NADCP supports MAT but questions lack of medication protocols

Drug courts are increasingly positioned as pathways to treatment for people with addiction who are in trouble with the criminal justice system, but medication-assisted treatment (MAT) is proving to be a sticking point. At a time when the opioid addiction epidemic is at a crisis point, the importance of MAT is increasingly pointing toward expanding methadone, buprenorphine and Vivitrol treatment. But traditionally, the criminal justice system has been opposed to methadone and, more recently, buprenorphine; the same is true for many drug courts. And, in general, courts prefer the non-agonist medication Vivitrol over metha-
done and buprenorphine, both opioids (see ADAW, May 12).

West Huddleston, CEO of the National Association of Drug Court Professionals (NADCP), is particularly concerned about the MAT because, he told ADAW, too little is known about what medications work for what patients, and for how long treatment should last. NADCP

Bottom Line...
Drug courts want nonviolent offenders to get treatment if they need it, but they aren’t ready to line up in support of methadone and buprenorphine.

The Business of Treatment

OTPs build electronic capability to improve documentation, payment

Fifteen opioid treatment programs (OTPs) have been striving for the past year to build on modest federal grants designed to fuel development or extension of electronic health record (EHR) systems, seen as offering an essential boost to these organizations’ regulatory compliance and reimbursement potential.

A public health adviser with the Center for Substance Abuse Treatment (CSAT) within the Substance Abuse and Mental Health Services Administration (SAMHSA), which awarded the one-year grants of a maximum of $50,000 last summer, told ADAW last week that 12 of the 15 grantees have been able to select an EHR vendor product over the past year. “This is a very proud community,” CSAT’s Wilson Washington Jr. said of the OTPs. “They’re trying to do a lot with a little.”

These grantees have had to deal with certain roadblocks, largely sur-

Bottom Line...
One-year funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) served as seed money for efforts toward acquisition of electronic health record systems by 15 opioid treatment programs (OTPs). Twelve of these programs made product selections by the close of the grant period.
MAT from page 1

is a “strong proponent of the proper use of MAT in drug courts,” he said, citing a 2011 position paper supporting it.

According to a survey conducted by National Development and Research Institutes about two years ago, half of adult drug courts utilize MAT, the highest use among corrections, said Huddleston. In jails, when MAT is offered, it is for detoxification, and only 7.5 percent of prisons and 5 percent of parole and probation agencies offer MAT.

But Huddleston made a distinction between “medication assisted treatment” and “medicine as treatment,” blaming buprenorphine for the confusion. (See the article beginning on page 4 for the controversy about raising the buprenorphine cap, something NADCP strongly opposes.)

Draft guidance forthcoming from NADCP

Huddleston calls the “do you or do you not support MAT?” discussion “tired,” saying that DATA 2000, the law that allowed buprenorphine diversion of the medications.”

Saying that there is only “imperfect knowledge,” the draft guide says “drug courts cannot be faulted for cautious hesitancy.”

Included in the 2011 position paper from NADCP supporting MAT is the requirement that drug courts “not impose blanket prohibitions against the use of MAT for their participants” and that the “decision whether or not to allow the use of MAT is based on a particularized assessment in each case of the needs of the participant and the interests of the public and the administration of justice.” However, the NADCP position paper and forthcoming guidelines are not binding upon drug courts, which report to the Administrative Office of the United States Courts, noted Huddleston.

The guidelines will be released by the end of the year, said Huddleston, who added that the identities of the peer reviewers are not being disclosed. “They are psychiatrists, physicians, and experts” from academe, he said.

Side-by-side comparison

Huddleston faulted the field for not creating a document drug courts — or treatment providers, for that matter — can use “to help them understand the medical rationale for which medication to use for which patient and for how long,” he told ADAW.

There are 2,800 drug courts across the United States, but NADCP doesn’t know how many are using MAT, or what kind of medication they are using, said Huddleston. “I can’t tell you what’s happening in all 2,800 drug courts,” he said. “That’s not our role. We don’t track drug court operations to that level.”

The draft guidance does state that methadone is the treatment modality for opioid dependence that is associated with the least morbidity and mortality. We asked Huddleston if drug courts take health outcomes into consideration, or if they also consider recidivism. “Drug court’s main goal is to save someone’s life, to get them clean and sober,” said Hud-
Huddleston. “That’s our job. We’re dealing with drug-added people, 144,000 drug-added people. Our job is to get them the treatment they need.”

Huddleston added that people can be diverted out of the criminal justice system into treatment without a drug court. “That’s our goal as well,” he said. “We just don’t think that jail or prison is the place for addicts.”

Huddleston is not the only person to have suggested “side-by-side comparisons” with regard to the three federally approved medications, said Mark Parrino, president of the American Association for the Treatment of Opioid Dependence (AATOD). Many NADCP members would probably like “some kind of clinical decision-making outline, indicating what medications should be used for specific populations,” he said. However, this is “a much more complicated issue than first meets the eye,” he said. “It would appear that many addiction professionals are of the judgment that buprenorphine should be the first medication used to treat opioid addiction. “We’re dealing with drug-added people, 144,000 drug-added people. Our job is to get them the treatment they need.” Huddleston is not the only person to have suggested “side-by-side comparisons” with regard to the three federally approved medications, said Mark Parrino, president of the American Association for the Treatment of Opioid Dependence (AATOD). Many NADCP members would probably like “some kind of clinical decision-making outline, indicating what medications should be used for specific populations,” he said. However, this is “a much more complicated issue than first meets the eye,” he said. “It would appear that many addiction professionals are of the judgment that buprenorphine should be the first medication used to treat opioid addiction in a younger patient population with less complicated addiction histories.” Some experts believe that buprenorphine should be the first medication for opioid addiction for adults as well. “Such clinicians indicate that if buprenorphine should not prove effective in treating the symptoms of withdrawal or otherwise stabilizing the patient, then methadone should be the second-line medication,” he said.

Courts as barrier to treatment

But treatment providers have said that courts repeatedly refuse to allow clients to remain on MAT, if they are on it, or to recommend them for it. “The courts have been an impediment to the progress of MAT treatment,” Jerry Rhodes, CEO of CRC Health Group, the Cupertino, Calif.-based treatment chain that has the largest number of OTPs in the country, told ADAW. “Courts have, unfortunately, been a font of discrimination against the use of MAT, and it is an imposition of less than a best practice for many potential clients,” he said. “Until the drug courts adopt a greater perspective on the use of MAT, they will risk enforcing politics and prejudice against what is widely acknowledged as an important alternative for treatment.”

Huddleston cited the Brooklyn Treatment Court in New York City as an example of a drug court with cooperative agreements with treatment providers, including with opioid treatment programs (OTPs), clinics that provide methadone maintenance. “The number-one job of a drug court is to understand addiction, to understand that it is a long-term process, and not to throw people away in prison,” said Huddleston.

There are experts who prefer naltrexone or Vivitrol (depot naltrexone) over methadone or buprenorphine for younger users or opioid-naïve users, Parrino said. “This varies depending on who you speak with,” he said. It also varies depending on who is sponsoring the research. “The distrust of methadone maintenance treatment is rooted in the past, even when I wrote an article for American Jail Magazine in 2000,” said Parrino. “The editor asked me to write the article, focusing on Rikers Island as a method of responding to jail administrators and their medical personnel, who refused to recognize methadone maintenance as a legitimate treatment for opioid addiction.”

If drug courts once thought buprenorphine was a valid option, their perspective may have “darkened” because of diversion, and because of the policy of encouraging the use of buprenorphine without any other treatment interventions, such as counseling, said Parrino. “Obviously, this is not a written policy but it is a frequent practice,” he said.

Stuart Gitlow, M.D., president of the American Society of Addiction Medicine, had no comment on the NADCP criticism of MAT. ASAM is supporting lifting the cap on the number of patients a physician can treat with buprenorphine, which has aroused opposition from NADCP and AATOD alike (see article, p. tk). Meanwhile, Michael Botticelli, acting director of the Office of National Drug Control Policy, is a stalwart supporter of MAT, based on his...
Continued from previous page

past statements, his history as SSA in Massachusetts, and his leadership at the recent heroin summit (see *ADAW*, June 30). However, the recently released national drug strategy seemed to pull back from full support of MAT, with Botticelli citing “hesitancy” in supporting it (see *ADAW*, July 14). No one from ONDCP would comment on the record for this story, but Botticelli has shown leadership by having the MAT conversation with treatment groups in the past. As for prosecutors and judges in drug courts, ONDCP has decided that convincing them of the science behind MAT will require a long-term strategy, something that won’t happen overnight. Stay tuned. •

Controversy boiling over as SAMHSA considers raising bupe cap

A congressional forum convened last month by Sen. Carl Levin (D-Michigan) opened the doors for the Substance Abuse and Mental Health Services Administration (SAMHSA) to consider raising the maximum number of patients a single physician is allowed to treat with buprenorphine, an opioid drug used to treat opioid addiction (see *ADAW*, June 23). Now key stakeholders in the treatment field have spoken out against raising the cap, which is currently 100 patients. The overall fear is that medication-assisted treatment (MAT) is becoming “medicine as treatment,” in the catchphrase being used by those who are opposed to raising the cap.

On the one side is the American Society of Addiction Medicine (ASAM), which wants to raise the cap. On the other is a host of drug-free treatment programs, opioid treatment programs (methadone clinics) and drug courts. Almost all of the criticism of raising the cap is due to concerns about lack of ancillary treatment, such as counseling, that should be provided in addition to medication. It would be easy to attribute the acrimony to turf issues, but the eloquence of the stakeholders — and the particular passion of people in this field — reveals how deeply held the beliefs are regarding this topic.

Buprenorphine, like methadone, is an addictive medication. But for opioid addicts, there is no sedation; it just removes withdrawal symptoms and allows stability. Withdrawing from buprenorphine, like

AATOD and NADCP

The controversy has produced strange bedfellows, such as methadone clinics and drug courts. On July 2, the American Association for the Treatment of Opioid Dependence (AATOD) issued a MAT Policy Paper that included a reminder of why the cap — originally 30 patients — was instituted in the first place. Federal and congressional authorities didn’t want to create large medical practices that were treating hundreds of patients at a single site, to avoid “negative public reaction in questioning why such physicians were treating opioid addicted individuals” in the absence of any regulations. “At the present time, it would appear that such admonitions have been forgotten given the current climate of urgency in needing to increase access to care,” according to the AATOD paper.

On July 8, the National Association of Drug Court Professionals (NADCP) sent a severely worded letter to SAMHSA Administrator Pamela Hyde calling into question “proposed changes” to the cap. Saying that buprenorphine prescriptions have increased 7,000 percent since the medication was first approved more than a decade ago, NADCP CEO West Huddleston wrote in the letter that the increase has “public health implications,” because it is being provided outside of the context of a “comprehensive treatment program that includes psychosocial counseling, monitoring and drug testing.”

In fact, there is no proposal to raise the cap, according to SAMHSA. However, the NADCP letter takes the further step of recommending a clinical practice: “probably the best course of treatment for an opioid-dependent person is to use medications, including buprenorphine, to detox the individual and, once fully detoxed, place them on long-acting, injectable naltrexone,” the letter to SAMHSA Administrator Hyde advises. “Once stable, immerse them in a year or more of intensive psychosocial counseling, trauma and other mental health therapy, 12-step work, and close monitoring.” Then the letter accuses physicians of “doing nothing more than writing a prescription for buprenorphine/naltrexone with no referral to outside treatment for opioid-dependence and doing nothing to identify and treat each patient’s alcohol and/or other non-opioid drug abuse/dependence, other underlying causes (trauma) and/or psychiatric disorders and/or infectious diseases.”

Interventionist accuses ASAM

Then Earl Hightower, an interventionist with ties to the National Association of Addiction Treatment Providers (NAATP), a trade association that represents private providers, some of whom provide MAT and some of whom are opposed to it, published a blog entry July 7 accusing ASAM of supporting expansion of buprenorphine while at the same time endorsing inadequate treatment. The blog entry says that buprenorphine “merely arrests their addiction temporarily until the other aspects of the continuing care can
take hold.” And it then goes on to say that no continuing care — therapy, the recovering community experience, drug testing — takes place. “The addicted patient is given a prescription and told to come back in 30 days for another prescription. Maybe a 5 minute talk at best. It is not Medication Assisted Treatment (MAT). It is Medication AS Treatment,” Hightower wrote.

Hightower, who asked the NAATP president to share the link to the blog entry with the press, also accused Stuart Gitlow, M.D., president of ASAM, of having a conflict of interest. Hightower incorrectly wrote that Gitlow is medical director of Orexo, which makes Zubsolv, a buprenorphine medication. In fact, Gitlow resigned from that position two months ago, but Hightower could be forgiven for not knowing this, as it was not announced, and in fact we didn’t know until we asked Gitlow about it last week.

**Gitlow and ASAM respond**

Gitlow told *ADAW* that the medical director position was not in-house, and that he was an outside consultant as a medical director during the launch phase. “I still do hourly consulting, as I do for about 20 different companies and government agencies, for them but am no longer medical director,” he said. “My work outside my private practice has been industry consulting for almost 20 years, so this is simply another consulting contract.”

And he noted that he never had any financial incentive for Orexo to sell greater amounts of Zubsolv. In fact, the cap keeps him from prescribing buprenorphine to more than 100 patients, even though as a top addiction physician he has many patients who could benefit from this medication. That’s the ethical dilemma he is faced with daily: “Do I follow the law, harming a patient by not prescribing a drug with demonstrated benefit, or do I treat the patient properly, thereby breaking the law?”

All ASAM physicians are distressed by the cap on patients, said Gitlow. “No other disease, no other specialty, and no other medication are limited in this manner,” he told *ADAW*. “A typical private practice addiction specialist physician can easily have 500–700 patients being regularly seen at varying intervals and at various levels of intensity. To suggest that such a physician would be able to prescribe any one medication to only 100 of these individuals has always been an absurd proposition leaving our hands tied despite waiting lists of hundreds of opioid addicts and an epidemic of addictive illness that we could address but for this legislated cap.”

It’s only because of the stigma of addiction that this “cap” approach is used, said Gitlow.

‘There’s no reason to punish the opioid addict in the meantime.’

Stuart Gitlow, M.D.

He also pointed to “bizarre market conditions” in which diversion of buprenorphine is actually increased as a result of the cap — potential patients who can’t get access to treatment. “Further, a few physicians have taken economic advantage of the situation by charging atypically high amounts for patient visits, something that would not be possible if a normal marketplace without restrictions were in place,” he said.

By removing the cap, diversion would be reduced, predatory pricing by physicians would be eliminated, and inappropriate prescribing would be removed or reduced, he said. “So our opposition to the 30/100 person cap is not new,” said Gitlow. “What is new is Washington’s receptivity to the issue, in part because of the reduction in stigma of addictive disease and in part due to the epidemic of opioid use in particular.”

Finally, Gitlow said the distinction between “medication-assisted treatment” and “medicine as treatment” is a false one. “This is, simply, treatment,” he said. “Just as treatment for hypertension includes counseling, dietary changes, behavioral modification and sometimes medicine; just as treatment for diabetes includes counseling, dietary changes, behavioral modification and sometimes medicine; treatment for addictive disease includes counseling, behavioral modification and sometimes medicine.” The term “medication-assisted” could be used for any disease, just as could “medicine as treatment,” he said. “But in fact for nearly all chronic potentially fatal conditions, the truth is a mixture of the two.” So treatment, not MAT, should be the phrase.

Asking whether therapy is being provided in addition to buprenorphine is a “red herring,” said Gitlow. Counseling is important, but it has nothing to do with the cap, he said. “I’m annoyed that the implication of the discussion is that we do not provide counseling at the same time as we write a prescription.”

That said, Gitlow admits that the sad fact of the matter is that some physicians do not provide such counseling, either for addiction or for diabetes. “I know we have some ‘hard liners’ who don’t want any medication, but most of us believe in the ‘sensible use’ of medication,” he said.

**NAATP and ‘sensible use’ of MAT**

Meanwhile, Walsh of NAATP is wrestling with an intensely controversial question among his membership. “I know we have some ‘hard liners’ who don’t want any medication, but most of us believe in the ‘sensible use’ of medication,” he said.

NAATP has been invited to discussions about this issue with the Office of National Drug Control Pol-

Continues on next page
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icy but, said Walsh, “we haven’t had the comprehensive collaboration I would hope to have over such an important issue.”

Still, whether or not someone is pro-MAT or not, they should be asking the questions in Hightower’s post, said Walsh. “If research shows that these treatments are recommended to be used in conjunction with therapy, how does this happen? Does this happen? What kind of therapy? For how long, for how often and with whom? How much training do the physicians have in addiction treatment? Are they working with counselors or counseling groups to ensure the therapy actually happens? Do they drug test to make sure the clients aren’t using alcohol, benzodiazepines, etc. in conjunction with the MAT?”

Although NAATP is not opposed to MAT “per se,” Walsh said that “there seems to be a rush to get this drug available to everyone,” said Walsh. He is concerned that a physician with a few hours of training shouldn’t have the same ability to provide buprenorphine treatment as a physician with a background in addiction treatment, as well as the support services “and all that comes with treating addicts.”

Walsh, like ASAM and ONDCP, is concerned about the patients who can’t get treatment because of the high numbers of patients seeking buprenorphine. “My concern is that certifying more physicians who don’t have the resources to comprehensively treat or lack a full understanding and knowledge of everything that is available for addicts is not the answer,” he said.

Editor’s note: We asked SAMHSA for a response to the NADCP letter. “Along with other approaches to this public health problem, addressing restrictions in prescribing of buprenorphine may increase the availability of one effective treatment for opioid addiction,” said spokesman Brad Stone. “SAMHSA continues to view prescription opioid and heroin abuse prevention, treatment and recovery as a top priority in accomplishing the agency’s mission to reduce the impact of substance abuse and mental illness on America’s communities.”

Faces & Voices supports retaining 42 CFR Part 2 as is

Comments on whether to loosen the confidentiality regulation applying to treatment records for substance use disorders (SUDs) are now in, and Faces & Voices of Recovery filed a clear statement supporting retaining the current protections. Under these protections, treatment history may not be disclosed to anyone without the patient’s individualized consent. Electronic health records (EHRs), according to some in the field, cannot be adjusted to incorporate this consent; in addition, other people say that the needs of integrated care require that all health care providers know about an individual’s entire health history.

The Substance Abuse and Mental Health Services Administration (SAMHSA), which promulgates 42 CFR Part 2, the confidentiality regulations, held an all-day “listening session” June 11 on weakening the regulations (see ADAW, June 16). Carol McDaid, representing Faces & Voices, the largest grassroots organization representing people in recovery, spoke at that session, and also filed comments stating that 42 CFR Part 2 can be retained without sacrificing the technical needs of EHRs.

Members of Faces & Voices reported being harmed by their treatment records being released. “After surveying our members, we learned that due to improper disclosure of their alcohol and drug treatment records, many individuals in or seeking recovery lost access to these basic benefits most Americans enjoy,” according to the comment. For example:

• “We spoke to a 29-year-old mother who lost her 3 year old in a child custody case because, after the unlawful disclosure of her addiction treatment records, she was deemed unfit by a judge and her child was put in the custody of child protective services.”

• “We met with a bright young lawyer who learned after two weeks at her new job that she would be terminated because the fact she was on methadone came up in a background check.”

Faces & Voices also received numerous cases where individuals were not able to get various types of insurance because their treatment records had been re-disclosed. “A small businesswoman had to give up her dream of owning her own business because she could not get a health insurance policy for her employees,” according to the comment.

In addition, ADAW has heard of numerous cases in which people in low-risk jobs were unable to get life insurance to protect their families, simply because they had the word “methadone” in their treatment records, or had been treated for alcoholism.

Currently only 10 percent of people with an SUD seek treatment. Removing the protections for SUD treatment confidentiality will further discourage people for accessing treatment, if such records can be used to prosecute them, deny them life insurance, or be used against them in a divorce or child custody proceeding, the Faces & Voices comment states.

“Faces and Voices of Recovery believes that patients in alcohol or drug programs should retain their power to decide when and to whom their records are disclosed, including to health insurance exchanges,
health homes and accountable care organizations, even for treatment and payment purposes,” the comment concludes. “Given the prevalence of stigma and discrimination in our society against those in or seeking recovery from addiction, we think the best way for patients to retain that power is by requiring patient consent for most disclosures, including a strong prohibition against re-disclosure.”

**OTPs from page 1**

rounding the fact that many technology vendors’ failure to include software to document methadone-dispensing functions in their products leaves OTPs with a limited number of options.

“Many vendors said they hoped to have that capability at some point in the future, but we couldn’t go with that,” Lisa Blanchard, director of outpatient operations at Spectrum Health Services in Massachusetts, told ADAW.

**Not starting from scratch**

A commonality shared by Spectrum and the other SAMHSA grantees involves some level of prior involvement in developing electronic records. For Spectrum, it had moved to electronic records for some of its other non-OTP treatment operations. At WellSpring Resources in Albion, Ill., an EHR had first been implemented in 2002 and was replaced by the CareLogic system last year.

“CareLogic did not have a specialty system for our opioid treatment program,” WellSpring Chief Financial Officer Mike Bozovich told ADAW. “So this grant opportunity from SAMHSA was great in terms of timing. We were seeking something Web-based that would integrate with our new EHR and could allow access to information remotely.”

CSAT’s Washington said the idea of the $750,000 grant program was to capture organizations that already had made some inroads in automating systems. Many already had begun building alliances with regional provider networks, and looking at more highly integrated care with mental health and primary care entities, he added.

At Spectrum, officials sought to identify an EHR system that would be effective for a network of 10 OTP sites (nine in Massachusetts and one in Maine) serving a current caseload of about 2,400. Some of the sites use methadone only, while others also dispense buprenorphine and injectable naltrexone, Blanchard explained. Some work with court-ordered populations such as repeat DUI offenders.

Spectrum ultimately selected Netsmart Technologies’ Avatar product for its EHR. Blanchard said it took about a month for each OTP site to be worked into the system at a rate of a couple of sites per week. “Eventually it will be implemented throughout our organization,” she said.

Blanchard sees the implementation of an EHR as paying major dividends in the highly regulated environment (both from the federal government and the states) in which OTPs operate. She said of Spectrum’s current level of progress, “So far it’s going OK. We’re not using all of what we’ll be able to over time.”

Quality-improvement areas that she sees as receiving a boost from the move to an EHR include better tracking of the extent to which client services are culturally responsive. Also, she said automation will allow

**HHS announces $100 million to help states improve Medicaid care, with focus on SUDs**

On July 14, the federal Department of Health and Human Services (HHS) announced a new program called the “Medicaid Accelerator Program,” which will invest more than $100 million in technical support to help states improve health care and decrease costs for Medicaid beneficiaries, with a focus on substance use disorders (SUDs). The July 14 announcement followed a July 11 informational bulletin from the Centers for Medicare & Medicaid Services (CMS) that went to state Medicaid directors. The entire focus of this bulletin is on medication-assisted treatment (MAT) for SUDs. The bulletin stresses that states, in paying for MAT, must ensure that the Mental Health Parity and Addiction Equity Act is followed.

The collaboration between CMS and states is hoped to “help jumpstart innovation by providing federal tools and resources to support states in advancing Medicaid-specific delivery system reform,” according to the HHS announcement.

Types of technical assistance include supporting “state-based innovative health care reform efforts by identifying and advancing new Medicaid service delivery and financing models to improve patient care by providing data analytics, improving quality measurement and rapid cycle evaluation capabilities, and advancing effective and timely dissemination of best practices and learning among states.”

Stakeholders were considering the implications of this last week. Stay tuned for more in coming weeks.


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Editor’s note: We will feature comments from both sides of the 42 CFR Part 2 discussion, as well as follow SAMHSA’s planning on this topic, in future issues.
Continued from previous page

Spectrum to establish a closer link between its client records and state Prescription Drug Monitoring Programs (PDMPs), which will enhance its risk management capabilities.

Washington emphasized the role of the federal grant as a catalyst for activity within the participating agencies, given that the total cost of acquiring and operationalizing an EHR far outpaces the grant amount. No plans for federal extension funding or a new round of grantees appear to be in the offing for now.

Fulfilling multiple goals

Bozovich explained that WellSpring selected Netalytics, Inc.’s MethaSoft product and expects to integrate it fully with the CareLogic EHR, resulting in a single system for billing and clinical documentation.

Bozovich cites these among WellSpring’s goals related to electronic records:

• Streamlined documentation to improve the productivity of clinical staff. “We can provide more direct service and spend less time documenting,” he said.

• Real-time outcome evaluation for every individual served in the organization. “We can tell what is working and what isn’t working more quickly and adjust our treatment schedule,” Bozovich said.

• More timely revenue capture. “In our old system we did double data entry into two systems,” he said. “Because MethaSoft and CareLogic integrate, we’re saving time and doing our billing more efficiently.”

Bozovich urges that OTPs or other providers considering a move to an EHR proceed deliberately, not being swayed too much by vendors but letting one’s particular business practices dictate what will be needed. He recommends evaluating multiple product options if available, and using the expertise of a multidisciplinary staff team in the selection process.

“You need people from multiple areas because the implementation will affect every part of your business,” he said. Physicians’ needs should be taken into account as part of this, he added.

Organizations also should be prepared to meet significant needs in staff training and retraining, said Bozovich. “Provide sufficient initial, refresher and retraining opportunities. This is a big one,” he said.

STATE NEWS

New England governors discuss Medicaid cross-border treatment

Five governors have announced a regional plan to address heroin addiction in New England. The strategy includes allowing patients on Medicaid to get treatment paid for out of state, to have prescription drug data cross borders and to launch a coordinated media campaign. The announcement on June 16 came after the five governors — all Democrats — met in a closed-door session at Brandeis University, the Hartford Courant reported June 17. Gov. Dannel P. Malloy of Connecticut, Gov. Deval Patrick of Massachusetts, Gov. Peter Shumlin of Vermont, Gov. Maggie Hassan of New Hampshire and Gov. Lincoln Chafee of Rhode Island met. Gov. Paul LePage of Maine, a Republican, was not part of that meeting. “We have a public health emergency,” Gov. Patrick said at a press conference following the meeting. “Individually we have moved initiatives in each of our states to combat abuse and increase prevention and treatment services … today we joined together to talk through whether there are opportunities to develop regional responses to bring an end to this epidemic.” Next month, the governors will discuss the issue at the New England Governors Association meeting.

In case you haven’t heard…

There’s nothing like the infusion of an additional $100 million to the addiction field to get every stakeholder out there looking at how to get hold of it (see boxed article on page 7). So far this week we have heard hopeful voices saying (1) that it could be used entirely for Vivitrol, (2) that it could be used entirely for prescriptions for various substance use disorders and (3) that there needs to be further discussions between stakeholders and the federal Department of Health and Human Services to agree on exactly how it can be used. We tend to agree with the third option. Whatever happens, it’s promising to be a hot summer in Washington, with discussions about 42 CFR Part 2, raising the buprenorphine cap and now additional money to fight over.