About This Manual

Welcome to the intervention manual for the Collaboration Leading to Addiction Treatment and Recovery from Other Stresses (CLARO) research study, implemented at First Choice Community Healthcare, Hidalgo Medical System, and University of New Mexico Southeast Heights, Southwest Mesa, North Valley, and South Valley Clinics in New Mexico; as well as Providence St. John’s Primary Care, Bell Health Center, Mid-Valley Comprehensive Health Center, and Hubert Humphrey Comprehensive Health Center in California. The CLARO intervention advances a collaborative care model of primary care–centered treatment for patients who have co-occurring opioid use disorder (OUD) with major depressive disorder and/or post-traumatic stress disorder. Through this intervention, clinical members of the collaborative care team—primary care providers, behavioral health providers, and behavioral health consultants—will work closely with a care coordinator to manage the patient’s overall care and ensure that they get high-quality, effective, and patient-centered care. By offering concurrent treatment for both OUD and mental illness, the CLARO intervention aims to improve patient outcomes for this vulnerable and underserved population.

This manual may be useful for researchers and practitioners interested in implementing the CLARO intervention. The introduction provides a general overview of the CLARO study; the remainder of the manual presents the step-by-step instructional format for members of the care team involved in the CLARO intervention. A companion CLARO Implementation Manual describes the implementation process and the supports used to bring the CLARO intervention to primary care clinics.

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RAND Health Care Communications
1776 Main Street
P.O. Box 2138
Santa Monica, CA 90407-2138
(310) 393-0411, ext. 7775
RAND_Health-Care@rand.org
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# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABOUT THIS MANUAL</td>
<td>III</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>V</td>
</tr>
<tr>
<td>ABBREVIATIONS</td>
<td>XI</td>
</tr>
<tr>
<td>CHAPTER 1: INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>CLARO Study Overview</td>
<td>2</td>
</tr>
<tr>
<td>Principles of Collaborative Care</td>
<td>3</td>
</tr>
<tr>
<td>Team Roles in the CLARO Intervention</td>
<td>4</td>
</tr>
<tr>
<td>Figure 1.1: The CLARO Care Team</td>
<td>4</td>
</tr>
<tr>
<td>Care Coordinators</td>
<td>4</td>
</tr>
<tr>
<td>Clinicians</td>
<td>5</td>
</tr>
<tr>
<td>Additional Care Team Members</td>
<td>6</td>
</tr>
<tr>
<td>Additional Clinic Staff</td>
<td>6</td>
</tr>
<tr>
<td>Special Considerations for the CLARO Care Team</td>
<td>7</td>
</tr>
<tr>
<td>Stigma</td>
<td>7</td>
</tr>
<tr>
<td>Trauma-Informed Approach</td>
<td>7</td>
</tr>
<tr>
<td>Family Systems</td>
<td>9</td>
</tr>
<tr>
<td>Patient Perspectives</td>
<td>10</td>
</tr>
<tr>
<td>Chapter 1 Sources</td>
<td>11</td>
</tr>
<tr>
<td>CHAPTER 2: COLLABORATIVE CARE</td>
<td>12</td>
</tr>
<tr>
<td>Overview of the Care Coordinator Role</td>
<td>13</td>
</tr>
<tr>
<td>Care Coordinator Workflow</td>
<td>14</td>
</tr>
<tr>
<td>Figure 2.1: Workflow Overview for Care Coordinators</td>
<td>14</td>
</tr>
<tr>
<td>Visit Frequency</td>
<td>15</td>
</tr>
<tr>
<td>Figure 2.2: Recommended Schedule for Patient Visits</td>
<td>15</td>
</tr>
<tr>
<td>Measurement-Based Care</td>
<td>16</td>
</tr>
<tr>
<td>Table 2.1: Summary of MBC Tools used in CLARO</td>
<td>18</td>
</tr>
<tr>
<td>Registry</td>
<td>18</td>
</tr>
</tbody>
</table>
Considerations for PCPs ........................................................................................................ 57
Integrated Treatment Considerations ................................................................................ 58
Quick Start Guides ........................................................................................................... 60
   Table 3.1: Quick Start Guide 1: OUD Treatment ......................................................... 60
   Table 3.2: Quick Start Guide 2: MDD and PTSD Treatment ....................................... 61
   Table 3.3: OUD TREATMENT Quick Start Guide 3: Prescribing Considerations ..... 62
Opioid Use Disorder Diagnosis ......................................................................................... 65
MDD and PTSD Diagnosis ............................................................................................... 70
Setting Up Treatment Plans ............................................................................................. 72
   Table 3.4: Summary of Treatment Options ................................................................. 73
Common Comorbidities ................................................................................................... 74
   Table 3.5: Common Symptoms and Conditions Among Patients with OUD and Co-Occurring MDD and/or PTSD .......................................................... 74
Additional Support ......................................................................................................... 76
   Other Resources ........................................................................................................... 76
In Closing ......................................................................................................................... 77
Chapter 3 Sources .......................................................................................................... 78

CHAPTER 4: PSYCHOTHERAPY FOR DEPRESSION AND POSTTRAUMATIC STRESS DISORDER ...................................................................................................... 79
Overview of the Behavioral Health Provider Role ........................................................... 80
Collaborative Care Workflow .......................................................................................... 80
   Figure 4.1: Workflow for BHPs and CCs in CLARO .................................................... 81
Treatment Considerations for Behavioral Health Providers ................................................ 82
Training ............................................................................................................................ 84
Chapter 4 Sources .......................................................................................................... 86

CHAPTER 5: CARE COORDINATOR SUPPORT TEAM ................................................... 87
Overview of the Behavioral Health Consultant, Care Coordinator Supervisor, and Care Coordinator Consultant Roles .............................................................................. 88
   Figure 5.1: Workflow for Communication Exchange Among CC, CC Support Team, and Care Team .......................................................... 88
BHC Workflow ................................................................................................................. 89
Qualifications .................................................................................................................. 91
Training ................................................................................................................................. 92
   ECHO in CLARO ............................................................................................................ 92
Care Coordinator Supervisor Workflow ................................................................................ 93
Care Coordinator Consultant Workflow ................................................................................ 94
   Qualifications .................................................................................................................. 94
Chapter 5 Sources ................................................................................................................ 95

CHAPTER 6: REGISTRY ..................................................................................................... 96

Overview ............................................................................................................................... 97
Care Coordinator Workflow ................................................................................................... 98
   Figure 6.1: Caseload List Page ................................................................................... 98
   Table 6.1: Quick Start Guide 1: Daily Registry Tasks ................................................. 98
Starting the Day .................................................................................................................... 101
   Figure 6.2: Reminders Page ......................................................................................... 101
   Figure 6.3: Referrals ..................................................................................................... 102
   Figure 6.4: Scheduling Module .................................................................................... 103
   Figure 6.5: Contact Attempt Form .............................................................................. 104
   Figure 6.6: MOUD Encounter Note ............................................................................ 106
   Table 6.2: BHP Documentation Options ................................................................... 106
   Figure 6.7: BHP Contact Form ................................................................................... 107
   Figure 6.8: Actions Step For Group Therapy (Scenario 1) ........................................ 107
   Figure 6.9: Behavioral Health Consultation Note ....................................................... 109
   Table 6.3: Quick Start Guide 2: Documenting Patient Visits with the CC ................. 110
Preparing for Patient Visits ............................................................................................... 111
   Figure 6.10: Contact Note ......................................................................................... 112
   Figure 6.11: Autosaved Notes—Reminders Page ..................................................... 113
During Patient Visits .......................................................................................................... 113
   Figure 6.12: MBC Section of Contact Note ............................................................... 114
   Figure 6.13: Medication Section of Care Coordinator Encounter .............................. 115
   Table 6.4: Score Change Guidelines ........................................................................ 118
   Figure 6.14: Social Determinants of Health Section of Contact Note ....................... 119
## Abbreviations

<table>
<thead>
<tr>
<th>ABBREVIATION</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIMS Center</td>
<td>Advancing Integrated Mental Health Solutions Center, University of Washington</td>
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<tr>
<td>BHC</td>
<td>behavioral health consultant</td>
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<tr>
<td>BHP</td>
<td>behavioral health provider</td>
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<tr>
<td>BID</td>
<td>twice daily</td>
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<tr>
<td>CBC</td>
<td>complete blood count</td>
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<tr>
<td>CC</td>
<td>care coordinator</td>
</tr>
<tr>
<td>CIDI-3</td>
<td>Compositite International Diagnostic Interview, version 3</td>
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<tr>
<td>CLARO</td>
<td>Collaboration Leading to Addiction Treatment and Recovery from Other Stresses</td>
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<tr>
<td>CMP</td>
<td>complete metabolic panel</td>
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<tr>
<td>CMTS</td>
<td>Care Management Tracking System</td>
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<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
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<tr>
<td>ECHO</td>
<td>Extension for Community Healthcare Outcomes</td>
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<tr>
<td>EHR</td>
<td>electronic health record</td>
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<tr>
<td>FQHC</td>
<td>federally qualified health center</td>
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<tr>
<td>ISI</td>
<td>Insomnia Severity Index</td>
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<tr>
<td>LAI</td>
<td>long-acting injection</td>
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<tr>
<td>MAT</td>
<td>medication-assisted treatment</td>
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<td>MBC</td>
<td>measurement-based care</td>
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<td>MDD</td>
<td>major depressive disorder</td>
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<tr>
<td>MI</td>
<td>motivational interviewing</td>
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<td>MOUD</td>
<td>medication for opioid use disorder</td>
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<tr>
<td>NM-ASSIST</td>
<td>National Institute on Drug Abuse Modified Alcohol, Smoking, and Substance Involvement Screening Test</td>
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<tr>
<td>OUD</td>
<td>opioid use disorder</td>
</tr>
<tr>
<td>OUD-5</td>
<td>Opioid Use Disorder-5 Questions</td>
</tr>
<tr>
<td>PCL-5</td>
<td>PTSD Checklist for DSM-5</td>
</tr>
<tr>
<td>PCP</td>
<td>primary care provider</td>
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<tr>
<td>PEG</td>
<td>Pain, Enjoyment of Life and General Activity</td>
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<tr>
<td>PHQ-9</td>
<td>Patient Health Questionnaire-9</td>
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<tr>
<td>PMP</td>
<td>prescription monitoring report</td>
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<tr>
<td>ABBREVIATION</td>
<td>DEFINITION</td>
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<tr>
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</tr>
<tr>
<td>PRN</td>
<td>when needed</td>
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<tr>
<td>PROMIS-7</td>
<td>Patient-Reported Outcomes Measurement Information System-7</td>
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<tr>
<td>PST</td>
<td>Problem-Solving Treatment</td>
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<tr>
<td>PTSD</td>
<td>posttraumatic stress disorder</td>
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<tr>
<td>QID</td>
<td>four times daily</td>
</tr>
<tr>
<td>QHS</td>
<td>every bedtime</td>
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<tr>
<td>RPR</td>
<td>rapid plasma reagin</td>
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<tr>
<td>SAMHSA TIP</td>
<td>Substance Abuse and Mental Health Services Administration Treatment Improvement Protocol</td>
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<tr>
<td>SSRI/SNRI</td>
<td>selective serotonin reuptake inhibitor/serotonin and norepinephrine reuptake inhibitor</td>
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<tr>
<td>SUD</td>
<td>substance use disorder</td>
</tr>
<tr>
<td>TAPS</td>
<td>Tobacco, Alcohol, Prescription medications, and other Substance use</td>
</tr>
<tr>
<td>TID</td>
<td>three times daily</td>
</tr>
<tr>
<td>UNM</td>
<td>University of New Mexico</td>
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<tr>
<td>UW</td>
<td>University of Washington</td>
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<tr>
<td>WET</td>
<td>Written Exposure Therapy</td>
</tr>
</tbody>
</table>
CHAPTER 1

Introduction

This chapter provides background information on the Collaboration Leading to Addiction Treatment and Recovery from Other Stresses (CLARO) research study, reviews the principles of collaborative care, and summarizes the roles of the members of the CLARO intervention care team. It also offers things for the care team to consider when working with patients with co-occurring opioid use disorder (OUD) with major depressive disorder (MDD) and/or posttraumatic stress disorder (PTSD).
CLARO Study Overview

CLARO is a research study that uses a collaborative care intervention to help medical and behavioral health providers in a primary care setting identify and support patients who have co-occurring OUD with MDD and/or PTSD. A care coordinator (CC) anchors each CLARO collaborative care team; they are the key point of contact with the patient, keeping the patient engaged in their care, routinely measuring the impact of treatment on their symptoms, and helping to identify and address any social needs that could be treatment barriers. At the same time, the CC serves a critical function on the care team, facilitating communication about the patient’s progress and maintaining linkages between others on the team to optimize the patient’s response to treatment.

The CLARO study will be conducted at federally qualified health centers (FQHCs). Patients will be screened for study eligibility and then randomly assigned to either the CLARO intervention or enhanced usual care. If assigned to the CLARO intervention, patients will be assigned a CC who will regularly meet with the patient. In addition, the CLARO study supports enhanced usual care by providing training in evidence-based treatments, including medication for OUD, pharmacotherapy for MDD and/or PTSD, and therapies such as Problem-Solving Treatment (PST) for MDD and Written Exposure Therapy (WET) for PTSD. Thus, patients in enhanced usual care may also receive these treatments but will not receive services from a CC. Primary care providers and behavioral health providers at each of the 13 participating FQHCs will be trained in each of these evidence-based treatments, allowing them to offer these treatments to patients in their clinic regardless of study participation.

Funded by the National Institute of Mental Health (NIMH), the CLARO study will run for five years (2019–2024). It will be conducted jointly by the RAND Corporation, University of New Mexico (UNM) Health Sciences Center, and Boston Medical Center, in collaboration with FQHCs in California and New Mexico.
Collaborative care is an integrative, team-based approach to patient care for CLARO intervention patients. The work and overall treatment philosophy of the collaborative care team are based on four core principles:

- **Patient-Centered Care**
  Primary care providers (PCPs), behavioral health providers (BHPs), and CCs collaborate with the patient to create shared treatment plans individually tailored to the patient’s specific ideas, values, preferences, and needs. Patients and providers share decisionmaking about treatment options. The CC oversees implementation of the treatment plan and works with the rest of the team to make adjustments as necessary.

- **Population-Based Care**
  The care team works together to treat a specific group of patients. In the CLARO intervention, the patient population is adults with co-occurring OUD with MDD and/or PTSD. Patient progress is tracked in a registry (see Chapter 6). Teams track and reach out to patients who are not improving or who are missing visits, and psychiatric specialists provide consultation for the population of patients enrolled in the CLARO intervention.

- **Measurement-Based Treatment to Target**
  Each patient’s treatment plan is based around achieving specific personal goals and clinical outcomes. The CC routinely measures progress toward these goals and outcomes. Treatments are adjusted if patients are not improving as expected until the patient is clinically stabilized and/or enters remission. For more information on how CLARO uses measurement-based care, see Chapter 2.

- **Evidence-Based Care**
  Patients are offered treatments with research evidence that supports their effectiveness in treating the target conditions. These treatments are further outlined in the patient “Treatment Options” handouts (Appendix D) and include pharmacotherapy for OUD, MDD, and PTSD; PST for MDD; and WET for PTSD.
Team Roles in the CLARO Intervention

The CLARO intervention uses a collaborative care approach to composing its care team. The care team includes multiple members working together to ensure the treatment needs of the patient are met and that patients are able to access resources to address their social needs.

Figure 1.1 shows the members of the care team. Shown at the center, the care coordinator (CC) is the linchpin of the care team. They are the key point of contact with the patient for the duration of the intervention (at least six months) and will help coordinate care across the primary care provider (PCP), the behavioral health provider (BHP, a therapist), and the CC Support Team, consisting of behavioral health consultant (BHC, a psychiatrist), two CC Supervisors, and a CC Consultant. While the PCP and BHP therapist are existing clinicians employed at the clinic, the CC Support Team is employed by the CLARO study as a unique source of counsel for CCs to carry out the CLARO intervention because primary care does not traditionally offer treatments for co-occurring disorders. Thus, the CC Support Team is designed to fill this resource gap.

Care Coordinators

CCs routinely monitor the patient’s symptoms and their responsiveness to treatment and feed that data back to the care team so that everyone knows whether the treatment plan needs to be adjusted. This involves scheduling and organizing treatment from
multiple providers and working with all members of the care team to ensure all stay up to date on the treatment plan and any changes required.

Chapter 2 provides extensive detail on the workflow and responsibilities of the CC, including step-by-step instructions and sample scripts, as well as numerous resources to fully empower the CC to carry out this essential role. Appendix A offers additional detail on assessments for measurement-based care.

Clinicians

Clinical members of the care team—the PCP; BHP, or therapist; and BHC, or psychiatrist—should feel confident in relying on the CC to help ensure the care provided in the intervention is patient centered and to help manage the patient’s related social needs. Each type of clinician oversees aspects of the patient’s medical (physical) and behavioral health care.

PCPs work directly with patients to manage their OUD and MDD/PTSD with medication and other supports. Chapter 3 offers detailed recommendations on medication options and comorbidity management, and Appendix B offers supplemental resources of interest to PCPs.

Team therapists—BHPs—work directly with patients who need mental health treatment. The CLARO intervention suggests that BHPs use PST for the treatment of MDD and WET for the treatment of PTSD, though they may also use their clinical judgment to choose appropriate courses of therapy suited to each patient. Chapter 4 and Appendix C offer additional recommendations and resources for these providers.

The CLARO care team also uses BHCs, who are board-certified psychiatrists with expertise in the treatment of OUD, MDD, and PTSD, to directly support the CC and provide recommendations to the rest of the care team. BHCs will work directly with CCs to review the clinical progress of patients identified as potentially needing a psychiatric consultation. On occasion, BHCs may also be part of the care team seeing patients. PCPs and BHPs may pose consultation questions for the BHCs at any time, with most interaction between these three types of providers initiated through notes in the patient’s electronic health record (EHR). Further details are available in Chapter 5.
Additional Care Team Members

As mentioned above, the BHC also heads the CC Support Team, which includes a **CC Consultant**, who is not a clinician but has expertise integrating community health workers with minimal clinical experience into care teams and addressing patients’ social needs; two **CC Supervisors** who will interface with the CCs, CLARO researchers, and clinic administration regularly; and other individuals on the CLARO team with expertise (e.g., in motivational interviewing, collaborative care, PST, and WET) who can provide additional consultation to CCs as needed.

Additional Clinic Staff

Two administrators at the clinic also support the CLARO care team: the **Clinic Champion** and the **Clinic Supervisor**. The Clinic Champion leads the CLARO implementation planning for the clinic, overseeing incorporation of the CLARO intervention into clinic activities. The CLARO Implementation Manual describes this role in greater detail. The Clinic Supervisor oversees administrative matters at the clinic, such as scheduling and paid leave. Figure 2.4 depicts these two roles in relation to the CC and other CLARO care team members.
Special Considerations for the CLARO Care Team

The CLARO intervention emphasizes patient-centered care that decreases stigma, instills a sense of safety, and incorporates both families and patients in shared decisionmaking.

Stigma

Substance use disorders (SUDs), MDD, and PTSD are among the most highly stigmatized conditions in medical care and in society at large. Many patients experience stigma both internally and externally, and stigma can delay obtaining life-saving treatment. Studies have shown that stigmatizing language (labeling the patient as an “addict” or as “mentally ill,” or someone who continues to use substances as “dirty”) has been linked to poorer health outcomes (van Boekel et al., 2015). Nonstigmatizing language puts the patient first (describing the individual as a “person with a substance use disorder” or a “person with depression”).

> See Appendix A.1 for tips on using nonstigmatizing language.

Trauma-Informed Approach

Nearly half of patients with OUD have a lifetime history of PTSD (Dahlby and Kerr, 2020; Ecker and Hundt, 2018). Care teams can establish a trauma-informed approach by addressing the psychological, emotional, and physical components of safety. This includes ensuring a safe and secure physical and emotional environment, developing service plans that build on patient strengths and address wellness, and responding to trauma using culturally and linguistically appropriate processes.

By its nature, trauma is distressing to talk or think about. That is true for patients who have PTSD, but also for CCs, supervisors, and other providers. We all have a tendency to want to avoid these topics and discussions—especially if they bring up difficult or traumatic experiences from our own past. An important part of trauma-informed care is recognizing the impact that trauma has on all of us and bringing it “out
of the shadows” to talk about what is happening. It is important to remember that trauma reminders by themselves cannot hurt us, and although avoidance may result in temporary relief, it does not promote long-term healing. This perspective can help CCs to take important steps, like discussing with a patient how their avoidance of trauma triggers is impacting their care, or bringing up to the supervision team when discussions of trauma have been personally difficult or impactful for the CC. For patients that may be more difficult to schedule visits with, being reassuring and “cheerful and relentless” may be really helpful to demonstrate the stability in your role. Sometimes saying “I am here when you’re ready to talk” will help engage patients.

» See Appendix A.2 for more on trauma-informed care.
Family Systems

When patients start treatment for OUD, MDD, and/or PTSD, they experience improved health and decreased mortality (as with other chronic health conditions), and they are more likely to engage with ongoing treatment, reduce harmful opioid use, and experience reductions in depression and PTSD symptoms. Families and friends can provide key positive or negative influences in a patient’s decision to start and/or stay in treatment. Those who support the need for the patient to stay on medications for co-occurring OUD and MDD/PTSD can be vital allies in treatment, but others may try to persuade the individual to stop taking medications. They may equate medications for OUD to problem opioid use (e.g., “swapping one drug for another”) or convince patients that medications are unnecessary. Family members may have had personal experiences with substance use, depression, and/or anxiety, which can also affect the patient’s recovery. In addition, domestic violence may be present in the family and may need to be examined using existing clinic procedures. It may also be helpful to provide the patient with educational materials, such as handouts, for people close to them, or ask the patient to consider inviting a close family member or friend to the clinic visit.

See Appendix D for handouts and resources geared toward patients and their families.
Patient Perspectives

At the heart of the CLARO intervention is the imperative to better serve patients who have co-occurring OUD with MDD and/or PTSD throughout their care journey. By working together in a collaborative care team and checking in regularly, it is hoped that patients will experience improved outcomes.

In developing this intervention, the research team talked with patients at the CLARO participating clinics to hear what they were looking for in a treatment program, what they struggle with, and what can help them most. We’ve compiled a few quotations from these interviews and include them throughout this manual.

“Then I started Suboxone . . . I didn’t feel like I needed that high from the pill. . . . It’s amazing how it just makes my life so much better. My kids have told me, ‘You’re like a whole different person now that you’re taking Suboxone.’”
Chapter 1 Sources

CHAPTER 2

Collaborative Care

This chapter outlines the major components of the CC role in the CLARO collaborative care intervention. It includes an overview of the workflow that CCs are likely to encounter, including the frequency of visits with patients and the assessments they will routinely administer. The chapter also includes sections on how CCs may prepare for the care initiation and care monitoring visits, including specific steps to undertake, sample scripts to follow, and menus of treatment options to offer patients. It also includes guidelines for home visits and emergency procedures. The chapter concludes with suggestions for self-care and ways to seek support within the care team. Appendix A provides additional resources, including the questionnaires that CCs will use with patients during their visits.
Overview of the Care Coordinator Role

The CC has an essential role in the CLARO intervention, working closely with patients and their care teams. The CC is the key point of contact with the patient, keeping the patient engaged in their care, measuring the impact of treatment, and helping to identify and address any social needs that could be barriers to treatment. At the same time, the CC serves a critical function on the care team, facilitating communication and maintaining linkages between others on the care team, including the medical and behavioral health clinicians (PCPs and BHPs).

CCs in the CLARO intervention will need to take a very proactive and persistent approach to working with both patients and care team clinicians by closely monitoring daily patient engagement and treatment progress, conducting shared decisionmaking with the patient if they are not doing well, communicating frequently with the care team, and ensuring that each patient receives appropriate care in a timely way. CCs will need to exhibit leadership, motivation, strong empathic skills, keen attention to detail and organization, community knowledge, and compassion for working with the intended patient population. They may be new to working within a medical or mental health team and will learn to play a proactive leadership role within the patient’s care team, with support from the CC Supervisor and CC Consultant.

The CLARO intervention takes place over a six-month period, during which CCs will meet directly with patients by phone or in person for at least 13 visits. The remainder of this chapter outlines the workflow that CCs can expect to encounter, from study entry to care initiation, care monitoring, and team communication. Throughout the intervention, CCs will use established clinical measures to assess and take action to improve patient symptoms, a motivational interviewing style to elicit intrinsic motivation and strategically direct patients toward change, and shared decisionmaking to discuss treatment options. They will use a registry on a daily basis to help manage their caseloads, track changes, and conduct their visits (see Chapter 6).
Below is an overview of the CC workflow (Figure 2.1). UNM research staff will recruit patients for the CLARO study and will refer patients in the CLARO intervention condition to CCs. The CCs are then responsible for monitoring patient attendance in the 13 CLARO intervention visits. Each visit has an agenda to get the “BALL” rolling through a series of steps that Build engagement with the patient; Assess for symptoms of OUD, MDD, and PTSD, as well as other social needs; Link the patient to care through other members of the care team; and have the CC Loop back to the team. As described in Chapter 1, the CC is supported by a robust care team that includes providers in the clinic (PCP and BHP) and the CC Support Team (CC Consultant, CC Supervisor, and BHC [team psychiatrist]). More-detailed information about this process is described below.

**FIGURE 2.1: WORKFLOW OVERVIEW FOR CARE COORDINATORS**
Visit Frequency

CCs should interact with patients a minimum of 13 times across six months (Figure 2.2). Visits will occur weekly at the beginning of the CLARO intervention for the first two months, decrease to biweekly in month three, and then decrease again to monthly in months four through six. This frequency was determined as acceptable by patients who were interviewed at the beginning of the study and reported that more regular visits at the start of the intervention would be helpful in troubleshooting problems that commonly arise early in treatment and for increasing patient engagement. More-frequent visits for patients who need more check-ins or monitoring can be conducted, including after the six-month period.

FIGURE 2.2: RECOMMENDED SCHEDULE FOR PATIENT VISITS

Patients will have at least 13 scheduled visits over the course of their six months in the CLARO intervention.

MONTHS 1 & 2  
8 visits, weekly

MONTH 3  
2 visits, biweekly

MONTHS 4, 5, & 6  
3 visits, monthly

“When you first get on [medication], it’s nerve wracking. . . . You don’t know how the medication is going to help you. . . . Knowing that you have someone there . . . would help make you feel comfortable about it.”

The current intervention is six months in duration, but visits with the CC can continue beyond this period based on clinical need and the recommendations by the behavioral health consultant and care team. If patients are transferred to another community health worker, CCs should defer to that staff member and not conduct monthly check-ins unless agreed upon by the care team. At the end of the six-month period, CCs will explore with patients their thoughts about continuing check-ins on a monthly basis thereafter. Patients can opt out if they do not prefer them. These check-ins are nondemanding such that CCs could leave a brief voicemail without requiring/asking the patient to call back. In addition, these check-ins are designed to be
brief and informal; measurement-based care would only be conducted if recommended by the care team and/or behavioral health consultant. In terms of the registry, patients should still be discharged when appropriate around the six-month mark. When conducting subsequent monthly check-ins, the CCs can document this through the CC note without affecting the original discharge date.

Example phone scripts:

- “Would it be alright if I quickly called you once a month to check in? I can leave a message, and you’re welcome to call back if you need anything. Otherwise, I’m happy to just leave you a quick message each month unless you let me know you don’t need a check-in.”

- “We can continue monthly check-ins, but, at any point, feel free to let me know if you don’t need them.”

Measurement-Based Care

An important part of the CC’s role is to monitor how patients are doing and whether their health is improving. This is an essential component of the CLARO intervention because we want the patient’s health to improve so that they feel better and can function better. Cravings (e.g., missing the high and their old lifestyle), isolation, and mood were common triggers reported by patients. The CC is the ideal person to help monitor cravings, symptoms, and the potential for relapse because they will be meeting more frequently with the patient than the medical and behavioral health clinicians. If patients are not improving, the CC can work with the patient’s care team to adjust their treatment plan and personal goals. The CC can monitor patients, in part, by talking to the patient and observing how the patient behaves. But the CC also has some powerful and objective measurement tools to check on how the patient is doing. The CC will use four short questionnaires, also called measurement-based care (MBC) scales, that ask about patients’ symptoms of substance use, MDD, and/or PTSD. These scales will help the team know if the patient is doing better or worse compared with earlier visits and let the care team know if the patient needs extra help and support.

“Cravings are a big deal because . . . I really miss it. . . . But remembering when I was at that breaking point in my life helps me.”
The four MBC scales are adapted from reliable, validated measurement tools (Table 2.1). The first scale, Opioid Use Disorder-5 Questions (OUD-5), was named by the CLARO team for its five questions about OUD and was adapted from the Brief Addiction Monitor (BAM; Cacciola et al., 2013). It should be administered to patients at each of the 13 visits. The other three scales should be administered monthly. However, there is flexibility to administer these scales in session 1 or as needed (e.g., administer the PTSD Checklist for DSM-5 [PCL-5] if a patient reports a recent traumatic event or recurrence of symptoms). The other three MBC scales are as follows:

- the Patient-Reported Outcomes Measurement Information System-7 (PROMIS-7; Pilkonis et al., 2015), specifically the Severity of Use-7a (SU-7a) version that assesses substance use. All patients are asked the PROMIS-7 monthly.
- the Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, and Williams, 2001), which is the nine-item version of the Patient Health Questionnaire that assesses depression symptoms. All patients are asked the PHQ-9. If they score 10 or higher, the PHQ-9 should be administered monthly.
- the PCL-5 (Prins et al., 2016), which assesses PTSD symptoms. Only patients with a worst traumatic event (the worst difficult or stressful event) noted in the registry should be asked the PCL-5.

Each questionnaire is located and described in greater detail in Appendix A. Additional questionnaires used in the CLARO intervention that assess social needs, sleep, and pain are also located in Appendixes A.3–A.8 and are described in further detail below.
TABLE 2.1: SUMMARY OF MBC TOOLS USED IN CLARO

<table>
<thead>
<tr>
<th>MBC SCALE</th>
<th>NO. OF ITEMS</th>
<th>SYMPTOMS ASSESSED</th>
<th>WHEN TO ADMINISTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUD-5</td>
<td>5</td>
<td>Opioid cravings, medication side effects, withdrawal, substance use</td>
<td>Every visit</td>
</tr>
<tr>
<td>PROMIS-7</td>
<td>7</td>
<td>Cravings, interpersonal challenges related to substance use, severity of use</td>
<td>Visits 2, 5, 9, and 11–13 (or monthly)</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>9</td>
<td>Depression symptoms</td>
<td>Visit 1 and then monthly (if applicable)</td>
</tr>
<tr>
<td>PCL-5</td>
<td>20</td>
<td>PTSD symptoms</td>
<td>Visits 2, 5, 9, and 11–13 (if applicable)</td>
</tr>
</tbody>
</table>

Registry

The research team for the CLARO intervention has developed a patient-tracking tool—a registry—that helps CCs manage their caseloads. Instructions for using this software tool are described in Chapter 6, with additional information in the University of Washington’s (UW’s) Care Management Tracking System (CMTS) User Guide. Here, we highlight some of the basic functions of the tool as it is meant to integrate with the daily work of being a CC, as well as how the tool is meant to be used in the context of preparing for and conducting a care monitoring visit.


Daily Use

Before or in between patient visits, CCs will need to review patients’ records in the EHR to record when patients see the PCP for medication for OUD (MOUD) or the BHP for psychotherapy. Based on the information in the patient record, the registry will prompt CCs to perform certain actions every day. These daily actions include following up on MOUD and BHP appointments and confirming upcoming care monitoring visits. This documentation is recorded in the registry within the Contact Note.

Visit-Related Use

In addition to daily tasks in the registry, CCs will need to directly enter information elicited from the patients during visits and transfer patient information from the clinic’s EHR. These actions will be done before, during, and after visits with the patient.
Table 2.2 summarizes tasks to be accomplished during each visit and the numbered steps to which they correspond, described in detail in Chapter 6. The next several sections of this chapter describe how to prepare for and conduct care initiation and monitoring visits.

### TABLE 2.2: REGISTRY TOOL USE FOR VISITS

<table>
<thead>
<tr>
<th>TIMING</th>
<th>CONTACT NOTE: Direct Entry</th>
<th>CONTACT NOTE: EHR Transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before</strong></td>
<td>Create new patient record (if first visit) that includes &lt;ul&gt;&lt;li&gt;patient first and last name&lt;/li&gt;&lt;li&gt;medical record number&lt;/li&gt;&lt;li&gt;date of birth&lt;/li&gt;&lt;li&gt;randomization date&lt;/li&gt;&lt;li&gt;diagnosis (PTSD)&lt;/li&gt;&lt;li&gt;worst traumatic event (if PTSD).&lt;/li&gt;&lt;/ul&gt; “Create a Patient Record in the Registry” (Note: This will be handled by research staff prior to CC warm handoff)</td>
<td>&lt;ul&gt;&lt;li&gt;Urine test information&lt;/li&gt;&lt;li&gt;Diagnoses&lt;/li&gt;&lt;li&gt;Medication status&lt;/li&gt;&lt;/ul&gt;</td>
</tr>
<tr>
<td><strong>During</strong></td>
<td>Record from patients and/or enter from EHR the following: &lt;ul&gt;&lt;li&gt;results from MBC assessments&lt;/li&gt;&lt;li&gt;medication status and adherence&lt;/li&gt;&lt;li&gt;social needs&lt;/li&gt;&lt;li&gt;future appointments.&lt;/li&gt;&lt;/ul&gt;</td>
<td>&lt;ul&gt;&lt;li&gt;Medication status&lt;/li&gt;&lt;li&gt;Future appointments&lt;/li&gt;&lt;/ul&gt;</td>
</tr>
<tr>
<td><strong>After</strong></td>
<td>Flag as needed for BHC and/or PCP and site supervisor if the patient is deemed a safety risk. Verify appropriate diagnoses with the BHC and adjust registry as needed.</td>
<td>&lt;ul&gt;&lt;li&gt;Copy details of patient visit from registry to EHR&lt;/li&gt;&lt;/ul&gt;</td>
</tr>
</tbody>
</table>
Motivational Interviewing Toolbox

CCs will be trained in motivational interviewing (MI), often described as a conversational style or language that someone uses with a patient. MI is collaborative and nonjudgmental; it focuses on strengthening the client’s motivation and commitment to change (Miller and Rollnick, 2012). Using the MI Toolbox below, the CC strategically elicits “change talk” statements from the patient about why it may be important to change versus reasons why the client does not want to change (i.e., “sustain talk”). Change talk is associated with reduced drinking and using, and research shows that change talk can be elicited using some of the tools described below. MI is used throughout the visits, especially in the early visits, to increase client engagement.

**TABLE 2.3: MOTIVATIONAL INTERVIEWING TOOLBOX**

<table>
<thead>
<tr>
<th>MI TOOL</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>elicit, provide, elicit</td>
<td>Ask open-ended questions or ask for permission (e.g., “What have you heard about . . .?“ “Is it OK if I share. . .?”). Provide information in nonjudgmental manner. Ask for feedback (e.g., “How does that fit with your experiences?”).</td>
</tr>
<tr>
<td>reflect</td>
<td>Make a statement summarizing the patient’s situation, values, or feelings (e.g., “Being a good mother is important to you”).</td>
</tr>
<tr>
<td>explore</td>
<td>Use open-ended questions and reflections to gather information. Let the patient do most of the talking (e.g., “Tell me some of the good and not-so-good things you’ve experienced from drinking or using”).</td>
</tr>
<tr>
<td>elicit change talk</td>
<td>Ask questions and reflect so that patients can say why change is important (e.g., “Tell me more about how you’d like to change your drinking or using”).</td>
</tr>
<tr>
<td>affirm</td>
<td>Reflect the patient’s strengths (e.g., “You’ve quit successfully before and have some ideas about your next steps”).</td>
</tr>
<tr>
<td>role-play</td>
<td>Clearly explain what the patient will do. The patient and the CC role-play; keep the role-playing realistic. Debrief and affirm strengths.</td>
</tr>
</tbody>
</table>
Preparation for the Care Initiation Visit

Once a patient consents to the CLARO study and is randomly assigned to the CLARO intervention, the research staff will introduce the patient to the CC—ideally in person or via video conference—with a “warm handoff” that helps the patient feel welcome and cared for. If the warm handoff is conducted in person or through video conference, the care initiation visit can occur immediately. The research staff will also inform the CC if the patient meets criteria for PTSD and/or MDD so that the CC can administer the correct MBC questionnaires.

If it is not possible to conduct the warm handoff in person (e.g., the CC is unavailable or the patient has limited time), the CC will call the patient to schedule a care initiation visit. In preparation for the care initiation visit, CCs should follow the steps below.

Preparation for Care Initiation Steps

- **Create a patient record in the registry**
- **Schedule the care initiation visit**
CREATE A PATIENT RECORD IN THE REGISTRY

The first step is to enroll each patient into the registry; this will be conducted by the research staff. For informational purposes, to create a new patient record, navigate to the top toolbar and select “Patient > New Patient.” This will bring up a new patient enrollment form containing a pre-populated “Patient ID” field (Figure 2.3). The research staff will enter the information below at the time of enrollment and will contact the CC after enrolling the patient in the registry. The research team will only see the following fields in the registry and will enter the relevant information:

- **Patient first and last name**
- **Patient date of birth**
- **Randomization date:** The date the patient was first randomized to the intervention arm of CLARO.
- **MRN:** The patient’s Medical Record Number in the clinic’s EHR system (provided by a member of the research staff).
- **Diagnosis:** Whether the patient meets criteria for PTSD.
- **Worst traumatic event (PTSD patients only):** The patient’s worst traumatic experience, for reference during the PCL-5 questionnaire.

In addition, the CC should enter:

- **Clinic:** The site where the patient will regularly receive care.
- **Providers:** The names of the CC and BHC as well as any other care providers that are documented in the EHR (e.g., PCP, BHP).

» See Chapter 6 and UW’s CMTS User Guide for more details on using the registry.
### FIGURE 2.3: PATIENT ENROLLMENT SCREEN, CLARO REGISTRY

#### Patient Enrollment

**Program Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient ID</td>
<td>1234</td>
</tr>
<tr>
<td>Clinic</td>
<td>Clinic 1</td>
</tr>
<tr>
<td>Population</td>
<td>CC (K)</td>
</tr>
<tr>
<td>Randomization Date</td>
<td>1/29/2020</td>
</tr>
<tr>
<td>Care Manager</td>
<td>BH Care Manager 1</td>
</tr>
<tr>
<td>PCP</td>
<td>PCP 2</td>
</tr>
<tr>
<td>Behavioral Health Provider</td>
<td>BH Provider 2</td>
</tr>
<tr>
<td>Behavioral Health Consultant</td>
<td>BH Consultant 1</td>
</tr>
<tr>
<td>MOUD Prescriber</td>
<td>Prescriber 3</td>
</tr>
</tbody>
</table>

**Patient Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>John</td>
</tr>
<tr>
<td>Last Name</td>
<td>Smith</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>10/19/1992</td>
</tr>
<tr>
<td>MRN</td>
<td>1234567</td>
</tr>
</tbody>
</table>

**Worst Traumatic Event**

[Blank field]
BUILD ENGAGEMENT

If the warm handoff occurs in person and the patient agrees, CCs may conduct the care initiation visit immediately (skip ahead to the “Care Initiation Visit” section). Otherwise, the CC can build engagement and schedule the visit for a later time:

- **Check EHR if possible**

  Before speaking to the patient, it will be helpful to check the EHR for such information as last visit, PCP name, medications, BHP name, and other social history.

- **Introduce self**

  “Hi [name], I’m [CC name], the care coordinator on CLARO. I know you’ve been on the call for a while, I just wanted to spend a few minutes with you. How did you hear about CLARO?”

- **Describe CLARO intervention and the CC role**

  “In this program, you’ll have a team of people working together to help you. You might be seeing a couple of different providers, like a primary care doctor and a behavioral health therapist. As your support person, my job is to act like the glue between you and these doctors. My goal is to support you at the clinic. For example, if you have a question for your doctor and you don’t have an appointment, you can call me directly and I can ask for you. How does that sound? My role is to communicate with your care team so that we can provide you with the best treatment, but I won’t share anything you say with me to people outside of the clinic or the CLARO project. Does that sound okay?”

  “I’d like to schedule our first visit in the clinic so we can get to know each other, and I can ask you some questions about your health and goals for treatment. After that, I’ll be following up with you for six months starting every week and then every other week, and then monthly. They’re just quick check-ins to see how you’re doing and if there’s anything I can help you with. If you’re already coming into the clinic for a visit, we can schedule a short chat in person before your visit. Otherwise, I’ll call you and we can talk over the phone. Part of my job is to be flexible and support you in whatever ways you need, so if something comes up and you need more support, we can
always change our follow-up schedule so that I’m checking in more often. Now, I want to be sure I’m doing a good job of talking about next steps. Can you tell me in your own words how you and I are going to connect with each other?”

**SCHEDULE THE CARE INITIATION VISIT**

“If it’s okay with you, we can schedule our first visit so that we can get to know each other a bit better. I have some questions I would like to ask that will take about 45 minutes. Would that work for you?”

Let the patient know that you’ll call to remind them about the appointment. Confirm the patient’s phone number and an alternate phone number or email address.

“I will call you in a few days to remind you about our appointment. If you have any questions at all before then, please call me! My number is XXX-XXX-XXXX. Also, you can call me if you urgently need to see the doctor or counselor, or if you would like to reschedule your appointment. Is this the best number to call you? [If no phone number:] How about an email or a place that you receive mail?”
Care Initiation Visit

The care initiation visit may be conducted in person, though it can also take place by phone or video conference and over the course of two visits, if necessary. To help increase patient engagement, the CC should schedule the care initiation visit(s) as soon as possible after consent to participate in the study has been obtained. During patient visits, CCs should follow the BALL acronym described above (Build engagement, Assess, Link to care, and Loop back with team). At care initiation, the CC gets the BALL rolling to help the patient begin treatment. The BALL steps for care initiation are outlined below and discussed further in the following pages.

### TABLE 2.4: SUMMARY OF CARE INITIATION STEPS

<table>
<thead>
<tr>
<th>ACTION</th>
<th>DETAILS</th>
</tr>
</thead>
</table>
| **Build engagement**    | • Introduce self  
                          | • Check in on how the patient is doing  
                          | • Read verbal consent for audio recording; document on Excel; document on Kiteworks  
                          | • Record level of engagement in registry |
| **Assess**              | • Conduct WellRx and discuss social needs; ask about existing case management  
                          | • Conduct OUD-5 and discuss substance use  
                          | • Ask informally about sleep and pain; conduct scales if needed  
                          | • Conduct PHQ-9 for MDD; conduct PCL-5 for PTSD (optional)  
                          | • Enter responses into registry  
                          | • Learn from patient and give feedback |
| **Link to care**        | • Identify behaviors to address  
                          | • Assess readiness and motivation for treatment  
                          | • Engage in shared decisionmaking about the menu of treatment options and establish a treatment plan  
                          | • Identify and address treatment barriers  
                          | • Schedule appointments as needed and summarize next steps |
| **Loop back with team** | • Check to see if assessment scores have triggered an alert in the registry; verify appropriate diagnoses with the BHC and adjust registry as needed  
                          | • Touch base with the patient’s PCP and BHP to review agreed-upon steps  
                          | • Upload audio recording to Kiteworks; delete once upload is confirmed |
Care Initiation Steps and Sample Scripts

BUILD ENGAGEMENT

Engagement will mostly likely have started with an in-person warm handoff; see the “Build Engagement” section earlier in this chapter for a full description and sample scripts. CCs will continue to build this engagement and trust with patients through the 13 (or more) visits over the course of the intervention. During the first visit, the CC should focus on building rapport. After the visit, record in the Contact Note in the registry your perception of the patient’s level of engagement (not engaged, engaged, highly engaged). Patients who are not engaged during the session may say very little during the visit and/or verbalize disinterest in the visit and/or treatment; those who are engaged may participate actively in the visit and offer ideas for improving their treatment plan; those who are highly engaged may demonstrate their engagement by talking about the struggles/successes they experienced during the visits with the CC, including adherence to assignments/action items assigned at the prior CC visit. This information will be helpful for the BHC and also for future reference.

- Build rapport (e.g., how are you? I’d like to get to know you, tell me about yourself, what led you to participate in CLARO)
- Ask for verbal consent to audio record session and document consent in Kiteworks

ASSESS

This step begins with assessing a patient’s symptoms. Depending on the patient’s preference, these questions can be asked verbally or printed for the patient to complete on their own. If the patient completes the questions on their own, ensure that each item is completed. In some cases, reassuring the patient that they are doing well and normalizing that all patients in the CLARO intervention receive these same questions will be helpful to keep patients engaged in the process and help with honest reporting. This step ends with assessing readiness for treatment and what motivates them to
change. Ask open-ended questions (MI toolbox, Table 2.3) about how the patient feels about their current situation and what their future goals are. Affirm the patient’s efforts and progress and ask how they would like to progress on their goals. These observations should be documented in the Contact Note in the registry.

“I’d like to go through some questions we ask of all clients about your substance use and mental health. All of us in this clinic work with people who are struggling with substance use and mental health problems. My job here is to get you the best possible care. The more you can share with me what is going on with you, the more helpful I can be. How does that sound?”

- **Conduct and discuss assessments (see Appendix A):**
  - Social needs: WellRx (Page-Reeves et al., 2016), Goal Attainment Scaling in registry (See Chapter 6)
    - “I’d like to ask you some yes or no questions to help me understand you a little better. I’ll take some notes and, afterward, we can talk more about them and identify some things that we can work on together. Is that okay? In the past two months . . . ”
  - Discuss any items endorsed on the WellRx and collaboratively decide with the patient one or two areas they would like support with while helping them prioritize goals that would help them succeed in CLARO (i.e., getting into or staying in treatment).
  - If the patient endorses abuse in the home, please view Appendix A.10, Suicide Plans. For the CLARO project, the care coordinator’s job is to triage or refer patients at risk for harm to a clinician. It is not within the CC’s scope of work to conduct a suicide assessment or create a safety plan. Instead, when a patient discloses these risk behaviors, they should follow clinic protocol and reach out to a licensed clinician for support.
  - Existing case management:
    - “What other services do you receive here at the clinic?”
    - ”Are there services that you receive outside the clinic, such as help with financial issues, legal issues, housing, or anything like that?”
  - MBC scale: OUD-5
“Now I’d like to ask you five questions about your opioid use. I will ask these questions every visit, and it will be a way for me and your care team to help you monitor any symptoms.”

- In the initiation visit, the OUD-5 is asked “in the past 30 days.” In subsequent visits, the wording should be phrased as “since the last visit.”

- The first question (Are you experiencing any side effects from any medication?) is specific to medications to treat OUD. If the patient is not taking Suboxone, Sublocade, or methadone, mark “no” to this question.

- The third question (How many days did you use any illegal/street drugs or abuse any prescription medications?) includes opioids. Thus, if the patient has used only heroin for 10 days in the past 30 and no other substances, mark the “9–15” option for questions 3 and 4.

- Discuss opioid use (see section below on learning/giving feedback) while helping them prioritize goals that would help them succeed in CLARO (i.e., getting into or staying in treatment).

- Depression: PHQ-9 [ask all patients; if score is 10 and above, continue asking every month] and discuss (see learn/give feedback below)
  - “Now I’d like to ask you a few questions about how you have been feeling for the past two weeks. After, we can discuss any concerns you may have and talk more about some treatment options, if you’d like. Over the last two weeks, how often have you been bothered by any of the following problems?”
  - If the patient endorses suicidality on the PHQ-9, the CC should contact the patient’s provider or the charge nurse per existing clinic protocol. For more details about crisis intervention, see Appendix A.10.

- Ask informally about sleep and pain (use Insomnia Severity Index [ISI] and Pain, Enjoyment of Life and General Activity [PEG] measures if necessary)
  - If necessary: Sleep (ISI; Department of Veterans Affairs, n.d.). “You mentioned that you are having difficulty sleeping. Do you mind if I
ask you seven questions about your sleep over the last two weeks to see if we can support you?”

- If necessary: Pain (PEG Pain Monitor; Krebs et al., 2009). “You mentioned that you have been in some pain recently. Do you mind if I ask you three questions about your pain and how it affects your life? Think about pain you have had during the past seven days . . .”

- Ask about naloxone (what do you know, do you have it; education on how to get it).

- Enter patient responses to OUD-5 into the registry (and enter PHQ-9 responses if the PHQ-9 was asked). The registry will automatically calculate scores for each assessment and inform you of any necessary next steps. See Chapter 6 for more on how to use the registry.

- Learn from patient and give feedback

  “Thank you for answering all of those questions, I really appreciate it. Is it okay if we talk about your responses?”

- Opioid use:
  - “You mentioned that you used [heroin or pain pills] in the past month. Tell me a little bit about a day in your life and where [heroin or pain pills] fit(s) in.”
  - “When you use, why do you use—what is it doing for you?”
  - “Does anyone close to you use? How about anyone you live with or see often?”
  - “What other substances are involved? Methamphetamine, alcohol?” [ask for more information; route of administration; frequency]
  - “How about the downsides—are there downsides to using?”
  - “If you were going to make a change in your use, what kind of change would you want to make?”
• Explore sleep problems and pain if applicable:
  o “Tell me about your sleep/pain and how that’s been for you.”

• Assess social support:
  o “Sounds like you’ve been going through a lot. Tell me about the people in your life. Are you living with anyone? What do they know about the things you are going through?”
  o “Who supports you when you struggle with your opioid use/depression/PTSD? Sometimes family members or other important people in our lives want to learn more about any treatment we might be receiving. Is there anyone like that in your life?”

Note that in some cases, patients may not have anyone supportive in their life. If so, ensure that they have a phone number for a crisis line and that they know how to reach out to the care team for help (see Appendix A.10 for CLARO’s suicide and homicide protocol). There may also be online support groups offering SMART (Self-Management and Recovery Training) that may be helpful. Also brainstorm if patients are interested in meeting new people and/or reconnecting with people from their past. Often, the opportunity to reconnect with people (e.g., family members) after being in treatment for a period of time may motivate patients to improve. Enter all scores and additional notes from the discussion into the registry Contact Note.

• Highlight their values and strengths.

---

**LINK TO CARE**

• **Identify behaviors to address**

  “Thank you for sharing about the things going on in your life. We just talked about your [opioid use, PTSD, depression, social needs]. I’m wondering if we can chat about some treatment options available to you.”
• **Assess readiness and motivation for opioid use/MDD/PTSD treatment**

  “Have you ever been in treatment for (diagnoses) before? Have you taken medication for (diagnoses) or spoken to a therapist/counselor about (diagnoses)? What was that like?”

  “How are you feeling about your (diagnoses) now? What changes, if any, would you like to make? What is motivating you to think about changing now?”

• Emphasize change talk and reasons why they want to change including values important to them.

  o E.g., “Heroin use is really getting in the way of your growth and you are ready to get your life back on track.”

  o “On a scale from 0 to 10, how willing are you today to choose a treatment option to address (X), where 0 is not willing and 10 is very willing?”

  o Add a reflection or open-ended question. If the patient gives a 0, ask, “What would get you to a 3?”

  o If a patient says a number other than 0, ask, “Why a [patient’s number] and not a 0?”

• **Depression:**

  o “The survey you just answered talks about symptoms related to depression. Your score on that survey was a [score], which indicates [minimal, mild, moderate, moderately severe, severe depression].”

  o “Depression is an illness that often causes people to experience what you mentioned [list depression symptoms that the patient endorsed].”

  o “How does that fit with your experience? How have these symptoms affected your life? Is it OK if I ask you some more questions about depression?”

  o “If you were to imagine a change in how you’re feeling, what kind of change would you want to feel?”
• “Depression can be treated so that you will have fewer of these symptoms and will feel better. How do you think our team at the clinic could help support you with feeling better?”

• Emphasize change talk.
  • “How about your confidence to do so if you wanted to change? On a scale from 0 to 10, where 0 is not confident and 10 is very confident, how confident are you that you would take medication/enroll in treatment, etc. if you needed to?”

• Add a reflection or open-ended question.
  • If the patient gives a 0, ask, “What would get you to a 3?
  • If a patient says a number higher than 0, ask, “Why a [patient’s number] and not a 0?”

• Emphasize change talk. Often, patients may be less willing to change but more confident that they could change when ready; highlight these differences.

• Engage in shared decisionmaking about the menu of treatment options and establish a treatment plan (see Appendix B.29 for a treatment plan template).

  • Summarize change talk, strengths, values, reasons to change, and goals.
    • “What do you think you can do to stay healthy and safe? What are some goals you would have for yourself to stay healthy? We have a few treatment options we could discuss if you’d like.”

• Discuss the menu of treatment options. If the patient is not interested in talking later, ask if you can check in with them at your next visit.

• Review materials on relevant treatments.
  • “Which of these options would be worth giving a try?”

• Make a concrete treatment plan for how to reach the patient’s goals (e.g., make appointments with medical and behavioral health care clinicians [PCP, BHP], and other social service agencies).

• Summarize next steps.
• “In your own words, what are your goals, and how are you going to reach them?”

• Summarize pros and cons of change, reasons for change, patient’s strengths/motivations to change, treatment plan, and next steps.

• **Identify and address treatment barriers**

  “What might get in the way of reaching your goals? For example, getting to your appointments, getting and taking your medication as scheduled, transportation, etc.?”

• Work with the patient to find solutions to treatment barriers they are facing, including any social needs (e.g., transportation, mobile phone minutes, etc.).

• Restate what motivates patients to improve their health.

• Provide additional resources, link to care, and adapt treatment plan as needed.

  • “Like many patients who have difficulties with [opioid use, PTSD, depression], there might be times when you’re feeling badly and don’t want to keep up with your visits. I know it can be hard to stay motivated if you’re feeling like that, but those are also the times when I could be most helpful to you. I will always work with you to go at your pace. But if it’s okay with you, I will keep checking in to make sure I can be there for you when you’re ready.”

• **Schedule appointments as needed and summarize next steps**

  “We’ve had a great discussion today and I appreciate you exploring next steps with me. I’ve made an appointment with [name] on [date], and I can give you a call a couple days before the appointment to remind you, if that is helpful. We will also meet next week to check in [describe if visit will be in person; it should be scheduled within a week of the initiation visit]. How does that sound?”
LOOP BACK WITH TEAM

- Check to see if assessment scores have triggered an alert in the registry.
  - If they have, determine reason for alert.
  - If safety risk, follow clinic protocol (see Appendix A.10)
  - Decide whether to escalate (report for PCP/BHC and/or flag for psychiatric review by the BHC).
  - If item isn’t flagged in the registry, the CC can still escalate if they think it’s necessary.

- Touch base with the patient’s medical and behavioral health care clinicians (PCP and BHP), as needed, to review agreed-upon steps.
  - Share a copy of the registry report with the PCP and BHP, as needed (see Chapter 6 and UW’s CMTS User Guide).
  - Prepare any questions to discuss with the BHC, CC Supervisor, and CC Consultant during the check-in meetings.
Preparation for Care Monitoring Visits

The CC will play a really important role in helping the patient to receive and stay in the care that they need. The CC will meet with the patient often to check in, offer support, and find out how the patient’s symptoms are changing. The CC will monitor patient care with regularly scheduled phone calls or brief in-person visits before or after the patient has an appointment at the clinic. This care monitoring will be critical in helping the patient get the care they need and stay engaged with treatment. As noted above, the CC will meet with the patient for a total of 13 visits over a six-month period to offer support and find out how the patient’s symptoms are changing. Staying connected with the patient by meeting at least once a week during the first two months will be essential to the patient’s success in the intervention. After that, if the patient is doing well, the CC can meet with the patient every other week in the third month, and then once a month after that (see Figure 2.2). More-frequent or longer monitoring may be needed for specific patients on a case-by-case basis.

Whenever possible, the CC should schedule a care monitoring visit before the patient’s appointment with their medical and/or behavioral health care clinicians (PCP and/or BHP). Meeting the patient before the PCP/BHP appointment allows the CC to gather insights that will be useful for the PCP/BHP in informing treatment decisions. A patient-level registry report can be automatically generated and printed/sent to the provider before the visit.

» See Chapter 6 and UW’s CMTS User Guide for more details on using the registry.

Before each care monitoring visit, the CC will review the patient’s treatment progress since the last care initiation or monitoring session. This review includes the following steps (Table 2.5) and must be documented in the registry.
<table>
<thead>
<tr>
<th>ACTION</th>
<th>QUESTIONS</th>
</tr>
</thead>
</table>
| Review clinic visits in the EHR as needed | • Were any PCP or BHP visits completed/no-showed/rescheduled since last visit that need follow-up?  
• Any other issues discussed at last visit that need follow-up? |
| Check medication status and urine test results | • What are the patient’s current prescriptions and dosages? Last medication refill date? Urine drug test results from prior visit? |
| Look for registry flags         | • Are there flags in the registry that need follow-up?  
• Is this patient at-risk for dropping out of treatment (e.g., discuss strategies with BHC/CC Supervisor; see Chapter 5)? |
| Check for referrals             | • Were any referrals made from last visit that need to be checked on (e.g., social issues/needs or external care)? |
Care Monitoring

Care monitoring visits are designed to keep the BALL rolling, make sure that the patient remains engaged with treatment, and address any issues that have arisen. Similar to the care initiation visit, care monitoring visits follow the BALL acronym described previously.

All of the MBC assessments do not need to be conducted at every care monitoring visit (see Table 2.1). As part of the MBCs that measure symptoms related to OUD, MDD, and/or PTSD, the CC should administer the OUD-5 at every visit. The PROMIS-7, PHQ-9, and PCL-5 should be administered monthly starting with the second visit. The CC can use their judgment to administer these measures earlier or at any other visit if it would be beneficial for understanding the patient’s symptoms (e.g., if the PHQ-9 is not due, but the patient notes feeling more sad lately; giving the option to skip the PCL-5 if the patient finds it triggering and doesn’t yet have a BHP to process with). The PHQ-9 and PCL-5 only need to be completed by patients who have been diagnosed with MDD and/or PTSD, respectively. The BHC will help guide the CC on when those diagnoses should be entered into the registry because a diagnosis should be made by a licensed professional and from a diagnostic assessment. In addition to the MBCs, the CCs will check in about other factors that might affect a patient’s treatment, including their social needs, sleep, and pain issues if there were concerns indicated in the care initiation visit. The social needs, sleep, and pain questionnaires should be readministered at the CC’s discretion in consultation with the BHC and CC Consultant. In some cases, if a patient has been having significant concerns in these areas, readministering the questionnaires would help the CC understand whether these behaviors have improved or worsened and to adjust the treatment plan accordingly. During care monitoring visits, CCs keep the BALL rolling with the steps outlined below (Table 2.6).
TABLE 2.6: SUMMARY OF CARE MONITORING STEPS

<table>
<thead>
<tr>
<th>ACTION</th>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Build engagement</td>
<td>• Check in on how things have been going since the last visit</td>
</tr>
</tbody>
</table>
| Assess               | • Check in about social needs, social support, engagement, sleep, and pain  
                        • Document progress regarding medication adherence  
                        • Assess MBCs  
                        • Learn and give feedback on opioid use, PTSD, and MDD, as needed  
                        • Identify and address treatment barriers  
                        • Identify behaviors and symptoms to address (e.g., craving, feeling intoxicated or sleepy, constipation, thoughts of self-harm)  
                        • Document in registry |
| Link to care         | • Engage in shared decisionmaking about the menu of treatment options  
                        • Link patients with medical and behavioral health care clinicians (PCP, BHP) and social needs referrals, if desired  
                        • Schedule next care monitoring visit  
                        • Document in registry |
| Loop back with team  | • Check to see if assessment scores have triggered an alert in the registry  
                        • Review agreed-upon steps with the patient’s PCP, BHP, and psychiatrist (BHC) |
The Second Visit

BUILD ENGAGEMENT

“Hi, [patient name]. This is [CC name], your care coordinator at the [clinic name] calling to see how you are doing. How have things been going since we last talked? Anything good or not so good that you want to share?”

- Follow up from prior session’s goals.
- Audio record if prior verbal consent was given.
- After the visit, record in the registry your perception of the patient’s level of engagement (not engaged, engaged, highly engaged). This information will be helpful for the BHC and also for future reference.

ASSESS

- Use the MBC scales:
  - OUD-5
    - “Now I’d like to ask you five questions about your opioid use. I will ask these questions every visit, and it will be a way for me and your care team to help you monitor any symptoms.”
  - PROMIS-7
    - “The following questions ask about your use of opioids (e.g., heroin, morphine, Dilaudid, Demerol, Oxycontin, oxy, codeine (Tylenol 2, 3, 4), Percocet, Vicodin, Fentanyl, etc.) other than your prescribed Buprenorphine. We will be going over this once a month as another way to measure your symptoms for the care team.”
  - PHQ-9 [ask all patients; if score is 10 and above, continue asking every month] and discuss (see learn/give feedback below).
    - “Now I’d like to ask you a few questions about how you have been feeling for the past two weeks. After, we can discuss any concerns you may have and talk more about some treatment options, if you’d like.”
Over the last two weeks, how often have you been bothered by any of the following problems?"

- If the patient endorses suicidality on the PHQ-9, the CC should contact the patient’s provider or the charge nurse per existing clinic protocol. For more details about crisis intervention, see Appendix A.10.

- PCL-5 [only ask patients if research assistant notes worst traumatic event in registry] and discuss (see learn/give feedback below).

- Keep in mind that avoidance of trauma reminders is a key symptom of PTSD. Being asked about their trauma-related symptoms can be uncomfortable or frightening for patients. You can be flexible with patients and give them autonomy in how often they complete the PCL-5 as well as provide them the measure ahead of time so they can reference. But avoiding reminders only provides temporary relief and does not help the patient recover from PTSD. You should keep exploring other options.

- Self-care (as needed): So before I continue to some more questions, I want us to think about how you can take care of yourself if you are feeling anxious or stressed. What are some things you do to take care of yourself? Examples could include self-care like breathing or taking a walk, or talking with family or friends, or processing with your therapist."

- [If patient has difficulty with care plan, or does not want to complete the PCL-5]: “That’s okay if you don’t want to answer these questions today. Let’s plan to do it sometime in the future, so that I have all the info that I need to help inform your care. I will check in with you regularly about this, but always give you a choice about whether we start the discussion.”

- PCL intro: “I’m going to read a list of problems that people sometimes have in response to a very stressful experience, and I’m going to ask how much you have been bothered by each problem in the past month. These questions can sometimes be sensitive for patients, so let me know if you want to pause or stop. We don’t need to go into details about each problem, just how bothered you are. This information will be helpful to plan your treatments at the clinic. In the past 30 days, how much were you bothered by: [continue with PCL-5].”
PCL debrief: “Thank you for answering these questions; it really helps our team understand how you’re feeling and how we might support you.” [Discuss any increases/decreases in scores without saying score number—e.g., “I noticed your symptoms were higher this week, how does that fit with your experience?; have you shared this with your provider?; I’m going to share with your care team so we can ensure you’re supported, how does that sound?; we talked about some self-care activities, what might you do until you can meet with your provider to care for yourself?”]

• If a patient requests to skip the PCL-5 more than once in a row, use your MI skills to explore solutions and check in with your team for more ideas. For example, you might say, “We had talked before about how challenging your PTSD symptoms can be sometimes. Let’s review the pros and cons of monitoring those symptoms versus skipping this measure. You rated your readiness to work on your trauma at a 5. What might need to happen to move you to a 6 or 7?”

• After asking the questions, always ask how they are doing.

• Enter patient responses into the registry. The registry will automatically calculate scores for each assessment and inform you of any necessary next steps. See Chapter 6 for more on how to use the registry.

• Learn from patient and give feedback.
  “Thank you for answering all of those questions, I really appreciate it. Is it okay if we talk about your responses?”

• PTSD
  • “The survey you just answered talks about symptoms related to posttraumatic stress disorder, or PTSD. [If score is 33 or higher: “Your score indicates you probably have PTSD”; if score is under 33: “Your score tells us that you’re having some symptoms from trauma, but you don’t have a full diagnosis of PTSD.”]
  • “PTSD is an illness that results from stressful events. People with PTSD often have symptoms like the ones you mentioned such as [list PTSD symptoms the patient endorsed]. These symptoms are often
very upsetting and hard on a daily basis, and I’m wondering what it’s been like for you. Is it OK if I ask you a few more questions about PTSD [or trauma]?”

- “What are some of the downsides to what you’re going through?”
- “If you were to imagine a change in how you’re feeling, what kind of change would you want to feel?”
- “PTSD can be treated so that you will have fewer of these symptoms and will feel better. How do you think our team at the clinic could help support you with feeling better?”
General Care Monitoring Steps and Sample Scripts

BUILD ENGAGEMENT

“Hi, [patient name]. This is [CC name], your care coordinator at the [clinic name] calling to see how you are doing. How have things been going since we last talked?”

- After the visit, record in the registry your perception of the patient’s level of engagement (not engaged, engaged, highly engaged). This information will be helpful for the BHC and also for future reference.

ASSESS

- Check in about social needs, social support, engagement, sleep and pain.
  “The last time we saw each other, your goals were to [treatment plan goals]. How is that going for you?”

  [As needed:] “Last time we talked about some problems you were having with [pain and/or sleep]. How has that been since we last touched base? Other concerns that have come up since we last talked?”

- Document progress regarding medication adherence.
  “Some people find that it’s really hard to take medicines every day. How is it for you? Is it different depending on the type of medicine? Tell me what makes it easy or hard for you to take your medications on most days.”

  “Would it be okay to talk about your medicines? Thinking about the last week, how many days did you not take your medicine? [If it has been more than a week since the last visit: “And was it about the same for the other weeks in the last month?”]

- Clarify dosing instructions if necessary, and brainstorm solutions to any barriers to medication adherence.
• **Assess MBC (see Appendix A).**

  “I’d like to also ask you some questions about your [heroin or pain pill] use, mood, and stress [as applicable] so that we can see if there are any changes. Again, I ask these questions of all patients and I won’t judge your responses. These questions are only to check in on how you’re doing so that we can adjust the services you’re getting as needed. How does that sound?”

• Every care monitoring visit:
  o Ask OUD-5 questions.

• At least once a month (at visit 5, 9, 11–13 or at next visit if a month has passed since asking the MBCs):
  o Administer PROMIS-7.
  o Administer PHQ-9 if patient has a MDD diagnosis.
  o Administer PCL-5 if patient has a PTSD diagnosis.

• **Learn and give feedback.**

  “It sounds like [summarize challenges and then progress toward goals]. Am I hearing that right?”

  • Try to mention difficult things first, and end with positive feedback that emphasizes and reinforces their strengths. For example, “It’s been pretty hard to get outdoors for a walk this past week. But you were successful in taking your medicine most days in the past week.”

  • Congratulate patient on progress (i.e., what they are doing to reach their goals). Highlight their values and strengths.

• **Identify and address treatment barriers.**

  “What, if anything, made it harder to reach your goals since the last time we talked? For example, getting to your appointments, getting and taking your medication as scheduled, etc.”

  • Work with the patient to find solutions to barriers they are facing.
  • Restate what motivates patients to improve their health.
• Provide additional resources, link to care, and adapt treatment plan, as needed.

• **Identify behaviors to address (e.g., opioid use, PTSD, MDD, social needs).**

  “Of the things we discussed, what behaviors are you interested in working on in the next week?”

• **Document responses/progress in registry.** The registry will automatically calculate scores for each assessment and inform you of any necessary next steps. For additional information, see Chapter 6.

**LINK TO CARE**

• **Engage in shared decisionmaking about the menu of treatment options.**

  At times, patients may show signs that they are at risk of dropping out (e.g., missed appointments, not taking medications, increasing use of substances, increased experience of depression and/or PTSD symptoms, suicidality). These signs may signal that the patient’s treatment plan needs to be adjusted and/or the therapeutic alliance needs to be improved upon. For example, CCs can help to resolve misunderstandings patients may have about their PCP and BHP visits or may help to appropriately advocate for the patient within the care team when patients have different treatment preferences. At other times, the patient may simply lose focus on a goal or not be able to make progress on the goal, and again this may signal that the treatment plan needs to be adjusted. If a patient had a goal of abstinence from all substances but does not achieve it, for example, then it may be useful to adjust the treatment plan with a harm-reduction focus, such as avoiding interactions with friends who use heavily or avoiding the most high-risk substances. The CC plays a very important role in noticing these signs and linking patients to their providers. If CCs recognize that a patient is not progressing, they should consult with their care team (PCP, BHP, BHC team, and CC Consultant) to modify the treatment plan.

• **Link patients with medical and behavioral health care clinicians (PCP, BHP), and social needs referrals, if needed.**
• **Schedule next care monitoring visit and document in registry.**
  - The CC may change the recommended schedule for visits. If the patient is doing worse, the CC may schedule the patient to come in sooner to modify their treatment plan.
  - The CC may also schedule additional visits for a brief check-in that do not include a formal administration of the OUD questions. These visits can instead focus on social needs/sleep/pain concerns (e.g., seeing the patient after their visit and asking how it went). Additional visits should be documented in the registry.
  - If additional visits are not needed, schedule the next care monitoring session according to the recommended schedule.

**LOOP BACK WITH TEAM**

• **Check to see if latest assessment scores have triggered an alert in the registry.**
  - If they have, determine reason for alert.
  - Decide whether to talk with the care team about the patient (report for PCP/BHP and/or flag for BHC review).
  - Even if item isn’t flagged by registry, the CC can still talk with the care team if they think it’s necessary.
  - Touch base and share a copy of the registry report with the patient’s medical care clinician (PCP) (see CLARO Implementation Manual). Highlight insights that might inform treatment planning.
  - As necessary, talk about psychiatric recommendations (from the BHC) with the other clinical care team members (PCP and BHP). If there is disagreement, follow the recommendations of the PCP and discuss further with the BHC, if needed.

• **Review agreed-upon steps with the patient’s PCP and BHC.**
  - Prepare any questions to discuss with the BHC and CC Consultant.
Menus of Treatment Options

This section includes three “menus” of options CCs can use to review potential treatment approaches with CLARO intervention patients. Here the options and their patient-oriented descriptions are presented in table form (Tables 2.7–2.9). Where additional materials for patients are available, we provide cross-references to the numbered resources in Appendix D. The appendix also contains tear-out versions of these menus for direct use with patients. Before meeting with patients, CCs may want to print these menus and their associated resources to give to patients to take home.
### TABLE 2.7: MENU OF TREATMENT OPTIONS: OPIOIDS

<table>
<thead>
<tr>
<th>OPTION</th>
<th>DESCRIPTION FOR PATIENT</th>
<th>RESOURCES</th>
</tr>
</thead>
</table>
| Starting treatment or therapy | There are some great programs in the clinic and community that can offer support. Some are inpatient, others are outpatient, and they can help with opioid use in addition to other co-occurring behavioral or physical health issues.                                                                                                                                                                                                                                                                                                                                                           | • Comparison of OUD medications  
  » Appendix D.4  
• Buprenorphine FAQ  
  » Appendix D.5  
• Naloxone booklet  
  » Appendix D.8  
• Overdose recognition and response instructions  
  » Appendix D.9  
• Nearby harm reduction programs (needle exchange, hepatitis C virus [HCV] testing)  
  » Appendix D.3  
• Mutual self-help groups and services (Medication-Assisted Recovery Anonymous, Narcotics Anonymous)  
  » Appendix D.2 |
| Starting medication for OUD | There are some medications available that can help people with dependence on prescription pain pills or heroin. Starting a medication could help you reduce or stop using. If you are interested, I can give you some information, and your doctor will help you decide if it is right for you.                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                  |
| Staying safe strategies     | Adopt ways to stay safe by decreasing risk of overdose or protecting yourself from accidents. This may include using sterile injection equipment, knowing what and how much you're taking, and reducing risk of assault while intoxicated in unsafe areas.                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                  |
| Connecting with supportive people | You can choose a support group online or in your area, such as a 12-step program offered through Narcotics Anonymous or a SMART (Self-Management and Recovery Training) group, and attend meetings as often as you like. Support groups often are run by other people who have substance use problems and can be very helpful to people wanting to change their habits. Or you might have a supportive family member or friend who does not use who you could talk with. If you are part of a faith community, you may find that they also offer recovery-focused support groups.                                                                 |                                                                                                                                                                                                                                  |
| Talk again later            | You may not feel ready right now to choose treatment options. I can come back later to talk more about this when you feel more ready.                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                  |
**TABLE 2.8: MENU OF TREATMENT OPTIONS: DEPRESSION**

<table>
<thead>
<tr>
<th>OPTION</th>
<th>DESCRIPTION FOR PATIENT</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Problem-Solving</td>
<td>Some therapies are very helpful for treating depression. One type of therapy is called Problem-Solving Treatment, which involves working with a counselor on ways to cope with depression symptoms by solving immediate problems that contribute to depression. This takes place over 4 to 12 sessions with a therapist at your primary care clinic.</td>
<td>• Problem-Solving Treatment › Appendix D.13</td>
</tr>
<tr>
<td>Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting medication</td>
<td>There are several different medications that are effective in treating depression. If you’re interested in starting a medication or getting more information about starting a medication, we can talk with your primary care doctor about what might work best for you.</td>
<td>• Medications for MDD › Appendix D.7</td>
</tr>
<tr>
<td>Getting active</td>
<td>Doing pleasant activities that you enjoy can help improve your mood. You could work with a therapist or we could talk about it a bit now to see what might work for you specifically.</td>
<td>• Getting active with depression › Appendix D.1</td>
</tr>
<tr>
<td>Talk again later</td>
<td>You may not feel ready to choose treatment options. We can talk again about this next time.</td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 2.9: MENU OF TREATMENT OPTIONS: PTSD**

<table>
<thead>
<tr>
<th>OPTION</th>
<th>DESCRIPTION FOR PATIENT</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Written Exposure</td>
<td>There are some therapies that are helpful for PTSD. One type of therapy is called Written Exposure Therapy, and it involves working with a counselor to write or talk about the traumatic event you experienced. This takes place over five half-hour sessions with a counselor.</td>
<td>• Written Exposure Therapy › Appendix D.13</td>
</tr>
<tr>
<td>Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting medication</td>
<td>There are some medications that can help people with PTSD. For instance, sertraline (Zoloft), paroxetine (Paxil), fluoxetine (Prozac), and venlafaxine (Effexor) are antidepressants that can help people with PTSD. If you are interested, we can talk with your primary care doctor about which medication might work best for you.</td>
<td>• Medications for PTSD › Appendix D.7</td>
</tr>
<tr>
<td>Self-care</td>
<td>There are self-care tools to help with other concerns you might be experiencing, such as problems with sleep or stress/anxiety. Self-care tips could include being around safe people who do not hurt you, eating healthy, exercising, and seeing your doctor for health concerns.</td>
<td>• Improving sleep › Appendix D.11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Coping with stress › Appendix D.12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Relaxation exercises › Appendix D.14</td>
</tr>
<tr>
<td>Talk again later</td>
<td>You may not feel ready to choose treatment options. We can talk again about this next time.</td>
<td></td>
</tr>
</tbody>
</table>
Guidelines for Home Visits

CCs may use home visits to check in with patients that have difficulty coming to the clinic, though this option should be discussed with the care team first. Home visitation is not for every patient, and a clear review of who is appropriate for this service should occur before initiating these visits. CCs should be trained to conduct home visits in a safe way in accordance with clinic policy. In addition, the following guidelines should be followed to ensure the safety of the CC:

- CCs should only provide patient visits at the clinic site if there is a question of safety. If safety issues are not a concern, CCs can offer home visits to patients who experience barriers coming to the clinic for their visits.
- CLARO requires all CCs to carry a cell phone when conducting home visits for safety reasons, both to notify the clinic supervisor in case of any problems and to assist patients who have no phone to be able to schedule appropriate appointments.
- No home visiting should be conducted if domestic violence or any other safety issues have been noted by the CC or the care team.
- Any safety-related issues must be immediately reported to the clinic supervisor, noted in the patient’s EHR, and flagged in the registry.
- CCs should always check in with the clinic supervisor before leaving for a home visit and upon return.

Home visits can provide an excellent opportunity to improve engagement with the patient and to increase the CC’s understanding of some of the strengths and challenges patients experience. Home visits can also help the CC understand how to help the patient make progress toward their goals.
Self-Care and Support

CCs have incredibly important, demanding, and often difficult jobs. This section provides some tips and tools to reduce work stress and suggestions of who to reach out to if problems arise.

What Is Burnout?

CCs may find it challenging to hear stories of trauma, manage their own personal reactions to them, and support patients through crises. Over time, these stresses can make some people feel drained or burned out at work. This reaction is understandable and normal. Feeling burned out is not a sign of weakness. Ongoing self-care can help prevent burnout and combat it if it arises.

CCs can use the following tips to ward off burnout:

- Recognize that the feelings of stress are normal.
- Get enough sleep.
- Eat and be mindful of diet.
- Take advantage of social support networks (work or personal) and avoid self-isolation.
- Talk with the CC Support Team—CC Supervisor, CC Consultant, and the psychiatrist (BHC)—about feeling burned out.
- Rest, relax, and recharge—exercise, listen to music, talk, meditate. This is not selfish; it is necessary for providing good care to patients.
- Set healthy professional boundaries. Ask for help from the CC Supervisor, CC Consultant, and/or BHC to clarify boundaries in cases that are confusing.
- Work with your clinic supervisor to take time off if needed.

ABCs of Self-Care

Below are some tips that can help with self-care on the job, at home, or anywhere.

- **Awareness:** Pay attention to inner experiences (thoughts, feelings, physical reactions, defenses, and avoidance). Plan ahead for how to get needed support. Remember why this work is meaningful on a personal level.
• **Balance**: Set priorities about how to spend time and energy. This may require adjustments, but it is achievable.

• **Connection**: Reach out to loved ones and the community by spending time with the people who offer support and managing boundaries around others who do not. For some people, spirituality or religion is helpful.

**Support and Supervision**

Another important aspect of self-care is knowing how and when to reach out to other people for support. CCs are part of a collaborative care team. CCs are not alone in their work; many other people work together to provide care for the patients. If questions or concerns come up, CCs should not hesitate to reach out to team members for support. Below are examples of a few situations in which specific people might be able to help assist you. If unsure who to go to, the CC Supervisor can suggest someone.

**FIGURE 2.4: SUPPORT FOR CARE COORDINATORS AMONG CLARO TEAM MEMBERS**
Chapter 2 Sources


CHAPTER 3

Medication for OUD and MDD/PTSD

This chapter is geared toward primary care providers (PCPs) and focuses on medication to treat OUD, depression, and PTSD. The chapter begins with an overview of the PCP role in the context of the CLARO study. It reviews the diagnosis of OUD, depression, and PTSD and the factors PCPs should consider when making integrated treatment decisions. The chapter goes on to summarize additional common comorbidities and their treatment considerations, as well as other factors to keep in mind for patients with co-occurring OUD with MDD and/or PTSD. General resources are provided at the end of the chapter, and Appendix B provides extensive additional detail. See the abbreviations list for a list of definitions for abbreviations used in this chapter.
Overview of Primary Care Provider Role and Expectations

PCPs play a key role on the collaborative care team. In CLARO, this involves supporting the patient’s remission from OUD, MDD, and PTSD. Along with managing OUD, PCPs assess and diagnose other behavioral health conditions; negotiate treatment goals with patients; review the appropriate treatment options using a shared decisionmaking framework; order and review laboratory testing; and offer pharmacotherapy to treat physical health conditions, mental health conditions, and SUDs.

For patients who are enrolled in the CLARO study, the PCPs continue to provide ongoing primary care as they normally would if the patient were not enrolled in the study. The difference is that the patients randomized to the CLARO intervention will be supported by a CC with a background as a community health worker and a BHC who is a board-certified psychiatrist with expertise in OUD, MDD, and PTSD. Their roles are described in Chapters 2 and 5, respectively. For patients not in the CLARO intervention, referrals to PCP will follow enhanced usual care procedures, which include a PCP screening for MDD and/or PTSD symptoms and pharmacotherapy.

Care Coordinators

CCs track and facilitate continuity of care and also act as a force multiplier, supporting PCPs by maintaining consistent outreach to patients between PCP visits. PCPs should reach out to CCs if there are specific clinical concerns, such as whether a patient initiated prescribed medications or followed through with a referral following a PCP visit. CCs in CLARO boost PCP efficiency by

- using standardized scales to monitor patients’ symptoms and help identify patients in need of extra attention
- following up with patients on treatment recommendations and upcoming appointments
- addressing patient barriers to care access or retention, including social determinants of health
- relaying communication among CLARO team members, including progress reports to PCPs
- keeping track of local resources for the treatment and management of comorbid conditions.

Considerations for PCPs

This chapter reviews the treatment of co-occurring OUD with MDD and/or PTSD by PCPs. Because diagnosing and treating OUD is initially an urgent priority, this chapter begins with primary care OUD management and then reviews MDD and PTSD management. PCPs will want to elicit additional support from other types of providers in specific cases, and the CLARO intervention supports the PCP obtaining this support. Specifically, PCPs should consult the BHC when there are clinical questions that require addiction medicine specialist and psychiatric input. Numerous resources geared toward PCPs and patients are also provided in Appendixes B and D, respectively.

Trauma-Informed Care

In patients with or who may have PTSD, PCPs play a key role in establishing a physically and emotionally safe environment, fostering trust, establishing boundaries, supporting autonomy and choice, creating collaborative relationships and participation opportunities, and using a strengths and empowerment-focused perspective to promote healing.

» See Appendix A.2 for information and resources about trauma-informed care.
Integrated Treatment Considerations

Depressive and anxiety symptoms are common in patients with OUD and often resolve when they enter remission. Remission of OUD is present when the patient no longer meets *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) criteria for OUD (at least three months for early remission; 12 months for sustained remission). PCPs may encounter patients being treated for OUD for whom additional MDD and/or PTSD treatment may be necessary, such as those with

- mild to moderate depressive/anxiety symptoms that don’t remit within the first few weeks of OUD treatment
- severe depressive/anxiety symptoms at any point
- a clinical history of depressive and/or anxiety symptoms that persist despite OUD remission.

For these patients, PCPs should assess whether co-occurring MDD and/or PTSD is present, diagnose and determine the severity of these disorders, review appropriate treatment options, assess the patient’s readiness to accept treatment, and negotiate a treatment plan that may include referrals. The clinical focus of the CLARO intervention is the treatment of OUD co-occurring with MDD and/or PTSD, and the strategies discussed below are focused on these disorders. However, anxiety disorders other than PTSD may also be present, and PCPs should continue to assess for and treat other anxiety disorders in patients with OUD co-occurring with MDD and/or PTSD.

Initiating medication to treat the OUD is the initial priority for those patients except in cases in which psychiatric safety risks require emergent intervention (e.g., when a patient reports a plan to attempt suicide). Medication treatment for moderate to severe OUD is strongly supported in the literature in all settings, including primary care—even for those patients with co-occurring depression, anxiety, and PTSD. Once OUD medication has been started, PCPs may also offer pharmacotherapy or other treatment options for depression/anxiety as needed. Patients in treatment for co-occurring OUD and MDD/PTSD show improved rates of remission when they receive treatment for each of these conditions in an integrated setting (Morse and Bride, 2017).
The remainder of this section describes considerations for integrated treatment decisions. For easy reference, we present several Quick Start Guides that outline likely treatment and prescribing action and follow these with a more detailed discussion.
Quick Start Guides

Use the following three Quick Start Guides as a reference for the essential steps to treat OUD with co-occurring MDD and/or PTSD.

**TABLE 3.1: QUICK START GUIDE 1: OUD TREATMENT**

<table>
<thead>
<tr>
<th>ACTION</th>
<th>DETAILS</th>
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</table>
| **Screen** for and assess readiness to address OUD (Appendixes B.5 and B.6). | • NM-ASSIST (National Institute on Drug Abuse Modified Alcohol, Smoking and Substance Involvement Screening Test)  
• TAPS (Tobacco, Alcohol, Prescription medication, and other Substance use) Tool |
| **Check** the prescription monitoring report (PMP). | • http://newmexico.pmpaware.net  
• Review information to assess the pattern of controlled substances that the patient has been prescribed and implications for the patient’s OUD |
| **Diagnose** using the DSM-5 (Appendix B.21). | The 11 diagnostic criteria can be lumped into the 3 Cs: Compulsive opioid use, Craving opioids, Consequences from opioid use. |
| **Refer** to additional appropriate services if patient is interested. | • If the patient is interested in additional addiction treatment services beyond what is available in primary care, ask BHP to conduct a level of care assessment and support an appropriate referral. Consult BHC when there are questions.  
• Refer patients who require inpatient alcohol or sedative withdrawal management. |
| **If OUD** |  
**Offer treatment** with buprenorphine/naloxone and a prescription for naloxone. | • Ask if the patient is interested in a medication to help them reduce problem opioid use.  
• Co-prescription of naloxone annually is required by New Mexico state law, and it is best practice. See http://prescribetoprevent.org  
• Offer patient-oriented resources (listed in Appendix D). |
| **Prescribe** and provide instruction on how the patient should take medications. | **Buprenorphine/naloxone:** 8 mg/2 mg tabs/films, take as directed, #28 with refills if the patient has barriers to follow-up in the clinic.  
**Naloxone:** 4 mg/0.1 ml nasal spray kit, #2, 2 refills.  
• See Quick Start Guide 3: Prescribing Considerations for more information. |
| **Offer lab testing/toxicology.** | **Serum:** complete blood count (CBC), complete metabolic panel (CMP), HIV, hepatitis, rapid plasma reagin (RPR); thyroid stimulating hormone (TSH), and vitamin B12 for depression and anxiety.  
**Urine:** hCG in appropriate patients of childbearing age.  
**Urine toxicology:** Point of care immunoassay testing for opioids, oxycodone, methadone, buprenorphine, benzodiazepines, barbiturates, amphetamine, methamphetamine, and cocaine. Fentanyl testing usually has to be ordered as a separate test.  
**Note:** Do not withhold buprenorphine/naloxone from patients with OUD if lab testing has not been performed. |
• Clinically disputed or equivocal results: If the result will change your clinical approach, send sample for quantitative laboratory confirmatory testing of just the questioned substance(s).
• Other substances: Send sample for testing for other substances, such as fentanyl, phencyclidine, and/or tetrahydrocannabinol if there is a clinical reason to assess for other substance use.

### TABLE 3.2: QUICK START GUIDE 2: MDD AND PTSD TREATMENT

<table>
<thead>
<tr>
<th>ACTION</th>
<th>DETAILS</th>
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<tbody>
<tr>
<td><strong>Stabilize</strong> OUD medication.</td>
<td>OUD pharmacotherapy is priority before medication management of MDD/PTSD.</td>
</tr>
</tbody>
</table>
| **Screen** for MDD and PTSD if not yet completed by the CC (Appendixes B.19 and B.20 for MDD; B.23 for PTSD). | MDD: PHQ-9.  
PTSD: PCL-5. |
| **Diagnose** MDD, and/or PTSD using the DSM-5 (Appendix B.21 for MDD; B.24 for PTSD). | MDD: > 2 weeks of depressed mood or anhedonia with five or more from the DSM-5 MDD diagnostic criteria (mnemonic: SIGECAPS [sleep, interest, guilt, energy, concentration, appetite, psychomotor function, and suicide]).  
Screen patient with depression for bipolar disorder using the Compositive International Diagnostic Interview, version 3 (CIDI-3) for bipolar disorder. Patients with history of one or more episodes of hypomania or mania not caused by intoxication or explained by medical illness should be considered for the diagnosis of bipolar disorder, which is treated differently than MDD.  
PTSD: A history of ≥ 1 traumatic event(s) followed by ≥ 30d of trauma-related symptoms, including ≥ 1 re-experiencing symptom, ≥ 1 avoidance symptom, ≥ 2 arousal and reactivity symptoms, ≥ 2 cognition and mood symptoms. |

**If MDD**

Offer treatment: (Appendix B.25).

- Offer medication treatment with an antidepressant.
- Individual and group counseling options are available.

**If PTSD**

Offer treatment: (Appendices B.26, B.27, B.28, and B.34).

- Offer prazosin; start 1 mg every bedtime (QHS) and titrate up every 3 to 4 days in 1 mg QHS increments as tolerated until symptoms improve.
- Additionally, offer SSRI or SNRI antidepressants, which are also first-line medication treatments for PTSD.
- Individual and group counseling options are available.

Counsel the patient to not stop taking medications without medical advice.

- For prazosin, increase dose until nightmares and insomnia resolve, or until there is persistent dizziness or other adverse effects that don't resolve within a week.
- For SSRIs/SNRIs, start low and titrate as tolerated. It may take 6–8 weeks for maximum benefit, so counsel patients not to stop these medications prematurely.
### TABLE 3.3: OUD TREATMENT QUICK START GUIDE 3: PRESCRIBING CONSIDERATIONS

<table>
<thead>
<tr>
<th>ACTION</th>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Determine feasibility of starting OUD medication.</strong></td>
<td>The initial treatment priority is offering buprenorphine/naloxone as quickly as feasible, prior to lengthy assessments or treatment planning sessions.</td>
</tr>
</tbody>
</table>
| **Prescribe OUD medication.** | **Buprenorphine/naloxone:** 8 mg/2 mg tabs/films, take as directed, #28.  
---  
**Naloxone:** 4 mg/0.1 ml nasal spray kit, #2, 2 refills.  
- Instruct the patient to wait until they are in mild to moderate opioid withdrawal and then put ½ to 1 tab of buprenorphine/naloxone under their tongue and hold it there until it is fully dissolved.  
- The recommended initial dose of buprenorphine/naloxone is 4 mg/1 mg to 8 mg/2 mg. Patients can titrate up by 4 mg/1 mg to 8 mg/2 mg in one-hour increments to 16 mg/4 mg during the first day, and can self-titrificate from 16 mg/4 mg to 24 mg/6 mg on or after the second day if needed.  
- Prescriptions of buprenorphine/naloxone of two weeks or more for those with a starting dose greater than 4 mg/1 mg have been shown to increase treatment success.  
- Write refills if there is any concern about the patient not having consistent telephone or transportation access that would interrupt their being able to easily follow up with the clinic for follow-up appointments.  
- Instruct the patient on how to use naloxone in case of opioid overdose (see Appendix D.8). |
<table>
<thead>
<tr>
<th>ACTION</th>
<th>DETAILS</th>
</tr>
</thead>
</table>
| **Offer treatment for MDD/PTSD.** | - Consult the BHC with questions.  
- Prazosin is a first-line treatment for PTSD, and prazosin can be safely combined with antidepressant medications. Start prazosin at 1 mg QHS and titrate up as tolerated to target nightmares and insomnia. See Appendix B.34.  
- SSRI/SNRIs are preferred to treat MDD and PTSD.  
  - For patients unlikely to be adherent to a daily medication, consider fluoxetine, which has a long half-life.  
  - For patients on multiple other medications, consider citalopram or escitalopram, which have fewer interactions with other medications.  
  - Venlafaxine has a severe discontinuation syndrome with any missed doses and so isn’t recommended for patients who aren’t scrupulously adherent to their regimens.  
- Occasionally a non-SSRI/SNRI may be preferred for specific reasons.  
  - For patients with insomnia and/or low appetite, consider mirtazapine or paroxetine, which are sedating and have weight gain as a side effect.  
  - For patients with MDD who want to avoid sexual side effects, consider mirtazapine or bupropion.  
  - Bupropion is not recommended as a sole medication for treating PTSD or other anxiety disorders as it can worsen anxiety, but it can be used in combination with other SSRIs or SNRIs.  
- Consult the BHC (psychiatrist on the care team) with questions. |
<table>
<thead>
<tr>
<th>ACTION</th>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screen</strong> for and assess readiness to address co-occurring alcohol use disorder (AUD), stimulant use disorder, and/or tobacco use disorder.</td>
<td></td>
</tr>
<tr>
<td><strong>If AUD</strong></td>
<td>Naltrexone LAI 380 mg intramuscularly (IM) monthly; alternative oral naltrexone if patient declines to receive injectable naltrexone or there are other barriers (e.g., insurance).</td>
</tr>
</tbody>
</table>
| **Consider** naltrexone long-acting injection (LAI) if the patient has stopped all opioid use for at least a week and declines buprenorphine/naloxone and is not taking methadone. | Start acamprosate 333 mg three times daily (TID) for three days, then increase to 666 mg by mouth TID. 
*and/or* 
Start topiramate 25–50 mg QHS and titrate up to 150–300 mg QHS as tolerated. 
If starting topiramate, don’t neglect to offer contraception to appropriate patients of childbearing age. 
*and/or* 
Start gabapentin 300 mg TID and titrate up to 600 mg TID as tolerated. |
| **Consider** acamprosate, topiramate, or gabapentin for individuals on buprenorphine or methadone to avoid opioid antagonist. | |
| **If stimulant use disorder with OUD and/or MDD** | Start mirtazapine at 15 mg QHS and increase to 30 mg QHS after 7 days. |
| **Consider adding** mirtazapine to decrease high-risk behavior associated with methamphetamine use (Coffin, 2019). | Contingency management involves giving patients tangible rewards to reinforce positive behaviors, such as abstinence or treatment adherence. |
| **Consider** contingency management for co-occurring stimulant use disorders. | See https://www.aafp.org/pubs/afp/issues/2021/0615/od1.html for smoking cessation treatment guidance. |
| **If tobacco use disorder with MDD** | Start bupropion XL 150 mg daily for 7 days, then increase to bupropion XL 300 mg daily. Can safety combine with other SSRIs/SNRIs. |
| **Consider** use of bupropion extended release (XL) | |
Opioid Use Disorder Diagnosis

To diagnose OUD, see Appendix B.7 for a DSM-5 criteria checklist. The patient should meet two or more of the 11 criteria within the preceding 12 months, assuming that the patient has been in their usual environment (i.e., not incarcerated). These criteria fall into three domains called the 3 Cs: Compulsive opioid use, Craving opioids, and Consequences from opioid use (as mentioned above in Table 3.1). Incarcerated patients can meet OUD criteria based on the presence of symptoms prior to incarceration. In patients who screen positive for opioid use, check the PMP to obtain relevant collateral information.

Guidelines recommend offering buprenorphine/naloxone maintenance therapy (instead of medically supervised withdrawal), and buprenorphine/naloxone should be offered without delay when an OUD diagnosis is made. The patient’s ability to participate in co-occurring MDD and/or PTSD treatment often requires the OUD to be medically stabilized before starting treatment.

Getting Started with Opioid Use Disorder Medication

Initiation of buprenorphine/naloxone: Start at either 4 mg/1 mg to 8 mg/2 mg (half to one of the 8 mg/2 mg tabs or films) and the patient can titrate up in either 4 mg/1 mg to 8 mg/2 mg increments up to 16 mg/4 mg during the start day. Patients sometimes need to increase to either 16 mg/4 mg to 24 mg/6 mg by day 2 based on their tolerability and response to buprenorphine/naloxone. Data suggest that a daily dose of greater than 4 mg and a prescription length of greater than 15 days at buprenorphine initiation may increase the chances that the patient will continue treatment within the first six months (Meinhofer, 2019).

Some patients take buprenorphine/naloxone in split dosing (e.g., twice daily [BID], three times daily [TID], or four times daily [QID]), and more-frequent dosing is appropriate when analgesia from buprenorphine is needed, such as in instances where a patient has both chronic pain and OUD.
If the patient agrees to accept treatment with buprenorphine/naloxone, you can proceed with instructions to start buprenorphine/naloxone at home. The primary care team should see the patient frequently after initiating buprenorphine/naloxone, usually within the first week. It is helpful to have a nurse, medical assistant, or CC speak with the patient by phone the day after the patient’s start date.

Patients with OUD should be screened for the use of methadone, any other long-acting synthetic opioid, or the receipt of a naltrexone LAI within the past month, as the approach to starting buprenorphine/naloxone in these patients requires adjustments from the recommended default. PCPs should consult the BHC (psychiatrist) in these instances if there are questions about initiating buprenorphine/naloxone.

**Do not withhold buprenorphine/naloxone from patients who are taking sedatives, such as benzodiazepines, or are consuming alcohol.** Continue to assess for the use of alcohol, sedatives, and other substances regularly during maintenance therapy to offer patients support when they are ready to change their use of these other substances. Patients who stop heavy use of alcohol or other sedatives are at risk for medically complicated withdrawal and should be assessed for and, when necessary, referred for inpatient withdrawal management when necessary.

**Maintenance treatment with buprenorphine/naloxone should be offered without arbitrary tapering or time limits.** Buprenorphine/naloxone should be discontinued only if it is worsening the patient’s health—not based upon an unexpectedly positive urine test result or single missed visit. Individualized psychosocial services should be continually offered but not required as a condition of receiving buprenorphine/naloxone. Buprenorphine/naloxone should not be withheld from patients who are not ready to participate in counseling or other psychosocial services.

There are instances when a patient meets OUD criteria in a controlled environment despite their not recently using opioids nor having active physiologic opioid dependence. They will still require medication treatment for prevention of relapse to opioid use. For these patients, we recommend a slower buprenorphine/naloxone initiation process (up to 4 mg/1 mg–8 mg/2 mg on day 1, and if dose increase is needed to prevent relapse, up to 8 mg/2 mg–12 mg/3 mg on day 2, then reassess at one week). Some patients may be candidates for naltrexone LAI as an alternative to buprenorphine/naloxone if they have been off of opioids entirely for > 7–14 days. Note
that the oral form of naltrexone has not been shown to be effective in treatment of OUD; however, there is evidence supporting the use of naltrexone LAI.

» See Appendix B.15 for more on naltrexone LAI.

Some patients don’t accept, or respond to, buprenorphine/naloxone in primary care settings and would benefit from referral to an Opioid Treatment Program (OTP) for OTP-managed buprenorphine/naloxone or treatment with methadone. In addition to primary care–managed buprenorphine/naloxone, some patients benefit from additional addiction treatment services. PCPs can refer patients to the BHP to conduct a level of care assessment and support an appropriate referral for patients interested in additional addiction treatment services beyond what is available in primary care.

Contact the BHC when there are questions about medication management of OUD or about what levels of care are appropriate for individual patients.

» See Appendix B.10 for a link to Substance Abuse Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol (TIP) 63, which includes a comprehensive review of medications for OUD.

Medication Maintenance

After initial stabilization with buprenorphine/naloxone, medical visits can be adjusted to every two weeks, monthly, and up to every three months, based on provider and patient agreement. The target dose range that has been found to be most likely to prevent relapse is 16 mg/4 mg–24 mg/6mg sublingual daily. **Due to the high risk of relapse when this medication is tapered/stopped, it is highly recommended that patients remain on treatment long term**, for as long as the benefits to the patient outweigh the risks and adverse effects. Please refer to the guides regarding buprenorphine/naloxone initiation and subsequent maintenance dose adjustment of buprenorphine/naloxone.

» See Appendixes B.13 and B.14 for more on buprenorphine products for OUD treatment and dose adjustment.
Inquire about the presence of naloxone in the home and training of family members/friends at regular office visits in case a new supply is needed more than once per year.

» See Appendix B.16 for more on prescribing naloxone to patients with OUD and information available to the friends and family of individuals with OUD.

**Adherence to Treatment**

Especially early in treatment, it may be difficult for patients to keep appointments. CCs should conduct frequent check-ins with the patient about medication adherence, side effects, ongoing craving or withdrawal symptoms, and any other barriers the patient is experiencing when participating in treatment. It can be helpful to have the CC and/or support staff reach out to the patient to explore possible reasons, such as transportation barriers, for not coming to an appointment. The key to successful treatment is keeping the patient engaged. Therefore, giving the patient the opportunity to reschedule the visit or, if your clinic permits, to be seen as a walk-in patient is likely to best support remission from OUD.

**Patients are at increased risk of relapse when taking buprenorphine intermittently.** Worrisome signs of relapse may manifest as frequent no-shows or low levels/negative levels of buprenorphine metabolites. In these cases, or if the patient expresses interest in a long-acting formulation of buprenorphine, consider extended-release monthly injection (Sublocade), which is a different medication formulation and alternative route of administration compared with sublingual buprenorphine/naloxone. However, do not withhold buprenorphine/naloxone from patients with OUD solely due to their opioid or other drugs use. Buprenorphine/naloxone should be continued for as long as the benefits to the patient outweigh the risks and adverse effects.

In case of pregnancy, PCPs can transition patients to the equivalent dose of buprenorphine/naloxone in mono-product form (buprenorphine/Subutex), which is an alternative to buprenorphine/naloxone in which the buprenorphine in the tablet is not coformulated with naloxone. If a pregnant patient requests to be newly initiated on buprenorphine treatment, consultation with an addiction specialist and/or obstetrician-gynecologist experienced in treating OUD is recommended, since many providers choose to hospitalize pregnant patients during treatment initiation.
Lab Testing/Toxicology

After performing the initial history and physical exam, the PCP may also want to obtain baseline labs for therapeutic monitoring, depending on clinical practice and patient agreement. PCPs should discuss with patients the need to incorporate a routine urine toxicology test as part of treatment and stress that it is not meant to be punitive. It is important to obtain a full medication history, including timing of last drug use, over-the-counter (OTC) medications, and herbal therapies, due to the potential that these may affect the toxicology results. Suggested labs include CBC, CMP, HIV, hepatitis, RPR, and hCG. The PMP should be reviewed as well. Both urine tests and PMPs should be reviewed routinely at follow-up visits.

PCPs primarily should use clinical judgment regarding the decision to proceed with treatment; lab results alone (or a lack thereof) should not prohibit treatment. As point-of-care tests and send-out screens may not be accurate, **it is important to not change treatment in response to disputed or unexplained toxicology immunoassay results without obtaining a confirmation toxicology test for verification.** It is helpful to discuss test results in person with the patient in order to make a shared decision regarding next steps in treatment. Lastly, for patients who are on buprenorphine prescriptions of one month or longer, it is recommended to check buprenorphine metabolites at least yearly to ensure appropriate use of medication. Patients who are prescribed buprenorphine who have confirmatory toxicology results consistent with buprenorphine nonadherence should be re-evaluated for the appropriateness of ongoing buprenorphine treatment.

Contact the BHC if there are questions about appropriate laboratory testing and monitoring of OUD with MDD and/or PTSD.

» See Appendix B.17 for more on the urine drug testing window.
MDD and PTSD Diagnosis

To diagnose MDD, see Appendix B.21 for a DSM-5 criteria checklist. The patient should meet at least five of the nine criteria within the preceding two weeks, with the caveat that the patient’s depressive symptoms are not caused solely by intoxication or better explained by another diagnosis or medical illness. Additionally, patients with a history of the mood episodes of hypomania or mania not caused by intoxication or explained by medical illness should be considered for the diagnosis of bipolar disorder, which is treated differently than MDD. Consult the BHC in instances where there are diagnostic questions about the presence of other mood disorders.

PTSD is defined by exposure to a traumatic event, either personally experienced or witnessed, that leads to the development of symptoms wherein the individual re-experiences the event; avoids people, places, or things that remind them of the trauma; has negative mood and thoughts associated with the event; and displays ongoing hypervigilance. PTSD is diagnosed when these symptoms persist for at least one month after the traumatic event. To diagnose PTSD, see Appendix B.24 for the DSM-5 Diagnostic Criteria for PTSD.

Getting Started with MDD/PTSD Medication

Guidelines recommend treatment of MDD and PTSD for 4–12 months after an initial episode and longer treatment with recurrent symptoms. Antidepressant selection depends on various factors, including prior treatment response, age, pregnancy/breastfeeding status, and potential medication interactions. Importantly, patients with co-occurring MDD and OUD have been found to have similar treatment responses to antidepressants as patients with MDD alone, and treatment of underlying depression/anxiety can benefit their recovery from OUD.

Several medications are available to treat PTSD (see decision tree in Appendix B.26). Prazosin is recommended as the first-line medication treatment for PTSD (H. Roggenkamp, personal communication, prazosin instructions for patients, May 26, 2020). For prazosin, PCPs should start with 1 mg at bedtime initially to support tolerability but titrate up until any nightmares resolve and sleep has improved (usually at doses over 2–3 mg at bedtime). Prazosin can be safely combined with SSRIs and SNRIs. See Appendix B.34 for prazosin instructions.
For SSRI/SNRI medication selection for both MDD and PTSD, the initial consideration is whether the patient has experienced a positive or negative response to a medication in this class previously. If the patient has no history to guide medication selection, the following options should act as a guide:

- For patients unlikely to be adherent to a daily medication, consider **fluoxetine**, which has a long half-life.
- For patients with insomnia and/or low appetite, consider **mirtazapine** or **paroxetine**, which are sedating and cause weight gain.
- For patients who want to avoid sexual side effects, consider **mirtazapine** or **bupropion**.
- For patients on multiple other medications, consider **citalopram** or **escitalopram**, which have fewer interactions with other medications.

**Bupropion** is not recommended as a sole medication for treating PTSD or other anxiety disorders, as it can worsen anxiety. However, bupropion can be used in combination with other SSRIs or SNRIs.

**Venlafaxine** has the disadvantage of a severe discontinuation syndrome (flu-like symptoms, insomnia, nausea, imbalance, sensory disturbances, hyperarousal, and Lhermitte’s sign) that can emerge with even one missed dose, so is not an appropriate treatment for patients who aren’t scrupulously adherent to taking medications daily.

Additionally, patients should be counseled that it may take 6–8 weeks to experience benefit and that they should not abruptly stop taking an SSRI/SNRI.

» See Appendixes B.25–B.28 for additional resources related to MDD and PTSD medications.

**Benzodiazepines** should be avoided, as they can worsen PTSD symptoms and have significant potential for misuse.

Contact the BHC if there are questions about medication management of MDD/PTSD.
Screening for Other Substance Use

There is a strong association between MDD/PTSD and SUDs other than OUD. Many screening tools exist to assess for other SUDs, including the NM-ASSIST, TAPS Tool. Treatment for co-occurring SUDs is usually indicated, if the patient is ready.

» See Appendixes B.4–B.6 for more on screening tools.

Tobacco Use Disorder

Tobacco use disorder is common among patients with MDD/PTSD and other SUDs, and successfully treating tobacco use disorder improves SUD and depression treatment outcomes. The American Academy of Family Physicians offers tobacco use disorder treatment and cessation guidance on the screening for, diagnosing, and treating tobacco use disorder.

» See Appendix B.6 for tobacco use disorder screening, diagnosis, and treatment planning tools.

In addition, the National Institutes of Health (NIH) has devised a Readiness Ruler to help clinicians assess how engaged and receptive patients might be to potential treatments. The Readiness Ruler asks the patient to rate on a scale of 1–10 their motivation to take a specific action. It also asks the patient to separately rate on a scale of 1–10 their confidence that they could take that specific action. PCPs and other clinicians then respond by asking them questions to evoke change talk.

» See Appendix B.32 for more on the Readiness Ruler.

Setting Up Treatment Plans

Shared decisionmaking between the PCP and the patient regarding treatment is essential to supporting patient adherence and should involve a review of MOUD options. CCs will review applicable “menus” of treatment options with patients (Chapter 2 and Appendix D), summarized in the table below.
TABLE 3.4: SUMMARY OF TREATMENT OPTIONS

<table>
<thead>
<tr>
<th>OUD</th>
<th>MDD</th>
<th>PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>Medication</td>
<td>Medication</td>
</tr>
<tr>
<td>Strategies to stay safe and/or reduce harm</td>
<td>Problem-Solving Treatment</td>
<td>Trauma-informed care approach to establish safety</td>
</tr>
<tr>
<td>Connecting with supportive people or groups</td>
<td>Getting active strategies</td>
<td>Medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Written Exposure Therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symptom management and relaxation exercises</td>
</tr>
</tbody>
</table>

PCPs establish the medication component of the patient’s treatment plan and, as such, should review the indications, risks, benefits, and alternatives to pharmacotherapy with patients. (See Quick Start Guide 3, Prescribing Considerations, at the start of this chapter.) PCPs should also work with their CCs and others on the collaborative care team to ensure that the psychosocial components of treatment are also fully addressed.

» See Appendixes B.29 and B.30 for a sample form for goal-setting and establishing coping strategies, and a suggested diversion control plan.
Common Comorbidities

PCPs will find that many of their patients with OUD and co-occurring MDD and/or PTSD may have insomnia, anxiety, nightmares, and such medical comorbidities as hepatitis or other types of liver diseases. Insomnia, in particular, is a common condition in patients with OUD, MDD, and/or PTSD and when untreated can make response to treatment for any of these conditions much more challenging.

Proactive management of comorbidities can help patients adhere to treatment. PCPs will need to determine whether additional patient information, for instance on establishing regular healthy bedtime routines for insomnia, will be sufficient. Patient-oriented handouts are recommended in Appendix D. Below we summarize medication guidelines for these common issues.

TABLE 3.5: COMMON SYMPTOMS AND CONDITIONS AMONG PATIENTS WITH OUD AND CO-OCcurring MDD AND/OR PTSD

<table>
<thead>
<tr>
<th>SYMPTOM / CONDITION</th>
<th>DETAILS</th>
</tr>
</thead>
</table>
| **Insomnia**        | For patients with OUD and insomnia, consider underlying diagnoses that may affect sleep, such as sleep apnea and PTSD. In addition to reviewing sleep patterns, consider medications such as trazodone or hydroxyzine.  
• Prazosin; start at 1 mg QHS and titrate dose up as patient tolerates since doses of 5 mg or more QHS are often needed for insomnia and nightmares. See Appendix B for detailed dosing instructions.  
• Trazodone 50 mg QHS (can titrate up dose if necessary and tolerated).  
• Diphenhydramine 50 mg QHS (can titrate up dose if necessary and tolerated).  
• Doxepin 10 mg QHS (can titrate up dose if necessary and tolerated). |
| **Anxiety**         | An SSRI or SNRI is recommended as first-line treatment for anxiety. In addition to an SSRI or SNRI, PCPs can consider adding  
• buspirone, start 7.5 mg BID, and titrate to a usual dose of 15 mg BID. The Food and Drug Administration (FDA) recommended max. is 30 mg BID.  
The following medications can be prescribed to be taken as needed in combination with daily SSRI or SNRI treatment:  
• hydroxyzine 25–50 mg TID PRN anxiety (avoid if patient taking another antihistamine).  
• propranolol 10 mg TID PRN anxiety (avoid if patient is on another beta blocker or has hypotension).  
• Clonidine, 0.1 mg BID to QID PRN anxiety (avoid if patient is on an alternative medication that lowers the heart rate or blood pressure).  
• gabapentin 300 mg TID PRN anxiety (has abuse/diversion risk). |
<table>
<thead>
<tr>
<th>SYMPTOM / CONDITION</th>
<th>DETAILS</th>
</tr>
</thead>
</table>
| Nightmares                | • Prazosin; start at 1 mg QHS and titrate dose up as patient tolerates since doses of 5 mg QHS or more are often needed for insomnia and nightmares. See Appendix B for detailed dosing instructions.  
                            • If patient’s blood pressure doesn’t tolerate or respond to prazosin, consider doxazosin 1 mg and titrate up in 1 mg increments every week to effect as tolerated. |
| Hepatic/renal disease     | Treatment with buprenorphine/naloxone is generally safe.  
                            • It is OK to prescribe to patients with cirrhosis and chronic hepatitis C; however, liver function should be monitored. Patients with hepatic disease may experience decreased clearance and therefore require decreased dosage. |
| Tobacco use disorder      | Treatment with nicotine replacement therapy, varenicline, and/or bupropion is recommended for smoking cessation.  
                            • See https://www.aafp.org/pubs/afp/issues/2021/0615/od1.html for Tobacco Use Disorder Treatment guidance |
| Other considerations      | • Consult the BHC (psychiatrist on care team) when there are questions related to the management of patients where the management plan is complex or unclear.  
                            • Avoid benzodiazepines and hypnotics (zolpidem, eszopiclone, and zaleplon) in patients with co-occurring OUD and with other SUDs.  
                            • Do not withhold buprenorphine/naloxone from patients taking benzodiazepines, taking other sedatives, or consuming alcohol.  
                            • Avoid antipsychotic medications unless the patient has some other indication for the use of these medications. |
Additional Support

PCPs should feel well supported and able to lean on their care team for additional guidance. CCs will be well equipped to assist PCPs, who should also regularly support CCs and encourage their patients to stay in touch with their assigned CC as well.

Some situations will warrant additional support from a BHC, and the threshold for when to call in additional support may not always be clear-cut. PCPs should err on the side of asking questions of the BHC (the care team psychiatrist) rather than leaving uncertainties unresolved.

PCPs should consult the BHC when there are questions about what diagnoses might apply to a patient based on their clinical history and examination, which medications and doses are appropriate in specific clinical circumstances, how to order or interpret laboratory test results, and when there are general medication or other management questions for specific patients.

BHCs help advise PCPs faced with patient-specific clinical situations, especially when there are constraints on what is feasible among the clinically recommended options. For instance, a patient who might be clinically appropriate for residential addiction treatment may not be able to access that treatment due to its expense, its lack of proximity, or other real-world constraints.

Other Resources

Appendix B pulls together numerous resources for the PCP, many of which are drawn from SAMHSA’s TIP 63 publication, which was revised in May 2020. Though some of its instructions on topics covered in this chapter may differ slightly from the above recommendations, it contains an abundance of detail on medications for OUD. The recommended treatment options presented in this manual are current as of the date of publication, though PCPs should keep in mind that clinical guidelines may change over time. In addition, Appendix D includes links to patient-oriented resources.
In Closing

Many patients arrive to treatment feeling hopeless and with low self-esteem. PCPs should remind patients that recovery is possible and that treatment works. There are vital benefits that come through the therapeutic alliance, so PCPs should indicate that they have not lost hope for their patients, even if the patient is pessimistic, and that successful treatment often depends on treatment being a partnership. PCPs should also regularly remind patients to connect with their CCs, who are essential sources of therapeutic connection and support. The human capacity for resilience in the face of overwhelming adversity is extraordinary. By engaging in treatment, patients are beginning their process of recovery toward increasingly fulfilled lives.
Chapter 3 Sources

CHAPTER 4

Psychotherapy for Depression and Posttraumatic Stress Disorder

BHPs play an essential role in supporting patients with OUD co-occurring with MDD and/or PTSD. This chapter is aimed at BHPs and discusses the role of the BHP within the CLARO intervention, considerations for BHPs in setting a treatment plan, and training that will be offered to participating BHPs. Appendix C provides additional information and resources on the two types of therapies that BHPs are asked to consider for CLARO patients.
Overview of the Behavioral Health Provider Role

The CLARO intervention includes psychotherapy options for patients with co-occurring OUD with MDD and/or PTSD. Members of the care team, including the PCP and CC, may refer patients to BHPs to evaluate the appropriateness of psychotherapy. Patients may be offered psychotherapy, though lack of available therapy slots could be one reason why the BHP does not offer therapy to the patient. This chapter describes the role of BHPs who provide psychotherapy to patients in the CLARO intervention.

Collaborative Care Workflow

Patients in the CLARO intervention will work with their CC to discuss treatment options with the patient. If the patient agrees to consider psychotherapy, the CC will refer the patient to a BHP and share visit information, including results from the MBC assessments, to facilitate formal assessment. The BHP may choose to conduct a biopsychosocial or level of care assessment with the patient to determine their appropriate level of care (Los Angeles County Department of Public Health, 2017).

The BHP and the patient will share decisionmaking on their next steps, including provision of PST, WET, or other psychotherapy as needed. The BHP will then loop back with the CC, who will document decisions in the registry, which also monitors treatment adherence and change in symptoms for the patients in their caseload.

» See Chapter 6 and UW’s CMTS User Guide for more on the registry.

BHPs will be asked to notify the CC on how the patient is progressing in therapy and communicate with the CC (and/or the PCP) about any concerns, including symptom progression, risk of suicide, poor session attendance/missed appointments, emergent distressing life events, etc. In addition, the CC may contact the BHP to discuss any concerns that arise throughout the course of the collaborative care management. For example, the CC may notice that a patient’s PHQ-9 or PCL-5 score has increased in severity, indicating that they may need more attention. BHPs may also contact the
psychiatrist (BHC) directly if urgent questions arise. Figure 4.1 shows the back and forth interactions likely to occur between the BHP and the CC.

**FIGURE 4.1: WORKFLOW FOR BHPS AND CCS IN CLARO**

For patients not in the CLARO intervention, referrals to the BHP will follow enhanced usual care procedures, which include a PCP screening for MDD and/or PTSD symptoms and referral to a BHP if symptomatic.

**Protocol for Handling No-Shows**

If a patient assigned to the CLARO intervention misses a scheduled appointment for PST, WET, or other form of psychotherapy, BHPs should take the following steps:

- Contact the patient and reschedule as soon as possible (within one week).
- If the patient misses another appointment, contact the CC, who will try to re-engage the patient with the BHP and the PCP.
The CLARO study team encourages BHPs to consider using one of two evidence-based therapies in the CLARO intervention: PST for MDD (AIMS Center, 2020; Mynors-Wallis et al., 2000; Nguyen, Chen, and Denburg, 2018; Renn, Mosser, and Raue, 2020) and/or WET for PTSD (Sloan and Marx, 2019; Sloan et al., 2012; Sloan et al., 2018; Sloan et al., 2019), though the BHP is free to determine whether other forms of psychotherapy may be preferable, depending on the patient’s needs. The CLARO team has worked with the PST and WET developers to tailor the training specifically for the study patient population.

Based on patient feedback, stigma and worry about being judged are common barriers to starting therapy. Thus, BHPs are encouraged to adopt a nonstigmatizing approach to patient interaction (see Chapter 1).

**Problem-Solving Treatment** is a cognitive-behavioral therapy that improves an individual’s ability to cope with depression symptoms. It teaches and empowers patients to solve immediate problems that contribute to their depression and helps increase self-efficacy. PST can be delivered individually or in a group format. The process involves taking a patient-identified problem and helping the patient come up with an action plan to address that problem using a seven-step process: (1) selecting and defining the problem, (2) establishing realistic and achievable goals, (3) generating alternative solutions, (4) implementing decisionmaking guidelines, (5) evaluating and choosing solutions, (6) implementing the preferred solution, and (7) evaluating the outcome. Patients work on putting their plans into action between PST sessions.

PST can be as brief as four sessions and as long as 12 sessions, depending on specific patient circumstances. Research has shown that the smallest effective dose is four sessions offered over an eight-week time frame. However, a nine-session treatment duration is considered the “sweet spot” for most patients to achieve outcome improvement. Each session typically lasts 45 minutes in usual behavioral health care or 30 minutes in primary care. The first session is typically longer (e.g., one hour).
See Appendixes C.1–C.6 for more on the literature on PST.

**Written Exposure Therapy** (WET) is an increasingly popular brief evidence-based treatment for PTSD. WET involves writing about traumatic experiences to reduce PTSD symptom severity. WET helps patients extinguish the fear that is associated with the traumatic event.

This brief therapy lasts five sessions and is easy for BHPs to learn and to deliver. It is also well tolerated by patients and has low attrition (~10 percent), much lower than other exposure-based PTSD treatments. Patient ratings of satisfaction with WET are high. It is also effective with patients who are of low literacy (as low as third-grade level), as the process of writing is more important than spelling, grammar, or writing quality. WET is delivered as an individual, weekly intervention. Patients are instructed during each therapy session to write about a specific traumatic event, focusing on the event details and their thoughts and feelings that occurred during the event. Patients are not required to do any between-session assignments or “homework.” WET is a good fit for the study population in participating clinics because it works for patients who are low-income and racially/ethnically diverse.

See Appendixes C.7–C.10 for more on the literature on WET for PTSD.
Training

All therapists participating in the CLARO study will receive training on PST and WET. For both therapies, the developers created practice cases and role-plays that are specific to patients who have OUD with co-occurring MDD and/or PTSD. The PST and WET trainings will also include education about common problems or crises (including stress from family) that come up among patients with OUD, along with suggested interventions (such as behavioral activation) that may be helpful.

Release time will be given to therapists to attend the group training sessions and individual supervision. For PST, the workshop is six hours long, with an additional four hours for practice sessions and six case presentation calls held monthly. For WET, the initial training is six hours plus 12 one-hour weekly supervisory calls over three months. In total, each BHP will devote about 30 hours to the trainings. Therapists will be offered continuing education credit for participating in the trainings.

After training has been completed, implementation of these therapies within CLARO will add little time beyond the usual time it takes BHPs to engage patients in and deliver psychotherapy. Only about five minutes per CLARO patient will be needed for brief consultations with the CC, and the frequency of this consultation will be coordinated with the trainer.

Training Materials

BHPs attending the PST training will receive a PST treatment manual and accompanying materials from the CLARO intervention team. In addition, Washington University’s Advancing Integrated Mental Health Solutions (AIMS) Center (2020) website provides an abundance of informative material about PST. Before the WET training, the CLARO intervention team will provide BHPs with a copy of the WET treatment manual.

» See Appendix C.2 for relevant materials from AIMS.
Qualifications

Most BHPs are already working in the study clinics and have master’s-level degrees in social work; some have Ph.D.s in psychology. PST and WET can be delivered by any licensed provider, including social workers, registered nurses, and psychologists.
Chapter 4 Sources

CHAPTER 5

Care Coordinator Support Team

The CC Support Team is designed to help the CC bridge care monitoring and coordination with the care team’s clinical decisionmaking. This team consists of a BHC (a board-certified psychiatrist), a CC Supervisor, and a CC Consultant, along with other individuals on the CLARO team who can provide additional guidance to CCs as needed. This chapter discusses the roles of the BHC and CC Supervisor, who will each meet weekly with CCs. In addition, the BHC team will meet with CCs in Extension for Community Healthcare Outcomes (ECHO) collaborative training sessions focused on monthly case presentations. The role of the CC Consultant is described briefly at the end of this chapter and in greater detail in the CLARO Implementation Manual.
Overview of the Behavioral Health Consultant, Care Coordinator Supervisor, and Care Coordinator Consultant Roles

The BHC advises on clinical issues during weekly conferences with the CC and may also communicate directly with the other clinicians on the care team in charge of a patient’s medical and behavioral health care (Figure 5.1). The goal of their consultation is to provide medical and behavioral care recommendations that optimize OUD/MDD/PTSD treatment for patients participating in the CLARO intervention. BHCs regularly review caseload registry reports generated by the CC (see CLARO Implementation Manual for more information), have access to the patient’s EHR, and provide clinical recommendations to the care team.

FIGURE 5.1: WORKFLOW FOR COMMUNICATION EXCHANGE AMONG CC, CC SUPPORT TEAM, AND CARE TEAM

The CC Supervisors work on the CLARO study and meet weekly with each CC to answer CLARO study-related questions, provide study support and encouragement, teach study procedures, conduct quality assurance on registry inputs (including EHR
lookups), and ensure CCs are efficiently using the time budgeted for them in the study. They’ll also support the CCs by relaying implementation issues for CLARO’s Clinic Champions to act upon (see CLARO Implementation Manual).

The CC Consultant meets with CCs every two weeks to specifically address the social issues patients face that could pose barriers to starting and/or staying in treatment. In addition, the CC Consultant helps assess the personal impact that patient encounters may have on the CC. If CCs are relatively new to working in medical settings and health care teams, the CC Consultant will also help the CC integrate into care teams and negotiate team dynamics.

BHC Workflow

The BHC’s primary point of contact with the rest of the care team is the CC. BHCs will meet individually with up to four CCs each week, typically via telephone or video conference. Additionally, BHCs help support the ECHO trainings involving small group conferences with CCs. This section describes the anticipated interactions between the BHC and the CC, and with the rest of the care team.

Weekly Registry Review Meetings

Prior to the meetings between the BHC and each CC, the CC will provide the BHC with an up-to-date registry report (see CLARO Implementation Manual) that includes all patients at the clinic site who are participating in the CLARO intervention. The registry report will include information about each patient’s diagnosis, treatment, and response to treatment. The CC will have obtained this information from the EHR, conversations with other members of the care team, and direct interactions with the patient.

The CC will have flagged certain patients for extended discussion with the BHC, and these patients will be the focus of the weekly conference. Newly enrolled patients will be included, along with patients whose clinical condition is not improving as anticipated under the current treatment plan. During the meeting, the CC will give a brief overview of the patient’s clinical status and describe specific concerns.

The BHC will review the EHR which contains the clinical notes, lab results, and other medical record information. Using information from the CC and the EHR, the
BHC provides recommendations for other collaborative care team members (including PCPs and BHPs) to consider in changing that patient’s treatment. This may include suggestions on how to increase patient engagement, ways to intensify or moderate behavioral health interventions, or changes in medication management. The BHC will also advise the care team on treatment for patients who may need more-intensive or more-specialized mental health care and on supporting treatment in the primary care setting until patients can be engaged in specialized care, as appropriate.

BHCs should make recommendations immediately during the weekly case review and, in cases where this is not feasible, within 24 hours of the weekly case review. While the BHC has the freedom to use clinical judgment to make treatment recommendations based on their clinical expertise, recommendations should be consistent with Chapters 3 and 4 of this manual that correspond to the optimal management (both pharmacotherapy and psychotherapy) for MDD, PTSD, and OUD.

Although BHCs will not, as part of their role, typically interact directly with patients in the CLARO intervention, they may have a clinical practice at participating sites. In these cases, the care team may recommend that the BHC interact with patients who may be unusually challenging or present with complex clinical situations. However, the BHC should have limited contact with patients enrolled in the CLARO study.

**Documentation of Recommendations**

After weekly registry review, the BHC will write brief clinical notes to summarize their recommendations. These notes can be entered directly into the EHR in the form of a “telephone note” (a field in the EHR) directed to members of the care team. Alternatively, the BHC can write the notes in a text document in a secure location and then securely transmit it to the CC, who can copy and paste it into a telephone note and then distribute it to other members of the team on behalf of the BHC.

As in-person evaluations will be rare, the BHC should clearly communicate the limitations of the registry review consultation and treatment recommendations. The following disclaimer statement is an example of how to acknowledge these limitations in consultation notes in an EHR:

> The above treatment recommendations are suggestions based on consultation with the patient’s CC and a review of information available in the registry. I have not personally examined the patient. It is up to the provider caring for this patient
to determine what actions to take in response to these recommendations based upon their overall knowledge of this patient and in consideration of the patient’s relevant prior history and current clinical status. Please feel free to contact me with any questions about the care of this patient. (adapted from Bland, Lambert, and Raney, 2014, p. 5)

BHCs not performing direct patient evaluation or treatment should not enter their recommendations as a “consult note” in the EHR. The only exception to this applies to a BHC whose clinical practice is at one of the clinics participating in CLARO. In this case, if the BHC provides a face-to-face consultation with the study participant, the BHC would write a consult note in the EHR. For all other input, the BHC documents recommendations in a telephone note, as described above.

**Availability for Consultation**

Although the CC will use the weekly registry review meetings to discuss patient-related questions with the BHC, questions outside this weekly meeting may arise. In such cases, the CC will follow the existing crisis management protocols in the clinic and attempt to address the question with other members of the collaborative care team. CCs and PCPs may contact the BHC for nonurgent and nonemergent assistance outside the weekly scheduled meetings in instances when complex clinical questions come up. The preferred method of contact will be specified in advance by the BHC, which will ensure that any personal health information will be transmitted via secure channels.

**Qualifications**

The BHC must be a board-certified psychiatrist who has training in treatment of SUDs and who has clinical experience treating OUD, MDD, and PTSD. The BHC must also possess a New Mexico medical license and carry their own liability insurance, unless they have institutional liability insurance that covers their consultation role as a BHC.
Training

The University of Washington AIMS Center provides a 30-minute overview of the BHC role in collaborative care. In addition, the American Psychiatric Association provides a four- to six-hour online training that provides a more in-depth coverage of the BHC role. The BHC will review these materials and complete the online training.

AIMS Center. (n.d.) Psychiatric Consultant Role Training Module. https://aims.uw.edu/training-support/online-trainings/psychiatric-consultant

ECHO in CLARO

CLARO will use the ECHO (Komaromy et al., 2016) model to provide virtual support and learning opportunities for the CCs. Once per week, CCs will join BHCs or the CC Consultant for an ECHO session designed to enhance the CC’s skills and understanding of how to engage with and coordinate care for the CLARO intervention patients. The ECHO will be a group video conference focused on case presentations by one or more of the CCs, followed by discussion of patient management with the BHC, CC Consultant, and other CCs. The CCs can choose which patients they want to discuss and can get advice and support from the experts and from each other (see Step 6, Table 6.1).

In a typical ECHO session, an expert meets with many primary care team members from different clinics in a video meeting. The expert gives a short talk about how to treat the condition on which the session is focused. Then one of the primary care team members gives a short case presentation describing a patient with that condition and poses a question to the group about how to care for their patient. Participants and the expert ask questions and then give suggestions about how to care for the patient. Later the presenter is given a written set of suggestions that the participants agreed on for how to care for their patient. Over time, the participants learn how to provide excellent care for patients with the condition.
The CC Supervisors will meet individually with the CC during a weekly group supervision meeting. The CC Supervisors focus on the administrative versus clinic duties of the CC to ensure that the CC has support when study-related questions or concerns arise. In addition, the CC Supervisors will help ensure study procedures are carried out with high fidelity and consistency by ensuring that registry inputs are thoroughly completed. Because the CC Supervisors are members of the CLARO research team, they will also support CCs by relaying implementation issues to the research team and to the Clinic Champions. If, for example, a CC is spending much of their time working on clinic-related tasks outside of the CLARO study, they may relay this concern to the CC Supervisor or Clinic Champion to resolve the role conflict.

Much of the CC Supervisors’ ability to carry out this role depends on their ability to carefully monitor the CC and patient progress, as documented in the registry. For this reason, the CLARO team has developed reports using information from the registry. These reports and processes are described in greater detail in the CLARO Implementation Manual.
Care Coordinator Consultant Workflow

The CC Consultant will meet with the group of CCs every two weeks in ECHO sessions. The CC Consultant focuses on both the needs of the patients and the needs of the CC. The CC Consultant explores with the CCs any social needs of patients that could be treatment barriers, such as lack of transportation and financial limitations. Patients may be involved with the criminal justice system; CCs will play a vital role in ensuring smooth treatment transitions into jail or prison—especially upon release. The CC Consultant also addresses CC needs, including issues related to burnout, patient encounters, and their role in the care team.

Prior to the small group meetings between the CC Consultant and CCs, each CC will provide the CC Consultant with a caseload or aggregate-level registry report that summarizes their patients. CCs will come prepared to discuss certain patients and any additional work concerns they would like to talk about. The report will include the number of patients in the CC’s caseload, the proportion on medication or in psychotherapy by diagnosis, the identification number (ID) of patients that have visits in the next week, and the ID of patients with a flag. The CLARO Implementation Manual further details the registry report.

**Reflective Supervision**

The CC Consultant uses reflective supervision (Heffron and Murch, 2010) by asking CCs to reflect on and share their feelings resulting from patient encounters. CCs may have lived experiences (e.g., substance use, mental health issues) similar to what the patients are working through, making it important for the CC Consultant to listen carefully and offer support to the CC when sensitive issues arise.

**Qualifications**

The CC Consultant must be proficient in motivational interviewing and have expertise working with community health/support workers in New Mexico and California. They must have expertise with reflective supervision to carry out meetings with CCs.
Chapter 5 Sources

CHAPTER 6
Registry

This chapter is aimed at CCs and describes the purpose of the registry and its customizations to support all aspects of the CLARO intervention. The chapter then offers guidance on daily use of this powerful tool to effectively manage caseloads, monitor patients’ progress and treatment plans, and document patient information. For further detail, CCs should see UW’s CMTS User Guide, listed in the source list at the end of the chapter.
Overview

The CLARO registry is a web-based program created specifically for this intervention by the University of Washington’s AIMS Center. CCs will use the registry daily to proactively track the most critical aspects of patients’ experiences by

- managing their caseload (e.g., check which reminder calls to make, what visits are coming up, what alerts to address)
- keeping track of patients’ symptoms (e.g., document and address changes in MBC questionnaires)
- monitoring patients’ treatment plans (e.g., shared decisionmaking with both the care team and patient).

This population-based care management system will help CCs and the care team track treatment outcomes, and the registry’s pre-programmed reminders and alerts will facilitate shared decisionmaking between the patient and the members of the care team. The registry is not simply a research tool; it is a practical tool that will help ensure that patients are getting the care they need.

CCs will be responsible for entering patient information into the registry, both from data collected during the patient initiation and monitoring visits, and from the clinic’s EHR system. With these data in the registry interface, CCs will be able to easily identify patients at risk of treatment dropout or who are not improving and may need a change in their treatment plan. Once identified, CCs can work with the care team to tailor treatment options, make necessary referrals, or schedule additional visits for patients. Thus, the registry is a tool used to facilitate proactive care as opposed to a static patient database.

The registry is meant to be used actively on a regular basis, as opposed to being a warehouse for patient data. It is designed to be a stand-alone system, apart from the clinic EHR, though CCs will need to populate its patient records with some data from the EHR throughout the course of the intervention. For this reason, we anticipate that CCs will likely need to use both systems side by side for some portion of their workflow.
CLARO MANUAL [March 2023]

Care Coordinator Workflow

CCs will use the registry on a daily basis to plan and prioritize action items to be completed with patients enrolled in the CLARO intervention. Daily use will include reviewing reminders, their caseload list (Figure 6.1), and contacts to be made. CCs will also use the registry on a daily basis—before, during, and after care monitoring visits—to document essential intervention protocol steps, summarized in Table 6.1. The remainder of this section walks through how a CC will likely use the registry in these two scenarios.

**FIGURE 6.1: CASELOAD LIST PAGE**

**TABLE 6.1: QUICK START GUIDE 1: DAILY REGISTRY TASKS**

<table>
<thead>
<tr>
<th>ACTION</th>
<th>LOCATION</th>
<th>DETAILS</th>
</tr>
</thead>
</table>
| 1. Check in on reminders | Navigate to Tools > Reminders via the top navigation toolbar. | The Reminders page shortlists actions for the CC to take. There are two sections within the Reminders page:  
  - **Autosaved Notes**: a list of incomplete visit notes that were automatically saved by the system; clicking into a row in section will bring up the draft for editing and review prior to submission.  
  - **Reminders**: a list of patients that require additional attention for the following reasons:  
    - upcoming or overdue CC encounter  
    - upcoming or overdue MOUD encounter  
    - upcoming or overdue BHP encounter (NOTE: A reminder will appear even if the patient is not currently receiving behavioral health care)  
    - pending referrals.  

CCs should work through each reminder to make sure patients are attended to in a timely manner.
<table>
<thead>
<tr>
<th>ACTION</th>
<th>LOCATION</th>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Reach out to patients</td>
<td>Select the patient and navigate to Patient &gt; Contact Attempt via the top toolbar</td>
<td>If CCs are unable to make contact while reaching out for appointment reminders or any other matter, the Contact Attempt (Patient &gt; Contact Attempt) form should be used to document the outreach. Additionally, CCs should document any notes that may be helpful for future reference.</td>
</tr>
</tbody>
</table>
| 3. Review the caseload | Navigate to Caseload > Caseload Lists | Choose one of the following options:  
- new patients  
- active patients  
- inactive patients  
- custom search. The Caseload List page is an overview of all patients on the CC’s caseload. Between visits, CCs should explore this page to identify any patients that may not be improving and take necessary steps to intervene. Options within this page:  
- sort the caseload by score severity  
- sort the caseload by those flagged for consult with the BHC  
- identify which patients are not improving as expected (scores in red or “Alert” icons)  
- identify patients with assessment scores that are older than 30 days (scores denoted with an asterisk)  
- identify patients who may need discussion with the BHC (“Alert” icons)  
- find patients who are due for an appointment |
<p>| 4. Enter recent MOUD (Prescriber) visits from the EHR a | Navigate to Patient &gt; New Contact &gt; MOUD Prescriber Encounter | CCs use the MOUD page to fill out a new MOUD (Prescriber) encounter note to document the most recent OUD-related (e.g., medication-assisted treatment) visit and medication information. CCs should be sure to enter the medication amount by indicating the frequency, daily dose, days prescribed (original prescription length), and number of refills the patient has been prescribed. Next visit date can also be recorded with the “Appointment” field toward the bottom. All changes must be saved to be entered into the registry. |
| 5. Enter recent BHP visits from the EHR b | Navigate to Patient &gt; New Contact &gt; BH Provider Encounter | CCs should use the BH Provider Encounter page to enter details about the visit to so that this information can be tracked in the registry. Reminders will be prompted before the patient’s next visit; they are calculated based on the date of the last BHP visit Enter the date of the visit and the provider name. All changes must be saved to be entered into the registry. |</p>
<table>
<thead>
<tr>
<th>ACTION</th>
<th>LOCATION</th>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Document weekly case reviews with the BHC&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Navigate to Patient &gt; New Contact &gt; Behavioral Health Consultation Note</td>
<td>CCs should use the Behavioral Health Consultation Note to document each time a patient is discussed with a BHC during weekly case reviews (ECHO or otherwise). Enter the date of the discussion, any specific recommendations for the patient by the BHC, and how long the patient was discussed for (minutes). NOTE: If the patient was discussed at an ECHO session instead of a weekly case review, note this distinction by entering “ECHO” in the “Recommendations from BHC” text field.</td>
</tr>
</tbody>
</table>

<sup>a</sup> Action will not be prompted by the tool.

<sup>b</sup> Denotes a weekly action.
Starting the Day

Using the Reminders Page

To help CCs prioritize caseloads, the **Reminders** page (Figure 6.2) is the first screen shown upon logging in to the registry. The purpose of this page is to highlight the patients who may need additional support. The page has four columns covering the four main reasons patients might need attention:

- upcoming or overdue CC encounter
- overdue MOUD encounter with a Prescriber
- overdue BHP encounter
- pending referrals.

If a patient has an entry in any of the three Encounter columns, CCs should follow up with that patient to either confirm an upcoming appointment or reschedule a missed appointment (CC visits). Values in red indicate a missed or overdue appointment, while values in black indicate upcoming appointments. Per usual procedures, clinic staff will remind patients of MOUD and BHP appointments to check in with medical care and behavioral health care providers. However, it is the CC’s responsibility to document the dates these visits occur in the registry.

**FIGURE 6.2: REMINDERS PAGE**

Figure 6.2 provides an example. This test patient has two overdue appointments—one with the CC and one with the BHP. In this case, the CC will need to work with clinic staff to contact the patient to reschedule these appointments. In some clinics, there may be designated staff to follow-up with patients. In other cases, CCs may have the opportunity to speak with the patient sooner and schedule them for missed appointments. Communicating and balancing team dynamics in these situations will be important to avoid duplicate effort and to maximize team effort. The CC Consultant Supervisor can help the CC negotiate these team dynamics.
Entries in the Referrals column, however, flag patients with open (active) referrals that are more than 28 days old. CCs seeing this reminder should navigate to the Referrals tab (Figure 6.3) by clicking on the patient name to enter their Patient Clinical Dashboard (or by navigating to Patient > Referral List). Within this dashboard (not shown), the Referrals section can be accessed on the left-hand side, and each active referral will be listed on its own row. CCs should use this information to check on the status of the referral with the patient and offer assistance if the patient is experiencing barriers. If the patient confirms follow-through, CCs should close out the referral by clicking on it, documenting any notes, and changing its status to Closed.

**FIGURE 6.3: REFERRALS**

When appointments are scheduled, they should be documented in the clinic’s scheduling system and, once confirmed, entered into the registry by navigating to the Clinical Dashboard and adding the date and time to the “Appointments” section. (Figure 6.4).
While appointments in the registry are duplicated in the clinic’s appointment system, the advantage to also including this information in the registry is that the population-level data are available through the registry reports (e.g., flags that alert CCs when a patient has missed two or more PCP/BHP appointments). This helps the CC monitor whether patients are receiving timely access to care.

**Reaching Out to Patients**

CCs should document all contact attempts (i.e., instances in which they’ve unsuccessfully reached out to the patient) to help the registry keep track of engagement and patient responsiveness, both of which may be used to quantify the impact of the CLARO intervention. The **Contact Attempt** dialog includes the Date of Contact as well as a Comments field in which CCs can add any relevant notes. After entering both items, CCs should be sure to “Add” the note to incorporate the data into the registry (Figure 6.5). Contacts with providers and research assistants can also be logged here.
Throughout the day, CCs should be actively reviewing their caseload to determine whether any patients either need to be discussed with the BHC during the weekly consult or need to be reached to confirm or reschedule an appointment. The Caseload List page (Figure 6.1) gives CCs quick access to an overview of their patients to ensure that patients do not “fall through the cracks.”

To view the Caseload List page, navigate to Caseload > Caseload List and choose one of the following options:

- **New Patients**: Displays all patients for the selected provider that have not yet had a Care Coordinator Initial Encounter entered.
- **Active Patients**: Displays all patients for the selected provider that are currently enrolled, including patients on a Recovery Support Plan.
- **Inactive Patients**: Displays all patients for the selected provider that are currently discharged.
- **Custom Search**: Displays a list of patients that can be sorted based on Patient ID, Randomization Date, Discharge Date, First Name, Last Name, Care Coordinator, Site, Clinic, Flag, or Population.

Between visits, CCs can explore this page to identify any patients that may not be improving and take necessary steps to intervene. CCs have several options to filter their caseload:
• Sort the caseload by score severity
• Sort the caseload by those flagged for consult with the BHC
• Identify which patients are not improving as expected
• Identify patients who may need discussion with the BHC
• Identify patients who are due for an appointment.

CCs can sort within results by clicking on a column header to bring the highest values to the top.

Within the caseload list or filtered results, three types of indicators may be displayed:

• Flags: Displayed when a patient is either manually flagged for review with the BHC or as a safety risk, or automatically if question 9 of the PHQ-9, regarding suicidal thoughts, is endorsed.
• Alerts (yellow warning icons): Displayed when a value is worsening (i.e., lower across two consecutive visits) or not improving. These will appear automatically based on the values in the registry.
• Colors: Indicate when a score is above or below a certain threshold. Red indicates a score indicative of a significant negative value; yellow indicates a potential cause for concern; and green indicates a clinically significant positive value. Values will be color coded automatically based on values in the registry.

A complete list of definitions for each of the column headers can be found in UW’s CMTS User Guide.

Enter Recent MOUD Encounters

In order to have accurate medication information and appointment reminders, CCs should proactively enter MOUD visit information on the MOUD page in an encounter note (Figure 6.6).

This module is very similar to a section located within the Care Coordinator Encounter, except that it includes Date of Prescription, Daily Dose, Days Prescribed, and Number of Refills and an Appointments module (used to document the next MOUD visit)—all of which may be found within the patient’s EHR.
FIGURE 6.6: MOUD ENCOUNTER NOTE

Enter Recent BHP Encounters

Similar to MOUD encounters, BHP encounters need to be proactively entered by the CC in order for the registry’s reminders to function as intended. For this reason, CCs should use the EHR to obtain information about recent BHP visits and document these dates within the registry (Table 6.3). To do so, CCs should navigate to this form by selecting Patient > New BHP Contact.

There are two types of BHP contacts that could be documented: (1) one-on-one sessions with a BHP and (2) medication-assisted treatment (MAT) group therapy sessions (e.g., MAT groups). At present, many clinics are experiencing a slight shortage in BHPs, and group therapy sessions are becoming more common. As a result, patients might be receiving one or both types.

For this reason, behavioral health visits should be documented in the following way (Table 6.2):

TABLE 6.2: BHP DOCUMENTATION OPTIONS

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>PROCESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-on-1 + Group Therapy</td>
<td>Use the BHP note to document last 1-on-1 session (as usual) Use “Action Step” in the Social Determinants of Health module to document group session (Figure 6.8)</td>
</tr>
<tr>
<td>1-on-1 only</td>
<td>Use the BHP note to document last 1-on-1 session (as usual)</td>
</tr>
<tr>
<td>Group Therapy only</td>
<td>Use the BHP note to document last group session; use the “Group Therapy Mat” option in provider dropdown (Figure 6.7)</td>
</tr>
</tbody>
</table>
Once on the contact form page (Figure 6.7), CCs should simply record the date of the encounter and the name of the provider, using the dropdown list.

**FIGURE 6.7: BHP CONTACT FORM**

- In the Social Determinants of Health assessment of the CC encounter note (Figure 6.8), select “Other Psychiatric” from the topic dropdown menu.
- Ignore the left-hand side of the module (i.e., don’t select a tracking tool or enter any goals/barriers/strengths).
- Under “My Action Steps,” select “Other” and enter “MAT group therapy started on [date].”
- At each subsequent visit, add another line within the textbox to include information about the latest MAT group therapy visit (i.e., “patient last attended group therapy on [date]”).

**FIGURE 6.8: ACTIONS STEP FOR GROUP THERAPY (SCENARIO 1)**
Document Weekly Case Reviews with BHC

There are two different types of meetings with the BHC that CCs will document using the registry: weekly BHC Case Reviews and ECHO Sessions.

- **BHC Case Reviews**: Weekly one-on-one meetings between the CC and their assigned BHC. In these case reviews, CCs will have the opportunity to discuss patients on their caseload that might need additional support. These are typically patients who were flagged over the course of the week or who the BHC identifies as needing attention based on abnormal values.

- **ECHO Sessions**: Biweekly group meetings with the BHC and/or CC Supervisor in which CCs have the opportunity to present specific patients to the team for discussion. CCs may present patients they might’ve already brought up during weekly case reviews in order to solicit input from a wider audience.

Both of the above meeting types should be documented in the registry by navigating to the toolbar at the top and selecting **Patient > New Contact > Behavioral Health Consultation Note** (NOTE: This option is only available for patients who have completed their initial CC encounter). See Figure 6.9. Alternatively, CCs can visit their Caseload List (**Caseload > Caseload List > Active Patients**) and click on the green “+” icon under the “Last BHC” column.

The note contains three fields:

- **Date**: the date on which the patient was discussed.
- **Recommendations from BHC**: text field used to document specific recommendations made by the BHC during weekly case reviews. If documenting an ECHO session, simply type “ECHO” in this field.
- **Session details**: two dropdowns and one text field to document how the meeting occurred (in clinic, over the phone, etc.), which BHC the CC met with, and how long the patient was discussed for with the BHC (in minutes).
### TABLE 6.3: QUICK START GUIDE 2: DOCUMENTING PATIENT VISITS WITH THE CC

<table>
<thead>
<tr>
<th>ACTION</th>
<th>LOCATION</th>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before Visit</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 6. **Prepare for patient visit** | Select the patient using the search function at the top or click the relevant name in the **Caseload List** page. Confirm information within the white box at the top right corner of the page, then navigate to **Patient > New Contact** to open up a new Contact Note. | CCs will need to check two items in the EHR before each care monitoring visit:  
- latest urine drug test results  
- latest medication information.  
Once this information has been entered into the registry, CCs should save the note as a draft until they are ready to see the patient. Draft notes may be accessed from the first section of the Reminders page. |
| **During Visit** | | |
| 7. **Administer assessments and record responses** | After reopening the draft note from the Reminders page, CCs should confirm the patient information in the top right corner and scroll down to the **Measurement-Based Care** section. | There are three assessments sections within the Contact Note:  
- OUD Assessment (OUD-5 administered at each visit; PROMIS-7 administered monthly)  
- PHQ-9 (Depression assessment; administered monthly)  
- PCL-5 (PTSD assessment; administered monthly).  
Recall that the PHQ-9 and PCL-5 need only be asked monthly if a patient is being treated for MDD and/or PTSD, respectively. |
| 8. **Check in on medication status** | Following entry of the MBC items above, CCs should continue scrolling down to find the **Medication** section of the encounter note. | Recall that much of this information should have been confirmed prior to the visit using the EHR in Step 3 of Table 6.3. The present step, however, involves gathering adherence information from the patient. There are two sections within the encounter note related to medication information, and each contains key fields:  
- **Medication for OUD Adherence** (MOUD medication information)  
  o Text window: displays most recent medication information (as entered in latest MOUD note; if different, reconcile with latest record in EHR)  
  o Adherence question: radio buttons to record patient’s response  
  o Number of missed days: textbox to enter the number of days of medication the patient missed  
  o Adherence notes: textbox to record any additional MOUD adherence information from the visit.  
- **Depression and PTSD Medications**  
  o Confirmation section: boxes to record how the information was verified  
  o Medication Name, Dosage, and Adherence: dropdowns to key medication information (may either be what the patient tells you or obtained from the EHR). |
9. **Evaluate patient goals**  
   Following entry of the medication information, CCs should continue scrolling down to find the Social Determinants of Health section of the encounter note. There are three subsections within this area that the CC will use to document the patient's goals in this area. These are goals that should be specific to ensuring success in the CLARO program that will help the patient get into/stay in treatment:
   - Goals, Barriers, and Strengths (text fields)
   - Personalized 0–10 Scale (buttons and text fields)
   - Action Steps (dropdown menu)
   These items will be assessed at each care monitoring visit.

10. **Schedule the next visit**  
   Scroll down until the Appointments section is fully visible on the Contact Note. Toward the end of the patient encounter, CCs should work with the patient to determine the best time for the next appointment. After deciding on a time, CCs should document it within using the Appointments section. Clicking on the Date & Time area brings up the calendar. Be sure to select the appropriate Visit Type (i.e., in clinic, phone, etc.) and enter any notes that might be helpful.

### Preparing for Patient Visits

#### Checking In on Urine Results and Medication Status

CLARO has developed a template to add new visit information that will be tracked within the registry. However, because some patient information is housed within the EHR, CCs will need to transfer this information before the care monitoring visit to maximize the quality of the visit.

CCs will need to fill in two main sections of the encounter note before the visit: (1) Urine Drug Test results and (2) Current Medication information. In order to populate this information, CCs should select the appropriate patient, navigate to **Patient > New Contact** and begin entering the information at the top of the **Contact Note** template shown below (Figure 6.10).
Urine drug test results may be obtained from the patient’s record in the clinic’s EHR. There are four fields within the Urine Drug Test section of the Contact Note that should be entered into the registry:

- **Date**: when the test was administered
- **Prescribed MOUD**: whether the patient’s prescribed MOUD was present in the urine sample
- **Nonprescribed Opioids**: whether any opioids that are not part of the patient’s MOUD were present in the urine sample
- **Other Nonprescribed Substance**: whether any drugs (excluding marijuana and alcohol) were present in the urine sample.

CCs should examine the patient’s record in the clinic’s EHR system to fill out the information. After doing so, CCs should save the note as a draft and reopen it from the Reminders page (Figure 6.11) when the patient arrives.
During Patient Visits

Administering MBC Assessments

As discussed in Chapter 2, the MBC assessments (OUD-5, PROMIS-7, PHQ-9, and PCL-5) are key to tracking patient progress throughout the intervention. The patient encounter template includes fields for each of these assessments, making it easy for CCs to document patient responses immediately after administering the assessments (Figure 6.12).

Recall that each assessment is administered on a specific schedule:

- OUD Assessment (OUD-5 administered at each visit; PROMIS-7 administered monthly)
- PHQ-9 (administered monthly, for those diagnosed with MDD)
- PCL-5 (administered monthly, for those diagnosed with PTSD).

The OUD-5 and PROMIS-7, both of which pertain to OUD, are automatically displayed on all Care Coordinator Encounter notes. The OUD-5 corresponds to the items marked with asterisks, whereas the PROMIS-7 items are not marked. This is because the OUD-5 will be asked at each patient encounter, but the PROMIS-7 items will only be asked monthly.

All three questionnaires can be given to the patient to complete on paper or administered verbally by the CC. CCs should monitor patient responses to ensure each item is completed unless the patient declines to answer. In addition, it is important to engage the patient in the questionnaire’s completion (e.g., “I appreciate you filling these questions out; we give these to everyone at their visit to check in on how they are doing. Your answers help us to provide you with the right type of care. The answers are not used to cut anybody off from care.”) When administering these assessments, CCs should read each question stem clearly and keep follow-up questions in mind for after the assessment.
(e.g., if a patient endorses craving, asking about their experiences, how stressful this is, and what might be helpful during those times). Any important developments that are not directly related to the questions may be documented in the text box toward the end of the patient note.

**FIGURE 6.12: MBC SECTION OF CONTACT NOTE**

**Checking In on Medication Status**

At each care monitoring visit, CCs will be expected to check in with the patient about any updates to their medication as well as whether they’ve been taking the medication as prescribed. The Medication for OUD Adherence section and the Psychotropic Medications section are both within the Care Coordinator Encounter (Figure 6.13) and facilitate collecting this critical information for tracking within the registry.

The top of the Medication for OUD Adherence section will display the most recent information as captured by the most recent MOUD encounter note (see Step 4 of Table 6.1). CCs should confirm this information with the patient during the visit. If there are changes, CCs should document this using the textbox and submit a new MOUD encounter note after the visit.
This section also includes a few questions regarding adherence. The first asks whether the patient has been taking the medication at the dosage prescribed each day. If CCs enter a patient response of “No,” an additional field will appear asking for the number of days the patient forgot to take or missed their medication. More-detailed information may be captured in the Adherence notes text field. One helpful suggestion for how CCs may ask this information is as follows: “Many people find that it is hard to take medicine every day. How many days were you able to take your medicine in the past week?” As always, CCs should do their best to capture as much information as possible so that the CC and the rest of the care team can understand what is happening for the patient and offer the best care.

Lastly, the Psychotropic Medications section includes checkboxes corresponding to how the medication information was obtained. CCs should work with the patient to record current psychotropic medications and/or confirm the information with the EHR.

**FIGURE 6.13: MEDICATION SECTION OF CARE COORDINATOR ENCOUNTER**

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### Evaluate Patient Goals

The CC will assess and discuss potential barriers to treatment with the patient (e.g., social needs such as transportation, housing). The registry includes a section that allows CCs to document information about socioeconomic challenges they might be facing.

As mentioned in Chapter 2, CCs will be evaluating patient progress using an adapted version of Kiresuk and Sherman’s Goal Attainment Scaling system (GAS). The system attempts to standardize progress by clearly outlining positive and negative
change by magnitude. Though GAS is typically administered twice (once at baseline, and once at follow-up), our application will ask you to evaluate patients at each visit. For this reason, the scale used by the registry ranges from 0–10 instead of 0–5.

There are three subsections within the Social Determinants of Health Assessment area (Figure 6.14):

- **Goals, Barriers, and Strengths (text fields)**
  - Identified Goals can be centered on the patient’s needs in these areas:
    - Psychiatric (Depression, Anxiety, Other Psychiatric)
    - Substance Use (Drug Use, Alcohol Use, Other Substance Use)
    - Medical (Pain, Diabetes, Weight, Hypertension, Hyperlipidemia, Other Medical)
    - Basic/Personal (Housing, Financial, Education, Vocational, Legal Services, Public Benefits, Other Personal/Basic)
    - Other
  - It is important to note that the Goals may not always fall under what is traditionally viewed as Social Determinants of Health, but for the purposes of this study are classified as such.
  - CCs should work with the patient to identify a goal that the patient would like to work on and will best support them during their time with CLARO.
  - The goal of the CLARO program is for patients to start or stay in treatment for their co-occurring disorders. Thus, the identified goal should be specific and help them achieve their treatment goals. Sometimes, patients’ goals are to wean off or stop their medications. In these cases, it is important to reframe the patient’s goals to be consistent with CLARO and the provider’s recommendations. For example, a goal such as “weaning off Suboxone” could be reframed as “continuing to attend clinic visits to talk with their provider about treatment options.”
  - CCs should use the text fields to enter the patient’s goal(s) in their own words in the Goal field. Each goal should be patient-centered and
specifically address a need that will support the patient during the CLARO program, or approximately 6 months.

- Working with the patient, the CCs will identify the barriers that might keep the patient from making progress on this specific goal. Barriers can be related to medical, psychiatric, personal, or social reasons.

- The Strengths field is a place for the CCs to record the patient’s internal and external items that will help the patient to achieve their goal. This can be a place to document a patient’s internal motivations and values, as well as any outside support systems. The CCs should work with a patient to self-identify strengths, supports, and resources that can help make progress on this goal.

- Personalized 0–10 Scale (buttons and text fields)
  - The Personalized 0–10 Scale is a tool for the CCs to use internally to help them identify the progress a patient is making on their identified goal. The CC will identify the number related to where they feel their patient is starting from with this goal. The CC will enter that number along the scale, and then enter a brief note in the adjoining text field on the patient’s situation and why they chose that score.
  - The CC should then decide what score they feel will adequately describe the score a patient can realistically achieve during their time together in CLARO. Once selected, the CC will enter that number in the Score to Achieve field, and they will see that score populated in the scale below. Again, a brief note in the adjoining text field should be entered.
  - As the client progresses on this goal, the CC should use this scale to show the small, intermediate steps that a patient is completing, or “baby steps.” The CCs are encouraged to ask the patient about their progress and to record the patient’s responses in their own words briefly, as much as possible.
TABLE 6.4: SCORE CHANGE GUIDELINES

<table>
<thead>
<tr>
<th>SUBJECTIVE ASSESSMENT OF EXPECTED OUTCOME AT FOLLOW-UP</th>
<th>SCALE (Δ FROM PREVIOUS MEASUREMENT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much more than expected</td>
<td>+2</td>
</tr>
<tr>
<td>More than expected</td>
<td>+1</td>
</tr>
<tr>
<td>Expected outcome</td>
<td>0</td>
</tr>
<tr>
<td>Less than expected</td>
<td>-1</td>
</tr>
<tr>
<td>Much less than expected</td>
<td>-2</td>
</tr>
</tbody>
</table>

- My (CC) Action Steps (dropdown menu)
  - After doing the above, CCs should record what strategies they (the CC) will employ when working with this patient and what action items either the patient or the CC will take before the next meeting.
  - These strategies or actions may be recorded by selecting the option in the dropdown menu that best matches what the CC and the patient have agreed to try. The CC will have the option to select from Medication, Psychotherapy, Motivational Interviewing, Behavioral Activation, Engagement, Referral, and Other.
  - If Medication is selected, the dropdown box will be populated if the CC recorded a medication under the Psychotropic Medications earlier in the encounter. Once recorded, the medications will auto-populate in that dropdown box. The CC may enter notes into the My Action Steps for Medications without selecting a medication first.
  - If making a referral, leave the action step blank and complete the note as usual. After submitting the note, click on the patient, navigate to Patient > Referral List and add a new referral using the green “+” icon. Once this is done, reopen the note that was submitted, and link the referral using the “Referral” option under the Action Step dropdown. For more information on entering a referral, refer to “Starting the Day” section of this chapter.
FIGURE 6.14: SOCIAL DETERMINANTS OF HEALTH SECTION OF CONTACT NOTE

To add another Goal, use the Topic dropdown below the Personalized 0–10 Scale section, shown at the bottom of Figure 6.14.

Schedule Next Visit

Toward the end of each visit, CCs should work with the patient to find the most convenient time for their next appointment. A scheduling module is included within the note template to facilitate scheduling. Once a time is mutually agreed upon, enter in the relevant information using the scheduling module (Figure 6.15).

FIGURE 6.15: APPOINTMENTS SECTION OF CC ENCOUNTER NOTE

Reflect on the Recent Visit

Finally, the CC should exercise discretion when deciding whether the patient should be discussed with the BHC. CLARO has included a few options in the Services section of the Contact Note (Figure 6.16) to help prompt CCs for specific actions:

- Flag as Safety Risk?
Selecting this box “flags” the patient’s name in the Caseload List page as a safety risk. CCs are expected to follow their site’s standard emergency protocol immediately following identification of such patients.

- Would you like to discuss this with the BH Consultant?
  - Selecting this flag reminds both the CC and the BHC to review the patient during the weekly consult.

- Notes for BH Consultant
  - CCs may enter any notes that may be helpful for the BHC to review.

- This session was:
  - CCs should use the dropdowns to select (1) how they engaged with this patient (i.e., in person at the clinic, over the phone, etc.), (2) their name from the provider’s list, and (3) the duration of the session in minutes.

**FIGURE 6.16: SERVICES SECTION OF CC ENCOUNTER NOTE**
Chapter 6 Sources

Appendixes

- A. Care Team and Care Coordinator Materials
- B. Primary Care Provider Materials
- C. Behavioral Health Provider Materials
- D. Patient Materials
Appendix A: Care Team and Care Coordinator Materials

Treating Patients with OUD/MDD/PTSD

*Nonstigmatizing Language*

A.1

These references provide recommendations on person-first language that reduces stigma:

http://www.psychiatry.org/newsroom/reporting-on-mental-health-conditions

http://journals.lww.com/journaladdictionmedicine/Pages/Instructions-and-Guidelines.aspx#languageandterminologyguidance


National Institute on Drug Abuse (n.d.). Words matter: Terms to use and avoid when talking about addiction.  

http://www.recoveryanswers.org/addiction-ary (the items listed with Stigma Alert are possibly stigmatizing terms).

http://www.shatterproof.org/about-addiction/stigma/stigma-reducing-language

http://www.workithealth.com/blog/reducing-addiction-stigma-through-language

*Trauma-Informed Care*

A.2

Trauma Informed Care Implementation Resource Center (n.d.). Homepage.  
http://www.traumainformedcare.chcs.org

The change packet below provides information, action steps, and tools to guide implementation of trauma-informed primary care.

Assessments

This section contains a brief description of each assessment that the CC will give to patients. When relevant, we also review what different scores mean and how the CC should respond. Following the overview of assessments, each assessment is listed in full. These pages can be printed out for reference or given to patients to complete as a hard copy.

A.3 Social Needs: WellRx

The WellRx is a set of 11 questions that ask about nonmedical issues that could affect a patient’s treatment. The questions cover topics such as housing, income, and transportation. The WellRx should be used to help connect patients with social services. The WellRx is shown later in this appendix.

A.4 Sleep: Insomnia Severity Index (ISI)

Sleep problems and insomnia are common in patients with co-occurring OUD with MDD and/or PTSD, and when untreated it can make successful treatment of these conditions more difficult. The ISI measures quality of sleep and has seven questions (included later in this appendix). To score the ISI, add the scores for all seven questions (questions 1 + 2 + 3 + 4 + 5 + 6 + 7 = total score).

TOTAL SCORE CATEGORIES FOR ISI

<table>
<thead>
<tr>
<th>SCORE RANGE</th>
<th>CLINICAL SIGNIFICANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–7</td>
<td>No clinically significant insomnia</td>
</tr>
<tr>
<td>8–14</td>
<td>Subthreshold insomnia</td>
</tr>
<tr>
<td>15–21</td>
<td>Clinical insomnia (moderate severity)</td>
</tr>
<tr>
<td>22–28</td>
<td>Clinical insomnia (severe)</td>
</tr>
</tbody>
</table>
**A.5**

*Substance Use: OUD-5 and PROMIS-7*

CCs will assess opioid use with the OUD-5 at every visit and with the PROMIS-7 questions once a month. The OUD-5 (included later in this appendix) is an assessment that has been put together by the CLARO research team, with four questions developed by the research team and one question from the PROMIS-7. Once a month, CCs will have patients complete the OUD-5 along with six additional questions from the PROMIS-7 (included later in this appendix).

The full PROMIS-7 includes question 5 from the OUD-5. This fifth question is not included in the PROMIS-7 in this appendix to facilitate the use of these pages as handouts.

These two sets of questions are a helpful starting point to check in with patients about their opioid use. Their responses will also help the PCP decide if a different medication or dosage should be prescribed. If any responses require consultation with the PCP, a flag will appear in the registry (see Chapter 6 for additional detail).

**A.6**

*Depression: PHQ-9*

The PHQ-9 measures depression. The CC will administer the PHQ-9 starting on the second visit and once a month thereafter. It does not diagnose MDD, but it is a tool to measure what symptoms of depression a person is experiencing. The full PHQ-9 is included later in this appendix. The scores for each answer option are listed on the questionnaire; each response is scored as follows: “not at all” is 0, “several days” is 1, “more than half the days” is 2, and “nearly every day” is 3. To compute the total score for the PHQ-9, add the scores for the first nine questions (questions 1 + 2 + 3 + 4 + 5 + 6 + 7 + 8 + 9 = total score).

If a patient answers 1, 2, or 3 for question 9 (stating that they have had thoughts of suicide), the CC should follow the clinic’s procedures for what to do if a patient expresses suicidal ideation. The CC can check with the clinic supervisor if they are unsure what these procedures are.
TOTAL SCORE CATEGORIES FOR PHQ-9

<table>
<thead>
<tr>
<th>SCORE RANGE</th>
<th>CLINICAL SIGNIFICANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5–9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10–14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15–19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20–27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>

A.7

PTSD: PCL-5

The PCL-5 measures symptoms of PTSD. The CC will administer the PCL-5 only if the patient reported a worst traumatic event to the research assistant. The CC will begin to administer the PCL-5 on the second visit and will ask the questions once a month. Typically, any symptom that a patient reports experiencing at least moderately is considered present. CCs can work with the patient and their providers to address symptoms that persist. To score the PC-5L, add together the scores for all questions. The scores for each answer option are listed on the questionnaire: “not at all” is 0, “a little bit” is 1, “moderately” is 2, “quite a bit” is 3, and “extremely” is 4. Patients with scores of at least 31–33 are considered to have probable PTSD. A decrease in total score of 5–10 points is considered to be a significant reduction in symptoms. The full PCL-5 is listed later in this appendix.

A.8

Pain: PEG Pain Monitor

Pain management can be an important part of treating OUD because many people use opioids for pain relief. The PEG is used to get a better sense of any pain a patient is experiencing. It has three questions, shown later in this appendix. There is no total score for the PEG, but it can be helpful to track any changes in pain over time. If a patient is reporting a lot of pain, it may be useful to discuss pain management with their PCP.
OUD-5

Now I’d like to ask you five questions about your opioid use. I will ask these questions every visit, and it will be a way for me and your care team to help you monitor any symptoms.

1. Are you experiencing any side effects from any medication you are taking for opioids (e.g., Suboxone, methadone, Sublocade)?
   - Yes
   - No

2. Are you having opioid withdrawal symptoms (e.g., dopesick)?
   - Yes
   - No

Since your last visit (or in the past 30 days if first visit or initiation visit) . . .

3. How many days did you use any drugs, other than alcohol, or abuse any prescription medications (including opioids)?
   - 0
   - 1–3
   - 4–8
   - 9–15
   - 16–30

4. How many days did you use opioids (e.g., heroin, morphine, Dilaudid, Demerol, Oxycontin, codeine (Tylenol 2,3,4), Percocet, Vicodin, Fentanyl, etc.) other than your prescribed Buprenorphine?
   - 0
   - 1–3
   - 4–8
   - 9–15
   - 16–30

5. How often did you crave opioids?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Almost always
   - 1
   - 2
   - 3
   - 4
   - 5
**PROMIS-7**

The following questions ask about your use of opioids (e.g., heroin, morphine, Dilaudid, Demerol, Oxycontin, oxy, codeine (Tylenol 2, 3, 4), Percocet, Vicodin, Fentanyl, etc.) other than your prescribed Buprenorphine. We will be going over this once a month as another way to measure your symptoms for the care team.

In the past 30 days . . .

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I felt that my opioid use was out of control.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. My desire to use opioids seemed overpowering.</td>
<td>Not at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Opioids were the only thing I could think about.</td>
<td>Not at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. My opioid use caused problems with people close to me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I have an opioid use problem.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I spent a lot of time using opioids.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PHQ-9

Now I’d like to ask you a few questions about how you have been feeling for the past two weeks. After, we can discuss any concerns you may have and talk more about some treatment options, if you’d like. Over the last two weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half</th>
<th>Nearly every</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed, or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

If you checked off *any* problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
</table>
PCL-5

1. Self-care (as needed): So, before I continue to ask some more questions, I want us to think about how you can take care of yourself if you are feeling anxious or stressed. What are some things you do to take care of yourself? Examples could include self-care like breathing or taking a walk, or talking with family or friends, or processing with your therapist.

[If patient has difficulty with care plan, or does not want to complete the PCL-5]: That’s okay if you don’t want to answer these questions today. Let’s plan to do it sometime in the future, so that I have all the info that I need to help inform your care. I will check in with you regularly about this, but I will always give you a choice about whether we start the discussion.

2. PCL intro: I’m going to read a list of problems that people sometimes have in response to a very stressful experience, and I’m going to ask how much you have been bothered by each problem in the past month. These questions can sometimes be sensitive for patients, so let me know if you want to pause or stop. We don’t need to go into details about each problem, just how bothered you are. This information will be helpful to plan your treatments at the clinic.

In the past 30 days, how much were you bothered by:

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Repeated, disturbing, and unwanted memories of the stressful</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>experience?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Repeated, disturbing dreams of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Suddenly feeling or acting as if the stressful experience</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>were actually happening again (as if you were actually back</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>there reliving it)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Feeling very upset when something reminded you of the</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>stressful experience?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Having strong physical reactions when something reminded</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>you of the stressful experience (for example, heart pounding,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>trouble breathing, sweating)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not at all</td>
<td>A little bit</td>
<td>Moderately</td>
<td>Quite a bit</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>6</td>
<td>Avoiding memories, thoughts, or feelings related to the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>Trouble remembering important parts of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
<td>Blaming yourself or someone else for the stressful experience or what happened after that traumatic event?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11</td>
<td>Having strong negative feelings such as fear, horror, anger, guilt, or shame?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12</td>
<td>Loss of interest in activities that you used to enjoy?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13</td>
<td>Feeling distant or cut off from other people?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14</td>
<td>Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15</td>
<td>Irritable behavior, angry outbursts, or acting aggressively?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16</td>
<td>Taking too many risks or doing things that could cause you harm?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
17. Being “superalert” or watchful or on guard?  
<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

18. Feeling jumpy or easily startled?  
<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

19. Having difficulty concentrating?  
<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

20. Trouble falling or staying asleep?  
<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

3. PCL debrief: Thank you for answering these questions; it really helps our team understand how you’re feeling and how we might support you. [discuss any increases/decreases in scores without saying score number—e.g., I noticed your symptoms were higher this week; how does that fit with your experience? Have you shared this with your provider? I’m going to share with your care team so we can ensure that you’re supported; how does that sound? We talked about some self-care activities; what might you do until you can meet with your provider to care for yourself?]
I’d like to ask you some yes or no questions to help me understand you a little better. I’ll take some notes, and, afterwards, we can talk more about them and identify some things that we can work on together. Is that okay? In the past two months . . .

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you or others you live with eat smaller meals or skip meals because you didn’t have money for food?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Are you homeless or worried that you might be in the future?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you have trouble paying for your utilities (gas, electricity, phone)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Do you have trouble finding or paying for a ride?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Do you need daycare, or better daycare, for your kids?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Are you unemployed or without regular income?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you need help finding a better job?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Do you need help getting more education?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Are you concerned about someone in your home using drugs or alcohol?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you feel unsafe in your daily life?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Is anyone in your home threatening or abusing you?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Insomnia Severity Index (ISI)**

You mentioned that you are having difficulty sleeping. Do you mind if I ask you seven questions about your sleep over the last two weeks to see if we can support you?

Please rate how much each problem has bothered you over the past 2 weeks.

<table>
<thead>
<tr>
<th>Question</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Difficulty falling asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Difficulty staying asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Problems waking up too early</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. How SATISFIED / DISSATISFIED are you with your CURRENT sleep pattern?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. How WORRIED / DISTRESSED are you about your current sleep problem?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g., daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
PEG Pain Monitor

You mentioned that you have been in some pain recently. Do you mind if I ask you three questions about your pain and how it affects your life? Think about pain you have had during the past seven days.

1. What number best describes your pain, on average?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td>Pain as bad as you can imagine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. During the past 7 days, what number best describes how pain has interfered with your enjoyment of life?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not interfere</td>
<td>Completely interferes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. During the past 7 days, what number best describes how pain has interfered with your general activity?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not interfere</td>
<td>Completely interferes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## A.9 CLARO Plan

### Upcoming Appointments

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Number:</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Location:</td>
<td></td>
</tr>
<tr>
<td>Transportation Plan:</td>
<td></td>
</tr>
<tr>
<td>Child Care Plan:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Number:</td>
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</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Location:</td>
<td></td>
</tr>
<tr>
<td>Transportation Plan:</td>
<td></td>
</tr>
<tr>
<td>Child Care Plan:</td>
<td></td>
</tr>
</tbody>
</table>

### Resources

**Appointment scheduling/refills:**

**Pharmacy:**

**CLARO Care Coordinator:**

**Suicide hotline:**

New Mexico Crisis and Access Line
24 hours a day, 7 days a week, 365 days a year
1-855-NMCRISIS (662-7474);
TTY 1-855-227-5485
711 for relay (hearing & speech impaired)

National Suicide Prevention Lifeline
1-800-273-TALK

Other (e.g., needle exchange, food bank, other local resources):
A.10

Example Suicide Plan

When a patient discloses thoughts related to suicide or homicide, it can be unsettling. This document summarizes some scenarios that may arise and options for how to respond. For the CLARO project, the CC’s job is to triage or refer the patient to a clinician when these issues come up. It is not within the CC’s scope of work to conduct a suicide assessment or create a safety plan. Instead, when a patient discloses these risk behaviors, the CC should follow clinic protocol and reach out to a licensed clinician for support. In some cases, a message can be sent to the primary care provider as part of a routine description of the patient’s visit. In other cases when it is clear the patient is in danger, the CC will need to urgently contact the PCP or other providers on the care team until referral is made. In your messaging, be clear, specific, and concise. Try to avoid generalities such as “patient is suicidal” without details on how the patient scored on the PHQ 9th question and what information the patient said to you.

<table>
<thead>
<tr>
<th>WHAT THE PATIENT MAY SAY:</th>
<th>WHAT THE CARE COORDINATOR DOES:</th>
</tr>
</thead>
</table>
| 1. PHQ 9th question score is 1–3, does not state they are planning to harm themselves or others, or the patient has a history of endorsing this item in prior assessments, but a clinician has assessed the patient as minimal risk. | • Message the patient’s provider per clinic procedures as you would typically share about visit:  
• “I saw this patient today and they scored a 2 (more than half the days) on the PHQ 9th question. Similar to their prior surveys, they stated to me: ‘xxxxx.’ Patient also endorsed xyz [summarize visit as you normally would]. What would you recommend as a next step based on your knowledge of the patient?”  
• Document in the EHR and registry |
| a. If patient appears distressed in the CC visit, and is NOT reporting thoughts of harming self or others | • Using the medical record, notify the PCP and counselor (if one is assigned in the case) that this occurred. This will serve as a nonurgent notification to the rest of the treatment team. |
| 2. PHQ 9th question score is 4 and patient has no history of endorsing this item in prior assessments. The patient also tells you they are planning to take their life or someone else’s, or CC is concerned about their safety. | • Message the primary care provider per clinic procedures or someone on the emergency call list until a clinician responds to your urgent request for help with a patient who is at high risk:  
• “I currently have a patient on the line that endorsed 4 (nearly every day) on the PHQ 9th question and said to me ‘xxxxx.’ I want to transfer the patient over to you now.”  
• Say to the patient: “I’m concerned about you hurting yourself and I want to make sure you are safe and have the support you need. I am going to bring a provider on the line.”  
• Stay on the phone with the patient until they are connected  
• Document in the EHR and registry  
• Discuss process in CLARO supervision/ECHO |
a. If patient reports suicidal thinking during the CC visit

- Gain as much info as possible about plan and intent, then send a message in the medical record to the PCP and counselor indicating what the patient had said. Be sure to indicate that you need a response now.
- If there is no response within 15 minutes, then call the clinic directly and ask to speak with the Clinic Charge Nurse. Report the situation to the Clinic Charge Nurse, who will determine next steps. This will serve as an urgent notification to clinic staff.
- Be sure to document all communications that occurred.

b. If you are sufficiently concerned about the patient's immediate welfare, and if the patient is not willing to go to an ER themselves

- Consider calling for a law enforcement welfare check. In this case, you should then utilize the medical record in the manner above and call the Clinic Charge Nurse if there is no the medical record response.
- This can help the patient get to emergency care immediately and will serve to notify clinic staff of what occurred.

### EMERGENCY CALL LIST

<table>
<thead>
<tr>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
</tr>
<tr>
<td><strong>2</strong></td>
</tr>
<tr>
<td><strong>3</strong></td>
</tr>
<tr>
<td><strong>4</strong></td>
</tr>
<tr>
<td>*</td>
</tr>
<tr>
<td><strong>5</strong></td>
</tr>
<tr>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>
Appendix B: Primary Care Provider Materials

This appendix compiles external resources relevant to the PCP chapter. First, we list general resources that contain numerous items of interest to PCPs participating in the CLARO study.

B.1
Center for Care Innovations (n.d.). Resource hub.
http://www.careinnovations.org/atshprimarycare-teams/resource-hub

B.2
https://aims.uw.edu/resource-library/commonly-prescribed-psychotropic-medications

B.3
http://www.naabt.org/education/literature.cfm

The remainder of this appendix provides resources referred to in the chapter itself, organized by topic. Many of the resources cited in the chapter draw upon SAMHSA’s TIP 63, and in the sections below we reproduce some of that content. Note that some images include numbered citations for that document, which are not relevant to this document. The TIP 63 publication was revised in May 2020 and is available in full at http://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006.

Screening Tools

B.4
TIP 63: Screeners

The following validated screening tools from TIP 63 can be used in the clinic to help identify risky substance use in adult patients. It is recommended to follow up a positive screen with further evaluation and indicated treatment.
B.5
http://www.drugabuse.gov/nmassist

National Institute on Drug Abuse. (n.d.). NIDA Quick Screen V1.0 (PDF version).

B.6

http://www.drugabuse.gov/taps
### TAPS Screening Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In the PAST 3 MONTHS, did you use heroin? If “Yes”, answer the following questions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. In the PAST 3 MONTHS, have you tried and failed to control, cut down, or stop using heroin?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. In the PAST 3 MONTHS, has anyone expressed concern about your use of heroin?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. In the PAST 3 MONTHS, did you use a prescription opioid pain reliever (for example, Percocet, Vicodin, Norco, Oxycontin) not as prescribed or that was not prescribed for you? If “Yes,” answer the following questions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. In the PAST 3 MONTHS, have you tried and failed to control, cut down, or stop using an opiate pain reliever?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. In the PAST 3 MONTHS, has anyone expressed concern about your use of an opiate pain reliever?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL**

Following yes responses to any of the screening questions above, clinicians should proceed to administer the DSM-5 Checklist.

**Source:** National Institute on Drug Abuse.

---

### OUD Diagnosis

#### B.7

**DSM-5 checklist for OUD**

The following checklist can be used to diagnose OUD as per the American Psychiatric Association’s DSM-5 criteria. These criteria should be met within the last 12 months that the individual has been in their usual living environment.
<table>
<thead>
<tr>
<th>DSM V Criteria for OUD</th>
<th>Yes</th>
<th>No</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids are often taken in larger amounts or over a longer period of time than intended.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a persistent desire or unsuccessful efforts to cut down or control opioid use.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Craving, or a strong desire to use opioids.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Important social, occupational, or recreational activities are given up or reduced because of opioid use.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent opioid use in situations in which it is physically hazardous.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Tolerance, as defined by either of the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) markedly diminished effect with continued use of the same amount of an opioid.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Withdrawal, as manifested by either of the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) the characteristic opioid withdrawal syndrome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL**

Severity: **Mild**, 2–3 symptoms; **Moderate**, 4–5 symptoms; **Severe**, 6 or more symptoms.

* Except opioids taken under medical supervision.

OUD Medication and Management

B.8
Food and Drug Administration (2016, August 21). FDA urges caution about withholding opioid addiction medications from patients taking benzodiazepines or Central Nervous System (CNS) depressants.

B.9
http://www.nomodeaths.org/medication-first-implementation

B.10
TIP 63: OUD Medications Overview (next page)
<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>BUPRENORPHINE*</th>
<th>METHADONE</th>
<th>XR-NTX**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>Daily (or off-label less-than-daily dosing regimens) administration of sublingual or buccal tablet or film. Subdermal implants every 6 months, for up to 1 year, for stable patients. Monthly subcutaneous injection of extended-release formulation in abdominal region for patients treated with transmucosal buprenorphine for at least 1 week.</td>
<td>Subdermal implants every 6 months, for up to 1 year, for stable patients. Monthly subcutaneous injection of extended-release formulation in abdominal region for patients treated with transmucosal buprenorphine for at least 1 week.</td>
<td>Daily oral administration as liquid concentrate, tablet, or oral solution from dispersible tablet or powder (unless patients can take some home). Every 4 weeks or once-per-month intramuscular injection.</td>
</tr>
<tr>
<td>Prescribing</td>
<td>Physicians, nurse practitioners (NPs), and physician assistants (PAs) need a waiver to prescribe. Until October 1, 2023, qualified clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives also can obtain a waiver to prescribe. Any pharmacy can fill a prescription for sublingual or buccal formulations. OTPs can administer/dispense by OTP physician order without a waiver.</td>
<td>Prescribers must have a waiver (as for transmucosal buprenorphine) and complete the product’s REMS program. Providers of the implantable rods must complete additional training in their insertion and removal. Both the implantable rods and subdermal injections are available via restricted distribution programs and are not available in retail pharmacies. OTPs can be providers of depot formulations of buprenorphine, provided the above criteria are satisfied. SAMHSA-certified OTPs can provide methadone for daily onsite administration or at-home self-administration for stable patients.</td>
<td>Physicians, NPs, PAs, and, until October 1, 2023, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives can prescribe or order administration by qualified healthcare professionals.</td>
</tr>
</tbody>
</table>

*Long-acting buprenorphine implants (every 6 months) for patients on a stable dose of buprenorphine are also available through implanters and prescribers with additional training and certification through the Probuphine Risk Evaluation and Mitigation Strategy (REMS) Program. Extended-release buprenorphine monthly subcutaneous injections are available only through prescribers and pharmacies registered with the Sublocade REMS Program.

**Naltrexone hydrochloride tablets (50 mg each) are also available for daily oral dosing but have not been shown to be more effective than treatment without medication or placebo because of poor patient adherence.
B.11

Opioid withdrawal symptoms:

- Abdominal cramping
- Agitation
- Anxiety
- Dilated pupils
- Diarrhea
- Increased tearing
- Insomnia
- Muscle aches
- Nausea
- Piloerection
- Runny nose
- Sweating
- Vomiting
- Yawning
**B.12**

TIP 63: Medications for Management of Opioid Withdrawal Symptoms

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>MEDICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>Ondansetron, metoclopramide (avoid promethazine; it potentiates opioids)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Loperamide</td>
</tr>
<tr>
<td>Anxiety, Irritability, sweating</td>
<td>Clonidine</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Diphenhydramine, trazodone</td>
</tr>
<tr>
<td>Pain</td>
<td>Nonsteroidal anti-inflammatory drugs</td>
</tr>
</tbody>
</table>
### Dose Equivalents

**B.13**

TIP 63: Buprenorphine Transmucosal Products for OUD Treatment

<table>
<thead>
<tr>
<th>PRODUCT NAME/ACTIVE INGREDIENT</th>
<th>ROUTE OF ADMINISTRATION/FORM</th>
<th>AVAILABLE STRENGTHS</th>
<th>RECOMMENDED ONCE-DAILY MAINTENANCE DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bunavail</strong>[^28] +[^29]</td>
<td>Buccal film</td>
<td>2.1 mg/0.3 mg, 4.2 mg/0.7 mg, 6.3 mg/1 mg</td>
<td>Target: 8.4 mg/1.4 mg, Range: 2.1 mg/0.3 mg to 12.6 mg/2.1 mg</td>
</tr>
<tr>
<td>• Buprenorphine hydrochloride</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Naloxone hydrochloride</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Generic combination product</strong>[^30] +[^31]</td>
<td>Sublingual tablet, film</td>
<td>2 mg/0.5 mg, 8 mg/2 mg</td>
<td>Target: 16 mg/4 mg, Range: 4 mg/1 mg to 24 mg/6 mg[^*^]</td>
</tr>
<tr>
<td>• Buprenorphine hydrochloride</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Naloxone hydrochloride</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Generic monoprodut</strong>[^31] +[^32]</td>
<td>Sublingual tablet</td>
<td>2 mg, 8 mg</td>
<td>Target: 16 mg, Range: 4 mg to 24 mg[^*^]</td>
</tr>
<tr>
<td>• Buprenorphine hydrochloride</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Suboxone</strong>[^33] +[^34]</td>
<td>Sublingual film</td>
<td>2 mg/0.5 mg, 4 mg/1 mg, 8 mg/2 mg, 12 mg/3 mg</td>
<td>Target: 16 mg/4 mg, Range: 4 mg/1 mg to 24 mg/6 mg[^*^]</td>
</tr>
<tr>
<td>• Buprenorphine hydrochloride</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Naloxone hydrochloride</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Zubsolv</strong>[^35] +[^36]</td>
<td>Sublingual tablet</td>
<td>0.7 mg/0.18 mg, 1.4 mg/0.36 mg, 2.9 mg/0.71 mg, 5.7 mg/1.4 mg, 8.6 mg/2.1 mg, 11.4 mg/2.9 mg</td>
<td>Target: 11.4 mg/2.9 mg, Range: 2.9 mg/0.71 mg to 17.2 mg/4.2 mg</td>
</tr>
</tbody>
</table>

[^*^]: Dosages above 24 mg buprenorphine or 24 mg/6 mg buprenorphine/naloxone per day have shown no clinical advantage.

Adapted from material in the public domain.[^28]

[^28]: Naloxone hydrochloride.
[^29]: Available as 0.3 mg/0.06 mg and 0.6 mg/0.12 mg.
[^30]: Available as 0.5 mg/0.1 mg and 1 mg/0.2 mg.
[^31]: Available as 1 mg/0.2 mg and 2 mg/0.4 mg.
[^32]: Available as 1 mg/0.2 mg.
[^33]: Available as 0.5 mg/0.1 mg and 1 mg/0.2 mg.
[^34]: Available as 1 mg/0.2 mg.
[^35]: Available as 0.7 mg/0.18 mg and 1.4 mg/0.36 mg.
[^36]: Available as 0.7 mg/0.18 mg, 1.4 mg/0.36 mg, 2.9 mg/0.71 mg, 5.7 mg/1.4 mg, 8.6 mg/2.1 mg, 11.4 mg/2.9 mg.
Dose Adjustment

B.14

TIP 63: Adjusting the Buprenorphine Dose

EXHIBIT 3D.6. Adjusting the Buprenorphine Dose

When to Increase the dose:
- Are patients taking medication correctly and as scheduled?
  - if they take at least 16 mg per day, mu-opioid receptors are approximately 80 to 95 percent occupied.\(^\text{246}\)
  - if there are adherence problems, assess causes and intervene to promote adherence and proper administration (e.g., offer supervised dosing at the clinic, by a network support, at a pharmacy).
  - if patients are taking doses correctly, a dose increase may be indicated, if certain conditions exist.
- Are patients taking other medications that may interfere with buprenorphine metabolism?
- If patients are taking doses properly, increase the dose if they still have opioid withdrawal (document with a clinical tool like COWS), opioid craving, or "good" effects (e.g., feeling "high") from using illicit opioids.
  - Craving can be a conditioned response. It may not decrease with dose increases if patients spend time with people who use opioids in their presence.
  - Dose increases typically occur in 2 mg to 4 mg increments.
  - It will take about 5 to 7 days to reach steady-state plasma concentrations after a dose increase.
  - Offer psychosocial referrals to help decrease and manage cravings.
- Determine whether nonpharmacological problems are contributing to the need for increase.
  - For example, do patients show signs and symptoms of untreated major depressive or generalized anxiety disorders? Are they living in a chaotic household? Do they have childcare problems or financial difficulties? Are they experiencing trauma or trauma-related mental disorders?
  - Address or refer to counseling to address these problems.

When to decrease the dose:
- Decrease the dose when there is evidence of dose toxicity (i.e., sedation or, rarely, clearly linked clinically relevant increases in liver function tests).
- Hold the dose when there is acute alcohol or benzodiazepine intoxication.
**Naltrexone Long-Acting Injection**


**B.15**

TIP 63: Chapter 3C: Naltrexone

Dosing Summary

Before administering Naltrexone Long-Acting Injection, keep it at room temperature for about 45 minutes.

- Use the correct needle length to ensure that the injection is in the gluteal muscle.
- Use the 2-inch needle for patients with more subcutaneous tissue and the 1.5-inch needle for patients with less adipose tissue.
- Use either length in patients with normal body habitus.
- Use proper aseptic technique.
- Use proper gluteal IM (intramuscular) injection technique.
- Never inject intravenously or subcutaneously.
- Repeat the injection every 4 weeks or once per month.
Prescribing Naloxone

**B.16**

Prescribe to Prevent

http://prescribetoprevent.org

Prescribing information is available at

http://prescribetoprevent.org/prescribers/palliative
OUD Lab Testing/Toxicology

**B.17**

TIP 63: Urine Drug Testing Window of Detection

<table>
<thead>
<tr>
<th>DRUG</th>
<th>POSITIVE TEST</th>
<th>WINDOW OF DETECTION*</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamine; methamphetamine; 3,4-methylenedioxy-methamphetamine</td>
<td>Amphetamine</td>
<td>1-2 days</td>
<td>False positives with bupropion, chlorpromazine, desipramine, fluoxetine, labetalol, promethazine, ranitidine, pseudoephedrine, trazadone, and other common medications. Confirm unexpected positive results with the laboratory.</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>Barbiturates</td>
<td>Up to 6 weeks</td>
<td>N/A</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Benzodiazepines</td>
<td>1-3 days; up to 6 weeks with heavy use of long-acting benzodiazepines</td>
<td>Immunoassays may not be sensitive to therapeutic doses, and most immunoassays have low sensitivity to clonazepam and lorazepam. Check with your laboratory regarding sensitivity and cutoffs. False positives with sertraline or oxaprozin.</td>
</tr>
</tbody>
</table>

*Detection time may vary depending on the cutoff. Continued on next page

(continued on next page)
B.18

TIP 63: Urine Drug Testing Window of Detection (continued)

<table>
<thead>
<tr>
<th>DRUG</th>
<th>POSITIVE TEST</th>
<th>WINDOW OF DETECTION*</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine</td>
<td>Buprenorphine</td>
<td>3-4 days</td>
<td>Will screen negative on opiate screen. Tramadol can cause false positives. Can be tested for specifically.</td>
</tr>
<tr>
<td>Cocaine</td>
<td>Cocaine, benzoylecgonine</td>
<td>2-4 days; 10-22 days with heavy use</td>
<td>N/A</td>
</tr>
<tr>
<td>Codeine</td>
<td>Morphine, codeine, high-dose hydrocodone</td>
<td>1-2 days</td>
<td>Will screen positive on opiate immunoassay.</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Fentanyl</td>
<td>1-2 days</td>
<td>Will screen negative on opiate screen. Can be tested for specifically. May not detect all fentanyl-like substances.</td>
</tr>
<tr>
<td>Heroin</td>
<td>Morphine, codeine</td>
<td>1-2 days</td>
<td>Will screen positive on opiate immunoassay. 6-monoacetylmorphine, a unique metabolite of heroin, is present in urine for about 6 hours. Can be tested for specifically to distinguish morphine from heroin, but this is rarely clinically useful.</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>Hydrocodone, hydromorphone</td>
<td>2 days</td>
<td>May screen negative on opiate immunoassay. Can be tested for specifically.</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>May not be detected</td>
<td>1-2 days</td>
<td>May screen negative on opiate immunoassay. Can be tested for specifically.</td>
</tr>
<tr>
<td>Marijuana</td>
<td>Tetrahydrocannabinol</td>
<td>Infrequent use of 1-3 days; chronic use of up to 30 days</td>
<td>False positives possible with efavirenz, ibuprofen, and pantoprazole.</td>
</tr>
<tr>
<td>Methadone</td>
<td>Methadone</td>
<td>2-11 days</td>
<td>Will screen negative on opiate screen. Can be tested for specifically.</td>
</tr>
<tr>
<td>Morphine</td>
<td>Morphine, hydromorphone</td>
<td>1-2 days</td>
<td>Will screen positive on opiate immunoassay. Ingestion of poppy plant/seed may screen positive.</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Oxymorphone</td>
<td>1-15 days</td>
<td>Typically screens negative on opiate immunoassay. Can be tested for specifically.</td>
</tr>
</tbody>
</table>

*Detection time may vary depending on the cutoff.
MDD and PTSD Assessment

Screening for MDD

B.19
A full copy of the PHQ-9 (questions and scoring shown in Appendix A) is available from the U.S. Preventive Services Task Force:
http://www.uspreventiveservicestaskforce.org/Home/GetFileById/218

B.20

DSM-5 Diagnostic Criteria for MDD

B.21

Assess for a history of hypomania/mania not caused by intoxication or explained by medical illness, as these patients should be considered for the diagnosis of bipolar disorder, which is treated differently than MDD. See the subsequent section on mania screening. Consult the BHC if unmanaged bipolar disorder is suspected to be present in a patient.

Also, assess for psychiatric and medical comorbidities (e.g., substance-induced depression, anxiety disorders, anemia, thyroid disease, sleep apnea, obesity, diabetes) that can mimic, exacerbate, and worsen MDD.

Mania Screening

B.22
http://www.hcp.med.harvard.edu/ncs/ftpdir/CIDI_3.0_Bipolar_Screening_Scales_final.pdf
CIDI-Based Bipolar Disorder (BPD) Screening

1. Stem questions:
   a. Some people have periods lasting several days or longer when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still, and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period liked this lasting several days or longer?¹
   b. Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you either started arguments, shouted at people, or hit people?

2. Criterion B screening question
   a. People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in ways they would normally think are inappropriate. Did you ever have any of these changes during your episodes of being (excited and full of energy/very irritable or grouchy)?

3. Criterion B symptom questions
   Think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following changes did you experience?
   b. Were you so irritable that you either started arguments, shouted at people, or hit people?²
   c. Did you become so restless or fidgety that you paced up and down or couldn’t stand still?
   d. Did you do anything else that wasn’t usual for you—like talking about things you would normally keep private, or acting in ways that you’d usually find embarrassing?
   e. Did you try to do things that were impossible to do, like taking on large amounts of work?
   f. Did you constantly keep changing your plans or activities?
   g. Did you find it hard to keep your mind on what you were doing?
   h. Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn’t keep track of them?
   i. Did you sleep far less than usual and still not get tired or sleepy?

¹ If this question is endorsed, the irritability stem question is skipped and the respondent goes directly to the Criterion B screening question.
² This question is asked only if the euphoria stem question is endorsed.
j. Did you spend so much more money than usual that it caused you to have financial trouble?

**Screening for PTSD**

**B.23**

The following document can be used to screen for PTSD in the primary care setting. Those screening positive will require further assessment and, in case of diagnosis, access to treatment.


http://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp

**PC-PTSD-5 Screen:**

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event? YES / NO

If NO, screen total = 0. Please stop here.

If YES, please answer the questions below.

In the past month, have you . . .

- Had nightmares about the event(s) or thought about the event(s) when you did not want to? YES / NO
- Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? YES / NO
- Been constantly on guard, watchful, or easily startled? YES / NO
- Felt numb or detached from people, activities, or your surroundings? YES / NO
- Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? YES / NO

An answer of YES to three or more of these five is probable for the diagnosis of PTSD.
PTSD Diagnosis Using DSM-5

B.24
Substance Abuse and Mental Health Services Administration. (2014). *Trauma-informed care in behavioral health services (TIP 57)*. Rockville, MD: Author, exhibit 1.3-4.

MDD and PTSD Medication

*Antidepressant Doses of Psychotropic Medications and Dose Adjustments*

B.25
This document provides a list of commonly prescribed psychotropic medications for treatment of depression, anxiety, and insomnia, as well as mood stabilizers and antipsychotic medications that are often prescribed in primary care. It also has several insights for providers regarding dose adjustments and reproductive health.


PTSD Medications

B.26
PTSD Medication Decision Tree
This figure provides a list of commonly prescribed medications for PTSD, including recommended doses and how to adjust medications based on patient response.
B.27

For level of evidence for pharmacotherapy targeting PTSD symptoms, see:


B.28

For discussion of additional medication treatments, see:

http://www.healthquality.va.gov/guidelines/MH/ptsd
**Smoking Cessation/Tobacco Use Disorder Pharmacotherapy**

**B.29**

https://www.aafp.org/pubs/afp/issues/2021/0615/od1.html
Treatment Planning

B.30

TIP 63: Goal Sheet and Coping Strategies Form

Sample Goal Sheet and Coping Strategies Form

Patient’s Name: ___________________________ Date: ___________________________

3-MONTH GOALS

1

2

3

6-MONTH GOALS

1

2

3

1-YEAR GOALS

1

2

3

List of Triggers to Using Drugs

People To Stay Away From

Places To Stay Away From

Ways To Cope or Manage Stress Without Using Drugs

M. Lofwall, February 27, 2017 (personal communication). Adapted with permission.
**Diversion Control**

**B.31**

TIP 63: Key Elements of an Office Based Opioid Therapy (OBOT) Clinic Diversion Control Plan

![EXHIBIT 3E.3. Key Elements of an OBOT Clinic Diversion Control Plan](image-url)
Readiness Ruler

B.32


http://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003

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**EXHIBIT 3.9. The Importance Ruler**

![Image of a ruler with scales from 0 to 10]

- Initial question: “On a scale of 0 to 10, how important is it for you to change [name the target behavior, like how much the client drinks] if you decided to?”
- Follow-up question 1: “How are you at a [fill in the number on the scale] instead of a [choose a lower number on the scale]?” When you use a lower number, you are inviting the client to reflect on how he or she is already considering change. If you use a higher number, it will likely evoke sustain talk (Miller & Rollnick, 2013). Notice the difference in the following examples:

  **Lower number**
  - Counselor: You mention that you are at a 6 on the importance of quitting drinking. How are you at a 6 instead of a 3?
  - Client: I’m realizing that drinking causes more problems in my life now than when I was younger.

  **Higher number**
  - Counselor: You mention that you are at a 6 on the importance of quitting drinking. How are you at a 6 instead of a 9?
  - Client: Well, I am just not ready to quit right this second.

In the higher number example, the counselor evokes sustain talk, but it is still useful information and can be the beginning of a deep conversation about the client’s readiness to change.

- Follow-up question 2: “What would help move from a [fill in the number on the scale] to a [choose a slightly higher number on the scale]?” This question invites the client to reflect on reasons to increase readiness to change.

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**EXHIBIT 3.10. The Confidence Ruler**

![Image of a ruler with scales from 0 to 10]

- Initial question: “On a scale of 0 to 10, how confident are you that you could change [name the target behavior, like stop drinking] if you decided to?”
- Follow-up questions:
  - “How are you at a [fill in the number on the scale] instead of a [choose a lower number on the scale]?” Using a lower number helps clients reflect on how far they’ve come on the confidence scale. Using a higher number with this question may discourage clients, which can elicit sustain talk, if that should happen, see strategies discussed previously for responding to sustain talk.
  - “What would help you get from a [fill in the number on the scale] to a [choose a slightly higher number on the scale]?” This open question invites clients to reflect on strategies to build confidence. Don’t jump to a much higher number, which can overwhelm clients and lower confidence.

Whatever the client’s response to these scaling questions, use it as an opportunity to begin a conversation about his or her confidence or perceived ability to move forward in the change process.
Contingency Management

B.33

Contingency management involves giving patients tangible rewards to reinforce positive behaviors such as abstinence or treatment adherence. A fishbowl draw following a negative urine toxicology result is a common strategy employed by community health centers.

Common Comorbidities

Prazosin Instructions

The following is a set of instructions that PCPs may want to share with patients. PCPs may also find the instructions useful for themselves. (H. Roggenkamp, personal communication, prazosin instructions for patients, May 26, 2020).

Prazosin is a blood pressure medicine that blocks adrenaline in the brain and can make nightmares go away and help you sleep better. Prazosin has been widely studied in active duty members of the military and in veterans of all eras, and may be helpful in treating posttraumatic stress symptoms.

Start at 1 mg and increase the dose slowly. Because it is a blood pressure medication, it may make your blood pressure drop and cause dizziness/lightheadedness. Do not increase the dose in increments larger than 1 mg (like in 2 mg increments at a time) unless your doctor tells you to. Prazosin is not a sedative or sleeping pill.

Dosing Instructions:

Start with one pill. Take it ½–1 hour before bed. Watch for dizziness/lightheadedness during the night and in the morning when you wake up. Be careful bending over (like doing yoga), and getting out of bed—stand up slowly and only start walking if you don't feel lightheaded and your vision is normal. Otherwise you could faint. For men: If you get up during the night to urinate, sit down on the toilet until you know how the medication affects you. Otherwise urinating can drop your blood pressure and cause you to fall/pass out.

Any dizziness/lightheadedness should be for a few minutes in the morning at most and go away completely after 3–4 days. Do not increase the dose of the medication until this side effect goes away. If, however, you are not having side effects but you are still having nightmares or sleep problems, increase the dose by 1 pill (1 mg). Continue to increase the dose until the nightmares go away, you are sleeping better, or until you experience side effects that do not go away. Never increase the dose if you are having side effects—if side effects aren’t going away, decrease the dose and call your doctor/psychiatrist.

There are pills with higher milligram doses (2 mg, 5 mg), so as you get to higher doses, we can give you those so you don’t have to take so many pills.

You are starting at 1 mg, but the amount of medication you need will probably be much more than that. Some patients need up to 30–40 mg of prazosin at night! If you are not having side effects, as long as the nightmares/sleep problems are continuing, keep increasing the dose! Prazosin can also help for daytime anxiety/adrenaline, so if that is a problem for you, and you like the prazosin, in the future we may talk about having you take a lower daytime dose as well.
Sample schedule for first month:

<table>
<thead>
<tr>
<th>SUN</th>
<th>MON</th>
<th>TUE</th>
<th>WED</th>
<th>THUR</th>
<th>FRI</th>
<th>SAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 mg</td>
<td>1 mg</td>
<td>1 mg</td>
<td>-&gt;2 mg</td>
<td>2 mg</td>
<td>2 mg</td>
<td>-&gt;3 mg</td>
</tr>
<tr>
<td>3 mg</td>
<td>3 mg</td>
<td>-&gt;4 mg</td>
<td>4 mg</td>
<td>4 mg</td>
<td>-&gt;5 mg</td>
<td>5 mg</td>
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<tr>
<td>5 mg</td>
<td>-&gt;6 mg</td>
<td>6 mg</td>
<td>6 mg</td>
<td>-&gt;7 mg</td>
<td>7 mg</td>
<td>7 mg</td>
</tr>
<tr>
<td>-&gt;8 mg</td>
<td>8 mg</td>
<td>8 mg</td>
<td>-&gt;9 mg</td>
<td>9 mg</td>
<td>9 mg</td>
<td>-&gt;10 mg</td>
</tr>
</tbody>
</table>
Appendix C: Behavioral Health Provider Materials

Problem-Solving Treatment Literature

Evidence for the effectiveness of PST is strong. One study (Mynors-Wallace et al., 2000) found that PST is an effective treatment for depressive disorders in primary care. Other studies have found PST to be equally effective across diverse groups of patients (Schmaling, 2019) and that a brief four-session PST can reinforce aspects of executive functioning that may enhance complex decisionmaking in healthy older adults (Nguyen, Chen, and Denburg, 2018).

C.1


This chapter presents the theoretical framework of PST and reviews a typical course of treatment, illustrated by a case of an older depressed patient with complex needs. Recent empirical findings and considerations for special populations are also presented.

C.2

http://aims.uw.edu/collaborative-care/behavioral-interventions/problem-solving-treatment-pst
http://aims.uw.edu/resource-library/problem-solving-treatment-pst

These links describe PST, explain how to become certified in PST, and provide information for how to obtain continuing education.

C.3


This article is a recent systematic review and meta-analysis of PST for depression and anxiety.
C.4

This article provides strong evidence for the effectiveness of PST for Primary Care (PST-PC) based on a randomized controlled trial. Although PST was originally developed for delivery by BHPs, this study adapted it for delivery by nurses and primary care providers (PCPs).

C.5

This article demonstrates the equivalent effects of PST-PC for patients from racial-ethnic minority or nonminority groups. It also found that women improved more than men in response to PST.

C.6

This study demonstrated that four-session PST reinforced components of executive functioning and, in turn, enhanced complex decisionmaking in healthy older adults.

Written Exposure Therapy Literature
Evidence for the effectiveness of WET comes from two randomized controlled trials (RCTs). One compared a group of patients who received WET treatment to a group who did not receive treatment until six months after the trial was over and found that patients receiving WET remitted after six months (Sloan et al., 2012). Another study showed that brief WET is equally as effective as a much more intensive cognitive processing therapy (CPT) (Sloan et al., 2018). There are also two RCTs in progress that are examining WET compared with CPT-cognition only (CPT-C) with active-duty service members and WET compared with prolonged exposure therapy (PE) with veterans. WET is now included in the Veterans Administration/Department of Defense PTSD Clinical Practice Guideline.
C.7

http://www.apa.org/pubs/books/4317524

This link takes you to the American Psychological Association (APA) site where you may purchase additional copies of the treatment manual.

C.8

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3433579/

This study showed that WET was effective for improving PTSD compared with a waitlist control group.

C.9


This is the first of two articles showing that WET is equally as effective as cognitive processing therapy (CPT).

C.10


This is the second of two articles showing that WET is equally as effective as CPT.
Appendix D: Patient Materials

Getting Active with Depression

D.1
Behavioral activation for depression.
http://medicine.umich.edu/sites/default/files/content/downloads/Behavioral-Activation-for-Depression.pdf

Mutual Self-Help Groups and Services

D.2
Medication-Assisted Recovery Anonymous (MARA)
http://www.mara-international.org

Narcotics Anonymous
http://www.na.org/meetingsearch/

SMART Recovery
http://www.smartrecovery.org/

Harm Reduction Services

D.3
New Mexico Online Resource Guide
http://nmhivguide.org

Medication Support

D.4

D.5
**D.6**


This is a helpful guide to give to your patients, after reviewing with them in clinic.

**D.7**

Medications for PTSD
http://www ptsd.va.gov/understand_tx/meds_for_ptsd.asp

Medications for MDD
https://www.ncbi.nlm.nih.gov/books/NBK559078/

Mental health medications

**Risk Reduction**

**D.8**

How to use a naloxone kit in the event of an overdose
https://www.narcan.com/

**D.9**

Patient overdose recognition and response instructions
http://prescribetoprevent.org/patient-education/materials

**D.10**

Rescue breathing (overdose pocket card)
http://nmhealth.org/publication/view/marketing/3197/

**Sleep**

**D.11**

Centre for Clinical Interventions. (n.d.) Sleep hygiene [to establish regular healthy bedtime routines].
Stress

D.12

Centre for Clinical Interventions. (n.d.). *Coping with stress.*

General Educational Resources

D.13

Problem-Solving Treatment

Written Exposure Therapy
https://www.ptsd.va.gov/professional/treat/txessentials/written_exposure_therapy.asp

D.14

Relaxation Exercises

Menus of Treatment Options

On the pages that follow, we provide tear sheets of patient-oriented menus of options for treatment that focus on opioids, depression, and PTSD.
Treatment Options: Opioids

Starting Treatment or Therapy
There are some great programs in the clinic and community that can offer support. Some are inpatient, others are outpatient, and they can help those who struggle with opioids in addition to other co-occurring behavioral or physical health issues.

Starting Medication for Opioid Use Disorder
There are some medications available that can help people with dependence on prescription pain pills or heroin. Starting a medication could help you reduce or stop using. If you are interested, I can give you some information, and your doctor will help you decide if it is right for you.

• Comparison of OUD medications
• Buprenorphine FAQ

Staying Safe Strategies
Adopt ways to stay safe by decreasing risk of overdose or protecting yourself from accidents. This may include using sterile injection equipment, knowing what and how much you’re taking, and reducing risk of assault while intoxicated in unsafe areas.

• Naloxone booklet
• Overdose recognition and response instructions
• Nearby harm reduction programs (needle exchange, hepatitis C virus [HCV] testing)

Connecting with Supportive People
You can choose a support group in your area, like a 12-step program offered through Narcotics Anonymous, a Self-Management and Recovery Training (SMART) group, or Medication-Assisted Recovery Anonymous, and attend meetings as often as you like. Support groups often are run by other people who have substance use problems and can be very helpful to people wanting to change their habits. Or, you might have a supportive family member or friend who does not use who you could talk with.
Talk Again Later

You may not feel ready right now to choose treatment options. I can come back later to talk more about this when you feel more ready.
Treatment Options: Depression

Starting Problem-Solving Treatment
Some therapies are very helpful for treating depression. One type of therapy is called Problem-Solving Treatment, which involves working with a therapist to work on ways to cope with depression symptoms by solving immediate problems that contribute to depression. This takes place over four to 12 sessions with a therapist at your primary care clinic.

Starting Medication
There are several different medications that are effective in treating depression. If you’re interested in starting a medication or getting more information about starting a medication, we can talk with your primary care doctor about what might work best for you.

Getting Active
Doing pleasant activities that you enjoy can help improve your mood. You could work with a therapist or we could talk about it a bit now to see what might work for you specifically.

Talk Again Later
You may not feel ready right now to choose treatment options. I can come back later to talk more about this when you feel more ready.
Starting Written Exposure Therapy

There are some very helpful therapies for treating PTSD. One type of therapy is called Written Exposure Therapy, and it involves working with a counselor to write or talk about the traumatic event you experienced. This takes place over five half-hour sessions with a counselor.

Starting Medication

There are some medications that can help people with PTSD. For instance, sertraline (Zoloft), paroxetine (Paxil), fluoxetine (Prozac), and venlafaxine (Effexor) are antidepressants that can help people with PTSD. If you are interested, we can talk with your primary care doctor about which medication might work best for you.

Help for Related Concerns

There are self-care tools to help with other concerns you might be experiencing, such as problems with sleep or stress/anxiety. Self-care tips could include being around safe people who do not hurt you, eating healthy, exercise, and seeing your doctor for health concerns.

- Improving sleep
- Coping with stress
- Relaxation exercises

Talk Again Later

You may not feel ready right now to choose treatment options. I can come back later to talk more about this when you feel more ready.
This intervention manual for the Collaboration Leading to Addiction Treatment and Recovery from Other Stresses (CLARO) research study intervention advances a collaborative care model of primary care–centered treatment for patients who have co-occurring opioid use disorder with major depressive disorder and/or post-traumatic stress disorder. Through this intervention, clinical members of the collaborative care team—primary care providers, behavioral health providers, and behavioral health consultants—will work closely with a care coordinator to manage the patient's overall care and ensure that they get high-quality, effective, and patient-centered care. By offering concurrent treatment for both opioid use disorder and mental illness, the CLARO intervention aims to improve patient outcomes for this vulnerable and underserved population. CLARO has been implemented at clinics in New Mexico and health centers in California.

The introduction provides a general overview of the CLARO study; the remainder of the manual presents the step-by-step instructional format for members of the care team involved in the CLARO intervention. A companion CLARO implementation manual describes the implementation process and the supports used to bring the CLARO intervention to primary care clinics.