



# Barriers Limit Access to Medication for Opioid Use Disorder in Philadelphia

Research indicates that a series of targeted strategies could help make such care more available

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# The Pew Charitable Trusts

**Michael Caudell-Feagan**, executive vice president and chief program officer  
**Frazierita Klasen**, senior vice president, Philadelphia

## About this report

This report was written by Seth Budick, a senior officer with The Pew Charitable Trusts' Philadelphia research and policy initiative, based on research that Pew commissioned from Health Management Associates, a national research and consulting firm in the health care industry. Donna Leong, formerly with the Philadelphia research and policy initiative, contributed to the analysis. The report was edited by Larry Eichel, Pew senior adviser, and Demetra Aposporos, officer, editorial.

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**Cover photo:** Craig F. Walker/The Boston Globe via Getty Images

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**Contact:** Elizabeth Lowe, communications officer

**Email:** [elowe@pewtrusts.org](mailto:elowe@pewtrusts.org)

**Project website:** [www.pewtrusts.org/philaresearch](http://www.pewtrusts.org/philaresearch)

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**The Pew Charitable Trusts** is driven by the power of knowledge to solve today's most challenging problems. Pew applies a rigorous, analytical approach to improve public policy, inform the public, and invigorate civic life.

# Overview

Opioid use disorder (OUD) is a public health crisis in Philadelphia. In 2020, the most recent year for which full data is available, there were 1,214 unintentional drug deaths in the city, the second-highest total on record and more than three times as many as a decade earlier. The data shows that fatalities rose among Black Philadelphians and fell slightly among Whites, and that the great majority of drug deaths throughout the city involved opioids.<sup>1</sup>

Medications have been shown to be effective for the treatment of OUD, and the three federally approved for opioid use disorder—methadone, buprenorphine, and naltrexone—are proved to reduce overdoses, withdrawal symptoms, and opioid cravings.<sup>2</sup> But methadone can be administered only in a specially licensed opioid treatment program (OTP), also known as a “methadone clinic,” and naltrexone can produce withdrawal symptoms in patients who have recently used opioids, which creates a barrier to initiating treatment.

Buprenorphine, on the other hand, can be prescribed in any treatment facility, does not require patients to have been opioid-free for several days, and has a low potential for abuse. For these reasons, public health officials and others in Philadelphia’s treatment community want to improve patient access to buprenorphine.

To help understand the barriers that limit the use of buprenorphine and other medications for opioid use disorder (MOUD)—and how they can be overcome—The Pew Charitable Trusts embarked on a research project with Health Management Associates (HMA), a national research and consulting firm. HMA’s work had two aspects. One, aimed at identifying the barriers themselves, involved nine focus groups with 31 local health care providers, who are labeled in this report as “participants.” The other part, designed to highlight strategies for dealing with these barriers, consisted of interviews with 10 other treatment experts from throughout the country. They are labeled as “interviewees.”

The process highlighted these challenges and potential solutions:

- **Coordination of care:** OUD is often accompanied by other physical and mental health conditions, requiring the work of multiple providers. Coordination can be improved by increased access to MOUD throughout the treatment system, improved support for patients transitioning between levels of care, and expanded use of peer recovery specialists with lived experience.
- **Stigma toward OUD and MOUD:** Some people, including health care providers, have highly negative attitudes toward OUD and treating it with “another drug.” One way to address this stigma—and the resulting treatment hesitancy among users—is via community-based programs that seek to reduce the negative consequences of drug use rather than strive for abstinence.
- **Competing priorities in primary care:** Many doctor’s offices and clinics lack the staff, training, and tools to incorporate OUD screening and treatment into their practices. The consensus is that it’s vital to build MOUD capacity among these providers, including Federally Qualified Health Centers (FQHCs), which are many patients’ first stop for medical care.
- **Administrative and cost burden:** Reimbursement models in the health care system fail to fully address the costs associated with treating individuals with OUD. Among the solutions are reimbursement and payment reform, adequate funding of all components of MOUD treatment and, perhaps, linking provider payment to health outcomes rather than to the services performed.
- **Social determinants of health:** Challenges such as unstable housing, a lack of strong social support, financial instability, and poor access to transportation make treatment more difficult and negatively impact health outcomes. Meeting these challenges requires drawing on community partners to craft solutions that address the needs of local groups and special populations.

Some of these findings no doubt will be familiar to providers, administrators, and others involved in the care of individuals with OUD. However, the research provides a comprehensive look at the situation in Philadelphia from multiple points of view and, taken as a whole, offers potential solutions on a larger scale.

## Background

In 2017, Philadelphia Mayor Jim Kenney convened a task force to address the city's growing opioid crisis. The task force presented 18 key recommendations to bolster the city's response and increase the provision of and access to MOUD.<sup>3</sup> They included destigmatizing OUD and the ways to treat it; establishing insurance policies that support reduced prescribing of opioids for pain and increased access to medication for dealing with OUD; expanding treatment access and capacity; and emphasizing "a warm handoff," or seamless transition of care, for opioid overdose patients from emergency departments to longer-term treatment providers.

To help achieve these goals, Philadelphia's major health systems committed in 2020 to having all of their primary care providers get the X waivers from the federal Substance Abuse and Mental Health Services Administration that allow them to prescribe buprenorphine, and in the following months the number of waived providers increased substantially.<sup>4</sup> As a result, provider X waiver rates in Philadelphia, which is both a city and a county, are relatively high compared with other large urban counties with high overdose rates. Even so, rates of buprenorphine prescribing have been relatively low, particularly through primary care providers.<sup>5</sup> Those low rates result in part from other barriers limiting access to MOUD, in line with multiple studies showing that access to treatment for OUD is restricted and inadequate nationally.<sup>6</sup>

The city's Department of Behavioral Health and Intellectual disAbility Services has mandated that all residential treatment facilities provide MOUD; Philadelphia was the first municipality in the country to do so.<sup>7</sup> In its 2021 action plan, the city continued to focus on prevention and treatment, with goals including mentoring medical providers, providing more education about buprenorphine, and expanding treatment options that utilize medication for treatment in various ways.

The following is an analysis of the key barriers to MOUD treatment in Philadelphia as discussed in the local focus groups, as well as ways to address those challenges as identified by key interviewees from throughout the country. The focus group participants were given confidentiality to let them speak freely; a list of their professional roles can be found in the Methodology section. And the names and affiliations of interviewees are listed in the Appendix.

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People gather outside Prevention Point Philadelphia on East Monmouth Street. *Jeffrey Stockbridge for The Pew Charitable Trusts*

## Care coordination

**The barrier:** Care coordination usually refers to health providers organizing care across facilities, often across multiple settings, so that patients have access to a wide range of social supports. Treating individuals with OUD and multiple comorbidities such as hypertension, diabetes, anxiety, and depression is particularly challenging. And when patients are handed off from one setting to another—for instance, from an emergency room to an inpatient treatment center—treatment is not always sustained and appropriate.

Many focus group participants mentioned the need for coordinating OUD care with the primary care setting. Sometimes, multiple providers get involved because one doesn't feel confident prescribing buprenorphine, or the patient has other problems that require the attention of specialists. The coordinating role, which is particularly crucial for "complex patients" with co-occurring conditions, can be filled by physicians, nurse care managers, behavioral health coordinators, or others.

When needed care goes beyond what's available within a clinic's walls, a host of other challenges emerge. One is that appropriate services often are not available, particularly for mental health conditions, which frequently co-occur with substance use. "Some of our patients wait months before they get assigned a regular provider for [mental health] therapy, and that's way too long," one provider said. Other participants cited a shortage of psychiatric providers in Philadelphia, with some unwilling to work with OUD patients.

Philadelphia's hospitals have limited to no on-site intensive outpatient or residential treatment services for OUD, according to an HMA adviser. Such an integration of multiple levels of care would allow, for instance, a patient who comes to the emergency department for an opioid overdose to be started on MOUD, have a comprehensive assessment, and be immediately placed in the appropriate level of care.

In part because that integration is lagging, and because of Philadelphia’s geographic overlap of multiple health systems, focus group participants frequently mentioned communications challenges. One is inconsistency in electronic health records systems among providers. Another is the confidentiality of patient records, restrictions mandated by the federal law known as 42 CFR Part 2.<sup>8</sup> As one focus group participant said, “The Part 2 confidentiality rules just destroy any part of coordinated care for mental health and substance abuse.”

A related barrier is a lack of clear and up-to-date information for those providing initial care about what treatment slots are available and whether treatment sites provide MOUD.

That lack of information, and the challenge of coordinating care for patients transitioning between settings, was consistently raised by emergency specialists who place patients into care following their discharge from the hospital. As one such specialist described it, “There should be [standards] that are developed and processes that are developed for the transition of care so that I know that when [patients] leave my care that a warm handoff has occurred ... and that I then get confirmation that they arrived [at the next facility] and the process has started.” As another provider put it, “We lose people through the cracks all the time”—meaning they don’t get to the next stage of care, either because they don’t show up or are turned away.

**How to address it:** The 10 health care providers from throughout the country stressed the importance of better care coordination and patient support throughout the system, starting in primary care settings, emergency departments, and substance use treatment programs.

These interviewees emphasized the importance of initiating buprenorphine treatment for OUD in emergency departments. Patients may be particularly open to treatment after having experienced an overdose, and so special efforts should be taken to engage them at the hospital. Many people with OUD also end up in the emergency department for non-opioid-related medical care because they do not regularly visit a primary care provider.

The interviewees said that one way to enhance care coordination and patient support is to treat OUD like any other disease and financially support drug treatment providers to integrate primary care clinicians into their practices. Another way is to require all treatment facilities to have someone on-site authorized to offer buprenorphine.

Since people with OUD engage with many different health systems and institutions, establishing a comprehensive communications system among them is critical, including the use of health information exchanges, which allow the electronic sharing of patient medical records across treatment settings.

According to the interviewees, many individuals in need of treatment require help navigating systems that could provide an appropriate level of care, housing, transportation, counseling, and other needs—which would take some of the burden for navigating these systems off clinicians. Help in system navigation is especially important for people with complex or special concerns, for example, those experiencing homelessness or chronic pain.

Peer recovery support specialists—people who have their own lived experience with OUD—can play a pivotal role in coordinating care for patients admitted to hospital emergency departments and in navigating the complex health and social service systems’ follow-ups. States have varying certifications and terminology for these specialists; Pennsylvania has a certification for the role under the state’s Office of Mental Health and Substance Abuse Services, and peer support services have been a part of the state’s Medicaid State Plan since 2007.<sup>9</sup> Throughout the country, many payment models exist; it’s possible for peer counselors to be hired directly by hospital systems or funded by external agencies and then embedded in the system. To be effective, one interviewee noted, peers require adequate training and compensation.

The New York City Department of Health and Mental Hygiene’s Relay program provides an example of the role that peers can play. Under the program, trained peer specialists arrive at the hospital within an hour of being called after a nonfatal patient overdose lands an individual in the emergency department.<sup>10</sup> The specialists offer their assigned patients overdose risk reduction counseling and rescue training, connect the patients with appropriate services, and stay in contact with each patient for up to 90 days.

Finally, multiple interviewees spoke about the challenge that patients can face in finding a provider willing and able to provide MOUD. One solution to this challenge would be the creation of a centralized database of providers who are accepting new patients and prescribe buprenorphine, complete with information about the provider’s policies. “That locator is really, really, really important,” said Dr. Caleb Banta-Green, principal research scientist at the Alcohol and Drug Abuse Institute at the University of Washington.

## **The stigma toward OUD and MOUD—and treatment hesitancy**

**The barrier:** Focus group participants frequently mentioned, as a barrier to accessing treatment, the stigma surrounding opioid use and its treatment.

Stigma may make people with OUD reluctant to seek treatment. That gives buprenorphine an advantage, compared with the other two federally approved medications for OUD, because it can be prescribed in outpatient, office-based settings. That way, as one primary care physician described it, when patients come in for an MOUD prescription, “They’re sitting [in the waiting room] next to somebody who’s there for the management of their high blood pressure, or next to somebody who’s managing their diabetes. They’re not standing outside the methadone clinic”—which is a situation, the physician said, in which “everybody that drives by knows what they’re there for.”

The use of any medication at all can be the source of stigma. Participants described the widespread perception that using methadone and buprenorphine amounts to “exchanging one drug for another” and that patients who are strong and dedicated should be able to stop using opioids without any medication.

The stigma, in some cases, comes from providers—who may have negative attitudes toward people with OUD. One focus group participant described a sense among some colleagues that people with OUD bring the disease on themselves and are undeserving of treatment—and that such treatment takes resources away from other patients. As one peer certified recovery specialist who had previously used drugs explained, “Something I really carry with me from being a drug user is how everywhere I turned I saw disapproval.” The person went on to say: “I don’t need a professional telling me what I shouldn’t do; I already know what I shouldn’t do. What was most meaningful to me was when people were accepting where I was in the process.”

Participants also said that expectations for patient abstinence while in treatment are unreasonable—and yet lead some health care providers to have a low tolerance for OUD patients who fail to adhere to an abstinence-focused treatment regimen. As one participant put it, “This [OUD] is the only problem where we have a 100% success bar as the measurement for success. If the goal is to get everybody off everything, we’re doomed to fail. Right? We don’t bounce a diabetic patient who had a doughnut for breakfast, and we don’t bounce somebody who had a heart attack because they had a Big Mac for lunch.”

The participants attributed resistance to MOUD among providers to the historically central role of abstinence-only approaches in Philadelphia; their comments were consistent with recent qualitative research.<sup>11</sup> As one participant said, some providers have given lip service to MOUD “so that they could continue to receive funding but did not believe in the model of care. The culture needs to change.” As one certified recovery specialist put it, some caregivers involved in 12 step-type abstinence programs frown on treatment with buprenorphine because



“it is still a substance. It comes back again to stigma,” adding that one hears people ask if taking buprenorphine “is considered cheating.”

**How to address it:** Several interviewees said that the use of community-based strategies—as is the case, for instance, at Prevention Point in Philadelphia—are crucial to reaching people with OUD who refrain from treatment due to stigma, a lack of resources, or an unwillingness to abstain from all substance use. These strategies prioritize the establishment of individualized treatment and recovery goals in a nonjudgmental, harm-reductionist way—one that seeks to minimize the negative consequences of drug use without demanding abstinence.

Such an approach means that providers accept that not all substance users are ready to stop using and offer techniques, supplies, and patient education to increase their personal safety.<sup>12</sup> These measures can help keep people safer during periods of active use while normalizing OUD as a disease and providing education about its treatment in a way that diminishes stigma.<sup>13</sup>

“I think that we know that ethnic and minority communities experience stigma whenever they access care,” said Danielle Kirby, director of the Division of Substance Use Prevention and Recovery at the Illinois Department of Human Resources, adding that finding ways to reach people “maybe through churches, through block-by-block interventions, really being in the community and connecting with our community providers is really important.”

Another way to make contact with people reluctant to seek treatment is with mobile units, which can be embedded in homeless outreach teams. Those units might be staffed by providers able to immediately prescribe buprenorphine, as well as by peer recovery coaches who can follow up with patients and connect them to other services. A recent study in Philadelphia documented the substantial value that mobile vans have on treatment engagement.<sup>14</sup>

Other ways to engage people in treatment include offering buprenorphine via syringe exchange programs, homeless services, and churches. “The reality is that you just have to treat each client individually,” said Dr. Gary Tsai, director of substance abuse prevention and control at the Los Angeles County Department of Public Health. If clients tell him they won’t stop using heroin but will use it once less a week “for you, Doc,” Tsai said, he responds with “‘Great, come again and we’ll talk again in a couple weeks.’ And that should be OK.”

Another interviewee mentioned distributing fentanyl test strips, which check heroin and other illicit drugs for fentanyl contamination. Several also suggested that safe consumption sites—places where individuals can use preobtained drugs with the support of trained personnel—could help reach people with OUD and get them interested in treatment. There are two such sites in the country; both recently opened in New York City. A proposed site in Philadelphia was blocked by the courts.

Since people with OUD enter treatment in different ways for different reasons and at various stages of readiness for change, participants stressed that the best approach is “person-centered care,” which includes patients in a shared decision-making process by providing them the full array of evidence-based treatment options to consider.

In addition, providers should do everything possible to retain patients in treatment. David Loveland, senior program director at the Community Care health insurer in Pittsburgh, said, “Whatever it takes to hold on to them, that’s what we should do,” adding that some providers drop people from treatment if they miss appointments or don’t finish their counseling. Some interviewees suggested that the counseling that is usually part of MOUD treatment should not be required if it inhibits someone from seeking or staying in treatment.

Added Loveland, “Those that don’t show up, we need to treat more, we need to go after them, we need to figure out why they’re not coming back and then get them back in.”

To make treatment more attractive to patients, providers can eliminate the need for appointments and make treatment available 24 hours a day. As Banta-Green of the University of Washington said, “[A local health care system] very importantly got rid of appointments for these [people with substance use disorder] because they basically said that people that have appointments don’t show up, the people without appointments do show up.”

## Competing priorities in primary care

**The barrier:** Treating individuals with OUD is time-consuming, which makes it hard for primary care providers to deliver treatment during their typical appointment times. And it can be too complex for some providers to handle, given their training.

Multiple focus group participants described being overwhelmed by the demands of caring for patients with OUD when, as one participant described, “you’re a clinic that is fighting diabetes, hypertension, HIV, and everything else in between.” Some expressed a desire to focus only on OUD, given the scale of the drug epidemic in Philadelphia. Others spoke about developing collaborative relationships with other providers who specialize in addressing needs such as behavioral health and case management.

And some suggested that clinicians could better cope with the demands of providing treatment for OUD patients if they had the appropriate experience, including more training, thereby increasing their confidence. “[These clinicians] just need kind of some hand-holding,” said one participant. “After prescribing [buprenorphine] to probably two, three, or four patients, they’ll be much more comfortable.”

**How to address it:** Key to broadening access to buprenorphine is building the capacity for treating OUD in primary care settings and Federally Qualified Health Centers (FQHCs). Primary care providers may be particularly well situated to address OUD alongside other medical conditions.

Several interviewees noted that FQHCs, as safety net providers that are required to provide primary care services in underserved communities, are ideally suited to prescribe MOUD. The law mandates that they provide medical care and case management, transportation, and mental health services that often are not covered by fee-for-service Medicaid payments.<sup>15</sup> In recent years, the majority of FQHCs have adopted a model that integrates behavioral health into the delivery of primary care.<sup>16</sup>

But these settings often lack the ability to provide treatment. Multiple interviewees recommended finding ways to give providers additional clinical support, including staff such as nurse care managers. At some FQHCs, nurse care managers support buprenorphine initiation, handle much of patient care, and work closely with the physician who makes the prescribing decisions.<sup>17</sup> Other key staff additions would be care coordinators, recovery coaches, and others who can fill case management roles, monitor patients’ progress, connect them with services, and ensure that patients who require higher levels of care can access it. A major new study in the Philadelphia area will help to measure the effectiveness of collaborative care interventions that treat both OUD and psychiatric disorders.<sup>18</sup>

To get primary care providers more comfortable with prescribing buprenorphine, several interviewees described using the Project Extension for Community Healthcare Outcomes to tap in to providers more experienced with MOUD.<sup>19</sup> The project connects local providers to remote specialists for training and ongoing support. It has also been used to create capacity-building “buprenorphine boot camps” that offer clinical teams tailored coaching and support.<sup>20</sup>

Interviewees also described their attempts to build capacity among primary care providers via local coaching and by learning collaborative models. Several focus group participants described similar efforts in Philadelphia, including the Health Federation of Philadelphia’s preceptor training program.<sup>21</sup>

The participants said that providers could be better trained on using nonstigmatizing language, understanding how OUD differs from other substance use disorders—such as those involving alcohol or stimulants like cocaine—and how MOUD is not simply “replacing one drug with another,” and learning how to care for people with polysubstance use. As Dr. Brian Grahan of Hennepin Healthcare in Minneapolis put it, “One wrong word from the front desk person and that patient doesn’t come back. We highlight in all our trainings that language really matters.”

Another way to increase buprenorphine prescribing capacity is to embed the necessary training in standard medical education. Banta-Green said, “One of our residency programs at the University of Washington, a family medicine residency program ... makes everybody get waived and makes everybody prescribe. And that is now spreading. ... And that’s essential.”



**Kensington Avenue, outside Prevention Point** *Jeffrey Stockbridge for The Pew Charitable Trusts*

## Administrative and cost burden

**The barrier:** Complicated or inadequate reimbursement structures get in the way of providing or accessing needed care.

Low reimbursement rates from Medicaid and private insurers mean that providers often don't have sufficient funds to provide necessary services, although this is less of a problem at FQHCs. In particular, focus group participants mentioned inadequate reimbursement for staff support, such as nurse care managers, care coordinators, and social workers. Many providers rely on grant-based funding to fill those gaps, creating concerns about the long-term stability of such staff.

Participants singled out low reimbursement rates for OUD treatment and mental health services as major barriers to providing crucial treatment to those receiving MOUD.<sup>22</sup> As one participant put it, "I need staff members who can actually sit down with a patient for an hour and talk about the life factors that have contributed to their opioid use disorder, and what are they going to do to tackle those factors along with this drug that we're giving them—and that requires someone to actually be reimbursed for an hour."

Beyond that, participants mentioned that for patients without commercial health insurance, inpatient or residential care—a key part of the treatment landscape—can be very difficult to access. They also said that low reimbursements limit the availability of certified recovery specialists.

Another financial challenge is obtaining prior authorization for medications not on an insurer's covered list for treating opioid use disorder. In such cases, providers often must wait to receive approval; without such approval, they often must absorb the cost of the medication, particularly for the first few weeks. In other cases, participants described subsidizing costs for uninsured patients until they can obtain insurance, which also can take weeks. As one focus group participant put it, "Any time we want to increase a dosage beyond 16 milligrams [the standard maximum dose for OUD], or we want to change to the brand name because the generic is ineffective, it takes a couple days."

Additional barriers arise from the way in which Pennsylvania's Department of Human Services "carves out" behavioral and physical health services, which are divided into two different programs that are managed separately under Medicaid.

Several participants said that as a result, they have faced challenges in integrating care for OUD patients—including two separate documentation, billing, and care management processes. They also noted that it can be challenging to coordinate care and referrals with behavioral health and opioid treatment providers—dealing with two different systems in terms of data, treatment, and financial or reimbursement structures.

Finally, financial barriers created by the upfront costs of adding capacity to provide MOUD include hiring new personnel and training existing staff. As one participant explained, "When we introduced [medication assisted treatment] into our program, we had to hire a nursing staff that was around seven days a week. We had to bring in a primary care doctor, at a higher level, so the costs certainly did increase significantly."

**How to address it:** Interviewees spoke repeatedly about the need for adequate funding to provide the full array of needed services, calling it critical to address antiquated payment models for behavioral health and OUD. Current reimbursement models are often fee-for-service and fail to take into account providers' true costs as well as accountability for outcome measures.

One often-mentioned path is value-based payment, under which providers are paid based on the quality of service they provide and the patient health outcomes they achieve. UPMC for You, a Pennsylvania Medicaid

managed care organization affiliated with UPMC Health System that serves Medicaid beneficiaries throughout Pennsylvania, has moved to value-based care; its new pay-for-performance model assesses providers on metrics including substance use disorder screening, care coordination, and length of retention in treatment.<sup>23</sup>

Interviewees said that sufficient reimbursement must be available for person-centered approaches, including MOUD with or without counseling, particularly among individuals in long-term recovery, and the ability for care to remain flexible to a patient's needs and treatment goals.

They also complained about inconsistent funding models for programs, including the reliance on grants, which allow for new initiatives but limit the ability to make them permanent. Some states and counties have focused on developing sustainable local funding streams, including a tax or fee on prescription opioids, to support expanding access to treatment services, including for the uninsured.<sup>24</sup> In addition, Medicaid expansion under the Affordable Care Act, which Pennsylvania has adopted, offers insurers and providers an opportunity to build durable systems of care for the treatment of OUD, if it provides sufficient funding to allow for responsive, ongoing care.<sup>25</sup>

## Social determinants of health

**The barrier:** Unmet social needs—such as stable housing, social supports, financial stability, and access to transportation—can be major barriers to people with OUD starting, and staying in, treatment.

People who lack financial resources may be unable to pay for out-of-pocket medication and visit copays. Patients who need to make regular visits to obtain treatment can be hard-pressed to meet other obligations, such as keeping a job.

Transportation can be a major obstacle, in part due to hospital closures in Philadelphia. One participant said some patients, because they take public transportation, might require a two-hour one-way trip to get to treatment.

Stable housing is another huge factor, noted one participant: “My homeless patients are some of the most challenging. And almost universally, once they get housing, their recovery becomes, you know, 30, 40 times more stable.”

**How to address it:** Target community needs and populations.

Interviewees emphasized that treatment interventions must be targeted to a community's unique underlying racial and ethnic disparities, gender-specific situations, and issues such as homelessness and poverty. They also stressed the need for public education campaigns to counter stigma and raise the visibility of treatment. Efforts such as billboards, radio and television advertisements, and mobile units can increase the reach of the treatment system and promote a “no-wrong-door” approach to getting help.

Providing recovery housing when necessary is essential. Darlene Owens, director of substance use disorder initiatives at the Detroit Wayne Mental Health Authority, said: “Sometimes you got to take that individual out of that toxic area or relationship ... and put them somewhere they're working on themselves and trying to get themselves together.”

Focus group participants noted the difficulty in the Philadelphia area in identifying the services available to support patients with OUD and collectively suggested that a central repository of services would be a great asset.

Interviewees described efforts throughout the country to work with community stakeholders to identify ways to share best practices among local groups and support them in developing treatment approaches tailored to local needs. For example, the Minnesota Department of Health has developed an inclusive, culturally specific approach with underserved communities, including Somali populations, that have been disproportionately impacted by overdoses.<sup>26</sup>

Several interviewees noted that additional considerations must be given to vulnerable populations, such as pregnant and postpartum people. Pregnancy increases the risk of adverse outcomes for those with substance use disorders (and their children); these patients are at substantial risk of relapse or overdose and require specialized treatment and wraparound supports and services—such as housing, child care, and supplemental nutrition assistance.

Illinois' Pregnant and Parenting Women with Opioid Use Disorder pilot program is a family-centered approach available to women with OUD that includes screening, referral, family-based interventions, and recovery support, including access to certified doula recovery specialists.<sup>27</sup> And in Philadelphia, Jefferson University Hospital's Maternal Addiction Treatment, Education and Research program is a long-standing provider of outpatient and residential treatment for pregnant and parenting people.

## Conclusion

OUD is a health emergency in the United States that affected an estimated 2.5 million people in 2020.<sup>28</sup> In that year, despite the proven efficacy of MOUD, only about 11% of individuals with this disease received treatment with buprenorphine, methadone, or naltrexone.<sup>29</sup>

This report presents findings from an array of local and national experts that outline steps for implementing the treatment system recommendations in the 2017 Philadelphia Opioid Task Force report—including increasing the provision of MOUD and expanding treatment access and capacity. The participants in local focus groups provided voices from the field detailing the challenges and opportunities to realizing those priorities. The additional perspectives of interviewees from throughout the country offered insights gained from programs that show results, insights that could help refine and reform existing policies in Philadelphia and Pennsylvania.

A central finding is that OUD is a highly complex and multidimensional condition, and that addressing it requires collaboration across health care, social services, schools, communities, and faith-based groups. To advance the health care element, policymakers and other stakeholders must consider solutions focused on harm reduction that are flexible, responsive, and based in sound evidence-based practice. Better leveraging of the existing primary care system as an entry point for treatment has great possibility, as does improving the coordination among Philadelphia's geographically overlapping private health systems, giving key providers access to the information needed to make accurate decisions that allow for early intervention and relapse prevention. But for this to happen, resources must be focused on a sustainable, robust integration of medical, behavioral health, and social services.

## Methodology

The Philadelphia focus groups and interviews with providers from throughout the country were conducted via video-conference from July through December 2020. All participants were guaranteed confidentiality; quote attribution was provided only with expressed consent. Participation in the focus groups and key interviews was entirely voluntary.

Nine 60-minute focus groups were conducted with a total of 31 Philadelphia area health care providers including primary care providers (10), hospital emergency department physicians (4), community-based addiction treatment providers (3), behavioral health consultants (5), certified peer specialists (3), and medical administrators (6). Participants were identified using HMA and Pew's professional networks and by soliciting participation from the region's major health systems and providers.

Focus group participants were asked a standard set of questions about accessing care for OUD in Philadelphia with an emphasis on MOUD in primary care. Participants were asked for their insights about barriers impacting

treatment providers and individuals seeking treatment and were provided \$25 gift cards as compensation for their time.

As for the interviews, nine of them were held with nationally recognized leaders in the substance use disorder treatment field in cities and counties with shared characteristics to Philadelphia, including high rates of opioid overdoses. Those jurisdictions were also among those known to Pew and HMA as implementing successful strategies to combat the opioid crisis. The interviewees were asked a standard set of questions to elicit their insights about policy initiatives taken in response to the opioid crisis in their jurisdictions. One additional interview was conducted with a Philadelphia expert to provide local context.

NVivo software was used for qualitative data management and for analysis of the focus groups and key interviews. This work was guided by thematic analysis, a systematic approach to understanding themes within qualitative data, with the goal of establishing key takeaways. This approach applied both to the focus groups and the separate interviews.

In reviewing the recorded focus groups, Pew researchers generated an initial set of framework codes that described the ideas expressed by the participants. Then, after reviewing the transcripts closely, the researchers assigned the ideas that emerged a pre-existing framework code or, if none of those applied, a new one. The codes assigned during the transcript reviews were then grouped with similar ones to create candidate themes, which were refined through independent review of the transcripts and discussion, then identified as final themes. This process was repeated for the analysis of the interviews. Those themes provide the structure for this report.

## Appendix

*Key experts interviewed:*

**Catherine Abrams**, opioid response program coordinator, Health Federation of Philadelphia

**Caleb Banta-Green**, Ph.D., principal research scientist, Alcohol and Drug Abuse Institute, University of Washington, Seattle

**Dr. Nicole Esposito**, assistant clinical director, Behavioral Health Services Department, County of San Diego

**Dr. Brian Graham**, medical director, Office-Based Addiction Medicine Services, Hennepin County Medical Center, Hennepin County, MN; director, Integrated Opioid and Addiction Care ECHO, Hennepin Healthcare

**Gail Goldstein**, senior director, Planning and Programs, Bureau of Alcohol and Drug Use Prevention, New York City Department of Health and Mental Hygiene

**Danielle Kirby**, director, Division of Substance Use Prevention and Recovery, Illinois Department of Human Resources, Chicago

**David Loveland**, Ph.D., senior program director, Community Care Behavioral Health Organization, Pittsburgh

**Dr. Yngvild Olsen**, medical director of the Institutes for Behavior Resources Inc./REACH Health Services, Baltimore

**Darlene Owens**, director of substance use disorder initiatives, Detroit Wayne Mental Health Authority, Detroit

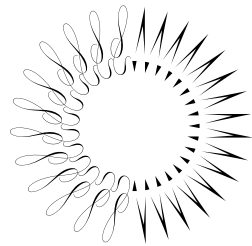
**Dr. Gary Tsai**, director, Substance Abuse Prevention and Control, County of Los Angeles, Department of Public Health, Alhambra, CA

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