Resources for Office Based Opioid Treatment Providers

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Magellan acknowledges and is grateful for the assistance of ***Health Analytics, LLC*** *in the development of the OBOT resource information for providers.*

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Introduction

Last year, Magellan Health Services, Inc. asked for your opinions about the use of buprenorphine for treatment of opioid dependence. We asked about your concerns, about the difficulties you face, and about ways that we can help you effectively treat and improve the quality of life for our members with an opioid dependence.

Of the 290 physicians who responded to our survey, more than 65 percent indicated a willingness to use Office Based Opioid Treatment (OBOT) to care for our members with opioid dependence. As part of this outreach, you told us about the difficulties you have in your office that prevent or limit your use of this highly successful, non-invasive method for treating opioid dependence. In response, Magellan convened a panel of physician experts who have been successfully using OBOT for some time. Panel members discussed the specific barriers that might limit your willingness or ability to provide OBOT treatment, and they offered a wealth of practical ideas for your consideration.

We have included these suggestions in this educational document. We've also provided data and resources to answer your questions about buprenorphine usage, diversion, effectiveness, and other issues you said were of concern to you.

The information provided in this document address two broad categories:

- **Resources to Support OBOT Best Practices**—This section addresses general issues related to the use of buprenorphine.
- **How Magellan Will Partner with You**—This section identifies specific ways that Magellan will support you in the use of OBOT.

Magellan hopes that you will find these materials to be informative and helpful. If you need additional assistance, we are here to help and support you in any way we can. If you have any questions or concerns, please feel free to call Magellan's physician buprenorphine mentor, Robert Ciaverelli, M.D., at 800-458-2740, extension 32043. If you prefer, you may send him an e-mail at rciaverelli@magellanhealth.com.

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About OBOT

Office Based Opioid Treatment programs have been proven to be effective, confidential, accessible, and safe. They have resulted in overall reduced substance use in patients, as well as in overall retention of patients in treatment, recovery, and in the mainstream. The following is a brief overview of some of the benefits of OBOT:

- OBOT programs are a breakthrough in access to care for patients who find it so difficult to abstain from opioids that they can not successfully complete treatment.
- Suboxone has a good safety profile and is designed to dissuade diversion to illegal trafficking. Also, both Suboxone and Subutex are safer in cases where over-dosing is a possibility. Unlike methadone, the active ingredient in Suboxone and Subutex (Buprenorphine) has a ceiling dose response.
- Prescriptions can be filled at the local pharmacy, normalizing the treatment experience rather requiring daily visits to a clinic. Buprenorphine patients typically report a much more "normal" feeling while on the medication, and the eventual taper seems easier, with fewer subsequent cravings.
- OBOT programs allow for better integration of health care needs for patients and thus serve to improve the quality of care provided.

Magellan hopes that by providing you and other physicians with access to the resources provided in this document, and by providing easy access to our national physician buprenorphine mentor, we can help to remove the barriers that may be limiting your participation in providing OBOT programs to our members across the country.

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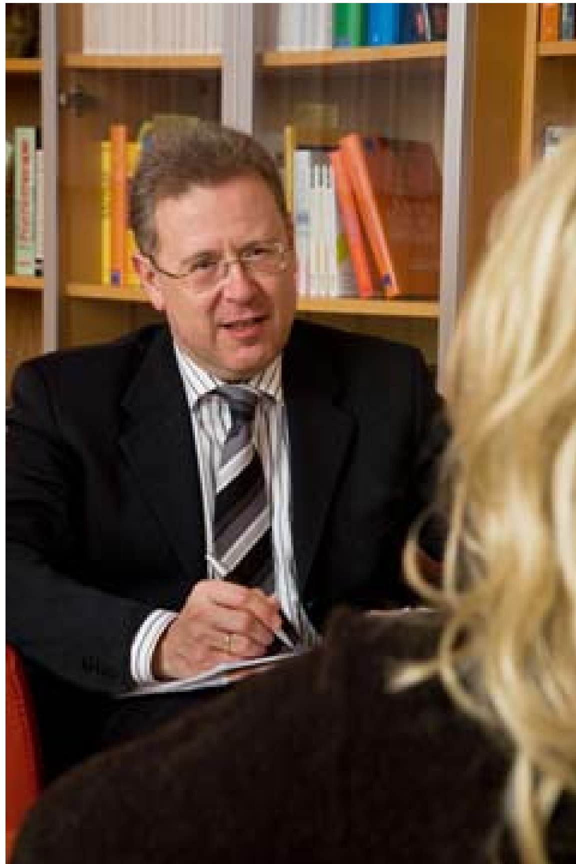
Resources to Support OBOT Best Practices



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Overcoming Logistical Issues

Barrier:	I'm concerned about lab testing, coordinating multiple providers, and other logistical issues.
Proposed Improvement:	Use simple, practical methods to test for abstinence from illicit substances and for appropriate presence of buprenorphine.

Abstinence from the use of recreational drugs is central to the OBOT model; therefore, providers who treat opioid dependence with buprenorphine are required to perform lab tests that detect drug use. Based on results of our survey, 45 percent of doctors reported that lab tests are a barrier that could dissuade them from treating opioid dependence. The purpose of this document is to offer solutions that will help OBOT providers prepare and carry out a sensible program of drug testing that fits well into their practice.

There are various types of tests and different methods of administering them. Tests are available that can be performed in the convenience of your own office, while others require the patient to travel to a local lab for specimen collection. Urine drug tests are easy to administer for most OBOT outpatients and are accurate within acceptable limits.

You can use urine tests to check for the presence of the following substances:

- Opioids
- Marijuana
- Cocaine
- Methamphetamine
- PCP
- Buprenorphine
- Benzodiazepine.

Urine drug tests are easy to administer for most OBOT outpatients and are accurate within acceptable limits.

You can purchase test kits from a variety of reputable suppliers. One such source is Redwood Labs. You can place orders via their Web Site, www.redwoodtoxicology.com, or by calling 800-255-2159.

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Suggestions From Experienced OBOT Providers

Use urine test cups in your office restroom.

You can complete the testing process using the restroom facilities in your own office. Simply provide the patient with a test cup, and send him or her to your restroom to collect the specimen. You must read the test cup results within a few minutes. After reading and recording the results, simply dispose of the specimen in the restroom toilet, and discard the cup in the restroom garbage can. You are not required to provide additional or extraordinary disposal methods—the Occupational Safety and Health Administration (OSHA) considers urine to be a sterile substance.

You can complete the testing process using the restroom facilities in your own office. Simply provide the patient with a test cup, and send him or her to your restroom to provide the specimen.

Send your patients to a lab.

If you prefer, you can send your patients to an outside lab for testing. It is best to work with one, local, inexpensive, and easy-to-use lab. Simply write the lab order as you would any other order, and send the patient to the lab with instructions to be tested on that same day. If the lab is closed, or if the appointment is late in the day, ask the patient to go to the lab the next day. You will receive the results in your office in about 10 days, and the results will indicate the date of collection.

Adjust the frequency of the testing.

You will need to adjust the frequency of testing based on the patient's treatment progress. For example, you may need to test those just entering the induction phase at every weekly visit, while for patients who have been clean for more than three months, you may randomly test them once every one or two months.

Absorb or transfer the costs.

Many physicians absorb the cost of test kits in their office overhead, while others require that patients purchase their own kits. Kits typically cost as little as $5 to $10, it usually is not too burdensome for the patient.

Be prepared.

Keep some test kits on hand for use as needed. For a practice of 25-30 OBOT patients, you will find that a package of 24 kits generally will be sufficient for your needs for a period of two or three months.

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Complying with DEA Requirements

Barrier:	I'm concerned about DEA intrusion into my practice.
Proposed Improvement:	Keep simple and accurate records to satisfy DEA requirements, should you be audited. States also have the authority to regulate opioid treatment programs. Please remember to consult your state law to see if there are requirements for treatment providers or locations.

The results of our OBOT physician survey revealed that 39 percent of those responding are concerned enough about Drug Enforcement Agency (DEA) audits that they might decide to not treat OD patients with buprenorphine. The DEA has a role in the buprenorphine waiver program, which is no different from its role in methadone programs. The DEA generally is charged with documenting use of the controlled substance to limit—as much as possible—any illegal use or diversion to the street.

Compliance with DEA requirements is primarily a matter of good record keeping. This document provides tools and tips for keeping records and preparing for an audit. You should record:

Office inventory (if you procure, store, or dispense buprenorphine from your office)

- Amounts received
- Amounts dispensed.

The DEA generally is charged with documenting use of the controlled substance to limit—as much as possible—any illegal use or diversion to the street.

Patient records

- Patient name or ID number
- Name of drug
- Strength and quantity prescribed
- Date prescribed.

Keep a copy of all prescriptions written for buprenorphine and all other drugs for OBOT patients in the patient record. You also should keep a master log for controlled substances, which is easier to review in the event of a compliance inspection. On the following page is a sample format you can download and print out for logging the use of controlled substances in your practice.

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Controlled Substances Master Log

Patient ID	Office Visit Date / Hour	Name of Rx	Strength/Quantity	Notes

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Reducing After-Hours Calls

Barrier:	I'm concerned that I'll need to be available 24/7 for my patients in OBOT.
Proposed Improvement:	You can significantly reduce after-hours calls by planning ahead for inductions and out-of-office backup.

Our survey indicated that 39 percent of the providers are concerned that they would need to be available at any time of day or night—whenever a detoxifying patient with opioid dependence might call. Our expert panel indicated that patients with opioid dependence are often less demanding in this regard than other psychiatric patients with severe mental disorders.

Patients with opioid dependence who are the best candidates for OBOT also are the least likely to make unscheduled demands on your time. Successful candidates for OBOT typically meet the following screening criteria:

1. The primary substance of abuse is an opioid. Patients with dual-dependency—including alcohol, cocaine, etc.—may not be successful with OBOT.
2. The patient has not used the opioid in the past 24 hours. This allows for proper induction during daytime hours.
3. The informed consent form is signed and understood. OBOT works best when the patient enters the therapy with a good understanding of the risks and benefits of treatment with buprenorphine.

> Patients with opioid dependence are often less demanding in this regard than other psychiatric patients with severe mental disorders.

One effective method of controlling potential late-night calls is through timing the start of induction. It is best to start buprenorphine induction in the morning. That way, the greatest need for patient monitoring is during the regular office hours. When starting a new patient induction with buprenorphine, you may anticipate that the patient will want to see you daily for the first 3 to 5 days of induction. You may also need to make yourself available by telephone or pager through the evening hours for those first several days.

Having backup arrangements with other buprenorphine-waivered physicians is a great resource. Magellan can help you identify other certified providers in your area, or you can find them online through the Substance Abuse & Mental Health Services Administration at www.samhsa.gov or through the National Alliance of Advocates for Buprenorphine Treatment at www.naabt.org.

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Managing the Number of OBOT Patients

Barrier:	I'm concerned that I will attract more drug users than I can comfortably manage in my practice if I start prescribing buprenorphine more regularly.
Proposed Improvement:	Set a limit for the number of OBOT patients you can treat in your existing practice without changing your current style and practice goals.

Successful OBOT practitioners find that opioid dependent patients do not "overwhelm" their practice as they may have once feared.

Some members of our panel of experts once feared that patients with opioid dependence would "overwhelm" their practice. This did not prove to be the case. What's more, once these physicians had some experience with OBOT, they often found that they could comfortably manage many more opioid dependence patients than they originally had thought.

Once a patient is stable, you may expect to see him or her once per month. Patients with dual dependencies, however, generally require a higher level of care, and you may wish to see them more frequently.

Examples of Three Successful OBOT Practices

Clearly, there is no one optimal number of OBOT patients for a successful practice—just as there is no one optimal number of mood, anxiety, or thought disorder patients. The number of OBOT patients that you are comfortable with each month will depend upon such factors as your style, the types of patients that you typically treat, and the structure of your practice.

We interviewed three physicians who successfully treat a number of opioid dependent patients with OBOT. As you will see, these physicians are quite different in the number of OBOT patients they treat each month. They also differ in the structure of their practices and in the way they approach the question of how many OBOT patients is enough each month.

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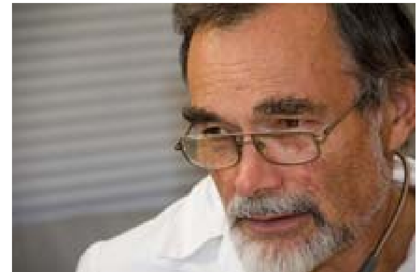
Physician 1



"I practice in a treatment center that specializes in substance abuse. I have a lot of support, including a physician's assistant, a large waiting area, and access to a local detox center."

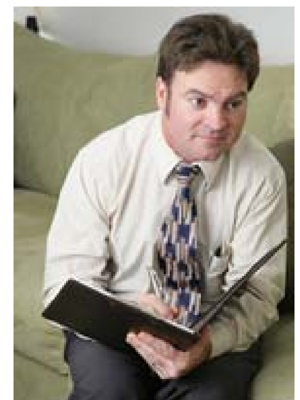
Tip: With lots of support, you may be able to manage up to 100 OBOT patients.

Physician 2

"I have a solo practice with a receptionist. The number of patients is not as important as the characteristics of each new patient. I look for patients who are ready to get off the miserable merry-go-round of opioid dependence."

Tip: Proper selection of candidates for OBOT is more effective than trying to manage the size of your OBOT panel. A population of OBOT patients who understand that they have an addiction, are highly motivated, and are prepared to embark on the journey with you can make a practice that is manageable, successful, and satisfying to the physician. When patients are ready for treatment, managing the OBOT panel is more effective, successful, and satisfying.

Physician 3



"I am a solo practitioner. I have been able to increase my OBOT patient load over time. However, sometimes I am able to handle more OBOT patients than at others, and ultimately I'm not sure what the optimal number of OBOT patients would be."

Tip: As a solo practitioner, you may find that 30-50 OBOT patients is a manageable number, given the other demands of your practice.

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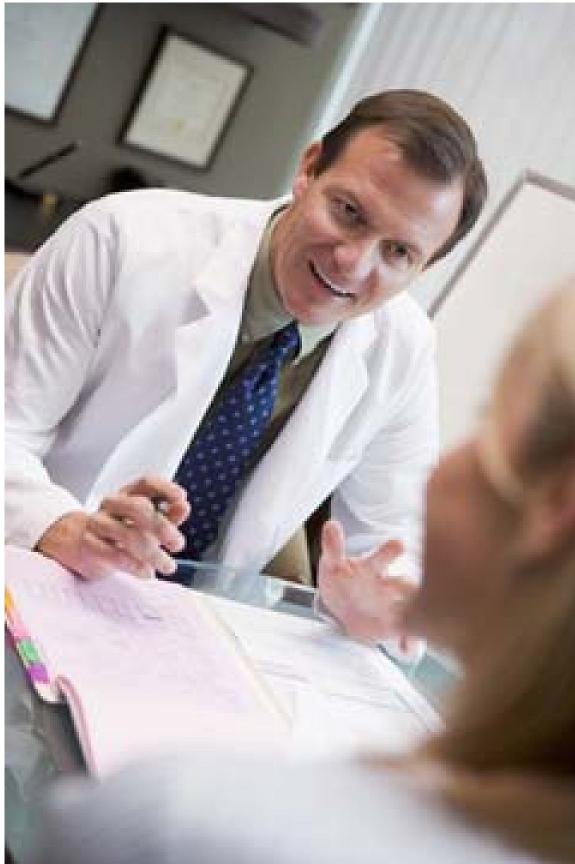
How Magellan Is Partnering with You



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Providing a Magellan OBOT Mentor

Barrier:	I want immediate telephone or Internet access to consult with an addiction/OBOT expert.
Barrier:	I am never really clear which treatment codes to use to ensure adequate and timely reimbursement for OBOT.
Proposed Improvement:	Call Magellan's physician mentor for guidance and support with both clinical and administrative answers to your OBOT questions.

Our physician survey results indicate that having a mentor available for consultation is desirable. Not every treatment case follows the same course, and you occasionally may find it helpful to get ideas and suggestions from another experienced provider.

That is why Magellan has appointed our vice president medical director, Robert Ciaverelli, M.D., as national OBOT mentor. As your OBOT mentor, he is available to you and other Magellan network physicians for "on-call" consultation.

> Magellan has appointed a National OBOT Mentor to support Magellan network OBOT physicians. Survey results indicate that having a mentor available for consultation is desirable.

Dr. Ciaverelli is ready to assist you with the following:

1. Referrals—such as not getting enough, getting too many, or timing.
2. "Curbside" consults—such as detecting abuse or diversion of Suboxone or titration and tapering.
3. Questions about the Magellan process—such as coding and reimbursement.

Dr. Ciaverelli also is prepared to answer your questions about Magellan's processes, such as coding and reimbursement. He understands that new treatment procedures not only affect your clinical procedures, but also your office and administrative staff. To help streamline the process, he suggests that you use the same codes with which you already are familiar. If you still have questions, feel free to contact him.

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Robert Ciaverelli, MD
Vice President Medical Director
Magellan Health Services

Dr. Robert Ciaverelli has been with Magellan Health Services since July 1991 and has more than 20 years of clinical and medical experience. He provides medical oversight and clinical operations guidance on physician practice pattern change projects and serves as medical director for Magellan's Care Management Center in Columbia, Maryland. Dr. Ciaverelli previously served as medical liaison to Magellan's Quality Improvement and Outcomes Research Department. Most recently, his quality improvement efforts focused on improving the care of patients in treatment for opioid dependence. Dr. Ciaverelli has functioned in both clinical and managerial roles in clinical settings, and since 1989, he has been in private practice in psychiatry across a full clinical continuum. Dr. Ciaverelli is Board Certified with the American Board of Psychiatry and Neurology. He received his Doctor of Medicine degree from the George Washington University School of Medicine, and he completed his residency in Psychiatry at The Sheppard and Enoch Pratt Hospital in Towson, Maryland.

You may contact Dr. Ciaverelli by telephone or e-mail:

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Locating Appropriate, Local Resources

Barrier:	I don't know which resources are appropriate for referring my patients who need counseling, social support, or family therapy.
Proposed Improvement:	Magellan can help you locate the clinical and self-help resources your patients need.

Addiction tends to be a bio–psychosocial disease process that often requires a bio-psychosocial style of treatment. Buprenorphine is the biological component of the OBOT solution for treatment of opioid dependency. Since OBOT is office-based—as opposed to clinic- or hospital-based—you need to be sure to use all the resources of outpatient treatment in caring for your OBOT patients. If you are unsure about the most appropriate treatment or treatment provider, call Magellan. We will help you coordinate the best team of providers for your OBOT patient.

Magellan is available to assist you in identifying local addiction treatment programs, psychotherapists, drug counselors, and other professionals.

You also have access to several sources of information that can help you develop a comprehensive treatment plan for new OBOT patients:

1. Magellan is available to assist you in identifying local addiction treatment programs, psychotherapists, drug counselors, and other professionals. Magellan also offers experience, methods, and ideas through our mentor program.
2. Substance Abuse and Mental Health Administration (www.samhsa.gov) offers a wealth of information in the form of tips and tools as well as a national listing of OBOT providers.
3. The National Alliance of Advocates for Buprenorphine Treatment (www.naabt.org) provides resources for OBOT providers, patients, and those who want to start OBOT.

The patient's commitment to his or her own recovery is crucial to the success of OBOT. Be sure that your patient fully understands all that is typically needed to recover from opioid dependence.

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Although some patients might not start all activities at the outset, encourage their participation in as many of the following as possible:

1. Involvement in an outpatient addiction treatment program.
2. Membership in a 12-step recovery program such as Narcotics Anonymous www.na.org and/or Alcoholics Anonymous www.alcoholics-anonymous.org. For these programs to have a significant impact, it is crucial that the patient:
   - Has a home group
   - Gets a sponsor
   - Gets involved beyond going to meetings.
3. Participation in psychotherapy
   - Individual addiction counseling
   - Cognitive / Behavioral Therapy (CBT)
   - Group Therapy.

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Referring to a Higher Level of Care

Barrier:	I don't have the ability to send difficult patients to a substance abuse treatment program.
Proposed Improvement:	Contact Magellan when it is necessary to change the level of care (for example, treatment termination or failure) to best suit the patient's needs.

For a variety of reasons, some opioid dependent patients may not be successful with OBOT. In such cases it may be necessary for you to terminate outpatient treatment and/or refer to a higher level of care. Based on results of a survey of buprenorphine-waivered psychiatrists, many doctors report that the lack of—or limited ability to send difficult patients to—a substance abuse treatment or other higher level of care could be enough of a barrier to dissuade them from treating opioid dependence.

How to Refer to a Higher Level of Care

Magellan is committed to ensuring that each of our members receives the level of care appropriate to his or her situation. When you call for information about alternative treatment methods, the care managers in your region will find local options for the appropriate level of care:

- Intensive Outpatient
- Partial Hospitalization
- Residential Treatment
- Inpatient Treatment.

> When you call for information about alternative treatment methods for difficult patients, the care managers in your region will find local options for the appropriate level of care.

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Reducing Disruption of Other Patients

Barrier:	I'm concerned that the presence of patients with opioid dependence in my office could possibly cause disruption of my other patients.
Proposed Improvement:	The environment in your waiting room is unlikely to change significantly with the addition of OBOT patients.

Our survey results indicated that 30.7 percent of physicians expressed a concern that having patients with opioid dependence in their waiting rooms could be disruptive to other patients. Perhaps this unease stems from the image of a severely addicted heroin patient suffering from acute withdrawal symptoms, while sitting amongst other psychiatric patients who are waiting for treatment.

Patients with opioid dependence in the early stages of withdrawal may indeed experience discomfort. It has been our experience, however, that most OBOT candidates represent a more heterogeneous population of addicts. They come from all social and economic groups, but tilted, it seems, toward the suburban prescription pill user.

OBOT patients come from all social and economic groups, but tilted, it seems, toward the suburban prescription pill user.

Dr. Robert Ciaverelli noted, "In my practice, my patients can't tell the patients with opioid dependence from other distressed patients. All are in some level of discomfort, and all are seeking help in order to feel better."

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Preventing Diversion of Buprenorphine

Barrier:	I'm concerned that patients might sell buprenorphine on the street or take more than the prescribed amount.
Proposed Improvement:	Implement simple but important methods to help encourage your patients not to divert buprenorphine.

OBOT is an effective treatment of opioid dependence, and as such, it reduces the availability of prescription pain killers.*

On our recent survey, physicians reported their concerns about the potential for diversion of buprenorphine. Clearly, you must take great care when prescribing controlled substances such as buprenorphine. Research indicates that diversion of pharmaceutical full opioid agonists is a great public health problem in the United States. Many children report that their first experience with drug abuse involved prescription pain killers. Although teen abuse of alcohol, tobacco, and illicit drugs is on the decline in the United States, abuse of opioids is on the rise in this age group.[1]

Though some physicians are concerned about possible diversion of buprenorphine, OBOT is an effective treatment of opioid dependence and will likely reduce the availability of prescription pain killers. The Substance Abuse & Mental Health Services Administration (SAMHSA) is working toward this same goal of reducing the availability of pain killers through a campaign to educate providers about diversion issues.

*At the population level, increasing the appropriate use of OBOT will decrease the demand for short-acting opioids by decreasing the number of people who are seeking these medications. This program will reduce diversion by reducing the demand for the diverted medications.

Tips

The following suggestions are aimed toward minimizing the possibility of diversion and increasing the likelihood of success with OBOT:

- Use urine tests to confirm that your OBOT patients test positive for buprenorphine. (Negative results can be an indication that the drug is being diverted.)
- Require OBOT patients to come to your office for a pill count on a random basis. (Having fewer than the expected number of pills could indicate diversion.)
- Conduct urine tests and random call-backs for patients on daily dosages that exceed 16mg.

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[1] Manchikanti, L National Drug Control Policy and Prescription Drug Abuse: Facts and Fallacies.

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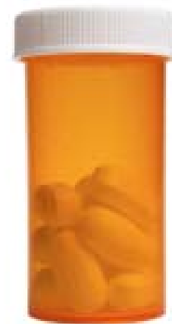
- Keep good records.
- Provide prescriptions in one-week amounts, initially.
- Monitor closely patients who are taking 16mg or more of Suboxone. (At 16mg, patients are likely past saturation and could be diverting a portion of their supply.)
- Require the patient to always fill the buprenorphine prescription at the same pharmacy—but a pharmacy of their own choosing.
- Use psychosocial counseling in conjunction with OBOT.
- Prescribe, when feasible, 8mg rather than 2mg tablets, which are more easily diverted.
- Hold patients accountable for lost prescriptions, early refills, lost medications.
- Dose your patient sufficiently. (Patients who are inadequately dosed sometimes go to an illegal market to obtain enough buprenorphine to stem their cravings.)

Behavior Flags

A patient's behavior may give signs of possible diversion. Look in particular for a cluster of the following behaviors.[2]

- Running out of a prescription too soon. (Be mindful of out-of-cycle refills. If your patient is using the medication as prescribed, he or she should run out on the expected day—often when the next appointment is scheduled.)
- Missing appointments.
- Reporting lost or stolen medication or losing prescriptions.
- Complaining of inadequate dosage.
- Exhibiting changes in behavior or employment.
- Refusing urine test.
- Making frequent or urgent inappropriate phone calls.
- Neglecting to mention a change of address or a change in a job or home situation.
- Making inappropriate outbursts of anger.
- Taking medications off schedule.
- Reporting frequent physical injuries or auto accidents.
- Failing to pay bills or respond to phone calls.



Close monitoring of these potential patient behaviors is an important component of OBOT care.

[2] The Addiction Technology Transfer Center Network, Northwest Frontier, "A Report Summarizing the Opiate Medication Initiative for Rural Oregon Residents (OMIROR)," November 2003, p.87.

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