April 2021

Utilizing Medication Assisted Recovery for Opioid Use Disorder in Illinois: A Planning and Implementation Toolkit

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USE OF THIS TOOLKIT

This toolkit was created for the benefit of all Illinois clincians, hospitals, health care facilities,substance use disorder treatment providers and recovery homes who are interested in working with patients interested in medication assisted recovery or providing medication assisted recovery (MAR) services to people who have an opioid use disorder (OUD). The toolkit provides information providers need to implement MAR services, including guidance on state-level regulations and workflow to induct patients into MAR. Additionally, it offers recommendations and best practices for administering MAR and locating and building collaborative relationships with prospective referral sources and recovery support systems to help build more supportive systems of care for people with OUD.

Toolkit Authors

This toolkit was developed by members of the Illinois Opioid Crisis Response Advisory Council MAR Committee with administrative support from Advocates for Human Potential, Inc. (AHP).

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Introduction

WHAT IS MAR?

Medication Assisted Recovery (MAR) is the use of U.S. Food and Drug Administration (FDA) approved drugs to treat an opioid use disorder (OUD). The medications for OUD (also referred to as MOUD), particularly methadone and buprenorphine, are effective in improving outcomes for patients with an OUD independent of other therapeutic services including counseling. Behavioral therapies and evidence-based recovery supports can assist patients in their recovery from OUD and/or polysubstance use disorder.[1–3]

There are currently three medications approved for MAR by the FDA. In order to be considered MAR, treatment must include one of the following:

- **Methadone** (Dolophine, Methadose, etc.)
- **Buprenorphine and Buprenorphine/Naloxone** (Subutex, Sublocade, Belbuca, Probuphine, Buprenex, and Butrans)
- **Naltrexone** (Narcan, Vivitrol, etc.)

WHY USE MAR?

Medication Assisted Recovery is the use of evidence-based Food and Drug Administration (FDA) approved medications (e.g., methadone, buprenorphine, naltrexone) for OUD by individuals with a substance use disorder (SUD) to support their recovery. IDHS/SUPR recognizes that individuals who identify themselves as being in recovery and take medications to manage their SUD *are* in recovery.[4] IDHS/SUPR endorses MAR as an evidence-based approach for individuals with a SUD.[5]

The most common FDA-approved medications used in the treatment of OUD are methadone and buprenorphine. Taking these medications is analogous to taking medication for diabetes or asthma—they help people manage their disorder so they can maintain their recovery. Using these medications for treatment of OUD is not the same as substituting one addictive drug for another. Once stabilized, patients can live a normal life and do not experience the compulsive thoughts and behaviors that define a substance use disorder. The World Health Organization (WHO), Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and other experts all agree that MAR is essential to treating those with OUD and helping them recover.[4] Organizations working with or encountering people with an OUD should have policies and procedures designed to prevent and respond to an opioid overdose.[6]

MAR with the use of methadone and/or buprenorphine decreases opioid-related deaths and reduces opioid use.[2,7,8] It also improves birth outcomes for pregnant women with OUD.[9] Individuals with OUD who participate in MAR:

- Are more likely to stay in OUD treatment[1,3]
- Are less likely to relapse[9,10]
- Have decreased criminal activity[11]
- Are more likely to find work and keep their jobs[12]
- Have a decrease in risky behaviors that are associated with HIV or hepatitis C transmission[11]

- Have better social functioning and improved relationships with families and friends[13]

Some patients find it beneficial to combine MAR with recovery support services (e.g., behavioral therapy, peer recovery coaches, 12-step groups, psychiatric consultations). Recovery support services can help people with OUD understand and modify the behaviors associated with their opioid misuse and treat the mental health symptoms that often accompany OUD and/or relapse triggers. With the exception of methadone (see 42 CFR § 8.12(f) (5) for regulations regarding counseling services for Opioid Treatment Programs - OTPs), patients are not required to utilize counseling or other recovery supports in order to utilize MAR. However, providing these services in conjunction with medications may help some patients stay engaged in treatment and improve their quality of life.[14] While IDHS/SUPR highly recommends medication alongside recovery supports, patients' acceptance of treatment, housing, or other recovery supports should not be a condition of MAR (see Medication First Approach).[6]

WHY OFFER MAR IN MY PRACTICE/PROGRAM?

By offering MAR, providers can help reduce fatal and non-fatal opioid overdoses.

> ***Community-based MAR programs are cost-effective and save lives!***[15]
>
> *Increasing access to MAR, behavioral therapy, and recovery support services across the state will reduce opioid misuse, overdoses, and deaths, as well as give people with OUD the evidence-based treatment they need to regain their quality of life.*[4]

Note—recommendations and resources in this toolkit are only intended to facilitate providers' clinical decision-making and are not intended to replace individual providers' clinical judgement.

Implementing MAR

MEDICATION CHARACTERISTICS

MAR medications have different characteristics that should be considered when prescribing to patients. The chart below summarizes the key differences to the current FDA approved medications.

Characteristics of Medications for Opioid-Addiction Treatmeant				
	Methadone	**Buprenorphine**	**Long-acting Buprenorphine Injectables**	**Naltrexone**
Brand names	Dolophine, Methadose	Subutex, Suboxone, Zubsolv	Sublocade	Depade, ReVia, Vivitrol
Class	Agonist (fully activates opioid receptors)	Partial agonist (activates opioid receptors but produces a diminished response even with full occupancy)	Partial agonist (activates opioid receptors but produces a diminished response even with full occupancy)	Antagonist (blocks the opioid receptions and interferes with the rewarding and analgesis effects of opioids)

Characteristics of Medications for Opioid-Addiction Treatmeant				
	Methadone	**Buprenorphine**	**Long-acting Buprenorphine Injectables**	**Naltrexone**
Uses and effects	Taken 1x per day orally to reduce opioid cravings and withdrawl symptoms	Taken buccally or sublingually (usally 1x daily) to relieve opioid cravings and withdrawl symptoms	1x monthly injection	Taken by injection to diminish the reinforcing effects of opioids (potentially extinguishing the assocation between conditioned stimuli and opioid use)
Advantages	High strength and efficacy as long as oral dosing (which slows brain uptake and reduces euphoria) is adhered to; excellent option for patients who have no response to other medications	Eligible to be prescribed by certified providers, including nurse practitioners and physician assistants, which eliminates the need to visit specialized treatment clinics and thus widens availability	Sublocade is covered by Medicaid and the Managed Care Organizations (MCOs) in Illinois if prior authorization is completed Removes the need for taking daily medication	Not addictive or sedating and does not result in physical dependance; a recently approved depot injection formulation, Vivitrol, eliminates need for daily dosing
Disadvantages	Only available through approved outpatient treatment programs; IDHS/SUPR licenses outpatient methadone treatment providers in Illinois. Initially observed dosing 6 days/week with 1 take home dose, but take-home doses can be increased based on meeting the CARF criteria[1] and a minimal amount of time has passed.	Subutex has measurable abuse liability; Suboxone diminishes this risk by including naloxone, an antagonist that induces withdrawl if the drug is injected	Only available through a restricted SUBLOCADE REMS program	Poor patient compliance (but Vivitrol should improve compliance); initiation requires attaining prolonged (e.g., 7-10 days) abstinence, during which withdrawl, relapse, and early drop out may occur.

[1] Commission on Accreditation of Rehabilitative Facilities (CARF) guidelines can be found here: *http://www.carf.org/Programs/OTP/*

Further, MAR medications vary in their benefits:

Research-established benefits compared to treatment without MAR	Methadone	Buprenorphine	Naltrexone
Increased retention in treatment	✓	✓	✓
Reduced illicit opioid use	✓	✓	✓
Reduced overdose death	✓	✓	--
Reduced death for any reason	✓	✓	--
Reduced HIV risk behaviors	✓	✓	--

MEDICATION BEST PRACTICES

Methadone Dispensing

Opioid Treatment Programs (OTPs) provide MAR for people diagnosed with an opioid use disorder. OTPs must be certified by the federal agency– Substance Abuse and Mental Health Services Administration (SAMHSA)– and accredited by an independent, SAMHSA-approved accrediting body to dispense opioid treatment medications. All OTPs must be licensed by IDHS/SUPR and must register with the Drug Enforcement Administration (DEA), through a local DEA office. For more information on licensing, see the *Regulations* section of this toolkit.

Methadone can only be prescribed in a licensed OTP. As such, a detailed discussion of methadone prescribing is beyond the scope of this toolkit. Illinois OTPs can be found in this directory: *https://dpt2.samhsa.gov/treatment/directory.aspx.*

Existing OTPs may find the following resources helpful guidance in their practice.

- A brief, four-page summary of best practices in the use of methadone and treatment has been created by the Pennsylvania Community Providers Association.

  ***Best Practices in Methadone Treatment*.**
  http://www.paproviders.org/archives/Pages/DA_Archive/Methadone_Best_Practices_2011.pdf

- A more detailed document of guidelines for recovery-oriented methadone maintance has been created by the Community Care Behavioral Health Organization:

  ***Supporting Recovery from Opioid Addiction: Community Care Best Practice Guidelines for Recovery-Oriented Methadone Maintenance*.**
  http://www.williamwhitepapers.com/pr/Recovery-oriented%20Methadone%20Maintenance%20Best%20Practice%20Guidelines%202014%20-%20CCBHO.pdf

- SAMHSA created a guidebook for ***Federal Guidelines for Opioid Treatment Programs.*** *https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP*
- **Safe methadone induction and stabilization: Report of an expert panel** by Baxter et. al[16]. *https://pubmed.ncbi.nlm.nih.gov/24189172/*

Buprenorphine Prescribing

Initial Assessment for Transmucosal Buprenorphine

The following assessment best practices are provided by the New York State Department of Health and Office of Alcoholism and Substance Abuse Services.[17]

- An extensive assessment is not necessary.
- Conduct a **focused** assessment:
    1) Assess the patient's history to establish presence of OUD, other drug use, history of drug treatment and significant medical and psychiatric history.
    2) Conduct a focused physical examination, refer for a physical exam, or get a record of a recent one.
    3) Assess for signs and symptoms of intoxication. Do not give a first dose to a patient who is sedated or intoxicated. Assess and treat him or her appropriately.
    4) Order relevant laboratory tests:
        - ❑ Conduct drug testing as needed to confirm history.
        - ❑ Conduct a pregnancy test. Pregnancy is not a contraindication to treatment but requires further counseling on options.
        - ❑ Order liver function tests if possible, but do not wait for results before starting transmucosal buprenorphine treatment as continued misuse of illicit opioids is far riskier than the risk of mild toxicity in those with undiagnosed moderate liver impairment.
- Conduct hepatitis and HIV tests if possible and refer to treatment as appropriate. Hepatitis, HIV, and other co-morbidities are not a contraindication to buprenorphine treatment and do not wait for results before starting buprenorphine treatment. Check the state prescription drug monitoring program database for other controlled substances.
- Initiate prescribing. SAMHSA guidance now supports both in-office and unsupervised induction.

Induction of Buprenorphine

The following buprenorphine induction procedure was adapted from a protocol developed by University of Illinois at Chicago (UIC) Center for Dissemination and Implementation Science, UIC Community Outreach Intervention Projects, and UI Health. A home induction handout of this protocol can be found in the Appendix.

1. Before taking the first dose of buprenorphine, the patient should have ***at least 3*** of the following symptoms. The greater the severity of withdrawl symptoms, the less chance the patient will experience a worse withdrawl:
    - ❑ Runny nose
    - ❑ Yawning

- ❑ Restlessness or anxiety
- ❑ Enlarged pupils
- ❑ Stomach cramps, nausea, vomiting, or diarrhea

2. The typical first dose of buprenorphine is 4/1mg and the sublingual tab/film should be dissolved completely under the tongue.
3. *For office induction only:* After the first dose, patients will need to wait in the office or waiting room and be checked for adverse effects (i.e., change in mental status, difficulty breathing, hives, sedation) and to repeat the COWS to evaluate symptoms.
4. A repeat dose of 2/0.5-4/1 mg can be used 3 hours after the first dose if withdrawal symptoms are still present. A maximum first day dose of buprenorphine/naloxone should not exceed 12mg.
5. After the first day's induction dose the patient may be contacted and/or observed in office by designated staff, but not necessary.
6. On Day 2, take the total dose from Day 1 as the first time dose in the morning. For breakthrough withdrawl symptoms, additional doses of 4mg can be taken every 3 hours until feeling normed. A maximum dose should not exceed 16mg.
7. On Day 3, take the total dose from Day 2 as the first time dose in the morning. During week 1, the maximum daily dose is 16mg.
8. It takes about 3 days of using buprenorphine/naloxone at the same dose to find the appropriate dosage. After the first week, reassess if dosing adjustments are needed.

Maintenance

During maintenance, the following tasks should be performed during follow-up visits:[18]

- ❑ Ask about support patients have received (if no support, discuss options).
- ❑ Ask about adherence to buprenorphine/naloxone.
- ❑ Ask about any opioid use in addition to buprenorphine/naloxone and discuss triggers for ongoing use.
- ❑ Ask about use of sedatives.
- ❑ Conduct urine drug screen to test for presence of buprenorphine and absence of other opioids and benzodiazepines. *Note*: The goal is harm reduction; it is important to have risk/benefits discussions with patients and not withhold medication for continued use of opioids.
- ❑ Determine whether changes in dose are needed or whether buprenorphine/naloxone should be discontinued.
- ❑ Ask whether the patient is attending psychosocial or counseling sessions, or obtaining other recovery support services.
- ❑ Encourage attendance and provide referrals or assistance in accessing counseling if needed.

Counseling

The following counseling best practices have been reproduced from a communication by the New York State Department of Health and Office of Alcoholism and Substance Abuse Services.[17]

- Federal law requires that waiver applicants attest to their capacity to refer patients for appropriate counseling and other appropriate ancillary services.[19]This is a relatively low-threshold requirement

and does not obligate prescribers to ensure that their patients attend or participate in counseling for which referrals are made. However, ideally, IDHS/SUPR supports the use of medications along with treatment and other recovery supports as the preferred approach to MAR.[5]

- Guidance from the Substance Abuse and Mental Health Services Administration (SAMHSA)[20] acknowledges that there is an intrinsic psychosocial component within the medical management buprenorphine prescribers provide which benefits patients. Many patients are likely to benefit from counseling at some point in their treatment for OUD. SAMHSA's guidance regarding counseling notes that prescribers should "offer referrals for adjunctive counseling and recovery support services as needed." The guidance further states that "patients who were not interested in adjunctive addiction or mental health counseling during induction may become receptive to it when they are feeling more stable."
- Prescribers should ensure continued access to buprenorphine even in the absence of counseling.[19,20]
- Prescribers should ensure immediate and continued access to buprenorphine for patients who, at the time, may be unwilling or unable to participate in counseling or other formal psychosocial services.

Polysubstance Use

The following best practices on prescribing buprenorphine during polysubstance use have been reproduced from a communication by the New York State Department of Health and Office of Alcoholism and Substance Abuse Services.[17]

- Some providers erroneously believe that prescribing buprenorphine is contrary to a standard of care when patients continue to use other opioids or other classes of drugs.
- Buprenorphine helps patients reduce or cease use of other opioids. Reduced opioid use is not only an acceptable outcome, it is a desirable one.
- There have been concerns about prescribing buprenorphine to patients who use or misuse benzodiazepines or alcohol, as the risk of adverse reactions may be higher when either of these is combined with buprenorphine. In 2017, however, the U.S. Food and Drug Administration issued a Drug Safety Communication stating that buprenorphine should not be withheld from these patients as "the harm caused by untreated opioid addiction can outweigh these risks."[21] Concomitant use of other opioids, cocaine, cannabis and amphetamines does not pose elevated risk in the patients taking buprenorphine and should not be a basis for terminating care.
- Maintenance with buprenorphine can reduce morbidity and mortality even when drugs other than opioids are being used and in the presence of relapse to opioid use.
- Prescribers should not discharge patients solely based on the use of prescribed or unprescribed substances including, but not limited to, cannabis, and benzodiazepines.
- Prescribers should ensure continued access to buprenorphine even in the presence of other drug use. [19,21]

Diversion of Buprenorphine

The following best practices on preventing the diversion of buprenorphine have been reproduced from a communication by the New York State Department of Health and Office of Alcoholism and Substance Abuse Services.[17]

- Buprenorphine, like many medications, can be given or sold to people who are not prescribed the medicine. The literature shows that most diverted buprenorphine is used to alleviate withdrawal or maintain abstinence rather than to become intoxicated. Lack of access to prescribed buprenorphine is believed to be a prime factor in diversion of the medication.[22,23]

- Prescribers should strive to minimize diversion and avoid allowing concerns about diversion to prevent them from treating OUD.
- Strategies for addressing medication nonadherence and diversion include carefully assessing the patient to understand underlying causes of the behavior. For example, medication may be shared with a person unable to access their own treatment. While there is no way to definitively determine if a patient is fully adherent to any medication, the following strategies may be helpful:
    - Asking patients to bring their unused medication into the office for counting.
    - Talking with family members or significant others (with appropriate consent).
    - Writing prescriptions for shorter duration.
    - Checking urine for buprenorphine and its metabolites.
    - Avoiding doses over 24 mg (save in rare cases).

Duration of Treatment

The following best practices on duration of treatment with buprenorphine have been reproduced from a communication by the New York State Department of Health and Office of Alcoholism and Substance Abuse Services.[17]

- Treatment with buprenorphine should continue for as long as the patient is benefiting.
- Risk of return to illicit opioid use is high when treatment is discontinued.
- If care is to be terminated for any reason, the prescriber should offer the patient a transfer to an alternative prescriber allowing the patient to continue medication without interruption.
- Patients, particularly those opting to stop medication, should also be referred to harm reduction, peer, or other supportive services.

Clinical Workflow

A flowchart of administering buprenorphine can be found in the Appendix.

Injectable Naltrexone (Vivitrol) Prescribing

Initial Assessment

- Determine that the patient is interested in remaining abstinent and ready to begin trying to do so.
- Acquire the following clinical exams:
    - A baseline evaluation which includes a physical exam, and, where that indicates likelihood of hepatic disease or injury or diminished renal function, appropriate laboratory testing such as liver transaminase levels and bilirubin within normal limits, or creatinine clearance (estimated or measured) 50 ml/min or greater.
    - Negative results on urine beta-HCG (human chorionic gonadotropin) pregnancy test for females.
    - A urine drug screen negative for all opioids, a negative Naloxone/Narcan IV or IM challenge (for patients with opioid addiction) immediately prior to the first injection and if the Naloxone challenge is negative, an oral Naltrexone Challenge (a half tab of 50 mg administered orally); with no opioid withdrawal present after 1 hour.
    - No signs or symptoms of opioid withdrawal.

- If any significant doubt remains about the assessment of the patient's opioid status or the veracity of patient self-reporting, **the Naloxone Challenge** should be administered for patients with opioid addiction because it minimizes the duration of severe withdrawal.[24]
    - In regions known to have significant prevalence of buprenorphine diversion, the Naltrexone Challenge should also be administered, following Naloxone Challenge, because Naloxone does not displace buprenorphine whereas naltrexone does.[24]
    - **The Naltrexone Challenge Test** involves oral administration of 25 mg of Naltrexone (i.e., half of a 50 mg tab), and is negative if no withdrawal signs or symptoms are apparent after 1 hour.[24]

Initial Induction

The following induction recommendations have been issued in physician guides created by SAMHSA[8] and Florida Alcohol and Drug Abuse Association (FADAA).[24]

- It is recommended providers and patients develop a relapse plan that includes strategies to decrease risks if relapse occurs.
- Complete detoxification from opioids is required before initiating or resuming extended-release injectable naltrexone to prevent withdrawal*; **at least 7-10 days without opioid use is recommended before beginning injectable naltrexone***.[25]
- Advise patients that they should be off all opioids, including opioid-containing medications, for a minimum of 7-10 days before starting Vivitrol in order to avoid precipitating opioid withdrawal.
    - Patients transitioning from buprenorphine or methadone may be vulnerable to precipitation of withdrawal symptoms for as long as two weeks.
    - Ensure that patients understand that withdrawal precipitated by administration of an opioid agonist may be severe enough to require hospitalization if they are not opioid-free for an adequate amount of time and is worse than the spontaneous withdrawals that occurs with discontinuation of opioids in a dependent individual.
    - Advise patients that it is imperative they notify their provider of any recent use of opioids.
- Medical personnel will monitor the injection site for any problems, observe the client of any adverse reactions, and monitor the client for medication effectiveness and side-effects over time.
- **The treatment plan should include overdose prevention education for clients, their families, and the people closest to the client that the client may be more sensitive to lower doses of opioids and the risk of accidental overdose should they use opioids when their next dose is due or if they miss a naltrexone dose, or after naltrexone treatment is discontinued. Clients, their families and supportive others also should be given information on the Illinois Helpline for Opioids and Other Substances. The Helpline is the only statewide, public resource for finding OUD and SUD treatment, including overdose prevention. Helpline staff are available 24/7 online and via phone, text, and chat (*https://helplineil.org/*). For more information on overdose prevention, see the section below: "Overdose Prevention: Becoming a Drug Overdose Prevention Program (DOPP)". Information on Overdose Education and Naloxone Distribution (OEND) programs and DOPPS are detailed in that section, as well as here: *https://www.dhs.state.il.us/page.aspx?item=116652*.**

Counseling

The following counseling practices have been recommended in a guide provided by SAMHSA.[25]

- Treatment in individual or group counseling sessions and participation in mutual-help programs are highly recommended in MAR. Patients have better treatment outcomes when naltrexone-based treatment is combined with behavioral therapies.
- Healthcare providers should be ready to offer brief intervention if patients relapse during treatment of opioid dependence.
- Motivational interviewing and relapse prevention strategies may also enhance the effectiveness of pharmacological treatments.
- Patients should not be denied MAR if they do not agree to participate in counseling (see section "Medication First Approach" below).
- Patient should have access to MAR during the SUD admission process and throughout the continuum of care.
- Patients who have initiated MAR should not be required to stop their MAR as a condition of their admission or transfer to SUD care.

MAR Prescribing in Special Populations: Pregnant Women

The use of MAR during pregnancy is a recommended best practice for the care of pregnant women with OUD, however, it is narrowed to the use of methadone and buprenorphine in this population, as is supported by the opinion of the American College of Obstetricians and Gynecologists (ACOG).[26,27] Therefore, women with OUD who are not in treatment should be encouraged to start methadone or buprenorphine treatment as early in pregnancy as possible and remain on that treatment throughout the duration of the pregnancy to avoid the dangers of withdrawal to the fetus. General guidelines for treating pregnant women with OUD are:

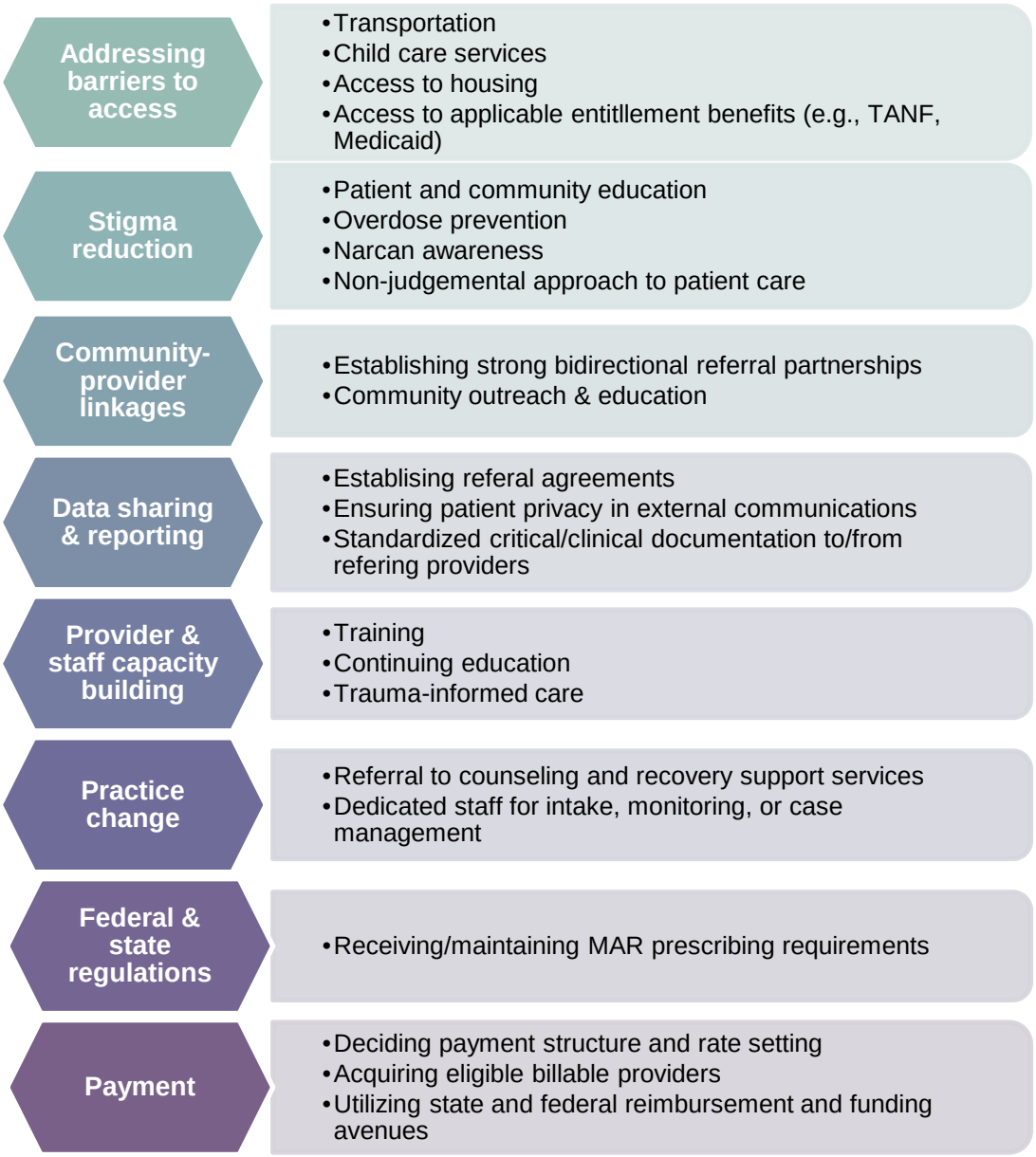
- Do not attempt to switch from methadone to buprenorphine, as the withdrawl process is a necessary part of the switch and dangerous to the fetus.
- Providers should be aware that pregnant women presenting with OUD are more likely to seek prenatal care late in pregnacy; providers should address gaps in prenatal care.
- Providers may anticipate that women may be reluctant to start MAR out of fear of the impacts on the fetus; providers should educate women on the safety of MAR in pregnacy and the relative harms of withdrawl and relapse.
- In-office induction may be preferrable for pregnant patients. Inpatient induction may be necessary for patients with acute medical or surgical illness or due to concern for the potential for adverse events, especially in the third trimester.
- Women should be counseled regarding the risk of Neonatal Abstinence Syndrome (NAS) in their infants.
- Initiation or induction of buprenorphine may lead to withdrawal symptoms in patients with physical dependence on opioids. To minimize this risk, induction should be initiated when a woman begins to show objective, observable signs of moderate withdrawal, but *before* severe withdrawal symptoms are evidenced.

SAMHSA provides additional information on MOUD during pregnancy here:
https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf

KEY COMPONENTS OF MAR SERVICES

Adding MAR to your clinical practice/program will likely mean developing workforce capacity and enhancing existing care coordination efforts, including increasing social service and behavioral health partners (i.e., mental health providers and other substance use disorder treatment providers). Additionally, if your organization has the bandwidth, integrating educational materials and community outreach sessions to what you offer would be best practice. Pharmacological treatment of opioid addiction is most effective when done within the context of addressing social determinants of health and the support of peers. The graphic below summarizes the critical components of care that are impacted by integrating MAR into existing practices/programs.

Critical Components of Delivering MAR and Related Activities



Adapted from the National Academy for State Health Policy's presentation "Why Integrate SUD treatment into Primary Care?"

Each MAR program/practice is recommended to have key staff members assuming the following roles:

1. Licensed or certified MAR provider, depending on the medication offered
    - Prescribing or administering MAR
    - Developing formal linkage agreements to substance use disorder treatment providers if available
2. Care coordinator/Case Manager (e.g., RNs, LPNs, MAs, BHCs, LCSWs)
    - Coordinates in-office induction
    - Administers drug tests (Can also be done by intake professional or lab technician)
    - Screening and monitoring (Can also be done by clinician)
3. Administrative staff
    - Obtaining intake information and consents
    - Billing and accounting procedures
    - Welcoming prospective and established MAR patients

Variations of this staffing pattern can happen based on patient needs, patient time in treatment, and other factors, including a variety of recovery support systems in place for the patient. For example, a patient who has been a participant in long term MAR may need much less direct treatment services and/or recovery support services than those indicated here.

TALKING WITH PATIENTS ABOUT STARTING MAR

The following guide has been adapted from a clinical guidebook for treating substance use disorders in primary care settings by the RAND Corporation. Please refer to this guide for additional resources: https://www.rand.org/pubs/tools/TL148-1.html.[18]

Recent research has shown that patients who receive medication plus brief physician-delivered counseling and advice (medical-management counseling), without participating in formal treatment, can achieve similar outcomes to patients receiving specialized counseling.

Therefore**, medication plus brief physician counseling** is an option for patient who are not willing or able to participate in a specialized drug treatment program or self-help program, such as Narcotics Anonymous. This guide provides a brief overview on identifying potential patients and introducing them to them program, as well as an overview of the medical-management counseling process.

Drug use is often a sensitive subject for patients; when confronted, they may deny that they have a problem or minimize the extent of it. Even patients who are motivated to change their drug use or drinking behaviors are often ambivalent or apprehensive about beginning treatment because of past experiences with stigma or fear that they may fail.

As a result, it is critical that providers avoid saying anything that patients may construe as judgmental. It is also important for providers use a **motivational**, **nonconfrontational, non-judgmental** approach when discussing drug use with patients. Providers should treat to build rapport and an alliance with patients and use normalizing statements such as “many patients tell me they have trouble controlling their drinking/drug use.”

Motivating Patients to Begin Treatment

Tell the patient:

- As your doctor, I am concerned about your opioid use.
- My assessment is that their opioid use is causing you/others harm.
- I recommend that you stop or cut down on your opioid use.
- But you are the only one who can change your behavior.
- I know you can do this, and I am happy to help.
- Is this something you're willing to try?

If the patient is NOT willing to change his or her opioid use:

- As I said, you are the only one who can change your behavior. I am ready to help you if you decide to make a change in the future.
- Could I see you in the future to discuss this again?

If the patient IS willing to change his or her opioid use:

- There are medications I can prescribe that may help you stop or reduce your opioid use. I can tell you more about this if you are interested.
- I can also give you information on counseling programs available at the clinic and elsewhere, as well as information on self-help groups, like SMART recovery. Are you interested in this?

The provider should then discuss the specifics of the medication.

Medical-Management Counseling

Patients who are being treated with extended-release, injectable naltrexone or buprenorphine/naloxone for opioid use disorder should receive brief medical-management counseling from the physician during each clinic visit.

Important things to remember when counseling patients receiving treatment:

- Changing opioid use is a process. Patients who have not quit opioids but have made progress (e.g., cut down, attended counseling sessions or self-help meetings) should be praised and encouraged to continue to try hard to stop or reduce their opioid use.
- Adherence to the medication is critical for success—especially for patients who are not participating in a substance use disorder treatment program.
- Attendance at counseling or self-help programs should be encouraged— but not mandated— in patients who are having success with medication and physician-delivered medical-management counseling alone.
- Use a motivational approach and avoid confrontation, which is likely to elicit denial and resistance on the part of the patient.

At each visit:

1. Assess opioid use since the last visit
    - Say, "Tell me about your opioid use since our last visit."

- Explore where the patient is in their recovery.
- For patients who use opioids, ask:
  - "Were you able to cut down some?"
  - "What were the circumstances that lead you to use opioids?"
  - "Even though you did use opioids, it is good that you are here and I will continue to help you change your opioid use."
  - Help patients to troubleshoot a plan to address their triggers for opioid use (e.g., deal with stress, avoid people, places, and things associated with drugs).

2. Assess medication adherence and any medication side effects:
   - Ask, "Patients often tell me they sometimes miss their medication or forget to take it. Does this happen to you?"
   - Address any barriers to medication adherence or side effects.
3. Assess participation in counseling or self-help program
   - Patients who are doing well with medication and medical-management couseling alone need not be mandated to attend specialized drug counseling or self-help groups.
   - Patients who are struggling should be encouraged to increase participation in SUD treatment program or self-help groups.

     NOTE FOR CLINICAL SUPERVISORS AND ADMINISTRATORS: Some counselors or self-help group members may discourage patients from taking medications. Advise patients that there **is no prohibitition against medication** in any of the groups or couseling programs and that taking medication will not conflict with participation in these groups. Patients should not change to a different meeting or program based on their MAR status.

EXAMPLE MAR PROGRAM MODELS

Overview of MAR Service Delivery Across Treatment Settings

MAR can be delivered within primary care (e.g., hospital, clinic), substance use disorder treatment program, stand-alone "MAR-only" and opioid treatment program settings. The table below provides an overview of staffing for buprenorphine and naltrexone, and MAR activities across these settings. You may have the capacity to provide prescribing and support services in house, while others will need to refer out in order to provide these services.

At a minimum, a prescriber (physician or non-physician), staff who can coordinate care including induction, drug test administration, linking to SUD treatment or recovery supports, and an established laboratory are needed to provide MAR. Implementation also occurs on a continuum. A more robust implementation would include community outreach and education and linkage to supports that constitute a Recovery Oriented System of Care (ROSC), which will be discussed in more detail in later sections.

Each MAR program should be able to:

1. Certify a physician or non-physician to prescribe MAR;
2. Identify a care coordinator or an existing staff who can fill this role to monitor induction, administer drug tests, refer to SUD recovery supports, etc.;
3. Partner with (at minimum) a social service agency and;
4. Develop formal linkage agreements with SUD treatment providers.

Note: Additional information about regulations regarding all three forms of MAR can be found in the Regulation section of this toolkit. *This table was borrowed from the New Hampshire Guidance Document on MAR best practices.*[28]

Overview of Buprenorphine and Naltrexone Service Delivery Across Different Treatment Settings				
	Primary Care Clinic or Office-Based	**SUPR-Licensed Substance Use Disorder Treatment Program**	**MAR-Specific Treatment Programs**	
			Free-standing MAR clinic	**Opioid Treatment Program (OTP)**
General Description	Engages existing PCP to become waivered Prescribes buprenorphine and/or naltrexone Arranges psychosocial treatment and recovery support services	Provides psychosocial treatment and recovery support services Employs or contracts with buprenorphine and/or naltrexone prescribers	Establishes clinic specifically to provide buprenorphine and/or naltrexone Engages prescriber, psychosocial treatment provider and care coordinator Provides or refers to recovery support services	May expands services to include prescribing of buprenorphine and/or naltrexone by waivered prescribers Enhance existing psychosocial treatment and utilize care coordination Provides or refers to recovery support services
Prescriber Roles **Diagnoses opioid use disorder** Inducts onto MAR Prescribes Provides routine follow-up visits	Employs waivered prescriber May link to other waivered prescriber for cross coverage	Employs Medical/Psychiatric Director or other waivered prescribers Partners with waivered prescriber in community	Employs waivered prescriber	Employs waivered prescriber

Overview of Buprenorphine and Naltrexone Service Delivery Across Different Treatment Settings				
	Primary Care Clinic or Office-Based	**SUPR-Licensed Substance Use Disorder Treatment Program**	**MAR-Specific Treatment Programs**	
			Free-standing MAR clinic	**Opioid Treatment Program (OTP)**
Counselor Roles Provides SUD group and/or individual counseling Provides counseling for co-occurring disorders as needed Assesses for and refers to recovery support, as needed	Become SUPR-licensed to hire counselor or create partnerships with SUPR-licensed organizations providing substance use disorder treatment services	Counseling provided by professional staff in accordance with licensure standards	Become SUPR-licensed to hire counselor or create partnerships with SUPR-licensed organizations providing substance use disorder treatment services	Counseling provided by professional staff in accordance with licensure standards
Care Coordinator/Case Manager Roles Facilitates communication between prescriber, counselor, and patient Provides routine support to patients outside of office visits Conducts drug testing and pill/film counts Links with recovery support services	Role may be assumed by various positions (e.g., nurse, medical assistant, counselor).			

Note: The Division of Substance Use Prevention and Recovery (SUPR) operates as the single state authority for substance abuse issues in Illinois. SUPR is responsible for the licensing and certification of all persons engaged in substance abuse treatment and intervention as defined in Section 301/15-5 of the Illinois Alcoholism and Other Drug Abuse and Dependency Act.

Illinois Hub and Spoke Model

As part of its State Opioid Response (SOR) initiative, the Illinois Department of Human Services/Division of Substance Use Prevention and Recovery (IDHS/SUPR) is implementing pilot projects utilizing an evidence-based model of delivering Access to Medication Assisted Treatment (A-MAR). The Hub and Spoke model has been implemented in areas of Illinois that currently have relatively few treatment resources for persons with Opioid Use Disorders (A-MAR "deserts").

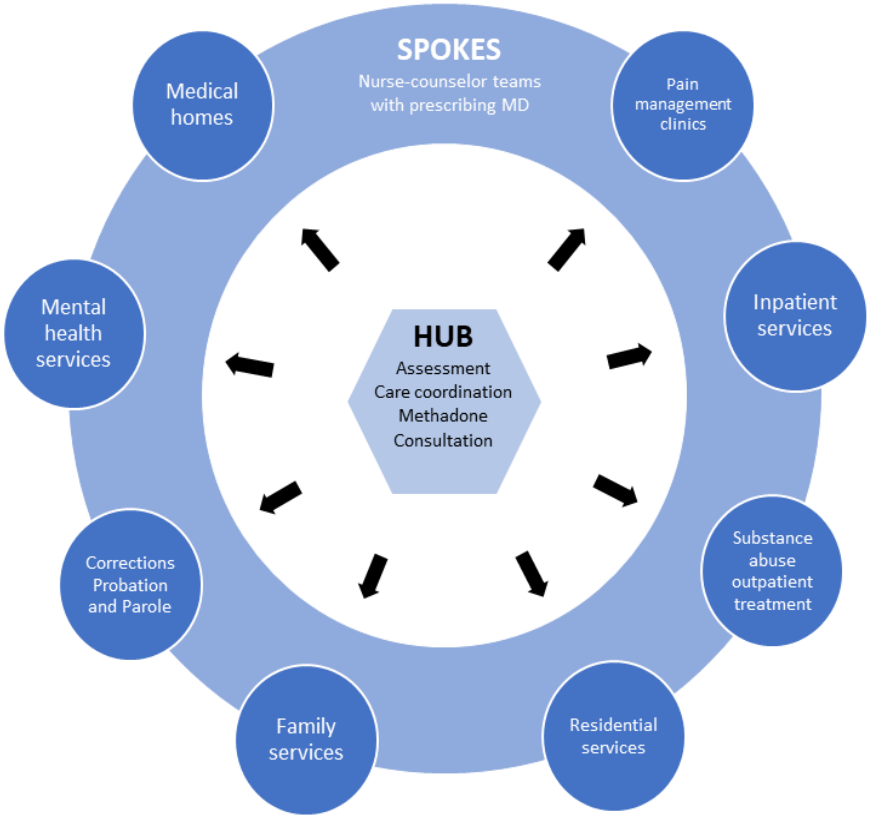
Developed from the Vermont hub and spoke system,[29] the goal of the Hub and Spoke pilot projects is to build a foundation for community providers and partners for creating a network of services that will be sustainable following the initial grant funding period. The Hub and Spoke Model is recognized as an evidence-based regional approach for delivering access to MAR to people who suffer from opioid use disorders. This approach is designed to coordinate opioid use disorder treatment with medical care and counseling, supported by community health staff and services, and effectively treat the whole person as they make their way along the path to recovery.

A Hub is a regional opioid treatment center responsible for coordinating the care and support services for patients who have complex substance use disorders and/or co-occurring mental health conditions. Patients who need methadone are treated in the hub and those who need buprenorphine or naltrexone may be treated.

A Spoke is a primary care practice, specialty practice or health center responsible for coordinating the care and support services for patients with opioid use disorders who have less complex medical needs. Only patients who are treated with buprenorphine or naltrexone receive treatment in the spokes.

In this model of OUD treatment, individuals with complex needs receive care through specialty treatment “hubs” responsible for coordinating care across health and SUD treatment systems, while individuals with less complex needs receive care through “spokes” comprising MAR-prescribing physicians and collaborating professionals who provide supportive services.

Hub and Spoke Model



Depending on the patient’s needs, **Support Services** may include mental health and/or SUD treatment, pain management, family supports, life skills, job development, and recovery supports.

The following organizations, targeting one or more counties, received SOR funding to implement the Hub and Spoke model:

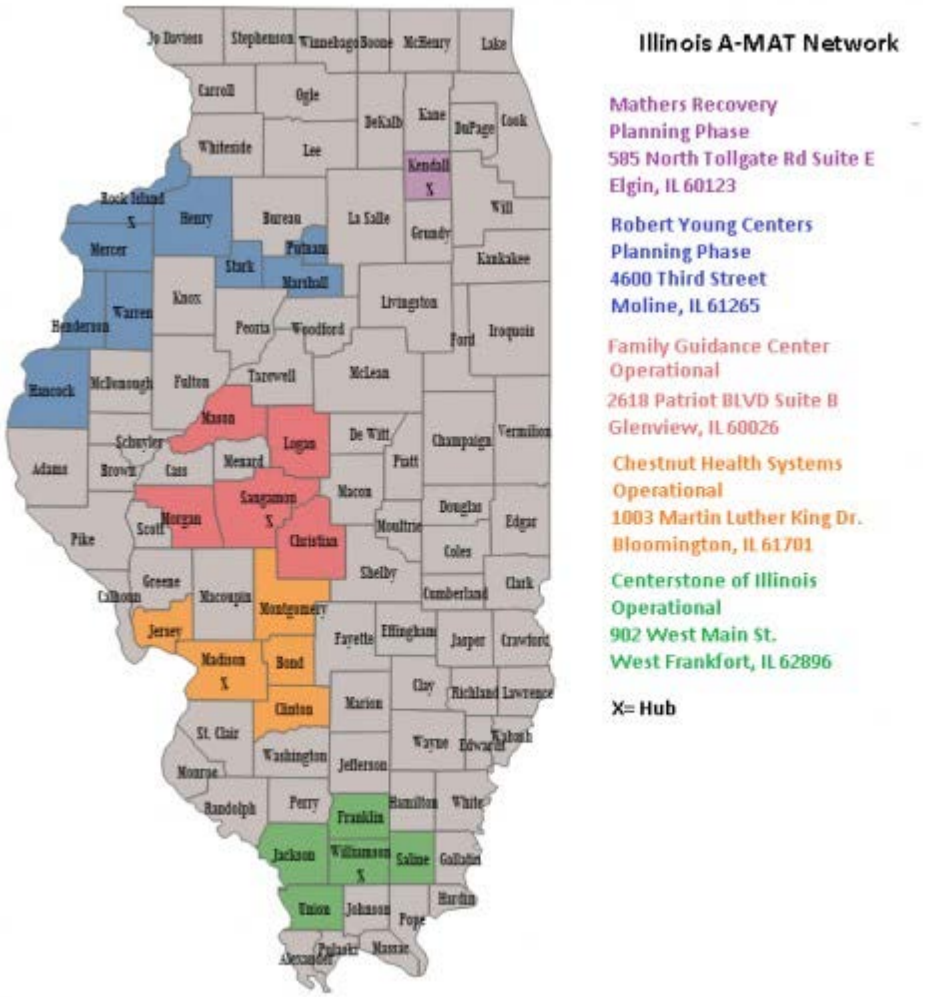
Centerstone of Illinois is targeting services to counties surrounding Marion, Illinois including Williamson, Johnson, Franklin, Saline, Jackson and Union.

Family Guidance Centers, Inc. is targeting services to counties surrounding Springfield, Illinois including Sangamon, Christian, Morgan, Logan and Mason.

Robert Young Center is targeting services to counties surrounding Rock Island, Illinois including Rock Island, Henry, Mercer, Start, Putnam, Marshall, Warren, Henderson, and Hancock.

Chestnut Health Systems is targeting services to counties surrounding Granite City, Illinois including Madison, Jersey, Montgomery, Bond, and Clinton.

Mathers Recovery is targeting services to communities surrounding Oswego, Illinois in Kendall County.



More information about the Illinois Hub and Spoke program can be found on the IDHS/SUPR website: *http://www.dhs.state.il.us/page.aspx?item=115412*

Example Office-Based MAR Program Model

Below is an **example** of an office-based MAR program provided by UIC Miles Square, a Federally Qualified Health Center. This program was adapted from the MAR Program Phases model from Daily Planet Health Services, Richmond, VA. Illinois providers need to implement services in accordance with IDHS/SUPR regulations and reimbursement rates. For more information go to: *https://www.dhs.state.il.us/OneNetLibrary/27896/documents/2020SmartAlerts/IDHS_SUPR_MAR_Guideline.pdf*

MAR Program Overview

Purpose: The purpose of the MAR program is to provide quality treatment for individuals living with Substance Use Disorder

Target population: Individuals must have a diagnosed Substance Use Disorder.

Example MAR Program Process

1. Prospective MAR clients complete the clinic's registration process.
2. Clients meet with a medical provider for an intake/induction appointment (at home or in office). Preferably this is the same day they present for intake or as a walk-in. Clients must be aware that meeting with a behavioral health clinician or medical provider ***does not guarantee*** that they will be placed on any medication. This is at the discretion of the provider, and the client's current medications and/or use of substances has a strong impact on this decision.
3. If during the appointment with the medical provider or intake coordinator, either professional believes that the client's level of need exceeds that which the MAR program provides, they will be referred to appropriate programs in their community.
4. The client will complete the MAR Treatment Contract with the MAR medical provider or Medical Assistant/LPN/CARN/LCSW/LSW.
5. Following induction, the client is in the MAR program.

Example MAR Program Phases

	Phase 1	Phase 2	Phase 3	Phase 4
Minimum Duration	Induction to 30 Days	60 Days	90 Days	180 Days
See Medical Provider	Once a week	2x Monthly	1x Monthly	1x Monthly
Group Participation*	Once a week	Once a week	2x Monthly	1x Monthly OR Participation in a weekly Non-MAR group
Drug Screens**	Occurs at least at the time of the initial evaluation and initiation of medication. Thereafter, occurs at least 1x/week (OTPs minimum 8 times per year)	At least 2x/month (OTPs minimum 8 times per year)	Random (OTPs minimum 8 times per year)	Random (OTPs minimum 8 times per year)
Individual Therapy	As needed	As needed	As needed	As needed

	Phase 1	Phase 2	Phase 3	Phase 4
Steps to successful completion (or continuation in Phase 4)	• 4 consecutive weeks of consistent drug screens • 4 consecutive weeks of correct pill counts (if applicable) • Consistent PMP • 4 consecutive weeks of meeting with provider • 4 consecutive weeks of meeting with LCSW or CARN (if available)	• 8 consecutive weeks of consistent drug screens • 8 consecutive weeks of correct pill counts (if applicable) • Consistent PMP • 8 consecutive weeks of meeting with prescriber (although client will only meet with provider every 2 weeks) • Meet with LCSW or CARN as needed	• 12 consecutive weeks of consistent drug screens • 12 consecutive weeks of correct pill counts (if applicable) • Consistent PMP • 12 consecutive weeks of scheduled monthly meetings with provider	• Continued consistent drugs screens • Consistent PMP • Continued monthly meetings with medical provider
Failure to Adhere to Phase Requirements* **	• Medication adjustment • Additional clinical contact • Cannot move to less than weekly visits	• Return to Phase 1	• Return to Phase 2 or 1 (at team's discretion)	• Return to Phase 3, 2 or 1 (at team's discretion)

***** Not required but preferred, internal or external (i.e., community support programs, outside agencies) – counseling is recommended but does not determine whether a patient is prescribed MAR, as there is a significant reduction in morbidity and mortality even using medication alone.*

*** According to SAMHSA TIP 63 document, the TIP expert panel recommends periodic random testing. Drug testing frequency should be clinically determined. It should occur at least at the time of the initial evaluation and initiation of medication (naltrexone, buprenorphine) and at a frequency consistent with office visits (e.g., weekly initially).*[20]

****Failure to adhere to these recommendations may not be an indication of MAR failure or the need to digress to a previous phase; provider should use clinical judgement to determine treatment phase when patient cannot adhere to phase requirements.*

Phase 5:

Clients who are in Phase 4 for at least six months can pursue taking medication alone with no required behavioral health contacts. These individuals can remain in Phase 5 indefinitely, and can continue to engage in groups, individual therapy, or other behavioral health services.

Incentives and Sanctions

Effective substance use disorder treatment programs use a variety of incentives (rewards) and sanctions (consequences) as part of the treatment process. Some actions are grounds from immediate termination from the program, regardless of the program phase or length of time in the program:

- Bringing substances and/or paraphernalia onto clinic property

- Falsifying, or attempting to tamper, with a urine drug screen
- Threatening, in any manner, including verbal abuse of clinic staff and/or patients
- Diversion of medications

Research shows that incentives (also called contingency management) can help clients be successful in treatment. Incentives for the MAR program can include:

- Transportation services (if availability of grant funding)
- Other incentives to be determined

Reinstatement to MAR Following Termination

Clients who are terminated from the MAR program may be considered for re-admission on a case-by-case basis. The final determination of the client's re-admission and any specific criteria that need to be agreed upon with the client will be made by the client's medical provider, the Behavioral Health Coordinator and the client's behavioral health clinician.

PRE-OPENING DOORS CHECKLISTS & PLANNING TOOLS

- SAMHSA provides a helpful MAR implementation checklist to aid policymakers in developing and implementing MAR programs in their communities. *https://tbhcoe.matrc.org/wp-content/uploads/2019/12/MAT-Implementation-Checklist-FINAL.pdf?9d4e56&9d4e56*
- Federally Qualified Health Centers must apply for a substance use disorder license from IDHS/SUPR if the center is directly providing SUD treatment services at any of its locations. SUPR provides a checklist to aid gathering application materials. *https://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/OASA/2019/Federally_Qualified_Health_Center_License_Application_Checklist.pdf*
- *The New Hampshire Guidance Document on MAR Best Practices* developed a program quality planning tool to help program providers review and assess their progress related to the development and implementation of MAR best practices. *http://1viuw040k2mx3a7mwz1lwva5.wpengine.netdna-cdn.com/wp-content/uploads/2018/04/FINAL_MAT_Quality_Planning_Tool_3-30-18.pdf*

CASE STUDIES

Case studies can be helpful to potential MAR service providers, they offer specific problems experienced by organizations planning to offer MAR services. Additionally, case studies provide explanations of how those problems were ultimately solved.

This link provides 15 case studies that offer lessons learned by individuals and groups getting started with offering MAR services. Many of the case studies focus on buprenorphine services, however, the issues maybe relevant for methadone providers as well. These case studies focus on multiple topics including the following:

- Building support for MAR
- State licensing rules (Go to *https://www.dhs.state.il.us/page.aspx?item=29747* for more information on Illinois licensing rules)
- Partnerships between states and providers

- Advocating MAR for adolescents
- Using customer input to focus efforts

Copy and paste the link below into your browser: *https://www.niatx.net/download/getting-started-with-medication-assisted-treatment/*

The next link offers guidance and support for those initiating or expanding MAR services in the state of New Hampshire: *https://www.dhhs.nh.gov/dcbcs/bdas/documents/MATguidancedoc.pdf*

Regulations

PRESCRIBING REQUIREMENTS

In Illinois, MAR providers must acquire and maintain certification to legally dispense and prescribe medications for opioid use disorder. IDHS/SUPR has specific requirements to meet certification guidelines. The section below summarizes key differences in who can perscribe these medications.

Methadone

Certification: Methadone (CII) for the treatment of opiate use disorder may only be provided in a state (IDHS/DSUPR) and federally (CSAT [Center for Substance Abuse Treatment], DEA) approved treatment program via a medical order from a licensed medical professional or dispensed at a certified Opioid Treatment Program (OTP). The federal regulations covering opioid treatment may be found in **CFR 42 Part 8***: https://www.samhsa.gov/medication-assisted-treatment/become-accredited-opioid-treatment-program*

Who can prescribe? Methadone can only be purchased and dispensed at federally and state approved OTPs and hospitals to treat opioid use disorders.

Buprenorphine

Certification: Buprenorphine (CIII) may be prescribed for the treatment of opiate use disorders by state-licensed medical professionals who have specific **DATA 2000 Waivers** (Drug Addiction Treatment Act of 2000) from CSAT. CSAT forwards these waivers to DEA which issues an “X” waiver under the medical professional’s existing DEA Registration.

Approved medical professionals may prescribe for up to 30 patients during their first year under the Waiver. After one year, prescribers may apply to serve up to 100 patients. Professionals with approvals for 100 patients may apply for approval to serve up to 275 patients if they have maintained that waiver without interruption for at least one year, hold “additional credentialing”, and practice in a “qualified practice setting. Physicians with a current waiver to prescribe up to 100 patients and who are not otherwise eligible to treat up to 275 patients may request a temporary (not longer than 6 months) increase to treat up to 275 patients in order to address emergency situations. More information about prescribing up to 275 patients in emergency and non-emergency situations can be found here: *https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/understanding-patient-limit275.pdf*

Who can prescribe? State-licensed medical professionals can include Physicians, and “Physician Extenders” such as Physician Assistants, and Nurse Practitioners

Where can I find more information? Visit *SAMHSA.gov* for more information about buprenorphine training for physicians.

Naltrexone

Certification: No special training or licensing requirements for providers to prescribe naltrexone.

Who can prescribe? Naltrexone can be prescribed by any health care provider who is licensed to prescribe medications and may be prescribed in an primary care setting. A NP, PA, MD, or DO can administer/prescribe naltrexone.

STATE & FEDERAL REGULATIONS

SUPR Licensure regulations for substance use disorder (SUD) treatment (i.e., counseling, behavioral health services, therapy)

- A physician licensed to practice medicine in all its branches does not need a license from IDHS/SUPR if he or she is rendering SUD services (individual and group counseling, etc.) in his or her own name. The prescription of medication for a SUD or an Opioid Use Disorder (OUD) is considered a medical service and not a SUD treatment service. Additionally, Screening, Brief Intervention and Referral to Treatment (SBIRT) is not licensed by IDHS/SUPR.
- IDHS/SUPR licensure is required if the physician has a practice that "holds itself out" as providing SUD services or is supervising other individuals with Illinois licenses or certifications that are considered professional staff under current IDHS/SUPR SUD regulations. Examples of this type of individual would be certified alcohol and drug counselors (CADC), licensed social workers (LSW), licensed professional counselors (LPC), that are either supervised by the physician or under sub-contract with the physician.
- "Holds itself out" means any activity that would lead one to reasonably conclude that the individual or entity provides or intends to provide licensable substance-related disorder intervention or treatment services. Such activities include, but are not limited to, advertisements, notices, statements, or contract arrangements with managed care organizations, private health insurance or employee assistance programs to provide services that require a license as specified in Article 15 of the Substance Use Disorder Act [20 ILCS 301/15-10]. As stated previously, those services do not include SBIRT or the prescription of medication for a SUD or OUD. They do include levels of care identified by the American Society of Addiction Medicine (ASAM) that range from Level 1 and 2 Outpatient, Level 3.2 and 3.7 Residential Withdrawal Management and Level 3.5 Residential care.

Visit *https://www.ilga.gov/commission/jcar/admincode/077/077020600C03090R.html* to learn more about Professional Staff Qualifications and *https://www.dhs.state.il.us/page.aspx?item=68564* for more information on licensure requirements and the IDHS/SUPR licensure application.

SAMHSA TIP 63
https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC

SAMHSA Certification for New Opioid Treatment Program
https://dpt2.samhsa.gov/sma162/

SAMHSA Buprenorphine Waiver
https://www.samhsa.gov/medication-assisted-treatment/training-Materials-resources/buprenorphine-waiver

DEA Registration and Guidelines

- Information for DATA waivered providers: *https://www.deadiversion.usdoj.gov/pubs/docs/index.html*
- Manuals and guidelines: *https://www.deadiversion.usdoj.gov/pubs/manuals/index.html*
- Registration and applications: *https://www.deadiversion.usdoj.gov/drugreg/index.html*

Federal Guidelines for Opioid Treatment Programs
https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP

LOCAL ZONING REGULATIONS

It is illegal to use local zoning laws to discriminate against OTP programs, regardless of community opposition to the facility. Zoning practices that treat OTP programs differently from other healthcare facilities violates the federal Americans with Disabilities Act (ADA). The ADA prohibits local governments from enacting laws that single out methadone programs and treat them differently from other medical facilities.[30]

Nevertheless, local zoning authorities have often restricted where and if OTPs can operate. Check with your local zoning authorities to see what kinds of substance use disorder treatment programs are permitted in your area. Further, buprenorphine and naltrexone can be prescribed outside of OTP settings, therefore, certified prescribers can potentially fill the gaps created by opposition to methadone programs.

Providers may find referring to this toolkit's section on building community support for MAR helpful for responding to community concerns to the provision of MAR.

OVERDOSE PREVENTION: BECOMING A DRUG OVERDOSE PREVENTION PROGRAM (DOPP)

Illinois state law allows for community members to carry, administer and distribute naloxone. People who have been trained to recognize and respond to an overdose using naloxone are not considered liable for administering naloxone when they believe a person is overdosing. **Overdose Education and Naloxone Distribution (OEND)** is one of the most effective strategies for reducing overdose deaths. It is **most important** that naloxone be given directly to people who use drugs and are at risk of an overdose. Substance use disorder treatment programs are therefore a vital touchpoint for addressing our current overdose crisis. There are two ways that people can get access to naloxone:

1. **Through a pharmacy**. In a pharmacy, naloxone is covered by Medicaid with no co-pay. Illinois' Naloxone Standing Order[31] allows eligible entities, namely pharmacies and OENDs, to provide naloxone to any requesting person with the intent to respond to a suspected opioid overdose without a prescription.
2. **Through a community-based OEND program** that is registered with the Drug Overdose Prevention Program (DOPP). Any group or organization, such as a SUD treatment center, can register as an OEND program with DOPP.

The application to become a DOPP includes a 3-page enrollment package and completion of the IDPH Standing Order (if no medical director is available to sign off on the enrollment package). OEND

programs are asked to report data related to the number of individuals trained and overdose reversals that are reported to them. Participation is voluntary but can be very helpful for monitoring and improving the impact of OEND/DOPP in Illinois.

Best practices for implementing OEND:

The Overdose Prevention and Harm Reduction Act[32] includes the following specific language for best practices to implementing OEND. Below are practices particularly relevant to SUD treatment providers:

(A) Training individuals who currently use drugs in the administration of opioid antagonists approved for the reversal of an opioid overdose.

(B) Directly distributing opioid antagonists approved for the reversal of an opioid overdose rather than providing prescriptions to be filled at a pharmacy.

(E) Collaborating with other community-based organizations, substance use disorder treatment centers, or other health care providers engaged in treating individuals who are using drugs.

(F) Providing linkages for individuals to obtain evidence-based substance use disorder treatment.

(H) Providing education and training to community-based organizations who work directly with individuals who are using drugs and those individuals' families and communities.

Additional information:

- More information specific to Illinois' DOPP programs can be accessed from this webpage: *https://www.dhs.state.il.us/page.aspx?item=58142*
- The **Drug Overdose Prevention Program Enrollment Package** to enroll with the Drug Overdose Prevention Program is available here: *https://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/OASA/Overdose_Prevention_Program/IL444-2051.pdf*

IDPH Standing Order for programs that want to register with DOPP and distribute naloxone: *http://www.idph.state.il.us/Naloxone/*

Reimbursement

Several medical office processes are appropriate for MAR induction, stabilization, and maintenance. It is recommended that the treatment team in a medical office include front office staff, nursing, prescriber, medical records/billings, and administrator.

REIMBURSEMENT THROUGH STATE AND FEDERAL FUNDING

Each state and federal funding source reimburses specific MAR and services. It is recommended that you review reimbursement information by the type of medication, funding source and eligible services. For more information about Medicare reimbursement, review the fact sheet at: *https://www.cms.gov/files/document/otp-billing-and-payment-fact-sheet.pdf*

BILLING MODELS IN MEDICAL OFFICE

One approach has the nursing team complete most of the paperwork, screening and diagnostic forms, medication history, and withdrawal scales, while the prescriber meets with the patient for a short period of time to confirm diagnosis and treatment plan and write appropriate prescriptions. This will typically result in a lower level of service code **(99213-99214 for induction)**.

A second approach is for the prescriber to spend additional time with the patient on the day of induction, completing the history and physical, administering the first buprenorphine dose, and then monitoring and rechecking the patient over 1-2 hours in the clinic. This will typically result in a higher level of service code **(99215 plus extended care 99354)**.

CODING PROCEDURES

Below is a list of example billing codes that may be used during patient care. Check with your payor annually as codes and reimbursement are subject to change.

MAR Medical Providers within Primary Care/Office Based Opioid Treatment (OBOT):

1. Assign ICD-10 Code F11.20 for opioid dependence.
2. Pre-Induction Visit
    a. Visit type: Adult Wellness Visit or acute visit for Opioid Use Disorder/Dependence
    b. Comprehensive evaluation of new patient or established patient for suitableness for buprenorphine treatment.
        i. New Patient: 99205
        ii. Established Patient: 99215
3. Induction Visit:
    a. Visit type: MAR medication induction
    b. Any of the new patient evaluation and management (E/M) codes can be used for induction visits. Codes are listed in order of increasing length of time with patient and/or severity of the problems.
        i. Established Patient E/M: 99212-99215
        ii. Patient Consult: 99241=45
            1. 99231 can only be used as a telephonic prescriber-to-prescriber consultation regarding a patient. Patient cannot be present.
    c. Prolonged visits codes (99534, 99355) may also be added onto E/M codes for services that extend beyond the typical service time, with or without face-to-fact patient contact. Time spent does not need to be continuous:
        i. 30-74 minutes: 99354
        ii. 75-104 minutes: 99355
        iii. 105+ minutes: 99354+99355x2
4. Maintenance Visits:
    a. Visit type: MAR medication. Acute visit for OURD/Opioid dependence.
    b. Any of the established patient E/M codes can be used for maintenance visits.
    c. Counselling codes are commonly used to bill for maintenance visits, since counseling and coordination of service with addiction specialists comprise the majority of the follow-up visits.
        i. Established Patient: 99212-15
5. SBIRT: substance use disorder and structured screening and brief intervention services (99408) can be offered and billed for naloxone education.

Coding procedure (MAR Counseling and Care Coordination):

Below is a list of example billing codes that may be used during patient care. Check with your payor annually as codes and reimbursement is subject to change. An organization must be a SUPR licensed facility to offer substance use disorder counseling services. As many patients with SUDs have co-occurring with serious mental illness, it is important to screen and offer mental health support internally or refer externally.

Counseling and coordination of services with MAR BHPs will be a large portion of maintenance visits. Counseling codes should be used in place of E/M codes (99212-15) when more than 50% of a visit is dedicated to counseling or coordination of care. Coding is then based on the total visit time, not just the time spent counseling or coordinating care.

- Assessment Visits (MAR Intake)
    - Visit type: Diagnostic Evaluation
    - New or Established Patient: 90791
- Induction Visits
    - Visit type: MAR Counseling and Care Coordination
    - Mental Health Assessment by a Non-Physician: H0031
- Maintenance Visits
    - Visit type: MAR Counseling and Care Coordination
    - BH consult during MAR med visits
        - Mental Health Assessment by a Non-Physician: H0031
    - Psychotherapy: For use in all settings with patient or family (with no medical evaluation and management.
        - 30 (16-37) minutes: 90832
        - 45 (38-52) minutes: 90834
        - 60 (53+) minutes: 90837
- SBIRT: Substance use disorder and structured screening and brief intervention services (99408) can be offered and billed for naloxone education.

Billing Considerations:

- Medicare only covers telepsychiatry in certain areas.
- Patients who do not have coverage or are uninsured can apply for a patient assistance program (PAP) for buprenorphine through the pharmaceutical company.
- Some patients may qualify for free medications for up to one year.
- Each certified prescribing physician is allowed three patients on this program.
- Coupons are also available for eligible patients at: *http://www.suboxone.com/treatment-plan/savings-card?cid=subx*
- Almost all major insurance companies cover the cost of the prescription. Some private health insurers have standard billing codes for buprenorphine treatment services. For example, Cigna requires that clinicians use the HCPCS code for “unspecified mental health care” for buprenorphine related visits.
    - H0033-Oral Medical Administration, Direct Observation

Prior Authorization

As of January 1, 2019, no prior authorization can be required for MAR for Medicaid and Medicaid MCOs.[2] For Medicare and commercial insurers, it is recommended that providers first check and confirm whether prior authorization is required. However, prior authorization is required for Sublocade.

[2] Note: Prior authorization is still required for Sublocade.

Creating and Navigating a Network

BUILDING YOUR NETWORK

Developing a network of MAR providers and community-based recovery supports is achievable for many providers and has several benefits. First, a robust MAR network is essential to creating sustainable health partnerships between service delivery settings and the community at large. Second, it improves communication, collaboration, and coordination between the networks' treatment providers. Broadly, it improves providers' capacity to provide MAR and facilitates the coordination of different services for patients receiving MAR.

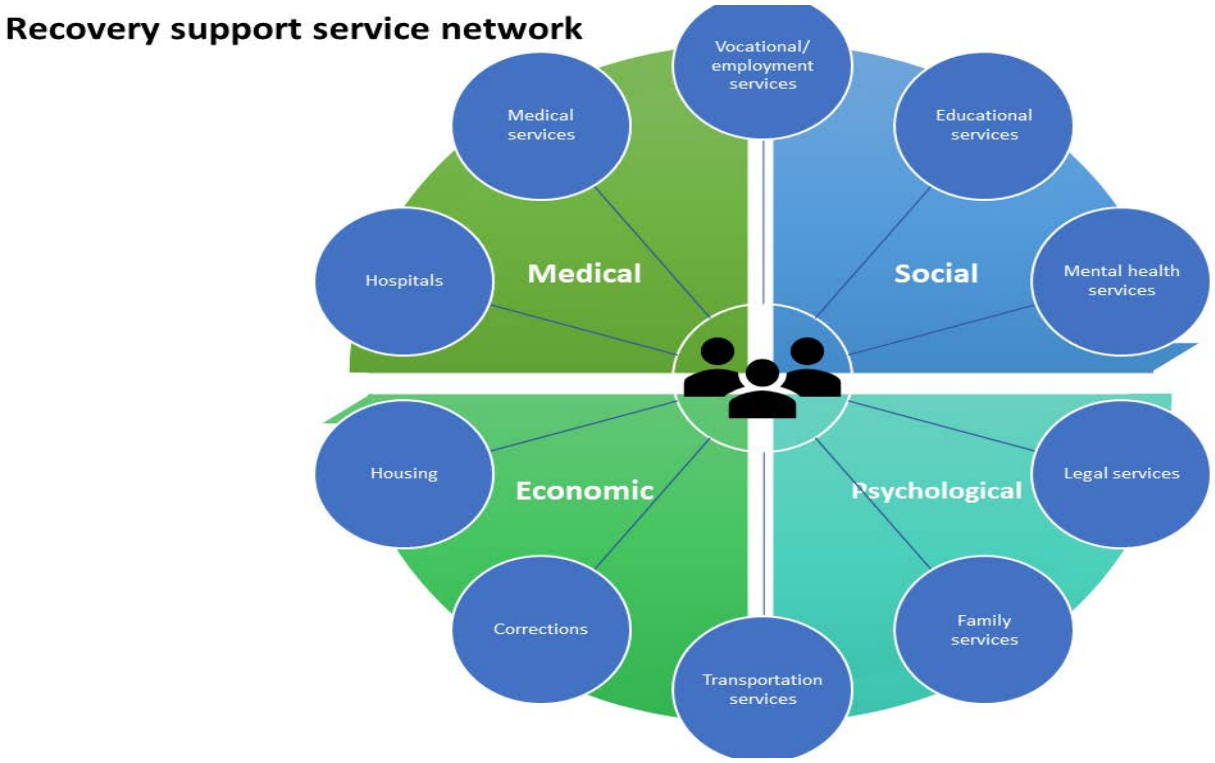
Ideally, a MAR network contains essential components and "aspirational" network components. Essential components for building a network for MAR services should include providers or agencies offering the following types of services:

- ❑ Pharmocological component (e.g., methadone, buprenorphine, suboxone)
- ❑ Psychosocial services (e.g., individual and group counseling/psychotherapy, parenting counseling, vocational counseling)
- ❑ Integration/coordination component (e.g., non/clinical staff to coordinate MAR prescribing and integration with primary and mental health care)
- ❑ Education and outreach
- ❑ Recovery supports (e.g., employment specialists, benefits counselor, housing agencies, family-based services, recovery residences, etc.)

Other components of a MAR network should be incorporated based on client needs and availability of resources:

- ❑ **Peer recovery elements** (e.g., peer recovery coaches)
- ❑ **Community coalitions**
- ❑ **Harm reduction** (e.g., syringe exchange)

The graphic on the next page models how both essential and aspirational components may be linked in a comprehensive recovery support service network.



Note for Rural Providers

The CDC has estimated that people in rural counties are approximately twice as likely as those in urban areas to overdose on prescription painkillers.[33] Thus, primary care is especially well suited to deliver MAR to patients in rural areas, where rural patients can access healthcare the easiest. Incorporating MAR into primary care would give many rural providers the tools they need to address substance use in their communities,[34] **even in the absence of counseling or peer recovery services on site or available locally**, as there is significant reduction in OUD morbidity and mortality with medication alone.

While integrating recovery supports into MAR treatment is highly recommended, many rural communities do not have an organized continuum of care between treatment services and recovery supports, making it difficult to fulfill a patient's basic needs such as health care, housing, and transportation.[35] It is important for providers delivering MAR services to coordinate care with other providers and agencies whenever possible to connect patients with the services needed to aid in their recovery.[36] We encourage providers to peruse examples of how they might build a network and incorporate those services into their referrals. Case studies can be found in the **Implementation** section. Further, a tool for taking inventory of prospective partners and resources can be found in the **Appendix**.

Further, rural providers may find it helpful to seek partnership or inclusion into nearby ROSCs and peer mentoring opportunities with other rural providers. For example, PCSS-MAR (Providers Clinical Support System-Medication Assisted Recovery) is a provider network which has a mentoring program that supports clinicians by improving their confidence in their ability to treat OUD: *https://pcssnow.org/mentoring/*

The following practice considerations for rural providers were given by the Agency for Healthcare Research and Quality (AHRQ)[34]:

- When providers lack referral options for counseling, they can take several steps to optimize psychosocial support during office visits. A survey of patients' experiences revealed they want physicians who are knowledgeable, trustworthy, and understanding, qualities that are not unique to substance use treatment providers. Further, providers should engage in patient-centered care by learning about motivational interviewing techniques[37] and shared decision making.[38] Some practices use prompts in the electronic health record to help novices move through motivational interviewing techniques.
- Some services, such as client counseling and provider guidance on MAR, may be offered via telehealth.
- Similarly, providers may consider home induction for buprenorphine and naltrexone.

IDENTIFYING AND LINKING WITH RECOVERY SUPPORTS

Treating opioid disorders ***most effectively*** requires the ongoing support for MAR, recovery supports, and access to social services, such as housing, employment, and benefits. As a result, as a MAR provider you likely will have to rely on existing community partners to provide some of these services or identify a staff who can devote time to developing partnerships with other organizations in order to best support clients in their recovery.

IDHS/SUPR supports Recovery Oriented System of Care (ROSC) approach to ensure that an appropriate mix of SUD services and recovery supports are available and accessible throughout the state.[39] A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of drug problems.[40] The coordinated community-based services include both traditional treatment providers as well as peer support services, housing, employment, child care and any other social needs that may facilitate MAR adherence. Illinois has multiple ROSCs across the state, which are listed at the end of this section.

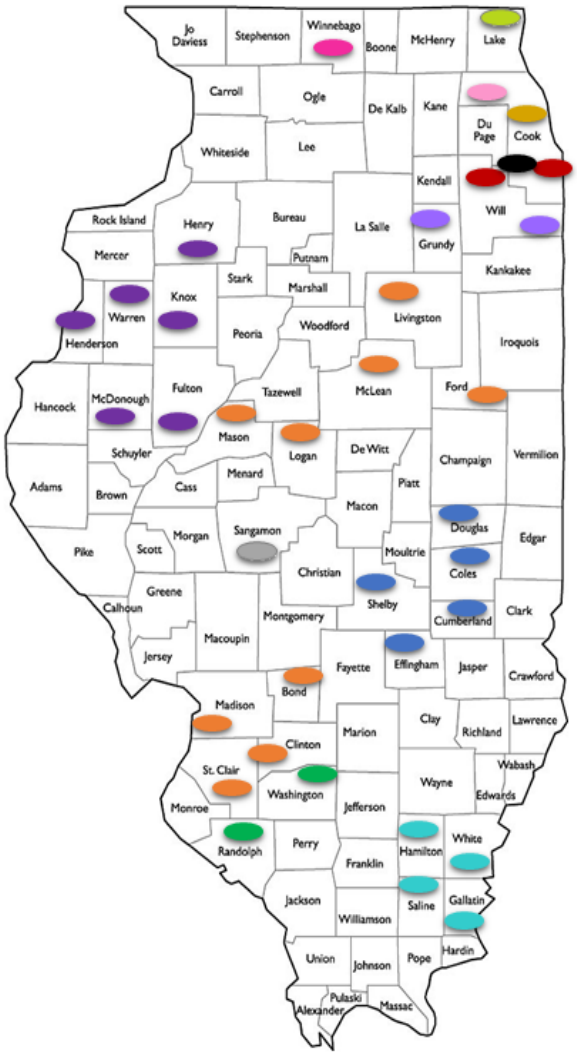
The central focus of a ROSC is to create an infrastructure or 'system of care' with the resources to effectively address the full range of substance use problems within communities. The specialty SUD field provides the full continuum of care (prevention, early intervention, treatment, continuing care and recovery) in partnership with other disciplines, such as mental health and primary care, in a ROSC. A ROSC encompasses a menu of individualized, person-centered, and strength-based services within a self-defined network. By design, a ROSC provides individuals and families with more options with which to make informed decisions regarding their care. Services are designed to be accessible, welcoming, and easy to navigate. A fundamental value of a ROSC is the involvement of people in recovery, their families, and the community to continually improve access to and quality of services. Connecting to a ROSC may provide access to local resources and recovery supports for patients with OUD. ROSCs in Illinois can be found listed in the table and county map below:

ROSC Name	Lead Agency	Counties/Geographic Areas Served
West Central Illinois ROSC (WCIR)	Bridgeway, Inc.	Knox, Warren, Henderson, Henry
McDonough and Fulton County ROSC (MFCIR)	Bridgeway, Inc.	Fulton, McDonough
East Central Illinois ROSC	Central East Alcoholism and Drug Council (dba Hour House)	Effingham, Douglas, Shelby, Coles, Cumberland

ROSC Name	Lead Agency	Counties/Geographic Areas Served
LM ROSC	Chestnut Health Systems	Logan, Mason
TBD	Chestnut Health Systems	Livingston, Ford
ROSC	Chestnut Health Systems	McLean
Metro-East Recovery Council (MERC)	Chestnut Health Systems	Madison, St. Clair
TBD	Chestnut Health Systems	Bond
Take Action Coalition of Clinton County	Chestnut Health Systems	Clinton
CRCC	Chicago Recovering Communities Coalition	Westside Chicago (Cook)
SISAA	ComWell	Southern Cook, Northern Will
EDDR	EDDR Foundation	Winnebago
SI SUPRT	Egyptian Health Department	Gallatin, Hamilton, Saline, White
Partners in Recovery – Sangamon County	Family Guidance Centers, Inc.	Sangamon
ROSC-ISN	HeartLife Ministries	Will, Grundy
KYC	Kenneth Young Center	Palatine, Hanover Park (Cook)
Lake County ROSC Council (LCRC)	Northern Illinois Recovery Community Organization	Lake
FSSRI	TEECH	Southwestern Cook

List of ROSC Councils updated 3/22/21. Note: Some Councils were newly formed and have not designated a name for their ROSC and are marked "TBD".

Map of IL ROSC Councils



Lead Agencies:

Bridgeway, Inc.: Knox, Warren, Henderson, Henry, Fulton, McDonough

Central East Alcoholism and Drug Council (dba Hour House): Effingham, Douglas, Shelby, Coles, Cumberland

Chestnut Heath Systems: Logan, Mason, Livingston, Ford, McLean, Madison, St. Clair, Bond, Clinton

Chicago Recovering Communities Coalition: Westside Chicago (Cook)

ComWell: Randolph, Washington

Cornerstone: Southern Cook, Northern Will

EDDR Foundation: Winnebago

Egyptian Health Department: Gallatin, Hamilton, Saline, White

Family Guidance Centers, Inc.: Sangamon

HeartLife Ministries: Will, Grundy

Kenneth Young Center: Palatine, Hanover Park (Cook)

Northern Illinois Recovery Community Organization: Lake

TEECH: Southwestern Cook

Map of Illinois ROSC Councils updated 3/22/21.

In lieu of access to an existing ROSC, you can rely on the community partners you currently refer to if these partners can provide one or more of the following:

- ❑ **Psychosocial services** (e.g., cognitive behavioral therapy, group therapy, motivational enhancement therapy, peer support)
- ❑ **Services that reduce barriers to treatment (housing, childcare, transportation)**
- ❑ **A range of Peer Support**, for example
    - o SMART Recovery: *https://www.smartrecoveryillinois.org*
    - o Narcotics Anonymous (NA): *https://www.na.org , https://www.chicagona.org*

We have included a planning document for outreach to potential community partners in the **Appendix** developed by the Florida Department of Children and Families and the Florida Alcohol & Drug Abuse Association.

Where should I go for more information about ROSCs?

> For more information about ROSC councils in Illinois, including information on how to join or create a ROSC, go to: *http://www.dhs.state.il.us/page.aspx?item=117096*
>
> For guidelines regarding Illinois ROSC principles, see: *http://www.dhs.state.il.us/OneNetLibrary/27896/documents/2020SmartAlerts/Illinois_ROSC_Principals.pdf*

CARE COORDINATION AND COLLABORATION

Facilitating Referrals to Other Providers

Written procedures should be established for the referral of patients to other providers for services that are not available within the organization and/or that are best recommended for the patient. An example referral policy can be found in the **Appendix**. These procedures should include the following:

- The method of obtaining any necessary written consent from the patient for transfer of any relevant portion of the patient record and for communication regarding patient services with that provider;
- The method for ensuring continuity of patient care which shall include a written referral document that indicates the reason for the referral, provides information about any service received to date and any additional services needed or requested, specifies any necessary continued coordination between the providers and the time frame for any necessary follow-up reports; and
- The method by which a patient may request a referral.

Patient Documentation Checklist for Referrals

Patients can arrive from a variety of referral sources. Whether the patient wants to transfer from their current OTP to another OTP, OTP to a (Federally Qualified Health Center (FQHC) or the patient is a transfer from a hospital or another private medical care provider, there are several documents and pieces of additional information that should help facilitate the request.

When receiving transfers from OTPs, the following documentation greatly facilitates immediate access:

- ❑ Documentation that reflects the patients length of current time in treatment, reason for transfer, dosage history and response to counseling
- ❑ Recent history and physical examination
- ❑ Recent labs results, including:
    - ❑ Basic chemistry profile
    - ❑ CBC with Differential
    - ❑ Urinalysis (U/A)
    - ❑ RPR screening for syphilis
    - ❑ Tuberculosis trest results
- ❑ Documentation of the last day dosed with methadone and number of milligrams the patient currently receives

- ❑ Last 90 days of toxicology drug screen results
- ❖ Recommended: The patient should have their current counselor contact the receiving clinic's intake staff to discuss scheduling, transfer documentation and transfer dates.

Warm Handoff Strategies

Warm handoff for opioids has been a new tool in the opioid epidemic designed to reduce barriers for opioid users to access substance use disorder treatment, primary care services and enhance opportunities for long term recovery.[41] Initially the strategy focused on recent victims of overdose in emergency settings but has now evolved to include people screened for opioid dependence in primary and specialty care settings. For people with OUD, lengthy assessments and waiting for drug treatment referral, approval and linkage could result in a missed opportunity and increase risk of overdose and fatality. To reduce barriers to accessing treatment, "warm handoff" strategies have been widely successful at getting individuals with OUD into treatment programs.

A warm handoff is the process of transitioning a patient with OUD from an intercept point, such as an Emergency Department, to a treatment provider. A general "warm handoff" consists of one team member presenting a patient face-to-face or via telephone to another team member or provider for a healthcare service.[42]

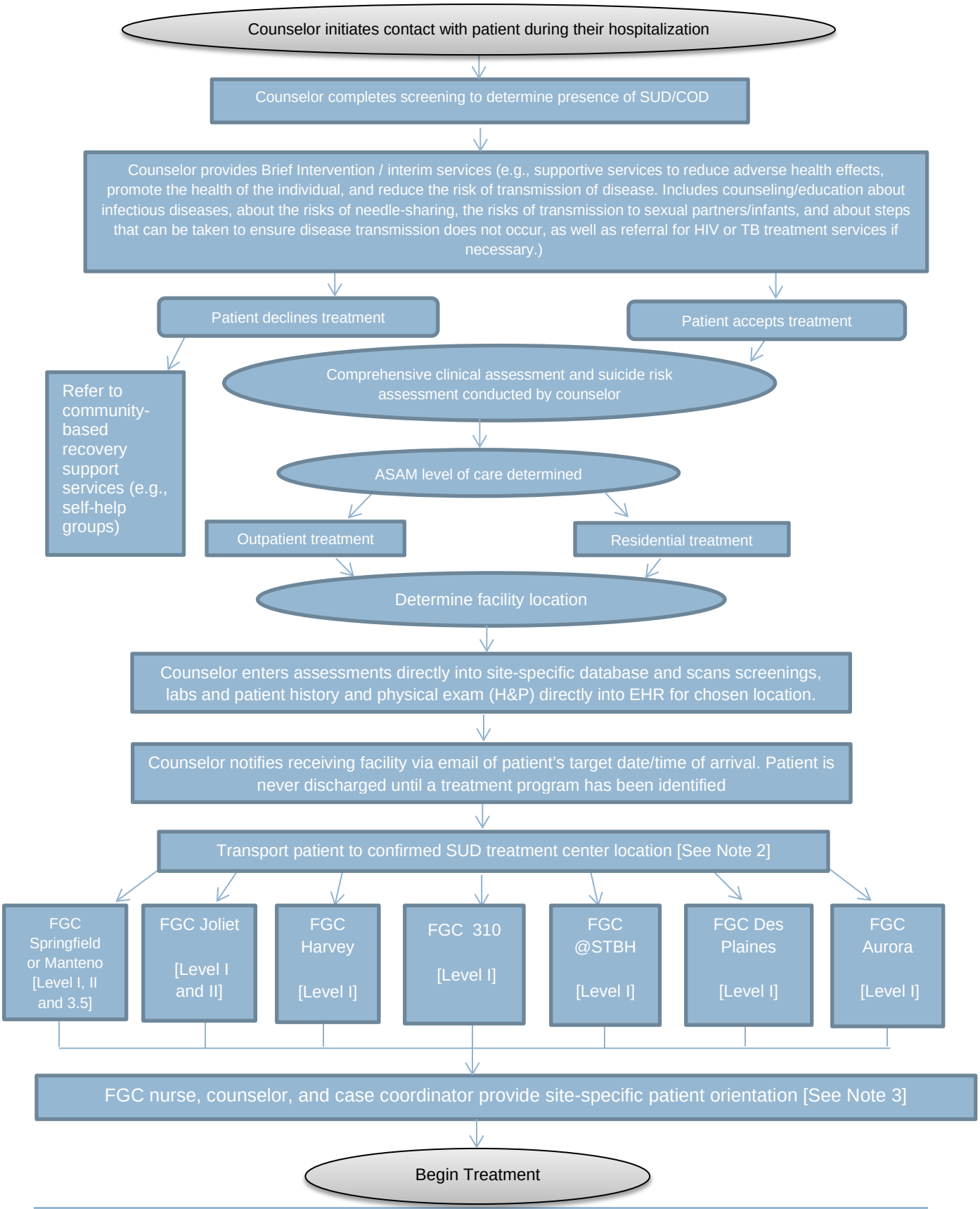
Warm Handoff Documentation Checklist

When receiving "**warm handoffs**" from hospitals or private practitioners, the following information should be forwarded to the receiving SUD treatment provider:

- ❑ Recent history and physical examination
- ❑ Recent labs results, including:
  - ❑ Basic chemistry profile
  - ❑ CBC with Differential
  - ❑ Urinalysis (U/A)
  - ❑ RPR screening for syphilis
- ❖ Recommended: The patient should have the hospital social worker or nurse or the private practitioner's nurse contact the receiving clinic's intake staff to discuss scheduling, transfer documentation and transfer dates.

Example Warm Handoff Workflow

Family Guidance Center (FGC) Warm Handoff Workflow



Note 1: Level II Services available at Joliet and Springfield locations. Level 3.5 Services only available at Manteno and Springfield site.

Note 2: Counselor/Case Coordinator provides Ventra Card, taxi voucher or Amtrak ticket to remove barriers to immediately accessing treatment.

Note 3: Confirm receipt of H&P and labs, gain consents for treatment and contact physician for orders.

Participating Warm Handoff Hospitals:

- Advocate Christ Medical Center, Oak Lawn, IL
- Advocate Condell, Libertyville, IL
- Advocate Good Shepherd, Barrington, IL
- Alton Memorial Hospital, Alton, IL
- Cook County Health and Hospital System, Chicago, IL
- Methodist Hospital, Chicago, IL
- Methodist Medical Center of Illinois, Peoria, IL
- Mount Sinai Hospital and Medical Center, Chicago, IL
- Norwegian American Hospital, Chicago, IL
- Presence Saints Mary and Elizabeth Medical Center, Chicago, IL
- Roseland Community Hospital, Chicago, IL
- Rush University Medical Center, Chicago, IL
- Silver Cross Hospital, New Lenox (Joliet), IL
- Southern Illinois Healthcare (encompasses three hospitals):
    - Memorial Hospital of Carbondale, Carbondale, IL
    - Herrin Hospital, Herrin, IL
    - St. Joseph Hospital, Murphysboro, IL
- Swedish American Hospital, Rockford, IL
- St. Anthony Hospital, Chicago, IL
- St. Bernard Hospital, Chicago, IL
- Thorek Hospital, Chicago, IL
- University of Illinois Hospital & Health Sciences System, Chicago, IL
- Vista Medical Center East, Waukegan, IL

IDHS/SUPR's Peer Recovery Support Services

> *"Peer recovery support services provide a vehicle to prevent relapse or to prevent lapses from progressing into full relapses." –H. Westley Clark, MD, JD, MPH, CAS, FASAM Director, CSAT*

Peer recovery support services are typically provided by paid staff or volunteers familiar with how their communities can support people seeking to live free of drugs and are often peers of those seeking

recovery. Some of these services may require reimbursement while others may be available in the community free of charge.

Definition of Services

The following is a brief description of peer recovery support services. Services are to be delivered face-to-face, individually or in a group setting.

Employment Coaching
One-on-one or group sessions (though one-on-one sessions are HIGHLY encouraged) that provide clients with skills related to overcoming barriers to achieving employment and prepare clients for the employment climate they will encounter. Employment Coaching can include career and goal setting, searching for available jobs, resume writing, mock interviewing, addressing gaps in previous employment, expungement, and employer expectations.

Peer Coaching
A peer is an individual who shares the direct experience of addiction and recovery. Peer Coaching sessions should be designed, delivered, and facilitated by peers to assist others in or seeking recovery to initiate and/or sustain recovery from substance drug use disorders and closely related consequences. Peer Coaching sessions can take place in one-on-one or group sessions where clients can discuss topics such as relapse prevention, coping skills, anger management, domestic violence, decision making, lifestyle choices, pursuing interests, and participating in drug-free recreation in an effort to share and learn from the experiences and journeys of others in recovery.

Recovery Coaching
Recovery Coaching should be provided in one-on-one sessions that engage and retain the client in a process designated to strengthen his or her resilience and personal efficacy of his or her sustained recovery, and should be tailored to assisting clients with individualized recovery needs. Topics may include relapse prevention, coping skills, anger management, domestic violence, decision-making, lifestyle choices, pursuing interests, and participating in drug-free recreation.

Recovery Home
Drug free housing authorized by an intervention license issued by the Department, whose rules, peer-led groups, staff activities and/or other structured operations are directed toward maintenance of sobriety for persons in early recovery from substance abuse or who recently have completed substance abuse treatment services or who may still be receiving such treatment services at another licensed facility.

Recovery Skills
Recovery Skills sessions should be designed to assist clients in or seeking recovery to initiate and/or sustain recovery from drug use disorders and closely related consequences. Recovery Skills should be group-oriented sessions and allow clients from different backgrounds and experiences to discuss recovery-related topics such as relapse prevention, coping skills, anger management, domestic violence, decision making, lifestyle choices, pursuing interests, and participating in drug-free recreation in an effort to share and learn from the experiences and journeys of others in recovery.

Spiritual Support
Spiritual support involves the degree to which spiritual resources and psychological understanding, including the way a person experiences a connection to a higher power, can be used for healing and growth. Session activities can include discussing recovery as a spiritual journey, encouraging involvement with a spiritual path, or engaging in religious and spiritual practices consistent with a client's beliefs (such

as prayer, meditation, silence, singing, reading spiritual books, acts of worship, ritual, forgiveness, and service). Sessions should be group-oriented with the goal of assisting clients to find spiritually based solutions to issues and problems, with a sense of spiritual purpose and meaning, along with hope and faith in something transcendent.

Transportation
Vouchers may be used to pay for transportation costs associated with commuting to and from individual's treatment and/or recovery support program and job search. Transportation costs must be preauthorized on an individual basis.

Employment Training
One-on-one or group sessions that teach a client a specific work skill or trade that will result in gainful employment opportunities, such as construction, masonry, commercial cleaning, sewing, barbering, cooking, or computer repair. All Employment Training programs must include a plan for utilizing Employment Coaching in conjunction with Employment Training classes or have a linkage agreement with an agency that does. All programs must also submit a curriculum for their program and be able to demonstrate criteria for determining whether clients meet prerequisites for course enrollment (e.g., if you are teaching construction, a client's math level may be a prerequisite for entering the course).

Recovery Support: Mental Health and Peers
Many people with OUD also experience mental health problems. In OUD treatment, addressing the client's underlying mental health challenges sometimes goes overlooked. However, in many cases mental health challenges may have been an underlying factor that led to misuse of opioids. It is possible that some people with OUD may experience mental health symptoms as a result of their opiate use. Mental health services should be offered to help support recovery. However, as stated in previous sections, mental health services are not required for initiating or continuing MAR.

While there is much discussion about the differences between the treatment of mental health and substance use disorders, one commonality is the use of peers and peer providers. As described above, peers are individuals who share direct, lived experience of addiction and recovery – and often, mental health problems. Peer support groups, including 12-Step groups and Wellness Recovery Action Planning (WRAP) can provide practical and emotional support from others who are experiencing similar mental health and/or substance use problems. Peers who are certified, trained and hired to provide peer support services, such as Certified Peer Recovery Specialists (CPRS) and Recovery Support Specialists (RSS), are increasingly seen as key members of mental health and substance use treatment teams. Their combined professional and personal experience are instrumental in engaging people with mental health symptoms and/or OUD in treatment, include MAR. Studies show that peers help reduce stigma, including personal feelings of shame and embarrassment people with OUD may experience as well as public misperceptions about people with OUD. Peers also are powerful mentors, providing real-life examples that help people with OUD attain and sustain recovery. In addition to peer coaches, CPRS and RSS, examples of peers working in OUD treatment settings can be found in the **Appendix.**

SUPR's Revised Billing Procedure for Recovery Support Services (RSS): March 2020
If RSS are provided in a licensed and funded IDHS/SUPR facility, they must be delivered and billed to the IDHS/SUPR contract as follows:

1. A Certified Peer Recovery Support Specialist (CPRS) or a Certified Recovery Support Specialist (CRSS) must deliver the service. If the organization is unable to meet this requirement, an

exception request must be submitted to IDHS/SUPR. If an exception is granted, at a minimum, the staff providing RSS must be a person with lived experience and one year of recovery.

2. RSS is a separate service from substance use disorder (SUD) treatment and should not be delivered by the same staff to the same patient. Ideally, professional staff are delineated such that they are not providing both treatment and recovery support services at the same organization.
3. RSS must be identified and documented as a need in the ASAM (American Society of Addiction Medicine) assessment or any continued stay review.
4. RSS must be documented in a recovery support plan that is separate from the treatment plan and must address the four major dimensions of recovery identified by the Substance Abuse and Mental Health Service Administration (*https://www.samhsa.gov/find-help/recovery*).
5. RSS services must be signed by the staff delivering the service and indicate the activity, time date and duration.
6. RSS delivered during treatment (except recovery home and transportation) is reported as case management (CM), activity code 21 and reimbursed at the CM rate. RSS delivered pre-treatment or post treatment is reported as community intervention (CI), activity code 32 and reimbursed at the CI rate. Reference the billing chart below for rates and documentation requirements.

Medication First Approach

In many state treatments programs, repeated unexcused absences from counseling and other support services is *cause* for involuntary discharge from MAR programs. Similarly, unwillingness to enroll in counseling services has barred clients from starting MAR.[43] Thus, clients may be denied SUD services or lose access to all SUD services, including MAR medications based on this policy. In areas where psychological services are not readily or consistently available in primary care or elsewhere, requiring attendance in counseling services in order to participate in MAR can become an additional barrier.

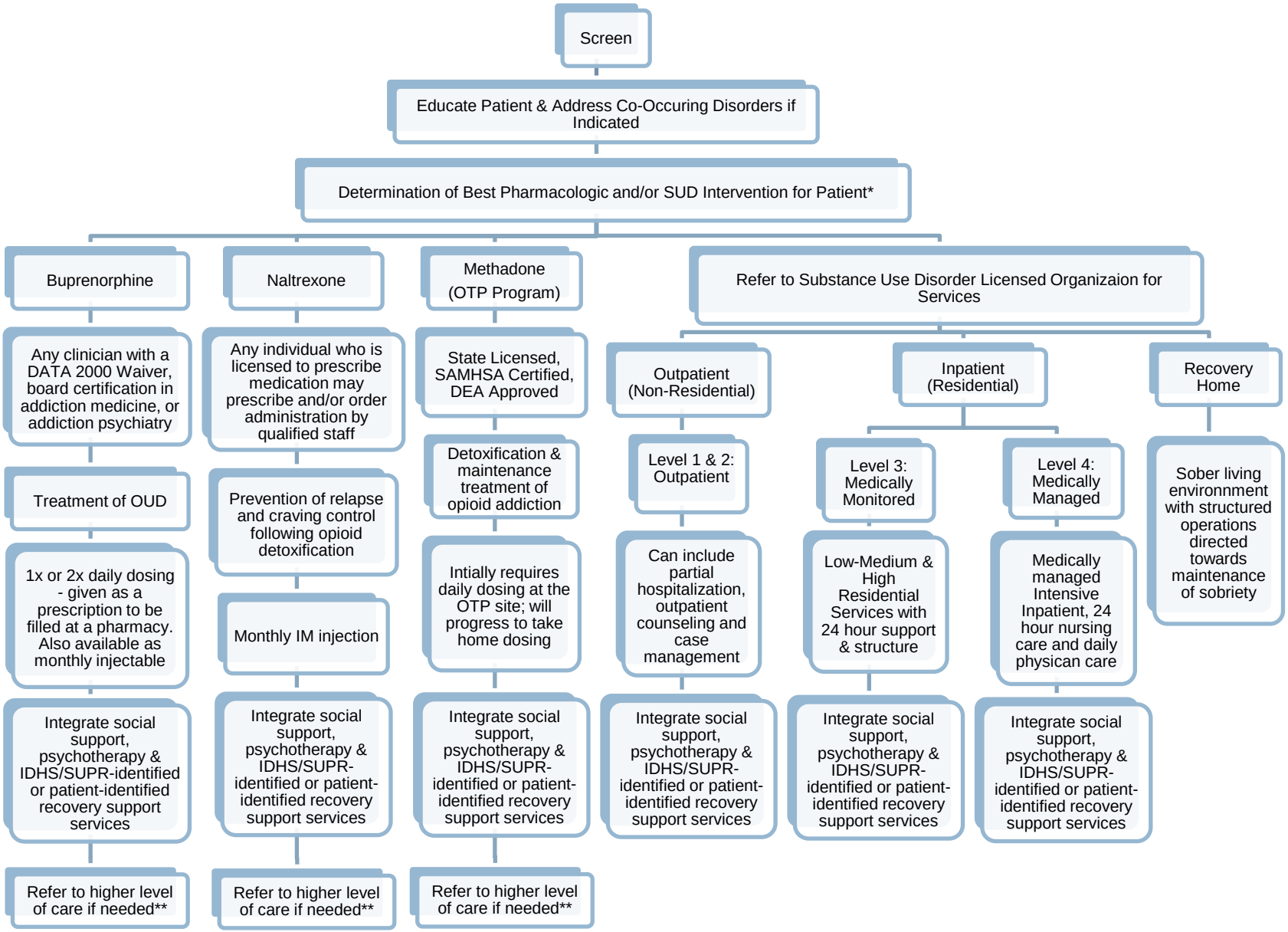
In order to address this barrier, Winograd *et al*. and the Missouri Department of Mental Health (DMH) developed a new framework to conceptualize OUD treatment called “Medication First”, or Med First. **The Med First approach posits that receiving MAR is not contingent upon adherence to counseling or other support services.** The Med First approach framework follows four key principles[43], summarized below:

1. Clients participate in pharmacotherpay as quickly as possible, without first requiring lengthy assessments or threatment planning sessions.
2. Maintainence pharmacotherapy is delivered without arbitary tapering or time limits.
3. Individualized psychosocial services are offered, but receiving pharmacotherapy is not contingent upon compilance or willingness to engage in psychosocial services.
4. Pharmacotherapy is discontinued only if it appears to be worsening the client’s condition.

In addition to these principles, we recommend providers use motivational interviewing,[44,45] an evidence-based, client-centered approach to helping people make behavior changes, to identify the recovery supports that patients identify for themselves as key to their recovery. Providers should encourage the use of services but not withhold MAR if patients refuse counseling or recovery support services.

The treatment decision tree on the next page summarizes the factors involved in deciding the appropriate pharmacological and SUD treatment options for the patient; these factors include the setting or level of

treatment, the types of providers and/or licensure required for administering the treatment, and patients' time commitment for each option. Selecting the appropriate pharmacological treatment (i.e., MAR) and SUD treatment options (i.e., counseling) are parallel processes determined through shared decision making between the patient and provider. Partnering with people in recovery from mental health and SUD and their family to guide and promote approaches that foster health and resilience is central to both pharmacological and non-pharmacological approaches to treating SUD.



*Patients may try different medications, cycle through different levels of care and/or just choose to receive SUD treatment.

**As indicated by patient preference and patient-centered shared decision making.

Community Education and Awareness

GAINING COMMUNITY ACCEPTANCE

Addiction and MAR services are still highly stigmatized in many areas. Stigma often prevents or discourages those with SUD from seeking or continuing treatment. To combat misperceptions and to achieve buy-in, communities need to be educated about the evidence of MAR.[34,46]

Further, providers must set the right example with their language choice when discussing SUDs with both patients and the community to reinforce that addiction is a chronic brain disorder. Providers should use clinical, non-stigmatizing, and person-first language when speaking about SUDs and avoid terms and avoid terms that imply moral judgements or fault. Regarding MAR specifically, the use of terms such as "replacement" or "substitutions" should be avoided as they reinforce the notion that one drug is simply being exchanged for another.[34]

Strategies for Educating the Community

- Sharing information on the evidence supporting MAR
- Overdose prevention and naloxone training
- Community forums and panels
- Towns halls
- Patient testimony
- Focus groups to identify perceptions and needs of the local community
- Media campaigns; for example, Advancing Recovery West Virginia used local media to share editorials featuring success stories of individuals who were treated with MAR for OUD

> Many excellent additional resources for providing community education can be found in the toolkit:
> ***MAR for the 21st Century: Community Education Kit***
> *https://files.eric.ed.gov/fulltext/ED478679.pdf*

Strategies for Educating Other Providers

- Meeting with other providers for education management
- Lectures on OUD at local hospitals
- CME lectures on substance use and MAR
- Peer mentoring
- On-going communication/meetings with other clinics and providers experiencing similar struggles.

PROVIDING EDUCATION ABOUT MAR SERVICES

Educating the Community

Effective community engagement would provide education to other providers, patients, and their communities about the following topics:

- The three forms of MAR and benefits of each

- What relapse looks like
- What to do if one form of MAR is not working

Flyers for educating patients and community members about MAR and recognizing an overdose can also be found in the **Appendix**.

Educating Other Providers

Providers should be aware of how to recognize and detect OUD. Early intervention saves lives and mitigates health hazards due to opioid use. The first barrier to accessing treatment is failure to recognize substance use disorder. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an approach in which screening is followed up as appropriate with brief intervention to promote healthy behavior change and with referral to treatment for those needing more extensive care (*www.samhsa.gov/sbirt*).

Below are some commonly reported signs of OUD that may be present in people you encounter as a physician:

- Lost or stolen prescriptions
- Running out of medications early
- Aggressive complaints about the need for additional prescriptions
- Urgent calls or unscheduled visits
- Unapproved or unauthorized use of prescribed opioid to self-medicate another problem such as insomnia
- Demanding a certain type of pain reliever over another
- Frequently missed appointments unless opioid renewal is expected
- Evidence of withdrawal symptoms visible at appointments
- Concurrent alcohol or illicit drug abuse
- Deterioration of function at work, with family, or socially because of medication effects
- Forging prescribed medication
- Selling prescribed medication

There are many physicians who do not feel comfortable exploring the possibility of offering MAR at their clinic. Below are common responses to offering MAR in non-SUD treatment settings. We encourage providers to be prepared to encounter and respond to these objections to MAR in order to combat stigma associated with MAR services.

<u>Reasons Why Physicians Won't Prescribe:</u>

- "I don't have those patients here"
- "I don't want to treat them"
- "I don't have time"
- "My practice isn't set up for that"
- "I don't have the appropriate staff"

- "I don't have the resources"
- "I am not an addictionologist"
- "I refer them to pain practice"

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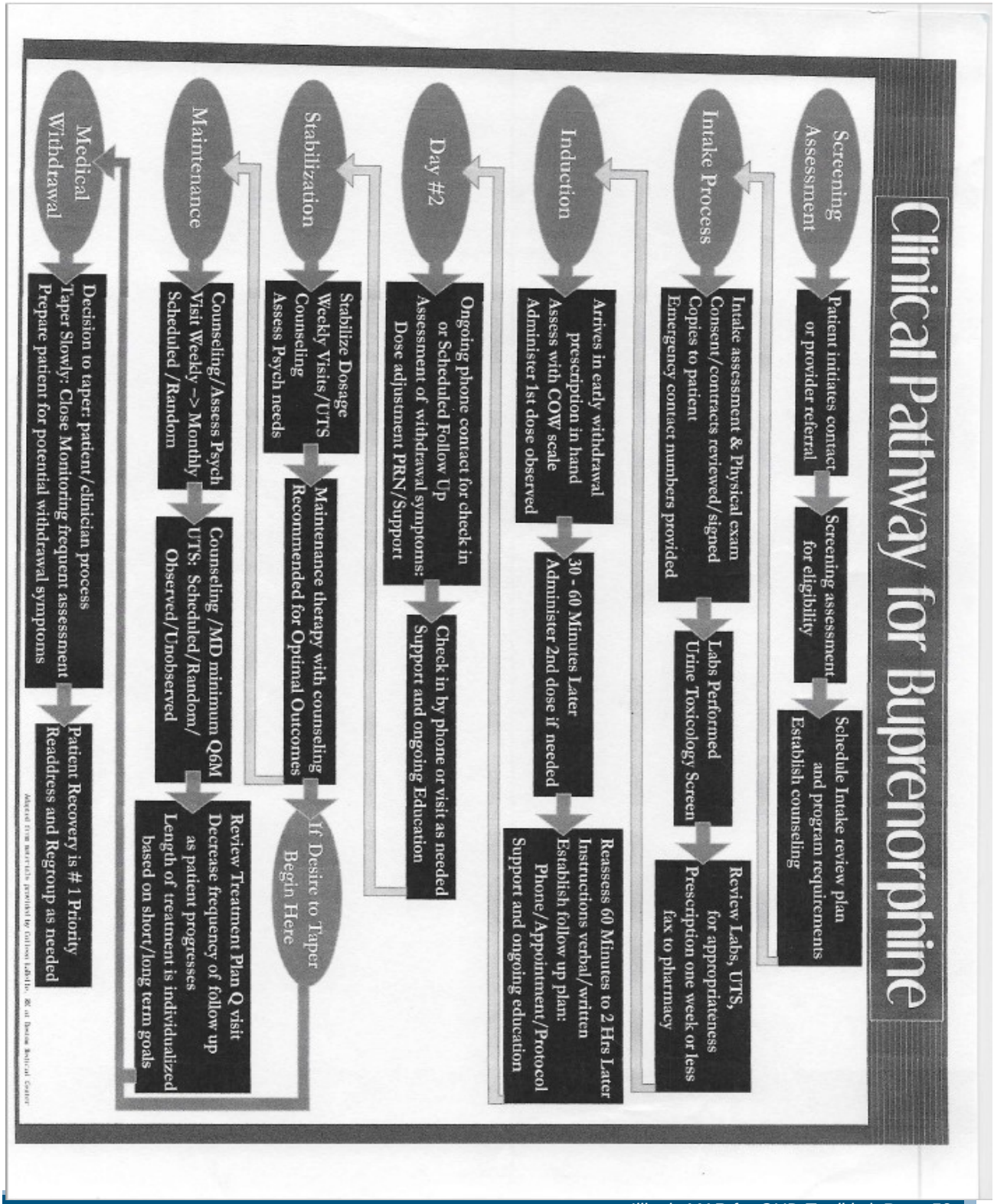
Appendix

PROVIDER TOOLS

Buprenorphine workflow handout



Clinical Opiate Withdrawl Scale (COWS)

The Clinical Opiate Withdrawal Scale can be used to assess the severity of withdrawal symptoms. It is a useful tool during induction of MAR services (see medication best practices.)

https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf

Addiction Risk Questionnaire

Assesses risk for addiction to opioids used to treat chronic pain with a 28-item questionnaire specifically designed for general practitioners.

The questionnaire is copy righted but freely available:

http://www.europeanreview.org/wp/wp-content/uploads/4898-4905.pdf

Example referral form

Below is an example client referral policy provided by Family Guidance Center.

_____

Patient Referrals

Policy Title: Patient Referrals

Effective Date: April 13, 2017

Policy: It is the policy of this Agency to ensure access to necessary services required by patients when those services are not available at this Agency. All patients shall be offered referrals to other providers for services not available within the organization and/or requested by the patient. Referrals will be coordinated according to the following procedures.

Procedures:

1. All patients may request referrals at any time by contacting their qualified primary counselor, program nurse, case manager, RSS, or, if necessary, the designated program manager. Support staff will be available during all business hours to assist patients in contracting the above personnel.

2. Need for potential referral is also evaluated upon admission, at treatment planning reviews, and as part of discharge planning.

3. Written consent for disclosure of information, necessary to facilitate referral on patient's behalf, will be obtained by program staff. The written consent will include:

a. Name of the patient in need of the referral

b. The name, title, address, and telephone number of the person or organization to which disclosure is to be made

c. The reason for referral

d. The kind and amount of information to be disclosed

e. Time frame during which consent for disclosure will be in affect

f. Statement prohibiting re-disclosure of information

g. Signature of patient

h. Signature of witness

i. Date of execution of consent

4. To ensure continuity of care, mutual exchange of information with the other service organization(s) will be made available including reason for referral, services received by patients to date, patient's response to treatment, services and other special patient needs

along with the process and time frame for any needed follow up.

5. Reasons for referral may include, but not be limited to the following:

a. Patient is relocating and in need of continued care.

b. Patient is successfully completing treatment and is in need of aftercare relapse prevention supports and/or other ancillary services post-discharge.

c. Patient is in need of a new level of care not currently available at this agency.

d. Patient has been seen to be in need of emergency medical and/or mental health service.

e. Patient is in need of ancillary, medical, mental health, vocational, childcare, family medical care, or other social services in conjunction with treatment received at this agency.

f. Change in patient job status (e.g. work schedule) or other conflicts with participation in treatment at this agency.

g. Change in patient's medical condition makes travel to this Agency a hardship and patient is in need of alternative setting or location.

h. Patient is not making measurable progress in treatment at this Agency and is in need of another level of care

6. Linkage agreements for patient referral will be established and maintained with various community organizations and licensed service providers.

7. The multidisciplinary treatment team (counselor, medical staff, RSS, case manager) will be responsible for overseeing coordination of the referrals and necessary follow up as well as documentation of appropriate consents and clinical information regarding the referral in the patient record. In the case of arranging a discharge with transfer of care to another service provider, the FGC treatment team will maintain responsibility for the care until transfer is completed as indicated by the receiving agency/organization's acceptance of the referral. The medical staff will confirm with the receiving agency/organization the last day of medication at FGC for patients in the OTP to ensure continuous care and to prevent double enrollment.

8. Patients will be referred for treatment or intervention services to IDHS/SUPR licensed providers for substance abuse treatment services, to those individuals or organizations that are specifically exempted from licensure, and to similarly licensed and regulated organizations in other states.

PATIENT TOOLS AND HANDOUTS

Subjective Opiate Withdrawal Scale (SOWS)

This is a self-administered scale for grading opioid withdrawal symptoms. Patients may use this tool to monitor the severity of their withdrawal symptoms, which could be particularly useful for at-home induction processes. Self-report measures can assist in reducing patient anxiety about their care, and their concerns about being appropriately medicated.

https://www.asam.org/docs/default-source/education-docs/sows_8-28-2017.pdf?sfvrsn=f30540c2_2

Pregnancy: Methadone and Buprenorphine patient handout

This PCSS handout is intended for pregnant women with OUD that addresses commonly asked questions regarding pregnancy and MAR.

https://30qkon2g8eif8wrj03zeh041-wpengine.netdna-ssl.com/wp-content/uploads/2013/10/WAGBrochure-Opioid-Pregnancy_Final.pdf

Suboxone Home Induction handout

Guide to taking Suboxone®

(Sub-OX-own)

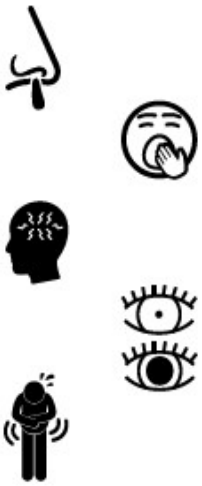
SUBOXONE® (BUPRENORPHINE-NALOXONE 8/2MG SL FILM)

Before

Check **at least 3** of the following feelings before taking your first dose of Suboxone®: →

The worse you feel when you begin the medication, the less chance of a worse withdrawal.

- ☐ Runny nose
- ☐ Yawning
- ☐ Restlessness (anxiety)
- ☐ Enlarged pupils
- ☐ Stomach cramps, nausea, vomiting, or diarrhea.



Drink water to moisten your mouth. Hold the film between two fingers by the outside edges.

Place Suboxone® Film under your tongue, close to the base, either to the left or right of the center.

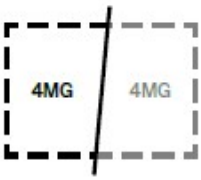
Day 1:

MAXIMUM DOSE OF 12 MG (1 ½ FILM) ON DAY 1.

1 film = 8mg

First dose = 4mg (½ film).

Take 4 mg (½ film) extra every 3 hours until feeling normal.



→Write in:
On Day 1, my total dose was:

Day 2:

MAXIMUM DOSE OF 16MG (2 FILMS) ON DAY 2 *ONLY IF NEEDED.*

Take the total dose you wrote from Day 1 as a first time dose in the morning.

If breakthrough withdrawal symptoms occur within 3 hours after the initial morning dose on Day 2, take 4mg (½ film shown above) every 3 hours until feeling normal.

→Write in:
On Day 2, my total dose was:

Day 3:

AND BEYOND.

Take the total dose you wrote from Day 2 as a first time dose in the morning.

DURING WEEK 1, THE MAXIMUM DAILY DOSE IS 16MG.

Important:

It takes about 4 days of using Suboxone® at the same dose to find the **right dose for you.**

After the first week, dosing adjustments **must be discussed with your healthcare provider.**

UI Health

"What is MAR?" Handout for Patients

Information from this handout was borrowed from SAMHSA's Decisions in Recovery website[47]: *https://mat-decisions-in-recovery.samhsa.gov/*

Medication Assisted Treatment (MAT) for Opioid Use Disorder

People use medications to help manage many health problems such as diabetes, cigarette smoking, or high cholesterol. Medications can help people get started while they make the lifestyle changes necessary for long-term recovery.

Medications for opioid use disorder can decrease cravings or withdrawal symptoms and reduce the stress of extreme highs and lows. Overall, the evidence shows that medication assisted treatment (MAT) helps people overcome opioid use disorder and sustain recovery, and people struggling with opioid use disorder are often more successful with MAT than non-medication alternatives. However, some people do recover from opioid use disorder without medications.

How does MAT work?

There are two key ways medications work to help reduce opioid use:

1. **Methadone** and **buprenorphine/Suboxone®** are long-acting medications that reduce craving and control withdrawal symptoms by satisfying areas of the brain affected by opioid use disorder. This allows people to continue to work and function normally.
2. **Naltrexone/Vivitrol®** blocks the actions of opioids. It stops their euphoric effects and their ability to take away pain. Research studies found that long-acting injectable naltrexone reduced cravings and helped people to stay in treatment longer and maintain their abstinence from opioid use.

Is MAT right for me?

MAT is not the answer for everyone. Some people do not want to use medications for treatment. Others have health conditions that could be affected by MAT. Some people prefer other approaches that have worked for them in the past. Talking with your physician and treatment team can provide the answers you need and help you weigh your options.

What are the differences in available MATs?

Methadone is a long-acting opioid medication that reduced craving and withdrawal symptoms. It is usually taken by mouth in liquid form, and dispensed daily, in single doses, only by certified opioid treatment programs. Limited take-home dosing may be permitted and can become more frequent over time if long-term treatment is going well. But, in order to begin treatment, you need to be able to get to an opioid treatment program daily.

Buprenorphine/Suboxone® is usually taken daily and must be dissolved under the tongue. It comes in tablet form and as a film. Once doctors complete the required training and certification process, they can prescribe buprenorphine for office-based treatment or for clients at various treatment programs. Patients making satisfactory progress may receive take home prescriptions for up to a 30-day supply.

This content on this handout was borrowed from the Substance Abuse and Mental Health Service Administration (SAMHSA) website *Decisions in Recovery: Treatment for Opioid Use Disorder*. Accessed, April 3, 2019, https://mat-decisions-in-recovery.samhsa.gov/Default.aspx

Buprenorphine has proven to be very effective. Although it has not been more effective than methadone, for some people it may offer advantages. Risk of overdose is lower and withdrawal from buprenorphine may be milder. Access to buprenorphine has helped many individuals seek treatment who otherwise might not have.

Research-established benefits compared to treatment without MAT	Methadone	Buprenorphine	Naltrexone
Increased Retention in Treatment	✓	✓	✓
Reduced illicit opioid use	✓	✓	✓
Reduced overdose death	✓	✓	--
Reduced death for any reason	✓	✓	--
Reduced HIV risk behaviors	✓	✓	--

Naltrexone/Vivitrol® is available in an extended release injectable form that is administered every 30 days. It blocks the action of opioids on the brain and stops their rewarding effects—the pain-relieving effects and the euphoria. This can help discourage relapse. The long-acting injection, Vivitrol® has been the most effective form for treating addiction. It has helped to prevent relapse when combined with counseling and other supportive treatments. Unlike methadone and buprenorphine, naltrexone requires 7–10 days of withdrawal prior to administration. Overdose risk is high for people who try to override the blocking effects of naltrexone by using large amounts of opioids, and for those who return to opioid use after a period on naltrexone. This can happen when people take amounts they were used to prior to treatment but are no longer are able to tolerate them.

Treatment Retention Rates	
Opioid treatment WITHOUT MAT	6%
Naltrexone	10-31%
Buprenorphine	60-90%
Methadone	74-80%

How can POINT help me access MAT?

A Project POINT recovery coach can talk through the different options available to you, discuss the potential benefits and drawbacks of each, and help schedule an appointment if you decide MAT is right for you. Recovery coaches can also assist you in accessing non-MAT treatment or help you to identify and access other non-treatment resources and social services that you might benefit from.

For more information on MAT, Visit: https://mat-decisions-in-recovery.samhsa.gov/Default.aspx

Buprenorphine/Naloxone for Opioid Use Disorder

People use medications to help manage many health problems such as diabetes, cigarette smoking, or high cholesterol. Medications can help people get started while they make the lifestyle changes necessary for long-term recovery.

Medications for opioid use disorder can decrease cravings or withdrawal symptoms and reduce the stress of extreme highs and lows. Overall, the evidence shows that medication assisted treatment (MAR) helps people overcome opioid use disorder and sustain recovery, and people struggling with opioid use disorder are often more successful with MAR than non-medication alternatives. However, some people do recover from opioid use disorder without medications.

Medication Information

Opioid medicines are used for three purposes: pain relief, severe coughing, and for the treatment of addiction to opioid drugs (heroin, prescription pain medicines). Buprenorphine is an opioid medication which has been used as an injection for treatment of pain while patients are hospitalized, for example for patients who have had recent surgery. It is a long acting medication and binds for a long time to the mu opioid receptor.

Buprenorphine/naloxone is a combination medication that can be used to treat opioid dependence (addiction). Patients only need to take the medication once daily. Buprenorphine is not absorbed very well orally (by swallowing) - so a sublingual (dissolve under the tongue) tablet or film containing the medicine that is also absorbed from under the tongue, has been developed for treatment of addiction. Buprenorphine/naloxone tablets also contain naloxone (Narcan) which is an opioid antagonist. Naloxone is poorly absorbed from under the tongue, but if the medication is injected, the naloxone will cause withdrawal symptoms. The reason that naloxone is combined with the buprenorphine is to help discourage abuse of this drug by injection.

Aside from being mixed with naloxone to discourage needle use, buprenorphine itself has a "ceiling" for narcotic effects (it is termed a "partial agonist") which makes it safer in case of overdose. This means that by itself, even in large doses, it doesn't suppress breathing to the point of death in the same way that heroin, methadone and other opioids could. These are some of the unusual qualities of this medication which make it safer to use outside of the usual strict methadone regulations at a clinic and, after stabilization, most patients would be able to take home up to one to four weeks' worth of buprenorphine/naloxone at a time.

However, this medicine can be dangerous and life-threatening overdose and death have occurred when buprenorphine is mixed with other drugs. It is important not to take street drugs with this medicine, not to drink alcohol to excess, and to tell your doctor that you are taking this drug so that they can be careful about prescribing other medicines with buprenorphine that might have an interaction that could be dangerous. It is up to you to make sure that you inform anyone who is prescribing medication for you of your addiction to opioids and your use of buprenorphine. Buprenorphine is also dangerous for children.

It is very important that you keep this medication safely away from any children as life-threatening overdoses have occurred when children take this medicine.

Follow-up with your healthcare provider

Your substance use treatment provider can talk you through the different options available to you, discuss the potential benefits and drawbacks of each, and help schedule an appointment if you decide MAR is right for you. The treatment team can also assist you in accessing non-MAR treatment or help you to identify and access other non-treatment resources and social services that you might benefit from.

For more information on MAR, Visit: https://MAR-decisions-in-recovery.samhsa.gov/Default.aspx

1.15.2020

Which medication for opioid use disorder is right for me?

These medications are proven to lead to better recovery outcomes than other types of treatment.

	Methadone	Buprenorphine (Suboxone®)	Naltrexone (Vivitrol®)
What you'll feel	You will have less intense withdrawal symptoms and your cravings will improve.	You will have less intense withdrawal symptoms and your cravings will improve.	You will not feel the effects of opioids or feel high. You might also have reduced cravings for opioids.
What you'll take	Methadone is a liquid that you drink.	Buprenorphine often comes in a film called Suboxone® that dissolves in your mouth. You can take home a 1–30 day supply. Pills, 30-day injections, and implants are less common.	Vivitrol® is injectible naltrexone that lasts for 28 days.
When you'll take it	You can start methadone at any time after you are enrolled in services at a methadone clinic, if you are physically able.	You need to feel withdrawal before starting, which depends on your personal opioid use.	You have to be completely off of all opioids for 7–10 days before you can get this injection.
Where you'll go to get it	Go to a dedicated clinic every day for a dose until you are eligible for take-home doses.	Bring your prescription to a pharmacy after visiting a certified clinician.	Visit any clinician who will write a prescription and provide the injection.
Steps you'll take	**1.** You schedule an intake appointment at a methadone clinic. **2.** During the appointment, you will be evaluated and agree on a treatment plan. **3.** You are most likely started on methadone that day or the next if the clinician feels it is appropriate.	**1.** You schedule an appointment at a clinic or health center. **2.** You are evaluated and prescribed buprenorphine. **3.** You may pick up your buprenorphine from a pharmacy as soon as your appointment is done.	**1.** After you stop using opioids, wait 7–10 days. **2.** You return to a clinician for the injection. **3.** A health-care worker will follow up about symptoms and another injection every 28 days.
More information	74–80% of people stay in treatment after 1 year.* This medication has been shown to reduce risk of overdose and death. The daily commitment provides a high level of accountability. Risk of overdose is high if you use other opioids or depressants with methadone. Counseling is required.	60–90% of people stay in treatment after 1 year.* This medication has been shown to reduce risk of overdose and death. Comes in different flavors, but choice might be limited by your insurance. Counseling is recommended.	10–21% of people stay in treatment after 1 year.* This medication has *not* been shown to reduce risk of overdose or death. If you miss an injection, your risk of overdose increases greatly.

*California Health Care Foundation. *Why health plans should go to the MAT in the fight against opioid addiction.*

Jarvis et al. Addiction. 2018;113(7):1188-1209

Issues you should discuss with your provider

- Your questions about outpatient detox, withdrawal symptoms, and discomfort.
- Your prior experiences with medications for opioid use disorder treatment.
- Possible interferences with treatment like employment, transportation, or child care.
- Access to the medicine that reverses opioid overdose: naloxone/Narcan® You could use it to save someone else's life, or someone could use it to save yours.

UI Health | UIC | UIC Center for Dissemination and Implementation Science | UIC Community Outreach Intervention Projects

COMMUNITY PARTNERSHIPS ACTION PLAN TOOL

Community Partnerships Action Plan

Organizations within My Network	
Organization	**Contact Person**

Organizations to Outreach	
Organization	**Contact Person**

Information to Collect	
Organization	**Resources (e.g. transportation, how to apply for housing and benefits)**

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

Sponsored by the Florida Alcohol & Drug Abuse Association and the State of Florida, Department of Children and Families

FADAA
FLORIDA ALCOHOL & DRUG ABUSE ASSOCIATION

RECOVERY SUPPORT SPECIALISTS: SUGGESTIONS FROM MENTAL HEALTH RECOVERY SUPPORT SPECIALISTS

Job Titles

The Certified Peer Recovery Specialist (CPRS) credential is for individuals with personal, lived experience in their own recovery from substance abuse issues or experience as a family member or loved one. CPRS are professionals trained to incorporate their lived experience of recovery with a distinct knowledge base and human service skills. The knowledge and skill base may be acquired through a combination of specialized training, education and supervised work experiences. CPRS professionals help consumers to address their physical, intellectual, emotional, social and spiritual needs to facilitate and maintain wellness throughout the behavioral health recovery process. They provide experience, education and professional services to assist and support individuals in developing and/or maintaining recovery-oriented, wellness-focused lifestyles. In addition, CPRS professionals refer clients to appropriate recovery supports and treatment services. See the Illinois Alcohol and Other Drug Abuse Professional Certification Association website for more information on the CPRS credential: *http://www.iaodapca.org/credentialing/certified-peer-recovery-specialist-cprs/*

Certified Recovery Support Specialists (CRSS) are often used in OUD treatment to help connect people to recovery support services. Increasingly, these staff may be peers: people who have lived experience of OUD/SUD. In mental health treatment, the Recovery Support Specialist position reflects the actual services offered. The Illinois Department of Human Services/Division of Mental Health Services (IDHS/DMH) has long discouraged the use of the term “peer” in job titles; the word “peer” in a job title is a form of involuntary self-disclosure that could potentially hurts an individual’s future career development, i.e., if a person is in a future job interview and is asked what it means to be a Peer Recovery Specialist and what they are a “peer” of.

In mental health, CRSS is the certification for persons with lived mental health experiences that have moved forward to become employed in the field. If the titles are the same for persons employed in both mental health and OUD with lived experience, this could cause confusion on who is qualified to work with specific populations. In a perfect scenario, those offering recovery support could potentially be cross trained to work with both populations.

Job Descriptions

Job descriptions can only be defined through core competencies. Employers should consider tasks Recovery Support Specialists will need to perform and the skills needed to carry out those tasks. The Illinois Certification Boards CRSS Model offers guidance on core competencies, such as Recovery Support, Mentoring, Advocacy, Professional Responsibility, and Ethics: *http://www.iaodapca.org/credentialing/recovery-support-specialist/*

Language

Person-first language decreases labeling and stigma. Mental health professionals refer to the person first, not the disorder: “person with schizophrenia” not “schizophrenia”. In substance use treatment, there is an increasing move away from referring to people who misuse drugs and/or are in recovery as “addicts”. Instead, refer to the individual as a person who use drugs, or a person in recovery from OUD. Referring to the person first puts the focus on the person, not their mental health and/or substance use disorder.

Self-care

The importance of self-care for Recovery Support Specialists cannot be overstated. To effectively care for others, Recovery Support Specialists need to take care of themselves. This includes paying attention to work-related stressors that, if ignored, might trigger a relapse. Recovery Support Specialists should be encouraged to attend their own personal support groups and other activities they may engage in to prevent relapse.

Wellness Recovery Action Plan (WRAP®) is an evidence-based program demonstrated to promote well-being among people who experience chronic health disorders, including mental health, substance use, and physical health challenges. Recovery Support Specialists can use WRAP to monitor and support their self-care. They also can use WRAP in their work with clients. For example, WRAP might be used as:

- An effective tool for organizing one's journey through the 12-Step programs
- An effective tool for monitoring and coping with one's mental health and/or physical health challenges
- Foster a lifestyle helps improve activities of daily living
- Help develop an expanded peer support system

WRAP is available throughout Illinois as a class/group option for those involved in mental health and substance abuse courts programs. To find a WRAP program in Illinois go to: *http://www.illinoismentalhealthcollaborative.com/wrap/search.action*

Nutrition Exercise and Work for Recovery (NEW-R) and Whole Health Action Management (WHAM) are also evidence-based programs can also assist in the Recovery Specialist personal wellness.

Self-Disclosure

How organizations approach peer providers' self-disclosure is a vital component to recovery support, as this is when the first impression is often made. Persons newer in recovery may tend to overshare or as they are listening to a person, try to "one-up" them. To address this, IDHS/DMH uses an outline from WRAP called Brief Compelling Personal Introduction (BCPI) that assist Recovery Specialists in having a good balance of "what it was like, what happened, and what it is like now".

Ongoing Support and Learning Collaboratives

It can be difficult for individuals entering the field of Recovery Support to feel that they fit in. Those receiving services will see the Recovery Specialist as staff, while the clinical staff will tend to see the individuals as clients themselves. Regional and statewide support systems can be very helpful. Recovery Support Specialist-only learning collaboratives can help reduce feelings of isolation and assist in problem solving. IDHS/DMH's Recovery Services Development Group (RSDG) has developed and delivered many training modules. RSDG has been delivering these modules to over 300 individuals a year in Mount Vernon, Springfield, and Chicago.

Examples of RSDG Training Modules

- Self-Disclosure/ Brief Compelling Personal Introduction
- Sharing Your Story Effectively
- Peer vs Hierarchical Relationships
- Active Listening
- Person-Centered Language

- Maintaining high standards of personal conduct
- Focusing on Strengths
- Assessing Your Circle of Support
- Layers of Support
- Boundaries
- Managing Complex Relationships
- Consumers in the Driver's Seat
- Ethical Decision Making
- Role Modeling
- Social Learning
- Suicide Prevention
- Motivational Interviewing
- Listening for Individual Differences & Cultural Diversities
- Cultural Humility
- Effective vs Ineffective Listening
- Stages of Change
- Individual Choice & Self-Determination
- Advocating for Mental Health and Substance Abuse Service Integration
- Using a Decision MARrix for Prioritizing Our Work (Covey)
- Taking Care of Ourselves while Supporting Others
- Trauma Informed Care
- Person-Driven Recovery
- Wellness-Focused Approach to Recovery
- Non-Judgmental Behavior
- Advocacy on a Treatment Team
- 3 Steps in Advocacy
- Serving as Agents of Cultural Change
- Motivating and Supporting Others to Find Their Own Direction
- Key Aspects of the Supervisory Relationship
- Closing the Power Gap
- Resolving Conflict in the Workplace

EXAMPLE PEER SUPPORT SPECIALIST JOB DESCRIPTION

EDUCATION AND EXPERIENCE:

A minimum of a high school diploma or GED with some formal or informal experience in behavioral healthcare and/or community relations arena is preferred. Past or present consumer of substance abuse services with a history of managing one's own illness. Awareness of the importance of recovery in living with an addiction problem. Past experience working directly with people in a service-oriented field is beneficial. Active membership in a consumer advocacy or self-help group.

CERTIFICATES, LICENSES, REGISTRATIONS:

Possess and maintain a valid Illinois Driver's License.

REPORTS TO: VP or Designated Program Leader

ESSENTIAL DUTIES AND RESPONSIBILITES: The Peer Support Specialist, informed by his/her positive lived recovery experience, will work closely with clients with substance abuse problems to enhance their recovery. This peer support service will be provided to individuals and groups.

1. To provide individualized, ongoing guidance, coaching and support.
2. To provide training in the use of personal and community resources.
3. Assist in developing formal and informal community supports.
4. Assist the person served increasing social support networks of relatives, friends and/or significant others.
5. To offer encouragement in times of crisis and stress to eliminate potential barriers to one's ongoing recovery.
6. To advocate on behalf of persons with behavioral health problems to protect the client's rights and to assist in reducing associated stigma.
7. To participate in required staff meetings, supervisions and needed trainings as deemed by Clinical Program Manager.
8. To clearly and accurately document individual and group peer support activities.
9. To perform other related duties as assigned.

Other Duties: Performs tasks which are supportive in nature to the essential functions of the job, but may be altered or redesigned depending upon individual circumstances.

Standard Requirements:

- Possesses a working knowledge of FGC applicable Standard Operating Procedures (SOP).
- Knowledgeable of patient rights and ensures an atmosphere which allows for the privacy, dignity, and well-being of all patients in a safe, secure environment.
- Attend in-service and other training events to continue education and expand knowledge to improve the quality of patient services.
- Ability to follow written and oral instructions and procedures.

Skills:

- Active reflective listening, ability to engage and motivate, de-escalation.
- Strong verbal and written communication skills.
- Ability to use analytical software.
- Ability to use calendar and scheduling software.
- Experience using desktop computers, copier, and fax machine.
- Experience using electronic mail software.
- Must have strong collaboration skills and the ability to work and travel to multiple sites in the course of each week if required. Leadership skills are necessary to ensure program development.

Physical Demands:

- The physical demands described are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.
- Ability to communicate in English via phone, in writing, and verbally in conversation with different levels of staff patient families, and any outside patients.
- While performing the duties of this job, the employee is frequently required to stand and walk, often up and down stairs. Must be able to lift 25 pounds. The employee is frequently required to sit; use hands or fingers, handle, or feel; reach with hands and arms, and talk or hear. Specific vision abilities required by this job include close vision and ability to adjust focus. Employee must

be able to utilize a computer, phone, etc. for extended period of time and write or type notes for at least two (2) to four (4) hours per day.

- While performing the duties of this job, the employee may be occasionally exposed to blood or other body fluids. The noise level in the work environment is usually moderate.
- Ability to travel to multiple program sites; is flexible with time and travel; and has a current Illinois Driver's License and automobile insurance coverage. If required, must provide copies of driver's license and proof of insurance to Human Resources.

Schedule: Regular: 8:30am-5:00pm M-F and rotating Saturdays 6am-2pm. (Hours may vary based on program and caseload needs.)

Job Description Review: I understand the job description, its requirements, and that I am expected to complete all duties as assigned. I understand that job duties may be altered from these duties. I will support the Mission, Values, and Vision of Family Guidance Centers and the facility.

_____ _____

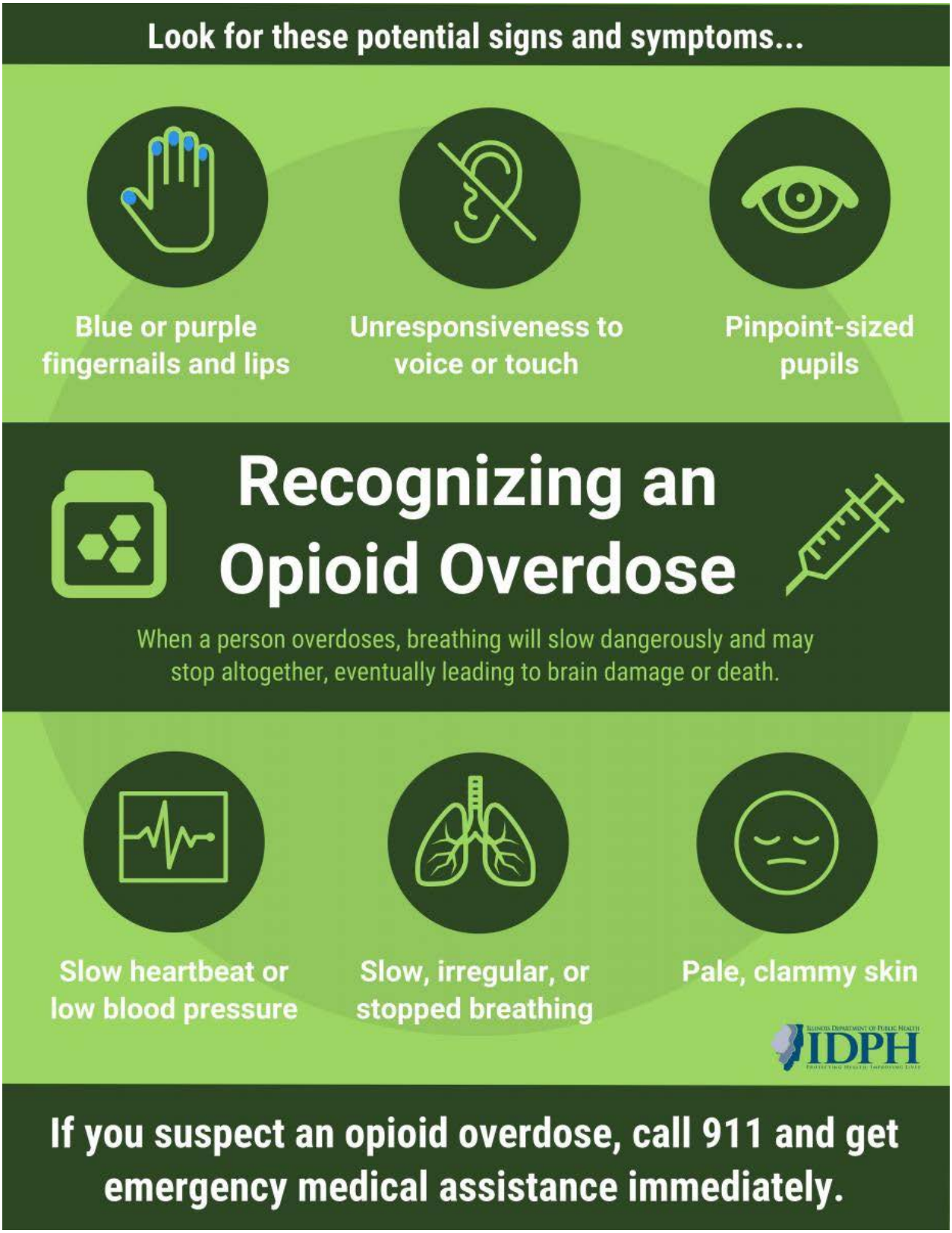
Employee (please print) Employee's Signature Date

_____ _____

Manager (please print) Manager's Signature Date

COMMUNITY EDUCATION RESOURCES

Recognizing OUD flyer



ONLINE RESOURCE LIBRARY

***Note**: In addition to the resources provided on this page, we recommend perusing the resource lists provided below:*

AHRQ—*clinical tools and resource library for providers and patients*
https://integrationacademy.ahrq.gov/sites/default/files/2020-06/mat-oud-environmentalscanvolume-2_revised.pdf

FADAA—*training for providers and community workers*
https://www.fadaa.org/page/Training_Library

PCSS—*clinical tools and resources for providers and patients*
https://pcssnow.org/resources/

Resources for providers

Treatment Support

- Illinois Helpline for Opioids and Other Substances (Helpline**)** is a statewide multi-lingual 24-hour, 7-day/week, 365 day/year helpline providing treatment referral and informational support services for individuals in Illinois suffering from OUD and substance use disorders (SUD) as well as their supporters.
  Phone: 833-2FINDHELP
  Website: *HelplineIL.org*

MAR Service Provision Guidebooks

- ASAM's Utilization Management for Medications for Addiction Treatment Toolkit
  https://30qkon2g8eif8wrj03zeh041-wpengine.netdna-ssl.com/wp-content/uploads/2020/08/Toolkit-080420.pdf

Decisions in recovery :
https://MAT-decisions-in-recovery.samhsa.gov/section/footer/online_resources.aspx

- SAMHA's MAR for Opioid Use Disorders Pocket Guide:
  https://store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-Pocket-Guide/SMA15-4907POCKETGUID
- MAR for Opioid Addiction – a Phased Approach Guide:
  https://www.quantumunitsed.com/get-material.php?id=644
- Federal guide for OTPs:
  https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP
- SUMMIT: Procedures for MAR of Alcohol or Opioid Dependence in Primary Care.
  Contains several provider guides, patient checklists, and handounts:
  https://www.rand.org/pubs/tools/TL148-1.html

- Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings: *https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/opioid-use-disorder_technical-brief.pdf*

Prevention Resources

- Minimizing the Misuse of Prescription Opioids in Patients with Chronic Nonmaligant Pain guidebook: *https://www.drugabuse.gov/sites/default/files/minimizingmisuse_part1.pdf*
- SAMHSA's opioid overdose prevention toolkit*:* *https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-4742*

Treating Special Populations

- Toolkit for adapting your practice to meet the needs of homeless client: *https://nhchc.org/wp-content/uploads/2019/08/hch-opioid-use-disorders_adapting-your-practice-final-to-post.pdf*
- Implementing Medication-Assisted Treatment for Opioid Use Disorder in Rural Primary Care – Environmental Scan by AHRQ: *https://integrationacademy.ahrq.gov/sites/default/files/2020-06/mat_for_oud_environmental_scan_volume_1_1.pdf*
- TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders *https://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671*
- PCSS Guidance for Pregnancy and Buprenorphine Treatment: *https://pcssnow.org/wp-content/uploads/2014/06/PCSS-MATGuidancePregnancy-and-Buprenorphine.Martin.pdf*

Community and Patient Engagement

- MAR for the 21st century community education kit: *https://files.eric.ed.gov/fulltext/ED478679.pdf*
- Using community outreach strategies to increase engagement (powerpoint): *https://cdn.ymaws.com/www.fadaa.org/resource/resmgr/files/resource_center/FADAA_Community_Outreach_Str.pdf*
- Substance Use Disorders: a Guide to the Use of Language: *http://www.naabt.org/documents/Languageofaddictionmedicine.pdf*
- Coalition resources from the Illinois Department of Human Services: *http://www.dhs.state.il.us/page.aspx?item=106179*

Billing Guidelines

- Medicaid coverage and financing of Medication to treat alcohol and opioid use disorders. *https://store.samhsa.gov/product/Medicaid-Coverage-and-Financing-of-Medications-to-Treat-Alcohol-and-Opioid-Use-Disorders/sma14-4854*
- Illinois Transportation Billing Guidelines for Managed Care Processing and Payment *https://www.molinahealthcare.com/providers/il/PDF/Medicaid/transportation-guide-july-30-18.pdf*

Resources for Patients

Treatment Support

- Illinois Helpline for Opioids and Other Substances (Helpline) is a statewide multi-lingual 24-hour, 7-day/week, 365 day/year helpline providing treatment referral and informational support services for individuals in Illinois suffering from OUD and substance use disorders (SUD) as well as their supporters.
  Phone: 833-2FINDHELP
  Website: *HelplineIL.org*

Education

- What is buprenorphine treatment like?
  http://naabt.org/education/what_bt_like.cfm

Recovery Support

- Decisions in Recovery website
  https://MAT-decisions-in-recovery.samhsa.gov/Default.aspx

Insurance Tools

- Your insurance rights: Mental Health and Substance Use Disorder Services
  http://parityat10.org/wp-content/uploads/2019/03/IL-FINAL-TOOLKIT.pdf
- Accessing Care and Treatment: Consumer Toolkit for Navigating Behavioral Health and Substance Use Disorder Care Through Your Health Insurance Plan
  https://2drbqn37bylzjbtx93fd7n7l-wpengine.netdna-ssl.com/wp-content/uploads/sites/32/2016/04/DOI_IL-Toolkit_Final-4-18-16-002.pdf

Legal Support

- Know Your Rights: Rights for Individuals on Medication Assissted Treament
  https://store.samhsa.gov/product/Know-Your-Rights-Parity-for-Mental-Health-and-Substance-Use-Disorder-Benefits/SMA16-4971
- MAR Advocacy Toolkit
  https://lac.org/MAT-advocacy/

Naloxone / Narcan Information

- Your brain on opioids (National Geographic):
  https://youtu.be/NDVV_M__CSI
- Naloxone Training Video (Chicago Recovery Alliance):
  https://youtu.be/3epkpT-V6c0
- *Naloxone Administration Video:*
  https://youtu.be/tGdUFMrCRh4

Resources for Pharmacists

Forms and Documentation

- Example Naloxone consent form: *https://www.ihs.gov/odm/includes/themes/newihstheme/display_objects/documents/IHS-Pharmacist-Prescribed-Naloxone-Rescue-Kit-Consent-Form.pdf*
- Naloxone Toolkit – What Pharmacists Need to Know! *https://www.papharmacists.com/page/Naloxone*

Resources for Policymakers, State, and Local Officials

Checklists and Planners

- SAMHSA provides a helpful MAR implementation checklist to aid policymakers in developing and implementing MAR programs in their communities. *https://tbhcoe.matrc.org/wp-content/uploads/2019/12/MAT-Implementation-Checklist-FINAL.pdf?9d4e56&9d4e56*

LIST OF ACRONYMS

ACOG	American College of Obstetricians and Gynecologists
ADA	Americans with Disabilities Act
AHRQ	Agency for Healthcare Research and Quality
A-MAR	Access to Medication Assisted Recovery
ASAM	American Society of Addiction Medicine
CARF	Commission on Accreditation of Rehabilitative Facilities
CDC	Centers for Disease Control and Prevention
CPRS	Certified Peer Recovery Specialist
CRSS	Certified Recovery Support Specialist
CSAT	SAMHSA Center for Substance Abuse Treatment
DATA 2000	Drug Addiction Treatment Act of 2000
DEA	Drug Enforcement Administration
FADAA	Florida Alcohol and Drug Abuse Association
FDA	U.S. Food and Drug Administration
FQHC	Federally Qualified Health Center
IDHS	Illinois Department of Human Services
IDHS/DMH	Illinois Department of Human Services/Division of Mental Health
IDHS/SUPR	Illinois Department of Human Services/Division of Substance Use Prevention and Recovery
IDPH	Illinois Department of Public Health
DOPP	Drug Overdose Prevention Program
MAR	Medication Assisted Recovery
MCO	Managed Care Organization
MOUD	Medications for Opioid Use Disorder
NAS	Neonatal Abstinence Syndrome
NIH	National Institutes of Health
OEND	Overdose Education and Naloxone Distribution
OUD	Opioid Use Disorder
OTP	Opioid Treatment Provider
PCSS	Providers Clinical Support System
RSS	Recovery Support Specialist
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SOR	State Opioid Response
STR	State Targeted Response (to the opioid crisis)
SUD	Substance Use Disorder
UIC	University of Illinois at Chicago
ROSC	Recovery Oriented Systems of Care
WHO	World Health Organization
WRAP	Wellness Recovery Action Plan