Opioid Response Network
STR-TA/SOR-TA

Office-Based Opioid Treatment (OBOT) Minimal Requirements and Best Practices

This document includes recommendations for minimal requirements for office-based opioid treatment (OBOT) [Column 1] along with "enhanced practice opportunities" or best practices for OBOT [Column 2]. This is primarily focused on healthcare or mental healthcare programs wishing to integrate buprenorphine treatment for opioid use disorder, but may also be helpful to solo providers delivering buprenorphine. We welcome feedback if you use this checklist!

Minimal Requirements	Best Practices and/or Practice Enhancements
☐ Regulations. Addiction treatment programs should comply with all Federal and State regulations (Check with Single State Agency for specific regulations in your state). There are typically fewer state level regulations for private practitioners.	Develop Community Relations ☐ Maintain professional curbside appearance ☐ Outreach to local pharmacies, addiction specialty programs, civic groups, law enforcement, local health department, etc. to develop relationships and understand available resources. These relationships help to support overall patient care.
☐ Training. The Consolidated Appropriations Act of 2023 enacted a new one-time training requirement for all DEA-registered practitioners, except veterinarians, on the treatment and management of patients with opioid or other substance use disorders. ☐ Provide training on observing HIPAA and CFR42 privacy requirements Training is 8 hours. For state specific training requirements, please contact your state medical board: https://www.fsmb.org/contact-a-state-medical-board/. See also: https://www.samhsa.gov/medications-substance-use-disorders/training-requirements-mate-act-resources	Additional Training ☐ All clinical and supportive staff trained in the basics of opioid use disorder and medications for opioid use disorder. Training could also include the specific privacy issues associated with addiction care. ☐ Additional staff positions may be considered: recovery coach/peer support specialist, behavioral health providers.

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☐ OUD Diagnosis. Document diagnosis and severity of OUD by established criteria; conduct urine toxicology to confirm diagnosis and identify co-occurring substance use. (Note: toxicology can be waived due to logistical or safety concerns, as during the COVID-19 pandemic, with a thorough clinical history.)	☐ Screen for co-occurring psychiatric disorders and other substance use disorders using validated tools (e.g., PHQ-9, GAD-7, AUDIT, TAPS). Conduct follow-up clinical assessment for positive screens when available.
Identify and Document Other Relevant Health States ☐ Major contraindications. Document physical and mental status examination (focused physical exam includes vital signs, OUD medical complications such as skin, veins, liver, stigmata, signs of intoxication, signs of withdrawal ☐ Review and document concomitant medications and active medical disorders ☐ Pregnancy. Document pregnancy status; ongoing discussion of pregnancy status and/or contraception for all women of reproductive age; testing when clinically indicated (if LMP >4 wks, check urine bHCG).	☐ Perform laboratory testing: Hep B and C, HIV, LFT's ☐ Order CBC, CMP, STD, PPD ☐ Attempt to obtain records from any previous treatment (comply with CFR42) ☐ For pregnant patients, provide counseling, perinatal planning, and linkage to obstetric providers familiar with patients on buprenorphine
State Prescription (Drug) Monitoring Program (PMP or PDMP) ☐ Review PMP at intake ☐ Regular PMP inquiries (minimum quarterly) or follow state regulations ☐ Review state specific PMP/PDMP regulations and requirements	Review PMP/PDMP each time a prescription for CS is written
☐ Utilize MOUD Shared Decision-making: discuss risks/benefits of three FDA approved opioid medications to support patient choice	Additional overdose prevention options ☐ Lockbox ☐ Naloxone kit offered on site (as opposed to prescription)

☐ Review Medication Safety: Include pediatric exposure prevention, access to overdose prevention training and naloxone kit for patient and other family/friends	

Minimal Requirements	Best Practices and/or Practice Enhancements
☐ Consent and Treatment Agreement: Provide and review informed consent for treatment with buprenorphine, to include rights and responsibilities as a patient and treatment agreement. Written informed consent (i.e., signature) or documentation of review of consent in patient chart should be completed. Informed consent for treatment (or agreement) allows the provider to demonstrate the reasoning for treatment, as well as the risks associated with treatment, and that these have been discussed with the patient. Many of the patient's responsibilities such as: visit attendance, medication safety, mitigating the risks of pediatric exposure, reasons for urine toxicology screening may be included in this document. In addition, the treatment facility's philosophy, treatment protocols, and policies should be clearly outlined. This document will not vary among patients. Provide the patient with a copy of the Agreement.	
Drug Screening Procedures ☐ Frequent drug screening and provider visits in early treatment stages or when patient becomes unstable. Less frequent testing (e.g., quarterly) is acceptable in stable patients. ☐ Written policy regarding drug screen type, frequency, and response to unexpected drug screen results (note that return to use is not, in itself, a reason for discharge). The following criteria suggest early stages of treatment or instability: a. Recent and/or recurrent unexpected drug screen results indicating continuing use of opioids	Additional Drug Screening Options ☐ Random screening ☐ Confirmatory testing of positive screens ☐ Direct observation (in some circumstances), typically with saliva screening

b. Continued withdrawal symptoms and/or frequent cravings on current medication dose c. Markedly unstable home or work life d. Recent involvement with the legal system e. Severe and/or poorly controlled psychiatric issues (e.g. suicidal ideations) without established provider f. Frequent no-shows or other issues with clinic behavior g. Recent hospitalization or ED visit for SUD-related issues	
Minimal Requirements	**Best Practices and/or Practice Enhancements**
Behavioral Health and Referral Capacity ☐ Able to provide, or refer, to behavioral health/counseling, psychiatric care, and other medical care (limited or no access to additional treatment should not preclude access to medications for OUD) ☐ Coordinate care as needed with other health care providers, observing HIPAA and CFR42 privacy requirements	☐ Be able to make connections with other community referral services such as mutual support (including meeting schedules) and peer recovery services. ☐ Provide co-located behavioral health services: relapse prevention or psychosocial counseling, case management (e.g., for employment, legal, dental, housing etc.), or other harm reduction education and services.
Minimize Diversion ☐ Reasoning for doses of >24mg/day clearly documented; important to document adherence before dose increase beyond 24mg/day. ☐ Treatment should include approved preparation. Monoproduct prescribed only with clearly documented reasoning (e.g. pregnancy or naloxone intolerance). ☐ Drug screen includes buprenorphine.	Additional Diversion Mitigation Strategies ☐ Self-audits to assure consistent and appropriate prescribing ☐ Call-back (to clinic or pharmacy) pill counts ☐ Consider switch to XR-buprenorphine in non-adherent circumstances
☐ Benzodiazepines. Do not withhold buprenorphine for patients treated with benzodiazepines; but benzodiazepines should be prescribed only for approved indications with documentation of informed discussion, clear treatment goal, and a monitoring plan.	
Develop Protocols for Specific Population ☐ People who are pregnant ☐ People with co-occurring hepatitis	Additional Protocols ☐ Adolescents ☐ Individuals living with HIV/HCV ☐ Patients with serious mental illness

	Identify and Monitor Quality Indicators ☐ Potential data to monitor (e.g., through the electronic health record) to understand how the program is performing and potential places for improvement or modification (e.g., retention in care, number of patients with OUD successfully initiated onto medication, provider prescriber, providers following best practices).

Minimal Requirements	Best Practices and/or Practice Enhancements
Sustained Remission and/or Discharge. ☐ If patient desires discharge, assist with medication change or tapering and aftercare plans; this should include discussion of increased risk of relapse and overdose unless one of the FDA-approved medications for OUD continues. ☐ There is no specific treatment duration; it is generally recommended patients should remain on medications for a minimum of 1-2 years without opioid use, preferably as long as benefits outweigh the risks. ☐ If services are determined to no longer be therapeutic or beneficial, assist patient with referral to different treatment facility or modality (e.g., higher level of care, greater structure) before discharge.	

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