OPPORTUNITIES TO INCREASE SCREENING AND TREATMENT OF OPIOID USE DISORDER AMONG HEALTHCARE PROFESSIONALS

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FOREWORD

Addiction is a public health crisis that impacts almost one in three families across the U.S. **Nearly 21 million people in the U.S. struggle with addiction, yet only 10 percent of those suffering receive any type of specialty treatment.** Over two million people in the U.S. have opioid use disorder (OUD), but medication for addiction treatment (MAT), one of the most effective options to treat OUD, has been underutilized. There are many contributing factors to this treatment gap, such as a lack of reliable screening for OUD, limited availability and access to on demand evidence-based treatment, and patients' experiences of stigma and fear of discrimination in the healthcare system.

In an effort to better understand and close the treatment gap, Shatterproof partnered with the Massachusetts Medical Society to gather insights and reactions from healthcare professionals with the goal of addressing and reducing the stigma associated with opioid use disorder (OUD). The organizations' aim was to help healthcare professionals increase their efforts in screening and treating patients with OUD, while also empowering those suffering with the disease to come forward and seek care.

The financial support for this initiative came from the GE Foundation and RIZE Massachusetts. The GE Foundation is committed to community health and fighting the opioid crisis in Boston and across Massachusetts. In 2016, the GE Foundation announced a $15 million commitment to community health in Boston and greater Massachusetts to help expand care in behavioral health and addiction medicine with a focus on the opioid epidemic.

RIZE Massachusetts is an independent nonprofit foundation working to end the opioid epidemic in Massachusetts and reduce its devastating impact on people, communities, and our economy.

This collaboration with Shatterproof and the Massachusetts Medical Society and its physician-led Task Force on Opioid Therapy has identified several opportunities to encourage and enable more healthcare professionals to screen and treat patients with OUD. We look forward to continuing to work with healthcare professionals (HCPs) across the state of Massachusetts to implement these recommendations to help reduce unjust stigma that prevents patients from seeking care, and to instead promote access and help reduce the impact of opioid use disorder across the state.

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BACKGROUND

Addiction is a public health crisis affecting nearly 1 in 3 families across the United States. Nearly 21 million people in the U.S. struggle with substance use disorders (SUD), yet only 10% of those suffering receive any type of specialty treatment* for the condition. Opioid use disorder (OUD) is a specific SUD characterized by an addiction to opioids. More than two million individuals in the U.S. suffer from OUD and approximately 130 people in the U.S. die from an opioid overdose every day — a six-fold increase since 1999. The current opioid epidemic has been declared a public health emergency and it remains an ongoing crisis. In addition to the human toll and suffering, the economic burden of the opioid epidemic was estimated to be $92 billion in 2016.[1–4]

Over the last 20 years, scientific evidence and understanding of SUD, and OUD more specifically, has evolved and it is now regarded as a chronic relapsing disease of the brain. Although evidence-based treatment such as MAT is effective in managing OUD, the disease remains grossly under-treated and stigmatized. Prior to 2002, when buprenorphine was approved for OUD treatment, methadone clinics were the only treatment available to individuals with OUD. Methadone clinics require patients to come daily to receive their medication. It was hoped that the approval of buprenorphine would offer a less restrictive treatment alternative to methadone for people with OUD by not requiring these daily visits, and not being restricted by facility licensing. However, after its approval, an additional licensing requirement was imposed on prescribers, requiring specific, time-consuming training to obtain a DATA 2000 waiver to be able to prescribe the medication. To further complicate OUD treatment, MAT is often viewed as "replacing one addiction with another," a perception held by some healthcare professionals (HCPs), the public at large, and even some in the recovery community.

To prevent overdose or death in people struggling with opioid use disorder, it is critical to screen and treat patients. Although progress has been made to provide access to treatment for OUD, more than 70% of those with this disease are not receiving care at an appropriate facility.[5] Stigma may be contributing to the treatment gap as studies have shown that individuals with OUD who experience stigma are much less likely to seek treatment, and perceive or experience more limited access to treatment.[6-8] Research also demonstrates that linking primary care and SUD services is effective and beneficial for individuals with addiction, yet many primary care professionals report preferring to refer patients to addiction specialists for treatment.[9,10]

Our research intended to explore the perceptions and barriers to screening and treating patients with OUD among HCPs to better understand treatment gaps and identify opportunities to support and educate healthcare professionals.

** Specialty treatment refers to substance use treatment at a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or outpatient), or a mental health center.[1]*

***Specialty Facility refers to treatment received at a hospital (inpatient only), rehabilitation facility (in-patient or outpatient), or mental health center in order to reduce or stop illicit drug or alcohol use, or for medical problems associated with illicit drug or alcohol use.*

PROGRESS IN MASSACHUSETTS

Massachusetts has been a national leader in improving patient care in SUD, including OUD — increasing treatment capacity and quality, preventing overdose deaths, combating stigma to ensure dignified care is provided, and increasing healthcare professional (HCP) preparedness to effectively manage the disease. Some initiatives include:

2012: Good Samaritan Law

The Massachusetts Good Samaritan Law encourages someone who witnesses an overdose to seek help from professionals, by providing the caller and person who overdosed protection from arrest and prosecution for drug possession

2014: MGH Substance Use Disorders Initiative

Massachusetts General Hospital (MGH) developed a new approach to treating SUDs that recognized the chronic, multi-stage nature of the disease. The goal of the MGH Substance Use Disorders Initiative is to provide resources and collaborative treatment so that SUDs are addressed along all levels of health impact, from primary community-based prevention to early intervention and treatment to chronic disease management. MGH was also the first emergency department to offer treatment initiation and linkage to care for those presenting with an SUD-related issue.

2015: State without StigMA

Massachusetts launched the "State without StigMA" campaign, which offers information and resources to dispel myths about SUD. Additionally, the program shares stories of those successfully in recovery and a helpline for those who may be struggling with SUD.

2015: Governor's Medical Education Working Group

The Governor's Medical Education Working Group on Prescription Drug Misuse partnered with the Massachusetts Department of Public Health, the Massachusetts Medical Society, and Massachusetts' four medical schools to develop and implement cross-institutional core competencies about prescription drug misuse. This program provides medical students the information and confidence necessary to prevent, identify, and treat SUDs.

2016: Deconstructing Stigma Campaign

The Deconstructing Stigma Campaign ("A Change in Thought Can Change a Life"), targeted at increasing awareness and decreasing stigma regarding mental health, began in Boston's Logan International Airport. The initiative, led by Boston's McLean Hospital, has since spread across several additional states.

2016: STEP Act

The Massachusetts Act Relative to Substance Use Treatment, Education and Prevention (STEP Act) went into effect, increasing funding for SUD services, expanding insurance coverage for treatment, and enhancing prevention efforts via the state's Prescription Monitoring Program.

2017: Grayken Center for Addiction

The Boston Medical Center Grayken Center for Addiction offered state of the art treatment for SUD, without the stigmatizing attitudes that have often led many to view and treat SUD as a choice rather than a chronic disease. Like many other institutions, the Grayken Center has also launched their own version of SAMHSA's Words Matter pledge, encouraging HCPs to pledge to use non-stigmatizing language when referring to SUD, and giving numerous examples of such language.

2018: Bill H4742, An Act for Prevention & Access

Governor Baker signed into effect Bill.H4742, An Act for Prevention and Access to Appropriate Care and Treatment of Addiction, which strengthens prevention and education efforts, espouses and encourages harm reduction principles, and increases access to treatment for MA residents.

PROGRESS IN MASSACHUSETTS (CONT)

In Massachusetts, the number of opioid-related overdose deaths fell 2% across the state from 2016 to 2017, and fell another 4% from 2017 to 2018.[9]

Additionally, the rate of individuals with opioid prescription 'activity of concern'◊ fell 56% from 2013 to 2018.[12] However, some challenges remain as the proportion of Massachusetts residents with OUD increased from 2015 to 2016, and nonfatal overdoses increased over the same period.[13]

INCREASING OUD SCREENING & TREATMENT

One component of combating the opioid epidemic is increasing screening and treatment of OUD. Although Massachusetts has made strides to increase treatment for OUD and reduce stigma, opportunities for improvement still remain.

With this in mind, Shatterproof, through the generous grant support of the GE Foundation and RIZE Massachusetts, and in partnership with the Massachusetts Medical Society, launched a multi-step project to identify barriers that primary care (including Family and Internal Medicine), Emergency Medicine (EM), and Obstetrics/Gynecology (OB/GYN) professionals in Massachusetts face that prevent them from screening and treating patients with OUD. The findings and insights from this research are intended to inform programs and behavior change interventions to provide the information, education, and support needed to reduce stigma and empower HCPs to provide the necessary care to patients with OUD.

◊ *Defined as an individual who received prescriptions for one or more Schedule II opioid drugs from four or more different prescribers and had them filled at four or more pharmacies during the specified time period.*

METHODS

We leveraged both qualitative and quantitative methods to understand HCP's attitudes towards patients with OUD. We have included the findings of our qualitative research in this section as it directly informed the quantitative survey approach and design.

QUALITATIVE RESEARCH AND HYPOTHESES GENERATED

This project began with a literature review of both stigma and stigma-reduction programs related to OUD to gain an understanding of the current state of research. This review substantially informed the background of this report. There were no peer-reviewed articles that described initiatives targeting only OUD stigma. Therefore, we reviewed multiple research-tested stigma-reduction initiatives for SUD overall (encompassing OUD in several cases) and observed several directional insights, including an HCP's exposure to patients with SUD leads to greater comfort levels in working with patients with SUD. Research also demonstrated that greater lengths of training and education leads to a more substantial reduction in negative HCP attitudes towards patients with SUD and possibly a feeling of increased responsibility in providing care.

The literature review findings were used to inform questions and discussion guides for focus groups held with patients with OUD and family members of patients. These groups were intended to provide a better understanding of the HCP behaviors, language, and quality of care the patients with OUD felt they received. We also used the findings of both the groups and the literature review to develop hypotheses for underlying stigmas or barriers to treatment that may be negatively impacting HCP screening and treatment of patients with OUD. The two patient focus groups consisted of a total of 14 individuals in the Boston area currently in recovery for OUD of varied ages, lengths of sobriety, and modes of treatment. The family focus group consisted of four family members of individuals with OUD in the Boston area. The key insights and learnings from the groups were:

Challenges around screening patients/ preventing OUD:

- Patients and family members experienced a lack of monitoring for potential addiction when opioids were prescribed
- Family members felt there was no process or avenue to raise concerns about addiction/ potential addiction with their primary care HCPs
- Family members struggled to find prevention and treatment resources and did not feel supported in navigating the systems of schools, insurance companies, and healthcare professionals

Challenges around treating patients with OUD:

- Patients who were identified by HCPs as having OUD felt they received lower quality care for conditions unrelated to OUD
- Negative experiences within the healthcare system dissuaded patients from discussing or seeking treatment; however, positive experiences had the opposite effect and improved patients' feelings towards treatment and medicine
- Many patients experienced negative language and behaviors by HCPs making it difficult to access adequate treatment for their OUD
- Patients felt their healthcare professionals lacked sufficient education and knowledge around how best to manage, support, and treat patients with OUD

QUALITATIVE RESEARCH AND HYPOTHESES GENERATED (CONT.)

We then convened a group of nine thought leaders from across the state of Massachusetts who have extensive experience working in, or advising on, the OUD treatment space to share our early research findings, hear their perspectives on the challenges and barriers in caring for patients with OUD, and brainstorm opportunities to address these barriers.

From the literature review, focus groups, and thought leader discussion, we generated hypotheses about the attitudes and beliefs that prevent or create barriers for EM, primary care, and OB/GYN HCPs to screen or treat patients with OUD, along with potential opportunities to increase screening and treatment for OUD (see Fig.1).

FIGURE 1

Hypotheses about Why HCPs Don't Screen Patients for OUD Consistently

- HCPs may not have the staff or resources to support patients with OUD
- Many HCPs feel addiction specialists are best equipped to treat patients with OUD
- HCPs may be reluctant and uncomfortable to ask screening questions
- Many HCPs may not have the knowledge or feel comfortable treating OUD, and therefore do not screen patients
- HCPs may feel skeptical about treatment efficacy, and therefore do not want to screen patients

Hypotheses about Why HCPs Don't Recommend or Provide Treatment for Patients for OUD Consistently

- HCPs are not aware of positive outcomes among patients on treatment
- HCPs may view OUD as a moral failing and not a treatable, chronic condition
- HCPs may not have a strong understanding of, or a positive perception around, treatment efficacy
- HCPs may view the time, effort, and hurdles to provide treatment to a patient with OUD as much more burdensome than for other chronic diseases
- HCPs are not aware of or have access to behavioral support for treating patients with OUD

QUALITATIVE RESEARCH AND HYPOTHESES GENERATED (CONT.)

These hypotheses were tested in qualitative research with HCPs in and around greater Boston, and in subsequent quantitative research. A total of five focus groups were conducted with 22 HCPs. Groups were conducted among distinct specialties and included physicians, nurse practitioners (NP), physician's assistants (PA), and registered nurses (RN). The five groups reflected the target groups for this project: (1) EM physicians, NPs, and PAs (2) EM RNs (3) Primary care physicians, NPs, and PAs (4) OB/GYN physicians, NPs, and PAs, and (5) Primary care and OB/GYN RNs. Many of the hypotheses generated from our initial qualitative research were consistent with the findings of these HCP focus groups. We heard the focus group participants say that they:

- Had experienced negative interactions with patients with OUD and therefore held negative attitudes toward these patients
- Do not feel they have sufficient knowledge or understanding of OUD-specific screening and treatment protocols
- Do not feel they have sufficient training or education more broadly to care for patients with OUD
- Feel specialists are better equipped to care for patients with OUD (and do not feel it should be non-specialists' responsibility)
- Prefer not to treat patients with OUD as it takes too much time and resources
- Can feel emotionally drained when caring for patients with OUD
- Often see patients with OUD at their worst (e.g. after overdose) and don't see many success stories

However, healthcare professionals did indicate data demonstrating improved outcomes from screening and treating, as well as additional training, education, and resources, could be effective in changing their attitudes and behaviors when caring for patients with OUD.

We leveraged the insights from the HCP focus groups in addition to existing peer-reviewed research studies to create a quantitative survey that was fielded to HCPs throughout Massachusetts in order to both understand the prevalence of these attitudes and behaviors and identify opportunities for change.

For the purposes of this white paper, we will focus on the methods and findings from the quantitative survey and the opportunities to reduce stigma, increase screening, and increase treatment for patients with OUD.

QUANTITATIVE SURVEY METHODS

In order to develop the quantitative survey, we built off of the insights discussed above, in addition to existing SUD/OUD stigma surveys.[14–18] We fielded the survey to the three main specialties targeted by this project — Emergency Medicine, primary care (including Family Medicine and Internal Medicine), and OBGYN/Women's Health – as well as addiction specialists, pediatric HCPs, psychiatry HCPs, and social workers, as a point of comparison. In our subsequent results, we refer to these main specialties as EM, FM/IM, and OBGYN.

We partnered with Massachusetts Medical Society (MMS) who fielded the survey to their own members and led the coordinated effort with an additional 10 provider organizations to field the survey to each of their member bases (see Appendix for complete list). The online survey took approximately 15 minutes to complete, and was fielded for 1.5 months from December 2018 to January 2019. There were no exclusion criteria — all targeted provider specialties and social workers were eligible to take the survey regardless of practicing status. As a form of appreciation, HCPs who completed the survey received a code from MMS that could be redeemed for 1-hour Continuing Medical Education credit training via the MMS website (social workers were not eligible for this honorarium because they have different continuing education requirements).

A total of 607 HCPs completed the survey, of which 43 were removed as part of quality control, creating a final analysis set of 564 surveys.◊ To ensure a minimum group size of 30 for calculations, some specialties and response categories were combined. Survey data were analyzed using pairwise comparisons between all specialties, waiver training, and tenure lengths.

The findings from this survey are intended to provide insight into the barriers HCPs may encounter that limit screening and treating for OUD. The quantitative survey obtained a total sample that is sufficiently large for research purposes (N=564), however, we recognize the sample sizes are fairly small for many of the HCP specialties and insights should be taken as directional indicators. Our overall approach also demonstrates the complementary findings and insights across the literary review, focus groups, quantitative survey, and thought leaders.

◊ Respondents whose response time was below the 5th percentile or above the 95th percentile, or who failed any of the survey quality control tests, were removed.

RESULTS

PARTICIPANT HEALTHCARE PROFESSIONAL PROFILE

20.6 YEARS
Average years in practice

74%
Average % of time spent seeing patients

51 PATIENTS
Average # of patients seen in a week

The survey response profile was fairly diverse. Family/Internal Medicine (FM/IM) HCPs were the bulk of respondents at almost half, and Psychiatry professionals the next most numerous. By field of practice, physicians and NPs/PAs were over 90% of respondents. Respondent population was balanced across type of practice/system (see Fig. 2).

ADDICTION TRAINING AND DATA2000 WAIVER STATUS

Almost all respondents had received some sort of training in managing addiction, most commonly via Continuing Education (CE) courses. Most HCPs had not received training during their medical education, residency, or graduate school. HCPs with more recent medical training were more likely to have received training in addiction during medical education or residency, potentially indicating a recent change in curriculum.

- **Only 1 in 4** HCPs had received training on addiction during medical education.*
- HCPs with 10 or fewer years of practice were **almost twice as likely** to have received training on addiction in medical education.

FIGURE 2: SURVEY RESPONDENT DEMOGRAPHICS FOR FIELD OF PRACTICE, PRIMARY SPECIALTY, AND TYPE OF PRACTICE/SYSTEM

Category	*Proportion N = 564*
Field of Practice	**100%**
Physician	75%
Nurse Practitioner/Physician Assistant	29%
Social Worker	5%
Other	1%
Primary Specialty	**100%**
Emergency Medicine	7%
Family Medicine/Internal Medicine	46%
OBGYN/Women's Health	5%
Pediatrics	6%
Addiction Medicine	8%
Psychiatry	13%
Social Work	5%
Other	8%
Type of Practice/System	**100%**
Private Practice	22%
Academic Medical Center	22%
Integrated Health Delivery System	20%
Federally Qualified Health Center (FQHC)/Rural Health Clinic	17%
Other Community Health Center	6%
Other	13%

ADDICTION TRAINING AND DATA2000 WAIVER STATUS (CONT.)

DATA2000 waiver status was high among the survey population — more than a third of respondents indicated having a waiver, substantially higher than the 5%*** of HCPs in Massachusetts who are waivered (see Fig. 3). If we combine the waivered respondents with those who indicated interest in obtaining a waiver, the resulting group includes more than 50% of all respondents. By specialty, Emergency Medicine (EM) HCPs were most interested in obtaining a waiver, and there is opportunity to improve interest in FM/IM HCPs (see Fig 3A). For those not interested in obtaining a waiver, the main reasons stated were lack of perceived need within their patient population, or lack of perceived responsibility.

- **55%** of all DATA2000 waiver-eligible respondents **had a waiver or were interested in obtaining one.**
- **33%** of those not interested in obtaining a waiver reported the reason as this condition **did not apply to their patient population**, or that they did not see patients with OUD.

FIGURE 3: SURVEY RESPONDENT ADDICTION TRAINING AND DATA2000 WAIVER STATUS

Category	*Proportion N = 564*
Addiction Training *(respondents could select more than one answer)*	
In medical education**	28%
During residency/graduate school**	31%
Continuing education courses	70%
DATA2000 waiver training	38%
Other	8%
None	8%
DATA2000 Waiver Status *(N=533)***	**100%**
Waivered	38%
Not waivered, interested in obtaining waiver	17%
Not waivered, not interested in obtaining waiver	33%
Not waivered, don't know interest in obtaining waiver	12%

FIGURE 3A: SURVEY RESPONDENT ADDICTION TRAINING AND DATA2000 WAIVER STATUS

*DATA 2000 Waiver Status (N = 533****)*	*EM*	*FM/IM*	*OBGYN*	*Pediatrics*	*Addiction Medicine*	*Psych*
Waivered	40%	37%	33%	3%	87%	46%
Not waivered, interested in obtaining waiver	36%	18%	27%	16%	7%	8%
Not waivered, not interested in obtaining waiver	14%	33%	30%	59%	7%	36%
Not waivered, don't know interest in obtaining waiver	10%	12%	10%	25%	0%	11%

** Including graduate medical education and/or social work school*

*** Includes social work placement*

**** Data provided by the Massachusetts Department of Public Health*

***** Only physicians, NPs, and PAs can qualify for a DATA2000 waiver. Social Workers who responded to the survey were not asked about their DATA2000 waiver status.*

PERSPECTIVES ON OPIOIDS AND PATIENTS WITH OUD

As a baseline for understanding attitudes that may influence screening for and treating patients with OUD, we assessed HCP attitudes toward opioids and patients with OUD. We found that overall, the majority of surveyed professionals across all specialties did not believe opioids to be effective for treating chronic pain, and believed they are prescribed too frequently for chronic pain. In addition, EM and FM/IM's indicated changes in legislation (prescription drug monitoring program and prescribing guidelines) and mandated training have reduced or changed their prescribing of opioids.

- **Less than 1 in 5**
  surveyed HCPs across all specialties agreed that opioids are **effective for chronic pain**.

- **Two thirds**
  of EM and FM/IM professionals surveyed **changed their practices of prescribing** opioids following changes in legislation.

PERSPECTIVES ON OPIOIDS AND PATIENTS WITH OUD (CONT.)

Attitudes were mixed regarding OUD itself. The majority of HCPs surveyed believed that OUD is a chronic disease, and that treating OUD is societally cost effective. However, EM and FM/IM HCPs were the least likely to believe that OUD is treatable. In addition, non-addiction specialists were unlikely to find caring for patients with OUD satisfying, and FM/IM and OB/GYN professionals were most likely to find patients with OUD more challenging to care for than other patients (see Fig. 4).

FIGURE 4: SURVEY RESPONDENT ATTITUDES TOWARD OUD AND PATIENTS WITH OUD

Healthcare Professional Specialty - Proportion of respondents who Agree or Totally Agree							
Statement	***EM*** *N=42*	***FM/IM*** *N=261*	***OBGYN*** *N=30*	***Pediat-rics*** *N=32*	***Addiction Medicine*** *N=45*	***Psychiatry*** *N=76*	***Social Work*** *N=31*
OUD is a treatable disease	45%	49%	60%	63%	89%	58%	81%
I find caring for patients with OUD satisfying	10%	21%	17%	6%	78%	16%	35%
Treating OUD reduces associated health and societal costs by far more than the cost of the treatment itself	48%	58%	77%	75%	82%	74%	90%
Patients with OUD are more chal-lenging to take care of than patients without OUD	36%	45%	47%	38%	11%	38%	6%
OUD is a chronic disease	65%	67%	90%	91%	84%	66%	94%
Healthcare Professional Tenure - Proportion of respondents who Agree or Totally Agree							
				0-10 years *N=140*	***11-20 years*** *N=111*	***21-30 years*** *N=124*	***30+ years*** *N=126*
I find caring for patients with OUD satisfying				55%	40%	38%	44%
I prefer not to work with patients with OUD				14%	20%	31%	27%

When looking at trends in attitudes by tenure, HCPs with 10 or fewer years were most likely to find caring for patients with OUD satisfying. Those with tenure of 20+ years tended to have a stronger preference for not working with patients with OUD.

- **Only 1 in 10**
  EM professionals found caring for patients with OUD **satisfying**.
- **Less than 50%**
  of EM and FM/IM professionals believed that OUD is **treatable**.
- **More than 50%**
  of HCPs with 10 or fewer years of tenure found caring for patients with OUD **satisfying** — more than any other tenure group.
- **Almost 1/3**
  of HCPs with more than 20 years of tenure **preferred to not work with** patients with OUD.

ATTITUDES AND BEHAVIORS REGARDING SCREENING FOR OUD

Attitudes and behaviors regarding screening for OUD indicated some contradictory thoughts. Overall, HCPs reported they most often screened by asking patients about their opioid use but did not use a systematic screening tool. Yet, few HCPs felt it is easy to identify patients with OUD without using any screening tool.

- **One third**
  of HCPs asked patients about their opioid **use with a systematic** screening tool.
- **Only 1 in 4**
  HCPs agreed it is **easy to identify** patients with OUD without a screening tool, even though rates of systematic screening tool use were low.
- **Almost half**
  of HCPs felt patients would **not be honest** about their opioid use if just asked directly.

Across practice settings, academic medical centers tended to be the most likely to screen inpatients for OUD, and community health centers had substantially higher reported rates of screening established outpatients annually.

FIGURE 5: SURVEY RESPONDENT SCREENING ATTITUDES

	Healthcare Professional Specialty *Proportion of respondents who Agree or Totally Agree*						
Statement	***EM*** *N=42*	***FM/IM*** *N=261*	***OBGYN*** *N=30*	***Pediat-rics*** *N=32*	***Addiction Medicine*** *N=45*	***Psychiatry*** *N=76*	***Social Work*** *N=31*
I use a systematic screening tool (such as the TCUDS II, CAGE, T-ACE, 5Ps, TAPS, BSTAD, BSAS, SBIRT) as my approach to screening for OUD	2%	22%	20%	31%	9%	8%	55%
It is easy to identify a patient with OUD without any screening tool	29%	14%	0%	6%	24%	24%	26%
Patients won't be honest about their opioid use	43%	40%	47%	34%	38%	55%	13%

ATTITUDES AND BEHAVIORS REGARDING SCREENING FOR OUD (CONT.)

FIGURE 6: SURVEY RESPONDENT SCREENING AND TREATMENT ATTITUDES AND PREPAREDNESS

Provider Specialty (Proportion of respondents who Agree or Totally Agree)							
Statement	***EM*** *N=42*	***FM/IM*** *N=261*	***OBGYN*** *N=30*	***Pediat-rics*** *N=32*	***Addiction Medicine*** *N=45*	***Psychiatry*** *N=76*	***Social Work*** *N=31*
I feel responsible to identify and diagnose patients with OUD	62%	83%	77%	84%	93%	86%	87%
I don't have enough time to screen for OUD	38%	28%	13%	25%	9%	11%	N/A
Proportion of respondents who feel Very Prepared							
To screen for OUD/opioid misuse	24%	38%	33%	22%	93%	59%	71%
To diagnose OUD	26%	36%	27%	13%	98%	62%	77%
To provide brief intervention after a diagnosis	24%	28%	20%	13%	96%	42%	61%
To discuss MAT for OUD	31%	39%	27%	N/A	100%	50%	71%
To prescribe MAT for OUD	26%	30%	20%	3%	98%	29%	N/A
To prescribe naloxone to prevent overdose deaths	64%	48%	27%	N/A	87%	34%	N/A

EM professionals reported having the most barriers to screening, and feeling the least responsible for identifying and diagnosing OUD. In addition, most non-addiction professionals indicated they did not feel prepared to screen, diagnose, or provide brief intervention for OUD, and, similarly, most did not feel prepared to discuss or provide treatment for OUD.

- **The majority** of HCPs across non-addiction specialties **feel responsible** for identifying and diagnosing patients with OUD, **but do not feel very prepared** to so.
- **Less than 1/3** of EM, OBGYN, or pediatric professionals **feel very prepared** to screen, diagnose, provide brief intervention for, or discuss or provide treatment for OUD.
- **More than 1/3** of EM professionals feel they **don't have enough time to screen** for OUD, and even more feel patients won't be honest about their use when asked.
- **Only 2/3** of EM professionals **feel very prepared to prescribe naloxone** to prevent overdose deaths, the second highest rate after addiction HCPs.

ATTITUDES AND BEHAVIORS REGARDING TREATING OUD

The majority of HCPs across all specialties agree medications for addiction treatment (MAT) are effective as long-term treatment for OUD. However, there are many barriers that limit treatment for OUD. Overall, the most commonly reported barrier to treating OUD is not feeling comfortable starting MAT for OUD without behavioral health support.

Lack of education around treating OUD and insurance requirements (such as prior authorization) were identified as the next most commonly reported barriers. Thirty-eight percent of EM professionals believe methadone treatment for OUD is substituting one addiction for another, and feel similarly, though less strongly, about buprenorphine as a treatment for OUD. EM professionals also feel most strongly that treating patients with OUD takes away time and resources from other patients.

- **38%**
  of EM professionals believe **methadone treatment** for OUD **is substituting one addiction for another** — twice as many as any other specialty.
- **1 in 4**
  EM or FM/IM professionals feel treating OUD will **attract undesirable patients** to their practice.
- **2 in 5**
  EM or FM/IM professionals feel treating patients with OUD **takes away time and resources** from other patients.
- **Two thirds**
  of HCPs reported **not feeling comfortable starting MAT** for OUD without behavioral health support.
- **More than 50%**
  of EM, FM/IM, OBGYN professionals feel they **don't have sufficient access to behavioral health support** to start patients on MAT.

By practice setting, professionals from federally qualified health centers (FQHCs) or rural health clinics consistently reported the lowest barriers to treating OUD, which may be reflective of their potentially more supportive practice-setting environments around caring for patients with OUD.

ATTITUDES AND BEHAVIORS REGARDING TREATING OUD (CONT.)

FIGURE 7: SURVEY RESPONDENT TREATMENT ATTITUDES

Provider Specialty (Proportion of respondents who Agree or Totally Agree)							
Statement	***EM*** *N=42*	***FM/IM*** *N=261*	***OBGYN*** *N=30*	***Pediatrics*** *N=32*	***Addiction Medicine*** *N=45*	***Psychiatry*** *N=76*	***Social Work*** *N=31*
If my practice treats for OUD, it will attract undesirable patients to our facility/agency	24%	24%	13%	16%	11%	17%	3%
MAT (e.g. methadone, buprenorphine, naltrexone) is effective as long-term treatment for patients with OUD	85%	81%	93%	78%	93%	92%	87%
Methadone treatment for OUD is substituting one addiction for another	38%	19%	7%	16%	18%	12%	6%
Buprenorphine treatment for OUD is substituting one addiction for another	17%	11%	3%	9%	9%	9%	6%
I don't feel comfortable starting medication-assisted treatment for OUD without behavioral health support	67%	66%	89%	81%	22%	47%	N/A
Treating patients with OUD takes away time and resources from other patients	43%	29%	40%	34%	7%	13%	3%
I don't have enough education to treat OUD	29%	41%	43%	81%	3%	39%	10%
Insurance reimbursement rates are too low to make treating OUD worth my time	14%	17%	27%	28%	36%	22%	3%
Insurance requirements (like prior authorization) are too time-consuming and onerous for me to want to treat OUD	43%	36%	40%	22%	33%	34%	10%
I don't have sufficient access to behavioral health support to link my patients to after starting MAT for OUD	57%	57%	53%	59%	20%	21%	N/A

INTEREST IN HCP-FOCUSED PROGRAMS AROUND OUD

Based on the insights and learnings from the focus groups and thought leader discussions, we developed 11 HCP-focused program concepts intended to reduce stigma by increasing HCP preparedness to work with, screen, and/or treat patients with OUD. Overall, each of the 11 program concepts generated interest among at least one-third of the respondents. The most popular concepts included training that gave direct guidance on how to manage and treat a patient's OUD with some variation in interest by specialty.

Top 3 Programs for FM/IM and OBGYN professionals:

1. General training on how to manage a patient with OUD
2. Training on how to best discuss medication as part of treatment for OUD
3. Training on how best to screen for opioid use disorder and provide support to patients

Top 3 Programs for EM professionals:

1. Training on how to best discuss medication as part of treatment for OUD
2. Presentation of data that demonstrate efficacy of OUD treatment
3. Harm reduction training on how to create a safety plan for patients with OUD (such as carrying naloxone, using sterile syringes, not injecting alone)

INTEREST IN HCP-FOCUSED PROGRAMS AROUND OUD (CONT.)

FIGURE 8: SURVEY RESPONDENT REACTIONS TO PROGRAM IDEAS

Healthcare Professional Specialty (Proportion of respondents who Agree or Totally Agree)							
Statement	***EM*** *N=42*	***FM/IM*** *N=261*	***OBGYN*** *N=30*	***Pediatrics*** *N=32*	***Addiction Medicine*** *N=45*	***Psych-iatry*** *N=76*	***Social Work*** *N=31*
Presentation of data that demonstrate screening leads to positive patient outcomes	33%	30%	30%	N/A	31%	28%	29%
Training on how best to screen for opioid use disorder and provide support to patients	40%	44%	57%	N/A	38%	45%	42%
Presentation of data that demonstrate efficacy of opioid use disorder treatment	48%	31%	30%	34%	42%	33%	35%
Peer discussion around experiences, struggles, and successes in treating patients with opioid use disorder	29%	39%	33%	53%	49%	39%	45%
Panel discussion among key opinion leaders and professionals who have extensive experience in treating opioid use disorder	26%	35%	20%	31%	47%	29%	42%
Training to reduce stigma towards opioid use disorder for office and hospital staff	33%	34%	50%	28%	51%	29%	35%
Case studies of, and discussions with, individuals who are on long-term medications for addiction treatment and successfully in recovery	21%	36%	43%	31%	49%	37%	39%
Presentation of data that demonstrate reduction in ER visits when patients are on medication for addiction treatment	40%	26%	23%	28%	38%	26%	32%
Training on how to best discuss medication as part of treatment for opioid use disorder	48%	46%	53%	53%	42%	37%	48%
General training on how to manage a patient's opioid use disorder	31%	48%	60%	56%	40%	45%	52%
Training on how to create a safety plan for opioid use disorder (such as carrying naloxone, using sterile syringes, not injecting alone)	45%	41%	53%	50%	42%	53%	55%

DISCUSSION AND OPPORTUNITIES

The findings and insights of this study represent an important step towards understanding where opportunities exist to provide additional education and program support to assist MA HCPs to reduce stigma and ultimately increase screening and treatment of OUD across the state.

The majority of HCPs surveyed believe OUD is a chronic disease and treating OUD is societally cost effective, even though attitudes towards treatments themselves are mixed. Over half of surveyed professionals already have, or are interested in obtaining a DATA 2000 waiver. Among HCPs surveyed who are not interested in being waivered, the main reason cited is a lack of perceived need or responsibility.

Eighteen percent of the survey respondents report using a systematic screening tool for OUD, while two-thirds ask patients directly about opioid use, but do so without a screening tool. Almost half of HCPs across each specialty also believed patients wouldn't be honest, if asked, with their opioid use.

The majority of professionals across all specialties agree MAT is effective as a long-term treatment for OUD. However, substantial barriers to treating OUD were reported, namely that HCPs surveyed believe patients with OUD take away time and resources from other patients, do not feel very prepared to discuss or provide treatment for OUD (except for Addiction Specialists), and do not feel comfortable starting MAT for OUD without behavioral health support. This represents a large need for increased education and training to help HCPs feel confident in treating patients with OUD.

The evident opportunities for change aligned well with overall respondent reactions to program concepts. Most HCPs surveyed were interested in direct guidance on how to manage and treat a patient's OUD. Program interests differed by specialty, consistent with the specialty's beliefs and current practices around managing patients with OUD.

By collating the insights from the survey and the qualitative focus group work, we have identified opportunities for change in systemic policies, communications, and education that build off of existing state initiatives to strengthen Massachusetts' approach overall to increasing screening and treatment of OUD. Select resources are provided in the Appendix to aid in implementing these opportunities.

SYSTEMIC OPPORTUNITIES

Based on our research, requiring a DATA2000 waiver in order to prescribe buprenorphine may hinder HCP treatment initiation by creating a negative underlying perception of buprenorphine medication, as HCPs are not required to be waivered to prescribe medication for other chronic conditions. In order to minimize this stigma, a **policy change** is required to eliminate the waiver requirement to prescribe buprenorphine. Some Massachusetts HCPs have already called for an end to this stymieing regulation, and efforts in the state and nationwide are currently underway.[19]

Many HCPs did not feel comfortable screening patients for OUD due in part to the fact they did not know where to link patients to care for those who were identified as having OUD. To combat this fear and encourage more consistent screening for OUD, creating **'bridge' or warm-handoff** programs may ensure continuity of care for individuals who are admitted to the Emergency Department due to a serious OUD-related event such as an overdose.

Similarly, training HCPs to create a **treatment plan** with patients can give these HCPs ownership over part of the process, while recognizing that getting the patient into treatment at the level of care they need may take more time.

On-call technical assistance (TA) programs, such as the Massachusetts Consultation Service for Treatment of Addiction and Pain (MCSTAP), can also increase provider confidence and sense of responsibility towards managing OUD by enabling HCPs access to real-time telephonic consultation on how to screen, treat, and/or manage patients with OUD. Such TA programs can also build out of existing support systems, such as poison control services (see case studies).

Language matters in the stigmatization of OUD and patients with the condition and changing this language can similarly be a large step towards eliminating stigma, as is evident from research.[20] In one 2010 experiment, clinicians shown vignettes with the term "substance abuser" were significantly more likely to judge the individual as deserving of blame and punishment than the same individual described as "having a substance use disorder."[21]

> **"[If a patient has] heart failure, I call heart failure [hospital team] and the patient has an appointment in 2 days. It's a very well-oiled machine. [OUD treatment] is not that."**
>
> EM physician
> HCP focus groups

SYSTEMIC OPPORTUNITIES (CONTNUED)

In the healthcare settings, it is important for all staff to receive training and reinforcement on using language that is non-stigmatizing. This includes education on how to use language that is person-first (using 'patient with OUD,' rather than 'opioid addict'); and recognizes OUD as a chronic condition, rather than a personal choice or moral failing (a 'positive test result for opioid use', rather than a 'dirty drug screen'). As noted, the Boston Medical Center Grayken Center for Addiction has taken a step towards tackling this by launching their own version of SAMHSA's Words Matter pledge. This document encourages HCPs to pledge to use non-stigmatizing language when referring to SUD, and giving numerous examples of such language.

Training on language should also be paired with instruction and practice on conversation approaches that can enable patients to feel comfortable opening up about their use and practices. Employing techniques such as **Motivational Interviewing** in clinical interactions can help recognize patient autonomy and choice, thus respecting and empowering patients, while giving HCPs the tools to elicit behavior change. Similarly, understanding models such as the Stages of Change can enable HCPs to recognize where they may and may not have the capacity to realistically change patient behavior.

Case study: *Offering weekly live TA to those treating SUD in an office setting*

Boston Medical Center Office-Based Addiction Treatment (OBAT's) ***Addiction Chat Live*** provides a weekly opportunity for HCPs and prescribers alike to participate in an informal drop-in chat session. HCPs have the opportunity to connect with peers and addiction specialists to address their most pressing substance use disorder-related challenges, hear updates, and share best practices. Participants are invited to drop in as needed with questions and/or cases.

Practice leadership can also reduce patient risk by setting best practices for HCPs around developing a **Safety Plan**, customized to each individual, for those who have OUD or are currently using opioids. Such a plan can include harm reduction information and resources as well as behavioral tools, and set check-ins, for the provider to stay engaged with the patient.

Ultimately many of these changes can take place at the practice level and should be implemented in order to set a clear model for positive treatment of patients with OUD.

OPPORTUNITIES IN FAMILY / INTERNAL MEDICINE AND OB/GYN

Similar to the Emergency Medicine setting, opportunities in the Family and Internal Medicine setting begin with identifying **practice champions or leadership** to share positive experiences of working with patients with OUD and managing the condition.

This should be coupled with **cultural competency training** for the full clinical team, as well as frontline office staff, on how to appropriately interact with patients with OUD and how to feel confident in caring for these patients. Similar to systemic opportunities, such a training should center around how to ask questions, what questions to ask, and how to act based on responses.

> **"My husband fell right back to those bad feelings every time he needs a drip for surgery. His veins are all collapsed and the nurses ask him which vein is best. The shame comes back. They need more training. More understanding. This is a lifelong struggle. Puts us back to the beginning."**
>
> Patient J
> Patient Focus Groups

Training should also focus on **dispelling myths** around barriers to treatment for patients with OUD, and **building confidence** that family and internal medicine HCPs can provide treatment to many patients with OUD in an outpatient setting. This can include programs that share **success stories** of individuals currently on long-term treatment in the primary care setting

Case study: *Waiver training for all practice physicians*

At **Gosnold on Cape Cod**, all physicians were required to obtain a DATA2000 waiver. Once they were trained on how to prescribe buprenorphine and execute an appropriate treatment plan, the physicians realized treatment for OUD was actually "easy". This led to the physicians being more willing to treat OUD patients, encourage new OUD patients to make an appointment, and created a positive change in mindset among the entire office staff.

Finally, in order to reinforce this training, **ongoing education** is needed both inside and outside of the practice. Information on OUD and its treatment should be comprehensively incorporated into training programs and continuing education throughout the state of Massachusetts, and practices should recommend or require ongoing training, via high quality, existing sources, such as the Provider Clinical Support System (PCSS). PCSS is a program funded by SAMHSA to train primary care HCPs in evidence-based prevention and treatment of OUD, as well as treatment of chronic pain. PCSS has numerous free online trainings available, both with and without Continuing Medical Education (CME) credit (see Appendix for sample list of relevant PCSS trainings).

> "I don't know how to screen for it...I don't even know the definition."
>
> Primary Care Physician
> HCP Focus Groups

> "The more knowledge, the better, especially for the office staff."
>
> Primary Care RN
> HCP Focus Groups

> "My doctor was really good — he knew about addiction, knew all the options."
>
> Patient T
> Patient Focus Groups

OPPORTUNITIES IN EMERGENCY MEDICINE

Case study: *Initiating buprenorphine treatment in the ED*

Massachusetts General Hospital (MGH) ED offers buprenorphine to patients with OUD who want to begin treatment on the spot. Once patients have been initiated, they are given a "warm hand-off" to the linked Bridge Clinic for further medical evaluation and linkage to treatment and recovery services.

Given the chronic nature of OUD, it is not a condition that lends itself to appropriate treatment in the Emergency Department (ED). However, overdose is a frequent cause of ED visits. This event identifies a patient with OUD at a critical time and is an excellent opportunity to **connect the patient to care**. While EDs in the state are required to have the capacity to initiate treatment for those who present with an opioid overdose, there are many current challenges facing EM professionals who wish to do so. These challenges can include an unfamiliar process, long waitlists for follow-up care after treatment is initiated, and consult processes generally not streamlined as they are with other conditions.

While the ED isn't the ideal setting for long term treatment, there are opportunities for EM HCPs to initiate MAT and provide a safety plan for patients. Several EDs across the state of Massachusetts have initiated programs that offer buprenorphine to patients with OUD, and a subsequent warm hand-off to further treatment.

Facilities across MA have also seen success in pairing **trained peers** with lived experience or **recovery coaches** in the ED to consult with patients with OUD to encourage treatment and discuss safety plans. There is a significant opportunity to expand these programs across the state and nation. In 2011, the Massachusetts Department of Public Health's Bureau of Substance Addiction Services (BSAS) adopted the Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy (RCA) model and had CCAR train the first class. Since then more than 1,060 people in the state have taken the RCA, and this opportunity remains open. BSAS also supports the peer recovery workforce by reimbursing peer recovery coaches.

> "The ER data would be good. That would make me feel good, knowing we're helping people. That would give me hope."
>
> EM RN
> HCP Focus Groups

> **"Coming off drugs I'm not in a good mood. One staff member took me to the side and talked to me. Made me feel better that someone really cared versus giving up on me."**
>
> Patient M
> Patient Focus Groups

EM professionals who often see patients with OUD at their worst (following overdose), aren't in a position to follow patients through the course of their treatment and rarely see the success stories of patients living in long-term recovery. Educational programs that provide data on positive outcomes for patients in long-term recovery as well as HCPs who are experiencing success providing treatment will help to expand the motivation to initiate MAT in the ED and help to reduce stigma.

OPPORTUNITIES IN COMMUNITY HEALTH

Community health centers are in a unique position to offer a multitude of services those at risk for, or currently experiencing, OUD. As such, community health centers can offer the **multi-disciplinary team care** that is necessary to tackle all aspects of OUD and ensure sustained recovery. These coordinated teams can include not only a physician or NP/PA and a prescriber, but also behavioral health and peer professionals.

With many providers of different focuses, and a strong collaborative atmosphere, community health centers also offer the chance for providers to learn from one another. **Provider-led peer mentoring** enables providers to learn about addiction prevention, screening, and treatment from individuals with similar perspectives and experiences, and can serve to increase provider confidence in these activities.

Case study: *Multidisciplinary addiction treatment model*

Boston Medical Center uses a revolutionary office-based model that relies on a multi-disciplinary team that includes a prescriber, nurse care manager, and a cadre of behavioral health professionals (including recovery coaches). The model is used in more than 14 health centers and community-based organizations across the state. Importantly, nurse visits are reimbursed by the state's MassHealth program, providing essential financial support for the model.

Case study: *Physician-Led Peer-Mentoring Model*

Developed by Massachusetts health centers as part of the SUSTAIN Communities initiative, this model pairs participants with experienced health center physicians already overseeing addiction treatment in their communities. These mentors support the development or expansion of programming, integration of addiction services into primary care, and modification of workflows to increase efficiency and better meet patient needs. This provider-to-provider relationship has helped to increase the confidence of waivered providers to assess and manage patients at risk for, or with, OUD.

FINAL THOUGHTS

While we continue to struggle with the impact of the opioid crisis, and we are a long way from overcoming the epidemic, our research has identified specific barriers and perceptions that FM/IM, EM, and OB/GYN physicians are facing today toward screening and treating of patients with OUD and clear opportunities to overcome them.

Our research has shown HCPs are feeling overwhelmed at the perceived additional staff, time, and resources required to screen and treat OUD; HCPs want and need more education and knowledge on how to best manage patients with OUD; and our healthcare system needs structural improvement to enable adequate linkage to chronic care management, access to behavioral health resources, and care that is respectful and non-stigmatizing for patients with OUD.

HCPs, especially those in EM, usually see or only recognize patients with OUD at their worst, often after an overdose. Yet success stories and data that demonstrate how successful treatment and recovery is possible provide compelling case studies for our front-line HCPs to screen and treat for OUD and may encourage them to do so.

We noted many areas where change is being made through existing efforts in Massachusetts. We hope facilities will use this white paper and cited resources to leverage or enhance existing initiatives and develop new initiatives to increase the HCPs' preparedness to screen and treat patients with OUD and, over time, reduce the stigma and increase quality of care for patients with OUD.

This project was led by Shatterproof, a national nonprofit organization dedicated to ending the devastation addiction causes families. The contributing authors for this report were:

- *Caroline Davidson, Research Analyst (lead author)*
- *Chetna Bansal, Strategy Director*
- *Shannon Hartley, Chief Marketing & Program Officer*

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APPENDIX

Partner Provider Organizations

We would like to acknowledge and thank the numerous partner provider organizations who helped distribute the survey:

1. MA Academy of Family Physicians
2. MA Association of Physician Assistants
3. MA Chapter, American College of Physicians
4. MA Coalition of Nurse Practitioners
5. MA College of Emergency Physicians
6. MA League of Community Health Centers
7. MA Medical Society
8. MA Psychiatric Society
9. MA Section, American College of Obstetricians and Gynecologists
10. MA Society of Addiction Medicine
11. National Association of Social Workers – MA Chapter

SELECT RESOURCES FOR HCPS AND FACILITIES TO IMPLEMENT OPPORTUNITIES

Starting MAT in the ED

- American College of Emergency Physicians (ACEP) – BUPE: Buprenorphine use in the Emergency Department Tool
- Massachusetts General Hospital Guide to Initiating Buprenorphine Treatment in the Emergency Department
- Yale School of Medicine – ED-Initiated Buprenorphine toolkit

Integrating Recovery Coaches into Your Practice

- Recovery Coaches in Opioid Use Disorder Care (prepared for RIZE Massachusetts)

Learning and Using Non-Stigmatizing Language about SUD and Patients with SUD

- Boston Medical Center, Grayken Center for Addiction – Words Matter Pledge
- Shatterproof – Words Matter: Starting Conversations without Stigma
- Shatterproof – Stigma Reducing Language

Conversation Techniques

- PCSS – Motivational Interviewing: Talking with Someone Struggling with Opioid Addiction
- A 'Stages of Change' Approach to Helping Patients Change Behavior (Zimmerman et al 2000)

Dispelling Myths about Treatment for OUD

- Primary Care and the Opioid-Overdose Crisis — Buprenorphine Myths and Realities (Wakeman and Barnett, 2018)
- American Association for the Treatment of Opioid Dependence, Inc. (AATOD) – Myths about Medication

PCSS Technical Assistance Resources for Managing Patients' OUD Behavioral Interventions

1. Motivational Interviewing for Clinical Practice (webinar)
2. The Role of Behavioral Interventions in Buprenorphine Maintenance Treatment (webinar)
3. Motivational Interviewing: Brushing up on the Basics (webinar)
4. Developing a Behavioral Treatment Protocol in Conjunction with MAT (Revised) (online module)
5. Medication and Behavioral Treatment of Substance Use Disorders (online module)

Respect and Cultural Competency

1. Respect and Dignity Key in Treating SUDs (training course)
2. Opioid Use Disorders in the American Indian/Alaska Native Communities (webinar)
3. Opioid Use Disorders in Hispanics/Latinos (webinar)
4. Parenting and Concerns of Pregnant Women in Buprenorphine Treatment (webinar)
5. Recovery Support for Young People with Opioid Use Disorders (webinar)

Medications for the Treatment of OUD

1. Role of Medication in the Treatment of Opioid Use Disorders (webinar)
2. Relapse-Prevention with Injection Naltrexone: Patient Selection and Treatment Initiation (webinar)
3. Opioid Dependence 101 and MAT (webinar)
4. MAT Roundtable: Lessons Learned from CBHOs Implementing MAT for Opioid Dependence (webinar)
5. Methadone Maintenance (online module)
6. Considerations in Medication Assisted Treatment of Opiate Dependence (online module)
7. Introduction to Medication Assisted Treatment (MAT) (online module)
8. Naltrexone Treatment for Opioid Use Disorder: Training for Clinicians (3-Part) (online module)
9. NEJM Knowledge+ Pain Management and Opioids