Camden Coalition
of Healthcare Providers

The National Center
for Complex Health & Social Needs

Medications for addiction treatment

Providing best practice care in a primary care clinic

Grace Katie Bell, MSN RN-BC CARN PHN

Shelly Virva, LCSW FNAP

About the authors

Shelly Virva

Shelly serves as the Associate Clinical Director and subject matter expert for the National Center for Complex Health and Social Needs within the Camden Coalition of Healthcare Providers. Her passion for social justice and caring for vulnerable patients spans over 20 years working as a licensed clinical social worker. She has an extensive background working with people who suffer from addiction and co-occurring mental health disorders, chronic medical and early life trauma. She also has experience working for a regional payer of both commercial and government plans. As the expert on addiction and co-occurring disorders she was part of an interdisciplinary group working with high cost, high utilizing patients. Additionally, she was part of a multi-disciplinary team that started an ambulatory ICU for high frequency emergency department users and pregnant women with substance use disorder. In her current role she is part of an interdisciplinary team that provides coaching, training and model co-design for vulnerable populations in health systems and FQHCs around the country.

Grace Bell

Grace "Katie" Bell MSN RN-BC CARN PHN is a nurse consultant with Telewell Indian Health MAT Project offering Technical Assistance, mentoring and training for California Indian Health clinics as they develop Medication-Assisted Treatment programs. Ms. Bell has co-facilitated in the UCLA Hub & Spoke Learning Collaborative and is a monthly participant for UCLA's Tribal Project Echo for Indian Health primary care clinics throughout California. Katie is currently Nurse Case Manager for the Medication-Assisted Treatment (MAT) program at Chapa-De Indian Health in Grass Valley, CA. Board-certified in Addictions RN, Katie has been working with the medication buprenorphine/naloxone (Suboxone) since a 2001 Phase 3 NIDA clinical trial. Having developed programs for OUD and other substance used disorders in multiple settings including Dept. of Veteran Affairs, the Betty Ford Center, a methadone clinic and now Primary Care, she brings understanding of patient care and advocacy in a variety of health care setting and systems. Katie is also a MAT Nurse Consultant/Clinic Coach for Center for Care Innovations Addiction Treatment Starts Here Primary Care.

About the Camden Coalition

We are a multidisciplinary nonprofit working to improve care for people with complex health and social needs in Camden, NJ, and across the country. The **Camden Coalition** works to advance the field of **complex care** by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and wellbeing. Supported by a robust data infrastructure, cross-sector convening, and shared learning, our community-based programs deliver better care to the most vulnerable individuals **in Camden** and **regionally**.

Through our **National Center for Complex Health and Social Needs** (National Center), the Camden Coalition's local work also informs our goal of building the field of complex care **across the country**. Launched in 2016, the National Center exists to inspire people to join the complex care community, connect complex care practitioners with each other, and support the field with tools and resources that move the field of complex care forward.

00 Introduction to the MAT best practice toolkit

Executive summary

This toolkit is designed to help program administration and clinical care teams establish effective programs to treat opioid use disorder using medications for addiction treatment (MAT). It contains a compendium of knowledge from several disciplines and reflects years of experience working in addiction medicine and more specifically, working to care for persons with opioid use disorders.

Successful MAT programs do more than just prescribe and dispense medication: they must also be designed to address the complex health and social needs of the patients seeking care. After reading this toolkit, you will better understand best practice dosing and clinical workflows for MAT, and you will also learn how to consider the whole person needs of our patients, challenge the context of stigma within the walls of care, blend the best of dueling recovery ideologies, utilize evidence-based best practices, and incorporate program data for sustainability.

Why MAT?

Advancements in addiction medicine, specifically the areas of the brain most impacted by addiction, have increased the availability and effectiveness of medications to help treat this disease. Medications for opioid use disorder are evidence-based and, in combination with evidence-based behavioral health interventions, are best practice. In fact, methadone has been one of the most widely researched treatments for opioid use disorder, spanning over 50 years. The findings are consistent across studies, with significant reductions in substance use, criminality, healthcare costs including transmission of hepatitis C and HIV. The data also show a significant increase in employment and overall societal function.[1]

In 2002, buprenorphine was introduced for the treatment of opioid use disorder. Unlike methadone treatment programs, which requires daily onsite dosing, buprenorphine can be prescribed in office and community settings, significantly increasing access to treatment. "Under the **Drug Addiction Treatment Act of 2000 (DATA 2000)**, qualified U.S. physicians can offer buprenorphine for opioid dependency in various settings, including in an office, community hospital, health department, or correctional facility."[2] CARA (Comprehensive Addiction and Recovery Act) was signed into law by President Obama in 2016. This expanded buprenorphine prescribing privileges mid-level providers such as physician assistants and nurse practitioners, thus expanding access to treatment.[3]

[1] Joseph H1, S. S. (2000). Methadone maintenance treatment (MMT): a review of historical and clinical issues. *Mt Sinai Journal of Medicine*, 347-64.
[2] SAMHSA. (2019, July 23). Buprenorphine. Retrieved from Substance Abuse Mental Health Service Administration Website: **https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine**
[3] CADCA. (2019, July 23). Comprehensive Addiction and Recovery Act (CARA). Retrieved from CADCA Building Drug Free Communities: **https://www.cadca.org/comprehensive-addiction-and-recovery-act-cara**

Methadone continues to be a highly effective evidence-based treatment for opioid use disorder, however this toolkit focuses on buprenorphine and best practices for its use, in primary care and other office-based settings.

How to use this toolkit

Medications for addiction treatment programs provide the best care when they are designed using an interprofessional care team of prescribers, nurses, pharmacists, medical assistants, and substance use disorder and behavioral health providers. The collaborative work in MAT programs presents new challenges for busy primary care settings. Often, departments are not expected to integrate care as closely as an MAT program demands. Our hope is that the contents and guidelines embedded in this toolkit will support the unique collaboration strategies of your clinic. Take what you need, modify the documents to fit your program, and start a pilot. There are also many resources embedded within the toolkit for MAT programs in the midst of growth.

The MAT best practices toolkit is the result of extensive interprofessional team-based care and collaboration experience, designing programs and learning from our failures as well as our successes. Treating addiction within a primary care setting is often like fitting a square peg in a round hole. Our hope is that this toolkit can provide the practical program development and day-to-day operations information you need to develop a sustainable MAT program.

We are committed to making sure every person who suffers from the disease of addiction has readily available access to evidence-based treatments, including medications. Until that time comes, our mission continues.

Why the term "medications for addiction treatment"?

You have likely heard that MAT stands for "medication-assisted treatment" and may be wondering why in this toolkit we are calling it "medications for addiction treatment" instead. The decision to use this term throughout the toolkit is very deliberate. We hope you, the reader, will start to use **medications for addiction treatment** as well.

Stigmatizing language continues to create barriers for persons with substance use disorders, including preventing access to evidence-based medications and therapies. Changing the words we use matters. It is essential for all of us working in addiction medicine and healthcare in general to use non-stigmatizing language.

In a 2017 commentary published in the *Journal of Addiction Medicine*,[4] Dr. Sarah Wakeman writes, "The stigma surrounding the use of pharmacotherapy, in particular opioid agonist therapy, is arguably more potent and harmful than the general stigma about addiction. The most widely held and stigmatizing belief is the notion that medication is simply a 'replacement addiction,' 'substituting one drug for another,' or even 'liquid handcuffs.' Not only does this false notion of replacement or substitution misunderstand the definition of addiction, but it is quite literally killing people.

[4] Sarah E. Wakeman, M. F. (2017). Medications for Addiction Treatment: Changing Language to Improve Care. *Journal of Addiction Medicine*, 11: 1-2.

She goes on to say, "No other medication for other health conditions is referred to this way (medication-assisted treatment). Insulin is not medication-assisted treatment, but rather a lifesaving drug that revolutionized diabetes care despite the fact that other components of diabetes treatment aimed at behavior modification are important and complementary. Methadone and buprenorphine should be described no differently."

Words matter and such is our decision to use the term "medications for addiction treatment" vs. "medication-assisted treatment." Buprenorphine and methadone are both life-saving medications for the treatment of opioid use disorder, a chronic medical condition.

About complex care

Substance use disorder treatment is part of the larger framework of complex care, an emerging, interprofessional field of care that seeks to address the needs of people whose combinations of medical, behavioral health, and social challenges result in extreme patterns of healthcare utilization and cost. Our hope is that this toolkit also provides a contribution to the larger field of complex care.

Complex care was born out of the understanding that the US healthcare system often fails individuals with the most complex health and social needs, including many who repeatedly cycle through multiple healthcare, social service, and other systems without lasting improvements to their health or well-being. To see different results we must deliver care differently: care must be flexible, interdisciplinary, evidence-based, and centered on the needs, goals, and circumstances of the individual.

Not all people with complex health and social needs have substance use disorders, and not all people with substance use disorders have co-occurring complex health and social needs. However, because addiction can take over so many areas of an individual's life, many patients with substance use disorders benefit from a complex care approach.

Complex care works at the individual and systemic levels: it coordinates better care for individuals while reshaping ecosystems of services and healthcare, including integrating evidence-based addiction care into existing healthcare and social services. By better addressing complex needs, complex care can reduce unnecessary spending in both healthcare and social services sectors.

For more information on some of the key competencies of complex care, see Appendix A.

The importance of authenticity: A note from the authors

Working with patient populations with complex care needs, including those with substance use disorders, has taught us the absolute necessity of authenticity. Real, genuine connection with our patients is essential for change to happen. Patients suffering from the disease of addiction have experienced discrimination and disenfranchisement in our current healthcare system. The patients come into our clinics and programs seeking help and instead are often fired for aberrant behavior, or further stigmatized as "non-compliant" or "drug seeking."

All too often we blame our patients for our failings as a healthcare system. It is no wonder at all why our patients are guarded, mistrusting and "don't get better." As healthcare workers we have an obligation to aid in our patients' wellness. Being genuine, kind, respectful, and non-judgmental should be non-negotiable for all of us working with vulnerable patients. Every person has their own life experience, and getting to know the patient story is essential to helping patients heal. This happens best when we are genuine and authentic human beings. "Humans are hard-wired for connection. In the absence of authentic connection we all suffer."[5]

[5] Brown, B. (2018). *Dare to Lead. Brave Work. Tough Conversations. Whole Hearts.* New York: Random House.

Acknowledgements

We would like to thank the following agencies and people for all of the support, sharing of resources, and time given to developing this toolkit.

California Health Care Foundation

Camden Coalition of Healthcare Providers
National Center for Complex Health and Social Needs

Center for Care Innovations

Hill Country Health and Wellness

Signal Key

Alinea Stevens, MD
Medical Director
Chapa-De Indian Health

Annie Mascorro BSN, RN-BC, CARN, PHN
Chapa-De Indian Health

Brian Hurley MD, MBA, DFASAM
Addiction Psychiatrist
Director of Addiction Medicine
Los Angeles County Department of Health Services

Darla Clark
Chief Operating Officer
Chapa-De Indian Health

Dawn Wiest, PhD
Director, Action Research and Evaluation
Camden Coalition of Healthcare Providers

Emily Wasuna
Program Manager, Field Building and Resources
Camden Coalition of Healthcare Providers

Felicia Santiago
Junior Graphic Designer and Web Developer
Camden Coalition of Healthcare Providers

Gayle Christiansen, MCP

Hannah Mogul-Adlin, MPH
Communications Manager
Camden Coalition of Healthcare Providers

Hunter Gatewood, MSW
Founder and CEO
Signal Key

Julie Garchow, MD
Chapa-De Indian Health Auburn MAT

Lauran Hardin MSN, CNL, FNAP
Senior Advisor
Camden Coalition of Healthcare Providers
National Center for Complex Health and Social Needs

Lisa Davies
Chief Executive Officer
Chapa-De Indian Health

Mark McGovern, PhD
Professor
Co-Chief, Division of Public Mental Health and Population Sciences
Department of Psychiatry
Medical Director, Integrated Behavioral Health, Division of Primary Care and Population Health
Department of Medicine
Stanford University School of Medicine

Martin Leamon, MD
Professor of Clinical Psychiatry
University of California, Davis

Mavis Asiedu-Frimpong, JD, MPH
Director of Communications and Content Development
Camden Coalition of Healthcare Providers

Michael Quion, MD
Chapa-De Indian Health Grass Valley MAT

Mindie Smith, MA, LPC, CAADC, CCS
Director of Behavioral Health and Substance Use Disorders
Family Health Center Kalamazoo

R. Corey Waller MD, DFASAM
Principal
Health Management Associates

Sandy Newman, MPH
Principal
LSN Health Strategy

Scott Haga MPA, PA-C
Senior Consultant
Health Management Associates

Tammy Fisher, MPH
Senior Director
Center for Care Innovations

Teagan Kuruna, MPH
Senior Communications Manager
Camden Coalition of Healthcare Providers

Commonly used acronyms and abbreviations

ABC - Antecedent-Behavior-Consequence
ACEs - Adverse childhood experiences
ADHD - Attention-deficit/hyperactivity disorder
AMP - Amphetamine
ANCC - American Nurses Credentialing Center
AOD program - Alcohol and Other Drug program
ASAM - American Society of Addiction Medicine
ASI - Addiction Severity Index
ATSH - Addiction Treatment Starts Here
AUDIT-C - Alcohol Use Disorders Identification Test
BAM - Brief addiction monitor
BAR - Barbiturates
BH - Behavioral health
BH therapist - Behavioral health therapist
BHC - Behavioral health consultant
BHCC - Behavioral health care coordinator
BLS - Basic life support
BUP - Buprenorphine
BuTrans - Buprenorphine Transdermal System
BZO - Benzodiazepine
CAADC - Certified advanced alcohol and drug counselor
CATC II - Certified addiction treatment counselor (level II)
CBC - Complete blood count
CDC - Center for Disease Control and Prevention
CHS - Cannabinoid hyperemesis syndrome
CHW - Community health worker
CMO - Chief Medical Officer
CMP - Comprehensive metabolic panel
CMS - Centers for Medicare and Medicaid
CNS - Central nervous system
COC - Cocaine
COWS - Clinical opiate withdrawal scale
CPS - Child Protective Services
CURES - The Controlled Substance Utilization Review and Evaluation System
DAST - Drug Abuse Screening Test
DATA 2000- Drug Addiction Treatment Act of 2000
DBT - Dialectical behavioral therapy
DEA - Drug Enforcement Agency
DOJ - Department of Justice

DSM-5 - Diagnostic and Statistical Manual of Mental Disorders-5
DUI - Driving under the influence
DWI - Driving while intoxicated
E&M - Evaluation and management
eCW - eClinicalWorks
EMR - Electronic medical record
EMS - Emergency medical services
EtOH - Ethyl alcohol
FDA - The Food and Drug Administration
FQHC - Federally Qualified Health Center
GAD7 - Generalized anxiety disorder-7
HCP - Health care provider
HCV - Hepatitis C
HIE - Health information exchange
HIV - Human Immunodeficiency Virus
HRC - Harm Reduction Coalition
HTN - Hypertension
ICD-10 - 10th version of the International Statistical Classification of Diseases and Related Health Problems
IM - Intramuscular injection
IOP - Intensive Outpatient Program
LCSW - Licensed clinical social worker
LFTS - Liver function tests
LLMSW - Limited licensed master social worker
LMFT - Licensed marriage and family therapist
LMSW - Licensed master social worker
LOC - Level of care
MA - Medical assistant
MAT - Medications for addiction treatment
MDMA - 3,4-Methylenedioxymethamphetamine
MED - Morphine Equivalent Dose
MET - Methamphetamine
MME - morphine milligram equivalent
MRN - Medical record number
MTD - Methadone
NA - Narcotics Anonymous
NAS - Neonatal abstinence syndrome
NCM - Nurse care manager
NCM - Nurse case manager
NEG - Negative
NEJM - The New England Journal of Medicine
NICU - Neonatal intensive care unit
NIDA - National Institute on Drug Abuse
NMDA - N-methyl-D-aspartate
NP - Nurse practitioner
NPI - National Provider Identifier
NTP - Narcotic Treatment Program
Nx - Naloxone

OARS - open questions, affirmations, reflective listening, and summary reflections
OB - Obstetrics
OBAT - Office based addiction treatment
OBOT - Office based opioid treatment
OIH - Opioid induced hyperalgesia
OP - Outpatient program
OPI - Opiates
OTC - Over-the-counter
OUD - Opioid use disorder
PA-C - Certified Physician Assistant
PCP - Primary care provider
PCP - Primary care provider
PDMP - Prescription drug monitoring program
PHQ9 - Patient health questionnaire-9
PIHP - Prepaid Inpatient Health Plan
POS - Positive
PTSD - Post traumatic stress disorder
QI - Quality improvement
QID - Four times a day
RN - Registered nurse
ROI - Return on investment
RPR - Rapid plasma reagin
S/Sx - Signs and symptoms
SA - Suicide attempt
SAMHSA - Substance Abuse Mental Health Services Agency
SBIRT - Screening, Brief Intervention and Referral to Treatment
SDOH - Social determinants of health
SI - Suicide ideation
SL - Sublingual
SQ - Subcutaneous
SSRI - Selective serotonin reuptake inhibitor
SUD - Substance use disorder
TAPS1 or TAPS2 - Tobacco, Alcohol, Prescription medications, and other Substance 1 or 2 Tool
THC - Tetrahydrocannabinol
TNQ - Treatment needs questionnaire
UDS - Urine drug screen
URICA - University of Rhode Island Change Assessment
UTOX - Urine toxicology screen
VA - The United States Department of Veterans Affairs
VTAs - Ventral tegmental areas

00 Table of Contents

01 The spirit of our work

1. The science of addiction

Dopamine is the neuro-transmitter primarily responsible for pleasure and motivation. Addiction medicine expert and colleague, R. Corey Waller, MD, MS (Principal Health Management Associates) often says, "We need three things to survive (besides oxygen): food, water and dopamine." Dopamine is what motivates us to get out of bed in the morning, seek out food when we are hungry or water when we are thirsty. It plays a significant role in our brain's reward circuit pathway, a part of the brain that is essentially hijacked by addiction.

> "Addiction is defined as a chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences. It is considered a brain disorder, because it involves functional changes to brain circuits involved in reward, stress, and self-control, and those changes may last a long time after a person has stopped taking drugs." — National Institute on Drug Abuse

Drugs and alcohol, including nicotine and some prescription medications when misused, flood the brain with dopamine, creating a pleasurable euphoria. The reward circuit pathway not only involves pleasure, but also motivation and memory. Pleasurable experiences imprint memory, and motivation drives our desire for repeated pleasurable experiences. Because the level of dopamine released by use of drugs and alcohol is so much higher than a "normal" pleasurable experience, the motivation to re-experience this is greater.

Addiction is a combination of many factors and not everyone who uses substances develops the disease of addiction. The patients who come to us seeking help for their substance use very likely have developed the disease of addiction. Understanding the role of dopamine is important for all of us working with patients who suffer from addiction. The reward circuit pathway's role in motivation, memory and pleasure is ultimately essential to our survival. More information about dopamine, the brain and the science of addiction can be found **here**.

Common terms used in substance use disorders

- Opioid use disorder
  - A diagnosis made based on criteria set in the DSM 5. (see MAT Tools Appendix D & E)
- Diversion
  - Selling, trading, borrowing of prescribed medications and illicit drugs
- Misuse
  - Loss of control in spite of consequences
  - Taking more than prescribed
  - Combining prescribed medications with alcohol or dangerous CNS depressant medications not prescribed

Source reading for this section:

- Drugs, brains, and behavior: The science of addiction (National Institute of Drug Abuse): **https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/overview**

2. The history of the opioid epidemic — how we got here

OxyContin's role in the opioid epidemic

OxyContin was developed by Purdue Pharmaceuticals and introduced as a new pain medication for malignant pain in 1996. Aggressive marketing and lax regulation of OxyContin and other prescription opioids helped contribute to the current epidemic of opioid use disorder (OUD) in the US. Here's how:

> "The worst man-made epidemic in modern medical history." — Jackson County, MO lawsuit against opioid markers

OxyContin properties:

- Long-acting oxycodone – advertised as *less addictive*
- Morphine equivalent to 1 ½ doses of hydrocodone
- Binds to Kappa opioid receptor as well as Mu opioid receptor – offers more relief and more reward – *more addictive*

Marketing pain management:

The letter to the editor that started it all:

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients[1] who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER
HERSHEL JICK, M.D.
Boston Collaborative Drug Surveillance Program
Boston University Medical Center
Waltham, MA 02154

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

A recent analysis was done looking at the number of times this letter was cited as support for low addiction risk associated with using opioids to treat chronic pain.

"We identified 608 citations of the index publication and noted a sizable increase after the introduction of OxyContin (a long-acting formulation of oxycodone) in 1995 (Figure 1). Of the

articles that included a reference to the 1980 letter, the authors of 439 (72.2%) cited it as evidence that addiction was rare in patients treated with opioids. Of the 608 articles, the authors of 491 articles (80.8%) did not note that the patients who were described in the letter were hospitalized at the time they received the prescription, whereas some authors grossly misrepresented the conclusions of the letter." — **A 1980 letter on the risk of opioid addiction**

The manufacturer of OxyContin and others' successful marketing and lobbying efforts increased the demand for opioid pain management, demand which became institutionalized in America.

- The hospice movement initiated new interest in improving pain management.
- The VA introduced the Fifth Vital Sign – measuring and treating pain with every visit.
- The Joint Commission made pain into the "fifth vital sign" and therefore a requirement of care.
- Physician surveys gave patients opportunity to score their providers based on how well pain was managed.
- In 2007, the manufacturer of OxyContin and three senior executives pleaded guilty to federal criminal charges that they misled doctors, regulators and patients about the risk of addiction associated with this drug.

Diversion of prescription opioids:

Diversion is a legal term that describes the common behavior of trading, selling, buying, and sharing prescribed medications. The large demand for opioids, combined with lax oversight, led to widespread diversion of prescription opioids like OxyContin into the underground drug economy.

- "Pill Mills:"
  - They were often advertised as pain clinics, where large prescriptions for opioids were easily obtained with minimal assessment or diagnosis for "chronic pain" by unscrupulous medical providers.
  - They became a common source for the "river" of opioid pain medications flooding communities.
  - Many states looked the other way as this problem intensified.
  - Anecdotally, the VA (Veterans Affairs) system across America also became a well-known source for the pills that became a source of income or way to access other drugs of choice for patients.
- The "Pill Ladies"
  - The Great Recession of 2008, triggered by the collapse of banks, led to massive loss of jobs and income.
  - Diverted opioids hold high value and provided much-needed income.
  - Low-income senior communities became unlikely participants in the underground-diverted prescribed narcotics economy, and became the go-to place for illicit OxyContin, Norco, Morphine Sulfate, and Fentanyl.

Shift from prescription opioids to heroin:

As efforts to decrease prescribing opioids were implemented, fewer doses of pain pills were available. This drove the cost of diverted pain pills up, making heroin a cheaper, more available alternative across America.

- Increasing concerns about diversion led to the establishment of state-based Prescription Drug Monitoring Programs (PDMPs)
- 49 states currently have an active PDMP.

    - For more information about Prescription Drug Monitoring Programs and to see which states have a PDMP, visit **this website**.
- Here is an example of California's PDMP mandate:
    - The Prescription Drug Monitoring Program (PDMP) requires use of CURES (CA. PDMP). The Controlled Substance Utilization Review and Evaluation System (CURES) was certified for statewide use by the Department of Justice (DOJ) on April 2, 2018.
    - The mandate to consult CURES prior to prescribing, ordering, administering, or furnishing a Schedule II–IV controlled substance became effective on October 2, 2018. Visit **CURES** for detailed information regarding **CURES 2.0**.

Responding to the opioid epidemic — Community opioid coalitions:

Many coalitions have formed spontaneously throughout California and the nation to address the opioid epidemic.

- Opioid coalitions facilitate:
    - Education throughout the community
    - Warm hand-offs between agencies
    - Community-specific problem solving, such as improving Narcan access
    - Multi-sector communication and information sharing
- California Health Care Foundation sponsored a Safe Rx project in 2016, which supported the building of the coalitions.
- California's Hub & Spoke System of Services is an example of a grant that specifically funds and supports the forming and sustaining of community opioid coalitions.
- In Nevada County, CA, a coalition to build a crisis stabilization unit decided to continue as the SUD Coalition.
- These coalitions include:
    - Jail team
    - Chief of Police
    - Hospital CMO and other staff
    - FQHCs
    - County behavioral health
    - School prevention programs
    - Judges
- There are local, state, and national communities focused on prevention, access to treatment, narcan distribution, and community collaboration among other topics.
- There are also many web based opioid coalition resources, such as:
    - **https://againstopioidabuse.org/** and **https://www.asam.org/advocacy/coalitions**.

Key lessons from the opioid epidemic:

- Switching from prescription pain medications to heroin escalates the problem.
- Lack of access to care is at the heart of the epidemic.

Source reading for this section:

- California Health Care Foundation sponsored a Safe Rx project in 2016, which supported the building of the coalitions: **https://www.chcf.org/resource-center/cosn/**
- California's Hub & Spoke System of Services is an example of a grant that specifically funds and supports the forming and sustaining of community opioid coalitions: **http://www.uclaisap.org/ca-hubandspoke/**

- In Nevada County, CA, a coalition to build a crisis stabilization unit decided to continue as the SUD Coalition: **http://www.pncms.org/scm-foundation-coalition/rx-drug-safety-coalition.aspx**
- Prescription Drug Monitoring Programs: **http://www.pdmpassist.org/**
- CURES website: **http://www.mbc.ca.gov/CURES**
- CURES 2.0: **https://oag.ca.gov/sites/all/files/agweb/pdfs/pdmp/cures-mandatory-use.pdf**

3. Addiction, trauma, and resilience

Why trauma matters:

Trauma is often the root cause, or underlying issue, for many patients suffering from substance use and co-occurring mental health disorders. The prevalence of early life trauma in patients with addiction and co-occurring mental health disorders is undeniable.

> "The first question—always — is not 'Why the addiction?' but 'Why the pain?'" — Gabor Maté, MD, author, *In the Realm of Hungry Ghosts*

One **study** examining early life trauma and opioid use disorder found 81% of the patients had experienced one or more of the following: emotional, physical, sexual or witnessing violence.

"In the United States, 61 percent of men and 51 percent of women report exposure to at least one lifetime traumatic event, **and 90 percent of clients in public behavioral health care settings have experienced trauma.** If trauma goes unaddressed, people with mental illnesses and addictions will have poor physical health outcomes and ignoring trauma can hinder recovery. To ensure the best possible health outcomes, all care — in all health settings — must address trauma in a safe and sensitive way." **Source**

Key knowledge about addiction and trauma:

- The prevalence of early life trauma in persons with substance use disorders is high.
- It is essential we understand what trauma is and how it impacts the brain.
- Siloed healthcare does not work, especially when treating patients with complex needs, including addiction, mental health, and chronic medical conditions in addition to early life trauma.
- Guilt and shame prevail when someone stops using, and this is exacerbated for a person with a trauma history.
- Trauma-informed care is the expectation, not the exception.
- Behavioral health and medical providers alike should be knowledgeable about trauma and its impact on the brain, behavior, and function.
- Persons living in unsafe housing or experiencing homeless are living in survival mode, and sobriety is not always considered part of surviving.

The adverse childhood experiences (ACEs) screen (see Appendix F) can help clinicians uncover potential root cause early in the assessment process. Ask permission of the patient to ask difficult questions, and screen with sensitivity and respect. Patients often have a moment of insight into their disease when guided through this screen. Patients can also fill this out on their own if it is more comfortable for them.

Types of trauma

Maltreatment during childhood: "Upon an assessment of individuals who had experienced childhood maltreatment, a study found that being mistreated during childhood caused frequent and *extremely high levels of stress that impede normal brain development*. Continuous stress from experiencing frequent maltreatment initiated physiological stress responses that, over

time, caused the structural disruptions that were observed in neurological scans and which are likely making victims of childhood trauma vulnerable to substance abuse disorders." **Source**

Interpersonal trauma: Intimate partner or domestic violence is one type of interpersonal trauma. This is rooted in the abuser's need for power and control. It may take place in the form of emotional, physical, and/or sexual violence. The abuser will use fear, economic control intimidation, shaming, name calling, isolation of the victim from friends and family, and often escalates to physical and sexual violence, as a way to maintain control of the victim. Another example of interpersonal trauma is being the victim of a personal crime such as robbery or theft, and in particular violent crime such as rape or assault. Witnessing such crimes can also cause a trauma response.

Historical trauma: Historical trauma is defined by Maria Yellow Horse Brave Heart, PhD, as "cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma." **Source**

Groups that may experience historical trauma include:

- Indigenous people
- Enslaved people
- Holocaust survivors
- Undocumented immigrants/Dreamers/Latino communities

Intergenerational trauma: Intergenerational trauma is trauma transferred from the first generation of trauma survivors to the second and further generations of offspring of the survivors via complex- post-traumatic stress disorder mechanisms. It is connected to historical trauma.

Groups that may experience intergenerational trauma include:

- Children and grandchildren of Native people kidnapped and abused in boarding schools
- Children of combat veterans
- Children and grandchildren of addicted persons
    - The group **Adult Children of Alcoholics** is an example of healing response to intergenerational trauma

War and opioids

Historically, there are complicated relationships between war and opioid use among enlisted individuals and veterans. This includes:

- A large upsurge in opioid use as Civil War veterans returned home after being treated by morphine on battlefields. Laudanum (tincture of opium), a high potency and highly addictive opioid, was a drug of choice in the Wild West along with alcohol. The opium-smoking Chinese laborers who worked on the Trans-Continental Railroad and in gold mining camps were the early opiate users in the west before the Civil War.
- After the Vietnam War, there was an increase of heroin use throughout the general population. Some Vietnam veterans have remained addicted to opioids for 40 + years. Many of them have acquired severe opioid pain medication addictions.
- High numbers of Iraq and Afghanistan War veterans with acute combat and military trauma are also opioid dependent. Many young people reportedly entered the military to get away from their opioid addictions.

Return of the felt experience and resilience

Important: unlike the broad numbing of physical, emotional and psychological pain that comes from the use of full agonist opioids, the partial opioid agonist buprenorphine allows *the return of the felt experience of life* - emotions and sensations. It is essential that we acknowledge this with patients, prepare them for the return of feelings, and develop a treatment plan that supports the challenges and opportunities of this 'tingling to life.'

- One patient told how after many years on heroin and methadone maintenance, after transitioning to buprenorphine/naloxone therapy the surprise and delight of crying at a movie and laughing with his children.

Cultivating resilience in early recovery

- Introduce the Resilience Questionnaire (See Appendix D)
- Ensure that groups (see Section 2 and Appendix D) are skills-based and focused on self-regulation
- Facilitate mindfulness with emphasis on body sensing and grounding techniques
- Keep in mind that deep breathing can be activating and overwhelming for our patients with severe trauma.

Source reading for this section:

- The Prevalence of Childhood Trauma Among Those Seeking Buprenorphine Treatment: **https://www.researchgate.net/profile/Michael_Wiederman/publication/23983909_The_Prevalence_of_Childhood_Trauma_Among_Those_Seeking_Buprenorphine_Treatment/links/5693a9ac08ae820ff07273c1.pdf**
- Trauma: **https://www.integration.samhsa.gov/clinical-practice/trauma**
- The Unfortunate Connection Between Childhood Trauma and Addiction in Adulthood: **https://www.dualdiagnosis.org/unfortunate-connection-childhood-trauma-addiction-adulthood/**
- Early postoperative effects of trunk vagotomy on intestinal motility: **https://www.ncbi.nlm.nih.gov/pubmed/1273375**

4. Approaches to care

a. Harm reduction

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

Harm reduction incorporates a spectrum of strategies from safer use to managed use to abstinence to meet drug users "where they're at." It addresses conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

However, the Harm Reduction Coalition (HRC) considers the **following principles** central to harm reduction practice:

- Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies that meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

Enabling

"Enabling is different from helping and supporting in that it allows the enabled person to be irresponsible."

- Elina Kala, MA Mental Health Professional

Those who are highly invested in abstinence-based approaches may confuse harm reduction with enabling. In fact, they are quite different.

Enabling behavior:

- Protects the addicted person from the natural consequences of their behavior
- Keeps secrets about the addicted person's behavior from others in order to keep peace
- Makes excuses for the addicted person's behavior (with teachers, friends, legal authorities, employers, and other family members)
- Bails the addicted person out of trouble (pays debts, fixes tickets, hires lawyers, and provides jobs)
- Blames others for the addicted person's behaviors (friends, teachers, employers, family, and self)
- Blames personality, character traits, or mental health (shyness, adolescence, loneliness, broken home, ADHD etc.)
- Avoids the addicted person in order to keep peace (out of sight, out of mind)
- Gives money that is undeserved or unearned
- Attempts to control that which is not within the enabler's ability to control (plans activities, chooses friends, and gets jobs)
- Makes threats that have no follow-through or consistency
- "Care takes" the addicted person by doing what they are expected to do for themselves

Abstinence-directed recovery

The American Society of Addiction Medicine (ASAM) **defines recovery** as:
"A process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction. This effort is in the direction of a consistent pursuit of abstinence, addressing impairment in behavioral control, dealing with cravings, recognizing problems in one's behaviors and interpersonal relationships, and dealing more effectively with emotional responses. Recovery actions lead to reversal of negative, self-defeating internal processes and behaviors, allowing healing of relationships with self and others. The concepts of humility, acceptance, and surrender are useful in this process."

Abstinence-directed patients often find safety, recovery support and stability in 12 Step Programs. The challenge is that patients who are taking prescribed medications for their addictions, such as buprenorphine or methadone, are often not considered "clean and sober" in the 12 Step culture. This can further the feelings of isolation, dishonesty, and mistrust. There has been a shift in some 12 Step groups to be more inclusive and supportive of patients taking medications for addiction treatment. 12 Step is one tool in the toolbox of recovery. Not every patient will find these groups helpful, but for those that do, it is recommended they seek out a 12 Step group that works for them or start their own.

b. ASAM criteria

The **ASAM criteria** are clinical guidelines developed by the American Society of Addiction Medicine (ASAM) to improve assessment and outcome driven treatment and recovery services.

It is important to learn and understand the 6 dimensions of ASAM Level of Care and the criteria for assessing treatment needs. You can find the ASAM Grid in the MAT Tools section. The six dimensions in the ASAM Grid are:

1. Detox needs
2. Medical needs
3. Behavioral health needs
4. Readiness
5. Relapse

6. Environment

In traditional treatment settings, the approach has been to blame the patient: "They were not ready to get clean and sober."

- Our job as clinicians is to consider the ASAM Level of Care, access to appropriate level of care, and identify real barriers for the person to succeed.
- The ASAM Grid is an excellent way to review the case of a patient who has left treatment and does not return. "What did we miss?" is a useful way to review a patient with repeated unsuccessful attempts. It often becomes clear as to what is driving this.

c. Motivational interviewing

Motivational interviewing is a way of helping people find their own reasons for change. It requires understanding:

- Empathy – the ability to accurately understand the client's meaning and then reflect that accurate understanding back to the client.
- The paradox of change: when a person feels *accepted* for who they are and what they do – no matter how unhealthy – it allows them the *freedom* to consider change rather than needing to defend against it.

The spirit of motivational interviewing:

- Dancing vs. wrestling
- Exploring and resolving ambivalence
- Honors autonomy
- Collaborative
- Warm and friendly
- Respectful

Motivational interviewing requires understanding the stage of change that the patient is in and allows the clinician to guide the patient through the subsequent stages. The stages of change are:

- Pre-contemplation: the stage in which people are not considering changing or initiating a behavior. They may be unaware that a problem exists.
- Contemplation: characterized by ambivalence about changing or initiating a behavior.
- Preparation: characterized by reduced ambivalence and exploration of options for change.
- Action: characterized by taking action in order to achieve change.
- Maintenance: characterized by seeking to integrate and maintain a behavior that has been initiated.
- Relapse: characterized by a recurrence of the undesired behavior.

What are the motivational interviewer's tools?

- Validation
- Kindness
- Body language/ tone
- Listening
- Asking questions – use your OARS (see below)
- Acceptance
- Respect
- Sensitivity

- Humor

Things of which to be careful:

- Too much teaching and information
- Giving advice
- Challenging the patient
- Offering personal perspectives
- The "righting reflex": he needs to…
    - Fix things
    - Set someone right
    - Get someone to face up to reality

When using motivational interviewing, always think of OARS:

- Open ended questions
    - "How concerned are you about your drinking?" rather than "Are you concerned about your drinking?"
- Affirmation
- Reflective Listening
- Summarizing

Important listening skills include:

- Presence – undivided attention
- Eyes, ears and heart
- Acceptance and non-judgment
- Curiosity
- Delight
- No interruptions
- Silence

Listen for "change talk" from the patient. Change talk represents movement towards change.

- Preparatory change talk:
    - Desire: "I want to…"
    - Ability: "I can…"
    - Reasons: "There are good reasons to…"
    - Need: "I really need to…"
- Activating change talk:
    - "I am going to…"
    - "I intend to…"
    - "I will…"
    - "I plan to…"

Encourage change talk with prompts like these:

- How important is it to you to make changes around your drinking/heroin use/etc.?
- How confident are you that you can make changes around your drinking/heroin use/etc.?
- How ready are you to change your drinking/heroin use/etc.?

d. Cultural humility

Cultural humility vs Cultural competency

"Cultural competency implies that one can function with a thorough knowledge of the values and beliefs of another culture, while cultural humility acknowledges that it is impossible to be adequately knowledgeable about cultures other than one's own."

"Humility denotes a willingness to accurately assess oneself and one's limitations, the ability to acknowledge gaps in one's knowledge, and an openness to new ideas, contradictory information, and advice" **— Recovery U: Diversity and Cultural Humility**

Three dimensions of cultural humility

- Lifelong learning & critical self-reflection
- Recognize and challenge power imbalances
- Institutional accountability

Lifelong learning & critical self-reflection

- Coming from a place of knowing that we don't know
- Being able to accept our own limitations
- Encouraged to be curious tied to that place of not knowing
- Openness — we can feel open to those around us who want to learn about us
- We hold ourselves accountable for constant learning and curiosity to understand those around us
- Frees us from feeling that we have to be experts on others and their culture

Recognize and challenge power imbalances

- We attempt to recognize when we are in a position of power and make attempts to neutralize this imbalance
- We notice when there is a power imbalance in systems and acknowledge this difference, also taking responsibility to point out and advocate

Institutional accountability

- At an institutional level, we need to encourage this philosophy/culture
- If the system has embraced this philosophy, it will be much easier for individuals to feel safe with the practice

Example of integrating cultural and traditional practices as part of MAT recovery care — Native recovery:

- Does your clinic have a vision for integrating **Native recovery** in your MAT program?
- Any staff trained in **White Bison**?
- What are your current cultural interventions?
- What are your cultural practices, if any, in your clinic?
- Are you utilizing traditional practitioners in your clinic?
- Have you identified barriers to establishing Native recovery programs in your MAT program?

Source reading for this section:

- HRC Principles of harm reduction: **http://harmreduction.org/about-us/principles-of-harm-reduction/**

- What is enabling?: **https://www.hazeldenbettyford.org/articles/kala/enabling-fact-sheet**
- The ASAM standards of care for the addiction specialist physician: **https://www.asam.org/docs/default-source/publications/standards-of-care-final-design-document.pdf**
- ASAM criteria: **https://www.asam.org/resources/the-asam-criteria/about**
- Recovery U: Diversity and Cultural Humility: **https://eipd.dcs.wisc.edu/non-credit/WI_Voices/Diversity/Transcript/RecoveryU_Diversity.pdf**

5. Stigma and changing clinic cultures

Stigma in clinical settings

> "Addiction is a chronic, progressive, relapsing disease." — American Society of Addiction Medicine

Often, we find the strongest stigma expressed towards persons with addictions within the walls of care — within our clinic cultures. Most of us have been impacted in a direct or indirect way by the disease of addiction. This often elicits feelings of frustration, anger, grief, and loss, which can shape an individual's attitudes towards our patients who suffer from this disease.

- Often, patients presenting to emergency departments with opioid withdrawal or craving are not treated with respect or adequate care. Health professionals often avoid having to interact with patients with substance use disorders. This results in:
    - Shorter visits
    - Less empathy shown to the patient during the encounter
    - Less patient engagement
    - Reduction in retention in treatment

- This avoidant attitude and stigmatization of addiction results in an increased risk of overdose and death and lost opportunity to provide appropriate treatment for the disease of addiction.

- Many commonly used terms around addiction are pejorative and inaccurate. Here are some examples of common words and phrases that are stigmatizing, along with non-stigmatizing language to replace them with:

Topic	Stigmatizing language	Non-stigmatizing
Urine drug screen	Dirty or clean	Positive or negative
Diagnosis	Substance abuse or abuse (no longer dx)	Substance misuse or substance use disorder
Labeling	Drug seeking	Relief seeking
	Addicts	Person with addiction or SUD
Newborns	Crack babies, addicted baby	Baby born dependent on opioids etc.

Stigma in 12 Step and recovery communities

Misunderstanding within the 12 Step and recovering community about medications for addiction treatment, including buprenorphine, can cause stable patients to taper off so that they can be considered "sober" in their fellowship.

- The culture can inappropriately "practice medicine." One patient described his experience in NA (Narcotics Anonymous) as 'persecution' because he was prescribed Suboxone and in a MAT program. In some NA fellowships, a person prescribed methadone is not permitted to share in a meeting.
- It is important for patients to be educated about their medical confidentiality. What they are prescribed is between patient and prescriber.
- Historically, 12 Step communities were equally resistant to the use of SSRI treatment when introduced in 1988.
- Many continue to view addiction as a moral failing. This is often because of the moral compromise which occurs with a progressively compulsive disease which involves destructive, illegal substances.
- Alcoholics Anonymous did not officially accept 'disease concept' until late 1980's.
- In 1988, the US Supreme Court, hearing a case regarding the disease concept of addiction, ruled that it was not fully known if alcohol dependence is a disease and therefore ruled against the challenge to the Dept. of Veterans Affairs refusal to make alcohol dependence a service connected disability. This ruling continues to the present. The correlation between military and combat trauma and substance use is well researched.
- Advancements in medical technology beginning in the mid-1990s enabled scientists to better study the impact of drugs and alcohol on the brain. Since then, there has been substantial research and evidence to support addiction being a chronic neuro-biological disease, primarily affecting the brain reward system.
- The reward circuitry of the brain involves the mesolimbic dopamine system, including the prefrontal cortex, the nucleus accumbens, and the ventral tegmental areas (VTAs).

Changing clinic culture

The stigma that exists in our programs and throughout our agencies will influence patient care. Addressing stigma on the treatment team is essential for developing a good MAT program. We must also address stigma throughout the entire agency. As long as stigma exists, patient care will be impacted.

- A useful way to introduce and establish a medication for addiction treatment program is to take the opportunity to spend time with every department in the primary care clinic.
- Schedule a brief ½-hour meeting with each department.
- This gives every staff member an opportunity to learn about and understand buprenorphine/naloxone (Suboxone), injectable naltrexone (Vivitrol) and naloxone (Narcan).
- Staff members can learn about the program itself. Education on the neurobiology of addiction basics is essential. This will help change attitudes and start to breakdown stigma. (see Appendix A)
- A one-page handout can be helpful. This handout should:
    - Explain how the medications work
    - Describe the patient pathway of care
    - Inspire compassion
    - Discuss common stigmatizing language
- Each department — call center, front desk receptions, medical assistants, billing, coding, dental, etc. — will require education on their role in MAT program specifics.

- Allow time for concerns and questions.
- Be available to clinic departments for check-ins as program gets up and running.

Source reading for this section:

- U.S. Reports: Traynor v. Turnage, 485 U.S. 535 (1988): **https://cdn.loc.gov/service/ll/usrep/usrep485/usrep485535/usrep485535.pdf**
- Predictors of retention in treatment in a tertiary care de-addiction center: **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4776577/**

02 Care

This section was written with the direct care clinical team, including prescribers, in mind. Our goal is to provide the most up to date, evidence-based information about medications for addiction treatment and current best practices. This section will provide the reader with a brief overview about current medications for addiction treatment, including general dosing information, diversion concerns and peri- and post-partum treatment. You will find links embedded throughout this section for additional topic-specific information. As this toolkit is meant to be a practical tool for the reader, you will find examples of clinical application and practice throughout.

Thank you to Scott Haga, PA-C, for dedicating his time to ensure all the prescribing information is accurate and up to date.

1. Brief overview of medications

Buprenorphine

History:

- First developed in the UK as an injectable analgesic in 1978.
- Semi-synthetic opioid/ Schedule III narcotic
- First used in Europe for treating opioid dependence in 1996
- Approved by the FDA in 2002 to treat opioid use disorder
- 30-second elevator speech on buprenorphine: "Takes away cravings, takes away withdrawal and does not offer a high."

Buprenorphine properties:

- Partial opioid agonist at the mu receptor.
    - Full agonist (almost all opioids) = fully stimulates receptor, like pushing gas pedal all the way to the floor in car
    - Partial agonist (buprenorphine) = partially stimulates receptor, like pushing gas pedal half way
- High affinity for mu receptors – if competing with most other opioids to bind to the receptor, it "wins" and can actually knock the other opioid off the receptor
- Long acting – half-life is 37 hours – offers a steady state
- Rapidly stabilizes and normalizes the brain dopamine level
- Buprenorphine can be an effective pain medication in addition to its use for OUD.

Delivery and dosing:

- Cannot be taken orally (high first pass metabolism in the liver) so needs to be taken sublingually or transdermal.
- Normal dosing range is 16-24 mg — opioid-dependent patients do not typically experience euphoria at this dosage. If they do, this very mild euphoria resolves within a few days.
- Maximum recommended dose is 32 mg/d.
- Metabolized through the liver and primarily excreted through bile.
- Can be taken once daily, though most patients divide their dose.
- In a Vermont Hub – some buprenorphine patients dose every 2 or 3 days although this is rare.

Formulations:

- Brand names include Suboxone, Subutex, Zubsolv, Bunavail. Different dosing for each product
    - Comes as tablets or film strips, both types are taken sublingually.
- Suboxone:
    - Suboxone is buprenorphine combined with naloxone to minimize diversion
    - Naloxone: Antagonist
        - Low bioavailability when taken sublingually – like an inactive ingredient
        - If used intravenously (IV) the antagonist effect will occur
        - Minimizes diversion
    - First developed and sold by Reckitt-Benckiser, a Swiss pharmaceutical firm. Their patent expired in Oct. 2012, and both tabs and strips are available as generic.

- Subutex:
    - Buprenorphine not combined with naloxone is brand name Subutex.
    - Subutex might be prescribed for patients with adverse reactions to naloxone. These patients often have a history of migraine headaches.
    - Standard of care for pregnant women has been to use buprenorphine only although no risk to using naloxone during pregnancy has been found.
- New buprenorphine formulations:
    - Probuphine – implants – 6 months dosing. Must be stable on 8 mg to be appropriate for this care.
    - Sublocade – subcutaneous (SQ) injectable monthly dose 300 mg SQ every four weeks for the first two months, then recommended to reduce to 100 mg SQ every four weeks. Can increase to 300 mg again if symptoms of withdrawal or craving return
    - BuTrans – weekly mcg/h dosing transdermal patch – prescribed for pain management not OUD. Can be helpful in complicated inductions and taper protocols.

Notes:

- One street name for buprenorphine is 'subs'.
- Recently identified as *the most sought after prescribed medication on the streets*. Its street value comes from its effective and quick relief of opioid withdrawal symptoms versus taking it to get high.
- Anecdotally, people with opioid dependence report trying to manage their own withdrawal with buprenorphine/naloxone obtained illicitly when they are unable to find a prescriber for buprenorphine.

Methadone

History:

- Full agonist opioid developed in Germany in 1937
- First federal methadone program in 1971 (Nixon) then became highly regulated in 1973; remains highly regulated
    - Daily dosing
    - Carefully managed take-home schedules
    - Required counseling
- Methadone clinics also known as narcotic treatment programs (NTP) usually in urban areas
- 500,000 people enrolled in methadone programs
- 30 years of research showing its efficacy as an evidence-based treatment for opioid use disorder.

Methadone properties:

- Long-acting (34-hour half-life)
    - Because of the long half-life and even longer half-life of metabolites converting to buprenorphine from methadone can be quite difficult
- Heroin has a half-life of 30 minutes – hence the rationale for switching to long-acting methadone as treatment.
- Can use other full agonist opioids such as heroin and prescription pain medications in addition to methadone
- Methadone has a complex metabolic pathway and dosing is non-linear.
    - Multiple drug-drug interactions

- Can be difficult converting doses of other opiates to and from methadone

Delivery and dosing:

- Requires daily dosing at a methadone treatment program (narcotic treatment program)
- Taken orally
- Common starting dose 20mg
- Titration up by 1mg
- Data shows typically need at least 60mg
- Average maintenance dose 60-90mg

Naltrexone injectable – Vivitrol – every 30 days

- Full antagonist blocks opioids
- Can be protective for persons newly abstinent with a reset tolerance, i.e., released from jail or completing residential treatment
- A former inmate's risk of death within the first 2 weeks of release is more than 12 times that of other individuals, with the leading cause of death being a fatal overdose. (NIDA (2018, 2019) The cravings are still there and the tolerance is reset.
- Vivitrol injection *does not relieve opioid cravings nor does it replace dopamine.*
- Some patients report minor injection site pain.
- Promoted as non-addictive treatment for opioid use disorder to the judges and providers who oppose opioid replacement therapies such as methadone and buprenorphine
- Naltrexone is also indicated for alcohol use disorder. Can be the best treatment option for opioid use disorder with alcohol use disorder, or can be helpful for patients who have multiple barriers to participating in MAT programs.
- Naltrexone – 50mg PO (taken orally) is often prescribed to decrease alcohol cravings – like a dimmer switch for cravings. It can be more effective for mild to moderate alcohol use disorder. Oral naltrexone is not indicated for OUD.
    - Some patients have reported IM Naltrexone (Vivitrol) more effective for controlling cravings and urges to drink.
    - It cannot be taken with any full or partial agonist opioids

Narcan (also naloxone)

- Full antagonist for opioid overdose reversal
- 43 states have standing order for non-medical personal to issue naloxone
- Increased availability for family members, friends, bystanders, etc. throughout the country

Opioids

Most commonly prescribed pain medications:

- Hydrocodone
- Hydromorphone
- Oxycodone
- Oxymorphone
- Morphine
- Tramadol
- Fentanyl
- Methadone
- Codeine

Morphine Equivalency Dose (MED)

- When converting between opioids or comparing doses it is useful to convert to Morphine Equivalency Dose (MED). This allows comparison of apples to apples.
- Multiple conversion tools available, one is linked below
- Use extreme caution when converting methadone, as dosing is non-linear and considerable disagreement exists on equivalent dose.
- **Dose calculator tool**

Street opioids

- Heroin
- Fentanyl is frequently found in heroin, and has resulted in an increase of overdose deaths.
- Carfentanyl – 100 times more potent than fentanyl and very deadly.

Source reading for this section:

- Opioid Dose Calculator: **http://www.agencymeddirectors.wa.gov/calculator/dosecalculator.htm**

2. Providing care: Buprenorphine inductions and more

Intake and evaluation for admission

- Patient meets initially for screening by behavioral health provider/addiction therapist/ nurse case manager
- Screened for opioid use disorder – use DSM-5 screening tool for OUD
- Readiness and barriers identified (i.e., homelessness and transportation)
- Motivation for starting treatment assessed
- ASAM assessment to determine the most appropriate level of care, i.e.:
    - Outpatient
        - ASAM 1.0
    - Intensive Outpatient/Partial Hospitalization
        - ASAM 2.1 & 2.5
    - Residential
        - ASAM 3.1 clinically managed low intensity residential
        - ASAM 3.3 clinically managed specialty population high intensity
        - ASAM 3.5 clinically managed high intensity residential
        - ASAM 3.7 medically monitored high intensity residential
- Whole person care – see grid

- Refer to RN for: *(recommended pathway in primary care)*
    - Buprenorphine nursing assessment – template in electronic medical record. Extensive drug and alcohol history along with psych and medical history. (see Appendix D for sample templates)
    - Schedule with waivered provider for MAT admission medical clearance and labs – routine labs + HCV + HIV.
    - Home induction or in-clinic induction planning including instructions for withdrawal required for induction (see MAT patient handouts in Section IV)
    - Schedule induction day and time. If home induction, must be monitored via phone or follow-up appointment with RN case manager
    - Must have transportation to and from clinic on induction day
    - Follow-up appointment after induction with substance use counselor for signing buprenorphine treatment agreement. (see MAT patient handouts)
    - Recommend signing the treatment agreement when patient is comfortable – no longer experiencing withdrawal and cravings. Helpful to have patient read it aloud so that the agreement is clear and all questions are answered. This will prove to be useful if agreement is violated by patient and requires changes in care or possible discharge from the program
    - Schedule with behavioral health for biopsychosocial intake if this is not part of the initial intake process

Induction

At time of medical clearance, waivered provider will determine if patient requires in-clinic induction (more often with pregnancy and methadone withdrawal). Some patients may already

have buprenorphine on-board from street access or be experienced with precipitated withdrawal and able to tolerate withdrawal hours at home.

    - **Always collect a urine drug screen prior to induction.** A recent and unreported, possibly inadvertent, long-acting opioid such as methadone or OxyContin can cause precipitated withdrawal. Avoid surprises!
- Also, be aware that if patient is "muscling" (IM) heroin, the withdrawal phase will not be 12-24 hours that is the usual time needed for induction, but closer to 36-48 hours, depending on recent quantity used.
- Patients must no longer be experiencing the agonist effects of an opioid.
- One way to gauge this is to observe symptoms of withdrawal.
- Clinical Opiate Withdrawal Scale (COWS), an 11-item instrument to measure severity of withdrawal symptoms. A score of 10-12 is generally the cutoff to start buprenorphine.
- Also, measure cravings on a scale of 1-10. Teaching patients to measure their cravings is a good competency for some patients, but for others it may lead to increased rumination and anxiety. Know your patient before having them measure cravings at every visit.
- Build buprenorphine induction template in electronic medical record. (*see Appendix E*)
    - See MAT induction template for both in-clinic and home inductions.
- A point of care urine drug screen should be completed in-house before induction.
- Often a quick team touch base can help to make sure everyone is on the same page.
- First dose is 'test dose' for sensitivity to buprenorphine for side effects and for possible precipitated withdrawal. Usually 2-4 mg.
- Monitor for one hour. If relief of symptoms and cravings, will continue with prescriber in determining next dose. Often dose in increments of 2-4 mg.
- Since buprenorphine has long half-life (37 hours), titrate slowly for a few days for optimum relief of withdrawal symptoms and cravings with minimal side effects.
- For a high utilizer of heroin or opioid pills, it is helpful for the patient to have 24 mg in 24 hours.
- The goal of induction is to transition patient to partial agonist opioid buprenorphine from full agonist and to eliminate withdrawal symptoms while restoring adequate dopamine in the brain.
- The doses may be adjusted over the first month in response to reported side effects, breakthrough withdrawal (rare) and increased craving.
- Each patient has their own 'right dose' or sweet spot – no cravings, no withdrawal, no or minimal side effects. Anywhere from 4 mg-32 mg.

Precipitated withdrawal

Precipitated withdrawal is a rapid and intense onset of withdrawal syndrome initiated by medication.

- Buprenorphine has a higher binding strength at the opioid receptors so it competes for receptor, "kicks off' and replaces the existing opioids.
- Due to the *high affinity* of buprenorphine at the mu receptor, buprenorphine displaces full agonist opioids at the mu receptor. As buprenorphine is a partial agonist it now is only stimulating the receptor partially. This net decrease in agonist effect results in a precipitated withdrawal syndrome.
- If precipitated withdrawal occurs several treatment options are available.
    - The addition of clonidine 0.1 mg PO can be helpful.
    - In some cases a single small dose of a benzodiazepine can be used.
    - One option for dosing buprenorphine is to wait 4-8 hours before dosing again.

- Other clinicians will reduce the dose of buprenorphine to 1 mg every hour. Eventually enough buprenorphine is present and binding to receptors to result in a net increase in agonist activity and the cessation of precipitated withdrawal.

Side effects of buprenorphine

- Sedation – most common
- Constipation – most common
- Headache – also common
- Nausea/vomiting
- Orthostatic hypotension/dizziness
- Itching
- Dry mouth
- Urinary retention
- Ankle edema
- Muscle twitching
- Chronic sweats – most often reported at night

The side effects resolve quickly for most patients. Many patients have no other side effects than constipation. Some side effects can be prevented or mitigated:

- Recommend prescribing bowel protocol at time of induction. Consider prescription Docusate + bisacodyl (or Senna) + Miralax for severe constipation.
- Prior to induction, patients must avoid using all opiates for 12-72 hours.
- Shorter acting opioids such as heroin will result in withdrawal symptoms sooner, allowing induction to be done sooner. Use COWS to guide induction.

Diversion of buprenorphine

Most prescription drug monitoring programs (PDMPs) also apply to prescribing of buprenorphine/naloxone. As long as a patient continues with prescribed Suboxone (buprenorphine/naloxone), the PDMP must be run every 4 months.

- Diverted Suboxone – Because of poor access to prescribed Suboxone with treatment care, many of those with opioid use disorders obtain their Suboxone on the streets. The cost is anywhere from $10 -$25 for one Suboxone 8/2 mg film or sublingual tab depending upon location. Many people have been self-treating their opioid addictions with diverted Suboxone for years.
- Many patients entering treatment have had prior experience with Suboxone, many of whom have had or witnessed precipitated withdrawal. These patients may do well with home inductions as they understand the importance of discontinuing all opioids first, followed by waiting for withdrawal symptoms, before taking their first Suboxone doses. Some patients may come in already on buprenorphine, having obtained it from the street, and thus do not require induction.
- Once a patient with OUD has been admitted to the MAT program, the behavior of diversion should be addressed. Recovery requires the person reclaim and invest in an honest, law-abiding lifestyle. Recovery is reflected in all relationships. A patient's relationship with their buprenorphine/naloxone provider must be one of honesty and trust. A provider cannot be viewed as a supplier of drugs by our patients or by the community.
- Ways a MAT program can limit and monitor for diversion of prescribed Suboxone:
    1. MAT treatment agreement identifies diversion as a possible reason for discharge as this behavior *directly affects the safety of the community*.

The MAT team must be willing to act decisively when evidence of a patient diverting prescribed buprenorphine has emerged.

2. Short Suboxone prescriptions such as seven-day prescription until patient has stabilized also supports establishing trust. Increase lengths of prescriptions as appropriate until patient receives and manages a month's supply of prescribed Suboxone.
3. Random call backs for pill or film counts. This can be a requirement of the progression through the phases of care (see below). For example, when a patient is ready to progress from Phase 2 (every 14-day Suboxone prescription) to Phase 3 (monthly prescription), they must have at least one successful callback.

Special populations

Treating perinatal patients with opioid use disorder

- High risk is activating premature labor because of intense withdrawal, which can occur with precipitated withdrawal
- Buprenorphine is often a better choice than methadone in pregnancy as lower rates of neonatal abstinence syndrome have been found compared to methadone.
    - If patient is past first trimester and on methadone, then maintain on methadone
- Although several studies have shown no adverse effects of naloxone in pregnancy, buprenorphine without naloxone is typically used (although this is widely variable).
- Induction is most often done in the office or other monitored setting as an added precaution in pregnancy.
- Neonatal abstinence syndrome (NAS) – work with delivering OB and NICU where delivered.
- "Affected newborns typically develop symptoms 48-72 hours after birth, including nervous system irritability, autonomic system dysfunction, and gastrointestinal and respiratory abnormalities." … "In the methadone group, 81% of infants developed NAS, compared with 50% of those in the buprenorphine group. The higher likelihood of developing NAS from methadone-treated mothers was statistically significant (*P* less than .001)." **Source**

Postpartum care:

- Due to the increased psychosocial stressors in the postpartum period it is recommended to see new mothers weekly in-group and individually. Refer to a Mothers in Recovery group if available.
- Breastfeeding on buprenorphine: breastfeeding should be encouraged. "Because of the low levels of buprenorphine in breast milk, its poor oral bioavailability in infants, and the low drug concentrations found in the serum and urine of breastfed infants, its use is acceptable in nursing mothers."
- Resource: "**Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants**."
- Assess frequently for postpartum depression.
- Provide patient and family with information on NAS. This brochure is available for download **here**.

Methadone to buprenorphine

- It is recommended that patients transitioning from methadone to buprenorphine slowly taper to 30 mg methadone daily or lower. The managed taper must be supervised by methadone prescriber (methadone clinic or other).
- Once a patient is down to less than 30 mg, then we recommend admission to detox setting (if possible) to manage the withdrawal phase, which can be difficult.
- COWS must be higher score (12-15) for safe, problem free induction.
- Methadone inductions will take more preparation, support, and increased monitoring in the first two weeks of stabilization.
- Because methadone also has activity in the NMDA system, patients switching from methadone to a different opioid, including buprenorphine, also have increased dysphoria, prolonged insomnia, and breakthrough withdrawal. These patients benefit from more than usual supportive monitoring and care.

Tapering down or coming off buprenorphine

- Patient agrees when signing treatment agreement to have all tapering medically monitored
    - Some patients may be inclined to "self-doctor," changing dose or tapering without discussing with prescriber and care team.
- Tapering can occur for several reasons.
    - Unable to safely continue on buprenorphine
        - Unable to keep follow up appointments. If this is the case:
            - Address transportation resources
            - Increase behavioral health support
        - Unable to take medication as prescribed
            - If taking more than prescribed, identify why patient is overtaking
                - If at maximum dose and still having withdrawal likely not a candidate for buprenorphine and recommend methadone
                    - This is often behavioral: patient is in habit of taking a drug to "chemically cope."
            - Not taking medication (no buprenorphine in UDS)
                - No need to taper, just discontinue prescription
    - Planned gradual taper after the patient is stable on buprenorphine for an extended period

        - Rate of taper and frequency of dose reduction is quite variable and depends on maintenance dose and individual patient.
        - One tapering plan is:

Dose	Duration
16 mg→14 mg	1-2 weeks
14 mg→12 mg	2-4 weeks
12 mg→10 mg	2-4 weeks
10 mg→8 mg	2-4 weeks
8 mg→6 mg	2-4 weeks
6 mg→4 mg	2-4 weeks
4 mg→3 mg	2-4 weeks
3 mg→2 mg	2-4 weeks
2 mg→1 mg	2-4 weeks
1 mg→0.5 mg	2-4 weeks

- Several medications can be used off label to assist with tapering. Each has its own risks and benefits. These include ondansetron (nausea/vomiting), clonidine (anxiety, sweating, overall discomfort), loperamide (diarrhea) and dicyclomine (GI cramping).
- BuTrans patches also help with slow tapers off on buprenorphine
- Tapers followed with naltrexone (Vivitrol 380 mg IM every 4 weeks) are also being studied and shown to be effective.
- Some may choose an inpatient detox setting for quicker taper.
- Tapers are also offered to those who are repeatedly unable to safely comply with treatment agreement. 14-day tapers are then started.

Buprenorphine as 10-14-day withdrawal medication

Research indicates the best outcomes for OUD are with buprenorphine maintenance for stabilization and recovery, but not all patients will or can choose maintenance. Buprenorphine is excellent withdrawal agent, especially if patient can work closely with an experienced treatment team.

- After induction (required abstinence, comfort meds, etc.), stabilize patient on 16 mg for 2 days then decrease by 4 mg/d until down to 2 mg daily, then slow this down for 2-3 days, decrease to 1mg for 2-3 days, then 1 mg QOD (every other day).
- If patient is still uncomfortable, can then try BuTrans patch for 1 week.
- After 5 days of abstinence from all buprenorphine, can try naltrexone 50 mg by mouth.
- Expect some dysphoria, anxiety, and insomnia that can be treated symptomatically.
- These patients will need weekly recovery support along with RN/MD monitoring.

Treating opioid use disorder with co-occurring substance use

Buprenorphine is an evidence-based treatment for OUD, not other substances. You should not expect use of buprenorphine to automatically result in improvements in use of other substances.

Alcohol

- If patient has alcohol dependence with opioid dependence, then it will be best to manage alcohol withdrawal in first 24-36 hours of required opioid abstinence, then initiate buprenorphine for opioid withdrawal.
    - If a patient is in a monitored detox setting, then this can be done concurrently.

    - If no detox option, then start the detox protocol on Monday and make sure patients can be seen by RN daily that first week. If done at home, the patient will need a support person to manage meds and take to ED if necessary. *(A monitored detox or consultation with an addiction medicine expert may be recommended for more patients with complex situations)*
- If a patient is using buprenorphine and alcohol, need to carefully assess risks and benefits using a harm reduction approach. Generally, do not recommend stopping buprenorphine as this significantly increases risk of relapse to opioids and potential overdose. Consider increasing level of care.
    - Offer MAT for alcohol (acamprosate, gabapentin, occasionally disulfiram)
    - Increase contact with team (RN, SUD counselor, therapist)
- Consider Vivitrol option. Switching a buprenorphine patient to Vivitrol requires detox from buprenorphine, followed by 5-7 day wait, then start naltrexone trial with 50 mg PO dose for at least 5 days. Once stable on PO dose, administer injection

Benzodiazepines

- New info from SAMHSA states that prescription for benzodiazepines does not preclude buprenorphine prescribing. However, must be aware that both benzodiazepines and buprenorphine suppress the central nervous system and prescribing both requires additional safety considerations.
- Consider consultation with psychiatry or addiction medicine if patient is on buprenorphine and a benzodiazepine.
- Due to seizure risk, taper of benzodiazepine needs to be done carefully. Consider using **Ashton Protocol**. A faster taper may be needed if patient is overtaking benzodiazepines. Consider adding an anticonvulsant such as gabapentin in these cases.
- If patient is failing in this treatment track, then safety is evaluated. It might be unsafe to continue prescribing. Patient is then offered 10-day detox or 14-day taper. Higher level of care should be offered and new treatment agreements should be signed.

Methamphetamines

Methamphetamine use disorder is a frequent co-occurring disorder with opioid use disorders. Users frequently combine and inject the drugs. It is not unusual to see continued use of methamphetamines in patients who have stopped using opioids.

- These patients can be in Phase 1 – weekly groups, etc. for many months.
- Point of care toxicology testing that is positive for non-prescribed or illicit substances which patient denies using MUST be confirmed with definitive testing before taking clinical action. If patient admits to use of the substance, clinical judgement should be used regarding confirmatory testing.
- Depression and anxiety should be aggressively treated for maximal beneficial outcomes with MAT
- Discharging a patient for persistent and prolonged methamphetamine use must be determined by the provider and by the MAT team.
- Persistent methamphetamine use may require a higher level of care. If possible, refer patient to inpatient setting for detox and stabilization from methamphetamines.
- Two weeks after last methamphetamine use, schedule with provider to evaluate for depression and possible treatment.
- Some providers will decrease Suboxone dose to encourage patient to change behavior. There is no evidence that this is an effective approach. There is evidence that this approach increases death from opioid overdose.

- There is increasing interest in developing more care for those in MAT with severe stimulant use disorder. Research supports contingency management programs.

Cannabis

As the laws change around use of cannabis, so does the culture.

- Monitor cannabis users with care. Discuss the positive UDS for cannabis with patient: "What does it do for you?"
- MAT provider and team must make decisions about continued cannabis use.
- Heavy daily cannabis use can be counter-productive to recovery.
- Educate patients around heavy cannabis use:
    - Health effects of smoking,
    - Safety concerns
    - Behavioral health issues such as a motivational syndrome.
    - Cognitive issues, such as those around adolescent and early adult brain development.
- Cannabinoid hyperemesis syndrome (CHS) is becoming more prevalent as more states decriminalize or legalize marijuana.
    - The links below provide additional information on CHS, including symptoms, diagnosis, and treatment.
        - **Cannabinoid hyperemesis syndrome: a guide for the practising clinician**
        - **Cannabinoid hyperemesis syndrome: Diagnosis, pathophysiology, and treatment-a systematic review**

More about urine drug screens

- Point of care (POC) urine drug screen (UDS)
- CLIA-waived 12-panel UDS includes buprenorphine
- If positive for anything other than prescribed medications such as buprenorphine or benzodiazepines or, in some cases THC, then send to outside lab for confirmation
- If concerned about alcohol use, then send out for alcohol confirmation
- If positive for any opioids, then consider the possibility of diversion or buprenorphine dose being too low

Source reading for this section:

- Buprenorphine linked to less neonatal abstinence syndrome than methadone: **https://www.mdedge.com/obgyn/article/147302/neonatal-medicine/buprenorphine-linked-less-neonatal-abstinence-syndrome**
- Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants: **https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054**
- Neonatal-Abstinence-Syndrome: **http://www.sstar.org/wp-content/uploads/Neonatal-Abstinence-Syndrome.pdf**
- Benzodiazepines: how they work and how to withdraw: **https://benzo.org.uk/manual/**
- Cannabinoid hyperemesis syndrome: a guide for the practising clinician: **https://www.ncbi.nlm.nih.gov/pubmed/26698198**

- Cannabinoid Hyperemesis Syndrome: Diagnosis, Pathophysiology, and Treatment-a Systematic Review: **http://www.ncbi.nlm.nih.gov/pubmed/28000146**

3. Medications for addiction treatment phases of care

Phased care

Best practice for MAT programs using buprenorphine is done in a phased treatment approach. These phases are generally identified as the initial induction/beginning stabilization, stabilization, and maintenance. Programs often use terms like Phase (1, 2, 3) or Tier (1, 2, 3) which are developed around the **SAMHSA Buprenorphine Treatment Guidelines**. This is not a strictly linear approach as patients can move from less intensive Phase 3 to the higher intervention of Phase 1 or 2.

Phase 1

This is the initial and most intensive phase. The overall goal of Phase 1 is medication induction and stabilization.

- Weekly MAT refill/stabilization group attendance along with urine drug screen and seven-day buprenorphine/naloxone prescription
- Harm reduction and early stabilization for all patients
- Required to have BH intake in first 30 days of program participation
- BH therapist will then refer for more therapy, if indicated
- Progressing to Phase 2 is patient-centered decision determined by patient's adherence to the treatment agreement, at least 4 consecutive negative UDS and stability determined by MAT team.
- A patient transferring from another MAT program who is stable can be fast-tracked to Phase 2 after four consecutive weeks of group attendance, negative UDS, and MAT team determination.

Phase 2

The focus of this phase is to increase patient stabilization, moving toward overall functional improvement. Transfer to Phase 2 often requires a meeting with SUD counselor/BH therapist or RN case manager to update treatment agreement and clarify the expectations of Phase 2 with the patient.

- Patient attends refill/stabilization group every two weeks
- UDS (we recommend UDS at every visit)
- 14 day buprenorphine prescription
- Continues with patient-centered treatment plan
- Minimum of four consecutive group attendances and negative UDS (eight weeks).

Patient's length of time in Phase 2 is determined by patient adherence to MAT treatment agreement and treatment plan and MAT team determination.

Phase 3

Progressing to Phase 3 indicates that the patient requires minimal case management or group attendance. Additionally, a noticeable increase in patient function and well-being is recommended.

- Monthly appointments with prescriber for 30-day buprenorphine/naloxone prescription
- If primary care provider (PCP) is waivered to prescribe buprenorphine/naloxone, then will leave MAT prescriber to care of PCP.

- UDS with every 30-day buprenorphine/naloxone (Suboxone) prescription
- Minimal RN case management required
- Patient must meet with SUD counselor–individual or group–for at least one session per month

If the patient relapses or needs increased support, return to Phase 1 or Phase 2 for additional care.

Source reading for this section:

- Buprenorphine: **https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine**

4. MAT refill/stabilization groups

At the heart of MAT phased care is the weekly MAT refill/stabilization groups. The refill/stabilization group serves several purposes:

1. Brief visit with prescriber for scheduled purposes.
2. Education for patients. Topics can be about side effects, treatment agreement updates, care of one's prescribed medications, and review of urine drug screens and they are required. In addition, topics can be about cravings, triggers, relapse prevention, patient check-in, answering patient questions, and providing support.
3. The groups tend to become a community of support for the patients.

Refill groups most often provide some level of psychoeducation or didactics along a therapeutic space for patients. Refill groups are most often run by one or two individuals on the MAT team. This can be the behavioral health or addictions counselor, nurse, and/or prescriber. Some refill groups incorporate the prescriber into the group process, while others will pull patients out individually to meet with the prescriber. The frequency of group attendance is generally tied to current phase of treatment.

A 7-day Rx limits diversion – selling, sharing, trading; and misuse – self-escalating or self-tapering dose. The standard of care requires urine drug screen (UDS) with these weekly groups.

Once negative urine drug screen and adherence to treatment agreement has been established then patients can increase to 7 days with one or two refills – still in Phase 1. ***A buprenorphine patient roster can be a MAT team's best friend. Have IT help develop a user-friendly excel version, an example can be found in Appendix D.***

When a patient stabilizes on buprenorphine and has completed the determined requisite treatment phase, they can be transferred out of the refill group to a provider for monthly or every other month appointments. This will free up room in refill groups for new patients who require more monitoring. If the patient relapses or requires more care and monitoring then the patient can return to refill/stabilization groups.

MAT scheduling and pharmacy

A MAT program must be built into the clinic schedule.

Scheduling for phased group-based program

Provider – (billable time)

1. MAT medical clearance, admission labs and induction planning.
   Designated *3-5* provider slots throughout the week for MAT only.
2. Home inductions can be part of the medical clearance appointment if patient is appropriate for home induction.
3. In-clinic inductions can be double-booked as a nurse case manager can manage this care.
4. Refill/stabilization group (for example, Wednesdays 10 am – 12 am)
   One hour for group – brief face-to-face visits with provider
   a. Second hour with three 20-minute slots for patients requesting follow-up care such as dose changes

Nurse case manager (non-billable time)

1. Nursing assessment
2. Induction planning
3. Induction, if in-clinic
4. Early stabilization/induction follow-up
5. Group time
6. Routine MAT follow-up or brief interventions

Behavioral health therapist (billable time)

1. Intake biopsychosocial (can be scheduled during group time for patient convenience)
    a. In this instance, the patient would miss group one time and BH would bill for the visit.
2. Therapy
3. Special MAT groups

SUD counselor (non-billable time)

1. SUD intake and treatment planning
2. Routine counseling visits
3. Follow-up with referrals

If your clinic does not have the ability or inclination to provide refill/stabilization groups:

- Establish a weekly clinic where patients are seen primarily by RN case manager or BH/SUD counselor in early stabilization weeks with monthly provider visits.
- A provider can establish a MAT clinic. For example, one local MD has two 4-hour clinic slots for brief refill visits every week. Can see patients in any phase of MAT.
    - Requires a well-organized support team – medical assistant, RNs, counselors

Visits should be frequent in the early months of stabilization and can be tied to brief check-in with provider with short prescribing for Suboxone and weekly urine drug screen.

Pharmacy

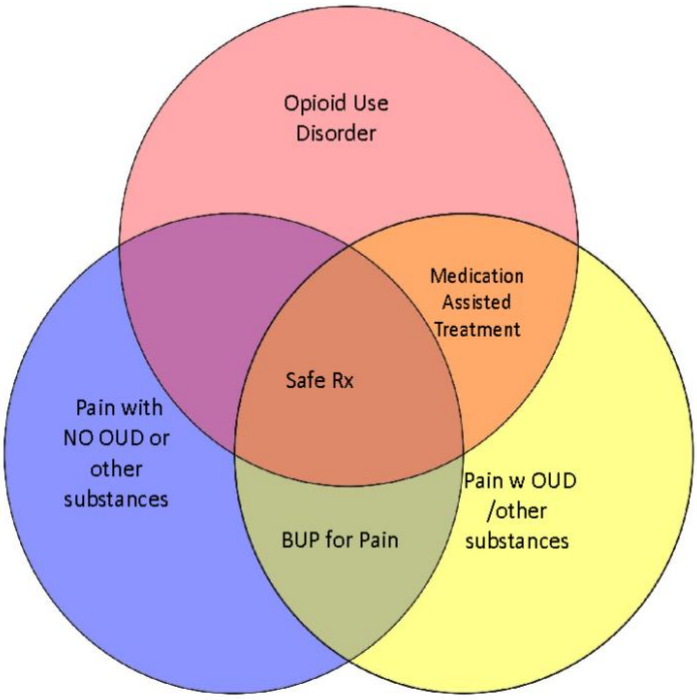
- An in-clinic pharmacy offers the opportunity to work closely with MAT care. For example, the pharmacist will hold refills until MAT RN clears patient.
- If using local pharmacies then ideal would be to have strong relationships with each one where seven-day and 14-day prescriptions and refills are understood and managed. This relationship might include information about the MAT program and requirements. Also, important, as in any community relationship, check in to see if there are any problems and engage in collaborative problem solving.

03 Opioids and pain

A special thank you to Scott Haga, PA-C for dedicating his time and talents to ensuring the information in this section is accurate and up to date.

1. Chronic pain and opioid use disorder

The current opioid epidemic was in essence started by a 1980 letter to the editor in NEJM (see Section 1 for more information), and fueled by big pharma's unethical and illegal business practices. The pendulum has swung the other way, from considering pain as the 5th vital sign to undertreating pain. Chronic pain patients are often caught in the current day political crossfire. Differentiating between poorly treated chronic pain and addiction in chronic pain can be a daunting task for a primary care provider. Heightened anxiety and fear can look very much like an addiction disorder, particularly for persons who are not pain or addiction specialists. Patients with chronic pain and addiction are often referred to MAT programs. We hope the information in this section helps to increase the readers' understanding and knowledge.



A few thoughts on chronic pain:

- Many patients with physiological dependence (tolerance, withdrawal, cravings) do not meet the criteria for opioid use disorder (misuse, diversion, persistent use and escalating negative consequences).
- Many patients continue to take prescribed opioids for pain in full compliance for years. These patients will also experience tolerance, withdrawal, and cravings.
- A chronic pain patient who occasionally self-escalates, runs out early in an episode of increased pain after years of compliance, despite how the patient presents, likely does not have an active addiction disorder. Pain and fear of pain are significant drivers for aberrant behavior.

- It is often difficult after years of long-term opioid therapy to have a clear *baseline of pain.* The pain plus dependence with breakthrough, low-grade opioid withdrawal muddies the pain picture.

When assessing patients on long-term opioid therapy:

- Obtain Prescription Drug Monitoring Program (PDMP) report
- Routine urine drug screening, and screening/testing for alcohol use disorder.
    - Benzodiazepines often show up as part of the long-term opioid therapy
    - Discuss possible increased alcohol use to manage pain
    - Educate about opioid-induced hyperalgesia

Helping patients on long-term opioid therapy get to safer prescribed medications or improving pain management will take time — weekly nurse case management and weekly behavioral health visits are recommended initially.

2. New CDC guidelines

Find the new CDC guidelines **here**.

- Opioids are no longer the first line of care for non-malignant pain.
- Start low, go slow.
- It is best to use opioids for briefest possible length of time. Frequent assessment. Be cautious with MME (morphine milligram equivalent of 50 mg/d and no higher than 90 mg/ d).

Source reading for this section:

- Factsheet CDC Guideline for Prescribing Opioids for Chronic Pain: **https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf**

3. Safe prescribing

Often the biggest challenges in a primary care clinic are the many patients who have been on long-term opioid therapy for chronic pain.

- More than 20 years of continuous opioid therapy is not unusual
- Often unsafe dosing of multiple opioids (long and short-acting) plus muscle relaxants, and benzodiazepines
- Changing course for these patients requires education, assessment and planning
- Discussion of change and/or taper can elicit significant fear and anger in patients. Support and respectful collaborating for effective, safe, and comfortable tapering is very important.
- Be prepared to prescribe for seven days when patient is on a taper schedule, for better management of taper and more support.
- Note there may be cases when taper is not necessary or appropriate for the patient. These questions can help guide the decision:
    - Is the patient stable and functioning on the current medication(s)?
    - Is the patient on a reasonable dose (<90 MME) without evidence of aberrant use?
    - Is a previous taper resulting in significant functional decline?

4. Behavioral health and chronic pain

With chronic pain, there is often underlying or poorly treated anxiety or depression. This can be exacerbated by tapering. Heightened anxiety along with fear of pain are common in patients who are asked to taper or change medications. When planning to taper a patient who is on long-term opioid therapy, keep in mind:

- Assess for history of childhood and adult trauma.
- Talking about tapering results in considerable fear and anxiety. Patients fear you are taking away the one thing that has worked for them. There may also be considerable fear of withdrawal.
- While tapering opioids and other controlled prescribed medications, refer to behavioral health for updating assessment and therapy.
- Tapering often increases fear and crisis for patients. Weekly behavioral health counseling can help mitigate escalating or aberrant behaviors.
- Mindfulness groups can also provide relief.

5. Inadequate pain management

Patients who are slowly tapered down to a safer opioid dose might perceive their pain as poorly managed.

- Poorly managed pain can increase alcohol use, increase depression, and decrease function and quality of life.
- Patients often experience fear of being tapered or cut off their pain medications. As such, they are less inclined to discuss their pain, alcohol, other substance use, depression, anxiety, and fear honestly with their provider.
- The patients are often stigmatized as "drug-seeking." This term is commonly added to the medical record and often found in the problem list available for anyone viewing their medical record.
- Patients often defensively refer to themselves as "not drug addicts."
- The patients often feel stuck taking opioids because they do not want to have to endure withdrawal or to live without any opioids —no matter how inadequate.

6. Buprenorphine for pain management

Buprenorphine can be an excellent pain management option for patients with poorly managed pain. Here are some guidelines for how to get patients started on buprenorphine for pain management.

- Anyone with a DEA number can prescribe buprenorphine for pain as well as for opioid use disorder. There is no need for an X waiver, but need to indicate on prescription "for pain."
- Only Balbuca and Butrans are indicated for pain. All other buprenorphine products can be used off-label for pain, which is common (as with many other drugs). The DEA has recognized the role of off-label buprenorphine for pain and has ruled favorably.
- A limited number of insurance companies pay for buprenorphine for pain.

- Their PCP can refer them to an MAT program or consult with MAT prescribers.
- Schedule an appointment for pain assessment, substance use, if any, current behavioral health, and education about buprenorphine for pain.
    - *If the patient has a substance use problem such as alcohol, methamphetamine, or benzodiazepine use disorder – offer detox and treatment before initiating buprenorphine.*
- Develop plan of care with PCP, including induction and follow-up care.
- This should not be an urgent care, PCP must maintain patient on opioids until induction.
- Most chronic pain patients can tolerate a home-induction with a good plan and ongoing RN monitoring and support.
- Pain patients will require a lower dose of buprenorphine if their MED is less than 80 mg/d, you might consider starting with Butrans patches.
- Patients with a MED of 80mg or higher will likely have some difficulty switching to Butrans, even at the 20mcg dose.
    - In this instance, consultation with pain and/or addiction medicine before switching to Butrans is recommended.
- There tends to be a higher sensitivity to side effects with pain management patients. It's okay to start low with Butrans and titrate dose as side effects clear.
- Finding the ideal pain management dose can take 2 weeks of close monitoring and dose changes.
- During this time, which often involves withdrawal symptoms and heightened anxiety, ensure more close involvement with behavioral health providers, and provide reassurance.
- If the patient is having mild withdrawal symptoms, consider using clonidine 0.1mg q6 hours or 0.1mg patch (refer to withdrawal management section for more suggestions)

7. Opioid induced hyperalgesia (OIH)

Once called 'rebound pain,' this phenomenon comes with the consistent use of opioids over time. OIH is characterized by increased sensitivity to pain and lower pain threshold due to down regulation of the opioid receptors, as well as increased headaches.

- The patient may find they need more opioids because of decreased pain relief.
- The medication has become a part of the pain problem.
- Buprenorphine shows promise in studies of having anti-hyperalgesia properties.
- Anecdotally, after starting buprenorphine, OIH tends to clear up over a period of 6 months. The chronic pain patient may find the pain flares less and even stabilizes at a much lower measure on the pain scale.
- With cravings well managed, the patient no longer 'needs' the pain to obtain opioids.
- Chronic pain patients with opioid dependence often report increased quality of life and improved overall wellness after switching to buprenorphine.

8. Care needs for patients with long-term opioid therapy for chronic pain

- Empathetic, caring provider acting in partnership with patient
- Nurse case management
- Behavioral health referral
- Pain support groups
- **PACE for Pain**

Source reading for this section:

- PACE for Pain: **https://www.paceforpain.org/**

04 Data

We would like to give a special thank you to Lauran Hardin, Dawn Wiest, Gayle Christiansen, Hannah Mogul-Adlin, Emily Wasuna and Hunter Gatewood and Mark McGovern for your dedication, expertise, writing and editing contributions. Your willingness to share your knowledge and time has made the drafting of this section a reality. Many thanks, Katie & Shelly

1. Why data is so important

As a clinician starting a MAT or addiction program, data may be the last thing you are thinking about. In fact, data can be one of the most powerful things to support success, funding, and partnerships for your work with vulnerable populations.

In this section, we cover multiple uses of data, including data for needs assessments, data for reporting to external funders and regulators, and data for quality improvement (QI) learning and decision-making within a service or program.

Three uses of data:

- Judgment/evaluation: Managers, staff, external auditors, or evaluators review what has happened to this point to see how well it is working, and if it meets expectations. Examples in healthcare: chart audits, inspections, reports to external funders or regulators. Outside healthcare: restaurant inspections, smog checks on cars.
- Improvement: Managers and staff focus on their current work processes and the results they are getting using measures data to track progress towards a time-bound goal. The work and use of data are future-focused, and focused on the patients and populations served. Data are reviewed monthly or more frequently to answer the question: "What can we do differently?"
- Research: Not common in most clinical care settings. A research team uses the scientific method. They seek to control conditions, get as much data as possible, and complete one big test (using a hypothesis), to generate one large analysis and one report. Examples: Developing a new medication, assessing the effectiveness of a weight management program.

Program evaluation and quality improvement are both important parts of running and sustaining effective programs. These two different types of work and their different uses of data should be harmonized, but seen as different in their goals and ongoing operations. A helpful distinction to keep in mind: Evaluation can be done by someone external to the people providing the care. QI work cannot.

2. Getting started

Answering three questions during initial design can help to target your data collection:

1. Which data are you required to collect for grant or funding requirements?
2. What measures will tell you how well your efforts are serving the goals of your program? These are your quality improvement measures.
3. What resources do you have for data collection and analysis?

Your first step to success will be to create a structure for capturing the data required for funding. If you have data analyst support, partner early and define what data can be pulled automatically from the EMR or other sources and what needs to be captured specifically by clinicians.

If you have no data analyst support, identify the measures you need to capture for funding, create a process where clinicians are capturing these measures during the clinical encounter so that you can retrieve them, and identify who on your team will collect and report data. These measures can be captured in a simple Excel spreadsheet. See Appendix E for examples.

Taking it to the next level

Often, measures for funding include indicators of where a program is with progression of implementation (i.e., how many patients seen in a quarter). These are helpful markers but are not the same as developing an effective database to support ongoing funding and investment in your program. Taking time on the front end to decide what measures will support your program for the long term is a valuable investment for the future. These measures are often the ones you can use to track and learn in your quality improvement work.

Identifying partners

Taking a 360-degree view of patient data can be helpful to identify partners who may be able to provide you with data, rather than having clinicians capture it during the clinical encounter.

Meeting with partners on the front end of data development can save you a lot of time and re-work. The following are common partners with potential outcome data for MAT programs:

- Payers
- Community mental health
- Hospitals
- Criminal justice
- EMS
- HIE

Each partner will have their own challenges with data, but finding out if any can provide you with cost and utilization data on your patients with intervention will save you a lot of time in data collection.

Creating your database

Regardless of the sophistication of your support resources, you will need baseline data on all of your patients with intervention. Baseline measure examples include demographics and start and end dates of the intervention. Here is a list of things to consider keeping in an excel spreadsheet (or having your data analyst pull from the EMR):

- MRN

- Name
- DOB
- Race
- Language
- ZIP code
- Start date of intervention
- End date of Intervention (and why if they dropped out of the program)

Utilization and cost measures

Every program will need utilization and cost measures to ensure future support and investment. These measures can come from payers, hospital records or community sources. It is helpful to build into your utilization reports a differentiation between inpatient, emergency room, primary care, and length of stay days in the hospital. If you can, add EMS, jail days, police encounters, and days in homeless shelters in the utilization assessment. You can simply count these 12 months before intervention and 12 months after intervention or have reports run from your partners at these same intervals.

For cost, it is important to differentiate how costs change between inpatient, emergency room, and primary care. If you have partners and support, differentiating changes in pharmacy costs, criminal justice, and community service costs can be helpful. You can also show revenue (from increased primary care or other visits you are billing) in this section. Cost data is most easily captured from partners. If you have no partners to pull financial data, you can make cost assumptions based on the utilization data you capture.

Quality improvement measures

Deciding on the front end what you will capture to show the impact on improved quality of care will save you a lot of time. Resource measures like connection to primary care, housing, insurance, and employment can be helpful things to capture if your program is addressing these needs. Evidence-based scales can be helpful to include in the program such as PHQ9 or GAD7 to show changes in anxiety and depression following treatment. Disease indicators like HTN or A1C for diabetes can also be helpful to track. Think about what your program is addressing in your model and what measures will round out the cost and utilization story. Building in an assessment of these measures at the start of intervention and 12 months later will build the case for the quality improvement impact of your program.

Data for quality improvement are unique from data for program evaluation and data for reporting to external funders or regulators, in that QI measures data are collected more frequently (usually monthly or weekly) and are for your team's internal learning. You measure frequently to see how your care processes are working. When you have a staff team that wants to make changes to get better results, it is worth the effort to capture and discuss data frequently. QI data answer questions like: "Are we on the right track?" and "Are we going to reach our goals for the patients we serve, or want to start serving?" and "How many of our patients are reaching their individual goals?"

Patient and provider satisfaction

Capturing stories or direct satisfaction surveys from patients and providers can also round out the data for support of your program. Having patients sign a release form (see Appendix G for sample) and capture their stories in writing, in a recorded interview, or a simple iPhone video is a powerful way to tell the success story for your program. The same thing applies to providers: impact on efficiency and burnout is a powerful motivator for investment in your program. Satisfaction surveys are a way to capture quantitative impact.

Program efficiency

Another area of data capture includes measures for program management, including how many patients are seen in a day, how many no shows, how long are the visits, or how many people drop out of treatment.

3. Why measurements matter

Sharing outcome data from your program can make a case for increased funding and support. For instance, data can show a reduction in utilization, a reduction in incarceration, and an increase in safe housing, an increase in medication compliance, and an increase in primary care connectivity, which can all make a case for your program. Without data, it is very difficult to demonstrate cost avoidance as a result of the program. Programs should consider what they want to measure in the program design phase so the appropriate data collection systems can be set up instead of after a program is already up and running, which may be disruptive and lead to collecting incomplete data.

1. Starting out with a needs assessment

A needs assessment, also referred to as a capacity assessment, is a way for programs to evaluate their strengths and areas for growth. A good needs assessment will help prioritize activities and goals. It helps to keep program development and growth on track.

Sharing outcome data from your program can make a case for increased funding and support. For instance, data can show a reduction in utilization, a reduction in incarceration, and an increase in safe housing, an increase in medication compliance, and an increase in primary care connectivity, which can all make a case for your program. Without data, it is very difficult to demonstrate cost avoidance as a result of the program. Programs should consider what they want to measure in the program design phase so the appropriate data collection systems can be setup instead of after a program is already up and running, which may be disruptive and lead to collecting incomplete data. Learn more about needs assessments in complex care in this **Health Affairs blog post**.

2. Outcome measures

What follows are suggested outcome measures to consider collecting when designing your MAT program. As a reminder, the process of developing outcome measures is most helpful after a program implementation assessment or evaluation is completed, and collecting process measures is also very important. The purpose of the lists is to think more broadly about what can be measured. For specific screening tools, see the **NIDA database**.

Outcome measures:

Basic quantitative patient measures:

- Number of patients engaged
- Number of patients completing the program
- Patient goals achieved (include the number and which ones)
- Connection to primary care, specialty care, relevant services (e.g., mental health treatment)
- Diagnosis
- Utilization: These include number of emergency department visits, number of hospitalizations (including psychiatric), number of crisis utilizations, amount of imaging and/or lab use, number of primary care provider visits

Patient retention measures:

- Days or months engaged in treatment

- Days/months on buprenorphine
- No show rate
- UDS positive for prescribed medications
- UDS negative for all other substances
- Engagement with ancillary services (e.g., are patients attending behavioral health appointments)

Patient overall wellness measures: to show an improvement in health:

- Blood pressure better controlled
- Decrease in A1C
- Attending physical therapy
- Decrease in cholesterol
- Weight loss
- Measures related to specific illnesses or diseases generally

Patient functional improvement and wellness (a mix of quantitative and qualitative measures):

- Increased connection and engagement with working, attending school, participating in a larger community, etc.
- Perceived well-being
- Perceived social support
- Self-efficacy (e.g., in terms of navigating the health care system, taking care of their needs)

3. Program measurements:

Program efficiency:

- Scheduling delays
- Referral delays
- Behavioral health no show rate
- Unanswered patient calls
- Overall no show rate

Patient program assessment (qualitative)

- Overall program assessment: what was helpful and what can be improved
- Description of care received from providers
- Perception of life quality and expectations for the future

Staff measures (qualitative)

- Degree to which staff have support
- Degree to which staff voices heard
- Team function
- Staff resilience measures
- Perception of patient outcomes

Additional resources:

Topic	Link	Purpose
Program evaluation and measurements	**https://www.ruralhealthinfo.org/toolkits/rural-toolkit/4/program-evaluation**	Additional Resources
Program evaluation	**http://www.qualityforum.org/prioritizing_measures/**	National Quality Forum resource with evaluation information in five content areas.
Quality improvement	**www.ihi.org** **https://www.ahrq.gov/evidencenow/tools/qi-essentials-toolkit.html** (includes data display templates)	General education and tools for use with the Model for Improvement
Quality improvement	**http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx**	Advice on how to establish a balanced measure set
Quality improvement	**https://www.signalkey.com/resources**	Guidance and tools on scaling up and sustaining improvement

Source reading for this section:

- Health Affairs blog post: **https://www.healthaffairs.org/do/10.1377/hblog20180622.306574/full/**
- Screening and Assessment Tools Chart: **https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools**

Appendix A: Key competencies for complex care

Note: The sections in this appendix were taken from a larger complex care manual written by Lauran Hardin and Shelly Virva and edited by Emily Wasuna.

This appendix provides the reader a brief description of the key competencies teams should have when working with patients with complex health and social needs, including many patients suffering from the disease of addiction. Each key competency in this appendix includes additional readings and recommended videos. This section is by no means exhaustive; the competencies listed here are those we have identified as critical in our experience working with opioid and other substance use disorders.

Learning about vulnerable populations

Authentic healing relationships and COACH

An "authentic healing relationship" is a term coined by the Camden Coalition of Healthcare Providers to describe the aspect of its complex care intervention that was most valued by patients with complex health and social needs. It has become a fundamental concept in the complex care approach that the Camden Coalition practices and teaches to organizations across the country.

The Camden Coalition was founded in 2002 by primary care physician Jeffrey Brenner, who aimed to change care for the most vulnerable residents of Camden, New Jersey. Through data analysis, he found that 30% of hospital costs were coming from only 1% of the patients in the city. He formed the Camden Coalition to understand and improve care for this invisible population. The work and insights of the Camden Coalition became part of the driving force in developing the field of complex care.

Focusing on the patients with the highest needs in Camden quickly taught the Camden Coalition that a different understanding and approach would be needed to change outcomes in the population. Social factors such as lack of housing, lack of transportation and lack of access to care were common. Even more important was the finding that many people with high utilization of hospitals and emergency services had significant childhood trauma or recent traumatic events as an adult. Building trust, safety and respect became critical elements of the care intervention.

Learning directly from patients, the Camden Coalition found that a critical element of care intervention was the development of an authentic healing relationship. The Camden Coalition

defines this as a respectful, trusting and non-judgmental partnership between the patient and the care team. Through interviews with patients, they identified three core elements of this relationship: security, genuineness, and continuity.

The Camden Coalition developed the COACH framework as a way to name and practice behaviors that lead to building authentic healing relationships. The five-part COACH framework trains staff to problem-solve with patients to effectively manage their chronic health conditions and reduce preventable hospital admissions.

Resources:

The core of care management: The role of authentic relationships in caring for patients with frequent hospitalizations (Grinberg, 2016)
Using qualitative methods, investigators identified and elaborated the core elements of the authentic healing relationship that is linked to patient motivation and active health management. These authentic healing relationships present significant implications for addressing the persistent health-related needs of patients with frequent hospitalizations.

COACH Manual

The COACH framework was developed from this understanding. The framework is a comprehensive approach to vulnerable patients with high inpatient utilization. There is an in-depth manual on COACH that you can review for further information:
https://www.nationalcomplex.care/research-policy/resources/toolkits/coach/

Patient Stories

Hearing directly from patients is one of the most powerful ways to understand how childhood trauma and recent adult trauma impact choices and health outcomes. Watch the following video and listen to the WHYY broadcast to hear directly from patients about what is important.

Healing Neen: Trauma and recovery (25 min) This short documentary shares the story of Tonier "Neen" Cain's emergence from drug addiction, multiple incarcerations and two decades of homelessness to become a tireless advocate and educator on the devastating impact of childhood abuse and the need to rethink how we treat the shattered adults severely traumatized as children.

When your symptoms don't tell the whole story (7 min) This broadcast from WHYY describes what was happening for a vulnerable young woman underneath her medical concerns and the approach that made a difference in her care.

Reflecting on the patient stories and materials you reviewed - answer the following questions:

- What experiences have you had with caring for patients with a history of trauma?
- What surprised you about the patient stories?
- What do you do now as standard practice to establish an authentic healing relationship with patients?
- What new practices will you add as a result of reviewing these materials?

Comprehensive patient assessment

Overview

Every discipline has learned standards of practice for patient assessment. Patients with complex needs often require integrated assessment across disciplines, which provides a deeper look at the patient story and root causes driving access to the healthcare system. The field of complex care is in the early stages of developing core competencies for comprehensive assessment. In this section, you will find key emerging areas to add to your current standards of practice for comprehensive patient intervention.

Root cause

Root cause

Regardless of your discipline, comprehensive assessment requires developing the ability to see root cause drivers of patient instability. Reviewing patterns in their medical record for at least 3 years prior to referral can help to identify patterns and opportunities for improving care. There are four common root cause quadrants of complexity – medical, behavioral health (mental health and substance use disorders), social, and systems root causes.

Medical

In addition to identifying the patient's medical diagnoses it is helpful to look at common root causes experienced by complex care patients. These include:

- Which diagnoses are actually driving high frequency access to the healthcare system?
- Is the patient receiving evidence-based treatment for these chronic diseases?
- Does the patient have high frequency access because of declining health and are they appropriate for hospice care? If so, do they have an advance directive?
- Is the patient competent to make their own decisions? If not, do they have a guardian?
- Does the patient have an evidence based plan for chronic pain and symptom management?

Learning to ask these baseline medical questions will help prepare you to see patients with complex needs through a more comprehensive lens.

Mental health and substance use disorder (SUD)

Many patients with complex health and social needs have an underlying mental health or substance use disorder (SUD) diagnosis. Learning to deepen your assessment of root causes in this quadrant will help you to identify potential areas to help complex care patients. Some questions you can add to your standard assessment include:

- Does the patient have a mental health or SUD diagnosis in the medical record?
- If so, are they receiving evidence-based treatment for this diagnosis?
- If the patient has a SUD diagnosis, what is(are) the patient's substance(s) of choice?
- Are there conflicting behavioral health and/or SUD diagnoses in the record?

These questions will begin to point to potential areas for improvement in the plan of care to help stabilize patients with complex needs.

Social

There is growing evidence of the important impact of social factors on health and high frequency acute care utilization. Many disciplines have not learned to ask questions about social

root causes as part of standard assessment. Some questions you can add to your assessment include:

- Does the patient have safe housing?
- Does the patient have transportation for medical appointments?
- Does the patient have communication barriers (i.e. limited access to phone or minutes on cell phone)?
- Does the patient have access to food?
- What is their level of health literacy (i.e. can they read, do they understand their disease)?
- Are they socially isolated or in an unsafe situation (e.g., domestic violence)?

These questions can help identify potential areas that may be influencing high frequency access to the healthcare system.

System

Complex care patients often require care from multiple, disconnected healthcare providers. This often creates serious gaps in care and services. Looking for system-related root causes can help identify areas for improvement within the delivery system. Here are examples of additional questions that can help to identify these system issues.

- Does the patient have access to primary care, specialty care and the medications they need?
- Are they receiving conflicting medications from different providers? Are they receiving opioid, benzodiazepine or amphetamine prescriptions from more than one provider?
- Are they experiencing ethical dilemmas (e.g., fired from care)?
- Are there gaps in the plan of care happening in transition between settings?

These questions can help identify potential areas within a healthcare system that may be influencing high frequency access.

Root cause pattern of access

Additionally, when completing a comprehensive assessment, it is helpful to review the patient's visits in the last 12 months. This helps to identify the root cause drivers that fuel their access to the system. Looking at the drivers of access instead of their diagnoses can point to important gaps in care, gaps in resources or undiagnosed mental health and/or substance use disorder issues.

Case study

Now that you have been introduced to root cause assessment, it is time to practice. Find one patient that is currently in your complex care program. Using the guiding questions above, review the medical record and complete the following assessment.

4 quadrants of complexity Please fill in the boxes below based on any information you know about the individual you're working with:	
Medical	Mental health and substance use disorder
•	•

Social	Systems
•	•

Utilization (past year)

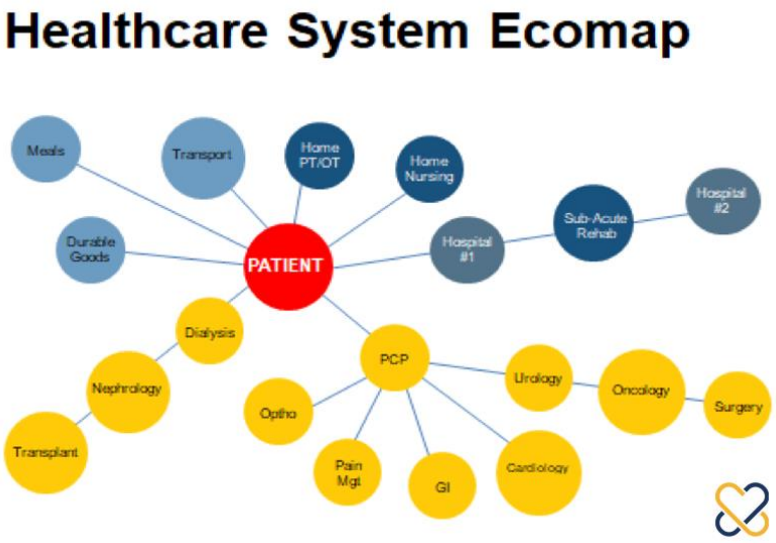
Type	Number in previous 12 months	Root cause
ED		
Inpatient admissions		
Length of stay (days)		

Reflecting on the patient stories and materials you reviewed, answer the following questions:

- What surprised you from this exercise? What did you find that you normally would not have seen with a standard assessment from your discipline?

Cross-continuum team

Complex care patients often interact with many providers in the healthcare system and across the community. Identifying the agencies and people currently engaged with the patient can be a helpful practice. This helps to identify who may be a partner or advocate for the person, thus moving the patient toward a stable plan of care. The diagram below gives an example of many of the cross-continuum team members that may be involved with a patient. It doesn't include the social, community, faith, and family resources that also have an important influence on outcomes for complex care patients.



Asking patients directly who is part of their cross-continuum team can round out the eco-map.

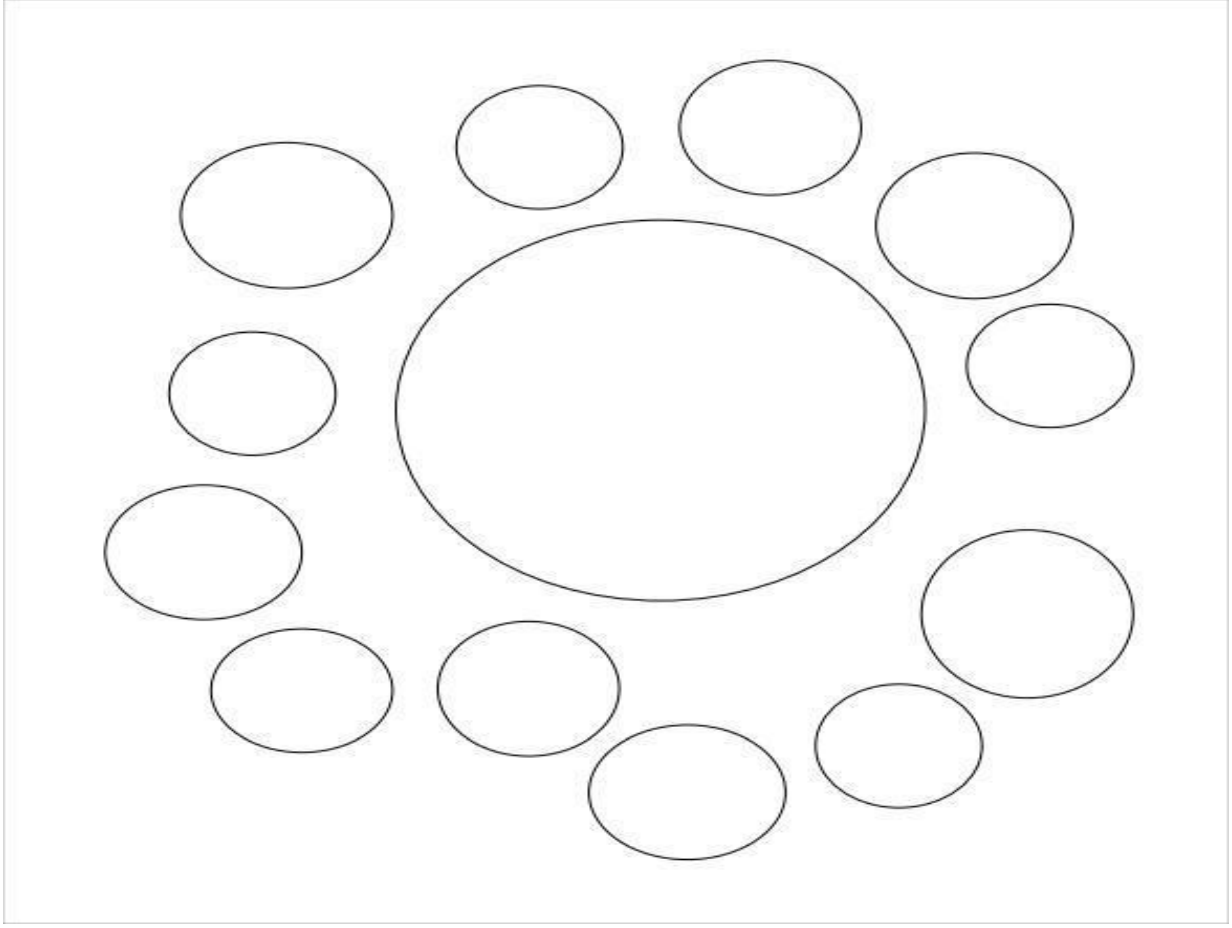
Chart of *(client initials)* existing relationships / Cross-continuum team			
Relationship (family, friend, provider, community organization, etc)	Type of relationship (strong, weak, stressed)	Potential long-term support (yes or no)	Notes/Action Items

Case study:

Now that you've been introduced to eco-mapping it's time to practice. Find one patient that is currently in the complex care program. Using the following **resource**, review the medical record and complete an eco-map for this patient.

Blank eco-mapping template:

Identify the agencies and important people connected to the patient.



Reflecting on the patient stories and materials you reviewed - answer the following questions:

- What new partners did you identify who may be able to help in improving the patient's plan of care and outcomes?

Chronic pain management

A common root cause driver of high frequency acute care utilization is chronic pain. The reasons for this are diverse but can include lack of access to a pain management service, lack of evidence-based pain management plan, overprescribing of opioids, or overuse of opioids. Many providers have not received comprehensive education in appropriate pain management. Review the following resources to build your competency in chronic pain management.

Dr. Corey Waller - The House of Medicine is Incomplete (11 min) This short video gives a compelling description of why competency in this area is important for intervention in the 5% of the population that drives 50% of healthcare spending.

Resources:

Understanding chronic pain management is a required competency for the team because of the impact this has on the complex care population. To build your competency in this area:

- Read the chronic pain informational page on the National Institute of Neurological Disorders and Stroke Website:
  - **https://www.ninds.nih.gov/Disorders/All-Disorders/Chronic-Pain-Information-Page**
- Complete the following courses from Providers Clinical Support System (PCSS).
  - **https://pcssnow.org/education-training/training-courses/course-overview-management-chronic-pain-core-curriculum-primary-care-providers/**

Case study/exemplar:

Now that you have been introduced to chronic pain management, it is time to demonstrate what you have learned. Find one patient that is currently in the complex care program and has chronic pain. Using the resources listed above, review the medical record and complete a chronic pain assessment and plan for the patient.

Patient initials: Age: Diagnoses: Pain assessment: Current treatment plan: Your evaluation and recommendations for intervention and treatment plan:

Resources:

Pain Edu - free website with downloadable tools, webinars, educational materials and articles.

Social determinants of health

Patients with complex needs often experience a constellation of factors that contribute to their high frequency acute care utilization. Understanding how issues like transportation, housing, violence, and social isolation, to name a few, affect a person's ability to access care as well as manage chronic disease is vital. Integrating screening and assessment of social determinants of health into practice gives us a broader understanding of the patient experience and what impact these issues have on the patient's health and wellness.

Watch the following video for an overview of the impact of social issues on healthcare:
Rishi Manchanda - What makes us get sick? Look upstream - (18 min)

In practice we have learned if a patient is experiencing housing insecurity (homelessness or unsafe housing) the patient is much less likely to follow disease management recommendations. If a patient has limited or no transportation, the patient is less likely to make it to primary care or specialist appointments. If a patient is unable to read or write, it is unlikely the patient will understand discharge instructions. Learning to integrate additional assessment or screening for these issues is critical for improving care for vulnerable populations.

Resources:

- **Resources for social determinants of health** (Health Begins)
- **Toolkits and manuals on social determinants of health** (National Center for Complex Health and Social Needs)

Read the following brief for an overview of different screening practices for SDOH:

- **Screening for social determinants of health in populations with complex needs: Implementation considerations** (Center for Healthcare Strategies, 2017)

Review the following discussion paper and social determinants of health screening tool:

- **Standardized screening for health-related social needs in clinical settings** (National Academy of Medicine, 2017)

Considering the materials you have reviewed, answer the following questions:

- What was your standard practice for assessing social determinants of health prior to joining your team?
- What screening practices did you learn from the resources (videos and websites listed above) that you would add to your intervention with patients?
- What areas do you need to learn about to effectively address social determinants of health with your patients?

Interprofessional teaming and resiliency

Overview:
Patients with complex needs often have high frequency utilization of acute care systems because their combination of medical, behavioral, and social needs requires intersection with many different systems for treatment and the expertise of several different disciplines for best practice intervention. Learning about teaming occurs best in practice and will be an evolving development for each member of the team.

In this section, you will find several resources to build your knowledge, awareness and practice for integrating the competency of interprofessional teaming and resiliency.

Stages of team development

A foundational step in understanding teaming is being aware of the stages of team development and the important practices that help teams to navigate the changes.

As part of a team, it will be helpful to be aware of these stages so that you can understand each other and create helpful practices for a healthy team.

Resources:
Watch the following video introduction and review the resources listed below:

- **Forming, storming, norming, and performing: Bruce Tuckman's team stages model explained** (2 min) - Explanation of Tuckman's Stages of Team Development
- **Tuckman's team development model** - Handout on Tuckman's Stages of Team Development
- **The five stages of team development: A case study** - A case study to review

In the space below, identify the stage of development your care team is in and two practices you commit to follow to contribute to healthy team development.

- Stage of team development:
- I commit to
  1)

  2)

Creating effective communication on the team

Teams working in the field of complex care can be faced with intense dynamics given the vulnerable populations served by these programs. It is very important for teams to develop healthy communication with each other so that they can collaborate and carry the intensity of the work together. Understanding common communication challenges and how to shift to healthy communication is an important part of developing interprofessional team competency. The following resources will introduce you to some key concepts to be aware of in team dynamics.

Review the following short videos for some tips on key areas in team communication:

- **The drama triangle: Victim perpetrator rescuer** (2 min)
- **Understanding the drama triangle vs presence** (3 min)
- **Four horsemen of the apocalypse**: (2 min) Key communication strategies for effective relationships, highly applicable to teams as well.

Competency reflection

Now that you have reviewed the materials about interprofessional teaming it is time to reflect on your experiences with this competency. In the space below write two case examples – one where you worked on an effective interprofessional team and one where you worked with an interprofessional team that was not as effective.

Case study #1 – The high functioning team

- What were the characteristics, practices and values that made the team work well together?
- What role did you play in that team and how did you contribute to these practices?
- What impact did that have on patients?
- How will you carry those practices into your new team?

Case study #2 – The low functioning team

- What were the characteristics, practices and values that caused the team to not work well together?
- What role did you play in that team and how did you contribute to these practices?
- What impact did that have on patients?
- Reflecting on what you've learned from this module – what would you do differently in that team if you were involved in it again?

Additional resources for deeper understanding:

Learning about interprofessional teaming is an on-going practice. As your team grows the following resources will be a helpful reference for continuing to build your competency in this area.

- **Core principles & values of effective team-based health care** (Institute of Medicine of the National Academies) - Common reference points to guide coordinated collaboration among health professionals, patients, and families to accelerate interprofessional, team-based care.
- **Implementing team-based care** (American Medical Association) - In STEPS Forward™, AMA uses several modules to describe individual elements of a team-based care model. This reference is focused on creating team based care in a clinic setting.
- **Interprofessional collaboration in health care: Lessons to be learned from competitive sports** - For the sports fans, this article compares team sports to teaming in healthcare listing the essential ingredients needed for successful.

Resources and webinars for additional learning (Center for the Advancement of Palliative Care) - The field of palliative care has a shared competency of interprofessional teaming. Many of their resources are available here.

Resiliency

Creating resilience in the team:

As a team member in complex care, it is very important to attend to resiliency in the team and in ourselves. The complexity of the population served requires a strong team and a strong investment in personal health and balance. You are one of the most important resources for success in intervention with vulnerable patients.

Resources

- **Individual strategies to promote well-being** (National Academy of Medicine Clinician Well Being Knowledge Hub)
- **Strategies for maximizing the health and function of a palliative care team** (Center to Advance Palliative Care)
- **Brene Brown - The power of vulnerability** (20 min)
- **Robert Waldinger - What makes a good life** (13 min)

Follow **this link** to review the latest information from the National Academy of Medicine on clinician wellbeing and resilience. One of their key graphics is depicted below.

Reflection

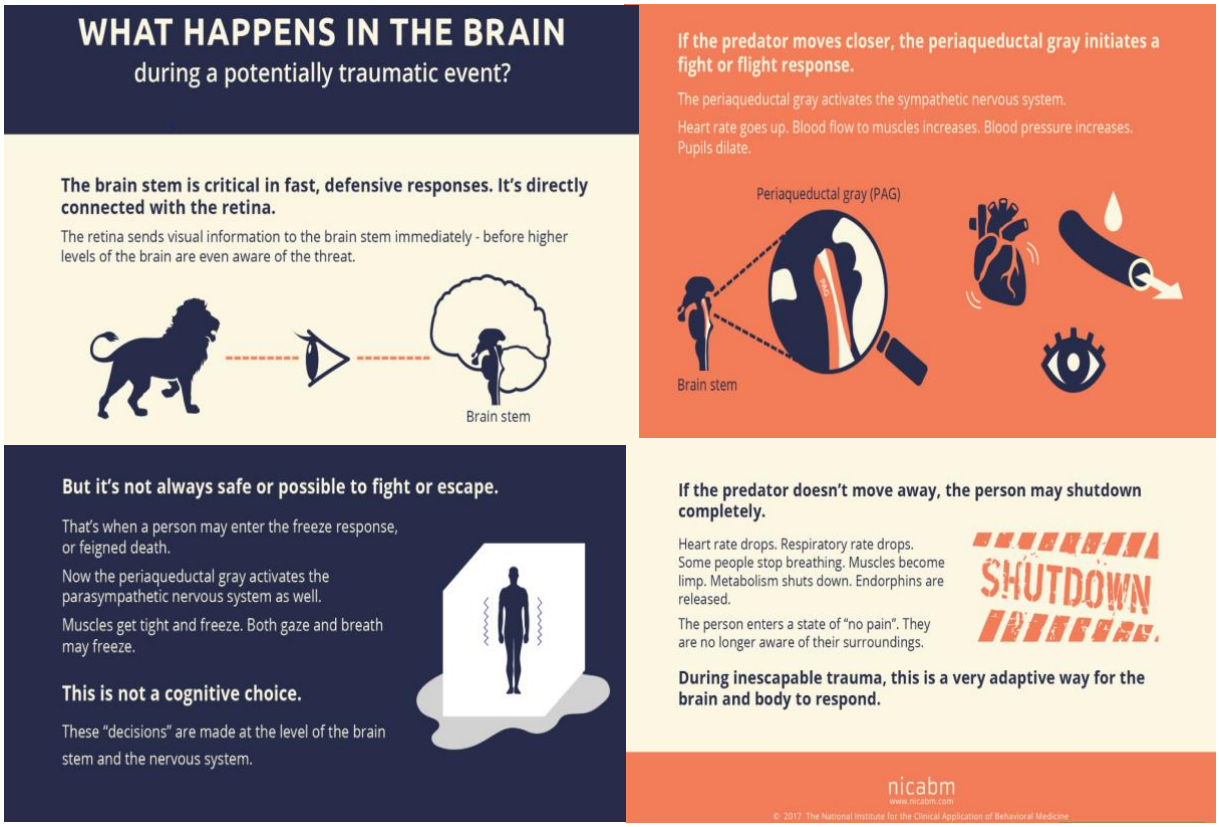
Using the resources above as a reference, identify two practices you will implement to contribute to team resiliency and two practices you commit to implement for your own health and wellbeing.

Early life trauma

Neurobiology of trauma

Overview

Emotional, physical, and/or sexual trauma, often times occurring in early childhood, is highly prevalent in patients with substance use disorders. Current research shows a significant neurological change in people who have been exposed to traumatic events. Understanding how this exposure impacts brain development and function, especially in early childhood, is a critical component. Often this is a significant root cause driver for mental and physical health problems, substance use disorder, as well as many social determinants of health. This section is focused on the neurobiology of trauma. Upon completion you will better understand how our brain is wired for survival, the neurobiology of the stress response system (fight, flight or freeze), and the changes that occur from repeated exposure to trauma, i.e. child abuse/neglect, interpersonal violence, war etc. The illustration below depicts how the brain and body respond to a perceived traumatic event. (NICABM 2017)



Resources

- **The neurobiology of trauma** (Australian Institute of Professional Counsellors) - This article focuses on the neurobiological effects trauma has on the brain.
- **Bessel Van der Kolk - Scientific publications on trauma**
- *The body keeps the score: Brain, mind, and body in the healing of trauma* Book by Bessel van der Kolk

Core videos to watch:

- **John Rigg -The effect of trauma on the brain and how it affects behaviors** (28 min)
- **American Museum of Natural History - Science bulletins: Brains change with trauma** (2 min)
- **National Institute for the Clinical Application of Behavioral Medicine - Three ways trauma can change the brain** (3 min)
- **Bessel A. van der Kolk - Trauma & attachment** (3 min)

Competency reflection, assessment, or demonstration

Now that you have reviewed the materials about early life trauma, it is time to reflect on your experiences with this competency. In the space below write two case examples – one where you have had a positive outcome or effective interaction with someone who has a known history of trauma and was either hyper- or hypo-aroused and one in which the intervention was not as effective. Please identify which type of arousal in each case.

Case study #1 – The effective intervention

- What were the characteristics, practices and values that contributed to an effective intervention?
- What role did you play? How did you contribute to the success?
- What impact or outcome did this have on patients?

Case study #2 – The ineffective intervention

- What were the characteristics, practices and values that contributed to the ineffective intervention?
- What role did you play?
- What impact did this have on patients?
- Reflecting on what you have learned from this module – what would you do differently if you were involved in it again.

Attachment

Overview

Attachment theory was developed in the 1960s by British psychoanalyst John Bowlby out of his interest in understanding the intense distress an infant experiences when separated from their caregiver. Research done within the field of interpersonal neurobiology helps us better understand early brain development and the significant impact fetal and infant exposure to trauma has beginning in the third trimester of pregnancy. Early life trauma often creates an insecure attachment style which continues through adulthood, impacting a person's relationship with others. Understanding the difference between secure and insecure attachment, and defining the three types of insecure attachment is a necessary component of working with complex patients. Upon completion you will better understand the four different types of attachment, how they develop and the resulting impact on adult relationships.

Core Videos to Watch:

- **Dr. Allan Schore - Attachment trauma and the effects of neglect and abuse on the brain** (5 min)
- **Dr. Allan Schore - Neurobiology of secure attachment** (13 min)
- **Dr. Dan Siegel - Disorganized attachment** (5 mins)

Attachment terminology

Taken from Dr. Dan Siegel's **work on attachment theory**.

Child terms	Adult terms
Secure/autonomous	Secure/autonomous
Anxious-resistant	Preoccupied
Anxious-avoidant	Dismissing
Disorganized/cannot classify	Unresolved/fearful/cannot classify

Attachment style	Parental style	Resulting adult characteristics
Secure	Aligned with the child; in tune with the child's emotions	Able to create meaningful relationships; empathetic; able to set appropriate boundaries
Avoidant	Unavailable or rejecting	Avoids closeness or emotional connection; distant; critical; rigid; intolorant
Ambivalent	Inconsistent and sometimes intrusive parent communication	Anxious and insecure; controlling; blaming; erratic; unpredictable; sometimes charming
Disorganized	Ignored or didn't see child's needs; parental behavior was frightening/traumatizing	Chaotic; insensitive; explosive; abusive; untrusting even while craving security

Competency reflection, assessment, or demonstration

Now that you have reviewed the materials about attachment styles it is time to reflect on your experiences with this competency.

In the space below write two case examples – one where you have had a positive outcome or effective intervention with a person who has an insecure attachment and one in which the intervention was not as effective. Please identify which insecure attachment style is applicable and why. Use the chart above as a reference.

Case Study #1 – The effective intervention

What were the characteristics, practices and values that contributed to an effective intervention?

What role did you play? How did you contribute to the success?

What impact or outcome did this have on patients?

Case study #2 – The ineffective intervention

What were the characteristics, practices and values that contributed to the ineffective intervention? What role did you play? What impact did this have on patients? Reflecting on what you've learned from this module – what would you do differently if you were involved in it again?

Additional resources for deeper understanding:

- **Regina M. Sullivan - The neurobiology of attachment to nurturing and abusive caregivers**
- **Joanna Chambers - The neurobiology of attachment: From infancy to clinical outcomes**

Adverse childhood experiences (ACEs)

Overview:

As we have learned, early childhood exposure to traumatic events can have a lasting effect on brain development and attachment to caregivers. These effects last throughout adulthood, and can also be a predictor of chronic disease. It's critical that healthcare teams understand the correlation between adverse childhood events and increased risk for chronic medical and mental health conditions as well as addiction disorders. Below you will find videos explaining the adverse childhood event (ACE) study, the link to increased risk of chronic medical and behavioral health disease, as well as ideas around prevention. There are also links to additional reading material including the CDC/ACE study website where you can find the ACE 10 question survey.

Core videos to watch:

- **Nadine Burke Harris - How childhood trauma affects across the lifetime**. (16 min)
- **Benjamin Perks - How do we stop childhood adversity from becoming a life sentence** (16 min)
- **Vincent Felitti - How childhood trauma can make you a sick adult** (7 min)

Competency reflection, assessment, or demonstration

Now that you have reviewed the materials about ACES it is time to reflect on your experiences with this competency.

In the space below write two case examples – one where you have had a positive outcome or effective interaction with someone who has disclosed having experienced adverse childhood

events or a situation in which you have completed the ACE survey with a patient. Additionally, give an example of an intervention or outcome that was not effective. Explain what you feel contributed to the negative outcome.

Case study #1 – The effective intervention

1. What were the characteristics, practices and values that contributed to an effective intervention?

2. What role did you play? How did you contribute to the success?

3. Was the patient asked to take the ACE survey as part of this intervention?

4. What impact or outcome did this have on patients?

Case study #2 – The ineffective intervention

1. What were the characteristics, practices and values that contributed to an ineffective intervention?

2. What role did you play?

3. Was the patient asked to take the ACE survey as part of this intervention?

4. What impact did this have on patients?

5. Reflecting on what you have learned from this module- what would you do differently if you were involved in it again?

Additional resources for deeper understanding:

- **Adverse childhood experiences study** (Center for Disease Control and Prevention)
- **Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults** (American Journal of Preventive Medicine)

Addiction

Neurobiology of addiction

Overview:

A basic understanding of the neurobiology of addiction is essential to understanding the disease of addiction including why behavior is a symptom. This provides the learner with an understanding of the addiction pathways in the brain, helps explain the "why" of the frustrating and often difficult behaviors, and explains the necessity for treatment using evidence-based medications in conjunction with evidence-based psychotherapies. Learning about the neurobiology of addiction can be done through online or in-person trainings. You will find several resources in this section that will build your knowledge, awareness, and best practice evidence-based care for onboarding this competency.

Core videos to watch:

- **Corey Waller - Addiction neuroscience 101** (23 min)
- **Nora Volkow- Why our brains get addicted** (16 min)
- **National Geographic - This is what happens to your brain on opioids** (4 min)
- **Raj Mehta - Addiction 101** (14 min)
- **Markus Heilig - Addiction in the age of brain science** (17 min)

Competency reflection, assessment, or demonstration

Now that you have reviewed the materials about addiction neurobiology it is time to reflect on your experiences with this competency. In the space below write two case examples – Describe a situation you've experienced with a patient who had a substance use disorder and displayed frustrating complex behaviors. Explain how you might perceive the behavior now?

Case study #1 – The effective intervention

What were the characteristics, practices and values that contributed to an effective intervention? What types of complex behaviors was the patient displaying? What role did you play? How did you contribute to the success? What impact or outcome did this have on patients?

Case study #2 – The ineffective intervention

What were the characteristics, practices and values that contributed to the ineffective intervention? What types of complex behaviors was the patient displaying?

What role did you play?

What impact did this have on patients?

Reflecting on what you've learned from this module – How would you apply this to have a different interaction?

Additional resources for deeper understanding:

- **Understanding drug use and addiction** (National Institute on Drug Abuse)
- **Drugs, brains, and behavior: The science of addiction** (National Institute on Drug Abuse)
- **Facing addiction in America** (Surgeon General's Report on Alcohol, Drugs, and Health) (Chapter 2)

Harm reduction

Overview:

Risky behavior is common in patients with substance use disorders. Harm reduction is an effective way to reduce risk and can also be the critical link to engaging the patient. Understanding the principles of harm reduction within the framework of addiction is vital. Harm reduction has been an effective part of chronic disease management for many years. Using these same principles for chronic disease management of addiction has resulted in a decline in opioid overdose deaths, HIV and Hepatitis C. It has also increased the recovery rates and provides a necessary component of stability in early recovery. Below you will find several resources that will help build your knowledge, and awareness of this competency including the myths and realities of harm reduction.

Core videos to watch:

- **Mark Tyndall - The harm reduction model of drug addiction treatment** (17 min)
- **Regent Park Community Health Center - Our harm reduction stories: Working toward healthier outcomes** (12 min)

Competency reflection, assessment, or demonstration

Now that you have reviewed the materials about harm reduction it is time to reflect on your experiences with this competency.

In the space below write two case examples – one where you have had a positive outcome or effective interaction using a harm reduction approach and one in which the intervention was not as effective. Please specify why this is a harm reduction approach.

Case study #1 – The ineffective intervention

What were the characteristics, practices and values that contributed to an effective intervention? What role did you play? How did you contribute to the success? What impact or outcome did this have on patients?

Case study #2 – The ineffective intervention

What were the characteristics, practices and values that contributed to the ineffective intervention? What role did you play? What impact did this have on patients? Reflecting on what you've learned from this module – what would you do differently if you were involved in it again?

Additional resources for deeper understanding:

- **Harm reduction myths and realities** (Simcoe Muskoka District Health Unit)
- **Principles of harm reduction** (Harm Reduction Coalition)
- **Quality healthcare is your right: A guide for people who use drugs — Getting better care** (Harm Reduction Coalition)

Medications for addiction treatment

Overview:

Medications for addiction treatment, (MAT), is evidence-based and should be available to any patient suffering from this disease. We currently have highly effective, evidence-based medications for treating opioid and alcohol use disorder. Researchers continue to work on medications for other substances such as cocaine and methamphetamine. Dopamine, the pleasure and reward chemical in our brain, plays a critical role in maintaining the addiction cycle. Subsequently, when a person stops using substances they experience a significant drop in dopamine. This translates to low motivation, anhedonia and depression. Using medications like buprenorphine or methadone help by raising dopamine levels thus enabling a person to engage in evidence-based counseling. Learning about the medications for addiction treatment for opioid and alcohol use disorders can be done through online or in person trainings. You will find

several resources in this section that will build your knowledge, awareness and best practice evidence-based care for onboarding this competency.

Core videos to watch:

- **Medication-assisted treatment overview: Naltrexone, methadone & suboxone** (5 min)
- **Medication assisted treatment** (10 min)

Competency reflection, assessment, or demonstration

Now that you have reviewed the materials about medications for addiction treatment (MAT) it is time to reflect on your experiences with this competency.

In the space below write two case examples – one where you have had a positive outcome or effective interaction with someone who is prescribed MAT for their addiction disorder and one in which the intervention was not as effective.

Case study #1 – The effective intervention

What were the characteristics, practices and values that contributed to an effective intervention? What role did you play? How did you contribute to the success? What impact or outcome did this have on patients?

Case study #2 – The ineffective intervention

What were the characteristics, practices and values that contributed to the ineffective intervention?

What role did you play?

What impact did this have on patients?

Reflecting on what you've learned from this module – what would you do differently if you were involved in it again?

Additional resources for deeper understanding:

- **National Practice guideline for the use of medications in the treatment of addiction involving opioid use** (American Society for Addiction Medicine)
- **Effective treatments for opioid addiction** (National Institute on Drug Abuse)

Evidence-based communication practices

Motivational interviewing

Complex care patients can have life circumstances and histories that create challenges in changing health behaviors. Motivational interviewing is an evidence-based communication practice that can guide practitioners in effective ways to address changing behavior while creating and respecting an authentic healing relationship.

Watch the following video for an introduction to the basic concepts of motivational interviewing:

- **Introduction to motivational interviewing** (17 min) - Introduction to basic concepts, Bill Matulich. PhD, Motivational Interviewing Trainer

Seeing motivational interviewing in practice is one of the most helpful ways to learn the concepts. Watch the following videos to see effective and ineffective motivational interviewing with a patient.

- **Ineffective motivational interviewing r/t smoking – Physician approach** (5 min)
- **The effective physician: Motivational interviewing demonstration** (6 min)

Reflection and case study

Considering what you have learned through reviewing the videos, write a case study of when you applied motivational interviewing well in a situation with a patient OR when you did not apply motivational interviewing with a patient.

Case study – Effective or ineffective motivational interviewing

- Describe the situation with the patient
- What underlying concepts of motivational interviewing (partnership, acceptance, compassion, evocation) did you use in that situation?
- Describe how you used the four skills (open questions, affirmations, reflections, summarizing) and four processes (engaging, evoking, motivating, planning) in that situation.
- What impact did that practice have on the patient?
- How will you carry that practice into your new team or how will you change your practice with your work in complex care?

Patient situation: Concepts used in the situation: Skills and processes used in the situation: Impact on the patient: Practice you will carry into your new team:

Verbal de-escalation

Overview:

Complex care patients, such as those with substance use disorders, can have complicated communication and agitation that comes from many sources: a history of childhood trauma, current life trauma, psychiatric illness, or addiction. Understanding how to honor an authentic healing relationship in the moment of care and to create safety and effective communication is an important competency for providers. Verbal de-escalation is an evidence-based practice that can be very effective for patients with complex needs.

Read the following guideline for a description of best practice with verbal de-escalation:

- **Best practices in evaluation and treatment of agitation** - (American Association for Emergency Psychiatry) The authors detail the proper foundations for appropriate training for de-escalation and provide intervention guidelines, using the "10 domains of de-escalation."

Reading the principles and evidence-based best practices for verbal de-escalation gives you the foundation for changing practice. The next series of videos will give you the opportunity to see verbal de-escalation in action and learn how you might apply it with your patients.

Review the following short videos from the Depression and Bipolar Support Alliance and the University of Colorado School of Medicine:

- **Verbal de-escalation – Understanding agitation – Psych patient** (9 min)
- **Verbal de-Escalation – Chapter 1 – BARS EB score** (8 min)
- **Verbal de-Escalation – Chapter 2 – Basic skills** (11 min)
- **Verbal de-Escalation – Chapter 3 – Opioid use disorder** (7 min)
- **Verbal de-Escalation – Chapter 4 – Teams and modeling** (8 min)
- **Verbal de-Escalation – Chapter 5 – Personal safety** (4 min)

Reflection and case study

Considering what you have learned through reviewing the article and videos, write a case study of when you applied verbal de-escalation well in a situation with a patient OR when you did not apply verbal de-escalation with a patient.

Case study – Effective or ineffective verbal de-escalation

- Describe the situation with the patient
- What role did you play in that situation and how did you practice verbal de-escalation or not practice verbal de-escalation?
- What impact did that practice have on the patient?
- How will you carry that practice into your new team or how will you change your practice with your work in complex care?

Patient situation: BARS assessment score: Your role and verbal de-escalation practice: Impact on the patient: Practice you will carry into your new team:

Appendix B: Sample care team roles and job descriptions

Interprofessional, team-based care is an essential component of a successful MAT program. This is often a new approach to patient care for primary care environments. Interprofessional teaming can be particularly challenging for clinical teams who are working together for the first time, and can be an adjustment for administration as well.

One clear lesson has been the importance of clarifying team roles. Job duties can overlap and create uncertainty about who should be doing what. When role confusion exists, it has the potential to create conflict and fear among team members. Taking the time to develop each team member's role will save a lot of administrative headaches and lost clinical time down the road.

This section provides samples of the different team roles and the job duties that typically fall within a specific role, as well as sample job descriptions.

Care team roles and responsibilities

The MAT PLUS care team will meet for weekly case management meetings to discuss each patient's case, identify patient challenges and review MAT care plans. Discuss strategies to best meet patient needs, and determine tier placement.

Patient

- The patient is responsible for meeting the program requirements on an ongoing basis. The patient must agree and sign the MAT Agreement prior to participation.
    - Have a willingness to engage in substance use disorder treatment and mental health services.
- Follow the recommendations given from the MAT- ASAM assessment, patient primary care provider, and MAT provider.
- Meet with LCSW for follow up appointments to monitor progress in the program and to update ASAM every six months.
- Have reliable transportation for medical and behavioral health appointments at the clinic (including urinalysis and pill counts), attendance to SUD treatment programs and self-help/recovery support groups.
- Maintain communication with MAT care team.
- Keep MAT Team updated on current contact information to coordinate care, including staying in contact with MAT case manager.

MAT nurse

- The MAT Nurse works in conjunction with the MAT provider, Behavioral Health and MAT case manager to conduct program intakes, including introduction and explanation of the program requirements.
- The nurse keeps in contact with patient to schedule MAT follow up appointments at the clinic.
- Conducts drug screens and pill counts with patients within the program and maintains and monitors the MAT Workbook.

Primary care provider (if not the MAT provider)

- The PCP is responsible for all non-MAT primary care needs of the patient. The PCP is responsible for being familiar with the MAT program requirements so to be able to discuss them with patients if needed. They are responsible for being aware of the MAT care plan and current tier status.

MAT provider

- The role of the MAT provider is to supervise the care provided by the team, provide clinical advice and backup for the team, and to reinforce the MAT program requirements at visits.
- The MAT provider notes should always include a clear plan of care for the MAT team or covering provider to execute.

Behavioral Health Clinician (LCSW)

- The LCSW is responsible for conducting a biopsychosocial assessment, including severity scoring and risks in the ASAM dimensions. The LCSW is responsible to document the recommendations of services and modalities to address needs identified during the assessment.

- Assist patient by facilitating a referral to internal or external resources to address patient needs.
- The LCSW is responsible to document pertinent information in the EHR and share with the care team.
- Have follow up visits with patients to monitor patient progress in the MAT Program and assess severity scoring, risks in the ASAM Dimensions and make recommendations for ongoing care.

MAT case manager

- The MAT case manager is responsible for assisting the patient to access mental health and/or substance use disorder (SUD) treatment services in the community.
- Communication with community agencies to coordinate care, obtain progress of engagement in services, and improve and strengthen professional relationships that provide services to meet patient needs.
- Will work in conjunction with the MAT nurse during introduction and explanation of program requirements.
- The MAT case manager is responsible to make contact with patients with the frequency following Tier assignment. Provide additional support, assist patients to identify personal needs and set goals to attain their goals. Maintain documentation of all patient contacts within the EHR.
- Maintains and monitors the MAT workbook.

MAT program coordinator

- The MAT Program Coordinator is responsible for the oversight of the program and the MAT Workbook
- Will coordinate with the MAT care team and Chief Medical Officer to discuss challenges and successes of the MAT Program to make workflow changes to improve implementation of the MAT Plus program.

Program manager role in medications for addiction treatment program

1. Manages training of MAT team.
2. Provides support for prescribers.
3. Keeps all teams of clinics informed of the program and updated on program changes. Including patient service reps/scheduling for frequent appointments and special scheduling.
4. Works with pharmacy to maintain availability of Buprenorphine/naloxone, Naltrexone and Naloxone opioid overdose reversal.
5. Develops, with assistance from team when needed, and implements best practices for patient care including:
    1. Pilot phase of developing weekly induction clinics and weekly refill/stabilization groups
6. Develops a series of educational segments for the refill/stabilization group. These educational segments will include behavioral health therapy and other speakers at times.
7. Manages warm hand-off and monitoring of the referral to treatment process for the patient.
8. Writes and updates patient information handouts, providing consistent information, with assistance from team when needed.

9. EHR – templates developed and written for prescriber notes as well as other team members if needed.
10. Integrates behavioral health team as part of the referral to treatment process.
11. Maintain DEA compliance and design the program so access to information when DEA requires will be easily accessed.
12. Develops a plan to track relevant data with data and analytics team.
13. Continually manages and improves outreach for all agencies involved with providing care for clinic patients with opioid use disorder such as county agencies, local emergency departments, community recovery providers, criminal justice and corrections, other medical clinics.
14. Participates in local opioid coalitions.
15. Trouble shoots as the pilot progresses and works closely with the team to focus on process improvements and implement changes.
16. Program manager uses chain of command to ensure best possible communication and integration of MAT program in clinic process.

Nurse case manager role in MAT program

1. Takes referrals from providers, outside agencies and directly from patients. Provides initial MAT screening and schedules for a nursing assessment.
2. RN case manager takes a complete assessment of patient. (Embedding the assessment into the EMR can save time and provides standardization).
3. RN Case manager may utilize a variety of validated tools of assessment and care including ASAM criteria, Adverse Childhood Experiences, Clinical Opioid Withdrawal Scale, DSM-5 Opioid Use Disorder screen.
4. After patient is assessed for admission, RN consults with team to discuss admission, barriers, appropriate level of care, possible referrals to another MAT program etc.
5. RN begins induction planning with waivered provider, determining best induction plan: home induction, in-clinic induction or induction in a residential setting.
6. Refers to provider for MAT medical clearance and labs including HIV HCV.
7. Induction planning and scheduling with provider.
8. RN manages all induction care, making sure the patient has education regarding induction, comfort medications, first Buprenorphine/Naloxone prescriptions and handouts with instructions.
9. Follows induction daily for first 7 days as patient stabilizes and begins to attend group.
10. Educates patient on program requirements and schedules patient for hand-off to SUD or BH counselor or patient navigator for treatment agreement and treatment planning.
11. Schedules patient for BH biopsychosocial intake within 7- 14 days of admission.
12. Monitors all UDS as patients stabilize and for s/sx of relapse. Participates in supportive interventions and consults regularly with entire MAT team.
13. Manages weekly case reviews with MAT team, including prescriber(s), identifying ongoing care needs with the team.
14. Can manage all buprenorphine/naloxone refill orders with provider. Entering orders, per provider instructions.
15. RN can help develop the weekly refill/stabilization group curriculum and share the facilitating duties with prescriber, behavioral health provider and/or SUD counselor.
16. RN manages and updates the buprenorphine patient roster weekly and makes it available for any DEA visits.

17. RN schedules patient as needed in the provider's schedule for any buprenorphine/naloxone dose changes or other MAT r/t questions. RN schedules patient with their PCP for all other medical needs.
18. RN case manager participates in the educational needs of the clinic, available to teach about the best practices and purpose of the MAT program to improve overall clinic culture towards treating OUD in clinic.
19. RN case manager works with all agencies to advocate for care and access for MAT patients, including jails, hospitals and emergency departments, county agencies, courts and recovery providing facilities. Occasionally, visits to other settings such as jails and hospitals will be required.
20. RN case manager might also be required to attend and participate in local opioid coalitions.
21. RN case manager attends required MAT training and continuously updates MAT best practices and research.

MAT medical assistant/nursing procedures:

1. Prior to group day, chart prep, move MAT refill/stabilization group template into chart
2. Collect and record UDS prior to MAT refill/stabilization group.
3. When collecting UDS, bring 2 patients back at a time and utilize both bathrooms in Pod for UDS collection.
4. If UDS is positive for anything other than prescribed meds such as BUP or BZO or THC, then the UDS must be sent to the lab for confirmation. There will be additional patient specific requests for send out of urine for alcohol confirmation.
5. Make sure patient's name is on the collection cup and do not discard any collected UDS until reviewed by MAT prescriber and RN.
6. Enter information from check-in sheet into EMR MAT group template, record UDS results on the Check-In (BUP half- sheet).
7. MA directs patients who are late for group making sure that UDS is collected and patient is brought into group with minimum disruption.
8. Once UDS results are recorded on Check-in sheet, MA gives the check-in sheet to NCM in group room.
9. After group, MA rooms the patients who have made an appointment with prescriber ahead of time. If patients have not scheduled but need to be seen, they can wait until those scheduled are seen.

Substance use counselor role in medications for addiction treatment program

1. Substance use disorders – admission assessment.
    a. This can be done before or after nursing assessment. Initial Screening, if required, can be done by provider or any MAT team member.
    b. This assessment by SUD counselors to identify level of care and whole person needs so that appropriate treatment referrals can be made for patient.
2. When patient is stable and not in withdrawal, SUD counselor will meet to review and sign a treatment agreement with the patient as part of the admission process.

3. A time of signing treatment agreement, patient will be instructed on Phase 1 expectations.
4. Treatment Plan developed and written and signed by patient with SUD counselor. All questions reviewed.
    a. Recommend using a treatment planning template if available.
5. SUD counselor will oversee and manage all appropriate referrals to community recovery providers for outpatient treatment, intensive outpatient recovery and residential treatment, utilizing county funding, as needed.
6. SUD Counselor schedules initial appointment for behavioral health intake.
    a. If SUD counselor is also behavioral health provider, then patient can be scheduled in their schedule.
7. SUD counselor will manage the counseling/group needs of all Phase 3 patients.
8. Group counseling sessions for all MAT patients as needed and for those referred by MAT provider/RN.
9. Individual interventions if patient is relapsing or struggling with relapse behaviors, as determined by MAT team. Individual interventions based on UDS results, MAT team following refill/ stabilization group.
10. Group sessions as needed per MAT team.
11. Developing and facilitating refill/stabilization group curriculum.
12. SUD counselor may participate in community opioid coalitions as determined by MAT team and MAT program manager.
13. SUD counselor will on occasion be going to jails, treatment facilities and hospitals to meet patients to support their recovery care.
14. SUD counselor can participate in the implementation of the SBIRT process.

(Qualifications and roles of SUD counselors can vary from state to state.)

Behavioral health therapist MAT role and responsibilities

1. Biopsychosocial intake for all new MAT patients.
    a. If patient is currently receiving BH services, then update biopsychosocial assessment to include OUD and MAT care.
2. Individual counseling sessions for all MAT patients or a referral for ongoing therapy in another program if indicated.
3. Refer to and consult with psychiatry when needed
4. Develop and facilitate groups for MAT program such as:
    a. Seeking Safety
    b. Dialectical behavioral therapy (DBT)
5. Facilitate weekly refill/stabilization Group when indicated
    a. BH topics for education and recovery tools
6. Case presentation in MAT team case review meetings and as needed.
7. Provide consultation for other providers and teams within agency upon request
8. Developing special groups for patients with specific needs, such as other SUDs, relapse prevention and trauma.
9. BH therapist, especially those with experience working with addiction, can also fulfill most duties listed for SUD counselors.

10. BH provider participates in the educational needs of the clinic, available to teach about the best practices and purpose of the MAT program to improve overall clinic culture towards treating OUD in clinic.
11. BH provider works with all agencies to advocate for care and access for MAT patients, including jails, hospitals and emergency departments, county agencies, courts and recovery providing facilities. Occasionally, visits to other settings such as jails and hospitals will be required.

Sample job descriptions

Medical assistant –MAT/complex care

Job description

Position: Medical assistant– complex care	
FLSA status: [XXXXX]	**Reports to:** [XXXX]

EOE statement

We are an equal employment opportunity employer. All qualified applicants will receive consideration for employment without regard to race, creed, color, religion, gender (including pregnancy), national origin, nationality, ancestry, age, familial status, marital/civil union status, domestic partnership status, affectional or sexual orientation, gender identity and expression, atypical hereditary cellular or blood trait, genetic information, liability for military service, disability status (mental or physical, including perceived disability, and AIDS and HIV status), protected veteran status or any other characteristic protected by law.

Position summary

A certified professional with strong managed care experience who can work collaboratively with team members and work independently to provide care management to the complex care/MAT teams.

Essential functions

1. Establish and maintain professional rapport with providers, members and other team members.
2. Attend departmental meetings.
3. Comply with all guidelines established by the Centers for Medicare and Medicaid (CMS).
4. Other duties assigned by the director and/or supervisor.

Non-essential functions

Qualifications

Education

Credentials/licensure

1. Current, unrestricted Medical Assistant Certification required. Bilingual Required.

Related experience

1. Minimum of 1 year experience providing care to the managed care population.
2. Knowledge of Case Management concepts preferred.
3. Personal computer experience including Microsoft Word, Excel, PowerPoint and Outlook at the intermediate level at a minimum.

4. Experience with an electronic medical record preferred.

Other knowledge, skills and abilities

1. Professional verbal and written communication skills, with the ability to clearly articulate thoughts and ideas.
2. Excellent telephonic customer service skills a must.
3. A self-starter who is successful with minimal supervision.
4. Exhibit leadership skills through performance, analytical thinking and process improvement.
5. Typing skills, at least 40 words per minute.
6. Be able to manage a system-based approach to preventive care.
7. Leadership skills needed to expand the complex care program.

Physical demands

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

1. While performing the duties of this job, the employee will frequently stand; walk and sit in an office environment.
2. There will be occasional lifting up to 15-20lbs.

Work environment

The work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

1. The noise level in the work environment is usually moderate.
2. Although work is primarily indoors, you may be required to travel outside to business community locations.

Nothing in this position description restricts management's right to assign or reassign duties and responsibilities to this job at any time.

I have read and acknowledge the receipt of this job description.

_____

Employee signature Date

Licensed clinical social worker – MAT/Complex Care

Job description

Position: Licensed clinical social worker - complex care	
FLSA status: [XXXXX]	**Reports to:** [XXXX]

EOE statement

We are an equal employment opportunity employer. All qualified applicants will receive consideration for employment without regard to race, creed, color, religion, gender (including pregnancy), national origin, nationality, ancestry, age, familial status, marital/civil union status, domestic partnership status, affectional or sexual orientation, gender identity and expression, atypical hereditary cellular or blood trait, genetic information, liability for military service, disability status (mental or physical, including perceived disability, and AIDS and HIV status), protected veteran status or any other characteristic protected by law.

Position summary

1. Utilizes clinical judgment and expertise to coordinate care management/behavioral health interventions.
2. Develops strategies to ensure cost effective, quality care outcomes to patients with complex care needs.
3. Identifies options for levels of care for individuals and populations of patients, focusing on strategies that will promote optimal health.
4. Assesses, plans, monitors, and provides therapeutic interventions as appropriate.
5. Collaborates with patient and family to facilitate understanding of diagnosis and to provide therapeutic interventions to support necessary lifestyle and behavior changes.
6. Partner with patients, families, other healthcare providers and community partners as needed for comprehensive coordination of care.
7. Respond to crisis situations and engage with patients and families to access the appropriate level of care across the continuum.

Essential functions

Duties and responsibilities are but not limited to:

1. Psycho-social assessments, depression, anxiety and addiction screening
2. Linking/referring to community resources and programs, crisis intervention, psychotherapy, coordination of care, education about services - programs-health to patient/caregivers
3. Working with multidisciplinary team to determine best care for all patients.

Non-essential functions:

Other knowledge, skills and abilities

1. Position would entail making home visits to patients with complex health and social needs.
2. Applicant must have a minimum of 5 years' experience working with addiction and co-occurring mental health disorder.
3. Must have strong knowledge of these disease processes, early life trauma and trauma informed care.

4. Knowledge of current evidenced based therapies for treating addiction and co-occurring mental health disorders, verbal de-escalation and crisis intervention skills.
5. Experience working in medical settings on a multi-disciplinary team a plus.

Qualifications

Education
Minimum: Masters of social work

Preferred:

Credentials/licensure
Minimum: Licensed (LMSW), or be eligible to pursue LLMSW, State of [xxxxx] Social Work License
Preferred:

Related experience
Minimum:

Other knowledge, skills and abilities
Minimum:

Physical demands
The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

1. While performing the duties of this job, the employee will frequently stand; walk and sit in an office environment.
2. There will be occasional lifting up to 15-20lbs.

Work environment
The work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

1. The noise level in the work environment is usually moderate.
2. Although work is primarily indoors, you may be required to travel outside to business community locations.

Nothing in this position description restricts management's right to assign or reassign duties and responsibilities to this job at any time.

I have read and acknowledge the receipt of this job description.

_____

Employee signature Date

Physician lead – complex care

Job description

Position: Physician lead – complex care	
FLSA status: [XXXXXX]	**Reports to:** [XXXXXX]

EOE statement

We are an equal employment opportunity employer. All qualified applicants will receive consideration for employment without regard to race, creed, color, religion, gender (including pregnancy), national origin, nationality, ancestry, age, familial status, marital/civil union status, domestic partnership status, affectional or sexual orientation, gender identity and expression, atypical hereditary cellular or blood trait, genetic information, liability for military service, disability status (mental or physical, including perceived disability, and AIDS and HIV status), protected veteran status or any other characteristic protected by law.

Position summary

Assists in the design, implementation, and support of a robust enterprise-wide population health management program, including managed care; consistent with the goals of the population health, the physician lead, complex care management continually develops and drives strategies that focus on improving outcomes and managing costs through the use of data analytics, application of technology and innovative care processes.

Essential functions

NOTE: The following are the duties performed by employees in this classification, however, employees may perform other related duties at an equivalent level. Not all duties listed are necessarily performed by each individual in the classification.

1. Works with Vice President, Population Health on developing a utilization management function for managed care patients which includes out-of-network concurrent review, repatriation, retrospective medical claim review, provider medical claim appeal review and prior authorization out-of-network outpatient services.
2. Works with Vice President, Population Health on developing a quality management and clinical compliance program for managed care patients which includes quality management, clinical compliance, health education and case review.
3. Provides physician direction for complex care management activities.
4. Works collaboratively with the Vice President, Care Management and other clinical leaders within Population Health on care coordination and complex care management initiatives.
5. Provides clinical guidance and oversight to the *(clinic name)* which provides care management services to patients who are high utilizers.
6. Provides input on *(clinic name)* policies and procedures, desktop procedures, workflows, job aides, training materials to help ensure that they are current and accurately reflect processes in order to provide consistent quality care and meet compliance with regulatory and *(clinic name)* requirements.
7. Participates on an interdisciplinary committee to implement healthcare predictive analysis and risk stratification tool(s) that will help *(clinic name)* provide targeted,

proactive, relationship-based (longitudinal) care coordination and care management to impaneled patients identified as at increased risk and who are likely to benefit from intensive care management, including patient visits in the hospital and post-acute settings.

8. Works collaboratively with Population Health team to develop and prepare departmental scorecards and dashboards showing high level results and trends.
9. Participates in planning initiatives to create a foundation for population health management, includes identifying relevant populations, creating a strong data governance mechanism, adopting of population health analytical tools, implementing an effective population health analytics solution for providers, analyzing care outcomes, designing and/or redesigning services based on data analysis and patient needs.
10. Serves as the *(clinic name)* clinical lead for its participation in the County of *[XXXXXX]* Initiative.
11. Serves as the *(clinic name)* clinical lead for its participation in the (*project name)*.
12. Performs other duties as assigned.

Non-essential functions

Qualifications

Required education
Minimum: Doctorate of Medicine.

Required experience
Minimum:

- Five years of progressive experience with programmatic and operational responsibility.
- Experience in healthcare, specifically in integrated delivery system operations and/or payer experience.
- Experience developing and implementing clinical, service, and operational process improvement initiatives on both a small and large scale.
- Experience in a hospital/health system environment with diverse services, patients and staff.

Preferred experience:
Experience building external relationships with physicians, clinical staff and other members of care teams in developing clinical programs focused on disease management or population health desired.

Required licenses/certifications
Licensed to practice medicine in the State of *(state name)*

X Waiver

Preferred licenses/certifications:
ASAM Board certification.

Other knowledge, skills and abilities

Minimum:

Physical demands

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

1. While performing the duties of this job, the employee will frequently stand; walk and sit in an office environment.
2. There will be occasional lifting up to 15-20lbs.

Work environment

The work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

1. The noise level in the work environment is usually moderate
2. Although work is primarily indoors, you may be required to travel outside to business community locations

Nothing in this position description restricts management's right to assign or reassign duties and responsibilities to this job at any time.

I have read and acknowledge the receipt of this job description.

_____

Employee signature Date

Substance use disorder counselor job description

As part of (*program name*) medications for addiction treatment (MAT) team and as part of addiction services, the substance use disorder (SUD) counselor provides individual and group counseling services to patients participating in MAT program and patients identified as requiring care under the Screening Brief Intervention and referral to treatment (SBIRT) program. The SUD counselor provides instruction to clients and family members on theories and treatment of substance use disorders. The SUD counselor functions as community liaison participating in outreach and serves in community coalitions and collaborative teams.

Minimum qualifications

High school diploma

Possess and maintain certification as an Alcohol and Other Drug (AOD) counselor issued by a certifying agency approved by the California Department of Healthcare Services such as CAADC/CATC II.

Two year's minimum experience counseling individuals with substance use challenges.

Knowledge and training in substance use disorders and related issues and understanding of recovery models including harm reduction.

Proficiency in motivational interviewing.

Experience working with people from diverse backgrounds and ability to be culturally competent.

Competence with electronic medical record systems.

Preferred experience/skills

AA or BS or MS/MA degree in a related field.

LCSW, LMFT with additional training in assessment and treating of substance use disorders.

Training in therapeutic modalities such as dialectical behavioral therapy, cognitive behavioral therapy, acceptance and commitment therapy, mindfulness for addiction and motivational interviewing/enhancement therapy.

Understanding of concurrent management of co-occurring disorders of patients with mental health diagnoses and substance use disorders.

Excellent interpersonal, verbal, and written skills.

Ability to effectively work with people from diverse backgrounds and be culturally competent.

Experience with and commitment to working with an underserved, low income community.

Knowledge of/skills and abilities to:

- Assess, diagnose and treat patients with substance use disorders.

- Principles, procedures, techniques, trends and literature of individual and group counseling.

- Apply the American Society of Addiction Medicine (ASAM) criteria to assess for appropriate level of care (LOC).
- Understands and applies the DHCS Drug Medi-Cal- Organized Delivery System of Care.
- Social aspects of psychological and emotional disturbances.
- Integrate care of substance use patients with Behavioral Health and Primary Care programs.
- Provide crisis intervention as needed.
- Work effectively with all recovery resource providers and all agencies in the community to provide seamless continuum of care for patients with substance use disorders.
- Work effectively with a multicultural client and family population with diverse backgrounds and needs.

Responsibilities:

- Coordinates with MAT team, with intake, admission, treatment agreement, program adherence and group and individual sessions.
- Conducts brief interventions and referral to treatment as part of SBIRT program.
- Conducts counseling sessions for individuals, groups and persons diagnosed with substance use disorders
- Participates directly in case reviews as needed
- Provides information about the substance use program to individuals, the general public and as outreach to community groups
- Provides psycho-therapeutic intervention, treatment, and other related mental health services to patients and their families

Nurse case manager for substance use disorders/medications for addiction treatment (MAT) Program manager

Job description

Department: Medical

Supervisor: Director of Nursing

Supervises: None

Classification: Exempt

Position summary:
The Nurse case manager for substance use disorders is responsible for collaborating with all medical providers and other staff to improve outcomes for our patients with substance use disorders. Additionally, this position will oversee the medications for addiction treatment Program.

DUTIES AND RESPONSIBILITIES:

1. Provide case management - collaborate with/ and under the supervision of all *(program name*) providers to improve outcomes for our patients with substance use disorders;
    a. This may include: assessing the need for medication protocols, patient counseling, and accessing community resources.
2. Within the RN scope of practice, independently assess and advise patients in areas related to substance use disorders.
3. Maintain the Screening, Brief Intervention and referral to treatment (SBIRT) program This program shall ensure that all adult patients receive screening for substance use disorders, primarily alcohol, and provides persons engaged in risky or hazardous substance use with brief behavioral counseling interventions to reduce substance misuse and/or provide referrals to mental health and/or substance use disorder services.
4. Develop and maintain for both clinics an SBIRT comprehensive referral to treatment packet. This packet should include handouts with all pertinent info on how to access detox/stabilization and in-patient or outpatient treatment.
5. Maximize reimbursement for all SBIRT care.
6. Understand and implement regulations and compliance for specific required programs such as the Screening, Brief Intervention and referral to treatment program (SBIRT).
7. Act as a resource for providers and develop special programs as needed to improve health of patients. These programs might include:
    a. Developing and piloting Suboxone for opioid dependent patients with chronic pain.
    b. Developing and providing smoking cessation classes.
8. Developing Wellness (lifestyle change) and stress management class
9. Serve as the key contact for staff, and provide staff education and development to improve patient care and outcomes, specifically in the area of substance use disorders.

10. Work with and communicate effectively with all support and medical teams, including administration, front and back office, medical, behavioral health and dental clinical staff.
11. Function as liaison to community, county, state agencies on behalf of patients diagnosed with substance use disorders.
12. Gather data to meet required measures and to evaluate and report on outcomes of specific programs.
13. Document patient encounters in the electronic health record (EHR). Develop templates to assist in documentation of the brief intervention and referral to treatment.
14. Occasionally the substance use disorder Nurse case manager may visit patients when they are hospitalized, incarcerated or in a treatment facilities and are unable to come into the clinic.
15. Understand and promote the mission, vision, and values of (*program name*) both in the work place and in the community.
16. Maintain compliance with all state and federal laws and regulations, as they pertain to position including; HIPAA, scope of practice, accreditation standards, OSHA and the Agency's policies & procedures.
17. Perform other duties as assigned by supervisor.

MAT program manager duties:

1. Manage training of MAT RN case manager.
2. Provide support for prescribing physicians and soon, prescribing mid-level providers.
3. Keep all teams of clinics informed of the program and updated on program changes. Including PSRs and call center for frequent appointments and special scheduling.
4. Work with pharmacy to maintain availability of buprenorphine/ naloxone, naltrexone and naloxone opioid overdose reversal.
5. Develop and implements best practices for patient care including:
    i. Pilot phase of developing weekly Induction Clinics and weekly refill/stabilization groups
6. Develop a series of educational segments for the refill/stabilization group. These educational segments will include behavioral health therapy and other speakers at times.
7. Manage warm hand-off and monitoring of the referral to treatment process for the patient. There is a plan in place for warm hand offs and monitoring with CoRR for outpatient services and residential services.
8. Write and update with the DEA waivered MDs and RN any patient information handouts, providing consistent information.
9. EHR – templates have been developed and written for both RN and MD notes.
10. Integrate Behavioral Health team as part of the referral to treatment process.
11. Maintain DEA compliance and design the program so access to information when DEA requires will be easily accessed.
12. Will develop a plan to track relevant data with QA RN.
13. Will continually manage and improve outreach for all agencies involved with providing care patients with opioid addictions such as county agencies, local emergency departments, community recovery providers, other medical clinics. Remains is active in both Placer and Nevada County, participating in coalitions, work groups and is available as a nurse educator for community.
14. Trouble shoots as the pilot progresses and works closely with the team to focus on process improvements and implement changes.

15. Program manager uses chain of command to insure best possible communication and integration of MAT program in clinic process.

Qualifications:

1. Bachelors or masters degree in Nursing.
2. Current BLS certification.
3. Addictions nursing specialty certification preferred.
4. Knowledge of and experience working with patients with substance use disorders.
5. Ability to interview and assess patients, using appropriate assessment tools, and observe, record and report on an individual's functioning.
6. Ability to communicate in a compassionate and professional manner with all patients and families.
7. Ability to interact effectively with all members of the healthcare team
8. Ability to utilize multiple technologies for gathering data to meet required measures and to evaluate outcomes of specific programs.

(program name) is an Equal Opportunity Employer.

Physical demands:

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is regularly required to talk and hear. The employee frequently is required to stand, walk, sit, use hands to finger, handle, or feel; and reach with hands and arms. The ability to distinguish letters and symbols as well as the ability to utilize telephones, computer terminals and copiers is required. The employee must occasionally be required to stoop. The employee must occasionally lift and/or move up to 25 pounds. Specific vision abilities required by this job include close vision, distance vision, color vision, peripheral vision, depth perception and ability to adjust focus.

I have read and understood the above job description:

Employee signature Date _____

Nurse case manager for substance use disorders

Job description

Department: Medical

Supervisor: Director of Nursing

Supervises: None

Classification: Exempt

Position summary:

The nurse case manager for substance use disorders is responsible for collaborating with all (*program name*) medical providers and other staff to improve outcomes for our patients with substance use disorders.

Duties and responsibilities:

1. Provide case management - collaborate with/ and under supervision of all (*program name*) providers to improve outcomes for our patients with substance use disorders;
    a. This may include: assessing need for medication protocols, patient counseling, and accessing community resources.
2. Within the RN scope of practice, independently assess and advise patients in areas related to substance use disorders.
3. Maintain the Screening, Brief Intervention and referral to treatment (SBIRT) program. This program shall ensure that all adult patients receive screening for substance use disorders, primarily alcohol, and provides persons engaged in risky or hazardous substance use with brief behavioral counseling interventions to reduce substance misuse and/or provide referrals to mental health and/or substance use disorder services.
4. Develop and maintain for both clinics an SBIRT comprehensive referral to treatment packet. This packet should include handouts with all pertinent info on how to access detox/stabilization and in-patient or outpatient treatment.
5. Maximize reimbursement for all SBIRT care
6. Understand and implement regulations and compliance for specific required programs such as the Screening, Brief Intervention and referral to treatment program (SBIRT).
7. Act as a resource for providers and develop special programs as needed to improve health of patients. These programs might include:
    a. Developing and piloting Suboxone for opioid dependent patients with chronic pain.
    b. Developing and providing smoking cessation classes.
    c. Developing Wellness (lifestyle change) and stress management classes.
8. Serve as the key contact for staff, and provide staff education and development to improve patient care and outcomes, specifically in the area of substance use disorders.
9. Work with and communicate effectively with all support and medical teams, including administration, front and back office, medical, behavioral health and dental clinical staff.
10. Function as liaison to community, county, state agencies and Indian Health Services on behalf of patients diagnosed with substance use disorders.
11. Gather data to meet required measures and to evaluate and report on outcomes of specific programs.

12. Document patient encounters in the electronic health record (EHR). Develop templates to assist in documentation of the brief intervention and referral to treatment.
13. Occasionally the substance use disorder nurse case manager may visit patients when they are hospitalized, incarcerated or in a treatment facilities and are unable to come into the clinic
14. Understand and promote the mission, vision, and values of both in the work place and in the community.
15. Maintain compliance with all state and federal laws and regulations, as they pertain to position including; HIPAA, scope of practice, Accreditation standards, OSHA and the Agency's policies & procedures.
16. Perform other duties as assigned by supervisor

Qualifications:

1. Bachelors or masters degree in Nursing.
2. Current BLS certification.
3. Addictions nursing specialty certification preferred
4. Knowledge of and experience working with patients with substance use disorders
5. Ability to interview and assess patients, using appropriate assessment tools, and observe, record and report on an individual's functioning
6. Ability to communicate in a compassionate and professional manner with all patients and families
7. Ability to interact effectively with all members of the healthcare team
8. Ability to utilize multiple technologies for gathering data to meet required measures and to evaluate outcomes of specific programs. (program name) is an Equal Opportunity Employer.

Physical demands:

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is regularly required to talk and hear. The employee frequently is required to stand, walk, sit, use hands to finger, handle, or feel; and reach with hands and arms. The ability to distinguish letters and symbols as well as the ability to utilize telephones, computer terminals and copiers is required. The employee must occasionally be required to stoop. The employee must occasionally lift and/or move up to 25 pounds. Specific vision abilities required by this job include close vision, distance vision, color vision, peripheral vision, depth perception and ability to adjust focus.

I have read and understood the above job description:

Employee signature Date _____

RN associate clinical director — complex care

Job description

Position: RN associate clinical director - Complex care	
FLSA status: Exempt [XXXXX]	**Reports to:** [XXXXX]

EOE statement

We are an equal employment opportunity employer. All qualified applicants will receive consideration for employment without regard to race, creed, color, religion, gender (including pregnancy), national origin, nationality, ancestry, age, familial status, marital/civil union status, domestic partnership status, affectional or sexual orientation, gender identity and expression, atypical hereditary cellular or blood trait, genetic information, liability for military service, disability status (mental or physical, including perceived disability, and AIDS and HIV status), protected veteran status or any other characteristic protected by law.

Position summary

The registered nurse will serve as the Associate Clinical Director in the Population Health Initiatives department of the *[Organization Name]*. He/She will assume the responsibility and accountability for the direction, implementation and evaluation of patient-care and provider-engagement services within the assigned unit. He/She will be responsible for supporting the Directors of Clinical Redesign and Care Management Initiatives in clinical oversight, mentoring, professional staff development, and quality-improvement initiatives. He/she will also serve as a key external clinical leader for the *[Organization Name]* in local and regional initiatives and collaboratives. Responsibilities will include supporting the oversight of all clinical programs, including the development of clinical policies and procedures, ensuring regulatory guidelines and standards are met, identifying opportunities for quality improvement for service delivery and outcomes, and ensuring compliance with State and Federal regulations and with organizational policies and procedures. This role is broad in scope and requires the ability to work independently and apply a high degree of judgment.

Essential functions

Clinical Leadership:

1. Consulting and ensuring appropriate clinical assessments including medical needs/barrier identification of patients referred and enrolled in the program.
2. Act as a liaison between hospitals, primary care providers, specialists, community resources, and managed care/insurance plans on behalf of enrolled patients to ensure patient-centered coordination of care.
3. Oversee activities of clinical staff and provide guidance and support regarding direct patient care.
4. Forge and nurture partnerships with hospitals, including Directors of Nursing, sub acute rehabs, home Visiting Nurse Associations, dialysis centers, primary pare offices, and local service organizations.

5. Enter and maintain electronic records, compile reports and complete other program documentation in a timely manner (e.g. progress notes, incident reports, client track, letters, etc.); other administrative responsibilities as needed.
6. Monitor collected data; ensure progress of care management towards graduation objectives.
7. Address emergency situations; safeguard employee and patient rights and promotes a safe and healthy environment.
8. Advance clinical-staff recruitment and retention initiatives through personal and team involvement.
9. Set standards for performance of clinical staff, guide the creation of relevant training and tools, and assist clinical managers creating conformity to those standards.
10. Work with the Associate Director for Clinical Redesign Initiatives to run "JOC" meetings for MCO contracts, to run meetings of the Quality Committee of the Medicaid ACO, and the like.
11. Support the Directors of Clinical Redesign Initiatives and Care Management Initiatives in ensuring that the *[Organization Name]* achieves shared savings and clinical objectives in the (*state name)* Medicaid ACO Demonstration Project.

Programmatic Leadership:

1. Develop and evaluate innovative clinical interventions to address population-health issues with diverse patient populations and help set overall clinical strategy for the *[Organization Name]*s work in *[City]*.
2. Bring clinical insight to the generation and evaluation of new programs or projects for Population Health Initiatives and the Medicaid ACO, and provide oversight during implementation.
3. Lead data-driven, rapid-cycle improvement processes in regards to clinical interventions in conjunction with members of the Population Health Initiatives and Strategy & Information departments.
4. Actively facilitate and engage staff members in diversity training to uncover biases and heighten awareness of personal interactions within a diverse.
5. Work in conjunction with Directors of Clinical Redesign and Care Management Initiatives to promote activities related to the delivery and quality of clinical services including, but not limited to, utilization review, quality assurance, and clinical protocol development.
6. Provide clinical expertise across organizational initiatives.
7. Actively facilitate and engage staff members in *[Organization Name]* care tenants such as COACH, trauma- informed care, motivational interviewing and harm reduction.
8. Work with departments to facilitate bi-directional learning, particularly in bringing outside expertise into the honing of clinical strategy.
9. Create clinical staff development opportunities including oversight of recruiting and credentialing processes and educational opportunities.
10. Actively identify project inefficiencies and finding collaborative solutions to the problems.
11. Lead cross-site learning activities on an as-needed basis.
12. Oversee and ensure compliance with licensure and organizational protocols.

Organizational Leadership:

1. Assist with personnel management for the units/department to include, but not limited to interviewing, hiring, orienting, training, scheduling, coaching, counseling, and evaluating employees.
2. Assist in using resources in a fiscally responsible manner works within established financial guidelines.

3. Make recommendations for required resources to enhance services and the delivery of care.
4. Assist in accountability/responsibility for the financial management of the department through active monitoring of resource consumption and in evaluating the use of supplies, materials, and other resources to reduce costs and increase efficiencies.
5. Continuously assess and coach staff to provide professional growth and development.
6. Support staff by consistently communicating and adheres to organizational and departmental policies and procedures for safety, compliance, infection prevention, patient satisfaction, etc.
7. Through role modeling, facilitates problem-solving and conflict resolution between staff, clinicians, departments, etc.

Qualifications

Experience

1. Current RN licensure in the State of *[state name]*
2. 3-4 years' experience providing clinical services OR equivalent combination of education and experience; experience in community/outpatient setting preferred

Education and licensure

Graduate from an NLN accredited school of nursing. Bachelor's degree in nursing required.

Other knowledge, skills and abilities

1. Bilingual (Spanish/English) a plus
2. Requires the ability to travel to multiple office locations; valid driver's license and automobile that is insured

Physical demands

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

1. While performing the duties of this job, the employee will frequently stand; walk and sit in an office environment.
2. There will be occasional lifting up to 15-20lbs.

Work environment

The work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

1. The noise level in the work environment is usually moderate
2. Although work is primarily indoors, you may be required to travel outside to business community locations

Nothing in this position description restricts management's right to assign or reassign duties and responsibilities to this job at any time.

I have read and acknowledge the receipt of this job description.

_____

Employee signature Date

Nurse practitioner–MAT/Complex care

Job description

Position: Nurse practitioner–MAT/Complex care	
FLSA status: [XXXXX]	**Reports to:** [XXXXX]

EOE statement

We are an equal employment opportunity employer. All qualified applicants will receive consideration for employment without regard to race, creed, color, religion, gender (including pregnancy), national origin, nationality, ancestry, age, familial status, marital/civil union status, domestic partnership status, affectional or sexual orientation, gender identity and expression, atypical hereditary cellular or blood trait, genetic information, liability for military service, disability status (mental or physical, including perceived disability, and AIDS and HIV status), protected veteran status or any other characteristic protected by law.

Position summary

In this role, the Nurse Practitioner will represent *(organization name)* as they provide primary care to patients in long term care settings; coordinate with their primary care provider and facility staff to deliver high quality care on site. The nurse practitioner will interact closely with the facility staff and providers throughout the community; educating, building relationships and showing leadership in how to best address the complex needs of the patient and family by using care coordination as a strategy.

This is a flexible, autonomous role that creates enormous satisfaction for the NP as you impact the care and comfort of our complex care population.

Essential functions

1. Develop strong competencies in complex care as you provide preventative and primary care for patients in assigned long term care facilities.
2. Collaborate with primary care physicians, the nursing staff and the patients' families to coordinate care in the manner best suited to the patient's needs.
3. Demonstrate a high degree of clinical expertise in working with patients with acute and chronic illnesses, specifically patients with medical complexity who have multiple organ systems. affected, are followed by multiple specialists and are high utilizers of the healthcare system
4. Deliver maintenance care and acute care, create and maintain comprehensive patient summary and crisis plans, which include collaboratively determined goals of care, and educate patients and their families on care and treatment plans for health disorders.
5. Help patients, families, and providers navigate the unique needs of patients enrolled in Complex Care Program during acute episodes requiring ED visits or inpatient stays, including proactively partnering with patients/families and members of the patient's healthcare team to ensure seamless transitions within different units in the hospital and between inpatient and outpatient settings.
6. Demonstrate excellent knowledge of the inpatient, outpatient, preoperative and operative, radiology, and emergency department systems.

7. Develop criteria for and participates in the evaluation of the quality and effectiveness of care
8. Maintain a database of patients enrolled in the Complex Care Program for quality benchmarking and research.
9. Plan and participate in learning opportunities for nursing students, advanced practice provider students, medical students, and resident physicians.
10. Work with administrative, nursing, physician, and university faculty to assure quality patient care and to promote education and research.

Qualifications

Education

Minimum: Master's or doctorate degree in nursing

Preferred:

Credentials/licensure

Minimum:

- Active RN and APNP license in State of *(state name)*
- Active DEA license or ability to apply for such license prior to or upon hire
- Clinical background and national certification as ANP, ACNP, FNP, GNP or PA-C required or the ability to obtain

Preferred:

Other knowledge skills and abilities

Minimum:

- Two years of relevant clinical experience preferred.
- CPR certified.
- Past experience working in a complex care environment or with medically complex patients in other settings.
- Extensive knowledge of physical assessment, differential diagnosis, pathophysiology, pharmacology and management of acute and chronic patient/family health problems.
- Ability to care for acutely and chronically ill patients.
- Excellent verbal and written communication skills.
- Professional demeanor.
- Ability to work as a member of a team.
- Ability to prioritize tasks
- Intermediate level of proficiency in PC based word processing including Microsoft Word and Outlook.

Physical demands

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

1. While performing the duties of this job, the employee will frequently stand; walk and sit in an office environment.
2. There will be occasional lifting up to 15-20lbs.

Work environment

The work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

1. The noise level in the work environment is usually moderate.
2. Although work is primarily indoors, you may be required to travel outside to business community locations.

Nothing in this position description restricts management's right to assign or reassign duties and responsibilities to this job at any time.

I have read and acknowledge the receipt of this job description.

_____

Employee signature Date

Appendix C: Suggested guidelines, policies, and procedures

Adding medications for addiction treatment programs often creates a challenge for primary care. MAT programs can require operational structure changes, including more frequent visits, changes to scheduling templates to accommodate interprofessional care teams, point of care urine drug screens, admissions/referral and no show policies to name a few. This appendix provides examples of program structures, including recommended guidelines, policies and procedures. Also included are samples of policies, including triage for afterhours calls. Because MAT clinical operations require flexibility, we suggest using guidelines instead of policies for items related to clinical care.

Policy and procedures

Purpose: *(program name)* is committed to delivering best practice, evidence-based and trauma-informed care for our patients diagnosed with opioid use disorders. Medications for addiction treatment (MAT) is a treatment approach that includes buprenorphine/naloxone (brand name Suboxone) along with supportive recovery care. Recovery care may be provided both within the clinic, utilizing trained substance use disorder and behavioral health clinicians and in collaboration with community resources. We offer our care in the spirit of non-judgement. We treat the whole person in a patient-centered program.

Policy: (program name) has adopted the nurse case manager with integrated behavioral health model for our MAT program. The MAT program serves patients at *(insert the name of the specific sites within your organization that provide MAT)*. *(name of site)* will continue to give priority and rapid admission to all native patients seeking care for opioid use disorder. (The following is optional as it applies specifically to clinics that provide Indian Health Services). *(name of site)* is developing and integrating a native recovery approach, utilizing tradition and culturally-based recovery for our native patients. Additionally, *(name of site)* is utilizing behavioral health therapists with native heritage and special training to treat historical and intergenerational trauma.)

MAT with buprenorphine

1. Suggested provider types for MAT programs

    - Prescribers: MD or NP/PA who has the DATA 2000 x-waiver to prescribe buprenorphine for opioid use disorder
    - RN: case manager, preferred ANCC certification in addictions nursing
    - Substance use disorder counselor: Licensed or certified in drug and alcohol specialty
    - Case manager: LCSW or LMFT for behavioral health needs, including assessment and diagnosis of co-occurring mental health disorders, counseling and case management

- Medical assistant
- Peer support
- Community health worker (CHW)

See Appendix A for sample job descriptions

2. Referrals example
    a. Referrals to MAT program can be by provider or by patient.
    b. Referrals can be made through *(insert names of programs)* program.
    c. Referrals may also be from county services, including jail and local hospitals.
    d. Internal referrals will be sent to MAT case managers via telephone encounters in electronic health record *(or insert your process for internal referrals)*.

3. Example admissions process
    a. Screening: LCSW, RN or SUD counselor
        i. MAT screening template in *(insert EHR name)*
        ii. Order Narcan: RN
    b. Nursing assessment: RN
        i. Nursing assessment template in eCW
    c. SUD assessment: SUD counselor
    d. Case review with RN, SUD counselor and prescriber to determine admission and review of American Society of Addiction Medicine (ASAM) Whole Person Level of Care criteria
        i. Chart
    e. Patient signs treatment agreement: SUD counselor or RN
        i. Patient receives copy and original to (insert location for original patient documents)
    f. Patient signs relevant release of information: SUD counselor or MA
        i. Patient receives copy, original to (insert location for original patient documents)
    g. New patient packet:
        i. Treatment agreement
        ii. Induction instructions
        iii. Program information
            1. Phases and requirements
            2. Refill/stabilization group schedule
        iv. Release of information examples:
            1. Hub & Spoke ROI
            2. Recovery providers
            3. CPS/foster care
            4. Probation officer
            5. Family member
        v. MAT brochure
    h. Prescription drug monitoring program (PDMP) report at the time of admission

4. Medical appointment example

a. Establishes care with MAT prescriber
b. Update labs
    i. Standing orders for MAT admission labs
    ii. HIV and HCV labs
    iii. Point of care UDS, also sent to lab for comprehensive
c. Induction planning
    i. In-clinic, scheduled with: RN/prescriber
    ii. Home induction with instructions: prescriber/RN
    iii. Close follow-up care and phone support: RN, LCSW or SUD counselor
    iv. Patient instructions handout
    v. Withdrawal comfort medications prescribed

5. SUD counselor, LCSW or RN can develop a treatment plan for Phase 1 care

    a. This can be part of the MAT treatment agreement, or part of a shared team treatment plan.
    b. Based on patient preferences and ASAM criteria.
    c. EHR template: SUD counselor.
    d. Scheduled with behavioral health for biopsychosocial intake:
        i. BH intake must be completed within 7 days of admission and before progressing to Phase 2.

6. Buprenorphine patient roster

    a. Protected/locked from view except for MAT teams.
    b. Roster is on Excel spreadsheet under medical drive: buprenorphine registry (or insert location name for where registry is maintained).
        i. Read/write access limited to person responsible for maintaining.
        ii. All other MAT team members, including prescriber, have read only access.
    c. Roster is way of tracking patient, date of induction, daily buprenorphine/naloxone dose, phase of care, prescriber and clinic.
        i. Useful worksheet for case managers.
    d. Roster for Phase 3 patients separate from the Phase 1/Phase 2 patients.
    e. Roster also tracks discharged MAT patients.
    f. Also used to track buprenorphine for pain patients by clinic.
    g. Roster is useful for audit visits, such as those by DEA and Hub & Spoke.

7. MAT medical assistant/nursing procedure examples:

    a. Prior to group day, chart prep, move MAT refill/stabilization group template into chart.
    b. Collect and record urine drug screen (UDS) prior to MAT refill/stabilization group.
    c. If UDS is positive for anything other than prescribed meds, and the patient denies using other substances (e.g., buprenorphine, benzodiazepines, THC) the urine sample should be sent to the lab for confirmation. We recommend waiting for lab confirmation before discussing with patient.

d. If patient admits to using other substances found in urine there is no need to send out for confirmation.
e. There can be additional patient specific requests for sending out urine. For example, alcohol confirmation or THC level.
f. Make sure patient's name is on the collection cup and do not discard any collected UDS until reviewed by MAT prescriber and RN.
g. Enter information from MAT refill/stabilization group check-in sheet into EHR template, record UDS results on the check-in (buprenorphine half-sheet).
h. MA directs patients who are late for group, making sure that UDS is collected and patient is brought into group with minimal disruption.
i. Once UDS results are recorded on check-in sheet, MA gives the check-in sheet to nurse case manager in group room, usually about (insert time).
j. After group, MA rooms patients who have an appointment with the prescriber ahead of time. If patients have not been scheduled but need to be seen, they can wait until those who have been scheduled are seen.

8. Refill/stabilization group

    a. Patient checks in at reception and is given a MAT check-in sheet
        i. Patient identifies cravings, triggers, side effects, mental health issues, recovery progress and requests to see prescriber.
        ii. After check-in sheet is complete, MA takes patient for UDS; MA records results on check-in sheet and gives the check-in sheet to the nurse case manager to review with prescriber and LCSW or SUD counselor.
    b. Harm reduction and abstinence-directed is determined by Phases (please see Phases)
    c. Weekly group facilitated LCSW/LMFT, SUD counselor or RN and prescriber
        i. Format
        ii. Group rules
        iii. Curriculum:
            1. Rotating 8-week curriculum
                a. Education
                b. Recovery tools
            2. Behavioral health therapists are presenters as well
        i. Prescriber bills **99213** for each patient
        ii. Hour following group for individual patient appointments with prescriber
            1. Dose adjustments
            2. Interventions
            3. Medical care
    d. Phased care
        i. Phase 1
            1. Weekly MAT refill/stabilization group attendance along with UDS and 7-day buprenorphine/naloxone prescription.
                a. Prescription can be less than 7 days for patients struggling with medication compliance and/or using.
            2. Harm reduction and early stabilization for all patients.

3. Required have BH intake within the first 14 days of program participation.
    a. Behavioral health intake recommended with in first 7 days.
    b. Behavioral health therapist can see patient individually for more therapy, if indicated, or refer out.
    c. If patient is out for psychotherapy, we recommend, if possible, referring to a behavioral health provider within your agency. This will make care coordination and case conferencing much easier.

1. Progressing to Phase 2 is patient-centered and is determined by patient's adherence to the treatment agreement, consecutive negative UDS and stability determined by MAT team.
2. A patient transferring from another MAT program who is stable can be fast-tracked to Phase 2 after 4 consecutive weeks of group attendance, negative UDS and MAT team determination.

ii. Phase 2

3. Transfer to Phase 2 requires a meeting with addictions RN, behavioral health provider or SUD counselor to update treatment agreement and clarify with patient the expectations of Phase 2 adherence.
4. Patient attends refill/stabilization group every 2 weeks.
    a. UDS
    b. 14 day buprenorphine/naloxone prescription
    c. Continues with patient-centered treatment plan
    d. Minimum of 4 consecutive group attendances and negative UDS
4. Patient's length of time in Phase 2 is determined by patient adherence to MAT treatment agreement and treatment plan and MAT team determination.
    a. Progressing to Phase 3 indicates that the patient requires minimal RN case management.

iii. Phase 3

5. Monthly appointments with prescriber for up to 30 day buprenorphine/naloxone prescription.
    a. If primary care provider (PCP) is x-waivered to prescribe buprenorphine/naloxone, then will leave MAT prescriber to care of PCP.
6. UDS with every visit.
7. Minimal RN case management required.
8. Patient must meet with SUD counselor and/or behavioral health therapist—individual or group—for at least one session per month.
    a. Current Phase 3 group sessions are held *(insert day, time, location).*
9. Patient MAT info moved to Phase 3 on roster.

10. If the patient relapses or needs more help, return to Phase 1 or Phase 2 for additional support and care.

e. Discharge
    i. When patient stops attending scheduled refill/stabilization groups and does not respond to phone calls, a discharge letter should be sent 14 days after last prescribed dose of buprenorphine/naloxone.
        1. Enter the letter in electronic health record.
        2. If patient wants to return to MAT program, the patient should be readmitted with new treatment agreement and new treatment plan.
            a. If patient needs a higher level of care, we recommend using ASAM criteria to determine the most appropriate level of care (i.e. Intensive outpatient, partial day program, residential treatment etc.)
        3. If patient is known to be diverting buprenorphine/naloxone, this should be addressed immediately with the patient and may result in discharge from the program.

f. Lost or stolen buprenorphine
    i. Patient must notify MAT program contact immediately.
    ii. Patient should file a police report; this can be done online with all law enforcement agencies.
    iii. Patient will meet with RN, submit UDS and will receive a short prescription until the next scheduled refill/stabilization group or next scheduled provider visit.
    iv. It is recommended developing written guidelines around early refill requests for patients, including after-hours refills. This will help provide consistency in patient care in both the MAT program and the agency.

9. Level of Care

a. American Society of Addiction Medicine (ASAM) Criteria.
    i. Identify in the patient's chart their whole person needs using ASAM criteria for the six dimensions.
        1. ASAM Criteria is evidence-based and standard of care
        2. Assess at time of intake assessment (nursing or behavioral health)
            a. Update as indicated
            b. Change in stability
            c. Relapse

b. Standard ASAM assessment tool in MAT buprenorphine file in *(insert location where ASAM assessment tool can be located)*

10. Fast-track protocol

a. For patients who are relatively stable, engaged in recovery activities and have job obligations.

b. Patients transferring from another provider with long term stability.
    i. All patients must be in Phase I for at least 4 consecutive weeks
        1. Group attendance
        2. Consecutive negative UDS
        3. Completion of BH requirement

11. Urine drug screen (UDS) protocol

a. We recommend using a 10+ panel *CLIA-waived* point of care UDS
b. Urine should be collected at every visit, this creates consistency in patient care
c. Any UDS which shows positive should be confirmed. UDS can be discussed with patient at time of positive result
    i. If patient admits to using X substance, UDS doesn't have to be sent to the lab for confirmation, and should be documented in the patient's chart.
    ii. If the patient denies using any other substances send to lab for confirmation.
    iii. MA with standing order sends all positive UDS to lab for confirmation.
    iv. Confirmed UDS protects patient as there may be a time when patient will request that results be sent to law enforcement, CPS or recovery providers.
    v. Positive for prescribed medications (e.g., buprenorphine, benzodiazepines) does not require confirmation.
    vi. If positive for THC, confirmation or THC level request determined by prescriber.
    vii. Sending UDS to laboratory for alcohol testing determined by MAT prescriber and MAT team.
    viii. Sending Phase 3 UDS to laboratory for EtOH testing determined by MAT prescriber and MAT team.

12. Suggested standing orders

a. Detox comfort meds for pre-induction withdrawal phase
b. Admission labs: CMP, CBC, LFTs, HIV and HCV
c. Narcan orders
    i. Narcan must be ordered for all MAT patients at the time of admission to MAT program
    ii. Can be ordered for any family member requesting Narcan
    iii. Can be ordered for any patient prescribed opioids for pain management
    iv. Order set in (insert EHR): naloxone nasal spray 0.4 ml as directed #2 doses with 2 refills

13. Suggestions for the EMR

a. Visit types in EMR

b. MAT designated slots in provider's schedule
    i. Individual for initial medical clearance/induction and Phase 3 refill
    ii. Group session – 1 hour
    iii. 3 individual medical appointments following group for as-needed care
c. Templates
    i. Initial MAT screening
    ii. Nursing assessment
    iii. Medical clearance
    iv. MAT group note
    v. MAT RN induction
    vi. MAT induction follow-up
    vii. MAT RN follow-up appointment
    viii. LCSW/LMFT intake
    ix. LCSW/LMFT follow note
    x. SUD counselor intake
    xi. SUD intervention note
d. Order sets

14. Progressing to Phase 3 protocol

a. Must meet with nurse case manager, behavioral health provider or SUD counselor to review and update treatment agreement.
b. Prescriber-to-prescriber handoff if patient is transferring to a waivered PCP for Phase 3.
c. Clarify with patient that they will see their prescriber monthly.
d. Schedule 1st appointment with prescriber. Make sure patient has prescription until the next appointment.
e. In order to maintain Phase III level of care, they must continue with negative UDS, take buprenorphine/naloxone as prescribed and keep their appointments
f. If patient struggles with relapse or relapse behaviors, patient will return to the next appropriate level of care for them, Phase I or Phase II to be determined by their provider, MAT nurse case manager, or MAT team.

15. Patient transfer protocol examples

a. Program X
    i. RN-to-RN – establishes warm hand off. Schedules patient with nurse case manager who will then take over the planning for patient.
        1. Meet with new RN
        2. Schedule first group appointment
        3. Schedule prescriber-to-prescriber call
        4. Schedule appointment with new provider
        5. Chart transfer note
b. Other buprenorphine providers/agencies
    i. Transferring patient meets with nurse case manager

1. Patient maintains care with the provider they are leaving until *(program name)* has assessed and determined admission to MAT program.
2. Obtain release of information for interagency communication if possible.
3. Nurse case manager contacts previous provider for continuum of care information.
4. Arrange provider-to-provider call if possible.

i. All patients transferring from another provider MUST be in Phase I for at least 4 weeks (if meets criteria for Fast-Track to Phase II).

16. Behavioral health

a. Every patient must have biopsychosocial assessment, target is within the first 7 days in Phase I but must be within the first 7-14 days.
b. Behavioral health should be a non-negotiable for patients participating in MAT program.
c. Behavioral health therapists available for these intakes can be concurrent with group sessions.
    i. Patients can utilize a group commitment to complete BPS intake.
d. Behavioral health can be guest facilitators for weekly Phase I/II groups.
e. Behavioral health provider should have 30 and 50 minute time slots in schedule for individual therapy appointments.

17. Suggested standard assessment tools

a. DSM-5 Opioid Use Disorder Checklist
b. Adverse Childhood Experiences (ACEs)
c. Clinical Opiate Withdrawal Scale (COWS)
d. American Society of Medicine (ASAM) Criteria

18. Patient information handouts

a. Treatment agreement
b. Phases of care information
c. Induction preparation
    i. In-clinic
    ii. Home induction
d. MAT brochure

Appendix

Forms

1. Suggested EHR templates
    a. Screening
    b. Nursing assessment
    c. SUD Intake
    d. BH intake
    e. Medical clearance by provider

f. Induction
    i. In-clinic induction
    ii. Home induction
g. Induction RN follow-up note
h. MAT treatment plan
i. Refill/stabilization group note
j. MAT follow-up visit
k. MAT discharge note

2. Patient induction preparations/instructions
3. Treatment agreement
4. Phases of care patient handout
5. MAT group check-in sheet
6. Discharge letter
7. Duty statements RN case manager
    i. SUD counselor
    ii. X-waivered provider

(See Appendix E for sample EHR templates and Appendix D for Sample Patient Agreements)

Sample SUD Admission Policy

Title: Admission criteria and intake for substance use disorders	
Area or Unit: Substance use disorder clinic	**Status:** Draft
Policy #:	**Updated Date:** N/A

Policy:
It shall be the policy of the *(program name)* to implement medically necessary admission criteria and intake processes which are considered an integral part of determining treatment, particularly in higher/short-term levels of care and consider the continuum of care and long-term recovery needs of the customer at every step of the screening and assessment process.

Purpose:
To establish operating procedures that clearly define and reflect admission criteria and intake practices for substance use disorders.

For individuals seeking treatment who contact the clinic directly, appropriately qualified professionally will gather basic information during a brief phone screen to determine if they are appropriate for the levels of care offered at the *(program name)*. Program requirements will be explained. If individuals appear appropriate and willing to participate in programmatic requirements they will be offered an opportunity to come in at the first available time. This could be a same day appointment. At the time of in person appointment, types of demographic information gathered during the intake screening process include but are not limited to:

- Name, address, and telephone number, when applicable
- Date of birth and gender
- Family and social history
- Educational history
- Health History
- Occupation/employment status
- Legal and court-related history
- Present substance abuse problem
- Date the information was gathered
- Signature of the staff member gathering the information
- Name of referring agency, when appropriate
- Address, telephone number, and name of nearest relative to contact in case of emergency
- History of current and past substance abuse or other counseling services received. The agency, type of service, and the date the service was received shall be indicated.
- Name, address, and telephone number of the most recent family or private physician.
- A substance abuse history, including information about prescribed drugs and alcohol which indicates, at a minimum, all of the following information:
    - Substances used in the past, including prescribed drugs.
    - Substances used recently, especially those used within the last 48 hours.

    - Substances of preference.
    - Frequency with which each substance is used.
    - Previous occurrences of overdose, withdrawal, or adverse drug or alcohol reactions.
    - History of previous substance abuse treatment received.
    - Year of first use of each substance.
- Lab work will be obtained.
- A urine screening will be conducted.

For individuals referred directly by a provider within *(program name)*, clinic staff will contact them and the same process will occur.
As part of the enrollment process, individuals receive a thorough explanation as to what buprenorphine and/or naltrexone are, their efficacy and purpose. The counseling options require either in-house or at a coordinating provided are also explained and patients are required to sign consent forms agreeing that they not only understand the treatment but they consent to it as well as consent to the requirements that go along with the treatment.
For individuals who appear to require a higher level of care than is presently offered through *(program name)*, such as methadone, residential, etc. or is needed adjunctive to what is offered, individuals will either be offered to call while onsite or be referred to *(program name)* for screening and referral for this additional level of care.

Definitions:
Buprenorphine, naltrexone, methadone- Are all FDA approved forms of Opioid replacement therapy for those with opioid use disorders. Naltrexone also has efficacy in treatment alcohol use disorders.

Responsibility/scope:
Chief Medical Officer/Direct of Substance Use Disorder Services

Policies, procedures, protocols and forms cross reference:
None

References:

Sample SUD program discharge protocol

Title: Substance use disorder discharge protocol	
Area or Unit: Substance use disorder clinic	**Status:** Draft
Procedure/protocol #:	**Updated Date:** N/A

Procedure/protocol:

Discharge/transition criteria – Discharge/transition criteria is the expected clinical improvement, recovery status, and/or discharge from the covered service. Discharge/transition occurs by either completion of treatment or through administrative discontinuation.

Completion of Treatment

- The individual has experienced a reduction in symptoms and/or is no longer benefiting from treatment; person can continue recovery through the use of community support services.
- The individual has begun receiving methadone dosing and outpatient therapy Treatment which will be provided by methadone treatment provider.
- Overall improvement in ASAM LOC dimensions; person can continue recovery through the use of community supports; and/or
- Treatment plan/goals have been met; or
- The individual is clinically and/or behaviorally non-compliant; or ASAM LOC need in one or more dimensions has increased requiring treatment in another setting.
- SUD diagnosis – All deferred diagnoses must be resolved upon discharge; may not leave a deferred diagnosis on any axis.
- Patient no longer wishes to participate in office based opioid therapy and requests to taper off of their dose following appropriate medical protocols.

Administrative discontinuation – Administrative discontinuation relates to non-compliance with treatment and recovery recommendations, and/or engaging in activities or behaviors that impact the safety of the outpatient treatment program environment or other individuals who are receiving treatment. The therapist will work with the individual to explore and facilitate compliance.

Non-compliance is defined as actions exhibited by the individual which include, but are not limited to:

- The repeated or continued use of illicit opioids and non-opioid drugs (including alcohol).
- Toxicology results that do not indicate the presence of illicit drugs including non-prescribed medications.
- Toxicology tests shall be conducted for both of the aforementioned circumstances for presence of opioids, cannabinoids, benzodiazepines, cocaine, amphetamines, and barbiturates.
- Repeated failure to submit to toxicology sampling as required.
- Repeated failure to attend scheduled individual and/or group counseling sessions or other clinical activities such as psychiatric or psychological appointments.

- Failure to manage medical concerns/conditions including adherence to physician treatment and recovery services and use of prescription medications that may interfere with the effectiveness of medication assisted treatment and may present a physical risk to the individual.
- Repeated unsuccessful treatment episodes and inability to follow through on other treatment and recovery plan related referrals. Repeated failure should be addressed on an individual basis and only after steps have been taken to assist the individual to comply with treatment recommendations. Repeated unsuccessful treatment does not mean that a customer is not allowed to attempt treatment again. Requests for service after multiple unsuccessful treatment episodes will be evaluated against medical necessity and stage matched treatment

The commission of acts by an individual that jeopardizes the safety and well-being of staff and/or other individuals, or negatively impacts the therapeutic environment, is not acceptable and can result in immediate discharge. Such acts include, but are not limited to, the following:

- Possession of a weapon on (program name) property.
- Assaultive behavior against staff and/or other individuals.
- Threats (verbal or physical) against staff and/or other individuals.
- Diversion of controlled substances, including Suboxone.
- Diversion and/or adulteration of toxicology samples.
- Possession of a controlled substance with intent to use and/or sell on agency property or within a one-block radius of the clinic.
- Sexual harassment of staff and/or other individuals.

It may be necessary for the therapist to refer individuals who are being administratively discharged to the PIHP access management system for evaluation for another level of care. Justification for non-compliance termination must be documented in the individual's electronic health record.
All possible steps including empowerment agreements, will be taken to avoid administrative discharge. Non-compliant behaviors are recognized as often being symptoms of the disease they are being treated for. Therefore, unless truly counter-productive to recovery or dangerous, either medically or environmentally, administrative discharges will be avoided when possible.

Purpose:
To identify protocols specific to discharge/transition planning from substance use disorder treatment.

Definitions:
N/A

Responsibility/scope:
Substance Use Disorder Clinic Director/Chief Medical Officer

Policies, procedures, protocols and forms cross reference:
Admission criteria and intake for substance use disorders

References:

Sample No Show Policy

As a patient of the (*clinic name*), I understand that it is in my best interest to arrive 15 minutes early for my scheduled appointments and to call at least 2 hours in advance if I am unable to keep my appointment time. If I arrive 15 minutes after my appointment time I understand I will not be seen, and rescheduled for another date and time.

An appointment will be considered a "**No Show**" if I **do not** notify the (*clinic name)* 2 hours prior to my appointment time.

A "**Pre-book**" appointment is an appointment that I schedule at least 48 hours in advance.

A "**Walk-in**" appointment is an appointment that is scheduled on the day of the appointment.

No Show	Will Result In:
1st/2nd	I will be reminded by front desk staff of my appointment time and may have to reschedule my appointment if my tardiness makes it difficult for me to be seen.
3rd	I will no longer have the privilege to **Pre-book** appointments and will only be able to be seen (by a medical provider) as a **Walk-in** appointment. I will be informed that in order to regain the privilege of scheduling Pre-book appointments I must attend to **two** appointments without a no-show during the current month.
4th	I will no longer be able to schedule an appointment; I will then have to come to the office and wait to see if there is a cancellation or no-show to be seen. There is no guarantee of being seen this day.

By signing this document, I agree as a patient of the (*clinic name)* to the terms and procedures listed above.

_____

Printed name

_____

Signature Date

Protocol: Medication assistance treatment (MAT PLUS) program	**Manual:** Medical services
Effective Date	**Revision/review date:**
Number of pages:	**Number of forms/enclosures:**

(program name)'s MAT PLUS Program is a comprehensive treatment approach for opioid dependence. Our 3-Tier design is structured to support recovery from addiction. The MAT PLUS program offers to significantly change the course of not only of the patients' life, but also the patients' family and community. Medication therapy alone is rarely sufficient treatment for addiction. The potential for recovery is greatly increased when medication assistance is combined with recovery support services. For most individuals, a recovery program includes engagement in substance abuse treatment program, attendance to recovery support groups within the community, and individual and family therapy.

Individuals with an addiction to substances often have complex problems that require additional services to promote a lifestyle change necessary to sustain remission from substance use. Patients are strongly encouraged to seek behavioral health therapy either inside or outside (program name). Patients with co-occurring mental health disorders are required to see behavioral health for follow up visits, if they are not engaged in ongoing counseling.

In an effort to make the necessary changes to support long-term recovery, it is essential to have individuals that have been identified as support. Patient's support network should include a therapist, counselor, a recovery group and a sponsor and/or life coach. Support from peers, family and friends can also help realize change to maintain motivation and support recovery efforts.

I. MAT plus program tiers

Tier 1: Induction/Stabilization (6-8 weeks)

Patient will be closely monitored by the MAT team during stabilization period.
Goal: *Adjust to medication and manage any cravings.*
Patient will:

- Have weekly MAT follow up medical visits
- Enroll into a substance use disorder treatment program.
- Attend community-based support groups (e.g. 12-Step, Celebrate Recovery, etc.)
- Engage in individual therapy.
- Develop a MAT care plan to set individual goals.
- Weekly contact with MAT case manager.

Tier 2: Engagement (6-8 weeks)

After stabilization, patients will move into Tier 2. They are engaged in your recovery, attending a treatment program and building a recovery support system. They may experience stressors that place you at risk to relapse.
Goal: *Gain healthy coping strategies to reduce risk to relapse.*

Patient will:

- Have MAT follow up medical visits every two weeks.
- Regular attendance to substance use disorder treatment program.
- Regular attendance to community-based support groups.
- Weekly/Bi-weekly contact with MAT case manager.
- Review MAT care plan to identify progress made on goals. Make adjustments to meet individual needs.

Tier 3: Maintenance (As needed)

In Tier 3, patients are actively engaged in their program of recovery with identified recovery support network.
Goal: *Able to maintain recovery and demonstrate ability to manage life problems*.
Patient will:

- Have monthly MAT medical visits.
- Have recovery support system in place.
- Regular attendance to substance use disorder treatment until completion of the program.
- Monthly contact with MAT case manager.
- Review MAT care plan to identify progress made on goals. Make adjustments to meet individual needs.

II. MAT plus program procedures

1. Identification of candidates

Candidates are identified from referrals from PCP, community agencies and self-referrals. If candidates are not currently *(program name)* patients, they must first be scheduled an appointment to establish with a *(program name)* PCP to have the initial medical evaluation.

The MAT plus care team will present and discuss candidates at the weekly case management meetings.

Initiation:

- Candidates that are established patients will *(program name)* will be contacted by the MAT nurse to discuss the MAT plus program and be scheduled for an appointment to review the MAT agreement.
- If a candidate is at the clinic for an appointment the MAT nurse, mAT case manager or the behavioral health care coordinator (BHCC) will meet to discuss the program.
- Patients will give their consent to participate in the MAT plus program by signing the MAT agreement.
- Patients will be introduced to MAT case manager.
- MAT nurse will schedule patient for MAT/ASAM assessment appointment.
- If a patient is not willing to participate in all components of the MAT plus program a referral will be given the patient to an outside MAT provider. The referral will be documented in the EHR chart. Patients will sign a release of information (ROI) for *(program name)* PCP to coordinate care with outside MAT Provider.

Behavioral health evaluation—MAT/ASAM Assessment

LCSW will perform MAT/ASAM Assessment. LCSW will diagnose patient per DSM-5, assess level of severity and provide recommendations for services determined with the patient. Patient will sign releases of information (ROI) for both agencies and support persons identified. LCSW will

complete documentation in the EHR and route the note to MAT Provider and primary care provider (PCP).

2. Tier program

Tier 1 - Stabilization procedure

MAT provider, MAT nurse and MAT case manager coordinate the induction and follow up visits during participation on the MAT plus program in all tier placements.

Induction visit

Patient is roomed by clinic staff.
MAT nurse takes vitals, performs COWS. Administers medication, observes and monitors patient.
MAT nurse will perform pregnancy test prior to induction.
MAT provider evaluates patient, determines appropriate Buprenorphine dosage.
*Primarily written Rx, although exceptions can be made to call a prescription to the pharmacy or print and fax a prescription to the pharmacy.
MAT case manager checks in with patient.
Patient is scheduled follow up visits.

Follow up visits

MAT nurse and/or MAT provider will evaluate patients
MAT nurse will perform UTOX and pregnancy tests as needed.
MAT case manager will check in with patient.
MAT care team will determine type of visit at the clinic for follow up visits. Patient may see MAT provider or LCSW.
MAT provider will perform evaluation to monitor progress in the program. Quarterly follow up visits will be scheduled with MAT provider for treatment medical problems and psychiatric issues and adjust medications as necessary.
Prescriptions are tied to MAT provider, MAT nurse or LCSW visit (including both individual and group visits).
*Primarily written Rx, although exceptions can be made to call a prescription to the pharmacy or print and fax a prescription to the pharmacy.

Tier 2 - Engagement

Follow up visits

MAT nurse and/or MAT provider will evaluate patients
MAT nurse will perform UTOX and pregnancy tests as needed.
MAT case manager will check in with patient.
MAT care team will determine type of visit at the clinic for follow up visits. Patient may see MAT provider, MAT nurse or LCSW.
MAT provider will perform evaluation to monitor progress in the program. Quarterly follow up visits will be scheduled with MAT provider for treatment medical problems and psychiatric issues and adjust medications as necessary.
Prescriptions are tied to MAT provider, MAT nurse or LCSW visit (including both individual and group visits).
*Primarily written Rx, although exceptions can be made to call a prescription to the pharmacy or print and fax a prescription to the pharmacy.

Tier 3 - Maintenance care
Follow up visits
MAT nurse and/or MAT provider will evaluate patients
MAT nurse will perform UTOX and pregnancy tests as needed.
MAT case manager will check in with patient.
MAT care team will determine type of visit at the clinic for follow up visits. Patient may see MAT provider, MAT nurse or LCSW.
MAT provider will perform evaluation to monitor progress in the program. Quarterly follow up visits will be scheduled with MAT provider for treatment medical problems and psychiatric issues and adjust medications as necessary.
Prescriptions are tied to MAT Provider, MAT nurse or LCSW visit (including both individual and group visits).
*Primarily written Rx, although exceptions can be made to call a prescription to the pharmacy or print and fax a prescription to the pharmacy.
During participation in the MAT plus program, patients will be education of variety of topics during visits.

Patient education topics:

a. Birth control options,
b. Mixing medications,
c. Co-occurring illicit substance abuse
d. Alcohol use.

3. Groups

MAT recovery support groups are included as a part of the MAT plus program. Groups occur weekly. They are based on the values that all members of the group have expertise, competence and can add value to enhance their recovery through participation. The MAT plus LCSW and case manager co-facilitate the groups. All group members are held to confidentiality to safeguard patients' disclosure during group discussions.
MAT recovery support groups are weekly on Thursdays from 2-3pm at *(program name)* location. Participants are placed on the EHR schedule. They sign in and engage in education and process groups. Each participant checks in with weekly status to identify what went well and any challenges experienced during the week. Group discussions include topics chosen by facilitator and/or participants.

List of topic/themes discuss at each group:

1. Psychoeducation on drugs of abuse
2. High-risk situations
3. Triggers/cravings
4. Stages of change
5. Relapse education
6. Relapse prevention
7. Coping skills
8. Self-management strategies
9. Recovery/social support
10. Goal setting

Group facilitator documents in the EHR using BH Group Note. A narrative to include topic discussed, attendance and participation.

III. Documentation and record keeping

The MAT plus care team will maintain appropriate records and documentation of all contacts and office visits with patients. All records will be stored electronically in accordance with *(program name)*'s policies and all federal, state and local laws and regulations.

The MAT plus program coordinator will be responsible for the oversight of the MAT plus program, data collection for reporting and management of the MAT workbook.
The MAT workbook is utilized to document information of all MAT patients. The MAT nurse and case manager will manage the MAT workbook to ensure information is up to date. Information documented in the MAT workbook include:

- Patient Demographics
    - Name and ID number
    - Insurance type
    - CIN numbers
    - Homeless status
    - Date MAT agreement signed
    - MAT start date
    - Assigned PCP, MAT Provider and BH provider
    - SUD program enrollment
- Assessments
    - Date of last CURES report—CURES will be obtained a minimum of quarterly
    - Date of initial and updated ASAM
    - Date of TNQ and OBOT completion
    - HIV/Hep C testing
    - Birth control type
- Visits
    - Monthly totals of office visits
    - MAT provider
    - Nurse visits
    - BHC/BH visits

Screening tools used as part of MAT plus program:

- COWS for induction to assist in assessing a patient's withdrawal severity.
- Initial behavioral health evaluation (prior to induction in most cases):
- Mental status assessment
- OBOT stability index
- Treatment needs questionnaire
- Opioid risk tool
- Adverse Childhood Experiences Questionnaire
- PHQ-9
- GAD-7
- Pain assessment
- Quality of Life score
- SBIRT
- DAST
- AUDIT
- Alcohol and drug addendum
- Clinician's discretion: PTSD, ADHD, mood disorder, etc.
- ASAM Dimension Assessment

Ongoing screenings: UTOX, PHQ-9, GAD-7, pain assessment, Quality of Life score, ASAM Dimensions and pill counts are also performed randomly.

IV. Communication with outside organizations

In a health emergency, staff at *(program name)* can inform emergency medical personnel of any medications/drugs that patient is taking, including Suboxone, as a safety precaution.

Members of the treatment team can speak with other healthcare and mental health providers, child welfare staff, substance use disorder programs, probation/parole staff, or pharmacy staff in order to provide the best comprehensive treatment available. Release of Information Forms are necessary to coordinate and report care and are signed prior to induction or at initial assessment.

V. Discontinuation

1. If despite intensification of treatment in the MAT plus program continues to struggle with program requirements, discontinuing of MAT should be considered, such as the following instances:
   - Continued use of illicit substances, RX opioids, or problematic use of prescription benzodiazepines that compromise the patient's ability to follow their MAT plus care plan.
   - Refusal to seek or engage with mental health care when recommended to do so
   - Negative buprenorphine and metabolite confirmation tests
   - Patient alteration of a prescription or urine drug screen
   - Repeated no-shows to scheduled office visits at the clinic and loss of contact with patients
   - Patient found to be diverting their medications
   - Patient or anyone acting on their behalf being verbally or physically abusive or threatening any staff or other patient at *(program name*).

2. With voluntary discontinuation for non-diversion, patients may be tapered per MAT Provider.
3. With involuntary discontinuation of the program, discretion for taper plan is directed by the MAT Provider; patients will be given a referral to access services with community MAT providers.
4. Patients who have successfully tapered their dose down and voluntarily discontinued may seek re-enrollment at any time needed without a waiting period.
5. Patient involuntarily discontinued from the MAT Program by the MAT care team, may be reassessed for readmission into the MAT Program. Patients must be willing to engage in all services recommended by the MAT care team
   a. Discretion for readmission into the program is given to the MAT care team

Sample after hours call policy

Full index

Caution: Route ALL encounters to:

- On-call medical provider for any issues with prescriptions and medical symptoms.
- On-call social worker (LMSW) for patients having behavioral health/mental crisis (anxiety and depression).
- See Epic office pool for routing.

Address:

Admissions:

Adults	Pediatrics	
Hospital	(name)	(name)
Who Admits	Hospitalist	Hospitalist

Courtesy: Route a telephone encounter to PCP's in-basket

Appointments:

After hours scheduler:

- General questions are communicated by patient to the office during business hours. Cancellations can be faxed to the office using the No Triage guideline.

- This office allows walk-in appointments, if patients do not want to schedule an appointment.
- If patient is NOT experiencing symptoms and requests to speak with a Social Worker, transfer them to Crisis Center *(xxx-xxx-xxxx)* - Do not transfer to nurse Triage.
    - Document telephone encounter and route to the Social Worker Pool.
    - If Crisis Center is called, document "Crisis Center was called" in your note.

Nurses:

- We do not schedule for this office. Please direct caller to call *(xxx-xxx-xxxx)* after 8:30 AM to schedule an appointment.

Closings:

When the office closes any time other than usual closing hours:

- If the caller agrees to call back when the office is open, ask them to do so.
- If the caller is unable to call back when the office opens, assess and refer. If you need to reach a HCP, either page the HCP who is on-call for the evening, or call the private back line to reach the HCP.

Refer to - Office closings calendar

Consultations:

- Office providers WILL NOT consult for inpatients and/or ED patients.

Death:

If a patient of this practice expires:

- Route a telephone encounter with the name of patient and time of death to the office Supervisor and PCP.
- Only call the on-call HCP if the caller identifies a concern.
- See Job Aide - 1-8887 Job Aide

Disposition:

This practice prefers their patients be sent to hospital and urgent care nearest to the patient.

Caution:

- Route ALL encounters to the on-call medical provider or the on-call social worker. See Epic office pool for routing.
- If office does not have an on-call social worker at this time and patient requests to speak with a social worker, transfer them to crisis center *(xxx-xxx-xxxx)*.

Provider preferences for guideline dispositions:

1. Activate EMS 911
2. See ED Immediately:
    - DO NOT send to ED: page to on call provider, do not call patients who have a true emergency should be referred directly to an ED. Do not contact the on- call HCP regarding those patients.
3. Call provider Immediately: Contact on-call HCP. For behavioral health concerns, ask the patient if they would like their social worker paged.
    - If the on-call social worker is paged, document "The social worker has been paged" in your note.

4. See provider within 4 hours, 24 hours, 72 hours, Lab in 24hrs: If the office is not open within the disposition time frame: Page to on call provider, do not call
    - For behavioral health concerns, ask the patient if they would like their social worker paged.
    - If the on-call social worker is paged, document "The social worker has been paged" in your note.
5. Caller demands to talk with on call physician: page on call provider to patient through Perfect Serve.

Disposition override /physician override: A provider's authorization is required if the nurse deems that the recommended disposition may be downgraded to a lesser disposition.

Epic contract name/number:

- Contract Name: (program name)
- Contract Number:

Epic department dame/number:

- Epic Department Name: (Program Name)
- Epic Department Number:

Epic office pool:

- Provider: for any issues with prescriptions and medical symptoms
    - If the medical provider is paged, document "The on-call medical provider was paged" in your note.
- *(program name)* social worker: for patients having behavioral health/mental crisis (anxiety and depression)
    - If patient is triaged and would still like their Social Worker paged, page on-call Social Worker (or transfer them to Crisis Center xxx-xxx-xxxx).
    - If the social worker is paged or crisis center called, document "The social worker was paged" or "crisis center was called" in your note.

Lab & X-Ray:

All abnormal lab and x-ray reports need to be paged out immediately to the on-call HCP.

- Page the HCP directly to the caller.
- Tell the caller to contact you if they do not receive a call from the HCP within 30 minutes.

Late policy:

Advise patient:

- Patients arriving more than 10 minutes after their scheduled appointment time will be seen at the discretion of the provider.
- Special considerations will be given to patients in the event of inclement weather, travel conditions, emergency, etc.
- Offer to reschedule patient while you have them on the line.

Newborn notifications:

- All newborn notifications are to be warm conferenced to the Charge nurse at *xxx-xxx-xxxx*.

Charge nurse

Healthy uncomplicated
- *(program name)*: route a telephone encounter to the PCP's in-basket.
- Call office at 8am with newborn notification information.

With medical concerns
- Route a telephone encounter to the PCP's in-basket.
- Call office at 8am with newborn notification information.

NPI:
- N/A

Nursing home:
- This office does not provide care for nursing home patients

Office has not returned call:
If patient was expecting a return call and hasn't heard from the office:
- If patient was expecting a return call and hasn't heard from the office, call the on-call provider if office is still open, but phones have been turned over.
- If office is closed follow normal protocols and register the call for nurse Triage.

Office hours:
- *Monday, Wednesday, Friday 8:00 AM – 5:00 PM*
- *Tuesday, Thursday 9:00 AM – 6:00 PM*

Phone hours:
- *Monday, Wednesday, Friday 8:30 AM – 4:30 PM*
- *Tuesday, Thursday 8:30 AM – 5:30 PM*

Nurse triage
Anytime the office is closed and holidays

Major holidays 24 Hours
- Memorial Day
- Fourth of July
- Labor Day
- Thanksgiving
- Christmas
- New Year's Day

Lunch hours
- Office is open during lunch

On-call and paging:
NOTE: This office has social workers. If patient is having an emotional crisis: page the n-call social worker to help.
- This office shares call with ____ *(clinic name)*.
- On-call changes at 8am on Fridays.
- Providers take call a week at a time.

- For *(program name)* patients, if the on-call provider does not retrieve page, escalate to (lead prescriber) (page, do not call).
- If on-call social worker does not retrieve page, escalate to (lead prescriber) (page, do not call).
- Link to (on call calendar)

Follow the paging health provider procedure

Phone numbers:
Office phone
Private line
Office fax
Navigation line N/A

Cisco internal ext N/A

- Office manager:
- Office phone number:

Pregnant/OB patients:

ALL pregnant patients who have an OB and calling with pregnancy related symptoms:

- Tell patient to contact OB office.

Prescriptions:

CAUTION: Nurse triage only: For ALL *(program name)* patients, please page ALL medication requests to the on-call medical provider (through Perfect Serve).

Priority 1:

- Symptoms chest pain shortness of breath
- Suicidal (blue envelope) homicidal
- Infants under 12 weeks with ANY symptoms
- Stroke symptoms
  a. Facial droop, abnormal speech, vision changes, weakness on one side of body, and balance issues

Navigator please see - Priority 1 Job Aide for Navigators
Scheduling CSR see - Priority 1 Job Aide for Schedulers

Private line usage:

Schedulers

NOTE: Do not use once phones are turned over to after hours service. Do not use the Private line unless one of the following exist:

- You have a newborn you are unable to schedule within 5 days
- Critical lab or X-Ray findings
- Wet reads

Nurses

Do not use once phones are turned over to after hours service.

- If a nurse has an urgent question in which they need to speak to the provider directly this line may be used.

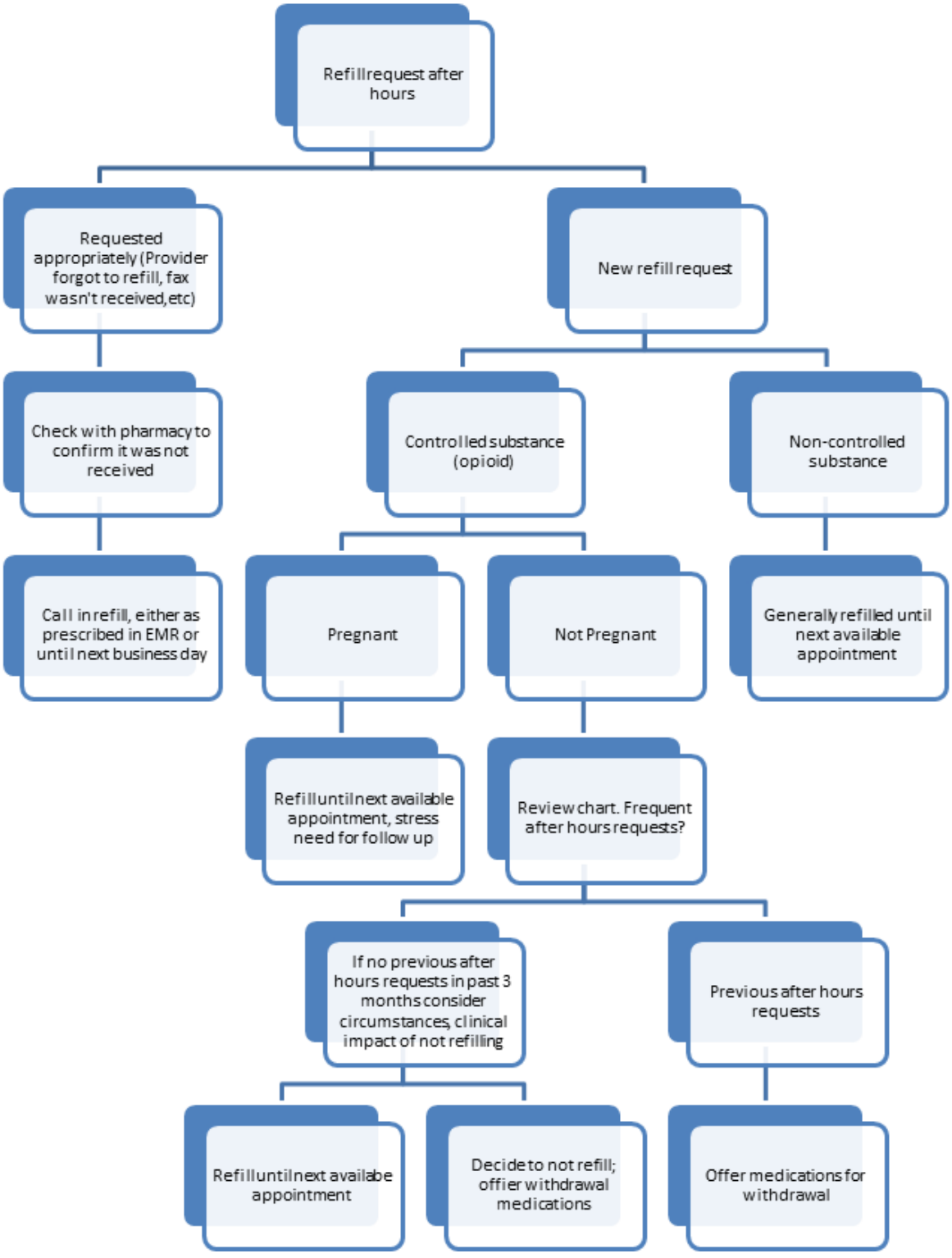
Providers

Provider Name	Credentials	Cell No.	Home No.
Lucy van Pelt	PsyD	123-456-7891	
Charlie Brown	MD	987-654-3211	

- PCP at ____
- Works at this location on TUESDAY'S (as specialty for addiction & complex care)
- Does NOT take call at this location

MD
LMSW
LMSW
LMSW

After hours refill decision tree



Appendix D: MAT treatment documents and workflows

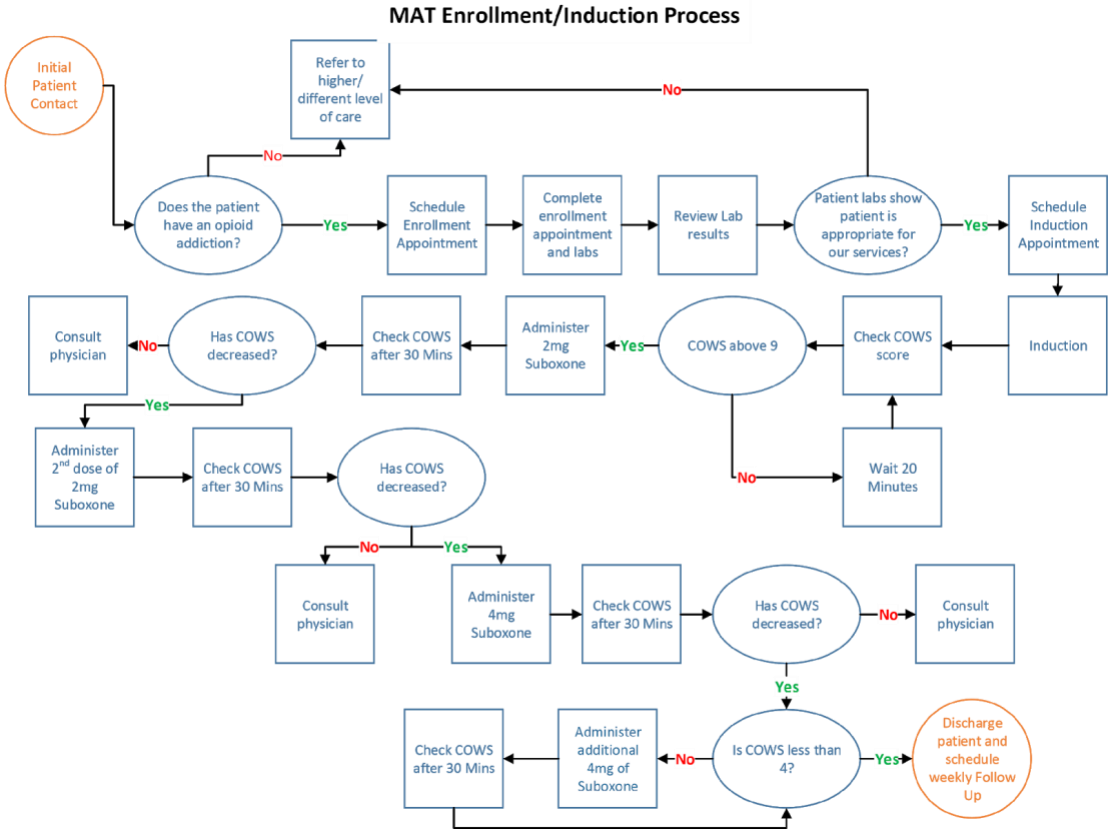
This appendix provides examples of various clinical workflows, patient handouts, and treatment structures. Though not all programs use a group format, such as the examples in this appendix, group refill visits are particularly helpful with larger patient populations.

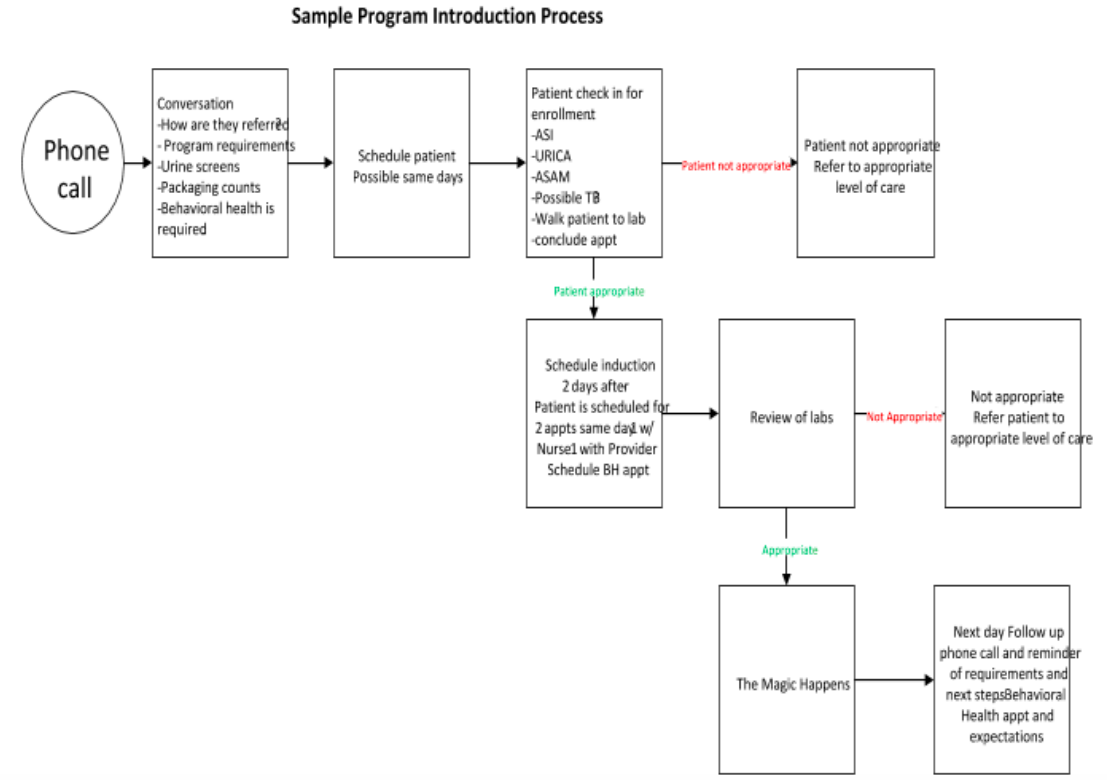
Section acknowledgements:

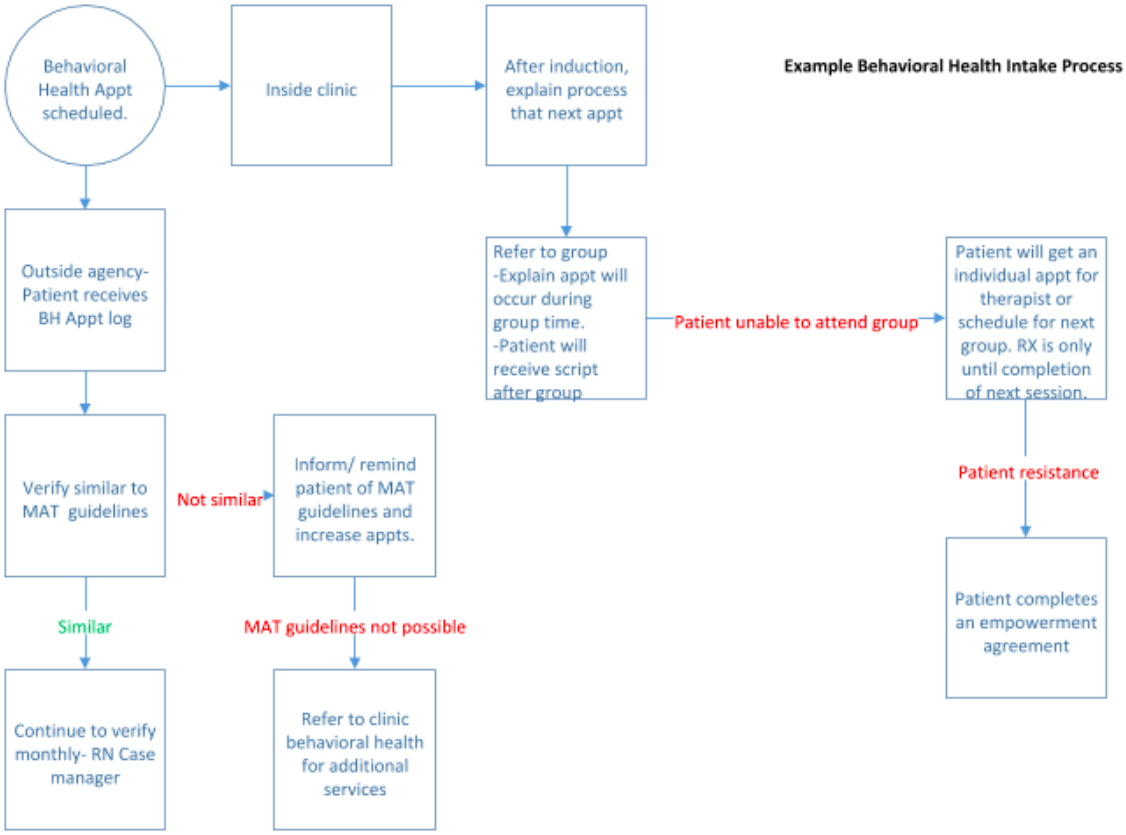
- Role descriptions, electronic health record templates, patient handouts, refill/stabilization group curriculum developed with and for Chapa-De Indian Health MAT team. Grass Valley, CA.
- Pre-group check-in first developed by Dr. Neal Mehra and MAT Team at El Dorado Community Health Center. Cameron Park, CA.
- Resilience Questionnaire: **http://www.traumainformedcareproject.org/resources/RESILIENCE_Questionnaire.pdf**

This questionnaire was developed by the early childhood service providers, pediatricians, psychologists, and health advocates of Southern Kennebec Healthy Start, Augusta, Maine, in 2006, and updated in February 2013. Two psychologists in the group, Mark Rains and Kate McClinn, came up with the 14 statements with editing suggestions by the other members of the group. The scoring system was modeled after the ACE Study questions. The content of the questions was based on a number of research studies from the literature over the past 40 years including that of Emmy Werner and others. Its purpose is limited to parenting education. It was not developed for research.

Sample MAT program workflows






Example Behavioral Health Intake Process
Behavioral Health Appt scheduled.
Inside clinic
After induction, explain process that next appt
Outside agency- Patient receives BH Appt log
Refer to group -Explain appt will occur during group time. -Patient will receive script after group
Patient unable to attend group
Patient will get an individual appt for therapist or schedule for next group. RX is only until completion of next session.
Patient resistance
Patient completes an empowerment agreement
Verify similar to MAT guidelines
Not similar
Inform/ remind patient of MAT guidelines and increase appts.
Similar
MAT guidelines not possible
Continue to verify monthly- RN Case manager
Refer to clinic behavioral health for additional services

Sample MAT program patient handouts

Medications for addiction treatment group rules

- We arrive on time for group
- We are respectful to ourselves and others
- We listen
- We turn off our cell phones
- We avoid "cross talk"
- We avoid giving advice
- We use respectful language at all times – please no swearing
- We do not discuss our buprenorphine dose in group
- Confidentiality and anonymity –

"Who we see here, what we hear here, stays here"

Example medication assisted treatment plus (MAT+) agreement with buprenorphine/naloxone (Suboxone)

Welcome to Hill Country Health and Wellness Medication Assisted Treatment Plus (MAT+) program. While medication can support individuals to engage in a program of recovery, studies have shown that Buprenorphine medication, when combined with counseling and other behavioral therapies, social and peer support can greatly increase motivation in recovery and positively affect a person's ability to make and sustain positive change.

The MAT Care Team at Hill Country Health and Wellness includes a prescribing doctor, your primary care provider, a Licensed Vocational Nurse Case Manager, a Behavioral Health Clinician and Care Coordinator. **We work as a team, with you** and others in the community to provide comprehensive treatment for opioid dependence. Medication therapy is only a component of Hill Country's MAT PLUS program.

Initial steps:

1. After receiving an appropriate referral to the MAT program, you will complete an ASAM Assessment to determine and recommendations for recovery and supportive services.
2. Complete an induction and/or start date for your Suboxone prescription.
3. Develop a MAT Care Plan with care coordinator.
4. Attend **all** appointments scheduled with Hill Country, including provider, behavioral health and care coordinator. Continual missed appointments may result in dismissal from the MAT program.
5. Enroll into treatment program (e.g. Visions of the Cross, Empire Recovery or Right Road Recovery)

**** It is YOUR responsibility to schedule all appointments with your Provider, Behavioral Health Clinician AND Care Coordinator. Assistance is available upon request.**
****All participants MUST have a working telephone and reliable transportation.**

MEDICATION SAFETY:

1. Hill Country Health and Wellness must be the only provider for Suboxone medication.
2. Your Suboxone prescription can only be filled at **Owens Pharmacy: 201 Lake Blvd. Unit B**
3. Do not mix other substances with Suboxone. The combination of Suboxone with substances such as benzodiazepines (Valium, Klonopin, Xanax and Ativan) and/or alcohol can have life-threatening risks.
4. Use of these medications will be done so under the direction of the MAT provider.
5. Take all medications as directed.
6. It is your responsibility to protect your medications from loss and theft. Keep them in a safe and secure location. **We do not replace stolen medications.**
7. Do not share or sell your medications.
8. Keep Hill Country informed of all current medications (including over the counter medications).
9. Inform providers at the emergency rooms (or any other provider) of all current medications (including Suboxone).

10. Comply with random urinalysis screening and pill counts.
11. Suboxone refills provided at office visits **IN PERSON** only.
12. **No early or replacement refills provided. Regardless of circumstances. NO EXCEPTIONS.**

The following steps are **required** for participation in Hill Country's MAT PLUS program:

☐ I have reliable transportation for visits (can be bike or walk). If assistance is needed inform staff.

☐ I must have phone contact for communication with Hill Country _____.

☐ I agree to show up for all scheduled appointments (including Hill Country MAT groups).

☐ I agree that I will provide a urine specimen (drug test) at all MAT appointments.

☐ I agree to attend community treatment program (e.g. Visions, Empire, Right Road, Redeemed).

☐ I agree to attend recovery support groups (e.g. 12-Step, Celebrate Recovery, Care Center group etc.)

☐ I agree to attend individual therapy as additional support during MAT treatment.

☐ I agree to conduct myself in a courteous manner during all office visits to Hill Country.

The purpose of this agreement is that each participant acknowledges and are in agreement with the MAT program rules and expectations, and with the understanding that **persistent noncompliance of the MAT Agreement may result in dismissal from the program**.

****All participants must sign a Release of Information forms necessary to coordinate care.**

I understand and hereby agree to comply with this Agreement, authorize and give my consent for treatment at Hill Country.

_____

Patient Signature Date

_____

Hill Country Staff Signature Date

Alcohol and/or drug treatment records are protected under Federal and State Confidentiality regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of

Federal Regulations (CFR) Part 2, and the Health Information Portability and Accountability Act of 1996 (HIPPA), 45 CFR Parts 60 and 164, and cannot be disclosed without written consent unless otherwise provided for in the regulations

1. Buprenorphine/naloxone (Suboxone) pre-induction and home induction instructions

Welcome to the Medications for Addiction Treatment with Buprenorphine (suboxone) Program. The pre-induction and home induction process is important for a safe and comfortable start of the medication.

Your induction date/time/ location_____. You are coming off of (opioid)_____. You will need to **STOP TAKING or USING all opioids** after____(day) _____(time).

You are also required to abstain from all alcohol, benzodiazepines and illicit drugs.

The reason you need to be in withdrawal from all opioids is that the opioid receptors in your brain and body will soon be occupied by buprenorphine. If there are still opioids in your system, there is a risk for precipitated withdrawal. ***Precipitated withdrawal*** is an intense withdrawal, which can last for many hours and even days.

If you and your provider have planned for a ***home induction***, you will have met with provider and submitted urine drug screen (UDS) and reviewed the plans for a successful comfortable induction.

For your comfort during your opioid withdrawal, your provider might prescribe:

_____Imodium for diarrhea
_____Clonidine for withdrawal symptoms
_____Hydroxyzine for nausea, anxiety and sleep
_____Gabapentin for withdrawal symptoms, anxiety and sleep
_____Ibuprofen for aches and pain
_____Other

Please read the instructions for the proper doses on the bottles of these medications, as they will be ordered specific to your expected withdrawal.

On day of induction, you will follow the additional directions provided to you by your provider.

Some initial **common side effects**:
Drowsiness, light-headedness, nausea, mild headache, urinary retention, constipation. These are usually mild side effects and some people do not experience any. Side effects such as sweating, constipation and muscle twitching might persist. Let us know of any side effects that you are experiencing. Please drink extra fluids, take ibuprofen or Tylenol for headache, stay in touch with your MAT team, keep your appointments and take care of your recovery. It is important that your provider knows about any side-effects you might be having.

Your MAT RN will be following your home induction daily for the first 3 days via telephone or in-clinic visits.

2. Buprenorphine/naloxone (Suboxone) pre-induction instructions for in-clinic induction

Welcome to our Medication Assisted Treatment with Buprenorphine (suboxone) Program. The pre-induction process is important for a safe and comfortable start of the medication.

Your induction date/time/ location_____. You are coming off of (opioid)_____ _____. You will need to **STOP TAKING or USING all opioids** after___(day) _____(time).

You are also required to abstain from all alcohol, benzodiazepines and illicit drugs.
The reason you need to be in withdrawal from all opioids is that the opioid receptors in your brain and body will soon be occupied by buprenorphine. If there are still opioids in your system, there is a risk for precipitated withdrawal. ***Precipitated withdrawal*** is an intense withdrawal, which can last for many hours and even days.

On the day of your in-clinic induction, please plan to be here for up to three hours. We will require a urine drug screen and will measure your opioid withdrawal symptoms.
For your comfort during your opioid withdrawal, your MD has prescribed:

_____Imodium for diarrhea
_____Clonidine for withdrawal symptoms
_____Hydroxyzine for nausea, anxiety and sleep
_____Gabapentin for withdrawal symptoms, anxiety and sleep
_____Ibuprofen for aches and pain
_____Other

Please read the instructions for the proper doses on the bottles of these medications, as they will be ordered specific to your expected withdrawal.

On day of induction, you will submit urine drug screen, meet with nurse case manager for evaluation of your withdrawal symptoms. When you are ready to start buprenorphine (Suboxone), you will pick up your prescribed first dose of buprenorphine/naloxone from the clinic pharmacy. You will then return to the waiting room where your RN will expect to find you to start the medication phase of induction process. Please do not open the bottle and do not take the medication. You will be taking the first two doses in the clinic once your nurse and MD have determined that it is safe to start the buprenorphine (Suboxone).

Some initial **common side effects**:
Drowsiness, light-headedness, nausea, mild headache, urinary retention, constipation. These are usually mild side effects and some people do not experience any. Side effects such as sweating, constipation and muscle twitching might persist. Let us know of any side effects that you are experiencing. Please drink extra fluids, take ibuprofen or Tylenol for headache, stay in touch with your MAT team, keep your appointments and take care of your recovery. It is important that your provider knows about any side effects you might be having.

1. **Buprenorphine for Pain** *Start Instructions* **for Patient**

Your Provider will be initiating a Buprenorphine for Pain trial for management of your chronic pain. The pre-start and home Bup Start process is important for a safe and comfortable start of the medication.

Your induction date/time/ location _____.

You are coming off (opioid) _____.

You will need to **STOP TAKING all opioids** after _____(day) _____(time).

You are also required to abstain from all alcohol, benzodiazepines and illicit drugs.

The reason you need to be in withdrawal from all opioids is that the opioid receptors in your brain and body will soon be occupied by buprenorphine. If there are still opioids in your system, there is a risk for precipitated withdrawal. ***Precipitated withdrawal*** is an intense withdrawal, which can last for many hours and even days.

If you and your provider have planned for a ***buprenorphine start at home***, you will have met with provider and submitted urine drug screen (UDS) and reviewed the plans for a successful comfortable buprenorphine start.

For your comfort during your opioid withdrawal, your provider might prescribe:

_____ Imodium for diarrhea

_____ Clonidine for withdrawal symptoms

_____ Ondansetron as needed for severe nausea

_____ Hydroxyzine for nausea, anxiety and sleep

_____ Gabapentin for withdrawal symptoms, anxiety and sleep

_____ Ibuprofen for aches and pain

_____ Other

Please read the instructions for the proper doses on the bottles of these medications, as they will be ordered specific to your expected withdrawal.

On day of buprenorphine start, you will follow the additional directions provided to you by your provider.

Some initial **common side effects**:
Drowsiness, light-headedness, nausea, mild headache, urinary retention, constipation. These are usually mild side effects and some people do not experience any. Side effects such as sweating, constipation and muscle twitching might persist. Let us know of any side effects that you are experiencing. Please drink extra fluids, take ibuprofen or Tylenol for headache, stay in touch with your MD/RN keep your appointments. It is important that your provider knows about any side-effects you might be having.

Your RN will be following your Buprenorphine for Pain Management daily for the first 3 days via telephone or in-clinic visits.

Medications for addiction treatment (MAT) with buprenorphine/naloxone (Suboxone) treatment agreement, informed consent and recovery treatment plan

Patient Name: **MR#:**

I am requesting that my (*program name*) medications for addiction treatment team initiate buprenorphine/naloxone (Suboxone) treatment for opioid use disorder. I freely and voluntarily agree to accept this MAT treatment agreement and informed consent, as follows:

1. **Timeliness.** I agree to keep, and be on time for all my scheduled MAT appointments including Phase 1/Phase 2 required groups, provider visits, behavioral health appointments and individual counseling.
2. **Courtesy**. I agree to conduct myself in a courteous manner at all times when at (program name).
3. **Required urine drug screen (UDS)**. I agree to submit to urine drug screens whenever required by my doctor, this includes random and scheduled drug screens.
4. **Pill/film counts**. I agree to bring in my bottle of buprenorphine/naloxone (Suboxone) for random pill or strip counts within 24 hours that this request is made by my MAT provider. I understand that this medication and all prescribed controlled medications must be kept in the bottle in which they came from the pharmacy. *This is required by law.*
5. **Do not come to clinic under the influence.** I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the staff may choose not see me and it may be determined, due to safety concerns, my medication refill(s) will be withheld until such time that I am no longer under the influence.
6. **Diversion.** I agree not to sell, share, trade, or give any of my medication to another person. I understand that such mishandling of my medication is a violation of this agreement and could result in my discharge from this program.
7. **Refills at scheduled times only.** I agree that my medication (or prescriptions) can only be given to me at my regular office or group visits. Any missed office or group visits could result in my not being able to get medication until the next scheduled visit
8. **Responsibility and lost/stolen buprenorphine**. I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I can request a lockbox from the MAT nurse case manager. I agree that lost medication will not be replaced until I have made a police report, submit a UDS and meet with RN.
9. **Benzodiazepines and alcohol use.** I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my treating physician. I understand that mixing buprenorphine/naloxone (Suboxone) with other medications, especially benzodiazepines and alcohol, can be dangerous. I also understand that I should not take non- prescribed benzodiazepines or drink alcohol while taking Suboxone as the combination could produce excessive sedation, impaired thinking, or other medically dangerous events.
10. **Stimulant use.** I understand that continuing use of any illicit drugs such as methamphetamines and cocaine may require a higher level of treatment such as intensive outpatient (IOP) or residential treatment.

11. **Take Suboxone as prescribed**. I agree to take my medication as the provider has prescribed, and not to increase or decrease my Suboxone dose without first consulting with my provider. If I decide to taper off of suboxone I will do so under medical supervision.
12. **Recovery/treatment.** I understand that medication alone is not sufficient treatment for my disease and I agree to participate in the recommended Phased MAT program which provides patient education, recovery tools and support, to assist me in my recovery.
13. **Willingness to go to higher Level of Care.** *I agree that if at any point in this program, it is recommended by my prescriber and MAT team that I enroll in intensive outpatient treatment or residential treatment that I will do so. I may also be referred to daily buprenorphine dosing and intensification of care here. I understand that my success in recovery depends on my willingness to engage in the recovery process.*
14. **Other options for care**. I understand that there are alternatives to buprenorphine/naloxone treatment for opioid addiction, of which not all are provided at this clinic, including:
    a. Medical withdrawal and medication-free treatment
    b. Injectable naltrexone treatment
    c. Methadone treatment
    d. My provider will discuss these with me and provide a referral if I request this.

15. **Reachable by phone.** *I agree to keep all contact numbers up to date so that my providers can contact me quickly. I will set my cell phone for voicemail messages. If my numbers change, I am required to inform the clinic.*

16. **Confidentiality.** I agree to maintain the *absolute confidentiality* of all (*program name*) patients in our medications for addiction treatment program at all times. This includes all 12 step groups, outside treatment settings, all public places and in the clinic.
17. **Discharge.** I understand that my buprenorphine/naloxone treatment may be discontinued and I may be discharged from this program if I violate this agreement.
18. My **recovery treatment plan** to which I agree to participate in and complete (patient specific: MAT Phase expectations, referral to Outpatient Treatment, Behavioral Health, etc.):

_____

Patient's Signature Date

_____

Witness Signature Date

Sample treatment agreement and recovery treatment plan: Hill Country Health and Wellness

A. RECOVERY SUPPORT

In an effort to make the necessary changes to support long-term recovery, it is essential to have individuals that you have identified as support. Your support network should include a therapist, counselor, a recovery group and a sponsor and/or life coach.

THERAPIST: _____ Phone: _____

TREATMENT PROGRAM: _____

COUNSELOR: _____ Phone: _____

My Care Team at Hill Country Health and Wellness includes:

_____

_____

B. MY SUPPORT NETWORK

Support from peers, family and friends can also help realize change to maintain motivation and support recovery efforts.

My support people are:

_____

_____

C. MEDICATION SAFETY

1. I agree to take medication as prescribed.

2. I will not share mediations with another person; taking medications that are not prescribed to you, can be extremely dangerous.

3. Should anyone other than me take my medication, I will immediately take the person to the emergency room or call 911.

4. Giving, sharing, or selling my medications to someone else is against this agreement and may result in immediate dismissal from the MAT PLUS program.

5. I will be responsible for my medications and agree to keep it in a safe, secure place away from pets and children. Should medications be lost or stolen, the medication will NOT be replaced until my next scheduled appointment with my provider.

6. I agree to not get medications from any other providers, emergency rooms, or hospitals without informing my Hill Country provider.

7. In an emergency medical situation, I agree to inform the emergency medical providers that I am taking Suboxone.

8. I agree that I will not "just drop by" the clinic for medications. I must schedule an appointment to meet with a provider to obtain medications.

9. Women of childbearing age should NOT become pregnant when taking Suboxone. I agree to be on a consistent birth control method, before and during treatment with Suboxone. I agree to have a pregnancy test performed in the clinic monthly.

10. I agree not to mix other substances with my Suboxone, especially benzodiazepines, alcohol, or other drugs of abuse (including opiates). Mixing Suboxone with other drugs and/or alcohol can cause me to stop breathing. It could be fatal. These medications, if used at all, should ONLY be used under the direction of the provider.

11. I understand that the use of benzodiazepines can cause serious problems during the MAT program:

- Benzodiazepines can interact with Suboxone and cause me to stop breathing,
- Benzodiazepines are highly addictive, and
- Benzodiazepines are more difficult and dangerous to get off of than opiates

Due to these serious problems, in most cases, the long-term goal will be to discontinue the use of benzodiazepines. Fortunately, therapy is very effective in helping people to manage their anxiety symptoms. Other medications may be offered that are not controlled substances.

12. If I am prescribed benzodiazepines, I agree to participate in therapy to gain strategies to manage anxiety.

D. COMMUNICATION WITH OUTSIDE ORGANIZATIONS

1) I agree that in a health emergency, staff at Hill Country can inform emergency medical personnel of any medications/drugs that I am on, including Suboxone, for my own safety and emergency treatment. I understand this is okay by law.

2) I agree that members of my treatment team can speak with other healthcare providers, CPS staff, drug and alcohol programs, probation/parole staff, or my pharmacy staff in order to provide the best comprehensive treatment available. I agree to sign the Release of Information Forms necessary to coordinate and report care, as appropriate in my case. (Please indicate here other programs/services in which you are involved and to whom your treatment team may speak:

_____

E. URINE, SWAB & BLOOD TESTS

1. I understand that I will be subject to random urinalysis and/or mouth swab test as a part of the MAT program.
2. I understand that food or herbal tinctures containing poppy seeds may cause a false positive result for opiates.
3. Women of childbearing age will agree to be on a consistent birth control method, before and during participation in the MAT program and agree to submit urine and/or blood tests for pregnancy when requested by staff.

F. VIOLATION OF TREATMENT GUIDELINES

1. Repeated no-shows to scheduled office visits at the clinic may result in dismissal from the MAT program.
2. I understand that I must stay in communication with Hill Country MAT team. Failure to keep in close communication is a violation of treatment guidelines.
3. Repeated inconsistent drug screening results, including negative results for Suboxone, positive results of non-prescribed narcotics or illegal substances could result in dismissal from the MAT program.

Patient Signature Date

MAT Team Member Signature Date

Alcohol and/or drug treatment records are protected under Federal and State Confidentiality regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Cod of Federal Regulations (CFR) Part 2, and the Health Information Portability and Accountability Act of 1996 (HIPPA), 45 CFR Parts 60 and 164, and cannot be disclosed without written consent unless otherwise provided for in the regulations.

Sample MAT program structure

Refill/stabilization groups: Every new patient is initially on short prescriptions of buprenorphine such as a 7-day supply, with or without refills. This gives your medications for addiction treatment team the opportunity to see you frequently in the early weeks of your recovery so that we can give you plenty of support. The prescriber will refill your medications at this group; there will also be behavioral health staff if you need to start therapy. We will also cover many topics about recovery and the medication you are taking. Refill/stabilization group will also give us an opportunity to make sure that the treatment plan for long term recovery support is effective or to reassess and adjust your treatment plan if needed.

The weekly MAT group is every__from__am. Please come ½ hour prior to start of group so the medical assistant can collect urine drug screen prior to the group. Every admitted MAT patient will be scheduled for a biopsychosocial intake or update.

Individual appointments: Additional sessions with an addiction nurse, prescriber or behavioral health therapist will be scheduled based on assessed need and request.

Maintenance visits: Once you are stable on the correct dose, have treatment agreement adherence established, and your behavioral health and treatment (recovery) needs have been identified and are being addressed, you will be scheduled for routine visits with your buprenorphine (Suboxone) provider.

Relapse: Addiction is a chronic progressive relapsing disease. We understand that relapse can occur. If this does happen we will work with you to provide increased support and monitoring until you are stable. Relapse includes resumption of use of alcohol, benzodiazepines, methamphetamines and opioids.

If you have any questions or concerns, please call our MAT RN case manager or BH therapist at _____.

Example of a phased program

Phase I

- Weekly prescriptions for buprenorphine/naloxone.
- Weekly urine drug screens – *must have a minimum of 4 consecutive negative drug screens.*
- Weekly attendance at refill/stabilization group.
- Complete behavioral health intake.
- Adhere to MAT treatment agreement and individual treatment plan for other identified health and recovery needs – referral to outpatient treatment in the community if needed.

Patient can request to be moved into Phase II and MAT team will assess on an individual basis.

Phase II

- Bi-weekly prescriptions, refill/stabilization group attendance and urine drug screens.
- Ongoing adherence to individual treatment plan.

Patient can request for MAT team to assess for move to Phase III after 1 month.

Phase III

- Monthly: appointment with your primary care provider, if wavered to prescribe buprenorphine, or MAT prescriber.
- Monthly attendance at Phase III group or Individual counseling.
- Monthly urine drug screens.
- Monthly buprenorphine prescriptions.

Patient can return to Phase I for added support and monitoring at any time at patient request and/or recommendations of prescriber and MAT team. **NEG Urine Drug Screen must be POS for BUP, NEG for all drugs except those prescribed. THC is assessed by prescriber on an individual basis.*

Sample phased program: Hill Country's Medication Assisted Treatment Plus (MAT+) Program

Hill Country's MAT PLUS Program is a comprehensive treatment approach for opioid dependence. Our 3 Tier design is structured to support recovery from addiction. Medication therapy alone is rarely sufficient treatment for addiction. The potential for recovery is greatly increased when medication assistance is combined with recovery support services. For most individuals, a recovery program includes engagement in substance abuse treatment program, attendance to recovery support groups within the community, and individual and family therapy. Individuals with an addiction to substances often have complex problems that require additional services to promote a lifestyle change necessary to sustain remission from substance use.

TIER 1: INDUCTION/STABILIZATION (minimum 6-8 weeks)
You will be closely monitored by the MAT team during stabilization period.
Goal: Adjust to medication and manage any cravings.
You will:

- Have weekly MAT follow up medical visits
- Enroll into a substance use disorder treatment program.
- Attend community-based support groups (e.g. 12-Step, Celebrate Recovery, etc.)
- Engage in individual therapy.
- Develop a MAT care plan to set individual goals.
- Weekly contact with MAT case manager.

TIER 2: ENGAGEMENT (minimum 6-8 weeks)
After stabilization, you will move into Tier 2. You are engaged in your recovery, attending a treatment program and building a recovery support system. You may experience stressors that place you at risk to relapse.
Goal: Gain healthy coping strategies to reduce risk to relapse.
You will:

- Have MAT follow up medical visits every two weeks.
- Regular attendance to substance use disorder treatment program.
- Regular attendance to community-based support groups.
- Weekly/Bi-weekly contact with MAT case manager.
- Review MAT care plan to identify progress made on goals. Make adjustments to meet individual needs.

TIER 3: MAINTENANCE (As needed)
In Tier 3, you are actively engaged in your program of recovery with identified recovery support network.

Goal: Able to maintain recovery and demonstrate ability to manage life problems.
You will:

- Have monthly MAT medical visits.
- Have recovery support system in place.
- Regular attendance to substance use disorder treatment until completion of the program.
- Monthly contact with MAT case manager.
- Review MAT care plan to identify progress made on goals. Make adjustments to meet individual needs.

Example structure of the refill/stabilization group visit:

- Scheduled as a 2-hour provider slot, patients scheduled in provider schedule. Bills for each patient with appropriate E&M office visit code, often 99213.
- First hour – Group time
    - The waivered provider attends group, and can lead group with RN and SUD counselor
    - Maintain a simple format. (See example of group format in Group)
- Second hour – Provider time for patients who need an appointment. Three slots. Best if scheduled, can bill for one visit so if seen, do not bill for group visit.
- An effective MAT refill group requires a well-organized team with a strong MAT program manager.

Refill/stabilization group care begins with checking in and medical assistant (MA) care.

- The medical assistant collects UDS prior to group and promptly enters results in electronic medical record.
- The MA may also address strip/pill counts when indicated for patient safety.
- The MA manages the flow of patients in and out of the group, if MD is meeting with patients individually during group.
- The MA can also call patients to remind them of their next refill/stabilization group appointment.

The nurse case manager (NCM) will have prepared for the group by updating the **BUP Patient Roster**, checking in with patients who might need additional care or need to see a prescriber ***after*** refill/stabilization group. The nurse case manager and/or addiction therapist oversees group content. The NCM can merge refill/stabilization group template and entire orders so that group moves quickly and smoothly.

A well-managed refill/stabilization group can and should be on time and can be done in an hour. Being timely is an excellent way to convey respect for our patients.

Group guidelines

The MAT refill/stabilization groups will require clearly stated expectations and guidelines, such as:

- Do not discuss your buprenorphine dose
- Do not request dose changes in group
- Keep discussion general and respectful. No "cross talk."
- No one is required to talk but all patients in the group are encouraged to participate. (See Group Rules in Group section).

Emphasize confidentiality and each member's obligation to be responsible for the well-being the group as well as themselves. This idea is summarized: *"What you hear here and who you see here, stays here."*

A refill group is not:

1. A therapy group – patients may want to do deeper processing in the group. It is recommended that they be gently and respectfully re-directed and have follow-up immediately after group with behavioral health or addictions counselor. That being said, maintain a group environment, which is honest, safe and responsive for authentic sharing.
2. A time for buprenorphine dose adjustments, addressing of other substance use issues to be treated by prescriber. Schedule an appointment or refer to urgent care setting, if available. Patient must see primary care provider, if available, for more extensive medical needs.

Treatment planning

As soon as the patient is stable, treatment planning should be done.
Meet with SUD counselor (or, if no SUD counselor, meet with RN case manager or BH therapist on MAT team):

- Using ASAM identified Level of Care refer patient to in-clinic SUD or AOD program. If no in-clinic SUD, refer to community recovery providers for IOP, OP or residential care
- Obtain all Release of Information for outside care collaborating agencies including probation, CPS, if needed.
- Phase 1 expectations
- Behavioral Health appointments

Use a MAT Treatment Planning Template

MAT curriculum for refill/stabilization group

Basic refill/stabilization group format

I. Intro

- Quote – encourage patients to bring quotes. Quote should be relevant to recovery topic of the day.
- Mindfulness - 5 minute guided meditation
- Announcements
- Agreement on group rules – Have a patient in group read the group rules each week.
- Introductions/check-ins – different themes (i.e. "what brought me joy this past week") (10 minutes)

II. Educational topics (see example curriculum)
(10 minutes)

III. Recovery tools (see example curriculum)
(40 minutes)

MAT curriculum rotating every 8 weeks (example)

1. Life management
    a. Basic need: shelter, food, income vehicle, support -
    b. Goal setting priorities – have handout
    c. Jobs/work
    d. Job interviews and resume writing
    e. Setting a new course; dreams, hopes, great ideas
    f. Healthy living
        i. Diet
        ii. Exercise
        iii. Sleep
        iv. Hydration
        v. Tobacco
2. Recovery 101
    a. Principles of recovery (12 Step) - have handout
    b. Resentment/forgiveness –have handout
    c. Values – have handout
    d. Phases of MAT
    e. Priorities in recovery
    f. Buprenorphine and other substances
3. Relationships

a. Boundaries – have handout
b. Communication – have handout
c. Parenting – have handout
d. Non-violent communication

4. Stress management
    a. Mindfulness workshop
    b. Self-compassion –have handout
    c. Wellness: outdoor activities, diet, sleep, exercise –
    d. Autonomic nervous system –

5. Creativity and healing
    a. Native recovery
        i. White Bison
        ii. Red Road to Wellbriety

    b. Arts

    c. Poetry
        i. Storytelling
        ii. Music
        iii. Art

    d. Cultivating an authentic spirituality
        i. Four agreements

6. Mental health in recovery
    a. Managing depression
    b. Managing anxiety
    c. Bipolar disorder
    d. ADHD
    e. Trauma/resilience

7. CBT and emotional health
    a. Thought traps – have handout
    b. ABC behavioral worksheet – have handout
    c. Returning to feelings – have handout
    d. Life stages – Erikson's Stages of Psychosocial Development/Maslow's Hierarchy of Needs – have handout
    e. Emotional intelligence/Social intelligence

8. Other/wild card week
    a. Group processes
    b. Special guests – behavioral health or visiting teachers

Education topics

9. Bup/Brain power point
    c. MAT treatment agreement

d. Side effects
e. UDS
f. Taking care of your prescriptions
g. Legal service
h. MD Q&A
i. Coming off of buprenorphine
j. Tobacco cessation
k. Alcohol and other drugs
    i. Cannabis
    ii. Alcohol
    iii. Benzodiazepines and sedative hypnotics
    iv. Methamphetamine and cocaine

MAT Pre-group check-in sample form

Name: _____

Buprenorphine Symptoms:
0 = Low 10 = High

Cravings:	0	1	2	3	4	5	6	7	8	9	10
Side Effects:	0	1	2	3	4	5	6	7	8	9	10
Pain:	0	1	2	3	4	5	6	7	8	9	10
Constipation:	0	1	2	3	4	5	6	7	8	9	10
Depression:	0	1	2	3	4	5	6	7	8	9	10
Anxiety:	0	1	2	3	4	5	6	7	8	9	10

Sleep: poor fair good very good

Triggers I encountered this week:

_____
_____

What I did for my recovery this week:

_____
_____
_____ **Other Concerns:**_____

Time constraints for group today:

_____
_____

Need to see the Dr. individually:

UDS: AMP BAR BUP BZO COC MET MDMA MTD OPI OXY THc

RESILIENCE Questionnaire

Please circle the most accurate answer under each statement:

1. I believe that my mother loved me when I was little.
Definitely true Probably true Not sure Probably not true Definitely not true

2. I believe that my father loved me when I was little.
Definitely true Probably true Not sure Probably not true Definitely not true

3. When I was little, other people helped my mother and father take care of me and they seemed to love me.
Definitely true Probably true Not sure Probably not true Definitely not true

4. I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.
Definitely true Probably true Not sure Probably not true Definitely not true

5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.
Definitely true Probably true Not sure Probably not true Definitely not true

6. When I was a child, neighbors or my friends' parents seemed to like me.
Definitely true Probably true Not sure Probably not true Definitely not true

7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me.
Definitely true Probably true Not sure Probably not true Definitely not true

8. Someone in my family cared about how I was doing in school.
Definitely true Probably true Not sure Probably not true Definitely not true

9. My family, neighbors and friends talked often about making our lives better.
Definitely true Probably true Not sure Probably not true Definitely not true

10. We had rules in our house and were expected to keep them.
Definitely true Probably true Not sure Probably not true Definitely not true

11. When I felt really bad, I could almost always find someone I trusted to talk to.
Definitely true Probably true Not sure Probably not true Definitely not true

12. As a youth, people noticed that I was capable and could get things done.
Definitely true Probably true Not sure Probably not true Definitely not true

13. I was independent and a go-getter.

Definitely true Probably true Not sure Probably not true Definitely not true

14. I believed that life is what you make it.

Definitely true Probably true Not sure Probably not true Definitely not true

How many of these 14 protective factors did I have as a child and youth? (How many of the 14 were circled "Definitely True" or "Probably True"?)
Of these circled, how many are still true for me?

Sample buprenorphine patient registry

Buprenorphine patient registry											
HR #	**Last Name**	**First Name**	**Induction Date**	**Provider**	**Last Rx date**	**Total daily dose**	**Qty**	**Days supply**	**# of refills**	**Next refill date**	**Comments**
12345	Weasley	Bill	11/7/2018	Dumbledore	6/20/2019	24 mg	42	14	1	7/18/19	Phase 1
6789	Hagrid	Rubeus	2/11/2018	Pomphrey	3/6/2019	24 mg	42	14	2	4/17/19	Phase 2
10111	Granger	Hermoine	5/9/2017	Dumbledore	2/27/2019	12 mg	11	7	3	3/27/19	Pregnant - subutext

Sample suboxone tracker

Suboxone tracker							
Name	**DOB**	**Insurance**	**Auth EXP**	**Last medical visit**	**Consent**	**Comments**	**Frequency**
Patient, Sample	6/16/73	Medicaid	12/31/17	6/20/17	Yes	7/12/17	4 week follow up

Appendix E: Sample MAT program templates

This appendix offers examples of various electronic medical record templates, including prescriber initial and follow up visits. These examples are for you, the reader, to use as needed.

It's recommended that templates for documentation be standardized as much as possible for all roles and added to the EMR. This can help create consistency across the team(s) as programs expand.

MAT program templates

Screening: Medications for addiction treatment

Note: this screening is specific to patient's current situation and can be done quickly over the phone by any staff member.

Current opioid use:

Began opioid use:

Other current drug use (alcohol, methamphetamine, benzodiazepine, cocaine) –

Buprenorphine/naloxone – prescribed or illicit:

Overdoses:

Most recent ER visit:

Current SDOH

Social

Housed

Employment

Income

Transportation

Reachable by phone

Plan:

MAT clinical assessment

(To be completed by BH or RN)

Clinical summary:

Substance use

Current opiate use (type, route, amount):

Last use:

History of overdose:

Access to Narcan:

Experience with buprenorphine:

Precipitated withdrawal/side effects:

Last use:

Other substances currently using (type, route, amount):

Are you ready to stop using these substances?

Substance use history:

Alcohol:

Age of first use?

Ever a problem?

In what way was/is alcohol a problem?

Periods of daily or heavy binge drinking?

DUIs?

Rehabs for alcohol?

Last drink?

THC:

Opioids: Heroin: Methadone:

Kratom:

Meth:

Cocaine:

Benzos:

Hallucinogens:

Tobacco:

History of SUD treatment (type, duration, sobriety):

Any periods of abstinence not related to treatment:

Family history of SUD:

Medical

Medical history:

Current medical problems:

Medications (prescribed, OTC, taking but not prescribed):

Chronic pain:

Birth control:

Psychiatry

Psych diagnoses:

History of suicide

Attempts/hospitalizations:

Current psych treatment/meds:

Current BH treatment:

Legal

Any current legal issues including

probation: History of legal issues:

CPS involvement:

Motivation

Why would you like to be in this program?

3 things motivating you to be/stay sober?

Barriers to being in this program:

What type of recovery program are you currently in or interested in?

Trauma and coping

ACE:
Other trauma:

What strategies do you currently use to cope with stress?

Social:

Housed:

Family life:

Drug or alcohol use in household:

Employment/income:

Vehicle/transportation:

Planning

Education:

Treatment agreement signed:

Induction planned:

Referral to treatment:

ASAM Score:

Labs done:

Narcan

prescription:

PDMP:

Notes:

Recovery treatment plan

Care team members

Primary care provider:
BH:
Psychiatry:
MAT team:
Pharmacy:
Clinical pharmacist:

Subjective

History of present illness:

Social history:

Recent opioid overdoses:

Adverse childhood experiences (ACE) Score:

ASAM Level of Care Criteria score:

Treatment goals

Patient preferences and

functional/lifestyle goals:

Barriers to meeting goals:

Strategies to address barriers:

Discussed with patient?

Notes:

Objective

Allergies: see chart

Active outpatient medications (including supplies): see chart

Problem list: see chart

MAT recovery treatment plan

The list below has important action steps to help you get the most from your recovery treatment plan:

ACTION STEPS: Reviewed and signed MAT treatment agreement ACTION

STEPS: Behavioral health intake appointment

ACTION STEPS:

ACTION STEPS:

ACTION STEPS:

Care plan given to patient

Provider medical appointment for admission to MAT program

Age_____M/F presenting with opioid use disorder and co-occurring_____use disorder/ psych conditions with last use of_____at_____date_____.

S: Patient reports he/she would like to stop using because:
Readiness to change indicator:
O: Vital Signs
COWs: UDS
A/P: F11.0 Opioid use disorder

- Ordered RPR, HIV, HEP panel, g/c
- Ordered baseline LFTS
- UDS/EtOH ordered
- Patient admitted into MAT panel
- Nurse intake scheduled

Buprenorphine induction(s) template

Home induction:

Opioid patient is withdrawing from:
Date/time of last use:

UDS results on day of induction:

COWS:

Cravings for opioid (scale of 0-10)

Does patient have clinic number to call if questions?

Does clinic have number to reach patient?

Instructions given and handout ____

All questions answered _____

Follow-up appointment _____

Refill group appointment _____

Addiction Therapist appointment ____

Additional notes from RN/MD:

In-clinic induction:

Opioid withdrawing from:

Last reported Use:

UDS:

COWS:

Cravings for opioid of choice (scale of 0-10)

Time of first dose (usual first dose is 4/1 mg bup/nx SL):

45-60 minutes after first dose:

COWS:

Cravings (scale of 0-10)

Side effects:

Time of second dose (usual second dose is 4/1mg bup/nx SL):

Patient ok to return home after 2nd dose if stable with instructions to take 4/1 mg Bup/nx in response to breakthrough withdrawal and then, if any cravings, take 4/1 mg bup/nx at

bedtime. In morning, instruct to take bup/nx 8/2mg SL and come for follow-up appointment or call RN for phone follow-up.

Patient scheduled with addiction therapist/behavioral health clinician by end of Induction day.

Medication-assisted treatment induction follow-up note

(Use this template for Day 1, Day 2, Day 3 etc. following induction)

Date of induction:

Current Rx'd bup/Nx dose:

Breakthrough withdrawal:

Pain level:

Cravings:

Triggers:

Treatment plan:

Next visit:

Medications for addiction treatment refill and stabilization group

MAT staff present:

Topics addressed in group:

Patient update:

UDS:

Rx/refill:

Phase:

Note:

MAT brief intervention for SUD counselor

RN or MD issues:

Changes

- using
- relationship
- housing
- work
- other changes

Cravings (measure 0-10)

Triggers: (people, places, things)

Recommended LOC

Interventions: (listening, coping strategy practiced)

Plan: (appointment, referrals, resources given)

Chronic pain patient care

Safe Rx program

Patient care

Complete assessment

Education

Plan of care

Other changes

Screening/diagnostic tools

DSM-5 opioid use disorder

AUDIT-C

DAST-10

Safe Rx

RN assessment template

Pain

Location

Onset

Surgeries

Pain level 0-10 ranged over a 24-hour period

Pain is worse when

Pain is least when

What relieves pain

Other pain treatments (chiropractor, physical therapy, acupuncture, etc.)

Physical limitations from living with pain

Disability

(*Do the above assessment for each reported chronic pain problem)*

Opioids

When first prescribed:
Previous opioid rx'd (list all and approximate dates

Current dosing:

Is your pain well-managed with this regimen?

Escalate dose on days of more pain?

Stretch out to next refill due?

Run out early?

Call provider for refills?

Obtain from friends/family/street?

Concerns about pain management?

Overall health goals:

Other medications Hx/current:

Muscle relaxants

Anxiolytics/benzos

Sleep meds

ED visits r/t pain in past year

Substances

Alcohol - (Ever a problem? DUI's? Rehabs? If still drinking, does patient drink more for pain and sleep management?

Benzos

Stimulants

Cannabis

Opioids

Tobacco

Other medical issues and treatments:

Diet and exercise:

Psych:

Diagnoses/dates dx'd

Current psych meds:

Hx of psych meds.

SA/Si/Hospitalizations

Education:
CDC Guidelines for treating pain

Opioid Induced Hyperalgesia (OIH)

Anxiety/benzo connection to long term opioid therapy for chronic pain

Buprenorphine for Pain

Planning:
If a substance use disorder is identified, notify provider, add this new SUD dx to problem list.

Does patient need alcohol detox before proceeding with changes?

Does patient have an interest in stopping alcohol use?

Does patient have a responsible support at home to manage a home detox for EtOH?

Med Changes
Written plan

If switching to buprenorphine:

1. Converting to short-acting opioids
2. Comfort meds for period of withdrawal

Buprenorphine for pain: RN assessment template
Pain
Location of pain:

Onset:

Surgeries:

Pain level 0-10 ranged over a 24-hour period

Pain is worse when:

Pain is least when:

What relieves pain:

Other pain treatments (chiropractor, physical therapy, acupuncture, etc.)

Physical Limitations from living with pain:

Disability:

(*Do the above assessment for each reported chronic pain problem)*

Opioids
When first prescribed:

Previous opioid rx'd (list all and approximate dates

Current dosing:

Is your pain well-managed with this regimen?

Escalate dose on days of more pain?

Stretch out to next refill due?

Run out early?

Call provider for refills?

Obtain from friends/family/street?

Concerns about pain management?

Overall health goals:

Other medications Hx/current:

Muscle relaxants

Anxiolytics/benzos

Sleep meds

ED visits r/t pain in past year

Substances

Alcohol - (Ever a problem? DUI's? Rehabs? If still drinking, does patient drink more for pain and sleep management?

Benzos

Stimulants

Cannabis

Opioids

Tobacco

Other current medical issues and treatments:
Diet and exercise:

Psych:

Diagnoses/dates dx'd

Current psych meds:

Hx of psych meds:

SA/Si/Hospitalizations

Social:

Support:

Housed:

Income:

Vehicle:

Identified Barriers to care:

Plan:

1. Always this care with urine drug screen.
2. Convert any long-acting opioids to short-acting equivalents. If a long-acting is converted to short-acting opioid then stay with it for 5-7 days before starting withdrawal and BUP start.
3. Plan Buprenorphine start (induction) with instructions to stop all opioids for 24 hours.
    a. Comfort meds for withdrawal phase. Some suggestions below – Provider might have another comfort med protocol.
        i. Ativan 1 mg BID for 1 day #2
        ii. Gabapentin 100 mg 1-3 caps QID prn for anxiety and sleep for 3 days # 40
        iii. Clonidine 0.1 mg (optional – assess for hypotension risk) #2
        iv. Ibuprofen 800 mg TID prn for aches
        v. Zofran 4 mg as directed prn nausea
        vi. Imodium 2 mg prn as directed for diarrhea
4. Start with BuTrans patch to assess for tolerance to Bup and for side effects.
    a. BuTrans dosing based on most recent opioid medications
    b. Add Buprenorphine 2 mg tab SL (take ½ tab SL BID initially) as needed to manage withdrawal and pain
    c. Titrate to eliminate withdrawal and to improve pain management.
5. Assess daily and adjust dose as needed
6. Once patient is stable, refer back to provider for ongoing Bup for Pain care.

Buprenorphine/naloxone (Suboxone) sample note templates

Nextgen

by Matt Perez, MD

Here for suboxone (buprenorphine) consult. would like to quit using illicit opioids.
Substance history:
Opioids:
Ever IV use?:

Methamphetamine:
Cocaine:
Benzos:
Alcohol:
Tobacco:
Marijuana:
Hallucinogens/party drugs/Rx meds/gambling:

Prior Medication Assisted Treatment (methadone, buprenorphine, naltrexone):
Prior Abstinence-based Treatment:

Prior Mental Health hosp/Diagnoses:

Social situation(where living, who living with, children/dependents, associates using drugs):

Assessment
We discussed treatment options for opioid addiction in detail (methadone, buprenorphine, naltrexone, abstinence only). Would like to start suboxone. We discussed treatment requirements, the induction, insurance issues and benefits of counseling. Handouts on the above, suboxone consent and WA Recovery helpline card given.
Utox today consistent with reported use.

Wrote Prescriptions for withdrawal meds & bup-nal 8/2mg tablet #14. We discussed the specifics of the induction and how to call us with questions.
Follow up 1 week (ideally 3-4 days into starting suboxone).

Induction patient instructions
I wrote a prescription for suboxone 8/2mg #14. When you are having moderately severe withdrawal (verge of having diarrhea), then take 1/2 a suboxone under the tongue.
IF YOU ARE FEELING BETTER (not worse) in 2-4 hours, then you can take another 1/2.

On day 2, take 1 full tablet. In 2-4 hours afterwards, you can take another 1/2 tablet, then another ½ if needed in a few hours.

On day 3, take 2 tablets or films.
Continue that dose until you see me next. Call us with any questions

Follow up 1 week (ideally 3-4 days into starting suboxone).

Stable Refills
Refilled suboxone 8/2mg to use 2 once daily. Disp #56
Follow up in 4 weeks.

Stable, utox appropriate. (additional counseling: smoking, birth control, etc)

Epic

by Paul Gianutsos, MD

1. Suboxone meet & greet 15 min
2. Suboxone H&P 30 min
3. Suboxone follow up

Buprenorphine Initial Visit
CC: @NAME@ is a @AGE@ y.o. @SEX@ who presents for discussion of opiate dependence.

History:
Drug of Choice:
Opiate history: Started using

Last use: ***

Previous Attempts to Quit: {Yes/No:694}
Longest period of abstinence:
How was abstinence obtained:

Medical or Legal Problems resulting from use: {Yes/No:694}
Typical Withdrawal Symptoms: {Drug Withdrawal Hx:7873}

Inpatient treatment history:

Outpatient treatment history:

Opiate Substitution Therapy
MMT: {NONE/YES(FT):3079}
Reason discontinued:

Buprenorphine: {NONE/YES (FT):3079}
Reason discontinued:

Other drug history:
Alcohol: {Alcohol use:15542}

Tobacco: see history
Cocaine:
Methamphetamine:
Benzodiazepines:
Hallucinogens:
Inhalants:
Marijuana:

Social History:
Stable housing? {HOUSING:7661}
Employment? {EMPLOYMENT STATUS:9484}

Family History:
Updated in chart

PMH:
PMH updated in chart

Psychiatric History:
Suicide attempt: never
Hospitalization: none
Bipolar disorder:
Depression:
Anxiety:

Current counseling:
NA/AA
Case manager:

Current medications:
@encmeds@

@VSP@

Gen: NAD
Mental status: {MENTAL STATUS EXAM:10650}
Psych: {PSYCH:16943}

UTox:
POS: {DRUG SCREEN:1938}
NEG: {DRUG SCREEN:1938}

Assessment/Plan:
@DIAG@

Patient meets the criteria for opiate dependence with the following in the last 12 months:
{ARS DX DEPENDENCE:7863}

Patient appears highly motivated*** to change. @HE@ is stable from a psychosocial perspective and has no uncontrolled use of sedative-hypnotics and no uncompensated mental health disorder. @HE@ will follow up for a complete H&P and instructions for induction.

@ME@ MD
@NOW@; @TD@

These problems updated on the problem list
@PROBEDITCOMM@

Suboxone H&P 30 min
CC: @NAME@ is a @AGE@ y.o. @SEX@ who presents for discussion of opiate dependence.

History:
Drug of Choice:
Opiate history:
Last use: ***

Treatment history:
Methadone
Location:
Dates:
Maximum dose:
Reason discontinued:

Buprenorphine
Location:
Dates:
Maximum dose:
Reason discontinued:

Inpatient treatment:

Outpatient treatment:

Other drug history:
Alcohol: {Alcohol use:15542}
Tobacco: see history
Cocaine:
Methamphetamine:
Benzodiazepines:
Hallucinogens:
Inhalants:
Marijuana:

Social History:
Lives with
Employment:
Legal issues:

Family History:
Updated in chart

PMH:
PMH updated in chart
Hepatitis C: {POSITIVE/NEGATIVE/COMMENTS:2999}
HIV: {POSITIVE/NEGATIVE/COMMENTS:2999}
DVT: never

Psychiatric History:
Suicide attempt: never
Hospitalization: none
Bipolar disorder:
Depression:
Anxiety:

Current counseling:
NA/AA
Case manager:

Current medications:
@encmeds@

Contraception:
{PGCONTRACEPTION:1720}

Exam:
@VS@
Gen: appears well
HEENT: normal appearance, pupils 3-4 mm, dentition {DENTITION/ ORAL HYG:16570}
Neck: supple, no masses, no thyromegaly
Lungs: lungs clear to auscultation
CV: RRR no murmur
Abd: protuberant, positive BS, soft, no tenderness, no masses, no HSM
Ext: no abscesses or erythema, sclerosed veins {ABSENT:3850}
Skin: no rash, no concerning lesions

Assessment/Plan:
@DIAG@

We discussed buprenorphine maintenance. I explained that buprenorphine is an opiate that abrupt discontinuation will result in withdrawal symptoms, injection of Suboxone will result in intense opiate withdrawal symptoms, most patients will do well in the 8 - 16 mg daily dose range, the clinic policy of seeing patients weekly for the first 6 - 8 weeks then bimonthly then monthly if stable, the importance of counseling in addition to medication therapy and the importance of keeping visits. The patient is told that failure to keep appointments may result in dismissal from the clinic.

The patient is offered the choice of a clinic or home induction.

The patient elects an unobserved induction and understands the risk of precipitated withdrawal if @HE@ fails to follow instructions. Printed instructions are given to the patient and reviewed with @HIM@. @HE@ is able to teach back the instructions.

@ME@ MD
@NOW@; @TD@

These problems updated on the problem list
@PROBEDITCOMM@

Suboxone follow up
CC: @NAME@ is a @AGE@ @SEX@ who presents for follow up for opiate dependence.

Interval History:

Interval substance use:
{DRUG USE:1849}
Tobacco: see History
Alcohol:
{Alcohol use:1763}

Current counseling:
{pgbupcdp:1860} {PGCDPFREQ:1859}

Mood: ***

Employment: ***

Current medications:
@MED@

Contraception:
{PGCONTRACEPTION:1720}

Exam:
@VS@
GEN: alert, cooperative, well groomed, pleasant and appropriate
PUPILS: 3-4 mm
SKIN: No piloerection, no diaphoresis

LABS:
UTox:
  POS: {DRUG SCREEN:1938}
  NEG: {DRUG SCREEN:1938}
Pregnancy: {POSITIVE:1933}

Assessment:

@NAME@ is a @AGE@ @SEX@ in the office @TD@ for follow up

{pgbupdiagnosis:1872}.

Plan:
{pgbupplan:1862} {pgbupsig:1863}, # , RF 0
F/U: {Number 0-5:11707} weeks.

@ME@ MD
@NOW@; @TD@

<u>These problems updated on the problem list</u>
@PROBEDITCOMM@

Appendix F: Supplemental tools and documents

1. Needs assessment for establishing and integrating MAT with buprenorphine
2. Adverse childhood events questionnaire
3. Worksheet for DSM-V criteria for diagnosis of opiate use disorder
4. OBOT Stability Index (Hub & Spoke)
5. Clinical Opioid Withdrawal Scale –COWS
6. Treatment Needs Questionnaire (Hub & Spoke)
7. CCC MAT Warm line
8. Brief Addiction Monitor (BAM)
9. Narcan Standing Orders
10. ASAM Level of Care grid
11. Safe RX Assessment
12. Example collaborative services agreement
13. Patient photography and audio visual consent form

Many of the above tools can easily be accessed on the Internet. A comprehensive list of evidence-based screening tools can be found here ***NIDA database****.*

This appendix offers commonly used, evidence-based assessment tools, ASAM dimensions grid, and other supporting documents. The first tool in this appendix, the needs assessment, was created by Katie Bell to help programs identify strengths, opportunities and needs. We recommend using this tool at the beginning stages of program development to help guide your implementation strategy.

Deciding on which assessment tools to use can be challenging for new MAT programs. As many states require the use of a specific assessment tool for Medicaid or block grant dollars, it is important to check your state's requirements first. Second, use the tool(s) that helps to best capture the right data for your program. Third, we strongly recommended incorporating the ASAM dimensions/Level of Care criteria into your assessment and treatment workflows. This provides national standardization of criteria for substance use disorders, which is no different than the care of other chronic disease in primary care. Many states are now requiring the use of ASAM criteria, and whether or not your state is one of them, we recommend it. Learn more about ASAM dimensions and level of care criteria **here**.

Needs assessment for establishing and integrating medications for addiction treatment with buprenorphine

Katie Bell, RN

1. Personnel

- ❑ DATA 2000 DEA waivered providers (how many per site?)
- ❑ MA program manager
- ❑ Psychiatry (telepsychiatry)
- ❑ RN case manager
- ❑ Medical assistants
- ❑ SUD counselor/behavioral health therapist (how many per site?)
- ❑ Patient navigators

Notes:

2. Best model for this clinic

- ❑ RN case managed
- ❑ BH/SUD case managed
- ❑ Interprofessional care team

3. Patient access/scheduling

❑ Referrals: provider or self-referred

- ❑ Screening
- ❑ Admission
- ❑ Treatment plans
- ❑ Patient education

- ❑ Treatment agreement

❑ Assessment and screening tools

- ❑ DSM-5 OUD screening
- ❑ Adverse Childhood Experiences (ACES)
- ❑ Addiction Severity Index
- ❑ ASAM Criteria/level of care
- ❑ TNQ
- ❑ OBAT

4. Induction (withdrawal planning with support and initiating buprenorphine)

- ❑ Patient instructions
- ❑ Comfort withdrawal medications - standing orders
- ❑ In-clinic induction
- ❑ Home induction
  - ❑ Patient instructions for home induction

Notes:

5. Refill/stabilization groups or individual appointments with prescriber?

- ❑ Refill/stabilization group
- ❑ Patient flow
- ❑ Staff flow
- ❑ Curriculum - education and recovery tools
- ❑ Phased care

- ❑ Frequency of refills/UDS

Notes:

6. Standing orders

- ❑ Routine refills
- ❑ Comfort medications
- ❑ Naloxone
- ❑ Admission labs

Notes:

7. Documentation

- ❑ Policies and procedures
- ❑ Building into schedules in EHR
- ❑ Electronic health record ***templates*** (multiple)
- ❑ Excel MAT roster - patient tracking
- ❑ Patient handouts - education, agreements, ROIs, brochures, packets
- ❑ Validated tools for assessment for level of care/QI. etc. measures

Notes:

8. **Persistent pain** (non-cancer chronic pain)

- ❑ With OUD
- ❑ Without OUD
- ❑ How to identify needs of patients with chronic pain?
- ❑ Pathways of care
    - ❑ Supportive care

Notes:

9. Competency/training for care teams

- ❑ DEA waivered
- ❑ Training needs for staff (See Appendix A)
- ❑ SUD counselors/behavioral health
    - ❑ BH intake pathways
    - ❑ Co-occuring treatment planning
- ❑ Address clinic culture with education
- ❑ Trauma-informed care/trauma sensitive
- ❑ ASAM criteria
- ❑ Motivational interviewing
- ❑ Seeking safety

- ❑ Relapse prevention
- ❑ Project Echo

❑ Neurobiology of addiction and trauma

Notes:

10. Front desk reception/call center consistent information

- ❑ Scheduling needs
- ❑ Checking in for MAT groups or intake
- ❑ Clear understanding of accessing care for callers and families

11. Will it be helpful to have a MAT direct phone line?

❑ Yes
❑ No

12. What will 'treatment' look like for our patients?

- ❑ Behavioral health - intake and ongoing care
- ❑ Outpatient, intensive outpatient, residential treatment, sober living environment/transitional living
- ❑ Clear understanding of accessing care for callers and families
- ❑ Who are the recovery services providers in the community?
- ❑ Partnership with community agencies?
- ❑ Regional opioid coalitions
- ❑ Emergency departments? County jails?

Notes:

13. Equipment, etc.

- ❑ BP/oximeter equipment

14. Space/room requirements

- ❑ **[ ]** In-clinic inductions can be done in nurse office or exam rooms
- ❑ Therapy rooms for behavioral health providers?

Notes:

15. Group room

- ❑ **[ ]** Capacity _____ ?

16. Urine drug screens with 12 panel dip/temp strip

- ❑ **[ ]** Point of care and the confirmatory laboratory

Notes:
Additional Notes:

Adverse childhood experience (ACE) questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often …

   Swear at you, insult you, put you down, or humiliate you?

   or

   Act in a way that made you afraid that you might be physically hurt?

   Yes No If yes enter 1

2. Did a parent or other adult in the household **often** …

   Push, grab, slap, or throw something at you?

   or

   Ever hit you so hard that you had marks or were injured?

   Yes No If yes enter 1

3. Did an adult or person at least 5 years older than you **ever…**

   Touch or fondle you or have you touch their body in a sexual way?

   or

   Try to or actually have oral, anal, or vaginal sex with you?

   Yes No If yes enter 1

4. Did you often feel that …

   No one in your family loved you or thought you were important or special?

   or

   Your family didn't look out for each other, feel close to each other, or support each other?

   Yes No If yes enter 1

5. Did you often feel that …

   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

   or

   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   Yes No If yes enter 1

6. Were your parents ever separated or divorced?

   Yes No If yes enter 1

7. Was your mother or stepmother:

Often pushed, grabbed, slapped, or had something thrown at her?

or

Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

or

Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes No If yes enter 1

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

Yes No If yes enter 1 _____

10. Did a household member go to prison?

Yes No If yes enter 1 _____

Now add up your "Yes" answers:____ This is your ACE score

Patient's Name:		Date of Birth:	
Worksheet for DSM-V criteria for diagnosis of opiate use disorder			
Diagnostic Criteria* (Opioid Use Disorder requires at least 2 within 12 month period)	Yes	No	Notes/supporting information
1. Opioids are often taken in larger amounts or over a longer period of time than intended.			
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.			
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.			
4. Craving or a strong desire to use opioids.			
5. Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.			
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.			
7. Important social, occupational or recreational activities are given up or reduced because of opioid use.			
8. Recurrent opioid use in situations in which it is physically hazardous			
9. Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.			

10. *Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid			
11. *Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms			

*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Severity: **Mild**: 2-3 symptoms, **Moderate**: 4-5 symptoms. **Severe**: 6 or more symptoms.

Signed_____Date_____

Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,. Washington, DC, American Psychiatric Association page 541.

OBOT Stability Index

1) Was the patient's previous urine drug screen positive for illicit substances? • Yes • No
2) If YES to #1 or if the patient was recently started on buprenorphine, does the patient have fewer than four consecutive weekly drug-free urine drug screens? • Yes • No
3) Is the patient using sedative-hypnotic drugs (e.g. benzodiazepines) or admitting to alcohol use? • Yes • No
4) Does the patient report drug craving that is difficult to control? • Yes • No
5) Does the patient endorse having used illicit substances in the past month? • Yes • No
6) Does the query of the Controlled Substance Utilization Review and Evaluation System (CURES) show evidence of the unexplained, unadmitted, or otherwise concerning provision of controlled substances? • Yes • No
7) Did the patient report their last prescription as being lost or stolen? • Yes • No
8) Did the patient run out of medication early from his/ her last prescription? • Yes • No

SCORING:

If NO to all, the patient is "stable" can be seen monthly for prescriptions and urine drug screens.

If YES to any of the above, the patient is "unstable" and needs to be seen weekly for prescriptions and urine drug screens.

Additionally, if YES to 1-6, the patient should be referred for addiction services.

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ **Date and Time:**____/____/___

Reason for this assessment:_____

Resting Pulse Rate:_____beats/minute
Measured after patient is sitting or lying for one minute
0 pulse rate 80 or below
1 pulse rate 81-100
2 pulse rate 101-120
4 pulse rates greater than 120

GI Upset: ***over last ½ hour***
0 no GI symptoms
1 stomach cramps
2 nausea or loose stool
3 vomiting or diarrhea
5 Multiple episodes of diarrhea or vomiting

Sweating: *over past ½ hour not accounted for by room temperature or patient activity.*
0 no report of chills or flushing
1 subjective report of chills or flushing
2 flushed or observable moistness on face
3 beads of sweat on brow or face
4 sweat streaming off face

Tremor *observation of outstretched hands*
0 No tremor
1 tremor can be felt, but not observed
2 slight tremor observables
4 gross tremor or muscle twitching

Restlessness *Observation during assessment*
0 able to sit still
1 reports difficulty sitting still, but is able to do so
3 frequent shifting or extraneous movements of legs/arms
5 Unable to sit still for more than a few seconds

Yawning *Observation during assessment*
0 no yawning
1 yawning once or twice during assessment
2 yawning three or more times during assessment
4 yawning several times/minutes

Pupil size
0 pupils pinned or normal size for room light
1 pupil possibly larger than normal for room light
2 pupils moderately dilated
5 pupils so dilated that only the rim of the iris is visible

Anxiety or Irritability
0 none
1 patient reports increasing irritability or anxiousness
2 patients obviously irritable anxious
4 patients so irritable or anxious that participation in the assessment is difficult

Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*
0 not present
1 mild diffuse discomfort
2 patients report severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort

Gooseflesh skin
0 skin is smooth
3 piloerections of skin can be felt or hairs standing up on arms
5 prominent piloerections

Runny nose or tearing *Not accounted for by cold symptoms or allergies*
0 not present
1 nasal stuffiness or unusually moist eyes 2 nose running or tearing
4 nose constantly running or tears streaming down cheeks

Total Score _____
The total score is the sum of all 11 items:

Initials of person completing Assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Provided by: Physician Clinical Support System, (877) 630-8812; PCSSproject@asam.org; www.PCSSmentor.org

Treatment needs questionnaire

Patient Name/ID:_____ **Date:**_____ **Staff Name/ID:**_____

Ask patient each question, circle answer for each	Yes	No
Have you ever used a drug intravenously?	Yes	No
If you have ever been on medication-assisted treatment (e.g. methadone, buprenorphine) before, were you successful? (If never in treatment before, leave answer blank)	Yes	No
Do you have a chronic pain issue that needs treatment?	Yes	No
Do you have any significant medical problems (e.g. hepatitis, HIV, diabetes)?	Yes	No
Do you ever use stimulants (cocaine, methamphetamines), even occasionally?	Yes	No
Do you ever use benzodiazepines, even occasionally?	Yes	No
Do you have a problem with alcohol, have you ever been told that you have a problem with alcohol or have you ever gotten a DWI/DUI?	Yes	No
Do you have any psychiatric problems (e.g. major depression, bipolar, severe anxiety, PTSD, schizophrenia, personality subtype of antisocial, borderline, or sociopathy)?	Yes	No
Are you currently going to any counseling, AA or NA?	Yes	No
Are you motivated for treatment?	Yes	No
Do you have a partner that uses drugs or alcohol?	Yes	No
Do you have 2 or more close friends or family members who do not use alcohol or drugs?	Yes	No
Is your housing stable?	Yes	No

Do you have access to reliable transportation?	Yes	No
Do you have a reliable phone number?	Yes	No
Did you receive a high school diploma or equivalent (e.g. did you complete > 12 years of education)?	Yes	No
Are you employed?	Yes	No
Do you have any legal issues (e.g. charges pending, probation/parole, etc)?	Yes	No
Are you currently on probation?	Yes	No
Have you ever been charged (not necessarily convicted) with drug dealing?	Yes	No

Totals____ + _____.

Total possible points is 26

Scores 0-5 excellent candidate for office based treatment

Scores 6-10 good candidate for office based treatment with tightly structured program and on site counseling

Scores 11-15 candidate for office based treatment by board certified addiction physician in a tightly structured program or Induction clinic followed by OBOT

Scores above 16 candidate for Opioid (Narcotic) Treatment Program

California Hub and Spoke System:
Opioid Use Disorder-MAT Expansion Project

CLINICIAN CONSULTATION CENTER
Translating science into care

Substance Use Warmline

For Peer-to-Peer consultation and decision support 855-300-3595 (6 AM– 5 PM PT Monday - Friday) or submit cases online at: **http://nccc.ucsf.edu/clinician-consultation/substance-use-management**

Free and confidential consultation for clinicians from the Clinician Consultation Center at San Francisco General Hospital focusing on substance use in primary care

Objectives of the Substance Use Warmline:

- Support primary care providers nationally in managing complex patients with addiction, chronic pain, and behavioral health issues
- Improve the safety of medication regimens to decrease the risk of overdose
- Discuss useful strategies for clinicians in managing their patients living with substance use, addiction and chronic pain.

Consultation topics include:

- Assessment and treatment of opioid, alcohol, and other substance use disorders
- Methods to simplify opioid-based pain regimens to reduce risk of misuse and toxicity
- Urine toxicology testing- when to use it and what it means
- Use of buprenorphine and the role of methadone maintenance
- Withdrawal management for opioids, alcohol, and other CNS depressants
- Harm reduction strategies and overdose prevention
- Managing substance use in special populations (pregnancy, HIV, hepatitis)

The CCC's multi-disciplinary team of expert physicians, clinical pharmacists and nurses provides consultation to help clinicians manage complex patient needs, medication safety, and a rapidly evolving regulatory environment.

Learn more at: **http://nccc.ucsf.edu/clinician-consultation/substance-use-management**

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1OHA30039-01-00 (AIDS Education and Training Centers National Clinician Consultation Center) in partnership with the HRSA Bureau of Primary Health Care (BPHC) awarded to the University of California, San Francisco

Brief Addiction Monitor (BAM)

Name:

Date:

Method of administration:

Self report time started:

Instructions

This is a standard set of questions about several areas of your life such as your health, alcohol and drug use, etc.

The questions generally ask about the past 30 days.
Please consider each question and answer as accurately as possible.

1. In the past 30 days, would you say your physical health has been?
    - Excellent (0)
    - Very Good (1)
    - Good (2)
    - Fair (3)
    - Poor (4)

2. In the past 30 days, how many nights did you have trouble falling asleep or staying asleep?
    - 0 (0)
    - 1- (1)
    - 4-8 (2)
    - 9-15 (3)
    - 16-30 (4)

3. In the past 30 days, how many days have you felt depressed, anxious, angry or very upset throughout most of the day?
    - 0 (0)
    - 1-3 (1)
    - 4-8 (2)
    - 9-15 (3)
    - 16-30 (4)

4. In the past 30 days, how many days did you drink ANY alcohol?
    - 0 (Skip to #6) (0)
    - 1-3 (1)
    - 4-8 (2)
    - 9-15 (3)
    - 16-30 (4)

5. In the past 30 days, how many days did you have at least 5 drinks (if you are a man) or at least 4 drinks (if you are a woman)? [One drink is considered one shot of hard liquor (1.5 oz.) or 12- ounce can/bottle of beer or 5 ounce glass of wine.]
    - 0 (0)
    - 1-3 (1)
    - 4-8 (2)
    - 9-15 (3)
    - 16-30 (4)

6. In the past 30 days, how many days did you use any illegal/street drugs or abuse any prescription medications?
    - 0 (Skip to #8) (0)
    - 1-3 (1)
    - 4-8 (2)
    - 9-15 (3)
    - 16-30 (4)

7. In the past 30 days, how many days did you use any of the following drugs:
    a. Marijuana (cannabis, pot, weed)?
    - 0
    - 1-3
    - 4-8
    - 9-15
    - 16-30

    b. Sedatives/Tranquilizers (e.g., "benzos", Valium, Xanax, Ativan, Ambien, "barbs", Phenobarbital, downers, etc.)?
    - 0
    - 1-3
    - 4-8
    - 9-15
    - 16-30

    c. Cocaine/Crack?
    - 0
    - 1-3
    - 4-8
    - 9-15
    - 16-30

    d. Other Stimulants (e.g., amphetamine, methamphetamine, Dexedrine, Ritalin, Adderall, "speed", "crystal meth", "ice", etc.)?
    - 0
    - 1-3
    - 4-8
    - 9-15
    - 16-30

e. Opiates (e.g., Heroin, Morphine, Dilaudid, Demerol, Oxycontin, oxy, codeine (Tylenol 2,3,4), Percocet, Vicodin, Fentanyl, etc.)?
- 0
- 1-3
- 4-8
- 9-15
- 16-30

f. Inhalants (glues/adhesives, nail polish remover, paint thinner, etc.)?
- 0
- 1-3
- 4-8
- 9-15
- 16-30

g. Other drugs (steroids, non-prescription sleep/diet pills, Benadryl, Ephedra, other over- the-counter/unknown medications)?
- 0
- 1-3
- 4-8
- 9-15
- 16-30

8. In the past 30 days, how much were you bothered by cravings or urges to drink alcohol or use drugs?
   - Not at all (0)
   - Slightly (1)
   - Moderately (2)
   - Considerably (3)
   - Extremely (4)

9. How confident are you in your ability to be completely abstinent (clean) from alcohol and drugs in the next 30 days?
   - Not at all (0)
   - Slightly (1)
   - Moderately (2)
   - Considerably (3)
   - Extremely (4)

10. In the past 30 days, how many days did you attend self-help meetings like AA or NA to support your recovery?
    - 0 (0)
    - 1-3 (1)
    - 4-8 (2)
    - 9-15 (3)

- 16-30 (4)

11. In the past 30 days, how many days were you in any situations or with any people that might put you at an increased risk for using alcohol or drugs (i.e., around risky "people, places or things")?
    - 0 (0)
    - 1-3 (1)
    - 4-8 (2)
    - 9-15 (3)
    - 16-30 (4)

12. Does your religion or spirituality help support your recovery?
    - Not at all (0)
    - Slightly (1)
    - Moderately (2)
    - Considerably (3)
    - Extremely (4)

13. In the past 30 days, how many days did you spend much of the time at work, school, or doing volunteer work?
    - 0 (0)
    - 1-3 (1)
    - 4-8 (2)
    - 9-15 (3)
    - 16-30 (4)

14. Do you have enough income (from legal sources) to pay for necessities such as housing, transportation, food and clothing for yourself and your dependents?
    - No (0)
    - Yes (4)

15. In the past 30 days, how much have you been bothered by arguments or problems getting along with any family members or friends?
    - Not at all (0) Slightly (1)
    - Moderately (2)
    - Considerably (3)
    - Extremely (4)

16. In the past 30 days, how many days were you in contact or spent time with any family members or friends who are supportive of your recovery?
    - 0 (0)
    - 1-3 (1)
    - 4-8 (2)
    - 9-15 (3)

- 16-30 (4)

17. How satisfied are you with your progress toward achieving your recovery goals?
    - Not at all (4)
    - Slightly (3)
    - Moderately (2)
    - Considerably (1)
    - Extremely (0)

Standing order to dispense naloxone hydrochloride

Naloxone is indicated for treatment of opioid overdose. It may be delivered intranasally or intramuscularly. This standing order is current as of *date* and issued in accordance with Section *enter state civil code* (i.e. 1714.22 of the California Civil Code*).

1. This standing order authorizes *program name*, to maintain supplies of naloxone kits for the purposes of distributing them in the community those at risk of an overdose or other potential bystanders.

2. This standing order authorizes program name to possess and distribute naloxone to opioid overdose responders who have completed an overdose training and required documentation.

3. This standing order authorizes opioid overdose responders, trained by program name to possess and administer naloxone to a person who is experiencing an opioid overdose.

Naloxone dosage and administration:

Program name will train opioid users and their contacts in the use of naloxone for reversal of opioid overdose.

Program participants must meet all of the following criteria:

- Current opioid users, individuals with a history of opioid use, or someone with frequent contact with opioid users;
- Risk for overdose or likelihood of contact with someone at risk, by report or history;
- Able to understand and willing to learn the essential components of Overdose Prevention and Response and naloxone administration.

An Overdose Prevention Educator from *program name* will complete the required documentation with an eligible participant and engage the participant in a brief (5-10 minutes) educational program about overdose prevention and response.

The educational program components will include:

- Overdose prevention techniques
- Recognizing signs and symptoms of overdose
- Calling 911
- Rescue breathing and/or chest compressions
- Naloxone storage, carrying, and administration
- Post-overdose follow-up and care

Upon completion of the educational component, naloxone will be dispensed to trained program participants who will carry and use naloxone to treat individuals experiencing an opioid overdose.

Order to dispense:

Upon completion of an Overdose Prevention Training, dispense at minimum: Two naloxone hydrochloride .4mg/ml vials and two 3ml syringes with 25g 1" needles. OR

Two Evzio® (naloxone HCl) .4mg/1ml auto-injectors OR
Two NARCAN® (naloxone HCl) 4mg/.1ml Nasal Spray

Refills: To be provided to previously trained participants as needed. When individuals return for a refill, a short report will be taken and training refresher will be offered.

Physician's Signature and License No.	**Date**
Physician's Name (Print)	**Order Expiration Date**

**Section 1714.22 of the CA Civil Code:*

c. *(1) A licensed health care provider who is authorized by law to prescribe an opioid antagonist may issue standing orders for the distribution of an opioid antagonist to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose.*

d. *(1) A person who is prescribed or possesses an opioid antagonist pursuant to a standing order shall receive the training provided by an opioid overdose prevention and treatment training program.*

(f) Notwithstanding any other law, a person who possesses or distributes an opioid antagonist pursuant to a prescription or standing order shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for this possession or distribution. Notwithstanding any other law, a person not otherwise licensed to administer an opioid antagonist, but trained as required under paragraph (1) of subdivision (d), who acts with reasonable care in administering an opioid antagonist, in good faith and not for compensation, to a person who is experiencing or is suspected of experiencing an overdose shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for this administration.

ASAM Level of Care grid

PRACTICE: _____; PATIENT: _____; DOB: ___/___/___ ;
DATE FORM COMPLETED: ___/___/___ ____

Results of past month UDS: Opioids: #____; # +___; Bup: #_____; # +___;
Other: 1)_____;
#_____; #+_____
2)_____; #_____;
#+_____
Current opioid medication: Bup_Meth_N IM_;
Dose:_;
Frequency of visits:/week or____/month

TREATMENT OF OUD COMPLEXITY INDEX (VSI) ***Version 1.3 (11/11/17)*** **TOTAL SCORE: _____**

ASAM CRITERIA DIMENSIONS		RISK ASSESSMENT 0 Minimal/None	1 Mild	2 Moderate	3 Significant	4 Severe
1	**Acute intoxication and/or withdrawal potential**	No use of opioids, alcohol or sedative-hypnotics	Sporadic use of alcohol or sedative/hypnotics (i.e. less than 4 times a week); No use of opioids	Regular use of alcohol or sedative-hypnotic drugs- no history of symptomatic withdrawal; Episodic use of opioids	Regular use of opioids, alcohol or sedative-hypnotic drugs- no history of complicated withdrawal	In active withdrawal from opioids, alcohol or sedative hypnotic drugs or with a history of complicated withdrawal
2	**Biomedical conditions and complications**	No significant history of medical problems	Some chronic medical problems- but well controlled/ on stable medication regimen	Chronic medical conditions that are stabilizing or responding to adjustments in treatment	Active medical problems, requiring close monitoring and follow-up	Active medical problems that are acute and interfere with functioning
3	**Emotional, behavioral, or cognitive conditions and complications**	No psychiatric history	On stable, well controlled regimen for any psychiatric condition and/or integrated in care with a therapist	History of psychiatric hospitalization, suicide attempts or para- suicidal behaviors and/or no	Active psychiatric problems requiring close mental health care and follow- up	Active psychiatric problems that are acute (risk to self or others; unable to self-regulate) and

				mental health care established, but there is an identified need		interfere with functioning
4	**Readiness to change**	Maintenance phase- already on stable medication regimen from previous provider	Action phase- engaging in treatment, taking steps to enact change	Preparation phase- compiling information and considering options-	Contemplation phase (willing to think/ talk about the need for a change)	Pre-contemplation phase (unwilling to think/talk about the need for change)
5	**Relapse, continued use, or continued problem potential**	In stable recovery- integrated in recovery community	Engaged in treatment and/ or peer support- lives close to clinic	Engaged in treatment and peer support- lives far from clinic	Sporadically attending treatment and/or peer support	Not attending treatment or peer recovery support
6	**Recovery/Living Environment**	Lives with sober, supportive, and concerned family/ friends; Is working and employer is supportive; Has no legal issues	Lives alone but is not isolated from social supports; Is working but not supportive of recovery; Has legal issues but is fully compliant	Lives with people who use substances recreationally; Lives alone and isolates; Is working but job is in jeopardy; Has legal issues and is engaged in risky or marginal activities	Unstable or tenuous housing situation; Is unemployed and interested but unable to work; Has legal issues but is not compliant and may be engaged in illegal activities presently	Homeless or living with active opioid users or dealers; Is unemployed and not interested in work; Has legal issues and is currently engaged in illegal activities

Transportation issues:

Chronic pain patient care

Safe Rx Program
(Assessment developed by Katie Bell)

Patient Care
Complete Assessment
Education
Plan of Care

Screening/Diagnostic tools
DSM-5 Opioid Use Disorder
AUDIT-C
DAST-10

RN Assessment Template

Pain

Location;
Onset:
Surgeries:
Pain level 0-10 ranged over a 24-hour period
Pain is worse when:
Pain is least when:
What relieves pain:
Other pain treatments (chiropractor, physical therapy, acupuncture, etc.)
Physical Limitations from living with pain:
Disability:

(*Do the above assessment for each reported chronic pain problem)*

Opioids

When first prescribed:
Previous opioid rx'd (list all and approximate dates
- Current dosing:
- Is your pain well-managed with this regimen?
- Escalate dose on days of more pain?
- Stretch out to next refill due?
- Run out early?
  - Call provider for refills?
  - Obtain from friends/family/street?

Concerns about pain management?
Overall health goals:
Other medications Hx/current:
Muscle relaxants
Anxiolytics/benzos
Sleep meds

ED visits r/t pain in past year

Substances
Alcohol - (Ever a problem? DUI's? Rehabs? If still drinking, does patient drink more for pain and sleep management?
Benzos
Stimulants
Cannabis
Opioids

Other medical issues and treatments:

Diet and exercise:

Psych:
Diagnoses/dates dx'd
Current psych meds:
Hx of psych meds.
SA/Si/Hospitalizations

Education:
CDC Guidelines for treating pain
Opioid Induced Hyperalgesia (OIH)
Anxiety/benzo connection to long term opioid therapy for chronic pain
Buprenorphine for Pain

Planning:

If a substance use disorder is identified, notify provider, add this new SUD dx to problem list.
Does patient need alcohol detox before proceeding with changes?
Does patient have an interest in stopping alcohol use?
Does patient have a responsible support at home to manage a home detox for EtOH?

Med Changes
- Written plan
- If switching to Buprenorphine
  1. Converting to short-acting opioids
  2. Comfort meds for period of withdrawal
  3. Induction plan – clinic or non-clinic

If tapering benzos:
- Converting to Librium or phenobarbital

Treatment Agreement for Bup for pain management

Weekly Rx, weekly UDS and scheduled follow-up visits.
The follow-up visits' should be as brief as possible

Example collaborative services agreement

This Collaborative Services Agreement ("Agreement") is effective as of _____, 2016 ("Effective Date") by and between _____ ("Practice"), a *state name* Corporation with its corporate office located at _____, *city, state* and the *organization name*, a *state name* nonprofit corporation with its office located at *organization address* The Practice shall not be required to participate in the *collaborative name*, however the Practice shall not be permitted to participate in the HIE without agreeing to be legally bound by this Agreement and any exhibits, schedules and appendices to this Agreement attached hereto and incorporated by reference.

WHEREAS, the *organization name* was formed to support the work of urban healthcare providers in the City of Camden dedicated to improving the health of the community, and has expanded its work to include the development of a regional HIE and operation of a Medicaid Accountable Care Organization;

WHEREAS, the Coalition desires to facilitate improved patient care and advance its Programs through the use of a shared database of detailed clinical information from community health care providers cooperating in the Camden HIE.

WHEREAS, as a Medicaid ACO, the Coalition is providing a range of services including care coordination and practice improvement programming for the purpose of improving the quality and efficiency of care delivered to patients.

WHEREAS, the Coalition has entered into a Master Software Agreement with CareEvolution, Inc. ("CareEvolution") for the purpose of hosting the Camden HIE and facilitating the implementation of an electronic health information exchange to the community of providers who wish to participate;

WHEREAS, the Practice may also seek additional services from the Coalition such as consulting and training services related to healthcare IT implementation, practice improvement and data security; and

WHEREAS, the parties have structured this arrangement with the intent to fulfill the requirements of the personal services, management contracts safe harbor (42 C.F.R. § 1001.952(d)) to the federal Anti-Kickback Statute. The parties agree that neither the Practice nor the Coalition is required to refer patients to each other.

NOW THEREFORE, in consideration of the mutual promises and obligations hereinafter contained, the parties hereto intend to be legally bound and mutually agree upon the following terms and conditions:

A. SERVICES AND DUTIES:

1. The Coalition will provide services targeted to the Practice described in Exhibit A attached hereto and made a part hereof. **The Practice may elect to participate in the Camden**

HIE by electing such Service on Exhibit A, signing Exhibit B and paying any required fees per section B of this Agreement.

The Practice will provide the Coalition with access to patient medical information for the purposes described in Exhibit A. The Coalition and the Practice agree to enter into a HIPAA Business Associate Agreement covering the Coalition's use and disclosure of protected health information received from or on behalf of the Practice.

B. COMPENSATION

1. The Practice shall pay an fee of xxxx to access the Camden HIE.

2. The Coalition reserves the right to increase the annual cost after the first year of the contract.

3. The current rates for Services contained in Exhibit A, beyond access to and training for the HIE, are:

a. Physician: $300/hour
b. Project manager: $125/hour
c. Data analyst: $125/hour

Rates are subject to change and Practice must enter into separate agreement with Coalition in order to obtain these additional services.

C. CONTRIBUTION OF DATA TO CAMDEN HIE

1. With the support of the Coalition's staff, Practice staff shall explore the feasibility of contributing data to the HIE. If appropriate and/or necessary, the Coalition will connect its HIE vendor with the Practice's EMR vendor so that the vendors may jointly explore the feasibility of contribution.
2. The Coalition understands that contribution may ultimately be infeasible due to technological restrictions. If the Practice determines that data contribution is infeasible, it shall provide a written explanation to the Coalition.

D. INDEPENDENT CONTRACTORS

1. Nothing in this Agreement shall be construed to create a joint venture or partnership between the parties. Each party shall act solely as an independent contractor and not as an agent, servant, employee, or representative of the other party.

E. GOVERNING LAW

1. This Agreement shall be governed and interpreted according to the laws of the State of New Jersey without regard to choice of law principles.

F. COMPLIANCE WITH LAW/ABILITY TO CONTRACT

1. The parties represent and warrant that they will perform their respective obligations under this Agreement in conformity with any applicable laws, regulations, and other legal mandates. Each represents and warrants that it has the unqualified right, power, and authority to enter into this Agreement and that it does not know or have reason to believe of anything that will prevent it from performing its obligations under the terms and conditions of this Agreement.

G. QUALIFICATIONS OF STAFF PERFORMING SERVICES

1. Coalition staff providing Services under this Agreement shall have and maintain appropriate licensure/registration, as required in the state of New Jersey, and shall not be subject to any disciplinary restrictions, nor shall they have been excluded or debarred from participation in any government payor program. Such staff also shall maintain appropriate malpractice insurance as required by New Jersey law.

H. TERM AND TERMINATION

1. This Agreement shall be effective for an initial term of one (1) year from its effective date and thereafter shall automatically renew for additional terms of one (1) year each, unless terminated in accordance with this Agreement.

2. This Agreement may be terminated at any time by either party upon at least ten (10) days' prior written notice of such termination to the other party for default or material breach by the other party of one or more of its obligations hereunder, unless such default or breach is cured within thirty (30) days of the notice of termination.

3. This Agreement may be terminated without cause at any time by either party upon at least thirty (30) days' prior written notice of such termination to the other party.

I. NOTICES

1. Any notice or communication required or permitted by this Agreement shall be in writing and shall be deemed sufficient upon receipt, when delivered personally or by courier, overnight delivery service or confirmed facsimile, or forty-eight (48) hours after being deposited in the regular mail as certified or registered mail (airmail if sent internationally) with postage prepaid, if such notice is addressed to the party to be notified at such party's address or facsimile number as set forth below, or as subsequently modified by written notice.

   If to (program name):CEO Smith

   12345 Public Place Drive

   Anywhere

   If to Practice: [insert name, title, and address]

2. Either of the parties may, at its sole discretion, designate new person(s) or address(es) for receipt of notices by providing written notice to the other party.

J. ENTIRE AGREEMENT/ASSIGNMENT

1. This Agreement, including all exhibits and attachments, constitutes the complete and sole understanding between the Practice and the Coalition with respect to its subject matter and supersedes any and all prior or contemporaneous communications, discussions, agreements, understandings, promises, and/or representations made by either party to the other, whether oral, written, or in any other form, not expressly included herein. No changes, amendments, or alterations shall be effective unless signed by duly authorized representatives of both parties. Neither party may assign any of its rights or delegate its

obligations hereunder without the prior written consent of the other parties hereto, and such consent shall not be unreasonably withheld.

K. SEVERABILITY

1. any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality, and enforceability of such provision in any other instance, or the validity, legality, or enforceability of any other provision of this Agreement.

L. WAIVER

1. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate or be construed to be a waiver of any subsequent breach or violation thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the party to be charged.

M. COUNTERPARTS

1. This Agreement may be executed in one or more counterparts, each of which will be deemed to be an original copy of this Agreement and all of which, when taken together, will be deemed to constitute one and the same agreement.

N. HEADINGS

1. The headings contained in this Agreement are included for purposes of convenience

only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

IN WITNESS WHEREOF, the parties, through their duly authorized officers, have executed this Agreement effective as of the Effective Date.

Practice Name **(Program Name)**

By: _____ **By:** _____

Print Name: _____ _____

Print Title: _____ **Executive Director/Medical Director**

Date: _____ _____

Patient photography & audio visual consent form

Patient Name (printed):

I hereby authorize (program name) to interview and/or make an audio/visual/electronic recording or photograph of me (collectively "Recording"). I authorize the (program name) to distribute any Recording through its website, social media, the press, and all other means of distribution for purposes of promoting the (program name) mission. I authorize the release and distribution of any information concerning my illness/injury, medical treatment and medical history that is contained in any Recording.

I agree to allow the Recording to be used for the following purposes:

☐ Internal storytelling: Educational trainings for (program name) staff and AmeriCorps members; informational updates to funders and board members.

☐ External publications: Print & digital media including but not limited to: websites, press releases, newsletters, social media (e.g. Facebook, Twitter, YouTube), brochures, advertisements, and other publications
The following restrictions apply:

☐ I authorize the (program name) to release additional information about me, including my medical diagnoses and hospital utilization in connection with the Recording.

I grant this authorization and release to help the (program name) increase the capacity, quality, and accessibility of healthcare for (program name/city) residents.

This agreement represents all terms and considerations; no other payments, inducements, statements or promises have been made to me. I understand that (program name) shall own any Recording or other resulting marketing or public relations material. I am not entitled to any compensation or royalties or other payment resulting from such Recording, media, marketing or public relations material.

I further understand that I will not have the option to review the final Recording, media, public relations material or news article before it is published or broadcast and that other news media may reprint or rebroadcast the information I am releasing following the initial publication or broadcast.

Patient Signature
Or signature of patient representative (if under 18)

X _____

Please check only one box below:
☐ I permit my Recording and full name to be used.
☐ I permit my Recording and first name to be used.
☐ I permit my Recording but not my name to be used.

Appendix G: Data tools

Thinking about data from the start is critical to program success and sustainability. This appendix provides the reader with examples of data outcome and program measures used by the Center for Care Innovations, developed in conjunction with Dr. Mark McGovern for the Addiction Treatment Starts Here Primary Care projects.

Quality improvement tools can help provide data driven, goal directed process improvements. Included are examples of how to create a process map and aim statements with common mat program primary drivers. For a more complete description of data collection and quality improvement measures see Section IV of this toolkit.

We would like to acknowledge and offer a special thank you to Mark McGovern, Hunter Gatewood, Tammy Fisher, Sandra Newman, and the Center for Care Innovations for their willingness to share these resources and offer their insights and wisdom.

Example Data Measures and Definitions

Required – Access Measures		
	MEASURE	DEFINITION
A.	Adoption	
A1	# of x-waivered prescribers	Total number of physicians, nurse practitioners or physician assistants, onsite and with whom the health center has contracts, who have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications approved by the U.S. FDA for this indication. This number must be current up to the reporting date. Planned, in process or pending waivers do not count.
A2	# of x-waivered prescribers actively prescribing	Total number of prescribers who have prescribed buprenorphine for opioid use disorder (OUD) to at least 1 patient over the three months prior to or on the reporting date.
A3	% of x-waivered prescribers of all eligible prescribers in practice	The numerator is calculated by the # in A1. The denominator is calculated by the total # of physicians, certified nurse practitioners and physician assistants who work onsite and who

		are under contract at the ATSH participating health center location. This denominator does not include providers at other locations of the participating health center.
A4	Ratio of x-waivered prescribers actively prescribing to the clinic's total patient panel size	The numerator is calculated by the # in A2. The denominator is calculated by an estimate of the total number of patients at, or active panel size of, the ATSH participating health center location.
B.	Reach	
B1	# of patients prescribed buprenorphine	The total number of unique patients in the ATSH participating health center location with a current, active prescription for buprenorphine. The buprenorphine medication should be FDA approved for the indication of OUD. Included patients may be newly prescribed or established. "Active" is defined as a prescription covering any of the past 30 days of the reporting month. This number must be current up to the reporting date.
B2	# of patients prescribed naltrexone long acting injection	The total number of patients in the ATSH participating health center location with a current, active prescription for naltrexone long acting injection. Included patients may be newly prescribed or established. "Active" is defined as a prescription covering any of the past 30 days of the reporting month. This number must be current up to the reporting date.
B3	% of patients prescribed buprenorphine or naltrexone long acting injection of all patients with OUD	The numerator is calculated by adding the total number of patients in B1 + B2. The denominator is calculated by counting the number of patients in the ATSH participating health center location with a current ICD10 or DSM5 diagnosis of OUD (i.e. valid within the past 30 days). This percentage is to be calculated quarterly during the ATSH project.

Required – Access Measures (continued)

	Measure	Definition
C.	Retention	

C1	# of patients prescribed buprenorphine or naltrexone long acting injection 6 months prior who have adhered to this medication continuously for 6 consecutive months	Total number of patients started on either buprenorphine or naltrexone long acting injection at 6 months prior to the reporting date, and who have remained in care continuously and without interruption. This includes new patients who have started on medication and continued with refills, and who have attended clinic visits. This also includes established patients who may have discontinued treatment for at least 2 months and have been "restarted".
C2	% of patients prescribed buprenorphine or naltrexone long acting injection 6 months ago who have continued in treatment for 6 consecutive months of all patients prescribed buprenorphine or naltrexone long acting injection 6 month prior	The numerator is calculated in C1. The denominator is calculated by including a count of the total of all patients started on either buprenorphine or naltrexone long acting injection at 6 months prior to the reporting date. This percentage is to be calculated only on the data panel of eligible patients (i.e. those who started or restarted at 6 months prior to the reporting date) at every quarter of the ATSH project.

Optional – Quality Measures

	MEASURE	DEFINITION
D.	~~Screening~~	
D1	% of patients screened for opioid use disorder of all patients seen during the last quarter	The numerator is calculated by counting the number of patients screened over the past 3 months. A standardized measure for OUD risk must be used to count in the numerator. Some options for measures include: NIDA Quick Screen, Drug Abuse Screening Test (DAST), DSM5 Checklist, the Tobacco, Alcohol, Prescription Medication and Other Substance Use

		(TAPS1 or TAPS 2), PRIME 1.1.1 or other validated screening tools. The denominator is calculated by counting the number of all patients seen during the last 3 months. The goal is at least 1 screening for OUD risk per year for all patients. This percentage is to be calculated quarterly during the ATSH project, and only for those patients not included in the previous quarter period data calculation.
E.	Initiation	
E1	% of patients with 1 follow-up visit within 14 days of starting buprenorphine or naltrexone long acting injection	The numerator is calculated by counting the number of patients started on either buprenorphine or naltrexone long acting injection and making at least 1 follow-up visit to the clinic within 14 days (2 weeks) of their initial prescription. Either individual or group visits count in the numerator. The denominator is calculated by counting the total number of patients prescribed either buprenorphine or naltrexone long acting injection. This percentage is to be calculated quarterly during the ATSH project, and only for those patients not included in the previous quarter period data calculation.
F.	Engagement	
F1	% of patients with 2 follow-up visits within 30 days of the date of the initial prescription for buprenorphine or naltrexone long acting injection	The numerator is calculated by counting the number of patients prescribed either buprenorphine or naltrexone long acting injection and making at least 2 follow-up visits (either individual or group) to the clinic within 30 days of their initial prescription. The denominator is calculated by counting the total number of patients prescribed either buprenorphine or naltrexone long acting injection. This percentage is to be calculated quarterly during the ATSH project, and only for those patients not included in the previous quarter period data calculation.

Optional – Quality Measures (continued)

	MEASURE	DEFINITION
G.	Toxicology Monitoring	
G1	% of patients prescribed buprenorphine or naltrexone long acting injection who received a urine toxicology test within 3 days of starting of all patients starting their	The numerator is calculated by counting the number of patients prescribed either buprenorphine or naltrexone long acting injection with documentation of one or more urine toxicology test results within 3 days of

	medication	starting either medication. If a saliva toxicology or other validated toxicology test is performed and documented, this counts towards the numerator. The denominator is calculated by counting the total number of patients prescribed either buprenorphine or naltrexone long acting injection. This percentage is to be calculated quarterly during the ATSH project, and only for those patients not included in the previous quarter period data calculation.
G2	% of patients taking buprenorphine or naltrexone long acting injection receiving a urine toxicology test at least once per month of all patients taking buprenorphine or naltrexone long acting injection	The numerator is calculated by pulling toxicology documentation on patients in C1 and counting the number who have at least 6 urine toxicology tests. The denominator is all patients in C1. This percentage is to be calculated quarterly during the ATSH project, and only for those patients not included in the previous quarter period data calculation.

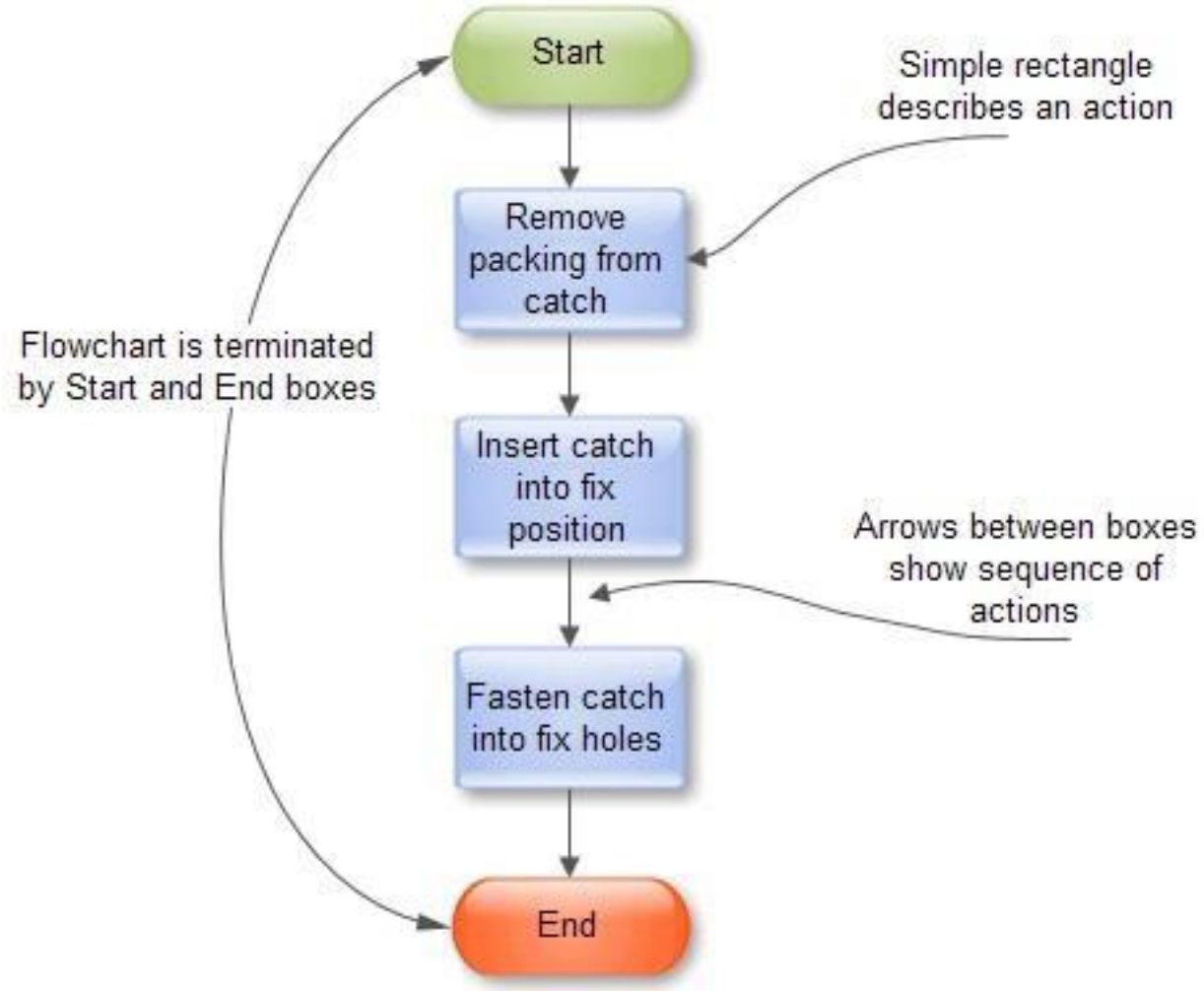
How to Draw a Process Map - Authored by Hunter

Gatewood

Basic structure

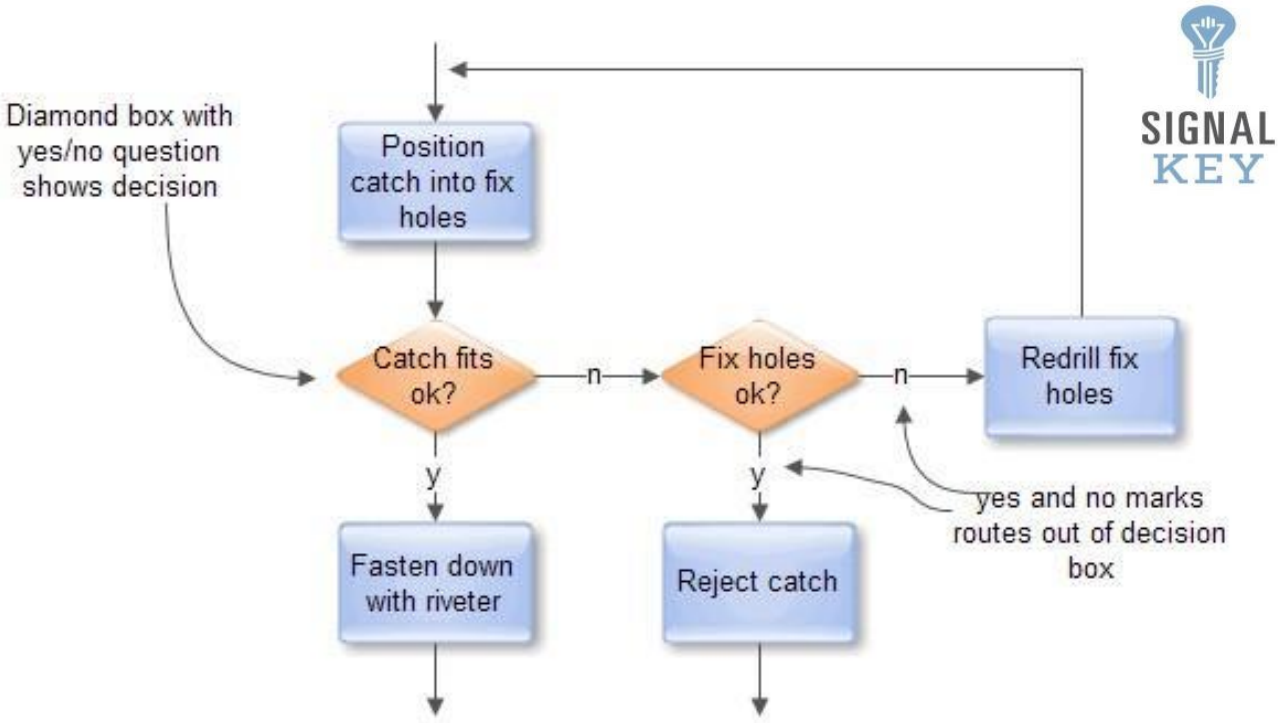
A process map (also called a flowchart) is a diagram that represents a process or workflow, showing each step of the process and connecting them with arrows to show their sequence.

The basic element of a process map is a simple action, which can be anything from striking an anvil to making a cash payment. A box containing a description of the action represents each action, or process step. The mapping of the sequence of actions is shown with arrows between sequential action boxes, as shown in the illustration.



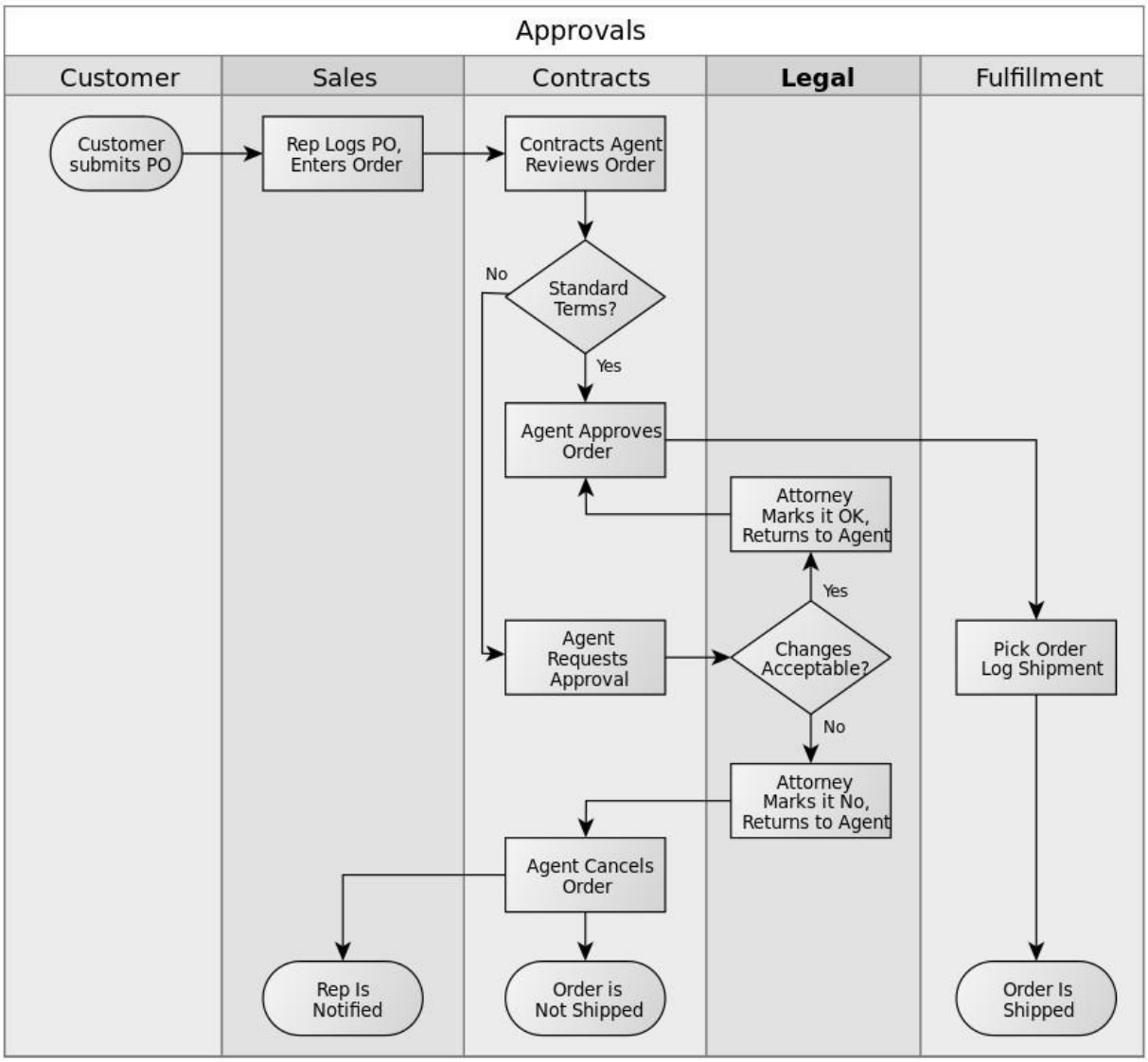
Decision steps

Processes become more complex when decisions must be made, when there are options to choose from or different steps to take based on different situations. A decision step is shown with a diamond-shaped box containing a simple question to which the answer is "yes" or "no." It is simplest to frame every decision as a yes/no choice, and to have only those two options branching from the decision diamond shape that holds the question. Decisions that are more complex are usually broken down into a series of yes/no decision boxes, as in the example below.

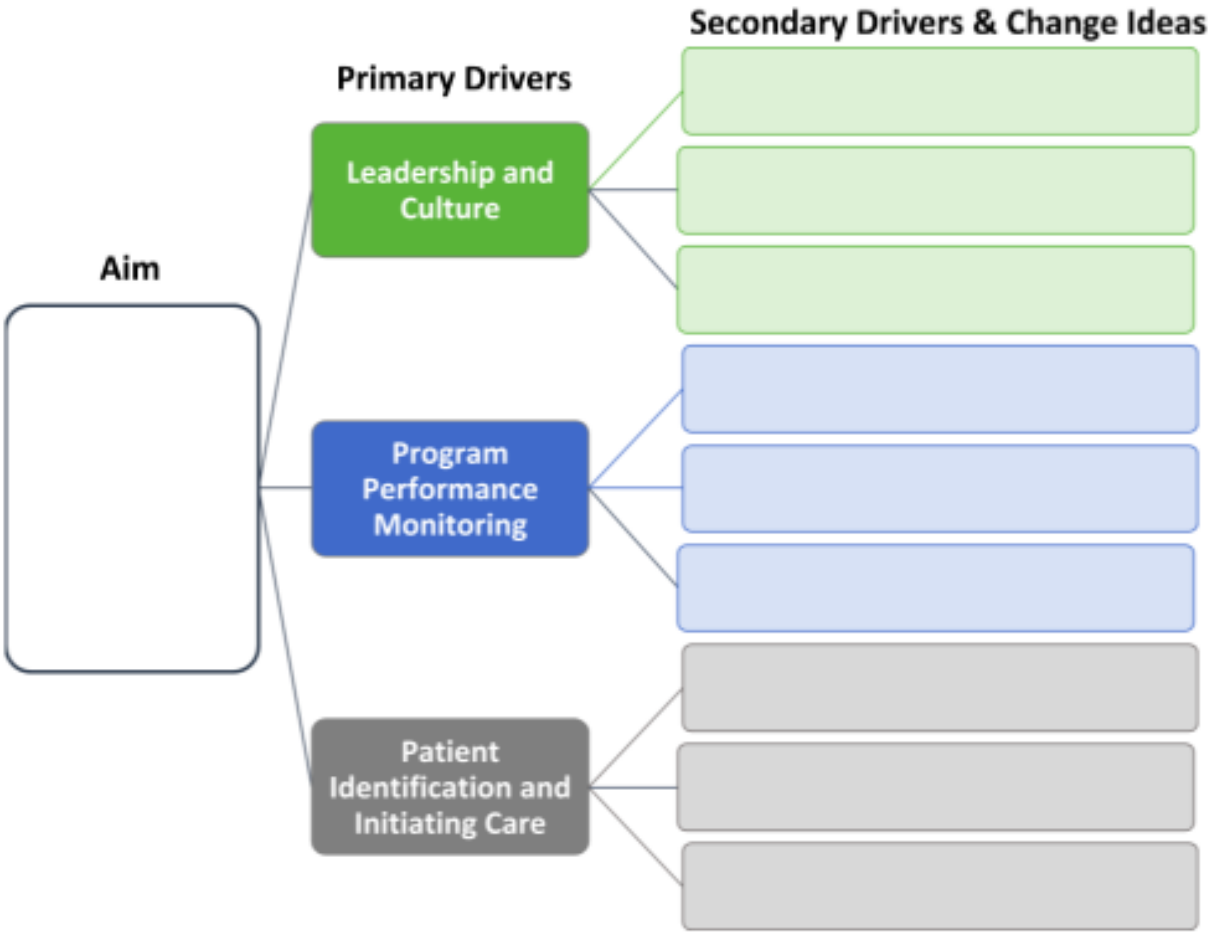


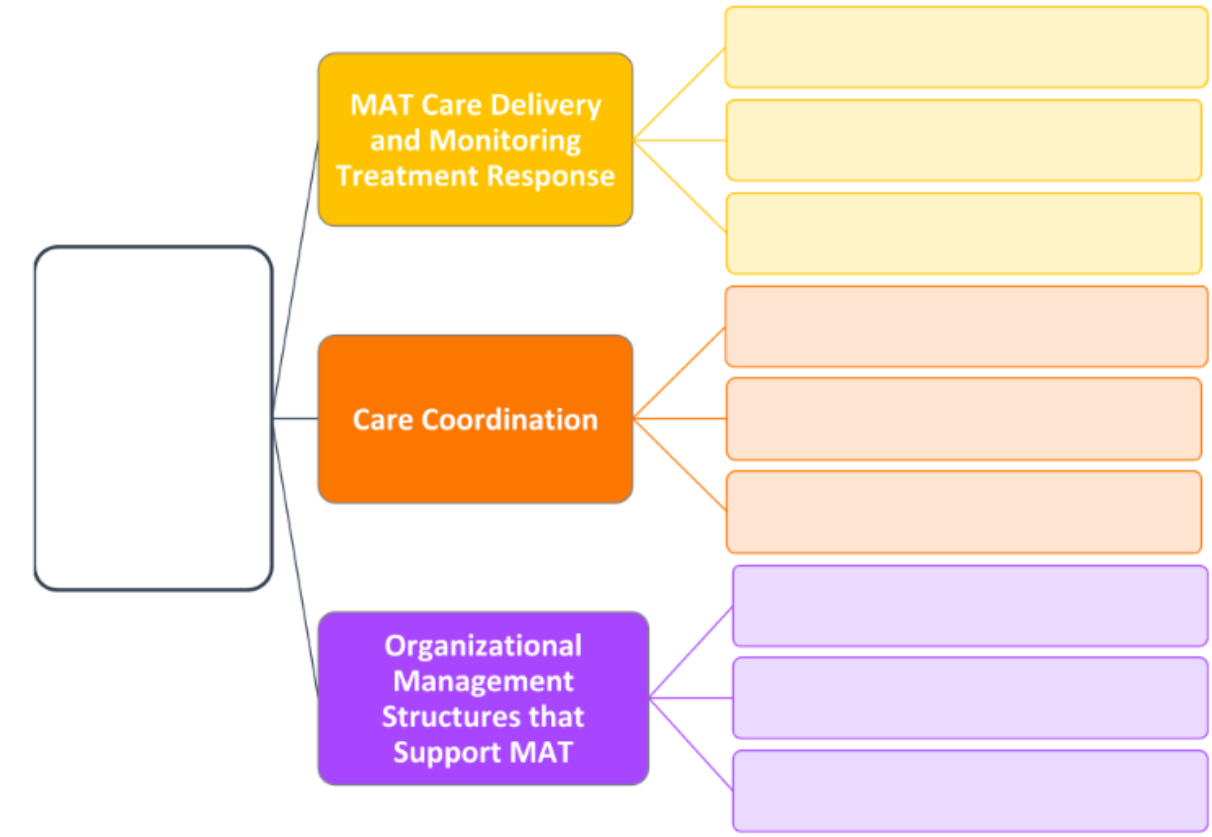
Multiple roles

When mapping a process with multiple roles for multiple people, use swim-lanes to separate tasks by job function. The example below has five roles delineated. Note that the arrows that create the sequence between tasks in the process cut across one or two lanes, and flow back and forth between lanes until the process is completed. The lanes can be arranged horizontally or vertically. (Swim-lanes are sometimes referred to as "functional bands.")



Diagrams and some text from edrawsoft.com and wikipedia.org


Secondary Drivers & Change Ideas
Primary Drivers
Leadership and Culture
Aim
Program Performance Monitoring
Patient Identification and Initiating Care


MAT Care Delivery and Monitoring Treatment Response
Care Coordination
Organizational Management Structures that Support MAT