CA BRIDGE

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Substance Use Navigation Toolkit

These resources have been developed by an interdisciplinary team based on published evidence and expert opinion. As the literature develops, best practices may change. They should never be used as a substitute for clinical judgment. Individual providers are responsible for assessing the unique circumstances and needs of each case. Adherence to these guidelines will not ensure successful treatment in every situation.

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Welcome to Your Role as a Navigator

You are stepping into a critically important position that may be one of the most challenging and rewarding of your life. When people who use drugs come to the hospital or emergency department (ED), your work as a navigator can transform this visit into a positive, life-changing event. In some communities, you may be the most important advocate for patients with substance use disorders (SUDs), helping to identify gaps and support the development of effective, high-quality systems of care.

What is a navigator?

A navigator helps people with SUD avoid the harms of substance use and engage in treatment that works for them. Navigators have many titles, such as behavioral health navigator, peer navigator, and substance use navigator, to name a few; this toolkit will use "navigator." You may have a different title and you may also have other responsibilities, but if you are helping people who use drugs access treatment, this toolkit is for you!

This toolkit is focused on navigators who work in hospitals, usually in EDs, to engage patients in evidence-based SUD treatment, such as buprenorphine or methadone, and may also help them access mental health services.

The job of a navigator will look different in every hospital, but generally includes these key components:

1. **Low-barrier Treatment:** Provide rapid, same-day treatment in response to patient needs. Make medication for addiction treatment (MAT) accessible in the emergency department and all hospital departments without complicated restrictions and procedures. As a navigator, you play a crucial role helping health care systems build services that actually work for people.

2. **Connection to Care and Community:** Link patients to ongoing care through active support and follow up by facilitating appointments at outpatient MAT clinics, addressing barriers to care, and serving as a resource for patients and clinicians. Reach out to community organizations and people who use drugs to increase access to care.

3. **Culture of Harm Reduction:** Create a welcoming culture in the hospital that does not stigmatize substance use and does recognize racial disparities in access to care. Promote harm reduction and trauma-informed practices. Build trust and lead with respect. You will model respectful interactions with people who use drugs, providing technical assistance to hospital staff to reduce stigma and discrimination.

CA Bridge is here to help!

CA Bridge is dedicated to advancing treatment for people struggling with SUD in all California hospitals. As a navigator, you are a critical part of our mission, and we want to support you and learn from you!

- Email us and introduce yourself: mentors@cabridge.org.
- We can support you with advice, resources, site visits, and most importantly, moral support!
- Join regular meetings with navigators in your health system or region to learn together.
- Participate in our statewide trainings and learn from experts.
- Join us at cabridge.org.

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SECTION 1

Getting Started

What are your first steps after you are hired? This section covers the foundation all navigators need to have a strong start. Your emergency department may not have a clinician ready to treat patients with opioid use disorder. Be patient—you can use your time to lay important groundwork for your role. Navigation is new to most hospitals, so be prepared to be flexible!

In this section, we start by helping you learn what your role is and how to integrate into the hospital. We then provide tools for understanding patient privacy and ensuring that you maintain high ethical standards.

SECTION CONTENTS:

1.1 Defining Your Role

1.2 Integrating into the Hospital

1.3 Hospital and ED Scavenger Hunt

1.4 Patient Privacy and Confidentiality

1.5 Ethics and Professional Conduct

All CA Bridge resources in orange can be searched by name at CA Bridge's resource directory at cabridge.org/tools/resources.

1.1 Defining Your Role

You may be hired as a navigator before anyone fully understands exactly how your position works. You should work with your clinical champions and supervisor to define your role. Below we provide a **Navigator Job Description** that you can download from our resource library. To help others understand the role of a navigator, you can also use our **Substance Use Navigator Frequently Asked Questions** in Appendix 2.1.

NAVIGATOR JOB DESCRIPTION

⇒ **NOTE:** This position may also be known as Behavioral Health Navigator, Community Health Worker (CHW), Treatment Coordinator, MAT Navigator, Patient Navigator, Substance Use Navigator, Care Coordinator, etc.

Summary

The navigator helps patients access evidence-based treatment for SUDs with a focus on low-threshold access to MAT and harm reduction. Navigators conduct outreach and identification of patients, conduct initial brief assessments, introduce patients to MAT programs and services, facilitate appointments at outpatient MAT clinics, serve as a resource and coach for their clients, and advocate for culture change in the hospital. They also assist with access to other services, such as mental health services, primary care, social services, and residential treatment facilities.

Job Duties

Patient Identification

- Assist with identification of patients with SUD or co-occurring mental health disorders in the ED and, where feasible, within inpatient units, by monitoring patient tracking systems and checking in with clinicians and nursing staff to receive referrals of eligible patients.
- Establish a positive relationship with patients struggling with drug use or co-occurring mental health disorders. If required by the hospital, to allow for billing, this may include initial patient assessments and brief interventions using standardized tools.
- Make navigator contact information available to patients and providers and respond to calls or texts.
- Advocate for a culture of low barrier access to MAT that includes signage or materials inviting patients to seek help for SUD in prominent areas of the ED and hospital.

Patient Engagement in Treatment

- Facilitate initiation of MAT with hospital clinicians.
- Use motivational interviewing techniques to communicate with patients in a respectful, culturally appropriate, nonjudgmental manner.
- Maintain up-to-date information about the effects of various substances, withdrawal symptoms, and treatment options to effectively educate and counsel patients.
- Promote harm-reduction strategies based on patients' goals, preferences, and life circumstances.
- Engage patients with co-occurring mental health disorders and help them access treatment.

Follow-up Care Navigation

- Help patients overcome barriers to filling prescriptions for MAT (e.g., insurance status, copay expense, cost differences between formulations, etc.).

- Schedule appointments at MAT-capable clinics for ongoing treatment and address access barriers by assisting with transportation, retrieving medical records, providing cell phones, or other supports, as determined by patient needs and community resources.
- Establish a relationship with patients and communicate via telephone, text, and/or email to remind patients of appointments, help navigate obstacles to follow-up treatment, and provide encouragement.
- Work with hospital staff to set up a robust system for ensuring patient referral and follow-up outside of the navigator's regular hours.
- Develop expertise in insurance benefits and exclusions related to treatment.
- Provide patients referrals to other services, such as mental health services, shelter, primary care, social services, and residential treatment facilities.
- Assist out-of-county patients to access MAT and other services in their home county.

Documentation

- Enter encounter data into the electronic medical record or other data collection system, as determined by hospital protocols.
- If required for program reporting, aggregate monthly or quarterly counts of targeted metrics (e.g., number of patients served, buprenorphine administrations, prescriptions, referrals to care, etc.).

Culture Change

- Advocate for a harm-reduction approach to patients who use drugs within the hospital and community to reinforce evidence-based, nonjudgmental approaches so that patients who use drugs get the same care as patients who do not use drugs.
- Promote the use of non-stigmatizing language by hospital staff when talking about people who use drugs.

Community Outreach

- Develop connections with a comprehensive array of community service providers to address the needs of people with SUD or co-occurring mental health disorders.
- Conduct outreach and build trust in settings where people are at high risk of SUD, such as jails, syringe distribution locations, homeless shelters, and SUD treatment programs.

Qualifications

- Nonjudgmental, energetic, positive, harm-reduction approach to assisting patients with SUD.
- Interest/proficiency in working with individuals recently released from incarceration, homeless individuals, and other marginalized populations.
- Understanding of SUD as a medical condition and MAT as an effective, evidence-based treatment.
- Understanding that abstinence-based behavioral programs that discourage MAT are not evidence-based.
- Ability to communicate with patients clearly, respectfully, and in a culturally appropriate manner.
- Ability to communicate in languages spoken in the local community is a plus.
- Preference for applicants with connections to, and reflecting the diversity of, the local community.
- Respect for patient confidentiality and privacy.
- Ability to use a computer and to learn to use electronic health records.
- There is no specific degree, certification, or training requirement, but candidates should be willing to obtain certification as a CHW.

1.2 Integrating Into the Hospital

Starting a job as a navigator will be rewarding and challenging. You may be new to your position, and your position may be new to the hospital. SUD treatment may not be a priority of your hospital. CA Bridge is here to help and to connect you with experienced navigators who have successfully overcome these challenges.

- **Be patient**. ED and hospital staff will get to know you and will realize that you make their jobs easier. Give it time and make yourself visible and readily available to step in to talk to patients.
- **Be adaptable**. You are stepping into the world of a busy ED that has been running for years. Offering treatment for SUD will be a change, and change takes time.
- **Be confident**. Most people in the ED will know very little about the experience of patients with substance use and will look to you. Hold your head up and have confidence in the value you are bringing to changing health care!

Becoming integrated into the hospital will take time. We recommend three steps to get you started.

LEARN YOUR WAY AROUND THE HOSPITAL

If you have not worked in a hospital before, one of your first steps should be to learn about key people and places. Several areas of the hospital are critical for any navigator. We have made you a hospital and ED scavenger hunt in Section 1.3. Take it with you as you walk around the hospital and find these areas!

CONNECT WITH CLINICAL CHAMPIONS

Successful MAT programs rely on a partnership between the navigator and one or more clinical champions who are spearheading the treatment of OUD in the ED. CA Bridge is also working closely with these champions to help them work effectively with navigators. To understand what type of support you can expect or request from your champion(s), see our guide for **Substance Use Navigator & Clinician Champion Collaboration** in Appendix 2.2.

MEET AND GREET

Take the initiative to introduce yourself to everyone. Explain your role and ask how you can help them. This will take time, but work your way through:

- Discharge planners
- Social workers
- Security guards
- Janitors
- Charge nurses
- Triage staff
- Clinicians
- Nursing staff
- Pharmacists
- Crisis workers
- Unit clerks
- Registration staff

If you are more comfortable having a written handout, you can create one using our **Substance Use Navigation Introduction Handout** template that you can download and customize.

- Introduce yourself to hospital staff answering the phone. Customize and hand out our **Hospital Education** sheet.
- Make daily ED rounds and attend staff meetings, committees, and shift huddles to build relationships and referrals. Get 5 minutes as a standing agenda item to give updates.
- Approach providers and staff individually and ask if you can tell them about what you do.
- Don't forget about inpatient units. You can attend rounds to meet staff and also present at their meetings.

1.3 Hospital and ED Scavenger Hunt

Time to learn your way around! Navigators should be familiar with these key locations or functions in the hospital:

- ❑ **Security**. Educate the security staff on your role and program so they can assist with directing patients to you and familiarize them with your role.
- ❑ **Charge nurse.** Always check in daily with the charge nurse by phone or in person. The charge nurse is in charge of the flow of your ED, so it is important that they are familiar with your position.
- ❑ **ED lobby/greeter**. Tell them about your role and how to direct patients to you.
- ❑ **ED communication**. Determine if there are means of electronic communication, such as Vocera, and ensure you have access.
- ❑ **Triage (process).** Become familiar with the triage process and key staff members.
- ❑ **ED tracking board and staff assignment.** Find out about your patient tracking system/tracking board and the best way to identify patients. Also, discuss ways to identify staff that is caring for a patient.
- ❑ **Dictation/charting areas/computer access.** Find the areas where clinicians dictate/chart. This is where you will frequently find the clinician caring for your patient.
- ❑ **Patient access and registration (Admitting**). Find out how they can assist you with patient information and insurance. Ask how patients are enrolled in emergency Medi-Cal.
- ❑ **Patient bathrooms**
- ❑ **Hand washing/PPE stations.** Learn protocols for personal protective equipment (PPE).
- ❑ **Patient care areas.** Learn where patients are located and how each area runs.
- ❑ **Patient supplies.** Find where you can get things patients might need, such as Band-Aids®, alcohol pads, bags for patient belongings, washcloths, sanitary pads, tissues, etc.
- ❑ **Nutrition Services**. Find out what you can offer to patients while in the ED. Ensure you check with a patient's nurse prior to giving them food or drink to make sure it is allowable based on their medical condition.
- ❑ **Pharmacist**. Establish rapport and verify where buprenorphine is stored.
- ❑ **Social Worker/Case Manager office.** Know where and how to access their services, as well as their normal hours.
- ❑ **Private/secure patient area.** Find a place to have sensitive conversations when the patient is not admitted.
- ❑ **Medical Records**. Find out the process for the patient to release their medical information.
- ❑ **Printer/copier/fax machine.** Determine the best machine to use for your purposes.
- ❑ **Landmarks around the hospital:**
  - Cafeteria/vending machines
  - Laboratory
  - Pharmacy
  - Bus stop and shuttle service

1.4 Patient Privacy and Confidentiality

Navigators need to follow Health Insurance Portability and Accountability Act (HIPAA) and hospital-specific regulations regarding information sharing.

As a general rule, all the information you get from a patient should not be shared outside the patient care team with anyone unless you have a signed release of information from the patient. Patient charts are confidential, and you should only access a patient record for the purpose of patient care and research, if applicable. Check with your supervisor if you have questions about what information you can access.

If you want to ask another navigator outside your hospital for help with a patient, it is important that no patient identifiers are revealed. Patient identifiers can be anything, such as name, age, or medical condition. Please check with your institution for specifics.

HIPAA

HIPAA is a federal regulation that protects patient health information from being disclosed without the patient's consent or knowledge. As a hospital employee, navigators have access to private health information and must receive HIPAA training. Completing all hospital training requirements in a timely manner is essential and must be done prior to providing any patient care. Training and additional information will be provided by the hospital and will vary from hospital to hospital. If you have not received training, ask your supervisor or human resources department. Information on HIPAA is available at hhs.gov/hipaa/index.html. Always share privacy policies with your patient and notify them of legal requirements.

42 CFR PART 2

42 CFR Part 2 is a federal regulation that provides special protection of the information of people receiving treatment for SUD. Some hospitals have mistakenly interpreted 42 CFR as a barrier to providing MAT in the ED. However, ED programs are a part of general medical care and do not fall under 42 CFR Part 2, which guarantees confidentiality for people seeking treatment for SUD from federally assisted programs. More information on 42 CFR Part 2 is available through the Substance Abuse and Mental Health Services Administration (SAMHSA) *Disclosure of Substance Use Disorder Patient Records* at samhsa.gov/sites/default/files/does-part2-apply.pdf and *42 CFR Part 2 Revised Rule* at samhsa.gov/newsroom/press-announcements/202007131330.

RELEASE OF MEDICAL INFORMATION

All hospitals require patients to sign a release of medical information (ROI) before sharing patient records with outside agencies. In addition, a release must be signed for a patient to receive their own medical information. Ask your Medical Records Department for your organization's process.

A signed release is important when referring patients for follow-up treatment and will avoid any privacy issues. You may want to standardize the process for easier patient workflow. An example is having a ROI form available for patients to sign. This will avoid unnecessary trips or calls to Medical Records. Once obtained, add the signed form to the patient’s chart.

DUTY TO REPORT

You may face a situation where you are required to report a life-threatening condition. Patients may verbalize an intent to harm themselves and others. As a navigator, you must notify the patient that you are required to report these instances. Always inform the health care team; they can assist you with the process to correctly report these cases.

MINOR CONSENT AND CONFIDENTIALITY

Confidentiality laws for minors are different in many states and can be confusing. Always check your facility resources and ask your supervisor for clarification of minor consent and confidentiality issues. For example, in California, health care providers may speak with a teen privately without a parent present. However, as a navigator, you should always encourage the best practice of open communication with all family members. Always ask for permission from the patient to establish trust. Additional guidance can be found in **Caring for Youth with Substance Use Disorders**.

A comprehensive guide to minor consent for behavioral health services can be found at the National Center for Youth Law's Teen Health Law Initiative at teenhealthlaw.org/consent.

SOCIAL MEDIA

It is important to know the specific policies of your hospital regarding the sharing of information, especially on social media platforms. Avoid mentioning anything that is work-/hospital-related on any social media platform unless it fits within your institution-specific guidelines and is approved for public information sharing.

1.5 Ethics and Professional Conduct

In your role as a navigator, you may become involved in ethical situations that you may not have encountered in your career. This may challenge your own beliefs, attitudes, and judgment. Dealing with ethical dilemmas is never easy and is based on moral duty principles and obligations to do the right thing.

When a situation arises, your first action is to immediately notify your supervisor, charge nurse, health care provider, or social worker. When making an ethical decision in the hospital setting, you have support. Most hospitals have guidelines and processes to assist staff in making ethical decisions. In some hospitals, an ethics committee is in place for moral dilemmas. Always check with your facility to access your resources and policies.

ETHICAL PRINCIPLES

Navigators should know four generally accepted principles of medical ethics and use them to guide their work:[1]

- Autonomy: Promote self-determination and freedom of choice
- Beneficence: Take actions in an effort to promote good
- Nonmaleficence: Take actions in an effort to avoid harm
- Justice: Seek fairness, treat "equals" equally and treat "unequals" according to their differences

CODE OF CONDUCT

The code, or codes, of conduct that you must follow as a navigator will depend on the policies of your hospital. They also depend on what licenses or certifications you hold, which may come with their own specific codes of conduct. The following guidelines for navigators are adapted from the State of California's code of conduct for certified alcohol and drug counselors. The full text of this code of conduct is on page 26 of this document: acbhcs.org/providers/SUD/docs/licensing/CA_Code_Regulation_AOD_Counselor.pdf. Although the role of a navigator is not the same as that of an addiction counselor, this state code of conduct provides a good foundation for a navigator's ethical conduct.

Navigators should:

- Comply with any codes of conduct developed by their employer or organization through which they have received a certification.
- Protect patients' confidentiality in accordance with applicable law (e.g., HIPAA).
- Cooperate with complaint investigations and supply information requested during these investigations unless such information disclosure would violate confidentiality protections.

Navigators should NOT:

- Provide services while under the influence of any amount of alcohol or illicit drugs (excluding lawfully prescribed or over-the-counter medications used as directed).
- Provide services beyond the scope of their training or any registration, certification, or licensing.
- Discriminate against patients or other staff members based on race, religion, age, gender, disability, national ancestry, sexual orientation, or economic condition.
- Engage in social or business relationships for personal gain with patients, their family members, or other persons who are significant to them.
- Engage in sexual conduct with current patients, their family members, or other persons who are significant to them.
- Verbally, physically, or sexually harass, threaten, or abuse any patient, their family members, other persons who are significant to them, or other staff members.

ETHICAL DECISION-MAKING

Dealing with ethical issues may be challenging. If this is your first professional job in the hospital, you may feel overwhelmed with a patient experience. The following questions can help you address challenging or unclear situations.

Is there a law or organizational policy that determines how you must respond? Many actions of hospital staff are controlled by laws or policies (see below).

If YES, you must follow the law or policy. At times, these policies may lead to a course of action that feels uncomfortable (e.g., mandatory reporting) or unhelpful (e.g., refusing a patient's request). However, laws and policies are there to protect you and the patient and must be followed.

If NO, you should consider the following:

1. **What is the clinical problem?** First, define the clinical issue/problem.
2. **What is the ethical principle of concern?** What implications do your choices have for autonomy, beneficence, nonmaleficence, and justice? Referring back to these principles can help you analyze the situation, determine which principles might be violated, and determine a course of action.
3. **Are there cultural issues or stereotypes that are affecting your, or the patient's, behaviors or actions?** We live in a complex, multicultural society where both staff and patients bring many different assumptions and perspectives to the encounter. How might bias or discrimination affect how you are looking at the situation? What assumptions is the patient making? Asking these questions may give you insight into possible options.
4. **What are your options?** Involve the health care team to look for alternatives. Having multiple solutions available may resolve the concern quickly and effectively.

The last step in making an ethical decision is creating a plan of action. The plan of action may not be perfect or comfortable for the entire health care team, but it should be the best solution with the fewest negative consequences. Finally, you should follow up with the patient and support them regardless of the outcome.

BOUNDARIES

Boundaries are a reliable tool used to protect you and your client. This work brings you close to people who are suffering and have many emotional, sexual, and practical needs. At some point, you may be asked by a client for a ride, money, or a date. Although these are broad examples, they are situations where an ethical problem may occur. If anything that a patient asks of you makes you feel uncomfortable or concerned about boundaries, step back from the interaction and talk to your supervisor or a mentor for support and guidance. By setting boundaries with patients, you can avoid issues that may develop into a moral dilemma. Some common scenarios include:

- **A patient requests a ride or transportation**. Offering a ride may seem harmless; however, it can lead to a blurring of boundaries as well as legal issues. Instead, ask your supervisor for bus passes/taxi vouchers to limit potential problems.
- **A patient asks for money.** Tell the patient it is against the facility's policy to give money to patients. In some cases, the hospital may have a fund to assist patients needing food and clothes.
- **A patient asks you out.** Emotional or physical intimacy of any kind can be misinterpreted as a romantic connection. Maintaining clear boundaries will protect your patient from this confusion. If such a situation does arise, do not shame or blame yourself or the patient, but make it clear that your relationship is strictly professional.
- **A patient is a neighbor, friend, or colleague.** Working with the public in a hospital setting, you may encounter people you know outside of your job. In these cases, it is important to pay extra attention to defining your role as a navigator, setting boundaries, and maintaining confidentiality and professionalism. Discuss medical issues in the hospital setting and have personal conversations outside of the hospital.

REFERENCE

[1] Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 8th ed. Oxford University Press; 2019.

SECTION 2

Understanding Substance Use Disorder and MAT

All navigators need a basic understanding of SUD and its treatment. If you are new to the field, consider this a foundation on which you will build your expertise the longer you work as a navigator. Even if you have worked in the field before, review this section to understand the terms used by CA Bridge. Section 2.1 presents our perspective on substance use and SUD. Section 2.2 describes the current opioid crisis, and Section 2.3 explains how MAT works and how it is used.

SECTION CONTENTS:

2.1 Understanding Substance Use

2.2 The Opioid Crisis

2.3 MAT Basics

All CA Bridge resources in orange can be searched by name at CA Bridge's resource directory at cabridge.org/tools/resources.

2.1 Understanding Substance Use

All people have a natural motivation to seek rewards, including making money, buying things, or helping people. Using substances is one form of reward for many people. Some use legal substances, such as coffee, nicotine, and alcohol; others use substances that are illegal in the US, such as heroin, peyote, or cocaine; and others use prescription drugs or cannabis.

Approximately 10% of the population report using some type of illicit drug during the past month. There are many ways people use illicit drugs, including:

- Experimental or situational
- Social
- Regular
- Ritual binging
- Habitual/daily
- Chaotic/persistent

WHAT IS SUBSTANCE USE DISORDER?

The reward system in our brains is essential to survival. It drives us to find food, shelter, and have children. Most of the great achievements of humanity have come from the drive of our reward system. When substances are consumed, it can provide a sense of reward and well-being we all seek. The brain can get confused and substitute drugs for food, shelter, and well-being, leading it to pursue even self-harming behaviors. Every drug has a unique set of risks, harms, and effects on the body, and not all people who use drugs develop a use disorder. But for some people, drug use can become a medical disorder that threatens their health and quality of life.

The Medical Model of Addiction

While the initial use of drugs may be a voluntary choice, drugs such as opioids can change brain chemistry so that the brain stops producing the natural chemicals that enable basic life functions and enjoyment. When these changes reach the level of physical dependence or addiction, if a person stops using drugs, it leads to a severe deficit of these important brain chemicals and control over behavior. The person goes into withdrawal, which feels like a life-or-death situation that leads to an overwhelming need to use drugs. At this point, using drugs is not about getting high, but about restoring a feeling of normality. This need is so great that it can replace the need for food and shelter with the need for the drug.

With treatment, the brain's chemistry can be rebalanced, and the physical symptoms of withdrawal can be managed. For many people, addiction requires evidence-based medical treatment and linkage to ongoing care and support. Substance use and addiction is not a moral failing and should be destigmatized and normalized within our culture so that all people can seek and gain access to care options.

⇒ **NOTE:** For a simple explanation of the medical model of addiction, see the video Addiction Neuroscience 101 at youtube.com/watch?v=M5Mky3Jr960.

Social Determinants of Health

While it is true that certain drugs produce changes in brain chemistry, it is important not to think of addiction as something that can be explained solely as a brain disease. What we do know is that a person's individual experiences and genetics play a role, as do the culture and environment in which they live. We know that substance use frequently occurs together with other life challenges, trauma, marginalization, and isolation. Addiction is a complex issue, and recovery requires taking care of the whole person as well as addressing social and structural factors. The harm-reduction approach recognizes that it may never be possible to say why a given person might develop a use disorder and accepts that, like many other diseases, it could happen to any of us.

Useful Definitions for Navigators

- **Substance Use Disorder** (SUD) occurs when a person's use of any substance, such as alcohol, cocaine, cannabis, methamphetamine, opioids, and/or prescribed drugs, leads to health issues, disability, or interferes with work or family relationships.
- **Drug tolerance** is when a person must increase the amount of drug over time, to reach the same effect.
- **Physical dependence** is when a person experiences withdrawal symptoms when a drug is discontinued.
- **Opioid Use Disorder** (OUD) is the chronic use of opioids that causes clinically significant distress or impairment and consists of an overwhelming desire to use opioids, increased opioid tolerance, and withdrawal when discontinued. OUD includes both dependence and addiction.
- **Drug overdose** is when a person takes too much of a substance, causing severe symptoms, including death. An overdose can be accidental or intentional.
- **Withdrawal** is when a patient stops or decreases long-term drug use and the body reacts by showing withdrawal symptoms. Signs of opioid withdrawal include fast heartbeat, sweating, restlessness/agitation, nausea, vomiting, diarrhea, dilated pupils, runny nose, yawning, and piloerection ("goose bumps").
- **Precipitated withdrawal** is characterized by the sudden onset of severe opioid withdrawal symptoms following administration of a medication that displaces opioids from the mu receptor, such as naloxone or buprenorphine. This is usually time-limited and resolves with supportive medications, such as administration of additional buprenorphine.

WHAT IS OPIOID USE DISORDER (OUD)?

Opioids are a class of drugs that include heroin; synthetic opioids, such as fentanyl; and legally obtained prescription pain relievers, such as oxycodone, hydrocodone, codeine, morphine, and many others. Although OUD is an easy diagnosis to make for the majority of our patients who are in crisis and asking for help, there is a specific set of criteria in the DSM-5 (the *Diagnostic and Statistical Manual of Mental Disorders*, which is the accepted professional reference document for behavioral health). OUD is defined as a problematic pattern of use leading to impairment or distress manifested by any two or more of the following in a 12-month time span:

1. Failure to fulfill responsibilities/obligations at work, school, or home
2. Use in physically hazardous situations
3. Increased desire (drug cravings)
4. Continued use despite social/interpersonal problems

5. Use in larger amounts or over a longer period of time than intended
6. Persistent desire or failed efforts to reduce drug use
7. Increased time spent obtaining, using, or recovering from use
8. Continued use despite drug use resulting in exacerbation of physical or psychological symptoms
9. Social, occupational, or recreational activities reduced due to drug use
10. Tolerance (a need to markedly increase the amount of opioid to achieve the prior effect or a markedly decreased effect with continued use of the same amount of drug)
11. Withdrawal syndrome when opioids are stopped or decreased; opioids taken to relieve symptoms of withdrawal

2.2 The Opioid Crisis

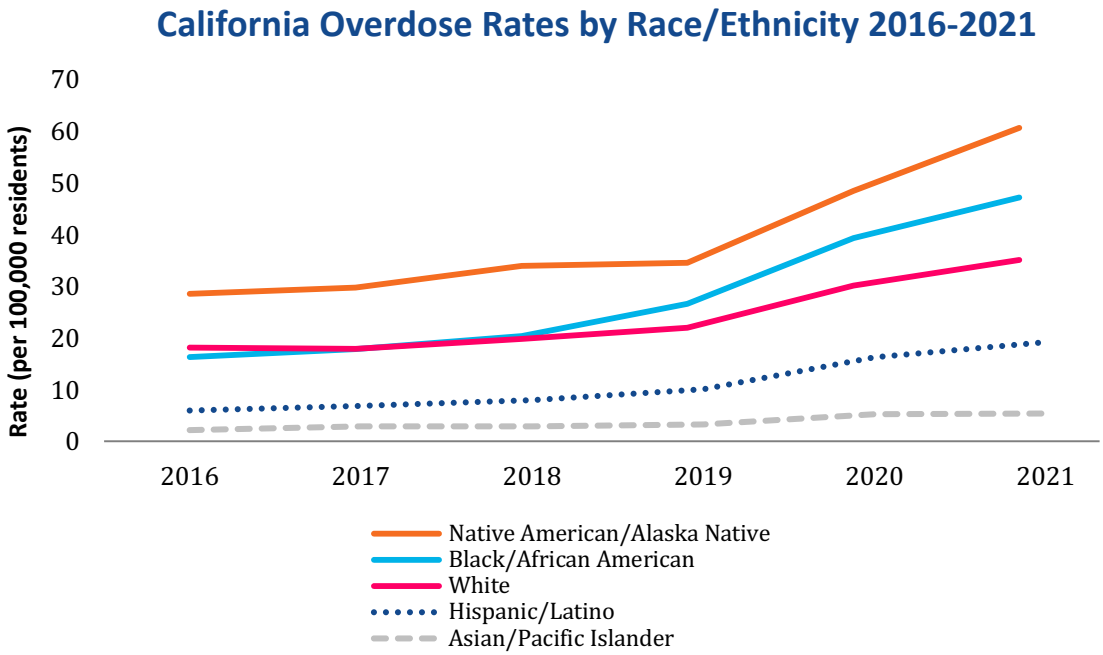
Drug overdose deaths in the US have risen dramatically in recent years from 72,000 in 2019 to 108,000 in 2021—a 50% increase. California had a 67% increase with drug overdose deaths rising from 6,600 in 2019 to 11,000 in 2021. The most up-to-date statistics are available from the Centers for Disease Control and Prevention (CDC) and for your local area at the California Overdose Surveillance Dashboard.

The rise in opioid overdose deaths had three waves. The *first wave* began with a dramatic increase in the exposure of the US population to opioids beginning in the 1990s. This was largely due to the prescribing of Norco, Vicodin, OxyContin, and other opioid pain relievers, which was driven by misleading marketing as well as profiteering of affiliated health care industries, including pharmacies, distributors, hospitals, and doctors.

The *second wave* of the epidemic started in 2010 as many with opioid dependency began using illicit heroin. Tragically, this wave was precipitated by efforts to reign in opioid prescribing that resulted in many patients who had been encouraged to start opioids by the health care industry being abruptly cut off without access to treatment for OUD.

Most recently, the evolution of illicit drug distribution and drug policy has resulted in decreased availability of heroin and increased availability of synthetic fentanyl, producing the *third wave* of the epidemic. Because of its potency, fentanyl results in greater dependency so that once fentanyl use begins, heroin may not even relieve withdrawal symptoms thereby "trapping" people with fentanyl. Fentanyl is a white powder and there is no way to gauge how strong the drug is, making accidental overdose much more likely than with heroin.

While rates of overdose are increasing across the entire population, specific racial groups are being impacted disproportionately. American Indian and Alaska Native people experienced the highest rate of overdose death in 2020 at a rate 30% higher than that for White people. In 2020, rates of overdose were 16% higher among Black people than those of White people. In a shifting of a pattern, overdose rates among Black people were higher than among White people for the first time in over 20 years.[1]



SOURCES OF DATA ON DRUG AND OPIOID OVERDOSES

- **Centers for Disease Control and Prevention (CDC)**. cdc.gov/drugoverdose/epidemic/index.html.
- **National Institute on Drug Abuse**. drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state.
- **California Overdose Surveillance Dashboard**. skylab.cdph.ca.gov/ODdash.

2.3 Medication for Addiction Treatment (MAT) Basics

MAT is treatment for SUD with medications approved by the Food and Drug Administration (FDA). These medications help reduce cravings, prevent overdoses, prevent withdrawal, and increase compliance with treatment, which literally saves lives.[2,3]

MAT is "evidence-based," which means there is research that has demonstrated that it actually works. MAT is an evidence-based treatment for OUD, which is a chronic disease—like hypertension or diabetes—that often requires medication for disease management to reduce the risk of morbidity and mortality. MAT is also safe and recommended during pregnancy.[4]

EDs and hospitals are already a 24/7 hub of health care access universally accessed by people facing an emergency and are a logical place to ensure that treatment for OUD is easily accessible. Treatment and referral from the ED has proven to be very successful.[5]

MEDICATION FIRST APPROACH

CA Bridge adheres to a "medication first" approach. This means that we do not make treatment with medication contingent on other steps in the recovery process, such as getting into counseling, completing comprehensive assessments, or having stable housing. There are no preconditions for starting MAT; it is not something that has to be "earned." Instead, we view stabilization of patients on medication as the *first* step, which then makes other steps in recovery more feasible.

HOW DO OPIOIDS WORK?

Opioids like heroin, fentanyl, and oxycodone are called "full agonist" opioids. They bind to the opioid receptors in our bodies and cause effects, such as feeling content, sleepy, or slowing our breathing. If someone is in opioid withdrawal, these opioids bring them out of withdrawal and make them feel normal.

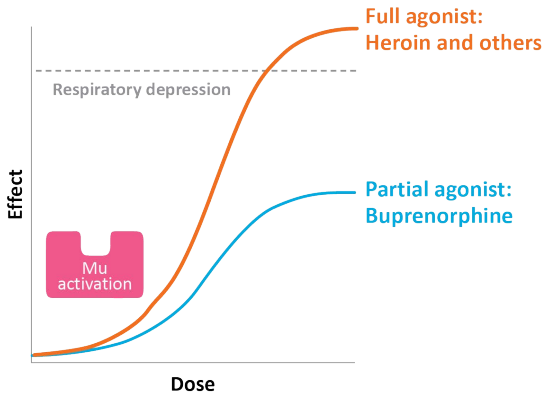
The opposite of an opioid is an opioid "antagonist" or blocker, such as naloxone (Narcan). These bind to the opioid receptor, kicking off opioids and preventing more opioids from binding. This is how naloxone can reverse an overdose and can also put someone into opioid withdrawal.

MEDICATIONS USED FOR OPIOID USE DISORDER

Multiple medications are utilized for MAT, all of which are safe, and FDA approved.

Buprenorphine (bup) is a long-acting "partial opioid agonist." This means that bup binds to the opioid receptors but does not fully activate them to get the same effect that a "full agonist" does. Because bup is a partial agonist, it treats cravings and physical withdrawal symptoms but is very unlikely to cause life-threatening respiratory depression and does not get you high.

When bup is at the right dose, it prevents withdrawal, decreases cravings, and makes it so that if a person slips and uses full agonist opioids, they will not feel the same high.



Lutfy, K., & Cowan, A. (2004). Buprenorphine: a unique drug with complex pharmacology. *Curr Neuropharmacol*. 2004 Oct;2(4):395-402.

Methadone is a full agonist, but it is used for treatment because it is long-acting, so it does not produce the highs and lows of other opioids. Methadone must be taken daily in-person at a regulated methadone clinic, although relaxation of these restrictions during the COVID-19 pandemic may lead to future policy changes.

Naltrexone is an opioid antagonist. This means that it is not an opioid and does not bind to the opioid receptors but *prevents* other drugs from binding to them. Naltrexone works like a long-acting version of naloxone (Narcan) and can be given daily in pills or monthly in injections. It blocks the effects of opioids if people slip and use, and it decreases cravings.

MEDICATION OVERVIEW

	METHADONE	BUPRENORPHINE (Suboxone®, Subutex®)	NALTREXONE (Vivitrol®)
Mechanism of Action	Full Agonist on Opioid Receptor	Partial Agonist on Opioid Receptor	Antagonist on Opioid Receptor
Dosing	80-100 mg (usual dose)	8-32 mg (oral)	380 mg (depot injection)
Advantages	• Provided in a highly structured supervised setting where additional services can be offered on-site and diversion is unlikely • May be effective for individuals who have not benefited sufficiently from partial agonists or antagonists	• Improved safety due to antagonism • Availability in office-based settings	• No addictive potential or diversion risk • Available in office-based settings • Option for individuals seeking to avoid all opioids

The handout **Medicines for Treating Opioid Use Disorder: What You Need to Know** provides more information and can also be given out to patients. You can find this handout in Appendix 1.1.

BUPRENORPHINE (BUP) BASICS

Although multiple medications are used for MAT, this toolkit focuses mainly on bup because it is effective and low risk. Bup goes by several brand names, including: Subutex, Suboxone, Buprenex, Sublocade, Butrans, and Zubsolv. Bup is primarily used to treat acute opioid withdrawal but can also be effectively used to manage pain.

What are the different forms of bup?

- The most common form of bup is a sublingual tablet or film that dissolves under the tongue. If these sublingual forms are swallowed, the bup will not work at all and may make the patient nauseated.
- Bup is formulated as a mono product (bup alone, like Subutex) or in combination with naloxone (like Suboxone). The combination product was made to prevent people from misusing and injecting the tablets. If you take the buprenorphine-naloxone under your tongue as prescribed, the naloxone does not get absorbed and you only feel the effects of the bup. But if the buprenorphine-naloxone is injected, the naloxone theoretically prevents people from feeling high.
- Patients who have previously tolerated tablets or strips can also get extended-release bup injections that last for a week or a month. Other forms used include intravenous (IV) injection or transdermal patch, which cannot be used for OUD treatment outside of the hospital.

How is bup used in treatment?

- Bup total dose will generally depend on how heavy the patient's use is. Doses should be increased until the patient doesn't feel cravings or withdrawal.
- Treatment should NOT be started if the patient is *not actually in withdrawal.* Because bup binds strongly to the opioid receptors, if a person is not in withdrawal when they take it, the bup will cause them to go into withdrawal. For example, if heroin is on the receptors because a patient recently used, and they take bup, the bup will kick the heroin off the receptors, and there will be a big drop in the opioid effect in the patient's body. This will make the patient feel really sick with withdrawal (*way* worse), almost as if they received naloxone. Current or recent methadone use may also cause a precipitated withdrawal—switching from methadone to bup is more complicated and takes time (and is not usually done in the ED).
- It is okay to treat with bup even if the patient has not continued treatment in the past or isn't sure if they want bup in the long term. The patient is safer while on bup for however long that is. *Each positive treatment experience supports a patient's understanding that OUD is a treatable medical condition.*
- **Providers do NOT need an X-waiver to order bup** for administration while in the ED or inpatient units. Any provider may order bup for administration to admitted or registered patients for the purposes of treating opioid withdrawal, starting MAT, or maintaining MAT.
- However, in order to *write a prescription for bup* for treatment of OUD for patients to fill at an outpatient pharmacy, as of August 2022, providers must have a DATA 2000 waiver for their Drug Enforcement Agency (DEA) license. This waiver is commonly called the "DEA-X" or "X-waiver." Previous education requirements have been eliminated. More information on obtaining an X-waiver can be found in our resource **DATA 2000 X-Waiver for Buprenorphine Prescribing**, which we will update with changes to X-waiver regulations.
- Though urine toxicology or "drug" tests are used to inform care in outpatient clinics, they should NOT be required in the acute care setting to receive treatment and should not exclude a patient from MAT.
- Adverse reactions include sedation, dizziness, headache, insomnia, diaphoresis, nausea, vomiting, abdominal pain, constipation, injection or application site discomfort, or pruritus (from subcutaneous injection and patch).

CA BRIDGE TREATMENT PROTOCOLS

CA Bridge has an extensive collection of treatment protocols for providers with best practices, dosing information, and important reminders to support initiation of treatment. While the decision to start bup is made by the provider, it is important for navigators to be aware of these protocols.

MORE INFORMATION ON MAT AND BUP

- **Buprenorphine Frequently Asked Questions** provides more information on bup pharmacology: Appendix 2.4.
- **Buprenorphine: What You Need to Know** is a patient handout: Appendix 1.2.
- **Buprenorphine Extended Release: What You Need to Know** is a patient handout: Appendix 1.3.
- **The California Substance Use Line**, 1-844-326-2626, is a free, 24/7 tele-consultation service for California physicians, nurses, and other clinicians with questions about substance use treatment. It is staffed by experienced physicians and pharmacists who can answer confidential questions about substance use evaluation and management, including MAT. The line is a collaboration between the National Clinician Consultation Center and the California Poison Control System. nccc.ucsf.edu/clinician-consultation/substance-use-management/california-substance-use-line.
- **Substance Abuse and Mental Health Services Administration.** Medication-Assisted Treatment. samhsa.gov/medication-assisted-treatment.
- **American College of Emergency Physicians.** About Bupe. acep.org/patient-care/bupe.

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Section 3

Starting Treatment

The CA Bridge model is built on a medication first model where treatment is started rapidly without imposing other barriers or conditions. Navigators play a critical role in this approach by building relationships with patients and helping clinicians understand the needs of people struggling with substance use. Many patients will be entering treatment for the first time; likewise many clinicians have limited experience treating OUD with medications. Misunderstandings and even conflict are common. You will become a trusted ally to fix problems and bring doctors and patients closer together.

This section covers the key aspects of the navigator's role in MAT initiation in the ED beginning with the overall framework of Screening, Brief Intervention, and Referral to Treatment (SBIRT), followed by tools for each step of the process of identifying and engaging patients, educating them about bup, and documentation and charting.

SECTION CONTENTS:

3.1 Screening, Brief Intervention & Referral to Treatment (SBIRT)

3.2 Identifying Patients and Building Relationships

3.3 Educating Patients and Facilitating Treatment

3.4 Communication to Engage and Motivate

3.5 Documentation and Charting

All CA Bridge resources in orange can be searched by name at CA Bridge's resource directory at cabridge.org/tools/resources.

3.1 Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT focuses on the delivery of early intervention and treatment services for persons with substance use disorder (SUD) before more severe consequences occur. SBIRT is a good framework for the work of a navigator under the CA Bridge model.

SCREENING

Screening assesses the severity of substance use and identifies the appropriate level of treatment. When navigators interact with patients using the engagement and motivational interviewing techniques in this toolkit, you are engaging in screening. You are engaging the patient in conversation to understand their history, needs, and goals, all of which help determine the appropriate treatment. This is the most common way that navigators perform screening.

Some sites may choose to use a more formal screening or assessment tool. Sometimes a formal tool will be required by the hospital to get reimbursed for the screening service. If this is the case in your hospital, you will be trained on how to use this tool. See Section 3.2 for more information on standardized tools.

BRIEF INTERVENTION

Brief intervention focuses on increasing patients' insight and awareness of their substance use and motivating them toward change. An important part of your role as a navigator is to engage patients in short conversations using techniques, such as motivational interviewing and de-escalation. These techniques are described in the sections below. Getting the patient out of the dangerous cycle of abstinence ("going cold turkey") and then returning to use, and possibly overdose, is the most important first step in helping people with OUD. A lot of evidence shows that when a patient is in the ED, it is a moment when they are open to making changes in their life and behaviors. These conversations are not necessarily therapy or counseling, but by taking the time to listen and engage with the patient, you can help them take small steps toward change.

REFERRAL TO TREATMENT

Referral to treatment provides those identified as needing care with access to services they need and desire. If you are seeing a patient in the ED and they are interested in treatment, you will be referring them to some type of treatment or services outside the hospital. If they start MAT in the hospital and wish to continue treatment, you will refer them to an outpatient MAT provider. You may also refer them to medical, mental health, or social services, depending on their needs and eligibility. Section 4.3 provides in-depth information about setting up and conducting effective referrals. Even if a patient is not interested in any services at the moment, you can tell them to come back to you in the ED at any time in the future when they are ready.

3.2 Identifying Patients and Building Relationships

If you are working in a hospital that is new to treating OUD, there may not be a system in place to identify patients who could benefit from treatment and get them connected to you.

These are some steps you can take:

PLACE SIGNS IN VISIBLE SPACES

Signs encourage patients to self-identify and ask for help. They have been very effective in hospitals implementing the CA Bridge model.

Patient-Facing Signage provides two sample signs in Appendix 2.5. You can photocopy or print them and put them up in visible areas, such as ED waiting areas, triage, and restrooms. You will need to get permission and notify your hospital marketing department and ED leadership, or they may remove them. For examples of how your colleagues have used signs, go to **Treatment Starts Here: Photos of Patient Facing Signage**.

LOOK AT EMERGENCY DEPARTMENT TRACKING BOARD

At some hospitals, the navigator sees patients before the provider. If this is the case in your hospital, you can find patients on the tracking board. We recommend the following steps:

- Look for patients with a diagnosis or chief complaint relating to substance use.
- Get a report on the patient from whomever has spoken with them: nurse, triage, or provider.
- Ensure that your charge nurse is aware you will be screening the tracking board and talking to patients.
- Make initial contact with the patient.
- Some navigators initiate an informal conversation with the patient first; others prepare appropriate materials (intake sheet, patient materials) for the first encounter.
- Your initial approach will vary based on hospital policies, individual patient needs, and circumstances.

SET UP A SYSTEM FOR CLINICIANS TO CONTACT YOU

In all hospitals, the primary way you will connect with patients is through referral from ED and hospital clinicians. You should develop a simple system so that you are able to receive referrals quickly while you are on shift, as well as a system to connect patients when you are not available.

During regular hours:

Communicate your regular hours of availability and workspace location to all clinicians. This should also include inpatient clinicians, social workers, and RNs. Make sure all providers have channels of communication to reach you, which can include one or all of the following:

- Navigator pager or work cell phone
- Direct messaging through the electronic health record (EHR) (e.g., EPIC chat, Tiger checks)
- Vocera communication devices
- Secure email

After hours:

When a patient is seen in the evening or over the weekend, you may not be present, and the follow-up clinic may not be open for immediate coordination of care. Set up a system for clinicians to create a list of patients for you to contact when you return to work.

- Email
- Electronic referral through the EHR (e.g., consult, referral to navigator, tagged in chart)
- Secure voicemail or text message
- Hard copy list or box where providers can drop patient information

⇒ **TIP:** Consider establishing set time drop-in slots at outpatient clinics so clinicians are able to easily refer patients even if a navigator is unavailable to set up an appointment.

LEARN THE SIGNS OF OPIOID WITHDRAWAL

To identify patients who may be appropriate for treatment, it is helpful to learn the signs of withdrawal. As you gain experience, when you see these signs, you can ask the patient if they are using opioids.

- Patients will report feeling: achy, hot and cold, stomach cramps, nausea
- Patients may say they are: "dopesick" or "kicking"
- Patients may appear: restless, agitated, sweaty
- Patients may have: goose bumps, dilated pupils, fast heart rate, vomiting, yawning, tears, runny nose, diarrhea

What is the Clinical Opioid Withdrawal Scale (COWS)?

COWS can be used to assess the severity of opioid withdrawal. Your hospital may use this scale to determine whether or not it is appropriate to initiate bup. However, many clinicians just ask for a self-report and check for one physical sign of opioid withdrawal. If your site uses COWS, you can familiarize yourself with the **Clinical Opioid Withdrawal Score** scale on the CA Bridge website.

CONSIDER STANDARDIZED SCREENING TOOLS FOR YOUR PATIENT POPULATION

There are helpful tools for charting that may be required for billing:

- **Alcohol Use Disorders Identification Test (AUDIT)** was developed by the World Health Organization for screening for unhealthy alcohol use or alcohol use disorder.
- **Drug Abuse Screening Test (DAST)** is a self-report type of instrument for screening for drug use and evaluation of treatment.[1,2] It can be used with adults and older youth.
- **NIDA-Modified ASSIST** is an interactive tool that guides clinicians through a series of questions to identify risky substance use in their adult patients. archives.drugabuse.gov/nmassist.

MEET PATIENTS

Engaging patients in discussions about their drug use can be challenging. However, insight from these discussions can be crucial to facilitating a successful outcome. This script suggests a possible approach and language to consider when faced with challenging conversations.

The primary goal is to build trust and provide patient-centered care by using destigmatizing language, giving the patient the power to guide the discussions, and offering safe and realistic options.

Fundamental components of patient engagement include:

- Develop rapport first and return to those topics if you start to lose the connection
- Allow the patient to guide the discussion
- Listen and say less, rather than more
- Be empathetic and sympathetic to the patient's current situation
- De-escalate, if necessary: *"I know you are upset; let's work through this together; I'm here to help."*
- Consider a blameless apology to de-escalate, if necessary: *"I am sorry you have had to wait so long…"*

Building trust with a patient begins with the very first moment of introduction

- Your first step is acknowledging the patient. You may use the patient's formal name until you establish a rapport. Check for preferred pronouns when able.
- Introduce yourself. *"Hi, my name is _____. I am the navigator and work in the ED. I work with Doctor _____. Is it okay if I sit down and talk to you?"*
- Get a chair so you are at eye level and not forcing the patient to look up at you.
- Break the ice with nonthreatening questions or statements that show that you care about them as a person. *"What do you want me to know about you?" "Are you from ____?" "Are you here with anybody that you want me to bring in here?" "Do you need a blanket or something to eat?" "I'm going to be here with you as long as you need me."*
- Don't rush.
- Start with open-ended questions and spend some time allowing the patient to talk without interruption. *"Your clinician asked me to sit down with you. What can I do to help you today?" "How is your living situation right now?" "Do you have a safe place to stay tonight?" "Do you have family?"*
- Thank them for coming in and recognize the courage it took.

DISCUSS SENSITIVE INFORMATION

After some trust is built with a patient, reading the situation is important. Seek to listen and understand the patient's needs; give them the power to lead the discussion by asking open-ended questions. This is a good time to explain confidentiality as well as your duty to report if you believe the patient is a danger to self or others (see Section 1.4).

SUD

If a patient has not already discussed SUD with a provider, or if the patient has not self-identified as an active SUD patient, or if you or the patient feel unsure about how to have a discussion about a possible SUD, some of the following questions may help start the conversation:

- *"Is it okay if I ask you some more personal questions?" "I'm not trying to be nosy, but I'm here to help and the more questions I ask, the more I can help you."*
- *"Is it okay if I ask about drugs and drug use?"*
- *"Do you want to stop?" "What do you want to do with your life?" "Do you want to see your family?"*
- *"Would you like to learn more about our MAT program?"*
- *"What can I offer you right now that will help you feel better?"*
- *"Do you have a clinic that you are able to follow up with?"*
- *"Is there anything I can do to make it easier for you to follow up?"*

As you begin to talk to the patient about their use, your skills and techniques of motivational interviewing become essential (see Section 3.4).

Mental Health

Questions about mental health may be triggering so be careful and sensitive to the patient's emotions. Make sure to check in with the patient's treating clinician to see if there is already a plan for behavioral health needs or if a crisis worker is already working with the patient. If a patient has not already discussed mental health with a provider, or if the patient has not self-identified as having challenges with their mental health, you can use questions like these to open the conversation:

- *"How are you doing with depression or any thoughts that are out of control?"* Explain that these are common issues for people who use drugs.
- *"You tell me: regardless of if you've been formally diagnosed or not, do you feel that you have any mental health issues or problems, such as anxiety, depression, PTSD, schizophrenia, or bipolar disorder?"*
- If yes: *"Is there a medication that you have taken in the past that has helped you?"*
- If yes*: "Would you like to be connected to any mental or behavioral health services now or possibly in the future?"*
- *"Do you have a therapist?" "Do you like them?" "Do you want to see someone else?"*

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3.3 Educating Patients and Facilitating Treatment

If you see the patient before the provider has started treatment, ask them if they want to try bup for opioid withdrawal.

You should phrase this in a way that does not imply that they have to make a big, long-term commitment to treatment. It can be as simple as:

- *"We can start you on treatment if you'd like to try it."*
- *"Would you like to try some buprenorphine/Suboxone to make you feel better?"*
- *"I will talk to your clinician and let them know if you are interested in trying medication."*

If the patient is interested, communicate with the clinician who will determine if starting bup is clinically appropriate. Other information that is helpful to relay to the clinician:

- Has the patient used bup before and what was their experience?
- Have they used methadone and when was the last time?
- When was the last time they used an opioid?
- Which drugs do they usually use?
- How sick does the patient feel?

⇒ **NOTE:** If the patient or provider is considering medications other than bup, you can use the handout **Medicines for Treating Opioid Use Disorder: What You Need to Know** in Appendix 1.1.

EXPLAIN BUPRENORPHINE/SUBOXONE

Key points to cover are:

- Bup is medicine for people who have chronic pain or addiction to opioids (heroin or pain pills). Many people know it by brand names, such as Suboxone® and Subutex®.
- Bup reduces cravings and withdrawal symptoms, without making them feel high.
- People have a lower risk for overdose when they are on bup.
- It is a safe medicine that has been used for 30 years.

Buprenorphine: What You Need to Know is a patient handout in Appendix 1.2.

TELL THE PATIENT WHAT TO EXPECT WHEN THEY GET THE MEDICATION

For patients who have never tried bup before, you can provide them with information about what it will be like and how it will help them relax. Some key points to share include:

- You must be in withdrawal. If you are not, this medication will make you feel worse!
- The medication goes under your tongue and must fully dissolve. Do not swallow it!
- It tastes terrible.
- You should start to feel better anywhere between 15 minutes to 1 hour.

EDUCATE PATIENTS ON SELF-STARTS

Some patients may not be able to start treatment in the hospital because they are not fully in withdrawal or have used opioids or methadone recently. If the clinician determines that these patients can start treatment after they leave the hospital, they may provide a prescription and instruct the patient on how to do a self-start. You can find a guide for **Buprenorphine Self-Start** in Appendix 1.4.

PROVIDE HARM REDUCTION EDUCATION

All patients, even those who are not ready for treatment, should receive naloxone or a prescription for naloxone. Providing harm reduction kits and education can set the stage for future engagement and create a culture of safety from the ED. See Section 5 for harm reduction guidance and patient handouts.

3.4 Communication to Engage and Motivate

MOTIVATIONAL INTERVIEWING

Motivational interviewing (MI) is a technique for building rapport and trust and motivating patients toward change. MI is not confrontational. The spirit of MI is partnership, acceptance, and compassion. This guide provides some techniques for MI, but remember the spirit of MI is more important than the techniques!

OARS is a technique for motivational interviewing. It stands for:

O: Open-ended questions
A: Affirmations
R: Reflections
S: Summary

Open-ended questions

Open-ended questions are questions that can't be answered with a yes or no.

- **Closed-ended**: *"Are you concerned about your drug use?"*
- **Open-ended:** *"What health issues are you concerned about?" "What about your drug use is concerning you?" "Tell me more about…."*

Open-ended questions stimulate thought in the patient and provide more information. They are usually not a natural conversational process and can be uncomfortable at times. Make a list of open-ended questions you can use in different situations.

Affirmations

Affirmations are statements made by the practitioner to the patient acknowledging:

- Small gains and efforts made toward positive change
- Healthy choices
- Honesty
- Resilience and strength for coming to the hospital

Reflections

Reflections are statements made back to the patient about what the patient said to the practitioner. Reflections convey to the patient that the practitioner understood what they said and or how they felt.

- *"I hear that you had a hard day and were frustrated."*
- *"It seems like you really love your child if you are willing to stop using for him."*

Summary

Summaries wrap up content and next steps toward change. You should restate what the patient told you with positivity and encouragement and outline next steps.

- *"It sounds like you have been using pills and you want to stop because you think it would help you be a better parent."*
- *"So, you are going to try this medication today and take my number so you can call me tomorrow."*

WHAT TO DO WHEN YOU ENCOUNTER	
Resistance—Behavior that suggests unwillingness to engage: • Anger, irritation, or aggression • Defensiveness • Denial • Withdrawal • Avoidance	**Change Talk**—Things a patient says that lean toward positive change: • *"I don't always feel good when I use."* • *"I have stopped using in the past… I can stop if I want to."* • *"I really care about my son and want a better life for him."* • *"I can't believe this is happening again."*
YOU SHOULD: Change direction and develop more rapport	**YOU SHOULD:** Encourage this thinking and start moving them toward action planning.

ACTION PLANNING

Action planning is a short-term activity to move toward meeting the longer-range goal—an agreement or plan between the patient and the care team specifying a behavior change a patient wants to make.

- **Have the patient choose the behavior**. Remember that usually a patient will be ready for one change, such as trying treatment or decreasing frequency of use but not ready for another change, such as a long-term commitment to completely stopping use.
  - ⇒ **TIP:** Small steps may not feel adequate for how severe the patient's health condition is but remain nonjudgmental by paying attention to what you say, how you act, and your facial expressions.
- **Be specific** (what? when? where? how?). The success of an action plan is found in the small changes. We want the patient to be successful and enjoy future successes.
  - ⇒ **TIP:** Identify both what you will do (e.g., I will call the treatment center when they open tomorrow) and what the patient will do (e.g., you get your ID from your friend's house).
- **Check confidence for success**. How sure are you that you can do this? What could get in the way?
- **Create a clear timeline**. Specify when each step will happen and when the patient needs to complete their action items. Keep them focused on the plan.
- **Follow up**. Checking back with the patient to see if they are moving forward on their action plan holds them accountable, shows that you care, and provides helpful reminders.

DE-ESCALATION

De-escalation is a combination of strategies and techniques to reduce a patient's agitation and aggression to reduce the risk of harm to patients and caregivers. Using these strategies can:

- Prevent violent behavior
- Avoid the use of restraints or seclusion
- Reduce patient anger and frustration
- Improve staff-patient connections
- Enable patients to manage their own emotions and to regain personal control
- Help patients to develop feelings of hope, security, and self-acceptance

RECOGNIZING AN AGGRESSIVE PATIENT

STAMP is a validated tool for use in the ED. These are signs of a potentially aggressive patient:

- **S**taring and eye contact
- **T**one and volume of voice
- **A**nxiety
- **M**umbling
- **P**acing

RESPONDING TO AGGRESSION

Be aware of your own actions and remain in control:

- Focus thoughts on safety
- Be aware of your own triggers
- Regulate and control your breathing
- Use self-talk, such as “remain safe” or “remain calm”
- Try to relax using quick physical relaxation skills, such as relaxing your hands
- Try not to personalize the person’s anger or share their emotion

Use de-escalation techniques:

- Be empathic and nonjudgmental
- Respect personal space
- Use nonthreatening nonverbals
- Avoid overreacting
- Focus on feelings
- Ignore challenging questions
- Set limits
- Choose wisely what you insist upon
- Allow silence for reflection
- Allow time for decision

RESOURCES

- **National Institute on Drug Abuse (NIDA).** Talking to Patients About Health Risk Behaviors. nida.nih.gov/nidamed-medical-health-professionals/ctn-dissemination-initiative/blending-initiative-motivational-interviewing-cmece-patient-simulation/talking-patients-about-health-risk-behaviors-module.
- **SAMHSA**. Enhancing Motivation for Change in Substance Use Disorder Treatment. store.samhsa.gov/sites/default/files/d7/priv/tip35_final_508_compliant_-_02252020_0.pdf.
- **UCLA Integrated Substance Abuse Programs**. Motivational Interviewing: Engagement, Listening, and Linking Tools for Outreach and Engagement Teams. vimeo.com/136256765.
- **Crisis Prevention Institute**. Training Programs Designed to Make your Facility Safe for Everyone. crisisprevention.com/Who-We-Serve/Health-Care-Professionals.

3.5 Documentation and Charting

Documentation in an EHR or "charting" provides important information for the care of a patient and could also provide the foundation for reimbursement of services that are provided in the future. All hospitals now store their patient data in an EHR that can be accessed from computer stations. The EHR stores information about the patient's health history and services received so that any provider who works with a patient can see their health history.

As a navigator, you will need access to the hospital EHR. You should coordinate with your clinician champion to arrange for an EHR orientation and to ensure that your permission settings allow you to document encounters and access patient demographics and past medical history. The hospital's clinical informatics department is a great resource for in-depth training on charting, reporting, shortcuts, and how to make the most of your EHR.

USING AN INTAKE TOOL

The CA Bridge **Patient Intake Form** is a helpful tool for note taking during a patient interaction that is provided in Appendix 2.6.

This tool will help you collect information you may need for appropriate referral, charting, and data collection. The first page of the tool covers the most essential information you should collect on all patients. The second page includes more detailed information that supports quality patient care. This tool can be customized to meet your needs and to generate information needed for a billable encounter. Any information you collect on the intake tool must be handled in accordance with hospital privacy regulations. If time is a factor, consider printing a patient demographic sheet so you have access to essential patient information when you meet with the patient.

⇒ **TIP:** You may also want to consider using standardized tools, which may be required for billing. See Section 3.2 for recommended tools.

CREATING A CHART NOTE

If the hospital EHR allows for template creation, consider creating templates and dot phrases to enter appropriate visit information from each patient encounter. CA Bridge has sample chart note templates for different types of encounters or data collection purposes, including:

- A basic note that minimizes charting time
- A comprehensive note that includes items from standardized tools AUDIT and DAST and can generate a billable encounter
- Notes for 5- and 30-day follow-up visits

Epic Dot Phrases for Substance Use Navigators was created for Epic EHRs and can be customized for your own practice. For other EHR systems, you may use these as examples to create your own templates, as applicable.

Section 4

Connecting Patients to Ongoing Care

Connecting patients to ongoing, outpatient medication for addiction treatment (MAT) care within 72 hours is one of the most important parts of a navigator's job. This section starts with guidance on how to set up a relationship with at least one outpatient MAT provider who will see your patients and work closely with you. It then provides tools for ensuring that a patient has a prescription for bup so that they can continue treatment until their follow-up appointment. Finally, sections 4.3 and 4.4 provide guidance on doing a "warm handoff" so that your referral is effective, including troubleshooting insurance issues.

SECTION CONTENTS:

4.1 Identifying Follow-Up Outpatient Care Options

4.2 Coordinating Post-Discharge Bup Access

4.3 Navigating Your Patient to an Outpatient Provider

4.4 Troubleshooting Insurance Coverage

All CA Bridge resources in orange can be searched by name at CA Bridge's resource directory at cabridge.org/tools/resources.

4.1 Identifying Follow-up Outpatient Care Options

All hospitals need a place to connect patients to ongoing outpatient treatment after they leave the hospital. Does your hospital have at least one option for low-barrier outpatient treatment where you can connect patients to care after they start bup in the hospital? If not, you may play an important role in finding the best outpatient treatment providers for your patients. You can also use this tool if you need more options for patients in different locations or with different insurance coverage.

SELECT AN OUTPATIENT PROVIDER(S)

Begin by familiarizing yourself with different types of outpatient MAT providers. CA Bridge's **Options for Post-Acute MAT Treatment** in Appendix 2.7 is a quick overview of outpatient treatment providers.

You can check with community health, case management, social work, or discharge planning for leads on outpatient providers. The State of California's website choosechangeca.org allows you to search for MAT providers by ZIP Code.

⇒ **NOTE:** In California, no state-certified SUD treatment program is allowed to deny people the help of medications like bup, but some privately funded programs are still based on dangerous "abstinence-only" models and should be avoided.

You should send patients to providers that are patient-centered and easily accessible. Take the time to visit the location and talk to the director. You should prioritize sites that:

- Will hold a standing appointment slot for your patients
- Accept walk-ins
- Have reasonable wait times for appointments
- Treat patients with respect
- Have a rapid intake process and will start patients on the same day (essential)
- Accept Medi-Cal and/or the insurance plans that are most common in your hospital
- Will continue to treat patients even if they relapse
- Will treat patients for OUD even if they are using other substances (e.g., meth, cannabis)
- Will keep patients on bup as long as the patient needs or wants it
- Offer injectable bup (long-acting)

If the best available outpatient provider does not provide care that is easy to access or patient-centered, you can offer suggestions for how they can improve their care. Outpatient treatment facilities are often eager to get patients referred from the hospital, so as you build a relationship with them, they may be receptive to your requests. **A Patient-Centered, Rapid Access Approach to Substance Use Disorder** provides more information about low-barrier care.

For areas that have limited MAT follow-up options, a good option is telehealth MAT care. Some EDs and urgent care facilities have developed telehealth programs—check with your institution. When identifying telehealth companies, consider the technology platform needed, appointment scheduling process, insurance coverage, and cost to patients. Although CA Bridge does not endorse any specific telehealth provider,
to find an appropriate provider, see our list of **California MAT Telehealth Providers** in Appendix 2.8.

DEVELOP A STRONG WORKING RELATIONSHIP

The key to successfully navigating patients to ongoing care is a strong relationship with outpatient providers.

- Visit the site so you can tell patients what to expect.
- Get to know the intake staff for the MAT program so you can refer patients to them by name.
- Have an open channel of communication so you can call or text them.
- Find out if the site can dedicate an intake slot for your patients.
- Establish a process for day-time referrals and a secure voicemail line for after-hours referrals.
- Check-in regularly to ensure the workflow is functioning well.

While it is not common, some hospitals prefer to have written, formal agreements between their hospital and the follow-up facility that cover the processes that the two institutions have agreed upon.

4.2 Coordinating Post-Discharge Bup Access

PRESCRIPTIONS

Once a patient has been initiated on (bup in the hospital, they need prompt follow-up, ideally within 72 hours. It is essential that they leave the hospital with a prescription for enough bup to last until their follow-up appointment. In some cases, you may want to ask for a 1- or 2-week prescription if there is a waitlist for appointments.

⇒ **TIP:** If you can't get your patient a prescription, they can come back to the ED the next day for another dose of bup.

Patients often experience difficulties filling prescriptions at commercial pharmacies. Navigators should build and maintain relationships with pharmacy staff so they can confidently send patients to supportive pharmacies, knowing there will be fewer barriers to accessing prescribed MAT. Key steps include:

- Contact all of the pharmacies in your area to confirm that they stock bup or Suboxone.
- Keep an updated list of pharmacies that treat patients who use drugs with dignity and respect.
- Document patients' reported experiences with pharmacies and pharmacy staff who act disrespectfully toward people who use drugs.
- Work with your hospital's outpatient pharmacy (if they have one) to make it easy for patients to fill prescriptions before leaving the hospital without encountering stigma.
- Check with your hospital's care coordination team to see if a program exists for uninsured, underinsured, or out-of-state patients to obtain their prescription, and learn how to navigate these situations.

A few things to know about your role as a navigator in prescriptions:

- You cannot call in a new prescription for a patient. This must be done by a clinician who is authorized to prescribe bup.
- You can call in a refill if you are trained by the prescriber to act as their assistant/agent.
  - These refills cannot have any changes in the dosage levels, form, route, frequency, and number of days' supply.
  - These refills cannot exceed 5 refills of the original prescription nor extend beyond 6 months from the date of the original prescription.
- **Substance Use Navigators and Prescriptions** has more details about your role and is in Appendix 2.9.
- **Buprenorphine and Pharmacy Frequently Asked Questions** has more information to help patients get prescriptions filled and is in Appendix 2.10.

Controlled Substances

Commercial pharmacies have specific protocols regarding orders for controlled substances, including bup which is a Schedule III drug. Electronic prescribing has been required since January 2022.

Identification

A pharmacy may require a form of identification from a patient in order for them to pick up a bup prescription, especially if they have not filled prescriptions at that specific pharmacy before.

If they do not have an ID, options include:

- Filling the prescription at a pharmacy they frequently use. If the pharmacy is familiar with the patient, they may not request an ID.
- Enlisting a friend, family member, or designated representative with an ID to accompany the patient to the pharmacy and pick it up with them; some pharmacies may allow this, but an ID may be required to sign for the prescription.

PATIENT EDUCATION

It is important to provide patients with clear written treatment and follow-up instructions. The following patient handouts and templates are available online and in multiple languages. You can copy and adapt these for your use.

- **Buprenorphine: What You Need to Know** is a patient handout that you can copy from Appendix 1.2.
- **Buprenorphine Sample Discharge Instructions** can be copied from Appendix 1.5 and filled in by hand or printed and customized for your site.
- **Bup XR Sample Discharge Instructions** can be printed and customized for your site.
- **Harm Reduction Sample Discharge Instructions** can be downloaded and customized for your site.

Remember to ask them if they have any questions!

Safe Medication Storage

Remind your patient to keep bup out of reach of children and pets. It is important to recognize that storing and keeping possession of bup is a real challenge for people experiencing housing instability. Patients should not be punished or discriminated against for this situation. Talk to them about making a plan for storage and what they will do if their medication is stolen. Discuss long-acting injectable bup if safe storage is likely to be a challenge.

4.3 Navigating Your Patient to an Outpatient Provider

SELECT THE BEST OUTPATIENT PROVIDER FOR YOUR PATIENT

If you have multiple options for patient-centered, low-barrier follow-up MAT, you can consider the following factors when deciding where to refer the patient:

- What insurance coverage does the patient have and which outpatient providers will accept their insurance?
- What does the patient want? Do they want to get MAT at the same place they receive primary care? Do they have a doctor they prefer?
- What providers are closest or most accessible by car or transit?

If the first referral does not work out, tell the patient they can always come back to you at the hospital for another referral.

CONDUCT A WARM HANDOFF

Set up the first appointment with an outpatient provider or assist the patient in using a hospital phone or tablet to do so themselves. Ideally, you will have visited the outpatient clinic and formed personal relationships with their clinicians and scheduling teams. You should be able to tell the patient what to expect, how to get to the clinic, and who their contact will be when they get there.

Troubleshoot barriers to access that many patients experience even with a warm handoff. You should work with patients to identify and minimize these barriers through strategies, such as: arranging for transportation, providing resources for free phones, identifying local pharmacies that fill bup prescriptions, helping to obtain the necessary discharge papers from the hospital, etc.

Plan for follow-up after evening or weekend starts. When a patient is discharged in the evening or over the weekend, you may not be present, and the follow-up clinic may not be open for immediate coordination of care. Set up a process for clinicians to create a list of patients for you to contact when you return to work. Consider establishing drop-in slots at outpatient clinics so patients have reliable and prearranged follow-up options even if you were not available to set up an appointment.

Stay connected. You are a safety net for the patient! Provide the patient with a phone number they can call after discharge to speak directly with you if they encounter obstacles accessing follow-up care. Most navigators distribute their number widely and continue to receive calls from patients when issues arise, often for many months.

Follow up to confirm that the patient has made it to their outpatient visit with a follow-up call to either the patient or the treatment provider within a specified number of days. Different hospitals will have different policies for how many days later follow up should occur and some may include two follow-ups at, for example, 5 and 30 days. If the patient does not attend the appointment, either you or the clinic should reach out to the patient.

⇒ **TIP:** If resource constraints do not allow for a full warm handoff, at a minimum, develop a handout with a list of clinics for follow-up along with contact information for each, including at least one telehealth option for patients who may have geographic or transportation challenges associated with follow-up at a physical clinic.

4.4 Troubleshooting Insurance Coverage

To get a patient a prescription for bup and follow-up care with an outpatient provider, you will need to address the issue of insurance coverage. Patients will have either Medi-Cal, which is California's coverage program for low-income individuals; Medicare, coverage for all Americans over 65; or private insurance obtained through an employer or purchased by the individual. Most of these options will involve some type of managed care plan. The type of coverage a patient has and the managed care plan they are enrolled in will determine where they can fill prescriptions, what co-pays they have, and which outpatient providers they can access. Once you have determined what type of coverage the patient has, be sure to ask the pharmacy and the outpatient provider if they accept this insurance.

MEDI-CAL

Counties offer addiction services for Medi-Cal patients through county providers or contractors as part of Drug Medi-Cal. Navigators should be familiar with the county system to refer Medi-Cal members to Drug Medi-Cal treatment services.

Emergency Temporary Medi-Cal (Medi-Cal Pending)

Individuals who present to the ED with no insurance coverage may qualify for emergency temporary Medi-Cal. Most hospitals have social workers or eligibility workers who specialize in fast-tracking these applications. For all new enrollments, patients can acquire temporary Medi-Cal at the hospital. The patient will have 6 months to complete the full Medi-Cal application. Failure to do so may result in the patient becoming uninsured and having high out-of-pocket costs for future medical visits and prescriptions.

Medi-Cal Verification

Medi-Cal insurance can be verified by visiting Medi-Cal Eligibility at medi-cal.ca.gov/MCWebPub/Login.aspx. Username and password are site-specific. Hospital eligibility workers or registration staff may provide this information to navigators or verify eligibility. Patient social security numbers will be required and subject to appropriate privacy regulations.

Medi-Cal Managed Care

Most patients on Medi-Cal are enrolled in a managed care plan. A small number are still in the Medi-Cal fee-for-service (Medi-Cal FFS) program. Medi-Cal is administered by counties so each county has different health plans that patients on Medi-Cal can choose from. Navigators working at hospitals that draw from a large geographic catchment will need to be familiar with plans in different counties, their prior authorization processes, and the required paperwork.

Medi-Cal FFS has a limit of 6 total prescriptions per 30 days. Individual county Medi-Cal managed care plans have variations on this relating to "carve-out" medications and total prescription limits.

- If a patient exceeds the 6-prescription limit for Medi-Cal FFS, the provider must submit a prior authorization to Medi-Cal, known as a Treatment Authorization Request (TAR), to give justification for the patient receiving an additional (i.e., 7th or 8th) prescription. This is necessary for medication dosing, quantity adjustments, or starting a patient on new medications. The ICD-10 diagnosis code and clinical justification are needed for a TAR. Either the pharmacy filling the prescription or the clinician's office staff may fill out the TAR electronically or via fax.

- Carve-out medications are those billed directly to the state Medi-Cal FFS program rather than county Medi-Cal managed care plans. The classes of medications billed as carve-outs include HIV/AIDs medications, alcohol detox and dependence medications (i.e., naltrexone), opioid detox and dependence medications (i.e., bup, naloxone), some psychiatric medications, and blood factor products.

MEDICARE

Medicare covers people over the age of 65 and younger people with disabilities or chronic illness, such as a serious mental illness. Most seniors with Medicare coverage also have private supplemental insurance, a Medicare advantage plan, which allows greater benefits and helps with out-of-pocket costs. Medicare part A and part B do not cover bup. Individuals will need to enroll in a Medicare part C or part D plan. Most Medicare advantage plans cover bup, but many of these plans do require a prior authorization for coverage. You may want to recommend prescribing a generic form to start.

Some patients are dual-eligible, or "Medi-Medi" patients, where they have a Medicare plan in addition to either Medi-Cal FFS or a county-specific plan. Generally, bup for OUD is covered under the Medi-Cal plan. For patients with Medi-Medi plans, billing for all prescriptions will be directly billed to the Medicare part D plan. If the patient who has a Medi-Medi plan does not have Medicare part D, prescriptions will be billed to the Medicaid part of the plan.

PRIVATE INSURANCE

Most private insurance plans will cover bup and Suboxone. Financial offices and eligibility workers in hospitals or clinics are good resources for understanding commercial insurers in your market, and whether any have restrictive policies related to MAT. Co-pays may vary depending on the formulation (tablets versus films) as well as whether the patient is prescribed brand name medication versus generic medication.

KAISER PERMANENTE

Kaiser Permanente (KP) is the largest health plan in California and includes both Medi-Cal and commercial members. Commercial members will need to visit a KP ED to receive fully covered treatment. KP covers large percentages of patients in many California counties, so it's very likely that KP members will show up to any ED across California. KP commercial members could face high co-pays and cost-sharing at non-KP facilities.

KP Medi-Cal members have limited access to addiction treatment at KP but can receive services from county Drug Medi-Cal providers. They should be able to access bup via their Medi-Cal coverage through a KP pharmacy or KP-contracted pharmacy. Navigators should provide KP members with the full slate of resources available to all patients and encourage them to follow up with their KP physician.

OTHER INSURANCE CONSIDERATIONS

Some patients may present in moments where they are in between enrollment in insurance coverage. This may be because they are moving to a new state or county or have changed employment status. Hospital financial counselors or eligibility workers can help determine the best method for accessing coverage.

PHARMACY

Billing

Nearly all retail pharmacies (e.g., CVS, Walgreens, etc.) accept Medi-Cal FFS, but may or may not contract with county Medi-Cal managed care plans. Furthermore, due to a discount drug program called 340B, many Medi-Cal members can only pick up prescriptions at large retail pharmacies.

You can help pharmacists and pharmacy technicians understand how to bill for these prescriptions. For Medi-Cal FFS and county managed care plan patients, for example, include the following message for the pharmacy: "Bill as carve-out to Medi-Cal FFS."

Costs, Prescriptions, and Refills

Price will vary depending on coverage and medication. Strips (films) are often more expensive than tablets; however, most patients prefer strips. Tablets are often less expensive than strips/films, and generic is less expensive than name brands. Subutex® is another name for the buprenorphine mono product; Suboxone® is bup and naloxone combined.

How to address lost or stolen medications:

1. Determine the quantity missing (in number of days).
2. The prescriber must authorize "okay to refill early" (verbal or written authorization will be requested by the pharmacy).
3. Call the pharmacy and reorder missing days of meds. You will likely need to explain to the pharmacist the reason for an early requested refill.
4. Pharmacists must send justification documentation to the patient-specific Medi-Cal or private insurance plan. Most plans have limits on how many times a prescription may be filled due to it being lost or stolen.

CONTROLLED SUBSTANCE UTILIZATION REVIEW AND EVALUATION SYSTEM (CURES)

Controlled Substance Utilization Review and Evaluation System (CURES) oag.ca.gov/cures is California's prescription drug monitoring program. This is a database of Schedule II, III, and IV controlled substance prescriptions. All prescribers need to check this system to screen for overprescribing and concurrent opioid or benzodiazepine prescriptions. ED prescriptions longer than 7 days require ED providers to check CURES prior to prescribing.

⇒ **TIP:** Encourage prescribers to check CURES regularly (Note: you cannot check CURES in the place of a provider). The most recent reporting requirements are available from the California State Board of Pharmacy at pharmacy.ca.gov/licensees/cures.shtml.

Section 5

Leading Change in Hospital Culture

As a navigator, part of your mission is to champion a culture shift in the hospital and emergency department in the way that people think and talk about people who use drugs. The unfortunate reality is that the current medical system does not work for most people who are using drugs. A huge gap often exists between what people using drugs need and what doctors and clinics offer as treatment.

This section begins with principles and tools of harm reduction in Section 5.1. An important element of a culture of harm reduction is the language we use to talk about people who use drugs. Section 5.2 includes tips for leading this change. Finally, recognizing the disproportionate harm that comes to people who use drugs in communities of color, particularly in the Black community, Section 5.3 explores our early steps to reduce these harms and advance equity.

SECTION CONTENTS:

5.1 Advocating for a Culture of Harm Reduction

5.2 Changing Language about Drug Use

5.3 Advancing Equity and Reducing Harm to Communities of Color from Drug Use

All CA Bridge resources in orange can be searched by name at CA Bridge's resource directory at cabridge.org/tools/resources.

5.1 Advocating for a Culture of Harm Reduction

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use, including safer use, managed use, and abstinence. Practicing harm reduction means meeting people who use drugs "where they are at" and providing them with compassionate care, regardless of their relationship to drugs.

Some of the principles of harm reduction advanced by the National Harm Reduction Coalition include:

- Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Calls for the nonjudgmental, noncoercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Establishes quality of individual and community life and well-being—not necessarily cessation of all drug use—as the criteria for successful interventions and policies.
- Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use.

Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. When harm reduction practices and principles are integrated into a hospital, it promotes a culture of respect and partnership with people who use drugs.

YOUR ROLE AS A NAVIGATOR

Be a Champion for Harm Reduction

The philosophy and practices of harm reduction are an important part of the CA Bridge model for treating SUD in the hospital. For some people who use drugs, harm reduction means abstinence; for others, it means working to reduce the harms of their drug-using behavior. As much as we might want people to just stop using forever, returning to use is part of the disease and recovery process. People who use drugs often blame themselves, carry shame, and behave defensively when exposed to hospital staff; they are expecting to encounter discrimination. Your work will contribute to building health care systems that do not discriminate and are accountable for providing high-quality care to all people, regardless of whether they use drugs or not.

⇒ **TIP:** When providers treat patients who use drugs with care and respect, give them a personal thank you or praise in front of their colleagues. Positive reinforcement is a strong motivator!

After you have settled into your role helping patients access treatment, you should discuss the importance of harm reduction with ED and hospital clinicians and explore bringing specific harm reduction practices to your hospital.

Educate Patients

- **Harm Reduction Sample Discharge Instructions** can be customized for your site.
- **Safe(r) Drug Use** is a patient handout from the National Harm Reduction Coalition that can be copied from Appendix 1.6.
- **Using Fentanyl?** is a patient handout in English and Spanish from the National Harm Reduction Coalition that can be copied from Appendix 1.7.

- **Prevent Overdose With Fentanyl Test Strips** can be copied from Appendix 1.8.
- **How to Use Naloxone to Reverse an Overdose** can be copied from Appendix 1.9.
- **Prevent & Treat Opioid Withdrawal in Your Baby** is a patient handout that can be copied from Appendix 1.10.

Distribute Naloxone/Narcan

Naloxone (also known by the brand name Narcan) is a drug that reverses potentially fatal opioid overdoses. It is often used by emergency personnel who respond to 911 calls. Training laypeople who are at risk for overdose and their friends or family to recognize and treat overdose and equipping them with naloxone has been proven to prevent overdose deaths.

- Consider having your hospital apply for the Naloxone Distribution Project (NDP) dhcs.ca.gov/individuals/Pages/Naloxone_Distribution_Project.aspx, a federally funded program administered by the California Department of Health Care Services (DHCS). This program will provide you with free naloxone.
- CA Bridge's **Guide to Naloxone Distribution** offers more information on how to set up naloxone distribution from the hospital.
- Even if your hospital is not yet distributing naloxone, you can remind providers to prescribe it.

Offer Safer Consumption Supplies

Accepting people's drug use and helping them use more safely not only saves lives, it creates a connection that can foster entrance to drug treatment and other health services.

- Provide people who inject drugs with sterile syringes, biohazard containers, and smoking/injecting kits. This helps prevent HIV and HCV as well as abscesses and infections. (Note: this practice is legal in California but not in all states.)
- Distribute harm reduction kits with items, such as hand sanitizer, alcohol pads, and condoms.

Interested in learning more about providing safer consumption supplies at your hospital? Reach out to us at info@cabridge.org.

Connect and Refer

If your hospital is unable to provide naloxone or safer consumption supplies directly to patients, refer to an agency that does. These sites can get you started:

- **Local Syringe Services Programs**. The North American Syringe Exchange Network (NASEN) website allows you to find syringe access programs near you. nasen.org/map.
- **National Harm Reduction Coalition**. The National Harm Reduction Coalition's mission is to promote the health and dignity of individuals and communities affected by drug use. Their resource center contains a wide range of up-to-date fact sheets, webinars, manuals, training guides, and best practices about evidence-based harm reduction strategies. harmreduction.org.
- **NEXT Distro**. NEXT Distro is an online and mail-based harm reduction platform where you can directly access supplies and information. nextdistro.org.

LEARN MORE ABOUT HARM REDUCTION

Because CA Bridge is a strong proponent of harm reduction, we encourage all navigators to educate themselves further about the principles and practices of harm reduction.

Learning Modules

This 3-video learning module series was developed specifically for anyone working in the hospital setting to become more familiar with the harm reduction approach and how it pertains to work with patients.

- **Principles of Harm Reduction**. youtu.be/91MmA6c0ulA.
- **Harm Reduction Services**. youtu.be/d4XCV4y5USA.
- **Stigma Reduction for the ED**. youtu.be/RvbXzUu8T_c.

Harm Reduction Tools

- **Foundations of Harm Reduction**. harmreduction.org/issues/harm-reduction-basics/foundations-harm-reduction-facts.
- **Safe(r) Drug Use**.
- **Respect to Connect: Undoing Stigma**. harmreduction.org/issues/harm-reduction-basics/undoing-stigma-facts.
- **Podcast: The Gold Standard with Dr. Kimberly Sue, Medical Director, National Harm Reduction Coalition**. anchor.fm/goldstandard.

5.2 Changing Language About Drug Use

USE PERSON-FIRST LANGUAGE

“Person-first” language means that you put the person first and then describe their condition or behavior second. For example, instead of referring to someone as a “drug user,” a person-first term would be a “person who uses drugs.” A person is a person first, and a behavior is something that can change. Terms like "drug addict" or "user" imply that someone is "something" instead of describing a behavior that can change. While this may not seem important, how we talk about people influences how we think about them and treat them. It also influences how they see themselves and how they see our ability and desire to help.

For specific examples of words to avoid and how to replace them, see the **Words Matter** handout on the next page or access it in our resource library.

BE A ROLE MODEL

As a navigator, part of your job is to shift hospital culture to be more respectful of people who use drugs, and language is an important part of that shift. You can start this process by being a role model. Work on your own language—it won’t change overnight! Here are some tips for increasing your impact:

- When others use stigmatizing language, confronting or correcting them may make them feel antagonized. Simply responding using person-first language may lead others to adopt it.
- If you see others treating a patient with SUD disrespectfully, you can respectfully point out that patients with other diseases, such as diabetes, are not treated this way.
- If you have built a relationship with another person that uses stigmatizing language, you can ask them what they aim to communicate. Reflecting on unconscious behavior can lead to change!
- If providers ask how you have been successful in working with patients who use drugs, you can use that opportunity to point out the importance of language as a way of showing respect and building rapport.

Seeing is believing! When people around you see that a new approach to SUD is working, they will start to change their language and their behavior. We have seen it happen in dozens of hospitals!

EXTEND YOUR REACH

Training

As you become familiar to people in the hospital, you can look for opportunities to encourage respectful language. Opportunities will vary across hospitals, some navigators make brief presentations at ED staff meetings, shift huddles for nursing staff, or meetings of different hospital departments. CA Bridge can provide you with a slide deck to get you started on these presentations! You can also share tools for helping patients with SUD, including **Words Matter**, by email or posting in high traffic places, such as the back of the bathroom door!

Written Materials

Look at existing brochures, posters, and electronic communication. Do they use person-first language (i.e., a person who uses opioids)? Do they create narratives about "good" and "bad" people who use drugs (i.e., pain patients vs heroin addicts)? Seek input from various stakeholders, especially people who use drugs. Over time you can work with hospital communications and marketing staff to edit language in these materials.

Words Matter

It is important to be intentional when communicating with or about patients. The language we use impacts the way care is received. Terms such as "addict," "drug seeker," and "junkie," can be extremely stigmatizing. Instead, refer to patients using "person-first" language, such as a "person who uses drugs." This acknowledges the person first, rather than identifying them by their relationship to drugs.

"When talking to people with SUD, their loved ones, and your colleagues, use non-stigmatizing language that reflects an accurate, science-based understanding of SUD, consistent with your professional role."[3]

INSTEAD OF…	USE…	BECAUSE…
Addict User Drug abuser Junkie Alcoholic Drunk Former addict Reformed addict	• Person with opioid/substance use disorder or person with opioid addiction • Patient • Person in recovery **For heavy alcohol use:** • Person with unhealthy or hazardous alcohol use • Person with alcohol use disorder	• Person-first language • The change shows that a person "has" a problem rather than "is" the problem. • The terms avoid elicit negative associations, punitive attitudes, and individual blame.
IV drug user	• Person who injects drugs	• Person-first language
Habit Relapse	• Substance use disorder • Drug addiction • Return to use/slip	• Inaccurately implies that a person is choosing to use substances or can choose to stop. • "Habit" may undermine the seriousness of the disease.
Clean	**For toxicology screen results:** • Testing negative **Referring to a person:** • Being in remission or recovery • Abstinent from drugs • Not drinking or taking drugs • Not currently using drugs	• Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions. • Set an example with your own language even if patients use stigmatizing slang. • May decrease patients' sense of hope and self-efficacy for change.
Dirty	**For toxicology screen results:** • Testing positive **Referring to a person:** • Person who uses drugs	

(Adapted from NIDA Words Matter handout)

5.3 Advancing Equity and Reducing Harm to Communities of Color From Drug Use

CA Bridge believes that substance use is a common part of the human experience. For some, substance use has negative consequences. Unfortunately, in the US, the consequences from drug use are not experienced equally, and people of color, particularly Black people, face worse consequences than White people. While CA Bridge strives to reduce the harms from drug use for *all* people, we believe that to achieve equity, we must focus special effort on reducing harms related to substance use in the communities of color that are disproportionately impacted. We strive to expose and disrupt the influence of racism on social attitudes, drug laws and policies, and treatment approaches on a personal and systemic level. We invite navigators to join us in this work.

A PUBLIC HEALTH PERSPECTIVE

Racial Inequities

For people of color, drug use is much more likely to lead to incarceration than it is for White people. Government data consistently show that people of all races use substances at equal rates,[1] but Black Americans are much more likely than White Americans to be arrested and incarcerated.[2,3] In 2018:

- Black and White people used marijuana at similar rates, but a Black person was over 3 times more likely to be arrested for marijuana possession than a White person.[4]
- Overall, Black Americans made up 27% of all drug-related arrests despite being only 13% of the population.[2]

These disparities stem, in part, from racist policies put forth in 1971 during the War on Drugs that disproportionately targeted communities of color. In the late 1980s, federal laws were passed that created the same penalties for 1 gram of crack cocaine as for 100 grams of powder cocaine. Since crack was more common in Black communities and cocaine, more common in White communities, Black people who used drugs received much harsher sentences than White people did.

The magnitude of harm is enormous

These differences in response to drug use affect *a very large number of people* because over the last 40 years, the US incarceration rate tripled to the *highest of any country in the world*.[5] The number of Americans incarcerated for drug offenses skyrocketed from 40,900 in 1980 to 443,200 in 2018, and on any given day, 1-in-12 Black men in their 30s is in prison or jail.[6]

Incarceration is a very significant source of harm from drug use, as it has negative consequences that affect a person's family relationships, mental health, employment, and eligibility for public housing and other benefits.

SUD treatment has not been provided equitably to people of color

When bup was approved for treatment of opioid addiction in 2002, it allowed treatment for OUD to be available for the first time in regular medical settings. However, primarily White patients have benefited from this newer, more convenient treatment.[7] A 2006 national study found that 91% of patients who received bup were White.[8] These disparities continue today. A 2019 study found that Black patients are 77%

less likely to receive bup than White patients in the outpatient setting.[9] In California, we found that although the state has reduced disparities in bup access based on income, communities with higher proportions of people of color continue to have lower rates of bup prescriptions.[10]

Disparities in bup access were also found in a national study of 3,142 counties where counties with high concentrations of Black and Latinx residents had more facilities to provide methadone per capita, while counties with high concentrations of White residents had more facilities to provide bup.[11]

These disparities are significant because methadone is highly stigmatized,[12] and it requires patients to line up, often in visible public spaces, to receive daily doses from specialized clinics.

This history affects our work

The opioid epidemic, which initially affected more White Americans, changed the national conversation about substance use and brought more recognition to substance use as a medical condition, in need of treatment rather than incarceration. This is a positive shift; however, as medical professionals, we should anticipate the understandable cynicism or mistrust in communities of color when we offer treatment for drug use while many people in these communities were, and still are, in jail for the same behaviors.

WHAT WE CAN DO

Provide Equitable Services

As clinicians and hospital staff, we have the most direct control over our own services. We can work to uplift communities that have been negatively impacted by drug use and unequal treatment. Working to offer services that are equitable and anti-racist will be a journey of continuous learning, trial and error, and reflection. We offer a few simple ideas of where to start, and we invite you to help us grow this list.

- Have strong wraparound services to help people with survival needs. It can be hard for patients to focus on substance use treatment when they are dealing with housing instability, food insecurity, or unemployment. Without addressing survival needs, you are not providing equitable access to care because treatment is more effective when these needs are addressed.
- Make sure your resources are equitably distributed so that you have options for people from different racial and ethnic groups, different parts of town, and people who are non-English speakers. Some examples include having translated materials available and ensuring you have a wide network of providers you refer to across ethnic backgrounds and different parts of your hospital's service area. CA Bridge has translated many patient-facing resources (see our **Guide to Translated Patient Materials**).
- Proactively reach out to communities of color to raise awareness of your services for people who use drugs and invite them in. Just because people from a community are not coming in, does not mean they do not need treatment. Show up in community settings in-person to listen and build trust. Doing outreach at community events can help you start building these connections.

Tell the Stories of Patients of Color

The opioid epidemic has begun to change the conversation around addiction from one of crime and moral failure to one of tragedy and illness. However, a review of media coverage shows a clear racial bias where White drug users' life stories are shared as part of their portrayal as sympathetic victims of unscrupulous drug companies, whose promising lives were derailed. On the other hand, Black and Latinx drug users are more frequently depicted in a criminal context with no humanizing details about their lives.[13] We can work

to change these narratives by choosing patients of color when we want to tell patient success stories and including details of their lives that humanize those who use drugs.

Advocate for Hospital Policies That Advance Equity

Many people who use drugs, particularly people of color who are disproportionately targeted by law enforcement, do not feel that hospitals are safe spaces. Hospitals can do more to engage with communities of color and build trust. Some places you can start:

- Talk to your clinical champion about engaging hospital security to make sure that people who use drugs feel safe and that the hospital follows the law prohibiting search and seizure of personal property including drugs. If you see a patient's drugs, it is not your responsibility to confiscate them or notify law enforcement. Read the Working Group on Policing and Patient's Rights' resource on how to engage with **Police in the Emergency Department** and protect patient privacy.
- Get involved in your hospital's community benefit program and advocate for investments in housing and community programs that reduce health disparities. As a navigator, you may have valuable connections to programs that help people who use drugs in communities of color. The National Center for Healthy Housing has resources on how hospital community benefit programs can advance equity through housing nchh.org/tools-and-data/financing-and-funding/healthcare-financing/hospital-community-benefits.

Commit to Learning More

We encourage everyone working with patients who use drugs to seek more information about race and racism in medicine. A core underpinning of anti-racism work is personal exploration of our own racial identity, privilege, and implicit bias. This self-exploration is a component of the diversity, equity, and inclusion work that CA Bridge is undertaking, and we look forward to sharing additional resources and trainings as that work advances. Here are some easily accessible resources to get started:

- **CA Bridge Racial Equity Resource Page**. This webpage includes a number of resources curated by the CA Bridge Racial Equity team to get you started on advancing equity in your ED.
- **American Public Health Association** Advancing Racial Equity Webinar Series. This is a free, self-guided learning series that includes 3 webinars, discussion guides, and activities. apha.org/-/media/files/pdf/webinars/2020/advancing_racial_equity_discussion_guide_part_i.ashx.
- **California Institute for Behavioral Health Solutions** (CIBHS) Webinar Series. CIBHS has a number of excellent webinars on race in behavioral health. cibhs.org/find/results/racism.
- **National Council for Behavioral Health** Addressing Health Equity and Racial Justice. This website has webinars, tools, and trainings. thenationalcouncil.org/center-for-consulting-training/addressing-health-equity-and-racial-justice.
- **Netflix** has an educational documentary "13th" that explores the history of racial inequality in the US netflix.com/title/80091741.

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SECTION 6

Patients with Co-occurring Substance Use and Mental Health Disorders

Navigators frequently work with patients who have ***both*** **mental health and substance use disorders**. This section provides guidance to navigators on your role in working with patients who have "co-occurring" disorders. It explains how you can identify mental health issues and provides actionable strategies that you can use in your interactions with patients. It also outlines how you can connect patients to mental health services and presents other resources that may assist you in providing care.

SECTION CONTENTS:

6.1 Introduction to Mental Health and Co-occurring Disorders

6.2 Support Strategies for Patients with Dual Diagnosis/Co-occurring Disorders

6.3 Connecting Patients to Mental Health Services

All CA Bridge resources in orange can be searched by name at CA Bridge's resource directory at cabridge.org/tools/resources.

6.1 Introduction to Mental Health and Co-occurring Disorders

WHAT IS A MENTAL HEALTH DISORDER?

Mental health disorders affect a person's thinking, mood, and/or behavior—and they can range from mild to severe.[1] Nearly 1-in-5 adults lives with a mental illness in California.[2]

Serious mental illness is defined by someone over 18 having a diagnosable mental disorder in the past year that causes serious functional impairment that substantially interferes with or limits one or more major life activities. For people under the age of 18, the term "**Serious Emotional Disturbance**" is often used.[3]

However, it is important to note that SUD, particularly stimulant use, can lead to presentations that look like serious mental illness, but with cessation, in some cases, the mental health symptoms resolve.

Some of the most common mental health disorders among people with SUDs include:

- Anxiety disorders: Involve persistent, excessive fear or worry in situations that are not threatening.[4]
- Psychotic disorders: Characterized by significant impairments in the way reality is perceived and certain changes in behavior, such as persistent delusions and hallucinations.[5]
- Mood disorders, such as bipolar disorder: Causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks.[6]
- Mood disorders, such as depressive disorders: Experiencing a depressed mood or loss of pleasure or interest in activities for an extended period of time.[7]
- Conduct disorders: Repetitive and persistent pattern of behavior in children and adolescents in which the rights of others or basic social rules are violated.[8]
- Post-traumatic stress disorder: Develops in some people who have experienced a shocking, scary, or dangerous event.[9]
- Attention deficit hyperactivity disorder: Marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.[10]

WHAT IS BEHAVIORAL HEALTH?

Behavioral health includes the emotions and behaviors that affect your overall well-being.[11] Behavioral health typically refers to both mental health conditions and SUD.

WHAT IS A DUAL DIAGNOSIS?

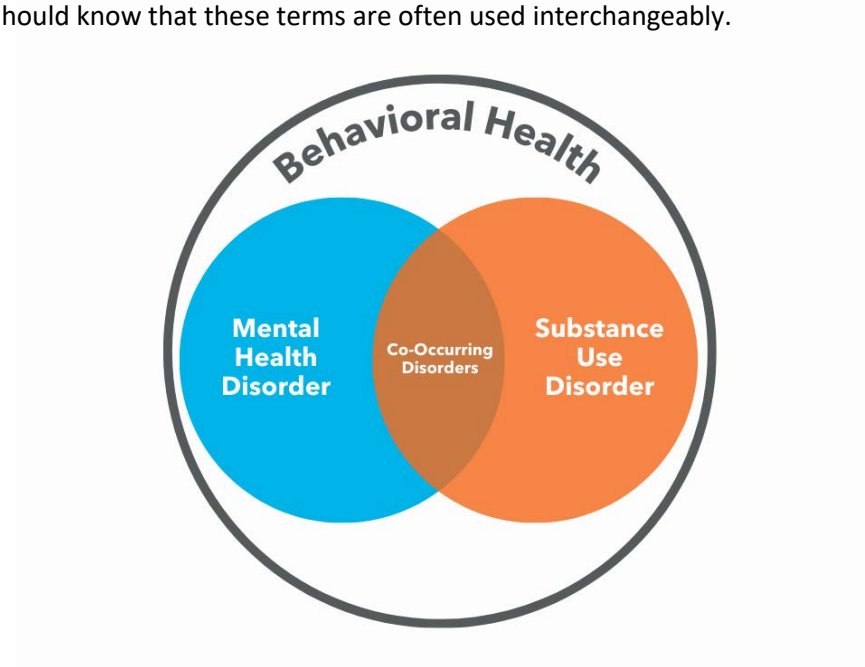
Dual diagnosis is a broad category for when someone experiences two illnesses at the same time. It is often used to refer to an individual who has both a mental health disorder and SUD. SUD can also lead to mental health issues because of the effects drugs have on a person's moods, thoughts, brain chemistry, and behavior.

⇒ **TIP:** Dual diagnosis is an important term to know because some treatment facilities will accept patients with dual diagnosis and others will not.

WHAT IS A CO-OCCURRING DISORDER?

Co-occurring disorder is similar to dual diagnosis but usually means that the mental health disorder developed *as a result* of the SUD. This term is used more frequently in SUD treatment facilities that also

provide mental health treatment. Dual diagnosis is often referred to as co-occurring disorders, and as a navigator you should know that these terms are often used interchangeably.



HOW COMMON IS A CO-OCCURRING DISORDER/DUAL DIAGNOSIS?

About a third of all people experiencing mental health disorder and about half of people living with severe mental illnesses also experience SUD. These statistics are mirrored among people with SUD, where about a third of people who use alcohol and more than half of people who use drugs report experiencing a mental illness. Men are more likely to develop a co-occurring disorder than women. Other people who have a particularly high risk of dual diagnosis include individuals of lower socioeconomic status, military veterans, and people with medical illnesses.[12]

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6.2 Support Strategies for Patients with Dual Diagnosis/Co-occurring Disorders

This section outlines your role as a navigator when working with patients who have co-occurring disorders.

BEHAVIORAL HEALTH WORKFLOW AND NAVIGATOR ROLE

There are a variety of individuals on the health care team that will work with individuals who have co-occurring disorders. Your specific role will vary depending on your hospital and your qualifications.

- Understand the roles of the health care team:
  - **Social Worker:** The social worker plays a key role in supporting patients with mental health needs. They complete mental health assessments and provide counseling.
  - **Registered Nurse:** The registered nurse is responsible for the patient's plan of care. The navigator should always consult with the nurse assigned to the patient and relay any mental health concerns.
  - **Case Manager:** The case manager navigates the patient plan of care with the care team and is a liaison for insurance.
  - **Discharge Planner:** The discharge planner assists with discharge plans for complex patients, including mental health services.

To determine the appropriate role in your institution, **ask these key questions.** Asking the social worker or registered nurse is a good place to start.

- What is the process for identifying mental health patients in your ED? (For example, the hospital may use a screening tool, such as C-SSRS or SAFE assessments.)
- What is the process for legal holds (described below) at your hospital?
- How can you best assist in referring individuals to mental health treatment or other social services?
- When is the best time to consult with a patient with dual diagnosis, after medically cleared or seen by a psychiatrist?
- In addition to the roles listed above, who else is on the health care team that supports patients with mental health disorders?
- Does your ED collaborate with outside agencies, county mental health, and local clinics?

⇒ **NOTE: Duty to report:** Working in the ED as a navigator, you must report a patient that threatens to harm themselves and/or others to the health care team.

RESPONDING TO AND SUPPORTING PATIENTS WITH SUICIDAL IDEATION AND SUBSTANCE USE

SUD is a risk factor for suicidal attempts and suicide completion. Patients may feel frustrated and hopeless, and you may be someone with whom they feel comfortable expressing these feelings. Always seek guidance from the health care team when a patient exhibits warning signs and suicidal thoughts. Consider screening patients post-overdose for suicidality. Not all overdoses are accidental.

Suicide can be intentional—a person intended to end their life—or unintentional—a person did not have the intent to harm themselves. Suicidal **ideation** means that a person is thinking about suicide. This includes:

- Passive suicidal ideation: Thoughts regarding suicide.
- Active suicidal ideation: Making a plan to end one's life.

Warning Signs and Prevention

The behaviors listed below may be some of the signs that someone is thinking about suicide.

Patients talking about:

- ❑ Wanting to die
- ❑ Great guilt or shame
- ❑ Being a burden to others

Patient feeling:

- ❑ Empty
- ❑ Hopeless or trapped
- ❑ Extremely sad
- ❑ Anxious
- ❑ Agitated or full of rage
- ❑ Unbearable emotional or physical pain

Changing behaviors, such as:

- ❑ Planning ways to die
- ❑ Withdrawing from others and saying goodbye
- ❑ Giving away important items or making a will
- ❑ Taking dangerous risks
- ❑ Having extreme mood swings
- ❑ Eating or sleeping more or less
- ❑ Using drugs or alcohol more often

Best Practices to Help a Patient Who Is Experiencing Suicidal Ideation

- Learn your hospital's process for patients experiencing suicidal ideation; refer to your social worker and nurse for guidance when given a consult.
- Provide a safe environment for the patient.
- Do not leave the patient alone.
- Ask permission from the patient to perform any interventions.
- Report to the health care team if the patient is at risk of harm to themselves or others.
- Provide resources when a patient is going home, including the National Suicide Prevention Lifeline: 988
- Provide a follow-up call after discharge and provide resources, when needed.
- Provide HOPE!

"Caring Contacts" is an evidence-based practice that has been found to decrease suicide. Providers send a short, confidential postcard, text, or phone call over the course of several months to express a caring concern for the patient's well-being. This communication is not the same as following up to see if the patient connected to services—it is simply an expression of support. You may want to consider this intervention and consult with your social service department or supervisor for guidance. Care should be taken not to send any communications that indicate the type of care a patient has received.

PATIENTS ON LEGAL HOLDS

A physician or licensed staff may place a patient on a legal hold when a person is a danger to themselves, others, or is gravely disabled/unable to care for themselves. If a patient meets these criteria, they can be placed on the following types of holds:

- **5150**: 5150 refers to Section 5150 of the Welfare and Institutions Code. This law allows a person to be involuntarily detained for a 72-hour psychiatric hospitalization. An individual on a 5150 can be held for up to 72 hours, but they do not have to be detained for the full 72-hour period. It is important to note that anyone on a legal hold has the same rights as any other patient with respect to consenting to medical care.
- **1799**: 1799 refers to Section 1799 of the Health and Safety Code. This law allows physicians and other licensed staff who provide **emergency medical care in general acute care** hospitals to detain a person for 24 hours.
- **5250**: 5250 refers to Section 5250 of the Welfare and Institutions Code. This law allows a person to be involuntarily detained for 14 days and is an extension of a 5150 hold.

Best Practices for Interactions with Patients Who are on Legal Holds and Collaboration with Other Staff

- Talk with the nurse, social worker, and/or another provider to see if the situation is safe enough for a navigator consult.
- Understand that patients may be on a legal hold, as described above, and you may see patients experience other types of restraints while in the hospital, including:
  - Physical: soft leather mittens
  - Chemical (emergency medication): pills or injection, sedation
  - Environmental: patient monitors, sitters, 1:1, bed rails
- If the patient can be stabilized on medication first, wait until stable before talking with them.
- Advocate for SUD treatment when appropriate and help teams anticipate and manage withdrawal symptoms, especially for patients who are in the ED for long periods of time:
  - Example scenario: A patient may have withdrawal symptoms that are so severe that they want to end their life, but when not in withdrawal, they don't necessarily have these thoughts of harm.
  - How you can respond: Advocate for the start of bup and then come back in an hour to see if they have stabilized.
- Even if there is no specific intervention needed, as a navigator, you can play an important role by talking to the patient, being kind, and giving HOPE!

RESPONDING TO PATIENTS IN CRISIS

Patients may come to the ED in crisis. It is important to familiarize yourself with your hospital's protocol for violent behavior and to know how to call for help. Never put yourself in danger. Always ask permission from the health care team before consulting with a patient in crisis.

> Assembly Bill 508 (AB 508) requires all hospital employees regularly assigned to emergency departments to receive training and education relating to security topics, including safety measures, aggression and violence predicting factors, and verbal and physical maneuvers to diffuse or avoid violent behavior. In your navigator role, you should receive annual training from the hospital on management of assaultive behavior. If you have not received this training, you should request it from your supervisor.

Stages of Crisis

Important concepts in the stages of crisis include:

- Stage 1: Crisis Prevention
  - Support the patient
  - Motivational interviewing (see Section 3.4)
- Stage 2: Crisis
  - Control an escalating situation/e-escalation (See section below)
  - Patient has been triggered and may resolve to violence; contact the health care team.
- Stage 3: Response
  - Alert staff/crisis prevention team
  - Physical intervention/imminent danger
- Stage 4: Post Crisis
  - Debrief (for patient and yourself)
  - Self-care

De-escalation for Agitated Patients

De-escalation is a combination of strategies and techniques to reduce any patient's agitation and aggression. By de-escalating, we can:

- Prevent violent behavior and reduce the risk of harm to patients and caregivers
- Avoid the use of restraints or seclusion
- Reduce patient anger and frustration
- Improve staff-patient connections
- Enable patients to manage their own emotions and to regain personal control
- Help patients to develop feelings of hope, security, and self-acceptance

Practical Strategies for Verbal De-escalation

During stage 2 of the crisis care, a patient may be resistant to care and begin escalating a situation. Consider these strategies as you work with a patient to verbally de-escalate:

- Respect the personal space of the individual; do not get uncomfortably close or block exits.
- Do not be provocative or respond in anger; be in control and measured.
- Ignore challenging questions.
- Establish verbal contact calmly with the individual.
- Be concise and speak in short, easy-to-understand sentences or phrases. Repeat yourself often.
- Be empathetic and nonjudgmental. Listen closely to what the person is saying.
- Identify the individual's wants and feelings, and try to accommodate reasonable requests.
- Choose wisely what you insist upon.
- Focus on feelings.
- Agree or agree to disagree with the person's concerns, while avoiding negative statements.
- Set clear limits with expected outcomes, but do not make demands or order specific behavior.
- Offer choices and optimism.
- Allow silence for reflection and decision making.
- Afterwards, review the event and look for areas of improvement.

RESPONDING TO AGGRESSION

Patients in crisis are unstable and may be argumentative, act out, or refuse treatment. STAMP is a validated tool for use in the ED to identify potentially aggressive patients:

- **S**taring and eye contact
- **T**one and volume of voice
- **A**nxiety
- **M**umbling
- **P**acing

Be aware of your own actions and remain in control:

- Focus thoughts on safety
- Be aware of your own triggers
- Regulate and control your breathing
- Try using self-talk—remain safe" or "remain calm"
- Try to relax—practice some quick physical relaxation skills, such as relaxing your hands
- Try not to personalize the person's anger or share their emotion

UNDERSTANDING TRAUMA

Trauma is an emotional response to a terrible event, such as an accident, attack, or natural disaster. Understanding that individuals with co-occurring disorders have probably experienced significant trauma is one of the first steps in providing trauma-informed care. This understanding can help you be more patient, compassionate, and nonjudgmental with patients.

What Is Trauma-informed Care?

Trauma-informed care is a patient-centered approach that helps providers understand that many physical and mental health problems come from having experienced trauma and from coping with the difficult and painful feelings that result from it.

Tips for Working with Patients Who Have Experienced Trauma:

- Reassure patients that they will be treated before asking them to do a lengthy intake.
- Ask permission first before asking about substance use or any sensitive history and give the patient permission not to answer any questions they don't want to answer. Respect the boundaries of what the patient does and does not want to share.
- Assume that patients likely have fears about EDs. Listen for and respond to fears with soothing tones and validation. Let patients know they will have more time and quiet space to share and be heard at their clinic follow-up visit.
- Thank patients for engaging, sharing, and seeking care. This shows respect, shares control, and starts building a relationship.
- Reinforce a nonpunitive approach and assure the patient that they will not be punished for sharing. Reinforce that opioid use is common and not a personal or moral failing.
- Recognize that many patients with co-occurring disorders have had traumatic experiences with health care and may feel more comfortable engaging with a peer or a navigator who shares lived experience rather than a medical provider.
- Use motivational interviewing to avoid triggering and retraumatizing the patient (see Section 3.4)

Resources

- National Institute on Drug Abuse. Talking to Patients about Health Risk Behaviors. nida.nih.gov/nidamed-medical-health-professionals/ctn-dissemination-initiative/blending-initiative-motivational-interviewing-cmece-patient-simulation/talking-patients-about-health-risk-behaviors-module.
- Substance Abuse and Mental Health Services Administration. Enhancing Motivation for Change in Substance Use Disorder Treatment. store.samhsa.gov/sites/default/files/d7/priv/tip35_final_508_compliant_-_02252020_0.pdf.
- UCLA Integrated Substance Abuse Programs. Motivational Interviewing: Engagement, Listening, and Linking Tools for Outreach and Engagement Teams. vimeo.com/136256765.
- Crisis Prevention Institute. Training Programs Designed to Make your Facility Safe for Everyone. crisisprevention.com/Who-We-Serve/Health-Care-Professionals.
- Mental Health First Aid: 8-hour comprehensive course for mental health training. mentalhealthfirstaid.org
- CA Bridge. Trainings on evidence-based treatment for substance use disorders. cabridge.org/trainings/.

6.3 Connecting Patients to Mental Health Services

As a navigator in the ED, one of your key roles is to connect patients to services after they leave the ED. While you may be the only person in the ED whose job is to connect patients to SUD services, in some hospitals there may be other people involved in connecting patients to mental health services, such as social services, case management, and discharge planning, particularly for patients with complex cases or those on legal holds.

⇒ **TIP:** Before making any referrals, you should consult with the health care team. They will help you find an appropriate role *for your hospital* in navigating patients to mental health services.

REFERRAL OPTIONS BASED ON INSURANCE COVERAGE

When referring a patient for mental health services, one of the first things you will need to do is determine their insurance status by:

- Asking the patient or family.
- Consulting with the hospital eligibility worker.
- Calling the county mental health access line.
- Assisting patients with Medi-Cal in calling the Medi-Cal Mental Health Care Ombudsman at (888) 452-8609 to find out what their managed care plan is.

For people who have Medi-Cal:

Medi-Cal patients have access to mental health services through two separate systems: Medi-Cal managed care plans and county Specialty Mental Health Services.

Medi-Cal Managed Care Plans

Medi-Cal managed care plans provide general mental health services for "mild to moderate" mental health conditions. These services can be provided by a primary care physician or other provider and might include psychotherapy, medications, or psychiatric consultation, among other services.

Navigators may need to assist patients with referrals to treatment through a managed care plan. A good place to start is to call the insurance plan to check the specific mental health services provided and to assist patients with referring to a primary care physician.

Specialty Mental Health Services

If a patient is experiencing a severe mental health condition, they may be eligible for Specialty Mental Health Services. Each county has a mental health plan that is responsible for providing or arranging for these services for people who have Medi-Cal in their county. Specialty Mental Health Services are provided by licensed mental health specialists and might include case management and psychiatrist services, among other options. Disability Rights California has more information at disabilityrightsca.org/publications/specialty-mental-health-services-through-a-county-mental-health-plan-mhp .

To assist patients with referrals for Specialty Mental Health Services, navigators should:

- Ask the patient, family, and friends if they are in a mental health program.
- Direct patients to the mental health plan for their county. You may find each county's mental health plan's contact information through the California DHCS at dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.
- Calling the number for the plan is the first step in getting a patient connected to care. When they call, patients should first verify that they are already enrolled as a beneficiary with the mental health plan. If not, the mental health plan can assist them in enrolling.

For people who have Medicare:

Medicare covers people over the age of 65 and younger people with disabilities or chronic illnesses, such as a serious mental illness. Some patients may be what is referred to as a "dual-eligible Medi-Medi patient," where they have a Medicare plan in addition to either Medi-Cal FFS or a county-specific plan.

- Assist the patient in contacting their Medicare health plan to determine what mental health services it covers. If you want to speak with someone about what Medicare covers, you can call: 1-800-Medicare (1-800-633-4227) or use the 24/7 Live Chat function at: medicare.gov/talk-to-someone.
- Individuals are not automatically enrolled in Medicare. If a patient is over the age of 65 and has not enrolled in Medicare, you can refer them to sign up at: medicare.gov/basics/get-started-with-medicare/sign-up.

For people who have private insurance:

Private insurance coverage for mental health varies.

- Always check with the treatment location and the patient's insurance before referring a patient for mental health services.
- Contact the patient's plan to get a list of contracted providers covered under their insurance plan.

For people without insurance:

Some patients may present in moments where they are uninsured or in between insurance coverage. This may be because they are moving to a new state or county, are an immigrant, or have changed employment status.

- Refer the patient to the hospital's financial counselors and/or eligibility workers who can help determine if the patient qualifies for any type of coverage.
- Consider connecting the patient directly to county mental health clinics and services. Most counties offer low-cost or no-cost services through the Department of Public Health for your city or county.

ADDITIONAL RESOURCES

Every community has different mental health resources. As a navigator, you can help your patients by becoming familiar with the places patients can turn for free services, education, or support.

- Determine whether your hospital has a resource center or a central list of referral options that you can use. Verify the resources on the list because oftentimes they are outdated.
- Check your local area for the nearest mental health crisis stabilization units. These sites provide immediate intensive mental health services to patients experiencing a mental health emergency or crisis. See Section 4.3 of this Toolkit for more tips on how to conduct a warm handoff.
- Connect with your county services, which may include telephone hotlines, community crisis teams, and referral services.

- Check for a National Alliance on Mental Illness (NAMI) chapter in your community (namica.org/). NAMI is the largest grassroots mental health organization in the country and provides services and peer and family support.
- Inform patients about the National Suicide Lifeline number 988, which can assist individuals in crisis and connect them with suicide prevention and mental health crisis counselors.
- Ask other navigators for recommendations on the CA Bridge navigator Slack channel!

COMMON MENTAL HEALTH SERVICES

Primary Care—Provides screening for mental health conditions, education on treatment options, and medications. Primary care providers will collaborate with other behavioral health care providers. Patients with mild mental health conditions may only require treatment from a primary care provider.

Inpatient Psychiatric Hospital—Provides 24-hour inpatient care for patients with mental health conditions and requires a referral from a doctor. These facilities are frequently used for patients on legal holds in need of safe, protected, and intensive therapy. These complex referrals are usually coordinated by social services or case managers. Patients can be admitted involuntarily if they are on a legal hold or voluntarily.

Partial Hospitalization or Day Hospitalization—Provides care and monitoring for a person who may be having acute psychotic symptoms without being a danger to self or others. It allows a person to return home at night and is considered less disruptive.

Crisis Stabilization Units (CSUs)—Consist of small inpatient facilities of less than 16 beds for people in a mental health crisis whose needs cannot be met safely in residential service settings. CSUs can admit on a voluntary or involuntary basis when a person needs a safe, secure environment that is less restrictive than a hospital.

Extended Observation Units (23-Hour Beds)—Can be a standalone service or embedded within a CSU. These units are designed for people who need short, intensive treatment in a safe environment that is less restrictive than a hospital.

Crisis Respite Care and Residential Services—Helps a person stabilize, resolve problems, and connect with support. Services may include physical and psychiatric assessment, daily living skills training, social activities, counseling, treatment planning, and connecting to services. Crisis residential services can be an alternative to hospitalization or a step-down setting upon leaving a hospital.

Psychotherapy—When a person speaks with a trained therapist in a safe and confidential environment to explore and understand feelings and behaviors and gain coping skills.

Peer Support—Peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Peer support workers may advocate for people in recovery, share resources and building skills, build community, and mentor those in recovery, among other possible activities.

Teletherapy and Telepsychiatry—Allows patients to receive therapy and psychiatric services via phone or video calls.

Section 7

Strengthening Community Connections

One of the qualities of successful CA Bridge programs is strong connections with the community and a good understanding of your patient population. Section 7.1 offers suggestions for gathering data and input about the needs in your community. Being able to address needs beyond MAT is a critical part of providing equitable access to care. Section 7.2 provides tools to get you started developing connections with other community providers and resources. When your program is stable and ready to serve more patients, it is time to raise awareness of your services. Section 7.3 provides tips for getting the word out in the community that SUD treatment is available to anyone 24/7 at the hospital emergency department (ED) to increase patient volume and make the hospital the cornerstone of a coordinated system of care.

SECTION CONTENTS:

7.1 Individual and Community Assessment

7.2 Building Capacity and Finding Resources

7.3 Outreach and Advocacy

All CA Bridge resources in orange can be searched by name at CA Bridge's resource directory at cabridge.org/tools/resources.

7.1 Individual and Community Assessment

To effectively address the needs of patients, navigators need a solid understanding of their patient population and the most pressing needs of those in the region. Race, ethnicity, socioeconomic demographics, transportation options, insurance coverage, and other factors influence both health and health care. Understanding these factors and how they affect access to care will help you and support successful treatment and follow-up.

LEARN FROM PEOPLE WHO USE DRUGS OR ARE IN RECOVERY

- **Talk directly with your patients** about their experiences using drugs and what would make the program work better for them. For example, what different drugs do they use, how do they use them, and what is working well or is problematic? Ask what would make ED and clinic services more welcoming. Whether it is a formal focus group or a series of informal conversations, these interactions can help you better serve people who use drugs in your community.
- **Find places where you can talk to other people who use drugs** from various segments of the community. This will differ in every community but might include shelters, homeless encampments, residential programs, syringe exchanges, or other community programs. Check with staff or service providers first to make sure that you enter these spaces appropriately and safely. Some organizations we work with include:
  - **Young People in Recovery** provides programs and advocacy to help people recover from SUD. Search for a chapter near you at youngpeopleinrecovery.org.
  - **The National Harm Reduction Coalition (NHRC)** can connect you with harm reduction programs near you to learn more about the strengths and challenges of people who use drugs but who might not be accessing your services. harmreduction.org/resource-center/harm-reduction-near-you.

EXPLORE DATA SOURCES

- **California Overdose Surveillance Dashboard**. This website provides data on opioid overdose deaths, hospitalizations, ED visits, and prescriptions at the ZIP Code level. This will help you understand the highest-risk areas in your community. skylab.cdph.ca.gov/ODdash.
- **US Census Bureau QuickFacts**. This website allows you to quickly look up the demographics of your city or county. census.gov/quickfacts/fact/table/US/PST045219.
- **Hospital Community Needs Assessment**. Nonprofit hospitals in California must complete a community needs assessment every 3 years. These assessments are not specific to SUD but may contain useful information about your community. You can get the needs assessment from the hospital's community benefit department, website, or search online at hcai.ca.gov/data-and-reports/cost-transparency/hospital-community-benefit-plans/.
- **County Public Health Departments**. Your public health department is a good source for reports and assessments to learn about community health issues such as HIV/Hep C prevalence.
- **Patient Resources**. Hospitals must provide translation services, including sign language. The hospital's patient materials can help you understand the regional patient diversity.

7.2 Building Capacity and Finding Resources

Your success as a navigator depends on having resources at your fingertips to support patients. Providing equitable access to care means assisting patients with other basic needs, that if left unaddressed, will make it hard for them to benefit from MAT. The longer you work as a navigator, the better equipped you will be to provide good patient referrals and coordinate care.

TIPS FOR GETTING STARTED

- Don't reinvent the wheel. Check first with community health, case management, social work, or discharge planning, as they will already have some resource lists.
- Identify the most common needs of patients with SUD and begin to build your resource list from there. See Section 6.1 for sources of data on community needs.
- Join your local opioid coalition to learn more about other resources. Visit the California Overdose Prevention Network (COPN) to find your local coalition: nopn.org/california/accelerator-program.
- Call or visit programs or services to see what patients will experience.
  - Introduce yourself and explain your hospital's program so that they recognize it when you refer patients.
  - Get the name of a key contact at each agency.
  - Create a patient resource list and have copies available.
  - Collect agency brochures and keep them on hand for patients.

RESOURCE LEADS

Mental Health Services. Many of your patients will need mental health services. Become familiar with the mental health clinics in your area, particularly those that specialize in treating people with co-occurring disorders.

- All counties have a behavioral health department that oversees mental health treatment and will typically list their access hotline and provider directory online. Links and phone numbers for county mental health departments can be found at dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.
- The National Alliance on Mental Illness (NAMI) supports patients and family members and has chapters all over the country. To find your local chapter, visit: nami.org.

Residential, Detox, Sober Living, Recovery Centers: Connecting with detox and sober living environments that accept MAT can facilitate patient transfer, promote patient safety, and enhance overall chances of sustained recovery.

- The DHCS certifies residential facilities and nonmedical drug and alcohol programs. For a current list of programs, visit: data.chhs.ca.gov/dataset/sud-recovery-treatment-facilities.
- Residential treatment locations within the Drug Medi-Cal Organized Delivery System (DMC-ODS) must allow patients to take MAT. More information about residential facilities can be found in the Department of Health Care Services' *MAT Toolkit for Residential Treatment Facilities* at californiamat.org/wp-content/uploads/2019/04/MAT_Toolkit_Part_Two.pdf.

Food. The Feeding America website directs you to your local food banks: feedingamerica.org/find-your-local-foodbank.

Cell Phones. Low-income Americans are eligible for the LifeLine Assistance Program, also referred to as "Obama phones." Details are provided on the California Public Utilities Commission website cpuc.ca.gov/lifeline. Options and processes vary by location. Other resources to explore for phones include managed care plans, hospital grants, and community organizations.

Transportation. Navigators should collect information on local and regional transportation options, including public transportation routes, ride-sharing partnerships, bus passes, or taxi vouchers. Look up the common health plans among your patients to see if they offer free transportation or bus services to help patients get to appointments.

Housing and Shelter. A patient's recovery is greatly facilitated by safe housing, with options including shelters, transitional and sober living facilities, women's and family shelters, domestic violence shelters, and other facilities for specific populations. Before referring a patient, check to see if MAT is allowed. The following link lists all shelters in California by county: shelterlist.com/state/california.

County Social Services. County social services departments can support patients in applying for or renewing Medi-Cal. They can also assist with obtaining an ID, veterans services, food assistance, disability, child and family resources, welfare, and employment access.

County Public Health. Contact the county public health department via phone or email to inform them of the MAT program, navigator role, and discuss services they provide. You can find your county public health department through the California Department of Public Health: cdph.ca.gov/Pages/LocalHealthServicesAndOffices.aspx#.

Harm Reduction and Syringe Exchange. If your facility does not offer a harm reduction program, find the nearest program at harmreduction.org/our-work/action/california. Find syringe exchanges at nasen.org.

Primary Care. To direct your patients to a regular source of health care, you can find community health centers near you using the "Find My Health+ Center" button at the top of the page at cpca.org/CPCA.

Post-Incarceration. The Transitions Clinic Network serves individuals returning from incarceration to the community and has a list of sites at transitionsclinic.org.

Tribal Outpatient Clinics and Programs. A variety of clinics and programs provide medical care and mental health and addiction treatment for tribal communities. Find resources near you through:

- Federal Health Program for American Indians and Alaska Natives at ihs.gov/california.
- California DHCS at dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-020-Att1.pdf.
- California Consortium for Urban Indian Health at ccuih.org/our-members.

Pregnancy: Pregnancy and the first year after childbirth are associated with an increased risk of return to use so it is useful to have resources available for these patients.

- See the California DHCS SUD Perinatal Services: dhcs.ca.gov/individuals/Pages/Perinatal-Services.aspx.
- See the National Harm Reduction Coalition's Pregnancy and Substance Use: A Harm Reduction Toolkit: harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit.
- See the Mother and Baby Substance Exposure Initiative: addictionfreeca.org/project/pregnant-and-parenting-women.
- Refer to community health centers for prenatal care: cpca.org/CPCA.
- Consult with the obstetrics/gynecology (OB/GYN) department in your hospital.

City Resources. Visit city offices by website, phone, or in-person to learn about city resources or try a web search. Some cities have community outreach meetings and may offer free substance use counseling or other services.

Faith and Community-based Organizations. These organizations may offer a variety of free services specially tailored to people in specific geographic, faith, or language communities.

WEBSITES AND HOTLINES

- **Findhelp.org** is a free directory of organizations offering food, shelter, transportation, rental assistance, and more. Search by ZIP Code at findhelp.org.
- **National Suicide Prevention Lifeline,** 988, available 24 hours a day.
- **SAMHSA's National Helpline**, 1-800-662-HELP (4357), (also known as the Treatment Referral Routing Service) or TTY: 1-800-487-4889 is a confidential, free, 24-hour-a-day, 365-day-a-year, information service, in English and Spanish, for individuals and family members facing mental health and/or SUD. This service provides referrals to local treatment facilities, support groups, and community-based organizations. Callers can also order free publications and other information.
- **Never Use Alone,** 1-800-484-3731 and 931-304-9452, provides a life-saving point of contact for people who use drugs.
- **California 2-1-1 Get Connected** makes it easy to find food, housing, job training, after-school programs, and much more.

Once you collect your best resources, don't forget to save your resource list for you and other navigators who may come after you! If you would like to help us add to this list of resources, contact us at info@cabridge.org.

7.3 Outreach and Advocacy

Creating equitable access to care requires an active approach to community outreach so that all members of the community, particularly those with high rates of SUD and the least access to care, are aware that treatment is available at your hospital 24/7.

WHEN TO START OUTREACH

Prior to broadly advertising your program to the broader community, it's important that the program be well-established and ready to serve more patients. Make sure that:

- The navigator's workload is manageable, hospital workflow is sustainable, and the navigator and clinical champion can work together on any necessary process improvements.
- There are providers trained in the low-barrier, medication first model.
- Hospital and community pharmacies have enough MAT medications in supply.
- Follow-up outpatient treatment providers have the capacity to accept more patients, and you have identified any barriers to follow up with the clinic.
- Your clinical champion or supervisor arranges a scheduled time for you to do community outreach.

WHAT TO PREPARE

As you prepare to meet with people in the community to discuss your services, your key tools will be:

- **Business cards** to pass out liberally as the cards will often get passed along to people who need help.
- **Brochures or flyers** let people know about the location and services that they can get 24/7 at the ED. CA Bridge has templates that you can adapt. Your hospital marketing department may also be able to help you.
- **Large signs** are useful for setting up a table at community events where you can display your brochures and other patient education materials.
- **Slide decks** are helpful when making more formal presentations. CA Bridge has slide presentations and templates that you can use as a starting point.

WHERE TO SHARE INFORMATION ABOUT YOUR SERVICES

Patients. One of the most effective ways of getting the word out is by word of mouth through the people you serve. Hand them a stack of your business cards and tell them to give them to others they know who want help. You should also place brochures in all waiting areas at your facility, where they are accessible to patients who have come in for other reasons.

Community Health Centers. Even health centers that offer MAT often prefer to have patients start in the hospital and will be an important source of referrals to your program. You can find community health centers near you using the "Find My Health+ Center" button at the top of the page at cpca.org/CPCA.

Emergency Medical Services (EMS). EMS sees patients in a time of medical crisis, such as overdose, acute intoxication, or severe withdrawal. Working with EMS can create a pathway for high-risk patients to access the navigator and MAT immediately after a medical crisis.

Police, Fire, and Security. Local or hospital police, firefighters, and hospital security are called when people or patients are disruptive or perceived to be a danger to self or others. Working with these personnel can promote therapeutic responses, connect people with your services, and reduce unnecessary punitive responses. First responders can also be important partners in naloxone distribution.

Harm Reduction and Syringe Exchanges. These are trusted programs that work with people who use drugs, many of whom will, at some point, want help with their use and can be referred to you.

County Social Services. Substance use is often a factor in Child Protective Services (CPS). If social workers are having difficulty getting a parent into treatment, they can refer to your program for 24/7 access. Contact County Social Services to explore sharing resources or making a presentation at a meeting of CPS staff.

Churches and Community-based Organizations. It is particularly important to reach out to organizations of, or for, populations with low access to care. These might include specific non-English speaking populations, isolated geographic regions, or populations where mistrust of medical providers is high, or fear of immigration or law enforcement makes people afraid to come to the hospital. NHRC has created a toolkit for faith communities at harmreduction.org/issues/harm-reduction-basics/spirit-of-harm-reduction-a-toolkit-for-communities-of-faith-facing-overdose/.

Food and Shelter. Shelters, food pantries, soup kitchens, and homeless encampments are all places that people struggling with substance use may turn to for help. Some navigators meet clients and pass out business cards at these locations; others meet with program directors and leave them with cards or brochures.

Local Media. Contact local papers or radio stations, including those in languages other than English, with information about your program. Stories on local media can be very effective in getting the word out.

School and Community Events. Attending events and celebrations to network and setting up a table are also great ways to meet people, show your support, and provide information about your program.

Corrections. Make contact with the local jail or prison medical director to find out how you can work with them to get people going into, or coming out of, custody started and continued on MAT. You can also connect with your local parole office, probation office, and drug court to get patients into low-barrier care as quickly as possible.

Section 8

Improving and Sustaining Your Program

Raising awareness of what you do throughout the hospital will not only increase referrals and buy-in, it is critical to the sustainability of the navigator position. The more people who understand and value the work of the navigator, the more likely the hospital is to find a way to sustain this position. Section 8.1 introduces you to data you may wish to collect to showcase success and improve your program. Section 8.2 provides suggestions for using your data and stories to raise the visibility of your work. Section 8.3 offers strategies to care for yourself while helping others. Section 8.4 covers options for certification to advance your career so you can play an increasingly important role as a champion for effective, equitable, and respectful treatment for people who use drugs.

SECTION CONTENTS:

8.1 Collecting Evaluation Data

8.2 Making Yourself Visible in the Hospital

8.3 Taking Care of Yourself

8.4 Investing in Your Future

All CA Bridge resources in orange can be searched by name at CA Bridge's resource directory at cabridge.org/tools/resources.

8.1 Collecting Evaluation Data

In your navigator role, you will be asked to document, collect, and submit data for your program. This may seem overwhelming at first, but documentation and data collection are crucial because they can validate your program's success or identify areas to improve. You can use the data to show the growth of your program or confirm the need for your position to the hospital's leadership.

Find allies in clinical leadership, administration, quality improvement, and information services (IS/IT) who can help you determine what is useful and feasible to implement. Your hospital is likely to apply for the Cal Hospital Compare Opioid Care Honor Roll, in which case the Quality Improvement Department will be interested in collecting data on your program. calhospitalcompare.org/programs/opioid-care-honor-roll.

CA Bridge offers the **Patient Intake Form** in Appendix 2.6 and several **Epic Dot Phrases for Substance Use Navigators** as tools to get you started.

SELECT METRICS

Selection of metrics and data collection should be based on a thoughtful review of the information you need to relay about your program to stakeholders, administration, and your team. As a starting point, CA Bridge recommends consideration of the following metrics:

- # of patients served by the navigator/behavioral health counselor or staff performing a similar function
- # of patient visits with bup administered or prescribed
- # of patients with OUD
- # of patient visits served with overdose diagnosis
- # of patients where the navigator facilitates a referral to follow-up mental health treatment
- # of patients discharged with a follow-up appointment with a SUD provider
- # of patients that successfully accessed follow-up care

IDENTIFY DATA SOURCES

Options for gathering data for the program include:

EHR and pharmacy reports. When possible, data collection will be the easiest and most accurate if it is pulled from the EHR and pharmacy reports.

Navigator records. If collecting data through the EHR is not an option, the navigator can manually track patients and their care outcomes using a paper or electronic spreadsheet.

Follow-up data. To collect data on follow-up, it will likely be necessary to obtain data from outside of the hospital system, either from the patient or follow-up treatment provider. To obtain follow-up information from another provider, you will need a release of information form for the patient.

Qualitative data. Patient or provider satisfaction surveys, focus groups, testimonials, or de-identified patient stories can provide valuable data for improving a program or communicating its value to others.

REPORT ON DATA

Simple summaries of your metrics will go a long way. You can calculate the average monthly volume of patients seen, average visits where MAT was provided, or the number of referrals to ongoing addiction treatment. Present your findings to fellow staff in your department or try to meet with hospital administration. It is ideal if your IT or Quality Improvement departments can help. If not, feel free to reach out to us at info@cabridge.org.

8.2 Making Yourself Visible in the Hospital

The sustainability of the navigator position is greatly enhanced by making you, the services you provide, and the outcomes you achieve visible to key stakeholders.

SIMPLE DAY-TO-DAY STRATEGIES

Build relationships. Make a point of systematically building relationships with everyone in the ED. This is important because the navigator role is often new and is not automatically understood or appreciated by other staff whose buy-in is important for long-term sustainability. Also, do not forget inpatient nurses and clinicians who can use you as a resource for referrals or consultations. You can build relationships by attending rounds, presenting at meetings, or simply introducing yourself!

Educate your hospital staff. Use our hospital education tool to train hospital operators and unit clerks. This tool is a one-page introduction to your services and contact information. Educating the staff who answer outside calls is important to promote your program. You do not want a patient to call in and get turned away from your services. The **Hospital Education** tool can be copied from Appendix 2.3.

Model collaboration. Work with your clinical champion to model a strong relationship. Other clinicians will see how the champion works with you and how this collaboration is effective and efficient for treating patients who use drugs. They, too, will come to rely on you to effectively treat patients who use drugs.

Share follow-up information. Send quick emails to providers with patient updates to let providers know their efforts paid off. Many ED providers report that making a difference with patients with OUD, for whom they previously offered no treatment, is some of the most satisfying work they do. When navigator funding is on the line, these provider voices can make a difference.

Share patient thank you letters. If patients send thank you notes or emails, share them far and wide (including to info@cabridge.org). Everyone in the ED can take credit for these successes and will feel a sense of satisfaction in this work.

PUBLIC RELATIONS EFFORTS

Working together, champions and navigators should seek out opportunities to showcase the program to key stakeholders.

⇒ **CONTACT US!** We can provide brochure templates and slide decks to get you started. info@cabridge.org.

Make presentations. Look for settings where you can present to hospital administrators, medical directors, or community members. Even if you do not have hard data, you can describe the program, how it has improved ED workflow, and share some patient cases.

Prepare flyers and brochures. Handing out simple materials describing the program and its impact gives people something to take away after a meeting.

Prepare data summaries. Generating support for the navigator position is a good reason to make data a priority. See suggestions in Section 8.1.

Write up success stories. Short summaries or quotations can be used in presentations to demonstrate the impact the navigator has made. Share stories from all angles: patients, clinicians, staff, family members, etc.

Engage your allies. In every hospital, there is usually a handful of staff who have developed a strong affinity for treating SUD and working with the navigator. Call on these people to join you in making presentations and talking to their colleagues about the importance of the navigator role.

EXAMPLES FROM YOUR COLLEAGUES

Navigator Videos

CA Bridge has a collection of professional 2-to-3-minute videos featuring navigators, patients, and clinicians talking about the human impact of the navigator. These videos are a great way to kick off a presentation or grab the interest of stakeholders who may not appreciate the importance of this work. This video collection can be accessed at youtube.com/playlist?list=PLR7AmWDc2JpIJt2BHIdNxSsOev6vpj-7k.

Navigator Success Stories

CA Bridge has created three profiles of how navigators operate in their hospitals. These can be found online at:

- **Substance Use Navigation at California Hospital**
- **Substance Use Navigation at Northern Inyo**
- **Substance Use Navigation at UC Davis**

In addition, we are always posting stories, blog posts, or news articles about navigators and hospital MAT programs. Join us at cabridge.org.

8.3 Taking Care of Yourself

Being a navigator for patients who use drugs or have co-occurring mental health conditions is a rewarding job but also one that can take a lot out of you. Taking care of yourself is crucial for sustaining your program! The stress of burnout can lead to compassion fatigue and make you feel like you do not have any options. If you burn out and leave, it may be detrimental to your program and your patients. Here are a few tips for self-care to maintain your own well-being.

WHAT DOES "BURNOUT" LOOK LIKE?

Obvious

- Exhaustion
- Physical symptoms, such as headaches or stomach issues
- Changes to your diet or sleep patterns

Subtle

- Withdrawing from activities
- Lack of interest in things you like to do
- Depression or irritability

STRATEGIES FOR SELF-CARE

- Talk to someone
- Engage in meaningful conversations
- Take some time for yourself
- Exercise
- Get more sleep
- Eat regularly
- Meditate

TAKE A MINDFUL MOMENT

- Stretch or take a 5-minute break
- Take deep breaths for 1 minute
- Reflect on a positive moment in your life
- Give a compliment to someone

8.4 Investing in Your Future

In many hospitals, no specific degree or certification is required to perform substance use navigation activities. However, obtaining a certification will increase your ability to retain your current position as a navigator, as well as to move into other roles serving patients with SUD in other agencies.

COMMUNITY HEALTH WORKER (CHW) CERTIFICATION

CHW is a new certification in California that is well-suited to the role of a navigator. CHW services include: health education, health navigation, screening and assessment, and individual support and advocacy. Services provided by CHWs are now billable through Medi-Cal. As a result, some employers may want their navigators to have a CHW certification.

The California Department of Health Care Services defines CHWs as follows:

> CHWs must have lived experience that aligns with and provides a connection between the CHW and the community or population being served. This may include, but is not limited to, lived experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background of one or more linguistic, cultural, or other groups in the community for which the CHW is providing services. Supervising providers are encouraged to work with CHWs who are familiar with and/or have experience in the geographic communities they are serving.

Initially, most navigators will be able to meet the minimum qualifications for a CHW through **work experience** if you have 2,000 hours of working as a CHW in paid or volunteer positions within the previous 3 years and your supervisor determines that you have the skills listed below.

After 18 months, you will need to complete a CHW certification that attests to demonstrated skills and/or practical training in the following areas:

- Communication
- Interpersonal and relationship building
- Service coordination and navigation
- Capacity building
- Advocacy
- Education and facilitation
- Individual and community assessment
- Professional skills and conduct
- Outreach
- Evaluation and research
- Public health principles and social determinants of health

Please visit cabridge.org or contact us at info@cabridge.org for options for CHW certification.

OTHER CERTIFICATIONS

Other certifications that may help you advance your career and open up more job opportunities include:

Certified Drug and Alcohol Counselor (CADC) is the most common certification specifically for assisting patients with SUD. Getting your CADC certification allows you to provide a wider range of services to patients and may open up more opportunities to advance your career. For information on this certification, go to dhcs.ca.gov/provgovpart/Pages/CounselorCertificationOrganizations.aspx.

Peer Recovery Support Specialists (PRSS) assist patients with SUD or behavioral health and incorporate their own lived experience to support patients. While most hospitals will not be able to bill for PRSS services, this certification may open doors for you within county-funded SUD programs. For more information on PRSS certification, go to capeercertification.org/.

CA Bridge offers continuing education units (CEUs) for our trainings through the California Association of DUI Treatment Programs (CADTP).

Contact us for more information at info@cabridge.org.

APPENDIX 1

Patient Materials

SECTION CONTENTS:

1.1 Medicines for Treating Opioid Use Disorder

1.2 Buprenorphine: What You Need to Know

1.3 Buprenorphine Extended Release: What You Need to Know

1.4 Buprenorphine Self-Start

1.5 Discharge Instructions Buprenorphine

1.6 Safe(r) Drug Use

1.7 Using Fentanyl

1.8 Prevent Overdose With Fentanyl Test Strips

1.9 How to Use Naloxone to Reverse an Overdose

1.10 Prevent and Treat Opioid Withdrawal in Your Baby

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Medicines for Treating Opioid Use Disorder:

What you need to know when choosing the best treatment for you

September 2020

Buprenorphine
(Suboxone®, Subutex®, Zubsolv®)

BENEFITS

- It is a well-studied medicine, and safe for long-term use.
- People who take buprenorphine are less likely to overdose or die than people who do not take it.
- It blocks cravings and prevents feeling "high" if you slip and use.
- It is more effective for chronic pain than methadone or naltrexone.
- It blocks withdrawal symptoms (unlike naltrexone or no medications).
- You can get to a comfortable dose in a couple of days (faster than with methadone).
- It does not produce a "high."
- Most people get it from a primary care doctor who can provide up to one month of medicine at a time—no need to go every day or go to a special clinic.
- Some people prefer the counseling and support of a methadone clinic—many clinics now also offer buprenorphine at the window.
- Safely used by patients who have employee health screens or on parole.
- It is covered by most health insurance programs.

CAUTIONS

- Side effects are rare AND less severe and less frequent than other opioids. All opioids can cause trouble sleeping, nausea, headaches, or overdose if mixed with other drugs.
- Some AA/NA groups, treatment programs, and police/judges may not support this.
- Usually, you should be in some withdrawal before you take the first dose.
- Stopping buprenorphine often is done slowly and with support of medical team.

Methadone

BENEFITS

- It is a well-studied medicine that is safe for long-term use.
- People who take methadone are less likely to overdose or to die than people who do not take it.
- It blocks cravings and prevents feeling "high" if you slip and use.
- It helps with chronic pain, but less than buprenorphine.
- It blocks withdrawal symptoms (unlike naltrexone or no medications) and may take longer to get to a comfortable dose than buprenorphine.
- It does not produce a "high" if taken at the right dose.
- Methadone users are less likely than those who don't take it to relapse, get HIV, or go to prison.
- Methadone clinics offer counseling and case management support.
- You do not need to go into withdrawal before starting it.
- It is covered by most health insurance programs.

CAUTIONS

- Side effects may include sleepiness (if dose is too high), constipation, or dangerous heart rhythms—these can be prevented by working with your medical team.
- If you take too much or mix with other drugs, you can overdose.
- It can only be taken by going to a methadone clinic frequently.
- Stopping methadone must be done slowly and with support of medical team.

Naltrexone
(Vivitrol®)

BENEFITS

- It blocks opioid and alcohol cravings and stops you from feeling high if you use opioids.
- You only need to get the shot once a month.
- It is not an opioid and does not cause withdrawal symptoms if you stop taking it.
- Even though studies show buprenorphine and methadone are as helpful, some AA/NA groups, treatment programs, and police/judges may prefer naltrexone.

CAUTIONS

- You are more likely to relapse and overdose in comparison to results from buprenorphine or methadone.
- Upon the first injection, if you have opioids in your system you will likely go into withdrawal. You must go through detox first and not use for 1-2 weeks.
- It can be very hard to start. Unlike methadone and buprenorphine, it does not help with withdrawal symptoms and can cause withdrawal for up to 2 weeks if taken too soon.
- It does not help with chronic pain.
- It can be expensive and hard to get; many insurance plans do not pay or only cover it after a long process.
- Your tolerance goes down when you don't take any opioid medicine. That means if you return to using, you may have a bigger risk of dying than if you took methadone or buprenorphine.
- If you need emergency surgery or have sudden bad pain, opioids will not work well.

No Medication

BENEFITS

- Some patients prefer to be off all medicines, even when there is a higher risk of relapse and overdose.
- Medication side effects are avoided. The side effect of no medication is increased risk of relapse and overdose death.

CAUTIONS

- You are much more likely to relapse, overdose, and die in comparison to results from buprenorphine or methadone.
- Cravings and withdrawal are not controlled when you are not taking medicines, and if you slip and use it can be much harder to stop.
- Your tolerance goes down when you don't take any opioid medicine. That means if you return to using, you have a bigger risk of dying than if you took methadone or buprenorphine.
- Because of increased risk of overdose death without medication, you should have naloxone rescue kit at home for your safety.

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More resources available
CABridge.org

Buprenorphine

What You Need to Know

September 2020

What is buprenorphine?

- Buprenorphine - or bup - is medicine for people who have chronic pain or addiction to opioids (heroin or pain pills). Many people know it by brand names like Suboxone® and Subutex®.
- Buprenorphine helps get rid of cravings and withdrawal, without making you feel high.
- People have less overdoses when they take buprenorphine.
  It is a safe medicine that has been used for 30 years.
- It is not substituting one drug for another—it is a daily medicine that you may need to stay healthy.
- Often buprenorphine and naloxone are taken together in 1 pill. Naloxone is the same as Narcan®, but if you take the medicine under the tongue the naloxone doesn't go in your body and can't make you sick. Naloxone is only there to make sure that people don't crush the pill and inject it—if you do that, the naloxone does go into your body and does make you sick.

What is it like to take buprenorphine?

- Many people say that their cravings and withdrawal go away, they feel "clear in the head," and their chronic pain gets better.
- Every morning you put a pill or a film strip under your tongue and let it dissolve—don't swallow it.
- People need to take it every day in most cases, and do feel sick if they stop taking it suddenly.
- Usually there are no side effects, but some people have headaches, stomach upset, or trouble sleeping.
- Many people keep taking it for years, or forever. If you want to stop taking it that is ok, but talk to your medical team first.
- The chance of an overdose on buprenorphine is very low, but if mixed with other drugs or alcohol overdose is possible.
- Some people take buprenorphine as a once a month shot under the skin of the belly. This is a great option if taking a medicine every day is hard for you.

Is buprenorphine right for me?

- If you are currently taking methadone, talk to your medical team before switching.
- Before taking the first dose of buprenorphine, most people need to feel some withdrawal. That is important because if you take it while other opioids are in your system, you can get very sick.
- **Talk to your medical team to see if buprenorphine is a good medicine for you.** There are many good choices for treatment, only you and your team know what is best for you.

How do I get buprenorphine?

- **You can go to any of the places below to get started.** You may need to visit more than once before getting the first dose. In some clinics (like methadone clinics), you may come in every day to pick up your buprenorphine dose.
- Instead of going to a methadone clinic, you can get the medicine from a **primary care doctor**. At first you may need daily visits, but many people can soon switch to weekly or monthly visits.
- Some **telemedicine groups** offer prescriptions over the internet/phone instead of in a doctor's office, so you need a phone and internet to use those services.

Provider—Please write in other options such as inpatient, medical respite, primary care, etc. as applicable to this patient.

Name of Organization			
Address			
Phone			
Hours			

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More resources available CABridge.org

Buprenorphine Extended Release (BUP-XR)

What You Need to Know

September 2020

What is BUP-XR?

- Sometimes referred to as "the shot", BUP-XR is pure buprenorphine (no naloxone) in liquid form and injecting it just under the skin (like a TB test).
- The buprenorphine stays there and turns into a solid that gradually releases the medication for about 4 weeks.
- We usually choose a spot under the skin of your belly around your belly button.
- Afterwards some people can feel a little lump about the size of a small cough drop under the skin. It's OK for a variety of body sizes.
- BUP-XR has been used all over the world by thousands of patients. It is very safe. It is fully covered by MediCal.

What are the side effects to BUP-XR?

- The side effects are similar to regular buprenorphine strips or tablets.
- If it is too strong for you, you will feel headache, nausea, dizziness.
- If it is too weak for you, you will have continued cravings for opioids.
- Some people get itch and pain at the site of the injection, or are bothered by the lump.

Is BUP-XR right for me?

- It depends on your body and goals.
- It is usually best for people who have felt good on 8-24 mg of buprenorphine a day.
- You may like it if you don't like taking pills/strips every day, or have trouble keeping track of your medicines.
- We have seen it work really well for people with light habits like someone taking 4-5 Norco 10's per day and really heavy habits, like someone using fentanyl. If you aren't up for an injection (it does burn), it may not be right for you.

How do I get BUP-XR?

- You will need to be stable on sublingual buprenorphine before starting BUP-XR.
- Talk to your sublingual buprenorphine prescriber about BUP-XR.
- Your healthcare provider may want to follow up a week after the injection to see how you are doing.
- Plan to return once a month for the BUP-XR injection.

Provider—Please write in other options such as inpatient, medical respite, primary care, etc. as applicable to this patient.

Name of Organization				
Address				
Phone				
Hours				

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More resources available CABridge.org

Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

- Plan to take a day off and have a place to rest.
- Stop using and wait until you feel very sick from withdrawals (at least 12 hours is best, if using fentanyl it may take a few days).
- Dose one or two 8mg tablets or strips UNDER your tongue (total dose of 8-16mg).
- Repeat dose (another 8mg-16mg) in an hour to feel well.
- The next day, take 16-32mg (2-4 tablets or films) at one time.

If you have started bup before:

- If it went well, that's great! Just do that again.
- If it was difficult, talk with your care team to figure out what happened and find ways to make it better this time. You may need a different dosing plan than what is listed here.

If you have never started bup before:

- Gather your support team and if possible take a "day off."
- You are going to want space to rest. Don't drive.
- Using cocaine, meth, alcohol or pills makes starting bup harder, and mixing in alcohol or benzos can be dangerous.

Place dose under your tongue (sublingual).

If you have a light habit: *(For example, 5 "Norco 10's" a day)*

- Consider a low dose: start with 4mg and stop at 8mg total.
- **WARNING:** Withdrawal will continue if you don't take enough bup.

If you have a heavy habit: *(For example, injecting 2g heroin a day or smoking 1g fentanyl a day)*

- Consider a high dose: start with a first dose of 16mg.
- For most people, the effects of bup max out at around 24-32mg.
- **WARNING:** Too much bup can make you feel sick and sleepy.

Not going well? Have questions? Contact your Navigator for help!

Call or text your Navigator for help at _____

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Buprenorphine Discharge Instructions

While you were in the hospital, you had withdrawal from opioids. We started you on a medication called Buprenorphine (brand names include Suboxone or Subutex).

MEDICATION: Buprenorphine

Buprenorphine ('bup' or 'bupe') helps stop withdrawal symptoms and cravings for opioids.

We are prescribing you this medication to take for the next few days while you get further assistance at one of our local Medication for Addiction Treatment or "MAT" clinics where you will see a provider that can help you continue this medication.

It is very important that you seek follow-up with a provider that can write for buprenorphine AS SOON AS POSSIBLE so you do not run out of your medication!

FOLLOW UP CLINICS

Follow up with any of the local MAT clinics we work with.
Please call or go to the clinic tomorrow morning; tell them that you were in the hospital and received bup.

Name of Clinic	
Location (Address)	
Hours (Days/Times)	
Phone number to schedule an appointment	

Name of Clinic	
Location (Address)	
Hours (Days/Times)	
Phone number to schedule an appointment	

TRANSPORTATION OPTIONS TO YOUR CLINIC VISITS

If you are concerned about getting transportation to your appointments, you can call LogistiCare for transportation services covered by your insurance provider. This information may vary from county to county.

To determine additional coverage in your area: ***www.logisticare.com/reservation-numbers-location-map***

- Blue Shield Health Plan – 866.290.9662
- Anthem Blue Cross Health Plan – 877.931.4755
- Health Net Cal Medi-Connect – 866.799.4465
- Health Net Medi-Cal Health Plan – 855.253.6863
- All other Health Plans – 877.440.7433

BOWEL MEDICATION

When you are on an opioid medication like buprenorphine, a very common side effect is constipation. Please start taking an over the counter Stool Softener – like Docusate Sodium (common brand is Colace) 100mg twice a day every day to help keep you from getting constipated. If you do not have a bowel movement in over 24-48 hours, try an over the counter laxative like Miralax, Dulcolax, Milk of Magnesia, or Magnesium Citrate. Talk to the pharmacist about these medications and for help picking the best one for you.

WHEN TO COME BACK TO THE ER/Hospital

Return to the emergency department with any other concerns like fever or severe pain, if you get sicker, or if you have any other emergencies.

REMEMBER - We are here for you!

Remember -- we are **always** here for you! We wish you the best of luck with your treatment! If you use opioids or other drugs in the future, have withdrawal, or need help - we are here for you!
You can come to the ED 24/7 any day if you need to be restarted on buprenorphine.

If you have questions or concerns, call our Substance Use Navigator:

Name of Substance Use Navigator	
Phone	
Hours (Days/Times)	

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More resources available CABridge.org

SAFE(R) DRUG USE

WAYS PEOPLE USE DRUGS

Smoking

Using a pipe, stem, or bong. Make sure everyone has their own pipe or mouthpiece. If you are smoking crack, use a filter.

Snorting

Crush powder as fine as possible & make sure everyone has their own straw. Alternate nostrils between hits.

Swallowing

Pills, crushed in thin paper, or a drink. Mix your own drink so you know how strong it is. Can take up to an hour to kick in so wait a while before consuming more.

Booty Bumping

Use a turkey baster or syringe without a needle. Avoid sharing equipment and get vaccinated for Hep A.

Injecting

Use your own sterile syringes & gear. If you need to reuse syringes, wash with cold water, bleach, &then water again.

BENEFITS OF INJECTING DRUGS

- Very efficient way to use - drugs are absorbed directly into the bloodstream. This can lead to a more intense & longer high.
- Can be more economically efficient - folks may need less drugs compared to smoking or snorting, which saves money.

RISKS OF INJECTING DRUGS

- Criminalization of injection paraphernalia.
- If sharing equipment, HIV/Hep C transmission.
- Higher rates of overdose & overdose related death for people injecting drugs compared to smoking or snorting.
- Skin and soft tissue infections, such as abscess and other bacterial infections - some can be fatal.

SAFER INJECTION TIPS

#1 | Prepare Yourself

- Find a safe, clean, well-lit area
- Clean hands or fingertips with soap & water or an alcohol pad
- Wipe injection area with alcohol pad in one direction

#2 | Prepare Solution

- Using your own clean cooker or spoon, mix drugs with sterile water; heat (add Vitamin C if necessary)
- Add a filter (piece of cotton ball or pellet, AVOID cigarette filters) using clean fingertips
- Insert tip of syringe into filter and pull up solution

#3 | Find A Vein

- Body heat can help veins be more accessible - find a warm place or bundle up!
- Use a tourniquet a few inches above the injection site to help the vein plump up (avoid using shoestrings or leather belts)
- Insert the needle bevel up into the vein.

#4 | Register Your Shot

- Before injecting, pull back slightly on the syringe to check for dark red blood (this means you hit a vein).
- If the blood is bright red, frothy, &
- pushes back the plunger, you hit an artery, take the syringe out immediately and seek medical advice!
- After registering, release tourniquet before injecting.

#5 | Do A Test Shot

- Inject a little bit of drug solution to "taste" and test strength & effect before injecting more from that syringe
- This can help prevent overdose.

#6 | Inject & Tidy Up

- Once you finish injecting, dispose of used syringe in a sharps container.

There are many reasons why people cannot adopt all these steps. If you can use as many of these as possible regularly, it will dramatically reduce harm. Even using just one reduces harm - celebrate small steps/any positive change!

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FOR MORE RESOURCES, VISIT HARMREDUCTION.ORG

/HarmReductionCoalition /HarmReductionCoalition @harmreduction @harmreduction

NATIONAL HARM REDUCTION COALITION

SKIN & SOFT TISSUE INFECTIONS (SSTI)

What are SSTI's?

- Skin and soft tissue infections (or SSTIs) are bacterial infections such as abscesses, cotton fever, and endocarditis.
- For people who inject drugs, they can be caused by improperly cleaned skin, a missed shot, non-sterile injection equipment, or contaminated drugs.
- It's critical to provide both the equipment & safer injection education to promote the safest possible injection every time.

Signs of an SSTI

- Bad odor or smell
- Affected area getting bigger
- Redness around edges
- Swelling
- Tenderness
- Thick pus
- Fever/chills
- Pain or loss of feeling

When someone presents with a wound that is causing them pain or other distress our first recommendation is ALWAYS they see a medical professional for diagnosis & treatment. Even if you are 99.9% sure something is wrong only a medical professional can give a diagnosis.

HOW TO MANAGE SSTI'S

- Symptoms might not always appear at the injection site.
- If you miss a shot, apply ICE or frozen item (peas, snow, cold drink) on the same day & elevate. If swelling occurs the next day, apply HEAT regularly using a cloth soaked in hot water, in a sink of warm water, or using a hand warmer.
- Avoid injection at or below the affected area.
- Do not squeeze or poke an abscess. This can introduce more bacteria to the wound.
- If things don't improve after 3 days, or if you are experiencing chills, fever, extreme fatigue or pain on the abscess, SEEK MEDICAL ATTENTION. This may be a blood infection which could be deadly.

HOW TO AVOID SSTI'S

- Clean skin prior to injection, including injection site & fingertips.
- Use sterile equipment including syringes, cookers, & cottons.
- Use safe injection techniques (see front) to avoid missed shots & vein injury.
- Cover injection site with a band aid to prevent bacteria from entering.

PROVIDER TIPS

Ask & Listen:

Your participants are the experts! They can tell you what they know, what they need, what's working, & what's not.

Research:

There are plenty of resources out there to help you.

Provide Options:

Cater to a range of ways that people take their drugs by offering a variety of safer use/sex options.

Celebrate Small Steps:

Celebrate small steps: Affirm any positive change!

RESOURCES

National Harm Reduction Coaltion:
harmreduction.org

Exchange Supplies:
exchangesupplies.org

Safety Works:
1800safety2.com

Injecting Advice:
injectingadvice.com

Tips:
harmreduction.tips

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FOR MORE RESOURCES, VISIT HARMREDUCTION.ORG

/HarmReductionCoalition /HarmReductionCoalition @harmreduction @harmreduction

NATIONAL HARM REDUCTION COALITION

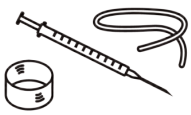
Using Fentanyl?

Here are some tips from people who use fentanyl on how to stay safe and prevent overdose!

Fentanyl is a very strong synthetic opioid. It's often described as 80 - 100 times stronger than morphine and 60 times stronger than heroin, but like any street drug, how strong something is also depends on your tolerance and the cut you're purchasing.

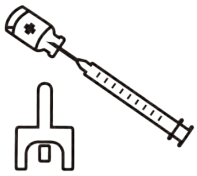
The same harm reduction practices that decrease your overdose risk when using heroin, other opioids, and other drugs will work for fentanyl and its analogues, too!

Narcan/naloxone works on fentanyl overdoses, but you should act fast. As soon as someone stops breathing, administer Narcan and start rescue breathing. One dose every two minutes, combined with rescuing breathing, will work!



Using alone means there's nobody there to respond if you go out, so make sure to be extra careful and double down on your other safety strategies when using alone, or have someone check on you!

Know the signs of an overdose and carry Narcan, no matter what drug you're using. If using in a group, make sure at least one person stays alert and has Narcan.



Fentanyl acts fast, so using **slowly** allows your body to adjust and gives you time to understand how it will hit you. Be mindful that the initial high can feel very intense, followed feeling more lucid—that doesn't mean the fentanyl has left your system, so "re-dosing" right away could lead to an overdose.

Because fentanyl is so strong, the margin of error is much smaller when it comes to overdose. Using less to start can help you gauge an appropriate dose for you!

Test your drugs so you can make the most educated decisions possible.

Try snorting or smoking instead of injecting. Injecting carries the highest risk for overdose, so shifting to snorting or smoking may help reduce risk. You can still overdose by smoking/snorting, especially with fentanyl, so start slow/use less to start!

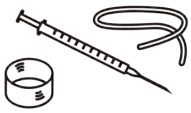
¿Consume fentanilo?

A continuación, le ofrecemos algunos consejos de personas que consumen fentanilo sobre cómo mantenerse seguro y evitar una sobredosis.

El fentanilo es un potente opioide sintético. Con frecuencia, se dice que es entre 80 y 100 veces más potente que la morfina, y 60 veces más potente con la heroína, pero, al igual que las drogas ilegales, esto depende de la tolerancia que usted tenga y de la pueza de la droga que adquiera.

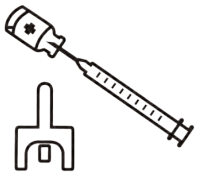
Las mismas prácticas de reducción de los riesgos que se usan para disminuir el riesgo de sobredosis de heroína, otros opioides u otras drogas también funcionarán para el fentanilo y sus análogos.

Puede usar Narcan (naloxona) para las sobredosis de fentanilo, pero debe actuar rápidamente. Al instante que la persona deje de respirar, adminístrele Narcan y comience la respiración de rescate. Con una dosis cada dos inuros, combinada con la respiración de rescate, logrará reanimar a la persona.



Si consume drogas solo, no habrá nadie para socorrerlo si pierde el conocimiento. Por lo tanto, debe ser más cuidadoso y extremar sus otras estrategias de seguridad en esos casos, o pedirle a alguien que lo controle.

Conozca las señales de sobredosis y siempre lleve Narcan, no importa qué droga consuma. Si consume en grupo, asegúrese de que una persona esté alerta y tenga Narcan.



El fentanilo actúa rápido, por lo que consumirlo lentamente le permite al cuerpo adaptarse y le da tiempo a usted para que perciba cómo la afectará. Tenga en cuenta que el primer efecto puede ser muy intenso, seguido de un período más lúcido, lo cual no significa que es el fentanilo haya dejado el organizmo; por eso, tomar otra dosis enseguida podría provocar una sobredosis.

Dado que el fentanilo es tan potente, el margen de error en el caso de una sobredosis es mucho menor. Consumir menos en un principio puede ayudarlo a encontrar la dosis adecuada.

Hacer una prueba de sus drogas para poder tomar una decisión informada.

Pruebe aspirar o fumar en lugar de inyectarse. Inyectarse implica el mayor riesgo de sobredosis; por eso, aspirar o fumar puede ayudar a reducir ese riesgo. También es posible que tenga una sobredosis por aspirar o fumar, especialmente con fentanilo, por lo que debería comenzar lentamente o consumir menos al principio.

Prevent Overdose With Fentanyl Test Strips

Test your drugs for fentanyl to lower overdose risk. Make sure you know what is going in your body.

Fentanyl is common in drugs across California, and fentanyl overdoses are increasing. Fentanyl is a much stronger opioid than heroin and raises the chance of overdose. Sometimes, fentanyl is sold as fentanyl. Other times, it is mixed into drugs like coke, crack, heroin, or pressed pills. It is impossible to tell if there is fentanyl in a drug by its look, smell, feel, or taste.

General Precautions

Always take these steps when using drugs, regardless of if you think there is fentanyl in your drugs.

- Have naloxone with you
- Use with a buddy who can call 911 and give naloxone
- Take turns in case someone overdoses
- Start with a much smaller than normal dose to test the strength. Wait before using more.
- If you can't use with a buddy, call Never Use Alone (800) 484-3731. A stigma-free operator will stay on the line and call 911 if you stop responding.

If you use fentanyl on purpose: Using with a buddy and naloxone can help you stay safe. Fentanyl is very strong and it's hard to get the dose you want. If you plan to use fentanyl, be extra careful and follow the general precautions above.

If you don't use fentanyl on purpose: Testing your drugs can help you stay safe. Follow the general precautions above.

- **If results are positive:** We recommend not using the drugs. The test can not tell you how much fentanyl is in the drugs.
- **If results are negative:** Fentanyl test strips aren't perfect. Always assume your drugs may have fentanyl or other strong drugs in them.

Choosing How to Test Your Drugs

- **More safe:** Dissolve all of the drugs and test the liquid. Heat and stirring help dissolve. Adding Vitamin C to crack cocaine will help it dissolve. After testing, inject or drink the liquid.
- **Less safe:** Testing only drug residue in the baggie, on the cooker, or part of a pill. The test might be negative, even if there is fentanyl, because it does not mix evenly in pills or powder.
- **For meth or ecstasy:** Dissolve about 5 mg of meth or ecstasy in at least 6mL of water (see image for Option 1 below). If test is positive, add another 1 tsp (5mL) of water to dissolved drugs and test again.

1. Prepare Supply

Option 1: Testing your full supply

- It is ideal to test all of your drugs. If you can't do that and are testing powder, use 5mg as illustrated.
- Crush the pill or rock into a powder.
- Put about 5 mg of the powder into a cooker (about the amount needed to cover half of Abe Lincoln's hair on a penny).
- Add 1 tsp (5mL) of clean water to the cooker and stir well.

Option 2: Testing residue or part of a pill or rock

- Crush part of the pill or rock into a powder (skip if you are testing residue).
- Put the powder into a cooker.
- Add 1 tsp (5 mL) of clean water to the cooker and stir well.

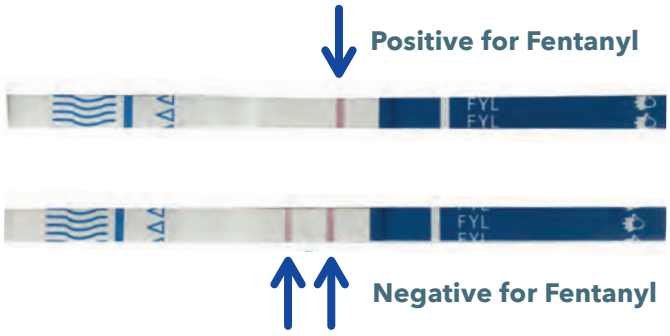
2. Test Supply

Hold the solid blue end of the strip and dip the wavy line end of the test strip in the water for 15 seconds.

3. Wait

Set the strip on a flat, non-absorbent surface. Wait for 2 minutes until lines show up in the middle.

4. Read Results



Fentanyl test trip. Los Angeles Blade website. Accessed January 2022. losangelesblade.com/2019/04/25/fentanyl-kills-in-45-seconds/fentanyl-test-strip/#respond

Read your test results and refer to page 1 for safety steps.
One red line = Positive for fentanyl.
Two red lines (no matter how faint) = Negative for fentanyl. Use Caution.
No red lines = Test error/invalid test. Redo test with a new strip.
The top red line (closest to the solid blue) should always show up on the strip. If it doesn't, the test is invalid. Redo test with a new strip. Do not use a test strip more than once.

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PATIENT MATERIALS

Naloxone

How to Use Naloxone to Reverse an Overdose

What is naloxone?

Naloxone, also known as its brand name Narcan®, is a medication that rapidly reverses opioid overdose. Overdose occurs when the level of opioids, or a combination of opioids and other drugs or alcohol, in the body causes a person to become unresponsive or slows/stops their breathing. Naloxone has a stronger attraction to opioid receptors in the brain and will kick off opioids that are present. This allows a person to breathe again and reverse the overdose.

Naloxone is a ***temporary drug*** that wears off in 30-90 minutes. This means that for 90 minutes after someone is given naloxone, they won't be able to get high and they could overdose again once Naloxone wears off. If the person decides to use again it is suggested to use a lower dose than previously used. Go low and slow to avoid another overdose.

When should you give naloxone?

Naloxone is administered when a person shows signs of an opioid overdose that could cause severe injury or death if not treated. Administer the first dose following instructions on the following page. Wait two minutes, if the person is still not responding give a second dose in the opposite nostril.

Typical signs of an overdose:

- Unconsciousness
- Small or pinpoint pupils
- Weak or ineffective breathing
- Gurgling/throat sounds
- Vomiting
- Pale skin including blue lips
- Snoring

Less common signs of overdose:

- Muscle spasms
- Locking limbs
- Rigid or wooden chest
- Chest/death rattle

What happens after you've given naloxone?

If the person experienced an opioid overdose, the naloxone should have restored their breathing and helped them regain consciousness. They may still feel altered, agitated, or feel like they are in withdrawal. If one dose/plunger of naloxone does not work, you may need to use an additional one and call 911 for emergency services, stay with the person until emergency services arrive. Replace any used naloxone with new doses.

How do I prevent another overdose?

Always take these steps when using drugs to reduce the risk of overdose:

- Have naloxone with you
- Use with a buddy who can call 911 and give naloxone
- Take turns in case someone overdoses
- Start with a much smaller than normal dose to test the strength. Wait before using more.
- If you can't use with a buddy, call Never Use Alone (800) 484-3731. A stigma-free operator will stay on the line and call 911 if you stop responding.

Treatment with buprenorphine or methadone decreases the risk of overdose. Buprenorphine will treat opioid withdrawal and prevent overdose. If you're still feeling the effects of withdrawal, go to the emergency department. Emergency department staff is trained to help you feel better.

References

1. *NIDA. Naloxone DrugFacts. National Institute on Drug Abuse website. https://www.drugabuse.gov/publications/drugfacts/naloxone. June 1, 2021 Accessed June 3, 2021.*
2. *National Harm Reduction Coalition website. Guide to Developing and Managing Overdose Prevention and Take home Naloxone Projects. https://harmreduction.org/issues/overdose-prevention/developing-overdose-prevention-and-naloxone-projects/basics/. August 31, 2020. Accessed June 7, 2021.*

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EMERGENCY RESPONSE

FOR OPIOID OVERDOSE WITH NASAL NALOXONE

CA BRIDGE

1 TRY TO WAKE THE PERSON UP

- Shake them and shout.
- If no response, grind your knuckles into their breast bone for 5 to 10 seconds.
- Tell them you will give them naloxone if they don't respond.

2 CALL 911

If you report an overdose, California State Good Samaritan Law protects you and the overdosed person from being charged with drug possession.

3 ADMINISTER NASAL NALOXONE

- Remove naloxone nasal spray from the package. Hold with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.
- Tilt the person's head back and provide support under the neck with your hand. Gently insert the tip of the nozzle into either nostril, until your fingers touch the person's nose.
- Press the plunger firmly to release the dose.
- If still not conscious after 2-3 minutes, repeat in the other nostril with a new device.

4 CHECK FOR BREATHING

If they are not breathing, CPR or rescue breathing is optional but encouraged.

Give CPR if you have been trained or do rescue breathing:

- Tilt the head back, open the mouth, and pinch the nose.
- Start with 2 breaths into the mouth. Then 1 breath every 5 seconds.
- Continue until help arrives.

5 STAY WITH THE PERSON

- Naloxone wears off in 30 to 90 minutes.
- When the person wakes up, explain what happened.
- If you have to leave, move the person on their side to prevent choking.

March 2022

More resources available cabridge.org

Prevent & Treat Opioid Withdrawal in Your Baby

Developed in collaboration with UCSF

August 2020

Here are three ways you can begin to care for your baby:

Eat	Sleep	Soothe
Breastfeed your baby. Breastmilk will ease your baby's withdrawal symptoms. A small amount of opioid may be in the breast milk, but not enough to harm your baby. **Feed your baby on demand.** Watch for your baby's hunger cues and supply milk to your baby whenever needed.	**Swaddle your baby.** Being swaddled can help your baby feel secure. **Dim lights.** Your baby is used to the darkness in your belly.	**Skin to skin.** Place your naked baby (with a diaper) on your naked chest. Other trusted adults can hold your baby if you're tired or sleepy. **Rock your baby.** Gentle movement can calm your baby.

You are your baby's biggest comfort to get through withdrawal.

How will my baby react to withdrawal?

After birth, your baby will no longer be getting the opioid in your blood supply. This may cause your baby to have withdrawal symptoms that may affect eating, sleeping and fussiness.

Caring for your baby in the neonatal intensive care unit (NICU)

Our nursery team will be checking in on your baby every few hours for signs of withdrawal. You can remind doctors and nurses to check your baby when he/she is awake and come back later if your baby is sleeping. Even if you are doing all you can to keep your baby comfortable, your baby may still need medication and stay in the nursery for additional care. You are welcome to spend as much time as you like in the nursery with them to provide comfort.

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More resources available CABridge.org

APPENDIX 2

Additional Tools and Resources

SECTION CONTENTS:

2.1 FAQ about SUNs

2.2 SUN and Champion Collaboration

2.3 Hospital Education Tool

2.4 Frequently Asked Questions: Buprenorphine

2.5 Sign Templates

2.6 Patient Intake Form

2.7 Options for Ongoing Treatment After Hospital Starts

2.8 California MAT Telehealth Providers

2.9 Substance Use Navigators and Prescriptions

2.10 Buprenorphine and Pharmacy FAQ

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FREQUENTLY ASKED QUESTIONS

Substance Use Navigator (SUN)

What is a substance use navigator (SUN)?

A SUN is a care coordinator and an integral team member working to improve access to treatment for substance use disorder (SUD) within the context of the California Bridge Program (CA Bridge) model. The SUN is embedded within either an emergency department or an inpatient setting to assist patients with SUDs, including patients who have been started on buprenorphine treatment for opioid use disorder (OUD).

SUNs conduct initial brief assessments, introduce patients to treatment programs, including programs that provide medications for addiction treatment (MAT), expedite appointments at MAT-capable clinics, serve as the primary coach for their clients, and maintain ongoing contact with their panel. They also assist with access to other services such as financial counseling, primary care, mental health services, social services, and residential treatment facilities.

SUNs are the link to the community. They outreach to treatment partners and facilitate transitions from the hospital to outpatient treatment. SUNs also provide a link to organizations and individuals seeking treatment.

A SUN is sometimes known as Treatment Navigator, Treatment Coordinator, Medication for Opioid Use Disorder Navigator Navigator, MAT Navigator, Patient Navigator, Linkage Coordinator, Care Coordinator, etc.

What credentials should the SUN have?

There is no specific degree, certification, or training requirement to be successful as a SUN within the CA Bridge model; intensive training and individualized technical assistance to SUNs are integrated throughout the course of the program. The SUN may have a designation such as certified drug and alcohol counselor or licensed clinical social worker, though the most important requirement is that they are nonjudgmental, energetic, and positive. A sample job description is available on the CA Bridge website (resources listed below).

Who employs the SUN?

The SUN can be employed by a hospital, health system, staffing group or clinic that provides MAT as a 1099 contract worker, full-time or part-time employee or per diem.

Who supervises the SUN at my health care facility?

The SUN can be supervised in a number of ways. Possible models include:

- A nurse manager acts as direct manager and manages activities such as hiring and administrative duties; ED or inpatient champion co-supervises day-to-day activities.
- A staffing group manages activities such as hiring and administrative duties; County Department of Public Health MAT program manager provides day to day supervision e.g. San Mateo Behavioral Health & Recovery Services Integrated Medication Assisted Treatment (IMAT).
- In the case that a clinical team already has embedded staff in the ED, grant funding is used to add staff & hours to provide full coverage embedded service.
- The SUN can be embedded into an existing team such as case management or social work.

November 2020

What training should the hospital provide to SUNs receiving support from the CA Bridge program?

The SUN should participate in site-specific training to onboard with their health care facility, including orientation with the hospital, EMR, safety/infection control procedures (ie PPE), and other training as required for new personnel. In addition to site-specific training, education on the scientific model of addiction treatment, harm reduction, motivational interviewing, and trauma informed care are essential to providing the level of support necessary to patients with substance use disorders. (See resources listed at the end of this document).

All SUNs participate in an ongoing and intensive training program with the CA Bridge team. SUNs are offered a comprehensive set of trainings and materials that include in-person instruction throughout the course of the SUN Training Series and coaching calls with CA Bridge subject matter experts.

What are some legal considerations for SUNs?

SUNs offer an array of general treatments services and need to follow HIPAA and hospital specific compliance. Some hospitals have mistakenly interpreted 42 CFR as a barrier to providing MAT in the ED. ED programs are a part of general medical care and do not fall under 42 CFR Part 2 which guarantees confidentiality for people seeking treatment for substance use disorders from federally assisted programs. More information on 42 CFR Part 2 is available through the Substance Abuse and Mental Health Services (SAMHSA) Disclosure of Substance Use Disorders and 42 CFR Part 2 Revisions.

What should a new SUN do first?

SUNs will need to connect with their clinical champion and with other site resources such as case management and social services before beginning patient interaction activities. SUNs are expected to adapt and guide culture change at their site. SUNs should work with the CA Bridge program regional director assigned to their site for personalized guidance.

What supplies will a SUN need to operate?

The SUN will need a cell phone with service provided by the health care facility. They will also need access to their health system EMR.

Is this person expected to travel within the community surrounding their site?

Yes. The role of the SUN is to connect patients with community resources and to link them from the hospital. This will involve SUNs to travel to community partners in order to form ongoing relationships. SUNs may be eligible for travel cost reimbursement based on the policies of their site. SUNs will receive significant training to help them identify the most important stakeholders in their community to support their work.

How do SUNs track the patients they see?

SUNs should track patient encounters as this data is important to illustrate trends and quality improvement insights. Each site can tailor how they keep track of their patients. We recommend a referral system for the SUN to follow up with patients seen in the hospital after hours and on weekends. Some options include a secure message line, a shared patient list in the EHR, or secured physical list in the ED.

How do I recruit a SUN for my site?

There are many organizations that can help identify an exceptional candidate for this role. Your regional coordinator also may be able to advise on resources for your organization. Some resources to consider include:

- Harm Reduction Coalition
- California Opioid Safety Network
- Mentoring In Medicine and Science
- Local MAT clinic, FQHCs, Departments of Public Health etc.

- Patient Care Navigators, Scribes, Case Managers, Community Outreach Workers, Health Coaches, etc can be trained into the role
- Local CADC/CDAC/CATC (Certified Alcohol and Drug Counselor/Certified Drug and Alcohol Counselor/Certified Addiction Treatment Counselor) training programs (as long as training is based on the medical model, evidence based, & supportive of MAT as opposed to training and approach based on the social model or abstinence-based model)

What options are there for paying for a SUN?

Generally if a SUN is not a licensed mental health provider or a certified drug and alcohol counselor, their services are not reimbursable under Medi-Cal. Several funding opportunities have been opening up to support activities in California related to increasing access to treatment including Sierra Health Foundation, and Department of Health Care Services (DHCS) California MAT Expansion Project, among others. While hospital-based navigators or counselors can support hospital-based buprenorphine starts, they are not required in order to begin prescribing buprenorphine for OUD.

Will a SUN save my health system money?

Most likely. Research has proven the cost-effectiveness of screening, brief intervention and referral to treatment[2] with some variability based on patient and SUN characteristics. More analysis on this topic is underway.[3]

RESOURCES

California Department of Health Care Services (DHCS) MAT Expansion Project californiamat.org
California Opioid Safety Network californiaopioidsafetynetwork.org
Harm Reduction Coalition harmreduction.org
Mentoring In Medicine and Science mimscience.org
Sierra Health Foundation MAT Access Points mataccesspoints.org

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1. Belfort, R., Manatt, A., Phelps & Phillips, undefined, & Dworkowitz, undefined. (2018). *Overcoming Data-Sharing Challenges in the Opioid Epidemic: Integrating Substance Use Disorder Treatment in Primary Care*. *Overcoming Data-Sharing Challenges in the Opioid Epidemic: Integrating Substance Use Disorder Treatment in Primary Care*. California Health Care Foundation. Retrieved from https://www.chcf.org/wp-content/uploads/2018/07/OvercomingDataSharingChallengesOpioid.pdfCalifornia
2. Clemans-Cope, L., Benatar, S., Epstein, M., & Holla, N. (2018). *Potential Cost Savings Associated with Providing Screening, Brief Intervention, and Referral to Treatment for Substance Use Disorder in Emergency Departments.* Retrieved from https://www.urban.org/sites/default/files/publication/98535/2001854-_potential_cost_savings_associated_with_sbirt_in_emergency_departments_rapid_review_finalized_1.pdf
3. Alla J., Collins D., Englander H., Gregg J., Gullickson D.J., Nicolaidis C., Patten A. (2019). "If It Wasn't for Him, I Wouldn't Have Talked to Them": Qualitative Study of Addiction Peer Mentorship in the Hospital. *J Gen Intern Med*. doi: doi: 10.1007/s11606-019-05311-0. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/31512181

CA Bridge disseminates resources developed by an interdisciplinary team based on published evidence and medical expertise. These resources are not a substitute for clinical judgment or medical advice. Adherence to the guidance in these resources will not ensure successful patient treatments. Current best practices may change. Providers are responsible for assessing the care and needs of individual patients.

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GUIDE

SUN & Clinician Champion Collaboration

Strong collaboration between a clinician champion and a substance use navigator (SUN) is essential to the development and sustainability of a successful and effective MAT program. Champions will greatly enhance the effectiveness of the SUN by actively supporting them and modeling a strong relationship with the SUN so that other clinicians can see how this position can assist with effective treatment for patients who use drugs. The recommended standard work below was developed by experienced champions who have established successful programs and can be performed with a limited time commitment.

IDENTIFYING A CLINICIAN CHAMPION

A clinician champion is usually identified as a first step in developing an MAT program. This person may be self-selected or recruited by leadership. The most successful clinician champion is someone with a special interest in establishing and continuing to drive evidence-based and patient-centered treatment for people who use drugs. Without the support of an engaged leader, a new SUN will have difficulty defining their role and integrating effectively into the ED.

ONBOARDING A SUN TO YOUR HOSPITAL

1. **Hiring:** The champion should participate in the SUN selection process. This could be as simple as providing the *SUN Job Description* to the administration responsible for hiring or joining the selection and interview process.
2. **Supervision:** The champion should play a role in determining the appropriate department for the SUN position within the organization and the most effective supervisory structure. To best set the SUN up for success, the champion should work with the SUN's direct supervisor to ensure that role expectations are clear.
3. **Orientation:** The champion should orient the SUN to the hospital, and introduce them to staff in the ED, hospital, administration, and leadership. This orientation is crucial to quickly integrate any SUN into the team. It is helpful to create a comprehensive list of hospital information and processes the SUN will need to learn about in order to be effective as a member of the hospital team, such as workspace, computer access, cell phone, business cards, and orientation to the electronic medical record (EMR). A tool like a scavenger hunt can be helpful for a SUN to learn more about the ED and hospital within the first few days on the job. (See *CA Bridge Scavenger Hunt for SUNs*).
4. **Workflow Development:** The champion supports the SUN's integration into the workflows of the ED and hospital. This includes the development of a process for contact with the SUN and an expectation of a daily workflow in support of achieving your hospital's programmatic goals. This may be done in collaboration with the SUN's supervisor and home department.
5. **EMR Access:** The clinician champion should take responsibility for facilitating that the SUN has access to a computer and EMR. The SUN's work is effective with appropriate access to the ED tracking board, the ability to receive electronic referrals and emails through the EMR, the ability to chart in the EMR, as well as the ability to have access to data and reports.
6. **Communication:**

   For referrals: Together the champion and SUN must establish a system for referrals for patients from the ED and hospital. Ideally, it is easy for clinicians to initiate the referral and easy for the SUN to access the patient's referral information. This referral process should be widely communicated to ED and hospital clinicians. If possible, initiate referrals using the EMR so that referrals and follow-up care are easily tracked and reported.

   For SUN-champion work: In addition to any project team or workgroup meetings, SUN and champion must develop the method, frequency, and expectations for SUN-champion check-ins (i.e., phone call, email, text, daily, weekly). Regular communication such as weekly meetings between SUN and Champion is important to work through barriers and issues, especially as the workflow is being established.

ONGOING COLLABORATION BETWEEN THE SUN AND CLINICIAN CHAMPION

Check-ins: Establish daily to weekly check-ins. This will vary depending on volume and role expectations. Agenda topics may include referral process, community outreach, engaging MAT patients, successes, and navigation of challenges.

Meetings: Establish SUN involvement in hospital and ED meetings. This is crucial to introduce the SUN to important stakeholders and integrate the position into expected ED and hospital resources.

Other departments: Engage other hospital departments (hospitalists, OB, social work, etc) and discuss meeting with other department leaders as a team. It is helpful to attend other department meetings to introduce the SUN and answer questions about the role since it is a new role to many hospitals.

Data: Review ED and hospital data with the entire team on a monthly basis. Refer to the CA Bridge *Substance Use Navigation toolkit* for tips on meaningful measures to track. Setting expectations for data analysis, analogous to hospital sepsis and stroke data, is helpful to analyze engagement and barriers to treatment in real-time. The SUN should play a key role in data collection and analysis.

Community outreach: Work together to outreach to community coalitions, organizations, and leaders. It is recommended to have the SUN engage in outreach to community resources in order to make a broad array of resources available to patients and to build relationships that facilitate successful referrals. The hospital's Community Health Department, or equivalent, may be helpful with initial outreach.

Other champions: Develop other champions within the department so the SUN has a community of support. This could be accomplished by establishing multi-disciplinary workgroup meetings that include different stakeholders. Recommended department champions may include OB, hospitalist, surgical specialties including trauma, pediatrics, toxicology, cardiology, and any outpatient bridge clinic partners.

CHAMPION ADVOCACY AND SUPPORT TO ADDRESS BARRIERS

Like any new program, the SUN and MAT program may encounter barriers, and as a program focused on substance use, these barriers may stem from stigma and discrimination against people who use drugs. It is very important for the champion to advocate for the SUN and to create a strong support network to educate and influence decision-makers.

The champion should anticipate advocating and providing support to address barriers to care including (but not limited to):

- Working with the pharmacy, administrative support, clinic referrals, and addressing discrimination throughout the hospital. This may include phone calls and/or meetings to work through any concerns that arise.
- Supporting the posting of program signage, sharing SUN business cards, and engaging in any efforts that increase community visibility of treatment access. Signage and visibility of the SUN program invites patient comfort in revealing a historically stigmatizing condition and has been more effective than universal screening.
- Community outreach, site visits, and increasing knowledge of the hospital's MAT program across the community.

DEVELOP A PLAN FOR ADDITIONAL EDUCATION AND SUPPORT

It is helpful to share successes and lessons learned so that the SUN and champion are able to move a program forward in alignment. Attend conferences or presentations together whenever possible.

1. Collaborate on a professional development plan for ongoing education or certification. There are Peer Support Specialist and Substance Use Counselor certification programs, SBIRT, motivational interviewing, and crucial conversations courses may be helpful for ongoing professional development.
2. Ensure the SUN is engaged with the CA Bridge SUN support network. CA Bridge program offers resources, coaching, and networking available to SUNs at all stages of establishing this role.

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Hospital Education

Do you know about the Medication for Addiction Treatment (MAT) program in the Emergency Department (ED)?

Your hospital received a grant to combat the national opioid crisis. That means anyone can come into your ED, 24/7, and request MAT. Patients should be able to access evidence-based treatment, such as buprenorphine for opioid use disorder. This low-barrier, rapid treatment reduces harm and saves lives. But we need your help to get them this vital treatment in the ED. Thank you for being part of the solution!

What can you do for patients calling for help?

When a patient calls and asks for help with substance use, you can direct them to the ED for treatment, 24/7. Patients may also ask about the CA Bridge program, MAT services, or a navigator who works in the ED in conjunction and should be referred to during normal business hours.

Contact your navigator for more information

An important part of this life-changing program is the role of the navigator embedded in your ED. Navigators are instrumental in assisting patients with all substance use disorders.

Navigator name:

[insert name]

Navigator phone number:

[insert number]

[office hours]

[after hours]

FREQUENTLY ASKED QUESTIONS

Buprenorphine

BUPRENORPHINE PHARMACOLOGY

What is buprenorphine?

Buprenorphine or 'bup' is a schedule III opioid medication. It is an effective medication for opioid use disorder and for pain. The most common formulations are sublingual as mono-product (i.e. Subutex) or in combination with naloxone (ie. Suboxone). It can also be transdermal for pain (ie. Butrans), intravenous for pain (Buprenex), buccal for pain (Belbuca), transmucosal or subcutaneous for opioid use disorder (Sublocade)[1].

OPIOID USE DISORDER			
PRODUCT NAME/ACTIVE INGREDIENT	**ROUTE OF ADMINISTRATION/FORM**	**AVAILABLE STRENGTHS**	**RECOMMENDED ONCE-DAILY MAINTENANCE DOSE**
Bunavail • Buprenorphine hydrochloride • Naloxone hydrochloride	Buccal film	2.1 mg/0.3 mg 4.2 mg/0.7 mg	**Target:** 8.4 mg/ 1.4 mg **Range:** 2.1 mg/0.3 mg to 12.6 mg/2.1 mg
Generic combination product • Buprenorphine hydrochloride • Naloxone hydrochloride	Sublingual tablet	2 mg/0.5 mg	**Target:** 16 mg/ 4 mg **Range:** 4 mg/1 mg to 24 mg/6 mg
Generic monoproduct • Buprenorphine hydrochloride	Sublingual tablet	2 mg 8 mg	**Target:** 16 mg **Range:** 4 mg to 24 mg
Suboxone • Buprenorphine hydrochloride • Naloxone hydrochloride	Sublingual film	2 mg/0.5 mg 4 mg/1 mg 8 mg/2 mg 12 mg/3 mg	**Target:** 16 mg/4 mg **Range:** 4 mg/1 mg to 24 mg/6 mg
Zubsolv • Buprenorphine hydrochloride • Naloxone hydrochloride	Sublingual tablet	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	**Target:** 11.4 mg/2.9 mg **Range:** 2.9 mg/0.71 mg to 17.2 mg/4.2 mg
Sublocade	Subcutaneous depot injection	Start with 300 mg	**Range:** 100 to 300 mg/month

CHRONIC PAIN		
PRODUCT NAME/ACTIVE INGREDIENT	**ROUTE OF ADMINISTRATION/FORM**	**AVAILABLE STRENGTHS**
Butrans	Transdermal patch	5 cmg 7 mcg 10 mcg 20 mcg
Belbuca	Buccal film	75mcg 150mcg 300mcg 450 mcg 600 mcg 750 mcg 900 mcg

What is the difference between buprenorphine and Suboxone®?

Suboxone is a brand name for a combination of buprenorphine and naloxone. The naloxone component is a deterrent that becomes inert when the tablet is taken sublingually; the naloxone is only active if the tablet is injected or snorted.[1]

I'm caring for a patient taking buprenorphine/naloxone, but we only have the buprenorphine mono-product (or vice-versa) at my institution, can I substitute?

Yes. Naloxone is added to deter injection of buprenorphine. While mono-products are not considered "A" rated (therapeutically bioequivalent) by the FDA and cannot be interchanged by an outpatient pharmacy without a prescriber order, they can be considered clinically similar at equivalent dosages and frequencies. Continuation of a patient's buprenorphine therapy should not be withheld due to lack of availability of a specific product as long as an equivalent dose is available.[1]

How long does buprenorphine take to act and when does it peak?

Sublingual buprenorphine takes 15 minutes to act when held under the tongue and peaks in one hour. A typical 0.3mg IV buprenorphine begins to work immediately after an IV push with peak effect in 5-10 minutes.[2]

Is buprenorphine safe?

Rates of adverse events following home or hospital emergency department initiation of buprenorphine are very low. Because buprenorphine has a "ceiling" effect at usual doses with opioid receptor agonism, it has a very low rate of respiratory depression or overdose. Case reports of overdose have occurred, usually when buprenorphine is co administered IV with large amounts of alcohol or benzodiazepines. It is recommended to caution patients about the risks of taking both benzodiazepines or alcohol with buprenorphine, but it is not a contraindication. A more common risk is precipitated withdrawal if too large of a dose of buprenorphine is given too soon after taking a full opioid agonist – this is uncomfortable but not life-threatening.[1,3,4]

Are there contraindications for buprenorphine?

If a patient who is physically dependent on opioids takes a high dose of buprenorphine when they have opioids in their system, the buprenorphine will rapidly block the effects of their opioid causing what is termed "precipitated withdrawal."

The severity of this effect varies from mild discomfort to severe distress. This is why there is a washout period for opioid-tolerant patients before starting buprenorphine unless doses are very low.[1,4,5]

How does a clinician give buprenorphine?

Buprenorphine tablets or films should be administered sublingually. IV formulations can also be used in some situations. If buprenorphine tablets or films are swallowed, very little medicine gets absorbed. No observation is required. Transdermal buprenorphine will generally be too weak to prevent withdrawal symptoms and is best used for patients with chronic pain.

A Cochrane Analysis reported no difference in adverse event rates with buprenorphine compared to non-opioid treatments for managing opioid withdrawal.[1,5]

How long do people use buprenorphine?

It depends.

Buprenorphine can be used for medically assisted withdrawal (detox) from opioids, however, this is not recommended as relapse potential is very high. The goal of the medication is for long-term therapy for opioid use disorder. However, it can take multiple tries before a patient is stable on buprenorphine.

A positive experience with buprenorphine can be a motivation to come back or to pursue long-term treatment after a return to use. The evidence is clear: the more weeks of stability on buprenorphine that a person with opioid use disorder achieves, the more their mortality risk goes down. Once a patient has stabilized on buprenorphine, they should be continued on it indefinitely. When patients stop their maintenance buprenorphine or methadone, the all-cause mortality more than doubles. The neural architecture of the brain is changed by addiction and it takes years to recover. When patients are in recovery they develop whole new patterns of behavior, stress response, and reward-seeking that then gets "hardwired" into the brain.[6,7]

Is there a need for an Alpha 2 agonist such as Clonidine?

Adjunct medications such as clonidine, ondansetron, and loperamide can be helpful in some cases to treat the symptoms of opioid withdrawal. It is not required. We avoid routine use of benzodiazepines.[4,6]

MEDICATIONS FOR OPIOID USE DISORDER (MOUD) IN THE HOSPITAL

What forms of buprenorphine should we have on the formulary?

At a minimum, sublingual tablet formulations of buprenorphine should be available to be administered and/or prescribed from the ED. Consider adding intravenous, and sublingual films or sublingual combination buprenorphine-naloxone.

When do you administer buprenorphine in acute care?

Starting buprenorphine when patients have moderate withdrawal symptoms (COWS >8 or at least one objective sign) provides immediate relief. Do NOT start bup on opioid-dependent patients who are not in withdrawal. For these patients, the buprenorphine causes withdrawal and decreases patients' desire to stay on buprenorphine or to try buprenorphine again. In general, a patient will need to wait ≥12 hours after short-acting opioids, ≥24 hours after a long-acting opioid, and ≥48-72 hours after methadone use. In some cases, very low dose buprenorphine (generally <2 mg) can be used even when a patient has not yet entered withdrawal.[1,4,8]

These cases are complex, consider consulting an experienced provider before your first transition of this type:

In California: For immediate assistance, the California Substance Use Line at 1-844-326-2626 is a free, confidential, 24/7 teleconsultation service for California clinicians. This line is staffed by experienced physicians, pharmacists, and nurses to provide evidence-based guidance on substance use evaluation and management for opioids, alcohol, sedatives, stimulants, and other substances and includes medications for substance use disorder treatment.

Nationally: For assistance, Monday through Friday, 9 a.m. and 8 p.m ET, the Clinical Consultation Center Substance Use Warmline at (855) 300-3595 offers free and confidential clinician-to-clinician telephone consultation focusing on substance use evaluation and management for primary care clinicians. Consultation is available from addiction medicine-certified physicians, clinical pharmacists, and nurses with special expertise in pharmacotherapy options for opioid use. Voicemail is available 24-hours a day.

How does a clinician give buprenorphine in acute care?

A streamlined approach for starting a patient on buprenorphine is available on the CA Bridge program website (see CA Bridge *Buprenorphine Quick Start Protocol*).

How should a patient be discharged?

Always offer a naloxone prescription or kit in hand prior to discharge. You can sign up to receive and dispense free naloxone kits through the Department of Health Care Services Free Naloxone Distribution Program.

- Option 1. No DEA X waiver: It is legal in all states to offer return ED visits for bup administration for 3 days in a row if necessary until the patient can follow up with an x-waivered provider. Consider providing a loading dose of bup (up to 32 mg total) prior to discharge for longer effect if the patient has close follow up (ie. 1-3 days) with an x-waivered provider. Detox is not recommended. Can provide comfort meds (e.g. clonidine, loperamide, ondansetron, NSAIDS) if needed.
- Option 2. DEA X waiver: Give bridge script to last until outpatient visit: e.g., 8mg Suboxone, SL tabs; Take 1 tab under the tongue twice a day for withdrawal symptoms; Dispense #6-14. Usual dose bup 16-24mg/day.

What licensing do I need to prescribe buprenorphine or methadone for an inpatient, either as a new start or as an initiation?

No additional licensing is required to prescribe buprenorphine or methadone for patients in the hospital who are admitted with a primary medical problem other than opioid dependency. This is true even for patients who have not previously started to take buprenorphine or methadone. However, to write a discharge prescription for BUP, the provider will need an x-waiver a.k.a DATA 2000 waiver.

What if the patient does not have a primary medical problem separate from opioid dependency or is not admitted?

Even in cases where a patient does not have a primary medical problem, buprenorphine or methadone may be administered for up to 72 hours. Most often, this comes up when a patient presents to the ED in withdrawal but does not need admission, or when an admitted patient has been discharged and has a short wait before they can be seen in an outpatient clinic. Buprenorphine or methadone can be administered without registration as a narcotic treatment program under Title 21, Code of Federal Regulations, Part 1306.07(b)[1]

I want to continue methadone for a patient stabilized on an outpatient dose, what steps should I take?

It is recommended to continue a patient's methadone therapy during their inpatient hospitalization whenever possible. The last dose amount and date should be confirmed with the patient's opioid treatment program upon admission prior to starting the methadone.[10]

What if I cannot confirm a patient's outpatient methadone dose?

If a patient has evidence of opioid use disorder and presents with opioid withdrawal symptoms, but their outpatient methadone clinic cannot be reached to confirm a dose, they should be treated as a new methadone start. Give methadone per the guidelines, and call the methadone clinic as early as possible to confirm the date and amount of their last dose. See CA Bridge *Methadone Hospital Quick Start*.

I want to continue buprenorphine for a patient stabilized on an outpatient dose, what steps should I take?

A call to the patient's pharmacy or checking CURES can help confirm that a patient is prescribed buprenorphine and at what dose. Please also confirm with the patient directly that they have been taking it as prescribed. If they have not been consistently taking the medication and have used other opioids, treat this as a new start, and follow the guidelines.

MOUD IN MEDICALLY COMPLEX PATIENTS

What if the patient has pain or will have surgery?

Continue their outpatient dose! Home buprenorphine or methadone can be split TID or QID to improve pain control, and additional non-opioid and opioid analgesics should be used. See guidelines.If the patient is on buprenorphine, receiving additional opioids will not put them at risk for precipitated withdrawal.[11]

My patient has renal impairment, can I continue/start buprenorphine, buprenorphine/naloxone or methadone?

Yes, neither buprenorphine, naloxone nor methadone are renally cleared to a clinically significant degree.

My patient has hepatic impairment, can I continue/start buprenorphine, buprenorphine/naloxone or methadone?

Both buprenorphine and naloxone are hepatically metabolized. However, it has not been shown to be clinically significant, even in patients with elevated transaminitis. Consider caution in patients with acute hepatitis with severe transaminitis, however, in most cases of liver disease (including Hep C) buprenorphine can be used safely.

The manufacturer of methadone does not provide guidance on dose adjustment in liver impairment. However, because methadone is metabolized by the liver, the half-life may be prolonged in moderate to severe liver impairment and dose reductions may be required.

If my patient is on buprenorphine, will opioid analgesics cause withdrawal or be ineffective for pain?

Although this is a common concern among patients on buprenorphine therapy, if a patient is currently taking buprenorphine, addition of a full opioid agonist does not precipitate withdrawal. Once a patient has been taking buprenorphine, they may add opioid agonists while continuing buprenorphine without risking precipitated withdrawal with their next dose of buprenorphine.[8]

How long do I need to observe a patient prior to discharge after a dose of buprenorphine?

Multiple studies have confirmed the safety and efficacy of home buprenorphine starts or unobserved starts. Low doses of buprenorphine should not cause respiratory depression in patients with known opioid tolerance. Monitoring following dosing inpatient or in the emergency department is only necessary for ensuring that the dose improved withdrawal, for about one hour.[11,12,13,14]

What should I know about buprenorphine and mental health?

Buprenorphine has been associated with insomnia and manic symptoms in patients with bipolar disorder. It has some antidepressant effects.[8]

REFERRALS TO ONGOING CARE FOLLOWING MAT STARTS FROM ACUTE CARE

What should I have in place prior to discharging a patient who has been started on buprenorphine or methadone?

Because a discharge prescription will likely be needed, it is helpful to have one or more prescribers with a DATA 2000 x-waiver available during day shifts to prescribe buprenorphine until the patient can see an outpatient x-waivered provider. If you do not have providers with x-waivers, either have the patient return for subsequent doses for 72 hours, administer a higher longer acting dose, or ensure next-day follow-up.

Until a routine relationship is established with a local provider or clinic, it is recommended to call a local buprenorphine prescriber (see SAMHSA Buprenorphine Practitioner Locator) before buprenorphine starts to arrange an appointment for the patient. Ideally, this appointment will be within 3 days of discharge.

Similarly, for methadone it is important to call an outpatient methadone clinic prior as soon as possible to arrange for follow up. Physicians outside of these programs cannot prescribe methadone for addiction, therefore discharge prescriptions cannot be written by hospital providers.[1,4,9]

What if there are not many outpatient buprenorphine or methadone prescribers in my community?

This is a challenge in many communities and is an incentive to have more providers be waivered. You can obtain your x-waiver for free with an online training at PCSS.

As more providers are receiving their x-waivers, there are more communities where buprenorphine is easier to access outpatient than methadone, therefore may be a better choice logistically. In California, the Hub and Spoke System will be supporting local providers ("spokes") in prescribing buprenorphine through close partnerships with expert "hubs."

You can use the SAMHSA Buprenorphine Practitioner Locator to locate providers with X waivers in your community and reach out to see if they would be able to accept your patients. If no providers are available in your community at this point, options like Groups, Project Echo, and telemedicine prescribing such as through Bright Heart Health or WorkIt Health, among others, may be good options for building local capacity.

FEDERAL REGULATIONS

What licensing do I need to prescribe buprenorphine or methadone for an inpatient, either as a new start or as an initiation?

Title 21, Code of Federal Regulations, Part 1306.07(b)[9]

72 Hour Rule[15]

(Title 21, Code of Federal Regulations, Part 1306.07(b), allows a practitioner who is not separately registered as a narcotic treatment program or certified as a "waivered DATA 2000 physician," to administer (but not prescribe) narcotic drugs to a patient for the purpose of relieving acute withdrawal symptoms while arranging for the patient's referral for treatment, under the following conditions: 1) not more than one day's medication may be administered or given to a patient at one time 2) this treatment may not be carried out for more than 72 hours and 3) this 72 hour period cannot be renewed or extended.

PART 1306 — PRESCRIPTIONS

GENERAL INFORMATION

§1306.07 Administering or dispensing of narcotic drugs.

(a) A practitioner may administer or dispense directly (but not prescribe) a narcotic drug listed in any schedule to a narcotic dependant person for the purpose of maintenance or detoxification treatment if the practitioner meets both of the following conditions:

(1) The practitioner is separately registered with DEA as a narcotic treatment program.

(2) The practitioner is in compliance with DEA regulations regarding treatment qualifications, security, records, and unsupervised use of the drugs pursuant to the Act.

(b) Nothing in this section shall prohibit a physician who is not specifically registered to conduct a narcotic treatment program from administering (but not prescribing) narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. Not more than one day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three days and may not be renewed or extended.

(c) This section is not intended to impose any limitations on a physician or authorized hospital staff to administer or dispense narcotic drugs in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction or to administer or dispense narcotic drugs to persons with intractable pain in which no relief or cure is possible or none has been found after reasonable efforts.

(d) A practitioner may administer or dispense (including prescribe) any Schedule III, IV, or V narcotic drug approved by the Food and Drug Administration specifically for use in maintenance or detoxification treatment to a narcotic dependent person if the practitioner complies with the requirements of §1301.28 of this chapter.

RESOURCES

Clinical Consultation Center nccc.ucsf.edu/clinical-resources/substance-use-resources

California Department of Healthcare Services Free Naloxone Distribution Program www.dhcs.ca.gov/individuals/Pages/Naloxone_Distribution_Project.aspx

SAMHSA Buprenorphine Practitioner Locator tinyurl.com/mtyjtm5

Providers Clinical Support System (PCSS) Free Online Training pcssnow.org/medication-assisted-treatment

California Hub and Spoke System www.uclaisap.org/ca-hubandspoke

Groups - Recover Together joingroups.com

Project ECHO echo.unm.edu

BrightHeart Health www.brightheartheath.com

WorkIt Health www.workithealth.com

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CA Bridge disseminates resources developed by an interdisciplinary team based on published evidence and medical expertise. These resources are not a substitute for clinical judgment or medical advice. Adherence to the guidance in these resources will not ensure successful patient treatments. Current best practices may change. Providers are responsible for assessing the care and needs of individual patients.

Documents are periodically updated to reflect the most recent evidence-based research. Materials provided through CA Bridge may be utilized for the sole purpose of providing information for the treatment of substance use disorders. Such materials may be distributed with proper attribution from the California Department of Health Care Services, Public Health Institute, CA Bridge Program. Questions may be submitted via email to info@CABridge.org

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Need Help With Pain Pills or Heroin?

Ask us about trying buprenorphine

CA BRIDGE

TOOL

Patient Intake Tool

This Patient Intake Form is designed to guide substance use navigators (SUNs) through conversations with patients and collect information along the way. The tool is meant to be adapted to fit the needs of your hospital and community. Ensure you are familiar with HIPAA regulations and standards of privacy at your hospital. Also, ensure that any information remains private and is stored in a HIPAA compliant manner.

The tool is organized into two sections in order to adapt to different types of patient encounters.

1. **The most important information a SUN will need to assist a patient:**
    - Always, especially if time is limited, ensure a reliable way to contact the patient and ensure their fundamental needs are met.
    - Obtain basic information: name, birthday, phone number
    - Identify the reason for the visit as well as the specifics of any referral that was made.
    - *At a minimum:* Grab a patient sticker and confirm cell phone/contact information.
        - Most of this information can be captured in the EMR or active patient chart.

2. **Additional information for more advanced support.**
    - This section is a deeper dive into the patient's history, and not generally required to be collected but will better help you understand the patient and facilitate care. The more you know, the more you can help.
    - SUNs should use judgment and discretion based on the needs and characteristics of the patient.
    - Many points will already be captured in conversation, other information may already be in the EHR.
    - Utilize any existing clinical experience as a SUN and focus on patient-centered care. This will yield responses to much of this information.
    - Additional needs related to other health conditions may be the most difficult to "capture" because of the sensitivity of these topics.
        - If your hospital does not allow for the SUN to ask anything related to any of these topics, please follow your specific site protocol.
        - Some of this information may be obtained from the patient's medical history in the EHR.
        - Use your best clinical judgment as a SUN to ensure the patient feels most comfortable if any of these questions are asked.

Patient Intake Tool for Bridge to SUD Care: Patient info and staying in touch

DATE: MRN:

NAME:

DOB:

PH#

Gender: ❑ Male ❑ Female
❑ Transgender MTF ❑ Transgender FTM
❑ Gender non Binary ❑ Declined to Answer

Race/Ethnicity:
❑ White ❑ Black/African American
❑ Hispanic/Latinx ❑ Native American/American Indian
❑ Asian/Pacific Islander ❑ Other/mixed

Who initially identified pt with SUD?:
❑ ED Clinician ❑ Inpatient Clinician ❑ EMS
❑ SUN or other staff (nurse, registration, social worker, etc.)

SUN made contact during initial ED/IP visit? ❑ Yes ❑ No
If no, reason: ❑ After hours referral ❑ SUN unavailable
❑ other_____

Insurance Status: *Did they need help with insurance* ❑ *Yes* ❑ *No*
❑ Private ❑ Kaiser
❑ Medi-Cal ❑ Medicare
❑ Military (e.g.Tricare, VA) ❑ Indian Health Service
❑ Unknown ❑ No insurance

Housing status: *"Where are you going to sleep tonight?"*
❑ Housed (apartment/house)
❑ Marginally housed (e.g. couchsurfing, motel, boarding house)
❑ Shelter
❑ Street or vehicle
❑ Sobering center/ Detox Facility (e.g. Cherry Hill)
❑ Sober living environment/halfway house
❑ In custody/Incarcerated
❑ Other:_____

Resources offered? ❑ Yes ❑ No

Accepted referral to treatment?
❑ No *If no, reason*_____
❑ Yes *If yes, plan for follow-up treatment:*
❑ Primary care based clinic
❑ OTP (methadone or buprenorphine)
❑ Addiction specialty clinic
❑ Street program
❑ Bridge Clinic
If in custody:
❑ MAT available and will be continued
❑ MAT unavailable, plan to resume MAT after release (patient notified bup prescriptions valid for 6 months)

Reason for ED/IP visit or hospitalization: *Check all that apply*
OPIOID-RELATED:
❑ Opioid withdrawal
❑ Recent Opioid Use/ "High"
❑ Opioid overdose
❑ Seeking detox or addiction treatment (MAT):
❑ MAT start ❑ MAT restart ❑ MAT lapse prevention
❑ Other opioid use related reason:
❑ abscess, ❑ cellulitis, ❑ endocarditis, ❑ osteomyelitis,
❑ seeking opioid pain med refill ❑ Other:_____

OTHER SUBSTANCE-RELATED:
❑ Meth/crystal/ cocaine/crack
❑ Alcohol use disorder
❑ Other substance _____

NON-OPIOID RELATED REASON:
❑ Appendicitis, trauma, stroke, et):
❑ Unknown
❑ Other: _____

Past complications to drug use
❑ Abscesses/Skin infections
❑ Spinal abscesses
❑ blood infection
❑ bone infection (osteomyelitis)
❑ heart infection (endocarditis)
❑ brain infection (meningitis)

Did they receive Buprenorphine today? ❑ Yes. ❑ No
If yes, where: ❑ ED ❑ Inpatient ❑ EMS **Total mg:** _____
If no, reason: ❑ Too soon ❑ Methadone ❑ Intoxicated
❑ Altered or too sick ❑ Clinician declined_____

BUP/SUBOXONE prescribed?
Daily dose: _____ mg
Other meds:_____

Pharmacy ph#_____

DISCHARGE & CARE LINKAGE

DATE: _____ **TIME:**_____

Was an appointment available within 72hrs? ❑ Yes ❑ No

Harm Reduction kit dispensed? ❑ Yes ❑ No

Did the patient attend their follow-up appointment?
❑ Yes *If yes, date (if known)* _____
❑ No *If no, did SUN attempt to re-engage the patient?* ❑ Yes ❑ No
❑ Unknown

PATIENT FOLLOW UP

Did SUN make contact within 7-14 days?
❑ Yes
❑ No
❑ Attempted - unable to contact
❑ No contact info available

Pt engaged with follow up treatment? ❑ 1st appointment

Collect information about drug experience and any special needs. The more you know, the more you can help.

SPECIAL SITUATIONS (current visit): *Check all that apply*

❑ Pregnant ❑ On psych hold (5150) ❑ In Custody

❑ Domestic Violence (DV) ❑ Sexual Assault (261)

❑ Other: _____

SUD TREATMENT CHALLENGES *Check all that apply*

❑ Transportation: *Can't get to appointments, no transportation*
❑ Housing: *Homeless, unstable housing*
❑ Incarcerated: *Arrested, being put in jail or incarceration*
❑ Not welcomed: *Unfriendly or mean staff who do not care*
❑ Financial: *Cannot afford to pay for medications*
❑ Insurance: *No insurance*
❑ Time/flexible appt: *Can't take time off work, no evening appts*

SUBSTANCE USE

Current opioid use:

❑ **Heroin** *How much per day?* ❑<1 gm ❑ 1-2gm ❑ 2-3gm ❑ >3gm
Route: ❑ Inject ❑ Snort ❑ Smoke ❑ Oral ❑ Other

❑ **Fentanyl** *How much per day?* ❑<1 gm ❑ 1-2gm ❑ 2-3gm ❑ >3g
Route: ❑ Inject ❑ Snort ❑ Smoke ❑ Oral ❑ Other

❑ **Street pain pills:** ❑ **Prescribed pain pills:**
Type: ❑ Oxy ❑ Norco/vicodin ❑ Morphine ❑ other_____
How much per day? ❑ ≤ 40mg ❑40-99mg ❑100-299 ❑300+
Route: ❑ Inject ❑ Snort ❑ Smoke ❑ Oral ❑ Other

Opioid Use History

Age when they first used ANY opioid for ANY reason? ❑ <17
❑ 18-25 ❑ 26-44 ❑ 45-64 ❑ ≥ 65

What was the first opioid used?
❑ Pain medication (prescribed) ❑ Opium ❑ Fentanyl
❑ Pain medication (not-prescribed) ❑ Heroin

On the heaviest use day ever, what was the <u>maximum</u> used?
Heroin/fentanyl ❑<1 gm ❑ 1-2gm ❑ 2-3gm ❑ >3gm

Pills Type: _____ #per day _____

Route: **❑ Inject ❑ Snort ❑ Smoke ❑ Oral ❑ Other**

Other substance use *(note any heavy usage)*

	Route(s):
❑ ETOH	❑ Inject
❑ Tobacco/Cigarette	❑ Snort
❑ Meth/crystal	❑ Smoke
❑ Cocaine/Crack	❑ Oral
❑ Benzos/Xanax	❑ Other
❑ Other:	

Ever been put on a psych hold / 5150 after meth/crystal use?
❑ Yes ❑ No ❑ Unknown

OPIOID OVERDOSE HISTORY

Has the patient ever overdosed on opioids? ❑ Yes ❑ No
If Yes How Many times? Date of last OD:

Overdosed more than once in a 7 day period? ❑Yes ❑ No

The <u>last</u> time they overdosed, can they explain why it happened?
❑ Intended to harm
❑ Took too much or too quickly
❑ Drug was stronger than thought
❑ Tried fentanyl
❑ Used stimulants containing unexpected fentanyl
❑ Mixed opioid with another drug
❑ Alcohol ❑ Benzo ❑ Meth ❑ Other

The last time they overdosed:
❑ Given naloxone by friend/bystander but EMS was not called
❑ Given naloxone by friend/bystander with EMS called
❑ Had EMS called and was given naloxone by EMS

Taken to the hospital? ❑Yes ❑ No
If yes what happened at the hospital
❑ Given take home naloxone in hand
❑ Administered Buprenorphine
❑ Given a prescription for buprenorphine
❑ Administered methadone
❑ Given a referral for methadone clinic
❑ None of the above/other

The last time they overdosed, what did patient do in the <u>48 hours</u> after naloxone administration?
❑ Returned to using opioids
❑ Started on Bup
❑ Started on methadone
❑ Stopped using opioids for at least 48 hours

PREVIOUS MAT

Has the patient ever taken buprenorphine?: ❑ Yes ❑ No
If yes: ❑ prescribed/hospital ❑ street/friend (illicit)

Has the patient ever taken methadone?: ❑ Yes ❑ No
If yes, ❑ prescribed/hospital ❑ street (illicit)

Are there other health needs that may promote the safety and wellbeing of this patient?

Mental Health History

"This is a self reported answer. Do you feel that you have any mental health issues?" or "Do you want assistance with mental health issues?"
❑ Yes ❑ No
❑ Anxiety ❑ Depression
❑ PTSD ❑ Schizophrenia
❑ Bi-Polar ❑ Other / not specified

"Have you ever been to a locked psychiatric facility or put on a hold (5150)?" ❑ Yes ❑ No

Patient report or anydocumentation of them every attempting suicide? ❑ Yes ❑ No

Hep C/ HIV testing

"Do you have or do you feel that you are at risk for Hep C and or HIV?"
❑ Yes ❑ No ❑ Unknown

"Would you like to be tested today?"
❑ Yes ❑ No

Was the patient tested during this visit?
❑ Yes (Hep C) ❑ No
❑ Yes (HIV)

"Would you like to be linked to possible Hep C or HIV treatment?" ❑ Yes (Hep C) ❑ No
❑ Yes (HIV)

Medical History (if known)

❑ Hypertension ❑ Stroke ❑ Asthma
❑ COPD ❑ Hep C
❑ Diabetes ❑ HIV

Chronic Pain

"Do you feel that you have any chronic pain? Like, every day you wake up with pain or experience pain daily." ❑ Yes ❑ No

"Have you ever used an opioid because of pain related to trauma?"
❑ Gunshot wound
❑ Other assault, stab wound etc
❑ MVC ❑ Fall ❑ Athletic Injury

Medication for Addiction Treatment (MAT)

Options for Ongoing Treatment After Hospital Starts

September 2020

Starting treatment for substance use disorder (SUD) in the emergency department or hospital increases access to treatment in all communities at any time, day or night. Strong relationships with providers that offer ongoing treatment linkage boosts the effectiveness of a hospital start. Below is an overview of treatment options available in some communities suitable for ongoing treatment.

Federally Qualified Health Centers and Community Health Centers

Community health centers (CHCs) and Federally Qualified Health Centers (FQHCs) are non-profit organizations that provide primary health care for individuals, families and communities. An increasing number of CHCs/FQHCs offer MAT. The number of x-waiver providers will vary from clinic to clinic, thus MAT may only be offered during limited hours.

BENEFITS

- FQHCs/CHCs accept a variety of insurances and also serve the uninsured.
- Because FQHCs/CHCs embed MAT within general primary care, patients may feel less stigma accessing these facilities.
- Patients can receive all of their medical care in one location.

CAUTIONS

- SUD treatment is a portion of services offered therefore clinics may have limited hours or policies that do not maximize access to MAT.
- Patients are often required to elect the FQHC/CHC as their primary care provider in order to receive MAT services.

Primary Care Practices

Some primary care physicians offer treatment with buprenorphine as part of their general practice which can make access to treatment easy for patients who need it. When evaluating the strength of an office based opioid treatment prescriber, look for evidence of linkages within their communities for resources and/or medical subspecialties (e.g. behavioral health, infectious disease, job retraining, etc.)

BENEFITS

- Patients may feel less stigma accessing these services when MAT is embedded within general primary care
- Patients can discuss all medical needs with one provider.

CAUTIONS

- SUD treatment is a portion of primary care services and there may be limited hours or policies that do not maximize access to MAT.
- Primary care providers may not offer psychosocial or behavioral health services, but they should be able to provide referrals.

Hospital Outpatient Clinic

Some hospitals offer MAT through a hospital outpatient clinic. Hospital-supported clinics may offer stand alone SUD services or operate within existing family health or primary care clinics. These clinics are most often located on the same campus as the hospital or in very close proximity, and are sometimes referred to as a "bridge clinic".

BENEFITS

- Hospitals can create a treatment setting that best matches their patient populations needs.
- Hospital outpatient clinics are generally close to the ED which can support effective connections to on-going care.

CAUTIONS

- Offering MAT into a specialized hospital outpatient setting requires space, staffing, and may lead to sustainability challenges.
- Often hospital MAT clinics operate on a part-time basis.

Urgent Care

Some urgent care centers are beginning to offer withdrawal management, lapse prevention, or on-going short term MAT. Services offered will vary from clinic to clinic, calling ahead is advised.

BENEFITS

- Most urgent care clinics accept patients on a walk-in basis and with no appointment required.

CAUTIONS

- Services offered vary from site to site depending on provider availability.

Narcotic Treatment Programs / Opioid Treatment Programs

Narcotic treatment programs (NTPs) and opioid treatment programs (OTPs) are commonly known as methadone clinics but now all offer buprenorphine in addition to methadone. NTPs/OTPs are regulated and licensed by the federal and state governments and must adhere to strict clinical practices. Patients are required to participate in a comprehensive treatment program that includes counseling.

BENEFITS

- Methadone is a good choice for some patients and is only available via NTPs.
- Daily dosing and structured visits are preferred by some patients as this builds a personal sense of accountability and provides access to services on a routine basis.

CAUTIONS

- Participation in counseling is mandatory but not appropriate for all patients.
- Daily visits are required for methadone and for the first several weeks/months for buprenorphine.

Medication Units

Medication Units (MUs) are satellite facilities of an NTP/OTPs where licensed private practitioners and/or community pharmacists dispense or administer OUD medications. Services are limited to administering or dispensing medications and collection of specimens for drug screening.

BENEFITS

- Patients are able to access daily medications and complete required drug screening at locations closer to their primary residence.

CAUTIONS

- Patients will need to travel to the sponsoring NTP/OTP for the remainder of treatment services such as counseling.

Residential Treatment Programs

A residential treatment center is a live-in facility that provides therapy for up to one year addressing substance abuse, mental illness, and other behavioral problems. Residential treatment programs include sober living environments, dual diagnosis treatment programs, faith-based treatment programs, and other specialized models. Each facility has specific rules and expectations for residents and their families.

BENEFITS

- The structured environment is free from temptations and distractions.
- Round-the-clock care and support is provided.
- Patients receiving MAT are eligible for programs that accept federal or state funding.

CAUTIONS

- Cost of programs can be prohibitive when not covered by insurance.
- Private pay programs may refuse patients on MAT.
- Family and work obligations may prevent
- Programs are impacted and often have long wait lists.
- Many programs do not offer MAT, patients will need MAT providers.

Telemedicine

Telemedicine is growing within the MAT treatment landscape. MAT is delivered by providers and counselors on a smartphone app or web browser supported platform. In the setting of COVID-19, telemedicine can be provided by phone without video. Some telemedicine providers have furnished EDs with tablets to facilitate access for these patients. An in-person intake appointment may be required.

BENEFITS

- Televisits offer greater confidentiality and can be held where the patient is most comfortable, reducing stigma.
- Sessions take place at the convenience of the client providing flexibility and autonomy.

CAUTIONS

- Access to a smart-phone or internet is required.
- Self motivation is required to continue treatment, which can be challenging for some patients.
- Not all health plans cover telemedicine.

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California MAT Telehealth Providers

This list is provided as a starting place for hospitals to arrange for telehealth MAT services for their patients, if needed. This list is not exhaustive, nor does it imply endorsement by CA Bridge.

Bright Heart Health

Available in all counties in California
Insurance accepted: Medi-Cal MCO, Commercial, Medicare and VA. Grant funding available for under-insured and uninsured.
brightheartheath.com

Bicycle Health

Available in all counties in California
Insurance accepted: Medicare, UnitedHealthcare, Aetna, Blue Shield (PPO) & and Cigna. Private pay options available as well.
bicyclehealth.com

Groups

Available in all counties in California.
Insurance accepted: Anthem Blue Cross and Blue Shield, Cigna, Humana, Optum UHC
Additional insurance accepted in Shasta County, CA: Partnership Health, Medi-Cal, Anthem Blue Cross and Blue Shield, Cigna, Humana, and Optum UHC
joingroups.com

Workit Health

Available in all counties in California.
Insurance accepted: Aetna, Medi-Care, Medi-Cal.
workithealth.com

ADDITIONAL RESOURCES

CHCF's Innovation Landscape: Telehealth MAT.

chcf.org/publication/innovation-landscape-telehealth-mat

January 2021

FREQUENTLY ASKED QUESTIONS

Substance Use Navigators and Prescriptions

This fact sheet provides answers to frequently asked questions regarding substance use navigators (SUNs) and prescriptions related to the treatment of opioid use disorder.

Can a SUN call in a new prescription?

No.[1] A SUN, after proper training, can be considered a medical assistant. However, according to the Medical Board of California, medical assistants may NOT call in new prescriptions or any prescription that has changed.

If a change is made to a prescription, the prescription is considered a new prescription. This includes changes to dosage form, dose, route, frequency, and number of days' supply. However, a SUN may fax any written prescription signed by a provider into a pharmacy for a provider.[1] It is the responsibility of the provider to ensure proper prescribing of controlled substances occurs,[2] which includes ensuring that only those permitted by law transmit prescriptions to a pharmacy as the provider's agent.

Can a SUN call in a maintenance script (i.e., a refill)?

Yes.[3] The California Board of Pharmacy laws state that "pursuant to an authorization of the prescriber, any agent of the prescriber on behalf of the prescriber may orally or electronically transmit a prescription for a controlled substance classified in Schedule III, IV, or V…"[2] A SUN can qualify to be someone that can call in a maintenance script if they are trained by the physician and acts as their assistant.[3,4]

However, the refill[1] cannot exceed five refills of the original prescription nor extend beyond six months from the date of the original prescription. The refill must be documented in the patient's chart[3] as a standing order and must be patient specific. In most cases, refills should be prescribed by outpatient clinics.

Can medical assistants call in refills to a pharmacy?

Prescriptions are only called-in within the restrictions of a clear procedure. Under the direct supervision of the physician, a medical assistant may call in routine refills that are exact and have no changes in the dosage levels, form, route, frequency, and number of days supply.[3] However, the medical assistant or staff person can NOT call in new prescriptions or change prescriptions.[4]

EXAMPLE SCENARIOS

Example case: Dr. B has a DEA-X number and has been directly training a SUN for several months. She sees a patient in the emergency department and provides a buprenorphine/naloxone script for three days until the patient is scheduled for a follow up appointment. The patient calls the SUN the day of the follow up appointment and states that he cannot attend the appointment because his young daughter is sick and he has no childcare alternative, but next week he will be able to attend in-person. He requests an additional four day prescription.

- Dr. B is on shift in the ER.

- The SUN calls Dr. B and explains the scenario. Dr. B checks CURES and it is consistent with the patient report. Technically, a change in the original prescription from a three day supply to a four day supply makes the prescription a new prescription.
- Dr. B tells the SUN to call in a refill for three days only and asks the SUN to inform the patient that he will be re-evaluated at his follow up appointment. Alternatively, Dr. B may write a new prescription with a total buprenorphine/naloxone supply for four days, sign the prescription, and have the SUN fax the new prescription to the patient's home pharmacy.
- The SUN calls the pharmacy and gives a verbal order per Dr. B's instruction to refill the prescription (or alternatively, faxes the new prescription into the pharmacy).
- Dr. B notes this in the medical chart.

Alternative to case: Dr. B writes in the ED chart at the first visit: "OK to refill buprenorphine/naloxone at the current dose and quantity one time if logistical barriers arise preventing attendance to follow up visit with the bridge clinic." As above, the patient calls the SUN and requests an additional four day prescription:

- Dr. B is on shift in the ER.
- The SUN reads the above documented note.
- The SUN calls the pharmacy and gives a verbal order per Dr. B's instruction for a refill for a three day supply only.
- The SUN calls the patient to inform him that only a three day supply may be filled until the SUN can contact the doctor to have the doctor call in a new prescription.
- The SUN notes the refill in the medical chart and contacts Dr. B for next steps.

Note: In the alternative to this case, it is preferable that the SUN attempt to contact the provider before calling in the refill if possible in order to confirm that a three day supply is appropriate or to see if Dr. B would prefer to call in a new prescription herself or have the SUN fax a new prescription manually signed by Dr. B to the patient's pharmacy with a quantity of four day supply. This will prevent the patient from having to pay a second co-pay for an additional one day supply should Dr. B decide a new script for four days is more appropriate after the refill for three days is called in and picked up by the patient.

Explanation

The pathway to calling in a maintenance script: California law authorizes medical assistants to "perform basic administrative, clerical, and technical supportive services."[4] The Medical Board of California interprets this law to allow a medical assistant – under the direct supervision of a physician – to call, email, or fax in routine medication refills that are "exact and have no changes in dosage level."

1. If a SUN is trained by the physician and acts as their assistant, they can qualify under the above regulation.[5] "Prior to performing technical supportive services, a medical assistant shall receive training, as necessary, in the judgment of the supervising physician, podiatrist or instructor to assure the medical assistant's competence in performing that service at the appropriate standard of care. Such training shall be administered in the following settings: "**under a licensed physician or podiatrist, or under a registered nurse, licensed vocational nurse, a physician assistant or a qualified medical assistant…"**

   Additional details:
   a. A medical assistant that ***does NOT train other medical assistants*** does NOT require a license.[4]
   b. Medical assistants are not licensed, certified, nor registered by the state of California to perform procedures within their "scope of practice."[3]

2. Prescriptions are only called-in within the restrictions of a clear procedure. Under the direct supervision of the physician, a medical assistant may call in routine refills that are exact and have no changes in the dosage levels.[3] However, the medical assistant or staff person can NOT call in new prescriptions or change prescriptions.[4]

   To be compliant with California law and to ensure patient safety:

   - The supervising physician should provide a procedure to be followed by a medical assistant in transmitting a prescription refill to a pharmacy.
   - The medical assistant must be trained and demonstrate competence in performing the task of transmitting prescription refills to a pharmacy.
   - The supervising physician must authorize the medical assistant to transmit a prescription refill to a pharmacy by writing a patient-specific order or with a standing order in the patient's medical record.
   - The medical assistant must document the medication refill in the patient's medical record. Documentation should include the reason for the refill (e.g., lost medication, scheduling difficulties with clinic, etc.), the medical assistant's name or initials, date and time, name of pharmacy and pharmacist, and the name of the physician authorizing the refill.

REFERENCES

1. PART 1306 - Section 1306.05 Manner of issuance of prescriptions. Drug Enforcement Administration: Diversion Control Division website. https://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_05.htm. Accessed September 1, 2020.
2. 2020 Lawbook for Pharmacy. California State Board of Pharmacy. https://www.pharmacy.ca.gov/laws_regs/lawbook.pdf. Accessed September 1, 2020.
3. McLain, A. May Medical Assistants Call in New Prescriptions or Refills to a Pharmacy?. Cooperative of American Physicians. https://www.capphysicians.com/articles/may-medical-assistants-call-new-prescriptions-or-refills-pharmacy. Published December 10, 2018. Accessed September 1, 2020.
4. Medical Assistants Training Without Certification. Medical Board of California. https://www.mbc.ca.gov/Licensees/Physicians_and_Surgeons/Medical_Assistants/. Accessed September 1, 2020.

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FREQUENTLY ASKED QUESTIONS

Buprenorphine and Pharmacy

PRESCRIPTIONS

What is the difference between prescription and administration?

A prescription is an order for medicine which a prescriber writes, and which is given to a pharmacist to prepare for the patient to take outside of the healthcare setting. An order for immediate administration in a hospital is NOT a prescription. According to the Drug Enforcement Agency (DEA), the term prescription means "an order for medication which is dispensed to or for an ultimate user... and not an order for medication which is dispensed for immediate administration to the ultimate user."

Is a written prescription required for buprenorphine/naloxone or buprenorphine?

No. Buprenorphine/naloxone and buprenorphine may be written on a controlled substance prescription form, called in, faxed, or sent electronically. As Schedule III substances, if written they are required[1,2] to be on a controlled substance prescription form. This requirement comes from the California Board of Pharmacy.

How long is a buprenorphine/naloxone or buprenorphine prescription valid?

According to the DEA,[3] buprenorphine/naloxone and buprenorphine prescriptions are valid for six months after the date of the original prescription or for up to five refills, whichever happens first. After six months or five refills have been processed, a new prescription is required.

When are X-waivers/DATA 2000 licenses required?

Providers do NOT need an X-waiver to order buprenorphine for administration while in the Emergency Department or inpatient units. Until January 2021, providers needed an X-waiver for take-home doses or prescribing. But recently, the federal government has issued an exemption so that physicians would no longer need an X-waiver to prescribe. At the time of this writing, regulations are still being developed. We will update our website, cabridge.org, as regulations are finalized.

SUBSTANCE USE NAVIGATOR, PRESCRIPTIONS, AND PHARMACY

Can a substance use navigator (SUN) call in a new prescription?

No.[3] A SUN, after proper training, can be considered a medical assistant. The California Board of Pharmacy laws state[2] that "pursuant to an authorization of the prescriber, any agent of the prescriber on behalf of the prescriber may orally or electronically transmit a prescription for a controlled substance classified in Schedule III, IV, or V…"; however, according to the Medical Board of California, medical assistants may NOT call in new prescriptions or any prescription that has changed. If a change is made to a prescription, the prescription is considered a new prescription. This includes changes to dosage form, dose, route, frequency, and number of days' supply. However, a SUN may fax any written prescription[3] signed by a provider into a pharmacy for a provider. It is the responsibility of the provider[2] to ensure proper prescribing of controlled substances occurs, which includes who is permitted by law to transmit prescriptions to a pharmacy as the provider's agent.

Can a SUN call in a maintenance script (i.e. a refill)?

Yes,[4] as long as the refill[3] does not exceed five refills of the original prescription nor extend beyond six months from the date of the original prescription. The refill must be documented in the patient's chart[4] as a standing order and is patient specific. In most cases, refills should be prescribed by outpatient clinics. For an example case, see the CA Bridge resource *SUNs and Prescriptions*.

What is the pathway to calling in a maintenance script?

A SUN can qualify[5] to be someone that can call in a maintenance script if they are trained by the physician and acts as their assistant.[6] A medical assistant that does NOT train other medical assistants does NOT require a license.[6] Medical assistants are not licensed, registered or certified by the State of California.[4]

Can medical assistants call in refills to a pharmacy?

Prescriptions are only called-in within the restrictions of a clear procedure. Under the direct supervision of the physician, a medical assistant may call in routine refills that are exact and have no changes in the dosage levels, form, route, frequency, or number of days supply.[4] However, the medical assistant or staff person can NOT call in new prescriptions or change prescriptions.[5]

PHARMACY FORMULARIES AND STOCK

What is a formulary?

A formulary is a list of medications approved to be prescribed by a provider at a specific hospital, in a particular health system, or through a specific health insurance plan known as a prescription drug plan. In regard to prescription drug plans, formularies are a list of medications available at no cost or a reduced cost to those enrolled in the plan. Not all formularies are the same. It is important for a provider and her/his staff to confirm which medications are covered by a patient's prescription drug plan before the patient is discharged from any hospital setting in order to prevent delays in the patient acquiring and taking necessary medications while in the outpatient setting.

Do all pharmacies have a formulary?

All inpatient pharmacies have a formulary. These pharmacies are located in a hospital setting and carry all the medications listed on the formulary at all times unless there is a shortage of a particular formulary medication or the pharmacy is waiting on a shipment from a distributor. Inpatient pharmacies also often stock a subset of non-formulary medications that are requested by providers on a relatively frequent basis. These non-formulary medications are dispensed for use through a non-formulary request process set by the hospital.

Outpatient pharmacies, also known as community pharmacies, do not have a formulary. If presented with a prescription for a medication a pharmacy does not carry (i.e. have in stock), the pharmacy may order the medication through a distributor or the pharmacy may call another local pharmacy to request to borrow that medication if the other local pharmacy has it in stock and is willing to allow the medication to be borrowed.

What are the steps to add buprenorphine/naloxone and buprenorphine on to a hospital formulary?

In order to add a medication to an inpatient pharmacy's formulary for the hospital it serves, generally, a request needs to be made to a Formulary Review Committee and/or a Pharmacy and Therapeutics Committee. This request often requires a provider to submit paperwork asking that a particular medication be added, the reason why the provider feels it should be added, a description with attached references of primary literature documenting the benefits to patient care, the expected use throughout the year, and any other requested information. Often a monograph is requested, which is a document detailing the characteristics, efficacy, safety, and cost of a particular medication. Each hospital and associated pharmacy have their own formulary review processes.

Are there generic versions of buprenorphine/naloxone and buprenorphine?

Yes. Buprenorphine/naloxone sublingual films, buprenorphine/naloxone sublingual tablets, buprenorphine patches, and buprenorphine sublingual tablets each have a generic version.

Do all outpatient/community pharmacies carry buprenorphine/naloxone and buprenorphine?

No. SUNs may encourage pharmacies to stock common formulations of buprenorphine as rates of prescribing rise. If a pharmacy does not have the medication, in most cases, they can order it and have it ready within a day. In other cases, the pharmacy may transfer the prescription to another local pharmacy who can fill it.

Can a provider force a patient to go to a particular pharmacy?

No. A prescriber can not tell a patient which pharmacy the patient must go to. A prescriber may recommend a pharmacy a patient can go to if the prescriber knows that the pharmacy often carries the medication the prescriber wants to prescribe.

What is the three-day rule?

Patients discharged from the ED can return to the ED for daily treatment with buprenorphine for up to 72 hours by physicians without an X-waiver. For each episode of opioid withdrawal, a patient may come to the emergency department up to 3 days consecutively[7] to be treated with buprenorphine or methadone to treat their opioid withdrawal or opioid use disorder. If a patient relapses and subsequently experiences opioid withdrawal again, they can initiate a new 3 days of treatment. This is commonly referred to as “The 3 Day Rule.”

INSURANCE

Do all insurance plans cover or buprenorphine or buprenorphine/naloxone ?

No. Many prescription drug plans cover buprenorphine/naloxone and buprenorphine, but not all do and some plans put restrictions on these medications.

Private insurance and Medicare: Coverage of medication varies by prescription drug plan.

Medi-Cal insurance: All Medi-Cal prescription drug plans have a pathway to cover the cost of buprenorphine/naloxone and buprenorphine. Generally, these medications are paid for by Medi-Cal FFS through what is known as a state carve-out. Carve-out medications are those billed directly to the state Medi-Cal FFS program rather than county plans. The classes of medications billed as carve-outs include HIV/AIDs medications, alcohol detox and dependence medications (e.g. naltrexone), opioid detox and dependence medications (i.e. buprenorphine, naloxone), some psychiatric medications, and blood factor products. If a patient has Medi-Cal of any kind and the pharmacy says that buprenorphine is not covered, ask the pharmacy to bill Medi-Cal FFS or the drug Medi-Cal carve out.

Do all pharmacies take all insurances?

No. A pharmacy must be contracted with a prescription drug plan in order for the insurance plan to pay for the medications being prescribed to a patient with that particular plan. For example, nearly all retail pharmacies accept Medi-Cal FFS (e.g., Walgreens), but may or may not contract with county-specific Medi-Cal plans. In fact, due to a discount program called 340B, many Medi-Cal HMO members can “only” pick up prescriptions at large retail pharmacies.

If a patient has to pay out of pocket for buprenorphine/naloxone or buprenorphine, where can the patient get the cheapest price?

Prices vary depending on coverage, the form of the medication, and which pharmacy a patient chooses to pick his or prescription up from. Generally, if a patient has to pay for a prescription out of pocket, CostCo and Walmart tend to have the lowest out of pocket costs for medications. There is also a free phone application called GoodRX that will provide coupons, price comparisons, and the nearest pharmacy location to any medication. The application can be downloaded for

both iPhone and Android and an online version of the application is also available via the website GoodRx.com. Generally, buprenorphine monoproduct tablets are the least costly formulation.

Links to on-line prescription plans

The California Department of Healthcare Services Medi-Cal Managed Care Health Plan directory[8] can be helpful to find contact information for Medi-Cal plans in your county.

PRIOR AUTHORIZATIONS AND TREATMENT AUTHORIZATION REQUESTS

What is the difference between a prior authorization (PA) and a treatment authorization request (TAR)?

PA: A prior authorization, also known as a PA, is a requirement by a prescription drug plan whereby a provider must request and obtain approval for the plan to cover some or all of the cost of a particular prescription medication. Every insurance plan has its own prior authorization process with its own requirements. A PA is used to help minimize costs to the prescription drug plan and is generally a form that is filled out by the provider's office and submitted to the insurance plan.

TAR: A treatment authorization request, also known as a TAR, is a version of a prior authorization for Medi-Cal FFS patients only. A TAR is generally filled out electronically by a pharmacy after attempting to process a prescription and obtaining a rejection. A pharmacy will fill the TAR out electronically, which is known as an eTAR.

When does buprenorphine or buprenorphine/naloxone require a TAR for Medi-Cal patients?

Generally, only when a patient with Medi-Cal FFS exceeds six prescriptions per 30-day period. The TAR is used to give justification for the patient to receive an additional (i.e. 7th or 8th) prescription. This is necessary for both medication dosing/quantity adjustments as well as starting a patient on a new medication.

Who can fill out a PA?

A PA often requires a provider's signature and therefore it is filled out by the provider and their office staff.

Who can fill out a TAR?

A pharmacy or a provider can fill out a TAR. However, a pharmacy usually fills out a TAR after receiving a rejection while processing a prescription through Medi-Cal FFS.

When and how will I know a TAR was approved?

Anywhere from a few hours up to 72 business hours (i.e. three business days). Unfortunately, Medi-Cal FFS can take up to three business days to approve or deny a TAR.

RESOURCES

Department of Healthcare Services Medi-Cal Managed Care Resource Directory
www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx

GoodRx GoodRx.com

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