Medication Assisted Treatment Guide

Key components for delivering community-based, medication assisted treatment services for opioid use disorders in Alaska
Medication Assisted Treatment Guide

Key components for delivering community-based, medication assisted treatment services for opioid use disorders in Alaska

Alaska Department of Health & Social Services
Division of Behavioral Health • Division of Health Care Services
Division of Public Health • Office of Substance Misuse and Addiction Prevention

Acknowledgements

Thank you to Dr. Sarah Spencer for collaborating with DHSS in the writing and development of this guide.

Technical assistance provided by the Opioid Response Network and New Hampshire Department of Health and Human Services, Bureau of Drug and Alcohol Services

November 2019
First Edition
# Table of Contents

Acronyms and Abbreviations ........................................................................................................... 3
Section I. Executive Summary ......................................................................................................... 7
Section II. Introduction ................................................................................................................. 10
  Alaska’s 2018 Statewide Opioid Action Plan ............................................................................. 13
Section III. Overview of Opioid Use Disorder Medications .......................................................... 15
  About Opioids ............................................................................................................................ 15
  Sampling of Research Findings .................................................................................................. 17
  Choosing the Most Appropriate Medication ............................................................................ 19
  Opioid Use Disorder Medication Differences ........................................................................... 21
Section IV. Service Delivery and Clinical Considerations .............................................................. 24
  Staffing: Establish a Core Team ................................................................................................ . 28
  Training and Resources: Provide Initial and Ongoing Training and Resources ......................... 33
  Billing ......................................................................................................................................... 37
  Evaluation: Establish a Process for Assessing Patients ............................................................. 38
  Treatment Planning: Monitor Patient Progress ........................................................................ 43
  Induction: How to Start Patients on Buprenorphine ................................................................ 47
  Psychosocial Treatment & Recovery Support Services: Identify How Substance Use Disorder Services will be Delivered .................................................................................. 54
  Drug Testing: Establish Policies and Procedures ....................................................................... 58
Section V. Telemedicine ................................................................................................................ 62
  Sample of Telemedicine Infrastructure at Tribal Health Systems in Alaska ............................. 62
  Medicaid Coverage of Telemedicine Services in Alaska ........................................................... 63
  Medicare Telemedicine Billing Information .............................................................................. 64
  Alaska Telemedicine Business Registry ..................................................................................... 64
  Prescribing Buprenorphine without an Initial In-person Visit .................................................. 64
Section VI. Special Populations ..................................................................................................... 69
  Pregnancy .................................................................................................................................. 69
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR, Part 2</td>
<td>Title 42, Part 2 of the Code of Federal Regulations</td>
</tr>
<tr>
<td>AI/AN</td>
<td>American Indian/Alaska Native</td>
</tr>
<tr>
<td>ANMC</td>
<td>Alaska Native Medical Center</td>
</tr>
<tr>
<td>ANTHC</td>
<td>Alaska Native Tribal Health Consortium</td>
</tr>
<tr>
<td>ASAM</td>
<td>American Society of Addiction Medicine</td>
</tr>
<tr>
<td>ASI</td>
<td>Addiction Severity Index</td>
</tr>
<tr>
<td>ATTC</td>
<td>Addiction Technology Transfer Center</td>
</tr>
<tr>
<td>AUD</td>
<td>Alcohol use disorder</td>
</tr>
<tr>
<td>BUP-NX</td>
<td>Buprenorphine-naloxone</td>
</tr>
<tr>
<td>CARA</td>
<td>Comprehensive Addiction and Recovery Act</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive behavioral therapy</td>
</tr>
<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
</tr>
<tr>
<td>CHC</td>
<td>Community health center</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>COWS</td>
<td>Clinical Opiate Withdrawal Scale</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>DBH</td>
<td>Division of Behavioral Health</td>
</tr>
<tr>
<td>DEA</td>
<td>U.S. Drug Enforcement Administration</td>
</tr>
<tr>
<td>DHCS</td>
<td>Division of Health Care Services</td>
</tr>
<tr>
<td>DHSS</td>
<td>Alaska Department of Health and Social Services</td>
</tr>
<tr>
<td>DPH</td>
<td>Division of Public Health</td>
</tr>
<tr>
<td>DSM-5</td>
<td>Diagnostic and Statistical Manual of Mental Disorders, 5th Edition</td>
</tr>
<tr>
<td>DUR</td>
<td>Data utilization review</td>
</tr>
<tr>
<td>EMS</td>
<td>Emergency medical services</td>
</tr>
<tr>
<td>FDA</td>
<td>U.S. Food and Drug Administration</td>
</tr>
</tbody>
</table>
FSMB – Federation of State Medical Boards
HIPAA – Health Insurance Portability and Accountability Act of 1996
HRC – Harm Reduction Coalition
IC – Incident commander
IVDU – Intravenous drug users
IM – Intramuscular
IOP – Intensive outpatient program
IV – Intravenous
MAC – Master addiction counselor, certification by NAADAC, the Association for Addiction Professionals
MAT – Medication assisted treatment
MCO – Managed care organization
MET – Motivational enhancement therapy
MI – Motivational interviewing
MOA – Memorandum of agreement
MRO – Medical review officer
NAS – Neonatal abstinence syndrome
NASEM – North America Syringe Exchange Network
NCAAC – National certified adolescent addictions counselor, certification by NAADAC, the Association for Addiction Professionals
NCAC – National certified addiction counselor, certification by NAADAC, the Association for Addiction Professionals
NCPRSS – National certified peer recovery support specialist, certification by NAADAC, the Association for Addiction Professionals
NCS – Nicotine dependence specialist, certification by NAADAC, the Association for Addiction Professionals
NCSE – National clinical supervision endorsement, certification by NAADAC, the Association for Addiction Professionals
NCM – Nurse care manager
NP – Nurse practitioner
OBOT – Office-based opioid treatment
OOWS – Objective Opiate Withdrawal Scale
ORP – Overdose response program
OSMAP – Office of Substance Misuse and Addiction Prevention
OTP – Opioid treatment program
OUD – Opioid use disorder
PA – Physician assistant
PAP – Premium assistance program
PCP – Primary care provider
PDL – Preferred drug list
PDMP – Prescription Drug Monitoring Program
PHP – Partial hospitalization program
PO – By mouth
PRSS – Peer recovery support services
PWUD – People who use drugs
QHP – Qualified health plan
QSO – Qualified service organization
SAMHSA – U.S. Substance Abuse and Mental Health Services Administration
SES – Socioeconomic status
SOWS – Subjective Opiate Withdrawal Scale
SUD – Substance use disorder
TAP – Technical assistance publication
TIP – Treatment improvement protocol
XR-NTX – Extended-release injectable naltrexone
Section I: Executive Summary
Section I. Executive Summary

The purpose of this guide is to provide information about the implementation of opioid treatment services in Alaska. It is intended to be used as a tool for providers that are interested in, or that are currently providing, office-based opioid treatment for substance use disorders. Opioids play an important role in many health conditions, however, the focus of this guide is to inform and support practice in the context of treatment for substance use disorders. The guide consists of a compilation of best practices in treating and supporting individuals with opioid use disorders (OUD) from harm reduction to medication management and ongoing recovery support. Like many other states, one of the challenges for Alaska to address the needs of individuals experiencing opioid use disorder is limited access to medication assisted treatment (MAT).

The Alaska Department of Health and Social Services has worked with community partners and stakeholders to identify strategies that continue to be implemented to address the needs of Alaskans experiencing substance use disorders (SUD), as well as to enhance factors to protect Alaskans from developing substance use disorders. As science evolves, so does the medicine and practices used to treat addiction. The standard of care to treat opioid use disorders is with the use of one of the three Food and Drug Administration (FDA)-approved medications – buprenorphine, methadone, and/or naltrexone – along with the psychosocial behavioral health treatment and supports. This tool further describes what those medications are, how they are used, and the evidence that supports their efficacy.

Also included in this guide are the descriptions and details of the behavioral health supports that are available to Alaskans statewide. With the use of pharmacology to treat opioid use disorders along with community-based supports, it is possible for Alaskans struggling with opioids to achieve stability and have support for their recovery. Limited residential substance use treatment beds has been a challenge for Alaskans searching for treatment and it is not always the most appropriate level of care for individuals. Therefore, it’s necessary for providers to offer other treatment and recovery services that can meet the needs of the individuals experiencing opioid use disorders without relying on residential beds.

It’s also beneficial for individuals experiencing opioid use disorder to have access to the recovery supports that will help increase their quality of life in terms of safe, supportive housing; employment; education; and community connection. The State of Alaska is implementing and funding a number of recovery-related activities and programs such as, developing peer support certification, establishing recovery residences in each region of the state, and providing technical assistance and support to these efforts so they are enhanced and continue to expand throughout the state.
There are several ways a provider can implement opioid treatment services. This guide provides information on how a variety of models work, as well as how the billing works in Alaska to reimburse for these services. There is reference to Alaska-specific regulations and to federal regulations that will guide providers’ delivery and ensure that a standard of care is met when delivering these services. In addition, there are a number of resources provided in areas of treatment and recovery that are state specific, as well as national resources.
Section II: Introduction
Section II. Introduction

The national opioid epidemic has rapidly grown into this decade’s defining public health crisis. According to preliminary data from the Centers for Disease Control and Prevention, overdose deaths in 2017 increased by almost 10 percent from 2016 – claiming the lives of more than 70,000 Americans. Nearly 48,000 of those were opioid overdose deaths, with the sharpest increase occurring among deaths related to illicitly made fentanyl and fentanyl analogs (synthetic opioids). The U.S. rate of opioid-related deaths increased more than four-fold between 1999 and 2016.

In Alaska, the highest number of opioid-related deaths identified in one year was 108 in 2017 (preliminary data); of which, 100 (93%) were due to overdose. During 2010-17, with 623 identified opioid overdose deaths, the opioid overdose death rate increased 77% (from 7.7 per 100,000 persons in 2010 to 13.6 in 2017). Synthetic opioids, excluding methadone, caused 37 deaths –37% of all 2017 opioid overdose deaths, with fentanyl contributing to 76% (28 of 37) of those deaths. From 2012-17, the rate of out-of-hospital naloxone administrations by emergency medical service (EMS) personnel more than doubled, from 8.0 to 17.7 administrations per 1,000 EMS calls in 2012 and 2017, respectively. The rates of opioid-related inpatient hospitalizations were 28.5 per 100,000 persons in 2016 and 26.0 per 100,000 persons in 2017, with total inpatient hospitalization charges exceeding $23 million.

Alaska’s response to the opioid crisis has been evolving. A great deal of work was started early on by communities across the state. One of the first developments at the state level was the Alaska Opioid Policy Task Force which was convened in 2016 by the Advisory Board on Alcoholism and Drug Abuse, Alaska Mental Health Trust Authority, and Alaska Department of Health and Social Services at Governor Bill Walker’s request. The 20-member task force, representing diverse constituencies across Alaska, held 12 public meetings to explore the public health dimensions of opioid misuse and abuse in Alaska. The task force heard testimony from national experts, received public comment at all task force meetings and other forums around the state, received input from local community heroin/opioid coalitions, and conducted research to understand the latest science and evidence-based practices.

The Alaska Opioid Policy Task Force organized 32 recommendations according to a public health framework developed by the Association of State and Territorial Health Officials in the following areas; environmental controls and social determinants of health; chronic disease screening; treatment and management; harm reduction; recovery; and collaboration.

After reviewing the task force’s recommendations in early 2017, Governor Walker issued Administrative Order #283 to address “the urgent need to raise awareness and develop solutions regarding the prevention, treatment, and recovery from opioid misuse and heroin
addiction in Alaska.” The administrative order outlines the governor’s plan to combat the heroin and opioid epidemic and overdose-related deaths in Alaska. The governor directed the departments of Health and Social Services, Corrections, and Public Safety to evaluate and apply for grants to assist Alaska in combating heroin and opioid abuse.

Several actions resulted, including:

**Project HOPE**
This statewide program was launched to get naloxone rescue kits into the hands of emergency first responders, family members and friends, and opioid users as well as individuals who are at risk for opioid overdose. DHSS authorizes private or public entities to distribute Project HOPE Narcan rescue kits and conducts educational programs using a core curriculum that includes information and training on how to recognize an opioid overdose and properly administer naloxone for the individual until emergency medical help arrives. Regional overdose response programs (ORPs) have been identified in the communities of high need, regional ORPs will have the authority to authorize local ORPs, provide Project HOPE education and training, and equip local ORPs and the community with Project HOPE Heroin/Opioid Overdose Rescue Kits.

**Alaska Opioid Command System**
The Alaska Opioid Command System was developed within the Governor’s Office with cabinet-level representation from 11 departments of state government: Health and Social Services; Law; Public Safety; Commerce, Community and Economic Development; Corrections; Education and Early Development; Transportation and Public Facilities; Fish and Game; Military and Veteran’s Affairs; Labor and Workforce Development; and Administration. The group met with the governor to provide updates and for strategic and tactical planning. Execution of the response was driven by a multi-departmental team, organized in traditional incident command structure with sections for operations, logistics, planning and finance. The response teams included community outreach, data, criminal justice, education and media relations, to name a few. The response teams met biweekly to discuss updates, data and strategies to combat the opioid crisis. This critical work set up a response system and collaboration between state departments.

**Data Dashboard**
The data team monitors a number of metrics to generate situational reports to the governor and to populate a public-facing opioid data dashboard containing a summary of Alaska opioid statistics, emergency department visits, and overdose deaths. This data is protected and does not include personally identified
The dashboard is available online at:
http://dhss.alaska.gov/dph/Director/Pages/opioids/dashboard.aspx

Prescribers
Expansion of medication assisted treatment and prescribers who have received waivers as a result of the Drug Addiction Treatment Act (DATA) which permits qualified physicians to treat narcotic dependence with schedules III-V controlled substances that are approved by the U.S. Food and Drug Administration for that purpose.

To address the lack of capacity to treat OUDs, the Department of Health and Social Services’ Division of Behavioral Health convened a panel of practitioners from health care, behavioral health and specialty SUD treatment services, and the Opioid Response Network to review existing MAT models in Alaska and other states and to identify key components and best practices to develop this compendium of resources and recommendations for implementing and delivering MAT.

The need for DATA-waivered prescribers in Alaska and the need to increase access to medication assisted treatment became a very clear gap within the system. Efforts to expand access to MAT were supported by federal funds that the Division of Behavioral Health applied for in 2017 through 2019. Efforts are underway to implement provider education opportunities to increase the comfort and knowledge base of providers treating the population of individuals with OUD, and to encourage providers to obtain their DATA waiver. Currently there are approximately 300 DATA-waivered prescribers in Alaska. This number has dramatically increased over the past two years and continues to increase. In addition to the public system – funded through federal grants passed through the state – that has supported expanding MAT services, there is also a private sector that has grown significantly in Alaska. There are several clinics operating statewide that provide medication assisted treatment and there are a number of interested groups that are seeking opportunities to set up services in Alaska.

Given the landscape of Alaska’s substance use prevention, treatment and recovery needs, and the unique cultural and geographical challenges Alaskans experience, it’s necessary to provide guidance to those entities and individuals providing opioid treatment services.

The pathway moving forward to continue addressing the opioid crisis is in part shaped by the Alaska Department of Health and Social Services’ efforts to develop a community-driven plan. The development of this plan was led by the Office of Substance Misuse and Addiction Prevention.
Alaska’s 2018 Statewide Opioid Action Plan

The purpose of the Statewide Opioid Action Plan is to identify and implement strategies that limit inappropriate access to opioids, prevent and reverse overdoses when necessary, and strengthen the treatment system by expanding services.

Included in the drafting of the plan were representatives from the Office of Governor, Office of Lieutenant Governor, Department of Health and Social Services, Department of Public Safety, Department of Corrections, Department of Commerce, Community and Economic Development, Department of Education and Early Development, Department of Law, Department of Military and Veteran Affairs, the Alaska Native Tribal Health Consortium (ANTHC), and local opioid task force chairs.

Five major initiatives are recommended:

- Expand treatment capacity through funding medication assisted treatment services—primary method to combat crisis.
- Use education and stringent regulatory oversight to reduce availability and access to controlled substances [mandate use of the Prescription Drug Monitoring Program (PDMP)].
- Adopt chronic disease management framework for SUD policies, health care coverage, increase naloxone and buprenorphine availability, and educational outreach.
- Collect and analyze cross-sector data to inform decision-making and evaluation of efforts (improve opioid surveillance).
- Cross-sector collaboration among state agencies, tribal health care system, and communities.

In order to remain focused on strategic policy-making regarding the opioid crisis across state agencies, the Department of Health and Social Services’ Office of Substance Misuse and Addiction Prevention has convened an interagency work group to review the Statewide Opioid Action Plan and formalize/expand content.

*2018-2022 Statewide Opioid Action Plan*

Section III: Overview of Opioid Use Disorder Medications
About Opioids

An opioid is a drug that affects the brain. Opioids are used to relieve pain and to address other health problems such as severe coughing. “Opioid” is a broad term that refers to both prescription pain medication (such as oxycodone, OxyContin, fentanyl) and illegal substances (heroin and carfentanil). When abused, opioids increase the risk of certain infections, accidents and death.

People may become dependent on or addicted to prescription opioids. This can happen when taking them long-term, misusing or abusing them (taking a prescription improperly, buying prescription opioids illegally, or snorting, injecting or smoking them), or by use of illegal opioids such as heroin. When a person becomes addicted, they begin to experience cravings for opioids, as well as a loss of control over their use. Misuse of legal opioids is often linked to use of illegal opioids.

Substance use disorder is a medical condition just like heart disease or diabetes and is treatable. MAT treats dependence and addiction by using medication to ease withdrawal and ongoing cravings. It must include counseling to address root causes of the dependence and to strategize recovery plans. Taking medication for opioid addiction is much like taking medication to control diabetes or heart disease and use of appropriate medications greatly improves treatment outcomes and quality of life for patients and decreases costs. Medication may need to be taken for a period of years.

MAT should be provided as part of a comprehensive treatment plan which is intended to support how patients function in all aspects of their lives. In MAT, patients must be assessed and monitored by a medical provider, meet consistently with a behavioral health professional, and follow treatment plans based on the patient’s goals for treatment. Providers and patients must both comply with safety requirements. Medication, counseling and support from loved ones are all important factors that contribute to success in recovery.

According to SAMHSA’s Addiction Technology Transfer Center (ATTC) Network, MAT is defined as:

*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:\textsuperscript{1-3}

- Decreasing mortality;
- Increasing retention in treatment;
- Reducing medical and 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 opioid use disorders – methadone, buprenorphine, and naltrexone – with several products or formulations available for each of these medications.

\textit{Methadone:} There is a large body of research supporting methadone’s efficacy in treating patients with opioid addiction. Methadone is a full agonist which allows the areas of the brain affected/damaged by the abused drug to feel normal again. However, methadone at appropriate maintenance doses does not make patients feel intoxicated or high. Patients can participate normally in work, school or other productive activities. Methadone prevents symptoms of opioid withdrawal and reduces cravings. Methadone is administered on a daily basis by mouth in a clinic at the beginning of treatment. However, as treatment progresses, a patient may be able to take the medication on their own at home. Some patients need methadone treatment for a matter of months; others may need methadone treatment for the rest of their life. If patients stop using methadone, they must do so gradually under a physician’s care.

\textit{Buprenorphine:} Buprenorphine is a partial agonist which has a “ceiling effect,” meaning larger doses do not generally increase the effect of the medication. Buprenorphine can be used for medically supervised withdrawal, as well as for addiction treatment. Buprenorphine can be prescribed by providers with special approval from the federal government and is taken by mouth at home. Buprenorphine patients generally do not experience a high because of the ceiling effect. If a patient chooses to stop using buprenorphine, they need to be monitored as they go through withdrawal. Suboxone, is buprenorphine mixed with naloxone. Naloxone (Narcan) is an antagonist, which means that it blocks the effect of opioids if the drug is misused by injecting it. Thus, Suboxone decreases withdrawal symptoms and blocks the chance of experiencing a high, which helps discourage patients in recovery from abusing buprenorphine or other opioids. Patients need to discuss what buprenorphine medication works best for them in treating their opioid use disorder.

\textit{Naltrexone:} Naltrexone injection (Vivitrol) works differently than methadone or buprenorphine. Naltrexone is an opioid antagonist which completely blocks the effects of opioids. This means that if a patient attempts to abuse opioids they do not experience a high. This also means that a
Patient must be completely off of opioids for 7 to 10 days prior to the initiation of naltrexone in order to prevent instant withdrawal upon receiving the medication. This medication can be given once a month as an injection, or by daily pills. Naltrexone is most appropriate for those who are highly motivated, can completely change their social situation, and cannot risk any impairment.

While all three pharmacotherapies are approved options with different indications and contraindications, this compendium will focus primarily on the following medications:

**Buprenorphine**
- *Brand names:* Suboxone, Subutex, Zubsolv, Bunavail, Probuphine, Sublocade

**Naltrexone**
- *Brand names:* Extended-release injectable/depot/XR-NTX Vivitrol

These medications were selected because they may be prescribed in an office-based setting, unlike methadone which, per federal regulation, must be dispensed at certified opioid treatment programs (OTP). Additionally, this guidance document focuses on depot naltrexone, specifically Vivitrol, the only commercial product currently available, rather than oral naltrexone (ReVia, Depade) because poor medication adherence has resulted in lower retention rates when compared to depot naltrexone.2 Prescribers are strongly advised, however, to have a thorough understanding of each therapeutic medication and the different products and formulations available in an effort to, in agreement with the patient, identify which pharmacotherapy will be the best treatment option.

**Sampling of Research Findings**

Research outcomes relative to buprenorphine, naltrexone and methadone are important to review as medications are considered.

For example, in an examination of buprenorphine maintenance versus placebo or methadone maintenance, which included 31 trials and 5,430 participants, findings indicated that buprenorphine retained fewer participants than methadone when dose intervals are flexible and at low fixed doses.

However, at medium to high doses, buprenorphine was as effective as methadone. 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:

- Low fixed-dose studies indicated that methadone (≤ 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).

• No difference in retention was observed between high-dose buprenorphine (≥ 16 mg) and high-dose methadone (≥ 85 mg), (RR 0.79; 95% CI 0.20 to 3.16).

Another study looked at the long-term (18-month) outcomes of office-based treatment with buprenorphine/naloxone and the impact of socioeconomic status (SES) and other characteristics. Of the 176 patients with an opioid use disorder who were on buprenorphine/naloxone and receiving intensive outpatient counseling, 110 completed the follow-up interview with 77% of those reporting they remained 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.

In a randomized, comparative effectiveness trial of 24 weeks of treatment – following an acute inpatient detoxification admission, done at typical community-based treatment programs across the U.S. – 570 participants were randomized to receive treatment with either extended-release injectable naltrexone (XR-NTX) (283) or buprenorphine-naloxone (BUP-NX) (287) and were intended to be treated. 474 participants were successfully inducted, with XR-NTX significantly more difficult to initiate than BUP-NX patients, with nearly 30% of patients failing induction despite intensive inpatient withdrawal management. Among patients that were successfully inducted, 24-week relapse events were similar across XR-NTX patients (52%) and BUP-NX patients (56%). Overall, if induction to either medication is successful, XR-NTX and BUP-NX were comparably effective and safe options.

In a recent study, 308 patients were randomly assigned to treatment: outpatient (N=201); short-term inpatient (N=59); and long-term inpatient (N=48) as usual (TAU) (N=155) or TAU + injection naltrexone (depot naltrexone; XR-NTX) (N=153). Five weeks after randomization, patients being treated with XR-NTX+TAU that initiated the study on short-term inpatient experienced little relapse (7%); however, those assigned to TAU experienced a high rate of relapse (63%). By the end of the study (26 weeks) there was continued relapse across treatment conditions and settings; however, relapse rates were lower among the XR-NTX+TAU condition patients across treatment settings. The XR-NTX exerted a protective effect among outpatients, reducing the relapse rate to 38% as compared to short-term inpatients (59%) and long-term inpatients (46%).

According to the results of a retrospective, longitudinal study comparing patients who received MAT versus 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 OUDs (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 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 health care costs by 29% for patients who received a medication for their opioid use disorder. 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 OUDs. In looking at total costs, this medication is not significantly different compared to oral naltrexone or buprenorphine, but is significantly lower than methadone.8

Choosing the Most Appropriate Medication

Ideally, all patients would have access to all three forms of MAT (methadone, buprenorphine and extended release naltrexone) along with the counseling. However, many factors including severity of disease, comorbid conditions, insurance issues, local resources available and patient preference, must be considered in choosing the right medication for an individual patient.

Extended release naltrexone (XR-NTX)

This medication may be a good first line therapy in most patients with a mild opioid use disorder. Young patients who have been using opioids for less than a year may also be a good fit for NTX, as well as patients with opioid use disorder in safety-sensitive occupations that prohibit opioid agonist use. XR-NTX can be a good medication choice in incarcerated patients or those in residential treatment programs who have already completed withdrawal. Ideally XR-NTX would be administered prior to release to provide protection from overdose and relapse. XR-NTX is also effective in the treatment of alcohol use disorder (AUD), so it can be useful in patient with comorbid AUD and OUD. Some patients may choose XR-NTX for treatment because they prefer to avoid agonist medications.

As naltrexone does not provide any positive reinforcement (doesn’t treat withdrawal symptoms or provide a sense of well-being), or negative reinforcement (patients don’t experience withdrawal symptoms when they stop their medication), it is best suited for patients that are highly motivated to stay in treatment. This is especially true if there is a loved one that can help them stay accountable to receive monthly injections or there’s an incentive to stay in treatment through drug court mandates, contingency management or other strategies.

Naltrexone can be difficult to initiate in the outpatient setting and patients must first undergo 5-14 days of opioid withdrawal before administration. It can cause a patient to go into withdrawal and therefore it can be dangerous if not done at the right time. Withdrawal management to prepare for antagonist administration is best performed in an inpatient setting,
and even with intensive inpatient withdrawal management, nearly 30% of patients may fail XR-NTX induction. Patients who are actively using and not willing or able to undergo withdrawal management are not candidates for XR-NTX. Naltrexone is not approved for use in pregnancy. It is not well suited to patients who have a high likelihood of requiring frequent medical interventions such as major surgery, when use of a full agonist may be needed. Naltrexone is suggested as third-line medication treatment for moderate to severe opioid use disorder in patients who have had poor responses to buprenorphine and methadone. Patients who fail treatment with naltrexone should be treated with an opioid agonist.

**Buprenorphine**

For most patients treated with medication for a moderate to severe opioid use disorder, buprenorphine is a good first-line choice. While methadone may have slightly better capacity to retain patients in treatment, it has a higher risk of lethal overdose and drug-drug interactions, and is not available in rural areas. Buprenorphine induction can be performed in the outpatient setting without first requiring the patient to complete withdrawal, making it more accessible to most patients. It can also be initiated in the emergency department, allowing low-threshold access to care. It provides both positive reinforcement (by relieving withdrawal symptoms and normalizing sense of well-being), and negative enforcement (if patients stop their medication they experience withdrawal symptoms), which encourages retention in treatment. For patients who struggle with medication compliance or diversion, monthly injectable buprenorphine (Sublocade) can be offered. For patients with moderate to severe opioid use disorder who continue to use opioids despite buprenorphine treatment, or have a history of a prior poor response to, misuse or diversion of buprenorphine, methadone might be a better fit. Daily observed dosing of buprenorphine can also be performed at a methadone clinic.

**Methadone**

For patients with moderate to severe opioid use disorder who require high levels of support, methadone is a good choice. Methadone clinics offer a broad range of social and behavioral health supports all in one place, which can be critical for success in patients who struggle with socioeconomic barriers such as homelessness. Methadone requires daily administration at a federally regulated opioid treatment program, which is currently available only in Anchorage, Fairbanks and Wasilla. Patients must travel daily to the clinic to obtain their medication dose, which can be difficult for patients with busy work schedules or lack of transportation. Methadone may also be a good choice for patients with severe chronic pain whose pain is not adequately controlled on buprenorphine. Methadone has multiple drug-drug interactions so may not be appropriate for some patients with complicated poly-pharmacy.
Opioid Use Disorder Medication Differences

The following table provides a brief overview of the differences between the three medications. For more detailed prescribing information, please refer to the ASAM National Practice Guidelines available online at [www.asam.org/resources/guidelines-and-consensus-documents/npg](http://www.asam.org/resources/guidelines-and-consensus-documents/npg).2,9-10

### Comparison of Medication Differences

<table>
<thead>
<tr>
<th>Prescribing considerations</th>
<th>Methadone</th>
<th>Buprenorphine</th>
<th>Naltrexone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product/Formulation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methadone</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suboxone,* Subutex, Zubsolv,* Bunavail,* Probuphine, Sublocade</td>
<td></td>
<td>Extended-release injectable/depot/XR-NTX; Vivitrol</td>
</tr>
<tr>
<td><strong>Mechanism of Action</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methadone</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td>Partial agonist: Binds to and partially activates opioid 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.</td>
<td>Antagonist: Binds and competitively blocks opioid reward effects.</td>
</tr>
<tr>
<td><strong>Uses of Medication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methadone</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Withdrawal and treatment</td>
<td>Withdrawal and treatment</td>
<td>Treatment</td>
</tr>
<tr>
<td><strong>Route of Administration</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methadone</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oral tablet or liquid</td>
<td>Sublingual tablet, sublingual or buccal film, implant, injection</td>
<td>Intramuscular (IM) injection</td>
</tr>
<tr>
<td><strong>Frequency of Administration</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methadone</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Daily</td>
<td>Based on formulation and clinical needs of the patient.</td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>Dosage</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methadone</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on formulation and clinical needs of the patient.</td>
<td>Based on formulation and clinical needs of the patient.</td>
<td>Based on formulation and clinical needs of the patient.</td>
</tr>
<tr>
<td><strong>Regulatory Context</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methadone</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>May only be dispensed at a certified opioid</td>
<td>Any licensed prescriber with a DEA registration</td>
<td>Any health care provider who has a license to</td>
</tr>
<tr>
<td>Prescribing considerations</td>
<td>Methadone</td>
<td>Buprenorphine</td>
<td>Naltrexone</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----------</td>
<td>---------------</td>
<td>------------</td>
</tr>
<tr>
<td>treatment program (see He-A 300 rules, part 304).&lt;sup&gt;11&lt;/sup&gt;</td>
<td>and a buprenorphine waiver.</td>
<td>prescribe (e.g., physician, nurse practitioner, physician assistant).</td>
<td></td>
</tr>
<tr>
<td>Typical Visit Requirement</td>
<td>Initial: Daily</td>
<td>Initial: Weekly Interval may change based on course of treatment</td>
<td>Monthly</td>
</tr>
<tr>
<td>Cost of Medication</td>
<td>Low</td>
<td>Depends on product</td>
<td>High</td>
</tr>
<tr>
<td>Controlled Substance Schedule</td>
<td>Schedule II</td>
<td>Schedule III</td>
<td>Not a scheduled medication</td>
</tr>
<tr>
<td>Diversion Value</td>
<td>High</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Discontinuation of Medication</td>
<td>Tapering required</td>
<td>Tapering required</td>
<td>No tapering required</td>
</tr>
</tbody>
</table>

*Suboxone, Zubsolv and Bunavail contain both buprenorphine and naloxone. Naloxone is an antagonist and is used to decrease potential for diversion and misuse. If used intravenously a person will experience immediate withdrawal as a result of the naloxone.*
Section IV: Service Delivery and Clinical Considerations
Section IV. Service Delivery and Clinical Considerations

There are many components related to the development, implementation, and integration of an MAT program for the treatment of OUD. An overview of each element will be described in the following sections. Federal and state requirements, best practice recommendations, and resources will be identified throughout this guidance document to assist with the initiation or expansion of office-based opioid treatment (OBOT) programs. Formal structuring of office systems to support best practices in MAT is strongly encouraged to facilitate efficient patient care and reduce system stress.

Many different service models can be used to deliver MAT within each setting. The following table provides an overview of the models that can be used in a primary care clinic or office, behavioral health/specialty addiction treatment program, and a MAT-specific setting.

### Overview of Buprenorphine and Naltrexone Service Delivery Models

<table>
<thead>
<tr>
<th></th>
<th>Primary Care Clinic or Office-Based</th>
<th>Behavioral Health/Specialty Addiction Treatment Program</th>
<th>Free-Standing MAT Clinic</th>
<th>Opioid Treatment Program (OTP)/Methadone Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>General description</td>
<td>Engages existing PCP to become waived</td>
<td>Provides psychosocial treatment and recovery support services</td>
<td>Establishes clinic specifically to provide buprenorphine and/or naltrexone</td>
<td>Expands services to include prescribing of buprenorphine and/or naltrexone</td>
</tr>
<tr>
<td></td>
<td>Prescribes buprenorphine and/or naltrexone</td>
<td>Employs or contracts with buprenorphine and/or naltrexone prescribers</td>
<td>Engages prescriber, psychosocial treatment provider and care coordinator</td>
<td>Engages waivered prescribers and uses existing psychosocial treatment provider and care coordinator</td>
</tr>
<tr>
<td></td>
<td>Arranges psychosocial treatment and recovery support services</td>
<td>Provides or refers to recovery support services</td>
<td>Provides or refers to recovery support services</td>
<td>Provides or refers to recovery support services</td>
</tr>
<tr>
<td>Role</td>
<td>Primary Care Clinic or Office-Based</td>
<td>Behavioral Health/Specialty Addiction Treatment Program</td>
<td>Free-Standing MAT Clinic</td>
<td>Opioid Treatment Program (OTP)/Methadone Clinic</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>Prescriber</strong>&lt;br&gt;Diagnoses OUD&lt;br&gt;Inducts onto MAT&lt;br&gt;Prescribes&lt;br&gt;Provides routine follow-up visits</td>
<td>Provides a prescriber or one is embedded within the clinic&lt;br&gt;May link to other waivered prescriber for cross coverage</td>
<td>Provides a medical/psychiatric director or other waivered prescribers or one is embedded within the clinic&lt;br&gt;Partners with waivered prescriber in community</td>
<td>Provides a waivered prescriber or one is embedded within the clinic</td>
<td>Provides a waivered prescriber or one is embedded within the clinic</td>
</tr>
<tr>
<td><strong>Counselor</strong>&lt;br&gt;Provides SUD counseling&lt;br&gt;Group&lt;br&gt;Individual&lt;br&gt;Provides counseling for co-occurring disorders as needed&lt;br&gt;Encourages and refers to recovery support</td>
<td>Embed addiction counselor or contracts with outside provider</td>
<td>Designates counseling staff</td>
<td>Designates counseling staff</td>
<td>Designates counseling staff</td>
</tr>
<tr>
<td><strong>Care coordinator</strong>&lt;br&gt;Facilitates communication between prescriber, counselor, and patient&lt;br&gt;Provides routine support to patients outside of office visits&lt;br&gt;Conducts drug testing and pill/film counts&lt;br&gt;Links with recovery support services</td>
<td>Role may be assumed by various positions (e.g., nurse, medical assistant, or counselor).</td>
<td>Role may be assumed by various positions (e.g., nurse, medical assistant, or counselor).</td>
<td>Role may be assumed by various positions (e.g., nurse, medical assistant, or counselor).</td>
<td>Role may be assumed by various positions (e.g., nurse, medical assistant, or counselor).</td>
</tr>
</tbody>
</table>
The table below references the federal and state requirements and the best practices that are strongly encouraged by the State of Alaska. The simplest form of MAT with buprenorphine which meets federal and state regulations involves a waivered prescriber writing a prescription for a patient who meets criteria for an OUD, 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, the state is promoting additional best practices to support the successful delivery of MAT. Some of these recommendations include querying the Prescription Drug Monitoring Program each time a prescription is written, conducting routine and random drug testing and pill/film counts and practicing timely communication among the prescriber, the patient and other providers.

### Federal and State Requirements and Recommendations

<table>
<thead>
<tr>
<th>Federal and State Requirements</th>
<th>Alaska Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Obtain buprenorphine waiver to prescribe</td>
<td>• Establish a core team of qualified staff to deliver MAT</td>
</tr>
<tr>
<td>o Physician (MD/DO) - eight hour waiver training OR</td>
<td>• Provide initial and on-going training and resources to all staff</td>
</tr>
<tr>
<td>o Nurse practitioner/physician assistant - 24 hours of training including the 8 hour waiver training</td>
<td>• Query the PDMP each time a prescription for a federally Scheduled II or III controlled substance is written, administered or directly dispensed</td>
</tr>
<tr>
<td>• Conduct full evaluation and medical exam</td>
<td>• Enroll and credential with managed care organizations (MCOs), qualified health plans (QHPs), and other insurers</td>
</tr>
<tr>
<td>o Verify that patient meets criteria for an opioid use disorder</td>
<td>• Perform routine and random drug tests</td>
</tr>
<tr>
<td>o Verify that patient is deemed appropriate for MAT and medication</td>
<td>• Perform routine and random pill/film counts</td>
</tr>
<tr>
<td>• Provide regular office visits</td>
<td>• Practice timely communication among the prescriber, the patient and other providers</td>
</tr>
<tr>
<td>• Document care properly (e.g. treatment plans, confidentiality)</td>
<td></td>
</tr>
<tr>
<td>• Ensure capacity to refer patients for appropriate counseling and other ancillary services</td>
<td></td>
</tr>
</tbody>
</table>
To further outline the MAT requirements and recommended best practices, a visual representation is provided below and a Quality Planning Tool is available in Appendix I to help MAT programs review and assess their progress related to the development and implementation of the recommended best practices. Periodic use of this tool is encouraged to inform continual quality improvement. Programs can anticipate that the first one to two years after implementation will involve assessing and adjusting programming and service delivery as necessary.
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. This team may involve clinic staff exclusively or may include partnering providers to provide comprehensive treatment services to meet patient needs.

To establish a team, it is important to identify or recruit interested and qualified staff who encompass the attitudes, values, and competence associated with treating patients with OUDs. It’s recommended that the team consist of, at a minimum, a prescriber, a care coordinator, a licensed or certified alcohol and drug counselor or behavioral health provider with training in the treatment of SUDs, and non-clinical administrative staff. Each of the recommended positions are described in more detail in this section.

Prescriber

**Buprenorphine**
Physicians (MD or DO), nurse practitioners (NP), and physician assistants (PA) who have received a waiver through the Drug Enforcement Administration (DEA) can prescribe buprenorphine.

Physicians have been able to prescribe buprenorphine since October 2002 when the FDA approved buprenorphine for clinical use in treating OUDs. The eight-hour DATA-waiver course is required in order to apply to prescribe to up to 30 patients in the first year and to increase the limit to 100 patients thereafter. Physicians who have prescribed buprenorphine to 100 patients for at least one year can apply to increase their patient limits to 275 patients under new federal regulations. As of February 27, 2017, prescribing of buprenorphine was extended to NPs and PAs per the Comprehensive Addiction and Recovery Act (CARA). 24 hours of training, including the eight-hour waiver training, is required in order to apply to prescribe to up to 30 patients.

**Naltrexone (NR-NTX)**
This medication may be prescribed by any health care provider (e.g., NPs, PAs) who is licensed to prescribe medications. There is no limit on the number of patients for whom this medication may be prescribed.

Approved in October of 2010, extended-release injectable naltrexone is the most recent drug authorized for the treatment of OUDs.

**Methadone**
For the treatment of pain, methadone can be prescribed by any prescriber with a DEA registration, but for OUDs this medication can only be dispensed at a licensed opioid treatment program/methadone clinic. If methadone is determined to be the most appropriate medication
for a patient, primary care offices and clinics, behavioral health/specialty addiction treatment programs, and free-standing MAT clinics can refer patients to one of the four licensed OTPs in Alaska:

**Anchorage:** Narcotic Drug Treatment Center and Anchorage Treatment Solutions  
**Fairbanks:** Interior AIDS Association  
**Wasilla:** Community Medical Services

The following table recommends prescriber models by setting and medication.

### Overview of Prescriber Models by Setting

<table>
<thead>
<tr>
<th></th>
<th>Primary Care Clinic or Office</th>
<th>Behavioral Health/ Specialty Addiction Treatment Program</th>
<th>MAT-specific Treatment Program</th>
</tr>
</thead>
</table>
| **Buprenorphine**         | Recruit interested prescriber(s) in practice to obtain buprenorphine waiver, prescribe medication, and oversee patient care. | Have prescriber obtain buprenorphine waiver.  
Establish a working relationship with a prescriber(s) in the community waivered to prescribe buprenorphine. | Hire prescribers to obtain buprenorphine waiver.                                                                 |
| **Naltrexone (XR-NTX)**   | Identify existing health care providers to prescribe naltrexone and oversee patient care.       | Have existing health care provider prescribe naltrexone.  
Establish a working relationship with a health care provider(s) in the community to prescribe naltrexone. | Have existing provider prescribe naltrexone.  
Hire or subcontract with a licensed health care provider to prescribe naltrexone and to participate in oversight of patient care. |

**Methadone**  
If methadone is determined to be the most appropriate medication for patients, providers can establish care coordination plans with one of the state’s four methadone clinics. For a list of OTPs, visit the Alaska substance use provider list online at [http://dhss.alaska.gov/dbh/Documents/TreatmentRecovery/SUD%20Providers/Medication%20Assisted%20Treatment%20Providers.pdf](http://dhss.alaska.gov/dbh/Documents/TreatmentRecovery/SUD%20Providers/Medication%20Assisted%20Treatment%20Providers.pdf)
**Buprenorphine Waiver Process**

To qualify for a buprenorphine waiver, a prescriber must:

- Be a licensed physician (MD or DO), nurse practitioner, or physician assistant.

Meet and verify any one or more of the following criteria:

- Complete DATA-waiver course on the management and treatment of patients with opioid use disorders as provided by an approved vendor. NPs and PAs are required to complete 24 hours of training, including the eight-hour waiver training.
- Hold a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties.
- Hold an addiction board certification from the American Board of Addiction Medicine or American Board of Preventative Medicine Subspecialty in Addiction Medicine.
- Hold a subspecialty board certification in addiction medicine from the American Osteopathic Association.
- 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.
- Have other training or experience that the state medical licensing board considers a demonstration of the physician’s ability to treat and manage patients with opioid dependency.

Submit notification of intent to SAMHSA at [http://buprenorphine.samhsa.gov/forms/select-practitioner-type.php](http://buprenorphine.samhsa.gov/forms/select-practitioner-type.php). SAMHSA will send a letter within 45 days with approval status. If approved, a DEA identification number will be provided to treat up to 30 patients for the first year.

Physicians who have prescribed buprenorphine for a year can submit a second letter of intent to treat 100 patients. After treating at this patient limit for a year, physicians can apply to increase to 275 patients.

Visit the SAMHSA website for more information on the waiver application and management process to prescribe or dispense buprenorphine for opioid dependency treatment.

**SAMHSA – Buprenorphine Waiver Management**

[www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management](http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management)

**Buprenorphine Waiver Trainings**

Training must be obtained from one of the following approved training providers. Different learning formats are offered at varying costs.
Continuing education options on opioids, pain management and addiction for Alaska
http://dhss.alaska.gov/dph/Director/Pages/opioids/education.aspx

Providers’ Clinical Support System for Medication Assisted Treatment (PCSS-MAT)
https://pcssmat.org/education-training/mat-waiver-training/

American Academy of Addiction Psychiatry (AAAP)
www.aaap.org/education-training/buprenorphine

American Society of Addiction Medicine (ASAM)
www.asam.org/education/live-online-cme/buprenorphine-course

American Osteopathic Academy of Addiction Medicine (AOAAM)
www.aoaam.org/?page=PCSSMAT&hhSearchTerms=%22PCSS-MAT%22

Care Coordinator

Care coordination is a critical component for effective delivery of MAT and patient care. How care coordination is provided often varies from program to program, but there are components of 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 but not limited to, coordinating induction, administering drug tests, and lab screens and monitoring results, collaborating with other providers in compliance with Title 42, Part 2 of the Code of Federal Regulations (42 CFR, Part 2), and assisting patients with accessing treatment, recovery support services, and other ancillary services. 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.

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 uses nurse care managers (NCMs) to provide clinical support to waivered 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 patient’s medical, social and psychiatric history; works with the patient through the induction process; provides stabilization and maintenance support through weekly appointments and telephone check-ins; and
conducts urine toxicology screens and verifies behavioral health counseling. Additionally, NCMs are responsible for relapse prevention, overdose education and support for patient self-management.13 Since the program’s inception, BMC has grown to serve over 500 patients with 24 waivered 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 2017, 33 health centers, in addition to BMC, were enrolled in the State Office-Based Addiction Treatment-Buprenorphine Program and the number of waivered physicians in Massachusetts increased from 24 to over 600.14 Since the grant was disseminated across the Commonwealth over 10,000 patients have been served. Each NCM has a caseload of 125 patients (8-12 patients per day) and receives assistance from a medical assistant. Additionally, as of 2013, 67% of the patients stayed in treatment for more than twelve months and 50% for more than five years.15

-Information obtained from Colleen LaBelle, MSN, RN- BC, CARN
Director of Boston Medical Center’s OBAT on February 9, 2018

Many existing MAT programs distribute responsibilities across available staff. However, treatment retention and compliance can be vastly improved through identifying one or more positions to coordinate care for all MAT patients. For MAT settings in which all services are not co-located, care coordination becomes even more critical.

Behavioral Health/Addiction Clinician

MAT combines medication assistance with behavioral health and/or SUD treatment and recovery support services such as peer support, recovery coaching and community-based support groups. Studies have found that programs providing regular, structured, SUD-focused counseling had better outcomes than programs providing little or no counseling.12 Having an on-site certified chemical dependency counselor, behavioral health aide, or a behavioral health clinician with training in the treatment of SUDs will help to encourage behavior change and will also hold patients accountable, thereby receiving the support they will need in recovery. If the MAT program does not have SUD treatment services on-site, it will be crucial that formal agreements be established with several treatment providers offering different levels of care in an effort to support a patient’s 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 providers. Please refer to the Psychosocial Treatment and Recovery section which describes the levels of care and suggested programming.
Administrative Staff

Non-clinical and administrative staff are often responsible for obtaining patient intake information and consents, 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 as a disease, pharmacotherapy and stigma-related issues. Staff should also receive ongoing record keeping and confidentiality training. Ensuring that the patient is welcomed into the program beginning at intake can positively influence the treatment experience.

Incentives and Supports for Recruiting and Retaining staff

- Establish shared collegial patient care
- Provide on-going supervision
- Provide initial and on-going training
- Pay training and registration fees
- Ensure for practical caseloads
- Offer competitive wages

Training and Resources: Provide Initial and Ongoing Training and Resources

... the attitude of staff members, is probably the next most important determinant of treatment effectiveness... 

Patient outcomes are influenced by a variety of factors. Staff can play a significant role. It is important to ensure that the attitudes, values, and competence around MAT and interactions with patients among all staff are conducive for delivering MAT services. All staff should have on-going access to training and supervision, current literature and other resources. The following is a list of resources related to MAT best practices and service delivery models, as well as resources by medication and topic area and information for accessing SUD treatment and recovery support services and other resources for patients, families and friends.

MAT Best Practices

ASAM National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use
SAMHSA TIP 63: Medications for Opioid Use Disorders
TIP: https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC

SAMHSA Medication Assisted Treatment of Opioid Use Disorder

American Hospital Association, Stem the Tide: Addressing the Opioid Epidemic
Guideline: www.aha.org/content/17/opioid-toolkit.pdf

Providers’ Clinical Support System for Medication Assisted Treatment
www.pcssmat.org

MATx Mobile App by SAMHSA
https://store.samhsa.gov/product/MATx-Mobile-App-by-SAMHSA/PEP16-MATAPP

MAT Models
Agency for Healthcare Research and Quality, Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings

Primary Care-Based Models for the Treatment of Opioid Use Disorder: A Scoping Review
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5504692/

By Medication

Buprenorphine

SAMHSA TIP 40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction
Buprenorphine Treatment: Training for Multidisciplinary Addiction Professionals

Naltrexone

Clinical Use of Extended Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide

**Methadone**

**SAMHSA TIP 43: Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs**
TIP: https://www.ncbi.nlm.nih.gov/books/NBK64164/
Knowledge Application Program Key: https://store.samhsa.gov/product/Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4108

**Recovery-oriented Methadone Maintenance**
Monograph: www.williamwhitepapers.com/books_monographs/

**By Topic Area**

**Screening**

**Screen and Intervene: NH S-BI-RT Playbook Version 2.1**
http://sbirtnh.org/playbook/

Institute for Research, Education, & Training in Addictions
www.ireta.org

**Assessment**

**SAMHSA TIP 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders**
TIP: https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992

**Induction**

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

**Withdrawal Scales**
Confidentiality

Substance Use Disorder Privacy Workbook: 42 CFR Part 2

Diversion Control

Diversion Control Protocol Template for Opioid Use Disorder Treatment Providers
http://media.campaigner.com/media/33/333080/MAT-PDOA%206-28-17/MAT_PDOA_DiversionControlTemplate.pdf

Drug Testing

Appropriate Use of Drug Testing in Clinical Addiction Medicine

Urine Drug Testing in Clinical Practice

ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine
Webinar Series: https://elearning.asam.org/drugtestingwebinars

Alaska Substance Use Disorder Treatment

Careline 1-877-266-HELP(4357)
https://carelinealaska.com/

Substance Use Treatment & Recovery
http://findtreatment.alaska.gov

Outpatient & Residential SUD Providers in Alaska

SAMHSA’s Buprenorphine Practitioner Locator for Alaska
www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator?field_bup_physician_us_state_value=AK

For Patients, Family and Friends

SAMHSA Decisions in Recovery: Treatment for Opioid Use Disorder
Billing

Establish Billing Protocol

Services can be covered through different 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.

Non-Insurance Payment Model

Establish a payment structure to identify the cost of services and when and how payment will be collected. Policies on how to address late payments and patients who may not be able to pay for services in full are strongly recommended.

Third-Party Payer Reimbursement Model

Enroll and credential with managed care organizations (MCOs), qualified health plans (QHPs), and other insurers. The MCOs and other third-party carriers use specific strategies to help manage the prescribing of addiction medicines. It is strongly recommended that MAT programs familiarize themselves with the requirements of each carrier, and the time it takes to meet requirements prior to prescribing medication to ensure that the patient does not become responsible for unpaid claims.

Review payer billing standards and rules with respect to office visits, travel, medication quantity limits and preferred agents.

Drug utilization reviews (DURs) may be initiated by an 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).

Medicaid Authorization

Medicaid is the state and federal program that provides health coverage for individuals with very low income, and is different from Medicare, a federal program that provides health coverage to individuals 65+ or under 65 and have a disability, no matter their income.

Behavioral Health Services

Title 7, Chapter 70 of the Alaska Administrative Code – Behavioral Health Services

http://www.legis.state.ak.us/basis/aac.asp#7.70
Evaluation: Establish a Process for Assessing Patients

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 is needed to determine the level of care the patient meets. 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 will be most appropriate.

It is recommended that the behavioral health clinician and prescriber be involved with the evaluation process. The following indicates the steps for conducting a thorough evaluation.²

Conduct Patient Assessment

Use evidence-based tools such as the Addiction Severity Index (ASI),¹⁸ a semi-structured assessment tool available in the public domain, to evaluate an individual.

- Evaluate the patient’s physical, mental, and emotional health, past and current substance use, and medical history.
- Identify current and past medications, allergies, pregnancy status, personal history of infectious diseases such as hepatitis, HIV, and TB, and social and environmental factors.
- Engage the patient in treatment by asking open-ended questions to identify his/her treatment goals.
- Use information gathered, including how patient’s overall assessment aligns with ASAM criteria, to assess level of care.

Sample Open-Ended Questions

- What was your first exposure to opioids? Tell me about your use.
- How do you use opioids?
- What other substances do you use?
- What prescribed medicines do you take regularly?
- What medical conditions do you have or have you been treated for?
- Is there a chance you could be pregnant?
- What are your goals for treatment?
- What services and supports have been helpful to you in the past?
- What services and supports would be helpful to you?
- Who is a support to you?

**Addiction Severity Index**


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.

**Observations by ASAM Dimension**

<table>
<thead>
<tr>
<th>ASAM Dimensions</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIMENSION 1  Intoxication and/or Withdrawal Potential</td>
<td>Physiologically dependent on opiates and requires some form of treatment to assist in alleviating withdrawal symptoms. It is possible that patients will qualify for MAT without being physically dependent on opioids (i.e., diagnosis of OUD without recent use but risk of use based on cravings or environment, or periodic use in setting of addiction).</td>
</tr>
<tr>
<td>DIMENSION 2  Biomedical Conditions and Complications</td>
<td>None or manageable with outpatient medical monitoring</td>
</tr>
<tr>
<td>DIMENSION 3  Emotional, Behavioral, Cognitive Conditions and Complications</td>
<td>None or manageable in an outpatient structured environment</td>
</tr>
<tr>
<td>DIMENSION 4  Readiness to Change</td>
<td>Ready to embark on changes associated with abstinence</td>
</tr>
<tr>
<td>DIMENSION 5  Relapse/Continued Use/Continued Problem Potential</td>
<td>At risk of relapse/continued use and willing to engage in structured treatment to promote treatment progress</td>
</tr>
<tr>
<td>DIMENSION 6  Recovery Environment</td>
<td>Has supportive recovery environment and/or options for a stable living environment</td>
</tr>
</tbody>
</table>
Conduct Physical Exam

An exam should be performed by either the prescribing physician or another health care provider prior to prescribing medication. The exam should include identifying physical signs of opioid use, intoxication, withdrawal, and other complicating signs of SUD (e.g., abscesses, cellulitis) as well as overall physical health including nutritional status. Several opioid withdrawal scales are available to help a clinician identify and quantify OUDs.

These scales include:

**Objective Opiate Withdrawal Scale (OOWS)**\(^\text{19}\)
Tool for determining level of withdrawal
See Appendix II: Objective Opiate Withdrawal Scale (OOWS)

**Subjective Opiate Withdrawal Scale (SOWS)**\(^\text{19}\)
Self-reporting tool for identifying opiate withdrawal
See Appendix III: Subjective Opiate Withdrawal Scale (SOWS)

**Clinical Opiate Withdrawal Scale (COWS)**\(^\text{19}\)
Tool for identifying signs and symptoms which integrates subjective and objective items
See Appendix IV: Clinical Opiate Withdrawal Scale (COWS)

Conduct Laboratory Tests/Drug Tests

The following should be considered at the time of initial evaluation:

- infectious disease (tuberculosis, hepatitis A, B, C, sexually transmitted diseases and HIV)
- pregnancy test
- drug testing
- liver function testing

Depending on the results of these tests further follow up may be required. If possible, the pregnancy and drug urine tests should be run before MAT medication is started. Other lab testing may be collected in the following few weeks of induction and stabilization.

Determine Diagnosis

A diagnosis of OUD must be identified before prescribing a medication. The assessment, physical exam, drug testing, and other information gathered during the evaluation process will be essential to determine the diagnosis. A patient must be diagnosed with at least a “mild” OUD with two out of 11 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 prescriber should confirm the diagnosis. The diagnosis of an SUD/OUD is followed similar to any chronic illness.
It is important to review continued drug and alcohol use with patients, symptoms of craving, physical symptoms that may occur with cessation of drug use and side effects of prescribed medications. For more details, see the Treatment Planning section.

**Query the Prescription Drug Monitoring Program (PDMP)**

The Alaska PDMP grants access to system accounts to practitioners and approved delegates so that they may enter and review controlled substance dispensing information on their patients. Per Alaska law, it is a requirement that prescribers review data prior to prescribing, administering and directly dispensing an opioid when treating or managing a patient for pain. It is essential that all prescribers review data prior to prescribing, administering and directly dispensing scheduled medications in an effort to ensure appropriate treatment according to established safe standards of practice.

**Submit information to PDMP**

Also per Alaska law, each dispenser is required to submit information into the PDMP regarding every prescription dispensed for a Schedule II, III, or IV controlled substance. In accordance with transmission methods, information is to be submitted daily by the close of business on the next business day from the date the prescription was dispensed. Veterinarians must submit data daily. Dispensers not living and dispensing in Alaska are not required to register with the PDMP and are not required to dispense. A dispensation exemption form is available to record dispensation status.

**Register in the Alaska Prescription Drug Monitoring Program**

Visit the Alaska Department of Commerce, Community and Economic Development’s website for detailed instructions on how to sign up for and use Alaska’s PDMP.

- [Alaska DCCED – PDMP Registration, Resources and Instruction](http://www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/PrescriptionDrugMonitoringProgram/RegistrationInstructions.aspx)

**Evaluation Components**

The following table provides recommendations for when and by whom each evaluation component may be initiated.
<table>
<thead>
<tr>
<th>Evaluation Components</th>
<th>Staff Responsible for Component</th>
<th>Initiation of Evaluation Component</th>
</tr>
</thead>
</table>
| Assessment             | Behavioral health/addiction clinician  
                      | Strongly recommended that prescriber conduct an abbreviated assessment. | Assessment may be completed over a period of a few sessions; however, a shortened version is essential at intake to identify patient history and needs necessary to prescribe the appropriate pharmacotherapy. |
| Physical Exam          | Prescriber or other health care provider | Prior to prescribing pharmacotherapy |
| Lab/Drug Tests         | Prescriber or other health care provider may order  
                      | May be conducted in-house or an outside lab may be used | Prior to prescribing pharmacotherapy and ongoing |
| Diagnosis              | Behavioral health/addiction clinician  
                      | Prescriber must confirm diagnosis | Prior to prescribing pharmacotherapy |
| PDMP Check             | Prescriber or other approved designee | Prior to prescribing, administering or directly dispensing pharmacotherapy, unless excused under the situational or supply-day exemptions listed in AS 17.30.200(k) or (u). |

**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.
Remember, if the patient is experiencing severe withdrawal symptoms, they will feel too sick to participate in a three-hour intake session. Withdrawal symptoms should be treated appropriately, which may mean that a patient receives a stabilizing dose of buprenorphine prior to the complete intake. (See the Induction section for more information.)

**Treatment Planning: Monitor Patient Progress**

After the patient has been evaluated, the prescriber will determine the appropriate medication based on information collected from the patient related to his or her history, and based on medical and social factors. A behavioral health clinician can assist with developing a plan for psychosocial treatment. The plan should be the result of shared decision-making with the patient, and may include supportive family or friends if the patient chooses.

To determine the best plan, the prescriber and clinician collaboratively review the following:

- Comorbid medical conditions
- Socioeconomic factors (e.g., transportation, child care, employment/education)
- Medication adherence
- Setting/level of care (e.g., more structure, frequency of visits)

If the prescriber and the clinician do not consider 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 behavioral health treatment, can be developed. One inclusive plan is acceptable for settings that provide both services.

**Medication Treatment Plan**

The following table highlights recommended components to include in the medication treatment plan and provides examples that may be included under each component. Plans should be individualized to meet the needs and goals of the patient.
## MAT Treatment Plan Components

<table>
<thead>
<tr>
<th>Components</th>
<th>Considerations/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>The diagnosis will be made by the prescriber, if possible with the assistance of a behavioral health professional, familiar with the DSM-5 criteria for use disorders; other comorbid diagnoses may exist and also need to be documented and addressed within the context of integrated care. (e.g., opioid use disorder, severity, dependence)</td>
</tr>
<tr>
<td>Goals of Treatment</td>
<td>Abstinence from illicit opioids or substances  &lt;br&gt; Abstinence from use of needles  &lt;br&gt; Treatment completion of hepatitis C infection (if appropriate)</td>
</tr>
<tr>
<td>Treatment Objectives (over a defined period of time)</td>
<td>By X week, MAT drug tests will be negative for illicit opioids</td>
</tr>
<tr>
<td>Medication Plan</td>
<td>Medication prescription (type of medication, dose, and other instructions)  &lt;br&gt; Participate in weekly in-person visits for first four weeks followed by…  &lt;br&gt; Every other week visits with prescriber alternating with nurse care coordinator  &lt;br&gt; Check-in calls once a week</td>
</tr>
<tr>
<td>Counseling Plan</td>
<td>Varies by patient and site  &lt;br&gt; Level of care will be determined by prescriber and behavioral health clinician</td>
</tr>
<tr>
<td>Recovery Support</td>
<td>Peer support activities  &lt;br&gt; Mutual support group meetings</td>
</tr>
<tr>
<td>Consequences for non-adherence to the plan</td>
<td>More frequent visits  &lt;br&gt; Adjust dosage of buprenorphine  &lt;br&gt; Shorter prescriptions  &lt;br&gt; More frequent UDS and med counts  &lt;br&gt; Increased intensity of counseling/peer support services  &lt;br&gt; Refer to higher level of care  &lt;br&gt; Switch to XR injectable MAT</td>
</tr>
</tbody>
</table>
Psychosocial Treatment Plan

- Goals of treatment
- Treatment objectives over a defined period of time
- Frequency and type of treatment (e.g. 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 VI: Sample Treatment Plan Form provides a template that can be used to document patient progress.

In addition to the treatment plan, a treatment agreement can prove to be a helpful tool to clarify treatment goals, identify and reinforce expectations and promote compliance. Additionally, an agreement and informed consent for medication, release of information (Appendix V) for any agencies and other physicians and providers induction to include labs, drug testing at each visit, and querying of the PDMP prior to visit to evaluate adherence are necessary.

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 for the prescribing of opioid medications is provided in Appendix VI: Sample Treatment Plan Form. This agreement can be modified for use in a psychosocial treatment setting.

The length of time that a medication is prescribed for a use disorder is not defined by best practices other than to note that the longer one is treated with medication, the longer the person typically remains abstinent. There are times that the patient and the prescriber will discuss changes to the original regimen. This might be the case when the patient has made changes in his or her life compatible with recovery (avoiding triggers, involvement with healthy activities, etc.). At other times it may be necessary to make changes because the medication is not effective or causing side effects. The prescriber and the clinician can work collaboratively to determine the best way to support the patient and the regimen that will suit the individual.

There are times that family members, friends or others in the person’s sphere exert pressure on the individual based on preconceived notions, opinions and inaccurate understanding of MAT.
Best practice does not support weaning medication once it is started unless reviewed with the prescriber and patients’ team of caregivers and all understand the risk and benefit involved.

**Sample Treatment Timeline**

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Week 0</strong></td>
<td>Intake, Diagnosis, Treatment Plan Development and Patient Expectation Discussion</td>
</tr>
<tr>
<td><strong>Week 1</strong></td>
<td>Induction</td>
</tr>
<tr>
<td><strong>Week 2</strong></td>
<td>Stabilize Patient</td>
</tr>
<tr>
<td><strong>Week 3</strong></td>
<td>Conduct Labs</td>
</tr>
<tr>
<td><strong>Week 4</strong></td>
<td>Review Treatment Plan</td>
</tr>
</tbody>
</table>
| **Week 6** | Review Patient Progress  
Drug testing should show absence of illicit substances.  
If unexpected opioid noted and confirmed, then consider 1) a change in dose of buprenorphine, 2) a change in medication or 3) a higher level of care.  
If other illicit substance found, recommend a higher level of care (e.g., IOP, PHP, residential). It is not recommended to discharge the patient from care nor stop medication altogether.  
Review patient record (includes infectious disease review) and refer for any treatment needed (hepatitis C, further medical work up for comorbid diseases). |
| **12 Weeks** | Review Patient Progress  
If abstinent, change diagnosis to OUD, severe (mild, moderate) in early remission. |
| **Every 2 Weeks** | Check-In Visits  
Schedule 15-minute visits with counselor, recovery coach or care coordinator.  
Schedule 5-15 minutes with prescriber (longer if office does not have counselor, coach or coordinator).  
Document progress on components consistent with treatment plan:  
Patient report of wellness/recovery  
Current living/housing/transportation or other potential barriers to care  
Psychosocial treatment progress  
Mutual help participation  
Medication adherence, side effects |
<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Substance use (opioids, benzodiazepines, alcohol, stimulants, other)</td>
</tr>
<tr>
<td></td>
<td>Other substance use and plan (include nicotine use and readiness to change)</td>
</tr>
<tr>
<td></td>
<td>Primary care follow-up needs (e.g., physical, immunizations)</td>
</tr>
<tr>
<td></td>
<td>Comorbid psychiatric disease</td>
</tr>
<tr>
<td></td>
<td>Comorbid medical issues</td>
</tr>
<tr>
<td></td>
<td>Infectious disease</td>
</tr>
<tr>
<td>Monthly</td>
<td>Conduct Drug Testing</td>
</tr>
<tr>
<td>Twice Per Year</td>
<td>Conduct Random Drug Testing and Film/Pill Count</td>
</tr>
<tr>
<td>At 6 Months</td>
<td>Test for Liver Enzymes</td>
</tr>
<tr>
<td>At 12 Months</td>
<td>Recheck for Infectious Disease</td>
</tr>
</tbody>
</table>

**Induction: How to Start Patients on Buprenorphine**

The goal of the induction phase is to find the dose of buprenorphine that relieves the patient of craving and withdrawal symptoms.

A waivered prescriber is responsible for evaluating and monitoring the patient during the induction phase. The induction phase has been described as an observed event in an office setting, though many experts cite home induction as effective and safe in appropriate cases. Before induction the patient should not have any signs of intoxication or sedation; drug testing needs to correlate with patient self-report. Symptoms of opioid withdrawal need to be documented. This can be evaluated using the Clinical Opiate Withdrawal Scale (COWS) (Appendix IV).

There may be situations in which induction with buprenorphine is conducted even though a patient has been free of opioids for some time and is not in acute opioid withdrawal (for example: post-detox, post-hospitalization, post-incarceration). In these cases, the COWS need not be used to determine timing of dosing.

Some patients may already be taking daily buprenorphine illicitly with no other opioids, as documented by drug test results. Induction may not be necessary in these cases as per the discretion of the prescriber, and the prescriber may move directly to titration and maintenance dosing. The typical starting dose in this situation would be the dose that the patient reports controls their cravings.
How to Choose the Best Method of Induction

Although the original protocols for buprenorphine induction focused on induction in a health care setting,

“Home induction programs began as early as 2003. Cohort studies, observational trials, and reviews found no adverse effects of home induction with appropriate patient education and telephone support. This adds to existing evidence that the 2 approaches are ‘essentially equivalent.’”

In TIP 63, SAMHSA recognized these research findings and advised that,

“...induction can occur in the office or at home. Most clinical trials were conducted with office-based induction, and expert guidance recommends this approach. Office induction has created hurdles for patients and clinicians in scheduling and has curtailed overall provision of buprenorphine ... as office-based induction can be a barrier to treatment initiation. ... home induction is increasingly common. Current evidence supports shared decision making in selecting the best location for buprenorphine transition. Practices should broadly support home induction.”

Health care setting induction requires daily travel to the office, which can be difficult for patients in remote areas who lack transportation. Also, driving is generally discouraged during the induction phase until dosage stabilization, and it can be difficult for patients to find someone to drive them. Office inductions generally require the patient to be re-evaluated every 1-2 hours until stable, which can make scheduling difficult, especially in busy clinics. Several studies indicate that providers' concern about managing the logistics of buprenorphine induction is a barrier to prescribing it.

However, health care setting induction has a number of advantages, especially for the inexperienced prescriber, including:

- Ability to evaluate patient withdrawal symptoms and ensure delay of buprenorphine administration until the COWS is sufficiently high (8-12) to reduce the risk of precipitated withdrawal.
- Ability to administer supportive medication in the event of precipitated withdrawal (i.e. clonidine, Zofran, promethazine, ketorolac). This can be especially reassuring to a patient who is anxious about induction due to prior negative experience with buprenorphine.
- Ability to verify minimally effective dosage of buprenorphine needed to adequately reduce objective withdrawal symptoms. However, although objective withdrawal symptoms may be controlled at lower dosages of buprenorphine (4-8 mg), cravings may not be controlled until the patient reaches higher dosages (12-24 mg).
Health care setting inductions can be an excellent learning opportunity for physicians new to buprenorphine prescribing, and they can provide a supportive environment to patients who are nervous about induction or who are at elevated risk of precipitated withdrawal. Studies have shown that as physicians become more experienced, their patients are about 85% less likely to experience precipitated withdrawal than those of the inexperienced prescribers. As prescribers get clinical practice experience, they likely become more effective in educating patients about proper induction protocols, and become more proficient in evaluating patient risk factors and developing appropriate individualized induction plans that minimize risk of discomfort during induction.

Patients at the highest risk of precipitated withdrawal include those with:

- Recent use of prescribed methadone or those taking long-acting opioids.
- Recent benzodiazepine use.
- No prior experience with buprenorphine.

According to a study that looking at complications that can occur during buprenorphine inductions,

“Most of the patients who experienced precipitated or protracted withdrawal and were not retained in treatment at 30 days dropped out of treatment within the first 3 days.”

So care should be taken when developing an induction plan to offer high risk patients more support and monitoring.

**Inpatient Induction of Buprenorphine for High Risk Populations**

Patients who are at higher risk for induction-related complications and may be better suited to inpatient induction include:

- Those who also need simultaneous withdrawal management for alcohol or benzodiazepines.
- Those transitioning from methadone.
- Those with severe medical comorbidities (such as end-stage organ failure).
- High risk pregnancy greater than 20 WGA.

Contact an addiction medicine specialist to discuss the best care plan for these high-risk populations.

**Understanding Precipitated Withdrawal**

According to the National Alliance of Advocates for Buprenorphine Treatment:

“Precipitated withdrawal can occur when an antagonist, such as naltrexone (Vivitrol), or partial antagonist, such as buprenorphine (Suboxone) is administered to a patient..."
dependent on full agonist opioids. Due to buprenorphine’s high affinity but low intrinsic activity at the mu receptor, the partial antagonist displaces agonist opioids from the mu receptors, without activating the receptor to an equivalent degree, resulting in a net decrease in agonist effect, thus precipitating a withdrawal syndrome.

It is a common misconception that the naloxone in Suboxone initiates precipitated withdrawal. This is false. The naloxone can only initiate precipitated withdrawal if injected into a person tolerant to opioids. Taken sublingually the naloxone has virtually no effect.

How to avoid precipitated withdrawal:
The best way to avoid this condition is through patient education. The patient should be informed, prior to the induction appointment, of what precipitated withdrawal is and how they can avoid it. The patient who understands that under reporting last use puts him/her at high risk for rapid and intense onset of withdrawal syndrome, is more likely to accurately report last use.\(^{25}\)

Health Care Setting Induction of Buprenorphine

Explain to the patient that they must be in mild to moderate withdrawal when they take their first dose of buprenorphine to avoid precipitated withdrawal. Instruct the patient to abstain from taking short acting opioids for 12-24 hours, and long acting opioids for 24-48 hours prior to arrival for induction. Do not give the first dose of buprenorphine until the COWS is at least 8 for short acting opioids and 12 or more for long acting opioids.

1. The typical first dose of buprenorphine is 2/0.5 to 4/1 mg and the sublingual tab/film should be observed to have dissolved completely under the tongue (this can take as long as 15 minutes).
2. Have patient demonstrate proper medication administration:
   a. Tab/film placed under tongue.
   b. No food/drink during administration or for 20 mins afterwards.
   c. Allow saliva to pool in front of mouth.
   d. Spit out saliva once tab/film dissolved.
3. After the first dose, patients will need to wait in the office or waiting room and be checked after 30-60 minutes for adverse effects (i.e., change in mental status, difficulty breathing, hives, sedation) and to repeat the COWS to evaluate symptoms.
4. A repeat dose of 2/0.5-4/1 mg can be used every 1-2 hours if withdrawal symptoms are still present. A total first day dose of buprenorphine/naloxone should not exceed 16/4 mg.
5. After the first day’s induction dose the patient should be contacted and/or observed in office by designated staff.
6. The patient should return to the office daily for the next few days to repeat dosing. Dosing should be based on the experience from induction.
   a. If symptoms were relieved, then the dose should be kept at the total dose used for induction.
   b. If symptoms were not relieved, then buprenorphine can be titrated in increments of 2/0.5-4/1 mg daily. This dose can be increase more rapidly if the patient has severe craving or withdrawal symptoms.

7. Stabilization/maintenance dosing is variable but generally falls between 12-16 mg daily. However some patients require up to 24 mg daily for adequate control of cravings. Although the maximum daily dosage is 32 mg a day, insurance companies generally will not cover doses greater than 24 mg daily as there is little evidence to support higher doses, and the risk of diversion may increase at doses above 24mg. It is important to note that doses below 12 mg may not be as effective at blocking the effect of illicit opioids, so patients with more severe OUD who are at high risk of relapse may be better suited to higher buprenorphine doses.

At-Home Induction

The patient should be given an instruction guide that explains the at-home induction protocol such as the one found on the National Institutes of Health website:

**A Guide for Patients Beginning Buprenorphine Treatment at Home**


The procedure for home induction is essentially the same as the health care setting induction procedure outlined above. A prescriber, nurse or case manager should call or text the patient daily to check on the patient’s progress and symptoms, and if possible, the patient should have access to an after-hours number to call in case of urgent medical questions. The patient should be scheduled to return to the office in a week or less to re-evaluate.

Emergency Department Induction

Emergency departments across the nation have started adopting new protocols to initiate buprenorphine in the emergency room for patients who present with complications of OUD. Federal law allows an ED provider who is not waivered to administer buprenorphine for patient stabilization for up to 72 hours in the ED.

Patients with OUD often access medical care through the ED during times of crisis, such as opioid overdose, opioid withdrawal or injection-related infection. During these periods, patients may be acutely motivated to initiate SUD treatment, and starting buprenorphine in the
ED is shown to double the chance that the patient will be engaged in treatment at 30 days (from 37% to 78%) as compared with referral alone. Patients who are induced in the ED also have only one-third the rate of needing inpatient SUD admission.²⁶

There is an excellent and simple toolkit available online through the California ED-Bridge program, which includes program development guidance, pre-made algorithms, patient instructional handouts and educational materials for physicians.

**ED Bridge**
[https://ed-bridge.org/](https://ed-bridge.org/)

Free online mentoring and technical assistance programs such as the ones below can assist emergency departments with the implementation of new programs that address OUD.

- **American College of Emergency Physicians**

- **Providers Clinical Support System - Mentoring**
  [https://pcssnow.org/mentoring/](https://pcssnow.org/mentoring/)

- **Opioid Response Network – STR-TA**
  [https://opioidresponsenetwork.org/](https://opioidresponsenetwork.org/)

MAT prescribers are encouraged to reach out to their local hospital ED to establish clear policies for referral and follow-up care. If at possible, all referrals from the ED should be followed up within three days (as the ED can only provide 72 hours of buprenorphine administration). After-hours case management or peer support contact can ease the transition from the ED to outpatient care, by providing a “warm handoff” point, and they can stay connected with the patient for the next few days to ensure rapid intake into care. Many patients prefer to text a support number, and should be encouraged to do so from the ED. If peer support workers are available, coming to the hospital to meet with the patient in person prior to discharge can be a great way to build a sense of trust and ensure follow-up care.

**Induction with Extended-Release Injectable Buprenorphine (Sublocade)**

To start a patient on extended-release buprenorphine, the patient must first be stabilized on sublingual buprenorphine for one week at 8 mg or higher, following one of the induction strategies above. The medication must be ordered from a specialty pharmacy and will be shipped directly to the clinic for administration. It may not be in the possession of the patient at any time due to the risk of thromboembolism if injected intravenously.

After at least one week of sublingual buprenorphine, the patient is given the subcutaneous injection in the abdomen, following packaging instructions. Local anesthesia with lidocaine is useful prior to injection to reduce the pain associated with the large 19 g syringe and viscous
medication. Site injection pain, swelling and itching occur in about one in five patients and are managed supportively. Cold packs are preferred to heat as the application of heat to the site will cause increased blood levels of buprenorphine. After injection, the depo is palpable as a firm 3 cm subcutaneous mass, will slowly shrink in size to about 1 cm over the next 4 weeks, and then gradually dissolve completely.

Injection sites are alternated monthly. After injection, the patient will no longer need to take any more sublingual buprenorphine as the blood levels after injection are quite high, similar to levels achieved by 24 mg/day sublingual dosing. Injection is repeated every 4 weeks, the first 2 months being loading doses at 300 mg/month, then 100 mg/month thereafter to maintain levels at a steady state. After the medication levels reach a steady state at 3-4 months, the patient may be able to extend the time between injections for up to 6 weeks without experiencing significant withdrawal symptoms. This flexibility in timing of administration can be well suited to patients that may live in remote areas where travel to appointments can be challenging, or who work in occupations such as fishing or oil field work, when they are away from home for long periods of time.

Management of Precipitated Withdrawal

Precipitated withdrawal is managed with supportive medications as listed below. Benzodiazepines are generally avoided in outpatients as they increase the risk of overdose death if patient relapses to full opioid agonist use.

Supportive medications for opioid withdrawal management:

- Myalgias: NSAIDS and Acetaminophen
- Muscle spasms: Tizanidine
- Nausea: Ondansetron or Promethazine
- Restlessness and sweating: Clonidine
- Anxiety and rhinorrhea: Hydroxyzine
- Insomnia: Trazodone

Supportive care for precipitated withdrawal is generally continued for 4-8 hours for patients transitioning from short-acting opioids, or 24 hours for patients transitioning from long-acting opioids, before further buprenorphine dosing attempts are made.

Induction with Extended-Release Naltrexone (Vivitrol)

The recommended dose of XR-naltrexone is 380 mg delivered intramuscularly every 4 weeks. The injection should be administered by a health care provider as an intramuscular (IM) gluteal injection, alternating buttocks for each subsequent injection. Prior to initiating XR-naltrexone, an opioid-free duration of a minimum of 7–10 days is recommended for patients, to avoid precipitation of opioid withdrawal that may be severe enough to require hospitalization.
Patients who are taking long-acting agonist medications such as methadone or buprenorphine may require 14 days or longer of abstinence before they can receive XR-Naltrexone. This extended period of abstinence can be very difficult for patients to achieve and is most easily accomplished in an inpatient or residential setting.

Prior to the first injection, the patient’s urine should be free of all opioids and the patient should undergo a naloxone challenge test.

**Naloxone (IM) Challenge Procedure**

- Obtain baseline COWS; if 4 or less proceed with the challenge.
- Administer naloxone 0.4 mg (1 cc) IM to deltoid and observe for 20 minutes.
- If no change in COWS, administer additional 0.8 mg (2 cc) to the other deltoid and monitor for additional 20 minutes.
- Test is considered positive if there is a COWS increase of 2 or more from the pre-injection score.
- In case of positive challenge, do not administer XR-naltrexone, wait 1-2 days and repeat the challenge.
- If the test is negative, proceed with the XR-naltrexone injection.

This testing does not need to be repeated prior to subsequent monthly injections unless the patient is 2 weeks late or more for their injection.

The Providers Clinical Support System MAT program offers a concise guide to initiating XR-naltrexone.

**Providers Clinical Support System – XR-Naltrexone: A Step-by-Step Guide**


**Psychosocial Treatment & Recovery Support Services: Identify How Substance Use Disorder Services will be Delivered**

There are three important parts to MAT: medication, SUD treatment and recovery support services, and care coordination. Studies have found that programs providing regular, structured, SUD-focused counseling had better outcomes than programs providing little or no counseling. Additionally, to maintain a buprenorphine waiver, the prescriber must be capable of referring patients for counseling and other ancillary services.

The following table highlights key considerations for ensuring patients receive psychosocial services.
## Delivery of Psychosocial Services

<table>
<thead>
<tr>
<th><strong>On-site</strong></th>
<th><strong>Off-site</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hire a chemical dependency counselor or behavioral health clinician who has training in the treatment of SUDs</td>
<td>Establish strong working relationships or formal agreements with providers offering different levels of treatment and recovery support services</td>
</tr>
<tr>
<td>Identify the type of treatment that will be provided (e.g., individual, group, intensive outpatient counseling)</td>
<td>Review psychosocial treatment expectations and responsibilities with patient</td>
</tr>
<tr>
<td>Identify the psychosocial approaches that will be used (e.g., CBT, MET)</td>
<td>Obtain signed consent form from patient to approve open communication</td>
</tr>
<tr>
<td>Determine the frequency of services</td>
<td>Routinely provide and obtain updates from the external provider to consistently monitor treatment attendance and progress</td>
</tr>
<tr>
<td>Review psychosocial treatment expectations and responsibilities with patient</td>
<td></td>
</tr>
<tr>
<td>Develop and routinely update treatment plan collaboratively with patient</td>
<td></td>
</tr>
<tr>
<td>Refer to recovery support and other ancillary services</td>
<td></td>
</tr>
</tbody>
</table>

Below are the most common treatment options used in conjunction with medication assisted treatment. MAT can be provided during any level of care. Advantages of group counseling over individual counseling include the opportunity for patients to interact and problem solve with their peers.¹²

**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.

**Intensive Outpatient Services**
Structured individual and group alcohol and/or other treatment services and activities that are provided according to an individualized treatment plan. Services for adults are provided at least nine hours per week and services for adolescents are provided at least six hours per week.

The following are additional treatment options available in Alaska:

**Partial Hospitalization Program (PHP)**
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.

Group medical visits have been used in some MAT practices in an effort to provide treatment services more efficiently. 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.

**EXAMPLE:**

**Using 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. This program is designed to be between 18-24 months. Each week patients are required to participate in a group visit which is facilitated by an addiction clinician, be involved with treatment planning, and complete a urine drug test which tests for 12 substances, including buprenorphine. The group structure is based on evidenced-based curriculum as well as some elements taken from 12 step programs. A prescriber is present during the group once a month (every 30 days) to answer and discuss any medical-related questions. Each group consists of no more than twelve 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, discuss 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.

-Information obtained from Groups, Heather Prebish, Clinical Director, on December 7, 2017

Different treatment interventions can be used to initiate behavior change. Some approaches use positive reinforcement while others capitalize on readiness to change. The list below includes examples of the more commonly used treatment interventions:

1. Cognitive behavioral therapy
2. Motivational enhancement therapy
3. Contingency management/motivational incentives
4. Community reinforcement approach
5. Behavioral couples counseling

Regardless of the type of treatment or approach used, several topics are essential including:

1. Education about addiction and the effects of substances
2. Education about relapse prevention strategies to learn skills to attain and maintain recovery
3. Education on opioid-related health issues (e.g., HIV, hepatitis)
4. Providing linkages to existing family support systems
5. Providing referrals to community supports

In addition to treatment services, recovery support services can be made available during any stage of a patient’s recovery. Specifically, peer recovery support services (PRSS) are non-clinical services designed to help people achieve and maintain their recovery provided by people with lived experience of addiction and recovery. Many of these services can be accessed at community-based recovery centers.

**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. 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 required to participate in 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, Florida on October 8, 2015

Drug Testing: Establish Policies and Procedures

Since the inception of medication assisted treatment for opioid addiction, drug testing has provided both an objective measure of treatment efficacy and a tool to monitor patient progress. Analysis of test results provides guidance for OTP accreditation, as well as information for program planning and performance improvement. Drug testing is a tool that uses a biologic sample to detect presence or absence of a specific drug as well as specific metabolites of drugs within a specified window of time. The use of drug testing provides a source of information to complement self-report, collateral reports, and provider assessments.

Drug testing should be considered therapeutic and not punitive and used for treatment planning assistance. In addition, it can be helpful in exploring denial, motivation, and actual substance use behavior. It’s important for a physician or other provider to understand the various testing techniques, their sensitivity and specificity, and cost to the medical system, insurance, and patient. It is strongly recommended that providers use the expertise of toxicologists or local certified medical review officers (MROs) for any questions arising for their patients’ individual situations.

Testing types

Urine is the biological sample that is most widely used, though tests using other samples such as blood, hair, saliva, sweat, and nails (toenails and fingernails) can all be used in different types of laboratory drug testing. However, urine samples are used most often, because they are easier to obtain.

Testing categories

There are two categories of drug testing: definitive and presumptive. Presumptive tests have lower sensitivity and/or specificity compared to definitive testing.
### Definitive and Presumptive Drug Tests

<table>
<thead>
<tr>
<th></th>
<th>Definitive Drug Testing (Quantitative)</th>
<th>Presumptive Drug Testing (Qualitative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test setting</td>
<td>Lab</td>
<td>Point of Care</td>
</tr>
<tr>
<td>Analytical method</td>
<td>Gas or liquid chromatography</td>
<td>Immunoassay</td>
</tr>
<tr>
<td>Purpose</td>
<td>Confirmation</td>
<td>Screening</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Any dispute of results should be definitively evaluated, especially in cases where the result may effect clinical care, legal status, or change in medication</em></td>
</tr>
<tr>
<td>Advantages</td>
<td>Gold standard method but can take more time to obtain results and can cost more</td>
<td>Immediate results at the cost of being less accurate</td>
</tr>
</tbody>
</table>

*For both presumptive and definitive testing it is important to understand the cut off concentrations for the substances to provide the best clinical utility.*

### Specimen Collection

**Setting and approach**

An important part of specimen collection methods is ensuring to protect patient’s dignity and privacy while minimizing opportunities for falsification. The bathrooms used for urine collection should be cleaned frequently and monitored to ensure soap and other toilet articles are available. To build trust and ensure there are no misunderstandings in regards to expectations, collection procedures should be in writing. Patients should be informed during admission and early treatment about how drug-testing specimens are collected and patient’s responsibility to provide specimens when asked. Patients should be given a copy of policies on and procedures for drug testing, including whether and when direct observation is indicated.

When indicated, a patient is sent to the bathroom to provide a urine specimen in a labeled container. Most programs monitor the bathroom to ensure that only one patient uses it at a time and that patients leave parcels outside the bathroom. Once the specimen has been checked to determine it is valid by a staff member, it is packaged and sent to a laboratory for testing. To ensure patient confidentiality, programs should store specimens and related
documents and material so that only authorized personnel can access and read them. For the safety of staff handling specimens, universal safety precautions should be followed.

**Documenting and reporting testing**

The proper reporting of a drug that is prescribed and present in the test is documented as “expected.” A substance that is not prescribed and present is documented as “unexpected.” It would also be unexpected if a prescribed medication is not definitively detected. OTP drug test results should be nearly 100% positive for treatment medication because lower percentages could indicate medication diversion, which requires investigation and a corrective-action plan.

**Recommendations for appropriate use of drug testing in clinical addiction medicine**

The following recommendations are not intended to substitute for independent clinical judgment:

- The frequency of testing should be determined based on patient situation (usually more frequent at beginning of treatment).
- Testing should be based upon clinical indication for a broad panel of drugs; knowledge of local drug use trends can guide the choice of panels.
- Use random drug testing over routine visit testing.
- Use different matrices (samples) depending on the patient situation (i.e., dry mouth, shy bladder, etc.).
- Improved sample collection and detection technologies can reduce sample adulteration and substitution.
- Consider cost to value ratio.
- Consider the medical necessity of test results.

**Recommended resources**

- **Appropriate Use of Drug Testing in Clinical Addiction Medicine**

- **Urine Drug Testing in Clinical Practice**

- **ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine Webinar Series**
  [https://elearning.asam.org/drugtestingwebinars](https://elearning.asam.org/drugtestingwebinars)
Section V: Telemedicine
Section V. Telemedicine  

Currently MAT resources are inadequate and misallocated across the state and as a result, many people suffering from opioid addiction have no access to an authorized MAT provider due to geographic or other barriers. Strategy 5.5 of Alaska’s Statewide Opioid Action Plan is to expand MAT options so that each community has access and options to the various medications used to treat opioid use disorder. That’s where telemedicine comes in, because it can remove time and distance barriers to get help quickly to the thousands of people who need it. With the use of telehealth technologies, providers in rural settings can receive assistance in providing the gold standard for opioid abuse treatment, medication assisted treatment.

Numerous studies published over the last decade have confirmed that MAT is an effective treatment for individuals with opioid addiction.28-30 Most recently, a study published in the Journal of Addiction Medicine in April 2017 concluded that MAT provided via telemedicine modalities is equally as effective as face-to-face MAT treatment for individuals diagnosed with opioid use disorder, as measured by additional substance use, average time to abstinence, and treatment retention rates. Telemedicine directed group visits for MAT monitoring and behavioral health support have also been shown to be effective.

Sample of Telemedicine Infrastructure at Tribal Health Systems in Alaska

There is already a well-established telemedicine system in Alaska through the Alaska Native health care system. Nearly every Alaska Native village health clinic has telemedicine equipment (such as AFHCAN carts) that can connect via secure video conferencing software (currently using Vidyo) to any other Alaska Native clinic or hospital in the state. The Vidyo system can also be used with laptops, tablets and smartphones.

Typically, a patient in need of MAT for OUD would be referred from a local village medical or behavioral health provider to the distant waivered prescriber. The patient should be asked to sign bi-directional release of information forms (ROI), including information about substance use, so that the prescribing provider can share information with the referring clinic. If possible, that patient should travel to the prescriber’s clinic so that the first visit can be face-to-face, and the prescriber and patient can have the opportunity to get to know each other in person and perform any physical examination that may be needed. (If an in-person visit is not possible, see the subsection below on prescribing without an initial in-person visit). If health care setting induction is planned, the patient may need to stay in town for a few days to stabilize on medication before returning home. If the prescriber works for the Alaska Native health care system, they can order MAT medications to be mailed to the patient’s home or village clinic from the Alaska Native Medical Center (ANMC) pharmacy.
Follow-up visits may then be conducted via telemedicine. At the scheduled appointment time, the patient would check into their local village clinic, and the local provider, medical assistant or community health aide/practitioner (CHAP) would collect vital signs, collect urine for drug screening and other labs as indicated, and perform medication counts. (A licensed provider is not required to be physically present with the patient at this follow-up visit). The patient would then be connected via Vidyo to the MAT provider at the distant site, and they would have a routine follow-up visit. After the telemedicine visit is finished, the MAT prescriber would communicate with the local provider regarding the follow-up care plan and send a copy of the visit note to the village clinic if the patient has authorized this release. The prescription is then typically sent to the pharmacy, to be mailed out to the patient.

It’s useful to have a memorandum of agreement (MOA) in place between the remote and prescribing clinics, so that each knows its role and responsibilities. These MOAs may include details on frequency of visits, random urine drug screen, and medicine counts. It can be helpful for MAT prescribers to meet initially with the staff of the remote clinics to provide them with some basic education about OUD and MAT.

ANMC recently added monthly injectable buprenorphine (Sublocade) to its formulary, however they are still in the process of developing policies, procedures and staff training on the use in remote clinics. Sublingual buprenorphine is already available through ANMC pharmacies.

**Medicaid Coverage of Telemedicine Services in Alaska**

In order to provide care for a patient in Alaska (including reading and interpreting films, samples, or images, or otherwise diagnosing, treating, or rendering an opinion), a physician must hold a current, active license issued by the Alaska State Medical Board. This requirement also applies to second opinions if the physician is charging a fee for providing the opinion. The only exception is for a “curbside” opinion given as a courtesy to a colleague (a licensed physician) for which there is no charge.

Information that must to be included in the visit note when documenting a telemedicine visit:

**Distant site** (patient not at the clinic)

1. Statement that the service was provided using telemedicine
2. Physical location of the patient
3. Location of the provider
4. Names of all persons participating in the telemedicine service and their role in the encounter
5. Documentation must meet current procedural terminology (CPT) guidelines
Patient site (patient in the clinic)

1. Date of Service
2. Name of patient
3. Name of distant site provider
4. Name of the patient-site presenter
5. Documentation must meet CPT guidelines

Medicare Telemedicine Billing Information


Alaska Telemedicine Business Registry

Before providing telemedicine services to a patient located in Alaska, a business providing telemedicine services must register on the telemedicine business registry.

Telemedicine Business Registry

www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/TelemedicineBusinessRegistry.aspx

Prescribing Buprenorphine without an Initial In-person Visit

On May 15, 2018, the U.S. Drug Enforcement Agency issued the “Use of Telemedicine While Providing Medication Assisted Treatment” statement to clarify how practitioners can use telemedicine as a tool to expand buprenorphine treatment for opioid use disorder under current DEA regulations.

According to the DEA’s statement, pursuant to the provisions of the Ryan Haight Act of 2008, DEA-registered practitioners acting within the United States, which include DATA 2000-waivered practitioners, are exempt from the in-person medical evaluation requirement as a prerequisite to prescribing or otherwise dispensing controlled substances via the internet if the practitioner is engaged in the “practice of telemedicine” as defined under 21 U.S.C. § 802(54).

The practice of telemedicine entails, among other things:

“The practice of medicine in accordance with applicable Federal and State laws by a practitioner (other than a pharmacist) who is at a location remote from the patient and is communicating with the patient, or health care professional who is treating the patient, using a telecommunications system referred to in section 1395m(m) of Title 42,” and in practices with certain features identified in 21 U.S.C. § 802(54).

Practitioners should familiarize themselves with all aspects of the “practice of telemedicine” definition provided in 21 U.S.C. § 802(54).1.
Practitioners may render a diagnosis, provide treatment, or prescribe, dispense, or administer a prescription drug, without first conducting a physical exam, however:

- The treating physician must be licensed by the Alaska State Medical Board.
- The treating physician, another licensed health care provider, or a physician in the treating physician’s group practice, must be available to provide follow-up care.
- The treating physician must request that the patient consent to sending a copy of the records to the patient’s primary care provider (if the treating physician is not the primary care provider).
- A physically separated physician may prescribe, dispense, or administer a controlled drug only if an appropriate licensed health care provider is physically present with the patient. (See example below.)
- The treating physician must practice in accordance with all relevant laws and practice standards, including compliance with:
  - American Medical Association (AMA) guiding principles for telemedicine practice, published in the AMA Council on Medical Service Reports, Coverage of and Payment for Telemedicine (adopted June 2014); and
  - Federation of State Medical Boards (FSMB) Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (adopted April 2014).

A physician **may not prescribe, dispense, or administer**:

- A prescription drug in response to an internet questionnaire or electronic mail message to a person with whom the physician does not have a prior physician-patient relationship; or
- An abortion-inducing drug, unless the physician complies with Alaska Statute (AS) 18.16.010.
Physician assistant

A physician assistant may (subject to their collaborative plan) prescribe, dispense, or furnish a prescription medication to a person without first conducting a physical examination, only if there is an established patient-physician assistant relationship; except:

- For use in emergency treatment
- For expedited partner therapy for sexually transmitted diseases; or
- In response to an infectious disease investigation, public health emergency, infectious disease outbreak, or act of bioterrorism.

A patient-physician assistant relationship is established when there is an in-person physical examination of the patient by the physician assistant, or by the collaborating physician, or by another physician or physician assistant in the same group practice, and the patient record is available to the treating physician assistant.

**EXAMPLE:**

**Clinical case scenario for prescribing buprenorphine to a new patient without conducting an in-person visit**

The following case scenario was developed to provide clinicians with an example of a clinical practice engagement consistent with the DEA statement and applicable DHSS administered authorities.

1. A patient is being seen in a rural health clinic staffed by a nurse practitioner licensed in the state and has a DEA registration consistent with the nurse practitioner’s scope of practice.
2. The nurse practitioner conducts an examination of the patient and determines that treatment with buprenorphine for opioid addiction is clinically indicated, and the patient agrees to treatment.
3. The nurse practitioner does not have a DATA 2000 waiver to prescribe buprenorphine for the treatment of opioid addiction, but the clinic has an agreement with an addiction specialist in a large city in the same state (or in another state so long as the remote addiction specialist is also registered with the DEA and licensed in the state where the patient is located) to provide remote telemedicine services for addiction treatment.
4. The remote addiction specialist has a DATA 2000 waiver to prescribe buprenorphine for the treatment of opioid addiction and is licensed and DEA-registered in the state where the rural health clinic is located.
5. At the patient visit, the nurse practitioner connects the patient to the remote addiction specialist via an appropriately safeguarded interactive telecommunications system.
6. The addiction specialist, after engaging with the patient remotely concurs with the nurse practitioner that buprenorphine is clinically indicated for this patient and issues a prescription for a specific formulation and dosage of a buprenorphine product to be filled at the patient’s local pharmacy.

7. After the initial encounter, the patient continues to have his/her buprenorphine treatment managed by the remote DATA 2000-waived practitioner (who remains the buprenorphine prescriber of record) in collaboration with the local nurse practitioner.

8. The patient will be considered a patient of the DATA 2000-waived practitioner for purposes of 21 U.S.C. § 823(g)(2), and 42 C.F.R. Part 8, Subpart F when applicable.

Note that different payers – including commercial payers, Medicare and Medicaid – may have different requirements in order for a practitioner to be reimbursed for telehealth services. Providers should become familiar with current billing rules to ensure all federal, state and plan requirements are met.
Section VI: Special Populations
Pregnancy

All pregnant women should be screened for opioid use disorder at part of comprehensive obstetrical care. All pregnant women with OUD should be offered MAT with either methadone or buprenorphine. Medically supervised withdrawal is not generally recommended in pregnancy due to high risk of relapse (50-90%). Relapse poses great risks to both mother and baby, including overdose, infectious disease exposure, lack of prenatal care, and pregnancy complications such as preterm birth. Naltrexone is not approved for use in pregnancy.

Naloxone is still recommended for use in pregnancy women to reverse life threatening opioid overdose. All pregnant women with OUD should be given overdose response training and a naloxone kit.

An excellent guide by U.S. Substance Abuse and Mental Health Services Administration for MAT in pregnancy is available online:

**Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants**

MAT with opioid agonist treatment has multiple benefits in pregnancy, including reduced overdose risk, improved engagement in prenatal care, access to SUD counseling and social services, and reduced risk of obstetrical complications. Although methadone is traditionally the first line treatment in OUD in pregnancy, buprenorphine is becoming much more widely used as it is more widely available and studies have shown that neonatal withdrawal syndrome is less severe and less likely to need treatment in babies exposed to buprenorphine. Plain buprenorphine (Subutex) is preferred in pregnancy, rather than the combination buprenorphine/naloxone (Suboxone) product. The reason for this choice is that there is a risk of precipitated withdrawal if the mother were to inject the combo product. No ill effects have been noted in mothers that do take the buprenorphine/naloxone combination product as directed and research is ongoing to determine if it’s safe for use in pregnancy.

Most pregnant women can be induced on buprenorphine as an outpatient, however inpatient induction with fetal monitoring may be indicated in pregnancy over 20 weeks gestational age when the risk of precipitated withdrawal is higher (such as when the mother is transitioning from a long acting opioid). Methadone induction does not carry the risk of precipitated withdrawal and so outpatient induction at the OTP is standard.

Neonatal abstinence syndrome (NAS) is a treatable condition that may result from maternal opioid use and occurs in about 30-80% of exposed infants during the first two weeks of life.
Newer protocols in many hospitals – such as the Neonatal Abstinence Evaluation Support Treatment, or NEST, program at Alaska Regional Hospital – have had good results in reducing NAS symptoms by encouraging rooming in and bonding with the mother. Mothers should be encouraged to tour the hospital before birth to learn about what to expect for their baby’s care.

Breastfeeding should be encouraged in women taking methadone or buprenorphine as long as they are abstinent from illicit drugs. Long term outcomes are good and most studies have shown no statistical difference in development to age five in babies exposed to methadone.

The American College of Obstetricians and Gynecologists and the American Society of Addiction Medicine provide important guidance on opioid use disorder in pregnancy in the following document online:

**Opioid Use and Opioid Use Disorder in Pregnancy**

[www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co711.pdf](www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co711.pdf)

**Youth**

The rate of drug overdose deaths involving heroin among adolescents aged 15–19 increased during the 1999–2015 period and was three times higher in 2015 (1.0 per 100,000) than in 1999 (CDC), however only 2.4% of adolescents treated for heroin use received MAT, compared to 26.3% of adults treated.31

“There tends to be a perception among patients, families, and clinicians alike that medications should be used as a last resort. That we should wait until things get worse is a discarded approach. As addiction specialists, it is imperative that we prevent and identify risky use and use disorders, then intervene early and offer timely, evidence-based treatment. We suggest that adolescents deserve special attention and that specific efforts should be made to reduce the stigma associated with treating adolescents with opioid use disorder with medications to optimize those efforts.”32

The American Academy of Pediatrics has made the following policy recommendations regarding MAT use in adolescents:33

_Methadone maintenance programs require their participants to be at least 18 years old and to be physically dependent on opiates for at least one year. Teenagers who are younger than 18 years of age may be admitted to methadone maintenance programs if they have current physical dependence and have had two previous attempts at detoxification or drug-free substance use disorder treatment. Consent of a designated responsible adult, such as a parent or guardian, is required._
Buprenorphine is approved for use in youth age 16 and older. However, studies in adolescents are limited. In one randomized trial, adolescents who received buprenorphine had significantly higher retention in treatment and that maintenance therapy was associated with a 63% lower dropout rate (95% CI 0.25-0.54) and a 27% reduction in reported heroin use (95% CI 0.57-0.95) versus detoxification. Due to reduced medication compliance seen in adolescents, monthly injectable buprenorphine may result in better adherence.

Naltrexone is approved for use in patients 18 and older, however a prescriber may choose to use it off label for an adolescent if it is the best available treatment option. Unlike opioid agonists, naltrexone has a very limited potential for misuse or diversion. The extended-release formulation may reduce patient adherence burden. Although there is not yet rigorous research support for efficacy in adolescents, growing experience and anecdotal reports support it as a promising practice. Naltrexone, which also reduces alcohol cravings, may be a good therapeutic option for adolescents and young adults with co-occurring alcohol use disorder, as well as those living in unstable or unsupervised housing. Naltrexone may be the medication of choice in youth who have less than one year of opioid dependence.

MAT compliance is associated with an increase in treatment retention and can help adolescents achieve long-term sobriety. In general, youth have lower rates of treatment retention compared with adults, underscoring the need to deliver developmentally appropriate treatment to achieve best outcomes. The prevention of relapse after detoxification for opioid use disorder requires proper aftercare in a comprehensive, long-term program. Long-term addiction treatment options for adolescent opioid users include residence in a drug-free community, outpatient day programs, and methadone maintenance programs.

Alaska Department of Health and Social Services maintains a statewide bed availability list for residential treatment options:

Substance Use Disorder Residential Treatment
http://bedcount.dhss.alaska.gov/BedCount/statewide.aspx?ProgramType=SRT

Criminal Justice

The United States has the highest rate of incarceration in the world (937 per 100,000 adults). Approximately one-third of heroin users pass through correctional facilities annually. Few receive MAT for opioid use disorder during incarceration, consequently, continued drug use is common among prisoners, and many individuals initiate intravenous drug use while in prison.

In addition to not initiating treatment for those who need it, most correctional facilities forcibly withdraw stable patients from opioid agonist therapy upon entry into the criminal
Justice system. This approach has been shown to decrease community treatment entry. It also functions to detract people with a history of incarceration from engaging in treatment due to fear of subsequent forced withdrawal.\textsuperscript{34}

Even when inmates maintain abstinence from opioids during incarceration, because opioid use disorder is a chronic relapsing illness, nearly three-quarters relapse to heroin use within three months of release and with simple referral to MAT upon release, as few as 8% enter treatment. Rates of opioid overdose-related deaths are tragically high following release, with the rate of overdose death rising to a staggering 1,700 per 100,000 patient years the first week after release.

Medication assisted treatment is rarely offered in prison systems. Randomized controlled trials and observational studies have demonstrated that starting methadone or buprenorphine prior to release improves entrance into and retention within addiction treatment and reduces opioid abuse following release.\textsuperscript{35}

MAT use during incarceration reduces the hazard of all-cause death during the first four weeks of incarceration by 94% lower and being on MAT in the four weeks post-release reduced the hazard of death by 75%.\textsuperscript{36}

Studies have shown MAT to reduce criminal activity by up to 80%.\textsuperscript{37}

ASAM national practice guidelines recommends all incarcerated individuals be offered MAT during their incarceration and that pharmacotherapy should be initiated at least one month prior to release. The President’s Commission on Combating Drug Addiction and the Opioid Crisis released a report in 2017 recommending that the U.S. Justice Department increase the use of MAT in prisons.\textsuperscript{38} The panel noted that multiple studies have shown that inmates who received treatment had lower recidivism rates than those who did not. The panel also called for drug courts in each of the 93 federal judicial districts to help direct offenders into treatment as an alternative to incarceration.

The Alaska Opioid Policy Task Force report from 2017 recommended state and federal authorities work together to expand access to drug courts and therapeutic justice alternatives.\textsuperscript{39} Drug courts and therapeutic justice programs reduce recidivism by connecting criminal defendants to appropriate substance use disorder treatment, as well as social supports, in a structured environment of accountability. Increased access to drug courts will contribute to increased utilization of substance use disorder treatment by justice-involved individuals and reduced recidivism for drug-related offenses (and related crimes).

Whenever possible, incarcerated individuals should be connected with MAT and SUD behavioral health care prior to release. Practitioners should contact their local re-entry coalition and drug courts to develop partnerships with them and encourage referral to MAT treatment for all eligible patients. Peer support workers can work with inmates to assist patients in
scheduling MAT intake appointments for the day of release and ensuring patients have transportation to these appointments. Obtaining a release of information (ROI) with the patient’s parole or probation officer can be useful in maintaining open communication on a patient’s progress in treatment and can improve patient accountability.

Extended release forms of buprenorphine (Sublocade) and naltrexone (Vivitrol), may have multiple advantages in patients dealing with the criminal justice system. When SUD treatment is court mandated, monthly injectable MAT allows easy documentation of patient compliance, and avoids any concern about medication diversion. Also, if a patient returns to incarceration in the future, XR buprenorphine will provide long lasting opioid agonist effect, even beyond the one-month timeframe, which can reduce the risk or severity of withdrawal symptoms and relapse to illicit use while incarcerated.
Section VII: Harm Reduction
Principles of Harm Reduction

The Harm Reduction Coalition (HRC) defines harm reduction as a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users “where they’re at,” addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

However, HRC considers the following principles central to harm reduction practice:

- Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being – not necessarily cessation of all drug use – as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.
Naloxone for Overdose Prevention

Relapse to opioid use is common in opioid use disorder and should be expected and planned for. Over 90% of patients with OUD who attempt to stay abstinent with behavioral therapy alone will relapse to use before the end of the first year. The use of MAT cuts relapse rates in half, to about 40%.40

Patients who have been abstinent from opioid agonists for an extended period are at particular risk for overdose death if relapse occurs. Tolerance to the respiratory depressive effects of opioids is lost quickly, after only a few weeks of abstinence. When patients return to use at the same dosages they were accustomed to prior to abstinence, they may suffer fatal respiratory depression. This is especially common in the era of fentanyl contamination of illicit drugs.

A cohort study of prisoners released from the Washington State Department of Corrections (WA DOC) between 1999 and 2009 examined the risk of overdose death in the two months after release from incarceration.41 Overdose was the leading cause of death at 167 per 100,000 person-years (10 times the standard mortality ratio). In fact, the first week after release from residential treatment or incarceration is the most dangerous, with the rate of overdose death rising to a staggering 1,700 per 100,000 patient years.

As relapses happen at unexpected times, it is critical to educate all patients to recognize and respond to overdose. All patients who come for an intake appointment for MAT should be provided naloxone training with a free nasal naloxone kit or prescription to fill at a local pharmacy. Additionally, this training should also be provided in the emergency department, inpatient and criminal justice settings.

The State of Alaska offers free naloxone rescue kits, through Project HOPE, to all patients at risk of experiencing or witnessing an overdose. Narcan nasal spray kits can be obtained by patients and family through public health offices free of charge.42

Additionally, clinics and providers can sign up to be an overdose response program (ORP) and order free Narcan nasal spray kits and educational materials through Project HOPE. These materials can be distributed free to patients, friends and family who are at risk of witnessing an overdose. As of September 2018, over 15,000 naloxone kits had been distributed by Project HOPE and preliminary data suggest a possible reduction in the number of overdose deaths in Alaska, with nearly 50% fewer deaths seen during the first six months of 2017.43

Narcan nasal spray is covered by Alaska Medicaid, Veterans Affairs, most Medicare part D plans and most private insurances. A prescription can be written for the patient to pick up a Narcan kit at the local pharmacy. Additionally, Narcan may be purchased without a prescription at the pharmacy after a brief consultation and training with the pharmacist, although the average cost (approximately $150) may be out of the reach of many patients.
EXAMPLE:

Writing a prescription for Narcan nasal spray

Narcan Nasal Spray 4mg/0.1ml
Sig: Spray one dose in nostril and Call 911
If no response in 2-3 minutes, repeat with second dose
Disp: 1 kit (contains 2 prefilled nasal atomizers)
Refill PRN

All patients who seek enrollment into a MAT program should be offered nasal naloxone prescription and overdose response training, ideally on the first visit. Ask the local pharmacist to require the patient to pick up the naloxone kit with their MAT prescription. Verify that they have a policy in place to waive the co-pay if the patient can’t afford it. If possible, partner with Project HOPE to have kits on hand to give out for free at the first visit.

Even patients who are stable on MAT may still be at risk for witnessing overdose in friends or family who are still actively using and may find themselves in a unique position to respond and save a life.

A study performed in New Mexico showed that:

...in a 3-month span, 12.7% of patients undergoing medication-assisted treatment (MAT) for opioid use disorder who were given take-home naloxone kits went on to use the opioid blocker on friends and others in the midst of an overdose. Among the group of 244 high-risk patients, 31 reported using the naloxone kits to successfully reverse 38 overdoses in their community.44

Community naloxone administration has been proven a safe and cost-effective way to reduce overdose mortality.45 Naloxone training and distribution does not encourage drug use and has actually been shown to reduce risk taking behavior in high risk patients. Additionally, emergence phenomena (agitation upon waking) is rarely seen with nasal naloxone, making it well suited for use outside of the hospital setting.

An easy way to train patients to use naloxone is to have them watch a video or go over a simple handout with them. It takes less than five minutes to train someone to safely use naloxone.

Patient Instructional Handout: Narcan Nasal Spray Quick Start Guide
www.in.gov/isdh/files/34_NARCAN-Quick-Start-Guide.pdf

Instructional video for patients and family: Narcan Nasal Spray 4mg Instructions for Use
https://vimeo.com/151191919
**Syringe Access**

The Alaska Native Tribal Health Consortium has a pilot harm reduction program that distributes safety kits to Alaska Native patients, which include clean injection supplies, condoms, STD testing information and needle disposal systems. Contact them to ask about enrollment in this program:

**I Know Mine**

[www.iknowmine.org/contact-us](http://www.iknowmine.org/contact-us)

In some situations, pharmacies can be an alternative access point to obtain clean injection supplies when syringe access programs are unavailable.

Many argue that pharmacies are an important but under-used resource in preventing the transmission of HIV and other blood-borne infections among people who inject drugs. Pharmacists are some of the most accessible health care professionals and are in an ideal position to reach this group who are often socially marginalized and wish to remain anonymous.46

By Alaska state law, a prescription is required to purchase syringes at a pharmacy (including through mail order), however, a pharmacist may dispense syringes at their discretion without a prescription. Unfortunately, some pharmacies require patients to sign a log book and this lack of anonymity can discourage use. Pharmacies that do sell syringes may limit the number a patient can purchase and patients living in remote areas may not have access to a pharmacy. If you have a pharmacist in your area, talk with them about allowing patients to purchase syringes anonymously there.

The North Carolina Harm Reduction Coalition notes there are important public health considerations for non-prescription syringe sales:

*The risk of negative impacts for nonprescription syringe sales on pharmacies and pharmacists are likewise very low. A national search of reported cases found no instance in which a pharmacist had been prosecuted under a paraphernalia law or pharmacy regulation for selling a syringe that was later used to inject drugs. Additionally, scientific studies from other states have demonstrated that the proportion of improperly discarded syringes at or around pharmacies did not increase after the nonprescription sale of syringes from pharmacies was legalized.*

*The unrestricted sale of syringes is supported by the American Pharmacists Association, whose statement reads: ‘APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of sterile syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases.’ Likewise, a recent study of 146 pharmacies and staff*
reported that 87% of participating pharmacists support the unrestricted sale of syringes as a disease reduction method.47

A prescriber may choose to write a prescription for syringes that the patient can pay cash for by ordering from an online medical supply store, thus potentially allowing patients to access affordable syringes in the quantity they need, while remaining anonymous.

EXAMPLE:
Writing a prescription for syringes

Diabetic syringes
29g, 1/2in or 31g, 5/16in - AKA “shorts” (ask patient which they prefer)
½ or 1 cc (ask patient which they prefer, ½ cc is more common)
Dispense #___ boxes of 100 syringes
Refill PRN

A provider may also choose to purchase syringes in bulk to distribute to patients in need at their clinic. The cost of syringes purchased through a nonprofit buyers club can be significantly lower than retail, as little as $35 per case of 500.

North America Syringe Exchange Network (NASEN)
Offers start-up kits and grants
www.nasen.org/operators

Guide to Establishing Syringe Services Programs in Rural, At-Risk Areas
Learn more about starting a rural syringe access program

Syringe Disposal

It is important to know the resources in your community to safely dispose of used sharps.

Found a syringe? How to safely dispose of used needles

Also, ask the environmental services department of your local hospital or clinic if they accept patient sharps for disposal, and what their hours and policies are. Some locations may only accept drop-off on a certain day of the month and sometimes will only accept sharps that are in certain containers. Providing patients with small inexpensive one-quart sharps containers can help encourage proper disposal.

However, disposing of used sharps should not be a requirement for patients to access clean equipment. One-for-one exchange is no longer recommended best practice according to most syringe access program guidelines as noted by the BETA Blog:
Allowing clients to choose the number of needles they receive—syringe “access” as opposed to one-for-one “exchange”—has been found to be the most effective to prevent infections and the best way for people who inject to protect their own health.

“Distribution approaches to syringe exchanges have a larger impact on reducing syringe sharing and unsafe injection practices than one-for-one exchanges, and do not result in increased unsafe discard of syringes,” said Robert Heimer, PhD, a professor of epidemiology and pharmacology and director of emerging infections program at Yale School of Public Health. “This is the policy that works best.”

The distribution model is, as Heimer described, a ‘how many do you need?’ way of distributing syringes. “If someone says they need a case [of syringes], you give them a case,” he explained. One-for-one syringe exchanges are much stricter: People can get new syringes, but only to replace the exact number that are returned. Often, one-for-one exchanges also have a cap on the number of syringes that can be accessed at one time.

“If you don’t want people sharing equipment, you have to give people adequate supplies so that they never have to share,” said Terry Morris, director of the San Francisco AIDS Foundation 6th Street Harm Reduction Center. 48

MAT as a Form of Harm Reduction in Patients with Severe Polysubstance Use Disorders

Medication assisted treatment is one of the most commonly used and effective forms of harm reduction. MAT is effective in reducing many of the harms that are associated with illicit opioid use, including overdose death, criminal activity and the spread of infectious disease. MAT can be an effective form of harm reductions even in patients with severe OUD who struggle with engagement in treatment. For example, many patients who use heroin also use methamphetamines and/or benzodiazepines. A patient who has a comorbid methamphetamine and opioid use disorder may be successful in reducing their use of opioids by taking methadone, buprenorphine or naltrexone, however they may continue to inject other drugs. Buprenorphine and naltrexone both act as opioid blocking agents, helping to protect the patient from overdose if they do inject an opioid. This is especially true for patients that use central nervous system (CNS) depressants such as alcohol or benzodiazepines with opioids, which can be a particularly deadly combination. The combination of buprenorphine with a CNS depressant carries some risk of overdose but is vastly safer in terms of respiratory depression risk than a full opioid agonist.
Of particular note is a special U.S. Food and Drug Administration Safety Communication issued in September 2017:

*Based on our additional review, the U.S. Food and Drug Administration (FDA) is advising that the opioid addiction medications buprenorphine and methadone should not be withheld from patients taking benzodiazepines or other drugs that depress the central nervous system (CNS). The combined use of these drugs increases the risk of serious side effects; however, the harm caused by untreated opioid addiction can outweigh these risks. Careful medication management by health care professionals can reduce these risks. We are requiring this information to be added to the buprenorphine and methadone drug labels along with detailed recommendations for minimizing the use of medication-assisted treatment (MAT) drugs and benzodiazepines together.*

MAT can help to keep a patient alive and engaged in treatment so that they can access a higher level of care when they are ready to do so. The American Society of Addiction Medicine no longer recommends discontinuing MAT simply for the use of other substances:

*The American Society of Addiction Medicine advises that use of other substances should not result in suspension of OUD treatment. Providing MAT for OUD is often a critical point of entry into ongoing health care and provides an opportunity to reduce harms associated with polysubstance use. Opioids are often the most hazardous substance patients use, and helping patients remain in treatment reduces their risk for harm. When non-opioid substance use occurs, practices should focus on treating it rather than punitively discontinuing buprenorphine care... Buprenorphine does not have a direct effect on other substance use, and this use should generally not influence care for OUD... Polysubstance use is common: Nearly one third of U.S. residents who received substance abuse treatment in 2013 reported treatment for both alcohol and drugs... Although inadequate MAT dosing has been related to increased polysubstance use, expecting OUD treatment to affect other substance use is unreasonable. As a comparison, patients not meeting type 2 diabetes goals would not have their asthma inhalers discontinued. Similarly, other substance use should not affect the decision whether to continue effective OUD care. Substance use disorders involving cocaine, alcohol, methamphetamine, and opioids can result in similar psychosocial penalties (such as job loss) and physical consequences (including death) but are very different diseases and require specific clinical approaches. Patients can succeed with MAT in the presence of other substance use. In a study comparing patients who did and did not use cocaine, those entering buprenorphine treatment who reported concomitant use at baseline (nearly 40%) had similar retention and reduction in opioid use.*

Another concern in patients who use other substances with buprenorphine is that they are at risk for diversion of a portion of their buprenorphine to obtain another drug, and may struggle with daily medication compliance. Additionally, patients with housing insecurity may not have
a safe place to store a large amount of medications safely and may be a target for theft of their prescription.

When compliance and diversion are concerns, then the patient should be offered a higher level of outpatient support, which may include:

- More frequent office visits
- More frequent phone and text check-ins
- Increased access to behavioral health support and peer support
- Shorter prescriptions (prescribing 3-7 days at a time)
- More frequent medications counts
- Switch to an extended release injectable medication like monthly subcutaneous buprenorphine (Sublocade)

Patients should be regularly offered referral and placement in a higher level of care (IOP, residential, OTP, inpatient withdrawal management), but refusal to engage in these services should not disqualify them from receiving outpatient MAT services.

Low Threshold Care

Making addiction treatment accessible to the patients when and where they need it is essential when trying to engage patients with the most severe OUD into treatment. Low-threshold programs are programs that make minimal demands on the patient, offering services without attempting to control their intake of drugs and providing counseling only if requested.

For example, many patients with severe opioid use disorder do not have a primary care physician and may only seek medical care in the emergency room during times of crisis. During these times a patient may be particularly motivated for change and making treatment services immediately available is key to engaging these patients. Studies have shown that starting buprenorphine in the emergency department with a “warm hand-off” to a peer support worker or case a manager, doubles the chance that a patient will remain in treatment for two months compared to referral alone. Many states have initiated ED-Bridge programs to train providers to treat addiction in the ED, and ready-made protocols are available online to help expand these programs nationwide. To be successful the ED must partner with a local provider who is willing and able to take new patients into care quickly. At Massachusetts General Hospital, they have a walk-in outpatient clinic that allows patients to come in for services when they are ready.

Our Bridge Clinic quickly expanded to be a low-threshold, treatment on demand, come as you are clinic where the primary goal is to welcome people and connect with them and build a relationship. That might be a cup of coffee or a conversation, or it might be starting buprenorphine that day. -Sarah Wakeman MD, Mass General
ED-Bridge: Emergency Buprenorphine Treatment
https://ed-bridge.org

Active Users Peer Support Groups

The authors of a case study and evaluation framework in British Columbia, Canada note:

‘Peers’ in the context of harm reduction are ‘people with lived experience of drug use work both behind the scenes and at the forefront of needle distribution services, harm reduction education, peer support, and community-based research initiatives,’ providing valuable insights about the barriers and facilitators to accessing harm reduction services in their communities. Peer roles can be considered across multiple dimensions, including political advocacy, research assistance, program governance, peer support, and harm reduction messaging.

Peer engagement has been defined as a community-based approach to decision making by ‘consulting and collaborating with decision makers using a bottom-up approach in order to better address the needs of the community.’

No one knows better what the needs of active drug users are than themselves. The excellent Canadian publication, Nothing About Us Without Us, makes the case for incorporating patient input into addiction care planning. Engaging active users in focus groups and support groups can be an effective way to provide a safe space for patients to access treatment and harm reduction information and allows patients to share their insight into what their biggest needs and barriers are. Offering incentives for attending groups such as a free meal, access to clean injection equipment, or the use of wireless services can encourage participants to come. Facilitators and group participants can include peers in recovery, behavioral health workers and medical personnel that can help answer questions about treatment and prevention. This can also be an excellent opportunity for patients to develop a sense of trust in the medical community by being able to interact with providers in a non-judgmental environment.

Pre-exposure Prophylaxis

Syringe access programs and peer support groups can also be opportunities for active intravenous drug users (IVDU) to access information and referral to medical care to prevent HIV and hepatitis.

Recent large-scale PrEP trials have shown PrEP to be safe, well tolerated, and highly efficacious in reducing the risk of HIV acquisition in individuals at increased risk for infection. Based on these trials, the Centers for Disease Control and Prevention (CDC) made recommendations and provided clinical practice guidelines on the use of PrEP for HIV prevention among most-at-risk populations, including PWUD.
People who inject drugs should be offered access to hepatitis vaccination and PrEP to reduce the spread of viral disease.

**Hepatitis C Treatment in Active IVDU**

Active drug use is no longer a contraindication to initiating hepatitis C treatment.

*Although guidelines recommend HCV treatment for drug users, ‘stigma ... has resulted in insurance restrictions and reluctance from providers to offer appropriate medical therapy.’ They conclude that HCV-infected injection drug users ‘can and should be treated with direct-acting antivirals.’* \(^{54}\)

Studies have shown that IVDU are no less likely than non-users to achieve success in HCV treatment, with over 90% of patients achieving sustained virologic response at 12 weeks, and with re-infection rates being low. Prior to initiation of treatment, patients should be educated on safer injection practices and have access to clean injection supplies. Targeting treatment to active IVDU can be an excellent way to reduce the spread of this virus among the highest risk population.

**Motivational Interviewing as Harm Reduction**

Motivational interviewing (MI) is a person-centered, guiding method of communication and counseling to elicit and strengthen motivation for change.

Motivational interviewing, first described by William Miller (1983), and later elaborated in the classic book, *Motivational Interviewing: Preparing People for Change* \(^{55}\), offers a practical, common sense approach for supporting clients in making and sustaining healthy behavior changes. Originally developed in the drug and alcohol field, over 200 clinical trials demonstrate the efficacy of MI across a range of populations, target behaviors, and medical conditions.

Motivational interviewing is a harm reduction strategy. Inherent in the approach of MI are the key concepts of expressing empathy, developing a discrepancy between where the patient is at the moment and where they want to be, avoiding argumentation, rolling with resistance, and supporting the patient’s self-efficacy. Using these principals, the MI practitioner begins by exploring the ambivalence a person has around their substance use. Using the stages of change as a guiding framework, a MI practitioner begins exploring ambivalence by inquiring about use in a way that reduces confrontation. \(^{56}\) Brief intervention in the form of MI enables patients to begin making arguments for change in their own lives. Rather than jumping to abstinence, the patient will begin to make smaller life changes designed to reduce the potential for risk in a person’s life. Initial forms of harm reduction with brief intervention range from beginning to use clean needles to not getting behind a wheel while drinking. Often, the initial steps of harm...
reduction lead to more lasting changes in a patient’s substance use, often resulting in abstinence from substance use.

Motivational interviewing is the evidence-based practice which has the greatest applicability to the population of Alaska. The state has a large Alaska Native population and dozens of Tribal health organizations. Motivational interviewing is an intervention which has shown good applicability to individuals from a variety of cultural backgrounds and is recognized as a behavioral counseling treatment modality in the National Institute on Drug Abuse’s *Treatment Approaches for Drug Addiction* fact sheet.\(^{57}\) There are several resources which indicate that motivational interviewing is also a good fit for individuals who identify as American Indian or Alaska Native. In a document from the Urban Indian Health Institute entitled *Introduction to Motivational Interviewing for American Indian and Alaska Native Communities* authors identify that MI’s focus on respecting individual sovereignty and self-determination, along with its emphasis that the professional using MI be non-confrontational and act as a guide to the client, are especially relevant and meaningful for individuals who identify as American Indian or Alaska Native.\(^{58}\) Another source of support for implementing MI techniques with AI/AN communities comes from the manual *Native American Motivational Interviewing: Weaving Native American and Western Practices* published by Venner, Feldstein and Tafoya (2007).\(^{59}\) In this manual, the authors identify culturally relevant strategies for implementing MI with individuals who are American Indian or Alaska Native, but keep the basic structure and key tenants of MI unchanged. With this evidence in mind, MI will be a good fit for our diverse population in Alaska.
Section VIII: Other Considerations
Confidentiality: 42 CFR Part 2

The federal substance use disorder confidentiality regulations issued by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) are meant to protect patients from unintended bias associated with SUDs. Thus, SUD providers must handle treatment information about SUD patients with heightened confidentiality. The CFR Part 2 non-disclosure requirements are stricter than the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Congress enacted the legislation in the 1970s to encourage individuals with SUDs to enter and remain in treatment. The regulations implementing the law are codified in 42 CFR Part 2 and are commonly referred to as Part 2.

42 CFR Part 2 – Confidentiality of Substance Use Disorder Patient Records
www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2

The heightened confidentiality obligations in Part 2 apply to the records created by a Part 2 program or records received from a Part 2 program.

A Part 2 program can be any of the following:

- A medical personnel or staff member who:
  - Holds themselves out as providing and does provide SUD treatment, diagnosis, or referral for treatment; or
  - Whose primary function is SUD treatment, diagnosis, or referral for treatment and is identified as such, and practices in a general medical facility; or
  - Is a certified addictions professional providing SUD services; or
- An entity (other than a general medical facility) that holds itself out as providing and does provide SUD treatment, diagnosis, or referral for treatment; or
- A unit within a general medical facility that holds itself out as providing and does provide SUD treatment, diagnosis, or referral for treatment.

A Part 2 program is one that meets the definition and is federally assisted, which means it receives federal financial assistance of any kind, is authorized by the federal government or is tax exempt through the IRS.

MAT providers are not automatically defined as a Part 2 program unless the provider “holds themselves out as providing” or identifies SUD treatment, diagnosis, or referral to treatment as their primary function.
**Part 2 Components**

Part 2 requires the following five components, as applicable:

**Patient Records Security Policies**
Specific policies and procedures are required to protect patient information.

**Notice of Privacy Rights**
Patients must receive a notice of the federal confidentiality requirements in writing immediately.

**Patient Consent Forms**
The consent form must include the following elements:

- Name of patient.
- Name of provider.
- Type and amount of information to be disclosed.
- “To Whom” the disclosure is to be made: Including the name of the entity if a treating provider or the name of the individual if a non-treating provider.
- Purpose of disclosure.
- Date when consent is signed.
- Signature of patient.
- Signature of parent or guardian (if applicable).
- Signature of individual authorized to sign in lieu of the patient (if applicable).
- Language regarding the right to revoke the consent. For example: *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.*
- Date consent expires.

**Non Re-Disclosure Notices**
Any information disclosed by a Part 2 program pursuant to a written consent must be accompanied by the following disclosure language:

*This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.*
Qualified Service Organization (QSO) Agreements

Part 2 providers can share SUD information with certain third parties who provide specific services to the organization pursuant to a QSO Agreement.

Minor Patients

Both HIPAA and 42 CFR Part 2 leave the issue of who is a minor and whether a minor can obtain health care or alcohol or drug abuse treatment without parental consent entirely to state laws. (“Parent” means parent, guardian, or other person legally responsible for the minor.) Although HIPAA and 42 CFR Part 2 have somewhat different approaches to the issue of minors, the final result is the same under both laws.

Under 42 CFR Part 2 (1) the program must always obtain the minor’s consent for disclosures, and cannot rely on the parent’s signature instead; and (2) parental consent for disclosure to a third party is required in addition to the minor’s only if the program is required by state law to obtain parental permission before providing treatment to the minor. In other words, if parental consent was not required to treat the minor, then parental consent is not required to make disclosures. If parental consent for treatment is required, the consent of both the minor patient and the parent or guardian is required to make any disclosures. Regardless, the minor’s written consent is required in all cases. Moreover, 42 CFR Part 2 generally requires the minor’s written consent even when the disclosure is to be made to the minor’s parents.60

In general, Alaska regulations (7 AAC 70.125) say to follow the federal laws. More specifically, Alaska state laws regarding minor consent for substance use disorder treatment are the same as its laws regarding medical and dental treatment (AS 47.30.590). The age of majority is 18 except in specific cases (emancipation, marriage), but SUD providers may serve someone under the age of 18 without parental consent if they are a minor living apart or have reached the “age of majority” through other means (AS 25.20.025) or in a crisis situation. Also, as mentioned above, the minor must give their consent in order for the parent(s) to have access to their treatment information.

Alaska regulations also require adherence to Federal Guidelines for Opioid Treatment Programs (methadone), adopted by reference in 7 AAC 70.910. As for buprenorphine, an adolescent must be 16 years of age or older to be prescribed this medication. Ongoing maintenance requires an adolescent 18 years and younger to have parental consent for both of the two types of treatment referenced above. Maintenance treatment means the dispensing of an opioid agonist treatment medication at stable dosage levels for a period in excess of 21 days in the treatment of an individual for opioid use disorder (42 CFR 8.2).

7 AAC 70.125 – Additional requirements for providing opioid use disorder treatment services

www.akleg.gov/basis/aac.asp#7.70.125
Communications

Effective and timely communication among the prescriber and other providers and the patient is critical. The communication must be well documented and confidential, consistent with SAMHSA confidentiality regulation Title 42 Part 2 of the Code of Federal Regulations (42 CFR Part 2). It is recommended that policies and practices be established for each level of communication to ensure that care is well coordinated and aligned with patient needs.

The table below highlights several communication factors to consider.

### Communication Factors

<table>
<thead>
<tr>
<th>Patient Communication</th>
<th>Intra-office Communication</th>
<th>External Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish and review program guidelines, and expectations and medication plan</td>
<td>Identify care coordinator and the responsibilities of the position (e.g. nurse, addiction clinician, other office staff)</td>
<td>Establish protocol for written and oral communication between prescriber and primary care provider and clinician (if not located in practice) and incorporate into electronic medical record</td>
</tr>
<tr>
<td>Discuss frequency of visits with prescriber and other treatment expectations</td>
<td>Document care plan in electronic record</td>
<td>Determine responsibility for monitoring adherence to program, need for change in treatment plan, etc.</td>
</tr>
<tr>
<td>Review how to communicate with prescriber and the office outside of scheduled visits</td>
<td>Document office visits and drug test results</td>
<td>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)</td>
</tr>
<tr>
<td></td>
<td>Establish routine meeting times for MAT team to discuss patient progress, challenges and administrative issues</td>
<td></td>
</tr>
</tbody>
</table>
**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’s important for all staff to recognize that:

- Addiction is a chronic, relapsing disease.
- On-going support will be needed to help a person reach their recovery goals.
- Treatment may require the use of medications, low- or high-intensity SUD treatment and/or recovery support services.
- The use of medication in conjunction with treatment and recovery supports is reinforced by literature in reducing the risk of relapse, overdose and death and is superior in efficacy to not being on a prescription.
- People are at a higher risk of addiction because of their genes, temperament, or personal situation.61

People who have an addiction are often extremely sensitive to the stigma attached to this disease and may also self-stigmatize due to feelings of guilt and shame. This stigma may be reinforced by past treatment they have received from medical providers, thus making them cautious about trust and open communication. Providers need to recognize this reluctance and train all staff to avoid stigmatizing language and behavior. Using person-first language, such as “person with a substance use disorder” or opioid use disorder and appropriate medical terminology, such as “unexpected” results related to drug testing rather than “dirty” results, is important. Stronger than the language that you use is the attitude that you convey through your interactions. It is necessary to:

- Be recovery-oriented rather than disease-oriented.
- Treat each patient with respect.
- Recognize and celebrate all levels of progress.

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.

*Remember: You are not just providing medical treatment for an opioid use disorder. You are also dispensing hope and a belief that recovery is possible for this particular patient.*
Voluntary Non-Opioid Directive (VNOD)

Under direction of Alaska Statute 13.55.010, the Department of Health and Social Services has developed a Voluntary Non-Opioid Directive (VNOD) form for public use. The VNOD aims to prevent providers from inadvertently offering certain controlled substances to those who could be adversely affected. It also empowers patients to proactively inform their provider that they do not wish to receive opioids for any reason.

DHSS encourages patients to complete the Voluntary Non-Opioid Directive in consultation with their primary care provider or behavioral health treatment provider. A signed VNOD should be given to a health care provider and recorded in the patient’s medical record.

The existence of a signed VNOD:

- Does not alter an advance health care directive.
- Does not limit the prescribing, dispensing, or administering of an opioid overdose drug.
- Does not prohibit offering, prescribing or administering opioid medications for the purpose of medication assisted treatment, as approved for such use by the FDA.

Questions may be directed to the Office of Substance Misuse and Addiction Prevention: email osmap@alaska.gov or call 907-332-2602.

AS 13.55.010 – Nonopioid directive; revocation; other requirements
www.akleg.gov/basis/statutes.asp#13.55.010

Voluntary Non-Opioid Directive form, implementation and additional guidance
http://dhss.alaska.gov/dph/Director/Pages/opioids/VNOD.aspx
Section IX: References
Section IX. References


Section X: Appendices
Section X. Appendices

Appendix I: Quality Planning Tool

Appendix II: Objective Opiate Withdrawal Scale (OOWS)

Appendix III: Subjective Opiate Withdrawal Scale (SOWS)

Appendix IV: Clinical Opiate Withdrawal Scale (COWS)

Appendix V: Release of Information

Appendix VI: Sample Treatment Plan Form

Appendix VII: Alaska Emergency Department Buprenorphine Guide

Appendix VIII: Patient Guide for Beginning Buprenorphine Treatment
Appendix I: MAT Quality Planning Tool

Organization/MAT Program Name: ____________________________ Date: ________________

Contact name: ____________________________ Email address: ____________________________ Phone number: ________________

This MAT Quality Planning Tool is intended to be used by MAT programs to review and assess their progress related to the development and implementation of the recommended best practices. Periodic use of this tool is encouraged to inform continual quality improvement. The tool is organized into two sections; Program Development (staffing, training, policies and procedures, and other infrastructure needs) and Program Implementation (staffing, training, treatment delivery). Suggested measures are provided for each recommendation to help programs assess the extent of their implementation of best practices. The page numbers referenced for each best practice recommendation indicates the section in the Alaska Medication Assisted Treatment Guide where more detail is available.

**PROGRAM DEVELOPMENT: Staffing**

<table>
<thead>
<tr>
<th>Best Practice Recommendations</th>
<th>Measures</th>
<th>Status: Not Developed</th>
<th>Status: In Development</th>
<th>Status: Developed</th>
<th>Status: Developed &amp; Regularly Implementing</th>
<th>Status: Not Applicable</th>
<th>Comments</th>
<th>Page #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish a core team to deliver MAT (to include at least one prescriber, behavioral health clinician, care coordinator, administrative support)</td>
<td># of Prescribers</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>22-27</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of Non-prescribing health care providers</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>22-27</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of BH clinicians</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>22-27</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of Care coordinators</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>22-27</td>
<td></td>
</tr>
<tr>
<td>2. Develop clearly defined, written roles and responsibilities for each member of the MAT team</td>
<td>Written protocol (e.g. workflow, job descriptions)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>22-27</td>
<td></td>
</tr>
<tr>
<td>Best Practice Recommendations</td>
<td>Measures</td>
<td>Status: No Staff Trained/Informed</td>
<td>Status: Some Staff Trained/Informed</td>
<td>Status: Most Staff Trained/Informed</td>
<td>Status: All Staff Trained/Informed</td>
<td>Status: Not Applicable</td>
<td>Comments</td>
<td>Page #</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------</td>
<td>---------------------------------</td>
<td>------------------------------------</td>
<td>-------------------------------------</td>
<td>----------------------------------</td>
<td>-----------------------</td>
<td>----------</td>
<td>-------</td>
</tr>
<tr>
<td>3. Ensure prescribers become waivered to prescribe buprenorphine</td>
<td>Total # of waivered prescribers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td></td>
<td># of MDs/DOs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Provide training to each prescriber on FDA-approved opioid and alcohol use disorder medications (e.g. pharmacotherapy, contraindications)</td>
<td># and types of trainings</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>27-30</td>
</tr>
<tr>
<td></td>
<td>% of providers in attendance by provider type</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Provide initial training and resources related to substance use disorders and MAT to all staff, including administrative staff</td>
<td># and types of trainings</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>27-30</td>
</tr>
<tr>
<td></td>
<td>% of staff in attendance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best Practice Recommendations</td>
<td>Measures</td>
<td>Status: Not Developed</td>
<td>Status: In Development</td>
<td>Status: Developed</td>
<td>Status: Developed &amp; Regularly Implementing</td>
<td>Status: Not Applicable</td>
<td>Comments</td>
<td>Page #</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>------------------------</td>
<td>------------------</td>
<td>-------------------------------------------</td>
<td>------------------------</td>
<td>----------</td>
<td>--------</td>
</tr>
<tr>
<td>6. Develop procedures to evaluate patients for eligibility onto MAT (e.g. screening, assessment, physical exam)</td>
<td>Documentation of procedures Assment instrument identified Screening tool identified</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>32-37</td>
</tr>
<tr>
<td>7. Establish a process to routinely review and share PDMP data with prescriber (e.g. frequency, person responsible for checking PDMP)</td>
<td>Written procedure Documentation of checklist of items to review in PDMP Role identified for checking and sharing data</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>35</td>
</tr>
<tr>
<td>8. Develop drug testing policies and procedures (e.g. frequency, testing type, responding to expected and unexpected test results, method of collection)</td>
<td>Documentation of drug testing policy</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>53-55</td>
</tr>
<tr>
<td>9. Develop written induction procedures</td>
<td>Documentation of induction procedures</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>42-48</td>
</tr>
<tr>
<td>10. Establish billing policies and procedures</td>
<td>Documentation of billing policy</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>31</td>
</tr>
<tr>
<td>Best Practice Recommendations</td>
<td>Measures</td>
<td>Status: Not Developed</td>
<td>Status: In Development</td>
<td>Status: Developed</td>
<td>Status: Developed &amp; Regularly Implementing</td>
<td>Status: Not Applicable</td>
<td>Comments</td>
<td>Page #</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------</td>
<td>-----------------------</td>
<td>------------------------</td>
<td>-------------------</td>
<td>------------------------------------------</td>
<td>------------------------</td>
<td>----------</td>
<td>--------</td>
</tr>
<tr>
<td>11. Establish policies and procedures specific to communicating with team, external providers, and patients (e.g. confidentiality, documentation)</td>
<td>Documentation of communication policies</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>81</td>
<td></td>
</tr>
<tr>
<td>12. Develop diversion control policies and procedures</td>
<td>Documentation of diversion policy</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>13. Create patient consent form that is compliant with 42 CFR Part 2 requirements</td>
<td>Consent form</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>79 &amp; 100</td>
<td></td>
</tr>
<tr>
<td>14. Create patient treatment agreement</td>
<td>Treatment agreement</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>40 &amp; 104</td>
<td></td>
</tr>
<tr>
<td>15. Establish continued patient practice participation guidelines (including for non-adherent patients, voluntary discharge, treatment completion)</td>
<td>Documentation of continued patient practice participation guidelines</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>38-41</td>
<td></td>
</tr>
</tbody>
</table>
## PROGRAM DEVELOPMENT: Other Infrastructure Needs

<table>
<thead>
<tr>
<th>Best Practice Recommendations</th>
<th>Measures</th>
<th>Status: Not Developed</th>
<th>Status: In Development</th>
<th>Status: Developed</th>
<th>Status: Developed &amp; Regularly Implementing</th>
<th>Status: Not Applicable</th>
<th>Comments</th>
<th>Page #</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Make modifications to electronic health record to collect, track, and measure patient outcomes</td>
<td>Description of new fields added</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
<td>Program specific</td>
</tr>
<tr>
<td></td>
<td>Successful retrieval of data (e.g. data reports)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Establish agreements with external behavioral health providers</td>
<td>Written agreement(s)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
<td>49-52</td>
</tr>
<tr>
<td>18. Establish agreements with external peer recovery support service providers</td>
<td>Written agreement(s)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
<td>49-52</td>
</tr>
<tr>
<td>19. Establish collaborative relationships with ancillary service providers (e.g. transportation, childcare)</td>
<td>Written agreement(s)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
<td>49-52</td>
</tr>
<tr>
<td>20. Identify process for determining treatment and recovery support and social service resources</td>
<td>Written agreement(s)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
<td>49-52</td>
</tr>
<tr>
<td>21. Determine mechanism for referring patients to higher levels of care and other supports, as needed</td>
<td>Role identified for managing referrals</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
<td>49-52</td>
</tr>
</tbody>
</table>
### PROGRAM IMPLEMENTATION: Staffing

<table>
<thead>
<tr>
<th>Best Practice Recommendations</th>
<th>Measures</th>
<th>Status: Not Developed</th>
<th>Status: In Development</th>
<th>Status: Developed</th>
<th>Status: Developed &amp; Regularly Implementing</th>
<th>Status: Not Applicable</th>
<th>Comments</th>
<th>Page #</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. Establish team meetings at least once a week</td>
<td>Regular meeting time, # of meetings held</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>81</td>
</tr>
</tbody>
</table>

### PROGRAM IMPLEMENTATION: Training

<table>
<thead>
<tr>
<th>Best Practice Recommendations</th>
<th>Measures</th>
<th>Status: Not Developed</th>
<th>Status: In Development</th>
<th>Status: Developed</th>
<th>Status: Developed &amp; Regularly Implementing</th>
<th>Status: Not Applicable</th>
<th>Comments</th>
<th>Page #</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. Provide ongoing training and resources related to substance use disorders and MAT to all staff, including administrative staff</td>
<td># and types of trainings, % of staff in attendance</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>27-31</td>
</tr>
<tr>
<td>Best Practice Recommendations</td>
<td>Measures</td>
<td>Status: None of the Time</td>
<td>Status: Some of the Time</td>
<td>Status: Most of the Time</td>
<td>Status: All of the Time</td>
<td>Status: Not Applicable</td>
<td>Comments</td>
<td>Page #</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------</td>
<td>--------------------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
<td>------------------------</td>
<td>----------</td>
<td>-------</td>
</tr>
<tr>
<td>24. Assess patients using ASAM dimensions</td>
<td>Assessment instruments used</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>32-34</td>
</tr>
<tr>
<td>25. Screen patients routinely for co-occurring diseases</td>
<td>Screening tool(s) used Documentation of screening results</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>38-42</td>
</tr>
<tr>
<td>26. Conduct physical exam, at a minimum identifying for intoxication, impairment or withdrawal</td>
<td>Documentation of physical exam Documentation of withdrawal risk assessment(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>34-35</td>
</tr>
<tr>
<td>27. Draw labs to include testing for infectious disease, pregnancy, liver function and blood counts</td>
<td>Documentation of lab results</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>35</td>
</tr>
<tr>
<td>28. Conduct drug tests</td>
<td>Documentation of test results</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>53-55</td>
</tr>
<tr>
<td>29. Determine diagnosis of opioid use disorder</td>
<td>Documentation of diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>32-38</td>
</tr>
<tr>
<td>30. Query PDMP</td>
<td>Documentation of PDMP Review (e.g. field in HER, administrative note)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>35-36</td>
</tr>
<tr>
<td>31. Inform patients about MAT medications available and recommended as most appropriate</td>
<td>Documentation of discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>38-39</td>
</tr>
</tbody>
</table>
## PROGRAM IMPLEMENTATION: Treatment Delivery

<table>
<thead>
<tr>
<th>Best Practice Recommendations</th>
<th>Measures</th>
<th>Status: None of the Time</th>
<th>Status: Some of the Time</th>
<th>Status: Most of the Time</th>
<th>Status: All of the Time</th>
<th>Status: Not Applicable</th>
<th>Comments</th>
<th>Page #</th>
</tr>
</thead>
<tbody>
<tr>
<td>32. Develop written individualized treatment plan with each patient</td>
<td>Documentation of treatment plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>36-42</td>
</tr>
<tr>
<td>33. Obtain signed treatment agreement from all patients</td>
<td>Signed agreement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>34. Obtain signed 42 CFR Part 2 compliant consent forms from all patients to allow for communication with external providers</td>
<td>Signed consent forms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>78-79</td>
</tr>
<tr>
<td>35. Start patient on medication assisted treatment (induct as needed)</td>
<td>Documentation of induction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>42-48</td>
</tr>
<tr>
<td>36. Schedule patients with routine prescriber visits based on treatment progress/ recovery status and other factors</td>
<td>Progress notes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>38-42</td>
</tr>
<tr>
<td>37. Query the PDMP each time a prescription is written</td>
<td>Documentation of PDMP check</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>35-36</td>
</tr>
<tr>
<td>38. Conduct drug tests</td>
<td>Documentation of drug results</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>53-55</td>
</tr>
<tr>
<td>39. Conduct random drug tests</td>
<td>Documentation of drug results</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>53-55</td>
</tr>
<tr>
<td>40. Conduct random pill/film counts</td>
<td>Documentation of random check</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>38-42</td>
</tr>
<tr>
<td>Best Practice Recommendations</td>
<td>Measures</td>
<td>Status: None of the Time</td>
<td>Status: Some of the Time</td>
<td>Status: Most of the Time</td>
<td>Status: All of the Time</td>
<td>Status: Not Applicable</td>
<td>Comments</td>
<td>Page #</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------</td>
<td>--------------------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
<td>------------------------</td>
<td>----------</td>
<td>-------</td>
</tr>
<tr>
<td>41. Review treatment plan at every visit for each patient</td>
<td>Documentation of review</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
<td>38-42</td>
</tr>
<tr>
<td>42. Update treatment plan as needed for each patient</td>
<td>Documentation of updated treatment plan</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
<td>38-42</td>
</tr>
<tr>
<td>43. Actively refer patients to SUD treatment services as needed</td>
<td>Documentation of treatment services # or % of patients referred to treatment services # or % of referrals by level of care</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
<td>49-52</td>
</tr>
<tr>
<td>44. Actively refer patient to peer recovery support services as needed</td>
<td>Documentation of recovery support services # or % of patients referred to recovery support services</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
<td>49-52</td>
</tr>
<tr>
<td>45. Provide care coordination to patients for other needs (e.g. mental health provider, primary care services)</td>
<td>Documentation of care coordination # or % of patients referred to other services # or % of referrals by service type</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
<td>25-26</td>
</tr>
<tr>
<td>46. Communicate regularly with external provider(s)</td>
<td>Documentation of communication with external providers</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
<td>81</td>
</tr>
<tr>
<td>Best Practice Recommendations</td>
<td>Measures</td>
<td>Status: None of the Time</td>
<td>Status: Some of the Time</td>
<td>Status: Most of the Time</td>
<td>Status: All of the Time</td>
<td>Status: Not Applicable</td>
<td>Comments</td>
<td>Page #</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------</td>
<td>-------------------------</td>
<td>-------------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
<td>------------------------</td>
<td>----------</td>
<td>-------</td>
</tr>
<tr>
<td>47. Provide routing support to patients outside of office visits (e.g. phone check-ins)</td>
<td>Documentation of communication</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>38-42</td>
<td></td>
</tr>
</tbody>
</table>

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

Observe the patient during a 5-minute observation period, then indicate a score for each of the 13 opioid withdrawal signs listed below. Add the scores for each item to obtain the total score.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

1. **Yawning**
   - 0 = no yawns
   - 1 = ≥ 1 yawn

2. **Rhinorrhoea**
   - 0 = < 3 sniffs
   - 1 = ≥ 3 sniffs

3. **Piloerection** (observe arm)
   - 0 = absent
   - 1 = present

4. **Perspiration**
   - 0 = absent
   - 1 = present

5. **Lacrimation**
   - 0 = absent
   - 1 = present

6. **Tremors** (hands)
   - 0 = absent
   - 1 = present

7. **Mydriasis**
   - 0 = absent
   - 1 = ≥ 3 mm

8. **Hot and cold flushes**
   - 0 = absent
   - 1 = shivering/huddling for warmth

9. **Restlessness**
   - 0 = absent
   - 1 = frequent shifts of position

10. **Vomiting**
    - 0 = absent
    - 1 = present

11. **Muscle twitches**
    - 0 = absent
    - 1 = present

12. **Abdominal cramps**
    - 0 = absent
    - 1 = mild-severe

13. **Anxiety**
    - 0 = absent
    - 1 = mild-severe

**TOTAL SCORE**

Appendix III: Subjective Opiate Withdrawal Scale (SOWS)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Not at all</th>
<th>A little</th>
<th>Moderate</th>
<th>Quite a bit</th>
<th>Extremely</th>
<th>Onset (hrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Anxious/nervous</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>2 Body aches &amp; pains</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>3 Constipation</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>4 Diarrhea</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>5 Drug hunger/craving</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>6 Goosebumps</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>7 Hot/cold flashes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>8 Muscle twitching</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>9 Nausea</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>10 Restlessness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>11 Runny nose</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>12 Sedation/sleepiness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>13 Shaking</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>14 Stomach cramps</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>15 Sweating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>16 Teary eyes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>17 Vomiting</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td>18 Yawning</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3-4 8 16 24</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

Appendix IV: Clinical Opiate Withdrawal Scale (COWS)

For each item, write in the number that best describes the patient’s signs or symptoms. 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.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine Induction:</td>
<td></td>
</tr>
</tbody>
</table>

Enter scores at time zero, 30 minutes after first dose, 2 hours after first dose, etc. Time of observation: __________

**Resting pulse rate: record beats per minute**

- 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
- 4 = pulse rate greater than 120

**Sweating: Over past ½ hour not accounted for by room temperature or patient activity**

- 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

**Restlessness: Observation during assessment**

- 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

**Pupil size**

- 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

**Bone or joint aches: If patient was having pain previously, only the additional component attributed to opiate withdrawal is score**

- 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

**Runny nose or tearing: Not accounted for by cold symptoms or allergies**

- 0 = not present
- 1 = nasal stuffiness or unusually moist eyes
- 2 = nose running or tearing
- 4 = nose constantly running or tears streaming down cheeks

**GI Upset: Over last ½ hour**

- 0 = no GI symptoms
- 1 = stomach cramps
- 2 = nausea or loose stool
- 3 = vomiting or diarrhea
- 5 = multiple episodes of diarrhea or vomiting

**Tremor: Observation of outstretched hands**

- 0 = no tremor
- 1 = tremor can be felt, but not observed
- 2 = slight tremor observable
- 4 = gross tremor or muscle twitching

**Yawning: Observation during assessment**

- 0 = no yawning
- 1 = yawning once or twice during assessment
- 2 = yawning three or more times during assessment
- 4 = yawning several times/minute

**Anxiety or Irritability**

- 0 = none
- 1 = patient reports increasing irritability or anxiousness
- 2 = patient obviously irritable/anxious
- 4 = patient so irritable or anxious that participation in assessment is difficult

**Gooseflesh skin**

- 0 = skin is smooth
- 3 = piloerection of skin can be felt or hairs standing up on arms
- 5 = prominent piloerection

**Score**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-12</td>
<td>Mild</td>
</tr>
<tr>
<td>13-24</td>
<td>Moderate</td>
</tr>
<tr>
<td>25-36</td>
<td>Moderately severe</td>
</tr>
<tr>
<td>More than 36</td>
<td>Severe withdrawal</td>
</tr>
</tbody>
</table>

≥8 needed to qualify for buprenorphine in ED

**Total score**

**Observer’s initials**

Appendix V: Release of Information

For an example of a Release of Information, see the Authorization and Consent to Disclose Protected Health Information form in the University of New Hampshire School of Law’s Substance Use Disorder Treatment Confidentiality Boot Camp workbook. Available online at https://chhs.unh.edu/sites/default/files/substance-use-disorder-privacy-part-2-idn-workbook-unh-1017.pdf

Before any form is used, it should be reviewed by your leadership or compliance team and counsel, as necessary, to ensure it is consistent with the 42 CFR Part 2 regulations.
Sample Treatment Agreement

_Treatment agreements are often employed in the treatment of addiction to make explicit the expectations regarding patient cooperation and involvement in the treatment process. Below is a sample addiction treatment agreement that may be a useful tool in working with patients in an office-based setting._

As a patient receiving opioid use disorder treatment with _____ (medication name)_______, I freely and voluntarily agree to accept this treatment as follows:

- I agree to keep, and be on time to, all my scheduled appointments with the prescriber and other providers.
- I agree to conduct myself in a courteous manner in the office.
- I agree to not arrive at the office intoxicated or under the influence of substances. If I do, the provider will not prescribe any medication until my next scheduled appointment.
- I agree to not 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 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 prescribers, pharmacies, or other sources without informing my treating prescriber. I understand that mixing buprenorphine with other medications, especially benzodiazepines such valium and other drugs, 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 instructed and not to alter the way I take my medication without first consulting my prescriber.
- I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in psychosocial treatment and recovery support services to support my recovery.

Patient name: ____________________________________________

Patient signature: ___________________________ Date: ____________

This guide provides an overview of the key steps to consider when a patient presents to the emergency department with evidence of opioid use disorder (OUD). This is intended to be an aid and not an exhaustive manual of all available management options. Providers should always use their own clinical judgment and are responsible for assessing the unique needs and circumstances of each patient.

1. Identify OUD patients appropriate for buprenorphine
   - Consider OUD in patients with opioid use and concerning circumstances.
     - Confirm patient has moderate (4-5 points) or severe (6 or more) OUD by DSM-5. See other side for DSM-5 criteria for OUD.
   - Many ED patients with OUD will be appropriate candidates for buprenorphine.
   - Consider whether abstinence is a realistic alternative. Relapse rates are very high.
   - Talk with patient about starting buprenorphine.

2. Identify and consider complicating factors
   - Use of long-acting opioid (methadone, OxyContin).
   - Heavy use of sedatives, including alcohol, benzodiazepines, Soma, Lyrica, gabapentin, etc.
   - Pregnancy. Buprenorphine can be used if in withdrawal, but do not precipitate withdrawal.
   - Liver failure.

3. Determine COWS score for timing of buprenorphine
   - **ED Induction** - See other side for COWS scoring.
     - COWS ≥8: Patient should be in adequate withdrawal and ready for buprenorphine. Many patients have used buprenorphine before and know when they are in sufficient withdrawal to begin, as well as a dose that has previously worked for them. Consider asking your patient. The more severe the withdrawal, the more likely induction will be effective.
     - COWS <8: Patient is not ready for buprenorphine yet. Have patient return to ED when withdrawal is more severe (12-24 hours after last opioid dose).
   - **Home Induction**
     - Requires prescriber with an X waiver.

See also: the “Alaska Patient Guide for Beginning Buprenorphine” and the ACEP POC “Buprenorphine Use in the ED Tool”

4. Follow-up
   Follow up with an office-based opioid treatment (OBOT) clinic or methadone clinic as soon as possible within 24-72 hours.

If a patient requires additional buprenorphine prior to follow-up:
   - A provider with an X wavier can prescribe buprenorphine, or
   - The patient can return to the emergency department once per day for a maximum of three days for buprenorphine administration.*

Other considerations

**Supportive medications**
*Generally not needed if prescribing buprenorphine*

- Clonidine 0.1-0.3mg, TID PRN
- Phenergan 25mg, TID PRN, nausea and vomiting
- Zofran 8mg, TID PRN, nausea and vomiting
- Bentyl 20mg, QID PRN, cramps
- Imodium, PRN, diarrhea
- Trazodone 50mg at HS, PRN, sleep
- Benadryl 50mg, TID PRN, anxiety or insomnia
- Acetaminophen/ibuprofen, PRN, pain

**Obtain additional data**

- Review PDMP
- Urine drug screen
- HCG
- Method of use (injection)
- Quantity of use/day
- Establish timing of last opioid use

**72-hour Rule**

Per title 21, §1306.07(c), a non-waivered prescriber can administer buprenorphine or methadone in the ED and the patient can return for three consecutive days to get buprenorphine or methadone as they wait for an appointment.
Clinical Opiate Withdrawal Scale (COWS)

For each item, write in the number that best describes the patient’s signs or symptoms. 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:** __________________________________________

**Resting pulse rate:** Record beats per minute; measured after patient is sitting or lying for one minute

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>pulse rate 80 or below</td>
</tr>
<tr>
<td>1</td>
<td>pulse rate 81-100</td>
</tr>
<tr>
<td>2</td>
<td>pulse rate 101-120</td>
</tr>
<tr>
<td>4</td>
<td>pulse rate greater than 120</td>
</tr>
</tbody>
</table>

**Sweating:** Over past ½ hour not accounted for by room temperature or patient activity

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>no report of chills or flushing</td>
</tr>
<tr>
<td>1</td>
<td>subjective report of chills or flushing</td>
</tr>
<tr>
<td>2</td>
<td>flushed or observable moistness on face</td>
</tr>
<tr>
<td>3</td>
<td>beads of sweat on brow or face</td>
</tr>
<tr>
<td>4</td>
<td>sweat streaming off face</td>
</tr>
</tbody>
</table>

**Restlessness:** Observation during assessment

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>able to sit still</td>
</tr>
<tr>
<td>1</td>
<td>reports difficulty sitting still, but is able to do so</td>
</tr>
<tr>
<td>3</td>
<td>frequent shifting or extraneous movements of legs/arms</td>
</tr>
<tr>
<td>5</td>
<td>unable to sit still for more than a few seconds</td>
</tr>
</tbody>
</table>

**Pupil size**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>pupils pinned or normal size for room light</td>
</tr>
<tr>
<td>1</td>
<td>pupils possibly larger than normal for room light</td>
</tr>
<tr>
<td>2</td>
<td>pupils moderately dilated</td>
</tr>
<tr>
<td>5</td>
<td>pupils so dilated that only the rim of the iris is visible</td>
</tr>
</tbody>
</table>

**Bone or joint aches:** If patient was having pain previously, only the additional component attributed to opiate withdrawal is score

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>not present</td>
</tr>
<tr>
<td>1</td>
<td>mild diffuse discomfort</td>
</tr>
<tr>
<td>2</td>
<td>patient reports severe diffuse aching of joints/muscles</td>
</tr>
<tr>
<td>4</td>
<td>patient is rubbing joints or muscles and is unable to sit still because of discomfort</td>
</tr>
</tbody>
</table>

**Runny nose or tearing:** Not accounted for by cold symptoms or allergies

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>not present</td>
</tr>
<tr>
<td>1</td>
<td>nasal stuffiness or unusually moist eyes</td>
</tr>
<tr>
<td>2</td>
<td>nose running or tearing</td>
</tr>
<tr>
<td>4</td>
<td>nose constantly running or tears streaming down cheeks</td>
</tr>
</tbody>
</table>

**GI Upset:** Over last ½ hour

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>no GI symptoms</td>
</tr>
<tr>
<td>1</td>
<td>stomach cramps</td>
</tr>
<tr>
<td>2</td>
<td>nausea or loose stool</td>
</tr>
<tr>
<td>3</td>
<td>vomiting or diarrhea</td>
</tr>
<tr>
<td>5</td>
<td>multiple episodes of diarrhea or vomiting</td>
</tr>
</tbody>
</table>

**Tremor:** Observation of outstretched hands

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>no tremor</td>
</tr>
<tr>
<td>1</td>
<td>tremor can be felt, but not observed</td>
</tr>
<tr>
<td>2</td>
<td>slight tremor observable</td>
</tr>
<tr>
<td>4</td>
<td>gross tremor or muscle twitching</td>
</tr>
</tbody>
</table>

**Yawning:** Observation during assessment

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>no yawning</td>
</tr>
<tr>
<td>1</td>
<td>yawning once or twice during assessment</td>
</tr>
<tr>
<td>2</td>
<td>yawning three or more times during assessment</td>
</tr>
<tr>
<td>4</td>
<td>yawning several times/minute</td>
</tr>
</tbody>
</table>

**Anxiety or Irritability**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>none</td>
</tr>
<tr>
<td>1</td>
<td>patient reports increasing irritability or anxiousness</td>
</tr>
<tr>
<td>2</td>
<td>patient obviously irritable/anxious</td>
</tr>
<tr>
<td>4</td>
<td>patient so irritable or anxious that participation in assessment is difficult</td>
</tr>
</tbody>
</table>

**Gooseflesh skin**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>skin is smooth</td>
</tr>
<tr>
<td>3</td>
<td>piloerection of skin can be felt or hairs standing up on arms</td>
</tr>
<tr>
<td>5</td>
<td>prominent piloerection</td>
</tr>
</tbody>
</table>

≥8 needed to qualify for buprenorphine in ED

**Score:** 5-12 = Mild | 13-24 = Moderate | 25-36 = Moderately severe | More than 36 = Severe withdrawal

---

**DSM-5 Criteria for Diagnosis of Opioid Use Disorder**

Check all that apply.

- [ ] Opioids are often taken in larger amounts or over a longer period of time than intended.
- [ ] There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- [ ] A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- [ ] Craving, or a strong desire to use opioids.
- [ ] Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
- [ ] Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- [ ] Important social, occupational or recreational activities are given up or reduced because of opioid use.
- [ ] Recurrent opioid use in situations in which it is physically hazardous.
- [ ] Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.

*The tolerance and withdrawal criteria do not apply to individuals taking opioids solely under appropriate medical supervision:*

- [ ] Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of opioids to achieve intoxication or desired effect, OR
  - Markedly diminished effect with continued use of the same amount of an opioid.
- [ ] Withdrawal, as manifested by either of the following:
  - The characteristic opioid withdrawal syndrome, OR
  - The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

**Score:** 4-5 boxes = Moderate | 6 or more boxes = Severe

---

**MAT Guide**

Section X. Appendix VII: Alaska Emergency Department Buprenorphine Guide 118
Before you begin, you want to feel *moderately sick* from your withdrawal symptoms

<table>
<thead>
<tr>
<th>It should be at least:</th>
<th>You should feel at least three of these symptoms:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ 12 hours since you used heroin/fentanyl</td>
<td>□ Restlessness</td>
</tr>
<tr>
<td>✓ 12 hours since you snorted pain pills (OxyContin)</td>
<td>□ Heavy yawning</td>
</tr>
<tr>
<td>✓ 16 hours since you swallowed pain pills</td>
<td>□ Enlarged pupils</td>
</tr>
<tr>
<td></td>
<td>□ Runny nose</td>
</tr>
<tr>
<td></td>
<td>□ Body aches</td>
</tr>
<tr>
<td></td>
<td>□ Tremors/twitching</td>
</tr>
<tr>
<td></td>
<td>□ Chills or sweating</td>
</tr>
<tr>
<td></td>
<td>□ Anxious or irritable</td>
</tr>
<tr>
<td></td>
<td>□ Goose bumps</td>
</tr>
<tr>
<td></td>
<td>□ Stomach cramps, nausea or diarrhea (vomiting not necessary)</td>
</tr>
</tbody>
</table>

Once you’re ready, follow these instructions to start on the medication:

### Day 1
8-12 mg of buprenorphine

Dosing depends on how early on the first day you start

*Most people feel better the first day after 8-12 mg*

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take 1st dose</td>
<td>Still feel sick? Take 2nd dose</td>
<td>Still uncomfortable? Take 3rd dose</td>
<td>Still uncomfortable? Take 4th dose</td>
</tr>
<tr>
<td>4 mg</td>
<td>4 mg</td>
<td>4 mg</td>
<td>4 mg</td>
</tr>
<tr>
<td>Wait 1 hour total</td>
<td>Wait 2 hours</td>
<td>Wait 2 hours</td>
<td>STOP</td>
</tr>
<tr>
<td>15 min</td>
<td>2 hours</td>
<td>2 hours</td>
<td></td>
</tr>
</tbody>
</table>

- Put the strip under your tongue. Do NOT swallow.
- Keep it there until fully dissolved (about 15 min.), then wait for 45 minutes.
- Do NOT eat, drink or talk at this time.
- Most people feel better after two doses or 8 mg.
- If feeling more withdrawal symptoms after the 1st dose, you will likely feel better after the 2nd dose.
- Take the 3rd dose only if needed.
- Stop after this dose.
- Do NOT exceed 16 mg on Day 1.

Day 2
8-12 mg of buprenorphine

- Most people feel better the second day using 8-16 mg of buprenorphine.
- If you wake up on day 2 and feel fine, take the same dose you took on day 1.
- If you wake up on day 2 feeling withdrawal, take the same dose you took on day 1, plus an additional 4 mg.
- If you feel withdrawal symptoms more than 2 hours after your initial dose, you can take an additional 4 mg every 2 hours up to a maximum of 16 mg/day.
- Repeat your total day 2 dose each day until your next follow-up appointment.

**Do NOT mix buprenorphine with alcohol, benzodiazepines — such as Xanax, Ativan or Valium — or other**

If you develop worsening symptoms while starting buprenorphine before your next scheduled outpatient appointment, return to the emergency department.
**Medications for opioid use disorder (OUD)**

**Naltrexone, methadone, and buprenorphine**

The right treatment for a person with OUD will depend on the severity of their disease, their readiness to engage in treatment, their preference regarding treatment, clinician preferences regarding treatment, and local options for treatment. In addition, the right medication for an individual may change over time as they are further along in their recovery or during relapse. Described below are the three different medications approved for OUD, and the different treatment environments in which these medications are prescribed.

In general, if a person can be successfully treated at an office-based opioid treatment (OBOT) program, it may be preferred to an opioid treatment program (OTP) as the OBOT is less restrictive. However, individuals with more severe opioid use disorder, who have other severe complicating use disorders (like alcohol, benzodiazepines or methamphetamine), have less support of sober family and friends, and those with complicating psychiatric illness and social and legal challenges may be better treated at an OTP as compared to an OBOT program.

While the effectiveness of an abstinence-only approach is low, and the risk of overdose with relapse is higher, the option of abstinence should be considered prior to starting buprenorphine.

<table>
<thead>
<tr>
<th>Clinic model</th>
<th>Buprenorphine</th>
<th>Methadone</th>
<th>Naltrexone&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regulatory treatment context</strong></td>
<td>Office-based opioid treatment (OBOT): A primary care clinic model that has additional expertise treating OUD. An OBOT may also treat other use disorders. Buprenorphine can also be administered within an opioid treatment program <em>(see methadone)</em>.</td>
<td>Opioid treatment program (OTP):&lt;sup&gt;1&lt;/sup&gt; A highly specialized and regulated clinic that is specifically designed to treat patients with OUD. An OTP is more intense, more supportive and more restrictive than an OBOT. An OTP may also treat other use disorders.</td>
<td>Any prescriber</td>
</tr>
<tr>
<td><strong>Visit frequency</strong></td>
<td>Suboxone can be prescribed by any licensed prescriber with a DEA registration and a buprenorphine waiver or in compliance with the 72-hour rule.&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Methadone can only be dispensed at a certified OTP or in compliance with the 72-hour rule.&lt;sup&gt;3&lt;/sup&gt;</td>
<td>While it is important to discuss the option of naltrexone for patients with OUD, it generally should not be initiated in the ED setting unless the prescriber has significant experience treating OUD.</td>
</tr>
<tr>
<td><strong>Counseling/recovery</strong></td>
<td>Variable. A typical schedule is 1-2 times per week for 1 month, progressing to every other week for 1-2 months, then to 1 visit every 1-3 months.</td>
<td>Daily for months, progress to earning “take home” privileges over a period of months to years.</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

<sup>1</sup>For many patients, the more intensive treatment environment, embedded behavioral health services, and daily contact that occurs in an OTP is beneficial and necessary at certain stages of recovery.

<sup>2</sup>Naltrexone has more limited evidence supporting its long-term efficacy when compared to buprenorphine and methadone.

<sup>3</sup>Per title 21, §1306.07(c), a non-waivered prescriber can administer buprenorphine or methadone in the ED and the patient can return for three consecutive days to get buprenorphine or methadone as they wait for an appointment.