**CME:** This article is offered for *AMA PRA Category 1 Credit.*™
See **CME Quiz Questions** on page 7.

# The Potential Role of Urgent Care in Addressing the Opiate Epidemic

**Urgent message:** Opioid abuse, addiction, and resultant deaths have drawn the attention of both the medical community and governmental bodies from the local health department to the White House. Urgent care is a frequent destination for addicts trying to secure drugs illicitly—but it also has the potential to be the first stop on the road to recovery.

ROBERT S. CRAUSMAN, MD, MMS and JASON M. RAMOS

## Case Presentation

Manny is a middle-aged white male who presented to our urgent care for the third time in 2 weeks complaining of severe arthritic low back and left knee pain. Although he claimed to have a primary care physician, he reported that he was unable to obtain timely follow-up and requested a prescription of Percocet.

A review of the state prescription monitoring program (PMP) revealed that Manny had received numerous, near weekly, short-term prescriptions for Percocet and other narcotic analgesics from multiple medical providers over the preceding year; the treating provider's clinical impression was that the patient was "narcotic seeking" and likely abusing prescribed opiates.

The provider spoke candidly about this with the patient as they reviewed the findings on the PMP, and the patient was asked if he would like to be evaluated for possible treatment with the medication buprenorphine.

Although the patient initially denied that he was misusing narcotics and left the practice, he later returned and requested the evaluation—and subsequently began treatment.

He has now been on daily treatment with a buprenorphine-containing medication for many months, and regular reviews of his PMP have shown that he has no longer been receiving narcotic prescriptions from other providers.

## Opiate Epidemic

Opioid abuse and addiction is the dominant public health crisis of our time. The Centers for Disease Control and Prevention (CDC) estimates that this epidemic has claimed over 500,000 lives in the U.S. since 2000.[1] Opioids were involved in over 33,000 deaths in 2015, the most recent year for which data are available, and the numbers are increasing. States in the Northeast and South show the most significant change over 2014; and West Virginia (41.5/100,000 population), New Hamp-

©fotolia.com

**Robert S. Crausman, MD, MMS** is a Clinical Professor of Medicine at Alpert School of Medicine at Brown University and a partner at Ocean State Healthcare. **Jason M. Ramos** is an undergraduate student at Hofstra University. The authors have no relevant financial relationships with any commercial interests.

shire (34.3), Kentucky (29.9), Ohio (29.9) and Rhode Island (28.2) led the nation with the highest rates.[2] It is estimated that 2 million Americans abuse prescription opioids and another 500,000 abuse heroin.

Clearly, much has changed since 1999, when many advocated that pain be considered as a fifth vital sign, when many states enacted statutes compelling physicians to evaluate all patients for pain, and when so-called experts routinely minimized the risks of addiction.

Much more than physician overprescribing lay at the root of this epidemic. Homelessness, joblessness, mental illness, high rates of incarceration, inexpensive heroin, synthetic high-potency opioids (eg, fentanyl, carfentanil) and, perhaps critically, inadequate access to effective treatment are also very relevant. Still, prescriptions for opioids remain a central issue, with 249 million prescriptions having been written by U.S. prescribers in 2013 alone. We therefore have a multifaceted public health emergency with no simple solutions.

Fortunately, medication-assisted treatment (MAT) with methadone, buprenorphine, or naltrexone has been shown to effectively treat opioid addiction and reduce overdose deaths,[3] but currently only 20% of patients who could benefit actually receive MAT due largely to limited access. While historically MAT was limited to opiate treatment facilities (OTPs), since 2000 federal law has allowed for the use of buprenorphine by qualified practicing physicians in ambulatory care settings,[4] including urgent care.

## Urgent Care

Urgent care providers and centers have the potential to be very important in responding to this epidemic. There are approximately 9,000 urgent care centers nationally, located in every state and most communities, representing convenient and affordable access points to our healthcare system.[5]

First, urgent care centers can have an impact through appropriate prescribing and by implementing policies and practices consistent with CDC guidelines.[6]

These guidelines direct that risks and benefits of opioid analgesics be clearly reviewed through appropriate informed consent, and that mutually agreed-upon treatment goals emphasizing function (not analgesia) be established; that clinicians increase consideration for nonpharmacologic therapies prior to initiating medications, especially for nonmalignant pain; and that they recognize opioids should not be considered first-line therapy for either acute or chronic pain. When opiates are to be prescribed, the lowest effective doses of immediate-release preparations are preferred over extended-release or long-acting opioids. Particular caution should be taken for daily doses above 50 morphine mg equivalents, and with patients taking any other controlled substances—especially benzodiazepines, which should be avoided if possible—or if there is a history of illicit drug use or alcohol abuse. Only limited quantities of narcotic analgesics should be prescribed for acute injuries, typically only ≤3 days and almost never >7 days; and there should be no prescribing for chronic pain syndromes outside of a longitudinal provider-patient relationship.

Prescribers must also review state prescription monitoring program information, where available, to help identify patients at highest risk for abuse or diversion with each new prescription, and at least every 3 months for patients treated chronically. Patients should also be offered naloxone (eg, naloxone nasal 4 mg spray or naloxone auto-injector 2 mg Sc or IM) if they have any risk factors for overdose.

Second, patients with addiction often present to urgent care centers, making them appropriate sites for screening, applying brief interventions, and referral for treatment (SBIRT).

Third, urgent care centers are attractive as potential sites where patients could be introduced to and initiated on MAT with buprenorphine or naltrexone, and then either maintained or referred elsewhere.

Although urgent care centers generally focus on acute care services, fully two thirds offer services more traditionally offered in primary care, such as routine immunization, and 50% actually offer primary care.[5] Further, many patients, particularly millennials, identify urgent care centers as their only source of healthcare. Thus, the suggestion that urgent care centers provide MAT for opiate addiction treatment is very sensible and not without precedent.

### *Urgent care treatment models*

There are essentially three models of evaluation and treatment to be considered for urgent care.

| Three Treatment Models | | |
|---|---|---|
| Identify and refer | Identify, induce, and refer | Identify, induce, and maintain |

First is the straightforward *identify and refer* model. This is essentially the minimum standard for what should be done in any healthcare setting. Patients with addiction are identified; some immediate counseling

and education may be provided; and appropriate referral for definitive treatment is made. Unfortunately, many patients not offered immediate treatment will continue with illicit use of drugs; thus, this model is suboptimal.

Second, federal law, by virtue of the Drug Addiction Treatment Act (DATA) and the Comprehensive Addiction and Recovery Act (CARA) now creates the opportunity for prescribers in urgent care settings not only to identify but also to initiate treatment. This second model, *identify, induce, and refer*, has the advantage of timeliness, with patients subsequently being referred for further stabilization and maintenance.

Third, with appropriate referral relationships for mental health treatment, counseling, and primary care, patients can be *identified, induced and maintained* safely through an urgent care center. Subsequent visits can be scheduled to allow for better matching of staffing and patient flow. There is no expectation that subsequent visits be done as "walk-ins," although that is certainly a possible approach.

Billing to third-party insurers follows the typical evaluation-and-management code sets and guidelines.

There are many practices that bill cash for management of patients on buprenorphine. A full discussion of cash billing is beyond the scope of this article, but it is important to note that there are several pitfalls to this approach and to urge that providers review their relevant provider agreements, as many insurers consider addiction management to be a covered service; it may also be considered Medicaid and Medicare fraud and abuse.[7]

## Treatment

### *Waiver, screening, harm-reduction education, targeted assessment and MAT*

Many urgent care providers may be unfamiliar with the process and requirements for becoming a buprenorphine prescriber. We will therefore outline the process for doing so and review SBIRT; harm-reduction education, an addiction-focused patient assessment; and MAT with buprenorphine.

There are no medication-specific regulatory requirements for a prescriber to treat patients with naltrexone for alcohol or opiate abuse beyond familiarity with the medication, its risks, and indications. Unfortunately, we find the requirement that a patient be fully abstinent from opiates for 10 days while on oral naltrexone therapy before initiating injectable naltrexone to be limiting in urgent care settings. So, we will therefore note it as another *potentially* useful MAT but focus primarily on buprenorphine because of its comparative effectiveness, ease of use, and general ready acceptance by patients.

### *Waiver process*

Physicians at the turn of the 20th century routinely managed patients with opioid addiction by prescribing opiates. However, the federal government outlawed this practice in 1914 with the Harrison narcotics tax act, which ended the practice until 1965 with the advent of methadone substitution therapy in state regulated OTPs.[4] Still, community-based prescribers were not allowed to use methadone to treat addiction. In 2000, DATA permitted physicians who meet certain qualifications to treat opioid dependency with buprenorphine-containing medications in treatment settings other than OTPs.[8] However, only about 4% of physicians nationally have qualified to do this (and only about half of them are actively prescribing buprenorphine).

To qualify, a prescriber must be granted a waiver of the registration requirements of the narcotic addiction treatment act of 1974. Physician prescribers must have an active controlled substance registration with the DEA, a state medical license plus either board certification in addiction psychiatry or addiction medicine, or have completed a minimum of 8 hours of specific training provided by the American Association of Addiction Psychiatry, the American Society of Addiction Medicine, the American Medical Association, the American Osteopathic Association or the American Psychiatric Association. In 2016, CARA expanded this provision to allow nurse practitioner and physician assistant prescribers to also be granted a waiver.[9] To qualify, PAs and NPs must complete the same 8 hours of required education plus an additional 16 hours of specified coursework. (The process is explained on the website of the Substance Abuse and Mental Health Services Administration [SAMHSA; see https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training]).[10]

After being granted a waiver, a prescriber may manage up to 30 patients in the first year. Subsequently, the provider can apply for a cap extension to either 100 patients or, in certain circumstances, 275 patients. It is incumbent upon the prescriber to maintain accurate records documenting that they are functioning under these cap limits; FDA inspectors routinely do site visits to waivered providers to inspect these records. Of note, some states have additional regulations and requirements. Prescribers can generally review these requirements at the state medical board website.

***SBIRT***

Establishing a baseline approach to all patients that includes targeted screening for addiction coupled with real-time intervention with focused education and referral for treatment should be standard at all urgent care centers regardless of whether a site offers MAT. The SBIRT process for addiction can be implemented using the 5As approach (ie, ask, advise, assess, assist and arrange follow-up) familiar to many by virtue of its role in smoking cessation. As a practical matter, medical assistant staff can readily perform preliminary screening. The SAMHSA website has a page dedicated to helpful resources and validated screening tools (https://www.integration.samhsa.gov/clinical-practice/sbirt/screening).[11-13] Additional helpful resources are available at the Physician's Clinical Support System websites;[14] alternately, although not validated scientifically, a simple invitation from a medical assistant with a question such as "Would you like to discuss addiction treatment and recovery services with your provider?" is likely sufficient to prompt many patients.

***Harm-reduction education***

Thoughtful harm-reduction education should be widely implemented and can be offered efficiently to patients who abuse drugs in the context of a clinical encounter. Patients who abuse opioids should be educated regarding the importance of using clean, sterile needles—the importance of never sharing needles cannot be over emphasized. Also, by comparison, snorting is safer than injection, and smoking is least risky for overdose.

Patients who abuse opioids should be cautioned to avoid using drugs with strangers, in strange places, or when alone; should be advised to avoid mixing drugs such as heroin and prescription opiates, opiates and other drug types such as cocaine and benzodiazepines or using alcohol with drugs (all of which increase the risk of overdose); and to avoid obtaining drugs from unfamiliar sources.

They must also be educated about the effects of abstinence on drug tolerance. Specifically, an opioid abuser can overdose on a previously well-tolerated dose of narcotics after a period of abstinence such as might take place during incarceration.

Patients who abuse opioids, and their close contacts, should be offered a prescription for Narcan (naloxone HCl), which is rapidly becoming a minimum standard of care. They should also be taught to recognize the signs of an opiate overdose in others and to administer Narcan, and to activate emergency services. Signs of an opiate overdose that laypersons can readily recognize include small, constricted pupils, slurred speech, confusion, lethargy, reduced respiratory rate, blue lips, decreased responsiveness, confusion, and loss of consciousness.

***Focused history, physical examination and laboratories***

Appropriate use of MAT in an office-based setting necessitates performing a history and physical examination, as well as targeted laboratory testing. The substance use history should include attention to the circumstances and timing of initiation of drug abusing behaviors, relevant transition points, and their precipitants. Additional pertinent historical factors include a patient's experience with prior treatment; history of incarceration, domestic violence and abuse; social history, including attention to the patient's living situation and available home supports; family history of drug abuse or mental illness; and a listing of past medical and psychiatric problems, including depression, anxiety, ADD/ADHD, or bipolar illness. Coexisting mental health disorders are very common, with approximately 40% having a "dual diagnosis" at presentation.

We also ask about cigarette smoking, alcohol consumption, and other illicit use of drugs, specifically inquiring about cocaine, stimulants, benzodiazepines, hallucinogens, and including marijuana, inhalants, and bath salts.

A focused physical examination looks specifically for drug-related signs, eg, needle track marks, skin abscesses, heart murmurs, and jaundice. Recommended laboratories include urine toxicology, blood testing for hepatitis B and C and HIV; and consideration for tuberculosis skin tests and STD testing.

Not every patient will be an appropriate candidate for treatment in an urgent care center, and patient preference is only one consideration. The assessment appropriately also includes attention to the patient's ability to comply with expected behaviors and treatment plans. Treatment goals, risks, and alternatives should be reviewed; and patient and program responsibilities should be outlined in discussion and in writing with an informed consent document including criteria for dismissal.[13] Draft policies and forms are available at the Provider Clinical Support System website.[14] Patients may be referred to an OTP at the outset if treatment at the UCC is inappropriate.

***MAT with buprenorphine***

Once identified as appropriate, patients can be offered

**Table 1. Buprenorphine-Containing Medications Used in Treatment for Opioid Addiction**

| Trade name | Generic name | Recommended dose range** | Administration route | Form | Strength |
|---|---|---|---|---|---|
| Bunavail | buprenorphine and naloxone | 2.1 mg/0.3 mg–12.6 mg/ 2.1 mg daily | buccal | Film | 2.1/0.3, 4.2/0.7, 6.3/1 mg |
| Suboxone | buprenorphine and naloxone | 2 mg/0.5 mg–24 mg/ 6 mg daily | sublingual | Film, tablet | 2/0.5, 4/1, 8/2, 12/19.2 mg |
| Subutex* | buprenorphine | 4-16 mg daily | sublingual | Tablet | 2 mg, 8 mg |
| Zubsolv | buprenorphine and naloxone | 2.8 mg /0.72 mg– 17.2 mg /4.2 mg daily | sublingual | Tablet | 0.7/0.18, 1.4/0.36, 2.9/0.71, 5.7/1.4 mg |

**Brand discontinued in U.S. market, generic available*
***In practice, some patients require doses above recommended range*

MAT. In the office setting, the two options are buprenorphine-containing medications or naltrexone, available orally or as a monthly injectable preparation. As noted, focus of this treatment review will be buprenorphine; the reader is referred elsewhere for a discussion of the use of naltrexone.[15]

Buprenorphine is a partial agonist of the opiate mu receptor that differs significantly from full agonists (eg, methadone). As a partial agonist, buprenorphine only weakly activates mu receptors and simultaneously acts as a "blocker" of the same receptors. Thus, while increasing doses of full agonists such as methadone elicits ever-increasing effects including obtundation, respiratory suppression, and death, buprenorphine demonstrates an early plateau effect with limited additional effect above therapeutic dosing. Further, quite separately from naloxone, which is often included in available preparations (**Table 1**) as an abuse deterrent, buprenorphine has opiate-blocking properties and can precipitate opioid withdrawal if administered when a patient is still under the influence of opiates.[10]

Although transcutaneous preparations are available for treatment of pain, the FDA recently approved a 6-month implant for addiction, and injectable depot preparations are in trials; most patients on buprenorphine maintenance receive it sublingually or, less often, transbucally.

## Specific Drugs

### *Buprenorphine/naloxone (Suboxone)*

Of the buprenorphine-containing medications available for addiction treatment, Suboxone has been on the market the longest (approved in 2002) and is the most widely used. Unlike Zubsolv and Bunavail, Suboxone is offered in a generic form and at a lesser cost, which contributes to its popularity. All three include naloxone as an abuse deterrent.

There are two equipotent formulations of Suboxone available as either a tablet or more rapidly dissolving film, both of which must be administered sublingually in order for effective absorption to occur. Films are packaged in child-deterrent individual foil packaging, making them the preferred preparation if young children are in the home.

### *Buprenorphine (Subutex)*

Subutex, although discontinued in the U.S. market, is still available as a generic. It is recommended for pregnant patients or those who have an allergy to, or experience severe nausea with, the naloxone component of the combination preparations.

### *Buprenorphine/naloxone (Zubsolv)*

Zubsolv, another combination formulation of buprenorphine and naloxone, has better bioavailability than Suboxone; comparable dosages are obtained with fewer milligrams of buprenorphine. Zubsolv is said to have improved taste, mouthfeel, and ease of use but is not yet available as a generic. In our experience, the comparative differences in patient satisfaction are minimal.

### *Buprenorphine/naloxone (Bunavail)*

Like Zubsolv, Bunavail is more effective at lower milligram doses because of its better bioavailability. The buccal formulation allows for an easier, more convenient administration, as it does not preclude speaking after placement while absorbing and may be preferred by patients with dentures.

Of note, except in pregnant women, for whom Subutex is recommended, and patients with young children, for whom Suboxone films are standard, third-party insurers often limit prescribers to a single buprenorphine-containing product.

*"We are in the midst of a public health crisis whose impact is measured in overdoses, hospital admissions, and deaths."*

Once a medication is selected, medical assistance in taking the first dose is offered; this process, known as *induction*, requires that the patient be in mild to moderate opiate withdrawal. Opiate withdrawal can be measured by a standard instrument such as the clinical opiate withdrawal scale (COWS).[12] Too-early administration of the buprenorphine can precipitate acute, usually mild, withdrawal. In our practice, we do not stock narcotics on site and so give patients a prescription and instruct them to return with their medication for assessment of withdrawal, first dose administration, and observation for 1-2 hours thereafter.

After induction, there is considerable flexibility for visit frequency that allows for tailoring of the approach to an individual patient or to a specific treatment setting as patients progress through an early stabilization phase and move on to maintenance and potentially, later on, to medication tapering and discontinuation.[13]

## Ongoing Treatment and Monitoring

After induction, the expected standard for ongoing treatment and monitoring includes regular visits with urine toxicology testing. Patients may be seen several times during the first week for frequent dose adjustments as they are stabilized. Most patients quickly progress to weekly visits and then continue weekly until medication dosing is stable, urines are free of the substances germane to the patient, and they have entered counseling or begun 12-step meetings or both. We then gradually advance to 2-week and then 4-week visits. Although buprenorphine is a schedule 3 medication and refills are allowed, we have chosen not to see patients any less frequently then every 4 weeks.

Of note, some patients are already experienced with the medication through prior treatment or may have been purchasing it on the street and therefore decline to return for an induction. It is a reality of practice and we do not penalize patients, but rather ensure that they are aware of the associated risks. Once stabilized, most patients do well attending office visits regularly and continue to meet with a counselor and/or attend 12-step meetings.

SAMHSA recommendations specify a minimum of eight drug abuse tests annually.[11] We do toxicology testing, typically urine, at all visits. It is debatable whether point-of-care urine toxicology cups are adequate or if more formal laboratory-based confirmatory toxicology testing is necessary. We generally use point-of-care CLIA-waived urine toxicology cup testing and reserve formal laboratory-based confirmation testing for suspected false positives or negatives. Toxicology testing via oral secretions or hair samples are alternatives that we use occasionally to discourage substituted urines; observed urine testing can serve the same purpose. Some programs also include random urine testing. In addition, some programs employ pill or film wrapper counts at visits as an added measure to encourage and monitor medication adherence.

Some programs adopt a *three strikes and you're out* paradigm whereby patients are discharged after three "dirty urines." While this is common, our approach recognizes that "slips" are expected in recovery and are not considered a treatment failure. We use them as an opportunity to encourage learning, to motivate development of new behavioral tools, and often as an indication that increased counseling or medical visits are required. We place an emphasis on appropriate in-practice behaviors, timely attendance to scheduled visits, and compliance with treatment plans and required follow-up. We have zero tolerance for use of profanity or aggressive behavior in the practice, with staff or other patients or over the phone.

For patients with coexistent psychiatric diagnoses, comanagement with a psychiatrist is helpful. Whether an urgent care provider is willing to medically manage psychiatric comorbidity is one aspect that can be specifically individualized. In our own program, we are "benzo-free," choosing to only prescribe benzodiazepines infrequently, and generally only prescribe stimulants and mood stabilizers as a bridge until a patient can secure formal psychiatric follow-up. We do frequently initiate patients on selective serotonin reuptake inhibitor antidepressants for depression or anxiety, and often prescribe the alpha-2 agonist clonidine as adjunctive therapy.

## Integrating MAT into an Urgent Care Center

The integration of MAT into an urgent care practice can

take many forms, and there is clearly no "one size fits all." For programs that elect to implement an induce-and-refer model, evaluations and inductions may be offered at all hours of operation, as with most other walk-in type conditions. Alternately, strict scheduling is another reasonable option. For programs that elect to also provide maintenance therapy, a program may elect to see follow-up patients on a walk-in or a scheduled basis. Scheduled patients may further be sorted throughout the schedule or batched, depending on facility resources and availability. Finally, one should expect a program to evolve over time as the practice gains experience and comfort caring for patients in recovery.

## Discussion

We are in the midst of a rapidly evolving public health crisis whose impact is being measured in overdoses, hospital admissions, and deaths. These patients come from every conceivable demographic, as this epidemic has cut across all racial, ethnic, religious, geographic, and socioeconomic boundaries. They are our neighbors, friends, family members, and colleagues.

People suffering from addiction are already our patients and are often recognized by providers either because they volunteer the information and may ask for help, or by identification of associated behaviors such as doctor shopping and narcotic seeking, medical complications, or formal screening. Unfortunately, too often patients are not identified or, when recognized, not offered timely treatment; consequently, they continue to abuse drugs.

Our communities are struggling to find effective strategies and to respond with limited resources. MAT with buprenorphine is one of the few proven means of reducing drug abuse and overdoses and facilitating recovery, but there is very limited availability and a large unmet need. This represents both a critical failing of our healthcare system and an incredible opportunity for the field of urgent care medicine. Urgent care centers could and should be a vital component of our nation's successful response. Urgent care centers have become ubiquitous, have extended and weekend hours, and are widely recognized as easy access points into the healthcare system

At a basic level, all urgent care centers should prescribe appropriately, consistent with CDC and applicable state-specific guidelines; actively screen; offer harm-reduction education; provide prescriptions for naloxone; and refer patients for treatment. SBIRT is not yet standard, and adding it to any practice will save lives.

We advocate for an even more impactful role for urgent care. Ideally, patients presenting to an urgent care center should not only be screened, but, when appropriate, be offered MAT and then either referred or offered maintenance treatment on site.

A simple, hypothetical calculation demonstrates that if each of 9,000 urgent care centers in the U.S. offered MAT to only 56 patients, then all 500,000 individuals addicted to heroin could be treated. Further, this is an excellent example of how a practice can "do well by doing good." Each stable patient in maintenance is generally seen monthly, so a clinician practicing to the limit of a waiver (maximum 275) would add at least 3,300 additional patient visits to a practice's annual volume.

As urgent care centers continue to define their expanding role in our ever-changing healthcare system, we assert that treatment of addiction and recovery represents a most important and rewarding new area of practice. ■

**References**

1. Centers for Disease Control and Prevention. Understanding the epidemic. Available at: https://www.cdc.gov/drugoverdose/epidemic/index.html. Updated December 16, 2016. Accessed May 28, 2017.
2. Centers for Disease Control and Prevention. Drug overdose death data. Available at: https://www.cdc.gov/drugoverdose/data/statedeaths.html. Updated December 16, 2016. Accessed August 23, 2017.
3. Volkow ND, Frieden TR, Hyde PS, Cha SS. Medication-assisted therapies – tackling the opioid-overdose epidemic. *N Engl J Med*. 2014;370(22):2063-2066.
4. Courtwright DT. Preventing and treating narcotic addiction—a century of federal drug control. *N Engl J Med*. 2015;372(22):2095-2097.
5. Brundage SC, Burke GC, Chang JE, Chokshi DA. Convenient care: retail clinics and urgent care centers in New York. United Hospital Fund. Available at: http://nyshealthfoundation.org/uploads/resources/united-hospital-fund-convenient-care-report.pdf. February 2015. Accessed July 19, 2017.
6. Centers for Disease Control and Prevention. CDC Guideline for Prescribing Opioids for Chronic Pain. Available at: https://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf. Accessed August 23, 2017.
7. The Official Website of the Attorney General of Massachusetts. AG Healey sues treatment center for illegally profiting off of patients seeking treatment for opiate addiction. Available at: http://www.mass.gov/ago/news-and-updates/press-releases/2015/2015-04-22-center-for-psychiatric-medicine-complaint.html. Accessed July 30, 2017.
8. Substance Abuse and Mental Health Services Association. Legislation, Regulations, and Guidelines. Available at: https://www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines#DATA-2000. Accessed July 19, 2017.
9. Substance Abuse and Mental Health Services Association. Qualify for nurse practitioners (NPs) and physician assistants (PAs) waiver. Available at: https://www.samhsa.gov/medication-assisted-treatment/qualify-nps-pas-waivers. Accessed July 19, 2017.
10. Substance Abuse and Mental Health Services Association. Buprenorphine. Available at: https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine. Accessed July 19, 2017.
11. Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005, reprinted 2006.
12. Wesson DR, Ling W. The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs*. 2003;35(2):253–259.
13. Substance Abuse and Mental Health Services Association. SBIRT. Available at: https://www.integration.samhsa.gov/clinical-practice/sbirt/screening. Accessed July 23, 2017.
14. Provider Clinical Support System MAT Training. Clinical Tools. Available at: http://pcss-mat.org/opioid-resources/clinical-tools/. Accessed July 30, 2017.
15. Substance Abuse and Mental Health Services Administration. *Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.