Missouri Department of Mental Health

Division of Behavioral Health

Provider Implementation Guide for the State Targeted Response Opioid Crisis Grant (Opioid STR)

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

Introduction

This guide is intended to help providers deliver treatment and supportive services to individuals with Opioid Use Disorder (OUD) under the State Targeted Response Opioid Crisis Grant (Opioid STR). DMH and the Opioid STR team have developed this Provider Implementation Guide to outline clear and consistent guidance with step-by-step clinical and administrative instructions on grant utilization.

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

- General **Overview of Grant** and Grant Requirements
- **Important Points** to Remember
- Clinical Guide **for Intake and Psychosocial Supportive Services**
- Clinical Guide for **Medical Treatment of OUD**

General Overview of Grant and Grant Requirements

The Opioid STR project is a $20 million two-year award from the Substance Abuse and Mental Health Services Administration (SAMHSA), using funds provided by the 21st Century Cures Act federal legislation. Missouri Opioid STR will expand access to integrated prevention, treatment, and recovery support services for individuals with OUD throughout the state. The primary focus is on rigorous, multidisciplinary provider training and education on medical treatment of OUD and the provision of evidence-based treatment services to uninsured individuals diagnosed with OUD presenting for care to state-funded programs.

Primary prevention activities will center on increased awareness and decreased availability of opioids, led by local agencies in high risk areas. Prevention of overdose deaths will be accomplished through training clinical providers and at-risk individuals on Overdose Education and Naloxone Distribution practices, and providing telemedicine didactic and consultation services to primary care providers treating chronic pain.

Recovery support services will be provided in the form of Recovery Community Centers, recovery housing, and recovery management checkups, all delivered with a focus on peer support in an effort to increase consumer engagement in their treatment and recovery. The State of Missouri Department of Mental Health (DMH) will lead the project, with administration, implementation, and evaluation activities provided by the Missouri Institute of Mental Health (MIMH) – University of Missouri, St. Louis, as well as healthcare agencies, additional academic institutions, and content experts throughout the state. The primary goals of the Opioid STR project include: 1) Increase provider and student-focused opioid use and overdose prevention initiatives and programs; 2) Increase access to evidence-based medical treatment for uninsured individuals diagnosed with OUD through provider training, direct service delivery, healthcare integration, and improved transitions of care; 3) Increase the number of individuals diagnosed with an OUD who receive recovery support services; and 4) Enhance sustainability through policy and practice changes, as well as demonstrate clinical- and cost-effectiveness of grant-supported protocols.

Important Points to Remember

Basic information of which providers should be aware:

1. The primary goal of this grant is to **SAVE LIVES**.

2. Medication in conjunction with behavioral health services is considered the **most effective treatment** for OUD.

3. Opioid STR funds can ONLY be used to treat **uninsured individuals diagnosed with OUDs in DMH substance use treatment programs**.

4. There are **no treatment levels in Opioid STR**. **The frequency and intensity of services are based on the individualized needs identified in the assessment**. Consumers may initiate and proceed with treatment at the frequency and intensity most appropriate to meet their needs. Some consumers may not need intensive psychosocial support services, though all should be offered the full menu of available and appropriate services. Individuals prescribed medication will not be "mandated" to attend or participate in an arbitrary number of services in order to continue to be prescribed medications to treat their OUD. (*Note: Federal guidelines for Opioid Treatment Programs [methadone clinics] do require a certain amount of counseling or non-medical visits within a certain timeframe [e.g., 1 hr per month for patients in long-term maintenance])

Clinical Guide for Intake and Psychosocial/Supportive Services

The Opioid STR grant has provided an opportunity to reevaluate our intake process, particularly as it relates to serving those diagnosed with OUDs. While it has typically been that an individual has to have a comprehensive assessment and multiple other forms completed prior to seeing a doctor, we are now implementing a "Medication First" model minimizing the burden of paperwork on the front end. Many times individuals with OUD present in the early stages of withdrawal…an opportune time to get them connected with a medical professional, stabilized, and *then* engaged in care planning. Thus, the goals of a re-imagined intake process are to 1) provide rapid access to medical treatment by eliminating known barriers; and, 2) prevent providers from losing reimbursement if an individual enrolls in services but does not return to complete the comprehensive assessment and treatment plan.

**Note: Many of these steps are written for a general audience of DMH providers. Providers in other care settings are encouraged to modify and adapt as appropriate, maintaining the intention and spirit of the guidelines.

The following represent "steps" to take in terms of engaging an individual in services supported through Opioid STR:

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

2. If first contact is **by phone, the provider will conduct their typical pre-admission screening in addition to supplemental brief screening** on opioid use *(see Appendix A; only triggered if individual reports uses opioids in pre-admission screening).* If the individual answers yes to any questions on the Opioid supplemental screening, the provider will schedule the consumer for first available medical appointment. ***The in-person brief screening*** *(described below)* ***will take place when the individual arrives for his/her first appointment prior to the medical appointment*** *in-person.*

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

3. **Alert appropriate staff of client contact and need for emergent medical visit** and proceed with scheduling medical visit. *Prior to the initial medical visit, the individual is administered a brief screening (see Appendix B for an example) by a medical staff coordinator (or other qualified staff) to determine presenting concerns and experience of current opioid withdrawal symptoms*. The screening shall collect the following data:

   a. Date of birth
   b. Vital signs
   c. Results of a drug screen
   d. Report of substances used in the past 30 days, frequency of use, date/amount of last use, and route of administration
   e. Report current or history of other psychiatric symptoms
   f. Report of current ideation or past attempts of self/other harm
   g. Report of prior overdose events

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

5. **Prescriber initiates** buprenorphine or methadone **induction** and **prescribes naloxone** (for take-home purposes) and other ancillary **medications** as clinically indicated. *(Vivitrol cannot be started if a person is in withdrawal. Methadone must be initiated in an Opioid Treatment Program [OTP]. Medication protocols are detailed in the following section, "Clinical Guide for **Medical Treatment of OUD**.")*
    a. **DMH strongly encourages the provision of overdose education and a naloxone prescription upon the earliest possible contact with a consumer, given the high risk of overdose before, during, and after treatment episodes. See step 7, below.** Ideally, this service would be provided during the first visit (following receipt of stabilizing medication); if not possible, please complete at the second visit. Whenever possible include a family member or caregiver in the discussion about naloxone use – *people who overdose cannot administer naloxone to themselves.*

6. Complete the **Eligibility Determination as soon as possible**. Required information includes:
    a. **Diagnoses**, including substance use and mental health disorders, medical conditions, and notation for psychosocial and contextual factors *(rendered by prescriber).*

        The following ***mental health professionals are approved to render diagnoses*** in accordance with the current version of the Diagnostic and Statistical Manual of Mental Disorders:

        - Physicians (includes psychiatrists);
        - Psychologists (licensed or provisionally licensed);
        - Advanced Practice Nurses;
        - Professional Counselors (licensed or provisionally licensed);
        - Marital and Family Therapists (licensed or provisionally licensed);
        - Licensed Clinical Social Workers;
        - Licensed Master Social Workers who are under registered supervision with the Missouri Division of Professional Registration for licensure as a Clinical Social Worker. (LMSWs not under registered supervision for their LCSW credential cannot render a diagnosis).

    b. **Initial treatment recommendations** (*Rendered by agency staff who is coordinating care in this early treatment stage.)*

    c. **Initial treatment goals to meet immediate needs within the first 45 days** of service. *Goals are established with individual prior to, during, or following visit with*

prescriber. Goals established prior to the medical visit will be by agency staff providing service coordination.

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

   OEND is a 10-15 minute conversation about overdose risk and response, including instruction on naloxone administration. (See Appendix C-E for an outline of what should be covered and handouts for clients, and visit the "Training" tab on www.mohopeproject.org to request staff OEND training.)

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

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

9. Facilitate the **comprehensive assessment within 30 days of the date of eligibility determination** *(see other DMH policy documents regarding the assessment components)*. Clinically, it is not appropriate to do a "comprehensive" assessment while the individual is in active withdrawal or before s/he is stabilized on medication.

10. Develop the **comprehensive treatment plan within 45 days of the date of eligibility determination** *(see other DMH policy documents regarding treatment plan components)*.
    a. The treatment plan should be a working document, with goals added and dropped as they are identified and achieved with the involvement of the individual served.
    b. Make sure the treatment plan addresses all life domains affected by the OUD.

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

    a. **Community Support** for those with needs related to entitlements, housing, employment, social supports, legal problems, physical health and wellness, etc.

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

c. **Peer Support** is a required service under Opioid STR, as recognition of its benefits is increasingly widespread. Peers have been used successfully in outreach, active treatment, and recovery services.

d. **Recovery Housing** should be provided for individuals treated through Opioid STR who have been through medical stabilization but need a safe, healthy environment to support engagement in treatment (including but not limited to medication services). DMH providers can bill Opioid STR for housing services at locations approved by the National Alliance for Recovery Residences (NARR) and certified as an Opioid STR housing provider by DBH (for updating listings of approved housing units, visit: https://missouriopioidstr.org/). More information on housing services are in Appendix G.

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

f. **Client-specific Outreach** can be used to facilitate and maintain client engagement (re-engagement efforts that are not billable as community support). This service may involve recovery management check-ups, which involve reviewing the individual's recovery and progress in the areas of substance use, housing, employment, criminal justice, and social connectedness.

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

    Individuals should continue in services as long as needed, receiving no more and no less treatment than is indicated by their individualized needs. That will look different for everyone!

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

Clinical Guide for Medical Treatment of Opioid Use Disorder

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

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

It should be noted that **the majority of the following guidance is in reference to induction, stabilization, and maintenance on buprenorphine**. Buprenorphine has been found to be highly effective for OUD stabilization and maintenance, but has yet to be broadly utilized within the DMH treatment system. This is likely because it comes with its own barriers and "learning curve."

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

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

Phases of Medical OUD Treatment:

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

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

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

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

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

1. Induction:

The goal of the induction is to find the patient's ideal daily dose of buprenorphine that safely suppresses opioid withdrawal and drug craving as rapidly as possible. For most opioid-dependent patients, the daily dose is 12 to 16 mg/day of the buprenorphine + naloxone combination film or tablet. Induction usually takes 2 to 4 days to complete. Buprenorphine + naloxone combination is preferred except for use in special populations such as pregnant women (in pregnany, use of buprenorphine monoproduct [or methadone] are best practice). The following recommendations are for buprenorphine + naloxone combination tablets or films.

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

Induction Steps:

- The first dose of buprenorphine + naloxone combination pill or film should be administered when an opioid-dependent individual has abstained from opioids for 12 to 24 hours and is in moderate withdrawal (If using the Clinical Opiate Withdrawal Scale (COWS), a score of 12 or 13).
- Day 1 of induction: Opioid-dependent patients should be inducted with a 4mgs of buprenorphine dose, and observed for 1-2 hours. If withdrawal symptoms are not well controlled or they reappear, an additional 4mgs should be given. Additional doses in increments of 2mgs can be given up to a dose of 12 to 16mgs.
- For office based induction, it is helpful to allow a 2-4 hour window of office time on the first day of induction. A nurse or medical assistant can perform the monitoring and titrate the medication based on the withdrawal symptoms, based on the physician/prescriber's order. The patient is not necessarily required to sit in the office the entire time.
- For off-site/home induction, on Day 1, remote support should be offered by a nurse (through phone or telehealth) to help assess withdrawal symptoms and determine readiness for induction. This could include but is not limited to assessment of discomfort, agitation, joint pain, stomach upset, diarrhea, chills, restlessness, and other common withdrawal symptoms. The Subjective Opioid Withdrawal Scale (SOWS) can be used by the nurse to assist with the assessment of opioid withdrawal symptoms via the phone.
- If the patient experiences continued withdrawal symptoms and cravings after Day 1, dosage should be increased on Day 2 in increments of 2-4 mg up to 16 mg. Some patients may need titration up to 24mgs. By Day 3 or 4, the dosage needed to fully control the withdrawal symptoms should be determined. There is limited evidence for the efficacy of doses greater than 24 mg, but some patients may benefit from doses up to 32 mg. Doses higher than this will not harm the patient but will do little to decrease patients' cravings, due to a ceiling effect.
- If switching from methadone to buprenorphine, the dosage of methadone needs to be tapered down to 30 mgs per day of methadone before the buprenorphine induction. It

may take more than 36 hours after the last dose of methadone for the patient to be in mild or moderate withdrawal. Also, start with 2 mg dose of buprenorphine and titrate by 2mgs to decrease risk of precipitating acute withdrawal.

Important things to note:

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

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

For individuals with MO HealthNet coverage requiring a Prior Authorization from the treatment provider, call this toll-free number and listen to the menu of options. Phone: (800) 392-8030; Fax: (573) 636-6470.

2. Stabilization:

Goals:

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

Stabilization Steps:

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

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

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

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

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

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

to precipitate a relapse to heroin or prescription opioid misuse and the associated risk to patients.

3. Maintenance:

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

Goals:

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

. ***Maintenance Steps:***

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

- When a patient resumes use of illicit substances, steps should be taken to re-engage them and provide medical stabilization as quickly as possible. Resumed use will often require patients to return for the induction and stabilization phases of treatment.
- Continue implementing the individualized care plan, including but not limited to medical care coordination, community support, peer engagement, vocational training, housing support, individual counseling, and other services as needed.

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

- If the patient is medically, socially, and environmentally stable, facilitate a warm handoff to continue maintenance treatment at an office-based treatment facility:
    - Many Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), Opioid Treatment Programs (OTPs) and other state-contracted and private treatment facilities are now offering buprenorphine treatment for OUD and could serve as excellent referral destinations for patients.

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

4. Tapering and Discontinuing Buprenorphine with Patients:

Things to note prior to initiating a taper:

- There is a high risk for relapse when medical treatment is discontinued, even if a patient has been in maintenance treatment for months or years.
- Discontinuing buprenorphine is not required. Patients can continue buprenorphine therapy indefinitely so long as:
    - *They choose to;*
    - *They experience no significant adverse events that would render treatment contraindicated;*
    - *The treatment improves their functioning and/or decreases their risk for morbidity and mortality.*
- Illicit opioid use should not be grounds for terminating buprenorphine treatment. Alternative responses include checking on proper use of buprenorphine and dose, increasing the frequency of medical and/or monitoring visits, and offering additional psychosocial support services.

Having the conversation*:

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

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

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

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

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

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

- It is important to inform patients that although it may seem like the gains they have achieved with the help of medication can be maintained in its absence, evidence strongly suggests that, *for the majority of patients,* this perception is not accurate. Indeed, for the majority of patients, the medication works when you take it and stops working when it is discontinued, not unlike hypertension or cholesterol medication.
    - For patients who have maintained abstinence from illicit opioids for 5 years or more, their likelihood of maintaining future abstinence is substantially higher than that for those who have been abstinence for <5 years.
- Providers should assess and address patients' motivations for wanting to discontinue treatment, paying attention to the degree to which these motivations are intrinsic (coming from internal factors) or extrinsic (coming from external factors). External factors that are impacting a patient's decision to discontinue buprenorphine might include: pressure from family or peers, negative social stigma, discrimination in the workplace or the job or housing market, etc. Providers should validate these real concerns and provide support to continue the medication, if such support is something the patient is lacking. Of course, <u>the provider's primary role in this exchange is to offer medical advice based on empirical evidence</u>.
    - **Specifically, providers should indicate that continuing buprenorphine therapy will (conservatively) decrease by 2 to 3 times their risk for relapse, overdose, and death.** The protective effect of buprenorphine is likely to be greater for patients who injected heroin or have other risk factors for overdose (such as previous overdose events, co-occurring mental health diagnoses, prior suicide attempts, etc.).
    - Patients should be informed that discontinuation of the medication is especially contraindicated if they are experiencing instability in any key domain of

functioning (e.g., mental/emotional health, primary support system, housing, employment) and if they do not have in place elements of a robust non-medical recovery plan (e.g., consistent and active involvement in a recovery community, a 12-step sponsor).

- **Risk of relapse and overdose will increase following the discontinuation of any medication** (though relative risk of overdose following buprenorphine or methadone is less than the risk following abstinence or naltrexone/Vivitrol treatment). Patients' tolerance to opioids has decreased and, should they resume use, they must start at much lower doses than they used prior to initiating treatment.

Tapering Steps:

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

- The more gradual the taper, the less likely that the patient will experience significant craving and withdrawal symptoms. **Therefore, the more gradual the taper, the safer the taper.**
- Tapers should be paced based on patients' ability to tolerate each decrease. As such, providers should increase the frequency of office visits during the taper process to regularly assess craving and withdrawal symptoms.
- The length of tapering steps and the magnitude of dose reductions should be individualized to the patient's response and, ideally, would take place over several months.
- In general, decreases should not comprise more than 25% of the current dose and not take place more frequently than every 10 days.
    - Some patients will benefit from even smaller and less frequent dose reductions. For example, a patient may be able to step down 4mg every two weeks when tapering from 24mg to 12mg, but need to step down 2mg every two weeks from 12mg to 4mg, and 1mg every two weeks from 4mg to 0mg.
- Often, the final reductions (lower than 4mg) take as long to taper down as the initial reductions. Go much slower when tapering down from 4 mg and monitor closely for cravings and withdrawal symptoms.
- Some patients can taper down to 2 or 4 mg but cannot discontinue the medication completely without uncomfortable withdrawal symptoms or a sharp increase in cravings. This possibility should be discussed with each patient.
- It is always safer to titrate back up to a higher dose (vs. continue with tapering) if a patient starts experiencing strong cravings to use illicit opioids.
- Offer the option of Vivitrol (long-acting naltrexone), if appropriate, for continued treatment of OUD. This option can further improve patients' chances of preventing relapse.

- Prior to starting Vivitrol (long-acting naltrexone shot), the patient should be off buprenorphine for about 7- 10 days to prevent precipitation of acute opioid withdrawal. The treatment plan should consider additional supports needed during this period to prevent a relapse.
- Patients who discontinue buprenorphine should be monitored and assessed for cravings by medical and psychosocial support staff for as long as they remain engaged in any form of care.
- Patients should be encouraged to return for maintenance medical treatment if strong or persistent cravings develop.

For more information about topics such as tapering and pain, emergency tapering, or to create a tapering schedule, providers and their patients can visit:
http://www.helpmegetoffdrugs.com/taper

Appendix A.

Example Opioid STR Phone Screening

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

Check All That Apply

1. Opioids

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

2. Other

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

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

Appendix B.
Example Initial Screen for Opioid Use Presentation

Date: _____ Time: _____ Referral Source: _____

Client's Name_____ Date of Birth/Age_____

Address_____
City/State/Zip_____

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

Drug Screen Results: _____
Alcohol Breathalyzer Results: _____

Last Treatment (when/where):
_____

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

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

Previous suicide attempts (method, date):

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

Signature of Staff Person (name and title): _____

Appendix C.

Points to cover in Overdose Education and Nalaxone Distribution (OEND) trainings

(document for clinicians)

MO-HOPE Project

Acute risk factors:

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

Recognize signs:

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

Rescue response/ how to use naloxone:

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

Tips for prevention:

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

MO-HOPE Overdose Field Report:

- *Walk through materials:*
  - Field Report Instruction Card
  - Field Report Business Card (wallet size for convenience)
  - Mini Field Report (to take notes for later web entry)
- *How to complete the overdose field report:*
  - Access the field report using one of the following methods listed on the field report instruction card *(also, on back of this sheet)*:
    1) Enter the survey link, OR
    2) If you have an app on your phone that is capable of scanning QR codes, scan the QR code.
- *Once you have accessed the survey,* ***add link to home screen*** *(see back of field report instruction card)*
- ***Reminder: answer questions as honestly as possible remembering that all information will be kept confidential!***

Appendix D.

Overdose Education and Naloxone Distribution Fact Sheet

(document for clients and community members)

MO-HOPE Project

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

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

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

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

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

Appendix E.

Overdose Field Report

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

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

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

To add the survey to your home screen:

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

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

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

MO-HOPE Project

Overdose Field Report

Please do not forget to upload this information online

mohopeproject.org/ODreport

Date: _____ **Zip Code of Overdose Event:** _____

Individual's city and state of primary residence: _____

Incident Location (circle one): A home or residence
A treatment facility
A public place (specify:_____)
Other (specify: _____)

Your relation to the person who overdosed:
Friend/ Partner or Spouse/ Clinician or Provider/ Parent/
Other family member (non-partner, non-parent)/ Self/ Stranger/ Other
(specify:_____)

For demographics, if you are unsure please select what your believe to be the correct answer!
Individual's age: Under 18/ 18-24/ 25-44/ 45-64/ 65+
Individual's sex: Male/ Female/ Intersex/ Unsure
Individual's race *(select all that apply):* White/ Black or African American/ Asian/
American Indian or Alaskan Native/ Native Hawaiian or Pacific Islander/ Unsure
Other (specify: _____)
Is the individual Hispanic: Yes/ No / Unsure

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

Was naloxone administered? Yes/ No
- *If yes, who administered naloxone?* A friend/ A partner or spouse/ A clinician or provider/ A parent/ Another family member (non-parent, non-partner)/A police officer/A paramedic, fire fighter, or other emergency responder/ A stranger/ Other (specify:_____)

- *If naloxone was administered, what form of naloxone was used?*
  AdaptPharma Narcan nasal spray/ Evzio auto-injector/
  Other intranasal device (with vial and atomizer)/ Other intramuscular device/ Unsure

- *If naloxone was administered how many doses were given?* 1 / 2 / 3 / 4+

- *If naloxone was administered were there any post-naloxone withdrawal symptoms? (circle all that apply)*
  None/ Physically combative/ Irritable or angry/ Vomiting/
  Dope sick (e.g., nauseated, muscle aches, runny nose, and/ or watery eyes)/
  Other
(specify:_____)

Was 911 called? Yes/ No/ Unsure
To the best of your knowledge, did the individual survive the overdose? Yes/ No/ Unsure
Was the individual transported to the hospital?
Yes/ No, escorted to treatment center/ No, escorted to residence/ No, transported elsewhere/
No, declined transport/ Unsure/ N/A; deceased at scene
Has this individual previously been administered naloxone? Yes/ No/ Unsure

Have you received overdose education and naloxone distribution training? Yes/ No
- If yes, which agency provided you with training?
_____
How did you hear about this field report? A training/ A flyer/ Other (Specify:_____)

Appendix F.

Addiction versus Medical Treatment for Addiction

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

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

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

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

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

Appendix G.

RECOVERY HOUSING INFORMATION

Recovery housing should be provided for individuals treated through Opioid STR within a participating DMH SUD treatment program who have been through medical stabilization but need a safe, healthy environment to support engagement in treatment (including but not limited to medication services). Opioid STR can be billed for housing services at locations accredited by the National Alliance for Recovery Residences (NARR) and approved by DBH (for updating listings of approved housing, visit: https://missouriopioidstr.org/).

All Opioid STR program housing must accept people no matter their medication status and place no requirements for step-down dosing or tapering. Other key characteristics of the recovery housing model include:

a. Participation is generally self-initiated with individuals having a preference for living in a recovery-focused environment;
b. Holistic services and peer supports are available to housing participants;
c. A lapse is not treated as an automatic cause for eviction, and relapse prevention and management are supported; and
d. Assistance is provided in finding permanent housing.

Recovery housing will be coordinated by the treatment provider in accordance with the individual's treatment plan. The treatment provider should have a written agreement with the recovery residence to determine payment and coordination of care.

The treatment provider will:

- Assess that the individual with OUD served is in need of recovery housing;
- Review the list of NARR accredited and DBH approved agencies); and
- Contact the recovery residence to determine space availability.

Once the treatment provider has placed an individual in the recovery residence the provider can be reimbursed $25.50 per day through CIMOR code Supportive Housing (Transitional) 12000. The treatment provider will then make payments to the recovery residence.