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# Guidance Document on Best Practices: Key Components for Delivering Community-Based Medication Assisted Treatment Services for Opioid Use Disorders in New Hampshire

*An initiative of the Bureau of Drug and Alcohol Services (BDAS) at the New Hampshire Department of Health and Human Services, with technical assistance provided by the New Hampshire Center for Excellence*

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# ACRONYMS AND ABBREVIATIONS

**42 C.F.R., Part 2** – Title 42, Part 2 of the Code of Federal Regulations  
**ASAM** – American Society of Addiction Medicine  
**ASI** – Addiction Severity Index  
**ATTC** – Addiction Technology Transfer Center  
**AUD** – Alcohol Use Disorder  
**BDAS** – Bureau of Drug and Alcohol Services  
**CBT** – Cognitive Behavioral Health  
**CHC** – Community Health Center  
**COWS** – Clinical Opioid Withdrawal Scale  
**DEA** – Drug Enforcement Administration  
**DHHS** – Department of Health and Human Services  
**DSM-5** – Diagnostic and Statistical Manual of Mental Disorders, 5th Edition  
**DUR** – Data Utilization Review  
**FDA** – Food and Drug Administration  
**IM** – Intramuscular  
**IOP** – Intensive Outpatient Program  
**IV** – Intravenous  
**LADC** – Licensed Alcohol and Drug Counselor  
**MAT** – Medication Assisted Treatment  
**MCO** – Managed Care Organization  
**MET** – Motivational Enhancement Therapy  
**MLADC** – Master Licensed Alcohol and Drug Counselor  
**NCM** – Nurse Care Manager  
**NHHPP** – NH Health Protection Program  
**OBOT** – Office-Based Opioid Treatment  
**OOWS** – Objective Opioid Withdrawal Scale  
**OTP** – Opioid Treatment Program  
**OUD** – Opioid Use Disorder  
**PAP** – Premium Assistance Program  
**PCP** – Primary Care Provider  
**PDL** – Preferred Drug List  
**PDMP** – Prescription Drug Monitoring Program  
**PO** – By Mouth  
**QHP** – Qualified Health Plan  
**SAMHSA** – Substance Abuse and Mental Health Services Administration  
**SES** – Socioeconomic Status  
**SOWS** – Subjective Opioid Withdrawal Scale  
**SUD** – Substance Use Disorder  
**TAP** – Technical Assistance Publication  
**TIP** – Treatment Improvement Protocol  
**UDT** – Urine Drug Testing

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# EXECUTIVE SUMMARY

In 2014, New Hampshire recorded 326 drug overdose deaths, and as of September 18, 2015, 232 more individuals were lost to drug overdoses. In the past year, 91% (211) of these deaths were related to opioids, the equivalent of twenty-seven deaths per month or on average one death per day. Specifically, in 2014, 70.3% (206) of the 293 opioid overdose deaths were caused by heroin or fentanyl; this has increased to 84.8% (179) of the 211 opioid overdose deaths in 2015 so far.<sup>1</sup>

In response to this opioid epidemic, NH has executed several activities including implementing screening, brief intervention and referral to treatment (SBIRT) in all community health centers to identify problem alcohol and drug use; passing legislation to allow physicians to prescribe naloxone (Narcan) to anyone who may be in a position to help someone experiencing an opioid-related overdose (House Bill 271) and providing protection from civil, criminal and professional liability to the prescriber, dispenser and administrator of naloxone, also known as the Good Samaritan Law (House Bill 270); making naloxone kits available to patients of ten community health centers at no cost; supporting community education and naloxone access events through the state's public health network system; and launching an opioid awareness and public education campaign. As a companion to these addiction prevention, early identification and overdose prevention initiatives, the state is making a concerted effort to expand the availability of addiction treatment through investment in and promotion of medication assisted treatment (MAT) for opioid use disorders (OUDs).

Similar to many other states across the country, MAT services are limited and desperately needed in NH. The need for expanded MAT is evident in the high rates of problem opioid use reflected in the sharp increases in emergency room visits and ambulance calls for opioid abuse, in opioid-related overdose deaths, and in the wait lists reported by all of the state's eight methadone clinics, with lengths of wait lists ranging from two weeks to two months.<sup>2</sup>

To address the evident lack of capacity to treat OUDs, the New Hampshire Department of Health and Human Services (DHHS) Bureau of Drug and Alcohol Services (BDAS) convened a panel of practitioners from health care, behavioral health, substance use disorder specialty treatment services, and the NH Medical Society to review existing practices in New Hampshire and other states and identified key components and best practice recommendations from the American Society for Addiction Medicine (ASAM) and other nationally-recognized resources.

This panel developed three core objectives to expand MAT for New Hampshire residents with an OUD:

1. Increase the number of waived buprenorphine prescribers;
2. Increase awareness of and access to extended-release injectable (depot) naltrexone and other medications by prescription; and
3. Increase office-based access to MAT programs through multiple settings, including primary care offices and clinics, specialty office-based ("stand alone") MAT programs, and traditional addiction treatment programs offering medication assistance.

<sup>1</sup> Data obtained from the NH Medical Examiner's Office

<sup>2</sup> Substance Use Disorder Treatment and Other Service Capacity in New Hampshire, Community Health Institute/JSI, NH Center for Excellence, 2014

The panel also contributed to the development of this compendium of best practice recommendations and resources for implementing and delivering effective MAT. The goal is to provide expanded capacity to serve more people with OUDs with effective treatment across a variety of settings.

# INTRODUCTION

This compendium of best practice recommendations and resources has been developed in response to the desire for guidance and supports communicated by health care and behavioral health professionals in order to initiate or expand MAT services for OUDs for patient populations in a variety of service settings. Each component is described in the order in which it is most commonly implemented; however, the setting, and how prepared this specific setting is to implement office-based treatment services, will determine whether several components may be implemented simultaneously or a section of a component may be initiated during the planning phase with the remainder completed during the delivery of services. Providers may skip to the section of interest depending on where they are in the MAT implementation process. This document is not intended to replace best practice resources such as *ASAM's National Practice Guidelines For the Use of Medications in the Treatment of Addiction Involving Opioid Use* or the *Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Improvement Protocols (TIPs)* or *Technical Assistance Publications (TAPs)*, but is rather a compilation of resources and recommendations identified from these sources.

The development of this compendium is based on several key principles:

- The disease of addiction is a complex biopsychosocial disease that is chronic in nature and is often characterized by periods of relapse and recovery;
- Medications such as methadone, buprenorphine and naltrexone have been determined by research to be highly effective in short-term withdrawal management and longer-term treatment for individuals experiencing addiction, particularly for those with opioid use disorders<sup>3</sup>;
- Access to medication assistance for those experiencing addiction is extremely limited, as evidenced by a comprehensive assessment conducted in the state in 2014<sup>4</sup>;
- Only 30% of treatment programs offer medications for opioid use disorder<sup>5</sup>; and
- Medical professionals from a range of primary care and specialty practices have expressed interest in delivering MAT to existing patient populations and/or to MAT-targeted patients provided they are able to access adequate training, technical assistance, and professional mentoring.

MAT can be delivered in a variety of service settings with the proper integration of specific components. This compendium has been designed to provide an overview of these essential components necessary for delivering MAT services with specific recommendations and resources highlighted relative to the following MAT setting types:

- Primary care based MAT delivery
- Behavioral health/specialty addiction treatment-based MAT delivery
- MAT-specific treatment programs

Each of these setting types exists in New Hampshire, and representatives from each were contacted to help the panel understand and consider the strengths, challenges, and opportunities that lay in each. Examples will be shared throughout the document to better describe the different models and components and are not intended for promotional purposes.

<sup>3</sup> The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.

<sup>4</sup> Substance Use Disorder Treatment and Other Service Capacity in New Hampshire, Community Health Institute/JSI, NH Center for Excellence, 2014.

<sup>5</sup> The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.

# OVERVIEW OF OPIOID USE DISORDER MEDICATIONS

According to the SAMHSA's Addiction Technology Transfer Center (ATTC) Network, *MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.* MAT is linked to many positive outcomes including:<sup>6,7</sup>

- Decreasing mortality;
- Increasing retention in treatment;
- Reducing medical and substance use disorder (SUD) treatment costs;
- Reducing opioid overdose among patients in treatment;
- Increasing abstinence from opioids; and
- Lowering a person's risk of contracting HIV or hepatitis C.

Three medications are approved by the U.S. Food and Drug Administration (FDA) for treating OUDs -- methadone, buprenorphine, and naltrexone -- with several products/formulations available for each of these medications. While all three pharmacotherapies are approved options with different efficacies and contraindications, this compendium will focus primarily on the following:

- Buprenorphine (all products/formulations: Suboxone<sup>®</sup>, Subutex<sup>®</sup>, Zubsolv<sup>®</sup>, Bunavail<sup>®</sup>)
- Naltrexone (extended-release injectable/depot/xr-npx: Vivitrol<sup>®</sup>)

These medications were selected because they may be prescribed in an office-based setting, unlike methadone which must be dispensed at certified opioid treatment programs (OTPs). Additionally, this compendium focuses on depot naltrexone, specifically Vivitrol, the only commercial product currently available, rather than oral naltrexone (ReVia<sup>®</sup>, Depade<sup>®</sup>) because poorer medication adherence with the oral form has resulted in poorer retention rates compared to depot naltrexone.<sup>8</sup> However, prescribers are strongly advised to have a thorough understanding of each therapeutic medication, and the different products and formulations available, in an effort to, in conjunction with the patient, identify which pharmacotherapy will be the best treatment option. Another therapeutic formulation is a buprenorphine implant which is currently being investigated by the FDA with an anticipated action date of February 27, 2016 if approved. It is also important to note that several medications are available to treat alcohol use disorders (AUDs) and can be prescribed in an office-based setting. SAMHSA's *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide*<sup>9</sup> provides more information.

## Sampling of Research Findings Associated with Buprenorphine, Naltrexone and Methadone

Research outcomes relative to these medications are important to review as medication assistance approaches are considered. For example, in an examination of buprenorphine maintenance versus placebo or methadone

6 Retrieved from Substance Abuse and Mental Health Services Administration (SAMHSA), Addiction Technology Transfer Center (ATTC) Network - <http://attnetwork.org/regional-centers/content.aspx?rc=northwest&content=STCUSTOM3>.

7 Connery, H. Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions. 2015. *Harv Rev Psychiatry*. 23(2):63-75.

8 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.

9 Substance Abuse and Mental Health Services Administration and National Institute on Alcohol Abuse and Alcoholism, Medication for the Treatment of Alcohol Use Disorder: A Brief Guide. HHS Publication No. (SMA) 15-4907. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

maintenance, which included 31 trials and 5,430 participants, findings indicated that buprenorphine retains fewer people than methadone when dose intervals are flexible and at low fixed doses. However, at medium to high doses no differences are seen. Additionally, based on the literature reviewed, no difference was observed between methadone and buprenorphine for reducing criminal activity or mortality rates. Specifically, this research found the following:

- Low fixed-dose studies indicated that methadone ( $\leq 40$  mg) was more likely to retain participants than low-dose buprenorphine (2 - 6 mg), (3 studies, 253 participants, RR 0.67; 95% CI: 0.52 to 0.87);
- No difference in retention was observed between medium-dose buprenorphine (7 - 15 mg) and medium-dose methadone (40 - 85 mg), (7 studies, 780 participants, RR 0.87; 95% CI 0.69 to 1.10); and
- No difference in retention was observed between high-dose buprenorphine ( $\geq 16$  mg) and high-dose methadone ( $\geq 85$  mg), (RR 0.79; 95% CI 0.20 to 3.16).<sup>10</sup>

Another study looked at the long-term (18-month) outcomes of office-based buprenorphine/naloxone maintenance therapy and the impact of socioeconomic status (SES) and other characteristics. Of the 176 opioid-dependent patients who were on buprenorphine/naloxone and receiving intensive outpatient counseling (IOP), 110 completed the follow-up interview with 77% of those who reported remaining on the medication. Individuals who were still on buprenorphine/naloxone were more likely to report abstinence, involvement with recovery programs, and to be employed. No differences were observed between high and low SES groups.<sup>11</sup>

Limited research is available comparing outcomes of depot naltrexone to buprenorphine and/or methadone. According to a 24-week, placebo-controlled, randomized trial of patients (n=250) who were either completing or recently completed detoxification and were receiving biweekly psychosocial support, the percentage of opioid-free weeks, negative urine drug results for opioids, was greater among the depot naltrexone group compared to the placebo group. Complete abstinence was sustained by 23% of the placebo group compared to 36% between weeks 5 and 24 for the depot naltrexone group.<sup>12</sup>

Depot naltrexone has been increasingly used with incarcerated and criminal justice-involved populations. In a retrospective study involving parolees and probationers (N=3,135), among those who identified opioids as a problem, individuals stayed in treatment longer (an average of 97 days) if treated with depot naltrexone (n=136) compared to those treated with oral naltrexone (63 days, n=34) or psychosocial treatment only (63 days, n=866). Those treated with buprenorphine/naloxone (69 days, n=163) showed no significant difference compared to depot naltrexone.<sup>13</sup>

According to the results of a retrospective, longitudinal study comparing patients who received MAT vs. those who did not receive medication to support recovery, of 10,513 patients who received one of the four approved medications for the treatment of opioid dependence (depot naltrexone, n=156, 1.5%; oral naltrexone, n=845, 8.3%; buprenorphine, n=7,596, 72% or methadone, n=1,916, 18.2%), the per-patient mean cost associated with treatment

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10 Mattick RP, Breen C, Kimber J, Davoli M. *Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence (Review)*. Copyright © 2014. The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.

11 Parran et. al. Long-term outcomes of office-based buprenorphine/naloxone maintenance therapy. *Drug and Alcohol Dependence*. 106 (2010) 56–60.

12 Vivitrol Prescribing Information and Medication Guide. July 2013. Alkermes, Inc.

13 Data obtained from Alkermes, Inc. Lundy C, Stringer M, Crits-Cristoph P, et al. Extended-Released Naltrexone (XR-NTX) in St. Louis Parolees and Probationers. Poster Presented at: Research Society on Alcoholism (RSA) annual meeting. June 21-25, 2014.

including inpatient, outpatient and pharmacy costs was \$10,710 vs. \$6,791 for patients receiving no drug treatment; however, six-month risk-adjusted outcomes indicated lower total healthcare costs by 29% for patients who received a medication for their opioid dependence. Specifically, treatment with depot naltrexone was associated with significantly fewer opioid and non-opioid related hospitalizations and fewer emergency department visits than patients who received methadone. It is important to note that the cost of depot naltrexone is much higher in comparison to other medications for opioid dependence. However, in looking at total costs, this medication is not significantly different compared to oral naltrexone or buprenorphine, but is significantly lower than methadone.<sup>14</sup>

The following chart highlights the differences among the three medications.

<b>DIFFERENCES AMONG OPIOID USE DISORDER MEDICATIONS</b> <sup>15,16,17,18</sup>			
<b>PRESCRIBING CONSIDERATIONS</b>	<b>METHADONE</b>	<b>BUPRENORPHINE</b>	<b>NALTREXONE</b>
<b>Product/Formulation</b>		All products/formulations; Suboxone,* Subutex, Zubsolv,* Bunavail*	Extended-release injectable/depot/xr-npx; Vivitrol
<b>Mechanism of Action</b>	Full Agonist: Binds to and activates receptors. Long-acting, providing steady blood levels which avoid reward (euphoria) due to peak effects and avoids withdrawal or craving due to low blood levels.	Partial Agonist: Binds to and partially activates opioid receptor. Long-acting, providing steady blood levels which avoid reward (euphoria) due to peak effects and avoids withdrawal or craving due to low blood levels.	Antagonist: Binds and competitively blocks opioid reward effects.
<b>Uses of Medication</b>	Withdrawal and Treatment	Withdrawal and Treatment	Treatment
<b>Route of Administration</b>	Oral tablet or liquid	Sublingual tablet or sublingual or buccal film	Intramuscular (IM) Injection
<b>Dose</b>	PO: 5 mg, 10 mg tablets; 10/mg/mL liquid	PO: 2 mg, 4 mg, 8 mg, 12 mg film and 8 mg tablet	IV/IM: 380 mg in 4cc

14 Data obtained from Alkermes, Inc. Baser O, Chalk M, Fiellin DA, Gastfriend DR. Cost and utilization outcomes of opioid dependence treatments *Am J Manage Care*. 2011;17:S235-248.

15 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.

16 National Council for Behavioral Health. Webinar: Making the Case: How MAT Improves Mental Health Care for those with OUDs held by Dr. Hilary Connery on October 6, 2015.

17 Retrieved from Substance Abuse and Mental Health Services Administration (SAMHSA). An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People With Opioid Dependence. Winter 2012. Volume 11. Issue 1, [http://www.integration.samhsa.gov/Intro\\_To\\_Injectable\\_Naltrexone.pdf](http://www.integration.samhsa.gov/Intro_To_Injectable_Naltrexone.pdf).

18 The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.

PRESCRIBING CONSIDERATIONS	METHADONE	BUPRENORPHINE	NALTREXONE
Product/Formulation		All products/formulations; Suboxone,* Subutex, Zubsolv,* Bunavail*	Extended-release injectable/depot/xr-npx; Vivitrol
Frequency of Administration	Daily	Daily	Monthly
Dosage	Initial dose: 10 – 30 mg (titration is slow and monitored) Typical daily dose: 60 – 120 mg	Initial: 2 – 4 mg (increase by 2 – 4 mg) Daily: ≥ 8 mg (typically started at 8 or 16mg/day) Maximum: 24 mg/day	1 Injection (380 mg and 4cc) every 4 weeks
Regulatory Context	May only be dispensed at a certified opioid treatment program (see He-A 300 rules, part 304). <sup>19</sup>	Any licensed physician with a DEA registration and a buprenorphine waiver may prescribe (see pages 17-19).	Any healthcare provider who has a license to prescribe (e.g., physician, nurse practitioner, physician assistant).
Typical Visit Requirement	Initial: daily Progressing to maximum of thirteen doses within 14 days	Initial: weekly Interval increases based on patient progress	Monthly injection
Cost of Medication	Low	Medium	High
Cost of Treatment	Varies		
Controlled Substance Schedule	Schedule II	Schedule III	Not a scheduled medication
Overdose Potential	High	Moderate	None
Diversion Value	High	High	Low
Level of Engagement	All patients diagnosed with a substance use disorder can benefit from recovery support programs		
Discontinuation of Medication	Tapering Required	Tapering Required	No Tapering Required
Retention Rate	See pages 8-10 for data		

\* Suboxone, Zubsolv, and Bunavail contain both buprenorphine and naloxone. Naloxone is an antagonist and is used to avoid the use of this drug intravenously. If intravenous abuse occurs, the person will experience immediate withdrawal compared to taking medication as prescribed.

# SERVICE DELIVERY AND CLINICAL CONSIDERATIONS

A high-level overview of each of the elements of an optimally organized office-based MAT program for the treatment of OUDs will be described in the following sections. Specific best practice recommendations and resources will be promoted throughout this guidance document to assist with the initiation or expansion of office-based MAT services for each of the various service delivery models: primary care based MAT delivery, behavioral health/specialty addiction treatment-based MAT delivery, and MAT-specific treatment programs as appropriate (see chart below).

Overview of Buprenorphine/Naltrexone Service Delivery Models				
	Primary Care Clinic or Office	Behavioral Health/ Specialty Addiction Treatment Program	MAT-Specific Treatment Programs	
			Free-Standing Buprenorphine Clinic	Opioid Treatment Program (OTP)/ Methadone Maintenance Clinic
<b>General Description</b>	Engages existing PCP to become waived, prescribes buprenorphine/ naltrexone and arranges psychosocial treatment and recovery support services	Provides psychosocial treatment and recovery support services  Either employs or contracts with waived physician to prescribe buprenorphine/ naltrexone	Establishes clinic specifically to provide buprenorphine/ naltrexone  Engages prescriber, psychosocial treatment provider and care coordination  Either engages or refers to recovery support providers	Methadone clinic expands services to include prescribing of buprenorphine/ naltrexone  Engages waived physicians and utilizes existing psychosocial treatment provider and care coordination  Either engages or refers to recovery support providers
<b>Prescriber Roles</b> <ul style="list-style-type: none"> <li>• Diagnoses opioid dependence</li> <li>• Induces onto MAT</li> <li>• Prescribes</li> <li>• Provides routine follow-up visits</li> </ul>	Waivered PCP or other waived MD  May link to other waived physicians for cross coverage	Medical/Psychiatric Director or other medical staff become waived  Partner with waived physician in community	Employed & waived staff physician	Employed & waived staff physician

## Overview of Buprenorphine/Naltrexone Service Delivery Models

<b>Counselor Roles</b> <ul style="list-style-type: none"> <li>• Provides addiction counseling                             <ul style="list-style-type: none"> <li>• Group</li> <li>• Individual as needed</li> </ul> </li> <li>• Engages in self-help and recovery support</li> <li>• Therapy for co-occurring disorders requiring attention</li> </ul>	Embedded addiction counselor  Contract with outside counseling provider  Prescriber provides counseling	Designated counseling staff	Designated counseling staff	Designated counseling staff
<b>Care Coordinator Roles</b> <ul style="list-style-type: none"> <li>• Facilitates communication between prescriber &amp; counselor</li> <li>• Phone contact with patient as needed</li> <li>• UDTs</li> <li>• Pill/film counts</li> <li>• Links with recovery support services</li> </ul>	Nurse  Medical assistant  Prescriber	Case manager  Counselor	Case manager  Counselor	Case manager  Counselor

Office-based MAT must aim to find the balance between maximizing access to life-saving medications and supporting recovery from opioid addiction, while minimizing unintended negative consequences such as diversion and misuse of treatment medications. The simplest form of MAT with buprenorphine which meets federal and state regulations involves a waived physician writing a prescription for patients who meet criteria for opioid dependence, providing regular office visits, documenting care properly and ensuring capacity to refer patients for appropriate counseling and other appropriate ancillary services.

In addition to these requirements, there are other best practices that this guidance document promotes. They include querying the Prescription Drug Monitoring Program (PDMP) each time a prescription is written, routine and random urine drug testing (UDTs) and pill/film counts and timely communication among the prescriber, the patient and external providers. This model can be successful for some providers and patients.<sup>20</sup> Formal structuring of office systems to support best practices in MAT is strongly encouraged to facilitate efficient patient care and reduce system

<sup>20</sup> Weiss, et al. Adjunctive counseling during brief and extended buprenorphine-naloxone treatment for prescription opioid dependence. Archives of General Psychiatry. 68(12):1238-1246. 2011.

stress, especially if a provider treats more than a few patients with MAT. These processes would apply to all MAT.

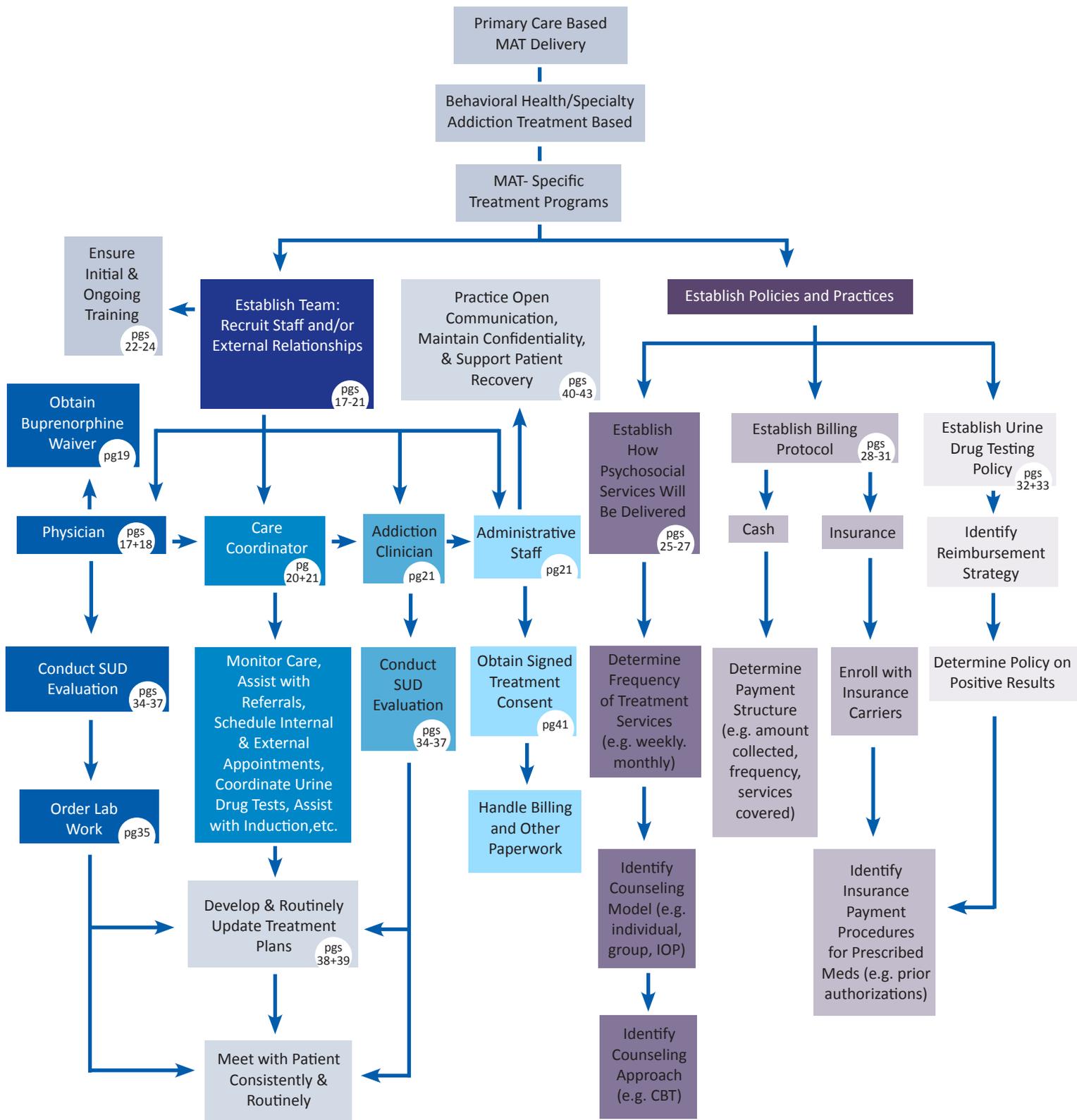
The following chart distinguishes federal and state requirements and the best practices (highlighted in blue) which New Hampshire is strongly promoting for its office-based opioid treatment (OBOT) programs to actively employ.

Federal Regulatory Requirements	State of New Hampshire Regulatory Requirements	New Hampshire Best Practices
<ul style="list-style-type: none"> <li>• Physician to obtain buprenorphine waiver to prescribe (8 hours CME and exam)</li> <li>• Verify that patients meet criteria for opioid dependence</li> <li>• Determine patients are deemed appropriate for MAT level of care and medication</li> <li>• Conduct full evaluation and medical exam</li> <li>• Provide regular office visits</li> <li>• Document care properly (e.g., treatment plans, confidentiality)</li> <li>• Ensure capacity to refer patients for appropriate counseling and other appropriate ancillary services.</li> </ul>	<ul style="list-style-type: none"> <li>• Physician to obtain buprenorphine waiver to prescribe (8 hours CME and exam)</li> <li>• Verify that patients meet criteria for opioid dependence</li> <li>• Determine patients are deemed appropriate for MAT level of care and medication</li> <li>• Conduct full evaluation and medical exam</li> <li>• Provide regular office visits</li> <li>• Document care properly (e.g., treatment plans, confidentiality)</li> <li>• Ensure capacity to refer patients for appropriate counseling and other appropriate ancillary services.</li> </ul>	<ul style="list-style-type: none"> <li>• Physician to obtain buprenorphine waiver to prescribe (8 hours CME and exam)</li> <li>• Verify that patients meet criteria for opioid dependence</li> <li>• Determine patients are deemed appropriate for MAT level of care and medication</li> <li>• Conduct full evaluation and medical exam</li> <li>• Provide regular office visits</li> <li>• Document care properly (e.g., treatment plans, confidentiality)</li> <li>• Ensure capacity to refer patients for appropriate counseling and other appropriate ancillary services.</li> <li>• Query the PDMP each time a prescription is written</li> <li>• Identify additional qualified staff to include care coordinator</li> <li>• Enroll and credential with managed care organizations (MCOs), qualified health plans (QHPs), and other insurers</li> <li>• Perform routine and random UDT checks</li> <li>• Perform routine and random pill/film counts</li> <li>• Practice timely communication among the prescriber, the patient and external providers</li> <li>• Provide initial and on-going training and resources</li> </ul>

Each of the components mentioned in the above chart is described in further detail in the following document in the order by which these tasks are most commonly implemented; however, the setting, and how prepared this specific setting is to implement office-based treatment services, will determine whether several components may be implemented simultaneously or a section of a component may be initiated during the planning phase with the remainder completed during the delivery of services. Providers may skip to the section of interest depending on where they are in the MAT implementation process.

Additionally, the MAT program should identify specific program goals before the implementation phase. These goals should be realistic and flexible. It should be anticipated that the first one to two years after implementation will involve identifying problems and adjusting programming and service delivery as necessary.

The following is a visual representation of the recommended best practices and tasks for the implementation of an OBOT program across multiple service delivery settings.



## A. STAFFING: Establish a Core Team

Establishing a core team dedicated to patient care and service coordination specific to MAT is fundamental for an organized MAT setting.<sup>21</sup> This team may be made up exclusively of clinic staff or may include partnering providers/organizations in the community to provide comprehensive treatment services to meet patient needs.

To establish an effective team, it is important to identify or recruit interested and qualified staff who encompass the attitudes, values, and competence associated with treating opioid misuse. It is recommended that the team consist of, at a minimum, a prescriber, a care coordinator, a licensed alcohol and drug counselor (LADC) or behavioral health provider with addiction training, and non-clinical/administrative staff. The following describes each of the positions necessary for delivering effective MAT.

### 1. Prescriber

For either buprenorphine or naltrexone, a medical professional who is licensed to prescribe medications is necessary to provide patients with medicines to assist with their treatment program.

*Buprenorphine* (Suboxone/Subutex/Zubsolv/Bunavail): A buprenorphine prescriber must be a physician (MD or DO) who has received a buprenorphine waiver through the DEA (Drug Enforcement Administration). Waivered physicians can prescribe for up to 30 patients in the first year and can then apply to increase the limit to a maximum of 100 patients.

Physicians have been able to prescribe buprenorphine since October 2002 when the FDA approved buprenorphine for clinical use in treating opioid dependency; however, very few physicians in NH have obtained the waiver compared to other states. According to SAMHSA, as of October 7, 2015, eighty-four physicians have been waived to treat at the 30-patient limit and fifty-nine physicians at the 100-patient limit. Of those 143 waived physicians, only sixty-six have listed their contact information on SAMHSA's Buprenorphine Treatment Physician Locator<sup>22</sup> (see Appendix I: *Map of Buprenorphine Prescriber Locations*). Some may not be currently practicing, some may be at capacity, or some have chosen not to be listed for other reasons.

*Naltrexone* (Vivitrol): This medication may be prescribed by any healthcare provider (e.g., nurse practitioners, physician assistants) who is licensed to prescribe medications. There is no limit on the number of patients for whom this medication may be prescribed.

This extended-release injectable medication is the most recent drug, approved in October of 2010, for the treatment of opioid addiction. Despite the less restrictive rules regarding who can prescribe naltrexone, and the allowable number of patients, NH has very few providers. According to Alkermes, Inc.,<sup>23</sup> as of November 16, 2015, twenty-one health care providers are current Vivitrol prescribers (see Appendix II: *Map of Vivitrol Prescriber Locations*).

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21 Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

22 Retrieved from the Substance Abuse and Mental Health Services Administration (SAMHSA) Buprenorphine Treatment Physician Locator, <http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator>

23 Retrieved from Pamela O'Sullivan, Director of Government Affairs and Policy of Alkermes, Inc. on November 16, 2015.

*Methadone:* While methadone can be prescribed for pain treatment by any prescriber with a DEA registration, for purposes of addiction treatment it can only be dispensed at a licensed opioid treatment program (OTP)/methadone clinic. For patients for whom methadone is determined to be the most appropriate option, primary care, behavioral health-based, and specialty addiction treatment programs can work with one of the eight licensed OTPs to coordinate integrated primary care, behavioral health, and opioid treatment services. New Hampshire has three organizations with a total of eight sites across the state certified to dispense methadone (see Appendix III: *Map of Opioid Treatment Program (OTP)/ Methadone Clinic Locations*).

The following table provides recommendations for identifying a prescriber by medication and setting type.

<b>OVERVIEW OF MAT PRESCRIBER OPTIONS BY SETTING</b>			
	<b>PRIMARY CARE</b> based MAT delivery	<b>BEHAVIORAL HEALTH / SPECIALTY ADDICTION TREATMENT</b> based MAT delivery	<b>MAT-SPECIFIC</b> treatment programs
<b>Buprenorphine (Suboxone, Subutex, Zubsolv, Bunavail)</b>	Have interested physician(s) in practice obtain buprenorphine waiver, prescribe medication, and oversee patient care.	Have staff physician obtain buprenorphine waiver.  Establish a working relationship with a physician in the community waived to prescribe buprenorphine.	Have staff physician obtain buprenorphine waiver.  Hire physician(s) waived to prescribe buprenorphine.
<b>Naltrexone (Vivitrol)</b>	Identify existing healthcare providers to prescribe naltrexone and oversee patient care.	Have staff physician prescribe naltrexone.  Establish a working relationship with a healthcare provider in the community to prescribe naltrexone.	Have staff physician prescribe naltrexone.  Hire or subcontract with a medical professional to prescribe naltrexone and to participate in oversight of patient care.
If methadone is determined to be the most appropriate medication for patients, providers can establish care coordination plans with one of the state's eight methadone clinics to support effective, integrated primary care, behavioral health care, and addiction treatment.			

## Buprenorphine Waiver Training Information

### TO QUALIFY FOR A BUPRENORPHINE WAIVER, A PHYSICIAN MUST:

1. Be a licensed physician (M.D. or D.O.)
2. Meet and verify any one or more of the following criteria:
  - a. Hold a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties
  - b. Hold an addiction certification from the American Society of Addiction Medicine (ASAM)
  - c. Hold a subspecialty board certification in addiction medicine from the American Osteopathic Association
  - d. Complete an eight-hour addiction course on the management and treatment of patients with opioid use disorders as provided by an approved vendor.
  - e. Have participated as an investigator in one or more clinical trials leading to the approval of a narcotic medication in Schedule III, IV, or V for maintenance or detoxification treatment.
  - f. Have other training or experience that the state medical licensing board or Health and Human Services considers a demonstration of the physician's ability to treat and manage patients with opioid dependency.
3. Submit notification of intent to SAMHSA.  
<http://buprenorphine.samhsa.gov/pls/bwns/waiver>

The DEA will send a letter within 45-60 days with approval status. If approved, an identification number will be provided to treat up to 30-patients for the first year.

After the first year of prescribing, a physician can submit a second letter of intent to treat up to 100 patients.

[http://buprenorphine.samhsa.gov/pls/bwns/additional\\_notification\\_form?prefilled\\_or\\_online=ONLINE](http://buprenorphine.samhsa.gov/pls/bwns/additional_notification_form?prefilled_or_online=ONLINE)

For more information: <http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/qualify-for-physician-waiver>

### BUPRENORPHINE WAIVER TRAININGS

*(must be obtained from an approved organization)*

#### American Academy of Addiction Psychiatry (AAAP)

<http://www.aaap.org/education-training/buprenorphine/>

- Half-and-Half Training - FREE  
3.75-hour online training  
4.25-hour in-person training
- Live training via computer on the 2nd Saturday (east coast morning) and 4th Wednesday (west coast evening) – FREE

#### American Society of Addiction Medicine (ASAM)

<http://www.asam.org/education/live-and-online-cme/buprenorphine-course>

- Half-and-Half Training - cost varies  
4-hour online training  
4-hour in-person training
- Blended course (online training and live webinar) - \$75

#### American Osteopathic Academy of Addiction Medicine (AOAAM)

<http://www.aoaam.org/?page=PCSSMAT&hhSearchTerms=%22PCSS-MAT%22>

- Online training only – FREE

#### American Psychiatric Association (APA)

<http://www.apaeducation.org/ihtml/application/student/interface.apa/index.htm>

- Online training only

Resident/Fellow – FREE

Medical Student - \$100

Member - \$100

Non-Member - \$200

## 2. Care Coordinator

Aside from the need for a prescriber to be involved in MAT programs in any setting, care coordination is the most critical component for effective addiction treatment and patient care. How care coordination is provided often varies from program to program, but there are components of effective care coordination that are consistent across different styles, approaches, and practice settings.

Care coordination often involves a range of tasks and responsibilities specific to medication assistance, including coordinating induction, administering urine/lab screens and monitoring results, collaborating with external providers in compliance with Title 42, Part 2 of the Code of Federal Regulations (42 C.F.R., Part 2), and assisting patients with accessing social services (housing, medical care, legal services, childcare, employment support, etc.). Depending on the structure and capacities of the MAT setting, a case manager, medical assistant, physician's assistant, nurse, or another staff member may assume the role of care coordinator for a MAT program.

**The most central component of successful MAT models is care coordination for patients.**

### Example: Using Nurses to Coordinate Patient Care

In 2003, Boston Medical Center (BMC) created the Collaborative Care Model of Office-Based Opioid Treatment also known as the Massachusetts Model in an effort to expand access to buprenorphine treatment. The model utilizes Nurse Care Managers (NCMs) to provide clinical support to waived physicians. Specifically, the NCM is the initial contact for patients and serves as the main liaison between the patient and physician throughout treatment. The NCM is responsible for conducting the initial patient assessment to better understand the patients' medical, social, and psychiatric history, supports the patient through the induction process, provides support and education through weekly appointments and telephone check-ins, conducts urine toxicology screens and verifies behavioral health counseling. Since the program's inception, BMC has grown to serve over 500 patients with twenty-four waived primary care physicians.

In 2007, this model was implemented in community health centers through support provided by the Massachusetts Bureau of Substance Abuse Services (BSAS). By 2013, fourteen CHCs were enrolled in the State OBOT-B Program and the number of waived physicians increased from 24 to 114. Since the grant was disseminated across the Commonwealth over 8,000 patients have been served. Each NCM has a caseload of 125 patients (8-12 patients per day) and receives assistance from a medical assistant. Seven out of the fourteen CHCs have expanded the size of their program and have hired an additional NCM to support the program. Additionally, as of 2013, 67% of the patients stayed in treatment for more than twelve months and 50% for more than five years.<sup>24</sup>

*Information obtained from Colleen LaBelle, B.S.N., RN – B.C., C.A.R.N., Boston Medical Center on September 18, 2015.*

24 LaBelle, C. et. al. Office-Based Opioid Treatment with Buprenorphine (OBOT-B): Statewide Implementation of the Massachusetts Collaborative Care Model in Community Health Centers. *Journal of Substance Abuse Treatment*. (2015).

Most essential for care coordinators is not a specific set of credentials as much as an understanding of the nature of addiction, and of the behaviors associated with people experiencing addiction, in combination with a caring and problem solving approach to challenges.

It is important to note that many existing MAT programs may tend to divide responsibilities across available staff; however, treatment retention and compliance can be vastly improved through identifying one position to coordinate care for all MAT patients. Also, for MAT settings in which all services are not co-located, care coordination becomes even more critical.

### 3. Behavioral Health/Addiction Clinician

Effective MAT combines medication assistance with behavioral health and/or addiction-specific counseling and recovery support services such as recovery coaching and community support groups. Studies have found that programs providing regular, structured, substance use disorder-focused counseling had better outcomes than programs providing little or no counseling.<sup>25</sup> Having an on-site Licensed Alcohol and Drug Counselor (LADC), Master Level Alcohol and Drug Counselor (MLADC) or a behavioral health specialist with addiction training will help to encourage behavior change but will also ensure that patients are attending sessions and, therefore, receiving the support they will need to recover. If the MAT program does not have an addiction specialist on-site to deliver treatment services it will be crucial that a formal agreement be established with several treatment providers offering different levels of care in an effort to support a patients' recovery. Additionally, it will be important for the care coordinator to consistently monitor treatment attendance based on program expectations and routinely provide and obtain updates from the external clinician. Please refer to Section C: Psychosocial Treatment Services and Recovery Supports (pg 25-27) which describes the levels of care and suggested programming.

### 4. Administrative Staff

Non-clinical and administrative staff can be considered the glue of the program. These staff members are often responsible for obtaining intake information from patients, handling the billing and other accounting procedures, and most importantly they are the first person the patient comes in contact with. Thus, it is important that these personnel receive the same education and training as clinical staff to include addiction pharmacotherapy with a specific emphasis on stigma of drug addiction. If the patient has a negative experience right upon entering the program, this could influence their treatment. Staff should also receive on-going record keeping and confidentiality training.

#### INCENTIVES & SUPPORTS FOR RECRUITING AND RETAINING STAFF:

- Establish shared collegial patient care
- Pay training and registration fees
- Provide on-going supervision
- Encourage refresher and on-going training
- Ensure for practical caseloads
- Increase wages

<sup>25</sup> Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

## B. TRAINING & RESOURCES: Provide Initial and On-Going Training & Resources

*How . . . interactions [between OTP staff and patients] are conducted, and particularly the attitude of staff members, is probably the next most important determinant of treatment effectiveness after an adequate dose of methadone.*

*(Bell 1998, p. 168)*

Patient outcomes are largely influenced by staff. It is important to ensure that the attitudes, values, and competence around MAT and interactions with patients among all staff are effective for delivering MAT services. All staff should have on-going access to training and supervision, resources and research. The following provides general resources and literature and training by discipline.

### GENERAL RESOURCES

#### MEDICATION ASSISTED TREATMENT

**The ASAM National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use**

<http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/national-practice-guideline.pdf?sfvrsn=22>

**Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Options**

The New England Comparative Effectiveness Public Advisory Council, Final Report, 2014.  
<http://cepac.icer-review.org/adaptations/opioid-dependence/>

**CMS, SAMHSA, CDC, NIH Informational Bulletin**

<http://www.medicare.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>

**SAMHSA TIP 43: Medication Assisted Treatment For Opioid Addiction in Opioid Treatment Programs**

<http://store.samhsa.gov/shin/content//SMA12-4214/SMA12-4214.pdf>

**Principles of Drug Addiction Treatment: A Research Based Guide (Third Edition), NIH**

<http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/preface>

**National Alliance for Medication Assisted Recovery**

<http://methadone.org/>

**Screening & Assessment Tools**

<http://www.ncbi.nlm.nih.gov/books/NBK64244/>

## RESOURCES BY MEDICATION

<b>BUPRENORPHINE</b>	<p><b>SAMHSA TIP 40 - Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction</b>  <a href="http://www.ncbi.nlm.nih.gov/books/NBK64245/pdf/Bookshelf_NBK64245.pdf">http://www.ncbi.nlm.nih.gov/books/NBK64245/pdf/Bookshelf_NBK64245.pdf</a></p> <p><b>National Alliance of Advocates for Buprenorphine</b>  <a href="http://www.naabt.org">http://www.naabt.org</a></p> <p><b>Clinical Opiate Withdrawal Scale (COWS) Flowsheet</b>  <a href="http://www.naabt.org/documents/cows_induction_flow_sheet.pdf">http://www.naabt.org/documents/cows_induction_flow_sheet.pdf</a></p> <p><b>Objective Opiate Withdrawal Scale (OOWS)</b>  <a href="http://www.ncbi.nlm.nih.gov/books/NBK143183/">http://www.ncbi.nlm.nih.gov/books/NBK143183/</a></p> <p><b>Subjective Opioid Withdrawal Scale (SOWS)</b>  <a href="http://www.buppractice.com/node/5775">http://www.buppractice.com/node/5775</a></p>
<b>NALTREXONE</b>	<p><b>An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People with Opioid Dependence</b>            SAMHSA Advisory, Winter 2012. Volume 11. Issue 1  <a href="http://store.samhsa.gov/shin/content//SMA12-4682/SMA12-4682.pdf">http://store.samhsa.gov/shin/content//SMA12-4682/SMA12-4682.pdf</a></p> <p><b>Clinical Use of Extended Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide</b>  <a href="http://store.samhsa.gov/shin/content//SMA14-4892R/SMA14-4892R.pdf">http://store.samhsa.gov/shin/content//SMA14-4892R/SMA14-4892R.pdf</a></p>
<b>METHADONE</b>	<p><b>Methadone Overview</b>  <a href="http://www.samhsa.gov/medication-assisted-treatment/treatment/methadone">http://www.samhsa.gov/medication-assisted-treatment/treatment/methadone</a></p>

## RESOURCES BY DISCIPLINE

<b>PHYSICIAN</b>	<p><b>Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT)</b> Mentoring from a physician, webinars &amp; learning modules, tools &amp; resources <a href="http://pcssmat.org/">http://pcssmat.org/</a></p> <p><b>One-hour refresher training for buprenorphine waived physicians</b> <a href="http://pcssmat.org/new-updated-buprenorphine-waiver-training-advanced-review-module/">http://pcssmat.org/new-updated-buprenorphine-waiver-training-advanced-review-module/</a></p>
<b>NURSE PRACTITIONER/ NURSE</b>	<p><b>TAP 30 – Buprenorphine: A Guide for Nurses</b> <a href="http://store.samhsa.gov/product/TAP-30-Buprenorphine-A-Guide-for-Nurses/SMA09-4376">http://store.samhsa.gov/product/TAP-30-Buprenorphine-A-Guide-for-Nurses/SMA09-4376</a></p>
<b>BEHAVIORAL HEALTH/ ADDICTION CLINICIAN</b>	<p><b>Six-hour training for multidisciplinary addiction professionals</b> <a href="http://www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/buptx/">http://www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/buptx/</a></p>
<b>NON-CLINICAL &amp; ADMINISTRATIVE PERSONNEL</b>	<p><b>Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs In-service Training</b> Covers basic principles, best practices, history, and regulation. Includes scripted modules and handouts <a href="http://store.samhsa.gov/product/Medication-Assisted-Treatment-for-Opioid-Addiction-in-OpioidTreatment-Programs/SMA09-4341">http://store.samhsa.gov/product/Medication-Assisted-Treatment-for-Opioid-Addiction-in-OpioidTreatment-Programs/SMA09-4341</a></p>

## WEBSITES

**Anyone.Anytime.NH Campaign - [anyoneanytime.org](http://anyoneanytime.org)**

Public education and awareness campaign designed to help anyone affected by opioid addiction, including people experiencing addiction, families, healthcare, safety and other systems.

**NH Alcohol and Drug Treatment Locator - [nhtreatment.org](http://nhtreatment.org)**

An on-line directory for locating alcohol and drug treatment service providers in New Hampshire who offer evaluation services, withdrawal management, outpatient counseling, residential treatment, recovery supports and other services by location, service type, population/specialties served, and/or payer.

**The Hungry Heart - [Thehungryheartmovie.org](http://Thehungryheartmovie.org)**

Documentary of a pediatrician who prescribes Suboxone to his patients from varied SES backgrounds struggling with prescription drug addiction and the challenges in treating this disease.

## C. PSYCHOSOCIAL TREATMENT SERVICES & RECOVERY SUPPORTS: Identify What and How Substance Use Disorder Services Will Be Delivered

There are three important parts to MAT: medication, counseling and care coordination. Studies have found that programs providing regular, structured, SUD-focused counseling had better outcomes than programs providing little or no counseling.<sup>26</sup> Additionally, when a patient is started on MAT, many third-party payers and the DEA require that the prescriber is capable of referring the patient to supportive psychosocial therapy or the patient has already started to receive behavioral therapy services along with their medication. These services can either be delivered on-site or off-site.

The following chart highlights what is needed depending on how psychosocial supports are delivered.

DELIVERY OF PSYCHOSOCIAL SERVICES	
ON-SITE	OFF-SITE
<ul style="list-style-type: none"> <li>• Already have or hire a behavioral health/addiction clinician</li> <li>• Identify the type of treatment that will be provided (e.g., individual, group, intensive outpatient counseling)</li> <li>• Identify the psychosocial approaches that will be used (e.g., CBT, MET)</li> <li>• Determine the frequency of services</li> <li>• Review psychosocial treatment expectations and responsibilities with patient</li> </ul>	<ul style="list-style-type: none"> <li>• Establish a strong working relationship with several treatment providers offering different levels of treatment</li> <li>• Review psychosocial treatment expectations and responsibilities with patient</li> <li>• Obtain signed consent form from patient to approve open communication</li> <li>• Routinely provide and obtain updates from the external clinician (see Section A: Staffing; pg 20) to consistently monitor treatment attendance and progress</li> </ul>

The most common counseling models used include individual, group, and family counseling.

- **Individual Outpatient Counseling** – Service provided by a clinician to assist an individual in achieving treatment objectives through the exploration of SUDs and their effects, including an examination of attitudes and feelings, and considering alternative solutions and decision-making with regard to alcohol and other drug-related problems.
- **Group Outpatient Counseling** – Service provided by a clinician to assist two or more individuals and/or their families/significant others in achieving treatment objectives through the exploration of SUDs and their effects, including an examination of attitudes and feelings, and considering alternative solutions and decision-making with regard to alcohol and other drug-related problems.
- **Family Counseling** – Provides education, allows family members to express their feelings and concerns, and helps secure the family's support for the person in recovery.

26 Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

Group medical visits have been used in some MAT practices as another therapeutic option. These involve the prescriber and behavioral health/addiction clinician co-facilitating a group with a ten-minute individual medical appointment preceding or following the group. Advantages of group counseling over individual counseling include the opportunity for patients to interact and problem solve with their peers<sup>27</sup> and more efficient provision of counseling services.

### Example: Utilizing Group Medical Visits to Provide Substance Use Disorder Treatment

An independent OBOT program uses a group medical visit approach for delivering psychosocial and medical treatment. Each week patients are required to participate in a group visit which is facilitated by an addiction clinician. A prescriber is, at times, present during the group to answer and discuss any medical-related questions. Each group consists of no more than fifteen people to ensure adequate opportunity for everyone to share. Before or after the group, the prescriber meets with each patient for a ten-minute check-in to review treatment plan goals, discussing medication adherence, side effects, treatment progress and concerns. This treatment model provides patients with the opportunity to problem solve and gain support from their peers while also being able to discuss medical concerns directly with the prescriber. Additionally, patients are required to attend group in order to receive a prescription to obtain their medication.

*Information obtained from Heather Prebish, Recover Together Program Coordinator, on September 18, 2015.*

It is important to note that MAT can be provided during any level of care. The following describes additional treatment options available in NH.

- **Intensive Outpatient Program (IOP)** – Structured individual and group alcohol and/or drug treatment services and activities that are provided at least three hours a day and at least three days a week according to an individualized treatment plan.
- **Partial Hospitalization** – Combination of 20 or more hours per week of group and individual sessions in conjunction with, either directly or through referral, medical and psychiatric services, psychopharmacological services, addiction medication management, recovery support services and 24-hour crisis services.
- **Residential Services** – Program providing 24-hour support and services where an individual lives full time at the program and receives individual and/or group counseling, educational sessions and introduction to self-help groups.
- **Recovery Support Services** – Services provided to individuals and/or their families to help stabilize and support recovery. Services may include employment services, anger management, recovery mentoring/relapse prevention management, peer recovery coaching, care coordination, childcare, transportation, sober housing, and other supports.

<sup>27</sup> Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

In addition to identifying the type of treatment that will be provided, the program will need to determine which psychosocial treatment approaches will be used to initiate behavior change. Some approaches utilize positive reinforcement while others capitalize on readiness to change. The table to the right lists some of the more commonly used psychosocial treatment approaches.

Regardless of the type of treatment or approaches used, several topics should be covered including:<sup>28</sup>

- Education about addiction and the effects of substances of abuse;
- Education about relapse prevention strategies to learn skills to attain and maintain abstinence;
- Education on opioid-related health issues (e.g., HIV, Hepatitis);
- Providing linkages to existing family support systems; and
- Providing referrals to community supports.

### Examples of Psychosocial Treatment Approaches:

- Cognitive behavioral therapy
- Motivational enhancement therapy
- Contingency management/ motivational incentives
- Community reinforcement approach
- Behavioral couples counseling



To locate service providers, visit the NH Alcohol and Drug Treatment Locator, [www.nhtreatment.org](http://www.nhtreatment.org) an on-line directory for locating alcohol and drug treatment service providers in New Hampshire who offer evaluation services, withdrawal management, outpatient counseling, residential treatment, recovery supports and other services by location, service type, population/specialties served, and/or payer.

### Example: Supporting Patient Needs by Offering Multiple Pharmacotherapy and Psychosocial Treatment Options

One OTP offers a full array of SUD services to include most products and formulations of methadone, buprenorphine, and naltrexone and a variety of psychosocial treatments including residential treatment. These services are made available to patients depending on multiple factors including physiological aspects, socioeconomic factors, setting (e.g., more structure, frequency of visits), and medication adherence. Patients are mandated to one group session per month, brief psychosocial counseling with a physician monthly, and are encouraged to participate in recovery support groups.

*Information obtained from Stephen Straubing MD, DABAM, Meridian Behavioral Healthcare, Gainesville, FL. on October 8, 2015.*

28 Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

## D. BILLING: Determine How Services Will Be Paid

Services can be covered through a variety of payer/payment mechanisms to include cash and third-party payers. While cash can be collected to cover the services that are delivered, it is recommended that office-based opioid treatment programs credential with third-party payers in an effort to better support patients and their ability to access available services.

1. **If services will be reimbursed via a non-insurance payment model:** Establish a payment structure to identify how much will be collected, how often and what services this payment will cover. Additionally, determine how late fees will be handled and how the practice will assist individuals who may not be able to pay for services in full.

### Example: MAT-Specific Treatment Program Using a Non-Insurance Payment Model

On-site counseling, consultation with a prescriber, urine drug screens and pill counts are provided at one OBOT program. This program does not accept insurance for its clinical services. Patients pay for services on a weekly basis via money order, credit or debit card. This fee covers weekly group counseling, consultation with a prescriber, and weekly prescriptions. The program will help the patient cover the cost of medication through insurance. A patient can carry over one week's worth of payment if needed.

*Information obtained from Heather Prebish, Recover Together Program Coordinator, on September 18, 2015.*

2. **If services will be reimbursed through third-party payers:** Enroll and credential with managed care organizations (MCOs), qualified health plans (QHPs), and other insurers. It is important to understand the various parts of the NH Health Insurance Marketplace to include the NH Health Protection Program (NHHPP) and the Premium Assistance Program (PAP). For more information please visit: <http://www.dhhs.state.nh.us/ombp/pap/>, [http://www.nh.gov/insurance/consumers/mp\\_plans.htm](http://www.nh.gov/insurance/consumers/mp_plans.htm), and <http://www.dhhs.nh.gov/ombp/nhhpp/>. Please take into consideration that enrolling with an MCO, QHP or other insurer takes time.

The following chart highlights the various insurers that are available in NH and the substance use disorder services that are covered by each payer.

<b>COVERED SUBSTANCE USE DISORDER SERVICES BY PAYER</b>		
<b>Insurance Type</b>	<b>Payer</b>	<b>SUD Service Coverage</b>
<b>Managed Care Organizations</b>	<ul style="list-style-type: none"> <li>• Cenpatico/NH Healthy Families</li> <li>• Well Sense/Beacon Health Strategies</li> </ul>	Screening; assessment; withdrawal management (detoxification) within acute care settings; treatment with methadone in Opioid Treatment Programs; individual, group and family counseling; crisis intervention; screening, brief intervention and referral to treatment (SBIRT); treatment with buprenorphine in Opioid Treatment Programs; office-based, medication-assisted treatment with a primary care provider; intensive outpatient services; partial hospitalization services; residential rehabilitative services; medically-monitored withdrawal management-residential and ambulatory; individual and group peer and non-peer recovery supports; and continuous recovery monitoring.
<b>Qualified Health Plans &amp; Other Insurers</b>	<ul style="list-style-type: none"> <li>• Ambetter (Cenpatico/NH Healthy Families)</li> <li>• Maine Community Health Options</li> <li>• Harvard Pilgrim</li> <li>• Anthem</li> <li>• Minuteman Health Plan</li> <li>• Tricare</li> <li>• Other Insurers</li> </ul>	Service array varies depending on payer and plan

The MCOs and other third-party carriers use specific strategies to help manage the prescribing of addiction medicines. It is important to be aware of the requirements of each carrier, and the time it takes to meet them, prior to prescribing medication, to ensure that the patient does not become responsible for unpaid claims. For example, some insurers require a prior authorization which must include a written statement that the patient is receiving addiction counseling from a qualified counselor. Approval of prior authorization may take up to 48 hours.

INSURANCE STRATEGIES FOR MANAGING MEDICATION ASSISTED TREATMENT <sup>29</sup>		
Preferred Drug List (PDL)	Prior Authorization	Medical Necessity: Quantity and Duration Limits
Identify if a medication is on the PDL.	If a prescribed medication is not on the PDL, the provider will need to obtain a prior authorization before the medication will be paid for.	A provider should be aware of utilization guidelines for each medication prescribed in that restrictions may be placed on the amount prescribed and the frequency of the prescription.

The following chart highlights the strategies that should be identified for each MCO and third-party payer.

INSURANCE STRATEGIES					
Medication	Is the medication covered?	Is the med on the PDL?	Frequency of prior authorizations?	Quantity limits?	Duration limits?
<b>Buprenorphine</b>					
<b>Suboxone</b>					
Suboxone MIS 12/3mg	Yes/No	Yes/No	Per month/year	# of films	# of days
Suboxone MIS 2/0.5mg	Yes/No	Yes/No	Per month/year	# of films	# of days
Suboxone MIS 4/1mg	Yes/No	Yes/No	Per month/year	# of films	# of days
Suboxone MIS 8/2mg	Yes/No	Yes/No	Per month/year	# of films	# of days
Suboxone MIS 2/0.5mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
Suboxone MIS 8/2mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
<b>Subutex</b>					
Subutex SUB 8mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
<b>Zubsolv</b>					
Zubsolv SUB 1.4/0.36mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
Zubsolv SUB 2.9/0.71mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
Zubsolv SUB 5.7/1.4mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
Zubsolv SUB 8.6/2.1 mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
Zubsolv SUB 6.3/1mg	Yes/No	Yes/No	Per month/year	# of tabs	# of days
<b>Bunavail</b>					
Bunavail MIS 2.1/0.3mg	Yes/No	Yes/No	Per month/year	# of films	# of days
Bunavail MIS 4.2/0.7mg	Yes/No	Yes/No	Per month/year	# of films	# of days
Bunavail MIS 6.3/1mg	Yes/No	Yes/No	Per month/year	# of films	# of days
<b>Naltrexone</b>					
<b>Vivitrol</b>					
Vivitrol IM 380mg	Yes/No	Yes/No	Per month/year	# of injections	# of days

29 Retrieved from CMS, SAMHSA, CDC, NIH Informational Bulletin - <http://www.medicare.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>.

It is essential that all prescribers utilize NH's prescription drug monitoring program (PDMP) to monitor and analyze prescribing and dispensing data prior to prescribing medication in an effort to ensure appropriate prescribing. The PDMP grants practitioners access to system accounts to look up and view controlled substance dispensing information on specific recipients. Individuals with a NH license and a DEA registration (from any state) are required to register with the PDMP. Prescribers are encouraged to register with the PDMP in contiguous states, if possible.

Drug utilization reviews (DURs) may be initiated by a MCO or third-party carrier in which claims documentation is reviewed against a clinical database to identify patient prescribing discrepancies (e.g., duplication of prescriptions, incompatibility with other prescriptions).

### To register in the NH Prescription Drug Monitoring Program (NH PDMP):

1. Open an Internet browser window and navigate to the following URL: [www.newhampshirepdmp.com](http://www.newhampshirepdmp.com)
  - Click the Practitioner/Pharmacist link located on the left menu
  - Click Registration Site (a login window is displayed)
  - Type "newacct" in the user name field
  - Type "welcome" in the password field
  - Click OK
  - Complete the fields on this form:
    - Account Type: Select "Master"
    - License line: Put the following if you are a:
      - Physician Assistant, please put PA(license#) example: PA1234
      - Optometrist, please put OD(license #) example: OD1234
      - Podiatrist, please put P(license#) example: P1234
      - Dentist – please just put D(license#) example: D1234
      - Veterinarian – please just put V(license #) example: V1234
      - MD, DO, APRN – please just put (license #) example:1234
      - Pharmacist please put (license#) – If you have an "R" before your license be sure to include this. example:1234 or R1234
  - Click submit

If information is incomplete or missing, a message is displayed indicating which fields must be corrected before your account request form can be submitted. Required fields are indicated with an asterisk (\*).

If all information has been properly supplied, a completed account request form is displayed along with a registration number and a prompt to print the form.

2. Email registration number to Michelle Ricco-Jonas at [Michelle.RiccoJonas@nh.gov](mailto:Michelle.RiccoJonas@nh.gov) to activate account.
3. If you are approved for an account, you will be notified via two separate e-mails. The first e-mail will contain your approval notification and user name information. The second e-mail will contain your temporary password, your personal identification number (PIN) that you will use to identify yourself if you need assistance from the Help Desk, and the steps to follow to log in to the system. You will be required to change the temporary password immediately when you first attempt to access the system.
4. While waiting for confirmation, submit your registration form to your respective regulatory board as "proof" of your registration when sending in your license application.

For any other questions, please call the NH Help Desk at 855-353-9903.

## E. URINE DRUG TESTING: Establish a Policy

Urine drug testing (UDT) is used in SUD treatment to confirm adherence to a prescribed medication as well as detect illicit or licit drugs that may interfere with a treatment and recovery program. It is an objective measure of treatment and a tool for monitoring patient progress. It is recommended that standard testing be integrated into the initial evaluation process and conducted throughout treatment.

Two types of tests are available:

**Qualitative drug testing** determines the presence or absence of a drug or drug metabolite. The test result is expressed in non-numerical terms.

**Quantitative drug testing** determines the specific quantity of a drug or drug metabolite. The test result is expressed in numerical terms.

The panel recommends, at a minimum, qualitative UDT during each visit, as well as random drug testing. More or less frequent drug testing may be needed, with more testing early in treatment or during periods of relapse, depending on several factors:

- stability of the patient;
- type of treatment;
- treatment setting; and
- half-life of medication taken.<sup>30</sup>

Drug screens may be conducted in-house or via a lab. A number of drug testing companies and hospitals are available to conduct these tests. Several factors should be taken into consideration when selecting a vendor:

- panels offered;
- cost (prices can vary and depend on the substances that the company tests for); and
- turn-around time of results.

Additionally, it is recommended that when utilizing UDT in clinical/confirmation settings (and not just screening situations) to have a resource to which to refer questions. This may be a toxicologist or another colleague with training in drug testing interpretation. Some reference labs offer free telephone consultation with their pathologist.

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<sup>30</sup> The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015

The following table summarizes the main steps recommended to implement a UDT policy.

URINE DRUG TESTING (UDT) POLICY		
UDT Guidelines	Reimbursement Strategy	Response to Results
Determine how tests will be conducted and frequency	Determine how each test will be paid for (cash vs. insurance)	Establish policy on drug screens: presence of unexpected substance and absence of prescribed medication.

While UDT is a management tool necessary in the care of patients with addictive disorders, insurers vary in benefits where insurer payment denials have been reported. Before ordering any testing, prescribers should become familiar with the type of test offered (i.e., immunoassay, LC/MS, GC/MS), which drugs are on the testing panel, and the cost. Having this information will help avoid patients being charged substantial fees and/or unpaid claims.

The following UDT information should be identified for each insurer.

- Panel
- Test Performed
- Need and Frequency of Prior Authorizations
- Quantity Limits
- Duration Limits
- Cost

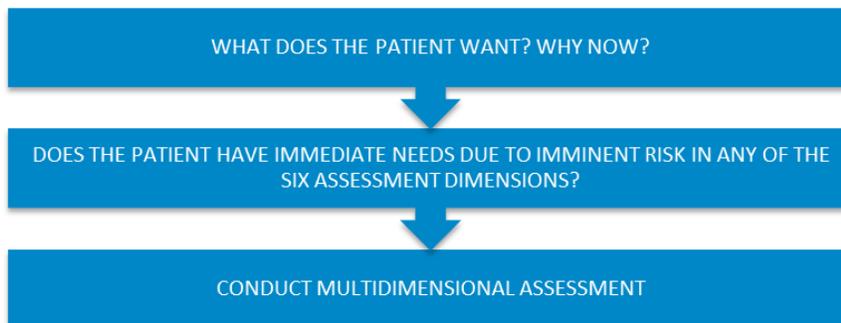
## F. EVALUATION: Establish a Process for Assessing the Patient

Prior to prescribing medication a thorough evaluation should be conducted with the patient to identify if he/she is an appropriate candidate for MAT and, if so, the type of medication that would be most suitable.

A clinical and medical assessment should be conducted with both specifically focusing on the six dimensions of an individual as described by the ASAM. Understanding the patient's medical history, past and current use of alcohol and/or drugs, family background, environment and other factors, will help identify which medication and psychosocial treatment would be most appropriate.

It is recommended that the alcohol and drug counselor and prescriber be involved with the evaluation process. On average, a thorough evaluation can take up to three hours to complete. The following indicates the steps for conducting a thorough evaluation.<sup>31</sup>

1. **Conduct Patient Assessment:** Evaluate the patient's physical, mental and emotional health, past and current substance use, medical history -- identification of medications, allergies, pregnancy, family medical history, history of infectious diseases such as hepatitis, HIV, and TB -- and social and environmental factors, to identify barriers to addiction treatment and other circumstances. Evidence-based tools such as the Addiction Severity Index (ASI)<sup>32</sup>, a semi-structured assessment tool available on the public domain, can be used to evaluate an individual. Additionally, it is critical to engage the patient in the treatment process by asking open-ended questions to identify what his/her treatment goals are and why.<sup>33</sup>



### Sample Evaluation Questions:

- How long have you been taking the opioid drug?
- Are you taking other drugs?
- How often do you use these substances?
- Have you been in treatment before? What were the outcomes?
- Do you have any other health problems?
- Are you taking any prescribed medications?
- Have you ever had a reaction to a medication?
- Are you pregnant?
- What are your goals for recovery?
- Do you have family and friends who are supportive of your recovery?

<sup>31</sup> The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, May 27, 2015.

<sup>32</sup> Retrieved from the Treatment Research Institute - <http://www.trresearch.org/tools/download-asi-instruments-manuals/>.

<sup>33</sup> Substance Abuse and Mental Health Services Administration. *Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends*.

Rate the severity of each dimension, based on the information gathered from the evidence-based assessment and additional questions asked, to determine an appropriate level of care for the patient.

The table below lists appropriate observations for each ASAM dimension that would qualify an individual for needing opioid pharmacotherapy as a component of overall treatment.

ASAM Dimensions	Observation
<b>DIMENSION 1:</b> Alcohol Intoxication and/or Withdrawal Potential	Physiologically dependent on opiates and requires opioid maintenance therapy to prevent withdrawal
<b>DIMENSION 2:</b> Biomedical Conditions and Complications	None or manageable with outpatient medical monitoring
<b>DIMENSION 3:</b> Emotional/Behavioral/Cognitive Conditions and Complications	None or manageable in an outpatient structured environment
<b>DIMENSION 4:</b> Readiness to Change	Ready to change the negative effects of opiate use, but not ready for total abstinence
<b>DIMENSION 5:</b> Relapse/Continued Use/Continued Problem Potential	At high risk of relapse/continued use without opioid maintenance therapy and structured treatment to promote treatment progress
<b>DIMENSION 6:</b> Recovery Environment	Has supportive recovery environment and/or skills to cope

2. **Conduct Physical Exam:** An exam should be performed by either the prescribing physician or another healthcare provider prior to prescribing medication. The exam should include identifying physical signs of opioid intoxication or withdrawal (e.g., restlessness, sweating, needle tracks) and signs of a substance use disorder (e.g., abscesses, cellulitis).
3. **Conduct Laboratory Tests/Urine Screens:** The following labs/urine drug screens should be considered at the time of initial evaluation:
  - a. infectious disease (tuberculosis, hepatitis A, B, C, sexually transmitted diseases and HIV);
  - b. pregnancy test;
  - c. blood count;
  - d. urine drug screen; and
  - e. liver function test.

Depending on the results of these tests further follow up may be required.

4. **Determine Diagnosis:** A diagnosis for OUD must be identified before prescribing a medication. The assessment, physical exam, urine drug screen, and other information gathered during the evaluation process should be used to help determine the diagnosis. A patient must be diagnosed with at least a “mild” opioid use disorder, two of eleven criteria indicated in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) met by the patient within the last twelve months. A non-medical clinician can determine this diagnosis; however the prescribing physician should verify this determination.
5. **Other Evaluation Tools:** Several opioid withdrawal scales are available to help a clinician identify and quantify OUDs. These include:
  - a. Objective Opiate Withdrawal Scale (OOWS)<sup>34</sup> – Tool for determining level of withdrawal (see Appendix IV: *Objective Opiate Withdrawal Scale (OOWS)*).
  - b. Subjective Opioid Withdrawal Scale (SOWS)<sup>35</sup> – Self-reporting tool for identifying opioid withdrawal (see Appendix V: *Subjective Opioid Withdrawal Scale (SOWS)*).
  - c. Clinical Opioid Withdrawal Scale (COWS)<sup>36</sup> – Tool for identifying signs and symptoms which integrates subjective and objective items (see Appendix VI: *Clinical Opioid Withdrawal Scale (COWS)*).

### Opioid Use Disorder Severity Classifications:

*Mild:* 2 – 3 symptoms

*Moderate:* 4 – 5 symptoms

*Severe:* 6 – 11 symptoms

34 Retrieved from the National Institutes of Health - <http://www.ncbi.nlm.nih.gov/books/NBK143183/>.

35 Retrieved from buppractice - <http://www.buppractice.com/node/5775>.

36 Retrieved from The National Alliance of Advocates for Buprenorphine Treatment - [http://www.naabt.org/documents/cows\\_induction\\_flow\\_sheet.pdf](http://www.naabt.org/documents/cows_induction_flow_sheet.pdf).

The following table summarizes when and by whom each evaluation component should be initiated.

Evaluation Components	Staff Responsible for Component	Initiation of Evaluation Component
<b>Assessment</b>	<ul style="list-style-type: none"> <li>Behavioral Health/Addiction Clinician</li> <li>Strongly recommended that prescriber conduct an abbreviated assessment</li> </ul>	Completion of the assessment may be completed over a period of a few sessions; however, a shortened version should be conducted at intake to identify information necessary to prescribe the appropriate pharmacotherapy.
<b>Physical Exam</b>	Prescriber or other health care provider	Prior to prescribing pharmacotherapy
<b>Lab Tests</b>	<ul style="list-style-type: none"> <li>Prescriber or other healthcare provider may order</li> <li>May be conducted in-house or an outside lab may be used</li> </ul>	Prior to prescribing pharmacotherapy
<b>Diagnosis</b>	<ul style="list-style-type: none"> <li>Behavioral Health/Addiction Clinician</li> <li>Prescriber must verify diagnosis</li> </ul>	Prior to prescribing pharmacotherapy

### Example: Promoting Individualized Care through Comprehensive Evaluation

A wide array of services to include primary care, addiction medicine and psychiatry are offered at one practice. The addiction program offers individual and group counseling and office-based opioid treatment. Prior to prescribing medication, an evaluation of the patient is conducted which takes approximately three hours. The patient meets with the intake and project coordinator who conducts a 1.5 – two hour assessment, a half hour is spent with the addiction medicine physician who also performs a physical exam, and a one-hour psychiatric consult is provided. This comprehensive evaluation allows the care team to identify the appropriate treatment needed. The model this practice utilizes, in which all services are available, assists with the evaluation process, and also allows for patients to receive specialized and coordinated care.

*Information obtained from Dr. Mark Logan, Green Mountain Family Practice Medicine, Rutland, VT in September 2015.*

## G. TREATMENT PLANNING: Monitor Patient Progress

After the patient has been evaluated, the prescriber and clinician will need to determine appropriate medication and psychosocial treatment. The plan should be the result of shared decision-making with the patient, and the conversation may include supportive family and friends if the patient chooses. Several factors will need to be taken into consideration when determining which medication and addiction treatment will be the best option. These include:

- physiological aspects;
- setting (e.g., more structure, frequency of visits);
- socioeconomic factors (e.g., transportation, child care, employment/education schedule); and
- medication adherence.

If the prescriber and clinician are not considerate of these factors, medication and psychosocial treatment adherence may be adversely affected and the patient's recovery compromised.

Two respective treatment plans, one for monitoring MAT and one for addiction treatment, will need to be developed. One inclusive plan is acceptable for settings that provide both services, medication and psychosocial treatment. Treatment plans should be developed following a M.A.T.R.S.<sup>37</sup> (measurable, attainable, time-limited, realistic, sensitive) approach. Appendix VII: *Treatment Planning M.A.T.R.S. Checklist* highlights specific questions that should be considered for each section of the treatment plan including the goals, objectives, and interventions.

### The M.A.T.R.S. Test

<b>Measurable?</b>	<i>Can change be documented (include dates, types and frequency of services, number of days drug free)?</i>
<b>Attainable?</b>	<i>Achievable within the active treatment phase?</i>
<b>Time-limited?</b>	<i>Is time frame specified (include dates and time frames)? Will staff be able to review within a specific period of time?</i>
<b>Realistic?</b>	<i>Is it reasonable to expect the client will be able to take steps on his/her own behalf (identify actions that can be attained based on client environment, supports, diagnosis, level of functioning)? Is it agreeable to client and staff?</i>
<b>Specific?</b>	<i>Will client understand what is expected and how program/staff will assist in reaching goals?</i>

<sup>37</sup> Retrieved from the Addiction Technology Transfer Center Network (ATTC), Treatment Planning M.A.T.R.S. - <http://atccnetwork.org/projects/txplanning.aspx>.

The following highlights recommended items to include in the medication and psychosocial treatment plans.

### Medication Assisted Treatment Plan

- Goals of treatment
- Treatment objectives over a defined period of time
- Medication and dose level
- Frequency and type of treatment (in-person visits/check-in calls)
- Counseling plan
- Consequences for non-adherence to the plan

### Psychosocial Treatment Plan

- Goals of treatment
- Treatment objectives over a defined period of time
- Frequency and type of treatment (individual and/or group counseling or higher level of care)
- Linkages to existing family support systems
- Referrals to community-based services (e.g. housing, employment assistance, legal services)
- Referrals to recovery support services (e.g. 12 step faith-based programs, recovery coaching)
- Medication plan
- Consequences for non-adherence to the plan

Appendix VIII: *Sample Treatment Plan Form* provides a template that can be used/modified to document patient progress.

Usually providers have a patient sign a treatment agreement to clarify treatment goals, help patients understand what is expected of them and promote compliance. The agreement should not be presented as potentially punitive. In the event that a patient does not follow the plan and/or relapses, it is recommended that the prescriber and clinician review and revise treatment plans accordingly, rather than summarily discharging a patient. There will be circumstances, of course, when discharge is necessary. A sample treatment agreement<sup>38</sup> for the prescribing of opioid medications is provided in Appendix IX: *Sample Treatment Agreement*. This agreement can be modified for use in a psychosocial treatment setting.

A person can be on opioid medication for an undefined amount of time, short- or long-term. During this time whether for a few months, a year, several years or longer, the prescriber and clinician should work collaboratively, consistently and routinely evaluating the patient to ensure he/she is receiving appropriate medication and the right level of treatment.

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38 Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.

## OTHER CONSIDERATIONS

In addition to the components described, there are others to consider when providing office-based MAT. It is important that practices looking to have a successful model of care consider the recommendations discussed in the following sections.

## A. Confidentiality/42 C.F.R., Part 2

A patient's confidentiality and privacy related to alcohol and drug treatment is protected by SAMHSA confidentiality regulation *Title 42, Part 2 of the Code of Federal Regulations* (42 C.F.R. Part 2). The following is an overview of 42 C.F.R., Part 2. For more information visit [http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr2\\_main\\_02.tpl](http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr2_main_02.tpl). Addiction treatment providers are required to handle patient information with increased confidentiality compared to other providers. To disclose information with another provider (e.g., pharmacist, primary care provider) written informed consent must be obtained from the patient. Consent should be obtained from the patient for anyone with whom the provider may discuss their treatment. It is recommended that consent forms be signed upon admission to avoid any issues during the course of treatment. There are some instances in which there may be exceptions to this policy, including:

1. a patient is in imminent danger of harming himself/herself or others;
2. crimes on agency/program property;
3. child abuse or neglect;
4. abuse, neglect, exploitation, or self neglect of incapacitated adults; and
5. other medical emergency.

### Third-Party Consent Examples (if applicable):

- ✓ Families
- ✓ Friends
- ✓ Employers
- ✓ Allied Healthcare Providers
- ✓ Third-Party Payers
- ✓ Law Enforcement Officers
- ✓ Pharmacists
- ✓ Social Service Agencies

### Consent Form Components

1. Name of patient
2. Name of provider
3. Type and amount of information to be disclosed
4. Name or title of the individual or organization to which disclosure is to be made
5. Purpose of disclosure
6. Date (on which this consent is signed)
7. Signature of patient
8. Signature of parent or guardian (if applicable)
9. Signature of individual authorized to sign in lieu of the patient (if applicable)
10. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate on: (specific date, event, or condition).

Disclosure Language (must be included on consent):

*This information has been disclosed to you from records protected by Federal confidentiality rules (Title 42, Part 2, Code of Federal Regulations [42 C.F.R. Part 2]). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.*

## B. Communications

Essential to a MAT program is effective, timely communication among the prescriber, the patient and a variety of providers, both internal and external. The communication must be well documented, confidential, and consistent with SAMHSA confidentiality regulation *Title 42, Part 2 of the Code of Federal Regulations* (42 C.F.R. Part 2). Policies and practices should be established for each level of communication to ensure that care is well coordinated and aligned with patient needs.

The chart below highlights several factors to consider.

Patient Communication	Intra-office Communication	External Communication
<ul style="list-style-type: none"> <li>• Establish and review program guidelines, expectations and responsibilities during first visit</li> <li>• Discuss frequency of face-to-face visits with prescriber</li> <li>• Review how to communicate with prescriber and prescriber's office outside of scheduled visits</li> </ul>	<ul style="list-style-type: none"> <li>• Identify care coordinator and responsibilities (e.g. nurse, addiction clinician, other office staff)</li> <li>• Document care plan in electronic record</li> <li>• Document office visits and UDT results</li> <li>• Establish routine meeting times for practice stakeholders to discuss patient progress, challenges and administrative issues</li> </ul>	<ul style="list-style-type: none"> <li>• Establish protocol for written and oral communication between prescriber and primary care provider (PCP) and counselor/therapist (if not located in practice) and incorporation into electronic medical record</li> <li>• Determine responsibility for monitoring adherence to program, need for increase in intensity of therapy or discharge</li> <li>• Collaborate with other health care providers who are managing concurrent health problems that are complicated by the patient's MAT (e.g., pregnancy, surgical procedures requiring pain control)</li> </ul>

## C. Stigma

Addiction is highly stigmatized on many fronts. Similarly, MAT can be a controversial issue. Some professionals in the field, as well as individuals in recovery, do not support the use of medication and consider methadone, buprenorphine and naltrexone as “replacing one drug for another.” It is important for all staff to recognize that:

1. addiction is a chronic, relapsing disease;
2. on-going support will be needed to help a person stop using alcohol and/or drugs;
3. treatment may require the use of medications, low- or high-intensity addiction treatment and/or recovery support services;
4. the use of medication in conjunction with treatment and recovery supports is most often the best choice for treating opioid addiction; and
5. people are at a higher risk of addiction because of their genes, temperament, or personal situation.<sup>39</sup>

If patients express concerns about stigma, reassure them that they have a disease in the same way that others may have diabetes, hypertension or other chronic conditions. In each of these cases, a treatment plan is developed which may include the use of medications. Commend efforts to seek help and participate in the necessary treatment to reach recovery goals.

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<sup>39</sup> Substance Abuse and Mental Health Services Administration. Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends.

# APPENDICES

**Appendix I:** Map of Buprenorphine Prescriber Locations

**Appendix II:** Map of Vivitrol Prescriber Locations

**Appendix III:** Map of Opioid Treatment Program (OTP)/ Methadone Clinic Locations

**Appendix IV:** Objective Opiate Withdrawal Scale (OOWS)

**Appendix V:** Subjective Opioid Withdrawal Scale (SOWS)

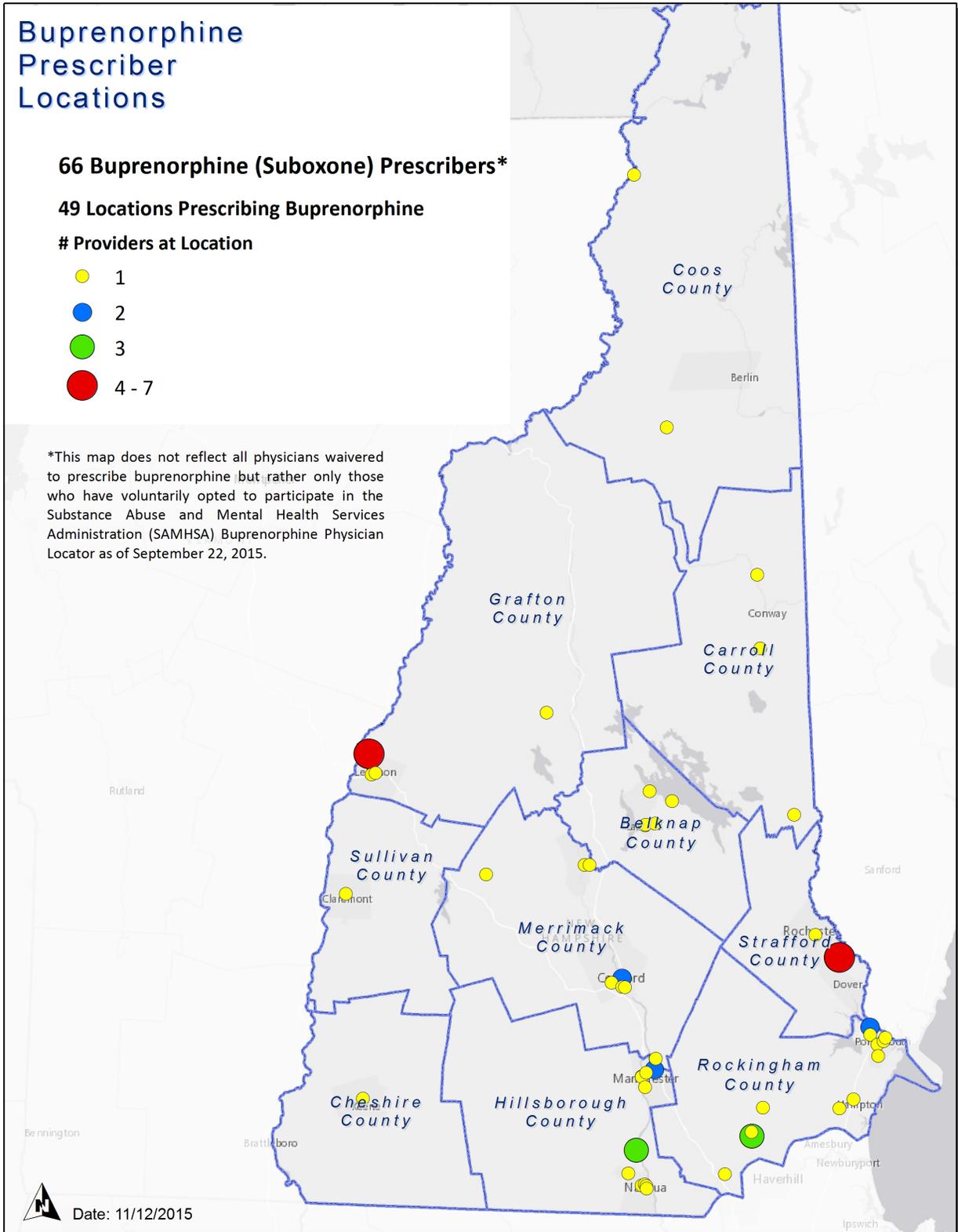
**Appendix VI:** Clinical Opioid Withdrawal Scale (COWS)

**Appendix VII:** Treatment Planning M.A.T.R.S. Checklist

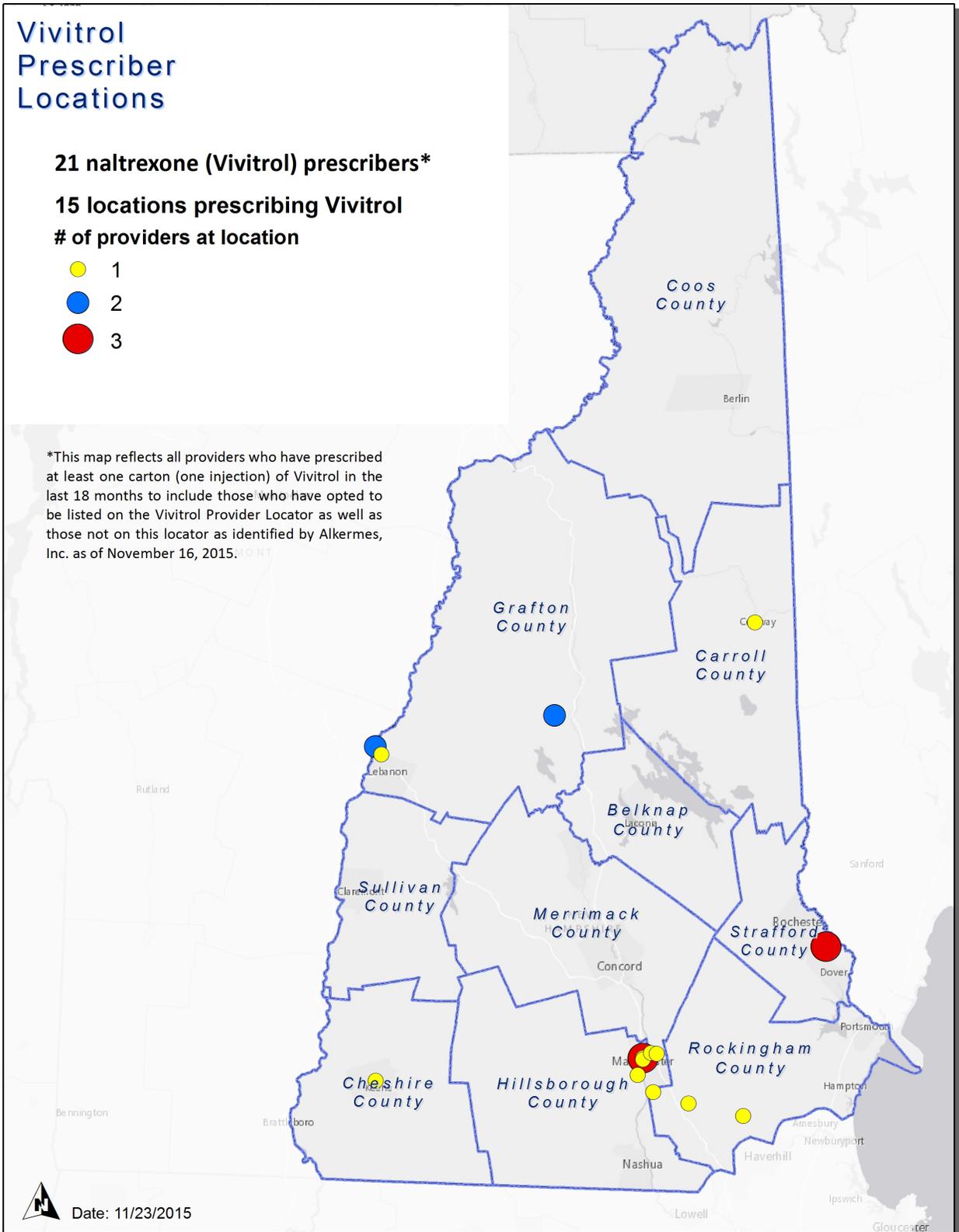
**Appendix VIII:** Sample Treatment Plan Form

**Appendix IX:** Sample Treatment Agreement

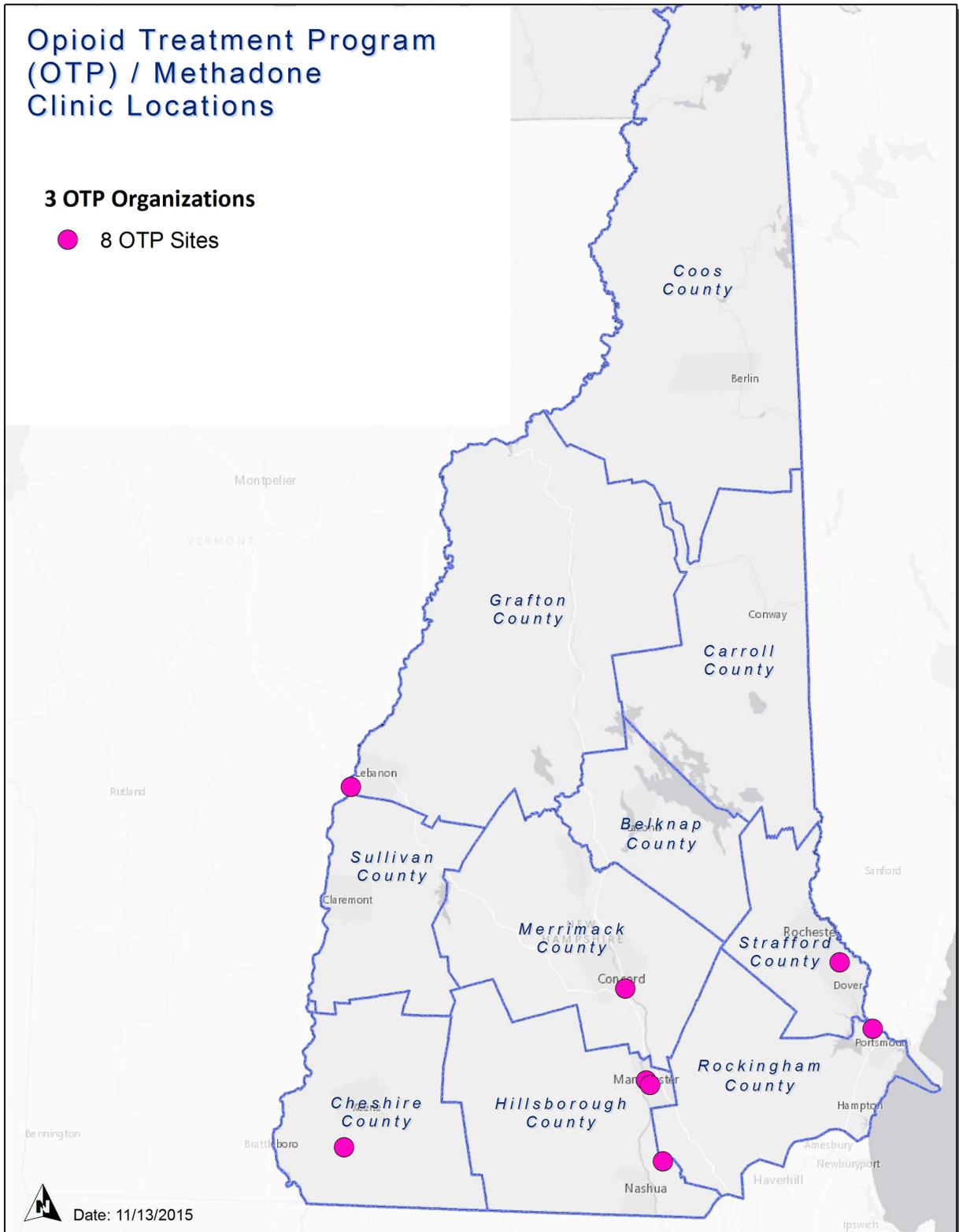
# APPENDIX I: Map of Buprenorphine Prescriber Locations



# APPENDIX II: Map of Vivitrol Prescriber Locations



# APPENDIX III: Map of Opioid Treatment Program (OTP)/ Methadone Clinic Locations



# APPENDIX IV: Objective Opiate Withdrawal Scale (OOWS)

Objective Opiate Withdrawal Scale (OOWS)						
Observe the patient during a <b>5 minute observation period</b> then indicate a score for each of the opioid withdrawal signs listed below (items 1-13). Add the scores for each item to obtain the total score						
<b>Date</b>						
<b>Time</b>						
1	<b>Yawning</b> 0 = no yawns 1 = $\geq 1$ yawn					
2	<b>Rhinorrhoea</b> 0 = $< 3$ sniffs 1 = $\geq 3$ sniffs					
3	<b>Piloerection</b> (observe arm) 0 = absent 1 = present					
4	<b>Perspiration</b> 0 = absent 1 = present					
5	<b>Lacrimation</b> 0 = absent 1 = present					
6	<b>Tremor</b> (hands) 0 = absent 1 = present					
7	<b>Mydriasis</b> 0 = absent 1 = $\geq 3$ mm					
8	<b>Hot and cold flushes</b> 0 = absent 1 = shivering / huddling for warmth					
9	<b>Restlessness</b> 0 = absent 1 = frequent shifts of position					
10	<b>Vomiting</b> 0 = absent 1 = present					
11	<b>Muscle twitches</b> 0 = absent 1 = present					
12	<b>Abdominal cramps</b> 0 = absent 1 = holding stomach					
13	<b>Anxiety</b> 0 = absent 1 = mild - severe					
	<b>TOTAL SCORE</b>					

Source: Handelsman et al 1987<sup>229</sup>

# APPENDIX V: Subjective Opioid Withdrawal Scale (SOWS)

## Subjective Opiate Withdrawal Scale (SOWS)

Instructions: Answer the following statements as accurately as you can. Circle the answer that best fits the way you feel now.

0=not at all

1=a little

2=moderately

3=quite a bit

4=extremely

	Not at all	A little	Moderately	Quite a bit	Extremely	How long after your last dose did THIS symptom begin? (hours)
1 I feel anxious.	0	1	2	3	4	
2 I feel like yawning.	0	1	2	3	4	
3 I'm perspiring.	0	1	2	3	4	
4 My eyes are tearing.	0	1	2	3	4	
5 My nose is running.	0	1	2	3	4	
6 I have goose flesh.	0	1	2	3	4	
7 I am shaking.	0	1	2	3	4	
8 I have hot flashes.	0	1	2	3	4	
9 I have cold flashes.	0	1	2	3	4	
10 My bones and muscles ache.	0	1	2	3	4	
11 I feel restless.	0	1	2	3	4	
12 I feel nauseous.	0	1	2	3	4	
13 I feel like vomiting.	0	1	2	3	4	
14 My muscles twitch.	0	1	2	3	4	
15 I have cramps in my stomach.	0	1	2	3	4	
16 I feel like shooting up now.	0	1	2	3	4	

The Subjective Opiate Withdrawal Scale (SOWS) consist of 16 symptoms rated in intensity by patients on a 5-point scale of intensity as follows: 0=not at all, 1=a little, 2=moderately, 3=quite a bit, 4=extremely. The total score is a sum of item ratings, and ranges from 0 to 64.

**Mild Withdrawal is considered to be a score of 1 - 10.**

**Moderate withdrawal is considered to be a score of 11 - 20**

**Severe withdrawal is considered to be 21 - 30.**

Source : Reprinted from Handelsman et al. 1987, p. 296, by courtesy of Marcel Dekker, Inc.

Other Sources : Gossop 1990; Bradley 1987.

# APPENDIX VI: Clinical Opioid Withdrawal Scale (COWS)

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## Clinical Opiate Withdrawal Scale (COWS)

Flowsheet for measuring symptoms over a period of time during buprenorphine induction.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example: If heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

Patient Name: _____		Date: _____			
Buprenorphine Induction: _____					
Enter scores at time zero, 30 minutes after first dose, 2 hours after first dose, etc.		Times of Observation:			
<b>Resting Pulse Rate: Record Beats per Minute</b>					
Measured after patient is sitting or lying for one minute					
0 = pulse rate 80 or below					
1 = pulse rate 81-100					
2 = pulse rate 101-120					
3 = pulse rate greater than 120					
<b>Sweating: Over Past 1/2 Hour not Accounted for by Room Temperature or Patient Activity</b>					
0 = no report of chills or flushing					
1 = subjective report of chills or flushing					
2 = flushed or observable moistness on face					
3 = beads of sweat on brow or face					
4 = sweat streaming off face					
<b>Restlessness Observation During Assessment</b>					
0 = able to sit still					
1 = reports difficulty sitting still, but is able to do so					
3 = frequent shifting or extraneous movements of legs/arms					
5 = Unable to sit still for more than a few seconds					
<b>Pupil Size</b>					
0 = pupils pinned or normal size for room light					
1 = pupils possibly larger than normal for room light					
2 = pupils moderately dilated					
5 = pupils so dilated that only the rim of the iris is visible					
<b>Bone or Joint Aches if Patient was Having Pain Previously, only the Additional Component Attributed to Opiate Withdrawal is Scored</b>					
0 = not present					
1 = mild diffuse discomfort					
2 = patient reports severe diffuse aching of joints/muscles					
4 = patient is rubbing joints or muscles and is unable to sit still because of discomfort					
<b>Runny Nose or Tearing Not Accounted for by Cold Symptoms or Allergies</b>					
0 = not present					
1 = nasal stuffiness or unusually moist eyes					
2 = nose running or tearing					
4 = nose constantly running or tears streaming down cheeks					
<b>GI Upset: Over Last 1/2 Hour</b>					
0 = no GI symptoms					
1 = stomach cramps					
2 = nausea or loose stool					
3 = vomiting or diarrhea					
5 = multiple episodes of diarrhea or vomiting					
<b>Tremor Observation of Outstretched Hands</b>					
0 = no tremor					
1 = tremor can be felt, but not observed					
2 = slight tremor observable					
4 = gross tremor or muscle twitching					
<b>Yawning Observation During Assessment</b>					
0 = no yawning					
1 = yawning once or twice during assessment					
2 = yawning three or more times during assessment					
4 = yawning several times/minute					
<b>Anxiety or Irritability</b>					
0 = none					
1 = patient reports increasing irritability or anxiousness					
2 = patient obviously irritable/anxious					
4 = patient so irritable or anxious that participation in the assessment is difficult					
<b>Gooseflesh Skin</b>					
0 = skin is smooth					
3 = piloerection of skin can be felt or hairs standing up on arms					
5 = prominent piloerection					
<b>Score:</b> 5-12 = Mild		Total score			
13-24 = Moderate					
25-36 = Moderately Severe		Observer's initials			
More than 36 = Severe Withdrawal					



The National Alliance of Advocates for Buprenorphine Treatment  
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\*Source: Wesson et al. 1999.

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# APPENDIX VI: Clinical Opioid Withdrawal Scale (COWS)



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The National Alliance of Advocates for Buprenorphine Treatment  
*Precipitated Withdrawal. What it is. How to avoid it.*

## What Is Precipitated Withdrawal?

It is a **rapid and intense onset** of withdrawal symptoms initiated by a medication. In the case of Buprenorphine, because it has a higher binding strength at the opioid receptor, it competes for the receptor, “kicks off” and replaces existing opioids. If a significant amount of opioids are expelled from the receptors and replaced, the opioid physically dependent patient will feel the rapid loss of the opioid effect, initiating withdrawal symptoms.

More precisely, precipitated withdrawal can occur when an antagonist (or partial agonist, such as Buprenorphine) is administered to a patient who is physically dependent on full agonist opioids. Due to the high *affinity* but low *intrinsic activity*



Full Agonist Opioid.  
Perfect receptor fit. Maximum intrinsic activity (opiate effect).



Partial Agonist Opioid (Buprenorphine). Imperfect Fit. Less intrinsic activity (opiate effect).

of Buprenorphine at the  $\mu$ -receptor, the partial agonist displaces full agonist opioids from the  $\mu$ -receptors, but activates the receptor to a *lesser* degree than full agonists which results in a net *decrease* in agonist effect, thereby precipitating withdrawal.<sup>1</sup>

A common misconception is that the naloxone in the buprenorphine/naloxone combination medication initiates precipitated withdrawal. Naloxone may only initiate withdrawal if *injected* into a person physically dependent on opioids. Taken sublingually, as directed, naloxone is clinically insignificant and has virtually no effect. (Except in rare cases of an allergic reaction or naloxone hypersensitivity.<sup>2</sup>)

## Avoiding Precipitated Withdrawal

**Patient education** and developing realistic expectations are essential before beginning treatment.

To **avoid** precipitated withdrawal, physically dependent patients must no longer be experiencing the agonist effects of an opioid. One way to gauge this is to observe objective symptoms of withdrawal sufficient to score a minimum of 5 to 6 on the COWS (Clinical Opioid Withdrawal Scale). Scores of >10 are preferable. Due to patient individuality, required abstinence times may vary considerably from patient to patient. Only use the time since last use as an estimate to anticipate the onset of withdrawal symptoms.<sup>4</sup>

The **induction begins** by assessing last use of all opioids, short and long acting, objective and subjective symptoms and a COWS score calculation. If not in sufficient withdrawal (mild to moderate: COWS of 5 to 24), it is in the patient’s best interest to wait. Long-acting opioids will require a longer period of abstinence, than short-acting opioids.

### Short-acting Opioids

(*Heroin, Crushed OxyContin®, Percocet®, Vicodin®, Oxycodone and others*)

Prior to induction, patients must abstain from all short-acting opioids for 12 to 24 hours **and/or** have objective withdrawal symptoms sufficient to produce a score of 5 to 24 on the COWS.<sup>1</sup>

### Long-acting Opioids

*OxyContin® (Taken Orally)*

Discontinue use for at least 24 hours prior to induction. A minimal score of at least 5 on the COWS is recommended, although some physicians prefer scores of 15 or higher.<sup>5</sup>

### Methadone

It is recommended that patients transitioning from methadone to Buprenorphine slowly taper to 30 mg./day of methadone, for at least one week. Last dose must be no less than 36 hours prior to induction, and may be 96 hours or more. A minimal score of at least 5 on the COWS is recommended, although some physicians prefer scores of 15 or higher.<sup>5</sup>

Patients transferring from methadone or another long-acting opioid to Buprenorphine may experience discomfort for several days and dysphoria for up to 2 weeks.<sup>3</sup>

The **goal of induction** is to safely suppress opioid withdrawal as rapidly as possible with adequate doses of Buprenorphine. Failure to do so may cause patients to use opioids or other medications to alleviate opioid withdrawal symptoms or may lead to early treatment dropout.<sup>3</sup> To achieve this, some physicians have found they may need to dose as high as 32 mgs. the first day with some methadone to Buprenorphine transfers.<sup>5</sup>

<sup>1</sup>Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Treatment Improvement Protocol (TIP) Series 40*. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004. [http://naabt.org/links/TIP\\_40\\_PDF.pdf](http://naabt.org/links/TIP_40_PDF.pdf)

<sup>2</sup>FDA. Full Prescribing Information on Subutex® (buprenorphine). Suboxone® (buprenorphine/naloxone). [www.fda.gov/cder/foi/label/2002/20732bl.pdf](http://www.fda.gov/cder/foi/label/2002/20732bl.pdf)

<sup>3</sup>Dosing Guide Maintenance therapy for Opioid Dependence. Suboxone®/Subutex® [www.suboxone.com/pdfs/DosingGuides.pdf](http://www.suboxone.com/pdfs/DosingGuides.pdf)

<sup>4</sup>Practical Considerations for the use of Buprenorphine. Hendrée E. Jones, Ph.D., Johns Hopkins University School of Medicine, Baltimore, MD

<sup>5</sup>Physician Clinical Support System: [www.pcssmentor.org/TransferFromMethadoneToBuprenorphine](http://www.pcssmentor.org/TransferFromMethadoneToBuprenorphine), Paul P. Casadonte, MD, PCSS guidance paper. 8/9/2006 [http://www.pcssmentor.org/pcss/documents2/PCSS\\_MethadoneBuprenorphineTransfer.pdf](http://www.pcssmentor.org/pcss/documents2/PCSS_MethadoneBuprenorphineTransfer.pdf)

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# APPENDIX VII: Treatment Planning M.A.T.R.S. Checklist

## Treatment Planning M.A.T.R.S. Checklist

Problem Statements	Check if addressed
1. Do problem statements reflect the 6 problem domains? (e.g., 1. Medical status; 2. Employment and support; 3. Drug/Alcohol Use; 4. Legal status; 5. Family/social status; 6. Psychiatric Status)	
2. Are problem statements written in behavioral terms?	
3. Are problem statements written in a non-judgmental and jargon free manner?	
4. Are problem statements based on priority needs?	
<b>Goals</b> <i>What does the client want to achieve during treatment?</i>	
5. Do goals address the problem statements?	
6. Are the goals attainable during the active treatment phase?	
7. Would the client be able to understand the goals as written?	
8. Would both the client and the treatment program find these goals acceptable?	
9. Has the client's stage of <i>readiness to change</i> been considered in the goal statements?	
<b>Objectives</b> <i>What will the client say or do? Under what circumstances? How often will he/she say or do this?</i>	
10. Do objectives address the goals?	
11. <b>M</b> measurable—Can change or progress toward meeting the objectives be documented/evaluated?	
12. <b>A</b> attainable—Can the client take steps toward meeting the objectives?	
13. <b>T</b> time-limited—Is the time frame specified for the objectives?	
14. <b>R</b> realistic—Can the client meet the objectives given their current situation?	
15. <b>S</b> specific—Are specific activities included? Could the client understand what is expected?	
16. Has the client's stage of <i>readiness to change</i> been considered in the objectives?	
<b>Interventions</b> <i>What will the counselor/staff do to assist client? Under what circumstances?</i>	
17. Do interventions address the objectives?	
18. <b>M</b> measurable—Will the counselor/treatment program be held accountable for the service(s)?	
19. <b>A</b> attainable—Do interventions reflect the level of care available or are outside referrals used when needed?	
20. <b>T</b> time-limited—Is the time frame specified for the interventions?	
21. <b>R</b> realistic—Do the interventions reflect the level of functioning or functional impairment of the client?	
22. <b>S</b> specific—Are specific staff persons responsible for assisting client/providing service?	
23. Has the client's stage of <i>readiness to change</i> been considered in the interventions?	
<b>General Checklist</b>	
24. Is this treatment plan individualized to fit the client based on their unique abilities, goals, lifestyle, socio-economic status (SES), work history, educational background, and culture?	
25. Are client strengths incorporated in the treatment plan?	
26. Has the client (and significant others) participated in developing this treatment plan?	
27. Is the plan dated and signed by all who participated in developing this treatment plan?	

# APPENDIX VIII: Sample Treatment Plan Form

Client Name:

Counselor Name:

Date	Problem Statement			
Goals				
D/C Criteria	Objectives <i>What will the client say or do? Under what circumstances? How often will he/she say or do this?</i>			
Interventions <i>What will the counselor/staff do to assist client? Under what circumstances?</i>		Service Codes	Target Date	Resolution Date
Participation in Treatment Planning Process				
Participation by Others in the Treatment Planning Process				
Note: All participants may not have participated in every area.				
<b>Client Signature/Date</b>				
<b>Counselor Signature/Date</b>				

I=Individual      G=Group      F=Family      **Service Codes**      P=Psychoeducational      H=Homework  
 R=Reading      M=Media      V=Videotape      C=Couples      A=Audiotape      R=Referral

# APPENDIX IX: Sample Treatment Agreement

## TREATMENT AGREEMENT

As a participant in the [NAME OF PROGRAM] for the treatment of opioid abuse and dependence with [TYPE OF MEDICATION], I freely and voluntarily agree to accept this treatment agreement, as follows:

- I agree to keep, and be on time to, all my scheduled appointments with the doctor.
- I agree to conduct myself in a courteous manner in the physician's office.
- I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the doctor will not see me, and I will not be given any medication until my next scheduled appointment.
- I agree not to sell, share, or give any of my medication to another individual. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.
- I agree not to deal, steal, or conduct any other illegal or disruptive activities in the doctor's office.
- I agree that my medication (or prescriptions) can be given to me only at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.
- I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.
- I agree not to obtain medications from any physicians, pharmacies, or other sources without informing my treating physician. I understand that mixing buprenorphine with other medications, especially benzodiazepines such as valium and other drugs of abuse, can be dangerous. I also understand that a number of deaths have been reported among individuals mixing buprenorphine with benzodiazepines.
- I agree to take my medication as the doctor has instructed and not to alter the way I take my medication without first consulting the doctor.
- I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in the patient education and relapse prevention programs, as provided, to assist me in my treatment.

### Patient:

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Prescriber:

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

