Implementing a Mobile MAT Program: Regulatory, Clinical and Other Considerations

Family Guidance Centers:

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Disclosure Information

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- No Disclosures

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- No Disclosures

Medication-Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA)

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Learning Objectives

- Learn information important to the fiscal and regulatory requirements involved in establishing a mobile MAT program.
- Understand the clinical best practices associated with mobile MAT services.
- Develop knowledge about successful strategies for involving community stakeholders in the development and implementation of mobile MAT programs.

Family Guidance Centers, Inc.

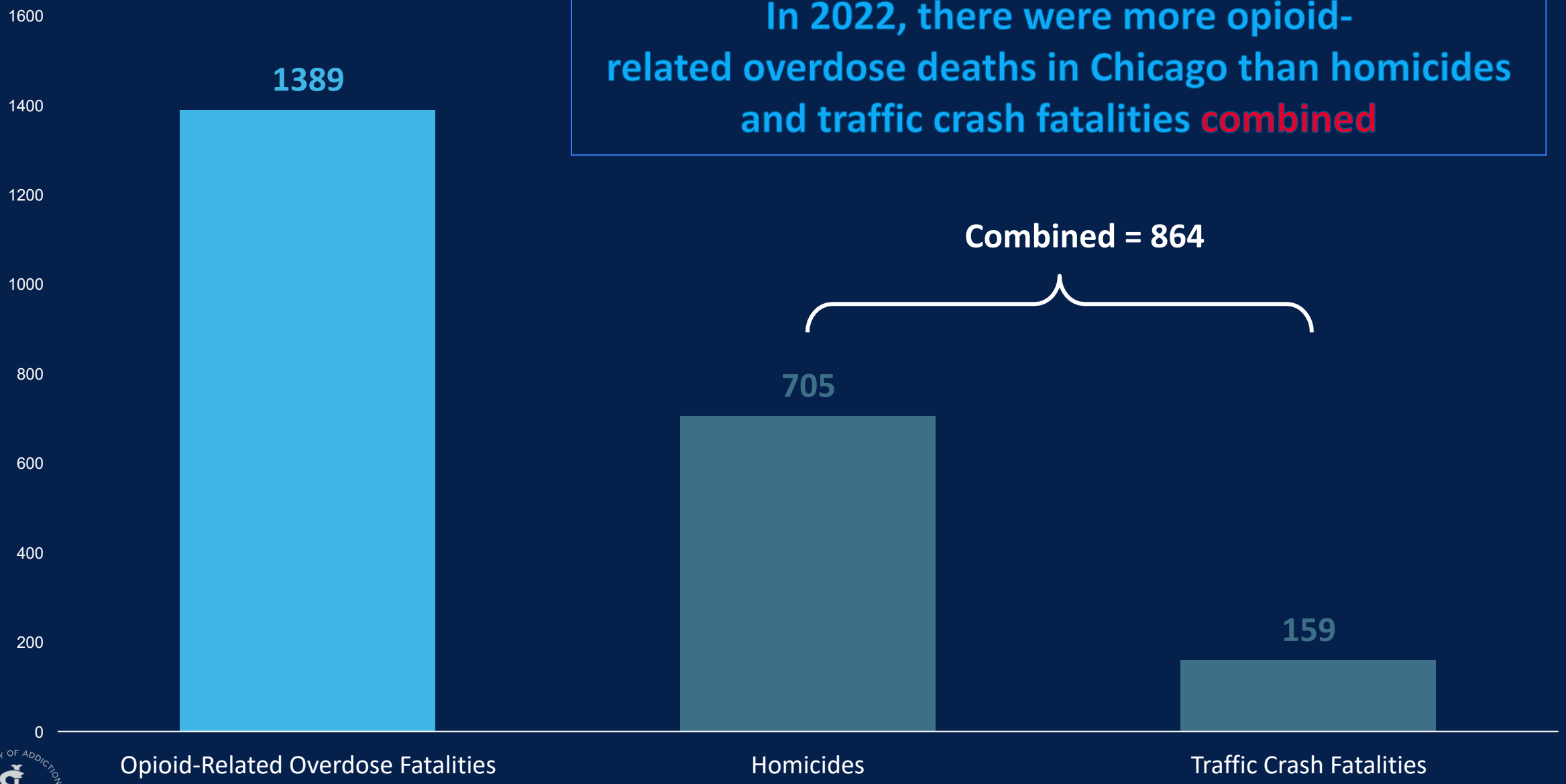
- Federal and state licensed opioid treatment program
- Serving over 8,000 patients annually
- 10 FGC Locations:
    - Chicago North – 310 W. Chicago Ave. (Outpatient)
    - Chicago South – 2630 S. Wabash Ave. (Outpatient)
    - Chicago West – UI Health Mile Square Health Center (Outpatient)
    - Aurora (Outpatient)
    - Des Plaines (Outpatient)
    - Harvey (Outpatient)
    - Joliet (Outpatient)
    - Manteno (Outpatient and Residential)
    - Springfield (Outpatient and Residential)
    - Quincy (Outpatient)

Family Guidance Centers, Inc.

Patients Served – SFY 2023	
310 W. Chicago	1,772
Aurora	494
Des Plaines	618
Harvey	424
Joliet	1,571
Manteno	812
Quincy	84
Springfield	1,245
UI Health-Mile Square	270
Wabash	1,694
Total	**8,984**

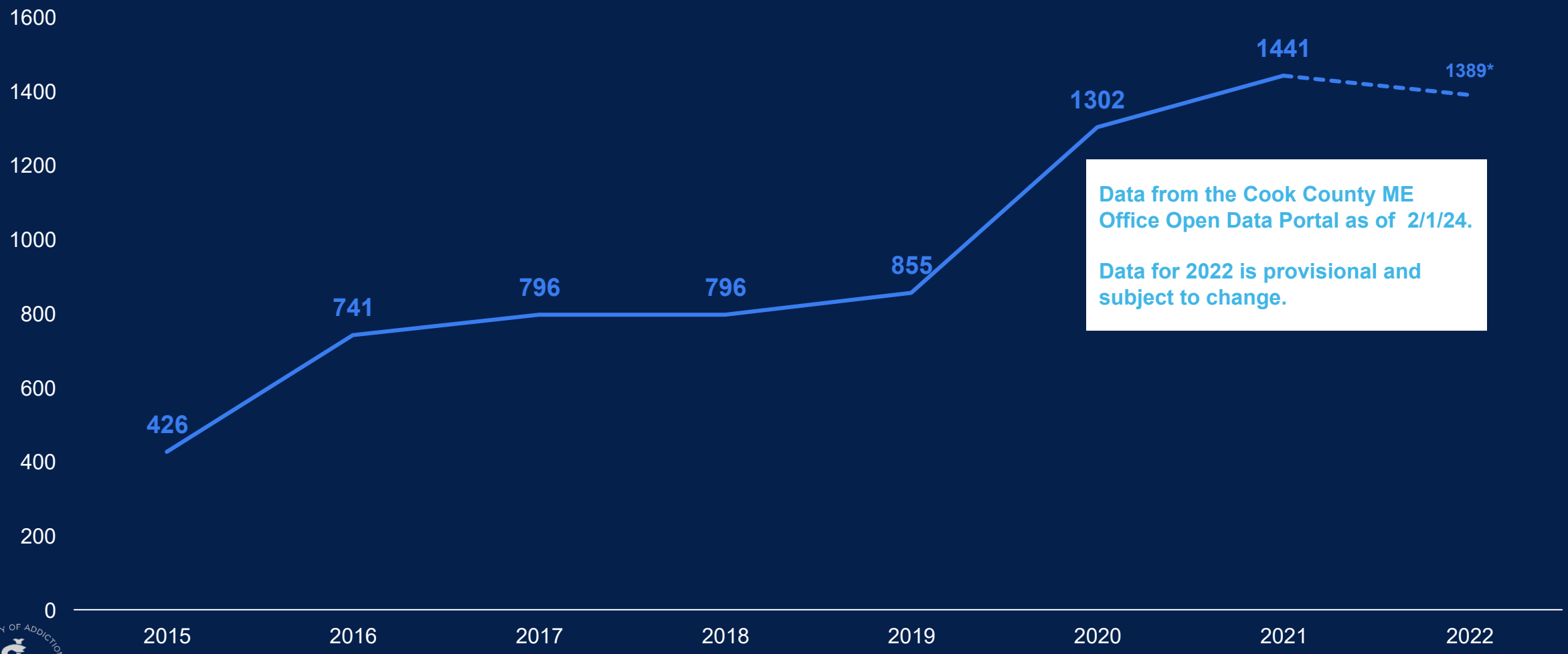
The Opioid Epidemic: Current Statistics in Chicago

In 2022, there were more opioid-related overdose deaths in Chicago than homicides and traffic crash fatalities combined



https://datacatalog.cookcountyil.gov/Public-Safety/Medical-Examiner-Case-Archive/cjeq-bs86/data

Overdose Fatalities in Chicago



Data Source: Cook County Medical Examiner's Office Open Data Portal as of 2/1/24. Data is provisional and subject to change.

Medications for the Treatment of Opioid Use Disorder

OUD Treatment

Behavioral health support - individual counseling, formal treatment programs

Medications for Opioid Use Disorder (MOUD)

1) Methadone

2) Buprenorphine (+/- naloxone)

3) Extended-release naltrexone

Clinical outcomes of MOUD vs treatment without medication

Outcome	Buprenorphine	Methadone	XR Naltrexone
Increased retention in treatment	X	X	X
Reduced illicit opioid use	X	X	X
Reduced risk of overdose death	X	X	
Reduced all-cause mortality	X	X	
Reduced HIV risk behaviors	X	X	

Source: SAMHSA Tip 63, 2020

Retention in Treatment at 12 Months With Reduced Illicit Drug Use

Treatment type	Retention in treatment at 12 months with reduced illicit drug use
Behavioral therapy without medication	6%
XR Naltrexone*#	10–31%
Buprenorphine*	60–90%
Methadone*	74–80%

https://www.chcf.org/wp-content/uploads/2017/12/PDF-Why-Health-Plans-Should-Go-to-the-MAT.pdf

Mobile Units to Improve Access to MOUD

- Despite the overwhelming evidence demonstrating the effectiveness of the medications for the treatment of opioid use disorder, researchers found that in 2021, of the estimated 2.5 million people aged 18 and older with an opioid use disorder (OUD), only 1 in 5 of them (22%) received medications to treat it (Jones et al., 2021).

Mobile Units to Improve Access to MOUD

- The severity of untreated OUD is particularly devastating among underserved Black communities, with a growing body of research documenting the racial disparity in opioid overdose death rates (Gondre-Lewis, Abijo & Condre-Lewis, 2023).

Mobile Units to Improve Access to MOUD

- The provision of MOUD and related recovery support services via mobile units is a growing, evidence-based approach to improving access to care, by widening the net of available services particularly to individuals in underserved areas who are unable to access traditional brick and mortar OTP facilities.

- Data on treatment outcomes show that mobile services are able to engage individuals who otherwise encountered insurmountable barriers to treatment access (Hall et al., 2014; Iheanacho, Payne & Tsai, 2020).

Mobile MAT Models

Model	Induction Methadone and Buprenorphine	Induction Buprenorphine Only	Home Induction (No Induction on Unit)
Pros	Patient Choice	Telehealth with Medical Provider	Fewer Staffing Requirements No DEA approval process
Cons	On unit staffing requirements (face-to-face H&P for methadone induction)* Could experience lengthy DEA approval process	Limited Patient Choice Could experience lengthy DEA approval process	Limited Patient Choice No immediate access to medication

*May change with final changes to 42 CFR part 8

Financial Considerations for Mobile Medication Units

Sources of Funding

- **Substance Abuse and Mental Health Services Administration (SAMHSA):**
  - Medication Assisted Treatment – Prescription Drug and Opioid Addiction (MAT-PDOA) grant program expands and enhances communities' access to medication-assisted treatment (MAT) services for people who have opioid use disorder (OUD). *Illinois, West Virginia*
  - State Opioid Response (SOR) *New Jersey*
  - Substance Abuse Prevention and Treatment Block Grant (SAPT-BG) *New York, New Jersey, Illinois*

Sources of Funding

- **Opioid Settlement Fund: Illinois**
  - Illinois Opioid Settlement Agreement's *Core Abatement Strategy #2 Medication Assisted Treatment/Medication Assisted Recovery*. Expansion of mobile MAR to underserved communities reflects several of the *Approved Uses* detailed in Schedule B of the Settlement Agreement, including the following:
    - Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH condition and for persons who have experienced an opioid overdose.

Sources of Funding

- **Illinois Opioid Settlement Fund**
  - Recommendation: $5M - rolling application to increases access to mobile services that provide medication assisted recovery, treatment, healthcare and recovery support services in areas with highest overdose rates and gaps in service. MAR must be the primary service. NOFO and/or expansion. Mobile Treatment services for MOUD and co-occurring SUD/MH conditions, including all forms of Medication Assisted Recovery ("MAR') approved by the U.S. Food and Drug Administration.

Example Budgets	Leased Vehicle/ All 3 MOUD (MAT-PDOA)	Purchased Vehicle/Buprenorphine Only (State-Funded)
Personnel	$ 98,000.00	$ 202,000.00
Fringe Benefits	$21,981.00	$ 37,602.30
Supplies	$9,500.00	$ 5,400.00
Equipment		$ 80,000.00
Consulting Services	$379,540.00	$ 160,610.00
Contractors		$ 250,050.00
Other		$ 178,717.49
In-Direct	$15,979.00	$ 71,720.21
Totals	$525,000.00	$ 986,100.00

Regulatory Considerations for Mobile Medication Units

Drug Enforcement Administration – Rule Change

- In June 2021, the DEA published a final rule, which repealed its moratorium on mobile medication units and waived the requirement that a mobile Narcotic Treatment Program (NTP) must have a separate registration.

- Under the new rule framework, only NTPs that are already registered with DEA would have the ability to start a mobile component and DEA would not approve a standalone mobile NTP.

- The change in DEA rule allows existing OTP's to establish mobile units, pending DEA approval.

Mobile Narcotics Treatment Program (NTP) Requirements – General Checklist

- Mobile NTP is stocked with narcotic drugs in schedules II–V only from the registered NTP location.

  Yes No

- The storage area for controlled substances in the Mobile NTP is not accessible from outside the vehicle.

  Yes No

- Controlled substances on the Mobile NTP are securely locked in a safe bolted or cemented to the floor or wall in such a way that it cannot be readily moved.

  Yes No

Mobile Narcotics Treatment Program (NTP) Requirements – General Checklist

- The safe on the Mobile NTP is equipped with an alarm system that transmits a signal directly to a central protection company or a local or State police agency, which has a legal duty to respond, or a 24-hour control station operated by the registrant

  Yes No

- The Mobile NTP will return to the registered program location each day, and remove and secure the controlled substances inside the registered location. (If NO, submit separate exception request for DEA approval).

  Yes No

- Mobile NTP will be van securely stored overnight/weekends

  Yes No

Mobile Narcotics Treatment Program (NTP) Requirements – General Checklist

- The Mobile NTP keeps keep a log with information on dispensed controlled substances (dose dispensed, patient, etc.). The log is stored at the registered program location.

  Yes No

- If Mobile NTP is using electronic log, DEA has preapproved electronic system.

  Yes No

- The registrant has a protocol in place to ensure that controlled substances on the Mobile NTP are secure and accounted for in the event that the mobile component is disabled for any reason (mechanical failure, accident, fire, etc.).

  Yes No

Clinical/Staffing Considerations for Mobile Medication Units

FGC Mobile MAT Unit Staffing

Physician/Provider	Required* on unit for completing history and physical (H&P) for individuals interesting in methadone induction, 1-4 hrs. per day.
Program Director	Provides program oversight, scheduling, reporting
Licensed Practical Nurse (LPN)	Assists in providing Mobile MAR Unit screening and assessment services, and development of initial diagnostic impressions. Helps develop an initial treatment plan in collaboration with individual patients and provide the initial MAR dosing consistent with the physician's order. The LPN ensures the safe keeping of FDA-approved medications stored on the Mobile Unit.
Peer Recovery Support Specialists	The PRSS assists in providing Mobile MAR Unit outreach and screening. The PRSS is responsible for developing an initial recovery support service plan in collaboration with patients. The PRSS assists in the development of warm hand-off referrals of patients to FGC and other providers (OTP's, FQHC's, other SUD providers, etc.) for further assessment and admission to treatment and recovery services. The PRSS also assists in the development of referrals of those individuals who are assessed to be in need of other services.
Driver/Security	Provides the security required by the DEA to safeguard medication.

*May change with final changes to 42 CFR part 8

Role of Peer Recovery Support Specialists

- SAMHSA Resources on PRSS:
  - *PRSS Definition: A peer-helping-peer service alliance in which a peer leader in stable recovery provides social support services to a peer who is seeking help in establishing or maintaining their recovery (SAMHSA, 2009).*
  - SAMHSA has made efforts to identify and describe core competencies for peer support workers in working with individuals with SUD as well as mental health disorders (SAMHSA, 2015).

SAMHSA (2009). *What are Peer Recovery Support Services?*. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Role of Peer Recovery Support Specialists

- Lived experience enables peer recovery specialists to assist with deescalating and empathizing with people experiencing SUD crisis because they can understand the challenges and opportunities that arise during those critical moments.

- They can improve engagement and participation in treatment by providing information, clarification and emotional support during the transition from crisis to ongoing treatment or support. Peer recovery specialists can also play a significant role in developing crisis response protocols, treatment plans and policies to ensure that the unique needs of individuals with SUDs are considered and addressed effectively (Gagne et al., 2018).

Community Engagement Considerations for Mobile Medication Units

Community Engagement

- Engaging with local stakeholders is crucial to the planning and implementation of mobile MAR units.
- Early stakeholder engagement efforts are a critical phase of the development process.
- This pre-work not only establishes key relationships for operations and referrals but also helps to reduce stigma and increase community buy-in.

Community Engagement

- Providers should reach out to community partners to:
  - Use existing data to demonstrate the need in target areas.
  - Describe the program design and goals, answer any questions, and address any concerns about the proposed program.
  - Solicit feedback on parking locations.
  - Establish linkages to local partners including hospitals, primary health care (FQHCs), housing programs, homeless shelters/services and other support services, and create a plan for seamless referrals to/from these services.
  - Consider establishing memoranda of understanding to formalize relationships.
  - Support care coordination with community partners to ensure successful referral/hand-off.
  - Engage with local pharmacies (depending on model).
  - Establish an ongoing dialogue and provide consistent updates to community partners.

Needs Assessment to Support Mobile MAT Funding

- Important to identify communities to be served and their needs and assets.
- Needs assessments should rely (as much as possible)on local data (e.g. county overdose death rates).
- Both quantitative data (e.g., number of overdose events, number of individuals receiving treatment, and length of waitlists for care) and qualitative data (e.g., community-identified priorities) help tell the story of a community's opioid challenges and current methods for navigating them.
- Identify populations of focus. No community is homogeneous and the needs of different subsets of a community may vary significantly.
- Needs assessments use data to identify discrepancies between a community's needs and its system capacity that warrant further investment/targeted resources.

Data Collection – Mobile MAT Units

Regardless of funding source, data collection is necessary to:

- Assess the program's reach
- Measure client satisfaction and access to services
- Measure client outcomes
- Document the challenges and the supports to program implementation.

Data Collection- Mobile MAT Units

Collected data may include the following:

- Number of unique individuals served
- Total number of visits to unit
- Total number of MAR visits
- Total number of individuals inducted on MAR
- Demographics on individuals served on unit
- Number of targeted areas (counties, communities, towns, neighborhoods, Zip codes, etc.) served
- Number of individuals successfully engaged in treatment
- Client satisfaction with services
- Client outcomes (substance use, mental health, housing, etc.)

FGC Mobile MAT Unit:

Initial Data from Medication-Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA) Grant

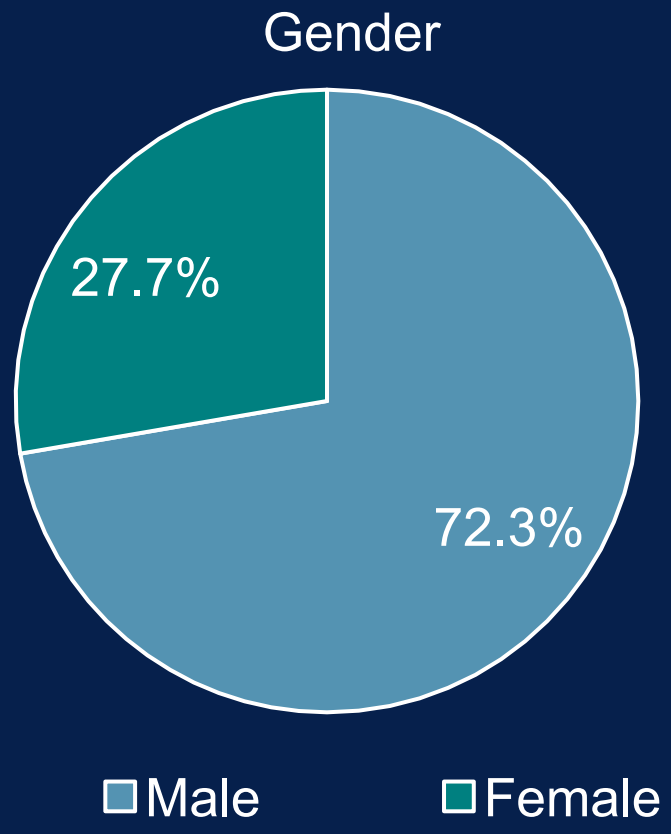
Summary Findings from Initial Analysis of FGC MAT-PDOA Patient Baseline Data

- From 1/23/22 – 1/31/24, 860 unduplicated individuals received induction on MAR from the FGC mobile unit.

- Of the individuals receiving mobile MAT services, 69.2% (N=595) were successfully connected to ongoing treatment.

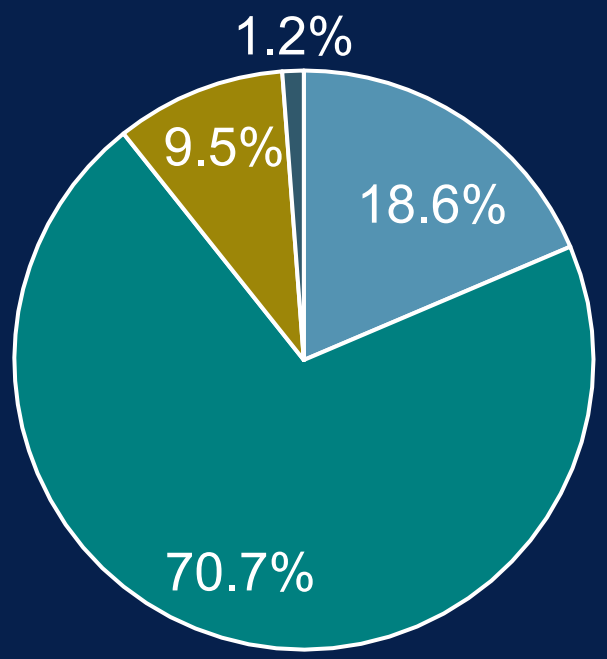
Summary Findings from Initial Analysis of FGC MAT-PDOA Patient Baseline Data

- In general, participant demographics mirror demographics of those most at risk for fatal overdose in Chicago.



Summary Findings from Initial Analysis of FGC MAT-PDOA Patient Baseline Data

- The average age of patients served on the unit is just over 50 years old. Racial/ethnic breakdown is as follows:



Summary Findings from Initial Analysis of FGC MAT-PDOA Patient Baseline Data

- Nearly 40% of the patients reported having less than a high school education, and one-third (33.8%) reported having no more than a high school education.
- Only 7.3% of the patients reported being employed either full-time or part-time at baseline. Nearly 20% reported being disabled.
- Over 25% reported “street/outdoors” and 11% of the patients reported a shelter as their living arrangements during the past 30 days. Over 35% reported living in someone else’s home in the past 30 days.

Summary Findings from Initial Analysis of FGC MAT-PDOA Patient Baseline Data

- Over 50% of the patients rated their current quality of life as "Poor."
- Less than 30% of the patients reported contact during the past 30 days with someone who supports their recovery.
- Nearly all (95.7%)of the patients reported heroin use during the past 30 days, with an almost daily frequency of use (average 27.7 days in past 30).

Client Outcomes at Six-Month Follow-Up

- As of January 31, 2024, the SAMHSA/CSAT GPRA six month follow-up tool had been completed with 233 out of 653 grant participants (35.7%).
- Factors contributing to low follow-up rate include housing instability, high rates of co-occurring mental health disorders, and limited social relationships.
- To address low follow-up rate, FGC began distributing phones to participants with no phones, no contacts.

Key GPRA Measures: Baseline to Six-Month Follow-Up

GPRA Item (Past 30 Days)	Statistical Test	Baseline	Six Month Follow-Up	% Change
Attended Self-Help Support Groups – Yes /Past 30 Days	$\chi^2=57.83$ $p < .001$, $df = 1$	3.0% (7)	28.8% (67)	+860.0%
Rating of Quality of Life – Very Good/Good	$\chi^2=79.28$ $p < .001$, $df = 4$	15.1% (35)	54.0% (126)	+257.6%
Interaction with Family/Friends Who are Supportive of Recovery	$\chi^2=24.38$ $p < .001$, $df = 1$	54.1% (125)	76.0% (177)	+40.5%
Degree of Satisfaction with Personal Relationships Satisfied/Very Satisfied	$\chi^2=44.20$ $p < .001$, $df = 4$	44.2% (102)	71.3% (166)	+61.3%

GPRA Item (Past 30 Days)	Statistical Test	Baseline	Six Month Follow-Up	% Change
Avg. Days of Alcohol Use/Past 30 Days	N.S.	2.5	2.5	0.0%
Abstinence Rate – Alcohol	$\chi 2=5.01$ $p = .024$, $df = 1$	82.8% (193)	74.2% (173)	-10.1%
Avg. Days of Cocaine Use/Past 30 Days	$z = -5.61$ $p < .001$	7.8	3.3	-57.7%
Abstinence Rate – Cocaine	$\chi 2=10.86$ $p = .001$, $df = 1$	58.8% (137)	73.3% (170)	+24.6%
Avg. Days of Marijuana Use/Past 30 Days	$z = -2.76$ $p = .006$	1.2	2.2	+83.3%
Abstinence Rate – Marijuana	$\chi 2=11.02$ $p = .001$, $df = 1$	91.0% (212)	80.2% (186)	-11.9%
Avg. Days of Heroin Use/Past 30 Days	$z = -11.19$ $p < .001$	27.1	10.0	-63.1%
Abstinence Rate – Heroin	$\chi 2=61.06$ $p < .001$, $df = 1$	6.4% (15)	36.1% (84)	+464.1%

GPRA Item (Past 30 Days)	Statistical Test	Baseline	Six Month Follow-Up	% Change
Experienced Depression	χ^2=19.63 p < .001, df = 1	55.4% (129)	34.9% (81)	-37.0%
Avg. Days Experienced Depression -Past 30 Days	z = -4.95 p < .001	10.1	5.6	-44.6%
Experienced Serious Anxiety	χ^2=11.23 p < .001, df = 1	52.8% (123)	37.3% (87)	-29.4%
Avg. Days Experienced Serious Anxiety -Past 30 Days	z = -4.62 p < .001	10.4	6.3	-39.4%
Prescribed Psychotropic Medication/Yes	χ^2=18.27 p < .001, df = 1	5.6% (13)	18.5% (43)	+230.4%
Bothered by Psychological/Emotional Problems – Extremely/Considerably	χ^2=10.30 p = .036, df = 4	40.9% (63)	35.2% (43)	-13.9%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Mobile Services


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Mobile Care Unit


RIP

Final Takeaways

- Establishing a mobile MAT program requires a great deal of lead time to engage community stakeholders and work through regulatory requirements.
- Funding to maintain staffing is critical. It is unlikely that fee-for-service billing can support program operations.
- Peer Recovery Support Specialists have an essential role in engaging individuals with OUD in mobile services and successfully connecting them to ongoing care.

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