Best-Practice Standards

2011-2012

for

Providers
of
Recovery-Oriented
Methadone Services

SBHM, INC.

VALUE BEHAVIORAL HEALTH
of PENNSYLVANIA
A VALUEOPTIONS® COMPANY

GENERAL INTRODUCTION

The Methadone Best Practice Guidelines presented herein were developed from work commissioned by Southwest Behavioral Health Management, Inc. (SBHM)* for implementation with providers serving HealthChoices (Value Behavioral Health of PA funded) residents living in the Pennsylvania Counties of Armstrong, Butler, Crawford, Indiana, Lawrence, Mercer, Venango, Washington and Westmoreland.

It is our collective belief that recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life.[1]

We view recovery as a life-long process that improves a person's quality of life, is always evolving, and should reflect each individual's unique pathway to wellness.

As the funders of services, we have an obligation to offer individuals in recovery access to the tools they need. These tools include formal services, inclusive of varying levels of treatment and the use of medications when appropriate. For many who struggle with a substance use disorder the proper medication can actually be the catalyst to embarking on that journey towards recovery.

We believe our goal needs to be one of treating the disease of addiction through a holistic approach that focuses on improving the likelihood of a long-term recovery, not just on abstinence from a particular substance. We believe that each individual has the ability to begin a path of lifelong recovery.

As a result of this belief in an individual's ability to recover from a substance use disorder, SBHM* partnered with the Institute for Research, Education, and Training in Addiction (IRETA)*, Value Behavioral Health of PA (VBH)*, and a panel of national experts in the field of Medication-Assisted Treatment (MAT), to develop Best Practice Guidelines* for offering Recovery-Oriented Methadone Services.

This collaboration was initiated because the SW6 counties of Armstrong, Butler, Indiana, Lawrence, Washington and Westmoreland, and the NW3 counties of Crawford, Mercer and Venango, which SBHM* represents, collectively agreed that they wanted to focus their purchases of Medication Assisted Treatment on services which are more compatible with this overall philosophy of recovery and which fully incorporate research and science-based best practices.

SBHM began its efforts in January 2009 when they, with the IRETA* started the process of gathering scientific research, including the TIP 43*, that would identify Best Practices in the delivery of MAT. As part of this initiative, which has spanned

[1] White, W. (2007), "Addiction recovery: It's definition and conceptual boundaries" *Journal of Substance Abuse Treatment* 33 (2007) 229–241.

over 18 months, there have been focus groups, meetings and numerous other communications between SBHM*, County Administrators, the IRETA*, the Pennsylvania Department of Health, Bureau of Drug and Alcohol Programs (BDAP), the panel of national experts and stakeholders (individuals who are currently, or who have in the past, received MAT). We knew it was vital to the success of this project to include all of these key figures in this development process.

INTRODUCTION TO THE STANDARDS

This document represents standards which methadone service providers who seek to be, or continue to be contracted with, VBH of PA to serve Health Choices recipients in the nine counties of Armstrong, Butler, Crawford, Indiana, Lawrence, Mercer, Venango, Washington and Westmoreland are required to implement.

These standards offer strategies that will assist providers in delivering care in ways that promote best practices and recovery; in other words, the care provided is grounded in science and is recovery-oriented. These standards resulted from a review of the most current science and from regular consultation with experts in the field in both methadone research and practice. These standards were developed to guide the provider and offer tools to use to improve the quality of care provided.

The intent of these standards is to improve the care provided to individuals and families receiving methadone medication assisted treatment. These standards are based upon work completed by the Institute for Research, Education, and Training in Addictions (IRETA) for Southwest Behavioral Health Management, Inc (SBHM). SBHM manages the Health Choices program for the nine Counties listed above. IRETA's work was completed through a multi-stakeholder approach and consensus development regarding scientifically- and clinically-based, recovery-oriented recommendations regarding the delivery of clinical services in opioid treatment programs using methadone.

This document outlines standards that, when applied in an opioid treatment program (OTP), ensure the greatest likelihood that a person receives individualized, quality care that can lead to recovery following a diagnosis of opioid dependence and conclusion to treat that dependence via the medication methadone.

Please note, the Counties supporting these standards do not advocate the "a priori" belief that one must be free of medication (including methadone) assisted treatment in order to initiate and state that one is in "recovery." The SAMHSA/CSAT Principles of Recovery[2] state quite clearly that there are many roads to recovery. The application of evidence-based treatment modalities, including medications such as methadone, is one road that many have used to achieve or sustain their recovery. The Counties honor this principle.

[2] Center for Substance Abuse Treatment. (2007) National Summit on Recovery: conference report. DHHS Publication No. SMA 07-4276. Rockville, MD: Substance Abuse and Mental Health Services Administration. From http://www.rcsp.samhsa.gov/resources/index.htm#summit (Accessed 11/23/09).

LEVEL OF CARE PLACEMENT AND CONTINUED STAY AND DECISIONS REGARDING THE INITIATION AND CONTINUATION OF THE MEDICATION OF METHADONE

INTRODUCTION

An individual must receive proper assessment which establishes the diagnosis of opioid dependence. There are six primary assessment areas that the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for Opioid Maintenance Therapy recommends treatment providers to evaluate in order to make appropriate treatment and placement decisions. The Patient Placement Criteria for Opioid Maintenance Therapy is found in the ASAM Patient Placement Criteria, Second Edition-Revised.[3]

Providers will be expected to utilize the ASAM Patient Placement Criteria for Opioid Maintenance Therapy for decisions regarding the use of methadone in medication assisted therapy.

All providers of substance abuse treatment services for VBH of PA are required to utilize the Commonwealth's Pennsylvania Client Placement Criteria (PCPC) when determining the appropriate level of cognitive care. The PCPC states methadone may be used with all levels and intensities of care. SBHM will make trainings on, and copies of, the PCPC available to all service providers. To support this, SBHM will also be working with VBH of PA and the Commonwealth to increase access to all levels of care for persons receiving methadone for opioid addiction.

If individual does not meet ASAM Patient Placement Criteria for Opioid Maintenance Therapy dependence, an alternative treatment approach other than MAT must be considered. If individual does meet the criteria, the individual must be provided education on, and offered all available appropriate treatment interventions (e.g. hospital detox, residential, IOP, or Buprenorphine) as most appropriate according to the PCPC and agreed to by the individual.

As this is written, the Counties are aware that the Commonwealth is beginning the process of reviewing how it can include criteria for the use of the medication of methadone in the PCPC. The Counties support that effort. Should the Commonwealth require the Health Choices programs to use any revisions to the PCPC which incorporate methadone or any other similar tools, the requirement to use the ASAM for Opioid Therapy will be modified to reflect the Commonwealth's changes.

[3] American Society of Addiction Medicine (1996). *Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition (ASAM PPC-2)*. Chevy Chase, MD.

BEST-PRACTICE STANDARDS
FOR
LEVEL OF CARE PLACEMENT AND CONTINUED STAY AND DECISIONS REGARDING THE INITIATION AND CONTINUATION OF THE MEDICATION OF METHADONE

I) METHADONE PROVIDERS SHALL USE THE SECTION OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) FOR OPIOID TREATMENT USING METHADONE IN ALL DECISIONS REGARDING THE INITIATION AND CONTINUATION OF THE MEDICATION OF METHADONE FOR SUBSTANCE ABUSE TREATMENT.

A. *The ASAM for Opioid Treatment Using Methadone (OTUM) shall be completed prior to administering the first dose of medication.*

B. *The ASAM for OTUM shall be completed at key intervals in the clients care.*

II) METHADONE PROVIDERS SHALL USE THE PENNSYLVANIA CLIENT PLACEMENT CRITERIA (PCPC) FOR ALL LEVEL OF CARE DETERMINATIONS.

A. *A PCPC shall be completed at intake and at key intervals throughout the clients stay.*

B. *Methadone providers shall document how a member's needs are to be met if the member does not accept the PCPC determination.*

C. *Methadone providers shall document member's decision if level of care indicated is not available at provider's agency.*

D. *Methadone providers shall document that if a level of care sought by the member is not available, the provider contacted the member's funding source to assist in accessing the recommended level of care.*

SBHM SUPPORTS THE COMMONWEALTH'S EFFORTS TO ESTABLISH A SINGLE DOCUMENT WHICH INCORPORATES BOTH THE COGNITIVE LEVEL OF CARE AND THE DECISIONS REGARDING THE USE OF METHADONE AS A MEDICATION. IF AND WHEN THE COMMONWEALTH'S WORK IS COMPLETED AND, A REVISED PCPC OR OTHER STANDARDS ARE REQUIRED OF PROVIDERS, THE ABOVE STANDARD WILL BE REVISED.

ASSESSING APPROPRIATE DOSAGE

INTRODUCTION

Assessing and providing appropriate dosing of methadone is critical to patient compliance and success in the treatment program.

Appropriate dosing of methadone is defined as being the dose at which both physical withdrawal symptoms and subjective cravings for narcotics are controlled. Determination of appropriate methadone dosing will be based on physician clinical judgment that demonstrates the use of at least the following*:

- Patient's report of physical and emotional comfort (physical withdrawal and/or cravings) bearing in mind that the patient may not agree with the physician's clinical impression. It is important to remember the pharmacokinetics of methadone and that there may be a lag between achieving a steady state and cravings (for guidance see TIP 43 Chapter 5).
- Evidence based instrument to assess for possible withdrawal symptoms (i.e. COWS).
- Urine toxicology screen results and any other laboratory findings.*
- Instrument for assessing impairment.*

Each clinic should have policies and procedures in place that address the process of dose establishment, response to toxicology screens showing drug use and management of potential impairment.

The clinic should also be able to demonstrate that such policies and procedures were followed. Chapter 5 of SAMHSA/CSAT TIP 43 is also to be reviewed for individual dosing guidance.

BEST-PRACTICE STANDARD
FOR
ASSESSING APPROPRIATE DOSAGE

III) METHADONE PROVIDERS SHALL HAVE IN PLACE A POLICY AND PROCEDURE FOR APPROPRIATE DOSAGE, WHICH INCORPORATES:

A. Best practices as identified in the Treatment Improvement Protocol (TIP) 43: Chapter 5.

B. The utilization of evidence-based instruments which include at a minimum:
   1) the member's report of physical and emotional comfort;
   2) an instrument to assess for possible withdrawal symptoms;
   3) urine toxicology screen results and any other laboratory findings;
   4) an instrument for assessing impairment.

C. Methadone providers shall document compliance with this Policy and Procedure in the members' charts.

SCREENING FOR SUBSTANCE ABUSE

INTRODUCTION

Urine toxicology screening is one of a variety of clinical/therapeutic tools that OTPs use to demonstrate treatment adherence, dose adequacy and illicit substance abuse.*

REGULATORY COMPLIANCE

- At least one test will be performed upon admission to the clinic.
- Minimum of 8x tests per year for Federal, monthly for Division of Drug and Alcohol Program Licensure (DAPL; Pennsylvania Dept of Health).
- Random for each patient (perhaps also using a confidence pool methodology).
- Required specific drugs/classes will be tested including Treatment Medication and SHAs (sedatives, hypnotics, anxiolytics) other drugs should be tested based on: those that are required, those in the patient's personal history and those common in the region.
- Certified labs and accepted technologies for appropriate interpretation of results will be used to appropriately interpret test results.
- On-site point of service tests may be used BUT do not count as the monthly tests according to DAPL.

CLINICAL INDICATIONS AND FREQUENCY

- The frequency of urine toxicology must be based on therapeutic reasoning, more often early and/or when patient is unstable, less often when stable and/or later in treatment, in concert with on-site dosing frequency. Testing frequency should also allow for reliable decisions on Take-homes and treatment progress.
- In the event that a patient appears intoxicated, along with testing for alcohol (alcohol should be tested with breath analysis or other test specifically approved for alcohol).
- Not all collected specimens have to be analyzed but analysis can be performed randomly for each patient or on each day of collecting.
- Urine specimens need not be given in an observed manner but clinic procedure must adequately protect against tampering

INTERPRETATION OF RESULTS

- Interpretation of tests must follow evidenced-based information, especially with regard to cross-reactivity and "false positive" results, and must be compared with patient self-report which includes over-the-counter medications and herbal preparations.
- Test results must be included in Treatment Plans as one of many indications of response to treatment.
- Tests positive for abused drugs and/or negative for treatment medication cannot be reason alone for reducing doses.
- If positive tests should be considered as one parameter for making decisions regarding continued treatment, they must be compliant with

policies and procedures of the clinic, especially with regards to the observation of urine specimens, tampering, and setting of collection site and responses to “positive” tests or other evidence of impairment (i.e. holding doses and/or No Drive Policy).

IV) METHADONE PROVIDERS SHALL HAVE IN PLACE A POLICY AND PROCEDURE FOR TOXICOLOGY SCREENING OF EACH MEMBER RECEIVING MAT SERVICES, WHICH PROVIDES AT A MINIMUM, THE FOLLOWING:

A. That at least one toxicology screening ("test") will be performed upon admission to the clinic;

B. That a minimum of eight (8) tests per year will be performed per member;

C. That testing will be random for each member;

D. That requires specific drugs/classes will be tested including Treatment Medication and SHAs (sedatives, hypnotics, anxiolytics); testing should also include those in the member's personal history and those common in the region;

E. That certified labs and accepted technologies for appropriate interpretation of results will be used to validly interpret test results;

F. That on-site point of service tests may be used but do NOT count as the testing required pursuant to 2) hereinabove;

OTP STAFFING

INTRODUCTION: The complexities of treating clients who are opioid dependent requires highly trained professionals who can provide direct patient care and successfully coordinate access to other services not offered by their OTP. To ensure these qualifications, OTPs should hire staff that are licensed or credentialed under State regulations for their discipline and have an employment history that verifies their competency working with the type of client being served by the OTP.

To provide the highest possible quality of recovery-oriented care, OTPs are expected to exceed required minimal education, training and other credentialing requirements. All requirements below consider that the respective staff/Board member will meet all Federal, PA State and CARF or JCAHO requirements. Optimal qualifications that providers should seek to achieve are as follows:

BEST-PRACTICE STANDARD
FOR
OTP STAFFING

V) METHADONE PROVIDERS SHALL SUBMIT A FIVE (5) YEAR PLAN FOR STAFF RECRUITMENT, TRAINING AND DEVELOPMENT. SAID PLAN SHALL INCORPORATE HOW: ALL MAT STAFF SHALL MEET ALL PA STATE AND JCAHO OR CARF EDUCATION, CERTIFICATION AND TRAINING STANDARDS AND REQUIREMENTS.

A. How staff shall complete the following SBHM sponsored and approved training on the following recovery oriented methadone services

- *a. Physicians, nurses, nurse practitioners, physician assistants*
  - *i. 3 hours on assessing and maintain adequate dosage*
  - *ii. 3 hours on integrating drug screening with clinical decision making*
  - *iii. 3 hours on the PCPC and the ASAM for Opioid Treatment Using Methadone*
  - *iv. 3 hours per year thereafter*
- *b. Counselors and other non medical clinical staff*
  - *i. 6 initial hours on ROM AND three hours per year there after*
  - *ii. 6 hours on the PCPC and the ASAM for Opioid Treatment Using Methadone*
- *c. Program Administrators*
  - *i. 6 initial hours on ROM AND three hours per year there after*
  - *ii. 6 hours on the PCPC and the ASAM for Opioid Treatment Using Methadone*
  - *iii. 3 hours on recovery oriented systems of care*

METHADONE PROVIDERS SHALL SUBMIT THEIR PLAN AND THEREAFTER, ANNUAL PROGRESS UPDATES

PROGRAM STRATEGIES TO FACILITATE RECOVERY

INTRODUCTION

The program strategies, represented by the below phases, were designed to identify strategies that a treatment provider would apply in order to maximize an individual's chances to choose, pursue, and sustain recovery. Note that these strategies are provider-level criteria and not client- or person-level criteria.

The core strategies are broken out by the Phases of Recovery. The specific strategies to address the treatment in each phase of recovery can be found in the attached.

OVERVIEW OF THE PHASES

The phases represented in this document are based upon the Substance Abuse and Mental Health Services Administration's (SAMHSA) recommended practices for Medication-Assisted Treatment (MAT) and were modified in consultation with an Expert Advisory Panel representing the recovery community, methadone treatment providers, physicians, researchers and policy-makers. The SAMHSA-recommended MAT practices can be found in the Treatment Improvement Protocol 43, available in hardcopy for free by mail or electronically by download from SAMHSA.[4]

The ROM phase model represents guidelines which describe treatment practices and other strategies that are science-based or recommended by expert consensus to promote recovery. The strategies promoted in each phase also reflect the SAMHSA Center for Substance Abuse Treatment "Guiding Principles of Recovery".[5] The ROM approach is focused holistically on an individual's recovery rather than medication management alone.

[4] Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.
[5] CSAT White Paper: Guiding Principles and Elements of Recovery-Oriented Systems of Care.

BEST-PRACTICE STANDARDS
FOR
PROGRAM STRATEGIES TO FACILITATE RECOVERY

VI) METHADONE PROVIDERS SHALL DOCUMENT IN THEIR ESTABLISHED POLICIES AND PROCEDURES THE IMPLEMENTATION OF EACH OF THE CONCURRENT TREATMENT STRATEGIES AND EACH OF THE RECOVERY STRATEGIES AS PUBLISHED ON THE VBH OF PA WEBSITE.

VII) METHADONE PROVIDERS SHALL DOCUMENT HOW EACH OF THE "CONCURRENT TREATMENT STRATEGIES" AND "EACH OF THE "RECOVERY ORIENTED STRATEGIES" AS PUBLISHED ON THE VBH-PA WEBSITE WILL BE AND ARE IMPLEMENTED AND ACCOMPLISHED, EITHER THROUGH LETTERS OF AGREEMENT OR THROUGH OTHER CONTRACTUAL ARRANGEMENTS.

Documentation of implementation of these strategies as per the established policies and procedures should be maintained.

Duplication of effort will be avoided whenever appropriate and possible - the evidence of implementation that would be used for PA State licensing and/or CARF or JCAHO accreditation will be accepted.

INTRODUCTION TO
PHASE 1: RECOVERY INITIATION AND STABILIZATION

***NOTE**: Individual must receive proper assessment which establishes the diagnosis of opioid dependence. If individual does not meet clinical criteria for dependence, an alternative treatment approach other than MAT must be considered. If individual does meet the criteria, the individual should be offered all available appropriate treatment interventions (e.g. hospital detox residential, IOP, MAT or Buprenorphine)* as *most appropriate for and agreed to by the individual.*

GOALS OF PHASE 1

A MAJOR GOAL DURING THE ACUTE PHASE IS TO ELIMINATE USE OF ILLICIT OPIOIDS FOR AT LEAST 24 HOURS, AS WELL AS INAPPROPRIATE USE OF OTHER PSYCHOACTIVE SUBSTANCES. THIS PROCESS INVOLVES:

- Educating the person about the risks and benefits of methadone maintenance treatment
- Providing the person with a choice of appropriate alternative or supplemental therapies/ approaches to achieve recovery
- Early therapeutic engagement and identification of person's treatment needs
- Initially prescribing a medication dosage that minimizes sedation and other undesirable side effects
- Assessing the safety and appropriateness of each dose after administration
- Rapidly but safely increasing dosage to suppress withdrawal symptoms and cravings and discourage the person from self-medicating with illicit drugs or alcohol or by abusing prescription medications
- Providing or referring the person for services to lessen the intensity of co-occurring disorders and medical, social, legal, family and other problems associated with opioid addiction
- Helping the person identify high-risk situations for drug and alcohol use and develop alternative strategies for coping with cravings or compulsions to abuse substances

INDICATIONS THAT A PERSON HAS REACHED THE GOALS OF THIS PHASE CAN INCLUDE:

- Elimination of symptoms of withdrawal, discomfort, or craving from opioids and stabilization
- Expressed feelings of comfort and wellness throughout the day
- Abstinence from illicit opioids and from abuse of opioids normally obtained by prescription, as evidenced by drug tests
- Engagement with treatment staff in assessment of medical, mental health, and psychosocial issues
- Satisfaction of basic needs for food, shelter and safety
- Personal commitment to pursuing his/her recovery plan

****REQUIRED****

CONCURRENT TREATMENT STRATEGIES - PHASE 1

***NOTE**: Consider these strategies as being performed at the same time*

ALCOHOL AND DRUG USE

- Opioid treatment program (OTP) has educated person about addiction as chronic illness and the phases of treatment during the intake process
- Program physician met with person prior to 1st dose administration
- OTP has scheduled random drug screens based on person's clinical need
- Intensity/frequency of psychosocial treatment is assessed and determined by person's treatment needs
- The medical director and/or program physician are responsible to assure all changes in methadone dosing are safe and care is individualized. The physician(s) as well maintain the goal to assure appropriate methadone dosing. The patient should have ready access to meet with medical staff - that may include either the medical director, program physician and/or medically supervised support medical staff (e.g. nurse practitioner, trained registered nurse) - to discuss changes in methadone dosage level, methadone dose adequacy and safety. All such discussions with authorized medical support staff shall be communicated to the program physician as soon as possible or warranted
- Physician utilized validated tools (e.g. COWS, impairment assessment tool), clinical judgment, and person's perspective to assess appropriate dosage of treatment medication

MEDICAL CONCERNS

- OTP has a risk management protocol in use to prevent! reduce likelihood of adverse medical event
- OTP referred person immediately to medical providers for any acute medical concerns
- OTP facilitated access to* screening and vaccination as appropriate (e.g. HIV, HCV, HBV)
- OTP coordinates with other physicians and/or prescribers in person's total care

CO-OCCURRING DISORDERS

- OTP identified acute co-occurring disorders that may need immediate intervention
- OTP identified chronic disorders that need ongoing therapy
- OTP actively linked person to other needed treatment services for co-occurring disorders

BASIC LIVING CONDITIONS

- OTP assessed needs for food, shelter and safety
- OTP explored transportation options with person
- OTP actively linked person to appropriate community services in order to ensure person's basic needs are met
- OTP working collaboratively with criminal justice system
- OTP actively linked person to case manager, legal advocate, caseworker or social worker

THERAPEUTIC RELATIONSHIP

- Counselor actively engages person to participate in the development of his/her recovery plan
- OTP educated person about goals of and dispelled myths about MAT
- Counselor and person have agreed upon the degree to which the person's family will be included in his/her treatment
- OTP has a standard protocol involving the person to assess the adequacy of dosage and to respond accordingly (see also Appendix 3 of ROM)
- Person and counselor have built a social support and a recovery support system
- Person reports trusting relationship with OTP staff (as evidenced by formal assessment)
- OTP engages person with coaching designed to address potential stigma

MOTIVATION AND READINESS FOR CHANGE

- Counselor, physician and person agree that person is receiving adequate dosage
- OTP has addressed person's ambivalence (as reported by person)
- OTP has empowered person to develop his/her recovery plan
- OTP has emphasized treatment benefits
- OTP has emphasized the importance of making a fresh start
- OTP exposes person to another individual in stable recovery on MAT*

****REQUIRED****

RECOVERY-ORIENTED STRATEGIES - PHASE 1

- Emergency contact information was provided to individual and family
- OTP explained to person effects of methadone dosage and possible side effects
- OTP has explained all risks and benefits of MAT to person
- OTP has offered person alternatives to MAT when warranted
- OTP has educated the person's family about opioid addiction, methadone treatment, and recovery
- OTP has educated person's family about peer-based recovery supports and has actively linked family to local resources
- OTP has actively linked person to a peer support resource local to where he/she lives
- OTP has assessed/assured that the person 'feels heard' in addressing his/her needs
- OTP has assessed/assured that the person trusts OTP with his/her care

INTRODUCTION TO
PHASE 2: EARLY RECOVERY AND REHABILITATION

GOALS OF PHASE 2

The primary goal of the rehabilitative phase of treatment is to empower individuals to cope with their major life problems-drug or alcohol abuse, medical problems, co-occurring disorders, vocational and educational needs, family problems, and legal issues-so that they can pursue longer term goals such as education, employment, and family reconciliation. Stabilization of dosage for opioid treatment medication should be complete, although adjustments might be needed later, and patients should be comfortable at the established dosage for at least 24 hours before the rehabilitative phase can proceed.

INDICATIONS THAT A PERSON HAS REACHED THE GOALS OF THIS PHASE CAN INCLUDE:

- Repertoire of coping skills
- Abstinence of opioid and other drug use and absence of alcohol use
- Stable medical and mental health status
- Involvement in productive activity: employment, school, homemaking, volunteer work
- Stable source of legal income from employment, disability, or other legitimate sources
- Social support system in place
- Increased responsibility for dependents (if relevant)
- Resolution of, or ongoing efforts to solve, legal problems
- Absence of illegal activities
- Engaged in recovery support activities

****REQUIRED****

CONCURRENT TREATMENT STRATEGIES - PHASE 2

***NOTE**: Consider these strategies as being performed at the same time*

ALCOHOL AND DRUG USE

- Physician met with person ongoing to assess adequate dosage
- Physician adjusted dosage as necessary to prevent continued opioid use
- OTP has scheduled random drug screens based on person's clinical need
- OTP considered medication assisted treatment for alcohol abuse
- OTP offered pharmacotherapy and cessation groups for tobacco use
- OTP intensified treatment services (psychosocial/ medical)
- OTP introduced positive incentives (take-home meds, recognition of progress)

MEDICAL AND MENTAL HEALTH

- OTP ensured onsite primary care or actively linked person to other services
- Physician addresses clinical issues or concerns with other medications the patient may be using, particularly if they may interfere with opioid treatment.
- OTP provided routine HIV, HBV, HCV, TB testing as
- appropriate
- OTP provided vaccinations as indicated
- OTP provided integrated treatment approach
- OTP provided education on diet, exercise, smoking cessation
- Physician assessed need and referred person for pain management

CO-OCCURRING DISORDERS

- OTP ensured early identification and referral for co-occurring disorders
- OTP referred person for psychotropic medication or psychotherapy as indicated
- OTP helps person to learn and exercise coping skills

VOCATIONAL & EDUCATIONAL

- OTP identified person's educational needs
- OTP provided onsite GED counseling or referral
- OTP provided literacy and vocational training with community involvement
- OTP provided training on budgeting of personal finances
- OTP provided employment opportunities or referral to a job developer

FAMILY & SOCIAL

- OTP encouraged person to become involved with community or faith-based, fellowship, recreation or other peer-based recovery support activities

- Person and OTP have collaboratively worked to increase person's involvement in family life (in absence of family dysfunction that impedes progress) as part of person's recovery plan
- OTP encouraged person to participate in family therapy and support groups
- OTP has facilitated access to well-child care
- Where space permits, OTP establishes a designated child/family friendly area

LEGAL

- OTP performed ongoing checkups on person's compliance with medical/ psychiatric regimens
- OTP facilitated access to legal counsel
- OTP has encouraged person to take responsibility for legal problems
- OTP and person have identified obstacles to eliminate illegal activities and replace them with constructive activities

****REQUIRED****

RECOVERY-ORIENTED STRATEGIES - PHASE 2

- OTP actively linked person and his/her family to peer-based recovery support activities
- OTP assessed person's recovery capital
- OTP helped person to develop a recovery plan that builds upon and expands the person's recovery capital.
- OTP has assessed/assured that the person 'feels heard' in addressing his/her needs

INTRODUCTION TO
PHASE 3: RECOVERY MAINTENANCE

GOALS OF PHASE 3

The goal of this phase is for the person to resume primary responsibility for his/her life. S/He is continuing opioid pharmacotherapy, participating in counseling, receiving medical care and, often, actively engaged with peer-based recovery supports in his/her community.

During this phase, the person should begin to receive take-home medications for longer periods and be permitted to make fewer OTP visits.

After a program-specified period of time (based on person's needs, progress, and comfort level), the OTP will help the person decide upon either medical maintenance or tapering off of methadone.

****REQUIRED****

CONCURRENT TREATMENT STRATEGIES - PHASE 3

***NOTE**: Consider these strategies as being performed at the same time*

ALCOHOL AND DRUG USE

- OTP provided ongoing checkups on person's substance use
- OTP has scheduled random drug screens based on person's clinical need

MEDICAL AND MENTAL HEALTH

- OTP performs ongoing checkups on person's ability to follow recommended medical/ psychiatric regiments
- OTP maintains communication with person's health care and mental health care providers

VOCATIONAL & EDUCATIONAL

- OTP provided assistance in addressing workplace problems
- OTP provided ongoing checkups on person's vocational/employment status and progress toward educational goals

FAMILY & SOCIAL

- OTP provided ongoing checkups on person's family stability and relationships
- OTP provided or referred for family therapy as needed

LEGAL

- OTP provided support as needed

****REQUIRED****

RECOVERY-ORIENTED STRATEGIES - PHASE 3

- OTP provided ongoing checkups on person's involvement in peer-based recovery supports
- OTP continues to help person and his/her family to assess and build recovery capital
- OTP has assessed/assured that the person 'feels heard' in addressing his/her needs

INTRODUCTION TO
PHASE 4: LONG-TERM SUSTAINED RECOVERY

GOALS OF PHASE 4

The goal of this phase is for the person to continue primary responsibility for his/her life and recovery. This phase may follow successful tapering and readjustment or a person may decide to maintain his/her long-term recovery with the use of methadone.

If person decides to maintain his/her long-term recovery with the use of methadone, the OTP will provide ongoing recovery checkups in all domains according to a frequency collaboratively decided upon between OTP staff and recovering person but no less frequently than that established by federal and state regulatory requirements.

If person has decided to taper off methadone, regular attendance at OTP should be unnecessary, except to return to a more intensive level of treatment if necessary for continuation of recovery. Person should have the opportunity to receive occasional (quarterly or biannually) recovery checkups from the OTP. Person may not want or need continuing-care services after tapering, preferring a complete break from OTP.

****REQUIRED****

CONCURRENT TREATMENT STRATEGIES - PHASE 4

***NOTE**: Consider these strategies as being performed at the same time*

ALCOHOL AND DRUG USE

- OTP provided ongoing (monthly, quarterly or annually) recovery check-ups

MEDICAL AND MENTAL HEALTH

- Physician provided medical follow-up or referral as needed

VOCATIONAL & EDUCATIONAL

- OTP provided ongoing (monthly, quarterly or annually) recovery check-ups

FAMILY & SOCIAL

- OTP provided ongoing (monthly, quarterly or annually) recovery check-ups

LEGAL

- OTP offered groups or individual counseling sessions to person as needed
- OTP provided ongoing (monthly, quarterly or annually) recovery Check-ups

****REQUIRED****

RECOVERY-ORIENTED STRATEGIES - PHASE 4

- OTP provided ongoing (monthly, quarterly or biannually) recovery checkups
- OTP provided any needed assistance for person and his/her family to maintain engagement with peer-based recovery supports in his/her community
- OTP allows person to return to participate in on site recovery support groups
- OTP allows person to return to the program to serve as a recovery support for newer recoveries
- OTP has assessed/assured that the person 'feels heard' in addressing his/her needs

CARE MANAGEMENT AND PROGRAM MONITORING

INTRODUCTION

For many clients, admission into an OTP facilitates the identification of various healthcare and/or psychosocial needs that must be addressed if progress in recovery is to occur. This may occur on-site at the OTP, or through the active linkage* of the client to an appropriate referral source.

The Program Strategies to Facilitate Recovery (Phases 1-4) offer the MAT provider a concise overview of where a client is in their recovery process, inclusive of their therapeutic, medical, vocational, family and/or social needs. This allows the MAT provider to effectively manage a client's overall care by coordinating with other treatment/medical/service providers involved in the client's recovery, both on-site and in the community.

BEST-PRACTICE STANDARD
FOR
CARE MANAGEMENT AND PROGRAM MONITORING

VIII) METHADONE PROVIDERS SHALL SUPPORT PROGRAM MONITORING AND INDIVIDUAL MEMBER CARE COORDINATION THROUGH TRACKING THE PHASE OF RECOVERY FOR EACH MEMBER RECEIVING MAT SERVICES.

Acronyms and Definitions

Southwest Behavioral Health Management, Inc. (SBHM): *The Southwest Six (SW6) counties (Armstrong, Butler, Indiana, Lawrence, Washington, and Westmoreland) have created and maintained this oversight corporation since 1998 for the purpose of oversight of the HealthChoices program and partnership with Value Behavioral Health of PA. The corporation is staffed with a multi-disciplinary team whose roles are to serve the counties collectively and individually in their respective areas of expertise. The corporation is governed by a Board of Directors including the MH/MR and Drug and Alcohol Administrators from each of the six counties and two Ex-Officio Board Members representative of the Mental Health and Drug and Alcohol consumers, families and/or advisory groups.*

The Institute for Research, Education, and Training in Addictions (IRETA); *Is a non-profit organization that works with national, state, and local partners to improve recognition, prevention, treatment, research and policy related to addiction and recovery. IRETA's overall goals focus on influencing health care policy related to addictions, transferring research knowledge into practice, educating and training providers of addiction care, and acting as an advocate for the addictions field. In the short-term, IRETA provides special training on significant topics in the field, responds to requests for topic-specific trainings, and creates educational materials, all with the goal of improving the knowledge, skills, and attitudes of providers. In the long-term, IRETA works toward the consistent and sustained use of evidence-based practices, policies that support care which treat addiction as the chronic illness that it is, and the elimination of stigma related to addiction.*

Value Behavioral Health of PA (VBH): *A Behavioral Health Managed Care Organization (BH-MCO) that provides mental health and substance abuse services to approximately 280,000 Medical Assistance (MA) recipients in 14 Western Pennsylvania counties.*

Northwest Behavioral Health Partnership (NWBHP): *In 2007 the Northwest counties (Crawford, Mercer, and Venango) incorporated with SBHM to provide a collaborative and coordinated approach to the administration and management of the HealthChoices Medicaid Managed Care initiative.*

HealthChoices: *The name of one of Pennsylvania's mandatory managed care programs for Medical Assistance recipients. Through Behavioral Health Managed Care Organizations (BH-MCO), recipients receive quality medical care and timely access to appropriate mental health and/or drug and alcohol services.*

TIP 43 - Medication-Assisted Treatment For Opioid Addiction in Opioid Treatment Programs: *Treatment Improvement Protocols (TIPs), developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services (DHHS), are best-practice guidelines for the treatment of substance use disorders. CSAT draws on the experience and knowledge of clinical, research, and administrative*

experts to produce the TIPs, which are distributed to facilities, and individuals, across the country. This TIP incorporates the many changes in medication-assisted treatment for opioid addiction that have occurred over the most active decade of change since the inception of this treatment modality approximately 40 years ago. The TIP describes the nature and dimensions of opioid use disorders and their treatment in the United States, including basic principles of MAT and historical and regulatory developments. It presents consensus panel recommendations and evidence-based best practices for treatment of opioid addiction in opioid treatment programs (OTPs). It also examines related medical, psychiatric, sociological, and substance use disorders and their treatment as part of a comprehensive maintenance treatment program. The TIP includes a discussion of the ethical considerations that arise in most OTPs, and it provides a useful summary of areas for emphasis in successfully administering MAT in OTPs.

Best Practices Guidelines: *The report "**Recovery-Oriented Methadone: Improving Practice to Enhance Recovery**" prepared for SBHM by the IRETA. Includes the Guideline Development Process, Program Strategies to Promote Recovery, ASAM Patient Placement Criteria for Opioid Maintenance Therapy, Program Strategies to Facilitate Recovery (Phases), Recommendations for Addressing Adequate Dosage and Urine Drug Screens, and a Toolkit.*