
**Report to
The Vermont Legislature**

The Opioid Addiction Treatment System

**In Accordance with Act 135 (2012, Adj.), Section 1(c)
*An Act Relating to an Opioid Addiction Treatment System***

Submitted to: Senate Committee on Health and Welfare
House Committee on Human Services
House Committee on Health

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Report Date: January 15, 2013



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Table of Contents

Executive Summary	3
Introduction	4
Background	5
Opioid Addiction	5
Vermont’s Opioid Drug Challenges	5
Opioid Addiction Treatment	7
Vermont’s Drug and Alcohol Treatment System	8
Regional Comprehensive Addictions Treatment Centers Description	10
Estimated Start Up Schedule Phase I	12
Status and Accomplishments	13
Conclusion	15
Appendix I – Integrated Regional Comprehensive Treatment Program (<i>Hub and Spoke</i> Model)	16
Appendix II – Medication Assisted Therapy	22
Appendix III – Performance, Quality and System Effectiveness	26

The Opioid Addiction Treatment System

Executive Summary

This report is submitted in accordance with *Act 135 (H.627)*, an act relating to an opioid addiction treatment system, which requires the Commissioner of the Vermont Department of Health to report to the House Committees on Human Services and on Health Care and the Senate Committee on Health and Welfare regarding the following: 1) the regional system of opioid addiction treatment, and 2) the system's effectiveness.

I. The Regional System of Opioid Addiction Treatment

Since the passage of Act 135 on May 5, 2012, the Vermont Department of Health, through the Division of Alcohol and Drug Abuse Programs (ADAP), has made significant progress in developing and strengthening the regional system of opioid addiction treatment. The achievements to date include the creation, adoption and implementation of Medication Assisted Therapy Rules, the design and start-up of the Integrated Regional Comprehensive Treatment System, and the further strengthening of the Vermont Prescription Monitoring System as it relates to prescription drugs use and misuse.

II. The Effectiveness of the Regional Opioid Addiction Treatment System

To ensure that the specialized Regional Addiction Treatment System proves effective, all *Hubs* will report on the National Outcomes Measures (NOMS) that the Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) submits annually to SAMHSA as a requirement of the Block Grant. Additional performance and quality measures will be integrated into the *Hub* grants to monitor clinical outcomes, quality care, improvements in managing chronic conditions, improvements in transitional care, improvements in preventative care, and National Committee of Quality Assurance Standards.

The Opioid Addiction Treatment System

Introduction

On May 5, 2012, Governor Shumlin signed H.627, which authorizes the Vermont Department of Health to establish a regional system of opioid addiction treatment. This legislation, Act 135, directs the department to establish the system by rule. It requires patients to:

“receive appropriate, comprehensive assessment and therapy; medical assessments to be conducted to determine whether short-term or long-term pharmacological treatment is medically appropriate for a patient; controlled substances to be dispensed only by authorized treatment programs and by health care professionals meeting certain federal requirements; comprehensive education and training requirements to apply to health care providers, pharmacists, and licensed clinical professionals; and patients to follow rules of conduct, including urinalysis and restricted medication dispensing designed to prevent diversion or relapse.”

This report is submitted in accordance with Act 135, Section 1 [18 V.S.A. Chapter 93, §4752 (c)], which requires the Commissioner of Health to report to the House Committees on Human Services and on Health Care and the Senate Committee on Health and Welfare about the regional system of opioid addiction treatment and the system’s effectiveness.

Background

Opioid Addiction

Individuals with significant medical conditions such as chronic pain, post-surgery discomfort, sickle-cell disease and cancer are often prescribed pain medication by their physicians. Some of these individuals are at risk for becoming dependent. Furthermore, Vermont data show that 6.0% of 12-17 year olds and 13.3% of 18-25% year olds have reported “non-medical use of prescription drugs” (National Survey on Drug Use and Health, NSDUH, 2009-2010). Some of these young people, too, are at risk of opioid addiction. The risk of dependence and/or addiction comes from changes these opioids cause in the brain.

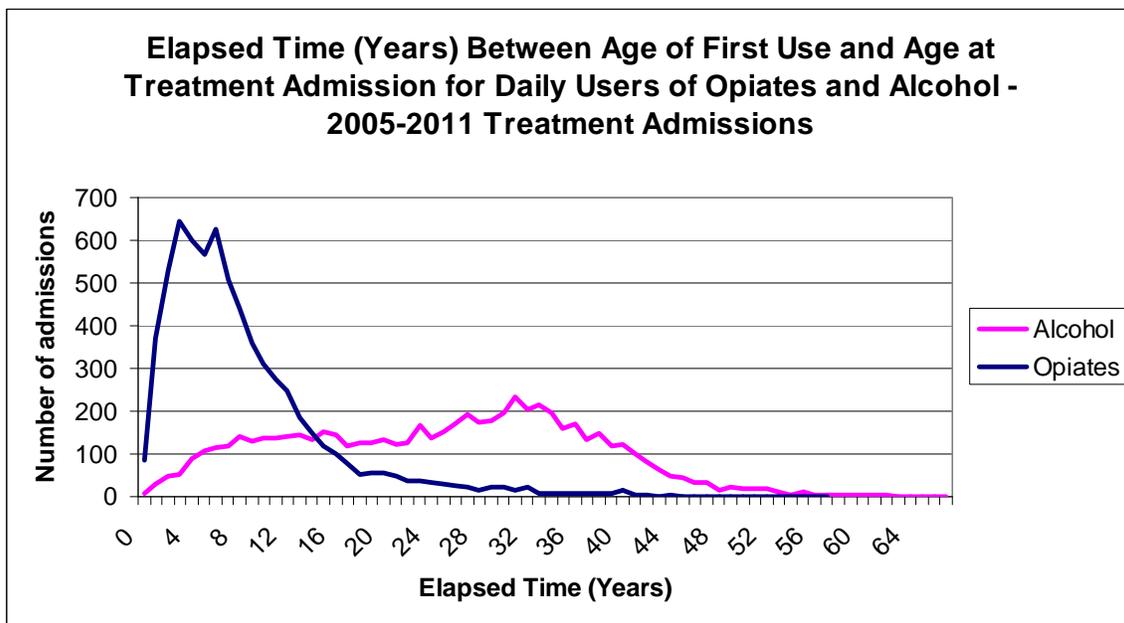
After prolonged opioid use, the nerve cells in the brain, which would otherwise produce endogenous opioids (*natural painkillers, or endorphins*), cease to function normally. The body stops producing endorphins because it is receiving opioids instead. The degeneration of these nerve cells subsequently causes a physical dependency on an external supply of opioids. Some people continue using these substances and become addicted, experiencing a loss of control over their choice to use them in spite of adverse consequences.

Vermont’s Opioid Drug Challenges

According to the most recent state level data from the National Survey on Drug use and Health (NSDUH) from 2010, Vermont is currently ranked 28th highest of all the states in “past year non-medical use of pain relievers among individuals 12 and older”. Among those 12-17 years old, the rate of past year nonmedical use of pain relievers has significantly declined since 2003. Other age groups (i.e., 18-25, 18+, and 26+) show neither an increase nor decrease from 2003 or 2010. In addition, the Youth Risk Behavior Survey (YRBS) shows a significant decrease for prescription drug misuse among 9th-12th

graders in Vermont. Similarly, a survey of adults 18 and over also shows a significant decrease in prescription drug misuse from 2007 to 2011 (Behavior Risk Factor Survey System [BRFSS]).

While the above data are relatively encouraging, the costs to Vermonters for even these prevalence rates of opioid misuse is high. First, the negative impact of opioid addiction on individuals far surpasses that of alcohol. As shown in the chart below, the elapsed time in years between the age of first use and age at treatment admission is much shorter for daily users of opiates compared to alcohol users.



Second, the above pattern reflects a corresponding spike in opioid related treatment which places consequent strains on the addictions treatment system, the medical system, and the criminal justice system, among other State resources.¹

¹ The recent jump in opioid related treatment admissions may also be corresponding to the newly expanded capacity to provide this specialty treatment service.

Third, abrupt or sudden abstinence from many of these drugs can result in uncomfortable physiological symptoms for some individuals. This risk can create a disincentive for addicted individuals to seek recovery and treatment for opioid dependence.

Finally, drug diversion of these substances, including illegal sale and distribution, “doctor shopping,” forged prescriptions, employee theft, pharmacy theft, and obtaining prescriptions over the internet, further exacerbates the problems of containing opioid addiction rates.

While Vermont has been relatively successful in reducing or keeping constant the prevalence rates of misuse across the various at-risk age groups, the State is proactively working to ensure that the problem continues to be contained. In this effort, the State is working with physicians and other medical practitioners for system improvements to ensure opioids are not over-prescribed, to reduce incidences of drug diversion, and to provide cost-effective and successful treatment approaches for opioid addictions.

Opioid Addiction Treatment

Medication assisted therapy (MAT)², such as methadone and buprenorphine, in combination with counseling, has long been recognized as the most effective treatment for opioid addiction. These medications suppress the craving for opioids, thereby reducing relapse. Effective MAT programs also provide services such as mental and physical healthcare, case management, life skills training, employment, and self-help. The length of the course of treatment is individually determined according to patient need and criteria. MAT services are cost effective over time because they help stabilize the health of patients, increase their rate of employment and decrease involvement in the criminal justice system.

² Medication Assisted Therapy is the use of medications in combination with counseling and other services to provide a whole-person approach to the treatment of substance abuse disorders.

Vermont's Drug and Alcohol Treatment System

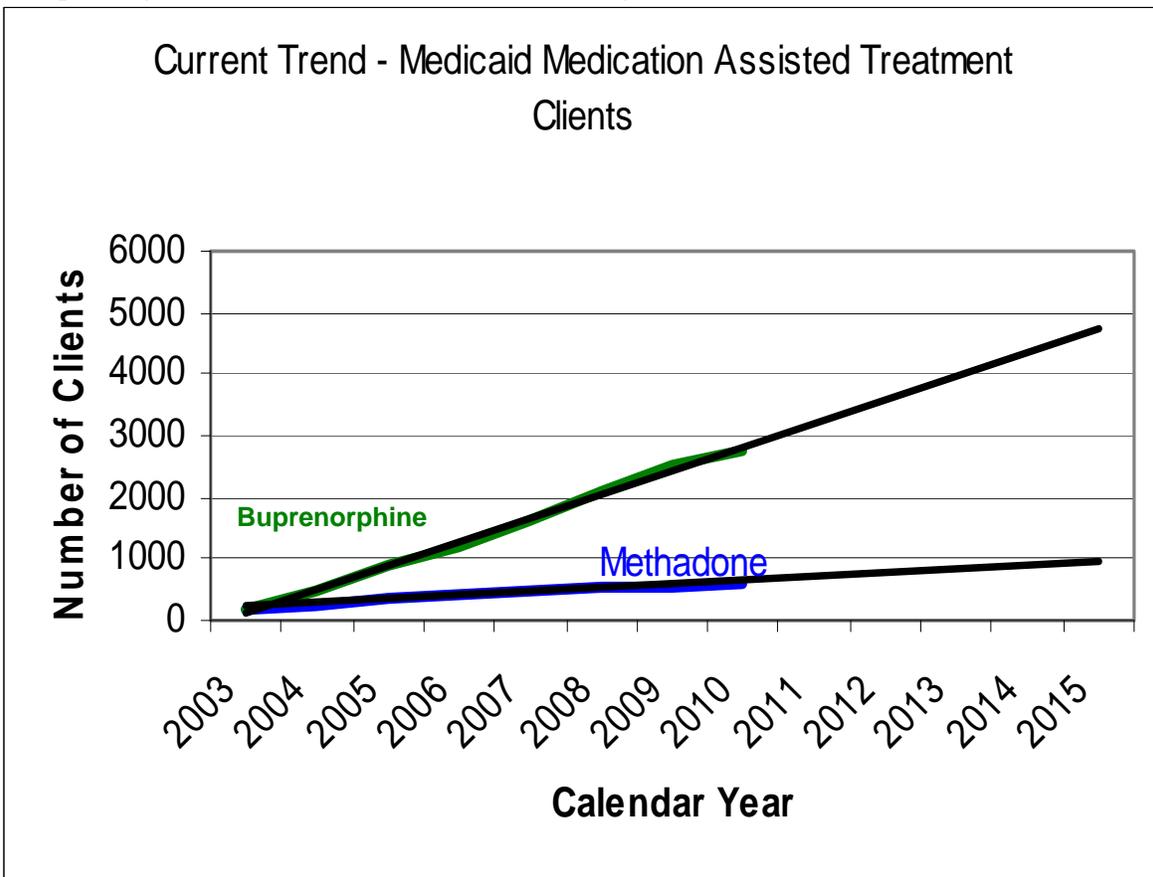
The Division of Alcohol and Drug Abuse Programs (ADAP) operates within the Department of Health as Vermont's Single State Agency (SSA) mandated to plan, operate and evaluate a consistent, effective program of substance abuse programs. Title 33 of Vermont state statutes authorizes ADAP as responsible for the following services statewide: 1) prevention and intervention; 2) licensure of alcohol and drug counselors; 3) project CRASH schools; and 4) alcohol and drug treatment.

The substance abuse treatment system is made up of ADAP-approved preferred provider treatment programs. Several of these providers are designated mental health agencies. Many of these providers are essential to providing a Resiliency and Recovery Oriented System of Care (RROSC) in their local communities. Currently, there are 19 providers serving multiple sites. ADAP approves a total of 39 community sites, plus 14 Department of Correction sites. There are also 11 recovery centers.

The system is designed to provide a continuum of timely, interconnected and coordinated components with multiple entry points. ADAP thus works with an array of partnerships including the ADAP-preferred providers, community-based public and private organizations, schools, recovery centers, transitional housing agencies, the courts, other state agencies, physical and behavioral health providers, and local non-profit agencies. Together they plan, support, and evaluate a comprehensive system of services to help Vermonters prevent and reduce problems caused by alcohol and other drug use. This system includes the entire range of services from prevention through recovery, and employs evidence-based practices and data-driven decision making to develop, implement and oversee substance abuse programming throughout Vermont.

Opioid dependent individuals in Vermont currently receive care, including medication assisted treatment, from primary or specialty practice physicians with limited access to coordinated health, mental health, rehabilitation, or recovery services. A smaller number of Vermonters receive methadone and associated addictions treatment services in six

specialty clinics. Waiting lists for methadone indicate insufficient treatment capacity in Vermont, and the number of providers willing to prescribe buprenorphine for new patients is declining. Furthermore, the current methadone clinics and MDs prescribing buprenorphine work in relative isolation from each other and with limited interface with the primary care health care and mental health systems.



Public spending patterns show very high costs for patients receiving buprenorphine and methadone. Overall health care costs are approximately three times higher among MAT patients than within the general Medicaid population.

	<u>Medicaid Population*</u>	<u>Buprenorphine Clients</u>	<u>Methadone</u>
<u>Clients</u>			
Total People Served	146,030	2801	614
Annual Per Capita Cost	\$4,553	\$12,985	\$13,523
Total Expenditures	\$561,221,169	\$36,372,106	\$8,303,369

In addition to the costs directly associated with medication assisted therapy, these individuals have high rates of co-occurring mental health and other health issues and are high users of emergency rooms, pharmacy benefits, and other health care services. In state fiscal year 2011, Vermont's Medicaid program paid nearly \$45 million in health, addictions treatment, and mental health care claims for the 3,400 Vermonters who received methadone or buprenorphine maintenance treatment.

Regional Comprehensive Addictions Treatment Centers Program Description

The Agency of Human Services (AHS) through three partnering entities - the Department of Health/Division of Alcohol and Drug Abuse Programs, the Department of Vermont Health Access(DVHA), and the Blueprint for Health – are working in collaboration with local health, addictions, and mental health providers to develop a program and cost model for a regional comprehensive addiction treatment infrastructure. This will supplement the existing treatment system to reduce overall costs and ensure more effective care for opioid dependent Vermonters.

Grounded in the principles of Medication Assisted Therapy (MAT), the Blueprint's health care reform framework, and the Health Home concept in the Federal Affordable Care Act, the collaborative partners proposed the "*Hub and Spoke*" initiative. Each center, or *hub*, will serve a defined geographic area and provide comprehensive addictions and co-occurring mental health treatment services to Vermonters with opioid addiction. In addition, these specialized centers will assure the provision of integrated health care, recovery supports, and rehabilitation services for clients of the centers. Each center will provide specialized Medication Assisted Therapy (MAT) for clients in combination with counseling and other services to provide a whole-person approach to the treatment of substance abuse disorders. Phase I of the initiative has involved

identifying and entering into service agreements with select organizations to establish and/or maintain Regional Comprehensive Addictions Treatment Centers, or *Hubs* in the areas designated for the start-up phase.

These *Hubs* will ensure comprehensive and systemic response to opioid addiction treatment needs in their designated regions. Although this initiative initially focused on medication assisted treatment for individuals with opioid addictions, this initiative will also create a framework for integrating treatment services for other substance abuse issues and co-occurring health disorders into the medical home through a managed approach to care. In addition, this treatment approach is expected to reduce recidivism in corrections and enhance outcomes for families where addiction is an identified problem for child welfare.

Less clinically complex patients who require MAT but not methadone will receive treatment within the *Spoke* system. *Spoke* entities may be primary care medical homes, Federally Qualified Health Centers, independent physicians (and psychiatrists), or specialty clinic-based outpatient substance abuse treatment providers, all with augmented counseling, health promotion, and care coordination services.

In later phases of the initiative, the regional *Hubs* will be expanded to ensure State-wide coverage for specialized, cost-effective opioid addictions treatment. Furthermore, the *Hubs* will be integrated with community health homes as health reform is implemented statewide. The future may also see the *Hubs* develop capacity to serve a consultative role for area prescribing physicians who need information about helping individuals manage pain while avoiding addiction. The current target is to have five regional *Hubs* operating in partnership with area physicians providing essential physician-assisted specialty services for opioid dependent individuals in a comprehensive recovery approach.

Estimated Start Up Schedule Phase I

There are five regional *Hubs* currently under development. The Northwestern *Hub* serving Chittenden, Franklin, and Grand Isle Counties has located space for this initiative and will begin implementation on January 1, 2013. Proposals for three *Hubs*, in Southeast Vermont (Windsor and Windham), Northeastern Vermont (Essex, Orleans, and Caledonia), and Central Vermont (Washington, Lamoille, and Orange) are under review. The Southwest *Hub* (Rutland and Bennington) system is in flux but the *Spokes* are poised to begin serving patients in January.

Timeline:

January 2013	Northwestern <i>Hub</i> Rutland <i>Spokes</i>
July 2013	Second <i>Hub</i> , location to be determined
January 2014	Remaining <i>Hub and Spokes</i>

Status and Accomplishments

1. The Regional System of Opioid Addiction Treatment

Since the passage of Act 135, the Vermont Department of Health, through the Division of Alcohol and Drug Abuse Programs (ADAP), has made significant progress in developing and strengthening the regional system of opioid addiction treatment. The achievements to date include:

- Creation and adoption of the Medication Assisted Therapy Rules (MAT Rules) by VDH/ADAP (see http://healthvermont.gov/regs/documents/opioid_dependence_rule.pdf);
- Formulation and dissemination of answers to the ten most frequently asked questions about Medication Assisted Therapy (MAT) – (see http://healthvermont.gov/regs/documents/opioid_dependence_rule_provider_faq.pdf);

- Development of protocols is currently underway between VDH/ADAP and the Medical Practice Board to conduct investigations and potential licensure sanctions for violation of the Medication Assisted Therapy Rules;
- Work in partnership with the Department of Vermont Health Access and Blueprint to design the Integrated Regional Comprehensive Treatment System (Phase I), identify partner contractors, and prepare for the January 1, 2013 start-up implementation of the specialized regional opioid treatment system per the “*Hub and Spoke*” model;
- Expansion of use by physicians and other medical practitioners of the Vermont Prescription Monitoring System (VPMS);
- Active investments by the Vermont Prescription Drug Abuse Workgroup including developing the Vermont Plan that prioritizes four focus areas (education and community prevention/treatment, monitoring, disposal, and law enforcement) for addressing prescription drug misuse;
- Formation of the Unified Pain Management System Advisory Council to advise the Commissioner of Health on matters relating to the appropriate use of controlled substances in the treatment of chronic, non-cancer pain and the prevention of prescription drug abuse; and
- Efforts between the Department of Health/ADAP and the Department of Corrections (DOC) are underway to ensure that dependent individuals connected to the DOC are referred in a timely fashion to *Hubs and Spokes* (as appropriate).

2. The Effectiveness of the Regional Opioid Addiction Treatment System

In order to ensure that the specialized Regional Addiction Treatment System proves effective the following progress has been achieved:

- A measure set for the management of addictions and Medication Assisted Therapy for opioid addiction is being developed for use by the *Hubs and Spokes*. This will supplement the Blueprint for Health’s Central Clinical Registry, named Covisint DocSite;

- ADAP will collect National Outcomes Measures (NOMS) from the *Hubs* and other preferred providers. These measures, are required annually by the federal Substance Abuse Prevention and Treatment Block Grant;
- ADAP will incorporate additional performance and quality measures into the *Hub* grants and *Spoke* agreements. This is also a condition of the Medicaid State Plan Amendment with Centers for Medicaid and Medicaid Services;
- The State Epidemiological Outcomes Workgroup is tracking several data sources that relate directly or indirectly to opioid use/misuse in Vermont.

Conclusion

Through all the above mentioned initiatives, the hope is to have a seamless and comprehensive system of care for Vermont families and individuals affected by an opioid dependent cycle. The attached appendices will provide additional detail about the concepts and program elements of Vermont's Drug and Alcohol Treatment System, the Integrated Regional Comprehensive Treatment Program for specialized treatment of opioid dependent individuals, and the means for ensuring system effectiveness.

Appendix I - Integrated Regional Comprehensive Treatment

The following provides additional detail to the program elements of the Integrated Regional Comprehensive Treatment Program and the progress achieved to date in Phase I.

Hubs

Hubs will function as regional treatment centers providing comprehensive addictions treatment, Health Home, and rehabilitation services for individuals receiving methadone maintenance therapy. In addition, *Hubs* will provide comprehensive addictions treatment, Health Home, and rehabilitation services for a subset of patients receiving buprenorphine treatment (those with more clinically complex substance addiction and co-occurring disorders). The model client will have both substance addiction and co-occurring mental health conditions; therefore, *Hub* services need to be capable of treating co-occurring addictions and mental health conditions in an integrated manner. In addition, the clients served in *Hubs* will use a broad spectrum of health, social welfare, housing, and recovery services, requiring that *Hubs* are capable of systematic and close coordination of care across a number of health and human services providers. As such, proposed *Hub* providers must demonstrate the capacity to either provide directly or to organize comprehensive care. *Hub* (and *Spoke*) services are not time limited; they are designed to provide continuity of services over time to clients similar to patient-centered medical homes. *Hub* providers will replace episodic care based exclusively on addictions illness with coordinated care for all acute, chronic, and/or preventative conditions in collaboration with primary care providers.

As regional treatment centers, the *Hubs* will provide support and consultation to primary care providers and to physician teams (*Spokes*) providing Buprenorphine treatment.

These consultation services may include the following.

- Consultation services for example: psychiatry, addictions medicine, expertise in management co-occurring mental health conditions, and recovery supports.
- Comprehensive assessments and treatment recommendations such as differential diagnosis, assessment of need for medication assisted treatment versus other services, use of methadone or Buprenorphine.
- Induction and Stabilization services for initiation of Buprenorphine especially for complex clinical presentations
- Re-assessment and treatment recommendations for individuals experiencing relapse.
- Support for tapering off maintenance medication including the provision of more intensive psycho-social supports
- Support and Consultation for Recovery and Rehabilitation Services assistance in designing individualized recovery plans and coordination with human services, housing, employment and other specialized services and supports.

Accreditation Requirements

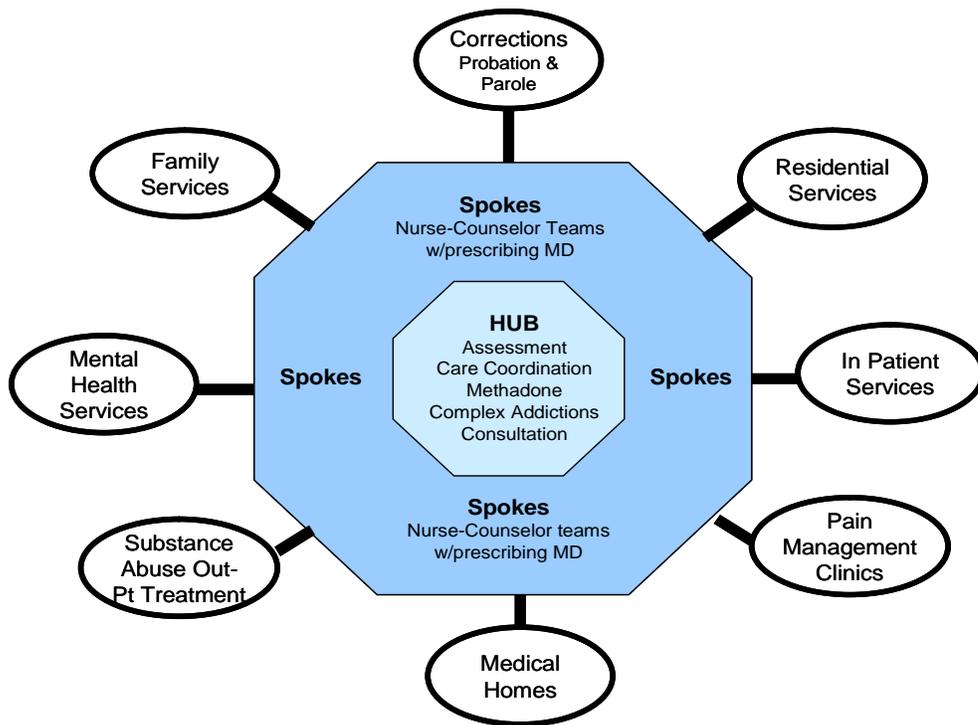
As comprehensive treatment centers, *Hubs* will demonstrate capability to plan, implement, and coordinate seamless care on behalf of clients across the health and human services systems. This includes co-management of care with primary care providers, management of referrals for community services such as vocational rehabilitation, and assuring successful transitions of care between organizations and across care settings (inpatient, residential, community, corrections, etc.). In addition, *Hubs* will demonstrate high standards of access for and communication with clients and the ability to measure and improve services.

Consistent with the requirement that primary care practices meet the National Committee for Quality Assurance (NCQA) Patient Centered Medical Home Standards to participate in the *Blueprint's* payment reforms and Community Health Teams, *Hubs* will participate

in the NCQA Specialty Practice Recognition Program. These Specialty Practice Standards are currently in development and mirror the Patient Centered Medical Home Standards and include timely appointments and communication during and after office hours; communication with patients about the role of the specialist, results of tests, visit summaries.

Spokes

A *Spoke* is the ongoing care system comprised of a physician prescribing buprenorphine and the collaborating health and addictions professionals who monitor adherence to treatment, coordinate access to recovery supports and community services, and provide health care, counseling, contingency management, and case management services. Less clinically complex patients who require MAT but not methadone will receive treatment within the *Spoke* system. *Spoke* entities may be primary care medical homes, Federally Qualified Health Centers, independent psychiatrists, or specialty clinic-based outpatient substance abuse treatment providers, all with augmented counseling, health promotion, and care coordination services. The figure below details the components of the system:



The Opioid Addiction Treatment System – January 15, 2013

Health Home Service

Comprehensive Health Home services for patients and additional support for Buprenorphine prescribers will be provided by augmenting Vermont's *Blueprint for Health (Blueprint)* Community Health Teams (CHTs) with one registered nurse care manager and one clinician case manager for every 100 MAT patients. The Department of Vermont Health Access is pursuing a state plan amendment to create a Health Home for individuals with opioid addiction and who are at risk of additional chronic conditions. The *Hub and Spoke* program will offer the new Health Home Services as part of the Medicaid State Plan Amendment. The specific Health Home activities authorized by the Affordable Care Act follow.

1. Comprehensive Care Management: The activities undertaken to identify patients for Medication Assisted Therapy (MAT), conduct initial assessments, and formulate individual plans of care. In addition, Care Management includes the activities related to managing and improving the care of the patient population across health, substance abuse and mental health treatment, and social service providers.

Specific activities include but are not limited to:

- Identifying potential MAT patients via referrals, prior authorizations, VCCI risk stratification, claims and utilization data, judicial referrals for treatment, and outreach to patients lost to contact.
- Assessing preliminary services needs and treatment plan development, including client goals.
- Assigning health team roles and responsibilities.
- Developing treatment guidelines and protocols for health teams to use in specific practice settings (e.g., primary care, specialty care) for transitions of care, for identified health conditions (e.g., opioid addiction with depression or chronic pain), and for prevention and management of substance relapse.

- Monitoring MAT patients' health status, treatment progress, and service use to improve care and address gaps in care.

Standard Care Processes

Hubs will offer standardized care processes based on evidence-based care guidelines, SAMHSA Tips and the work of the ADAP/DVHA/Blueprint Clinical Leadership Committee. *Hubs* will be expected to demonstrate the consistent use of standard care protocols across the client population being served.

Examples of **standard patient care protocols** include:

- An algorithm to determine whether medication assisted therapy for opioid addiction is clinically appropriate and if so, whether buprenorphine or methadone is indicated.
- A comprehensive assessment.
- Shared decision-making.
- An individual plan of care for each patient.
- Induction, stabilization, maintenance, and taper protocols for methadone and buprenorphine.
- Taper protocols for methadone and buprenorphine.
- Establishment of written individual self-management and recovery goals and progress tracking.
- Outreach to clients missing from services.

Examples of standard **care management protocols** include:

- Identification and outreach with local health and human service providers to identify individuals in need of *Hub* services, including referral protocols with local hospitals, primary care providers.
- Identification of age and gender appropriate health screenings for *Hub* clients and coordination to assure that these screenings are completed on time.
- Identification of the most common transitions of care experienced by *Hub* clients and proactive management plans to support coordination with key partners in these transitions.
- Employment status of *Hub* clients and coordination of referrals to Vocational Rehabilitation.
- Coordination with probation and parole.
- Reports of *Hub* clients admitted to emergency rooms and inpatient care and follow-up services to reduce length of inpatient stay or ER admissions for ambulatory care sensitive conditions.

Appendix II - Medication Assisted Therapy

This appendix details Vermont's achievements in advancing the policy and system underpinnings for delivering Medication Assisted Therapy as a specialized treatment practice for opioid addicted individuals.

Medication Assisted Therapy Rules (Mat Rules)

Vermont created and promulgated the Medication Assisted Therapy rules in April 2012. The *MAT RULES* are regulatory requirements for practitioners that serve methadone or Buprenorphine for opioid dependent individuals. ADAP will continue to work in partnership with the Vermont Prescription Monitoring System as well as the Vermont Medical Board to interpret and apply the rules as it relates to professional licensing, practice and investigations. These extensive rules can be found at the following link. See http://healthvermont.gov/regs/documents/opioid_dependence_rule.pdf.

The Ten Most Frequently Asked Questions

To supplement the MAT Rules, ADAP developed 10 frequently asked questions (FAQs) for the Vermont Department of Health Substance Abuse website. Both the MAT Rules and FAQs were sent to all participating medical practitioners of the Vermont Prescription Monitoring System and Vermont Medical Practice Board. Below, please find these FAQs. They are currently posted to the Vermont Department of Health's website and can be found at the following link. See http://healthvermont.gov/regs/documents/opioid_dependence_rule_provider_faq.pdf.

Medication Assisted Treatment Rules (MAT)

Frequently Asked Questions for Providers

I am a physician prescribing Buprenorphine in my office; does this rule apply to me?

Any physician with 30 or more MAT patients is responsible for complying with the MAT rules. The rule in its entirety is on the Vermont Department of Health website at:

http://healthvermont.gov/regs/documents/opioid_dependence_rule.pdf.

The 2010 Vermont Buprenorphine Practice Guidelines are available at:

http://healthvermont.gov/adap/treatment/documents/BuprenorphinePracticeGuidelinesFINAL_01-15-2010.pdf.

I have heard that everyone will need counseling, is this true?

All patients must meet with a licensed behavioral health professional for an initial assessment and on-going treatment, as clinically indicated. For further guidance on the role of assessment and counseling in the comprehensive treatment of opioid dependence, please refer to SAMHSA Tip 40 at http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf

What if my patient has more medical needs than I am able to effectively treat, beyond their opioid dependence?

Providers should develop a mechanism for referral and consultation with addiction/obstetrical/ medical/ psychiatric/ and other providers for subspecialty care as needed.

When should I address my expectations with my patient and are there steps I should take before discharging my patient for not meeting expectations?

Provider responses to non-compliance with treatment, on-going illicit substance use, medication diversion and/or other criminal behavior should be addressed, similar to other treatment concerns. This is why all clients are required to sign the treatment consent

forms, upon initiation of treatment. Before discharging patients, attempts to consult with an addiction specialist and/or referral to another treatment provider is preferred. When there will be a break in treatment, if clinically indicated and feasible, patients being discharged should be titrated off from their medications.

What are my responsibilities for managing emergencies with my patients?

Physicians must identify a mechanism for dealing with emergencies after business hours, consistent with their practice with other medical conditions. Examples of this might include: cooperative agreements with local mental health emergency service programs, after hour phone messages directing individuals to call 911, to utilize the local emergency room, or directing patients to an on-call or coverage service.

Can a non-physician provider prescribe from my office?

Consistent with federal statutes, only **physicians** may legally prescribe Buprenorphine within the context of Office Based Opioid Treatment (OBOT). Physicians must obtain informed consent for each new patient.

I have mid-level providers in my office can they have any role in the care of these patients?

Each patient is provided with informed consent for treatment by the physician with appropriate contracts and releases of information signed for each patient and maintained in the patient record. Mid-level providers may intervene with the patient, obtain releases and finalize required treatment contracts however only the waived physician can prescribe Buprenorphine for the treatment of addiction.

I am aware that medication diversion is a concern, is there anything I need to do?

Diversion control strategies should be employed and participation in Vermont Prescription Monitoring System (VPMS) is made mandatory by these rules to help reduce incidence of poly-pharmacy use and/or reduce the potential for medication diversion.

Examples of diversion control strategies include: random pill/medication “strip” counts and random urine toxicology screenings. For information and assistance registering with the VPMS, please contact ADAP at 802-651-1550.

Before starting a patient on MAT, what kind of exam should I conduct?

Physical exam reviewing: health history, identification of other chronic or acute health conditions, current objective measures of health, pregnancy status of female patients, and selected lab work as deemed medically appropriate by the physician and as available given the existing community resources.

Do I need to be concerned with urine drug testing and, if so, what do I do with the results?

Drug testing is required and results reviewed by the physician. Responses should be based upon the principles of addiction medicine.

Further information on the principles of addiction medicine may be located through the American Society of Addiction Medicine at <http://www.asam.org/>.

For further information on urine toxicology testing laboratories, a list is available at:

http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Laboratory_Registry.html.

A list of Clinical Laboratory Improvement Amendments (CLIA) waived office testing products is at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2321CP.pdf>.

If you have questions please call (802) 651-1550 and ask to speak to Tony Folland, State Opioid Treatment Authority.

Appendix III – Performance, Quality and System Effectiveness

The Vermont Department of Health maintains a robust system for ensuring program and system effectiveness. Firstly, it works in partnership with other Agency of Human Service Departments to evolve appropriate health information technology and data management systems. For example, it is working to interface with The Blueprint for Health's Central Clinical Registry, Covisint DocSite in support of comprehensive patient care, including specialized Medication Assisted Therapy. Secondly, the Vermont Department of Health works in partnership with the federal government to measure and monitor quality. And thirdly, it relies on findings from the State Epidemiological Work Group and the Vermont Prescription Monitoring System to track several data sources that relate directly and indirectly to opioid and other substance use/misuse in Vermont. Finally, it ensures effectiveness by working with implementing partners, service providers, grantees and contractors, to define, maintain and monitor key performance and quality measures. The most notable are listed below.

NATIONAL OUTCOMES MEASURES (NOMS)

ADAP collects National Outcomes Measures (NOMS) that are reported to SAMHSA annually as a requirement of the federal block grant. The *Hubs* will routinely report these measures. They are:

- Employment/Education Status – Clients employed or student at admission vs discharge.
- Housing Stability – Clients reporting being in a stable living situation at admission vs discharge.
- Arrests – Clients reporting arrests at admission vs discharge.
- Alcohol Abstinence Among All Clients – Clients with no alcohol use at admission vs discharge.

- Drug Abstinence Among All Clients – Clients with no drug use at admission vs discharge.
- Social Support of Recovery – Clients attending self-help programs at admission vs discharge.

ADDITIONAL PERFORMANCE AND QUALITY MEASURES

Additional performance and quality measures will be incorporated into the *Hub* grants and the *Spoke* agreements and are required as a condition of the Medicaid State Plan Amendment with Centers for Medicaid and Medicaid Services. Results for Medicaid clients (approximately 70% of the opioid treatment population) will be used as a proxy for the system as a whole.

Reduce Avoidable Hospitalization - Clinical Outcomes:

1. All Cause Readmission – number of acute patient stays during measurement year followed by an acute readmission for any diagnosis within 30 days.
2. Ambulatory Care – Sensitive Condition Admission – Age standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years.

Reduce Avoidable Emergency Department Utilization – Clinical Outcomes:

1. Emergency Department Visits – Preventable/ambulatory care sensitive condition emergency department visits.

Improve Management of Chronic Conditions

1. Follow-Up after Hospitalization for Mental Illness – Percent discharged for hospitalization for treatment of selected mental health disorders with visit with mental health practitioner within 7 days.
2. Self Management for any Chronic Condition.

Improve and Increase Use of Preventative Services

1. Adult BMI Assessment – Calculated BMI documentation.
2. Age and Gender appropriate health screenings.

Quality of Care

1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.
2. Alcohol Misuse annual screening.
3. Tobacco cessation screening – receipt of advice to quit smoking.
4. Tobacco cessation screening – receipt of information on smoking cessation medications.

Improve Transitional Care (under development)

1. Care Transition – transition record transmitted to health care professional.
2. Care Transition – Transition Records – receipt of transition record at time of discharge with specified elements.
3. Care Transitions – Receipt of reconciled medication list.

In addition to these measures, the *Hub and Spoke* programs will receive site visits to evaluate the program using National Committee on Quality Assurance standards, and be required to abide by the Division of Alcohol and Drug Abuse Programs (ADAP) Treatment System Program Standards and Rules, and related requirements.