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OTPs Can Help Support Primary Care Buprenorphine Prescribers

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Opioid treatment programs (OTPs) can do “all the heavy lifting” when it comes to counseling and wraparound services for patients with opioid use disorders (OUDs), and can expand access to care and treatment in the community by collaborating with primary care prescribers, according to Kenneth B. Stoller, MD, assistant professor of psychiatry and behavioral sciences at Johns Hopkins University School of Medicine, and director of the Johns Hopkins Broadway Center for Addiction.

In his collaborative opioid prescribing (CoOP) model linking opioid treatment programs with office-based buprenorphine providers, Dr. Stoller wanted to figure out a way to increase access to buprenorphine in Baltimore, where his Johns Hopkins Broadway Center substance use disorders program, including an OTP component, is located.

As is well known, many physicians who have obtained the waiver to prescribe buprenorphine for patients with OUDs are not in fact prescribing it, not anywhere near the 30- or 100-patient cap, and sometimes not prescribing it at all. One of the main reasons is that physicians are afraid of what Dr. Stoller calls the “heavy lifting.” They are worried that treating patients with addictions is “time-consuming and difficult,” he told *AT Forum*. “It can be,” he added. That’s where the OTP comes in—to do the difficult part.

Dr. Stoller presented his model at the Addiction Health Services Research (AHSR) Conference in Boston a year ago. He published a summary in *Addiction Science and Clinical Practice* in February (see



Resource).

Increasing Access and Quality

The goals of the CoOP model are to increase participation by primary care physicians in office-based opioid treatment (OBOT) with buprenorphine, and to enhance the quality of care for patients receiving those OBOT services—mainly, by involving the OTP heavily.

Since 2009, 81 OTP patients at his relatively small program have received OBOT from 22 primary care providers who were already waived, or who became newly waived. About half the patients were ages 25 to 44, and the other half 45 to 64. By performing the initial assessment of patients, providing concurrent psychosocial treatment, as well as expert consultation for the primary care providers, and by dispensing the medication during initial stabilization and episodes of instability, the OTP was able to enhance the quality of care.

“We’re encouraging physicians in the community to start to get their waivers, and to use their waivers,” Dr. Stoller said. “At the same time, we’re improving the quality of care by providing the prescribing physicians the support of the OTP, which has a high degree of expertise and experience, especially with more challenging and severe cases.”

About half the patients in the Johns Hopkins Broadway Center are in the OTP, most on methadone, and a few on buprenorphine. The patients on medication-assisted treatment (MAT) go to the same groups as other patients, with the same counselors, said Dr. Stoller. “We treat MAT as one component of a comprehensive treatment plan.” It’s important to stop defining treatment based on what medications a patient is getting, he added.

Similar to the “hub and spoke” model of Vermont (see *AT Forum* <http://atforum.com/2012/03/vermont-to-expand-medication-assisted-treatment-for-opioid-addiction-using-a-managed-care-approach/>), the CoOP model used the OTP to provide initial assessment, including deciding what medication (methadone, buprenorphine, or naltrexone), if any, the patient would start on. Then the OTP would provide medication induction and stabilization. After about two weeks, the source of buprenorphine would be shifted to the primary care provider during visits—typically every two weeks initially, then monthly.

Making Physicians Comfortable

When Dr. Stoller first started looking at the surrounding physicians and OBOT, he found that one Hopkins-based primary care practice, East Baltimore Medical Center, was underutilizing buprenorphine. “It was in stark comparison to another primary care practice on a nearby Hopkins campus, where those practitioners were all prescribing in terms of OBOT, and all had quite a few patients,” he said. “We were trying to improve the scope of care for Johns Hopkins Medicine patients with OUDs, and wanted to figure out why there was this disparity.”

What he learned from the director of the East Baltimore Medical Center was that more support was needed for physicians to feel comfortable providing buprenorphine. Doing the assessment alone was “overwhelming, especially to someone without a behavioral health background,” said Dr. Stoller. “And the induction was intimidating.”

So Dr. Stoller told the director, Michael Albert, MD, that the OTP would help. “I told Dr. Albert, we will take care of all that, because this is what we do all the time—this is what OTPs do; we have 50 years of expertise.” OTPs are the “trauma centers of opioid dependence.”

During the two-week stabilization phase, patients need to come in every day, take drug tests, and

answer questions about how they're feeling and whether they are craving. "That's the nice thing about an OTP—they get that daily interaction with a nurse, which helps them to engage in treatment early on," said Dr. Stoller. In the typical medical practice, a patient with an acute illness might get a follow-up appointment two weeks later. That won't work with early treatment for a substance use disorder.

Once a patient is on a stable maintenance dose of buprenorphine and demonstrates good treatment response, the OTP makes an appointment for the patient with the primary care physician, who will continue with buprenorphine prescribing. Key to the success of the program is the fact that the patient remains concurrently enrolled in the OTP, where the patient gets comprehensive services.

The Adaptive Stepped-Care Model

There are four steps in the step-down—or step-up, depending on how the patient is doing—model.

- Step 1 is for people who are very stable, get a month's supply of prescriptions, and as little as one counseling session a month.
- Step 2 is for patients who should have only weekly prescriptions and need intensive outpatient treatment, which in Maryland means at least nine hours of scheduled counseling per week. If patients are not stabilized, they are put in Step 3.
- Step 3 returns to daily dispensing at the OTP, and removal of prescriptions by the primary care provider.
- Step 4 is for patients who refuse to participate in counseling; their continued medication is then at risk.

"If they are continuing to use, or not coming to treatment sessions, we'll reassess their treatment plan," said Dr. Stoller. "We will make a change such as switch to methadone, intensify their care (e.g., to residential treatment), or in rare cases, begin a reversible (if adherence improves) against-medical-advice buprenorphine taper."

This model expands upon the work of Robert K. Brooner, PhD, director of addiction treatment services at Johns Hopkins Bayview Medical Center, who developed "adaptive stepped care" for patients with substance use disorders being treated in OTPs.

Reimbursement

Maryland has recently implemented a progressive system of reimbursement for patients treated in the OTP with buprenorphine. This may not be possible yet in other states, said Dr. Stoller. The rate structure in Maryland includes a bundled weekly rate, and a supplemental payment for the induction week, recognizing that more physician effort is involved.

The rate also includes reimbursement for the buprenorphine, which, in Maryland, based on the formulary, is Suboxone. OTPs also get reimbursed for urine toxicology screens, another benefit that doesn't exist in all states. There is not, however, a reimbursement rate for case management, and counselors do need to do this, said Dr. Stoller.

"It does take some time," said Dr. Stoller of treatment. "The reality is that the OTP is the patients' medical home, at least informally. This is where they go and are seen. They have chronic medical and psychiatric problems, and they want to live longer and more productively. Our clinicians understand what they are going through and have confidence that their patients are capable of success."

Destigmatizing MAT



But it's important to have broader communication with the medical community. The work with primary care can help destigmatize MAT, said Dr. Stoller. "My counselors have become, through this process, very proficient and comfortable with speaking with community physicians about their patients' issues," he said.

"Coordinating buprenorphine treatment sends tendrils out from the OTP, through our community, whether it's to a psychiatric provider or a primary care provider," he said. "It helps glue the OTP to the medical community, and the patient is that glue." That connection helps the other providers understand that the OTP is not acting in a black box; it's a part of their whole medical care. By coordinating care across settings, treatments, and recovery support services, the providers and agencies around the OTP become a system of care—more than the sum of its parts.

The key is combining access with quality. "You can't leave quality out of the discussion," said Dr. Stoller. "If it's not high quality you end up with warehousing patients."

Ultimately, if buprenorphine "pill mills" are established, some patients will abandon meaningful treatment in OTPs and other high-quality treatment settings, said Dr. Stoller. "If a provider keeps writing prescriptions, no matter what the status is of the patient's disorder, what you have is warehousing. Experience has shown me and my staff that given the access to high-quality care in models that motivate good adherence, every patient has potential to respond vigorously, and build a productive, healthier life."

Resources

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