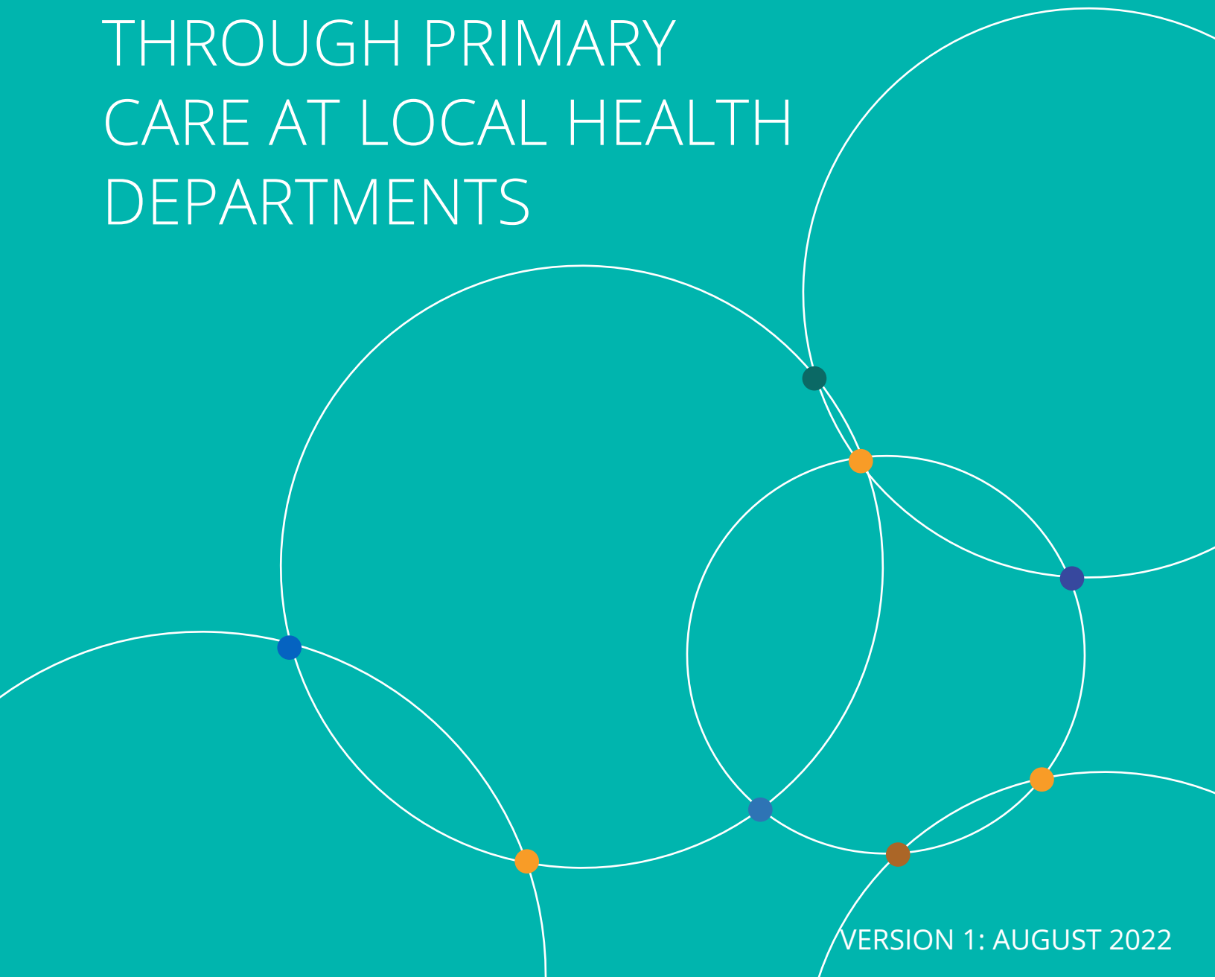
PRACTICAL GUIDANCE FOR IMPLEMENTATION OF OFFICE-BASED **OPIOID TREATMENT** THROUGH PRIMARY CARE AT LOCAL HEALTH DEPARTMENTS



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This project was part of the Duke Opioid Collaboratory, funded by The Duke Endowment and administered through the Duke School of Medicine Department of Population Health Sciences. The Collaboratory convenes diverse partners to save lives, reduce stigma, and mitigate the harmful impact of drugs through the development, implementation, and evaluation of system-level interventions.

1. Purpose of This Document

This document is intended to provide practical guidance and offer considerations for providing medication for opioid use disorder (MOUD) through a local health department's primary care or other office-based clinic. It is a product of a collaboration between Granville Vance Public Health (GVPH) and the Duke University Opioid Collaboratory, housed under the Department of Population Health Sciences, and draws upon interviews with providers, staff, and patients.

Whose needs does this document address?

- **Providers and practice managers** interested in starting an office-based opioid treatment (OBOT) program in their clinic or local health department
- **Local government leaders** interested in supporting OBOT programs in their communities

What topics does this document address?

This document walks through three key steps in developing an OBOT program:

- **Building an implementation team**
- **Designing your program**
- **Funding your program**

It concludes with a deep dive into the experience of providers, clinic staff, and patients involved in GVPH's OBOT program.

What makes this document unique?

This document gives practical guidance on how to begin and develop your OBOT program. It also compiles helpful freely available online resources to support steps 1-3 in developing an effective OBOT program.

2. Introduction

From May 2020 to April 2021, more than 100,000 Americans died from unintentional drug overdose—and more than 9 North Carolinians died each day, with opioids involved in the large majority of these deaths.[1,2,2]

The COVID-19 pandemic has accelerated rates of drug overdose deaths, and its disruptions to daily life have been particularly impactful on people with opioid use disorder (OUD) and our communities.[3]

MOUD is the most effective evidence-based approach to address OUD.[4,5] Medications such as buprenorphine or methadone help manage cravings and symptoms of withdrawal that come from reducing or stopping the use of opioids. MOUD has been shown to reduce opioid use, help retain patients in treatment, and prevent death.[4,6]

Despite demonstrated efficacy, access to MOUD is still low in many parts of the country, especially among those who are uninsured or under-insured.[7] People in rural areas face even greater barriers to access. Making MOUD more accessible by establishing programs in local health departments and other office-based clinics is a vital step for addressing the overdose epidemic.

GVPH has been providing MOUD in the form of buprenorphine/naloxone within an OBOT setting since 2018.[A] In 2020, the Duke University School of Medicine's Department of Population Health Sciences' Opioid Collaboratory partnered with the GVPH district health department to document programming and lessons learned from their novel OBOT program serving both Granville and Vance counties in North Carolina. GVPH's experience shows that local communities would benefit from local health departments and clinics adopting a model similar to GVPH.

This Practice Guide includes recommendations and guidance derived from qualitative interviews with patients, staff, and providers involved in GVPH's OBOT program and informal listening sessions with GVPH staff and providers. It provides insights and practical guidance for other local health departments and office-based clinics interested in developing and implementing an effective OBOT program.

A guiding principle for many successful public health programs, including programs designed to prevent drug overdose, address OUD, and reduce infections, is **harm reduction**.[8,9] Harm reduction is a set of practical strategies and perspectives focused on treating individuals with respect, and meeting individuals where they are in

A All patients enrolled in the GVPH program are at least 18 years of age.

their substance use journey with a goal of reducing harm.

Principles of harm reduction

1. **Taking a non-judgmental approach that treats every person with dignity, compassion, and respect**
2. **Accepting behavior change as an incremental process**
3. **Recognizing complex social factors that influence vulnerability to drug use and drug-related harm, including poverty, social inequities, discrimination, and trauma**
4. **Focusing on the whole patient**

Harm reduction principles have been endorsed by organizations such as the United States Department of Health and Human Services (including the Substance Abuse and Mental Health Services Administration [SAMHSA] and the Centers for Disease Control and Prevention [CDC]) and the Office of National Drug Control Policy and are backed by state and federal laws.[10,11] Examples of how harm reduction principles can help guide program decisions can be found in green boxes throughout this document.

For more information on harm reduction, see:

National Harm Reduction Coalition. Principles of Harm Reduction. https://harmreduction.org/about-us/principles-of-harm-reduction/

North Carolina Harm Reduction Coalition. Harm Reduction. https://www.nchrc.org/harm-reduction/

Taylor JL, Johnson S, Cruz R, et al. Integrating harm reduction into outpatient opioid use disorder treatment settings. *J Gen Intern Med.* 2021;36:3810-3819. https://doi.org/10.1007/s11606-021-06904-4

3. Developing an Office-Based Opioid Treatment Program

This document outlines the process for developing an OBOT program in three overarching steps, which could occur linearly or simultaneously when developing a new program.

A. Building an implementation team

This section describes the processes of identifying the key actors needed to implement a successful OBOT program, obtaining buy-in from local decision-makers, and identifying or hiring clinic staff that will be involved in patient care. This section also emphasizes training to reduce stigma and help individuals better understand MOUD and OBOT.

B. Designing your program

This section details components of OBOT programs, including clinic workflow, supportive services that are helpful to offer patients, and data collection strategies to track outcomes.

C. Funding your program

This section outlines cost considerations for OBOT programs, and potential sources of funding and resources.

A. Building an implementation team

Building your implementation team includes:

1 | Identifying and getting key people and local partners engaged in the design and implementation of an OBOT program

2 | Identifying and/or hiring staff that will be engaged in OBOT patient care, or staffing the program

Training and education on OUD, OBOT, personal bias and stigma, and harm reduction is crucial at this stage and ongoing.

Getting key people on board

When designing an OBOT program, building partnerships and getting support from key people is a priority, because engagement provides opportunities to support each other and work as a community. Starting with this step helps ensure programming has needed approval from decision-makers, such as elected leaders, and support from local providers where OBOT patients can be linked with other services. It is also important to meaningfully engage organizations that have similar or complementary objectives, as well as individuals with lived experience to ensure that the program is designed with your specific community and the needs of impacted individuals in mind.

Some key people and organizations that should be considered when planning your OBOT program are listed below.

- Leadership and staff within your organization who will be closely involved with the implementation of your program
- Individuals with lived experience
- Local or regional organizations or agencies that may benefit from referring patients to the program, for example, recovery centers, law enforcement, courts, employers, and social service providers
- Local or regional organizations or resources that patients can be referred to for mental and behavioral health support, inpatient treatment and detox, and access to supportive services for social drivers of health (e.g., housing, employment, transportation)
- Local organizations that distribute naloxone and harm reduction agencies such as syringe services programs
- Certified Opioid Treatment Programs – federally-approved to administer and dispense methadone (and other MOUD)
- Local Management Entities/Managed Care Organizations or other entities that help uninsured individuals pay for behavioral health care
- Other local physicians, especially psychiatrists and primary care
- Pharmacists
- Support groups, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or Self-Management and Recovery Training (SMART) recovery groups

Getting these people and organizations on board often starts with structured engagement and education. It is useful to schedule regular meetings that provide space for:

1. Education on local overdose rates, currently available resources and services and remaining gaps, and potential benefits of MOUD and OBOT programming
2. Conversations that address hesitance or misconceptions about OUD, MOUD, and OBOT

3. Discussions around which type of OBOT programming is appropriate for your setting and context, and what options might need to be offered to individuals
4. Conversations about how stakeholders might contribute to OBOT programming

It is helpful to educate partners on harm reduction at this stage, so that group decision-making is founded on a common understanding of these principles. Some useful training resources can be found in Appendix 1. End meetings with clear next steps and action items delegated to specific stakeholders.

Staffing the program

Another key part of the implementation team is the individuals involved in patient care within your OBOT program.

It is often not necessary to hire individuals specifically for your OBOT program, as in many ways, patients receiving MOUD may be integrated into the typical patient load or the workflow for clinic staff. Instead, it is important to identify which clinic staff will play a role in the program and to determine whether new staff members need to be added to the team as the program grows. This way, you can begin engaging clinic staff in training and provide ample time for any necessary hiring.

Note that hiring individuals from the local community can be beneficial, as these individuals may have more personal understanding of patients' social and cultural contexts. Individuals who live locally also likely have more awareness of resources in the area. To recruit staff and providers from the local community, it can be helpful to reach out to local harm reduction organizations, detox or recovery programs, and other treatment programs.

The following staff play key roles in an OBOT program:

- Medical doctors (MDs) or Doctors of Osteopathic Medicine (DOs) prescribe MOUD and/or provide supervision for other providers such as nurse practitioners (NPs) or physician associates (PAs) prescribing MOUD
- Nurses or designated care managers (part- or full-time) provide clinical support and follow up with patients, answer questions, and address more urgent patient needs including return to use or challenges to obtaining medication.
- Counselors/social workers[B] can provide psychosocial/behavioral health support and also serve as case managers to help connect patients to supportive services like housing and food assistance
- Trained phlebotomists and lab staff collect and process samples for testing
- Administrative staff or patient navigators can manage questions about insurance and scheduling and provide support for filling out intake forms
- Pharmacists monitor and provide patient care in some OBOT settings. Pharmacists can provide counseling during the induction phase, as well as help with medication refills and prior authorizations.

Remember that not every setting will need to or be able to hire all staff listed above due to challenges with hiring or availability of funding. OBOT services can be tailored to utilize the staff and resources that are available. Providing any services for MOUD is an impactful step forward.

While all clinic staff should be engaged in program planning and receive education about

B Such an individual could be a Licensed Clinical Social Worker (LCSW), Licensed Clinical Addiction Specialist (LCAS), or Licensed Clinical Mental Health Counselor (LCMHC).

OUD, OBOT, and reducing stigma in the care they provide to patients receiving MOUD, those with specific roles may require more specific training and/or formal qualifications.

Training is no longer required for physicians, NPs, PAs, Clinical Nurse Specialists (CNSs), Certified Registered Nurse Anesthetists (CRNAs), and Certified Nurse-Midwives (CNMs) treating no more than 30 patients.

The practitioner would still need to submit a Notice of Intent to SAMHSA.

For guidance on the training process, see:

Providers Clinical Support System. Applying for Your Waiver. https://pcssnow.org/medications-for-opioid-use-disorder/buprenorphine-waiver-application/

SAMHSA. Become a Buprenorphine Waivered Practitioner. https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner

B. Designing your program

Once your leadership, team members, providers, and clinic staff are engaged and have bought in, you are ready to engage in program design and start making decisions about clinic workflow, templates for documentation, formal contracts, services you will provide, and data that you will collect.

To design a program, you need not reinvent the wheel. Learn how other clinics, including GVPH, have designed OBOT programs and talk to those already doing the work to find out what worked well and what challenges they have encountered. Consider differences and similarities in your community's demographics, needs, and available resources to tailor programming to your specific context.

To identify clinics in your area that provide MOUD, see:

SAMHSA. Opioid Treatment Program Directory. https://dpt2.samhsa.gov/treatment/directory.aspx

SAMHSA. Buprenorphine Practitioner Locator. https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator

Clinic workflow

This refers to how patients will move through your OBOT program. The "clinic workflow" for OBOT programs often looks like this:

Program enrollment

Because offering MOUD may be new for your clinic, it is important to consider whether you need to raise awareness of the available OBOT services before you start enrolling patients.

When implementing an OBOT program, it can be helpful to start slowly with just a few patients to allow for a "pilot" period, and then scale up as you refine program protocols and as providers and clinic staff become more comfortable with the clinic workflow and patient load. Efforts to advertise the new OBOT services should also start slowly to accommodate for this start-up pace. As a first step, consider smaller-scale marketing approaches like hanging informational flyers in your clinic waiting room or speaking individually with current patients who may benefit from the program. Once you are ready to scale up, spread the information across your partner networks and enlist local service providers to help share information with their participants seeking supportive services for OUD.

To enroll in the program, it can be useful to train front desk staff to have patients complete a brief phone intake to determine whether your OBOT program offers services that are appropriate for a patient's needs or if you need to make an outside referral.

It is important to remember that during this enrollment process, front desk staff will be the first to interact with the potential OBOT patients. Ensuring that front desk staff are well-versed in harm reduction and trauma-informed approaches, as well as information about the OBOT program and other local resources, and have received training to address stigma and ensure OUD patients are treated with respect and dignity is critical for success of the program.

After scaling up, it is likely that your OBOT program will reach capacity, and you will need to establish a process for managing a patient waitlist. When your clinic does not have capacity to admit new patients, individuals who reach out should be at least offered information on other local resources for treatment, provided with access to naloxone in the event of overdose, and added to a waitlist so they can be contacted if a spot becomes available. Sometimes an individual's contact information may change during the time they are on the waitlist. Administrative staff may also suggest that individuals check back with the clinic after a specified amount of time to see if a spot has opened up.

WAYS HARM REDUCTION PRINCIPLES CAN HELP GUIDE OBOT PLANNING AND DECISION-MAKING

HARM REDUCTION PRINCIPLE 1: Taking a non-judgmental approach that treats every person with dignity, compassion, and respect, regardless of circumstance or condition

- **Take measures to reduce stigma in your clinic:**
  - As part of onboarding, provide training to clinic staff and providers about how substance use disorder affects the brain and body; the influence of environmental, socio-cultural, and other contextual factors including adverse childhood events and trauma; and the continuum of recovery.
  - Know that not all providers and staff are aware of their own biases, and basing additional drug tests or shortened revisit intervals on "something weird about the visit" creates space for those biases to affect patient care.
  - Have a specific list of what is considered "for cause" for additional monitoring: examples include missed visits or pill counts not adding up. Tell your patients about these examples up front so expectations and commitments for both providers and patients are clear.
  - Make continuing education available to keep staff up to date on the science and emerging trends in harm reduction and substance use disorder treatment.
- **Work on building trust between providers and patients:**
  - Ensure that patients are engaged in determining their treatment goals and desired outcomes—patients should have self-determination and agency over their own health.
  - Honesty is fundamental in this programming—ensure that protocols establish an environment that promotes trust and values honesty from providers and patients.
  - Remember that many patients have experienced trauma in healthcare settings. Some providers may have withheld care the first time a patient was unable to meet higher-barrier requirements for treatment.
  - Nurses and peers can help reassure patients that being open and honest with the providers prescribing MOUD will help them have better outcomes.
  - It is very important for prescribing providers and nurses to be on the same page about program expectations and patient communication.
  - Ensure that patients know that providers and clinic staff will not share private information without patient consent.
  - For example: Providers can type up a letter for the patient's primary care physician explaining their OUD care plan and allow the patient to review before it is shared. This holds the honesty standard both ways.

"We're constantly doing things to be supportive, to be engaging, to meet people where they really are, and to really hear what the community is saying."

—GVPH CLINIC STAFF

Intake appointment

When your clinic has capacity to admit new patients, the next step will be scheduling their intake visit with an MOUD provider.

When designing your program, engage your MOUD providers in deciding whether they would prefer to schedule all OBOT patients on set days or spread them throughout the week. Also consider that when OBOT patients are all scheduled on a specific day, it may provide opportunities for patients to interact with others in the program. For some patients, this can help facilitate peer support, but for others, it may lead to interactions that are not welcome nor helpful for their recovery. Make sure to discuss these potential issues with the patient before scheduling their intake visit.

Intake appointments are often the longest visit an OBOT patient will attend as they should include:

- Performing a physical exam, baseline labs,[C] and urine toxicology screen
- Completing assessment forms and questionnaires to learn about patient behavioral health indicators and other support needs to best tailor care plans for that patient and help track outcomes and progress over time
- Explaining clearly roles and responsibilities for both the patient and the provider team
- Going over visit and/or medication costs that patients may be responsible for
- Explaining the process for starting medication at home (patient instructions for home induction of buprenorphine/naloxone can be found in Appendix 2) or for in-office induction
- Answering any patient questions or concerns (more information in Table 1)
- Checking your state's reporting system for controlled substances, to determine whether the patient is already receiving MOUD elsewhere (if the patient is already receiving MOUD elsewhere, the provider should discuss this with the patient and determine a plan for how and where they would like to continue with their care) or other controlled substances (for example, benzodiazepines)

During this visit, it can also be helpful to provide patients with a lock box for storing their medication and educate them how to use it to help them control who accesses their medication and protect others around them. (See the next section on funding for materials, such as lock boxes.)

C Baseline labs can include testing for HIV, syphilis, hepatitis C, gonorrhea, chlamydia, tuberculosis, complete blood count (CBC), comprehensive metabolic panel (CMP), hepatitis A and B antibodies, and pregnancy. Some patient records may be available to document baseline labs so they do not need to be performed at the clinic. Patients should be permitted to decline participating in baseline labs if they prefer.

TABLE 1

Addressing Common Patient Concerns

COMMON PATIENT CONCERNS	WAYS TO ADDRESS
What is expected of me in this program? Do I have to come to weekly appointments forever?	Clearly explain program protocols and expectations, including the process for transitioning to less frequent visits and urine toxicology screening.
Will I go through withdrawal? What are potential side effects?	Explain possible symptoms a patient may have while being initiated on MOUD, and provide information on how to reach out with questions or concerns and manage symptoms. It is also useful to provide medication to address common symptoms of withdrawal like nausea. Providing information on strategies such as micro-dosing inductions can be useful for individuals who have had difficulty starting MOUD in the past (Appendix 3).
How can I get in touch if I need help?	Establish channels for timely communication and educate patients on how to use these platforms, whether this is direct messaging with a provider or having a point person that patients can call if needed, especially during induction. If your electronic medical record platform includes a mobile application that allows patients to message their provider, help patients with internet access download and learn to access and use this application.
What happens if I return to use or use other (non-opioid) drugs?	Thoroughly explain how urine toxicology screening results are used—to promote safety, document positive change, inform potential changes to the care plan, and not to punish patients for continued substance use. Discuss supports available and circumstances under which someone might be referred to a higher level of care.
What will group visits be like? Will it be triggering to be around other people who use/have used drugs?	If your clinic offers group follow-up visits, describe the flow and expectations for the group visits (how many patients are usually present, structure and format, whether everyone is expected to participate). Establish a Code of Conduct for group visits (example in Appendix 4) and share with patients so they understand expectations for respectful listening and communication. Take time to assess and discuss any concerns the patient might have about group visits.

Follow-up visits

After the intake appointment, many OBOT programs will check in about induction during the first few days and then schedule patients for weekly follow-up visits. Once patients are on a stable dose of medication, they may move to less frequent check-ins (example in Appendix 5).

Follow-up visits can be in the form of one-on-one visits or group visits depending on the patients' needs.

For group visits, multiple patients can come to the clinic at the same time to complete their individual health monitoring check-in and then participate in facilitated group discussions that cover topics related to personal wellness, behavioral health, and health education (guidance on facilitating group discussions can be found in Appendix 6). Two clinic staff members or providers might be needed to manage these visits—one could be responsible for checking in patients and facilitating the session, while the other completes the individual health monitoring check-ins and labs. Consider whether it is helpful to offer evening group visits, acknowledging that this means some clinic staff or providers may need to stay past usual clinic hours.

FOLLOW-UP VISITS TYPICALLY INCLUDE THE FOLLOWING ACTIVITIES:
• Patient completes form about medication adherence, satisfaction, side effects, use of other prescription or illicit drugs, and other concerns (sample forms can be found in Appendix 7)
• Nurses ask patients and count medication wrappers to assess patient adherence to medication
• Urine toxicology screening may be conducted[D]
• Pregnancy tests can be performed (if indicated by a missed period or requested by the patient)
• Patient meets with the MOUD provider to discuss their responses on the form, their toxicology results, and any concerns
• MOUD provider submits their prescription renewal
• For group visits: patients participate in facilitated group discussions (resources with guidance on facilitation can be found in Appendix 6)

D Clinics will need to decide which substances are most important to include in urine toxicology screening. It is useful to test for opioids and presence of buprenorphine to confirm patients are taking prescribed medications, but clinics may decide to test for other substances as well to track behavior change. A traditional 14-panel drug test screens for amphetamine, barbiturate, buprenorphine, benzodiazepine, cocaine, methamphetamine, ecstasy, morphine, methadone, oxycodone, phencyclidine, ethyl glucuronide (ETG), fentanyl, and cannabis in urine. If a patient indicates that they have been using a substance, testing may not be necessary. Screening could miss clorazepam due to a slight change in its structure.

When designing your OBOT program, it is important to establish a protocol for how urine toxicology results will be used during follow-up visits to enhance patient care. Results should be used to identify behavior change or as a prompt for conversations between the provider and patient (see box on harm reduction principle 2 for discussion of how urine toxicology screening results can be used in a non-punitive manner). Following the harm reduction approach, patients should not be automatically removed from the program for screening positive for opioids or other substances. Providers might consider discharging a patient from the program only if they show continued behaviors that suggest that a higher level of care would be beneficial, for example, continued urine toxicology results that suggest they may not be taking their medication.

After two to three months of care, if a patient's weekly toxicology screenings are showing progress towards addressing OUD (i.e., consistently positive for buprenorphine and decreasingly positive for other opioids), urine toxicology screening can be performed every two weeks, then every month. With continued progress towards addressing their OUD, patients can be moved to less frequent toxicology screening. Providers should inform patients ahead of time that they may receive random toxicology screenings or "for cause" screening if there is concern about their safety, and clearly inform patients of reasons they may be asked to complete these screenings. Some reasons may include multiple missed appointments, inaccurate wrapper counts suggesting potential medication non-adherence, patient reports of missing or stolen medication, and unexplained changes in behavior.

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HARM REDUCTION PRINCIPLE 2: Accepting behavior change as an incremental process in which individuals engage in self-discovery and transition through "states of change."

- Make sure all patients with OUD, individuals seeking related services, and families and caregivers are provided with naloxone or information on where they can access naloxone in case of opioid overdose. Directly providing naloxone is the best way to ensure that they have it on hand in case of emergency.
- Ensure that patients are aware of overdose prevention tools and practices, such how to use fentanyl test strips and using with a friend rather than alone. NaloxoneSaves.org has tips.
- Urine toxicology screens should be used to ensure patient safety and as a tool for patient-provider conversations, not to simply confirm abstinence or as reason to withhold care
- Develop protocols around urine toxicology screens that support program goal of incremental positive behavior change rather than total abstinence. Helpful approaches for toxicology screens are listed on the following page.

Helpful approaches for toxicology screens that test positive for illicit substances or negative for buprenorphine:

- Positive reinforcement and encouragement is a good way to build patients' self-efficacy and encourage them to continue with the program
- Remember that drugs are unregulated and often mixed with other substances. Sometimes substances can be found in urine toxicology screening that patients did not know they consumed (e.g., fentanyl may be added to cocaine).
- The key is to talk with patients about their results and what they might mean instead of making assumptions about their behavior
- Keep in mind what you are treating through the OBOT program: OUD
  - Even if a patient is receiving treatment for their opioid use, it does not necessarily mean it will impact their use of other drugs (though evidence shows it might).E A parallel example is that treating someone's asthma does not necessarily change other health behaviors. Patients who test positive for non-opioid substances should not be removed from the program but instead offered other support as needed.
- Treatment comes down to safety: Do you feel like you can safely write a prescription?
  - Incremental positive change and reduction of risk behavior are worth celebrating
  - As long as the patient is making progress, continue treating them
  - Although a higher level of care (such as in patient treatment) may be ideal for some patients, barriers to this level of care make it not feasible for many individuals

Helpful conversation prompts related to toxicology screens:

- "The goal is not to punish you; I'm asking you to come to more frequent visits to make sure we can best support you."
- "It looks like there is [substance] in your urine. Any idea how that got there?"
- "In your urine, this is what we are seeing…" rather than, "You took…."
- "I am concerned about your use of [this substance] because it puts you at higher risk for overdose. Some drug interactions can be especially dangerous."
- "I recognize that treating your OUD may not help with your [substance] use. Let's talk about other resources that could help you."
- Rapid tests that are positive for opioids when patients have denied use: "We are going to send this to the lab. If there are no opioids that are not prescribed to you, then great. If there are, then we may need to talk more about the result. If the screening continues to show opioids not prescribed, I'll be concerned about my ability to continue to care for you safely and we may need to talk about connecting you to a provider who can give you more attention and a higher level of care." The key is not to surprise people and to clearly let them know what happens next.
- "If I can't monitor your care plan, I cannot treat you safely."

E For example, Ahmadi J, Sahraian A, Biuseh M. A randomized clinical trial on the effects of bupropion and buprenorphine on the reduction of methamphetamine craving. Trials. 2019;20:468.

Other services to offer

Patients benefit from OBOT programs emphasizing a whole-person approach to care by integrating services beyond MOUD. Though these services are not always available or accessible locally, when possible, some complementary services that are helpful to include for OBOT patients are listed below.

- Provide access to naloxone and overdose education for patients and their families. NaloxoneSaves.org, NC Harm Reduction Coalition, and your local harm reduction organization are all great resources.
- Assess social drivers of health (example screeners in Appendix 8) to better understand patient needs (e.g., access to food, housing stability), have resources ready to share, and make referrals as needed
- Offer connections to other clinic services including:
  - Primary care
  - Infectious disease testing and treatment
  - Screening for sexually transmitted infections (STIs)
  - Mental and behavioral health services including group counseling, one-on-one behavioral health counseling, support for other substance use, and referrals to psychiatry consults[F]
  - Family planning
- Link to other community support and services including:
  - Food assistance, supplemental nutrition programs (e.g., WIC), food banks, and employment services
  - Housing, employment, and transportation support
  - Donations such as clothing and household goods
  - Harm reduction services like syringe services programs and naloxone access
  - Support for obtaining a personal identification card
  - Support for obtaining and navigating health insurance
  - Local support groups like NA or SMART recovery programs
  - Local inpatient treatment and detox facilities
- Make linkages to support groups and recovery education for families and/or caregivers interested in better supporting their loved ones

NC 211 and NCCARE360 are great resources to link patients to supportive services. While NCCARE360 and social drivers of health screenings are not yet required, North Carolina Department of Health and Human Services (NCDHHS) highly encourages all providers to use them.

Remember that some of your OBOT patients may live in bordering states, so it may be useful to also be aware of resources that can be accessed by patients who do not live in the state where your clinic is located.

F With patient permission, it is useful to formalize communication among a patient's OBOT and behavioral/mental health providers so that care can be effectively coordinated.

WAYS HARM REDUCTION PRINCIPLES CAN HELP GUIDE OBOT PLANNING AND DECISION-MAKING

HARM REDUCTION PRINCIPLE 3: Recognizing complex social factors that influence vulnerability to drug use and drug-related harm, including poverty, social inequities, discrimination, and trauma

- If you have the capacity, it is helpful to provide primary care services, infectious disease testing and treatment, immunizations, family planning, and other care services along with MOUD
- Provide support to address drivers of health as much as possible
- Use a standardized screener for major drivers of health (e.g., food, transportation, housing, interpersonal violence), though it is helpful to ask about the patient's needs more broadly, too
- The "whole person" can include individuals who are part of the patient's support system for some aspects of their treatment
  - With patient permission, involving trusted family members or other members of their support system in their treatment can be helpful for establishing support systems, understanding family dynamics, and ensuring that their support system is educated on substance use disorder and MOUD
    - » Remember that involving family or support systems may not be appropriate for every patient; allow the patient to determine whether this will be helpful for reaching their goals or to make adjustments

"We do the screening, but the screening just ensures that we're not missing the four major categories that North Carolina has deemed as the most important social determinants of health. But even beyond that, one of our patients was having trouble with their mom and needed a wheelchair ramp. Screening for food, transportation, housing, and interpersonal violence does not necessarily cover wheelchair ramps, but just from knowing her and having conversations with her, we were able to identify that as a need and make an effort to help her."

—GVPH CLINIC STAFF/PROVIDER

Program evaluation and data collection

Drafting an evaluation and data collection plan is an important step in designing your OBOT program so that you can learn about how implementation is going for your team, measure patient health and quality of life indicators over time in the program, and assess how your program can better support patients. Program evaluation data can be a useful tool to identify needed program refinements or process improvements, highlight successes patients experience other than abstinence from opiates or other substances, and advocate for more program funding.

Some key data points to collect from all patients could include:

- Demographic information (e.g., age, race, gender, education, insurance type, employment status)
- Visit attendance/retention
- Vaccination history (e.g., flu, hepatitis A and B, COVID)
- Behavioral health indicators for depression and anxiety such as the Patient Health Questionnaire-9 (PHQ-9) and General Anxiety Disorder-7 (GAD-7) assessments; risk factors and protective factors for substance use disorder, collected using assessments such as the Brief Addiction Monitor-Revised (BAM-R) (see Appendix 8 for more information)
- Results of urine toxicology screening for opioids and other substances, such as cocaine, benzodiazepines, and marijuana
- Patient-reported substance use or overdose history
- Patient-reported cravings, withdrawal symptoms, or side effects
- Testing results for HIV; hepatitis A, B, and C; STIs including gonorrhea, chlamydia, and syphilis; tuberculosis; and pregnancy (if appropriate)
- Emergency department visits
- Changes in insurance status
- Patient-identified goals and successes outside the program
- Patient feedback on what is working well or not working well with the program, collected via methods including anonymous feedback forms, verbal discussions during patient visits, and external evaluations or research studies especially focusing on patient experiences with clinic staff and providers

Including quality of life indicators that are patient-identified can help you track positive changes other than abstinence from opiates or other substances, which can help patients build self-confidence and highlight the positive impact having access to MOUD can have on patients' overall well-being and health. Visit attendance and retention information can provide an evidence-based view of how long patients may need to participate in the program, and what typical trajectories look like for patients. This information can be useful for quantifying community needs for funding.

HARM REDUCTION PRINCIPLE 4: Focusing on the whole patient and enhancing quality of life

- Use standardized tools to regularly measure behavioral health indicators (such as PHQ-9, GAD-7, and BAM-R; see Appendix 8)
  - These measures can help identify patients who could benefit from linkage to behavioral health resources like counseling or support groups
  - They can also help identify positive change in patients' mental health over time—an important indicator for improved quality of life
- Have conversations with patients about their "non–treatment-related goals" by discussing topics like those listed below, and help patients form plans for achieving these goals, including incremental changes in substance use behaviors that will bring them closer to achieving goals related to:
  - Relationships with family and friends
  - Finances and savings
  - Hobbies or activities they enjoy doing or would like to do
  - Other health-related issues, including physical and mental health
  - Jobs, education, or training opportunities they are currently or interested in engaging in

"I'm looking into going back to school in the near future…which has been a goal of mine for about 10 years now."

—GVPH PATIENT

"Right now, my current goals are to continue working on my physical health - I'd like to quit smoking cigarettes - and I'm trying to save some money. Things just keep getting better and better… I'm taking it as it comes and just enjoying it."

—GVPH PATIENT

C. Funding your program and anticipated expenses

The primary components of an OBOT program that need to be funded include:

1. **Time and effort for clinic staff and MOUD providers**
2. **Medication**
3. **Laboratory testing**
4. **Other supplies**

When drafting a budget for your OBOT program, consider funding from multiple sources to cover different program components. This is necessary because most funding mechanisms will not cover all components. Program costs differ for individuals who are insured versus those who are not. For insured patients, many OBOT costs can be reimbursed by insurance. However, in some states, Medicaid may set quantity limits for visits and laboratory testing. It is important to be aware of these limits and, if possible, have billing staff call for approval to go beyond this number. Staff should indicate that the visits and testing are medically necessary.[G] To support uninsured patients, fundraising may be needed to make services more affordable.

Specific budget considerations for each component of OBOT programs are listed below. **Table 2** provides more details on potential funding mechanisms by OBOT program component.

Time and effort for clinic staff and MOUD providers

- OBOT visits can be billed as regular physician visits with diagnosis code F11.20 so the clinic is reimbursed for insured patient visits
- To cover effort for serving patients without insurance, it is useful to pursue funding that addresses cost barriers to care such as federal or private grant funding, or donations

Medication

- Many grants do not cover medication costs, but some do, and private foundations may provide funding to cover medication costs
- If medication costs are a barrier for patients, it is important to inform them of other options for accessing medication that may be able to cover the cost, such as opioid treatment programs that provide medications. GoodRx offers discounts on prescription medications, which could help some individuals.

Laboratory testing

- Laboratory testing can be funded by insurance or by grants
- To bill laboratory testing to insurance, the below coding can be used:
  - Urine toxicology screening – "therapeutic drug monitoring" – z51.81
  - Viral disease screening (hepatitis) – "encounter for screening with other viral diseases" – z11.59
  - Screening for STIs – "screening for infections with predominately sexual mode of transmission" – z11.3

G In the state of North Carolina, visit quantities may be negotiable for patients with Medicaid, but laboratory tests are typically not.

- For rapid urine drug testing completed at your clinic or health department, the code 80305 with modifier QW can be used
- For health departments, tests for conditions such as HIV, hepatitis C, and other STIs can be sent to the state at no charge to the patient. Private clinics may need to bill for these services or refer to the local health department.
  - Remember that some patients may live in states other than the state where your clinic is located. Labs may need to be performed in the patients' state of residence to be Medicaid-eligible.
- Consider implementing a sliding scale for laboratory testing costs for uninsured patients

Other supplies

- Direct Relief (https://www.directrelief.org/apply/) provides surplus or soon-expiring medications (including naloxone) and other supplies. Providers who sign up for the newsletter receive a monthly email to let them know what is available.
- Some optional recovery support supplies that can be helpful are inspirational books with quotes written by people in recovery (e.g., https://www.jftna.org/jft/), journals with guided reflections, personal care items, and activities such as adult coloring books and coloring pencils. Donations might be a great way to pay for these supplies.

The Table below outlines components of OBOT programs and entities that may have funding available. It shows which program components can be covered by different funding entities.

TABLE 2

Potential Funding Sources for OBOT Programs by Component

PROGRAM COMPONENT	INSURED PATIENT – BILLED TO INSURANCE[a]	UNINSURED PATIENT – PAID OUT-OF-POCKET[b]	FUNDED BY GRANTS – FEDERAL[c]	FUNDED BY GRANTS – PRIVATE OR LOCAL ORGANIZATIONS[d]	FUNDED BY PRIVATE DONATIONS (CHURCHES OR INDIVIDUALS)
Provider time/ effort	●	●	●	●	
Counselor and/ or social worker time/effort	●	●	●	●	
Medication	●	●	●	●	
Naloxone	●	●	●	●	●
Vaccines	●	●		●	
Laboratory testing costs	●	●	●	●	
Patient medicine lock box			●	●	
Recovery support supplies			●	●	●

When managing multiple funding sources, it is useful to ensure there is clarity on allowable expenses and continuous communication between providers and billing and finance teams about the requirements for each funding source. Funders may have different spending restrictions, for example, some have stipulations around offering free care or free medication, and different requirements for tracking and reporting spending and program data

[a] There could be additional costs to patients depending on the insurance provider—consider how grants or other dollars might help cover these.

[b] Local Management Entities/Managed Care Organizations may support relevant costs through programs for uninsured patients. These programs vary by state, region, or county. Check with your local agency.

[c] Federal funders include organizations such as SAMHSA, CDC, and Health Resources and Services Administration.

[d] Private funders include organizations such as Hospital Legacy Foundation and United Way or other philanthropies. Grant funding begins and ends on a cycle; therefore, it is important to stay on top of funding application timelines to ensure a steady stream of grant funding. Some patients may not be able to participate in the program without financial support.

4. Key Recommendations

When developing an OBOT program in local health departments, it is important to remember:

- Start small and slowly ramp up to seeing more patients
- Seek mentorship and guidance from other health departments and clinics with OBOT programs (see Appendix 1)
- Remember that communities and their needs differ, so while learning from other programs is key, no two programs will look exactly alike. Make sure to tailor your program to your community's specific needs.
- Integrate harm reduction principles for providers and staff into your health department's program and emphasize providing compassionate care and support for the patient as a whole person
- Your program will need to continuously evolve to adapt to changing policy and funding environments, availability of community resources, and patient needs. Formalize processes for collecting program data and patient feedback to inform necessary changes and ongoing fundraising efforts.

5. Future Considerations for OBOT Programming

Maintaining your OBOT program will require ongoing knowledge of training, legislation, and funding:

- Qualification requirements for obtaining a waiver from the federal SAMHSA to provide MOUD have changed over time (especially during the COVID pandemic) and may continue to evolve. Reviewing these policies is important to ensure clinics implementing OBOT programming are aware of provider training requirements and patient limits set forth in the Controlled Substances Act (https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines).

- In 2015, the NC General Assembly enacted legislation directing NCDHHS to transition Medicaid and NC Health Choice from fee-for-service to managed care. Under managed care, the state contracts with insurance companies, which are paid a predetermined set rate per enrolled person to provide all services. NC Medicaid Managed Care was authorized to begin July 1, 2021, for Standard Plans and July 1, 2022, for Behavioral Health, Intellectual, and Developmental Disability Tailored Plans. It is important that clinics implementing OBOT programming understand and consider the impact of these changes in coverage.

- Established infrastructure and reimbursement for telehealth options are becoming more common, and offering telehealth services can help address transportation or time barriers. Telehealth can also be an effective way to connect patients with mental/behavioral health resources in communities with few resources.

6. Case Study: MOUD at Granville Vance Public Health

This section offers a deeper exploration into GVPH's OBOT program that provides MOUD through a local health department in North Carolina. It includes findings from interviews with clinic providers and staff, and patients enrolled in the GVPH OBOT program. It also provides insights on patient experiences, impacts of the program, what is working well, and ways GVPH is working to improve or expand services.

Introduction

In 2017, GVPH implemented their OBOT program through the health department in Granville County, becoming one of the only clinics offering MOUD in Granville or Vance County.

The OBOT program offers patients services including:

- MOUD (buprenorphine/naloxone [Suboxone] medication management)
- Support for medication costs
- One-on-one counselling (availability dependent on funding)
- Weekly or twice-monthly group visits that include individual health monitoring check-ins and facilitated group discussions
- Infectious disease testing
- Primary care services
- Linkages to needed community resources and wrap-around services like job support, food assistance, and clothing and appliance donations

Granville and Vance are rural counties with populations of approximately 59,000 (Granville) and 44,200 (Vance).[12] In North Carolina, 13.6% of individuals were living in poverty in 2019. In comparison, 14.6% of Granville County residents and 18.5% of Vance County residents were living in poverty in the same year.[13] Despite a shrinking unemployment rate, the poverty rate has remained almost unchanged in both counties over the last two decades. Black individuals, Indigenous individuals, and people of color (BIPOC) are more likely to live in poverty in both counties.

Patient experiences

Goals for the program

We asked patients to describe their goals when they started the program and their current goals. Patients described diverse and evolving goals over their time in the program. Some discussed OUD-related goals like "work on my recovery," while other patients described goals related to diverse aspects of their life including:

- Financial
  - Saving money and getting out of debt
  - Buying a home
  - Getting a job
- Personal
  - Improving relationships with friends and family
  - Getting comfortable sharing their personal story in group sessions
  - Going back to school
- Health
  - Getting dental work done
  - Working on healthier sleep habits
  - Improving mental health, especially anxiety
  - Managing other substance use in addition to opioids
  - Quitting smoking

"[My goal is to] just get my life back on track... get off of the opioids all together and have a normal routine. Joining family and friends and not having to get out and search for opiates and stuff like that."

—GVPH PATIENT

"My goal was to get my career back on track because I have a record, and I can't [do my former job] any more. [The provider] sent me through a training to get my peer support specialist license. And I just finished it yesterday. I wouldn't have been able to do it without her help and her support."

—GVPH PATIENT

Perceived impacts of program

Many patients express that being part of the OBOT program helps them live a better quality life and gives them time to find things they enjoy because they do not have to constantly seek opioids and manage withdrawal symptoms.

Patients shared the following impacts of GVPH's program:

- Improved relationships with family and friends
- Ability to manage use of or stay abstinent from illicit substances
- Feeling generally more "stable" and having more time to engage in preferred activities
- Obtaining a job or engaging in a training opportunity
- Improving mental and physical health
- Being able to save money and/or plan for and work toward future goals

"I get up, I go to work, I come home, I cook supper. You just go through your normal day, but you're able to do it without this crutch."

—GVPH PATIENT

"I live every day now. I always look forward to tomorrow. I've got more money in my savings than I've ever had in my life, and that's thanks to getting off drugs. I think that every day is exciting for me now. I'm living my life in a totally different way. Like I said, I've been clean for a good while, but I hadn't been in a good situation like I am now... and I definitely give a lot of credit to my doctors and OBOT."

—GVPH PATIENT

What is working well

Patients and clinic staff/providers explain that the following components of the GVPH OBOT program help facilitate positive outcomes:

- Training clinic staff and providers on harm reduction principles and devoting time and effort to building trusting relationships among patients and providers has contributed to a culture of honesty and respect that builds patients' confidence and self-efficacy

"A huge benefit of a harm reduction versus abstinence-based model is that you start to build confidence, because if you "mess up" it's not the end of the world. It doesn't mean you're kicked out of the program. It doesn't mean we believe in you any less, so I think that a lot of patients start to regain some of their confidence, and that can translate into other areas as well, like performing better at work to get promotions or even to be able to get a job or in their relationships with family and friends."

—GVPH CLINIC STAFF OR PROVIDER

- Covering the cost of medication has been a motivator for patients to join the program and also enables them to save money or pay for other necessities

"The fact that they paid for it and they got a grant or whatever, and were able to cover it. That was just a God-send because I couldn't afford to go."

—GVPH PATIENT

- Hiring from the local community means that clinic staff and/or providers have a more personal understanding of their patients' cultural and social contexts

"[Because many staff are from the community,] we know the space. We know the challenges. We know why some people make decisions they do because of the situations they're in, the generational things that are happening. So I think the negative judgment is just not there, and sometimes negative judgment is what prevents people from being able to truly heal their community... We don't think that way because you're not going to help anyone thinking negatively like that."

—GVPH CLINIC STAFF OR PROVIDER

- Teaching patients to use messaging platforms through the electronic medical record system allows patients to engage in timely communication with their providers
- Accessing MOUD in a centralized location like the health department that also offers primary care, vaccinations, and STI testing makes it easier for OBOT patients to access care they otherwise might not and helps reduce stigma
- By focusing on drivers of health as part of patient wellness, clinic staff and providers have helped patients to secure jobs and training opportunities; obtain affordable or donated clothing, furniture, and appliances; and connect with other services to support their well-being
- Offering options for telehealth has helped to reduce the burden of transportation and provided alternative ways to participate in OBOT for patients who feel that avoiding particular locations or other people in recovery helps support their personal recovery journey
- Including group visits as part of the OBOT program has helped facilitate social support among patients, including help with transportation and emotional support

"Being able to connect with the people in the group, it really helps with the mental state for me… because you're able to speak to people that you can connect with that have similar issues… That makes all the difference in the world, being able to talk to somebody."

—GVPH PATIENT

Ongoing efforts to improve GVPH OBOT programming

Based on the experiences of clinic staff and providers and feedback from patients, GVPH continues to work on better ways to:

Effectively screen for drivers of health and connect patients to needed support services

- The clinic currently uses several formalized ways to collect information on drivers of health, but is interested in expanding the topics they cover to better address the patient as a "whole person." Other potential tools include the Healthy Opportunities Risk Assessment (https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions), the PRAPARE Assessment Tool (https://prapare.org/), and the AAFP EveryONE Project Toolkit (https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/assessment.html).

Establish formal linkages with local behavioral health resources like therapy or psychiatry so patients with these needs have a place to go

- GVPH has hired more staff to expand capacity to offer behavioral health support and facilitated group visits; however, linkages to psychiatry are still a barrier for patients needing higher levels of mental health care

- Collaborative care is a model by which trained primary care providers and embedded behavioral health professionals provide evidence-based medication or psychosocial treatments (https://aims.uw.edu/collaborative-care)

Establish a formal process for getting patient feedback about the program

- GVPH has feedback surveys available for patients to fill out and anonymously submit and is considering implementing more formal, routine patient satisfaction surveys

Facilitate personal connections during public health crises such as the COVID-19 pandemic

- GVPH implemented virtual group visits during COVID; however, difficulties with technology and concerns regarding privacy have made the group visits a challenge for clinic staff to manage

Ensure sustainability in funding so that medication costs do not become a barrier

- Currently, grant opportunities are monitored and pursued by the clinical team. Having a specific staff member dedicated to identifying grants and managing the application process would be useful for securing new opportunities for funding.

Granville Vance Public Health and the Duke Department of Population Health Sciences at the Duke University School of Medicine participated together in this evaluation and communication initiative as part of the Rural Academic Health Department Model. The synergy created to document the good work in local health departments takes effort and funding initiatives outside of what LHDS are traditionally funded to accomplish. Good work is happening community by community and local health departments can be a resource for individual care, community interventions, health equity, policy work, and systems change. The authors would like to acknowledge the importance of these partnerships to tell the story of the work happening. More information about the Rural Academic Health Department model is online at: https://www.gvph.org/about/ahd/.

7. Appendices

Appendix 1: Training and Mentorship

Resources to support staff training related to MOUD include:

National Harm Reduction Coalition's Training Series
https://harmreduction.org/our-work/training-capacity-building/online-training-institute/

North Carolina Medical Board – Getting Started with MAT
https://www.ncmedboard.org/landing-page/MAT

SAMHSA's Practitioner Training
https://www.samhsa.gov/practitioner-training

American Society of Addiction Medicine Website
www.ASAM.org

Providers Clinical Support System Website
www.PCSSnow.org

University of North Carolina at Chapel Hill's Project ECHO Website
https://echo.unc.edu/

Institute for Healthcare Improvement Website
http://www.ihi.org/?gclid=Cj0KCQjw6s2IBhCnARIsAP8RfAivDcI-PLJCD5Do9ZUudf3ONnV_jciTWC62VJRNa10gfvZgsL4UsMIaAr5TEALw_wcB

Governor's Institute's Addiction Medicine Training
https://addiction-medicine.org/training/

Mountain Area Health Education Center Website
https://mahec.net/innovation-and-research/substance-use/mat-training

Stop the Stigma
https://files.nc.gov/ncdhhs/Stop-the-Stigma--electronic--8.19.19.pdf

Appendix 2: Buprenorphine/Naloxone Home Induction Protocol

California Bridge provides guidance on buprenorphine self-start here: https://cabridge.org/resource/rapid-guidance-for-patients-starting-buprenorphine-outside-of-hospitals-or-clinics/

GVPH provides patients starting MOUD with the below handout:

STARTING BUPRENORPHINE ("Bupe" or "Suboxone")
Congratulations on starting treatment!

WHAT TO START WITH?

✓ ___ Buprenorphine (Bupe) pills or films (8 mg)
(**There are many different brand names and generic forms of Bupe. Some are shown below.)

☐ 6 Ibuprofen pills (200 mg) – for body pain, take 1-2 pills every 8 hours as needed
☐ 6 Clonidine pills (0.1 mg) – for anxiety, take 1 pill every 8 hours as needed
☐ 6 Promethazine pills (25 mg) – for nausea, take 1 pill every 8 hours as needed
☐ 6 Imodium pills (2.0 mg) – for diarrhea, take 1 pill after each episode of diarrhea. Max 6 pills per day

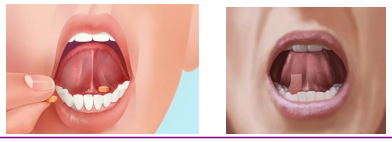
WHEN AM I READY TO START BUPE?

✓ Use the list of symptoms on the back to see when you are ready to start Bupe.
✓ Wait until you have **at least 17 points** to start Bupe. If you don't have 17 points, wait a bit longer and review the symptoms again. It is very important that you wait! To be sure that you are ready to start, it's best to have at least 1 of these 5 symptoms: yawning, nose running, goose bumps, muscle twitching, muscle or bone aches.

THINGS *NOT TO DO* WITH BUPE

✘ DON'T use Bupe when you are high—it will make you dope sick!
✘ DON'T use Bupe with alcohol –this combination is **not safe**.
✘ DON'T use Bupe with benzos (like Xanax ("sticks"), Klonopin, Valium, Ativan) unless prescribed by a doctor who knows you are taking Bupe.
✘ DON'T use Bupe if you are taking pain killers until you talk to your doctor.
✘ DON'T use Bupe if you are taking more than 60 mg of methadone.
✘ DON'T swallow Bupe – it gets into your body by melting under your tongue.
✘ DON'T lose your Bupe – it can't be refilled early.

HOW TO TAKE BUPE



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

PLAN DAY 1 – max one pill/film

- Use your last heroin / methadone / pain pill: _____
- When you have at least 17 points from the list, then you are ready to start.
- Start with 1/2 pill or film under your tongue. Wait 40 minutes.
- If you feel the same or just a little better, then take another 1/4 pill or film. Wait 2 hours.
- If you still feel sick or uncomfortable, take another 1/4 pill or film.

PLAN DAY 2 – max two pill/films

- Take the same amount you took yesterday PLUS if your score is over 10 take an extra 1/4. Wait 2 hours.
- If you still feel sick or your score is over 10, take another 1/4 pill or film up every 2 hours up to 3 times

PLAN DAY 3 – max 2 ¼ pill/films

- Take the same amount you took yesterday. If you feel sick or your score is over 10 take an extra 1/4.
- Continue today's dose every day until your office visit. **Bring any leftover medication to your office visit

PROBLEMS OR QUESTIONS? Contact Dr. Shauna Guthrie at IMYourDoc call 919-693-2141

Appendix 3: Resources to Guide Patient Care

Information on "microdosing" buprenorphine initiations: an approach to avoiding precipitated withdrawal in individuals who have been using fentanyl consistently, or who have had trouble starting buprenorphine products in the past

- **California Bridge:** https://cabridge.org/resource/starting-buprenorphine-with-microdosing-and-cross-tapering/
- **Kelly R., Microdosing: A Guide to Using Buprenorphine During the Illicit Fentanyl Pandemic.** September 24, 2021. Presentation – Slides – Handout

North Carolina Naloxone Distribution Toolkit
https://www.injuryfreenc.ncdhhs.gov/DataSurveillance/NaloxoneDistributionToolkitFinalApproved-042219.pdf

Tobacco Cessation
https://quitlinenc.dph.ncdhhs.gov/

Appendix 4: Group Visit Code of Conduct Example

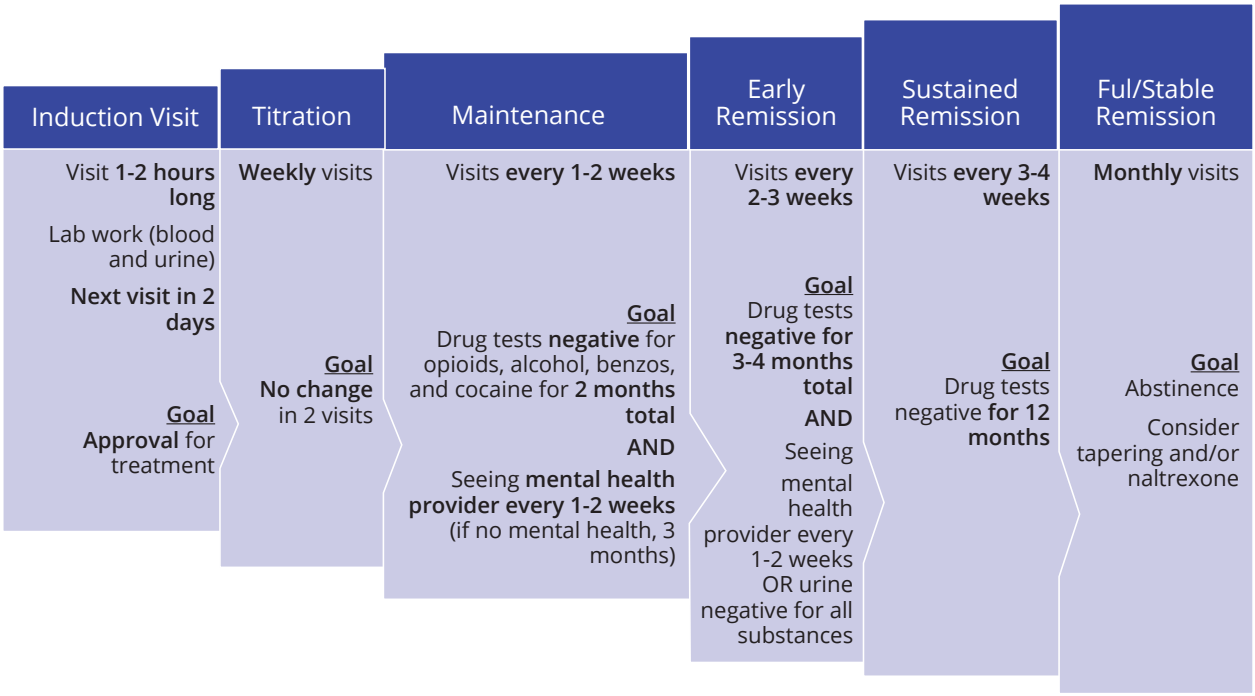
(The group visit code of conduct should be drafted collaboratively during the first group session and revisited periodically, as the group membership and dynamics may change.)

1. Be on time and ready to give a sample (if visit is in person)
2. Be open and honest with the group. Share what you are comfortable.
3. It's OK to pass sometimes
4. Don't come to group high
5. Do not glorify past drug use – no "war stories"
6. Respect each other and our stories
7. Speak only for yourself, for example: "I feel..."
8. Stay on topic during conversations – not OK to jump in while someone else is talking
9. No side conversations/cross-talk when someone else is talking
10. Don't dominate the conversation: give others a chance to speak
11. What is said here stays here – confidentiality in and outside the clinic
12. Avoid foul language as much as possible, no foul language directed at someone (no name calling)
13. Silence your cell phones, no texting

Treatment guidelines

1. The group shall be a safe place to share feelings and to obtain or provide support, information, reassurance, and encouragement
2. Although group can be therapeutic, it is not meant to replace individual or group therapy
3. Let us know if you are not coming AS SOON AS POSSIBLE so we can work with you on your care
4. If you come to group late, you may have to wait until the group is over to be seen or reschedule
5. Reasons for not being spaced out to every two weeks: opioid or benzo use, missed visits, incorrect counts
6. Reasons for not being spaced out to every four weeks: non-opioid drug (cocaine, etc.) or alcohol use

Appendix 5: GVPH OBOT Patient Care Path



*Regardless of stage, you may be called in at any time for a pill count and/or drug testing as stated in treatment contract.

**If you miss your appointment and your prescription has run out for two weeks, you will no longer be considered a current medication-assisted treatment patient and may have to be on the waitlist to get back into treatment.

Last Updated: 6/29/2021 3:37 PM

As a reminder, goals for participation in the OBOT program should be determined by providers and patients together. For example, if a patient is considered in stable remission, but does not have a goal of tapering off MOUD, the provider should take this into account with their treatment moving forward.

Appendix 6: Group Visit Discussion Guide

Resources for facilitating group visit discussions can be found at the below link:

SAMHSA Substance Abuse Treatment: Group Therapy
https://store.samhsa.gov/sites/default/files/d7/priv/sma15-3991.pdf

Appendix 7: Sample Patient Forms for Intake and Follow-up Visits

GRANVILLE VANCE
public health

Lisa Macon Harrison
Health Director
BSPH | MPH

Medication Assisted Treatment Intake Form

Patient Name: _____ **DOB:** _____ **Phone:** _____

PMP Findings: _____

Significant Criminal Database Findings: _____

Records Review Findings: _____

Drug Use History

- How did drug use **begin**? _____ Last Opioid Use: _____
- Have **ever** used: Oxycodone("Pills"), Heroin, Cocaine, THC/MJ, PCP, Meth, Benzos, Alcohol, Suboxone (from the street), **IVDU Hx** ☐Y ☐N
- **Past Month** Drug Use: Oxycodone("Pills"), Heroin, Cocaine, THC/MJ, PCP, Benzos, Alcohol, Suboxone (from the street), Other: _____
- Opioid **Amount**/day or Suboxone Dose: _____
- History of **opioid overdose**? ☐Y ☐N: _____
- Substance Use **Treatment** Experience(s): Inpatient Detox, Inpatient Stay (>7 days), Methadone, Suboxone Program, Counseling, Support Group, NA/AA _____

Mental Health History

- **Diagnosis**/Hx: Depression, Anxiety, ADHD, PTSD, Physical, Emotional, Sexual Abuse, DV _____
- **Past** Treatment: Inpatient, Counseling, Medication, Other/Detail: _____
- **Current** Treatment: _____
- Functional Status: Working FT/PT, Custody of Children, _____
- Education Level Completed: _____

Physical Health History

- Current Medical Problems: Chronic (daily) Pain, Liver Disease/Cirrhosis, Other: _____
- **Primary Care Provider**: _____

Behavior Change Indicators

- Why now? _____
- Facilitators (what will make this easier)? _____
- Barriers (what will get in the way)?: _____

Turn Over➔

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Patient Name: _____ **DOB:** _____

DAST-10 Drug Use Screening: Answer the following for any drug use (not just opioids):

In the past 12 months…		**Circle**	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you use more than one drug at a time?	Yes	No
3.	Are you unable to stop using drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped using drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No

SCORE (YES): _____

Tentative Diagnosis

☐ Mild (1-2), F11.10
☐ Moderate (4-5) F11.20
☐ Severe (6+) F11.20

Contact Attempts

Date/Time: _____ By: _____ Result: _____
Date/Time: _____ By: _____ Result: _____
Date/Time: _____ By: _____ Result: _____

Preliminary Treatment Level Recommendation

☐ OBOT ☐ OBOT+IOP ☐ OTP ☐Pain Management ☐ Other: _____

☐ GVPH Initial MAT Appt Made @ _____ ☐Patient counseled re: cost of visit, visit schedule, and being hydrated at first visit

☐ Referral(s) sent to _____
☐ Patient to arrange own treatment as above.
Notes: _____

_____

GRANVILLE VANCE public health

Lisa Macon Harrison
Health Director
BSPH | MPH

Medication Assisted Treatment Initial Visit Form

Patient Name: _____
DOB: _____ **Date of Visit:** _____

Drug Use History (see intake form)

- Type of opiates used in the past month: _____
- Date of last opioid use (best guess): _____
- Drug use in the past 2 weeks: Marijuana/THC/CBD Oil/Synthetic Marijuana, Cocaine, PCP, Benzos (Ativan/lorazepam, Klonopin, etc), Kratom, Stimulants, Meth, Other: _____
- How often do you have a drink containing alcohol (circle)? Never, Monthly or Less, 2-4 Per Month, 2-3 Per Week, 4 or More Per Week (*Ever➔AUDIT, CPT 99408)
- Arrests or other legal issues related to drug or alcohol use: _____
  _____

DAST-10 Drug Use Screening: (see form); Score: _____

Mental Health History (see intake form)

- Do you currently regularly see a counselor or therapist? ☐YES ☐NO
  - If so, who/when _____
- Have you ever attempted to hurt or kill yourself (suicide)? ☐YES ☐NO

Depression/Anxiety Screening

PHQ-9: _____ GAD-7: _____

- What is going well and going to help you with your recovery (facilitators)? _____
  _____
- Would could get in the way of your recovery (barriers)? _____
  _____
- What are your goals in recovery? How do you see your life in the future being different? _____
  _____
  _____

Patient Name: _____

DOB: _____ **Date of Visit:** _____

DSMV Diagnostic Criteria: Answer the following based only on your opioid use:

Have you taken opioids for a longer period of time or higher doses than you intended?	YES	NO
Have you tried or wanted to cut back but couldn't?	YES	NO
Do you spend a significant amount of time in activities necessary to obtain the opioid, use the opioid, or recover from its affects?	YES	NO
Do you experience cravings (a strong urge to use opioid substances)?	YES	NO
Has your opioid use led to failure to fulfill requirements at work or complete important tasks at home or school?	YES	NO
Have you continued to use opioids even though it causes social or interpersonal problems (problems with friends or family)?	YES	NO
Have you given up or reduced important social, work, or fun activities because of opioid use?	YES	NO
Do you use opioids in situations in which it is physically hazardous/dangerous?	YES	NO
Do you have persistent or recurrent physical or psychological problems caused or made worse by substance use? STOP AND MARK ANSWER IF NO If yes, do you continue to use opioids despite this? (CIRCLE ANSWER)	YES	NO
Have you developed tolerance (reduced effect of the same amount of use or needing to use more to get the same effect)?	YES	NO
Have you experienced withdrawal symptoms from opioids or have you taken opioids to prevent or treat withdrawal symptoms?	YES	NO

Number of criteria met: _____

Physical Health History

Please list any medical problems you have: _____

_____

Have you ever been diagnosed with (circle if yes) Hepatitis B, Hepatitis C, Cirrhosis, HIV?

What other concerns or questions do you have? _____

_____

_____

_____

_____

_____

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_____

_____

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GVPH Consent for Treatment with Buprenorphine/Naloxone

Patient's Name:_____ Date: _____

DOB:_____

_____Buprenorphine is a medication approved by the Food and Drug Administration (FDA) for treatment of people with opioid use disorder. I am aware that there are alternatives to treatment with buprenorphine and these include inpatient detoxification and counseling, methadone maintenance, naltrexone, and outpatient individual and group therapy. **I desire to continue with outpatient buprenorphine treatment.**

_____I understand that I am dependent on opiates, and I should be in noticeable withdrawal when I take the first dose of buprenorphine. If I am not in withdrawal, buprenorphine may cause significant opioid withdrawal and physical discomfort. **I agree to take my medication as the doctor has instructed, and not to alter the way I take my medication without first consulting my prescriber.**

_____I have been informed that any use of other opioids during the induction phase may cause an increase in symptoms. After I am stabilized on buprenorphine, I have been informed that other opioids will have less effect. Attempts to override the buprenorphine by taking more opioids could result in an opioid overdose. I have been informed that it is important for me to inform any medical provider who may treat me for any medical problem that I am enrolled in an opioid treatment program so that the provider can provide the best possible care and can avoid prescribing medications that might affect my chances of successful recovery from addiction. I have been informed that combining buprenorphine with alcohol or benzodiazepines may also be hazardous and has resulted in deaths. **I agree not to take such medications with buprenorphine without prior approval from my medical team.**

_____I understand that if the tablet or strip were dissolved and injected by someone taking heroin or another strong opioid, it could cause severe withdrawal. **I agree not to inject buprenorphine and agree not sell, share, or give any medication to another person.** I have been informed my medications are at risk for being stolen or taken accidentally by others and this could cause serious harm. **I agree to keep my medications locked away at all times.**

_____I have been informed that I must always fill my prescriptions from _____ pharmacy and if I change pharmacies I will do so after first notifying my treating clinician.

_____It has been explained to me that I will undergo periodic drug testing to confirm compliance with the treatment plan. This testing may be done at an appointment or I may be contacted to provide a sample and for a "pill count" visit within 24 hrs. **I agree to report my history and symptoms honestly.** I am aware that any missed office visits will result in my not being able to get medication until the next scheduled visit. **I agree to bring my pill bottle/box and any wrappings to all visits so that supplies can be counted.**

_____I have been informed that medication management of addiction with buprenorphine is only one part of the treatment of my addiction, and **I agree to participate in a regular program of professional or peer counseling and support.** I have been informed that the support of loved ones is an important part of recovery, and inviting significant persons in my life to participate in my treatment will be beneficial. **I authorize communication between my treatment team and outside parties including physicians, therapists, probation and parole officers, child services, support persons and any other parties the staff has deemed necessary in order to provide me with optimal care.**

_____I understand that buprenorphine treatment can result in physical dependence. I have been informed that I may withdraw voluntarily from this treatment program and discontinue use at any time. Should I choose this option, I have been informed I will be offered medically supervised tapering to reduce withdrawal symptoms. I understand that if I am over **two weeks overdue** for a visit I will be considered **inactive** and may not be able to continue treatment at this time.

_____ _____
Patient Signature Date Witness Date

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BSPH | MPH

Medication Assisted Treatment Follow Up Visit Form

Patient Name: _____

DOB: _____ **Date of Visit:** _____

Medication Use

- **When** was your **last dose** of medication (suboxone, buprenorphine, zubsolv)? _____
- Are you storing your medication securely in a **lock box or safe**? ……..☐YES ☐NO
- Have you taken your medication **exactly as prescribed**?.....☐YES ☐NO
- Do you want to continue treatment **at this dose** at this time? ……..☐YES ☐NO
- In the last 2 days have you been **free of withdrawal symptoms and side effects**?☐YES ☐NO
  - If no, circle: Sweats, Anxiety/Restless, Joint Aches, Runny Nose, Nausea, Tremor, Yawning, Goosebumps, Headache, Constipation, other: _____
- In the last 2 days have you been **free of any cravings** for opioids? …… ☐YES ☐NO
- Do you have **Narcan/naloxone** in a place where others can access it if needed? ☐YES ☐NO

Explain any "NO" answers: _____

Drug Use: SINCE YOUR LAST VISIT HAVE YOU…

- …had any relapses of opioid use (circle) (oxy, methadone, heroin, other)?.....☐NO ☐YES
- …had any close calls? Explain: _____☐NO ☐YES
- … taken any **substances listed below or other illegal drugs**?..... ☐NO ☐YES
  - If yes, circle: **Alcohol**, Marijuana/THC/CBD Oil/Synthetic Marijuana, Cocaine, PCP, **Benzos** (Ativan/lorazepam, Klonopin, etc), Kratom, Stimulants, Meth, Other: _____

Mental Health

- What therapy/support groups have you gone to **since your last visit** (or NA, AA, etc):_____

Physical Health

- Today's Weight: _____lbs BP: _____/_____ HR: _____ O2:_____%
- What other medical questions or concerns do you have? _____

Pill Count (For Medical Staff Use)

PMP shows new medications from other medical providers since last visit: ☐ **YES** ☐ NO
Fills Since Last Visit: Date: _____ #: _____ Date:_____ #: _____
Left Expected: _____ # Per Day Dose: _____ # Left Today: _____
Today Within # Per Day of Expected? ☐ YES ☐ **NO**
Patient brought all prescription labels/packaging to visit: ☐ YES ☐ **NO** **Staff Initials:** _____

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Appendix 8: Example Screening and Outcome Measure Resources

Brief Addiction Monitor – Revised (BAM-R) Screening Tool

Link to copy of the BAM-R tool:
https://www.mirecc.va.gov/cih-visn2/Documents/Clinical/BAM_2017.pdf

How to use the tool:
https://www.mirecc.va.gov/cih-visn2/Documents/Clinical/BAM_with_Info_Sheet.pdf

Sources:

Cacciola JS, Alterman AI, Dephilippis D, et al. Development and initial evaluation of the Brief Addiction Monitor (BAM). *J Subst Abuse Treat*. 2013;44:256-263. doi: 10.1016/j.jsat.2012.07.013

Hallinan S, Gaddy M, Ghosh A, Burgen E. Factor structure and measurement invariance of the Revised Brief Addiction Monitor. *Psychol Assess*. 2021;33:273-278. doi: 10.1037/pas0000973

Depression: Patient Health Questionnaire (PHQ)

Links to copies of the PHQ-2 and PHQ-9:
https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf
https://www.phqscreeners.com/

How to use the tool/Scoring instructions:
https://www.phqscreeners.com/images/sites/g/files/g10016261/f/201412/instructions.pdf

Source:
Kurt K, Spitzer RL, Williams JBW. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med*. 2001;16:606-613. doi: 10.1046/j.1525-1497.2001.016009606.x

Generalized Anxiety Disorder-7 Screening Tool Resources

Link to copy of the GAD-7:
https://adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf

How to use the tool/Scoring instructions:
https://www.phqscreeners.com/images/sites/g/files/g10016261/f/201412/instructions.pdf

Source:
Spitzer, Robert L., et al. "A brief measure for assessing generalized anxiety disorder: the GAD-7." *Archives of Internal Medicine* 166.10 (2006): 1092-1097.

Drivers of Health Screeners

Links to tools:
https://www.aafp.org/journals/fpm/blogs/inpractice/entry/social_determinants.html
https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

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