

Integrated Service Delivery Models for Opioid Treatment Programs in an Era of Increasing Opioid Addiction, Health Reform, and Parity

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Introduction

This is the second of three policy papers that the American Association for the Treatment of Opioid Dependence (AATOD) has developed for the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services (HHS). The papers have a common theme, which is to provide a blueprint for more innovative and integrated service delivery, focusing on opioid treatment programs as comprehensive treatment hubs in the treatment of opioid addiction.

Opioid addiction treatment programs (OTPs) have operated in the United States since the 1960s. In 1972, through an act of Congress, OTPs became a close-paneled system of care. This congressional legislation bifurcated the regulatory oversight of OTPs between the Department of Justice's Drug Enforcement Administration (DEA) and HHS, initially through the Food and Drug Administration. HHS subsequently transferred the regulatory authority to SAMHSA in 2001. As a point of reference, treating heroin addiction with methadone maintenance treatment was stigmatized from the beginning. Mainstream medical practices did not demonstrate an interest in treating such patients, which led to the development of OTPs.

At the present time, there are approximately 1,400 OTPs in the United States, treating approximately 350,000 patients on any given day. These treatment programs operate in 48 states. The Drug Abuse Treatment Act of 2000 created a new access point for OTPs through private physician practices that would seek special waiver authority through SAMHSA, and receive a separate and distinct registration with the DEA, in order to provide patients with Schedule III, IV, V opioids to treat chronic opioid addiction.

We are currently operating in a period with the Affordable Care Act and the Mental Health Parity and Addiction Equity Act providing opportunities for more integrated care. There is also an increasing focus on the integration of service delivery, especially for patients who are opioid addicted and need an array of comprehensive treatment services, either offered through or connecting to other sites through case management and other managed care models of service delivery. Successful service integration provides a more coordinated level of care for the patients, as illustrated by the Vermont Hub and Spoke model. Additionally, such coordinated care models better address treating patients' multiple needs, including infectious disease and psychiatric co morbidity.

While service integration is an important component to improving patient care, as indicated above, it is important to underscore the protections afforded to patients receiving medication-assisted treatment (MAT) through 42 CFR. Part 2 in the Code of Federal Regulations. Illustratively, patients need to provide informed consent to their service providers as the field of addiction treatment works with other providers of primary and behavioral health care.

At the present time, OTPs are able to use all three federally approved medications in their treatment programs as they see fit based on the clinical needs of the patient. Based on SAMHSA data from the National Survey of Substance Abuse Treatment Services (NSSATS), the majority of such patients in OTPs receive methadone maintenance treatment. A smaller but increasing number are gaining access to the use of buprenorphine in OTPs. There have been several

impediments hindering the greater use of buprenorphine in OTPs. A significant impediment that still exists is the fact that the majority of states which do have Medicaid reimbursement benefits for Medicaid beneficiaries in OTPs still do not have any specific Medicaid reimbursement rate for the use of buprenorphine or extended release naltrexone products in the OTP setting. Several states are making progress, and the most recent example is New York, which recently implemented a buprenorphine reimbursement rate for Medicaid beneficiaries who are treated in OTPs. As readers may know, there are approximately 16 states that do not provide any Medicaid reimbursement for any of the three federally approved medications in OTPs.

The third medication that has been approved by the Food and Drug Administration (FDA) in 2010 to prevent relapse to opioid use is naltrexone (Vivitrol[®]). This is also a medication of interest to OTPs, and AATOD has recommended, as have other medical organizations, that such medications should be considered for use as a relapse prevention tool in OTPs at the very least. These organizations have also made such a recommendation as linkages will be created with other parts of the criminal justice system, notably drug courts, probation and parole authorities, and correctional facilities. In fact, these kinds of integrated care models with criminal justice will be covered in the third and last policy paper for SAMHSA and HHS.

The United States is also experiencing a major change in opioid use and misuse patterns. Such changes were captured in a recently published article in the *New England Journal of Medicine* (January 15, 2015), “Trends in Opioid Analgesic Abuse and Mortality in the United States.” Dr. Richard Dart served as the lead author of the article, focusing on the data gathering work of the Denver Health and Hospital Authority through the Researched Abuse, Diversion, and Addiction-Related Surveillance (RADARS[®]) system. The article focused on such opioid analgesic misuse trends between 2002 and 2013. OTPs have learned a great deal about changing patient characteristics, especially when patients they admitted in 2005–2010 indicated a high rate of prescription opioid misuse. The southeastern corridor was particularly impacted by prescription opioid misuse, as reflected in the surveys submitted by patients in the participating programs in the southeastern states (Dart et al., 2015).

Multiple reports from various federal agencies and the RADARS[®] system have also shown that there has been a change from the use of prescription opioids, both legal and illicit, to the use of intravenous heroin. The northeastern corridor has been the most impacted region in the United States with regard to this trend. SAMHSA-published data indicate that approximately 80 percent of new heroin users had previously misused prescription opioids.

Clearly, there is a need for more integrated service delivery among OTPs, Drug Addiction Treatment Act of 2000 (DATA 2000) practices, and primary and behavioral health care settings. The two sections that comprise this policy paper were developed by Dr. Kenneth Stoller and Dr. Mary Ann Stephens of the Department of Psychiatry and Behavioral Sciences at Johns Hopkins University School of Medicine.

The second section was written by Allegra Schorr, who serves as the vice president of the West Midtown Medical Group, a comprehensive OTP primary care setting in New York City, in addition to serving as the president of the New York State Coalition of Medication-Assisted Treatment Providers and Advocates (COMPA). Each of these sections provide forward thinking

blueprints for how OTPs can work with other drug addiction treatment providers, especially DATA 2000 practices, and behavioral and primary health care settings.

The basic point of this paper is to offer OTPs models of integrated service delivery as a means of improving the care offered to their patients. There is an excellent history of providing guidance to OTPs in the United States with regard to improving the quality of treatment services. This dates back to when SAMHSA issued the first Treatment Improvement Protocol (TIP), State Methadone Treatment Guidelines, in 1993. These guidelines were subsequently updated in 2005 through TIP #43, Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. SAMHSA took on the oversight responsibility from the FDA for all OTPs in 2001, using accreditation standards to guide treatment improvement for patients in care. Both the SAMHSA regulations, in addition to the TIPs referenced above, have been further bolstered by the recent release of SAMHSA's Federal Guidelines for Opioid Treatment Programs (March 2015).

It is hoped that the paper will stimulate active discussion among OTPs and their provider and policy collaborators, using these recommended service delivery models based on principles of effective integrated service delivery.

The Opioid Treatment Program as a Hub for Coordinated Care

Kenneth B. Stoller, M.D., and Mary Ann C. Stephens, Ph.D.

BACKGROUND

A Public Health Emergency

Over the last 2 decades, opioid analgesic prescribing has increased fourfold. This increase has been accompanied by a dramatic rise in opioid-analgesic related misuse, hepatitis C virus (HCV) prevalence, and drug-related mortality. In 2013, opioid analgesics were involved in 16,235 overdose deaths, and heroin in 8,257 overdose deaths. This figure translates to about 67 deaths per day. Deaths involving heroin almost tripled from 2010 to 2013, while the rate involving opioid analgesics has been stable (Hedegaard et al., 2015). Nonfatal opioid overdoses have also dramatically increased in recent years. In 2011, there were 465,564 emergency department (ED) visits specifically related to misuse of prescription opioids, representing an increase of over 186 percent since 2004.

In the same year, there were 258,482 ED visits for heroin use, resulting in a combined average of over 1,800 opioid-use-related ED visits per day. Almost a quarter of these ED visits result in hospital admissions, yet only eight percent result in referral to treatment (SAMHSA, 2013). Treatment engagement typically relies on self-referral to community-based substance use disorder (SUD) treatment settings. The treatment offered is largely determined by the services provided by the specific program where the person presents. That treatment may or may not match the individual's needs.

People with opioid use disorder (OUD) typically benefit most from an integrated and comprehensive system of care. The most effective treatment delivers an array of services tailored to match the varying needs of the individual over time. By optimizing treatment outcome, the greatest public health benefit can be achieved.

A Complex Population, Broad Set of Needs

Treatment for SUD should be multifaceted. This is especially vital for individuals with OUD, due to high rates of co-occurring medical and psychiatric problems. If untreated, these problems are associated with significant morbidity and mortality, and they threaten public health, incur high cost, and hinder SUD treatment engagement. Persons with OUD are also likely to concurrently misuse other substances, including alcohol, cocaine, and sedatives/hypnotics. Social corollaries of severe SUD include deficits of basic necessities such as stable housing and employment. Additionally, job skills and access to transportation are often lacking.

All of these problems can be best addressed through individually tailored and extensive social support services. It can be difficult to find effective care coordination of the range and type of services necessary for optimal outcomes for persons with severe OUD. Providers of OUD treatment too often function in isolation from other sectors of health care. The result can be an overreliance on single elements of care (e.g., counseling or medication or supportive housing),

underutilization of pharmacotherapies, and elements/durations chosen out of convenience and adjusted infrequently.

Treatment Gap

In 2012, the number of persons with past year opioid misuse or dependence far outnumbered the availability of treatment slots (Jones, Campopiano, Baldwin, & McCance-Katz, 2015). A person with opioid use disorder, more so than with misuse of other substances, is likely to be physically dependent and will likely benefit from pharmacotherapies such as methadone, buprenorphine, or extended-release injectable naltrexone. Buprenorphine or naltrexone pharmacotherapy can also be provided in office-based settings.

Medication-assisted therapies (MAT) are well-established first-line elements of an evidence-based treatment approach to OUD. Yet, despite high demand, MAT is substantially underutilized (Kraus et al., 2011; Sigmon, 2015; Volkow et al., 2014). Moreover, the risk of premature treatment drop-out is high (Gryczynski et al., 2013; Pinto et al., 2010). More work is needed to increase access to OUD treatment and, once people are admitted to treatment, to engage and retain them while enhancing treatment effectiveness.

Access to treatment is limited by stigma, underserved geographical locations, underutilized medical settings, outdated service delivery structures, and funding restrictions. There is a reluctance to use MAT (buprenorphine, naltrexone) among general medical and psychiatric providers, and even among specialty SUD care providers. Even more troublesome is the reluctance of some SUD providers to accept patients already receiving MAT, especially methadone. The discomfort may stem from negative attitudes or prejudice against MAT, insufficient or inaccurate knowledge about MAT, inadequate reimbursement for MAT services, or a lack of resources needed to provide or support MAT.

Reimbursement for the full complement of treatment strategies, especially for provision of methadone-based services, is lacking across many states and across public and private payers. Public policy decisions, such as moratoria on new OTPs or maximum treatment duration mandates, sometimes limit treatment access. Also, judges sometimes impose prohibition of MAT for probationers or individuals in drug court.

Another contributor to the treatment gap is the lack of basic social necessities among the OUD population. Treatment entry and engagement is difficult without stable housing, employment, daycare, or transportation.

Finally, a lack of coordinated and comprehensive care across providers and agencies reduces the likelihood that individuals will receive the necessary services and supports to recover from SUD. This is a costly shortfall as it increases the likelihood of medical sequelae—for example, human immunodeficiency virus (HIV) or hepatitis—as well as avoidable emergency room visits, inpatient hospital admissions, and arrest/incarceration.

Opportunities: Capitalizing on Opioid Treatment Programs

Individuals with OUD often have more significant physical and behavioral health needs that result in high healthcare utilization and cost. States and the federal government are looking for

innovative, cost-effective ways to integrate and coordinate treatment for this high-need population. The aim is to assure access to a wide range of services, while improving the cost-effectiveness of care.

OTPs can be a key component in accomplishing these goals. OTPs can streamline the administration, coordination, and continuity of care, and thereby enhance treatment access, quality, and retention. OTPs have provided treatment to opioid-addicted patients for over 40 years. This has imparted a level of expertise and experience that has yet to be meaningfully tapped by the larger addiction, psychiatric, and general medical treatment community.

In 2013, there were 1297 OTPs nationwide that provided treatment, typically including methadone, to more than 330,000 individuals. The number of OTPs has increased, and there were approximately 1,400 SAMHSA-certified OTPs in 2015. OTPs offer a rich array of resources and expertise that are not typically available in office-based practices. They provide a setting where complex co-occurring problems can be managed.

OTPs are open 6 or 7 days per week to provide medication, counseling, and other daily services for patients. With these broad hours of operation and observed medication dosing, clinical contacts with staff are frequent. This is particularly the case early in treatment and during periods of relative instability, when unobserved dosing is limited. Frequent visits can facilitate patient retention and engagement, allow for staff to motivate behavioral change, and provide case management.

Behavioral contingencies that tie together medication, psychosocial, and behavioral interventions can also enhance adherence to treatment. Motivated stepped-care (MSC) (Brunner et al., 2004) is an example of an adaptive treatment model that has been proven effective and is now considered a gold standard in OTP treatment (King & Brunner, 2008). MSC delivers opioid treatment services that match the intensity of counseling services to each patient's clinical progress and reinforce counseling attendance. This model improves both counseling attendance and drug abstinence.

OTPs are uniquely mandated to include medical staffing and infrastructure (program physicians, medical director, nurses, mandated physical exams, and accreditation standards requiring programs to address mental health needs). This structure promotes close collaboration with medical and psychiatric providers. OTP clinical staff can be trained to perform motivational interviewing and to have basic knowledge about common medical and psychiatric problems. Close collaboration with other providers can transform OTPs into specialized agents of health behavior change, and it helps support the efforts of primary care and mental health providers.

Collaboration also leverages the unique setting and structure of OTPs so they may serve a key role in an integrated and coordinated health care delivery system. The integrated care system is especially relevant in the context of health reform, which increasingly applies principles of population health to address our nation's most pressing health needs. OTPs across the nation can serve as hub sites of treatment and expertise that is both specialized and centralized in a modernized addiction treatment delivery system. Having OTPs in this role creates a referral and care coordination system with tendrils extending to DATA 2000 prescribers, primary care

providers, mental health providers, pain management and other medical specialists, hospitals, and even the criminal justice and social service systems.

PRINCIPLES TO FACILITATE COORDINATED CARE

There are several guiding principles to facilitate the adoption of new models, such as integrative care, involving OTPs as hubs. First and foremost, the OTP leadership, as well as leaders of other involved entities, must be supportive and engaged early in the process of change. OTP leadership should offer the opportunity for OTP staff to not only buy into the goals for these changes but also receive adequate training for any new or expanding roles. Resources such as the Providers' Clinical Support System for Opioid Therapies (PCSS-O, <http://pcss-o.org/>) and Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT, <http://pcssmat.org/>) can be used to provide training and mentorship on evidence-based practices, helping staff to establish new competencies.

Successful coordination is also facilitated by designating a single point of contact to optimize referrals and communication in both the OTP and the collaborating entities. A cooperative team-based model of care should be adopted to minimize opportunities for maladaptive "splitting" of care providers by patients with co-occurring personality vulnerabilities. Open and ongoing verbal and electronic forms of communication are essential to integrated and coordinated care, especially between providers in dispersed locations.

It is also important that all parties recognize both intrinsic and extrinsic incentives for success and build models that align such incentives. For example, OTPs can benefit from linkages with primary care or psychiatric providers through resultant improvements in somatic and mental health among their patients, ease of access to these providers, and referrals from new sources. Likewise, medical and psychiatric practices benefit from coordinated care when their patients reduce drug use and associated risk behaviors and improve adherence to prescribed treatments. They also benefit from having access to expert consultation and mentorship through OTP clinical leadership regarding SUD treatment. The OTP's provision of case management services to some of their most needy and complex individuals is yet another benefit that providers collaborating with OTPs can anticipate.

INTEGRATED CARE OPPORTUNITIES INVOLVING OTPs

1. Coordination with Physicians Prescribing Buprenorphine (DATA 2000 Practices)

DATA 2000 permits physicians who receive specified training to treat OUD with buprenorphine. Office-based buprenorphine treatment is typically delivered via primary care or psychiatric settings. As of 2015, over 29,000 physicians had been DATA certified to prescribe buprenorphine. However, buprenorphine waivers have been underutilized (Volkow et al., 2014). For example, 53.4 percent of U.S. counties have no waived physicians, and in rural counties that figure is 82.5 percent (Rosenblatt et al., 2015). Further, in a random sample of 545 waived physicians, only 58 percent had prescribed buprenorphine (Kissin, McLeod, Sonnefeld, & Stanton, 2006). Physicians in that study cited induction logistics, poor compliance, and limited counseling availability as barriers to providing buprenorphine treatment. These barriers can

reinforce physician perception that effective treatment of SUD is, by nature, difficult and time-consuming, and always best left to specialized treatment programs.

Buprenorphine prescribers can greatly benefit from strengthened collaboration with OTPs. OTPs have the capability to dispense agonist medication on site during periods of clinical instability. OTPs can also provide counseling and wrap-around services to patients, including those receiving office-based buprenorphine in the community. This capability of OTPs to provide medication dispensing and intensive counseling when needed broadens the range of patients considered candidates for office-based treatment, especially for providers with little experience. It provides an intermittently necessary service for particularly complex patients. Strengthening such collaborative care for patients allows for the dynamic adjustment of the type, intensity, and setting of care, in addition to medication options, over time.

Vermont's Hub and Spoke Model

Coordinated care models have been developed from both top-down and bottom-up initiatives. Coordinated care models encourage uptake of MAT while also improving quality of care. For example, using a top-down approach, the State of Vermont has developed a regional comprehensive addiction treatment infrastructure described as a Hub and Spoke system that was implemented statewide (<http://www.healthvermont.gov/adap/documents/HUBSPOKEBriefingDocV122112.pdf>).

Each center, or Hub, serves a geographic area and provides comprehensive addiction and mental health services to residents with OUD. In addition, these specialized centers assure the provision of integrated health care, recovery supports, and rehabilitative services in coordination with medication treatment and counseling. This model assures a “whole-person” approach to treatment of substance use disorders.

Less clinically complex patients who would benefit from MAT but are not best suited for methadone can receive treatment within the Spoke system. A Spoke comprises a designated provider (prescribing physician) and a team of collaborating health and addiction professionals who monitor adherence to treatment and coordinate access to recovery supports. They provide counseling, contingency management, and case management services. Spokes may consist of entities such as primary care medical homes, federally qualified health centers, physician practices, or specialty clinic-based outpatient mental health or SUD treatment providers.

The Hub and Spoke model is comprehensive, expansive, and standardized, but it may appear challenging to recreate in a larger state, or without top-down authority. Dissemination of this model seems most feasible in a smaller jurisdictional system, such as a county or an urban center.

Collaborative Opioid Prescribing Model

The Collaborative Opioid Prescribing (CoOP) model (Figure 1), a bottom-up care coordination model of care, has been developed at Johns Hopkins Hospital (Stoller, 2015). CoOP is an adaptive stepped-care model similar to MSC (described above), but it encompasses both internal (OTP) and external (DATA 2000 physician) providers. A CoOP model is easily designed, implemented, and maintained using a single OTP as a hub. It does not require larger systems

transformation as in the Vermont model. The model links primary care, psychiatric, or other office-based buprenorphine (OBB) sites with an OTP.

The goal of the CoOP model is to increase the availability, utilization, and efficacy of OBB maintenance. It does so through concurrent provision of OTP-based verbal therapies, collaborative stepped-care, wrap-around services, and expert consultation. The OTP can provide the initial comprehensive SUD assessment, and when buprenorphine maintenance is recommended, induct and stabilize the patient through its medication dispensary. The OTP also provides ongoing counseling. Once the patient is stabilized, buprenorphine provision shifts to prescriptions by the OBB site while verbal therapies continue at the specialized SUD treatment (OTP) site.

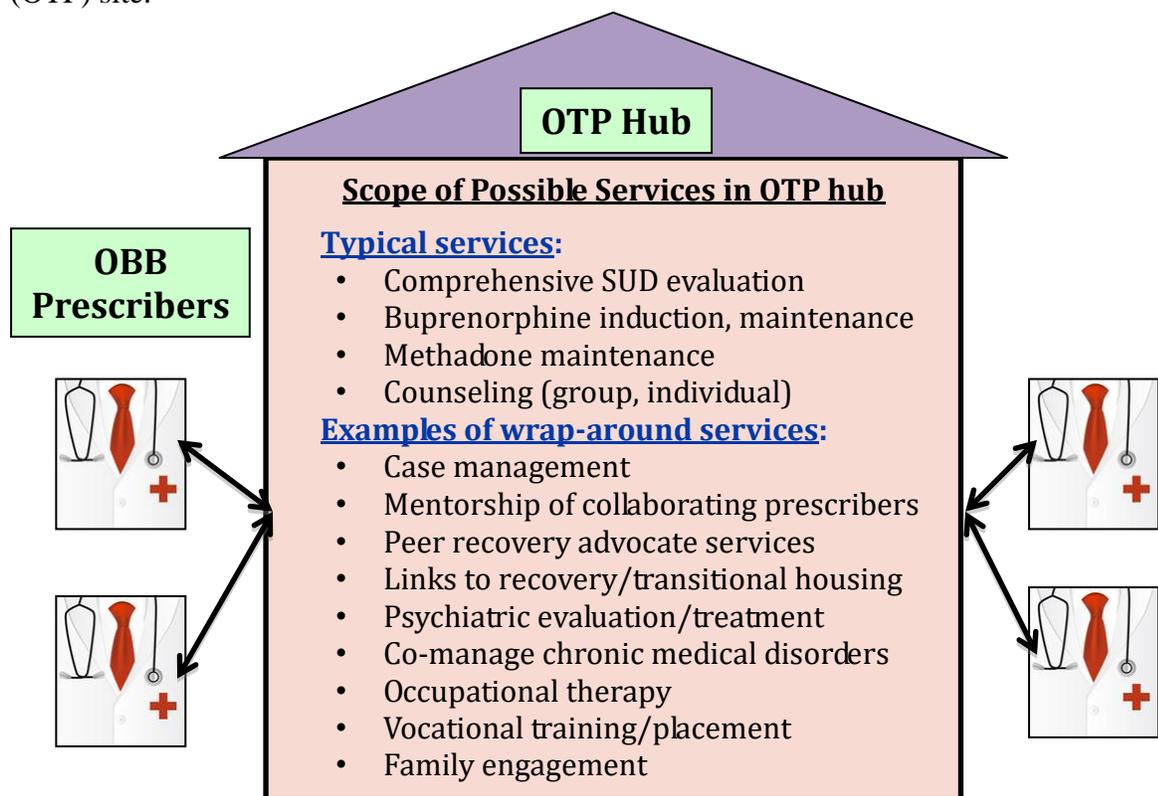


Figure 1. Collaborative Opioid Prescribing (CoOP) program model design developed and implemented at Johns Hopkins Hospital (Stoller, 2015)

An adaptive stepped-care model (Table 1) adjusts counseling intensity and medication prescribing and dispensing based on ongoing indicators of treatment response (e.g., toxicology screen results and percent counseling adherence). If there are indications of clinical destabilization (e.g., positive toxicology screen or decline in counseling adherence), counseling schedules can be intensified. When necessary, medication dispensing is shifted from the OBB to the OTP dispensary site. Conversely, as the patient stabilizes, counseling intensity is decreased and medication prescribing in the office-based setting is resumed.

Care is coordinated during the entire treatment episode through ongoing telephonic and electronic communication between the OTP staff and OBB providers. Patients ultimately not

responding to treatment can be offered a change in medication (e.g., to methadone) or setting (e.g., to residential care). This local, bottom-up approach fosters system creation that takes into account unique features of all participants and considerations—the patient served, the providers participating, and the local treatment system structure. The exact design of a CoOP model should be tailored to patients served, participating providers, and local reimbursement logistics.

Table 1. CoOP: A Multiprovider System for Buprenorphine Treatment (Example of an adaptive stepped-care model that may be used)

Step	Opioid Agonist Medication	Prescribing or Dispensing Location	Prescribing or Dispensing Frequency	OTP Counseling Intensity
1. Stable OBB	Buprenorphine	OBB prescription	1 month prescription	Low
2. Intensive OBB	Buprenorphine	OBB prescription	1 week prescription	Intensive
3. Intensive OTP	Buprenorphine	OTP dispensary	Daily dispensing	Intensive
4. Methadone OTP	Methadone	OTP dispensary	Daily dispensing	Intensive

Shaded cells indicate intensified treatment elements.

The CoOP model above, as implemented at the Johns Hopkins Hospital OTP and surrounding primary care providers, is one iteration of many possible collaborative models between OTPs and DATA-waivered physicians. It has demonstrated early success in increasing the number of physicians willing to obtain and use a buprenorphine waiver. Perhaps even more encouraging and impactful is the observation that in practice sites that precept medical residents, those physician trainees have completed the buprenorphine training course and appear to be very energized to provide buprenorphine as part of their future medical practices post-residency.

2. Coordinating with Primary Care Practices

OTP patients frequently have multiple chronic somatic health problems that are ignored or poorly managed, especially during periods of ongoing drug use. Successful treatment of substance use reduces the risk of contracting, and can slow the progression of, addiction-related medical diseases such as hepatitis and HIV. Adherence to medical treatments is improved when substance use declines.

Case management that is available in OTPs can address barriers to self-management of health problems, such as lack of transportation, unstable housing, and spotty insurance coverage. OTPs have the ability to provide directly observed therapy for medical conditions such as HIV, hepatitis, and tuberculosis exposure pharmacotherapy. Collaborative care by OTP nurses and other medical providers can enhance treatment of chronic medical conditions such as hypertension or diabetes, through clinical monitoring at the OTP.

While this sort of coordinated care is helpful, a fully integrated (e.g., co-located) medical service within the OTP would be ideal. An effective collaborative care model may serve as a step toward development of a more fully integrated, and even co-located, care system over time.

3. Coordinating with Psychiatric Providers

Co-occurrence of SUD and other psychiatric disorders among persons with OUD is exceedingly common. Addressing mental health conditions is paramount to treating SUDs. Elimination of substance use reduces the occurrence of episodes of severe mental illness and can prevent or delay development of more severe symptoms of mental illness, such as psychosis. Reduction in substance use also improves adherence to psychiatric treatment and thereby reduces the need for more intrusive, intense, and costly interventions, such as psychiatric hospitalization. Case management available in OTPs can complement treatment efforts in psychiatric practices by reducing or eliminating barriers related to transportation, poor housing, and lack of access to insurance.

The frequent, even daily, contact between OTP staff and patients can provide powerful support to psychiatric providers. It enables OTP staff to develop very productive, trusting relationships with the individual patient. OTP staff can thereby help monitor the patient's psychiatric symptomology and encourage adherence to the psychiatric providers' recommendations. Additionally, OTPs can provide directly observed therapy of psychopharmacologic agents, as well as deliver targeted therapeutic messages during routine encounters (e.g., self-efficacy, positive self-regard, use of effective coping skills, and the benefits of continued mental health care). This approach can improve engagement, retention, and efficacy of psychiatric treatment.

While this type of collaborative treatment is helpful, fully integrated (e.g., co-located) psychiatric evaluation and treatment within the OTP is ideal. The process of establishing collaborative care models may over time serve as a step toward development of a more fully integrated behavioral health care system within the OTP.

4. Coordinating with Specialty Medical Providers

Pain Treatment Providers

Co-occurrence of SUD and chronic pain is very common. Since approximately half of patients presenting to treatment for OUD report having started through misuse of prescription pain medications, the concurrent treatment of addiction and pain is essential. The OTP can serve as a source of expert addiction-related consultation to pain treatment clinicians. Also, the OTP can be utilized as a facility to refer their patients for evaluation and treatment when they begin to exhibit behavior concerning for misuse of prescribed medications. The OTP can detect, monitor, and treat co-occurring non-opiate SUDs.

Management of pain can be enhanced through refinements of the individual's treatment at the OTP. For example, by splitting the daily dose of methadone or buprenorphine dispensed through the OTP, a greater duration of analgesia coverage can be achieved. Dividing the opioid agonist dose into a two- to four-times-per-day regimen can avert the need to prescribe additional opioids (e.g., oxycodone) for "breakthrough" pain. Such medications can reinstate addiction

behaviors, as well as confuse the interpretation of routine toxicology testing. Through their relationship with pain treatment providers, OTP medical providers can develop proficiency in pain treatment approaches that present less risk of addiction/misuse.

The OTP can also assist the pain management physician through regular monitoring for problematic drug use and for medication diversion. This can be accomplished through toxicology testing, clinical observation, and episodic requirement to bring the prescribed medication in for counting. Effective management of chronic pain in addicted populations requires a multidisciplinary, team-based approach. The OTP team can play an important role when it functions as a hub of care coordination (Clark, Stoller, & Brooner, 2008; Dunn, Brooner, & Clark, 2014).

Obstetric Providers

Neonatal abstinence syndrome (NAS) is a constellation of signs and symptoms indicating autonomic, gastrointestinal, and respiratory system dysfunction that occur from intrauterine exposure to opioids such as heroin. NAS and other sequelae from SUD during pregnancy are associated with low birth weight, premature birth, and higher rates of mortality. Affected newborns have substantially longer neonatal intensive care unit stays, early childhood medical costs, and increased risk for developing problems than healthy newborns.

From 2000 to 2009, the incidence of NAS in the U.S. increased almost threefold and the incidence of maternal opioid use, almost fivefold (Patrick et al., 2012). Treating women who are identified as using opioids during pregnancy is thus a public health priority. However, treatment resources for pregnant women with SUDs in general, and especially for agonist maintenance for OUD, are scarce. Obstetric providers can play a critical role in improving access to OUD treatment for their patients.

Pregnant women with SUDs require enhanced specialized care to improve outcomes for mother and infant. Model programs include integrated, co-located obstetrics, SUD treatment, and other wrap-around services, such as temporary housing, psychiatric evaluation and treatment, parenting classes, and newborn pediatric care (Jansson et al., 1996). In some cases, onsite childcare and transportation may also be provided to facilitate attendance to counseling and medication appointments.

Obstetric practices often have limited access to important ancillary services that promote healthy birth outcomes in pregnant women with OUD. Moreover, obstetricians typically have little experience with buprenorphine induction. Pregnant and post-partum women with OUD also require appropriate pain management strategies that can be challenging for obstetricians who have limited time and experience to assess and treat OUD in their patients. Both methadone and buprenorphine improve maternal and fetal outcomes when moderate to severe OUD is present in the mother. Prenatal treatment with buprenorphine results in less severe NAS than with methadone (Jones, Finnegan, & Kaltenbach, 2012).

OTPs can develop ongoing collaborative relationships with nearby obstetric providers to fill a critical role by providing assistance with buprenorphine induction and maintenance through a collaborative model (such as CoOP, as above). Also, OTP staff can provide added services for

women during their pregnancy. In this way, access to and quality of OUD treatment for pregnant women can improve.

Infectious Disease Treatment Providers

The prevalence of HIV and hepatitis C virus (HCV) infections is to a large extent driven by injection opioid use. About 80 percent of people with HIV who inject drugs are also co-infected with HCV. HCV is now the most common blood-borne pathogen in the U.S. HCV infections increased 150 percent from 2010 to 2013, especially among young nonurban people with infectious disease, often in association with misuse of injected prescription-type opioids (Suryaprasad et al., 2014). As such, OTPs see a large percentage of HIV and HCV positive patients.

Collaboration with infectious disease treatment providers can improve the health status of these patients. Effective SUD treatment through the OTP, as well as educating patients regarding risk reduction strategies, decreases the risk of infecting others and slows the progression of the patient's own disease. Additionally, as the patient's recovery strengthens, adherence to prescribed pharmacotherapies for HIV or other infectious diseases improves. This is critical in the case of HIV and newer HCV pharmacotherapies, which require excellent adherence. Medication adherence can be virtually guaranteed through use of directly observed pharmacotherapy at the OTP's medication dispensary. Increasing the role of the OTP in the management of patients with infectious diseases, through support of the OTP as a hub of collaborative care, can be a powerful public health strategy that has been largely underutilized.

5. Collaborating With Payers

By supporting treatment of SUDs and other behavioral health conditions, payers can help their members improve general health behaviors. Effective SUD treatment, especially when coupled with psychoeducation regarding general health maintenance topics, can improve adherence to medication and attendance to medical services. It can also enhance compliance with preventative care recommendations, such as prescribed diet regimens, sleep hygiene, and exercise. Decreases in high-risk behaviors such as intravenous drug use mitigate risk for serious and often costly medical conditions, such as infectious hepatitis, HIV, or endocarditis.

A payer's care manager can be embedded in an OTP on a set (e.g., weekly) schedule, to facilitate direct contact with members being treated in the OTP and to collaborate face-to-face with OTP staff regarding health care needs/deficits. OTPs are well equipped to address the difficulties that payers face in locating and contacting members with SUD since they may present to the OTP multiple times per week. Collaboration between the payer and the OTP can optimize performance on various quality measure targets on which the payer is judged during accreditation reviews, such the Healthcare Effectiveness Data and Information Set (HEDIS). High patient regard for the value of care manager services embedded in a managed care organization can also improve patient regard for OTP program value and thereby increase engagement and retention.

6. Health Homes in Opioid Treatment Programs

The Affordable Care Act has enabled reimbursement for health home services in behavioral health care settings. The Medicaid health home state plan option (Affordable Care Act Section 2703) offers states a mechanism to promote integrated physical and behavioral health services. Certification for OTP-based health homes is now available through national accreditation bodies such as the Joint Commission (TJC) and the Commission on Accreditation of Rehabilitation Facilities (CARF). Health homes in the OTP setting provide a structure that fosters integrated medical care within the OTP, as well as productive collaborations with outside medical and psychiatric providers.

7. Hospital-based Opioid Treatment Programs

OTPs that are part of a hospital system present unique opportunities. Convenient pathways to facilitate OTP admission from more acute settings (e.g., inpatient units and EDs) foster engagement and treatment entry at a clinically critical time, when distress caused by acute health problems punctuate the need for SUD treatment. Hospital-based OTPs often share, or have convenient access to, hospital resources, including the hospital's electronic health record, clinics, laboratories, and pharmacies. These connections facilitate communication between the OTP and other service providers. They also make it easier to embed within the OTP services such as psychiatric evaluation and treatment, basic medical services, directly observed therapy for HIV, occupational therapy, or integrated obstetrical care. When the hospital-based OTP is part of an academic health system, this can facilitate performance of high-quality clinical research on innovative treatment models that may have the potential for wider dissemination when proven effective.

For these reasons, the hospital-based OTP, especially when connected to an academic medical center, can serve as a “hub among hubs,” delivering the most comprehensive treatment to individuals with particularly high levels of need. Such a program can serve as a resource for other nearby OTPs and can function as a center of clinical research.

8. Collaborating with Local and State Government, Regulatory Bodies, Policy Makers

Creating close collaborations between OTPs and their local and state oversight agencies can foster the identification of gaps between public health needs and resources. This can, in turn, lead to the development of policies, administrative supports, and delivery systems that address such gaps, creating a more “smart,” effective, and efficient treatment system. Such close and dynamic associations can, over time, help dispel myths about MAT and thereby reduce negative attitudes regarding the population served and the treatments being offered. It can encourage the creation of laws, regulations, and policies that are based on well-established medical research rather than preconceived bias against MAT. Collaborating with these agencies can create innovative systems such as Vermont's Hub and Spoke model or behavioral health homes within the OTP (both described above).

9. Functional Linkage Between Substance Use Disorder Providers

OTPs can coordinate within a local jurisdiction (such as county and city health departments) to transform what was an unrelated group of OTPs and other SUD treatment providers into a synergistic and highly effective system of care. Sharing of resources and referrals of patients

between treatment and recovery support providers can create a well-coordinated network, better able to match patients to services based on clinical and social needs. The system could function to dynamically assign and adjust treatment modality, setting, and intensity to each individual's needs by cross-referral to providers that best match those needs over time.

10. Improving Access to Community-Based Recovery Support Services

Although a community's social services and recovery resources may be vast, they are often underutilized by patients in OTPs, who are a vulnerable population perhaps most in need of such services. Underutilization may also be related to poor communication regarding what services are locally available. However, prejudice against MAT among service providers is another barrier OTP patients encounter in the community. Creating forums for information dissemination, with OTP participation, can help community-based social and recovery support providers learn more about treatments for SUD, including pharmacotherapies. Likewise, OTPs can be informed about community resources within reach of its patients.

Through such efforts, OTPs can create productive collaborations with housing agencies, social services, vocational or psychosocial rehabilitation, family resource centers, and the spiritual community. Potential for particularly fruitful collaboration can be formalized through memoranda of understanding and even by embedding staff from such entities within the OTP premises on some regular schedule.

11. Telemedicine and Mobile Technology

As technology continues to advance, OTPs can help facilitate and coordinate the use of effective telecommunication tools in medical and behavioral health care delivery. Telemedicine seeks to improve a patient's health by permitting two-way (or group-based), real-time interactive communication between the patient and the practitioner at a distant site through use of interactive audio and video telecommunications equipment.

Telemedicine can play an essential role in implementing integrated models of care, particularly in less populated areas where OTPs and other treatment providers are geographically dispersed, and in serving patients who have limited transportation or mobility. It provides a cost-effective alternative to face-to-face communications when the latter is impractical. Telemedicine may be particularly helpful in rural areas where the expertise and basic counseling resources of the OTP would be beneficial, but where there is no OTP physically located. States should consider allowing reimbursement for telemedicine under Medicaid.

Similarly, mobile applications ("apps") are innovative and highly accepted tools that have the potential to deliver behavioral change interventions within the context of integrated care models. Mobile applications can track and monitor behaviors among OTP patients, reminding patients to take medications and reporting mood symptoms and proximity to high-risk localities. They can collect useful data about patient behaviors that help them self-manage their health care and deliver consistent quantitative information to primary and behavioral health care providers for better integration and collaboration in medical decision making.

ADDRESSING BARRIERS TO OTP-BASED COLLABORATIVE MODELS

To establish and foster collaboration between OTPs and other entities, concrete recommendations are offered to address institutional barriers that often impede coordination of care:

- Government and treatment advocacy groups must make strong efforts to eradicate stigma through educating the public, policy makers, treatment providers, service agencies, payers, and the criminal justice system about MAT, OTPs, and the efficacy of treatment.
- OTP leadership must recognize opportunities created by collaborative care and reach out to engage health care providers, recovery support service entities, and governmental/regulatory bodies, to conceive and implement collaborative relationships and systems of care.
- In many states, the lack of Medicaid coverage for a full complement of addiction treatment, especially methadone-based treatment within OTPs, is an insurmountable barrier to providing treatment access and to implementing these collaborative models of care. This situation must be remedied.
- Likewise, the lack of Medicare coverage for OTP services precludes the widespread use of these coordinated care models. Such systems of care would be particularly useful to an aging opioid-addicted population with multiple medical morbidities. This situation too must be remedied.
- OTPs must become more flexible by offering and billing for counseling when patients are not receiving MAT (methadone or buprenorphine) in the clinic. Doing this allows patients to remain concurrently enrolled in the OTP even when medications are being provided in an office setting (as in the CoOP model).
- Provider payment for time spent in care coordination activities is typically not allowed. Reimbursement models for care coordination should be implemented to encourage the development and utilization of collaborative models of care.
- Integrating outcomes research (e.g., through federal funding mechanisms) can help establish which models of coordinated care are most effective for which populations and determine the economic impact on the health care system. Such research should be encouraged and supported.

SUMMARY

Persons with OUD often have complex treatment needs that require concurrent and coordinated attention to addiction, medical, psychiatric, and social problems. OUD patients do best when they have access to a full range of MAT options in a variety of settings. They can benefit from assistance in locating and navigating an array of social and recovery support services.

OTPs can fill a critical need for expert and efficient management of OUD treatment. With over 4 decades of experience and related medical research, OTPs provide multidisciplinary and comprehensive services, including the potential for a full range of pharmacotherapies for opioid

and other SUDs. OTPs offer a treatment setting that allows for frequent patient contact with staff who come to know the patient and the patient's individual needs particularly well. In many cases, the OTP serves as the greatest, or only, source of stability in the patient's life. These qualities impart the OTP with the ability to coordinate care among other health care providers and recovery support agencies. OTPs can also help other providers take better care of patients they serve by facilitating comprehensive treatment services, including counseling and care management. OTP staff can make their expertise accessible to others by providing guidance and support to providers outside the OTP setting.

Such productive connections with other care providers can also enhance the OTP's clinical outcomes by providing a broader spectrum of services for its patients. These service enhancements include OBB treatment and improved access to community resources and medical providers. Fostering these relationships also establishes referral sources of new patients into OTP-based services, patients who otherwise may not have found their way to an SUD treatment setting.

Patients, providers, governments, and payers can all benefit from models of coordinated care through OTPs. When the OTP functions as a hub and coordinates with primary care providers, OTP staff can help the patient progress on treatment plan goals related to somatic health. Additionally, the physician who is given the support and access to counseling the OTP provides may become more comfortable prescribing buprenorphine or naltrexone. This benefits the patient, who receives more effective somatic and SUD treatment. It also benefits the community, as more physicians become willing to provide OBB to more patients. As treatment access, engagement, and effectiveness progress, population health status improves and healthcare costs decline. This is extremely desirable from the perspective of agencies responsible for improving public health and controlling health care expenditures. Strong governmental advocacy is critical in order to achieve these "win-win" scenarios.

This paper asserts that OTPs have the expertise and infrastructure to centralize many core elements of engaging patients and implementing an integrated and coordinated approach for treating OUD. OTPs are in a central position of managing patient care while facilitating access to other treatment services.

Implementation requires organizational changes that value collaboration and that provide new competencies. Within the context of health reform, the Affordable Care Act provides a range of resources to assist states with this transformational change. Each state will choose to implement these changes differently; however, this paper provides some examples of statewide (Vermont) and local (CoOP) implementation of innovative models.

With opioid use on the rise, the field is primed to design, implement and evaluate collaborative care models focused around the OTP. Further implementation of the Affordable Care Act will help address barriers to treatment access, making collaborative care models more conceivable. The climate for healthcare delivery has become ideal for mobilizing resources that can help implement and improve treatment innovations. Through this process, treatment for individuals with OUD can become more accessible and effective, health outcomes will improve, and mortality can begin to decline.

Recommended Resources

Integrating primary and behavioral health services

- SAMHSA–HRSA Center for Integrated Health Solutions
 - <http://www.integration.samhsa.gov/>
- Agency for Healthcare Research and Quality— The Academy: Integrating Behavioral Health and Primary Care
 - <http://integrationacademy.ahrq.gov/>
- Centers for Medicare & Medicaid Services (CMS)—The CMS Innovation Center
 - <http://innovation.cms.gov/>
- Center for Health Care Strategies—Integrated Services for People with Complex Needs
 - http://www.chcs.org/focus_area/integrated-care-for-people-with-complex-needs/

Other TIPs and SAMHSA Center for Substance Abuse Treatment (CSAT) documents

- Medicare Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders
 - <http://store.samhsa.gov/product/Medicaid-Coverage-and-Financing-of-Medications-to-Treat-Alcohol-and-Opioid-Use-Disorders/SMA14-4854>
- Federal Guidelines for Opioid Treatment Programs
 - <http://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP>
- Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders
 - KAP Keys for Clinicians: <http://store.samhsa.gov/product/Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4785>
 - Quick Guide for Clinicians: <http://store.samhsa.gov/product/Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4792>

Training

- PCSS-MAT—Providers’ Clinical Support System for Medication Assisted Treatment
 - <http://pcssmat.org/>
- PCSS-O—Providers’ Clinical Support System for Opioid Therapies
 - <http://pcss-o.org/>
- AATOD—Hepatitis Education for Opioid Treatment Providers
 - <http://www.aatod.org/projectseducational-training/hepatitis-c/>
- SAMHSA—Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs: Inservice Training Based on TIP 43
 - <http://store.samhsa.gov/product/Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA09-4341>

Funding opportunities for innovative care delivery systems

- SAMHSA/CSAT Grants
 - <http://www.samhsa.gov/grants>

- Federal Grant Opportunities
 - Grants.gov: <http://www.grants.gov/>
 - CMS State Innovation Models Initiative: <http://innovation.cms.gov/initiatives/state-innovations/>
- The Commonwealth Fund
 - <http://www.commonwealthfund.org/grants-and-fellowships/programs>

National provider associations and local chapters/organizations

- American Association for the Treatment of Opioid Dependence (AATOD)
 - <http://www.aatod.org/>
 - Useful Links: <http://www.aatod.org/home/useful-links/>
- American Academy of Addiction Psychiatry (AAAP)
 - <http://www.aaap.org/>
 - Practitioner Resources/Area Resources: <http://www.aaap.org/practitioner-resources/area-resources/>
- American Society of Addiction Medicine (ASAM)
 - <http://www.asam.org/>
 - Membership/State Chapters: <http://www.asam.org/membership/state-chapters>
- AcademyHealth
 - <http://www.academyhealth.org/index.cfm>

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Opioid Treatment Programs and New York’s Medicaid Redesign

Allegra Schorr

New York State is actively transforming its health care delivery system. The state has the largest Medicaid program in the country, spends more than twice the national average on Medicaid per capita, and ranks 50th among all states for avoidable hospital use and costs (Rodin & Meyer, 2014). In 2011, New York created a Medicaid Redesign Team whose vision for reform embraces the “Triple Aim” of improving experience, improving health, and reducing per capita cost.

In order to achieve these goals, innovation and new models of care are needed. New York’s multiyear action plan—*Better Health, Better Care, Lower Costs*—aims for “improving health by addressing root causes of poor health e.g., poor nutrition, physical inactivity, and *substance use disorders*[emphasis added].” It states: “In particular, the biggest problem with the state’s health care system is that it is not successful in ensuring that complex, high-cost populations obtain the coordinated care they require” (New York State Department of Health, n.d.-c).

The complex, high-utilization populations that significantly impact the cost of the health care system in New York through avoidable hospitalizations and use of the EDs are those with behavioral health disorders. The presence of drug and alcohol disorders or mental illness is associated with higher per capita costs and hospitalization rates (Boyd et al., 2010). Individuals with SUD are among the highest-risk populations for medical rehospitalizations and are often underdiagnosed at initial hospitalization (Irmiter, Barry, Cohen, & Blow, 2009).

In New York, success in restructuring the health care delivery system will hinge on coordinating and integrating the care of behavioral health care patients who suffer with comorbid physical health conditions and chronic illness. An innovative care model envisioned to achieve this coordination is a behavioral health care site with fully integrated, co-located primary health care.

New York’s OTPs are in a unique position to provide this innovative model of integrated behavioral health and primary care. OTPs are able to respond to the needs of high-risk, high-cost patients whom they successfully treat daily. These patients receive and have managed medication for their OUD, along with comprehensive individual and group counseling (at admission and thereafter), annual physical examinations, physical health care, and additional supportive services. OTP patients return to their programs up to 6 days a week, depending on their time and progress in treatment. This frequent contact combined with the established multidisciplinary team collaborative model used by OTPs, is a powerful tool available for preventive primary care. In fact, it is a proven and tested combination that has had impressive results when used in combating HIV.

The OTPs have the infrastructure, expertise, staffing, and relationships to treat patients in a fully integrated behavioral and primary health care model. The patients will benefit from both

improved quality and improved health, and the savings to the health care system are incalculable. The goal of integrating care and pursuing the Triple Aim can be achieved in the OTPs.

Achieving the Triple Aim

In their well-known article, *The Triple Aim: Care, Health, And Cost*, Berwick, Nolan, & Whittington (2008) explain that the pursuit of the Triple Aim requires preconditions and that the organization responsible for integrating care must include five components in order to ensure success:

Improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Preconditions for this include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an “integrator”) that accepts responsibility for all three aims for that population. The integrator’s role includes at least five components: partnership with individuals and families, redesign of primary care, population health management, financial management, and macro system integration.

The remaining barriers to integrated care are not technical; they are political.

Prerequisites for the Triple Aim, then, are an identified population, a commitment to universality, and the existence of an organization/integrator. By fully integrating primary care into the OTPs, all three preconditions are met.

The Opioid Treatment Program Population

The patients at greatest risk for repeated hospitalizations and the highest cost to the health care system are the patients who match the demographic of the patients that are currently treated at OTPs.

The opioid epidemic and growing use of heroin have begun to change the picture of an opioid dependent individual in the public’s vision. The epidemic is centered on prescription opioid misuse, which has fueled an alarming increase in heroin use. New York OTPs have seen an increase in patients seeking treatment as a result of this epidemic. There is also a population of long-term heroin-injecting users who are severely addicted being treated by OTPs for multiple disorders.

In 2011, the New York State Health Foundation’s *Chronic Illness Demonstration Project* concluded its study of improvements in managing chronic illness. The study analyzed the state’s Medicaid data to identify high-cost fee-for-service (unmanaged care) patients who were at high risk for hospitalization. The data (New York State Health Foundation, 2011) showed that:

- 76 percent had a history of chronic disease.
- 52 percent had multiple chronic diseases.
- 73 percent had a history of alcohol/substance use.
- 69 percent had a history of mental illness.

- 54 percent had a history of both alcohol/substance use and mental illness.
- 28 percent had had no primary care or specialty care use in the prior 12 months.

The 2012–2013 New York City patient data on admission to the OTPs showed:

- 25 to 78 percent of clients with high dysfunction.
- 18 to 85 percent of admissions for mental illness and chemical abuse (MICA).
- 9 to 88 percent of clients with other major physical health conditions.
- 1 to 52 percent of clients who were homeless at admission.
- 68 to 100 percent of clients with prior treatment history.
- 4 to 63 percent of clients with criminal justice involvement.

The prevalence of comorbid health conditions among opioid dependent individuals is well established and can be seen throughout the nation. Illinois notes two or more of the following conditions in 50–90 percent in its patient population: diabetes, hypertension, high cholesterol, obesity, psychiatric disorders, nicotine dependence, chronic obstructive pulmonary disease, and asthma (Mahoney, 2013).

Patients with a history of long-term opiate misuse may present with hepatitis C, HIV or acquired immune deficiency syndrome (AIDS), lung complications, soft tissue infections, abscesses, collapsed veins, and co-occurring mental health disorders. Furthermore, many opiate-dependent individuals face severe social barriers to positive outcomes and better health. Homelessness or lack of permanent housing, illiteracy or inadequate education, and lack of social supports are some of the enormous barriers that many OTP patients face.

Many OTP patients enter treatment with far less severe presentation, or they may have progressed through treatment. Considering a “phased approach” (see TIP 43) to treatment, most OTPs will have patients enrolled in treatment with a range of severity (Center for Substance Abuse Treatment, 2005). This integrated model of primary care focuses on the high-risk, high-cost Medicaid population.

Chronic, long-term use of opiates and heroin leads to devastating medical complications.

The Opioid Treatment Program Organization/Integrator

The FDA has approved three medications for the treatment of opioid dependence: methadone, buprenorphine, and naltrexone. All three medications are available through the OTP system. As indicated in the introduction, methadone maintenance is the most utilized of the three federally approved medications in OTPs. Buprenorphine use is increasing, but there continue to be reimbursement-related challenges, impeding a broader utilization of both buprenorphine and naltrexone/Vivitrol[®] products through OTPs. Opioid dependence is a chronic relapsing condition that alters the structure of the brain. Medication combined with a comprehensive approach to treatment (MAT) has proven successful in the treatment of opioid dependence.

OTPs are highly regulated and must be registered with the DEA, certified by the HHS SAMHSA, and licensed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS). CARF, TJC, or the Council on Accreditation nationally accredits OTPs.

OTP patients are seen in an outpatient setting, with the lowest costs per successful outcome (Barnett & Hui, 2000).

OTP patients are mandated to receive a full physical examination within one week of admission, which is repeated annually. OTPs are required to have a medical director and registered nurse on staff and frequently have mid-level practitioners as well as additional staff in their medical departments. The qualifications of the medical director include either a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties, an addiction certification from ASAM, a certification by the American Board of Addiction Medicine, or a subspecialty board certification in addiction medicine from the American Osteopathic Association. As such, OTP medical directors are highly qualified in New York State, with years of specialized training and experience.

New York regulations for OTPs also specify additional physician, mid-level practitioner, and nursing hours based on the number of patients treated. They require OTPs to be equipped with the necessary exam rooms and equipment to perform the required exams, and they require the medical team to coordinate care with the patient's counselor and nursing. OTPs are using health homes to provide care coordination services for eligible patients and some OTPs are becoming certified as health home care coordinators.

As part of a comprehensive treatment plan, and in compliance with federal and state regulations, methadone patients receive daily doses of medication at the program, with take-home medication given over time as a patient stabilizes and meets criteria for receiving it. OTPs have frequent, often daily, contact with the most severely addicted OTP patients. This contact and the relationships developed between the patient and the OTP multidisciplinary team of providers creates a unique environment to engage the patient and respond to the individual's needs. The medical staff at the OTP is aware of the OTP patient's addiction and physical health and is in a unique position to care for both.

Providing primary care in an OTP setting is an opportunity to provide care that is fully integrated, co-located, and continuous.

Physical Health Care in Opioid Treatment Programs

Currently, New York State's Medicaid reimbursement system—the Ambulatory Patient Groups (APGs) payment methodology—allows the OTP medical staff to treat and bill for the physical health care needs of OTP patients. Physical health care is intended for urgent care only. The billing and clinical guidance for physical health care visits clearly intends for patients to be referred to a primary care provider for ongoing care. Furthermore, an OTP is limited to submit no more than five percent of its total program billing for physical health care.

Adding physical health care within the OTPs was an important and logical first step toward a new model of care. These additional services take advantage of existing medical staff and services that were ready and available in OTPs, building on the opportunity from the physical exams that are required by both state and federal regulations. Patients receive care, and New York State prevents costly emergency room visits, while OTPs use existing staff and infrastructure.

According to guidance provided by the New York State Office of Alcoholism & Substance Abuse Services (2013):

Many patients admitted to chemical dependency treatment have significant medical problems associated with their use of substances and lifestyle. Many of these patients are not aware of acute or chronic health problems and are not connected to a primary care provider. Medical staff in chemical dependency programs can assess and treat a wide variety of addiction related acute and chronic conditions and receive reimbursement through Medicaid. Patients must be seen directly by the medical staff performing and billing for the service and the program should attempt to link patients to a primary care provider for ongoing care, if the patient does not have a primary care provider.

The challenge is that many OTP patients have been passively enrolled to primary care providers they do not know and rarely see, despite the urging of care coordinators, counselors, and OTP medical providers and staff. To quote the guidance, “Many of these patients are not aware of acute or chronic health problems and are not connected to a primary care provider.” When patients are seeking medical care, they look for it in their OTP programs, which they often visit several times a week for medication purposes. It is natural and wise to seek care through the medical providers and staff in the OTP who are well acquainted with the patient and can provide continuity of care. The “partnership” between provider/integrator and individual already exists.

There are several studies, which specifically address the benefits of providing primary care in the OTP setting. The benefits include reduced hospitalizations (Laine, et al., 2001), reduced ED and hospital services (Friedmann, et al. 2006), and significantly reduced costs for integrated care for patients with medical conditions related to substance use (Parthasarathy, Mertens, Moore, & Weisner, 2003).

The Background of OTPs and Primary Care

The majority of OTPs in New York State are also licensed by the New York State Department of Health as diagnostic and treatment centers under Article 28 of the Public Health Law. These clinics are certified to provide primary care and have undergone a rigorous certificate of need process and inspection. These Article 28 diagnostic and treatment center OTPs are primary care providers; however, they are NOT designated as the official primary care provider for their OTP patients.

An OTP patient must have the same Medicaid managed organization for both the patient’s primary care coverage and behavioral health care coverage (currently carved out), with the OTP assigned as the provider.

When Medicaid managed care for primary care was implemented, the Article 28 clinics that were co-located with OTPs were able to apply to join the networks to become providers with managed care plans. However, many of the Article 28 OTP clinics were not accepted into the managed care networks, or OTP patients were not assigned to their OTP providers for primary care. Freestanding Article 28 OTPs frequently found the new primary care Medicaid managed

care panels were “full” and weren’t accepting providers that were associated with OTPs. Without the benefit of statistically healthier populations to help balance the managed care equation, many Article 28 clinics associated with OTPs were not warmly welcomed into managed care plans. OTP Medicaid patients were passively enrolled into Medicaid managed care for their primary care at other locations. The patients who had been receiving primary care where they were seen regularly by OTPs were “autoassigned” to primary care providers they didn’t know. Managed care resulted in deintegration of care for these patients.

The result is that today, when OTP patients present for an admission or annual physical, and the OTP medical staff asks, “Who is your primary care provider?” often the patient doesn’t know or can’t say when was the last time they were seen by the primary care provider.

A 2009 United Hospital Fund study of New York City of high-cost Medicaid patients voices this frustration: “I always see somebody different, a different doctor all the time.... I don’t know if he’s going to remember what I told him last month. They don’t really know you” (Birnbaum & Halper, 2009).

During the AIDS epidemic, many OTPs certified onsite, co-located medical services to be available for their high-risk patients and added infectious disease specialists to their medical staff. Article 28-certified OTPs that provided primary care for their patients were eligible to receive enhanced rates for HIV care.

Studies have shown that being a patient in an OTP is linked to lower incidence of HIV disease in this high-risk population. According to one study (Hartel & Schoenbaum, 1998):

Properly dosed, long-term methadone treatment was found to be a central protective factor in preventing HIV infection from the earliest days of the epidemic in New York City. It is crucial to have high quality drug treatment programs in place before an epidemic draws our attention to the inadequacies through excess and unnecessary morbidity and mortality.

Redesigning New York's Medicaid Program

New York has a vision to transform the Medicaid system from a fee-for-service system to a value-based managed care model. The implementation has been phased to roll out in stages, with the transition to “carving in” all behavioral health care in New York City by October 2015 and the rest of the state and children’s services in 2016. The integration of behavioral health and physical health is a key goal of Medicaid redesign. The homepage of the website says, “The behavioral health Medicaid managed care transition will facilitate a fully integrated behavioral health and physical health service system.” The financial management and macro system management components of the Triple Aim will be fully addressed during this phase. The redesign of primary care component has been planned and requires full implementation in the OTPs.

Care integration is included in the Medicaid Redesign Team Behavioral Health Reform Work Group’s mission (New York State Department of Health, n.d.-b), which reads:

- Consider the integration of substance abuse and mental health services, as well as the integration of these services with physical health care services, through the various payment and delivery models.
- Examine opportunities for the co-location of services, and also explore peer and managed addiction treatment services and their potential integration with BHOs.
- Provide guidance about health homes, and propose other innovations that lead to improved coordination of care between physical and mental health services.

New York’s goals correspond to SAMHSA’s strategic plan, “Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015–2018.” In the new Health Care and Health Systems Integration Initiative, SAMHSA specifies the leadership potential of OTPs in the area of primary care and addiction services integration.

The SAMHSA–HRSA *Standard Framework for Levels of Integrated Healthcare* (Heath, Wise, & Reynolds, 2013) envisions a fully integrated level of care in a co-located system at the highest level:

Level 6 — Full Collaboration in a Transformed/Merged Practice: The highest level of integration involves the greatest amount of practice change. Fuller collaboration between providers has allowed antecedent system cultures (whether from two separate systems or from one evolving system) to blur into a single transformed or merged practice. Providers and patients view the operation as a single health system treating the whole person. The principle of treating the whole person is applied to all patients, not just targeted groups.

This highest level of collaboration and integration level is achievable in OTPs because the OTPs are a single transformed program, use a team of multidisciplinary team providers, co-located in the same space, with a history and shared experience of collaboration.

Health Care and Health Systems Integration Strategic Initiative

→ **New Program Proposal: Primary Care and Addiction Services Integration (PCASI)**

- Allow addiction treatment providers to offer an array of physical health and addiction treatment services
- Modeled after Primary/Behavioral Health Care Integration (PBHCI) program
- OTPs can be leaders in this area

Delivery System Reform Incentive Payment

Delivery System Reform Incentive Payment (DSRIP) is the main mechanism by which New York State will implement the Medicaid Redesign Team Waiver Amendment. DSRIP's purpose is to fundamentally restructure the healthcare delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25 percent over 5 years. Up to \$6.42 billion dollars are allocated to this program, with payouts based on achieving predefined results in system transformation, clinical management, and population health (New York State Department of Health, n.d.-a).

The DSRIP program created regional lead performing provider systems (PPSs) that in turn formed large networks of safety net providers from across the health care continuum. The goal is for the newly-formed partnerships to collaborate on specified projects that will encourage system transformation to a value-based, outcomes-driven model, thereby achieving the desired 25 percent reduction in avoidable hospitalizations across New York State over 5 years.

A key theme and high-scoring project (DSRIP funds are awarded through a scored project application process) is Project 3.a.i: The Integration of Primary Care and Behavioral Health Services.

COMPA, the advocacy organization representing the OTP system in New York, worked with the New York State OASAS to present OTPs as providers that are uniquely qualified and positioned to respond to participate in this project. Fully integrated care in the OTPs with the following elements can be quickly implemented:

- OASAS has agreed to immediate approval of the simple single-agency and license waiver required for the regulatory change, which would include the elimination of the 5-percent cap on billing physical health visits and establish OTPs as primary care providers.
- The current APG reimbursement rates and mechanism for physical health visits will be used.
- OTP programs will have the option to become the primary care providers for their enrolled OTP patients, with an option to increase capacity annually.
- Enrolled OTP patients will be assigned to their current OTP provider for primary care, with provision for patients to opt out to remain with or choose a different primary care provider.
- Medicaid managed care organizations will coordinate coverage for behavioral and physical health care.
- Linkages will be established with health home care coordination teams and peers used to facilitate referrals for specialty care, etc.

There is a wealth of evidence to support this integrated model of care:

- Hundreds of peer-reviewed scientific studies published over decades prove success of medication in treating opiate dependence.
- OTPs have the lowest cost per successful outcome.

- OTP comprehensive treatment includes frequent patient contact by regulation, allowing for effective monitoring.
- Providers are able to respond to opiate epidemic through medications and immediate increased capacity for and access to buprenorphine treatment.

According Dennis McCarty et al. (2010):

An analysis of the cost and utilization of health care among opioid dependent individuals enrolled in a large integrated health plan reported a mean annual cost per opioid dependent member of \$11,200 (2004 dollars); the most expensive opioid dependent members were those with minimal (one visit) or no contact with addiction medicine (M = \$18,604) while those who received addiction counseling services (M = \$14,157) and methadone plus counseling (M = \$7,163) used less inpatient and emergency care.

The total costs of care for patients receiving methadone maintenance were 50 percent less than the costs for patients receiving counseling without medication. They were 62 percent lower when compared to those for opioid dependent patients who did not receive addiction medicine services.

Importantly, these cost savings reflect only health care costs, not criminal justice costs or other social costs. Health plans that offer buprenorphine and methadone for opioid dependence reduced the use of relatively expensive emergency and inpatient services and reduced total health care costs.”

There are some disadvantages to integrating care in the OTPs through DSRIP. There has been inconsistent involvement and inclusion of the OTPs in DSRIP Project 3.a.i, Integration of Primary Care and Behavioral Health Services, across PPS networks in New York State. Overall, there is little familiarity with the OTP treatment system. The task of educating the PPS networks about the role that OTPs can play in the healthcare transformation is complicated by the short project timelines and regionalization of the DSRIP system. This challenge poses a risk to the universality that is a precondition of the Triple Aim.

An alternate path to integration, and one that can easily be used by any state, would be for the state agency to authorize the OTP as the primary care provider. In New York, this would include a waiver to eliminate the 5-percent limit on physical health visits in OTPs and a corresponding listing of the OTP as all OTP patients’ managed care primary care provider, with an opt-out option for patients and providers. Authorizing the OTP as the primary care provider will ensure that a uniform, high-quality level of care is provided whether a patient is receiving integrated co-located treatment services in Staten Island or in Buffalo.

This proposal will enable an immediate cost-savings seen in reduced avoidable hospitalizations that is the ultimate goal of DSRIP.

Roads to Primary Care Integration

To summarize, two possible roads to primary care integration are:

- Integrated primary care in OTPs through the DSRIP waiver applied for by a regional PPS is one path to integrated primary care.
- An overall waiver for the OTP system from OASAS through Medicaid redesign.

Readiness Is All

Developing the current, co-located physical health care OTP model which is now providing urgent care throughout New York to a fully integrated model which can also provide preventive primary care requires far less adjustment than would be necessary for a behavioral health provider with no experience providing physical health care. OTP medical staff are currently contemplating edits to electronic medical records, (population health management) and considering outcome measures. The infrastructure and expertise is in place. There are relationships with labs, diagnostic services, and specialty referrals. There is a system for hospital backup and emergency coverage. There is also experience treating the special medical needs of this population. Most importantly, in this fully integrated model, medically complicated, high-risk patients who are already receiving an annual physical exam and needed medical care from providers with whom they have established relationships with, will be able to access preventive primary care without being asked to go somewhere else to find it.

Fully integrating primary care for OTP patients into the OTPs will improve the outcomes for patients. This new model of integrated primary care in OTPs will achieve the Triple Aim.

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