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Department of Psychiatry
Associate Professor

10 April 2012

Department of Vermont Health Access
Blueprint for Health Division (DVHA)

Dear Review Committee:

Attached please find our application to support the Medication Assisted Treatment Learning Community being initiated in Vermont.

We are excited by the prospects for this statewide program, and believe it has significant public health potential.

We would be honored to contribute our knowledge and expertise to this endeavor.

Please contact me if there are any questions about the application.

Sincerely,

Mark P. McGovern

Proposal: Department of Vermont Health Access, Blueprint for Health Division (DVHA)

From: Dartmouth Psychiatric Research Center (Mark McGovern, PI)

REGIONAL LEARNING COLLABORATIVES ON MEDICATION ASSISTED TREATMENT FOR OPIATE DEPENDENCE

BACKGROUND

Confronted with the current public epidemic of opioid use disorders, including heroin and prescription narcotics, the State of Vermont has initiated an innovative plan to improve access to treatment. The “Hub” and “Spoke” model is designed to establish regional centers that provide Medication Assisted Treatment (MAT), including both FDA approved medications for opioid use disorders as well as psychosocial treatments. Five regional *hubs* will offer both methadone and buprenorphine with the integrated psychosocial therapies. Within each of the five regions, primary and specialty care *spoke* practices will offer buprenorphine and psychosocial treatments. The hubs and spokes will provide care under DVHA, but as an emerging treatment delivery system, thoughtful planning and monitoring is necessary to insure quality care and minimize practice variation and disparities.

The Learning Community model has its formal origins in the Institute for Health Care Improvement (IHI, 2003) and has demonstrated effectiveness in a variety of general medical and specialty practice areas. Although research-based evidence is still emerging, learning communities in health care are associated with improved quality and patient outcomes. Characteristics of effective learning communities include common benchmark or patient outcome data, a manageable number of participants (8-10), regular meetings—including face-to-face, as well as trust in those who convene the meetings and in one another (Schouten et al, 2008). This last element pertains to the importance of a community where the emphasis is on improvement, and in the benefits of sharing common struggles and barriers (Vannoy et al, 2011).

As a system in its infancy, establishing a learning community among the new provider constituents in the Vermont MAT has great potential. We are excited at the prospect of being involved.

The learning community model can provide expert and peer input on administrative and clinical matters (both protocol and specific cases), comparative outcomes, workforce training and continuing education, practical solutions to barriers, and systemic challenges. The learning community model is conducive to developing leaders, generating energy, and instilling a greater sense of a common mission.

QUALIFICATIONS

Mark McGovern, Ph.D., is an Associate Professor of Psychiatry at Dartmouth Medical School. His career has been focused on improving community-based care for persons with substance use disorders, in particular those with co-occurring substance use and psychiatric disorder. He has received a National Institute on Drug Abuse (NIDA) Career Development Award for this exact purpose, and has since been awarded grants from the Robert Wood Johnson Foundation (RWJ), SAMHSA and NIDA to examine integrated treatments, services and systems for persons with co-occurring disorders. Dr. McGovern is familiar to the Vermont mental health and addiction treatment providers through the SAMHSA COSIG initiative (Vermont Integrated Services Initiative [VISI]), and spearheaded the statewide use of standardized organizational measures to assess integrated capacity (DDCAT, DDCMHT and DDCHCS). One of his NIDA-funded grants features the participation of five Vermont community treatment programs, all delivering manual guided behavioral therapies (Integrated Cognitive Behavioral Therapy; Individual Addiction Counseling) within a randomized controlled trial (RCT) design. The study is in its second of four years. Dr. McGovern has extensive past and present experience with the learning community model. He chairs the RWJ and SAMHSA funded National DDCAT/DDCMHT/DDCHCS Learning Community, which includes 32 participating entities (primarily state agencies and tribal authorities), and presently consults on two other learning communities (State of New Jersey Department of Mental Health and Addiction Services; Fairfax County [Virginia] Services Board—Behavioral Health Division). He is based at the Dartmouth Psychiatric Research Center (PRC) along with many other faculty members who are actively engaged in the implementation of evidence-based practices, including using learning community models, over the past twenty-five years.

Benjamin Nordstrom, M.D., Ph.D., is an Assistant Professor at Dartmouth Medical School, and is the Director of Addiction Services and the incoming Director of the Addiction Psychiatry Fellowship at Dartmouth-Hitchcock Medical Center. Dr. Nordstrom is board certified in psychiatry and addiction psychiatry by the American Board of Psychiatry and Neurology. He has provided buprenorphine in a number of venues, including private practices, faculty practices, and in large academic multispecialty practices. In addition, Dr. Nordstrom ran an addiction treatment program in Philadelphia prior to coming to Dartmouth. He also has five years of experience providing addiction consultation services to physicians in hospitals in Philadelphia and at Dartmouth-Hitchcock Medical Center and won an award for excellence in addiction education from the University of Pennsylvania where he taught a class about addiction and public policy.

Andrea Meier, M.S., is a dually-licensed substance abuse and mental health clinician with extensive experience and expertise in the implementation of psychosocial therapies. Prior to joining the Dartmouth PRC, Ms. Meier was a clinical supervisor and clinician at Spectrum Youth and Family Services (Burlington) for 6 years, and is presently the project manager for the NIDA funded RCT being conducted at Howard Center, Central Vermont Substance Abuse Services, Clara Martin Center, Rutland Mental Health Center (Evergreen) and Brattleboro Retreat. Ms.

Meier's focus is the training, supervision and quality monitoring of community clinicians in delivering evidence-based therapies.

Chantal Lambert-Harris, M.A., is a project coordinator at the Dartmouth PRC, and has served on both the RWJ and SAMHSA funded learning communities. She has been responsible for preliminary statistical analyses and presentation of aggregate data to the learning community, preparing the necessary reports for the funding agencies, outlining and referencing sections on scientific journal articles and grant applications, and managing the scheduling of meetings, and related correspondence from the learning community members. She also manages the daily operations of the learning community website, document preparation, and interface of all parties.

APPROACH

Our approach would directly correspond to the Project Specifications as outlined in the Request for Proposals. As the project is underway, the approach will likely need adaptation and reality-based revision. Such adaptations will be, in all instances, discussed *a priori* and resolved through written and verbal communication with the appropriate DVHA authorities.

1. Develop a network of clinical leaders and practice expertise in MAT in Vermont consistent with nationally accepted evidence-based practice guidelines.

The Dartmouth team has expertise in the medications, psychosocial and program design aspects of MAT. As the learning community gains momentum, Vermont's own leaders will emerge. The learning community model will highlight the contributions and capability of these leaders and promote opportunities both within the network, and at the national level such as the annual meetings of the College on Problems of Drug Dependence (CPDD) or the American Association for the Treatment of Opioid Dependence (AATOD). Dr. Nordstrom has expertise in medication treatments for opioid use disorders and runs the buprenorphine clinic and the addiction psychiatry fellowship at the Dartmouth Hitchcock Medical Center in Lebanon, New Hampshire. He will develop clinical leaders and practice expertise among prescribers at multiple levels. Dr. McGovern and Ms. Meier have been involved in all aspects of the implementation of evidence-based psychosocial therapies. In a presentation at AATOD later this month, we are presenting the results of an RCT evaluating an integrated combined therapy in a methadone treatment. Through training and clinical supervision (and providing actual therapy manuals), Vermont clinicians will develop expertise and leadership in evidence-based approaches. Dr. McGovern has experience in systems change and implementation of evidence-based practices, so it is expected that as this project evolves and processes documented, other states and regions will be interested in the "Vermont" model of care for opioid dependence.

2. Recruit practices to participate in the three regional learning collaboratives.

Treatment providers in general and medical providers in particular, have challenges in committing to activities beyond directly billable patient care. In our experience, support for attendance at a learning community is essential at the state regulatory agency level. Although this may not be necessarily required, we suggest at minimum it be strongly encouraged and incentivized. For our part, we recognize the task is to make the learning community experience positive and productive. It needs to be worthwhile. We intend to create an atmosphere of trust and open sharing of problems and barriers, while focusing on solutions and improvements. We intend to provide the most current research to inform the clinical processes. We intend to tap local talent, providers from the hubs and spokes, who can present to the larger group with authority and expertise. Finally, Continuing Medical Education (CME) Level I credits will be obtained for the onsite aspects of the learning community.

3. Design the course of learning, technical assistance, data collection and evaluation for each collaborative.

The exact course of learning and technical assistance can only be determined once the MAT providers have been identified and a training needs assessment conducted. We would recommend conducting such an assessment using the familiar framework of the DDCAT/DDCMHT/DDCHCS. The balance between validity and resources may require these assessments to be based on provider self-report. If support is available, in addition to the hubs, a representative volunteer sample of spoke providers may also benefit from onsite objective assessment.

Data collection and evaluation would be also based upon the procedures in place at the provider level, as well as the DVHA requirements. We would utilize any relevant data to track comparative provider processes and patient outcomes. If uniform data are not being collected across providers, this should be considered. If such an option is not available for other reasons, establishing data collection on access, engagement and retention (i.e. Washington Circle or process indicators) may be more realistic.

We are not proposing to collect new data, simply to recommend and utilize existing aggregate data. This also enables us to avoid obtaining informed consent for participation in “research” which would otherwise be necessary through the Dartmouth Committee for the Protection of Human Subjects. If this is of interest to the DVHA, this option could be exercised, but is not budgeted for in this proposal.

4. Arrange for the logistics of the in-person learning, data collection and evaluation for each collaborative.

Given the project is for one year, our approach would include bi-monthly (every other month) face-to-face meetings of the 3 learning communities: 1) Northwest region spoke providers; 2) Southwest region spoke providers; and 3) Chittenden region hub-spoke providers. The “off”

month would be teleconference meetings, using a toll-free conference call line arranged by us. The in-person and teleconference meetings would last 2 hours. Each meeting would have an agenda, a training (CME) topic, and dedicated time for the learning community members to interact. Drs. McGovern and Nordstrom would facilitate each meeting. The initial meeting would focus on the aims and scope of the learning community as well as the use of the quality improvement methods including: 1) Implementation planning, team and leader; 2) PDSA cycles; 3) Measuring outcomes. Each representative provider would be expected to identify goals, responsible parties, timelines, and measurable outcomes to report on by the second month. If at all possible, we may try to tie in the results of the needs assessment information (DDCAT/DDCMHT/DDCHCS) data to organize the implementation plans and PDSA objectives.

5. Secure continuing education credits for the collaborative activities for physicians, nurses, LADC, social workers, case managers, and mental health counselors.

We will obtain Category I CME credits through Dartmouth Hitchcock Medical Center Office of Continuing Medical Education for each hour of participation. Roll call, sign in and course evaluations are required for each participant. These credits are typically recognized by all health care licensing/certification boards, including nursing, psychology, social work, mental health and addictions counseling.

6. Provide on-site support and technical assistance to participating practices in collaboration with Blueprint practice facilitators.

On-site support and technical assistance will be determined based on needs assessment, provider interest, and specific goals. Examples of such support and technical assistance might include: assessment procedures; prescribing and dosage issues including induction and tapering; interactions with other medications; dealing with challenging clinical situations including rule or boundary violations, other drug use, obstreperous “drug seeking” behavior; evidence-based psychosocial therapies for persons in MAT; establishing and facilitating peer recovery supports for persons in MAT; and/or dealing with negative community or other professional attitudes about MAT.

Patients in MAT are in excellent position to benefit from peer recovery support. However, there are many barriers to attendance and participation at traditional mutual-aid meetings (AA, NA). These barriers are not insurmountable, but MAT treatment providers need to be able to effectively address common concerns and reluctance to attend meetings and engage in peer recovery support. Providers can learn to utilize adapted Twelve Step Facilitation (TSF) approaches to increase likelihood of patient connection with peer recovery supports. In addition, the learning communities will engage leaders (individuals in service positions) from the peer recovery support group community to assist in building accessible bridges for patients in MAT.

7. Develop a manual, including quick reference guides, summarizing practice guidelines, tools, data collection and methods, and key process improvements to support dissemination of the findings from each of the collaboratives to improve MAT state-wide. Manuals need to be easily usable and accessible to the target audience.

Similar to the potential topics above, for manuals and reference guides, pending the needs identified by the learning community and DVHS, the following are possible products: Examples of such support and technical assistance might include: assessment procedures; prescribing and dosage issues including induction and tapering; interactions with other medications; dealing with challenging clinical situations including rule or boundary violations, other drug use, obstreperous “drug seeking” behavior; evidence-based psychosocial therapies for persons in MAT; establishing and facilitating peer recovery supports for persons in MAT; and/or dealing with negative community or other professional attitudes about MAT.

Since this initiative is designed to deal with the “whole” person, it will be essential for providers to recognize that methadone and buprenorphine are medications for opioid use disorders, and do not directly target other substance use or psychiatric disorders. For this reason, comprehensive integrated assessment, treatment planning and monitoring should include these issues. In addition, increased health risks, including HIV, hepatitis C, and other infections must be addressed, along with other common medical problems.

Practice support materials would be targeted to the needs of the front line providers, not researchers. So the writing would be brief, to the point, and as practical as possible. When possible, we will utilize the checklist approach.

In addition, we have experience training practices to track access, engagement and retention data. Simple Excel workbooks can be provided to either hub or spoke practices to use these data to track the impact of their quality improvement efforts.

In addition to “hard” copies of these resources, we would also develop a website on which to post downloadable versions of guidelines, documents, relevant research, upcoming conferences and calendar of events. For some elements, the website would have a password protected capacity for access by learning community members only. In this domain, questions could be posted by learning community members, and discussion monitored by our team.

Given that not all MAT hub and spoke providers will be participants in the learning community, the website may be a powerful resource for practical information and guidance. As has been our experience with other learning communities, we also expect that it will stimulate broader interest in joining this learning community in the coming years.

8. Provide monthly written progress reports.

We have experience summarizing the outcomes of learning community meetings and quality improvement initiatives. Monthly reports would include a combination of quantitative (number of attendees, progress on plans, service and patient level outcomes) and qualitative (group cohesiveness, emerging leaders, themes, common barriers) data. We would expect a close working relationship with the DHVA.

SCHEDULE A: BUDGET SUBMITTAL FORM			
BUDGET SUBMITTAL FORM			
BUSINESS NAME: Dartmouth PRC			
CONTACT NAME AND NUMBER: Mark P. McGovern, 603-448-0263.			
LINE #	BUDGET CATEGORY	% FTE	TOTAL COST
PERSONNEL-SALARIES & WAGES:			
1	Mark McGovern, Ph.D.	20%	\$23,633
2	Benjamin Nordstrom, M.D., Ph.D.	20%	\$33,825
3	Andrea Meier, M.S.	20%	\$13,725
4	Chantal Lambert-Harris, M.A.	40%	\$22,804
5			
6	TOTAL SALARIES & WAGES		\$93,987
7	FRINGE BENEFITS		\$34,305
8	% OF SALARIES		
DIRECT OPERATING			
9	TRAVEL		\$3,080
10	RCL #1; 200 miles round trip, 6 trips = \$660		
11	RCL #2; 200 miles round trip, 6 trips = \$660		
12	RCL #3; 200 miles round trip, 6 trips = \$660		
13	TBD Sites: 200 miles round trip, 10 trips = \$1,100		
14	@.55 cents per mile		
15	OTHER		\$10,184
16	Manuals, quick reference guides, etc. = \$5,000		
17	Conference Calls: 20 participants, 120 minutes,		
18	18 calls @ .12 per minute per line = \$5,184		
19			
20			
21			
22			
23			
24			
25			
26			
27			
28	TOTAL OPERATING		\$141,556
29	TOTAL DIRECT COSTS		\$141,556
INDIRECT ALLOCATIONS (IF APPLICABLE):			
30	ADMINISTRATION (NOT TO EXCEED 13%)		\$18,402
31			
32	TOTAL INDIRECT		\$18,402
33	TOTAL COSTS		\$159,958
34			

Schedule B: Detail of Expenses

PERSONNEL

Salaries are budgeted at actual cost for the contract period.

Fringe Benefits are budgeted at Dartmouth's Federally-approved rate of 36.5%. The fringe benefits rate consists of pension, FICA, health insurance, life insurance, worker's compensation, unemployment compensation insurance, disability insurance, and employee tuition assistance, employee advising program, severance pay-out plans, and TIAA/CREF.

Mark McGovern, MAT Learning Community, Advisor, .2 FTE, will be primarily responsible for the Dartmouth team, and be the principal liaison with DVHA and the learning community. In addition to overall administrative responsibilities, he will attend all learning community meetings, face-to-face and teleconference, and be responsible for the agenda and group process. His primary focus will be on the effective functioning of the learning community, implementation of strategies for quality improvement (e.g. PDSA cycles, implementation process), psychosocial treatments and system enhancement. An additional focus of his effort will be on developing linkages between MAT providers and the peer recovery community in Vermont, including the Friends of Recovery, Vermont Psychiatric Survivors, the Turning Point clubhouses, Vet-to-Vet program, Vet Centers, NAMI and other mutual aid options.

Benjamin Nordstrom, MAT Learning Community, Medical Advisor, .2FTE, will be primarily responsible for the medical aspect of the MAT learning community, including practices and ethics regarding use of methadone and buprenorphine, attitudinal considerations, training and consultation, and development of practice support materials. Dr. Nordstrom will be available to the medical providers on such topics. He will attend all learning community meetings.

Andrea Meier, MAT Learning Community, Psychosocial Treatment Consultant .2FTE, will be primarily responsible to support implementation of evidence-based psychosocial therapies, including Integrated Combined Therapy (ICT) which includes: Motivational Enhancement Therapy (MET), Cognitive Behavioral Therapy (CBT) and Twelve Step Facilitation (TSF) therapy. Other evidence-based manual-guided psychosocial therapies that could be disseminated are: Integrated CBT for co-occurring PTSD and substance use disorders (high rates of PTSD co-exist with opioid use disorders), and Individual Addiction Counseling. Ms. Meier will be available to the hub and spoke sites to assist in the implementation of these therapies.

Chantal Lambert-Harris, MAT Learning Community, Outcomes Data Consultant, .4 FTE, will be responsible for the daily management of the Dartmouth, DVHA and learning community provider relationships, including scheduling, correspondence, reporting, obtaining resource material, preparing presentations, and managing the learning community website and interactive portal. If aggregate data analysis and reporting is available, she will also perform all tasks associated with this element.

TRAVEL

Funds have been budgeted for Project Staff to make six trips from Lebanon, NH to each of the three (3) to be determined (TBD), regional learning collaboratives sites (RCL). In addition, ten trips have been budgeted from Lebanon, NH to TBD sites in Vermont. Each trip from Lebanon has been budgeted at 200 miles round-trip. Mileage has been budgeted at Dartmouth's current reimbursement rate of .55 cents per mile. \$3,080 has been budgeted for travel.

OTHER

Manual Costs: \$5,000 has been budgeted for the printing of manuals and other documents specified in #7 of the Project Specifications listed in the RFP.

Conference Calls: Funds have been budgeted for eighteen conference calls throughout the year between the Dartmouth staff and the learning collaboratives members within Vermont. A total of 20 participants have been budgeted for each two-hour call at a rate of .12 cents per minute per participant. \$5,184 has been budgeted for conference calls.

Total Direct Costs

\$141,556

Schedule C: Allocation Methods

Total Administrative Costs: \$18,402

Dartmouth's current Federal approved Facilities & Administrative rates are 58% for on-campus programs and 26% for off-campus programs. The off-campus rate includes all administrative costs including but not limited to Human Resources, Procurement, Departmental and Central Administration, and the Office of Sponsored Projects. Per RFP guidelines administrative costs have been budgeted at 13%.

Schedule D: Related Party Disclosure

There are no relationships to disclose.

REFERENCES ON LEARNING COMMUNITY LEADERSHIP

Tison Thomas
SAMHSA
Tison.Thomas@SAMHSA.hhs.gov

Joan Rodgers
Fairfax-Falls Church Community Service Board
Joan.Rodgers@FairfaxCounty.gov

Julienne Giard
State of Connecticut Department of Mental Health and Addiction Treatment Services
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Alysa Fornarotto-Regenye
State of New Jersey Department of Mental Health and Addiction Treatment Services
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PRIMARY CONTACT

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Dartmouth College

Office of Risk and Internal Controls Services

August 22, 2011

To Whom It May Concern:

The Trustees of Dartmouth College, at all times, maintain the following insurance coverages:

1. Workers' Compensation and Workers' Liability self-insured in accordance with the laws of the State of New Hampshire including Employers Liability in excess of statutory limits, with commercial excess coverage.

Insurer: Midwest Employers Casualty Company
Policy Number: EWC 008364
Effective: 7/01/11 Expires: 07/01/12
Insurer: Continental Casualty Company
Policy Number: 2099375438
Effective: 7/01/11 Expires: 07/01/12

2. Comprehensive General Liability Insurance including personal injury, property damage, products liability, completes operations and contractual liability. Primary limits of \$2,000,000 per occurrence with combined single limit for personal injury and property damage.

Insurer: Pinnacle Consortium of Higher Education
Policy Number: PCHE 2011-03
Effective: 07/01/11 Expires: 07/01/12

3. Comprehensive Automobile Liability Insurance, including coverage for owned, leased, hired and non-owned vehicles with combined single limit for bodily injury and property damage for each occurrence of \$2,000,000.

Insurer: Zurich American Insurance Company
Policy Number: BAP9267272
Effective: 07/01/11 Expires: 07/01/12

4. Medical Professional Liability primary coverage of \$2,000,000 each claim.

Insurer: Pinnacle Consortium of Higher Education
Policy Number: PCHE2011-03
7/01/11 Expires: 07/01/12

There is a minimum of 30-day notification for cancellation for these policies.
For any additional information, you may contact the writer.

Leslie L. Seabrook ARM, CRIS
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