

STATE OF RHODE ISLAND
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS
DIVISION OF BEHAVIORAL HEALTH CARE

UNIT **Center of Excellence**

POLICY/PROCEDURE NO.

COE - 018

SUBSECTION EFFECTIVE DATE

2/10/17

POLICY/PROCEDURE

Patient Protocol for Follow-up
Appointments

AMENDMENT / REVISION HISTORY

Approved:

Amended:

POLICY

This protocol outlines patient follow-up appointments, their scheduling, and what type of activities shall occur at those appointments. It also outlines patient behaviors to identify to assist with relapse prevention and the COE's response to those behaviors.

PROCEDURE

Description

1. **Outline of patient visits starting from the induction visits and going through the Week 24 including the activities related to follow up appointments.**
Appointment Schedule
Week 1: 2 Induction visits, 1 additional visit
Weeks 2-8: 2 visits/week
Weeks 9-12: 1 visit/week
Weeks 13-16: 2 visits/month
Weeks 17-24: 1 visit/month
2. **If the patient exhibits the 'red flag' behaviors related to possible relapse, the patient's treatment team will evaluate those behaviors and determine what a supportive and appropriate clinical response should be.**
3. **These interventions will be based on an individualized clinical assessment and recorded in the patient's record. Progress notes must be recorded at each visit. Variance from the above schedule must be justified in the patient record.**

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals Center of Excellence for the Treatment of Opioid Use Disorder PROTOCOL for FOLLOW-UP APPOINTMENTS

Follow-up appointments should occur on the following schedule. Deviations from this schedule should be explained in progress notes.

Week 1: 2 Induction visits; 1 additional visit

Weeks 2-8: 2 visits weekly

Weeks 9-12: 1 visit weekly

Weeks 13-16: 2 visits monthly

Weeks 17-24: 1 visit monthly

Discharge planning begins at admission with a goal of stabilization and referral to a community provider for ongoing care by Week 24 (6 months of treatment)

The activities at follow-up appointments are focused on evaluating adequacy of treatment and danger for relapse. They should include:

- pill counts, including reserve tablets (once every 2 months, random)
- urine testing for drugs of abuse and alcohol (every week, random)
- prescription of medication
- an interim history of any new medical problems or social stressors

DANGEROUS BEHAVIOR, RELAPSE AND RELAPSE PREVENTION

The following behavior "red flags" should be addressed with the patient as soon as they are noticed:

- missing appointments
- running out of medication too soon
- taking medication off schedule
- not responding to phone calls
- refusing urine or breath testing
- neglecting to mention new medication or outside treatment
- appearing intoxicated or disheveled in person or on the phone
- frequent or urgent inappropriate phone calls
- neglecting to mention change in address, job or home situation
- frequent physical injuries or auto accidents
- inappropriate outbursts of anger/threatening/illegal activity at program
- lost or stolen medication

These behaviors should be evaluated by the treatment team and should be brought to the patient's attention. The patient should be supported and an appropriate response made (e.g.: increased level of care: more frequent counseling sessions, referral to inpatient or intensive outpatient substance abuse treatment if needed, withdrawal from buprenorphine/naloxone or injectable naltrexone treatment (particularly for illegal activity which could result in legal charges) and referral to higher level of care (e.g.: methadone maintenance). Decisions need to be based on clinical assessment and documented in patient's medical record. Review Addressing Relapse (Policy/Procedure 030A).

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POLICY/PROCEDURE NO.

COE - 019

SUBSECTION EFFECTIVE DATE

2/10/17

POLICY/PROCEDURE

Progress Note Format for Physicians

AMENDMENT / REVISION HISTORY

Approved:

Amended:

POLICY

This policy outlines a standardized structure for patient progress notes written by their physician(s). There is an example provided to help bring increased clarity to the physician's notes.

PROCEDURE

Progress notes are to be written following each clinical interaction and at least monthly.

7/29/16

Progress Note Structure (Physicians)

Date/Time

Subjective: Patient statement of status in treatment

Objective: Current pertinent history, drug/alcohol use, adherence to buprenorphine/naloxone or injectable naltrexone, craving, medical/psychiatric issues, psychosocial issues, participation in other therapies

Physical Examination (as indicated)

Laboratory/Urine Drug Screen Results

Assessment: Current problems

Plan: Medication prescribed, any new medical/psychiatric interventions, next visit

Progress Notes – Sample

7/15/2016 10 AM

S: Denies heroin or other illicit drug use. States things are 'ok' except for marital relationship.

O: Last urine 7/12/2016 was positive for cocaine, which patient adamantly denies using. Indicates that his wife is becoming more intolerant of use and threatening to leave although patient denies that this contributes to his drug use. Although he agrees that going to a support group is a good idea, he has actually attended only once in the past month. Liver enzymes slightly elevated on lab of 7/8/2016, otherwise wnl. Patient seems more irritable, although when this is pointed out to patient, his response was "now don't you start on me too."
Patient refused permission for me to talk with his wife.

A:

1. Patient has likely relapsed to cocaine use
2. Appears to be in denial about the severity of drug use and its adverse effects on his relationship.
3. Liver enzyme elevation probably secondary to HCV, which was previously diagnosed.

P

1. Increase urine testing to twice weekly
2. Increase clinical check in to twice weekly
3. Add weekly group therapy on polysubstance use
4. Referral to gastroenterology for evaluation of HCV
5. Update Treatment Plan to reflect changes in care.

Signature:

Name:



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POLICY/PROCEDURE NO.

COE - 020

SUBSECTION EFFECTIVE DATE

2/10/17

POLICY/PROCEDURE

Progress Note Format for Case
Managers

AMENDMENT / REVISION HISTORY

Approved:

Amended:

POLICY

This policy outlines a standardized format for patient progress notes that can provide guidance as to important content to be included in progress notes written by case managers and provides an example of such notes.

PROCEDURE

Description

See attached format.

Progress notes are to be written documenting each clinical interaction with a patient and must be recorded at each visit.

7/29/16

BUPRENORPHINE/NALOXONE or INJECTABLE NALTREXONE MAINTENANCE TREATMENT

Progress Note Structure (Case Managers)

Date/Time

Subjective: *Patient statement of status in treatment*

Objective: *Current pertinent history, drug/alcohol use, adherence to MAT (either buprenorphine/naloxone or injectable naltrexone), craving, status for medical/psychiatric issues, psychosocial issues being addressed (family issues, housing, entitlements, legal, educational/vocational), participation in other therapies (individual, group, family)*

Laboratory/Urine Drug Screen Results

Assessment: *Current problems*

Plan: *any additional interventions or continue present management and monitor clinically, next visit*

Sample:
July 12, 2016
3 PM

S: Ok, except for problems with my wife

O: Patient has a history of cocaine use and last tox screen was positive for cocaine which patient denies. Wife suspects cocaine use and is confronting patient about this. Patient shared in group that he had one brief slip but denies ongoing use. Expressing frustration with wife's lack of trust. Received feedback from peers on need to establish trust.

A: Patient has had a slip with cocaine use, but adherent to buprenorphine treatment.

P: will have patient attend clinic twice a week with UDS at each visit; encourage attendance at group for polysubstance use; treatment plan will be updated to reflect change in treatment.

Signature:

Name: