

# **BUSINESS PLAN** *for* Medication-Assisted Treatment (MAT)



NATIONAL ASSOCIATION OF  
Community Health Centers

PREPARED AUGUST 2017



# TABLE OF CONTENTS

---

## **EXECUTIVE SUMMARY 4**

Primary Care Landscape  
The Business Case

## **VALUE-BASED POPULATION HEALTH 5**

An Unmet Need  
Success Stories from Our Health Centers

## **CLINICAL OVERVIEW 7**

Organizational Readiness  
Three Medication Categories  
Clinical Best Practices Overview  
Quality Metrics

## **MANAGEMENT SUMMARY: SERVICE LAUNCH AT 30, 60, & 90 DAYS 10**

Days 1–30  
Days 31–60  
Days 61–90

## **FINANCIAL PLAN 12**

Billing & Coding  
Health Center Visits Generated from one DATA 2000-waivered Physician  
Scalability

## **TRAINING & TECHNICAL ASSISTANCE 14**

Online Resources

## **FUTURE DIRECTIONS 14**

---

## PRIMARY CARE LANDSCAPE

### The Role of the Health Center

***“80% of behavioral health and addiction medicine/psychiatry is handled in primary care, whether or not we call it that.”***

- Expert panel on Addiction in Primary Care, National Association of Community Health Centers, March 2017

***“Integration of primary care and addiction care can help by ensuring higher quality care.”***

- SAMHSA-HRSA, May 2013

New medications for office-based treatment of opioid addiction are comparable in efficacy to other chronic conditions such as diabetes, asthma, and hypertension when combined with other interventions and as part of a comprehensive care plan. They are safe, highly effective, can be prescribed and/or administered at the Community Health Center, with a sustainable business plan.

### The Patients We Already See

Over 1 in 4 Americans will suffer from a substance use disorder during their lifetime.<sup>1</sup> National costs related to crime, loss of productivity, and health care as a result of substance use amounts to \$600 billion annually.<sup>2</sup> Individuals with substance use disorders will incur 2–3 times the total medical expenses of patients without these disorders.

#### PERSONS WITH SUBSTANCE USE DISORDERS HAVE:

- 9x greater risk of congestive heart failure
- 12x greater risk of liver cirrhosis
- 12x risk of developing pneumonia<sup>3</sup>

Yet, many individuals served in substance abuse settings do not have a primary care provider.<sup>4</sup>

*Instead of sending our patients to substance use disorder treatment, we must shift the paradigm to integrate behavioral health services into our health centers and with primary care providers. There is a high comorbidity in primary care with behavioral health concerns, particularly trauma, depression, and anxiety.*

### Why Treat Addiction in Primary Care?

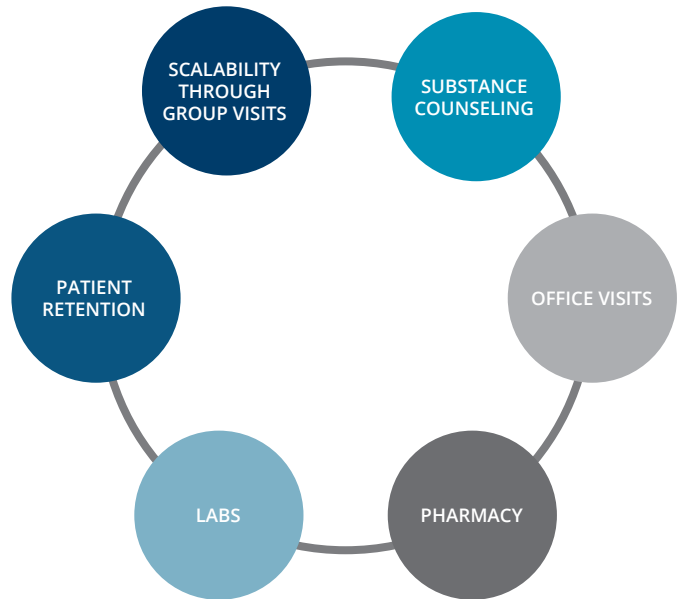


Figure 1: Integrated Clinical Business Areas Served by MAT

Regular primary care for people with substance disorders has been shown to decrease hospitalizations by up to 30%. Alcohol and drug use screening and services reduce overall costs to the health care system while providing affordable, cost-effective, geographically accessible, and comprehensive care.

*Opioid use disorders may be intimidating topics for providers and administrators.*

Opioid use disorders are increasingly treated in primary care settings using our regular office visits. Primary care providers benefit from additional tools to treat patients with chronic pain and addiction, especially as these patients are associated with some of the highest morbidity and costs to systems.

## THE BUSINESS CASE

- Retention of current patients through expanded in-house services
- Access to substance-specific grants and funding
- Integrated referrals and increased service utilization
- Each DATA 2000-waivered physician can see 30 active patients for the first year of registration and up to 275 patients by the start of the third year participating in buprenorphine Medication-Assisted Treatment (MAT) for opioid use disorders. Each DATA 2000-waivered physician assistant or nurse practitioner can see up to 30 active patients. Enrolled patients may engage in other health center services, for an estimated \$115,000 billed per month per eligible physician, or an estimated \$418 per enrolled patient per month.<sup>5</sup>

## AN UNMET NEED

### Opioids: Suffering From Our Treatment of Pain

- Opioid prescribing has **almost doubled** since the late 1990's due to pain treatment initiatives and guidelines. Opioid use disorders are highly related to increased health care utilization costs.<sup>6</sup>
- Opioids were involved in **33,091 deaths in 2015**, and opioid overdoses have **quadrupled since 1999**.<sup>7</sup>
- **60%** of drug overdose deaths are related to pharmaceuticals and **75%** include prescription opioids.
- Tightening of opioid prescribing trends has been correlated with **increased heroin use** and **heroin overdose**.
- Long-term preventive care decreases costs on high opioid-related emergency room utilization rates.<sup>8</sup>
- **23.5 million people** are estimated to need substance use disorders treatment, **yet only 2.6 million** receive it. <sup>9,10</sup> Nationwide, there are **under 40,000 prescribers** for buprenorphine, which is estimated to be *far below* the national access needs; less than half of the **2.2 million people** who need treatment for opioid use disorders receive it.<sup>11</sup>
- Results from a 2005 congressionally mandated evaluation study show that **in-office MAT** has **increased the availability of treatment** for opioid dependence; treatment is generally *safe and effective*; diversion, adverse clinical events, and public health consequences have been minimal.<sup>12</sup>

### Benefits of Office-Based Treatment

- 1 Improved access
- 2 Private, confidential, and safe treatment that can be provided in any physician's office or health center
- 3 Allows for continuity of care with primary provider including supervision of any controlled substances
- 4 Does not require daily visits to a clinic or out-of-town, costly residential treatment
- 5 May allow more patient time for work, family, and other activities
- 6 Close supervision and regular use of clinic services for monitoring and diversion

### About Medication-Assisted Treatment (MAT)

- Used as a **harm-reduction model** and **evidence-based treatment** for patients who already suffer from opioid use disorder. Goals include:
  1. A **decrease symptoms of opioid use disorder** (such as illicit opioid use)
  2. Decreased mortality
  3. Reductions in criminal activity.<sup>13</sup>
- It is recommended that MAT be offered in conjunction with **psychosocial supports**, which may include:
  1. Alcohol and Other Drugs of Abuse (AODA) counseling
  2. Psychotherapy
  3. Referral to social services such as employment and education assistance

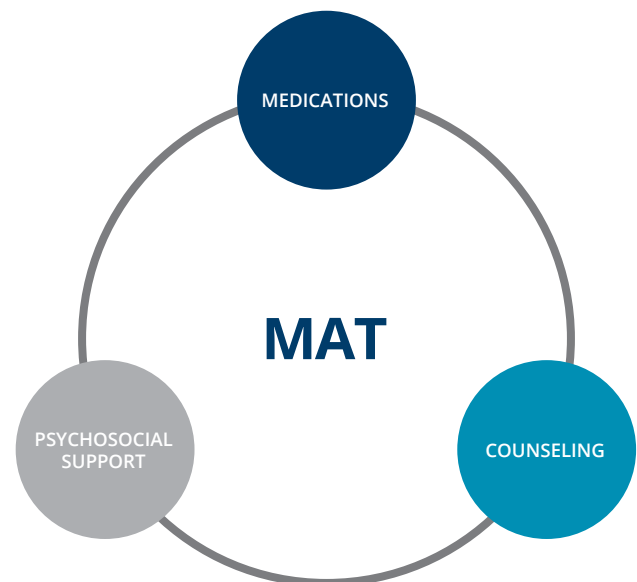


Figure 2: MAT involves Medications, Counseling, & Psychosocial Support

## SUCCESS STORIES FROM THE FIELD

### *Greater Lawrence Family Health Center*

In this highly underserved population, Greater Lawrence Family Health Center has innovatively combined buprenorphine treatment as an essential option for patients with addiction or pain management needs. As pioneers of the “buprenorphine group visit,” they enhance service utilization and productivity while offering key substance services.

- LAWRENCE, MA

### *Open Door Community Health Centers*

As a tie-in to their consultation behavioral health service, Open Door streamlines buprenorphine visits, enhancing their in-house psychiatrists’ productivity to up to 30 billable visits per half-day.

- EUREKA, CA

### *Penobscot Community Health Center*

At this 10-site Federally-Qualified Health Center, buprenorphine treatment is initiated at one

site with their addiction medicine specialist. After attending a group-counseling program and reaching stabilization, the primary care provider at the patient’s clinic of origin resumes responsibility for buprenorphine prescribing.

- BANGOR, ME

### *The Massachusetts Model<sup>14</sup>*

In the Boston Medical Center Collaborative Care Model, a Nurse Case Manager (NCM) does the initial intake and collects data, allowing the physician to focus on the physical exam and documentation. The NCM also supervises on-site induction and managed stabilization. On average in one study, each NCM saw 75 patients per week.<sup>15, 16</sup> Over 40 health centers use NCMs to expand access to treatment and minimize provider burden. This model is being implemented in other states and has been published by the United States Agency for Healthcare Research and Quality.<sup>17</sup>

*... And Countless Others*

# ORGANIZATIONAL READINESS

- **Environmental Assessment:** federal, state, and local support around addiction medicine/addiction psychiatry and behavioral health integration
- **Internal Assessment:** provider and expanded care team attitudes, beliefs, practices to inform train opportunities and next steps
- **Needs Assessment:** identifies community support such as other CBOs, behavioral health centers, hospital and/or residential programs
- **Resource Assessment:** to inform care coordination teams and the development of strategic partnerships

### RECOMMENDED STAFFING INCLUDES:

1. DATA 2000-waivered physicians, nurse practitioners, and physician assistants
2. Nurses: registered nurses, nurse care managers
3. Behavioral health: social workers, counselors, psychologists and substance use disorder counselors
4. Clinicians who can practice in an integrated model, addressing both primary care and behavioral health issues

### PHYSICAL SPACE AND LOGISTICS:

1. Regular office exam rooms suffice, with **no additional space or equipment needed**
2. On-site **urine drug rapid tests** may be helpful, though many sites use send-out labs
3. Many sites scale services, access, and productivity through the use of group visits, which may occur in a larger room

*For many Community Health Centers, MAT can be achieved successfully with current staff & office space.*

# THREE MEDICATION CATEGORIES

## 1 Opioid Agonist: Methadone

- Dispensing is restricted to Federal and State-approved opioid treatment programs (OTPs).
- Pharmacies and medical providers that do not participate in OTPs are prohibited from prescribing or dispensing methadone for opioid dependence.
- While Methadone is a successful harm-reduction model and a useful comparison for MAT, it is **impractical for most Health Centers.**

## 2 Opioid Partial Agonist/Antagonist: Buprenorphine (Subutex®) or Opioid Partial Agonist/Antagonist combination product Buprenorphine/naloxone (Suboxone®)

- Office-based therapy **commonly utilized in outpatient, Community Health Center settings**
- Can **safely be given to patients in active opioid withdrawal**
- Federal Drug Addiction Treatment Act (DATA) of 2000 allows qualified prescribers to receive a DEA waiver commonly referred to as “X number” or “X license,” as the first letter of the DEA number for approved prescribers is replaced with an “X” on buprenorphine-related prescriptions.
- Initial physician waiver restricts treatment to 30 patients concurrently; after 1 year, a second waiver may be obtained to increase to 100 patients at one-time maximum.<sup>18</sup>

- 2016 federal regulations have increased maximum limit to 275 patients per qualifying prescriber at one time following 1 year of treating 100 concurrent patients (2 years after initial approval) with buprenorphine.<sup>19</sup>  
<https://www.federalregister.gov/documents/2016/07/08/2016-16120/medication-assisted-treatment-for-opioid-use-disorders>
- The 2016 Comprehensive Addiction and Recovery Act (CARA) expanded prescribing privileges for a maximum of 30 active patients per provider to nurse practitioners (NPs) and physician assistants (PAs) for 5 years.<sup>20</sup>
- Combination (buprenorphine/naloxone) pill used for induction unless patient is pregnant or documented allergy to naloxone.
- SAMHSA TIP 40 offers information on the Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction.<sup>21</sup>

### 3 Opioid Antagonist: (Naltrexone, Vivitrol®)

- May be used for alcohol cravings or to prevent the effects of opioid prescriptions such as pain medications
- Prevents relapse to opioid use following detoxification, reduces opioid use and opioid cravings
- One must be opioid (including Methadone) naïve and have completed opioid withdrawal (detoxification) prior to starting Naltrexone, as its use causes sudden, precipitated withdrawal symptoms
- Available in daily by-mouth tablets or once-monthly injection
- No need for a special license or waiver to administer treatment

## CLINICAL BEST PRACTICES OVERVIEW

### 1 Patient Selection

- Referral from SBIRT
- Diagnosis of opioid use disorder
- Desire for outpatient treatment
- Appropriateness of outpatient treatment (some may need in-patient care first)
- Ability to provide informed consent including an understanding of risks and benefits
- Motivation for engagement (willingness to make weekly appointments, etc.)
- Expectation for adherence and following of safety procedures
- Psychiatric and psychosocial stability or concurrent mental health treatment to support psychiatric stabilization
- No or very limited concurrent use of alcohol and benzodiazepines

### 2 Initial Visit

Stability of recovery environment (housing, transportation, food security, etc.); availability of care management/social services capable of providing support”.

- History and physical for patients new to practice
- Assess and identify behavioral health concerns
- For established patients, may be done as a follow-up visit with focus on relevant screenings, exam, and psychoeducation
- Labs: at the discretion of the provider and what is clinically indicated. Common studies include liver function tests, infectious diseases (HIV, hepatitis panel), urine drug screen, buprenorphine and methadone labs (often not detected on standard urine toxicology screen). A pregnancy test should be completed for all reproductive-age female patients.
- Clinical Opiate Withdrawal Scale (COWS)  
<https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf>
- Patient education
- Written and signed consent for treatment and controlled substance agreement



- Check and record state prescription drug monitoring program
- Arrange psychosocial treatment / counseling (motivational interviewing, network therapy, relapse prevention counseling, cognitive behavioral therapy, and/or 12-step as a form of social and recovery support)
- Consider family involvement
- Develop comprehensive care plan to address medical, behavioral, and substance use concerns
- Treatment of co-occurring illness
- Emphasis on collaboration of care both within and beyond the four walls of the health center; this speaks to the need for coordination within the community including with emergency rooms, urgent care centers, other prescribers, and pharmacies.
- Individualize treatment: based on clinical need, some patients may require more long-term close follow-up and support while others may be seen less frequently
- Use of therapeutic dose
- Random pill counts
- Enlist aid of pharmacists
- Consider lock boxes
- Contingency management principles; for example, if a patient is found selling or diverting medication, a higher level of care such as inpatient or a Methadone clinic may be indicated

### 3 Maintenance Visits

- Emphasize once-daily dosing for most patients to help improve adherence
- Use of below strategies to minimize diversion
- Treatment without pre-specified duration works best as chronic treatment, as with other chronic disorders (e.g., diabetes)
- Higher doses may be more effective and tapered over time as clinically indicated
- Maintaining continuity may also be achieved through quarterly visits for preventive and primary care

### 4 Strategies to Minimize Diversion

- Regular assessment of readiness/fit for office-based treatment
- Open discussion of diversion concerns and need to keep medication safe, protected, and secured
- Provide education on medication storage: not in public places, avoid shared places such as bathrooms, keep in labeled prescription bottles
- Treatment agreement
- Random urine drug screens or as clinically indicated
- Monitoring of state prescription drug monitoring program
- Counseling/care collaboration

---

## QUALITY METRICS

- Access to MAT and appropriate pain/addiction control may help to improve other measures for quality, including but not limited to goals for managing diabetes and hypertension.
- Integration and monitoring of data from drug screens and prescription drug monitoring programs.
- Engagement in care and visit adherence.
- Community level: number of overdoses, number and/or frequency of opioid prescriptions, legal recidivism.
- If metrics plateau or stall, barrier may be related to behavioral health. Be sure to track comorbid behavioral health conditions (e.g. depression, traumatic stress).
- In 2016, HRSA provided \$94M to 271 health centers to provide substance use disorders treatment with a focus on MAT for opioid use disorders. New reporting requirements/metrics include:
  1. Number of patients receiving SBIRT services,
  2. Number of FTE substance abuse services providers,
  3. Number of patients receiving substance abuse services,
  4. Number of visits for substance abuse services,
  5. Number of physicians who obtained a DATA waiver
  6. Number of patients who received MAT

## SERVICE LAUNCH AT 30, 60 AND 90 DAYS

Days 1-30

Identify program champion to oversee implementation and integration. Program champion may take on leadership, coordination, and reporting to boards, leadership, and staff with all subsequent recommendations.

- PCSS-MAT offers free, tailored mentoring options, online modules, webinars, small group discussions, clinical guidelines, coaching, and waiver training: <http://pcssmat.org>.

Consider discussion with local partners already working in MAT.

Consider substance use disorder education for all staff as a way of increasing addiction-informed care in order to have buy-in from all staff and not just those directly involved with MAT plan.

Estimate access needs

- Markers may include patients with “pain” diagnoses, opioid prescriptions, or data from SBIRT.
- Patient appointment utilization rates should be considered in order to anticipate staffing needs.
- Other options to increase access include: group medical visits, nurse visits, utilization of NP/ PAs, and behavioral health provider support.

Identify physician(s), nurse practitioner(s), and/or physician assistant(s) in possession of the DATA 2000 waiver and able to prescribe buprenorphine products for MAT

- For prescribers with the DATA 2000 waiver, verify current number of patients being treated with buprenorphine relative to the number able to treat (30 for first year, with ability to apply for increase to 100 patients after 1 year, and as of 2016, 275 patients after 2 years)
- Verify practitioner status if needed using the SAMHSA pharmacist verification tool <sup>22</sup>

If no prescriber(s) in possession of waiver or insufficient prescribers to meet access need, determine method to complete DATA 2000 waiver training

- Resources, including in-person and low-cost online training available at SAMHSA <https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training>
- After completing a minimum 8 hours of training, physician may apply for physician waiver, which is necessary to prescribe buprenorphine products for opioid dependence. No prescriptions may be issued until DATA 2000 waiver is applied to individual physician’s DEA license.
  - *Each physician prescriber new to the DATA 2000 waiver may only prescribe for up to 30 current patients for the first year.*
- Nurse practitioners and physician assistants who have completed the required 24-hours of training may seek a DATA 2000 waiver for up to 30 patients <https://www.asam.org/quality-practice/practice-resources/nurse-practitioners-and-physician-assistants-prescribing-buprenorphine>.
- All prescribers must have access to the state’s prescription drug monitoring program.

**SERVICE LAUNCH AT  
30, 60 AND 90 DAYS (CONTINUED)**

<b>Days 31-60</b>	Determine integration methods with clinic, SBIRT, and existing behavioral health resources.
	Create local directory for substance-related resources, both for clinical care teams and as a patient handout.
	Determine referral mechanisms for patients to access new, in-house MAT service.
	Build or adapt controlled substance and informed consent agreements.
	Develop relevant internal policies and procedures such as eligibility, referral, staffing, supervision, confidentiality, and quality metrics.
	Develop tracking and mechanisms to ensure that each DATA 2000-approved MAT prescriber does not exceed patient limits (e.g., no more than 30 patients for the first year). Each prescriber should maintain a secured list of “active” MAT patients for both internal tracking as well as external audit.
	Develop clear policies for when patients are no longer considered “active” and how they may re-apply for MAT services.
	Build templates for electronic health records and scripts for care teams. Standardized policies and procedures will help for safe and consistent care.

<b>Days 61-90</b>	Contact local payers to verify patient eligibility, any local billing/coding recommendations, and provide details on estimated access and referrals.
	Contact local pharmacies to determine which have stock or access of buprenorphine products. In rural areas, consider agreement with one or more local pharmacies to order stock and provide HIPAA-compliant care coordination and tracking.
	Provide staff training. This may include topics such as implicit biases, trauma, language, and relapse awareness.
	Establish after-hours and out-of-the-office coverage plans.
	Practice run-throughs of process and address any discrepancies.

## BILLING AND CODING

### Diagnoses (ICD-10)

As of October 1, 2015, buprenorphine-related diagnoses for MAT visits are included in Opioid-Related Disorders in DSM-5 and ICD-10 with heading (F11). Examples may include:

1. [Most commonly] Opioid use disorder: F11.10 (mild), F11.20 (moderate), F11.20 (severe).
2. Opioid intoxication: F11.129, F11.229, F11.929, F11.222, and/or F11.922
3. Opioid withdrawal: F11.23
4. Unspecified Opioid-Related Disorder: F11.99

Additional detail available at: <http://www.icd10data.com/ICD10CM/Codes/F01-F99/F10-F19/F11->

### Current Procedural Terminology (CPT) & Documentation

- Will follow standard evaluation and management (E&M) coding based on complexity and time with four contributing components: history, physical exam (or mental status exam), complexity of

decision-making, and contributing factors. In general, these codes are the same for primary care physicians and psychiatrists; there are no specific CPT codes unique to MAT.

- New patient/induction visits: 99203-99205
- Follow-up/maintenance visits: 99211-99215
- Psychiatrists may additionally bill using E/M modifiers for psychotherapy (+90833, +90836, +90838)
- Psychologists and Social Workers may bill for individual psychotherapy services: 90832, 90834, 90837
- Group therapy (including outpatient buprenorphine services): 90853
- Some private health insurers or government entities utilize HCPCS codes for buprenorphine treatment services, which will be determined on a local basis: Examples include:

1. H0001 – IOP Alcohol and/or drug assessment
2. H0002 – Screening to determine eligibility for admission to treatment program
3. H0003 – Alcohol and Drug Screening
4. H0015 – Intensive Outpatient Treatment
5. H0034 – Medication Training and Support
6. H0038 – Self-help/Peer Services

## HEALTH CENTER VISITS GENERATED FROM ONE DATA 2000-WAIVERED PHYSICIAN

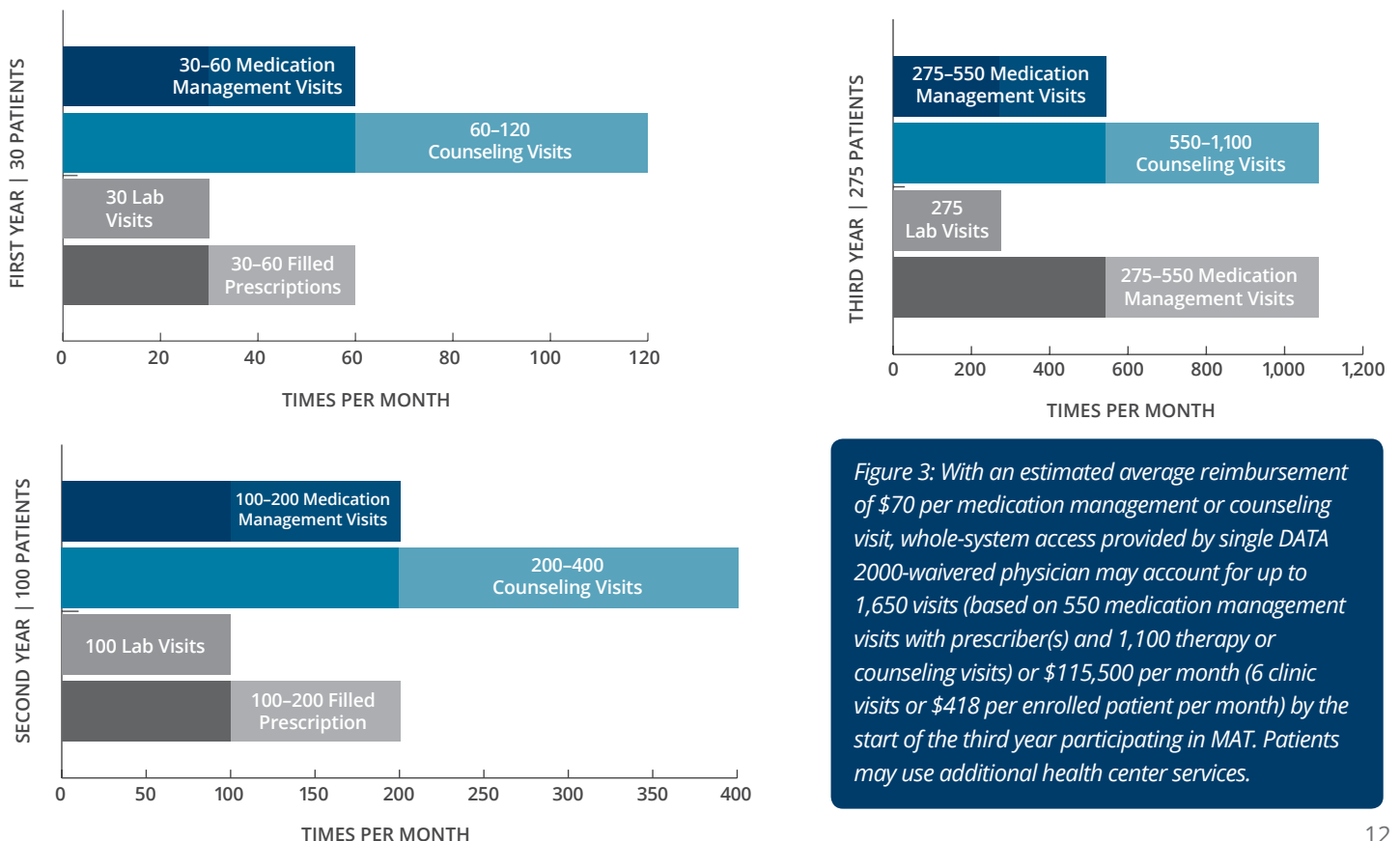


Figure 3: With an estimated average reimbursement of \$70 per medication management or counseling visit, whole-system access provided by single DATA 2000-waivered physician may account for up to 1,650 visits (based on 550 medication management visits with prescriber(s) and 1,100 therapy or counseling visits) or \$115,500 per month (6 clinic visits or \$418 per enrolled patient per month) by the start of the third year participating in MAT. Patients may use additional health center services.

## Case Study: One Health Center's MAT Model During Most Recent 1-Year Period

The growth with 1 physician was steady through the year, growing from 35 active MAT patients in December 2016 to 100 in November 2017. While 100 patients were actively being managed in November, 144 received a qualifying service from the MAT team.

- MD - 1.00 FTE
- NP - 0.33 FTE
- RN - 1.00 FTE
- BHC (Behavioral Health Consultant- PhD or LCSW)- 2.00 FTE
- CHC (Community Health Coordinator); focus on access to community supports and supporting the care plan. For addiction services, this has involved helping to organize transportation, housing, as well as co-facilitation of intensive outpatient groups (along with licensed behavioral provider) - 0.67 FTE
- PSR (Patient Services Representative); scheduling, admin support for clinic operations - 0.67 FTE
- Billing, IT, through corporate & business offices

*The staffing from MAT Program included:*

Staff costs including benefits are estimated between **\$440,000–\$480,000**. The nurse practitioner also sees patients that are either no longer in MAT or have not entered MAT. The visits she generated for non-MAT patients are excluded from this model. Also, the CHC, PSR, RN, and BHC also see non-MAT patients but FTE's have been adjusted to **reflect estimated time spent with MAT patients, only**.

*During the 12 month period reviewed:*

- The doctor saw **210 patients** which represented **1,789 medication** visits.
- The NP provided **784 visits** to these patients.
- BHC visits added another **2,154 visits (711 individual and 1,443 group)**.
- In all, there were 3,284 visits that qualified as FQHC encounters. At a hypothetical PPS rate of \$150, that equates to \$492,600 in revenue.

*Averages, per patient, are as follows:*

- Monthly Visits = 4.5 (MD 1.9, BHC 2.1, NP 0.5)
- Annual Visits = 22.5 (MD 8.5, BHC 10.3, NP 3.7)

*Monthly Prescriptions Filled=4*

## SCALABILITY

### Diagnoses (ICD-10)

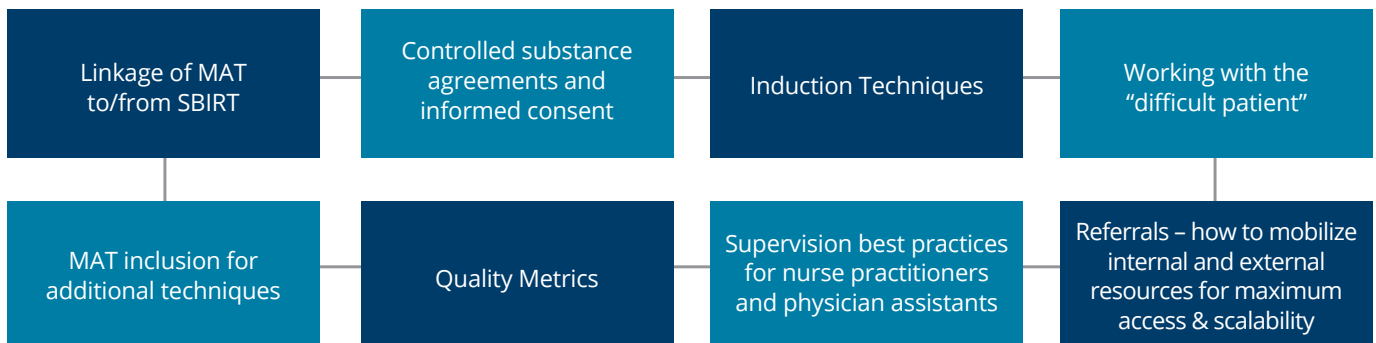
- Screening tools/visits may allow more comprehensive referrals and integration: PHQ-2/9, NIDA, domestic violence, CAGE-AID, ACES, and SDOH.
  1. These programs have used ancillary staff such as social workers, nurses, and case managers to provide time-consuming clinical services allowing the prescriber to focus specifically on MAT.
  2. May facilitate self-management and peer-to-peer connections.
- Each additional DATA 2000 provider may expand access relative to the case availability on his or her waiver [30, 100, or 275 patients, as above].
  1. Flag prescribers to apply for an increase in waiver status on the relevant anniversary of waiver receipt.
- Practice toolbox may help to spread responsibilities between staff, services, and billable visits: primary care, nutrition, behavioral health, labs, etc.

## ONLINE RESOURCES

New medications for office-based treatment of opioid addiction are comparable in efficacy to other chronic conditions such as diabetes, asthma, and hypertension when combined with other interventions and as part of a comprehensive care plan. They are safe, highly effective, can be prescribed and/or administered at the Community Health Center, with a sustainable business plan.

1. Providers' Clinical Support System (PCSS) for Opioid Therapies: <http://pcss-o.org>
2. PCSS for Medication Assisted Treatment: <http://pcssmat.org>
3. American Society of Addiction Medicine (ASAM) Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use: <https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf>
4. ASAM Summary of the Comprehensive Addiction and Recovery Act (CARA): <https://www.asam.org/advocacy/issues/opioids/summary-of-the-comprehensive-addiction-and-recovery-act>
5. ASAM Treatment of Opioid Use Disorder Course (includes waiver-qualifying requirements): <https://elearning.asam.org/buprenorphine-waiver-course>
6. American Association of Nurse Practitioners (AANP) State Practice Environment Interactive Map: <https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment>
7. SAMHSA Facts about Buprenorphine for Treatment of Opioid Addiction: <https://store.samhsa.gov/product/The-Facts-about-Buprenorphine-for-Treatment-of-Opioid-Addiction/SMA15-4442>
8. SAMHSA Buprenorphine Waiver Notification: <http://buprenorphine.samhsa.gov/forms/select-practitioner-type.php>
9. HRSA Substance Abuse Expansion Technical Assistance: <https://bphc.hrsa.gov/programopportunities/fundingopportunities/substanceabuse/>
10. SAMSHA Publications and Resources on Medication-Assisted Treatment (MAT): <https://www.samhsa.gov/medication-assisted-treatment/training-resources/publications>
11. Project ECHO pain clinic: <http://echo.unm.edu/>
12. PainNET, through the Weitzman Institute, CHC, Inc.: <https://painnet.net>

## FUTURE DIRECTIONS



- 1 National Institute on Drug Abuse. Trends & Statistics Retrieved from <http://www.drugabuse.gov/related-topics/trends-statistics>.
- 2 Thomas, Marshall R., et al. Prevalence of psychiatric disorders and costs of care among adult enrollees in a Medicaid HMO. *Psychiatric Services* 56.11 (2005): 1394-1401.
- 3 SAMSHA-HRSA, 2013
- 4 Saitz, R., M. J. Larson, et al. (2004). "Linkage with primary medical care in a prospective cohort of adults with addictions in inpatient detoxification: room for improvement." *Health Serv Res*, 39(3): 587-606.
- 5 Based on an estimated average reimbursement per visit of \$70 used for this example
- 6 SAMHSA 2016 data from 2014 NSDUH
- 7 <https://www.cdc.gov/drugoverdose/data/statedeaths.html>
- 8 <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.jsp>
- 9 <https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/physician-program-data>. Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4856 Findings). Rockville, MD.
- 10 Substance Abuse and Mental Health Services Administration. (2010)
- 11 <https://www.hhs.gov/sites/default/files/Factsheet-opioids-061516.pdf>
- 12 [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/medication\\_assisted/evaluation-buprenorphine-waiver-program-study-overview.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/evaluation-buprenorphine-waiver-program-study-overview.pdf)
- 13 Tetrault JM, Fiellin DA. Current and potential pharmacological treatment options for maintenance therapy in opioid- dependent individuals. *Drugs*. 2012;72(2):217-228.; Nosyk B, Anglin MD, Brissette S, et al. A call for evidence-based medical treatment of opioid dependence in the United States and Canada. *Health Aff (Millwood)*. 2013;32(8):1462-1469.
- 14 LaBelle CT, Han SC, Bergeron A, Samet JH. Office-Based Opioid Treatment with Buprenorphine (OBOT-B): Statewide Implementation of the Massachusetts Collaborative Care Model in Community Health Centers. *Journal of substance abuse treatment*. 2016;60:6-13. doi:10.1016/j.jsat.2015.06.010.
- 15 Alford Dp et al. *Arch Intern Med*. 2011
- 16 <http://pcssmat.org/wp-content/uploads/2014/10/PCSSMAT-Online-Module-Role-of-FQHC-in-OBOT-Colleen-Labelle-AMERSA.pdf>
- 17 <https://effectivehealthcare.ahrq.gov/topics/opioid-use-disorder/technical-brief>
- 18 <https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/increase-patient-limits>
- 19 <https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/qualify-for-physician-waiver>
- 20 <https://www.asam.org/resources/practice-resources/nurse-practitioners-and-physician-assistants-prescribing-buprenorphine>
- 21 <https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine>
- 22 <https://www.samhsa.gov/bupei/lookup-form>