CoOP: Integrative buprenorphine delivery – Increasing treatment access and quality to address Maryland’s overdose epidemic

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Disclosures

• No relevant financial relationships with commercial interest over the past year.
• No discussion of unapproved uses of a commercial product, or investigational use of a product not yet approved for this purpose.
Discussion Points:

1. Buprenorphine Treatment Access
2. Buprenorphine Treatment Quality
3. Role of Opioid Treatment Programs
4. CoOP – an model of coordinated care
5. Case example
6. Lessons learned / Summary
Buprenorphine (DATA 2000) Waivers are Under-utilized.

- Few waivered physicians…
- Who often do not prescribe at all, and…
- Prescribing physicians are typically treating far fewer than 100 patients
Buprenorphine Waivers are Under-utilized

National study of 545 waivered MD’s (Kissin et al., 2006):
• Only 58% had prescribed
• Barriers: Induction logistics, poor compliance, limited counseling

Study of 330 waivered MD’s (Center for a Healthy MD, 6/2007):
• Only 50% were prescribing
• Barrier: Perceptions that effective treatment of addiction is difficult and time-consuming.

Consistent with review in the 2015 Jones report
• 44% to 66% of waivered MD’s actually prescribe
Barriers to PCP Prescribing Buprenorphine

Eliza Hutchinson, et al., Annals of Family Medicine, 2014
Quality of OBB (not just Access) should be optimized

Methods:

• Data from 17,189 Medicaid enrollees with buprenorphine claim
• Claims and encounter data, and Rx drug claims
• Examined enrollee characteristics, quality of care
Major findings:

- Bup Rx fills increased 2007-2012: $2,985 \rightarrow 12,691$
- 26% - 32% each year had no documented diagnosis of opioid use disorder
- 40% had no urine drug screen claim
- 59% had no BH treatment claim (inpt, outpt, profee)
- Wide range of mean daily dose across counties: (9.5 - 18.4 mg/d in 2012)
- Other prescription claims same year as bup Rx: 35% opiates; 38% benzos
Opioid Treatment Programs (OTPs)

- **Medication component:** Historically methadone. *Buprenorphine now allowed.*
- **Challenge:** *Few linkages* to other SUD, medical, and MH clinics (stigma).
- **Opportunity:** Can fill a critical need for supporting office-based buprenorphine (OBB) prescribers. *Role as an Integration Hub*
Reluctance to obtain or use buprenorphine waivers

OTPs can encourage waivers and support physician practice, by addressing concerns:

• **Initial assessment**: time-consuming
• **Induction**: initially intimidating
• **Instability** (relapse, diversion, nonadherence): How to intervene to avoid consequences to office, community, patients?

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Collaborative Opioid Prescribing ("CoOP") model*

Aim: Increase access to and effectiveness of OBB through concurrent OTP-based counseling, case management, collaborative stepped care, and expert consultation.

What is “CoOP”? 

Adaptive Stepped Care, Multi-Provider, Multi-Site System for Buprenorphine Treatment

Critical components:

• Opioid Treatment Program (OTP)
• Office-Based Buprenorphine (OBB) Prescriber
• Adaptive stepped care evidence-based model
CoOP: Collaborative Care - OTP + OBB’s

Scope of Possible Services in OTP hub

**Typical services:**
- Comprehensive SUD evaluation
- Buprenorphine induction, maintenance
- Methadone maintenance
- Counseling (group, individual)

**Examples of wrap-around services:**
- Case management
- Mentorship of collaborating buprenorphine prescribers
- Peer recovery advocate services
- Links to recovery/transitional housing
- Psychiatric evaluation/treatment
- Co-manage chronic medical disorders
- Occupational therapy
- Vocational training/placement
- Family engagement
CoOP’s Adaptive Stepped Care System

Adherence and tox screens determine:

- Counseling intensity
- Prescription duration
- Periods of OTP dispensing

- Changes based on ongoing data
- Consistent nonresponders or poorly-engaged are offered treatment plan change

Collaborative Opioid Prescribing ("CoOP") model

Potential options for treatment plan changes at highest step:

- Switch to methadone
- Referral to higher (e.g., partial or ICF) level of care
- Mandatory pro-recovery activity
- AMA buprenorphine taper (reversible) if refuses to engage, with offer for readmission.
**“CoOP”: An Adaptive Stepped Care System for buprenorphine Tx**

<table>
<thead>
<tr>
<th>Step</th>
<th>Opioid Agonist Medication</th>
<th>Prescribing or Dispensing Location</th>
<th>Prescribing or Dispensing Frequency</th>
<th>OTP Counseling Intensity</th>
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<tbody>
<tr>
<td>1. Stable OBB</td>
<td>Buprenorphine</td>
<td>OBB office prescription</td>
<td>1 month prescription</td>
<td>Low</td>
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<tr>
<td>2. Intensive OBB</td>
<td>Buprenorphine</td>
<td>OBB office prescription</td>
<td>1 week prescription</td>
<td>Intensive</td>
</tr>
<tr>
<td>3. Intensive OTP</td>
<td>Buprenorphine</td>
<td>OTP dispensary</td>
<td>Daily dispensing</td>
<td>Intensive</td>
</tr>
<tr>
<td>4. Methadone OTP or other tx plan change</td>
<td>Consider Methadone</td>
<td>OTP dispensary</td>
<td>Daily dispensing</td>
<td>Intensive</td>
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Collaborative Opioid Prescribing (“CoOP”) model

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<td>Ongoing primary or psychiatric care</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Comprehensive SUD/psychosocial evaluation</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Decide which (if any) MAT to use</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine dispensing, (induction, stabilization)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Counseling, case management</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Ongoing buprenorphine Rx’s</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Maintain communication</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Mentorship activities</td>
<td>✓</td>
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CoOP: Aligning Incentives

Why would OTP’s want to do this?

• Wider spectrum of services
• Individualized to patient needs
• Generates volume / revenue
• Increased access to waived physicians
• Collaboration with medical providers regarding complex co-occurring conditions
CoOP: Aligning Incentives

Why would primary care clinics want to do this?

• Addiction is finally addressed
• Free expert support for buprenorphine provision
• Help in managing behaviorally challenging cases
• *Improve medical adherence, morbidity*
FQHC’s benefit from providing buprenorphine

Buprenorphine Maintenance Treatment Retention Improves Nationally Recommended Preventive Primary Care Screenings when Integrated into Urban Federally Qualified Health Centers

Marwan S. Haddad, Alexei Zelenev, and Frederick L. Altice
Buprenorphine in FQHC’s - Haddad et al:

- Observational cohort study at a Connecticut FQHC network
- 266 buprenorphine initiates from 2007-2008
- Buprenorphine maintenance improved engagement in primary care, boosted Quality Health Care Indicator scores
- HIV+ patients on buprenorphine longer were more likely to be prescribed ART, achieve viral suppression
- HIV+ prison releasees on buprenorphine were more likely to maintain viral suppression
- Each month retained on buprenorphine associated with a 17% reduction in emergency department use
Collaborative Buprenorphine Maintenance at our OTP

Prior to July 2009:
• Discharge if buprenorphine is Rx’d externally

2011-2014:
• 81 patients treated under CoOP model
  – Demographics:
    61% Af-Am, 39% Cauc; 64% male, 36% female
    Ages: 18-24: 5%  25-44: 48%  45-64: 47%
• 26 OBB prescribers
• 83% patients were newly inducted
54 y.o. woman admitted to OTP for opioid, cocaine use. HTN, COPD, sarcoid, DJD, disk herniations. Inducted onto buprenorphine, assigned IOP counseling.

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<td>4: <em>Methadone OTP</em></td>
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CoOP: Case Example

Coordinated care with PCP, and within 2 weeks PCP took over prescribing.

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Later that month **OTP counseling intensity was reduced due to continued stability while receiving Rx’s from PCP**

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CoOP: Case Example

At 6 months, cocaine+ tox at OTP. “My housemate put it in my ice tray.” Started missing OTP counseling. Move to IOP.

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**CoOP: Case Example**

Stabilized within 1 month (negative tox, good attendance). Reduce counseling. Still getting Rx’s from PCP.

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## CoOP: Case Example

2 months later: Positive tox screen. “People near me at a party smoked cocaine….also a man spilled heroin on me in a cab.” Increase to IOP counseling again.

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CoOP: Case Example

1 month later: Took opiate for “neck pain. Failed med callback; reported falling and crushing all tablets. Changed to OTP observed dispensing.

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CoOP: Case Example

Toxicology cleared within 1 month. Transferred back to OBB prescribing. Successfully remained for many months.

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CoOP model: 
Our early experience

• Successful partnerships formed and maintained
• Increased access to MAT
  ✷ Physicians obtaining waivers
  ✷ Greater use of waivers
  ✷ Early positive response from trainees
• Coordination of SUD, medical care
• Rapid, effective management of relapse
• Challenges: 1) Convincing primary care leadership to try, and 2) Maintaining communication
CoOP model:
Our lessons learned - How to Succeed

1. **Incentivize** all parties ("win-win-win")
2. Involve **leadership** early
3. Keep lines of **communication** open
4. Assign **single points of contact**
5. Encourage progressive **reimbursement** systems
6. **Dispel myths.** Co-treatment of MAT and non-MAT patients is NOT problematic
For More Information…

Kenneth B. Stoller, M.D.       kstolle@jhmi.edu       Phone: 410-614-0654

Links related to CoOP:

SAMHSA/AATOD White Paper on integrated service delivery models involving OTPs:
(email Dr. Stoller for the link; or soon to be posted at http://www.aatod.org/)

Addiction Science and Clinical Practices:
http://www.ascpjourn.org/content/10/S1/A63

ATTC Messenger September 2015:

Addiction Treatment Forum, August/September 2015

CoOP Toolkit: Soon to be posted on AATOD website at: http://www.aatod.org/

Other links:

SAMHSA-HRSA Center for Integrated Health Solutions: www.integration.samhsa.gov/
The National Council for Behavioral Health: www.thenationalcouncil.org/
Center for Health Care Strategies: www.chcs.org/