On November 18, 2021, Penobscot Community Health Care (PCHC) — Maine’s largest community health center (CHC) — and Maine Primary Care Association (MPCA) — the state’s membership organization for all of Maine’s community health centers (CHCs) — will launch a joint 12-month Project ECHO on implementation of a low barrier treatment model for Opiate Use Disorder (OUD).

Together, the seven participating CHCs, along with PCHC, represent roughly 65% of the total patients served by Maine’s CHC network (nearly 210,000 patients each year, or 1 in 6 Maine people) and encompass a significant geographic footprint, especially in rural areas. As a result, this pilot will support increased access to vital treatment services in areas most hard-hit by the opiate crisis, and aligns with priorities outlined in the treatment and recovery sections of the Governor’s Maine Opioid Response Strategic Action Plan.

This project is a culmination of over three years of work to develop strategies to address OUD. Using the ECHO learning collaborative model, PCHC will share its years-long journey relative to implementation and ongoing maintenance of the state’s first primary-care focused low barrier treatment program. Together, the participating health centers will begin to test effectiveness and impact (via formal evaluation) across multiple rural and urban CHCs in Maine. Through the ECHO model, teams from each of the CHCs will learn through case study, clinical review, and operations-focused meetings that help to address questions in as close to real time as possible. In addition, experts from PCHC’s clinical and operations teams will act as faculty and will provide coaching and support to the learning sites throughout the duration of the collaborative.

What makes a low-barrier model unique?

- Medication Assisted Therapy (MAT) is a proven, effective method of addressing SUD/OUD for those individuals who can access those services. In fact, low-barrier MAT is the only evidenced-based model we have to work with.

- A low-barrier treatment model seeks to create access by meeting the patient where they are and supporting recovery in a timely manner and with as few hurdles as possible. The goals of the pilot are to connect with people not currently being served by, or not able to access, more typical treatment modalities, as well as to provide key points of access within the community. Investments in low barrier treatment are meant to augment, not supplant, current treatment programs, because we know that not all patients access services the same way.

- CHCs are well positioned to support a long-term and multifaceted healthcare relationship with people who may have not succeeded with other treatment models. CHC sites are embedded in the community, where it has been suggested there is a “break down” of access and continuity of care and are committed to short and long-term solutions to this crisis. As such, they present a natural countermeasure to this breakdown.
COMMUNITY HEALTH CENTER PARTICIPANT PROFILES

The Learning Collaborative is comprised of six participant sites and one training lead. The snapshot of each health center below provides information on the number of patients each serves and services they provide. 

TRAINING LEAD:

Providing care to 57,300+ people through service sites in Bangor, Brewer, Old Town, Jackman, Belfast, and Winterport. 
Services¹: 86.16% Medical, 15.76% Dental, 7.35% Mental Health, 2.19% Substance Use Disorders, 1.74% Enabling Services²
CEO: Lori Dwyer
Participating Staff Credentials*: MD, FAAFP (2); MD, FAPA; LCPC; PharmD; FNP-C
*2 are Board Certified in Addiction Medicine
pchc.com

PARTICIPANT SITES:

Providing care to 6,300+ people in and around Bucksport through service sites in Bucksport and Ellsworth. 
Services¹: 82.05% Medical, 25.11% Dental, 9.32% Mental Health, 3.90% Substance Use Disorders, 13.39% Enabling Services² 
CEO: Carol Carew
Participating Staff Credentials: MD, FNP, MA, LCSW (2)
www.bucksportrhc.com

Providing care to 13,000+ people in Lewiston and Auburn at three services sites throughout Lewiston and Auburn. 
Services¹: 46% Medical, 14.64% Dental, 50.36% Mental Health
CEO: Coleen Elias
Participating Staff Credentials: DO, FNP (2), CMA (2)
communityclinicalservices.org

Providing care to 10,300+ people through service sites in Lee, Lincoln, Medway, Millinocket, and West Enfield. 
Services¹: 92.55% Medical, 12.26% Dental, 5.70% Mental Health, 4.68% Substance Use Disorders 
CEO: Nicole Morrison
Participating Staff Credentials: MD, PhD, RN-CARN, LCSW
hanfqhc.org

Providing care to 25,400+ people through service sites in Albion, Belgrade, Bethel, Bingham, Coopers Mills, Kingfield, Livermore Falls, Madison, Rangeley, Richmond, and Strong. 
Services¹: 92.20% Medical, 12.88% Dental, 0.52% Mental Health, 1.21% Substance Use Disorders, 1.38% Enabling Services²
President/CEO: Constance Coggins
Participating Staff Credentials: FNP (2), PA, LCSW
healthreachchc.org

¹The number of patients served includes those served at satellite sites.
²Encouraged and verified by the Addiction Medicine Board.
Providing care to 7,000+ people with service sites in Bridgton, Leeds, Monmouth, and Turner.
**Services**: 99.66% Medical, 0.43% Dental, 8.18% Mental Health, 16.90% Enabling Services
**CEO**: Laurie Kane-Lewis
**Participating Staff Credentials**: MD, PA-C
dfdrussell.org

Providing care to 5,600+ people with service sites in Dexter and Newport.
**Services**: 84.36% Medical, 24.62% Dental, 7.04% Mental Health
**CEO**: Robin Winslow
**Participating Staff Credentials**: FNP, BSRN, LCSW
hometownhealthcenter.org

Providing care to 5,100+ people in and around Porter through a service site in Porter.
**Services**: 84.86% Medical, 20.02% Dental, 13.95% Mental Health, 3.97% Substance Use Disorders, 8.81% Enabling Services
**CEO**: Carol Murphy
**Participating Staff Credentials**: LCSW, FNP, RN, MHCA, FACHE
www.svhc.org

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2 Enabling Services are non-clinical services that aim to increase access to healthcare, and to improve health outcomes. Examples include care coordination; health education; transportation; and assistance with obtaining food, shelter, and benefits.
HealthReach Community Health Centers and all twelve of our practice locations are proud to be partners in the effort to reduce barriers and improve access to Medication-Assisted Treatment for those living with Substance Use Disorder (SUD). We are committed to supporting patients with SUD, and we look forward to incrementally improving our care model to achieve greater outcomes for patients. We are working hard to raise awareness of SUD as a disease, and to ensure that all our patients can have meaningful conversations with their clinicians that result in concrete steps forward and the identification of practical, available resources. This work was always important, but under the COVID-19 pandemic, it has become an increasing priority to ensure that patients with SUD feel connected, supported, and have the tools necessary to recover.

We wish to thank the Maine Primary Care Association for their leadership and coordination on this front, as well as the many other partners involved in these and related projects for their hard work to “meet patients where they are at” and ultimately to attain positive health outcomes. It is clear that this effort benefits not only the direct patients involved, but also their families, our communities, and in fact our whole state.
COMMUNITY HEALTH CENTER PLEDGE REGARDING RESPONSE TO THE OPIOID CRISIS

Maine Primary Care Association

The opioid crisis has devastated our state, our communities and our families. Maineres are dying unnecessarily and the diseases of despair (addiction, depression and suicidality) do not distinguish among people by age, race, gender, or socioeconomic status. As the backbone of primary care in Maine, most especially for the State’s most vulnerable populations and in rural Maine, the Federally Qualified Health Centers represented by the MPCA have mobilized to address this epidemic and know that we must continue this work, increase our capacity to respond to this crisis, and maintain our sense of urgency.

We hereby commit to continuous action, and pledge specifically as a network to:

- Practice responsible stewardship in the prescribing of all controlled substances in order to reduce the exposure of our patients and community members to the risks of developing a use disorder.
- Share best practices across the network of Health Centers to standardize prescribing practices and protocols.
- Work across the communities we serve to make naloxone (also referred to as “Narcan”) as easily available as possible, targeting the populations most at risk for overdose and death, which includes people getting prescriptions for drugs like opioids and benzodiazepines, as well as people who use drugs.
- Expand access to evidence-based treatment for opioid use disorder by
  - Committing to reliably screening all patients consistently and in a standard way for at-risk use of substances (including alcohol) and for substance use disorder and taking action when a patient is determined to be at risk, and
  - Taking immediate steps to increase the number of providers in our own practices and/or communities who have X Waivers and are actively treating this disease,
  - Collaborating with other health care organizations and urging them to do the same,
  - Lowering barriers to treatment through innovations like bridge clinics and other evidence-based approaches,
  - Targeting high-risk populations, such as people with OUD who are in or about to be released from prison, people with OUD and a co-morbid mental illness, and those who have had overdoses.
- Deepen partnerships with hospitals, community mental health agencies, private practices, local government and other community agencies to deploy and expand as appropriate the services necessary for a comprehensive response system to address the opioid epidemic.
- Address stigma through education for our own employees and board members, our communities and public figures and policy-makers, and through a commitment to the use of patient-centered, affirming language in all discussions of this challenge and in all interactions with patients and colleagues.
- Engage in youth and adult prevention efforts.
- Work within our communities to address the social determinants of health and diseases of despair.