
**Report to
The Vermont Legislature**

**Annual Report on Vermont's Substance Abuse System of Care
January 2016**

In Accordance with Act 135 (2012),
An Act Relating to Vermont's Treatment of Opioid Addiction, Section 1 (c),
and Senate bill S.42 (2015), as passed by the Senate,
An Act Relating to the Substance Abuse System of Care.

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

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Report Date: January 13, 2016



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**Annual Report on Vermont's Substance Abuse System of Care
January 13, 2016**

Executive Summary

This report is an overview and analysis of the current Vermont system of care for substance use disorders. It encompasses the entire range of services: prevention, intervention, clinical, and recovery services. Although several agencies and departments are involved in the implementation of the system, the primary points of contact are the Vermont Department of Health Division of Alcohol and Drug Abuse Programs (ADAP) along with the Department of Vermont Health Access (DVHA).

Vermont ranks in the top ten states for alcohol and marijuana use, while it has significantly lower rates than the national average for prescription opioid misuse. Approximately 50,000 Vermonters met clinical criteria for a substance use disorder in calendar year 2014.

Funding for services is complex and often cumbersome for both the state departments and the providers of services. Prevention services are funded primarily through federal grants; intervention services are funded through a mixture of entities including a federal demonstration grant for Screening, Brief Intervention, and Referral for Treatment (SBIRT), state funds that support the Public Inebriate Program and fees derived from the Impaired Driver Rehabilitation Program (IDRP). Recovery services are funded by a state grant and clinical services are funded by several state programs and federal grants including Medicaid. These funding sources have individual reporting and oversight requirements that are not coordinated either administratively or programmatically. Several barriers to access also complicate the system, specifically in the clinical services area. Wait lists for care are a function of several interrelated factors including lack of an appropriate number of addiction specialists in the state (both medical and social), differences between licensure requirements, and variation in location of specialized addiction services. There is a high turnover rate among substance abuse professionals due to a relatively low pay structure and the psychological demands of the work.

The report includes several recommendations for enhancing the comprehensive system of care in all areas including a more efficient and coordinated administrative structure across levels of clinical services (e.g., dually diagnosed patients, 42 CFR Part 2 restrictions, etc.), improved recruitment and retention of substance abuse treatment specialists at all levels, and the development of an evaluation plan for the full system of care that would result in continuous improvement of the quality of care provided.

Annual Report on Vermont's Substance Abuse System of Care January 13, 2016

INTRODUCTION

This report responds to the following legislative requirements and requests:

- **Senate bill S. 42, (2015), as passed by the Senate.** This requirement is for an annual report on the substance abuse system of care including discussions about system capacity, utilization, timeliness of services, effectiveness and performance measures, and an analysis of system gaps and future needs and policy directions.
- **Act 135 (2012), Section 1 (c).** This requirement is for a report on Vermont's regional system of opioid addiction treatment, including the system's effectiveness.
- **Incorporated by reference is a report required by Act 179 (2014), Section E.306.2.** This report was submitted to the Legislature as *Substance Abuse Treatment Services Objective and Performance Measures* on January 12, 2016.
- Also to be submitted to the Legislature in January, 2016 is report by the Vermont Agency of Human Services (AHS) on **service gaps and duplication of services.** **This report was required by Act 54 (2015), Section 25.**

Because this report responds to the legislative requirements above, there are aspects of Vermont's substance abuse system that are not addressed. Specific questions and additional details about the system and its performance can be posed and requested during legislative testimony during the 2016 legislative session.

OVERVIEW

The report addresses Vermont's state system for both alcohol and drug abuse services. A range of services including, but not limited to, prevention, intervention, treatment, and recovery services comprise Vermont's substance abuse system. Vermont's services are organized, delivered, overseen and financed by a disjointed system involving state-financed services, federally-funded services and privately financed and delivered services. This report describes and analyzes the service system overseen by the State of Vermont Agency of Human Services. It does not address the system of private substance abuse providers or services paid for by private insurance.

The report presents an overview of the prevalence of substance abuse in Vermont followed by a description of the state system structure, financing and utilization patterns. This portrait of the system is followed by an analysis of the current system's effectiveness and apparent gaps, ending with recommendations for action or further analysis. In response to the requirement of Act 135 (2012), and the concern about the escalating burden of opioid addiction, much of the latter part of the report focuses on the system of opioid treatment in terms of access to care and treatment capacity.

PREVALENCE OF SUBSTANCE ABUSE IN VERMONT

Alcohol and illicit drug use is common in Vermont. Illicit drugs include illegal drugs such as marijuana, cocaine, and heroin. They also include legal drugs that are being abused, such as prescription opioids that are not used in the prescribed amount or are being used by someone other than the person for whom they were prescribed. According to the National Survey of Drug Use and Health (NSDUH), the most commonly used substances in Vermont are alcohol and marijuana, where Vermont's rates are higher than the national average (Figures 1-3).

Figure 1

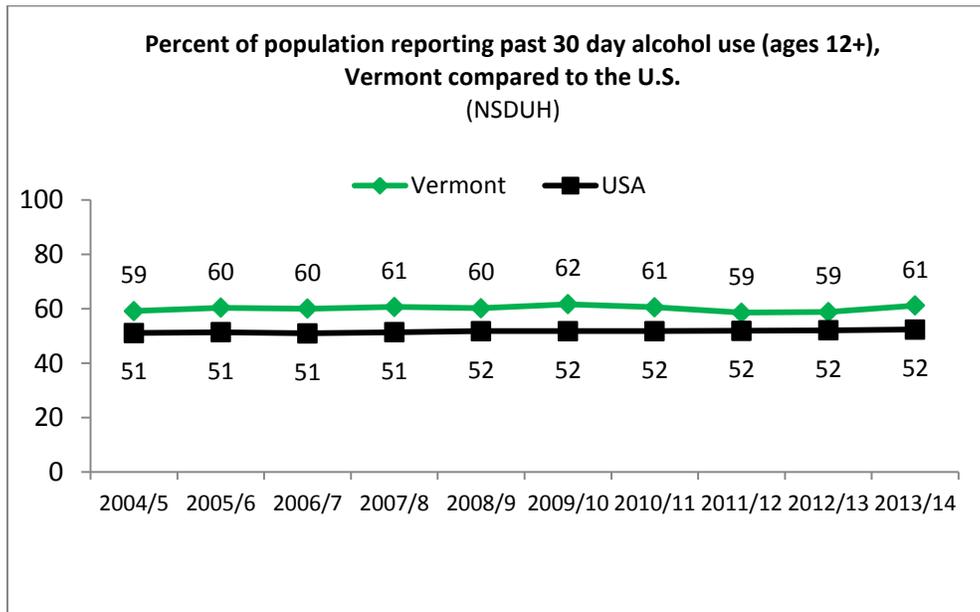


Figure 2

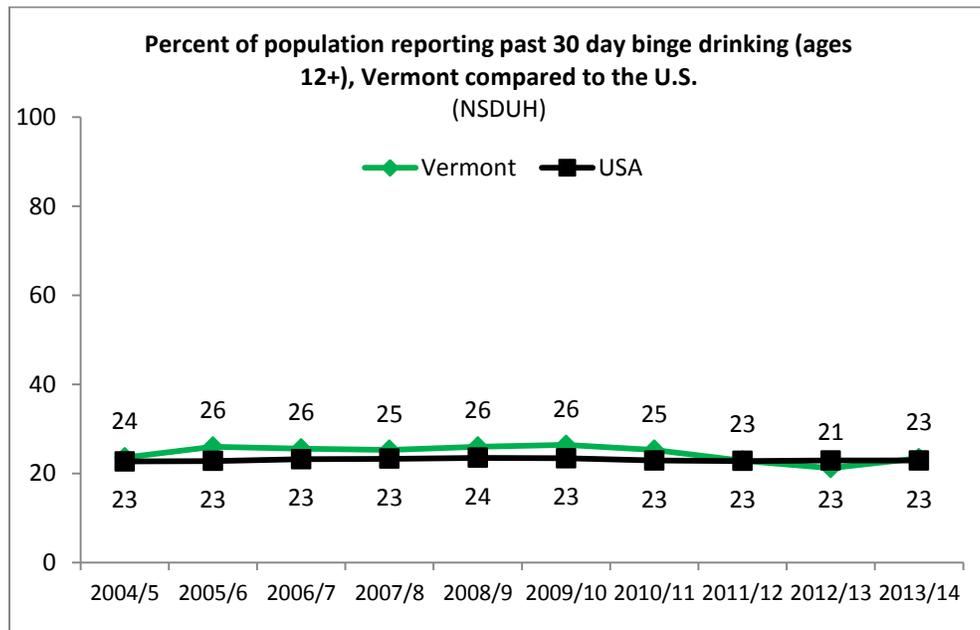
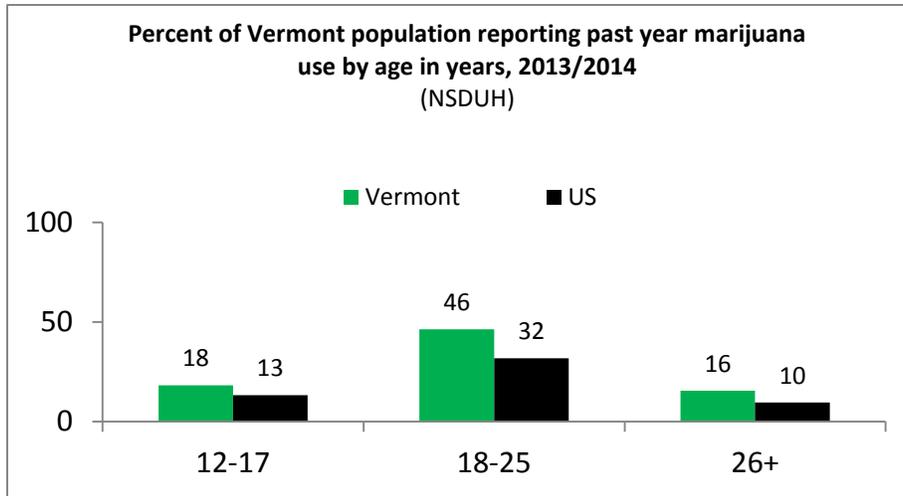
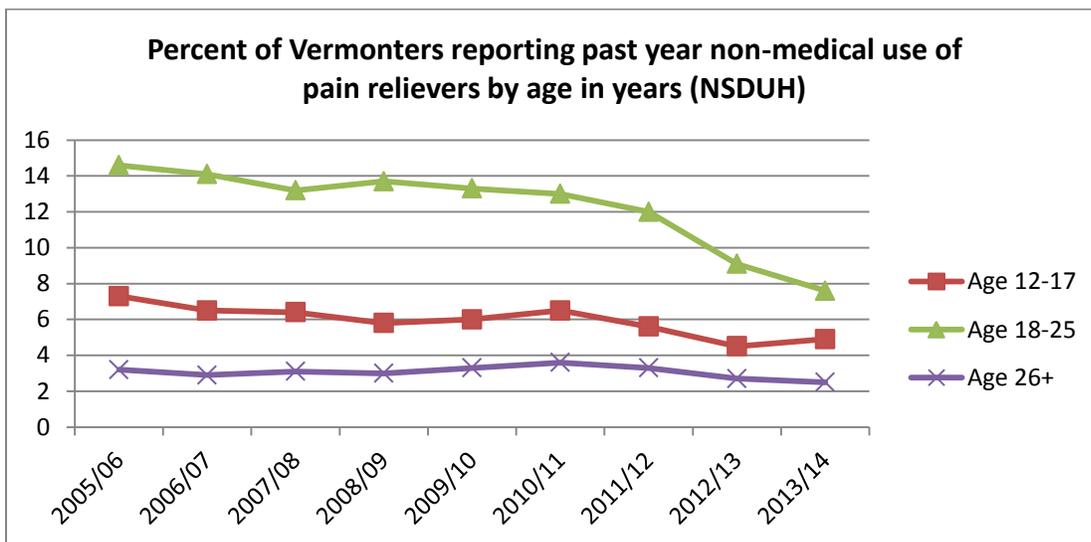


Figure 3



While rates of alcohol and marijuana use continue to remain high, the rate of non-medical use of pain relievers, typically opioids, has been decreasing. Data show statistically significant decreases in use between 2011-2012 and 2012-2013 for 12-17 and 18-25 year olds, as well as between 2012-2013 and 2013-2014 for 18-25 year olds. (Figure 4) However, because non-prescription opioids, primarily heroin, are widely available in Vermont and are inexpensive, the decrease in non-medical pain opioids has been replaced by a dramatic increase in Vermonters who use and are addicted to heroin as demonstrated by the more than 350% increase in number of people seeking treatment for primary heroin addiction between state fiscal years 2011 and 2015 (Figure 9).

Figure 4



The prevalence rate for heroin use is unknown as the survey sample sizes are too small to provide a representative measure. In 2014, NSDUH estimated that 7.2% of the Vermont population ages 12 and up abuse

According to NSDUH's 2012/2013 survey, approximately 50,000 Vermonters ages 12 and up meet the criteria for alcohol or illicit drug abuse or dependence and 12,000 Vermonters meet criteria for illicit drug dependence. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically, and methamphetamine.

NSDUH estimates that 17,000 Vermonters meet criteria for alcohol dependence. An additional 4000 meet criteria for illicit drug abuse and an additional 20,000 meet criteria for alcohol abuse. This is considered the population in need of care. The number of individuals who actually seek care is defined as the demand. In Vermont approximately 14,500 of the estimated 50,000 individuals indicated above seek care. This is approximately 29% of those in need of treatment.

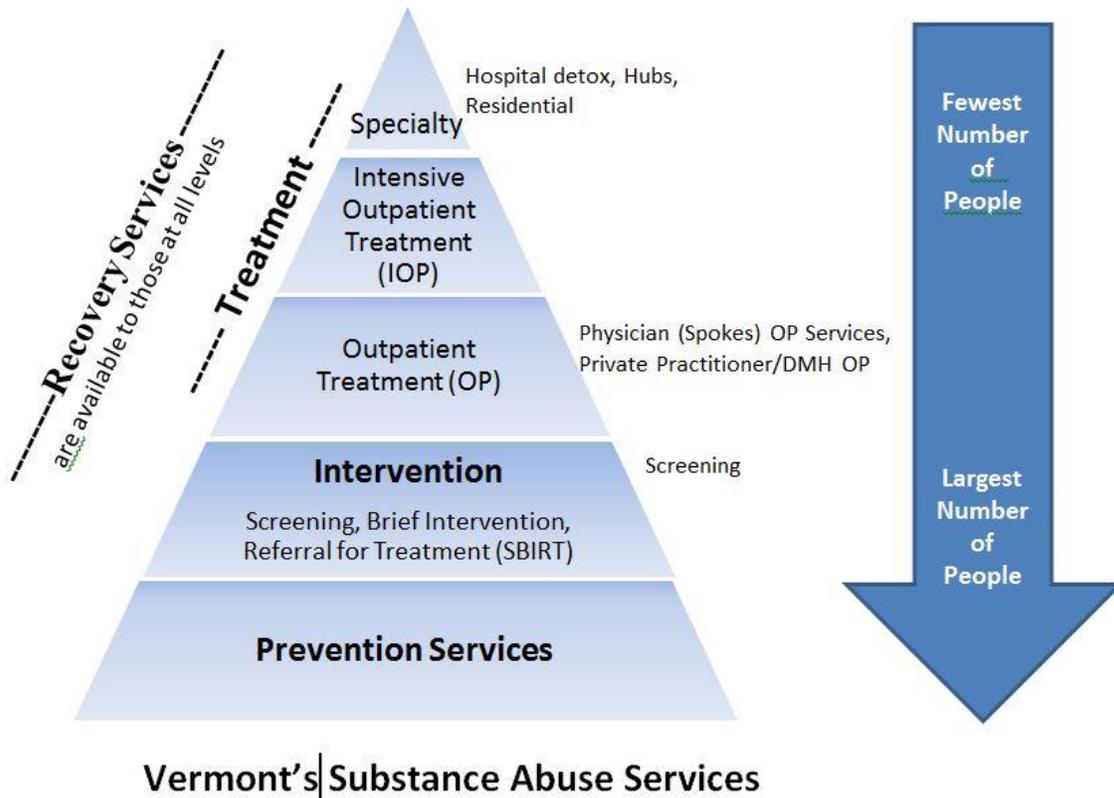
STRUCTURE AND FUNDING OF VERMONT'S SUBSTANCE ABUSE SYSTEM OF CARE

The Vermont Department of Health's (VDH) Division of Alcohol and Drug Abuse Programs (ADAP) is the designated Single State Agency (SSA) for substance abuse services in Vermont. The majority of ADAP's funding is composed of the federal Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) Block Grant and the allocation to ADAP of Vermont's 1115 Global Commitment to Health Waiver (Medicaid). ADAP uses these funds to support prevention, intervention, treatment, and recovery services in Vermont.

Vermont's substance abuse services, and the proportion of the system each service composes, are illustrated in Figure 5. Prevention services apply to the whole population, particularly those at risk for misusing substances. The primary focus of prevention is promotion of constructive lifestyles and norms that discourage drug use. Intervention services target and identify early

substance abuse, before an individual is dependent. When an individual is dependent on substances, there are several types of treatment available. The type of treatment an individual receives is based on a clinical assessment by a licensed professional and the resulting treatment plan developed with the client. Peer recovery services are available statewide to individuals at any point in the system. These services are supported by grants to the recovery centers.

Figure 5

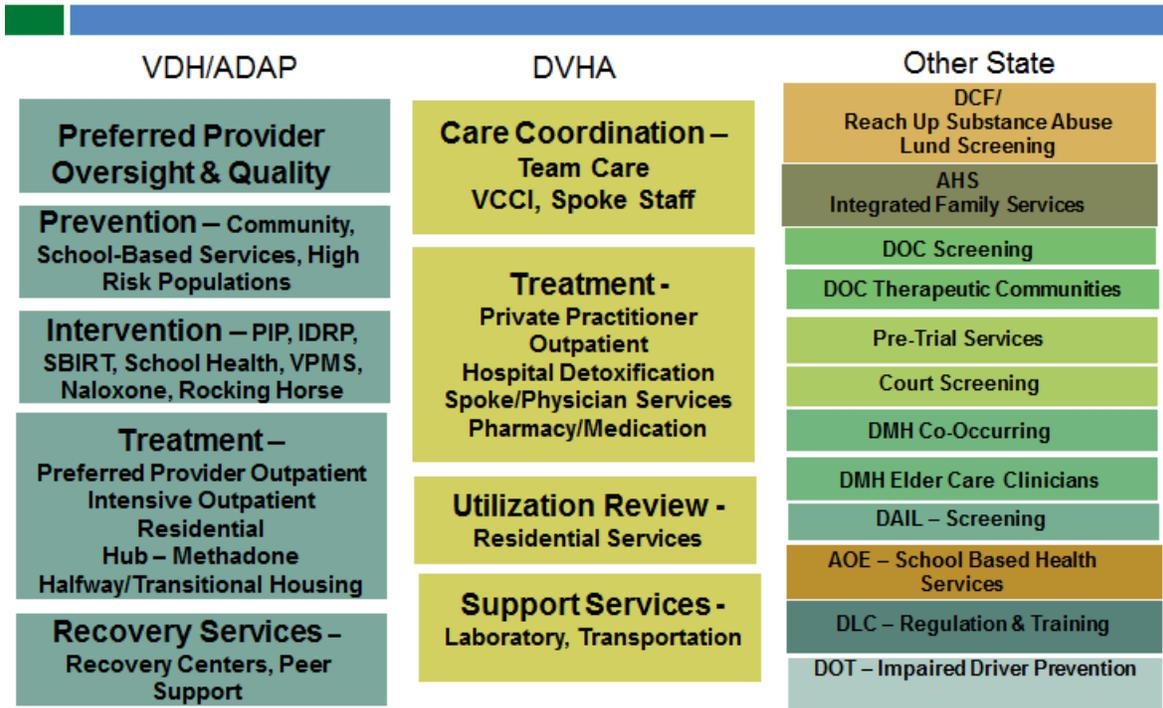


The majority of treatment services are funded by the Medicaid funds allocated to ADAP and the Department of Vermont Health Access (DVHA). Substance abuse services are also provided and funded by other parts of state government. The oversight and provision of services lies with the funding agencies, departments and divisions. Figure 6 illustrates the entire state and federally funded substance abuse service system by the agency that provides and oversees the services.

Figure 6



State Substance Abuse Services



Substance abuse is a common condition for many individuals and families receiving services managed and funded by the State of Vermont. There is no single agency or department with oversight responsibility for the full system of care which complicates coordination of care and makes it difficult to provide a full accounting of services and funding. Currently, the most comprehensive effort to coordinate the system of care is done through the Substance Abuse Treatment Coordination Workgroup (SATC). The SATC is a team of Agency of Human Services (AHS) managers working together to establish a coordinated approach to serving Vermonters with substance abuse problems across all departments. This work is led by the Deputy Commissioner for Alcohol and Drug Abuse Programs of the Vermont Department of Health. AHS recognizes the substantial burden that substance abuse has on individuals seeking AHS services, particularly those who need multiple services and therefore enter the AHS system through different doors. When state programs identify and intervene early, Vermonters dealing with substance abuse issues receive necessary care which, in the long run, can improve overall outcomes.

The involvement of all AHS departments is essential to address the prevention, screening, treatment and recovery needs of people with substance abuse challenges. The following briefly summarizes the funding and oversight of Vermont's substance abuse system.

Services of Vermont's Substance Abuse System

The following describes the range of substance abuse services provided in Vermont:

Prevention: Prevention services are fundamental to Vermont's system in that they attempt to reach as many individuals as possible at risk for initiating risky alcohol and illicit drug use, with a primary emphasis on adolescents and young adults. Substance abuse prevention is funded by the SAPT Block Grant and federal demonstration grants overseen by ADAP. Although a small amount of specific program funding also comes from the state, typically with other Health Department collaboration through the Division of Health Promotion and Disease Prevention and the Agency of Education, the majority of funding for large-scale prevention efforts has historically been through competitive Federal grants. Vermont has been particularly successful in securing these grants since 1997 to the present.

Intervention: These services involve screening people for substance misuse and early intervention programs. They are funded through a demonstration grant for screening, brief intervention and referral to treatment (SBIRT), Medicaid fee for service billing for SBIRT intervention services, the SAPT Block Grant, special funding for programs such as the Public Inebriate Program and the Vermont Prescription Monitoring Program, and fees for the Impaired Driver Rehabilitation Program (IDRP). Screening services are also provided by state staff in AHS programs and through grants and contracts throughout the Agency of Human Services (AHS), i.e., the Lund screeners and the Reach Up coordinators in the Designated Agencies through the Department of Children and Families.

Clinical Services (Treatment): Clinical services are intended to improve access to treatment for those in need, increase the use of evidence-based treatment services, and increase the number of individuals who complete the treatment process and advance to recovery services in order to

maintain long-term recovery. The majority of funding for treatment programs is Medicaid.

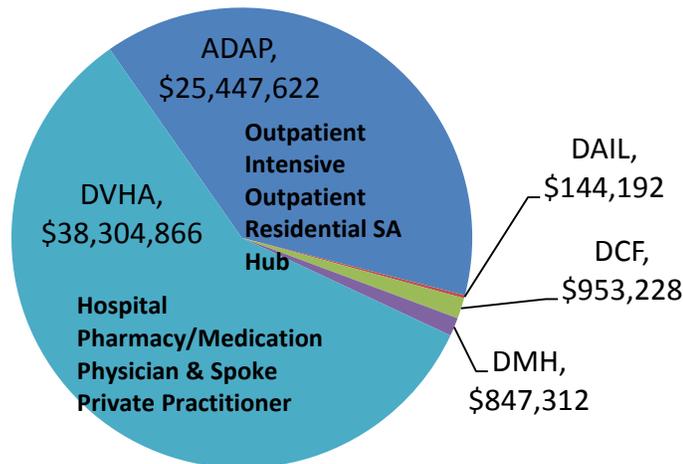
Different departments oversee Medicaid funding depending on the service type and where the services are provided as shown in Figure 7. In addition, ADAP pays for uninsured individuals and for services that are not Medicaid billable through the SAPT Block Grant.

Some essential treatment services are paid for by a combination of AHS programs. The Care Alliance for Opiate Addiction, also known as the Hub and Spoke system, is an example of this shared and complex funding. ADAP-allocated Medicaid pays for treatment services and methadone in the Hubs, typically paid as a monthly case rate. ADAP also pays for treatment, methadone, and buprenorphine for uninsured individuals in the Hubs. The DVHA allocation pays for buprenorphine, urinalysis testing, and transportation services for those in the Hubs as well as Spoke services which include primary care physician visits, buprenorphine, urinalysis testing, and transportation. The Blueprint for Health also provides staffing to Spoke providers.

Recovery Services: Recovery represents the long-term maintenance of being alcohol and/or drug free. ADAP uses SAPT Block Grant and Global Commitment Investment funds for recovery center and transitional housing services across the State. Other departments within AHS also fund housing that may be used for those in treatment or recovery.

Figure 7

More than 90% of SFY15 Medicaid Substance Abuse Services are paid through the DVHA and ADAP Global Commitment Allocations



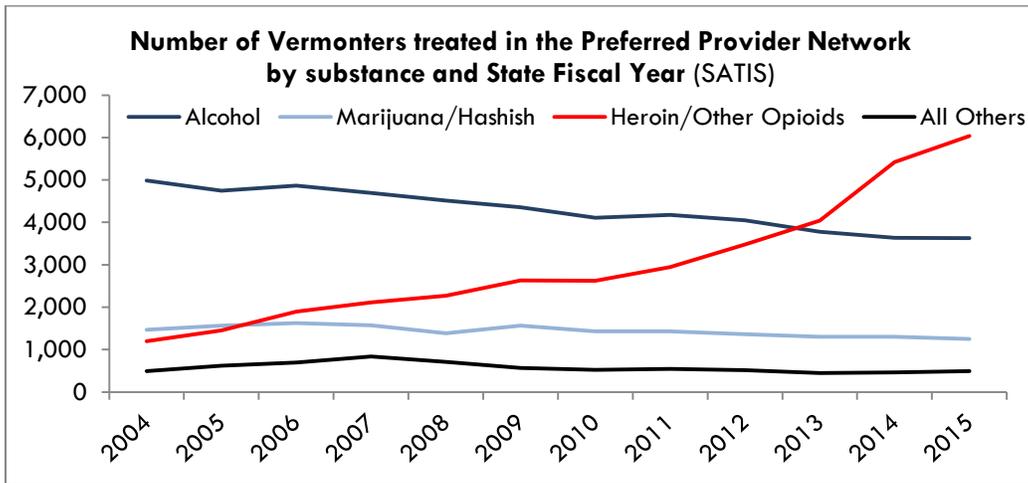
UTILIZATION OF VERMONT'S SYSTEM OF CARE

The Vermont substance abuse system of care provides services to many Vermonters. There is no one correct way for individuals to move through the continuum given the risk of relapse with this chronic condition. Individuals should be able to move across and within the different services based on their varying needs. Services across the continuum are available in Vermont but the existence of a range of services does not mean that individuals are always able to access the care they need at the time they need it. Sufficient outpatient treatment capacity is crucial to a responsive, efficient system of care.

Many individuals access treatment during a crisis, such as acute intoxication or overdose, an accident or acute exacerbation of another health condition that is caused by substance use. In many crisis situations, individuals enter treatment following an emergency department visit. In other circumstances, individuals begin treatment following an arrest for criminal behavior related to intoxication or addiction. Individuals may seek referrals to treatment from their primary care provider or be identified with unhealthy substance use as part of an annual visit through routine screening. Many individuals self-refer to acute treatment services and outpatient services, including medication assisted treatment services. The most frequently utilized services are outpatient services.

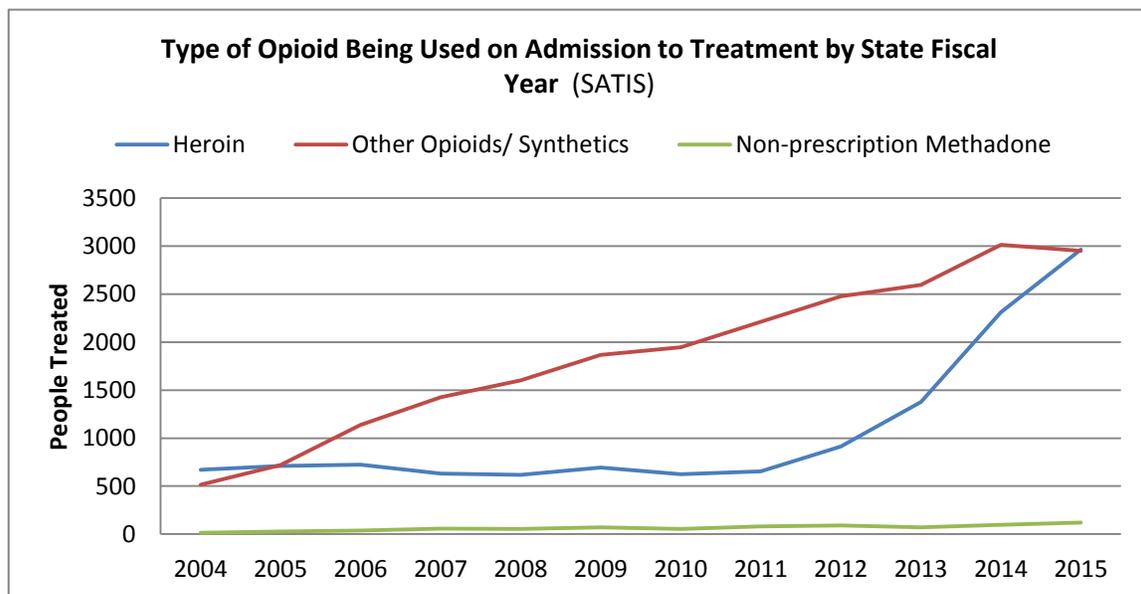
The number of individuals being served in the Vermont Department of Health's alcohol and drug abuse preferred provider network appears in Figure 8, This graphic shows that most individuals seeking care in the preferred providers system have opioids as the primary substance of abuse. This is not consistent with the prevalence information in the earlier discussion of NSDUH estimate of people in need of treatment which show that alcohol and marijuana are the most commonly used substances. One factor contributing to this discrepancy is that individuals dependent on opioids seek care sooner than those dependent on alcohol creating disproportionate demand for treatment for opioids. Vermont has responded to this demand by increasing the treatment capacity for opioid addiction.

Figure 8



In SFY15, for individuals using opioids at treatment admission, more used heroin as the primary substance than other opioids/synthetics, which includes prescription opioids (Figure 9). The emergence of chemical tolerance toward opioids/synthetics, and the increasing difficulty in obtaining these medications illegally, may in some instances explain the transition to abuse of heroin, which is cheaper and easier to obtain than prescription opioids.

Figure 9



The following summarizes the utilization of Vermont’s system by type of service:

Prevention: Current prevention programs are focused on the prevention and/or reduction in underage drinking, marijuana use, and opioid misuse among those under age 25. In SFY15, approximately 393,500 Vermonters received prevention services and ADAP expenditures were \$3,549,893 (\$9 per person served).

Intervention: Intervention services are spread across a number of departments and agencies. Services include screening, brief intervention, and referral to treatment (SBIRT), school-based substance abuse services, the Impaired Driver Rehabilitation Program, and the Naloxone opioid prevention pilot program. In SFY15, approximately 25,500 Vermonters received intervention services at an ADAP cost of \$4,043,957 (\$159 per person served).

Treatment: In SFY15 approximately 14,500 individuals received clinical services in Vermont. Since 2011, the number of individuals accessing both outpatient and residential services has remained consistent. Since 2013, the number of individuals accessing medicated-assisted treatment for opioid addiction has increased significantly (Figure 10). ADAP expenditures for treatment services in SFY15 were \$36,059,656 (\$3,148 per person served in the preferred provider system). There were additional Medicaid expenditures in the amount of \$40,249,598 by DVHA, DMH, DAIL, and DCF for claims with primary substance diagnoses. The number of individuals receiving Medicaid-funded clinical services is shown in Figure 10.

Figure 10

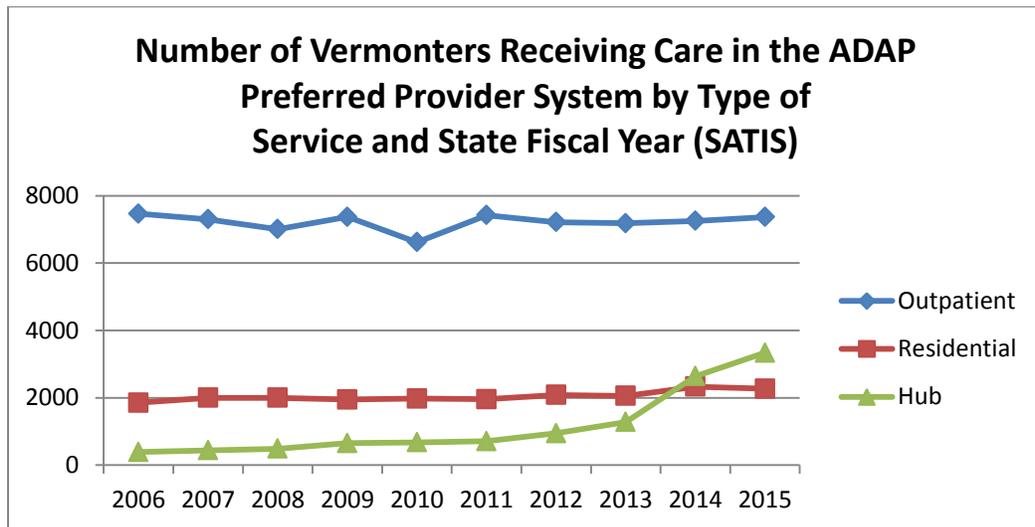
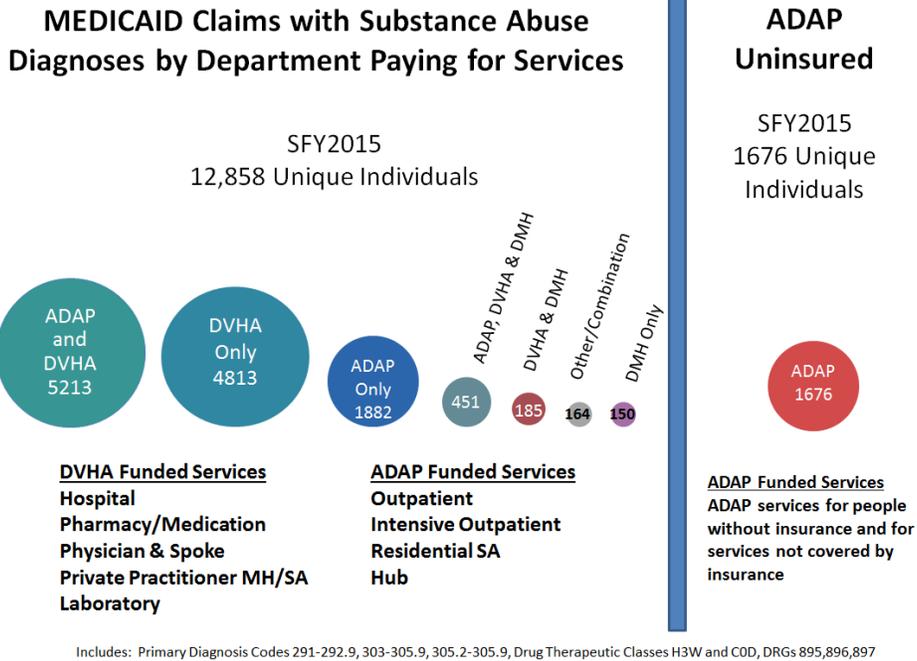


Figure 11



Recovery: In order to accommodate and continue such success for more Vermonters, increases in peer-led recovery support services, the number of trained peer leaders, and in support services such as access to safe housing are needed. In SFY15, approximately 4,600 individuals received recovery services at an ADAP cost of \$2,064,089 (\$453 per person served).

ANALYSIS OF SYSTEM GAPS AND NEEDS

Although a range of substance abuse services is available to Vermonters, there are a number of systematic challenges to managing the Vermont system of care that cross departments and agencies. VDH utilizes multiple sources of data in order to assess the gaps and needs of the substance abuse system of care. One data source is a publically accessible Performance Dashboard. Built on the concepts of *Results Based Accountability*TM the Performance Dashboard is made up of scorecards that display population indicators and performance measures. The scorecards show outcomes/results tied to performance measures, at the program/activity level, for all major programs/activities. The first scorecard includes general performance measures on treatment initiation and engagement, access to medication assisted treatment (MAT), and treatment completion rates. It can be accessed at:

http://healthvermont.gov/hv2020/dashboard/alcohol_drug.aspx.

The second scorecard is devoted to opioid use and abuse in Vermont and tracks relevant measures across VDH, ADAP, and the Department of Public Safety. Performance measures include prevalence of prescription drug misuse, rates of emergency department visits for heroin overdose, number of accidental overdose deaths from prescription drugs and heroin, MAT waitlists, number of prosecutions for sale of heroin, number of charges for possession or trafficking in heroin, and number of opioid seizures by law enforcement. This scorecard can be accessed at: <http://healthvermont.gov/adap/dashboard/opioids.aspx>.

Another source of information about the substance abuse system's performance is the annual site visits to the preferred providers performed by ADAP staff. These visits focus on providers' compliance with the Substance Abuse Treatment Certification Rule and its accompanying Substance Abuse Services Guidelines. During these visits, information on the provider's strengths and needs is gathered from leadership, staff, clients and stakeholders.

Using the aforementioned data, VDH has identified the following gaps and needs for Vermont's substance abuse system:

1. The substance abuse services system In Vermont is disjointed. There is no single agency or department with comprehensive oversight responsibility for the full substance abuse system of care. This creates challenges in ensuring the most efficient use of the network, the coordination of services across the continuum, the consistency in the provision of services, and ensuring individuals are receiving the appropriate level of care.

Because service funding and oversight is typically done at the program level, there is a lack of coordination across the Agency of Human Services resulting in potential service duplication and fragmentation. Poor communication between local providers of different levels of care can result in inefficiencies such as providers not accepting information from previous assessments done by other providers, case management services being provided by more than one department within AHS; and the lack of integration of special projects, such as the pre-trial services program and the Reach Up program, into the system of care. This issue is discussed further in a report required by Act 54 (2015), Section 25 that will be submitted to the legislature in January, 2016. This report focuses

on reducing duplication of services by identifying funding silos, and gaps and duplication in technology/data systems, documentation and reporting, oversight and monitoring, and organizational culture and development among AHS services.

2. Vermont has no single data system for collecting information about the services provided, no single organization in state government that has access to all the available data, and little analytical capacity to complete the cross-department and cross-agency evaluations needed to determine the overall impact of substance abuse services on the state. As a result, it is difficult to provide a full accounting of performance, services and funding.
3. Substance abuse prevention services rely heavily on demonstration grant funding which results in unpredictable resources and changing focus areas based on the requirements of the grants. This makes it challenging to develop a consistent approach over time.
4. The current AHS strategy for screening and intervention is addressed through the work of the SATC as well as the SBIRT demonstration grant. This work is ongoing and implementation is slow as it involves multiple AHS departments as well as many community stakeholders. While there is strong AHS support for intervention efforts, continued training opportunities are needed on an ongoing basis.
5. Recovery services are primarily funded through grants to the recovery centers and most funds are used for expenses associated with keeping the centers open such as rent, utilities and a center director. Centers are reliant on volunteers and peers for programming which leads to variation from center to center.
6. There are regulatory barriers that make it difficult to coordinate treatment. Substance abuse treatment services must comply with specific federal confidentiality requirements outlined in 42 CFR Part 2¹. These requirements prohibit substance abuse treatment service providers from sharing treatment information with other care providers unless the

¹ <http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2>

client specifically permits it. This requirement is more stringent than the confidentiality requirement that applies to medical providers through HIPAA. This complicates data sharing and often results in the exclusion of substance abuse treatment information from service planning. It has also prevented substance abuse specialty treatment providers who dispense methadone or buprenorphine in Hubs from reporting into the Vermont Prescription Monitoring Program (VPMS). As a result, when a prescriber looks up an individual’s prescription record in VPMS, methadone or buprenorphine dispensed in the Hubs is not included in that report.

Treatment Capacity

Perhaps the single most important aspect of addiction treatment is access to available services. As discussed earlier, approximately 50,000 Vermonters are in need of treatment but many do not seek care. In order to improve access, it is necessary to remove barriers such as those listed in Table 1. For some individuals, accessing services appears to be a difficult process. This is likely compounded for those in low socioeconomic strata, racial and ethnic minorities, and immigrants.

Table 1

Most common reasons for not receiving treatment among individuals aged 12 or older who needed and made an effort to receive treatment but did not receive treatment and felt a need for treatment: annual averages, 2010 to 2013, NSDUH

Reason	Percent
No health coverage/could not afford	37.3%
Not ready to stop using	24.5%
Did not know where to go for treatment	9.0%
Had health coverage but did not cover treatment or cover costs	8.2%
No transportation/inconvenient	8.0%

In addition to the barriers outlined above, the capacity of the treatment system is a challenge in Vermont. Capacity limitations lead to waiting for treatment. Backlogs occur due to lack of

appropriate facilities, qualified and experienced staff, and funding. Vermont has significantly increased access to treatment for opioid addiction, but waiting lists remain. An additional contributor to access barriers is the lack of medical providers who are trained and prepared to treat addicted individuals with multiple co-occurring problems that require substantial effort. Waiting lists can also be affected by external factors such as a coordinated law enforcement effort that interdicts large shipments of illicit drugs which may drive individuals to treatment because of lack of drug supply or a large cost increase.

The availability of a qualified workforce continues to be a challenge both in Vermont and nationally. Licensed Alcohol and Drug Counselors (LADC) in Vermont are aging and new counselors are not attracted to the profession. There are significant disparities between the salaries in the medical professions and those of the substance abuse profession, and variations among provider organizations lead to staff turnover when individuals seek higher-paying positions. The pay structure and stressful work environments in the preferred provider system contribute to reduced morale and a high staff turnover rate, both of which can have a negative impact on care. There is a need for more substance abuse counselors but the requirements for becoming a Licensed Alcohol and Drug Counselor (LADC) are more extensive and costly than the requirements to become a Licensed Clinical Mental Health Counselor (LCMHC) or a Licensed Clinical Social Worker (LCSW). In 2015 the Division of Alcohol and Drug Abuse Programs conducted a resource and needs assessment with Vermont professionals working in the field of substance abuse prevention, treatment, recovery and transitional housing, as well as workforce development providers to inform workforce planning activities. The recommendations include development of a statewide strategy to address workforce and determine how to recruit and retain professionals to the field. However, this challenge is well beyond the scope of the Department of Health to address alone.

PERFORMANCE AND GAPS SPECIFIC TO THE OPIOID DEPENDENCE TREATMENT SYSTEM

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,

also known as the Hub and Spoke system, through a collaboration between the Blueprint for Health, the Department of Vermont Health Access, and the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs. This effort includes local health, addictions, and mental health providers and is focused on effective, coordinated and supported care for opioid addiction.

Specializing in the treatment of complex addiction (e.g. multiple substances and/or comorbid mental health issues), the regional centers (Hubs) provide intensive treatment to individuals and consultation support to medical providers (Spokes) treating individuals with buprenorphine in medical settings in the community. Implementation of the Hub component of the system was completed on 1/1/14, although medication-assisted treatment (MAT) availability varies by county. A more detailed description of the model is available at:

<http://healthvermont.gov/adap/documents/CareAllianceOpioidAddiction.pdf>

The Hubs and Spokes use medication to reduce cravings for opioids (e.g., heroin, prescription pain relievers, etc.), thereby allowing individuals the opportunity to lead normal lives. 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 whereas buprenorphine can be prescribed by community physicians who attain a DEA data 2000 waiver.

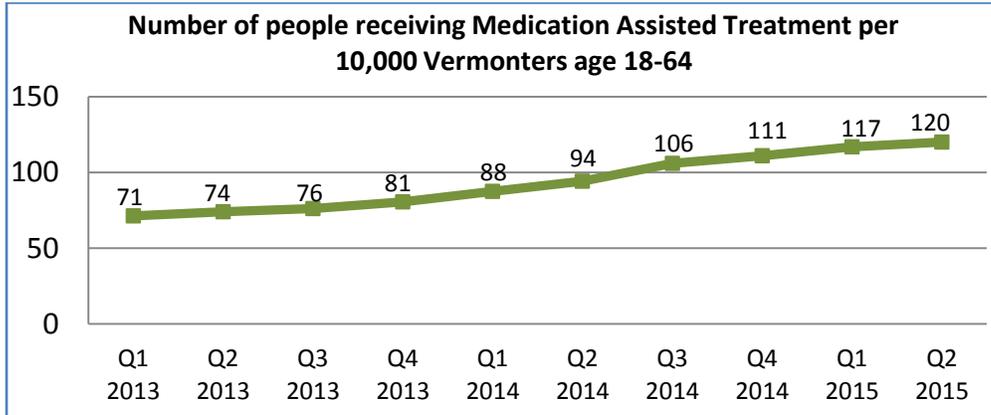
There is clear evidence that both methadone and buprenorphine are highly effective in the treatment of opioid dependence.²

Another option is long-acting injectable naltrexone, also known as Vivitrol®, which is useful to those individuals who have difficulty maintaining a daily medication protocol. Desired outcomes for medication-assisted treatment include: abstention from or reduced use of illicit opiates, reduction in non-opioid illicit drug demand and use (e.g., cocaine), decreased criminal behavior, and decreased risk behavior linked to HIV and hepatitis C.

² *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.

Statewide, there has been a significant increase in MAT treatment capacity as shown in Figure 12.

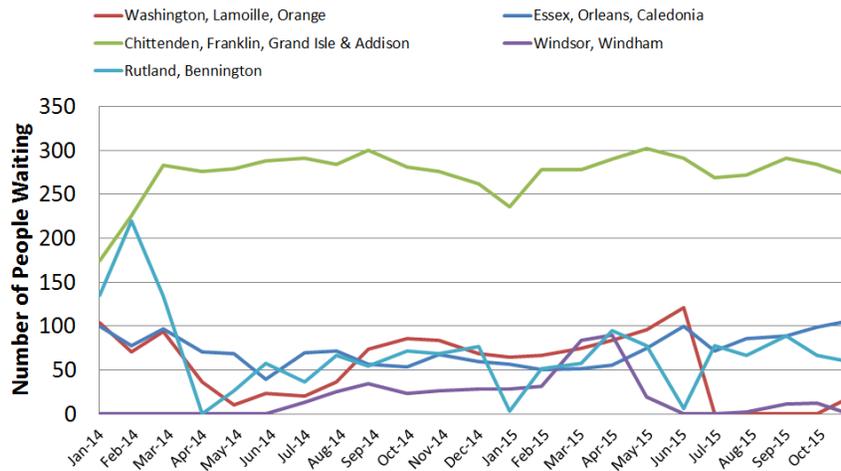
Figure 12



Despite the increased treatment capacity, the number of people waiting for services has not decreased in the northwest region of Vermont. The majority of those waiting for services are located in the northwestern part of the state (Figure 13).

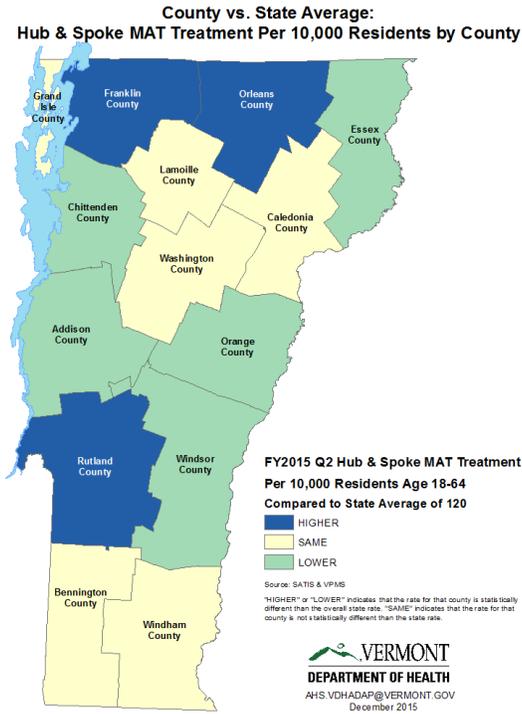
Figure 13

Number of People Waiting for Hub Services by Region



Medication-assisted treatment utilization varies based on availability of services. The map below (figure 13) shows the counties that have MAT utilization rates that are statistically different from the state average. With over 25% of the state’s population, Chittenden County has a utilization rate lower than the statewide average indicating that additional capacity is needed in this region.

Figure 14

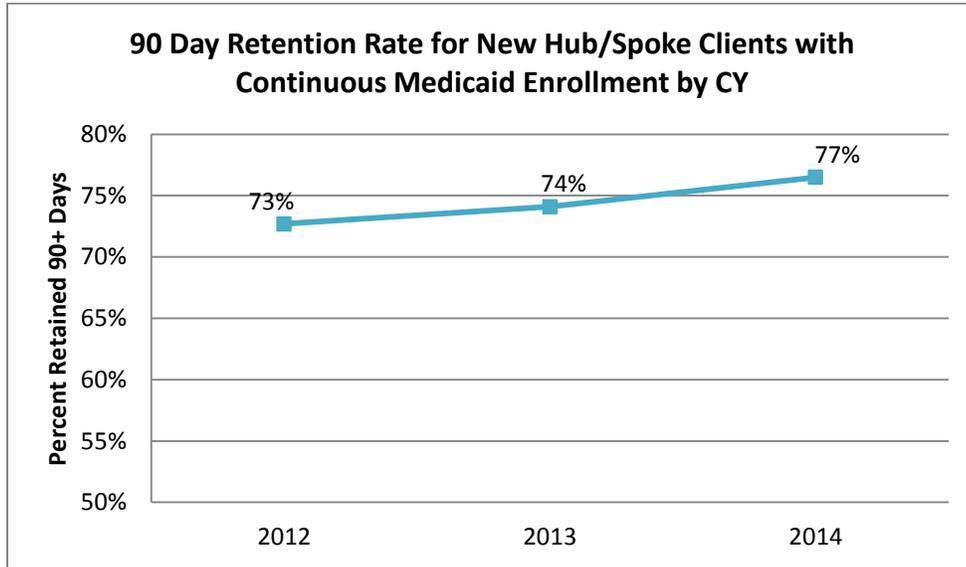


Highlights of Vermont’s Opioid Treatment System to Date:

1. The number of individuals receiving MAT in Hubs has increased by nearly 70% since the implementation of the Hub and Spoke system in January 2013 - 179% in Hubs and 18% in Spokes. There are now over 4800 individuals receiving MAT in Vermont, up from 2867 in January 2013.
2. The percentage of Vermont Medicaid-eligible individuals served by the Hub and Spoke system who remain in treatment for 90 days or longer, known as the retention rate, is

greater than the national average of 70% and is increasing.

Figure 15



3. Those who stay in treatment in the Hubs longer than 90 days show improved overall functioning at discharge.
4. All four of five Hubs have begun the National Committee for Quality Assurance (NCQA) Specialty Practice recognition baseline development process and one, Chittenden Center, has received recognition.
5. The majority of MAT is funded by the state through Medicaid payments, Blueprint Community Health Team (CHT) staff, and grants for uninsured individuals; private insurers such as Blue Cross Blue Shield, MVP, Cigna, and Tri-Care reimburse for only some services provided in the Hub and Spoke system. Private insurers have consistently paid for physician intervention and the prescribing of buprenorphine in general medical settings. Private insurers also contribute funds for the Blueprint CHTs, but third party payment methodologies do not fully support the Hub level of care or the staffing enhancements in the Spokes. Hub providers made significant progress in negotiating

payments for the full range of Hub services for individuals with Blue Cross Blue Shield and MVP. Medicare does not reimburse for care provided in Hubs. Currently, only Medicaid supports the increased staffing (RN and addictions counselor) for the Spokes.

6. ADAP and DVHA are collaborating with the Department of Corrections to establish an expanded MAT program for offenders reentering the community. The program focuses on the selection and coordinated support for inmates who choose to use abstinence as a recovery strategy. Selected inmates will be given a long-acting injection of naltrexone (Vivitrol®) prior to leaving the corrections system. Naltrexone is used in instances where a monthly injection to treat opioid addiction is preferable to daily doses of methadone or buprenorphine. This pilot will produce a standardized protocol for clinical practice and communication between clinicians working in the correctional setting and in the community, thereby enhancing continuity of care and improved support. Once established, this model may be generalized to include other clinical populations.

An extensive ongoing evaluation of the opioid treatment system in Vermont is currently being prepared by the Department of Vermont Health Access (DVHA) Blueprint for Health in consultation with the Vermont Department of Health's (VDH) Division of Alcohol and Drug Abuse Programs. The first report assessing the impact of the Hub and Spoke services enhancements is expected to be complete in the first quarter of calendar 2016.

DVHA and VDH continue to collaborate on solutions for the remaining challenges existing in the system of care. These include Vermonters waiting for MAT services in certain parts of the state where treatment capacity remains inadequate, 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.

CONCLUSION

Vermont has developed a framework for a full continuum system of care for those suffering from a substance use disorder. The system has been extremely responsive to perceived changes in the needs of the population demonstrated by the rapid establishment of the Care Alliance for Opioid

Addiction (Hub and Spoke). However, further structural and implementation improvements are necessary to enhance the efficacy and efficiency of the system. This will involve continued cooperation among funding and service providers across agencies and departments.

In addition, performance measure evaluation is an integral part of quality improvement and should be continuously enhanced and extended to cover all facets of the system. Quality improvement is a direct function of the willingness of responsible individuals in the system (providers, funders, policy makers) to adapt and embrace both subtle and major modifications in order to enhance and/or expand treatment services for substance use disorders in Vermont.

RECOMMENDATIONS

The following recommendations relate to five specific domains of Vermont's substance abuse system. ADAP's leadership in collaborating with stakeholders, state and federal policy makers and other entities will be essential to accomplish the recommendations.

Funding

1. Explore the inclusion of substance abuse services, including the Hub and Spoke system, in the All Payer Waiver³ which is an agreement with the federal government in which all third-party payers – Medicare, Medicaid, and commercial insurers – agree to use a standardized methodology to pay for health care services. This would allow CMS payment for Medicare recipients who are served in the ADAP preferred provider treatment network.
2. Investigate the feasibility of including substance abuse prevention services as Medicaid billable services.
3. As part of work being done in the health care reform efforts, investigate mechanisms for sustained funding for substance abuse prevention services to decrease the long-term need

³ http://www.leg.state.vt.us/jfo/healthcare/All-payer_model_overview.pdf

for treatment as well as the society costs associated with substance use.

4. Identify mechanisms by July 2018 for sustainable funding to maintain the knowledge base and substance abuse screening and intervention capacity developed by the Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant.

System Capacity

1. Complete focus groups of individuals and family members who have accessed the system to determine possible strategies to improve access to care.
2. Expand efforts of the Substance Abuse Treatment Coordination (SATC) initiative⁴ to improve the coordination of care between substance abuse treatment providers, AHS programs and medical professionals.
3. Co-locate substance abuse and mental health services where individuals access other services such as primary care clinics and schools.
4. Increase access to medication assisted treatment in Hubs and Spokes by opening a Hub in northwestern Vermont.
5. Develop a standard release form across AHS programs consistent with 42 CFR Part 2 that allows better coordination of care and monitoring of the system.

Workforce

1. Identify opportunities to leverage current funds as well as federal grant resources to further workforce development activities.
2. Continue to provide specialized training on the treatment of substance abuse to medical, mental health, and substance abuse professionals.

⁴ <http://healthvermont.gov/adap/treatment/documents/SATCOverview.pdf>

Evaluation

1. Develop a formula, a per person per year, that will provide knowledge about developing a consistent and sufficient funding for substance abuse prevention services, similar to the methodology the Centers for Disease Control and Prevention uses to estimate prevention and cessation services for tobacco.
2. Develop a performance evaluation plan that addresses the full substance abuse system.

Quality Improvement (QI)/Technical Assistance (TA)

1. Develop a mechanism to provide technical assistance on quality improvement approaches to assist the preferred providers in implementing data informed quality improvement projects for the improvement of treatment approaches.
2. Continue to use the indicators and performance measures on the AHS scorecards to monitor and lead change over time.
3. Support AHS efforts to develop technology systems that integrate data from multiple programs and provider types.