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Health Leadership Perspectives on Challenges to Providing & Expanding Withdrawal Management Capacity in Maine

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Background

Maine's alcohol and substance use crisis has continued to grow over the past decade, evolving into one of the state's top health concerns.[1] Numerous efforts have been made across the state to reduce the rate of substance use, particularly as it pertains to opioid-use disorder (OUD), but little progress has been made regarding interventions for alcohol, stimulant, or polysubstance use, despite their increasing contributions to Maine's substance use crisis.

What is Withdrawal Management?

The medical and psychological interventions used to manage withdrawal symptoms.[6]

A form of palliative care that reduces the intensity of withdrawal symptoms.[6]

Also referred to as medically supervised withdrawal or detoxification.

In recent years, there has been a high prevalence of stimulant related deaths in Maine,[2] and stimulants have emerged as the third leading cause of individuals seeking treatment.[3] Alcohol has consistently been the most common substance for Emergency Department (ED) visits and EMS overdose response for the past several years.[4] Alcohol is also the second leading substance, only behind opioids, that MaineCare members seek treatment for.[4] For many people, the first step in treatment and subsequent recovery from substance use disorders involves a period of withdrawal.[5] While withdrawal is undoubtedly an uncomfortable process for all individuals suffering from a use disorder, the withdrawal process for heavy alcohol users can have catastrophic side effects, including death, when not closely monitored by a medical professional.[6] Despite this, there is limited capacity in Maine to support those in need of non-opioid withdrawal services, especially in rural communities. According to data obtained from the Maine Drug Data Hub and information provided by Maine DHHS, there are currently up to 13 facilities in Maine that have the capacity to offer medically supervised withdrawal services.[7] These facilities serve only five of Maine's sixteen counties: Androscoggin, Cumberland, Kennebec, Knox, and Penobscot[1]. Only three of these facilities accept MaineCare.[8] With such few low barrier treatment options for SUD throughout the state, Maine faces a serious health equity problem.

Currently, the Maine Department of Health and Human Services (Maine DHHS) and the Cutler Institute's Substance Use Research and Evaluation Team (SURE) are working together through the SUPPORT for ME Cooperative Agreement to monitor and assess Maine's behavioral health system. As a part of this Cooperative Agreement, **Maine DHHS and the SURE team have identified withdrawal management (WM) as an area of interest and have determined that more information is needed to understand the landscape of WM in Maine, especially as it pertains to non-opioid substances.** Therefore, this project will involve collecting data through interviews with health care leadership from around the state to identify the perceived barriers and gaps to both offering and expanding WM services for non-opioids. These insights will allow policymakers and other state leaders to have a greater understanding of the root causes driving the lack of services in Maine, so that state-level policy changes can be made to address those barriers and ensure that those in need of medically supervised withdrawal from non-opioid substances can have equitable access to care.

[1] At this point in the project, the team is still inquiring if one additional facility with locations in three additional counties is currently offering Withdrawal Management

Methodology

Participant Recruitment

This research project was submitted to the University of Southern Maine Institutional Review Board for approval. It was determined this activity is not research involving human subjects, and therefore no further review or determination was required. Interview recruitment occurred over a three-week period from February 28th to March 19th. Partners from Maine DHHS assisted in identifying eligible participants. Eligibility criteria included being a health systems leader (e.g., Executive Director, Medical Director, Program Manager) at a facility that offers SUD related services, regardless of whether their facility currently offers WM services. Overall, 21 individuals were identified, and multiple outreach attempts were made to these individuals via email. Of those, 11 individuals agreed to participate and completed interviews. All interviews were included in this analysis. To ensure that feedback from participants was representative of the state, a strong effort was made to involve representatives from institutions in each county. This effort was strongly influenced by the lack of existing institutions throughout the state. Ultimately, seven of Maine's 16 counties are represented in this analysis (Figure 1).

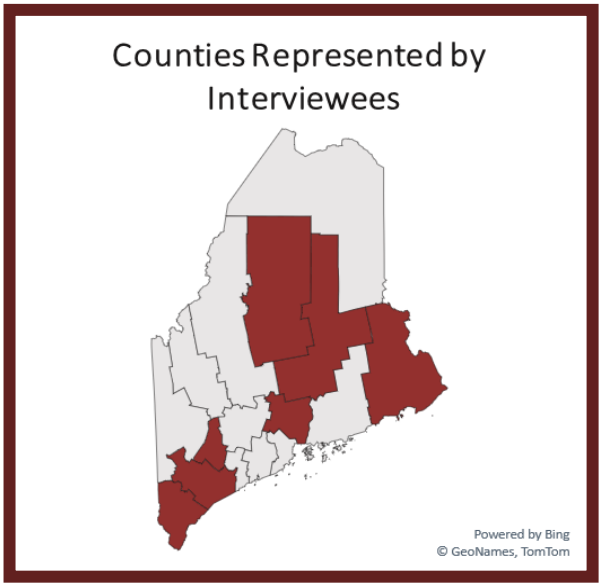

Figure 1. Counties with interviewee representation.

Qualitative Interviews

The Maine DHHS and SURE teams partnered to develop research domains and questions, which the SURE team used as a framework to develop an interview protocol. Following the recruitment of eligible participants, all interviews were conducted by members of the SURE team from March 11 to March 28 via Zoom. On average, interviews were completed in 45 minutes. Each interview was recorded and transcribed verbatim for analysis. Interview questions covered many topics related to the availability of WM services, capacity to expand, and identifying gaps in the SUD continuum of care. This report will focus on:

- The gaps and barriers that influence organizations' **willingness and readiness** to expand WM services; and
- The gaps and barriers that influence health systems **ability** to provide WM services.

Data Analysis

Ten of the eleven interviews were analyzed using NVIVO software. The eleventh transcript was not received in time to be included in NVIVO analysis, but insights from the interview have still been included. Analysis was guided by the grounded theory approach. The initial coding structure was informed by the interview questions and prompts. Each transcript was coded by two members of the SURE team. Regular team discussions allowed code definitions to be refined and the coding scheme to be updated as themes emerged.

Grounded Theory Approach

Grounded theory is one of the most well-known and widely used methodologies employed in qualitative research. Data is collected and analyzed in an iterative manner, allowing researchers to derive theories from the data. Transcripts are broken up line-by-line into individual excerpts. As patterns are identified between excerpts, they are grouped together to form codes.[9] Similar codes are then grouped together to form categories. This continuous analytical cycle continues and prompts the evolution of theories that are grounded in data.[10]

Findings

Health Leaders Perspectives on Maine's Capacity for Withdrawal Management

Interviews provided insight into some of Maine's SUD health leaders perspectives on the state's current capacity to provide and support WM. Overall, interviewees perceive the state as having limited capacity when considering the ASAM Levels of Care (Table 1). Interviewees reported that Maine has minimal capacity to provide levels 1.7 and 3.7, and virtually no capacity to provide levels 2.7 or 4.0. Health leaders also reported perceived gaps and barriers contributing to this lack of capacity, and some shared their experiences with recent WM service expansion or expansion attempts.

Table 1. Interviewee Perceptions of Maine's Capacity to Provide the ASAM Levels of Care

Level of Care	ASAM Definition	Maine Capacity
1.7	Ambulatory Withdrawal Management **without** Extended On-Site Monitoring	Minimal
2.7	Ambulatory Withdrawal Management w**ith** Extended On-Site Monitoring	Non-existent
3.7	Medically Monitored Inpatient Withdrawal Management	Minimal
4.0	Medically Managed Intensive Inpatient Withdrawal Management	Almost non-existent- only alcohol

Note. Definitions for ASAM Levels of Care are from Letourneau, L., O'Connor, A., Smith, G. (2023).[8]

Summary of Key Findings

Interviews revealed several factors that health systems leaders perceive as a gap or barrier that influences their ability to provide or expand WM services for the community. Identified gaps/barriers fall into the following domains:

Licensing and Regulatory Requirements: Facility licensing categorizations, local zoning laws, and state regulation requirements all reportedly posed significant process and financial barriers.

MaineCare Coverage: Reimbursement rates were described by most interviewees as a main barrier to providing WM. Many interviewees also indicated that MaineCare does not provide adequate patient coverage for behavioral health needs.

The Start-Up Process: Insufficient existing experiencing managing medical infrastructure and the enormous initial investment were reported as factors that made tackling WM insurmountably overwhelming for some interviewees.

Workforce Challenges: Staffing shortages of qualified behavioral health workers, high turnover rates, and provider willingness to provide WM constrains facilities' ability to offer WM. Stigma, lack of provider experience with WM, concerns over patient safety, and discomfort due to a lack of SUD recovery supports in Maine were all reported as contributing to provider willingness.

Patient Engagement: Patients face various challenges when seeking care, including fear, which may stem from trauma or stigma faced in previous experiences seeking care; transportation to behavioral health facilities; and the various factors contributing towards Maine's high barrier admission process such as calling frequently, going through a screening, and being required to schedule an appointment to initiate treatment.

Licensing & Regulatory Requirements

Interviewees indicated that regulatory and licensing requirements hinder their ability to provide or expand WM services, particularly as they relate to facility licensing and physical infrastructure regulations.

Facility Licensing

Health leaders reported that licensing protocols impose barriers to offering WM because state licensing categorization determines the level of services and resources that MaineCare will cover. They conveyed that current licensing categorizations do not align with the needs of behavioral health sites to successfully provide WM. Interviewees perceive that behavioral health settings are not equipped with necessary medical resources that are common practice in a primary care setting, such as beds or blood pressure cuffs, to be able to provide inpatient or ambulatory WM, and current licensing structures do not guide MaineCare to elect to cover these services for behavioral healthcare centers. That said, the relationship between SUD and behavioral health leads to many instances where SUD could be treated in behavioral health settings, but these facilities currently do not have the resources necessary to do so.

Physical Infrastructure

Interviewees with recent experience expanding WM discussed the challenges that arose in trying to find a building that meets the regulation requirements described by Maine DHHS. Some of these requirements include a medical grade building, easy access by emergency services, having fob doors, the right sprinklers, and square footage requirements.

Recently, in an attempt to ease the burden of the regulatory requirements for facilities looking to expand WM, interviewees explained that Maine DHHS combined the licensing requirements of substance abuse treatment facilities and mental health agencies. One interviewee reported an unintended consequence of this change being a drastic increase in room size, which resulted significant additional construction costs.

Local, town-specific zoning laws were also identified as a challenge when trying to navigate expansion. Health leaders discussed how zoning laws vary between each town/city, and some entities have fewer barriers to establishing new WM locations. For example, one interviewee explained that Portland has a Private Non-Medical Institution zone that makes expansion easier to navigate, but this is not a universal occurrence.

> ***"One of the things that is particularly challenging in the new regulations that just came out is they're requiring that the rooms be 80-100 square feet per person, so that would make them kind of enormous, bigger than any college dorm I was ever in. And so- our rooms are about 120 [square feet] for two people because they're only there for a few days, but to go up to 160 [square feet] for two people, that's an additional 40 square foot at $300-400 a square foot, so you're adding $15,000 to the cost of every single room. It's nice if people have more space, I totally get that, but, as our finance director I was like, oh my God, people are dying, we need to get them in here."***

MaineCare Coverage

Reimbursement Rates

Health leaders consistently reported the impact of inadequate MaineCare reimbursement rates as being a major barrier to being able to provide WM services. This is because reimbursement rates affect nearly every element of the services necessary to provide WM. Some interviewees explained that inpatient WM requires 24-hour, high-level care comparable to hospital-level care. This includes around the clock nursing care, beds, medical equipment, meals, laundry, access to a doctor, and counseling. One interviewee shared that ***"You can't even break even on reimbursement rates."*** Some interviewees also reported challenges in getting authorizations for certain medications from MaineCare. Currently, interviewees perceive that MaineCare reimbursement rates do not cover the costs of each of these necessary services, and many expressed frustrations in the state's reimbursement rates compared to other comparable states in New England.

"Massachusetts and New Hampshire had a $417/night [reimbursement rate] and then immediately when Maine raised to $417/night, they went to $600. So, there is just this lag…[and] in a private insurance, they would reimburse you at $1000-600/night."

Interviewees that were able to expand despite these hurdles still feel the effects of the reimbursement rates, describing that high nursing costs result in a large portion of the budget being allocated to payroll and often requires the use of funds that were originally allocated for other resources, including equipment and supplies. Thus, this reportedly leads to a diminished quality of supplies.

"…When you walk in and you look at the quality of the bed and you look at the quality of the furniture, or the staff need supplies, and that is not a result of the agency not wanting to well equip their providers, that's a result of them having zero budget and having to dedicate every penny they get to payroll and overhead and so the system's just flawed, right? I walked in there and thought no, no, no, this isn't okay."

Some health leaders also expressed frustrations that MaineCare does not reimburse for some services that, while not required, would help support patients in their journey to recovery, such as peer recovery coaches. Reported uses for peer recovery coaches that are not currently reimbursable are shown in Figure 2 below.

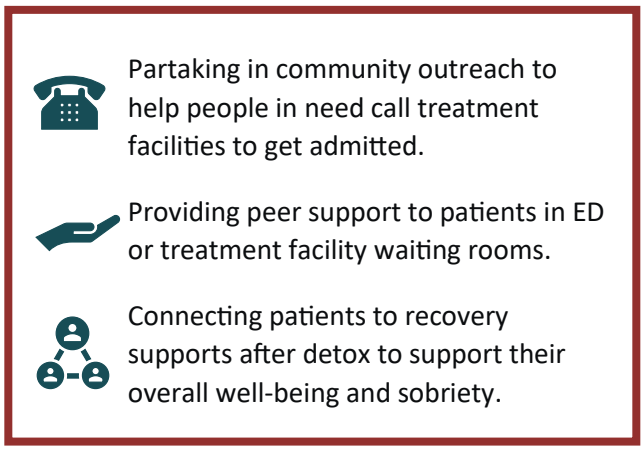

Figure 2. Reported peer recovery coach services that are not currently reimbursable.

Patient Coverage

Some interviewees suggested that historically, insurance coverage for behavioral health needs can be a challenge for patients. Numerous interviewees reported that most behavioral health facilities will not admit patients for the purpose of supporting withdrawal because they do not have the resources to safely offer WM. However, many also reported that hospitals do not admit patients for the purpose of detoxification of any substance. One interview suggested that a lack of MaineCare allowance for hospital-related admission for SUD is a limiting factor and explained that unless a patient is experiencing an unrelated illness or is experiencing severe side effects from withdrawal, such as seizures or delirium tremens, they will not be admitted to the hospital.

"I was literally reading a HealthInfoNet this morning for an individual who went into the [health system] four times in the last 30 days and said I need help, I need to withdraw, I'm sick, I don't want to kill myself, I want to live, please help me, and he was out within an hour each time."

The Start-Up Process

Many health leaders expressed feeling overwhelmed when thinking about implementing WM services, both from a professional and financial lens, because withdrawal management involves more medical infrastructure than many behavioral health facilities are used to managing. With little to no guidance and a limited medical background, some interviewees reported feeling insufficiently experienced and, ultimately, opted to take on other projects that they "felt more equipped to do well."

Compounding with the general discomfort of taking on WM, one interviewee referred to the enormous initial cost that implementing both ambulatory and inpatient WM entails, particularly when considering the costs required to rent or purchase a space and then properly equip and staff the facility. An interviewee, despite having a successful expansion experience, expressed that tackling the initial investment was a heavy lift to expect from small nonprofits.

"…You're going to have to swallow a cost to begin a program, right? And so, the initial investment that that would take, not knowing if it was a program that we could ultimately make sustainable, that was [too risky]."

When considering committing time, money, and personnel resources towards WM, multiple interviewees expressed concerns over the political sustainability of expanding SUD services throughout Maine. While the current state administration is interested in addressing SUD, there is a concern that these programs may not be sustainable if a new administration that does not have the same viewpoint is elected. There is also a concern that a new administration could reverse any progress that is made between now and then.

Workforce

Many interviewees reported that the ability of organizations to offer or expand WM is significantly constrained by workforce shortages, staff turnover, and provider willingness to provide WM services.

Staffing Shortages & Turnover

A statewide shortage of behavioral health workers, and specifically people with expertise in SUD, consistently emerged as theme among interviewees as a barrier to offering WM. Nurses, managers, and medical directors were identified as particularly challenging positions to fill with sufficiently qualified individuals. Some health leaders discussed the importance of whole-person care in SUD treatment and noted that it's important for staff to work together and not in their segmented roles. One interviewee described the difficulty finding staff with a background that allows them to understand the culture of treating people with addiction and how each role (i.e., nurses, counselors, physicians) should contribute.

Almost all interviewees reported that in addition to the challenges faced in finding qualified nurses, there are also challenges retaining these individuals because nurses tend to rather quickly move onto the next institution that can pay them more. Inadequate MaineCare reimbursement rates contribute to facilities being unable to pay nurses a competitive wage. This often leads to staffing shortages, which contributes to challenges in staffing facilities overnight and results in existing staff working more overtime, ultimately leading to high turnover rates.

Provider Willingness

Health leaders reported that provider willingness to offer WM is likely hindered by stigma, discomfort due to insufficient experience providing services, and general wariness due to the lack of a supportive continuum.

Provider willingness to address SUD is highly influenced by stigma. Stigma may present in many forms, including fear, reluctance to view SUD treatment as a necessary medical service, or confusion as to why SUD treatment warrants so many resources. This is especially true in the ED. Compounding with this, multiple health leaders explained that patients experiencing withdrawal side effects are often sent to the ED, however a lack of SUD training among staff, combined with the already overwhelming working conditions that ED staff face, contribute to patients receiving poor care. Some health leaders reported that ***"it's hard to get providers to treat SUD"*** and that ***"detox requests end up getting treated like second-class citizens sometimes."***

Many health leaders also report that provider discomfort and a lack of prior experience with WM services greatly contributes to their willingness to provide services, often due to underlying concerns about patient safety. This appears particularly true in relation to ambulatory WM. Health leaders report that some providers in the ED and primary care arenas are comfortable implementing initial WM services but are concerned that if the patient ultimately needs a higher level of care than they can offer, there will be nowhere to send the patient for help because additional levels of care do not currently exist in Maine. Other providers reportedly will not offer WM due to a lack of training. Ideally, their patients would be referred elsewhere to get the services that they need, however health leaders report that this often does not happen for various reasons, including:

- Frontline workers do not know how to refer patients or how to access a bed;
- The beds they are looking for do not exist; and
- There is not a consistent protocol on what to do if someone presents with needing care for acute withdrawal.

From health leaders' perspectives, the key contributors to patients not receiving appropriate WM services are providers' lack of knowledge on how to properly identify SUD service needs and an overall lack of SUD services in Maine.

Additionally, many health leaders expressed discomfort with having providers guide patients through withdrawal without having the existing infrastructure in place to then support patients throughout their recovery and support their mental health. Many interviewees emphasized the importance of discharge planning and expressed that ***"withdrawal management is just one infinitely small part of recovery for anybody"*** and that ***"sending people back to where they came from is usually a good recipe for them to come see us a few more times."*** Most interviewees discussed the importance of establishing ultra-low barrier housing for those in recovery in all areas of Maine. Overall, strengthening the continuum and supporting patients throughout recovery was reported as a critical need by interviewees to improve both health leadership and provider comfort providing WM services.

Patient Engagement

Multiple interviewees shared the sentiment that ***"the hardest part about detox is typically getting someone into it, getting someone to begin."*** Challenges reaching patients affect providers' ability to support WM. Interviewees shared various factors that create barriers to engaging patients in treatment, including patient fear, transportation, and Maine's high-barrier intake process.

By nature, withdrawal was universally described as a scary and difficult process for many individuals, both physically and psychologically. Many interviewees expressed that fear often prevents patients from showing up and may stop them from continuing treatment once they begin. Interviewees report that this fear is often compounded by the stigma they face and previous traumatic experiences, particularly in the ED. One interviewee placed an emphasis on the fact that ***"The person is not the barrier. Not only do our members traumatize the community, but the community traumatizes the hell out of them."***

Most interviewees agreed that transportation poses a significant challenge in engaging patients in the SUD continuum and that ***"nine times out of ten, if they don't show, it's because transportation failed them."*** Multiple health leaders expressed that organizations struggle in supporting their clients to get into residential programs when beds are available.

> *"We are so challenged with transportation in the state of Maine and where we have such rural communities with high incidence of alcohol use and other substances, a patient actually being able to get to treatment is huge."*

Finally, most interviewees perceive that Maine has an incredibly high-barrier admissions process which makes it difficult for patients to initiate or engage in services. Interviewees explained that facilities require patients to call for consecutive days to secure a bed, undergo a lengthy screening process, make an appointment, and then ultimately come back for that appointment. Interviewees further explain that for most people in active use, making a phone call multiple days in a row is not sustainable. They expressed that screening protocols are not consistent, which results in patients developing a history of being turned away, and at a certain point opting not to engage at all. Many interviewees emphasized that facilities must be ready to accept patients for treatment when they are ready, or that window of opportunity will close.

> *"Withdrawal management is like the ignition or it's a point of entry for a whole recovery, you know, the whole SUD system of care…You can't build a withdrawal management system that's independent of a SUDs system, because then what's the point?"*

Recommendations

Despite the numerous barriers that stand in the way, health leaders recognize the critical need to expand WM services. All interviewees provided valuable ideas and recommendations on how the state can help alleviate some of these barriers.

Build the state's capacity to support recovery after patients go through detox. Many interviewees include housing as a priority in this recommendation.

Provide financial support for training healthcare professionals on WM practices, the various aspects of SUD, the social determinants of health, and trauma informed care. Interviewees believe that SUD work is a specialty, and that training would allow providers to become more comfortable with the practice and, over time, destigmatize the workforce.

Provide guidance on how to navigate local zoning laws to facilities interested in expanding their WM capacity to a new building.

Do a rate study to determine what the actual cost is to run a program and provide certain services. Interviewees believe this may lead to a necessary re-evaluation of the current reimbursement rates.

Standardize care and protocols so that no matter where an individual seeks help, they get the same level of care. One interviewee specifically suggested focusing on the ASAM levels of care.

Re-evaluate facility licensing categorization so that the licensing assignment by Maine DHHS and resulting coverage by MaineCare meets the coverage needs of behavioral health facilities offering WM.

Summary

Maine continues to grapple with the evolving alcohol and substance use crisis and improving access to services across the SUD continuum of care will improve health outcomes for those who are affected by SUD. This project provides invaluable information about the barriers Maine's health system leadership currently encounter while offering or expanding WM services within their health systems. By understanding these barriers, policymakers can begin to identify ways to overcome these obstacles. Health leaders identified many barriers such as licensing and regulatory requirements, inadequate MaineCare reimbursement rates and coverage, the daunting process of implementing WM services with little guidance, workforce challenges, and patient engagement as key factors contributing to their inability or unwillingness to offer or expand WM. In the coming months, the SURE team will build upon these findings as we interview providers from facilities that do offer medically supervised withdrawal, and from facilities that do not currently have capacity to offer medically supervised withdrawal. We will also interview community members with experience seeking or accessing withdrawal support. Multiple viewpoints on the perceived factors driving the lack of SUD services in Maine are needed to improve state capacity to offer WM while also strengthening the entire SUD continuum of care. Ultimately, this will result in the availability of comprehensive SUD treatment for Mainers in need.

> ***"I feel like we're stepping up and driving change and I think that if entities could be driving change instead of simply individuals within systems that have a passion for this, I think we'd get a lot further with it."***

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