# (INSERT CLINIC NAME HERE)

(INSERT TRIBAL OR DEPARTMENT LOGO HERE)

MEDICATION ASSISTED TREATMENT PROGRAM (INSERT CLINIC NAME HERE MAT)

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Cowlitz Tribal Health

###### Authors:

###### Disclaimer

The views and content of this publication are those of the authors and the (INSERT CLINIC NAME HERE) MAT Program Treatment team.

###### Originating Office

(INSERT CLINIC OR TRIBAL DEPT. NAME AND ADDRESS HERE)

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###### INTRODUCTION

###### Purpose of the Manual

The purpose of this manual is to provide detailed policies and protocols of (INSERT CLINIC OR TRIBAL DEPT. MAT PROGRAM) for the use and monitoring of suboxone, other buprenorphine containing formulations, and other medications used in the treatment of opioid use disorder (OUD), alcohol, and other drug addictions.

###### Introduction to the (INSERT CLINIC OR TRIBAL DEPT. NAME HERE) MAT Program

Buprenorphine/naloxone is an effective treatment for OUD. It is the first OUD medication available for prescription from a prescriber’s office or clinic outside a traditional opioid treatment program (OTP). Before the advent of buprenorphine/naloxone, methadone was the only Food and Drug Administration (FDA)-approved medication to treat OUD in the United States. A major limitation of methadone is that it is available only at licensed methadone maintenance OTP clinics. Providing buprenorphine/naloxone medication in a doctor’s office or community clinic—such as through (INSERT CLINIC NAME) is an important step toward expanding access to addiction treatment in traditional medical settings.

Nationally, AI/ANs use and abuse alcohol and other drugs at younger ages, and at higher rates, than all other ethnic groups (Mental Health America, 2017). INSERT LOCAL/STATE DATA Many (INSERT CLINIC NAME) patients have SUD which has significant negative consequences on their medical and mental health. Multiple (INSERT CLINIC NAME) providers have obtained Drug Addiction Treatment Act of 2000 (DATA 2000) waivers to qualify for providing buprenorphine/naloxone treatment in our clinics. The (INSERT CLINIC NAME) MAT program was established to promote, coordinate, and support opioid addiction treatment in outpatient settings.

###### Treatment Philosophy

The (INSERT CLINIC OR TRIBAL DEPT. NAME) MAT Program has adopted evidence based treatment recommendations for opioid use disorder and/or other substance use disorders set forth by the following federal agencies: Substance Abuse

and Mental Health Services Administration (SAMHSA), American Society of Addiction Medicine (ASAM),and the US Food and Drug Administration (FDA) to promote the best patient outcomes possible in alignment with (INSERT CLINIC NAME) Mission, Vision, and Values. (INSERT CLINIC NAME) MAT Program practices are based on lessons learned over past decade of addiction research. Our philosophy is that addiction is a chronic disease which negatively affects a person’s ability to function in an emotional, physical, and spiritual capacity. We are steadfast in our commitment to the Native American patients we serve as a Tribally operated and federally funded program. Our program’s philosophy is less reliant on rule-based protocols and more on an interdisciplinary team approach to make important and sometimes difficult clinical treatment decisions. Because of the complexity of the illness, (INSERT CLINIC NAME) MAT Program’s overall goal of medication assisted treatment is improved quality of life and freedom from illicit drugs.

###### (INSERT CLINIC OR TRIBAL DEPT. NAME) MAT Program Staffing

**Licensed Staff Waivered Prescribers**

* (INSERT CLINIC NAME) MAT prescribers have obtained DATA 2000 waivers to prescribe Schedule III, IV, and V controlled substances and FDA-approved medications to treat patients during medically supervised opioid withdrawal or OUD maintenance treatment. Each prescriber has a current state medical license and a valid Drug Enforcement Administration (DEA) registration number. These prescribers have completed either 8 hours of an approved training course on the management of patients with OUD or board subspecialty certification for addiction psychiatry or addiction medicine.
* Advanced registered nurse practitioners (ARNPs) and prescriber assistants (PAs) may also obtain DATA 2000 waivers to prescribe buprenorphine/naloxone. The requirements for these waivers include 24 hours of training from a certified organization such as the American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Medical Association, and any other organization that the Secretary of Health and Human Services determines is appropriate.
* For the first year after receiving a waiver, prescribers, ARNPs, and PAs are limited to treating 30 active patients at any given time; after the first year, they can apply to the Substance Abuse and Mental Health Services Administration’s Center for Substance Abuse Treatment (CSAT) for an extended waiver to treat up to 100 patients.
* Providers who have treated 100 patients for at least 1 year can apply to expand their treatment limit to 275 patients if they also meet other criteria as outlined by CSAT. ARNPs and PAs are not eligible to apply for an extension to the 275- patient limit.
* (INSERT CLINIC NAME) providers with Buprenorphine prescribing privileges will have at least one patient chart reviewed each month. All providers who are actively managing patients with Buprenorphine will attend monthly treatment team meetings and participate in the peer review process. The results of peer review meetings for Buprenorphine privileged providers will be reported on a quarterly basis to the (INSERT CLINIC NAME) Medical Staff Committee and to the (INSERT CLINIC NAME) Quality Improvement Committee. The report will be included in the Medical Staff Committee minutes. (INSERT TRIBAL STAFF) Medical Director and Quality Improvement Committee process will ensure that appropriate Focused Periodic Performance Evaluation (FPPE) review is accomplished for all prescribers who are granted Buprenorphine prescribing privileges for the first time. See also Appendix 8, Focused Periodic Performance Evaluation & Peer Review Form.
* Oversight for the overall quality of care of waivered providers and support staff for (INSERT CLINIC NAME) MAT is provided by the (INSERT CLINIC NAME) Medical Director. Clinical supervision of care takes place through ongoing monthly peer review and focused peer review as needed (see above).

###### Nurse Care Managers

* Hold a state registered nurse license.
* Complete an initial 8-hour training curriculum covering MAT with buprenorphine/naloxone, including the use of buprenorphine/naloxone for OUD treatment in office settings based on CSAT’s Technical Assistance Publication 30: Buprenorphine—A Guide for Nurses, or an equivalent training.
* Attend periodic booster trainings on topics relevant to the (INSERT CLINIC NAME) MAT program (e.g., hepatitis C treatment and management, urine toxicology screening, relapse prevention, motivational interviewing, treatment retention, harm reduction techniques, compassion fatigue), participate in case discussions, review current materials, and network with other NCMs.
* Are responsible for:
  + Overseeing buprenorphine/naloxone intake assessment, induction, stabilization, maintenance, and relapse prevention.
  + Ensuring that state and federal guidelines are followed.
  + Collaborating with (INSERT CLINIC NAME) MAT prescribers, social workers/counselors, psychiatrists, pharmacists, primary care prescribers, and specialty care prescribers to whom the patient has been referred.
  + Coordinating between MAT prescribers and pharmacists and assisting with prescription handling and refill requests.

###### Mental Health and Chemical Dependency Counselors

* Mental health and substance use disorder counseling is integrated into the (INSERT CLINIC NAME) MAT program. Licensed mental health and chemical dependency professionals provide supportive counseling, behavioral activation counseling, cognitive behavioral therapy, and other forms of therapy. Psychiatric Advanced Practice Nurse Practitioners are available for consultation and for direct patient evaluation as needed.
* Patients participating in MAT may meet with a dual credentialed mental health and substance use disorder counselor any time before induction, during therapy, or after discharge.
* Some patients participating in MAT prefer outside counseling or may already be assigned to other settings for mental health treatment. To ensure seamless coordination with outside counselors, patients sign a release of information form at intake visit so that providers can communicate with one another.
* Although mental health and substance use disorder counseling is strongly encouraged, engagement in counseling is not required to continue receiving MAT, except in cases where the patient is legally mandated to receive SUD or related treatment. (INSERT CLINIC NAME) MAT receives referrals from Drug Courts and other justice system agencies and in those cases (INSERT CLINIC NAME) has an obligation to report to those agencies on the progress of the patients with respect to their treatment plans. (INSERT CLINC NAME) MAT confers with their Drug Court and other justice system agencies to coordinate care and to fully support each referred patient’s compliance. Patients struggling with continued substance use or mental health stability are offered counseling as a way to intensify treatment in the office-based setting. In the

event of a relapse, patients meet with their treatment team and any external agencies to determine how the treatment plan can be amended to better support recovery. Relapse alone is not grounds for discharge from MAT services.

###### Support Staff Program Manager

* Directly responsible to (INSERT CLINIC NAME) Clinic Director for MAT program oversight and receives clinical direction by (INSERT CLINIC NAME) Medical Director.
* Supervise the clinic’s operations according to the organization’s administrative and clinical protocol’s, as well as all applicable federal and state regulations.
* Accountable for implementing (INSERT CLINIC NAME) policies and procedures as outlined, and in compliance with CARF standards.
* Ensures program compliance with the various regulatory bodies (SAMHSA, DEA, CARF, HIPAA, etc.).
* Assists with partnering opportunities, relationship building, and outreach to forge critical relationships to drive census growth and meet regulatory requirements.
* Provides management reporting to (INSERT CLINIC NAME) Clinic Director monthly and as requested.
* Develops, monitors and provides reports on key performance indicators of clinic measures and reacts accordingly.
* Responsible for maintenance & updating of policy & procedure manual and clinic operations manuals and procedures.
* Maintains patient, employee and company confidentiality Ensure effective coordination and delivery of (INSERT CLINIC NAME) treatment services.
* Oversight of the State Targeted Response (STR) grant and other grants related to Medially Assisted Treatment (MAT) services.
* Assists in the annual budgetary process with Clinical Director and CFO, and ensures compliance in accordance with budget during the fiscal year.
* Attends various workshops, seminars and professional meetings to keep abreast of best practice models for integration of behavioral health and substance use treatment.
* Provide, or arrange for staff development and training. Ensures clinic staff completes new employee and annual competency.
* Resolve patient grievances as needed, resolve staff complaints as needed, evaluate Incident reports as needed.
* Conducts and leads daily clinic huddles, weekly staff meetings, and monthly MAT administrative meetings.
* Function as a liaison with other community-based agencies and tribal partners.

###### Program Coordinator

* Provide administrative support to the team by addressing insurance issues, assisting with patient scheduling, and managing prescriber files (e.g., DEA numbers, state licensure).
* Manage incoming referrals and complete initial telephone screening with potential (INSERT CLINIC NAME) MAT patients.
* Collaborate with outside agencies to foster relationships with the (INSERT CLINIC NAME) MAT program and to better serve patients.
* Manage lists of patients per provider to ensure compliance with DEA requirements (i.e., provider limits of 30, 100, or 275 patients).
* Ensure adherence to SAMHSA Comprehensive Substance Abuse Treatment Model (CSAT) administrative requirements, including:
  + Obtaining certification, accreditation, and waiver approval.
  + Ensuring accurate prescriber records (e.g., keeping records on prescription and dispensation of medications for OUD detoxification and maintenance treatment in accordance with DEA regulations 21 CFR 1304.03(c)).
  + Making sure that electronic health record systems comply with federal regulations.
  + Maintaining accurate records of patient identifier, name, dose, quantity of drug prescribed/dispensed, and visits.
  + Providing DEA with records to ensure compliance with DATA 2000 regulations. Because DEA reviews only medications used in OUD treatment, program managers are encouraged to keep separate records for these medications to facilitate the review.

###### Medical Assistants

* Gathers patient’s medication history, measures vital signs, such as pulse rate, temperature, blood pressure, weight, and height, and records information on patients' electronic health record and/or chart.
* Prepares examination/treatment rooms for patient’s appointment.
* Inventories and orders clinic supplies and materials.
* Independently operates electrocardiograph (EKG), and other diagnostic equipment for in-house routine test or therapeutic equipment as ordered by licensed Prescriber or Family Nurse Practitioner.
* Administers oral and injection medication or treatments per scope of practice under the supervision of a licensed Prescriber or Family Nurse Practitioner.
* Specimen collection: Urine drug screening and venipuncture; Performs routine urine drug screens for Point of Care laboratory tests, including venipuncture/phlebotomy for the collection of blood and urine for external lab analysis.
* Observe and report patients’ signs or symptoms.
* Keys data into computer to maintain office and patient records.
* Process and track prescriber and family nurse practitioner outside medical referrals and follow ups for additional appointments.
* Enter patient visits, patient billing and financial transactions in electronic health records system.
* Participates in team huddles, MAT clinic and administrative meetings.
* Other duties as delegated by the medical staff and MAT program manager.

###### Community Health Worker

* Directly transport and/or help patients connect with transportation resources between the (INSERT CLINIC NAME) MAT program and external agencies such as in-patient treatment facilities, primary care, pharmacies, and related destinations.
* Work closely with Transportation staff to access vehicles as necessary as well as to obtain external transportation resources such as bus and train tickets, Hope Link transport, and other transportation resources.
* Pick up prescriptions when necessary.
* Assist patients in completing applications and registration forms, securing appointments for services required for in-patient services such as TB tests and test results, detox services, and related.
* Provide referrals as directed by the Nurse Care Manager to external agencies and resources.
* Provide ongoing follow-up, basic motivational interviewing and positive communication with patients.
* Assist patients who have relapsed to re-engage in services through basic motivational interviewing, positive communication and support in reconnecting with MAT and other (INSERT TRIBE NAME HERE) staff.
* Follow-up with patients via phone calls, home visits and visits to other settings where patients can be found. Follow-up should be continuous from initial assignment through closure or discharge, and subsequently for re-engagement where necessary and as directed by the Nurse Care Manager.
* Document all services in the electronic health record or other database(s) within 24 hours of service or as directed by the Nurse Care Manager. Prepare reports as directed.
* Participate in case staffing, consult and other forms of staff collaboration and care coordination as directed.
* Attend regular staff meetings, trainings, and meetings external to the MAT program as directed.
* Manage assigned caseload of patients.
* Exhibit excellent working relationships with patients, staff, visitors and anyone who comes in contact with our clinic, effectively projecting the mission and vision of the (INSERT CLINIC HERE).

###### PROGRAM PROCEDURES

**Eligibility Criteria**

1. The following individuals are eligible for (INSERT CLINIC HERE) MAT services:
   * Member of the (INSERT TRIBE HERE) Indian Tribe
   * Alaska Native enrolled with a Corporation, Village, or Alaska Bureau of Indian Affairs.
   * Member of a Federally Recognized Tribe
   * Direct descendent (within two generations) of a Member of a Federally Recognized Tribe/AK Native (mom, dad, or grandparents must be enrolled)
   * Spouse of a Native
   * Step child of a Native, must be in household
   * Custodial grandparent of a Native American (Non-Native)
   * Custodial and non-custodial parent of an eligible child
   * State Recognized Tribes with a billable resource
   * First Nation, Canadian Tribal Member with a billable resource
   * Self-Attesting Native Adult/Adolescent with a billable resource
   * At least 18 years old
2. The following individuals are not eligible for services:
   * Those who do not meet the above listed criteria.
   * Those who do not meet medical necessity.
   * If diagnosis level of care is not within the scope of (INSERT MAT

###### Referral to (INSERT CLINIC HERE) MAT

Referrals are accepted from a variety of sources including other (INSERT CLINIC TRIBAL DEPT. HERE) programs, primary care prescribers, needle syringe exchange programs, hospital emergency rooms, inpatient units, jails, drug court and self-referrals. MAT staff consider the following when evaluating a referral:

* Patient must meet Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5) criteria for a moderate to severe OUD or SUD.
* Patient must be in stable mental and physical health or engaged in appropriate treatment to address these issues.
* Patient must be willing to comply with program requirements.
* Patient must agree with the goals of the MAT program, which are to:
  + Prevent or reduce withdrawal symptoms and cravings for substances through use of medications.
  + Restore normal physiological functions that may have been disrupted by drug use and improve quality of life.
  + Address any psychiatric problems.
  + Address other medical issues, including preventive health and co-morbidities that may be the results of substance use.
* Patient must be able to meet the following logistic requirements:
  + Can attend required visits during hours of office operation.
  + Can comply with visit and counseling recommendations.
* Patient must not have chronic pain issues requiring additional opioid management beyond buprenorphine/naloxone. Patients with co-occurring OUD and chronic pain can often obtain adequate pain relief with buprenorphine, in conjunction with other non-opioid therapies.
* Patient’s required level of care cannot exceed higher levels of care with more intensive management (e.g., daily monitoring and assessment, medication administration because of advanced psychiatric illness).
* Patient must be willing to work toward recovery goals and abstinence from other illicit substances and not drinking alcohol. Discontinuation of other substances before induction is not typically required, although inpatient medical detoxification may be necessary for patients with heavy alcohol or nonprescribed benzodiazepine use.

###### MAT Staff Screening

Screening is completed either by phone or in person and includes the following components:

* Medical, social, and substance use histories, as well as current use, are reviewed. Demographics, living situation, insurance coverage, safety issues, and treatment goals are also examined (see Appendix 1: Telephone or In-Person Screening for Buprenorphine/Naloxone).
* Patients prescribed controlled substance, especially benzodiazepines and stimulants, must agree to consider alternative treatments and sign a release allowing coordination of care between the (INSERT CLINIC HERE) MAT team and the prescribing provider. Users of alcohol or illicit benzodiazepines who are at risk of significant withdrawal will need assessment by the treating prescriber or provider to determine whether medical detoxification needs to be coordinated with MAT treatment initiation.
* Program expectations are briefly reviewed, and patients determine whether they can meet these expectations.
* Intake appointments with the NCM and prescriber are typically scheduled but may also be done on a walk-in basis.
* Urine drug screen (UDS) testing can be completed during the in-person screening with the patient’s permission.

###### NCM Intake

Intake is completed by a NCM or their designated staff during an in-person visit. The intake appointment with the NCM can occur on the same day as the patient’s visit with the waivered prescriber or provider. It includes the following elements:

* Patients’ medical histories, medications, addiction histories, and results from physical exams, if needed, are assessed. The NCM also confirms the DSM-5 diagnosis of moderate to severe OUD and assesses appropriateness of buprenorphine/naloxone treatment in the office- based setting (see Appendix 2: Nurse Care Manager Intake Tool).
* Patients who are not currently physically dependent on opioids (e.g., those who have been released from incarceration) must have a prior moderate to severe OUD diagnosis that can be documented through medical or addiction treatment records or physical exam findings.
* UDS and other baseline laboratory tests are completed per MAT protocol and standing orders. These tests include complete blood count; comprehensive metabolic panel, hepatitis panel; pregnancy test (required on all people who could become pregnant, unless not clinically indicated); and HIV testing.
* Patients complete a behavioral health screening including the Patient Health Questionnaire (PHQ9), Generalized Anxiety Disorder Screener (GAD7), and PTSD Checklist for DSM-5 (PCL5).
* Patients receive education on buprenorphine/naloxone: what it is, how it works, medication administration, interactions, safety, storage, self-care, induction, maintenance, detoxification, tapering, and withdrawal. They also review and sign treatment consent forms (see Appendix 3: Sample Consent Forms).
* The NCM explains program expectations. Patients review these expectations and sign medication consent form and medication orientation packet (see Appendix 4: Buprenorphine Treatment Agreement).
* The NCM checks the state prescription drug monitoring program (PDMP) database to find out what controlled substances patients have been prescribed and how often they have been prescribed these medications.
* The NCM makes a plan for induction. This entails making a recommendation to prescribers as to whether the patient can begin treatment through home induction or whether in-office induction is warranted. In-office induction is preferred when the patient’s diagnosis must be confirmed, when the patient is transitioning from methadone, or when the patient has experienced previous adverse reactions.
* The NCM educates patients on overdose prevention, including how to use naloxone and where to access naloxone kits.
* At this time the patient will also receive an orientation packet and the NCM or designated staff and patient will sign the packet verifying they have gone over all of the above

information and additional information in the orientation packet with the patient. See appendix 10 Orientation Packet.

* NCM intake and information gathered will be documented in the patient chart.

Note: (INSERT CLINIC HERE) MAT embraces low barrier approach to services and strives to be rapid and responsive to patients who need MAT. Where possible our agency works to engages patients in services same day they are referred for services. In the event a patient presents needing MAT services and there are no available MAT appointments, clinical staff will work with (INSERT CLINIC HERE) MH and SUD programs to coordinate interim care until next available MAT intake. As a Tribally operated program, in these situations MAT will give priority to patients as follows and in the following order: 1) Tribal Members, 2) AI/AN patients, 3) pregnant patients, and 4) patients who are IV drug users.

###### Visit with Waivered Prescriber or Provider

* The first visit with the prescriber includes conducting medical, mental health, and SUD histories; completing other appropriate screening (e.g., physical exam, lab tests); confirming a moderate to severe OUD diagnosis, and the creation of the person-centered plan. Person centered plan will include (See also MH.3 Individual Service Plan and SUD.3 Individual Service Plan):
  + The identification of the needs/desires of the person served.
  + Specific treatment objectives.
  + Identification of specific interventions, modalities, and/or services to be used.
  + Frequency of specific interventions, modalities, or services.
  + Safety plan (as appropriate).
* If the patient is a good candidate for MAT, the provider writes a prescription not to exceed seven days for buprenorphine and gives it to the NCM for the induction appointment.
  + In circumstances where a patient is admitted into an inpatient treatment facility as part of their treatment plan the prescriber may authorize a longer prescription to accommodate the needs of the patient and the procedures of the inpatient facility. In these cases a care coordination plan with the inpatient facility will be developed.
* If the patient has completed the NCM intake and has been cleared to safely start medication at home, the prescriber arranges with the nurse for the patient to begin same-day home induction. See also: https://[www.ncbi.nlm.nih.gov/pmc/articles/PMC2849656/.](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2849656/)
* Before leaving the clinic, the patient receives education on overdose prevention and a prescription for naloxone.
* Provider will document the visit, including the person-centered plan, in the electronic health record.
* The PDMP must be assessed in advance of initial consult with the provider or during visit before buprenorphine is to be prescribed to the patient per Washington Health Care Authority requirement.

###### Mental Health Intake Appointment

* Mental health services are optional but strongly encouraged and, in consultation with the treatment team, can be initiated at any point. Where there is medical necessity for mental health services patients may engage in culturally informed services with (INSERT CLINIC HERE) or can also choose to engage in counseling outside (INSERT CLINIC HERE).
* To engage a MAT patient for mental health services a referral must be completed on the patient’s behalf and given to the Mental Health Care Coordinator for scheduling.
* The Mental Health Care Coordinator visits with the patient for 60 minutes to establish rapport, understand the patient’s mental health and addiction histories, and assess mental health needs. At the end of the session, a follow-up visit is scheduled.
* After the visit, the mental health counselor generally discusses the patient’s plan of care with the consulting psychiatric nurse practitioner and/or the treatment team.
* The mental health care coordinator informs the provider of any concerns about candidacy for the (INSERT CLINIC HERE) MAT program.

###### Induction

Induction is performed by the NCM either in the office or at home with support by phone. Home induction is preferred to avoid delay in starting medication. An office induction may be indicated if withdrawal needs to be documented for diagnostic reasons, the patient is transitioning from methadone, the patient has experienced a previous adverse reaction (e.g., an allergic reaction or precipitated withdrawal), or the patient prefers to be at the clinic. Other factors such as level of support, stability, employment status, history of crack/cocaine or sedative/benzodiazepine use, prior buprenorphine use and severity of substance abuse should also play a role in determining which patients will be comfortable and successful with a treatment strategy that draws on self- management skills and therefore should influence decisions about the appropriate induction type for particular patients.

(See: https://[www.ncbi.nlm.nih.gov/pmc/articles/PMC2849656/)](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2849656/))

###### Day 0: Office Induction

* + The NCM sends the prescription to the pharmacy, and patient will pick up medication from pharmacy before appointment. When appropriate (ie. patient is unable) MAT staff will pick up medication prior to scheduled appointment.
  + The patient arrives at the clinic in early withdrawal.
  + The NCM assesses symptoms with the Clinical Opiate Withdrawal Scale (COWS). If the COWS score is higher than 8, the NCM instructs the patient to take an initial buprenorphine/naloxone 4/2 mg dose as prescribed (see Appendix 5: Induction Protocols).
  + The patient removes the initial buprenorphine/naloxone dose from the medication bottle and takes the dose sublingually (i.e., places it under the tongue). The nurse observes the patient and provides additional administration instructions if necessary.
  + After 30–60 minutes, the NCM reassesses the patient using COWS, instructs the patient to take a second 4/2 mg dose sublingually if needed, and again observes and supervises the patient for proper administration. The second dose is not needed if the patient shows improvement in the COWS score or feels subjectively better. The second dose may be reserved to take at home later in the day when symptoms of withdrawal worsen or return.
  + The NCM provides the patient with written instructions and a follow-up plan that includes the clinic’s telephone number and a list of scheduled clinic visits.
  + The NCM telephones the patient later in the afternoon, the following day, and as needed and schedules a return clinic visit within 1 week. Patients will not receive more than a 7-day supply of medication at the time of induction.

###### Day 0: Home Induction

* + The NCM reviews instructions for home induction, including signs and symptoms of withdrawal, dosing, and safe storage. The patient is given written instructions. This can be done at NCM intake if the patient is a candidate for home induction.
  + The NCM and patient agree on a start date and time and develop a phone follow-up plan.
  + The NCM sends the prescription to the pharmacy for the patient to pick up.
  + The patient assesses symptoms to ensure and if in withdrawal as defined by instructions, administers an initial buprenorphine/naloxone 4/2 mg dose as prescribed (see Appendix 5: Induction Protocols).
  + The NCM telephones the patient later in the afternoon, the following day, and as needed and schedules a return clinic visit within one week (See also Health Care Authority Clinical Guidelines and Coverage Limitations for Medication Assisted Treatment, Effective: June 2018). Patients will not receive more than a 7 day supply of medication at the time of induction.
  + Initial induction prescription strengths may differ between individuals and alternate schedules will be documented in the individual plan.
* **Day 1:** The patient checks in with the NCM by telephone. The medication is taken per prescription instructions and until symptoms stabilize.
* **Day 2 through Day 5:** The NCM may check in with the patient as needed during the week. The patient is instructed to return to the clinic as needed and no later than 1 week following induction.

###### Stabilization

Stabilization involves weekly appointments with the NCM and follow-up with the prescribing provider within the first month after starting medication.

* Goal: Stabilize medication dose and engage patient in the treatment plan.
* The target buprenorphine/naloxone dose is 16 mg/day or less. BID dosing (i.e., twice daily dosing) is especially helpful for patients with chronic pain to maximize the analgesic effect of the medication.
* Daily doses higher than 16 mg can be considered to address persistent opioid use, craving, or withdrawal symptoms, but usually not until after week 3 or 4. For patients with Apple Health, the Washington State Healthcare Authority allows up to 32mg per day without prior authorization for patients who meet DSM-IV criteria for opioid dependence or DSM 5 criteria for moderate or severe opioid use disorder. Forms to request over 32mg/day can be found at: https://[www.hca.wa.gov/billers-providers-partners/programs-and-services/apple-health-](http://www.hca.wa.gov/billers-providers-partners/programs-and-services/apple-health-) medicaid-drug-coverage-criteria.
* The patient returns to clinic after taking the medication for 1 week. The NCM repeats a UDS, assesses symptoms of withdrawal and craving, and refills the prescription as appropriate. Prescriptions are limited to a 1-week supply during this phase. Because symptoms of withdrawal and craving are common in the first week or two and lessen over time, usually the dose is not increased before week 3 or 4.
* A urine drug screen documenting the buprenorphine is being taken (either a GCMS or LCMS for buprenorphine and norbuprenorphine) should be collected twice during the 1st month of treatment.
* Washington State Health Care Authority guidelines require at least 2 UDS per month for people on Medicaid.
* The patient sees the NCM or prescriber weekly for 4 to 6 weeks or until stable. If UDS results are appropriate and the patient attends weekly visits, then the patient generally progresses to the maintenance phase.
* If the patient has an alcohol use disorder history and is currently drinking, consider additional monitoring with breathalyzer and/or urine ethyl glucuronide UDS.
  + Alcohol use disorder medications (e.g., gabapentin, topiramate, acamprosate, or disulfiram) may be offered to patients.
  + Patients managed on buprenorphine/naloxone cannot simultaneously be treated with naltrexone.

###### Treatment Agreement Review (see Appendix 4: Buprenorphine Treatment Agreement)

* Goal: Engage the patient in the treatment plan and individualize treatment to meet the patient’s needs.
* Because the initial focus is on medication adherence and adjustment, other elements of the treatment plan may need reinforcement.
* The NCM or prescriber and patient review the treatment agreement several times during treatment to reinforce expectations and answer questions: at intake, a few weeks after treatment is initiated, and annually thereafter or more frequently as needed. This review includes several components:
  + Make clear that the rules and expectations are reviewed with all patients being treated with buprenorphine/naloxone and that they apply to all patients equally. Patients who cannot comply with the treatment agreement may be better served in other treatment settings.
  + Set clear expectations and guidelines. In addition to specific items, the rules and expectations can include general items such as the prescriber’s philosophy of treatment for substance use.
  + Encourage patients to ask questions.
  + Review the treatment agreement together and provide it in written form. After they sign and date the form, patients should be given a copy of it to take home. The original is filed in the patient’s record. An abbreviated “Friendly Reminders” version of the treatment agreement may be given to patients at their third or fourth follow- up visit.
  + Reassure patients about common issues that others have experienced. Patients may have concerns about entering treatment or changing from other medication treatment settings (e.g., methadone). Ambivalence about these changes should be addressed. Patients should understand that treatment is maintenance and should be continued for at least 6 months.
  + Ensure patients can contact a member of the (INSERT CLINIC HERE) MAT team during business hours.

###### Maintenance

Maintenance involves visits with the NCM every 2 to 4 weeks and with the waivered prescriber or provider every 3 months.

* Goal: Establish a stable dose of buprenorphine with sustained abstinence from opioids and less frequent clinical monitoring.
* Initially, clinic visits are scheduled with the prescriber or NCM every 2 weeks with refills that coincide with visits.
* Each decrease in visit frequency requires consensus of the treatment team.
* Twice monthly UDS are required for patients on Medicaid.
* Prescribers can review annual labs from outside PCP or order as indicated.
* Follow-up clinic visits include (see Appendix 6: Nurse Care Manager Follow-up Form):
  + UDS testing.
  + Assessment of status. This involves a discussion of recovery, relapse, and relevant medical issues.
  + Review of current buprenorphine/naloxone dose, adherence, correct administration techniques, side effects, and any difficulties obtaining or taking buprenorphine/naloxone.
  + Review of the treatment plan. This may include counseling, meetings, need for further psychiatric treatment, and other recovery supports.
  + Review of contact information, including pharmacy information to ensure prescriptions are faxed to the correct pharmacy.
  + Medication refills. Prescription should last until the next scheduled appointment. Refills are faxed to the patient’s preferred pharmacy at the end of the visit.
  + Check of the PDMP database every 3 months and as needed. Unexpected results are discussed with the patient.
* Visits with the waivered (INSERT CLINIC HERE) MAT providers occur at least every 3 months. These visits include a review of medical and mental health issues, lab test results, recovery status, and UDS results.
* The NCM is available for treatment support and planning by phone in between scheduled visits. The treatment plan may be affected by medical issues, pregnancy status, medication changes, pending needs for surgery, acute/chronic pain management, or need for psychiatric assessment.
* The intervals between appointments can be decreased and prescription quantity adjusted if more treatment support is indicated because of relapse to opioid use, medical needs, or psychiatric destabilization.
* For providers and patients in rural areas where there is not ready access to transportation, the week 3 and week 4 visits may be conducted by phone. A fourteen-day supply of medication may be prescribed in these instances. These phone visits must be scheduled at the time of the week 2 visit. The need and indication for conducting phone visits to replace in person visits must be clearly documented in the medical record, and telephone visits are not a reimbursable service.

###### Tapering and Relapse Prevention

Maintenance therapy is the recommended course of treatment. Risk of relapse during or after taper should be carefully considered with the patient. Tapering may be initiated voluntarily by the patient or given to the patient as an alternative when discussing referral to another treatment program. In the event of a taper, review the following with the patient:

* Upon abrupt discontinuation, a mild to moderate withdrawal syndrome will occur.
* Subjective withdrawal symptoms begin within the first 3 days, peak between 3 and 5 days, and return to baseline usually within 10 to 14 days, maybe longer. Post-acute withdrawal symptoms or craving often persist for months.
* Autonomic withdrawal signs (e.g., lacrimation, rhinorrhea, tremors, chills, gooseflesh) may occur.
* General complaints include restless legs, insomnia, anxiety, and abdominal distress.
* Buprenorphine/naloxone should be tapered over days, weeks, or months, depending on patient tolerance of symptoms.
* Following a taper, the provider and patient should consider treatment with intramuscular naltrexone for relapse prevention.
* If the taper is voluntary, the NCM maintains periodic contact with the patient. The treatment team should observe a low threshold for restarting buprenorphine if the patient identifies a need to restart medication.

###### Prescription Procedure

* Specific protocols are followed when handling prescriptions.
  + Prescriptions are ordered by the waivered prescribers through the electronic medical record, printed, signed, and given to the MAT NCM or program manager.
  + The NCM faxes the prescription to the pharmacy on record following a scheduled visit or phone encounter.
  + After the prescription has been faxed, the NCM verifies and documents the fax confirmation.
  + Prescriptions are destroyed in a secure recycle bin.
  + Prescription records are maintained in the electronic health record system for review by clinicians as needed and for DEA regulatory purposes.
* Patients should keep scheduled appointments to obtain prescription refills.
* Prescribers must see patients at least every 3 months in order to prescribe controlled medications.
* Special precautions should be taken when a patient reports that the buprenorphine/naloxone medication has been lost, stolen, or destroyed.
  + Lost, stolen, or destroyed prescriptions and medications are generally not replaced. Patients are informed of this at the time of intake. This notification is stated verbally and included in writing in the treatment agreement.
  + Cases are reviewed individually by the (INSERT CLINIC NAME) MAT team, if requested by the patient, and a decision will be rendered. The team may decide to replace the medication or note, after case review.
  + If a patient loses the medication and the prescription is for more than 1 week, the prescription amount will go back to weekly prescriptions until the team thinks it is safe for the patient to be given a larger quantity of medication.
  + Recurrence of lost, stolen, damaged, or destroyed medications may lead to referral to a more structured treatment setting.
  + All reports of lost, stolen, or destroyed medication are tracked in a log that includes patient name, quantity of lost medication, and recommendations of the treatment team regarding replacement.

###### UDS Procedure

* UDS samples are generally required at each visit. An order for a urine drug screen is not required with the initial request for buprenorphine prior to initiating treatment, but urine drug screens must be performed during the first month of treatment.
* All belongings (e.g., coats, bags) are left in the office of the medical assistant or outside the bathroom door. Patients may keep their wallets and cell phones with them.
* The patient hands the UDS sample to the gloved medical assistant in a biohazard bag.
* UDS results will be documented in patient’s medical record in EHR.
* Urine drug test must include: buprenorphine, methadone, oxycodone, benzodiazepines, amphetamines, methamphetamines, cocaine, aand other opiates (testing THC, barbituates, other substances should be guided by medical necessity. Serial testing with supporting documentation by provider to be covered by Medicaid.

###### TREATMENT DECISION-MAKING

Decisions to change the treatment plan, setting, or structure are guided by the program treatment philosophy.

* Priority is placed on continuation of medication treatment, whether in the office-based setting or elsewhere.
* Decisions should be based on patterns of patient behavior rather than on single data points (e.g., one UDS result, a missed appointment).
* Patients may make progress in one or more domains of addiction severity (i.e., social, family, legal, employment, mental, or physical health) before full discontinuation of substance use; progress in any area may be rationale for continuation of treatment in the office-based setting, at least temporarily.
* Challenging situations or decisions about changing the treatment setting should be addressed by the treatment team.

Central to treatment is the support and consistency provided for patients and all providers by the (INSERT CLINIC HERE) MAT team, which meets weekly when most or all team members are available. This process becomes the foundation of a consistent and fair treatment milieu.

* By discussing difficult clinical situations and clinic policies, team members develop consistent practices, shared knowledge, and confidence that clinical backup is close at hand, thus minimizing staff stress and burnout.
* Attention to unintentional bias in clinical decision-making can be facilitated in an open and supportive group setting.
* Even team members who cannot regularly attend team meetings benefit from the support and shared decision-making that occur during these meetings.

Many patients receiving (INSERT CLINIC HERE) MAT services have court ordered treatment and reporting requirements. These requirements can often affect the treatment plan and treatment decision making. (INSERT CLINIC HERE) MAT staff works closely with (INSERT CLINIC HERE) SUD to ensure legally mandated treatment requirements and reporting requirements are met. See also SUD.28 Outpatient Services for Persons Subject to RCW 46.61.5056, SUD.32 Involuntary and court ordered treatment- Noncompliance Reporting, and SUD.33 Involuntary and court ordered- Driving under the influence.

###### ADDRESSING SUBSTANCE USE DURING TREATMENT

Persistent illicit drug use during the stabilization period is common, and relapse of varying severity can occur during the maintenance phase. Illicit drug use is generally reported by the patient and confirmed by UDS results, but illicit use can also be initially identified by UDS.

* Patterns of drug use and resulting effects on recovery vary considerably, at times making treatment decisions difficult or ambiguous.
* Getting the patient’s perspective on progress in treatment and any challenges to recovery is the first step in evaluating evidence of persistent substance use. Each story is different, and identifying key details requires assessment of evolving patient circumstances.

###### Self-Report vs. UDS Results

When ongoing illicit substance use is reported by the patient, a collaborative plan can be developed. The plan should pay particular attention to whether the home environment is conducive to recovery or includes key social supports who are actively using substances.

* In general, working toward patient-identified goals is preferred over provider admonitions to stop illicit substance use. When a patient is allowed to lead changes in the treatment plan and is not successful, collaborative agreement on a transition to a different treatment setting is more likely.
* In spite of reassurance that disclosure of use will not threaten continuation of treatment in the office-based setting to the same extent as persistent use without disclosure, patients can be embarrassed by or not recognize the severity of their substance use. Recognizing that disclosure of use is difficult for patients at times and requires considerable trust in the treatment team can provide perspective for providers and the team.

Strategies for assessing differences between patient self-report and UDS results depend on the specific UDS testing strategies of the clinic.

* Knowledge of the characteristics of the UDS test being used and any laboratory protocols for reflexive testing of positive tests is important in creating clinic policies.
* Some programs await confirmation of positive tests before making treatment decisions, whereas other programs call patients back within 24–48 hours to repeat the testing if self- report and UDS results differ.

Note: (INSERT CLINIC HERE) MAT will work closely with (INSERT CLINIC HERE) SUD to ensure that UDS results are reported to Drug Court per the terms of the participation of the patient as a Drug Court defendant. See also SUD.28 Outpatient Services for Persons Subject to RCW 46.61.5056, SUD.32 Involuntary and court ordered treatment- Noncompliance Reporting, and SUD.33 Involuntary and court ordered- Driving under the influence.

###### Buprenorphine Adherence and Diversion

Buprenorphine adherence is crucial to successful treatment. Nonadherence can occur for a variety of reasons and may be self-reported or found on a UDS that is negative for buprenorphine metabolite (norbuprenorphine).

* Urine drug screens and/or random call backs of patients requesting they return to the clinic within a specified time frame with their remaining medications for a pill count must be conducted at least every month during the first 6 months for patients new to buprenorphine or more often at the discretion of the provider. After six months, urine drug screens and/or

pill counts can be performed at the discretion of the provider but must occur no less often than every six months.

* The Prescription Monitoring Program database must be checked at three-month intervals for the first six months and then at the provider’s discretion but no less frequently than every six months for clients receiving ongoing maintenance treatment.
* Urine drug screens must include testing for buprenorphine, methadone, oxycodone, benzodiazepines, amphetamine/methamphetamine, cocaine, and other opiates. Testing for barbiturates, THC and other substances should be guided by medical necessity. Documentation should support the request for testing of additional substances. Serial quantitative testing is not considered medically necessary and will not be covered.
* Early in buprenorphine treatment, patients who relapse may be afraid to continue buprenorphine, for fear of precipitated withdrawal. Patients need reassurance that once they have been through induction, they are not at risk for precipitated withdrawal even if they relapse and that they should continue with their buprenorphine medication.
* Incarceration can also disrupt buprenorphine adherence. If patients have completed detoxification while incarcerated, their opioid tolerance will be lower. Consider reinitiating buprenorphine/naloxone at a lower dose or transitioning to extended-release injectable naltrexone.
* Finally, buprenorphine adherence can be disrupted when patients raise their dose without prior discussion with their providers. In this situation, patients should be urged not to change their dose (“don’t be your own doctor”) and returned to scheduled weekly visits so that they can be accurately assessed on the prescribed dose.
* If pain is involved with buprenorphine dose escalation, efforts should be made to provide alternative pain treatment strategies.

Despite careful discussion of what the program considers diversion, patients may feel pressure to lend or give medication as a way of “helping out” a member of their social group.

* If patients who report taking buprenorphine regularly are found to have a UDS result without buprenorphine metabolites, diversion and/or submission of a false urine specimen are possibilities.
* An observed urine specimen collection should be done.
* Some urine screening tests may not be adequately sensitive to detect buprenorphine doses less than 4–6 mg, requiring a confirmatory test.

Providers can call the patient back between dispensing visits to be sure the patient has the medication. As a routine practice MAT staff will instruct patient to bring empty buprenorphine packets to follow-up appointments for accountability, which is to be documented in patient’s

medical record in EHR. Diversion is usually grounds for changing the treatment setting to an OTP for daily buprenorphine dispensing or methadone maintenance.

###### Ongoing Illicit Opioid Use

Ongoing or recurrent opioid use during treatment should lead to maintaining or returning to weekly visits.

* Buprenorphine adherence needs to be addressed and ensured.
* Craving and signs and symptoms of opioid withdrawal should be assessed, and a buprenorphine dose increase considered.
* A PDMP check is indicated.

An increase in treatment intensity is often the best response, but if the patient does not respond positively to buprenorphine, consideration should be given to switching to methadone or naltrexone.

###### Ongoing Illicit Non-Opioid Substance Use

Because no medications are available to treat SUDs other than opioid and alcohol use, progress in treatment of illicit non-opioid substance use is usually tied to improvement in social support, formal or informal.

* Ongoing or recurrent non-opioid illicit substance use usually leads to maintaining or returning to weekly visits and intensification of treatment. Positive UDS results for methamphetamine should be confirmed by a more specific test if the patient does not admit to use, because false-positive test results are common.
* Illicit benzodiazepine use should prompt a PDMP check, consideration of the possibility of serious benzodiazepine withdrawal, and, for those with significant anxiety, consideration of an underlying psychiatric condition.
* Alcohol use may necessitate breathalyzer testing and consideration of alcohol use disorder treatment, including medications (other than naltrexone).
* More severe presentations of alcohol or benzodiazepine problems (e.g., emergency room visits, clinical intoxication or sedation) require prompt consideration of alternative treatment settings.

(INSERT CLINIC HERE) will comply with all reporting requirement for (INSERT CLINIC HERE) MAT patients referred by Drug Court or other justice system agencies and participating in the (INSERT CLINIC HERE) Substance Use Disorder program.

Where appropriate and in the clinical judgement of the treatment team (INSERT CLINIC HERE) will advocate for the patient in the reporting process. See also SUD.28 Outpatient Services for Persons Subject to RCW

46.61.5056, SUD.32 Involuntary and court ordered treatment- Noncompliance Reporting, and SUD.33 Involuntary and court ordered- Driving under the influence.

###### UDS Tampering

* If a urine sample is deemed questionable by clinic staff (e.g., specimen is cold), the test should be repeated the same day. Random observed urine tests can be conducted by same-sex personnel if absolutely necessary; however, this is not routine. Some programs may have access to alternative clinical laboratories with chain-of-custody procedures for observing and ensuring accurate results.
* A UDS found to have high levels of buprenorphine and no buprenorphine metabolite is consistent with adding buprenorphine directly to the urine sample.
* Patients suspected of taking illicit opioids instead of prescribed buprenorphine could be asked to take a buprenorphine dose under supervision to assess for precipitated withdrawal.
* UDS tampering reduces available clinical information, questions the therapeutic alliance, and makes collaborative treatment planning difficult. Thus, if urine tampering is identified more than once, a transfer to a difference treatment setting should be strongly considered. Programs where alternative medication treatment is not available will have to make difficult decisions about the risks and benefits of continuation of buprenorphine in this situation.

###### Relapse During the Maintenance Phase

* Exploring changes in mental health, relationships, employment, and other circumstances is important to identify possible triggers for relapse. Patients may be embarrassed and not disclose promptly, so care should be taken to encourage disclosure as a strategy that allows continued treatment more readily than discrepancy between self-report and drug testing results. Often such patients can return to better function by addressing a previously ignored trigger.
* Patients with substantial treatment success may be the best judge of the response to relapse, so treatment staff should trust patients’ judgment on the best way to proceed.

###### Progress Notes/ Revision of the Treatment Plan

Each patient visit to the (INSERT CLINIC HERE) MAT program will be documented in EHR as a progress note. Progress notes will include:

1. Progress toward achievement of identified:
   1. Objectives.
   2. Goals.
2. Significant events or changes in the life of the person served.
3. The delivery and outcomes of specific interventions, modalities, and/or services that support the person-centered plan.
4. Changes in:
   1. Frequency of services.
   2. Levels of care.

All progress notes are signed and dated by the provider automatically in EHR.

The treatment plan may need revision to address ongoing clinical instability. A collaborative and patient-centered plan to intensify treatment in a supportive environment is ideal. Revisions to the treatment plan may include:

* + - More frequent visits and urine testing.
    - Shortened prescriptions.
    - Loss of refill privileges.
    - Addition or increased intensity of group or individual psychosocial treatment or sober support.
    - Increased intensity of mental or physical healthcare.
    - Changes in the recovery environment.

###### Evaluation of OBOT Effectiveness

Situations in which the (INSERT CLINIC HERE) MAT team may recommend a higher level of care include:

* + - Ongoing opioid use despite adequate buprenorphine/naloxone dosing (as evidenced by the absence of cravings and withdrawal and adequate opioid blockage).
    - Negative UDS results for buprenorphine/naloxone.
    - Ongoing abuse of higher doses of benzodiazepines or barbiturates causing impairment, sedation, overdose, medical events, or hazardous behaviors despite interventions by the (INSERT CLINIC HERE) MAT team.
    - Use of alcohol causing sedation, impairment, or hazardous behaviors despite interventions by the (INSERT CLINIC HERE) MAT team.
    - Continued use of cocaine or other stimulants despite intensification of treatment with more frequent (INSERT CLINIC HERE) MAT visits and monitoring.
    - Threatening or abusive behavior.

###### Changing the Care Plan

All decisions to refer patients to a higher level of care are made by consensus of the treatment team. Continuation of medication treatment is a priority, and patients are encouraged to continue services in the clinic whether or not buprenorphine prescribing is continued.

The NCM or prescriber reviews treatment options with the patient and asks the patient to consider these options until the next scheduled clinic appointment, ideally in 1 week. At that time, the patient is asked to select the treatment option that meets their needs. Medication is continued while the patient considers options. Treatment options include:

* + - Directly observed treatment with buprenorphine.
    - Inpatient or residential addiction treatment (preferably with buprenorphine).
    - Methadone maintenance.
    - Dual diagnosis/addictions clinic admission.
    - Intensive outpatient treatment (preferably with buprenorphine).
    - Detoxification.
    - Discontinuing buprenorphine prescribing (“taking a break from treatment”).

At the next visit, the team initiates a referral based on the patient’s decision. Medication is continued until the patient connects with the alternative treatment setting. Patients who can be stabilized at a higher level of care may be eligible to return to OBOT at a later date. Patients may also choose to discharge from treatment, in which case they are given a 1-week prescription with which to taper.

###### Transition and Discharge

Patients who are receiving (INSERT CLINIC HERE) MAT services may be transitioned/exited (discharged) based on the following criteria:

1. Patient has been able to achieve the goals articulated in their individual treatment plan.
2. Patient requires higher level of care.

In most situations the treatment team will staff the case during its weekly MAT clinical meeting to discuss alternative treatment options before a consensus decision is made regarding retention versus discharge. A discharge summary is completed when a patient stops receiving services at (INSERT CLINIC HERE) planned or unplanned.

Discharge/transition summaries will be documented in the patient’s EHR and will include:

* + - Date of admission
    - Services provided
    - Diagnosis upon intake
    - Presenting condition
    - End of treatment diagnosis
    - Condition upon ending treatment
    - Active medications
    - Reason for ending treatment
    - Outcome of treatment goals
    - Aftercare recommendations
    - Changes in strengths, needs, abilities and preferences

###### Unplanned Discharge Procedure

Patients who wish to transfer care to another agency will sign a release allowing (INSERT CLINIC HERE) MAT Program to transfer information to new agency.

When a patient is discharged from services (planned or unplanned):

1. The patient is informed as to the reasons.
2. In accordance with the choice of the patient:
   1. The family/support system is informed as to the reasons.
   2. The referral source is informed as to the reasons.
3. Recommendations are made for alternative services.

When an unplanned discharge/transition occurs, the following will be documented in EHR:

* + - Date of admission
    - Services provided
    - Diagnosis upon intake
    - Presenting condition
    - Active medications
    - Condition at last contact
    - Reason for discharge
    - Attempts at outreach
    - Additional services recommendations
    - Changes in strengths, needs, abilities, and preferences

All patients who receive services from (INSERT CLINIC HERE) MAT Program and are discharged will receive follow-up phone calls at 30 days, 60 days, 90 days, 180 days, and 1 year. These calls are documented in the patient’s EHR. If patient or family member requests no further contact patient is removed from phone list. Patients will be discharged from (INSERT CLINIC HERE) MAT Program 30 days after the last day of buprenorphine prescription was written by prescriber in compliance with Washington Health Care Authority (HCA) Clinical Guidelines (effective: 2018).

**Community Education**

Mental Health and Substance Use Disorder Program Managers will work with community partners to provide education on medication assisted treatment. As appropriate, program managers will provide the (INSERT CLINIC HERE) MAT Buprenorphine Patient Handout to partners to help spread awareness Information on community, resources, such as transportation, hospital emergency services, ambulance services, and information and referral services are available upon request.

(INSERT CLINIC HERE) will look to partner with other Tribal MAT programs in the region to spread awareness and optimize community resources.

(INSERT CLINIC HERE) leadership actively participates in committees at the Tribal, state, and federal levels to ensure communication and feedback regarding (INSERT CLINIC HERE) services is heard. (INSERT CLINIC HERE) values maintaining a good relationship to its peers and will work to ensure continued open lines of communication with community partners through its participation in committees at the Tribal, state, local, and federal level.

**Staff Education**

(INSERT CLINIC HERE) provides Narcan overdose education at hire and annually thereafter through its online learning management system. Efforts by (INSERT CLINIC HERE) leadership to provide information and education about the effectiveness of MAT services are ongoing.

###### SPECIFIC POPULATIONS

###### Methadone Transfers

Transition is difficult, and rationale for change in treatment should be carefully considered. There is significant risk of relapse when tapering methadone from the usual maintenance dose (80–120 mg) to a dose where buprenorphine transition is possible (30 mg or less). In addition, precipitated withdrawal is more likely when transitioning from methadone compared with short-acting opioids. It is difficult to anticipate which patients will feel better on buprenorphine. Because of these risks, the OBOT team usually suggests that patients on methadone maintenance seek additional take- home methadone doses as a way to make treatment less burdensome.

Patients may prefer a less structured treatment environment and a setting where care can be integrated. If patients are considering a methadone taper to prepare for buprenorphine transition, the OBOT team recommends that the taper be slow enough to avoid craving and other withdrawal symptoms. If craving or withdrawal occurs, holding the methadone dose constant for a specified period may be prudent. Working collaboratively with the patient and the methadone treatment provider allows for safe and appropriate methadone dose titration or return to prior dosing.

Returning to a stable methadone dose should be an option at any stage of the transition.

Once a stable methadone dose of approximately 30 mg has been achieved, transition to buprenorphine can occur. Staff should advise the patient to arrange for time off work during the transition and seek family support with childcare and other responsibilities as discomfort may last 1 to 2 weeks. The last methadone dose should be approximately 36 hours before the patient visits the OBOT clinic to accurately assess the level of withdrawal. Because timing between the last methadone dose and safe administration of the first buprenorphine/naloxone dose is difficult to predict, buprenorphine administration should be guided by withdrawal symptoms objectively documented with a COWS score between 13 and 15. Clonidine, anxiolytics (including benzodiazepines), and NSAIDs may be used to manage distressing withdrawal symptoms and continued during induction. Inpatient detoxification is another option to assist a patient in the transition from methadone to buprenorphine/naloxone.

###### Pregnancy and OUD

Untreated OUD during pregnancy is high risk for spontaneous abortion, withdrawal-induced fetal distress, premature labor, and intrauterine death. Medication treatment is associated with major reductions in these risks and is recommended for all pregnant patients with OUD. Methadone has been used successfully in this patient population for decades, and increasing evidence also supports the use of buprenorphine.

Buprenorphine is associated with less severe neonatal abstinence syndrome (NAS) compared with methadone, resulting in less need for medication and shorter hospital stays. However, buprenorphine is also associated with lower treatment retention compared with methadone.

Pregnant patients taking buprenorphine should be counseled on the importance of switching to methadone if buprenorphine treatment is not going well.

Patients already maintained on stable buprenorphine doses who become pregnant should be encouraged to continue treatment throughout pregnancy to achieve the best outcomes for them and their baby. Many pregnant patients have concerns about remaining on medication treatment because of the risk for NAS, which occurs in about half of babies regardless of which medication is being taken. The risk of NAS, which can be successfully treated in nearly all cases, is clearly outweighed by the risk to both the pregnant woman and the baby of tapering buprenorphine.

Treatment providers should be prepared to counsel a patient throughout the pregnancy on the importance of maintaining adherence to medication.

Pregnant patients who present for treatment should be cared for by providers with experience treating this population if at all possible. Close coordination of prenatal care and OUD treatment is crucial, with a priority on maintaining medication adherence, whether using buprenorphine or methadone.

Breast feeding should be encouraged as usual, and patients encouraged to continue their buprenorphine (or methadone) treatment after delivery. Very little buprenorphine is passed to the infant through breast milk.

Buprenorphine monotherapy for pregnant clients is limited to a maximum of a seven-day supply throughout the course of treatment, with a minimum follow-up visit frequency of weekly visits for the first month, weeks five through eight visits every two to four weeks, and week 9 and beyond providers discretion.

###### Patients with Dual Diagnoses

Patients with dual diagnoses can be treated with buprenorphine/naloxone in an office-based setting. It can be difficult to determine whether psychiatric symptoms represent a primary disorder or a substance-induced disorder until patients are stable on buprenorphine/naloxone and not using other substances. A careful history may establish a prior primary psychiatric diagnosis during a period of abstinence, in which case resumption or initiation of appropriate psychiatric medication can be considered. The MAT team recommends screening for psychiatric symptoms at intake and when patients are more stable.

###### Patients Requiring Surgery

Few evidence-based studies are available on the management of patients on buprenorphine/naloxone maintenance in the peri-procedure period. Experts have developed some guidelines based on pharmacological principles that avoid under treatment of acute pain, the potential of opioid withdrawal, and disruption of opioid addiction treatment.

* + - The appropriate treatment of acute pain in patients on buprenorphine/naloxone maintenance includes continuing the patient’s baseline opioid requirements to avoid increased pain sensitivity associated with opioid withdrawal. Thus, daily opioid maintenance treatment requirements must be met before attempting to achieve analgesia.
    - Patients have been shown to have increased pain sensitivity and cross-tolerance to opioid analgesics; therefore, adequate pain control will often necessitate higher opioid doses at shorter dosing intervals.
    - All patients on buprenorphine/naloxone maintenance should be co-managed with their buprenorphine/naloxone provider during the pre- and post-procedure periods.

###### Acute Pain Management in Patients on Buprenorphine/Naloxone

Little empirical or experimental evidence is available to guide management of acute pain in patients taking buprenorphine/naloxone. Whenever possible, (INSERT CLINIC HERE) staff should discuss acute pain management options before invasive procedures to reduce anxiety about uncontrolled pain or relapse to illicit opioid use. Local or regional anesthesia should be considered, if possible.

Communication between the buprenorphine provider and clinicians managing acute pain is imperative.

Several acute pain management options are possible:

1. Maintain current buprenorphine dosing and add non-opioid medications for acute pain. For instance, a routine dental procedure could be treated with NSAIDs, acetaminophen, or the combination of the two.
2. Split the current buprenorphine dose into three daily doses, in addition to non-opioid medication.
3. Increase and split the buprenorphine dose temporarily for a few days after the procedure, in addition to non-opioid medications. This may be necessary for a complicated dental or surgical procedure.
4. Split and increase or maintain buprenorphine and add short-acting full agonist opioid medication, in addition to non-opioid medications. This option may be necessary for more painful surgical procedures. Fentanyl and hydromorphone are preferred in this situation, because their affinity for the opioid receptor is higher than other full agonists. Patients on

buprenorphine/naloxone, like patients in methadone maintenance treatment, can be expected to require higher full agonist opioid doses provided at shorter intervals.

1. Discontinue buprenorphine in the pre-procedure period, treat pre-operative and peri- operative pain with full opioid agonists, and return to buprenorphine once post-operative pain has lessened. If this option is chosen, buprenorphine should not be discontinued more than 24 hours in advance of elective surgery.

When acute pain management cannot be planned in advance, option 4 or 5 can be used. Patient- controlled analgesia (PCA) without a basal rate may be appropriate. Recent clinical practice has increasingly favored maintaining or increasing buprenorphine dose and adding full agonist opioids. This has the advantage of avoiding the anxiety and relapse risk that a patient may experience when successful buprenorphine treatment is interrupted.

###### Patients Requiring Chronic Pain Management

Buprenorphine/naloxone maintenance may not reliably alleviate all pain; however, patients transferring to buprenorphine from full opioid agonists prescribed for chronic pain often report significant analgesia and improved functional status. General principles for chronic pain management include:

* + - Reassure patients that their addiction will not be an obstacle to aggressive pain management.
    - Become familiar with non-opioid management of chronic pain.
    - Include patients in the decision-making process to allay anxiety.
    - Establish clear goals for pain management:
      * Pain reduction rather than elimination
      * Improved function
      * Addressing associated symptoms
    - Use a multidimensional approach to pain management, including non-opioid medications and non-medication modalities:
      * Try non-opioids initially.
      * Try adjuvant therapies next.
    - If opioid analgesics are necessary for treatment of chronic pain, discontinue buprenorphine/naloxone and initiate methadone maintenance.

###### Incarcerated Patients

(INSERT CLINIC NAME) MAT will work diligently to ensure patients who are incarcerated and are in need of medication assisted treatment have continuity of care and proper case management. Guidelines for serving patients who are incarcerated and/or released from the criminal justice system are:

* + - Patients will agree to (INSERT CLINIC HERE) MAT program rules and expectations upon admission, explained during their orientation into the program.
    - Patients who are detained may be able to continue their MAT at the discretion of the facility where they are detained at.
    - Patients admitted to the (INSERT CLINIC HERE) MAT program will be given instructions during their orientation to notify the medical care team specifying details of their detention.
    - Upon release from detention, patients will be responsible for any outstanding (unused or left over) medications.
    - Unused, left-over, medications are to be brought with them to (INSERT CLINIC HERE) MAT program as soon as possible after released from detention. Additional doses may not be prescribed until the medications are accounted for.
    - Patients will be informed that all medications are administered at the discretion of the detention center. The (INSERT CLINIC HERE) MAT treatment team will attempt to ensure there is communication between the prescriber and medical staff to ensure continuity of care is delivered appropriately.
    - In the case of extended incarceration, or inability of the facility to continue MAT while incarcerated, the (INSERT CLINIC HERE) MAT treatment team may decide to discharge a patient in the program and initiate an administrative taper.
    - (INSERT CLINIC HERE) MAT program will make efforts to assist those eligible patients who have detoxed while incarcerated to be able to start MAT as soon as possible after their release.

###### Detox/Inpatient Treatment:

* + - (INSERT CLINIC HERE) MAT providers will make every effort to ensure patients being stabilized on buprenorphine continue treatment during inpatient stay.
    - MAT Program Coordinator will facilitate appropriate bed placement connecting patients with inpatient treatment facilities that allow buprenorphine medication management.
    - SUD Program Coordinator will provide MAT team with weekly patient updates and will facilitate discharge planning to ensure seamless continuity of care for patients returning to outpatient care.

## APPENDIX 1: TELEPHONE OR IN-PERSON SCREENING FOR BUPRENORPHINE/NALOXONE

###### DEMOGRAPHIC INFORMATION

**How did you hear about our program?**

* 1 = Spouse
* 2 = Friend
* 3 = Provider
* 4 = Flier
* 5 = Parent
* 6 = State hotline
* 7 = Physician locator
* 8 = Other (specify)

**Are you pregnant?**

* 1 = Yes
* 2 = No
* 3 = Don’t know
* 4 = Tubal ligation
* 5 = Menopause
* 6 = History of hysterectomy

**If no, do you use contraception?** 1 = Yes 2 = No

**Current address**

**Phone Is it OK to leave a message?** 1 = Yes 2 = No

**Emergency contact Phone**

**Is the emergency contact aware of your addiction?** 1 = Yes 2 = No

###### DRUG USE HISTORY

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **What is your drug of choice?** | **Age at First Use**  0 if never used | **Last Use**  1 = 12 or more months ago (specify date)  2 = 3–11 months ago  3 = 1–2 months ago  4 = 1–3 weeks ago 5 = Used this week | **How Often Used?**  1 = Less than 1/month 2 = 1–3 times/month  3 = 1–2 times/week  4 = 3–6 times/week  5 = Daily | **Route of Admin.**  1 = Oral  2 = Smoking  3 = Intranasal  4 = Intravenous injection 5 = Skin popping  6 = Other | **Amount Used** |
| **Opioid**   * Heroin * OxyContin * Other oxycodone- containing product * Methadone * Other |  |  |  |  |  |
| **Benzodiazepine** |  |  |  |  |  |
| **Alcohol** |  |  |  |  |  |
| **Cocaine** |  |  |  |  |  |
| **Amphetamines Including Methamphetamine** |  |  |  |  |  |
| **Tobacco** |  |  |  |  |  |
| **Other** |  |  |  |  |  |

**Have you ever shared needles?** 1 = Yes 2 = No

**Have you ever participated in a needle exchange program?** 1 = Yes 2 = No

**Have you ever overdosed?** 1 = Yes 2 = No

**Number of lifetime overdoses**

**Have you ever been hospitalized due to an overdose?** 1 = Yes 2 = No

###### SUBSTANCE USE TREATMENT HISTORY

**Have you had any substance abuse treatment?**

* 1 = Yes
  + 2 = No

**If yes, how many times for each type?**

Detox Drunk driving program

Residential rehabilitation or halfway house Methadone maintenance

Buprenorphine/naloxone maintenance

**Are you currently participating in any form of substance abuse treatment?**

* + - 1 = 12-Step program (for example, Narcotics Anonymous, Alcoholics Anonymous)
    - 2 = Outpatient counseling
    - 3 = Acupuncture
    - 4 = Intensive outpatient program
    - 5 = Other (specify)

**How many attempts have you made to stop using?**

**Do you attend meetings? Check all that apply.**

* + - 1 = AA
    - 2 = NA
    - 3 = Smart Recovery
    - 4 = Other (specify)

**How many meetings do you attend each week?**

* + - 1 = 1–2 per week
    - 2 = 3–4 per week
    - 3 = 5–6 per week
    - 4 = Daily
    - 5 = None
    - 6 = Other (specify)

**Do you have a sponsor?** 1 = Yes 2 = No

**Do you have a history of any other addictive behaviors such as?**

* + - 1 = Gambling
    - 2 = Sex
    - 3 = Shopping
    - 4 = Eating disorder (for example, overeating, bulimia, anorexia)
  + 5 = Other (specify)
  + 6 = No

###### CRIMINAL HISTORY

**Have you ever been incarcerated?** 1 = Yes 2 = No

**What is the longest period of time you spent in jail/prison?**

**Are you on probation?** 1 = Yes 2 = No

**Are you on parole?** 1 = Yes 2 = No

**Are you facing potential jail time?** 1 = Yes 2 = No

**Do you have outstanding legal issues?** 1 = Yes 2 = No

**If yes, can you tell us about them?**

###### METHADONE HISTORY

**Have you ever been on methadone maintenance?** 1 = Yes 2 = No

**When were you on methadone maintenance?**

**Where were you on methadone maintenance?**

**How long were you on methadone maintenance?**

**What was your dose?**

**What was your maximum dose?**

**Why did you stop methadone treatment?**

**Are you currently on methadone maintenance?** 1 = Yes 2 = No

**What is your dose?**

**Where are you receiving services for your methadone treatment?**

**What is the name of your counselor at the methadone clinic?**

**How long have you been in your current methadone maintenance program?**

**Are you receiving take-homes doses?** 1 = Yes 2 = No

**If yes, how many?**

###### BUPRENORPHINE HISTORY

**Have you ever been prescribed buprenorphine/naloxone before?** 1 = Yes 2 = No

**If yes, when were you on buprenorphine/naloxone?**

**What was your dose?**

**Why did you stop taking the buprenorphine/naloxone?**

###### MENTAL HEALTH HISTORY

**Have you ever been diagnosed with any of the following mental health conditions?**

* + - 1 = Depression
    - 2 = Anxiety
    - 3 = Bipolar
    - 4 = Schizophrenia
    - 5 = Obsessive compulsive disorder (OCD)
    - 6 = Post-traumatic stress disorder (PTSD)
    - 7 = Attention deficit disorder
    - 8 = Panic attacks
    - 9 = Other (specify)

**Are you taking medications for this/these problem(s)?** 1 = Yes 2 = No

**If yes, what medications are you taking?**

**Have you ever taken medications for a mental health condition?** 1 = Yes 2 = No

**If yes, what medications did you take?**

**Are you seeing a psychiatrist, psychologist, or counselor for this/these problem(s)?**

* + - 1 = Yes 2 = No

**Where do you see your psychiatrist, psychologist, or counselor?**

**What is this individual’s name?**

**How often do you see this person?**

**How many times have you seen this person in the last 6 months?**

**Will you sign a consent form to release information so that we can communicate with your psychiatrist, psychologist, or counselor about your treatment plan?**

* + - 1 = Yes 2 = No

**Have you ever been hospitalized for mental health issues?** 1 = Yes 2 = No **Have you ever attempted to end your life or to hurt yourself?** 1 = Yes 2 = No **How many times did you try to end your life or to hurt yourself?**

**Do you currently have thoughts about hurting yourself or ending your life?**

* + - 1 = Yes 2 = No (If no, skip the next two questions.)

**Do you currently have a plan for how you would hurt yourself or end your life?**

* + - 1 = Yes 2 = No

**Do you have the means to carry out your plan?** 1 = Yes 2 = No

**Have you ever attempted or thought about homicide (killing someone else)?**

* + - 1 = Yes 2 = No (If no, skip the next two questions.)

**Are you thinking about killing someone?** 1 = Yes 2 = No

**Do you have the means to carry this out?** 1 = Yes 2 = No

###### HEALTH STATUS

**Have you ever been diagnosed with other medical conditions? Check all that apply.**

* + - 1 = Diabetes (specify type)
    - 2 = Heart disease (specify type)
    - 3 = Cancer (specify type)
    - 4 = Asthma
    - 5 = Hepatitis C If yes, have you been treated? 1 = Yes 2 = No
    - 6 = Tuberculosis (TB)
    - 7 = Endocarditis
    - 8 = Abscesses
    - 9 = Skin infection
    - 10 = HIV If yes, are you currently in care? 1 = Yes 2 = No
    - 11 = Hepatitis B
    - 12 = Hepatitis A
    - 13 = Seizure disorder Are you on medications? 1 = Yes 2 = No
    - 14 = High blood pressure
    - 15 = Head trauma/injuries
    - 16 = Pancreatic problems
    - 17 = Other (specify)
    - 18 = None

**Are you taking any other medications?** 1 = Yes 2 = No

**If yes, what medications are you taking? Have you been tested for HIV?** 1 = Yes 2 = No

**If yes, did you go back for the results?** 1 = Yes 2 = No

**If yes, when was the last time you were tested? Have you ever had surgery?** 1 = Yes 2 = No

**If yes, why did you have surgery?**

**Do you have any pending surgeries**? 1 = Yes 2 = No

**What kind of medical insurance do you have? Check all that apply.**

* + - 1 = Medicare Does the patient have Medicare Part D? 1 = Yes 2 = No If yes, which plan?
    - 2 = Medicaid (specify)
    - 3 = Hospital/Clinic Free Care
    - 4 = Private insurance (specify)
    - 5 = No insurance (self-pay)
    - 6 = Don’t know
    - 7 = Other (specify)

###### PAIN ASSESSMENT

**Do you have chronic pain?** 1 = Yes 2 = No

**Please rate your pain, on a scale from 0 to 10, without any pain medications (prescribed or bought on the street).**

0 1 2 3 4 5 6 7 8 9 10

###### PHYSICIAN INFORMATION

**Where do you get most of your healthcare services?**

**When was the last time you saw a doctor?**

* + - 1 = Last week 4 = Within the past 6 months
    - 2 = Last month
    - 3 = Within the past 3 months
* 5 = Within the past year
* 6 = More than 1 year ago

**What is the name of your doctor?**

**Are you willing to change your primary care to the** (INSERT CLINIC HERE) **primary care clinic?** 1 = Yes 2 = No

###### EMPLOYMENT

**Are you currently employed?** 1 = Yes 2 = No

**If yes, what do you do for work?**

**Are you working full or part time?**

**What days of the week do you work and how many hours per day do you work?**

###### SOCIAL SUPPORT

**What is your relationship status?**

* + 1 = Single (skip the remaining questions in this section)
  + 2 = Married
  + 3 = Long-term relationship
  + 4 = Divorced
  + 5 = Other (specify)

**Do you live with your partner/significant other?** 1 = Yes 2 = No

**Does your partner have a history of substance use/abuse?** 1 = Yes 2 = No

**Is your partner/significant other currently in treatment?** 1 = Yes 2 = No

**If yes, what kind of treatment are they in?**

* + 1 = Buprenorphine/naloxone
  + 2 = Methadone maintenance
  + 3 = Abstinence
  + 4 = Residential
  + 5 = Other (specify)

**How satisfied are you with the support you get from your partner/significant other?**

* + 1 = Very satisfied
  + 2 = Satisfied
  + 3 = Fairly satisfied
  + 4 = Not satisfied
  + 9 = N/A

###### FAMILY HISTORY

**Do any other family members have a history of substance use/abuse?** 1 = Yes 2 = No

###### TRANSPORTATION

**How do you get around?**

* + 1 = I drive Do you have your own car? 1 = Yes 2 = No
  + 2 = Public transportation
  + 3 = Walk or bike
  + 4 = I get a ride from a family member/friend
  + 5 = Other (specify)

**Do you have a driver’s license?** 1 = Yes 2 = No

**How would you get to** (INSERT CLINIC HERE) **Tribal Health if you needed to get here?**

* + 1 = I would drive
  + 2 = Public transportation
  + 3 = I would walk or bike
  + 4 = I would get a ride from a family member/friend
  + 5 = Other (specify)

**Would you be able to come in within 48 hours’ notice?** 1 = Yes 2 = No

###### HOUSING

**Have you spent 1 or more weeks on the street or in a shelter in the last 3 months?**

* + 1 = Yes 2 = No

**What type of place are you living in now?**

* + 1 = House or apartment you own
  + 2 = House or apartment you rent
  + 3 = House or apartment owned or rented by family or friends
  + 4 = Hotel
  + 5 = Alcohol or drug treatment program
  + 6 = Shelter
  + 7 = Street or car
  + 8 = Other (specify)
  + 9 = Don’t know

**Who do you live with at this time?**

* + 1 = I live alone
  + 2 = I live with my partner/significant other
  + 3 = I live with family members
  + 4 = I live with friends
  + 5 = Other (specify)

**Can you tell me what your goals are for treatment?**

## APPENDIX 2: NURSE CARE MANAGER INTAKE TOOL

Before intake, the nurse case manager reviews the phone screening completed by the program manager.

###### Nursing Summary

**Name**

**Are you pregnant?**

* + 1 = Yes
  + 2 = No
  + 3 = Don’t know
  + 4 = Tubal ligation
  + 5 = Menopause
  + 6 = History of hysterectomy

**If no, do you use contraception?** 1 = Yes 2 = No

###### DRUG USE HISTORY

**What are you currently using?**

* + 1 = Heroin (amount)
  + 2 = OxyContin (amount)
  + 3 = Methadone (amount)
  + 4 = Other pain relievers (for example, Percocet, Vicodin) (amount)
  + 5 = Cocaine
  + 6 = Benzodiazepines (for example, Klonopin, Xanax, Ativan) (amount)
  + 7 = Nothing
  + 8 = Alcohol
  + 9 = Amphetamines
  + 10 = Buprenorphine/naloxone How much are you using per day?
  + 11 = Other (specify)

###### METHADONE AND BUPRENORPHINE HISTORY

**Are you currently on methadone maintenance?** 1 = Yes 2 = No

**What is your dose?**

**Have you ever been prescribed buprenorphine/naloxone before?** 1 = Yes 2 = No

**If yes, when were you on buprenorphine/naloxone?**

**What was your dose?**

**If you stopped taking buprenorphine/naloxone, why did you stop taking it?**

**Are you still on buprenorphine/naloxone?** 1 = Yes 2 = No

**Have you ever taken illicit buprenorphine/naloxone?** 1 = Yes 2 = No

**Have you ever experienced precipitated withdrawal when taking buprenorphine/naloxone?**

* + 1 = Yes 2 = No

###### MENTAL HEALTH HISTORY

**Have you ever been diagnosed with any of the following mental health conditions?**

* + 1 = Depression 5 = Obsessive compulsive disorder (OCD)
  + 2 = Anxiety
  + 3 = Bipolar
  + 4 = Schizophrenia
* 6 = Post-traumatic stress disorder (PTSD)
* 7 = Attention deficit disorder
* 8 = Panic attacks
* 9 = Other (specify)

**Are you taking medications for this/these problem(s)?** 1 = Yes 2 = No

**If yes, what medications are you taking?**

**Have you ever taken medications for a mental health condition?** 1 = Yes 2 = No

**If yes, what medications did you take?**

###### HEALTH STATUS

**Have you ever been diagnosed with any other medical conditions? Check all that apply.**

* + 1=Diabetes (specify type)
  + 2=Heart disease (specify type)
  + 3=Cancer (specify type)
  + 4=Asthma
  + 5= Hepatitis C If yes, have you been treated? 1 = Yes 2 = No
  + 6=Tuberculosis (TB)
  + 7=Endocarditis
  + 8=Abscesses
  + 9=Skin infection
  + 10= HIV If yes, are you currently in care? 1 = Yes 2 = No
  + 11= Hepatitis B
  + 12= Hepatitis A
  + 13= Seizure disorderAre you on medications? 1 = Yes 2 = No
  + 14= High blood pressure
  + 15= Head trauma/injuries
  + 16= Pancreatic problems
  + 17= Other (specify)
  + 18= None

This information may already be documented in the patient’s electronic health record.

**Past Medical History**

**Current Medications**

**Allergies**

**Have you been tested for HIV?** 1 = Yes 2 = No

**If yes, did you go back for the results?** 1 = Yes 2 = No

**If yes, when was the last time you were tested?**

**Do you have any pending surgeries?** 1 = Yes 2 = No

###### PAIN ASSESSMENT

**Do you have chronic pain?** 1 = Yes 2 = No

**If yes, please explain:**

**Please rate your pain, on a scale from 0 to 10, without any pain medications (prescribed or bought on the street).**

0 1 2 3 4 5 6 7 8 9 10

**Has your pain lasted 3 months or longer?** 1 = Yes 2 = No

**Comments**

**Can you tell me what your goals are for treatment?**

* + The (INSERT CLINIC HERE) MAT program reviewed requirements with the patient including appointments, UDSs (observed and unobserved), and possible random call-backs with pill counts. The patient is aware of their responsibility for their buprenorphine/naloxone medication. The patient has been informed to keep medication in a safe undisclosed place and out of reach of children and visitors. If living in a shelter, the patient has been informed to keep medication in a locked storage unit.

The (INSERT CLINIC HERE) consent form and contract have been read to and reviewed with the patient.

* + The patient voluntarily signed and dated the consent form. A copy was given to the patient and the original was placed in the patient’s records. The patient had the opportunity to ask questions.

The (INSERT CLINIC HERE) program reviewed the following aspects of buprenorphine/naloxone treatment

* + with the patient: medication doses, potential side effects including elevations in transaminases, potential lethal interaction with benzodiazepines and alcohol, safe administration, and secure storage. Written information was provided to the patient. The patient expressed that they understood the information provided and wished to schedule the induction phase time and date.

UDS specimen was submitted to the lab.



## APPENDIX 3: CONSENT FORMS

### Consent for Treatment with Buprenorphine/Naloxone

Buprenorphine/naloxone is a Food and Drug Administration-approved medication for treatment of people with opioid use disorder (OUD). Buprenorphine/naloxone can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary. It is estimated that a patient will take buprenorphine/naloxone for at least 6 months.

Buprenorphine/naloxone treatment can result in physical dependence of an opioid. Withdrawal from buprenorphine/naloxone is generally less intense than withdrawal from heroin or methadone. If buprenorphine/naloxone is suddenly discontinued, some patients have no withdrawal symptoms; others may have symptoms such as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize the possibility of opioid withdrawal, buprenorphine/naloxone should be discontinued gradually over several weeks or more.

If you are dependent on opioid, you should be in as much withdrawal as possible when you take the first dose of buprenorphine/naloxone. If you are not in withdrawal, buprenorphine/naloxone can cause

severe opioid withdrawal.

It may take several days to transition from the opioid that you had been taken to buprenorphine/naloxone. During this time, use of any other opioids may cause an increase in symptoms. After stabilizing on buprenorphine/naloxone, the use of other opioid will have less effect. Attempts to override the buprenorphine/naloxone by taking more opioids could result in an opioid overdose.

###### Do not take any other medications without first talking to your healthcare provider.

**Combining buprenorphine/naloxone with alcohol or other medications may be hazardous. Combining buprenorphine/naloxone with medications such as Klonopin, Valium, Haldol, Librium, and Ativan has resulted in deaths.**

The form of buprenorphine that you will be taking (buprenorphine/naloxone) is a combination of buprenorphine with a short-acting opioid blocker (naloxone). If the buprenorphine/naloxone tablet were dissolved and injected by someone taking heroin or another strong opioid (e.g., morphine), it would cause severe opioid withdrawal.

Buprenorphine/naloxone tablets and films **must** be held under the tongue until they completely dissolve. Buprenorphine/naloxone will not be absorbed from the stomach if it is swallowed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Print Name |  | Signature |  | Date |
| Witness Name |  | Signature |  | Date |

### Consent for Release of Information

Many standard release of information forms include an option to include drug and alcohol treatment records. This option should be routinely included when requesting or releasing (INSERT CLINIC HERE) MAT addiction treatment records.

I, , born on ,

(patient name) (patient birth date)

SSN , authorize to

(patient Social Security #) (clinic or doctor’s name)

disclose to (name and location of person/organization to receive information)

the following information:

.

The purpose of this disclosure is .

This authorization expires on , or whenever is no longer providing me with services.

I understand that my records are protected under federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Signature of patient Date

Signature of witness Date

###### ATTENTION RECIPIENT

**Notice Prohibiting Redisclosure**

This information has been disclosed to you from the records protected by federal confidentiality rules (42 CFR, Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Special Consents**

In addition to standard Health Insurance Portability and Accountability Act laws, federal regulations mandate strict confidentiality for information about patients being treated for substance use disorders (42 CFR, Part 2). The law requires written patient consent before information about substance abuse treatment can be disclosed to any other source. For buprenorphine/naloxone treatment, this may include any communications with other physicians, treatment centers, significant others, or pharmacies.

Specific actions that are prohibited without consent include the following:

* + - Providing information regarding a patient’s past, present, or future participation in substance abuse treatment.
    - Disclosing or transmitting a patient’s substance use-related medical records.
    - Use of a letterhead that identifies the office as a substance use treatment provider.
    - Providing information about those who have applied for treatment or have been interviewed, regardless of whether they actually commenced treatment.
    - Providing information about deceased patients.
    - Verifying information that inquirers already possess—in other words, a program can neither confirm nor deny that a patient was being treated there.

Some exceptions to the disclosure laws include medical emergencies or legal situations.

I hereby release and agree to hold harmless the (INSERT CLINIC HERE) Indian Tribe Health & Human Services, its medication assisted treatment program, the prescribing provider, and the organization's officers, directors, agents, and employees from any liability that may arise in connection with my taking buprenorphine (Subutex®) during my pregnancy.

Patient Date/time

Provider prescriber Date/time

Witness Date/time

### Consent for Parental Notification

(INSERT TRIBE, TRIBAL DEPT/CLINIC NAME HERE) Medication Assisted Treatment (MAT) program has a policy for patients under age 18 that requires that program staff be permitted to contact parents/guardians of the patient.

It is important for (INSERT CLINIC HERE) MAT staff to be able to contact your parents or guardians if changes to your treatment are needed. Contact with parents/guardians might be warranted to report results of urine drug screens (positive or negative), if (INSERT CLINIC HERE) MAT staff feel that more intensive treatment needs to be considered, or if staff are concerned about your safety. We will do everything we can to respect your confidentiality, but if we feel you need intensified treatment, you have a positive urine drug screen, or you are at risk of harming yourself or someone else, we are required to contact your parents or guardians.

(INSERT CLINIC HERE) MAT staff feel that communicating with parents/guardians as needed is critical to providing you with safe and effective treatment. We feel that your parents’ support and involvement will be beneficial to you and to your success in your recovery.

The signature below certifies that I have given (INSERT CLINIC HERE) MAT staff permission to contact my parents/guardians regarding my treatment provided by (INSERT CLINIC HERE) MAT.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Print Name |  | Signature |  | Date |
| Witness Name |  | Signature |  | Date |

## APPENDIX 4: BUPRENORPHINE TREATMENT AGREEMENT

As a patient in the buprenorphine protocol for treatment of an opioid use disorder, I freely and voluntarily agree to accept this treatment agreement, as follows.

###### I agree to keep, and be on time to, all my scheduled appointments with my provider and nurse and to conduct myself in a courteous manner in the clinic.

I agree not to arrive at the clinic intoxicated or under the influence of drugs. If I do, the provider or nurse may not see me, and I will not be given any medication until my next scheduled appointment.

###### I agree not to sell, share, 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 would result in my treatment being terminated without recourse for appeal.

I agree not to deal, steal, or conduct any other illegal or disruptive activities in the clinic or within the exterior boundaries (INSERT TRIBE AND RESERVATION); this is grounds for immediate discharge.

###### I agree not to tamper with specimens for urine drug screens. If I do so, this may be grounds for immediate discharge and referral to a more intensive treatment program or I will be asked to submit to a supervised urine specimen in a setting with chain of custody.

I agree that my prescriptions can be given to me only at my regularly scheduled times. Missed appointments may result in my not being able to get medication until the next scheduled visit.

###### I agree that the medication I receive is my responsibility and that I will keep it in a safe and secure place. I agree that lost medication may not be replaced regardless of the reasons for such a loss.

I agree that if I obtain medication from any doctors, pharmacies, or other sources that I will inform my

provider and/or (INSERT CLINIC NAME) MAT nurse case manager immediately.

###### I understand that mixing buprenorphine with other medications, especially benzodiazepines (such as Klonopin, Ativan, Valium, and Xanax), and other drugs can be dangerous. I understand that a number of deaths have been reported among people mixing buprenorphine with benzodiazepines.

I agree to take my medication as the prescriber has instructed and not to alter the way I take my medication without first consulting my doctor or nurse.

###### I agree to random urine drug screens and to bring in my remaining buprenorphine tablets when requested by my doctor or nurse.

I agree not to consume poppy seeds while in this treatment program. Poppy seed consumption will not be accepted as an excuse for a positive opioid screen.

###### I understand that my treatment plan may change to random call-back visits only and that I need to have working telephone contacts that are updated as changed. When called for random call- backs, I need to respond within 24 hours by telephone. Non-response to call-backs will be considered the same as positive urine specimens.

I understand that should I choose to abuse other illicit substances, this issue will be addressed through changes in my treatment plan to help me address this use. If I continue to struggle with ongoing drug use, this could be grounds for transfer to more intensive treatment options.

###### Positive urine screens for opioids will be evaluated by the treatment team. Ongoing positive results (specifically, 2 positive results in 1 month) or missed urine tests may be grounds for transfer to more intensive treatment options.

Urine screen results that are negative for buprenorphine will be evaluated by the team and toxicologist and are grounds for transfer to another level of care or discharge.

###### (INSERT CLINIC HERE) MAT will periodically access the state prescription drug monitoring program to review medication profiles on all patients to ensure patients are not receiving other controlled substances from other providers. If patients are found to be accessing prescriptions from other providers, this finding will be reviewed by the (INSERT CLINIC HERE) MAT team. If it is determined that the medications obtained by other non-(INSERT CLINIC HERE) providers are in violation of the treatment agreement, the (INSERT CLINIC HERE) MAT team will evaluate the situation and may discharge me from the (INSERT CLINIC HERE) MAT program.

I understand that the (INSERT CLINIC HERE) MAT program will not release the results of my urine toxicology screens to any other agency, program, or institution. The reason for this policy is that (INSERT CLINIC HERE) MAT does not have a chain of custody over the urine specimens; these tests are for my treatment at (INSERT CLINIC HERE) MAT only. If patients have legal or program requirements that require observed urine toxicology testing, this should be done independent of my treatment at (INSERT CLINIC HERE) MAT.

###### If I am woman of childbearing age, it is strongly recommended that I use contraceptives while on treatment. If I become pregnant while on buprenorphine/naloxone, I will alert my healthcare providers immediately so they can assist me in taking steps to keep me and the fetus safe.

If at any time I am discharged from this program, I may be reconsidered at a future time to determine whether office-based medication assisted treatment may be an option for me.

###### I understand that medication alone may not be sufficient treatment for my disease, and I agree to participate in the patient education, substance abuse counseling, and relapse prevention programs, as provided, to assist me in my treatment.

I understand that my records, course of treatment, and medical care will be kept in an electronic health record under a confidential locked filing system. These notes will be visible to any healthcare professional involved in my care.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Print Name |  | Signature |  | Date |
| Witness Name |  | Signature |  | Date |

**Appendix 5: Naltrexone/Vivitrol Treatment Agreement**

**(INSERT CLINIC OR DEPARTMENT HERE) – Medication-Assisted Treatment (MAT) Vivitrol-Medication Counseling and Treatment Agreement:**

I, , have been informed of the risks and benefits of taking Naltrexone (Vivitrol) and provided with education regarding treatment for opioid and/or alcohol dependence:

I understand that once Vivitrol is injected once monthly, administered in clinic by professional MAT staff.

I understand that I need to be off all opioids, including opioid-containing medications for at least 7-10 days before starting Vivitrol in order to avoid precipitated withdrawal.

I agree not to take any other medications with Vivitrol without prior permission from (INSERT CLINIC HERE) MAT provider.

I understand the goal of treatment for alcohol and opioid dependency is to learn to live without abusing alcohol and drugs. Vivitrol injections should continue as long as necessary to prevent relapse and then stopped.

I understand that a reaction at the site of Vivitrol injection may occur. Reactions include pain, tenderness, induration, swelling, redness, bruising and itching. I should seek medical attention for worsening skin reactions.

I understand that I may experience nausea/vomiting following the initial injection of Vivitrol. These episodes of nausea tend to be mild and subside within a few days post-injection. Nausea is less likely with subsequent injections. I may also experience tiredness, headache, vomiting, decreased appetite, painful joints and muscle cramps. I understand other side effects include muscle cramps, somnolence or sedation, anorexia, decreased appetite or other appetite disorder,

I understand other side effects include muscle cramps, somnolence or sedation, anorexia, decreased appetite or other appetite disorder,

I understand that Vivitrol may cause liver injury and I need to notify my healthcare provider if I develop symptoms and or signs of liver disease.

I understand that dizziness or fainting may occur with Vivitrol treatment and I should avoid driving or operating heavy machinery until I have determined how Vivitrol affects me.

I understand that I may experience depression while taking Vivitrol. It is important that I inform family members and people close to me that I am taking Vivitrol and that they should call a doctor right away if I become depressed or experience symptoms of depression.

I understand that I am to notify my MAT provider if I am breast-feeding, if I become pregnant, if I think I might be pregnant, or if I am thinking about becoming pregnant.

I understand that the use of Vivitrol is a form of Medication Assisted Therapy (MAT) helping me stay sober while I receive the appropriate psychotherapy needed for long term recovery. Vivitrol has been shown to treat alcohol and opioid dependence when used as part of a treatment program that includes counseling and support. My MAT provider will recommend that I participate in chemical dependency counseling as part of my ongoing treatment regimen.

I allow my provider to communicate with other providers regarding my medical care, consistent with HIPAA guidelines. Treatment disclosure may include, but is not limited to, discussing my medications with the pharmacist. I understand that records released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence.

These records may contain confidential information about communicable diseases including Hepatitis, HIV(AIDS) or related illnesses.

I will submit a urine specimen (my own urine) for drug screen (narcotic, pot, cocaine, amphetamine, PCP, alcohol, benzodiazepine, and others) upon my providers request as often as directed. My provider may ask that a clinical staff member observe me providing the appropriate specimen. If my drug screen indicates the presence of illegal/inappropriate substances, I may be discharged.

I allow my provider to communicate with other providers regarding my medical care, consistent with HIPAA guidelines. Treatment disclosure may include, but is not limited to, discussing my medications with the pharmacist. I understand that records released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence.

These records may contain confidential information about communicable diseases including Hepatitis, HIV(AIDS) or related illnesses.

Regarding **alcohol:** I understand that I am required to not have used alcohol or alcohol containing products for the past 4 days and that I am not having any signs of Delerium Tremens (DT's). I understand that DT's may be life threatening and if any signs occur I will call 911.

Regarding **opioids**: I understand that I must be opioid drug free (detoxed) for 7 days and for 14 days detoxed from Methadone and Buprenorphine. If I am not detoxed than the Vivitrol injection will precipitate immediate and sometimes severe opioid withdrawal (to include but not limited to nausea, vomiting, muscle cramps, tremors, headache and sweating).

I understand that I need to carry documentation to alert medical personnel to the fact that I am taking Vivitrol (naltrexone for extended-release injectable suspension). This is important information if I need to obtain medical treatment in an emergency and am unable to tell other health care providers that I am on Vivitrol.. I agree to wear a medical alert (card, bracelet, dog tags).

**I have read and understand all the information about Vivitrol treatment. I have received answers to any questions I have. I agree that I am responsible to abide by these instructions. I wish to be treated with Vivitrol.**

Patient Name: HRN:

Date:

Physician or Physician’s Representative Signature:

Date: \_

**Appendix 6:** (INSERT CLINIC HERE) **BUPRENORPHINE INDUCTION PROTOCOL-CLINIC BASED**

1. Evaluate the patient’s level of withdrawal using COWS/SOWS. Clinicians may need to solely rely on the COWS if patient is not feeling well or feels unable to complete screening.
2. Patient should be in mild to moderate opiate withdrawal (score 6-10) before taking medication.
3. Provide medication instructions to patient, place under the tongue, no talking and swallow when fully dissolved.
4. Patient may self-administer first dose of 2-4mg under observation in clinic.
5. Have patient remain in clinic for at least thirty minutes to an hour to determine the effect of the initial dose, and document the effect in the patient’s medical record.
6. Depending on the amount and type of opioid use, the first day’s dose may range from 2-16mgs. Dosing is largely dependent upon level of physical dependence.
7. If withdrawal occurs after the patient is discharged from their induction appointment, request that the patient return to clinic to be reassessed. Additional doses may be recommended later in the day or evening if withdrawal symptoms return.
8. Ensure there is close follow up with the patient by contacting them by phone within the first 24-48 hours post-induction.
9. Provide patient with sufficient medication until the next scheduled appointment, within 7 days.

(INSERT CLINIC HERE) **BUPRENORPHINE INDUCTION PROTOCOL-HOME INDUCTION**

1. The decision to allow for patients to do home-based inductions will be negotiated between provider and patient. It is advisable to make this decision only after patient education is provided, and documented knowledge of risks and benefits completing patient consent, medication care agreement, and orientation is done allowing for provider and patient to mutually determine this to be a safe and viable option. If the patient expresses significant fear of withdrawal, he/she may not be a good candidate for home induction due to the potential for starting buprenorphine too early and causing precipitated withdrawal.
2. Patient should be provided with explicit written instructions regarding the subjective and objective assessment of opioid withdrawal, the timing and dose of buprenorphine, and phone numbers for assistance.
3. The provider or Nurse Care Manager should maintain close telephone contact with patient during the course of the home induction and document these interactions in the patient’s electronic medical record.
4. The patient should be seen within 24-48 hours of starting buprenorphine, no longer than 7 days.
5. Provide patient with sufficient medication until the next scheduled appointment, within 7 days.

**Management of Precipitated Withdrawal:**

If an unexpected precipitated withdrawal occurs during the early phases of the induction period, supportive treatment with or without medication will be necessary.

Types of supportive treatment:

* 1. Repeated 2 mg doses of buprenorphine every 1-2 hours
  2. Clonidine 0.1 mg every 8 hours (caution regarding hypotension)
  3. Antiemetics for nausea
  4. Non-steroidals for arthralgias and myalgias

Some patients may resist supportive treatment and return to full agonist opioid use as a method to self- medicate their precipitated withdrawal.

References:

## INDUCTION PROTOCOLS

* Patient presents for first induction.
* Patient evaluated using COWS.

Patient scored on COWS first assessment.

Patient self-administered mg sublingually as prescribed.

* Patient was assessed and instructed in proper administration.
* Patient observed to tolerate medication.

**Summary 1**

COWS First Assessment

**Resting Pulse Rate**

* + 0 = Pulse rate 80 or below
  + 1 = Pulse rate 81–100
  + 2 = Pulse rate 101–120
  + 3 = Pulse rate greater than 120

**Sweating**

* + 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

**Restlessness During Assessment**

* + 0 = Able to sit still
  + 1 = Reports difficulty sitting still, but is able to do so
  + 3 = Frequent shifting or extraneous movements of legs/arms
  + 5 = Unable to sit still for more than a few seconds

**Pupil Size**

* + 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

**Bone or Joint Aches**

* + 0 = Not present
  + 1 = Patient reports mild diffuse discomfort
  + 2 = Patient reports severe diffuse aching of joints/muscle
  + 4 = Patient is rubbing joints/muscles and is unable to sit still because of discomfort

**Runny Nose or Tearing**

* + 0 = Not present
  + 1 = Nasal stuffiness or unusually moist eyes
  + 2 = Nose running or eyes tearing
  + 4 = Nose constantly running or tears streaming down cheeks

**GI Upset**

* + 0 = No GI symptoms
  + 1 = Stomach cramps
  + 2 = Nausea or loose stool
  + 3 = Vomiting or diarrhea
  + 5 = Multiple episodes of diarrhea or vomiting

**Tremor**

* + 0 = No tremor
  + 1 = Tremor can be felt, but not observed
  + 2 = Slight tremor observable
  + 4 = Gross tremor or muscle twitching

**Yawning**

* + 0 = No yawning
  + 1 = Yawning once or twice during assessment
  + 2 = Yawning three or more times during assessment
  + 4 = Yawning several times per minute

**Anxiety or Irritability**

* + 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

**Gooseflesh Skin**

* + 0 = Skin is smooth
  + 3 = Piloerection of skin can be felt or hairs standing up on arms
  + 5 = Prominent piloerection

**Total COWS Score**

**Score:** 5–12 = Mild

13–24 = Moderate

25–36 = Moderately severe

More than 36 = Severe withdrawal

## APPENDIX 7: NURSE CARE MANAGER FOLLOW-UP FORM

###### (INSERT CLINIC HERE) MAT Follow-Up

Date Patient Name

**Patient reports (check all that apply)**

* No illicit substance use
* Marijuana
* Opioid use
* Amphetamine use
* Alcohol use
* Benzodiazepine use
* Other use (specify)

**Patient is taking buprenorphine**

* As directed Other than prescribed (specify) Patient has doses remaining. Patient’s most recent dose was
* Yesterday Today

**Patient reports**

* No symptoms of withdrawal or craving
* No adverse effects
* Craving
* Symptoms of withdrawal
* Other (specify)

###### Subjective Data

**Assessment and Plan**

Prescription for (specify amount) films/tablets sent to (specify)

pharmacy. Prescription should last until (specify)

.

**Most Recent UDS Results and Dates**

**Patient Data**

Primary care physician

Buprenorphine prescriber

**Appointment Interval**

* Weekly Every 2 weeks Monthly

**Buprenorphine History**

Medication start date Nurse order date Buprenorphine Dose

* 2 mg 8 mg 16 mg
* 4 mg
* 6 mg

10 mg 20 mg

12 mg 24 mg

**Dose Adjustments (date and reason)**

**Date of Last PDMP Check**

## APPENDIX 8: PEDIATRIC EXPOSURE HANDOUT

#### Pediatric Exposure to Buprenorphine/Naloxone

**Guidelines From the Centers for Disease Control and Prevention:**

**Recommendations to prevent harmful exposures to buprenorphine**

Buprenorphine-containing products can be harmful to children not only when a whole table or film is swallowed, but also when they are licked or placed in the mouth.

* Keep medication out of sight and reach of children.
* Use a locked box, bag, or cabinet for safe storage of medication.
* Always keep medication in its original, labeled prescription container, with child-resistant closure when appropriate.
* Do not place tablets or films on counters, sinks, dressers, or nightstands for later use.
* Discard used buprenorphine film wrapping immediately by folding the package together, placing it in the trash, and securing the trash. Buprenorphine bottles and film wrapping can contain enough leftover medicine to cause problems for young children.
* Do not store medication in your pocket, back, purse, backpack, or other carrying case.
* Avoid leaving medication in the bathroom, car, or any publicly accessible space.

Washington State Poison Control Hotline: (800) 222-1222

## APPENDIX 9: Cows Scale

### Opioid Withdrawal Record (Induction Form)\*

(Adapted from the Clinical Opiate Withdrawal Scale)

**Patient Name Treatment Start Date Circle the number/description that best corresponds to your patient’s present symptoms.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Parameter** | **Baseline Observation**  **1st Dose**  mg  Time given  am / pm | **1st Dose Observation**  minutes after 1st dose | **1st Dose, 2nd Observation** (if needed)  minutes after 1st dose | **2nd Dose**  (if needed)  Time given  am / pm | **2nd Dose Observation**  minutes after 2nd dose |
| **Resting Pulse Rate** beats/minute *Measure after patient is sitting/lying for 1 minute*   1. Pulse rate 80 or below 120 2. Pulse rate 81–100 3. Pulse rate 101–120   4 Pulse rate greater than 120 | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 |
| **Sweating**  *Over past 30 minutes; not accounted for by room temperature or patient activity* 0 No report of chills or flushing   1. Subjective report of chills or flushing 2. Flushed or observable moistness on face 3 Beads of sweat on brow or face   4 Sweat streaming off face | 0  1  2  3  4 | 0  1  2  3  4 | 0  1  2  3  4 | 0  1  2  3  4 | 0  1  2  3  4 |
| **Restlessness**  *Observation during assessment*   1. Able to sit still 2. 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 | 0  1  3  5 | 0  1  3  5 | 0  1  3  5 | 0  1  3  5 | 0  1  3  5 |
| **Tremors**  *Observation of outstretched hands*   1. No tremor 2. Tremor can be felt, but not observed 2 Slight tremor observable   4 Gross tremor or muscle twitching | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 |
| **Pupil Size**   1. Pupils pinned or normal size for room light 2. Pupils possibly larger than normal for room light 3. Pupils moderately dilated   5 Pupils so dilated that only the rim of the iris is visible | 0  1  2  5 | 0  1  2  5 | 0  1  2  5 | 0  1  2  5 | 0  1  2  5 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Parameter** | **Baseline Observation**  **1st Dose**  mg  Time given  am / pm | **1st Dose Observation**  minutes after 1st dose | **1st Dose, 2nd Observation** (if needed)  minutes after 1st dose | **2nd Dose**  (if needed)  Time given  am / pm | **2nd Dose Observation**  minutes after 2nd dose |
| **GI Upset**  *Over last 30 minutes* 0 No GI symptoms 1 Stomach cramps  2 Nausea or loose stool 3 Vomiting or diarrhea  5 Multiple episodes of diarrhea or  vomiting | 0  1  2  3  5 | 0  1  2  3  5 | 0  1  2  3  5 | 0  1  2  3  5 | 0  1  2  3  5 |
| **Anxiety or Irritability**   1. None 2. Patient reports increasing irritability or anxiousness 3. Patient obviously irritable/anxious 4 Patient so irritable/anxious that   participation in assessment is difficult | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 |
| **Bone or Joint Aches**  *If patient was having pain previously, gauge the additional component attributed to opioid withdrawal only*   1. Not present 2. Mild diffuse discomfort 3. Patient reports severe diffuse aching of joints/muscles   4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 |
| **Yawning**  *Observation during assessment*   1. No yawning 2. Yawning once or twice during assessment 3. Yawning three or more times during assessment   4 Yawning several times/minute | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 |
| **Runny Nose or Tearing**  *Not accounted for by cold symptoms or allergies*   1. Not present 2. Nasal stuffiness or unusually moist eyes 2 Nose running or tearing   4 Nose constantly running or tears  streaming down cheeks | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 | 0  1  2  4 |
| **Gooseflesh Skin**  0 Skin is smooth  3 Skin piloerection can be felt or hairs standing up on arms  5 Prominent piloerection | 0  3  5 | 0  3  5 | 0  3  5 | 0  3  5 | 0  3  5 |

* Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *Journal of Psychoactive Drugs, 35*(2), 253–259.

### Clinical Opiate Withdrawal Scale (COWS)

*For each item, write in the number that best describes the patient’s signs or symptoms. Rate just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Buprenorphine induction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Enter scores at time 0, 30 minutes after first dose, 2 hours after first dose, etc.**  **Times: \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_** | | | | |
| **Resting pulse rate**: (record beats per minute)  *Measured after patient is sitting or lying for one minute*   1. pulse rate 80 or below 2. pulse rate 81–100 3. pulse rate 101–120   **4** pulse rate greater than 120 |  |  |  |  |
| **Sweating:**  *Over past half---hour, not accounting for room temperature or patient activity.*   1. no report of chills or flushing 2. subjective report of chills or flushing 3. flushed or observable moistness on face 4. beads of sweat on brow or face 5. sweat streaming off face |  |  |  |  |
| **Restlessness:**  *Observation during assessmen*t   1. able to sit still 2. reports difficulty sitting still, but is able to do so   **3** frequent shifting or extraneous movements of legs/arms  **5** Unable to sit still for more than a few seconds |  |  |  |  |

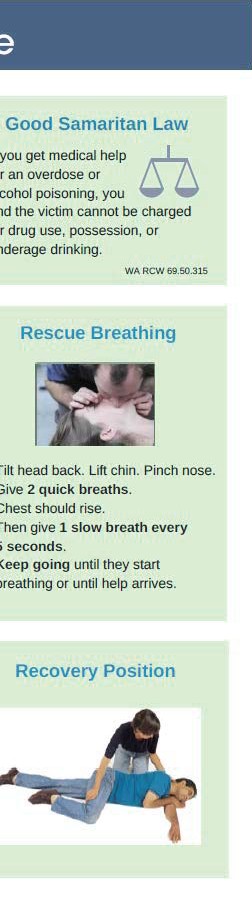
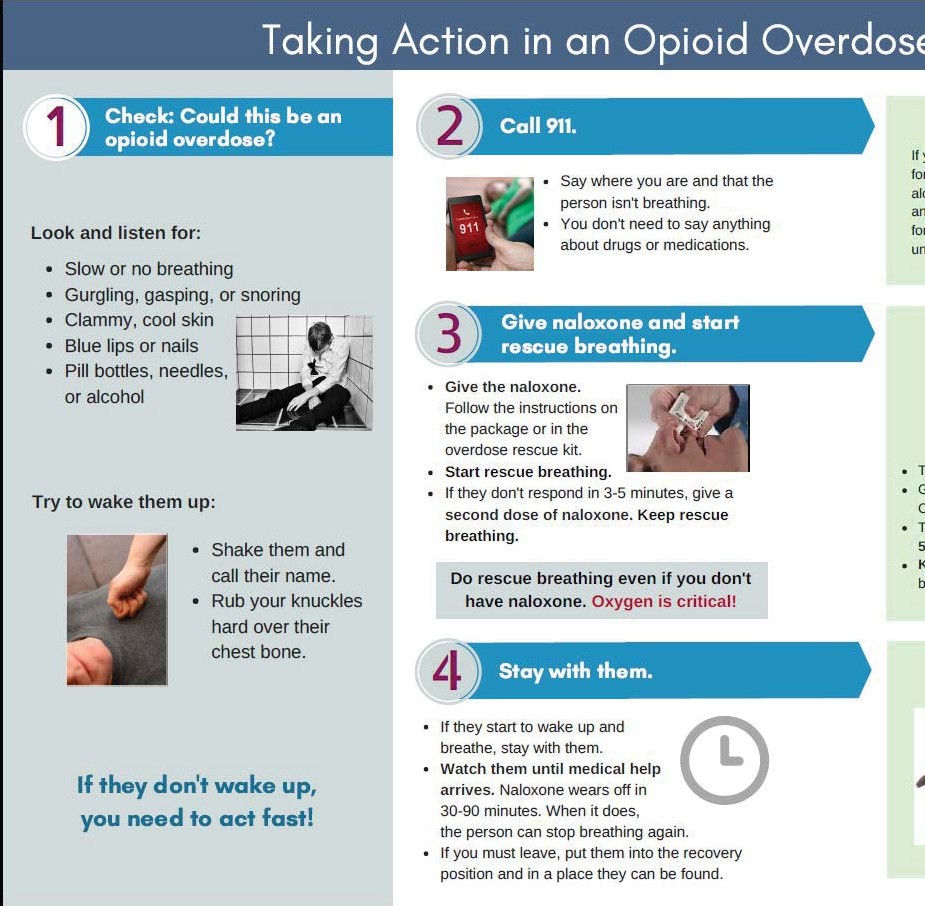
|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Yawning:**  *Observation during assessment*  **0** no yawning   1. yawning once or twice during assessment 2. yawning three or more times during assessment   **4** yawning several times per minute |  |  |  |  |
| **Anxiety or irritability:**  **0** none   1. patient reports increasing irritability or anxiousness 2. patient obviously irritable or anxious   **4** patient so irritable or anxious that participation in the assessment is difficult |  |  |  |  |
| **Gooseflesh skin:**  **0** skin is smooth  **3** piloerection of skin can be felt or hairs standing up on arms  **5** prominent piloerection |  |  |  |  |
| **Total score**  5–12 = Mild  13–24 = Moderate  25–36 = Moderately severe  More than 36 = Severe withdrawal  **with observer’s initials:** |  |  |  |  |

## APPENDIX 10: Overdose Education



**How can I get naloxone?**

\*Source: [stopoverdose.org](http://stopoverdose.org/). Included with permission.



## APPENDIX 11: MAT Patient Flow Map



|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MAT X Functional Process Map** | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **MAT Intake Map** | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Oritentation | |  |  |  |  |  |  |  |  |  |  |  | Induction | | | | | | | | |  |  |
|  | Pre-  screening Mini Reg, HRN  form and Oritentation #, client  golden rod. tracker, VOB, | | |  | SUD Assessment | MAT  Triage |  | Check in | Provider Intake |  | Baseline Labs |  | Scheduling and Check Out |  | Check In |  | Drug Screen (UA) |  | Vital Signs |  | Provider Consult | Self Administer of Medication and Monitor | Schedule follow-up |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  | Ongoing |
|  |  |  |  |  |  |  |  |  |
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|  |  |  |  | 0 min |  |  | 24-48 hrs |  |  | 0 min |  | 0 min |  | 48 hrs |  | 0 min |  | 0 min |  | 20 min |  |  |  |  |  |
|  | 5-60 min | 30-60 min | 5 min |  | 120 min | 30-45 min |  | 5 min | 60-90 min |  | 30 min |  | 15 min |  | 5 min |  | 10 min |  | 5 min |  | 10 min | 60-120min | 2 min |  |  |
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|  |  |  |  |  |  |  | UA and CDP finishes Schedule collateral assessment and Intake information Target | | |  | Intake (1.0  and 2.1) Individual | |  | Group (Can be individuals if actively using) |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  | 8 weeks to 2 years | |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  | 3-7 days | ? |  | 1 day> | 15 min | 45 min | 1-3 days | 90 min-180 min |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |  | IOP= 3 times a week | |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  | OP= 1 time a week | |  |  |  |  |  |  |  |  |  |  |
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| **Legend** | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | Tasks | Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Provider |  |  | Provider Intake, Provider  Consult | 100 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Receptionist |  |  | Record contact info, check-in, scheduling and check out, check in, schedule follow-up | 32 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| NCM |  |  | MAT Intake, | 30 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MA |  |  | Drug screen, vital signs, self administer | 75 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| CDP |  |  | SUD Check in,  Sud  assessment | 140 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |



OBOT NCM:

-Keeps prescription that was signed off by MAT prescriber

-Contacts patient by phone to review induction plan

-Faxes prescription to pharmacy for patient to pick up for induction



OBOT NCM:

-Induction occurs in clinic or at home.

-Patient is followed up by telephone as needed.

-Patient returns weekly or more frequently if needed over 4–6 weeks.

-Patient visits weekly to biweekly, monthly, randomly, or PRN.



-MAT provider sees patient at least once every 6 mos.

−Patient sees primary care physician as needed.

−Electronic health record information documents lab and UDS results and treatment plan changes.

−Patient receives phone consultation/support as needed.



OBOT NCM:

-Maintenance

-Call-backs/check-ins

-Medical issue such as surgery, acute/chronic pain, medication changes, pregnancy, and taper

-Mental health including need for psychiatric evaluation, medication, counseling, and intervention

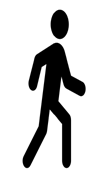


**Green = Patient**

 **Blue = Nurse care manager (NCM) ** **Black = MATProvider/prescriber**



MAT Provider provides ongoing maintenance, primary care and specialty provider referrals.



Patient initiates contact or receives referral from SUD department or outside provider.



-NCM triage/screens potential patient.

−If patient is in system, NCM reviews info from other sources and chart review (e.g., SUD, MH).

−NCM schedules intake assessment.



OBOT NCM intake visit includes:

-Nursing assessment

-Review and signing of consent and contract form/copies to patient

-Education

-Specimen collection for lab work and UDS (per MAT protocol

MAT provider visit includes:

-MD/provider assessment

-Physical exam

-Review of lab results

-Sign off on appropriateness of diagnosis and treatment plan

## APPENDIX 12: Alcohol Use Disorder

**Alcohol Use Disorder (AUD)**

Purpose: MAT program clinicians will assess for alcohol use in patients seen in its clinic as a general screening process to ensure patients are receiving comprehensive treatment evaluation on an ongoing basis.

Alcohol Screening/Alcohol Use Disorders Identification Test:

AUDIT-C: A 3 question brief alcohol screen that reliably identifies patients who are hazardous drinkers or have active alcohol use disorder (see appendix #). Clinic staff should document this screening at least once monthly, and referred to MAT provider or NCM for further evaluation.

* + Scoring: The AUDIT-C is scored on a scale of **0-12** (scores of **0 reflect no alcohol use)**. In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.
  + AUDIT: A 10-item screening tool developed by the World Health Organization (WHO) used to assess alcohol consumption, drinking behaviors, and alcohol-related problems (see appendix #). The AUDIT has been validated across genders and in a wide range of ethnic/racial groups and is well-suited for use in the primary care setting.

ASSESSMENT (for Medication Management/Naltrexone):

* + History & Physical: Conduct a medical, psychiatric, substance use, and substance use treatment history.
  + Urine drug tests: Use reliable urine tests for opioids (including morphine, methadone, buprenorphine, and oxycodone). Use breathalyzer to estimate patient’s blood alcohol content (BAC).
  + Lab tests: CBC, CMP w/ liver functions, creatinine, PT/INR, uHCG
    - **Severe liver disease or acute hepatitis:** Patients should not be treated with naltrexone if severe liver dysfunction is present. Mild to moderate transamintis (AST/ALT ≤ 3 upper limit of **normal**) is common in alcohol-dependent patients and in conditions of often comorbid with alcohol dependence, such as hepatitis C and HIV infections, and not contraindication to treatment with naltrexone.
    - **Creatinine:** Use caution with an estimated GFR of less than 50, as the safety of injectable naltrexone has not been established in this population.
    - **Plateletcountand PT/INR.** Extended-release, injectable naltrexone requiresa deepintra- muscular injection, and thereforecaution isrecommendedinpatients with a severe coagulopathy (platelet count < 50,000 or INR > 2) or in patients treated with

anti-coagulant medications(exceptingaspirinorstandard NSAID treatment).

* + - **Pregnancy test.** There are no studies assessing the safety and efficiency of naltrexone for alcohol dependence in pregnancy. Naltrexone is not recommended for opiate use disorder (OUD) treatment in pregnancy.
  + Prescription Monitoring Program (PMP): Ensure patient is not currently being prescribed

opioids from an outside provider. A report should be verified prior to initial consult with the provider or during intake appointment with the NCM.

* + Clinical Opioid Withdrawal Scale (COWS) should be used to assess for evidence of opioid dependence.
  + Reports no allergies to naltrexone or components of vivitrol preparations.
  + Assess for signs and symptoms of intoxication.
    - CIWA-Ar

Alcohol Detoxification Assessment:

Patients who are currently experiencing symptoms of alcohol withdrawal, have a history of hospitalization for severe alcohol withdrawal, seizures, or delirium tremens should be treated for their alcohol withdrawal and may receive therapy with naltrexone concurrent with this treatment.

Alcohol Withdrawals during Naltrexone Treatment:

Patients who reduce or stop alcohol use may experience alcohol withdrawal symptoms. Naltrexone does not treat alcohol withdrawal. Patients with severe alcohol withdrawal symptoms or previous episodes of severe alcohol withdrawal should be referred to an inpatient detoxification program or the emergency department if necessary. Patients with mild to moderate alcohol withdrawal who are medically and psychiatrically stable, and have stable housing, may be treated as outpatients (e.g., chlordiazepoxide or off‑label gabapentin) and given naltrexone concomitantly.

Assess the level of alcohol withdrawal. If you are in doubt about alcohol withdrawal, use the **Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised (CIWA-Ar) (Appendix F)** to determine the level of withdrawal.

(INSERT CLINIC HERE) MAT Emergency Transfer Process:

* + Patients experiencing acute alcohol withdrawal symptoms should be transferred via EMS to the nearest emergency room for further medical evaluation and management.
  + Provider will assess the patient’s current mental status, medical stability, and risk assessment prior to transferring patient for higher level of care.
  + Provider will direct nursing staff of decision to transport patient, and NCM will ensure request for transfer is accomplished in a timely manner.
  + Verbal report will be provided to EMS staff at time of arrival including copy of provider notes, patient demographic information, and lab available lab results.
  + NCM will follow-up on patient status same day of transfer.

Naloxone Challenge:

If there is any remaining doubt that the patient is opioid-free, consider administering a naloxone challenge prior to injecting naltrexone (vivitrol).

* + Administer naloxone 0.8 mg naloxone intramuscularly or subcutaneously.
  + Observe for signs or symptoms of opioid withdrawal (chills, piloerection, pupil dilation, nausea, diarrhea, anxiety) for up to one hour.
  + If there are no signs or symptoms of opioid withdrawal after one hour, proceed with naltrexone injection.
  + If the patient shows any signs or symptoms of opioid withdrawal during the observation period, do not administer naltrexone.

DIAGNOSIS:

* + DSM–IV described two distinct disorders, alcohol abuse and alcohol dependence, with specific criteria for each. **DSM–5** integrates the two DSM–IV disorders, alcohol abuse and alcohol dependence, into a single disorder called alcohol use disorder (AUD) with **mild, moderate, and severe sub-classifications.**
  + The NCM or provider will complete the DSM-V alcohol use disorder diagnosis tool and document appropriate patient responses in the patient’s record in EHR (see appendix #).

TREATMENT (Medication Management/Naltrexone):

* + Informed consent: Patients must be provided all risks and benefits of medication and non- medication treatment options. Document discussions in patient’s medical record.
    - Provide patient with written education of medication side effects
    - Caution patient about increased risk of opioid overdose if treatment is stopped and return to illicit opioid use or attempt to override the receptor blockade.
    - Patients must be abstinent for 7 to 10 days (short acting) or 10 to 14 days (long acting) before naltrexone is to be taken.
    - Patient must sign a treatment agreement before starting treatment (see appendix #).
    - Monthly Vivitrol injections will be administered in clinic by nursing staff; nursing orders must be placed by provider on same day patient presents for appointment. It is the patient’s responsibility to pick up medication from the pharmacy, however (INSERT CLINIC HERE) MAT staff may assist accessing medication for patient if requested in advance.

MEDICATION OPTIONS:

1. Naltrexone (Revia) Naltrexone is an opioid antagonist available for once-daily oral administration and considered a first-line medication in treatment of alcohol use disorder. Patients should be trialed in initial dose of 25-50mg oral dosing.
2. Naltrexone (Vivitrol) is an extended-release suspension for once-monthly intramuscular injection. The two formulations have not been directly compared to evaluate whether the long-acting injectable formulation improves treatment adherence and clinical outcomes; patients may benefit if daily dosing is a concern by the provider.
3. Disulfram (Antabuse) is a deterrent medication used for alcohol dependence. Patient should be instructed to abstain from alcohol for at least 12 hours before administration as they will experience unpleasant symptoms such as Nausea and vomiting, chest pain, dizziness, sweating and flushing, difficulty breathing, confusion, and weakness.
4. Acamprosate (Campral) used to decrease cravings for alcohol, often recommended in treating patients with history of abusing multiple substances.
5. Other medications: Gabapentin

COUNSELING**:**

Extended-release, injectable naltrexone with brief physician support may achieve similar outcomes as specialty alcohol treatment and self-help programs alone. Therefore, participation in counseling or self-help should be encouraged but not mandated. (INSERT CLINIC HERE) MAT staff will encourage clients to participate in a

variety of appropriate counseling options to support their sobriety (e.g. SUD counseling, weekly MAT groups, AA groups).

**Assessing Alcohol Withdrawal with the CIWA---Ar**

* 1. Complete the CIWA-Ar worksheet in Appendix (sample is shown on next page). Record the date and time of the patient’s last drink on CIWA-Ar form and scan to patient record in EHR. **Note**: Patients with recent alcohol intake may have minimal withdrawal symptoms but can develop symptoms later in the course of alcohol abstinence.
  2. Add the scores for each question to obtain the total CIWA-Ar score for the patient and use it to assess the severity of current alcohol withdrawal symptoms according to the following:

|  |  |  |
| --- | --- | --- |
| **Total CIWA-Ar Score** | **Severity** | **Treatment Setting** |
| 0 to 9 points | Very mild withdrawal | Ambulatory detoxification |
| 10 to 15 points | Mild withdrawal | Ambulatory detoxification |
| 16 to 20 points | Modest withdrawal | Inpatient detoxification |
| 21-67 points | Severe withdrawal | Inpatient detoxification |

* **Patients with a CIWA---Ar score of >15**: Should be referred for inpatient medical detoxification, including transport to the nearest emergency department, if appropriate. These patients may continue evaluation for possible treatment with extended-release, injectable naltrexone following completion of the inpatient alcohol detoxification.
* **Patients with a CIWA---Ar score of <10:** May not need pharmacological treatment for withdrawal but may need repeat assessment during the first 3 to 4 days of alcohol abstinence to monitor for the emergence of additional symptoms.
* **Patients with a CIWA---Ar score of 10 to 15:** Assess for potential ambulatory alcohol detoxification treatment (described below).

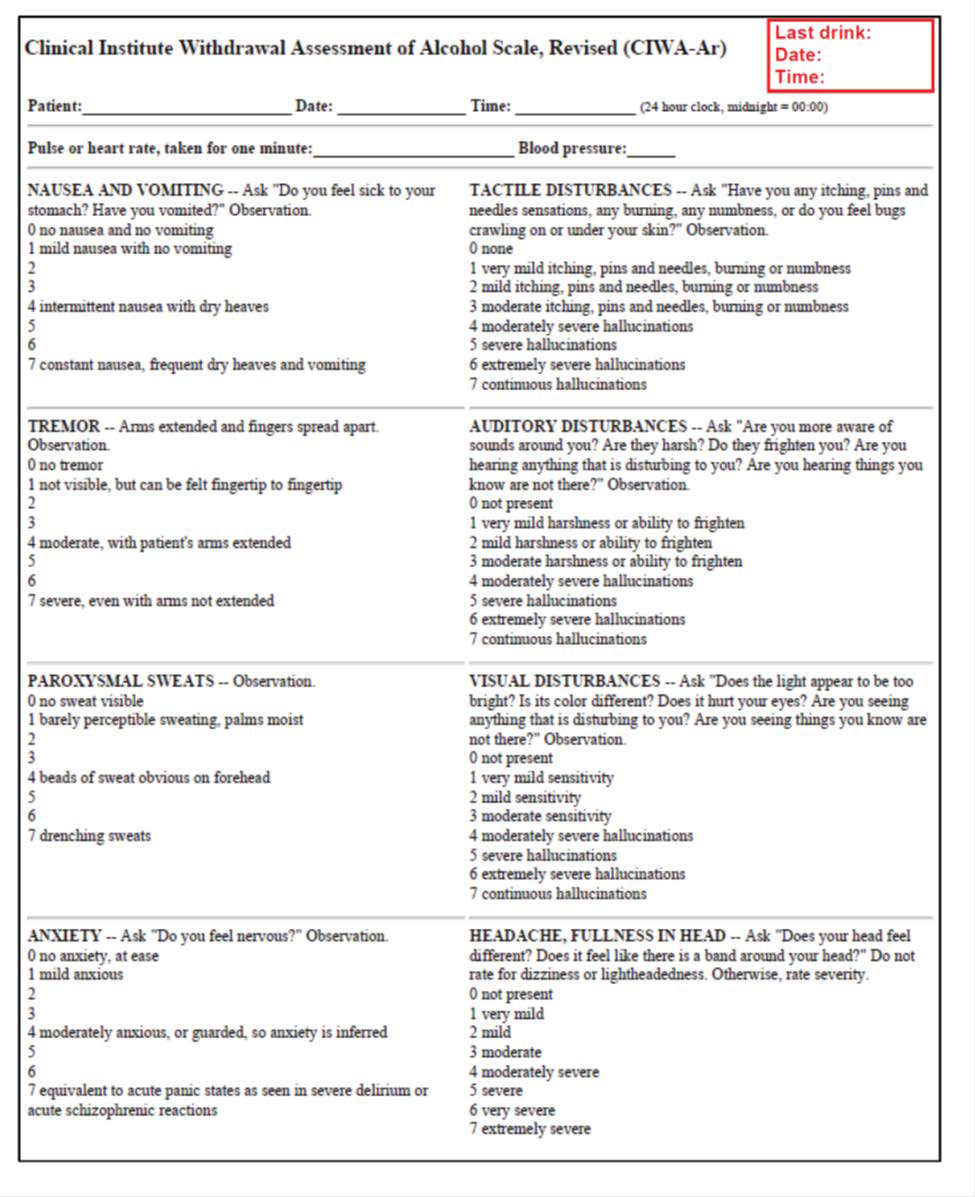
Patients who meet the following criteria may undergo **ambulatory alcohol detoxification**

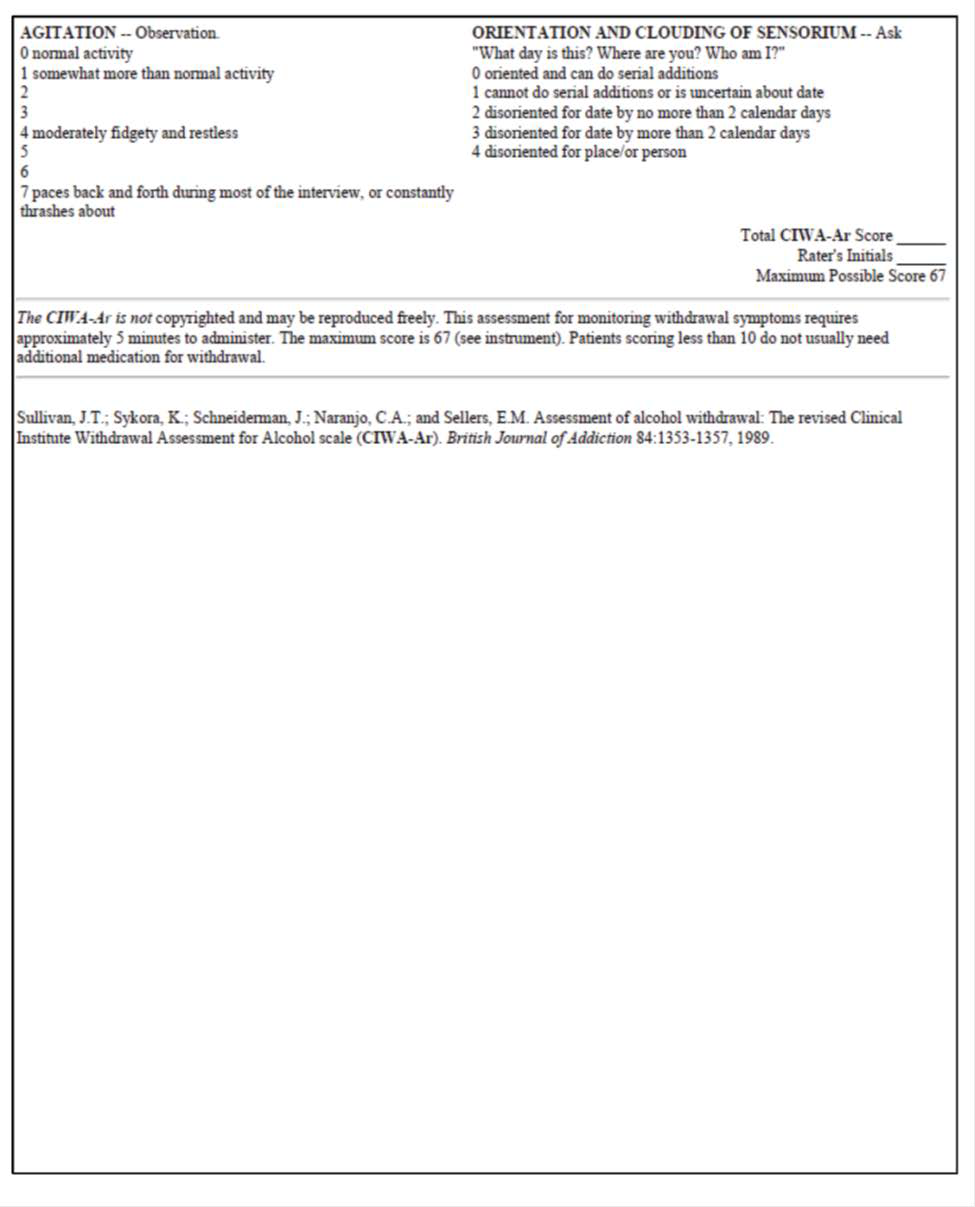
treatment:

* + CIWA-Ar score of 10 to 15
  + Able to take oral medications
  + Have stable housing and a reliable family member or care support who can monitor the patient for the first 3 to 4 days and get help if symptoms worsen
  + No unstable psychiatric or medical condition
  + Not pregnant
  + No concurrent other substance abuse that might lead to withdrawal symptoms (e.g., narcotic or other sedative withdrawal)
  + No history of previous severe alcohol withdrawal episodes (e.g., delirium tremens) or alcohol withdrawal seizures

Possible treatment for ambulatory alcohol detoxification:

* + Possible benzodiazepines or off-label use of anticonvulsants, such as gabapentin
  + Ask patient to return to clinic for reassessment and repeat CIWA-Ar on day 3 of alcohol abstinence, or sooner if symptoms worsen





## APPENDIX 13: Buprenorphine Patient Handout

**(INSERT CLINIC OR DEPT. HERE)**

MEDICATION ASSISTED TREATMENT PROGRAM:

**BUPRENORPHINE COMPONENT**

**Introduction:**

Welcome to the Buprenorphine Component of the Medication Assisted Treatment (MAT) Program of the (INSERT CLINIC HERE) ((INSERT CLINIC HERE)).

The purpose of our Buprenorphine Component is to provide you with an alternative to active addiction to narcotics (heroin, methadone, OxyContin, Percocet, Vicodin, etc.). (INSERT CLINIC HERE) believes that treating the physical dependence to opioids is only part of a holistic solution to address the complex nature of addiction.

**What is Buprenorphine?**

Buprenorphine is a medication used to treat chronic opioid dependence. This can be prescribed in different formulations, such as sublingual tablets or film strips. Different formulations have different brand names such as mono-Buprenorphine (Subutex), Buprenorphine/naloxone (Suboxone, Zubsolv). Your provider will explain why a particular formulation would be chosen over another.

**What are opioids?**

Natural opioids (morphine, codeine) are substances that are derived from the opium poppy. Endogenous opioids (endorphins) are produced by the human body during exercise. Semi- synthetic opioids (oxycontin, hydrocodone, oxymorphone) are produced in the laboratory from natural opioids. Synthetic opioids (fentanyl, propoxyphene) are manufactured 100% in the lab.

The Buprenorphine Component is part of the (INSERT CLINIC HERE) MAT Program. Buprenorphine is medication that patients take as a substitute for narcotics (like heroin and oxycontin). In addition to using Buprenorphine, all of our patients are involved in counseling to address the psychological aspects of drug addiction. The (INSERT CLINIC HERE) MAT Program provides the medical management of Opioid Addiction (prescribing Buprenorphine, drug screening for illegal drugs (so as to keep patients on track) and counseling and referrals determined by patient need). All blood work will be conducted through the (INSERT CLINIC HERE) Health Clinic or referred to local labs (depending on location) to test the liver function of our patients to make sure they are able to continue taking Buprenorphine.

**How does Buprenorphine Work**?

Buprenorphine is an opioid. Like all opioids, Buprenorphine works by binding to a receptor called the mu- receptor. The mu-receptor lives on the surface of cells in the body and the opioid is what activates the receptor. Think of it as a door with a lock on it where the receptor is the lock and the opioid is the key. In order to get high from morphine or treat pain with Percocet, the key must fit into the lock.

During exercise, endorphins are the key. If you are using street drugs, they are the key. If you are on Buprenorphine, Buprenorphine is the key.

Some drugs bind for a long time, others for a short time. Some bind and turn the receptor on; others bind and turn the receptor off.

The Buprenorphine website is a great resource for further information about how Buprenorphine works physically: [www.samhsa.gov/medication-assisted-](http://www.samhsa.gov/medication-assisted-) treatment/Buprenorphine

When opioids enter the bloodstream, they go to the brain and attach to the mu-receptor, which is located on the outside surface of the cell. This causes the chemical **dopamine** to be released in an area of the brain called the nucleus accumbens.

Increased levels of dopamine cause euphoria; repeated use of opioid drugs cause the mu- receptors to become tolerant, which means that you need higher and higher doses of the drug in order to get the same high feeling. Over time, the brain changes so that it only functions “normally” when opioids are present and bound to the receptors.

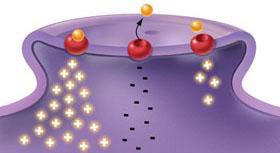
Mu-receptor



Opioid Molecule

Dopamine

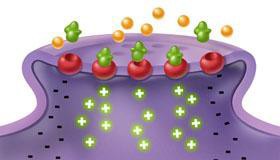
If you stop using drugs, the opioids leave the receptor. Brain chemistry goes out of whack and noradrenalin is released.



Noradrenalin

If, when the opioid leaves the receptor you experience symptoms of withdrawal, you are physically dependent on the drug. Increasing levels of noradrenalin cause the symptoms of withdrawal. Cravings may also be present at this time.

Enter Buprenorphine:



Once you take BUPRENORPHINE, the medication ( ) enters the blood and travels to the brain where it binds to the mu receptor. The dopamine levels rise and you feel better. As a partial agonist (it blocks other opioids but only partly binds the receptor), Buprenorphine produces less euphoria than a full opioid agonist but is sufficient to suppress withdrawal and cravings.



Buprenorphine sticks to the mu-receptor better than other opioids and therefore keeps them from binding. Buprenorphine stays in the system for a long time. Therefore, once a maintenance dose is established, withdrawal and cravings will be controlled.

Kosten TR, George TP. The neurobiology of opioid dependence: implications for treatment.

*Science & Practice Perspectives*. 2002;1:13-20.

**Who Can Prescribe Buprenorphine?**

Not all providers can prescribe Buprenorphine. To prescribe Buprenorphine, a provider must either be a specialist in Substance Abuse treatment, or they must have completed specialized training that certifies them as a Buprenorphine Provider. Once providers are certified as Buprenorphine Providers, they may care for up to 30 patients during their first year of practice and up to 100 patients per year thereafter.

**What is the philosophy of the (INSERT CLINIC HERE) MAT Program with regard to treating opioid dependence?**

At the (INSERT CLINIC HERE) MAT Program we believe that opioid dependence is a chronic brain disease. Chronic diseases such as opioid dependence, asthma, diabetes, and obesity are best treated through a combination of medication management and behavioral changes. Buprenorphine is one of several medications approved by the FDA to treat chronic opioid dependence.

Our philosophy is that addiction is a chronic brain disease which negatively affects a person’s ability to function in an emotional, physical and spiritual capacity. (INSERT CLINIC HERE) believes that restoration from active opioid addiction requires access to the most promising forms of treatment, including access to evidence based treatments.

**Why does the (INSERT CLINIC HERE) MAT Program recommend Buprenorphine patients be in therapy?** Research has shown that successful treatment of opioid dependence requires a program that combines medical management (Buprenorphine) and behavioral therapy (counseling, intensive outpatient therapy, Alcoholics Anonymous, Narcotics Anonymous, etc.) Therapy is an integral part of this program. Each patient will be evaluated to determine the course of treatment, there will be a minimum of one Buprenorphine therapy group per week.

**Is it possible to ever get off Buprenorphine?**

Yes. The ultimate goal is to taper all of our patients off Buprenorphine. Generally, the patients who are the most successful in tapering are involved in intensive therapy, have an extensive social support network, have changed their lives in a way that they are “comfortable” in recovery, and choose to taper off Buprenorphine over a long period of time.

**What happens if I use opioids while I am taking Buprenorphine?**

At the (INSERT CLINIC HERE) MAT Program, we understand the nature of chronic opioid dependence. Relapse can be a part of this disease. If you relapse, please inform your counselor and provider so we can address your relapse. If you continue to struggle with relapse you’re treatment plan could be modified (ie. more frequent visits, referral to a higher level of care, etc.).

As discussed above, treatment of chronic opioid dependence with Buprenorphine has two parts: medication management and behavioral therapy. A Buprenorphine Waivered Provider must supervise medication management while a therapist, counselor, psychologist or psychiatrist monitors behavioral therapy. Medication management is individualized and follows a six step protocol which includes:

1. Prescreening/Consultation
2. Assessment/Admittance
3. Induction (home or office based)
4. Stabilization
5. Maintenance
6. Medical withdrawal

**Prescreening/Consultation**

A consultation appointment will be scheduled when you call, walk-in, or are referred for opiate treatment. During that appointment staff will review your substance use history with you and give you information about the (INSERT CLINIC HERE) MAT Program. You will then be asked to complete the paperwork for the assessment process. You will complete your first urine drug screen during this appointment.

**Assessment/Admit**

The chemical dependency assessment takes two hours with a CDP. If you appear to meet criteria for opiate dependence, you will be referred to the (INSERT CLINIC HERE) MAT Program to undergo a physical examination and labs will be drawn to make sure you are healthy enough to be taking Buprenorphine. The admit portion of the program involves review of all the requirements of the program with a chemical dependency professional and signed Buprenorphine Program participant contract. The provider and the counseling staff will then meet to determine your eligibility into the program.

**Induction**

The induction transitions you from your current opioid to Buprenorphine. Because of the way that Buprenorphine works in your cells, you must be in moderate to severe withdrawal before you take your first dose of Buprenorphine. Your degree of withdrawal will be assessed using the Subjective Opiate Withdrawal Scale, or SOWS. If your SOWS scale is an 11 or higher, you can begin induction. If not, you will have to wait. On the day of your induction you will receive a

prescription for Buprenorphine which you will take to one of our designated contract pharmacies in the local area to be filled. Home inductions?

You will return to the (INSERT CLINIC HERE) MAT Program to take your first dosing of Buprenorphine and will be observed by a (INSERT CLINIC HERE) MAT provider. This allows the provider to teach patients how to properly take medication and observe them for any adverse reactions. Buprenorphine should not be swallowed but rather should be placed under your tongue and allowed to dissolve. This usually takes about five minutes. If you take Buprenorphine and there are still high levels of narcotics in your system or if you are not in an adequate state of withdrawal, you will probably feel worse and may need stabilizing treatment, which may include a trip to the emergency room.

After the induction you will be scheduled for a follow up appointment as per your treatment plan, usually the next day. This appointment will be scheduled with you before you leave the induction. Home inductions?

**Stabilization**

Stabilization lasts anywhere from a few days to a few months. During stabilization, you will have weekly to bi-monthly doctor appointments and random drug screening. You will be seen weekly until we feel you are ready to be seen less frequently.

We also understand that relapses happen. If you relapse and produce urine that is positive for an opiate or another substance for which you do not have a prescription, we will see you on a weekly or more frequent basis, if warranted. If you have any questions about what constitutes positive urine please ask your (INSERT CLINIC HERE) MAT staff.

**Maintenance**

Maintenance lasts from weeks to months and sometimes even years, depending on your situation. The focus will be on continued participation in counseling and relapse prevention.

**Medical Withdrawal**

At some point in the maintenance stage of our program you will talk with your provider about gradually decreasing the dose of Buprenorphine. When you are ready and when it is medically appropriate, you will be able to reduce your Buprenorphine dose.

**Will I have any discomfort during withdrawal?**

Yes. Withdrawal is uncomfortable. There are several non-narcotic medications that can be prescribed for patients feeling poorly during the induction or during the medical withdrawal phase of our program.

**How is Buprenorphine dosed?**

Buprenorphine is taken once, twice, or three times per day as is medically appropriate. Medication may be prescribed in either oral pill form or sublingual strips dependent upon provider or patient preference or pharmacy availability.

The results of your urine toxicology screens will be linked to the time of day you take your Buprenorphine. If you spread the doses out, the urine levels will be low. Low levels of Buprenorphine in the blood could indicate diversion (i.e. selling or giving Buprenorphine to someone else) at this point we may suggest you move off the Buprenorphine program to a higher level of supervision such as methadone maintenance, inpatient, or intensive outpatient treatment.

**Is there any safety issues associated with taking Buprenorphine?**

Some patients taking Buprenorphine will experience an elevation in their liver enzymes (hepatitis). If this happens, your dose will have to be lowered or stopped. Shooting Buprenorphine can kill you. Most deaths from Buprenorphine overdose occur because Buprenorphine is mixed with alcohol or a medication that depresses brain activity (Valium, Ativan, Xanax, sleeping pills, tranquilizers, etc.). Buprenorphine has the potential for abuse and can produce dependence. Buprenorphine withdrawal is not considered to be as severe as withdrawal from other narcotics.

**Does Buprenorphine have any side effects?**

All medications have side effects. Signs and symptoms of a severe allergy include difficulty breathing and a rash. If this occurs, call 911 immediately and/or go to an emergency room immediately. Less serious side effects include abdominal pain, constipation, nausea, headache and loss of appetite.

**What happens if I lose my pills or film?**

If you lose your prescription, or if it is stolen or damaged, you will have to wait until your next scheduled appointment to receive another prescription. Loss or damage of your script should NEVER happen. Please keep your prescription in a safe, dry place to which only you have access. If something does happen, however, please call the clinic as soon as possible so that we can make a note of it in your medical record and call law enforcement when appropriate.

**What happens if I don’t take all of my pills or film?**

It will be assumed that you are selling or giving them to someone else. This is called “diversion” which is illegal and can cause dismissal from the program. You are expected to be able to produce any medications that you have not yet taken at a scheduled visit or if we call you in for an unannounced “medication callback.”

Do you require urine collections?

Yes, we utilize this level of supervision to discourage anyone from attempting to provide something other than his or her own urine. Any intentional tampering or manipulating of a urine test could result in potential discharge from the program.

**Can you explain program non-compliance?**

Patients receiving MAT treatment who are non-compliant should be provided education and the opportunity to correct the non-compliance issue. If clients fail repeatedly to be compliant, the treatment team should staff the patient and determine the best course of action to correct the behavior, such as increase in clinic visits, reducing length of prescriptions, increased urine drug screening, or discharge the client to a higher level of care. There are several 1ci.rcumsFtainluceres twohaicdhhewrielltroesyuolutrinsentocno-ucnosmeplinliagnscceh.eTdhueley include (but are not limited to):

1. Abusive behavior in the clinic by the patient or any member of their party/family
2. Not attending “call back” appointment
3. Urine positive for any drug of abuse or non-prescribed drugs
4. Failure to appear for an appointment
5. Report from a pharmacy that you are picking up a prescription for a drug of abuse.

**What circumstances would cause me to be discharged from (INSERT CLINIC HERE) MAT program?** Sometimes we have to take patients out of (INSERT CLINIC HERE) MAT immediately and suggest they enter a more structured environment such as inpatient, intensive outpatient, or methadone maintenance. Examples for which this may occur include (but are not limited to):

1. A negative urine test for Buprenorphine. The testing is so sensitive now that you test positive even if you are taking 2 mg a day and miss a dose.
2. If you are caught selling your prescription.
3. If you are abusive, verbally or physically, to any member of our staff or another patient in our facility.
4. If you chronically miss scheduled appointments.
5. If you falsify or tamper with your urine in any way, at any appointment.
6. Patient may re-enter the (INSERT CLINIC HERE) MAT program following a positive review from the treatment team.

**What are the other requirements for Participation in the Buprenorphine Program**?

1. You are required to inform (INSERT CLINIC HERE) MAT Program of any new medications that you are
2. You are required to inform (INSERT CLINIC HERE) MAT Programs of any side effects that you are experiencing from your medications.
3. Chemical dependency or mental health counseling may be recommended by your MAT team as a part of your treatment plan, however more rigid or defined requirements may be set forth by CPS or drug court.
4. You are required to keep all your appointments here, and if you cannot, you are required to call 24 hours before the appointment. See no-show policy.

**Why should I try Buprenorphine instead of just quitting on my own?**

Years of experience have shown that methadone maintenance decreases death rates among opiate users. You are much more likely to die from an overdose if you relapse while trying to abstain than if you are in a methadone maintenance program. The same hope exists for Buprenorphine.

**Do I have to sign an agreement to participate in the Buprenorphine Program at** (INSERT CLINIC HERE)?

Yes. You will be signing a treatment agreement with (INSERT CLINIC HERE) MAT Program. This agreement states that you have read, understood, and will adhere to the requirements of the program. All drugs, no matter how safe, have side effects and can even cause death. We would not prescribe a drug that we believe would harm you, but you must be aware of the risk of side effects when you take this drug and that all drugs are potentially lethal.

## APPENDIX 14: DSM-5 for OUD

**DSM-5 Criteria for Diagnosis of Opioid Use Disorder**

**Diagnostic Criteria\***

These criteria not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Check all that apply

|  |  |
| --- | --- |
|  | Opioids are often taken in larger amounts or over a longer period of time than intended. |
|  | There is a persistent desire or unsuccessful efforts to cut down or control opioid use. |
|  | A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects. |
|  | Craving, or a strong desire to use opioids. |
|  | Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home. |
|  | Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids. |
|  | Important social, occupational or recreational activities are given up or reduced because of opioid use. |
|  | Recurrent opioid use in situations in which it is physically hazardous |
|  | 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. |
|  | \*Tolerance, as defined by either of the following:   1. a need for markedly increased amounts of opioids to achieve intoxication or desired effect 2. markedly diminished effect with continued use of the same amount of an opioid |
|  | \*Withdrawal, as manifested by either of the following:   1. the characteristic opioid withdrawal syndrome 2. the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms |

**Total Number Boxes Checked:**

Severity: **Mild**: 2-3 symptoms. **Moderate**: 4-5 symptoms. **Severe**: 6 or more symptoms

\*Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,. Washington, DC, American Psychiatric Association page 541.

## APPENDIX 15: AUDIT questionnaire

#### Please circle the answer that is correct for you

##### How often do you have a drink containing alcohol?

* Never
* Monthly or less
* 2-4 times a month
* 2-3 times a week
* 4 or more times a week

1. How many standard drinks containing alcohol do you have on a typical day when drinking?

* 1 or 2
* 3 or 4
* 5 or 6
* 7 to 9
* 10 or more

1. How often do you have six or more drinks on one occasion?

* Never
* Less than monthly
* Monthly
* Weekly
* Daily or almost daily

1. During the past year, how often have you found that you were not able to stop drinking once you had started?

* Never
* Less than monthly
* Monthly
* Weekly
* Daily or almost daily

1. During the past year, how often have you failed to do what was normally expected of you because of drinking?

* Never
* Less than monthly
* Monthly
* Weekly
* Daily or almost daily

1. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

* Never
* Less than monthly
* Monthly
* Weekly
* Daily or almost daily

1. During the past year, how often have you had a feeling of guilt or remorse after drinking?

* Never
* Less than monthly
* Monthly
* Weekly
* Daily or almost daily

1. During the past year, have you been unable to remember what happened the night before because you had been drinking?

* Never
* Less than monthly
* Monthly
* Weekly
* Daily or almost daily

1. Have you or someone else been injured as a result of your drinking?

* No
* Yes, but not in the past year
* Yes, during the past year

1. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

* No
* Yes, but not in the past year
* Yes, during the past year Scoring the AUDIT

Scores for each question range from 0 to 4, with the first response for each question (eg never) scoring 0, the second (eg less than monthly) scoring 1, the third (eg monthly) scoring 2, the fourth (eg weekly) scoring 3, and the last response (eg. daily or almost daily) scoring 4. For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4 (from left to right).

A score of 8 or more is associated with harmful or hazardous drinking, a score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

Saunders JB, Aasland OG, Babor TF et al. Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption —