

# **Medication-Assisted Treatment**

*Providing Best Practice Care in a  
Primary Care Clinic*

*A Handbook*

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## **A few words about this MAT Best Practices Handbook**

*Copyright pending. Please share respectfully and with permission.*

This handbook was designed to be a part of my site visit/trainings to primary care clinics – my talking points. It reflects years of experience working in addictions nursing and more specifically, the care of persons with opioid use disorders. The Handbook offers a mix of many things: ways to consider the whole person needs of our patients, challenging the context of stigma within the walls of care, blending the best of dueling recovery ideologies and how to utilize evidence-based best practices.

All Medication-Assisted Treatment programs are a collaboration of Providers, Nurses, Pharmacists, Medical Assistants, Substance Use Counselors and Behavioral Health therapists. The collaborative work in MAT programs presents new challenges in busy primary care settings, where departments are not expected to integrate care as closely as a Medication-Assisted Treatment program demands. My hope is that the contents and guidelines can support the unique collaboration strategies of each clinic. Take what you need, modify the documents to fit your clinic and start a pilot. If your clinic has a Medication-Assisted Treatment program which requires a remodel or an update, you will find what you need here to make that happen.

The MAT Best Practices Handbook comes from years of building and learning with providers and buprenorphine teams in many care settings beginning with a Phase 3 NIDA clinical trial at the Betty Ford Center in 2001. It was then I had the opportunity to see for myself how buprenorphine relieves suffering, stabilizes the brain and buys time for a person to reclaim their lives. I went on to learn about treating low-income persons with opioid use disorders in an urban methadone clinic where we launched a buprenorphine (suboxone) program in 2004. I then spent 7 years at a VA Behavioral Health clinic developing and launching a strong program for our veterans. These veterans often presented with co-occurring and untreated combat and military trauma. For the past 4 years, I have been working at Chapa-De Indian Health, a primary care clinic with a site in Auburn and Grass Valley, where we provide medical, dental, vision and behavioral health care to Native and non-Native patients. Our Medication-Assisted Treatment program was launched with an exceptional MD/RN team at our Auburn site November 2016. We now have flourishing Medication-Assisted Treatment programs in both our Auburn and Grass Valley clinics. Many of the Electronic Medical Record templates come from team collaborations at both the VA and Chapa-De Indian Health. Together, we are a work in progress as we turn the tide of the opioid epidemic.

The mission continues.

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## **The Spirit of Our Work**

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## 1. On Dopamine

“We need three things to survive (besides oxygen): food, water and dopamine. If you deprive study subjects of water for three days, then put them in a functional MRI and place water on their lips, the relative size of the craving is like a baseball. Do the same with food, and it is like a basketball. Then take someone with an addiction to opioids, up to one year after their last use, and talk about OxyContin while they are in a functional MRI, and the relative size of that craving is the size of a baseball field.” (Corey Waller MD, 2016)

## 2. Decreasing Stigma and Shifting Cultures

“Addiction is a chronic, progressive, relapsing disease.”

– American Society of Addiction Medicine

- Often, patients presenting to Emergency Departments with opioid withdrawal or craving are not treated with respect or adequate care.
  - “Health professionals may have an avoidant approach to delivery of care with substance use disorder patients compared to other patient groups. This avoidance may result in shorter visits, expression of less empathy, and less patient engagement and retention.” (Kelly, 2016)
- Many problems cascade with this stigmatizing avoidant approach including risks of overdose/death and expense of untreated addiction.
- “What to do about stigma: education, personal witness, shift language/terminology.” (Kelly,2016)
- Language can be pejorative and confusing.
  - Describing lab results, specifically Urine Drug Screens as ‘clean’ or ‘dirty’. The correct language is Positive or Negative.
  - Using the word ABUSE in diagnosis. “Substance Abuse” is no longer a diagnosis and the term is outdated, though still common.
  - ‘Misuse’ or simply ‘use’ can replace the word ‘abuse’.
  - Describing patients as ‘drug seeking’. Relief-seeking is a better way to provide care, including intervention and referral.
  - “Persons with addictions “or “addicted people” rather than “addicts”.
  - “Heroin users “rather than “heroin addicts”.
- Misunderstanding among the 12 Step and Recovering community about medication-assisted treatment with 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 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.
- Patients need to be educated to maintain their medical confidentiality. What their MD prescribes is between patient and MD. No one else needs to know, including sponsors.

Historically, 12 Step communities were equally resistant to the use of SSRI treatment when introduced in 1988.

Addictive Disease Concept (Medicine) and Substance Use Disorder concept (Psychiatry and Psychology)

- Many providers 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 decided 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.

### 3. Opioid Epidemic and how we got here

“The worse man-made epidemic in modern medical history.”

- Center for Disease Control and Prevention (2016)

- OxyContin, developed by Purdue Pharmaceuticals introduced as new pain medication for malignant pain in 1996
- Long-acting oxycodone – advertised as *less addictive*
- Morphine Equivalent 1 ½ times of hydrocodone
- Binds to Kappa opioid receptor as well as Mu opioid receptor – offers more relief and more reward – *more addictive*
- Sackler Brothers (3 MDs) and the art of selling medications to America
- Aggressive marketing based on poor research.
- One letter to the editor in Journal of American Medical Association shows a small number of patients did not acquire addiction from opioids prescribed while in hospital.
- Hospice movement initiated new interest in improving pain management.
- VA introduced the 5<sup>th</sup> Vital Sign – measuring and treating pain with every visit.
- Joint Commission made 5<sup>th</sup> Vital sign a requirement of care.
- Physician surveys gave patients opportunity to score their providers based on how well pain was managed.

As the river of pain pills began to dry up, heroin cheaper and easily available throughout America.

Recommended Reading: Dreamland - Sam Quinones

Drug Dealer MD – Anne Lemke MD

- Opioid Use Disorder –
  - Screening using the Opioid Use Disorder DSM-5 tool (see MAT Tools)
- Diversion
  - Selling, trading, borrowing of prescribed medications and illicit drugs
- Misuse
  - Loss of control in spite of consequences
  - Taking more than prescribed, running out early, combining prescribed medications with dangerous CNS suppressant medications not prescribed or alcohol

Switching from prescription pain medications to heroin escalates the problem.

Lack of access to care is at the heart of the epidemic.

#### 4. Harm Reduction, Enabling and Abstinence-Directed Care

From the Harm Reduction Coalition -

##### Principles of 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,” addressing 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, 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 which 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.

<http://harmreduction.org/about-us/principles-of-harm-reduction/>

From Hazelden Betty Ford

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

Elina Kala, MA Mental Health Professional

### **Enabling behavior:**

- Protects the addicted person from the natural consequences of his 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)
- Sees "the problem" as the result of something else (shyness, adolescence, loneliness, broken home, ADHD, or another illness)
- 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 she is expected to do for herself

<https://www.hazeldenbettyford.org/articles/kala/enabling-fact-sheet>

### **Abstinence-Directed Recovery**

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The American Society of Addiction Medicine (ASAM) defined 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 not considered to be “clean and sober” in the 12 Step culture.

## 5. Whole Person Care, Level of Care and “What Did we Miss?”

Learn and Understand the 6 dimensions of whole person care and criteria for assessing needs.

ASAM Grid (see MAT Tools)

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.”  
This may be true but our job as clinicians is to consider the level of care, access to appropriate level of care, identify real barriers for the person to succeed.
  - The ASAM Grid is an excellent way to review the case of patient who has left treatment or fails to return. “what did we miss?” is a useful way to review a patient with repeated failed attempts. It often becomes clear as to what is driving treatment failures.

## 6. Heroin, Trauma and Resilience

“The first question—always—is not “Why the addiction?” but “Why the pain?”

~ Gabor Mate MD, author In the Realm of the Hungry Ghosts

- Self-harm behaviors –using a needle is a form of ‘cutting’
- The numbing of all pain –physical, mental and emotional
- Opioids relieve symptoms of Post-Traumatic Stress Disorder.

Adverse Childhood Experiences (ACEs) screen (see MAT Tools) in early assessment process – ask permission of the patient to ask difficult questions, screen with sensitivity and respect. Patients often have a moment of insight into their addiction when guided through this screen.

*Persistent poverty in childhood is traumatic and reflects in a child’s life as neglect from society.*

“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 impeded 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.<sup>3</sup>

**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.”

Indigenous people

Enslaved people

Holocaust Survivors

Undocumented immigrants/Dreamers/Latino communities

**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.

Connected to historical trauma

Children and grandchildren of Native people kidnapped and abused in boarding schools

Children of Combat veterans

Children and grandchildren of addicted persons

Adult Children of Alcoholics is an example of healing response to intergenerational trauma

### **War and opioids**

- Large upsurge in opioid use as Civil War veterans returned home after being treated by morphine on battlefields. Laudanum (tincture of opium), high potency opioid and highly addictive, 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 Vietnam War, increase of heroin use throughout general population. Some VN 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 which comes from 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 our patients, prepare them for the return of feelings and a develop a treatment plan which 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 Group addendum)
- Must be skills based and focused on self-regulation
- Mindfulness with emphasis on body-sensing and grounding techniques.

Deep breathing can be activating and overwhelming for our patients with severe trauma.

*Seeking Safety*

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*Dialectical Behavioral Therapy (DBT)*  
*Acceptance Commitment Therapy*

## **7. Diversion – what to consider**

Diversion is a legal term which describes the common behavior of trading, selling, buying, sharing prescribed medications.

- Prescribed opioid medications have become a currency in the vast underground illicit drug economy. In the case of the opioid epidemic, the over-prescribing of opioids fueled the problem and the rampant criminal activity around the epidemic.
- As the prescribing of opioids began to slow down due to pressure on providers and the concerns about diversion, the costs of the diverted pills increased in value and the market forced changes in opioid using. As the flow of prescription opioids slowed to a trickle, many addicted persons found their way to heroin.
- “Pill Mills” advertised as Pain Clinics where large prescriptions for opioids were easy to obtain became a source for the river of opioid pain medications, often with minimal assessment or diagnosis for ‘chronic pain’ by unscrupulous medical providers. Many states looked the other way as this problem intensified. Anecdotally, the VA system across America also became a well-known source for the pills which became a source of income or a way to access other drugs of choice.
- The Pill Ladies – The Great Recession of 2008 triggered by the collapse of banks and the massive loss of jobs brought some unlikely participants into the underground diverted prescribed narcotics economy. With diverted opioids holding high value and incomes crashing, it was not uncommon for low-income senior communities to become the go-to place to buy OxyContin, Norco, Morphine Sulfate, Fentanyl at a good rate. This provided much-needed income for people. I once spoke with such a person who said they had to choose between managing their pain or buying food. A patient in one of our buprenorphine programs described the befriending of lonely seniors living in mobile home parks to gain access to their prescription opioids. This patient called these sources of diverted opioids “the Pill Ladies”.
- The Prescription Drug Monitoring Program (PDMP) requires use of CURES – The Controlled Substance Utilization Review and Evaluation System (CURES) was certified for statewide use by the Department of Justice (DOJ) on April 2, 2018. Therefore, the mandate to consult CURES prior to prescribing, ordering, administering, or furnishing a Schedule II–IV controlled substance becomes effective on October 2, 2018. Visit [www.mbc.ca.gov/CURES](http://www.mbc.ca.gov/CURES) for detailed information regarding CURES 2.0.  
<https://oag.ca.gov/sites/all/files/agweb/pdfs/pdmp/ures-mandatory-use.pdf>

The CURES law applies to prescribing of buprenorphine/naloxone. As long as a patient continues with prescribed suboxone (buprenorphine/naloxone), the CURES 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. We can safely assume that almost all of our patients have engaged in diversion of prescribed medications, it is part of the lifestyle and culture of using. One way of thinking about diverted suboxone is that it is safer for the addicted individual to be using suboxone than heroin.
- With patients entering programs with experience with suboxone, many have experienced or witnessed precipitated withdrawal. These patients may do well with home inductions because they understand the importance of discontinuing all opioids and waiting for withdrawal symptoms before taking their first suboxone doses. Some come into our programs with diverted suboxone on board so they do not require inductions.
- Once a patient with opioid use disorder has been admitted to the Medication-Assisted Treatment program, the behavior of diversion must stop. 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 an 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 impacts 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 7-day Rx 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. For example, when a patient is ready to progress from Phase 2 (every 14-day Suboxone Rx) to Phase 3 (monthly Rx), they must have at least one successful callback.

## 8. Changing Clinic Culture

Often, we find the strongest stigma expressed towards person with addictions within the walls of care, within our clinic cultures. Most of us have been directly touched by alcoholism and addiction – there are often feelings of frustration, anger, grief and loss which can color an individual's attitudes towards our patients who suffer with the disease of addiction.

- A useful way to introduce and establish a Medication-Assisted Treatment program is to take opportunity to spend time with every department in your 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.
- A one-page handout can be helpful
  - How the medications work
  - 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 each department's 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.

## 9. Motivational Interviewing – a few useful basics

- Motivational Interviewing is a way of helping people find *their own reasons* for change.
- Empathy – to accurately understand the client’s meaning and then the ability to 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.

### Spirit of Motivational Interviewing

- Dancing vs. Wrestling
- Exploring and resolving ambivalence
- Honors autonomy
- Collaborative
- Warm and friendly
- Respectful
- Stages of Change
- 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 Interviewer’s tools?

- Validation
- Kindness
- Body language/ tone
- Listening
- Asking questions – use your OARS
- Acceptance
- Respect
- Sensitivity
- humor

### Be Careful Of:

- Too much teaching and information

- Giving advice
- Challenging
- Offering personal perspectives
- The “righting reflex”
  - The need to...
    - Fix things
    - Set someone right
    - Get someone to face up to reality

#### OARS

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

#### Listen With:

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

#### 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...”
- How important is it to you to make changes around your drinking?
- How confident are you that you can make changes around your drinking?
- How ready are you to change your drinking?

## 10. Community Opioid Coalitions

- Many coalitions have formed spontaneously throughout the state and nation to address the opioid epidemic
- California Health Care Foundation sponsored a Safe Rx project in 2016 which supported the building of the coalitions
- CA Hub & Spoke System of Services grant specifically funds and supports the forming and sustaining of community opioid coalitions
- In Nevada County, a coalition to build a Crisis Stabilization Unit decided to continue as SUD Coalition.
  - Jail team
  - Chief of Police
  - Hospital CMO and other staff
  - FQHCs
  - County Behavioral Health
  - School Prevention Programs
  - Judges
- Opioid Coalitions improve:
  - Education throughout the community
  - Warm hand-offs between agencies
  - Community specific problem solving such as improving Narcan access

## **11. Cultural Humility – the fundamentals**

Brett Kuwada, PsyD. "Cultural Humility, Empathy & Compassion" (2017)

### **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
- All leads to lifelong learning and ongoing critical self-reflection
- 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 the individuals to feel safe with the practice

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## 1. Brief Overview of Medications

### Buprenorphine Properties and History

#### Buprenorphine

History:

- First developed in 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 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
- High affinity for mu receptors – if competing with any other opioid for the receptor, it wins
- Low intrinsic activity
- Long acting – half-life is 37 hours – offers a steady state
- Rapidly stabilizes and normalizes the brain
- Bioavailability optimum when taken sublingually and trans dermal
- Ceiling effect at about 16 mg - opioid dependent patients do not experience euphoria at this dosage. If they do, this very mild euphoria resolves within a few days.
- Maximum recommended dose is 32 mg/d.
- Effective for pain management for those with iatrogenic, acquired Opioid Use Disorder from opioid therapy for chronic pain.
- Less is more. Over time a patient will begin to feel as if they might want to decrease their dose.
- Metabolized through the liver and primarily excreted through bile.
- Comes as tablets or film strips, both types are taken sublingually.
- 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. Injection: 100 mg/0.5 ML and 300mg/1.5mL provided in a prefilled syringe with a 19 Gauge 5/8-inch needle. First 2 months – low dose to assess how tolerated.
  - BuTrans – weekly mcg/h dosing transdermal patch – prescribed for pain management. Can be helpful in complicated inductions and taper protocols.
- **Naloxone** (combined with buprenorphine becomes brand name Suboxone)
  - Antagonist
  - Low bioavailability when taken sublingually – like an inactive ingredient
  - If used parentally (IV) the antagonist effect will occur
  - Minimizes diversion

- Brand name – Suboxone first developed and sold by Reckitt-Benckiser, a Swiss pharmaceutical firm. Patent expired in Oct. 2012. Now multiple generic SL tabs available. Suboxone strips still in patent.
- Buprenorphine not combined with naloxone is brand name Subutex. Subutex might be prescribed for patients with adverse reactions to naloxone. These patients often have history of migraine headaches. Standard of care for pregnant women is to use buprenorphine only.
- Street name for buprenorphine is ‘subs’.
- Can be taken once daily, though most patients divide their dose.
- In a Vermont Hub – some buprenorphine patients dose every 2 or 3 days. It is that long-acting.
- Comes in three combined dosages. Sublingual tabs and sublingual film strips (faster melting). Film Strips individually wrapped.
- Suboxone comes in 2 mg/naloxone 0.5 mg, 4mg/1mg and 8 mg/2mg and 12/3 mg.
- Buprenorphine not combined with naloxone also comes in same dosing (subutex).
- Recently identified as *the most sought after prescribed medication on the streets*.
- It is not sought in the streets for the possibility of getting high though it can be popular with some opioid-naïve people as there is a mild euphoria. Popular in high schools.
- It is sought because it relieves withdrawal quickly and effectively. At this point, there are few opioid addicted persons who have not tried diverted suboxone. The high value of suboxone reflects the poor access to this treatment.
- Anecdotally, people with opioid dependence report trying to manage their own withdrawal with buprenorphine/naloxone.

### **Methadone**

- Full agonist opioid developed in Germany 1937
- Long-acting (34-hour half-life)
- Heroin has a half-life of 30 minutes – hence the rationale for switching to long-acting methadone as treatment.
- First Federal Methadone Program 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
- ½ million people enrolled in methadone programs
- Can use other full agonist opioids such as heroin and prescription pain medications on top of methadone

### **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

- Risk of overdose increased by 18% for persons released from jail – the cravings are still there and the tolerance is reset
- Vivitrol injection *does not relieve opioid cravings*
- There can be site pain. Once described by a nurse administering the Vivitrol injections as similar to injecting peanut butter in the hip.
- Promoted as non-addictive treatment for Opioid Use Disorder to the judges and providers who oppose Opioid Replacement Therapies such as methadone and buprenorphine
- Can be best treatment option for severe opioid use disorder with severe alcohol use disorder or can be helpful for patients who have multiple barriers to participating in Medication-Assisted Treatment programs.
- Naltrexone – 50mg PO is prescribed to decrease alcohol cravings – like a dimmer switch for cravings, more effective for mild to moderate alcohol use disorder.
  - It cannot be taken with any full or partial agonists opioids

### **Narcan (also naloxone)**

- Full antagonist for Opioid Overdose Reversal
- Prescribe at initial encounter with using patient per standing order (see MAT Tools)
- Available upon request for family members of opioid users
- Update your Narcan Info:

<https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/NaloxoneGrantProgram.aspx>

### **Opioids – Schedule II**

#### **Prescribed Pain Medications**

Hydrocodone

Hydromorphone

Oxycodone

oxymorphone

Morphine

Tramadol

Fentanyl

Methadone

#### **Morphine Equivalency Dose (MED)**

<http://www.agencymeddirectors.wa.gov/calculator/dosecalculator.htm>

### **Street opioids**

Heroin

Carfentanyl – 100 times more potent than fentanyl. Deadly. Comes into country from China.

## 5. Providing Care

### Buprenorphine Inductions and More

#### Intake and evaluation for admission

- Patient meets initially for screening by Addiction Therapists/ Nurse Case Manager.
- Screened for opioid dependence –use DSM-5 screening tool for Opioid Use Disorder
- Readiness and barriers identified (ie. Homelessness and transportation)
- Motivation for entering treatment – OP, IOP, or residential
- ASAM assessment – whole person care – see grid
  
- Referred to RN for
  - Buprenorphine Nursing Assessment – template in Electronic Medical record. Extensive drug and alcohol history along with psych and medical history. (see MAT Templates)
  - Schedule with waived 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)
  - Schedule induction day and time. If home induction, must be monitored via phone or follow-up appt. 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 out loud so that the agreement is clear and all questions are answered. This will prove to be useful when agreement is violated by patient and requires changes in care or possible discharge from program.
  - Schedule with Behavioral Health for Biopsychosocial intake.

#### Induction

*At time of Medical Clearance, waived provider will determine if patient requires in-clinic induction (always with pregnancy and always with 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 which is the usual time needed for induction but closer to 36-48 hours, depending of 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 readiness to start buprenorphine.
- Also measure cravings on a scale of 1-10. Teach measuring cravings as a competency for patients.
- Build Buprenorphine Induction Template in Electronic Medical Record. (see MAT Templates)
- See MAT Induction template for both in-clinic and home inductions.
- In house Urine Drug Screen (UDS) prior to beginning induction. Once Clinical Opiate Withdrawal Scale scored (COWS), call MD who meets with RN and patient to determine readiness and starting buprenorphine dose.
- First dose is ‘test dose’ for sensitivity to buprenorphine for side effects and for possible precipitated withdrawal. Usually 4 mg.

Monitor for one hour. If relief of symptoms and cravings, will continue with MD in determining next dose.

- Since buprenorphine has long half - life (37 hours), we 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. This will give MAT provider and RN a sense of effective treatment of withdrawal symptoms, management of cravings and side effects.
- Goal of induction is to safely suppress opioid withdrawal and cravings as rapidly as possible with adequate doses of buprenorphine.
- The doses may be adjusted over the first month in response to reported side effects, breakthrough withdrawal (rare) and increased craving.
- Each patient has his or her own ‘right dose’ or sweet spot – no cravings, no withdrawal, no or minimal side effects. Anywhere from 8 mg – 32 mg.
- The MDs in this clinic usually prescribe 12 – 20 mg for first day and then follow up next day. We titrate to the right dose.

A useful induction standing order can be: *buprenorphine/naloxone 8-2 mg film strips # 3 strips. Sig: for induction days 1 and 2, take up to 2 strips in divided dose on day one and then take one strip in morning of second day.*

The person will then be seen in induction clinic or followed via telephone by RN for next rx. It can be helpful for RN to track stabilization in Follow-up notes which identify changes: Day 1, Day 2, etc.

### **Precipitated Withdrawal**

- A rapid and intense onset of withdrawal syndrome initiated by medication.
- Buprenorphine has a higher binding strength at the opioid receptor so it competes for receptor, “kicks off” and replaces the existing opioids.
- Due to the *high affinity* but *low intrinsic activity* of buprenorphine at the mu receptor, the partial agonist displaces full agonist opioids at the mu receptor but activates to a lesser degree, which results in a net decrease in agonist effect thereby precipitating withdrawal syndrome.

If Precipitated withdrawal occurs, stop buprenorphine and wait 4-8 hours ( or longer) depending on the long or short action of the withdrawing opioid. Diazepam 5 mg or 10 mg one time can ease the discomfort and agitation which occurs for most people with precipitate withdrawal.

### **Side Effects**

- Sedation – most common
- Headache – also common
- Nausea/vomiting
- Orthostatic hypotension/dizziness
- Itching
- Dry mouth
- Urinary Retention
- Constipation
- 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. RECOMMEND prescribing bowel protocol at time of induction. Consider Rx Docusate + bisacodyl (or senna) + Miralax for severe constipation.

- Prior to induction, patients must abstain from all short-acting opioids for 36 – 48 hours.

- Heroin is shortest acting opioid and inductions can often be successful 12-24 hours after last use. COWS will guide induction.
- Short-acting opioids include Heroin, oxycodone (Percocet), hydrocodone (Vicodin, Norco), crushed Oxycontin, Morphine, Codeine.
- Long acting opioids such as Oxycontin (taken orally) and all extended release opioid analgesics require 72 hours' abstinence.

### 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 better option than methadone
- If patient is past first trimester and on methadone, then maintain on methadone
- Use Subutex rather than suboxone
- Induction must be done in-clinic or in detox setting with close monitoring – minimal withdrawal, slow, steady titration of buprenorphine
- 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).”

<https://www.mdedge.com/pediatricnews/article/147302/neonatal-medicine/buprenorphine-linked-less-neonatal-abstinence>

- Post-partum care – see new mothers weekly in group and individually. Mothers in Recovery groups if available.
- Breastfeeding on buprenorphine. “Because of the low levels of buprenorphine in breastmilk, 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.” [www.drugs.com](http://www.drugs.com)
- <https://store.samhsa.gov/shin/content/SMA18-5054c/SMA18-5054.pdf> for “Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants.”
- Assess frequently for post-partum depression.

**Methadone to Buprenorphine**

- It is recommended that patients transitioning from methadone to buprenorphine slowly taper to 30 mg 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 is difficult and takes a minimum of 104 hours (4 days + 8 hours) off of methadone.
- Best way to keep patient comfortable is to switch to equivalent of short –acting opioid such as Morphine IR. (for example: methadone 30 mg can be converted to Morphine IR 150 mg/d -180 mg/d in divided dose)
- Keep patient on Morphine IR for at least 7 days, then initiate withdrawal plan and comfort meds (24 hours)
- COWS must be higher score (minimum 15) for safe, problem free induction.
- Methadone inductions will take more preparation, support and increased monitoring in first 2 weeks of stabilizing.
- Methadone patients 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
- Patients inclined to ‘self-doctor’: changing dose or tapering without discussing with prescriber and bup team
- Slow tapers do best with gabapentin in the last few weeks to manage mild withdrawal symptoms
- BuTrans patches also help with slow tapers off on bup
- Tapers followed with Naltrexone are also being studied and shown to be effective. Naltrexone can be PO or IM (every 4 weeks) – Vivitrol.
- Some will choose to go into 10-day opioid detox in social detox setting and come off quickly.

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 best outcomes for OUD are with Buprenorphine maintenance for stabilization and recovery

- Not all patients will or can choose maintenance
- Buprenorphine is excellent withdrawal agent, especially if patient can work closely with RN/MD
- 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. 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 which can be treated symptomatically.
- These patients will need weekly recovery support along with RN/MD monitoring.

### Alcohol

- If patient has alcohol dependence with opioid dependence, then it will be best to manage alcohol withdrawal (diazepam 10 mg QID) in first 24 -36 hours required opioid abstinence then initiate buprenorphine for opioid withdrawal. If possible to have in monitored detox setting, then can be done concurrently. If no detox option, then start the detox care on Monday and make sure patient can be seen by RN daily that first week. If done at home, patient will need a support person to manage meds and take to ED if necessary. Obviously, detox setting highly recommended.
- If patient begins drinking while on buprenorphine, offer higher level of care such as residential and very close medication monitoring. Because of unsafe combining of buprenorphine with alcohol, consider offering Antabuse and decreasing Buprenorphine dose to 8 mg. Stopping Buprenorphine entirely can contribute to de-stabilization; lower dose increases safety. Must be seen at least weekly by Counselor and RN.
- Consider Vivitrol option. Switching a buprenorphine pt. 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 Rx for benzodiazepines does not preclude buprenorphine Rx. However, must be aware that both benzodiazepines and buprenorphine suppress Central Nervous System and prescribing both requires additional safety considerations.
- In our clinic, we require Psychiatrist to prescribe benzodiazepines to our MAT patients. This is not always available.
- If patient is misusing non-prescribed diverted benzodiazepines, stop benzos, use phenobarbital or chlordiazepoxide conversion/ taper protocol. This is best done in a

social detox setting. If no social detox, then close RN monitoring with short buprenorphine and short phenobarbital or Librium Rx. Evaluated and managed individually.

- Conversion to phenobarbital or Librium for safe benzo tapers can be found online.
- <http://clincalc.com/benzodiazepine/>
- If patient is failing in this treatment track, then safety is evaluated. It might be unsafe for MD to continue prescribing. Patient is then offered 10-day detox or 14-day taper. Higher level of care is offered. New Treatment Agreements are signed.

### **Methamphetamines**

- Methamphetamine use disorder is a frequent co-occurring disorder with heroin 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 and report no cravings for opioids.
- These patients can be in Phase 1 – weekly groups, etc. for many months.
- Every UDS showing POS for Methamphetamine must be confirmed by lab before action taken.
- Refer to psychiatrists for assessment for depression and appropriate treatment.
- Discharging a patient for persistent and prolonged methamphetamine use must be determined by provider and by the MAT team.
- Persistent meth use indicates a need for a higher level of care. If possible, refer patient to inpatient setting to go through the meth detox period and stabilization.
- 2 weeks after last meth 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 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?”.
- Decisions about continued cannabis use must be made by MAT provider and team.

- Heavy daily cannabis use can be counter-productive to the Recovery process.
- Educate patients about the health (effects of smoking) and safety, behavioral (*Amotivational Syndrome*) and cognitive issues (adolescent and early adult brain development) around heavy cannabis use.

### **More about Urine Drug Screens**

- Point of Care (POC) Urine Drug Screen (UDS)
- [https://www.cliawaived.com/web/items/pdf/CLIAwaived%20Inc%20IDTC%20Training\\_Final\\_2018~3932file3.pdf](https://www.cliawaived.com/web/items/pdf/CLIAwaived%20Inc%20IDTC%20Training_Final_2018~3932file3.pdf)
- 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 possibility of diversion or buprenorphine dose too low.

### **3. Medication-Assisted Treatment Phases of Care with Refill/Stabilization Groups Phased Care**

#### **Phase 1–**

- Weekly MAT Refill/Stabilization group attendance along with urine drug screen and 7-day Buprenorphine/naloxone Rx
- 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, 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 II after 4 consecutive weeks of group attendance, NEG UDS and MAT team determination.

#### **Phase 2**

Transfer to Phase II requires a meeting with SUD counselor to update Treatment Agreement and clarify with patient the expectations of Phase II adherence.

- Patient attends Refill/Stabilization group every 2 weeks
- UDS
- 14 day Bup/nx Rx
- Continues with patient- centered Treatment Plan
- Minimum of 4 consecutive group attendances and Neg UDS (8 weeks).

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

Progressing to Phase III indicates that the patient requires minimal RN case management or group attendance.

#### **Phase 3**

- Monthly appointments with prescriber for 30 day bup/nx Rx
- If Primary Care Provider is waived to prescribe bup/nx, then will leave MAT prescriber to care of PCP.

- UDS with every 30-day Buprenorphine/naloxone (suboxone) Rx
- Minimal RN Case Management required
- Pt must meet with SUD Counselor –indiv or group for at least one session per month.
  - Required for all patients enrolled in Hub & Spoke grant

If patient relapses or needs increased support, return to Phase I or Phase II for additional care.

### **MAT Refill/Stabilization Groups**

At the heart of MAT Phased care is the weekly MAT Refill/Stabilization groups.

Refill/Stabilization group care begins with checking in and Medical Assistant (MA)care.

- The Medical Assistants 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 the 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.
- Scheduled as a 2-hour Provider slot, Patients scheduled in provider schedule. Bills for each patient as 99213 visit.
  - First hour – Group time

Second hour – Provider time for patients who need an appointment. Three slots. Best if scheduled, can bill for one visit so if seen, then do not bill for group visit.

- An effective Medication–Assisted Treatment refill group requires a well-organized team with a strong MAT program manager.

The waived Provider attends group, can lead group with RN and SUD counselor.

Maintain a simple format. (see example of group format in Group)

*A 7-day Rx also 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 1 or 2 refills – still in Phase 1.

***A buprenorphine patient roster can be an MAT team’s best friend. Have IT help develop a user-friendly excel version. Can be obtained directly from Katie Bell. kbell@chapa-de.org.***

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

The MD will bill for brief visit. 99213

The refill/stabilization group serves several purposes:

1. Brief visit with MD 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 why we require them. Also, 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.

The MAT Refill/Stabilization groups will require some clearly stated expectations and guidelines such as: do not discuss your buprenorphine dose, do not request dose changes in group, and keep discussion general and respectful. Include 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 of the group as well as themselves.

*"What you hear here, 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 Bup/nx dose adjustments, addressing of other substance use issues to be treated by MD. Schedule an appointment or refer to urgent care setting, if available.  
*Patient must see primary care provider, if available, for more extensive medical needs.*

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 see MD **after** refill/stabilization group. The nurse case manager and/or addiction therapist (if there is one)

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 easily be done in an hour. Being timely is an excellent way to convey respect for our patients

### **Treatment Planning**

As soon as patient is stable, treatment planning must 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 (see MAT Templates)

### **Integrating Cultural and Traditional practices as part of MAT Recovery Care**

- 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?
- Identified barriers to establishing Native Recovery programs in your Medication-Assisted Treatment program?

<http://www.whitebison.org/>

<https://www.nativeamericanfathers.org/training>

Telewell White Bison and Native Recovery Consultant:

[a.titman.cultural@telewell.org](mailto:a.titman.cultural@telewell.org)

### **MAT Scheduling and Pharmacy**

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A Medication-Assisted Treatment 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.
  - a. 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 nurse case manager can manage this care.
4. Refill/Stabilization Group (for example, Wednesdays – 10 am – 12 am)
  - a. One hour for group – brief face-to-face visits with provider
  - b. Second hour with three 20-minute slots for patients requesting follow-up care – 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 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 for

### **If your clinic does not have 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.

- Provider can establish MAT clinics 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

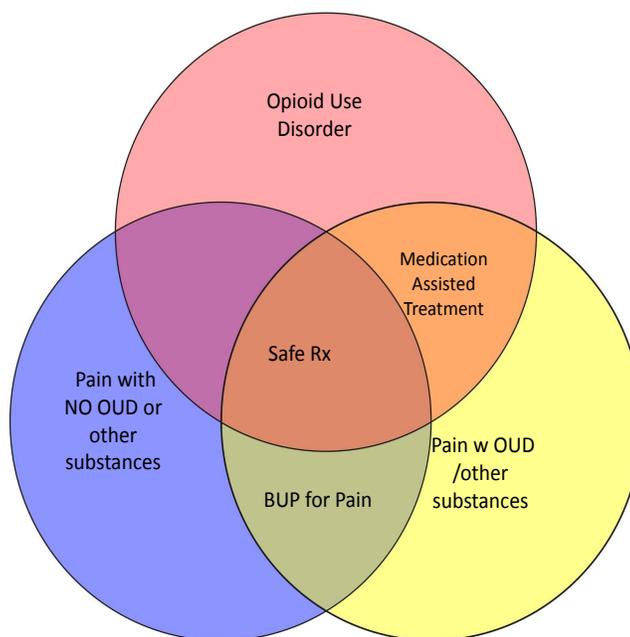
Visits which should be frequent in early months of stabilization and can be tied to brief check-in with provider with short Rx for Suboxone, weekly Urine Drug Screen.

### **Pharmacy**

- An In-clinic pharmacy offers the opportunity to work closely with MAT care. In our clinic, the pharmacist will hold refills until patient is cleared by MAT RN.
- If using local pharmacies then ideal would be to have strong relationships with each one where 7-day and 14-day Rx 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 for any problems and collaborative problem-solving.

**Section III Opioids and Pain – a few thoughts**

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## 1. Chronic Pain

A few thoughts

- Not all patients with physiological dependence (tolerance, withdrawal, cravings) 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 does not automatically meet the OUD criteria, even if the MD decides to taper the patient off of prescribed opioids.
- It is often difficult after years of long-term opioid therapy to have clear *baseline of pain*. The pain + dependence with breakthrough, low-grade opioid withdrawal muddies the pain picture.
- When assessing patients on long-term opioid therapy:
  - Obtain CURES report (PDMP)
  - Routine UDS for possible SUD
    - Any hx of methamphetamines
    - 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 these patients get to safer prescribed medications or improving pain management will take time – possibly weekly nurse case management visits initially.*

## 2. New CDC Guidelines

[https://www.cdc.gov/drugoverdose/pdf/guidelines\\_at-a-glance-a.pdf](https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf)

- Opioids are no longer the first line of care for non-malignant pain.
- Start low, go slow.
- 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).

### 3. Safe Prescribing

Often the biggest challenges in a primary care clinic are the many patients who have been prescribed opioids for chronic pain.

- More than 20 years of continuous opioid therapy not unusual
- Often unsafe dosing of multiple opioids (long and short-acting) plus Soma, muscle relaxants, and benzodiazepines
- Changing course for these patients requires education, assessment and planning.
- These patients are often fearful and angry – need support and respectful partnering for effective, safe and comfortable tapering.
- Be prepared to Rx for 7 days when patient is on a scheduled taper – for better management of taper and more support.

### 4. Behavioral Health and chronic pain

- Often underlying or poorly treated anxiety or depression
- Assess for hx of childhood and adult trauma
- While tapering opioids and other controlled prescribed medications, refer to BH for updating assessment

### 5. Inadequate Pain Management

- Patients who have been tapered slowly down to safe opioid prescriptions will have poorly managed pain.
- Poorly managed pain can increase alcohol use, increase depression, decrease function and quality of life.
- These patients might be afraid of being discontinued entirely off opioids so do not discuss their pain, their alcohol use, their depression honestly with their provider.
- These patients are often stigmatized as “drug-seeking” or defensively refer to themselves as “not drug addicts”.
- These 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

- **Suboxone is for treating OUD only.**

### Prescribe buprenorphine only for pain management.

- Buprenorphine can be an excellent pain management option for patients with poorly managed pain.
- Must be referred by their PCP.
- Schedule appointment for pain assessment, substance use, if any, current behavioral health and education about buprenorphine for pain.
  - *If a substance use problem such as alcohol use disorder or methamphetamine use 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 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 lower dose of buprenorphine and if their MED is less than 80 mg/d, might consider starting with BuTrans patches.
- There tends to be a higher sensitivity to side effects with pain management patients and okay to start low with BuTrans and titrate dose as side effects clear.
- Finding ideal pain management dose can take 2 weeks of close monitoring and dose changing.

## 7. Opioid Induced Hyperalgesia (OIH)

- Once called 'rebound pain', this phenomenon comes with heavy use of opioids for long periods of time.
- Increased sensitivity to pain. Lower pain threshold.
- The patient may find they need more opioids and are getting decreased pain relief.
- The medication has become a part of the pain problem.
- Buprenorphine shows promise in studies of having anti-hyperalgesic 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 over- all wellness.

#### **8. Care Needs for Patients with long-term opioid therapy for chronic pain**

- Nurse Case Management
- Behavioral Health
- Pain Support groups
- PACE for Pain:  
<https://www.paceforpain.org/>

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5. BH Therapist ... p. 9

**Program Manager duty statement Medication Assisted Treatment Program**

1. Manages training of MAT RN case manager.
2. Manages training of MAT SUD counselors.
3. Provides support for prescribing Physicians and Nurse Practitioners.
4. Keeps all teams of clinics informed of the program and updated on program changes. Including PSRs and call center for frequent appointments and special scheduling.
5. Works with pharmacy to maintain availability of buprenorphine/ naloxone, naltrexone and naloxone opioid overdose reversal.
6. Develops and implements best practices for patient care including:
  - i. pilot phase of developing weekly Induction Clinics
  - ii. and weekly Refill/Stabilization groups
7. Develops a series of educational segments for the refill/stabilization group. These educational segments will include behavioral health therapy and other speakers at times.
8. Manages 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
9. Writes and updates with the DEA waived MDs and RN any patient information handouts, providing consistent information.
10. EHR – templates have been developed and written for both RN and MD notes.
11. Integrates Behavioral Health team as part of the Referral to Treatment process.
12. Maintain DEA compliance and design the program so access to information when DEA requires will be easily accessed.
13. Develops a plan to track relevant data with QA RN.
14. Continually manages and improves outreach for all agencies involved with providing care for clinic patients with opioid addictions such as county agencies, local Emergency Departments, community recovery providers, other medical clinics.
15. Participates in both Placer and Nevada County, participating in coalitions, work groups and is available as a nurse educator for community.
16. Trouble shoots as the pilot progresses and works closely with the team to focus on process improvements and implement changes.
17. Program manager uses chain of command to insure best possible communication and integration of MAT program in clinic process.

**Nurse Case Manager Role in MAT program**

1. Takes referrals from providers, from outside agencies, from patients directly. Provides initial MAT screening and schedules for a Nursing Assessment.
2. RN Case manager takes a complete assessment of patient using the Nursing Assessment template in eCW.
3. RN Case manager utilizes all validated tools of assessment and care including ASAM Whole Person criteria, Adverse Childhood Experiences, Clinical Opioid Withdrawal Scale, Treatment Needs Assessment (Hub & Spoke), OBOT (Hub & Spoke), DSM-% 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 or to Hub.
5. RN begins induction planning with waived Provider, determining best induction plan: home induction, in-clinic induction or induction in social detox setting.
6. Referral 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 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 counselor for Treatment Agreement and Treatment Planning and Hub& Spoke enrollment.
11. Schedules patient for BH Biopsychosocial intake within 30 days of admission.
12. Monitors all UDS as patients stabilize and for s/sx of relapse. Participates in supportive interventions with or without other members of the MAT team.
13. Manages weekly case reviews with MDs and SUD counselors, identifying ongoing care needs with the team.
14. Manages all Buprenorphine/naloxone refill orders with Provider. Entering orders, per Provider instructions.
15. If patient needs referral to Hub or other higher level of care, RN manages the transfer or admission to other facilities.
16. RN can develop the weekly Refill/Stabilization Group curriculum and share the facilitating duties with Providers and with the SUD Counselor.
17. RN manages and updates the Buprenorphine Patient Roster weekly and makes it available for any DEA visits.
18. 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.
19. RN consults with Provider and SUD counselor as patient progresses to Phase 2 and Phase 3.

20. 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 over-all clinic culture towards treating OUD in clinic.
21. 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.
22. RN case manager might also be required to attend and participate in local opioid coalitions.
23. RN Case Manager attends required MAT trainings 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 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 MD and RN.
6. Enter information from Check-In sheet into eCW 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, usually about 10:15 or later.
9. After group, MA rooms the patients who have made an appointment with MD ahead of time. If patients have not scheduled but need to be seen, they can wait until those scheduled are seen.

**Substance Use Counselor - Medication-Assisted Treatment Program**

1. Substance Use Disorders – admission assessment.
  - a. This will be done 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 Treatment Agreement with patient as part of admission process.
3. At 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. Will use Treatment Planning Template.
5. All Hub & Spoke documents signed along with additional Release of Information forms for other agencies involved with patient care.
6. 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.
7. SUD Counselor schedules initial appointment for Behavioral Health intake.
  - a. Appointment schedule through the BH Support person.
  - b. If SUD counselor is LMFT, then patient can be scheduled in their schedule.
8. SUD counselor will manage the counseling/group needs of all Phase 3 patients.
9. Individual Counseling sessions for all MAT patients as needed and for those referred by MAT provider/RN.
10. 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.
11. Group sessions as needed per MAT team.
12. Developing and facilitating Refill/Stabilization group curriculum.
13. Developing special groups for patients with specific needs, such as other SUDs, relapse prevention and trauma.
14. SUD counselor will be involved in development and support of Native Recovery at Chapa-De.
15. SUD counselor will participate in Community Opioid Coalitions as determined by MAT team and MAT program manager.
16. SUD counselor will on occasion be going to jails, treatment facilities and hospitals to meet with Chapa-De patients to support their recovery care.
17. SUD counselor will be part of the implementation of the SBIRT process.

**Substance Use Counselor - Medication-Assisted Treatment Program**

18. Substance Use Disorders – admission assessment.
  - a. This will be done after Nursing assessment. Initial Screening, if required, can be done by provider or any MAT team member.
  - b. This assessment will be developed by SUD counselors with MAT team to identify level of care and whole person needs so that appropriate treatment referrals can be made for patient.
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32. SUD counselor will participate in Community Opioid Coalitions as determined by MAT team and MAT program manager.
33. 16. SUD counselor will on occasion be going to jails, treatment facilities and hospitals to meet with Chapa-De patients to support their recovery care.
34. SUD counselor will be part of the implementation of the SBIRT process.

### **Behavioral Health Therapist MAT Job Description**

1. Biopsychosocial intake for all new MAT patients.
  - a. If patient is currently receiving BH services, then update BPS to include OUD and MAT care.
2. Refer for on-going therapy if indicated
3. Refer to psychiatry if patient requires medications
4. Develop and facilitate groups for MAT program
  - 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. Consults with MAT team in monthly case reviews and as needed.

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## 1. Screening - Medication Assisted 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:

Social:

Housed:

Employment:

Income:

Transportation:

Reachable by phone:

Plan:

## 2. MAT Nursing Assessment

### Clinical Summary:

#### Substance Use

Current opiate use (type, route, amount):

Last use:

Hx 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:

Bell 2019

Meth:

Cocaine:

Benzos:

Hallucinogens:

Tobacco:

Gambling:

History of SUD treatment (type, duration, sobriety):

Any periods of abstinence not related to tx:

Family hx of SUD:

-----

**Medical**

Medical hx:

Current medical problems:

Medications (prescribed, OTC, taking but not prescribed):

Chronic pain:

Birth control:

**Dental:**

Last dental visit:

Refer to dental –

**Psychiatry**

Psych dx:

Current or History of SI:

History of SA/hospitalizations:

Current psych treatment/meds:

Current BH treatment:  
-----

**Legal**

Any current legal issues including probation:

Hx 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:

Bell 2019

Drug or alcohol use in household:

Employment/income:

Vehicle/transportation:

-----

**Planning**

Education:

Tx agreement signed:

Induction planned:

Referral to tx:

ASAM Score:

Labs done:

Narcan rx:

CURES:

Notes:

### 3. 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 \_\_\_\_\_

#### 4. 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 2<sup>nd</sup> 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.

**5. 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:

## 6. 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 \_\_\_**

## 7. MEDICATION ASSISTED TREATMENT Refill and Stabilization Group

MAT Staff present:

Topics addressed in group:

Patient update:

UDS:

Rx/refill:

Phase:

MD Note:

1 hour was spent with this patient today.

The Medication-Assisted Treatment Stabilization Group meets weekly for refills of prescribed buprenorphine/naloxone (suboxone). Initially, patients receive short prescriptions with 0-1 refills. As the patient stabilizes with correct dose, exhibits adherence to the treatment agreement and engages in treatment, patient progresses through Phase 1 (weekly) to Phase 2 (bi-weekly) to Phase 3 (monthly). The Refill Stabilization Group also provides opportunity for monitoring and identifying additional needs for care.

Each patient checks in with MAT staff and the group in a general way. RN has assessed the patients prior to group for cravings, side effects and update on participation in treatment. Urine Drug Screen has been submitted and entered in chart prior to group.

MD meets briefly with patient for face-to-face visit.

**8. 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 (ASAM) \_\_\_\_\_

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

### **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:  
Bell 2019

**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

3. Bup Start (Induction) plan – clinic or non-clinic
4. If Bup for Pain initiated – start w BuTrans patch

BuTrans is a low but very stable dose so it gives provider opportunity to start low to see how well Buprenorphine is tolerated.

If tapering benzos:

Converting to Librium or phenobarbital – use conversion tables.

*Note: tapering a long-preferred benzodiazepine is more difficult for the patient. Converting to Librium equivalency and then tapering slowly is as comfortable and contributes to the concept of making a change. Weekly Rx also helpful until patient feels confident and committed to this change.*

Informed Consent for Bup for Pain Management

Schedule: Weekly Rx, weekly UDS and scheduled follow-up visits.

The follow-up visits should be as brief as possible

## Buprenorphine for Pain Template

### 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

Once patient is stable, refer back to provider for ongoing Bup for Pain care.

Bell 2019

**III. MAT Patient Handouts**

1. Pre-Induction for Home Induction ... p .29
2. In-clinic Induction ...p. 30
3. Bup for Pain Instructions ...p. 31
4. Program Structure ... p. 32
5. Phased Program Info ... p. 33
6. Treatment Agreement ... p. 34

## 1. Buprenorphine/Naloxone (Suboxone) Pre-Induction and Home Induction Instructions

Welcome to the Medication Assisted 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 waiting room where your RN will expect to find you to start 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.

### 3. 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 of (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

#### 4. Medication-Assisted Treatment 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 Medication Assisted 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 doctor 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 if your Treatment plan requires re-assessment and adjustment. Please see handout on *MAT Phase Program*.

**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, if you are already receiving behavioral health care at Chapa-De.

**Individual Appointments:** Additional sessions with Addictions nurse, MD or behavioral health therapist will be scheduled based on assessed need and request.

**Maintenance visits:** Once stable on correct dose, treatment agreement adherence established, and behavioral health and treatment (recovery) needs have been identified and are in place, 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 the individual to provide increased support and monitoring until they 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 at: \_\_\_\_\_.

## 5. Medication Assisted Treatment

### Our Phased Program

#### Phase I

- Weekly prescriptions for buprenorphine/naloxone.
- Weekly Urine Drug Screens – *must have minimum of 4 consecutive \* NEG 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 community.

Patient can request to be moved into Phase II and MAT team will assess on 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 waived to prescribe buprenorphine, or MAT MD.
- 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 recommendation of MD and MAT team.

*\*NEG Urine Drug Screen must be POS for BUP, NEG for all drugs except those prescribed. THC is assessed by MD on individual basis.*

## 6. Medication-Assisted Treatment (MAT) with BUPRENORPHINE/NALOXONE (SUBOXONE) TREATMENT AGREEMENT, INFORMED CONSENT and RECOVERY TREATMENT PLAN

**Patient Name:**

**MR#:**

I am requesting that my Chapa-De Indian Health Medication-Assistant 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 Chapa-De Indian Health clinics.
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 will not see me and I will not be given any medication until my next scheduled appointment.
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 serious violation of this agreement and could result in my treatment being terminated.
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 or impaired thinking or other medically dangerous events.
10. **Stimulant use.** I understand that continuing use of any illicit drugs such as methamphetamines and cocaine will require increased treatment such as intensive outpatient (IOP) or residential treatment.
11. **Take Suboxone as prescribed.** I agree to take my medication as the doctor 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 doctor and MAT team that I enroll in Outpatient Treatment, Intensive Outpatient Treatment or Residential Treatment that I will do so. I may also be referred to daily buprenorphine dosing and intensification of care at the Aegis Hub. 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 Chapa-De patients in our Medication Assisted Treatment Program at all times. This includes all 12 step groups, outside treatment settings such as CoRR or Common Goals, 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 the clinic 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.):  

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\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**IV. MAT Curriculum for Refill/Stabilization Group**

1. Basic Refill/Stabilization Group Format ... p. 38
2. Group Curriculum (rotating) example ...p. 39
3. Patient Pre-Group Check-in Sheet (cut this form in half and keep at reception) ...p. 41
4. Template for EHR Refill/Stabilization group note (also in MAT Templates) ...p. 42
5. MAT Group Rules ...p. 43
6. Resilience Questionnaire ...p. 44
7. Sources ...p. 45

## **1. Medication Assisted Treatment Group Format/Draft**

### **I. Intro**

- Quote – encourage patients to bring quotes. Quote should be relevant to recovery topic of the day.
- Mindfulness - 5 minute guided
- 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)

## **2. 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. Bup 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. Potential
  - c. Arts
    - i. Poetry
    - ii. Storytelling
    - iii. Music

- iv. Art
  - d. Cultivating an authentic spirituality
    - i. Four Agreements
6. Mental Health in Recovery
- a. Managing Depression
  - b. Managing Anxiety
  - c. Bipolar DO
  - 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**

- c. Bup/Brain power point
- d. MAT Treatment Agreement
- e. Side Effects
- f. UDS
- g. Taking care of your prescriptions
- h. Legal service
- i. MD Q&A
- j. Coming off of buprenorphine
- k. Tobacco Cessation
- l. AOD
  - i. Cannabis
  - ii. Alcohol
  - iii. Benzodiazepines and sedative hypnotics
  - iv. Methamphetamine and cocaine

**3. MAT Pre-group Check-In**

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**

**MAT Pre-group Check-In**

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**

#### 4. MAT Refill and Stabilization Group

*TEMPLATE for EHR*

MAT Staff present:

Topics addressed in group:

Patient update:

UDS:

Interventions done by MAT Staff:

Phase:

MD Note:

1 hour was spent with this patient today.

The Medication-Assisted Treatment Stabilization Group meets weekly for refills of prescribed buprenorphine/naloxone (suboxone). Initially, patients receive short prescriptions with 0-1 refills. As the patient stabilizes with correct dose, exhibits adherence to the treatment agreement and engages in treatment, patient progresses through Phase 1 (weekly) to Phase 2 (bi-weekly) to Phase 3 (monthly). The Refill Stabilization Group also provides opportunity for monitoring and identifying additional needs for care.

Each patient checks in with MAT staff and the group in a general way. RN has assessed the patients prior to group for cravings, side effects and update on participation in treatment. Urine Drug Screen has been submitted and entered in chart prior to group.

Provider meets with each patient for brief face-to-face visit.

***Medication-Assisted 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”

## 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? \_\_\_\_\_

## Sources

- Job descriptions, Electronic Health Record Templates, Patient Handouts, Refill/Stabilization Group Curriculum developed with and for Chapa-De Indian Health MAT team.
- Pre-Group Check-in first developed by Dr. Neal Mehra and MAT Team at El Dorado Community Health Center
- Resilience Questionnaire:

[http://www.traumainformedcareproject.org/resources/RESILIENCE\\_Questionnaire.pdf](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.*

**Section V. MAT Tools**

1. Adverse Childhood Events
2. DSM-5 OUD
3. OBOT Stability Index (Hub & Spoke)
4. Clinical Opioid Withdrawal Scale –COWS
5. Treatment Needs Questionnaire (Hub & Spoke)
6. CCC MAT Warm line
7. Brief Addiction Monitor (BAM)
8. Narcan Standing Orders
9. 9. ASAM Level of Care Grid

*All of the above tools can easily be accessed on the internet*

## Adverse Childhood Experience (ACE) Questionnaire

### Finding your ACE Score ra hbr 10 24 06

**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:	
<b>Worksheet for DSM-V criteria for diagnosis of opiate use disorder</b>			
Diagnostic Criteria* (Opioid Use Disorder requires at least 2 within 12 month period)	Meets criteria		Notes/supporting information
	Yes	No	
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
3) Is the patient using sedative-hypnotic drugs (e.g. benzodiazepines) or admitting to alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No
4) Does the patient report drug craving that is difficult to control? <input type="checkbox"/> Yes <input type="checkbox"/> No
5) Does the patient endorse having used illicit substances in the past month? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
7) Did the patient report their last prescription as being lost or stolen? <input type="checkbox"/> Yes <input type="checkbox"/> No
8) Did the patient run out of medication early from his/ her last prescription? <input type="checkbox"/> Yes <input type="checkbox"/> 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.



California Hub and Spoke System:  
*Opioid Use Disorder-MAT Expansion Project*



### 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: _____	
<b>Resting Pulse Rate:</b> _____beats/minute <i>Measured after patient is sitting or lying for one minute</i> 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	<b>GI Upset: over last ½ hour</b> 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting
<b>Sweating: over past ½ hour not accounted for by room temperature or patient activity.</b> 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	<b>Tremor observation of outstretched hands</b> 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
<b>Restlessness Observation during assessment</b> 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	<b>Yawning Observation during assessment</b> 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
<b>Pupil size</b> 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	<b>Anxiety or Irritability</b> 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult
<b>Bone or Joint aches</b> <i>If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</i> 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	<b>Gooseflesh skin</b> 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
<b>Runny nose or tearing</b> <i>Not accounted for by cold symptoms or allergies</i> 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	<p style="text-align: right;">Total Score _____</p> 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](http://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?	2	0
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)	0	2
Do you have a chronic pain issue that needs treatment?	2	0
Do you have any significant medical problems (e.g. hepatitis, HIV, diabetes)?	1	0
Do you ever use stimulants (cocaine, methamphetamines), even occasionally?	2	0
Do you ever use benzodiazepines, even occasionally?	2	0
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?	2	0
Do you have any psychiatric problems (e.g. major depression, bipolar, severe anxiety, PTSD, schizophrenia, personality subtype of antisocial, borderline, or sociopathy)?	1	0
Are you currently going to any counseling, AA or NA?	0	1
Are you motivated for treatment?	0	1
Do you have a partner that uses drugs or alcohol?	1	0
Do you have 2 or more close friends or family members who do not use alcohol or drugs?	0	1
Is your housing stable?	0	1
Do you have access to reliable transportation?	0	1
Do you have a reliable phone number?	0	1
Did you receive a high school diploma or equivalent (e.g. did you complete > 12 years of education)?	0	1
Are you employed?	0	1
Do you have any legal issues (e.g. charges pending, probation/parole, etc)?	1	0
Are you currently on probation?	1	0
Have you ever been charged (not necessarily convicted) with drug dealing?	1	0

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 HUB induction with follow up by office based provider or continued HUB status

Scores above 16 candidate for HUB (Opioid Treatment Program-OTP) only



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California Hub and Spoke System:  
Opioid Use Disorder-MAT Expansion Project





**Substance Use Warmline**  
**Peer-to-Peer Consultation and Decision Support**  
**6 am – 5 pm PT Monday - Friday**  
**855-300-3595**

**Or**

**New! 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 U10HA30039-01-00 (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:**

**7A. Marijuana (cannabis, pot, weed)?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**7B. Sedatives/Tranquilizers (e.g., “benzos”, Valium, Xanax, Ativan, Ambien, “barbs”, Phenobarbital, downers, etc.)?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**7C. Cocaine/Crack?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**7D. Other Stimulants (e.g., amphetamine, methamphetamine, Dexedrine, Ritalin, Adderall, "speed", "crystal meth", "ice", etc.)?**

**0**

**1-3**

**4-8**

**9-15**

**16-30**

**7E. 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**

**7F. Inhalants (glues/adhesives, nail polish remover, paint thinner, etc.)?**

**0**

**1-3**

**4-8**

**9-15**

**16-30**

**7G. 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)**

**PROGRAM NAME**  
**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 1714.22 of the California Civil Code.\*

1. This standing order authorizes **YOUR PROGRAM**, 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 **YOUR PROGRAM** 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 **YOUR PROGRAM** to possess and administer naloxone to a person who is experiencing an opioid overdose.

**Naloxone Dosage and Administration:**

**YOUR PROGRAM** will train opioid users and their contacts in the use of naloxone for the 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 **YOUR PROGRAM** 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.

<b>Physician's Signature and License No.</b>	<b>Date</b>
<b>Physician's Name (Print)</b>	<b>Order Expiration Date</b>

*\*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.*

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
<b>1 Acute intoxication and/or withdrawal potential</b>	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
<b>2 Biomedical conditions and complications</b>	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
<b>3 Emotional, behavioral, or cognitive conditions and complications</b>	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 parasuicidal behaviors and/or no mental health care established, but there is an identified need	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 interfere with functioning
<b>4 Readiness to change</b>	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)
<b>5 Relapse, continued use, or continued problem potential</b>	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
<b>6 Recovery/Living Environment</b>	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:

Medication-Assisted Treatment  
Policies and Procedures

Policy and Procedures

1. Medication Assisted Treatment Program for treating opioid use disorders

2. Medical

3. Section Number

4. Grace Katie Bell MSN RN-BC CARN PHN

Purpose - Chapa-De Indian Health is committed to delivering best practice, evidence-based and trauma-informed care for our patients diagnosed with opioid use disorders. Medication-Assisted Treatment – a program which offers Buprenorphine/naloxone (brand name; Suboxone) along with supportive recovery care both within in 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 – Chapa-De has adopted the Nurse Case Manager Model for Medication-Assisted Treatment program. The MAT program serves patients at both Chapa-De sites. Chapa- De will continue to give priority and rapid admission to all native patients seeking care for opioid use disorder. Chapa-De is developing and integrating a native recovery approach, utilizing tradition and culturally-based recovery for our native patients. Additionally, Chapa-De is utilizing Behavioral Health therapists with native heritage and special training to treat historical and intergenerational trauma. In addition, to tradition-based recovery, Chapa-De has coordinated MAT care with the Baby Luv prenatal program in Auburn clinic utilizing the specialties of the MAT providers at Auburn site to provide seamless perinatal care for mothers and babies.

Medication Assisted Treatment (MAT) with Buprenorphine

**1. Staffing of MAT**

MD or NP/PA – must be waived to prescribe buprenorphine for opioid use disorder

RN – case manager, preferred ANCC certified in addictions nursing

Substance Use Disorder Counselor – Licensed or Certified in Drug and Alcohol Specialty – case manager

LCSW or LMFT – for Behavioral Health needs and case management

Medical Assistant

(please see job descriptions in appendix)

**2. Referrals**

- a. Referrals to MAT program can be by provider or by Chapa-De patient
- b. Referrals can be made through Baby Luv prenatal program.
- c. Referrals may also be from county services, including jail and local hospitals.
- d. Internal referrals will be sent to RN MAT Case Managers (NCM) via Telephone Encounters in eCW

### **3. Admissions**

- a. Screening –RN or SUD counselor
  - i. MAT Screening Template in eCW
  - 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 MD to determine admission and review of ASAM Whole Person Level of Care criteria
  - i. Chart Note –RN
- e. Patient signs treatment agreement –SUD counselor or RN
  - i. Pt receives copy and original to Health Information
- f. Patient signs relevant Release of Information- SUD counselor
  - i. Pt receives copy, original to Health Information
- 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, if needed
    - 1. Hub & Spoke ROI
    - 2. Recovery Providers
    - 3. CPS
    - 4. Probation Officer
    - 5. Family member
  - v. MAT Brochure
- h. CURES (PDMP) report at time of admission

### **4. Medical appointment**

- a. Establishes care with MAT prescriber
- b. Update labs
  - i. Standing orders MAT admission labs
  - ii. HIV and HCV labs
- c. Induction Planning
  - i. In-clinic – scheduled with RN/MD
  - ii. Home Induction with Instructions MD/RN
  - iii. Close follow-up care and phone support with RN
  - iv. Patient Instructions handout
  - v. Withdrawal comfort meds prescribed

### **5. SUD Counselor or Addictions RN develops a Treatment plan for Phase 1 care**

- a. This can be written for patient on the last section of MAT Treatment Agreement
- b. Based on patient preferences and ASAM whole person criteria for level of Care

- c. TEMPLATE in eCW – SUD counselor
- d. Scheduled with Behavioral Health for Biopsychosocial Intake – SUD counselor
  - i. BH Intake must be completed within 30 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
  - i. Access limited to Nick Taylor and MAT RN Case Managers
  - ii. Providers and SUD counselors/LMFT have read-only access
- c. Roster is way of tracking patient, date of induction, daily bup/nx dose, Phase of Care, MD 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 tracks Bup for Pain patients by clinic
- g. Roster is useful for audit visits such as DEA and Hub & Spoke.

**7. MAT Medical Assistant/Nursing procedures:**

- a. Prior to group day, chart prep, move MAT Refill/Stabilization group template into chart.
- b. Collect and record UDS prior to MAT Refill/Stabilization group.
- c. When collecting UDS, bring 2 patients back at a time and utilize both bathrooms in Pod for UDS collection.
- d. If UDS is positive for anything other than prescribed meds such as BUP or BZO or THC, then the UDS must be sent to lab for confirmation. There will be additional patient specific requests for send out of urine for alcohol confirmation.
- e. Make sure patient's name is on the collection cup and do not discard any collected UDS until reviewed by MAT MD and RN.
- f. Enter information from Check-In sheet into eCW MAT Group Template, record UDS results on the Check-In (Bup half- sheet)
- g. MA directs patients who are late for group making sure that UDS is collected and patient is brought into group with minimum disruption.
- h. Once UDS results are recorded on Check-in sheet, MA gives the Check-in sheet to NCM in group room, usually about 10:15 or later.
- i. After group, MA rooms the patients who have made an appointment with MD ahead of time. If patients have not scheduled but need to be seen, they can wait until those scheduled are seen.

**8. Refill/Stabilization Group**

- a. Patient checks in at reception and is given a MAT check-in sheet.

- i. Pt identifies cravings, triggers, side effects, MH issues, recovery progress and requests to see MD (*see Bup Half-sheet*)
    - ii. After Check-in sheet is completed, MA takes patient for Urine Drug Screen; records results on Check-in sheet and gives the check-in sheet to Nurse Case Manager to review with MD and SUD counselor.
  - b. Harm Reduction and Abstinence-directed determined by Phases (please see Phases)
  - c. Weekly group facilitated SUD Counselor or RN and MD
    - i. Format
    - ii. Group Rules
    - iii. Curriculum – developed by RNs with some MD input
      - 1. Rotating 8-week curriculum
        - a. Education
        - b. Recovery Tools
      - 2. BH Therapists can be guest presenters
    - iv. MD bills 99213 each patient
    - v. Hour following group for individual patient appointments with MD
      - 1. Dose adjustments
      - 2. Interventions
      - 3. Medical care
  - d. Phased Care
    - i. Phase I –
      - 1. Weekly MAT Refill/Stabilization group attendance along with urine drug screen and 7-day Buprenorphine/naloxone Rx
      - 2. Harm Reduction and Early stabilization for all patients
      - 3. Required to have BH Intake in first 30 days of program participation
        - a. BH therapist will then refer for more therapy, if indicated
      - 4. Progressing to Phase II is patient-centered determined by patient's adherence to the treatment agreement, consecutive Negative UDS and stability determined by MAT team.
      - 5. A patient transferring from another MAT program who is stable can be fast-tracked to Phase II after 4 consecutive weeks of group attendance, NEG UDS and MAT team determination.
    - ii. Phase II
      - 1. Transfer to Phase II requires a meeting with Addictions RN or SUD counselor to update Treatment Agreement and clarify with patient the expectations of Phase II adherence.
      - 2. Patient attends Refill/Stabilization group every 2 weeks.
        - a. UDS
        - b. 14 day Bup/nx Rx
        - c. Continues with patient- centered Treatment Plan
        - d. Minimum of 4 consecutive group attendances and Neg UDS (8 weeks).

3. Patient's length of time in Phase II is determined by patient adherence to MAT treatment agreement and treatment plan and MAT team determination.
  - a. Progressing to Phase III indicates that the patient requires minimal RN case management.
  - b. Must meet Hub & Spoke monthly 50-minute counseling session with individual appointment or Phase 3 Group Attendance
- iii. Phase III
  1. Monthly appointments with prescriber for 30 day bup/nx Rx
    - a. If Primary Care Provider is waived to prescribe bup/nx, then will leave MAT prescriber to care of PCP.
  2. UDS with every visit
  3. Minimal RN Case Management required
  4. Pt must meet with SUD Counselor –indiv or group for at least one session per month.
    - a. Current Phase 3 group sessions every Wednesday in both clinics 4-5 pm.
  5. Patient MAT info moved to Phase III on roster
  6. If patient relapses or needs more help, return to Phase I or Phase II for additional support and care
- e. Discharge
  - i. When patient stops attending scheduled Refill/Stabilization groups, does not respond to phone calls, a discharge letter will be sent 14 days after last prescribed dose of bup/nx.
    1. Letter in eCW
    2. If patient wishes to return to MAT program, must be re-admitted with new treatment agreement and new treatment plan.
      - a. If assessed for higher level of care, can be referred to Outpatient, Intensive Outpatient, or Residential Treatment through county placement.
    3. If patient is known to be diverting buprenorphine/naloxone, the patient can be discharged immediately.
- f. Lost or stolen buprenorphine
  - i. Pt must notify RN Case Manager or SUD case manager and prescriber immediately
  - ii. Pt must file police report – this can be done online with all law enforcement agencies
  - iii. Pt will meet with RN, submit UDS and will receive a short Rx until next scheduled Refill/Stabilization group or next scheduled provider visit

## 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. Standard of Care per DHCS Drug Medi-Cal- Organized Delivery System (DMC-ODS).
2. Assess at time of Nursing assessment and SUD assessment.
  - a. Update as indicated.
  - b. Change in stability
  - c. Relapse
- b. Standard ASAM assessment tool in MAT Buprenorphine file in Medical drive

#### **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 NEG UDS
    3. Completion of BH requirement

#### **11. Urine Drug Screen (UDS) Protocol**

- a. 2 panel Clia Waive Point of Care Urine Drug Screen must be collected at time of every refill of buprenorphine/naloxone.
- b. Any UDS which shows POS must be confirmed before action is taken but can be discussed with patient at time of POC.
  - i. MA with standing order sends all POS UDS to lab for confirmation
  - ii. Confirmed UDS protect patient as there may be a time when patient will request that results be sent to law enforcement, CPS or Recovery Providers.
  - iii. POS for prescribed medications such as BUP and Benzos did not require confirmation
  - iv. If POS for THC – confirmation determined by prescriber
  - v. Sending UDS to laboratory for alcohol testing determined by MAT provider and MAT team
  - vi. Sending Phase 3 UDS to laboratory for EtOH testing determined by MAT Provider and MAT team

#### **12. 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 time of admission to MAT program.
  - ii. Can be ordered for any family member requesting Narcan
  - iii. Can be ordered for any patient rx'd opioids for pain management
  - iv. Order Set in eCW – naloxone nasal spray 0.4 ml as directed #2 doses with 2 refills.

#### **13. eCW**

- a. Visit types in eCW
- 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 indiv 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. SUD counselor Intake
    - ix. SUD Intervention note
  - d. Order sets

#### **14. Progressing to Phase III Protocol**

- a. Must meet with Nurse Case Manager or SUD counselor to review and update treatment agreement.
- b. MD to MD handoff if patient is transferring to a waived PCP for phase III
- c. Clarify with patient that they will be seeing their MD monthly.
- d. Schedule 1<sup>st</sup> appointment with MD. Make sure they have rx until next appointment.
- e. In order to maintain Phase III level of care they must continue with negative UDS, take bup/nx as prescribed and keep their appointments, as well as continuing with their recovery activities.
- f. If patient struggles with relapse or relapse behaviors, pt will return to the next appropriate level of care for them – phase I or phase II to be determined by their provider and MAT NCM.

#### **15. Patient transfer protocols**

- a. Within Chapa-De
  - 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 MD-MD 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 Chapa-De MAT has assessed and determined admission to MAT program
    - 2. Obtain Release of Information for interagency communication if possible.
    - 3. NCM contacts previous provider for continuum of care info

4. Arrange Provider-to-provider call if possible
- ii. 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 within first 30 days in Phase I.
- b. BH therapists available for these intakes can be concurrent with group sessions.
  - i. Patients can utilize a group commitment to complete BPS intake
- c. BH can be guest facilitators for weekly Phase I/II groups

**17. 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) Whole person level of care

**18. Patient info handouts**

- a. Treatment Agreement
- b. Phases of Care Info
- c. Induction Preparation
  - i. In-clinic
  - ii. Home induction
- d. Medication Assisted Treatment Brochure
- e. Info regarding transfer from Spoke to Hub

**19. Transfer Spoke to Hub**

- a. MAT team consults regarding appropriate level of care for patient struggling.
- b. If determined to transfer to Hub setting for daily monitoring and daily dosing of buprenorphine or methadone (MAT provider recommendation and patient choice).

I. Transfer of an enrolled Spoke MAT patient to care at Hub:

1. RN Case Manager Phone to Aegis.

- a. Raquel – intake person: 916-774-6647
- b. email in subject line: “Chapa-De Transfer”
- c. Fax: 916-774-6456 or 916-774-0106:
  - i. ROI
  - ii. Transfer note – specifying the reason patient requires higher level of care.
  - iii. Last Rx for buprenorphine/naloxone (Suboxone) including # - make sure that the Rx will cover patient for 3-5 days.

NOTE: Pt. is no longer on the Spoke Roster while at Hub.

2. Aegis will then call patient and initiate care.

I. Chapa-De patients not enrolled in Spoke MAT.

1. Pt can call for consultation and begin care.

## Chapa-De Indian Heath Medication Assisted Treatment Policies & Procedures

2. If patient chooses, they can sign ROI for Chapa-de. If ROI signed, the RN Case manager can facilitate by calling, faxing brief note and emailing if indicated.
3. Aegis will contact patient and begin care.

Patient can initiate discussion with Hub and Spoke about readiness to return to Spoke Level of Care. Transfer back to Spoke will be a reverse of above Spoke to Hub process.

Aegis Roseville Hours: M-F 5:00 am – 1:30 (lunch 9 -10 am)

Sa – Sun 6:00 -2:30 (lunch 10- 11 am)

Forms

1. EHR templates
  - a. Screening
  - b. Nursing Assessment
  - c. SUD Intake
  - d. Medical clearance by provider
  - e. Induction
    - i. In clinic induction
    - ii. Home induction
  - f. Induction RN follow-up note
  - g. MAT Treatment Plan
  - h. Refill/Stabilization group note
  - i. MAT f/u visit
  - j. MAT discharge note
2. Patient Induction preparations/instructions
3. Treatment Agreement
4. Phases of Care patient handout
5. MAT group check-in sheet – “Purple Half Sheet”
6. Discharge letter
  
7. Duty statements
  - RN Case Manager
  - SUD counselor
  - Waivered provider