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RURAL OPIOID PROGRAM
FAMILY MEDICAL CENTER

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This project is part of a $45 million State Innovation Model (SIM) cooperative agreement awarded to the Minnesota Departments of Health & Human Services in 2013 by the Center for Medicare & Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.

INTRODUCTION

We hope that you find this manual helpful. At this time, the opioid epidemic is a public emergency and communities, clinics and hospitals need to work together to implement programs like ours in an effort to decrease the staggering number of deaths our country is experiencing. One can continue to be alarmed by the epidemic and its devastating effects on families, but taking action and participating in the solution with a comprehensive plan that both addresses prescribing and dosing practices as well as the treatment of opioid addiction is, in our opinion, the only way to achieve the desired decline in deaths. We have spent the last three years refining our program while thoroughly documenting the process in hopes that others would consider implementing it in their communities as well. The largest hurdle we need to overcome as a society is the prevailing individual bias against people with addiction and the stigma that fuels it.

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ABOUT THE AUTHORS

In 2012, Dr. Heather Bell began her family medicine practice in rural MN. With her visionary leadership, Dr. Bell has been influential in redesigning the primary care delivery model across the clinic by adopting whole person centered care and instituting guiding principles which led to the clinic earning recognition by the state of Minnesota as a Medical Home. As an emancipated minor, Dr. Bell's childhood brought many challenges. Losing a mother as an early teen and coping through family chemical abuse and addiction instilled the strength of perseverance, courage and desire to make a difference through the practice of medicine. As opioid use and related issues became increasingly apparent, Dr. Bell identified that the whole-person care approach of the medical home model was most appropriate for re-engineering the approaches to care.

Dr. Heather Bell, MD

Dr. Bell became very active in the Controlled Substance Care Team within the clinic setting and recently introduced medication-assisted addiction treatment using buprenorphine as part of her primary care practice. Her leadership and perseverance are transforming the clinic practice, demonstrating success in both cost savings and patient care outcomes.

Education:
Gustavus Adolphus College, 2009 – BA Biology/English, Magna Cum Laude
University of MN School of Medicine – Medical Degree, 2009

Residency:
Sioux Falls Family Practice Center Program, 2012

Licensure:
State Medical License: MN 53537 Date issued: 11/13/2010

Certification:
American Board of Family Medicine
Certified: 2012

ABOUT THE AUTHORS

Kurt DeVine, MD

Dr. Kurt Devine has been a full spectrum family medicine physician for more than 26 years. As a practicing physician in Rural Minnesota, he has faced many unique challenges caring for patients in the primary care setting amid evolving care delivery models demanding forward-thinking and creative strategies for change. As opioid use and its attributing issues became increasingly apparent, he became more engaged and involved with the local community task force assembled to address concerns of opioid use and dependency within the county. He quickly discovered the importance of guiding change with a strong provider champion and building impactful community partnerships. His leadership has enabled grant funding to be put to practical use, demonstrating positive outcomes both financially and from a patient care perspective.

Recently, he has begun medication-assisted addiction treatment, introducing the use of buprenorphine as part of his primary care practice. As he continues to provide ongoing support and education to his colleagues, Dr. Devine has been a change agent, creating a culture shift within his practice. It is through his remarkable leadership that a small rural clinic has made significant progress related to the treatment of opioid misuse that is recognized across the country.

Medical/Professional Education:
St. John's University, Collegeville, MN 1983, BS, Biology
University of MN, 1987, MD

Residency:
Sioux Falls Family Practice Center Program, 1990

Licensure:
State Medical license: MN 33505 Date issued: 5/05/1990

Certification:
American Board of Family Medicine
Certified: 1990

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HISTORY

Understanding the history of events that led to the current opioid epidemic is important, although it does not help solve the problem. In 1986 Dr. Portenoy co-wrote a paper discussing opioids in the treatment of 38 patients with chronic non-malignant pain. From this study, in which six patients were maintained longer than seven years, he stated, "We conclude that opioid maintenance therapy can be safe, salutary and a more humane alternative to the options of surgery or no treatment in those patients with intractable non-malignant pain and no history of drug abuse" (Portenoy & Foley, 1986). The reality was the paper looked at few patients, very low doses (usually <20mEq of morphine) and, as such, "Few substantial gains in employment or social function could be attributed to the institution of opioid therapy" (Portenoy & Foley, 1986).

It would not be until ten years later that Dr. James Campbell, president of the American Pain Society, gave a speech that labeled pain as the fifth vital sign stating: "If pain were accessed with the same zeal as other vital signs, it would have a much better chance of being treated properly" (Neilson, 2016). Coincidentally, it was the same year (1996) that Purdue Pharma released OxyContin. Several medical organizations, including the Joint Commission for Accreditation of Healthcare Organizations (JCAHO or now The Joint Commission or TJC), American Pain Foundation, and the Veterans Health Administration, all followed suit by adopting pain as the fifth vital sign. Drug representatives suggested that a mere 1% of patients had the potential to become addicted to narcotic pain medications. They quoted the *New England Journal of Medicine* article by Porter and Jick (Porter & Jick, 1980), as well as another article by Perry and Heidrich in *Pain* (Perry & Heidrich, 1982). The cited studies, however, were based on patients in the hospital receiving the medications for acute pain, not daily long-term chronic use. This 1% statistic was then used by Purdue Pharma in its marketing of OxyContin. Aside from Purdue Pharma using this information to sell OxyContin, pain specialists and teaching seminars exploited this information as "evidence" of the low risk of addiction. What they chose to ignore, however, were the

numerous studies, summarized in a paper by VanZee entitled *The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy,* that showed addiction rates from 3-43% in patients using narcotic pain medications chronically (VanZee, 2009).

The push for prescribers to treat pain increased in the years that followed. By 1998, the Federation of State Medical Boards "recommended" policy stated that doctors would not face disciplinary action for prescribing even large amounts of narcotics for chronic pain. TJC published a prescribing guide for doctors, paid for by Purdue Pharma, that stated "some clinicians have inaccurate and exaggerated concerns" about addiction, tolerance and risk of death. "This attitude prevails despite the fact there is no evidence that addiction is a significant issue when persons are given opioids for pain control" (JCAHO, 2001). Prescribing opioids accelerated in 2004, when the Federation of State Medical Boards began to hold physicians accountable for under-treating a patient's pain. Ironically, the Federation of State Medical Boards received nearly $2 million in funding from Purdue Pharma and other narcotic manufacturers. Minnesota followed suit releasing the following statement by the Controlled Substance Work Group on November 10, 2007: "Untreated pain or under-treated pain is as serious a departure from the standard of care, and as serious a violation of the Minnesota Medical Practice Act as is excessive prescribing of controlled substances or prescribing of controlled substances for non-therapeutic purposes" (Group, 2007). This statement is in stark contrast to a recent publication by the Centers for Disease Control and Prevention (CDC) released in March 2016:

> No evidence shows a long-term benefit of opioids in pain and function versus no opioids for chronic pain with outcomes examined at least one year; extensive evidence shows the possible harms of opioids (including opioid use disorder, overdose, and motor-vehicle injury); and extensive evidence suggests some benefits of non-pharmacologic and non-opioid pharmacologic treatments compared with long-term opioid therapy, with less harm (CDC, 2016).

In just 10 years, the consensus and guidelines changed dramatically thanks to staggering and overwhelming statistics. According to the *Pain Physicians Journal,* in 2010 the U.S. has 4.6% of the world's population, yet has 80% of the world's opioid consumption and 99% of the world's hydrocodone consumption (Fellows, Ailinani, Manchikanti, & Pampati, 2010). In Minnesota (MN Department of Health statistics) alone in 2000, there were 23 opioid deaths compared to 317 in 2014. In 2013, national opioid overdose deaths surpassed car accidents as the leading cause of accidental deaths, with an average of one person in the U.S. dying every 20 minutes.

It became the perfect storm illustrated by physicians and other providers being strongly encouraged to aggressively treat pain, while heavy marketing by profit- seeking narcotic producers targeting providers with less-than-accurate statistics regarding addiction and other risks. Our community, like virtually every other community, was being negatively affected by the overprescribing of opioids, the diversion of such medications, and an increasing number of patients becoming addicted to opioids including heroin. Inadequate and misinterpreted studies and questionable data ushered us into an opioid epidemic that would take the lives of thousands of U.S. citizens.

The rapidly changing stance of the MN State Board of Medical Examiners together with the CDC guidelines released in March of 2016, require us to not only quickly, but efficiently change prescribing practices for the medico-legal safety of physicians as well as the safety of the population as a whole. Through this manual, we hope to accomplish two objectives: 1) show an easy-to-use process to cut back overprescribing practices though community collaboration and aggressive patient monitoring and management; and 2) illustrate our approach in treating those already addicted to opioids.

PHYSICIAN CULTURE

Our facility, like many others, is made up of physicians from multiple generations which can, at times, make implementing change more difficult. There are different schools of thought in regard to narcotics and how chronic pain is treated. Physicians who were practicing when the state boards emphasized pain as the fifth vital sign and urged pain to be treated aggressively with narcotics appear to be more generous with their prescribing. Physicians, and other prescribers, who went through training later, appear to be more receptive to closer monitoring and limiting the prescriptions of narcotics. In our practice, it took a gentle, less-confrontational approach to improve prescribing habits. Continuing education using memos, newsletters, talks at physician meetings, and emphasizing the framework of the CDC guidelines helped shift our local physician culture. Prescribers were educated with a consistent message about the guidelines, both in regard to the amount of narcotics prescribed, as well as the dangers in the concurrent use of narcotics with other medications such as benzodiazepines.

Physicians' primary concerns revolved around whether or not this program would slow them down, cause additional work, or add additional time. They were uncomfortable with others "watching" their patients and charts. By prescribers giving up some control, more was accomplished as the majority of the work fell to the care coordinator RN and/or the social worker. The nurse or social worker would go through the care plan and get forms signed with each patient, ensuring all were kept up to date. This alleviated any extra work being forced upon by the primary care provider. The care team social worker and RN were also typically the ones who watched and monitored the Prescription Drug Monitoring Program (PDMP) at the initiation of the care plan. Later, the PDMP was monitored by the clinic nurse. Physician "buy-in" was slowly altered by showing the physicians that the "extra work" was not going to fall on them. Along with getting care plans completed for patients on controlled substances, another priority was initiating and enforcing urine drug screens (UDAS) and pill counts. Random urine drug screens and pill counts were ordered by the care team RN and performed by an injection room nurse.

This also allowed less work for the physician, while maintaining uniform screening. The care team RN was then responsible for ordering any and all confirmatory testing to be run on the urine results as well as aiding in the interpretation of the results. The care team physicians would also review urine testing and use the flow sheet to interpret results (Appendix A), ensuring the primary physicians were understanding the results and acting accordingly. Prior to the development of this workflow, there were many instances where UDAS testing was misinterpreted in regard to urine metabolites and results.

Despite relieving the work of the providers, it was still some time before uniform physician buy-in took place. Many felt the care team was using a "Big Brother" approach, which some physicians tried to avoid by "protecting" their patients, rather than letting the care team get too involved. Changes in attitudes came with unexpected abnormal urine testing results. Several situations involved patients that were extremely trusted by their physician thus enlightening physicians to uniform monitoring. Uniform monitoring is important as there is no single identifying profile to determine which patients are trustworthy and which are diverting or using other illicit substances. As an example, in one situation we found an elderly lady who would bake cakes for her provider only to later discover she was selling her narcotics to supplement her Social Security check. An untimely overdose death in the community also made physicians acutely aware of the true severity and prevalence of the issue.

We believed it would not be advantageous to have prescriber mandates, rather we continued to encourage compliance with the CDC guidelines. Along with active care plans and monitoring, changes also included improvement in provider documentation. Physicians and other prescribers were urged to maintain thorough documentation in accordance with the guidelines to avoid legal ramifications, especially if any deviation from the guidelines took place. We do foresee a time when a more formal guideline or mandate will be in place, especially with regard to morphine equivalents for non-cancer or end-of-life pain, but this we see as being a mere formality (eventually).

COMMUNITY COLLABORATION

The partners that you develop in your community bring different assets/skills/resources to the table. Whereas the clinic and hospital have information about the health of patients, the greater community representatives and their unique perspectives give additional insight into the severity of opioid-related issues. The information gathered can alter your perspective and guide where your treatment efforts should be focused.

Although the greater task force isn't working directly with patients to cut back on narcotic prescribing and elimination of medications, they are critical to the health and safety of the community. It is important to understand that HIPAA laws limit what information providers are able to give to anyone, including law enforcement. Law enforcement is able, however, to give direct feedback to the providers about patients and may notify providers about the possible abuse of medications and diversion. Providers are not able to provide patient-sensitive information back to law enforcement with the exception being knowledge of a crime being committed or issues surrounding vulnerable patients. Any clarification on what is or is not allowed should be first discussed with your clinic or hospital legal team.

Our Community Task Force Members, along with the roles they play are as follows:

- ***Law Enforcement:***
    - ***Little Falls Police Department and Morrison County Sheriff's Office:***
        - The Little Falls Police Department and Morrison County Sheriff's Office each have one local officer that attends our monthly meetings and alerts us to local trends in illegal drug use. Much of this information revolves around the types of substances most sought after or combinations of these medications. These task force members also empty prescription

drop boxes in the community and transport unused medications for incineration. Drug "take back" days and other educational events are coordinated with this officer. Finally, private communication with the physician champions also takes place when suspicious drug activity exists or diversion is encountered. This allows physicians to more closely monitor those individuals.

- ***Little Falls School District and Stand Up 4U Coalition:***
    - The school district has a Drug-Free Communities grant, which provides funding to oversee prevention activities through the **Stand Up 4 U Coalition.** The activities of the coalition revolve around mentoring youth in making good choices and are promoted within the scheduled school day, and also included the formation of an Improv Troupe. The Troupe has been a vital part of community events, forums and service organization meetings, incorporating messages about the harmful effects of drug use, including prescription drug abuse. The Troupe also collaborates with the Task Force for "take-back" events, training opportunities and prevention efforts within the community.
- ***Coborn's Pharmacy****:*
    - Coborn's Pharmacy provides a pharmacy resident-on-site in the clinic to collaborate with the Controlled Substance Care Team and participate in face-to-face patient encounter consultations as needed. Coborn's was instrumental in starting and setting up the program and are now equally important with the maintenance of the community effort. The pharmacist collaborates with

providers ordering individual lab tests and aids in interpreting the results. The pharmacist also educates opioid patients, and/or family members, on the safe use of opioids as well as helps develop appropriate narcotic-tapering plans for individual patients. The pharmacy manager attends the monthly task force meetings to provide data and collaborates with the MN Board of Pharmacy on issues such as proper disposal and works with physicians to reduce early-refill requests by complying with new policies and procedures set forth by the Controlled Substance Care Team. When we started our Suboxone Program, they were a critical part of ensuring the availability of Buprenorphine products for our opioid-addicted patients. They have also helped streamline the prior-authorization process.

- ***Morrison County Attorney's Office:***
    - The Morrison County attorney updates the task force on activities with the Morrison County Drug Court, which has been in place for approximately two years. The county attorney's office attends monthly task force meetings and acts as the liaison between the task force and the Drug Court. It provides legal explanations on new policy development or other legal documentation and communicates with county commissioners as needed. The county attorney's narcotics prosecutor also attends meetings to gain insight on community resources and programs that may further help those with prescription drug crimes and also advise the court on other possible solutions for offenders, other than the continuous cycle of jail and probation.

- ***Morrison County Social Services :***
    - This agency contracts with CHI St. Gabriel's Health to provide a social worker as a member of the Controlled Substance Care Team. The social worker's primary role is to provide information on county resources as well as to set up referrals to these resources by meeting with and assessing the social needs of individual patients.
- ***CHI St. Gabriel's Health:***
    - ***CHI St. Gabriel's Health Foundation:*** All grants and funding through philanthropic means are conducted through the foundation. This financial sourcing is instrumental in launching and continuing the program's activities. The foundation also plays a key role in relationship-building with both existing and potential community partners, and bringing the community together for local task force meetings.
    - ***Family Medical Center:*** The predominant primary care medical community (physician practice) within Morrison County is the Family Medical Center, which has locations in Little Falls, Pierz and Randall. The clinic is a recognized medical home, and this patient-centered care model, is championed by Dr. Heather Bell. The patient-centered approach to care was instrumental in the design of the Controlled Substance Care Team (CSCT). As champions of the CSCT, Dr. Kurt Devine and Dr. Heather Bell have led the practice transformation for opioid prescribing within Morrison County. The CSCT has developed best-practice recommendations, clinic policy and procedures, and case review with care recommendations, in collaboration with physicians and advanced clinical practitioners. The entire CSCT are members of the community task force and are active in promoting similar programs or activities to other communities.

- ***CHI St. Gabriel's Health:*** Numerous staff members are involved in the task force, including the Director of Quality, the Pharmacy Director and the Emergency Department Director. The majority of these representatives' involvement is to provide the task force with information regarding emergency department (ED) trends concerning narcotic use. The director of the hospital pharmacy can assess if diversion is occurring within the hospital setting. The ED director has been instrumental in decreasing opioid prescriptions originating in the emergency department. He alerted the group at the start that opioids were an issue after noticing in 2014 that the number one reason for emergency department visits at CHI St. Gabriel's was drug-seeking behavior (for chronic pain). This diagnosis is no longer in the top 20.

- ***Morrison County Public Health:***
  - The public health director attends the project leadership meetings and also the monthly county task force meetings to collaborate with both groups and report progress to county commissioners. The director incorporates the work within the Community Health Needs Assessment (CHNA) strategies as substance abuse has been an area of focus for the last two community health needs assessments. Public health helps identify available county resources and reports feedback on funding needs to county commissioners. The public health director is also involved in prevention strategies concerning substance abuse and educates on abuse and mental health in the community.

- ***St. Otto's Care Center***:
    - This long-term care facility provides a social worker for the task force and provides updates on the use and/or misuse of narcotics among the senior population.
- ***Horizon Health Services****:*
    - The agency's representative informs task force members on the current status of the agency's assisted-living facilities. It also provide home health and hospice services. They have educated the task force on the disposal of controlled substances and risk for diversion at end-of-life situations.
- ***CHI Health at Home:***
    - CHI St. Gabriel's Health owns a full-service home health and hospice program. CHI Health and Home has addressed the safe disposal of unused medications upon the time of death of hospice patients. Policies were written and approved to ensure that high-strength pain medications are disposed of at the time of death and the sheriff's office is informed if family members are not willing to dispose of narcotics. The home-health representative attends monthly task force meetings to collaborate and inform staff of safe and appropriate use of narcotics in the home health and hospice settings.
- ***Northern Pines Mental Health Center:***
    - A certified behavioral health home, this partner was added in 2016 to address the mental health and behavioral health needs of opioid users. A behavioral health coordinator from Northern Pines was added to the Controlled Substance Care Team

to assist with patients using medication-assisted treatment for their prescription drug or heroin addiction. The representative develops other community partnerships in the area of chemical dependency.

THE ROLE OF THE CONTROLLED SUBSTANCE CARE TEAM

It is our belief that education plays the most important role in addressing the opioid epidemic. The Controlled Substance Care Team (CSCT) was formed out of the county task force from within the clinic to address the problem from the source, the inappropriate and overprescribing of narcotic medications. A community can do a lot to combat deaths such as getting patients to treatment as well as giving out Narcan, but those are only reactions to the problem. All of the other tools such as Narcan, Suboxone and treatment facilities that we use to combat this crisis are reactionary and their use can be greatly diminished by addressing, and limiting, the narcotics coming out of the clinics. It is our hope that by limiting the prescribing, we can curtail the eventual dependence and addiction to opioids and subsequent transition to heroin. Encouraging responsible prescribing and appropriate monitoring of patients is a main goal, but the primary focus always needs to be to care for each individual patient's medical as well as social needs. The CSCT is modeled after the Patient Centered Medical Home concept, thus placing the individual patient's needs and safety as the emphasis. This is addressed by monitoring medications and getting patients access to any services they may need (such as social services or therapies). Our team and our recommendations rely on the CDC guidelines published in March of 2016 to help ensure patients receive appropriate and safe medication treatment.

METRICS

Monitoring progress, or lack of progress, is one of the initial things you need to do in order to justify additional resources set aside to combat this issue. Cost savings from this program will likely be found in many areas including, decreased ED visits for pain medications, decreased number of pills and office visits for medication refills, elimination of nursing time for early refills of narcotics and in the long term, reduced need for law enforcement. Tracking the specific cost differences can be done, but we have chosen to focus on numbers of pills prescribed as the indirect cost savings are more challenging to quantify. Our initial program was not set up as a research program, so our data focus was on numbers of pills and impact on numbers of ED visits related to opioid/narcotics abuse.

Data can be deciphered in a number of ways, internal data from your EHR numbers as well as external data through units leaving your local pharmacies. We started with a discussion with all local pharmacies to know how many controlled substances were being distributed; including narcotics, benzodiazepines and stimulant medications. Using your clinic's electronic health record (EHR), you should also determine how many patients you have that are on chronic pain medications and other controlled substances. Patients are considered chronic pain medication patients if they are on controlled substances for three consecutive months. This list can be further separated into those who have active care plans or pain contracts, those who have updated urine drug screens, and those with the highest morphine equivalents. Further dividing the "master list" into each doctor and prescriber is also recommended so each provider knows how many patients they have on controlled substances. Tracking patients who have been tapered down or off medications as well as quantities of their mediations is an important aspect as it allows you to gauge the success of your efforts and, in some cases, grant funding. For example, our program keeps track of how many pills have been eliminated in order to show ongoing progress. Once patients have been tapered off of their medications, or onto lower doses, they should continue to be tracked as you'll want to know how many fewer pills are being prescribed. In our

program, one data point found in our initial review was the number one reason to visit our emergency department was for pain and early refills. We elected to follow that metric to show program adherence as once patients had a care plan, they were not allowed to visit the ED for these reasons. The EHR list helps us prioritize our patients based on dosing and poly-pharmacy (using multiple pharmacies and providers for prescriptions). However, other patients may have priority and need to be addressed sooner than anticipated based on information from law enforcement, red flag behaviors, or pharmacy concerns. Focusing on and educating the high-prescribing providers in our group enabled us to impact more patients over a shorter period of time as those prescribers would apply the guidelines not just to the patients that we already met with but also other patients on their panel. This is a good strategy to start with, allowing for a more significant impact earlier on in your program.

GETTING STARTED

Our first goal is that every patient on a controlled substance will have an active care plan. In a perfect world, you would start at the top of the list and work your way through. In reality, however, on a daily basis, high-risk patients present themselves without warning. The most effective flow of the team isn't working slowly through the list, rather it is addressing the high-risk patients as they present and then working the list as they are able.

The ways in which these high-risk patients can present are variable. They can present as a dispute over early refills, making a scene at a pharmacy, from law enforcement concerns regarding misuse, or have a history of frequent ED visits. Law enforcement information will earn patients closer scrutiny, as will visits to the emergency department for overdose of medications. Patients with a history of drug-related crimes or history of overdose or incarceration will also be evaluated sooner and will be watched more closely. When higher-risk patients are identified by these situations, their names are given to our CSCT nurse coordinator for chart and case review. Our experience tells us that these patients end up frequently failing urine tests, pills counts or eventually breaking their care plans. Discovering diversion is not an unusual outcome in this group of patients.

We take special notice of patients who have combinations of medications and medical problems that increase their risk for respiratory depression and death. This includes opioids combined with benzodiazepines as well as chronic health problems including obesity, sleep apnea, asthma, and COPD. (Disclaimer: they are at increased risk if they are actually taking the medications they are prescribed).

WORKING THE LIST

Once your list is created, each patient will need to be evaluated individually. The nurse coordinator and/or social worker will get a thorough history from the patient during a scheduled visit, easily coordinated with a previously scheduled appointment. This should include past medication history, including all controlled substances as well as non-controlled substances both past and current. Substance abuse history including alcohol and cigarettes, marijuana and all illicit drugs, drug-related convictions and other convictions should be documented. PMP review, family history, diagnosis requiring controlled substances, ED visit history, and work history are also important factors during the intake. Particular attention should be placed on mental health history including previous medications, hospitalizations and treatments. It is helpful to have a pharmacist on your team to review medication interactions, side effects as well as alternative medications for specific diagnosis (migraines and fibromyalgia, etc.). Social media is a tool that can be used to "get to know" patients and their acquaintances. A lot of information can be gleamed by understanding a patient's social circle and what their friends are also doing/using. Using the CSCT Review form (Appendix B), helps keep this all organized. The social worker will often use an opioid risk calculator as well to get a baseline "risk" level. Our clinic employs the DIRE scoring system (Appendix C) with an additional "D" (DIRE-D) for distance (miles traveled to get to the clinic). DIRE-D stands for: Diagnosis, Intractability, Risk, Efficacy and Distance. See the next section for how and why this tool is applicable. Finally, in situations especially where addiction is a concern, a patient's ACE score (Adverse Childhood Experiences) will be calculated (Appendix D).

During weekly meetings, care team physicians review history of physical therapy, injections, imaging studies as well as other modalities that have been tried. Many times patients will have diagnosis or be on chronic pain medications for things that do not have any objective findings that require controlled substances. Low back pain without imaging studies to give a cause is one example. Patients

often have diagnosis for which pain medications are not indicated, (i.e., fibromyalgia and migraines). These diagnosis require time, education and other modalities, and these patients can be more of a challenge to educate. It is important to reassure these patients that you believe they have pain and are going to adjust their medications to address the causes of their pain. For example, medications such as triptans for migraines and pregabalin or duloxetine for fibromyalgia are important considerations. Not only are inappropriate diagnosis for pain medications identified during the intake portion, there are times where patients are discovered to be on medications chronically for acute diagnosis where the medications were just not stopped. This is especially true for benzodiazepines.

The team will review of any history of urine drug screens or pill counts that were previously done. Often, urine drug screens will be misinterpreted or confirmatory testing wasn't done. This is required information for basing medication management. See Appendix A for the urine drug screen diagrams. It is important to understand the metabolites as diversion can frequently be identified by the presence or absence of controlled substances. Also, urine drug screens will show other drugs of abuse. Presence of these substances will automatically disqualify a patient from being on a controlled substance. It is important to understand that failing a urine drug screen does not "fire" a patient from your practice. A 'non-punitive' approach is essential. When patients are found to be diverting, using other illicit substances, showing behaviors concerning for addiction, or when other things are discovered through the information gathering process, the next level of the medical home care team takes over. The social worker can help connect patients with services they qualify for, suggest referrals to mental health treatments or assess for chemical dependency needs. Caring for the whole patient involves discovering, assessing and meeting all the needs of the patient.

CARE TEAM AND ROLES

- Physicians
    - Review charts for appropriate evaluations of chronic pain patients to ensure thorough workup of the diagnosis has been done.
    - Review notes from consultations that have been obtained including specialty clinic evaluations.
    - Review appropriateness of prescribed medications and identify high-risk combinations and co-morbid conditions that may increase a patient's risk for respiratory depression and death.
    - Evaluate urine drug screens and confirmatory testing to ensure proper interpretation.
    - Make further recommendations in certain circumstances including gaining additional information such as old records, history with the department of corrections and other past workup in outside facilities.
    - Recommendations for further workup or referral.
    - Serve as liaison to law enforcement, receiving information they want to share.
    - Educate clinic physicians on the CDC guidelines and importance of adherence.
    - 1:1 physician conferences, if necessary, to discuss recommendations.
    - Chronic pain medication recommendations including tapering and discontinuation with justification.
    - Oversee the activities of the other team members, including daily questions and correspondence concerning new patient care plans and workups.
    - Review potential Suboxone patients and accept or decline.
    - Complete Appropriate Use Checklist for Suboxone patients (Appendix E).
    - Fill our DSM 5 Opioid Use Disorder Checklist for complete diagnosis (Appendix F).

- MAT using Buprenorphine/naloxone

- Care Coordinator
  - RN Navigator
    - Complete a personal interview with patients to build a patient history.
    - Review care plans (Appendix G), expectations, and goals with patients as well as obtain signatures, ROI (Appendix H, I). Renew care plans yearly or as needs change.
    - Develop a personal plan of care with each patient, one that is patient-centered. Assess each patient's strengths and needs, functionality and goals. Identify, plan, arrange, coordinate, implement services in accordance with clinic protocols, and assist with referrals to mental health, Rule 25 and County social worker that are within the Family Medical Center.
    - Maintain contact with patient, meeting face-to-face at minimum of one time per year, and have phone contact quarterly.
    - Assist with collection of urine drug screens per UDAS policy.
    - Track and provide data and patient informational stories for grant writing.
    - Attend training with the team to promote cohesion and continued program development.
    - Write and present presentations to public and other interested partners.
    - Provide support to clinic providers and patients on as needed basis.
    - Request random pill counts and urine drug screens. If needed, administer the urine drug screen. Arrange as needed. (Appendix J)
    - Address behavior and expectations with patient per results of team consultation.

- Attend weekly team consultation meeting and monthly drug task force meetings.
- Complete case reviews (similar to mapping) utilizing CSCT review consultation process (Appendix B): Review patients that are in need of taper plans, concerns for diversion, failed UDAS, early refills, MME in excess of 90 or provider concerns for patient's wellbeing. Bring this information to our weekly care team meetings.
- Provide staff training regarding UDAS, care plan completion, CSCT protocols.
- Support providers and nurses with patient concerns regarding their individual care plan or taper plan.
- **Suboxone patients (Appendix K for flow sheet):** Complete initial phone assessment interview (Appendix L), Substance Use Assessment (Appendix M). Discuss patient case with Suboxone providers who either accept or decline patient.
- Coordinate Suboxone patient's initial visit.
- Case manage Suboxone patients and develop treatment plan. Support patient through the Rule 25 process and throughout their treatment. Advocate for patients. Implement and monitor services.
- Obtain releases for all providers to coordinate care for Suboxone patients throughout their treatment process.
- Explain to each patient in a way they can understand the following forms: Suboxone Medication agreement (Appendix N), Consent for Treatment with Buprenorhine (Appendix O), and Family Medical Center Substance Program Care Plan (Appendix G). Assure that patients have a clear understanding of the

Suboxone program at our facility. Sign above forms with patient, witnessing as needed.

- Meet with patients during their scheduled appointments for initial face-to- face screening, complete all forms related to their Suboxone medication-assisted-treatment (MAT).
- Be present at patients' induction appointment, perform COWS (Appendix P).
- Be a point of contact for patients, direct line provided to patients.

o Mental Health Care Coordinator

- Coordinating services/resources, including mental health and chemical health services.
- Enroll patients in Patient Centered Medical Home.
- Complete Rule 25 Assessments (chemical use assessments) for those patients in the Suboxone program, and provide information on treatment options and relapse prevention.
- Follow-up telephone encounters and identify and re-engage patients who may be lost to relapse or other issues.
- Provide patient education about common mental and substance abuse disorders and available treatment options.
- Coordinate patient care as needed among various service providers (social service agencies, probation, medical providers and treatment providers).

o Social Worker

- Build a patient history along with a genogram or eco map.
- Review care plan expectations with patients, obtain signatures, and update yearly or as plans change (Appendix G).

- Coordinate and arrange for diagnostic assessments or neuropsychological assessments.
- Refer for MnChoices assessments and Rule 25 assessments.
- Arrange referrals to WIC, County public assistance programs, MnSure, housing, food programs, in-home services, support groups, Faith in Action, transportation resources, utility programs, renter's assistance and refunds.
- Provide and coordinate referrals to mental health supports (ARMHS, MHBA, CBT, DBT, EDMR, CMH, DD/Rule 185, and AMH), Crisis Team, Vocational Rehab, SCHA benefits, Yellow Ribbon program, health clubs, free cell phone, Headstart, and DHS.
- Maintain contact with patient, meeting face-to-face at minimum to one time per year, and have phone contact quarterly.
- Assist with collection of urine drug screens per UDAS policy (Appendix J).
- Assist with program development, writing policies and best practices.
- Track and provide data and patient informational stories for grant writing.
- Attend trainings with the team to promote cohesion and continued program development.
- Write and present presentations to public and other interested partners.
- Provide social worker interventions and support to other clinic providers and patients on as-needed basis.
- Obtain releases for MCSS and any other providers working with patient on goals to coordinate their care (Appendix H, I, Q).
- Attend weekly team consultation meeting and monthly drug task force meetings.

        - Complete case reviews (similar to mapping) utilizing CSCT review consultation process (Appendix B).
        - Support Suboxone patients through the Rule 25 process and throughout their treatment.
        - Obtain releases for all providers to coordinate care for Suboxone patients throughout their treatment process.

- Pharmacist
    - Provides a direct link between a community pharmacy and the Controlled Substance Care Team (CSCT).
    - Design opioid taper plans for providers to review with patients.
        - Taper no faster than 25% every three days to avoid withdrawal symptoms
        - Normal taper goal is a decrease of 10-20% every two weeks
        - Tapers can be as slow as 5% every month
        - If on high opioid doses, the first half may go faster than the second half
    - Meet with patients if needed to educate on the risk of opioid dosing.
    - Suggest adjuvant medications to treat potential withdrawal symptoms such as clonidine (usually not needed for gradual tapers), NSAIDs, acetaminophen, trazodone for insomnia, hydroxyzine for anxiety.
    - Helps verify that the results from confirmatory testing are consistent with medications prescribed.

IMPORTANT CALCULATIONS AND UTILITY

DIRE-D score (scoring sheet in Appendix C).

DIRE scoring is used to determine whether a patient is appropriate for chronic opioid therapy with a higher score (>14) indicating increased appropriateness and decreased probability of misuse. The following is a breakdown of what each letter stands for although each area is well explained on the scoring tool:

- D: The *Diagnosis* section breaks down patient's diagnosis into diagnosis not suitable for chronic opioid therapy, progressive conditions with objective findings and advanced conditions. The more severe the diagnosis the higher the score.
- I: The *Intractability* section gives a score based on non-opioid treatments tried, as well as how engaged the patient is/was in the treatment.
- R: The *Risk* section is broken down into:
    - Psychological - the more dysfunction or mental illness the lower the score
    - Chemical health - active use or addiction issues give lower scores, no history of chemical dependency give higher scores
    - Reliability - the more reliably a patient with proper follow through and follow up the higher the scores
    - Social support - the more chaos the lower the score, the more social stability the higher the score
- E: The *Efficacy* score evaluates how a patient responds to narcotics treatment and has functional improvement while on them. If they have more stability with functional improvement on lower doses, they get a higher score; escalating doses with minimal relief get lower scores.

These scores are all added up to determine potential suitability for chronic opioid analgesia treatment. In our clinic we also look at an additional "D" for distance. We have found that patients

that are traveling >30 miles to get to our clinic have a higher risk of opioid abuse, doctor shopping and diversion.

ACE scoring: (Adverse Childhood Experiences), (See Appendix D for the questions)

Calculating a patient's ACE score can also be helpful. A patient answers 10 yes/no questions, with a point given for each "yes" response. According to a 1998 study by Fellitti, (Fellitti, 1998), the higher the patient scores the greater the risk of experiencing poor physical and mental health as well as significant negative social consequences later in life. This includes an increased risk of opioid use/abuse. Dr. Daniel Sumrok, Director of the Center for Addiction Sciences at the University of Tennessee Health Science Center's College of Medicine calls addition "ritualized compulsive comfort-seeking" and states it is a normal response to adverse childhood experiences. This thought process parallels our patient-centered [medical home] treatment of our patients as it focuses on treating people with respect, treating patients with MAT (medication-assisted therapy) like Buprenorphine (Suboxone), and engaging them in treatments with group therapies.

MME (Morphine Equivalents) (Appendix R)

In order to adequately and appropriately determine if a patient on chronic narcotic treatment is on "too much," you must calculate morphine equivalents. This calculation equalizes the strengths of opioids for comparison. For instance, 10mg of hydrocodone is 10 morphine equivalents whereas 10mg of oxycodone is 15 morphine equivalents. Our practice adheres to the CDC opioid-prescribing guidelines from March of 2016. According to these guidelines, it is not recommended to start chronic opioid treatment above 50MME and it is not recommended to go above 90MME at all. The guidelines show that above 90MME the risk of opioid side effects, morbidity, and mortality increase with little additional benefit in pain control. When working the controlled substance patient list, each patient's daily MME is

calculated and, if they are above the 90MME threshold, the first recommendation is always to attempt to taper at or below this level. This can be quite upsetting to some patients who feel they will not tolerate lower doses. Our experience has been that with most patients who have been gently tapered to the lower levels suggested by the CDC guidelines, actually find that their pain is just as adequately controlled at the safer level.

The team pharmacist is critically important in this process and at times calls patients to assess how the taper is going. They also engage the patient to gain insight as to how patients feels their medications would be best arranged. For instance, one can achieve 80MME with twice daily oxycodone 20mg (50MME) with oxy IR 5mg given four times a day or with twice daily long acting morphine 40mg given twice daily. One patient may prefer to take their pain medication twice daily, whereas another may prefer to have short acting pain medications available for breakthrough pain. In a patient-centered care team, this interaction and communication can be vital in the relationship between the care team and the patient. When working these calculations and communicating with the patients, the pharmacist may also propose other, non-opioid, treatment options for patients as well.

WORK-FLOW OF THE CONTROLLED SUBSTANCE CARE TEAM

Establishing a workflow and practice to achieve an appropriate standard of care was the first goal of the Controlled Substance Care Team (CSCT) maintaining uniformity across all patients, without creating additional work for the physicians. If a “high risk” patient was identified when the patient wasn’t currently in the clinic, the RN care coordinator would typically determine when they would next be in clinic by looking for the next scheduled office visit. The RN would then approach the [primary] physician and notify them that he/she was planning on speaking with the patient after the clinic visit to get the care plan filled out. This allowed for a thorough review of the care plan without causing more work for the physicians as the RN would perform this task. The social worker also could meet with the patient at that visit to let the patient know what services could be offered to the patient, if they are qualified and not yet receiving (i.e., do they need insurance, food stamps, housing issues, etc.). The social worker could make referrals to mental health as well. If an identified patient didn’t already have an appointment scheduled, the RN would hold the next controlled substance prescription until the patient came to pick it up at the clinic and privately meet with the patient to discuss the care plan and get it discussed and signed. Narcotic prescriptions need to be filled monthly, so this requirement afforded an additional contact point. This is the less-ideal situation, as the patients would not typically know this visit was going to take place and they may feel targeted. Making an effort to get forms signed during or after an already scheduled office visit is preferred.

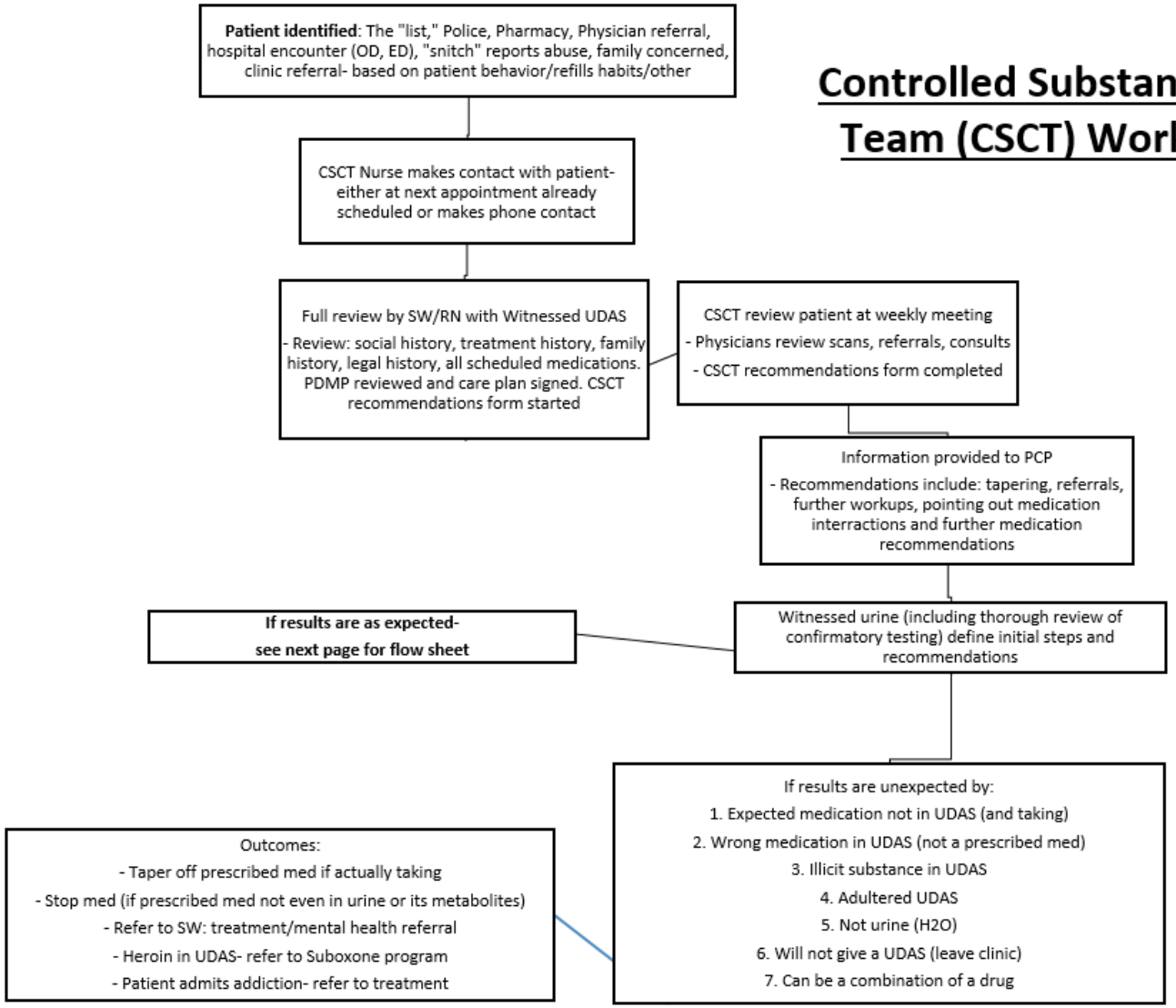
Once all “red flag” or “high risk” patients have active care plans (they need to be updated and re-signed yearly), the rest of your chronic controlled substance patients can be addressed by watching when they have appointments, then following the same procedure as above.

A baseline urine drug screen is also gathered at the time of the care plan being signed. It is of utmost importance to be sure to also order any and all confirmatory tests on the urine for substances that are present in the urine as well as for substances that are supposed to be in the urine but are not.

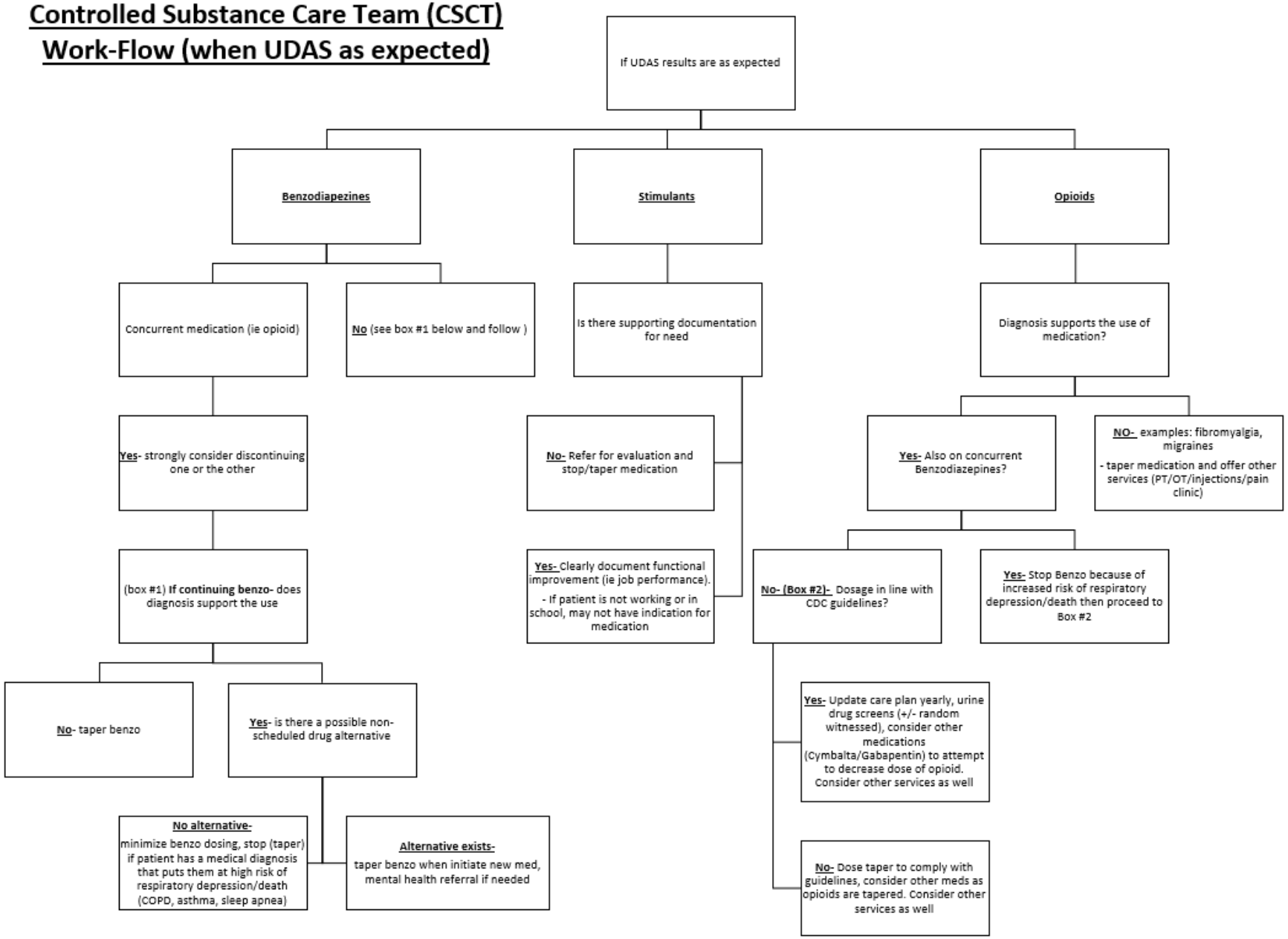
Occasionally, a patient is being compliant with their benzodiazepines but they will not show up on a preliminary urine drug screen but will be present in the confirmatory. You do not want to make judgments on patients or change medications erroneously. If illicit substances are found on initial drug screens, they aren't always "deal breakers" to immediately stop a patient's chronic substances. Rather, that can open the door to conversations about quitting drugs and/or getting help with addictions or drug treatment. Throughout, it is important to remember to treat the patient as a whole person and rather than dismissing. It is one's responsibility to help patients get help where needed. There does come a point where illicit substances in the urine do become deal breakers, however. This would be in the case of persistent methamphetamines and, in some cases, persistent marijuana as well. Drug levels can be monitored to ensure they are going down.

Once a care plan has been signed, the CSCT is able to review the patient's chart, including history of the pain complaint, imaging studies and other modalities that have been attempted and then fill out the Recommendations Form (Appendix B). The Recommendations Form puts the patient's history in one place so when the CSCT makes prescribing recommendations to the primary providers, it is easy to review. The Recommendations Form gets signed by the CSCT physician and, after review by the primary provider, is scanned into the patient's chart. This allows for review if questions arise in the future. It is important to notify your full patient population that care plans for all controlled substances will be made. If this information isn't transparent and made right away, patients on controlled substances, even if appropriately so, often feel discriminated against. It is important for all patients to be aware of this change and for the reasons why. Most patients will understand and gladly participate, and those that resist, oftentimes, will need to be watched more closely. A clinic-wide notification is recommended, see Appendix S for an example of what was hung on the back of our exam room doors. Community-wide fliers are also made available to raise awareness that treatment to addiction is at your local health care facility (Appendix T).

Controlled Substance Care Team (CSCT) Work-Flow



Controlled Substance Care Team (CSCT) Work-Flow (when UDAS as expected)



TREATING ADDICTION IN A FAMILY PRACTICE SETTING

It became obvious early on in our program that we also needed to treat patients who had become addicted to their medications (narcotics) or whom had transitioned to heroin. These patients were much more challenging to taper off their medications, if not impossible. We had to have another treatment option to help these patients with their addiction.

It is important to understand the difference between tolerance, dependence and addiction. Tolerance is defined by a person needing more and more of a substance to achieve the same benefit (thus escalating doses). Dependence occurs when a person will physically be in withdrawal if the substance is removed. Patients who are now dependent on their narcotics will require a taper period to get off them, rather than having their medications discontinued. When a patient will go to any length, no matter the harm to one's life or irresponsibility of it, to acquire their drug, they are then addicted. Patients who display dependence on a substance over time are at risk of addiction. Long term opioid use produces changes to the brain, inhibiting one's normal executive functioning. It can take up to three months for these brain changes to heal, which is why it is imperative to monitor these patients very closely during this time. Many inpatient drug treatment programs are less than three months, a disadvantage to the patient who is still incapable of responsible decision-making and relapse avoidance. If patients do relapse at this time, their risk of overdose death is high as their tolerance decreases during their treatment stay.

When patients are identified in your drug program as having an addiction, it is important to have a treatment option for them. Medication-Assisted-Therapy (MAT) has been proven to be most beneficial to the opioid addict over abstinence-based treatment. Providers need to get a special prescribing license and have a limited number of patients they are allowed to treat. Treatment beds are also limited so once patients are identified as needing treatment, having the ability to start MAT in your local clinic will benefit both your patients and your community.

BUPRENORPHINE

Buprenorphine is a form of MAT that we found most compatible with our local community. Suboxone combines Buprenorphine, which is a long-acting opioid, with Naloxone, which is the antagonist to opioids. It is therefore an agonist-antagonist medication that works by eliminating the patient's cravings for their drug while also preventing them from getting "high" from their drug if they were to use. Cities with strong MAT programs have been shown to have lower crime rates and more patients returning to work and being productive members of society. After only one year of doing MAT, it has also been our experience that patients have returned to work and rejoined our community, regaining their pre-addiction lives. The issue of how long a patient should remain on Suboxone continues to be controversial. There is data showing that discontinuing Suboxone prior to four years can have an 86% chance of relapse. Ultimately, we feel it is of utmost importance to get patients started on treatment, but then each case needs to be individualized. Some patients stay on treatment indefinitely with dose reductions over time and others taper sooner.

To get your Suboxone waiver, there is an eight-hour online course you must first take followed then by an application to the DEA. After applying, it can take six weeks to get your waiver. The first year with your waiver you are limited to 30 patients. After the first year, you can apply to prescribe for more. The limit previously was 100 patients and more recently was raised to 275 patients. Nurse practitioners and physicians assistants also have the opportunity to get a prescribing waiver.

When starting our Suboxone program, our goal was to continue to follow a patient centered medical home approach with our Suboxone patients, rather than simply becoming a "pill mill" for MAT. Many MAT clinics offer only the medications versus including the opportunity for other services. Our program offers access to a social worker and RN case manager as well as physicians at each visit. These services are provided without judgment or punitive consequences. We anticipate that there will be times of trouble, especially early on in treatment and, with the exception of our patients selling their

Suboxone, we work through their issues with them rather than dismissing them from our program. We try to impress upon our patients that our job is to support them in maintaining their sobriety not to punish them. We understand that addiction, especially to opioids, is very strong and we want our patients to be honest with us so we can help them avoid relapse. Dismissal from our program is rare and only linked to the selling of their Suboxone or the ongoing use of concomitant Benzodiazepines despite repeated warnings about safety.

Patient inquiries about our program are directed to our CSCT RN case manager who completes an intake phone call. The RN's phone number is also found on fliers in our community. After the phone call, the intake form (Appendix U, V) is evaluated by our physician(s) who decide at that time whether the patient will have an intake clinic visit. The clinic visit is then used to further decide if the patient is appropriate for our program. Even if deemed not appropriate, they are still given social work contact to assist them in pursuing other options for treatment. Patient logs are maintained as well, both a running list of patients we have met with (Appendix W) as well as all patients have a form documenting their visits, dosages and urine results (Appendix X).

Patients accepted to be in our MAT program, are scheduled to see one of our Suboxone providers in clinic. The intake visit in clinic generally involves the physician, RN and social worker, when available. The visit usually starts with a clinic nurse obtaining a UDAS. The provider will then review with the patient all the information that was gathered on the phone intake form and do a physical exam focusing on signs of infection from IV drug use, signs of current use (sniffing, pin-point pupils, fidgeting) or signs of withdrawal. Typically at this visit, a patient is actively using. Lab work will then be obtained including: HIV, pregnancy test (where applicable), hepatitis panel, CBC, LFTs, and BMP. An induction appointment will then be scheduled (typically early in the week) and Suboxone will be prescribed. If the patient is currently withdrawing, attempts will be made to start Suboxone immediately. Patients who are currently using at their intake visit, will need to return in withdrawal for their Suboxone induction.

After the physician leaves the visit, the RN and/or social worker will then go through all of the forms with the patient including the care plan, Suboxone agreement forms, and diagnostic form (Appendices G, H, M, N, O, P, Q, R, and S). The nurse and social worker give additional paperwork to the patient about local NA/AA meetings and give the patient a Group Meeting Attendance Form (Appendix Y). Additionally, they will work with patients on getting their Rule 25 set up, if they don't already have one, and getting them started on looking for treatment programs. The patient has to make contact with treatment programs. The type of treatment (inpatient or outpatient) a patient will need is determined by their Rule 25. It is helpful if someone in your facility is trained to perform Rule 25 assessments as they often expedite the process of getting a patient into treatment.

Obtaining Buprenorphine for your patients on occasion is difficult because of the prior authorization process. Many insurers have lifted their prior authorization process for Suboxone, however Medical Assistance providers or state-funded programs may be more difficult to navigate. It is important to make connections with those people to assist in making this a smooth process. Documentation in advance of applying for the medication will make the process of obtaining the medication easier. This includes the documentation in Appendix Y, the form we created that we fax to the pharmacy with the prescription.

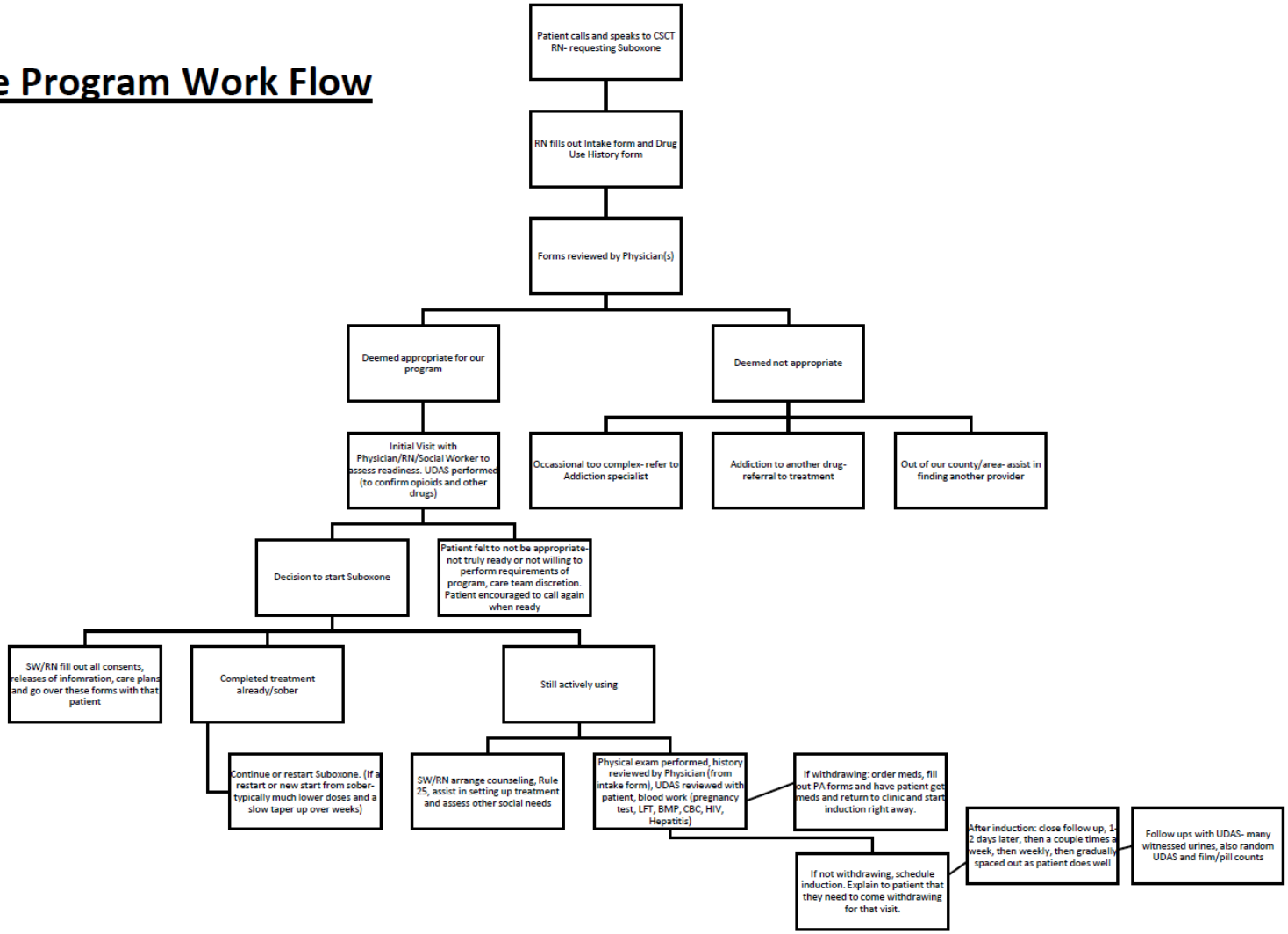
The most important part of Buprenorphine induction is the patient needs to be in withdrawal. The clinic nurse rooms the patient, obtains a UDAS and calculates the patient's COWS score (Appendix P). A score greater than 10 is necessary when starting Buprenorphine therapy. Patients below 10 are reevaluated every 15 minutes until Buprenorphine can be safely given. When medication is started, it is generally given in 2-4mg increments. Patients are then reassessed roughly every 30 minutes. We use the COWS score to help guide our dosing. When withdrawal symptoms have resolved, a couple of hours after starting, we allow them to leave the clinic. They usually return for reassessment later in the day and to assess further dosing for that day. Generally, we follow up the next day which helps solidify what

their daily dose will be based on how much was given on day one and how they are feeling. The first day maximum dose is 12mg but in general 8mg BID is a common dose schedule. There appears to be a trend depending on opioid of choice and route taken. Lower daily doses are observed for pill-addicted patients and higher daily doses are observed for IV heroin-addicted patients. For example, we have many pill-addicted patients on 4mg BID and IV heroin-addicted patients on 12mg BID.

Checking a UDAS (often witnessed) the day of induction is very important, as it is important to note other substances in the urine, especially benzodiazepines. All patients are aware that they cannot, in our program, have any benzodiazepines in their urine while on Suboxone. We also list it as an allergy to alert other prescribers to avoid benzodiazepines as well. It is also important to note whether or not opioids are even present, as degree of withdrawal can vary. At times patients will have Suboxone (Buprenorphine) present in their urine that they obtained illegally prior to their own induction.

It should be noted that there are Buprenorphine providers that do home inductions. We believe clinic inductions are more appropriate as it gives us the ability to know what is in their urine the day of induction as well as to further educate and communicate with the patient. Patients, by the time they leave the clinic on day one, will feel better than they have in a long time. It is impressive how ill patients are when they arrive for their induction and how well they look and feel by the time they leave. When an induction is done in clinic, the physician and care team are able to share in the patient's first step of sobriety. We believe the patient benefits by feeling the support of the care team.

Suboxone Program Work Flow



EXPANDING BUPRENORPHINE

We are currently working on expanding our Buprenorphine program to include our county jail as well as hospital emergency department. One problem with our Buprenorphine patients is dealing with their previous legal issues. Many times patients are needing to return to jail for old charges and most county jails do not allow patients to be on Suboxone while incarcerated. We have facilitated, on two occasions, as of the writing of this, two patients being able to remain on their stable MAT while in the county jail. Coordinating this was necessary because of our experience with patients otherwise needing to be taken off of their stable MAT to go to jail, which then resulted in their relapse following their release. We accomplished this by partnering with our county jail staff and physician. In the future, we envision MAT being initiated on patients who are withdrawing while entering the jail who then, upon release, will have close follow up with a comprehensive Buprenorphine program.

Additionally, we are working with our emergency department staff and physicians to better coordinate patients who are in need of MAT. Patients who are withdrawing or overdosing in the emergency department often request treatment and help. We want to better this communication and referral process so we are able to directly help and, if able, treat with Suboxone. Too often, addicted patients are sent home from emergency departments after a Narcan save only to go home, use again, and subsequently overdose and die. Coordinating with your local emergency department should be considered, once your Suboxone program is established, in order to make MAT services more available to your community.

SUMMARY

We hope that you find this manual helpful. At this time, the opioid epidemic is a public emergency and communities, clinics and hospitals need to work together to implement programs like ours in an effort to decrease the staggering number of deaths our country is experiencing. One can continue to be alarmed by this epidemic and its devastating effect on families, but taking action and participating in the solution with a comprehensive plan that both addresses prescribing and dosing practices as well as the treatment of opioid addiction is, in our opinion, the only way to achieve the desired decline in deaths. We have spent the last three years refining our program while thoroughly documenting the process in hopes that others would consider implementing it in their communities as well. The largest hurdle we need to overcome as a society is the prevalent individual bias toward this issue and the stigma that often fuels it.

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APPENDIX PIECES

CHI ST. GABRIEL'S HEALTH URINE ALGORITHM....A
CSCT REVIEW....B
D.I.R.E. SCORE....C
ADVERSE CHILDHOOD EXPERIENCE SURVEY....D
APPROPRIATE USE CHECKLIST....E
OPIOID USE DISORDER CHECKLIST....F
CONTROLLED SUBSTANCE PROGRAM CARE PLAN....G
AUTHORIZATION OF USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION....H
AUTHORIZATION OF USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES....I
CSCT COORDINATED CARE TO MANAGER PILL COUNTS/URINE DRUG ABUSE SCREENS....J
FLOW SHEET/CSCT....K
SUBOXONE SCREENING CRITERIA....L
SUBSTANCE USE ASSESSMENT....M
CHI ST. GABRIEL'S HEALTH SUBOXONE MEDICATION AGREEMENT....N
CONSENT FOR TREATMENT WITH BUPRENORPHINE....O
CLINICAL OPIATE WITHDRAWAL SCALE....P
MORRISON COUNTY SOCIAL SERVICES CONSENT FOR RELEASE OF INFORMATION....Q
MORPHINE EQUIVALENTS....R
NOTICE TO PATIENTS: PRESCRIBED CONTROLLED SUBSTANCES....S
ABOUT ADDICTION PAMPHLET....T
BUPRENORPHINE INTAKE CHECKLIST....U
REQUIREMENTS TO FAMILY MEDICAL CENTER'S SUBOXONE THERAPY PROGRAM....V
SUBOXONE PATIENT SUMMARY....W
INDIVIDUAL SUBOXONE PATIENT INFORMATION....X
MUTUAL SUPPORT GROUP MEETING ATTENDANCE FORM....Y
PRIOR AUTHORIZATION RATIONALE....Z

CHI St. Gabriel's Health Urine Algorithm

MedTox (In House UDAS)

Basic Immunochemistry Screen

ORDER CODE: LAB0297895

Collect Urine Sample:

MedTox, (0.5 mL, min) or

C-DAU12, (10 mL, min)

C-DAU12 (CentraCare)

Basic Immunochemistry Screen

ORDER CODE: LAB0293839

If adulteration is suspected, order ADULT confirmatory test

Note: If urine is limited, choose the most important test

TO ORDER CODED TESTS USE SMART SET, ***UDAS***

AMPHU: LAB0208140

BENZU: LAB0214049

MTDNU: LAB0293840

OPATU: LAB0214056

THCU: LAB0212969

TO ORDER A NON-CODED TESTS

M. BATTERY CODE: LAB0231498

Use TEST NAME (i.e. TRAM, Mayo, Urine);

TO COMPLETE ORDERS

SELECT SMART SET *UDAS*, ROUTINE, LAB COLLECT, FUTURE, IDC10 G89.4 Chronic Pain Syndrome. **THEN CALL LAB TO**

Confirm all positives and missing expected negatives in new or suspected patients

Patient Passes:

Confirm pass interpretation.

Choose to continue or modify pain management as needed. F/U with pill counts and urine tests as needed.

Patient Fails:

Confirm failure interpretation.

Choose to partially taper, taper, release or re-home patient.

IDC10 Codes

Patient Problem List Additions

R82.5 Positive Urine Drug Screen

R89.2 Abnormal Drug Screen

Z79.899 Broken Pain Contract

UDAS Code

G89.4 Chronic Pain Syndrome

What to order (Confirmatory, Common):

AMPHU: Amphetamines, methamphetamines, MDA, MDMA (ecstasy)

BENZU: Alprazolam, Clonazepam, Diazepam, Lorazepam, Oxazepam, Temazepam

OPATU: Hydrocodone, Hydromorphone, Morphine, Oxycodone, Oxymorphone

THCU: Marijuana

MDTNU: Methadone

What to order (Confirmatory, Other)

BARBU: Butalbital (Fioricet, Fiorinal) plus many others.

BUPM: Buprenorphine

FENTU: Fentanyl

6MAM: Heroin metabolite

TAPEN: Tapentadol

TRAM: Tramadol

THCS: Synthetic marijuana, Spice, K2

Basic Interpretation:

High levels of parent without metabolite = suspicious for spiking

Low levels of parent without metabolite = probable that metabolite is there but too low to be detected

High metabolite with no parent = could have taken the metabolite or fast metabolism

Low metabolite with no parent = you caught the tail end of the drug

Appendix A

Appendix A

QUICK TIP SHEET WITH METABOLITES

1. **COLLECT** urine sample in an appropriate bathroom (blue dye in toilet water, water turned off).
2. **ASK** and **RECORD** when the patient last took their medications (amount and time).
3. **GET** an initial urine test.
4. **GET** a confirmatory test after initial screening as per algorithm.
5. **WAIT for the confirmatory urine test** (and interpretation if needed) **for decision making.**
6. **INVOLVE** the **CSCT** in the decision process. **In-basket: FMC CSCT**

AMPHU Amphetamines and Methamphetamine (AMPHU, 2.5 mL min)

Drug	MedTox (+)	Confirm, Mayo	You Should See	Poss. Ratios
Amphetamine	Amphetamine	*AMPHU*	amphetamine	
Methamphetamine	Methamphetamine	*AMPHU*	methamphetamine, amphetamine	3:1
MDMA (ecstasy)	Methamphetamine	*AMPHU*	MDMA, MDA	
MDA	Amphetamine	*AMPHU*	MDA	

***BENZU* Benzodiazepines (*BENZU, 5 mL* min). Note: MedTox is not tested for Z-drug positives in Benzodiazepine Screen**

Drug	MedTox (+)	Confirm, Mayo	You Should See	Poss. Ratios
Alprazolam	Benzodiazepine	*BENZU*	alpha-OH-alprazolam	itself
Clonazepam	Benzodiazepine	*BENZU*	7-NH-clonazepam	itself
Diazepam	Benzodiazepine	*BENZU*	nordiazepam, oxazepam, temazepam	1:1:1
Lorazepam	Benzodiazepine	*BENZU*	lorazepam	itself
Oxazepam	Benzodiazepine	*BENZU*	oxazepam	itself
Temazepam	Benzodiazepine	*BENZU*	oxazepam, temazepam	1:1
Triazolam	Benzodiazepine	*BENZU*	alpha-OH-triazolam	itself

OPATU Opioids (OPATU, 2.5 mL) Note: Codeine, you may see codeine, hydrocodone, hydromorphone, Norcodeine and morphine

Drug	MedTox (+)	Confirm, Mayo	You Should See	Poss. Ratios
Codeine	Opiate	*OPATU*	* see note above.	?
Hydrocodone	Opiate	*OPATU*	hydrocodone, hydromorphone, dihydrocodeine	2:1 to 1:10
Hydromorphone	Opiate	*OPATU*	hydromorphone	itself
Morphine	Opiate	*OPATU*	Morphine, normorphine, hydromorphone	itself
Oxycodone	Oxycodone	*OPATU*	oxycodone, oxymorphone,, noroxycodone	2:1 to 1:10
Oxymorphone	Oxycodone	*OPATU*	Oxymorphone, 6-hydroxy-oxymorphone	itself

Other Opioids (Specific Tests, See Algorithm)

Drug	MedTox (+)	Confirm, Mayo	You Should See	Poss. Ratios
Buprenorphine	Buprenorphine	*BUPM, 0.75 mL*	buprenorphine, norbuprenorphine	?
Fentanyl	NA	*FENTU, 3 mL*	fentanyl, norfentanyl	?
Heroin	Opiate	*6MAMU, 2.1 mL*	6-monoacetylmorphine, morphine	> morphine
Methadone	Methadone	*MTDNU, 2.1 mL*	methadone, EDDP	
Tapentadol	NA	*TAPEN, 0.1 mL*	tapentadol, N-desmethyltapentadol	
Tramadol	NA	*TRAM, 0.1 mL*	tramadol, O-desmethyltramadol	

Adulterant (ADULT, 0.4 mL)

Drug	MedTox (+)	Confirm, Mayo	You Should See	Poss. Ratios
Creatinine	NA	*ADULT*	normal adult 20-320 mg/mL	
Specific Gravity	NA	*ADULT*	1.002 to 1.030	
pH	NA	*ADULT*	4.6 to 8.0	
Oxidants	NA	*ADULT*	Negative	

Appendix B

CSCT REVIEW

Dr._____, Date: _____

The CSCT has reviewed the following patient:

Patient Name: _____ DOB: _____ MRN: _____

Diagnosis: _____

_____

Medication Agreement/Care plan signed: Y/N, Date: _____

Anxiety: Y/N, Depression: Y/N, Mental Health issues: Y/N,_____

Mental Health Provider/Therapist: _____

Current Medications of Concern:

_____

_____

_____

Images Reviewed: Y/N_____

Other Modalities attempted: _____

_____

UDAS in past year: Y/N, Date of most recent UDAS: _____

UDAS Findings:

- _____
- _____
- _____

Pill Counts: _____

PMP Reviewed: Y/N, Findings: _____

Social History: _____

_____

Social Needs identified:_____

Recommendations: _____

_____

Form scanned in to EMR: Y/N

Signed: _____

Appendix C

D.I.R.E Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanation in the right hand column.

Score	Factor	Explanation
	Diagnosis	1= Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, nonspecific back pain 2= Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3= Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	Intractability	1= Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2= Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3= Patient fully engaged in spectrum of appropriate treatments but with inadequate response.
	Risk	(R= Total of P+C+R+S below)
	Psychological	1= Serious personality dysfunction or mental illness interfering with care, Example: personality disorder, sever affective disorder, significant personality issues. 2= Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3= Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical Health	1= Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2= Chemical coper (uses medication to cope with stress) or history of CD in remission. 3=No CD history. Not drug-focused or chemically reliant.
	Reliability	1= History of numerous problems: medication misuse, missed appointments, rarely follows through. 2= Occasional difficulties with compliance, but generally reliable. 3=Highly reliable patient with meds, appointments and treatment.
	Social Support	1= Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2= Reduction in some relationships and life roles. 3= Supportive family/close relationships. Involved in work or school and no social isolation.
	Efficacy Score	1= Poor function or minimal pain relief despite moderate to high doses. 2= Moderate benefit with function improved in a number of ways (or insufficient info-hasn't tried opioid yet or very low doses or too short of a trial). 3=Good improvement in pain and function and quality of life with stable doses over time.

_____ Total Score = D+I+R+E

Score 7-13: Not a suitable candidate for long-term opioid analgesia

Score 14-21: May be a candidate for long-term opioid analgesia

Source: Milles Belgrade, Fairview Pain & Palliative Care Center © 2005.

Appendix D

Adverse Childhood Experience Survey

Question	Yes	No
Had a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?		
Did a parent or other adult in the household often or very often… Push, grab, slap or throw something at you? Or ever hit you so hard that you had marks or were injured?		
Did an adult or person at least 5 years older than you ever…Touch or fondle you or have you touch their body in a sexual way? Or attempt or actually have oral, anal, or vaginal intercourse with you?		
Did you often or very often feel that…No one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?		
Did you often or very often feel that…You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?		
Were your parents ever separated or divorced?		
Was your mother or stepmother: often or very often pushed, grabbed, slapped, or had something thrown at her? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?		
Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?		
Was a household member depressed or mentally ill, or did a household member attempt suicide?		
Did a household member go to prison?		
Add up your "yes" answers- that's your ACES score.		

Appendix E

Patient Name: _____

BTOD|REMS

APPROPRIATE USE CHECKLIST:

BUPRENORPHINE-CONTAINING TRANSMUCOSAL PRODUCTS FOR OPIOID DEPENDENCE

This checklist is a useful reminder of the safe use conditions and monitoring requirements for prescribing buprenorphine-containing transmucosal products for opioid dependence.

Requirements to address during each patient's appointment include:

- understanding and reinforcement of safe use conditions
- the importance of psychosocial counseling
- screening and monitoring patients to determine progress towards treatment goals

If a patient continues to abuse various drugs or is unresponsive to treatment, including psychosocial intervention, it is important that you assess the need to refer the patient to a specialist and/or a more intensive behavioral treatment environment.

Additional resource: Providers Clinical Support System for Medication Assisted Treatment: http://pcssmat.org/

This checklist may be used during the induction period and filed in patient's medical record to document safe use conditions. Once a maintenance dose has been established, use the maintenance checklist.

MEASUREMENT TO ENSURE APPROPRIATE USE	NOTES
Date:	
INDUCTION	
☐ **Verified patient meets appropriate diagnostic criteria for opioid dependence**	
☐ **Discussed risks described in professional labeling and Medication Guide with patient**	
☐ **Explained or reviewed conditions of safe storage of medication, including keeping it out of the sight and reach of children**	
☐ **Provided induction doses under appropriate supervision**	

☐ **Prescribed limited amount of medication at first visit**	
☐ **Scheduled next visit at interval commensurate with patient stability** • Weekly, or more frequent visits recommended for the first month	

DSM 5 Opioid Use Disorder Checklist

Published on BupPractice (https://www.buppractice.com)

DSM 5 Opioid Use Disorder Checklist

Patient's Name:

Date of Birth:

Worksheet for DSM-5 criteria for diagnosis of Opioid Use Disorder

Diagnostic Criteria (Opioid Use Disorder requires at least 2 criteria be met within a 12 month period)	Meets criteria? Yes OR No	Notes/Supporting information
1 . Opioids are often taken in larger amounts or over a longer period of time than intended.		
2 . There is a persistent desire or unsuccessful efforts to cut down or control opioid use.		
3 . A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.		
4 . Craving, or a strong desire to use opioids.		
5 . Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.		

DSM 5 Opioid Use Disorder Checklist

Published on BupPractice (https://www.buppractice.com)

6 . Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.		
7 . Important social, occupational or recreational activities are given up or reduced because of opioid use.		
8 . Recurrent opioid use in situations in which it is physically hazardous		
9 . Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.		
10 . *Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid		

DSM 5 Opioid Use Disorder Checklist

Published on BupPractice (https://www.buppractice.com)

11 . *Withdrawal, as manifested by either of the following:	
(a) the characteristic opioid withdrawal syndrome	
(b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms	

*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

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

Signed_____Date_____

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

Links:
[1] https://www.buppractice.com/node/ 19556

Appendix G

CHI St. Gabriel's Health
Family Medical Center

Controlled Substance Program Care Plan

The purpose of this agreement is to prevent misunderstandings about controlled medicines you will be taking as part of the care plan for your condition. This agreement will help you and your Clinical Provider, members of your care team (RN's, social workers, pharmacists, clinical nurses, CMA's) as well as other CHI Providers at the Family Medical Center in Little Falls, MN to comply with the law and best practice guidelines regarding controlled medicines. Examples of controlled medicines include, but are not limited to: oxycodone, hydrocodone, methylphenidate, amphetamines salts, lorazepam, zolpidem, tramadol, Suboxone, etc.

Since other treatments have not improved my condition, my provider, _____ at the Family Medical Center has decided to prescribe a controlled medicine to help manage my condition and improve my social and work activities. This is a serious decision. I understand that I must adhere to several conditions outlined in the following document.

I, _____ (patient name), _____ (DOB), have agreed to use the following medications as part of a care plan for my condition. I understand that these medicines may not eliminate my condition but may improve my condition and my activities of daily living.

Diagnosis (es):

Goal:

Plan:

Agreement Start Date:
Agreement Expiration Date:
Provider:
Refill Schedule:

Terms of Agreement

- I have been made aware of the risks associated with using controlled substances to treat my condition.
- I will not use illegal substances, street drugs or abuse alcohol while taking controlled medicines. I will not take controlled medicines prescribed for others nor will I share controlled medicines that are prescribed to me with others. I will keep all controlled medicines away from children.
- I will not be involved in the sale, illegal possession or diversion of controlled medicines such as opioids (narcotics), sleeping medicines, ADHD medicines or anxiety medicines.
- If I develop a problem with drug or alcohol addiction, the following programs that may be recommended by my Clinical Provider:

    a. 12 Step Program with a Sponsor
    b. Counseling
    c. Inpatient or Outpatient treatment

  If any of the above programs are recommended, I am aware that my Clinical Provider may be in communication with the specified program. I will not expect refills of controlled medicines until documentation of initiation and progress in my recommended program(s) have been received. Monthly updates will also be expected.
- I will actively participate in any program(s) designed to improve function including social, physical, psychological and daily/work activities.
- I agree to inform my Clinical Provider at the Family Medical Center of all medicines I am taking. I agree to inform other providers of my prescribed medicines including specialists, emergency department providers and hospital providers.
- I agree to allow my Clinical Provider at the Family Medical Center to communicate with other health care professionals regarding my controlled medicine use as deemed necessary.
- I agree to obtain all of my controlled medicines from The Family Medical Center's Clinical Provider that I have specified on the first page of this document.
- I agree to take my medicines as prescribed. I will not make changes to the directions for my controlled medicine without first consulting my Clinical Provider. In the event of an emergency or if my Clinical Provider is away from the clinic, alternative arrangements will be made through the Family Medical Center.
- I agree to use only one pharmacy to fill my prescriptions for controlled medicines.

  Pharmacy: _____
  Phone Number: _____

- In the event that my prescription insurance changes and I can no longer fill at this pharmacy, I agree to inform my Clinical Provider of my new pharmacy.
- I agree to adhere to the current arrangement that exists between the Family Medical Center and my pharmacy for transport of hard copy prescriptions.

- I agree to make no early refill requests and no refill requests after 4 pm Mon-Thu and after 12 pm on Fri, nor on holidays or on weekends. I understand that early or inappropriate refill requests will be considered a violation of my care plan. **Regarding special circumstances:**

    a. Replacement prescriptions will **NOT** be provided in the majority of cases, regardless of circumstance. I will protect my prescriptions and tablets/capsules.
    b. Travel plans interfering with refills will be discussed with my Clinical Provider at least 5 days in advance. My Clinical Provider will determine if an adjustment or alternative refill plan is necessary.
- I am aware that I may be requested to come to The Family Medical Center to pick up my written prescription and/or meet with a member of the Controlled Substance Care Team at least once per year or as determined by my care team.
- I agree to regularly follow-up with my Clinical Provider at the Family Medical Center regarding control of my condition and to keep all scheduled clinic appointments regarding my condition.
- I agree to contact the Family Medical Center in Little Falls, MN at 320-631-7000 within 24 hours if an unavoidable emergency occurs requiring a prescription for a controlled medicine from another provider. Unavoidable emergencies include hospitalizations, trauma-associated emergency department visits and surgeries. (This does **NOT** include emergency room observations).
- I agree to random pill counts and testing of urine and/or blood to screen for drugs and/or alcohol when my Clinical Provider requests it. I understand that these are laboratory tests that will help determine medicine taking behaviors. The contact number that I can be reached for pill counts and/or urine drug screens is: _____. **If this number becomes invalid I will notify the clinic within 24 hours of updated contact information.**
- I agree to respond within 24 hours for random pill counts and drug screens. Failure to keep these appointments will be considered a violation of my care plan.
- I understand this mode of treatment will be stopped if any of the following occur:
    a. I do not show improved pain control or my physical activity has not improved
    b. I give away, sell or misuse my prescribed medicines or use controlled medicines prescribed for others
    c. I am non-adherent with any of the terms of this contract including inappropriate refill requests
    d. I disrespect or harass clinic or pharmacy personnel
    e. I do not follow-up for pill counts, drug screenings, or as requested by my Clinical Provider
    f. I develop significant side effects, rapid tolerance or loss of function as a result of my treatment
- I understand that violations of this agreement may also result in dismissal from the Family Medical Center.

I have read and understood these terms and have asked all relevant questions. I consent to the use of controlled medicines in my care plan under the terms of this agreement. This agreement will remain in effect for duration of therapy and updated as appropriate, and/or annually.

Patient Signature: _____ **Date: _____**

Provider Signature: _____ **Date**: _____

Witness Signature: _____ **Date**: _____

CHI St. Gabriel's Health

Imagine better health.℠

- St. Gabriel's Hospital
- Family Medical Center
- Little Falls Orthopedics
- Health at Home
- St. Camillus Place

Authorization for Use or Disclosure of Protected Health Information

I, _____ , [*Print name of individual patient, resident or client hereby authorize CHI St. Gabriel's Health (St. Gabriel's Hospital, Family Medical Center, Little Falls Orthopedics, Health at Home, etc.)*] to use and/or disclose my individually identifiable health information as described below:

_____

I authorize the following person(s) or organization to receive the information:

_____

Street Address: _____

City, State, and Zip Code: _____

The following individually identifiable health information may be used and/or disclosed:
Check (✔) all that apply:

___ Discharge Summary	___ Reports of Tests & X-rays	___ Inpatient Records
___ Outpatient Records	___ Face sheets with Final Diagnosis	___ Abstracts
___ Consultation Reports	___ Emergency Room Records	___ Physical Therapy Notes
___ Outpatient Clinic Notes	___ Complications, and Procedures	
___ History and Physical Records	___ Immunization (shot) Record	___ Other*:

* If authorization is for marketing, indicate if CHI St. Gabriel's Health will receive compensation in exchange for the use and/or disclosure of the PHI. ___ YES or ___ NO

Dates of treatment to be released: _____

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Reason or purpose for the use and/or disclosure of the information:

_____

I understand a fee may be charged for copies of my medical record.

If you are requesting copies of your own medical record, indicate here if would prefer to receive them in an electronic format. ___ YES or ___ NO

If YES, please specify format you are requesting _____

Prohibition on Conditioning of Authorization

CHI St. Gabriel's Health will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., physical education physical).

Re-disclosure

I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration

This authorization will expire _____
(Insert date, event or "once purpose stated above is served.")

Revocation

I understand that I may revoke this authorization at any time by notifying CHI St. Gabriel's Health in writing by sending a letter to Medical Records, CHI St. Gabriel's Health, 815 2nd Street SE, Little Falls MN 56345 or completing the Revocation of Authorization Form. I understand that if I revoke this authorization, it will not affect any actions that CHI St. Gabriel's Health took before it received my revocation letter. For example, CHI St. Gabriel's Health cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is Binding

The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the CHI St. Gabriel's Health Notice of Privacy Practices.

_____ _____

Signature of Individual or Personal Representative **Date**

Printed name of individual's personal representative, if applicable:

_____

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):

_____

FOR INTERNAL PURPOSES ONLY

When CHI St. Gabriel's Health is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel

Received by: _____ Date: _____

Was a signed copy provided to the individual? ___ YES ___ NO

Approved for individual access? ___ YES ___ NO

Appendix I

CHI St. Gabriel's Health

Imagine better health.℠

AUTHORIZATION FOR USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES

I, _____, **[Print Name of Individual (i.e., patient, resident or client)]** hereby authorize Family Medical Center to use and/or disclose my psychotherapy notes as described below:

I authorize the following person(s) or organization(s) to receive my psychotherapy notes:

Name: _____

Street Address: _____

City, State, and Zip Code: _____

The following **psychotherapy notes** may be used and/or disclosed:

Date(s) of session(s) to be released: _____

I authorize the release of any information contained in the above records concerning the treatment of:

- Drug or alcohol abuse;
- Drug-related conditions;
- Alcoholism;
- Psychiatric/psychological condition;
- Psychiatric/mental health treatment; and/or
- HIV-related conditions

Reason or purpose for the use and/or disclosure of the information:

_____

_____

Prohibition on Conditioning of Authorization: Family Medical Center will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Appendix I

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially redisclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire _____ (insert date or event or insert "once purpose stated above is served").

Revocation: I understand that I may revoke this authorization at any time by notifying Family Medical Center in writing by sending a letter to Family Medical Center, 811 Second Street SE, Little Falls, MN 56345, or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that Family Medical Center took, made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Unity Family Notice of Privacy Practices.

PERMANENT CHART COPY

Representative Signing _____

Printed name of individual's personal representative, if applicable:

_____

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):

_____

FOR INTERNAL PURPOSES ONLY

Staff Personnel:

Release received by: _____
Date:_____

Identification verified by photo ID? YES NO

BY: _____

Appendix J

CSCT Coordinated Care to Manage Pill Counts

1. CSCT forwards request to injection nurse in-basket
2. Injection nurse schedule pill counts to fit her schedule
3. Injection nurse notifies patient to schedule pill count (within 24 hours from patient contact is ideal)
4. Pill counts are not valid if done later than 48 hours from request
5. Document details on scheduling telephone call

CSCT Coordinated Care to Manage Urine Drug Abuse Screens

1. CSCT forwards request to injection nurse in-basket
2. Urine drug abuse screen will have been ordered (contact CSCT if UDAS needs to ordered)
3. Injection nurse schedules UDAS to fit her schedule
4. Injection nurse notifies patient to schedule UDAS (within 24 hours from patient contact is ideal)
5. UDAS results are not valid if done later than 48 hours from request
6. Document medication taking history; last pill taken when
7. Collect samples using lab bathroom in hall 2
8. Patient empties pockets, leaves personal item with injection nurse
9. Spray water blue
10. Turn off tap with switch on wall outside door
11. Sample to clinic lab
12. Route documentation to CSCT and PCP

Flow Sheet/CSCT

- ☐ Initial Suboxone Screen Criteria Form and Substance Use Assessment completed with patient
- ☐ Appropriate Use Checklist
- ☐ DSM 5 Opioid use disorder checklist completed with patient and signed with MD
- ☐ CHI St. Gabriel's Health Suboxone Medication Agreement signed
- ☐ Consent for treatment with Buprenorphine signed by patient
- ☐ Buprenorphine Maintenance Treatment/Patient Responsibilities initialed and signed by patient
- ☐ Controlled Substance Program Care Plan completed with and signed by patient
- ☐ ROI for Treatment/CD Provider signed by patient
- ☐ ROI for Case Manager(s) signed by patient
- ☐ ROI Mental Health Providers/Psychotherapy Notes signed by patient
- ☐ ROI Probation officer/social worker signed by patient
- ☐ UDAS collected
- ☐ Documents scanned in to EMR

_____

_____

_____

Appendix L

Suboxone Screening Criteria

1: Where do you live? County:

2. What is the drug/Substance that you are currently using?

3. Have you been on Suboxone in the past or currently?

A: If current, dose?

B: Why are you changing Suboxone providers?

4. Who is your doctor now? If no one, who in the past?

5. Have you had any previous treatment? Rule 25 completed? Y/N

A: Inpatient Legal issues? Y/N

B: Outpatient Current Insurance?

6: Are you currently in counseling?

A: NA or AA?

7. What medications are you currently taking? Please list all meds including herbals, supplements, OTC and prescriptions.

Appendix M

Substance Use Assessment

Instructions: Fill out the section for each of the drugs that you have used, even if that substance was never a problem for you. If you don't remember specifics, give your best estimate.

	Age of first use (ex. 16)	**When did you last use? (ex. 1 month ago)**	**Frequency of most recent use. (ex. 3x per week)**	**Was this substance ever a problem? (yes/no)**
Alcohol				
Benzodiazepines (Xanax, Valium, etc.)				
Cocaine				
Crack				
Hallucinogens (LSD, mescaline, etc.)				
Heroin				
Inhalants ("Huffing")				
Marijuana				
Methamphetamine				
Methadone				
MDMA ("Ecstasy")				
PCP ("Angel Dust")				
Prescription Medicine (Vicodin, "Oxys," etc.)				
Other (list)				

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Appendix N

CHI St. Gabriel's Health
Suboxone Medication Agreement

I understand that my provider is prescribing Suboxone to assist me in managing my opioid dependence or chronic pain that has not responded to other treatments. These medications are intended to improve function and/or ability to work. The risk, benefits, and side effects of Suboxone has been explained to me and I agree to the following conditions for this treatment.

1. I will participate in other treatments to assist with Medication Assisted Recovery program, such as a Suboxone group, AA, NA, behavioral therapy, or other recommended counseling that my provider recommends.
2. I will take my medications exactly as prescribed and will not change the medication dosage or schedule without my provider's approval. Refills will not be given if I run out early,
3. Prescriptions will be provided after attending group, random UA, and meeting briefly with your provider
4. I will keep all regular appointments at the clinic (this includes nurse appointments and appointments with PT, behavioral medicine, or Suboxone group). Suboxone cannot be given if an appointment is missed, it may be prescribed at the next appointment.
5. I will not request or accept prescriptions for controlled substances from other physicians or individuals for my chronic pain condition. If I develop another condition that requires the prescription of a controlled medication or if I am hospitalized for any reason, I will inform the new provider that I am on Suboxone, and will call clinic within one business day of receiving any other treatment or medications.
6. I will be ready to taper or discontinue Suboxone if I need other pain medications for acute pain situations.
7. I will designate one pharmacy where all of my prescriptions will be filled.
8. Refills of Suboxone will be made only during regular office hours, during a scheduled appointment with my provider.
9. I am responsible for my prescriptions. If the medication is lost or stolen, I understand it will not be replaced.
10. I agree to abstain from all illegal and recreational drugs and will provide urine or blood specimens as requested.
11. If I am late for a scheduled appointment, I may not be able to be added to the schedule at a later time that day, and you may have to reschedule. If you have to reschedule, the Suboxone cannot be prescribed that day, but may be prescribed at your next appointment.
12. If asked, I will meet with controlled substance team nurse or social worker.

I understand that if I violate any of the above conditions my Suboxone and/or treatment may be terminated. If the violation includes obtaining any controlled substances from other healthcare providers or individuals a report may be made to my physician, pharmacy, and other authorities including the police.

I have read this agreement and it has been explained to me. I fully understand the consequences of violating this agreement.

_____

Patient

Appendix O

Consent for Treatment with Buprenorphine

Buprenorphine is an FDA approved medication for treatment of people with opiate dependence. Qualified physicians can treat up to 30 patients for opiate dependence. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary.

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

If you are dependent on opiates, you should be in as much withdrawal as possible when you take the first dose of buprenorphine. If you are not in withdrawal, buprenorphine can cause severe opiate withdrawal. For that reason, you should take the first dose in the office and remain in the office for at least 2 hours. After that, you will be given some tablets to take at home.

Some patients find that it takes several days to get used to the transition from the opiate they had been using to buprenorphine. During that time, any use of other opiates may cause an increase in symptoms. After you become stabilized on buprenorphine, it is expected that other opiates will have less effect. Attempts to override the buprenorphine by taking more opiates could result in an opiate overdose. You should not take any other medication without discussing it with me first.

Combining buprenorphine with alcohol or some other medications may also be hazardous. The combination of buprenorphine with medication such as Valium, Librium, and Ativan has resulted in deaths.

The form of buprenorphine (Suboxone) you will be taking is a combination of buprenorphine with a short-acting opiate blocker (naloxone). If Suboxone is dissolved and injected by someone taking heroin or another strong opiate, it would cause severe opiate withdrawal.

Buprenorphine tablets or films must be held under the tongue until they dissolve completely. Buprenorphine is then absorbed over the next 30-120 minutes from the tissue under the tongue. Buprenorphine will not be absorbed from the stomach if it is swallowed, so you should not swallow it.

Buprenorphine may cost $5-20/day just for the medication. If you have medical insurance, you should find out whether or not buprenorphine is a benefit. If any case, office fees must be kept current.

Alternatives to Buprenorphine

Some hospitals that have specialized drug abuse treatment units can provide detoxification and intensive counseling for drug abuse. Some outpatient drug abuse treatment services also provide individual and group therapy; which may emphasize treatment that does not include maintenance of buprenorphine or other opiate like medications. The other opiate maintenance therapy medication is methadone. Some opiate treatment programs use Naltrexone, a medication that blocks the effects of opiates, but has no opiate effects of its own.

_____

Signature

_____

Print Name

_____

Date

Buprenorphine Maintenance Treatment

Patient Responsibilities

_____ **I agree to store my medication properly**. Medication may be harmful to children, household members, guest, and pets. The pills/film should be stored in a save place, out of reach of children. If anyone besides me ingests the medication, the Poison Control Center or 911 will be called immediately.

_____ **I agree to take the medication as prescribed**. The indicated dose should be taken daily and I will not adjust the dose on my own. If I wish a dose change, I will call the clinic for an appointment to discuss this. Sharing or selling of this medication is prohibited and will result in discharge. I agree not to obtain this medication from another doctor.

_____ **I agree to comply with the required pill or film counts and urine tests**. Urine testing is a mandatory part of office maintenance and I must be prepared to give a urine sample for testing at clinic visits, as well as to show the medication bottle for a pill count, including reserve medication. I may also be called in for a random urine screen at times other than that of a scheduled visit and then l must provide the screen that day.

_____ **I agree to notify the clinic immediately in case of lost or stolen medication**. If a police report is filed, l will bring in a copy for the record. It is the policy of this clinic that lost or stolen medication will not be replaced. Therefore, I will store it securely.

_____ **I agree to notify the clinic immediately in case of relapse**. Relapse to opiate drugs can be life-threatening, and an appropriate treatment plan has to be developed as soon as possible. The physician should be notified about a relapse before any urine test shows it. A relapse does not mean automatic discontinuation of Suboxone.

_____ **I will review the procedures of office maintenance at this site**. This includes the hours, the phone numbers, the procedure for making appointments, the fees, the relationship to methadone maintenance programs, the requirements for participation in office maintenance and the clinic's responsibilities for patient care. You must be willing to be seen at least monthly or more frequently as determined by the physician. No other physician in this clinic will be able to provide or make changes in this medication.

Signature _____ Date_____

Witness _____ Date_____

Buprenorphine Maintenance Treatment

Information for Patients - Frequently Asked Questions

Specific information for patients who are considering treatment with buprenorphine.

Buprenorphine -Treatment for Opioid Addiction

Addiction medicine doctors consider addiction to be a chronic disease and treat it accordingly. Buprenorphine is one of the medications which can be used to treat opioid addiction. Opioids consist of drugs such as heroin, opium, morphine, codeine, oxycodone, hydrocodone, etc.; which can be abused and lead to tolerance and dependence. This means that the user's body becomes accustomed to even higher amounts, and, when the drug is stopped, there are symptoms of withdrawal. Even after the worst part of physical withdrawal is over, some patients still don't feel right for a long time and may relapse to drugs again, just to "feel normal."

Medical research shows that drug use has negative effects on the brain, and the goal of treatment is to achieve both physical and mental stability.

Not all patients who have problems with opioids need medication to treat their addiction. Many addicted persons do very well with counseling, or residential treatment, or in NA groups. But [n some cases, these approaches alone are not enough to keep the person stable, and maintenance medication is used. Maintenance medication is slower and longer-acting in its effects on the brain that heroin or other drugs of abuse. This allows for a steadying of brain function, which is part of treatment. The best way to use buprenorphine in maintenance treatment is to find the correct dose, where the patient feels normal, and keep that dose steady for a long time. This means taking the medication on a regular schedule as prescribed, the same way one would take blood pressure medication. Abstinence from drugs of abuse is the goal of this treatment, and buprenorphine is one component of treatment. Counseling, self-help, or other recovery activities are essential to long-term success.

Q: What other drugs are used for opiate addiction treatment?

A: Besides buprenorphine, there are three other maintenance medications that are used to treat opiate addiction: methadone, naltrexone, and long-acting injectable naltrexone. Methadone is also a long-acting opioid and works by stabilizing the brain. This medication is given in specifically-regulated clinics called Opioid Treatment Programs, and its use is carefully regulated by federal and state agencies. Naltrexone blocks the opiate receptor and prevents the effects of opiates.

Q: What procedures are required for buprenorphine treatment?

A: Buprenorphine is bound by some federal regulations. For this reason, patients on buprenorphine will be asked to give urine samples for drug screens, and bring their bottles in for pill or film counts. Buprenorphine is best started when the patient is in withdrawal, and the dose is adjusted over several days. It is given as a pill or film that dissolves under the tongue. The take-home buprenorphine pills or films also contain a small amount of naltrexone (Narcan), which is an opioid antagonist. The purpose of the naloxone is to discourage illicit injection of the pill. The patient would not feel the effects of naloxone when taken by mouth, but if it were dissolved an injection, it might cause severe withdrawal.

Q: For what reason will buprenorphine be discontinued?

A: Buprenorphine treatment may be discontinued for several reasons. Here are some examples:

- Buprenorphine controls withdrawal symptoms and is an excellent maintenance treatment for many patients, but not all patients respond to this therapy. Some patients may need stronger maintenance medication or an alternative form of treatment. If you are unable to abstain from opiates, or if you continue to feel like using, even at the top doses of buprenorphine, then the doctor may advise you to obtain additional or alternative treatments, including methadone at a licensed clinic.
- There are certain rules and patient agreements that are part of buprenorphine treatment, which are signed by all patients or admission. If you do not keep these agreements, you may be discharged from buprenorphine treatment.
- Prompt payment of clinic fees is part of buprenorphine treatment. If you can't pay your fees, please discuss arranging a payment plan. If you still cannot pay, you will be discharged from buprenorphine treatment.
- Dangerous or inappropriate behavior that is disruptive to the clinic or to other patients will result in discharge from buprenorphine treatment. This includes patients who come to the clinic intoxicated.
- Selling or giving buprenorphine to other persons (e.g., diversion).
- Obviously, in the rare case of allergic reaction to the medication, it has to be discontinued.

The usual method of ending treatment is a taper, which means a decreasing dose of buprenorphine over several weeks. After this time, you would no longer be enrolled in the buprenorphine program, and your treatment slot would be used for another patient. In some cases, a direct transfer to another kind of maintenance treatment can be made, such as to methadone maintenance at a clinic with a special license for using methadone.

In the case of dangerous behavior, there will be no taper.

Appendix P

Clinical Opiate Withdrawal Scale (COWS)

Flow-sheet for measuring symptoms over a period of time during the buprenorphine induction.

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

Patient's Name:
Date:
Buprenorphine Induction:
Enter scores at time zero, 30min after first dose, 2h after first dose, etc.

Times				
Resting Pulse Rate: (record beats per minute) *Measured after patient is sitting or lying for one minute* *0 pulse rate 80 or below* *1 pulse rate 81-100* *2 pulse rate 101-120* *4 pulse rate greater than 120*				
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness: *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequently shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds				
Pupil Size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				

MORRISON COUNTY SOCIAL SERVICES

Consent for the Release of Confidential Information

A photo copy/facsimile of this authorization is valid as original

Name *(Last)* *(First)* *(Middle)*
Birthdate:
Regarding: ☐ **Self** ☐ **Child** **If Child-Child's Name:**
Child's Date of Birth:

Authorizes:
Agency/Person: Morrison County Social Services
Address: 213 SE 1st Ave, Little Falls, MN 56345
Phone: Fax: 320-632-0225
Contact:
Contact's e-mail:

☒ **To exchange with** ☒ **release to** ☒ **receive information from**
Agency/Person: Family Medical Center/CHI
Address: 811 SE Second St Suite A Little Falls, MN 56345
Phone: 320.631.7216 Fax: 320.632.0534
Contact:

Information which may be released includes *(check appropriate boxes)*:

☒ Discharge Summary
☒ Discharge Aftercare Plan
☒ Treatment Plans/Summary
☒ Social History
☒ Veterans Service Information
☒ Medical Reports (specify)
☒ Psychological Assessment/Consultation
☒ Vocational Rehabilitation
☒ Educational Records
☒ Employment Records
☒ Psychiatric Assessment/Consultation
☒ Chemical Dependency evaluation
☒ Social Service Case Records
☒ Disability Information and Records
☒ Child Support Records
☐ Other (specify

I understand that the information authorized to be shared, or released, with the entity above may be shared in verbal, written, or electronic formats.

This information will be released for the purposes of *(check appropriate area)*:

☒ *Determining eligibility for services* ☒ *Coordinate/monitor service delivery*

I understand that my records are protected under State and Federal confidentiality regulations and cannot be disclosed without my prior written consent, unless otherwise provided for in these regulations. I also understand that I may revoke this consent at any time and that in any event this consent expires automatically in one calendar year from the date of my signature on this consent. I understand that information (organization holding data) is limited to staff whose work assignments reasonably require access to my data within the purposes specified in this document.

I consent to this release: _____ Date: ____/____/____
(Signature of client)

_____ Date: ____/____/____
(If client is a minor or incompetent, Signature of Parent or Guardian)

I revoke my consent to this release: _____ Date: ____/____/____
(Signature of client)

_____ Date: ____/____/____
(If client is a minor or incompetent, Signature of Parent or Guardian)

Morrison County Social Services' Contact Person:
Phone #:
Fax#
E-mail:

Morphine Equivalents

Prior Oral Opioid	Multiply dose by a factor of:
Hydrocodone	**1**
Hydromorphone	**4**
Morphine	**1**
Oxycodone	**1.5**
Oxymorphone	**2**

Methadone- not a linear relationship, exponential as dose increases

Appendix S

NOTICE TO PATIENTS PRESCRIBED CONTROLLED SUBSTANCES

At Family Medical Center, we are committed to providing our patients with the best care possible, focusing on the patient as a whole person. We understand the importance of caring for each patient individually while maintaining standards of appropriate and responsible care. To ensure safety and achieve positive health outcomes, we have developed a process of care for all patients who are prescribed controlled substances for chronic or daily use.

What is a controlled substance?

Controlled substances are medications that have significant risk associated with them, including addiction, dependence, and many other side effects. A controlled substance includes medications such as:

- Stimulants (i.e. Adderall, Ritalin)
- Benzodiazepines (i.e. Xanax, Ativan, Klonopin)
- Narcotics (i.e. oxycodone, morphine, hydrocodone, fentanyl)

Chronic use means the medication prescribed for more than 3 consecutive months.

What to expect

We want to ensure the best health outcome possible. For this reason, our clinic closely monitors medication use for all patients prescribed controlled substances for use on a chronic or daily basis. This will include:

- Signing a care plan
- Urine drug screening
- May include pill counts
- Meeting with members of our controlled substance care team (social worker, pharmacist, RN Health Navigator) in addition to your primary care provider.

Following your care plan is very important. Plan accordingly for your refills.

Monitoring medication use is important for the safety of all of our patients and our community. Each patient will be treated with respect, dignity and equally fair. Do not hesitate to ask your provider's nurse or provider if you have any questions or concerns.

CHI St. Gabriel's Health

*Imagine better health.*SM

ADDICTED to opioids?

If you would like help with your opioid (heroin or prescription pain medication) addiction, or know someone who would, please contact our controlled substance care team (CSCT) at the Family Medical Center.

320-631-7274

We care
and are here to help!

At Family Medical Center, we have physicians certified to prescribe medication to help patients overcome opioid addiction. This is known as medication-assisted treatment (MAT).

What is Medication-assisted treatment (MAT)?
MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.

What will these medications do?
These medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. MAT programs provide a safe and controlled level of medication to overcome the use of an abused opioid.

What can I expect at my first visit?
Members of the care team and a physician will meet with you to assess suitability for MAT. If you are a suitable candidate, you will develop a plan of care with members of the care team.

There is **HOPE**

About Addiction

Did you know...

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry.

Addiction is more than a behavioral disorder.

Addiction can cause disability or premature death, especially when left untreated or treated inadequately.

As in other health conditions, self-management, with mutual support, is very important in recovery from addiction.

Recovery from addiction is best achieved through a combination of self-management, mutual support, and professional care.

We care
and are here to help!

320-631-7274

There is **HOPE**

Appendix U

Buprenorphine Intake Checklist

Form/Test	Date & Initials
Intake visit with nurse	
Consent form signed	
Parental consent signed	
Pharmacy form signed	
Contract signed	
Labs drawn	
UTS obtained	
HQN (for all women)	
BCP review done and documented (for all women)	
Medication list	
Allergies list	
Consent for counselor/psychiatrist	
Consent for Parole Officer	
Other consent signed, if needed	
Emergency contact information and clinic contact information recorded	
Check in	
Last PPD/PPD (if greater an six month)	
Orientation to the team and location	

Adapted from materials produced by Colleen LaBelle, RN at Boston Medical Center

Appendix V

Requirements to Family Medical Center's Suboxone Therapy Program

1. **Just because you are meeting with a Suboxone provider does not imply that you will be their patient.**
2. Patients will be expected to have random urine drug testing.
3. Patients will be expected to make a minimum of monthly visits. At the start of the program patients will be seen more frequently. Sometimes even daily in the clinic.
4. Patients will meet annually with our registered nurse and social worker to be sure your social needs are being met.
5. We will require past medical records and proof of treatment.
6. Patient will be required to attend treatment meetings (ie: AA, NA) for support.

Suboxone Patients

#	Name	DOB	Date we started prescribing suboxone	Completed Treatement (Y/N)	Date Contract Signed	Current Dose	Last Visit	Primary Physician	Suboxone Provider	Active (Y/N)
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2										
3										
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Appendix X

Patient Name: _____
DOB: _____
MRN: _____
Date Started Suboxone: _____
Date Started Suboxone at our Clinic: _____
Name/Form of Medication on: _____

Visit #	Apt Date	Dose at Appt Time	Dose When Left Clinic	Last UDAS	Next Follow Up (# Weeks)	Completed Treatment (Y/N)	Date Contract Signed

Appendix Y

Family Medical Center
811 2nd Street SE
Little Falls, MN 56345

Mutual Support Group Meeting Attendance Form

NOTICE

- You are required to document your attendance at mutual support group meetings and to have regular contact with your sponsor.
- You may document your mutual support group attendance by having someone sign this attendance sheet at each meeting you attend.

PARTICIPANT – PRINT Name: _____ Date: _____

Ask group leader or member to document your attendance below:

Meeting Date	***Meeting Location***	***Signature or Initials of Group Leader or Member***

Meeting Date	***Meeting Location***	***Signature or Initials of Group Leader or Member***

Appendix Z

Prior Authorization Rationale:

1. PDMP reviewed
2. Urine drug screen updated and reviewed
3. Pregnancy test, where applicable, negative
4. Avoiding benzodiazepines, and other illicit drugs, reviewed with patient
5. With our program, patient will either need to have completed treatment or be in the process of getting into or going through treatment
6. Patient has been complaint with treatment plan laid out in our clinic

For new starts/induction:

1. Dosage is currently being adjusted to meet patient's needs
2. Patient will be seen and new prescription give quite frequently until stability reached

For chronic/maintenance:

1. Stable dose in stable patient- maintenance phase of treatment
2. Dosage reviewed and deemed to still be an appropriate dose to meet patient's needs

Kurt Devine, MD

NPI:

Heather Bell, MD

NPI:

SAMPLE POLICIES

CHI St. Gabriel's Health

Family Medical Center

Section:	Patient Centered Medical Home
Title:	**FMC URINE DRUG SCREEN PROTOCOL**
Effective Date:	February 2016
Revised Date:	June 2017
Reviewed Date:	
Approved by:	CSCT Leadership Team, Ambulatory Quality Committee, POC

PURPOSE

To promote consistency and standardization with management of urine drug abuse screens.

POLICY STATEMENT.

Urine drug testing is an important component of the treatment plan for patients who are prescribed controlled substances which are subject to random and/or witnessed screening.

DEFINITIONS (if applicable)

Controlled Substance Care Plan (Care Plan): An agreement for long-term pain management between a primary care provider (PCP), a patient, and the CSCT.
Controlled Substance Care Team (CSCT): Nurse Navigator, Pharmacist, Physician Champion and Social Worker.
Controlled Substances: Substances with high potential for abuse which may lead to high physical and/or psychological dependence.
UDAS: Urine Drug Abuse Screen

PROCEDURE

1. Patient is identified by their primary care provider (PCP) or a CSCT member.
2. UDAS is ordered in the electronic medical record (EMR) by the PCP or by the CSCT RN.
3. Sample is obtained at a scheduled office visit or when a patient is notified of a random urine drug abuse screen.
    a. Document medication taking history in the nurses notes in the EMR as reported by patient before sample is obtained
    b. Prepare the bathroom with blue colored dye in the toilet and shut water off.
    c. Have patient empty pockets, remove coat, sweatshirt.
    d. Have patient wash hands.
4. Urine sample will be labeled appropriately with the following information:
    a. Patient name
    b. Date of birth
    c. Medical record number
    d. Time of collection

    e. Date of collection
    f. Initials of collector
5. After urine sample is labeled, place into biohazard bag and transport to lab.
6. Inform patient results will take approximately 1 week to return.
7. The UDAS results are reviewed by PCP and CSCT.
8. The CSCT will review the UDAS and the CSCT RN will reflex this order to confirm initial screening results by following the CHI St. Gabriel's Health Urine Algorithm.
9. After the confirmatory results are received, the CSCT will discuss patient plan with the PCP utilizing the Quick Tip Sheet With Metabolites.
10. Patient will be notified of results.

CHI St. Gabriel's Health

Family Medical Center

Section:	Patient Centered Medical Home
Title:	**FMC CONTROLLED SUBSTANCE CARE MANAGEMENT**
Effective Date:	August 2015
Revised Date:	September 2015, December 2017
Reviewed Date:	November 2016
Approved by:	PCMH Leadership Team, Ambulatory Quality Committee, POC, Vice President of Patient Care

PURPOSE

To identify, enroll and facilitate care for patients receiving controlled substances for long term medication management.

POLICY

This policy states the Controlled Substance Care Team will assess the whole person and their long-term controlled substance management therapy, which may include: narcotics, stimulants, and/or benzodiazepines, needs upon enrollment and whenever there may be adjustments to the care plan.

DEFINITIONS

Controlled Substance Care Plan (Care Plan): An agreement for long-term controlled substance medication management between a primary care provider (PCP), a patient, and the CSCT.
Controlled Substance Care Team (CSCT): Nurse Navigator, Pharmacist, Physician Champions, Mental Health Provider/Worker, and Social Worker.
CSCT review: a patient review inclusive of DIRE tool, interview, PMP analysis and referral source.
DIRE: Diagnosis, Intractability, Risk, and Efficacy (DIRE) tool that assesses the suitability of candidates for long-term opioid therapy. Includes chart review.
Onsite/Offsite: Onsite refers to health care providers at the Family Medical Center and St. Gabriel's hospital. Offsite refers to health care providers and adjunct stakeholders who are not employed by CHI.
Patient, adherent: a patient that abides by the terms of the care plan.
Patient, non-adherent: a patient that breaks the terms of the care plan.
Prescription Monitoring Program (PMP): A tool used by prescribers, pharmacists and delegates which assists in managing patient care, detecting diversion, and the abuse/misuse of controlled substance prescriptions.
Controlled Substances: CII substances and/or substances with high potential for abuse which may lead to high physical and/or psychological dependence.
Stakeholder, adjunct: Non-healthcare providers involved in patient outcomes such as family, law enforcement, and social workers.
Long Term Use/Chronic: greater than or equal to 3 months of controlled substance use.

PROCEDURE

1. An attempt should be made that all patients receiving long term, chronic, controlled substances be referred by onsite or offsite health care providers and adjunct stakeholders.
2. Patients referred to CSCT undergo a CSCT review.
3. A care plan is initiated with controlled substance management.
4. CSCT will confer with prescribing physician regarding appropriateness of controlled substance use in the patients care plan.
5. Adherent patients are managed to their appropriate therapeutic management outcomes.
6. Non-adherent patients are managed towards their best outcome within the paradigm of discontinuing care plan.

REFERENCES

Substance Abuse and Mental Health Services Administration https://www.samhsa.gov/

CHI St. Gabriel's Health

Family Medical Center

Section:	Patient Centered Medical Home
Title:	**FMC CONTROLLED SUBSTANCE REFILL PLAN OF CARE**
Effective Date:	October 2013
Revised Date:	November 2015
Reviewed Date:	November 2016, December 2017
Approved by:	Ambulatory Quality Committee, Vice President of Patient Care Services, and POC

PURPOSE

The purpose of this plan of care is to prevent misunderstanding about controlled medications.

POLICY STATEMENT

This policy defines a consistent process of how controlled substance medications are refilled.

PROCEDURE

1. Controlled Substance Care Plan will be signed and scanned into the electronic medical record.
2. Copy of signed care plan will be given to the patient.
3. An FYI flag will be placed in the patient's electronic medical record identified as Medication Contract.
   a. Please see the Controlled Substance Program Care Plan for controlled substance procedure.
4. All controlled medications shall state "Do not fill until XXX" based on last fill date.

REFERENCES

Substance Abuse and Mental Health Services Administration https://www.samhsa.gov/