Toolkit for Ensuring Access to Medication Assisted Treatment in Rural Maryland

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ABOUT THE PROGRAM

Clinical Scholars is a national leadership program of the Robert Wood Johnson Foundation led by the University of North Carolina at Chapel Hill. Learn more about RWJF's Leadership for Better Health programs by visiting: rwjf.org/leadershipforbetterhealth

ABOUT THE TOOLKIT

This toolkit serves as a road map to identify how to approach a "wicked problem" utilizing an experienced and diverse team, while developing collaborative partnerships with community stakeholders to promote the equitable sharing of information and resources.

Toolkit for Ensuring Access to Medication Assisted Treatment in Rural Maryland

Rural communities in American are disproportionately affected by the opioid epidemic. Rural communities in the State of Maryland are no exception. From 2010-2015, deaths related to prescription and non-prescription opiate overdose in Maryland nearly tripled with substantial increases occurring in rural communities in Western Maryland and the Eastern Shore. Factors associated with the rise in opiate use in rural communities include: (1) an older population with more chronic pain; (2) increased occupational injury from heavy labor jobs; (3) cultural acceptance of the use of opioids to keep individuals working in heavy-labor occupations; and (4) lack of economic opportunity resulting in unemployment and financial hardship. Although Medication-Assisted Treatment (MAT), which includes the use of medications (e.g. Methadone or Buprenorphine) with psychosocial interventions, is a lifesaving, evidence-based treatment for opioid use disorders, there are numerous barriers to accessing MAT in rural areas.

Rural communities are not only disproportionately affected by the opioid epidemic, there are a myriad of barriers for individuals and families living in rural areas trying to access MAT services. For example, methadone maintenance clinics are overwhelmingly located in urban areas, are highly regulated by both state and federal regulations, and require daily clinic/program attendance during the early phases of treatment. Although buprenorphine treatment can be delivered in a less regulated manner, which may overcome some of the accessibility issues historically associated with methadone maintenance treatment, only two percent of buprenorphine waivered physicians in the U.S. practice in small and remote rural areas. The paucity of buprenorphine waivered physicians is equally true for rural communities in Maryland.

Providing increased access to evidence-based, telehealth services to address the opioid crisis saves lives

Our central project goal is to increase access to medication assisted treatment to rural communities in Maryland using the telehealth model piloted in an existing treatment program (Wells House) located in Western Maryland. In order to advance this central goal, a small, diverse, multi-disciplinary, clinical team was created. Our primary team is comprised of a clinical social worker, nurse practitioner, and two addiction psychiatrists possessing a wealth of experience working in multi-disciplinary substance use settings. As our team and project has evolved, the necessity of cultivating relationships with both internal and external program stakeholders to help champion the cause of expanding access to medication assisted treatment.

In 2018, an estimated **2 million people had an opioid use disorder** which includes prescription pain medication containing opiates and heroin.

The ultimate goal of MAT is **full recovery**, including the ability to live a self-directed life.

– SAMHSA

Planning

The graphs below provide a quick overview of the scope of the problem and frames both the importance and necessity of establishing and expanding the Buprenorphine Telehealth treatment model to address opioid addiction in rural communities.

1. **THREE WAVES OF OVERDOSE DEATHS**
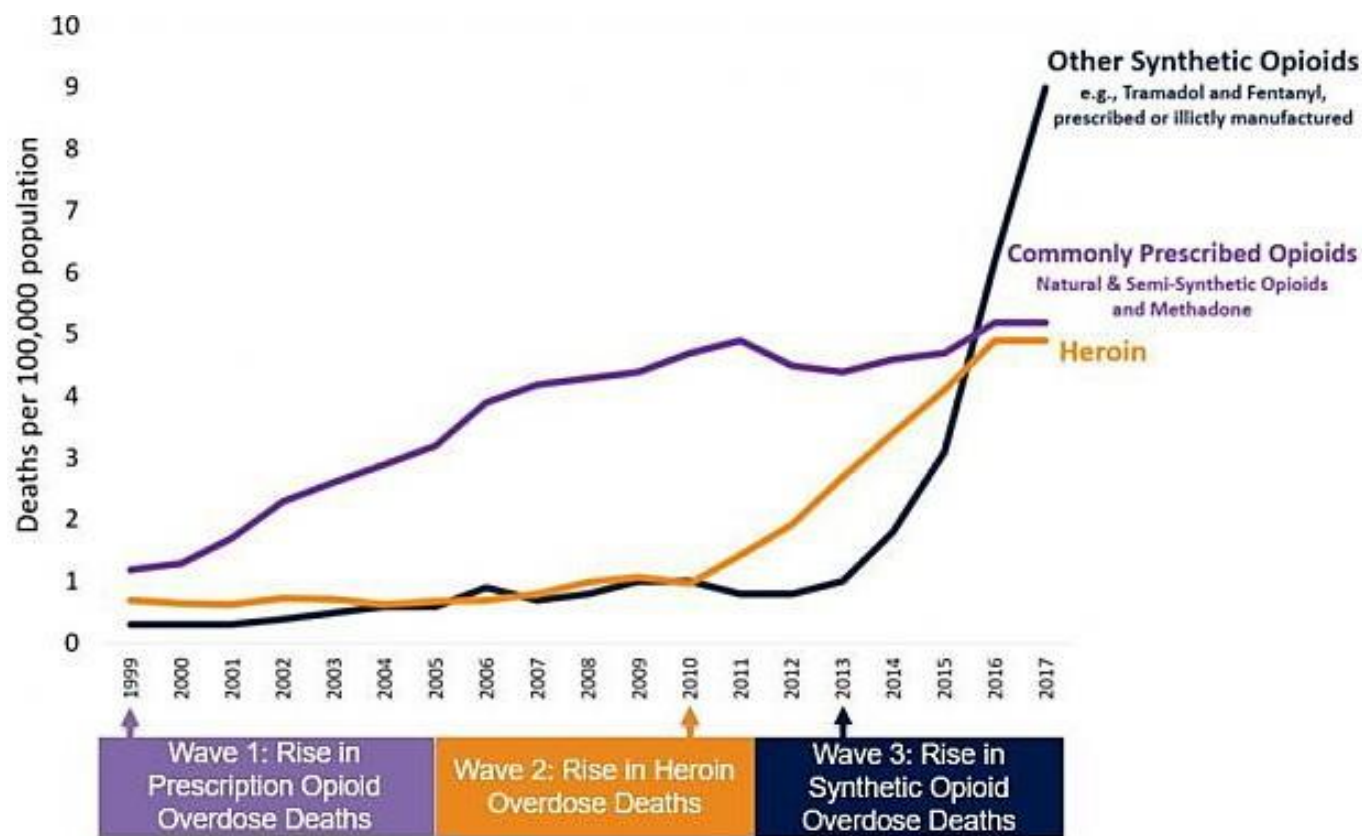
SOURCE: National Vital Statistics System Mortality File.

2.   COMPARISON OF RURAL AND URBAN SUBSTANCE ABUSE RATES

	Non-metro	Small metro	Large metro
Alcohol use by youths aged 12-20	37.8%	35.3%	34.3%
Binge alcohol use by youths aged 12 to 17 (in the past month)	5.5%	4.9%	4.7%
Cigarette smoking	28.5%	24.1%	20.5%
Smokeless tobacco use	8.5%	5.0%	3.0%
Marijuana	11.2%	13.2%	15.0%
Illicit drug use	14.2%	17.3%	19.4%
Misuse of Opioids	4.0%	4.4%	4.5%
Cocaine	1.1%	1.8%	2.1%
Crack	0.2%	0.3%	0.4%
Methamphetamine	0.7%	0.6%	0.4%

Source: Substance Abuse and Mental Health Services Administration (SAMHSA), Results from the 2016 National Survey on Drug Use and Health: Detailed Tables.

3.   U.S. COUNTIES LACKING ANY PUBLICLY AVAILABLE MEDICATION FOR OPIOID USE DISORDER IN 2017

North America Lambert Conformal Conic Projection

≥1 MOUD provider
No MOUD provider
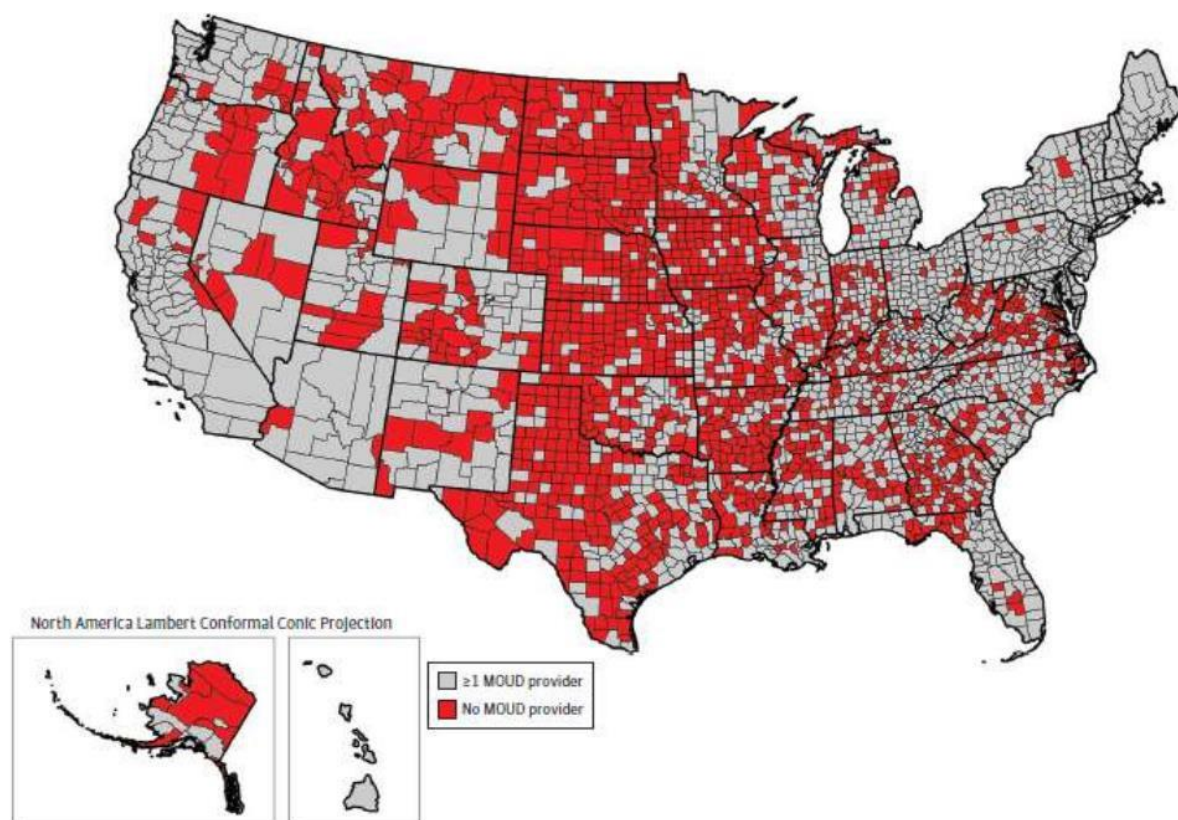
Medication for opioid use disorder providers are defined to include publicly listed opioid treatment programs, buprenorphine-waivered clinicians, and/or extended-release naltrexone-prescribing clinicians in late 2017.

WICKED PROBLEM

Our team was compelled by both the severity and impact of the opioid epidemic in the rural communities in the State of Maryland and throughout the country. Our team's awareness of the key categories of the social determinants of health (economic stability, neighborhood and physical environment, education, food, community and social context, and health care system) and their intersection with the opioid epidemic and broader community response or lack thereof stimulated our interest in tackling this wicked problem. A deeper dive and analysis of the problem led to the identification conditions and circumstances faced by citizens living in rural American seemed to highlight the lack of accessible, quality, integrated, comprehensive care.

- Restricted access to comprehensive, quality care

- Transportation issues

- Geographic isolation

- Poverty and unemployment caused in part by the closing of traditional industries and markets

- Public transportation limitations

- Limited healthcare workforce and presence in rural communities

- The role of culture, stigma, community norms, and political orientation

Our treatment team conceptualized our wicked problem (the opioid crisis in rural communities) as being largely impacted by the lack of accessible treatment services and infrastructure in rural America. Our project – "Somewhere to Go: Ensuring Access to Medication Assisted Treatment in Rural Maryland" was implemented with the decided intention to expand the use of tele-health MAT services, using Suboxone directly to rural areas in need. Building upon a prior pilot project embolden our team's confidence and belief in being able to successfully collaborate with geographically distant rural substance abuse treatment programs in being able to employ a proven, evidenced-based treatment approach, utilizing a multi-disciplinary team, utilizing a telehealth model.

The use of Suboxone, (rather than Methadone) and the telehealth model were selected intentionally based upon both clinical assumptions supported by pilot data that the impact of several barriers could be mitigated. The nature and location of our "Wicked Problem" necessitated the formation of an experienced, interdisciplinary, culturally competent healthcare team with knowledge of opioid substance use disorders and their treatment.

KEY SKILL SETS

The nature and location of our "Wicked Problem" necessitated the formation of an experienced, interdisciplinary, culturally competent healthcare team with knowledge of opioid substance use disorders and their treatment. Our team is composed of a nurse practitioner, physicians, and social worker all of whom have experienced

BENEFITS OF TELEHEALTH APPROACH USING SUBOXONE
Increases access to care
Reduce need for distant, daily travel to MAT programs
Addresses the cost, time, and legislative hurdles involved with setting up comprehensive methadone programs locally
Use of Suboxone has potential to reduce the need for daily clinic attendance
Overcome geographic barriers such as distance, travel time, isolation
Increases presence of waivered physicians remotely
Provides learning opportunities and support to other healthcare providers
Largely mitigates "Not In My Back Yard" or NIBY issues

working with working with individuals and their families confronting opioid addiction in a variety of clinical settings. Our team members have both front line and administrative experience which has lent itself to examine our wicked problem from the patient, population, and community levels as well as experience working with local, state, and federal officials in a variety of ways. All team members have some experience and skill in teaching, consultation, supervision and research which lends itself to working and collaborating with both internal and external stakeholders. Most importantly however was the development of a team to work together, collaborate, and make the long-term commitment to addressing this wicked problem.

- Marian Currens, RN, NP – Nurse Practitioner
- Seth Himelhoch, MD – Psychiatrist
- Eric Weintraub, MD – Psychiatrist
- Jewell Benford, MSW, LCSW-C – Social Worker developing and implementing policies and procedures, engagement with program stakeholders, knowledge of accreditation, certification, and regulatory requirements.

TEAM COMPOSITION

- Seth Himelhoch, MD
- Marian Currens, RN, NP
- Jewell Benford, MSW, LCSW-C
- Eric Weintraub, MD

Project work

Our four-step implementation model is intentional and strives to highlight the inter-connection between each implementation step and its dynamic capacity to both guide and inform our teams approach. More importantly our implementation model recognizes the important role of our various stakeholders and the initiation of input systems that foster and facilitate the sharing of their input and perspectives. In many respects our team had to embrace the posture of being able to follow before being able to lead.

Our team also understood the both the necessity and importance of gaining the trust and confidence of our projects key program stakeholders and to remain mindful of the saying "people what to know that you care, before caring about what you know". Our implementation strategy at the inception of the project had to take in consideration of the political and legal ramifications of implementing the use of suboxone therapy utilizing a telehealth platform and directly addressing the regulatory barriers posed by the Ryan-Haight Act in providing our projects intervention.

Identification — Assessment — Implementation — Evaluation

PHASE ONE

At this initial phase, emphasis was placed on the development of materials (policies, procedures, protocols) addressing legal issues and enlisting new rural treatment sites. Initially, the development of our materials was largely informed by completing a needs assessment which involved the identification of the scope, severity and impact of the opioid epidemic in rural communities, but also by identifying the intersection of the social determinants of care intersection with the environmental conditions (i.e. demographics, economics, infrastructure, workforce, political climate and affiliation). Laying this foundation paved the way for identifying potential community stakeholders willing to partner and collaborate in addressing the opioid epidemic. An early critical implementation issue was the negotiation of the Ryan Haight Act of 2008 which was aimed at protecting the consumer and public but provided a need to carefully negotiate and implement a service delivery model that could attend to tolerance level of several stakeholders (i.e. University and Medical Center leadership, Drug Enforcement Administration, local and state officials).

PHASE TWO

The implementation phase focused on providing clinician training, ensuring treatment site preparations and evaluating stakeholder satisfaction with telehealth services. Our project was initially implemented without full, codified resolution of Ryan Haight Act consideration, but Dr. Weintraub took the lead in establishing ongoing communication with our lead, local DEA representative which paved the way for the establishment of waiver to provide telehealth services related to this project. Subsequent to consultation with key Robert Wood Johnson Foundation Clinical Scholars staff, our team drafted a letter intended to enlist the support of the Honorable William H. Frist to secure additional support for the need of telehealth services in addressing the opioid epidemic. During the implementation phase, telehealth program sites were expanded, and additional physician faculty support was obtained to provide increased capacity, training, and supervision to local providers. The momentum gained during the implementation phase was maintained by securing a CareFirst grant focused on using the telehealth model to expand accessibility to MAT services in rural communities in Maryland.

PHASE THREE

The Dissemination & Liaison Phase is ongoing and focusing on the continued expansion of the accessibility of medication-assisted treatment by continuing to enlist program sites and provide ongoing consultation, training and supervision to programs and healthcare providers invested in this wicked problem. The dissemination and expansion of this project has been aided using outcome measures and data to demonstrate the impact.

| OUTCOME MEASURES	PLANNING GOALS	KEY MESSAGES
- Number of patients initiating treatment - Patient retention - Average number of days of abstinence from Opiate use - Patient satisfaction with telehealth delivery platform – in process	- Identification, engagement, and involvement with key project stakeholders - Completion of stakeholder analysis and documentation of key variable and characteristics (i.e. power/influence, key interests and issues, political orientation, frequency of contact, and communication plan)	- The scope and impact of the opioid epidemic in rural MD - The benefits and value of the telehealth model - The necessity of stakeholder input and participation - Transparency in communicating project successes, outcomes, barriers and lessons learned
CLARIFY TARGET AUDIENCE TO STRATEGIZE COMMUNICATIONS		
Training, conferences, webinars and workshops; Papers, abstracts, and presentations; Newspaper/community publications; Community stakeholder meetings/gatherings; Provider level supervision and consultation services		

Challenges and lessons learned

In facing our wicked problem, our team encounter several challenges and hurdles which ultimately paved the way for some key programmatic successes and valuable lessons learned.

CHALLENGES

The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 was a formidable barrier which had the capacity to derail or significantly curtail or project at inception. Dr. Eric Weintraub took the lead in "walking up to the line" and not crossing it, and lead to the development of several key critical partnerships with program stakeholders which allowed the project to flourish.

Our team became acutely aware of the impact and potential impact of intended an unintended consequence of disseminated information. Implementing innovative projects has a way of testing the risk tolerance of program stakeholders and promote further engagement or distancing from the project at hand. Interactions with the media always presents some degree of risk which may invoke the need for crisis communications, negotiation, and risk management and reframing of the message as illustrated in the Politico article below *"Facing mounting opioid overdoses, Maryland doctor defies federal law"*:
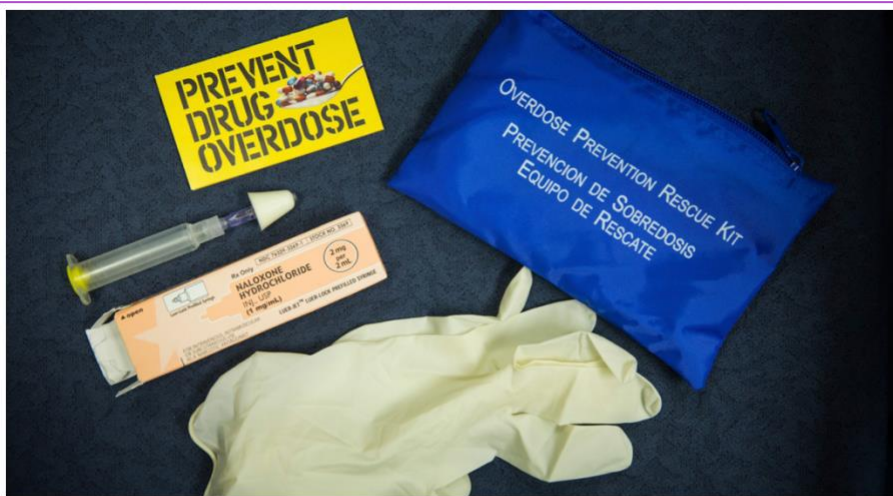
The American Telemedicine Association has been pressing for several years to get the federal government to act on a waiver allowing opioid treatment via telemedicine. | Getty

Facing mounting opioid overdoses, Maryland doctor defies federal law

JESSICA'S STORY

Our team was compelled by both the severity and impact of the opioid epidemic in the rural communities of Maryland and throughout the country. Our team's awareness of the key categories of the social determinants of health (economic stability, neighborhood and physical environment, education, food, community and social context, and health care system) and their intersection with the opioid epidemic and broader community response or lack thereof stimulated our interest in tackling this wicked problem.

A deeper dive and analysis of the problem led to the identification conditions and circumstances faced by citizens living in rural American seemed to highlight the lack of accessible, quality, integrated, comprehensive care. However, the power of our project was highlighted by Jessica sharing her story of addiction, recovery and how involvement with our project positively impacted her life.

LESSONS LEARNED

- First and foremost, having a cohesive team, with a shared vision, and value orientation coupled with nimble and flexible leadership proved critical in being able to lean into this project, expand our capacity, and implement an effective intervention.

- Our ability to implement our intervention was grounded in our ability to both listen and give voice to the needs of our stakeholders living in the rural areas of Maryland ravaged by the opioid epidemic. Taking time to meet with these stakeholders enhanced our ability understand the cultural context and needs or our target population. Our ability to gather, analyze, and utilize stakeholder input and minimize our own biases has hopefully increased our ability to implement a sustainable and viable intervention.

- Our collaboration with our colleagues at the Community-Campus Partnerships for Health (CCPH) expanded our leadership bandwidth and credibility with rural stakeholders by employing the core principles of "developing partnerships that balance power and share resources equitably among partners". Our collaborations at CCPH help our team modify our paradigm from inviting community members to a seat at our table to asking for permission to sit at theirs.

KEY PROGRAM STAKEHOLDERS