Missouri Department of Mental Health

Division of Behavioral Health

Provider Implementation Guide Using a Medication First Model

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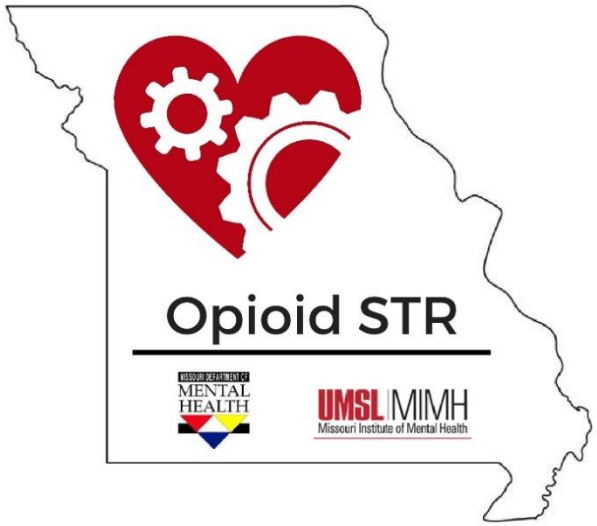

Developed by the Missouri Department of Mental Health, Division of Behavioral Health, and members of the Opioid STR team

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Introduction

This guide is intended to help providers deliver treatment and supportive services to individuals with Opioid Use Disorder (OUD). The Missouri Department of Mental Health and Opioid State Targeted Response (STR) team have developed this Provider Implementation Guide to outline clear and consistent guidance for implementation of the Medication First treatment model. The guide is intended for providers and agencies serving individuals with OUD outside of the DMH treatment system (for a Guide with administrative instructions and grant-related guidelines, see this version: DMH Implementation Guide.)

This guide is divided into multiple sections, as many provider staff are involved in the consumer experience. We encourage you to distribute particular sections to the staff who could most benefit from the information. These sections include:

- General **Overview of Grant**
- **Important Points** to Remember
- **DBH Guidelines for the Use of Medications for OUD**
- Clinical Guide **for Intake and Psychosocial Supportive Services**
- Clinical Guide for **Medical Treatment of OUD**

General Overview of the State Targeted Response (STR) Grant

The Opioid STR project is a $20 million two-year award from the Substance Abuse and Mental Health Services Administration (SAMHSA), using funds provided by the 21st Century Cures Act federal legislation. Missouri Opioid STR has expanded access to integrated prevention, treatment, and recovery support services for individuals with OUD throughout the state.

Primary prevention activities center on increased awareness and decreased availability of opioids, led by local agencies in high-risk areas. This includes training clinical providers and at-risk individuals on Overdose Education and Naloxone Distribution (OEND) practices and providing telemedicine didactic and consultation services to primary care providers treating chronic pain. The focus on the provision of evidence-based treatment services to uninsured individuals diagnosed with OUD who present for care to state-funded programs has driven the rigorous, multidisciplinary provider training and education on the medical treatment of OUD. Recovery support services are provided in the form of Recovery Community Centers, recovery housing, and recovery management checkups, all delivered by peer support specialists in an effort to increase consumer engagement in treatment and long-term recovery.

The Missouri Department of Mental Health (DMH) leads the project, with administration, implementation, and evaluation activities provided by the Missouri Institute of Mental Health (MIMH) – University of Missouri, St. Louis, as well as healthcare agencies, additional academic institutions, and content experts throughout the state.

The success of the strategies implemented through the grant has prompted the DMH and MIMH-UMSL to develop this guide in order to give all providers access to information that can better equip them to effectively treat individuals with OUD.

Important Points to Remember

Basic information of which providers should be aware:

1. The primary goal of the STR grant and associated efforts is to **SAVE LIVES**.

2. Medication in conjunction with offered behavioral health services is considered the **most effective treatment** for OUD (See Appendix A).

3. There are **no treatment levels using the Medication First Model**. **The frequency and intensity of services must be based on the individualized needs identified in the assessment**. Consumers may initiate and proceed with treatment at the frequency and intensity most appropriate to meet their needs. Some consumers may not need intensive psychosocial support services, though all should be offered the full menu of available and appropriate services. Individuals prescribed medication **should not be "mandated"** to attend or participate in an arbitrary number of services in order to continue to be prescribed medications to treat their OUD. Agencies have reported that the use of **peer supports** at the time of medication induction and thereafter has been very helpful in engaging consumers in psychosocial services.

4. Agencies serving individuals with OUD should utilize and collaborate with **Recovery Community Centers** (Appendix B) and local **Peer Ambassadors** (Appendix C). For more information please visit: https://missouriopioidstr.org/recovery/

Guidelines for the Use of Medications for OUD

"10 Do's and Don'ts of Medical Treatment for OUD"

1. Do not initiate a taper or discontinuation of buprenorphine or methadone in response to any client "infraction" (e.g., missing therapy sessions).

2. (Other side of #1) Do not mandate participation in individual or group counseling as a requirement for continued medical treatment. (See #10 for what to do instead.)

3. Do not set a "time limit" for maintenance medical treatment.

4. Do not encourage 'rapid' buprenorphine taper protocols with the goal of transitioning to antagonist medications or no medications at all.

5. Do not discharge a client based on positive drug test results for illicit substances.

6. Do not discharge a client from a residential setting without enough medication to supply them to their first outpatient physician visit.

7. Do not withhold medical treatment if the treatment provider does not have staffing capacity to provide psychosocial services at the time the client presents.

8. Do not switch a client from Vivitrol to oral naltrexone solely for cost-saving purposes.

9. **Do individualize dose decisions based on individual client factors, particularly craving intensity and environmental support** (i.e., be wary of underdosing – most clients do best when stabilized between 16mg-24mg of buprenorphine per day).

10. **Do increase client accountability measures** (e.g., drug testing, frequency of medication/dosing visits) -- if and when adherence to treatment protocols becomes disrupted by client behaviors described above -- **without discontinuing the needed medications.** Use motivational interviewing and make clear the rationale for the recommendation of individualized psychosocial supports. Peer support services can also be effective in helping a consumer engage in needed services.

Compiled from guidelines within the following sources:

American Society of Addiction Medicine (ASAM) National Practice Guidelines (2015)
SAMHSA's Clinical Guidance for Buprenorphine Treatment TIPS 40 (2004)
The World Health Organization's (WHO) Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence (2009)
The FDA Drug Safety Communication (2017)

Clinical Guide for Intake and Psychosocial/Supportive Services

The STR grant has provided an opportunity to reevaluate the intake process in treatment settings, particularly as it relates to serving those diagnosed with OUDs. Historically, an individual had to have a comprehensive assessment and multiple other forms completed prior to seeing a physician; however, the implementation of a "**Medication First**" model minimizes the burden of paperwork on the front end. Often, individuals with OUD present in the early stages of withdrawal, which is an opportune time to get them connected with a medical professional, stabilized, and *then* engaged in care planning. Medical stabilization should occur first not only because it eases client suffering and quickly reduces drug craving, but also because an individual in active withdrawal is unable to adequately participate in the care-planning process.

The following represent "steps" to take in terms of engaging an individual with OUD in services through the Medication First model:

1. The individual seeking services makes **first contact with the organization**. *(Note: There is no "wrong door." First contact could be through outpatient clinic, crisis stabilization site, withdrawal management unit, etc.)*

2. If first contact is **by phone, the provider will conduct their typical pre-admission screening in addition to supplemental brief screening on opioid use.** *(See Appendix D; only triggered if individual reports use of opioids in pre-admission screening)* If the individual answers "yes" to any questions on the opioid supplemental screening, the provider will schedule the consumer for first available medical appointment.

   The in-person brief screening should take place when the individual arrives for his/her first appointment prior to the medical appointment. The screening (see Appendix E for an example) is completed by a medical staff coordinator (or other qualified staff) to determine presenting concerns and experience of current opioid withdrawal symptoms. The screening **may** include information such as the following:

   a. Date of birth
   b. Vital signs
   c. Results of a drug screen
   d. Report of substances used in the past 30 days, frequency of use, date/amount of last use, and route of administration
   e. Report of prior overdose events
   f. Current medications

   The individual is designated as an **emergent** client for immediate treatment access.

3. **Alert appropriate staff of client contact and need for emergent medical visit** and proceed with scheduling medical visit.

4. If the individual is in **active opioid withdrawal** and/or has used opiates within the past five (5) days:
    a. Connect individual with a prescriber onsite, via telehealth, or locally.
    b. If the individual must travel for the appointment and has no means of transportation, facilitate transportation as needed and appropriate.

5. **Prescriber initiates** methadone (in an OTP) or buprenorphine (in clinic or at home) **induction** and **prescribes naloxone** and other ancillary **medications** as clinically indicated. (Vivitrol cannot be started if a person is in withdrawal. Medication protocols are detailed in the following section, "Clinical Guide for Medical Treatment of OUD.") (Note: the naloxone is for take-home purposes.)
    a. **DMH strongly encourages the provision of overdose education and a naloxone prescription upon the earliest possible contact with a consumer, given the high risk of overdose before, during, and after treatment episodes.** (*See step 7, below.*) Ideally, this service would be provided during the first visit (following receipt of stabilizing medication); if not possible, please complete at the second visit.

       Whenever possible, include a family member or caregiver in the discussion about naloxone use – *people who overdose cannot administer naloxone to themselves.*

6. The care coordinator, nurse, or other appropriately trained staff conducts **Overdose Education and Naloxone Distribution (OEND) training** with the individual and natural supports whenever possible.

   OEND is a 10-15 minute conversation about overdose risk and response, including instructions on naloxone administration. *(See Appendix F-H for an outline of what should be covered and handouts for clients, and visit the "Training" tab on www.mohopeproject.org to request staff OEND training. For additional information, please visit https://youtu.be/YzapzRfALFI.)*

    a. Review overdose prevention, recognition, and response strategies, including how to use naloxone.
    b. Prescribe naloxone (recommended forms are AdaptPharma Narcan nasal spray and intramuscular injection naloxone hydrochloride).
    c. Instruct client to pick up naloxone at the pharmacy at the same time other medications are collected.

7. **Schedule appointments** with staff whose services are identified as needed (e.g., counselor, community support specialist, peer specialist).

8. Facilitate a **comprehensive assessment when clinically appropriate.** The assessment does NOT need to be completed within 72 hours for residential or three outpatient office visits. Clinically, it is not appropriate to do a "comprehensive" assessment while the individual is in active withdrawal or before s/he is stabilized on medication.

9. Develop a **comprehensive treatment plan when clinically appropriate.**

a. The treatment plan should be a working document, with goals added and dropped as they are identified and achieved, with the involvement of the individual served.
b. Services are billable if they relate to an identified need in the assessment and are included on the treatment plan.
c. Make sure the treatment plan addresses all life domains affected by the OUD.

10. **Provide comprehensive, person-centered, individualized services.** To highlight just a few:

    a. **Community Support** for those with needs related to entitlements, housing, employment, social supports, legal problems, physical health and wellness, etc. There are 25 service functions under the Community Support Service -- be sure to use this service for all those who have identified needs in life domains. *(Reference: Community Support Definitions and Key Service Functions: http://dmh.mo.gov/docs/mentalillness/keyservicefunctions.pdf*)

    b. **Individual Counseling** must be highly individualized. **Motivational interviewing** should be utilized. **Cognitive-behavioral therapies and interventions** have the best outcomes in the literature, particularly those focusing on craving management and behavior modification. Remember that individuals with specialized needs may benefit from **Co-Occurring and/or Trauma-Specific** Individual Counseling when provided by qualified staff. *(Included in Appendix I is a helpful psychosocial exercise: Addiction Versus Dependence: Medical Treatment for Addiction.)*

    c. **Peer Support** is encouraged as recognition of its benefits is increasingly widespread. Peers have been used successfully in outreach, active treatment, and recovery services. *(Reference: Clinical Services Bulletin #30 Peer Support Services: http://dmh.mo.gov/docs/ada/clinical30peersupportservicesbulletin.pdf.)*

    d. Consumers should be provided with information about **Recovery Housing** if they need a safe, healthy environment to support engagement in treatment.

    (Many recovery housing providers still refuse housing to individuals receiving medical treatment for OUD. It is important to ensure that the housing providers you refer consumers to do not engage in this discriminatory practice. *(More information on housing services are in **Appendix J**.)*

    e. **Transportation.** Individuals who lack adequate transportation should receive this service through community provider agencies. (*see **Appendix K***).

    f. **Medically Monitored Inpatient Detoxification (MMID)** may be indicated for a subset of individuals served. However, MMID should not include traditional “detox” and tapering protocols, but rather induction and stabilization on a therapeutic dose of buprenorphine for continued dosing through outpatient maintenance.

g. **Social setting detox is NOT supported in the literature as an appropriate intervention for individuals in opioid (or alcohol or benzodiazepine) withdrawal.** *[See TIP 45: "…hospitalization (or some form of 24-hour medical care) is generally the preferred setting for detoxification based on principles of **safety** and **humanitarian** concerns."]*

   Every effort should be made to have a consumer seen by a physician (or other prescribing provider), and addiction medication initiated, PRIOR to admission to a SSD setting. Clients should self-administer medication (as they would any other prescribed medication in this setting), communicating as directed with the prescriber/staff (as they would with an at-home induction).

h. **Client-Specific Outreach** can be used to facilitate and maintain client engagement. This service may involve recovery management check-ups, which involve reviewing the individual's recovery and progress in the areas of substance use, housing, employment, criminal justice, and social connectedness.

i. **Recovery Community Centers** are available as a resource in St. Louis, Kansas City, and Springfield. *(For a complete list of STR-funded RCC's see Appendix B.)* Recovery Community Centers offer supportive services such as peer-to-peer support, support groups, overdose education and naloxone distribution, housing referrals, monthly telephone check-ups, and substance-free social activities.

11. **Continue providing comprehensive, person-centered, individualized services.** There is no established timeframe for engagement in treatment for substance use disorders. There is not a finite number of hours of treatment one must complete. Neither are there timeframes established for how long an individual should take medications prescribed for his/her chronic medical illness(es), addiction being one of them.

    Individuals should continue in services (which may include maintenance medications) **as long as needed, receiving no more and no less treatment than is indicated by their individualized needs**. That will look different for everyone!

12. **Transition to other care settings through warm hand-offs**. Individuals on maintenance medication for OUD who have stable environments and do not require a high level of care may not be best suited for ongoing care in an SUD specialty setting. Instead, an outpatient setting like primary care or an Opioid Treatment Program (OTP) may be used to continue maintenance. Once the referral is made to an alternate care setting, the consumer should have an adequate supply of medication and remain engaged with the provider until it has been verified that the consumer presented for his/her first appointment with the new provider(s). If circumstances change and the individual requires a higher level of care in the future, he/she should readily resume care at the SUD agency. This requires bi-directional "warm handoff" relationships between appropriate agencies, as well as a potential revision of discharge policies and procedures.

Clinical Guide for Medical Treatment of Opioid Use Disorder

The frequency and extent of treatment and rehabilitation services should be adjusted based on individual patient needs.

Individuals enrolled in a Medication First Treatment program *need not receive treatment in accordance with levels of care.* Consumers may initiate and proceed with treatment at the frequency and intensity most appropriate to meet their needs. Some consumers will not need intensive psychosocial support services, though all should be offered the full menu of appropriate services, consistent with their individualized needs.

It should be noted that **the majority of the following guidance is in reference to induction, stabilization, and maintenance on buprenorphine**. Buprenorphine has been found to be highly effective for OUD stabilization and maintenance.

Methadone and Vivitrol remain appropriate treatments for many individuals and these medications are supported by DMH. However, because methadone is administered in a controlled OTP setting (by clinicians well-versed in Federal OTP guidelines and state standards of care), and because Vivitrol is a non-controlled substance that has been increasingly used within the DMH treatment system since 2011, this guidance document does not go into significant detail about either medication.

A subset of patients may require **Modified Medical Inpatient Detoxification** (MMID). Patients who also use high doses of benzodiazepines, alcohol, or other substances with risk of respiratory depression, along with opioids, should be considered for MMID. However, **MMID should not include tapering protocols, but rather induction and stabilization on a therapeutic dose of buprenorphine for continued dosing through outpatient maintenance.** Arrangements for discharge and follow-up appointments should begin on Day 1 of MMID. Upon discharge from MMID, patients should be prescribed an adequate supply of medication to last until their first follow-up outpatient appointment with a prescriber. Following MMID, patients should engage in standard Opioid STR treatment protocol, outlined below.

Phases of Medical OUD Treatment:

The descriptions and guidelines presented in this section reflect best practices and guidance provided by the:

American Society of Addiction Medicine (ASAM) National Practice Guidelines (2015)

SAMHSA's Clinical Guidance for Buprenorphine Treatment TIPS 40 (2004)

The World Health Organization's (WHO) Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence (2009)

For comprehensive, yet succinct guidance for physicians, nurse practitioners (NPs), and physician assistants (PAs) regarding medication induction, stabilization, and maintenance protocols, DMH recommends frequent consultation of ASAM's pocket guide.

1. Induction:

The goal of the induction is to find each patient's ideal daily dose of buprenorphine that safely suppresses opioid withdrawal and drug craving as rapidly as possible. For most opioid-dependent patients, the daily dose with the most therapeutic benefit is 16-24 mg/day of the buprenorphine + naloxone combination film or tablet. Induction usually takes 2 to 4 days to complete. Buprenorphine + naloxone combination is preferred except for use in special populations such as pregnant women (in pregnancy, use of buprenorphine monoproduct [or methadone] are best practice). The following recommendations are for buprenorphine + naloxone combination tablets or films.

Induction can either be done in the outpatient clinic setting or in the patient's home environment. Office-based induction is recommended if the physician/prescriber or patient is unfamiliar with the process, or either of them do not feel comfortable with initiating home induction with buprenorphine. However, more experienced providers may feel confident and comfortable facilitating home induction with good nursing support to intermittently guide the patient through the process over the phone or through telehealth.

Induction Steps:

- The first dose of buprenorphine + naloxone combination pill or film should be administered when an opioid-dependent individual has abstained from opioids for 12 to 24 hours and is in moderate withdrawal (If using the Clinical Opiate Withdrawal Scale (COWS), a score of 12 or 13).
- Day 1 of induction: Opioid-dependent patients should be inducted with a 4mgs dose of buprenorphine, and observed for 1-2 hours. If withdrawal symptoms are not well controlled or they reappear, an additional 4mgs should be given. Additional doses in increments of 2mgs can be given up to a dose of 12 to 16mgs.
- For office-based induction, it is helpful to allow a 2-4 hour window of office time on the first day of induction. A nurse or medical assistant can perform the monitoring and titrate the medication based on the withdrawal symptoms, based on the physician/prescriber's order. The patient is not necessarily required to sit in the office the entire time.
- For off-site/home induction, on Day 1, remote support should be offered by a nurse (through phone or telehealth) to help assess withdrawal symptoms and determine readiness for induction. This could include but is not limited to assessment of discomfort, agitation, joint pain, stomach upset, diarrhea, chills, restlessness, and other common withdrawal symptoms. The Subjective Opioid Withdrawal Scale (SOWS) can be used by the nurse to assist with the assessment of opioid withdrawal symptoms via the phone.
- If the patient experiences continued withdrawal symptoms and cravings after Day 1, dosage should be increased on Day 2 in increments of 2-4 mg up to 16 mg. Some patients may need titration up to 24mgs. By Day 3 or 4, the dosage needed to fully control the withdrawal symptoms should be determined. There is limited evidence for the efficacy of doses greater than 24 mg, but some patients may benefit from doses up

to 32 mg. Doses higher than this will not harm the patient but will do little to decrease patients' cravings, due to the ceiling effect of buprenorphine.

- If switching from methadone to buprenorphine, the dosage of methadone needs to be tapered down to 30 mgs per day of methadone before the buprenorphine induction. It may take more than 36 hours after the last dose of methadone for the patient to be in mild or moderate withdrawal. Also, start with a 2 mg dose of buprenorphine and titrate by 2mgs to decrease risk of precipitating acute withdrawal.

Important things to note:

- Initial and maintenance dosing depend on several patient use factors. **Avoid under-dosing on both induction and maintenance dose**. Under-dosed patients are at increased risk of overdose. (Severity of factors below suggest higher induction dose and maintenance dose)
    - Types of opioids
    - Quantity of opioids
    - Other addictive substances used routinely or episodically
    - Age of onset of use of addictive substances

- At a minimum, weekly visits are recommended with the physician/prescriber until the stabilization occurs (often 1+ month).
- Between follow-up appointments with the physician/prescriber, patients can be assessed by nursing support staff.
- During the office visits, urine drug screens or salivary drug screens for other substances and for the presence of buprenorphine or its metabolites should be administered. Other recommended labs: liver function tests and pregnancy test for female patients.
- The role of community support specialists, peers, care managers, and other psychosocial support staff during the induction phase should focus on:
    - Motivational enhancement
    - Treatment engagement
    - Craving management
    - Other strategies to support the patient during what is often a physically distressing period
    - Securing a safe environment
- Extensive talk therapy sessions or assessments may serve as a barrier to treatment at this point and should be avoided until the patient has stabilized.

*Note: **DMH recommends this protocol be utilized for all individuals, no matter their payer source.** For individuals with insurance (MO HealthNet, private, or other), prior authorization for the initial buprenorphine prescription may be required. This underscores the importance of having a partnership with a nearby pharmacy to streamline the prescription process and, for individuals with Medicaid, being familiar with MO HealthNet prior authorization rules and practices.*

For individuals with MO HealthNet coverage requiring a Prior Authorization from the treatment provider, call this toll-free number and listen to the menu of options. Phone:

(800) 392-8030; Fax: (573) 636-6470.

2. Stabilization:

Goals:

- To determine the appropriate stabilizing dose of medication needed to:
  - block the effects of illicit opioids
  - eliminate or greatly reduce opioid craving and illicit opioid use
  - facilitate patient engagement in recovery-oriented activities including psychosocial interventions
- To inform the patient of the variety of psychosocial support services available through the treatment program.

Stabilization Steps:

- The next 6-8 weeks after the induction is the stabilization period, during which time patients should be maintained at their daily dose with close monitoring and adjustments as needed.
- At an ideal daily dose, the patient should experience no withdrawal symptoms and no cravings.
- Regular and frequent clinic visits (recommended: weekly) should continue until the patient stabilizes medically and psychosocially.
- Continue urine or salivary drug screens for buprenorphine, illicit opioids, and other substances relevant to the patient's treatment. (If a patient continues to test positive for illicit opioids or other drugs, s/he may be under-dosed, and the dosage should be re-evaluated. See special note on the following page.
- Deliver individualized treatment and recovery support services.
- Begin to address environmental and psychosocial needs (e.g., peer and community support, housing, counseling), with the understanding that medical stability remains the treatment priority. **Psychosocial services should not serve as a barrier to medical treatment**.
- Take reasonable steps to reduce the chances of diversion while keeping patient care, functioning, and stability as the top treatment priorities. Strategies to reduce diversion include:
  - Requiring frequent office visits (e.g., every three days instead of weekly)
  - Drug testing
  - Observed dosing
  - Recall visits for medication/pill counts
  - Conduct "wrapper counts" for Suboxone; match serial numbers with records
  - Patient education on strategies to secure medication and prevent theft

***A special note about **drug testing** and treatment implications:*

- At this time, it is widely recommended that drug testing is done at each medication-related visit and includes testing for buprenorphine.

- If patients test positive for illicit opioids, the following may increase compliance and improve engagement:
  - Increased buprenorphine dose (after assessment for cravings and need for on-going use of illicit opioids)
  - Increased medical visit frequency
  - Motivational interviewing/peer support

Important things to note:

Most patients will eliminate their illicit opioid use ***gradually*** as they stabilize on buprenorphine and develop confidence in its therapeutic effects. Some will continue to use other substances but will nevertheless experience significant improvements in functioning. Discontinuing buprenorphine therapy is generally not clinically indicated if its use is associated with any decrease in illicit opioid use.

Patients should be educated about the risk of combining buprenorphine with alcohol or benzodiazepines, but a high degree of caution should be exercised before discontinuing buprenorphine due to drug or alcohol misuse. Discontinuing buprenorphine is very likely to precipitate a relapse to heroin or prescription opioid misuse and the associated risk to patients.

Consider some creative dosing in prescriptions, for example:

- Write prescriptions and instruct patients to allow for an extra 5-10 days of 4 mg Suboxone
- Discuss other medications and/or non-medication tools to help on higher craving days

3. Maintenance:

The maintenance phase is reached when the patient is functioning well on a steady dose of buprenorphine with little or no cravings and little or no illicit opioid use. The maintenance phase will continue indefinitely for most patients. Long-term maintenance is recommended due to high relapse rates.

While it is best to maintain a patient on the lowest effective dose of any therapeutic agent, be mindful, particularly in the first year of maintenance, that patients will have good days and bad days, higher craving days, and changes in their lives. This is a normal part of the recovery process.

Goals:

- Prevent or decrease risk of relapse.
- Retain patients in treatment.
- Avoid under-dosing.
- Assist patients in making continued improvements in functioning and quality of life.
- If the patient is medically, socially, and environmentally stable, facilitate a warm handoff to continue maintenance treatment with a community provider with ability to continue buprenorphine prescription.
- If the patient is medically, socially, and environmentally stable, AND expresses wishes to taper off medication or transition to Vivitrol/long-acting naltrexone, assist with this gradual and highly collaborative process.

. ***Maintenance Steps:***

- Continue medical visits approximately monthly or more frequently if a patient demonstrates non-adherence.
- Monitor the patient's cravings for opioids and develop strategies for effective management of cravings.
- Labs:
    - Monthly urine toxicology screens including buprenorphine
    - After the initial pregnancy tests for all women of childbearing age, ask each month thereafter if the patient thinks they may be pregnant, or test the patient as indicated. Request to be notified if they think they are pregnant.
    - Liver function tests every 6 months if the initial test was abnormal, or with liver disease

- When a patient resumes use of illicit substances, steps should be taken to re-engage them and provide medical stabilization as quickly as possible. Resumed use will often require patients to return for the induction and stabilization phases of treatment.

- Continue implementing the individualized care plan, including but not limited to medical care coordination, community support, peer engagement, vocational training, housing support, individual counseling, and other services as needed.

  However, *psychosocial support services should never function as a barrier* to *treatment*. For example, if an individual requests less frequent psychosocial visits because the current appointments interfere with procuring or maintaining employment, accommodations should be made to continue providing medical services while reducing the frequency of psychosocial visits.

- If the patient is medically, socially, and environmentally stable, facilitate a warm handoff to continue maintenance treatment at an office-based treatment facility:

    - Many Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), Opioid Treatment Programs (OTPs) and other state-contracted and private treatment facilities are now offering buprenorphine treatment for OUD and could serve as excellent referral destinations for patients.

- If a patient plans to transfer to another care setting:
    - The patient should have a buprenorphine prescription/supply to last until their appointment with a prescribing provider at the new facility.
    - Should the patient later require a higher level of care, they should resume treatment at the SUD treatment facility with minimal wait time and barriers. This "cooperative" model of specialty and primary care will likely require alterations to existing protocols and the development of memoranda of understanding between cooperating agencies.

***A Note about Accountability Structures:**

Explain to patients initially – and repeat frequently – that accountability structures are ways to promote patient safety. They are **NOT** intended to be punishments. Urine drug screens, PDMP alerts, wrapper counts, etc., are conversation starters, not sledgehammers. Alarming results, including indications of diversion, should be met with a question, such as "What's going on?" or "Can you help me understand your situation?"

Explore options with the treatment team to promote accountability-oriented communications. These may include:

- Utilizing a brochure with guidelines based in contingency-management (***See Appendix L*** for an example that can be modified to suit the needs of your agency)
- Support staff counting Suboxone wrappers since the client's last visit
- Routine outreach, recovery management checkup, and appointment reminder calls
- Utilizing a Treatment Agreement
    - Discussing rules and expectations is an important step when starting a client on buprenorphine treatment. Some providers choose to use a printed and signed Treatment Agreement (see this example from ASAM. Note – this content may differ from your clinic's protocol. Review and revise as necessary before use.)

4. Tapering and Discontinuing Buprenorphine with Patients:

Things to note prior to initiating a taper:

- Tapering and discontinuing Suboxone for a patient who wants Suboxone maintenance and is responding well to Suboxone therapy is not a recommended treatment priority.

- There is a high risk for relapse when medical treatment is discontinued, even if a patient has been in maintenance treatment for months or years.
- Discontinuing buprenorphine, methadone, or Vivitrol is not required. Patients can continue medication therapy indefinitely so long as:
    - *They choose to;*
    - *They experience no significant adverse events that would render treatment contraindicated;*
    - *The treatment improves their functioning and/or decreases their risk for morbidity and mortality.*
- Illicit opioid use should not be grounds for terminating buprenorphine treatment. Alternative responses include checking on proper use of buprenorphine and dose, increasing the frequency of medical and/or monitoring visits, and offering additional psychosocial support services.
- Assess for under-dosing as a driver for desire to discontinue (i.e., the medication is prescribed at too low a dose to achieve optimal therapeutic benefit)
- If anyone on the treatment team becomes aware that a patient wants to discontinue Suboxone, s/he should inform the prescribing provider and the RN or staff member coordinating the patient's care.

Having the conversation *(to be facilitated by both medical and psychosocial providers):*

Although the majority of patients who discontinue buprenorphine do so involuntarily, some may choose to discontinue the medication. If a patient expresses an interest in discontinuing the use of addiction medications, providers should engage in a collaborative decision-making process with the patient (and key primary support persons, if possible).

- When a patient is considering a buprenorphine or methadone taper, or a discontinuation of injectable naltrexone, providers should invite them and their loved ones to reflect on the role the medication has had on their recovery and their lives. For example, providers might ask:

"What are your reasons for wanting to discontinue medical treatment?"

"How effective has this medication been in helping you stop your opioid use?"

"How has your life improved as a result of this change?"

"Would you want to stop the medication if you knew these positive gains might be lost?"

- It is important to inform patients that although it may seem like the gains they have achieved with the help of medication can be maintained in its absence, evidence strongly suggests that, *for the majority of patients,* this perception is not accurate.

Indeed, for the majority of patients, the medication works when you take it and stops working when it is discontinued (not unlike hypertension or cholesterol medication!).
    - For patients who have maintained abstinence from illicit opioids for 5 years or more, their likelihood of maintaining future abstinence is substantially higher than that for those who have been abstinence for <5 years.

- Providers should assess and address patients' motivations for wanting to discontinue medical treatment, **paying attention to the degree to which these motivations are intrinsic (coming from internal factors) or extrinsic (coming from external factors).** External factors that are impacting a patient's decision to discontinue medications might include: pressure from family or peers, negative social stigma, discrimination in the workplace or the job or housing market, etc. Providers should validate these real concerns and provide support to continue the medication, if such support is something the patient is lacking. Of course, the provider's primary role in this exchange is to offer medical advice based on empirical evidence.
    - **For buprenorphine specifically, providers should indicate that continuing buprenorphine therapy will (conservatively) decrease by 2 to 3 times their risk for relapse, overdose, and death.** Explicitly share that Suboxone discontinuation is associated with a 50-90% relapse rate. The protective effect of buprenorphine is likely to be greater for patients who injected heroin or have other risk factors for overdose (such as previous overdose events, co-occurring mental health diagnoses, prior suicide attempts, etc.).
    - Patients should be informed that discontinuation of the medication is especially contraindicated if they are experiencing instability in any key domain of functioning (e.g., mental/emotional health, primary support system, housing, employment) and if they do not have in place elements of a robust non-medical recovery plan (e.g., consistent and active involvement in a recovery community, a 12-step sponsor).
    - **Risk of relapse and overdose will increase following the discontinuation of any medication** (though relative risk of overdose following buprenorphine or methadone is less than the risk following abstinence or naltrexone/Vivitrol treatment). Patients' tolerance to opioids has decreased and, should they resume use, they must start at much lower doses than they used prior to initiating treatment.

Tapering Steps:

If, following discussion of the above, the patient and provider agree to proceed with discontinuation, the provider should note the following and share this information with the patient:

- The more gradual the taper, the less likely that the patient will experience significant craving and withdrawal symptoms. **Therefore, the more gradual the taper, the safer the taper.**
- Tapers should be paced based on patients' ability to tolerate each decrease. As such, providers should increase the frequency of office visits during the taper process to regularly assess craving and withdrawal symptoms.
- The length of tapering steps and the magnitude of dose reductions should be individualized to the patient's response and, ideally, would take place over several months.
- In general, decreases should not comprise more than 25% of the current dose and not take place more frequently than every 10 days.
    - Some patients will benefit from even smaller and less frequent dose reductions. For example, a patient may be able to step down 4mg every two weeks when tapering from 24mg to 12mg, but need to step down 2mg every two weeks from 12mg to 4mg, and 1mg every two weeks from 4mg to 0mg.
- Often, the final reductions (lower than 4mg) take as long to taper down as the initial reductions. Go much slower when tapering down from 4 mg and monitor closely for cravings and withdrawal symptoms.
- Some patients can taper down to 2 or 4 mg but cannot discontinue the medication completely without uncomfortable withdrawal symptoms or a sharp increase in cravings. This possibility should be discussed with each patient.
- It is always safer to titrate back up to a higher dose (vs. continue with tapering) if a patient starts experiencing strong cravings to use illicit opioids.
- Offer the option of Vivitrol (long-acting naltrexone), if appropriate, for continued treatment of OUD. This option can further improve patients' chances of preventing relapse.
- Prior to starting Vivitrol (long-acting naltrexone shot), the patient should be off buprenorphine for about 14 days to prevent precipitation of acute opioid withdrawal, and providers should utilize a "**naltrexone/naloxone challenge***" to confirm the patient is sufficiently detoxed/opioid-free. (A naltrexone/naloxone challenge refers to the administration of a small amount of naltrexone to determine if opioids are still in an individual's system; if they are, the naltrexone will result in the experience of precipitated withdrawal symptoms in the patient). The treatment plan should consider additional supports needed during this period to prevent a relapse.
- Patients who discontinue buprenorphine or any addiction medication should be monitored and assessed for cravings by medical and psychosocial support staff for as long as they remain engaged in any form of care.
- Patients should be encouraged to return for maintenance medical treatment if strong or persistent cravings develop.

Naltrexone/Naloxone (i.m.) Challenge Procedure

• Obtain baseline COWS, if 4 or less proceed with the challenge

• Administer naloxone 0.4 mg (1 cc) i.m. to deltoid and observe for 20 minutes. (OR, administer 25mg of an oral naltrexone tablet [half of a 50mg tablet])
• If no change in COWS administer additional 0.8 mg (2 cc) to the other deltoid and monitor for additional 20 minutes
• Test is considered positive if there is a COWS increase of 2 or more from the pre-injection score
• In case of positive challenge, do not administer XR-naltrexone, wait 1-2 days and repeat the challenge
• If the test is negative, proceed with the XR-Naltrexone injection.

For more information about topics such as tapering and pain, emergency tapering, or to create a tapering schedule, providers and their patients can visit:

XR-Naltrexone: A Step-by-Step Guide (from PCSS)

Appendix A: The Evidence of Medical Versus Non-Medical Treatment for Opioid Use Disorder

Extensive research demonstrates people with opioid addiction who follow detoxification with complete abstinence (i.e., no treatment medication) are likely to relapse (e.g., Bart, 2012, Mattick et al., 2008 & 2009, Volkow et al., 2014). Though relapse is a common and expected step on the path to recovery, it can also be life threatening, raising the risk for a fatal overdose. Thus, an important way to reduce mortality and support recovery from heroin or prescription opioid addiction is to maintain abstinence from those drugs using medications that reduce the negative effects of withdrawal and craving. Use of these medications is commonly referred to as Medication Assisted Treatment, or, preferably, **medical treatment for opioid use disorder (OUD)**.

Medications commonly used to treat OUD include:

- Methadone
- Buprenorphine (e.g., Suboxone®)
- Extended-release injectable naltrexone (e.g., Vivitrol®)

National and international professional bodies consider medical treatment for OUD the evidence-based best practice for treating OUD. This includes the National Association of State Alcohol and Drug Abuse Directors (NASADAD), the American Academy of Addiction Psychiatry (AAAP), the American Society of Addiction Medicine (ASAM), the World Health Organization (WHO), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Understanding substance use disorder as a brain disease is widely accepted. It is considered a disease that has "cognitive, behavioral, and physiological characteristics that contribute to continued use of drugs despite the harmful consequences." (NIDA, 2012).

The Effectiveness of Methadone

Methadone is a **synthetic opioid agonist** that eliminates withdrawal symptoms and relieves drug cravings by acting on opioid receptors in the brain. When appropriately dosed, methadone improves treatment retention, decreases relapse and overdose mortality (e.g., Clausen, Anchersen, & Waal, 2008; Connock et al., 2007), as well as the health and criminal problems associated with illicit opioid use (see Cochrane Review, Mattick et al., 2009). Long-term methadone (i.e., taken over the course of many months or years) maintenance therapy is more effective than either detoxification with methadone or medication-free treatment in decreasing heroin use and retaining patients in treatment (Mattick et al., 2009; Sees et al., 2000). A review of the literature showed that, in 11 clinical trials involving 1,969 people, methadone improved treatment retention and reduced heroin use compared with non-medication treatment (Mattick et al., 2009). A recent report in the *Annals of Internal Medicine* found treatment with methadone following a non-fatal overdose event was associated with a 60% decreased mortality rate in the 12 months following the overdose (Larochelle, et al., 2018). Additionally, Bhati et al. (2008) found if outpatient methadone treatment were expanded to all eligible offenders, 3.3 million nondrug crimes could be averted. Every dollar

spent on ongoing methadone treatment yields almost $38 in benefits through reduced crime, better health, and gainful employment (Zarkin et al., 2005).

The Effectiveness of Buprenorphine

Buprenorphine is a **partial opioid agonist**, meaning it partially binds to opioid receptors, the same receptors that other opioids such as heroin, morphine, and opioid pain medications activate. Buprenorphine activates these receptors less strongly than full agonists (i.e., methadone).

Similar to methadone, maintenance buprenorphine is more effective than abstinence-based treatment or placebo in the treatment of OUD (e.g., Fielen et al., 2014; Mattick et al., 2008; Veillux, 2010). Studies comparing the effectiveness of buprenorphine to that of methadone have been mixed. Buprenorphine does appear to be as effective as *moderate* doses of methadone. However, buprenorphine is unlikely to be as effective as *higher* doses of methadone and therefore may not be the treatment of choice for patients with higher levels of physical dependence. Magura et al. (2009) found that among people who were incarcerated, most preferred buprenorphine to methadone when released back into the community. A recent report in the *Annals of Internal Medicine* found treatment with buprenorphine following a non-fatal overdose event was associated with a 40% decreased mortality rate in the 12 months following the overdose (Larochelle, et al., 2018).

It is important to understand that methadone and buprenorphine are *maintenance* medications, not cures. A maintenance medication is one taken to stabilize and control an illness or symptoms of illness over time. It is effective only for as long as the patient takes it. Some individuals may be able to discontinue methadone or buprenorphine and continue in recovery without it. However, long-term maintenance with methadone or buprenorphine yields the best results and is considered the standard of care.

The Effectiveness of Extended-Release Injectable Naltrexone

Naltrexone is an **opioid antagonist**, which means it works by blocking the activation of opioid receptors. Instead of controlling withdrawal, it treats addiction by preventing any opioid drug from producing rewarding effects, such as euphoria.

Extended-release injectable naltrexone (Vivitrol®) has not been studied for as long as either methadone or buprenorphine, but results of its use in certain settings are promising. Studies have found the injectable form of naltrexone can increase treatment retention (Bart, 2012; Comer et al., 2006; Krupitsky et al., 2011). Treatment retention is particularly important because it provides clinicians sufficient time to engage patients in psychotherapy or counseling so they can learn to make psychological and social adjustments that support a life without opioids (Comer et al., 2006).

Injectable naltrexone has been found to be effective in reducing relapse and re-incarceration among people involved in the criminal justice system (Lee et al., 2016; Crits-Christoph, 2015; Gordon et al., 2015). A recent comparison study of buprenorphine versus Vivitrol treatment found Vivitrol to be more difficult for patients to initiate, even within an inpatient treatment

setting. However, once patients were stabilized, outcomes for the two medications to be comparable once individuals at six month follow-up (Lee et al., 2017). Of note, no published studies have yet compared Vivitrol to buprenorphine or methadone in with initiation in outpatient settings or studied comparisons in patients for longer than six months.

Conclusion

The standard of care for OUD is medical treatment with maintenance medication, rather than mandated (medication-free) abstinence with psychosocial support only. Compared to traditional, non-medical abstinence-based treatment, utilization of this chronic care model improves treatment retention, reduces relapse, controls cravings, and, most critically, significantly reduces mortality.

Footnotes and References

This document is primarily adapted from SAMHSA – Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence (2014), and NIDA – Medications to Treat Opioid Addiction (2017).

References

American Society of Addiction Medicine. (2011). *Public policy statement: Definition of addiction* (p. 1). Retrieved June 16, 2014, from http://www.asam.org/docs/publicy-policy-statements/1definition_of_addiction_long_4-11.pdf?sfvrsn=2

Bart, G. (2012). Maintenance medication for opiate addiction: The foundation of recovery. *Journal of Addictive Diseases, 31*(3), 207–225.

Bhati, A. S., Roman, J. K., & Chalfin, A. (2008). *To treat or not to treat: Evidence on the prospects of expanding treatment to drug-involved offenders*. Washington, DC: The Urban Institute.

Clausen, T., Anchersen, K., & Waal, H. (2008). Mortality prior to, during and after opioid maintenance treatment (OMT): a national prospective cross-registry study. Drug and alcohol dependence, 94(1), 151-157.

Comer, S. D., Sullivan, M. A., Yu, E., Rothenberg, J. L., Kleber, H. D., Kampman, K., et al. (2006). Injectable, sustained-release naltrexone for the treatment of opioid dependence: A randomized, placebo-controlled trial. *Archives of General Psychiatry, 63*(2), 210–218.

Connock, M., Juarez-Garcia, A., Jowett, S., Frew, E., Liu, Z., Taylor, R. J., ... & Burls, A. (2007). Methadone and buprenorphine for the management of opioid dependence: a systematic review and economic evaluation. NIHR Health Technology Assessment programme: Executive Summaries.

Crits-Christoph, P., Lundy, C., Stringer, M., Gallop, R., & Gastfriend, D. R. (2015). Extended-release naltrexone for alcohol and opioid problems in Missouri parolees and probationers. Journal of Substance Abuse Treatment, 56, 54-60.

Fiellin, D. A., Schottenfeld, R. S., Cutter, C. J., Moore, B. A., Barry, D. T., & O'Connor, P. G. (2014). Primary care–based buprenorphine taper vs maintenance therapy for prescription opioid dependence: a randomized clinical trial. JAMA internal medicine, 174(12), 1947-1954.

Gordon, M. S., Kinlock, T. W., Vocci, F. J., Fitzgerald, T. T., Memisoglu, A., & Silverman, B. (2015). A phase 4, pilot, open-label study of VIVITROL®(extended-release naltrexone XR-NTX) for prisoners. Journal of Substance Abuse Treatment, 59, 52-58.

Krupitsky, E., Nunes, E. V., Ling, W., Illeperuma, A., Gastfriend, D. R., & Silverman, B. L. (2011). Injectable extended-release naltrexone for opioid dependence: A double-blind, placebo-controlled, multicentre randomised trial. *Lancet, 377*(9776), 1506–1513.

Larochelle, M.R., Bernson, D., Land, T., Stopka, T.J., Wang, N….Walley, A.Y. (2018). Medication for opioid use disorder after nonfatal opioid overdose and association with mortality: A cohort study. *Annals of Internal Medicine.*

Lee, J. D., Friedmann, P. D., Kinlock, T. W., Nunes, E. V., Boney, T. Y., Hoskinson Jr, R. A., ... & Gordon, M. (2016). Extended-release naltrexone to prevent opioid relapse in criminal justice offenders. New England Journal of Medicine, 374(13), 1232-1242.

Lee, J. D., Nunes Jr, E. V., Novo, P., Bachrach, K., Bailey, G. L., Bhatt, S., ... & King, J. (2017). Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X: BOT): A multicentre, open-label, randomised controlled trial. The Lancet.

Magura, S., Lee, J. D., Hershberger, J., Joseph, H., Marsch, L., Shropshire, C., & Rosenblum, A. (2009). Buprenorphine and methadone maintenance in jail and post-release: A randomized clinical trial. *Drug and Alcohol Dependence, 99*(1–3), 222–230.

Mattick, R. P., Breen, C., Kimber, J., & Davoli, M. (2009). Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews*, (3), 1–32. doi:10.1002/14651858.CD002209.pub2

Mattick, R. P., Kimber, J., Breen, C., & Davoli, M. (2008). Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database Syst Rev, 2(2).

National Institute on Drug Abuse. (2012). *Principles of drug abuse treatment for criminal justice populations: A research-based guide* (p. 1). NIH Publication No. 11-5316. Bethesda, MD.

SAMHSA. (2014). Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence. 8(1).

Sees, K. L., Delucchi, K. L., Masson, C., Rosen, A., Clark, H. W., Robillard, H., et al. (2000). Methadone maintenance vs 180-day psychosocially enriched detoxification for treatment of opioid dependence. *JAMA, 283*(10), 1303–1310.

Veilleux, J. C., Colvin, P. J., Anderson, J., York, C., & Heinz, A. J. (2010). A review of opioid dependence treatment: Pharmacological and psychosocial interventions to treat opioid addiction. *Clinical Psychology Review, 30*(2), 155–166.

Volkow, N. D., Frieden, T. R., Hyde, P. S., & Cha, S. S. (2014). Medication-assisted therapies—tackling the opioid-overdose epidemic. New England Journal of Medicine, 370(22), 2063-2066.

Zarkin, G. A., Dunlap, L. J., Hicks, K. A., & Mamo, D. (2005). Benefits and costs of methadone treatment: Results from a lifetime simulation model. *Health Economics, 14*(11), 1133–1150.

Appendix B: Recovery Community Center Contact Information

Recovery Community Centers receiving funding and support through STR are listed below.

Services offered include but are not limited to: substance use support groups, peer-to-peer support, naloxone and overdose reversal training, treatment referrals, housing referrals, and substance-free social activities.

Missouri Network for Opiate Reform
4022 S. Broadway
St. Louis, MO 63118
(844)-REBEL UP (844-732-3587)
www.Monetwork.org
Drop-in Hours: Monday – Friday (10:00 am – 5:00 pm) and Saturday – Sunday (12:00 pm – 6:00 pm)
See website for groups and activities.

St. Louis Empowerment Center
1908 Olive Street
St. Louis, MO 63101
(314) 652-6100
www.Dbsaempowerment.org
Drop-in Hours: Every day (9:00 am – 3:00 pm)
See website for groups and activities.

Springfield Recovery Community Center
1925 E. Bennet St.
Springfield, MO, 65804
(417) 368-0852
www.Spfdrcc.org
Drop-in Hours: Monday – Friday (9:00 am – 9:00 pm) and Saturday (6:00 pm – 10:00 pm)
See website for groups and activities.

Healing House
4602 St. John Avenue
Kansas City, MO 64123
(816) 920-7181
www.Healinghousekc.org
Drop-in Hours: Monday – Friday (9:00 am – 4:30 pm) and Sunday (1:00 pm – 3:00 pm)
See website for groups and activities

Appendix C: Peer Ambassador Contact Information

Missouri Recovery Network (MRN) Peer Ambassadors are working to provide support to peer specialists. Their primary objectives include:

1. Develop local peer specialist networks in St Louis, Kansas City, Southeast Missouri, and Southwest Missouri.

2. Coordinate monthly support meetings for peers who are working in the area, including recovery community centers and clinical treatment programs.

3. Connect peer specialists and facilitate opportunities to share best practices, opening dialogue about problems faced as a peer and identifying local recovery resources.

4. Provide peer specialists with support, tools, and skills to ensure success, reduce burnout, and encourage peers to obtain certification.

For questions about Missouri's Peer Ambassador operations, please contact Brenda Schell with Missouri Recovery Network: bschell@morecovery.org; (573) 634-1029

Amanda Gebel
amgebel@gmail.com
St. Louis, MO
(314) 775-9139
Missouri Network for Opiate Reform and Recovery
4022 S Broadway, St. Louis, MO

Samantha Jo Stewart
sammyjostewart6@gmail.com
(417) 598-1816
The Springfield Recovery Community Center
1925 E. Bennett St. Springfield, MO
(417) 368-0852

Kristi Booth
kristi1booth@gmail.com
Kansas City, MO
(573) 837-8773

Barbie Daniel
barbiecdaniels@gmail.com
(816)-673-9248
The Healing House Recovery Community Center
4600 St. John, Avenue, Kansas City, MO
(816) 920-7181

Appendix D: Example OUD Phone Screening

Client Name: _____
Date of Birth: _____
Address: _____
Insurance Type: _____

Check All That Apply

1. Opioids

- ☐ Patient uses heroin or fentanyl
- ☐ Patient uses prescription opioids recreationally (such as OxyContin, Vicodin, Hydrocodone, Percocet, Morphine, Suboxone, etc.)
- ☐ Patient uses prescription opioids as prescribed by a doctor, but wants to discontinue these meds

2. Other

- ☐ Patients drug of choice is not opioids, but sometimes uses opioids

If ***ANY*** of the above are checked patient is a candidate for medication for their OUD and should be sent for evaluation by a physician immediately

Appendix E: Example Initial Screen for Opioid Use Presentation

Date: _____ Time: _____ Referral Source: _____

Client's Name_____ Date of Birth/Age_____

Address_____
City/State/Zip_____

Blood Pressure: _____ Pulse: _____ Respiration: _____ Temperature: _____

Drug Screen Results: _____
Alcohol Breathalyzer Results: _____

Last Treatment (when/where): _____

Name of presenting substance/s (all substances used within the last 30 days)	Age First Used	Describe any difficulty the client has had when they stopped using this substance in the past	Date Last Used	Quantity and Duration of Use	Route of administration

Medical, psychological, physical problems (including current withdrawal symptoms and thoughts of self-harm or harm to others):

Previous suicide attempts (method, date):

Summary/Initial Treatment Goals/Recommendations based on the screening:

Signature of Staff Person (name and title): _____

Appendix F: Points to cover in Overdose Education and Naloxone Distribution (OEND) trainings

(Document for clinicians)

MO-HOPE Project

Acute risk factors:

- Periods of abstinence (decreased tolerance)
- Mixing with other sedatives (benzos, alcohol)
- Injecting
- Change in supplier/dosage
- Increased purity; presence of fentanyl
- Using alone or in a new environment

Recognize signs:

- Cold, clammy skin
- Shallow breathing/no breathing
- Unresponsive
- Gurgling/snoring
- Small “pinpoint” pupils

Rescue response/ how to use naloxone:

- Check for breathing/clear airways
- Administer Narcan nasal spray
- Call 911
- Administer rescue breaths, turn person on side in recovery position
- Administer 2nd dose if no response in 2-3 minutes
- Stay with person until medical help arrives to ensure safety and prevent repeat use/overdose

Tips for prevention:

- Share this information with family/loved ones
- If you choose to use: don't use alone, avoid mixing, start small, be extra cautious when sick/in poor respiratory health
- Keep naloxone accessible and out of extreme temperatures

Overdose Field Report:

- *How to complete the overdose field report:*
  - Access the field report using one of the following methods listed on the field report instruction card *(also, on back of this sheet)*:
    1) Enter the survey link, OR
    2) If you have an app on your phone that is capable of scanning QR codes, scan the QR code.
- *Once you have accessed the survey,* ***add link to home screen*** *(see back of field report instruction card)*

Appendix G: Overdose Education and Naloxone Distribution (OEND) Fact Sheet

(Document for clients and community members)

MO-HOPE Project

- **What are risk factors for an overdose?**
  - Previous overdose
  - Period of abstinence/sobriety (e.g., following rehab or jail) → Decreased tolerance
  - A change in strength, amount, supplier of the opioid, or location of use
  - Being physically ill/respiratory disease (flu, pneumonia, bronchitis)
  - Mixing opioids with other substances (benzodiazepines, sedatives, alcohol)
  - Using alone
  - Injecting

- **How can you tell if someone's overdosing:**
  - Cold, clammy skin
  - Shallow breathing/no breathing
  - Unresponsive
  - Gurgling/snoring
  - Small "pinpoint" pupils

- **What to do if someone overdoses:**
  1. Check for breathing/clear airways
  2. Administer Narcan nasal spray
  3. Call 911
  4. Administer rescue breaths, turn person on side in recovery position
  5. Administer 2nd dose if no response in 2-3 minutes
  6. Stay with person until medical help arrives to ensure safety and prevent repeat use/overdose
  7. Complete the Overdose Field Report

- **Tips for prevention:**
  - Share this information with family/loved ones
  - If you choose to use: know your tolerance, don't use alone, avoid mixing drugs, start small, be extra cautious when sick/in poor respiratory health
  - Keep naloxone accessible and out of extreme temperatures

- **How to complete the overdose field report (see back of sheet):**
  - Access the field report using one of the following methods *(see back of sheet):*
    - Enter the survey link, OR
    - If you have an app on your phone that is capable of scanning QR codes, you may scan the QR code.
  - Once you have accessed the survey, answer the questions as honestly as possible remembering that all information will be kept confidential.

Appendix H: Overdose Field Report

If you experience, witness, or are informed of an overdose event, please complete the overdose field report as soon as you are able to do so.

To start the survey, you may use any of the choices below:

Use the Survey Link:	Scan the QR Code:
Open your browser and go to this web address: **mohopeproject.org/ODreport**	If you have a device that has an app capable of reading QR codes, you may, scan the QR code below:

To add the survey to your home screen:

Once you have opened the field report survey on your phone you can save the link to your home screen for quick, easy access later when you are in the field.

Instructions for Apple:	Instructions for Android:
Tap the share button on the browser's toolbar - that's the rectangle with an arrow pointing upward. It's on the bar at the top of the screen on an iPad, and on the bar on the bottom of the screen on an iPhone or iPod Touch. Tap the Add to Home Screen icon in the Share menu. A new icon should now appear on your home screen that with take you directly to the field report.	Tap the menu button and tap Add to Home screen. You'll be able to enter a name for the shortcut and then Chrome will add it to your home screen. This will take your directly to the field report.

For questions about evaluation, contact:
MOHOPEproject@mimh.edu
(314) 516-8420

MO-HOPE Project

Overdose Field Report

***for visual purposes only – can only be submitted online at:* mohopeproject.org/ODreport**

1. Date and time: _____ **2. Zip Code of Overdose Event:** _____

3. Your relation to the person who overdosed:

- Emergency Responder (Agency: _____)
- Parent
- Partner or Spouse
- Friend
- Other family member (non-partner, non-parent)
- Clinician or Provider
- Stranger
- Self
- Other (specify: _____)
- *Test/demo* (for training purposes only

4. Individual's state of primary residence: _____ **5. In what county did the overdose occur?**_____

6. Incident Location: A home or residence/ A treatment facility / A public place (specify: _____)/ Other (specify: _____)

7. Individual's age: Under 18/ 18-24/ 25-44/ 45-64/ 65+

8. Individual's sex: Male/ Female/ Intersex/ Unsure

9. Individual's race *(select all that apply):* White/ Black or African American/ Asian/ American Indian or Alaskan Native/ Native Hawaiian or Pacific Islander/ Unsure/ Other (specify: _____)

10. Is the individual Hispanic? Yes/ No/ Unsure

11. Type of drugs involved (circle all that apply): Heroin/ Prescription Painkiller/ Fentanyl/ Benzos (e.g., Xanax)/ Alcohol/ Unsure/ Other (specify: _____)

12. Was naloxone administered? Yes/ No (If no, skip to question 13)

If yes, who administered naloxone?

- EMS
- Fire Crew
- Police
- Other ER (specify: _____)
- A parent
- A partner or spouse
- A friend
- Another family member
- A clinician or provider
- A stranger
- Someone else (specify: _____)

What form of naloxone was used and how many doses were given? (Circle all that apply)

- AdaptPharma Narcan nasal spray (**Doses**: 1 / 2 / 3 / 4+ / Unsure)
- Evzio auto-injector (**Doses**: 1 / 2 / 3 / 4+ / Unsure)
- Other intranasal device (with vial and atomizer) (**Doses**: 1 / 2/ 3 / 4+/ Unsure)
- Intravenously (IV) (**Doses**: 1 / 2/ 3 / 4+/ Unsure)
- Other intramuscular devicev(with vial and syringe) (**Doses**: 1 / 2/ 3 / 4+/ Unsure)
- Unsure

Where was naloxone obtained? (Skip question if you are an emergency responder)

Unsure, Naloxone was administered by someone else/ Pharmacy (specify: _____)/ Treatment program (specify: _____)/ Recovery Community Center (specify: _____)/ Jail or treatment court program (specify: _____)/ Other (specify: _____)

Were there any post-naloxone withdrawal symptoms? (circle all that apply)

None/ Physically combative/ Irritable or angry/ Vomiting/ Dope sick (e.g., nauseated, muscle aches, runny nose, and/ or watery eyes)/ Other (specify: _____)

13. Was 911 called? Yes/ No/ Unsure

14. To the best of your knowledge, did the individual survive the overdose? Yes/ No/ Unsure

15. Was the individual transported to the hospital? Yes/ No, escorted to treatment center/ No, escorted to residence/ No, transported elsewhere/ No, declined transport/ Unsure

Appendix I: Addiction Versus Dependence: Medical Treatment for Addiction Group Exercise

This exercise is meant to help clients (and sometimes agency staff!) understand addiction as an attachment that causes them to compromise their own priorities. It also helps clients distinguish between the effects of medication and illicit drug use.

A. ***Take a moment to list the most important things in human life. There are no wrong answers, just start listing things as they come to you****.* Persons with or without addiction tend to create very similar lists of human priorities. Here is an example list:

Relationships	*Emotional Well-being*	*Reputation*
Health	*Friendship*	*Career Success*
Family	Spirituality	*Community*
Financial Security	*Shelter*	*Religion*
Purpose	*Food*	*Integrity*
Self-esteem	*Emotional Safety*	*Loyalty*
Physical Safety	*Principles*	*Legal status*

B. ***Which of the things we've listed on the board have you sacrificed or significantly compromised due to addiction?*** Among persons seeking treatment, the almost unanimous response is: "All of the above." Persons with addiction can easily perceive that they have compromised almost everything of value for their addiction. Sometimes the "functional alcoholic" in the room will protest that they've never lost their job. But upon probing, they usually agree that their relationships, values, self-esteem, and even work performance have suffered as a result of alcoholism. Question "B" also allows you to contrast minor dependencies such as caffeine dependence with addiction. People may routinely drink a cup of coffee in the morning and get a headache when they try to abstain. But even if coffee became hard to acquire, few people would steal from their families or sell their possessions to obtain it. Coffee causes mild physical dependence but rarely causes addiction.

C. ***Which of the things on the board have you sacrificed or significantly compromised by taking your OUD medication****?* Typically clients are a bit confused by this question because the medication has begun to help them pursue and invest in their priorities; it has not caused them to sacrifice or compromise them. On medication, clients typically start attending to the things they value—like their relationships, basic needs, and management of their mental and physical health. Helping clients to see that medication supports recovery can help them deflect the stigma they often face for taking OUD medications. This exercise can be especially helpful when a client is starting to think that they should stop their medication. When they realize what a huge difference the medication has made in their life, they often reconsider their desire to discontinue it.

Appendix J: Recovery Housing Information

Individuals treated for OUD should be made aware of **recovery housing** options for individuals if they have been through medical stabilization and need a safe, healthy environment to support engagement in treatment (including but not limited to medication services).

Before referring, please ensure that OUD recovery housing accepts people no matter their medication status and place no requirements for step-down dosing or medication tapering. Other recommended key characteristics of the recovery housing model include:

a. Participation is generally self-initiated with individuals having a preference for living in a recovery-focused environment;

b. Holistic services and peer supports are available to housing participants;

c. A “slip” or “lapse” are not treated as an automatic cause for eviction, and relapse prevention and management are supported; and

d. Assistance is provided in finding permanent housing.

Recovery housing will be coordinated by the treatment provider in accordance with the individual’s treatment plan. The treatment provider will:

- Assess that the individual with OUD served is in need of recovery housing;
- Review the list of NARR-accredited agencies; and
- Contact the recovery residence to determine space availability;
- Establish a written agreement with the recovery residence to determine payment and coordination of care.

Appendix K: Transportation Services

**NOTE: Transportation is often a large barrier for access to treatment. Therefore, STR has created billable transportation services. Please consider adding transportation to your billable services to help people better access care. An example is provided below:

Transportation - Mileage. (A0080, $0.37/mile) Transportation assists consumers in achieving and sustaining recovery goals when they do not have the means to provide personal transportation.

1. Transportation shall be limited to specific destinations and/or appointments as defined by the department. Allowable transportation services shall include:

a. To and from certified alcohol or drug treatment and rehabilitation programs;
b. To and from recovery support services;
c. To and from doctor's appointments, dental appointments, or appointments with other healthcare providers;
d. To and from probation and parole, court or other criminal justice agencies; and
e. To and from employment-seeking activities and/or active employment.

2. Staff or volunteers who provide transportation services shall meet the background screening requirements in 9 CSR 10-5.190 and hold a class E chauffeur's license, or if transporting more than fifteen (15) passengers, a CDL license.

3. The vehicle used for transportation shall be currently licensed, properly insured and provide safe and reliable transportation for consumers.

4. Transportation – Mileage is limited to 100 miles per consumer per day.

Documentation includes the consumer name, the date of transportation, the originating location name and address, the destination name and address, miles traveled, the purpose of the travel, the rendering practitioner (Driver). Each consumer being transported shall sign a transportation log. The provider shall maintain transportation logs with original consumer signatures. For confidentiality concerns, actual home address of consumer does not need to be recorded on the log, and may be recorded as "consumer's residence."

Transportation-Public (T2004, unit actual cost of buss pass) Consumers must be actively engaged in treatment services to be eligible for transportation services. Eligible transportation services include; to and from treatment, recovery support services, physician visits, dental appointments, probation and parole, court, employment seeking, and employment. The contractor may distribute bus passes daily, weekly, or monthly.

Documentation includes public transportation system name, serial number of the bus pass, purchase price of the bus pass, length of bus pass (Daily, weekly, monthly), date pass was issued, and staff member issuing the bus pass.

Appendix L: Sample brochure outlining buprenorphine clinic protocols (to adapt based on agency needs)

A quick guide to your buprenorphine program

NP drugs include all non-prescribed drugs and alcohol

Starting

How often do I need to come to the clinic?

We will give you enough medication for 3-4 days at each visit with your doctor or care manager.

When can I move to the next phase?

When your lab is:

- – heroin and painkillers
- + buprenorphine

What if this phase isn't working?

If your lab is:

- – buprenorphine

and you don't have your unused medication, we will prescribe you daily buprenorphine to take with us at the clinic.

Getting stable

How often do I need to come to the clinic?

We will give you enough medication for 1 week at each visit with your doctor or care manager.

When can I move to the next phase?

When you have 4 weekly labs that are:

- – all NP drugs except marijuana
- + buprenorphine

This phase takes at least 8 weeks.

When would I enter Starting again?

If your lab is:

- + heroin, painkillers OR
- – buprenorphine

Taking strides

How often do I need to come to the clinic?

We will give you two weeks of medication at each visit with your doctor or care manager.

When can I move to the next phase?

When you have 4 labs that are:

- – all NP drugs except marijuana
- + buprenorphine

This phase takes at least 8 weeks.

When would I enter Getting Stable again?

If your lab is:

- + any NP drug except marijuana
- + buprenorphine

When would I enter Starting again?

If your lab is:

- + any NP drugs except marijuana
- – buprenorphine

Maintaining

How often do I need to come to the clinic?

We will give you enough medication for 4 weeks at each visit with your doctor or care manager.

When would I enter Getting Stable again?

If your lab is:

- + any NP drugs except marijuana
- + buprenorphine

When would I enter Starting again?

If your lab is:

- + any NP drugs except marijuana
- – buprenorphine

These guidelines should help you know what to expect. Your physician may make different decisions based on clinical information not considered here.

For 24-hour support, call
###-###-####