# Coordinated Opioid Recovery

## A NETWORK OF ADDICTION CARE

Florida HEALTH

AGENCY FOR HEALTH CARE ADMINISTRATION • STATE OF FLORIDA

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES • MYFLFAMILIES.COM

CORE

# TABLE OF CONTENTS

# EXECUTIVE BRIEF

## BACKGROUND

Opioid Use Disorder (OUD) affects thousands of Americans annually. **In 2021, over 6,400 persons died from an opioid overdose in Florida and in 2022, Florida emergency medical services responded to over 40,000 suspected opioid-involved overdoses**. Deaths from opioid use continue to rise each year.

Those who seek treatment and recovery from OUD have traditionally found themselves attempting to navigate siloed and fragmented social, medical, and behavioral health services in their communities. This fragmented approach has resulted in poor outcomes, recidivism, overdoses, and even death among those with the fewest resources and capability to know where to go to get the help they need.

The Coordinated Opioid Recovery (CORE) Network is an initiative designed to establish a coordinated system of care for those seeking treatment for opioid use disorder. Patients seeking treatment for other substance use disorders can also benefit from CORE.

**The three main prongs of CORE are:**

1. First responders.
2. Hospital emergency departments with skilled practitioners in addiction medicine.
3. Treatment facilities that can assist the patient with long-term medication assisted treatment, primary care, and other psychosocial needs.

These entities work together in the community to create a seamless system of care, utilizing a warm hand-off approach from each entity by non-judgmental peer navigators. Patient's care and treatment plans are always supervised by a physician.

The CORE Network is similar to a trauma or stroke center – meaning that those who are suffering from OUD have the best chance of a positive outcome and full recovery from an agency that offers specialized care and treatment. First responders participating in CORE follow a protocol to transport an OUD patient to the participating CORE hospital emergency department (ED). After stabilization and induction on medication assisted treatment (MAT) at the emergency department, patients are given a warm hand-off to a participating treatment facility for follow up and long-term care.

### 22 ESSENTIAL COMPONENTS OF CORE NETWORK

1. **24/7 access point where a patient can access MAT, including weekends.**
2. Availability of peer support staff to assist in navigating the CORE network and other services needed.
3. Availability of a variety of medication assisted treatments, including buprenorphine (Suboxone) and vivitrol, and referrals for methadone, if needed.
4. The willingness/ability to continue prescribing MAT a year or more, if needed.
5. Approach to dosing MAT that considers the situation and use pattern of the individual.
6. **A clinic that is available to receive patients from the 24/7 access point, and first responders willing to provide MAT until the patient can be seen in the clinic.**
7. **Testing for fentanyl at the 24/7 access point and the receiving clinic.**
8. Established clinic intake process.
9. Established protocol for induction on buprenorphine.
10. Ability to treat co-morbid alcohol and benzodiazepine use disorder.
11. Available naloxone (Narcan) kits.
12. Access to higher levels of care if needed, including outpatient detox.
13. Available clinical expert in addiction medicine.
14. Therapists available in outpatient services.
15. Access to primary care for patients.
16. Ability to perform lab work on all patients for infectious diseases.
17. Access to psychiatric care at the clinic or in the community.
18. Access to group therapy for patients.
19. Access to individual therapy for patients.
20. Procedures to address phases of treatment.
21. Ability to provide care for pregnant women.
22. **Consistent monitoring of outcome measures and data including the use of the Brief Addiction Monitoring (BAM) tool.**

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**These items are considered CRITICAL components that must be present in a local CORE Network.**

There are 22 essential components in the CORE framework - four of which are critical components. The other 18 components include peer support services, long-term use of MAT, access to higher levels of care if needed, and primary care access for patients. CORE is modeled after an evidence-based program in Palm Beach County.

## DATA REPORTING

The CORE Network under the leadership of DOH, setup reporting metrics for each functional area of the network: EMS, emergency departments, and receiving clinics. Each partner is required to report biweekly to track the overall performance of the CORE Network services.

Data expectations are defined in the CORE Data Book to develop outcomes for CORE Network of Care which included the Brief Addiction Monitor (BAM). Additionally, ClearPoint performance management platform was chosen for the project, evaluated on ease of use and accessibility to partners around the state.

# PILOT PROGRAM MODEL

## *Health Care District of Palm Beach County's Response to the Opioid Crisis*

Over the past several years, Palm Beach County has found itself in the epicenter of a growing nationwide opioid crisis, experiencing over 600 deaths annually from opioid overdoses. Something fundamentally needed to change in the way care is provided for this very complex, relapsing, lifelong and life-threatening illness – an illness for which treatment resources are scarce, fragmented and not very well defined by national medical associations.

The Health Care District of Palm Beach County's response set out to create a different model of care that would go beyond the "traditional" models used to treat addiction disorders. Several criteria served as guiding principles: (1) provide evidence-based medical treatment; (2) ensure that life-saving treatment is readily available to the largest number of patients; and (3) make sure patients are treated with a warm hand-off from the point of emergency overdose treatment through access to long-term treatment.

### MEDICATION ASSISTED TREATMENT CLINIC

The district's involvement and immediate response in early 2017 delivered positive results to combat the overdose crisis. What started as a pilot program with 30 patients through a partnership between Palm Beach County Fire Rescue, JFK Medical Center, and the Heath Care District of Palm Beach has become a comprehensive outpatient based MAT clinic caring for more than 600 patients since the beginning.

The pilot program tested and confirmed the success achieved in 2015 by Yale University researchers. The treatment approach recognized that addiction is both a medical condition and a psychiatric illness with many complex medical comorbidities that needs to be treated under the "house of medicine" like any other chronic medical condition, by an addiction trained psychiatrist and a team of providers who follow evidence-based practices. These practices include treatment with the use of medication when indicated. In addition to psychiatric assessment and MAT treatment, addiction-focused counseling services provided by licensed social workers in both individual and group settings, primary and dental care, along with infectious disease treatment, are all integral parts of the comprehensive care offered at the Health Care District's clinics. The program is based on a one-stop-shop model where patients receive all of their care in one location.

### ADDICTION STABILIZATION UNIT

Building upon the success of the outpatient treatment clinic, the Health Care District of Palm Beach sought to develop a sustainable approach to addiction care and access to treatment. Borrowing elements from the nationally recognized central receiving facility approach for overdose care and the evidence-based solution found in MAT models, the district sought to develop a response that would leverage the best elements of each model to create a unique Palm Beach County approach. Palm Beach County was fortunate to have the ideal partners in the community come together.

The district worked with JFK Medical Center (North Campus) to develop the idea of an addiction stabilization unit (ASU) as the entry point of care providing readily available treatment for patients during the motivational moment after an overdose. Instead of a traditional central receiving facility, often developed as ER and jail diversion programs, this unit functions as a regular emergency room with clinical staff who have additional training in addiction. The team consists of addiction-trained ER physicians, nurses, EMTs, hospitalists, and psychiatrists on staff, along with other medical professionals trained in MAT treatment. The MAT treatment is introduced in the ER and continuously offered to patients throughout their stay at the hospital as well as during patient admissions for medical or mental health reasons.

Similar to regional centers of excellence that address other complex conditions that require high levels of expertise, as found in trauma, heart, stroke, and cancer care, Palm Beach County now has the first-of-its-kind specialized center for evidence-based addiction care. Here, medical professionals are ready 24/7 for patients to arrive to provide them with acute care for their addiction and all other medical problems. This specialized emergency department functions

similarly to trauma centers where EMS and ambulance services prioritize overdose patients to bring them directly to the addiction stabilization unit. Fire rescue municipalities have an option to adopt defined protocols whereby they bypass the closest emergency room and transport the overdose patient directly to the ASU as the facility specialized to treat this illness.

For patients transferred to the ASU after an overdose, MAT is readily available and offered within the first few hours of arrival. This transformative practice has the potential to stabilize the cycle of withdrawal and patient drug use. Additionally, the treatment will postpone withdrawal symptoms for 12 hours during which time compassionate care and appropriate assessment by a team of professionals at the ASU might increase the probability of compliance with the post-discharge, longer-term treatment plan.

Once treated and stabilized in the ASU, patients are discharged using a "warm hand-off" where a personal referral is made with the patient directly with an individual at the most appropriate next level of treatment.

A majority of patients will qualify for outpatient treatment and they will be referred to a panel of community network providers. For patients who choose the health care district's clinic, it is conveniently located adjacent to the JFK North Addiction Stabilization Unit, permitting an easy transition. At the Health Care District of Palm Beach's clinic, the patient will receive comprehensive treatment and counseling for all of their medical needs as well as medication and lab services for as long as needed. The district's clinics are federally qualified health centers that offer a sliding fee scale to patients and treat everyone regardless of their ability to pay. The clinic functions as a patient centered medical home and provides comprehensive chronic disease management, including addiction. Patients who need a higher level of care for their addiction treatment are referred to an available network of providers.

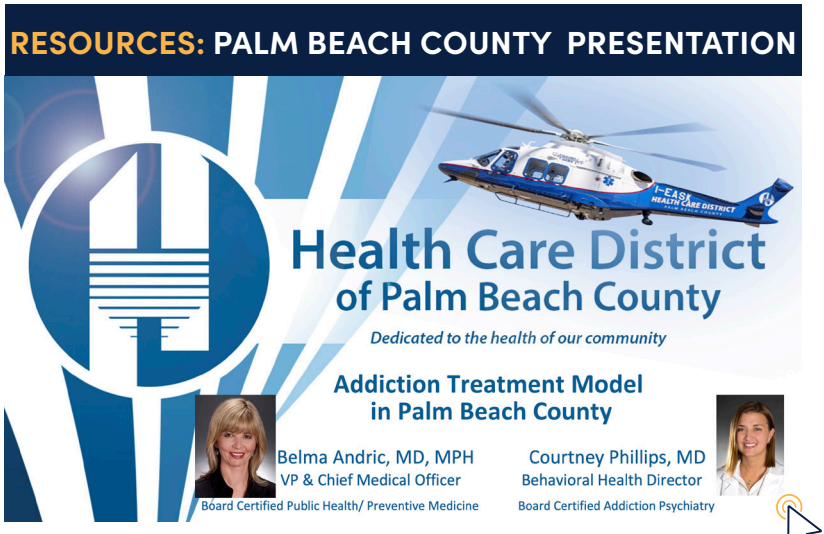
## COMMUNITY APPROACH

The response to the opioid crisis in Palm Beach County brought together leaders in the community to develop something new and sustainable to address what had essentially become an abandoned field of medicine. The Health Care District of Palm Beach recognized that a public health approach to the crisis was necessary to ensure that the largest number of patients would have access to addiction treatment through an outpatient model. Providing care in a manner that works the best for the largest number of patients (outpatient care) also makes precious, publicly funded "beds" more available for those patients who need the highest level of addiction care.

To fund the new addiction stabilization unit, the Palm Beach County Board of County Commissioners, a critical leader in the county's response to the opioid crisis, provided funding for other uninsured patients who arrive at the ASU. JFK Medical Center North Campus has invested in the start-up and implementation of the new program. Additionally, the district is addressing the needs of Palm Beach County residents with substance abuse disorders by adding addiction care to the specialty care benefit program, "District Cares," that covers patients below 100% of the federal poverty level.

The work of other community partners, including the Southeast Florida Behavioral Health Network, Sober Home Task Force led by State Attorney Dave Aronberg, and Palm Beach County Board of County Commissioners led by Commissioner Melissa McKinlay, collectively contributed to improve care for everyone in Palm Beach County.

What came together was a true public – private approach to a genuine public health crisis.



# LEADERSHIP TEAM ROLES

**PROJECT MANAGER**
Primary responsibility for communication to all stakeholders, and project management/implementation duties.

**BUDGET COORDINATOR**
Primary responsibility to coordinating, processing, and tracking annual budgets, statements of work, forms, invoicing, and purchase orders for CORE counties and partners.

**CONTRACTED CLINICAL EXPERTS IN ADDICTION PSYCHIATRY**
Primary responsibility coordination and training of CORE partners and providing guidance in implementing the 22 CORE components.

**EMS AND EMERGENCY MEDICINE**
Primary responsibility for providing guidance and support to EMS and emergency department partners, and data team including a data analyst.

**DATA SPECIALTY TEAM WITH EMS DATA**
Primary role of providing data to the CORE data team.

**AGENCY PROJECT MANAGER**
Manager of the CORE project team.

**AGENCY LEADERSHIP**
Executive leadership roles, as applicable.

**COMMUNICATIONS**
Primary role of developing and implementation of media and communication strategies for the CORE Network.

# SELECTION CRITERIA (FLORIDA COUNTIES)

## STEP 1. CAPACITY: ASSESS INFRASTRUCTURE NEEDED TO BEGIN

Capacity based on medical infrastructure and ability to provide addiction and behavioral health services are essential to a successful pilot.

- Counties that have at least one hospital with an emergency department and at least one federally qualified health center that offers behavioral health services move forward to Step 2 of the selection process.

## STEP 2. NEED: IDENTIFICATION OF SUBSTANCE USE DISORDER HOT SPOTS

Areas of greatest need were identified using data on fatal overdoses, non-fatal overdoses, and neonatal abstinence syndrome.

- Vital statistics death certificate data from the Florida Department of Health for calendar year 2020 were used to calculate age-adjusted rates of drug overdose deaths.
- Emergency department discharge data from AHCA for calendar year 2020 were used to calculated age-adjusted rates of drug-involved emergency department visits.
- Data reported by DOH's Birth Defects Program was used to identify neonatal abstinence syndrome rates for the years 2015-2020 combined.
- Counties with rates of fatal overdoses, non-fatal overdoses, and neonatal abstinence syndrome that were higher than the state of Florida rate move forward to Step 3 of the selection process.

## STEP 3. COMMUNITY CHARACTERISTICS: EVALUATION OF COMMUNITY CHARACTERISTICS

Information about each county's population size, density, as well as geographic coverage statewide are important to ensure counties are diverse and can be used to evaluate program implementation in various community settings.

1. **Community characteristics included in this step for consideration include:**
   - Rural and non-rural - section 288.0656, Florida Statutes, defines rural as a county with a population size of (1) less than 75,000 people or (2) less than 125,000 people that is contiguous to a county with a population of less than 75,000.
2. **County health department designation based on population size:**
   - Small: population less than 100,000.
   - Medium: population 100,000 – 200,000.
   - Large: population 200,000 – 1,000,000.
   - Metro: population greater than 1,000,000.
3. **Regional/geographic distribution:**
   - County health department consortium region.
   - Managing entity region.
   - Statewide Medicaid managed care region.
4. **County population size**

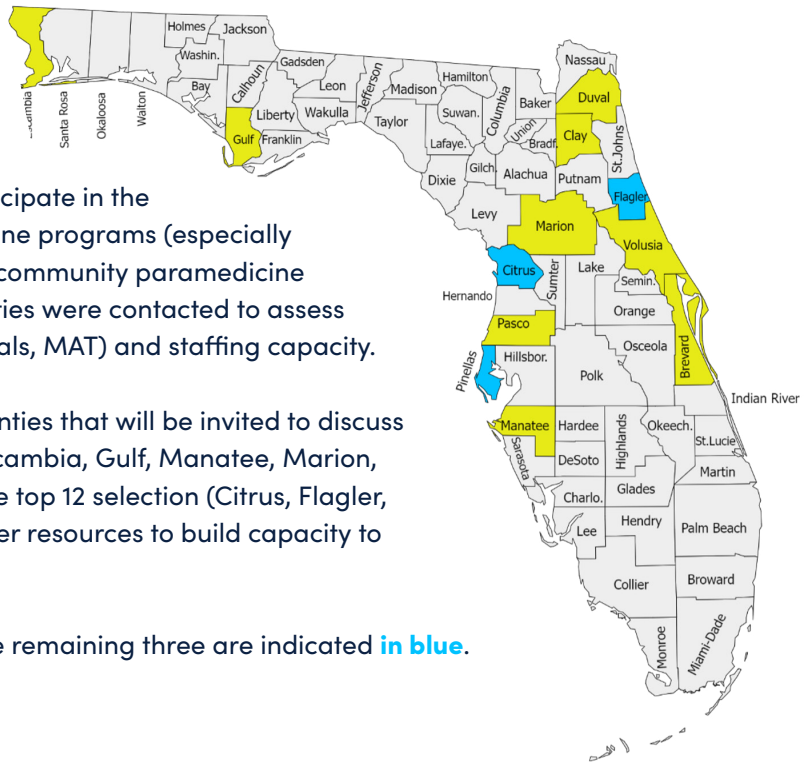
## STEP 4. RESOURCES: CURRENT PARTICIPATION IN EVIDENCE-BASED AND PILOT PROGRAMS

Participation in a current statewide quality improvement project or other substance abuse disorder related programs demonstrates sufficient resources to aid in the implementation of a successful pilot program. The following indicators are provided to help assess readiness and current resources:

- **Number of methadone clinics**
- **Number of Narcan providers**
- **Number of hospital bridge programs**
- **Number of Oxford Houses**
- **Number of Oxford House beds**
- **Perinatal mental health participation**
  Through a partnership between DOH and Florida State University, providers throughout the state have been trained and are using resources associated with the Perinatal Mental Health Grant.
- **Hospital-based quality improvement initiative: Neonatal Abstinence Syndrome (NAS)**
- **Hospital-based quality improvement initiative: Maternal Opioid Response Effort (MORE)**
  NAS and MORE initiatives have been offered through a partnership between the Florida Department of Health and the Florida Perinatal Quality Collaborative (FPQC).
- **Helping Emergency Responders Obtain Support (HEROS)**
  Funding from the state of Florida is used to distribute free naloxone to emergency medical services agencies.
- **Community Paramedicine Programs**
  Partnerships with local emergency medical services to provide follow up for individuals who have recently experienced an overdose to encouraged compliance with medication assisted treatment.
- **Overdose Data to Action (OD2A)**
  Grant funding from the U.S. Centers for Disease Control and Protection (CDC) has been used to support overdose-related activities.

## STEP 5. VERIFICATION: CONFIRM EXISTING RESOURCES AND INFRASTRUCTURE

At this step, 12 counties were considered based on the criteria established in steps 1 and 2: Brevard, Citrus, Clay, Duval, Escambia, Flagler, Gulf, Manatee, Marion, Pasco, Pinellas, and Volusia.




EMS agencies were assessed to determine ability to participate in the pilot project by reviewing existing community paramedicine programs (especially any already using MAT) and/or interest in establishing a community paramedicine program. Federally qualified health centers in all 12 counties were contacted to assess existing behavioral treatment services (counseling, referrals, MAT) and staffing capacity.

The findings from this step were used to identify nine counties that will be invited to discuss participation in the pilot project: Brevard, Clay, Duval, Escambia, Gulf, Manatee, Marion, Pasco, and Volusia. The remaining three counties from the top 12 selection (Citrus, Flagler, and Pinellas) will be offered technical assistance and other resources to build capacity to prepare to participate in the future.

The nine selected counties are indicated **in green** and the remaining three are indicated **in blue**.

| County | Drug Poisoning Deaths, Age-Adjusted Rate Per 100,000 Population, 2021 | Number of Drug Poisoning Deaths, 2021 | Drug-Involved ED Visits, Age-Adjusted Rate Per 100,000 Population, 2021 | Number of Drug-Involved Emergency Department Visits, 2021 | Neonatal Abstinence Syndrome (NAS), Rates per 10,000 Live Births, 2015-2020* | Number of Infants Diagnosed with NAS, 2015-2020* |
|---|---|---|---|---|---|---|
| Alachua | 16.6 | 41 | 148.6 | 393 | 61.6 | 102 |
| Baker | 46.7 | 14 | 294.1 | 83 | 170.7 | 35 |
| Bay | 53.3 | 84 | 281.1 | 448 | 108.2 | 142 |
| Bradford | 35.5 | 11 | 179.5 | 48 | 153.8 | 27 |
| Brevard | 58.3 | 333 | 409.7 | 2,105 | 128.2 | 399 |
| Broward | 34.8 | 693 | 192.9 | 3,595 | 22.6 | 295 |
| Calhoun | 15.5 | 3 | 128.5 | 17 | – | – |
| Charlotte | 41.0 | 54 | 256.6 | 308 | 110.4 | 68 |
| Citrus | 83.8 | 94 | 553.2 | 561 | 96.9 | 61 |
| Clay | 40.8 | 85 | 264.8 | 542 | 155.1 | 204 |
| Collier | 34.9 | 111 | 208.8 | 635 | 54.6 | 105 |
| Columbia | 32.3 | 24 | 252.9 | 166 | 98.7 | 47 |
| DeSoto | 11.1 | 320 | 217.2 | 71 | 30.6 | 7 |
| Dixie | 20.6 | 7 | 196.1 | 28 | 290.6 | 27 |
| Duval | 34.5 | 7 | 321.1 | 3,107 | 101.0 | 788 |
| Escambia | 54.3 | 535 | 294.1 | 908 | 77.7 | 180 |
| Flagler | 69.1 | 214 | 306.2 | 268 | 110.0 | 53 |
| Franklin | 30.7 | 29 | 198.6 | 22 | – | – |
| Gadsden | 12.4 | 2 | 136.9 | 60 | 18.9 | 6 |
| Gilchrist | 12.0 | 5 | 136.9 | 22 | 86.7 | 10 |
| Glades | 21.3 | 4 | 82.2 | 10 | – | – |
| Gulf | 34.2 | 4 | 226.7 | 25 | 167.6 | 12 |
| Hamilton | 18.5 | 2 | 190.3 | 25 | 70.6 | 7 |
| Hardee | 32.6 | 7 | 229.9 | 57 | – | – |
| Hendry | 25.9 | 6 | 171.8 | 70 | 63.3 | 22 |
| Hernando | 40.5 | 16 | 275.7 | 439 | 103.1 | 98 |
| Highlands | 64.9 | 109 | 316.9 | 242 | 30.9 | 16 |
| Hillsborough | 42.1 | 36 | 221.4 | 3,288 | 48.6 | 502 |
| Holmes | 34.0 | 534 | 152.3 | 28 | 134.1 | 16 |
| Indian River | 24.8 | 6 | 302.4 | 373 | 83.8 | 63 |
| Jackson | 50.6 | 63 | 212.2 | 87 | 50.1 | 15 |
| Jefferson | 26.8 | 12 | 148.6 | 20 | – | – |
| Lafayette | 24.6 | 3 | 44.3 | <5 | – | – |
| Lake | 36.5 | 3 | 306.8 | 961 | 94.4 | 187 |
| Lee | 41.7 | 141 | 267.4 | 1,633 | 95.8 | 390 |
| Leon | 47.6 | 303 | 138.9 | 413 | 26.1 | 47 |
| Levy | 15.6 | 45 | 226.6 | 76 | 89.2 | 22 |
| Liberty | 55.7 | 20 | 150.3 | 10 | – | – |
| Madison | 0.0 | 0 | 140.0 | 25 | – | – |
| Manatee | 21.5 | 3 | 373.0 | 1,187 | 140.5 | 291 |
| Marion | 42.2 | 148 | 386.8 | 1,157 | 113.8 | 239 |
| Martin | 61.4 | 193 | 284.0 | 230 | 53.3 | 40 |
| Miami-Dade | 41.9 | 53 | 78.4 | 2,114 | 3.8 | 70 |
| Monroe | 49.6 | 39 | 181.5 | 121 | 21.1 | 9 |
| Nassau | 35.5 | 28 | 281.5 | 222 | 141.0 | 70 |
| Okaloosa | 41.6 | 83 | 240.1 | 467 | 114.3 | 186 |
| Okeechobee | 43.0 | 17 | 349.7 | 136 | 70.8 | 22 |
| Orange | 28.0 | 419 | 188.0 | 2,764 | 43.8 | 436 |
| Osceola | 28.9 | 117 | 219.2 | 881 | 27.8 | 73 |
| Palm Beach | 41.1 | 556 | 252.3 | 3,224 | 30.1 | 267 |
| Pasco | 56.9 | 294 | 311.4 | 1,523 | 112.5 | 343 |
| Pinellas | 57.4 | 539 | 319.4 | 2,695 | 149.4 | 731 |
| Polk | 32.6 | 228 | 216.5 | 1,477 | 24.2 | 114 |
| Putnam | 45.2 | 32 | 334.6 | 203 | 251.3 | 125 |
| St. Johns | 21.1 | 51 | 140.7 | 319 | 96.1 | 125 |
| St. Lucie | 36.0 | 101 | 220.3 | 624 | 62.1 | 114 |
| Santa Rosa | 34.6 | 67 | 213.5 | 374 | 58.2 | 67 |
| Sarasota | 47.9 | 156 | 219.9 | 658 | 175.8 | 300 |
| Seminole | 31.4 | 155 | 185.1 | 857 | 42.1 | 117 |
| Sumter | 43.0 | 31 | 317.1 | 233 | 110.1 | 31 |
| Suwannee | 19.3 | 7 | 227.9 | 93 | 33.3 | 9 |
| Taylor | 4.8 | 1 | 212.2 | 42 | 51.0 | 7 |
| Union | 6.6 | 1 | 122.9 | 19 | 132.7 | 12 |
| Volusia | 68.5 | 342 | 449.9 | 2,127 | 133.1 | 391 |
| Wakulla | 33.0 | 12 | 186.6 | 60 | 40.8 | 8 |
| Walton | 50.0 | 39 | 133.1 | 96 | 102.3 | 49 |
| Washington | 15.4 | 4 | 171.2 | 41 | 46.5 | 7 |
| **Florida (Statewide** | **36.7** | **7,719** | **226.4** | **45,171** | **62.1** | **8,227** |

# FUNDING AND BUDGET CONSIDERATIONS

## STEPS FOR PROCUREMENT

1. The provider will create a budget aligned with the tasks and deliverables the county is requesting they provide. The budget is reviewed and approved by the county.
2. A statement of work (SOW) is created by the county outlining the tasks, deliverables, payment method, and financial consequences for the project. The SOW is then sent for budget and legal review and approval.
3. Once approved, the SOW will be attached to the purchase order so that it is sent to the provider when the purchase order is fully approved.
4. Once the budget and SOW is completed, the method of procurement (MOP) can be defied. EMS is a governmental entity so L can be chosen as the MOP.
5. Once the budget, SOW, and other budget forms are completed, the purchase order can be finalized and submitted for approval. This can either be done by the county or at the central office.
6. Once approved the funds will be sent to the county for them to create the purchase order. If the central office is doing the purchase order then they will create the purchase requisition, and attach the budget, other forms, and SOW to the order. The SOW will outline how the purchase order should be created. If the billing will be done monthly or quarterly. Once the order is created it will be submitted for approval.
7. Once fully approved, the order will be sent to the provider and the services can begin.

# EXPERT-LEVEL GUIDANCE

## MEETINGS

### Biweekly Meetings

Leadership ran a communication agenda every other week to communicate expectations, share data, schedule future trainings, as well as receive feedback from county partners.

### Training Meetings

This was facilitated by assessments and what specific clinical needs groups in those counties need as well as what individual counties require for implementation.

**RESOURCES:**
**COUNTY TRAINING MEETINGS**

### Specific Meetings

Clarification/training meetings on components that need additional clarification or assistance:

**RESOURCES:**
**BEGINNER - MODERATE LEVEL TRAINING**

**RESOURCES:**
**ADVANCED LEVEL TRAINING**

### Data Tracking

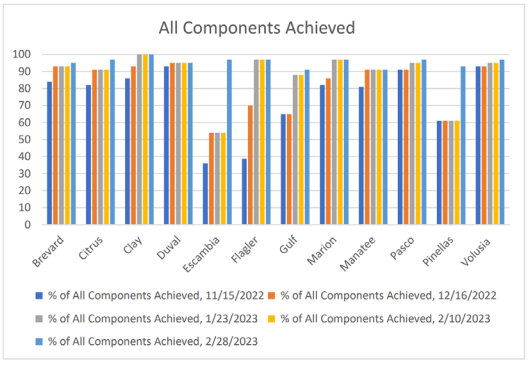
Each county was provided a login to ClearPoint, individual ClearPoint training, and addressed outstanding questions during biweekly meetings.

### Accountability/Check-in Meetings

If counties were struggling with a component, such as reaching financial barriers or collecting data, breakout meetings were scheduled with groups of counties or individual counties focused on that topic.

Example of ClearPoint graph showing change in components over time. These changes are part of the discussions addressed at biweekly meetings:

| | % of All Components Achieved, 11/15/2022 | % of All Components Achieved, 12/16/2022 | % of All Components Achieved, 1/23/2023 | % of All Components Achieved, 2/10/2023 | % of All Components Achieved, 2/28/2023 | % of All Components Achieved, 3/24/2023 |
|---|---|---|---|---|---|---|
| Brevard | 84 | 93 | 93 | 93 | 95 | 95 |
| Citrus | 82 | 91 | 91 | 91 | 97 | 97 |
| Clay | 86 | 93 | 100 | 100 | 100 | 100 |
| Duval | 93 | 95 | 95 | 95 | 95 | 95 |
| Escambia | 36 | 54 | 54 | 54 | 97 | 97 |
| Flagler | 38.6 | 70 | 97 | 97 | 97 | 97 |
| Gulf | 65 | 65 | 88 | 88 | 91 | 91 |
| Marion | 82 | 86 | 97 | 97 | 97 | 97 |
| Manatee | 81 | 91 | 91 | 91 | 91 | 91 |
| Pasco | 91 | 91 | 95 | 95 | 97 | 97 |
| Pinellas | 61 | 61 | 61 | 61 | 93 | 97 |
| Volusia | 93 | 93 | 95 | 95 | 97 | 97 |



## ASSESSMENTS

Assessment/progression of each county in development of 22 CORE components, with four considered critical.

| Individual County Assessment Template | | |
|---|---|---|
| **Element** | **Description** | **Element already exist or will?** |
| 24-7 Access to Care | 24-7 availability of treatment with MAT in your county in clinic, CRF, ED, EMS, etc. Specifically, buprenorphine must be available 24-7 in an emergency setting with no need for admission to inpatient to receive treatment immediately. | If yes, describe:<br>If no, describe plan or barriers: |
| Peer Support Services | Peer support with warm hand-off from 24-7 crisis (ED, CRF, EMS) clinic and continuous follow-up. | If yes, describe:<br>If no, describe plan or barriers: |
| All MAT Services | Buprenorphine, suballocate, naltrexone, vivitrol, and methadone all available in clinics throughout the county. Public/private relationship with a methadone clinic as an option for treatment. | If yes, describe:<br>If no, describe plan or barriers: |
| Maintenance of MAT According to Guidelines | Recommendation for patients is that MAT should be maintained at least one year of stability, or longer, without taper recommendation. | If yes, describe:<br>If no, describe plan or barriers: |
| Individual Approach to Dosing Without Limits | Buprenorphine should not be restricted to a certain dose, because of fentanyl, as increasing doses enhances retention and decreases cocaine use. Dosing should be based on decreasing withdrawal over 24 hours. | If yes, describe:<br>If no, describe plan or barriers: |
| Clinic Receive Patients from 24-7 Care and Continued Lifelong Treatment | FQHC or CMHC that can take patient during business hours for intake and serve as substance use medical home for lifelong care providing MAT, substance use therapy, psychiatry, and primary care. | If yes, describe:<br>If no, describe plan or barriers: |
| Clinic and ER Fentanyl Testing / PDMP | E-FORCE every visit and fentanyl testing with drug panels in clinic and 24-7 access point. | If yes, describe:<br>If no, describe plan or barriers: |
| Established Intake Process | An intake and assessment that includes doctors visit to start SUD treatment and a bio psychosocial by a social worker/LMHC/ psychologist. | If yes, describe:<br>If no, describe plan or barriers: |
| Established Protocol for Induction on Buprenorphine | High dose and low dose induction protocol with preference given to the high dose induction protocol that can be given immediately after use or Narcan reversal. | If yes, describe:<br>If no, describe plan or barriers: |
| Treating comorbid Alcohol and Benzodiazepine Use Disorder | Evidence-based medicine supports that comorbid use of benzodiazepines and alcohol should not stop or slow down induction on buprenorphine as these sedatives with fentanyl are deadly. Outpatient protocols and clinical judgment need to direct whether the patient will come off comorbid sedatives in outpatient or if the patient requires inpatient detox (can be based on ASAM level of care and/or clinical judgment). It is recommended that the patient come off these agents while in an outpatient-based program as a requirement. Patients should also not get controlled substances (i.e., Xanax) from outside prescriber. | If yes, describe:<br>If no, describe plan or barriers: |

| | | |
|---|---|---|
| Naloxone (Narcan) Readily Available | Naloxone quickly reverses an overdose by blocking the effects of opioids. It can restore normal breathing within 2 to 3 minutes in a person whose breath has slowed, or even stopped, as a result of opioid overdose. | If yes, describe:<br>If no, describe plan or barriers: |
| Access to Higher Levels of Care for All | Functional referral relationship with public/private detoxification programs to assist with complex detox (benzodiazepines/alcohol patients with DTs). Access to public/private residential, PHP, IOP, outpatient levels of care for adults and pregnant women. | If yes, describe:<br>If no, describe plan or barriers: |
| Clinical expert in Addiction Medicine or Champion | Established MD/DO who is primary care or psychiatrically trained, who has addiction medicine or addiction psychiatry certification. | If yes, describe:<br>If no, describe plan or barriers: |
| Therapists in Outpatient Setting | LMHCs, psychologists, LCSWs, interns who provide group and individual therapy as part of the SUD program. | If yes, describe:<br>If no, describe plan or barriers: |
| Primary Care Access | All patients should have access and be required to start having primary care, preferably, this is given in an FQHC that also provides SUD treatment with MAT. | If yes, describe:<br>If no, describe plan or barriers: |
| Infectious Disease Screening | All patients enrolling in SUD program should be tested for HIV, hepatitis panel (especially hepatitis C), syphilis, and tuberculous as needed, as part of the intake. | If yes, describe:<br>If no, describe plan or barriers: |
| Access to Psychiatry at the Clinic or Community | Psychiatric provider should be available and all patients entering the SUD program should receive a psychiatric evaluation to assist with underlying psychiatric problems as they can be comorbid with SUD diagnosis. | If yes, describe:<br>If no, describe plan or barriers: |
| Group Therapy Access in Clinic or with Partner | Group therapy availability for patients. | If yes, describe:<br>If no, describe plan or barriers: |
| Individual Therapy Access in Clinic or with Partner | Individual therapy access for patients. | If yes, describe:<br>If no, describe plan or barriers: |
| Clinic Structured by Phases of Treatment | Patients should start receiving MAT with methadone or buprenorphine in a phased approach, with ability to increase amount of medication given based on objective signs of recovery (negative drug screens, negative PDMP, attending all treatment recommendations etc.), and the ability to drop to a lower phase with objective signs of relapse (positive drug screens, PDMP positive, missing treatment etc.). | If yes, describe:<br>If no, describe plan or barriers: |
| All Levels of Care to Assist with Pregnant Women | Evidence-based pregnancy care with buprenorphine/methadone options available and RES, PHP, IOP, and outpatient. This should also be coordinated with OBGYN team and OB triage that is comfortable managing. | If yes, describe:<br>If no, describe plan or barriers: |
| Following of outcome measures and data, Specifically BAM | The brief addiction monitor is completed monthly by all SUD patients in the clinic as well as question: "How many overdoses have you had in the last month?" The interval of when the BAM is completed is also noted (1 month, 2-month, etc.). | |

# PARTNER TRAININGS

Clinical and systems training provided to counties to help with evidence-based delivery of each component. Training topics were developed based on need in counties, evaluated from assessment findings.

## EMERGENCY MEDICAL SERVICES

**RESOURCES:**
**LIFESAVING CARE EMERGENCY MEDICAL SERVICES (EMS) AND FIRE RESCUE PARTNERS**

### EMS PRE-HOSPITAL BUPRENORPHINE-NALOXONE INDUCTION FOR OPIOID USE DISORDER TO GENERATE OFFICIAL EMS PROTOCOL

**Purpose of Protocol**

This medical protocol is intended for the EMS providers in the pre-hospital setting when treating patients who were reversed by naloxone following a suspected or known opioid overdose. This may also apply to patients who call EMS in active opioid withdrawal by objective findings and meet criteria for opioid withdrawal while wanting to start immediate treatment.

Patients with opioid use disorder who have overdosed and required naloxone reversal are at increased risk for recurrent overdose and death and also present an opportunity for intervention.

- Utilizes existing EMS resources to bring MOUD to the pre-hospital setting in order to offer a new avenue to longer term care, engage patients in treatment faster, and minimize the risk of overdose after the patient leaves the EMS system.
- The induction protocol uses up to 16 mg of buprenorphine to relieve and prevent withdrawal symptoms.
- Patients are provided with outpatient follow-up or transferred to an ED if telehealth services warrant this irrespective of ED transport.

**Definitions**

- **Clinical Opioid Withdrawal Scale (COWS)**: Numbered scale designed to help clinicians tailor opioid withdrawal treatment to individual people. It is used in both inpatient and outpatient rehabilitation settings to determine the severity of opioid withdrawal and monitor how symptoms change over time during treatment. The scale uses 11 common symptoms of opioid withdrawal and measures their severity.
- **Buprenorphine**: Partial opioid agonist that provides some relief from opioid withdrawal symptoms. It is safe and effective for paramedic administration with these parameters and guidelines.
- **Naloxone**: Medication approved by the U.S. Food and Drug Administration (FDA) designed to rapidly reverse opioid overdose. It is an opioid antagonist, binding to opioid receptors and can reverse and block the effects of other opioids.
- **Precipitated withdrawal**: Rapid and intense onset of withdrawal symptoms initiated by medication as part of addiction treatment. In the case of buprenorphine, because it has a higher binding strength at the opioid receptor, it competes for the receptor, "kicks off" and replaces existing opioids. If a significant amount of opioids are expelled from the receptors and replaced, the opioid physically dependent patient will feel the rapid loss of the opioid effect, initiating withdrawal symptoms. More precisely, precipitated withdrawal can occur when an antagonist (or partial agonist, such as buprenorphine) is administered to a patient with a physical dependence on full agonist opioids. Due to the high affinity but low intrinsic activity of buprenorphine at the μ-receptor, the partial agonist displaces full agonist opioids from the μ-receptors, but activates the receptor to a lesser degree than full agonists which results in a net decrease in opioid agonist effect, thereby precipitating withdrawal.

**Inclusion Criteria**

- Age 18 years or older.
- Confirmed or suspected opioid overdose requiring naloxone administration or patient is in severe opioid withdrawal with other objective signs and symptoms and is asking/wanting for help with OUD.
- Acute opioid withdrawal as a chief complaint or one of the chief complaints.
- COWs >7 and wanting help with OUD.

**Exclusion Criteria**

*All excluded patients who report opioid use disorder should be transferred to an emergency department for assessment for induction.*

- Age < 18 years.
- Known pregnancy (relative exclusion criteria – physician discretion).
- Methadone use in the last 5 days.
- Altered mental status (unable to consent).
- Severe medical illness (such as sepsis) or psychiatric illness (suicidal thoughts, psychosis, etc.).
- Unwilling to provide full name AND date of birth.
- Received chest compressions/CPR prior to or after EMS arrival.
- COWS <7: If a patient admits to a problem with OUD and has cows less than 7, transport to local ED for further assessment.

**Protocol: OVERDOSED PATIENT**

1. If the patient is overdosed and requires naloxone, this will be managed first according to Naloxone protocol with BLS/ACLS guidelines to first address ABCs and stabilize the patient's airway.
2. If the patient is revived with naloxone, not requiring intubation, and the patient medically stabilizes, COWs and vitals will be assessed. The patient will be screened by EMS for inclusion and exclusion criteria.
3. Patient will be asked a small history of opioid use history, recent use and desire for help.
4. If patient admits to a problem but is ambivalent or refusing buprenorphine, offer to transfer to the emergency department for further assessment.
5. Patient will be offered buprenorphine induction at 16 mg and consented that this is an opioid and for the risk of precipitated withdrawal. While discussing risk of precipitated withdrawal, EMS provider should also reassure patient that this is unlikely and treatable emergently.
6. If the patient agrees, 16 mg of buprenorphine-naloxone will be given sublingually under the tongue. If the patient disagrees, the patient will be transported to the ED for further assessment and discussion but will be offered clonidine and ibuprofen supportively.
7. If buprenorphine-naloxone is given, EMS will complete a COWS and a second set of vitals every 10 minutes for 30 minutes.
8. If COWS decrease from the original number, twice after 30 minutes, induction will be complete and follow-up plans can be made. If COWs increase and precipitated withdrawal is occurring, the patient will be transferred to the medical ED and the EMS provider will be able to administer up to two doses of 8 mg of buprenorphine-naloxone, total max dose 32 mg. While transporting, COWS and vitals should be repeated every 10 minutes.

9. If the induction is completed and successful (COWS decreasing), the EMS provider will set up a telehealth ED consult from the EMS bay after 30 minutes to gain a recommendation for follow-up plans for the patient (either dosing by EMS until bridged to clinic or transfer to ED for other reasons).
10. If there are acute medical/psychiatric comorbidities for the patient evident by EMS provider or telehealth emergency department, the patient should be referred to the emergency room even if induction was successful. Successful induction may increase the compliance of the patient with seeking assistance for other services.
11. Throughout induction, supportive medications such as clonidine 0.1 mg once, bentyl once, ondansetron once, or ibuprofen once, can be used to alleviate symptoms for the patient.

**Protocol: NON-OVERDOSED PATIENT**

1. If the patient is not overdosed and medically stable, COWs and vitals will be assessed. The patient will be screened by ems for inclusion and exclusion criteria.
2. Patient will be asked a small history of opioid use history, recent use and desire for help.
3. If patient admits to a problem but is ambivalent or refusing buprenorphine, offer to transfer to the emergency department for further assessment.
4. If patient has COWs over 7 and is wanting assistance for OUD, patient will be offered buprenorphine induction at 16 mg and consented that this is an opioid and for the risk of precipitated withdrawal. While discussing risk of precipitated withdrawal, EMS provider should also reassure patient that this is unlikely and treatable emergently.
5. If the patient agrees, 16 mg of buprenorphine-naloxone will be given sublingually under the tongue. If the patient disagrees, the patient will be transported to the ED for further assessment and discussion but will be offered clonidine and ibuprofen supportively.
6. If buprenorphine-naloxone is given, EMS will complete a COWS and a second set of vitals every 10 minutes for 30 minutes.
7. If COWS decrease from the original number, twice after 30 minutes, induction will be complete and follow up plans can be made. If COWs score increases and precipitated withdrawal is occurring, the patient will be transferred to the medical ED and the EMS provider will be able to administer another 8 mg of buprenorphine-naloxone while in transport. While transporting, COWS and vitals should be repeated every 10 minutes.
8. If the induction is completed and successful (COWS decreasing), the EMS provider will set up a telehealth ED consult from the EMS after 30 minutes to gain a recommendation for follow up/transfer plans for the patient (either dosing by ems until bridged to clinic or transfer to emergency department for other reasons).
9. If there are any acute medical/psychiatric comorbidities for the patient evident by EMS provider or telehealth ED provider, the patient should be referred to the emergency room even if induction was successful. Successful induction may increase the compliance of the patient with seeking assistance for other services.
10. Throughout induction, supportive medications such as clonidine 0.1 mg once, bentyl once, ondansetron once, or ibuprofen once can be used to alleviate symptoms for the patient.

**Administration Instructions Buprenorphine/Naloxone 16 mg Sublingual (SL) Film or Tablet**

- Give a small sip of water to moisten mucous membranes and then administer sublingually. Patient must keep under the tongue until it dissolves and not drink. The patient cannot swallow the medication.

**Post Induction Plans**

1. Whether the patient follows in the ED or goes home with a referral for the clinic, the EMS call back team should reach out to the patient within 24 hours to continue engagement in care.
2. In the follow up call, if the patient cannot get to the clinic, ems should dose the patient daily until a hand-off to the clinic has been made.
3. Post induction transport options include:
    - Patients are transported to a ***CORE Network hospital*** for continued care.
    - Patients are transported to an established ***DCF bridge program emergency department*** for continued care.
    - Patients are transported to an emergency department for continued care.
    - Patients are NOT transported, and a teleconference call is made to assist in setting the patients up for MIH (community paramedicine) care with a warm hand-off to established providers for ongoing care.
    - Patients are transported to a clinic Monday through Friday for definitive care (FQHC, CMHC, or DOH clinic depending on the county). Off hours patients receive care from EMS provider or local ED.

## *POST EMS ADDICTION INTERVENTION CALL GUIDANCE*

- Tread lightly.
- Avoid judgmental language.
- Avoid leading the caller, instead guide them along with open-ended questions (those that require a response other then yes, no, or maybe). Example: "Did you use heroin today," versus "Tell me about your drug use this week."
- Feel free to share your own connection with addiction if you have one. It helps build trust with the caller, but keep details brief about your own experience, and immediately refocus on their story.
- Do not share your personal contact information!
- If the caller reports they are suicidal, continue the discussion and call dispatch from another phone line to notify law enforcement. Try to get current location. Engage them with open ended questions with what is happening right now in their life to keep the conversation going (Examples: "I am hearing you say you are ready to end the pain, tell me what is causing your pain right now," or "I am hearing you say you have given up; tell me about some other times you have felt this sad. What did you try those other times you felt this sad?" Do not hang up with the caller.
- If you hear information that you believe indicates a risk to a vulnerable adult, or there is a minor involved in the situation that you believe may be unsafe, after the call has ended immediately call report to DCF at 1-800-962-2873. Document the report by indicating the time of report, concerns shared, if the report was accepted for investigation, and the DCF employee's name and ID number in a Safety Pad case note.

**Potential Conversation Starters**

- "We cared for you recently during a 911 call and we wanted to follow-up and see how you are doing."

If the caller says they do not want to talk:

- "I respect you don't want to talk right now, but I want you to know that if you ever need help you can call the number 211 anytime, 24/7 and speak to someone confidentially who cares and wants to hear about how they can support you."

If the caller says they are concerned you will share their information:

- "I understand your concern about privacy. This call is confidential. I am part of _____ and our conversation is not recorded. We don't share this with law enforcement. My goal is solely to just listen to you talk about what is happening in your life right now and see if I can help. I do want to be honest and tell you that if you are share with me that you are thinking of harming yourself or someone else I would need to act on that information because I care about you, but otherwise this conversation is only between you and I."

**If They are Open to Talking**

- "When we were with you during your 911 call you shared that you are currently using drugs/alcohol. I wanted you to know that I have no judgment of you, but I do care about you. I wanted to see if you are open to talking to me about your use and how it is impacting your life right now."
- "It sounds like drugs/alcohol are having a major impact on your life, are you feeling like you may be ready to take your control back from the drugs/alcohol, learn about recovery, and options for care to help you get there?"
- "I know you said right now you are not interested in getting help, but I want you to know you can change your mind anytime. 211 is a number you can call 24/7 to speak to someone who cares confidentially and they have resources to help you with anything going on in your life right now."
- "I believe in you and am glad that you want to start to take control back from the drugs/alcohol; there are a lot of resources and options to help get you started. First, always know you can call 211. It is an easy number to remember and you can call them 24/7 to speak to someone who cares, will never judge you, and has resources to help you with anything going on in your life. I also want to give you a few other resources that can help:
    - Rebel Recovery: 561-252-3532 (they will likely speak to Justin or Nancy).
    - Narcotics Anonymous: NA.org (find meetings online).
    - Alcoholic Anonymous: AA.org (find meetings online).

**Closing**

- "I am really honored you shared some of your story with me. I do care and I want to know if it would be OK for me to call you again in a week to see how you are doing and to hear about the connections you made to the resources we talked about?"
- "I am really honored you shared some of your story with me. I know you said that right now is not the time for you to seek help for your addiction but I do care and I want to know that if the time ever comes that you do want support that you can call 211 and they will be ready to listen, and to give you the resources you need to start toward recovery."

**Refer to post EMS addiction intervention for additional guidance regarding confidentiality and HIPAA.**

## EMERGENCY DEPARTMENTS

### BUPRENORPHINE-NALOXONE INDUCTION PROTOCOL

**Patient comes to EMS/24-7/clinic Overdosed or Asking for Help**

*COWS >7, positive fentanyl, or opioid screen, and has OUD per DSM-5*

**Offer High Dose Induction**

- **Patient Refuses** → **Offer Low Dose Induction** *See Diagram Flowchart*
- **Patient Agrees** → **Proceed with giving 16 mg of buprenoprhine, monitor for 30 minutes, have supportive medications ready (clonidine, bentyl, ibuprofen prn), have second 8 mg dose ready**

**Proceed with giving 16 mg of buprenoprhine, monitor for 30 minutes, have supportive medications ready (clonidine, bentyl, ibuprofen prn), have second 8 mg dose ready**

- **COWS decrease and patient feels better** → **Stop and prescribe for outpatient 16 mg per day**
- **COWS increase after 20 minutes and precipitated withdrawal** → **Give supportive meds and another 8 mg of buprenorphine, repeat if not well to max 32 mg in 24 hours** → **Write RX for 24mg per day or less no matter what induction dose was and follow outpatient next day**

**RESOURCES:**
SPECIALIZED STABILIZATION HOSPITAL EMERGENCY DEPARTMENTS PROVIDING ADDICTION SPECIALTY SERVICES

## ADDITIONAL RESOURCES

**RESOURCES:**
IMPLEMENTING SUBSTANCE USE SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT IN EMERGENCY DEPARTMENTS

**RESOURCES:**
EMERGENCY DEPARTMENT SCREENING AND INTERVENTIONS FOR SUBSTANCE USE DISORDERS

**RESOURCES:**
EMERGENCY PRACTITIONER AND UNHEALTHY DRINKER TRAINING VIDEOS

## ASSESSMENT AND CLINICAL INTAKE AND PLACEMENT SUGGESTED CLINICAL PROCEDURE

**Day 1**

Patients will be processed through registration, prior to beginning their intake appointment, as follows:

1. Verification of government issued identification.
2. General registration procedure.
3. Signing of general treatment consent.

**Intake**

Intake will occur once the patient is identified as eligible for the program through the screening process, which will verify that they meet the adult outpatient American Society of Addiction Medicine (ASAM) Level I criteria.

All patients shall undergo an assessment of the nature and severity of their substance use problem, once general consents are signed at intake. The assessment will include a physical health assessment and a psychosocial assessment. Risk assessment and screening will be completed for both patient high-risk behavior and symptoms of communicable disease. Actions to be taken on behalf of the patients identified as high-risk and patients known to have an infectious disease will be documented and addressed.

The intake assessment shall include the **following components**:

**Nursing Physical Screen**

- Completed on each person considered for placement at intake.
- Completed by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.), and countersigned by an R.N. or the physician.
- This includes, but is not limited to, urine drug screen, fentanyl screen, urine pregnancy test, withdrawal scale (COWS), vitals, PHQ 2 and/or 9, CIWA, PDMP.
- Purified protein derivative skin test (PPD) will be administered to all appropriate patients, as determined by the use of the TB screening form. Other screening will be ordered if PPD is found to not be appropriate.

**Medical History**

- Will be completed within 30 calendar days prior to or upon placement; although best practice is to do the day of intake:
    - If PDMP shows an outside prescriber of a controlled substance in the past three months, the patient will be required to sign a release of information to get controlled substances at the clinic to centralize prescribers giving controlled substances. The patient will be informed that they are not able to get controlled substances from outside prescribers to prevent "doctor shopping." The nurse will call the office of the outside prescriber and inform them of the patient's involvement in the program and the need to centralize controlled substances. Benzodiazepines will be tapered in the program, if given, and stimulants will be held and evaluated by the psychiatric evaluation at the end of the month.
- The medical history will be completed by the patient or the client's legal guardian, and nurse during the nursing physical screen. Patients will sign acknowledgment of their participation in the completion of their medical history.

- The medical history will be maintained in the patient record and updated annually if a patient remains in treatment for more than one year.

**Physical Exam**

- An initial targeted physical exam will be performed by the physician or mid-level at the time of intake.
- Lab orders to include but not limited to will be completed for HIV, hepatitis B and C, and syphilis. Other infectious disease workup will be deferred to the clinical judgment of the provider.
- The full physical exam will be completed through a referral to the [clinic name] medical physician within 30 days of patient's intake/placement but preference would be to do so as soon as possible.
- The physical exam will be maintained in the patient record and updated annually if a patient remains in treatment for more than one year.

**Laboratory Tests**

- Urine drug and fentanyl screens will be collected by the SUD clinical staff at intake visit as well as in the future, if placed in program.
- Pregnancy test will be performed on all female patients, by the AOTP clinical staff at intake visit as well as in the future as needed, if placed in program.
    - If a patient has a positive in-house pregnancy test result, they will be offered MAT services and the appropriate referrals will be made to resources for obstetrics/gynecology care and treatment. Specifically, prior to 22 weeks gestation, the pregnant woman could and should be offered buprenorphine or methadone if suffering from an OUD with the same induction protocol as non pregnant patients. After 22 weeks gestation, the induction should occur in an OBGYN triage setting where the baby can be monitored during induction. Other MAT (naltrexone, vivitrol, sublocade) are thought to be safe, but not standard of care for pregnant women.

**Psychosocial Assessment**

- Any psychosocial assessment completed within 30 calendar days prior to placement may be accepted, otherwise, it will be completed within 30 calendar days of placement.
- Assessment is completed, signed, and dated by qualified professional.
- The assessment will include a clinical summary, including an analysis and interpretation of the results of the assessment, and the identification of patients with mental illness and other needs. Such patients will be accommodated directly or through a referral, which is recorded and maintained in the patient's record.
- Assessments are updated annually for continuous treatment over one year.

***Psychosocial Assessment Readmission Requirements***

Readmission within 180 calendar days of discharge requires an update to the psychosocial assessment, if clinically indicated. Information to be included will be determined by the qualified professional. A new assessment will be done if it has been over 180 calendar days.

***Assessment Requirements for Referred or Transferred Patients***

1. A new assessment is not necessary if one of the following criteria is met when patient is referred or transferred from another provider:

- Provider initiating the referral or transfer forwards copy of psychosocial assessment prior to client's arrival (if the content of the forwarded psychosocial assessment does not comply with the regulations, the information will be updated or a new assessment will be completed).
- Directly referred or transferred from specified level of care to a lower/higher level of care.
- Directly referred or transferred to the same level of care.

2. If a patient is admitted with the [clinic name] later than seven calendar days following discharge from the provider who initiated the referral/transfer, but within 180 calendar days, the qualified professionals of the [clinic name] will determine the extent of the update needed.
3. If a patient is placed with the [insert clinic name] more than 80 calendar days after discharge from the referring/transferring provider, a new psychosocial assessment must be completed.

***Information Requirements***

The psychosocial assessment shall include the client's history as determined through an assessment of the client's current addiction and history of addiction.

- Emotional or mental health.
- Level of substance use impairment.
- Family history, including substance abuse, by other family members.
- The patient's substance abuse history, including age of onset, choice of drugs, patterns of use, consequences of use, and types and duration of, and response to, prior treatment episodes.
- Educational level, vocational status, employment history, and financial status.
- Social history and functioning, including support network, family and peer relationships, and current living conditions.
- Past or current sexual, psychological, physical abuse, or trauma.
- Client's involvement in leisure and recreational activities.
- Cultural influences.
- Spiritual or values orientation.
- Legal history and status.
- Client's perception of strengths and abilities related to the potential for recovery a clinical summary, including an analysis and interpretation of the results of the assessment.

***Other Medical/Psychiatric Issues***

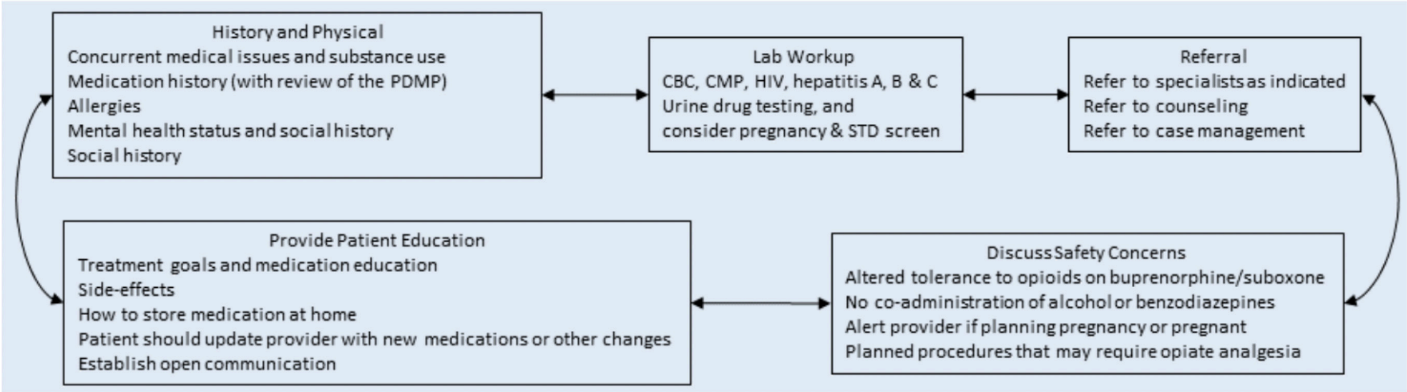
Referrals for medical services will be provided for patients with medical issues or needs. These referrals may be created by the [clinic name] physicians. Documentation of these referrals are maintained in the patient's chart, as well as follow up. These referrals can be internal or external depending on the clinic's resources.

***Placement***

Upon completion of the intake process the patient will be placed/admitted into the [clinic name] if all criteria are met as described above. The patient will complete orientation and will be asked to complete labs at the contracted laboratory. The patient will also be offered MAT services, if appropriate. If they agree, consent for the MAT option recommended and accepted treatment will be signed by the patient and treatment will begin. If a patient is not eligible for placement, they will receive the necessary community referrals and be offered a [clinic name] medical clinic appointment, as well as behavioral health services.

## Algorithm for In-Office Induction (for home induction prescriptions may be given)

### Initial Assessment




## PHASES OF SUBSTANCE USE DISORDER TREATMENT AFTER ASSESSMENT AND INTAKE

**Induction Phase**

After assessment and intake are complete and the patient is accepted into the MAT program and buprenorphine/naloxone is the recommended treatment for the patient, they will be consented for treatment in the program, by the prescriber. Initial dosing will be initiated as described below. Alternatively, the patient may already come in on the first day as a transfer from a referring hospital or facility on a stable suboxone (buprenorphine/naloxone) dose. Patients will be required to complete a medical record request to obtain records so dosing can be verified. The program provider will then reassess the current dose and determine the stabilization dose.

The patient should preferably be exhibiting early signs of opioid withdrawal (sweating, yawning, rhinorrhea), which will be confirmed by use of the COWS, but a high dose induction is possible within a few hours of a reversal with naloxone or a low dose induction. Deciding to do a high dose induction versus a low dose induction is based on the clinical judgment of the provider and the individual needs of the patient. Both are supported in the literature. It is important that the prescriber read about both and understand them in the literature to implement in practice.

**Subjective Opiate Withdrawal Scale (SOWS)**

Instructions: We want to know how you're feeling. In the column below today's date and time, use the scale to write in a number from 0-4 about how you feel about each symptom right now.

Scale: 0 = not at all 1 = a little 2 = moderately 3 = quite a bit 4 = extremely

| | | | | | | |
|---|---|---|---|---|---|---|
| | DATE | | | | | |
| | TIME | | | | | |
| | SYMPTOM | SCORE | SCORE | SCORE | SCORE | SCORE |
| 1 | I feel anxious | | | | | |
| 2 | I feel like yawning | | | | | |
| 3 | I am perspiring | | | | | |
| 4 | My eyes are tearing | | | | | |
| 5 | My nose is running | | | | | |
| 6 | I have goosebumps | | | | | |
| 7 | I am shaking | | | | | |
| 8 | I have hot flushes | | | | | |
| 9 | I have cold flushes | | | | | |
| 10 | My bones and muscles ache | | | | | |
| 11 | I feel restless | | | | | |
| 12 | I feel nauseous | | | | | |
| 13 | I feel like vomiting | | | | | |
| 14 | My muscles twitch | | | | | |
| 15 | I have stomach cramps | | | | | |
| 16 | I feel like using now | | | | | |
| | TOTAL | | | | | |

**Mild Withdrawal = score of 1 – 10**
**Moderate withdrawal = 11 – 20**
**Severe withdrawal = 21 – 30**

**Dosing Day 1: Low Dose Induction Protocol**

The following protocol is what is in research studies and can be done at home or in the office after SOWS is 11. The patient should also have clonidine prescribed, bentyl, ibuprofen, and other supports and should get ample amounts of 2 mg doses with a plan to return to the clinic 24-72 hours after induction is successful. After successful induction, doses should be increased by 4-8 mg at a time, up to a maximum of 32 mg daily to eliminate withdrawal for 24 hours, per clinical judgment.

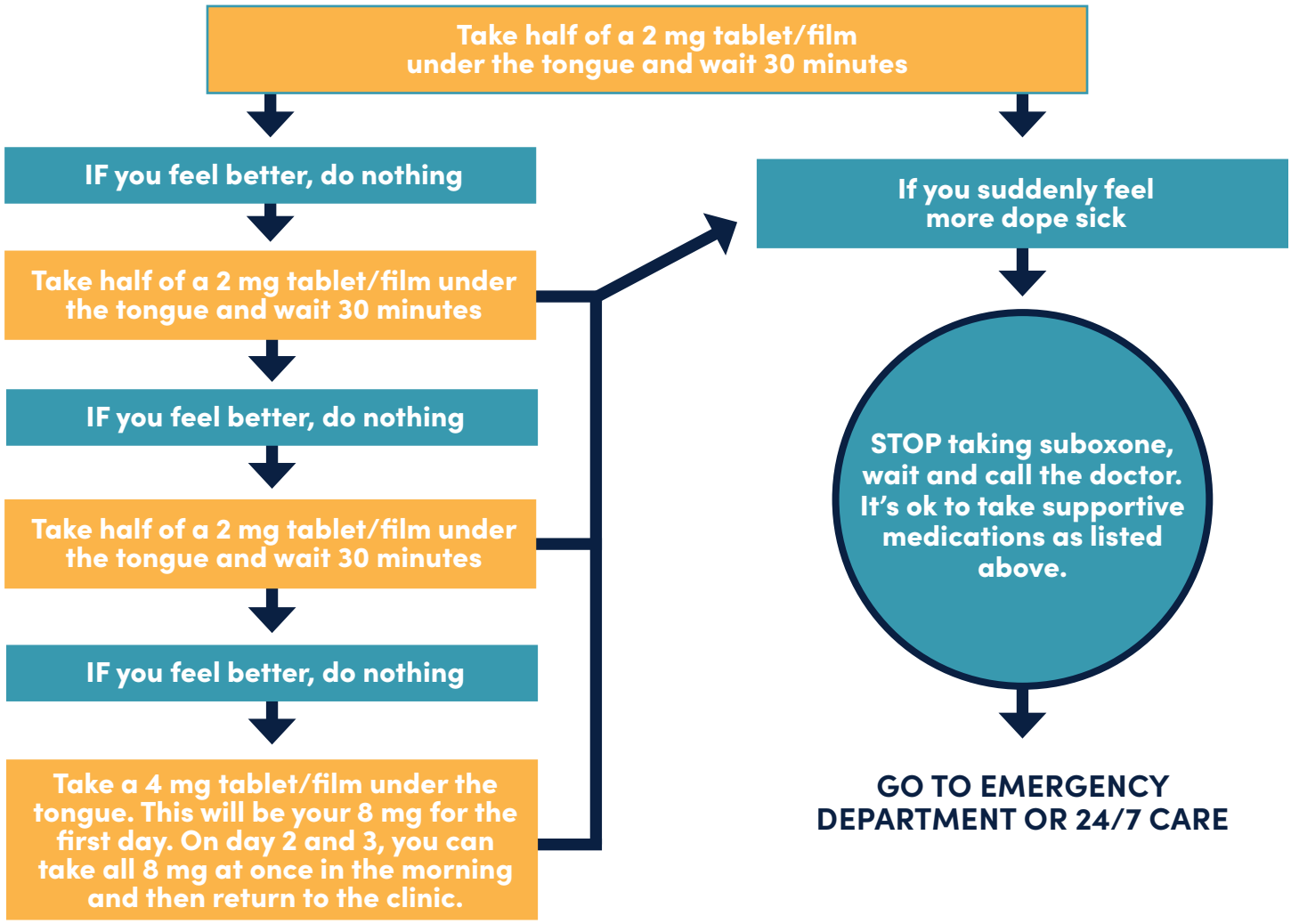
If the provider is struggling to have a patient cut the pills into ¼ and only ½ pills is possible, please use the following modified low dose protocol at home or in the office.

Table 2. Outpatient Microinduction Protocol Using Sublingual 2 mg Buprenorphine/Naloxone Tablets or Films

| Day | Bup/Nlx Dose and Frequency | Full Agonist Opioid |
|---|---|---|
| 1 | 0.5 mg daily (1/4 tablet or film) | No change |
| 2 | 0.5 mg BID | No change |
| 3 | 1 mg BID (half-tablet or film) | No change |
| 4 | 2 mg BID | No change |
| 5 | 2 mg TID | No change |
| 6 | 4 mg TID | No change |

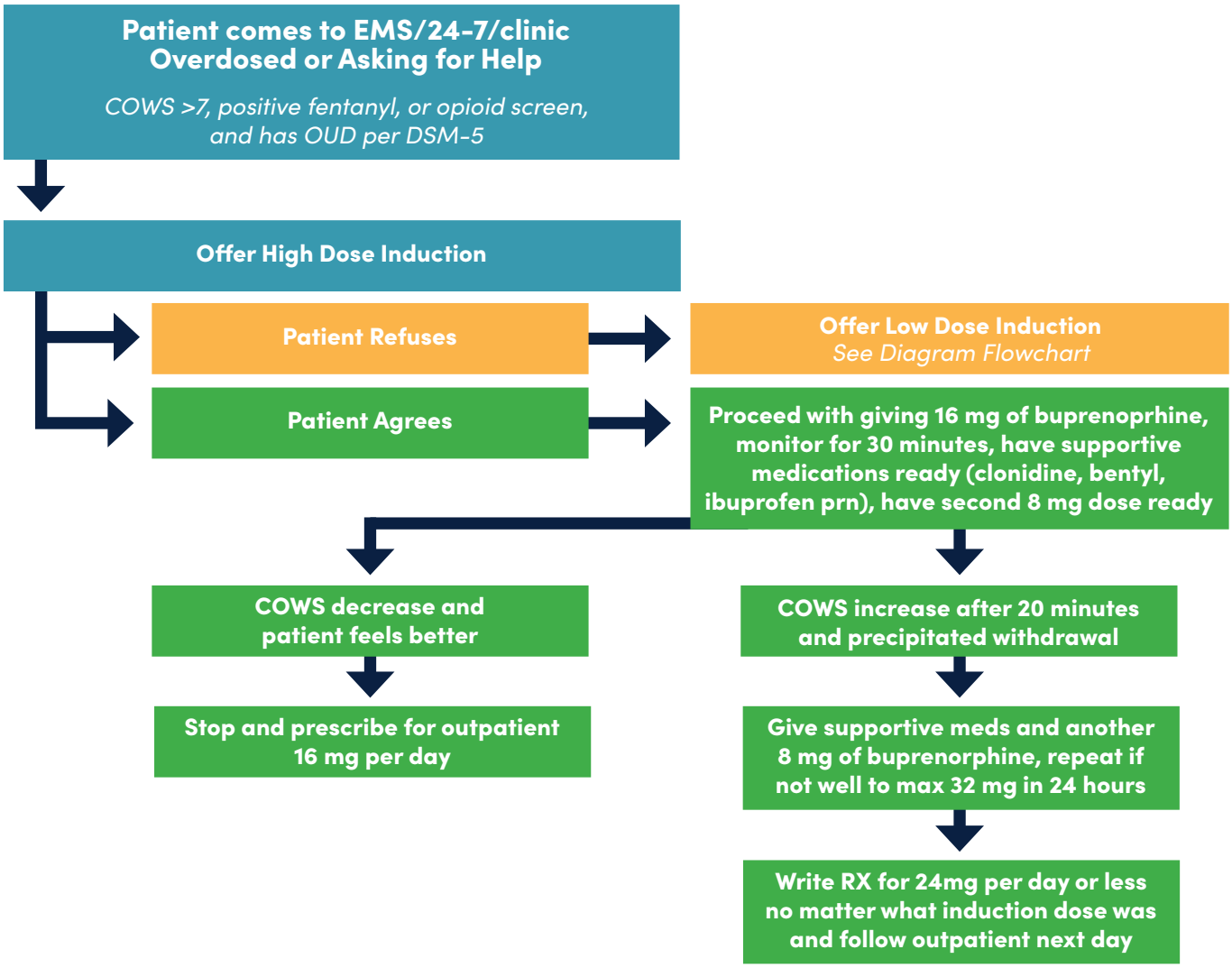
## HOME INDUCTION BUPRENORPHINE INSTRUCTIONS FOR ILLICIT FENTANYL ONLY

Wait at least 24 hours after last fentanyl use and make sure SOWS score is at least 21 and in the severe range. Patient must take as needed supportive medications (clonidine, Imodium, and ibuprofen) while waiting for this time to pass. Then, follow the diagram below:



**High-Dose Induction Protocol**

The following protocol is what is in research studies and can be done at home or in the office after SOWS is 11. The patient should also have clonidine prescribed, bentyl, ibuprofen, and other supports and should get ample amounts of 8 mg doses with a plan to return to the clinic 24 hours after induction is successful. If using this, the patient should start immediately at 12-16 mg. If precipitated withdrawal starts, increase by 8 mg every 30-60 minutes up to 32 mg to eliminate. After successful induction, doses should be increased by 4-8 mg at a time up to a maximum of 32 mg daily to eliminate withdrawal for 24 hours per clinical judgment. If the patient required 32 mg on day one, the prescriber can decrease the maintenance dose if the 32 mg was only needed to override the illicit opioid.




**Dosing Day 2 or 3**

Patients returning on day 2 will receive a COWS, CIWA as needed, vital signs, and urine drug screen as needed, prior to dosing. Program provider will assess the patient for side effects and withdrawal as it pertains to dosing. Most patients will only return on day 2 for subacute medical or psychiatric reasons or by the provider's discretion.

Most patients will follow up on day 3 with a nursing visit that will be converted to a provider's visit if needed. Doses may be subsequently increased by no more than 8/2 mg increments each day to a maximum dose of 32/8 mg per day. Despite the maximum dose ranges, the provider should aim to prescribe the lowest effective dose to minimize side effects while alleviating withdrawal symptoms for a 24-hour period. If doses over 24/6 mg are needed for maintenance, there should be consideration to send out the urine for norbuprenorphine metabolites to quest as a

way to verify the patient is taking that dose and that there is no diversion. If side effects occur, the dose of suboxone (buprenorphine/naloxone) will be maintained or lowered until these side effects disappear. If the patient continues to experience withdrawal symptoms while at the maximum dose, they will be referred to an alternative level of care (i.e. methadone) or augmentation medications will be added. The patient will also be referred for weekly group or individual counseling as a requirement of the SUD program.

Appointments for 1:1 counseling with an in-house behavioral health provider will also be scheduled at a minimum of once a week for the first month to continue to provide counseling and prevention education during the treatment process.

**First Four Weekly Visits**

Patients will be seen weekly for the first month. In the first two visits, primary care will dose and do an initial physical exam to establish primary care. In the 3rd visit, primary care will review labs in addition to prescribing MAT. In the fourth visit, the psychiatrist will do MAT and perform a psychiatric evaluation. The patient will also see the therapist one on one to do a full therapy assessment. At the end of the month, the therapist will give a full recommendation for a therapeutic treatment plan and place the patient in a group and individual according to that plan and the patient's preference.

**Stabilization Phase**

The induction phase is completed and the stabilization phase is begun when the patient is experiencing no withdrawal symptoms within 24 hours, and is experiencing minimal or no side effects.

Dosage adjustments may be necessary during early stabilization, and frequent contact with patients increases the likelihood of compliance. Until full stabilization is achieved, weekly assessment of patients will occur to make necessary dosage adjustments. Doses may be subsequently increased by no more than 8/2 mg increments each day until stabilization is achieved. If a patient continues to use illicit opioids and is deemed to be clinically unstable, despite the maximal treatment dose available in the clinic setting, the program provider will consider referral to a higher level of care for a more intensive therapeutic environment (i.e. methadone). If the patient needs >or = 24 mg per day, MD/DO providers out of the training phase may proceed and mid-level providers (ARNP or PA) will need to consult with the MD/DO supervisor and have the note cosigned by the clinical supervisor and send-out for norbuprenorphine levels to eliminate the possibility of diversion. The patient will have to show regular negative drug screens for illicit opioids at > or = 28 mg dose. If not showing this after two weeks on the 28 mg or 32 mg dose, the patient will either need to go to a methadone clinic or the patient will be dropped to 24 mg daily as harm reduction (overdose protection) is still maintained at lower doses. The patient will continue to complete the COWS form during this phase to monitor the patient's objective withdrawal symptoms, as long as the program provider deems necessary.

Patients will continue to receive UDS testing in the clinic during this phase, at minimum on a weekly basis or at the frequency deemed appropriate by the Program Provider. In house dosing is rare and if going on long term, sublocade or a methadone dispensing clinic should be considered.

Patients in the stabilization phase will be seen, at minimum, every week by the behavioral health provider in group or individual. The patient will also be offered services by care coordinators as needed for case management assistance.

If a patient is frequently late to the appointment and not in withdrawal, it will be assumed that he/she is "stretching" the dose and a dose adjustment down will be made to make adherence to on time appointments more likely.

| INDUCTION AND STABILIZATION | PHASE I | PHASE II | PHASE III | PHASE IV+ |
|---|---|---|---|---|
| Starting visit with induction | 1 week of MAT medication | 2 weeks of MAT medication | 3 week of MAT medication | 4 week of MAT medication |
| Weekly visits with therapist | Weekly visits with therapy (group or individual) in GBAT | Live visits every 2 weeks in GBAT required | Live visits every 3 weeks in GBAT required during medication visit | Live visits every 4 weeks in GBAT |
| First 2 primary care provider appointments with MAT | Can be using on and off | Must have labs done and negative drug screen, not including THC<br>On-time for appointments | Must have labs done and negative drug screen, not including THC<br>On-time for appointments | Must have labs done and negative drug screen, not including THC<br>On-time for appointments |
| First psychiatric evaluation with MAT | Continued primary care and psychiatric care as needed | Continued primary care and psychiatric care as needed | Continued primary care and psychiatric care as needed | Continued primary care and psychiatric care as needed |

Patients in the maintenance phase of treatment will have completed 30 days in the program and be on a consistent dose of suboxone (buprenorphine/naloxone). The goal of this phase is to begin increasing the amount of take home-dosing. If the patient is stable and is meeting program requirements for individual and/or group counseling per table above, follow up appointments with the prescriber and appointments with primary care, the patient can increase phases.

Take home doses will never be increased by more than seven days at a time with increases allowed at prescriber visits. Patients may be required to return to the clinic on a less frequent basis, per program provider's discretion, but never to exceed a period of one month. Urine drug screens with fentanyl testing will be performed at a minimum of monthly.

**Phase I:** One week of buprenorphine with weekly group or therapy visits required live. In order to escalate from Phase I, all required labs must be done, the patient must have seen primary care and psychiatry. Drug screens must be negative and any sedative tapers must be complete (with the exception of marijuana). The patient also must be following the behavioral health provider weekly in group or individual. If there are significant medical, psychiatric, or psychosocial concerns despite the above criteria being met, the patient may be held back in phase given the team's discretion.

**Phase II:** Two weeks of buprenorphine with required weekly telehealth therapy, live therapy, or group therapy. Required labs must be completed. Patients will be seen live for therapy and medication visit every other visit. If the patient is on Phase I or Phase II, it is acceptable for the patient to see the prescriber every other visit with a nursing visit in between and be granted a refill but the patient must see the behavioral health provider weekly in group or individual. All nursing visits in the substance use clinic must be reviewed with and signed off by a prescriber even if the prescriber doesn't see the patient. If during the nursing visit, the patient is unstable clinically (early or late for appointment; has a positive drug screen, or has a positive Eforse), the nurse and prescriber will convert the nursing visit into a prescriber visit.

**Phase III:** Three weeks of buprenorphine. Patients will come in once every three weeks for therapy and for medication visits.

**Phase IV+**: Four weeks of buprenorphine prescribed. Patient can reach this phase if he/she has been stable at Phase III for a minimum of three months. At this phase, therapy is not required. Patients will have monthly check-in by BHC along with prescription visits. Therapy is at the discretion of the treatment team but not a requirement for one month of medications. Patients will only be phased down if late/early, showing a positive drug screen or getting outside controlled substances. If the patient is phased down, will need to go to Phase III and work his/her way back to Phase IV.

After three months at Phase IV+ successfully in the SUD specialty clinic program, the patient may be transferred to a primary care clinic outside of the specialty clinic, and this should be considered for the convenience of the patient. When a patient has transitioned to general primary care for buprenorphine follow-up, they will come monthly for a visit with the primary care physician and receive medication and a live warm hand-off follow-up by the BHC in that clinic.

If the patient relapses, has a positive PDMP (outside prescriber of controlled substance), or is not on time for the appointment (early or late) while with general primary care, the primary care doctor can reach out to director of behavioral health for consultation. Generally, the patient should be dropped to three weeks of medication and continued on medication with follow-up by the primary care physician and behavioral health center for three weeks.

If the patient improves at the next visit, they can be moved back to Phase IV+. If the patient continues to struggle after a few visits with relapse, adherence problems, or positive Eforse (controlled medication from another provider), the patient can be transitioned back to the specialty SUD clinic for more intensive care with prescribers and BHCs after consultation with the director of behavioral health. Alternatively, a patient can be kept in primary care depending on the clinical appropriateness and discretion of the entire care team and supervisory team. The patient should not be automatically be tapered due to relapse/nonadherence without consultation and co signatories of the note with director of behavioral health.

**Taper Phase**

The goal of treatment is long-term healthy recovery regardless of whether a patient needs to continue medications or not. Opioid Use Disorder is a chronic disease, and just like with many other chronic diseases, some patients may require many years or even lifelong medication to remain healthy. However, if both the clinician and the patient agree, after a period of at least one year of stability, and a taper of the medication is in the patients best interest, then this section applies.

Treatment success depends on the achievement of specific goals that are agreed on by both the patient and the program provider and behavioral health team. Following successful stabilization, decisions to decrease or discontinue suboxone (buprenorphine/naloxone) should be based on a patient's desires and commitment to becoming medication-free, and on the program provider's and behavioral health team's confidence that tapering would be successful.

Attention must be maintained on the psychosocial and family issues that have been identified during the course of treatment. Other issues that will be monitored continually are related to cravings for opioids and to preventing relapse.

Patients should be maintained on suboxone (buprenorphine/naloxone) for no less than one year from the time of stabilization. It is the patient's and provider's decision whether suboxone (buprenorphine/naloxone) maintenance should continue longer than one year. If a patient decides to discontinue treatment sooner than recommended by the

provider, the P and P will be followed as an "against medical advice" decision. Patients should be advised about the increase risk of overdose and death, and patient should sign that this is "against medical advice."

Discontinuation of suboxone (buprenorphine/naloxone) will occur when a patient has achieved the maximum benefit from treatment and no longer requires continued treatment to maintain a drug-free lifestyle, when a patient is not progressing satisfactorily and will be discharged from the program, or when a patient voluntarily decides to discontinue the program. The patient will be tapered off of the suboxone (buprenorphine/naloxone) slowly, using a dosage reduction schedule established by the program provider. Mid-level providers (ARNP or PAS) must consult the supervising physician about tapering and the schedule and have the director of behavioral health be a cosigner for the note. Behavioral health services will continue to be provided to patients during this period. Tapers should be slow and can be halted if the patient finds it too difficult. This is a very individual decision between the prescriber and patient

Regardless of the reason for taper (recommended or not recommended), supportive medications (clonidine, Zofran, etc.) should be offered to ease symptoms of the step down of the dose. The prescriber should recommend naltrexone or vivitrol as a next step in treatment to continue to prevent overdose.

If a patient is discharged from the program due to nonadherance with the program requirements/treatment agreement or due to voluntary termination, efforts will be made to taper the patient slowly from the suboxone (buprenorphine/naloxone) and to ensure that the patient has an appropriate level of care available once their own therapeutic involvement has ended. Appropriate referrals will also be provided to the patient as necessary.

During taper, motivational interviewing will be utilized if the patient's decision to taper is not in line with our recommendation. Also, methadone, sublocade, and a higher level of care will be offered. Patient's will never cease to lose medical or psychiatric services if they tapered against recommendation or based on recommendation. Taper can also be halted or reversed if the situation changes to make buprenorphine management appropriate again.

**RESOURCES:**
**SUGGESTED PROTOCOL FOR GROUP BASED ADDICTION TREATMENT**

**RESOURCES:**
**HOT TOPICS IN PROVIDING MEDICATION ASSISTED TREATMENT**

**RESOURCES:**
**CLINIC FORM - SUD PRE-APPOINTMENT RETURN VISIT SELF-ASSESSMENT**

**RESOURCES:**
**GROUP BASED ADDICTION TREATMENT MODEL FOR RECEIVING CLINIC**

## URINE DRUG SCREEN PROCEDURE

**Definitions**

- **Urine Drug Screen (UDS)** - The process of in-house rapid testing of patient's urine specimen to detect the presence of drugs.
- **Positive Drug Screen** - Unexpected findings on the UDS panel, which reveal the presence of drugs without a prescription.
- **Specimen Tampering** - Suspected methods used by the patient to alter the results of their urine sample.
- **Confirmatory Testing** - Process of sending a positive rapid in-house urine drug screen specimen out to the external contracted laboratory for confirmation of the positive results. The external contracted laboratory will process the specimen using Chemiluminescence Immunoassay (CIA) or by sending the specimen out to their contracted laboratory Gas Chromatography/Mass Spectrometry testing, if appropriate.
- **Behavioral Health Team** - All staff involved in the SUD program.
- **Program Provider** - Provider assigned to treat patients in the SUD program.
- **Observed Urine Drug Screen** - Direct observation is the process in which an observer will witness the urine pass from the donor's body into the collection container.

**Procedure**

Patients who are participants in the SUD program will be required to have UDS during their treatment. This includes both a 12 panel drug screen test by "First Sign" that also reads temperature (there is a separate procedure for this in regards to directions on administering the test) in addition to a separate one step fentanyl screen (also has a separate administration procedure). Both the 12 panel drug screen and the fentanyl screen must be done when drug testing is ordered. Positive drug screens will not be confirmed through confirmatory testing routinely, but per the patient's request and/or based on the program provider's discretion. The confirmatory drug screens will be processed by the SUD contracted an external laboratory. The specimen will be collected by the SUD staff. Patient's whose drug screen results are confirmed to be positive may be at risk of being decreased in phase or discharged from the SUD program, per provider's discretion.

**Detection of Drugs/Drug Metabolites**

- **AMP- d-Amphetamine**: Amphetamine is generally only detectable by a standard drug test for approximately 24 hours, although a high dose may be detectable for two to four days.
- **BAR- Secobarbital**: Barbiturates normally remain detectable in urine for four to six days after use (up to 30 days for phenobarbital).
- **BUP- Buprenorphine**: Complete elimination of a single dose of buprenorphine can take up to six days.
- **BZO- Oxazepam**: Oxazepam is detectable in the urine for up to seven days.
- **COC- Benzoylecgonine**: Cocaine is primarily excreted as benzoylecgonine and can generally be detected for 24-60 hours after cocaine use or exposure.
- **THC- 11-nor - 9-Tetrahydrocannabinol-9-carboxylic acid**: 80-90% of the total dose of -9- THC is excreted within 5 days.
- **MET- d-Methamphetamine**: Methamphetamine can be detected in the urine within four to six hours after use and for three to five days, depending on the urine pH level.

- **MTD - Methadone**: Methadone can be detected in the urine for up to 14 days. The length of time following drug use for which a positive result may occur is dependent upon several factors, including the frequency, amount of drug, metabolic rate, excretion rate, drug half-life, and the drug user's age, weight, activity, and diet.
- **MOP- Morphine**: Morphine and other Opiates can be detected in the urine within two to six hours after use and remains detectable up to three days. However, the length of time following drug use for which a positive result may occur is dependent upon several factors including the frequency, amount of usage, metabolic rate, excretion rate, drug half-life, and the drug user's age, weight, activity, and diet.
- **OXY- Oxycodone**: The length of time following drug use for which a positive result may occur is dependent upon several factors including the frequency, amount of drug, metabolic rate, excretion rate, drug half-life, and the drug user's age, weight, activity, and diet.
- **Fentanyl**: This is a separate one test.

**RESOURCES:**
**INFORMED CONSENT OF RAPID FENTANYL TEST**

**Positive Urine Drug Screens**

**Confirmatory Testing**: If a patient's urine drug screen produces a positive result for any of the drugs on the panel, and the patient expresses disbelief in accuracy of testing, it is the patient's right to request that the test be confirmed by an external laboratory. This confirmatory test specimen will be collected in-house and the testing will be performed by the external laboratory contracted by the program to perform this service.

The program provider will place a separate laboratory order for each drug that resulted as positive and is in question. The lab order will be printed and taken to the lab, along with the specimen, by the same SUD program staff member who was present during collection of the specimen. All urine drug screens that are challenged by a patient and tested through an external lab, will be entered on the Confirmatory Urine Drug Screen Log for tracking purposes.
When results are received, the appropriate information will be documented on the log. This log will be reviewed, monthly, by the quality department/Nurse manager to monitor the number of challenged results and whether the quality of in-house testing is involved. Drug screens all have a chance to have false negatives or false positives.

**Positive Results**

Patients are expected to have negative Urine Drug Screen (UDS) results, with the exception of suboxone when receiving suboxone treatment or other controlled substances that are known to be prescribed or if the patient has drugs that he/she has disclosed to the prescriber already. If results are positive, the program provider will review with the treatment team to determine what action will be taken, which may include a phase change, moving forward with confirmatory testing and/or placing the patient on a benzodiazepine tapering plan (if appropriate). If urine drug screens continue to be positive, motivational interviewing, frequent check in, dose adjustments, psychiatric intervention, or a movement to a higher level of care should be considered.

**Sample Rejection**

Urine samples may be rejected by the collection staff if observed or suspected tampering has occurred. An example of suspected tampering may be a sample that is cool to the touch, which may be grounds for rejection. If a sample is rejected upon collection, the patient will be asked to provide another sample at the same clinic visit as soon as they are able. The program provider may interpret tampering as a positive result. All rejected samples will be documented in the patient's chart, within the results of the UDS procedure, by the provider.

**Inability or Refusal to Produce a Specimen**

If a patient is unable to produce a urine sample or refuses to produce a urine sample, the provider will be notified, which could lead to the provider interpreting refusal as a positive result. The patient will be offered at least 30 oz of water and encouraged to stay in the clinic to provide a sample. If the patient cannot, he/she will get one day of medications and be asked to come the next day to give another sample.

**Observed Urine Drug Screen Procedure**

The following situations require an observed urine automatically (the patient can refuse but the sample will likely be considered positive):

- Patient turns in a sample that appears nothing like human urine or is not consistent with the temperature of human urine.
- Patient appears intoxicated at a visit where nothing is appearing in the urine that would explain the level of intoxication.
- Patient adamantly denies using a substance that appears in urine and is requesting repeat.
- Treatment team may use clinical discretion to mandate an observed urine on patients early or late for controlled prescription appointments.

The following will be the procedure for randomized observed urine drug screen:

1. The nursing team will observe at least one urine randomly on each patient if their last name is part of the monthly schedule. This can occur anytime during the month but must occur at least once during the month.

| **Monthly by Last Name** | **Schedule** |
|---|---|
| Month I: Last names A-G | JANUARY: Month I: Last names A-G |
| Month II: Last names H-M | FEBRUARY: Month II: Last names H-M |
| Month III: Last names N-S | MARCH: Month III: Last names N-S |
| Month IV: Last names T-Z | APRIL: Month IV: Last names T-Z |
| | MAY: Month I: Last names A-G |
| | JUNE: Month II: Last names H-M |
| | JULY: Month III: Last names N-S |
| | AUGUST: Month IV: Last names T-Z |
| | SEPTEMBER: Month I: Last names A-G |
| | OCTOBER: Month II: Last names H-M |
| | NOVEMBER: Month III: Last names N-S |
| | DECEMBER: Month IV: Last names T-Z |

2. An identified lead nurse will audit the last name observed urine at the close of each month and provide the report to the clinical leadership.

   **Documentation of observed urine**: The staff must write "observed urine by staff due to _____ should indicate if the observed urine was due to the following, randomization (indicates last name reason); required observed based on the procedure and what required the urine to be observed.

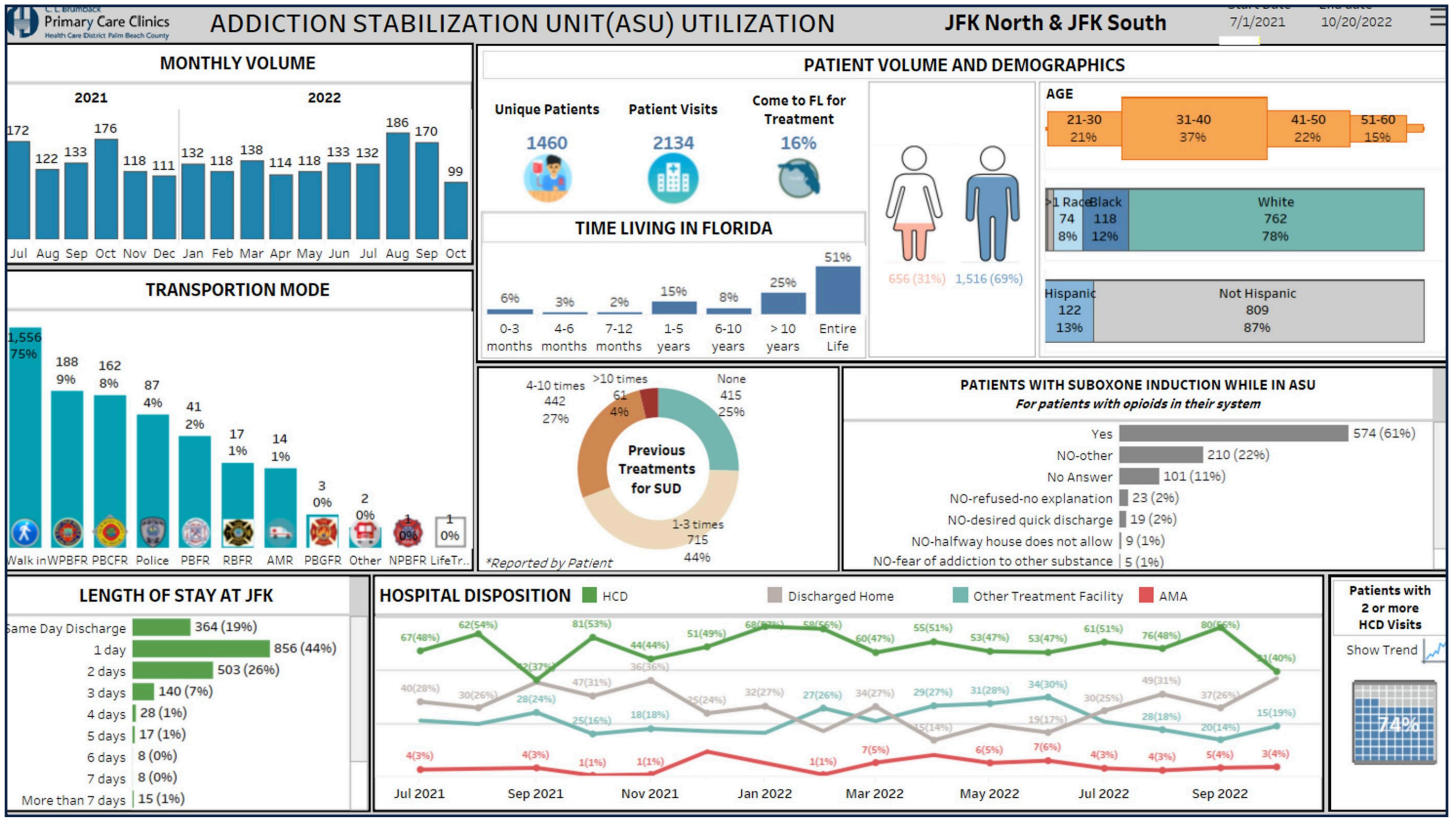
## BRIEF ADDICTION MONITOR (BAM)

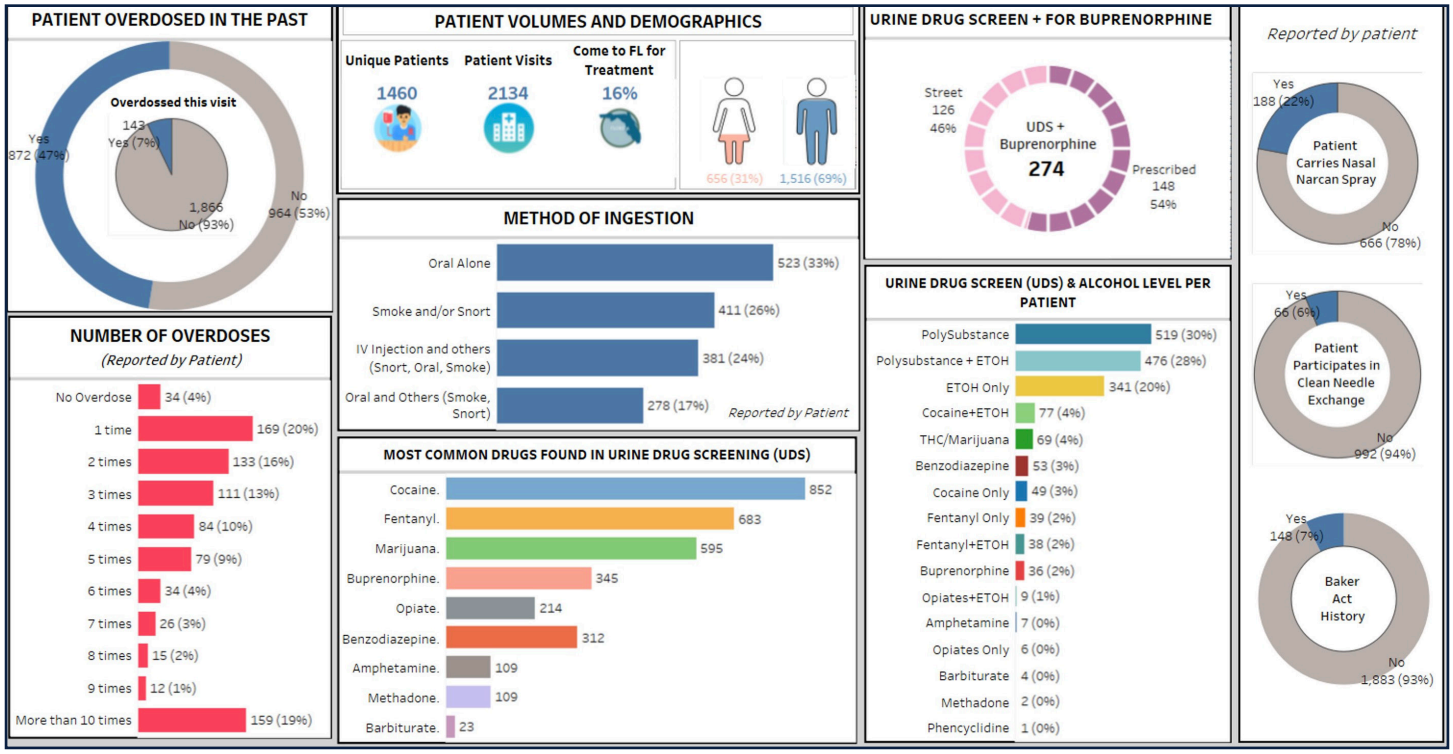
**RESOURCES:**
**BRIEF ADDICTION MONITOR TOOL**

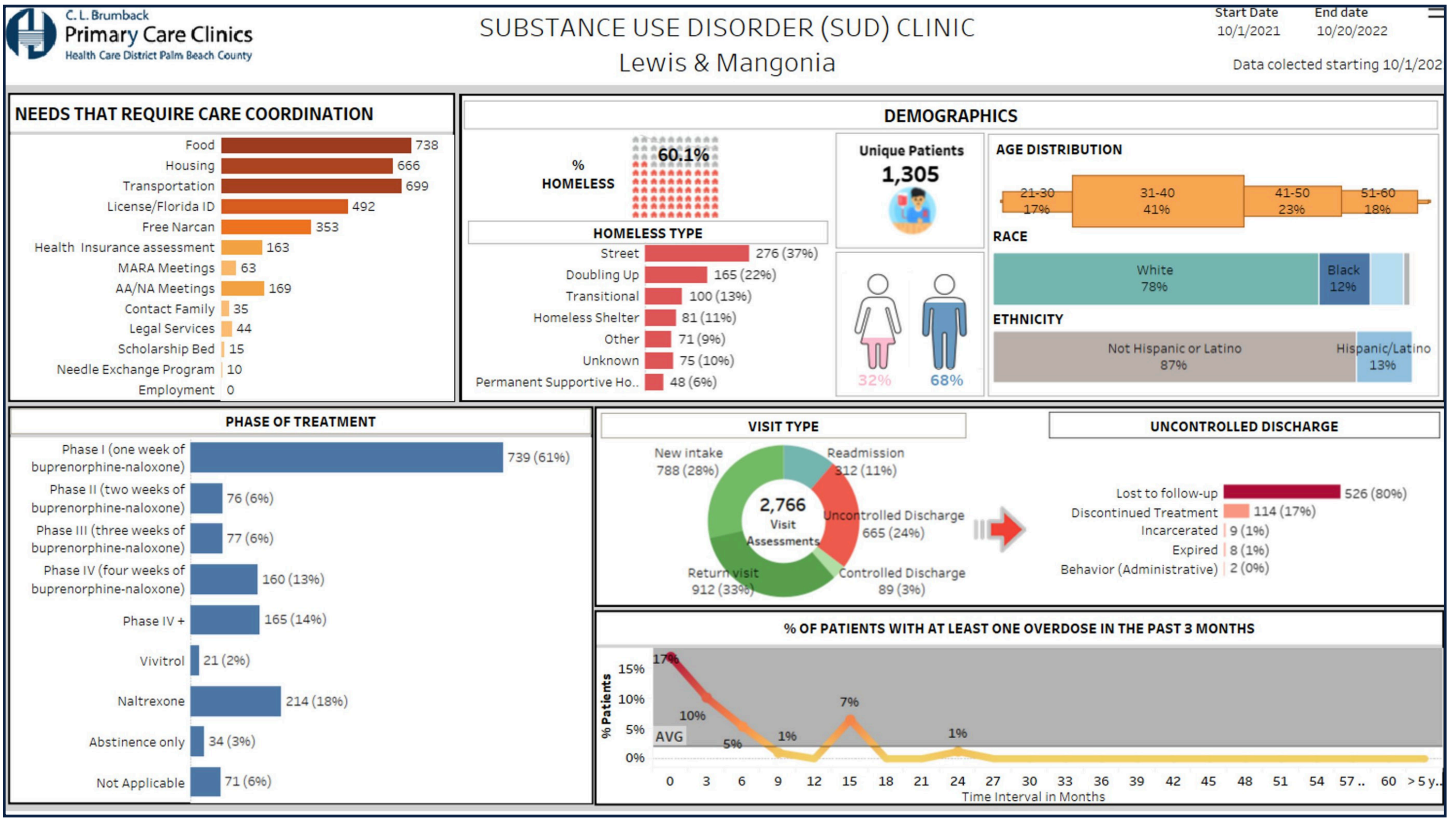
**RESOURCES:**
**DEVELOPMENT AND INITIAL EVALUATION**

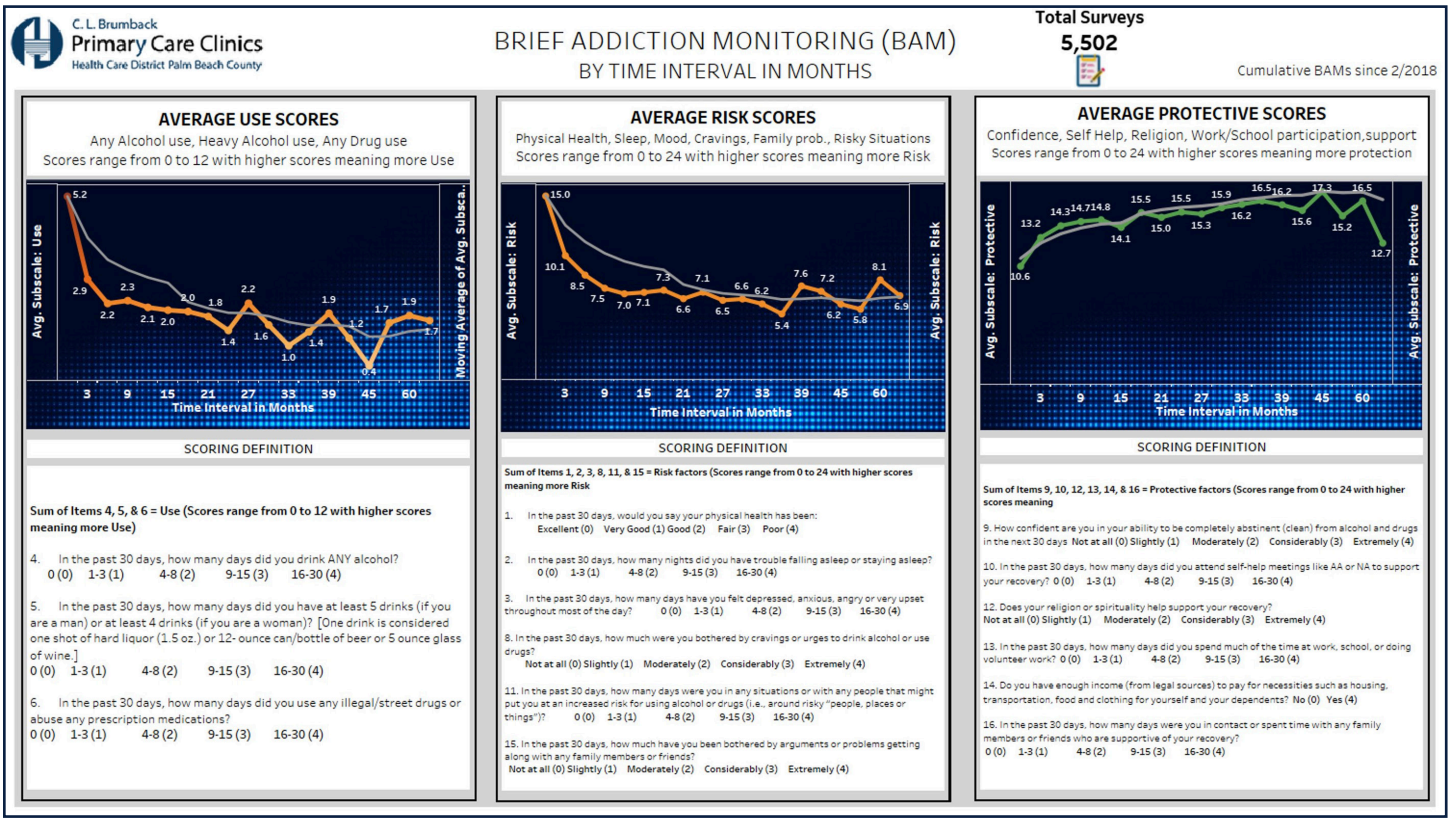
**RESOURCES:**
**AMNET ON TOOL AS METRIC (2021)**

### Examples of Palm Beach BAM Dashboard




C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County
SUBSTANCE USE DISORDER (SUD) CLINIC
Lewis & Mangonia
Start Date 10/1/2021
End date 10/20/2022
Data colected starting 10/1/202
NEEDS THAT REQUIRE CARE COORDINATION
Food 738
Housing 666
Transportation 699
License/Florida ID 492
Free Narcan 353
Health Insurance assessment 163
MARA Meetings 63
AA/NA Meetings 169
Contact Family 35
Legal Services 44
Scholarship Bed 15
Needle Exchange Program 10
Employment 0
DEMOGRAPHICS
% HOMELESS 60.1%
HOMELESS TYPE
Street 276 (37%)
Doubling Up 165 (22%)
Transitional 100 (13%)
Homeless Shelter 81 (11%)
Other 71 (9%)
Unknown 75 (10%)
Permanent Supportive Ho.. 48 (6%)
Unique Patients 1,305
32%
68%
AGE DISTRIBUTION
21-30 17%
31-40 41%
41-50 23%
51-60 18%
RACE
White 78%
Black 12%
ETHNICITY
Not Hispanic or Latino 87%
Hispanic/Latino 13%
PHASE OF TREATMENT
Phase I (one week of buprenorphine-naloxone) 739 (61%)
Phase II (two weeks of buprenorphine-naloxone) 76 (6%)
Phase III (three weeks of buprenorphine-naloxone) 77 (6%)
Phase IV (four weeks of buprenorphine-naloxone) 160 (13%)
Phase IV + 165 (14%)
Vivitrol 21 (2%)
Naltrexone 214 (18%)
Abstinence only 34 (3%)
Not Applicable 71 (6%)
VISIT TYPE
New intake 788 (28%)
Readmission 312 (11%)
2,766 Visit Assessments
Uncontrolled Discharge 665 (24%)
Return Visit 912 (33%)
Controlled Discharge 89 (3%)
UNCONTROLLED DISCHARGE
Lost to follow-up 526 (80%)
Discontinued Treatment 114 (17%)
Incarcerated 9 (1%)
Expired 8 (1%)
Behavior (Administrative) 2 (0%)
% OF PATIENTS WITH AT LEAST ONE OVERDOSE IN THE PAST 3 MONTHS
% Patients
AVG
Time Interval in Months


C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County
BRIEF ADDICTION MONITORING (BAM)
BY TIME INTERVAL IN MONTHS
Total Surveys 5,502
Cumulative BAMs since 2/2018
AVERAGE USE SCORES
Any Alcohol use, Heavy Alcohol use, Any Drug use
Scores range from 0 to 12 with higher scores meaning more Use
Avg. Subscale: Use
Moving Average of Avg. Subsca..
Time Interval in Months
SCORING DEFINITION
Sum of Items 4, 5, & 6 = Use (Scores range from 0 to 12 with higher scores meaning more Use)
4. In the past 30 days, how many days did you drink ANY alcohol?
0 (0) 1-3 (1) 4-8 (2) 9-15 (3) 16-30 (4)
5. In the past 30 days, how many days did you have at least 5 drinks (if you are a man) or at least 4 drinks (if you are a woman)? [One drink is considered one shot of hard liquor (1.5 oz.) or 12- ounce can/bottle of beer or 5 ounce glass of wine.]
0 (0) 1-3 (1) 4-8 (2) 9-15 (3) 16-30 (4)
6. In the past 30 days, how many days did you use any illegal/street drugs or abuse any prescription medications?
0 (0) 1-3 (1) 4-8 (2) 9-15 (3) 16-30 (4)
AVERAGE RISK SCORES
Physical Health, Sleep, Mood, Cravings, Family prob., Risky Situations
Scores range from 0 to 24 with higher scores meaning more Risk
Avg. Subscale: Risk
Time Interval in Months
SCORING DEFINITION
Sum of Items 1, 2, 3, 8, 11, & 15 = Risk factors (Scores range from 0 to 24 with higher scores meaning more Risk
1. In the past 30 days, would you say your physical health has been:
Excellent (0) Very Good (1) Good (2) Fair (3) Poor (4)
2. In the past 30 days, how many nights did you have trouble falling asleep or staying asleep?
0 (0) 1-3 (1) 4-8 (2) 9-15 (3) 16-30 (4)
3. In the past 30 days, how many days have you felt depressed, anxious, angry or very upset throughout most of the day? 0 (0) 1-3 (1) 4-8 (2) 9-15 (3) 16-30 (4)
8. In the past 30 days, how much were you bothered by cravings or urges to drink alcohol or use drugs?
Not at all (0) Slightly (1) Moderately (2) Considerably (3) Extremely (4)
11. In the past 30 days, how many days were you in any situations or with any people that might put you at an increased risk for using alcohol or drugs (i.e., around risky "people, places or things")? 0 (0) 1-3 (1) 4-8 (2) 9-15 (3) 16-30 (4)
15. In the past 30 days, how much have you been bothered by arguments or problems getting along with any family members or friends?
Not at all (0) Slightly (1) Moderately (2) Considerably (3) Extremely (4)
AVERAGE PROTECTIVE SCORES
Confidence, Self Help, Religion, Work/School participation,support
Scores range from 0 to 24 with higher scores meaning more protection
Avg. Subscale: Protective
Time Interval in Months
SCORING DEFINITION
Sum of Items 9, 10, 12, 13, 14, & 16 = Protective factors (Scores range from 0 to 24 with higher scores meaning
9. How confident are you in your ability to be completely abstinent (clean) from alcohol and drugs in the next 30 days Not at all (0) Slightly (1) Moderately (2) Considerably (3) Extremely (4)
10. In the past 30 days, how many days did you attend self-help meetings like AA or NA to support your recovery? 0 (0) 1-3 (1) 4-8 (2) 9-15 (3) 16-30 (4)
12. Does your religion or spirituality help support your recovery?
Not at all (0) Slightly (1) Moderately (2) Considerably (3) Extremely (4)
13. In the past 30 days, how many days did you spend much of the time at work, school, or doing volunteer work? 0 (0) 1-3 (1) 4-8 (2) 9-15 (3) 16-30 (4)
14. Do you have enough income (from legal sources) to pay for necessities such as housing, transportation, food and clothing for yourself and your dependents? No (0) Yes (4)
16. In the past 30 days, how many days were you in contact or spent time with any family members or friends who are supportive of your recovery?
0 (0) 1-3 (1) 4-8 (2) 9-15 (3) 16-30 (4)

## DISCHARGE AND TRANSFER CRITERIA PROCEDURE - SUBSTANCE USE DISORDER PROGRAM

**Definitions**

- **Discharge** - Discharges occur when patients complete services or leave the provider prior to completion of services.
- **Transfer** - Transfers occur when patients move from one component to another within the same provider or move one provider to another.
- **Primary Counselor** - Employee who is part of the clinical staff and who has primary responsibility for delivering and coordinating clinical services for specific patients.

**Procedure**

Patients in the SUD program may leave the program for the following reasons:

1. **Patient Completed Treatment** - When a patient has achieved the maximum benefit from treatment and no longer requires continued treatment to maintain a drug-free lifestyle.
2. **Patient Referred/Transferred to a Higher Level of Care** - When a patient is not progressing satisfactorily and/or requires treatment that is beyond what the SUD clinic is able to provide.
3. **Patient Relocated** - When a patient has moved to a location that makes them unable to participate in the SUD clinic. Efforts will be made to link patient to care within the area the patient is relocating.
4. **Patient Discontinued Treatment** - When a patient voluntarily leaves the SUD clinic for any reason and will not be participating any longer.
5. **Patient no Longer Available for Treatment** - When a patient is consistently non-compliant in attending scheduled SUD clinic related appointments.
6. **Patient Behavior** - Behavior that significantly compromises the safety of other patients or is considered illegal.

To provide safe and effective care to the patients in the SUD clinic, the patient is responsible for adhering to the program requirements. If the patient is non adherent with any of the expectations, the patient is at risk for being discharged from the program or referred/transferred to a higher level of care if necessary. Patients who meet the criteria for discharge, will have their case reviewed by the program provider and behavioral health team prior to the decision being made. Patients may also be discharged voluntarily from the program. It is important to convey to patients that he/she can always be readmitted at any time if this level of care is appropriate with no cap on the number of admissions as long as the patient is not discharged from clinic services due to a significant behavioral incident compromising the safety of other patients and staff.

A discharge summary will be completed for patients who complete treatment or who leave prior to completion of treatment. The summary will include a summary of the patient's involvement in treatment and the reason for discharge and the provisions of other services needed by the patient following discharge, including aftercare. The discharge summary will be signed and dated by a primary counselor.

A transfer summary will be completed for patients who transfer from one component to another within the same provider and shall be completed within five calendar days when transferring from one provider to another. In all cases, an entry will be made in the patient's chart regarding the circumstances surrounding the transfer and that entry and transfer summary will be signed and dated by a primary counselor.

Upon discharge for any reason, staff will ask for the patient's verbal consent to contact them in 30 days via phone or mail to follow up on the patient's health status. The patient's verbal consent or declination will be documented in the chart. If a patient verbally consents, they will be placed on a recall list to track contact. Patients will also be provided with appropriate referrals if necessary.

7. **Completed Treatment** (Program Completed)

   For patients who are enrolled in the MAT program, current recommendations (per treatment improvement protocols series 40- TIP 40) suggest that a taper should not be initiated for patients until at least 1 year of stability is achieved in the following areas: substance use, psychiatric wellness, medical wellness, and psychosocial determinants. The provider and patient may decide to maintain a dose of suboxone longer than 1 year if that is a more appropriate recommendation. Prior to tapering, the program provider will discuss the risks and benefits of the taper with the patient and document education and agreement to taper in the electronic health record (EHR).

   If the patient has achieved these goals and the provider and patient proceed with the tapering of suboxone, it should be done during a minimum four week taper duration, following the program provider's recommended tapering schedule. If during the taper, the program provider and the patient determine that the taper should be held or reversed, the patient will remain in treatment until deemed appropriate to resume taper. Treatment is considered completed when a patient has tapered off of suboxone, complete withdrawal from suboxone has occurred as indicated by a negative urine drug screen result, and patient has a zero COWS score.

8. **Referred/Transfered to Higher Level or Equivalent Level of Care**

   Referral/transfer to higher level of care may occur when a patient does not meet the ASAM Level 1 Outpatient Criteria and it is beneficial for the patient to be referred/transferred to a higher level of care. Also, the patient may be transferred if they are unable to adhere to the requirements of the program, despite the program's attempts over a sufficient period of time, to maximize dose prescribed and address factors contributing to patient's non-adherence (psychosocial, medical, psychiatric, etc.). Appropriate referrals will be initiated by the program provider and documented in the EHR.

9. **Patient Relocated**

   See definition above.

10. **Patient Discontinued Treatment**

    If a patient decides to voluntarily discontinue treatment in the program (dropped out voluntarily and were consented on risk), the risks of early termination will be discussed with the patient and they will be asked to sign the *Refusal of Care and Treatment - Against Medical Advice (AMA)* form prior to discharge if the patient's decision does not comply with the program provider's recommended treatment. Alternative treatment options will be discussed with the patient at this time.

11. **Patient no Longer Available for Treatment** (lost to follow-up)

    The patient under this discharge plan would be a 'no-show' for appointments or unable to be contacted by clinic staff, which would classify them as unavailable for treatment.

    **No show for appointments**: Patients are expected to keep their appointments in the program and inform staff, prior to the appointment, if they will be unable to show as scheduled. If after 14 days a patient has had no contact with the clinic and has not been to the clinic for their appointment(s), the patient will be discharged from the program and a letter sent informing them of the decision.

    If the patient has had contact with the clinic but has not been to the clinic for any appointments in 30 days, the patient will be discharged from the program and a letter sent informing them of the decision. If contact is made after the discharge, they may be considered for readmission, if appropriate. Staff will make every attempt to contact the patient if an appointment is missed and document each attempt in the patient's chart. It is required that staff make three attempts (two phone calls and one letter) to reach the patient when an appointment is missed.

12. **Patient Behavior** (Administrative)

    If a patient is exhibiting behavior that is considered illegal or endangers the safety of other patients and staff, an incident report will be completed following program policies and procedures. The program provider and behavioral health team will review the behavior as well as follow procedures in place to determine whether the patient will be discharged.

13. **Readmission to Program**

    Patients may be considered for readmission into the SUD clinic after they are previously discharged and substance use outpatient treatment is still indicated. Prior to readmission, the program provider and the behavioral health team will review the patient's records, circumstances under which they discontinued treatment from the program, and the patient's current situation, prior to making a decision regarding readmission into the program. The patient will be required to sign all consents upon readmission.

    If there is no availability for the patient to re-enter the program at the time they are requesting, the patient will be given referrals to appropriate resources to assist with their treatment.

14. **Expired**

    Patient deceased during treatment. This will need to be documented as an incident.

15. **Incarcerated**

    Patient was taken into the legal system during treatment.

# DATA EXPECTATIONS AND REPORTING

## DATA BOOK FOR EMS, ED, OR 24-7 ACCESS POINT, AND RECEIVING CLINICS

### CORE REPORTING - FREQUENTLY ASKED QUESTIONS

**When it states "total encounters" does that mean just with the MAT provider or with all parts of the system (counseling, care coordination, peer support, and community paramedics)?**
All parts of the system.

**RESOURCES:**
**DATA BOOK FOR REPORTING IN CORE**

**Does unique patient mean new patient and/or new episode of care patient?**
It means non duplicated patients.

**Do you also want unique patients counted who do not arrive through the 24/7 access point. We receive referrals from community partners, walk-ins, etc.**
Yes.

**Are each reporting period cumulative, would this be a cumulative number each reporting period?**
Yes.

**Does it have to be reported biweekly?**
We are requesting biweekly reporting.

**Where are the data sources coming from to report the data that's put into ClearPoint?**

Emergency Medical Services Source of Data:

- EMSTARS/centralized - EMS data was provided by DOH's EMSTARS data team monthly to upload and report in ClearPoint for each CORE EMS partner.

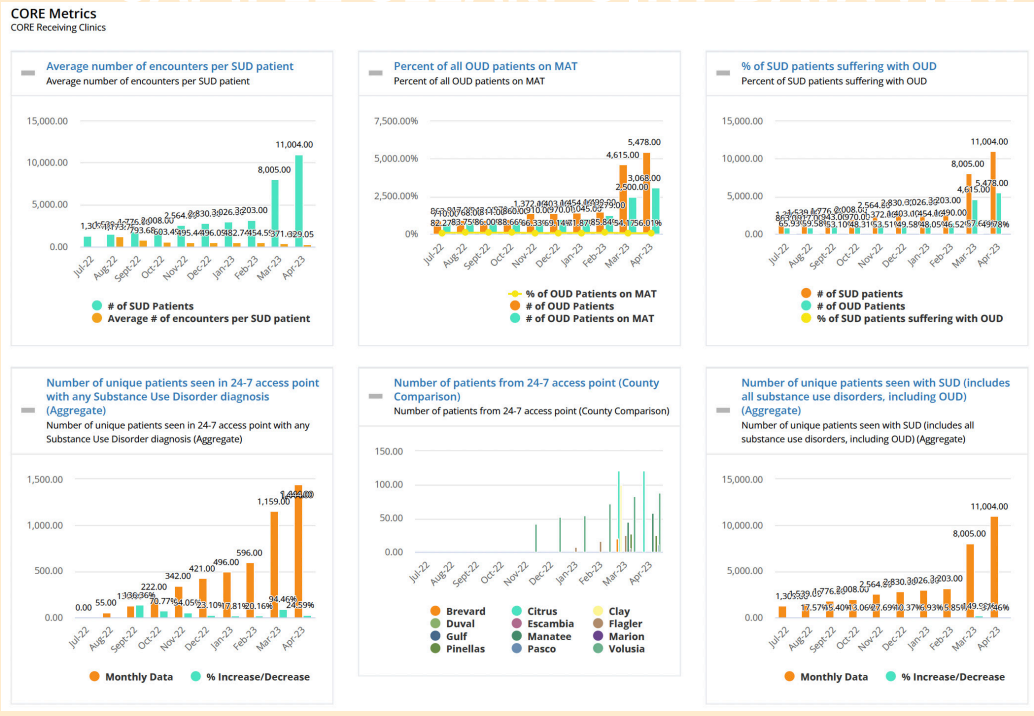
Emergency Department / 24-7 Access Point Source of Data:

- Electronic medical record(s) system.

Receiving Clinic Source of Data:

- Electronic medical record(s) system.
- Intake Form.
- BAM:
  - Data provided - chart will auto-populate as data is entered in the spreadsheet.

SAMPLE CLEARPOINT DATA VIEW



# SUMMARY OF CORE NETWORK PILOT

## DISCUSSION AND CONCLUSION OF THE CORE NETWORK PILOT

**Successes**

- Coordinating and streamlining medical and behavioral health agencies by breaking down silos and providing state and local interagency cooperation.
- Opportunity to standardize evidence-based substance use disorder treatment in Florida, regardless of an individual's ability to pay.
- Provided hands-on training opportunities that strengthened outcomes.
- Improved communication and coordination to create a hybrid network of information sharing.
- Developed expected outcomes data that reflect CORE's impact on morbidity and mortality, for sustainability and additional data points that can be used to reflect validity and effectiveness as the program matures.
- Decreasing the stigma by normalizing the needs of the community and raising awareness of addiction treatment as any other chronic illnesses, such as diabetes.

**Lessons Learned**

- Set reporting expectations and training earlier in the process while simultaneously developing the statement of work for the contracts.
- Identify subject matter experts in addiction medicine, EMS, emergency medicine, data analyst, grant administration, and communication staff to support stakeholders. Staff should be identified prior to engaging with service providers.
- Individualized meetings and trainings are best to facilitate needs, guide specific requirements, and manage expectations for fulfillment of SOW obligations.
- Creating objective benchmarks for goal setting can streamline the reporting process and increase communication.
- Once essential CORE components are in place, additional components can be evaluated and potentially integrated.

**Future Considerations to Enhance the CORE Network**

- Competent care for adolescents with addiction (>16 offered MAT and specialty therapy for families and adolescents with addiction, as well as higher level of care for adolescents).
- Coordination with drug courts and criminal justice system.
- Prehospital buprenorphine induction by EMS.
- Contingency management.
- Benchmarking data with national American Psychiatric Association to assist in the standardization of treatment.
- Require MAT services for alcohol use disorders in CORE including naltrexone, vivitrol, acamprosate, and disulfiram to treat alcohol use disorder.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