

ASAM Disclosure of Relevant Financial Relationships

Content of Activity: Managing the Medication Assisted Dragon

Date of Activity:8/22/2008

Name	Commercial Interests	Relevant Financial Relationships : What Was Received	Relevant Financial Relationships : For What Role	No Relevant Financial Relationships with Any Commercial Interests
Todd Mandell	None	None	None	None

Glossary of Terms

Commercial Interest - The ACCME defines a “commercial interest” as any proprietary entity producing health care goods or services, with the exemption of non-profit or government organizations and non-health care related companies.

Financial relationships - Financial relationships are those relationships in which the individual benefits by receiving a salary, royalty, intellectual property rights, consulting fee, honoraria, ownership interest (e.g., stocks, stock options or other ownership interest, excluding diversified mutual funds), or other financial benefit. Financial benefits are usually associated with roles such as employment, management position, independent contractor (including contracted research), consulting, speaking and teaching, membership on advisory committees or review panels, board membership, and other activities from which remuneration is received, or expected. ACCME considers relationships of the person involved in the CME activity to include financial relationships of a spouse or partner.

Relevant financial relationships - ACCME focuses on financial relationships with commercial interests in the 12-month period preceding the time that the individual is being asked to assume a role controlling content of the CME activity. ACCME has not set a minimal dollar amount for relationships to be significant. Inherent in any amount is the incentive to maintain or increase the value of the relationship. The ACCME defines “relevant” financial relationships” as financial relationships in any amount occurring within the past 12 months that create a conflict of interest.

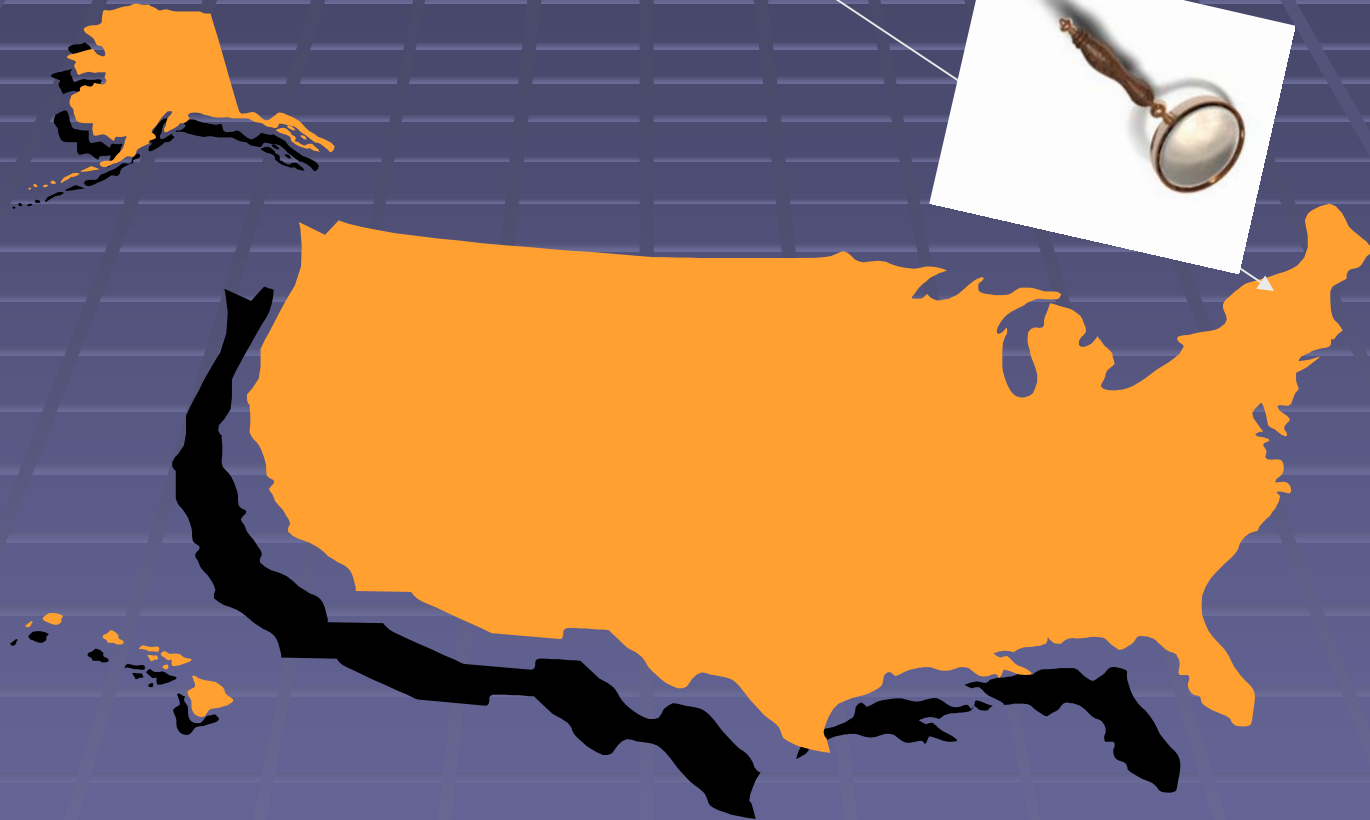
Conflict of Interest - Circumstances create a conflict of interest when an individual has an opportunity to affect CME content about products or services of a commercial interest with which he/she has a financial relationship.

Managing the Medication Assisted Dragon

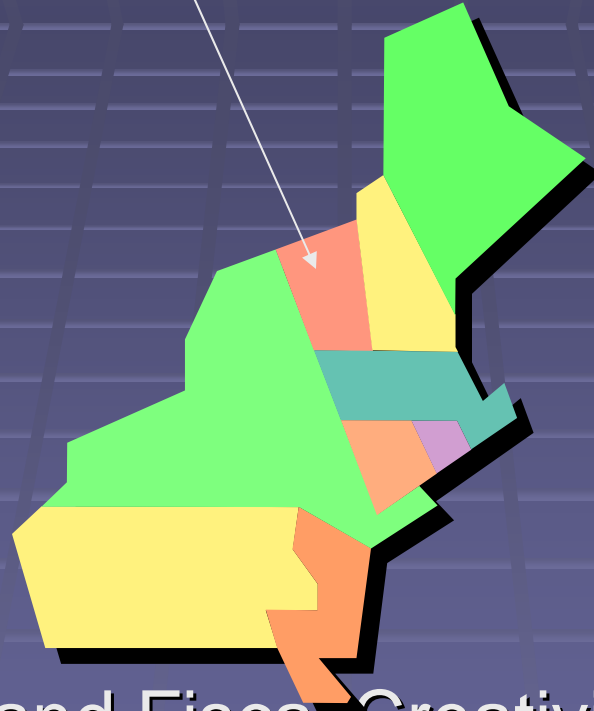
State Systems Development
Program Conference
August 22, 2008

Todd W. Mandell, M.D.
Medical Director; ADAP

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

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

Percent of Total Treatment Population Using Other Opiates or Unprescribed Methadone by FY

Age Group	2000	2001	2002	2003	2004	2005	2006	2007
<18	3.6%	4.7%	6.4%	8.3%	13.3%	11.1%	10.7%	11.8%
18-24	5.1%	6.6%	9.7%	14.6%	18.4%	23.7%	27.9%	31.8%
25-34	5.6%	7.6%	10.6%	14.3%	20.1%	26.4%	32.8%	38.1%
35-44	5.3%	6.3%	7.4%	9.6%	12.4%	15.1%	21.1%	21.0%
45+	3.4%	4.9%	6.7%	7.5%	8.9%	11.3%	13.2%	15.3%
Total	4.8%	6.2%	8.5%	11.6%	15.4%	19.3%	23.4%	26.3%

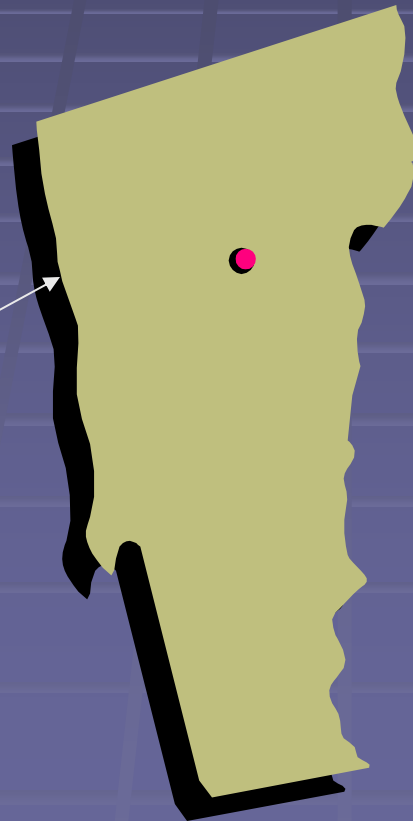
2000	2001	2002	2003	2004	2005	2006	2007
315	451	646	944	1255	1618	2124	2408

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: 215!

Burlington: The
Chittenden Center



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

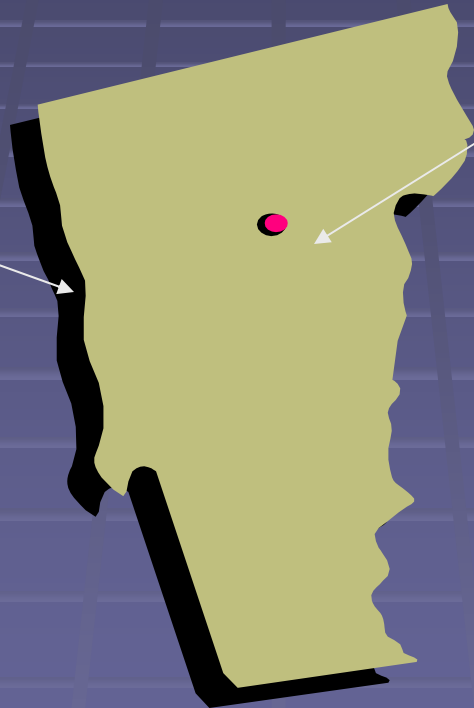
- List serve of waived MD's hosted by Vermont Medical Society
- >80 MDs have obtained waiver through Hybrid Trainings with High satisfaction responses to questionnaires
- Vermont has highest waived MDs per capita in the US: 166 Six have requested waivers to treat 100 patients

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

Induction Center

Chittenden
Center



Induction Center

Central Vermont Substance
Abuse Services: MAT

As of July, 2008

470 patients have been evaluated
400 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

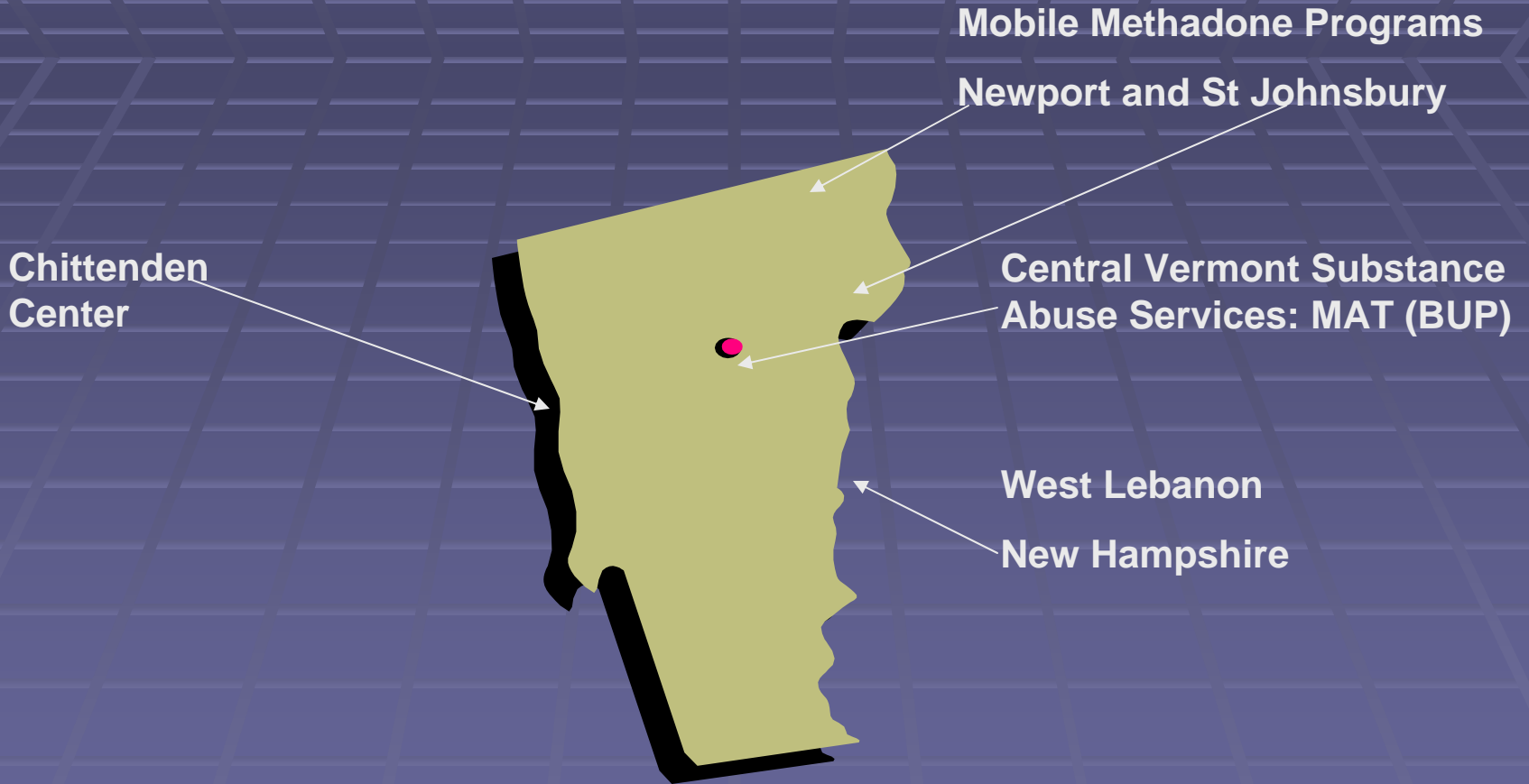


- The law requiring a methadone program to be affiliated with a medical center was allowed to “sun set”
- BAART awarded the grant to provide MAT services – priority being given to those traveling out of state for services
- Two vans that go to dosing sites
- Total Capacity: 150 Medicaid patients and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

Methadone Program Expansion

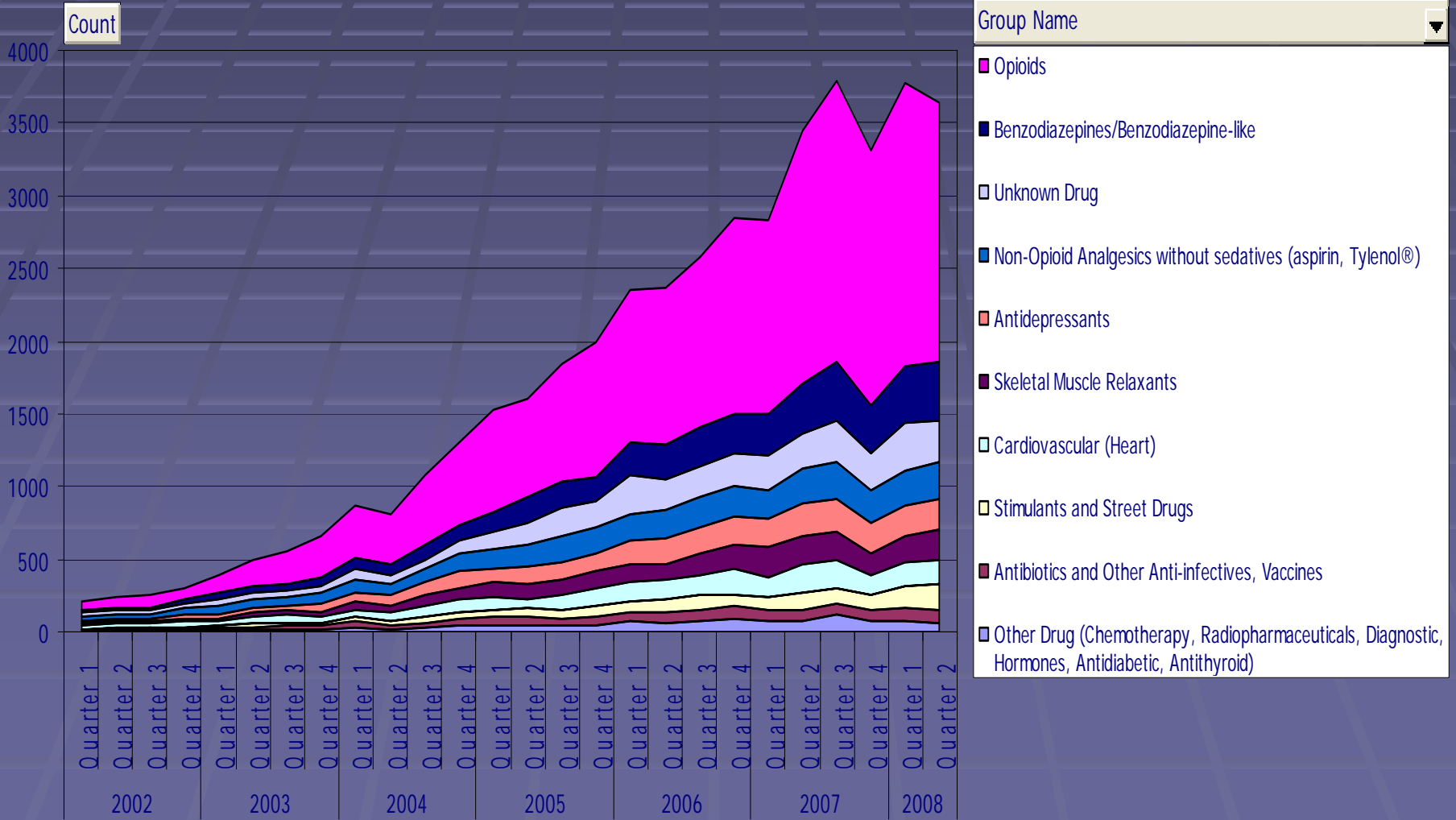
- Free standing program in West Lebanon, New Hampshire (considered a Vermont Provider) 2004

New Treatment Programs



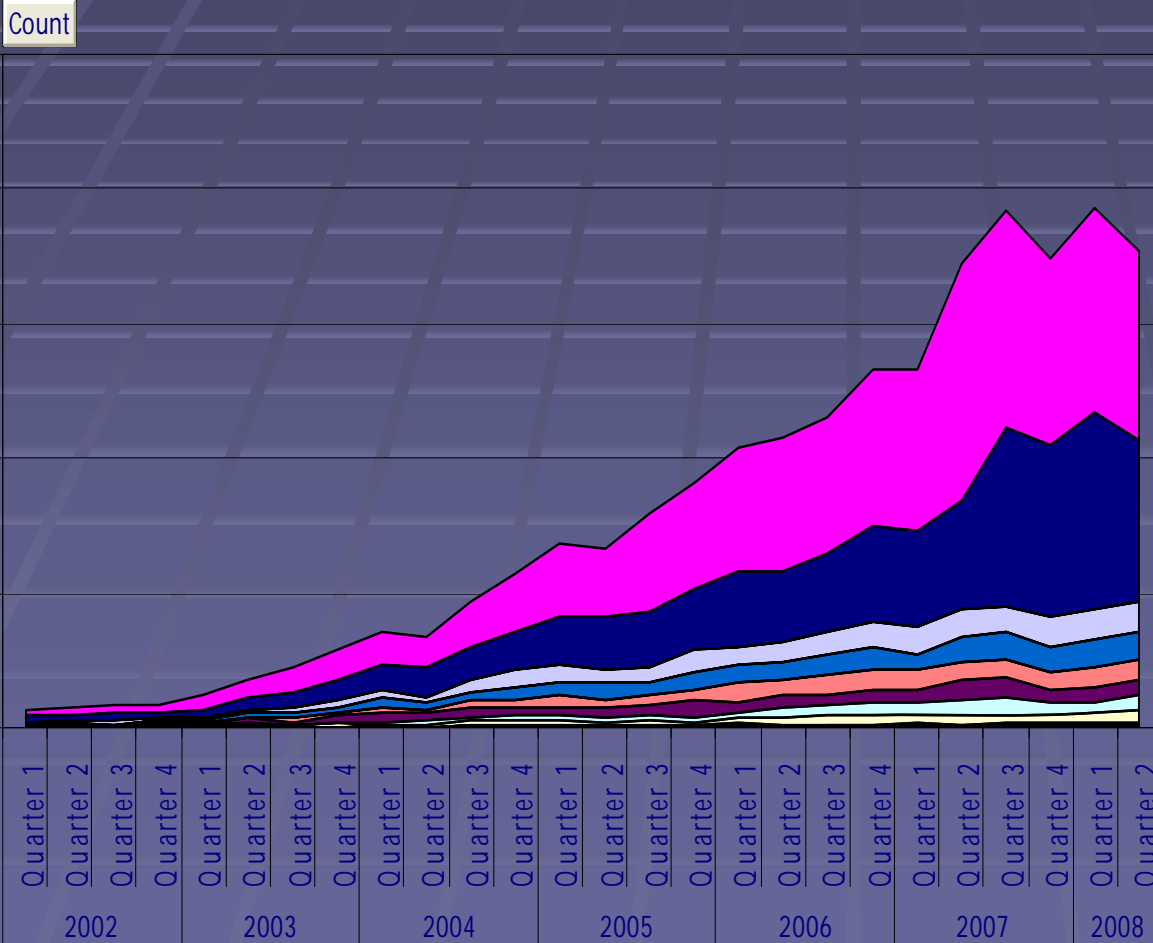
Substance Abuse-Related Questions Vermont - All Questions (Top 10)

Northern New England Poison Center's SASRS Database



Substance Abuse-Related Questions Vermont - Opioids

Northern New England Poison Center's SASRS Database



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 - Buprenorphine (Suboxone®)
- Opioids - Stomach Opioids (Loperamide, Diphenoxylate)

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!**

Have we released a Dragon?



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 waived 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.

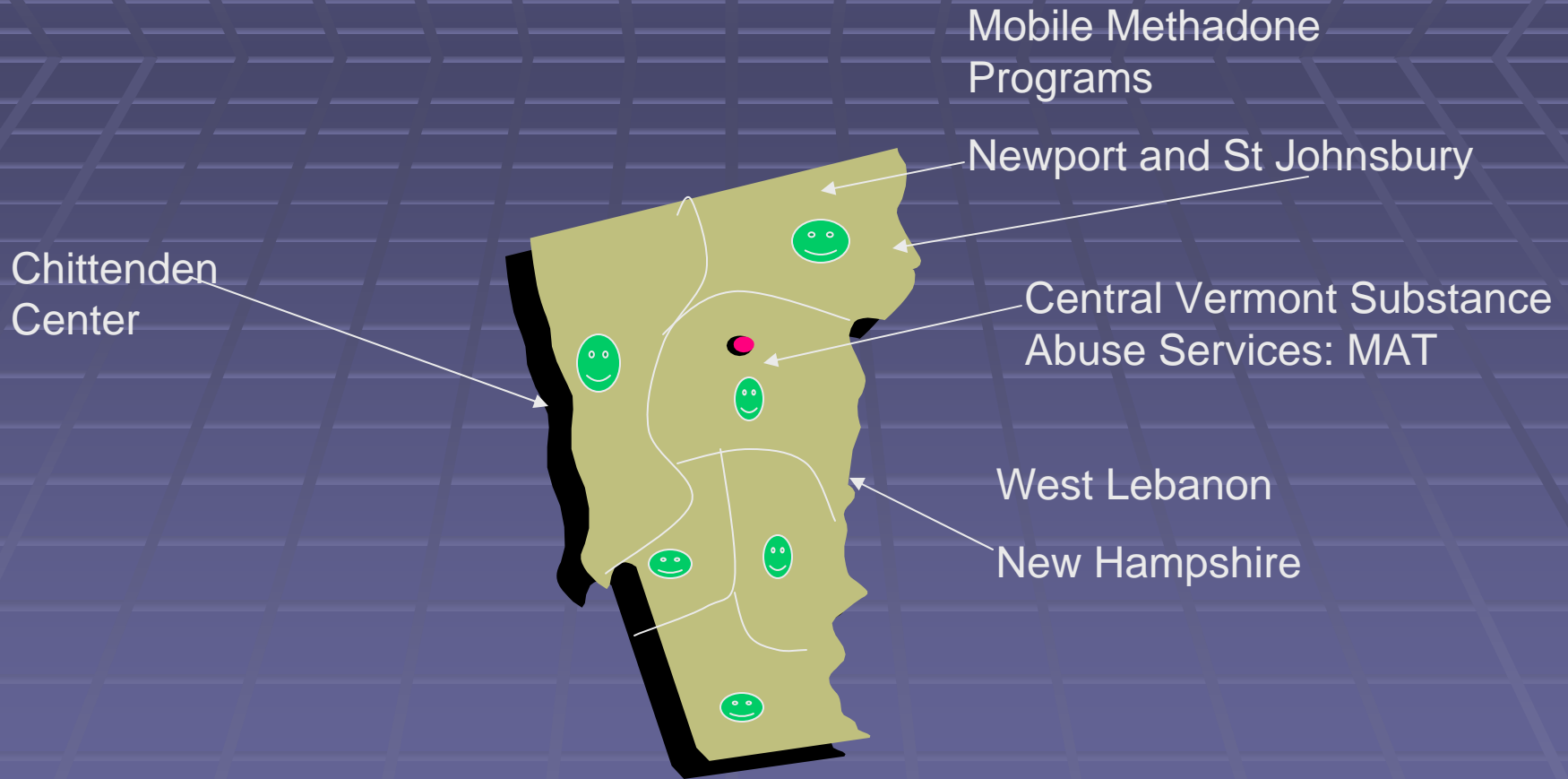
One state wide coordinator

Six regional coordinators

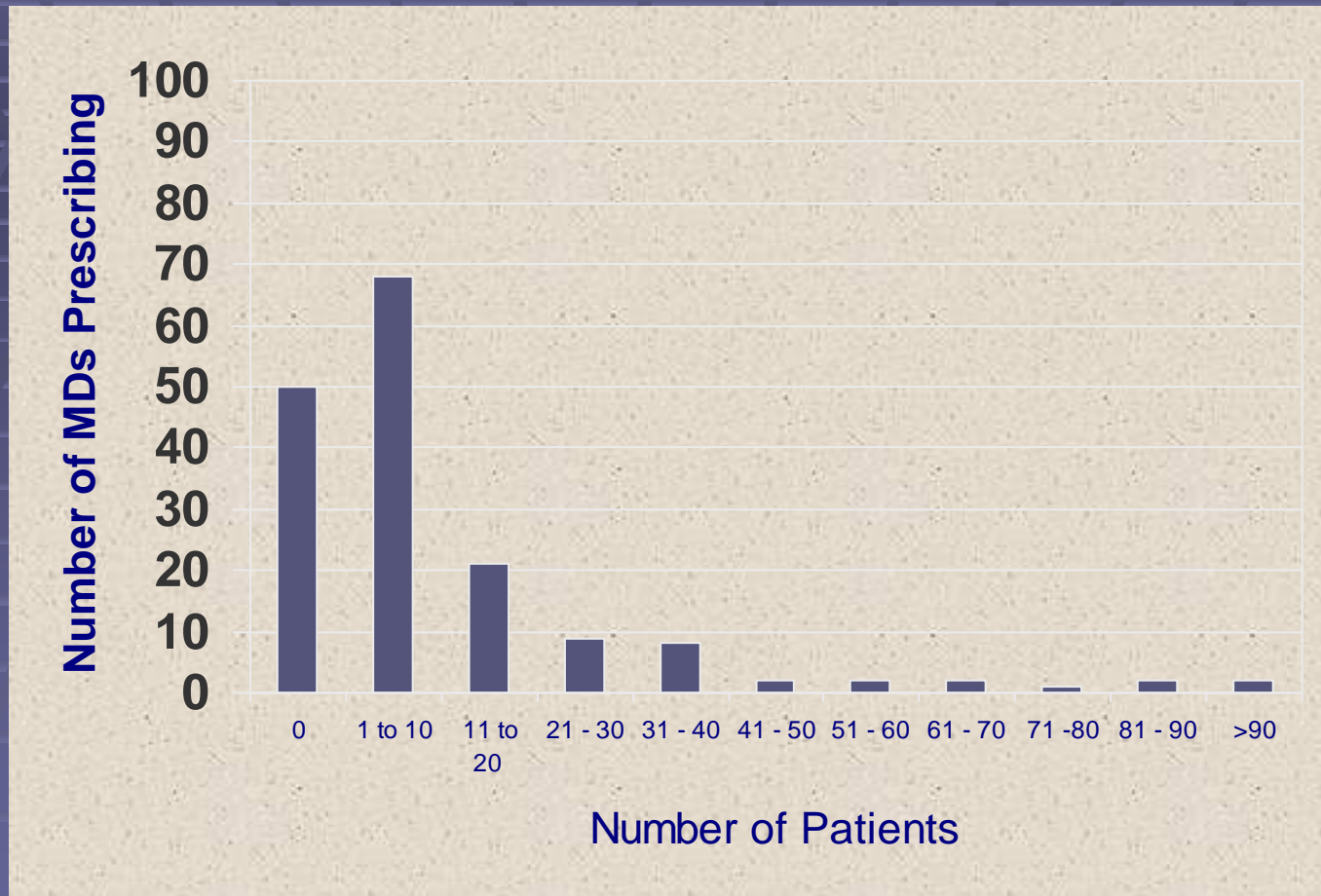
MAT Tool Kit

Start up date: December 1, 2006

COB-MAT Regions



Waivered MD Prescribing Patterns



Number of MDs prescribing for 1 patient – 19
including 3 licensed in New Hampshire

Number of Waivered MDs not prescribing for
Medicaid patients - 50

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 (program ended December 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.

Vermont MAT Services



ADAP and Medicaid Magic

Background:

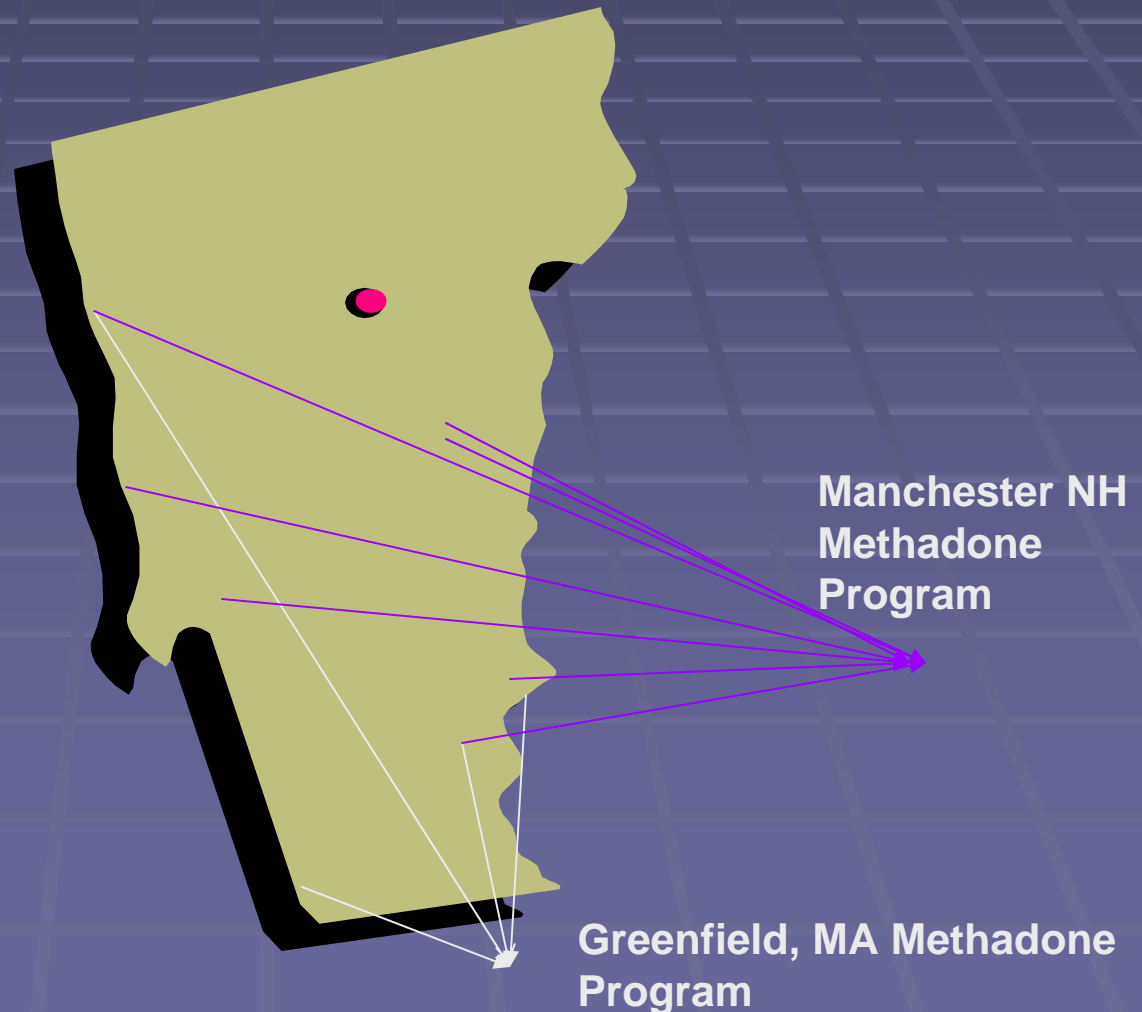
ADAP pays for methadone treatment through Block Grant and General (State) Funds

Medicaid provides funding for travel to treatment

Transportation to out of state methadone programs

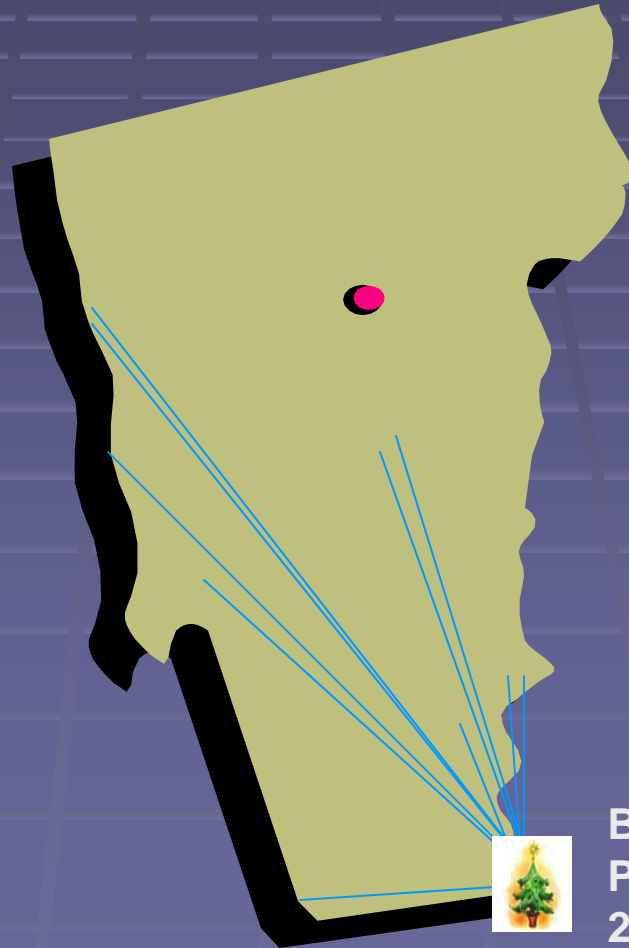
Transportation of 11 patients to out of state clinics:

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



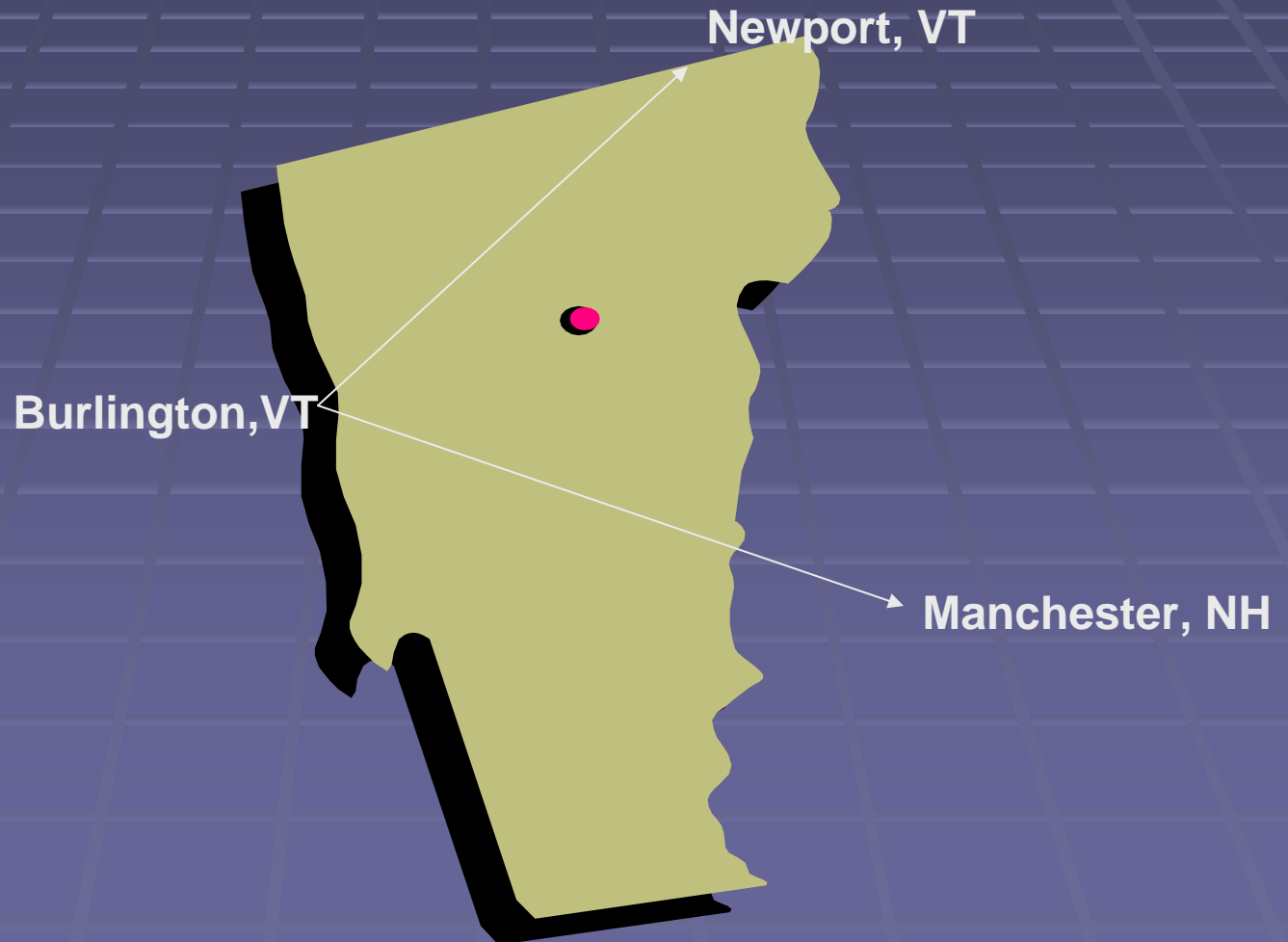
A program in Brattleboro for the same 11 patients would:

- 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



Increase Capacity: save on travel

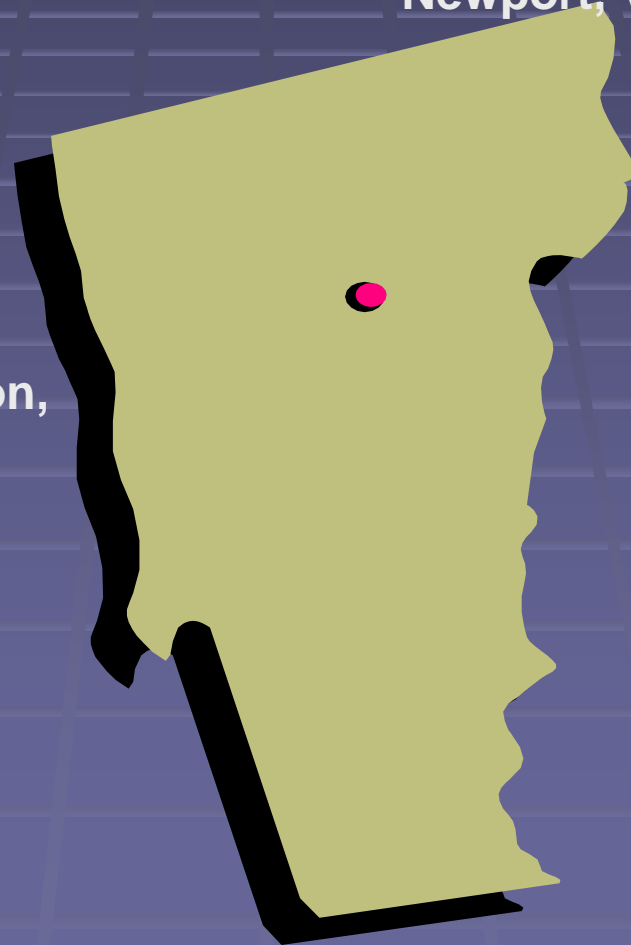
The estimated travel savings for 5 patients traveling from Burlington to Newport, VT or Manchester, NH is ~\$151,000!

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

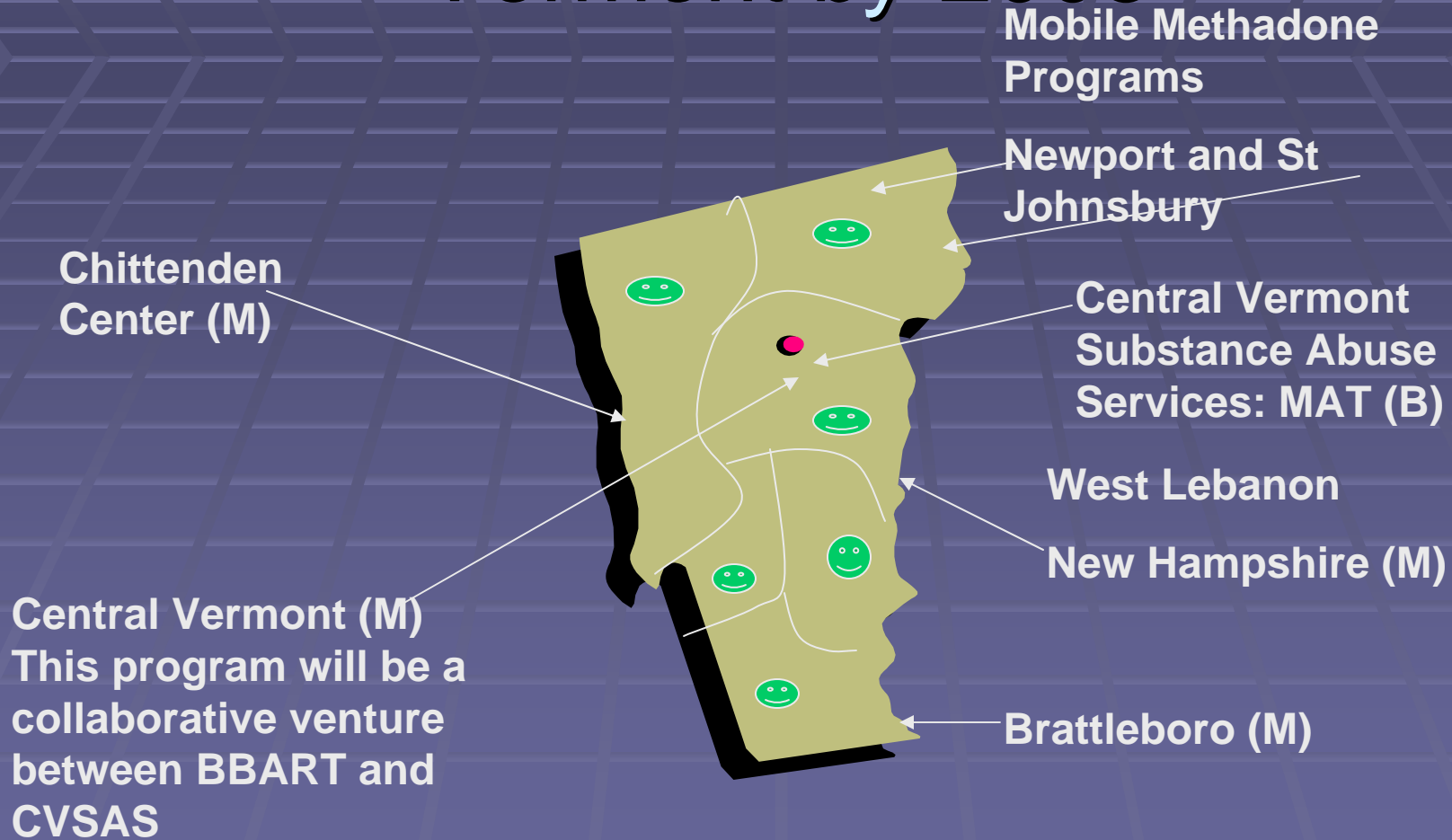
Burlington, VT

Newport, VT

Manchester, NH



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