Index of Protocols

OUD.1A

The goal of this program is for the Opioid Response Team (ORT) to contact participants within 24-72 hours of an overdose to determine the needs of the patient and connect them to services to support treatment and recovery from opioid use disorder. This includes, but is not limited to, recovery outpatient programs at a partnering treatment center, support groups, and/or Medication Assisted Treatment (MAT) programs. In cases where patients are experiencing severe symptoms of withdrawal and who meet the criteria, the goal then includes the stabilization of withdrawal symptoms quickly through an approved Medication Assisted Recover (MAR) protocol so the patient can mentally attend and participate in a facilitated admission process to an outpatient recovery program.

When patients meet the inclusion criteria for MAR, the program hopes to start immediate Medication Assisted Recovery with administration of **Buprenorphine-Naloxone (Suboxone) Sublingual** titrated to symptom control as a value-added treatment with subsequent referral, facilitated warm-handoff and transportation to an available outpatient treatment center.

When patients meet the criteria for enrollment into the MAR program, the outpatient medication therapy will be provided at No Cost for up to five days or until the patient is admitted into a rehabilitation program. Patients that are excluded from Suboxone administration may still be referred to an Urgent Recovery Center (URC) or treatment facility.

Procedure:

At the beginning of each shift, the Overdose Response Team (ORT) member will generate an ESO report to identify the previous days' 911 responses to opiate overdoses or other possible substances misuse responses that may require intervention from the Overdose Response Team. Once identified and validated, a patient record will be created for the potential participant, including demographics, past medical history, medications prescribed, allergies, insurance information, and closest relatives. The potential participant will be assigned to the Overdose Response Team as their program with a status of 'pending enrollment – phone call'. The 'referral date' will be the date of the 911 response.

ORT will attempt to locate or schedule the potential participant for a home visit. Attempts to contact the potential participant can be made via phone, text, and in-person (drive-by). The ORT Paramedic will not attempt visits to anyone that has, or is known to have, a history of violent behavior, or that the crew feels will be a substantial safety concern. During the scheduled visit, the ORT will complete and document the following:

- History of Present Illness
- Physical Examination
- Vital Signs
- Clinical Opiate Withdrawal Scale
- Short Intake Form
- Resource Referrals
- Naloxone Training
- Hands-Only CPR Training
- Provide Options for MAT

OUD.1A cont.'

During this same visit, the participant will be introduced to the Navigation Specialist/Peer Services Specialist, who will provide appropriate follow-up interventions as necessary. At the conclusion of the visit, the participant's program status timeline will be updated to include 'Enrolled'. If no additional intervention is required by the Overdose Response Paramedic, the program status timeline will be updated to include 'Closed/Graduated'.

Enrolled patients will be given a Naloxone Opioid Kit (NOK). The Kit contains the following:

- Narcan Nasal Spray 4 mg Two Pack
- Hands Only CPR Instructions
- Medical Gloves
- Fentanyl Test Strips
- Directions to use all included products
- Addiction Assistance brochure

If the patient is believed to meet the MAR inclusion criteria, they will be connected to the Urgent Recovery Center staff using a video call. The URC will assess the patient for inclusion in their recovery program and the need for Medication Assisted Recovery to be started in the field. If the patient meets criteria for immediate MAR then Dr. Goodloe or Dr. Knoles with the Office of the Medical Director will be contacted to approve induction using Suboxone. The patient will then be offered Buprenorphine 8-24 mg (Suboxone) sublingual (per physician verbal order) for symptom relief. If during the intake process patient score has not decreased significantly, a second dose can be administered by the ORT Paramedic maximum daily dose of 32 mg.

MAR Inclusion Criteria

- History of overdose or high-risk substance abuse
- History of opiate dependence with noted current presence of withdrawal symptoms with abstinence of use of at least 24 hrs. (72 hrs. for methadone)
- COWS (Clinical Opiate Withdrawal Score) >= 8
- Willingness to engage in recovery in Outpatient program at participating URC or contracted outpatient center.

MAR Exclusion Criteria

- Current evidence of intoxication due to alcohol or other substances (can re-evaluate in 24 hrs.)
- Known history of recent benzodiazepine or other sedative use/abuse
- Known current pregnancy (High risk patients may be treated with medical direction consultation in rare circumstances)
- Presence of severe cirrhosis, liver failure or renal failure (dialysis)
- Unstable vital signs or signs of hemodynamic or respiratory instability.
- Active infection or trauma needing medical attention.
- Taking methadone or any other long-acting narcotic within 72 hrs.
- Chronic pain patients who are prescribed opioids
- Patient is in an established program currently.

OUD.1A cont.'

Medication Protocol (Direct Online Medical Director Consultation is required each day)

- **Pre-Medicate**
  - Ondansetron (Zofran) 8 mg ODT sublingual prn nausea
  - Acetaminophen (Tylenol) 1000 mg prn pain
  - Loperamide (Imodium) 8mg prn diarrhea/ abdominal cramps
  - Diphenhydramine (Benadryl) 25-50 mg prn anxiety/abdominal cramps
  - Clonidine 0.1-0.3 PO for narcotic withdrawal (if not using Buprenorphine consult Medical Director)

- **Buprenorphine (Suboxone) Sublingual strips or ODT tabs**
  - 8-24 mg buccal per physician verbal order
  - Second dose 8-16 mg (Max 32 Mg) in 15 minutes if COWS score >8 or symptoms not resolved.
  - Second and subsequent day doses covering weekend and holiday periods will be dose based on previous dose effectiveness.

In case of precipitated withdrawal, contact Medical Director Immediately and attempt IV access.

- IV Fluid bolus 500 ml
- Ondansetron (Zofran) 8 mg IV or ODT sublingual prn nausea (max. 16 mg total)
- Diphenhydramine (Benadryl) 25-50 mg IV for anxiety/abdominal cramps (max 75 mg total)
- Additional Buprenorphine (Suboxone) sublingual strips or ODT tabs 8-16 mg or as directed by physician max 32mg total.

Buprenorphine 8 mg (Suboxone) Sublingual is a Schedule III DEA classified medication and approved narcotic tracking processes already in place. Documentation of medication administration will be done on the existing electronic patient care record ePCR (ESO PCR) or OMD approved documentation platform with 100% quality assurance review of the medical record by the Office of the Medical Director (OMD). The medical director will provide additional training and close oversight to MIH Paramedics participating in this program along with online and offline medical direction.

MIH 10A – BUPRENORPHINE-NALOXONE (SUBOXONE®)

MOBILE INTEGRATED HEALTH PARAMEDIC

Class: Opioid Partial Agonist

Actions/Pharmacodynamics: Buprenorphine is a partial agonist at the mu opioid receptor and an antagonist at the kappa receptor. It has very high affinity and low intrinsic activity at the mu receptor and will displace morphine, methadone, and other opioid full agonists from the receptor. Naloxone competes with and displaces narcotic substances from opiate receptors.

Indications:

- History of overdose or high-risk substance abuse
- History of opioid dependence with presence of withdrawal symptoms and abstinence of use of at least 24 hrs. (72 hrs. for methadone)
- COWS (Clinical Opiate Withdrawal Score) >= 8
- Willingness to engage in outpatient recovery through an identified outpatient center.

Contraindications:

- Current evidence of intoxication due to alcohol or other substances (can re-evaluate in 24 hrs.)
- Known history of recent benzodiazepine or other sedative use/ abuse
- Known current pregnancy (High risk patients may be treated with medical direction consultation in rare circumstances)
- Presence of severe cirrhosis, liver failure or renal failure (dialysis)
- Unstable vital signs or signs of hemodynamic or respiratory instability.
- Taking methadone or any other long-acting narcotic within 72 hrs.
- Chronic pain patients who are prescribed opioids
- Patient is in an established program currently.
- Known hypersensitivity or anaphylaxis.
- Opioid naïve patients
- Any active medical issue requiring urgent medical attention (infection, trauma)
- Concurrent use of Monoamine Oxidase (MAO) inhibitors.

Pharmacokinetics: Onset of action within 2 minutes after IVP/IOP/IN administration with duration of effect up to 2 hours.

MIH 10A – Buprenorphine- Naloxone (Suboxone®) cont.'

Side Effects: Diaphoresis, abdominal pain, constipation, nausea, headache, withdrawal syndrome, vasodilation, palpitations, CNS depression, hepatic events, hypersensitivity reactions, hypotension, QT prolongation.

Dosage:
8-24 mg sublingual per physician verbal order
Second dose 8-16 mg (Max 32 mg) in 15 minutes if COWS score >8 or symptoms not resolved.
Second and subsequent day dosing will be dosed based on previous dose effectiveness.

How Supplied:
Buprenorphine 2 mg and naloxone 0.5 mg sublingual tablet
Buprenorphine 8 mg and naloxone 2 mg sublingual tablet

Buprenorphine 2 mg and naloxone 0.5 mg sublingual film
Buprenorphine 4 mg and naloxone 1 mg sublingual film
Buprenorphine 8 mg and naloxone 2 mg sublingual film
Buprenorphine 12 mg and naloxone 3 mg sublingual film

Special Comment: Buprenorphine-Naloxone (Suboxone) sublingual is a Schedule III DEA classified medication and appropriate storage in a locked vehicle safe will be mandated along with use of the DEA approved narcotic tracking processes already in place in accordance with the Office of the Medical Director (OMD) policies/protocols.

MIH 10B – Clonidine Hydrochloride

MOBILE INTEGRATED HEALTH PARAMEDIC

Class: Alpha-2 Adrenergic Agonist

Actions/Pharmacodynamics: Stimulates alpha-2 adrenoreceptors in the brain stem, thus activating an inhibitory neuron, resulting in reduced sympathetic outflow from the CNS, producing a decrease in peripheral resistance, renal vascular resistance, heart rate, and blood pressure.

Indications:

- Premedication for Medication Assisted Recovery.
- History of overdose or high-risk substance abuse.
- History of opioid dependence with presence of withdrawal symptoms and abstinence of use of at least 24 hrs. (72 hrs. for methadone).
- COWS (Clinical Opiate Withdrawal Score) >= 8.
- Willingness to engage in outpatient recovery through an identified outpatient center.

Contraindications:

- Hypotension
- Current evidence of intoxication due to alcohol or other substances (can re-evaluate in 24 hrs.)
- Known history of recent benzodiazepine or other sedative use/ abuse.
- Known current pregnancy (high risk patients may be treated with medical direction consultation in rare circumstances), clonidine crosses the placenta.
- Presence of severe cirrhosis, liver failure or renal failure (dialysis).
- Unstable vital signs or signs of hemodynamic or respiratory instability.
- Taking methadone or any other long-acting narcotic within 72 hrs.
- Chronic pain patients who are prescribed opioids.
- Patient is in an established program currently.
- Known hypersensitivity or anaphylaxis.
- Opioid naïve patients.
- Any active medical issue requiring urgent medical attention (infection, trauma).
- Concurrent use of Monoamine Oxidase (MAO) inhibitors.

Pharmacokinetics: Oral: Immediate release: 0.5 to 1 hour (maximum reduction in blood pressure: 2 to 4 hours).

MIH – 10B Clonidine Hydrochloride cont.'

Side Effects: Bradycardia and hypotension may occur with therapeutic or supratherapeutic dosing of Clonidine in all ages. Those adverse reactions may require intervention and are generally reversable with discontinuation.

Dosage: 0.1 to 0.2 mg (Pts > 90kg may receive up to 0.3mg)

How Supplied: 0.1mg tablet