Preparing for Office-Based Opioid Treatment

Prior to embarking on the provision of office-based addiction treatment services, medical practices that will be new to this type of care should undertake certain preparations to ensure the highest quality experience for patients, providers, and staff. Providers and practice staff should have an appropriate level of training, experience, and comfort with this new form of treatment. Linkages with other medical and mental health professionals should be established to ensure the availability of comprehensive community-based treatment services.

Physician Training, Experience, and Comfort Level

Physicians who intend to treat opioid addiction should seek to establish a level of comfort and expertise with this form of care. A physician's comfort level in providing treatment for addiction will vary according to the physician and his or her practice situation. For example, a physician might choose to refer a patient with addiction and depression, depending on the severity of depression, whether a psychologist or psychiatrist is available in the area, and whether the patient can afford specialized mental health care, among other factors.

Expertise in treating opioid addiction includes knowledge of applicable practice standards or guidelines, familiarity with the evidence supporting the recommended treatments, protocols for primary treatment or referral of patients with certain complicating conditions (e.g., severe depression), and knowledge of any applicable regulations or laws. Physicians must become knowledgeable about the most up-to-date treatments for opioid addiction, including pharmacotherapy, psychosocial interventions, self-help and mutual-help groups, and other appropriate treatments. Physicians who treat opioid-addicted patients with buprenorphine should participate in addiction medicine training and professional activities and should learn from other professionals in addiction treatment. Basic and ongoing training in addiction treatment will greatly enhance a physician's effectiveness in treating opioid addiction.

Each patient presents with different and usually complex needs. Physicians who treat patients with opioid addiction in the office-based setting must consider and plan for the full range of their patients' needs before initiating treatment. Candidates for buprenorphine treatment of opioid addiction should be assessed for a broad array of biopsychosocial needs in addition to opioid use and addiction, and should be treated and/or referred for help in meeting those needs.

Establishing Office Procedures

Before undertaking the provision of office-based buprenorphine treatment, physicians should make arrangements to provide comprehensive care and contingency plans for patients who may not be appropriate candidates for this treatment. In addition, physicians should arrange for other physicians with DATA 2000 waivers to be available to provide care to the treating physician's opioid addiction patients in the treating physician's absence (e.g., while on vacation).

Office policies and procedures for opioid addiction treatment should be established, written, and clearly communicated to staff members and patients. Staff members should be trained and

educated about opioid addiction, addiction treatment, patient confidentiality (see "Confidentiality and Privacy" section below), medication treatments, nonpharmacological treatments, behavioral characteristics of addiction, and the medical approach to addiction treatment.

Common behaviors and defense mechanisms of addicted patients should be anticipated. Medication must be stored in a secure location, and the possibility of diversion must be minimized. Office items (e.g., prescription pads, syringes, needles) and staff possessions should be secured to minimize theft.

Establishing Treatment Linkages

Establishing linkages with other medical professionals is essential. Because patients addicted to opioids commonly have coexisting medical and psychiatric conditions, most physicians will need to establish linkages with other medical and mental health specialists, particularly those specializing in the evaluation and treatment of common comorbid conditions (e.g., hepatitis B and C, HIV, tuberculosis, mood disorders, anxiety disorders, personality disorders, risk of suicide and homicide). Physical examinations and laboratory evaluations will need to be completed either onsite or offsite from the office of the physician who provides office-based buprenorphine treatment.

An up-to-date listing of community referral resources (e.g., therapy groups, support groups, residential therapeutic communities, sober-living options) should be given to patients. Referral resource lists are available from the substance abuse agencies of some local and State governments. To maximize follow through with referrals, it is most helpful if the physician has firsthand knowledge of these groups and programs. When referrals are made, compliance will increase if staff call to make appointments in the presence of patients. When making referrals to support groups, it is helpful to have an individual in the group who is willing to accompany the patient to his or her first meeting. Referrals to social workers and case managers are often beneficial in helping patients address legal, employment, and family issues.

Summary

Figure 6-1 summarizes the policies, procedures, and items that should be established or arranged for in a medical practice prior to initiating office-based opioid addiction treatment.

Figure 6-1. Policies, Procedures, and Items for Medical Practices To Establish Prior to Initiating Office-Based Opioid Addiction Treatment

- Office policies and procedures for buprenorphine treatment
- Staff education and training
- Backup coverage for the practice
- Assurance of the privacy and confidentiality of addiction treatment information
- Linkages with qualified colleagues who will accept new referrals for buprenorphine treatment
- A referral network of medical specialists
- Timely physical examinations

- Linkages with medical treatment facilities, including opioid treatment programs
- A referral network of psychologists and psychiatrists with expertise in addictions, affective disorders, and chronic pain
- Linkages with addiction and psychiatric treatment programs
- Listing of community referral resources, including specific self-help groups who would welcome buprenorphine patients (e.g., Self Management and Recovery Training [SMART] Recovery, Moderation Management)
- Online/Internet listings of self-help groups (e.g., SMART Recovery, Moderation Management) that are accepting of individuals in recovery who are using medications as a part of that recovery

Confidentiality and Privacy

Prior to initiating office-based opioid addiction treatment, practice policies and procedures should be established that will guarantee the privacy and confidentiality of addiction treatment patients. Providers must comply with all applicable laws and regulations regarding the privacy and confidentiality of medical records in general, and of information pertaining to addiction treatment services in particular.

The privacy and confidentiality of individually identifiable information relating to patients receiving drug or alcohol treatment is protected by SAMHSA confidentiality regulation Title 42, Part 2 of the Code of Federal Regulations (42 C.F.R. Part 2). This regulation mandates that addiction treatment information in the possession of substance abuse treatment providers be handled with a greater degree of confidentiality than general medical information.

Occasionally, physicians will need to communicate with pharmacists and other healthcare providers about the addiction treatment of a particular patient (e.g., to verify a Suboxone® or Subutex® prescription). Regulation 42 C.F.R. Part 2 requires physicians providing opioid addiction treatment to obtain signed patient consent before disclosing individually identifiable addiction treatment information to any third party. A sample consent form with all the elements required by 42 C.F.R. Part 2 is included as appendix D. It is recommended that physicians have each new buprenorphine patient sign a copy of this form to prevent confidentiality problems at pharmacies when patients present with buprenorphine prescriptions. It is particularly important to obtain patient consent when telephoning or faxing prescriptions to pharmacies, as this information constitutes disclosure of the patient's addiction treatment. When physicians directly transmit prescriptions to pharmacies, further redisclosure of patient-identifying information by the pharmacy is prohibited, unless signed patient consent is obtained by the pharmacy. Regulation 42 C.F.R. Part 2 does not apply to pharmacies, however, when the patient delivers a buprenorphine prescription without telephone confirmation or other direct communication from a physician to the pharmacist.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191 (see http://aspe.hhs.gov/admnsimp/pl104191.htm), which amends the Internal Revenue Service Code of 1986, mandates standardization of exchange formats for patient health, administrative, and financial data; requires development of unique identifiers for individuals, employers, health plans, and healthcare providers; and establishes security standards for protecting the

confidentiality and integrity of individually identifiable health information. SAMHSA has prepared a document titled *Comparison Between the Confidentiality of Alcohol and Substance Abuse Patient Records (42 C.F.R. Part 2)* and the *Health Insurance Portability and Accountability Act 1996*. This document and a number of other HIPAA technical assistance tools are available on the SAMHSA HIPAA Web pages at http://www.hipaa.samhsa.gov/. See also the SAMHSA Treatment Assistance Publication (TAP) 13 *Confidentiality of Patient Records for Alcohol and Other Drug Treatment* (Lopez 1994), available on the SAMHSA Treatment Improvement Exchange Web site at http://www.treatment.org/taps/index.html. Additionally, the Subutex® and Suboxone® package labels (available on the FDA Web site at http://www.fda.gov/cder/drug/infopage/subutex_suboxone/default.htm) also contain information on Federal confidentiality rules and regulations. Physicians should also consult with their State medical authorities concerning privacy and confidentiality rules in their locales. Figure 6-2 lists some of the privacy and confidentiality issues that can arise in the course of addiction treatment.

Figure 6-2. Privacy and Confidentiality Issues in Addiction Treatment

- Information covered by the doctor/patient privilege
- Circumstances in which confidential information is protected from disclosure
- Exceptions to State laws protecting medical information
- Duty to report
- Communications with third parties (e.g., families, employers, allied health care providers, third party payers, law-enforcement officers, responses to subpoenas)

Go to:

Buprenorphine Use in OTPs

On May 22, 2003, SAMHSA announced an interim final rule permitting OTPs serving individuals addicted to opioids to offer buprenorphine treatment along with methadone and levo-alpha-acetyl-methadol (LAAM). The rule enables OTPs that are certified by SAMHSA to provide Subutex® and Suboxone® for opioid maintenance or detoxification treatment.

The provision of opioid addiction treatment with Subutex® and Suboxone® in SAMHSA-certified OTPs does not require a DATA 2000 waiver. Additionally, such treatment is not subject to the 30-patient limit that applies to individual physicians and group practices providing opioid addiction treatment outside the OTP system under the authority of a DATA 2000 waiver. The provision of opioid addiction treatment with Subutex® or Suboxone® in treatment settings other than OTPs, even by physicians who are licensed to work in OTPs, does require a DATA 2000 waiver and is subject to the 30-patient limit for individual physicians and group practices.

OTPs providing Subutex® and Suboxone® for opioid maintenance or detoxification treatment must conform to the Federal opioid treatment standards set forth under 42 C.F.R. § 8.12. These regulations require that OTPs provide medical, counseling, drug abuse testing, and other services to patients admitted to treatment. To offer Subutex® and Suboxone®, OTPs need to modify their registration with the DEA to add Schedule III narcotics to their registration certificates. OTPs can initiate this streamlined process by fax or letter. The letter should include the OTP's DEA

registration number and request that the registration be amended to list Schedule III narcotic drugs. The letter must be signed by the program sponsor (program director) or medical director. Further information about this process can be found on the DEA Drug Registration Web site at http://www.deadiversion.usdoj.gov/drugreg/change_requests/sched_change.htm.

From: Bankhead, Jamal (SAMHSA) [mailto:Jamal.Bankhead@samhsa.hhs.gov]
Sent: Thursday, March 08, 2018 7:03 AM
To: Roshonda Bowden; Deborah Motley-Bledsoe; Castle, Walter; Pickens, Katherine; Walden, Nicole; Makanjuola, Abayomi; Marks, Katie (BHDID/Frankfort); Melody Winston; Ann Rodio; Borys, Suzanne; Julie Griffin Salvador; Beedle, Jeffrey (OASAS); Kawola, Matt (OASAS); Grinstead Rusha; Tari, Mika, HSD
Subject: Implementing Medication-Assisted Treatment for Opioid Use Disorder in Rural Primary Care - AHRQ Publications

Morning,

I thought the below may be of interest:

A new AHRQ report examines factors that may limit access to medication-assisted treatment (MAT) for opioid use disorder (OUD) in rural primary care settings. Peer-reviewed articles and grey literature on implementing MAT for OUD were examined. The report also includes links and descriptions to nearly 250 tools and resources to support the delivery of MAT in rural primary care settings. **Access the report**: Implementing Medication-Assisted Treatment for Opioid Use Disorder in Rural Primary Care: Environmental Scan

INTERESTING: Three innovative models of care were found that represent promising ways to overcome a number of challenges to implementing MAT services in primary care practices in rural areas. These include the **Hub and Spoke model from Vermont, Project ECHO (Extension for Community Health Care Outcomes) from New Mexico, and the Office-Based Opioid Treatment with Buprenorphine (OBOT-B) Collaborative Care Model from Massachusetts**.

Because circumstances and resources vary greatly across communities, those who want to develop primary care-based MAT in rural areas can also develop unique local solutions as long as they include several essential elements:

- Care coordination;
- Providers with prescription authority;
- Counseling and psychosocial services; and
- Consulting resources.

These elements may be provided in person, via telehealth, or through referral, keeping in mind local laws and regulations, as well as rules related to reimbursement for services. Monitoring of patient

outcomes and a commitment to continuous quality improvement can help ensure that problems are identified and addressed on an ongoing basis.

This environmental scan demonstrates that, while offering MAT services in rural primary care settings may appear complex, many primary care providers view it as the treatment and "long-term management" of a chronic recurring disorder. Thus, in many ways, it is similar to the treatment they already provide for patients with asthma, diabetes, hypertension, and other chronic health conditions.

Please read the full 2 volumes of this publication by clicking the link above.

Best,
jZB

Jamal Z. Bankhead, MPH

Public Health Advisor – Opioid STR & MAT-PDOA Project Officer (Regions II,IV,X)
SAMHSA/CSAT/DSCA/PMB/HIT
5600 Fishers Lane, RM 13E70-F
Rockville, MD 20857
Ph: 240-276-1758
Fax: 240-276-2900
jamal.bankhead@samhsa.hhs.gov