Recovery-Oriented Methadone Maintenance: A Coming of Age

AT Forum spoke in November with William L. White, MA, and Lisa Mojer-Torres, JD, about their newly released, ground-breaking monograph, Recovery-Oriented Methadone Maintenance (ROMM). William White is a world-wide leader in recovery-focused research and advocacy, and Lisa Mojer-Torres is a civil rights attorney and methadone-patient advocate. Both have served as volunteers for Faces and Voices of Recovery since its inception in 2001.

This is the most recent volume in a series of monographs on recovery management and recovery-oriented systems of care (ROSC) written by William White and coauthors, sponsored by the Great Lakes Addiction Technology Transfer Center (ATTC) and the Northeast ATTC, and supported by the Philadelphia Department of Behavioral Health and Mental Retardation Services (DBHMRS).

The visionaries who developed methadone maintenance (MM) many years ago foresaw the day when chronic opioid addiction, like diabetes and other chronic disorders, would be treated with methadone medication and professional and peer-based recovery support services, aided by successful methadone-maintained patients. William White and Lisa Torres are convinced that the time to reach for that goal is now.

What is ROMM?
Recovery-oriented methadone maintenance (ROMM) is an approach to treating opioid addiction by combining medical treatment with methadone medication and a sustained menu of professional and peer-based recovery support services. The goal is to help patients and families initiate and sustain long-term recovery.

Monograph Overview
The monograph consists of four articles, each with a core message:

Historical Context – Evidenced-based practices linked to long-term recovery outcomes in opioid treatment programs (OTPs) have evolved over the years. MM now needs to be recaptured and extended as a person-centered, recovery-focused treatment of opioid addiction.

Recovery and Methadone – This section explores the controversy over the meaning and measurement of recovery in MM. The authors define a patient in recovery first in the methadone context, as someone who is stabilized on an optimal dose of methadone, free of all substance-use disorders, integrated into the community, and showing improved personal and family health. An MM patient who is in recovery by this definition may choose to continue taking methadone, taper the dosage, or stop taking methadone. But these are matters of personal choice—not the boundary between addiction and recovery. As Lisa Torres emphasizes, without making any changes, this patient “is the equivalent of someone who is opiate-abstinent, and should be subject to the same criteria for recovery as anyone else.”

The authors urge healthy, stable MM patients in recovery to stand up and be counted, if recovery and methadone treatment are ever to be fully accepted. The National Alliance for Medication Assisted Recovery (NAMAR) has established an e-mail address specifically for long-term, stabilized, successful patients who are interested in helping transform methadone maintenance into recovery-oriented pharmacotherapy (matrecovery@methadone.org). Working together, volunteers will have a potentially powerful impact toward integrating the interests of long-term stabilized patients.

(continued on page 5)
The American Association for the Treatment of Opioid Dependence, Inc. (AATOD), and hosts—the Illinois Department of Alcoholism and Substance Abuse (DASA) and the Illinois Association for Medication Assisted Addiction Treatment (IAMAAT)—held the 24th AATOD National Conference at Chicago’s Hilton Hotel in late October. Severe storms and violent winds developed during the conference, prompting quips about “Chicago—the windy city.” According to some locals, the nickname refers not to the velocity of Chicago’s winds, but to the longwindedness of its politicians.

Despite the economic downturn, this important conference attracted 1,115 attendees from 70 countries, including a contingent of 21 from Vietnam, a country embarking on a major expansion of its opioid treatment programs (OTPs).

The conference theme, “Building Partnerships: Advancing Treatment & Recovery,” was the focus of many workshop sessions and poster presentations, including reports on linking patients with communities of recovery, integrating a peer-to-peer recovery-oriented system of care (ROSC) into medication-assisted treatment (MAT), and combining delivery strategies, as in New York’s Transforming Out-Patient Services (TOPS).

**Opening Plenary Highlights**

Susan McKnight, MPH, the conference chair, welcomed attendees and presented an overview of the conference. Theodora Binion-Taylor, ThD, M.Div, CADC, director of the Illinois Department of Alcoholism and Substance Abuse (DASA), and Congressman Danny K. Davis of Illinois’ 7th District, House of Representatives, eloquently described the state’s goals and accomplishments in building partnerships to improve treatment and recovery in Illinois and in the nation. Ms. Binion-Taylor underscored the importance of engaging OTP patients in all aspects of recovery, including rebuilding relationships with family and friends. She reinforced the concept that “one size does not fit all” in MAT, moving providers toward individualized, patient-centered treatment.

Mark W. Parrino, MPA, AATOD president, stressed the need for partnering with federal and state agencies, legislators, and patient advocacy groups, to advance MAT. He discussed the challenges facing OTPs, including the need to balance risk management with good clinical judgment and quality care. On that topic, he noted that AATOD is working with the Center for Substance Abuse Treatment (CSAT), under the Substance Abuse and Mental Health Service Administration (SAMHSA), to advance its risk-management training.

Mr. Parrino focused on AATOD’s ongoing Prescription Opioid Use Study, comprising 43,500 patients in 75 OTPs (see related article on page 8).

These study findings led AATOD to focus on using a valuable resource, states’ Prescription Drug Monitoring Programs (PDMPs). Mr. Parrino said that AATOD is working closely with the Legal Action Center and other groups to find ways to best utilize the critical prescription data collected by states’ PDMPs “without violating federal confidentiality regulations—a very difficult balance to achieve.”

Mr. Parrino concluded that prescription monitoring has been a vexing issue. Some states allow patients to opt-in or opt-out of monitoring; others maintain that a patient who enters an OTP must be checked for drug use in the state’s data base. Some states even ask OTPs to use the prescription-monitoring program proactively.

**MAT and the Criminal Justice System**

Speakers at the middle plenary session addressed their longstanding concern: providing MAT within the criminal justice system (CJS). About half of the 600,000 prisoners released every year are re-incarcerated, “many, if not the majority, because of an addiction, primarily opioid addiction,” according to Melody Heaps, president emeritus of Treatment Alternatives for Safer Communities. She views the current drastic cuts in state and local budgets as an opportunity “to make a case for treatment in the criminal justice system as never before,” because building more prisons isn’t an affordable option.

Ms. Heaps said that the White House Office of National Drug Control Policy is looking at criminal justice “as a major priority,” and has supported federal efforts to train presiding and chief judges—the courts’ administrative and political powers—about MAT and the disease of addiction.

According to Ms. Heaps, SAMHSA is going to have a new focus on MAT within the CJS. SAMHSA/CSAT has identified MAT as a significant topic in its grant portfolio, indicating that new criminal justice research grants will be available. “So we have a new alert at the federal level that says they have to do more in helping us...”
educate those in this system,” Ms. Heaps said. But change won’t be easy, and will require advocacy and science.

“The criminal justice system doesn’t really believe in treatment. If it did, we wouldn’t have 2.3 million people locked up, half of them addicted.”

C. West Huddleson, president of the National Association of Drug Court Professionals (NADCP), noted that one in every 100 adults in the U.S. is behind bars. Half meet the diagnostic criteria for dependence, yet, according to the National Institutes of Health, only about 15 percent of them are being treated for drug addiction. “The criminal justice system doesn’t really believe in treatment,” Mr. Huddleson said. “If it did, we wouldn’t have 2.3 million people locked up, half of them addicted.”

In almost all arrests involving substance abuse, a prosecutor and a district attorney work out a plea agreement, and the prosecutor determines the sentence. Only five percent of arrestees go to trial by jury. Even if the judge recommends methadone therapy, the treatment center may decline to treat the individual.

Speakers suggested that the key priorities are to educate the CJS “gatekeepers”—prosecutors and judges—and to provide opportunities for entry into MAT at every point in the CJS, from arrest to incarceration.

Health Care Reform
Federal matching dollars to set up health homes for Medicaid recipients are now available to State’s behavioral health agencies, as determined by their state’s Medicaid agency, may be eligible health home providers. States are pursuing funding to prepare for health care reform, including integrating substance abuse and mental health care into traditional primary health care settings.

At the Policy Makers luncheon, John O’Brien, senior advisor on health care financing at SAMHSA, presented Healthcare Reform Impact: The Road Ahead. He emphasized that health care workers need to be active advocates in preparing for 2014. Key decisions about medications, Medicaid, and the scope of services for parity are already being made, and the government is seeking input from people in the field. Mr. O’Brien urged attendees to send suggestions to SAMHSA, and to work closely with their state health, Medicaid, and substance-abuse directors. “If there are any specific ways you think medication addiction treatment should be integrated into health care reform, tell us now.”

Awards Banquet
Mary Jeanne Kreek, MD, professor and head of the Laboratory of the Biology of Addictive Diseases at the Rockefeller University, and a member of the original team that developed methadone treatment, presented the Nyswander/Dole “Marie” Awards to nine recipients (see below). Banquet honorees included C. West Huddleston, who received the prestigious Friend of the Field Award, and Lisa Mojer-Torres, JD, given the Richard Lane/Robert Holden Patient Advocacy Award for her work on behalf of methadone and recovery.

The next AATOD National Conference will convene in April 2012 at the Paris Hotel in Las Vegas, Nevada.

Sue Emerson, Publisher
ATForum@ATForum.com

2010 Nyswander-Dole “Marie” Award Recipients

Recipients were nominated and selected by their peers for extraordinary service in the opioid treatment community.

<table>
<thead>
<tr>
<th>Name</th>
<th>State</th>
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<tbody>
<tr>
<td>Miriam Ochshorn Adelson, MD</td>
<td>Nevada</td>
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<tr>
<td>Lawrence S. Brown, Jr., MD</td>
<td>New York</td>
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<tr>
<td>Gregory Carlson</td>
<td>Minnesota</td>
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<td>Sergey Dvoryak, MD</td>
<td>Ukraine</td>
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<td>Penny Hall, RPh</td>
<td>Georgia</td>
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<td>Roland C. Lamb, MAOM</td>
<td>Pennsylvania</td>
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<tr>
<td>Peter William Lee, MA</td>
<td>Vermont</td>
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<tr>
<td>John J. McCarthy, MD</td>
<td>California</td>
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<tr>
<td>Theodora Binion-Taylor, ThD</td>
<td>Illinois</td>
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The American Academy of Pain Medicine (AAPM)
27th Annual Meeting
March 24-27, 2011
Washington, DC
Contact: www.painmed.org/conf_schedules/index.html

American Society of Addiction Medicine (ASAM)
42nd Annual Medical-Scientific Conference
April 14-17, 2011
Washington, DC
Contact: www.asam.org/AnnualMeeting.html

National Association of Addiction Treatment Providers (NAATP)
2011 Annual Conference
May 14-17, 2011
Phoenix, Arizona
Contact: www.naatp.org

American Psychiatric Association (APA) 164th Annual Meeting
May 14-18, 2011
Honolulu, Hawaii
Contact: www.psych.org
Under a 1986 federal regulation (32 CFR 199.4[e]) that also applies to buprenorphine, methadone can be used only for detoxification or medically supervised withdrawal, explains Austin Camacho, chief of public affairs for Tricare. This is in contrast to the Veteran’s Administration (VA), which operates medication-assisted treatment (MAT) programs in many hospitals.

The 1986 rule precludes the use of methadone as a covered benefit for anyone insured by Tricare—including family members, retirees and their family members, and active service members. For troops returning home from Afghanistan and Iraq with traumatic injuries and post-traumatic stress disorder (PTSD), the risk of prescription opioid addiction is particularly high. Yet, Tricare still refuses to cover methadone treatment, even with federal parity laws and regulations now requiring substance abuse to be covered in the same way as medical conditions.

“Tricare is stuck with the regulation,” says H. Westley Clark, MD, director of the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, who formerly ran a methadone clinic for the VA. “But that creates a conundrum, particularly considering prescription opioid problems, that Tricare and the providers have to confront,” says Dr. Clark. “We don’t control Tricare, all we can do is work with all the federal agencies to promote the use of MAT.”

**Tricare Rationale for Denying MAT**

A. Thomas McLellan, PhD, former deputy director of the Office of National Drug Control Policy (ONDCP), tried to convince Tricare to change its policy. Especially for people not on active duty—retirees, family members—there should be no question of covering MAT, says Dr. McLellan. “I don’t understand why standards of care, like those used by the VA, aren’t being applied” for these Tricare beneficiaries. “I don’t know if the reason is financial or ideological,” because even as second-in-command at ONDCP he “had a tremendous amount of difficulty gaining any kind of collaboration” with Tricare.

“I’m comfortable blaming myself—but I can tell you that I tried many times” to convince Tricare to change its policy, Dr. McLellan tells AT Forum. Military health is the responsibility of ONDCP, but “we could not get answers” to the reasons for the MAT exclusions. Tricare finally told Dr. McLellan that “they needed to review current science to find out more.”

Dr. McLellan does think, however, that there is a difference between active-duty and non-active-duty beneficiaries. “In fairness, Tricare isn’t the same thing as the VA. I think Tricare is appropriately concerned about fitness for duty” among active troops fighting for our nation.

The VA has historically recognized the importance of providing MAT, says Dr. Clark. But the VA is completely separate from the Department of Defense, which administers Tricare. “If the regulations need to be changed, they would have to be changed by the Department of Defense. We can only point to the problem.” Like Dr. McLellan, he stressed that VA beneficiaries are no longer on active duty.

“The question is, given the extent of opioid abuse, which now includes abuse of narcotic pain relievers and heroin, does Tricare want to provide access to the evidence-based practices that would allow them to facilitate recovery?” asks Dr. Clark.

With parity and health care reform now taking place, this question will have to be addressed, or veterans returning from Afghanistan and Iraq may not be able to access “appropriate care,” says Dr. Clark. “We know that methadone treatment is fairly inexpensive and is effective.” Unfortunately, Tricare isn’t the only insurance plan with a history of refusing to pay for methadone maintenance. George Woody, MD, professor of psychiatry at the University of Pennsylvania, and until 2004 with the VA, believes that not only Tricare but many private insurance companies need to change their policies about MAT. “As far as I know, very few insurance companies pay for methadone.”

The good news is that change may be coming. Tricare’s Mr. Camacho tells AT Forum. “Tricare is pursuing changes to the CFR that would permit the use of medications like methadone and buprenorphine for maintenance treatment of opioid dependence in non-active-duty service member beneficiaries,” he says. But for active-duty troops, there is still no indication that Tricare is going to change its policy.

The Department of Defense did not respond to questions about how many troops, family members, or others now covered by Tricare need treatment for opioid use disorders. Yet with Afghanistan the opium capital of the world, and the plan for many troops to return over the next year—many needing opioid pain medications—treatment providers are bracing for a surge in demand. At this juncture, many policy makers have been advocating a change in policy, so that military personnel can access methadone and other maintenance medications. Yet, as AT Forum goes to press, there have been no announcements regarding coverage for effective MAT with methadone in the military.

Dr. McLellan, after his year of experience inside the federal government, recommends contacting legislators to help make Tricare change its discriminatory policy.
Recovery-Oriented Methadone Maintenance: A Coming of Age

It’s time to change the image of the methadone patient. The faces, voices, and stories of successful patients who, until now, have remained both invisible and silent, will be powerful antidotes to the stigma attached to opioid addiction and methadone. Volunteers need not surrender their anonymity in order to participate.

**Vision Statement** — Enhancing recovery in MM requires changing many service practices, among them patient assessment, service planning, and long-term recovery checkups and supports. As William White notes, most patients do not continue in methadone therapy for life. “Lisa and I were concerned about how to enhance the health of people on medication, and what responsibility we have to monitor, support, and re-intervene, when patients are no longer on medication.”

**Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery** — This section of the monograph was developed for the DBHMRS as part of their effort to incorporate ROSC into all programs licensed by the DBHMRS, including OTPs. It reviews stigma research and outlines strategies DBHMRS and its community partners can implement to reduce stigma.

Stigma related to methadone is the major barrier to medication-assisted recovery. Reducing or eliminating stigma will require an educational campaign led by people in recovery—people who are eager to change the field “so others won’t have to suffer, and their own futures can be more manageable,” Lisa Torres told AT Forum.

**Origin and Applications of the Monograph**

In drafting this well-documented monograph, the authors sought input from leading practitioners, counselors, and researchers across the country, and from long-term, stabilized, successful patients. Of key importance, William White emphasizes, is the fact that the monograph reflects the thinking of people in recovery, “whose personal stories offer living proof of the potential role of medication in long-term recovery from opioid dependence.”

William White has a vision that this monograph “is fresh enough and provocative enough, with enough depth and legitimacy, that the staffs of OTPs and other treatment systems using it will begin to change the way they think about treatment and recovery goals in methadone maintenance, and will integrate patients and peers into the decision-making process.

Recapturing and extending MM as recovery-oriented methadone maintenance will not be easy. It will mandate an individualized, strength-based approach. It will require moving away from a “one size fits all” attitude, focusing instead on the patient and on concepts of addiction and recovery, including clinical and recovery support practices, policies, and guidelines, with an eye toward the goals of ROMM.

Lisa Torres proposes that OTPs learn from long-term successful patients. “These patients played a significant role for us by reading and critiquing our drafts. They shared their experiences, which began to shape the monograph.” The authors suggest that as OTPs begin to integrate recovery into MM, they seek input and help from their own patients who are in sustained recovery, bringing them together with patients who are starting treatment.

**Goals of Recovery-Oriented Methadone Maintenance**

- Attract people at an earlier stage of problem development via programs of assertive community education, screening, and outreach;
- Resolve obstacles to initial and continued treatment participation;
- Achieve safe, individualized, optimum dose stabilization;
- Transition each patient from a professionally directed treatment plan to a patient-directed recovery plan;
- Shift the service relationship from a professional/expert model to a long-term recovery partnership/consultation model marked by mutual respect, hope, and emotional authenticity;
- Ensure minimum (at least one year) and optimum (individualized) duration of treatment via focused retention strategies and assertive responses to early signs of disengagement;
- Expand the service menu to include ancillary medical/psychiatric/social services, and nonclinical, peer-based recovery support services;
- Engage the community through anti-stigma campaigns and recovery community development activities;
- Provide post-treatment monitoring and support, and stage-appropriate education, support, and, if needed, early re-intervention for all patients, regardless of discharge status;
- Evaluate MM treatment using proximal and distal indicators of long-term personal and family recovery; and
- Revise accreditation criteria to reflect the substantial steps OTPs are making towards a transformation to recover-oriented care, including integrating successful patients.

**A patient in recovery may choose to continue taking methadone, taper the dosage, or stop taking methadone... but these are matters of personal choice—not the boundary between addiction and recovery**

The authors hope that, as a result of the monograph, “OTPs will develop a broader menu of services, including those traditionally associated with drug-free programs.” They also hope that “therapeutic communities will begin to integrate medication into their system of care, breaking down the barriers between these systems.” AT Forum will continue to report on the implementation of the authors’ vision of recovery.

# # #

AT Forum has learned that NAMAR and the American Association for the Treatment of Opioid Dependence (AATOD) are collaborating in distributing the monograph to OTPs. In addition, AATOD board members will send the monograph to all programs in their associations, to be downloaded, distributed, and discussed. The board members will work with NAMAR to develop a curriculum to help OTPs include patients in their discussions in a meaningful way, and to set up or adopt in their programs a recovery project similar to the existing medication-assisted recovery service (MARS) (see Peer Recovery Support in MAT, in the Fall 2010 issue of AT Forum).

Study Confirms Changing Trends in OTP Admissions

In December, AT Forum talked with three experts about the Opioid Use Study, a project started more than five years ago by the American Association for the Treatment of Opioid Dependence (AATOD) and the National Development and Research Institutes (NDRI). We interviewed lead investigator Andrew Rosenblum, PhD, of NDRI; Mark Parrino, MPA, president of AATOD; and Nicholas Reuter, MPH, senior public health advisor, Division of Pharmacologic Therapies, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. We discussed in depth the changing demographics of patients newly admitted to opioid treatment programs (OTPs).

It’s also notable that of the new patients who use prescription opioids to get high, 50 percent also use heroin, said Dr. Rosenblum. There are much higher rates of injecting prescription opioids in patients who also use heroin than in patients who don’t, suggesting it’s important to screen for HIV and hepatitis in these patients.

Younger patients: The new population of younger patients tends to be—like all young people—more impatient, said Mr. Parrino. “They think treatment is short-term, not long-term. The perception is, “I’m not going to be here very long,” or “I don’t want to be here very long.” That means it’s essential for OTPs to educate patients that opioid dependence is a chronic illness, and to hold regular clinical discussions about MAT.

Clinicians should spend more time with these patients during OTP admission, so they understand the implications of comprehensive care and counseling. “You need admitting staff who are trained and mature, and who can clearly explain the safety of the medication being prescribed, and the reasons the patient should not be using other drugs.”

Mr. Reuter cautioned that while there are provisions for detoxification in the federal regulations, patients should be told that there is an 80-percent chance of relapse if they take that route. However, some younger patients may need lower methadone doses than long-term users.

Benzodiazepines: There are implications regarding benzodiazepines as well. “While this study looks at prescription opioids, we know there’s a tremendous amount of benzodiazepine use,” said Mr. Parrino.

The study—based on surveys completed by patients entering medication-assisted treatment (MAT)—captures opioid usage patterns, socio-demographic characteristics, and other key data. The data are currently being collected from 75 participating OTPs in 34 states. OTPs in areas where prescription opioid abuse is prevalent, eg, the Southeast, were over sampled. Findings as of August 2010 were based on data from 42,000 new patients admitted to OTPs in these states. The study is funded by Denver Health as part of the Research on Abuse, Diversion, and Addiction-Related Surveillance (RADARS®) System.

Key Findings
Patients entering OTPs are young, and most are white. Fewer than half are employed, and almost half are entering MAT for the first time (see Table). Close to half (45 percent) the patients reported prescription opioids, not heroin, as their primary drug of abuse at admission.

The data show that a sizable minority of patients need to spend a lot of time traveling every day to an OTP. More than one-quarter (26 percent) travel more than 15 miles, and 6 percent commute 50 to 200 miles, to attend their OTP.

More than one-third (35 percent) cited bodily pain as a reason for seeking OTP treatment. Approximately 40 percent reported having had their pain for more than a year.

Implications for OTPs
CSAT hasn’t developed any specific guidance or protocols for treating prescription opioid abuse vs. heroin abuse, said Mr. Reuter. “The pharmacology involved in treating the two is the same.” But there may be varying levels of dependence, and patients may be abusing other prescription drugs as well, such as benzodiazepines. These factors could influence clinical decisions, such as induction dosing. CSAT clearly emphasizes that induction dosing must be individualized.

<table>
<thead>
<tr>
<th>Table: Socio-Demographics of Patients Entering OTPS as of August 2010</th>
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<tr>
<td><strong>New Patients Entering OTPs</strong></td>
</tr>
<tr>
<td>Age</td>
</tr>
</tbody>
</table>
| (average) | 34  
| 16-21 | 7  
| 22-34 | 49  
| 35-49 | 33  
| 50+ | 11  
| Sex |  
| Male | 59  
| Female | 41  
| Ethnicity |  
| White | 77  
| Latino | 11  
| Black | 9  
| Other | 2.5  
| Major Source of Income |  
| Employment | 44  
| Public Assistance | 20  
| Friends/Family | 23  
| Other | 13  
| Entered Methadone Treatment |  
| Less than 1 month ago | 13  
| More than 1 month ago | 40  
| Never (before current program) | 47  

Source: NDRI
Is Methadone Maintenance Cost Effective in an Insured Population?

A recent study in Drug and Alcohol Dependence determined the cost of treating members of a health care plan who were opioid dependent, and the effects of methadone maintenance (MM) treatment on those costs. The investigators are affiliated with Oregon Health and Science University and the Center for Health Research, Kaiser Permanente Northwest (KPNW).

Background. Most U.S. cost studies have focused on low income, unemployed, Medicaid populations that use heroin. Those studies have examined primarily the cost savings of MM to society, such as reduced criminality. Little is known about the relative costs and cost-effectiveness of MM for patients who are employed or have commercial health care insurance, or both. Accurate cost information would help in making informed decisions about MM.

Despite the controversial nature of maintenance treatment, “our analyses suggest that its value in commercial and public health plans is strong.”

Costs of care are often considerably higher among patients who are opioid dependent than those who are not. Plans may be disinclined to cover MM treatment because it could involve chronic care, but the recent parity requirements mean that plans that previously did not pay for MM must now reconsider, or decide to establish MM as a covered service.

MM is effective; it helps people avoid emergency department visits and hospitalizations. It can uncover hepatitis, HIV infection, and other conditions that would eventually require treatment, and postponing treatment could mean higher costs.

The study. The study was carried out within KPNW, a not-for-profit, pre-paid health maintenance organization (HMO) enrolling about 475,000 members in northwest Oregon and southwest Washington State. KPNW enrollees include employer groups, individuals, and Medicare and Medicaid recipients. The addiction treatment program offers a full range of services. When appropriate, it provides long-term MM treatment under contract with licensed opioid treatment programs (OTPs).

Because the study was based on calendar years, some patients had only a few days or weeks of methadone treatment during a given year. Consequently, the average total days of methadone therapy per patient were 257, rather than 365.

Patients were divided into three groups: one or more methadone visits during the year; two or more outpatient addiction treatment visits, no methadone; and one or no outpatient addiction treatment visits, no methadone. Patients had at least two diagnoses of opioid dependence in any year, and at least nine months of health plan eligibility.

(continued on page 8)
Data were gathered from 2,523 observations in 1,518 patients during the years 2000 through 2004. Data analysis was based on electronic health records extracted annually during those years.

Key finding: Total average yearly costs for patients who received MM treatment were significantly lower than for the non-methadone groups: slightly more than one-third of the cost of those receiving one or no outpatient addiction treatment visits, and about half the cost of those receiving two or more outpatient addiction treatment visits (see Table).

Table. Methadone Reduces Average Yearly Costs

<table>
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<tr>
<th>Patient Group</th>
<th>Medical Visits (not related to addiction)</th>
<th>Cost, 2004 Dollars</th>
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<tr>
<td>Any methadone treatment</td>
<td>9.5</td>
<td>7,163</td>
</tr>
<tr>
<td>Outpatient addiction treatment visits,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>no methadone</td>
<td>Two or more visits</td>
<td>18.7</td>
</tr>
<tr>
<td></td>
<td>One or no visits</td>
<td>24.5</td>
</tr>
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Compared to both of the non-methadone groups, the MM group had significantly fewer emergency department visits (1.3 vs 2.6 and 3.7; primary care visits, 3.8 vs 7.5 and 9.0; inpatient stays [days], 0.2 vs 0.6 and 1.1; and visits unrelated to addiction treatment [other counseling, other treatment, and physical therapy]—4.4 vs 8.6 and 11.8).

This study provides helpful cost information for those who need to make informed choices about health care coverage in private insurance programs, Medicare, and Medicaid. The authors note: “Our data suggest that it may be advantageous for commercial health plans to consider purchasing methadone maintenance services for members with opioid addiction.” They also comment that despite the controversial nature of maintenance treatment, “our analyses suggest that its value in commercial and public health plans is strong.”

OTPs and national and state coalitions can use this study as a valuable tool to help communities and the criminal justice system better understand the costs of health care for opioid-dependent individuals, and the proven benefits of MM treatment in this group.

Study limitations. This was not a controlled, prospective, randomized trial. Also, factors involved in MM may vary, and the groups may differ in characteristics that were not measured.