Beyond Expansion:

Tackling the enduring barriers to accessing Medications for Opioid Use Disorder (MOUD)

Savannah O'Neill, MSW

FACENTE CONSULTING
UNDERSTAND • IMPLEMENT • TELL YOUR STORY

Introductions

- Savannah O'Neill, MSW
- She/Her
- Expertise in harm reduction, MOUD, overdose prevention and program planning
- No disclosures

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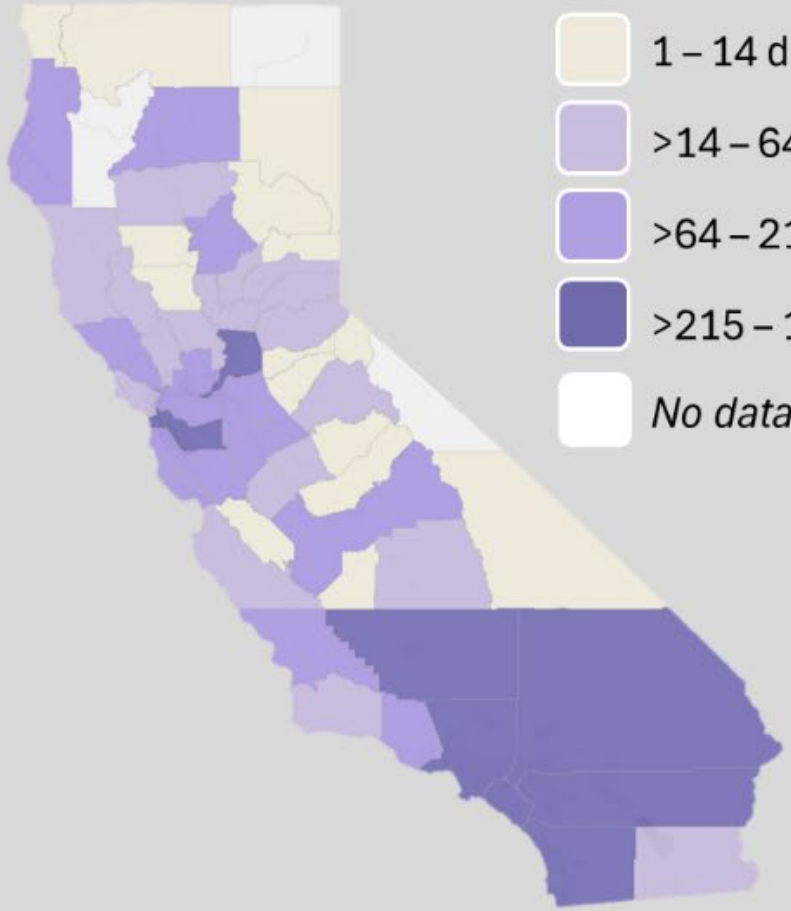
Background

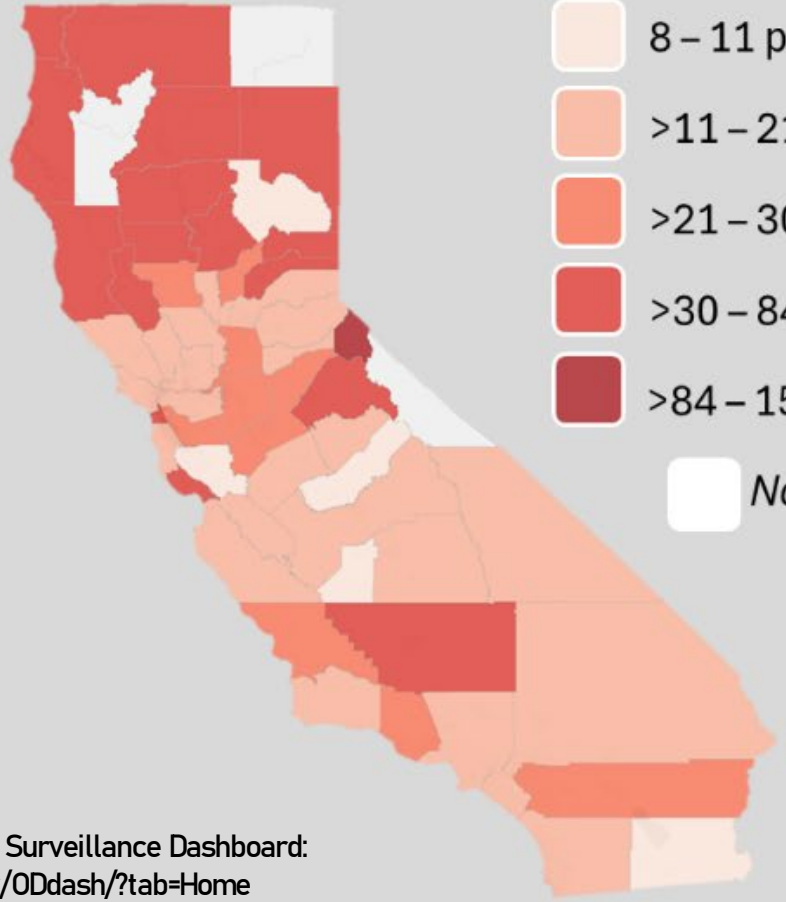
High Overdose Rates

Fatal Overdose Count (2023, by county)



- 1 – 14 deaths
- >14 – 64 deaths
- >64 – 215 deaths
- >215 – 1,603 deaths
- *No data available*

Age-Adjusted Fatal Overdose Rate per 100K people (2023, by county)



- 8 – 11 per 100K
- >11 – 21 per 100K
- >21 – 30 per 100K
- >30 – 84 per 100K
- >84 – 151 per 100K
- *No data available*

Data from California Overdose Surveillance Dashboard:
https://skylab.cdph.ca.gov/ODdash/?tab=Home


"When fentanyl first came out, I literally got PTSD because of how many overdoses I had to deal with on a daily basis."
-Client
DANIELLE
DAN BIGG
Becky
Marty
ALEC + ERIK

Medications for Opioid Use Disorder

- MOUD = key tool for reducing opioid morbidity/mortality

Methadone (full agonist)

Less common

Naltrexone (antagonist)

Buprenorphine (partial agonist)

Key Question: What is the landscape of MOUD in California?

Landscape Analysis Approach

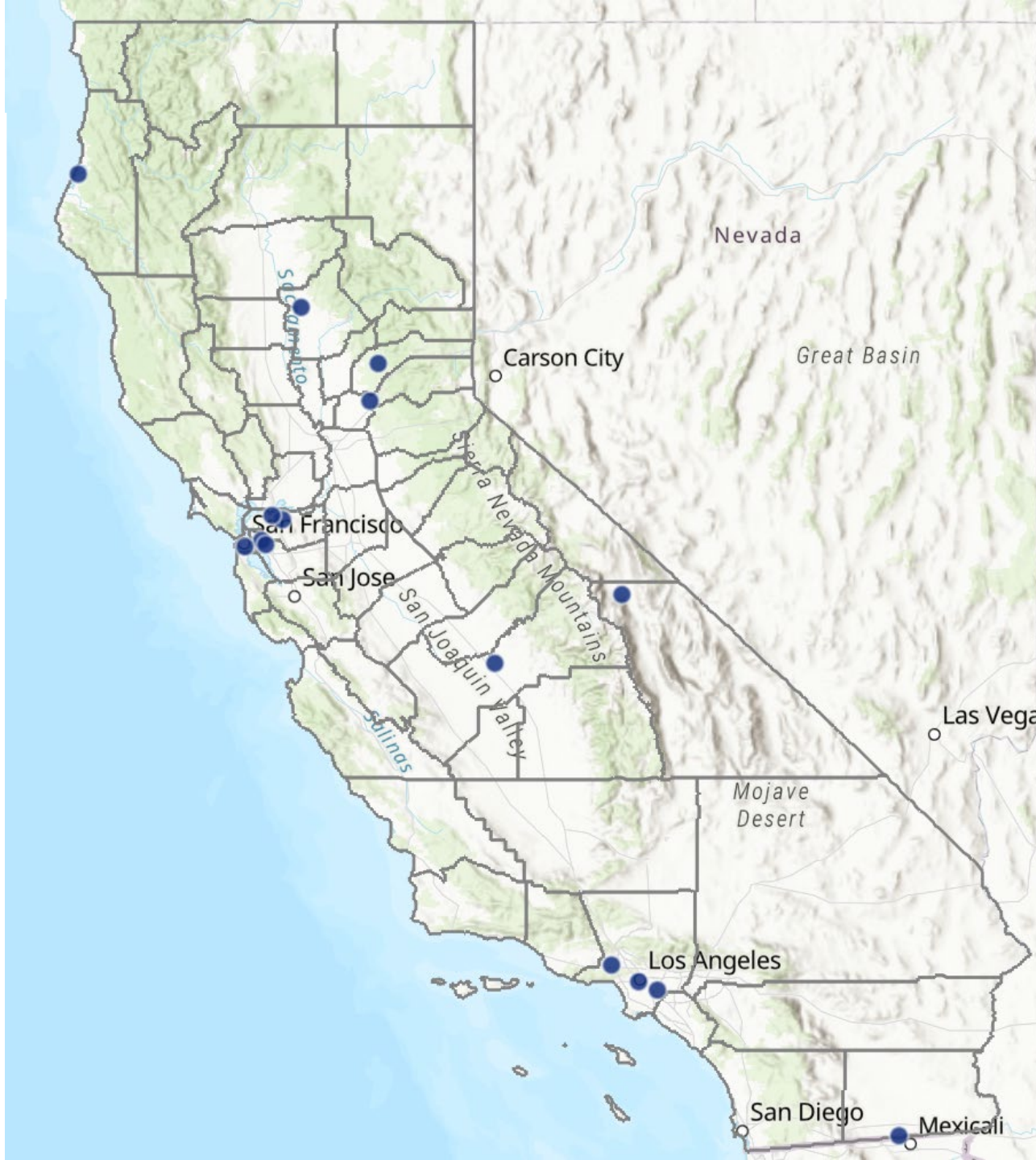
- Facente Consulting was hired by The Center at Sierra Health Foundation (2024-2025) to analyze the landscape of MOUD access in California, including nontraditional models

Approach

- Literature review and secondary data analysis
- Statewide survey of MOUD providers
- Site visits to 15 MOUD programs across California (11 counties)
- Engagement of 120+ MOUD providers, subject matter experts, people who use opioids, and other stakeholders via focus groups & interviews

Diverse Settings

- 15 site visits, urban, periurban, and rural areas
- Included mix of MOUD programs settings:
  - Clinics
  - Hospitals
  - Primary care/outpatient
  - Licensed residential treatment facilities
  - Syringe services programs, and
  - Emergency transport



Policy and Funding Changes

2014
The federal Affordable Care Act expands Medicaid eligibility. California expands its Medicaid program (Medi-Cal), covering more Californians.

2015
California launches Drug Medi-Cal Organized Delivery System, allowing Medi-Cal coverage of MAT with no prior authorization.

2016
New federal funding for MAT becomes available through State Targeted Response Grants. California launches Hub & Spoke System of MAT networks.

2017
New California policy requires and funds pilot MAT programs in state prisons.

2018
The federal government launches State Opioid Response (SOR) grants, leading to new California MAT investments in buprenorphine, the Hub & Spoke System, Tribal MAT, and other settings.

2019
California prohibits residential treatment programs from denying admission to people on MAT.

2020
COVID-19 drives loosened MAT regulations, including telehealth-based MAT (2020), expanded methadone take-home doses (2020), and licensing of new mobile narcotic treatment programs (2021).

SOR grants are renewed by the federal government.
Medicare begins to cover methadone.

2021
California requires residential treatment programs to offer or refer to MAT.

The X-waiver to prescribe buprenorphine (requiring a training and application) is partially (2021) and then fully (2022) eliminated.

2022
First round of opioid settlement funding is distributed to the state and local governments. SOR grants are renewed by the federal government.

California adds billing codes for culturally competent MAT, including Traditional Healer, Natural Helper, and peer support services.

2023
California allows people in carceral settings to start Medi-Cal up to 90 days pre-release.

2024
SOR grants are renewed by the federal government.

The federal government makes loosened COVID-19 regulations around take-home methadone permanent.

2025
The federal government makes most telehealth-based MAT allowances from COVID-19 permanent.

California loosens state methadone regulations to align more closely with federal law.

Investment in MOUD

- Federal funding
- State funding (SOR)
- Opioid settlement funding
- Plus Medicaid (Medi-Cal) coverage expanded to more people

> **"2015 is when you saw the first large boost of admissions for MOUD... you have to acknowledge the role that the ACA played...**
>
> **Then [a restructured Medi-Cal system] started shifting how MOUD services were being offered in of California and how MOUD was beginning to be viewed...**
>
> **Then the State started heavily investing, and every year since 2017, it's shifted to the positive."**
>
> ***-Statewide Expert***

What has improved?

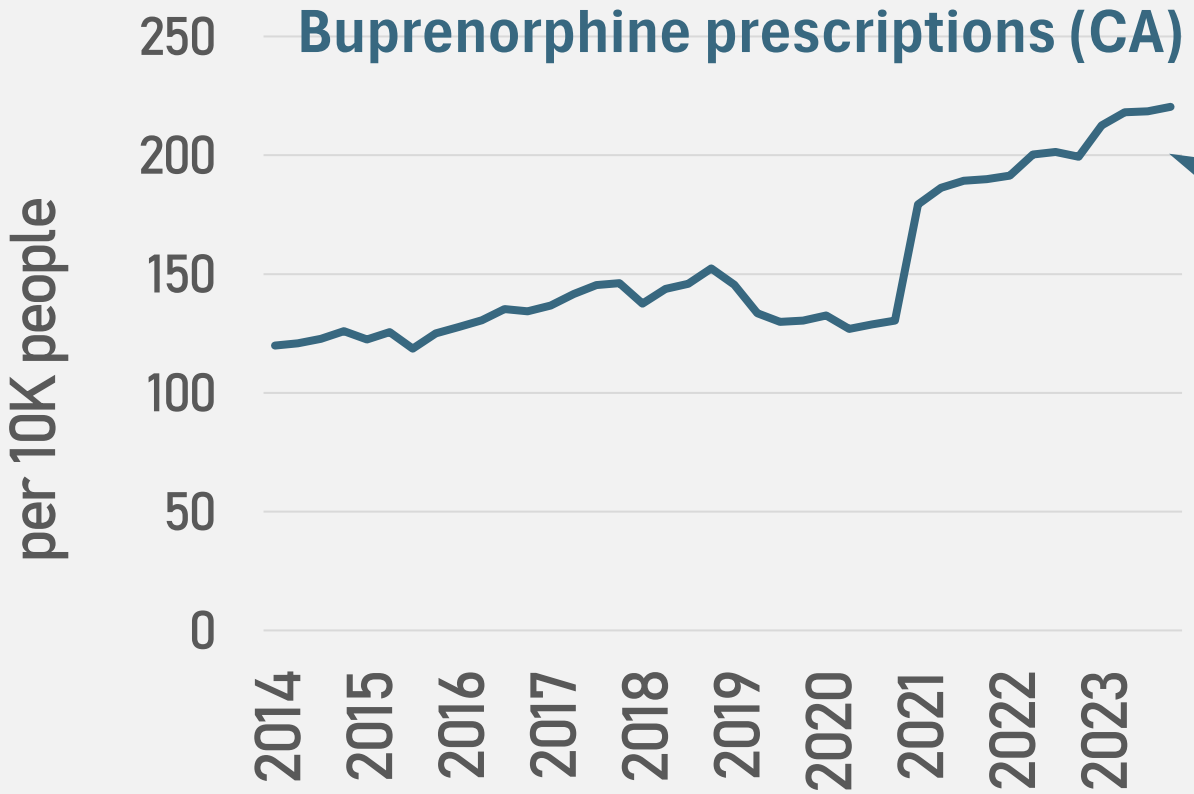
National Shifts Towards Access

- X-waiver removal
- Permanent telehealth prescribing
- Diversified settings outside of formal opioid treatment programs (narcotic treatment programs)

MOUD settings

- Emergency departments
- Emergency transport
- Hospitals
- Primary care
- Syringe services programs
- Mobile units
- Carceral settings

Buprenorphine Prescribing is Up



"In the last two years... [buprenorphine] volume has increased statewide. It's just huge. Everybody's access is improving."

-MOUD provider

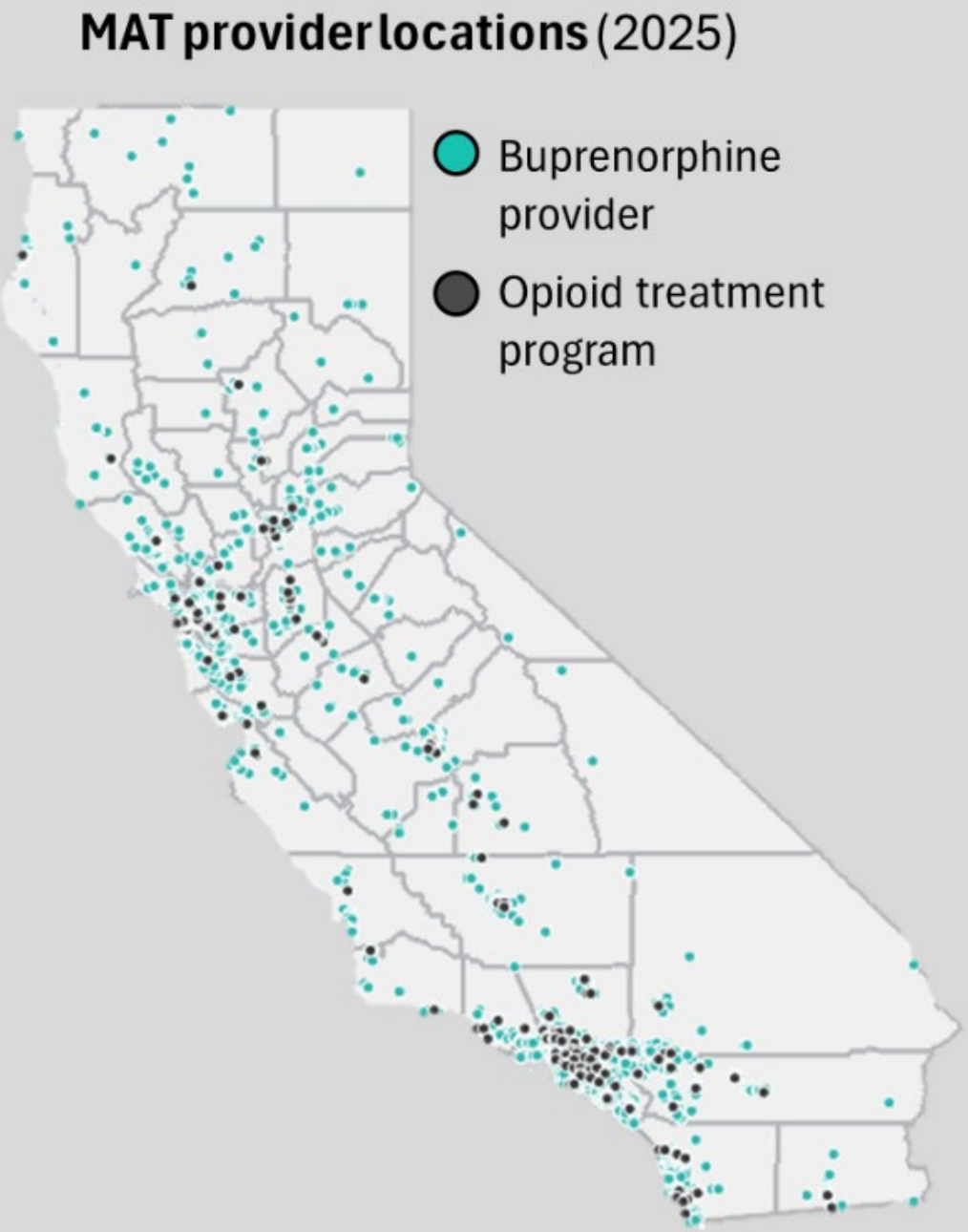

"Access [to MOUD] -it's incredible the changes that have happened over the last decade"
-Statewide Expert

What are the gaps?

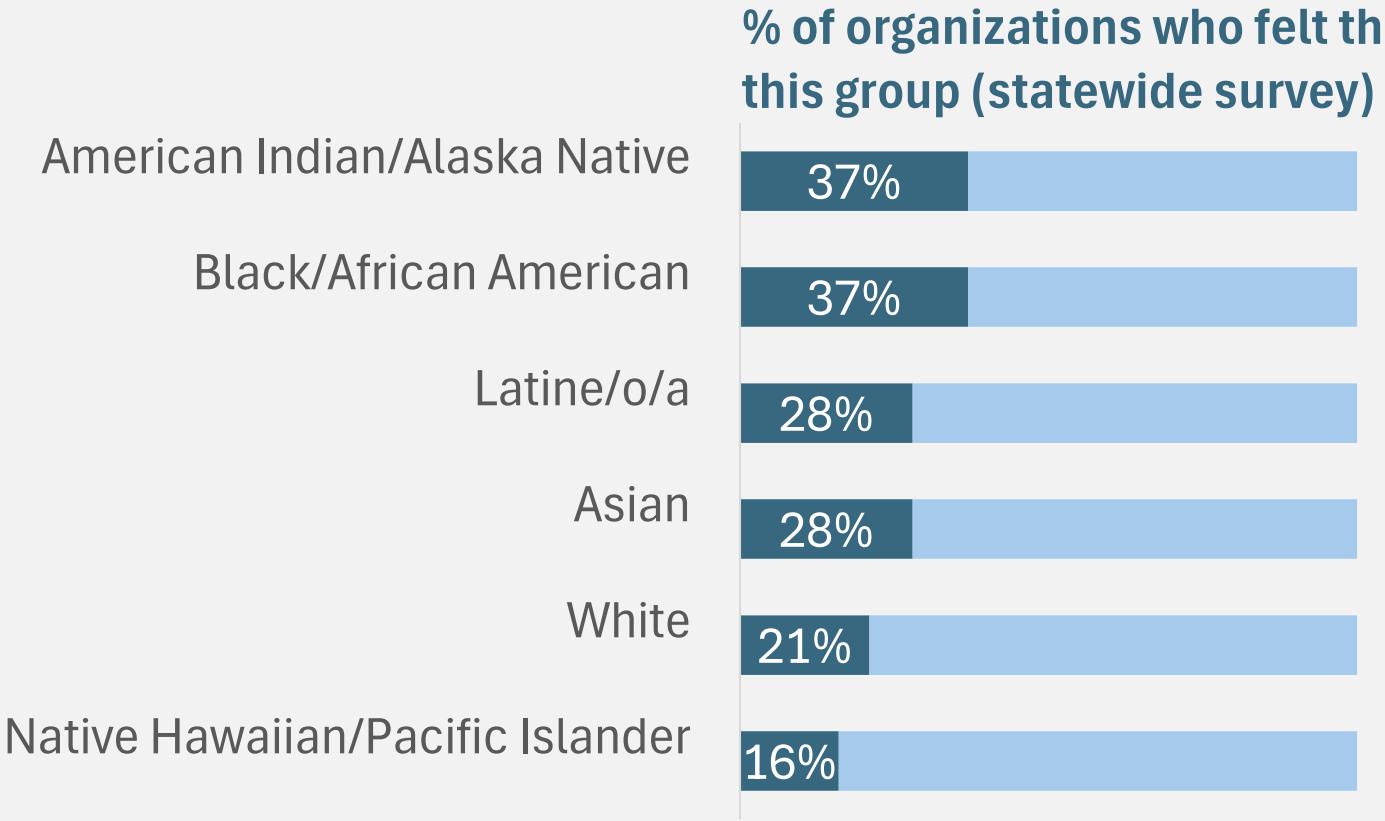
MOUD is not reaching all Californians who might benefit

"It's still difficult to find clinics that have…providers that prescribe [MOUD]. I work with…a lot of rural counties, and they're like, 'we literally have zero clinics to send these patients to."

-MOUD provider



Disparities in access and outcomes for Black/African American, Latine/o/a, and American Indian/Alaska native people



"We know that Black and brown folks are suffering more from the opioid epidemic and have less access to MAT, and that's because of bias and racism in our healthcare system."

-MAT provider

- What growth in MOUD access do you see in Montana?
- Do you see the same gaps?

Five Barriers

1. Stigma

- Pharmacy stigma
- MOUD "replacing one drug for another"
- Methadone carries additional stigma relative to buprenorphine
- Stigmatizing health care experiences drive distrust

In the statewide survey for this assessment, MOUD providers ranked negative experiences with MOUD or MOUD programs as the second-highest barrier to patient engagement in MOUD

What ways do you imagine stigma is impacting the people you serve?

What have you directly observed?

2. Induction Fear

- Precipitated withdrawal = fear that is heightened in era of fentanyl
- **Disconnect** between providers and patients perception of precipitated withdrawal

"If you've gone through opiate withdrawal, you're gonna be really motivated to not go through that again. So, if we can't make it comfortable for people, that's a huge barrier."

-MOUD client

"They looked at the incidence of precipitated withdrawal in the era of fentanyl, and found it was like 1%. So, there's a lot of fear of precipitated withdrawal that is a little bit overblown."

-Statewide expert

- How do you approach induction?
- What do your conversations look like for patients interested in buprenorphine?

3. "A Doctor-Centered Fantasy"

- Logistics of initiating/continuing MOUD can hinder engagement
  - Insurance
  - Scheduling
  - Transportation
- Compounded by experiences like homelessness, stimulant use, mental health concerns

> "It's kind of an emergency when someone decides that they're going to get sober. You can't be like, 'Let's wait 'til next month when your insurance kicks in.'"
>
> –MOUD provider

- What is the single most common logistical barrier that drops your patients out of care?
- What can you do about it?

4. Overregulation

- Strict methadone requirements create steep barriers
- Buprenorphine less regulated but still overregulated (esp. injectable)

> "We need to take a hard look again at all the accreditation and regulatory requirements. What actually do you need to…safely give someone this medication?"
>
> *-MOUD provider*

4. Overregulation

- Required administrative paperwork burdensome:
  - **Providers** expressed this burden limits their capacity to serve patients
  - **Patients** frequently used the term "waiting" to describe the bureaucracy
- Also limits innovation

> "We have people sign a minimum of 11 forms on day one, when they are exhausted, sleep deprived, malnourished, sometimes a bit under the influence or crashing..."
>
> *-MOUD provider*

5. Funding

93% of surveyed MOUD providers **wanted to expand their programs**

- **Insufficient funding was the number one barrier to expansion**
- Flexible grant funding <u>really</u> matters for equity
- While grants are key they complicate MOUD program **sustainability**

> "In one grant, we couldn't spend more than $3 per person per service day [on food]…getting some creamer and coffee might not seem inherently associated with a [MOUD] program, but when the people you're serving have been sleeping outside in the rain …making sure they have a little bit of warmth and some food in their belly can make all the difference in the world."
>
> *-MOUD provider*

Five Promising Practices


HACHR
HUMBOLDT ARCA CENTER FOR HARM REDUCTION

Low Threshold, Harm Reduction Models

- Allow patients to **define success** – even if it does not include abstinence
- Support **patient choice and cultural humility**
- Allow people with **lived experience** to shape programming

> "The [peer] substance use navigators are the heartbeat of our clinic. They do everything. **They're the only reason patients get what they need here.**"
>
> *-MOUD provider*

Low Threshold, Harm Reduction Models

- Allow patients to **define success** – even if it does not include abstinence, it could look like

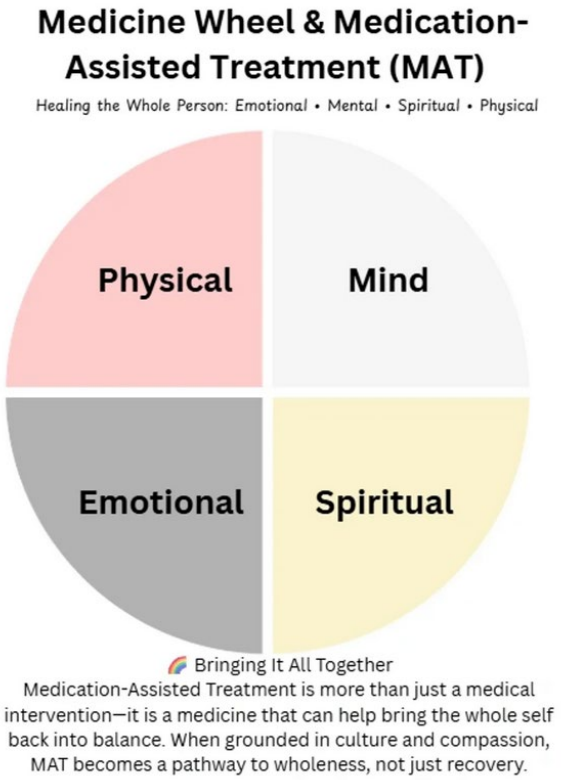
Lower Overdose Death Rates

Lower Risk of Relapse

Increasing Stability and Connection with Loved Ones

Low Threshold, Harm Reduction Models

- Support **patient choice and cultural humility**



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Adjusted Induction Protocols

- Explore new dosing strategies for buprenorphine
- Increased shared decision making through direct transparent conversations

> "I'm getting better at making an assessment and really explaining to my patients what the risks and benefits are. **If people do precipitate, and they were involved in that decision making process, it's a lot less scary and painful for them** than if they feel like the decision-making process was forced upon them."
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- Explore new dosing strategies for buprenorphine
  - Macrodosing
  - Microdosing
  - High dose buprenorphine following naloxone
  - Direct to inject

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  What do you know about induction?

  What is realistic for you?

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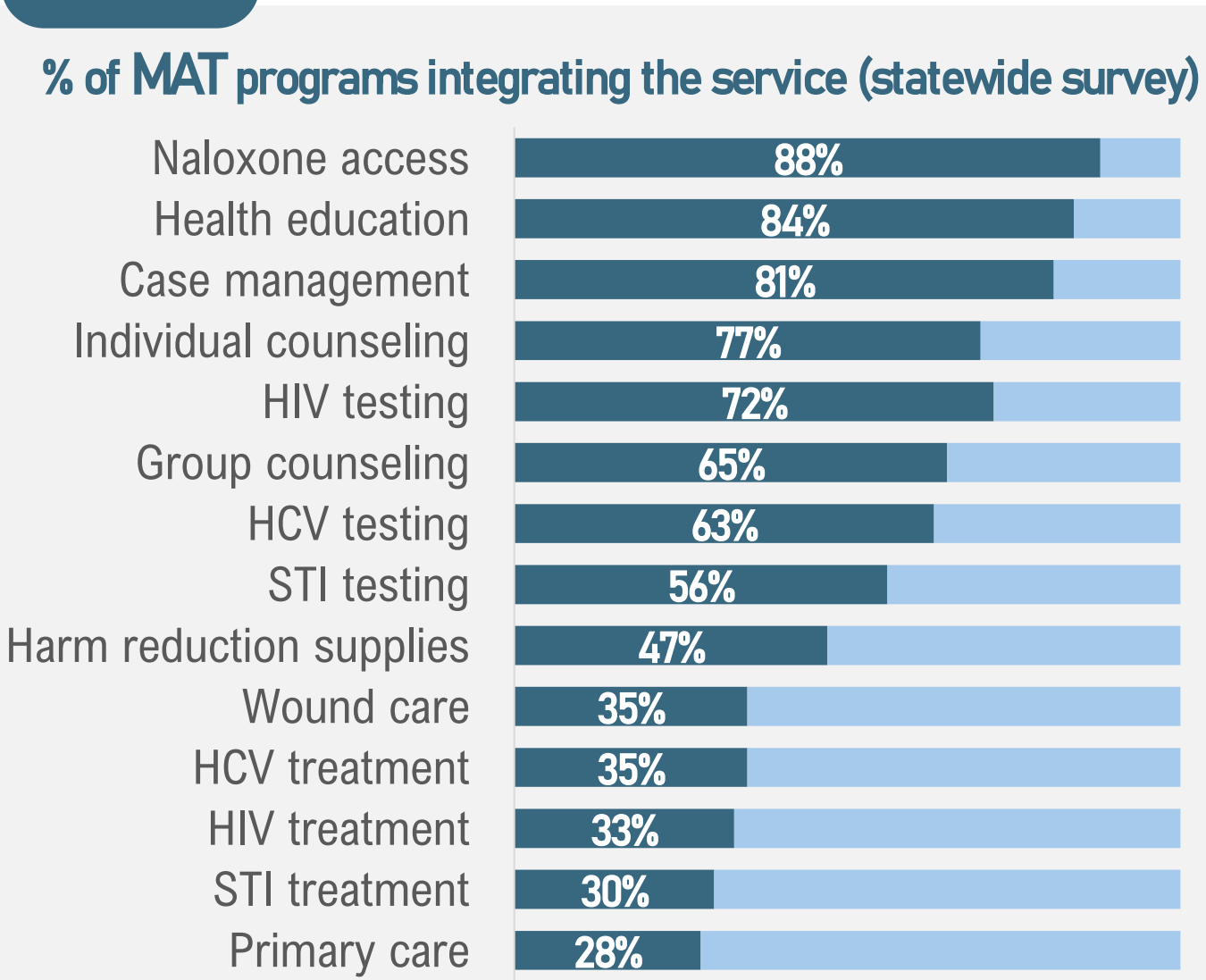
Whole-person care



> "We put all this money into expansion of MAT, but **people are whole humans**, so what else is going on for people that we need to address?"

De-stigmatize MOUD

- **Peer-to-peer approaches**
  - Research suggests that peer-to-peer learning may be promising for increasing buprenorphine prescribing
  - Learning collaboratives, champions speaking and trainings were named as supportive
- **Prioritize offering accurate, destigmatizing information**

> "We made sure word got out there on the street, not by posting on social media and hitting up a bunch of doctors, but by going around to people that we were talking to on the [MOUD] van."
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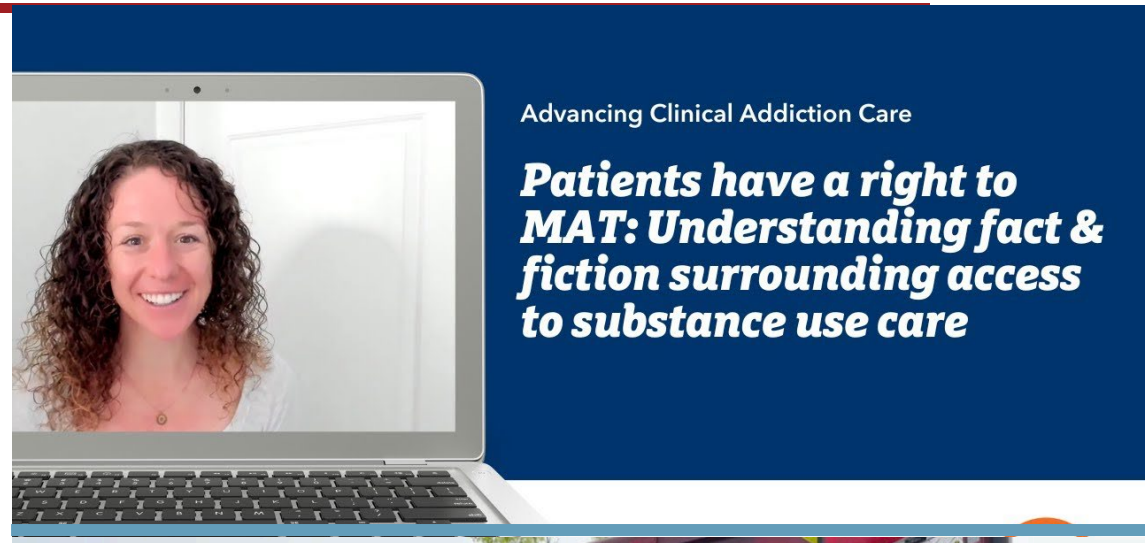

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Build Resilience and Support Staff

- Build a **multidisciplinary team** - supports retention and builds a foundation of trust
- Identify and support **champions**
- Implement **non wage-related strategies** to retain high-quality staff (and wage-related ones, if possible)
- **Streamline internal systems** to reduce bureaucratic strain on providers

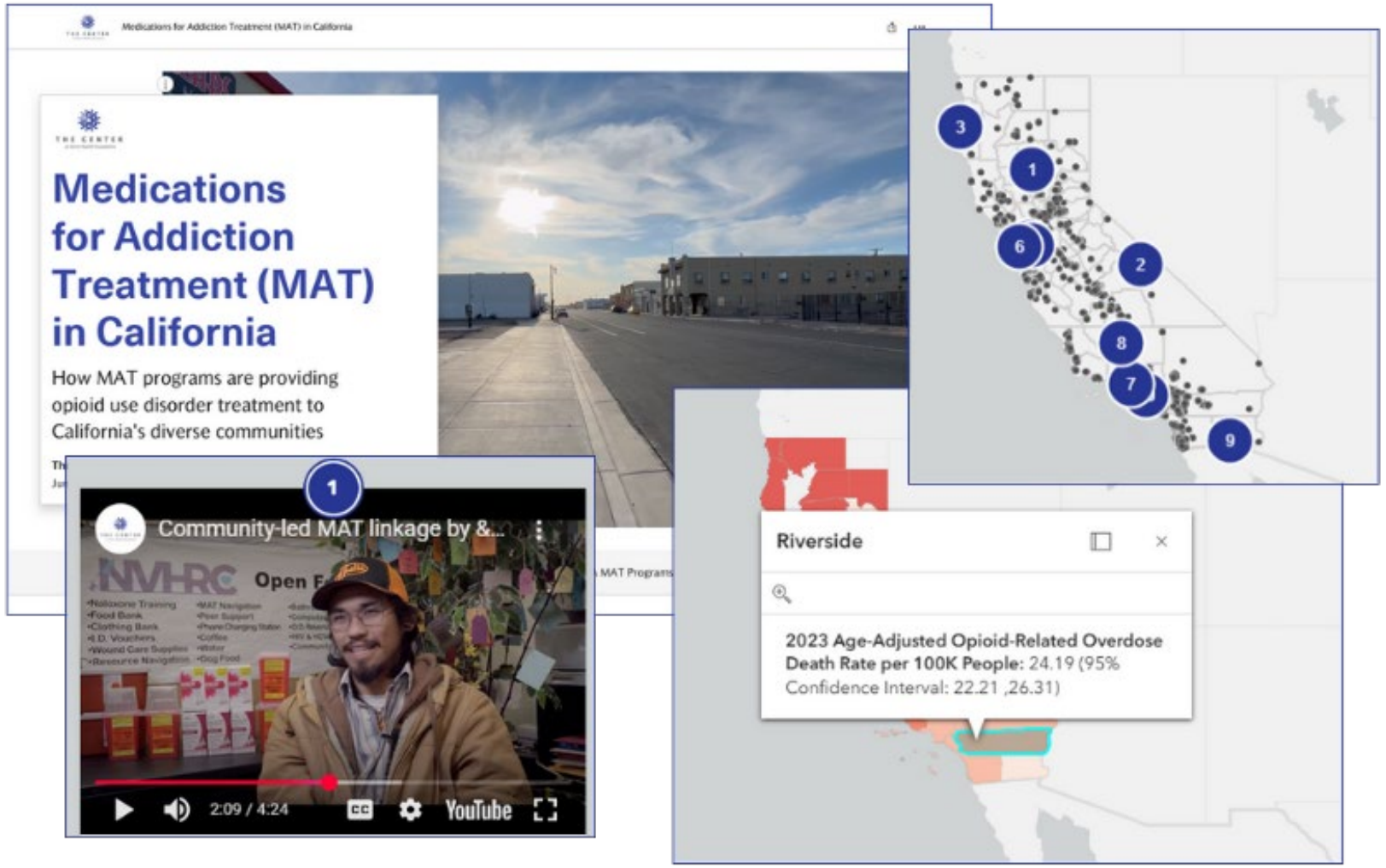
What can you take away from today?

Three Concrete Steps

- ☑ Review your buprenorphine induction protocol
- ☑ Name the single largest barrier your patients face and see how you can mitigate it
- ☑ Ask a peer support specialist or person with lived experience about improving your program


"I want policymakers to know that the addiction crisis isn't over. We shouldn't accept overdose deaths as an acceptable norm. Being back to the level when we declared the emergency is not a win. It's not done."
-Statewide expert
CHARLEY

MAT Landscape Analysis Website



Thank you!

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