Report to
The Vermont Legislature

The Effectiveness of Vermont's System of Opioid Addiction Treatment

In Accordance with Act 135 (2012),
***An Act Relating To the Treatment of Opioid Addiction,* Section 1**

Submitted to:	**House Committees on Human Services** **House Committee on Health Care** **Senate Committees on Health and Welfare**
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Report Date:	**January 15, 2015**

VERMONT
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Act 135 (2012), Section 1
January 15, 2015

Executive Summary

The Commissioner of the Vermont Department of Health submits this report pursuant to Act 135 (2012), *An Act Relating To Vermont's Treatment Of Opioid Addiction*. Act 135 was enacted with the intention of establishing a regional system of opioid treatment in Vermont. As called for in Section I of Act 135, this report describes the effectiveness of opioid addiction treatment services currently being provided in Vermont.

The use of heroin and other opioids has been identified as a major public health challenge in Vermont. The potential health, social, and economic consequences of this problem have led to the development of a comprehensive treatment system, the Care Alliance for Opioid Addiction, which is focused on effective, coordinated and supported care for opioid addiction. Specializing in the treatment of complex addiction, the regional centers (Hubs) provide intensive treatment to patients and consultation support to medical providers (Spokes) treating patients in the general practice community.

Implementation of the hub component of the system was completed with the addition of the Northeast Kingdom sites on 1/1/14. One of the primary goals of this initiative was to increase access to medication assisted treatment. Highlights of the progress made since January 2013 include:

- A new hub facility has opened in Rutland.
- Care has become more comprehensive with the addition of supportive health home services.
- The number of people receiving care has increased by more than 40%.
- The majority of those receiving treatment remain in treatment longer and those who remain on treatment for more than 90 days show improved overall functioning at discharge.

A full evaluation which will include an analysis of treatment outcomes as well as estimates of cost savings associated with the Care Alliance initiative is expected to be complete in late 2015.

The Department of Vermont Health Access (DVHA) and the Vermont Department of Health (VDH) continue to collaborate on solutions to the remaining challenges observed within the system of care. These include Vermonters waiting for Medication-Assisted Therapy, lack of Medicare payment for services in specialty providers, the sensitivity of the population seeking services to out of pocket costs, and the lack of workforce with the necessary specialized training and skills.

The Effectiveness of Vermont's System Of Opioid Addiction Treatment January, 2015

Overview/Background

Vermont's Act 135 established a regional system of treatment for opioid addiction in Vermont. In accordance with this act, the Commissioner of Vermont Department of Health must report on the effectiveness of this system of care per Section 1.

The use of heroin and other opioids has been identified as a major public health challenge in Vermont. The potential health, social, and economic consequences of this problem have led to the development of a comprehensive treatment system that is focused on opioid addiction. This report describes Vermont's system for treating opioid addiction.

Vermont has a multipronged approach to addressing opioid addiction that includes multiple community partners. Programs and services include regional prevention efforts, drug take back programs, intervention services through the monitoring of opioid prescriptions with the Vermont Prescription Monitoring System (VPMS), recovery services at eleven Recovery Centers, overdose death prevention through the distribution of Naloxone rescue kits, and a full array of treatment modalities of varying intensities.

Methadone and buprenorphine are medications used to reduce cravings for opioids (e.g., heroin, prescription pain relievers, etc.), thereby allowing patients the opportunity to lead normal lives. Medication assisted treatment (MAT) was originally developed because detoxification followed by abstinence-oriented treatment had been shown to be unsuccessful in preventing relapse to opiate use. Methadone has been used in this capacity since 1964; buprenorphine was approved for addiction treatment in 2000. Methadone is dispensed only in specialty treatment facilities; buprenorphine can be prescribed by physicians who attain a special license in a general medical office setting.

There is clear evidence of a high level of effectiveness for medication assisted treatment using either methadone or buprenorphine.[1] Medication assisted treatment outcomes include: abstention from or reduced use of illicit opiates; reduction in non-opioid illicit drug use (e.g., cocaine); decreased criminal behavior; and decreased risk behavior linked to HIV and hepatitis C.

Three partnering entities - the Blueprint for Health, the Clinical Operations units of the Department of Vermont Health Access, and the Vermont Department of Health Division of Alcohol and Drug Abuse Programs - in collaboration with local health, addictions, and mental health providers are implementing a statewide treatment program. Grounded in the principles of Medication Assisted Treatment[2], the Blueprint's health care reform framework, and the Health Home concept in the Federal Affordable Care Act, the partners have created the Care Alliance for Opioid Treatment, often referred to as the Hub & Spoke initiative. This initiative:

- *Expands access to Methadone treatment* by the opening of a new additional methadone program in the Rutland area and supporting providers to serve all clinically appropriate patients. Vermont now has 5 Hubs, with 8 sites, for treating people with methadone.

- *Enhances Methadone treatment programs (Hubs)* by augmenting the programming to include Health Home Services to link with the primary care and community services, provide buprenorphine for clinically complex patients, and provide consultation support to primary care and specialists prescribing buprenorphine

- *Embeds new clinical staff (a nurse and a Master's prepared, licensed clinician) in physician practices that prescribe buprenorphine (Spokes)* through the Blueprint Community Health

[1] *Assessing the Evidence Base Series* is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The goal of the AEB Series is to provide a framework for decision makers to build a modern addictions and mental health service system for the people who use these services and the people who provide them. The framework is intended to support decisions about the services that are likely to be most effective.

[2] Medication Assisted Treatment (MAT), the use of medications, in combination with counseling and behavioral therapies, is a successful treatment approach and is well supported in the addictions treatment literature. The two primary medications used in conjunction with counseling and support services to treat opioid dependence are methadone and buprenorphine. MAT is considered a long-term treatment, meaning individuals may remain on medication indefinitely, akin to insulin use among people with diabetes.

Teams (CHTs) to provide Health Home services, including clinical and care coordination supports to individuals receiving buprenorphine

Under the Care Alliance approach, each patient undergoing MAT has an established medical home, a single MAT prescriber, a pharmacy home, access to existing Blueprint CHTs, and access to Hub or Spoke nurses and clinicians. The most common Spoke practice settings are: primary care, ob-gyn, psychiatry, and practices specializing in the management of chronic pain.

As part of the Blueprint for Health Community Health Teams, a Registered Nurse and a Licensed Counselor are hired for every 100 Medicaid beneficiaries who are prescribed buprenorphine for opioid addiction. Embedding the staff directly in the prescribing practices allows for more direct access to mental health and addiction services, promotes continuity of care, and supports the provision of multidisciplinary team care. As with the Blueprint CHTs, Spoke staff (a nurse and clinician case manager) are provided free of cost to patients receiving MAT, essentially as a "utility" to the practices and patients.

Building on the concept first introduced by Vermont physician John Brooklyn, MD, the "Hub & Spoke" is characterized by a limited number of specialized, regional addictions treatment centers working in meaningful clinical collaboration with general medical practices. Specializing in the treatment of complex addiction, the regional centers (Hubs) provide intensive treatment to patients and consultation support to medical providers (Spokes) treating patients in the general practice community. This framework efficiently deploys addictions expertise and helps expand access to care for Vermonters.

The Care Alliance for Opioid Treatment innovation is the coordinated, reciprocal clinical connection between the specialty addictions centers and the general medical practices. The framework facilitates the development of a treatment continuum that spans the federal regulatory framework for medication assisted treatment and supports the dissemination of addictions treatment capacity in the larger health system. Success in this framework depends on the capacity at both the Hubs and Spokes to make and receive referrals. It also requires a funding mechanism that supports the clinical care management activities that comprehensive and coordinated care for chronic conditions requires.

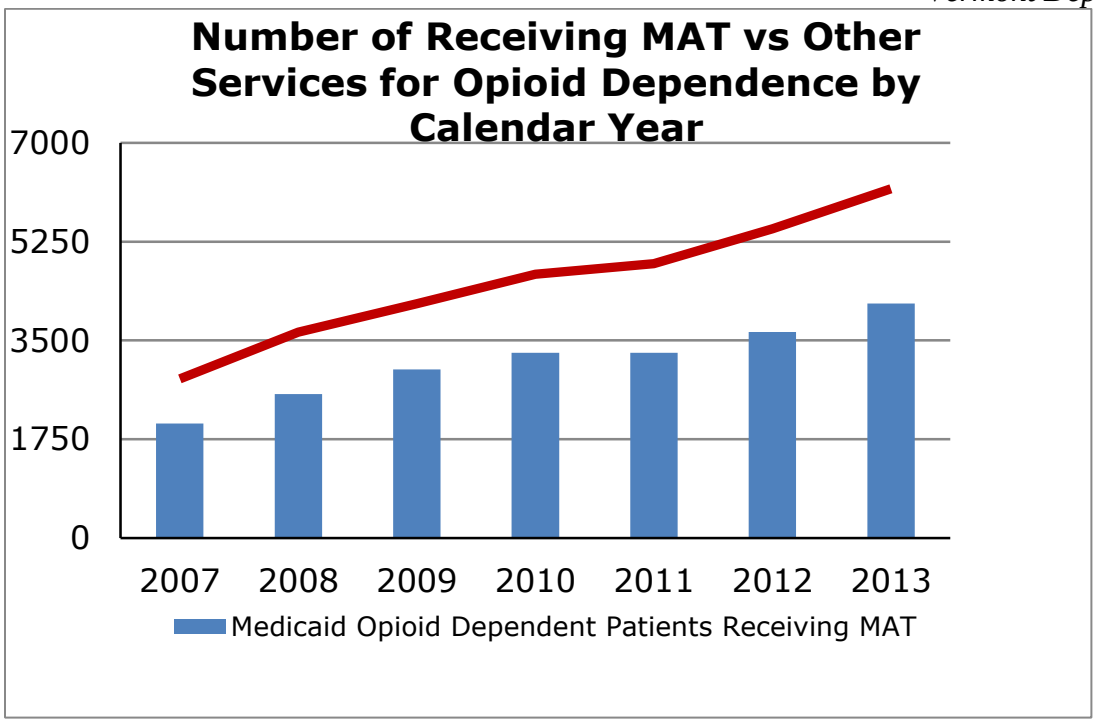
The Care Alliance for Opioid Treatment (Hub and Spoke) was implemented statewide in 2013 and 2014. The Methadone treatment programs began offering Health Home Services and started dispensing buprenorphine to patients with complex needs. A new, and fifth, Hub program opened in the Rutland area in November 2013. "Spoke" staff (nurses and licensed counselors) have been recruited and deployed statewide to all willing physician practices that prescribe buprenorphine. To date, just under 40 FTE nurses and addictions counselors have been hired and deployed to over sixty different practices.

The Centers for Medicare and Medicaid Services (CMS) has approved two Health Home State Plan Amendments (SPAs) one beginning July 2013 and the second beginning January 2014. The SPAs make Medicaid beneficiaries with opioid addiction eligible for enhanced services including care coordination, health promotion, transitions of care, and community support. See Appendix I for the implementation schedule.

The components of MAT programs in Vermont are outlined in the "Vermont Department of Health Medication Assisted Therapy for Opioid Dependence Rules"[3], and the "Vermont Buprenorphine Practice Guidelines"[4].

In Vermont, approximately 70% of Medicaid recipients with an opioid dependence diagnosis at any point in 2013 also received medication assisted treatment during the year. Others received a variety of services from hospital detoxification, to residential, outpatient treatment, or physician based services.

[3] http://healthvermont.gov/regs/documents/opioid_dependence_rule.pdf
[4] http://healthvermont.gov/adap/treatment/documents/BuprenorphinePracticeGuidelinesFINAL_01-15-2010.pdf



It is beneficial to patients and the state to intervene early, before higher levels of care such as inpatient detoxification, residential, and long-term medication assisted treatment are needed, to avoid negative consequences that can accrue individually as well as societal costs associated with long-term opioid addiction.

Where there has been a significant focus on treatment for opioid addiction to address an immediate need, it is also critically important to focus on prevention and intervention to provide a long term solution to opioid addiction. There are Vermont opioid-specific prevention efforts underway[5] to reduce the burden of substance abuse and addiction in Vermont. The best prevention is evidence-based and comprehensive - with interventions at the state, community, school, family and individual levels. The same dimensions of wellness and community environments that help to prevent substance abuse also support recovery. Investing in prevention as early as possible can prevent and reduce the tremendous suffering that addiction causes for individuals, families and communities. For every dollar invested in prevention efforts there is a $10-$18 savings of societal costs[6] (health care costs, lost productivity, etc.)

[5] http://www.healthvermont.gov/adap/treatment/opioids/documents/PreventOpioidsBrief_June2014.pdf
[6] http://www.samhsa.gov/sites/default/files/cost-benefits-prevention.pdf

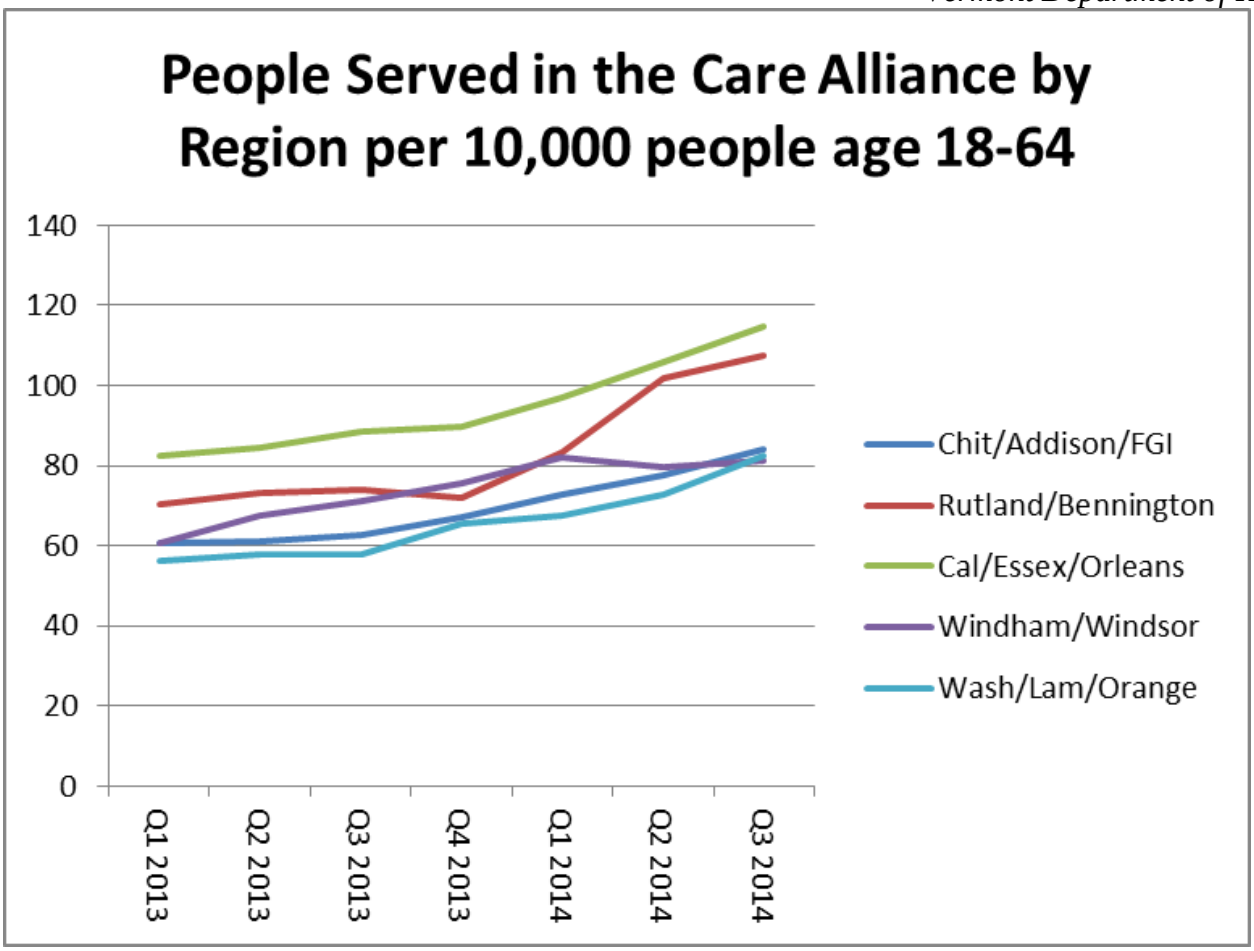
Care Alliance for Opioid Addiction Outcomes and Performance Measures

The Care Alliance has been fully implemented only recently. The Blueprint for Health, along with the VDH, is in the process of designing an evaluation for the Care Alliance system to assess empirically the impact of Medication Assisted Treatment (MAT) in Vermont. The primary source of data for this study will be the Vermont All Payer Claims Database known as the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). At this time, the evaluation is expected to include a review of the impact of MAT on health care utilization patterns and overall patient cost. Because outcomes for this population transcend the medical system, this evaluation will also investigate the relationship between MAT and incarceration. It is anticipated that the evaluation report will be available in January 2016.

Performance Measures

The primary focus of the Care Alliance to date has been to improve access to care for individuals presenting for treatment for opioid addiction. The number of people receiving MAT services has increased significantly throughout the state between 1/1/2013 and 7/30/14 with overall state capacity increasing by more than 40%. The "hub" system has significantly increased caseload over the past year. The number of physicians prescribing buprenorphine is only beginning to increase so the Spoke caseloads have not grown significantly.

Total MAT utilization has increased in all regions of the state with the most rapid increases occurring in the Rutland/Bennington region driven primarily by the opening of the West Ridge hub.



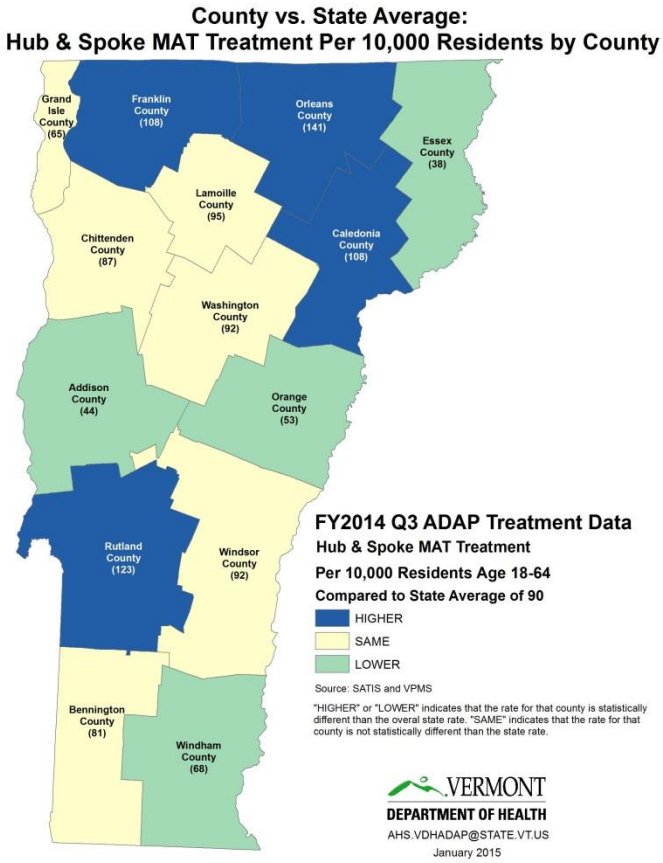
Orleans and Rutland counties have the highest overall MAT utilization rates, Essex and Addison have the lowest.

Number of People per 10,000 Residents Age 18-64 Receiving MAT in Hubs/Spokes[7]								Number of People Treated in Most Recent Period
County	**Q1 2013**	**Q2 2013**	**Q3 2013**	**Q4 2013**	**Q1 2014**	**Q2 2014**	**Q3 2014**	**Q3 2014[8]**
Addison	30	28	27	29	33	40	44	118
Bennington	61	70	71	73	78	81	81	202
Caledonia	70	72	77	80	90	102	108	234
Chittenden	60	62	65	69	76	82	87	1045
Essex	24	19	26	24	29	32	38	16
Franklin	88	86	85	91	94	95	108	375
Grand Isle	44	53	46	61	63	63	65	33
Lamoille	76	79	76	84	87	84	95	171
Orange	36	36	37	41	46	51	53	109
Orleans	110	113	117	117	122	127	141	259
Rutland	76	75	76	72	86	114	123	526
Washington	57	59	60	70	70	78	92	390
Windham	63	70	71	78	80	66	68	211
Windsor	59	66	71	73	84	90	92	355
Total State	64	66	68	72	78	84	91	4003

Medication assisted treatment availability continues to vary by type of care and county. The map below shows which counties have utilization of MAT services that are statistically different from the state average.

[7] Using a rate based on number of individuals in treatment per 10,000 Vermonters age 18-64 allows comparison of care utilization rates from county to county. The actual number of people receiving care, shown in the last column, is not population-adjusted.

[8] Q3 2014 data reflects the number of people treated in July 2014. There are significant lags in data collection that allow the calculation of county level values.



To date, there has been only limited increase in the number of physicians who prescribe buprenorphine. The following table displays the per capita rate of Vermonters receiving buprenorphine prescribed by a physician in each county. There is significant variation in access from county to county.

Number of People per 10,000 Residents Age 18-64 Receiving MAT in Spokes								Number of People Treated in Most Recent Period
County	**Q1 2013**	**Q2 2013**	**Q3 2013**	**Q4 2013**	**Q1 2014**	**Q2 2014**	**Q3 2014**	**Q3 2014**
Addison	19	15	14	13	16	20	20	53
Bennington	56	64	65	67	70	74	75	185
Caledonia	40	27	29	31	35	33	31	68
Chittenden	31	30	31	25	26	27	28	336
Essex	19	14	14	12	14	21	26	11
Franklin	75	72	71	72	73	73	79	274
Grand Isle	40	47	40	51	51	51	51	26
Lamoille	63	66	63	65	68	71	68	122
Orange	24	25	23	23	24	26	23	48
Orleans	56	56	56	44	45	44	44	81
Rutland	69	68	68	64	66	66	63	269
Washington	43	43	42	40	41	40	40	169
Windham	33	39	37	38	35	35	34	105
Windsor	41	43	45	44	50	53	53	207
Total State	44	43	43	41	43	43	44	1935

Hub utilization is currently lowest in Bennington County with Essex and Grand Isle also remaining quite low. Caledonia and Orleans counties have the highest utilization rates.

Number of People per 10,000 Residents Age 18-64 Receiving MAT in Hubs								Number of People Treated in Most Recent Period
County	**Q1 2013**	**Q2 2013**	**Q3 2013**	**Q4 2013**	**Q1 2014**	**Q2 2014**	**Q3 2014**	**Q3 2014**
Addison	11	13	13	16	17	20	24	65
Bennington	4	6	6	6	8	7	7	17
Caledonia	30	46	47	49	55	69	76	166
Chittenden	29	32	34	44	50	55	59	709
Essex	5	5	12	12	14	11	12	5
Franklin	13	14	14	19	20	22	29	101
Grand Isle	4	6	6	10	12	12	14	7
Lamoille	13	13	14	19	19	13	27	49
Orange	13	11	14	18	22	25	30	61
Orleans	54	57	61	73	77	83	97	178
Rutland	6	7	7	7	20	48	60	257
Washington	14	16	18	30	29	38	52	221
Windham	30	32	34	41	45	32	34	106
Windsor	18	22	26	29	34	37	38	148
Total State	20	23	25	31	35	41	47	2068

Since implementation began, the number of people being served in the hubs has more than doubled, from 912 to over 2100. During the same period, spoke counts have remained level at just under 2000 people. Even as the number of people being served in hubs has increased, the number waiting has remained at 500 people, 300 of whom are from the northwest corner of the state. This region reached the maximum Hub capacity of 950 people in November 2014 due to both space and staffing limitations. The number of people served in the southwest hub decreased by 90 people between September and October 2014 due to transferring patients to spokes. Habit Opco in West Lebanon is limiting new admissions until a new director and

clinical staff is hired to assure that there are appropriate ratios of staff and patients. Hiring clinical staff has been an ongoing problem for all hub locations making workforce development crucial to the success of the Care Alliance. It is important to note that the state is not limiting access to care. Providers determine the appropriate census based on their ability to provide quality care.

Overall, the greatest area of unmet need is in the northwest region of the state. While the overall MAT rate of 84 per 10,000 is somewhat below the state average of 91 per 10,000, this region includes 42% of the adult population age 18-64. This means that there are a greater number of people seeking both hub and spoke services than in the other regions of the state which is reflected in the hub wait list numbers.

Treatment Retention

Medication Assisted Treatment is a long term treatment. Successful treatment requires that patients consistently comply with treatment protocols over a long period of time. Retention, for purposes of this initiative, is defined at the percent of new patients who remain in treatment at least 90 days [9].

Retention rates for continuously enrolled Medicaid beneficiaries accessing hub or spoke services have remained stable over the implementation expansion period with approximately 73.5% of new hub or spoke patients still receiving services at 90 days. Hubs, whose model includes

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9 **Remaining in treatment for an adequate period of time is critical.** The appropriate duration for an individual depends on the type and degree of the patient's problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment. http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment

greater level of oversight, more frequent contact, greater service coordination and daily visits, have average retention rates of 82.8% compared to spokes, with an average retention rate of 69.3%. Maintaining retention rates while implementing changes in the treatment system and significantly increasing the census is an indication that these system stresses did no negatively impact care.

Client Functioning at Hub Discharge

While treatment retention is an important measure, it's also important to know why people leave treatment.

Because the Substance Abuse and Mental Health Services Administration (SAMHSA) requires ADAP to collect admission and discharge information for services funded through the Substance Abuse Prevention and Treatment Block Grant (SAPT BG), it is possible to determine discharge reason and level of functioning for people leaving hubs. These data are not available for those leaving spoke services because spokes don't receive SAPT BG funds.

Some patients leave the hubs for positive reasons – they have completed treatment or are transferred to a more appropriate level of care. These are considered good outcomes. There are discharges the hubs have little control over such as death or incarceration.

The data suggests that most individuals leave treatment against professional advice or treatment is terminated by the facility for a variety of reasons including rules infractions. Many patients in the hubs have very complex problems across multiple domains such as housing, criminal justice, employment, childcare, mental health, and health that make it challenging to participate in this program. Of those leaving treatment due to treatment completion or transfer, 75% show improved overall functioning at discharge. When patients are discharged for any other reason, only 34% show improved functioning at discharge. Similarly, longer retention times are associated with improved functioning: of those retained more than 90 days, 54% show improved functioning compared to 31% of those discharged in less than 90 days.

Quality Assurance Standards

Under the Blueprint for Health, Vermont's primary care practices, some of which are spokes, are supported to meet the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Homes (PCMH) Standards. These standards support higher quality care and improve patient and provider experiences of care.

The Blueprint for Health is also supporting the hubs to meet the NCQA Specialty Practice Standards. The specialty standards focus on quality improvement and increasing coordination of care between primary health care and specialty services. This is one of the first uses of the NCQA specialist standards for addictions treatment in the nation.

The goal is for all five hubs to complete a baseline measure against the standards by July 2015. Three of the five hubs have begun the process: Chittenden Center, Central Vermont Addiction Medicine, and West Ridge.

Third Party Payer Inclusion in the Care Alliance Model

While the majority of medication assisted treatment is funded by the state through Medicaid payments, Community Health Team (CHT) staff, and financial support for uninsured patients in hubs, some patients have third party insurance through Blue Cross Blue Shield, MVP, Cigna, and Tri-Care. Medicare does not pay for MAT provided by specialty treatment providers such as the hubs, but it will pay for services provided in physician's offices (also referred to as spokes. Insurers have consistently paid for direct medical care through the spokes as well as buprenorphine dispensed in pharmacies. Third party payers also contribute funds for the Blueprint CHTs, but third party payment methodologies did not originally fully support the Care Alliance hub level of care. Hub providers made significant progress in negotiating payments for the full range of hub services for patients with private insurance as shown below. Hubs are continuing to pursue payment mechanisms with the insurers listed below.

Progress varies by insurer; Cigna has stated they are currently not negotiating new agreements. Currently, only Medicaid supports the increased staffing (RN and Addictions Counselor) for the Spokes.

Hub	Blue Cross Blue Shield	MVP	Cigna	Tri Care
Chittenden	Executed	In Process	In Process	
Southeast	Executed	In Process	Hold	
Central VT	Executed	Executed	In Process	In Process
Rutland	Executed	In Process	Hold	
NEK	Executed	Executed	In Process	In Process

Hub Naloxone Pilot Implementation

In 2013, the Vermont Legislature tasked the Department of Health with developing and administering a statewide pilot program for distributing emergency overdose rescue kits to people at risk of an overdose, as well as to family members and others who may be in a position to help in the event of an overdose. Naloxone hydrochloride, also known by the trade name Narcan®, is an opioid antagonist that safely and quickly reverses the life-threating effects of an opioid overdose. Because patients treated in the hubs and their families may have contact with people at high-risk of overdosing on opioids, the hubs are uniquely positioned to enroll people in the program and provide training and intervention resources.

As of October 2014, three of the five hubs have implemented the naloxone program. The implementation date for BAART in the Northeast Kingdom is November 2014 and Habit Opco in the southeast has a target date of February 2015.

Improving the Standard of Care

Implementation of the Care Alliance model has required ADAP and DVHA to work very closely with participating service providers throughout the development process. Although there were exiting rules for physicians and Opiate Treatment Programs that exited separately there were no existing processes,
procedures or guidelines to support this combined program. Over the past year and a half, ADAP and DVHA have developed the following mechanisms to assure successful project implementation:

- Processes for provision of best-practice services
    - Standard screening tools to determine appropriate placement within hub or spoke
    - Standardized definition of spoke stability and associated frequency of visits required
    - Standard patient referral protocols between hubs and spokes
    - Cross department and agency treatment planning processes
- Billing and payment specifications for services provided by hub and spokes and community health teams
- Standardized methods for determination of wait lists
- Hub transfer protocols
- Standardized drug toxicology testing protocols
- Medication Assisted Treatment rules
- Use of Learning Collaboratives[10] to review:
    - Use of Vermont Prescription Monitoring System (VPMS)
    - Urine analysis standards

[10] Widely used to improve care for targeted conditions in primary care settings, Learning Collaboratives involve convening teams of a physician leader, nurse, office manager and other staff from four to up to ten practices. They participate in a facilitated structured process of didactic learning, rapid trial implementation cycles (known as Plan Do Study Act, or PDSA) and measurement of the impact of process changes over several months. The practices agree to collect data across a common set of quality of care measures, to identify and test practice improvements in each participating practice, and to share data and measurement about practice changes with each other. The process accelerates practice improvement in applied settings and often results in a core team able to collaborate across organizational boundaries on the implementation of common care standards.

- Treatment retention
- Rates of patients receiving above the recommended dose or more than 16 mg of Buprenorphine daily (a risk for diversion)
- Travel time to care
- Use of benzodiazepines (contra indicated when buprenorphine is prescribed)

Conclusion/Recommandations

Vermont has made significant progress in developing a system of care to treat opioid addiction over the past two years. Access to care has improved and steps toward integrated health / addictions care have been made. The Health Home framework has also enabled services to be more comprehensive. People are being retained in treatment and, when discharged for treatment completion or transfer, show overall improved functioning compared to status at admission. The state has developed prevention and intervention strategies to try to decrease the number of people who become addicted to opioids. An evaluation currently under development will provide greater information about the outcomes for individuals receiving opioid addiction treatment as well as overall cost of care.

Still, there are ongoing challenges to this system of care. The recruitment and retention of workforce, particularly clinicians with specialized skills such as Licensed Drug and Alcohol Counselors (LADC), remains a challenge. Many of the current LADCs are nearing retirement age and the field is less attractive to people beginning their careers due to low salaries, the inability of private practitioner LADCs to bill Medicaid, and the challenging population being treated. This issue is not unique to Vermont; it's a problem nationwide. National issues and recommendations are summarized in a study[11] completed by the Addiction Technology Transfer Center Network (ATTC).

ADAP is planning to conduct a needs assessment, convene a stakeholder meeting, and coordinate a conference on workforce and training across the continuum of care.

[11] http://www.attcnetwork.org/documents/VitalSignsReport.pdf

There are people waiting for MAT services, not unlike other types of healthcare where resources are limited, and actions are being taken to increase the total system capacity. In addition to increases in funding and training, VDH and DVHA are working with Federally Qualified Health Centers and other medical practices to increase the number of physicians who treat patients with opiate addiction.

There is a portion of stable hub patients who no longer need the full array of hub services but who cannot access spokes due to lack of capacity, especially in the northwestern region of the state. Transferring stable patients allows hubs to focus on their target group, patients with greater needs, and decrease hub waiting lists. Because federal policy caps the total number of patients a physician can prescribe to at 100 patients, and MAT is a long term treatment, the only way to assure more access is to increase the number of physicians who will prescribe buprenorphine. The combination of consultation support from the Hubs and offer of embedded Spoke staffing is attractive to physicians considering adding MAT to their practice setting.

In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) is currently evaluating an increase in the "cap" of 100 patients an established physician can treat with buprenorphine. Because Vermont provides additional supports to physicians treating this population in the form of the spoke staff, this would allow existing qualified physicians to treat more patients while maintaining high quality care.

An ongoing challenge for hubs, which translates into the use of state funds to pay for services for insured patients, is that Medicare does not pay for substance abuse treatment at specialty treatment facilities such as the opioid hubs. In 2013, there were seven people age 65 and above treated in the hubs. While this is a small absolute number, it does indicate limitations of Medicare for providing services to a growing portion of the population. There has been ongoing discussion of this issue with Senators Leahy and Sanders as this must be addressed at a Federal level.

This population and level of service is very sensitive to insurance co-pay and deductible requirements which has been an issue for patients who purchase plans through the health exchange.

Low premium plans typically have high deductibles which people have difficulty paying. In addition, hub services may require daily visits and if co-payment is required at each visit, the total monthly co-payment costs may add up to more than the total cost of service for a self-pay patient.

Because of this, and because there is funding for uninsured patients in the hubs, the co-payments and deductibles have become a disincentive for people to sign up for insurance. In addition, hub providers have difficulty collecting deductibles and co-payments from patients, which leads to program losses. ADAP has been working with the Green Mountain Care Board to address co-payment issues; but, if patients sign up for high-deductible plans, this will remain an issue.

Appendix I – Hub and Spoke Implementation Timeline

Hub Implementation Schedule

Hub	Service Area	Start Date
Chittenden Center (HowardCenter)	Chittenden, Addison, Franklin and Grand Isle Counties	January 2013
Central Vermont Addictions Medicine (BAART and Central Vermont Substance Abuse Services	Washington, Lamoille, and Orange	July 2013
Habit Opco/Brattleboro Retreat	Windsor and Windham Counties	July 2013
West Ridge Center for Addiction Recovery (Rutland Regional Medical Center)	Rutland and Bennington Counties	November 2013
BAART Behavioral Health Services	Caledonia, Orleans, and Essex Counties	January 2014

Spoke Implementation Schedule

Spoke implementation is defined by the date funding for spoke staff became available to provide Health Home services to Medicaid beneficiaries. These services are provided by registered nurse care managers and licensed clinician case managers with expertise in opioid addiction treatment who were added to existing Blueprint Community Health Teams.

The enhanced staffing is modeled at one FTE nurse and one FTE licensed clinician case manager for every 100 MAT patients.

There are continuing efforts to increase the number of spoke practices participating in the program.

Health Service Area	Date Medicaid Funds Available for Spoke Staff
Bennington	January 2013
St. Albans	January 2013
Rutland	January 2013
Chittenden	January 2013
Brattleboro	July 2013
Springfield	July 2013
Windsor	July 2013
Randolph	July 2013
Barre	July 2013
Lamoille	July 2013
Newport & St. Johnsbury	January 2014