Linking Buprenorphine Prescribers with Opioid Treatment Programs: Expand Capacity while Improving Quality
“Clinical Integration”

The extent to which patient care services are coordinated across people, functions, activities, and sites over time so as to maximize the value of services delivered to patients.

Integration models

Single Location

“Multispecialty Team”

“Co-Location” or “Shared Space”

Multiple Locations

“Collaboration”

Single Provider Entity:

Multiple Provider Entities:
Integration models

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Single Provider Entity:

Multiple Provider Entities:
Integration Hub – A Role for Opioid Treatment Programs (OTPs)

• OTP’s often function without formal linkage to other parts of the addiction, medical, and mental health treatment system.
• We are thereby missing a critical opportunity.
Response to a public health crisis: A plea to provide MAT

“If you are not using your waiver or not treating as many patients as you could I would urge you to do so.”

- H. Westley Clark, M.D., Director, CSAT, July 2013
Buprenorphine is Under-utilized

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

Maryland study of 330 waivered MD’s
(Center for a Healthy Maryland, Inc. June 2007):
• Only 50% were prescribing
• Barriers: Perception that effective treatment is both difficult and time-consuming.
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?
Collaborative Care: OBOT* + OTP

(*Office-based opioid treatment)
Collaborative Opioid Prescribing ("CoOP") model*

Purpose:
Increase **availability** and **effectiveness** of office-based buprenorphine through concurrent OTP-based psychosocial treatment, collaborative stepped care, and expert consultation.

Collaborative Opioid Prescribing (“CoOP”) model

- Concurrent treatment: OTP and OBOT.
- Comprehensive assessment and individualized treatment plan at OTP.
  - Determine which (if any) MAT to start (buprenorphine, methadone, naltrexone).
- Buprenorphine induction/stabilization at OTP, eventually prescribed by OBOT doctor.
- Ongoing Counseling, monitoring at OTP.
Collaborative Opioid Prescribing ("CoOP") model

- Ongoing communication: OTP ↔ OBOT
- Adaptive stepped care system*:
  - Adherence and substance use determine:
    - Counseling intensity
    - Prescription duration
    - Periods of OTP dispensing
- Consistent nonresponders or poorly-engaged are offered switch to methadone or high intensity (e.g., residential) care, vs. AMA Suboxone taper.

### “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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<td>1. Stable OBOT</td>
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<td>OBOT office prescription</td>
<td>1 month prescription</td>
<td>Low</td>
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<td>2. Intensive OBOT</td>
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Collaborative Buprenorphine Maintenance

OTP is incentivized:

- Generates patient volume
- More prescribers to refer to
- Collaboration with medical providers regarding complex co-occurring conditions
Collaborative Buprenorphine Maintenance

OBOT prescriber is incentivized:

• Previously untreated addiction is addressed
• Buprenorphine provision with support and ready access to expertise – partner in managing behaviorally challenging cases
• Improve medical adherence, morbidity
Collaborative Buprenorphine Maintenance at our OTP

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

Tracking since July 2011:
• 81 patients receiving buprenorphine from…
• 22 external providers
• 83% were newly inducted
• Demographics:
  61% African American, 39% Caucasian
  64% male, 36% female

  Ages: 18-24: 5%    25-44: 48%    45-64: 47%
54 y.o. woman admitted for opioid, cocaine dependence. HTN, COPD, sarcoid, DJD, disk herniations. **Admitted, inducted, IOP counseling.**

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2 weeks later PCP willing to take over prescribing since service was coordinated.

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Later that month patient stable receiving prescriptions from PCP, and in **reduced counseling** at OTP.

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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

**Adm**

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Stabilized within 1 month (negative tox, good attendance). Reduce counseling.

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

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CoOP: Case Example

1 month later: Took opiate for “neck pain.” When asked for buprenorphine recall, reported falling and crushing all tablets. **Transferred dosing to OTP.**

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Toxicology cleared within 1 month. **Transferred back to OBOT prescribing**, and successfully remained for many months.

Now

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CoOP model: Early experience

• Successful partnerships built and maintained
• Increased access to MAT
  ✦ More waivered physicians
  ✦ Greater use of waivers
• Enhanced primary care coordination
• Rapid, effective management of relapse
CoOP model: How to facilitate success

1. **Incentivize** all parties (“win-win-win”)
2. Involve **leadership** early
3. Maintain **communication**
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
CoOP model: Future directions

- Develop, study other possible CoOP models
- Disseminate (PCSS/AAAP mini grant)
- Extend to other settings (e.g., mental health, infectious disease, obstetric practitioners)
- Establish metrics for success (e.g., numbers of prescribers, patients treated, ease of access, provider/patient satisfaction)
Questions?