

Expansion of Services for Vermonters in Need of MAT for Opiate Dependence

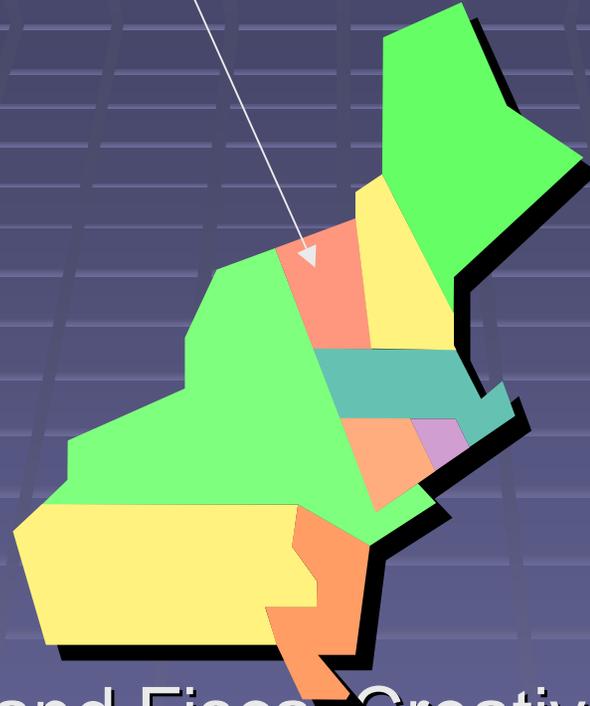
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Vermont



Vermont



Clinical and Fiscal Creativity in a Tiny
New England State

Increases Access to Medication
Assisted Treatment!

Vermont's Service Expansion

- Needs in Vermont for medication assisted treatment
Heroin and prescription opiate crisis
- Roll outs of methadone programs and buprenorphine trainings
- Successes and continued challenges

Extra Christmases:

Vermont Legislative Response to two issues!

ADAP and Medicaid Make Magic!



Opioid Use in Vermont: At Crisis Level



Increased demand for treatment through publicly funded programs for opiate dependence

Year – 2000

Requests -- 423

Year -- 2005

Requests – 1,522



System of care for opioid-dependent pregnant patients and their newborns began 5 years ago. Number of deliveries and newborns cared by the service increased by approximately 50% each year.

Opioid Use in Vermont: At Crisis Level

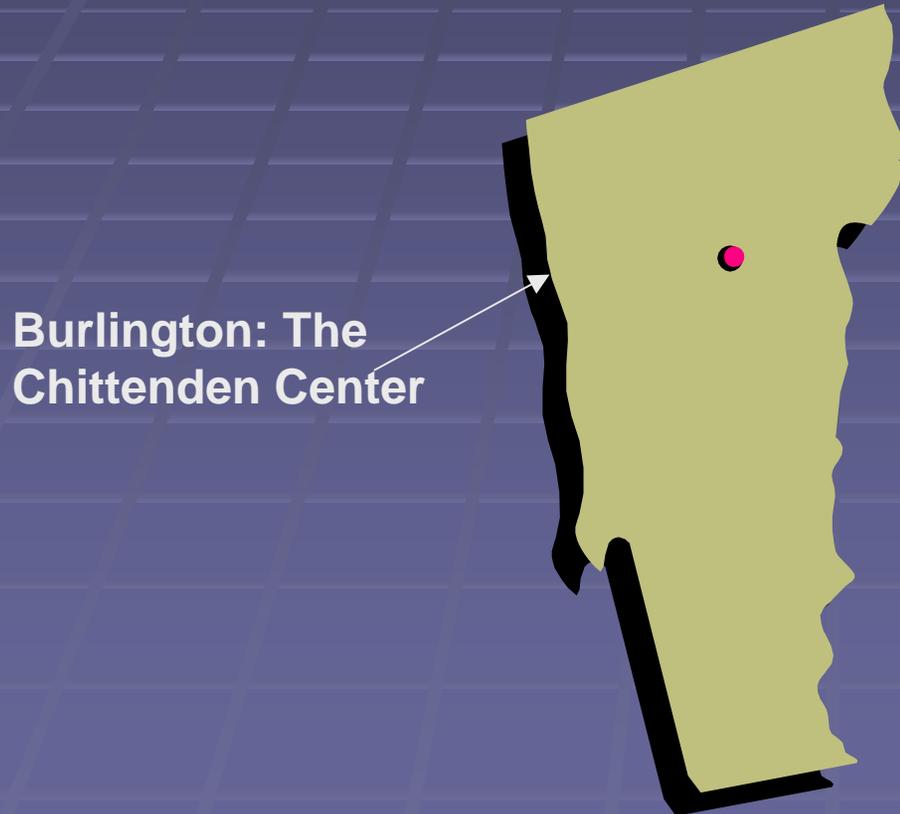
🔥 Prescription opiate use on a dramatic rise

🔥 Heroin is inexpensive and potent and available

Lack of resources to meet needs

- Prior to late 2000, Vermont treatment programs were only abstinence based
- Vermonters in need of MAT had to travel to New Hampshire, New York and Massachusetts
- Medicaid only covered “detox and out” for inpatient treatment

Vermont's First Methadone Program
Opened October 28, 2002 with an initial
census of 40
Current Census: 207!



**Burlington: The
Chittenden Center**

Arrival of buprenorphine for OBOT

Drug Addiction Treatment Act of 2000

- Intended for a rather select population
- Eight hour training required (expensive to attend, and required time away from practice and billing hours)

Arrival of buprenorphine for OBOT

- Initially very limited numbers of patients allowed ie 30 per practice
- On-line training rather isolating/non-interactive
- Vermont Bup practice guidelines posted 2003

Ten Factor Office Based Criteria Check List

In general, 10 factors help determine if a patient is appropriate for office-based buprenorphine treatment. Check off “yes” or “no” next to each factor.

Factor	Yes	No
▪ Does the patient have a <i>diagnosis of opioid dependence</i> ?		
▪ Is the patient <i>interested in office-based buprenorphine treatment</i> ?		
▪ Is the patient <i>aware of the other treatment options</i> ?		
▪ Does the patient understand the <i>risks and benefits</i> of buprenorphine treatment and that it will address some aspects of the substance abuse, but not all aspects?		
▪ Is the patient expected to be <i>reasonably compliant</i> ?		
▪ Is the patient expected to <i>follow safety procedures</i> ?		
▪ Is the patient <i>psychiatrically stable</i> ?		
▪ Are the <i>psychosocial circumstances</i> of the patient stable and supportive?		
▪ Are <i>resources available in the office</i> to provide appropriate treatment? Are there other physicians in the group practice? Are treatment programs available that will accept referral for more intensive levels of service?		
▪ Is the patient <i>taking other medications that may interact</i> with buprenorphine, such as naltrexone, benzodiazepines, or other sedative-hypnotics?		

ADAP's efforts to increase access to MAT

Hybrid Bup Trainings

- AAAP online training
- Hard copy sent to participants ahead of time
- Facilitator “talks” participants through the online course; Vermont resources provided

ADAP's efforts to increase access to MAT

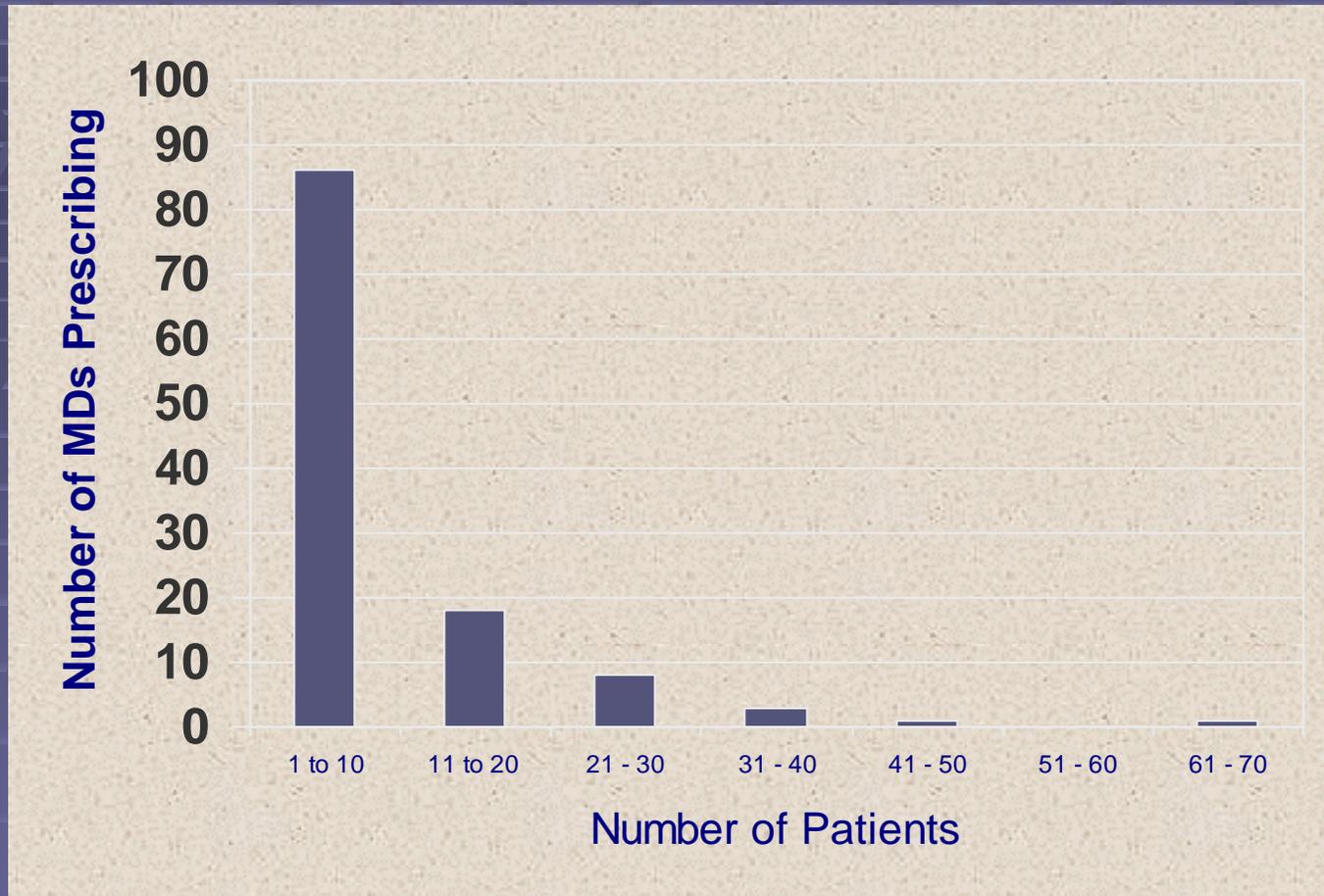
Hybrid Bup Trainings

- List serve of waived MD's hosted by Vermont Medical Society
- >80 MDs have obtained waiver through Hybrid Trainings with High satisfaction responses to questionnaires
- Vermont has highest waived MDs per capita in the US: 140 Six have requested waivers to treat 100 patients

Demand Increases Even as Resources Increase

- High number of calls to providers and ADAP office requesting “A bup program”
- Six month waiting list at the methadone program and many calls to providers and ADAP requesting MAT including methadone
- Most waived MDs:
 - Wary about doing inductions
 - Wishing to treat only those patients identified in their own practices

Waivered MD Prescribing Patterns



Number of MDs prescribing for 1 patient – 24

Number of Waivered MDs not prescribing for Medicaid patients - 50

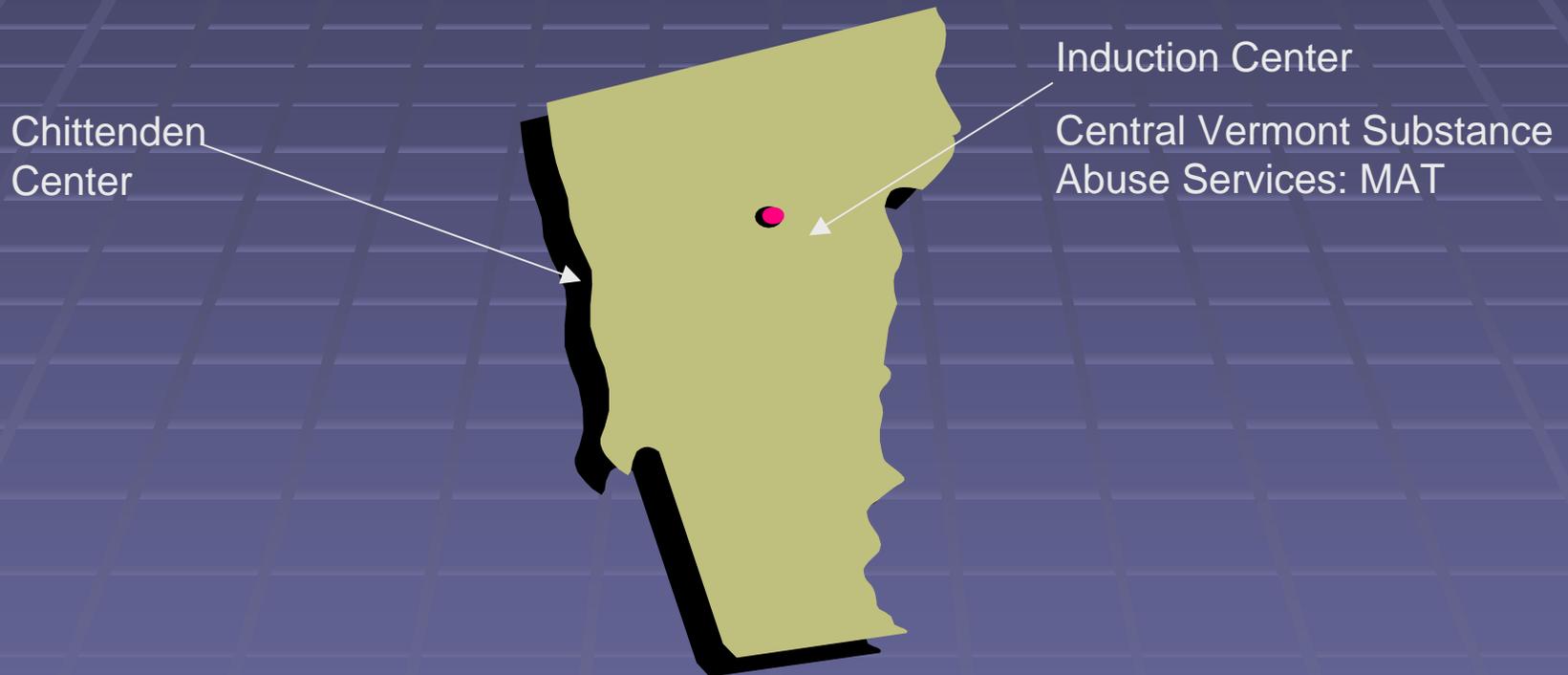
Medication Assisted Treatment Induction Center: July 2004

- Response to the Community Heroin Task force and limited availability of methadone
- Evidence based screening and assessment
- Evaluation for appropriateness for medication assisted therapy and level of care ie methadone clinic or OBOT with bup

Medication Assisted Treatment Induction Center: July 2004

- Induction, stabilization and transition to waivered MDs in the community
- Challenges: “log jam” due to limit of 30 patients per practice and limited number of community MD’s accepting patients
- Question to consider: might some of the needs be met with expanded methadone services?

Induction Center



As of August 1, 2007

399 patients have been evaluated
346 have been inducted onto bup

Challenges



Different approaches by waived MDs:

- Zero tolerance to more flexibility ie with THC
- Very liberal script writing – weeks or months
- Use of single agent medication
- Inconsistent use of tox screens
- Varied experience in management of addictions



The 8 hour training does not make an addiction specialist

Challenges Con't

 Reports of diversion – usually “lateral” reinforcing need for more treatment

 Non-static nature of drug availability and population requesting treatment – Neighboring state drug seizures

 DOC reports that buprenorphine is one of the most commonly discovered contrabands in the prisons

Challenges Con't

-  Reports of IV use of both preparations of bup
-  Variable availability of counseling and other treatment services
-  Number of OBOT patients allowed:
Changed to 30 per MD in a practice, then as of 2007 MDs may apply for a waiver to treat 100 patients.

Methadone Program Expansion Northeast Kingdom - 2005



- The law requiring a methadone program to be affiliated with a medical center was allowed to “sun set”
- BAART awarded the grant to provide MAT services – priority being given to those traveling out of state for services
- Two vans that go to dosing sites
- Total Capacity: 150 Medicaid patients and that still doesn't handle all the calls we get!

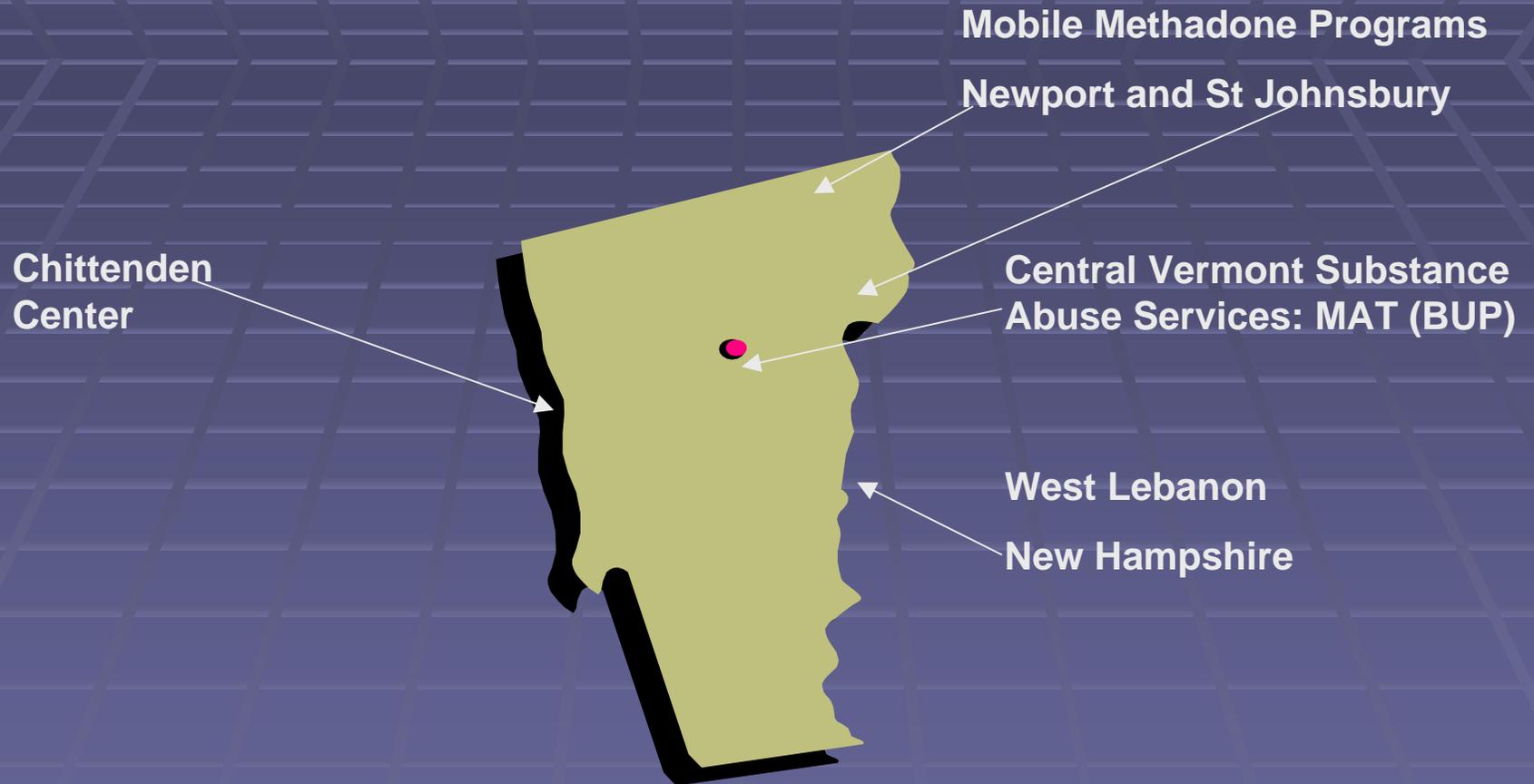
Methadone Program Expansion

- Free standing program in West Lebanon, New Hampshire (considered a Vermont Provider) 2004

Initial census of VT medicaid patients: 9

Current census of VT medicaid patients: 73

New Treatment Programs



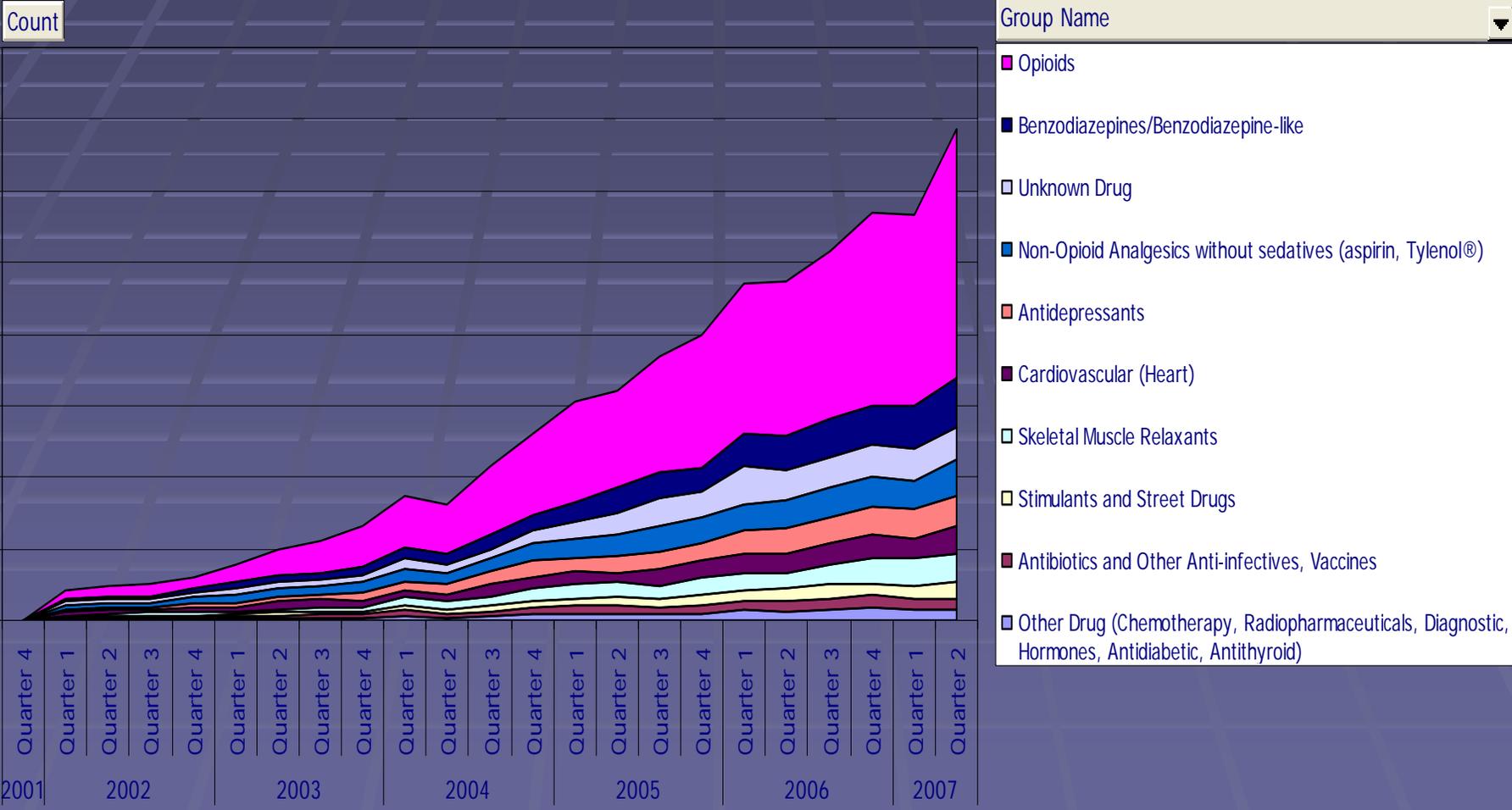
Surveillance: Continued and New Concerns

 Increased calls to poison control re: prescription opiates and benzos



Substance Abuse-Related Questions Top 10 Categories - Vermont

Northern New England Poison Center's SASRS Database



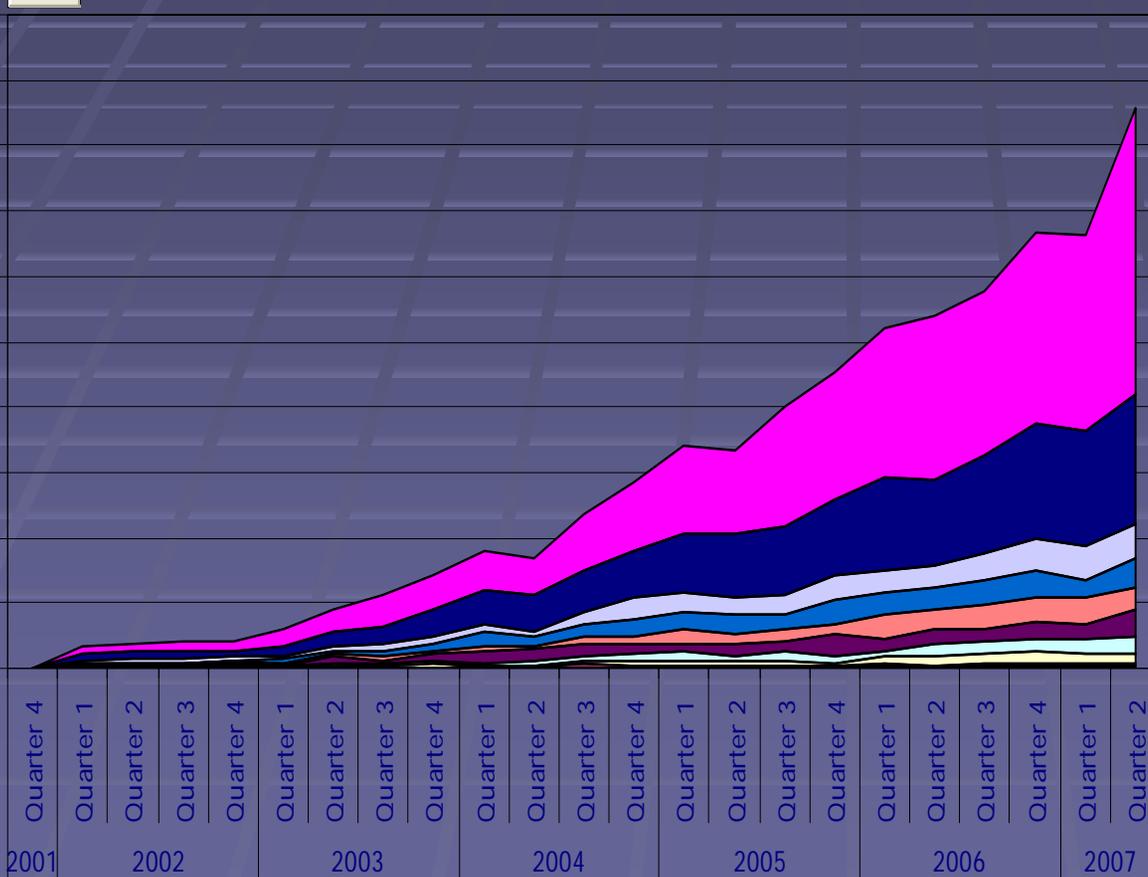
County VT

Substance Abuse-Related Questions Top 10 Opioids - Vermont

Northern New England Addiction Treatment Center's SASRS Database



Count



Group Name

Sub Group Name

- Opioids - Oxycodone (OxyContin®, Percocet®)
- Opioids - Hydrocodone (Lortab®, Tussionex®, Vicodin®)
- Opioids - Morphine (Avinza™, Kadian®, MS Contin®, Oramorph®)
- Opioids - Tramadol (Ultram®)
- Opioids - Methadone (Dolophine®, Methadose®)
- Opioids - Propoxyphene (Darvocet®, Darvon®)
- Opioids - Hydromorphone (Dilaudid®, Palladone™)
- Opioids - Codeine (Tylenol®, Fiorinal® or Soma® with codeine)
- Opioids - Stomach Opioids (Loperamide, Diphenoxylate)
- Opioids - Buprenorphine (Suboxone®)

Year Quarter

Surveillance: Continued and New Concerns

Vermont Medical examiner: Drug related deaths in Vermont, half of 2007

48 Drug related deaths

37 Accidental related to either substance abuse or an accidental overdose of prescribed pain meds

Oxycodone, Methadone, Antidepressants, Fentanyl, Benzos

7 Deaths from cocaine: 4 cocaine alone 3 in combination with other drugs

8 Included ETOH

7 Suicides: all included prescription and/or OTC medications

Surveillance: Continued and New Concerns



Medicaid Data: Benzos and bup from different providers; several bup providers



Non-waivered MDs, PAs and APRNs prescribing buprenorphine for “pain”



MDs identified as being “easy” to get scripts for bup from



Are the right patients getting OBOT with bup?

MD Concerns

 OBOT is much harder than originally thought!
Need help!

- “Lost scripts”
- Waiting room disruption
- Pain Management concerns
- Very difficult to follow up on compliance with other treatment
- Many calls from SAMHSA list

 NOT PAID ENOUGH!

Surveillance: A Positive Note

- Medicaid: Reported a decrease in utilization of other medical services for patients being treated with MAT

Where there are little fires, are there Dragons?



In our efforts to improve access are we:

- 1) Asking too much from MDs with limited addictions treatment experience and from a system with a lack of MAT experienced counseling?
- 2) Contributing to the prescription meds used on the street?
- 3) Revisit of the question: Are the right people getting buprenorphine?

**Vermont Legislature Response*
to Continued Treatment Needs:
One-Time Funding to**

ADAP

&

OVHA



**Increase Treatment Availability to MAT
(Specifically Bup)**

and

MD/Consumer Satisfaction

* Senator Bartlett

ADAP: Support and Coordination of Treatment for Waivered MDs \$350,000

Dispersement Plans:

- 25K to pay for MD CMEs and a one time stipend to offset time away from practice
- 315K Granted to the Howard Center to provide care coordination to waivered MD practices (Coordination of Office Based-Medication Assisted Therapies)
- 10K to FAMC for evaluation component of project



Office of Vermont Health Access (OVHA): Capitated financial incentive \$500,000

Dispersement Plans:

- Calculated Percent increase above Medicaid reimbursement depending on acuity of patient
- 5% lump sum bonus incentive for each increase in patient numbers by five
- 10K match to FAMC to match ADAP's contribution for evaluation component

Coordination of Office Based-Medication Assisted Therapies



(COB-MAT)



Care Coordination offered to all waived MDs. Mandatory if MD plans to participate in increased remuneration program.

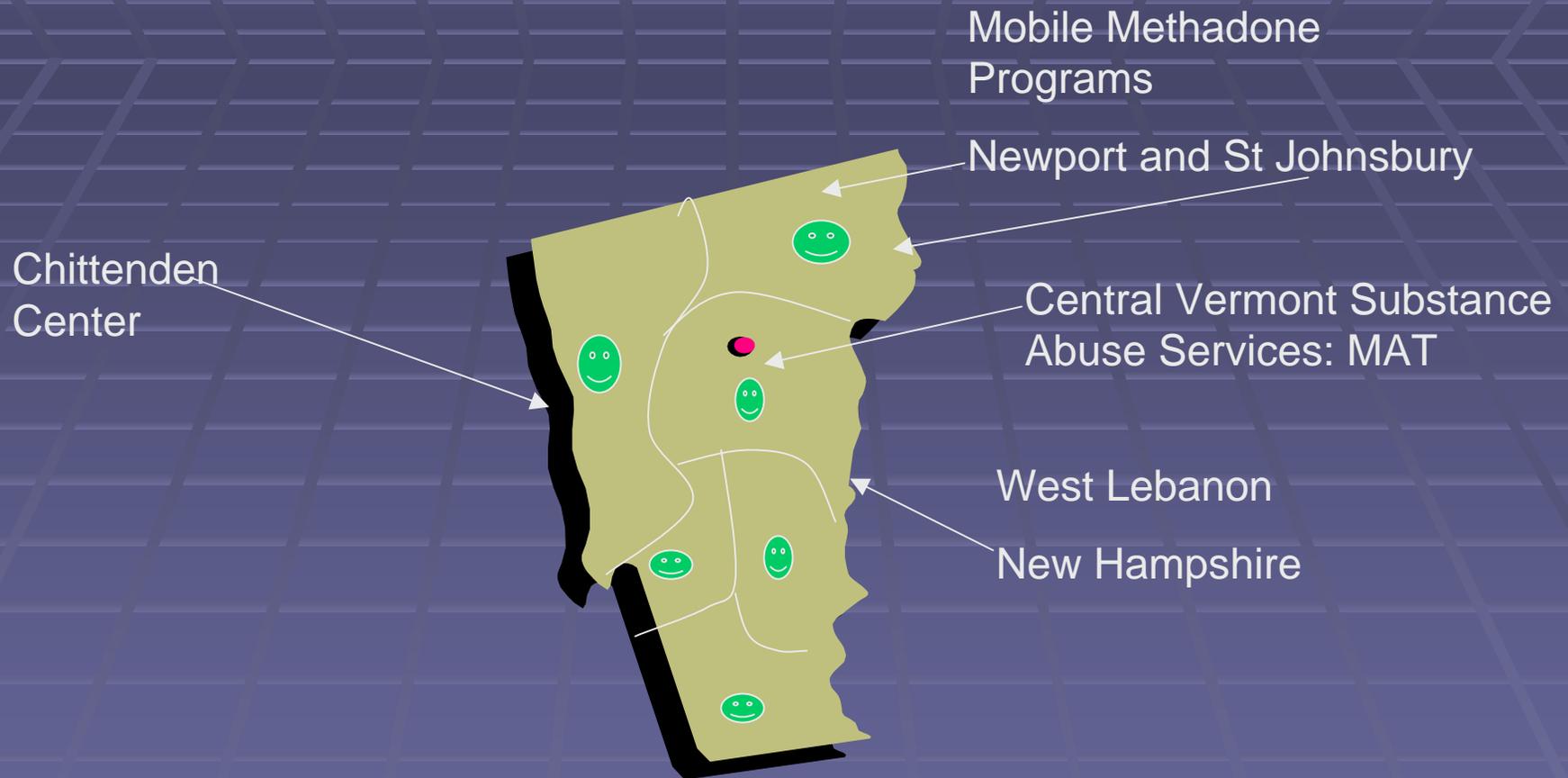
One state wide coordinator

Six regional coordinators

MAT Tool Kit

Start up date: December 1, 2006

COB-MAT Regions



Coordination of Office Based-Medication Assisted Therapies

Development of MAT “Tool Kit” for offices

Provision of education to MD office staff re: MAT, contracts, tox screens, legal obligations (ie for termination)

Facilitation of transition of patients from Induction Center to community Based, waivered MDs

Follow up on treatment plan to assess efficacy (not treatment “cops”)

Distribute MD satisfaction questionnaires

Provide data to state wide coordinator

Coordination of Office Based-Medication Assisted Therapies

State Wide Coordinator

Oversees regional coordinators

Collects data and works with research team at Fletcher Allen Medical Center for assessment portion of project

Fletcher Allen Medical Center Research Team

Participating physicians:
35 new MDs waived since the one-time expenditure.

As of June 30, 2007

79 MDs were participating in the project

Region 1 (Northeast Kingdom): 48 clients

Region 2 (Chittenden County, and Northwestern Vermont): 61 clients

Region 3 (Rutland and Central Vermont): 43 clients

Region 4 (Southern Vermont): 10 clients

Fletcher Allen Medical Center Research Team

(Dr. Thomas Simpatico)

Establishment of data bases and collection
formats

Will be providing feedback regarding
increases in access to treatment and
satisfaction

Comparison of increasing access, use of
capitated program and overall medical
service use of patients treated

Phase I Results

Program Participants Show:

Very low rate of arrest and incarceration:

Anecdotal reports indicate this may represent a reduction when compared to pre-program arrest and incarceration rates.

Variability in retention*:

The tendency to drop out of the program may correlate with identifiable and addressable issues including treatment modality assignment

Phase I Results

Variability in terms of:

Illicit substance abuse and honesty about it*

* Potentially predictive concerns ie: matching treatment to patient needs

Phase I Results

There may be a relationship between attitude of physician, RCC, and program councilors with positive treatment outcomes

Phase I Continued

“Positive relationships with their siblings”

Greater probability of remaining active throughout the sample period of the evaluation

Helpful in devising strategies and protocols that would best match candidates for treatment with particular treatment modalities (e.g. methadone vs. buprenorphine).

Phase I Continued

IOP Surprise

IOP may be less effective for Bup patients

This result may be a proxy for various factors ie:

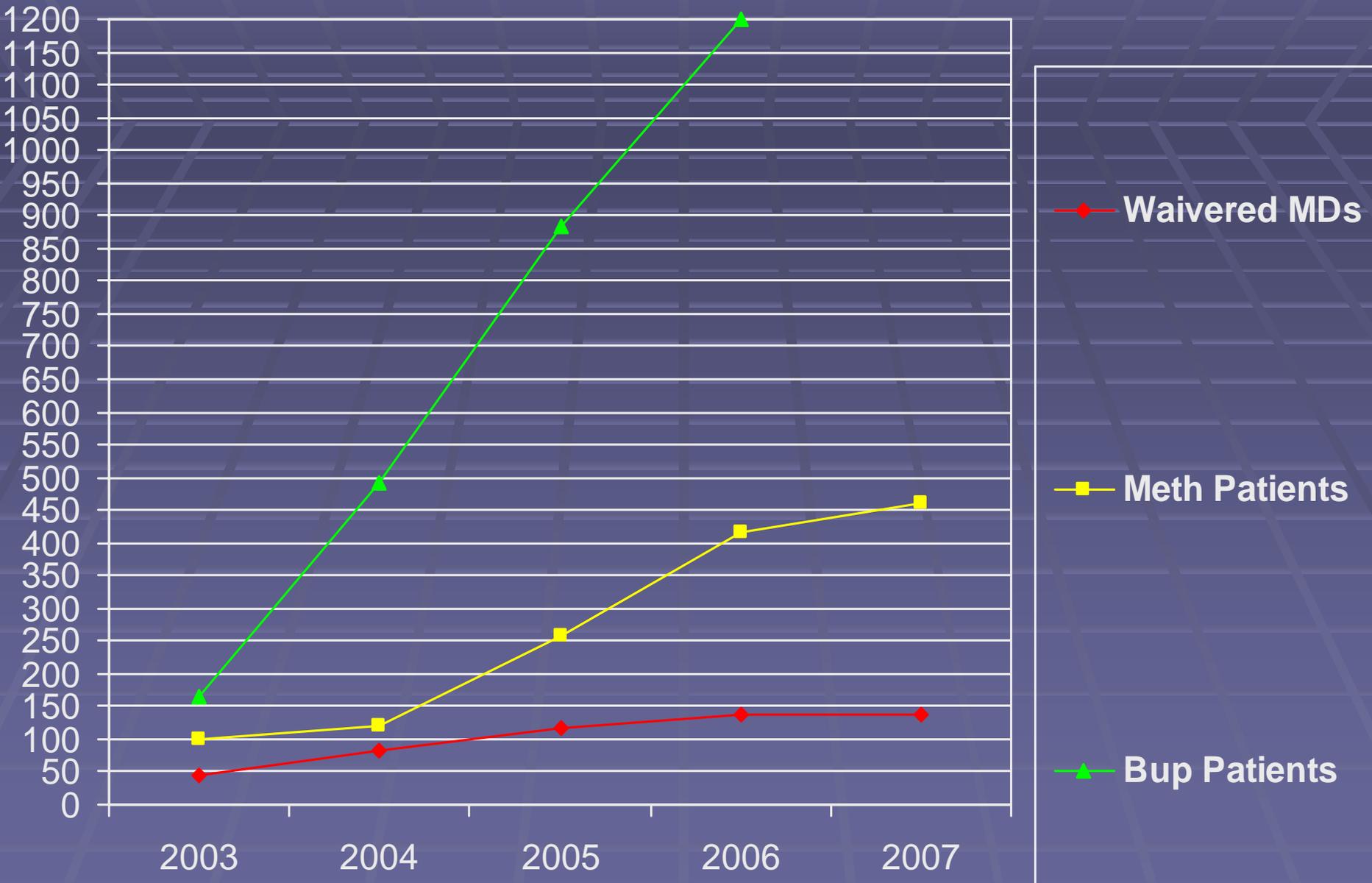
A selection bias which places the most challenging clients in the more intensive programming, thereby selecting a group which may have a natural inclination to fail programming.

And still the needs are not yet met!

One size fits all for substance abuse,
especially for patient with co-occurring
disorders does not work

How can we expand options, not JUST
access?

Vermont MAT Services



Methadone Treatment Availability

Distribution and location of programs in addition to available “slots” still problematic



Our Supply Sergeant to the rescue!

ADAP and Medicaid Magic

Background:

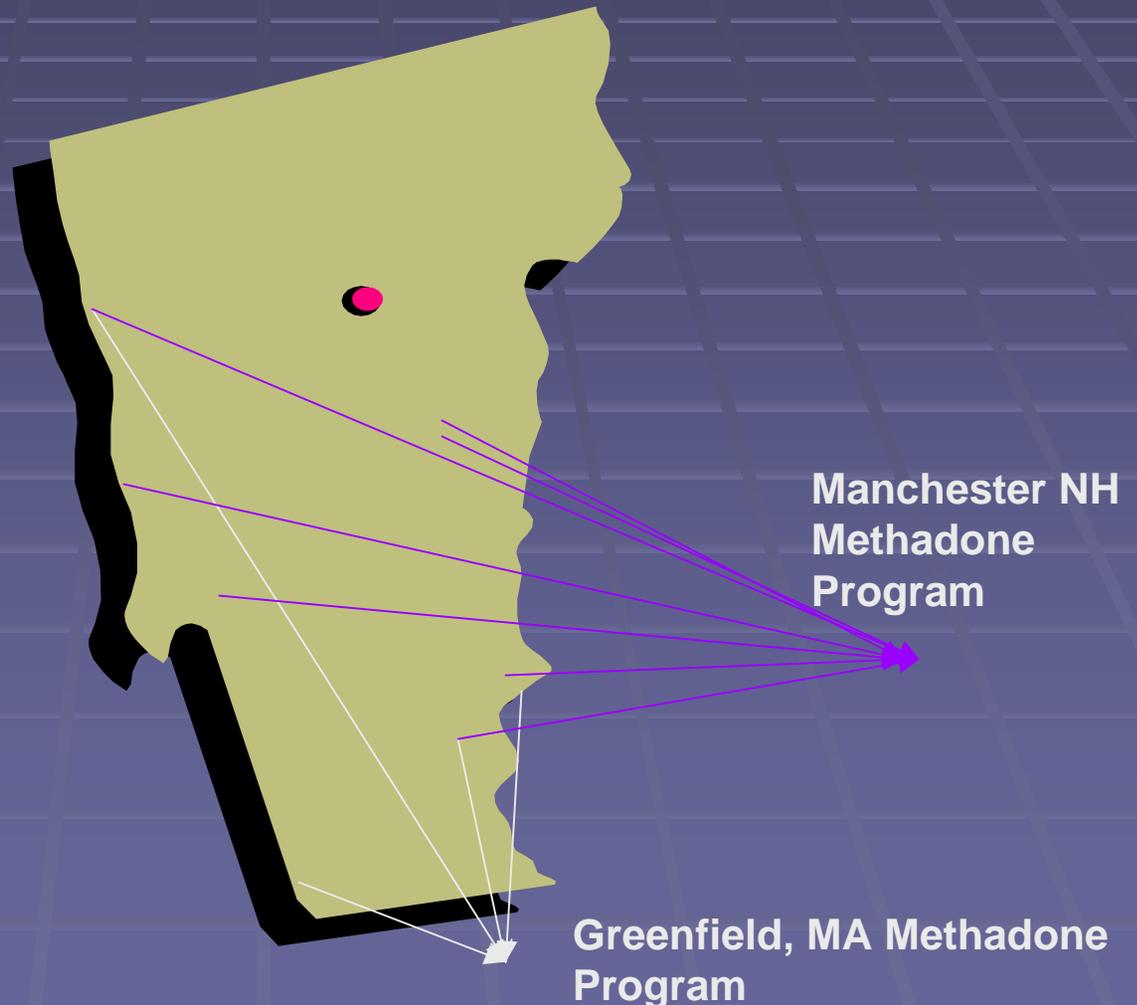
ADAP pays for methadone treatment through Block Grant and General (State) Funds

Medicaid provides funding for travel to treatment

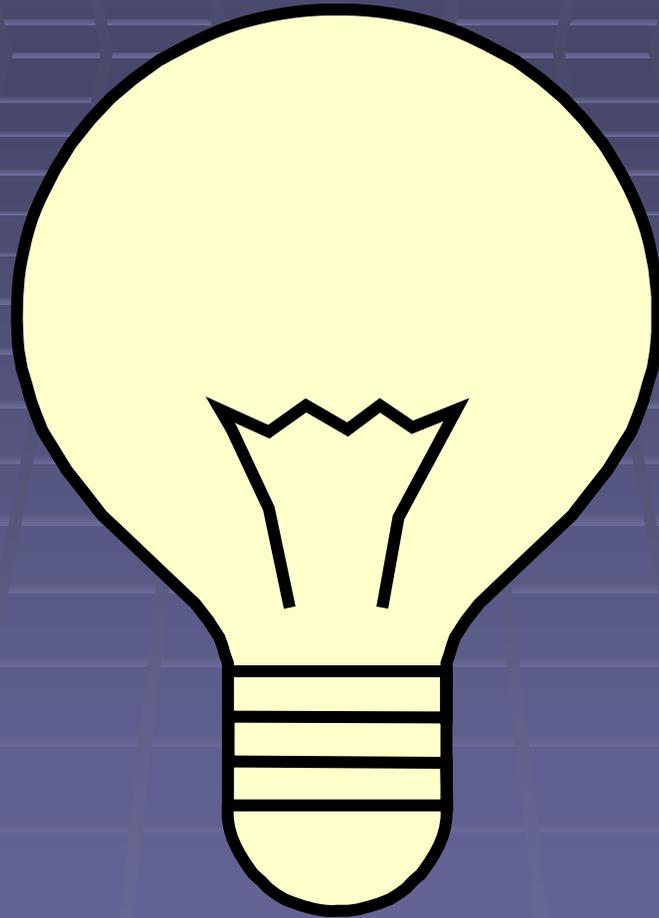
Transportation to out of state methadone programs

Transportation of 11 patients to out of state clinics:

- 1) Huge travel expense
- 2) Tremendous time commitment for patients

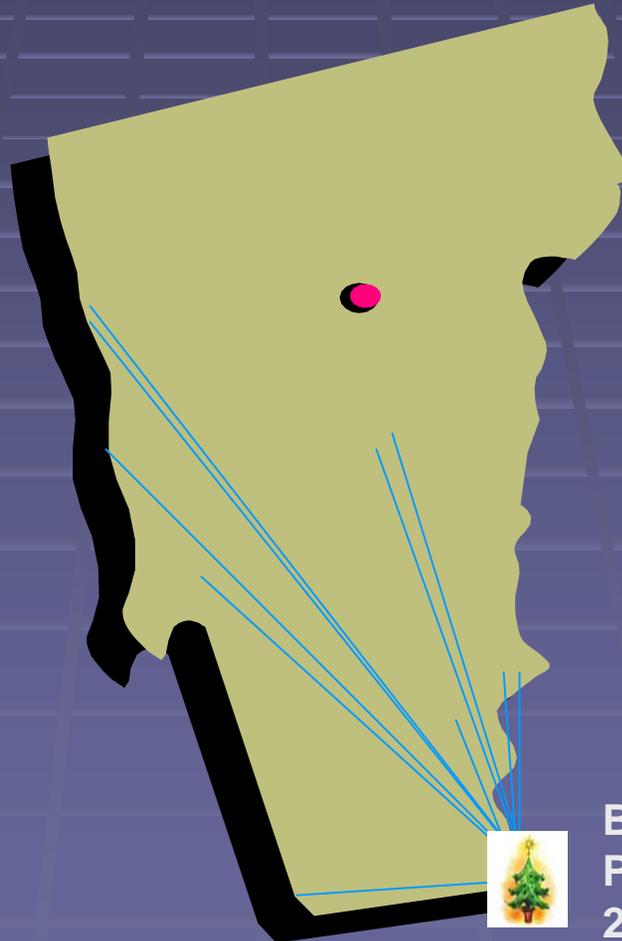


IDEA!



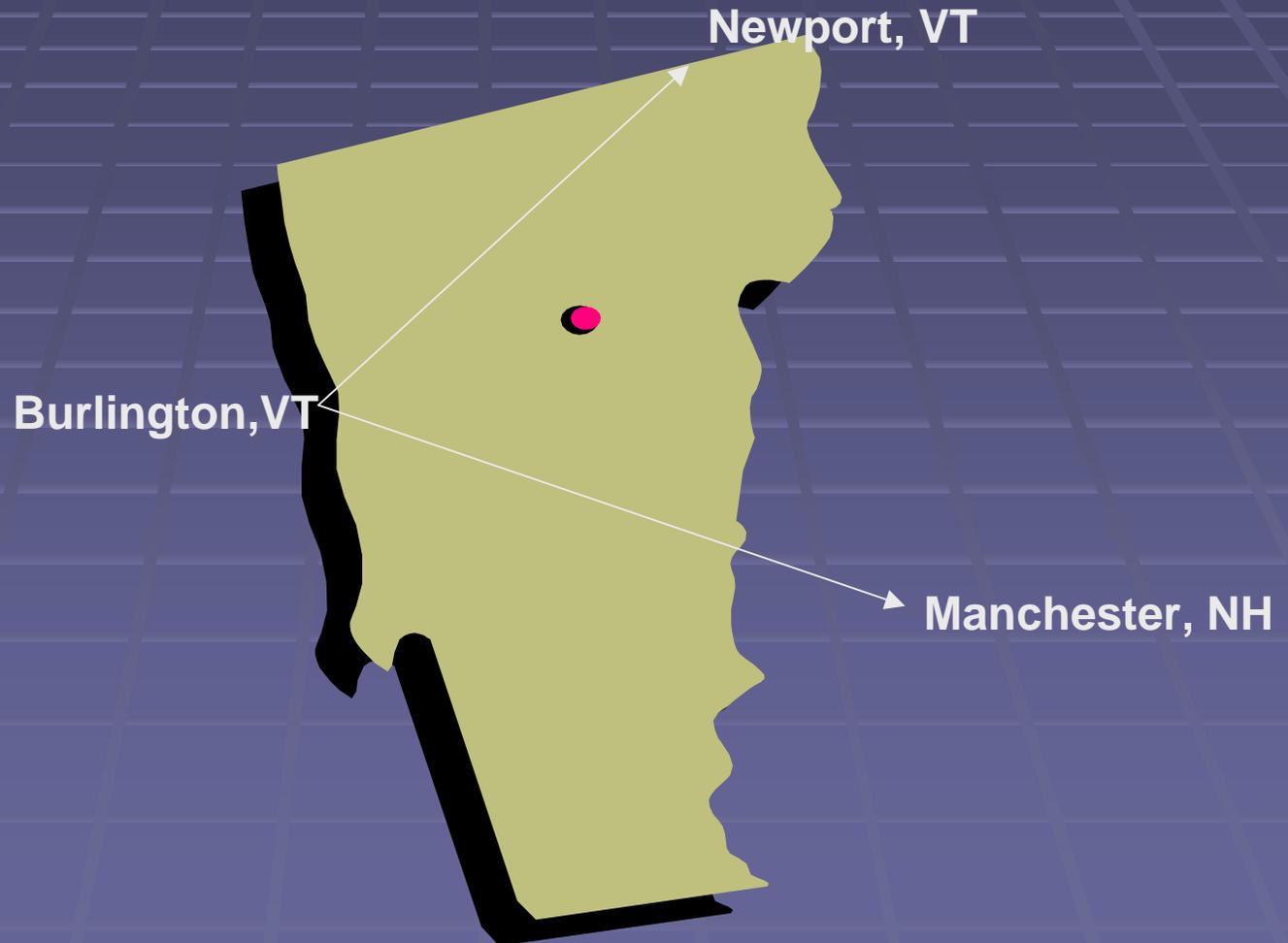
A program in Brattleboro for the same 11 patients would:

- 1) Save the state ~\$150,000 in travel expense!
- 2) Save patients travel time allowing them to begin to establish healthier patterns in their lives
- 3) Medicaid agreed to use this savings to off set ADAP's cost of \$98 per patient for treatment (\$56K) and still have a net savings!
- 4) Allow Medicaid funding for a new program starting with 25 patients!

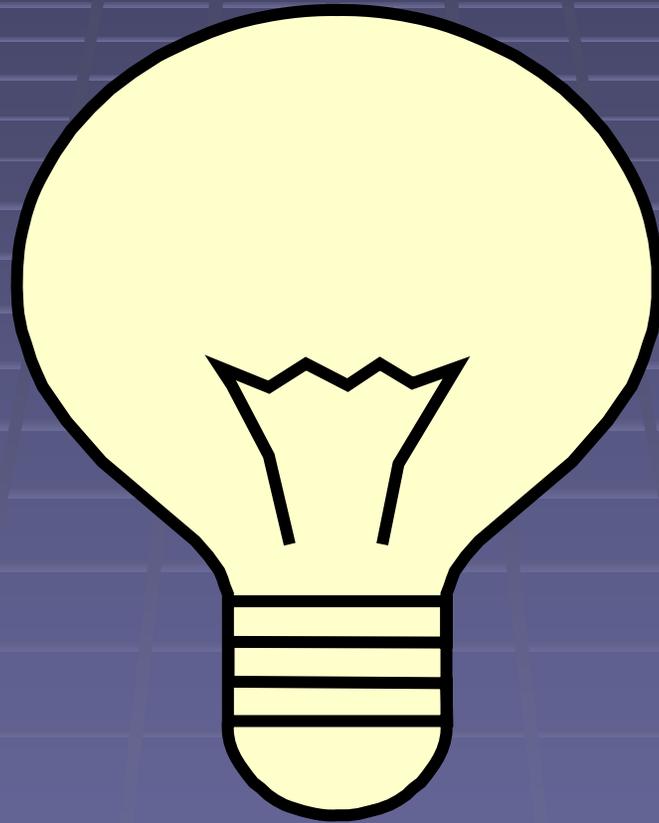


Brattleboro Methadone
Program (Opened Fall,
2006)

Lack of capacity at existing methadone program means in and out of state travel



IDEA!



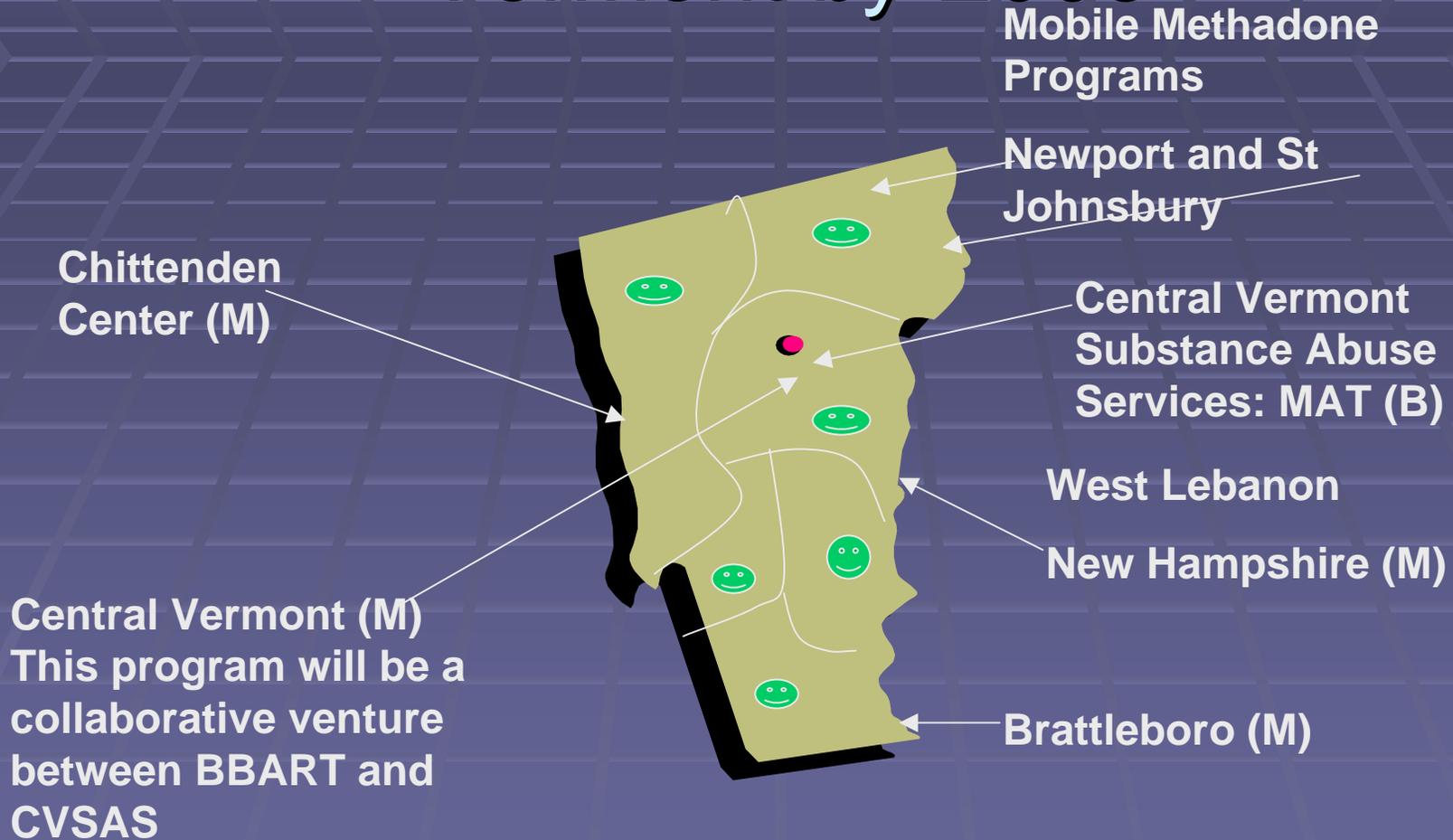
Increase Capacity: save on travel

The estimated travel savings for 5 patients traveling from Burlington to Newport, VT or Manchester, NH is ~\$151,000!

Result? Funding for an additional 20 patients at the Chittenden Center!

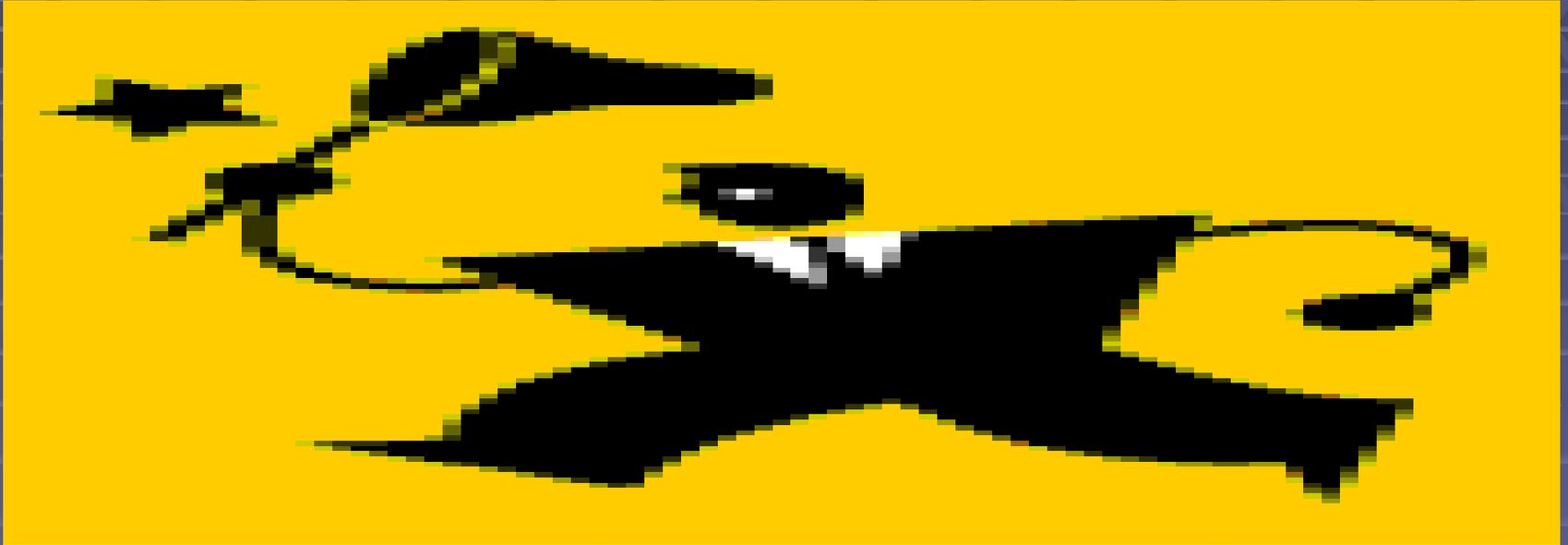


Medication Assisted Treatment in Vermont by 2008



 COB-MAT Regions

Dreams



Enough treatment options for the treatment of opiate dependence

Buprenorphine and COB-MAT vs Methadone Programs

Decrease in high prescribing of narcotics and other substances that may be abused

Improved education to MDs and public
Surveillance through Poison Control and Prescription Monitoring