

Implementing Medication-Assisted Treatment Statewide

White Paper

Developed for the

Center for Substance Abuse Treatment

August 2010

Prepared under the

**Center for Substance Abuse Treatment
State Systems Technical Assistance Project
Contract No. 270-03-1000/HHSS27000020T**



U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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I. INTRODUCTION

The Center for Substance Abuse Treatment (CSAT), Division of State and Community Assistance and Division of Pharmacologic Therapies, invited representatives of 12 Single State Authorities for substance abuse services—plus the National Association of State Alcohol and Drug Abuse Directors (NASADAD), NAADAC, the Association for Addiction Professionals, and the State Associations of Addiction Services—to discuss and share their experiences and challenges in implementing medication-assisted treatment (MAT). The final participant list is included as appendix A.

Participants shared program, funding, regulatory, and other strategies and discussed lessons learned. Appendix B includes a list of MAT resources that participants shared, and the following sections summarize participants' insights. There was uniform agreement that MAT is effective, and there was uniform support for its expanded use. While participants also clearly pointed out that MAT faces challenges, the substance abuse field, including MAT, is moving steadily toward integration—with mental health, developmental disabilities, and ultimately mainstream medicine. Such integration reflects the growing strength and integrity of the substance abuse field and recognition that achieving important outcomes requires providers to put individual client needs first in service planning and delivery. MAT and medication-assisted recovery occupy an important place in this process and in the recovery-oriented continuum of care.

II. MEETING SUMMARY

A. What is MAT?

The treatment of substance use disorders (SUDs) has advanced from the days when disulfiram (Antabuse) was the only medication used to promote long-term recovery in alcohol-dependent clients and methadone was the only medication used to promote long-term recovery in opiate-dependent clients. In discussing the concept of MAT, participants noted that the term has been defined differently. Today, MAT refers to a range of pharmacotherapy that encompasses a variety of medications that are available to detoxify and medically manage clients and treat addiction, including prescription drug, alcohol, and tobacco addiction. This broader definition of MAT reflects an important change because it sets the stage for a new vision of substance abuse treatment and the role that medications can play in client recovery and in the quality of care that substance abuse providers deliver.

B. Vision for MAT Implementation

States are in different stages of implementing MAT, with a wide range of plans envisioned for future development. (See “Appendix C: Brief Examples of State MAT Implementation.”) With a broad spectrum of activities already underway, participants discussed both a long-term perspective as well as immediate developmental strategies for MAT.

In the long term, participants envision full integration of addiction treatment and MAT with primary health care. Based on this vision, MAT becomes part of the mainstream health care system and takes its place as a means of addressing disease conditions and restoring the health and well-being of substance-dependent and addicted individuals. States are moving toward this long-term vision through various strategies. Some are implementing pilot projects in which they introduce MAT incrementally through regulatory, contractual, and workforce changes. For example, one State has collaborated with its drug courts to begin offering Vivitrol (naltrexone) to clients, while another State has begun dispensing buprenorphine through its outpatient treatment clinics. Still other States are reaching out to local medical societies and physician communities, educating these professionals about MAT to begin normalizing addiction as part of the human condition. Participants agreed that MAT for SUDs must become part of mainstream medicine, particularly as more medication options become available. Primary care physicians, and newer physicians in particular, need training to understand that, as a disease, SUD treatment requires an integrated team of specialists and medications like the treatment of many other diseases. Physicians also need to recognize that effective tools and knowledgeable substance abuse treatment professionals need to be an active part of the care team.

C. Importance of Strategic Partnerships

The importance of forming strategic partnerships emerged as a core theme and strategy for MAT implementation. States are effectively creating and expanding partnerships with other systems, such as child welfare, corrections, and primary health care, to coordinate planning and priorities and to advance understanding and acceptance of MAT. In many States, substance abuse provider organizations are in place and strong partnerships with these groups have proven especially valuable in the following ways:

- Securing legislative support for MAT
- Supporting and implementing regulatory changes
- Encouraging use of patient-centered, evidence-based practices
- Removing barriers to opening opioid treatment programs (OTPs) in communities
- Encouraging openness to MAT within and across multiple levels of care (e.g., drug courts, outpatient clinics, and residential treatment centers)
- Promoting coordination within the field

Some States have also established clinical provider and consumer advisory groups to obtain guidance and valuable feedback on specific MAT policies, review patient care issues, and improve performance of clinicians and provider organizations.

With substance abuse as a factor for a significant number of persons involved in the justice system, States have recognized the importance of reaching out to educate drug courts and judges about MAT, dispelling myths, emphasizing the benefits of MAT for clients, and encouraging drug court acceptance of MAT clients. Intensive, one-on-one efforts to establish relationships with correction officials have culminated in introducing methadone into a State prison for the first time, and, in another instance, adding a methadone clinic to a detention center. These and other efforts are promoting the seamless transfer of adjudicated individuals back into the community and linking them to treatment. A participant also reported that in 2010, the Department of Justice, under its Second Chance Act initiatives, authorized \$15 million to strengthen collaboration between the substance abuse and criminal justice fields and to introduce pharmacological treatment into prisons.

States are addressing the needs of underserved populations through partnerships with organizations such as the Veterans Administration. In one State, a new initiative focuses on assessing traumatic brain injury and comorbid drug problems among veterans. Due to the increase in availability of opiates and consolidation of drug cartels in some border areas and tribal lands, States now recognize that stronger partnerships with tribal leaders are also essential.

Participants identified the recovery community as an important partner for MAT providers and clients. States are encouraging individuals receiving MAT to engage with recovery support services in the community; and educating these service providers about using MAT and the outcomes achieved for clients is now part of effective MAT delivery. State efforts to communicate with and train members of the recovery community about MAT have also led to more openness about this treatment approach among groups at the national and local levels, such as Narcotics Anonymous, that previously have rejected medication treatments for SUDs.

Participants said that forming linkages with federally qualified health centers (FQHCs) and community health centers is an important but challenging strategy for States and MAT implementation. Nevertheless, several States are successfully reaching out to and collaborating with FQHCs around MAT. As a result, there have been opportunities for increased integration with primary health care, enhanced support for medication monitoring, and increased likelihood that FQHC clients are effectively linked with substance abuse treatment providers for counseling and other essential support services.

Despite these ongoing and positive efforts, participants agreed that States must forge additional strategic partnerships and strengthen and expand existing ones. Participants clearly stated that developing partnerships with primary care physicians is extremely important. They generally agreed that sometimes poor coordination exists between primary care physicians and MAT providers. A range of strategies and initiatives are underway to address this issue. For example, several States are now engaging primary care physicians in substance abuse screening and brief interventions through the CSAT-funded Screening, Brief Intervention, and Referral to Treatment (SBIRT) training grants. Other States have successfully engaged medical societies to educate their members on substance abuse, particularly MAT. In one State, physicians at several medical schools received training through a large grant to introduce substance abuse material within the primary care curricula. Also, trained substance abuse staff members are working alongside physicians and nurses in emergency departments to provide screening, brief interventions, and referrals to treatment.

In addition, participants agreed that the time is right to educate members of Congress about MAT. Current interest concerning prescription drug abuse is high among these elected officials, providing an opportunity for briefings by representatives of the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, States, and providers, who are focused on MAT and its capacity to enhance the quality of life for constituents and help reverse the consequences of prescription drug abuse.

D. Need for Workforce Development Measures

All States are paying considerable attention to workforce development. A primary workforce development goal is to ensure that competent, trained professionals deliver MAT, and States recognize that substance abuse clinicians and physicians have knowledge and skill deficits in delivering and monitoring MAT. A second goal is to ensure that substance abuse providers integrate MAT into their programs and collaborate effectively on behalf of clients with existing OTPs, prescribing physicians, and others.

States reported that training has reduced the considerable resistance to MAT among some treatment providers. Relevant topics for training of substance abuse providers have included addiction neuroscience; craving; pharmacological actions of the various prescribed medications, including methadone, Vivitrol, and buprenorphine; attitudes regarding MAT; the stigma attached to clients and use of MAT; and the complexities of co-occurring disorders. Also, participants said this is an educational priority: the need to foster a culture of competency by educating providers about their new level of responsibility and accountability as medications are introduced into the treatment environment.

One State is now requiring physicians in its treatment programs to be certified by the American Society of Addiction Medicine (ASAM) within a few years and is collaborating with ASAM to offer relevant courses and mentoring opportunities. States have also recognized that primary care physicians are often poorly informed about medical interventions for addiction, safer opioid prescribing, and the stigma associated with substance abuse in general and MAT specifically.

States identified other workforce development issues, including poor retention of trained staff and the difficulty of attracting qualified personnel to underserved and rural communities. The low pay structure for provider staff members remains part of the problem, leading to high turnover, staff vacancies, and a workforce with limited MAT knowledge. To address this challenge, one State petitioned its licensure body to waive certain licensing requirements so that a broader, nonlicensed group of individuals could be considered for employment.

Participants identified a range of strategies they employ to address workforce development needs, including the following:

- **E-learning.** States reported using this learning methodology to conveniently disseminate content on a range of topics to dispersed groups. For example, States also reported that e-learning tools are used to educate physicians and other emergency department personnel, such as nurses and social workers, on SBIRT. Groups of individuals with similar learning needs and interests have formed collaboratives to enhance their learning experience. In another instance, a substance abuse agency is collaborating with a mental health agency to fund e-learning systems and continuing education courses.
- **Videoconferencing.** States are using this capability to bring together clinical, medical, and other groups of professionals and to connect those located in different areas of a State to discuss various topics and practices, provide supervision, and offer case presentations for review and discussion.
- **Learning Thursdays.** Substance abuse professionals who require certification and/or a license to practice must routinely participate in continuing education activities and courses. One State supports its workforce to obtain such educational units by sponsoring biweekly webinars—“Learning Thursdays”—with free educational credits. These 1- to 2-hour webinars feature clinical guidance, patient stories, information sharing on MAT, tobacco cessation approaches, and related topics.
- **Cross-agency training.** In one jurisdiction, the Office of Public Health (OPH) requested and received training on addictions because it operated shelters with clients who often had SUDs and co-occurring disorders. The jurisdiction developed protocols linking the systems of care for

addictive and co-occurring disorders, and is conducting quarterly videoconferencing on MAT and addiction treatment conducted for OPH and mental health personnel.

- **Governor’s Institute on Alcohol and Drug Abuse.** This institute in one State provides training and technical assistance in such areas as MAT and opioid prescribing for physicians; supports safer opioid prescribing training; and has successfully partnered with local medical societies to encourage physicians to participate in training. Institute training workshops have also focused on the State-controlled substances reporting system, and the institute distributes a monthly online newsletter to physicians, nurses, and other providers. A new institute project is to provide training for drug courts on MAT, initially focusing on attitudes about addiction.

E. Role of Statutes, Regulations, and Policy in MAT

States identified several examples that illustrate the role that statutes, regulations, and policies play in delivering MAT. For instance, States have revised their statutes to allow use of general funds to establish an MAT program and to expand the range of services that substance abuse providers must offer. The expansion in the number of for-profit OTPs has caused some States to review how they should regulate these providers. Many States require all providers to be licensed; in other States, regulations apply only to providers receiving public funds. In other instances, contractual requirements ensure that program and client data reporting occurs, that programs address standards regarding delivery of counseling as well as medications, and that sanctions are in place.

States are using regulatory and other reforms to address discriminatory practices toward MAT clients. Some States have instituted regulations prohibiting non-MAT providers who receive public funds from discriminating against methadone patients. When one State changed regulations to merge MAT with its outpatient system of care, resistance to serving MAT clients surfaced. Thus, the State revised provider contracts, requiring that providers offer clients an opportunity to receive MAT, either on site or through a memorandum of understanding. Based on the effectiveness of this approach, other States are considering a similar solution to end the practice of providers turning away MAT clients. Another jurisdiction—to address community restrictions on establishing new MAT programs to expand capacity—implemented mobile service units that did not require zoning changes.

As the overall substance abuse treatment field moves toward the chronic disease model and availability of MAT expands, participants suggested that States may need to reexamine their statutes or regulations regarding the size of clinical caseloads. The large caseloads of many clinicians have typically included multiple, long-term MAT clients, and clients who require more intensive services need some of these slots. Reducing clinicians’ caseloads to respond to these needs may require statutory or regulatory revisions that support a better balance between clients who are in the early phases of treatment versus those in the later phases.

States have a range of laws in place to stipulate who delivers MAT. For example, one State requires that a certified professional perform client assessments, while another State requires all prescribing physicians in substance abuse treatment programs to be ASAM certified. The professional licensing requirements of still other States are limited. At a minimum, a physician must be licensed and trained to prescribe and monitor medications, and State medical directors are typically engaged in training, mentoring, and providing oversight for the MAT medical staff.

Participants said confidentiality regulations are often misunderstood, hindering collaboration among substance abuse, mental health, and primary health care providers. Some States viewed the need to maintain compliance with Federal confidentiality regulations (Title 42 of the Code of Federal Regulations, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records) as supporting client protections and ensuring appropriate communication with and effective monitoring of clients who are receiving MAT, particularly those with comorbid conditions and clients in emergency environments. Other States indicated that, typically, counselors obtain written releases from clients and that counselors generally secure required releases to facilitate the exchange of client information. There was a mentioned need for continuing assistance with establishing agreements and interpreting the regulations.

States are using statutes, regulations, and policies to ensure that best practices are in place. From a practical perspective, States are writing regulations and policies to ensure that programs, such as mobile units, store and dispense medications appropriately. Because MAT linked with counseling is a best practice that has been shown to improve client outcomes, some State statutes require counseling as part of treatment. Participants, however, voiced some concern that, as States move toward integration with mental health and primary health care, they are no longer linking counseling consistently to MAT.

F. Use of Technology

Participants acknowledged that technology is a valuable and integral part of a fully developed system of care for MAT clients. As already noted, States in varying degrees use such technologies as webinars, videoconferences, and e-learning tools for staff training and information sharing. A few have formed multidimensional learning systems to strengthen education and training within and across systems.

Participants identified the following examples of additional technologies that their States employ to improve MAT access and quality:

- **Telepsychiatry and e-counseling.** The development and use of telepsychiatry addresses the severe shortage across the country of addiction psychiatrists trained to provide MAT and other behavioral health services. Using online systems, these specialists can efficiently extend their reach to programs and clinics, especially in rural and medically underserved areas. One State that has implemented this service worked with its Medicaid office and made statutory, policy, and procedural changes to authorize delivery of psychiatric services, including involuntary commitments under specific circumstances. Participants agreed that using telepsychiatry and nurse practitioners in areas with few physicians will expand in the future.

Closely resembling telepsychiatry, e-counseling offers client access to trained clinicians regardless of location, time of day, mobility, or other factors. At least one State indicated an interest in creating regulations to allow for delivery of and payment for e-counseling.

- **Central patient registry.** States are using central patient registries to track residents receiving methadone treatment across a State. The registry helps in authorizing appropriate doses of methadone for clients during emergencies such as Hurricane Katrina.
- **Prescription drug monitoring system.** Multiple States have implemented this system, which supports improved quality of care, by giving physicians ready access to information about prescriptions that clients may be receiving and on which critical treatment decisions are based. While many physicians have access to a prescription drug monitoring system, some do not consistently use it. One State also reported that the Veterans Administration prohibits its physicians from accessing the prescription monitoring system.

G. Role of Medical Directors

Since 1993, the Substance Abuse Prevention and Treatment Block grant regulations have required States to employ a State medical director. Over time, the medical directors have assumed different roles and responsibilities within States, and, in some areas, multiple medical directors with assigned specialty areas are in place. States that have involved their medical director in the implementation of MAT services have found it to be an effective practice.

A consistent role for medical directors responsible for substance abuse and mental health is developing policies and procedures. For instance, in States with combined substance abuse and mental health organizations, the medical director has worked with the addictions staff to develop policies and procedures regarding such issues as using methadone and benzodiazepines, managing drug interactions, prescribing during emergencies, and overseeing pilot projects that explore new dosing protocols with pain management patients. Regarding mental health, medical directors have also

developed policies and procedures regarding delivery of psychiatric services and operation of psychiatric hospitals. In addition, medical directors have been engaged in efforts as diverse as helping to secure Medicaid reimbursement for substance abuse services and educating legislative staff on MAT issues and benefits.

State medical directors are also starting to focus on a second key area: workforce development. With workforce issues prominent in many States, medical directors have been instrumental in encouraging training on evidence-based practices and in working with patients with co-occurring disorders. Medical directors have led efforts to develop protocols for cross-system training on MAT for child welfare and corrections staff members, and they worked to develop linkages with entities such as hospital emergency departments, community mental health centers, and FQHCs.

State medical directors have played an important role in guiding and supervising clinical treatment directors in OTPs and in substance abuse treatment programs. For instance, they have conducted regular meetings with program personnel, providing direction on implementing policies, regulations, and best practices. Other medical directors make OTP site visits or mentor providers via teleconferences.

H. Physicians and Buprenorphine

Physicians are increasingly prescribing buprenorphine for detoxification and treatment of opiate addiction. While multiple States dispense the medication through their outpatient programs, hundreds of individual primary care physicians in private practice settings in many States are certified to prescribe and monitor patients receiving buprenorphine.

Despite intensive efforts to certify primary care physicians as prescribers of buprenorphine, State after State reported that significant numbers of these physicians are not prescribing the medication. Participants could not say for sure why physicians spend the effort to become certified and then do not follow through with client treatment, but they offered the following possible explanations:

- First, the buprenorphine training that physicians received may have caused them concerns about their ability to effectively manage induction and maintenance with a potentially challenging client population.
- Second, a recent letter from the Drug Enforcement Administration that referred to inspections of physician offices also may have contributed to physicians' reluctance to become buprenorphine prescribers.
- Third, there is often a lack of support for the physicians or a lack of effective linkages to counseling and other services that are needed to support recovery.
- Finally, participants considered the low level of Medicaid reimbursement to likely be a strong disincentive for physicians in private practice to prescribe buprenorphine.

States have made efforts to introduce and expand buprenorphine use to treat opiate addiction. Initiatives to train physicians, including using local medical societies, have helped. Another resource for physicians is ASAM's (American Society of Addiction Medicine) Physicians Clinical Support System (PCSS). States have contemplated engaging other service professionals, such as social workers, to support prescribing physicians in the community. At least one State is exploring special induction centers, since this is the phase of MAT that appears to cause physicians greatest concern. Participants suggested that a brief online survey of certified physicians could help identify barriers to the prescribing of buprenorphine and lead to targeted strategies for removing the barriers.

I. Health Disparities—Equity and Engagement Issues

Participants acknowledged that health disparities continue to exist within State systems of care and that these disparities include and extend beyond issues of access to treatment or a failure to achieve cultural competency within treatment environments. Participants said that States also need to understand health disparities within the context of equity and engagement for underserved populations, especially adolescents, women, African Americans, Native Americans, and Hispanic individuals.

Participants suggested several strategies to address a lack of equity for and engagement of target populations who could benefit from MAT. Optimally, substance abuse providers need to link with FQHC and community health centers to provide information, discuss these issues, and identify practical solutions. Participants also suggested finding and encouraging indigenous community leaders who are trained and engaged as substance abuse treatment clinicians and administrators. These clinicians will help build trusting relationships with clients, optimize engagement within the first few critical visits, and retain clients in treatment. As administrators, they will be able to listen deeply to community and client voices, help programs to focus more on the individuals they are serving, and achieve greater equity and engagement for underserved populations. The peer recovery support approach offers a good model for how to listen and engage others. Participants identified the Network for the Improvement of Addiction Treatment (NIATx) as another proven approach that requires constant examination of methods and outcomes so that “one size fits all” programs will become history. Another suggestion to help address health disparities included translation of documents into Spanish and other target languages.

J. Pain Management and Addiction

Some evidence indicates that more people are becoming addicted to opioid medications prescribed for pain management. In a few communities, for instance, physicians are sending these individuals to methadone programs for treatment. States agreed that pain management transcends the scope of MAT and requires physicians with specialized skills. At the same time, an individual’s clinical picture is not always clear. Persons with substance use disorders may also have chronic pain, and individuals prescribed pain management medications may have addiction issues. MAT providers are addressing these concerns by developing good working relationships with pain management clinics and providers in their communities. In at least one State, educational forums on dosing and pain management for OTPs were conducted. Participants also suggested that States need guidelines and procedures for substance abuse providers regarding addiction and pain management to achieve enhanced collaboration with other health professionals.

K. Enhanced Performance Measures

States face a common challenge of developing relevant performance measures for MAT. Participants agreed that capturing only admission and discharge data or using National Outcome Measures (NOMs) are not adequate or meaningful enough for MAT. While participants acknowledged that they continue to struggle with identifying and designing meaningful measures for MAT, they suggested the following as possible performance measurement candidates:

- Access to care
- Client progress through phases of treatment/levels of care
- Change in status
- Retention in treatment
- Client satisfaction
- Frequency of substance use (reduced number of drinks, days of drinking, etc.)
- Cost effectiveness
- Level of functioning (particularly for clients with co-occurring disorders)
- Utilization of services, including overuse
- Post-treatment engagement with peer recovery support
- Reduced symptom severity (e.g., using ASAM criteria)

- Implementation of a model with fidelity

States are at different stages in assessing performance of their MAT providers. There are States just starting on the journey, using NOMs while exploring detoxification, relapse, and other measures. Some States are conducting regular client satisfaction surveys, including use of separate instruments for adolescents and adults. Collaborating with providers, other States have developed provider report cards that include MAT, producing scores that focus on access, retention, and followup. Some States are interested in measuring practice fidelity at the clinical level as well as outcomes, and then assessing if the two are connected. Participants acknowledged that the needs for performance data can vary among clinicians, program administrators, and state and Federal officials.

A participant identified five quality indicators that this individual's State is using. These indicators include time from first contact through assessment, detoxification, and treatment; linkages; polypharmacy issues; cost-effectiveness; and trends in occurrence of sentinel events at regional and provider levels (e.g., suicides). Further, NASADAD is now compiling the medical literature on performance measures. While there are consistent performance measures in health care (Healthcare Effectiveness Data Set, National Quality Forum, etc.) that are widely used and accepted, the use of various adaptations of these measures for performance contracting is less consistent. Given recent work in the area of performance measures (e.g., Veterans Administration, Washington Circle) and the growing body of work in the area of performance contracting for substance use treatment, it appears promising that the substance abuse field will be able to develop a host of performance measures that are on par with those in medicine. The following are overall objectives of the NASADAD research effort:

- Identify criteria for effective substance abuse performance measures
- Determine the specific measures to implement
- Test the validity of the selected measures

III. CONCLUSION

MAT is among a number of key approaches and practices that can lead to an improved quality of life for many individuals with SUDs. States are advancing toward full integration of substance abuse, mental health, and developmental disabilities with primary health care services based on individual client needs—and MAT is an integral part of the continuum of care. States are implementing MAT with integrity, using different approaches but reflecting the common vision of full integration with the primary health care system.

States are developing effective strategies to address and persistently challenge barriers to MAT implementation. These key barriers include provider resistance to using medications to treat addiction, the lingering stigma attached to substance abuse, the urgent need for workforce development, and reluctance of other systems (e.g., corrections) to accept or incorporate MAT for their clients.

States have developed and are consistently employing certain approaches to strengthen MAT implementation and effectiveness. These common approaches include developing strategic partnerships; creating internal and cross-agency training opportunities; developing and advocating for changes to statutes, regulations, and policies; creatively using technology; attending to issues of equity and engagement; preparing guidance on pain management issues and expanding use of buprenorphine; and fully engaging the skills and knowledge of medical directors.

States are urgently searching for valid measures of organizational performance and client success to more fully integrate MAT within their programs and broader systems of care. MAT now plays a significant role in the continuum of care and client recovery, as evidenced by the use of continuous quality improvement and NIATx, implementation of pilot projects to demonstrative cost-effectiveness, and the resetting of performance measurement criteria in multiple States. With valid and reliable outcome data, States will be better able to improve existing MAT delivery systems and expand the reach of this life-saving and life-enhancing treatment.

APPENDIX A

**The Substance Abuse and Mental Health Services Administration
(SAMHSA)**

presents

Implementing Medication-Assisted Treatment Statewide

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APPENDIX B

MAT RESOURCES

NAADAC, The Association for Addiction Professionals—www.naadac.org

NAADAC is a membership organization serving addiction counselors, educators, and other addiction-focused health care professionals who specialize in addiction prevention, treatment, recovery support, and education. With 10,000 members and 43 State affiliates, NAADAC's network of addiction services professionals spans the United States and the world.

NAADAC's Life-Long Learning Series

Medication Management for Addiction Professionals: Campral Series

Published June 2006

Project Leader: Tom Freese, PhD

NAADAC, in partnership with Forest Laboratories, Inc., is pleased to introduce its Life-Long Learning Series with "*Strengthening the Will to Say No*" Medication Management for Addiction Professionals – Campral Series.

NAADAC's Life-Long Learning Series has evolved from NAADAC's long history of providing quality education courses led by counselors and other addiction-related health professionals who are trained and experienced in both pharmacology and clinical application of therapies. These seminars are aimed at NAADAC's 11,000 members, consisting of doctors, nurses, psychologists, social workers, counselors, prevention specialists and those who work in various clinical settings.

Campral is a pharmaceutical developed by Merck Santé s.a.s., a subsidiary of Merck KGaA of Darmstadt, Germany, and is licensed to Forest Laboratories, Inc. for use in the United States. Campral is designed to help clients stay alcohol free and is intended for people who are alcohol dependent, who have decided to stop drinking entirely, and are prepared to participate in counseling. Campral has been approved by the Federal Drug Administration and has been used for more than a decade in Europe.

Campral works differently than other medications for alcohol dependence. Campral is not intended to cause illness if the person drinks alcohol nor is it meant to block the "high" associated with drinking alcohol. Instead, it focuses on reducing symptoms of distress once the patient has become alcohol free. Clinical trials of Campral showed that patients on Campral are three times more likely to stay alcohol free than people taking placebo tablets. This is thought to occur by reducing the symptoms of withdrawal (anxiety, sweating, difficulty sleeping) which often lead alcohol dependents to drink again.

Counselors are in a unique position to work with others in the addiction related health care profession. As the people who know clients best, counselors can assess treatment plans and help determine if Campral is appropriate for their clients.

This distinct seminar on medication management is specifically designed for the addiction treatment professional. The education and training program will consist of dynamic workshops, which both challenge the participant to apply the knowledge to their existing skills as clinicians, while engaging addiction professionals in case studies and peer discussion.

Participants will be provided with a comprehensive reference guide and will be able to use this curriculum in their clinical practice. Following in the tradition of NAADAC's previous educational seminars, the handbook will also contain chapters regarding the relationship between physicians, counselors and clients and an appendix that will contain elaborate assessment worksheets.

Pharmacotherapy: Integrating New Tools into Practice

Published March 2007

Project Leader: Tom Freese, PhD

Alcohol abuse and dependence affects millions of Americans each year. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that alcohol abuse affects 9.7 million people and alcohol dependence touches 7.9 million people. In the addiction profession, bio-psycho-social treatment traditionally has been the mainstay of alcohol and drug treatment programs, but more and more, there has been a growth in the availability of medications that may be able to supplement traditional treatment.

The goal of NAADAC's Life-Long Learning Series *Pharmacotherapy: Integrating New Tools into Practice* is to bring together addiction professionals from many backgrounds to discuss pharmacotherapy in a way that challenges ideas and perceptions, and to present unbiased information that can be used to assess the best possible treatment for patients.

This educational program will discuss the four facets of alcohol dependence and addiction (biological, psychological, social and spiritual), will discuss addiction as a disease and the scientific evidence to support this claim, will compare of FDA-approved pharmacotherapies for alcohol dependence, focus on overcoming treatment obstacles, apply strategies to match patients to the most appropriate therapy and plans to motivate patients in treatment.

New Innovations with Opioid Treatment: Buprenorphine

Published March 2008

Project Leader: Tom Freese, PhD

The goal of NAADAC's Life-Long Learning Series *New Innovations with Opioid Treatment: Buprenorphine* is to bring together addiction professionals from many backgrounds to discuss medication-assisted treatment in a way that challenges ideas and perceptions and to present unbiased information that can be used to assess the best possible treatment for patients.

This educational program will discuss the four facets of opioid dependence and addiction (biological, psychological, social and spiritual), addiction as a disease and the scientific evidence to support this claim, three FDA-approved medications for opioid dependence, applying strategies to match patients to the most appropriate therapy, methods of motivating patients in opioid dependence treatment and building cooperative relationships between addiction professionals and prescribers.

New Horizons: Integrating Motivational Styles, Strategies and Skills with Pharmacotherapy

Published August 2008

Project Leader: Carlo DiClemente, PhD

The goal of NAADAC's Life-Long Learning Series *New Horizons: Integrating Motivational Styles, Strategies and Skills with Pharmacotherapy* is to educate participants on various motivational approaches to help alcohol dependent clients make positive behavior change in their lives. This educational program will discuss how addiction counselors and other helping professionals can utilize a motivational style in addiction treatment, as well as how to integrate appropriate motivational strategies and skills to help the alcohol dependent move through the Stages of Change. This educational program will provide an introduction to open-ended questions, reflective listening, affirmation, summarizing, eliciting change talk, asking permission, giving advice, providing a menu of options, rolling with resistance and the four FDA-approved pharmacotherapies for alcohol dependence.

Integrating Treatment for Co-occurring Disorders: An Introduction to What Every Addiction Counselor Needs to Know

Published February 2010

Project Leader: Mary Woods, RNC, LADC, MSHS

Integrating Treatment for Co-occurring Disorders: An Introduction to What Every Addiction Counselor Needs to Know is a skill—based training program that will help addiction counselors improve their ability to assist clients who have co-occurring disorders, within their scope of practice. This educational program will discuss the many myths related to mental illness treatment, barriers to assessing and treating co-occurring disorders, relevant research and prevalence data, commonly encountered mental disorders, applicable screening and assessment instruments and issues surrounding medication management and coordinating with other mental health professionals. This education program will also introduce the integrated model of mental health and addiction treatment services, outlining how to utilize current substance abuse treatment best practices when working with this population. Through the use of case studies, video clips and interactive exercises, participants will feel more comfortable and competent in addressing mental health issues with clients who have co-occurring disorders.

Michigan

http://www.michigan.gov/documents/Treatment_Policy_05_Enrollment_Criteria_for_Methadone_145925_7.pdf

Michigan's policy for enrolling clients for services with methadone.

http://www.michigan.gov/documents/Treatment_Policy_04_Off-Site_Dosing_147368_7.pdf

The policy that assists with the regulation of off-site dosing and take-homes for methadone.

http://www.michigan.gov/documents/mdch/TA-T-06_Counseling_Requirements_206190_7.pdf

A guidance document established to help methadone programs understand the requirements involving a change in the administrative rules for how counseling should be provided to clients receiving methadone.

http://www.michigan.gov/mdch/0,1607,7-132-27417_27655_30419---.00.html

This webpage contains all of the documents required for establishing a new treatment program in Michigan.

http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin_Num=32514401&Dpt=&RngHigh=32599408

Specific rules and regulations for methadone treatment programs in Michigan.

New York

<http://www.oasas.state.ny.us/Admed/index.cfm>

The New York State Office of Alcoholism and Substance Abuse Services (OASAS) maintains a robust Addiction Medicine Web site. Sections include Addiction Medications, Drugs of Abuse, Prescription Drug Abuse, Medical Consequences, and Physician Resources. Through this Web site, OASAS also offers a free Addiction Medicine Educational Series.

New Jersey

<http://www.state.nj.us/humanservices/das/feefor/forms/NETI%20App.doc>

New Jersey's fee-for-service (FFS) Medication-Assisted Treatment Initiative (MATI) Network application. Interested providers need to complete this application to join the network of approved FFS providers for this medication-assisted treatment FFS initiative. The application includes the qualifying criteria.

<http://www.state.nj.us/humanservices/das/feefor/descriptions/Standardized%20Service%20Descriptions%20Jan%202009.doc>

The link on the Web site to treatment service descriptions, which includes medication services as well as STR, LTR, etc.

<http://www.state.nj.us/humanservices/das/treatment/neti/index.html>

The Web site link to background information on the MATI. The MATI consists of five mobile medication sites, one fixed site, six corresponding office-based services sites, outreach to the syringe exchange programs and community-based agencies, two intensive supportive housing providers serving 62 individuals with wrap-around services, the creation of ten enhanced sub-acute detoxification beds, vouchers for additional treatment services in a fee-for-service network of 28 providers, and an evaluation of the entire initiative conducted by CASA at Columbia. The site also includes links to our biannual reports to the Governor and Legislature on this pilot initiative.

<http://www.state.nj.us/humanservices/das/information/AB-Buprenorphine.pdf>

The Web site link to the administrative bulletin on buprenorphine, which details guidelines for its use in New Jersey substance abuse treatment facilities.

The State of New Jersey also provided the following documents (included in this appendix):

- Annex As for New Jersey's MATI, which are similar to contractual terms and conditions to which providers must adhere. These documents are just one component of New Jersey's contract package, and they include descriptions of deliverables for the services.
- The Request for Proposal Nondiscrimination language for clients using MAT.
- A brief description of New Jersey's quarterly medical directors' meetings.

Methadone Maintenance Treatment Annex A

In addition to the General Requirements stated in Annex A-Sections I and II, the contractee shall comply with the following requirements and all services provided and/or referred shall be documented in the clients' file.

***DAS reserves the right to amend this document as necessary during the contract period.**

A. Contract Specific Requirements

1. The contractee shall accurately complete the New Jersey Substance Abuse Monitoring System (NJ-SAMS). The NJ-SAMS admission and discharge screen forms shall be completed for all clients to ensure participation in the National Outcome Measures (NOMS).
2. The contractee shall ensure that upon admission each client shall be assigned to a substance abuse counselor, with assignment documented in the client's treatment file.
3. The contractee shall ensure a minimum of (150) methadone clients at all times.
4. The contractee shall ensure clients being referred by the mobile unit for methadone maintenance and requiring office-based services be accompanied by mobile unit staff, ensuring that client's receive the recommended level of treatment.
5. The contractee shall ensure that during all hours when medication is being administered, there shall be at least one registered professional nurse (RN) present in the mobile unit for 150 or fewer active clients and at least one additional licensed nurse present in the mobile unit for each additional 150 or fewer active clients.
6. The contractee shall provide priority treatment to the following in this order: Pregnant injecting drug users, pregnant drug users, injecting drug users, and all other drug users.
7. The contractee shall ensure that all pertinent and required documents shall be visibly posted, including priority treatment for pregnant women and IV drug users, DAS license, DAS complaint hotline, and how to request for sign language interpreter services.

B. Clinical Services

1. The contractee shall ensure that appropriate assessments are completed on each client including a completed New Jersey Substance Abuse Monitoring System (NJSAMS), Addiction Severity Index (ASI), Diagnostic Statistical Manual (DSM) IV Diagnoses (all 5 Axes), American Society of Addiction Medicine (ASAM) Level of Care Index, and medical clearance and evaluation.
2. The contractee shall ensure that each substance abuse counselor's caseload does not exceed 50 clients.
3. The contractee shall ensure that group therapy includes no more than 12 clients per session.
4. The contractee shall ensure that all individual, group, and didactic sessions shall be a minimum of 45 minutes in duration regardless of the modality of treatment.
5. The contractee shall ensure that clients have been educated about the Phase system of methadone maintenance and what they must do in order to progress through the Phases.

6. The contractee shall ensure that all outpatient methadone detoxification programs shall provide a minimum of one counseling session per week to each client during the first four months after initiation of treatment and at least one counseling session every two weeks thereafter until discharged.

7. The contractee shall ensure that their outpatient methadone maintenance program(s) assign each client to one of the following Phases and provide counseling to the client in accordance with the following schedule:

Phase I. At least one counseling session per week with at least one individual session per month, for a total of four sessions per month.

Phase II. At least one counseling session every two weeks with at least one individual session, for a total of two sessions per month.

Phase III. At least one individual counseling session per month.

Phase IV. At least one individual counseling session every three months.

Phase V. Clients who have had twenty-four consecutive months of negative drug screens and meet other program criteria for treatment progress shall receive counseling services at a frequency determined by the multidisciplinary team and program policy.

Phase VI. Clients who have had thirty-six consecutive months of negative drug screens and meet other program criteria for treatment progress shall receive counseling services consistent with their clinical needs and the documented recommendations of the multidisciplinary team.

Phase I-A. Clients in Phase I, for a period of at least twelve (12) months, who have failed to progress in treatment despite documented efforts by the program to intensify treatment services and where referral to supplemental treatment services or a residential program is not available, may be retained in treatment at a lesser level of service designated as Phase I-A in accordance with the following:

- The program can document a multidisciplinary team case conference that determines a substantial identifiable benefit exists to the client and/or the general public that supports retaining the client in treatment despite the client's continued lack of progress in treatment;
- The program's decision to retain a client in Phase I-A shall be based on a benefit to the client and/or general public which is documented in the client record and supported in writing by the counselor, director of substance abuse counseling, director of nursing services and medical director; and
- Written documentation of alternative treatment (i.e., IOP, residential, hospitalization, etc.) options explored by the program shall be included, along with reasons why these options are inappropriate (i.e., not available in area, etc).
- Clients designated as Phase I-A shall receive at least two (2) counseling sessions per month, including one (1) individual counseling session, and shall receive at least one monthly drug screening; and
- The multidisciplinary team shall review and document the status of clients designated in Phase I-A on a quarterly basis.

Phase I-A Client who refuses treatment services:

- All Phase I clients shall be maintained on a therapeutic dose of methadone for a minimum of one year.
 - All clinical interventions to engage client into treatment shall be documented in the clients file.
 - If, after a minimum of one year on a therapeutic dose of methadone, the client does not make any progress in treatment, despite repeated attempts to engage the client into treatment, the multidisciplinary team may recommend that the client be detoxed from methadone.
 - The contractee shall notify the DAS Project Director at Jude.lheoma@dhs.state.nj.us or at (609) 292- 3326 at least 3 days prior to initiating detoxification off of methadone.
8. The contractee shall ensure that all client Phases be clearly documented in progress notes.
 9. The contractee is required to document in a consistent manner, and by client signature, all client contact and counseling sessions.
 10. The contractee shall provide and/or refer for the clients for:
 - Educational services
 - Vocational counseling and training
 - Job placement for clients
 - Legal services
 11. The contractee must conduct and document client education (developed by medical personnel- i.e. physician, nurse practitioner, physician assistant, registered nurse) specific to methadone pharmacology and to include, but not be limited to:
 - Drug interaction
 - Physical effects
 - Withdrawal effects
 - Long term treatment options
 - Disease management
 - Other medication options
 12. The contractee shall ensure that each client has an up-to-date individual treatment plan that includes goals and objectives of treatment with time frames.
 13. The contractee shall ensure that each client's treatment plan is reviewed every 90 days by a multidisciplinary treatment team.
 14. The contractee shall ensure that each client has a discharge plan and/or continuum of care plan that begins on the onset of treatment.

C. Co-occurring Disorder Requirements

1. The contractee shall have a policy regarding the assessment, treatment and/or referral of clients with co-occurring disorders (classified in Quadrants I , II, III and IV by the National Association of State Mental Health Program Directors and The National Association of State Alcohol and Drug Abuse Directors (NASMHPD/NASADAD)
2. The contractee shall admit and medicate all clients (classified in Quadrants I thru IV, NASMHPD/NASADAD) with co-occurring mental health and substance abuse/dependence disorders.

Level of Care Quadrants

<u>Quadrant III</u> High Substance Abuse Disorder Low Severity Psychiatric Disorder	<u>Quadrant IV</u> High Substance Abuse Disorder High Severity Psychiatric Disorder
<u>Quadrant I</u> Low Substance Abuse Disorder Low Severity Psychiatric Disorder	<u>Quadrant II</u> Low Substance Abuse Disorder High Severity Psychiatric Disorder

- 1) The contractee shall admit and provide counseling services for methadone clients classified in Quadrants I and III, with co-occurring mental health and substance abuse/dependence disorders, and/or who meet the agency's admissions criteria.
 - The contractee shall ensure that the referral of a client for psychiatric assessment, differential diagnosis, and/or assessment/prescription for, and monitoring of medication, shall be clearly documented in the client's treatment plan.
- 2) The contractee shall ensure that all methadone clients classified in Quadrants II and IV, with co-occurring mental health and substance abuse/dependence disorders are referred to and receive at a minimum the following services:
 - Clients shall be referred to an appropriate mental health agency for counseling services and medication monitoring other than suboxone.
 - The contractee shall work collectively with the mental health facility to ensure participation in the client's treatment plan.

D. Urine Drug Screens

1. The contractee shall ensure that all clients continuing in treatment receive a minimum of 12 random urine drug screens within the first year and at least 8 random urine drug screens in each subsequent year. Any client receiving 6 or more take home bottles shall have random monthly urine drug screenings.
2. The contractee shall ensure that for clients with positive urine drug screens in any Stage of treatment, additional individual, group, and family counseling sessions must be provided, with a focus on addressing the circumstances behind the positive urine drug screens. The client's treatment plan must be reviewed by the multidisciplinary team with the treatment plan revised as appropriate. The review, recommendation and subsequent actions must be appropriately documented in the client chart.

- A client with a positive urine drug screen, the first time after admission, shall return to a minimum of one counseling session per week until symptoms cease and shall remain in the present phase of treatment.
- A client with a second or subsequent positive urine drug screens any time after admission may be returned to a lower stage of treatment.

E. Policies and Procedures:

1. The contractee shall establish and adhere to take-home medication policies which are consistent with State and the Drug and Enforcement Administration (DEA) regulations.
2. The contractee providing methadone treatment or other opiate substitution treatment shall maintain on-site, and make available upon request, an electronic daily log which permits the identification of clients by Phase, length of time in Phase, form of medication and dosing, and urine drug screen results.
3. The contractee shall have written policies and procedures to ensure that when the mobile unit is at full capacity all IVDU clients who are in need of treatment are admitted to an appropriate program. The contractee shall ensure that all clients in need of Medical detoxification are appropriately placed.
 - The Division of Addiction Services Program Director shall be notified immediately if the contractee is unable find treatment for the client.
 - Clients shall be provided and/or referred to interim services immediately.
4. The contractee shall have policies and procedures in place to ensure the provision of treatment for priority populations.

MATI Mobile Unit Annex A

In addition to the General Requirements stated in Annex A-Sections I and II, the contractee shall comply with the following requirements and all services provided/referred shall be documented and/or maintained on file.

***DAS reserves the right to amend this document as necessary during the contract period.**

A. Contract Specific Requirements

1. The contractee shall adhere to the standards for licensure of ambulatory care facilities.
2. The contractee shall appoint an administrator of the mobile unit [satellite] who shall be accountable to the governing authority. The administrator of the satellite may be the same person as the administrator of the licensed facility with which the satellite is affiliated. The administrator of the satellite, or a designated alternate, shall be available on the mobile unit during its hours of operation.
3. The contractee shall accurately complete the New Jersey Substance Abuse Monitoring System (NJ-SAMS) on a computer located in the mobile unit. The NJ-SAMS admission and discharge screen forms shall be completed for all clients to ensure participation in the National Outcome Measures (NOMS).
4. The contractee shall ensure that all clients requesting treatment at the mobile unit (regardless of their choice of drugs) are to be assessed using the Addiction Severity Index (ASI) and entered into the NJSAMS. If it is found that the client is not a candidate for the mobile unit (not using heroin), the client is then to be referred to an appropriate substance abuse treatment facility. The mobile unit shall keep documentation of such referrals.
5. The contractee shall provide all assessments and all necessary medical services on the mobile unit.
6. The contractee shall ensure that all necessary release forms are signed by the client and witnessed. The signed release forms shall be maintained in the client file.
7. The contractee shall provide suboxone induction on the mobile unit in accordance with Federal and state accepted guidelines and regulations.
8. The contractee shall ensure that the physician has face-to-face interaction with every client being prescribed Suboxone. The physician is responsible for:
 - Completing a physical exam for the client
 - Generating a clinical diagnosis
 - Beginning the Suboxone Induction phase
 - Medication orders
 - Supervision of nurse
9. The contractee shall provide methadone maintenance on the mobile unit in accordance with the Drug and Enforcement Administration (DEA) regulations and state accepted guidelines.
10. The contractee shall ensure a minimum of 50 suboxone clients and 150 methadone clients on their census at all times.

11. The contractee shall ensure that the mobile unit will operate at least eight hours a day six days per week. The time shall be divided between two or more consistent sites based on need and final approval from DAS. Induction and maintenance shall be provided on the mobile unit at all locations.
12. The contractee shall ensure that the hours of operation and locations be visibly posted on the mobile unit and the agency. The hours of operation and locations shall be submitted to DAS for approval. All changes in the hours of operation/locations shall be reported to the DAS Program Director immediately.
13. The contractee shall provide transportation as clinically and/or medically needed for clients.
14. The contractee shall ensure clients being referred by the mobile unit for office-based services be accompanied by mobile unit staff ensuring that client's receive the recommended level of treatment.
15. The contractee shall ensure that all mobile unit staff (physician, nurse, case manager, counselor) attend DAS trainings that are scheduled to assist in the development and implementation of the mobile medication unit project.
16. The contractee shall have linkages/affiliation agreements with agencies providing needed services (medical, psychiatric, legal, housing, vocational, etc.). Affiliation agreements shall be maintained on file.

B. Medical Services

1. The contractee's mobile unit shall be able to respond to medical emergencies occurring on the premises during its hours of operation. The agency shall have a written policy and procedure in place and accessible on the mobile unit.
2. The contractee shall ensure that emergency medical services not provided on the mobile unit, or at the fixed site, shall be provided by a hospital or hospitals through written affiliation agreements. The contractee shall have a written plan for emergency transportation of patients.
3. The contractee shall ensure that laboratory services are provided only by facilities that are licensed or approved by the NJ Department of Health and Senior Services.
4. The contractee shall report confirmed and suspected cases of communicable diseases as required by New Jersey state law.

C. Syringe Exchange Program (SEP)

1. The contractee shall collaborate with the local Syringe Exchange Program (SEP) to facilitate access to, and linkage of, IVDU clients interested in treatment services.
2. The contractee shall ensure that the mobile unit's scheduled route(s) and hours of operation correspond with the local SEP site to facilitate access for SEP clients seeking treatment services, to the extent this is practical.

D. Program Reporting Requirements

1. The contractee shall submit a separate budget and quarterly expenditure report identifying expenses incurred by the program to the Division of Addiction Services (DAS) Fiscal Unit.
2. The contractee shall submit signed monthly rosters to DAS for all clients receiving services on the mobile unit. The roster should include at a minimum the following:

- Client I.D.
- Date of Birth
- Date of Admission
- Phase
- Modality of treatment
- Funding source
- Gender
- Household size
- Household income

E. Policies and Procedures

1. The contractee shall have written policies that address the following but not be limited to:
 - Infection control and prevention measures
 - Laboratory services
 - The use and sterilization of patient care items
 - The care and use of sterilizers
 - The handling of regulated medical waste
 - The provision of emergency medical services
 - Patient care services
 - Control of drugs
 - Medical records
 - Treatment planning and updating of treatment plans

2. The contractee shall have a facility-wide policy which prohibits discrimination against clients of substance abuse prevention, treatment and recovery support services who are assisted with legitimate prescribed medication/s, without limits to frequency and duration. The contract ensures that all agencies with which the contractee has linkages/affiliations agreements also have such a policy.

3. The contractee shall have a policy available for DAS review and approval for providing interim services. The policy shall include a list of available services, the frequency of service availability and any associated client fee schedule. At minimum, interim services shall include:
 - Counseling
 - Education about HIV, tuberculosis and Hepatitis C
 - The risks of needle-sharing
 - The risks of HIV and Hepatitis C transmission to sexual partners and infants
 - Steps that can be taken to ensure that HIV and Hepatitis C transmission does not occur
 - Referral/testing for HIV, tuberculosis and Hepatitis C treatment services

4. The contractee shall ensure that written policies for disaster planning, contingency planning and response shall address all hazards and be communicated to staff in annual trainings with updates as needed.

5. The contractee shall conduct full criminal background checks supported by fingerprints for all staff, volunteers, interns and any other personnel routinely scheduled to work in the mobile unit and agency in accordance with their policies and procedures. Documentation of this shall be maintained in the staff's personnel file. The contractee may use DAS funds for this effort. The contractee shall submit a listing of these costs with the final expenditure report for this contract.

F. Staffing

1. The contractee shall ensure that Suboxone is prescribed by a certified physician in Addiction Medicine who has satisfied qualifications set-forth by the provisions of the Drug Addiction Treatment Act of 2000 (DATA 2000) and the Office of National Drug Control Policy Reauthorization Act of 2006 (ONDCPRA). The contractee shall ensure that the physician has face-to-face interaction with every client being prescribed Suboxone and ASAM certified or is monitored by an ASAM-level physician. The physician shall be responsible for:
 - Completing a physical exam for the client;
 - Generating a clinical diagnosis;
 - Beginning the Suboxone induction phase;
 - Writing medication orders; and
 - Supervision of nurse.
2. The contractee shall ensure compliance with Title 45, Chapter 6, Clinical Supervision in the New Jersey Office of the Attorney General, Division of Consumer Affairs, State Board of Marriage and Family Therapy Examiners Alcohol and Drug Counselor Committee, Statutes and Regulations and DAS Licensure Regulations.
 - A supervision schedule shall be maintained and submitted to DAS on a quarterly basis.
 - All clinical supervision shall be documented, include date, type, name of supervisor and supervisee, and cases/topics reviewed and discussed.
3. The contractee shall have at a minimum one master level Certified Drug and Alcohol Counselor (CADC) or Licensed Clinical Alcohol and Drug Counselor (LCADC) to provide the following services but not limited to:
 - Supervise the case manger and other support staff
 - Provide clinical supervision
 - Conduct cognitive/behavioral/motivational counseling services
4. The contractee shall ensure that each substance abuse counselor's caseload does not exceed fifty (50) clients. No counselor's caseload of up to 50 clients shall include more than 35 clients in Phase I-III.
5. The contractee shall ensure that the Case Manager have a Bachelor's degree in the human services field.
6. The contractee shall utilize a case management model or combination of models as described in the Center for Substance Abuse Treatment (CSAT) TIP #27, "Comprehensive Case Management for Substance Abuse Treatment." The contractee shall focus on models such as, but not limited to the ones utilized for "Strengths Perspective", "Assertive Community Treatment" or "Clinical Rehabilitation". The model shall require at minimum that case management efforts include the following:
 - Performing eligibility screening for available resources for treatment
 - Ensuring that MATI Eligibility Criteria is met prior to clinical assessment
 - Conducting assessments for recovery support needs
 - Providing client's a single point of contact for multiple health and social services systems
 - Focusing on practical problems of daily living
 - Motivational interviewing techniques/methods
 - Ensuring timely access to various levels of care through DAS fee for service voucher program
 - Monitoring of client's progress through the continuum of care
 - Assertive advocacy methods on behalf of the client

G. Voucher Network

1. The contractee shall ensure that if a client requires another level of care or support services not provided via the mobile unit or office-based program, the contractee should request a MATI voucher through DAS.
2. If issued a DAS-approved voucher, the contractee shall ensure that the client be referred to a DAS MATI Network approved provider for the appropriate services, as clinically indicated.

MATI Office-Based Site Annex A

In addition to the General Requirements stated in Annex A-Sections I and II, the contractee shall comply with the following requirements and all services provided/referred shall be documented and/or maintained on file.

***DAS reserves the right to amend this document as necessary during the contract period.**

A. Contract Specific Requirements

1. The contractee shall adhere to the standards for licensure of ambulatory care facilities.
2. The contractee shall accurately complete the New Jersey Substance Abuse Monitoring System (NJ-SAMS). The NJ-SAMS admission and discharge screen forms shall be completed for all clients to ensure participation in the National Outcome Measures (NOMS).
3. The contractee shall ensure that all clients requesting treatment be assessed using the Addiction Severity Index (ASI) and entered into the NJSAMS. If it is found that the client is not a candidate for the office-based site (not using heroin), the client is then to be referred to an appropriate substance abuse treatment facility. The office-based site shall keep documentation of such referrals.
4. The contractee shall provide all assessments and all necessary medical services at the office-based site.
5. The contractee shall ensure that all necessary release forms are signed by the client and witnessed. The signed release forms shall be maintained in the client file.
6. The contractee shall provide suboxone induction in accordance with Federal and state accepted guidelines and regulations.
7. The contractee shall ensure that the physician has face-to-face interaction with every client being prescribed Suboxone. The physician is responsible for:
 - Completing a physical exam for the client
 - Generating a clinical diagnosis
 - Beginning the Suboxone Induction phase
 - Medication orders
 - Supervision of nurse
8. The contractee shall provide methadone maintenance in accordance with the Drug and Enforcement Administration (DEA) regulations and state accepted guidelines.
9. The contractee shall ensure a minimum of 50 suboxone clients and 150 methadone clients on their census at all times.
10. The contractee shall provide transportation as clinically and/or medically needed for clients.
11. The contractee shall ensure that all office-based staff (physician, nurse, case manager, counselor) attend DAS trainings that are scheduled to assist in the development and implementation of the MATI project.

12. The contractee shall have linkages/affiliation agreements with agencies providing needed services (medical, psychiatric, legal, housing, vocational, etc.). Affiliation agreements shall be maintained on file.

B. Medical Services

1. The contractee shall be able to respond to medical emergencies occurring on the premises during its hours of operation. The agency shall have a written policy and procedure in place and accessible at the office-based site.
2. The contractee shall ensure that emergency medical services not provided at the office-based site be provided by a hospital or hospitals through written affiliation agreements. The contractee shall have a written plan for emergency transportation of patients.
3. The contractee shall ensure that laboratory services are provided only by facilities that are licensed or approved by the NJ Department of Health and Senior Services.
4. The contractee shall report confirmed and suspected cases of communicable diseases as required by New Jersey state law.

C. Syringe Exchange Program (SEP)

1. The contractee shall collaborate with the local Syringe Exchange Program (SEP) to facilitate access to, and linkage of, IVDU clients interested in treatment services.
2. The contractee shall ensure that the office-based site schedule correspond with the local SEP site to facilitate access for SEP clients seeking treatment services, to the extent this is practical.

D. Program Reporting Requirements

1. The contractee shall submit a separate budget and quarterly expenditure report identifying expenses incurred by the program to the Division of Addiction Services (DAS) Fiscal Unit.
2. The contractee shall submit signed monthly rosters to DAS for all clients receiving services at the office-based site. The roster shall include at a minimum the following:
 - Client I.D.
 - Date of Birth
 - Date of Admission
 - Phase
 - Modality of treatment
 - Funding source
 - Gender
 - Household size
 - Household income

E. Policies and Procedures

1. The contractee shall have written policies that address the following but not be limited to:
 - Infection control and prevention measures
 - Laboratory services
 - The use and sterilization of patient care items
 - The care and use of sterilizers
 - The handling of regulated medical waste

- The provision of emergency medical services
 - Patient care services
 - Control of drugs
 - Medical records
 - Treatment planning and updating of treatment plans
2. The contractee shall have a facility-wide policy which prohibits discrimination against clients of substance abuse prevention, treatment and recovery support services who are assisted with legitimate prescribed medication/s, without limits to frequency and duration. The contract ensures that all agencies with which the contractee has linkages/affiliations agreements also have such a policy.
 3. The contractee shall have a policy available for DAS review and approval for providing interim services. The policy shall include a list of available services, the frequency of service availability and any associated client fee schedule. At minimum, interim services shall include:
 - Counseling
 - Education about HIV, tuberculosis and Hepatitis C
 - The risks of needle-sharing
 - The risks of HIV and Hepatitis C transmission to sexual partners and infants
 - Steps that can be taken to ensure that HIV and Hepatitis C transmission does not occur
 - Referral/testing for HIV, tuberculosis and Hepatitis C treatment services
 4. The contractee shall ensure that written policies for disaster planning, contingency planning and response shall address all hazards and be communicated to staff in annual trainings with updates as needed.
 5. The contractee shall conduct full criminal background checks supported by fingerprints for all staff, volunteers, interns and any other personnel routinely scheduled to work in the mobile unit and agency in accordance with their policies and procedures. Documentation of this shall be maintained in the staff's personnel file. The contractee may use DAS funds for this effort. The contractee shall submit a listing of these costs with the final expenditure report for this contract.

F. Staffing

1. The contractee shall ensure that Suboxone is prescribed by a certified physician in Addiction Medicine who has satisfied qualifications set-forth by the provisions of the Drug Addiction Treatment Act of 2000 (DATA 2000) and the Office of National Drug Control Policy Reauthorization Act of 2006 (ONDCPRA). The contractee shall ensure that the physician has face-to-face interaction with every client being prescribed Suboxone and ASAM certified or is monitored by an ASAM-level physician. The physician shall be responsible for:
 - Completing a physical exam for the client;
 - Generating a clinical diagnosis;
 - Beginning the Suboxone induction phase;
 - Writing medication orders; and
 - Supervision of nurse.
2. The contractee shall ensure compliance with Title 45, Chapter 6, Clinical Supervision in the New Jersey Office of the Attorney General, Division of Consumer Affairs, State Board of Marriage and Family Therapy Examiners Alcohol and Drug Counselor Committee, Statutes and Regulations and DAS Licensure Regulations.

- A supervision schedule shall be maintained and submitted to DAS on a quarterly basis.
 - All clinical supervision shall be documented, include date, type, name of supervisor and supervisee, and cases/topics reviewed and discussed.
3. The contractee shall have at a minimum one master level Certified Drug and Alcohol Counselor (CADC) or Licensed Clinical Alcohol and Drug Counselor (LCADC) to provide the following services but not limited to:
 - Supervise the case manager and other support staff
 - Provide clinical supervision
 - Conduct cognitive/behavioral/motivational counseling services
 4. The contractee shall ensure that each substance abuse counselor's caseload does not exceed fifty (50) clients. No counselor's caseload of up to 50 clients shall include more than 35 clients in Phase I-III.
 5. The contractee shall ensure that the Case Manager have a Bachelor's degree in the human services field.
 6. The contractee shall utilize a case management model or combination of models as described in the Center for Substance Abuse Treatment (CSAT) TIP #27, "Comprehensive Case Management for Substance Abuse Treatment." The contractee shall focus on models such as, but not limited to the ones utilized for "Strengths Perspective", "Assertive Community Treatment" or "Clinical Rehabilitation". The model shall require at minimum that case management efforts include the following:
 - Performing eligibility screening for available resources for treatment
 - Ensuring that MATI Eligibility Criteria is met prior to clinical assessment
 - Conducting assessments for recovery support needs
 - Providing client's a single point of contact for multiple health and social services systems
 - Focusing on practical problems of daily living
 - Motivational interviewing techniques/methods
 - Ensuring timely access to various levels of care through DAS fee for service voucher program
 - Monitoring of client's progress through the continuum of care
 - Assertive advocacy methods on behalf of the client

G. Voucher Network

1. The contractee shall ensure that if a client requires another level of care or support services not provided via the office-based program, the contractee should request a MATI voucher through DAS.
2. If issued a DAS-approved voucher, the contractee shall ensure that the client be referred to a DAS MATI Network approved provider for the appropriate services, as clinically indicated.

Suboxone Treatment Annex A

In addition to the General Requirements stated in Annex A-Sections I and II, the contractee shall comply with the following requirements and all services provided/referred shall be documented and/or maintained on file.

***DAS reserves the right to amend this document as necessary during the contract period.**

A. Contract Specific Requirements

1. The contractee shall accurately complete the New Jersey Substance Abuse Monitoring System (NJ-SAMS). The NJ-SAMS admission and discharge screen forms shall be completed for all clients to ensure participation in the National Outcome Measures (NOMS).
2. The contractee shall ensure that Suboxone is prescribed by a certified physician in Addiction Medicine who has satisfied qualifications set-forth by the provisions of the Drug Addiction Treatment Act of 2000 (DATA 2000) and the Office of National Drug Control Policy Reauthorization Act of 2006 (ONDCPRA) (www.buprenorphine.samhsa.gov)
3. The contractee shall ensure Suboxone treatment for New Jersey residents 18 years or older with at least a one-year documented history of Opioid addiction and prior treatment attempts. Exemptions, such as treatment for individuals fewer than 18 years of age, shall be made in accordance with Federal guidelines.
4. The use of Buprenorphine by the contractee shall be approved for the treatment of opioid dependence in the formation of either Suboxone or Subutex. Injectable buprenorphine is not approved for the treatment of opioid dependence.
5. Contractees providing Suboxone treatment or other opiate substitution treatment must maintain on-site (both the mobile van unit and the office-based services site) and make available upon request, an electronic daily log or other record-keeping system, which permits the identification of clients, form of medication and dosing, and urine drug screen results by case.
6. The contractee shall ensure a minimum of fifty (50) suboxone clients at all times.
7. The contractee shall ensure clients being referred by the mobile unit for office-based services be accompanied by mobile unit staff ensuring that client's receive the recommended level of treatment.
8. The contractee shall provide priority treatment to the following in this order: Pregnant injecting drug users, pregnant drug users, injecting drug users, and all other drug users.
9. The contractee shall ensure that all pertinent and required documents be visibly posted, including priority treatment for pregnant women and IV drug users, DAS license, DAS complaint hotline, and request for sign language interpreter.

B. Medical Services

1. The contractee shall ensure that ancillary treatment services be in conformance with the guidelines set forward through the Center for Substance Abuse Treatment (CSAT), Office of Pharmacological and Alternative Therapies, and CSAT TIP #40, Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction, as well as the DAS guidelines on the use of buprenorphine.

2. The contractee shall ensure that all clients are instructed to abstain from use of any opiates twelve (12) hours prior to the induction phase of Suboxone treatment.
3. The contractee shall ensure that during the induction and stabilization phase of buprenorphine therapy, medical care and consultation is available on a 24-hour on-call basis. This care shall be supervised by the certified physician performing the induction.
4. The contractee shall ensure that opiate dependent pregnant clients receive proper education about Subutex (the formulation of choice for pregnant opiate dependent clients) treatment. The risks of Buprenorphine (a Category C drug) must be explained in detail to the client by the physician. Once thoroughly discussed with the client, a client can consent to treatment.
 - The discussion shall be clearly documented in the client's file
 - A signed and witnessed informed consent shall be maintained in the client's file.
5. The contractee shall ensure that all necessary physical and psycho-social services, in addition to the induction and use of Suboxone induction treatment, be provided:
 - Directly by the contractee; or
 - Via contractual arrangements with DAS Approved Licensed Treatment Programs.

C. Clinical Services

1. The contractee shall ensure that appropriate assessments are completed on each client including a completed New Jersey Substance Abuse Monitoring System (NJSAMS), Addiction Severity Index (ASI), Diagnostic Statistical Manual (DSM) IV Diagnoses (all 5 Axes), American Society of Addiction Medicine (ASAM) Level of Care Index and Medical evaluation and clearance.
2. The contractee shall ensure that each substance abuse counselor's caseload does not exceed fifty (50) clients.
3. The contractee shall ensure that group therapy includes no more than 12 clients per session.
4. The contractee shall ensure that all individual, group, and didactic sessions shall be a minimum of 45 minutes in duration regardless of the modality of treatment.
5. The contractee shall ensure that all necessary release forms are signed by the client and witnessed. The signed release forms shall be maintained in the client file.
6. The contractee shall utilize Suboxone therapy in conjunction with stabilization (detoxification or maintenance), rehabilitation (counseling and education) and follow-up (aftercare counseling and support groups).
7. The contractee shall ensure that all clients accepted into Suboxone therapy receive substance abuse counseling at a state licensed substance abuse treatment facility.
8. The contractee shall ensure that all counseling services are provided by either a Master's level Certified Alcohol and Drug Counselor (CADC) or a Master's level Licensed Certified Alcohol and Drug Counselor (LCADC) counselor.
9. The contractee shall ensure counselors collaborate with physicians to treat opioid-addicted clients, ensuring both the physician and counselors have access to each other for any client concern.

10. The contractee shall conduct and document client education specific to buprenorphine pharmacology and developed by medical personnel (either a Medical Director, Nurse Practitioner, Physician Assistant, Registered Nurse) to include, but not limited to:
 - Drug interaction
 - Physical effects
 - Withdrawal effects
 - Long-term treatment options
 - Disease management
 - Other medication options available
11. The counselor shall reinforce precautions regarding sedative drug use previously provided by the physician and relate any new pertinent information to the physician.
12. The counselor shall encourage the client to ask questions and discuss concerns with physician throughout the course of treatment.
13. The contractee shall develop a Cognitive/Behavioral/Motivational counseling curriculum and shall have prior approval by DAS.
 - The curriculum shall focus on:
 - Maintaining client involvement in the Suboxone treatment;
 - Assessing for and providing access to support/wraparound services; and
 - Assessing and motivating clients to continue in any and all necessary treatment.
14. The contractee shall immediately refer all clients post-induction to a mandatory stabilization program at an office-based site. This program shall include client participation in a twelve (12) week Cognitive/Behavioral/Motivational counseling curriculum.
15. The contractee shall ensure that clients who require an extended length of stay beyond the initial 12 weeks be approved for an extended length of stay seven days prior to the culmination of the 12 week period. In such cases the contractee should conform to the extension request policy by contacting the Program Coordinator, Adam Bucon (adam.bucon@dhs.state.nj.us) at DAS. The extension request form can be downloaded from <http://www.state.nj.us/humanservices/das/index.htm>.
16. The contractee shall complete an ASAM (American Society of Addiction Medicine) multidimensional level of care review using the LOCI (Level of Care Indicator) tool in NJSAMs (New Jersey Substance Abuse Monitoring System) for each extension request. The LOCI should be completed prior to contacting DAS to request an extension.
17. The contractee shall ensure that clients receiving Suboxone receive counseling services in accordance with 42 CFR requirements for Opioid Treatment Programs.
18. The contractee shall provide and/or refer for the clients for:
 - Educational services
 - Vocational counseling and training
 - Job placement for clients
 - Legal services
19. The contractee shall ensure that each client has an up-to-date individual treatment plan that includes goals and objectives of treatment with time frames.

20. The contractee shall ensure that each client's treatment plan is reviewed every 90 days by a multidisciplinary treatment team, which shall include at minimum the client's physician, nurse, and counselor.
21. The contractee shall ensure that each client has a discharge plan and/or continuum of care plan that begins at the onset of treatment and is updated on an as needed basis.

D. Co-occurring Disorder Requirements

1. The contractee shall have a policy regarding the assessment, treatment and/or referral of clients with co-occurring disorders (classified in Quadrants I , II, III and IV by the National Association of State Mental Health Program Directors and The National Association of State Alcohol and Drug Abuse Directors (NASMHPD/NASADAD)).
2. The contractee shall admit and medicate all clients (classified in Quadrants I thru IV, NASMHPD/NASADAD) with co-occurring mental health and substance abuse/dependence disorders.

Level of Care Quadrants

<u>Quadrant III</u>	<u>Quadrant IV</u>
High Substance Abuse Disorder Low Severity Psychiatric Disorder	High Substance Abuse Disorder High Severity Psychiatric Disorder
<u>Quadrant I</u>	<u>Quadrant II</u>
Low Substance Abuse Disorder Low Severity Psychiatric Disorder	Low Substance Abuse Disorder High Severity Psychiatric Disorder

- 1) The contractee shall admit and provide counseling services for Suboxone clients classified in Quadrants I and III, with co-occurring mental health and substance abuse/dependence disorders, and/or who meet the agency's admissions criteria.
 - The contractee shall ensure that the referral of a client for psychiatric assessment, differential diagnosis, and/or assessment/prescription for, and monitoring of medication shall be clearly documented in the client's treatment plan.
- 2) The contractee shall ensure that all Suboxone clients classified in Quadrants II and IV, with co-occurring mental health and substance abuse/dependence disorders are referred to and receive at a minimum the following services:
 - Clients shall be referred to an appropriate mental health agency for counseling services and medication monitoring other than suboxone.
 - The contractee shall work collectively with the mental health facility to ensure participation in the client's treatment plan.

E. Urine Drug Screening Requirements

1. The contractee shall ensure that clients with any positive urine drug screen(s) after the induction phase of treatment have their treatment plan reviewed by the interdisciplinary team with the treatment plan revised as appropriate. The review, recommendation and subsequent actions must be appropriately documented in the client chart.

2. The contractee shall ensure, following the induction phase, clients with more than one positive urine drug screen within a 30-day period be assessed and/or referred for an increased level of care, to include ancillary services, such as co-occurring assessment, social services, etc. This must be clearly documented in the client chart.

F. Education Requirements

1. The contractee shall ensure that all counselors working with Suboxone clients have taken the three (3) hour online course entitled, Buprenorphine Treatment of Opioid Addiction: A Counselor's Guide (www.danyalearningcenter.org/courseprofile.asp?cid=7)
Documentation of successful completion shall be maintained in the staff's personnel file.
2. The contractee shall ensure registration in the Physician Clinical Support System (PCSS) <http://www.pcssbuprenorphine.org/pcss/index.php>. for all physicians providing services under this contract. Documentation of successful registration shall be maintained in the physician's personnel file.

G. Policies and Procedure Requirements

1. The contractee shall have written policies and procedures to ensure that when the mobile unit is at full capacity all IVDU clients who are in need of treatment are admitted to an appropriate program. The contractee shall ensure that all clients in need of Medical detoxification are appropriately placed.
 - The Division of Addiction Services Program Director or Coordinator shall be notified immediately if the contractee is unable to find treatment for the client.
 - Clients shall be provided and/or referred to interim services immediately.
2. The contractee shall have policies and procedures in place to ensure the provision of treatment for priority populations.

NON-DISCRIMINATION LANGUAGE FOR RFPs

All providers of drug treatment services under these contracts must have in place established, facility-wide policies which prohibit discrimination against clients of substance abuse prevention, treatment and recovery support services who are assisted in their prevention, treatment and/or recovery from substance addiction with legitimately prescribed medication(s). These policies must be in writing in a visible, legible and clear posting at a common location which is accessible to all who enter the facility.

Moreover, no client who is admitted into a treatment facility, or a recipient of or participant in any prevention, treatment or recovery support services, shall be denied full access to, participation in and enjoyment of that program, service or activity available, or offered to others, due to the use of legitimately prescribed medications.

Capacity to accommodate clients who present or are referred with legitimately prescribed medications can be accomplished either through direct provision of services associated with the provision or dispensing of medications and or via development of viable networks/referrals/consultancies/sub-contracting with those who are licensed and otherwise qualified to provide medications.

DAS QUARTERLY MEDICAL DIRECTORS MEETINGS

This serves as a knowledge transfer mechanism through:

- Utilizing a case presentation format for each meeting.
- Advising physicians and medical directors on latest changes in the arena of medication assisted treatment (MAT).
- Providing a collegial framework for the physicians to ask one another and the DAS medical directors questions regarding MAT and treatment.
- Providing a framework for physicians and medical directors to understand how MAT fits into practice and the Division's vision.

APPENDIX C

BRIEF EXAMPLES OF STATE MAT IMPLEMENTATION

- A. Delaware established a State pharmacy that uses State general funds to pay for mental health and substance abuse medications. Clients who require medications for mental health conditions have previously been eligible to receive them through the State pharmacy, but medications for SUDs were recently added. Clients pay a small co-payment and there are no caps on the availability of medications. The program is too new to know if this expansion in medication availability will explode State costs or change the populations that seek treatment.
- B. Maryland had multiple regions without access to MAT. To address these service gaps, the State established mobile treatment units. The vans were initially deployed in urban Baltimore City due to the growing number of opioid overdoses and the City's zoning ordinances. Recently, a mobile medication unit was established in a rural portion of the State to improve access to care in an area with scarce health care resources. The mobile units are also linked to other psychosocial service programs and have added buprenorphine to their treatment capability.
- C. North Carolina has set out to establish a new comprehensive provider model—Critical Access Behavior Health Agencies (CABHAs)—to support its migration to a recovery oriented system of care and the enhanced use of evidence-based practices. The CABHAs are required to have a medical director, clinical director, quality assurance manager, and a training director; provide five services including MAT; and use performance management techniques. The goal is to fund up to 100 providers as CABHAs using Medicaid and State resources.
- D. Thirty mobile crisis teams operate in all counties of North Carolina. Team members are credentialed and trained in substance abuse treatment screening, assessment, and referral to treatment. Teams spend approximately 40 percent of their time in emergency departments to relieve overburdened medical staff. Efforts are underway to encourage law enforcement professionals to bring individuals with SUDs to the mobile crisis teams instead of directly to emergency departments to further relieve the health care system.
- E. Connecticut has implemented an initiative to reduce chronic recidivism among opioid treatment clients. Individuals who have four presentations in six months are encouraged to accept methadone while in the detoxification phase. Most individuals accepted this invitation, completed induction, were assigned a Case Manager for intensive follow-up, and referred to a maintenance program. The initiative has reduced the chronic recidivism rate among opioid treatment clients in the State.
- F. Heroin and other opiates are the primary drugs of choice in New Jersey and MAT is an essential treatment modality. Since 2007, using \$10 million in new treatment funds, the State launched five mobile treatment units and one fixed site providing suboxone and methadone treatment. Maryland and Connecticut provided valuable technical assistance to help implement the units. Two hundred clients are being served at each site, counseling services are mandated as part of treatment, and a continuum of tailored services is available for MAT clients through its MATI network.
- G. New York prepares single-sheet program provider report cards with scores on retention, access, and follow-up measures (includes MAT). During year 1, each program provider receives its own scores and data on statewide averages for comparison purposes. During year 2, all program provider report cards are being shared with the entire provider community. During year 3, all program provider report cards are being shared with the general public. The report card concept and implementation approach were developed by the State in collaboration with the treatment provider community and, as a result, the initiative has received little opposition. Report card data will be used by the State as an incentive to lengthen the period of provider certification if scores are high.
- H. New York was among the first States in the Nation to institute a smoke-free initiative and 80 percent of its treatment programs are now entirely smoke-free.

- I. Arizona's Governor's Initiative on Alcohol and Drug Abuse includes representatives of many State government agencies, private and nonprofit organizations, court systems, and tribal entities. The group is chaired by the Governor's Chief of Staff and is a key vehicle for creating and coordinating substance abuse prevention and treatment plans, priorities, and initiatives that impact the State. With the support of the State's chief executive, the Governor's Initiative is a strategic and visible force for change.