# 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

# MIH 10C – Olanzapine (Zyprexa)

**MOBILE INTEGRATED HEALTH PARAMEDIC**

**Class:** Second generation antipsychotic

**Actions/Pharmacodynamics:** blocks dopamine D2 receptors, resulting in mild sedation and improvement of psychotic symptoms. The effect of olanzapine in the D2 receptor is reported to produce the positive effects of this drug such as a decrease in hallucinations, delusions, disorganized speech, disorganized thought, and disorganized behavior. On the other hand, its effect on the serotonin 5HT2A receptor prevents the onset of anhedonia, flat affect, alogia, avolition and poor attention. Based on the specific mechanism of action, olanzapine presents a higher affinity for the dopamine D2 receptor when compared to the rest of the dopamine receptor isotypes. This characteristic significantly reduces the presence of side effects.

**Indications**: Mildly agitated patients are eligible for oral olanzapine administration. These are patients who are:

- restless and anxious but verbally redirected

**Or**

- agitated with frequent non-purposeful movements and resists EMS care and requires gently physical redirection to allow for care.

**And**

- unresponsive to other de-escalation strategies
- compliant with oral medication and administration
- consent to receive olanzapine

**Contraindications:**

**Absolute:**

- Allergy or history of adverse drug reaction
- History of dementia
- History of dystonia
- Age less than 16 years or greater than 65 years
- Evidence of Sepsis

**Relative:**

- Current use of CNS depressants
- Evidence of hypoperfusion

**MIH – 10C Olanzapine, cont.**

**Pharmacokinetics:** Olanzapine is well absorbed and reaches peak concentrations in approximately 6 hours following an oral dose. It is eliminated extensively by first pass metabolism, with approximately 40% of the dose metabolized before reaching the systemic circulation. Food does not affect the rate or extent of olanzapine absorption. Pharmacokinetic studies showed that olanzapine tablets and Zyprexa Zydis (olanzapine orally disintegrating tablets) dosage forms are bioequivalent. Olanzapine presents a half-life ranging between 21 to 54 hours with an average half-life of 30 hours.

**Side Effects:** Potential side effects include orthostatic hypotension and interference with cognitive and motor performance. Specifically, olanzapine has the potential to impair judgment, thinking and motor skills.

**Dosage:**

- Age 16 to 65: **10mg**
  - **Total maximum dose 20mg in 24 hours**
  - The second dose may be administered at 20 minutes if symptoms persist.
- Age greater than 65, cachectic or frail: **5mg**
  - **Total maximum dose 10mg in 24 hours**
  - The second dose may be administered at 20 minutes if symptoms persist.

**How Supplied:** Zyprexa Zydis (olanzapine orally disintegrating tablets) 10 mg.

**BPH.1A**

The goal is to determine if the patient is safe for inpatient or outpatient psychiatric evaluation, outside of a hospital, based on information available at the time of the examination.

The MIH paramedic will use a combination of history, clinical examination and laboratory data to make this determination.

All the following criteria must be evaluated to determine if a patient requires a visit to the emergency department for further medical clearance prior to psychiatric evaluation.

In the event that the patient does not meet all criteria, or the final disposition is unclear and OLMC consult with the Office of the Medical Director should be obtained.

**Criteria to forgo emergency department evaluation**

**All criteria must be checked**

__ Patient consents to examination from medical personnel on scene

__ Patient voices no desire to go to the emergency department

__ Vitals – abnormal vitals may be rechecked in 10 minutes to see if they improve

- HR between 60 and 110 bpm
- Systolic BP 100-180 mmHg
- Respiratory Rate 12-20 bpm
- SPO2 92% or better.

__ No Respiratory Distress or shortness of breath

__ No Chest Pain

__ No Bony tenderness

__ No Open Wounds (may consult medical control for tele-review)

__ No deviation of mental status from baseline

__ No focal neurological deficits (weakness, gait disturbance, double vision, etc.)

__ No hypoglycemia

__ No dysrhythmia

__ No crepitus or subcutaneous air

__ No history of LOC

__ No concerning mechanism of injury (if applicable)

**BPH.1A cont.'**

**Chronic Health Issues**

Hypertension that is previously diagnosed, consistent with the patient's normal readings AND asymptomatic may forgo ED evaluation if all other criteria are met.

Chronic health issues reported by the patient to be stable may forgo ED evaluation. Medic may choose to transport based upon clinical evaluation and gestalt, always erring on the side of caution.

**Any of the following toxicology emergencies require transport**

*Poison control should be contacted for any suspected ingestion if considering transporting to psychiatric facility [(800) 222-1222] and recommendations should be documented.* The patient should be transported to the ED if Poison control recommends prolonged period of observation.

If medications were administered, including Narcan or Benzodiazepines.

Mild to moderate alcohol withdrawal symptoms such as vomiting, shaking or feeling anxious.

Suspected ingestion with any of the following:

QRS duration greater than 100 msec

QTc duration greater than 500

HR > 100 or <60

Resp rate >20 or < 8

Abnormal ETCO2

History suggests acetaminophen (Tylenol) ingestion: acetaminophen has no toxidrome and would not be detected on physical examination.

**BPH.1A cont.'**

**Taser Barb removal:**

May be removed by paramedic unless the barb involves the following areas (any checked requires transport)

__ Ribs (anterior, lateral or posterior)

__ Genitals

__ Face

__ Neck

**CS Gas:**

Twenty (20) minutes after the exposure and decontamination, patient may be cleared if **all other criteria** are met.

**Less Lethal Rounds:**

Patient may be cleared if **all other criteria** are met. EKG should be performed if rounds contact the chest area. Abnormal EKG requires transport.