Report to
The Vermont Legislature

Opioid Addiction Treatment Programs

In Accordance with Act 75, 2013, Section 15a

Submitted to:	**House Committees on Human Services, Health and Judiciary** **Senate Committees on Health and Welfare and on Judiciary**
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Executive Summary

The Commissioners of the Vermont Departments of Health and of Health Access submit this report pursuant to Act 75 (2013), Section 15a, an act relating to strengthening Vermont's response to opioid addiction and methamphetamine abuse. Act 75 was enacted with the intention of providing a comprehensive approach to combatting opioid addiction and methamphetamine abuse in Vermont through strategies that address prevention, treatment, and recovery. As called for in Section 15a, this report describes opioid addiction treatment and recovery services being provided in Vermont and responds to specific questions posed in the Act.

The use of heroin and other opioids is a major public health challenge in Vermont. The health, social and economic consequences of this problem have led to the development of a comprehensive treatment system that responds specifically to opiod addiction. This report describes Vermont's system for treating opiod addiction, and the evolution of that system. The newly implemented Care Alliance for Opioid Treatment, sometimes referred to as the Hub and Spoke System, for delivering Medication Assisted Therapy such as methadone and buprenorphine is described with an emphasis on the care coordination and support that is integral to addiction recovery. This system represents a unique partnership between the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs and the Department of Vermont Health Access's Blueprint for Health.

The report responds to six questions posed in Act 75, Section 15a, with information about service capacity, people served at difference levels of care and data on service waiting lists. The structure of the system as it relates to the coordination of care is addressed as are the continuing challenges for future work. Key to the future challenges is the issue of provider capacity. Vermont is experiencing a shortage of experienced counselors and physicians who are well trained in addiction treatment. The report concludes with plans for future work and action.

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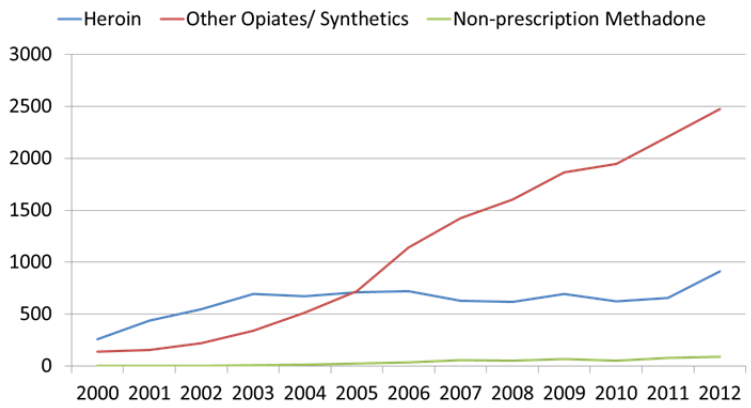
Introduction

The Commissioners of the Vermont Departments of Health and of Health Access submit this report pursuant to Act 75 (2013), Section 15a, *an act relating to strengthening Vermont's response to opioid addiction and methamphetamine abuse.* Act 75 was enacted with the intention of providing a comprehensive approach to combatting opioid addiction and methamphetamine abuse in Vermont through strategies that address prevention, treatment, and recovery. Community safety will also be increased by reducing drug-related crime. The act specifies that, to the extent possible, the initiatives are to be integrated with the Blueprint for Health, Vermont's health care system and health care reform initiatives. As called for in Section 15a, this report describes opioid addiction treatment and recovery services being provided in Vermont and responds to specific questions posed in the Act.

Vermont's Challenge

Vermont had the second highest per capita rate of all states for admissions to treatment for prescription opiates in 2011, with only Maine being higher[i]. The majority (57%) of these admissions were young people 20 to 29 years old.[ii] In 2006, other opiates, including oxycontin and other prescription opioids, surpassed heroin as the primary source of opioid addiction for people receiving treatment at programs funded by the Division of Alcohol and Drug Abuse Programs (ADAP) at the Vermont Department of Health (VDH). However, heroin use increased by more than 35% in 2012. Furthermore, the number of people seeking and in treatment for addiction to other opiates has continued to increase each year (Figure I.). The challenge for Vermont is to develop a service system that has the capacity to respond to opioid dependence and addiction.

Figure 1: Treatment for Opioid Use by State Fiscal Year (Vermont)



Vermont's System of Opioid Addiction Services

ADAP has a multipronged approach to addressing opioid addiction. Programs and services range from regional prevention efforts to recovery at eleven Recovery Centers, with a full array of treatment modalities in between. This system is supplemented by additional components including the monitoring of opioid prescriptions through the Vermont Prescription Monitoring System (VPMS), and, with the Department of Vermont Health Access and Blueprint for Health, the Care Alliance for Opioid Treatment, sometimes referred to as the Hub and Spoke initiative, discussed below. In addition to a range of clinical and support interventions to address addiction, the last decade has seen growth in the use of medications such as methadone and buprenorphine (Suboxone) to treat opioid addiction. A discussion of the role and use of these medications in an evolving treatment system appears below.

Vermont's Addiction, Treatment and Recovery System

ADAP has contracted with 21 agencies making up a preferred provider addiction treatment system for over 30 years. The levels of care provided in this network include outpatient, intensive outpatient, residential and Hub medication assisted treatment (methadone and buprenorphine) services. (See discussion below). Since 2008, ADAP's budget has also funded eleven recovery centers. These centers provide clients an informal network and connection to a variety of recovery resources before and after formal treatment. Some of the services found at these 11 centers are Alcoholics Anonymous, Narcotics Anonymous, jobs postings, recovery coaches and peer support.

Prior to October 2002, medication therapies for opioid addiction treatment were not available through the preferred providers or physicians' offices in Vermont. Individuals requiring methadone treatment were previously treated out of state. In October 2002, the HowardCenter methadone clinic opened with limited state funding; however, at its origin, as today, the demand for services exceeds capacity within the state.

Methadone services were expanded to the Northeast Kingdom in 2005 with BAART (based on the Bay Area Addiction Research and Treatment model) Clinics in Newport and St. Johnsbury. In 2008, BAART Central Vermont began offering methadone services in a Berlin location; and in 2004, HabitOpCo began services in West Lebanon, New Hampshire and later, in Brattleboro in 2007. All of these clinics operated with fixed "caps" on the number of people they could serve. The capacity was determined by funding allocated through the state budgeting process. In May 2013, these caps were removed to increase service capacity.

Simultaneously, Congress passed the Federal Drug Addiction Treatment Act (DATA) of 2000. This legislation provided a process for physicians to prescribe Schedule III narcotics (buprenorphine, also known as Suboxone) for the office-based treatment of opioid dependence. In late 2003 and early 2004, buprenorphine became available for Vermont physicians to treat individuals in office- based settings. Subsequent changes to DATA 2000 allow physicians to prescribe buprenorphine for up to 30 patients in their first year and up to 100 patients beginning in a second year of practice.

Throughout the last decade, ADAP and Vermont's Medicaid program partnered to support Vermont physicians in prescribing buprenorphine in office-based programs. The number of prescribing providers expanded rapidly in Vermont, and by 2010, over one hundred and fifty Vermont physicians prescribed buprenorphine, often to very small numbers of patients (ten or fewer). Because any physician who obtains a waiver under DATA 2000 can prescribe, the Vermont buprenorphine prescribers reflected different specializations including primary care, pediatrics, Ob-Gyn, orthopedists, and psychiatry. In 2010, Vermont physicians prescribed more buprenorphine per capita than any other state in the United States (SAMHSA 2010).

Despite Vermont's continued development of methadone capacity and the rapid expansion of office based opioid treatment (OBOT), the demand for medication for treatment continued to exceed capacity. VDH/ADAP and DVHA continued to partner on improving access to care and improving the quality of care by developing treatment guidelines, and, in 2010, adopting a rule to regulate prescribers with larger practices (30 or more patients).

In 2012, DVHA created a substance abuse unit to manage high risk patients with substance use disorders. This unit provides a single point of contact for prescribers, pharmacists, and Medicaid beneficiaries. The substance abuse unit also coordinates with the Vermont Chronic Care Initiative on behalf of high-cost beneficiaries, assists in management of the Medicaid pharmacy benefit and supports the prior authorization process for buprenorphine treatment. In the spirit of collaboration, this unit has regular contact with ADAP.

Implementation of the Care Alliance for Opioid Treatment

In 2013, implementation of the Care Alliance for Opioid Treatment, also known as the Hub and Spoke initiative began. This unique partnership between ADAP and the DVHA/Blueprint for Health is designed to expand the capacity of both the methadone programs and office-based treatment services for buprenorphine by creating a coordinated, systemic response to the complex issues of opiate and other addictions in Vermont. Integral to this system is the delivery of Medication Assisted Therapy (MAT). The definitions of MAT and other key components of the system follow:

> **Medication Assisted Therapy (MAT)** is the use of medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of opioid addiction. Research shows that when treating substance use disorders, a combination of medication and behavioral therapies is most successful. MAT in Vermont is delivered through an integrated treatment model, called the Care Alliance for Opioid Treatment, or Hub and Spoke, and relies on the strengths of the specialty methadone addiction treatment clinics, the physicians who prescribe buprenorphine in office-based settings, and the local Blueprint Community Health Teams and Medical Home infrastructure. This model consists of Hubs and Spokes described below.

HUB is a regional opioid treatment center responsible for coordinating care and support services for patients who have complex addictions and co-occurring substance abuse and mental health conditions. Patients who need methadone must be treated here due to federal regulatory requirements. Patients who need buprenorphine may be treated at a hub or may be treated in an office based practice, depending on their clinical profile and addiction history. Vermont's five regional Hubs, and seven Hub dispensing sites, will replace the state's former methadone clinics. Hubs serve as the regional consultants and subject matter experts on opioid dependence and treatment. The Hubs enhance the capacity of methadone treatment programs by supporting increased caseloads, implementing a health home framework to collaborate with health providers, and dispensing buprenorphine in addition to methadone. In addition, the Hubs provide consultation and support to the office-based physicians (Spokes), essentially linking the two previously separate systems of care.

Spoke is a team of health care professionals providing ongoing care for patients receiving buprenorphine in Office Based Opioid Treatment Programs (OBOT). The Spoke system provides buprenorphine MAT to patients who are less clinically complex than the patients who must receive buprenorphine in the Hubs. Using the Blueprint patient-centered medical homes and community health team infrastructure, nursing and clinical staff with expertise in opioid addiction treatment are embedded with the physicians who prescribe buprenorphine in Spokes. The team of collaborating health and addictions professionals monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency management, and case management services. This enhanced staffing is modeled at one FTE RN nurse and one FTE licensed addiction/mental health clinician case manager for every 100 MAT patients; these professionals work with a prescribing physician. As part of the Blueprint Community Health Teams, these new staff help drive integration of services between substance abuse treatment providers and primary care.

While this Hub and Spoke design focuses primarily on individuals with opiate addiction, it offers a regional framework to support and improve the capacity of the health care and addictions

treatment systems to provide a more holistic approach to health care for individuals with other addiction and mental health conditions. In addition to providing addiction treatment services to Vermonters, this treatment approach is expected to reduce recidivism in the corrections system and enhance outcomes for families where addiction is an identified problem for child welfare.

Responses to Questions in Act 75, Section 15

The following responds to the six questions posed by Act 75, Section 15a:

1. ***What is each program's capacity, including the number of persons currently served and the program's maximum capacity?***

   Figure 2 presents data on the caseload of various levels of care in the treatment system. Outpatient and Intensive Outpatient (OP/IOP) services are the most commonly used and lowest level of care in the addictions treatment continuum. They are the most appropriate level of care for the majority of people accessing the treatment. The OP/IOP services are available in every county but are often limited by shortages of professionals trained in addiction treatment. For those requiring more intensive services, there are four residential facilities that serve clients statewide. Sixty percent of clients receiving residential treatment in SFY 2012 also used opioids. The level of care is dictated by not only availability but by the American Society of Addiction Medicine Patient Placement Criteria-2 Revised (ASAM PPC-2R) criteria as determined by a comprehensive biopsychosocial assessment.

   The capacity of the opioid treatment system via the Care Alliance for Opioid Treatment increased through SFY13 with the addition of Spoke nurses and clinicians, case load expansion at the existing Hubs, and the opening of a new regional Hub in Rutland. By January 2014 all Hubs will provide buprenorphine treatment and will have linkages to spokes.

Figure 2: Caseload by Level of Care and Substance Use Category

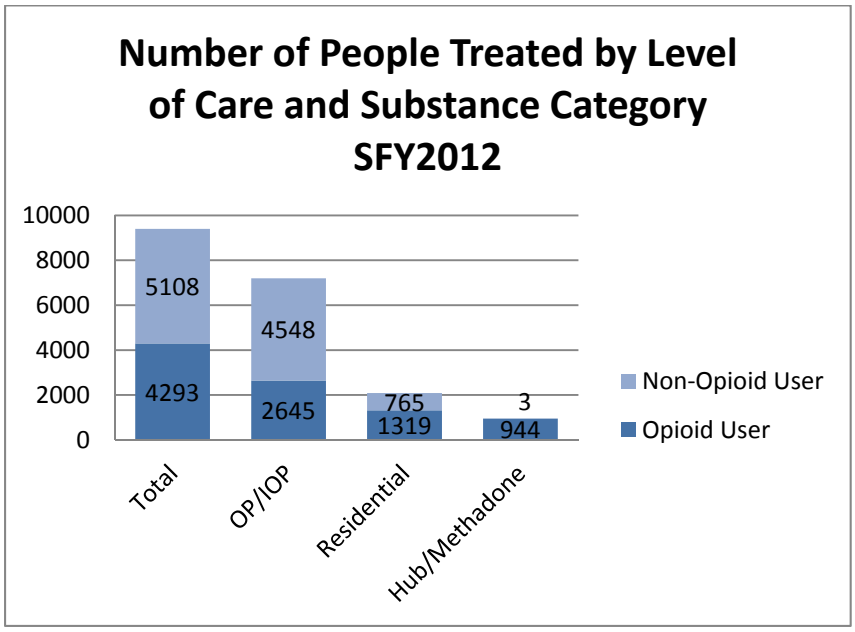


Table I summarizes the caseload in each of the methadone treatment facilities, or regional Hubs, on October 1, 2013. The total current caseload as shown is 1,482 individuals served. This is a significant expansion over the previous year. In SFY 12 the Hub programs served 804 clients. In addition, a new Regional program serving Rutland and Bennington counties opened in early November 2013.

Table I: Individuals Served -- Regional Hubs and Current Caseload on 10/13

Regional Hubs	**Caseload**
Chittenden Center – Chittenden/Franklin/Grand Isle/Addison Counties	592
Habit Opco/Brattleboro Retreat – Windham/Windsor Counties	411
BAART – Washington/Lamoille/Orange Counties	148
BAART – Caledonia/Orleans/Essex Counties (scheduled to convert to a Hub 1/2014)	296
Rutland Regional Medical Center – Rutland/Bennington Counties	35
Total current caseload	**1482**

With the development of the Hub and Spoke system of care, the only limit on the number of patients served will be due to workforce capacity issues. Recruiting well-trained and experienced addiction counselors and physicians to work in the system is an ongoing challenge. Consistent with health care services, the Hub programs will serve clinically eligible Vermonters with no limits on the caseload as long as the staffing capacity is adequate in the Hubs and Spokes. A statewide workgroup has been charged with implementing a strategic plan for ensuring adequate healthcare workforce capacity as part of health reform.

2. **How many people are on the waiting list for each program, if applicable, and what is the average length of time a person spends on the program's waiting list before services become available**

Act 50, the Appropriations Bill of 2013, Section E.313, calls for VDH to compile and maintain an unduplicated count of individuals who need substance abuse treatment. Work is underway to create more uniform waitlist reporting protocols across the substance abuse treatment system to:

- eliminate duplicate counts,
- ensure the appropriateness of being placed on a formal waitlist (via an assessment),
- distinguish between those seeking services and/or in need of an assessment but not yet waiting, and
- establish a common time frame for reporting

Table II presents current waitlist data for Vermont. The waitlist is based on reported counts from treatment providers identifying individuals seeking services for substance abuse treatment when appropriate treatment slots are not available and service capacity has been reached. ADAP is in the process of developing a policy that will standardize the waitlist definition across the system and develop processes to insure that individuals are on the appropriate program waitlist based on their level of care needs and geographic residence.

The estimated wait time for OP/IOP services is one to two weeks. There is access to residential services within three to five days at Valley Vista and Serenity House and within two weeks at Maple Leaf Farm. Wait time to access to MAT/Hub services is reported as two weeks or less with the exception of the Northwest Hub (Chittenden Center) where access to

service is currently estimated at twelve to eighteen months due to the delayed opening of the new center and lack of an adequate number of Spoke physicians to accept patients transferring from the Hub.

Table II: Current Waitlist by Provider and Program Type October, 2013

County	Provider	People Waiting
OP/IOP Statewide		
Addison	Counseling Services of Addison County	5
Bennington	United Counseling Service	0
Chittenden	Day One	0
	HowardCenter Mental Health & SA Services	4
	HowardCenter Centerpoint Adolescent Treatment Services	0
	Lund Family Center	10
	Spectrum Youth and Family Services	5
Franklin/ Grand Isle	HowardCenter	1
Lamoille	Behavioral Health and Wellness Center	0
Orange/ Windsor	Clara Martin Center	0
Orleans/Essex/ Caledonia	Northeast Kingdom Human Services	6
Rutland	Evergreen Services	0
Washington	Central Vermont Substance Abuse Services	0
	Washington County Youth Services	0
Windham/ Windsor	Health Care & Rehab Services	0
	Starting Now	6
OP/IOP Statewide Total		**37**
Residential Statewide		
	HowardCenter Act One/Bridge	56
	Maple Leaf Farm	93
	Valley Vista	8
	Serenity House	2
	Dublin –Phoenix House	2
Residential Statewide Total		**159**
Hubs		
Chittenden/Franklin/Grand Isle/Addison	The Chittenden Center	903
Rutland/Bennington	Rutland Regional Medical	0
Orleans/Essex/ Caledonia/ Washington	BAART Behavioral Health Services	91
Windham/ Windsor/Lebanon	Habit OpCo	0
HUB Statewide Total		**994**
Total Waitlist Statewide		**1190**

It is expected that the Care Alliance for Opioid Treatment will alleviate pressure on the broader treatment system by providing specialized services for high-risk opioid dependent individuals. This will reduce the need for residential services. Additionally, the federal grant for Screening, Brief Intervention, and Referral to Treatment (SBIRT) recently awarded to VDH/ADAP will establish screening and early intervention protocols and processes to identify and intervene with high-risk substance users before the individual becomes addicted to the substance. This intervention has the potential to further reduce pressures on the treatment system by addressing emerging substance use problems before the individual becomes addicted to the substance.

3. **Provide specific information regarding the number of persons served by each program that uses buprenorphine, buprenorphine/naloxone, or methadone for the treatment of opioid addiction and the number of persons on the waiting list for that program, if any.**

   Hubs began to dispense buprenorphine in the past year. This improves access to care for individuals who benefit from the more intensive services of an opioid treatment program and facilitates the movement of patients between Hubs and Spokes. As the Hub and Spokes are coming on line, this allows for treatment that meets the clinical needs of the presenting patient. If a individual does not require intensive Hub services and can have their MAT needs met in a Spoke, they will. Conversely, individuals with more intensive needs will have them met at a Hub.

Table III: Hub Caseload and Clients Receiving Buprenorphine (October 2013)

Regional Hub Programs	Total Served	Receiving Buprenorphine
Chittenden Center – Chittenden/Franklin/Grand Isle/Addison Counties	592	147
Habit Opco/Brattleboro Retreat – Windham/Windsor Counties	411	51
BAART – Washington/Lamoille/Orange Counties	148	45
BAART – Caledonia/Orleans/Essex Counties (scheduled to convert to a Hub 1/2014)	296	49
Rutland Regional Medical Center – Rutland/Bennington Counties (scheduled to open 11/2013)	0	0
Total	**1,447**	**292**

There are 108 Spoke physicians treating an estimated 1,750 Medicaid recipients with buprenorphine. Table IV presents the number of providers by county and the number of Medicaid beneficiaries they serve.

Table 4: Buprenorphine Providers, and Medicaid Beneficiaries by Region, 2013

Region	Providers	Medicaid Beneficiaries
Bennington	6	131
St. Albans	7	236
Rutland	5	206
Chittenden	12	352
Brattleboro	6	237
Springfield	3	41
Windsor	1	56
Randolph	3	78
Barre	8	198
Lamoille	6	117
Newport & St. Johnsbury	3	98
Total	57	1,750

Table Notes: Beneficiary count based on pharmacy claims May-July 2013. Provider count based on MD's prescribing 10 or more Medicaid beneficiaries.

4. **Provide specific information about the implementation of the Hub and Spoke Opioid Integrated Treatment Initiative, including a description of specialty addiction treatment programs and general medical practices currently providing medication-assisted**

treatment (MAT) and the number of persons currently being served in specialty addiction treatment programs and in Blueprint primary care practices toward a goal of reducing current waiting lists statewide by 90 percent by January 15, 2015.

Implementation of the Care Alliance for Opioid Treatment began in January 2013 with the Northwest Hub (Chittenden, Franklin, Addison and Grand Isle Counties). Spoke staffing was also put in place in Bennington, Rutland, Chittenden, Franklin, and Grand Isle counties. In July, 2013 the Central Vermont and Southeast Vermont Hubs began services. The Spoke staff were also recruited in Lamoille, Washington, Orange, Windsor, and Windham counties to support the Hubs in these regions.

The West Ridge Center for Addiction Recovery Hub (Rutland Regional Medical Center), serving Rutland and Bennington counties, opened on November 6, 2013. The final phase of implementation will begin in January 2014 with the Northeast Hub and Spoke staffing serving Caledonia, Essex, and Orleans counties.

Strategies to decrease the number of people waiting for services are addressed in the responses to question 2, and information about the number of people receiving Hub and Spoke services is summarized in the answer to question 3.

5. **How are opioid addiction treatment services integrated with existing recovery and counseling programs in Vermont?**

For patients with opioid addiction who are served in a Hub, Hub personnel coordinate care across all levels of substance abuse treatment. When a patient is served in a Spoke, the nurse and clinician assist the prescribing physician to provide outpatient treatment services and coordinate other necessary care. Coordination of care is included as one of the Health Home services provided through the Care Alliance for Opioid Treatment model.
Care, including recovery services, is coordinated along a continuum,. The formal link between Hubs and recovery centers will be enhanced because the recovery network has recently been awarded a Federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant to establish and strengthen the links between Hubs, peers,

recovery centers, and spoke providers. Since the fall of 2012, the Blueprint and ADAP have partnered with Dartmouth College and Medical Center to provide a series of Learning Collaboratives to improve care, measure practice against evidence based benchmarks, and creates statewide MAT care networks.

6. **What are the Department of Health's plans for addressing the need for additional opioid addiction treatment programs? Describe the resources that the Department would need to meet the statewide demand for specialty services, continued barriers to treatment and workforce needs?**

   The following are some of the remaining system and policy issues that need to be addressed to ensure that individuals with opioid dependence can gain full access to opioid treatment services in Vermont:

   1. Achieving appropriate staffing levels at Spokes is difficult because of workforce shortages of well-trained physicians and substance abuse counselors. As a result, stable clients who should move smoothly from a Hub to a Spoke cannot.
   2. The delayed opening of the Howard Center's Chittenden Center has led to persistently high waitlists for Chittenden/Franklin/Grand Isle/Addison residents.
   3. Not all payers cover all Hub services. Medicare, for instance, will not cover substance abuse treatment at specialty treatment facilities. Private insurers sometimes pay but at lower levels for reduced services. Similarly, no other payers are participating in supporting Spoke staffing costs. The Department of Health is submitting a proposal to the Green Mountain Care Board for a payment reform pilot with the private insurers to include Hub and Spoke services as covered services.
   4. There are uncertainties around the implementation of health reform, especially determining the level of substance abuse treatment coverage in benefit plans.
   5. The Preferred Provider system, including Hubs, has had difficulty hiring staff to fill clinical positions.

ADAP has hired an individual to oversee the implementation and operation of the Hub system. This position was funded in the FY13 VDH budget. ADAP plans to address the issues above include the following:

1. Optimize the Hub system by transferring clients currently traveling long distances for service to newly opened Hubs or to Hubs with expanded capacity. This will decrease Medicaid transportation costs while improving quality of life for these clients.
2. Increase Spoke capacity through the provision of education and training as well as development of further incentives to increase the number of physicians prescribing buprenorphine.
3. Explore the feasibility of adding a new Hub in Franklin/Grand Isle counties to serve the northern NW region.
4. Develop a mechanism for physicians who are affiliated with the Hub and Spoke system to provide methadone to people in need of opioid treatment (per Act 75, Sec. 14b).
5. Work with third party insurers and the Green Mountain Care Board to align payment structures with Hub programming.
6. Investigate use of generic tablet form of buprenorphine for uninsured clients in the Hubs to decrease medication costs for uninsured clients.
7. Determine the feasibility of adding more outpatient programs and/or Licensed Alcohol and Drug Abuse Counselors to the system to increase the accessibility of specialty addiction services. This should be considered in the larger context of health care reform.
8. Expand outpatient treatment capacity to address addiction issues earlier in the process, before they need specialty treatment services at Hubs, Spokes, or residential treatment facilities. This will be explored through the Screening, Brief Intervention, and Referral to Treatment (SBIRT) federal grant described above. Another option is to allow private practitioner Licensed Alcohol and Drug Counselors (LADCs) to bill for services provided to Medicaid recipients whom the current Medicaid state plan does not allow. This is being explored between VDH and DVHA.
9. Support workforce development efforts to enhance the skills of clinicians and bring more people into the substance abuse treatment workforce. Ensure that this workforce group is addressed in health care reform efforts.
10. Work is underway in response to Act 75, Section 14b, to study and determine how Vermont can further increase access to opioid treatment, including methadone and buprenorphine through the use of *hublets* located in surrounding counties of the five Hubs.

Conclusion

Vermont has responded to the need to expand services and transform the way treatment is delivered statewide, particularly around methadone, buprenorphine, and office- based opioid treatment. These system and service expansions are being implemented in collaboration with key players to insure integration with health reform, and continuity across both the substance abuse treatment and health care systems. The progress is encouraging, yet there are remaining system issues to address. One of the most significant challenges is reaching an adequate statewide staffing capacity of professionals trained in addiction treatment. Resolving these issues to improve access to effective treatment will continue to be a high priority.

Endnotes

[i] Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 10.10.11.

[ii] Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 10.10.11.