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SUPPORT for ME: Key Stakeholder Interview Summary

Katie Rosingana BA
University of Southern Maine, Catherine Cutler Institute, katherine.rosingana@maine.edu

Mary Lindsey Smith PhD
University of Southern Maine, Catherine Cutler Institute, m.lindsey.smith@maine.edu

Karen Pearson MLIS, MA
University of Southern Maine, Catherine Cutler Institute, karen.pearson@maine.edu

Evelyn Ali BS
University of Southern Maine, Catherine Cutler Institute, evelyn.ali@maine.edu

Tyler Egeland BA
University of Southern Maine, Catherine Cutler Institute, tyler.egeland@maine.edu

See next page for additional authors

Authors

Katie Rosingana BA; Mary Lindsey Smith PhD; Karen Pearson MLIS, MA; Evelyn Ali BS; Tyler Egeland BA; and Mark Richards BS

SUPPORT for ME
Key Stakeholder Interviews Summary

In 2019, Maine's Department of Health & Human Services (ME DHHS) received a $2.1 million grant from the Centers for Medicare and Medicaid Services' SUPPORT Act, establishing the SUPPORT for ME initiative within the Office of MaineCare Services (OMS). As part of this initiative, ME DHHS contracted with the Cutler Institute at the University of Southern Maine to conduct a needs assessment, designed to gather information from a wide variety of stakeholders. The primary goals of this assessment are to identify the current capacity for addressing substance use disorder (SUD) in Maine; identify gaps and barriers to accessing and utilizing SUD treatment and recovery services in the state; and provide feedback from stakeholders to inform the creation of a plan to enhance the state's infrastructure for addressing SUD. Data collected as part of the needs assessment will document facilitators, which increase access to and use of SUD treatment and recovery services for MaineCare members in Maine, providing valuable information to OMS on opportunities to support and build upon current strategies having a positive impact on addressing the needs of MaineCare members with SUD.

As part of this effort, the Cutler Institute is gathering information from a variety of key stakeholders including Mainers impacted by SUD and their family and friends across the state, as well as providers. This brief summarizes feedback from twelve key stakeholder organizations with a variety of experience in addressing the needs of persons with SUD. These key stakeholders (n=19) represent leadership from the following SUD service categories: Health Systems, Behavioral Health Agencies, Emergency Departments, Residential Treatment, and Recovery Housing.

This summary feedback report is organized to inform OMS' goal of addressing barriers and finding new and/or improved ways to increase capacity in Maine for people who seek SUD treatment and recovery services. Interview protocols were designed to assess critical domains of interest for the state, which include: current and potential provider capacity, access to care & service delivery provider willingness, and financial/ administrative policies.

Methodology

Cutler Institute staff developed protocols for each key informant interview category, tracking questions by domain and anticipated barrier addressed; all interview protocols were reviewed and approved by OMS (See Appendix for matrix of questions). After key stakeholders were identified by OMS, Cutler staff scheduled and conducted all interviews via Zoom. Interviews were conducted from December of 2020 through February 2021.

Key Take-Away Points

- While there have been improvements in the integration of care for persons with behavioral health (BH) diagnoses, this integration has not fully synced with substance use disorder (SUD) services in Maine; better integration of BH and SUD is needed.
- BHH and OHH are regarded as excellent models of care, and many key stakeholders would like to see this model of care expand for all members with a diagnosis of SUD.
- Low reimbursement rates for some SUD services including outpatient therapy, residential treatment, medically supervised withdrawal services and intensive outpatient treatment programs affect the quality of workforce, available services, and hinders capacity building efforts.
- Stigma exists regarding serving the population with SUD, at all levels- from state policy makers, to providers, and to the community.
- Maine lacks what some consider as basic SUD service options available elsewhere (e.g., variety of medication-assisted-withdrawal services, plus intermediate levels of care).

Service Type	Interviews Conducted	# Stake-holders (*n=19*)
Health System	2	2
Emergency Department	2	2
Behavioral Health Agency	3	7
Recovery Housing	3	5
Residential Treatment	2	3

Interviews were recorded and transcribed verbatim for analysis. Using NVivo software, qualitative data analysis was conducted iteratively to identify recurring themes. An initial set of codes was created to capture topics from the interview questions and prompts. Once the high-level coding structure was developed, each transcript was coded by a minimum of two coders and reviewed by the coding team. During the analysis phase, regular team meetings were held to discuss the coding process, compare coding, and review and refine code definitions. This iterative process was used by the Cutler team to update the coding scheme with emerging themes and constructs with attention to elements suggested to be important regarding facilitators or barriers related to the domains — current and potential provider capacity, provider willingness, access to care/care provision, and financial/administrative policies. The final coding structure included overarching themes based on barriers and facilitators, as well as state policy/reimbursement, to include:

- unmet needs and service gaps;
- barriers and facilitators to provider willingness, access and care provision;
- desired components for improved administrative and billing policies; and
- ideas for increasing current capacity.

It is important to note that due to the small number of interviewees, summary themes are presented in aggregate rather than organized by interviewee type. The report represents the perspectives and opinions of the interviewees; for more information on current policies please refer to the MaineCare Benefits Manual and Comprehensive Rate System Evaluation Report.[1,2] Information from the key stakeholder interviews will be triangulated with other qualitative and quantitative data collected as part of the SUPPORT for ME needs assessment to further explicate and validate findings and to identify areas needing additional exploration.

Current Capacity

Key stakeholders discussed their organizations' existing ability to serve individuals with substance use disorder, as well as strategies and challenges to maintaining their current capacity.

Among behavioral health agency leadership, all reported that their agencies were able to provide medications for opioid use disorder (MOUD) in at least an outpatient setting, although they leveraged different models of implementation.

Stakeholders from emergency departments reported their healthcare systems' emergency departments were, at a minimum, able to induce patients on Suboxone and they were aware of other clinics and/or departments in the organization that provide MOUD. However, emergency department leadership reported varying levels of capacity to connect individuals with treatment options outside of the emergency department through current standardized workflows.

Key stakeholders within healthcare system leadership reported inconsistent ability to provide individuals with MOUD, though they spoke of physician champions within their organizations.

Both residential treatment key stakeholders indicated that they provided intensive outpatient services to individuals transitioning from a higher level of care, and one reported offering MOUD services.

Recovery housing stakeholders mentioned being able to offer different levels of support to residents, some reported embedded case management and inter-organizational referrals capacity, but reported that MOUD was not accepted at all residences.

While current capacity to address SUD varied by setting, all key stakeholders reported having some infrastructure to address the needs of individuals with SUD.

Facilitators

Key stakeholders reported on a number of factors that contribute to maintaining their organization's capacity to serve individuals with SUD.

[1] For more information about MaineCare policies, see the MaineCare benefits manual: https://www.maine.gov/sos/cec/rules/10/ch101.htm

[2] For more information about MaineCare reimbursement, see MaineCare's Comprehensive Rate System Evaluation Interim Report: https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/MaineCare-Comprehensive-Rate-System-Evaluation-Interim-Report-2021.01.20.pdf

Key stakeholders agreed that a critical factor to maintaining the ability to provide accessible, patient-centered care for individuals with SUD is the implementation of workflows and procedures that promote care coordination through established communication channels between sites within a healthcare organization, between healthcare organizations, and among critical cross-sector partners such as schools and correctional institutions.

Regular communication was touted as foundational to facilitating transitions in level of care within and across various locations of care. Beyond communication, establishing relationships and networks of support between organizations within a particular service area was reported to enhance provider confidence and decision-making in patient care.

All key stakeholders reported that telehealth has played a crucial role in maintaining capacity to treat and support patients with SUD during the COVID-19 pandemic, with many appreciating their organization's ability to provide and be reimbursed for telehealth services.

> *"…We have really nimble staff that were really quick to adapt to the new way of doing services. I think we moved…clients to telehealth in ten days."*

Barriers

Key stakeholders agreed there are a number of barriers to maintaining existing levels of care, including the ongoing prevalence of stigma among some providers, the lack of availability of a skilled workforce in Maine, and insufficient community supports for patient referrals. Interviewees discussed the burdens of increased costs of maintaining a healthcare organization, such as the inflation in costs of renting an appropriate space, and/or inflation costs of compensating a skilled workforce not matched by increased reimbursement rates.

Building Capacity

A number of common factors related to capacity building were identified across key stakeholder types as described in this section. Interviewees discussed their own organizational infrastructure and affiliations; reimbursement rates and funding; state policies; and how the ongoing stigma around SUD has an impact on their ability to build capacity for SUD treatment and recovery services. Recovery housing and behavioral health agencies mentioned the need for increased funding and staffing resources as ongoing capacity building challenges.

Facilitators

Key stakeholders discussed several factors that are crucial to implementing strategies to increase capacity for SUD treatment and recovery support services in Maine.

Improved provider referral networks, communication, community connections and increased awareness of local needs and services were all mentioned as factors that can help providers serve more individuals with SUD, particularly for those in carceral settings. Organizational strengths such as leaders that are committed to addressing SUD, enhanced infrastructure (e.g. integrated EMRs), strategic planning, and open communication among staff, were reported to promote efficiencies and growth. The increased availability of grants and other outside funding is welcomed and necessary; increased funding from any source helps expand capacity and mitigate costs.

> *"I think [rates] are a lot better than five years ago and certainly there's potential for it to get better."*

State Policy Facilitators to Building Capacity

Key stakeholders mentioned a variety of ways that recent state policies have helped them build capacity for SUD treatment and recovery services, including:

- Provider trainings and technical assistance that promote collaborative models of care;
- Increased reimbursement rates for behavioral health providers;
- Improved state responsiveness to SUD needs and communications with providers (note, there is sense of renewed energy around SUD in Maine from the current Administration);
- Opioid Health Homes (OHH), seen as a sustainable way to grow capacity for MOUD; and
- The DHHS OPTIONS Program, which offers opportunities for greater integration among medical and community providers while offering outreach and education on harm reduction.

In addition to the above facilitators, key stakeholders discussed possible modifications to state policies that could help facilitate service expansion for SUDs, to include:

- Expand MaineCare eligibility for individuals with a SUD diagnosis who are actively engaged in recovery (i.e,. up to 300% of FPL);

- Continue to improve treatment reimbursement rates to attract new providers;
- Support and reimburse transportation to recovery support programs;
- Continue to move towards value-based care, specifically, bundling care under one rate;
- Offer funding/grants to support recovery-housing beds for MaineCare members or uninsured individuals;
- Fund specialized MaineCare recovery houses;
- Support short-term (7-10 days) outpatient medically supervised withdrawal programs; and
- Expand the DHHS OPTIONS Program and Opioid Health Home Model (i.e., create health home model for all SUD).

Barriers

Across all stakeholders interviewed, reported challenges to improving capacity include sufficiently compensating, hiring and retaining staff, particularly in areas that are more rural. Grants and other funding available, while necessary, is largely insufficient to meet the current needs of those with a SUD seeking treatment. In addition, it was reported that ongoing stigma in some communities has a marked impact on organizations ability to expand SUD treatment and recovery services. For example, it was noted that the development of residential treatment programs and recovery residences can be affected by community-wide stigma related to SUD. Moreover, key stakeholders indicated that some providers remain unwilling or unable to serve persons with SUD and/or offer MOUD because of provider-level biases and stigma within their organization and/or community.

> *"We would like to be able to offer more, we would like to be able to be more responsive, we would like to have this additional clinical expertise, but it's not something we can afford."*

State Policy Barriers to Building Capacity

Key stakeholders identified several ongoing challenges to implementing and/or expanding SUD treatment and recovery services within their organization. The most frequently cited barriers to capacity building are listed below.

- Reimbursement rates, while improved, still do not fully cover the cost of providing treatment services such as outpatient treatment, residential services, medically supervised withdrawal, and intensive outpatient treatment which pose a challenge for hiring, sufficiently compensating, and retaining qualified staff.
- The state mandates caseload limits of 50 for licensed SUD counselors, however with proper staff configuration, raising this to 60-65 would not affect quality of care, could expand capacity, and make providing services for individuals with SUD more financially viable.
- State restrictions on opening new clinics in certain areas due to total patient capacity restrictions hinders expansion efforts; expansion waivers are not always approved, and the approval process can be lengthy.
- Maine's behavioral health treatment and counseling standards are more stringent than national standards, regarding clinic and individual provider capacity limits.
- MaineCare exclusion of 16-inpatient bed maximum has been restrictive; while the state's CMS 1115 SUD waiver will allow for the expansion of IMD beds, lifting that exclusion is not an "instant fix."
- Fee-for-service is not seen as ideal - providers need a different payment model, such as Certified Community Behavioral Health Clinics.
- No MaineCare Partial Hospitalization Program (PHP) level of care for substance use/recovery housing is a major gap.
- Currently, in-house pharmacies are only allowed in hospitals/FQHCs and methadone clinics; not having in-house pharmacy can create barriers to expanding SUD treatment services for providers/ organizations.

Access to Care and Service Delivery

Feedback within this domain focuses on access to care for persons with SUD, as well as the integration and coordination of care provided to individuals with SUD.

Facilitators

All key stakeholders highlighted the use of telehealth as a successful strategy for increasing their ability to provide and sustain care for individuals with SUD. Additionally, they reported that a patient-centered focus helps facilitate coordination of care and the provision of appropriate treatment and recovery plans. Strong community relationships, with social service organizations as well as with healthcare providers was noted as essential to care provision. Key stakeholders highlighted the benefits of formal and informal relationships with primary care practices, correctional facilities, and recovery housing to facilitate warm handoffs and transition in levels of care. The support of senior leadership, along with grant funding, were also frequently cited as critical components to facilitating an

organization's ability to provide integrated and coordinated care for individuals with SUD. In addition, some organizations indicated that state programs, including the implementation of OHHs, has facilitated organizational capacity to provide wraparound services to support care integration.

State Policy Facilitators to Access to Care & Service Delivery

Key stakeholders indicated that the regulatory context for care provision greatly affects the ability of healthcare professionals and organizations to provide integrated care and care across the continuum. Below are facilitators recognized as currently aiding in the provision of care for persons with SUD.

- Recent reimbursement rate increases have enabled organizations to serve more individuals with SUD.
- The establishment of the OHH program has allowed organizations to implement efficient workflows to support wraparound services, which has improved the quality of treatment and recovery services for individuals with SUD.
- Enhanced programming that addresses comorbidity has enabled individuals to receive services on multiple fronts.
- The removal of pre-authorization requirements has removed administrative barriers to providing SUD services.
- Implementing service rates that allow for coverage of operating costs increases organizational capacity to address SUD.
- New rates specific to medication-only clients/patients have helped to increase patient engagement.
- Eased regulatory environment has bolstered the delivery of therapy and telemedicine leading to increased client/patient access, engagement and retention in SUD treatment and recovery services.

> *"This year, we had a rate increase, which we are very grateful for, which has helped us a great deal…I think we're seeing more folks [staff] interested in coming into Maine to provide services."*

Barriers

While telehealth was cited as a facilitator, all key stakeholders also noted its downside especially for individuals with SUD; lack of broadband and internet (especially in rural areas), challenges with the technology, lack of cell phones or computers, and the isolation of this mode of service delivery were all mentioned as factors impacting SUD service delivery. For many providers, the uncertainty of sustained flexibility of providing and billing for services via telehealth post-pandemic remains a concern. All key stakeholders stressed COVID-19's impact on many aspects of SUD care provision. It was frequently noted that rurality compounds most barriers to SUD treatment and recovery service delivery. Long travel distances for both clients/patients and clinicians, lack of services to support care integration, and lack of transportation were all cited as barriers to providing SUD treatment and recovery services in rural communities. Key stakeholders also noted the difficulty in recruiting and retaining qualified staff especially in rural communities. Low reimbursement rates and payment polices also make it difficult to engage and retain providers in the delivery of SUD services. Several key stakeholders spoke to the difficulty in coordinating care and providing referrals without the benefit of a systematic workflow, screening tools, or follow-up mechanisms. Key stakeholders in recovery housing and residential treatment organizations spoke about the lack of capacity and long wait times, due to a system-wide lack of beds, for persons with SUD. Finally, stakeholders indicated that stigma remains a barrier to the access and delivery of SUD treatment and recovery services.

> *"We have a number of X waivered physicians who were interested in maybe opening up their own Suboxone clinic but the reimbursement from MaineCare is so low that we just wouldn't be able to do it."*

State Policy Barriers to Access to Care & Service Delivery

Feedback from interviewees indicate a number of policy barriers that might hinder access to care and provision of high-quality SUD treatment and recovery services:

- Limited types of SUD services are covered by MaineCare;
- Low reimbursement rates for providing SUD treatment and recovery services;
- Strict requirements for patients to access OHHs—the general sense that this care model is good for many more than currently served;
- MaineCare Benefits Manual Section 13 limitations for case management and supports for limited populations;

- Generally strict MaineCare requirements on covered SUD services compared to many private insurers; and
- While many stakeholders were very pleased with the increased use of telemedicine, there is a perception that providers might preferentially push in-person visits for greater reimbursement over telemedicine.

Provider Willingness

Provider willingness is a multifaceted concern central to the success of the SUD recovery process, and specifically, can be a key barrier or facilitator to enhancing state infrastructure and capacity to address SUD. Key stakeholders across the five delineated subgroups most frequently cited stigma, education, capacity, comfort, and coordination as key factors influencing provider willingness to provide SUD treatment and recovery services.

Facilitators

Facilitators to provider willingness often enhance an organization's ability to serve individuals with SUD through increased provider capacity. Improvements in provider willingness also closely tie to stigma reduction, which can improve patient comfort and overall recovery experience, as indicated by key stakeholders. Additionally, a robust infrastructure facilitates patient outreach and communication which is particularly important amidst the COVID-19 pandemic and makes it easier for providers to deliver services. Stigma reduction and education can further promote provider willingness by helping providers understand the importance and efficacy of evidence-based treatments for SUD such as MOUD. Furthermore, key stakeholders indicated that collaboration between providers can help to improve their comfort in delivering MOUD.

State Policy Facilitators to Provider Willingness

Financial incentives were discussed as a critical factor in improving provider willingness to offer SUD treatment and recovery services particularly when reimbursement mechanisms support collaborative care models. Medicaid or state policy that allows for this could increase provider willingness to screen and treat patients with SUD, and/or provide MOUD, which in turn increases capacity.

Barriers

Key stakeholders identified several barriers they perceive as hindering provider willingness to address SUD. Firstly, some providers reportedly disagree with the use of medications to address SUD and personally opt out of providing services such as MOUD. Some reported reasons for this include a lack of understanding of how MOUD works, an inherent stigma against opioids misuse, or the belief that non-MOUD options focusing on abstinence are sufficient. Some key stakeholders noted that lack of provider education about treatments for individuals with SUD impedes provider comfort and self-perceived expertise (or lack of expertise) regarding this type of work (for example, how to address pain management for a patient who is already on MOUD).

State Policy Barriers to Provider Willingness

Some barriers specific to MaineCare and Medicaid policy were mentioned in relation to provider willingness, including:

- Limited number of providers are willing to "take on" additional work, whether it be MOUD, increased screening for SUD and/or integrating care of physical and behavioral health, compounded by low reimbursement for SUD services.
- Payment barriers can shift the focus of care to populations that aren't as vulnerable as the MaineCare population (i.e., certain services or providers do not accept MaineCare and MaineCare members cannot get same level of care as those with private insurance).
- Lack of statewide infrastructure makes it difficult for some providers to be able to refer patients to community resources or auxiliary/ wrap-around treatment and/or recovery services.

> *"In some of these rural communities there may be one person that's … X waivered and willing to offer the service. And so … if that person, gets sick or gets tired of it, then it really makes an already-vulnerable population even more vulnerable."*

Administrative Policies/ Procedures, Payment & Billing

Key stakeholder feedback on administrative policies and procedures, which include payment and billing policies, denote their perceived impact on organizations' systematic ability to provide a flexible, well-funded spectrum of care for persons SUD.

Facilitators

Nearly all key stakeholders discussed MaineCare's OHH and BHH models of care as exemplary and would like to see this type of care more readily accessible to persons with SUD—not just to those with OUD or co-occurring disorders. These models of payment and care provision

were perceived to allow for more integration of care, while the fee-for-service model "hamstrings" service leaders in the ability to do the "things asked of them." Over all, key stakeholders perceived these more integrated models of care as ideal mechanisms for expanding access to treatment and recovery services for individuals with SUD; building upon and expanding the health home model was seen as an ideal way to enhance state SUD capacity and infrastructure.

State Policy Facilitators- Policies and Payment

Two primary facilitators to expanding capacity for addressing SUD were discussed by key stakeholders:

- Reimbursement rate increases across the board "help everyone", particularly for residential care, behavioral health care, and SUD services.
- The establishment of both BHH and OHH has allowed for the provision of efficient wraparound services, which has improved the delivery of SUD treatment and recovery services for persons with SUD.

Barriers

As discussed above, the primary barriers to expanding SUD treatment and recovery services mentioned by stakeholders were reimbursement rates from insurers, administrative burdens (such as excessive paperwork), stigma, and MaineCare benefit policies, Additionally, several respondents discussed the sense that at a systems level, behavioral health services are progressing into a more patient-centered model without always including SUD services. The shared perception is that this is a universal issue which is driven by the decisions of state, town, and local level policy makers, and permeates all levels and systems of care for persons with SUD.

> *"Massachusetts, New Hampshire, Florida, all … have this PHP level of care, which MaineCare has with psychiatric treatment… but they don't apply it to substance use."*

State Policy Barriers- Policies and Payment

Policy barriers cut across domains discussed in this summary report. It is important to note that these are barriers perceived at the ground level, and any misperceptions about policies are opportunities for communication and collaboration between ME DHHS and providers.

- Low rates of reimbursement prohibit providers from offering services for MaineCare members and/or accepting as many MaineCare patients as they would like.
- Generally, MaineCare is perceived as more stringent in what SUD treatment and recovery services are covered when compared to private insurers.
- There is a lack of SUD-focused partial hospitalization program (PHP) funding from MaineCare for a level of care between residential treatment and IOP which leads to a gap in the care continuum, and is viewed as a missed opportunity for an intermediate level of care for persons—often critical to supporting long-term recovery for individuals with SUD.
- Administrative policies in Section 13 of the MaineCare Benefits Manual are perceived as a barrier since these rules can prevent individuals with a primary diagnosis of SUD from receiving assistance from a caseworker, depending on how and where they currently receive services within the MaineCare system.
- Stigma at the legislative and state level hinders properly funding the current demand for SUD services/supports in the state.

> *"I think when you talk about investment of (SUD-related) resources at the legislative and state level, there's incredible stigma."*

Summary

Maine is among the states hardest hit by a national trend of non-medical use of opioids, with subsequent increases in opioid related morbidity and mortality. In addition, the state has high rates of alcohol use and increasing rates of polysubstance and stimulant use. Addressing the treatment and recovery needs of individuals with SUD in Maine is particularly challenging given the rural nature of the state, which creates unique challenges for service providers as well as persons who are seeking treatment. Feedback from key stakeholders indicated that efforts to enhance the state's capacity to address SUD should focus on strategies aimed at creating a continuum treatment and recovery supports, which will ensure individuals have access to the appropriate level of care and facilitate care transitions.

Stakeholders indicated that reducing administrative and regulatory burdens; supporting the development of comprehensive workflows and referral processes; implementing enhanced systems to promote information sharing across agencies to support care coordination; and working with organizations to expand and/or

implement clinical-community linkages to support the provision of wrap-around services are all seen as facilitators to expanding SUD treatment and recovery capacity in the state. Stakeholders indicated that MaineCare's shifts toward value-based care are largely positively regarded, seen as important to expanding SUD capacity, and many would like to see these integrated models of care both continue and expand. It is important to note that while there have been recent increases in reimbursement rates, low reimbursement continues to be seen as a major barrier to engaging and retaining providers as well as robust treatment and recovery programs. There was recognition that both the BHH and OHH models of care have been successful; many would like to see this type of care integration and payment model proliferated to serve more MaineCare members with various types of SUD. Finally, stakeholders indicated that stigma remains a barrier to increasing capacity and infrastructure at all levels, from funding and expanding services for policy makers, to providers serving persons with SUD, and community members. Given the chronic nature of SUD, enhancing the state's treatment and recovery services infrastructure is critical to facilitating low barrier access to services and promoting ongoing engagement in treatment and recovery services.

"[There is a] separation that we have between substance use disorder treatment and mental health treatment and we have separate licensing boards and requirements. You don't have a substance use disorder without a behavioral health struggle and we somehow have created this artificial distinction between the two…it would be wonderful if we were able to someday really recognize these as co-occurring and provide fully-integrated treatment no matter what."

Key Stakeholder Interview Feedback

Substance Use Disorder (SUD) Treatment and Recovery Services in Maine

Facilitators	Barriers
Current Capacity	
• Providing accessible, patient-centered care • Workflows and procedures that establish and maintain communication channels • Establishing relationships with other provider sites	• Stigma among providers • Lack of availability of skilled workforce in Maine • Lack of community supports • Inflation of costs of service provision
Building Capacity	
• Improved provider referral networks • Communication • Community connections • Increased awareness of local needs and services	• Inability to sufficiently hire, compensate, and retain staff • Grant funding is largely insufficient • Ongoing stigma among communities and providers
Access to Care/Care Provision	
• Increased use of telehealth • Patient-centered focus • Strong community relationships • Coordination between primary care practices, correctional facilities, and recovery housing staff	• Rurality and isolation • Lack of services • Stigma • Poor care coordination and referral process • Long wait times
Provider Willingness	
• Increased provider capacity (# providers in state) • Stigma reduction • Robust infrastructure • Collaboration between providers	• Stigma • Lack of education surrounding medication-assisted treatment (MAT) • Lack of comfort or self-perceived expertise managing MAT patients
Administrative Policies/ Procedures, Payment & Billing	
• Reimbursement rate increases • Behavioral Health Homes and Opioid Health Homes: build off these models • Bundled payment models can incentivize integrated care	• Low rates of reimbursement • Stringent MaineCare coverage of SUD services • Failure to consider SUD as part of mental health when integrating care • Stigma at policy maker level

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