Low Barrier Medication for Opioid Use Disorder at Community Health Centers and Primary Care Clinics: Recommendations for Implementation

BACKGROUND

As opioid overdose death rates continue to rise,[1,2] access to medication for opioid use disorder (MOUD) becomes even more critical as it substantially reduces mortality[3] and improves health and wellbeing.[4] However, many barriers prevent patients from accessing medication, including lack of treatment availability, cost, stigma, regulatory requirements, social isolation, discrimination, criminalization of substance use, and structural racism.[5-12]

To improve patient engagement and retention on MOUD, treatment programs are increasingly implementing low barrier models of care. Although there is no universal definition of low barrier treatment, typical features of these programs include a harm reduction approach, prioritizing reduction of drug-related harms instead of abstinence, same-day medication initiation, flexible attendance policies, and access to medication through non-traditional settings.[13,14]

Traditional office-based buprenorphine treatment has often included multi-step initiation, requirements for abstinence, office-based inductions, and other processes that can reinforce barriers to care for some patients. Expanding low barrier buprenorphine treatment to community health centers and primary care clinics can improve access to care, make MOUD more accessible to high risk populations, and address treatment gaps. Provision of buprenorphine through these settings with a harm reduction approach is critical for addressing the unmet need for OUD treatment across the United States.[15]

RECOMMENDATIONS

1. **Designate time for training and facilitated discussion among clinic staff to prepare for the transition to low barrier MOUD**. Based on different educational, clinical, and lived experiences, providers and staff may have different perspectives on low barrier MOUD, especially related to the harm reduction approach to treatment. To facilitate buy-in from clinic staff, it is important to provide education and opportunities for facilitated discussion on the rationale for a low barrier model of care, the evidence for MOUD, and the harm reduction philosophy. This training should also address stigma faced by people who use drugs and aim to establish a welcoming, supportive, non-judgmental environment at every step in the care process.

2. **Anticipate that a low barrier model of MOUD treatment may engage a higher needs patient population**. Providing access to MOUD for a higher needs patient population is a goal of low barrier MOUD, and these patients may require additional flexibility with services and clinic procedures. To avoid disruptions in clinic flow, it is important to have designated staff and established procedures to serve walk-in patients, provide care to patients who miss

Department of Population Health Sciences
Duke University School of Medicine

This project was part of the Duke Opioid Collaboratory, funded by The Duke Endowment and administered through the Duke School of Medicine Department of Population Health Sciences. The Collaboratory convenes diverse partners to save lives, reduce stigma, and mitigate the harmful impact of drugs through the development, implementation, and evaluation of system-level interventions.

or present late to appointments, and provide support for patients lost to follow up who wish to reengage in care. It is also key to provide training for clinic leadership and other staff to reinforce the value of allowing this flexibility for MOUD patients and to ensure all staff are aware of any procedural changes.

3. **Build your team around a care manager model**. To provide low barrier MOUD treatment, it is useful to hire or designate at least one team member to act as a care manager in your setting. Care managers may be behavioral health providers or nurses (see Massachusetts OBAT Nurse Care Manager Model – www.bmcobat.org). Care managers can triage new and existing patients who drop in or require more flexibility with appointment times, help existing patients maintain consistent access to MOUD by performing interim patient evaluations and requesting "bridge" prescriptions from medical providers, provide psychosocial support, address phone calls from patients, and reach out to patients lost to follow-up. With a care manager model, a clinic will be prepared with more designated staff to help address barriers patients may experience in accessing MOUD.

4. **Establish reliable, on-demand systems for patients to communicate with clinic staff**. Treatment teams will need staff who have designated time to respond to established patient calls, new patient treatment requests, and referrals in an expedited manner given the urgency of MOUD access.

5. **Provide support to promote patient engagement and retention in treatment**. Loss to follow-up is often high during the first months of MOUD treatment. From the initial visit, it is important to ensure patients know how to reconnect to care after any treatment interruptions. It may be helpful to prioritize staff time for calls, texts, or in-person outreach to support individuals in addressing barriers and reengaging in care. Peer support staff can be particularly well-suited to this role as their lived experience may allow them to better understand patient challenges and build trusting relationships.

6. **Remove cost barriers for all patients, as resources allow**. Visit copays and medication costs can be barriers to care for many patients. Securing funding to cover these costs can expand access to MOUD, especially for patients who are un- or under-insured.

7. **Integrate the skills and expertise of behavioral health staff into the care model to support patient needs without limiting access to MOUD**. In some traditional MOUD treatment models, patients are required to complete a behavioral health assessment or attend ongoing counseling to access medication. Under a low barrier model, the priority is providing consistent access to lifesaving medication as quickly as possible, while also providing options for behavioral health support. The transition to a low barrier model of care can initially make the role of behavioral health feel less defined or structured. Your team can work together to determine how your clinic's care model can continue to value behavioral health expertise while also not making MOUD access contingent on behavioral health engagement in a way that limits access to medication. For example, for patients who would benefit, behavioral health providers can meet with patients at the time of medical provider visits when MOUD is prescribed.

8. **Identify community resources to address lack of childcare and transportation**. Lack of childcare and transportation to the clinic and pharmacy are common barriers to accessing MOUD, especially in rural communities. It is important to consider these challenges and identify local resources to support patients.

9. **Advocate for other local MOUD treatment programs to implement and support community-wide standards for low barrier care**. Ensuring other community treatment programs are supportive of and active in implementing low barrier models of MOUD is critically important to increase

access to evidence-based care and to prevent consolidation of high needs patients in a single clinic.

10. **Make incremental changes toward a low barrier model of care as staffing and resources allow**. Even if your team is not equipped to implement all aspects of low barrier MOUD treatment, your clinic can make a difference by implementing components of a low barrier model to make MOUD as accessible as possible and further prioritize improved health, patient-identified goals, and reduction of opioid-related harms.

APPENDICES

Appendix A: Transitioning to Low Barrier Medication for Opioid Use Disorder (MOUD) – Experiences of a Federally Qualified Health Center in North Carolina: Process and Outcomes

In 2019, an FQHC in North Carolina began transitioning to a low barrier model of medication for opioid use disorder (MOUD) treatment in response to rising overdose rates in the community, concern about loss to follow-up of patients early in treatment prior to MOUD initiation, and support from community partners.

Prior to implementation of low barrier MOUD treatment, patients interested in accessing MOUD at the FQHC followed the below process:

1. Patients attended a scheduled appointment with a behavioral health provider to complete a comprehensive behavioral health assessment
    a. At one point, the clinic also required patients to attend a group information session about MOUD before scheduling the behavioral health assessment
2. After the assessment, patients were scheduled for an appointment with a medical provider to initiate MOUD and receive their initial prescription

Uninsured patients could pay a sliding scale fee based on income ($10 for most patients) for their appointment and receive a voucher to cover the cost of buprenorphine at the FQHC's on-site pharmacy. Under this model of care, initiating MOUD required at least two visits and could take up to several weeks.

Through implementation of a low barrier model of care, the FQHC prioritized MOUD initiation by eliminating the requirement for a behavioral health assessment prior to the medical provider visit and by establishing pathways for same-day treatment initiation.

The clinic established protected MOUD visits on medical provider schedules for new appointments, such that any patient who walks in or is seen in the clinic for another reason can establish care on-demand and receive a same-day prescription. Each day, a waivered provider has one appointment late in the day blocked for a same-day new MOUD appointment. If the appointment is not filled by a patient seeking MOUD, it is opened as an urgent care visit.

Under the low barrier model, patients continue to receive integrated behavioral health services, typically meeting with both a behavioral health counselor and a medical provider at every medical visit, and with counselors available for interim visits as needed.

Uninsured patients who cannot afford services or medication receive vouchers to cover the costs of both the visits and the medication. Vouchers were initially available only for a patient's first 10 visits but were later expanded to cover all patients at all visits.

In addition to streamlining the intake process, the low barrier model of care centers a harm reduction approach, aiming to provide care that meets patients where they are in their

treatment and prioritizes patient-identified goals, improved health and wellbeing and reduction of drug-related harms. Based on this philosophy, providers do not withhold treatment from patients who have ongoing use of opioids or other substances. In these cases, patients are offered and encouraged to engage in higher levels of care or other supportive services when appropriate and available, but access to MOUD is not contingent on engagement with such services. In addition, although patients have scheduled appointments, the behavioral health team works to accommodate patients who need flexibility with appointments and meet with them on a walk-in basis, arrange a bridge prescription of buprenorphine when necessary, and reschedule with medical providers to maintain consistent access to MOUD.

In an analysis of outcomes of the low barrier model of MOUD at the FQHC, low barrier treatment engaged a higher risk patient population, with higher rates of uninsured, public insurance and chronic disease, and achieved equivalent retention to a traditional treatment model, with a trend towards improved retention in care at 6 months.

Appendix B: Clinical Guidelines Supporting Low Barrier MOUD

Several national organizations including the Substance Abuse and Mental Health Services Administration (SAMHSA), the American Society of Addiction Medicine (ASAM), and the National Academies of Sciences, Engineering and Medicine have guideline documents related to opioid use disorder which support a low barrier approach to MOUD. Below are excerpts from these documents that highlight a low barrier, harm-reduction approach to treatment and providing treatment within primary care.

SAMHSA Tip 63: Medications for Opioid Use Disorder (2021)

https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002

Treatment setting

- “Almost all healthcare settings are appropriate for screening and assessing for opioid use disorder (OUD) and offering medication onsite or by referral. Settings that offer OUD treatment have expanded from specialty sites (certified opioid treatment programs (OTPs), residential facilities, outpatient addiction treatment programs, and addiction specialist physicians’ offices) to general primary care practices, health centers, emergency departments, inpatient medical and psychiatric units, jails and prisons, and other settings.”
- “OUD medications should be available to patients across all settings and at all levels of care—as a tool for remission and recovery. Because of the strength of the science, a 2016 report from the Surgeon General urged adoption of medication for OUD along with recovery supports and other behavioral health services throughout the healthcare system.”
- “To the extent possible, coordinate primary care, behavioral health, and wraparound services needed and desired by the patients to address their medical, social, and recovery needs. Individuals with co-occurring physical, mental, and substance use disorders may benefit from collaborative care”

Course of Treatment/Harm Reduction Philosophy

- “Every visit is a chance to help patients begin healthy changes and move toward treatment and recovery. Patients may not be ready to change right away. Successfully quitting drug use can take many attempts. Returns to substance use, even after periods of remission, are expected parts of the recovery process.”
- “Patients should take buprenorphine as long as they benefit from it and wish to continue.”
- “Maintaining illicit opioid abstinence is ideal, but imperfect abstinence does not preclude treatment benefits. Patients should do better

in treatment than before treatment."

- "The typical course of OUD treatment is varied. There is often not a direct pathway from heavy illicit opioid use to no illicit opioid use."
- "Some patients may need a more structured environment when there is continued opioid use or comorbid use of substances other than opioids or when mental disorders are impeding their progress toward remission and recovery. In these cases, medication for OUD should not be interrupted."
- "If a patient does not discontinue all illicit drugs for extended periods, it doesn't mean treatment has failed and should not result in automatic discharge."
- "The treatment improvement protocol's (TIP's) expert panel recommends that providers not discharge patients from treatment solely because of continued illicit opioid use if the benefits of treatment continue to outweigh the risks."
- "Forcing a patient to taper off of medication for nonmedical reasons or because of ongoing substance misuse is generally inappropriate."

Barriers to Care

- "In scheduling patient visits, be sensitive to treatment barriers such as: work and childcare obligations, cost of care and lack of insurance coverage, driving time and lack of public transportation to visits, which may be particularly challenging for patients in rural areas."

ASAM National Practice Guideline for Treatment of OUD (2020 Focused Update)

https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline

Prioritizing Timely Access to MOUD

- "Comprehensive assessment of the patient is critical for treatment planning. However, completion of all assessments should not delay or preclude initiating pharmacotherapy for opioid use disorder."
- "Patients' psychosocial needs should be assessed, and patients should be offered or referred to psychosocial treatment based on their individual needs. However, a patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacotherapy, with appropriate medication management."

Management of Ongoing Substance Use/ Harm Reduction Philosophy

- "The use of cannabis, stimulants, alcohol, and/or other addictive drugs should not be a reason to withhold or suspend opioid use disorder treatment."
- "The use of benzodiazepines and other sedative-hypnotics should not be a reason to withhold or suspend treatment with methadone or buprenorphine. While the combined use of these medications increases the risk of serious side effects, the harm caused by untreated opioid use disorder can outweigh these risks."

National Academies of Sciences, Engineering and Medicine: Medications for Opioid Use Disorder Save Lives (2019)

https://nap.nationalacademies.org/catalog/25310/medications-for-opioid-use-disorder-save-lives

Summary of Conclusions

- Opioid use disorder is a treatable chronic brain disease.
- U.S. Food and Drug Administration (FDA)-approved medications to treat opioid use disorder are effective and save lives.
- Long-term retention on medications to treat opioid use disorder is associated with improved outcomes.
- A lack of availability of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder.

- Most people who could benefit from medication-based treatment for opioid use disorder do not receive it, and access is inequitable across subgroups of the population.
- Medication-based treatment is effective across all treatment settings studied to date. Withholding or failing to have available all classes of FDA-approved medication for the treatment of opioid use disorder in any care or criminal justice setting is denying appropriate medical treatment.
- Confronting the major barriers to the use of medications to treat opioid use disorder is critical to addressing the opioid crisis.

REFERENCES

1. National Institute on Drug Abuse. Overdose Death Rates. National Institute on Drug Abuse. Published January 20, 2022. Accessed August 29, 2022. https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates

2. National Center for Health Statistics. Provisional drug overdose death counts. Published May 22, 2022. Accessed August 29, 2022. https://www.cdc.gov/nchs/nvss/vsrr/provisional-drug-overdose.htm

3. Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ. 2017;357:j1550. https://doi.org/10.1136/bmj.j1550

4. National Academies of Sciences Engineering and Medicine. Medications for Opioid Use Disorder Save Lives. The National Academies Press; 2019. https://doi.org/10.17226/25310

5. Sharma A, Kelly SM, Mitchell SG, Gryczynski J, O'Grady KE, Schwartz RP. Update on Barriers to Pharmacotherapy for Opioid Use Disorders. Curr Psychiatry Rep. 2017;19(6):35. https://doi.org/10.1007/s11920-017-0783-9

6. Duncan LG, Mendoza S, Hansen H. Buprenorphine Maintenance for Opioid Dependence in Public Sector Healthcare: Benefits and Barriers. J Addict Med Ther Sci. 2015;1(2):31-36. https://doi.org/10.17352/2455-3484.000008

7. Oliva EM, Maisel NC, Gordon AJ, Harris AHS. Barriers to use of pharmacotherapy for addiction disorders and how to overcome them. Curr Psychiatry Rep. 2011;13(5):374-381. https://doi.org/10.1007/s11920-011-0222-2

8. Mackey K, Veazie S, Anderson J, Bourne D, Peterson K. Barriers and Facilitators to the Use of Medications for Opioid Use Disorder: A Rapid Review. J Gen Intern Med. 2020;35(Suppl 3):954-963. https://doi.org/10.1007/s11606-020-06257-4

9. Meges D, Zevin B, Cookson E, et al. Adapting Your Practice: Recommendations for the Care of Homeless Patients with Opioid Use Disorders. Healthcare for the Homeless Clinicians' Network; 2014. Accessed August 29, 2022. https://nhchc.org/wp-content/uploads/2019/08/hch-opioid-use-disorders_adapting-your-practice-final-to-post.pdf

10. Canavan R, Barry MM, Matanov A, et al. Service provision and barriers to care for homeless people with mental health problems across 14 European capital cities. BMC Health Serv Res. 2012;12(1):222. https://doi.org/10.1186/1472-6963-12-222

11. Krausz RM, Clarkson AF, Strehlau V, Torchalla I, Li K, Schuetz CG. Mental disorder, service use, and barriers to care among 500 homeless people in 3 different urban settings. Soc Psychiatry Psychiatr Epidemiol. 2013;48(8):1235-1243. https://doi.org/10.1007/s00127-012-0649-8

12. Lagisetty PA, Ross R, Bohnert A, Clay M, Maust DT. Buprenorphine Treatment Divide by Race/Ethnicity and Payment. JAMA Psychiatry. 2019;76(9):979-981. https://doi.org/10.1001/jamapsychiatry.2019.0876

13. Strike C, Millson M, Hopkins S, Smith C. What is low threshold methadone maintenance treatment? Int J Drug Policy. 2013;24(6):e51-56. https://doi.org/10.1016/j.drugpo.2013.05.005

14. Jakubowski A, Fox A. Defining Low-threshold Buprenorphine Treatment. J Addict Med. 2020;14(2):95-98. https://doi.org/10.1097/ADM.0000000000000555

15. Wakeman SE, Barnett ML. Primary Care and the Opioid-Overdose Crisis — Buprenorphine Myths and Realities. N Engl J Med. 2018;379(1):1-4. https://doi.org/10.1056/NEJMp1802741