Recovery Center of Excellence

RURAL OPIOID AND DIRECT SUPPORT SERVICES (ROADSS) MODEL

IMPLEMENTATION PACKET

This Rural Opioid and Direct Support Services (ROADSS) Model Implementation Packet can be utilized as an example and for guidance by substance use disorder (SUD) treatment organizations interested in implementing this program in rural communities. Please note that some material is specific to New York State regulations. Kentucky, Ohio, and West Virginia regulations are also available in the toolkit on our website, and we are available to consult on regulations in other states. These and other elements may need to be removed, replaced, or adapted as appropriate for your location, organization, and practice, and based on conversations with local providers of SUD treatment.

Please contact our Program Assistance if you have questions, would like to learn more, or for hands-on help implementing the ROADSS model.

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ROADSS PRELIMINARY OPERATING PLAN

SUMMARY

The Rural Opioid and Direct Support Services (ROADSS) model was developed at Strong Recovery in August 2019 to increase access to and retention in methadone treatment programs in rural communities. ROADSS involves a partnership between a central opioid treatment program (OTP) and auxiliary medication units (AMUs) or mobile methadone units (MMUs) in rural areas. These AMUs may be embedded in partnering rural substance use disorder (SUD) treatment programs, Federally Qualified Health Centers (FQHCs), primary care offices, local hospitals, or other health and human services locations.

The following sample procedures and protocols are meant to serve as a guide for discussing program development and implementation of the ROADSS model in a rural community. They are based on New York State regulations and guidelines taken partly from the New York State Certified Community Behavioral Health Clinic Scope of Services Provider Manual and Managed Care Organization Operations Manual.

UR Medicine Recovery Center of Excellence's online toolkit contains additional resources related to ROADSS. Please contact Program Assistance for more information.

STAFFING PLAN, COMPENSATION, AND FINANCIAL TOOL

SUMMARY

The ROADSS model is designed to increase access to methadone in rural communities where there is limited or no access through the growth of auxiliary clinics or mobile methadone units (MMUs) that work with a central clinic.

The model will support and encourage opioid treatment programs (OTPs) and other organizations involved in opioid use disorder (OUD) treatment as they take steps to increase access to methadone in rural communities.

Please visit our online toolkit to view a **staffing plan**, **sample job descriptions**, and **financial tool**.

PROCEDURES FOR OPERATIONS

ACCESSABILITY AND AVAILABILITY OF SERVICES

PROCEDURES

SUMMARY

The ROADSS model utilizes the Substance Abuse and Mental Health Services Administration (SAMHSA) and Certified Community Behavioral Health Clinics' (CCBHC) (NYS specific) guidelines to ensure all services are offered in a manner accessible and available to all individuals in their respective communities.

IMPORTANT CONSIDERATIONS FOR ACCESSIBLE AND AVAILABLE CARE

Service times and settings are convenient to the community served:

- Services that meet the needs of the community should be reasonably accessible.
- Clinics shall utilize the community needs assessment to ensure service settings and hours are appropriate.

Consideration of where the service recipient lives:

- Clinics should consider acceptable travel times from the individual's home when ensuring accessibility of services.

Prompt intake and engagement in services include:

- Screening
- Assessment

Access to adequate care, regardless of residency or ability to pay:

- The ROADSS model highly suggests clinics comply to ensure access and that no individual be denied behavioral health care services, including but not limited to crisis management services, because of an inability to pay for such services.
- Any fees or payments required by the clinic for such services will be reduced or waived to ensure appropriate accessibility and availability.
- ROADSS model clinics are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence.
- Clinics must have protocols in place to address the needs of individuals who do not live close to the clinic or within the clinic's catchment area.

Person-centered treatment planning and service provision:

- Clinics should exercise person-centered care whenever possible to ensure accessibility and availability of services.
- Treatment planning and service provision should reflect an individual's goals and emphasize self-direction and choice.

Access to adequate crisis services:

- Emergency departments (EDs) are often a source of crisis care. ROADSS model clinics must have clearly established relationships with regional EDs to facilitate care coordination, discharge and follow up, such as relationships with other sources of crisis care.

Availability of community-based services and telehealth:

- Service provision should meet the needs of the community being served.
- Community-based peer recovery and clinical supports, as well as telehealth and/or telemedicine, shall be used to increase accessibility and availability of services, where available.

ADMISSION

PROCEDURES

SUMMARY

Please note the following procedure applies to all patients being admitted.

PRE-ADMISSION PROCEDURES

1. Upon having scheduled an initial face-to-face contact with the clinic, the patient will complete an intake Level of Care assessment with designated counselor.
2. Designated nurse will place Purified Protein Derivative (PPD) and provide patient with instructions to complete necessary laboratory tests. Patient will be notified of their physical exam appointment by the designated nurse.
3. Patient will return to clinic to complete physical exam and have PPD read. Program Physician will review lab test results. Any contraindication for treatment with methadone will be communicated to the intake counselor.
4. Intake counselor, opioid treatment program supervisor, and physician (if required) will review intake assessment and any laboratory results or information from medical staff. If there is no contraindication, patient will be scheduled for admission session.

ADMISSION PROCEDURES

1. Patient will return to the clinic for admission session, which will include:
    a. Admission session with opioid treatment program (OTP) supervisor or designee
    b. Medication orientation with registered nurse
    c. Final assessment and approval by program physician
    d. Medication dispensing
2. Patient will sign appropriate consents as part of the orientation process. Designated staff will initiate a clearance inquiry with the state's Central Registry prior to admission. The OTP supervisor or designee will report any admission, transfers, and/or discharges to the Central Registry.
3. Patients are started on up to 30 milligrams of methadone per physician's orders at the completion of admission session.
    a. If patient is transferring from another OTP, patient can be maintained on current dose, pending medical assessment. Adjustments may be made per clinical indication.
4. Intake counselor will follow up with patients who do not follow through on admission requirements and will assess appropriateness for a later admission date.

APPOINTMENT FOR INTAKE ASSESSMENTS

PROCEDURES

SUMMARY

Appointments for intake assessments are made by the Intake and Referral Team (IRT) at the Central Clinic. Intake appointments are scheduled Monday through Friday. Information obtained by telephone at first contact includes name, age, address, phone numbers, referral source, reason for referral, and type of insurance coverage. Patients are informed of the need for prior authorization of visits if they are members of a Health Maintenance Organization.

Special potential appointment examples:

- Internal referral sources make referrals via email or in the electronic medical record (EMR).
- Intake appointments for referrals from a regional Department of Health and Human Services agency could be made directly through shared electronic systems and then coordinated by the IRT.

INSURANCE

A telephone fee-for-service interview is held for all patients to establish:

- An account with a medical record number, if the patient is new to the clinic
- The patient's responsibility for payment for services
- Level of insurance coverage

DENIAL OF CARE EXCLUSIONS

Individuals will not be denied admission for evaluation based solely on any one or combination of the following:

- Ability to pay
- Prior treatment history or referral source
- Pregnancy
- History of contact with the justice system
- HIV and/or AIDS status
- Physical or mental disability
- Lack of cooperation by significant others in the treatment process
- Medication for opioid use disorder prescribed and monitored by a medical professional
- Geographic location

INTAKE, SCREENING, AND COMPREHENSIVE ASSESSMENT

PROCEDURES

SUMMARY

Intake evaluations generally require 45-60 minutes to complete the interview of the patient and/or family member or significant other, when applicable. During the intake assessment the patient completes a level of care assessment to determine whether opioid treatment is appropriate. The intake counselor gathers data to complete the level of care determination (LOCADTR), within the New York State Health Commerce System (HCS).

The Intake and Referral Team (IRT) is comprised of certified addiction counselors and overseen by the opioid treatment program's supervisor/director. Their primary responsibility is to screen and schedule patients who are seeking admission to the opioid treatment program. This team may be a dedicated group of counselors or counselors from the opioid treatment program, depending on personnel availability and structure.

INTAKE ASSESSMENT

The following sequence of events characterizes what should take place in the processing of new patients presenting for an intake for opioid treatment services:

1. The patient speaks with IRT counselor to schedule an intake appointment. The IRT counselor completes phone screen note in the electronic medical record (EMR) and schedules the patient for an evaluation or screens them for a more appropriate service. The IRT counselor routes the phone screen note to the intake counselor.
2. The patient is seen by the intake counselor at the appointed time.
    a. If the patient is late, the counselor will make every effort to see the patient and complete the intake, as long as it will not interfere with the next scheduled appointment.
    b. If the patient has not arrived at the appointed time, the intake counselor should reach out to the patient and determine if they will arrive in time to be seen or if they will need to be rescheduled. This should be noted in the EMR. If the patient needs to reschedule the appointment, the intake counselor will inform the IRT.
    c. If the patient has been seen, the intake counselor must complete all components of the Intake Assessment note in EMR, including the diagnosis flowsheet, Mini-Mental Status Screen, other indicated screens, the LOCADTR, and the safety plan. A naloxone kit is offered to patients.

3. In addition to the EMR documents listed above, the following paperwork must be completed:
    a. All release of information (ROI) forms should be filled out completely and signed by the patient. Consent(s) for prior treatment agencies to release information to the program are most important, along with consent(s) to release information to referral source(s).
    b. ROI forms **must always** be completed for the patient's primary care physician (PCP). If the patient declines to sign a release of information form for the primary care physician, it should be documented in the chart that efforts were made to obtain consent. For patients without primary physicians, attempts should be made to link them to a PCP.
    c. The charge capture and closing of the note must be done by the end of the following business day after the intake assessment appointment.
    d. In cases that involve a referral from the U. S. Department of Health and Human Services (HHS) through the state system, results will be communicated by the intake counselor to HHS through the state system within 2 days of the scheduled appointment.

REVIEW OF INTAKE CASES

Review of opioid treatment program intake cases takes place in a weekly intake meeting. In this meeting the intake counselor, opioid treatment program supervisor/director, physician, and/or additional medical staff will confirm the diagnosis of opioid use disorder and the treatment recommendation, including the level of care determination. In addition, a determination of the appropriateness of treatment, timing of program entry, and assignment of primary counselor will be done during this meeting.

Possible Review Outcomes

- Direct referral of a new patient into the program.
- Referral to other outpatient or inpatient substance use disorder treatment programs.
- Deferral of diagnosis due to incomplete data and/or need for further evaluation. This may require scheduling of medical-psychiatric consultation, laboratory testing, further data collection from the patient, the family referral source, other professionals, or other records.

Note: The intake counselor remains responsible for conveying the treatment recommendations to the patient, completing the referral process, and documentation requirements.

LEVEL OF CARE DETERMINATION

The intake counselor completes the LOCADTR form in EMR the day of the intake and sends it to a clinical supervisor for review and approval. The level of care determination must be approved prior to admission into service.

COMPREHENSIVE ASSESSMENT

Once admitted the patient then completes the comprehensive assessment with the assigned primary counselor. The goals of this assessment are:

- To establish rapport with the patient
- Collect toxicology screen and blood alcohol content (BAC)
- Determine the reason for seeking treatment
- Establish substance use disorder diagnosis
- Ascertain potential and motivation for treatment
- Arrange circumstances for further data collection and assistance, if needed
- Acquire needed ROIs (medical, emergency, collateral)
- Interview with necessary collaterals including providers, family or significant other(s)
- Assist in patient acceptance of diagnosis and recommendation
- Follow up on admission into the opioid treatment program
- Assess for patient safety, short and long term
- Develop a safety plan
- Review, provide information, and obtain signed consent relating to LOCADTR, HIPAA law and its limitations, and program regulations and expectations
- Determine appropriateness for treatment
- Determine a person-centered initial plan of treatment (types of services and frequency)

A total of up to three pre-admission visits may be held to complete the intake. The Medical Director or designee must approve all intake assessments. When intake assessment is completed by a Non-Qualified Health Professional (QHP), a QHP must also approve the assessment.

DIAGNOSIS

Accurate diagnoses will be established as a result of a thorough and complete assessment process. The intake counselor will use Diagnostic and Statistical Manual (DSM) V for diagnostic formulation and document it in EMR and then communicate the diagnostic findings to the patient (and family if applicable and approved by the patient). Additional diagnoses may be determined by the primary therapist from the post-admission comprehensive assessment.

- **Presumptive diagnosis:** The diagnosis that matches the presenting problem will be used by clinicians on intakes where no firm diagnoses can yet be made. Choosing the appropriate presumptive diagnosis is based on referral and interview context.

- **Actual diagnosis:** List all applicable diagnoses for the patient for the current course of treatment. The diagnosis determines the program enrollment and is essential for accurate billing and conceptualization of care. Diagnosis updates are entered in the *visit diagnosis* when applicable.

In situations with polysubstance use, choose the primary diagnosis which reflects the substance that puts the patient at most risk and that brought the patient to evaluation or treatment. The only exception is if there is a longer history of greater problems with another drug. In this case, choose a primary diagnosis that names the other drug. In the case of multiple substance use disorder, list the substances in a presumed hierarchy. Opioid use disorder is the primary diagnosis for opioid treatment program cases.

INELIGIBILTY

When patients are deemed ineligible for treatment, they will be provided with the reason by the counselor conducting the intake assessment and offered alternative treatment options when applicable.

MEDICAL SERVICES

PROCEDURES

INITIAL MEDICAL EVALUATION

An initial medical evaluation will be performed by a program medical provider at the time of admission and documented in the patient's electronic medical record.

This examination will include:

- Personal and family health history
- Review of systems
- Physical examination
- Laboratory tests to include but not limited to: EKG, CMP, PPD or chest x-ray, and viral hepatitis

Testing for sexually transmitted diseases, pregnancy, and HIV will be offered to the patient and ordered with their consent. Results of ordered tests will be reviewed with the patient by the medical provider at the time of the admission physical.

Patients who are being admitted directly to the opioid treatment program (OTP) from another OTP are not required to have a physical examination if they have had one within the past 12 months and this examination has been reviewed by the program medical provider and determined to be current.

ANNUAL PHYSICAL EXAM

Patients will be offered an annual physical exam. If the patient elects to complete an annual physical exam, the following tests will be ordered: EKG, CMP, PPD, and viral hepatitis; and an appointment will be scheduled with a medical provider to review the results. In addition, HIV and viral hepatitis testing will be offered yearly to all patients within the OTP.

If a patient declines a full annual medical exam, medical staff is to strongly encourage that the patient complete at minimum an EKG to identify any cardiac health concerns that may contradict the use of methadone medication.

PRIMARY COUNSELOR

PROCEDURES

SUMMARY

Every patient will be assigned to a primary counselor who will have the responsibility of providing continuity for the overall treatment of the patient. The primary counselor will be a Qualified Healthcare Professional (QHP) such as substance use counselor, registered nurse, physician, or a resident in training who works under the supervision of a qualified health professional. The primary counselor will be assigned with regard to patient need. Every effort will be made to meet the unique needs of each patient including pregnant patients, patients who are victims of domestic violence or sexual abuse, patients with HIV, and chronically ill patients.

PRIMARY COUNSELOR ROLE

Primary counselor responsibilities include but are not limited to the following:

- Orient the new patient to program services, policies, rules, benefits and risks of methadone treatment, program requirements regarding toxicology screens, payment for services, and counseling sessions. This will be in addition to the patient completing the orientation group session.
- Serve as the primary resource person for the patient to discuss treatment-related issues and treatment goals. Patients enrolled in the opioid treatment program are encouraged to schedule weekly sessions for the first 90 days in treatment unless they are in weekly group therapy. After the first 90 days, patients are encouraged to schedule at least one counseling session per month or more frequently when clinically indicated.
- Discuss the patient's progress in multidisciplinary team meetings according to team meeting protocol and clinical expectations. Discuss in team meeting, as necessary, the problems or progress in treatment that require modification of medication dosage, or dispensing schedule changes, or group therapy participation, etc.
- Arrange for enrollment of the patient into group therapy and monitor patient's progress in group via the available written group notes and/or consults with group counselors/facilitators.
- Arrange alternate counselor coverage in the event of counselor's absences from work due to vacation, conference, other planned absences.
- Maintain patient's clinical record in accordance with the applicable record-keeping policies and protocols.
- Oversee referral process to needed and/or recommended services. Complete necessary paperwork, guide the patient through the process, and maintain follow-up contact, as needed.
- Establish contact with patient's family, significant other(s), or other health professionals or agencies serving the patient to coordinate care and in accordance with established

rules concerning confidentiality and written consent and according to the clinical requirements of the patient's treatment and recovery from substance use disorder.
- Establish the appropriate level of contact or liaison with other healthcare professionals in the event of the hospitalization of the patient so as to optimize patient's recovery.
- Consult with program's Clinical Supervisor, Clinical Coordinator, Clinic Director, and/or Medical Director if questions arise regarding any aspect of the patient's treatment.
- Meet the patient as soon as possible to inform them of any changes regarding their care (e.g. change in take-home status, need for physical exam, or changes in level of care). If the patient decides not to meet with the counselor to discuss changes, the patient will be informed of changes in treatment in written form.

COORDINATION OF CARE PROCEDURES

General Information:

For services an active patient may need which are not provided directly by the program, a referral will be made with continued follow-up as needed for coordination of care. The responsible counselor will obtain necessary release(s) of information, provide information to the intended provider and maintain weekly/biweekly/monthly, or as needed contact regarding the patient's need and progress. Such coordination will be documented in each patient's individualized treatment plan and progress notes.

Types of Services and Primary Referral Resources:

- Emergency departments
- Detoxification or ancillary withdrawal services
- Inpatient rehabilitation
- Residential housing
- Supportive living
- Mental health treatment services
- Vocational/educational services
- Healthcare services (e.g. primary care, infectious disease care)
- Family services
- Case management

REFERRALS, OUTREACH, AND ENGAGEMENT

PROCEDURES

REFERRALS OF NON-ADMITTED PATIENTS

When the intake assessment results in a decision that the patient needs substance use treatment but ambulatory treatment is not appropriate, a referral to the most appropriate inpatient facility or program will be made. The patient is contacted by the intake counselor, informed of the recommendation, and helped in the referral process. Since most treatment programs require the patient to make the initial appointment, patients are urged to do so, and written permission is sought to allow release of diagnosis and recommendation to the designated program. The clinic is generally available to these patients for the aftercare phase of treatment.

For patients requiring substance use crisis services, detoxification referrals are made to the appropriate facility. Patients with an associated physical or psychiatric disorder that is disabling to a degree that prevents ambulatory care, but who will likely respond to treatment once they are stabilized, will be referred to appropriate levels of care at another facility.

For inpatient detoxification, patients will be referred to the nearest facility able to accommodate the detoxification.

OUTREACH AND ENGAGEMENT

Outreach, engagement and retention are essential components of care for patients being served and require consistent, personalized follow-up by the assigned primary counselor. Reasonable efforts should be made to engage patients in treatment. All outreach and follow-up activities with a patient must be documented in the patient's medical record.

A. Internal referrals from like medical systems:

    a. Once the patient consents to the referral, the information is sent to the clinic electronically. The Intake and Referral Team (IRT) will follow up to schedule an appointment for an intake.

    b. If the patient is already enrolled in the clinic, the IRT will schedule an appointment with their current primary counselor and send documentation necessary for discharge paperwork.

B. The clinician or provider responds if the patient fails to attend this appointment according to the level of risk identified on the discharge instruction sheet. Level of risk is determined by the discharging provider and divided into two categories, routine and outreach required:

    a. Routine follow-up

        i. A phone call is made to the patient the day of the missed appointment to reschedule.

        ii. If the patient cannot be reached directly by phone, a letter is sent asking that the patient contact the counselor.

    b. Outreach indicated

        i. If the patient fails to make the appointment, the receiving counselor contacts an individual or agency (e.g. mobile crisis services) to ask them to provide community outreach.

        ii. If the patient does not respond to outreach efforts, counselors should consider notifying the primary care provider that the patient missed the appointment and is lost to contact.

REFERRALS FOR ALL OTHER INTAKE APPOINTMENTS

A. A phone call is made to the patient the day of the missed appointment, and instructions for rescheduling are provided. The counselor is responsible for the outreach phone call if a patient misses and documents the attempt.

B. If the patient does not answer, a letter is sent out the same day requesting response within 7 business days.

C. In situations such as repeated missed appointments or non-response to outreach efforts, the receiving counselor will make a clinical decision regarding appropriateness of initiating outreach, such as using mobile crisis services for further assessment depending on the severity of the situation.

ONGOING TREATMENT APPOINTMENTS

A. A phone call is made to the patient the day of the missed appointment to reschedule unless otherwise clinically indicated (e.g. if it is a reoccurring appointment or the patient meets with the counselor multiple times per week).

B. If the patient can't be reached directly by phone, a letter is sent asking that the patient contact the counselor.

C. In situations such as repeated missed appointments or non-response to outreach efforts, the counselor will present the patient at case conference to the multidisciplinary team and/or consult with the clinical supervisor prior to making a clinical decision regarding appropriate outreach, such as using a crisis team for further assessment.

D. The counselor must consult with the treatment team before discharging the patient from the clinic to ensure that all reasonable efforts have been made to engage the patient in clinic services. All discharge decisions require clinical supervisor approval.

TELEMEDICINE/TELEPSYCHIATRY

PROCEDURES

SUMMARY

Telemedicine/telepsychiatry services within the ROADSS model provide timely and appropriate services at the central and auxiliary clinics. As approved by the New York State Office of Addiction Services and Supports (NYS OASAS), telepsychiatry services may be provided to patients when equivalent in-person services are not available and/or feasible. The Center for Connected Health Policy, which includes information about policy changes due to COVID has specific guidance related to state licensing policies within medical boards.

EVALUATION AND ELIGIBILITY

Telepsychiatry services can be offered to any patient who has completed a comprehensive assessment by a counselor and for whom ambulatory substance use disorder services has been deemed appropriate. Telepsychiatry services will be provided as well as in-person services throughout an episode of care when indicated. All patients will have an in-person evaluation by a counselor prior to an offer of telepsychiatry services.

Telepsychiatric assessment criteria will ensure that the patient is assessed for appropriate psychological, physiological, and medical stability. The counselors and providers will assess the patient's appropriateness for telepsychiatry services based on the following criteria:

- Clinical situation
- Patient's awareness of the process
- Symptoms that could worsen with telepsychiatry (psychosis with ideas of reference, paranoid/delusions related to technology, escalating the crisis, etc.)
- Medical issues/complications, cognitive/sensory concerns
- Cultural awareness

In instances where there is a language barrier, clinicians and providers will utilize interpreting services. Before telepsychiatry services are provided to patients under age 18, the parent or guardian will be consulted.

INFORMED CONSENT TO UTILIZE TELEPSYCHIATRY SERVICES

Obtaining and documenting informed consent

Explicit informed consent for telepsychiatry services will be obtained and documented in the patient's electronic medical record (EMR). All consents for treatment and other procedures applicable to face-to-face encounters will be obtained for telepsychiatry encounters.

Providing patients with sufficient information

The telemedicine consent form explicitly states that the patient has been provided with alternatives to a telemedicine service.

Patient must be aware of potential risks, benefits, and consequences

The telemedicine consent form explicitly states the potential risks, benefits, and consequences of using this technology. It also explicitly states that the patient can elect to not participate or terminate the service at any time.

Patient education

The counselor or provider will provide patients with sufficient information and education about telepsychiatry to assist them in making an informed choice, including the process, risks, benefits, and the patient's right to refuse telepsychiatry services but still receive care on-site.

Consent form

The counselor or provider will gain written consent to start telepsychiatry services using the telemedicine consent form. The counselor or provider will document in the EMR if the patient decided to utilize or refuse telepsychiatry services.

SCHEDULING

Program scheduling protocols include processes for telepsychiatry. Clinicians and providers will inform support staff when an appointment will be telepsychiatry versus in-person. When services will be delivered through telepsychiatry, support staff will send a link to patients.

Patients will receive a reminder call the day prior to the session to confirm they received the link for the session.

CHECK-IN PROCEDURES

Support staff will check the patient in through the EMR. They will assist the counselor or provider with the videoconferencing connection and manage any link failures.

The onsite counselor or provider will establish the audio/visual connection by activating a videoconferencing program.

CONDUCTING THE TELEPSYCHIATRY SESSION

Identification of Patient

The counselor or provider will verify the identity of the patient before beginning the communication. The counselor or provider will remain on the connection for the duration of the service.

Location

The patient will engage in telepsychiatry services at a location where it is safe for them to receive services. The clinical staff will provide telepsychiatry services from the licensed clinic location or from a secure and private setting in their home to protect the patient's privacy.

Room setting

The telepsychiatry counselor or provider will perform the services in an environment where there is a reasonable expectation of absence of intrusion by individuals not involved in the patient's care.

Lighting/backdrop

The counselor or provider will ensure that the connection, video, lighting, and audio capabilities are functioning properly.

DOCUMENTATION

When the telepsychiatry service is completed, documentation of the encounter will be completed by clinician/provider.

All documentation applicable to face-to-face and telephone calls will be maintained for all telepsychiatric encounters. The telepsychiatry provider will document the encounter in the patient's electronic medical record (EMR), including identifying the telepsychiatry provider, the location of the patient, the location of the telepsychiatry provider. Disruptions to the session due to equipment failure and the plan for follow up will also be documented.

ADDRESSING TECHNICAL DIFFICULTIES

If the service is interrupted because of technical difficulties, that will be documented by the clinician or provider in the patient's EMR. If an acceptable telepsychiatry transmission cannot be established and this renders the service undeliverable, contingency options include:

- In cases of video communication interruption, the counselor or provider will contact the patient immediately by phone to provide support and management of any crisis the patient may be experiencing at the time.
- The support staff personnel will schedule a face-to-face encounter with the counselor at either the central site or the auxiliary site.
- The support staff personnel will schedule a face-to-face encounter with the patient at the patient's home.
- The telepsychiatry counselor can speak with the patient via telephone to determine whether an alternative face-to-face session will be scheduled.
- In cases of disruption due to equipment failure, the plan for follow up will be documented in EMR. The counselor or provider will follow up for appropriate coordination of care.

EMERGENCY PROCEDURES

Clinical or safety concerns on-site

If clinical or safety concerns occur during the telepsychiatry session, the counselor or provider will address the issue and carry out a plan of action. Face-to-face assessment between patient and counselor or psychiatric provider may be scheduled through the central site or the auxiliary site via a home visit by appropriate support staff personnel.

Designation of emergency contact at auxiliary site

The counselor or provider will work directly with the patient to manage any crisis during the telepsychiatry session. If unable to reach the patient directly, the counselor or provider will contact the patient's emergency contact. When clinically indicated, a crisis team will be deployed accordingly or the counselor or provider will call 911.

Education and training related to emergency procedures

Clinicians and providers engage in safety and emergency trainings.

COLLABORATING WITH PATIENT'S INTERDISCIPLINARY TREATMENT TEAM

Sharing contact information of providers

All patients are provided with the contact information of the central clinic and/or auxiliary clinic, as well as a direct number for their assigned primary counselor.

Specifications regarding collaboration

With the patient's consent, the clinical team will send a copy of the assessment, evaluation, and outcome to other providers involved in the patient's care.

PRESCRIPTIONS, LABS, AND ORDERS

When indicated, the telepsychiatry provider will ensure the availability of prescriptions that are electronically transmitted to the patient's preferred pharmacy. The telepsychiatry provider will also ensure orders and results related to necessary laboratory examination are available either electronically or by physical transmission. When medication is recommended during the telepsychiatry session, the provider discusses risk and benefits of the medication with the patient. If the patient is a minor, the consent of the guardian and the assent of the minor are obtained.

CONFIDENTIALITY AND PRIVACY OF HEALTH INFORMATION

Confidentiality procedures

The telepsychiatry counselor or provider will be in a secured location to ensure the confidentiality of the upcoming patient-clinician interaction before activating the service or communicating with the patient. Site appropriateness for telehealth privacy will be equivalent to the NYS OASAS privacy policies for a face-to-face encounter.

The patient will engage in telepsychiatry services in their home, an alternative location that is safe and suitable for maintaining privacy, or the auxiliary site. The video transmission will be hosted on a HIPAA-compliant videoconferencing platform. Devices used for telepsychiatry should be password protected. All hardware is approved by the Medical Director. The counselor or provider at the auxiliary site will confirm the identity of the patient before any telepsychiatry service is provided.

Central site provider access to patient records

The telepsychiatry provider will have remote access to the EMR system when needed for documentation.

QUALITY REVIEW

All quality improvement activities related to psychiatric treatment will be conducted in a consistent manner for telepsychiatry encounters. Quality reviews will be conducted quarterly to identify specific risks and quality failures and will include:

- Equipment and connectivity failures
- Number of attempted and completed visits/sessions
- Patient and provider satisfaction with the virtual visit/session
- Measures of clinical quality such as whether the visit/session was appropriate for a virtual visit/session

Counselors and providers will inform the clinical supervisor(s) of quality concerns, equipment failures, connectivity problems, etc. The clinical supervisor will compile these concerns on an ongoing basis to inform quality improvement activities for telepsychiatry services. Clinical oversight of telepsychiatric services will be provided by the clinical supervisor and Medical Director.

VIDEOCONFERENCING GROUP THERAPY

Roles

The counselor leads the 60-minute group via the videoconferencing platform and chooses the day, time, and topic of the group.

The host is an additional counselor or clinic personnel—such as support staff, or a peer support professional—who assists the counselor with the needs of the group. This includes technical assistance, calling patients to troubleshoot access to the videoconferencing link, assisting via the private chat feature if applicable, and working with patients in a breakout room to manage crisis or behavioral needs. The host does not take on the role of co-facilitator. Hosts introduce themselves at the beginning of the group and then keep their video off for the remainder of the session.

Support staff creates the videoconferencing link for the counselor weekly and sends the link via email to the counselor and host. The support staff sends the link via email (unless the patient has specified an alternate mode of communication). The counselor must provide the support staff with scheduling privileges in the videoconferencing platform settings.

Patient privacy

Support staff will create and send a new videoconferencing link weekly to participating patients, the host, and the counselor as an additional effort to increase privacy. The feature

that allows patients to privately chat with each other is disabled in the advanced settings. The host is responsible for renaming patients to include the first name and last initial only. Full names are prohibited from display on the patient screen. The group norms that are outlined at the beginning of the group include a private remote location for each individual including; the counselor, the host, and the patient. Each participant in the group process must be in a private location (that could include the auxiliary site) and maintain the fidelity of the group by not having any other person within range of the device streaming the session.

Technical complications

The host serves as the staff member to provide support to patients in a manner that reduces disruption to the group process. If a patient is having technical difficulties, the host will follow up with the patient and troubleshoot to resolve them. If the system fails and the videoconferencing link is no longer available to use to facilitate the group, the counselor reaches out to all of the patients and documents the situation accordingly. The email message that is sent to patients includes the central or auxiliary clinic phone number, should the patient need another method to resolve technical problems.

Patient accessibility

Patients have the option of participating in telehealth sessions remotely or at the auxiliary or mobile sites. Utilizing the auxiliary site encourages those that might not have access to videoconferencing capabilities or be comfortable utilizing telehealth independently to obtain support from a counselor or support staff. The counselor could support patients with limited accessibility by helping them to identify resources to obtain additional minutes on a phone plan, to explore grants to obtain a smart phone, or to learn how to use a videoconferencing platform.

ADDITIONAL RESOURCES

Below are additional resources to help providers and patients with telehealth:

- UR Medicine Recovery Center of Excellence videoconferencing group therapy resource
- Health Resources and Services Administration telehealth website
- Rural Health Information Hub Rural Telehealth Toolkit
- For broadband/internet, Universal Service Administrative Co.'s Lifeline program (individuals) or Rural Health Care program (providers and facilities)
- Center for Connected Health Policy

TREATMENT EPISODE

PROCEDURES

COMPREHENSIVE ASSESSMENT

A comprehensive assessment will be completed within the first two weeks after admission by the primary counselor to begin the treatment planning process. Comprehensive assessments will include:

- Assessment of life areas: family, legal, educational/vocational, social/recreational, and cultural
- Updates of information from intake assessment when applicable
- Summary of findings and diagnostic formulation
- Formulation of problem statements to be linked to treatment planning

The comprehensive assessment is completed in an individual session with the patient. Completed comprehensive assessments must be approved and co-signed by a provider.

TREATMENT PLANNING

Treatment planning will be developed in concert with the patient to identify goals in reference to identified “problem areas” and “goals” from the comprehensive assessment and reflect measurable treatment objectives and timelines in which these objectives should be reviewed. (Maximum length of time is within every 180-day window). The treatment plan must be signed by the primary counselor, a program physician, a clinical supervisor, and a program nurse.

- Initial treatment plans are prepared by the patient and primary counselor within 29 days of admission. A review of the treatment plan is completed within every 180-day window.
- The primary counselor will discuss the treatment plan with their supervisor during clinical supervision if/when necessary.

All treatment plans are reviewed by the patient and primary counselor during their individual counseling sessions, and this is recorded in the progress note of the session. The patient will also be offered a copy of the treatment plan.

Ongoing Progress and Changes

In the time period between treatment plan reviews, the primary therapist will document patient progress and any changes in treatment in the plan section of the individual session progress notes. Any changes documented in the plan section of all applicable individual session progress notes will be reflected in the corresponding treatment plan review.

MULTIDISCIPLINARY TEAM MEETINGS

The program holds multidisciplinary team meetings each week, and every clinician is assigned to attend these meetings. The multidisciplinary team consists of the primary counselors and representatives from other disciplines as needed (i.e., physician, nursing). Pertinent topics that can be addressed at these meetings include:

- Treatment planning and program movement/transfers
- Take homes and specials
- Case conferences
- Discharges
- Miscellaneous and announcements

RETENTION IN TREATMENT

Post admission, patients must meet the following criteria in order to remain in the treatment program:

- Continue to have a valid substance use disorder diagnosis
- Continue to be able to participate in and benefit from treatment in an outpatient program
- Continue to be in compliance with program rules
- Not be in need of a higher level of care (for substance use disorder, mental health, or physical health)

TERMINATION OF TREATMENT EPISODES

1. A patient's episode of care remains active as long as there is documented medical necessity for treatment and the patient meets retention criteria. Treatment episodes will be closed when patients meet discharge criteria. Additionally, the treatment episode will be automatically terminated for patients who do not show to the program and without any other contact for more than 60 days unless otherwise determined in special circumstances.
2. Patient's status that changes from active to inactive requires that the treatment episode be closed with a completed discharge summary in the electronic medical record (EMR) to not exceed 60 days from the patient's last face-to-face visit (billed or non-billed) to the program unless reason for continuing treatment past that period is identified and documented in the EMR. The last date of service is the discharge date. If the patient attended three or fewer total services for the entire episode (this only excludes medication administration, i.e. methadone dispensing), the case can be closed using a clinical management note in EMR and a state discharge form, if required (i.e. NYS PAS 45 or 61). All discharge summaries/notes require a clinical supervisor signature. Clinical supervisors will forward discharge summaries/notes to designated support staff to process the discharge.

3. The protocol for closing any treatment episode requires the completion of state discharge forms, if required. The forms, if required by the state, are to be submitted to a clinical supervisor.
4. A TREATMENT EPISODE DISCHARGE IS NOT COMPLETE WITHOUT BOTH CLINIC AND STATE FORMS COMPLETED.

DOCUMENTATION COMPLETION TIMEFRAME

PROCEDURES

SUMMARY

Documentation is required to be completed in the patient's electronic medical record (EMR) for each and every billable visit and/or face-to-face session with a patient. Documentation is recommended for most indirect contact with the patient or patient representative (e.g. collateral information).

DOCUMENATION REQUIREMENTS

The documentation must include the patients'

- Name
- Patient's demographic information (unless automatically populated by the EMR)
- Medical record number
- Date of service
- Length of the visit
- Modality of the visit (in person or telepsychiatry)
- Signature of the clinician delivering the service

TIMEFRAME FOR DOCUMENTATION

The **required** timeframe for completing documentation for any billable service is by the end of the next calendar day, following the date of service.

PROTOCOLS FOR METHADONE DISPENSING

ORDERING, DELIVERY, AND STORAGE

PROTOCOLS

SUMMARY

The ordering, delivery and storing of methadone medications is the responsibility of the Nurse Manager at the central clinic and the Lead Nurse at the auxiliary clinic. The ordering, delivery, and storage of the medications is crucial to the integrity and maintenance of the clinics. Any errors in either the ordering, delivery and/or storage of the medication can result in disciplinary actions and/or negative patient implications.

RESPONSIBILITY

The ordering of Methadone is the responsibility of the designated registered nursing staff or nurse manager with Power of Attorney (POA) for Drug Enforcement Administration (DEA) ordering forms. The program is to enroll in the DEA Controlled Substance Ordering System (CSOS) for placing methadone orders. Methadone is ordered electronically through a secure DEA approved e-222 ordering website. A copy of the approved e-222 form is retained in the "order and invoice folder" maintained in the methadone dispensing room.

DELIVERY

Methadone arrives at the clinic within two business days of order placement. Delivery cannot be made during dispensing times or after the clinic is closed. The medication carrier arrives directly at the front door to signal he/she is here where a security officer will meet the carrier. Methadone is brought to the dispensing area and secured by nursing. The order is received and counted by two nurses (any nurse, regardless of POA status, can receive orders).

RECEIPT

The order is added to inventory and documented in the dispensing software system using the receive inventory form. All new bottles are numbered in sequence. Receipt of the order is entered in the DEA e-222 system by a nurse with POA. Delivery packaging slips are kept in the methadone dispensing room.

STORING

All new bottles are numbered in sequence as a double check of bottles on hand. The number of bottles received is added to the inventory in the dispensing software system. Exact order

received is also added to a methadone dose dispensing report to include data received, nurse, lot number(s), and assigned numbers to each lot number(s).

Bottles from a new order are combined with remaining bottles in the storage room following handwritten numbers assigned to each bottle.

Storage room/safe is closed when medication is secure, and code is applied to secure the storage room/safe.

Completed e-222 DEA Form is filed in the current year folder kept in the dispensing room.

ACCESS

Access to methadone is limited to the program's medical/nursing staff members which include the Medical Director, Nurse Manager, RN and LPN designees that are licensed or registered to order the medication. The methadone storage area is physically separate from the patient areas and securely maintained in accordance with DEA requirements.

METHADONE RECORDS AND INVENTORY

PROTOCOLS

METHADONE RECORDS

Electronic records are kept of all methadone dispensed. The following records are printed daily from the dispensing system and kept in designated binders in the dispensing area:

- Pump calibration
- Current bottle inventory detail
- Total dispensed
- Daily dispensing activity (contains spill, return, and adjustments)
- No show by availability
- Daily pouring schedule
- Spilled inventory
- Exception doses report
- Medication orders changed

MANUAL DISPENSING

If the computer system fails, nursing staff may return to manual dispensing until the problem is corrected. The following steps are used in manual dispensing:

- Make copies of the daily dispense log and absence report printed the previous day.
- Use daily dispensing log to identify patient, patient dose, and take home doses (if patient receives them).
- The following information is to be included on any patient take home dose:
    - Patient name
    - Methadone dose in milligrams
    - Date
    - Clinic name
    - Clinic Address
    - Clinic phone number
- Document all doses dispensed on a downtime dispensing log.

ONCE DISPENSING SOFTWARE IS BACK ONLINE

- Set up for dispensing
- Calibrate pumps
- Start with a new, un-opened bottle of methadone, this will help with the reconciliation backdate dosing process

- Backdate dosing should occur after dispensing has ended for the day
    - If a third nurse is available, reconciliation may begin during dispensing
- After reconciliation/backdate is complete, transfer any remaining amount of methadone into the current open bottle
- Reconcile dispensing record/amount dispensed

INVENTORY

An inventory of all controlled substances is completed every two years in accordance with Substance Abuse and Mental Health Services Administration (SAMHSA) and Drug Enforcement Administration (DEA) standards by Nurse Manager (Lead Nurse) or nursing designees.

METHADONE MEDICATION DISPENSING

PROTOCOLS

CLINIC HOURS

Methadone medication is dispensed [insert dispensing times]. A patient may receive a single take-home dose for the days that the clinic is closed for business including Sundays and state and federal holidays.

MEDICATION ADMINISTRATION POLICY AND PROCEDURE

The patient's record is accessed by scanning the patient's unique clinic ID or entering the patient's name or clinic ID into the dispensing software.

The nurse reviews the individual patient's medication record through the dispensing software and checks to ensure the right drug, dose, time, patient and route.

Patients are identified using two patient identifiers (i.e. comparing the name and clinic ID number or birth date with the same information in the medical record/medication dispensing software).

Nursing staff should contact a provider for any questions or discrepancies with an order and/or medication and notify the provider of any untoward effects from medications, which should be documented in the Events Reporting System as applicable. Refer to **Methadone Medication Change Request Protocol** and **Physician Orders Protocol**.

Patients who present impaired or show signs of intoxication will be evaluated by medical staff to determine if it is safe and appropriate to medicate.

Medication is dispensed utilizing the dispensing software. The medication is provided to the patient, and the nurse observes that the patient has swallowed the medication. Medication is administered to one patient at a time.

If a patient is scheduled to receive take-home medication, the take-home medication is placed into approved medication container(s) and sealed with safety (child-resistant) caps. Take-home medication bottles are labeled with patient and clinic identifiers as per Drug Enforcement Administration (DEA) requirements. Patients are encouraged to provide their own container or lock box to transport medication safely.

If a medication is dispensed but not administered, the medication is wasted. This is documented through the dispensing software system. A second nurse (RN or LPN) witnesses the waste of medication.

Clinical staff use appropriate hand hygiene (e.g. use of approved alcohol-based hand sanitizer or hand washing with approved soap).

DISULFIRAM

If disulfiram is ordered by a provider for a patient to receive with methadone dispensing, this is noted in the dispensing software system. Disulfiram is dispensed by the nurse and recorded on a patient-specific paper medication administration record by the dispensing nurse.

DAILY METHADONE DISPENSING SET UP AND CLOSING PROCESS

Liquid methadone is dispensed via the dispensing software using liquid medication pump. A quality control calibration check is completed daily for each medication dispensing pump prior to dispensing patient medication.

Pump calibration is completed once daily and prior to use for medication dispensing and after a system downtime event. A daily pump calibration report is printed and filed.

Medication inventory is opened for dispensing following dispensing software steps.

At the end of dispensing, the inventory is closed and returned to the medication storage safe. The pump tubing is cleaned by using the alcohol-based solution first and then repeating the cleaning cycle using distilled water.

SECURITY PLAN

Security officer(s) are present during dispensing times to provide a safe and secure environment. The security officer(s) will assist in patient care as prompted by clinical staff.

TAKE-HOME SCHEDULE

PROTOCOLS

SUMMARY

Take-home doses are dispensed in childproof, self-sealing bottles labeled with the patient's name, physician's name, and dosage. All bottles are to be returned in undamaged condition. Damaged bottles or altered labels without reasonable explanation may lead to loss and/or reduction of take-homes privileges. All changes in schedules will be reviewed by the treatment team and approved by a provider and documented in the electronic medical and dispensing records.

Patient take-home schedules are in compliance with the federal regulatory time in treatment requirements (42 CFR Part 8.12) following the eight-point criteria or following federal and state waivers regarding increased take-home medication schedule. The Medical Director or designee reviews and confirms the appropriateness for take-home medication.

REDUCTION OF TAKE-HOME SCHEDULE

If a patient is not meeting their treatment goals, including ongoing harmful substance use, the take-home schedule may be modified to allow for increased support and structure in treatment.

MISSING BOTTLES

The patient will not receive any take-homes until the missing bottle is returned and/or the case is reviewed by the treatment team. The return of another patient's bottle will result in the same and must always be reviewed by the treatment team.

MISSED METHADONE DOSING

PROTOCOLS

MISSED DISPENSING DAYS

If a patient misses a dispensing day, the reason for inability to come to the clinic will be reviewed by the treatment team and a decision on the patient's medication schedule will be made on an individual basis.

DOSE ADJUSTMENT

For patients that have missed schedule dispensing days:

- All dose adjustments are made after medical assessment and in accordance to a written medication order by the ordering physician.
- Doses will resume in accordance with the procedure below once a medical assessment is completed and the patient is cleared.

MISSING 1-2 DAYS

- Nursing staff will assess and medicate at the regular dosage providing the patient does not appear to be under excessive influence of a substance or in medical crisis.

MISSING 3 OR MORE DAYS

- If a patient misses 3 or more consecutive scheduled medication visits, upon the patient's next attendance a medical assessment will be conducted by a program physician or nurse practitioner (NP) to determine whether an adjustment in dose is indicated.
- Once the medical assessment is complete, the physician or NP will write an appropriate order.
- If the 3rd day after missing 2 consecutive days of clinic attendance falls on a Saturday, the patient will be asked to return on the next available business day.

METHADONE MEDICATION CHANGE REQUESTS

PROTOCOLS

SUMMARY

The goal of treatment is to stabilize patients with methadone medication to alleviate opioid cravings and symptoms of opioid withdrawal, and prevent symptoms of withdrawal for a minimum of 24 hours.

Patients may request increases or decreases of medication dosage during the duration of their treatment in the opioid treatment program.

DOSE CHANGE REQUESTS

This process starts with a session with a counselor or provider to discuss current symptoms. The assessment is to include, but is not limited to the following:

- Current methadone dose
- Date last dose change was requested on
- Date of last electrocardiogram (EKG) and the corrected for heart rate (QTc) interval measurement was conducted
- Date of last toxicology screen and results
- Discussion regarding last used, substance used, or most recent toxicology screen
- Current symptoms being experienced
- Presence of opiate cravings (yes/no)
- Medical provider must review request and any other items contained in the patient's electronic medical record to determine the appropriateness of a dose increase or decrease
- Medical provider will approve medication dose change, if appropriate.

PHYSICIAN ORDERS

PROTOCOLS

SUMMARY

Physician orders are required to change the methadone dose of patients enrolled in the opioid treatment program.

PHYSICIAN ORDERS

Whenever possible, physicians will enter order changes directly into the methadone dispensing software system.

Verbal orders can be accepted by the registered nurses who are dispensing the methadone. If a provider is unable to directly place the order, these orders must be printed and signed by the physician within 24 hours and scanned into the patient record.

The physician order printed from the dispensing software system is a permanent part of the patient's medical record..

DIVERSION OF MEDICATION AND PATIENT RECALL

PROTOCOLS

SUMMARY

- All inventories of methadone medication are checked and signed for by two registered nurses (RNs).
- A biannual inventory is to be completed by the nursing staff.
- Patients are subject to recall if there is an apparent safety, diversion, or other clinical concern by the opioid treatment program (OTP) staff, or as part of the clinic's random recall process.

PATIENT RECALLS

All patient recalls will follow the same protocol. Patient recalls will occur in a random and unannounced manner. Patients with take-home schedule are contacted by phone or approached by a member of the program's OTP staff while on clinic grounds to inform them of the recall.

Patients are expected to respond to phone calls regarding recall immediately and will have 24-hours to return to the clinic with all take-home bottles. A failure to respond to recall will be addressed accordingly by the treatment team and will jeopardize the patient's take home status.

Patients will be asked to present his or her take home doses to designated nursing staff for inspection of the paper seal and inspection of the bottle label and correct number of bottles. OTP nursing staff will check state prescription drug monitoring program (PDMP) in preparation and patient will also be asked to bring all other prescribed medication with them for the recall.

Toxicology screen and breath alcohol concentration (BAC) test will be completed as part of recall procedure.

All recall results are documented in electronic medical record.

POSITIVE RECALL OUTCOME

A positive recall outcome will entail the patient responding to the clinic's phone call and attending recall appointment with nursing staff within 24-hours, completing a toxicology screen, producing BAC of 0.00, correct number of take-home medication bottles with seals and labels intact, and the correct number of medication tablets of other prescribed medication, if applicable.

The takehome medication and other prescribed medication will be returned to the patient.

NEGATIVE RECALL OUTCOME

When there is a negative recall outcome, the clinic's nursing staff will promptly notify patient's primary counselor/clinical supervisor/OTP director, and prescribing provider. This multidisciplinary treatment team must be notified in order to determine appropriate next steps with patient.

Examples of negative recall outcome or other diversion relating concerns include but are not limited to the following: take home bottles are not returned and or labels are missing or illegible, if patient returns the wrong take home bottle (e.g., bottle with another patient name), take home bottle returned with inaccurate dose/missing methadone, or take homes are reported as stolen or lost.

In incidents such as these, take home status will be reviewed by treatment team. The OTP clinic does not refill or replace medication once take-home bottles are given to the patient.

If the findings are a missing bottle, or tampered contents or label, the bottle will be retained, plus all other take-homes collected by the nursing staff, unless directed otherwise by medical provider. When necessary, take homes will be disposed of appropriately by nursing team and patient's take-home schedule will be suspended and the case will be reviewed in team meeting.

Failure to properly care for and present take-home dose will result in immediate suspension of take-home schedule.

MOBILE METHADONE UNIT (MMU) EMERGENCY MANAGEMENT

PROTOCOLS

SUMMARY

In the event the MMU becomes inoperable during a typical operating day due to a mechanical breakdown or crash/accident on the road to a dispensing site, the program will establish the following protocols.

INOPERABLE MMU

If a mechanical breakdown occurs before leaving the central opioid treatment program (OTP), the nursing staff will pre-pour each patient's medication for the day in take home bottles. Bottled medication will be delivered to patients at our OTP partner dispensing site(s) (e.g. auxiliary clinic) by a nurse.

The nurse will be accompanied by the assigned MMU security officer and they will use one of the fleet vehicles of the program's outreach team, or other approved vehicle.

The take home bottles will be placed in a transportable locked container.

CRASH/ACCIDENT ON ROAD

If unable to arrive at dispensing site due to accident on the road the MMU Security Officer will inform local law enforcement of the crash location and about the supply of medication onboard.

The nursing staff and the security officer will remain with the medication supply at all times.

The central clinic should deploy additional nursing staff in one of its outreach team vehicles, or other approved vehicle to travel to the MMU location.

If MMU personnel are physically unable to remain with the medication supply, the program staff/security officer will ask responding law enforcement officers to remain with the medication supply until the deployed nursing staff arrive at the site (in this instance, we would request law enforcement to accompany the nurse if our security officer is physically unable to return to the OTP with the nurse).

Once the secured medication is back at the OTP or partner dispensing site (e.g. auxiliary clinic), follow the above protocol for Inoperable MMU.

EXTREME WEATHER EVENTS

For extreme weather events where there would be a state of emergency declared by local authorities, the OTP will plan to provide patients with take home bottles in advance of the weather event in order to mitigate the impact to patients and comply with the state of emergency.

TRAINING AND ONBOARDING OF AUXILIARY MEDICATION UNIT OR MOBILE METHADONE UNIT STAFF

TRAINING AND ONBOARDING

SUMMARY

The training and onboarding of staff for auxiliary medication clinics or mobile methadone units is to be done by the central clinic to ensure the procedures and protocols are standardized. The utilization of an onboarding checklist is strongly encouraged. An example is provided in our online toolkit. Each position may require its own checklist to track completion of trainings based on job role.

DATA ELEMENTS AND OUTCOME MEASURES FOR TREATMENT

DATA ELEMENTS AND OUTCOME MEASURES

SUMMARY

Tracking data elements and outcomes measures of patients enrolled in an auxiliary medication unit or mobile methadone unit is strongly recommended and in some instances required by the state or federal government. Please check with your regulatory body for further guidance.

Below we have provided lists of data to collect related to:

- Patient admission to the auxiliary medication unit or mobile methadone unit
- Annual update for patient's prescribed methadone, buprenorphine, or naltrexone as a medication for opioid use disorder to track patient progress in the program
- Patient discharge data to track patient outcomes from their time in the program

For more information please contact Program Assistance.

ADMISSIONS

- Patient name
- Patient date of birth (DOB)
- Patient assigned medical record number (MRN)
- Intake date
- Admission date
- Level of care
- Demographics
    - Sexual orientation
    - Gender identity
    - Race
    - Ethnicity
    - Primary language
- Military status
    - Veteran
    - Active duty
    - Reserves/National Guard
    - Both active duty and Reserves/National Guard
- Zip code of primary residence
- County of residence
- Type of residence
- Living arrangements
- Referral source
    - Substance use disorder treatment

    - Prevention/intervention services
    - Justice system involvement
    - Health care services
    - Employer/educational/special services
    - Social Services
    - Recovery Support Services
- Education level
- Employment status
- Primary source of income
- Family history
    - Marital status
    - Child of someone who uses alcohol/other substances
    - Number of children
    - Number of children living with patient
    - Number of children living in foster care
    - Case with child protective service agency
- Justice system involvement
    - Agency involved
- Primary substance of use
    - Primary route
    - Primary frequency
    - Primary age of first use
- Secondary substance of use
    - Secondary route
    - Secondary frequency
    - Secondary age of first use
- Tertiary substance of use
    - Tertiary route
    - Tertiary frequency
    - Tertiary age of first use
- Is patient attending self-help (yes/no)
- Nicotine use
    - Has patient ever used nicotine (yes/no)
    - Age of first use
    - Frequency (in last 30 days)
    - Date last used
    - Primary route of administration
- Prior treatment episodes
- Physical health related conditions
- Mental health related conditions
- Gambling screening outcome
- Trauma screening outcome
- Orientation to change status

ANNUAL UPDATE FOR PATIENT'S PRESCRIBED METHADONE, BUPRENORPHINE, OR NALTREXONE

- Patient name
- Patient date of birth (DOB)
- Patient assigned medical record number (MRN)
- Annual update date
- Zip code of primary residence
- County of residence
- Type of residence
- Living arrangements
- Education level
- Employment status
- Primary source of income
- Justice system involvement
    - Agency involved
- Current prescribed medication for opioid use disorder
- Daily dose
- Take-home schedule
- Medications prescribed in last 12-months
- Substances used in last 6 months (based on seriousness of use)
    - Primary substance and frequency
    - Secondary substance and frequency
    - Tertiary substance and frequency
- Nicotine use
    - Has patient ever used nicotine (yes/no)
    - Age of first use
    - Frequency (in last 30 days)
    - Date last used
    - Primary route of administration
- Physical health related conditions
- Mental health related conditions
- Number of days patient was in inpatient treatment (last 6 months)
- Number of days patient was in detoxification/stabilization treatment (last 6 months)
- Number of emergency room visits (last 6 months)
- Number of days patient was hospitalized for non-detoxification/stabilization service (last 6 months)
    - Reason for hospitalization (e.g. medical, psychiatric, both)

DISCHARGES

- Patient name
- Patient date of birth (DOB)
- Patient assigned medical record number (MRN)
- Date last treated
- Education level
- Employment status
- Zip code of primary residence
- County of residence
- Type of residence
- Living arrangements
- Primary source of income
- Mental health related conditions
- Gambling goal achievements
- Nicotine goal achievements
- Total treatment visits
    - Total number of visits
    - Individual counseling sessions
    - Group counseling sessions
    - Family counseling sessions
- Justice system involvement
    - Agency involved
    - Number of arrests
    - Days incarcerated
- Number of days patient was in inpatient treatment (last 6 months)
- Number of days patient was in detoxification/stabilization treatment (last 6 months)
- Number of emergency room visits (last 6 months)
- Number of days patient was hospitalized for non-detoxification/stabilization service (last 6 months)
    - Reason for hospitalization (e.g. medical, psychiatric, both)
- Primary substance of use (from admission)
    - Primary frequency
- Secondary substance of use (from admission)
    - Secondary frequency
- Tertiary substance of use (from admission)
    - Tertiary frequency
- Status of different problem substances used (not reported on admission)
    - Primary substance
    - Primary route of administration
    - Primary frequency of use
    - Secondary substance
    - Secondary route of administration

    - Secondary frequency of use
    - Tertiary substance
    - Tertiary route of administration
    - Tertiary frequency of use
- Nicotine use
    - Has patient ever used nicotine (yes/no)
    - Age of first use
    - Frequency (in last 30 days)
    - Date last used
    - Primary route of administration
- Physical health related conditions
- Discharge reason
- Referral disposition
- Referral agency classification
- Patient goal achievement
    - Drug use
    - Alcohol use
    - Medical conditions
    - Social functioning
    - Vocational/educational
    - Legal
    - Family situation
    - Emotional functioning
- Medication for opioid use disorder prescribed during treatment episode
- Additional medications prescribed during treatment episode
- Trauma screening
- Orientation to change status

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