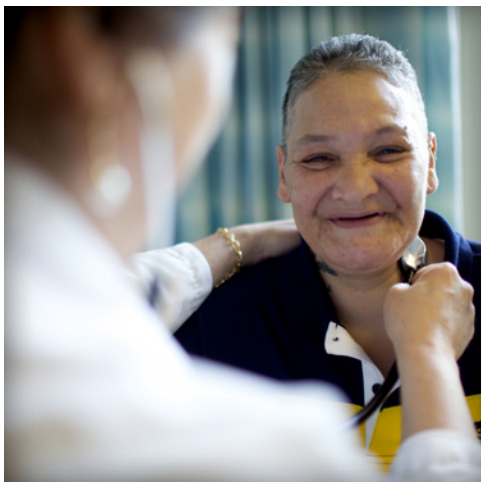
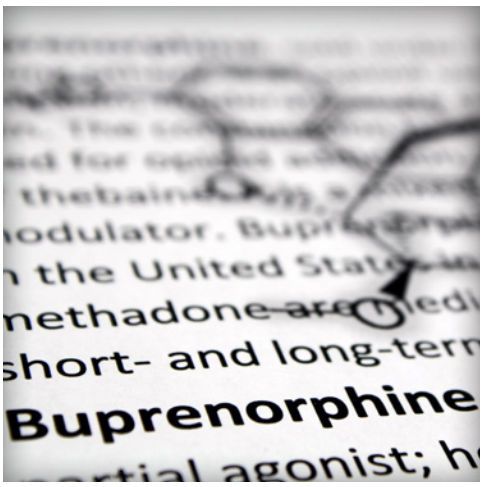
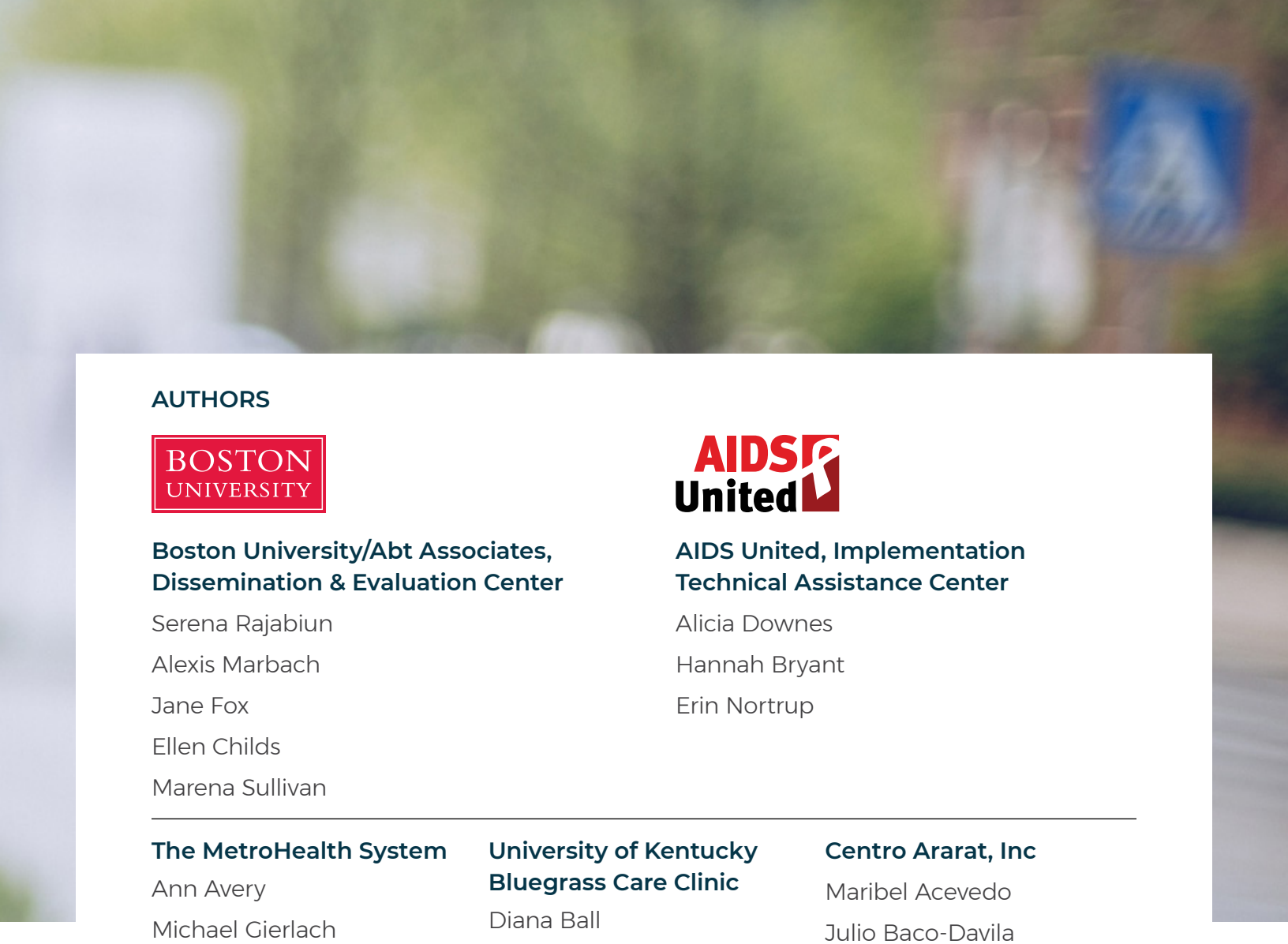
CARE AND TREATMENT INTERVENTIONS





Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS



AUTHORS

Boston University/Abt Associates, Dissemination & Evaluation Center

Serena Rajabiun
Alexis Marbach
Jane Fox
Ellen Childs
Marena Sullivan

AIDS United, Implementation Technical Assistance Center

Alicia Downes
Hannah Bryant
Erin Nortrup

The MetroHealth System

Ann Avery
Michael Gierlach
Melissa Jenkins
Jason McMinn
Michaelle Patterson

University of Kentucky Bluegrass Care Clinic

Diana Ball
Xian Brooks
Laura Fanucchi
Jillian Richardson
Alice Thornton
Ryan Weeks

Centro Ararat, Inc

Maribel Acevedo
Julio Baco-Davila
Romano Baroni
Carlos Carrero
Delgia Cruz Torres
Ana Gonzales
Lourdes Faria
Ivan Melendez

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Contents

Executive Summary

Purpose of This Manual

This manual is designed to share best practices for integrating buprenorphine, a medication used to treat opioid use disorder (OUD), into HIV primary care clinics. This manual can be used by HIV primary care clinical providers, coordinators, administrators, and other clinic stakeholders.

Intervention Description

The Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care intervention is designed provide OUD treatment in the HIV primary care setting utilizing a one-stop-shop model through the following steps:

- **Identify eligible patients**
- **Assess patients for treatment**
- **Prepare patient for and schedule treatment initiation**
- **Initiate treatment**
- **Titrate and stabilize patients**
- **Conduct monitoring visits**
- **Provide ongoing treatment and recovery support to help patients achieve their goals**

This intervention is not time-limited, understanding that "the best results occur when a patient receives medication for as long as it provides a benefit." TIP 63

Rational and Need

Untreated opioid use disorder is problematic for people with HIV as it interferes with antiretroviral treatment adherence[1,2,3,4,5,6,7] and impedes HIV viral suppression.[8,9,10,11] People living with co-occurring HIV and OUD may have inconsistent clinic visits, delayed initiation of antiretroviral therapy (ART), and lower rates of ART adherence.[12] OUD treatment is key to addressing gaps along the HIV care continuum for people with co-occurring HIV and OUD.

Using This Manual

The fields of substance use disorder (SUD) and OUD are constantly evolving and treatment options are always improving. Specific clinical guidance for providers can be found through:

TIP 63: Medications for Opioid Use Disorder 

Providers Clinical Support System 

Acronyms Used Throughout This Manual"

ADAP-AIDS Drug Assistance Program

COWS-Clinical Opiate Withdrawal Scale

DOT-Direct Observed Therapy

HRSA-Health Resources and Services Administration

IDU-Injection Drug Use

IOP-Intensive Outpatient Program

MAT-Medication Assisted Treatment

MOUD-Medication for Opioid Use Disorder

OBOT-Office-Based Outpatient Treatment

OTP-Outpatient Treatment Program

OUD-Opioid Use Disorder

PAWS-Post-Acute Withdrawal Syndrome

PDMP-Prescription Drug Monitoring Program

PWID-People who Inject Drugs

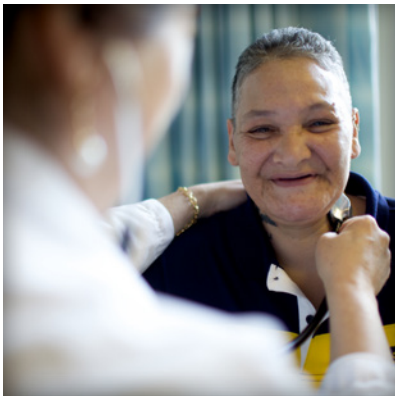
SAMHSA-Substance Abuse and Mental Health Services Administration

SUD-Substance Use Disorder

UDS-Urine Drug Screen

42CFR Part 2-Governs the use and disclosure of alcohol and drug abuse related patient records that are maintained at federally funded substance abuse programs.

*Visit the **NIH for a glossary of terms related to substance use disorder***



Intervention Summary

Essential pre-implementation activities

- Secure clinic stakeholder buy-in
- Hire or identify team members
- Train team members
- Review federal and local prescribing regulations
- Develop, review, and implement intervention specific protocols
- Prepare patient kick-packs

Essential implementation activities

- Identify patients for treatment
- Assess patients for treatment
- Prepare patients for and schedule patient initiation
  - Create treatment agreement, recovery plan, and treatment plan
- Initiate treatment
- Titrate and stabilize patients
- Conduct monitoring visits

Evaluation of the Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care intervention

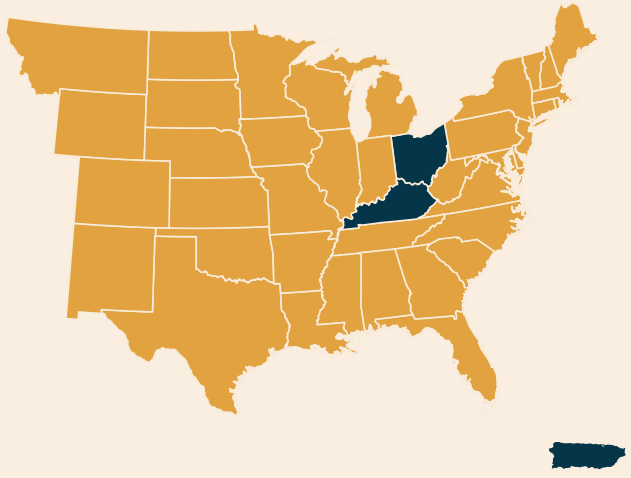
Between 2016-2019, **a total of 94 people received services across the three sites:**

- 64 of clients were linked to care in 90 days
- 60 were retained in care defined as 2 medical appointments at least 90 days apart in 12 months
- 53 achieved viral suppression at 12 months after enrolling in the intervention

Intensity of Services: On average, each individual patient received 23 encounters (range 1-160 encounters) with the clinical coordinator. Patient needs varied, and patients who needed more intensive case management and treatment support had up to 160 encounters with the clinical coordinator. The average encounter was 58 minutes (range 8-325 minutes), and addressed 5 needs (range 1-14 needs).

INTRODUCTION

From 2016 to 2019, three clinics (Centro Ararat, Ponce, PR; MetroHealth, Cleveland, OH; and University of Kentucky Bluegrass Care Clinic, Lexington, KY) were tasked with replicating the Integration of Buprenorphine for Opioid Use Disorder in HIV Primary Care intervention to increase patient engagement in OUD and HIV care. This intervention had previously been shown to increase engagement with both SUD treatment and HIV primary care, improving health outcomes for **both**. Buprenorphine treatment delivered in HIV clinics is associated with decreased opioid use, increased ART use, higher quality of HIV care, and improved **quality of life**.



Three Ryan White HIV/AIDS Program care providers implemented the Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care intervention through the Dissemination of Evidence-Informed Interventions project:

- Centro Ararat, Inc **(Ponce, PR)**
- The MetroHealth System **(Cleveland, OH)**
- University of Kentucky Research Foundation, Bluegrass Care Clinic **(Lexington, KY)**

"We always try to say, "We're glad you're here. We're glad you came back. Let's see what we can do now to move forward." There are certainly times where limits have to be set, both for the safety of the patient and... the clinic, but... But for the most part, we always take the patient's preferences into account in coming up with a treatment plan."

– DEII implementation site

The intervention was funded through a grant made available to AIDS United through the U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Special Projects of National Significance. The funding was part of the Dissemination of Evidence-Informed Interventions (DEII) initiative, which focused on using an Implementation Science framework to evaluate and replicate models of care in diverse geographical and organizational settings.

Key Objectives

- ☑ Link and engage patients with co-occurring HIV and OUD in buprenorphine treatment.
- ☑ Support patients through buprenorphine treatment initiation and stabilization.
- ☑ Provide coordinated support to address unmet ancillary needs of patients.

Implementation Science Approach

DEII sites implemented previously tested interventions that had demonstrated improved patient outcomes along the HIV Care Continuum. Rather than ask "does this intervention work?" DEII asked "what makes the intervention work?" To answer this question, the DEII initiative used an implementation science approach to study the implementation process itself. DEII evaluators used qualitative and quantitative instruments such as key informant interviews, patient encounter forms, and site visit reports to document key factors for successful implementation, challenges encountered by the interventionists, and adaptations needed for successful implementation. This manual reflects findings from implementation science data collected throughout the initiative.

At-a-Glance: Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care

Main challenge: Opioid use disorder (OUD) is a chronic, treatable illness. The Food and Drug Administration (FDA) has approved three forms of medication assisted treatment (MAT) or medications for opioid use disorder (MOUD) to treat OUD: methadone, naltrexone, and buprenorphine.

Buprenorphine is a form of MOUD that can be delivered in the primary care setting. Buprenorphine, a partial opioid agonist, was approved by the FDA in 2002 for the treatment of opioid dependence. Since that time, new buprenorphine formulations have been introduced to the market (e.g., sublingual films, sublingual tablets, buccal films, implants, and extended-release injection).

Improving access to MOUD for people is identified by SAMHSA as a key public health strategy. For people with HIV, office-based buprenorphine treatment delivered in HIV clinics is associated with decreased opioid use, increased ART use, higher quality of HIV care, and improved quality of life (goals in service to the "Ending the Epidemic: A Plan for America" initiative).[13,14,15,16]

This manual focuses on Buprenorphine (e.g., Suboxone®, Subutex®, Zubsolv®, Bunavail®, Probuphine®, Sublocade®),* but lessons learned from the DEII initiative have broad implications for wider MOUD provision within HIV primary care settings.

There is no "one size fits all" approach to treating OUD. MOUD treatments such as buprenorphine work in concert with psychosocial/behavioral treatments (e.g., outpatient or residential treatment, motivational interviewing, contingency management) and recovery supports (e.g., mutual help, peer support, and recovery coaching).

Focus population: Individuals with co-occurring HIV and OUD.

PCSS TIP 63

See PCSS and TIP 63 for:

- Key terms related to OUD
- Links to MOUD waiver training
- An overview and comparison of OUD medications
- Clinical details of buprenorphine medication, formulations, and contraindications
- Comparative effectiveness

For a comprehensive background of the neurobiology of OUD, prevention programs and policies, health care systems and SUD, and intervention, treatment, and management of SUD, refer to the Surgeon General's Report ***"Facing Addiction in America: The Surgeon General's Spotlight on Opioids"***

*Note: Check the availability of these medications in your local area. For example, Subtex and Vivitrol were not available to the Centro Ararat team.

Model description:

Treatment team members collaborated on the following key activities to implement the model:

- Recruit and screen potential participants with co-occurring HIV and OUD
- Assess potential participants for readiness for MOUD
- Determine if buprenorphine is the most appropriate treatment option
- Conduct patient intake and prepare patient for treatment
- Start patient on buprenorphine
- Address ancillary patient needs (e.g., benefits, housing, employment, transportation, food security)
- Provide high-quality HIV primary care
- Conduct monitoring appointments to support stabilization on buprenorphine
- Use a patient-centered approach to revisit treatment assessment, initiation, dosage, and monitoring (as needed)

Staff background and training: Core staff members include prescribing providers and clinical coordinators. Prescribing providers are physicians (both MDs and DOs), nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, or physicians assistants who are trained and waivered to prescribe buprenorphine and who have specialty training in HIV primary care. Clinical coordinators are mental health professionals, nurses, social workers, or case managers who support patients in adhering to buprenorphine and addressing unmet needs (i.e., housing, transportation, food security).

Management and integration: Management of the intervention can happen at any level. Prescribing providers, clinical coordinators, or clinic administrators can be the champions of the intervention and provide the necessary oversight, resource allocation, and support to integrate the intervention into the clinic.

Financing: The adjusted average cost per patient per year across the three sites was $2,834 (2019 dollars). The number of patients served across sites ranged from 53-87 per year. The calculated costs included: salary and fringe benefits for intervention staff and supervisors, materials and consumables for non-research related activities, transportation cost for staff and patients, other direct costs to provide patient services such as incentives for medical visits and agency overhead rates. Medical and behavioral health provider salary was included only if it was a direct charge to the grant. Startup costs for the intervention, including staff training and salaries, averaged $19,681 (range: $17,180-$23,786). Data were gathered from administrative reports provided by the agency at the close of the fiscal grant year reported to AIDS United.

Resource Assessment Checklist

The following items are beneficial for implementation but are not essential precursors to implementation. Clinics looking to implement this intervention should consider the following recommendations and can start with their existing resources and clinic systems.

Resource or clinic system	How the resource supports implementation
Space for inductions and patient meetings	Patient inductions can be time consuming and will last longer than a standard office visit.
Flexible schedules	Clinics should be flexible and willing to adjust schedules to accommodate the needs of patients, which will include increased frequency of visits. Clinics can integrate HIV/buprenorphine visits OR have dedicated time for buprenorphine management within the HIV clinic.

Tip: At Centro Ararat, the clinical teamscheduled HIV clinic on separate days when inductions would not occur inductions would not occur. With buy-in from front desk staff, time was set aside to create separate appointments for buprenorphine and HIV care, and HIV-only care visits. This was important as the team found that buprenorphine management visits could be much more time intensive than a standard HIV appointment.

Preset charting tools, guided provider notes, and templates in the electronic health record (EHR)	Development of preset charting tools or guided provider notes makes it easier for providers to consistently and systematically document in the EHR.
A designated point person to address potential challenges with insurance coverage	Working on issues related to insurance coverage and prior authorizations is time consuming and crucial to successful initiation and maintenance of buprenorphine treatment. Clinic administration will need to determine and document fees, payment plans, and policies, including the types of insurance accepted and whether or not to apply to patient assistance programs. Clinic administration will need to identify the staff person at the clinic (oftentimes the clinical coordinator) who will be the point person for addressing issues related to insurance authorization. Authorization for this particular treatment may be different in each community, so each treatment team will need to determine if buprenorphine is on the AIDS Drug Assistance Program (ADAP) formulary, and how insurance will cover buprenorphine at their individual site before implementation.

A strong relationship with local or on-site pharmacy

Successful implementation relies on sustainable patient access to buprenorphine medication. Treatment teams need a strong relationship with an on-site or community pharmacy to dispense medication and work with clinical coordinators/benefits counselors to obtain coverage for opioid treatment pharmacotherapies. Confirm that the pharmacy is able to stock all the various sublingual formulations of buprenorphine (unless the patient is pregnant, most patients will receive co-formulated buprenorphine and naloxone tablets or film).

Considerations:

- Insurance companies may dictate medication type.
- In order to receive a prior authorization (which may take up to two days), the prescribing provider will need to know the final dosage.
- Healthcare settings and pharmacies must get Sublocade REMS Program certification to dispense this medication and can only dispense it directly to healthcare providers for subcutaneous administration.

Urine drug screening (UDS) point of care testing

UDS in clinical practice is a consensual diagnostic test that:

1. Provides objective documentation of compliance with the mutually agreed-upon treatment plan;
2. Aids in the treatment and management of SUD or drug misuse;
3. Provides a tool to advocate for the patient in family and social circles as it provides an objective measure of existing substance use.

Become familiar with the urine drug tests available in your health care systems. It is ideal to include buprenorphine in the UDS, along with opiates, oxycodone, and methadone. Other substances included in the UDS (cannabinoids, methamphetamines, benzodiazepines, cocaine, etc.) often depend on particular labs and regional epidemiology of substance use.

For more information on UDS screens, visit TIP 63, Exhibit 2.12: Urine Drug Testing Window of Detection.

Tip: Treatment teams should respond to results demonstrating ongoing opioid use or other substance use (e.g. cocaine) in a non-punitive, non-judgmental manner. Negative opioid urine tests should receive positive reinforcement. Unexpected results of urine tests are opportunities for counseling and brief intervention. Remember, opioid agonist therapy is not an effective treatment for SUDs other than OUD.

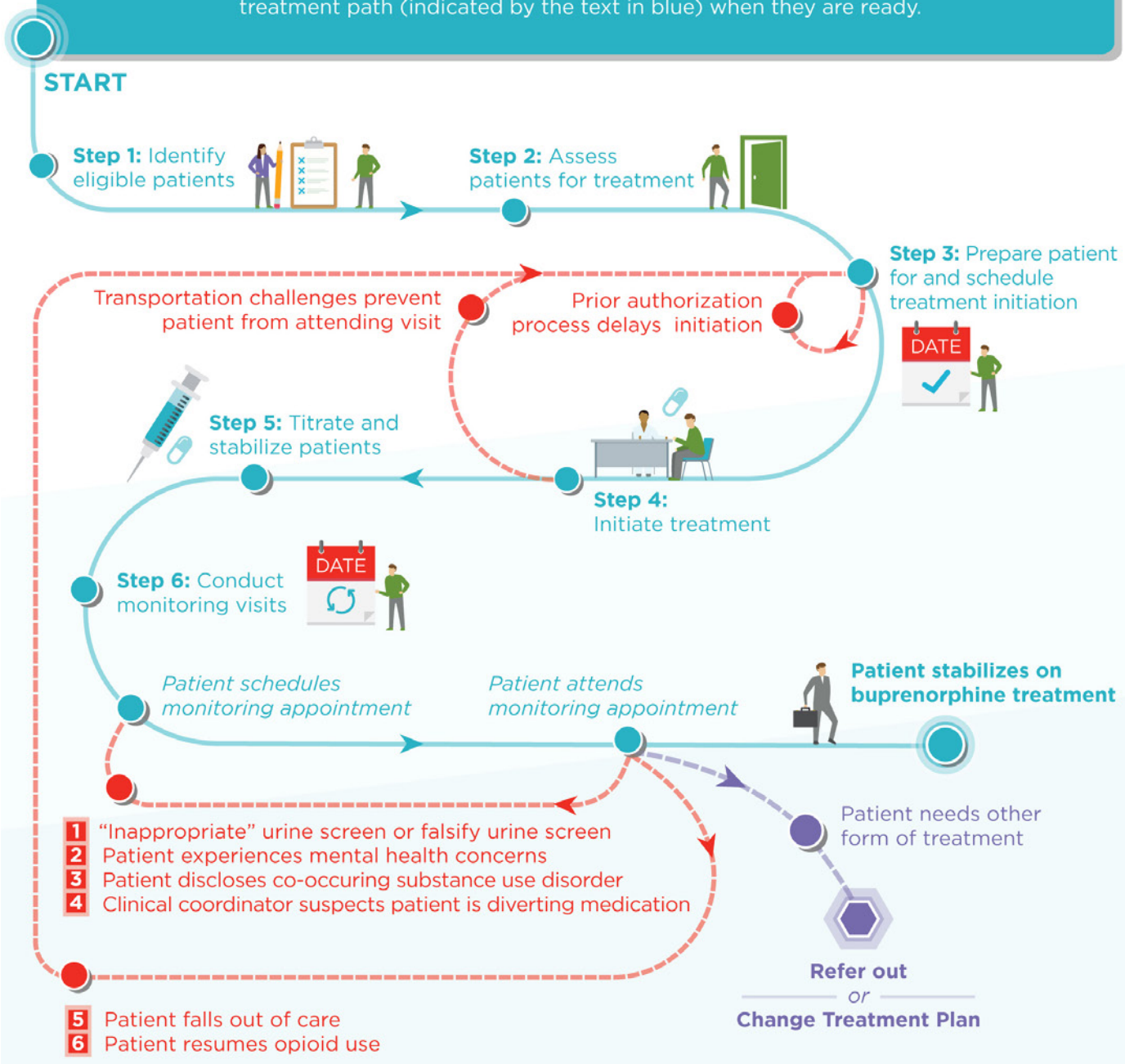
Resources

- ***Appropriate Use of Drug Testing in Clinical Addiction Medicine.***
- ***Urine Drug Testing in Clinical Practice.***
- ***The ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine Webinar Series.***

A designated team member to provide back up or have a back-up plan	Establish back-up systems and protocols for on-call support to managing patient care outside of normal clinic hours. **Considerations:** ◆ Do all clinic patients currently have access to an HIV provider during clinic hours and through an answering service at night and on weekends? ◆ Does that provider know how to manage patients on buprenorphine for the treatment of opioid use disorder? ◆ If not, does that provider know how to contact the buprenorphine provider on call? ◆ Who can serve as a back-up for the clinical coordinator?

Treating SUD: A non-linear process

The path between identifying eligible patients and stabilizing those patients on buprenorphine is rarely linear. Patient experience roadblocks and challenges along the way (as indicated in this graphic in red text). This intervention is designed to meet patients where they are at, and to get them back on to the treatment path (indicated by the text in blue) when they are ready.



CONCURRING ACTIVITIES

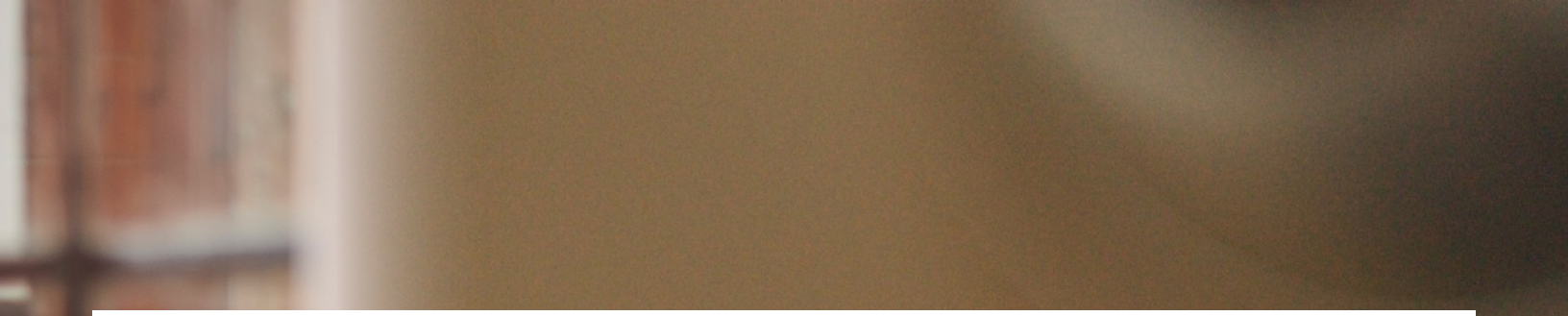
1. Participate in ongoing communication between treatment team members
2. Address the ancillary needs of patients
3. Maintain open communication between treatment team members and patients
4. Conduct outreach to re-engage patients as needed
5. Engage key administrators, stakeholders, and additional providers within the clinic system to increase the number of waivered providers available to serve patient population

PRE-IMPLEMENTATION ACTIVITIES

I. Pre-Implementation Checklist

- ☑ Secure clinic stakeholder buy-in
- ☑ Hire or identify team members
  - Prescribing providers
  - Clinical coordinator
- ☑ Train team members
- ☑ Review federal and local regulations
- ☑ Develop, review, and implement intervention-specific protocols
- ☑ Build new and strengthen existing relationships with community partners
- ☑ Prepare patient education materials
- ☑ Prepare patient kick-packs
- ☑ Create communication plan for treatment team

* *For more information on pre-implementation activities, refer to Module 2 and 3 in the **Training Manual***



Secure Clinic Stakeholder Buy-In

> *"Getting buy-in from clinic staff was the single most important thing we did to effectively implement this program. Buy-in may come slowly and may require staff to see firsthand the changes that addiction treatment make in patients' lives."*
>
> – DEII implementation site staff

Identify an **internal champion** who can advocate for an OUD treatment program within an HIV primary care clinic, and secure institutional buy-in for the program.

- This internal champion does not have an established list of activities, rather the champion will help secure the internal support and resources necessary to implement the program.
- The internal champion may or may not be part of the intervention, but must be on staff at the clinic and available to the treatment team.

Regular meetings with institutional leaders and principal decision makers are key ways to build relationships, share successes and challenges, and brainstorm potential ways to strengthen the organization's effort to implement a buprenorphine intervention for people with HIV.

Buy-in from all levels of the clinic is essential to creating a **welcoming environment**. Creating a welcoming environment starts with a patient's first phone call or step into the clinic setting. All team members (including front desk staff, nurses, clinic administrators, and leadership) need to help patients feel safe disclosing OUD and getting the care and treatment they need.

Hire or Identify Team Members

Clinic administrators are is responsible for hiring or identifying treatment team members who have experience working with patients with HIV and SUD and who have relationships with partner organizations. See in ***Appendix A*** for job descriptions and staffing plan.

Key Roles for the Intervention

1. **Prescribing providers** provide both buprenorphine and HIV primary care. Physicians, nurse practitioners, and physicians assistants are eligible to receive a buprenorphine waiver.
   - As per DEA requirements, each type of clinician will complete a different level of training to obtain their buprenorphine waiver.
   - Prescribing buprenorphine implants requires ***Probuphine REMS Program*** Certification.
     - ***Learn how to qualify for a DATA 2000 physician waiver***
     - ***Learn how to qualify for a nurse practitioner, physician's assistant, clinical nurse specialist, certified registered nurse anesthetist, or certified nurse midwife waiver***
     - ***Learn how waivered providers can increase their patient limit from 30 to 100, and then to 275 patients***
   - Clinics may be able to ***identify existing waivered providers*** in their local area to join the treatment team or to use as a referral network.
2. **Clinical coordinators:** play an essential role in intervention implementation and providing ongoing patient support, providing education, conducting screenings, and monitoring and counseling patients during treatment. Both prescribing providers and patients rely on the clinical coordinator to develop and monitor individualized care plans and track clinical outcomes.

   While the specific role of the clinical coordinator and their level of effort or full-time equivalent will differ depending on the clinic structure and size, the clinical coordinator is essential for providing high quality, intensive services to patients who often have comorbid medical and psychosocial conditions that can challenge the treatment process (due to issues including, but not limited to, mental health, polysubstance use disorders, transportation challenges, and barriers to treatment adherence).

   The role of the clinical coordinator is distinct from a HIV case manager, but the two roles work in tandem to support patients. Clinical coordinators can have a range of prior experience and training, including mental health counseling, SUD counseling, social work, and nursing.

Funding the Clinical Coordinator Role in HIV Primary Care Clinics

1. Work with the local Ryan White HIV/AIDS Program grantee (Part A), state Ryan White HIV/AIDS Program grantee (Part B), Ryan White HIV/AIDS Program Part C, and/or the local drug and alcohol board/ mental health board. Ryan White HIV/AIDS Program funding allows for salary support for mental health counselors, medical and non-medical case managers, and SUD counselors. The clinical coordinator often falls into these roles.
2. If the clinical coordinator provides case management, or screening and counseling for SUD and/or other mental disorders, these services may be billable to insurance and/or Medicaid or Medicare. However, this depends greatly on state regulations, insurance policies, and the education/ licensure of the clinical coordinator.
3. If the clinical coordinator is split-funded across projects and roles, assess their availability and commitment to this role. Patients receiving buprenorphine treatment can be time-intensive patients, so clinical coordinators, their supervisors, and prescribing providers will need to work together to identify sustainable and manageable caseloads.

DEII intervention sites used a full-time clinical coordinator. The ultimate FTE designation should factor in anticipated patient caseload and other case management or counseling services available within the clinic.

Additional treatment team members: Depending on clinic and community-specific needs, the treatment team can include additional staff and teams in project planning and implementation, such as an outreach team or an SUD counselor to help find and support patients with staying engaged in their buprenorphine and HIV treatment Refer to the ***Centro Ararat site spotlight*** to learn more about how one DEII implementation site integrated an outreach team into the intervention.

Once the treatment team is established, team members establish team communication frequency and channels.

Train Team Members

Training needed to prescribe buprenorphine

New prescribing providers will need to complete their waiver training and file for their DEA waivers. New prescribing providers should start with the information provided through the waiver training and then layer on additional trainings that are responsive to their patients' needs.

As a form of ongoing professional training and development, buprenorphine prescribers identify and have access to a **clinical mentor**, defined as another health professional with expert knowledge and practical experience in buprenorphine treatment. Ideally, this mentor will maintain a buprenorphine practice in the same health network or geographic locale and meet for case conferences monthly. Clinic prescribers are also encouraged to participate in the Physician Clinical Support System for Medication Assisted Treatment (PCSS-NOW), a national training and mentoring project.

PCSS

See additional recommendations for staff member training through the SUD 101 Core Curriculum

Resources

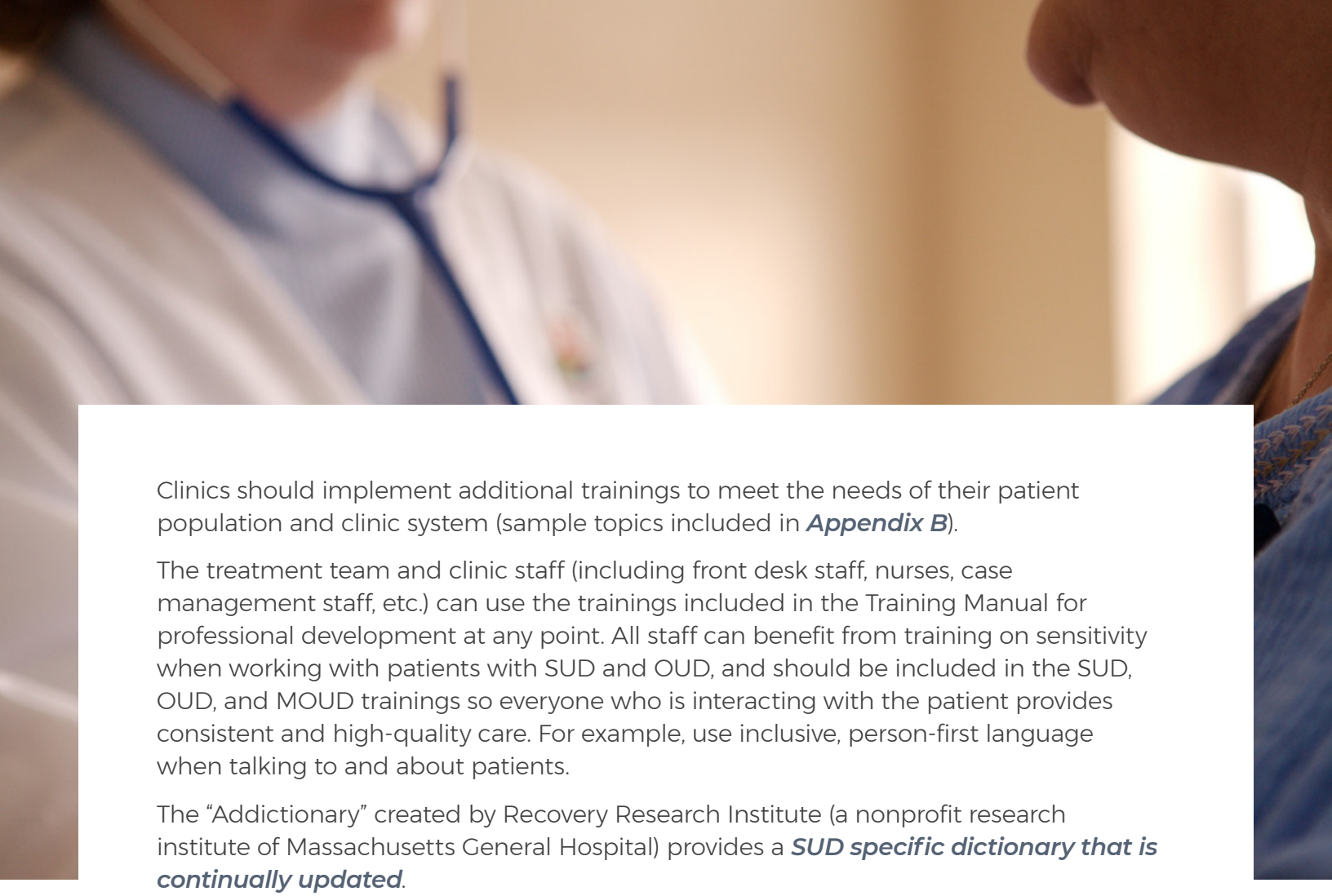
- ***Find a mentor or learn more about PCSS mentorship***
- ***Opioid Addiction Treatment ECHO Hub at Boston Medical Center,*** or other specialized ECHOs across the country

Training needed to implement the intervention

Prepare the treatment team and others who support implementation activities with a Training Manual developed by the Implementation and Technical Assistance Center (ITAC) for the ***DEII initiative***.

The Training Manual covers the following topics:

- Pre-implementation system review
- Pre-implementation protocols and materials
- Substance Misuse and Use Disorder 101
- Selecting, assessing, and preparing patients for treatment
- Initializing, stabilizing, and maintaining patients
- Buprenorphine patient stabilization
- Maintenance visits
- Transitioning patients to the standard of care
- Stigma, shame, and the power of language
- Relapse sensitive environments and strategies to support retention in care
- Referrals to higher levels of care, other treatment options, and tapering off of buprenorphine
- Mental health and SUDs
- Pain and SUDs



Clinics should implement additional trainings to meet the needs of their patient population and clinic system (sample topics included in ***Appendix B***).

The treatment team and clinic staff (including front desk staff, nurses, case management staff, etc.) can use the trainings included in the Training Manual for professional development at any point. All staff can benefit from training on sensitivity when working with patients with SUD and OUD, and should be included in the SUD, OUD, and MOUD trainings so everyone who is interacting with the patient provides consistent and high-quality care. For example, use inclusive, person-first language when talking to and about patients.

The "Addictionary" created by Recovery Research Institute (a nonprofit research institute of Massachusetts General Hospital) provides a ***SUD specific dictionary that is continually updated***.

A shared philosophy among the treatment team around working with patients will impact client care, and should be reflected in training provided, policies and procedures developed for the program, and ongoing patient-clinic interactions. For example:

- Our patient is acting out -> we should recognize and monitor their withdrawal symptoms
- Our patient needs medication, so we'll put in a request with the provider -> timely buprenorphine refills are crucial, we will follow up with the provider until the patient gets what they need
- Our patient is a failure for not adhering to treatment -> SUD is a medical condition and our patient needs our support, and resuming opioid use is not failure
- We need to police our patient's activities -> urine drug screening helps us to keep our patient safe
- We can schedule the induction whenever it works for our clinic schedule -> timing of induction is patient specific and should be patient driven

More information available ***here***.

Review Federal and Local Regulations

It is important to understand state and federal requirements, including 42CFR Part 2, documentation requirements, and frequency of visits. State-level requirements set the tone for space considerations, scheduling, technology, and insurance processes. Work with organizational leadership to assess and implement protocols to address any state level policies and requirements, and to update protocols as federal and local policies change.

Record keeping practices: As discussed during the buprenorphine waiver training, prescribing providers will follow federal and state mandates for record keeping practices. This includes keeping and maintaining a patient log for each prescriber, ensuring secure medical record storage, and maintaining records for Drug Enforcement Administration (DEA) visits.

Confer with your organization's legal department to determine how your organization's documentation policies will need to comply with the regulations outlined in 42 CFR Part 2.

a. SAMHSA's ***Disclosure of Substance Use Disorder Patient Records: Does Part 2 Apply to Me?***

b. SAMHSA's ***Disclosure of Substance Use Disorder Patient Records: How Do I Exchange Part 2 Data?***

Prescription Drug Monitoring Program (PDMP): Each state has different requirements for their PDMP. In some states a provider can delegate staff to access the PDMP database on behalf of the provider. Learn more with the following resources: ***What States Need to Know about PDMPs and Prescription Drug Monitoring FAQs***.

Substance Abuse Confidentiality Regulations: ***All providers who treat patients with SUD must adhere to federal regulations on confidentiality.***

Develop, Review, and Implement Intervention-Specific Protocols

Successful buprenorphine programs begin before the clinic identifies its first patient. Use this checklist to identify existing and needed materials, knowing that protocols will change over time to reflect what works in each clinic.

Existing or needs to be created?	Protocol	Considerations
	Outreach and recruitment protocol	◆ Does your clinic have an outreach team to increase recruitment efforts? ◆ Are there opportunities for internal networking with fellow providers and clinic staff to facilitate internal referrals? ◆ Does your outreach and recruitment protocol include any inclusion and exclusion criteria specific to your clinic site?
	Initial patient intake and assessment process	◆ Who will conduct the initial intake and assessment process? ◆ What are the steps that this person will need to take to determine if the patient is a good candidate for buprenorphine treatment?
	Treatment referrals for patients with non-opioid substance use disorder	◆ If you are screening for substance use disorders, it is important to decide beforehand what you will do to help those who have a substance use disorder but do not qualify for buprenorphine. ◆ Do you have capacity to treat them in-house? ◆ Do you refer them to behavioral health services elsewhere?
	Patient preparation for treatment protocol and materials	◆ Includes patient education information about withdrawal, kick-packs, buprenorphine medication, and how to get support and work with the treatment team throughout treatment. ◆ Determine how buprenorphine will be funded.
	Treatment initiation and stabilization process	◆ Will your office use home or office-based initiation? ◆ If both, how will the treatment team determine which form of initiation is most appropriate for individual patients? ◆ How will the treatment team determine the frequency of visits and patient dosing information? ◆ How often will the treatment team proactively contact patients?

Process for conducting, testing, and communicating the results of urine drug screens (UDS)	◆ Treatment teams should identify which clinic staff/treatment team member will conduct, test, and communicate the results of the UDS. ◆ Will the UDS be sent to a lab or will your clinic provide testing? ◆ Will UDS be conducted at each appointment or will it be random? ◆ How will treatment team members work with patients with UDS who show opioid or polysubstance use? ◆ More information on UDS available through Module 12: Lab Testing in Assessment of Substance Use Disorders in the PCSS Core Curriculum. 
Process for determining patient-centered treatment intensification	◆ Buprenorphine treatment may not be enough for some patients. Treatment teams should be prepared to determine how and when to intensify treatment. ◆ Additional treatment may include more frequent visits, more counseling, or referral to other outpatient drug treatment programs. Treatment teams will also need to have a list of providers within the community who can provide more intensive treatment if necessary.
Treatment failure and/or transfer of care protocols	◆ Buprenorphine treatment may not be successful for some patients. ◆ These patients may need alternative treatment options, including transfer to another clinic. ◆ Clinics should be prepared to navigate these changes quickly to avoid interruptions in care.
Managing patients with polysubstance use	◆ While patients may be working to reduce their opioid use, they may continue to use other substances (both legal and illicit). ◆ Treatment teams should create a non-judgmental, non-punitive environment to work with patients with polysubstance use.
Appointment scheduling and rescheduling	◆ Patients may face challenges with scheduling (transportation, child care, employment). ◆ SUD can create its own life stressors. Patients may experience side effects, relapse, or struggle with medication adherence. ◆ As a result, clinics should have a plan for patients who need urgent appointments—getting patients in quickly, being flexible, and accommodating last-minute schedule changes.
Missed appointment policy	◆ Do patients still receive medicine if they miss an appointment? ◆ If so, do they need to meet with a clinical coordinator or another staff member to obtain it?

Safety and boundaries for patients and staff	◆ Staff safety should be a key priority in delivering high quality, consistent care to patients. ◆ Your clinic may already have a safety plan, so consider adding or amending an existing plan if it already exists. ◆ Treatment team members should refrain from giving out their personal cell phone or email information and create boundaries with patients around phone calls, text messages, and emails outside of clinic hours. There is a boundary between being available to patients and having unhealthy boundaries that can lead to burnout and vicarious trauma. ◆ Depending on the clinic, patients may see people they know from the community in the waiting room or hallways. These can be positive social supports or could be challenging interpersonal relationships. ◆ Clinics should have a safety plan in place in the event that an altercation breaks out between patients, and should help patients proactively plan to avoid appointment times that coincide with the appointments of other patients they do not want to see.
Availability of and patient expectations for ongoing recovery support	◆ Ongoing recovery supports, including counseling, 12-step meetings, and additional social support groups, should be available to but not mandatory for all patients.
Relapse management	◆ The path to stabilizing on buprenorphine treatment is not linear, and patients may relapse. ◆ Are there consequences for relapse, such as more frequent appointments or higher intensity of care? ◆ How are these decisions made—what factors are important for the treatment team to consider?
Managing diversion	◆ Diversion occurs when a patient gives or sells their prescribed controlled substance to another individual. ◆ Patients may divert their medications for a number of reasons. For example, they may be able to sell their medication for money, or they share their medication with someone else who wants buprenorphine treatment but isn't able to afford it. ◆ Are there consequences for diversion, such as more frequent appointments or higher intensity of care? ◆ How are these decisions made—what factors are important for the treatment team to consider?
Case conferencing protocol for team to discuss ongoing cases and address difficult situations	◆ Establishing a mutual understanding about how the treatment team might handle difficult situations will reduce conflict and confusion. ◆ Patients' lives may be highly chaotic when they enter treatment. Modeling healthy relationships, boundaries, and communication strategies is essential to help patients gain recovery skills and decrease the likelihood that the treatment team will experience burnout.

Build New and Strengthen Existing Relationships with Community Partners

Conduct a community partner assessment to:

- Identify the services each community partner provides and the eligibility criteria for receiving these services.
- Identify MOUD-friendly SUD treatment facilities and protocols to refer patients to these facilities (i.e., other OBOT programs, methadone, intensive outpatient, and residential treatment programs).
- Assess geographical accessibility of community partners.
- Verify which agencies can provide transportation services to patients.
- Identify existing community partner meetings that treatment team members could attend .

To determine if the local SUD community is pro-MOUD, assess the following:

- Are there local advocates for MOUD?
- Has the state or local area dedicated any money or resources to providing MOUD?
- Are there options for patients to attend 30-day residential treatment and intensive-outpatient treatment in a MOUD-friendly environment?
- The landscape of SUD treatment and MOUD is constantly evolving, so it is important to revisit this assessment periodically.

To facilitate open communication and referral agreements, intervention champions or clinical coordinators establish new (or strengthen existing) relationships with mental health and substance use treatment providers (on-site or in the community).

- Create a Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or informal agreement for referrals of patients who need more intensive services for addiction medicine with an agreed upon process and timeline for referral appointments. As one DEII site said: “Turn competitors into collaborators.”
- Establish community referral networks with organizations providing the following services: mental health services, recovery support groups, detox/withdrawal management, vocational training, methadone treatment, intensive outpatient treatment, and residential treatment and housing. Examples of types of care include inpatient and outpatient mental health services, recovery support groups, detox/withdrawal management, methadone treatment, intensive outpatient SUD treatment, crisis management interventions, and residential treatment.

Prepare Patient Education Materials

Review the patient education materials referenced in this manual and make any necessary clinic-specific additions. ***Note: Patient materials should use plain language at an appropriate health literacy level.***

Patient education materials should include:

1. Information on potential side effects
2. Best practices for secure buprenorphine medication storage
3. Discussion about treatment agreements
4. When patients need to communicate to providers:
    a. Starting any over-the-counter medications or new medications
    b. ***Experiencing side effects***
    c. If the patient discontinues medication, changes their medication dosage, or starts a new medication (regardless of the medical guidance received from their providers)
    d. Experiencing potential interactions between buprenorphine and alcohol, illicit opioids, and/or benzodiazepines
    e. Experiencing interactions between HIV medications and buprenorphine treatment
    TIP 63
    f. If the patient becomes pregnant
    g. If the patient is having a medical procedure where they might need pain medication
5. Information on treatment readiness and opioid withdrawal

> Patient education is an ongoing process. Many patients come to us knowing a little about buprenorphine, but do not understand the differences between treatment options. We want patients to be able to make an informed decision about what is going to give them their best chance at recovery. [The clinical coordinator] often provide[s] education in a variety of ways: written, verbal discussion, and imagery. One metaphor [she] frequently uses is to imagine opioid receptors like an electrical socket. Full opioid agonists (heroin, Percocet, methadone) are like a plug in the socket. Buprenorphine is like a child safety plugs that fits into the socket but it doesn't do much. Naltrexone is like a metal plate that fits over the socket.
>
> – DEII Implementation Site

Sample handouts

- ***The Facts About Buprenorphine for Treatment of Opioid Addiction (U.S. Department of Health and Human Services)***
- ***Useful information for patients about what buprenorphine treatment is like and how to prepare for treatment initiation can be found at the website of The National Alliance of Advocates for Buprenorphine Treatment***
- ***Behavioral Health Treatment Services locator***
- ***HIV/Buprenorphine medication interactions***

"Don't be surprised if things that you never dreamed of will be an obstacle, and you just have to be patient and just be persistent"

– DEII implementation site

Prepare Patient Kick-Packs

Medications to provide symptomatic relief, or "kick-packs," medications are taken prior to buprenorphine induction to help patients manage the side effects of opioid withdrawal. Delivering written instructions helps the patient remember what they discussed with the treatment team and use the kick-packs appropriately.

Kick-packs typically include the following:

Symptom	Medication
Nausea	Ondansetron, metoclopramide (avoid promethazine; it potentiates opioids)
Diarrhea	Lopermide
Anxiety, irritability, sweating	Clonidine
Insomnia	Diphenhydramine, trazodone
Pain	Nonsteroidal anti-inflammatory drugs

Tip: To address potential burnout related to the nature of the clinical coordinator work, Centro Ararat, in Ponce, PR, hired an employee assistance director who offers trainings on self-care, mindfulness, transference, and counter transference.

Create a Communication Plan for the Treatment Team

Throughout implementation, treatment team members should regularly connect to ensure that there is an open flow of communication and that each team member feels supported in their work. The meeting intervals will be different based on an organization or team's internal philosophy and structure. Suggested intervals are as follows:

1. The treatment team initially meets on a weekly basis for case conferencing and project implementation updates (over time, these meetings can happen on a monthly basis).
2. The treatment team communicates on a daily or ad hoc basis about patient needs (can be in person, but can also be through email, phone, etc.).
3. The clinical coordinator initially receives weekly supervision from the prescribing provider (over time, these meetings can transition to an ad hoc basis).
4. The prescribing providers should meet with their clinical mentors on a monthly basis in the beginning. Once prescriber confidence is established, they can meet less frequently.
5. The treatment team should identify regular points of communication with upper management, clinic leadership, stakeholders, and intervention champions to discuss intervention successes and challenges.

IMPLEMENTATION ACTIVITIES

Implementing Buprenorphine Treatment Checklist

- ☑ Identify patients for treatment
- ☑ Assess patients for treatment
- ☑ Prepare patients for and schedule treatment initation
  - Create a treatment agreement
  - Create a recovery plan
  - Create a treatment plan
- ☑ Initiate treatment
- ☑ Titrate and stabilize patients
- ☑ Conduct monitoring visits

For more information on identifying patients for treatment, review:

- ***Training Module 5-6 on Selecting, Assessing, and Preparing Patients for Treatment***
- TIP 63 Addressing Opioid Use Disorder in General Medical Settings

Step 1: Identifying Patients for Treatment

Patients can connect with the program in a number of ways:

- Self-referral
- Referrals from other providers (physicians, clinical coordinators, etc.) in the clinic or in the community
  - SUD screenings are universally indicated. Any patient in the HIV clinic could be screened for SUD, and then referred to appropriate treatment.

In the absence of a prior screening, clinical coordinators can use the tools identified below.

- Screening, Brief Intervention, and Referral to Treatment (SBIRT) using Motivational Interviewing techniques
- Alcohol Use Disorders Identification Test (AUDIT)
- Drug Abuse Screening Test (DAST)
- NIDA Screen and Modified-ASSIST
- NIAAA Rethinking Drinking[SM]
- DSM criteria (11 criteria in 4 categories)
- Opioid Risk Tool
- Stages of Change Readiness and Treatment Eagerness (SOCRATES) Scale
- Addiction Severity Index (ASI)
- Substance Abuse Module (SAM)
- Global Appraisal of Individual Needs (GAIN)
- Psychiatric Research Interview for Substance and Mental Disorders (PRISM)

If a patient screens positive for OUD, the clinical coordinator can offer brief counseling and treatment referral, MOUD, and ongoing assessment and support.

- The clinical coordinator assists with providing education to potential new patients about current MOUD options, helping individuals determine what, if any, MOUD treatment is right for them. Clinical coordinators can use the Stages of Change to guide their efforts in identifying patient readiness for OBOT (see Appendix F, Clinical Coordinator Manual).

If a patient screens positive for SUDs or substance misuse for substances other than opioids, the clinical coordinator can offer brief counseling, monitoring and follow-up, and referrals for treatment.

More information on screening tools can be found through the PCCS SUD Core Curriculum PCSS, through the NIH National Institute on Drug Abuse, and TIP 63

Step 2: Assessing Patients for Treatment

Prior to assessing patients, identify a specific person responsible for each step of the assessment process to reduce duplication of effort and the possibility of conducting an incomplete assessment. One option is to conduct assessments as a team, engaging both prescribing providers and clinical coordinators in the same appointment.

The objectives of the assessment process are to:

- Determine the patient's clinical eligibility for buprenorphine treatment (using the protocol established during pre-implementation);
- Provide the basis for a treatment plan;
- Establish a baseline measure to evaluate a patient's response to treatment; and
- Determine with the patient, whether the potential benefits of buprenorphine treatment (improved health outcomes, reduced HIV and viral hepatitis transmission risks) outweigh any potential risks (overdose, diversion) to the patient or to the community.

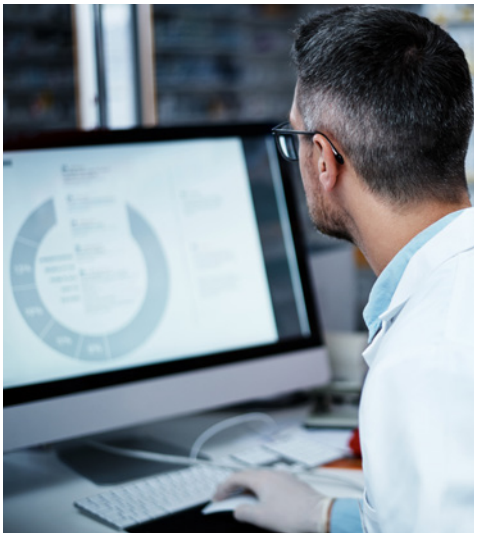
Prior to the assessment, obtain permission from the patient to complete an assessment (i.e., "Would it be alright with you if I asked you some questions about your drug use?"), then follow up with open-ended questions and motivational interviewing techniques to allow for replies in the patient's own words and evoke more thoughtful responses. An assessment should incorporate ***trauma-informed approaches*** while understanding that patients with OUD may not feel comfortable sharing their opioid use history

How to Incorporate a Trauma-Informed Approach into the Assessment Process:

- Assume patients participating in the assessment process have experienced trauma
- Normalize the experience of opioid use disorder as much as possible
- Respect the patient's personal space
- Allow patients to stay in one place and have providers come to them, rather than shuffling the patient around the clinic
- Outline the assessment process so that the patient knows what to expect
- Obtain patient's permission to complete assessment and any physical examinations
- Create an assessment and referral process for additional mental health services if necessary

More information on trauma-informed care in behavioral health services is available ***here.***

Initial Assessment Checklist



For clinical guidance on UDS, windows of detection, and lab tests that should accompany patient assessment, consult PCSS TIP 63

- ☑ Briefly review the purpose of the assessment, the length of time to complete (typically an hour or longer), and include an after-care plan so the patient has a plan for self-care after the assessment.
- ☑ Determine OUD diagnosis and severity.
- ☑ Conduct physical examination (Identify co-morbidities and contraindicated medications)
  - ***Discuss whether or not the patient is currently or may become pregnant in the near future***
- ☑ Identify SUD and treatment history.
  - Discuss current opioid use and patterns, including level of tolerance, prior quit attempts, prior experiences with any OUD treatment, nature and severity of opioid withdrawal symptoms, time of last use, history of overdose, and current withdrawal status (DSM worksheets available in TIP 63)
  - Document the patient's use of other substances, including tobacco, alcohol, benzodiazepines, and other drugs.
  - Review past treatment experiences, including patient response to treatment, side effects, and perceived effectiveness.
  - Identify patients who need medically supervised withdrawal management from alcohol, benzodiazepines, or other sedatives prior to initiating buprenorphine treatment.

    Resource: ***Working with patients with co-occurring disorders***
  - Assess injection drug use history. Educate patients who inject drugs on how to access sterile injection equipment.
- ☑ Assess patient for co-morbid mental health conditions that could complicate their treatment plans or worsen their prognosis.
- ☑ Assess social history (including social environments, supports, and relationships). Assess patient's access to social supports, family, friends, employment, housing, finances, and legal assistance. Assess whether patients are in an environment that is conducive to engaging in MOUD.
- ☑ Assess if a patient has a stable place to safely store medications.

- ☑ ***Check state prescription drug monitoring program (PDMP)*** to determine whether patients can receive prescriptions for controlled substances from other healthcare professionals.
  - For more information about state PDMPs (and state-level regulations), visit www.pdmpassist.org/content/state-profiles.
- ☑ Conduct psychosocial assessment and readiness for treatment.
- ☑ Assesses willingness to participate in treatment plan, attend regular outpatient appointments, and attend SUD treatment programs.
  - Set shared expectations for frequency of visits and additional activities that the patient will be asked to participate in outside of their buprenorphine treatment visits (i.e., support groups, counseling, etc.).
- ☑ Talk to the patient about MOUD options and help them to understand the best MOUD option for their recovery.
  - More information on MOUD treatment options available in TIP 63
  - More information on guiding conversations with patients on decisions in recovery can be found ***here*** and more information on integrated treatment for co-occurring disorders can be found ***here***.
- ☑ Provide ***overdose prevention education and provide naloxone prescription.***

Post-Assessment

- ☑ The clinical coordinator will schedule the initial appointment with a prescribing provider and help coordinate initial induction visit.
- ☑ Identify how the buprenorphine treatment will be financially covered (on an individual basis).

When a Patient is Not Ready to Start MOUD

Although MOUD may be medically indicated, not all patients want MOUD. Using motivational interviewing and harm reduction principles, the clinical coordinator helps the patient create their own plan. Depending on the clinical coordinator role and program availability, comprehensive screening may be conducted regardless of patient interest in MOUD. Comprehensive screening can assist the clinical coordinator in helping the patient connect with resources that fit their own goals for treatment.

Continue to work with patients who are contemplating starting MOUD through the stages of change, even if they are not ready to start MOUD now. Use motivational interviewing techniques and readiness assessment scales like the **SOCRATES scale** to monitor and engage the patient.

Resources:

- Circumstances, Motivation, Readiness, and Suitability (CMRS) Scales for Substance Abuse Treatment

Step 3: Preparing Patients for and Scheduling Treatment Initiation

Identify who on the team is responsible for each of the various steps involved in preparing patients for treatment. Typically, the clinical coordinator conducts this work.

- ☑ Create a treatment agreement. In partnership with the patient, complete a treatment agreement describing the goals of treatment, the risks and benefits of treatment, and the relationship between the patient and the treatment team (***Appendix D***). Using this treatment plan, the clinical coordinator can also plan for and build recovery supports (see ***Appendix F***, Clinical Coordinator Manual).
- ☑ Create a recovery plan. The recovery plan is a goal-setting tool that the clinical coordinator and patient can use throughout treatment. The clinical coordinator can initiate this recovery plan during treatment initiation or during stabilization (depending on the individual patient). More detail on building a recovery plan is included in ***Appendix F***, Clinical Coordinator Manual.
- ☑ Prescribing providers create a treatment plan to address medication management and related treatment needs.
  - Treatment plans include treatment goals, conditions for changing or stopping treatment, and therapeutic contingencies for nonadherence and failure to meet treatment goals.
  - The treatment team will communicate the patient's treatment plan with their circle of providers, especially with other substance use treatment or mental health providers. This may require signed releases of information to exchange health information protected by federal 42 CFR Part 2 confidentiality regulations. ***For more information on SUD confidentiality regulations, click here.***
- ☑ Provide the patient with patient education materials on how to properly administer, safeguard, and discard medication, what they can expect to experience at each stage of treatment, and alternatives to buprenorphine treatment (using materials designed in the pre-implementation phase).
- ☑ Prepare patients for the potential side effects of buprenorphine and any potential interactions between buprenorphine and HIV medications.
  - **Resources:** Information on ***potential drug interactions*** and information on ***potential side effects*** of buprenorphine.
- ☑ Discuss awareness and use of harm reduction strategies available in your community, including syringe services programs and ***intranasal naloxone***.
- ☑ Determine timing for induction.

When creating the treatment agreement, it is important to understand your local context and policies related to the provision of behavioral health treatment.

Chapter III article 3.06 Specific rights of the Mental Health Law of Puerto Rico, which addresses the Individualized Plan as a patients' right.

"(d) Individualized Plan for Recovery and Rehabilitation Treatment:

Every adult shall have the right to be designed an Individualized Plan of Treatment, Recovery and Rehabilitation, inter or multidisciplinary insurance and human, within an environment that is as least restrictive as possible, according to their condition.

The adult who receives the services will participate in the formulation and revision of the plan to the extent that such participation is possible. In addition, the participation of the closest relative will be required. The case manager will be responsible for following up on the implementation of the Individualized Treatment Plan for Recovery and Rehabilitation, inter or multidisciplinary. The clinical file must contain the signature of all professionals involved in the preparation of the plan and the adult or family member who represents him in the preparation of the same."

Step 4-6: Patient Initiation, Stabilization, and Maintenance

For more information on physical signs of opioid withdrawal, time to onset, suggested buprenorphine dosing, and treatment phases, see PCSS Module 6: Integrating Opioid Use Disorder Treatment in Clinical Care in the SUD 101 Core Curriculum an TIP 63 Exhibit 2.10: Physical Signs of Opioid Withdrawal and Time to Onset.

Prior to implementation, team members should review the ***DEII Training Manual***, specifically Module 7: Initializing, Stabilizing, and Maintaining Patients.

Step 4: Treatment Initiation

The goal of treatment initiation (also referred to as "induction") and stabilization is to find the lowest dose of buprenorphine each patient can take without experiencing withdrawal symptoms, significant side effects, or cravings. Induction takes between 1-3 days.

- ☑ On the day of initiation, the patient should exhibit signs of at least mild withdrawal (through both objective evidence and a tool such as the Clinical Opiate Withdrawal Scale (COWS) prior to receiving their first dose of buprenorphine).
  - COWS measures withdrawal symptoms, guides timing of initial buprenorphine dose, and can be easily administered. COWS assesses: resting pulse rate, sweating, restlessness, pupil size, bone and joint aches, GI upset, tremors, and more.
  - Sample COWS scales are available ***here*** and ***here***
- ☑ Refer patients who need medically supervised withdrawal management from alcohol, benzodiazepines, or other sedatives prior to initiating buprenorphine treatment.
  - Prepare patients to achieve a mild to moderate state of opioid withdrawal on the day of buprenorphine initiation. There is a tremendous amount of variability in the onset of withdrawal after last use. Talk to patients about when they will experience withdrawal and what their withdrawal symptoms will look like (e.g., goose bumps, nausea, abdominal cramps, running nose, tearing). A general guide to estimate time till onset of moderate or greater withdrawal is available ***here***.
- ☑ Prescribe kick-pack.
- ☑ Clinical coordinators will need to follow up with patients throughout initiation week to offer support and address any immediate needs (frequency to be determined on a patient-by-patient basis).

Office-Based or Home Induction: How to Decide?

Factors to consider when deciding between home and office-based induction.

Candidates for Office-Based Induction

Patients without telephones, who are homeless/have unstable home environments, or who live with partners, family members, or friends who are PWID or have OUD may do better with an office-based induction.

Patients who are very concerned or anxious about experiencing withdrawal may feel more comfortable in a clinical setting where they can be observed by the treatment team. Patients with underlying anxiety may have difficulty differentiating their symptoms due to anxiety versus opioid withdrawal.

Patients transferring from methadone to buprenorphine may have difficulty with induction for two reasons:

- They may have not experienced opioid withdrawal symptoms in years (because of methadone treatment history) and be fearful or anxious of experiencing withdrawal.
- Because methadone is so long acting, they are at higher risk of precipitated withdrawal than patients who use opioids other than methadone. These patients are likely best suited for office-based inductions.

Candidates for Home-Based Induction

Patients with stable housing and telephone access to providers for advice and/or coaching through the induction are better candidates for home-based induction.

Patients with prior experience with buprenorphine tend to have better outcomes than those who do not have experience with buprenorphine. Patients who are familiar with buprenorphine pharmacodynamics, know their withdrawal/craving symptoms, and have demonstrated both comfort and skill at starting the medicine without clinical observation, could be considered for home-based inductions.

If a patient has a difficult time taking several days off work during buprenorphine treatment initiation, they would likely benefit from a home induction that can occur over a weekend.

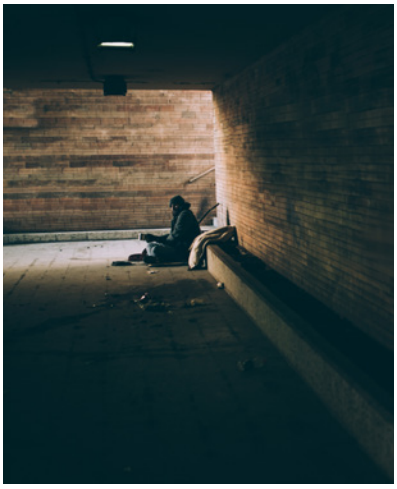
The treatment team will determine if they will offer home and/or office-based treatment induction to patients and review protocols for each (and make any clinic-specific additions). The DEII initiative sites did not conduct home inductions for new patient inductions. Therefore, information on office-based inductions is included below, and information on home inductions is included in ***Appendix D***.

Office-Based Induction

1. One of the most important aspects for office-based induction is to assess the level of opioid withdrawal that patients are experiencing. Use the COWS to score the patient's opioid withdrawal as mild, moderate, or severe.
    a. Patients should exhibit signs of moderate to severe withdrawal prior to receiving their first dose of buprenorphine. If patients appear intoxicated or exhibit no signs of withdrawal, then they should not be started on buprenorphine at this visit. The treatment team should reschedule patients for a later date or time and counsel patients to present when they are experiencing at least mild opioid withdrawal.
    b. Patients who have experienced medical detoxification (e.g., inpatient detoxification program) or non-medical detoxification (e.g., jail) with loss of physical dependence are still eligible for buprenorphine and are at increased risk for overdose death.
2. In addition to assessing opioid withdrawal, also assess for possible substance intoxication (using the UDS as appropriate).

Initial Buprenorphine Doses for Office-Based Initiation

Visit TIP 63



"Patients with opioid use disorder often have decreased distress tolerance. They may feel they are in more withdrawal than can be observed. We stopped telling patients to come to clinic in "mild to moderate" withdrawal, because many would not have observable withdrawal. Now, we tell them to come in moderate withdrawal and describe the physical elements of withdrawal. Preparation can also encompass education about potential time in clinic for induction."

– DEII implementation site

Step 5: Titration and Stabilization Visits

For more information on titration and stabilization, review the DEII Training Manual, specifically Module 8: Buprenorphine patient stabilization: ***https://target.org/deii-buprenorphine***

After buprenorphine initiation, the treatment team monitors patients either daily (for unstable patients) or once or twice weekly (for stable patients).

During this phase:

- Prescribing providers focus on regularly evaluating patients for the continued use of buprenorphine and adjust the dose and/or formulation as necessary. The prescribing provider will increase the buprenorphine dose daily until the patient no longer has signs and symptoms of withdrawal or craving and has not developed signs or symptoms of opioid excess.
- Clinical coordinators provide support, discuss challenges, coach patients in healthy living skills, and assist patients in overcoming barriers as they appear. Clinical coordinators can support patients in remembering to take their daily doses of both buprenorphine and HIV medications (as prescribed).

The prescriber and clinical coordinator team may see the patient concurrently during stabilization. In most cases, once the dose adjustment of the medication is stabilized, the patient typically sees the clinical coordinator more frequently for recovery support.

The goals of early titration and stabilization visits are to assess tolerability, assess dose adjustment, and treat for drug cravings. Most patients reach their target dose within the first two weeks of treatment. Stabilization typically occurs over two visits (around day 3-7 and again around day 10-14).

Some patients may believe (or may have people in their lives that believe) that using buprenorphine treatment means that they are still "using" and not in recovery. Remind the patient that the following organizations consider individuals to be in recovery if they are taking their OUD medications as prescribed:

- The American Medical Association
- The American Society of Addiction Medicine
- The National Institute on Drug Abuse
- The Office of the Surgeon General
- SAMHSA
- The World Health Organization

- ☑ Review use of any adjunct medications for symptom management (for example, no use of benzodiazepines).
- ☑ Order a UDS for toxicology.
  - ◆ During titration: Once weekly during initiation and stabilization
  - ◆ Once stable: Weekly to monthly depending upon clinical stability
- ☑ Give total daily dose administered on the previous day. Add additional mg as needed based on severity of withdrawal symptoms. Some patients may benefit from higher doses of buprenorphine.
  - ◆ Criteria for dose increases:
    - — Significant opioid craving (especially towards end of dosing cycle)
    - — Significant opioid withdrawal symptoms (especially towards end of dosing cycle)
    - — Urine toxicology persistently positive for opioids
- ☑ Review with patients that diversion or misuse of buprenorphine may result in treatment discontinuation.
- ☑ Make sure that patients have an adequate supply of medication until their next visit.
- ☑ Assess patients for evidence of stabilization including: markedly reduced or eliminated illicit opioid use, reduced cravings, suppression of opioid withdrawal, and/or minimal side effects.

When considering titration or tapering, consider the following with the patient:

- ◆ How has the patient responded to buprenorphine?
- ◆ Does the patient have adequate recovery support and a plan to engage members of this support network to reduce the risk of a return to opioid use?
- ◆ Why does the patient want to taper?
  - — Motivations (inconvenience, insurance coverage, side effects, stigma, recovery support) can impact the success of potential titration or tapering.
- ◆ Do they have a safety plan in place?

Tip: The treatment team should be aware that the path to stabilization for most patients is not linear. Patients may start and abruptly stop their MOUD medications, therefore requiring another induction. They may stabilize for a few weeks and then fall out of care. The treatment team will benefit from having plans that ensure a rapid return to care as soon as possible when previously engaged patients return to care for MOUD.

Stabilization is the process of reaching a stable buprenorphine dose and does not imply the patient is stable in all aspects of their early recovery. Therefore, the clinical coordinator plays a critical role during the stabilization phase. Patients may need additional support, advocacy, and referrals during this period. It is not uncommon for a patient to experience relapse and/or non-opioid substance use during the first 4-8 weeks. The clinical coordinator role during stabilization includes encouraging patients to adhere to their medication, assist them with using their recovery-based supports (peer mentors, groups, friends, social events, etc.), and to remind patients to contact their medical team right away if a relapse happens. Relapse and overdose prevention are common topics of discussion during stabilization visits. It would be appropriate at this time to provide the patient with a naloxone prescription and training on how to use this (if this has not occurred at earlier visits).

Step 6: Monitoring and Medication Management Visits

For more information on monitoring and medication management visits, review the ***DEII Training Manual***, specifically Module 9: Maintenance Visits

SAMHSA TIP expert panel and the American Society of Addiction Medicine (ASAM) recommend that patients be seen approximately once a week until they demonstrate significant reductions in or abstinence from illicit substance use.

Monitoring visits, which may include counseling and functional assessments and urine drug testing, can be scheduled weekly or monthly, depending on patient's clinical stability.

Medication management visits, which are specifically tailored to addressing medication needs, can be scheduled weekly or monthly, depending on patient's clinical stability. At a minimum, stable patients should see the prescribing provider at least every three months. (Prescription frequency could be variable according to the laws and insurance coverage). If patients relapse or destabilize, they should return to more frequent monitoring or to a higher level of care.

Clinical coordinators have a major role in this phase of treatment and are responsible for the following:

- Ensuring the patient attends their prescriber appointments
  - Clinical coordinators help patients overcome barriers to attending medical management visits (e.g., transportation, competing needs/priorities, work obligations, childcare obligations)
- Regularly revisiting the treatment plan with the patient and adapting it as needed (consider revisiting at each visit or at every other visit)
- Addressing unmet needs identified by the patient during the screening phase
- Providing structured supportive services around buprenorphine adherence if determined by the treatment team. This may include being available to perform random pill counts or in some cases facilitate Direct Observed Therapy (DOT)
- Assisting patient with navigating services that may require advocacy around remaining on MOUD (jail, treatment programs, transitional or SUD free housing)
- Providing feedback to treatment team and patient regarding frequency of visits
- Helping patients understand post-acute withdrawal syndrome (PAWS) and how to manage symptoms
- Conducting relapse prevention planning
- Providing outreach and support via telephone; the clinical coordinator may also utilize smartphone tools such as Facetime or texting to keep the patient engaged and in communication with their treatment team

For additional strategies on adherence, refer to TIP 63

Building for Success

Key patient-level factors that contribute to patient adherence to treatment include:

- Social or family support
- Understanding of OUD supported by written materials and psychoeducation
- Empowerment in the use of medication
- Support groups and other community resources
- Appointment reminders
- Access to transportation services
- Support in obtaining social and educational services
- Linkage to housing
- Availability and quality of wrap-around services

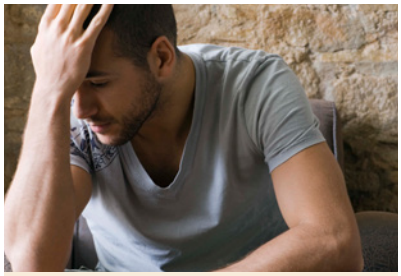
Recurrence of Substance Use

While providing MOUD services, it is important for the treatment team and the patient to be aware of the likelihood of recurrence of substance use (or "relapse") and/or non-opioid substance use. Neither are indicators for treatment cessation, rather they serve as an opportunity to explore with the patient either the reasons for their non-opioid substance use and/or the relapse with an opioid.

Use a harm reduction perspective to explore the reasons for the non-opioid substance use and be prepared to work with the patient either through the stages of change or just provide support during pre-contemplation.

Re-assess for risk of overdose. Talk about overdose prevention with the patient, including addressing tolerance, testing their shot, and ensure that the patient/family/friends have received and been trained in administering naloxone.

Encourage a patient to return to care immediately, providing reassurance along with ongoing prevention planning. Talk to the patient to learn what may have led up to use and explore the emotional, mental, or physical reasons restarting opioids may have occurred. Reaffirm that **recurring substance use is not failure**. It simply means one is learning about themselves and how they react to certain triggers and stimuli and provides an opportunity to look further into why the opioid use occurred and what can be done to prevent it next time.



Patients who use opioids and additional substances tend to struggle more than those who only use opioids. Many enter treatment saying, "*Heroin is my real problem. I can stop cocaine/meth anytime, but heroin, I need help with that.*" Within a few weeks of taking buprenorphine, they discover that cocaine/meth is much harder to stop than they thought. This is where counseling becomes a key element of treatment.

– DEII Implementation Site

Conversation Tips:
Starting a Conversation with a Patient around Recurrence of SUD

- "Would you like to tell me a little bit about what happened before your relapse?"
- "What has your drug use been like during the past week?"
- "What do you plan to do next?"
- "What do you think about the possibility of going through detoxification?"

Referral to Higher Level of Care

Higher and more intensive levels of care may be indicated for the following reasons:

- *Increasing structure and supervision:* Alternative MOUD programs, including buprenorphine/naloxone program offering MOUD services including methadone, have more structure and guidelines and typically tend to have more wrap around services. Patients in need of more structure could also benefit from an intensive outpatient program (IOP) or completing a residential treatment program and then returning to the outpatient MOUD program.
  - Increased structure can also come from supervised dosing within the clinic and more frequent patient visits. Patient-centered care and flexibility is key to responding to patient needs.
- *No improvement or worsening clinical course:* When a patient shows no significant improvement or a worsening clinical course, it may be due to progression of the illness, additional physical or psychological stressors, inadequate or inappropriate treatment, or noncompliance with treatment. The treatment team should work closely with patients during these times to help identify contributing factors and strategies to overcome them. The treatment team should increase the frequency of monitoring and counseling visits. When the current level of care cannot meet the needs of the patient, outside providers or programs such as intensive case management, day treatment, supportive housing, or residential treatment should be considered and offered. Transfer from office-based buprenorphine to more structured methadone treatment may be another option.

The clinical team and patient can work together to determine when it is appropriate to refer to higher levels of care. The clinical coordinator can help ensure the transition to a new program is successful for the patient. Patients may need an intensification of efforts of more frequent visits prior to referral, and the treatment team should address all possible pathways for providing care.

Referring patients to a higher level of care is not "kicking them out" of your care, rather, admitting they may benefit from treatment that the outpatient program cannot provide. It may be helpful to remind them they may return to the office-based setting when life settles out and they are better equipped to be successful in your program.

Misuse or Diversion

Become familiar with ways to identify and respond to misuse or diversion. Although there is no way to completely prevent diversion, having clear guidelines for how to handle it when there are suspicions will help reduce the likelihood of it occurring frequently.

Diversion can happen as a result of peer pressure, a patient wanting to support a family member or friend who is living with SUD, or to make money. Patients may indicate that they are diverting their medication by requesting maximum doses, higher than needed does, identifying friends or family using opioids, or showing signs of injection drug use. Substance misuse can happen as a result of habit, perceived under-dosing, or to relieve anxiety, depression, or pain, among other reasons.

Strategies for working with patients who are misusing or diverting their medications:

- Reduce risks of diversion by first ensuring policies and procedures are in place to respond to misuse and diversion.
- Confirm with the patient that they been informed of these policies by revisiting their Treatment Agreement (signed during Treatment Initiation) detailing clear steps that the treatment team will take if misuse or diversion occurs.
- Document and describe misuse or diversion and the clinical thinking that supports the clinical response.
- Utilize monitoring techniques to reduce diversion or misuse through:
  - Random UDS
  - Schedule unannounced pill/film counts
  - Directly observe ingestion (this can be done in person or via an app like Skype)
  - Limiting medication supply to shorter prescription time frames
  - Using the lowest dose that works for the patient
  - Consider long acting forms of buprenorphine

Conversation Box: Starting a Conversation with a Patient around Misuse or Diversion

"Your UDS was negative for buprenorphine; can you tell me how you are taking your buprenorphine?"

"It is not uncommon for someone to relapse in the early phases of OBOT, which is why we use the UDS as a tool to better understand how you are doing during your treatment. Would you mind if we talk about your UDS results from last week?"

Discontinuing Buprenorphine

For more information about discontinuing buprenorphine, refer to the DEII Training Manual, specifically Module 10: Transitioning Patients to the Standard of Care

TIP 63

Tapering patients off buprenorphine happens on a case-by-case basis, following the protocols developed by the treatment team during pre-implementation.

> ***"In most cases, treatment will be required in the long term or even throughout life. The aim of treatment services is not only to reduce or stop opioid use, but also to improve health and social functioning, and to help patients avoid some of the more serious consequences of drug use. Such long-term treatment, common for many medical conditions, should not be seen as treatment failure, but rather as a cost-effective way of prolonging life and improving quality of life, supporting the natural and long-term process of change and recovery."***
>
> **-World Health Organization**

Patients can stay on buprenorphine treatment indefinitely but could be transitioned to working with their primary care provider instead of the treatment team. Alternatively, prescribing providers can taper patients off buprenorphine.

Diversion, theft, threatening behavior, or violence: Diverting the medication and not taking it at all (supported by buprenorphine negative UDS) is cause for discontinuing buprenorphine treatment. Refer to the protocol established in the pre-implementation phase and the guidelines established in the treatment agreement when addressing diversion, theft, threatening behavior, or violence.

As a general rule, a provider can't force a patient to take more medication than they want, but a provider can prescribe less or none based on risk-benefit. Witnessed diversion activity usually results in involuntary detoxification and discharge.

Other reasons for termination may include: An act or threat of violence against a patient or clinic staff; possession of weapons; violation of the program rules and regulations; harassment of other patients or staff on the basis of gender, ethnicity, or sexual orientation; stealing or other illegal acts on the clinic grounds; duplicate registrations in this and other opioid agonist treatment programs (methadone or buprenorphine); and tampering with urine toxicology samples.

Counseling and Recovery Support Services

Additional supportive services are key to the long-term success of patients in the intervention. Additional supportive services can include individual counseling, group counseling, contingency management, recovery coaching, mental health services, or mutual-help groups (e.g., Alcoholics Anonymous, 12-step programs). SUD is both physical and psychological. Buprenorphine only treats the physical element of SUD.

Legislation mandates all providers have the ability to refer buprenorphine-treated patients to counseling; however, recommend counseling to patients on a case-by-case basis. All patients should receive an assessment of whether counseling is indicated, which should then affect treatment decisions and care plans.

"We are finding providing Bup alone is not helping our patients. While we are not mandating mental health or IOP, we are finding that patients REALLY do need this additional support."

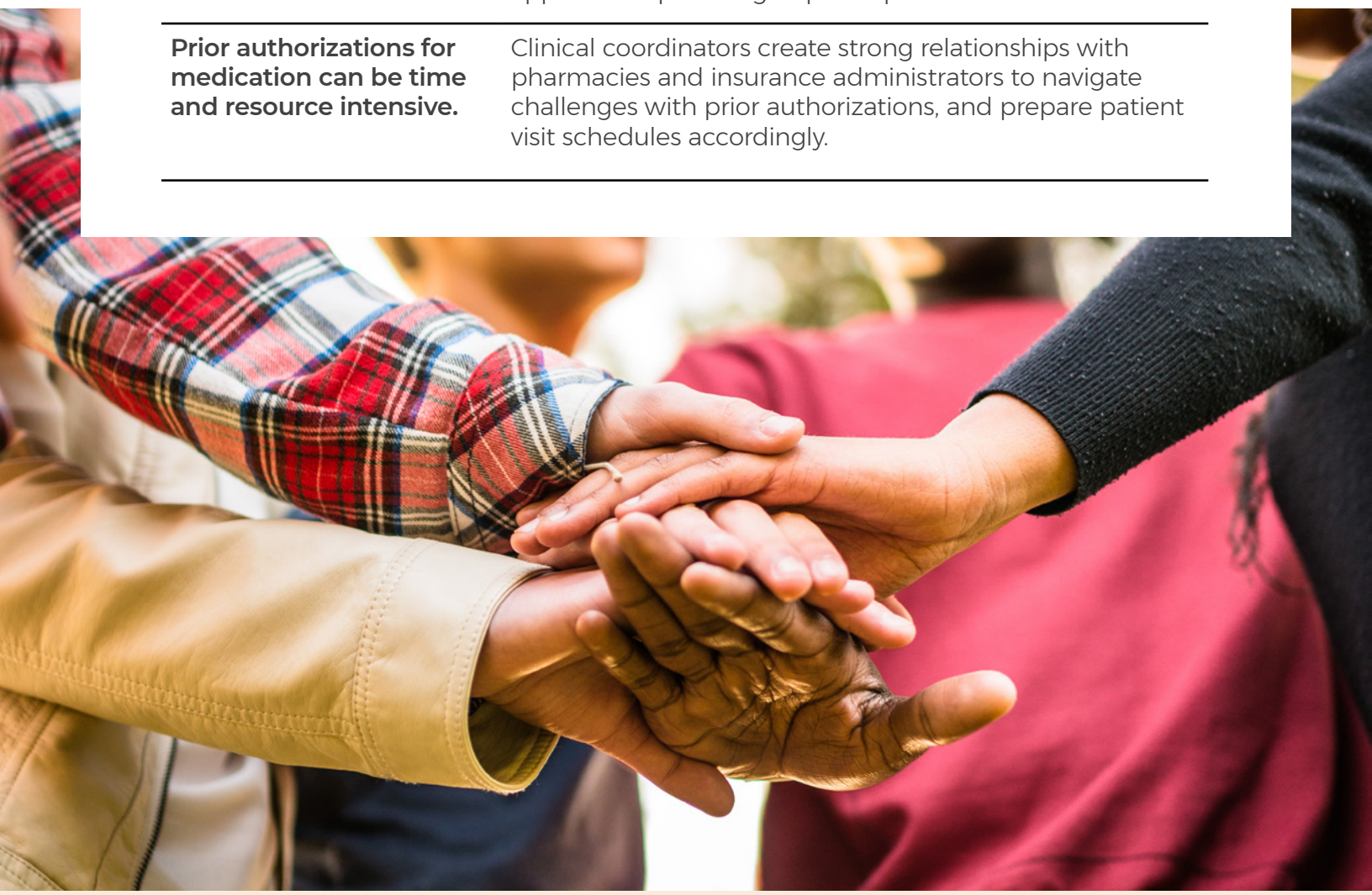
– DEII Implementation Site

The types of supportive services offered during a patient's treatment on MOUD will vary depending on the role of the clinical coordinator and their facility. In some settings, the clinical coordinator, an addictions counselor, or a psychiatrist may be responsible for providing the following supportive services:

- Delivering evidence-based interventions for SUD and underlying mental health conditions for patients on MOUD. Examples include:
  - Replacing drug using activities
  - Drug resistance skills
  - Problem solving skills
  - Motivation
  - Interpersonal relationships
  - Self-care skills
  - Craving diary
  - Functional analysis
  - More resources can be found on the PCSS website: Developing a Behavioral Treatment Protocol in Conjunction with MAT
- Facilitating evidenced-based group interventions. Examples include: harm reduction, dialectical behavioral therapy skills, seeking safety, coping skills, and symptom management.
- Creating, documenting, and monitoring a plan to address unmet behavioral health needs (for example: mental health, substance use, and community resources).
- Developing educational and training materials, and conducting sessions on behavioral health/substance use treatment for internal and external community partners.
- Providing some case management and supporting a smooth interface and linkage between physical health and other external specialty services by matching the patient's level of need to the appropriate level of care.
- Providing education about overdose prevention and assisting the patient, friends, and family with accessing a naloxone prescription and training.

Overcoming Implementation Challenges

Implementation Challenge	Implementation Solution
Intensity of services needed by patients with high acuity, co-occurring substance use disorder, mental health concerns, and high levels of experienced stigma.	Pace enrollment in intervention services so that caseloads are sustainable for prescribing providers and clinical coordinators. Create a clinical schedule that offers prescribing providers and clinical coordinators flexibility so they can quickly respond to the needs of patients. Patients may experience high levels of stigma for their HIV diagnosis and/or their substance use disorder, which can become a barrier to seeking treatment for either condition. If a patient walks in the door and wants to engage in treatment, treatment teams work together to make sure that that patient feels welcome and gets a visit as soon as possible. One strategy to accomplish this is to offer walk-in appointment slots.
MOUD for SUD is not a linear process.	Treatment teams can create safe, non-punitive environments that welcome patients back into care should they fall out of care or relapse. Treatment teams may need to re-initiate treatment more than once before a patient stabilizes. There is no "normal" process or one-size fits all approach in providing buprenorphine treatment.
Prior authorizations for medication can be time and resource intensive.	Clinical coordinators create strong relationships with pharmacies and insurance administrators to navigate challenges with prior authorizations, and prepare patient visit schedules accordingly.



PROMOTING SUSTAINABILITY AND INTEGRATION ACTIVITIES

The following activities take place to solidify integration of the intervention throughout the clinic setting:

Treatment Team Activities:

- Create an internal communication plan that outlines the ways in which information is diffused throughout the clinic setting. This plan will address:
  - How is information about new programs or interventions typically disseminated at a clinic?
  - How is information about new programs or interventions typically shared with community partners?
  - What are the best ways for the treatment team to communicate with each other?
- Work with clinic staff to assess which patients could benefit from the buprenorphine intervention.
  - In order to accomplish this goal, the treatment team and clinic staff should:
    - Provide ongoing training to clinic staff on SUD treatment (e.g., overview of SUD and SUD treatment, urine toxicology, confidentiality issues, motivational interviewing), polysubstance abuse, and buprenorphine-specific subjects (e.g., patient selection, induction, stabilization, documentation, forms, regulations, and case studies).
    - Participate in at least two annual meetings with all clinic staff and treatment team members to review the status of the intervention and how all staff roles intersect with the intervention (or ways that staff roles could better intersect with the intervention in the future).
- Hold ongoing meetings that discuss the buprenorphine treatment process, eligible patients, patient outcomes, and case conferences.
- Determine if any changes need to be made in the clinic EMR to better support documentation of patient-level data in the intervention.
- Recruit and train additional prescribing providers at the clinic site.
- Support, send providers to, sponsor, or host buprenorphine prescription waiver training in order to grow a network of prescribing providers. The determination to either support, sponsor, or host a training will be clinic specific, and dependent on clinic resources and community (or regional) training needs. Each clinic will document their decision to either support, sponsor, or host a training.
- Participate in two annual meetings with community partners to discuss intervention activities, the opioid problem in the local community, and systems coordination.

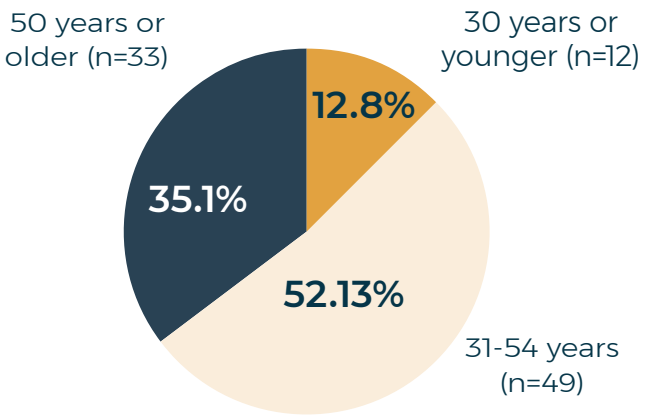
Clinic Administration Activities:

- Meet with the treatment team at least quarterly to discuss the status of the intervention, any ongoing programmatic needs or concerns, and potential methods for spreading information about the intervention throughout the clinic (or clinic system if the site is part of a larger clinical network).

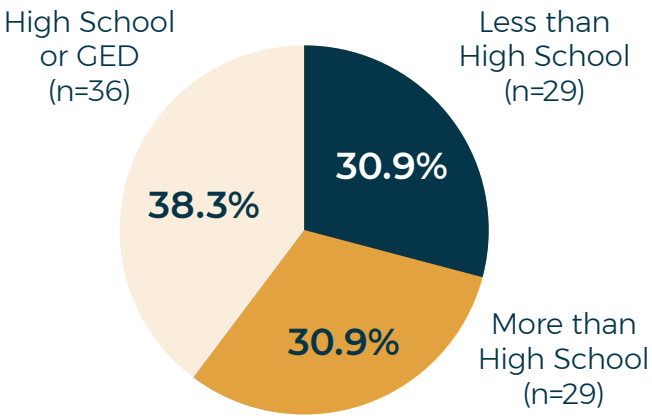
Sustainability is an important component of implementing this evidence informed intervention—both to support continuity of services for patients as well as strengthen investments by individual staff and organizations. DEII grantees had the option to use the Program Sustainability Assessment Tool (PSAT) to evaluate the sustainability capacity of their program and engage in sustainability planning processes. The PSAT was developed by the Center for Public Health Systems Science (CPHSS), Brown School, Washington University in St. Louis through a comprehensive literature review and expert-informed Concept Mapping. Whether your organization uses the PSAT or another resource, have conversations about sustainability early and often.

OUTCOMES/IMPACT

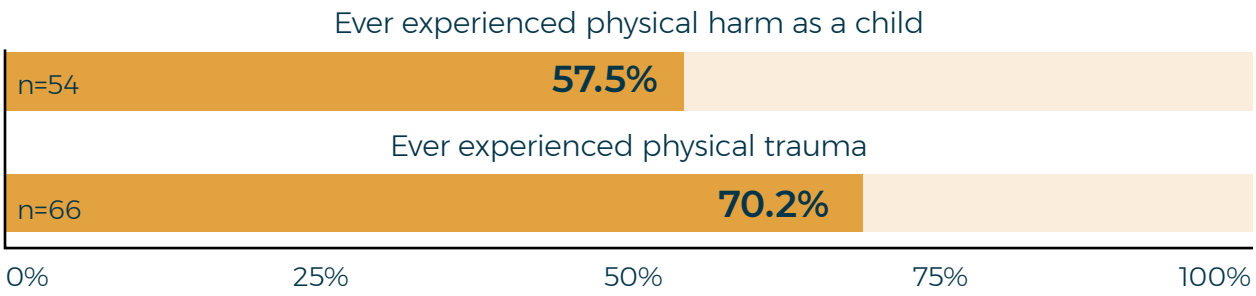
Age



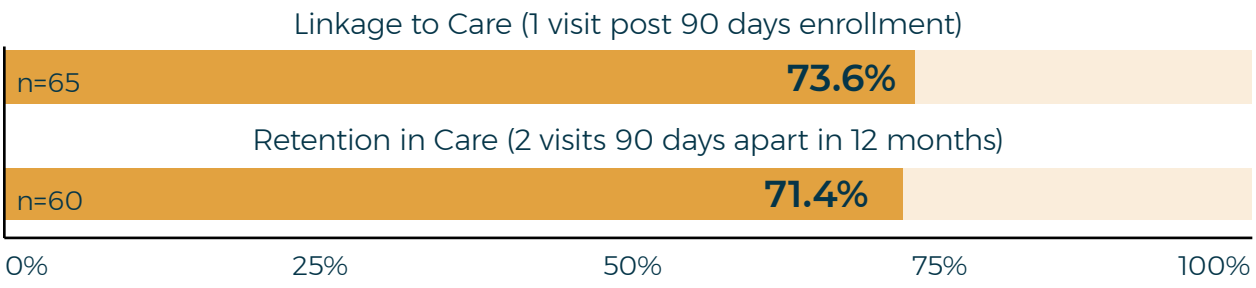
Education



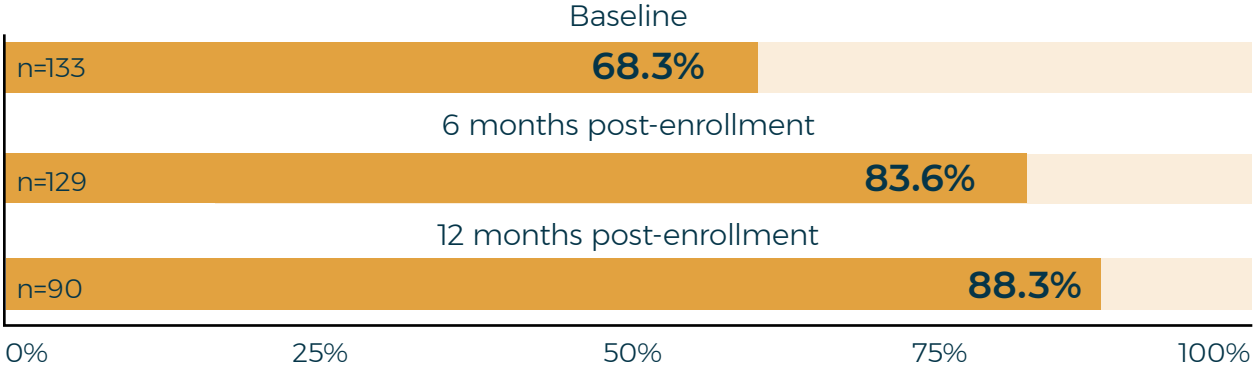
Experience of Trauma



HIV Care Outcomes



Viral Suppresion



Considerations for Replication

- Start where you're at. The pre-implementation checklist can look intimidating, so don't wait until everything is in place before you start treating patients. Patients with untreated OUD and HIV need your help NOW!
- Successful MOUD programs take a team effort. Everyone from front-desk staff to billing specialists to case managers to pharmacists need to be involved in order to make sure that patients get the high-quality care they need.
- Meet the patient where they are at. This may mean interacting with them multiple times before they start buprenorphine treatment, or may mean that they need your help with an ancillary service need before they start treatment. Being present for them and responding to their needs is crucial to establishing a relationship with the patient and helping them connect to care.
- Treatment is not a linear process! When patients struggle to adhere to their buprenorphine, relapse, or temporarily fall out of care, welcome them back into the clinic with open arms. Every time they connect with you, they have another opportunity to sustain their recovery.
- Work with fellow providers to break down myths and stigma related to OUD treatment and people living with SUD and OUD. Engage fellow providers in the effort to treat people in your community to increase the number of patients that are able to receive timely, and sometimes life-saving treatment.

Conclusions

- Integrated MOUD and HIV services are vital for improving both SUD and HIV related health outcomes , and can be successfully integrated into HIV primary care settings to support people with HIV and co-occurring OUD.

Care and Treatment Intervention (CATIs) are a series of evidence informed interventions supported by HRSA/HAB to promote linkage, retention and viral suppression across Ryan White HIV/AIDS Program. The CATIs replicate four previously Ryan White HIV/AIDS Program Part F Special Projects of National Significance initiatives:

- Transitional Care Coordination: from Jail Intake to Community HIV Primary Care
- Peer Linkage and Re-engagement for Women of Color Living with HIV
- Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care
- Enhanced Patient Navigation for Women of Color Living with HIV

* *For more information on the Dissemination of Evidence Informed Interventions Initiative:* ***https://targethiv.org/deii***

Appendices

Appendix A: Staffing Plan and Job Descriptions

Prescribing Providers (at least 2)	The lead prescribing provider is responsible for all aspects of patient treatment including: ◆ Conducting or reviewing patient assessments; ◆ Prescribing buprenorphine in accordance with Schedule III requirements; ◆ Managing initiation, stabilization, and maintenance of buprenorphine treatment (with the support from the Clinical Coordinator); ◆ Record keeping that may be referenced for a DEA inspection; ◆ Providing clinical guidance and direct supervision to the Clinical Coordinator. A second prescribing provider is required to provide backup coverage in the event that the lead physician is on vacation, ill, or unavailable for any other reason
Clinical Coordinator	The Clinical Coordinator is responsible for: ◆ Being available to see patients in the clinic daily, participating in patient assessment, and preparation, including day-to-day program concerns, education, and counseling; ◆ Supporting the patient and prescriber in buprenorphine initiation, stabilization, and maintenance treatment procedures under the supervision of the prescribing physician; ◆ Assisting the prescribing physician in making referrals to community providers for counseling or higher levels of care when needed; ◆ Maintaining therapeutic relationships with both the patient and the medical provider; ◆ Overseeing the following patient care components: – Case management; – Medication management and treatment monitoring; – Insurance authorization and troubleshooting; – Relationship building and patient linkage to additional support (drug treatment services and mental health care); – Relationship building and facilitation of ancillary services (including patient transportation).

Appendices

Prescribing Provider

Job Description

Description of the Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Intervention

This HIV primary care model intervention aligns with the medical home model as it allows patients to readily access comprehensive HIV and addiction medicine under one roof. The Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care model follows principles of harm reduction, including reducing the harms of substance use disorder. This enables providers to treat substance use disorder along with other chronic medical conditions experienced by their patients. The approach secures additional patient buy-in by investing in the existing trust and communication they develop with their primary care providers.

Purpose of Position

The prescribing provider is responsible for all aspects of patient treatment and the supervision of the clinical coordinator.

Key Responsibilities

The prescribing provider is responsible for all aspects of patient treatment including:

1. Conducting patient assessments;
2. Reviewing patient assessments;
3. Prescribing buprenorphine in accordance with Schedule III requirements;
4. Managing initiation, stabilization, and maintenance of buprenorphine treatment (with the support from the Clinical Coordinator);
5. Overseeing record keeping that may be referenced for a DEA inspection; and
6. Participating in professional development and supervision meetings with a clinical mentor.

The prescribing provider has overall clinical responsibilities including:

1. Providing clinical guidance and direct supervision to the Clinical Coordinator;
2. Completing 8 hours of approved training; and
3. Obtaining a waiver from SAMSHA's Center for Substance Abuse Treatment (and receiving an accompanying ID number and Drug Enforcement Agency [DEA] registration number). After the first year of prescribing buprenorphine, submitting a second notification to be able to treat up to 100 patients.

Appendices

Qualifications/Requirements

- Licensed MD, DO, NP, PA (check state level regulations)
- Prior clinical experience working with patients with substance use disorders, and mental health diagnoses.
- Knowledge of harm reduction philosophy, patient-centered counseling, and motivational interviewing techniques.
- Demonstrated ability to work collaboratively in a team environment.
- Demonstrated computer literacy in Microsoft and web-based applications.
- Excellent verbal and written communication skills.
- Excellent interpersonal and organizational skills.
- Knowledge of community resources; demonstrated ability to network and build strong relationships with community organizations serving priority populations as identified by the agency and/or funder.
- Demonstrated ability in working with patients of diverse backgrounds, underserved communities, and co-morbidities.
- Demonstrated knowledge of working with patients with HIV/AIDS.

Preferred Skills

- American Academy of HIV Medicine (AAHIVM) credentials.
- HIV Medicine Association (HIVMA) credentials.
- 2 years of experience managing HIV primary care

Appendices

Clinical Coordinator

Job Description

Description of the Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Intervention

This HIV primary care model intervention aligns with the medical home model as it allows patients to readily access comprehensive HIV and substance use disorder medicine under one roof. The Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care model follows principles of harm reduction, including reducing the harms of substance use disorder. This enables providers to treat substance use disorder along with other chronic medical conditions experienced by their patients. The approach secures additional patient buy-in by investing in the existing trust and communication they develop with their primary care providers.

Purpose of Position

The clinical coordinator is a key member of the buprenorphine treatment team and serves an essential role in the implementation process. This person must possess not only the clinical knowledge and skills to participate in individual patent treatment, but also the organizational and communication skills to execute systems-level activities. The clinical coordinator is the point person who will have the most contact with the patients, and will be in constant contact with the physicians and prescribing providers in order to communicate patient needs and shape patient care.

Key Responsibilities

The Clinical Coordinator is responsible for:

1. Seeing patients in the clinic daily, participating in patient assessment, and preparation, including day-to-day program concerns, education, and counseling;
2. Supporting the initial patient assessment for treatment;
3. Supporting the patient and prescriber in buprenorphine initiation, stabilization, and maintenance treatment procedures under the supervision of the prescribing physician;
4. Assisting members of the health care team in the formulation and implementation of the plan of care;
5. Assisting the prescribing provider in making referrals to community providers for counseling or higher levels of care when needed;
6. Maintaining therapeutic relationships with both the patient and the medical provider;

7. Overseeing the following patient care components:
    a. Care coordination including medication management and treatment monitoring;
    b. Insurance authorization and troubleshooting;
    c. Relationship building and patient linkage to additional support (drug treatment services and mental health care);
    d. Relationship building and facilitation of ancillary services (including patient transportation);
8. Sharing information with other members of the health care team through chart documentation, interdisciplinary team meetings and email; and
9. Record keeping that may be referenced for a DEA inspection.

Qualifications/Requirements

- Licensed RN, Social Worker, Addiction, or Mental Health Counselor.
- Knowledge of harm reduction philosophy, patient centered-counseling, and motivational interviewing techniques.
- Prior experience conducting individual patient education and counselling sessions.
- Demonstrated ability to work collaboratively in a team environment.
- Demonstrated computer literacy in Microsoft and web-based applications.
- Excellent verbal and written communication skills.
- Excellent interpersonal and organizational skills, including problem solving with a team.
- Knowledge of community resources; demonstrated ability to network and build strong relationships with community organizations serving priority populations as identified by the agency and/or funder.
- Demonstrated ability to working with patients of diverse backgrounds, underserved communities, and co-morbidities.
- Demonstrated knowledge of working with patients with HIV/AIDS.

Preferred Skills

- Prior clinical experience working with patients with substance use disorders and mental health diagnoses.
- Completion of the Addiction Technology Transfer Center Network Buprenorphine Training for Multidisciplinary Addiction Professionals.

Appendices

Appendix B: Additional Training Topics

1. **Integrating a harm reduction approach.** Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. The approach works to minimize harmful effects of substance use, as opposed to ignoring or condemning them. Those who practice a harm reduction approach offer non-judgmental and non-coercive services and resources, and recognize that "substance use" exists on a continuum of behaviors that range from abstinence to substance abuse and that abstinence is not the primary goal for all patients. A harm reduction approach recognizes that talking to patients about safer drug use practices is an important step in improving the long-term health outcomes of those living with SUD. The clinical coordinator should be prepared to provide harm reduction information including safe injection practices and referrals to local syringe services programs. The Harm Reduction Coalition: ***Principles of Harm Reduction***
2. **Conducting overdose prevention education with patients.** The treatment team should be routinely providing overdose prevention education and materials for patients identified as having an OUD. If available, the Clinical Coordinator should assist patients with active OUD to obtain prescription naloxone and train the patient and family/friends on how to use it during an overdose. The clinical coordinator should be familiar with Good Samaritan laws in their area and inform patients/friends/family how these laws protect them in the event of an overdose. (***prescribetoprevent.org***)
3. **Creating a trauma-informed environment.** This approach recognizes that trauma is a contributing risk factor to developing SUD. Trauma-informed care includes empowering patients to develop and/or maintain control over their lives and treatment. Programs providing MOUD should include methods that treat both the SUD and any associated trauma in order to increase long-term positive patient outcomes.
    a. ***Trauma & Addiction Treatment & Recovery***
    b. ***What is Trauma-Informed Care?***
    c. ***TIP 57: Trauma-Informed Care in Behavioral Health Services***
    d. ***SAMHSA 6 Key Principles of Trauma Informed Care***
    e. ***Refer to Appendix 2 in the Training Manual***
4. **Working with co-occurring disorders and comorbidities:** Co-occurring disorders are defined as the occurrence of two disorders or illnesses in the same person (e.g. psychiatric illness and SUD). When a person has been diagnosed with two or more disorders, the symptoms may interact between the conditions to influence the course and prognosis of both disorders. There are typically barriers to treatment for persons living with dual diagnosis. It is important for long-term positive patient outcomes that both disorders are treated concurrently. ***Recovery Research Institute: Co-Occurring Disorders***
    a. Mental Health First Aid training/certificate for all personnel. ***Mental Health First Aid*** is an 8-hour course that provides the skills needed to help someone who is developing or experiencing a mental health crisis.

Appendices

5. **Motivational Interviewing:** Motivational Interviewing (MI) is a framework and set of strategies for assisting patients in the development of goals and motivation to work toward these goals. ASAM's ***Motivational Interviewing: A Brief Introduction (video)*** and ***SAMHSA's clinical practice resource for Motivational Interviewing***.
6. **Shared decision making:** is a collaborative process that enables patients and providers to make healthcare decisions together that take into account the best medical information as well as a patient's preferences. SAMHSA's ***Decisions In Recovery: Treatment for Opioid Use Disorder***.
7. **Understanding and Addressing Stigma for SUD/OUD:** A person experiencing SUD often lives with their own internalized stigma and shame based on how the world around them has historically responded to SUD related behaviors. Providers and treatment systems can further add to that stigma if they are not aware of how things like language and program practices can impact this. Programs providing SUD treatment should incorporate practices that are non-stigmatizing while also ensuring that the persons receiving treatment have access to resources and treatment to reduce their own internalized stigma. ***ATTC Network Anti-Stigma Toolkit***
8. **SUD 101:** It is helpful for all staff involved in MOUD or SUD treatment programs to have a basic overview on identifying and treating SUD. PCCSNOW: ***Introductory Training for Understanding and Treating Substance Use Disorders***
9. **Peer Recovery Support:** Peer Recovery Supports are an invaluable resource for patients on MOUD. They can provide additional recovery support and often are able to meet the patient where they are at in the community. The facility you work at may already have Peer Recovery Supports in place or they may be interested in developing a relationship with an outside community partner to have Peer Recovery Support staff available. Department of Behavioral Health and Intellectual Disability Services: Peer Support Toolkit
    a. Suggested resources for additional information:
        i. ***Recovery LIVE! Ethics and Boundaries in Peer Support Services" webinar recording***
        ii. ***Peer Support Toolkit***
10. **Introductory information for Medications to Treat OUD:** PCCSNOW: ***Quick Overview of medications for treating OUD***
11. **NAABT Graphic:** ***How Buprenorphine Works***
12. **Federal Regulatory Requirements for Buprenorphine:** The Drug Addiction Treatment Act 2000 (DATA 2000) requires specific training and regulatory practices in order for a program to provide MOUD using Buprenorphine. Providers prescribing buprenorphine will have completed the appropriate ***waiver process*** and ***required training***. The clinical coordinator is often involved in managing the ***Record Keeping Requirements*** which include maintaining records and inventories for all patients prescribed buprenorphine.

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13. **42CFR:** Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records governs how patient SUD records are maintained and shared to prevent disclosure to a third party. OBOT programs should consult with their program's management team to ensure that their program is in compliance. Use the following documents to better understand what programs are considered Part 2 providers and how to exchange patient information accordingly.
    a. SAMHSA's ***Disclosure of Substance Use Disorder Patient Records: Does Part 2 Apply to Me?***
    b. SAMHSA's ***Disclosure of Substance Use Disorder Patient Records: How Do I Exchange Part 2 Data?***
14. **State-specific regulations surrounding buprenorphine prescribing:** Some state regulatory boards may have more stringent requirements for buprenorphine prescribing. Although adhering to these regulations are ultimately the responsibility of the prescriber, the clinical coordinator may be responsible for keeping track of these regulations and providing adequate documentation of prescriber adherence to regulations.
15. **Computerized Therapeutic Education System (TES):** Using technology can enhance patient access to the program and may be vital for serving patients who either lack transportation resources and/or live in rural communities where attending in-office appointments for MOUD may be a barrier to care.

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Appendix C: List of Community Partners for Office-Based Opioid Treatment Referral

Purpose: This list provides an overview of common agencies that a program providing Office-Based Opioid Treatment (OBOT) will most likely utilize during the course of treating patients with substance use disorders (SUD) and developing individualized treatment plans.

Programs offering OBOT will benefit from having a comprehensive list of local resources at hand to assist with referrals and connecting patients to additional treatment services. Establishing relationships and memoradums of understanding (MOUs) with these community partners will improve patient outcomes in OBOT and facilitate comprehensive treatment.

Detoxification Services

- Withdrawal management and stabilization services for people seeking treatment for substance use disorders.
- OBOT programs will benefit from having a fast track referral system to local detox services to ensure rapid treatment access when an OBOT patient may need higher level of care services than what can be provided for in an OBOT setting.
- OBOT programs may utilize their inpatient detox program to start a patient on MOUD and then have their care transferred to the OBOT program once the patient is stabilized.

Residential Treatment Programs

- Treatment can be provided in inpatient or residential sessions. This happens within specialty substance use disorder treatment facilities, facilities with a broader behavioral health focus, or by specialized units within hospitals.
- OBOT programs will benefit from establishing a system of referral and linkage to local residential treatment programs as an additional resource for comprehensive substance use disorder services.
- OBOT patients may be identified as needing a higher level of care for stabilization prior to starting MOUD or may need to be referred during the course of OBOT for additional stabilization.
- Some patients may be stable on MOUD but still experience substance use related disorders for another substance that is not treated by MOUD. These patients may benefit from residential treatment services. OBOT programs should check with their local residential programs to ensure they accept patients on MOUD and determine the referral process required to ensure that a patient's MOUD services will not be interrupted while in residential treatment.
- OBOT programs may find that some residential treatment programs will not accept patients on MOUD. In this scenario, the OBOT team will need to work on a taper plan for their patient prior to entering into residential treatment services.

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Intensive Outpatient Treatment Programs (IOP)

- IOP provide comprehensive treatment services for those who do not need medically-supervised detox. IOP can also enable people in recovery to continue their recovery therapies following successful detox, on a part-time yet intensive schedule, designed to accommodate work and family life.
- OBOT programs may find that some outpatient treatment programs will not accept patients on MOUD. If this is the case, then the OBOT team will need to work on a taper plan for their patient prior to entering into outpatient treatment services.

Methadone Clinics

- OBOT programs should be familiar with their local methadone clinics (in some cases they also provide buprenorphine).
- Patients in an OBOT program may need to be transferred to a methadone clinic for higher level of care services. Methadone clinics provide comprehensive treatment services in a more structured and regulated environment to ensure a patient's success on MOUD.
- OBOT programs will benefit from having referral and linkage to service resources for their local methadone clinics.

Alcoholics Anonymous/Narcotics Anonymous/Other Treatment Groups

- 12-step facilitation therapy seeks to guide and support engagement in programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). Most AA/NA programs have groups that target specific populations (women only, youth, LGBTQ) and this should be considered when referring an OBOT patient.
- OBOT programs should be aware of specialty and/or alternative treatment groups in their area that may target specialty populations (youth, LGBTQ, SMART Recovery, non 12-step focus, self-help support groups, faith based).
- OBOT programs should be aware that some treatment groups are abstinence only based, and this includes abstinence from MOUD. This should be taken into consideration when referring OBOT patients to local treatment groups.

Individual or Group Counseling

- Counseling can be provided at the individual or group level. Individual counseling often focuses on reducing or stopping substance use, skill building, adherence to a recovery plan, and social, family, and professional/educational outcomes. Group counseling is often used in addition to individual counseling to provide social reinforcement for pursuit of recovery.
- OBOT programs will benefit from creating relationships with counseling services that are familiar with working with patients on MOUD, and provide an environment that is supportive to ongoing MOUD adherence.

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Housing (transitional, sober housing, alcohol and drug free subsidized housing, shelters)

- Stable housing can be a key component to the success of a patient treated in an OBOT setting. There are several types of housing programs to assist patients with their sobriety. OBOT programs should be familiar with the different types of housing available locally.
- Establishing referral and linkage to these programs can help a patient in OBOT access safe, secure housing.
- OBOT programs should be aware of each housing program's policy for patients on MOUD.

Emergency Departments (ED)

- OBOT programs should be familiar with local ED services for managing patients who have entered the ED for substance use related emergencies. ED systems are beginning to implement treatment referral or initiation services, and coordination with the ED can help link patients to OBOT programs, especially for a patient that may have fallen out of care.
- Patients seen in the ED for a recent overdose may be prescribed naloxone to take home with them as a preventative measure.

Psychiatric Inpatient/Respite Care

- OBOT patients may have comorbid chronic mental health conditions requiring additional stabilization prior to starting MOUD services and/or may experience a mental health crisis during the course of OBOT treatment and need referral to immediate psychiatric services.
- OBOT programs should be aware of community resources for either inpatient psychiatric services (typically in a hospital setting) or respite care.
- Respite care services assist patients who are experiencing an emotional or psychiatric crisis, who can be safely diverted from the emergency room or being admitted on an inpatient level of care.
- OBOT programs should be informed of both inpatient and respite care protocols around MOUD continuation for patients they may refer for psychiatric stabilization. OBOT programs can assist with coordinating ongoing MOUD to ensure continuity of care.

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Jail and Court/Legal Services

- OBOT programs should check with local jails to determine if these systems have programs or protocols in place to maintain a patient's MOUD while in jail. If there is a system in place, OBOT programs should work on establishing relationships with the jail that ensure coordination and transfer of MOUD services upon release from jail.
- If MOUD services cannot be sustained while a patient is incarcerated, OBOT programs may be able to establish a system of coordination and referral for their patients being released from jail, referring them to the OBOT program for initiation of MOUD services upon release.
- Aftercare, discharge service planning, and other services tailored to criminal justice patients' specific needs are critical for interrupting substance use patterns, in addition to breaking cycles of criminal justice involvement. Some justice service programs have direct linkage to treatment services that specialize in serving this population. OBOT programs should familiarize themselves with such programs and be aware of programs open to continuing a patient on MOUD.
- Some legal systems may require initiation of MOUD services as a part of court-ordered treatment. Coordination of referrals and linkage to care can assist with directing patients to your OBOT program for sustained MAT services.

Peer Supports

- Peers are individuals in recovery who can use their own experiences to help others working towards recovery. Peer support services are a critical component of the substance use disorder treatment system.
- OBOT programs should establish either in house or linkage to peer support services. Peers should be included in OBOT programmatic development and planning, and be a referral resource for providing support to patients in your OBOT program.
- Peers have the ability to engage in reality-based candor with patients in a way that is contraindicated for those who are seen as carrying significantly more power than the patient in clinical interactions.

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Recovery Support Services

Non-clinical services that are used with treatment to support individuals in their recovery goals. These services are often provided by peers, or others who are already in recovery. Recovery support can include:

- Transportation to and from treatment and recovery-oriented activities
- Employment or educational supports
- Peer-to-peer services, mentoring, and coaching
- Parenting education
- Self-help and support groups
- Outreach and engagement
- Staffing drop-in centers, clubhouses, respite/crisis services, or warmlines (peer-run listening lines staffed by people in recovery themselves)
- Education about strategies to promote wellness and recovery

AIDS Service Organizations (ASOs)

Specific to OBOT programs that provide primary care to people living with HIV/AIDS.

- ASOs are community-based organizations that provide support for people affected by HIV/AIDS.
- OBOT programs that provide HIV/AIDS primary care services will most likely have established relationships with their local ASOs. OBOT programs that are new to providing MOUD services should communicate their programs policies and procedures with their local ASOs to ensure supportive treatment referral and linkage services.

References: ***SAMHSA Treatments for Substance Use Disorders***

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Appendix D: Buprenorphine Treatment Agreement

This agreement has 5 parts:
Part 1: Tells you how and when to take your medicine
Part 2: Describes the goals of treatment
Part 3: List things that you and your doctor agree to do
Part 4: List things that could happen if you do NOT do the things listed in Part 3.
Part 5: Sign the form. You and your doctor must sign the form.

Part 1: My medicine

Medicine	Breakfast	Lunch	Dinner	Bedtime

Part 2: Goals of treatment

I understand that my cravings may not completely go away. I understand that buprenorphine may not work for me.

My goals for treatment include:

Part 3: Things I agree to do

I will:

- Only get buprenorphine from my doctor
- Tell all my other doctors that I am taking buprenorphine and cannot take any other opiate medications
- Tell my doctor about ALL of the medicines I am taking (over the counter, herbs, vitamins, those ordered by other doctors)
- Tell my doctor about all of my health problems
- Only get refills during my doctor appointment (refill requests may not be honored)
- Tell my doctor if I get pain medicine from another doctor or emergency room
- Keep my buprenorphine in a safe place AND away from children
- Only get my pain medicine from [insert pharmacy name, address, phone number]
- Bring all of my unused pain medicine in their original pharmacy bottles to my doctor visits if my doctor asked me to. He or she may count the number of pills left in my bottle(s)
- Allow my doctor to check my urine (pee) or blood to see what drugs I am taking
- Try all treatments that my doctor suggests, including social work and mental health referrals if necessary

I will NOT:

- Share, sell, or trade my buprenorphine with anyone
- Use someone else's medicine
- Alter my urine sample (e.g., add water, use someone else's urine)
- Change how I take my medicine(s) without asking my doctor
- Ask my doctor for extra/early refills if I use up my supply before my next appointment
- Ask my doctor for extra refills if my medicine or prescription is lost or stolen

My doctor will:

- Work with me to find the best treatment for my addiction
- Refer me for additional help when needed

Part 4. I understand:

- This is a controlled narcotic medication that may result in withdrawal symptoms when stopped immediately
- If I drink alcohol or use street drugs while taking my medicine:
  - may not be able to think clearly
  - I could become sleepy
  - I may injure myself or overdose
- If I ever:
  - Steal
  - Forge prescriptions
  - Sell my medicine
  - Disrespect clinic staff

My doctor will stop my buprenorphine treatment immediately

- If my goals in part 2 are not reached, my doctor may stop my buprenorphine treatment.
- If I do not follow this agreement, or if my doctor thinks that my medicine is hurting me more than it is helping me, my doctor:
  - Will continue to be my primary care doctor but will stop my buprenorphine treatment immediately
  - Will refer me to a specialist for treatment of pain and/or drug problems

I hereby authorize and give consent to the above-named physician and/or any appropriately authorized assistants they may select, to administer or prescribe buprenorphine for the treatment of opioid use disorder.

The procedures to treat my condition have been explained to me. I understand that it will involve my taking the prescribed buprenorphine on the schedule determined by the treatment team.

It has been explained to me that buprenorphine itself is an opioid, but for some individuals it may not be as strong an opioid as heroin or morphine. Buprenorphine treatment can result in physical dependence. Buprenorphine withdrawal is generally less intense than that with heroin or methadone. If buprenorphine is suddenly discontinued, some patients have no withdrawal symptoms; others have symptoms such as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize the possibility of opioid withdrawal, buprenorphine should be discontinued gradually, usually over several weeks or more.

For my first dose, I should be in withdrawal as much as possible. If I am not already in withdrawal, buprenorphine can bring on severe opioid withdrawal. For that reason, for the first few days I will be asked to remain at the clinic or pharmacy for a period of time after I take a first dose. After that, I will receive a prescription and return to the designated pharmacy to pick up the medication. I will comply with the correct dosing method for buprenorphine: holding it under the tongue until it dissolves completely, without swallowing it. Swallowing the buprenorphine will lessen its effectiveness.

I understand that it may take several days to get used to the transition from the opioid I had been using to buprenorphine. I understand that using any other opioids (like heroin) will complicate the process of stabilization on buprenorphine. I also understand that other opioids will have less effect once I become stabilized on buprenorphine. Taking more opioids to try to override the effect of buprenorphine can result in an overdose. In addition, I understand that intravenous use of buprenorphine can produce serious problems including severe withdrawal, overdose, and even death.

I understand that I will not take any other medication without first discussing it with my primary physician because combining buprenorphine with other medications or alcohol may be hazardous. The combination of buprenorphine with Valium, Librium, or Ativan has resulted in death.

I understand that during the course of treatment, certain conditions may make it necessary to use additional or different procedures than those explained to me.

I realize that for some patients, treatment may continue for relatively long periods of time. I understand that I may withdraw from the program and discontinue use of buprenorphine at any time. In this event, I shall be transferred to medically supervised withdrawal treatment or to a methadone treatment program.

I will not allow any other individual to use my buprenorphine. It is dangerous for an individual not on buprenorphine to ingest the medication. Doing so may result in serious injury or even death for that individual.

For female patients and patients who are able to get pregnant of child-bearing age:

To the best of my knowledge,

☐ I am pregnant at this time. ☐ I am not pregnant at this time.

If I do become pregnant, I will inform my medical provider or one of their assistants immediately.

For all patients:

Alternative methods of treatment, the potential benefits of treatment, possible risks involved, and the possibility of complications have been explained to me. I certify that no guarantee or assurance has been made as to the results that may be obtained from addiction treatment.

Part 5: Sign the form

Sign your name and write the date.

Sign your name: _____

Date: _____

Print your name (First and Last): _____

Address: _____

_____

Doctor Name: _____

Doctor signature: _____

Date: _____

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Appendix E: Home-Based Induction Protocol

Home-based induction occurs under the supervision of providers experienced with inductions and is best suited for patients who have prior experience with buprenorphine, reliable telephone access, and have demonstrated both comfort and skill at starting the medicine without clinical observation. In addition, patients who cannot take several days off work would benefit from a home induction that can occur over a weekend.

For home-based induction, the patient reviews the protocol and receives induction instructions from the provider. This takes place after the initial assessment. Together the provider and patient:

- Review the "home induction protocol" handout
- Create a clear plan that includes:
  - When to stop opioids and begin induction
  - How to assess withdrawal symptoms
  - When the patient will take their medication each day, including the length of time that patients should wait to reassess their withdrawal symptoms
- Provide enough medication to achieve a dose of 16 mg per day until the first scheduled stabilization visit (in about a week)
- Review how to take medication sublingually
- Review how to track and record doses
- Consider prescribing a kick-pack to treat symptoms of withdrawal
- Review what patients should not do: e.g., drink alcohol, take benzodiazepines

Provide contact information for patients if they have questions or problems

Starting Buprenorphine at Home:

What do I need to start?

- Handout
- 4 buprenorphine (bup) pills or films (8 mg). There are many different brand names and generic forms of bup.
- 6 Ibuprofen pills (200 mg) - for body pain, take 1-2 pills every 8 hours as needed
- 6 Clonidine pills (0.1 mg) - for anxiety, take 1 pill every 8 hours as needed
- 6 Imodium pills (2.0 mg) - for diarrhea, take 1 pill after each episode of diarrhea. Max 6 pills per day.

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When I am ready to start Bup?

- Use the list of symptoms below to see when you are ready to start bup.
- Wait until you have at least 5 symptoms to start bup. If you don't have 5 symptoms, wait a bit longer and review the symptoms again. It is very important that you wait until you feel at least 5 symptoms before starting bup!

Symptoms: Do I have this?

_____ I feel like yawning

_____ My nose is running

_____ I have goose bumps

_____ My muscles twitch

_____ My bones and muscles ache

_____ I have hot flashes

_____ I am sweating

_____ I feel unable to sit still

_____ I am shaking

_____ I feel nauseous

_____ I feel like vomiting

_____ I have cramps in my stomach

_____ I feel like using

Things NOT to Do with Bup

- DON'T use bup when you are high – it will make you dope sick!
- DON'T use bup with alcohol – this combination is not safe.
- DON'T use bup with benzos unless prescribed by a doctor who knows you are taking bup.
- DON'T use bup if you are taking pain killers until you talk to your doctor.
- DON'T use bup if you are taking more than 60 mg of methadone.
- DON'T swallow bup – it gets into your body by melting under your tongue.
- DON'T lose your bup – it can't be refilled early.

How To Take Bup

- Before taking Bup, drink some water.
- Put Bup under your tongue.
- Don't eat or drink anything until the Bup has dissolved completely.

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Plan

- Use your last heroin/methadone/pain pill at date: _____ time:_____
- When you have at least 5 symptoms from the list, then you are ready to start.
- Start with pill or film under your tongue.
- Wait minutes.
- If you feel the same or just a little better, then take another pill or film.
- Wait 2 hours. If you still feel sick or uncomfortable, take another pill or film.

Problems? Questions?

- Call (___)___ -____
- Call if you still feel sick after taking a total of pills or films (___mg).

Next Steps

Appointment with _____ at _____

Appointment with Dr. _____ at _____

Time: Amount of Pills or Films

Day 1	Day 2	Day 3
___:___ am/pm	___:___ am/pm	___:___ am/pm
___:___ am/pm	___:___ am/pm	___:___ am/pm
___:___ am/pm	___:___ am/pm	___:___ am/pm
___:___ am/pm	___:___ am/pm	___:___ am/pm

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Appendix F: Clinical Coordinator Manual

Introduction/Background: A key outcome from previous Ryan White HIV/AIDS Program Part F Special Projects of National Significance programs that were successful in integrating buprenorphine for opioid use disorder in the HIV primary care setting was the importance of the clinical coordinator role. Prescribing providers and patients relied on this "glue person" to develop and monitor individualized care plans and track clinical outcomes. The clinical coordinator provided education, conducted screenings, and monitored and counseled patients during treatment. The clinical coordinator remains an imperative role in the implementation and ongoing support for programs providing MOUD services with buprenorphine.

Scope and Purpose: This manual is a companion resource to the "Integrating Buprenorphine for Opioid Use Disorder in HIV Primary Care" manual and is designed to provide specific guidance to a buprenorphine clinical coordinator. The role of the clinical coordinator differs in each clinic depending on the overall clinic structure and size, and the FTE allotted to each clinical coordinator to carry out these responsibilities. Here, guidance is provided on the core components of the clinical coordinator role and resources to support additional professional development among clinical coordinators.

Intended Audience: The intended audience for this manual includes clinical coordinators, administrative and clinical supervisors, prescribing providers, and administrators engaged in hiring new clinical coordinators.

Limitations and Clarifications: This manual is designed to supplement, not replace, clinical training and formal guidance on inducing, stabilizing, and maintaining patients on buprenorphine. Clinical coordinators must also participate in clinic-level orientation and ongoing trainings on policies and procedures, best practices in providing clinical care, assessment and treatment for SUD, and MOUD.

Overview of the Clinical Coordinator (CC) Role

The CC's primary role is to support and stabilize patients in buprenorphine care. To achieve this, the CC works in collaboration with the treatment team and the patient. The CC often works with a multidisciplinary team and is expected to exercise considerable initiative and independent judgement to lead the team and support both patient and program goals. The varying roles of the CC may overlap or be assigned to different individuals within the clinic.

The CC may be trained or have knowledge about HIV/AIDS, mental health, and substance use disorders. The clinical coordinator role may be filled by people in the fields of social work, medical case management, nursing, addiction counseling, and counseling/therapy. Other skills important for this role include: communication, collaboration, community networking and linkage, advocacy, harm reduction practice, de-escalation, medical terminology, and ability to work with a large range of service providers. See ***Appendix A*** for a sample job description.

Appendices

Pre-Implementation: Creating an Effective Program

Successful MOUD programs begin before the first patient is identified. It is important for the treatment team to have created protocols, resource lists, and educational materials prior to meeting with patients. These elements will change over time, however establishing a mutual understanding about how difficult situations might be handled will reduce conflict and confusion. Patients' lives may be highly chaotic when they enter treatment. Modeling healthy relationships, boundaries, and communication strategies is essential to help patients gain recovery skills and decrease the likelihood the treatment team will experience burnout.

*Refer to the **pre-implementation** section of the manual for resource assessment and policy checklists.*

Implementation Activities

Identifying Patients for Treatment

The CC will work with the treatment team to identify potential new patients and in many cases, may be the contact person for referrals.

Patients can connect with the program in a number of ways:

- Self-referral
- Referrals from other providers (physicians, clinical coordinators, etc.) in the clinic or in the community
  - SUD screenings are universally indicated. Any patient in the HIV clinic could be screened for SUD, and then referred to appropriate treatment.

Screening for SUD

In the absence of a prior screening, clinical coordinators can use the tools identified below.

- Screening, Brief Intervention, and Referral to Treatment (SBIRT) using Motivational Interviewing techniques
- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Single-item or two-item drug screener
- Alcohol Use Disorders Identification Test (AUDIT)
- Tobacco, Alcohol, Prescription Medications, and Other Substance Use (TAPS)
- Drug Abuse Screening Test (DAST-10)
- NIAAA Rethinking Drinking℠
- DSM criteria (11 criteria in 4 categories)
- Opioid Risk Tool
- Stages of Change Readiness and Treatment Eagerness (SOCRATES) Scale
- Addiction Severity Index (ASI)
- Substance Abuse Module (SAM)
- Global Appraisal of Individual Needs (GAIN)
- Psychiatric Research Interview for Substance and Mental Disorders (PRISM)

If a patient screens positive for OUD, the CC can offer brief counseling and treatment referral, MOUD, and ongoing assessment and support.

- The CC assists with providing education to potential new patients about current MOUD options, helping individuals determine what, if any, MOUD treatment is right for them. CC can use the Stages of Change to guide their efforts in identifying patient readiness for OBOT.

If a patient screens positive for other SUDs or substance misuse, the clinical coordinator can offer brief counseling, monitoring and follow-up, and referrals for treatment.

More information on screening tools can be found through the PCSS SUD Core Curriculum through the NIH National Institute on Drug Abuse, and TIP 63

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Assessing Patients for Treatment

The CC will assist with providing education to potential new patients about current MOUD options available. The CC should be prepared to work with patients who are motivated but not ready to start MOUD through identifying their current stage in the stages of change model, then working to support them as they move to the next stage of change (rather than moving them across multiple stages all at once). Moving too quickly through the stages of change will make the change less likely to become a new steady state for a patient.

The Cycle of Change

Prochaska & DiClemente

Precontemplation: A logical starting point for the model, where there is no intention of changing behavior; the person may be unaware that a problem exists

Contemplation: The person becomes aware that there is a problem, but has made no commitment to change

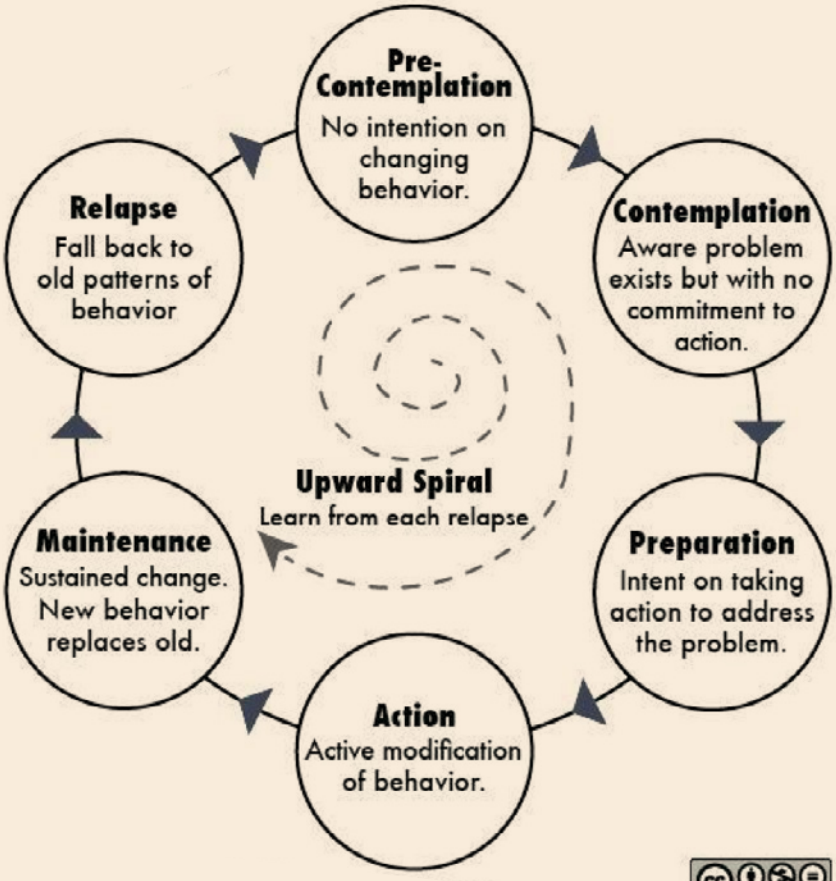
Preparation: The person is intent on taking action to correct the problem; usually requires buy-in from the client (i.e. the client believes s/he can make a change)

Action: the person is in active modification of behavior

Maintenance: Sustained change occurs and new behavior(s) replaces old ones. Per this model, this stage is also transitional

Relapse: The person falls back into old patters or behaviors

Upward Spiral: Each time a person goes through the cycle, they learn from each relapse (hopefully) grow stronger so that relapse is shorter or less devastating.



Social Work Tech!

The Cycle of Change
Adapted from a work by Prochaska and DiClemente (1983) | Ignacio Pacheco

- The CC should start with obtaining permission to complete an assessment ("Would it be alright with you if I asked you some questions about your drug use?"). Throughout the assessment, the CC should focus on asking open-ended questions during the assessment to allow for replies that are in the patient's own words and evoke more thoughtful responses. Briefly review the purpose of the assessment, the length of time to complete (typically an hour or longer), and include an after-care plan so the patient has a plan for self-care after the assessment.

- Assess patients' motivation and preferences for treatment. Although MOUD may be medically indicated, not all patients want MOUD. Using Motivational Interviewing and Harm Reduction principles, the CC helps the patient create their own plan. Depending on CC role and program availability, comprehensive screening may be conducted regardless of patient interest in MOUD. Comprehensive screening may assist the CC in helping the patient connect with resources that fit their own goals for treatment.
- For **patients ready to participate in MOUD**, conduct a comprehensive screening (see next section).
- For **patients not ready to participate in MOUD**, continue to work with patients who are contemplating starting MOUD through the stages of change. Use motivational interviewing techniques and readiness assessment scales like the SOCRATES scale to monitor and engage the patient.

Conversation Tips: Open-Ended Questions to Help Patients Create their Own Plan

- "In what ways has heroin affected your life?"
- "What is it about your drug use that you enjoy?"
- "What are the reasons you see for making a change?"

An assessment should use trauma-informed approaches based on the understanding that patients with OUD may not feel comfortable sharing their opioid use history.

Tip: How to Incorporate a Trauma-Informed Approach into the Assessment Process:

- Assume that patients who are participating in the assessment process have experienced trauma
- Normalize the experience of opioid use disorder as much as possible
- Respect the patient's personal space
- Allow patients to stay in one place and have providers come to them, rather than shuffling the patient around the clinic
- Outline the assessment process so the patient knows what to expect

Comprehensive Screening

Once a patient has been identified as having an OUD, has met the eligibility criteria, and indicates that they are ready to participate in MOUD, a comprehensive assessment should be conducted. This assessment is often done by the CC, however, the treating provider or other members of the team may also complete their own assessment.

The purpose of the assessment is to establish the diagnosis and severity of OUD, identify contraindicated medications, indicate other medical conditions to address during treatment, and identify mental health and social issues to address.

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The CC can support the treatment team during the comprehensive screening process by conducting:

1. **Medical history screening:** Document any medical history reported by the patient while taking special note of conditions that might contraindicate or alter dosing approaches for OUD pharmacotherapies, reveal chronic pain issues, or reveal medical effects of substance use (e.g., endocarditis, Hepatitis B or C, abscess/soft tissue infections). If the CC is in a setting with an Electronic Health Record (EHR), review any other medical records that may document emergency department visits or hospitalizations for SUD-related incidents or medical conditions as a result of SUD.
2. **Mental health history screening:** Mental health disorders are common among patients with substance use disorder. Document any mental health history the patient reports and note any medications they are using to manage mental health symptoms. Document any psychiatric hospitalizations and note any history of suicidal ideation. If possible (due to time and training), assessment for common mental illnesses may be helpful. Common co-morbid mental health conditions include: depression, anxiety, PTSD, ADHD, bipolar disorder, and personality disorders.
3. **Substance use history screening:** A thorough substance use history provides the CC and treatment team with the information needed to inform a treatment plan. The substance use history should help determine the severity of OUD, highlight any potential drug interactions, and provide a better understanding of the impact of the patient's substance use disorder. A thorough history should include historical information about when they started using each substance and note the periods of their life when it was problematic. Document all substances that the patient has used, even if the patient does not identify the substance as problematic.

   Substance use history should include:

   - Age of first use
   - Routes of administration (oral/nasal/IDU)
   - History of tolerance, withdrawal, polysubstance use, and overdose
   - Patterns of use (frequency/intensity/recency)
   - Negative consequences of use (health/relationships/work/legal involvement/housing)
   - History of previous treatment engagement (OTP, residential, support groups/previous MOUD)
   - Patient's family history of substance use (parents/siblings)
   - Current environment (e.g., housing, employment, social supports)
   - Any current legal involvement (DHS, warrants, parole/probation, past incarcerations)
   - Stage of change: Determine patient's readiness to participate in treatment and their goals for engaging in treatment

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A completed assessment provides the criteria to diagnose the severity of OUD and highlight areas where the patient may need additional support.

Once team members complete the assessment(s) and the patient is clinically indicated for buprenorphine with a desire to engage in MOUD, the CC works with the treatment team to arrange treatment initiation.

Preparing for Treatment Initiation

The following example of an induction workflow is based on a patient being induced in a clinical setting at a primary care provider's office. The process of treatment initiation (referred to as "induction" may vary based on your settings (e.g., mobile van, hospital).

Prior to treatment initiation, the CC will:

- Identify how the buprenorphine treatment will be paid for and complete tasks required by the insurance provider (e.g., prior authorizations). Some insurance providers have a process that will not allow same day medication at the pharmacy.
- Work with state ADAP (AIDS Drug Assistance Plan) to facilitate assistance with payment for MOUD.
- Review prescription drug monitoring programs (PDMP). Each state has different requirements for their PDMP. In some states, a provider can delegate staff to access the PDMP database on behalf of the provider.
- Obtain UDS for baseline. The CC and provider often work together to ensure a baseline UDS is obtained. In some settings, the CC is authorized to facilitate this process using advanced orders from the PCP to obtain UDS.
- Create a plan for how the patient will get their induction day medication. State and facility policies may vary on how and when the prescription can be obtained.
- Ensure the patient has obtained their kick-pack (i.e., small quantities of medications to provide symptomatic relief of opioid withdrawal symptoms).
- Ensure the patient fully understands the treatment settings and services available to them.
- Provide support and reassurance as the patient plans to come to the clinic in withdrawal. The CC will often need to assist the patient with planning when to stop last use of opioids the day before induction. The CC should be aware it can be hard for a patient to present in withdrawal and it is common for patients to either not show for their induction appointment or leave early prior to receiving induction medications. The CC should continue to work with the patient to ensure the patient's needs are met and that they are supported and encouraged to show up for induction day.

A general guide to estimate time until onset of moderate or greater withdrawal is:

- Heroin: 12-24 hours
- Long acting opioids (Oxycontin): 24-48 hours
- Methadone: 48-72+ hours

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Recovery Plan

From the assessment, the CC and patient develop a recovery plan taking into consideration the patient's current environment, use patterns, and readiness to change. The CC supports the patient in obtaining referrals and creating a plan to access housing, legal, financial, or employment assistance, as applicable. There is no perfect time to initiate the recovery plan. It can be started during treatment initiation or post-treatment initiation, depending on patient needs and preferences, and happens in parallel to the treatment plan (initiated by the prescribing provider) and the treatment agreement (initiated by the CC).

A recovery plan should always be patient-directed and focused. The CC assists the patient with identifying specific things the patient wants to work on and then guides them in developing goals and objectives to provide the framework of the treatment plan. Goals should be SMART goals: Specific, Meaningful, Action-oriented, Realistic, and Time-sensitive.

Date	Problem Statement #1
12/12/2000	Continued opioid use despite negative consequences on home, work, and health
Long-Term Goal	"I want to stop using drugs"

Short-Term Goal	Action Step	Target Date	Completion Date
1. Learn to recognize at least 3 triggers to reduce the chance of relapse within 1 month.	1A. Participate in relapse prevention group sessions 3 times a week.	1/12/2021	
2. Increase control over cravings by learning to use coping skills, going from 0 per week to 3 per week to prevent relapse.	2A. Individual counseling sessions at least 3 times per week will be the forum to learn these additional coping skills.	2/12/2021	

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While providing MOUD and treatment planning, have conversations with the patient about how MOUD alone is not a strong recovery support plan. Drug-associated cues or "triggers" as they are more commonly known, play a big role in reminding addicted individuals about their drug-seeking behavior, and they are often enough to restart old behaviors, even among those who have been absent for a while and especially for those unprepared for their effect. A strong recovery support plan includes looking at how a patient can work on changing things in their lives to ensure they are building strong recovery supports.

Problematic recovery supports	Ways to building strong recovery support
Still have dealer's contact information in their phone	Delete contacts or get a new phone number so dealers and people you got high with cannot reach you.
Spending time with people who may not support your recovery	Look for places to find supportive connections, including support groups (in person or online), recovery oriented social events, or while pursuing personal hobbies or interests.
Going to the corner store where you used to get high in the bathroom	You may not be able to avoid the corner store completely, but you can start to build coping skills to help address any triggers you experience when returning to that store.

Treatment Initiation Day

Ensure the patient has their induction medication. Meet with the patient during the assessment and evaluation with the prescribing provider. Offer support, reassurance, and comfort measures during the process. Once the patient has completed the induction, assist with scheduling the follow up visit based on the provider's decision and treatment plan.

During treatment initiation, the patient is often seen 1-2 days later. This is a brief check-in appointment to ensure the patient is doing well and to manage any dosing changes. The provider and CC may see the patient concurrently during the induction period.

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Example of guide for visit frequency (this may vary depending on your setting)

Guidelines	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
RX Total	3 days induction, plus 1 week	1 week	2 weeks	3 weeks	4 weeks	4 weeks + 2 refills
UDS	Weekly	Weekly	Twice a month	Monthly	Monthly	Q 3 months
Random Call-in	Every 2 weeks or PRN	Every 4 weeks or PRN	Every 8 weeks or PRN	Every 12 weeks or PRN	Every 12 weeks or PRN	Every 12 weeks or PRN
MAT Prescriber Visits	Weekly	2 weeks	4 weeks	4 weeks	4 weeks	12 weeks
MAT Specialist Visits	Twice a week	Weekly	Twice a month	Monthly	Monthly	12 weeks
Minimum time to next tier	2 weeks	4 weeks	8 weeks	16 weeks	Upon transfer	6 months at Tier 4 or 5

Titration and Stabilization Phase (Approximately 1-4 weeks)

Stabilization is the process of reaching a stable buprenorphine dose and does not imply the patient is stable in all aspects of their early recovery. Therefore, the CC plays a critical role during the stabilization phase. Patients may need additional support, advocacy and referrals during this period. It is not uncommon for a patient to experience relapse and/or non-opioid substance use during the first 4-8 weeks. The CC role during stabilization includes encouraging patients to adhere to their medication, assist them with using their recovery-based supports (peer mentors, groups, friends, social events, etc.), and to remind patients to contact their medical team right away if a relapse happens. Relapse and overdose prevention are common topics of discussion during stabilization visits. It would be appropriate at this time to provide the patient with a naloxone prescription and training on how to use it (if not previously discussed).

The prescriber and CC team may see the patient concurrently during stabilization. In most cases, once the dose adjustment of the medication is stabilized, the patient typically sees the CC more frequently for recovery support.

The treatment team should be aware that the path to stabilization for most patients is not linear. Patients may start and abruptly stop their MOUD medications, therefore requiring another induction. They may stabilize for a few weeks and then fall out of care. The treatment team will benefit from having plans that ensure a rapid return to care as soon as possible when previously engaged patients return to care for MOUD.

Monitoring Visits (Approximately from 4 weeks-Ongoing)

The CC's primary role is to encourage the patient to remain engaged in their OBOT care. For most patients, they should take MOUD as long as they benefit from it and wish to continue. The CC remains in regular contact with the patient and typically assists with the following throughout monitoring visits:

- Ensuring the patient attends their prescriber appointments
- Regularly revisiting the recovery plan with the patient and adapting it as needed. (Note: frequency could mean weekly or monthly, depending on the patient and their needs. Frequency also may be influenced by insurance reimbursement guidelines)
- Addressing any other unmet needs the patient has identified during the screening phase
- Providing more structured supportive services around medication adherence if determined by the treatment team; this may include being available to perform random pill counts or in some cases, facilitating Direct Observed Therapy (DOT)
- Assisting the patient with navigating services that may require advocacy around remaining on MOUD (jail, treatment programs, transitional or SUD free housing)
- Providing feedback to the treatment team and patient regarding frequency of visits
- Helping patients understand post-acute withdrawal syndrome (PAWS) and how to manage symptoms
- Relapse prevention planning
- Providing outreach and support via telephone; the CC may also use Facetime or texting to keep the patient engaged and in communication with their treatment team

There is no set time period of monitoring visits. Most patients can take MOUD as long as they benefit from it and wish to continue.

Counseling and Recovery Support Services

The types of supportive services offered during a patient's treatment on MOUD will vary depending on the role of the CC and the facility. In some settings, the CC may be responsible for providing the following supportive services:

- Delivering evidence-based interventions for SUD and underlying mental health conditions for patients on MOUD. Examples include:
  - Replacing drug using activities
  - Drug resistance skills
  - Problem solving skills
  - Motivation
  - Interpersonal relationships
  - Self-care skills
  - Craving diary
  - More resources can be found on the PCSSNOW website: Developing a Behavioral Treatment Protocol in Conjunction with MAT.

- Facilitating evidenced based group interventions. Examples include: harm reduction, dialectical behavioral therapy skills, seeking safety, coping skills, and symptom management.
- Creating, documenting, and monitoring a plan to address unmet behavioral health needs. Examples include: mental health, substance use, and community resources.
- Developing educational and training materials, and conducting sessions on behavioral health/substance use treatment for internal and external community partners.
- Providing some case management and supporting a smooth interface and linkage between physical health and other external specialty services by matching the patient's level of need to the appropriate level of care.
- Providing education about overdose prevention and assisting the patient, friends and family with accessing a naloxone prescription and training.

Addressing Challenges Experienced by Patients in MOUD Treatment

Recurrence of Substance Use

While providing MOUD services, it is important for the treatment team and the patient to be aware of the likelihood of recurrence of substance use (or "relapse") and/or non-opioid substance use. Neither are indicators for treatment cessation, rather they serve as an opportunity to explore with the patient either the reasons for their non-opioid substance use and/or resuming opioid use.

Use a harm reduction perspective to explore the reasons for the non-opioid substance use and be prepared to work with the patient either through the stages of change or just provide support during pre-contemplation.

Re-assess for risk of overdose. Talk about overdose prevention with the patient, including addressing tolerance, testing their shot, and ensure that the patient/family/friends have received and been trained in administering naloxone.

Encourage a patient to return to care immediately, providing reassurance along with ongoing prevention planning. Talk to the patient to learn what may have led up to use and explore the emotional, mental, or physical reasons restarting opioids may have occurred. Reaffirm that recurring substance use is not failure. It simply means one is learning about themselves and how they react to certain triggers and stimuli and provides an opportunity to look further into why the opioid use occurred and what can be done to prevent it next time.

Conversation Tips: Starting a Conversation with a Patient about Recurrence of SUD

"Would you like to tell me a little bit about what happened before your relapse?"

"What has your drug use been like during the past week?"

"What do you plan to do next?"

"What do you think about the possibility of going through detoxification?"

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Referral to Higher Level of Care:
Some patients may be better served in an environment with higher levels of care than what can be provided in a typical OBOT setting. This might be an OTP program offering MOUD services including methadone. These programs have more structure and guidelines and typically tend to have more wrap-around services. The clinical team and patient can work together to determine when it is appropriate to refer to higher levels of care. The CC can help ensure the transition to a new program is successful for the patient.

A higher level of care may also include continuing with buprenorphine but adding on intensive outpatient program (IOP) or completing a residential treatment program and then returning to the outpatient MOUD program. Referring patients to a higher level of care is not "kicking them out" of your care, rather, admitting they may benefit from treatment that the outpatient program can't provide. It may be helpful to remind them they may return to the office-based setting when life settles down and they are better equipped to be successful in your program.

Misuse or Diversion
Become familiar with ways to identify and respond to misuse or diversion. Although there is no way to completely prevent diversion, having clear guidelines for how to handle it when there are suspicions will help reduce the likelihood of it occurring frequently.

Diversion can happen as a result of peer pressure, a patient wanting to support a family member or friend who is living with SUD, or to make money. Patients may indicate that they are diverting their medication by requesting maximum doses, higher than needed does, identifying friends or family using opioids, or showing signs of injection drug use. Substance misuse can happen as a result of habit, perceived under-dosing, or to relieve anxiety, depression, or pain, among other reasons.

Strategies for working with patients who are misusing or diverting their medications:

- Reduce risks of diversion by first ensuring policies and procedures are in place to respond to misuse and diversion.
- Confirm with the patient that they been informed of these policies by revisiting their Treatment Agreement (signed during Treatment Initiation) detailing clear steps that the treatment team will take if misuse or diversion occurs.
- Document and describe misuse or diversion and the clinical thinking that supports the clinical response.

Starting a Conversation with a Patient around Misuse or Diversion
"Your UDS was negative for buprenorphine; can you tell me how you are taking your Buprenorphine?"

"It is not uncommon for someone to relapse in the early phases of OBOT, which is why we use the UDS as a tool to better understand how you are doing during your treatment. Would you mind if we talk about your UDS results from last week?"

- Utilize monitoring techniques to reduce diversion or misuse through:
  - random UDS
  - schedule unannounced pill/film counts
  - directly observe ingestion (this can be done in person or via an app like Skype)
  - limiting medication supply to shorter prescription time frames
  - using the lowest dose that works for the patient
  - consider long acting forms of buprenorphine

Ongoing work to facilitate implementation of direct patient services

Working with Partners (Internal and External)

The CC will frequently work with both internal and external community partners to help facilitate referral to services, additional support, and ongoing care for the patient. Strong community partner relations enable the CC to advocate on behalf of their patient and to help educate community partners about the effectiveness of working with patients on MOUD.

Referral to other treatment services: During the course of MOUD a patient may need to be referred to a higher level of care or supplemental treatment programs to improve their overall outcome with MOUD and to meet individual treatment needs. See **Appendix C** for a list of service agencies for OBOT referral.

Families and recovery support: Family members and significant others are often integral parts of the recovery support system for patients in treatment with MOUD. If the patient identifies family as a part of their recovery support system, the CC should be prepared to provide education and training to those identified family supports. This may include information about how MOUD works and why it's an important part of recovery. This should also include overdose prevention training. Additional reference information for friends and families can be found at NIDA: Patients and Families.

Community outreach/education/training to internal and external community partners: The CC will typically take the lead in providing education and training for community partners unfamiliar with MOUD. This may be informal, via advocacy for a mutual patient, or the CC may be asked to provide more formal training on MOUD services. The CC may encounter community partner agencies unfamiliar with MOUD or resistant to serving or working with patients on MOUD. Often times, advocacy and information sharing can help agencies understand the importance of continued MOUD.

Facilitate MOUD transfers to other systems of care: In some situations, a patient may need assistance transferring their MOUD care to another facility (i.e., methadone clinic, jails, hospital, inpatient residential treatment). The CC can assist the transfer by providing clinical documentation, a medication list, and other supportive services to ensure the patient is able to maintain MOUD without interruption in treatment during the transfer. In some case, continued MOUD may not be an option. At that point the CC will need to work with the prescribing provider and patient to develop a safe taper plan.

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Starting MOUD via a local hospital/emergency department (ED)/jail/detox facility: The CC may encounter a patient who has a hard time presenting in appropriate withdrawal for OBOT induction. This patient may be able to start via a planned and coordinated induction with a local detox facility. In other cases, the patient may be identified as a MOUD candidate during a hospital or ED stay. The CC will often assist with planning with the facility a transfer in care to OBOT once the patient is started and stabilized on MOUD in the other setting.

Continuous Quality Improvement for OBOT/MOUD Programs

The CC can assist the treatment team by providing ongoing support to help improve the overall program and patient outcomes. This may include:

- Continuing to participate in the planning, design, and implementation of the clinical MOUD program. This should include data collection to demonstrate outcomes related to patient care. This could include documenting any changes in patient viral load, access to care, or reduction in other risk behaviors prior to initiating treatment and after treatment has been sustained.
- Determining how to create and maintain a sustainable caseload throughout the duration of MOUD services in an OBOT setting.
- Providing ongoing resource and referral development. Find resources at the Recovery Resource Hub: https://resources.facingaddiction.org/find-it
- Working with the treatment team to continually address challenges for patients in accessing and remaining engaged in OBOT.

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Appendix G: Logic Model

Resources

- Treatment team (prescribing providers, clinical coordinator)
- Supportive clinic administrators and an intervention champion
- Clinic technology (EMR, urine drug screens)
- Pharmacy access
- Community partners for social services (housing, employment, food security), intensified/ alternative substance use disorder treatment, mental health support

Activities

Pre-implementation

- Secure stakeholder buy-in, hire/identify team members, train team, review federal and local regulations, build/strengthen relationships with community partners, prepare patient education materials and kick-packs, create internal communications plan

Implementation activities

- Identify patients for treatment, assess patients for treatment, initiate treatment, titrate and stabilize patients, conduct monitoring visits, connect patients with social and behavioral health services

Integration/ sustainability activities

- Participate in clinic meetings, recruit new prescribing providers, coordinate and collaborate to identify eligible patients for treatment, disseminate lessons learned from intervention to clinic and community

Outputs

- # prescribing physicians
- # eligible patients
- # patients who complete treatment initiation
- # patients maintained
- # prescriptions made
- # patient visits
- # patients referred to alternative substance use disorder treatments
- # referrals made to community partners

Short Term Outcomes

Clinic-level:

- Increased number of waivered prescribers at the clinic
- Increased awareness of SUD treatment options within the clinic system
- Increased coordination and collaboration with community partners

Patient Level

- Increased awareness of SUD treatment options
- Increased linkage to buprenorphine treatment team for assessment
- Reduction in opioid and substance use
- Increased linkage to social services

Intermediate Outcomes

- Increased patient retention in buprenorphine treatment
- Increased patient retention in HIV primary care
- Increased provider confidence in maintaining, sustaining, and supporting a patient on buprenorphine
- Increased dissemination of implementation lessons learned to clinic and community

Long Term Outcomes

- Reduction in patient opioid and substance use
- Improvement in the following patient outcomes:
  - HIV viral load
  - Quality of life
- Increased patient satisfaction with care
- Integrated buprenorphine treatment for opioid use disorder in HIV primary care clinics
- Clinic sponsors or supports buprenorphine waiver training

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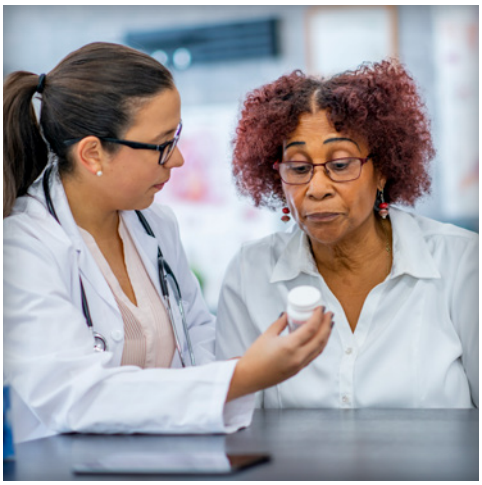

For more resources from the Dissemination of Evidence-Informed Interventions Initiative visit:
https://targethiv.org/deii