MCHRC
Maryland Community Health Resources Commission

GARRETT COUNTY HEALTH DEPARTMENT

Using Telehealth to Provide Medication-Assisted Treatment for Opioid Disorders

October 5, 2017

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Mark Luckner, Executive Director, Maryland Community Health Resources Commission

Our Presenters

- Kathy Beals, LCSW-C: Substance Abuse Clinical Supervisor at the GC Health Department
- Mark Luckner, MA: Executive Director of the Maryland Community Health Resources Commission
- Eric Weintraub, MD: Director of the Division of Alcohol Abuse at the Univ. of Maryland
- Bob Stephens, MS: Garrett County Health Officer

GARRETT COUNTY HEALTH DEPARTMENT

MCHRC Maryland Community Health Resources Commission

UNIVERSITY of MARYLAND SCHOOL OF MEDICINE

The Identified Problem

- Garrett County and Maryland are in the midst of a nationwide heroin epidemic
- The number of persons in treatment with a primary diagnosis of opioid addiction will increase from 12% in 2012 to 31% in 2017
- To treat opioid addiction it is important to have access to medication assisted treatment
- Maryland has 630 physicians on the SMAHSA registry to prescribe buprenorphine; Garrett County only has one physician who is prescribing buprenorphine
- Persons unable to be seen by that physician have to travel up to 120 miles daily to obtain medication assisted treatment outside of Garrett County

BACKGROUND ON THE CHRC

MCHRC
Maryland Community Health Resources Commission

- **The Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 to expand access for low-income Marylanders and underserved communities.**
- **Eleven Commissioners of the CHRC are appointed by the Governor.**
- **Since 2007, CHRC has awarded 190 grants totaling $60.3 million. Ninety-nine grants (totaling more than $26 million) have supported programs in rural areas.**
- **CHRC has supported programs in all 24 jurisdictions, which have served over 332,000 Marylanders.**
- **$60.3 million has leveraged $20.3 million in <u>additional</u> federal, private/non-profit, and other resources.**

Overview of the Project

Demonstrate a Tele Buprenorphine Expansion Program that will:

- Increase access to medication assisted treatment for persons with opioid addictions
- Provide a collaborative treatment approach that combines medication for the treatment of opioid disorders with supportive out-patient counseling
- Improve patient compliance for medication assisted treatment

METRICS FOR GARRETT TELEHEALTH PROJECT

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- **Process metrics**
  - Number of providers newly licensed to provide buprenorphine treatment
  - Number of new patients in medication-assisted treatment through Garrett County Health Department program
  - Number of patient treatment sessions
- **Outcome metrics**
  - Number of ED visits due to opioid addiction related overdose of program participants
  - Number of hospital admissions due to opioid addiction related overdose of program participants
  - Number of deaths due to opioid addiction related overdose of residents of Garrett County

HILLTOP EVALUATION

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- **The grant with Garrett County is one of four programs participating in an assessment by the Hilltop Institute at UMBC to determine the extent to which the interventions had an impact on health care utilization and costs for participating Medicaid beneficiaries.**
- **An interim report on basic demographic and Medicaid eligibility information for participants enrolled in the four projects is due November 30, 2017.**
- **The final report on the four project is due June 30, 2018.**

Opioid Epidemic

- 2 million Americans with substance use disorder due to prescription pain pills/2015
- 591,000 Americans with substance use disorder due to heroin/2015

TIME
They're the most
powerful
painkillers
ever invented.
And they're creating
the worst addiction
crisis America
has ever seen.
By Massimo Calabresi

Opioid Overdose

- Opioid overdose deaths have quadrupled since 1999
- 33,091 died of an opioid OD in 2015
- 91 Americans die of an overdose every day

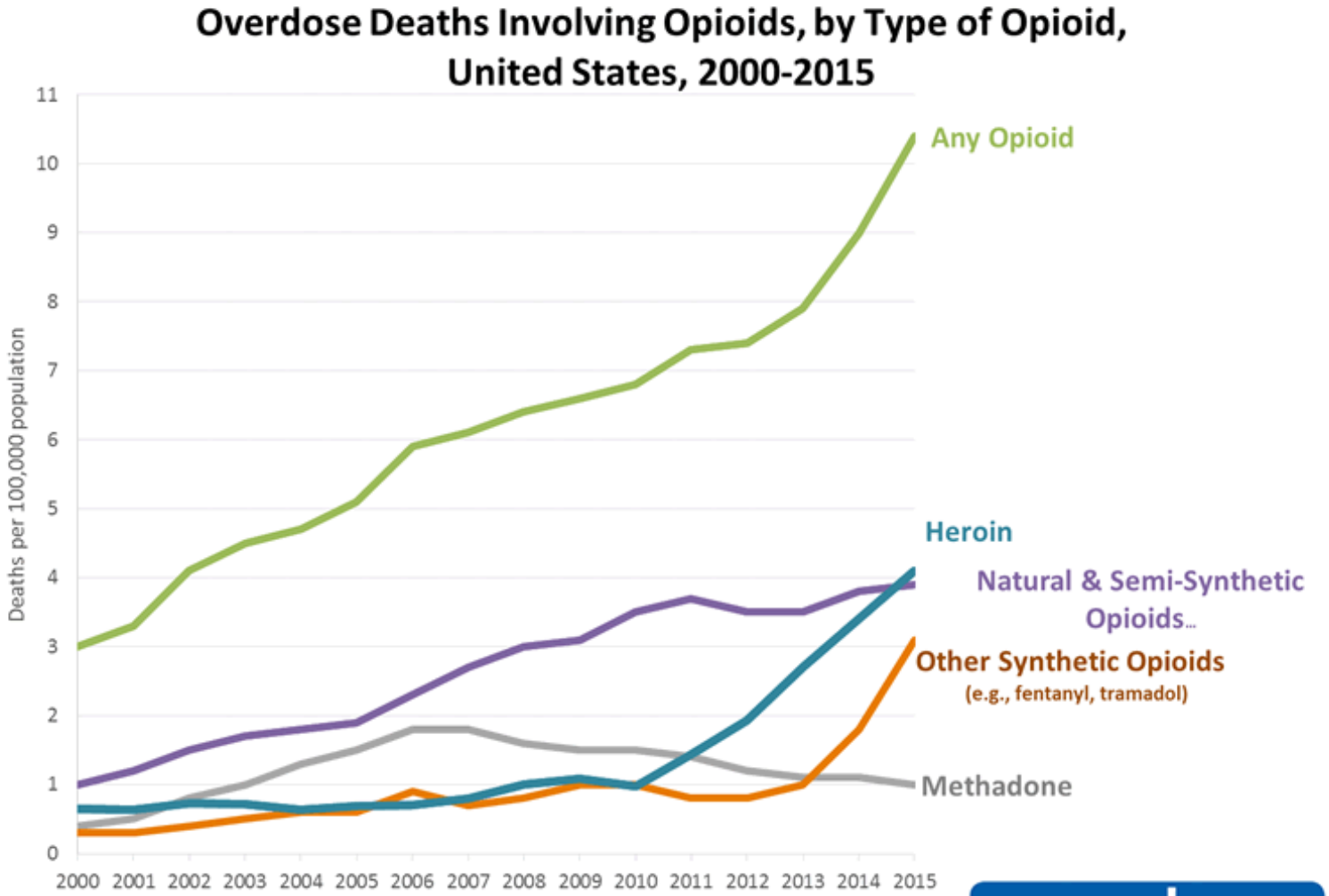
CDC

Opioid Overdose

- Drug overdose is the leading cause of death in the United States for individuals under 50
- Marked increase in middle-aged (45-54) mortality for white non-Hispanic men and women in US between 1999-2013
- Deaths from drug overdose now exceed those from firearms, motor vehicle accidents and the AIDS epidemic during it peak in the 1990's

Causes of Rapid Rise in Opioid Overdose

- Increase in prescription opioid availability
- Significant increase in supply of heroin and decrease in cost
- Increased availability of high potency synthetic opioids such as fentanyl



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2016. https://wonder.cdc.gov/.

www.cdc.gov
Your Source for Credible Health Information

Opioid Overdose Deaths 2016

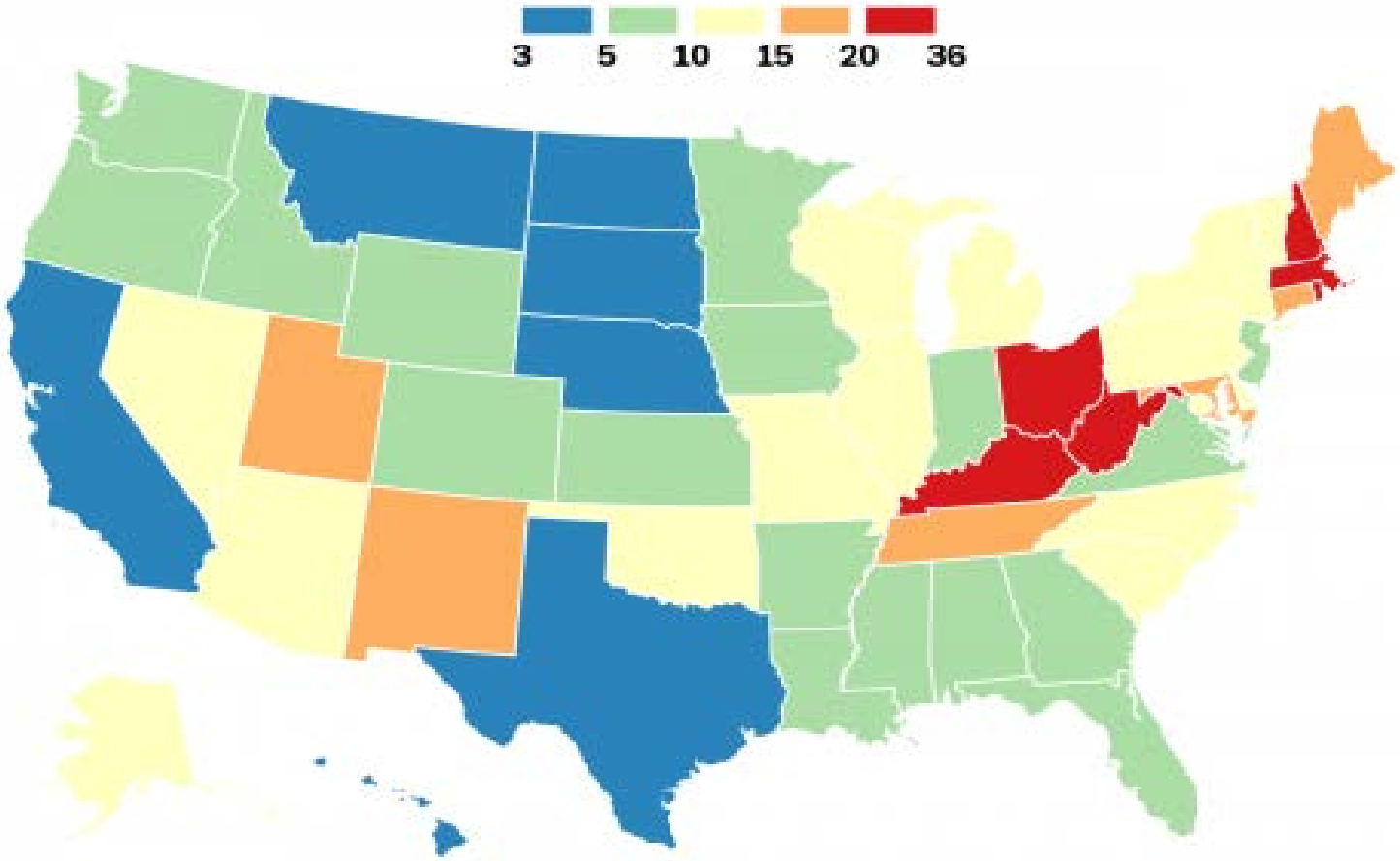
- Prescription opioids 14,400
- Heroin 15,400
- Fentanyl and its analogues 20,100
  1. Doubled in one year
  2. Increased from 3,000 to 20,000 in 3 years which is a 540%

Impact of Epidemic

- Acute care medical costs
- Children and families of overdose victims
- Pregnant addicted women
- Significant increase in rates of Hepatitis

Opioid deaths in 2015

Age-adjusted death rates (per 100,000) for overdose deaths from all opioid drugs



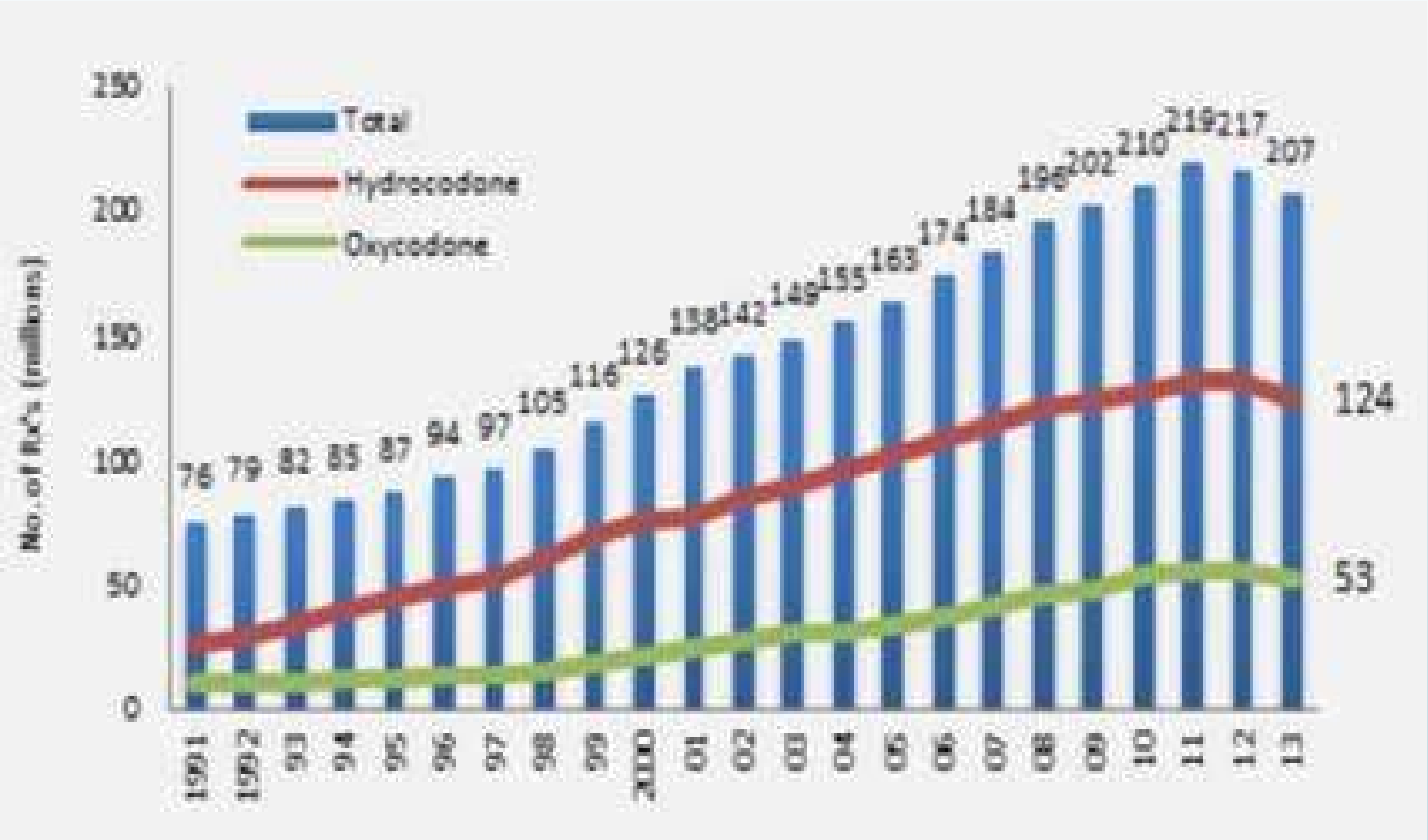
WAPO.ST/**WONKBLOG**

Source: CDC WONDER

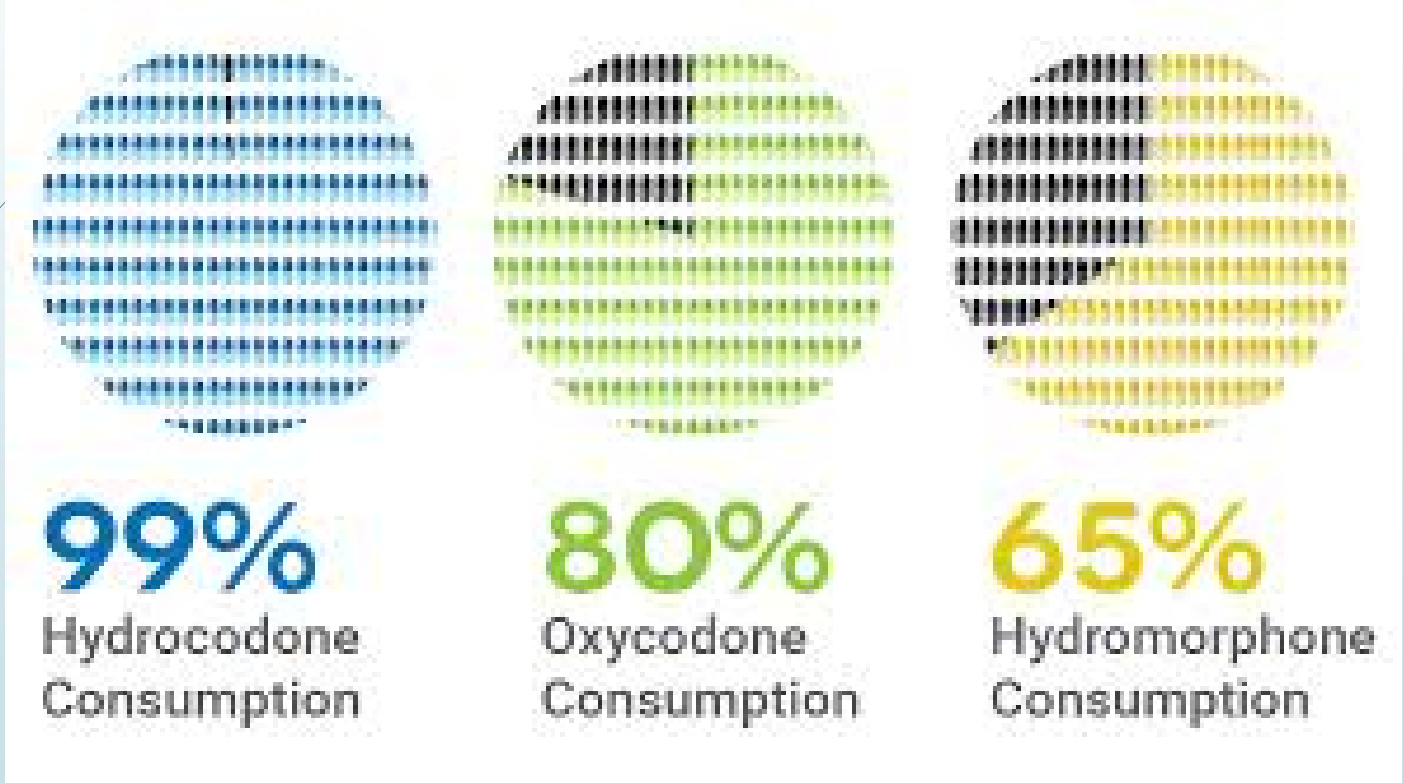
Prescription Opioids

- In 2012, 259 million prescriptions were written for opioids, enough for one bottle for each adult in US
- 80% of all opioids are prescribed in the US (4.6% of the worlds population)

Opioid Rx Dispensed by US retail pharmacies.



2010 US Consumption



After surgery, more than two-thirds of patients wind up with leftover rescription opioids, study finds

By Karen Kaplan
AUGUST 2, 2017, 8:00 AM

Surgical patients who are prescribed opioids for their pain are frequently left with unused pills, a new study finds. (John Moore / Getty

Rise In Opioid Prescribing

- 1980 NEJM Letter to Editor
- Russell Portnoy MD
- Pain is the fifth vital sign
- Use of opioids to treat non malignant pain
- Long acting opioids non-addictive
- Big Pharma
- OyContin
- Patient satisfaction

Pain
the 5th vital
sign™
American Pain Society

BUSINESS DAY

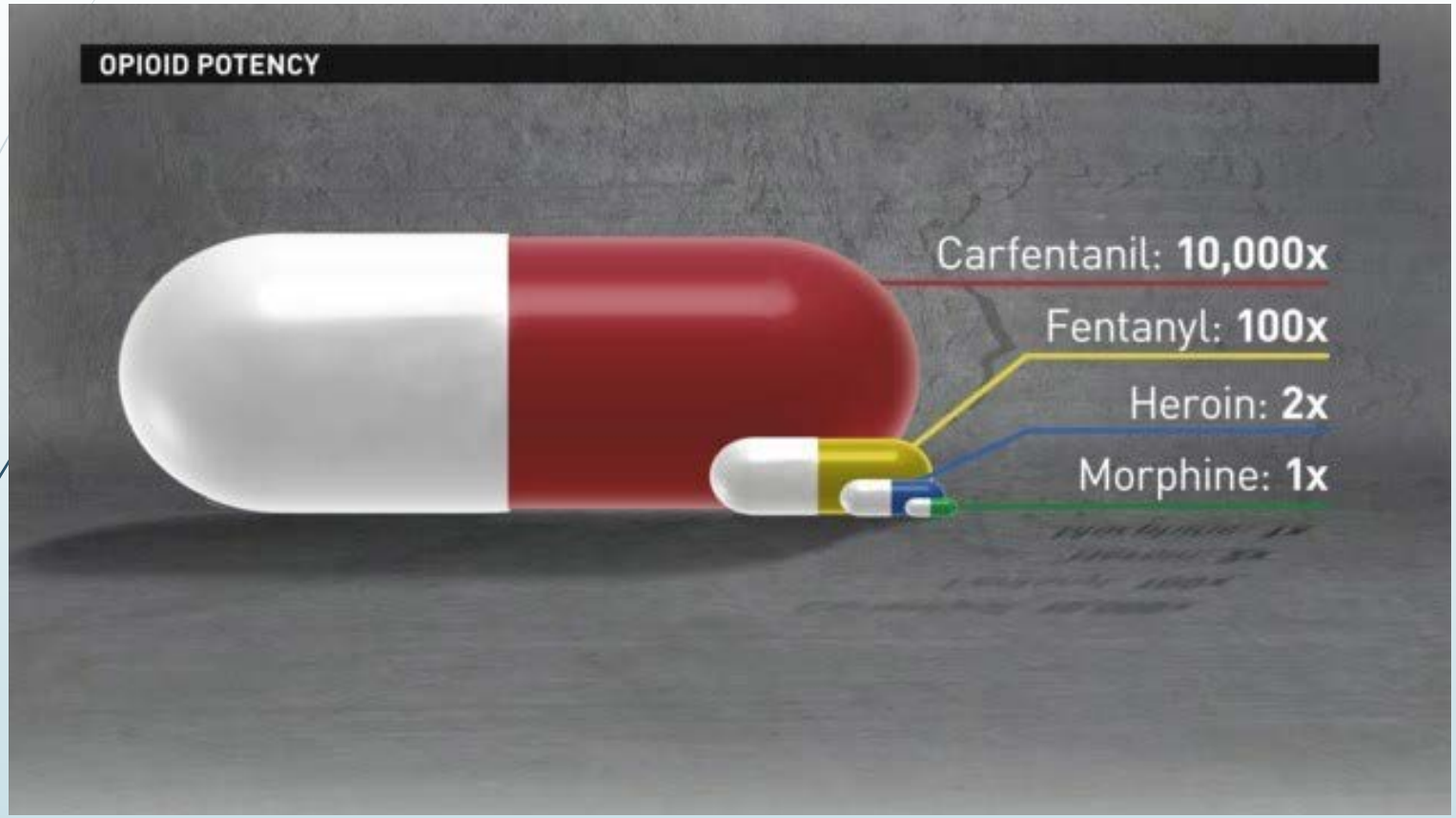
In Guilty Plea, OxyContin Maker to Pay $600 Million

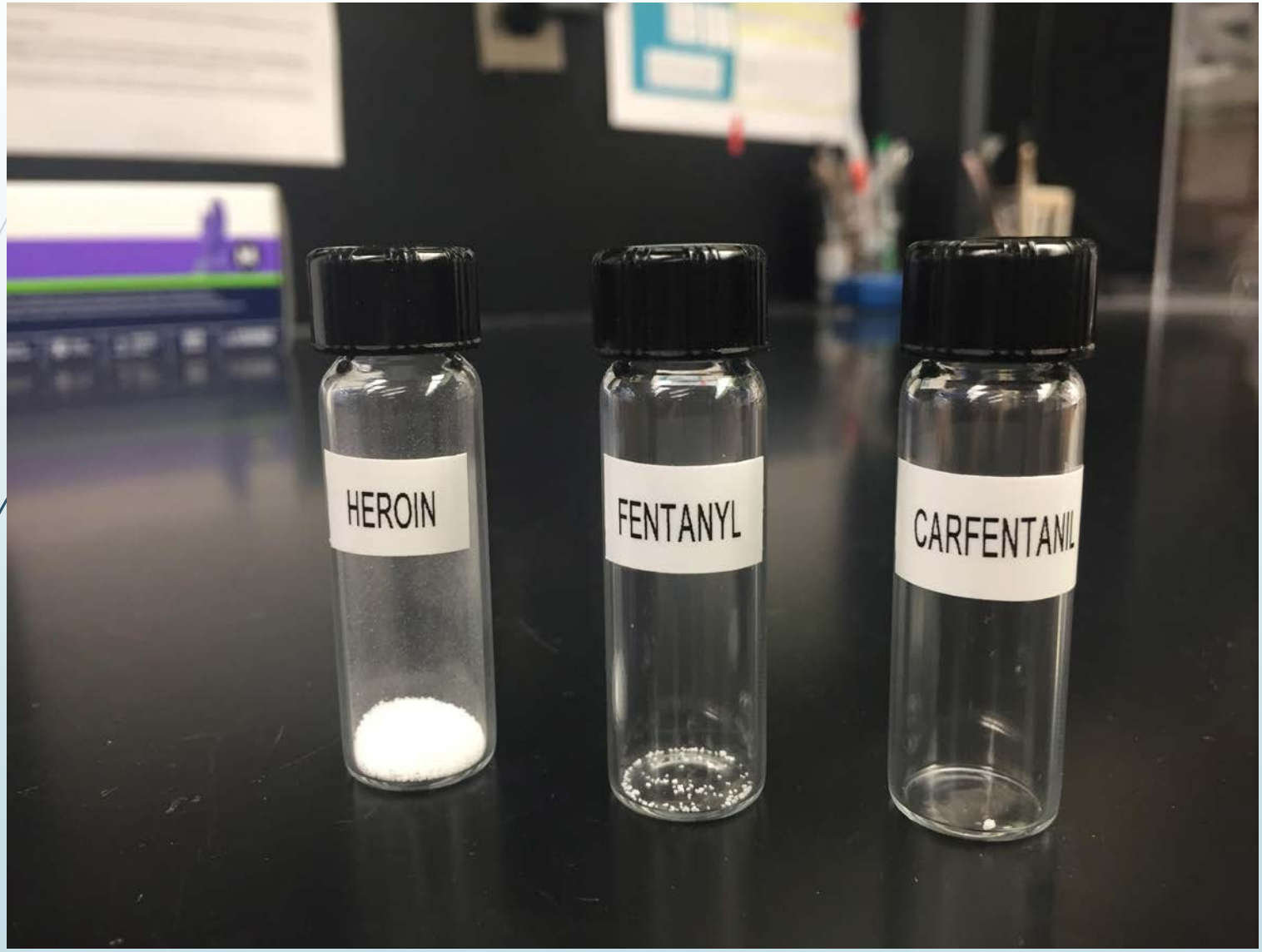
Heroin

- Users of heroin have approximately doubled since 2008
- Price of heroin has decreased dramatically since the 1980's and continues to drop (halved again between 2010-14)
- Supply has increased/seizures were up close to 150% between 2010-15
- Source has changed and now 80% of US heroin is being imported from Mexico
- Potency of heroin purer and more potent

Median bulk price of heroin per pure gram

Source: Office of National Drug Control Policy

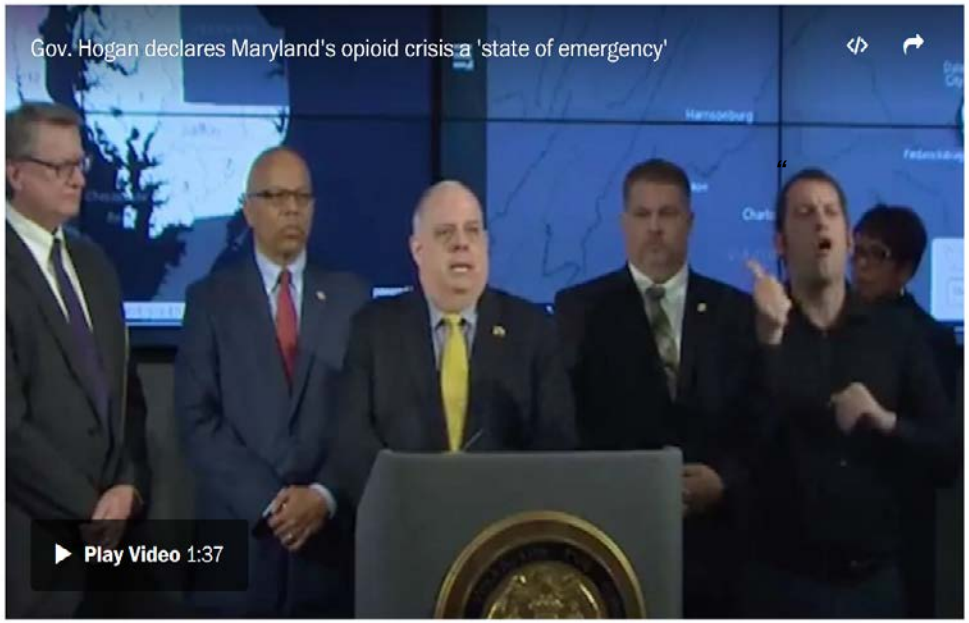

OPIOID POTENCY
Carfentanil: 10,000x
Fentanyl: 100x
Heroin: 2x
Morphine: 1x


HEROIN
FENTANYL
CARFENTANIL

The Washington Post

Maryland Politics

Maryland governor declares state of emergency for opioid crisis



At a news conference on March 1, Maryland Gov. Larry Hogan (R) said he will sign an executive order to declare the state's opioid crisis a "state of emergency," a legal step that will allow state agencies to better coordinate their response to the growing opioid addiction crisis. (Facebook/larryhoganmd)

By Bill Turque March 1

Deaths from drug, alcohol overdoses skyrocket in Maryland
Maryland health officials reported Thursday that fatal overdoses
are up 66 percent from 2015 to 2016.

Meredith CohnContact ReporterThe Baltimore Sun

Total drug and alcohol intoxication deaths for 2016

State: 2,089
Baltimore City: 694
Baltimore County: 336
Anne Arundel County: 195
Prince George's County: 129
Montgomery County: 102
Frederick County: 88
Harford County: 84
Washington County: 66
Allegany County: 59
Wicomico County: 48
Carroll County: 47
Howard County: 46
Charles County: 45
Cecil County: 30
Worcester County: 28

Source: Maryland Department of Health and Mental Hygiene

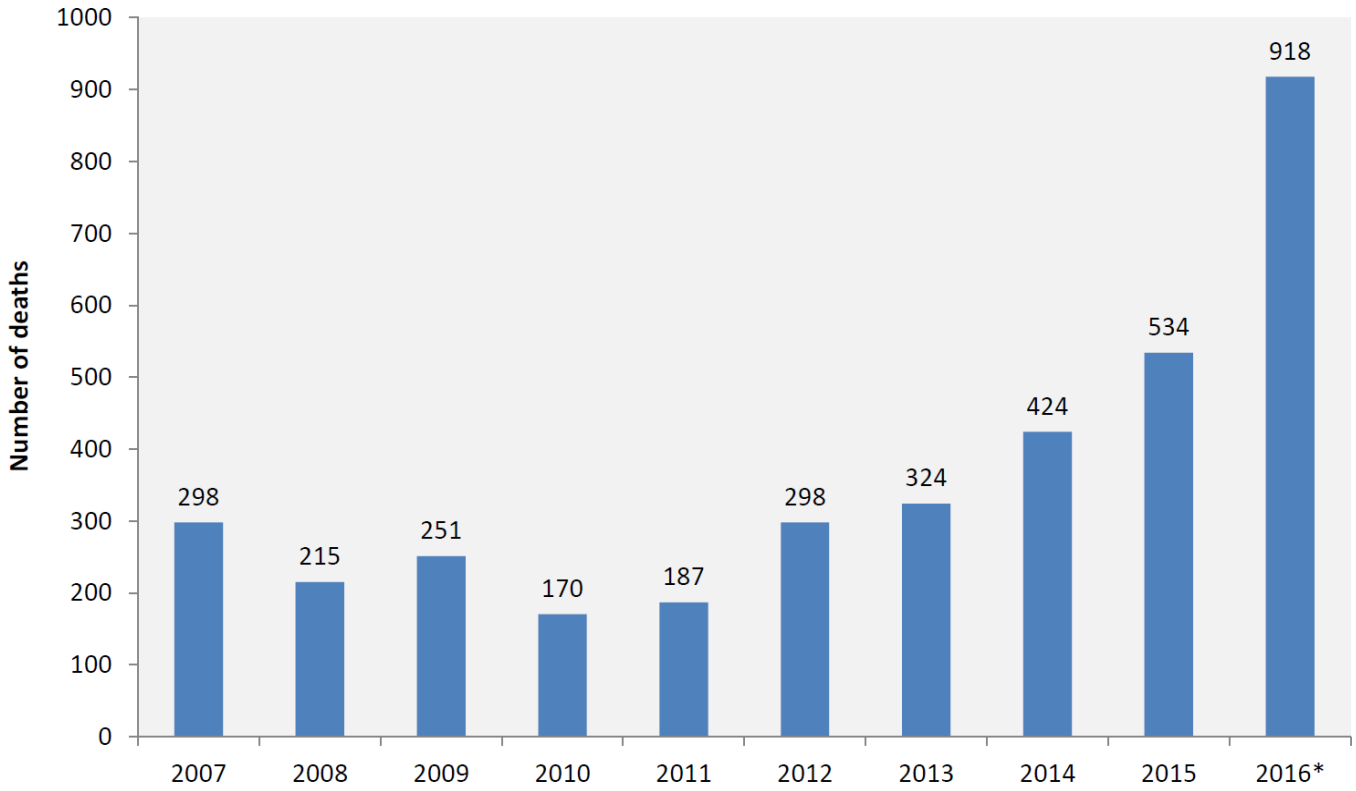
PROVISIONAL COUNTS OF DRUG OVERDOSE DEATHS, as of 8/6/2017

CDC • National Center for Health Statistics • National Vital Statistics System

Selected Jurisdictions	Drug overdose deaths			Data quality	
	Number of deaths for 12 month-ending			12 month-ending Jan-2017	
	Jan-2016	Jan-2017	% Change	% Complete	% Pending investigation
US Total	**52,898**	**64,070**	**21**	**99+**	**0.25**
22 Reporting Jurisdictions	**21,061**	**26,841**	**27**	**100**	**0.07**
Alaska	126	126	0	100	0.09
Arkansas	378	382	1	100	0.08
Colorado	913	970	6	100	0.05
Delaware	181	309	71	100	0.01
Florida	3,324	5,167	55	100	0.06
Georgia	1,299	1,366	5	100	0.10
Illinois	1,893	2,518	33	100	0.04
Indiana	1,228	1,566	28	100	0.02
Iowa	303	324	7	99+	0.00
Kentucky	1,253	1,480	18	100	0.01
Louisiana	890	1,015	14	100	0.01
Maine	270	359	33	100	0.11
Maryland	**1,303**	**2,171**	**67**	**100**	**0.04**
Minnesota	607	655	8	100	0.00
Missouri	1,096	1,384	26	100	0.02
Nebraska	122	112	-8	100	0.04
New York City	987	1,478	50	100	0.08
North Dakota	62	80	29	99+	0.28
Texas	2,593	2,799	8	100	0.18
Virginia	1,005	1,387	38	100	0.02
Washington	1,134	1,102	-3	100	0.04
Wyoming	94	91	-3	100	0.00

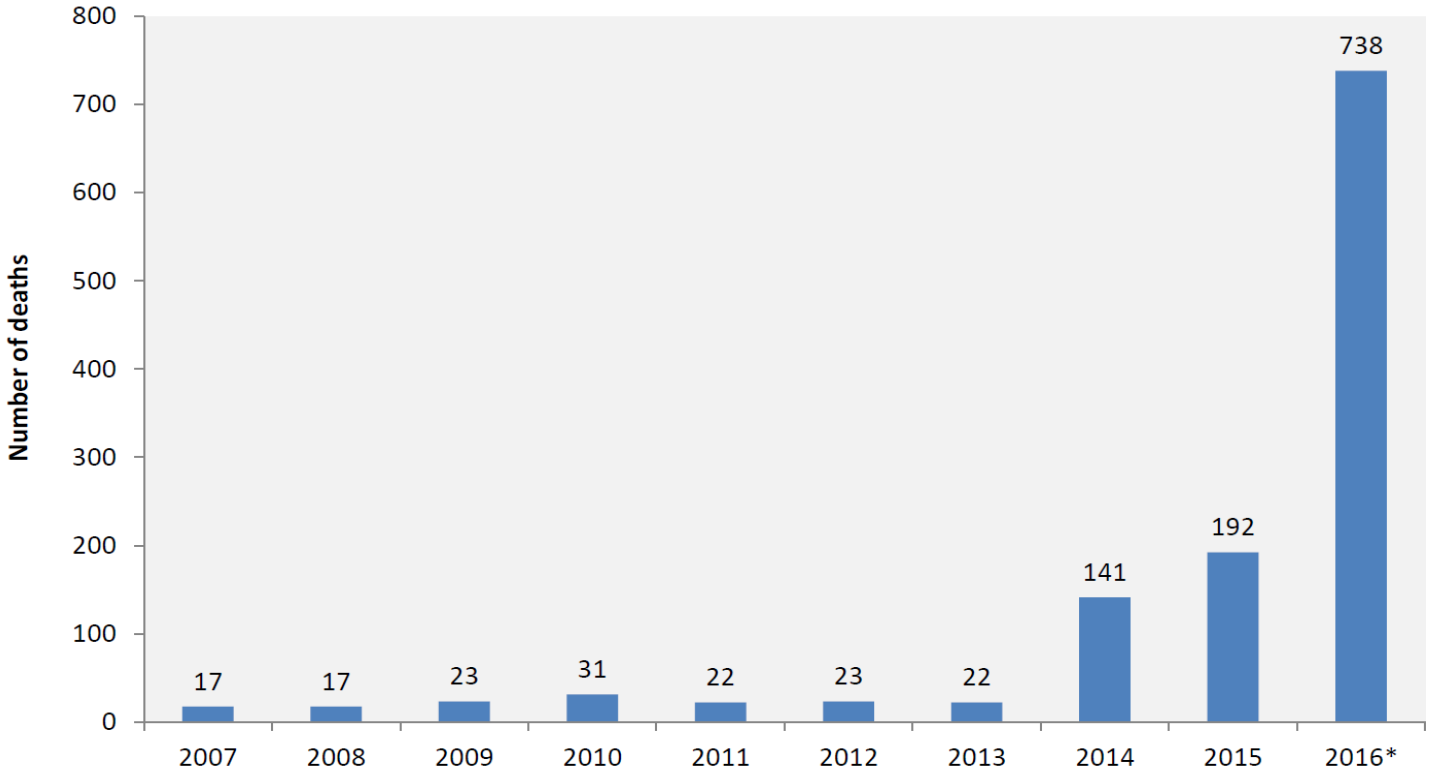
Drug Type	United States		Alaska		Iowa		Maine		Maryland		New York City		Virginia		Washington	
	Number of deaths ending 12 months in															
	Jan-16	Jan-17	Jan-16	Jan-17	Jan-16	Jan-17	Jan-16	Jan-17	Jan-16	Jan-17	Jan-16	Jan-17	Jan-16	Jan-17	Jan-16	Jan-17
Heroin (T40.1)	13,219	15,446	35	50	40	52	49	54	418	679	421	595	339	451	323	285
Natural and semi-synthetic opioids (T40.2)	12,726	14,427	60	40	76	87	108	131	394	712	222	337	270	346	272	281
Methadone (T40.3)	3,276	3,314	13	11	22	15	34	38	179	200	125	177	73	70	119	127
Synthetic opioids excluding methadone (T40.4)	9,945	20,145	13	10	47	61	111	208	386	1,222	154	628	263	692	61	101
Cocaine (T40.5)	6,986	10,619	9	15	17	18	32	58	154	328	308	537	168	263	86	82
Psychostimulants with abuse potential (T43.6)	5,922	7,663	27	55	61	11	23	31	21	48	49	60	45	68	316	338
Quality: % of overdose deaths with drug(s) specified	83%	85%	90%	99%	90%		99%		99%	99%	98%	100%	98%	99%	95%	93%

Figure 2. Number of Heroin-Related Deaths Occurring in Maryland from January through September of Each Year.*



*2016 counts are preliminary.

Figure 3. Number of Fentanyl-Related Deaths Occurring in Maryland from January through September of Each Year.*



*2016 counts are preliminary.

THE BALTIMORE SUN

"Opioid users filling Maryland hospital bed and emergency rooms"

Opioid Usage Impact in Maryland

- **Maryland ranked #1 among all states in 2014 in rate of opioid related inpatient hospital stays**

- **Maryland ranked # 2 among all states in opioid related Emergency Department visits**

*Agency for Healthcare Research and Quality
Healthcare Cost and Utilization Project

Medication Assisted Treatment

- Combination of medications with counseling and behavioral therapies to treat substance use disorders

Medication Assisted Treatment

FDA Approved

- **Methadone (Methadose; Dolophine)**
- **Buprenorphine(Suboxone; Suboxone Film; Subutex; Bunavail; Zubsolv)**
- **Naltrexone (Trexan; Vivitrol)**

Medication Assisted Treatment

- Recommended as treatment for opioid use disorders by the following:

  United States Federal Government

  American Society of Addiction Medicine(ASAM)

  World Health Organization

  United Nations

Barriers to Medication Assisted Treatment

- **Stigma**
  - **addicted to another drug**
  - **covering up the addiction**
  - **personal bias based on experience**
  - **adherence to abstinence based treatment**
  - **negative attitudes towards individuals with addiction disorders.**

Medication Assisted Treatment

- Decreases rate of overdoses
- Increases retention in treatment
- Decreases illicit opioid use
- Improves social functioning
- Decreases transmission of infectious diseases
- Decreases criminal activity

Rural America

- Disproportionally impacted
- Higher rates of opioid prescribing
- Demographic, economic and environmental factors
- Higher overdose rates
- Higher rates of neonates in withdrawal
- Physical jobs with more injuries
- Larger social networks

Barriers to Medication Assisted Treatment in Rural Areas

- Lack of methadone programs/less than 5% in rural areas
- Methadone programs are highly regulated and require frequent attendance
- Geography/ transportation/weather
- Lack of buprenorphine waivered physicians/ less than 2% in rural areas

Using Tele-Health for MAT The Mechanics

- Intake Process
- Rules and Guidelines
- Treatment Agreement
- Paperwork
- Personnel

Garrett County Health Department

"Working Together for a Healthier Garrett"

www.garrettcohealth.org

GCHD-SRD MAT Program Guidelines

1. Intake assessment with a therapist to establish an opiate related disease diagnosis, moderate or severe.
2. A urinalysis will be done at intake. If client is positive for other illicit drugs, a contract will be made to begin weaning off those substances.
3. Client must attend IOP or designated plan without any absences for a minimum of one week.
4. Client will sign a treatment contract.
5. Client will be seen by the nurse, prior to acceptance in the program, for a medical assessment.
6. Client will meet with the physician, prior to acceptance in the program, for a medical assessment.
7. Client, nurse, and physician to start induction.
8. After induction and stabilization, the nurse will meet with the client one time per week, or at the discretion of the treatment team.
9. The therapist will meet with the client to discuss any changes in the level of care recommended.

Criteria for entering the program:

- Client must attend IOP or designated plan, as designed by the Clinical Supervisor, without any absences for a minimum of one week prior to admission to the MAT Program.
- Opioid use disorder diagnosis, moderate to severe.
- Client UA for other medications or illicit drugs other than opiates need to be assessed.

Induction Phase:

- Doctor will write a prescription.
- Client will get the prescription filled at the Walgreens pharmacy and return to the Health Department Behavioral Health-SRD.
- The induction phase will be 2 days where the client comes in to meet with the nurse to receive their dose and be monitored by the nurse and trained therapist for 2-4 hours each day to determining the milligrams needed for each patient.
- Urinalysis
- Client will remain in one of the group rooms during the induction phase and be monitored by the nurse.
- Client will bring a lock box for their medication.

After Induction Phase:

- Client will see the doctor one time per week, or less, at the discretion of the doctor.
- Client will remain in IOP, or designated plan, until the treatment team feels they are ready to step down.
- The treatment team will determine the number of times the client will continue to attend per week.
- Continued weekly random urinalysis.
- Random pill count. If the client does not present on the day they are called for a pill count, they do not get their medication refill.

Criteria for staying in the program:

- Follow all the guidelines of the program stated in the treatment agreement signed by the client at admission into the program.
- Follow all treatment recommendations of the treatment team like referral to a higher level of care like:
    1. Return to IOP
    2. Inpatient treatment
    3. Outside support group attendance.

Criteria for discharge from the program:

- Refusing to follow through with treatment recommendations.
- Continued positive UA results for illicit drugs.
- Missing counseling or doctor's appointments.

Client Signature: _____ Date:_____

Therapist Signature: _____Date: _____

MAT Program Agreement

Garrett County Health Department

"Working Together for a Healthier Tomorrow"

www.garretthealth.org

Medication Assisted Treatment Program Agreement

As a part of participating in the buprenorphine protocol for treatment of opioid addiction, moderate to severe, I freely and voluntarily agree to accept this treatment agreement/contract as follows:

1. I agree to keep, and be on time to, all my scheduled appointments with the doctor, nurse, and counselor.
2. I agree to conduct myself in a courteous manner.
3. I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the doctor, nurse, or therapist will not see me, and I will not be given any medication until my next scheduled appointment.
4. I agree not to sell, share, or give any of my medication to another individual. I understand that such mishandling is a serious violation of this agreement and would result in my treatment being terminated without recourse appeal.
5. I agree not to deal, steal, or conduct any other illegal or disruptive activities in/on the Garrett County Health Department property.
6. I agree that my medication (or prescription) can be given to me only at my regular office visits. Any missed office visits will result in my not being able to get my medication until the next scheduled appointment.
7. I agree that the medication/or prescription I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reason for such a loss.
8. I agree not to obtain medications from any physicians, pharmacies, or other sources without informing my treatment team. I understand that mixing buprenorphine with other medications, especially benzodiazepines such as valium and other drugs of abuse can be dangerous. I also understand that a number of deaths have been reported among individuals mixing buprenorphine with benzodiazepines.
9. I agree to take my medication as the doctor has instructed and not alter the way I take my medication without first consulting the doctor.
10. I understand the medication alone is not sufficient treatment for my disease, and I agree to participate in the patient education and relapse prevention programs, as provided, to assist me in my treatment.
11. I agree to submit to a supervised urinalysis and breathalyzer testing upon request with no exceptions. I understand that failure to submit requests for testing will result in an automatic positive status. I understand that positive results from testing may result in modification of my treatment.

Client name :_____ Date: _____

Witness: _____ Date: _____

Approved: 11/9/16
P:/Forms/MAT/Treatment Agreement

MAT Patient Rights

Garrett County Health Department

"Working Together for a Healthier Tomorrow"

www.garretthealth.org

Medication Assisted Treatment

Patient Rights Statement

The medication treatment service you have enrolled in supports and protects the fundamental human, civil, constitutional and statuary rights of each patient. You have the right to:

1. Impartial access to treatment regardless of race, religion, sex, ethnicity, age, or handicap.
2. Be treated in a fashion that recognizes your personal dignity in all aspects of care.
3. Have your confidentiality protected in accord with federal and state statutes and regulations.
4. Request the opinion of a consultant at or request staff to review your treatment plan.
5. Not to be subjected to experimental or unusual procedures without your expressed informed consent.
6. Know the risks, side effects and benefits of all medication and treatment procedures. If these are not explained to your satisfaction, please ask the physician, nurse or counselor at your treatment location for additional information.
7. Be informed of other procedures available in addition to those you are currently receiving.
8. Refuse specific medication and treatment procedures, to the extent permitted by law.
9. Know that if you refuse medication or treatment, the clinic may terminate its relationship with you upon reasonable notice.
10. Know the cost of your care and the source and limitations of your funding (contact your primary counselor who can refer you to the Fiscal Department).
11. Know the reason for any proposed change in professional staff responsible for your care or for transfer either within or outside the facility.
12. Initiate a complaint or grievance procedure and obtain a hearing or review of the complaint.
13. Participate in the formulation of your treatment plan.
14. Participate in the formulation of your discharge and aftercare plans.

Patient signature: _____ Date: _____

Approved: 6/13/16
P:/Forms/MAT/Patient Rights Statement

Treatment Contract

Garrett County Health Department

Robert Stephens, MS, Health Officer
1025 Memorial Drive
Oakland, Maryland 21550

Public Health
301-334-7700 or 301-895-3111
FAX 301-334-7701
Equal Opportunity Employer

Treatment Contract

By signing below, I agree to the following:

1. Buprenorphine treatment for opiate dependence is most effective when combined with drug abuse counseling, 12-step recovery work, and/or a recovery support group. During my treatment with buprenorphine, I agree to attend counseling and to work on a program of recovery.
2. I understand that buprenorphine itself is an opiate (or "narcotic") and can produce "physical dependence," meaning that stopping it suddenly is likely to cause physical withdrawal symptoms similar to stopping heroin or opiate pain medication (but generally less severe).
3. I understand that on the day I start buprenorphine, I should come to the office already in opiate withdrawal. I will not use any opiate (heroin, methadone, codeine, or other opiate containing medications) after 6:00 p.m. the evening before I am to begin induction. If I do not have observable signs of opiate withdrawal, induction onto buprenorphine may be delayed a day or more.
4. I understand that take home doses and frequency of visits will be determined by how well I am doing.
5. I agree to take buprenorphine as prescribed at the dosage determined by my physicians, and not to allow anyone else to take medication prescribed for me.
6. I understand that I must have a means to store take-home supplies or prescriptions of buprenorphine safely, where it cannot be taken accidentally by children or pets, or stolen by unauthorized users. I agree that if my buprenorphine pills or film are swallowed by anyone besides me, I will call 911 or Poison Control at 1-800-222-1222.
7. I agree that, if my doctor recommends that my home supply of buprenorphine should be kept in the care of a responsible member of my family or another third party, I will abide by such recommendations.
8. While on buprenorphine or otherwise in treatment for addiction, I agree not to use any alcohol, any benzodiazepine medicine, sedatives, any illegal substances, or take any opiate medication without prior permission from my doctor (the doctor who prescribes my buprenorphine). If I have been taking regular long-term doses of benzodiazepines and are showing signs of addiction, a plan will be developed to slowly decrease these medicines with the goal of eventually discontinuing them, in a way that avoids any significant benzodiazepine withdrawal symptoms. If any opiate medicines may be needed, I agree to discuss this with my substance abuse doctor in advance, before accepting or filling any such prescription. If I take or am given any such medicines in an emergency (such as for acute pain or surgery) I will report this to the substance abuse doctor within 24 hours and bring the medication bottle with any remaining medication promptly to the treatment program.
9. I agree not to take other medications with buprenorphine without prior permission from my doctor. I understand that overdose deaths have occurred when patients have taken other medications (particularly medications like Librium®, Valium®, or other benzodiazepines) with buprenorphine.
10. I understand that if I continue to consistently use opioids despite buprenorphine treatment, it will be taken as an indication that buprenorphine treatment has not been successful, and I will be tapered off of buprenorphine and/or transferred to another form of treatment.

11. I understand that relapse or slip can cause a fatal overdose of heroin (or other opiate) which is more common during early recovery. This is because it takes only five days of abstinence to lose tolerance to heroin (the ability to tolerate a certain dose) or to methadone or pain pills. This means that if I use the same amount of heroin (or other opiate) that I used in the past, a fata overdose can result.
12. I understand that the goal of buprenorphine treatment is abstinence from opioid use and that, if I continue to use opioids for more than 60-90 days while on buprenorphine, I may be detoxified and transferred to a more appropriate form of treatment.
13. I understand that the goal of treatment of opiate dependency is to learn to live without abuse of drugs. Buprenorphine treatment should continue as long as necessary to prevent relapse to opiate abuse/dependence.
14. I understand that there is no particular time limit for the duration of buprenorphine treatment; it should be continued as long as necessary to prevent relapse to opiate addiction. Decisions about if, when, or how rapidly to tape are made by the physician, based on input and discussion with the patient and the treatment team.
15. I consent to periodic, random testing for drugs of abuse in order to help detect early relapse and to document my progress in treatment. This may be done through a urine or saliva test.
16. I understand that, once I am receiving prescriptions for buprenorphine, it will be prescribed in quantities to last from visit to visit. The frequency of visits depends on how I am progressing.
17. I understand that routine and random pill counts are a practice of the GGHD and I may be asked to bring in my medication. Lost prescriptions or buprenorphine tablets/films are serious issues and may result in discontinuation of buprenorphine therapy from this office. I have been informed that if I report that my supplies have been lost or stolen, that my doctors will not be requested or expected to provide me with make-up supplies. This means that if I run out of my medication supplies it could result in my experiencing symptoms of opiate withdrawal. Also, I agree that if there has been a theft of my medication, I will report this to the police and will bring a copy of the police report to my next clinic visit.
18. I understand that all staff has the responsibility to maintain my confidentiality. I agree not to share any information about other clients, including whether or not they attend this program, with anyone.
19. I understand that I have the right to be treated with dignity and respect, and the right to confidentially inform the treatment program of any instance where I feel I have not been treated with respect. I understand that the goal of treatment, including the goal of any changes in the frequency of visits or urine testing, is not for punishment but to help and support me in my goal of recovery.
20. **Women Only:** I agree to an initial pregnancy test and, for the remainder of my treatment, to tell the physician, nurse, or counselor if I become pregnant or even think that I may be pregnant. If I do become pregnant, the physician will discuss with me the options of switching to methadone or switching to another form of buprenorphine called Subutex® that does not contain naloxone.

It is acknowledged by my signature and date that I have read this agreement and understand that these details about buprenorphine treatment. I wish to be treated with buprenorphine through the Garrett County Health Department Medication Assisted Treatment Program.

Signature of patient: _____ Date: _____

Signature of provider obtaining consent: _____ Date: _____

Approved: 11/17/16
P:/Forms/MAT/Treatment Contract

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garretthealth.org
Toll Free Maryland Department of Health 1-877-463-3464
TDD for Disabled Maryland Relay Service 1-800-735-2258

Induction

- What treatment staff do the first day
- What Eric does
- Follow up
- Stabilization

Successes

- Data from across the State and for GC
  - Number of patients
  - Number who are now working
  - Number who are in therapy ≤ weekly

Challenges

- Diversion
- Stigma
- Political environment
- Staffing

Opportunities for replication

Questions

Thank You