MAT Focus Group

1. How to expand availability of MAT Services beyond Methadone? And address the specific needs in rural areas?

The providers suggested that we have more access to Suboxone to give Methadone clients other options in recovery.

BAART suggested the Vermont Hub and Spoke Model or Vermont Blueprint Model for MAT services. It would work well in Fresno since Fresno is very spread out. The Hub would serve high need patients and serve as a starting point for MAT Services. The Spoke would be used for clients with less intense needs (ex. Outpatient). They could receive Buprenorphine as a prescription and access the Spoke for group or individuals treatment sessions. Case Management could also be provided at the Spoke sites. The Hub site would be the only place that would have Methadone due to restraints. Suboxone could be administered in the Spoke (or satellite) location.

2. What should procedures be for clients with meds in residential levels of care?

Treatment facilities would have to examine their policy for abstinence. If they do not allow clients in who have used in the last 24 hours, does Methadone count as "using"?

Some issues that the treatment providers see are:

- The patients many not have transportation or need a chaperone to get MAT in first several weeks of treatment.
- Mental Health professionals are seen by provider to discriminate against clients on Methadone.
- Some clients have to taper off Methadone to be admitted into residential treatment facilities.
- Clients should have the right to self-determination. This is a violation of ADA to discriminate against individuals on Methadone.
- Education is necessary in regard to MAT. Providers need to monitor appropriately to make sure that the client is appropriately stabilized (ex. no nodding). If they are nodding they might have too high a dose of Methadone or possible mixing drugs.

Providers will have to look at coordinated care for clients. One of the residential providers attending does not dispense medication in the house.

When the Waiver comes into effect the County and State do not foresee any attempt to limit MAT locations.

Some statements regarding MAT Clients:

- Patients come into treatment and then are not seen again.
- When a client is coming for MAT Services it is important for the provider to let them know that they understand about the disorder. If the client misses treatment or 'disappears', there will be a warm reception when they return for treatment.
- Clients may need more MAT than others. There can be permanent brain chemistry damage with opioid use.
- Opioid clients may be using other drugs along with opioid based drugs.

BAART employees are also AOD counselors. They do after care, relapse prevention.

Provider asked if prior authorization will impact them. The county replied that we have not considered changes for MAT. NTP providers may not go through Centralized Intake. County do not see a significant change and do not wish to add more burden to MAT treatment. If the client does call the Centralized Intake and opioid dependency becomes apparent, the client should be advised of all of their options at that time and referred to a MAT provider.

A few other questions and answers:

- In Vermont 50% of clients can get Suboxone at the window.
- BAART only has a few clients who use Vivitrol
- Medi-Cal pays for Vivitrol
- Potentially interested in Probufine.