



STATE OF MARYLAND

**DHMH**

Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

OCT 24 2007

The Honorable Martin O'Malley  
Governor  
State House  
Annapolis, MD 21401

**RE: FY 2008 Buprenorphine Initiative Report - 2007 JCR Page 111**

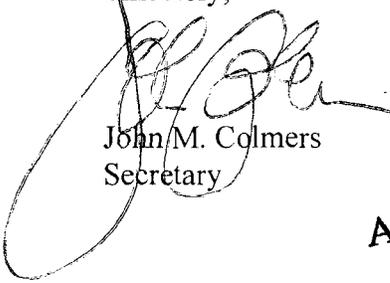
Dear Governor O'Malley:

As required by the FY 2008 Operating Budget Legislation the Alcohol and Drug Abuse Administration has compiled a plan for utilization of \$3,000,000 of the appropriation to expand the use of buprenorphine treatment throughout the state.

The report includes background information establishing the need for this treatment, collaboration among jurisdictions, unmet regional needs, the proposed program of services, and the anticipated implementation schedule.

Thank you for your continued commitment to drug treatment and the expansion of substance abuse services. If you have any questions, please feel free to contact Peter F. Luongo, Ph.D., Director of the Alcohol and Drug Abuse Administration at 410-402-8612.

Sincerely,

  
John M. Colmers  
Secretary

Enclosure

cc: Michelle A. Gourdine, M.D.  
✓ Peter F. Luongo, Ph.D.  
Anne Hubbard  
Barbara DiPietro

**Alcohol and Drug Abuse  
Administration**

**OCT 26 2007**

**Director's Office  
RECEIVED**





STATE OF MARYLAND

**DHMH**

Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

**OCT 24 2007**

The Honorable Ulysses Currie  
Chairman, Senate Budget and Taxation Committee  
Miller Senate Building, 3 West Wing  
Annapolis, MD 21401

The Honorable Norman H. Conway  
Chairman, House Appropriations Committee  
Lowe House Office Building, Room 130  
Annapolis, MD 21401

**RE: FY 2008 Buprenorphine Initiative Report - 2007 JCR Page 111**

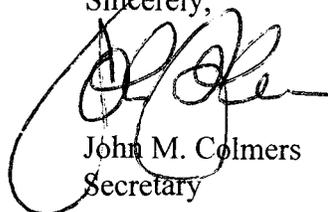
Dear Chairmen Currie and Conway:

As required by the FY 2008 Operating Budget Legislation the Alcohol and Drug Abuse Administration has compiled a plan for utilization of \$3,000,000 of the appropriation to expand the use of buprenorphine treatment throughout the state.

The report includes background information outlining the need for this treatment, collaboration among jurisdictions, unmet regional needs, the proposed program of services, and the anticipated implementation schedule.

Thank you for your continued commitment to drug treatment and the expansion of substance abuse services. If you have any questions, please feel free to contact Peter F. Luongo, Ph.D., Director of the Alcohol and Drug Abuse Administration at 410-402-8612.

Sincerely,



John M. Colmers  
Secretary

Enclosure

cc: Michelle A. Gourdine, M.D.  
Peter F. Luongo, Ph.D.  
Anne Hubbard  
Barbara DiPietro

Toll Free 1-877-4MD-DHMH • TTY for Disabled – Maryland Relay Service 1-800-735-2258

Web Site: [www.dhmh.state.md.us](http://www.dhmh.state.md.us)



## Background

Maryland admits more than twice the number of heroin addicted individuals to treatment than the national average (30% vs.14%).<sup>1</sup> Further, indications are that individuals are presenting in increasing numbers with an opiate addiction from substances other than heroin, primarily prescription medications.<sup>2</sup>

Primary care medicine, however, has developed over the years neither the protocols nor an affinity for treating addicted individuals. Virtually all addiction treatment has shifted to the specialty addiction system. That system alone cannot and should not, be the sole provider of care.

Recently, a medication that received approval from the federal government for treating opiate addicted individuals has specifically been designated for use in the primary medical care system. Buprenorphine is now available for detoxification, stabilization and maintenance. The advantages of this drug include its safety, including negligible potential for abuse or diversion.

The introduction of buprenorphine invites the primary care system to become involved in the direct care of opiate addicted individuals and extends the treatment options available to the individual. This development is not without its challenges.

## Integration, Collaboration and Consultation

The effective use of buprenorphine as a reasonable treatment option requires a functional integration between the specialty addiction and primary care systems, and the ongoing collaboration between components of those systems to manage individual patient care. Additionally, expert consultation needs to be available on both an individual case basis and a system wide basis to ensure the efficient design and implementation of a local buprenorphine option that is *workable for each jurisdiction*. One design will not work for every jurisdiction in Maryland, and just as clearly, ad hoc efforts have no chance of succeeding.

This proposal establishes the buprenorphine treatment option throughout Maryland in a sustainable, efficient way through local jurisdictions and regional collaborations. It builds on the locally managed specialty system, the Alcohol and Drug Abuse Administration (ADAA) system of technical assistance and the training and support of local primary care physicians.

---

<sup>1</sup> ADAA, *Outlook & Outcomes; 2006 Annual Report*, p 34 (2007).

<sup>2</sup> ADAA, unpublished data, Substance Abuse Management Information System, (2007).

## Local Focus

For the past several years jurisdictions have developed local drug and alcohol abuse strategic plans, updated every six months, with yearly priority action items. Some of those plans have included the introduction of the buprenorphine option, giving the state valuable real time experience in both design and implementation of local models. Yet other jurisdictions do not have the infrastructure to support the implementation of this option. To provide a state wide option that is implemented locally, infrastructure support for small and rural jurisdictions must be included or the integration and collaboration needed for success will be lacking.

## Estimate of Need

The actual numbers of individuals with opiate addiction are neither evenly nor proportionally distributed across the state. An accepted statistical methodology utilizes actual admissions, individuals treated and readmitted, to provide estimates for each jurisdiction or regions.<sup>3</sup> Regions are used because actual estimated numbers in some jurisdictions are too small to be practical for the establishment of an efficient buprenorphine option. The estimates use FY 2007 data as of September 17, 2007 for the number of individuals treated, the number in need of treatment, and the difference between them, i.e. the “unmet need.” *Please note that these estimates reflect only individuals to be served by the public sector.*

TABLE 1

Region <sup>4</sup>	Estimated Need	# Treated	Unmet Need	Percent of Unmet Need
Western	2,847	882	1,965	4
Suburban	3,006	942	2,064	4
Southern	1,364	486	878	2
Lower Shore	1,131	355	776	2
Upper Shore	1,705	560	1,145	2
Central	15,279	4,205	11,074	23
Baltimore City	42,560	12,291	30,269	63
Total	67,892	19,721	48,171	100

<sup>3</sup> All statistical estimation methodologies have limitations. Recognizing the importance of developing a methodology to routinely provide assessments of the population in need, the 2007 General Assembly enacted and funded a statute requiring the ADAA to conduct a triennial needs assessment. That assessment is underway. Once completed, that study will provide a jurisdiction by jurisdiction estimate of need that will be used for the next 3 years. Until then the current methodology is used.

<sup>4</sup> Western: *Allegany, Garrett, Frederick and Washington counties*; Suburban: *Montgomery and Prince George's counties*; Southern: *Calvert, Charles and St. Mary's counties*; Lower Shore: *Dorchester, Somerset, Wicomico and Worcester counties*; Upper Shore: *Caroline, Cecil, Kent, Queen Anne's and Talbot counties*; Central: *Anne Arundel, Baltimore, Carroll, Harford and Howard counties*.

There is no empirically based methodology to predict how many addicted individuals will present for treatment each year. A generally accepted standard in health planning is that 25% of a population in need will present for care. This does not match actual experience in addiction treatment. The publicly funded system treated 19,721 of the estimated 67,892 opiate addicted individuals or almost 29% of the estimated individuals needing care.

This proposal increases the state's capacity to serve approximately another 1,000 individuals annually and ensure treating 31% of the estimated individuals needing care. The numbers of individuals served is dependent upon both the medication protocol and the level of counseling and support services required. Both need to be developed.

Proposed Program of Services

This program focuses on developing a local buprenorphine option in each jurisdiction, or region, by providing for physician training, case management and purchase of medication. It incorporates a collaborative consultation model for individual cases and provides for ongoing consultation for the management and monitoring of the local system.

The funds in this proposal are annualized. Seventy percent (70%) or \$ 2,100,000 will be made available to the seven regions/jurisdictions identified in Table 1. Funds are allocated based on the region's proportion of the unmet statewide need. This is summarized in Table 2.

TABLE 2

Region <sup>5</sup>	Estimated Need	# Treated	Unmet Need	Percent of Unmet Need	Funding
Western	2,847	882	1,965	4	\$84,000
Suburban	3,006	942	2,064	4	\$84,000
Southern	1,364	486	878	2	\$42,000
Lower Shore	1,131	355	776	2	\$42,000
Upper Shore	1,705	560	1,145	2	\$42,000
Central	15,279	4,205	11,074	23	\$483,000
Baltimore City	42,560	12,291	30,269	63	\$1,323,000
Total	67,892	19,721	48,171	100	\$2,100,000

<sup>5</sup> Western: *Allegany, Garrett, Frederick and Washington counties*; Suburban: *Montgomery and Prince George's counties*; Southern: *Calvert, Charles and St. Mary's counties*; Lower Shore: *Dorchester, Somerset, Wicomico and Worcester counties*; Upper Shore: *Caroline, Cecil, Kent, Queen Anne's and Talbot counties*; Central: *Anne Arundel, Baltimore, Carroll, Harford and Howard counties*.

Funding will be released to jurisdictions pending approval of a local plan that includes case management services, buprenorphine induction sites and sufficient counseling services. Funds may be used for any component of the local buprenorphine option including medication.

Thirty percent (30%) of the funds or \$900,000 will be directly held by the ADAA. These funds will provide for physician training, implementation of the automated information system in primary care settings, to purchase buprenorphine to fill in gaps in local medication budgets, and for use in rural and smaller jurisdictions where the original allocation of funds may be insufficient to adequately operate the program. Additionally, some of these funds will be used to support innovations that, after testing, may have wider application throughout the state.

ADAA will bring in expert consultation from academic health centers, as needed, to supplement ADAA staff and providers in developing clinical and patient selection protocols to determine which individuals are likely to benefit from buprenorphine detoxification vs. maintenance vs. methadone vs. drug free treatments. These protocols will be essential to measuring the efficiency and effectiveness of the initiative.

#### Implementation

Regional meetings will be held throughout the state in mid October to review and solidify local buprenorphine plans. Jurisdictions already operating some component of the proposed program will receive the funding as a supplemental grant award by November 2007.

ADAA will pay particular attention to the infrastructure needed to support this initiative in the smaller jurisdictions and regions. Some of the funding retained by the ADAA will be used to adjust allocations to these jurisdictions and regions. It is anticipated that these funds will be awarded by the end of December 2007.

A Buprenorphine Initiative Committee has been established at the ADAA and is chaired by Dr. Peter Cohen, Medical Director, ADAA. This committee will provide direct technical assistance to the jurisdictions and regions and approve local plans.