TEMPLE HEALTH

OBOT Hub-Spoke Policies and Procedures

2020

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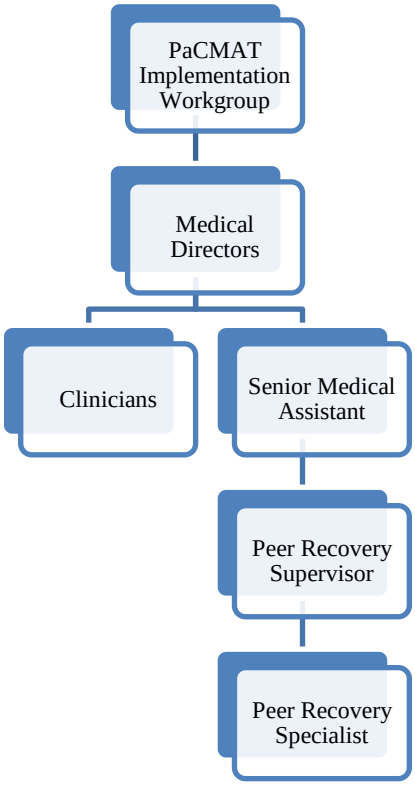
1. Program Operations

A patient-centered hub and spoke model superimposed on an integrated community commitment to population health will lead to methods for managing opioid abuse based on scientific evidence and evidence-based practice. With Temple's experience and current alliances within the community, we remain committed to expansion of current substance abuse care services and can leverage existing partnerships to develop a practical, feasible, and sound approach. A portion of the infrastructure required for a strong foundation at the hub already exists in our current buprenorphine clinic staffed by two experienced physicians. Expansion has been accomplished through the formation of TRUST (Temple Recovery using Scientific Treatment), an interdisciplinary center for addiction medicine that provides intensive services including, but not limited to, peer recovery specialists, medication assisted treatment programs, social services, and links to community service agencies to address unmet health-related social needs. Centralization of services at the hub is critical to providing the education, support, referral base, and mentorship needed for expansion of OUD treatment in North Philadelphia and beyond. The Hub will also provide a central data platform for data collection and analysis, program evaluation and real-time improvement.

1.a.i. Hub Staff roles and responsibilities

TRUST will serve as a central treatment location for both primary as well as specialty treatment of OUD. Critical to the success of this model is coordination of services under one roof with a coordinated team including the following staff:



PacMAT Hub Roles/Responsibilities

Title	Required Credentials	Responsibilities	Reports to
Medical Directors	MD, at least 1 board certified addiction medicine specialist	• Oversees overall operations of the Hub and Spoke model. • Work closely with the PaCMAT implementation team to ensure deliverables, as assigned by the State, are met by the deadlines (see work statement).	Implementation Team
Clinicians	MD, NP, PA	• Elicits and records information about patient's medical history. • Orders or executes various tests, analyses, diagnostic images to provide information on patient's condition. • Analyzes reports and findings of tests and examination, and diagnoses condition of patient. • Administers or prescribes treatments and medications. • Promotes health by advising patients concerning diet, hygiene, and methods for prevention of disease. • Inoculates and vaccinates patients to immunize patients from communicable diseases • Administer buprenorphine to patients presenting with OUD.	Medical Directors
Peer Recovery Supervisor	Experienced Peer Recovery Specialist.	• Guide Peer Recovery Specialists in providing wrap around services. • Work closely with Social Worker/Case Manager to ensure connection with resources. • Work closely with staff to ensure programming is optimal.	Senior MA
Peer Recovery Specialist	• Past or present personal experience of mental health or substance misuse services with a history of managing one's own illness or recovery process successfully • Demonstrated ability to work collaboratively in a team environment • Demonstrated commitment to serving North Philadelphia community • Ability to manage time effectively,	• The Peer Recovery Specialist is a key member of the buprenorphine treatment team and serves an essential role in the onboarding and maintenance treatment of individuals in the Temple Recovery Using Scientific Treatments (TRUST) Clinic. • The person must possess the background and skills to participate in individual patient treatment, including the organizational and communication skills to coordinate are amongst community partners and programs. Service provision will focus on working with individuals to enhance their recovery. The Peer Recovery Specialist is responsible for: • Providing individualized, ongoing guidance, coaching and support • Providing training in the use of personal and community resources	Peer Recovery Supervisor

	prioritize multiple tasks, and multi-task • Ability to work with diverse staff and populations whose interests, learning styles, and style of communication vary	• Assisting with development of community support plan with care coordination to such support organizations • Providing encouragement and recovery support in times of crisis • Advocating on behalf of persons to reduce associated stigma • Working in cooperation with treatment team and family members or significant others involved in the recovery plan • Assisting individuals with o Care coordination including medication management and treatment monitoring o Insurance authorization and troubleshooting o Relationship building and patient linkage to additional support o Relationships building and facilitation of ancillary services • Attending staff meetings, case conferences, and group meetings • Attending staff recovery support meetings • Observing all rules of confidentiality relating to clinical information and treatment, both internally and externally • Understanding patients' rights policy and procedures • Maintaining professional standards at all times • Performing other related duties as assigned	
Senior Medical Assistant	• Bachelor's Degree o Combination of relevant education and experience may be considered in lieu of degree. • 5 years' experience in a related role • 2 years' experience in a healthcare setting	• The Senior Medical Secretary provides administrative and secretarial support to assigned physicians/personnel in a medical department. • The Senior Medical Secretary acts as a liaison for all administrative activities of assigned personnel including conferences, projects, and meetings both internally and externally	Medical Director

1.a.ii. Spoke Staff Roles and Responsibilities

With TRUST developed, the Temple Hub and Spoke model will be prepared to provide a strong foundation to support spoke organizations and make expansion of MAT into primary care settings throughout Philadelphia more feasible. TRUST physicians will serve as mentors to newly waivered physicians to assist in providing consultative services for care delivery. As lack of support and mentorship, as well as poor coordination of services, are listed as barriers for providers to provide MAT, TRUST's learning collaborative will serve as the infrastructure to remove this barrier. The learning collaborative will assist each site with a readiness assessment for implementation while physicians are completing their waiver training. As a supplement to the waiver training, the spokes will have the benefit of TRUST's developed standardized protocols to make implementation not only easier but also consistent with evidence-based practice

guidelines. This supplemental education will occur in the context of the learning collaborative as well as in-service sessions at the spoke sites. Just as TRUST receives patients through warm handoffs from Temple Health and outside organizations, the Spoke sites will also have current and new patients that present and are candidates for MAT. The pliability within the hub and spoke model allows some practices to immediately implement and provide MAT services while others may prefer initial care to occur at TRUST with transfer to the spoke once stabilized. This bidirectional flow and pliability acknowledges the variation that will undoubtedly be part of the diverse practices recruited. In order to participate as spoke in the PacMAT program, sites agree to the following:

1. Providers are credentialed with Medical Assistance FFS and Medical Assistance Managed care organizations.
2. Practice has current MAT providers and or willing to have provider's trained.
3. Practice has existing care management resources to support program and / or willing to utilize the HUB care management and peer coach resources.
4. Practices have the ability to accept patients at least 5 days / week for MAT.
5. Practice is willing to document MAT services provided in tracking database developed by the Hub.

1.b. Multi-Disciplinary Treatment

The Temple Hub and Spoke model acknowledges that MAT expansion in a primary care setting must address a patient-centered; whole-person approach to care that includes not simply addressing the OUD but the bio-behavioral factors that contributed to this. As such, evidence-based mental health screening for depression, substance use history, as well as unmet social needs of patients in this population will be critical to delivering comprehensive care. The Temple Hub and Spoke model will coordinate such screening through use of a validated screening tool, which patients will complete both at the hub and spoke organizations. On arrival, patients are asked to complete a confidential survey available in English and Spanish. The data are immediately available to the provider for development of an action plan, as needed.

To optimize collection of patient reported data, certified recovery specialists will assist in coordination of these screenings at the hub and spoke sites. Standardization of clinical workflows will go into the standardized protocols developed for the spokes. An addiction index may be utilized to triage patients to the most appropriate level of care. These screenings will further elucidate key areas that will need to be addressed to reduce the burden of social determinants negatively affecting health and promote a more effective recovery strategy. Critical to addressing these social determinants are the TRUST resources, the spokes, and key partners that will further foster development of a coordinated medical neighborhood to more adequately address the unique aspects of treating those with OUD.
The standardized protocols will be developed by Hub staff to form a protocol that follows Samhsa's TIP 63 protocols closely.

1.c. Documentation Requirements
All care provided to patients enrolled in the PacMAT program will be properly documented and submitted by deadlines set by Hub staff on an as needed basis. Documentation includes:

- billing for medical/mental health services,
- screening tools
- research tracking
- care management tracking

1.d. Meeting Requirements
All sites providing services through the PacMAT grant must agree to attend, at minimum, monthly check-ins with medical directors to discuss programs.

1.e. Reporting Requirements
All sites providing services through the PacMAT grant must agree to submit monthly reports articulating details around patients served as requested by HUB staff.

2. Patient and Setting Identification

The hub and spoke care and transfer of patients policy provides direction for providers and patients to address mechanisms to determine whether a patient will receive initial care through the hub or through the spoke, transfer of care from the hub to the spoke and vice versa, and care coordination through conference calls.

2.a. Determination of Ideal Location of Treatment:

- Patient-centered care dictates that patients are offered location for initiation of their treatment and every effort will be made to provide the patient with initiation of treatment at their preferred location.
- For patients with unique care needs, discussion regarding the benefits of initiation at the hub will be reviewed with the patient; however, patient preference for location of treatment supercedes all other factors.

2.b. Transfer of Patients from the Hub to the Spoke:

- Patients will be followed in care at the hub in accordance with the Treatment Maintenance Policy.
- For those patients who have demonstrated stability in their recovery process at the hub (defined as greater than 3 months of engagement) AND who desire transfer to a more convenient hub site, the transfer will be discussed directly between hub and spoke site during the monthly communication calls with spokes.
    - If the spoke is able to accept the patient for transfer, a coordinated warm handoff with appointment scheduling is coordinated by the peer recovery specialist ensuring that the patient has information regarding the appointment, clinic location site, and transportation to access the site.
    - A treatment summary will be completed by the hub and sent directly to the spoke to provide seamless warm-handoff to the spoke site for the patient.

2.c. Procedures for Transfer of Patients from the Spoke to the Hub:

- Patients will be followed in care at the spoke in accordance with the Treatment Maintenance Policy.
- Patients desiring a transfer from the spoke site to the hub site will be discussed directly between hub and spoke site during the monthly communication calls.
    - If the hub is able to accept the patient for transfer, a coordinated warm handoff with appointment scheduling is coordinated by the spoke site ensuring that the patient has information regarding the appointment, clinic location site, and transportation to access the site.
    - The patient will be scheduled with intake with the program manager in accordance with the hub workflow.
- Patients who the spoke site wishes to transfer to the hub site will undergo the following checkpoints:
    - For those patients who have demonstrated lack of stability in their recovery process (defined as persistent (>4) abnormal urine drug screens) AND who agree to transfer to

the hub site, the transfer will be discussed directly between hub and spoke site during the bi-weekly communication calls with spokes.
    - A coordinated warm handoff with appointment scheduling is coordinated by the certified recovery specialist with the spoke site ensuring that the patient has information regarding the appointment, clinic location site, and transportation to access the site.
    - The patient will be scheduled with intake with the program manager in accordance with the hub workflow.
    - A treatment summary will be completed by the hub and sent directly to the spoke to provide seamless warm-handoff to the spoke site for the patient.

3. Patient Policies

While increased services for those struggling with opioid use disorder (OUD) are often concentrated in urban areas, many overdose deaths still occur in Kensington and North Philadelphia neighborhoods. These areas, relative to others, have higher poverty levels and reduced access to substance abuse care. That being said, patients participating in the PacMAT program will be expected to adhere to the following policies:

3.a. Agreement of Responsibilities

The Agreement of Responsibilities is a written document that sets clear expectations and guidelines for both the treatment team as well as the patient. The goal of the Agreement of Responsibilities is to engage the patient in the treatment plan along with the treatment team as well as to clearly explain that the patient will be treated with dignity and respect and the same will be expected of the patient towards the treatment team and staff.

Procedures for Initiation of Agreement of Responsibilities:

- At the initial visit, the Agreement of Responsibilities will be explained verbally to the patient, line by line, and provided in written form, which the patient will sign and date.
- The signed form will be kept in the patient record and a copy will be provided to the patient at that visit and upon request at future visits.
- The patient will be encouraged to ask questions during and after review of the Agreement of Responsibilities.

Procedures for Review of Agreement of Responsibilities:

- The provider will review the Agreement of Responsibilities intermittently with the patient at their discretion during the course of treatment.
- The provider will review the Agreement of Responsibilities with each refractory behavior that violates the Agreement.

3.a.i. Behavior Policy

The behavior policy provides for the direct safety of the patient, the treatment team, and other patients in the clinical setting.

Procedures for Behavior:

- The provider reviews in detail expected behaviors in keeping with those outlined in the "Agreement of Responsibilities."
- Patients are expected to maintain appropriate behaviors including no illegal activities, no disruptive behavior, no verbal or physical threats toward anyone, and no possession of weapons or other harmful objects on clinic property.

Procedures for Failure to Comply with Behavior Standards:

- If the patient does not comply with behavior standards as outlined in the "Agreement of Responsibilities," the treatment team will review the behavior and align action with the severity of the behavior.

- The provider has the discretion to dismiss any patient to maintain the safety and security of the treatment team, staff, and other patients.
- Any unlawful or threatening behaviors or possession of weapons on clinic property is immediate grounds for dismissal.

4. Provider Policies

Identification of the root cause of an individual's addiction is a key to successful recovery. Addressing hopelessness, depression, physical and mental pain without attention to homelessness or housing insecurity, food insecurity, utility needs, transportation issues, violence or abuse, health literacy and other social determinants of health will not lead to the desired outcomes. Screening for and addressing social needs by linking patients with community agencies and closing the loop to assure intervention is a key element to the program. With expansion of MAT to underserved areas that are also high areas of poverty and patients who are uninsured or underinsured, TRUST's services can make a direct impact on improving health through directly identifying as well as addressing medical homelessness, connecting patients with insurance and/or primary and substance abuse care. The following policies are directors towards providers in an effort to standardize care across settings.

4.a. Treatment Initiation & Induction Policy

Purpose: The treatment initiation and induction policy provides for direction for providers and patients to address process for patients to enter into buprenorphine program to ensure that thorough evaluation is performed as well as patient willingly enters into program, appropriately informed.

Procedures for Treatment Initiation & Induction:

- Patients presenting for treatment will have a comprehensive history and physical examination.
    - History and Exam should target complications of and risks of substance use
    - Substance Use History will include obtaining:
        - Drug of choice
        - Method of Use
        - Timeline and Frequency of Use
        - Maximum Daily Use
        - Last use
        - Reasons for seeking buprenorphine
        - Substance Use History
        - Prior Treatment or Rehab History (including dates, locations, and reasons for relapse)
        - Family History of Substance Use Disorder
    - Include screening for depression
- Urine drug testing is performed
- Pregnancy testing for women of childbearing age
- Provider will ensure that evaluation sufficient to determine whether individual meets DSM-5 diagnosis of opioid use disorder.
- "Agreement of Responsibilities" is reviewed and signed
- Identification of location for counseling or other support services in place
- Provider discusses appropriate initiation for home induction of medication including appropriate administration and timing for initiation.
    - Typical timeline (variable and patient-dependent)
        - Short-acting opioids: typically 8-12 hours after use
        - Long-acting opioids: typically 12-24 hours after use
        - Methadone: typically 36 hours after use

4.b. Clinical Appointment

The clinical appointment policy provides clear guidance and understanding as outlined in the Agreement of Responsibilities of need to keep and maintain appointments for treatment.

Procedures for Appointment Scheduling:

- Upon reviewing and signing the Agreement of Responsibilities, the provider will explain to patients that at initiation, they will be seen weekly for a total of 4 weeks, and pending course, will be transitioned to every other week and finally monthly.
- The provider will explain to patients that it is their responsibility to make and keep their appointments for both buprenorphine therapy as well as their behavioral health sessions.
- The provider will explain to patients that they must make every effort to arrive on time for all scheduled appointments. Patients arriving late (in keeping with the clinical site's late policy) should be seen at the end of the schedule.

Procedures for Unable to Make Visits:

- If an appointment cannot be kept, it is the patient's responsibility to reschedule the appointment prior to the actual appointment.
- If the patient calls prior to their appointment to cancel and reschedule, medications can be called in to the patient's pharmacy at the provider's discretion and the patient should be seen the following week.
- If a patient does not keep the visit and calls at a later time, medications can be called in to the patient's pharmacy at the provider's discretion and the patient should be seen as coordinated by the provider.

Procedures for Visits Not Kept without Follow-up:

- If a patient does not keep a visit and does not call to schedule a follow-up within 1 week of the missed appointment, the patient may be allowed to reschedule at the provider's discretion.
- Patients not keeping visits and not scheduling follow-ups should be considered for referral to the hub site.
- For patients not allowed to reschedule, a certified letter of dismissal should be sent to the patient and kept in the medical record.

The treatment maintenance policy provides for direction for providers and patients to address ongoing care through the buprenorphine program to support recovery and maintain patient engagement in care.

4.c. Treatment Maintenance:

- Patients will be seen weekly for a minimum of 4 visits after treatment initiation and induction visit. After 4 weekly visits with success determined by appropriate urine drug screen and patient comfort, visits intervals can be increased to every other week for 2 visits at the discretion of the provider and with approval of the patient. After at least 2 successful biweekly visits as defined above, visit intervals can be increased to monthly at the discretion of the provider and with approval of the patient.
- At follow-up visits, patients present for complete assessment, prescription renewal, toxicology screening, counseling, education, support, and evaluation of medical, mental health, and social needs.
- Documentation should include medication dose, adherence, tolerance, side effects, cravings and withdrawal; safe storage, recovery, relapse, as well as medical, social, and psychiatric issues.
- Laboratory testing as indicated may occur for management of co-occurring chronic conditions such as HIV and HCV.
- Providers should engage in discussion with patients regarding effective dose and consideration of dose wean at the discretion of the patient whether the patient desires wean of therapy.

4.d. Telemedicine

- Patients will be contacted prior to their appointment and informed of an option for a telemedicine appointment.

- Telephone visits will occur during the session accordingly and the physician will contact that patient at the preferred modality.
    - Document the time you spent either in minutes or start/end times.
    - Use the appropriate ICD10 diagnosis codes for what was discussed.
- The provider will delineate with the patient based on risk factors and information gathered to what degree the patient needs closer monitoring and follow-up which might mean another telemedicine or in-person visit within a week or two.
- Pharmacy delivery options should be considered for patients if an option.
- Patients should be advised to carry all of their medications with them if they are relocated, even temporarily, and to bring with them the following items so that they can more easily obtain medication refills, as needed, from a new medication-dispensing facility:
    - A photo ID
    - Medication containers of currently prescribed medications (even if empty)
    - Packaging labels that contain dose, physician, and refill information

4.d.i. New Patient TeleMedicine Visits

While a prescription for a controlled substance is issued by means of the Internet (including telemedicine), generally, it must be predicated on an in-person medical evaluation, the Controlled Substances Act contains certain exceptions to this requirement. For as long as the Secretary's designation of a public health emergency remains in effect, the DEA notes that practitioners have further flexibility during the nationwide public health emergency to prescribe buprenorphine to new and existing patients with OUD via telephone by otherwise authorized practitioners without requiring such practitioners to first conduct an examination of the patient in person or via telemedicine. This additional flexibility under which authorized practitioners may prescribe buprenorphine to new patients on the basis of a telephone evaluation is in effect from March 31, 2020, until the public health emergency declared by the Secretary ends, unless DEA specifies an earlier date.

OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.

4.e. Medication Administration

The medication administration policy provides for direction around provider and patient responsibilities in ensuring safe storage and administration of medication.

Procedures for Medication Administration:

- The provider reviews with patient that medication must be taken as directed by the prescribing provider and not adjusted without first discussing this as outlined in the "Agreement of Responsibilities."
- Providers will only prescribe enough medication to last until the next scheduled follow-up visit. For example, if a patient is seen every 4 weeks, the patient will receive only 28 days of medication and not 30.
- The provider will review the PDMP with each prescription of buprenorphine.
- Patients should have a safe place to store their medication and should be strongly advised not to carry it on them, keep it in a vehicle, or bring it to work if possible as it is a controlled medicine.
- Patients are expected to inform other providers that they are taking buprenorphine and likewise should disclose to the treatment team if they are being seen by other providers (pain

management specialists, psychiatrists, counselors, physicians) and whether they have been prescribed medications by these providers.

Procedures for Lost or Stolen Medication:

- The provider reviews with patient that the lost or stolen medicine requires filing of a police report and presentation of a copy or number of the police report as outlined in the "Agreement of Responsibilities."
- A new prescription for lost or stolen medicine will be provided at the provider's discretion only once in a calendar year or as allowed by the patient's insurance coverage.

4.f. Misuse and Diversion

Diversion, defined as the unauthorized rerouting or misappropriation of prescription medication to someone other than for whom it was intended, and misuse, defined as taking medication in a manner other than prescribed, are concerns that must be addressed by office-based opioid treatment (OBOT) programs. These procedures will establish the steps to be taken to prevent, monitor, and respond to misuse and diversion of buprenorphine. The response should be therapeutic and matched to the patient's needs.

Procedures for Prevention:

- Use buprenorphine products only when medically indicated and patients are actively willing to engage in program including all items established in the "Agreement of Responsibilities."
- Counsel patients on safe storage of, and nonsharing, medications during review of pertinent section and signing of the "Agreement of Responsibilities."
- Counsel patients on taking medication as instructed and not sharing medications during review of pertinent section and signing of the "Agreement of Responsibilities."
- Check the prescription drug monitoring program (PDMP) every visit as required by PA law.
- Prescribe a therapeutic dose that is tailored to the patient's needs with medication prescribed only to cover until next scheduled visit.
- Ensure understanding on process for each prescription, refills, and rules on "lost" prescriptions during review of pertinent section and signing of the "Agreement of Responsibilities."

Procedures for Monitoring:

- Urine drug screens (UDS) will be obtained at every visit with the options for such testing to be (1) observed collection; (2) disallowing carry-in items in the bathroom; (3) turning off of running water until sample provided; (4) monitoring the bathroom door so that only one person can go in; and (5) testing the temperature of the urine immediately after voiding.
- Patients may be called to present for random UDS at random, unscheduled intervals during treatment.
- Unannounced pill/film counts may occur at intervals decided by the provider either in conjunction or at separate intervals than random UDS.
- Unannounced monitoring requires that patients be contacted and must appear within a 48-hour time period from the phone call. If the patient does not show without due cause (transportation issues, etc), the provider will consider this as a positive indicator of misuse or diversion.

Procedures to Respond to Misuse or Diversion

- Misuse or diversion does not automatically result in discharge from the program.
- All misuse and diversion must be evaluated within 1 week of identification.
- A management plan to address misuse or diversion must be documented in the medical record and must be tailored to the specific behavior.
- Patients remaining in treatment must resume a 1-week interval appointment for a time period decided by the provider.

- Patients must provide proof of current behavioral health counseling and should be considered for increasing the level of care.
- Patients who may require observed administration should be considered for transition to hub care delivery site or methadone maintenance program.

4.g. Random Callback

The random callback policy provides direction for the treatment team to reduce misuse and diversion through random urine drug screens and pill/film counts.

Procedures for Random Callback:

- At the provider's discretion, patients at risk or those struggling with treatment will be called to present to the clinical site for either a random urine drug screen or a random pill/film count.
- The patient must respond to the call within 24 hours.
- The patient must present to the clinic within 48 hours to provide urine sample or with medicine bottle and all of the remaining buprenorphine pills/films.
- The patient may be asked to do an observed urine drug test or an observed dosing while present in the clinic setting.

Procedures for Failure to Comply with Random Callback:

- If the patient does not return for a random callback monitoring visit within the outlined timeframe, the patient will be scheduled for a visit with the provider for evaluation in keeping with the Misuse and Diversion Policy.

4.h. Counseling

The counseling policy provides direction for the treatment team to understand the behavioral health counseling requirement for individuals in the program to ensure that comprehensive, multifaceted care is provided for recovery.

Procedures for Counseling:

- Patients are required to participate in formal counseling by a licensed counselor for the program.
- Providers will educate patients at the onset and ongoing about the importance of adjunct counseling and recovery support and its role. It will be reinforced that medication alone rarely addresses all aspects of recovery and building recovery capital will improve their chances of success.
- Patients will agree to sign consent to release information so that the treatment team can communicate with the patient's entire team, including outside counseling and recovery support.
- Patients will be expected to discuss their engagement in counseling and other outside recovery services with the treatment team.
- Groups, Intensive Outpatient Programs (IOPs), Residential, and Halfway houses are methods of treatment that are accepted as counseling.
- Self-help peer-support groups are strongly encouraged but do not satisfy counseling requirements.

Procedures for Failure to Participate in Counseling:

- If the patient does not participate in counseling, the patient should be seen more frequently with required documentation of active participation in counseling.
- If the patient does not participate despite frequent visits, the patient should be considered for referral to the hub.

4.i. Special Circumstances

While all circumstances can't be accounted for, the following policies address potential special circumstances where providers can find direction for treatment.

4.i.i. Perioperative Care

The perioperative care policy provides for direction for providers and patients to address care in the perioperative period to ensure the patient has adequate pain control as well as maintains recovery.

Procedures for Perioperative Care:

- Patients must make treatment team aware of any pending elective procedure including name and contact of the surgical treatment provider.
- Treatment provider will coordinate directly with surgical team regarding perioperative care and pain management for patients.
- Options for perioperative management include switching to opioids prior to procedure, continuing buprenorphine through surgery and postoperative time period, or using opioids postoperatively with plan for resumption of buprenorphine upon discharge or other postoperative care.
    - Patients maintained on buprenorphine should take their AM dose on the day of the procedure. The frequency of their home dose may be adjusted postoperatively as q6-8 may assist better with pain control. Escalation of home dose may need to occur postoperatively. Encourage multimodal non-opioid pain management postoperatively (NSAIDs, acetaminophen, epidural/spinal or regional blocks) as indicated.
- Buprenorphine is not a contraindication to receiving postoperative opioids. If a PCA is being used, it should be used without basal dosing.
- Perioperative care can be coordinated along with the hub.

4.i.ii. Substance Use During Treatment

The substance use during treatment policy provides for direction for providers and patients to address substance use during the course of treatment. As this is a harm reduction model, automatic discharge is not the recommended course of action for patients who struggle with substance use while engaged in treatment.

Procedures for Substance Use During Treatment:

- When a patient discloses substance use, the provider should assess the circumstance surrounding use (home environment, work environment, role of support persons, etc). The details will be used to adjust the treatment plan to meet the evolving needs of the patient.
- In addition to adjustment of treatment plan, visit frequency should be adjusted and elevation in the level of behavioral health care should be considered.
    - If the patient is adherent with intensified treatment plan and is able to be stabilized, the treatment is restructured and relaxed and medication is continued.
    - In the case of continued use, the patient should be considered for referral to the hub.
- Potential situations in which the risk of continuing treatment may outweigh the benefit:
    - Inability to stabilize care in office setting
    - Multiple negative buprenorphine UDS results
    - Ongoing use of benzodiazepines, cocaine/stimulants, alcohol or other harmful/illicit substances causing impairment, sedation, overdose, medical events, and/or hazardous, unsafe behaviors
    - Repeat incidents of presenting intoxicated or ER/hospital visits for overdose or substance use-related

4.i.iii. Transition from Methadone to Buprenorphine

The transition from methadone to buprenorphine policy provides for the safe initiation of buprenorphine as patients wish to transition from their methadone program to buprenorphine therapy.

Procedures for Transition from Methadone to Buprenorphine:

- Patients wishing to transfer from methadone to buprenorphine should be informed upon attempting to make their visit that they need to be weaned down to 20-30 mg/day, preferably for one week but not mandatory, to make their visit.
- Timing for last methadone dose/first buprenorphine dose is difficult to predict.
    - Generally, at least 36-96 hours after last methadone dose, but utilizing clinical assessment and judgment is essential.
    - Initiation of buprenorphine should be guided by withdrawal symptoms.
    - Close monitoring and small amount of clonidine, hydroxyzine, ibuprofen, and immodium may be used to manage distressing withdrawal symptoms and continued during induction, if desired by provider.
- For patients with significant risk or concern, inpatient detoxification to make this transition can be a safer, more effective way to transition a patient from methadone maintenance to buprenorphine.

4.i.iv. Treatment of Patients with Chronic Pain

The treatment of patients with chronic pain policy provides direction for providers on the evaluation and management of individuals on buprenorphine treatment who also struggle with chronic pain pathology.

Procedures for Care of Patients with Chronic Pain:

- For patients with chronic pain, buprenorphine can assist in the management of their chronic pain. Patients should be reassured that their substance use disorder will not be an obstacle to aggressive yet safe pain management.
- Establish clear goals for pain management.
    - Discuss goal of reduction of pain to functionality over cessation/elimination of pain
    - Complete pain agreement if indicated in addition to agreement of responsibilities for buprenorphine program.
- Use multimodal approach to pain management:
    - Consider splitting the patient's usual buprenorphine dose into every 6 or every 8 hour dosing to address half-life of medication for pain.
    - Consider modest increase in patient's buprenorphine maintenance dose.
    - Try non-opioid and adjuvant therapies next including acupuncture, acupressure, massage, physical therapy, hydrotherapy, meditation, NSAIDs, acetaminophen, topical lidocaine, SNRIs, TCAs, etc.
    - Address concurrent behavioral health diagnoses and ensure appropriate treatment.
- If chronic opiates must be used for the management of chronic pain, patients should be transferred to methadone maintenance.

4.i.v. Treatment of Women of Childbearing Age

The treatment of women of childbearing age policy provides direction for providers on the evaluation and management of women of childbearing age as well as those who are pregnant or breastfeeding with opioid use disorder with regards to their buprenorphine treatment.

Procedures for Care of Women of Childbearing Age:

- All women of childbearing age will have a documented negative urine pregnancy test prior to initiation of treatment. Preconception care will be reviewed including discussion of pregnancy or pregnancy avoidance planning routinely with women of childbearing age to develop care plan.
    - For women planning pregnancy, preconception care counseling regarding treatment in the perinatal period will be reviewed including the risks and benefits.
    - For women who do not wish to become pregnant, contraceptive options will be reviewed and prescribed accordingly.

Procedures for Treatment of Pregnant or Breastfeeding Mothers:

- Patients will be treated in accordance with the Treatment Initiation and Induction Policy and the Treatment Maintenance Policy.
- Patients will be educated on the benefits of maintaining in treatment during pregnancy and breastfeeding.
    - Decreased risk for relapse and therefore reduced complications from illicit opioid use.
    - Constant levels of fetal opioid exposure result in reduced fetal risk for adverse fetal outcomes related to multiple withdrawals.
    - Decreased rate of adverse fetal outcomes such as low birth weight or preterm delivery.
- Pregnant patients can be initiated or maintained on buprenorphine/naloxone formulations or transitioned to buprenorphine for their pregnancy.
    - All patients should be offered the opportunity to receive care through the Temple-Wedge Center of Excellence where both buprenorphine and obstetrical care will be coordinated; however, patients are not required to transition their care if not desired.
    - Patients should be referred for high-risk obstetric service where indicated.
    - Patient doses may change during pregnancy requiring increased dosing and treatment should be focused on symptom management and recovery-oriented care
- Women desiring to breastfeed can be maintained on buprenorphine and should be encouraged to breastfeed provided urine drug screen testing is negative for substances and positive for buprenorphine.
    - Because of poor oral bioavailability of buprenorphine, the breastfeeding infant is exposed to only 1/10 of buprenorphine ingested.
    - Breastfeeding during buprenorphine use does not suppress neonatal abstinence syndrome (NAS); however, the close contact afforded by breastfeeding assists with NAS and enhances maternal-child bonding.
    - Cessation of breastfeeding is not associated with onset of neonatal abstinence syndrome.