



September 2022

# Blueprint for Hospital Opioid Use Disorder Treatment

A patient-centered approach to 24/7 access to medication for  
addiction treatment

# Table of Contents

<b>Introduction</b>	<b>4</b>
<b>Implementation Checklist</b>	<b>5</b>
<b>Get Ready</b>	<b>6</b>
Identify key players and early adopters	6
Form a substance use disorder workgroup	7
Train providers on buprenorphine basics	7
Educate hospital staff	8
<b>Start Treatment</b>	<b>10</b>
Ensure buprenorphine is available in the hospital	10
Identify patients with opioid use disorder	10
Implement treatment protocols	12
Remove clinical barriers to treatment	13
Provide medications on discharge	14
<b>Connect Patients to Ongoing Care</b>	<b>16</b>
Hire a navigator or dedicate staff to linking patients to care	16
Provide training and support to navigators	17
Establish connections with outpatient providers	18
Establish a patient-centered referral process	18
Equip navigators and staff to provide patient education	19
<b>Change Hospital Culture</b>	<b>20</b>
Distribute naloxone	20
Encourage the use of non-stigmatizing language	21
Integrate harm reduction and trauma-informed care into emergency department practice	22
<b>Sustain Your Program</b>	<b>24</b>
Bill for services	24
Generate support	25
Forge partnerships	27
<b>References</b>	<b>28</b>

## Acknowledgements

CA Bridge acknowledges the courage and persistence of patients, providers, navigators, and Bridge teams that have brought hope to patients and families and developed the treatment practices that make this toolkit possible.



CA Bridge, a program of the Public Health Institute, works to ensure that people with substance use disorder receive 24/7 high-quality care in every California health system. We seek to fully integrate addiction treatment into standard acute care medical practice—increasing access to treatment to save lives.

---

This toolkit was last updated in September 2022. Specific policies and regulations surrounding addiction care and medication dispensing and prescribing may have changed since that time. CA Bridge disseminates resources based on published evidence and medical expertise. These resources are not a substitute for clinical judgment as current best practices may change. Providers are responsible for assessing the care and needs of individual patients.

© 2022, California Department of Health Care Services. Content available under Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International ([CC BY-NC-ND 4.0](https://creativecommons.org/licenses/by-nc-nd/4.0/))

## Introduction

Substance use disorder (SUD) is a chronic illness like type 2 diabetes or coronary artery disease. Its etiology is similarly multifactorial, with contributions from genetics, environment, and human behavior.<sup>1</sup> Medication for addiction treatment (MAT) is evidence based for SUD treatment; a prime example is buprenorphine for the treatment of opioid use disorder (OUD).<sup>2</sup> Randomized controlled trials have shown that initiation of buprenorphine in emergency departments (EDs) prior to community discharge increases rates of linkage to outpatient treatment over brief interventions without medication.<sup>3</sup> Similarly, for patients who are admitted to the hospital, buprenorphine initiation and dose stabilization can control withdrawal symptoms and increase rates of linkage to outpatient treatment.<sup>4</sup> Despite evidence that MAT is associated with decreased illicit opioid usage,<sup>5</sup> improved adherence to addiction treatment programs, and cost savings,<sup>6</sup> 60-80% of people who use opioids do not have access to these medications.<sup>7</sup>

Since EDs and hospitals provide 24/7 access to health care, they offer a unique opportunity to make treatment for SUD universally accessible. This blueprint covers treatment for OUD in acute care hospitals with buprenorphine. Despite strong evidence for buprenorphine initiation in acute care as well as guidance from emergency medicine societies, many hospitals do not offer this service. The goal of CA Bridge is that all hospitals in California will treat OUD by 2025.

The CA Bridge Model for MAT in acute care hospitals has been implemented at over half the hospitals in California. While the details of implementation vary, this scale demonstrates feasibility at large and small, public and private, urban and rural hospitals. The CA Bridge model is based on three pillars:



1. **Low-barrier Treatment:** Provide rapid, same-day treatment in response to patient needs. Make MAT accessible in the ED and all hospital departments without complicated restrictions and procedures.



2. **Connection to Care and Community:** Link patients to ongoing care through active support and follow-up. Reach out to the 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.

This blueprint provides step-by-step guidance on how to set up a MAT program in an acute care hospital following the CA Bridge model. Start in whatever way you can. Once you start treating patients, you can see that treating OUD is simple and effective.

### GET IN TOUCH!

CA Bridge is dedicated to advancing treatment for OUD, and ultimately all SUDs, in all of California's hospitals and health systems. We welcome you to become part of the amazing and committed group of clinicians who have found changing their hospital's approach to people who use drugs to be some of the most rewarding work they have done. We want to support you and learn from you! You can join the conversation at [www.cabridge.org](http://www.cabridge.org).

# Implementation Checklist

## Get ready

- Identify at least one clinician champion and navigator.
- Identify providers who are X-waivered and facilitate X-waiver registration.
- Form a SUD workgroup.
- Educate clinicians and hospital staff on the MAT program, treatment protocols, and referrals to ongoing care.

## Start treatment

- Ensure buprenorphine is on formulary for MAT and available in the hospital for administration within 30 minutes.
- Identify patients with OUD. Post signs that inform patients that treatment is available.
- Implement treatment protocols and share with nursing teams, pharmacy teams, and coordination teams (e.g., social work, case management, patient navigation) and post in visible locations.
- Remove clinical barriers to treatment, such as unnecessary diagnostic testing.
- Provide medications on discharge.

## Connect patients to ongoing care

- Hire a navigator or dedicate other staff to link patients to care.
- Provide training and support to prepare navigators so they can work effectively.
- Establish connections with at least one clinic or outpatient setting that provides MAT.
- Establish a patient-centered referral process, including workflows for night and weekend follow-up.
- Equip navigators and staff to provide patient education.

## Change hospital culture

- Distribute naloxone from the ED.
- Encourage the use of non-stigmatizing language among providers and staff.
- Integrate harm reduction and trauma-informed care into ED practice.

## Sustain your program

- Bill for services.
- Generate support in the hospital.

## Get Ready

Like any practice change in acute care, implementing a MAT program can be done in a variety of ways based on the resources available. Below we outline four key steps and offer tips for scaling these up if you have the capacity:

- Identify key players.
- Form a SUD workgroup.
- Increase X-waivered providers.
- Educate hospital staff.

### Identify key players and early adopters

A single provider (champion) who uses buprenorphine to treat opioid withdrawal paired with a person to make referrals to ongoing treatment (a navigator) is the essence of a Bridge program.

Clinician champions are critical to the success of any practice change as clinicians want to learn from their peers. Clinician champions will get X-waivered, start treatment, help ensure adequate education for their team, and serve as a resource on-shift when others have questions. Ideally, champions should be awarded administrative time or a stipend to conduct this work. While these individuals will remain champions for the long term, funded time is extremely helpful in the first year to launch the program.

Navigators are the second critical element of a Bridge program. Navigators conduct initial brief assessments, introduce patients to treatment programs, 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. For guidance on bringing on this critical staff member, see our [Hiring a Substance Use Navigator](#). If a navigator is not available, a case manager, community health worker (CHW), social worker, nurse, or other team member can fill this role.

#### ● TIP:

---

It's unrealistic to change the entire department at once. Start with one or two "early adopters" or providers who already have X-waivers and engage them first.

#### X-WAIVERS

Any provider may order buprenorphine for administration to admitted or registered patients for the purposes of treating opioid withdrawal and starting or maintaining MAT. However, as of July 2022, in order to write a prescription for buprenorphine for patients being discharged to fill at an outpatient pharmacy, providers must have a DATA 2000 waiver for their DEA (Drug Enforcement Agency) license. This waiver is commonly called the "DEA-X" or "X-waiver." This regulation may change, and updated guidance will be available at [cabridge.org](http://cabridge.org).

## Form a SUD workgroup

Engaging key stakeholders in the ED/hospital in a workgroup to develop treatment and referral pathways for patients with SUD and behavioral health issues facilitates the rollout and success of the program. Many sites have found that bringing together champions from different hospital departments is critical to identifying and overcoming obstacles that inevitably arise in implementation.

A robust SUD workgroup includes stakeholders from various disciplines, including:

- Clinician/provider groups (e.g., inpatient and ED, physician or advanced practice provider [PA, NP])
- Nursing
- Pharmacy
- Care coordination (e.g., social work, case management)
- Hospital and health system administration
- Other staff, such as information technology, patient registration, security, community health, and volunteer services

### ENGAGING HOSPITALISTS

*“Our biggest challenge has been in the inpatient setting. Looking back, I believe if we had engaged the hospitalist right off the bat through our Bridge champion, we would have had more success.”*

## Train providers on buprenorphine basics

While it is possible to start buprenorphine in acute care without X-waivered providers, having providers register for the X-waiver is invaluable. The more providers there are in the hospital who are comfortable prescribing buprenorphine, the more treatment of OUD will become the standard of care as opposed to a special program. You can also conduct outreach and, resources permitting, create incentives for more providers to receive training on treating with buprenorphine and become X-waivered.

*X-waivers no longer require an 8-hour training.* Registering for an X-waiver is quick and easy; see CA Bridge’s [How to Apply to Get Your X-waiver](#). Training can be completed in a few minutes by watching CA Bridge’s [8 Hours in 8 Minutes](#) video. For additional details about the X-waiver, see CA Bridge’s [DATA 2000 X-waiver for Buprenorphine Prescribing](#).

Hosting trainings on buprenorphine on-site or connecting people with remote trainings can encourage more providers to participate and build familiarity with treating patients.

## Educate hospital staff

24/7 provider support lines. Any provider seeking support for first-time buprenorphine starts or assistance with complex cases may utilize the substance use support lines, which should be posted visibly in areas frequented by clinicians.

- California Substance Use Line
  - California providers only, service of Poison Control
  - 24 hours a day, 7 days a week
  - Rapid access to advice for acute care buprenorphine starts; other issues routed to the national line
  - (844) 326-2626
- National Clinician Consultation Center Substance Use Warmline
  - Monday-Friday 6 AM-5 PM PST; Voicemail 24 hours a day, 7 days a week
  - Specialty addiction medicine consultation, regardless of substance, issue, or clinical setting
  - (855) 300-3595

All staff education. In addition, the program rollout will proceed more smoothly if plans are made to proactively educate providers, nurses, social workers, and pharmacists rather than waiting until questions arise. Ideas for educational activities include:

- Place posters in public spaces, such as the ED lobby and patient-care areas, break areas, and bathrooms.
- Host “lunch and learns” and in-services. Work with your education department to get Continuing Medical Education (CMEs) for these presentations to encourage providers to attend.
- Join grand rounds and/or present at department meetings.
- Incorporate MAT education into continuing education and onboarding materials for new employees, locums, and traveling nurses.
- Invite a guest speaker to a hospital-wide forum. You can request a speaker from [cabridge.org](http://cabridge.org).
- Prepare and upload patient discharge instructions into the electronic health record (EHR) or make paper copies available to those who will be caring for patients.
- Reach out to [info@cabridge.org](mailto:info@cabridge.org) for presentation decks you can use at your site.

Staff	Suggested Educational Topics
Providers (physicians, PAs, NPs) and nurses	<ul style="list-style-type: none"> <li>● Identifying patients with OUD</li> <li>● Treatment protocols: <a href="#">Quick start guides</a></li> <li>● <a href="#">Legality of buprenorphine administration</a></li> <li>● <a href="#">Linkage options for ongoing outpatient SUD care</a></li> <li>● Nursing protocols: <a href="#">MAT Toolkit for Nurses</a> and <a href="#">Nurses Drive Care for Opioid Use Disorder (video)</a></li> <li>● Stigma reduction: <a href="#">Words Matter</a></li> </ul>
Pharmacists	<ul style="list-style-type: none"> <li>● <a href="#">Buprenorphine and Pharmacy</a></li> <li>● <a href="#">Legality of buprenorphine administration</a></li> <li>● Treatment protocols: <a href="#">Quick start guides</a></li> <li>● Stigma reduction: <a href="#">Words Matter</a></li> </ul>
Social workers and care coordination teams	<ul style="list-style-type: none"> <li>● Navigator role and connecting with the navigator</li> <li>● <a href="#">Linkage options for ongoing outpatient SUD care</a></li> <li>● Stigma reduction: <a href="#">Words Matter</a></li> </ul>
Technicians (e.g., ED techs) Hospital operators and unit clerks Patient registration, front desk greeters, and security guards	<ul style="list-style-type: none"> <li>● Awareness of the MAT program</li> <li>● Importance of patient-facing signs, training on steps to take if a patient expresses interest in treatment</li> <li>● Answers to questions frequently asked by patients</li> <li>● Stigma reduction: <a href="#">Words Matter</a></li> </ul>

## Start Treatment

Buprenorphine prevents and treats withdrawal, helps control opioid cravings, and is associated with retention in care and reduced mortality.<sup>8,9,10</sup> ED initiation of buprenorphine is feasible and associated with increased linkage to outpatient care.<sup>3</sup> Patients with untreated withdrawal are at risk for using in an unsafe way that puts them at risk of fatal overdose. This section covers the key components of a treatment program based on the model developed by CA Bridge.

### Ensure buprenorphine is available in the hospital

---

#### Key Resources

- [Buprenorphine and Pharmacy](#)
- 

Buprenorphine must be easy to order in the ED setting and from other departments that will provide MAT so that patients can be treated within 30 minutes. Coordinate with the pharmacy to put this medication on formulary, if it is not already available, and ensure buprenorphine is available and stocked in the ED (e.g., in Pyxis or Omnicell). Buprenorphine monoprodut and buprenorphine/naloxone are available in 4-mg and 8-mg tabs or strips for sublingual administration.

#### ● TIP: [Work with Information Technology](#)

---

Coordinate with IT to ensure that buprenorphine can be ordered in the EHR, prescribed at discharge (i.e., continuation and self-start versions), and that DEA-X is added to prescriber profiles.

### Identify patients with OUD

---

#### Key Resources

- [Signs template](#)
  - [Treatment Starts Here: Sign of the Times](#)
- 

Identify patients with OUD by asking about opioid use and posting signs to invite patients to seek care. Clinicians and navigators should ask about opioid use in patients with:

- Opioid withdrawal symptoms (see below)
- Sequelae of injection use
- Skin and soft-tissue infections
- Endocarditis
- Flu-like symptoms
- Nausea, vomiting, and/or diarrhea
- Acute or Chronic Hepatitis C or HIV positivity
- Positive urine toxicology testing
- Use of alcohol, methamphetamine, or other drugs

Screening questions can be used but should be interpreted with caution as patients may not disclose their use disorder if they are concerned about stigma or do not know that they will be offered treatment.

Growing evidence supports patients' self-report of withdrawal as sufficient for buprenorphine initiation in the non-facility setting.<sup>11,12</sup> Therefore, some providers ask the patient if they have symptoms and look for at least one objective sign.<sup>13</sup>

## Symptoms of Opioid Withdrawal

### Objective Signs:

- Tachycardia
- Diaphoresis
- Restlessness and/or agitation
- Dilated pupils
- Rhinorrhea or lacrimation
- Vomiting, diarrhea
- Yawning
- Piloerection (“goose flesh” or “goose bumps”)

### Subjective Symptoms:

Patient reports feeling "bad" due to:

- Nausea
- Stomach/abdominal cramps
- Body aches
- Achy bones/joints
- Restlessness
- Hot and cold
- Nasal congestion

### ● TIP: Post signs inviting patients to seek treatment.

Signs offering treatment or asking if people want help with their substance use invites patients to speak openly with providers about their use of substances. Download and print your own signs using our [signs template](#) and post them at registration, triage, hallways, bathrooms, and any place in the hospital that patients visit. This empowers patients to self-identify as having an SUD, which CA Bridge advocates over formal screening or urine testing. Coordinating with administration and maintenance is often necessary to ensure that signs are not removed.

### 42 CFR PART 2

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 SUDs from federally assisted programs. More information on 42 CFR Part 2 is available through the Substance Abuse and Mental Health Services Administration's (SAMHSA) [Disclosure of Substance Use Disorders](#) and [42 CFR Part 2 Revised Rule](#).

## Implement treatment protocols

These treatment protocols are designed to be simple resources for providers and include best practices, dosing information, and important reminders for providers prior to initiating treatment.

CA Bridge Treatment Protocols	Overview
Buprenorphine emergency department quick start <ul style="list-style-type: none"> <li>● <a href="#">Buprenorphine Emergency Department Quick Start</a></li> </ul>	Acute withdrawal and OUD can be started in the ED using this algorithm. Urine drug screen and lab testing are not necessary for treatment initiation. Prolonged monitoring is not required.
Buprenorphine patient self-start options <ul style="list-style-type: none"> <li>● <a href="#">Buprenorphine Self-start</a></li> </ul>	Patients who are not yet in enough withdrawal to start buprenorphine can be sent home with a prescription to start buprenorphine using these instructions.
Buprenorphine immediately after naloxone resuscitation for opioid overdose <ul style="list-style-type: none"> <li>● <a href="#">Starting Buprenorphine Immediately After Reversal of Opioid Overdose With Naloxone</a></li> </ul>	Buprenorphine can be administered following an overdose reversal using naloxone using this algorithm.
Buprenorphine hospital quick start in pregnancy <ul style="list-style-type: none"> <li>● <a href="#">Buprenorphine Quick Start in Pregnancy</a></li> <li>● <a href="#">FAQ: Medications for Addiction Treatment and Trauma-informed Care in Pregnancy</a></li> </ul>	The American College of Obstetricians and Gynecologists recommends providing MAT for OUD during pregnancy. Detoxification from opioids, without continuation of medications for OUD, is NOT recommended. Buprenorphine and methadone are safe and effective during pregnancy and breastfeeding. Fetal monitoring is not required for MAT starts. In labor, analgesia beyond MAT is required.
Acute pain management for patients on buprenorphine <ul style="list-style-type: none"> <li>● <a href="#">Emergency Department/Critical Care</a></li> <li>● <a href="#">Medical/Surgical Units</a></li> </ul>	<p>We do <u>not</u> recommend stopping a patient’s maintenance buprenorphine or methadone; this leads to uncontrolled withdrawal and therefore pain that is difficult to control. Their maintenance dose of buprenorphine or methadone is not sufficient to treat acute pain, so other analgesics must be offered, including opioids, if needed.</p> <p>Do not be afraid to treat pain for people with an SUD as untreated pain can lead patients to return to use.</p>
Buprenorphine for patients in custody <ul style="list-style-type: none"> <li>● <a href="#">Care for Patients With Opioid Use Disorder Who Are in Custody</a></li> </ul>	People in custody are at high risk for overdose death and are excellent candidates for treatment of opioid withdrawal and OUD. Hospitals can support these patients using this guide.

◉ **TIP: Create order sets**

---

Order sets can encourage best practices and make it easy for providers to use appropriate dosing and ensure that everyone is prescribed naloxone. Work with your IT department to create easy-to-order discharge prescription options in your EHR. Two examples include:

1. Buprenorphine/naloxone  
8-mg/2-mg sublingual (SL) film (Okay to substitute SL tablets)  
2 strips under the tongue once a day  
Quantity: #14 (7 days)
2. Buprenorphine/naloxone (self-start/self-titration)  
8-mg/2-mg sublingual (SL) film (Okay to substitute for SL tablets)  
1/2 strip under the tongue, as needed for withdrawal every 2-8 hours up to 32 mg per day  
Quantity: #56

See CA Bridge [Clinical Considerations for Order Sets](#) for recommendations on building order sets. We also offer a sample [Order Sets](#) and cover this topic in our [Buprenorphine in the Hospital: How Do We Do It? \(video\)](#).

## Remove clinical barriers to treatment

---

### Key Resources

- [Patient-centered, Rapid Access Approach to Substance Use Disorder](#)
  - [Treatment, Culture, and Connection \(video\)](#)
- 

Patients seeking treatment for SUD routinely encounter barriers, such as long wait times and prolonged intake processes, increasing the risk of continued illicit substance use and premature death.<sup>14</sup> A patient-centered, rapid-access approach includes welcoming patients with a medication-first approach and including patients' goals in the treatment plan. Do not make treatment contingent on labs, on their abstinence from stimulants, benzodiazepines, or alcohol, nor on their participation in psychosocial support.<sup>15</sup>

A urine drug screen is not diagnostically necessary to start a patient on buprenorphine. Urine toxicology is used to inform care but should not be required in the acute care setting, as it only adds time (waiting for results) and cost to the patient's visit and can delay time to treatment. Furthermore, a positive urine drug test for a separate substance (i.e., amphetamines or cocaine) should not prompt cessation (or delay starting) of MAT.

Removing these barriers is critical to creating equitable access to care.

## Provide medications on discharge

---

### Key Resources

- [DATA 2000 X-waiver for Buprenorphine Prescribing](#)
  - [Discharge Instructions: Buprenorphine starts template](#)
  - [Discharge Instructions: Harm reduction for patients who use drugs template](#)
- 

Once a patient has been initiated on buprenorphine in the hospital, they should get prompt follow-up after they leave the ED. It is essential that they leave the hospital with a prescription for enough buprenorphine to last until their follow-up appointment.

Any provider may order buprenorphine or methadone for *administration* to admitted or registered patients for the purposes of treating opioid withdrawal, starting MAT, or maintaining MAT. Providers may start ordering and administering buprenorphine as soon as the hospital has it on formulary.

However, in order to *write a prescription* for buprenorphine for treatment of OUD for patients being discharged to fill at an outpatient pharmacy, as of July 2022, providers must have a DATA 2000 waiver for their DEA (Drug Enforcement Agency) license. This waiver is commonly called the “DEA-X” or “X-waiver.” More information on obtaining an X-waiver can be found in our resource [DATA 2000 X-waiver for Buprenorphine Prescribing](#), which will also be updated with any change to X-waiver regulations.

### For buprenorphine prescribers (X-waivered):

- Prescribe buprenorphine-naloxone combination or buprenorphine monoprodut (per patient preference) sublingual tablets or films.
  - Most patients will require 16-32 mg of buprenorphine per day, daily dosing.
- Prescribe 7-14 day supply to allow patient time to follow up with ongoing outpatient treatment.
  - In California, providers are required to check the Controlled Substance Utilization Review and Evaluation System (CURES) database when prescribing opioids. Prescriptions from the ED for longer than 7 days and all non-ED prescriptions do require providers to first check CURES.<sup>16</sup> The results of this search should *not* prevent the patient from receiving MAT but may reveal information that should be discussed honestly with the patient.
  - OUD patients with chronic pain syndrome and pregnant patients in second and third trimesters can receive split dosing (i.e., BID or TID).
- For electronic prescribing, DEA-X number must be entered in comments for the pharmacy in the following format: NADEAN:X\*\*\*\*. Also, enter the ICD-10 F11.0. Some pharmacies or insurers may require additional information to dispense per their controlled substance protocols (e.g., treatment plans, etc).
- Always provide naloxone directly to the patient (preferred) or by prescription (at a minimum) for all patients with SUD.

### For providers who do not prescribe buprenorphine (non-X-waivered):

- Refer to an X-waivered colleague to provide a telehealth consultation and call in a prescription. For more information on providing care through telehealth, see CA Bridge's [Guide to Telehealth in California](#). (Note: This is allowed due to a relaxation of federal policies in 2020 that may change in the future.)
- If an X-waivered colleague is unavailable to assist with a discharge prescription, several options include:
  - A loading dose can be administered to prevent withdrawal for approximately 48 hours until the patient is able to link to care with an outpatient X-waivered provider. The usual loading dose is 24-32 mg of buprenorphine.
  - Instruct the patient to return to the ED daily for up to 3 days to receive administration of buprenorphine while connection to ongoing care is being arranged.
  - Patients can be dosed in the ED and the next day follow-up with an outpatient X-waivered provider can be arranged.
- For inpatients, anticipate the upcoming discharge and seek support from an X-waivered provider in advance.

Patients often experience difficulties filling prescriptions at commercial pharmacies. Clinicians should work with their navigators to build relationships with pharmacy staff so that they can confidently send patients to supportive pharmacies that will fill prescriptions and treat patients respectfully.

## Connect Patients to Ongoing Care

Once a patient has been initiated on buprenorphine in the acute care setting, they need prompt follow-up, ideally within 72 hours. Although EDs should offer patients the opportunity to return for repeat dosing if they experience issues in connection to outpatient services, the program goal should be connection to outpatient care. This section describes the key steps needed to ensure effective follow-up outpatient care for the patients you start on treatment in the hospital.

### Hire a navigator or dedicate staff to linking patients to care

---

#### Key Resources

- [Substance Use Navigator FAQ](#)
  - [Substance Use Navigator Job Description template](#)
  - [Hiring a Substance Use Navigator](#)
- 

Linking patients who use drugs with follow-up outpatient treatment requires time and specific skills and is best handled by a staff member who is dedicated to this work. The CA Bridge model fills this function with a full-time navigator, as described in our [Substance Use Navigator FAQ](#) and [Substance Use Navigator Job Description](#). Other programs use different terms for this position, including behavioral health counselor, treatment navigator, patient navigator, care coordinator, etc.

A navigator is a staff member embedded within an ED or an inpatient setting to engage with patients who use drugs and facilitate treatment for SUD. Navigators become experts on regional treatment resources and conduct extensive community outreach to improve connection to ongoing care and raise awareness about SUD treatment options. Successful navigators are flexible and creative problem solvers, able to leverage interpersonal skills to build relationships throughout their hospital and with community organizations, law enforcement, EMS, schools and universities, tribal populations, and more. Most importantly, a navigator should be able to establish a human connection with people who use drugs. For guidance on bringing this critical member onto your team, see our [Hiring a Substance Use Navigator](#).

#### THE VALUE OF NAVIGATORS

*“Patients feel more supported with a navigator and they are able to feel some relief that someone is looking out for them. It also gives hope to caregivers, who have seen a familiar face previously, that one day they get to hear that person’s success story.”*

While a dedicated full- or part-time navigator is ideal, it may not be feasible for all hospitals. The functions of a navigator can be performed by other hospital staff members. Alternative options include:

- Training care coordination teams (e.g., social workers, case managers) to serve patients with SUD
- Using charge nurses or nurse shift managers to serve this role while on shift
- Training *all* nurses or providers to counsel their patients and refer them to ongoing care
- Recruiting a volunteer from the community (e.g., nearby outpatient clinic patient navigators) to collaborate with and share compilations of patient resources

## Provide training and support to navigators

---

### Key Resources

- [CA Bridge Navigation Toolkit](#)
  - [Substance Use Navigators \(video\)](#)
  - [Substance Use Navigator & Clinician Champion Collaboration](#)
- 

The role of a navigator is complex and requires intentional training and support. One of the keys to success is a strong relationship between the navigator and the medical staff, as described in our [Substance Use Navigator & Clinician Champion Collaboration](#). The clinician champion will be helpful in determining the chain of command, orienting a navigator to the hospital environment and culture, bringing navigators to meetings, and introducing them to department heads and nurse leaders.

The [CA Bridge Navigation Toolkit](#) is a comprehensive resource for navigators, staff who supervise them, and anyone who will be connecting patients to ongoing care. This [Substance Use Navigators \(video\)](#) presents concrete examples and tips for experienced navigators. Navigators should:

1. **Engage patients:** Navigators play a critical role in establishing human connections with patients. We offer tools to help navigators build these connections.
2. **Understand buprenorphine:** The navigator should know what buprenorphine is for, how patients take it, and how to continue a prescription versus a “self-start” after leaving the hospital. This is essential to a navigator’s ability to counsel the patient prior to discharge and answer their questions.
3. **Link patients to ongoing care:** The navigator should be able to call the patient’s desired clinic and facilitate prompt follow-up. Ideally, they should visit the connected outpatient clinics and build relationships with clinicians and scheduling teams. Follow-up visits should be scheduled within 72 hours in most cases, and clinics should be encouraged to offer drop-in availability, as needed.
4. **Provide patient education:** Patients should receive information on buprenorphine, the clinic where they will follow up, and home starts, as needed. [These materials](#) can be downloaded from CA Bridge’s [resource library](#). Navigators should review these with each patient prior to discharge.
5. **Document:** Navigators should document a note in the patient’s medical record describing the counseling offered and plan for follow-up so other care team members understand the plan and resources provided. Consider developing a template for this.
6. **Coordinate care for patients seen on weekends and evenings:** When a patient is discharged in the evening or over the weekend when the navigator is not working, the navigator needs to establish a system for follow-up.
7. **Know local community resources:** These resources will include primary care clinics providing MAT, harm reduction services, residential programs, shelters, 12-step support groups, or other resources for people with SUD. Ideally, navigators will visit these settings so they can do warm handoffs and encourage referrals from these providers into the Bridge program.

- **TIP: Ensure that navigators have protected time to do community outreach.**

Their familiarity and personal relationships with community providers are what enable them to be so successful in connecting patients to care.

## Establish connections with outpatient providers

---

### Key Resources

- [Options for Ongoing Treatment after Hospital Starts](#)

Every hospital should have at least one option for low-barrier outpatient treatment, and having several options is ideal given variations in patients' insurance coverage.

A variety of entities offer outpatient MAT, including federally qualified health centers, narcotic treatment programs, office-based primary care, hospital outpatient clinics, and others. When considering clinics to refer patients to, look for care that is patient-centered and easily accessible. Specific details to consider are the referral process, typical wait times for appointments, insurance coverage accepted, and staff culture as it relates to caring for patients with SUD. Your navigator should visit the outpatient clinic and form a personal relationship with clinicians and scheduling teams, so they can tell the patient what to expect, how to get to the clinic, and introduce them to a contact there.

In communities with limited access to treatment, telemedicine can be an option. For more information, see CA Bridge's [Options for Post-Acute MAT Treatment](#) and [California MAT Telehealth Providers](#).

Most CA Bridge sites do not have formal agreements with outpatient clinics, but agree on a process for referrals and check in over time to ensure the workflow is functioning well. Although not required, some hospitals prefer to have written, formal agreements between their hospital and the follow-up facility that cover agreements, such as: providing guaranteed clinic follow-up within a specific number of days (i.e., allocating dedicated intake slots), establishing a process for day-time referrals and a secure voicemail line for after-hours referrals, and naming point persons at the hospital and clinic.

## Establish a patient-centered referral process

---

### Key Resources

- [CA Bridge Navigation Toolkit](#)

### Ensure that your navigator conducts a warm handoff

The [CA Bridge Navigation Toolkit](#) provides guidance for navigators on this process. Key steps include:

- Set up the first appointment with an outpatient provider, or assist the patient in using a hospital phone or tablet to do so themselves.
- Troubleshoot barriers to access that many patients experience even with a warm handoff. Navigators can arrange for transportation, provide resources for free phones, identify local

pharmacies that fill buprenorphine prescriptions, help to obtain the necessary discharge papers from the hospital, etc.

- Stay connected by providing the patient with a phone number that they can call after discharge to speak directly with the navigator if they encounter obstacles accessing follow-up care.
- 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 7 days or based on hospital policies. If the patient has not attended the appointment, the navigator should reach out to the patient.

### Establish workflows for night and weekend follow-up

When a patient is discharged in the evening or over the weekend, the navigator may not be present and the follow-up clinic may not be open for immediate coordination of care. Create a list of patients for the navigator to contact when they return to work. Consider establishing drop-in slots at outpatient clinics so patients can present even if a navigator was unable to set up an appointment. Buprenorphine prescriptions should be written until the patient is able to follow up with the outpatient clinic if next-day appointments cannot be arranged. If no X-waivered provider is available, use higher-dose buprenorphine for longer effect or arrange for the patient to come back to the ED for re-dosing, as needed, for up to 72 hours.

#### FORMAL REFERRAL RELATIONSHIPS

To bridge care gaps, St. Joseph Health, Eureka, in rural Humboldt County developed a formal relationship using an MOU with a local inpatient recovery center. Under this agreement, the inpatient recovery center agrees to accept same-day referrals for at least one patient. If the referral is made after-hours, the recovery center will hold an appointment for the patient the following day.

### Equip navigators and staff to provide patient education

---

#### Key Resources

- [Buprenorphine: What you need to know](#)
- [Discharge Instructions: Harm Reduction for Patients template](#)
- [Discharge Instructions: Buprenorphine starts template](#)
- [Discharge Instruction: Bup-XR template](#)

---

Patient education may be provided by a navigator, clinician, or nurse, depending on workflow and staff availability. Key patient education materials should be easily accessible for all ED staff. [Buprenorphine: What you need to know](#) has instructions for filling and taking buprenorphine and is available in multiple languages. Templates are available that can be adapted for patient education.

Patients should also be counseled on safe storage of their medication, which can be a challenge for people experiencing housing instability. Additional patient-facing materials are [available on our website](#).

## Change Hospital Culture

Stigma in society and in health care settings is the top barrier to evidence-based medical treatment for people with SUD.<sup>18</sup> Health care providers often have unconscious stigmatizing attitudes toward people who use drugs that can result in behaviors that lead to suboptimal health care outcomes for these patients.<sup>19,20</sup> Changing this culture in a hospital is a long-term process that can be started with a few basic steps.

### HUMAN CONNECTION

*“The biggest success has been connecting patients to ongoing MAT and breaking down the stigma for those seeking treatment. We had several patients thank us for treating them ‘like a person.’”*

## Distribute naloxone

---

### Key Resources

- [Guide to Naloxone Distribution](#)

---

Apply for the [Naloxone Distribution Project \(NDP\)](#), a California statewide program funded at the federal level by SAMHSA and administered by the California Department of Healthcare Services (DHCS) to combat opioid overdose-related deaths throughout California. The [Guide to Naloxone Distribution](#) offers more information on how to set up naloxone distribution from the hospital.

In California, prescribers are legally required by California state law (Business and Professions Code Article 10.7 of Division 2 of Chapter 1) to offer naloxone and overdose education to populations at risk for overdose.<sup>17</sup> If possible, give the naloxone kit in-hand prior to discharge since many naloxone prescriptions are never filled.

Every patient who takes opioids or uses drugs purchased from the street, as well as their loved ones, should be given or prescribed naloxone and educated on its use. This can include people prescribed opioids and benzodiazepines, people with OUD, or people who use stimulants or benzodiazepines that may be fentanyl contaminated. Integrating naloxone information into the discussion with a patient signals that you think people who use drugs have a life worth saving.

## Encourage the use of non-stigmatizing language

### Key Resources

- [Words Matter](#)

The language we use to discuss SUD has been shown to be associated with outcomes in medical settings.<sup>28,29</sup> Consider using clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions to decrease stigma in your clinical practice.

Instead of...	Use...	Because...
Addict User Substance or drug abuser Junkie Alcoholic Drunk Former addict Reformed addict	<ul style="list-style-type: none"> <li>• Person with opioid/substance use disorder or person with opioid addiction</li> <li>• Patient</li> <li>• Person in recovery</li> </ul> <p>For heavy alcohol use:</p> <ul style="list-style-type: none"> <li>• Unhealthy, harmful, or hazardous alcohol use</li> <li>• Person with alcohol use disorder</li> </ul>	<ul style="list-style-type: none"> <li>• Person-first language.</li> <li>• The change shows that a person “has” a problem rather than “is” the problem.</li> <li>• The terms to avoid elicit negative associations, punitive attitudes, and individual blame.</li> </ul>
IV drug user	<ul style="list-style-type: none"> <li>• Person who injects drugs</li> </ul>	<ul style="list-style-type: none"> <li>• Person-first language.</li> </ul>
Habit Relapse	<ul style="list-style-type: none"> <li>• Substance use disorder</li> <li>• Drug addiction</li> <li>• Return to use/slip</li> </ul>	<ul style="list-style-type: none"> <li>• Inaccurately implies that a person is choosing to use substances or can choose to stop.</li> <li>• “Habit” may undermine the seriousness of the disease.</li> </ul>
Clean	<p>For toxicology screen results:</p> <ul style="list-style-type: none"> <li>• Testing negative</li> </ul> <p>Referring to a person:</p> <ul style="list-style-type: none"> <li>• Being in remission or recovery</li> <li>• Abstinent from drugs</li> <li>• Not drinking or taking drugs</li> <li>• Not currently using drugs</li> </ul>	<ul style="list-style-type: none"> <li>• Use of such terms may evoke negative and punitive subconscious thoughts.</li> <li>• Set an example with your own language when treating patients who might use stigmatizing slang.</li> </ul>
Dirty	<p>For toxicology screen results:</p> <ul style="list-style-type: none"> <li>• Testing positive</li> </ul> <p>Referring to a person:</p> <ul style="list-style-type: none"> <li>• Person who uses drugs</li> </ul>	<ul style="list-style-type: none"> <li>• May decrease patients’ sense of hope and self-efficacy for change.</li> </ul>

(Adapted from NIDA [Words Matter: Terms to Use and Avoid When Talking About Addiction](#))

## Integrate harm reduction and trauma-informed care into ED practice

---

### Key Resources

- [Harm Reduction Strategies for the Hospital Setting](#)
  - [How to inquire and respond to recent and past trauma in health care settings](#)
  - [Nadine Burke Harris: How Childhood Trauma Affects Health Across a Lifetime \(Video\)](#)
  - [Fostering Resilience and Recovery: A Change Package](#)
- 

### Harm reduction

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. These strategies include safer use, managed use, abstinence, and meeting drug users “where they are at.” 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.

The following strategies integrate harm reduction into the hospital setting and are described in greater detail in CA Bridge’s [Harm Reduction Strategies for the Hospital Setting](#).

- Use person-first language rather than terms like “drug addict” or “user,” which imply someone is “something” that cannot change. Instead put the person first and describe behavior as in, “a person who uses drugs.”
- Review and edit hospital materials by checking for use of person-first language and inclusion of harm reduction principles. Replace any outdated materials with new materials.
- Hire staff dedicated to building relationships and trust with people who use drugs, ideally including people who have lived experiences of drug use.

- Actively include people who use drugs and experience marginalization for their expertise when developing new programming or evaluating a current one.
- Provide training on harm reduction at all levels for hospital staff. Sensitize providers to how criminalization of drug use, trauma, violence, layers of disadvantage, and stigma may affect a person's ability to engage with health care.
- Increase syringe access by supplying safe consumption kits at discharge or prescribing syringes.<sup>21</sup> Studies consistently demonstrate the effectiveness of syringe access in preventing transmission of infectious disease<sup>22</sup> and skin and soft tissue infections,<sup>23</sup> while also supporting the overall health of people who use drugs<sup>24</sup> through connection to drug treatment,<sup>25,26,27</sup> medical care, housing, overdose prevention, and other vital social services.

### Trauma-informed care

Trauma-informed care is an approach to interacting with patients that facilitates a trusting, safe connection between patients and providers and makes it possible for treatment for OUD and co-occurring conditions to succeed. Trauma-informed care involves designing policies, procedures, and practices to prevent re-traumatization of patients.<sup>30</sup>

Trauma is common among people with SUD, including intimate partner violence, adverse childhood experiences, and more. These common comorbid conditions are independent risk factors for mortality and may pose barriers to attaining treatment goals for OUD. California's former surgeon general, Dr. Nadine Burke Harris, explains How Childhood Trauma Affects Health Across a Lifetime (Video).

Kindness is often the first step to engaging people with SUD. Trauma-informed care can start with providing a warm blanket and food. Be open to your patients setting the agenda and pace of care. Look for ways you can help address their priorities. The CA Bridge model creates the opportunity for implementing trauma-informed practices by emphasizing the role of the navigator in engaging with patients on a human level. Navigators can set a tone in the hospital that advances trauma-informed policies, procedures, and practices.

Strategies for implementing trauma-informed care in your hospital can be found in From Treatment to Healing: Inquiry and Response to Recent and Past Trauma in Adult Health Care and Fostering Resilience and Recovery: A Change Package.

#### CULTURE SHIFT

*"There was a dramatic shift in the culture in the emergency room. Instead of the team feeling frustrated and letting that show when patients arrived with concerns or side effects related to SUD, they were instead excited to identify them as someone who would be a part of our program. I feel that this program gave our team the tools they needed to actually help people with this need, and once they had the tools, it brought them joy to help them."*

## Sustain Your Program

The State of California has provided multiple rounds of grant funding for ED MAT and behavioral health navigation. These are start-up funds designed to launch programs that become part of the standard of care after the funding ends. The clinical champion and navigator have critical roles to play in advocating for sustainability that may require you to learn about hospital billing, advocate to hospital leadership, or reach out to outside partners. CA Bridge is here to help build your capacity to take on these new roles that can help you make a lasting change in the standard of care in your ED.

### Bill for services

Three main billing mechanisms in California can be leveraged to sustain navigator positions at a hospital: the community health worker (CHW) benefit, which covers the services of the navigator; screening, brief intervention, and referral to treatment (SBIRT) billing; and the MAT procedure code.

#### Billing for navigator services through the community health worker (CHW) benefit

As of July 1, 2022, the services of CHWs (including navigators implementing the CA Bridge model), are reimbursable under Medi-Cal as preventive services. This new [regulation](#) can be used to sustain CA Bridge navigators:

- Patients with diagnosed or suspected SUD are eligible for CHW services.
- Most substance use navigators will meet the requirements for CHWs through the work experience pathway, which is 2,000 hours working as a CHW in the past 3 years. (Completion of certification will be required within 18 months.)
- Services provided by substance use navigators are consistent with CHW services: *health education, health navigation, screening and assessment, individual support, or advocacy.*

For more details:

- Read the [DHCS Newsflash](#) on CHWs.
- Download the [Community Health Worker \(CHW\) Preventive Services](#) sections in Medi-Cal Provider Manual. Current rate information for these codes can be found on the [Medi-Cal Rates](#) webpage.
- Check CA Bridge's [Sustainability](#) webpage for updated information and resources.

### SBIRT billing

SBIRT services are [defined by SAMHSA](#) as alcohol and/or substance abuse (other than tobacco) structured assessment, such as the Alcohol Use Disorders Identification Test ([AUDIT](#)) or Drug Abuse Screening Test ([DAST](#)) and brief intervention. Services provided in hospitals are billable to commercial insurance using codes 99408 and 99409 and to Medicare using codes G0396 and G0397.

Certified drug and alcohol counselors (CADCs) can perform an SBIRT under the supervision of a provider trained in SBIRT. If this provider is a physician, the staffing group would bill under the supervising physician. If the supervising provider is a hospital-employed licensed clinical social worker, SBIRT can be billed as an add on to the hospital facility charges as long as ED visits are not reimbursed by the payor through a flat, capitated rate.

Medi-Cal does not require coverage of SBIRT in the ED; however, your local Medi-Cal Managed Care Plan may be interested in reimbursing for SBIRT services to improve their performance the HEDIS metric for follow-up after an ED visit for an SUD that is now required for Medi-Cal Managed Care Plans. Medi-Cal billing codes are H0049 and H0050.

### MAT procedure code

In 2021, DHCS approved a new CMS add-on billing code for initiation of MAT to be billed with E/M visit codes used in the ED setting. This new code will cover the resource costs involved with initiation of medication for the treatment of OUD and referral for follow-up care. Code G2213 also includes payment for assessment, referral to ongoing care, follow-up after treatment begins, and the arrangement of access to supportive services.

For more details:

- See guidance provided by the American College of Emergency Physicians.
- Current rate information for these codes can be found on the Medi-Cal Rates webpage.
- See CA Bridge's examples from several hospitals on how to bill for this code.

Because G2213 is a provider code, the revenue will accrue to the provider group. Using this revenue to support the navigator will be most applicable to hospitals where the navigator is employed by the provider group rather than the hospital.

### Generate support

The goal of every Bridge program should be to make the navigator position a permanent line item in the ED budget. Whether or not navigators are able to generate significant revenue through billing, it is important to begin building support among key hospital stakeholders. Many hospitals have decided to keep their navigators in the ED budget *based solely on the merits of the program*. We recommend that you take all three steps below as soon as your program launches.

### Make the navigator's work visible

The sustainability of the navigator position is greatly enhanced by making the navigator, the services they provide, and the outcomes they achieve visible to key stakeholders. Ways that clinical champions can help elevate the visibility of the navigator include:

- Proactive relationship building: Encourage your navigator to introduce themselves and build relationships with everyone in the ED. The navigator role is often new and is not immediately appreciated by other staff whose buy-in is important for long-term sustainability.

- Modeling collaboration: Demonstrate to other clinicians how working closely with the navigator leads to effective and efficient treatment for patients who use drugs.
- Sharing follow-up information: Encourage your navigator to send quick emails to providers with patient updates to let them know that 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.
- Public relations: Seek out opportunities to showcase the program to key stakeholders and hospital leaders by making presentations, writing up patient success stories, preparing data summaries, or simply describing the program and how it has improved ED workflow.

### Identify talking points

When thinking through how to make the case to hospital leadership, consider current hospital priorities and pain points. Some of the following have been effective at different sites:

- Navigators improve hospital workflow efficiencies. Navigators reduce ED wait times, decrease inpatient admissions,<sup>31</sup> and prevent repeat ED visits.<sup>32</sup>
- Navigators are cost effective. A study in a Baltimore hospital found that substance use navigation generated \$17,780 in savings per participant.<sup>31</sup>
- Navigators support the effectiveness and job satisfaction of the entire ED team. Patients who use drugs have often been complex, time-consuming, and frustrating for ED staff who have had little to offer them. A skilled navigator with dedicated time to care for these patients makes evidence-based treatment both feasible and satisfying for staff.
- Navigators improve patient care. Numerous studies have found that follow-up rates after MAT initiation in the ED are significantly improved with navigation or SBIRT services.<sup>3,31</sup>

### Use data

Aggregation of the number of patients seen by the navigator and the number treated with buprenorphine is a simple way to make others in the hospital aware of what your program is doing. When resources and capacity allow, we encourage hospitals to conduct analyses of specific subsets of patients or services. Some examples include:

- Comparison of ED or inpatient utilization among a group of patients who present to the ED with SUD before and after contact with the navigator.
- Analysis of the number of patients with SUD leaving the hospital AMA.
- Analysis of number and length of psychiatric holds in the ED in patients with co-occurring mental illness and SUD before and after the program.

These analyses do not need to involve large numbers of patients, random selection, or sophisticated statistics. Some champions have generated interest in their program by pulling data on as few as 4 patients selected nonrandomly to illustrate the benefits that can be achieved for high-risk patients.

◉ TIP:

---

Focus on a patient with high ED utilization whom the ED staff has not been able to help. By developing care plans and facilitating discharges and outpatient connections, you can show them how you can make a big difference for just one person.

## Forge partnerships

While the most common scenario for sustaining a navigator continues to be through the hospital, partnerships can open up other sources of funding or institutional arrangements to keep a navigator in the ED.

### Staffing groups

In some hospitals in California, the navigator is hired by a medical staffing group. This arrangement may be advantageous if the staffing group is able to bill for CHW services and the MAT initiation procedure code and can use the revenue to support the navigator.

### Outpatient treatment and community partners

A variety of agencies and clinics accept patients referred from the ED. Some of these entities, such as federally qualified health centers or county-funded SUD programs, have access to funding streams that make it more feasible for them to sustain a navigator than it is for the hospital. There are several hospitals in California where the navigator is employed by an outpatient treatment or community partner, which can have the added advantage of increasing coordination between the ED and these partners.

### Managed care plans and county Drug Medi-Cal Organized Delivery Systems (DMC-ODS)

Both health plans and a county DMC-ODS have the potential to support the navigator through funding, pay for performance incentives, or hire the navigator. The DHCS has identified a 50% increase in the HEDIS metric on follow-up after an ED visit for SUD as one of its top five goals for Medi-Cal quality improvement and is requiring both Medi-Cal Managed Care and DMC-ODS plans to report on this metric. Because navigators in the ED are uniquely positioned to improve follow-up, we encourage hospitals to engage in conversations with health plans and DMC-ODS about how to ensure continuation of these services in the ED. Managed Medi-Cal plans may be willing to reimburse for SBIRT services for navigators to help improve their metrics.

## References

- <sup>1</sup> Waller, RC. Addiction Neuroscience 101 [Video]. Youtube. <https://www.youtube.com/watch?v=bwZcPwIRcc&feature=youtu.be>. Published April 4, 2018. Accessed August 24, 2020.
- <sup>2</sup> MAT Medications, Counseling, and Related Conditions. Substance Abuse and Mental Health Services Administration; 2020. Accessed August 24, 2020.
- <sup>3</sup> D’Onofrio G, O’Connor PG, Pantalon MV, et al. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. *JAMA*. 2015;313(16):1636-1644. doi: 10.1001/jama.2015.3474
- <sup>4</sup> Liebschutz JM, Crooks D, Herman D, et al. Buprenorphine treatment for hospitalized, opioid-dependent patients: a randomized clinical trial. *JAMA Intern Med*. 2014;174(8):1369-1376. doi: 10.1001/jamainternmed.2014.2556
- <sup>5</sup> The SAMHSA Evaluation of the Impact of the DATA Waiver Program. Substance Abuse and Mental Health Services Administration; 2006. Accessed August 24, 2020.
- <sup>6</sup> Mohlman MK, Tanzman B, Finison K, Pinette M, Jones C. Impact of medication-assisted treatment for opioid addiction on medicaid expenditures and health services utilization rates in Vermont. *J Subst Abuse Treat*. 2016;67:9-14. doi: 10.1016/j.jsat.2016.05.002
- <sup>7</sup> Haffajee RL, Bohnert ASB, Lagisetty PA. Policy pathways to address provider workforce barriers to buprenorphine treatment. *Am J Prev Med*. 2018;54(6 Suppl 3):S230-S242. doi: 10.1016/j.amepre.2017.12.022
- <sup>8</sup> Liebschutz JM, Crooks D, Herman D, et al. Buprenorphine treatment for hospitalized, opioid-dependent patients: a randomized clinical trial. *JAMA Intern Med*. 2014;174(8):1369-1376. doi: 10.1001/jamainternmed.2014.2556
- <sup>9</sup> Wakeman SE, Larochelle MR, Ameli O, et al. Comparative effectiveness of different treatment pathways for opioid use disorder. *JAMA Netw Open*. 2020;3(2):e1920622. doi: 10.1001/jamanetworkopen.2019.20622
- <sup>10</sup> D’Onofrio G, Chawarski MC, O’Connor PG, et al. Emergency department-initiated buprenorphine for opioid dependence with continuation in primary care: outcomes during and after intervention. *J Gen Intern Med*. 2017;32(6):660-666. doi: 10.1007/s11606-017-3993-2
- <sup>11</sup> Sohler NL, Li X, Kunins HV, et al. Home- versus office-based buprenorphine inductions for opioid-dependent patients. *J Subst Abuse Treat*. 2010;38(2):153-159. doi: 10.1016/j.jsat.2009.08.001
- <sup>12</sup> Cunningham CO, Giovanniello A, Li X, Kunins HV, Roose RJ, Sohler NL. A comparison of buprenorphine induction strategies: patient-centered home-based inductions versus standard-of-care office-based inductions. *J Subst Abuse Treat*. 2011;40(4):349-356. doi: 10.1016/j.jsat.2010.12.002
- <sup>13</sup> Bergeria CL, Huhn AS, Tompkins DA, Bigelow GE, Strain EC, Dunn KE. The relationship between pupil diameter and other measures of opioid withdrawal during naloxone precipitated withdrawal. *Drug and Alc Depend*. 2019;202:111-114. doi: 10.1016/j.drugalcdep.2019.05.010
- <sup>14</sup> Sigmon SC, Ochalek TA, Meyer AC, et al. Interim buprenorphine vs. waiting list for opioid dependence. *N Engl J Med*. 2016;375:2504-2505. doi: 10.1056/NEJMc1610047
- <sup>15</sup> Martin SA, Chiodo LM, Bosse JD, Wilson A. The next stage of buprenorphine care for opioid use disorder. *Ann Intern Med*. 2018;169(9):628-635. doi: 10.7326/M18-1652
- <sup>16</sup> The Controlled Substance Utilization Review and Evaluation System Mandatory Use. Medical Board of California; 2018. Accessed August 24, 2020. [https://www.mbc.ca.gov/Licensees/Prescribing/CURES/Mandatory\\_Use.aspx](https://www.mbc.ca.gov/Licensees/Prescribing/CURES/Mandatory_Use.aspx)
- <sup>17</sup> AB-2760 Prescription Drugs: Prescribers: Naloxone Hydrochloride and Other FDA-approved Drugs. California Legislative Information; 2018. Accessed August 24, 2020. [https://leginfo.ca.gov/faces/billTextClient.xhtml?bill\\_id=201720180AB2760](https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2760)

- <sup>18</sup> Wakeman SE, Rich JD. Barriers to medications for addiction treatment: how stigma kills. *Subst Use Misuse.* 2018;53(2):330-333. doi: 10.1080/10826084.2017.1363238
- <sup>19</sup> Crapanzano KA, Hammarlund R, Ahmad B, Hunsinger N, Kullar R. The association between perceived stigma and substance use disorder treatment outcomes: a review. *Subst Abuse Rehabil.* 2019;10:1-12. doi: 10.2147/SAR.S183252
- <sup>20</sup> van Boekel LC, Brouwers EPM, van Weeghel J, Garretsen HFL. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. *Drug and Alc Depend.* 2013;131(1-2):23-35. doi: 10.1016/j.drugalcdep.2013.02.018
- <sup>21</sup> Pharmacy Syringe Sales. Contra Costa Health Services. Accessed September 16, 2020. [https://cchealth.org/hiv/syringe-sales.php#:~:text=California%20law%20\(AB1743\)%20permits%20licensed,acquired%20from%20an%20authorized%20source](https://cchealth.org/hiv/syringe-sales.php#:~:text=California%20law%20(AB1743)%20permits%20licensed,acquired%20from%20an%20authorized%20source)
- <sup>22</sup> Gibson DR, Flynn NM, Perales D. Effectiveness of syringe exchange programs in reducing HIV risk behavior and HIV seroconversion among injecting drug users. *AIDS.* 2001;15(11):1329-1341
- <sup>23</sup> Phillips KT, Stein MD, Anderson BJ, Corsi KF. Skin and needle hygiene intervention for injection drug users: results from a randomized, controlled stage I pilot trial. *J Subst Abuse Treat.* 2013;43(3):313-321. doi: 10.1016/j.jsat.2012.01.003
- <sup>24</sup> Pollack HA, Khoshnood K, Blankenship KM, Altice FL. The impact of needle exchange-based health services on emergency department use. *J Gen Intern Med.* 2002;17(5):341-348. doi: 10.1046./j.1525-1497.2002.10663.x
- <sup>25</sup> Wodak A, Cooney A. Do needle syringe programs reduce HIV infection among injecting drug users: a comprehensive review of the international evidence. *Subst Use Misuse.* 2006;41(6-7):777-813. doi: 10.1080/10826080600669579
- <sup>26</sup> Hagan H, McGough JP, Thiede H, Hopkins S, Duchin J, Alexander ER. Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. *J Subst Abuse Treat.* 2000;19(3):247-252. doi: 10.1016/s0740-5472(00)00104-5
- <sup>27</sup> Strathdee SA, Celentano DD, Shah N, et al. Needle-exchange attendance and health care utilization promote entry into detoxification. *J Urban Health.* 1999;76(4):448-460. doi: 10.1007/BF02351502
- <sup>28</sup> Ashford RD, Brown AM, McDaniel J, Curtis B. Biased labels: an experimental study of language and stigma among individuals in recovery and health professionals. *Subst Use Misuse.* 2019;54(8):1376-1384. doi: 10.1080/10826084.2019.1581221
- <sup>29</sup> Kelly JF, Westerhoff CM. Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *Int J Drug Policy.* 2010;21(3):202-207. doi: 10.1016/j.drugpo.2009.10.010
- <sup>30</sup> SAMHSA's Concept of Trauma and Guidance for a Trauma-informed Approach. SAMHSA Trauma and Justice Strategic Initiative. Substance Abuse and Mental Health Services Administration; 2014. Accessed August 24, 2020. [https://ncsacw.samhsa.gov/userfiles/files/SAMHSA\\_Trauma.pdf](https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf)
- <sup>31</sup> Orme S, Zarkin GA, Dunlap L, et al. Cost and cost savings of navigation services to avoid rehospitalization for a comorbid substance use disorder population. *Med Care.* 2022;60(8):631-635. doi: 10.1097/MLR.0000000000001743
- <sup>32</sup> Moulin AK, Wu EF, Trevino TG, Richards JR. The impact of SBIRT and dedicated alcohol and drug counseling for domiciled and homeless patients in the emergency department. *J Subst Use.* 2020;26(2):156-159. doi: 10.1080/14659891.2020.1789231