Moving Toward Evidence-Based Programs:

Medication-Assisted Treatment for Opioid Use Disorder in Utah

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Analysis in Brief

Drug overdose is the leading cause of injury death in Utah,[i] and opioid-related drug overdoses are a significant contributor to the rise in drug overdose deaths in recent history. In 2018, close to half of all opioid overdose deaths were prescription related, and 47% involved illicit opioids such as heroin.[ii]

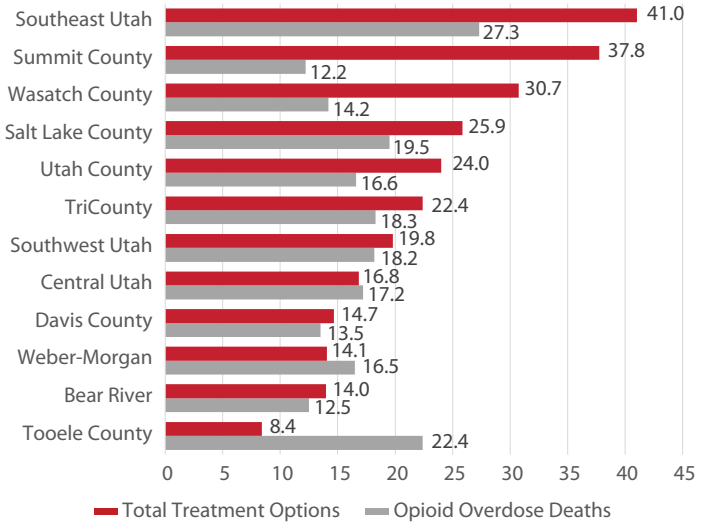
Fortunately, opioid use disorder (OUD) can be treated. Medication-Assisted Treatment (MAT) is "a combination of psychosocial therapy and U.S. Food and Drug Administration–approved medication"[iii] and has positive, evidence-based effects on OUD.[iv]

This report provides information on MAT availability in Utah. It also highlights gaps in services, barriers to providing and accessing MAT, and considerations for improving the system—developed from discussions held with a range of stakeholders involved in addressing Utah's opioid epidemic.

Key Findings:

- **Some urban and rural residents lack access to MAT**—An inventory of MAT programs and locations developed by the Gardner Institute shows several areas across the state may have insufficient access to medication treatment options.
- **One area of clear concern is Tooele County**—Tooele County has the second-highest need for OUD medication treatment options in the state, but the lowest rate of availability.
- **Waivered prescribers expand access to medication treatment**—Qualifying physicians and other health practitioners can obtain a waiver to prescribe OUD medications in a traditional doctor's office setting. Discussion groups noted having a variety of treatment options is important, given the complexity of patients' life circumstances and varying behavioral therapy needs.

Opioid Overdose Deaths vs. Medication Treatment Options by Local Health District (Per 100,000 Population Age 18+), 2019



Note: Opioid overdose death rates by local health district are 2013–2017 averages. San Juan County local health district overdose death data are not included due to data suppression. Use caution in interpreting overdose death rate estimates for Summit and Wasatch County local health districts. They have coefficients of variation greater than 30% and are therefore deemed unreliable by UDOH standards.
Source: Kem C. Gardner Policy Institute's inventory of Utah OUD medication treatment options. Opioid overdose death rates from the Utah Department of Health.

- **Public education is needed to overcome MAT stigma**—Discussion groups agreed stigma is a barrier to accessing and providing MAT, particularly in rural and underserved areas.
- **Changes in program availability and geographical coverage should be evaluated over time**—The report's inventory can be used as a baseline to determine if MAT availability is growing and assess whether the changing MAT landscape is meeting the state's evolving OUD needs.

i. Public Health Indicator Based Information System (IBIS), Utah's Public Health Data Resource. Utah Department of Health. https://ibis.health.utah.gov/ibisph-view/indicator/view/PoiDth.html
ii. Opioid Data Dashboard. Utah Department of Health. https://dashboard.health.utah.gov/opioid/
iii. Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder. (2016, November). The Pew Charitable Trusts. https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder
iv. Wakeman, S., Larochelle, M., Ameli, O., et al. (2020, February). Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. Journal of the American Medical Association (JAMA). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032

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Introduction

In 2018, 417 people in Utah died of an opioid-related overdose.[1] Close to half of these deaths were prescription opioid overdoses, and 47% involved illicit opioids such as heroin.[2] These statistics are a snapshot of the fast-growing opioid epidemic, in which Utah experienced an almost 400% increase in prescription drug overdose deaths between 2000 and 2015.[3]

Fortunately, opioid use disorder (OUD) can be treated. Medication-Assisted Treatment (MAT) has positive, evidence-based effects for OUD.[4] However, large-scale adoption of MAT is still relatively new, and system gaps and barriers limit both access to and availability of this treatment.

This report provides a comprehensive picture of MAT for OUD in Utah. It includes information on the availability of medication-based treatment, highlights gaps in services and barriers to providing and accessing MAT, and presents considerations for improving the system—developed from discussions held with a range of stakeholders involved in addressing Utah's opioid epidemic (e.g., law enforcement, state officials, and treatment providers, among others). The information in this report can help inform future discussions and decisions regarding improvements to Utah's MAT system for OUD.

Utah's Opioid Epidemic

According to the Utah Department of Health (UDOH), drug poisoning deaths are "the leading cause of injury death in Utah, outpacing deaths due to firearms, falls, and motor vehicle crashes."[5] Prescription opioids "are responsible for half of the unintentional and undetermined drug poisoning deaths in the state."[6] Figure 1 shows Utah's opioid overdose death rates compared with the national average from 2000 to 2018. Utah's age-adjusted opioid death rate was higher than the national average (14.8 vs. 14.6 per 100,000 people) in 2018, and Utah's opioid death rate ranked 27th highest in the country.

A National Perspective

Since 2000, the annual number of drug overdose deaths in the U.S. has almost quadrupled from 17,500 per year to almost 70,000 in 2018.[7,8]

As an increasing number of people become aware of the prevalence of OUD and the need for substance use disorder treatment, the characteristics of the epidemic continue to change. The age-adjusted rate of drug overdose deaths involving synthetic opioids such as fentanyl, fentanyl analogs, and tramadol increased from 0.3 per 100,000 in 1999 to 9.0 in 2017, and 9.9 in 2018.[9]

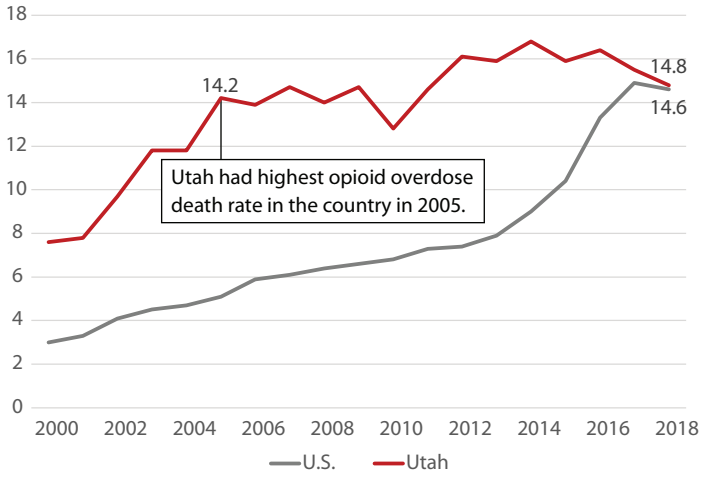
This epidemic comes with high costs. The Centers for Disease Control and Prevention estimates national health care, productivity, treatment, and criminal justice costs of prescription opioid misuse is $78.5 billion a year.[10]

Opioid Use Disorder (OUD)

According to the DSM-5,[11] "at least two of the following should be observed within 12 months to confirm a diagnosis of OUD:

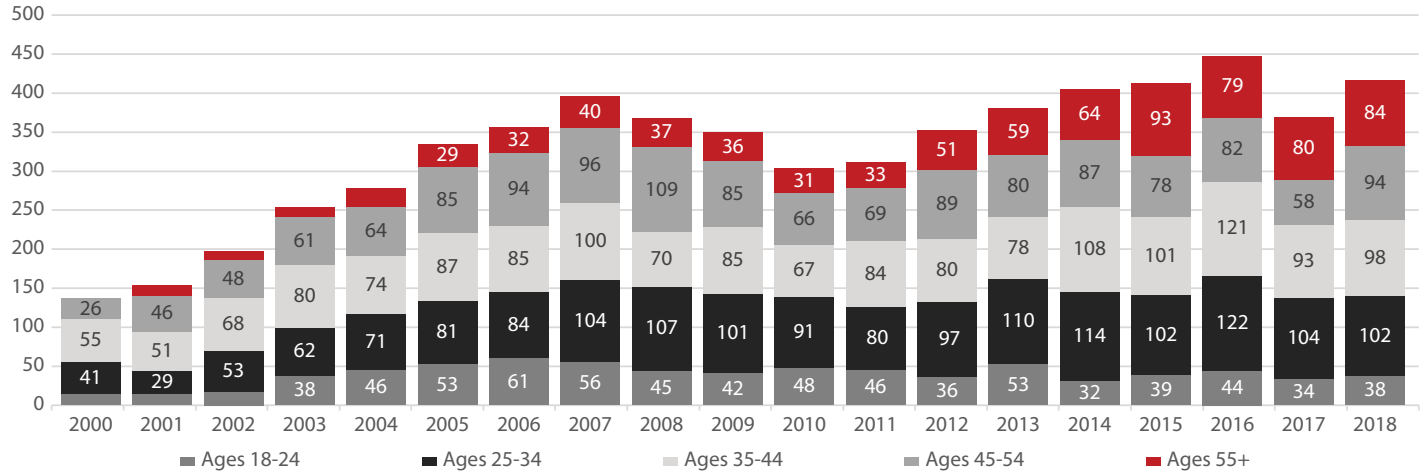
- Opioids are often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- Craving, or a strong desire or urge to use opioids.
- Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- Recurrent opioid use in situations in which it is physically hazardous.
- Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Exhibits tolerance.
- Exhibits withdrawal."

Figure 1: Opioid Overdose Death Rates per 100,000 Population, 2000–2018



Note: Data are age-adjusted.
Source: Kaiser Family Foundation analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics

Figure 2: Number of Opioid Deaths in Utah by Age Group, 2000–2018

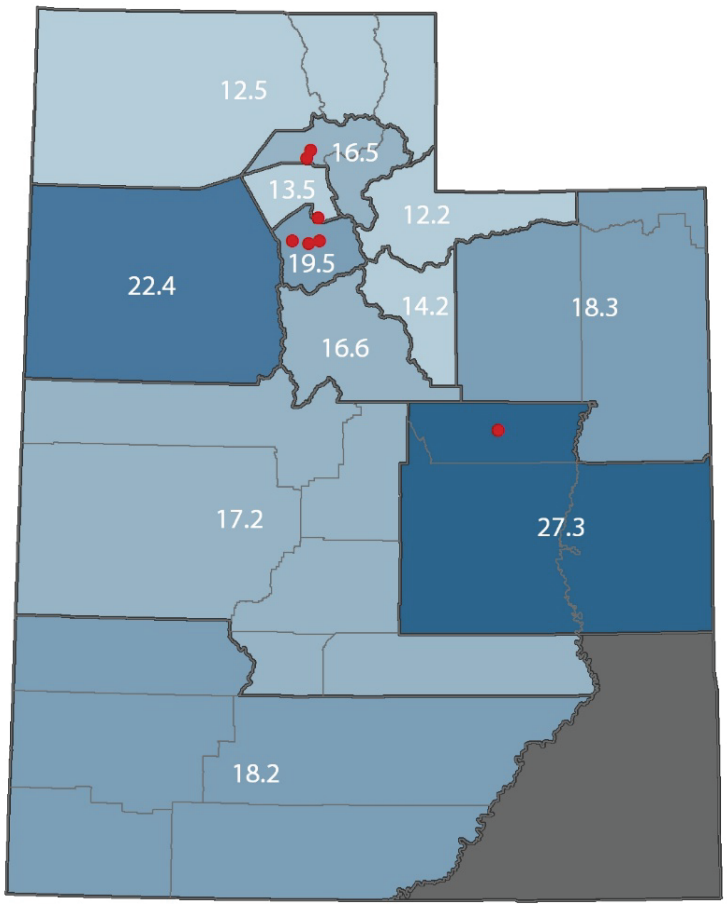


Note: Undetermined and unintentional opioid deaths only. 2018 data are pending.
Source: Utah Death Certificate Database, Utah Medical Examiner Database, U.S. Census Bureau

Data also show that this epidemic has not impacted all areas in Utah equally. Figure 3 shows Utah's opioid overdose death rates by local health district. The Southeast district, which includes Carbon, Emery, and Grand counties, has the highest opioid overdose rate at 27.3 per 100,000 population. Tooele County has the second-highest rate, with 22.4 opioid overdose deaths.

Figure 3 also highlights the "hot spots" for opioid overdose deaths based on Utah's small areas.[12] The six hot spots, or red dots, identified by UDOH include: (1) A combined total for Carbon/Emery counties—47.7, (2) downtown Ogden—39.1, (3) Glendale—33.9, (4) Rose Park—30.0, (5) Magna—29.0, (6) Riverdale—27.9, and (7) South Salt Lake—27.8.[13]

Figure 3: Opioid Overdose Death Rate per 100,000 Population by Local Health District and Highest Opioid Overdose Death Rates among Utah Residents by Utah Small Area, Age 18+



Note: Opioid overdose death rates by local health district are 2013–2017 averages. Red dots indicate Utah small area opioid overdose death rates (2014–2016 averages). Utah small areas are geographic boundaries defined by UDOH to facilitate reporting data at the community level. Areas are determined based on specific criteria, including population size, political boundaries of cities and towns, and economic similarity. For more information, see https://ibis.health.utah.gov/ibisph-view/pdf/resource/UtahSmallAreaInfo.pdf.
San Juan County local health district overdose death data are not included due to data suppression. Use caution in interpreting estimates for Summit and Wasatch County local health districts. They have coefficients of variation greater than 30%.
Source: Utah Department of Health. Local health district data from CDC, National Center for Health Statistics. Multiple Cause of Death 1999–2017 on CDC WONDER Online Database, released December 2018. Utah small area data from Utah Opioid Overdose Fatality Review Hot Spots Report. (2019, March). Utah Department of Health.

Medication-Assisted Treatment for Opioid Use Disorders

Medication for Opioid Use Disorders

The FDA has approved three medications for OUD: buprenorphine, methadone, and naltrexone.[14,15,16] Each medication works through slightly different mechanisms, but all three can be effective in relieving opioid withdrawal symptoms or blocking the euphoric effects of drugs.[17]

Opioid treatment programs have existed since the 1950s, but the use of medication to treat opioid addiction significantly increased in the last two decades in response to the epidemic. Research on the effectiveness of using medication to treat OUD has also grown and shows that it has positive, evidence-based effects.

Medication-Assisted Treatment

MAT is "a combination of psychosocial therapy and U.S. Food and Drug Administration–approved medication"[18] and, according to the American Society of Addiction Medicine and U.S. Department of Health and Human Services, "is the most effective intervention to treat opioid use disorder and is more effective than either behavioral interventions or medication alone."[19] Studies show MAT to be effective for people confronting alcohol or opioid use disorder, demonstrating reduced illicit drug use, decreased overdose deaths, increased treatment retention, and reduced HIV transmission.[20] Psychosocial therapy is an important component of MAT as it "can help patients manage cravings, reduce the likelihood of relapse, and assist them in coping with the emotional and social challenges that often accompany substance use disorders."[21] The medically monitored startup of OUD medications is known as the induction phase. Some OUD medication can be administered when a person has abstained from using opioids for "12 to 24 hours and is in the early stages of opioid withdrawal."[22]

MAT can be provided in specialized opioid treatment programs (OTP), substance use or addiction treatment programs, or as part of general health practice or physician offices using an office-based opioid treatment (OBOT) model.

Opioid Treatment Programs (OTP)

OTPs are opioid treatment programs certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and accredited by an independent, SAMHSA-approved accrediting body.[23] All OTPs must also be licensed by the state in which they operate. OTPs meet certain standards, including having a specific administrative and organizational structure, continuous quality improvement, credentialed staff, specified patient admission criteria, drug testing, a confidential recordkeeping system, medication provision standards (such as administering or dispensing opioid treatment medication only by practitioners "licensed under the appropriate state law and registered under the appropriate state and federal laws"[24]), and counseling, vocational, and educational services.[25] Only certified, accredited, and licensed OTPs can provide methadone. They can also provide other FDA-approved drugs for MAT of OUD.

FDA Approved Drugs for Medication Treatment of Opioid Use Disorders

Buprenorphine

Partially stimulates opioid receptors but creates a "ceiling effect" to reduce opioid withdrawal symptoms and cravings. Must experience withdrawal before use. It can be prescribed by a physician, nurse practitioner, or physician assistant to up to 30 or 100 patients at a time after completing the required training. Some physicians with additional qualifications or in specific practices may treat up to 275 patients at a time.[29]

Other names:

Suboxone: sublingual films (taken under the tongue) containing buprenorphine and naloxone (an opiate antagonist that blocks opioid receptor sites, also preventing misuse of films by injection).

Sublocade: once-monthly injectable buprenorphine. It was made available in 2019.

Zubsolv: (buprenorphine and naloxone) sublingual tablets.

Naltrexone

Blocks opioid receptors and euphoric and sedative effects of opioids to reduce cravings. Must complete 7–10-day opioid detoxification before use. No addictive properties. It can be prescribed by a licensed health care professional or practitioner.

Other names:

ReVia, Depade: pill form.

Vivitrol: Injection with 28-day extended release.

Methadone

Initially requires onsite daily dosage. Long-acting full opioid agonist that reduces opioid craving and withdrawal and blunts or blocks the effects of opioids. It can be administered only by a SAMHSA-certified opioid treatment program that has registered with DEA as a narcotic treatment program.

Substance Use or Addiction Treatment Programs

Substance use or addiction treatment programs can offer MAT by obtaining OTP certification or employing or contracting with a physician or other qualifying health practitioner who can prescribe naltrexone or who obtains a waiver via the Drug Addiction Treatment Act of 2000 (DATA). DATA-waivered prescribers can prescribe buprenorphine or buprenorphine/naloxone.[26]

Office-Based Opioid Treatment (OBOT)

Given the growing need for MAT, there is an increased focus on providing OUD services through primary care physician offices and general health care practices.[27] In an OBOT model, a primary care or general health care practitioner obtains a DATA waiver to treat their patient population with OUDs.[28]

Integrated psychosocial therapy and behavioral health services are not a requirement for OBOT, so to meet the MAT standard, OBOT prescribers connect or refer patients to behavioral health specialists located onsite or at a different location. That said, some research suggests that requiring psychosocial therapy as part of an OBOT program can "deter individuals from initiating or continuing treatment with buprenorphine,"[30] particularly if these services are inaccessible for patients or if patients prefer not to have concurrent therapy services. The researchers noted that more information is needed to better understand the impact of requiring psychosocial therapy on access to and engagement with treatment, both overall and among key populations.

Methodology

With support from The Pew Charitable Trusts, the Kem C. Gardner Policy Institute (Gardner Institute) was directed to provide the Utah Office of the Legislative Fiscal Analyst with a comprehensive picture of MAT for OUD in Utah. This study (1) assesses the current availability of MAT in Utah through the development of an inventory of medication treatment options, and (2) highlights gaps in services, barriers to providing and accessing care, and considerations for improving the system—based on ideas developed from discussion groups and interviews held with a range of industry stakeholders.

This report specifically focuses on MAT because evidence suggests that it "is the most effective intervention to treat OUD."[31] The report provides information on the availability of both MAT programs (i.e., OTPs or other substance use or addiction treatment programs providing MAT through a licensed or DATA-waivered prescriber) as well as OBOT prescribers without a known association with behavioral treatment.

Inventory of OUD Medication Treatment Options

To assess the availability of MAT in Utah, the Gardner Institute created an inventory that identifies the location of "MAT," "OTP," and "OBOT" programs. In the inventory:

- **"MAT"** designation is used for programs or locations that appear to offer both psychosocial therapy and FDA-approved medication at the same location. DATA-waivered prescribers associated with a "MAT" program or location are counted as part of the MAT program, and not included in the OBOT designation.
- **"OTP"** designation is for programs that are certified by SAMHSA, accredited by an independent, SAMHSA-approved accrediting body, and licensed by the Utah Division of Substance Abuse and Mental Health (DSAMH) to provide methadone onsite. They also provide counseling, vocational, and educational services[32] and can be licensed to provide other FDA-approved medications for OUD.
- **"OBOT"** designation is for programs or locations that have a DATA-waivered prescriber, but it is unknown whether psychosocial therapy is offered onsite or through referral.

The Gardner Institute developed the inventory by combining and refining a list of MAT programs identified in the Addiction Policy Forum Resource Database,[33] a United States Drug Enforcement Administration (DEA) list of DATA-waivered prescribers, a list of Opioid Treatment Programs (OTP) provided by DSAMH, and local treatment program databases and directories. The Gardner Institute reviewed other national program lists and directories used in similar studies, like SAMHSA's Opioid Treatment Program Directory and the Utah Department of Human Services Office of Licensing Substance Abuse Database. These directories, however, were not included in the formal compilation of program data given concerns about their completeness[34] and duplication of programs identified through the sources listed above.

To compile the inventory, the Gardner Institute matched DATA-waivered prescribers to a unique list of MAT programs identified through the Addiction Policy Forum Resource Database, the OTP list provided by DSAMH, and a program list developed from local treatment program databases and directories. DATA-waivered prescribers that could not be matched to OTP or MAT-designated substance use or addiction programs were classified as OBOT unless other sources indicated they should be categorized as MAT.

A series of maps illustrating the geographic location of medication treatment options in Utah represents the information in the inventory. The visuals provide insight into the availability of medication treatment options and whether the supply meets the relative need in different areas of the state, as indicated by opioid death rates.

Study Limitations

While the Gardner Institute feels the data and processes used to develop the inventory resulted in a program list that approximates available MAT programs and prescribers in Utah, there are several limitations. For example, the inventory:

- May not capture all addiction treatment centers that do not offer OUD medication onsite, but provide it through contracting prescribers.
- May not capture all OBOT locations that prescribe only naltrexone, and not buprenorphine or methadone.

- Does not provide information on whether DATA-waivered prescribers are actively treating patients with OUD.
- Associates DATA-waivered prescribers with only one MAT program or OBOT location, when some prescribers may practice at multiple locations (some of which may not be captured in the inventory).
- Provides a current snapshot of MAT availability in a system that is continuously evolving to meet changing needs.
- Does not directly align with current OUD "need" as measured by opioid death rates given delays in aggregating data on opioid overdose deaths and data suppression in areas with low numbers of deaths.

Discussion Groups and Interviews

To better understand gaps in services, barriers to providing and accessing care, and considerations for improving the system, the Gardner Institute held seven one-hour discussion groups with a range of stakeholders involved with addressing Utah's opioid epidemic or the professional treatment of OUD. These stakeholders included law enforcement, MAT program providers and psychosocial therapists, peer support specialists, insurance companies or payers, OBOT physicians, and rural stakeholders. The Gardner Institute also conducted 14 interviews and three feedback groups with state officials and industry experts to further assess the current availability, challenges, and outcomes with MAT in Utah.

Like other forms of research, qualitative research has strengths and limitations. Most notably, the qualitative findings in this report are not generalizable because participants were not selected randomly, and the sample of participants was not large enough to be representative of the broader population. For example, the rural-area discussion groups could speak to barriers and challenges specific to their area, but not the experience of all rural areas. However, the qualitative findings in this report allow for a more nuanced understanding of the availability and accessibility of MAT in Utah.

The discussion groups focused specific attention on barriers and challenges to accessing and providing MAT. The report highlights these gaps and challenges, considerations for improving the system, and examples of successful MAT in Utah.

Treatment Availability

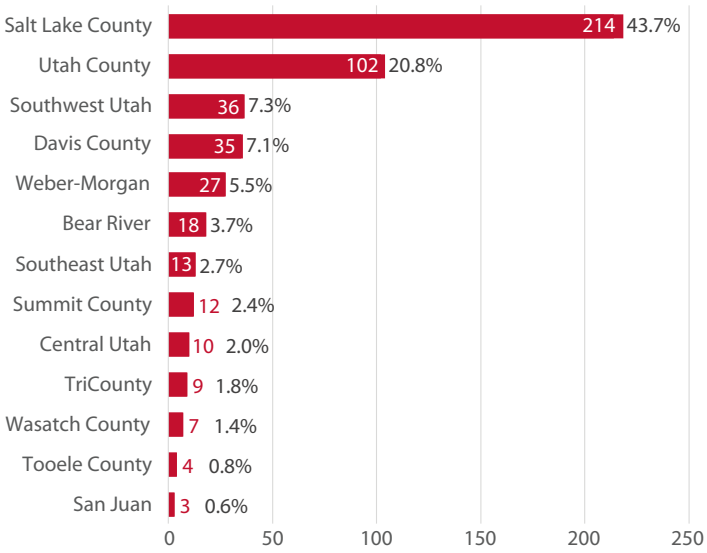
Medication Treatment Options

Figure 4 shows the total number of medication treatment options available in Utah by local health district (MAT, OTP, and OBOT) and the percent of options located in each district. For example, Salt Lake County has 214 medication treatment options, which represents 43.8% of all medication treatment options in Utah.

To better understand the availability of medication treatment options in urban vs. rural areas, Figure 5 shows the rate of medication treatment options (MAT, OTP, and OBOT) per 100,000 people compared with opioid overdose deaths by local health district. Interpreting the data requires some caution. For instance, while the Southeast district (Carbon, Emery, and Grand counties) has a high number of available medication treatment options, it also has the highest "need" in the state as measured by opioid overdose death rates. Summit County has the second-highest availability of options and is the second-lowest area of need, indicating either (1) an over-distribution of MAT programs and waivered prescribers (OBOT), or (2) a reduced opioid overdose death rate due to the number of available medication treatment options. It is not clear from the data which, or if both scenarios are true.

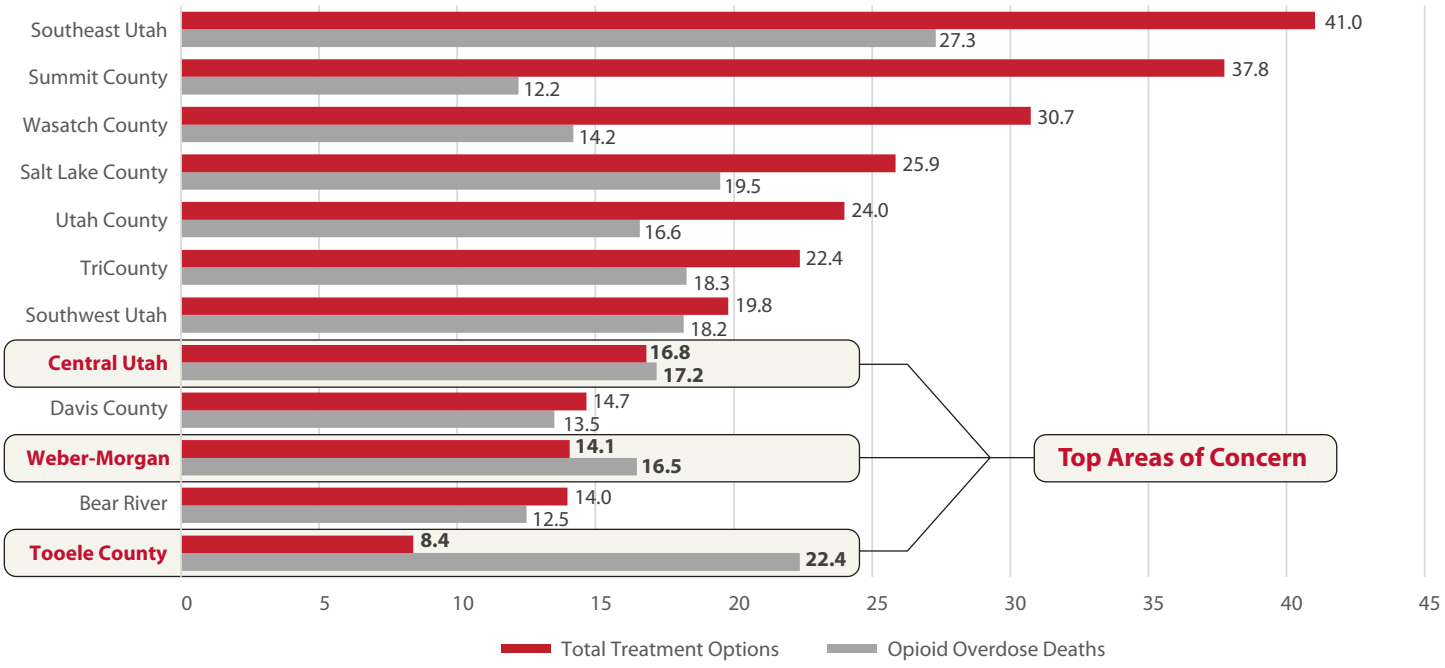
It is also important to note that data representing "demand" (opioid overdose death rates) lag data on the current "supply" of medication treatment options. Available data on the rate of opioid overdose deaths by local health district are an average of 2013–2017 (aggregating several years of data was necessary to reduce data suppression and obtain reliable estimates). MAT program and prescriber data are from 2019. That said, the lag between data sources may help illustrate the reaction in some communities to past OUD deaths. Future analyses using this data as a baseline could examine whether areas with a high rate of program availability have experienced a reduction in opioid overdose death rates.

Figure 4: Total Medication Treatment Options (MAT, OTP, and OBOT) by Local Health District, 2019



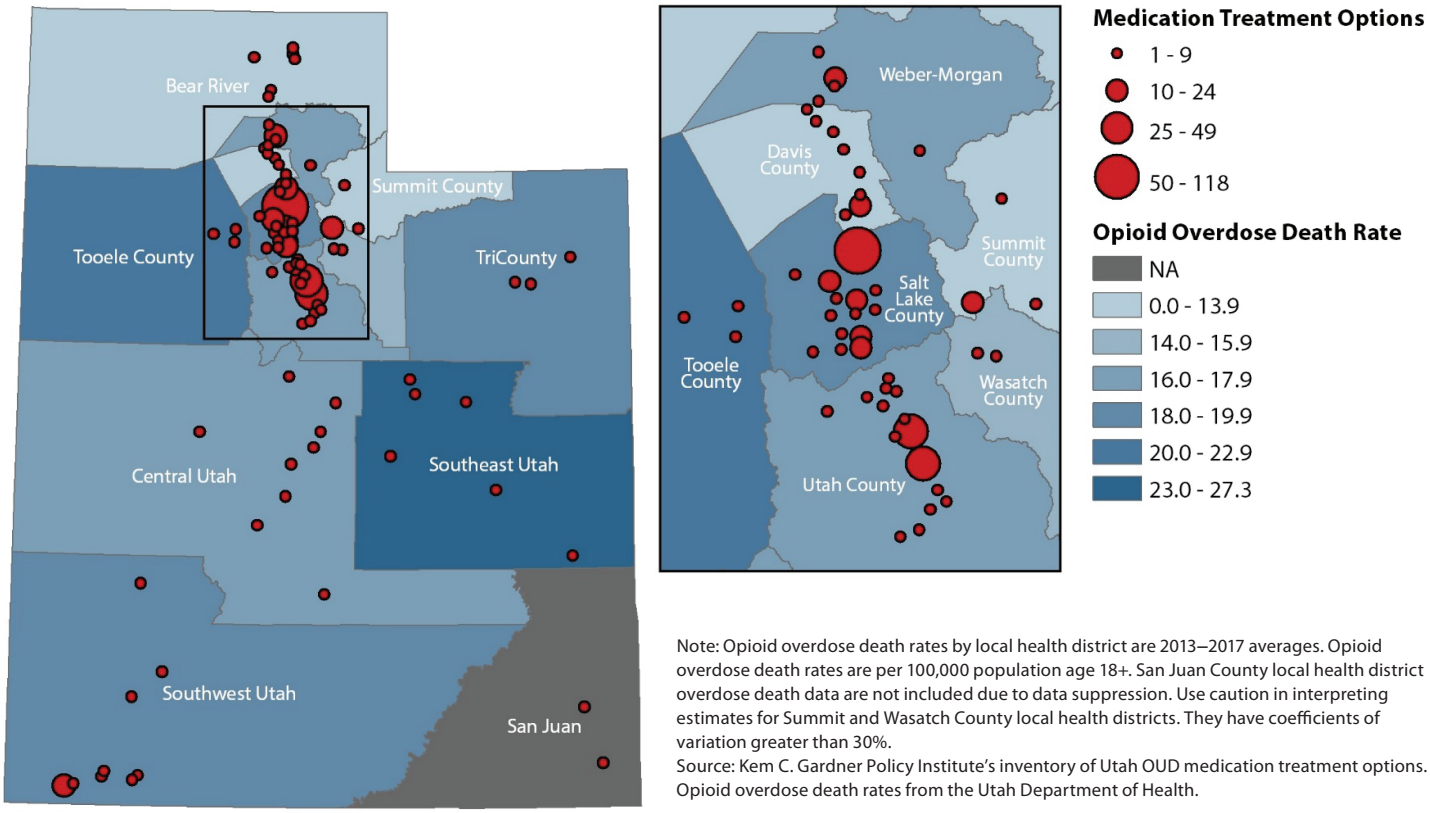
Source: Kem C. Gardner Policy Institute's inventory of Utah OUD medication treatment options.

Figure 5: Opioid Overdose Deaths vs. Medication Treatment Options (MAT, OTP, and OBOT) by Local Health District (Per 100,000 Population Age 18+), 2019



Note: Opioid overdose death rates by local health district are 2013–2017 averages. Central Utah local health district comprises Juab, Millard, Sanpete, Sevier, Piute, and Wayne counties. San Juan County local health district overdose death data are not included due to data suppression. Use caution in interpreting overdose death rate estimates for Summit and Wasatch County local health districts. They have coefficients of variation greater than 30%.
Source: Kem C. Gardner Policy Institute's inventory of Utah OUD medication treatment options. Opioid overdose death rates from the Utah Department of Health.

Figure 6: Distribution of Medication Treatment Options (MAT, OTP, and OBOT) Compared with Opioid Overdose Death Rates by Local Health District, 2019



Note: Opioid overdose death rates by local health district are 2013–2017 averages. Opioid overdose death rates are per 100,000 population age 18+. San Juan County local health district overdose death data are not included due to data suppression. Use caution in interpreting estimates for Summit and Wasatch County local health districts. They have coefficients of variation greater than 30%.
Source: Kem C. Gardner Policy Institute's inventory of Utah OUD medication treatment options. Opioid overdose death rates from the Utah Department of Health.

In general, the data help visualize that some urban and rural areas in the state are well served by programs, while other urban and rural areas are underserved (Figure 5). One clear area of concern is Tooele County, which has the second-highest need for OUD medication treatment options in the state, but the lowest rate of availability.

Figure 6 illustrates the location of medication treatment options (MAT, OTP, and OBOT) compared with need as measured by opioid death rates.

Distribution of Medication-Assisted Treatment Programs

Figure 7 illustrates the availability of MAT programs across the state, including OTPs. As noted before, the "MAT" designation is for programs or locations that appear to offer both psychosocial therapy and FDA-approved medication at the same location.

Similar to Figure 6, figure 7 highlights the need for more MAT programs in rural areas, like Tooele County. Rural-area discussion groups noted a lack of transportation as a critical barrier to accessing MAT programs.

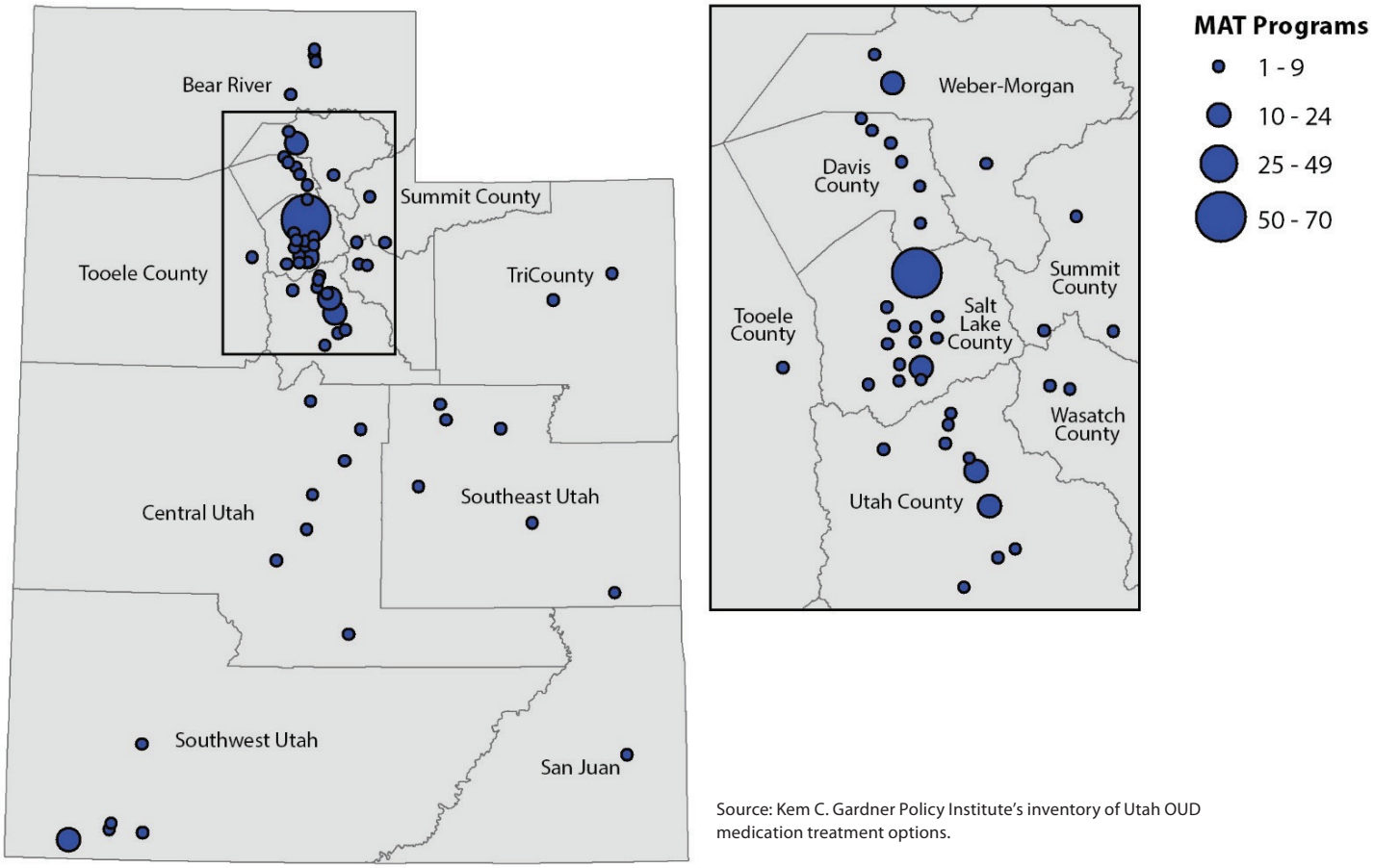
Figure 8 illustrates the location of Utah's OTPs. These programs are certified, accredited, and licensed to provide methadone onsite (they can provide other FDA-approved OUD medications as well). They also provide counseling, vocational, and educational services. The availability of OTPs is extremely limited in Utah's rural areas. As noted by discussion groups, rural areas could benefit from more access to these programs and the onsite connection to counseling, vocational, and educational services.

Distribution of DATA-Waivered Prescribers

Figure 9 shows how the distribution of medication treatment changes when viewing DATA-waivered prescribers. While some of these prescribers align with the MAT programs in Figure 7, Figure 9 illustrates how DATA-waivered prescribers helped expand access to medication treatment for OUD across the state. As noted before, the Gardner Institute matched DATA-waivered prescribers to a unique list of MAT programs. DATA-waivered prescribers that could not be matched to OTP or MAT-designated substance use or addiction programs were classified as OBOT.

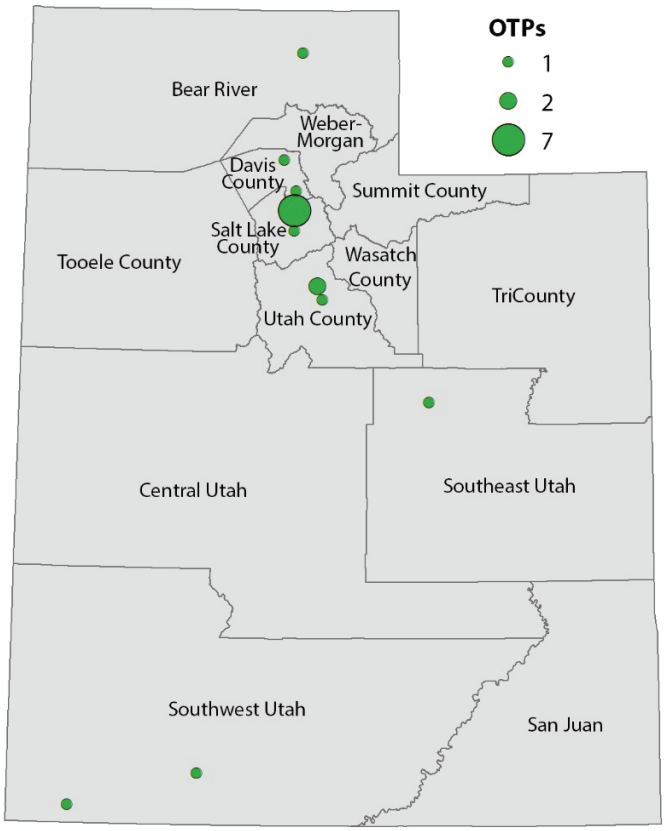
Buprenorphine can be prescribed by a physician, nurse practitioner, or physician assistant to up to 30 or 100 patients at a time after completing the required training. Figure 10 shows the distribution of DATA-waivered prescribers by profession.

Figure 7: MAT Program Distribution, 2019



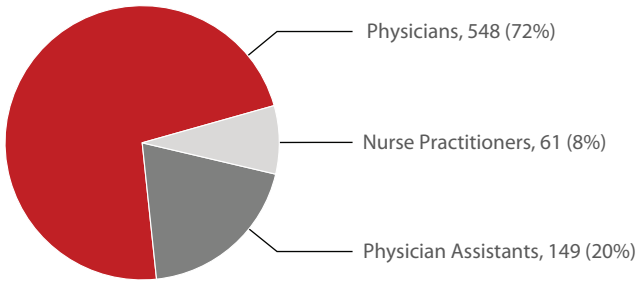
Source: Kem C. Gardner Policy Institute's inventory of Utah OUD medication treatment options.

Figure 8: Distribution of Opioid Treatment Programs, 2019



Source: Utah Division of Substance Abuse and Mental Health. From Kem C. Gardner Policy Institute's inventory of Utah OUD medication treatment options.

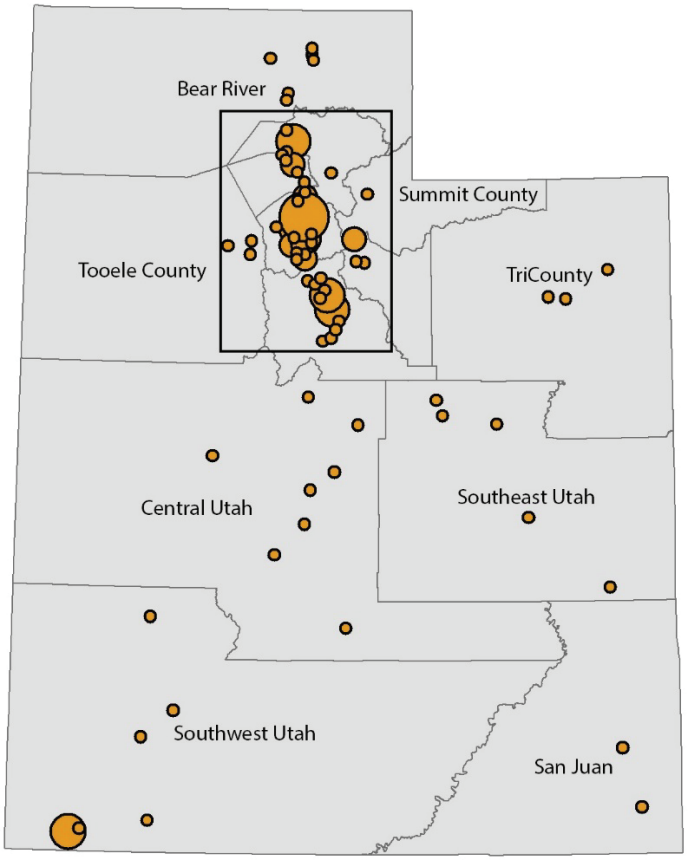
Figure 10: Distribution of DATA-Waivered Prescribers by Profession, 2019

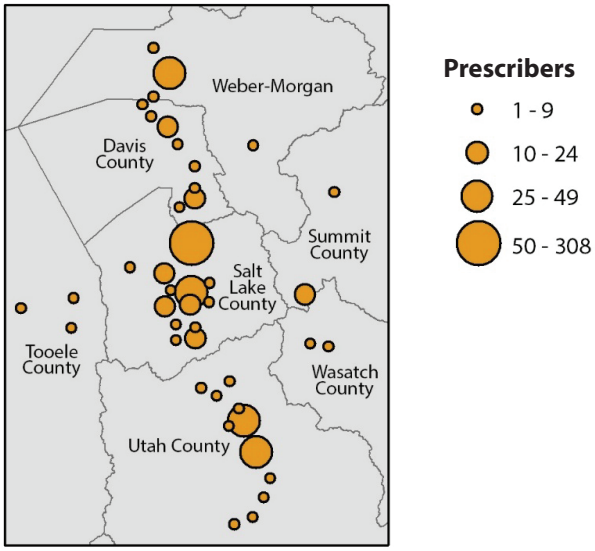


Note: Physicians include doctors of medicine (M.D.) and doctors of osteopathic medicine (D.O.).
Source: United States Drug Enforcement Administration. From Kem C. Gardner Policy Institute's inventory of Utah OUD medication treatment options.

Figure 11 shows the distribution of MAT programs (including OTPs) and OBOT locations by local health district. Discussion groups noted that having a variety of medication treatment options is important to improving access to MAT because of the complexity of patients' life circumstances and varying behavioral therapy needs.

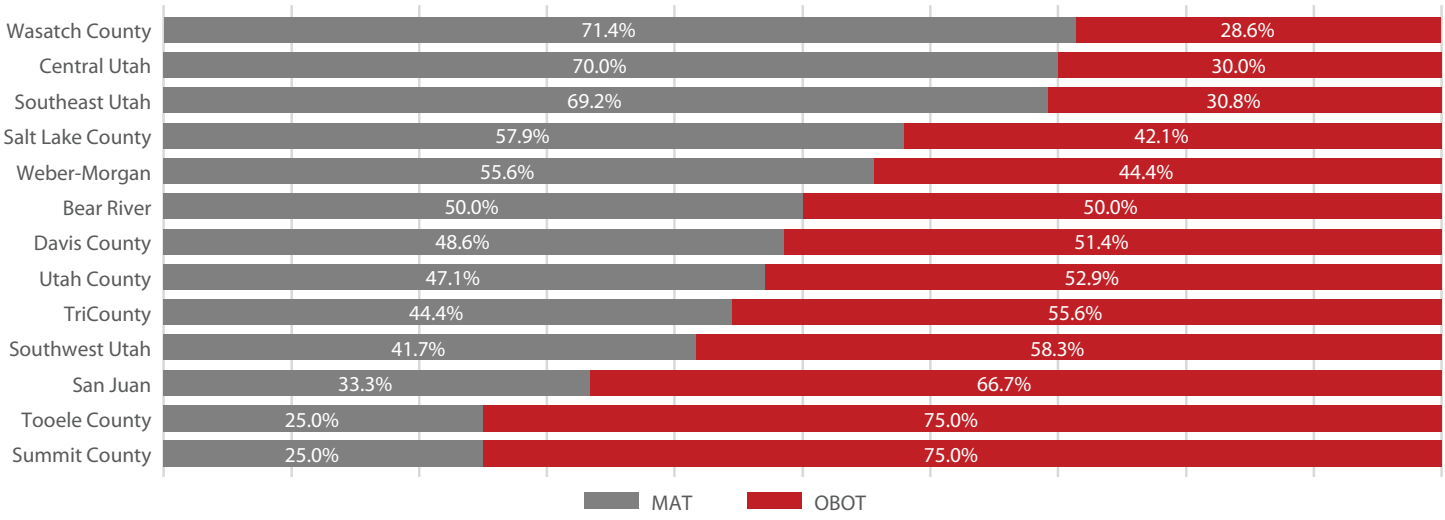
Figure 9: Distribution of DATA-Waivered Prescribers, 2019





Source: United States Drug Enforcement Administration. From Kem C. Gardner Policy Institute's inventory of Utah OUD medication treatment options.

Figure 11: Share of MAT Programs and OBOT Locations by Local Health District, 2019



Note: MAT programs include OTPs.
Source: Kem C. Gardner Policy Institute's inventory of Utah OUD medication treatment options.

Barriers and Challenges to Accessing and Providing Medication-Assisted Treatment

Stigma

All of the discussion groups mentioned the stigma that surrounds OUD as a barrier to accessing and providing MAT.

Stigma stems from a wide range of perspectives, including:

- Individuals who are not ready or willing to admit they have an OUD and could benefit from MAT.
- Viewing MAT as "replacing one drug with another" rather than OUD as a disease or chronic condition that can be treated over time through medication and psychosocial therapy.
- Primary care physicians or general health practitioners who are unwilling to become DATA-waivered prescribers due to concerns with taking on patients with substance use and behavioral health issues.
- Using stigmatizing language such as "dirty" vs. "clean," and "recovery" vs. "treatment," even within the prescribing and therapeutic community.
- The idea that "the only real recovery is abstinence recovery," even among some in the recovery community.
- Negative impressions of certain drugs. For example, while methadone is an evidence-based, effective treatment for OUD, it was initially used to treat people with heroin addiction. This historical impression may influence people's current perceptions of MAT.
- Preferences for certain drugs in one organization or area due to cost, marketing, or therapeutic effects, which can limit access to other drugs in that area.
- Including MAT as a component of court sentencing. Although viewed positively for connecting people with needed treatment, discussion groups observed that court orders can create a negative association with treatment for some patients.

Key Discussion Group Finding

Stigma Reduces Access to MAT in Rural Areas

Stigma can have a particularly negative impact on patients' access to MAT in rural and underserved areas. Having one or more key officials who don't understand the efficacy of MAT can be a barrier to implementing programs in the community, at a hospital, in the jail, or as part of the drug court system. It can also limit the ability to draw down federal, state, and private grants or donations to support OUD treatment.

"Some waivered prescribers are willing to provide MAT, but don't want to advertise that they're doing it… they don't want to be considered 'addiction treatment specialists.'"

Key Discussion Group Finding

Concerns with Court-Ordered Treatment

- Some patients view court-ordered treatment as a threat or punishment rather than as a pathway to independence and health (e.g., a necessary step in regaining custody of children rather than a health recommendation).
- It feels inappropriate for the criminal justice system to refer people to treatment. "You can't incarcerate people out of addiction."
- Some judges may lack qualifications to create appropriate treatment plans for individualized care.
- Some judges mandate treatment in areas where treatment is not available.
- The outcome of court-ordered treatment shouldn't be "completed" treatment; it should be "adherence" to treatment and a determination that sufficient improvements have been made to close the case.

"Threatening people into treatment through court orders is not a long-term solution. OUD needs to be treated as a disease rather than a moral failing."

Barriers to Accessing Medication-Assisted Treatment

There is a short window of opportunity to engage individuals in MAT.

Many discussion group participants emphasized the time-sensitive nature of providing MAT. They noted that patients seeking treatment need to receive an evaluation and have medication administered before re-using opiates. Naltrexone-based treatment, for example, is best provided during the short window of opportunity when a patient is interested in MAT and has detoxified for 7 to 10 days.[35] Being placed on a waitlist for services or treatment programs reduces the probability of reaching people during this critical window.

Wide-scale adoption and awareness of MAT as an evidence-based best practice is relatively new.

According to discussion groups, one potential reason for stigma surrounding MAT is that wide-scale awareness of it as an evidence-based best practice is relatively new. Despite more than 40 years of research supporting methadone as an effective treatment for OUD,[36] some established substance use disorder programs only recently adopted a MAT approach.

Discussion groups suggested the recent increased use of MAT has stemmed from (1) positive patient outcomes and experiences, (2) increased knowledge of supporting research, and (3) the gradual extension of authorized coverage of FDA-approved medications. Data showing the public benefits of MAT, such as lower recidivism for jail population patients with access to MAT, are also relatively new and could provide valuable insights to policymakers and the general public.

Discussion group participants recognized that many individuals and families in need of OUD treatment are unaware of the effectiveness of MAT. Participants explained that current public education campaigns, such as the "Use Only as Directed" campaign, raise awareness of the potential for prescribed opioids to become addicting, but do not mention MAT as an evidence-based, effective program.

Key Discussion Group Finding

A Changing Perspective Toward MAT

Several discussion group participants said that they did not personally understand the benefit of MAT until they saw a positive impact on patients firsthand. Some used to believe that only an abstinence-based approach to treatment could lead to patient success.

There are gaps in available programs and support services, particularly in rural areas.

Beyond the concern that wide-scale adoption of MAT as an evidence-based best practice is relatively new, is the reality that there are gaps in available programs and support services. Participants noted a lack of both DATA-waivered prescribers and licensed behavioral health therapists in most communities. The problem is magnified in rural areas where the nearest DATA-waivered prescriber, MAT program, or residential detoxification facility could be two or more hours away from a patient's residence.

Additional gaps and barriers to accessing MAT noted by discussion groups include:

- Lack of places for formal induction of MAT
- Lack of prescribing physicians
- Lack of prescribing physicians willing to take Medicaid enrollees
- Lack of 24/7 prescribing physicians, walk-in centers, and pharmacy hours
- Shortages of available and affordable psychosocial therapists and behavioral health providers
- Waitlists for residential treatment programs that provide MAT
- Inadequate housing and a lack of other social supports to help people seeking treatment
- Lack of transportation, particularly in rural areas that don't have access to bus, taxi, or rideshare systems

Key Discussion Group Finding

Challenges Attracting and Maintaining MAT Providers

It can be particularly challenging to attract and recruit physicians and licensed behavioral health providers in rural areas. Discussion groups noted the loss of even one prescriber or licensed behavioral health provider can be devastating. It can sometimes take more than a year to refill the position, which makes it difficult to maintain continuity and consistency in providing OUD treatment.

Cost and health care coverage create additional limitations.

Despite the need for increased access to MAT, cost, programmatic, and legal limitations have been slow to change, which has hindered the delivery of MAT. The following is a list of cost- and coverage-related barriers mentioned by discussion group participants.

Cost-related barriers:

- **Medication costs**—While the cost of generic versions of some OUD medications can be relatively low, the cost of non-generic medications can range from $100 to upwards of $1,000 per dose. These prices are prohibitive for low- and middle-income families who are uninsured or underinsured. Some participants suggested that without assertive monitoring at the state or federal level, these costs could continue to grow.
- **Treatment costs**—The cost of behavioral health services can also be prohibitive. For example, the cost for private counseling or therapy ranges from $50 to $240 for a one-hour session.[37] While Utah has an established network of safety net programs for the uninsured, these programs have limited capacity and are not always located in areas accessible to people in need of treatment.
- **High deductible health plans and copays**—High copays or deductibles can preclude access to medication and behavioral health treatment for individuals with insurance. Commercial health insurance typically covers only a portion of the cost of physician visits and behavioral health sessions, even if a network provider provides them.

Coverage-related barriers:

- **Preauthorization requirements**—Several discussion groups mentioned that Medicaid's preauthorization requirements for some OUD medications are cumbersome for prescribers, particularly given the time-sensitive need for medication. That said, several participants also noted that both Medicaid and commercial health insurance plans have recently changed their preauthorization requirements to cover more medications.
- **Limits on prescriptions, prescriber visits, and behavioral health services**—Discussion groups noted that restrictions on OUD medications, prescriber visits, and behavioral health services (particularly detox and residential services) are significant barriers to providing and accessing MAT. Some discussion groups specifically mentioned insurance requirements to taper individuals off medication when not medically indicated, not paying for court-ordered treatment, and a lack of mental health parity[38] as barriers to MAT.
- **Reimbursement rules**—Reimbursement rules, such as same-day billing, result in providers not being reimbursed for physical and behavioral health services provided on the same day and can prevent the timely provision of MAT.
- **Federal limits on the number of patients a prescriber can treat**—As noted before, buprenorphine can be prescribed by a qualified provider for up to 30 or 100 patients at a time. Even though some providers (with additional qualifications) may treat up to 275 patients,[39] participants suggested that additional expansion of the number of allowed patients per prescriber could improve access.

Addiction treatment is a business.

Discussion groups expressed concerns about the "business" side of medication and addiction treatment. Examples provided by discussion group participants include:

- Marketing certain drugs to influence people's perceptions of the effectiveness of those drugs compared with others.
- Providing pressure or incentives to enroll people in residential treatment programs despite the programs being unaffordable or the inappropriate level of care for an individual.
- Charging Medicaid enrollees out-of-pocket costs for the therapy component of MAT due to having to bill the two services separately.
- Charging Medicaid enrollees fees for missing appointments.
- Claiming to provide "MAT," but not providing evidence-based services.
- Steering inmates with OUD to work release programs rather than enrolling them in Medicaid40 so they can get access to appropriate treatment.

These types of "business" practices limit access to care for low-income individuals who cannot afford the cost of treatment. They can also make it difficult for payers to build networks with prescribers or treatment programs that align with a mission of delivering effective, evidence-based treatment.

Incorporating MAT into the correctional system creates both opportunities and barriers to care.

Involvement in the criminal justice system provides an opportunity for individuals to access MAT, but can also serve as a barrier to receiving uninterrupted care. For example, some jails and prisons offer onsite access to MAT, which allows for induction and treatment. Ideally, treatment will continue when the individual is released from prison or jail and transitioned to a community-based program or program covered by Medicaid or their health insurance. As an example, Salt Lake County Behavioral Health Services partners with Project Reality to offer MAT in the Salt Lake County Jail. The Jail Medication-Assisted Treatment Program provides qualifying program participants with medication (methadone, buprenorphine or naltrexone), substance use disorder behavioral therapies, and coordinated referrals to community treatment services upon release.[41]

Entering the correctional system can, however, serve as a barrier to care for individuals who are engaged in treatment if the correctional facility does not offer MAT. Discussion group participants also noted that there is an increased likelihood of overdose if an individual released from the criminal justice system does not have an initiated treatment plan.

Key Discussion Group Finding

Risk of Relapse Increases Without Accessible Programs

Individuals with OUD are at higher risk for overdose when released from an institution such as a hospital or correctional facility because of reduced drug tolerance.[42] If these individuals are not able to access appropriate support services, then their risk of relapse and overdose increases.

Specific to Utah, discussion groups felt that attitudes toward MAT among jails and law enforcement officials vary, with some expanding MAT and establishing jail as an induction point for treatment, and others resisting prescribing medication onsite. This resistance stems from:

- The frequency with which inmates access these medications surreptitiously.
- Perceptions that MAT is "replacing one drug with another."
- The lack of available treatment programs inmates can access upon release, which can result in prison being a "revolving door" for treatment.
- The resources required to maintain continuous connections and referrals with community-based programs.
- A lack of trained professionals who can appropriately administer MAT in a correctional facility.
- A preference for certain medications rather than offering access to multiple OUD medications.
- A hesitancy to sign on to new programs without better information on outcomes and long-term funding requirements.

That said, some discussion groups noted this resistance is changing. The Utah State Prison, for example, is finalizing its written protocol for MAT starting in 2020 and plans to offer one injection of Vivitrol before qualifying offenders leave the facility. Upon release, a probation and parole case manager will assist them in finding and following through with a clinic for additional injections and therapy.

Discussion Groups: Considerations for Improving the System

Barriers to Accessing MAT

1. **Promote a better understanding of MAT.** While industry providers understand the effectiveness of MAT, there is a need to continue to improve education and awareness of MAT's positive outcomes across the general public. Target populations for education or media campaigns include, but are not limited to, patients, families, youth caretakers, providers, law enforcement personnel, court systems, and policymakers. Discussion groups suggested that having the Utah Department of Health, the executive branch or legislature, or higher education sponsor these campaigns would improve their reach and success. These campaigns could also help reduce stigma and promote a unified language that destigmatizes addiction and moves the public away from terms like "substance abuse," "clean," and "dirty."[43]

2. **Develop a shared understanding of the goals and outcomes of MAT.** Discussion groups noted a need to better understand the short- versus long-term outcomes of MAT. For example, a short-term outcome may be stabilization, while a long-term goal could be abstinence. That said, it was noted that some people on MAT might never reach abstinence, but—like many chronic conditions—can stabilize with medication.

   Discussion groups felt promoting this understanding and measuring success through appropriate metrics such as (1) access to treatment, (2) treatment adherence or program retention, or (3) reductions in overdose and overdose deaths will help reduce stigma, increase access to MAT, and help the legislature make informed decisions regarding resource allocation and funding.

"Relapse rates for substance use disorders (40–60%) are comparable to those for chronic diseases, such as diabetes (20–50%), hypertension (50–70%), and asthma (50–70%)." [44]

"OUD should be treated like any other chronic condition. People with diabetes are not punished for bad eating habits. If their A1C levels are high, their physician doesn't take away their medication, but may recommend additional services such as meeting with a dietician."

"The goals of substance use disorder treatment are similar to those of treatments for other serious, often chronic, illnesses: reduce the major symptoms of the illness, improve health and social function, and teach and motivate patients to monitor their condition and manage threats of relapse." [45]

3. **Establish no-wrong-door treatment options.** Discussion groups recommended developing a systemwide "one-stop" shop approach to treatment. Given the short window of opportunity to engage individuals in MAT, establishing accessible, walk-in points of access with systemwide referrals to appropriate treatment programs for follow up care will help individuals, families, and providers capitalize on that window.

4. **Establish a statewide MAT-focused referral platform**. A referral platform could help support a no-wrong-door approach by coordinating systemwide referrals to MAT prescribers and programs as well as to other organizations that provide behavioral health-focused services, stabilization supports, and social services like housing, transportation, family support services, and employment services. It could improve referrals to appropriate treatment programs and create better linkages between OBOT and behavioral health services. Improving insurance coverage of case managers could increase referral effectiveness. Creating a closed-loop referral process could allow providers to know if their patients are engaging with the referred-to services.

5. **Support the development and continued operation of recovery community centers.** Discussion group participants noted that **r**ecovery community centers are an effective way to promote MAT as a pathway to recovery. Recovery community centers are peer-operated centers that provide information on local resources and community-based recovery supports. Services can include advocacy training, recovery information, resource mobilization, peer support, and recovery-focused social activities. The centers can also connect recovering individuals to social services, employment and skills training, and educational opportunities.[46]

Discussion Groups: Considerations for Improving the System *(Continued)*

6. **Increase insurance coverage and use of recovery support staff and peer support specialists.** Several discussion groups mentioned the value recovery support staff and peer support specialists provide to people in OUD treatment, including (1) providing positive relationships and support, (2) engaging people "where they are" (i.e., at their homes or on the street), (3) conducting assertive outreach when people miss appointments, and (4) helping people re-engage with treatment centers by scheduling appointments.

7. **Partner with law enforcement**. Several local health districts, including Salt Lake, Davis, and Southeast, have developed effective MAT-based partnerships and programs with their local jails and law enforcement officers. These partnerships and programs promote increased use of MAT in jails and warm hand-offs between police, adult probation and parole, local MAT programs, and other community partners.

8. **Increase the availability of MAT**. To address gaps in services, discussion groups recommend:

   a. Establish a mobile MAT center.
   b. Promote virtual treatment options and coverage of telehealth, tele-prescribing, and tele-psych services.
   c. Encourage more physicians to become DATA-waivered prescribers.
   d. Encourage prescribers to "moonlight" at multiple treatment centers or rural offices.
   e. Expand the number of emergency departments that provide MAT induction and referral services.
   f. Review Medicaid prior-authorization requirements to improve access.
   g. Establish 12-month continuous eligibility for specific Medicaid populations with OUD or substance use disorders.
   h. Increase access to all forms of OUD medications, with a specific focus on increasing rural access to sustainable and evidence-based OTPs. Many rural areas benefit from the onsite connection to counseling, vocational, and educational services OTPs offer.

      Data from the inventory used in this report show that, of the programs where the types of medication offered are known, 50.6% of programs offer more than one medication, while 49.4% offer either buprenorphine or naltrexone alone.

   i. Increase the availability of MAT services for pregnant women.

      Data from the inventory used in this report show that less than 10% of the unique locations that offer OUD medication treatment in Utah serve pregnant women. Some discussion group participants felt that most prenatal and children-specific programs are targeted to Medicaid patients and not readily available to people with higher incomes.

9. **Encourage increased physician training of MAT**. Some discussion group participants suggested that medical providers who prescribe controlled substances should (1) receive training on MAT, available programs, and the importance of prescribing naloxone; (2) share information with their patients on the risk of taking opiates; and (3) better understand the effects of withdrawal on infants and how in-utero exposure to opioids negatively impacts the health of children.

"While MAT is effective, it is more effective to prevent people from getting addicted in the first place."

Challenges with Providing Medication-Assisted Treatment

OUD requires an individualized approach to treatment.

Individualized intervention is critical for patients seeking MAT because of the complexity of patients' life circumstances and behavioral therapy needs[47] (see text box: Individuals Seeking MAT Experience a Wide Range of Circumstances). Patients also respond differently to different medications, as the medications have different action mechanisms biologically.

While maintaining an individualized approach to treatment is important, this individualized approach makes it more challenging to collect and track standardized program outcomes. This is particularly true for persons who leave, change, or complete treatment programs.

Key Discussion Group Finding

Individuals Seeking MAT Experience a Wide Range of Circumstances

- Some seek treatment as a result of a court order.
- Some are self-admitting due to their self-perception of crisis.
- Some need inpatient treatment, while some have success at home with the support of outpatient programs.
- Some lack positive support systems (family and friends).
- Some may be able to continue to care for their children while others cannot.
- Some lack stable housing and access to phones, which limits the ability of providers to follow up with them.
- Some will be able to taper off medications over time.
- Some may remain on medication for the foreseeable future.
- Many have co-occurring mental health issues.
- Some may not need mental health services and prefer to see an OBOT provider or DATA-waivered primary care physician.
- Some may not feel comfortable with available prescribers or psychosocial therapists in their area but have no alternative options due to a shortage of local providers.
- Health insurance plans determine patients' eimbursable treatment options.

"MAT requires a holistic approach to treatment that recognizes the unique life situation and treatment experiences of the patient to achieve an enduring positive outcome."

Data sharing is limited.

Most discussion groups noted that data sharing is a significant barrier to providing coordinated MAT, making real-time referrals, and using data to better drive outcomes. This is due to the constraints around data sharing from privacy regulations, data ownership, and delays in data collection and aggregation. Some felt 42 CFR Part 2, the federal statute that limits the sharing of patients' medical histories, should not apply in a primary care setting, and that it makes getting medical records from MAT programs and OUD specialists nearly impossible. Others acknowledged its importance in protecting patient privacy. Congress is currently evaluating changes to 42 CFR Part 2.

A need for consistent, sufficient, and long-term funding.

Many community-based and safety-net substance use or addiction treatment programs rely on short-term grants (each with unique funding terms and restrictions) to support or supplement their MAT. Applying for these grants is time- and resource-intensive, and the short-term nature of the grants limit the ability to provide consistent services or staffing over time. This problem is more acute in Utah's rural areas and for treatment programs providing services to the uninsured or underinsured.

Participants also noted both commercial health insurance and Medicaid reimbursement rates were insufficient. Several participants mentioned that most of the major health insurance companies in Utah were reimbursing less than Medicare, and that Medicaid rates were so low, physicians were taking fewer Medicaid clients to remain financially viable.

Participants also expressed concern that short-term grant funding may phase out once opioid death rates start to fall, key officials determine that the "issue is solved," or when there are more pressing public health needs. Because OUD is not an acute care condition, but rather a chronic condition treated over time, consistent funding levels are critical to maintaining services and treatment.

"You don't expect a person with cancer to be cured in a short time. OUD needs to be viewed as a chronic condition, and not an acute care need that can be resolved in a certain number of days or visits. People with OUD often engage in treatment for at least nine months, if not longer."

Varying perceptions and practices regarding behavioral health treatment in MAT.

MAT is "a combination of psychosocial therapy and U.S. Food and Drug Administration–approved medication."[48] However, discussion groups revealed varying perceptions as to whether—and to what degree—psychosocial therapy and behavioral health services should be included in an individual's treatment

program (see text box: Differing Opinions on Behavioral Therapy). Other concerns expressed by discussion groups regarding behavioral health treatment include:

- While MAT is the "combination of psychosocial therapy and U.S. Food and Drug Administration-approved medication,"[49] in practice, these two components are often separated.
- The types and number of licensed behavioral health personnel a program can employ depend on funding levels. Some community-based and safety-net programs expressed concern with having sufficient resources for ensuring ongoing training and retention of their behavioral health staff.
- The shortage of behavioral health providers exacerbates this issue, given the limited supply of licensed behavioral health personnel (see Figure 12). Payers noted they also struggle with finding a sufficient number of providers to maintain a robust behavioral health network.
- A person's health insurance determines the types of behavioral health providers a person can see and their allowable number of behavioral therapy sessions.
- Maintaining an individualized approach to OUD treatment is supported by having a variety of therapy options and professionals. However, some discussion group participants expressed concern about MAT not using, or not referring individuals to, evidence-based, addiction-focused psychosocial therapy, or behavioral health services. While most MAT programs have internal policies to ensure their behavioral health providers use evidence-based approaches, there is some concern that not all behavioral health providers adhere to evidence-based models.

Many participants felt a system that better integrates physical and behavioral health would improve MAT outcomes and promote better access to appropriate levels of care.

"The supply of licensed behavioral health providers is at a crisis level. As the need for services grows, and treatment expands, programs are all competing for the same folks."

Key Discussion Group Finding

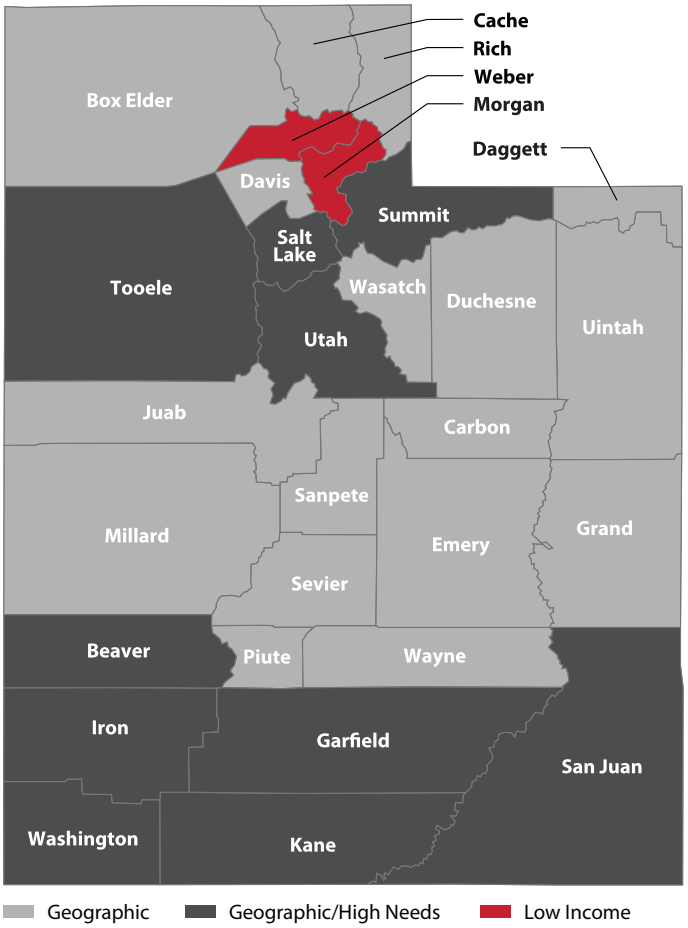
Differing Opinions on Behavioral Therapy

Conversations about the behavioral health component of MAT highlighted a point of disagreement among discussion group participants. Some participants believe that ongoing behavioral therapy is an essential component of MAT and expressed concern that it is not sufficiently incorporated into patient care. They feel building stable relationships between patients and behavioral health providers results in better outcomes and can yield better treatment adherence.[50]

Other discussion group participants feel that while behavioral therapy is a necessary component of initial treatment, it can be tapered off or eliminated after a patient stabilizes with medication. They feel the need for therapy should be assessed on an individual basis so that it does not deter individuals from initiating or continuing medication-based treatment.

A 2017 report from SAMHSA found about 1 in 8 adults who misused opioids also had a serious mental illness.[51]

Figure 12: Mental Health Care Professional Shortage Areas by County, 2017



Note: "Geographic" means there is a shortage of providers for the entire population within a defined geographic area. "Low Income" means there is a shortage of providers for low-income individuals within the defined geographic area. Areas qualify as "high needs" geographic areas if at least 20% of the population has income below 100% of the federal poverty level, there is a high ratio of children or elderly in the population, there is a high prevalence of alcoholism, or there is a high degree of substance use disorders.
Data from 2017. HPSA Detail - Mental Health Care.
Source: First Quarter of Fiscal Year 2019 Designated HPSA Quarterly Summary. (2018, December). Health Resources and Services Administration.

Discussion Groups: Considerations for Improving the System

Barriers to Providing MAT

1 **Ensure long-term, sustainable funding for MAT.** Many community-based and safety-net treatment programs rely on short-term funding to support or supplement their MAT. These short-term grants limit the ability to provide sufficient or consistent services over time. Long-term, sustainable funding mechanisms are needed to meet the growing needs of OUDs in Utah. This includes, but is not limited to:

   a. Improving Medicaid and commercial health care coverage, including increasing reimbursement rates, adjusting preauthorization requirements and other coverage limits to reflect the chronic nature of OUD, and changing reimbursement rules such as same-day billing to better align payment for the medication and behavioral health components of MAT.
   b. Establish capitated, value-based, or bundled payments for MAT. Current reimbursement models make it difficult to provide the full range of integrated physical and behavioral health services required in MAT. Some discussion group participants felt moving to capitated or value-based payments could allow them to better meet the needs of their patients, hold them more accountable for program outcomes, and provide mechanisms to reimburse case managers, recovery support staff, and peer support specialists.
   c. Provide ongoing legislative funding for evidence-based MAT to ensure sustainable financing beyond short-term state and federal grants. Sustainable funding sources will result in improved continuity of care for patients with OUD.
   d. Ensure opioid settlement funds the state or local areas may receive are invested back into OUD prevention, education, and MAT system support.

2. **Promote integrated primary care and behavioral health services.**[52] Many discussion group participants felt an integrated system could improve treatment outcomes, promote better access to physical and behavioral health services, and address provider shortages. However, they acknowledged that integrated care models vary, and different approaches should be evaluated for effectiveness. Some participants supported the use of collaborative care teams. In contrast, others felt having a statewide MAT-focused referral platform could promote integration through improved consultation and care coordination among MAT programs and prescribers.

3. **Increase the use of screenings to identify appropriate levels of care for individuals with OUD.** Discussion groups generally supported the use of screenings to better support individualized approaches to treatment and place people in appropriate programs or levels of care. Some suggested statewide use of tools like the Brief Assessment Recovery Capital Tool (BARC), which assesses clients' strengths and engagement levels. Increasing the use of screenings will require improved reimbursement for this service, but could benefit the system by improving coordination and placing people in appropriate care settings. The development of a statewide MAT-focused referral platform aligns and supports this recommendation.

4. **Develop a systemwide MAT assessment process.** Discussion group participants noted that an effective no-wrong-door treatment approach and MAT-focused referral platform should be coupled with a systemwide MAT assessment process. This could enable providers and payers to identify and refer patients to MAT programs, prescribers, and behavioral health providers who meet specific qualifications and standards. The assessment process could also ensure a system approach to program improvement through evidence-based, state-determined assessment guidelines, training opportunities, and the sharing of best practices. Some discussion group participants acknowledged the difficulty in developing this type of process, given the range of MAT options (e.g., addiction treatment programs versus OBOT versus OTPs) and levels of care in the system.

5. **Leverage Project Echo to expand MAT training opportunities.** Several discussion group participants recommended using Project Echo to help train MAT providers. Project ECHO trains "community providers through HIPPA-compliant, technology-enabled collaborative learning to address specialty care–level health concerns in the primary care setting."[53] The virtual training and consultation platform is particularly useful in rural areas and for newly waivered prescribers who are starting to treat patients with OUD. Leveraging Project Echo to expand evidence-based MAT training could also support a systemwide MAT assessment process.

Considerations for Future Studies

This report provides a comprehensive picture of MAT for OUD in Utah, highlighting gaps in services, barriers to providing and accessing care, and considerations for improving the system—developed from discussions held with a range of stakeholders involved in addressing Utah's opioid epidemic. It is important to note, however, that this report represents a snapshot of the current system—a system that is evolving to meet the changing needs of Utah's opioid epidemic. Additional studies are needed to continue to understand how effectively Utah's MAT system is addressing OUD. A few considerations for future studies are detailed below.

1. **Evaluate changes in program availability and geographical coverage over time.** The inventory developed for this report can be used as a baseline to determine if MAT availability is growing and assess whether MAT is meeting the evolving OUD needs of the state. For example, future analyses could examine whether areas with a high rate of program availability have experienced a reduction in opioid overdose death rates—and, if not, what other factors may be causing death rates to increase, and whether the programs available in those areas are providing effective treatment or not. Evaluating changes over time will be particularly important given Medicaid expansion and the potential for more individuals to have access to MAT. UDOH and the Utah Department of Human Services will receive the inventory for continued analysis.

2. **Explore additional areas of study.** Example areas of possible research include:

   a. *Assess whether DATA-waivered prescribers are treating patients with OUD and at what capacity.* This analysis could provide a deeper understanding of potential gaps in the system and whether existing waivered prescribers, who are not currently treating patients, can fill them. One local health district, for example, conducted an assessment of its DATA-waivered prescribers to determine whether it should actively recruit other physicians. Based on this assessment, it determined existing prescribers had the capacity and willingness to take on new clients, allowing the district to direct its resources elsewhere.

   b. *Understand the specific challenges of DATA-waivered prescribers.* This study could examine the challenges of being a practicing DATA-waivered prescriber, including why physicians are not becoming DATA-waivered, why waivered prescribers are not taking on OUD patients, and whether waivered prescribers are continuing to treat existing patients or take on new patients over time.

   c. *Evaluate the availability of all forms of OUD medication (buprenorphine, naltrexone, and methadone).* Since patients respond differently to different medications, having access to all forms of OUD medication is important to improving MAT access and program outcomes.

   d. *Evaluate access to MAT using different measures of need.* It could be helpful to evaluate program availability compared with current data on opioid deaths by zip code or Utah "small area" (which are not publicly available). Other possible measures to compare with program availability include opioid prescribing rates by region or physician.

   e. *Conduct discussion groups or a survey of individuals who currently receive MAT or are seeking OUD treatment.* Due to research constraints, this report did not include the perspectives of individuals who are presently receiving MAT or seeking OUD treatment; however, their input is critical in assessing gaps in services and barriers to accessing MAT.

   f. *Expand the analysis.* Future analyses could (1) evaluate the availability of MAT at emergency departments, Instacare, and urgent care locations and determine whether expanding MAT at such sites could improve program accessibility; (2) include treatment centers that do not offer OUD medication onsite but provide it through contracting prescribers; (3) conduct research on the availability of MAT for specific populations such as pregnant women and youth; and (4) understand what percentage of all substance use or addiction treatment programs in Utah provide MAT or offer OUD medication.

3. **Invest in evidence-based programs.** As Utah evaluates how best to address the gaps in treatment availability identified in this and future reports, state leaders should seek to adopt evidence-based programs. Information on the effectiveness of programs in a range of policy areas—including workforce training, substance use disorder treatment, and behavioral health—is available in the Results First Clearinghouse Database,[54] which compiles information on the national evidence-base of human services programs.

4. **Look to other states for examples on how best to address gaps in services, barriers to providing and accessing care, and considerations for improving the system.** The opioid epidemic is not specific to Utah. All states are struggling to identify strategies to effectively address OUD and improve the health of their population. The Oregon Health and Sciences University recently built out a publicly available online resource containing an array of policy reports, implementation guides, fact sheets, and program information to help states tackle the opioid epidemic. Users can sort documents in the "opioid library" by type, audience, and evidence ranking. For more information, see https://www.opioidlibrary.org/. Future studies could continue to examine what other states have done to address the specific barriers and challenges highlighted in this report.

Appendix: Examples of Medication-Assisted Treatment in Utah

Discussion groups emphasized the importance of having a continuum of MAT options to meet different levels of severity, circumstance, and need. While there are many great examples of MAT in Utah that support this continuum, a few programs are highlighted below.

Davis Behavioral Health

Davis Behavioral Health started a comprehensive MAT program in 2015 that serves Davis and Weber counties. The program utilizes a team-based approach to care that includes therapists, National Institute of Drug Abuse (NIDA) assessments, recovery support specialists, nurses, and medication treatment. The team-based approach provides immediate access to a therapist, follow-up with a prescribing physician and pharmacy (within two days), and a team of nurses and recovery support specialists to help keep clients engaged. Davis Behavioral Health is a part of the Opioid Community Collaborative (OCC), which was founded by Intermountain Healthcare and includes DSAMH, UDOH, Weber Human Services, and other community agencies. Davis works closely with these and other agencies to provide appropriate care to special populations such as pregnant women. Intermountain Healthcare provided initial funding for Davis Behavioral Health's MAT program. Today the work is supported through a combination of federal, state, and county dollars as well as insurance collections, co-pays, and grants.

Project Reality

Project Reality is a nonprofit outpatient substance use treatment program that has been in operation since 1970. It is a federally certified OTP and licensed by the State of Utah as an outpatient mental health therapy program as well as an outpatient substance abuse treatment program. Project Reality provides a full range of interdisciplinary services in addition to medication (e.g., addiction specialists, mental health therapy, caseworkers, substance use disorder therapists, housing supports, and employment services). Onsite physicians can prescribe buprenorphine, methadone, and naltrexone, and interdisciplinary services are provided by coordinated care teams to address whole-patient wellness. Project Reality treats patients regardless of income, insurance, or ability to pay. It currently provides services in Salt Lake, Utah, and Carbon counties (through a partnership with Four Corners Community Behavioral Health) and is overseeing a program initiated in collaboration with Salt Lake County Behavioral Health Services to provide methadone treatment to inmates in Salt Lake County Jail.

University of Utah Opioid Bridge Recovery Program

The University of Utah Opioid Bridge Recovery Program initiates MAT at the University of Utah Emergency Department (ED) and serves as a bridge to long-term treatment of OUD. Patients over age 18 who agree to participate in the Bridge program (1) receive MAT induction in the ED, a five-day prescription for buprenorphine, and a naloxone rescue kit; (2) are connected to Utah Support Advocates for Recovery Awareness (USARA); and (3) are seen at the University Neuropsychiatric Institute (UNI) Addiction Recovery Clinic where they receive outpatient services for one month. At the clinic, patients meet with a psychiatrist for behavioral health services and a case manager who assists them with insurance coverage and finding community- based treatment programs for ongoing care. USARA provides peer support and will contact patients if they miss appointments. Several funding sources support this open-door approach to MAT, including a DSAMH grant that helps fund one-month of MAT and UNI treatment for each patient.

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Endnotes

1. Opioid Data Dashboard. Utah Department of Health. https://dashboard.health.utah.gov/opioid/
2. Ibid.
3. Opioid Overdoses. Utah Department of Health -Violence and Injury Prevention Program Prescription Medication Program Database.https://www.health.utah.gov/vipp/topics/prescription-drug-overdoses/index.html
4. Wakeman, S., Larochelle, M., Ameli, O., et al. (2020, February). Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. Journal of the American Medical Association (JAMA). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032
5. Public Health Indicator Based Information System (IBIS), Utah's Public Health Data Resource. Utah Department of Health. https://ibis.health.utah.gov/ibisph-view/indicator/view/PoiDth.html
6. Ibid.
7. U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. (2017). Drug Poisoning Mortality: United States, 1999–2015. https://www.cdc.gov/nchs/data-visualization/drug-poisoning-mortality. U.S. Centers for Disease Control and Prevention. (2019, January 4). Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017. Morbidity and Mortality Weekly Report, 67(5152), 1419-1427. https://www.cdc.gov/mmwr/volumes/67/wr/mm675152e1.htm?s_cid=mm675152e1_w. From Planalp, C., Hest, R., Lahr, M. (2019, June). The Opioid Epidemic: National Trends in Opioid-Related Overdose Deaths from 2000 to 2017. State Health Access Data Assistance Center. https://www.shadac.org/sites/default/files/publications/2019%20NATIONAL%20opioid%20brief%20FINAL%20VERSION.pdf
8. Hedegaard, H., Minino, M., Warner, M. (2020, January). Drug Overdose Deaths in the United States, 1999–2018. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/products/databriefs/db356.htm
9. Ibid.
10. Florence CS, Zhou C, Luo F, Xu L. The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013. *Med Care*. 2016;54 (10):901-906. From Opioid Overdose Crisis. (2019, January). National Institute on Drug Abuse. https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis#two
11. Module 5: Assessing and Addressing Opioid Use Disorder (OUD). Department of Health and Human Services. https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html
12. Utah small areas are determined by population size, political boundaries of cities and towns, and economic similarity. Utah Opioid Overdose Fatality Review Hot Spots Report. (2019, March). Utah Department of Health. http://www.health.utah.gov/vipp/pdf/RxDrugs/OFRCHotSpots2019.pdf
13. Ibid.
14. Information about Medication-Assisted Treatment (MAT). (2019, February). Food and Drug Administration. https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat
15. Effective Treatments for Opioid Addiction. (2016, November). National Institute on Drug Abuse. https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction. Buprenorphine. (2019, November). Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine. Safawi, A. (2018, June). Suboxone vs. Vivitrol: Which Is Better, Bupes Or The Shot? Workit Health. https://www.workithealth.com/blog/suboxone-vivitrol-which-is-better
16. FDA News Release: FDA approves first once-monthly buprenorphine injection, a medication-assisted treatment option for opioid use disorder. (2017, November). Food and Drug Administration. https://www.fda.gov/news-events/press-announcements/fda-approves-first-once-monthly-buprenorphine-injection-medication-assisted-treatment-option-opioid
17. Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder. (2016, November). The Pew Charitable Trusts. https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder
18. Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder. (2016, November). The Pew Charitable Trusts. https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder
19. Kampman, K., et al. (2015, June). The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. American Society of Addiction Medicine. http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24. Addressing Prescription Drug Abuse in the United States: Current Activities and Future Opportunities. (2013). U.S. Department of Health and Human Services. https://www.cdc.gov/drugoverdose/pdf/ hhs_prescription_drug_abuse_report_09.2013.pdf. From Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder. (2016, November). The Pew Charitable Trusts. https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder
20. Kresina, T. F., Melinda, C., Lee, J., Ahadpour, M., & Robert, L. (2015). Reducing mortality of people who use opioids through medication assisted treatment for opioid dependence. Journal of HIV & Retro Virus, 1(1). Schwartz, R. P., Gryczynski, J., O'Grady, K. E., Sharfstein, J. M., Warren, G., Olsen, Y., . . . Jaffe, J. H. (2013). Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995–2009. American Journal of Public Health, 103(5), 917-922. Fiellin, D. A., Friedland, G. H., & Gourevitch, M. N. (2006). Opioid dependence: Rationale for and efficacy of existing and new treatments. Clinical Infectious Diseases, 43(Suppl 4), S173-S177. From Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. (2016, November). U.S. Department of Health and Human Services (HHS) - Office of the Surgeon General. 175. https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf#page=175
21. Kampman, K., et al. (2015, June). The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. American Society of Addiction Medicine. https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24
22. Buprenorphine. (2019, November). Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine
23. Certification of Opioid Treatment Programs (OTPs). (2015, September). Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs
24. Electronic Code of Federal Regulations: Part 8—Medication Assisted Treatment For Opioid Use Disorders. (2020, February). U.S. Government Publishing Office. https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=3&SID=7282616ac574225f795d5849935efc45&ty=HTML&h=L&n=pt42.1.8&r=PART
25. Electronic Code of Federal Regulations: Part 8—Medication Assisted Treatment For Opioid Use Disorders. (2020, February). U.S. Government Publishing Office. https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=3&SID=7282616ac574225f795d5849935efc45&ty=HTML&h=L&n=pt42.1.8&r=PART
26. Office Based Opioid treatment (OBOT). U.S. Department of Health and Human Services – Indian Health Service. https://www.ihs.gov/opioids/recovery/obot/
27. DSM Reference: American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. (2013). Arlington, VA. American Psychiatric Association. https://www.ihs.gov/opioids/recovery/obot/
28. Office Based Opioid treatment (OBOT). U.S. Department of Health and Human Services – Indian Health Service. https://www.ihs.gov/opioids/recovery/obot/
29. Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose. (2018). Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/system/files/medicaidfinancingmatreport_0.pdf

30. Burns, R., Pacula, R., Bauhoff, S., Gordon, A. (2015, November). Policies Related to Opioid Agonist Therapy for Opioid Use Disorders: The Evolution of State Policies from 2004 to 2013. National Center for Biotechnology Information - U.S. National Library of Medicine.
31. Kampman, K., et al. (2015, June). The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. American Society of Addiction Medicine. http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24. Addressing Prescription Drug Abuse in the United States: Current Activities and Future Opportunities. (2013). U.S. Department of Health and Human Services. https://www.cdc.gov/drugoverdose/pdf/ hhs_prescription_drug_abuse_report_09.2013.pdf. From Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder. (2016, November). The Pew Charitable Trusts. https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder
32. Electronic Code of Federal Regulations: Part 8—Medication Assisted Treatment For Opioid Use Disorders. (2020, February). U.S. Government Publishing Office. https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=3&SID=7282616ac574225f795d5849935efc45&ty=HTML&h=L&n=pt42.1.8&r=PART
33. Addiction Policy Forum is a nationwide 501(c)(3) dedicated to eliminating addiction as a major health problem. For more information see www.addictionpolicy.org.
34. Flavin, L., Malowney, M., et al. (2020, January). Availability of Buprenorphine Treatment in the 10 States With the Highest Drug Overdose Death Rates in the United States. Journal of Psychiatric Practice, 26(1). https://journals.lww.com/practicalpsychiatry/Fulltext/2020/01000/Availability_of_Buprenorphine_Treatment_in_the_10.3.aspx
35. Naltrexone. (2019, September). Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone
36. Bonhomme, J., Shim, R. S., Gooden, R., Tyus, D., & Rust, G. (2012). Opioid addiction and abuse in primary care practice: a comparison of methadone and buprenorphine as treatment options. Journal of the National Medical Association, 104(7-8), 342-350. Perkins, M. E., & Bloch, H. I. (1970). Survey of a methadone maintenance treatment program. American Journal of Psychiatry, 126(10), 1389-1396. Fiellin, D. A., Friedland, G. H., & Gourevitch, M. N. (2006). Opioid dependence: Rationale for and efficacy of existing and new treatments. Clinical Infectious Diseases, 43(Suppl 4), S173-S177. From Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. (2016, November). U.S. Department of Health and Human Services (HHS) - Office of the Surgeon General. 176. https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf#page=176
37. How much does therapy or counseling cost? Informed Choices About Depression. https://depression.informedchoices.ca/types-of-treatment/counseling-or-therapy/how-much-does-therapy-or-counseling-cost/
38. Not all employer-sponsored or commercial health plans are subject to the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
39. Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose. (2018). Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/system/files/medicaidfinancingmatreport_0.pdf
40. The Targeted Adult Medicaid Program provides Medicaid services to a capped number of adults without dependent children who are: (1) chronically homeless; (2) involved in the justice system through probation, parole, or court ordered treatment needing substance abuse or mental health treatment; (3) needing substance abuse treatment or mental health treatment. Targeted Adult Medicaid Program. (n.d.). Utah Department of Health.
41. SLCO Behavioral health Services Alternatives to Incarceration Initiatives. (2019, May 6). Salt Lake County Behavioral Health Services.
42. Utah Opiod Overdose Fatality Review Recent Release Report. (2019, March). Utah Department of Health Violence & Injury Prevention Program. http://www.health.utah.gov/vipp/pdf/RxDrugs/OFRCRecentRelease2019.pdf
43. For example, see Addictionary® https://www.recoveryanswers.org/addiction-ary/
44. Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. (2016, November). U.S. Department of Health and Human Services (HHS) - Office of the Surgeon General. 169. https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf#page=169
45. McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. JAMA, 284(13), 1689-1695. From Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. (2016, November). U.S. Department of Health and Human Services (HHS) - Office of the Surgeon General. 168. https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf#page=168.
46. Special Topics and Resources – Recovery Community Centers. (2017, May) Recovery Research Institute. https://www.recoveryanswers.org/resource/recovery-community-centers/
47. Kampman, K., et al. (2015, June). The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. American Society of Addiction Medicine. 39. https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24
48. Medication-Assisted Treatment (MAT). (2019, September). Substance Abuse and Mental Health Services Administration.https://www.samhsa.gov/medication-assisted-treatment
49. Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder. (2016, November). The Pew Charitable Trusts. https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder
50. Burns, R., Pacula, R., Bauhoff, S. Gordon, A. (2015, November). Policies Related to Opioid Agonist Therapy for Opioid Use Disorders: The Evolution of State Policies from 2004 to 2013. National Center for Biotechnology Information - U.S. National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4801690/
51. The CBHSQ Report: 1.5 Million Adults Have Serious Mental Illness and Misused Opioids in the Past Year. (2017, January). Substance Abuse and Mental Health Services Administration – National Survey on Drug Use and Health. https://www.samhsa.gov/data/sites/default/files/report_2734/Spotlight-2734.pdf
52. Of note, the newly established Utah Medicaid Integrated Care (UMIC) program creates integrated Medicaid managed care plans to manage the physical and behavioral benefits of the Adult Expansion Medicaid population, eliminating the behavioral health carve-out in five counties.
53. Project Echo. The University of Utah – University of Utah Health. https://physicians.utah.edu/echo/
54. Results First Clearinghouse Database. (2015, June). The Pew Charitable Trusts. https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database

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