Frequently Asked Questions

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Initiative Overview

1. What is the timeline for the Clinic OUD Capacity Building Initiative?
   The Clinic OUD Initiative has six-month cycles and will go for approximately three years. Every six months, clinics will 1) Have a representative join a webinar; 2) Complete a new self-assessment survey to report on their progress and rate themselves on how they are doing with each best practice; and 3) Choose a new best practice to work on during the next six months. The goal is that over each six-month period, clinics will improve on the best practice they choose. Some best practices may take longer to implement than 6 months, so clinics might finish implementing one while simultaneously planning for the next.

2. Is this a mandatory project for A31 clinics?
   Yes, this initiative is mandatory for all OMH freestanding, hospital-based, and state-operated mental health clinics, including those that have an integrated OASAS license. In response to the opioid epidemic, the governor’s office asked OMH to support all programs, starting with the mental health clinic system, to increase capacity to work with current clients with opioid use disorders. However, OMH is taking a flexible approach and asking clinics to take small steps over time.

3. Does this Initiative include clinics that mainly serve children and adolescents?
   Yes. The OUD Best Practices (including screening) are for ages 12 and up. Child and adolescent clinics may not have as many clients who screen positive and may not need to provide naloxone/MAT as often, but the goal is that statewide clinics have the systems in place to screen and the capacity to treat those who screen positive. OMH will be using the self-assessment survey to learn about clinics that only serve younger children and will revise expectations as we go based on what is learned. However, adolescents do develop opioid use disorders and are at risk for overdose, so it is vital to include clinics serving adolescents in this work.

4. Is this a PSYCKES CQI project?
   No. This is not a CQI project. Those usually involve monthly learning collaborative calls and reporting, much more intensive clinical implementation support, and they come with the CQI enhancement. The current cycle of CQI projects is still ongoing (QARR, Suicide Prevention, CTN) and will end in December 2019. New CQI projects will be offered in 2020.

5. Will there be any funding available for our clinic to cover the costs associated with these best practices?
   Funding is not available at this time, which is why OMH is phasing in these best practices over a long timeframe and in a self-directed manner where clinics can choose their own priorities. Please see sections below for recommendations for addressing specific topics within best practices.
6. Can an Agency/Facility or an individual Clinic work on more than one best practice at a time?
   Yes. However, clinics are still expected to “add” a new best practice to work on during the following six-month period.

7. Can an Agency/Facility with several sites work on different best practices at different sites?
   Yes. Clinics can indicate this in their self-assessment survey. Clinics should also “roll-up” satellite responses into the main clinic’s self-assessment.

8. Is there someone we can contact for help with planning implementation of these best practices?
   If you still have questions after reviewing the resource packets, please do not hesitate to reach out at PSYCKES-Help@omh.ny.gov.

9. How is this Initiative different from the existing regulations for OMH and OASAS providers to screen for mental health and substance use needs and provide the appropriate plan of care?
   According to the 599 standards of care, clinics should already be screening for SUDs and providing person-centered integrated treatment. So many clinics may find that they have already implemented some aspects of the best practices. Given that there are certain measures that are unique to OUD and that truly save lives, the purpose of this Initiative is to ensure that clinics have necessary resources and knowledge to address OUD in particular.

10. How do agencies operating clinics under both Article 31 and Article 32 fit into this Initiative?
    These agencies are well-positioned for this Initiative. The goal is for everyone in NY State with a co-occurring disorder to be able to receive effective evidence-based treatment in the place that they feel most comfortable receiving services.

11. Our clinic is a CCBHC that is already treating OUD patients and doing these best practices. How do we participate in this Initiative?
    Clinics already using these best practices should still fill out the self-assessment and can indicate their CCBHC status in that survey. CCBHCs may still have areas where they can improve on the best practices already in place. OMH will be reviewing the survey to better understand the capacity and current practices of CCBHCs for this population.

12. Does this initiative require us to serve a new patient population?
    No. Based on Medicaid data, many clients already being seen at A31 mental health clinics have OUD, half of which are not identified or treated. The goal of this Initiative is to improve clinics’ capacity to identify and treat these clients within the clinic.

13. Will OMH change admission criteria to allow clients with a primary SUD diagnosis to be treated in A31 clinics?
    Not in the immediate future. There are groups at OMH and OASAS looking into regulations and integrated care, so that may change in the future, but as it stands, a primary mental health diagnosis is required on the episode of care and on the treatment plan.

14. Do we need to add this work as a special service or population on our A31 license?
    No, treating individuals with co-occurring disorders is stipulated in the current clinic regulations and standards of care; individuals with opioid use disorder form a subset of the population with co-occurring substance use disorders. Clinics do not have to update their license or certification.
15. Are you collaborating with OASAS for trainings and programs?
Yes. OASAS is a full partner with OMH on this initiative. There are multiple regional learning collaboratives across the state that do combine OMH, OASAS, and primary care providers, in which clinic participation is encouraged. One example is the learning collaborative in Staten Island run by the Performing Provider System (PPS). A31 clinics that have an OASAS provider nearby and would like to collaborate on this work should feel free to do so and contact OMH for help if needed. OASAS clinics are not required to participate in this initiative because they have different regulations and billing, and have done work historically that OMH clinics have not. However, working closely together on project development allows for sharing strategies across systems.

16. Will there be concerns that OMH clinics are taking business away from OASAS clinics?
No. OASAS is a full partner with OMH on this Initiative, and OMH is not trying to (or able to!) take over business of Article 32 clinics. In order to address the opioid epidemic, service providers in a variety of settings, including primary care clinics licensed by DOH, are being asked to provide MAT. We know that clients with co-occurring opioid use disorder will be best served in the treatment setting they are currently in, where they feel comfortable with providers they already trust.

Best Practice 1: Clinics use standardized OUD-specific screen for all clients at intake

1. How can clinics meet Best Practice #1?
There are two options to meet the screening requirement for all clients over 12:

1) Clinics can use an approved screening tool that asks specifically about opioid use (the ASSIST, NIDA modified ASSIST, SBIRT with ASSIST, or NYSCRI assessment), or

2) Clinics can use a general substance use screen approved by OMH, OASAS and/or SAMHSA (MSSI-SAA, CRAFFT, DAST, CAGE-AID and AUDIT-C) plus a brief opioid-specific screening tool like the Rapid Opioid Dependence Screen (RODS).

The first option may be a good choice for clinics not currently using any screening tool. For clinics already using a generalized substance use screening tool, adding the (very) brief RODS to capture opioid use specifically may be a good option. To achieve the highest level of the best practice, screening should be integrated into intake protocols; systems should be in place to confirm screens have been completed and, if positive, OUD diagnosis is documented and billed. PSYCKES or a QE/RHIO should be checked for all applicable clients at intake to help identify OUD.

2. Can a clinic do full SUD assessments at intake instead of screening? If so, are there any recommended full assessments?
Yes, the clinic can choose to complete a full SUD assessment instead of a screening. However, screening is recommended to save clinician time and because these are validated and sensitive tools to identify clients who need a full assessment.

3. We see many clients who are on opioids from other doctors. Would they be classified as having an OUD?
Not necessarily. Clients who are prescribed opioids from other doctors require more assessment and collateral information from providers than a simple screen can provide. Screening tools can help pick up whether clients have addiction-related problems or misuse of opioid medications, but they may not lead to as direct a diagnosis for these clients compared to clients using opioids that are not prescribed. Screens can flag individuals so that clinicians can start having those discussions with the client and, with permission, the prescriber of their pain medication. It is also advised for any physician or nurse practitioner concerned about prescription drug abuse to check the New York Prescription Monitoring Program through the Health Commerce System. Clinicians can work with the client to make sure that the pain medications are helping them and not creating more problems. If the assessment determines that the individual has an OUD, there are options to transition that person off the opioid medications and onto MAT.
Note: Anyone on pain medication, even if there are no signs of misuse or OUD, can benefit from a naloxone prescription, in case they accidentally take too much opioid medication, do not metabolize it well, etc. This is particularly relevant for people on a high level of opioid medications, or who are also taking sedating medications such as benzodiazepines.

4. How often should clients be rescreened?
While the goal is to start screening new intakes, we are encouraging clinics to incorporate opioid use screenings into regular reassessment workflows, whether it is adding to a TPR or at some other frequency. Expanding the screening to all clients at reassessment will help avoid missing any existing clients who may be at risk or whose substance use risk has changed since the last time they were screened.

5. Do we need special permission to incorporate the Rapid Opioid Dependence Screen (RODS) in our electronic medical record (EMR)?
No. The RODS is not copyrighted; it is in the public domain and free to use without permission. The project team is working with the developer, Dr. Sandra Springer, to keep her informed on this initiative. Please let us know if your EMR vendor has any questions or concerns about this.

6. Can our clients self-administer the RODS and then clinicians score it?
No, the RODS has to be administered by a staff member.

7. Is the RODS available in other languages, such as Spanish?
The RODS is currently only available in English and Spanish. We are working on translating the RODS into other languages and will let Clinics know when translated screens are available.

8. The RODS uses DSM 4 language, for example “Opioid Dependence” instead of “Opioid Use Disorder” (mild, moderate or severe). Is there an updated version of this screen?
The screen was developed before the DSM 5, and there is not an updated version. However, our clinical experts believe that it still performs well as a screening tool that is sensitive to opioid use. After screening, clinicians should still assess and diagnose along DSM 5 lines.

9. What age group should use the CRAFFT screen?
The CRAFFT is only validated for use with youth. The RAFFT is the adult version.

Best Practice 2: Clinics provide or prescribe Naloxone to clients with OUD

1. How can clinics meet Best Practice #2?
On the same day that a client is identified with OUD, the clinic provides the client with:
   • A prescription for naloxone
   • Overdose prevention education & demonstration of how naloxone is administered
   • Educational materials, including how to obtain naloxone without a prescription
And systems are in place to monitor the above protocol.

2. Are clinics expected to dispense naloxone directly to clients?
No. To directly dispense naloxone to clients, a clinic has to become an Opioid Overdose Prevention Program (OOPP) certified by DOH. A clinic may choose to become an OOPP, but it is not a requirement of this Initiative. OOPPs dispense naloxone kits (which include the naloxone, an administration device, educational materials, rescue breathing mask, and gloves) and also provide community trainings on how to use naloxone. Clinics who prescribe the naloxone and provide resources to help the client obtain the naloxone will still meet the best practice requirement. Any prescriber can prescribe naloxone- it is not a controlled substance and is a very low-risk medication to use. The biggest risk is not using it.
3. **Is a prescription required to pick up naloxone at a pharmacy?**
   In NYS, there is a standing order for pharmacies to be able to dispense naloxone without a prescription, and many pharmacies participate in this program. A directory of pharmacies dispensing naloxone is available from NYS DOH, and in New York City, DOHMH has a list and locator map.

   However, people with co-occurring disorders often have difficulty engaging fully in care and following all recommendations. Having the naloxone prescribed to a pharmacy makes it more likely that they will receive it, since they can pick it up with their other medications.

4. **Who can prescribe naloxone in A31 clinics?**
   Anyone with a license to prescribe other medications can prescribe naloxone. There is no special training or certification required. Psychiatrists, for example, can prescribe naloxone, but RNs cannot.

5. **When prescribing naloxone, is a clinician required to provide naloxone administration training?**
   A naloxone prescription without education is better than no prescription at all. However, to achieve the highest level of the best practice, clinics can provide overdose prevention materials and a demonstration of how naloxone is administered. OMH has resources to help, including handouts, posters, and links to web trainings that demonstrate naloxone administration. This educational work does not have to be done by prescribers; it can also be done by other clinic staff, or in a group setting, in individual therapy, etc.

6. **Do clients have to pay for naloxone?**
   If someone is prescribed naloxone, or if they use the DOH Commissioner’s standing order at a pharmacy, the price of naloxone is charged to their health insurance. There is no copay for clients covered under Medicaid. If there is a copay under clients’ commercial insurance, then up to $40 of the copay can be covered using the DOH’s Copayment Support Program (N-CAP). There is a specific code and procedure that the pharmacist needs to use, so we will provide you with a "Dear Pharmacist" letter for clients to present to their pharmacists. Uninsured clients can get a naloxone kit for free at a community-based OOPP - a list of community-based OOPPs can be found here.

7. **Is prior authorization required for Medicaid patients to receive naloxone?**
   No. In fact, prior authorization for naloxone and MAT is illegal for insurance plans regulated by NY State.

8. **Best Practice #2 states that clients should be prescribed naloxone on the same day they are identified with an OUD. What if the prescriber does not have coverage every day?**
   Though the best practice is the ideal, clinic capacity varies. If a clinic identifies someone as having OUD, and there is no prescriber available, it is acceptable to send that client to the pharmacy to pick up naloxone without a prescription or to an OOPP.

9. **Do methadone treatment providers provide naloxone?**
   Many OASAS OUD treatment programs are also OOPPs that dispense naloxone kits.

10. **Does naloxone expire?**
    Yes. Naloxone has a shelf life of 18-24 months and is required to have an expiration date of at least 12 months after it has been prescribed. It should be kept at room temperature. However, some studies show that it maintains its efficacy after the expiration date and that it is not as temperature-sensitive as the manufacturer suggests. While OMH encourages following manufacturer instructions, prescribers should not be anxious about it.

11. **If naloxone is prescribed to a child or adolescent, who is responsible for training clients and parents on its use?**
    The resource package for this best practice include materials on naloxone administration that 1) clinics can give to individuals and 2) that help providers educate family and other supports. Clinics can also
refer clients to community-based organizations for this training. Prescribing naloxone and providing a handout on its use is still better than no naloxone at all, so that should not be a barrier to prescribing it.

**Best Practice 3: Clinics refer clients with OUD to a MAT provider**

1. **How can clinics meet Best Practice #3?**
   Integrated treatment in a single location is the best practice, as clients with co-occurring diagnoses should be able to be treated in a treatment setting of their choice, such as an Article 31 clinic that offers MAT. However, some individuals will need to be referred out for OUD treatment, including clients who choose methadone treatment and clients who upon assessment would be better served in a specialty setting (e.g. the substance use disorder is dominant and/or much more severe than the mental illness). Clinics may want to develop protocols to support decisions about when to refer. When a decision is made to refer, the best practice is to:
   - Support appointment scheduling to a verified MAT provider within two weeks of the diagnosis
   - Follow-up to ensure initial and ongoing treatment engagement
   - Continue mental health treatment for referred clients as appropriate

   The clinic has systems in place to monitor referrals.

2. **When is it necessary to refer a client with OUD to a primary OASAS setting?**
   This must be a clinical determination based on what is best for the client, what the client says they want, and what the local provider treatment system can or cannot provide. For example, if a client with OUD and depression has had success on methadone before, an A31 clinic may refer them to a methadone clinic. Or, if an A31 clinic only has one prescriber with a buprenorphine waiver and are close to their buprenorphine caseload limit with limited hours at the clinic, has a client who would benefit from buprenorphine but also has mild depression, the clinic might send them to a local Article 32 or their primary care provider who has the capacity to prescribe buprenorphine. Having an effective, timely referral process is crucial, even if A31 clinics are providing MAT.

3. **What if no OUD or MAT providers are available, or if those providers are cash-only?**
   OMH is working with State and City agencies to create as comprehensive a list as possible of providers who take Medicaid. NYS OASAS has a treatment availability dashboard [here](#) that can show MAT providers by location but does not indicate if providers take Medicaid.

4. **How can an A31 clinic ensure that clients get appointments within two weeks with a MAT provider? Will there be a system in place to enable clinics to provide emergency referrals?**
   An appointment within two weeks is the goal that clinics will work to meet, and the OASAS treatment availability dashboard can support finding verified MAT providers. It is recommended that agencies and hospitals develop relationships with OASAS MAT providers to support referrals and communication. OMH will appreciate feedback from clinics about referral roadblocks and challenges so those issues can be worked through at a systems level.

5. **What about harm reduction approaches for clients who are not yet interested in stopping their opioid use?**
   OMH encourages clinics to fully embrace a harm reduction, person-centered approach. While going on MAT is a client's choice, stopping all opioid or all drug use is *not* a necessary precondition for starting MAT.

6. **Can clinics located in hospitals that also provide OUD treatment just screen and refer?**
   Clinics located in hospitals that provide OUD treatment should also provide OUD treatment themselves. Strong research shows that sending patients to different places for different aspects of treatment often does not succeed, even if it is in the same building. Some clients are best served with a referral, and others do best if they receive their OUD treatment/MAT in their mental health clinic. OMH is not trying to replace
the addiction system but rather offering another treatment option for clients with co-occurring mental health diagnoses and OUD. This is similar to the work being done in primary care settings.

**Best Practice 4: Clinics have (primary & backup) waived prescriber/s for Buprenorphine**

1. **How can clinics meet Best Practice #4?**
   Clinics will meet the best practice with at least one prescriber with the DATA-2000 waiver to prescribe buprenorphine, who is available to prescribe buprenorphine at least 50% of the time that any prescriber is available in the clinic, and back-up coverage is available at the clinic’s agency/facility in the event of prescriber vacation or leave.

2. **If an agency is co-located with an Article 28 or Article 32 clinic, and the agency can provide buprenorphine through the other clinic’s prescriber, does that count for this best practice?**
   Primary care is also being asked to do MAT because primary care physicians comprise a large part of the healthcare workforce. However, primary care physicians are largely not trained in behavioral health, so the best practice is for A31 clinics to provide the integrated treatment. A31 clinics can provide treatment by using prescribers in A28 or A32 settings if the treatment is offered in an integrated way.

3. **Who can receive a DEA waiver to prescribe buprenorphine and how long is training?**
   Training is free, and can be taken online, in-person, or a mix of the two. The DEA waiver (called DATA-2000) is available to: 1) Physicians- Physician require 8 hours of training for the waiver. In A31 clinics specifically, psychiatrists can prescribe buprenorphine. 2) Nurse practitioners- NPs require 24 hours of training for the waiver. In A31 clinics specifically, psychiatric nurse practitioners can prescribe buprenorphine. 3) Physicians’ Assistants- PAs require 24 hours of training for the waiver. However, under OMH regulations, PAs cannot prescribe medications in OMH clinics. If a clinic finds that this is a barrier to prescribing, please share with OMH.

4. **Is there any funding to pay for prescribers’ buprenorphine training, given that it takes away from billable services?**
   Not right now. OMH is also exploring an adjunct voluntary MAT CQI project that might also provide additional funding for freestanding clinics. Given the 6-month cycle of the initiative, a clinic can start planning how, in a year from now, to budget for and cover costs. The 8 hours of online psychiatrist training can be spread out over 3 months, and all of these trainings offer free CMEs. However, if taking time for training is a significant barrier for clinics, they should note this in the self-assessment and/or share with OMH, so there is data to show this need.

5. **Does the waiver need to be renewed if a prescriber has not used it?**
   No, once a prescriber has it, it does not need to be renewed. However, prescribers must use the waiver to be able to apply for increases in caseloads. For example, a prescriber must successfully prescribe at the 30-person limit to be able to apply for the 100-person limit.

6. **If a PA works under an MD or DO, do they share the waiver cap between themselves?**
   No, each provider has their own waiver that comes with caseload requirements. The PA cannot use the physician’s waiver but rather needs their own. When the PA receives their own waiver, they have their own caseload. However, PAs are not able to prescribe medications at OMH clinics.

7. **How can clinics address prescribers who have, or might get, a waiver, but are unwilling to prescribe?**
   OMH recognizes this challenge, and resources provided during the course of this initiative should support working with prescribers around various prescribing issues. In some cases, that includes prescriber education. For example, some waived prescribers hesitate to prescribe because they fear attracting more drug users to the clinic and/or increasing meds-only clients and waitlists. In practice, however, prescribing will mainly affect patients already in your A31 who need life-saving OUD treatment. Experiences and
presentations from fellow prescribers can also help reduce fears of increased conflicts with drug-seeking patients, and the resource packet includes links to webinars and mentorship opportunities. The project team will also hold office hours in between webinars for clinic questions.

8. Rural clinics face a lack of prescriber staff. Will OMH provide funding to attract prescribers to these areas?

Right now, there is no funding specifically for funding prescribers. As the initiative proceeds, data collected and learning regarding prescriber challenges will be used to advocate for change.

Best Practice 5: Clinics prescribe MAT (Buprenorphine, Naltrexone/Vivitrol)

1. How can clinics meet Best Practice #5?

Clinics can meet the highest level of Best Practice #5 by providing MAT to clients with OUD, including MAT induction and maintenance services for both buprenorphine and XR-naltrexone. Systems are in place to ensure that clients are engaged in MAT services within two weeks of identification of OUD, and MAT services delivered are appropriately reflected in billing invoices.

2. What are the types of MAT that can be provided in A31 clinics? Can A31 clinics bill for MAT?

Yes. Medicaid and other insurances reimburse for services given to clients with SUDs in OMH settings. A primary mental health diagnosis is still required on the episode of care on the treatment plan. However, an individual bill on an individual day can have a primary diagnosis of SUD or OUD. OMH will issue billing guidance on this topic in the next few months.

3. Do managed care contracts have to be changed to make this happen?

This has not yet been determined, but OMH stakeholders are meeting with managed care plans to discuss this soon. It is a priority of OMH and the Governor’s office that these services would be paid for.

4. Is prior authorization required for MAT?

According to current law, insurance plans cannot require prior authorization for MAT. However, they can have MAT options in a preferred formulary that do not require prior authorization, but then require them for options outside of the preferred formulary.

- Methadone- All plans will cover methadone.
- Buprenorphine- There are multiple brands of generic formulations of buprenorphine and buprenorphine-naloxone, but plans may choose to only cover one of them.
- Naltrexone- There are no generic formulations for naltrexone. Plans may choose to cover PO naltrexone and not Vivitrol.

Plans are not allowed to dictate doses within FDA indicated dose ranges.

5. Are clinics required to store medication to provide MAT?

No. Clients can administer buprenorphine at home with the proper instructions, or they can pick it up at the pharmacy and bring it to the clinic to be administered. The same goes for naltrexone. It may not be appropriate or feasible for certain clinics to store or administer the medication.

6. Is psychosocial treatment required to prescribe MAT in A31 clinics?

No. The federal law that allows buprenorphine to be prescribed requires the ability for the practitioner to refer to (any) psychosocial supports. All A31 clinics already provide many psychosocial supports to people with mental health conditions. Clinics can enhance their ability to provide psychosocial supports to people with SUD, including OUD, by using the resources provided through this initiative. Both OMH and OASAS remain committed to psychosocial options for individuals with both SUDs as well as co-occurring disorders.

However, data shows that MAT by itself, without any psychosocial supports, still saves lives. For example, a patient who is not compliant with psychosocial support should still continue receiving MAT. Failure to engage in psychosocial treatment is not a reason to withhold MAT; that is not the standard of care. Clinics
that do not typically provide medication-only services may want to focus on a robust referral protocol with follow-up to ensure engagement with MAT providers.

7. What if our non-prescribing mental health clinicians are not comfortable treating OUD?
This initiative includes resources to help staff feel more comfortable over time. However, clinicians trained in mental health or behavioral health have a core skill set (e.g. counseling) that can be adapted to address co-occurring OUD- with extra training, self-learning, and supervision. These clinicians are also already familiar with issues such as trauma, building resiliency, and strengths-based approaches. For context- most of the State and national effort to address the opioid epidemic is focused on providing MAT in primary care, because there are more primary care clinicians than mental or behavioral health clinicians. If primary care clinicians are being asked to do this work, mental health clinicians certainly have the core skill set to do this work well for people with co-occurring disorders.

8. What are the clinical details of XR-naltrexone?
Naltrexone (brand name Vivitrol) is one of two types of evidence-based MAT that can be prescribed in an A31 clinic. It is newer than buprenorphine and methadone, but the evidence behind it is increasing. Its advantages are that it is not a controlled substance and therefore does not require a special waiver to prescribe, and it works for an entire month (no daily pill or film under the tongue). Disadvantages include more limited efficacy data and a complete detox from opioids before induction, which can be challenging in an outpatient setting. Vivitrol is very expensive but is required to be covered by all Medicaid managed care plans and does not require a prior authorization.

9. Can buprenorphine be prescribed via telemedicine?
Yes. Clinics may use telemedicine to prescribe buprenorphine as they would other medications, provided the clinic follows all OMH regulations around the use of telemedicine. The Ryan Haight Act of 2008 historically has prevented prescription of buprenorphine and other controlled substances via telemedicine. However, in response to the opioid overdose epidemic the Federal Drug Enforcement Agency and the Department of Health and Human Services released new guidance in 2018: “According to the DEA’s Use of Telemedicine While Providing Medication Assisted Treatment (MAT) statement, pursuant to the provisions of the Ryan Haight Act of 2008, DEA-registered practitioners acting within the United States, which include DATA 2000-waivered practitioners, are exempt from the in-person medical evaluation requirement as a prerequisite to prescribing or otherwise dispensing controlled substances via the Internet if the practitioner is engaged in the “practice of telemedicine” as defined under 21 U.S.C. § 802(54).”

10. What is the abuse potential of buprenorphine?
It is possible to get a high from buprenorphine, but the high is not close to that of a full opioid agonist. The most commonly prescribed formulation is buprenorphine combined with naloxone (brand name Suboxone). The naloxone is not bioavailable sublingually or gastrointestinally, so when someone uses Suboxone as directed, there is no naloxone. But if someone tries to snort or inject it, the naloxone becomes bioactive and puts the person into immediate opioid withdrawal. This is an anti-diversion mechanism built in, so clinics are recommended to use this formulation of buprenorphine. Urine drug screening as an anti-diversion check is also recommended; clients should take at least some buprenorphine, so it will show up in their urine. Another anti-diversion check is random drug supply checks. Unlike Suboxone, methadone, for example, does not have an anti-abuse mechanism built in. Therefore, methadone can only be dispensed for the treatment of addiction in specially certified programs and often requires daily visits on the part of the client.

11. Local law enforcement is very concerned about buprenorphine diversion - what explains the street value of buprenorphine?
Experts believe that buprenorphine’s use for withdrawal symptoms mostly explains its street value. When people cannot get heroin or are tired of their heroin habit, and they cannot access treatment, they turn to buprenorphine on the street.
12. Are urine drug screenings mandatory for this initiative?
No - OMH does not advise routine or require automatic urine screening for MAT prescribing. The decision to order a urine screen should be made on clinical grounds. Urine screens can be helpful in OUD treatment for three key reasons: 1) They provide an additional piece of clinical information that can help in OUD treatment. For example, if the urine screen is positive for benzodiazepines, clinicians can educate your client about the increased overdose risk of using both benzodiazepines and opioids. 2) It is important to monitor for diversion—the urine screen should be positive for opioids if the client is taking buprenorphine. 3) Naltrexone induction requires a complete detox from opioids because it can lead to protracted opioid withdrawal in intoxicated patients, which is very uncomfortable and potentially medically dangerous. It is also appropriate to order a urine screen if there is a concern of underreporting of opioid use.

13. Do prescribers need to have the capacity to conduct express urine testing if clinically necessary for MAT?
No, having the capacity to conduct express urine testing is not mandatory for this initiative. The standard of care is met by ordering a urine drug screen and obtaining results from an outside lab. However, clinics can choose to have capacity for on-site lab testing. Longer wait times can be especially challenging for naltrexone inductions, which cannot be started without urine screen results.

14. If an A31 clinic chooses to do urine drug screens, what procedure should be used?
Urine drug screens can be conducted either on-site or sent out to a lab, based on your clinic’s capacity. In order to do on-site urine drug screening, clinics must apply for a DOH lab permit. It is acceptable to send patients to commercial labs for screening. OMH also strongly discourages observed urine screens because they are not recovery-oriented or person-centered, and they put an unnecessary burden on staff. Observed urine screens are mainly for forensic/criminal justice settings and some substance use program settings.

15. Does an entity need to have an OASAS-certified clinic to do a urine drug screen?
No - OMH-certified clinics can complete urine screens on-site if facilities are available.

16. Do clinics need to get urine drug screen results immediately for MAT inductions?
For buprenorphine induction, a urine screen is not necessary because the patient does not have to be completely free of opioids. Rather, the patient just needs to be in mild or moderate opioid withdrawal. Buprenorphine treats mild to moderate opioid withdrawal and makes the person feel much more comfortable. Clinicians can use an opioid withdrawal scale OR tell patients to be in withdrawal before home induction. Naltrexone induction is easier in inpatient substance use settings or during medical or psychiatric hospitalizations; outpatient is mostly for maintenance. However, in order to do naltrexone inductions, urine drug screens are part of the protocol to ensure the person is free of opioids in their system. Otherwise, there is a risk of protracted withdrawal, which is very uncomfortable and possibly even medically dangerous.

Please feel free to contact us with any additional questions at PSYCKES-Help@omh.ny.gov.

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