

## ORGANIZATIONAL REQUIREMENTS

1. Documentation of all Federal accreditation, certifications, & authorizations of the OBMAT program.
2. Staff listing including: counseling staff, medical director, program physician(s) & other prescribers.
3. Develop detailed job descriptions for credentialed and non-credentialed staff.
4. Develop description of Peer Recovery Support Services description.
5. Description of organizational structure.
6. Documentation for supervision for all staff requiring supervision.
7. Develop continuing education plan for all employees and volunteers involved in the MAT program.
8. Develop a policy that delineates procedures governing disciplinary actions and non-voluntary termination of staff and volunteers.

## PROGRAM REQUIREMENTS

9. Each OBMAT shall have a policy regarding co-morbid disorders.
10. Develop a procedure for verifying that a new patient is not currently participating in and receiving medication from another OTP or OBMAT program, (document Prescription Drug Monitoring System checks for OBMATs and (faxes to the closest OTPs).
11. Results from these verifications shall be contained in the clinical record, patient chart and individualized plan of care.
12. Develop policies and procedures for urine drug screens (UDS), including witnessed drug screens which include at least one random drug screen per month for the first year of treatment.
13. Each OBMAT shall develop and implement policies and procedures for positive UDS based on sound clinical judgement and individualized for each patient.
14. Develop and implement policies and procedures to minimized misidentification of urine specimens and correct chain of custody to ensure sample can be traced to donor.
15. Develop a diversion control plan (including checking the PDMP for all new or returning patients).
16. For voluntary withdrawal (**successful completion**): Develop and implement policies and procedures for continuing care following the last prescription given and for re-entry to

maintenance treatment if relapse should occur or should the patient reconsider withdrawal for voluntary withdrawal from the program.

17. Develop and implement policies and procedures for involuntary withdrawal from the program.
18. Upon admission to the program, the patient will be given a New Patient information that will include much of the information contained in the program and clinical requirements that apply to patient information needed.
19. Upon admission to the program, the patient will be given a copy of the involuntary withdrawal policies and procedures and *will sign* an acknowledgement of receipt of such.
20. Involuntary withdrawal may result from non-payment of fees, disruptive or adverse effect conduct or incarceration or other confinement.
21. For each involuntary withdrawal patient, the program shall document in the individualized care plan all efforts at referral or transfer of care to another suitable, alternative treatment program.
22. All female patients will have a negative pregnancy screen prior to administrative withdrawal.
23. Create reports of statistics and records required (total no. patients, etc. from section 13.2.) and including patients who were denied admission and reason for denial, including referrals that were made for the patient.
24. Develop & implement policies and procedures for documenting, investigating, taking corrective action and tracking instances of known adverse events or incidents.

### **CLINICAL REQUIREMENTS**

25. Each program will develop policies and procedures which ensure that single sex groups and same sex counseling are available should a patient request it.
26. Initial Assessment (establishes eligibility, need for TX, indicators for initial dose, ASAM) with procedures that specify that admission is only AFTER assessment by qualified personnel. Initial assessment must also be conducted by *the Medical Director* by meeting criteria as listed in the DSM 5. Documented biopsychosocial assessment by program counselor PRIOR to receiving first dose of Buprenorphine Exceptions to regular admission procedures include: Pregnant women, prisoners released within 6 months of admission, former patient who feels he or she is at risk for relapse, HIV patient, or other patient deemed high risk by the medical director. Patients discharged from another program should sign a release of information so records can be requested from prior program for treatment history. Initial assessment to

include a consent for treatment and consents for coordination of care between all providers involved in the care of the patient.

27. The *primary counselor* will complete a post-admission assessment within 14 days of admission and develop an initial individualized plan of care, with a coordination of care agreement completed (if appropriate, i.e., when counseling is completed by referral outside the medical provider).
28. Program will have in place a detailed relapse prevention plan, developed in conjunction with the patient.
29. If the counselor is not employed with the medical provider, the medical provider will consistently monitor attendance and progress of each shared patient and maintain documentation from the counselor of the same.
30. Primary counselor shall develop and implement the psychological and social portions of the patients individualized plan of care or treatment strategies.
31. Have a procedure through which patient can discuss the prescriptions and dosages of medication he or she receives with appropriate staff regularly and upon request (included with information provided to new patients).
32. Develop, implement and maintain current quality assurance and quality control that includes provisions for: a) regular and continuous staff education; b) a service delivery assessment as described in 17.1.b.; and c) an ongoing assessment, measurement and monitoring of patient outcomes, treatment outcomes and various processes as described in 17.1.c.1 –c.5.

**\*\* NOTE:** Section 31.3. addresses positive UDS and UDS without buprenorphine and the re-evaluation of the individualized treatment plan and stating that both benzodiazepines and buprenorphine shall be given special consideration. This requires an immediate discussion with the patient which shall be documented in the patient's record.

**CHECKLIST**

Accreditations, certification, authorizations of the OBMAT on display

- Organizational Chart
- Staff listing with supervision indicated
- Detailed Job descriptions for every staff member
- Educational plan for all staff members
- Policy that delineates disciplinary actions for termination of staff and volunteers

**POLICIES REQUIRED**

- Policy regarding Co-occurring disorders
- Policy for same sex groups or specific sex counselor should as much be requested or required by a patient.
- Policy & Procedures for verification that patient seeking admission is not currently receiving services and medication from another OTP or OBMAT (results documented in chart)
- Policy for UDS (witnessing, random drug screens no less than monthly) and for positive UDS based on sound clinical judgement. Policy should also detail chain of custody to minimize chances for misidentification of samples.
- Policy and procedures for diversion control.
- Policy for involuntary withdrawal from the program including medication tapering and referral procedures
- Policy for documenting, investigating and taking corrective action as well as tracking of adverse events or incidents.
- Policy for successful completion (voluntary withdrawal) of the program including procedures for continuing care and re-entry for maintenance medication in the event of relapse or should the patient deem necessary.

**CLINICAL POLICIES REQUIRED**

**Admission Policy** that includes statistical information regarding the OBMAT.

- Consent for treatment and Coordination of Care, if the latter is required.
- Program's Infection Control Policy given probability of communicable diseases.
- Policy for initial assessment by the Medical Director, approved program physician or supervised physician extender prior to the first administration of medication and initial assessment by the primary counselor within 14 days of admission into the program. Both assessments document the appropriateness of patient for the MAT program as indicated by the DSM 5, ASAM guidelines and patient history. Patients discharged from another program within the last year require a release of information for the previous program.
- Policy includes provisions for prioritized admission for high risk patients: pregnant women, HIV positive patients, recent prison releases, and other high risk patients as deem such by the medical director.
- A relapse prevention plan that is developed with the individual patient.
- Procedure for patient to discuss prescriptions and dosages of medication with the appropriate staff, both regularly and upon request.
- Develop, implement and maintain current quality assurance and quality control that includes provisions for: a) regular and continuous staff education; b) a service delivery assessment as described in 17.1.b.; and c) an ongoing assessment, measurement and monitoring of patient outcomes, treatment outcomes and various processes as described in 17.1.c.1 –c.5.

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