



DDAP ASAM Technical Assistance Series

Questions and Answers

November 1, 2021

1. Will these slides be shared after the presentation or are they available for download now?

Yes, the slides and the recording of the meeting have been posted to the DDAP website.

2. If we have direction from the NTP medical Director, we still need DEA approval to act on that recommendation?

The Medical Director would have no authority once a prescribed medication is dispensed to the patient by a pharmacy.

If the client/patient leaves treatment Against Medical Advice (AMA) and leaves a supply of Methadone at the residential facility, the DEA will need to be consulted regarding the methadone.

The facility should work with their legal counsel to create a policy (maybe a patient waiver of rights) to address abandoned medication. If turned over to law enforcement to destroy the medication, best practice would be to carefully document and have a witness to any action taken.

3. Could DDAP please provide the contact information for whom at the DEA we should be contacting when patients leave AFA.

The NTP where the client receives Methadone will have a DEA contact. The residential program should alert the NTP, who will then alert the DEA.

4. Just to be clear, what is the difference between the "guidance" you're providing vs. the requirement of the regs. (e.g., urinalysis requirements)?

The "Guidance" outlines the applicable regulations the facilities need to apply. It is meant to help facilities navigate the requirements.

5. Will licensed Recovery Houses be required to accept participants on all forms of MAT?

Yes. Recovery House licensing regulations regarding resident rights provide that “Residents may attend a treatment facility of their choice outside of the drug and alcohol recovery house.”

6. Please provide a definition and examples of "Bridge Medications".

A “Bridge” prescription refers to the practice of Medical Providers inducting patients on buprenorphine in the ER and then providing a short-term prescription of the buprenorphine naloxone to patients who have an intake or assessment scheduled at a provider who can offer longer term, often more comprehensive care once they are released from the ER. Another example is a patient who is not able to get in to see a Buprenorphine provider close to home due to waiting lists, etc. and a Buprenorphine provider elsewhere can assess and induct the patient on Buprenorphine and provide a prescription or prescriptions of the medication until the patient can transfer to care with the provider closer to home. Please reference this helpful resource related to the practice of Bridge Medications. [Use of Medication-Assisted Treatment in Emergency Departments \(samhsa.gov\)](https://www.samhsa.gov/medication-assisted-treatment/emergency-departments)

7. Can we get the transcripts so I can get it to the appropriate people?

Yes, the slides and recording will be posted to the DDAP website at a later date.

8. We are 2.1 level of care. Do we need to transport to NTP their entire stay? We would encourage engagement with Case Management Services to support individuals in 2.1 LOC (any LOC really) with transportation needs.

Ideally, the patient should be able to receive all outpatient services in one setting to increase access to treatment.

Most Narcotic Treatment Programs are located in an outpatient setting, and ASAM Level 2.1 (Intensive Outpatient Programs) is a service that falls under an Outpatient License. NTP’s should be able to offer the 9-19 hours of programming required of an ASAM Aligned IOP program. PA Narcotic Treatment Program Regulations [28 Pa. Code Chapter 715. Standards For Approval Of Narcotic Treatment Program \(pacodeandbulletin.gov\)](https://www.pacodeandbulletin.gov/standards-for-approval-of-narcotic-treatment-program) state that NTP’s “Shall provide each patient an average of 2.5 hours of psychotherapy per month during the patient’s first 2 years, 1 hour of which shall be individual psychotherapy. Additional psychotherapy shall be provided as dictated by ongoing assessment of the patient.” 2.5 hours of counseling is the minimum, NOT THE MAXIMUM, and as stated in the regulation, all patients should be assessed and offered the amount of support they are indicated as needing in the assessment. This could include higher levels of care, including Intensive Outpatient Programs.

9. If a patient has to be administratively discharged for a crime or other serious offense, and MAT provider will not accept patient back, how should a facility proceed?

When the client/patient is referred from the NTP to the residential facility, the patient/client is NOT discharged from the NTP. Because they remain an active NTP patient/client, they should return to treatment at the NTP after the residential stay.

If a crime on premise occurs at the residential treatment facility, it does not apply to the NTP and would not be a reason for discharge from the NTP.