdemeanors
"Because of that grant money, we could only work with felonies. So, we exclude a huge population of opiate addicted individuals that are simply on for a misdemeanor are excluded as well. So, we can't work with them at this point." 0033

"Something I've heard preached a lot lately and backed up by research, is the need to address criminal thinking through either Thinking for a Change, or MRT, or some sort of cognitive-behavioral programming. . . . I would not say that that programming is essential for every client I have, but now that I know what that looks like, and what they're talking about, for some of my clients, it really is essential. And we don't have those resources like we should." 0019

"There might be a lot of recovery housing based on funding that's out here that can be received from it. But a lot of it's not truly recovery supportive." 0020

A7. Clients with dual diagnosis

"The resources in the recovery houses and the staff education of, you get a lot of recovery houses that pop up because somebody wants to help people and thinks they know what they're doing and. . . . The clinical piece of recovery is not just, 'put them in a sober house.' It's dealing with the trauma, I can't tell you, I would say 95% of our people come in here and started using due to a trauma in their life. We can get them sober, but if we don't address that trauma." 0025

"A lot of patients have a dual diagnosis and there's not a lot of facilities that deal with that directly." 0022

"Typically, our clients have all been through trauma, childhood trauma, sexual abuse. Their upbringings were, you know what I mean? They had some sort of trauma and we try to help them get through that, because that's basic—typically what starts their road down addiction anyways. I mean, it's all over the board. Some of them come in here with nothing, like the clothes on their back and that's all they have, and they have no one. So, we're going to have families who are helping them through it. It's kind of all walks of life that we get here." 0027_28

"If they [client] have schizophrenia or something like that, we don't even bring them in because there's 40 [people] here. So, we also have to protect the other [people] that are here, and we don't want to do more harm to them. Mental health is a huge thing and there's just nowhere for [clients] to go." 0027_28

"A lot of times we find them, particularly people with schizophrenia, with a long history of, you know, in and out of these clinics." 0031

A8. Increase availability of behavioral/residential/inpatient treatment

"What else is needed? I mean, it would be nice if we had more beds just to get more women help. You know, I've—like I said, I'm the one over the wait list, so I see that all the time and I see the people, it's, there's a need always for it." 0027_28

"And at the inpatient level, we need male beds. Or male options. Because with the women, they're able to get so many people in quickly." 0019

"I think maybe one thing I would add is, just having more physicians and therapists and social workers in our behavioral health care system that can care for [clients], so that maybe the wait isn't quite as long because that's what we run into." 0029

A9. Address barriers to treatment

"[W]hen we're not looking at some of those barriers that exist like, 'Where do I live? I mean, am I there where the entire community that I live in is caught in this epidemic of using. Am I part of a family?' And I'm not saying that in treatment we must go and fix everything for everyone. But

if we truly want to give a fighting chance, we do have to really assess those barriers. And assessing is not enough. How do I connect this individual with the opportunity to not fall back into that trap?" 0020

A10. Increase opportunities for stable housing

"I do wish that we had a part in, like I said, housing, I wish we had a partnership with housing. I think that would be so helpful to have somebody that would just, so these women like once they're ready to leave here because you're going to tell when they're ready to leave, they've been here, that they know their stuff and then they get so frustrated looking for housing and you know, get denial letter after denial letter and you're just like, it's going to happen." 0027_28

"So really also trying to push towards more permanent housing though to increase our housing stock. Because shelters aren't always the answer. We need more permanent supportive housing." 0021

A11. Gaps in treatment availability, including on-demand treatment (timing) and standards of care

"At the inpatient level, we need male beds. Or male options. Because with the women, they're able to get so many people in pretty quickly." 0019

"The biggest problem we're running into is one, people prescribing it just a lot. It's being prescribed a lot. I've noticed lately and the dosages, we'll have some of our women, we had a client who got on Suboxone and then she was like, this dosage is way too high for me. She was like nodding off and when she went to try to lower it, they were like, 'Won't lower you for at least another year.'" 0027_28

"Giving a person a fighting chance in that moment of clarity, trust me, one that's using, there's a moment of clarity that says, 'I don't want to do this anymore. I want to change my life.' And I believe that it's incumbent on us that are providing that treatment and providing those services to really capitalize on that moment, because it goes away very quickly." 0020

"We need a little more understanding. I don't know how we can address the idea of that addiction is a disease. I firmly believe in that but it's important for people to understand that when you're in this cloud, in this fog, you can't respond appropriately. I think especially in the health care system that needs to be discussed more. There needs to be more education about you've got a patient, yes, this patient is not cooperating with you and is guarded. They're terrified. It's all self-centered fear. . . . The drug they use takes away the fear. They're insecure and they have, their whole life is insecure, and their head is chaotic. They just kind of need you to be just a little bit more understanding." 0022

"It would be, I think that some more education too about MAT because there's a lot of people, a lot of recovery homes, a lot of people within recovery that are really against it. If you're on this you're not sober, you're not really clean." 0022

"There's definitely a variance in quality of these residential programs. Some are held very accountable, some are not held accountable, some offer programming, some don't." 0025

"There's available opportunities for treatment, but there's really not available opportunities for treatment. [For example] I need a three-day detox. I decided today that I want to go into detox. There's no bed. You didn't catch me; tomorrow I'm getting high. And so, yes, there are opportunities, but there's not enough opportunities for detox programs and inpatient treatment. I want to go in today, is there a bed for me? No, same thing. If you could say that there were 10 programs and there was only 80% capacity and in all of them and you still had beds, then [there would be enough opportunity]. But if you only have one or two programs that have a detox program and they're full all the time and so you don't know how many of you're missing." 0026

"Physicians or psychiatrists who are outside the addiction treatment realm get very nervous about prescribing Buprenorphine and you know, EDs have a real hard time saying, 'You know what, I'm going to give you a 10-day or a 30-day bridge script until you can get in to see a psychiatrist.' Often EDs will manage your withdrawal symptoms in the moment and then send you on your way. Well that does nothing for you because within 12 to 16 hours you're going back into withdrawal so you're either going to use or you're going to come back into the ED." 0030

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