MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

Role of OBOT Nurse Care Manager in Federally Qualified Community Health Centers

Colleen T LaBelle, BSN, RN-BC, CARN
AMERSA

Colleen T. LaBelle, Disclosures

- Colleen T LaBelle, BSN, RN-BC, CARN has no financial relationships with an ACCME defined commercial interest.

The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.

Planning Committee, Disclosures

AAAP aims to provide educational information that is balanced, independent, objective and free of bias and based on evidence. In order to resolve any identified Conflicts of Interest, disclosure information from all planners, faculty and anyone in the position to control content is provided during the planning process to ensure resolution of any identified conflicts. This disclosure information is listed below:

The following developers and planning committee members have reported that they have no commercial relationships relevant to the content of this module to disclose: PCSSMAT lead contributors Maria Sullivan, MD, PhD, Adam Bisaga, MD; AAAP CME/CPD Committee Members Dean Krahn, MD, Kevin Sevarino, MD, PhD, Tim Fong, MD, Robert Milin, MD, Tom Kosten, MD, Joji Suzuki, MD; AMERSA staff and faculty Colleen LaBelle, BSN, RN-BC, CARN, Doreen Baeder and AAAP Staff Kathryn Cates-Wessel, Miriam Giles and Blair Dutra.

Frances Levin, MD is a consultant for GW Pharmaceuticals and receives study medication from US Worldmed. This planning committee for this activity has determined that Dr. Levin's disclosure information poses no bias or conflict to this presentation.

All faculty have been advised that any recommendations involving clinical medicine must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients. All scientific research referred to, reported, or used in the presentation must conform to the generally accepted standards of experimental design, data collection, and analysis. Speakers must inform the learners if their presentation will include discussion of unlabeled/investigational use of commercial products.

Accreditation Statement

- This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of American Academy of Addiction Psychiatry (AAAP) and Association for Medical Education and Research in Substance Abuse (AMERSA). American Academy of Addiction Psychiatry is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Designation Statement

- American Academy of Addiction Psychiatry designates this enduring material for a maximum of 1 (one) *AMA PRA Category 1 Credit*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.
  - Date of Release October 21, 2014
  - Date of Expiration October 21, 2014

System Requirements

- In order to complete this online module you will need Adobe Reader. To install for free click the link below:
  - http://get.adobe.com/reader/

Target Audience

- The overarching goal of PCSS-MAT is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.

Educational Objectives

- At the conclusion of this activity participants should be able to:
  - List barriers reported by physicians to prescribing buprenorphine in an office based setting
  - Describe a collaborative care model for OBOT expansion
  - Identify the benefits of FQHC model to expand OBOT
  - List functions of the NCM in an OBOT setting

A New Law

Drug Addiction Treatment Act (DATA) 2000

- Amendment to the Controlled Substances Act
- Allows physician to prescribe narcotic drugs scheduled III, IV or V, FDA approved for opioid maintenance or detoxification treatment
  - Prior 10/2002 no drug existed
  - Methadone does not qualify

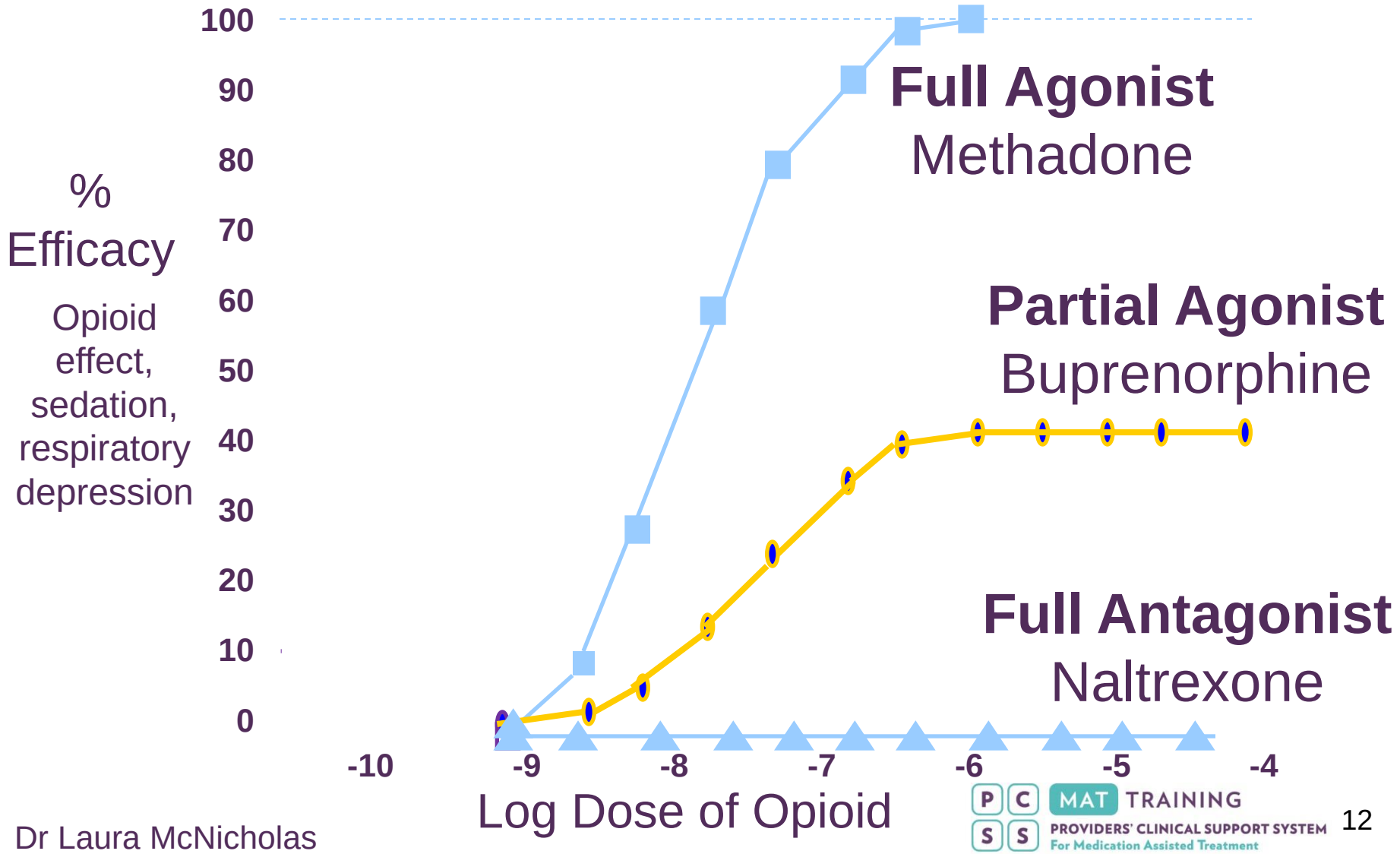
DATA 2000: Physician Qualifications

Physicians must:

- Be licensed to practice by his/her state
- Have the capacity to refer patients for psychosocial treatment
- Limit number of patients receiving buprenorphine to 30 patients for a least the first year
- File for a new waiver after first year to increase their limit to 100 patients.
- Be qualified to provide buprenorphine and receive a license waiver

BUPRENORPHINE

Opioid Potency



Dr Laura McNicholas

PC MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

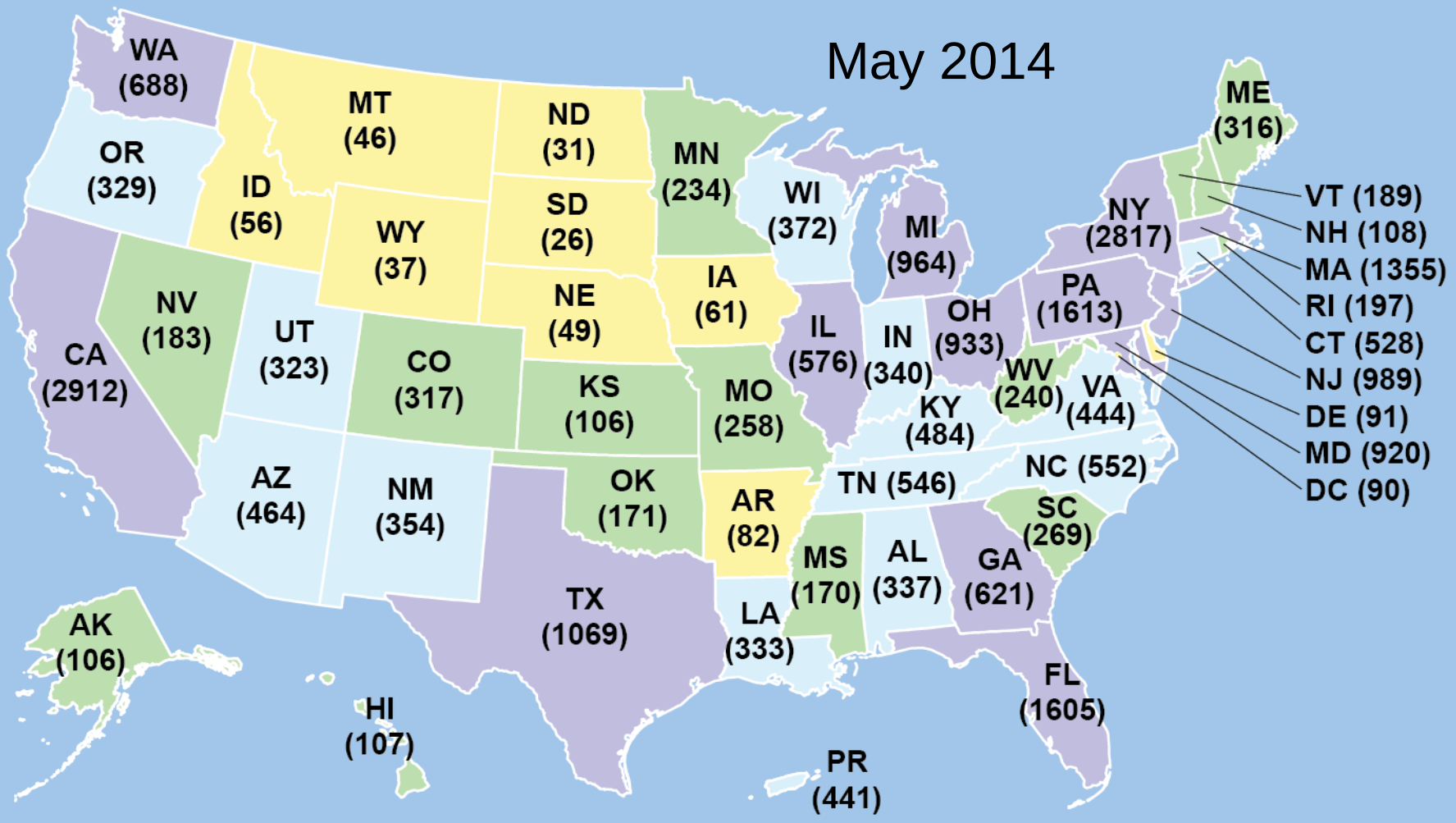
How Does Buprenorphine Work?

- “Ceiling effect” on opioid effects
- High affinity for opioid receptor
- Slow dissociation from opioid receptor
- Formulated with naloxone
  - Naloxone blocks opiate effect if injected
  - Naloxone is degraded (inert) if taking orally

Goals of Pharmacotherapy with Buprenorphine:

- Prevention or reduction of withdrawal symptoms
- Prevention or reduction of drug craving
- Prevention of relapse to use of addictive drug
- Restoration to or toward normalcy of any physiological function disrupted by drug abuse

Only 4% of Eligible US Doctors are Certified to Prescribe Buprenorphine



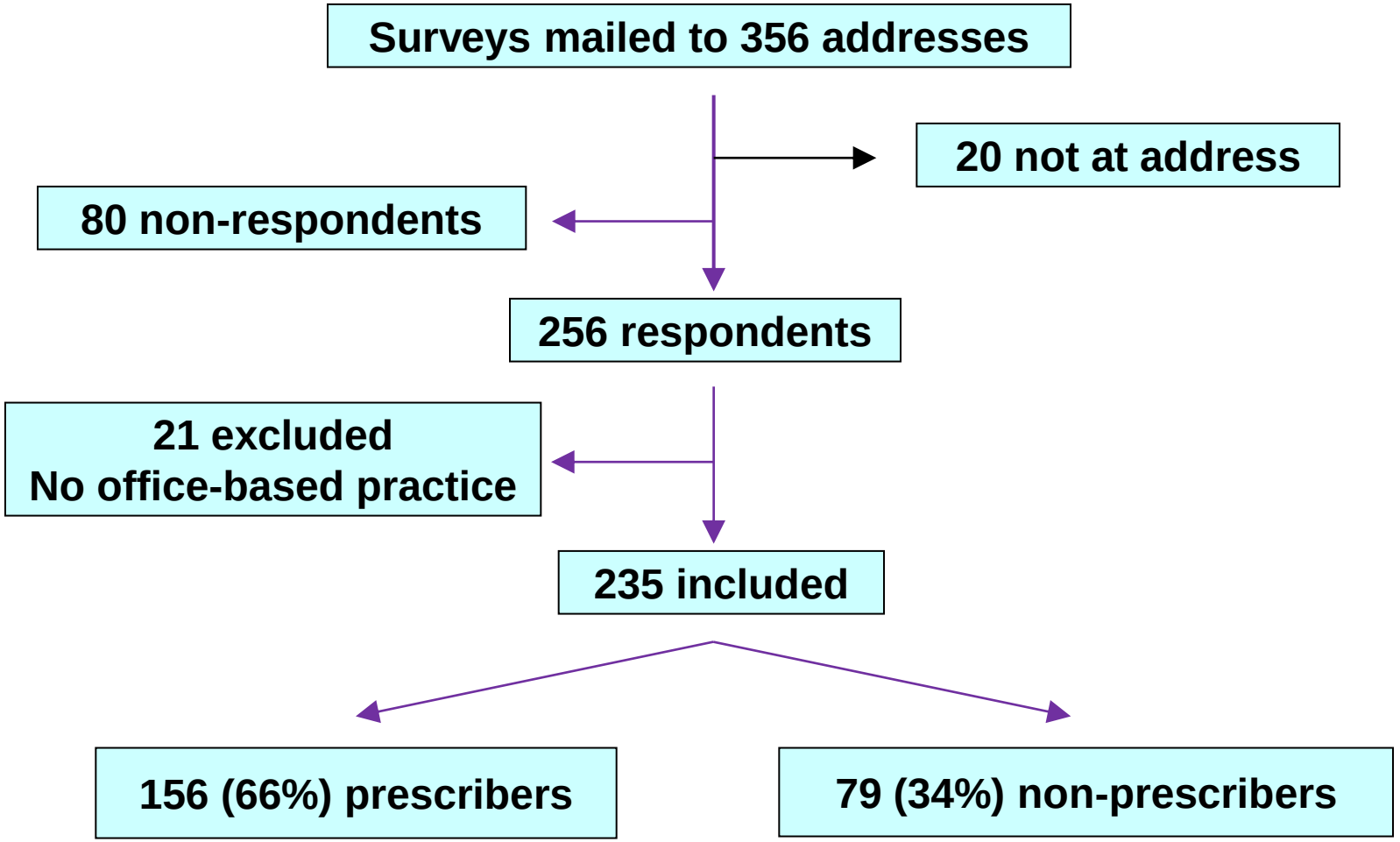
Center For Substance Abuse Treatment
CSAT 2014

Needs Assessment in MA with Bureau of Substance Abuse Services

- High rate of opioid addiction
- High number of fatal and non-fatal opioid overdoses
- Long waits for opioid treatment, both methadone and buprenorphine
- Some people refuse Methadone maintenance
- Not enough MA physicians had waivers
- Some waivered physicians were not prescribing

MA Department of Public Health Bureau of Substance Abuse Services 2007

October/November 2005 MDPH sent survey to all 356 waivered physicians



Walley AY et al. J Gen Intern Med 2008; 23(9): 1393-8

PCSS MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

Barriers to Prescribing Office Based Treatment with Buprenorphine

Prescriber Status and Specialty (n=235)

	Total	Prescriber N=156	Non-prescriber N=79
Total	235 (100)	156 (66)	79 (34)
Psychiatrist	126 (54)	74 (47)	52 (67)
Primary Care	102 (44)	78 (50)	24 (31)
Other	6 (3)	4 (3)	2 (3)

Walley AY et al. J Gen Intern Med 2008; 23(9): 1393-8

Barriers to Buprenorphine Prescribing

Insufficient nursing support	20 %
Insufficient office support	19 %
Payment issues	17 %
Lack of institutional support	16 %
Insufficient staff knowledge	12 %
Pharmacy issues	8 %
Low demand	7 %
Office staff stigma	5 %
Insufficient physician knowledge	3 %
One or more barriers	55%

Walley AY et al J Gen Intern Med 2008; 23(9): 1393-8

Non-prescribers

If barriers improved:

- 54% (33/61) of those who had never prescribed buprenorphine, will prescribe
- 67% (10/15) of those who had prescribed, will prescribe

Walley AY et al J Gen Intern Med 2008; 23(9): 1393-8

Only physicians can prescribe.

However, it takes a Multidisciplinary Team Approach for effective addiction treatment.

Boston Medical Center Collaborative Care Model in General Internal Medicine

- **5/2003**
  - 1 patient, 1 physician and 1 RN
- **7/2010**
  - 425 patients (3-6 admissions per week)
  - 9 physicians
    - 1 medical director
    - 3 ABAM certified
    - Part-time clinical practices – mean 3 half day sessions/week (range 1-6 sessions)
  - 3 RNs (3 FTE)
  - 1 medical asst (1 FTE)
  - 1 program coordinator (1 FTE)
  - 1 program director (.4 FTE)

Alford DP et al. Arch Intern Med. 2011

BMC Collaborative Care Model

- Program Coordinator intake call
  - Screens the patient over the telephone
  - OBOT Team reviews the case for appropriateness
- NCM and physician assessments
  - Nurse does initial intake visit and collects data
  - Physician: PE, and assesses appropriateness, DSM IV criteria of opioid dependence
- NCM supervised induction (on-site) and managed stabilization (on- and off-site (by phone))
  - Follows protocol with patient self administering medication per prescription

Alford DP et al. Arch Intern Med. 2011

BMC Collaborative Care Nurse Care Managers (NCM)

- Registered nurses, completed 1 day buprenorphine training
- Performed patient education and clinical care by following treatment protocols (e.g., UDT, pill counts, periop mgnt)
- Ensured compliance with federal laws
- Coordinated care with OBOT physicians
- Collaborated care with pharmacists (refills management) and off-site counseling services
- Drop-in hours for urgent care issues
- Managed all insurance issues (e.g., prior authorizations)
- On average each NCM saw 75 patients/wk

Alford DP et al. Arch Intern Med. 2011

BMC Collaborative Care

- Maintenance treatment patient in care (at least 6 months)
  - NCM visits weekly for 4-6 wks, then q2 wks, then q1-3 months and as needed.
  - Patients seen less than monthly had up to 6 random callbacks/yr
  - **OBOT physician visits at least every 6 months**
- Medically supervised withdrawal *considered* after 6 months of stability if the patient requested to taper, paced with patient needs and stopped if patient requested
- Transferred to Methadone if continued illicit opioid use or need for more structured care
- Discharged if continued non-adherence or disruptive behavior

Alford DP et al. Arch Intern Med. 2011

BMC Collaborative Care Preadmission Factors Associated with Treatment Success

Characteristic	OR (95% CI)
Older age	1.40 (1.09-1.80)
Employed	2.24 (1.33-3.77)
Illicit buprenorphine use	3.04 (1.32-7.00)
African American	0.50 (0.26-0.99)
Hispanic/Latino	0.45 (0.22-0.93)

Alford DP et al. Arch Intern Med. 2011

BMC Collaborative Care Urine Drug Tests

Month	3	6	9	12
Illicit Opioid NEG	95%	94%	93%	95%
Cocaine NEG	95%	96%	95%	98%

Alford DP et al. Arch Intern Med. 2011

Table 2. Treatment Outcomes at 12 Months of 382 Opioid-Dependent Patients Entering Office-Based Opioid Treatment in Primary Care

Outcome	Patients, No. (%)
Successful treatment	196 (51.3)
Treatment retention	187 (49.0)
Successful taper after 6 months of adherence[a]	9 (2.4)
Unsuccessful treatment	162 (42.4)
Lost to follow-up	113 (29.6)
Nonadherence despite enhanced treatment[a]	46 (12.0)
Administrative discharge due to disruptive behavior	2 (0.5)
Adverse effects of buprenorphine hydrochloride	1 (0.3)
Transfer to methadone hydrochloride treatment program	24 (6.3)

Alford DP et al. Arch Intern Med. 2011

BMC Collaborative Care Model Conclusions

- Patient-level outcomes comparable to physician-centered approaches
- Allows efficient use of physician time to focus on patient management (e.g., dose adjustments, maintenance vs taper)
  - Allowed physicians to managed > numbers of patients due to support of NCM
- Improved access to OBOT and daily management of complex psychosocial needs (e.g., housing, employment, health insurance)
- Open communication between NCM and addiction counselors improved compliance

Alford DP et al. Arch Intern Med. 2011

MA STATE OBOT B: Nurse Care Manager Model in FQHCs

State Initiative Project Goals in Federally Qualified Health Centers FQHCs

- Treatment expansion and access to buprenorphine
- Create a model for the effective delivery of buprenorphine services:
  - Modeled after BMCs Nurse care manager program
- Integrate addiction treatment into primary care settings
- Increase the number of MD's with waivers
- Increase the number of individuals treated for opioid addiction
- Focus on high risk areas, homeless individuals and pregnant women, Latino, African American
- Collect and analysis data
- Sustainability of project after funding ends

MA Department of Public Health Bureau of Substance Abuse Services 2007

MA Department of Public Health Bureau of Substance Abuse Services Released two RFR's: In Response to Unmet Need

- Funding for a Nurse Care Manager Model in all Community Health Centers (CHC) in the state who submitted responses to RFR
- Required CHC to partner with addictions counseling service providers
- Funding for training and technical assistance to the CHC OBOT's and to all nonprofit providers interested in providing OBOT or needing support/consult
- Funding awarded for 3 years with an 8/07 start date, renewable for a total of 7 years and has since been extended using Block grant and state funds
- Modeled after Boston Medical Centers Nurse Care Manager Model

MA Department of Public Health Bureau of Substance Abuse Services 2007

RFR Funding

- $270,000 per year for Technical Assistance: training, booster sessions, quarterly state educational sessions, conference calls, site visits, support staff and admin assistance, support to statewide providers in nonprofits, accountability of grant deliverables.

- $100,000 per CHC for Nurse Care Manager
  - 1 full time RN
  - 1:100 staff to patient ratio
    - Rolling admission of new patients each week to reach the 100
  - 1:125 with addition of Medical Assistant in year 4 of the grant, and less funding to support NCM
- Funding allowed billing for
  - Nurse Care Manager Salary initially
    - In year 4, 25% to nurse salary the remainder to MA as the NCM is reimbursable, the MA allows for additional patients and transfer of non nursing tasks to MA
  - Fringe
  - Transportation
  - Supplies

TA Support

- Nursing training and ongoing support
  - Phone, email, site visits, chart reviews
  - Quarterly statewide NCM meetings:
    - addiction education, support, networking
- Site support:
  - Education all providers
    - Trainings: addiction, buprenorphine, stigma, management, set up
  - Support practice: MD and nursing issues
  - Care for or triage patients to other sites due to closures, staff changes, emergency issues
  - DEA Support: Education and preparation, support at visits
  - Waiver assistance, insurance support, coverage, carrier issues

MA Department of Public Health Bureau of Substance Abuse Services 2007

What is a Federally Qualified Community Health Centers (FQHCs)

- In 1965, federal government created a demonstration project funding CHC's
  - Current model was established in 1975
  - 1996 funding streams merged to create health center grant program under Section 330 of the Public Health Act
  - Health Resources and Service Administration (HRSA) distributes grant funding to FQHC's
- FQHC's are nonprofit organizations delivering Team based integrated care with physicians, advanced practice nurses, physicians assistants, nurses and other non-physician practitioners.
- Tasked with caring for medically underserved patients in underserved areas

Health Resources and Services Administration HRSA

Benefits Provided at FQHCs

Services FQHCs are required to provide that are not reimbursed by Medicare	Included in the Medicare FQHC all-inclusive payment rate	Separately billable by the FQHC provider under Part B
Case management	Visiting nurses to the homebound	Technical components of lab tests
Translation/interpretation services	Incidental services, supplies, and overhead	Durable medical equipment
Preventive dental care	Primary and preventive services provided by physicians and nonphysician practitioners	Ambulance services
Transportation	Otherwise covered drugs that are not self-administered	
	Diabetes self-management training	
	Medical nutrition therapy	

CSM Medicare benefit policy manual, 2009

Comparing Medicare's FQHC and RHC payment to physician office visit and hospital outpatient visit, 2011

	Medicare payment amount
Payment limit	
FQHC, rural	$109.24
FQHC, urban	126.22
RHC	78.07
Physician office	
Physician fee schedule, office visit by an established patient	68.97
Hospital outpatient department	
Facility	75.13
Physician work	49.27
Total	124.40

***Level 3 Visit**

Note: FQHC, RHC, the physician fee schedule and outpatient department (OPD) figures are the national payment amount. Healthcare Procedure Coding System code 99213 for the physician fee schedule and OPD payment amounts. Medicare's payment rate for a physician office visit includes the practice expense (i.e facility-level) payment.

2011 physician fee schedule, Hospital Outpatient Prospective Payment System

Public Health Service Act (defines FCHC)

Benefits Improvement and Protection Act 2000

- Establishes payment requirements for Medicaid
- Federally mandates paying FCHC's "average reasonable costs" to service medically under-served populations
- Gives each state the authority and flexibility to define services, providers, and rates

Section 330(a) of the PHS Act

- Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services. (Section 330(h)(2) of the PHS Act)

Cost Modeling in FQHCs in MA Concluded:

- Allows RN's to bill for an "Individual Medical Visit"
- Rate is the same as for an MD visit
- Assuming a nurse to patient ratio of 1:100
  - 90% utilization for a mixed frequency caseload
  - Included overhead and administrative costs
  - Federally QHC would make a profit of approximately $180,000 per fulltime NCM
  - NCM providing OBOT is sustainable and viable in a Federally Qualified Community Health Center

MA Department of Public Health Bureau of Substance Abuse Services 2010 Cost modeling report by Paul Cote

UMass Study Findings in Massachusetts

- Studied 5,600 Mass Health Clients prescribed buprenorphine and methadone
- Overall Mass Health expenditures lower than for those with no treatment
- Clients on Medication Assisted Treatment (MAT) had significantly lower rates of relapse, hospitalizations and ED visits: no more costly than other treatments
- Buprenorphine attracting younger and newer clients to treatment

R.E. Clark; Health Affairs, August 2011

Nurse Care Manager Model

- Screener by coordinator or nurse
- RN intake: labs, UTS, contracts, education
- Counselor - intake, refer to psych if warranted
- Intake reviewed by the OBOT team (RN, MD)
- Bupe MD visit: review, assess, clear for treatment appropriateness with DSM IV Dx Opioid Dependence
- Induction: stabilization, maintenance
  - Management by RN with waivered prescriber
    - Visits, assessments, education, UDS, labs, MD contacts
    - Facilitate prescription refills, medical monitoring, relapse, surgery, pregnancy, mental health needs, social supports, treatment plans

OBOT RN Nursing Assessment:

- Intake assessment
  - Review medical hx, treatment hx, pain issues, mental health, current use, and medications
- Consents/Treatment agreements
  - Program expectations: visits & frequency, UDS, behavior
  - Understanding of medication: opioid, potential for withdrawal
  - Review, sign, copies to patient and review at later date
- Education
  - On the medication (opioid), administration, storage, safety, responsibilities and treatment plan
- Urine toxicology screen
  - Screen drug of use and ? Others: If positive what that may mean for treatment
- LFT's, Hepatitis serologies, RPR, CBC, pregnancy test

OBOT MD

- Review of history
  - Mental health, substance use, medical, social
- Physical Exam
- Lab and urine review
  - Assess contraindications, toxicology
- Confirm Opioid Dependence diagnosis
  - DSM IV criteria
- Confirm appropriate for office treatment
- Writes the orders and prescription
- Develop Treatment Plan with OBOT Team

OBOT RN Role In FQHC's

- Review and support program requirements:
  - Nurse/ Physician Appointments:
    - Frequency, times, location
  - Counseling:
    - Weekly initially, self help, mental health as needed
  - Obtain urine toxicology:
    - At visits, call backs, as needed and follow up
  - Support abstinence/ harm reduction
    - Abstinence from opioids is the goal
    - Safety with the goal to minimize substance use
  - Educate and monitor for Safety:
    - Medication storage, management, adherence
    - Relapses, assess risk benefit

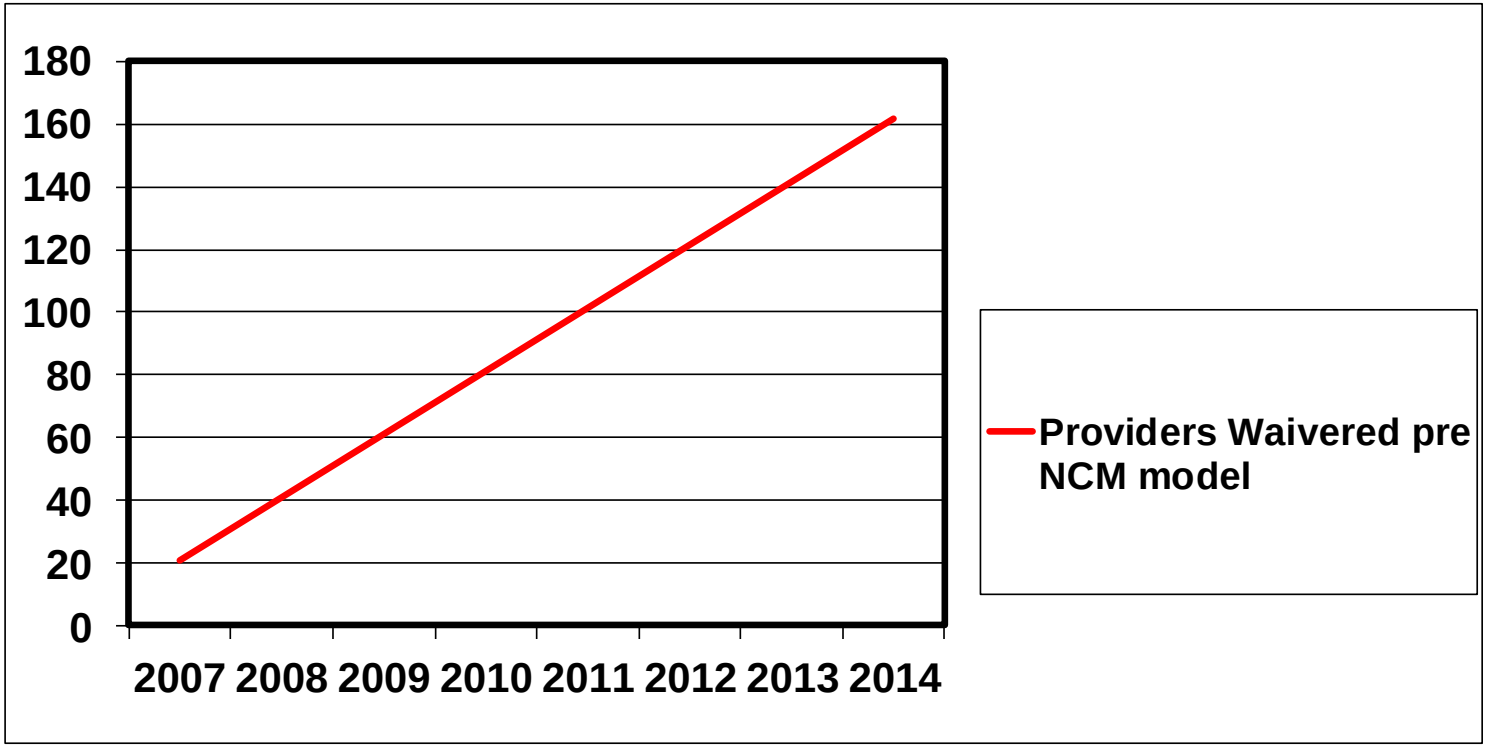
OBOT RN
Follow up Visits:

- Assess dose, frequency, cravings, withdrawal
- Ongoing education: dosing, side effects, interactions, support.
- Counseling, self help check in
- Psychiatric evaluation and follow up as needed
- Medical issues: vaccines, follow up, treatment HIV, HCV…Engage in care
- Assist with preparing prescriptions
- Facilitating prior approvals and pharmacy
- Pregnancy: if pregnant engage in appropriate care
- Social supports: housing, job, family, friends

NCM Model in FQHC Allows:

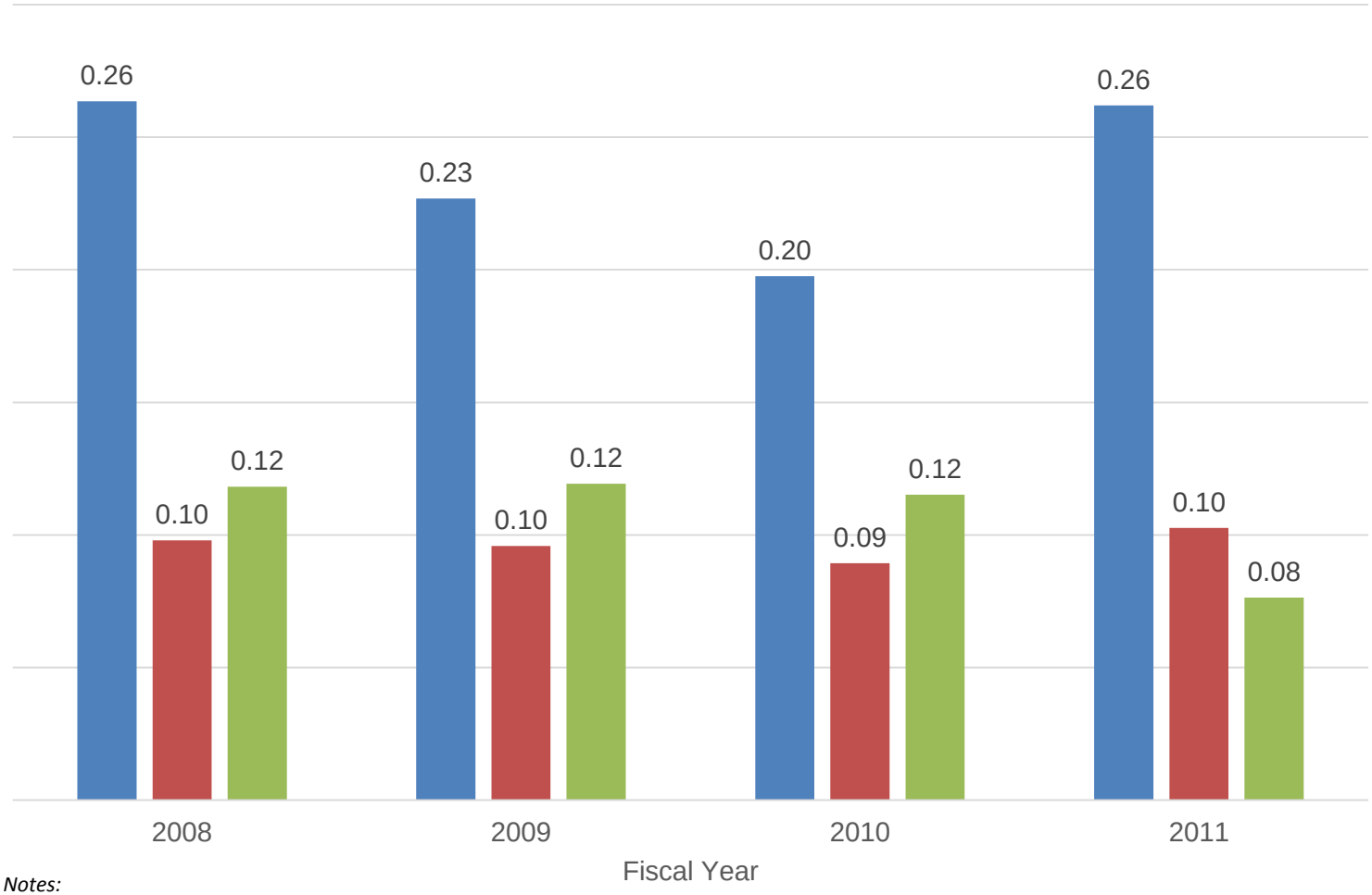
- Greater numbers of patients able to access treatment
- Supports complex patient needs without burdening providers
- Allows patients to access treatment in their community
- Integrated within primary care therefore supports primary care needs: HTN, HCV, HIV, DM, etc.
- Integrates addictions care into medical treatment
- Individualizes treatment
- Removes Stigma
- Engages providers
- Is financially sustainable

STATE OBOT B MD's Waivered in Community Health Centers:



Hospital Admissions

Average Hospital Admissions Per OBOT Enrollment

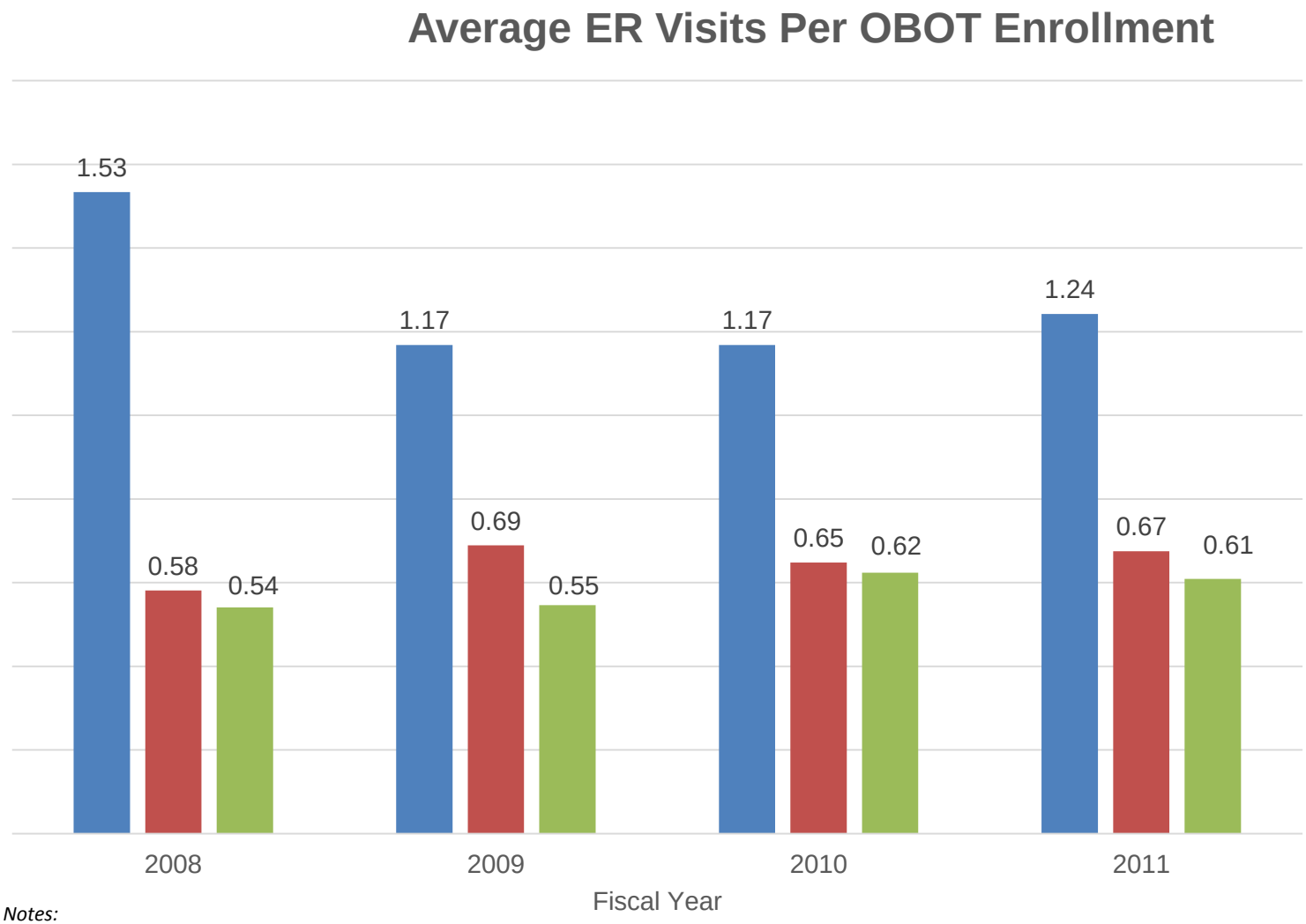


2008: N=296
2009: N=595
2010: N=582
2011: N=458

Notes:

- *Hospital data is only available through 9/30/2012*
- *Enrollments must have lasted at least 12 months*
- *Paid amounts are calculated using hospital specific pay to charge ratios*

ER Visits

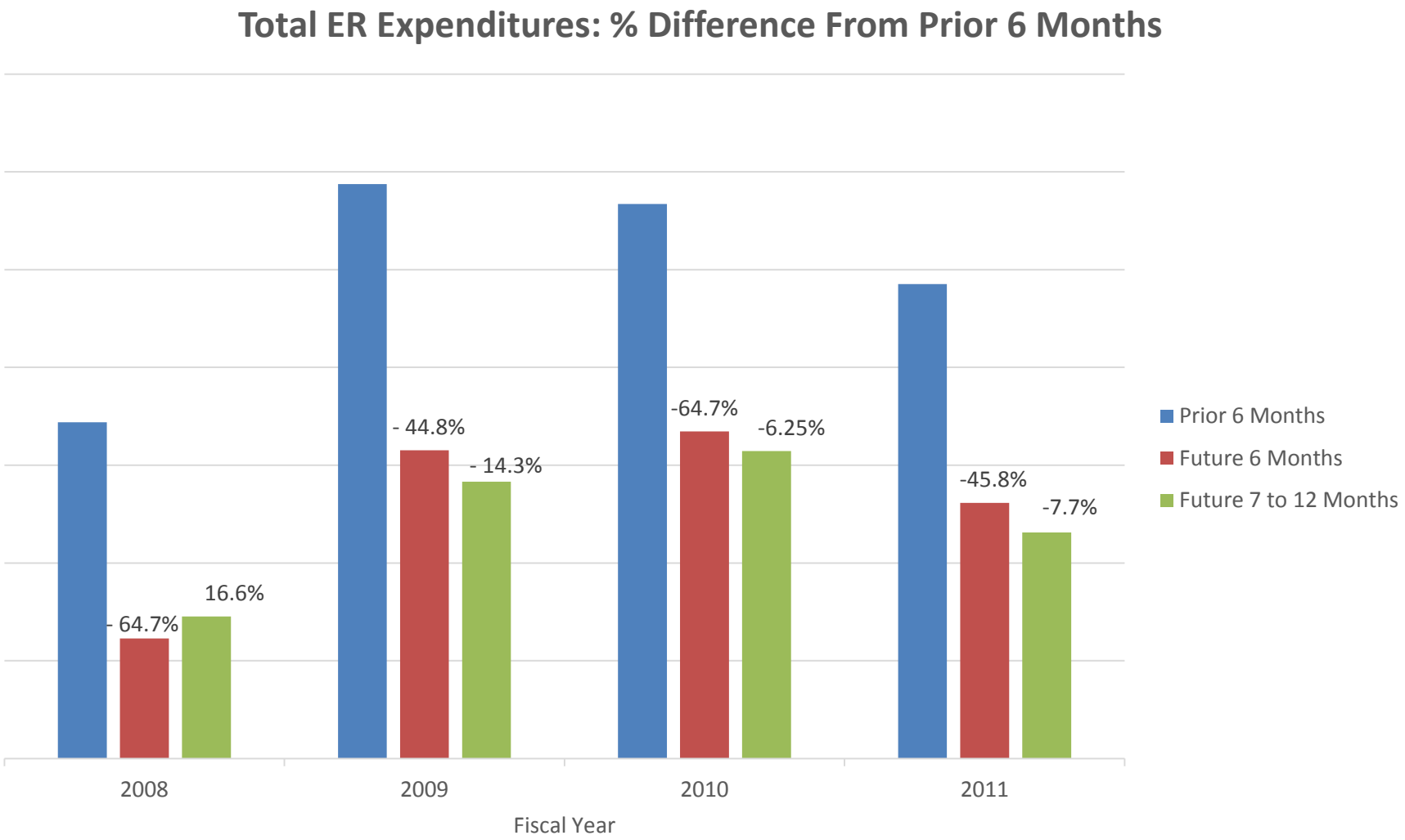


2008: N=296
2009: N=595
2010: N=582
2011: N=458

Notes:

- *Hospital data is only available through 9/30/2012*
- *Enrollments must have lasted at least 12 months*
- *Paid amounts are calculated using hospital specific pay to charge ratios*

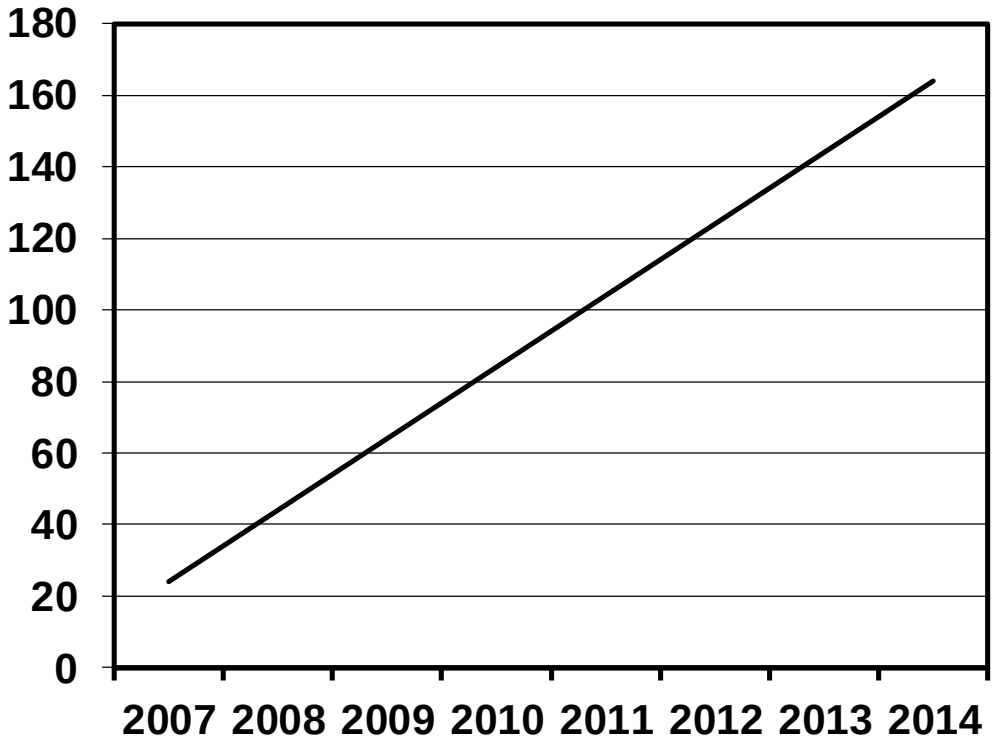
ER Expenditures



Notes:

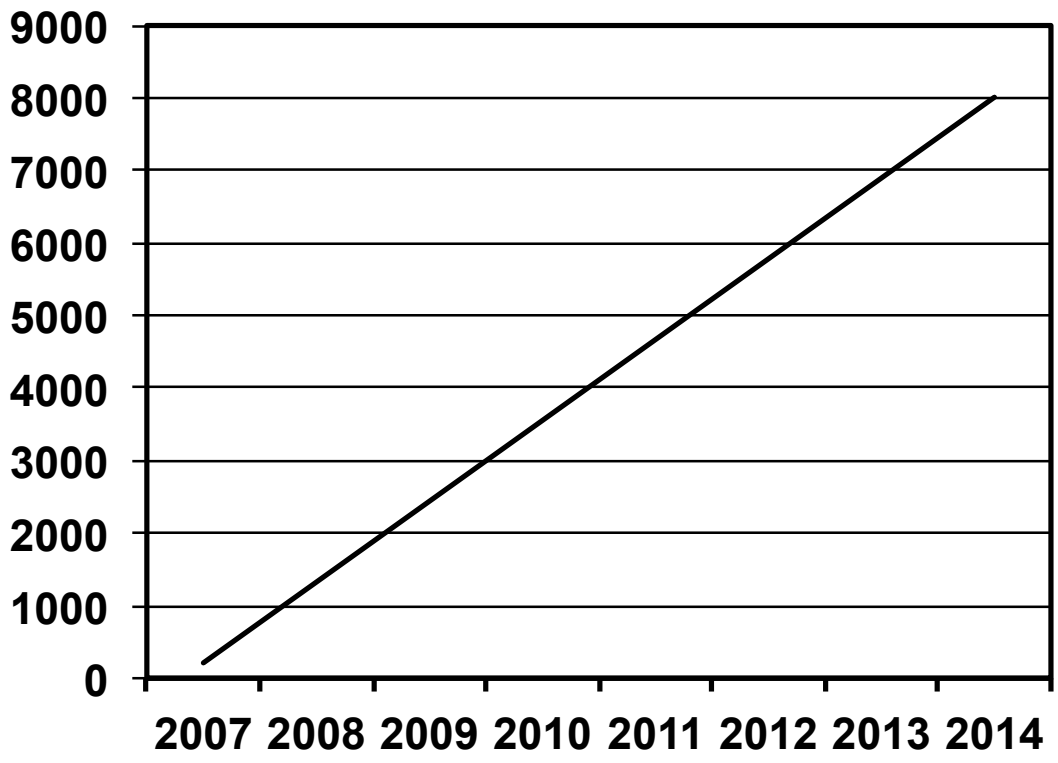
- *Hospital data is only available through 9/30/2012.*
- *Enrollments must have lasted at least 12 months*
- *Paid amounts are calculated using hospital specific pay to charge ratios*

STATE OBOT B Physicians waivered in CHC's pre and post grant :



Providers waivered to prescribe buprenorphine pre and post NCM model in funded CHC's in MA

STATE OBOT B Patients receiving buprenorphine in CHC's:



Patients treated with buprenorphine pre and post NCM model in funded CHC's in MA

Challenges for Addiction Nurses in FQHC's

- Many with limited to no addiction experience
  - Require initial training; booster sessions, educational opportunities
  - Ongoing support, training, mentoring
    - Need access to addiction providers: cell phone, email, meetings, site visits
- Difficult to hire experienced addiction nurses into health center
  - Salary
  - Environment: isolated, limited addiction colleagues
  - Support network: doing this alone within center
  - Many doctors turn to RN: have waiver limited experience

Challenges in FQHC's Waivered Physicians:

- Physicians with limited addiction experience or support
  - Mentors, resources are key
- Limited waivered providers
  - Back up support: vacation, moves, leaves
  - Try to engage and enlist other providers
- Physician leaves practice
  - Need to train and enlist other MD's
  - Back up of waivered providers
  - Providers at cap: State support network allows for transfer to other practice
- Health center has minimal buy in
  - May not require providers to be waivered, limiting numbers of providers

Next Steps

- Utilizing nurse care manager models to expand treatment to more sites
- Increase level of education among providers in addiction treatment
  - Nurses, doctors, support staff, and administration
- Require all physicians to obtain and X number
- Integrate in to the medical home model of care
- Look at drop out rates and reasons: improve retention
- Follow treatment and prevention outcomes when patients are in care for addiction

References

- Alford DP, LaBelle CT, Kretsch N, Pierson A, Botticelli M, Winter M, Samet, JH. Collaborative Care of Opioid Addicted Patients using Buprenorphine in Primary Care: Five Year Experience. Archives of Internal Medicine 2011;171(5) 425-431

- Alford DP, Salsitz E, Martin J, Renner JA. Clinical case discussion: Treating opioid dependence with buprenorphine. J Addict Med. 2007;1:73-78Alford DP, LaBelle CT, Richardson JM, O'Connell JJ, Hohl CA, Cheng DM, Samet JH. Treating homeless opioid dependent patients with buprenorphine in an office-based setting. Journal of General Internal Medicine, January 2007.

- Center for Medicare & Medicaid Services, Department of Health and Human Services, 2009. *Chapter 12: Rural health clinic and federally qualified health center services. Medicare benefit policy manual.* Baltimore, MD: CMS.

- Center for Medicare & Medicaid Services, Department of Health and Human Services, 2011d. Rural health clinics and federally qualified health centers billing guide. *MLN Matters no. SE1039.*

- Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment Improvement Protocol (TIP) Series, No. 43.) Available from: http://www.ncbi.nlm.nih.gov/books/NBK64164/

References

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

- Center for Substance Abuse Treatment. Clinical Guideline for Buprenorphine: A Guide for Nurses, TAP 30, Technical Assistance Publication Series http://buprenorphine.samhsa.gov/TAP 30. DHHS Publication. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2009.

- Clark, R.E., Samnaliev, M., Baxter, J.D., & Leung, G.Y., (2011). *The Evidence Doesn't Justify Steps By State Medicaid Programs to Restrict Opioid Addiction Treatment with Buprenorphine. 30(8), 1425-1433.*

- Fiellin DA, Rosenheck RA,Kosten TR. Office-based treatment for opioid dependence: reaching new patient populations. Am J Psychiatry.2001;158(8):1200–4.8

- Fiellin DA, O'Connor PG. Clinical practice. Office-based treatment of opioid-dependent patients. *N Engl J Med.* Sep 12 2002;347(11):817-823.

References

- Health Services and Resource Administration*: Section 330 of the Public Health Service Act* http://bphc.hrsa.gov/policiesregulations/legislation/index.html (42 USCS § 254b) Authorizing Legislation of the Health Center Program.

- Kuehn BM. Office-based treatment for opioid addiction achieving goals. JAMA. 2005;294(7):784– 6.11 National Conference of State Legislatures. 50-state table: Medicaid. financing of medication-assisted treatment for opiate addiction [Internet]. Washington (DC): NCSL; 2008 Apr 1 [cited 2009 Sep 10]. Available from: http://www.ncsl.org/default.aspx?tabid= 14144#32

- Massachusetts Department of Public Health Bureau of Substance Abuse Services Office Based Opioid Treatment RFR, 2007

- Massachusetts Department of Public Health Bureau of Substance Abuse Services, Cost modeling analysis by Paul Cote on FQHC sustainability and billing OBOT in CHCs, 2010.

- Saitz, R, Larson J, **LaBelle C**, Richardson J, Samet JH. The Case of Chronic Disease Management for Addiction. Journal of Addiction Medicine, 2008.

- Walley AY, Alperen J, Cheng DM, Botticelli M, Castro-Donlan C, Samet JH, **Alford, DP**. Office-based management of opioid dependence with buprenorphine: treatment practices and barriers. J Gen Intern Med 2008; 23(9):1393-8

PCSS-MAT Mentoring Program

- PCSS-MAT Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.
- PCSS-MAT Mentors comprise a national network of trained providers with expertise in **medication-assisted treatment, addictions** and **clinical education**.
- Our 3-tiered mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.
- The mentoring program is available, at no cost to providers.

For more information on requesting or becoming a mentor visit:

pcssmat.org/mentoring

MAT TRAINING

PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

PCSSMAT is a collaborative effort led by American Academy of Addiction Psychiatry (AAAP) in partnership with: American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA) and American Society of Addiction Medicine (ASAM).

For More Information: **www.pcssmat.org**

Twitter: @PCSSProjects

Funding for this initiative was made possible (in part) by Providers' Clinical Support System for Medication Assisted Treatment (5U79TI024697) from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Please Click the Link Below to Access the Post Test for this Online Module

Click here to take the Module Post Test

Upon completion of the Post Test:

- If you pass the Post Test with a grade of 80% or higher, you will be instructed to click a link which will bring you to the Online Module Evaluation Survey. Upon completion of the Online Module Evaluation Survey, you will receive a CME Credit Certificate or Certificate of Completion via email.

- If you received a grade of 79% or lower on the Post Test, you will be instructed to review the Online Module once more and retake the Post Test. You will then be instructed to click a link which will bring you to the Online Module Evaluation Survey. Upon completion of the Online Module Evaluation Survey, you will receive a CME Credit Certificate or Certificate of Completion via email.

- After successfully passing, you will receive an email detailing correct answers, explanations and references for each question of the Post Test.