Medication Assisted Treatment

Building specialty outpatient care for opioid use disorder

Written and edited by:
Kaitlan Baston, MD, MSc- Medical Director, Addiction Medicine
Kerianne Guth, MSW- Senior Program Manager
Emily Glover, MPH- Administrative Director
Dr. Jeff Brenner- Medical Director, UHI
Kathy Stillo, MBA- Executive Director

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Executive Summary
There is an increasing rate of opioid addiction across the Southern New Jersey region and this opioid epidemic is impacting patients at the Cooper Urban Health Institute. To better address the complex needs of medically underserved patients with opioid addiction, the Cooper Urban Health Institute (UHI), a business unit at the Cooper Health System, developed a pilot buprenorphine medication assisted treatment (MAT) service. This was added in the 3rd and final year of a grant funded project with the Nicholson Foundation. To staff the clinic, UHI was able to recruit and hire Dr. Kaitlan Baston, a board certified, fellowship trained addiction specialist. Two other emergency medicine physicians were recruited part-time to work in the clinic as well. The clinic has been highly successful and had a waiting list after just 2-3 months. Only one other outpatient primary care clinic in Camden provides MAT - Project HOPE - which has a waiting list as well.

Background
The US currently spends $2.8 trillion dollars on healthcare, which is twice the per capita spending of other industrialized countries. Despite our high spending, significant disparities in care exist and internationally we rank at the bottom in measures of quality, access, and patient satisfaction. For state governments, the fastest rising cost and the biggest part of their budget is Medicaid. Fundamental and painful restructuring of Medicaid and Medicare will be necessary to find savings and avoid draconian rationing. Designing and implementing new models of healthcare delivery, which can provide better care at lower cost for the most vulnerable, is a crucial task moving forward.

UHI was established in 2012 by the Cooper Health System as a dedicated business unit focused on improving care of the underserved. With 32,000 visits per year across 23 different specialties, UHI is the primary source of Medicaid specialty care across the region. UHI was formed to improve quality, reduce cost, expand access, and build a replicable model.

In 2014, there were 494 lethal heroin overdoses across Cooper University Hospital and Our Lady of Lourdes Hospital, which are both in Camden. Opioid-dependent residents in Camden are currently underserved by the Camden healthcare system. Opioid

1 Working paper for The Nicholson Foundation- Please consult authors before circulating.
addiction is a highly complex progressive brain disease and is most successfully treated when patients are offered medication-assisted treatment as well as psychosocial counseling. The three most common medications for treating opioid use disorder are methadone, buprenorphine, and depo naltrexone (Vivitrol). Currently, there are not enough medication-assisted treatment programs to meet the demand in Camden, with only one methadone clinic and one primary care office prescribing buprenorphine-naloxone (bup-nx) other than our new program at UHI. Given the burden of morbidity and mortality directly resulting from this disease, expanding addiction services is an important and necessary area of growth in healthcare.

In the three years of the UHI’s existence, addiction was a severe and unaddressed factor complicating care of complex patients in the UHI innovative care models. Patients suffering from substance use disorders are not well cared for in traditional medical systems that lack adequate support and skilled providers, resulting in poor medical, social, and institutional outcomes for all involved. The launch of an outpatient medication assisted treatment clinic using buprenorphine treatment was the first step towards holistically and appropriately addressing the unique needs of patients with identified substance use disorders seeking care at Cooper. 

Medication assisted treatment in Camden
Camden historically had two certified outpatient treatment centers for methadone maintenance. Unfortunately, one closed in 2011 leaving one open license for the city and a lack of access to opioid maintenance treatment (OMT). In 2013 one family physician began to offer treatment with buprenorphine at Project Hope, a federally qualified health center in Camden. Due to the overwhelming need, the clinic quickly developed a 300+ patient wait list, even with the addition of a second prescribing physician.

To date, Cooper is the only major health system in our region that offers addiction specialty care for Medicaid and Medicare patients on a continuum of care. There continue to be programs in the surrounding suburban areas that accept cash only for buprenorphine treatment and charge $150 to $300 per visit. Given the demographics of our target population, this is not an effective or financially viable option for long term

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2 In this context, Medication Assisted Treatment indicates buprenorphine-naloxone (Suboxone) treatment for opioid use disorder as the first and primary treatment method for this program; More general language is used to alternative medications for opioid use disorder, and other substance use disorders will be incorporated into the services as appropriate
care. The ongoing challenge that we face is the demand for services, and the necessity of a wait list when patients and their families are in crisis.

**Medication Assisted Treatment- An Overview**

Buprenorphine is an extremely effective and safe treatment for opioid use disorder when used as a maintenance medication. Patients on buprenorphine treatment have higher rates of sobriety, engagement with treatment, lower rates of incarceration and overdose, and higher rates of employment. Buprenorphine’s long acting nature and partial agonist activity prevent development of tolerance over time. Unlike other opioids such as oxycodone or morphine, patients can stay on the same dose of buprenorphine for the duration of treatment without having diminished effects. The partial agonist activity also creates a ceiling effect, and this along with its high affinity for opioid receptors can prevent overdose and keep patients safe. Patients undergoing this effective medical treatment are also recommended to undergo adjunctive mental and behavioral drug treatment services.

The Urban Health Institute won executive leadership approval to begin an addiction medicine program because a medication assisted treatment clinic will reduce unnecessary admission and readmission for patients who are difficult to manage and have low/no reimbursement. A business model was prepared which demonstrated the model would break even due to downstream cost avoidance and some revenue from inpatient consultations and outpatient fee for service revenue. The model showed a loss in the pilot year, returns close to break even in Year 2, and approximately $50,000 profit by Year 3.

The following document outlines the launch of the project (plan, launch, scale), highlights essential and ideal organizational conditions, describes lessons learned, and recommends alternative activities or approaches as a result of retrospective analysis of our process and ongoing learning through local, regional, and national collaborators.

We created the following mission and vision for the clinic:

**Mission:** Our mission is to increase access to buprenorphine-naloxone in the community by providing medication assisted treatment to patients with Opioid Use Disorder at a specialized clinic.

**Vision:** The Addiction Medicine program is committed to improving the lives of Cooper patients and Camden residents through evidence based treatment for substance use disorders.
Implementation
At the time of the clinic’s launch in November 2015, the care team staff included a full-time addiction medicine physician and two part-time physicians specially licensed by the DEA to prescribe buprenorphine
, with support from existing UHI clinical and operational staff. Two full-time hires, a licensed behavioral therapist and a certified medical assistant to serve as an outreach healthcare assistant dedicated to front line clinical support, were approved for hire after three months of successful clinic operations.

The recruitment goal for the end of December 2015 established a patient panel of at least 10 that received and filled Suboxone prescriptions for opioid use disorder. By the end of March 2016, that goal increased to 20 patients, and by the end of Nicholson Foundation funding in June 2016, at least 30 patients were to receive their medication assisted treatment through this clinic. At the time of this paper, more than 40 patients actively participate in treatment and there is a wait of at least 5 weeks (75 patients) to obtain a new appointment.

Legal, Compliance, and Medical Records
Launching the MAT clinic required extensive conversations with the legal and compliance departments at the Cooper Health System. Treating addiction generates concern across an institution unfamiliar with this type of treatment modality. Management of patient confidentiality and privacy were a significant legal concern given the confusing and overlapping federal and state statutes. Individuals or entities receiving federal assistance and provide specialty medical care for addiction must comply with an additional confidentiality regulation in the Health Insurance Portability and Privacy Act of 1996 as 42 Code of Federal Regulations (CFR) Part 2. 42CFR is interpreted in a variety of different ways with regards to documentation of patient notes. There are several approaches that addiction treatment facilities around the country take to comply with 42CFR while offering modern health care: all patients are consented to allow their records to be contained with the system’s electronic health records with minimal additional protection (ie. “break the glass” functionality in EPIC, the electronic health record system); patients records are kept in the EHR system with additional layers of protection (ie. Records blacked out to other departments), using a separate EHR system not connected to a larger health system records, or using paper charting.

3 An additional waiver to a physician’s DEA license that is granted by the Substance Abuse and Mental Health Services Administration that allows qualifying physicians to prescribe and dispense buprenorphine. For more information see http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management
4 Health Insurance Portability and Privacy Act. 1996. 42 CFR. 2.11
In primary care settings, or clinical practices that do not hold themselves out as specific to addiction treatment, 42CFR does not apply, and medical record taking can continue as done with routine care. There are ethical justifications and legal interpretations which justify any of these approaches. Cooper opted to have the outpatient addiction program at UHI document on paper upon initiation of the program until a solution with an integrated electronic health record was implemented. The program worked closely with Cooper’s Legal team and created both a consent for 42CFR and confidentiality functionality in EPIC that allowed the program to begin the process of EPIC functionality built for outpatient addiction medicine. Inpatient, the team is able to see patients in the context of other primary health conditions and offer care that is not covered under 42CFR, and therefore has been able to utilize the EPIC EHR.

Patient eligibility/segmentation
Our business plan identified a target population of 18 to 65 year olds, which intentionally excludes the pediatric population. The target payor population for this program is Medicaid and Camden-based Medicare patients, which is UHI’s defined patient population.

Initially only UHI primary care patients were to be considered eligible for care. However, through established patient referrals and connections to community partners, our reach quickly expanded well beyond Cooper, with patients driving from mid-state and coastal cities due to lack of access to OMT state wide. In order to focus on our local population, UHI will refocus our catchment to Camden county residents and internal referrals only to streamline processes and support sustainability.

Insurance coverage
It is paramount to quality clinic practices to have a deep understanding of the insurance plans patients utilize, specifically appointment copay, medication coverage, and process for engaging in mental health care. In New Jersey, Medicaid HMOs cover the medical office visit and the prescription, though there are complexities to the credentialing process. Addiction services historically were billed under behavioral health services, not as outpatient medical services. With the advent of medical treatment for addiction and the recognition of Addiction Medicine as an accredited medical specialty by the American Board of Medical Specialties, this has changed.

Start up team-
- Medical Provider with X Waiver
- CPA/ MA
- Health coach
- Senior Program Manager
Final Complete Interdisciplinary Team-

- **Addiction Medicine Specialist/Medical Director**: UHI recruited a physician with fellowship training in addiction medicine. Her role includes inpatient and outpatient consultation, provider/staff training, and protocol development.

- **Support Physicians**: Two emergency medicine physicians with specific training, board certification, and interest in addiction who provide specialty care and medication assisted treatment to patients under the direction of the medical director.

- **Behavioral Health Therapist**: The BHT supports the providers and provides behavioral health care coordination for established and prospective patients. This includes tracking and compliance with adjunctive treatment programs (intensive outpatient, group therapy, etc) as well as provides brief intervention and assessment for appropriate levels of care within clinic and for external referrals for patients and families.

- **Outreach Healthcare Assistant**: Provides specialized medical assistant and registration activities for outpatient addiction clinics including facilitating prior authorizations, appointment scheduling, and orienting patients to the practice.

- **Health coach**: Volunteer, non-permanent position; provides health education for increased health literacy

- **Senior Program Manager**: Programmatic leadership, strategic planning, operational oversight

- **Program Assistant**: Administrative support and process improvement facilitation

**Launch**

The team developed an operations manual which served as an essential activity and deliverable for movement into the “launch” phase of this project. A robust, practice specific plan outlining key responsibilities, regulations, work practices, and documents was finalized at the end of 2015 after two months of clinic operations.

The following figure outlines considerations specific to the organization, community, and state in which the program will live and provide services.

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http://www.addictionmedicinefoundation.org/accreditedfellowships/
<table>
<thead>
<tr>
<th>Topic</th>
<th>Specifics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative work</td>
<td>Check-in/out, secure storage for paper charts if EHR is not set up, charting and compliance with 42CFR.</td>
</tr>
<tr>
<td>Scheduling</td>
<td>Schedule must be structured enough to offer predictable new patient appointments and follow up slots; but flexible enough to accommodate changing visit frequency based on patients’ unique recovery and engagement process.</td>
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<tr>
<td>Staff training</td>
<td>MAT 101; Addiction 101; Mental Health FirstAID; Narcan</td>
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<tr>
<td>Recruitment</td>
<td>The clinic recruited patients through direct outreach to the hospital and referrals.</td>
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<tr>
<td>Reimbursement, credentialing, and billing</td>
<td>Need to credential with insurance company as either a specialist or primary care provider. May need board certification to credential and bill as a specialist.</td>
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<tr>
<td>DEA preparedness</td>
<td>Need to maintain a list of all active scripts for record keeping as part of the providers’ X waiver licenses.</td>
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<tr>
<td>On call rotations</td>
<td>Medical and behavioral health providers available after-hours/over weekends &amp; holidays for urgent medical or mental health concerns</td>
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<tr>
<td>Equipment and labs-</td>
<td>Point of care testing for urine drug and pregnancy test in office; relationship and workflow for sending specimen out for comprehensive urine drug screen.</td>
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<tr>
<td>Prior authorizations</td>
<td>In depth knowledge of insurance company requirements and time lines (need more than 1 staff person).</td>
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<tr>
<td>Call handling</td>
<td>New patient scheduling, established patient communication, provider questions, referrals, &amp; pharmacy communication.</td>
</tr>
<tr>
<td>Relationships with pharmacies</td>
<td>Determine resources available at local pharmacies (buprenorphine formulations carried, availability, narcan availability): our program established a close relationship with the on-site retail pharmacy, DirectMeds, located on the first floor of Cooper Hospital.</td>
</tr>
<tr>
<td>Prescription Monitoring Systems</td>
<td>NJ participates in a multi-state regional prescription monitoring program, and specifically hosts NJRx as the channel to confirm appropriate prescription behaviors as it relates to treatment.</td>
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**Scale**

After our initial pilot of 10 patients, our panel quickly expanded to more than 20 patients. Word of our services spread far and wide through established patient networks, other healthcare providers in the city, and community service partners such as counseling and care management agencies. At the same time, several patients “graduated” to needing less frequent appointments with the providers, creating capacity to bring in new patients. We imagine we will remain in the “scaling phase” for at least as year, as space, staffing, and provider resources grow to match more closely with patient demand. Additionally, the behavioral health therapist was hired and on-boarded and has shifted some patient care responsibilities off of the medical assistant and the medical providers.

**Treatment Philosophy**

“Patients don’t fail treatment, treatment fails patients.” No one gets fired, however, treatment plan may be interrupted or modified depending on individual patient needs including: assessment of benefit of current treatment plan and risk/benefit of continuing vs transferring to different treatment plan, conditions of patient’s behavior towards staff, concerns of diversion, and compliance with visit attendance and therapeutic activities. Patients can continue to engage with the clinic and attend clinic visits even if they are not receiving buprenorphine prescriptions.

**Current Data Collection and Planned Outcome Measures**

While too early to measure outcomes, the following is a list of planned measures:

- Demographics
- Medical conditions
- Behavioral health diagnosis
- Social barriers
- Changes in ER/hospital utilization across the region
- Patient satisfaction
- Treatment retention rates
- Addiction complication (endocarditis, osteomyelitis, skin infections)

**Lessons learned**

Overall the launch of an MAT clinic at a large regional healthcare system within 3-4 months was successful. The initial start-up was very lean and relatively understaffed, which created significant challenges for the treatment team. This choice was made to avoid taking on staffing fixed costs before the clinical revenue started to come in. Another operational barrier to expansion had been our flexible eligibility criteria for geographical proximity to clinic (caused significant transportation issues) and primary
care provider connection. If we were to do it over, the team agreed that a strict geographical catchment including Camden County and any existing Camden-based primary care would have been required.

Other key lessons-
1. Flexibility/Stakeholder Management- Setting up a new MAT service in a large healthcare system unaccustomed to addiction services required significant flexibility and stakeholder management from the implementation team.
2. Stakeholder education- MAT makes institutions nervous when implemented for the first time. It is important to explain to all non-clinical leaders and support staff the importance and value of MAT for treatment of addiction.
3. Connection to local services- It is important to have face to face meetings with key regional services prior to the start of an MAT clinic. This includes mental health treatment and housing services.
4. Network of MAT providers- If available, having a network of similar MAT providers is helpful to share protocols, forms, and advice. The implementation team had several visits and calls with staff from Project HOPE which was invaluable in the launch of the clinic.
5. Training All Staff in Harm Reduction- All of UHI’s staff were trained in the basics of addiction and harm reduction. Even if they are peripheral to the direct MAT clinic operations they will still come in contact with patients. It’s important for the entire clinic to project a non-judgmental and open attitude towards patients with addiction.

Conclusions
The initial launch of an MAT clinic at Cooper has been successful, and at the same time has only begun to meet the regional need. The clinic is looking to expand its size, add additional provider time, and add support staff. The clinic is also beginning to use the group visit space at UHI to conduct Suboxone group visits for both treatment initiation and follow-up. UHI is studying a model called the “Bridge Clinic” in Boston, which works in conjunction with an Addiction Consult Team (the ACT team) under their Department of Addiction Medicine. The bridge clinic model utilizes a “walk-in” patient engagement approach. In this model, patients are initiated in treatment and once stabilized can transfer to a local primary care office. In order for this model to work, local primary care offices need to be trained in Suboxone treatment and need to be willing to care for patients with addiction. We aim to continue to destigmatize treatment of addiction and to educate and train other local providers to accomplish this goal.