

A Patient-Centered, Rapid Access Approach to Substance Use Disorder



Patients seeking treatment for substance use disorders (SUDs) within the standard addiction treatment system routinely encounter barriers such as long wait times and prolonged intake processes, increasing the risk of continued illicit substance use and premature death.¹

A patient-centered, rapid access approach prioritizes timely access to medications, reduces unnecessary use of resources, and improves the effectiveness of care. This approach expands on a 'low-threshold' model. It focuses on meeting patients 'where they are,' including them in the treatment plan, and developing shared goals of care.

To increase access to treatment and reduce risks and barriers, the CA Bridge Program advocates a patient-centered rapid access approach to treating SUDs. This model allows patients to begin treatment as soon as they seek care by reducing any delays caused by structural barriers as much as possible. In some cases, patients may benefit from more structured programs, but this should not be at the expense of rapid access and low barrier intake.

A patient-centered rapid access approach can be implemented by any care provider that treats SUD whether they are in acute care, specialty addiction treatment, or primary care.

SUGGESTIONS TO SUPPORT A PATIENT-CENTERED, RAPID ACCESS APPROACH

1. Welcome patients to care with a medication first approach

Complex intake processes are generally not beneficial to patients. While there may be some mandatory elements of intake due to regulations, any additional elements should be minimized as much as possible. Where possible, intake should be completed either concurrently with withdrawal treatment or after withdrawal has resolved. Intakes should never become barriers to patients starting care or receiving evidence-based medication for addiction treatment. In acute care, treatment should begin immediately.

In all treatment locations, medications should be initiated no greater than 72 hours from first contact, with treatment available the same day, Monday through Friday. Provide buprenorphine and instructions for 'home starts' (also known as non-clinical starts) for patients who are not experiencing withdrawal symptoms yet, but will be soon based on their last opioid use. Provide naloxone and harm reduction education in every visit.

2. Avoid strict appointment slots. Flexible drop-in access leads to better patient engagement and superior outcomes.

Follow-up visits for patients on evidence-based MAT should be individually determined to best meet patient needs. Place emphasis on timely access to buprenorphine or other maintenance pharmacotherapy without requiring psychosocial services or discontinuation for any reason other than harm to the patient.² Offering psychosocial support is beneficial, but if patients decline those services, they should still be able to access MAT.

Frequent visits may be a barrier to treatment retention, including early in recovery, therefore visit schedules should be individualized to patients' needs. Have drop-in hours or flexible appointments available daily, with at least one appointment held for next-day referrals from the acute care setting. Clinic policies that penalize patients for arriving late to appointments disproportionately harm people who do not own a car or control their work schedule.³ Patient-centered care considers the whole person and their everyday challenges.

3. For patients who experience relapse, provide additional support rather than cessation of buprenorphine treatment.

There should be no punitive consequences when patients with opioid use disorder relapse.⁴ Relapses should lead to patient-centered refinements of care, free from judgment and stigma. When a patient's A1C is elevated, their diabetes medications are not discontinued but rather intensified. Similarly, when patients have worsening of their opioid use disorder (OUD), medications and other support may be increased.

4. Have flexibility and willingness to accept different insurance coverage, treat uninsured patients, and offer sliding scale options for visits.

Staff should be trained on how to complete the necessary paperwork and navigate insurance barriers. Although insurance restrictions may apply at a given clinic, it is the responsibility of the clinic to make sure a patient gets appropriate rapid access to care. This can include continuing to treat patients on a temporary, short-term basis, or ensuring expedited follow up at an outside clinic with a medication bridge.

Warm handoffs may expedite transferring a patient to a clinic that meets their needs. Continue treatment and provide sufficient prescription doses of medication while ensuring a connection is made at an appropriate clinic.

5. Write prescriptions with consideration to medication cost, patient insurance status, need for prior authorizations, and maintaining a therapeutic relationship with patients.

Identify lower cost generic alternatives to name brand medications whenever possible. Because insurance companies place caps on both the number of prescriptions written and the amounts that can be prescribed at once, clinic staff should be educated to prescribe accordingly.

Offer patients information regarding drug rebate programs, or other drug discount programs to reduce financial barriers. Develop relationships with local pharmacies to reduce barriers and ensure medications are regularly available.

6. Do not make treatment contingent on urine drug screen results or other labs.

Drug testing is a tool for supporting recovery, not a method of punishment.⁴ Do not use urine drug screens to confirm or restrict eligibility to begin evidence-based medication for addiction treatment. Use urine drug screens with caution and never as the sole basis for a treatment decision. Errors can result from cross-reactivity, making false negative and false positive results possible. Urine drug screens are only one data point and should be used in the context of the entire patient presentation.⁵

7. Do not exclude a patient from appropriate treatment with buprenorphine for OUD because they use stimulants, benzodiazepines, or alcohol.

Buprenorphine does not have a direct effect on other substance use. Patient's use of other substances should generally not influence care for OUD.⁴ The American Society of Addiction Medicine (ASAM) advises that use of other substances should not result in the suspension of OUD treatment.⁶ Evidence-based MAT for OUD is often a critical point of entry into ongoing health care and provides an opportunity to reduce harms associated with other substance use.⁴ Buprenorphine and methadone should not be withheld from patients taking benzodiazepines or other drugs that depress the central nervous system (CNS).⁷ If a patient has additional use disorders beyond OUD, they should be offered treatment for these disorders. Do counsel patients on risks of CNS depression when multiple substances are used in combination.

8. Do not exclude a patient from appropriate treatment with buprenorphine for OUD because they do not attend or plan to attend to psychosocial support.

Psychosocial treatment, including therapy, 12 step groups, etc., may be offered to each patient. However, if patients decline those services they should still be able to receive buprenorphine and fully participate in the clinic. Furthermore, if access to psychosocial treatment is not available at your clinic, that should not prevent you from offering medications.

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