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# Blueprint for Hospital Opioid Use Disorder Treatment

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

## Authors and acknowledgments

CA Bridge acknowledges the courage and persistence of patients, providers, substance use navigators, and Bridge teams that have provided treatment and brought hope to patients and families throughout the state.

### AUTHORS

Alicia Mikolaycik Kurtz, MD, Hannah Snyder, MD, Sky Lee, MD, Amy Lund Stone, RN, Sarah Windels, Serena Clayton, PhD, Aimee Moulin, MD, Andrew Herring, MD, Arianna Sampson, PA-C

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Bharath Chakravarthy, MD, Reb Close, MD, Christian Hailozian, Vanessa Lara, Sky Lee, MD, Josh Luftig, PA, Meghan O'Brien, MD, MBE, Shannon Robinson, MD, Alex Stack, MPH, Tommie Trevino, Rebecca Trotzky-Sirr, MD, Rais Vohra, MD, Jennifer Zhan, MD

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This toolkit was last updated September 2020. Specific policies and regulations surrounding addiction care and medication dispensing and prescribing may have changed since that time.

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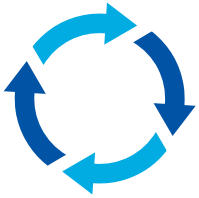
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**MORE INFO AT:**  
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# Introduction



*SUD is a chronic illness, like type 2 diabetes or coronary artery disease.*

*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.<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 buprenorphine 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 healthcare, they offer a unique opportunity to make treatment for SUD universally accessible. 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 2023.

*The CA Bridge Model* has been implemented at 52 hospitals across California. While the details of implementation vary, these sites demonstrate feasibility at large and small, public and private, urban and rural hospitals.

## The CA Bridge model is based on three pillars:



**1. TREATMENT:** Provide quick start, low-barrier access to evidence-based medication for addiction treatment for substance use disorder in all hospital departments.



**2. CONNECTION:** Establish pathways to link patients to outpatient care through active support and follow-up. We actively advertise our services to patients through outreach.



**3. CULTURE:** Create a welcoming, non-stigmatizing hospital culture for people who use drugs that is reflected in patient facing communications throughout the hospital and an emphasis on human connections that build trust.

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. Recognizing that not all hospitals will have the capacity to implement the full model, we offer practical alternatives when possible. 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).

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# Implementation Checklist

## Start Treatment

- Ensure buprenorphine is on formulary and available in the hospital.
- Share treatment protocols with nursing teams, pharmacy teams, and coordination teams (social work, case management, patient navigation) and post in visible locations.
- Ensure there are no barriers (e.g., unnecessary diagnostic testing) that delay the start of treatment.
- Provide medications on discharge.

## Connect Patients to Ongoing Care

- Hire a substance use navigator (SUN) or dedicate other staff to link patients to care.
- Provide training and support to prepare navigators to function effectively.
- Establish informal or formal relationships with at least one clinic or outpatient setting that provides MAT.
- Develop patient materials including list of MAT follow-up options, discharge instructions, home start guidance, and harm reduction.
- Establish a patient-centered referral process including workflows for night and weekend follow-up.

## Change Hospital Culture

- Learn about harm reduction and trauma-informed care and integrate them into your clinical practice.
- Educate providers and staff about the use of non-stigmatizing language through flyers or presentations.
- Print and hang patient-facing signs in ED lobby and patient care areas.

## Build Your Bridge program

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

## Measure and Communicate Success

- Select metrics that will provide useful data for your hospital.
- Identify data sources and start data collection.
- Plan targeted analyses and regular review of data to monitor progress.

## Plan for Sustainability

- Evaluate options for SUN sustainability and initiate discussions on those that are most feasible for your site.
- Engage your SUN in making themselves visible to key stakeholders.

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# CA Bridge MAT Program Basics

## Start Treatment

This toolkit covers treatment for OUD in acute care hospitals with buprenorphine. Buprenorphine prevents and treats withdrawal, helps control opioid cravings, and is associated with reduced mortality.<sup>8,9,10</sup> ED initiation of buprenorphine is feasible and associated with increased linkage to outpatient care.<sup>11</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.

### KEY STEPS FOR STARTING TREATMENT

### RESOURCES

- |  |   |
|--|---|
| ✓ <b>Ensure buprenorphine is available in the hospital</b> so that it is easily administered from the ED and inpatient settings. | • <a href="#">Buprenorphine and Pharmacy</a>  |
| ✓ <b>Identify and treat OUD</b> using CA Bridge protocols for rapid, patient-centered treatment.                                 | • <a href="#">CA Bridge Treatment Protocols</a><br>• <a href="#">Clinical Opioid Withdrawal Score (COWS) template</a>   |
| ✓ <b>Remove clinical barriers to treatment</b> so that patients can begin treatment immediately.                                 | • <a href="#">Patient-Centered, Rapid Access Approach to Substance Use Disorder</a><br>• <a href="#">Treatment, Culture &amp; Connection (video)</a>  |
| ✓ <b>Provide medication on discharge</b> to ensure continued access until a connection to outpatient treatment is made.          | • <a href="#">DATA 2000 X-Waiver for Buprenorphine Prescribing</a><br>• <a href="#">Discharge Instruction: Buprenorphine starts template</a><br>• <a href="#">Discharge Instruction: Harm Reduction for Patients Who Use Drugs template</a> |

## Ensure buprenorphine is available in the hospital

Buprenorphine must be easy to order in the ED setting and from any other departments that will provide MAT. Coordinate with 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 monoproduct and buprenorphine/naloxone are available in 4mg and 8mg tabs or strips for sublingual administration.

### ○ TIP: Work with Information Technology (IT)

Coordinate with IT to ensure that buprenorphine can be ordered in the EHR, prescribed at discharge (continuation and self-start versions), and that DEA-X is added to prescriber profiles. CA Bridge has created an FAQ on [Buprenorphine and Pharmacy](#).

**MORE INFO AT:**  
[CABridge.org](http://CABridge.org)

## Identify and treat OUD

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
<p><b>Buprenorphine Hospital Quick Start for Opioid Withdrawal</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Buprenorphine (Bup) Hospital Quick Start Protocol</a></li> </ul>	<p>A patient in the ED or inpatient settings who is experiencing opioid withdrawal can be started on buprenorphine following the “Quick Start” protocol of sublingual buprenorphine. Patients do not need to commit to ongoing care in order to be started on buprenorphine. A urine drug screen and lab testing are not necessary for treatment initiation. Prolonged monitoring is not required.</p>
<p><b>Buprenorphine Hospital Quick Start in Pregnancy</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Buprenorphine (Bup) Quick Start in Pregnancy</a></li> <li>• <a href="#">Frequently Asked Questions Medications for Addiction Treatment and Trauma Informed Care: Pregnancy</a></li> </ul>	<p>The American College of Obstetricians and Gynecologists (ACOG) 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.</p>
<p><b>Acute Pain Management for Patients on Buprenorphine</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Acute Pain Management in Patients on Buprenorphine (Bup) Treatment for Opioid Use Disorder – Emergency Department/Critical Care</a></li> <li>• <a href="#">Acute Pain Management in Patients on Buprenorphine (Bup) Treatment for Opioid Use Disorder – Medical/Surgical Units</a></li> </ul>	<p>Patients currently on MAT or who are newly started on buprenorphine in the ED may experience acute pain.</p> <p>We <b>do not recommend stopping a patient’s maintenance buprenorphine or methadone</b>; 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><b>Do not be afraid to treat pain for people with a substance use disorder</b> as untreated pain can lead patients to return to use.</p>
<p><b>Buprenorphine immediately after naloxone resuscitation for opioid overdose</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Buprenorphine Immediately after Reversal of Opioid Overdose with Naloxone</a></li> </ul>	<p>Patients who receive naloxone to reverse opioid overdose should be given buprenorphine following the reversal.</p>
<p><b>Buprenorphine for patients in custody</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Care for Patients with Opioid Use Disorder Who Are in Custody</a></li> </ul>	<p>Many hospitals care for patients who are in custody. In these settings, using MAT remains standard of care, however issues specific to the criminal justice system must be considered.</p>
<p><b>Buprenorphine Patient Self-Start Options</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Gentle Self-Start</a></li> <li>• <a href="#">Rapid Self-Start</a></li> </ul>	<p>For patients who are not yet in enough withdrawal to start buprenorphine, write a prescription of buprenorphine with self-start instructions. We offer two different versions depending on patient preference and characteristics:</p> <ul style="list-style-type: none"> <li>• <b>Gentle Self-Start guidance</b> is for people with major medical issues or with lower opioid tolerance (for example, using opioid pills)</li> <li>• <b>Rapid Self-Start guidance</b> is for patients familiar with buprenorphine or who have higher opioid tolerance</li> </ul>

## Identify patients who are candidates for buprenorphine

To find patients who may benefit from buprenorphine in your hospital, consider the following:

1. Visible [signs](#) in public spaces in the hospital encourage patients to self identify opioid use.
2. Clinicians and SUNs should ask about opioid use in patients with opioid withdrawal symptoms or sequelae of injection use.
3. Screening questions can be used, but should be interpreted with caution as patients may not self identify their use disorder if they are concerned about stigma or do not know that they will be offered treatment.

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### SYMPTOMS OF OPIOID WITHDRAWAL

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#### 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

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#### Symptoms may mimic the following conditions:

- Viral gastroenteritis or Food Poisoning
- Influenza
- Sepsis
- Pancreatitis or other causes of abdominal pain
- Alcohol withdrawal

#### Ask about opioid or chronic pain medication use in patients with:

- Abscesses
  - Cellulitis
  - Endocarditis
  - Acute or Chronic Hepatitis C
  - Patients with HIV
  - Positive urine toxicology testing
  - Admitted or signs of alcohol, methamphetamine, or other substance use
- 

A Clinical Opioid Withdrawal Scale (COWS) can be used to help providers identify when a patient is in opioid withdrawal. The [COWS](#) can be checked prior to administering the first dose of buprenorphine if there is concern for insufficient withdrawal. Growing evidence supports patients’ self report of withdrawal as sufficient for buprenorphine initiation in the non-facility setting,<sup>12,13</sup> therefore some providers do not conduct formal COWS prior to initiation and instead ask the patient if they have symptoms and look for at least one objective sign.<sup>14</sup> See [Clinical Opioid Withdrawal Score \(COWS\) template](#).

#### MORE INFO AT:

[CABridge.org](http://CABridge.org)



**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 (OK to substitute sublingual 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 (OK to substitute for sublingual tablets)  
 1/2 strip under the tongue as needed for withdrawal every 2-8 hours up to 32mg per day  
 Quantity #56

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

**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 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](#).

**Remove clinical barriers to treatment**

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>15</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>16</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 they only add 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, and many of the practices detailed in our [Patient-Centered, Rapid Access Approach to Substance Use Disorder](#) are applicable in the hospital setting. More insight on processes in the ED that can remove clinical barriers to treatment is also available in our [Treatment, Culture & Connection video](#).

**MORE INFO AT:**  
[CABridge.org](http://CABridge.org)

## Provide medications on discharge

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 from the hospital or emergency department to fill at an outpatient pharmacy, providers must have a DATA 2000 waiver for their DEA 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](#).

### For X-waivered providers

- Prescribe Buprenorphine-Naloxone **combination** sublingual tablets or films
  - Most patients will require 16-32mg of buprenorphine per day, daily dosing.
- Prescribe a 7-14 day supply to allow the patient time to follow-up with ongoing outpatient treatment.
  - In CA, there are requirements for providers 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>17</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 can be entered in comments for the pharmacy. Some pharmacies will not accept the electronic prescription without the X-number.
- For handwritten prescriptions include provider DEA-X number and handwritten date. State number of prescriptions and refills on the script.
- **Always provide naloxone** directly to the patient (preferred) or by prescription (at minimum) for all patients with SUD.

### For non X-waivered providers

- 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, there are several options:
  - 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 24-32mg 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 next day follow up with an outpatient X-waivered provider can be arranged.
- For inpatients, anticipate upcoming discharge and seek support from an X-waivered provider in advance.

**MORE INFO AT:**  
[CABridge.org](http://CABridge.org)

## Naloxone distribution

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*.

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>18</sup> If possible, give the naloxone kit in-hand prior to discharge since many naloxone prescriptions are never filled.

### **TIP: Apply to distribute free naloxone**

Consider having your hospital apply for the [Naloxone Distribution Project \(NDP\)](#), a California statewide program funded at the federal level by SAMHSA and administered by the 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.

### **NALOXONE DISTRIBUTION PROJECT**

The Naloxone Distribution Project (NDP) aims to reduce opioid overdose deaths through the provision of free naloxone. As of August 2020, the NDP has:

- Approved more than 1,700 applications for naloxone
- Distributed more than 450,000 units of naloxone
- Reversed more than 19,000 opioid overdoses

#### **MORE INFO AT:**

[CABridge.org](https://www.cabridge.org)

## 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 goal of the program 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.

### KEY STEPS FOR CONNECTING PATIENTS TO ONGOING CARE

✓ **[Dedicate staff to linking patients to care](#)** through the role substance use navigator (SUN) or another trained staff position (case manager, social worker, etc).

✓ **[Provide training and support to navigators](#)** so that they are equipped to effectively engage and link patients to care.

✓ **[Establish connections with outpatient providers](#)** to facilitate successful connection to ongoing treatment.

✓ **[Conduct patient-centered referrals](#)** so that patients have clear guidance, support, and resources needed to make it to the next step of their treatment.

### RESOURCES

- [Substance Use Navigator \(SUN\) FAQ](#)
- [SUN Job Description template](#)
- [Hiring a Substance Use Navigator](#)
- [SUN & Clinician Champion Collaboration](#)
- [Substance Use Navigation Toolkit](#)
- [Substance Use Navigator \(SUNs\) \(video\)](#)
- [Options for Ongoing Treatment after Hospital Starts](#)
- [Discharge Instructions: Harm Reduction for Patients template](#)
- [Discharge Instructions: Buprenorphine starts template](#)
- [Discharge Instruction: BUP-XR template](#)
- [Buprenorphine – What you need to know](#)

## Dedicate staff to linking patients to care

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

A SUN is a staff member embedded within an ED or an inpatient setting to engage with patients who use drugs and facilitate treatment for SUD. SUNs 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 SUNs 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 SUN should be able to establish a human connection with people who use drugs. For guidance on bringing this critical member onto your team, see [Hiring a Substance Use Navigator](#).

**MORE INFO AT:**  
[CABridge.org](http://CABridge.org)

While a dedicated full or part-time SUN is ideal, it may not be feasible for all hospitals. The functions of a SUN 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 be able 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

## THE VALUE OF SUNS

*“Patients feel more supported with a Substance Use 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.”*

## Provide training and support to navigators

The role of a SUN is complex and requires intentional training and support. A key to success is a strong relationship between the SUN and medical staff as described in [SUN & Clinician Champion Collaboration](#). The clinician champion can help define the chain of command, orient a SUN to the hospital environment and culture, invite them to meetings, and introduce them to department heads and nurse leaders.

The CA Bridge [Substance Use Navigation Toolkit](#) is a comprehensive resource that we recommend as essential reading for SUNs, staff who supervise them, and anyone who connects patients to ongoing care. This [Substance Use Navigators \(SUNs\) \(video\)](#) presents concrete examples and tips. SUNs should:

1. **Engage patients:** SUNs play a critical role in establishing human connections with patients. We offer tools to help SUNs build these connections in our [SUN & Patient Engagement](#).
2. **Understand buprenorphine:** The SUN should know what buprenorphine is for, how to take it, and how to continue a prescription vs. do a “self-start” after leaving the hospital. This is essential to a SUN’s ability to counsel the patient prior to discharge and answer their questions.
3. **Link patients to ongoing care:** The SUN should be able to call the patient’s desired clinic and facilitate prompt follow-up. 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. **Develop patient facing materials:** Patients should receive handouts with information on buprenorphine, the clinic where they will follow up, and home starts as needed. SUNs should review these with each patient prior to discharge.
5. **Document:** SUNs 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 when the SUN is not working, the SUN needs to establish a system for follow up.
7. **Know community resources:** These may include primary care clinics providing MAT, harm reduction services, residential programs, shelters, support groups, or other resources for people with SUD. Ideally, SUNs will visit these settings so they can do warm hand-offs and encourage referrals.

**MORE INFO AT:**  
[CABridge.org](http://CABridge.org)

## SUN CHAMPION COLLABORATION

At Northern Inyo HealthCare District (NIHD), the MAT program’s ED clinician champion and SUN work hand in hand to strengthen their MAT program. Together, they educate hospital providers and staff on MAT services and engage the broader community on opioid addiction, access to treatment, and overdose prevention. As a result of their work together, the ED clinician champion now offers outpatient addiction care once a week, at NIHD’s outpatient Rural Health Clinic. This partnership has been critical to the success of NIHD’s MAT program because it has enabled them to ensure a smooth and reliable transition to follow-up, outpatient care.

## Establish connections with outpatient providers

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.

There are a variety of entities that 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, look for care that is patient-centered and easily accessible. Specific details to consider are referral process, typical wait times for appointments, insurance coverage accepted, and staff culture as it relates to caring for patients with SUD. In communities with limited access to treatment, telemedicine can be an option. For more information, see CA Bridge’s [Options for Ongoing Treatment after Hospital Starts](#).

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: guaranteed clinic follow-up within a specific number of days (i.e., allocating dedicated intake slots), establishing process for day-time referrals and a secure voicemail line for after hours referrals, and naming point persons at the hospital and clinic. See [MOU example](#).

## Conduct patient-centered referrals

While practices will vary by hospital and based on community resources, an effective patient-centered referral process should include some of the following elements:

- **Provide written treatment and follow-up instructions:** Develop patient [handouts that clearly explain buprenorphine](#) and instructions for filling and taking prescription medication. We have some templates that can be adapted for this purpose: [Discharge Instructions: Harm Reduction for Patients template](#); [Discharge Instructions: Buprenorphine template](#); [Discharge Instructions: BUP-XR template](#).
- **Conduct a warm hand-off:** 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 the SUN has visited the outpatient clinic and formed personal relationships 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.
- **Facilitate access:** Even with a warm hand-off to an outpatient provider, many patients experience barriers to accessing care. The SUN 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 buprenorphine prescriptions, helping to obtain the necessary discharge papers from the hospital, etc.

**MORE INFO AT:**  
[CABridge.org](http://CABridge.org)

- **Plan for follow up after evening or weekend starts:** When a patient is discharged in the evening or over the weekend, the SUN 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 SUN to contact when they return to work. Consider establishing drop in slots at outpatient clinics so patients can present even if a SUN 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 up to 72 hours.
- **Follow up:** The SUN should 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 seven days. If the patient does not attend the appointment, either the SUN or clinic should reach out.
- **Stay connected:** Provide the patient with a phone number that they can call after discharge to speak directly with the SUN if they encounter obstacles accessing follow-up care. Most SUNs distribute their number widely and continue to receive calls from patients when issues arise, often for many months.
- **Create a back-up plan.** If resource constraints do not allow for a full patient-centered referral process, 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.

### 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.

#### MORE INFO AT:

[CABridge.org](https://www.CABridge.org)

## Change Hospital Culture

Stigma in society and in health care settings is the top barrier to evidence-based medical treatment for people experiencing SUD.<sup>19</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>20,21</sup> Changing this culture in a hospital is a long-term process that can be started with a few basic steps.

### KEY STEPS FOR CULTURE CHANGE

### RESOURCES

<p>✓ <b>Promote harm reduction practices</b> that make patients safer if they do continue to use drugs.</p>	<ul style="list-style-type: none"> <li>• <a href="#">Harm Reduction Strategies for the Hospital Setting</a></li> </ul>
<p>✓ <b>Use non-stigmatizing language</b> that promotes respect for people who use drugs and avoids negative labels.</p>	<ul style="list-style-type: none"> <li>• <a href="#">NIDA: Words Matter – Terms to Use and Avoid When Talking About Addiction</a></li> </ul>
<p>✓ <b>Post signs inviting patients to seek treatment</b> in the ED and waiting areas.</p>	<ul style="list-style-type: none"> <li>• <a href="#">Signs template</a></li> <li>• <a href="#">Treatment Starts Here: Sign of the Times</a></li> </ul>
<p>✓ <b>Practice trauma-informed care</b> that centers on empathy and human connection and allows patients to drive the agenda and pace of care.</p>	<ul style="list-style-type: none"> <li>• <a href="#">How to inquire and respond to recent and past trauma in health care settings</a></li> <li>• <a href="#">Trauma-informed Care and a Ryan White Model of Delivery: Essential ingredients to Treat SUD and Mental Illness (video)</a></li> <li>• <a href="#">Nadine Burke Harris How Childhood Trauma Affects Health Across a Lifetime (video)</a></li> <li>• <a href="#">Fostering Resilience and Recovery: A Change Package</a></li> </ul>

## Promote harm reduction

According to the National Harm Reduction Coalition, harm reduction encompasses “a set of practical strategies and ideas aimed at reducing negative consequences associated with 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. Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users ‘where they’re at,’ addressing conditions of use along with the use itself.”

The following strategies integrate harm reduction into the hospital setting and are described in greater detail in our [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.

**MORE INFO AT:**  
[CABridge.org](http://CABridge.org)



- **Actively include people who use drugs** and experience marginalization for their expertise when developing new programming or evaluating 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.
- **Distribute naloxone** and train people who are at risk for overdose and family members in overdose recognition and response. See CA Bridge's [Guide to Naloxone Distribution](#).
- **Increase syringe access** by supplying safe consumption kits at discharge or prescribing syringes,<sup>22</sup> [Studies consistently demonstrate the effectiveness of syringe access](#) in preventing transmission of infectious disease<sup>23</sup> and skin and soft tissue infections,<sup>24</sup> while also supporting the overall health of people who use drugs<sup>25</sup> through connection to drug treatment,<sup>26,27,28</sup> medical care, housing, overdose prevention and other vital social services.

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## 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'."*

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### MORE INFO AT:

[CABridge.org](https://www.CABridge.org)

## Use non-stigmatizing language

The language we use to discuss SUD has been shown to be associated with outcomes in medical settings.<sup>29,30</sup> Consider using these alternate terms 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 use disorder (OUD)/substance use disorder (SUD) or person with opioid addiction</li> <li>Patient</li> <li>Person in recovery or long-term recovery</li> </ul> <p><b>For heavy alcohol use:</b></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><b>For toxicology screen results:</b></p> <ul style="list-style-type: none"> <li>Testing negative</li> </ul> <p><b>For non-toxicology purposes:</b></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 or actively using drugs</li> </ul>	<ul style="list-style-type: none"> <li>Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions.</li> <li>Set an example with your own language when treating patients who might use stigmatizing slang.</li> <li>Use of such terms may evoke negative and punitive implicit cognitions.</li> </ul>
Dirty	<p><b>For toxicology screen results:</b></p> <ul style="list-style-type: none"> <li>Testing positive</li> </ul> <p><b>For non-toxicology purposes:</b></p> <ul style="list-style-type: none"> <li>Person who uses drugs</li> </ul>	<ul style="list-style-type: none"> <li>Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions.</li> <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](#))

**MORE INFO AT:**  
[CABridge.org](http://CABridge.org)

## Post signs inviting patients to seek treatment

Signs offering treatment or asking if people want help with their substance use invite 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 patients visit. This empowers patients to self identify as having an SUD, preventing the need for formal screening and urine testing. Coordinating with administration and maintenance is often necessary to ensure that signs are not removed. For examples of how signs are used see [Treatment Starts Here: Sign of the Times](#).

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### 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.”*

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## Practice 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 prevent re-traumatization of patients.<sup>31</sup>

Trauma is common among people experiencing SUD, including intimate partner violence, adverse childhood experiences, and more. These common comorbid conditions are independent risk factors for mortality and may also pose barriers to attaining treatment goals for OUD. California’s Surgeon General, Nadine Burke Harris, explains [How Childhood Trauma Affects Health Across a Lifetime \(video\)](#).

Empathy and kindness are often the first steps to engagement for people not interested in starting MAT. 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 SUN, a person who has the time and skills to engage with patients on a human level. SUNs can be critical in setting a tone in the ED or hospital setting that advances the adoption of trauma-informed policies, procedures and practices.

In this [video](#), Dr. Edward Machtinger from UCSF explains the principles of trauma-informed care through the story of a patient. More strategies for implementing trauma-informed care in your hospital can be found in [How to inquire and respond to recent and past trauma in health care settings](#) and [Fostering Resilience and Recovery: A Change Package](#).

### MORE INFO AT:

[CABridge.org](http://CABridge.org)

# Program Launch Strategies

## Build Your Bridge Program

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 two key steps and offer tips for scaling these up if you have the capacity.

- Identify key players
- Educate hospital staff

### Identify key players

A single provider (champion) who uses buprenorphine to treat opioid withdrawal paired with a person to make referrals to ongoing treatment (a SUN) 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.

SUNs are the second critical element of a Bridge program. SUNs 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 [Hiring a Substance Use Navigator](#). If a SUN is not available, a case manager, social worker, nurse, or other team member can fill this role.

Engaging stakeholders early in the process, holding regular team meetings, and designating a team member as a project lead can facilitate 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.

### **○ TIP: Form a Bridge Program team**

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A more robust Bridge program includes stakeholders from various disciplines including:

- Clinician/Provider Groups (inpatient and ED, physician or PA/NP)
- Nursing
- Pharmacy
- Care Coordination (e.g., Social Work, Case Management)
- Hospital and Health System Administration
- Others such as Information Technology, Patient Registration, Security, Community Health, and Volunteer Services

**MORE INFO AT:**  
[CABridge.org](http://CABridge.org)

## Educate hospital staff

**X-Waiver Training.** While it is possible to start buprenorphine in acute care without X-waivered providers, having providers get this training is invaluable. The more X-waivered providers there are in the hospital, the more treatment of OUD will become an integral part of the standard of care as opposed to a special program. Start by identifying existing X-waivered providers and engaging them in the program. You can also conduct outreach and, resources permitting, create incentives for more providers to get X-waivered. Hosting X-waiver trainings on-site or connecting people with remote trainings can encourage more providers to participate. For details on X-waiver training see CA Bridge's [DATA 2000 X-waiver for Buprenorphine Prescribing](#).

**24/7 provider support lines.** Any provider seeking support for first-time buprenorphine starts or assistance with complex cases may utilize the substance use 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](#)  
M-F 6am-5pm; 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 like the ED lobby and patient care areas, break areas, and bathrooms.
- Host 'lunch and learns' and in-services.
- 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](#).
- Prepare & upload patient discharge instructions into the EHR or make paper copies available to those who will be caring for patients.

### MORE INFO AT:

[CABridge.org](https://www.CABridge.org)

STAFF	SUGGESTED EDUCATIONAL TOPICS
<b>Providers (physicians, PAs, NPs)</b>	<ul style="list-style-type: none"> <li>Identifying patients with OUD</li> <li>Using treatment protocols: <a href="#">CA Bridge Quick Start Guides</a></li> <li>Legality of buprenorphine administration: <a href="#">DATA 2000 X-waiver for Buprenorphine Prescribing</a></li> </ul>
<b>Nurses</b>	<ul style="list-style-type: none"> <li>Options for linkage to ongoing outpatient SUD care</li> <li>Nursing protocols: <a href="#">CA Bridge Nursing Toolkit</a> and <a href="#">Nurses Drive Care for Opioid Use Disorder (video)</a></li> <li>Stigma reduction: <a href="#">NIDA Words Matter</a></li> </ul>
<b>Pharmacists</b>	<ul style="list-style-type: none"> <li>Different uses of buprenorphine and typical dosing for those uses: <a href="#">Buprenorphine and Pharmacy</a></li> <li>Legality of buprenorphine administration: <a href="#">DATA 2000 X-waiver for Buprenorphine Prescribing</a></li> <li>Treatment protocols: <a href="#">CA Bridge Quick Start Guides</a></li> <li>Stigma reduction: <a href="#">NIDA Words Matter</a></li> </ul>
<b>Social workers and care coordination teams</b>	<ul style="list-style-type: none"> <li>How to contact the SUN and what the SUN's role is</li> <li>Where and how to refer patients to outpatient SUD care</li> <li>Stigma reduction: <a href="#">NIDA Words Matter</a></li> </ul>
<b>Technicians (e.g., ED techs)</b>	<ul style="list-style-type: none"> <li>Awareness of the MAT program</li> </ul>
<b>Hospital operators, unit clerks</b>	<ul style="list-style-type: none"> <li>Importance of patient facing signs, training on steps to take if a patient expresses interest</li> </ul>
<b>Patient registration, front desk greeters, security guards</b>	<ul style="list-style-type: none"> <li>Answers to questions frequently asked by patients</li> <li>Stigma reduction: <a href="#">NIDA Words Matter</a></li> </ul>

### 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. Unfortunately, when we started the program, the hospitalist group was in flux and now that it has stabilized, it is a good time to engage them and see less resistance in the future.”*

### INTERDISCIPLINARY TEAM APPROACH

*“The Clinical Social Workers have been instrumental in helping us to identify SUD patients in our inpatient department, and we have been able to help many of them with either an additional ED visit post discharge or direct referral, scheduling, and follow up for SUD patients within our inpatient department.”*

**MORE INFO AT:**  
[CABridge.org](http://CABridge.org)

## Measure and Communicate Success

Soon after your program launches, you should begin thinking about the data you will need for both quality improvement and sustainability. How will you know if you are meeting your patients' needs? How can you generate evidence of the program's impact to obtain the resources needed to sustain it? This section covers the steps needed to begin data collection and reporting:

- Select metrics
- Identify data sources
- Analyze and report on data

### Select metrics

Selection of metrics and data collection should be based on a thoughtful assessment of the information you need to generate for specific audiences and purposes (see section below on Plan for Sustainability). As a starting point, CA Bridge recommends consideration of the following metrics:

- # patients served by the SUN/behavioral health counselor or staff performing similar function. (**Note:** this measure is required for recipients of California's Behavioral Health Pilot Project)
- # patient visits with MAT (buprenorphine) administered or prescribed
- # patients with OUD
- # patient visits served with overdose diagnosis
- # patients served on 5150/1799
- # patients who received a referral for ongoing MAT, mental health services, residential treatment, and other support services
- # patients who successfully attended follow up appointment for outpatient MAT

#### **TIP: Create a data team**

Finding allies in clinical leadership, administration, quality improvement, and IT facilitates data collection, review, and reporting. Hospital quality and/or clinical informatics teams can pull EHR reports and tap into other relevant data your hospital might already collect, such as community health assessments, patient satisfaction surveys, or readmission information. Anyone engaged in data collection and sharing should be familiar with [42 CFR Part 2](#). For more information on data sharing, see the California Health Care Foundation's resource: [Overcoming Data-Sharing Challenges in the Opioid Epidemic](#).

### Identify data sources

Options for gathering data for the program include:

- **EHR and pharmacy reports.** When possible, data collection will be easiest and most accurate if it is pulled from the EHR and pharmacy reports.
- **SUN records.** If collecting data through the EHR is not an option, the SUN can manually track patients and their care outcomes using a paper or electronic spreadsheet. This method avoids customization or changes to the EHR and allows collection of detailed data that may be of specific interest to the program but is not included in the EHR. While this method can be effective, it is labor intensive.

**MORE INFO AT:**  
[CABridge.org](http://CABridge.org)

- **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 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.

## Analyze and report on data

**CA Bridge and Behavioral Health Pilot Project reporting.** CA Bridge has created a simple [reporting portal](#) for hospitals to report aggregate data to track the adoption of Bridge programs across the state. This portal captures data elements required of recipients of California’s state-funded Behavioral Health Pilot Project. By demonstrating the numbers of patients reached, we can ensure that Bridge programs are recognized as a critical component of a treatment system.

**Focused analyses.** When resources and capacity allow, we highly encourage hospitals to conduct focused analyses of specific subsets of patients or services for the purpose of answering specific questions. Some examples include:

- Reduction in the number of emergency department visits by high utilizers who present to the ED with SUD<sup>32,33</sup>
- Reduction in the number of patients with SUD leaving the hospital AMA
- Reduction of SUD-related hospital care
- Reduction in number and length of psychiatric holds in the ED in patients with co-occurring mental illness and SUD

**Regional or statewide data can provide context for these analyses.** Publicly available data can be found in a variety of places:

- The [California Opioid Overdose Dashboard](#) has overdose-related data that can be filtered by year, geographic area, and demographics.
- [Healthcare Cost and Utilization Project \(HCUP\)](#) has opioid-related hospital use at the state and national level, comparing rates annually and stratifying data by patient demographics, hospital setting, and expected payer.
- The [Office of Statewide Health Planning and Development \(OSHPD\)](#) has an Emergency Department Report on patients treated at the hospital and county level, with data on demographics, dispositions and diagnoses.

### **TIP:** Use quality improvement tools

Implementing a MAT program can be strengthened by using quality improvement tools such as Plan-Do-Study-Act (PDSA) cycles. Small, rapid tests of change will help you gain buy-in, understand the strengths and limitations of the change you plan to make, and determine whether the change will result in the intended improvement. The Institute for Healthcare Improvement offers a comprehensive set of [tools](#) for applying a quality improvement framework to practice change. The copy on the next page shows a sample PDSA cycle for a MAT program based on this [PDSA cycle template](#) which can be operationalized using the [PDSA cycle worksheet](#).

**MORE INFO AT:**  
[CABridge.org](http://CABridge.org)



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## SAMPLE PDSA CYCLE FOR A MAT PROGRAM

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**PROJECT:** Medication Assisted Treatment

**GOAL:** Initiate buprenorphine in the ED for >90% of eligible SUD patients requesting MAT

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### ▶ PLAN

**Description of test:** Clinician champion will educate providers on risk, benefits of bup, and how to access in the ED at next department meeting.

**What do you predict will happen?** With providers increasingly aware of MAT they will be more likely to request a SUN consult and/or initiate bup when the patient is still in the ED, even without SUN consult.

**How will you measure if your test made an improvement?** For 10 SUD patients track # of bup initiations.

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### ▶ DO

**Date(s) of test:** 8/31 – 9/4

**Notes:** Will also complete a chart review for additional detail.

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### ▶ STUDY

#### Results/Key Learning

- 50% (2/4) of eligible patients in sample identified during day shift received bup while in the ED with SUN and pharmacy support.
  - Only 1/6 of SUD patients identified during the night shift received bup.
  - Not all-night providers and staff knew about the new MAT program and protocol for prescribing bup.
  - No X-waivered providers at night.
- 

### ▶ ACT

#### What will you do next? (abandon change, more testing, implement)

- Add MAT program update as an agenda item for the next week.
- Clarify X-waiver process – patients can come back to the ED for bup, don't need a waiver to initiate bup while in the ED.
- Consider supporting at least 1 night ED doc in getting the X-waiver.
- Consider developing a resource binder for the ED providers and staff to refer to with info on the MAT program, outpatient contact information, referral forms, etc.

**MORE INFO AT:**

[CABridge.org](http://CABridge.org)

## Plan for Sustainability

Many aspects of a Bridge program are sustainable once they become part of the standard of care and culture of a hospital. The California Health Care Foundation’s [How to Pay for It Series](#) offers useful tools for financing a Bridge program and related services.

However, a critical component of a robust Bridge model is a SUN or other staff member with time dedicated to working with people with SUD. Current financing for SUNs through state and federal grants is time limited, and SUN services are not currently reimbursable. Out of the initial 52 hospitals funded by CA Bridge in 2019-2020, 19 reported that they would be able to maintain the SUN position after termination of the grant funding. To maximize your ability to sustain your SUN after grant funding ends, we recommend starting with three steps:

- Evaluate options for SUN sustainability
- Make the SUN’s work visible

### Evaluate options for SUN sustainability

The SUN role will be more sustainable if additional revenue can be generated to support it. CA Bridge conducted an in-depth analysis of ways in which hospitals or staffing groups could generate new revenue for the SUN or develop partnerships that would support this position. These options are described in [Options to Support Substance Use Navigators in Emergency Departments](#). We recommend reviewing these options while simultaneously assessing the potential for various stakeholders to be critical champions. Some key groups to consider include:

- **Hospital administrators.** Some Bridge programs have been sustained because the hospital became convinced of the value of the program. Demonstrating cost savings or changes in utilization of costly resources can make a compelling case to administrators. In addition, administrators are sensitive to staffing needs and the hospital’s reputation, so showing the program’s impact on patient, nurse, or provider satisfaction can also be persuasive.
- **Providers.** Some programs are sustained largely on the basis of provider demand. The benefits that accrue to providers may include better ED flow, fewer disruptions, or reduction in psychiatric holds resulting in less pressure on bed space. Many providers report increased job satisfaction because they have effective treatment for SUD, a problem they previously felt powerless to address. Program sustainability can be enhanced by elevating the positive experiences of providers through data, stories, or quotations that help bring other providers on board.
- **Patients.** Community reputation and trust are critical to both the mission and the viability of any hospital. Documenting patient satisfaction can be a valuable component of a sustainability plan. Many who will not be swayed by data will see impact in a single compelling patient story.
- **Health plans:** Health plans are acutely focused on costs and are interested in reduced utilization of high cost services. They also report quality metrics to employers and government agencies, including the proportion of ED visits for members 13 years and older with a principal diagnosis of alcohol or other drug abuse or dependence, who received follow up for their substance use disorder within 7 and 30 days of the ED visit. Demonstrating that a hospital MAT program can help improve the plan’s performance on this metric may increase the plan’s interest in supporting the program. Some hospitals directly pay SUN salaries for these reasons.

**MORE INFO AT:**  
[CABridge.org](http://CABridge.org)

- **County Behavioral Health.** Medi-Cal’s substance use services are the responsibility of county behavioral health departments under Drug Medi-Cal. Drug Medi-Cal programs are evaluated based on whether they get people who are identified as needing SUD care into treatment. Thus demonstrating high follow-up rates for patients identified and started on care in the ED would make a case for counties to support hospital-based programs.

## Make the SUN’s work visible

The sustainability of the SUN position is greatly enhanced by making the SUN, the services they provide, and the outcomes they achieve visible to key stakeholders. Some of the practices that Bridge programs have found effective in elevating the visibility of the SUN include:

- **Proactive relationship building:** Many SUNs make a point of systematically introducing themselves and building relationships with everyone in the ED. This is important because the SUN role is often new and is not automatically understood or appreciated by other staff whose buy-in is important for long-term sustainability.
- **Modeling collaboration:** Champions can greatly enhance the effectiveness of the SUN by actively modeling a strong relationship with the SUN. Other clinicians will see how this position can assist with effective treatment for patients who use drugs and come to rely on them.
- **Sharing follow-up information:** Sending quick emails to providers with patient updates can be extremely effective in letting providers 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 SUN funding is on the line, these provider voices can make a difference.
- **Public relations:** Working together, champions and SUNs should seek out opportunities to showcase the program to key stakeholders such as hospital administrators, medical directors, or community members. Effective strategies include writing up patient success stories, preparing data summaries, or simply describing the program and how it has improved ED workflow.

### MORE INFO AT:

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## Appendix

### Treatment Protocols

- [\*Buprenorphine \(Bup\) Hospital Quick Start\*](#)
- [\*Buprenorphine \(Bup\) Quick Start in Pregnancy\*](#)
- [\*Frequently Asked Questions Medications for Addiction Treatment and Trauma Informed Care: Pregnancy\*](#)
- [\*Acute Pain Management in Patients on Buprenorphine \(Bup\) Treatment for Opioid Use Disorder – Emergency Department/Critical Care\*](#)
- [\*Acute Pain Management in Patients on Buprenorphine \(Bup\) Treatment for Opioid Use Disorder – Medical/Surgical Units\*](#)
- [\*Buprenorphine Immediately after Reversal of Opioid Overdose with Naloxone\*](#)
- [\*Care for Patients with Opioid Use Disorder Who Are in Custody\*](#)
- [\*Gentle Self-Start\*](#)
- [\*Rapid Self-Start\*](#)

### Guides, FAQs, Toolkits

- [\*The CA Bridge Model\*](#)
- [\*Patient-Centered, Rapid Access Approach to Substance Use Disorder\*](#)
- [\*Clinical Considerations for Order Sets\*](#)
- [\*DATA 2000 X-Waiver for Buprenorphine Prescribing\*](#)
- [\*MAT Options for ongoing treatment after hospital starts\*](#)
- [\*Telehealth in CA\*](#)
- [\*Hiring a Substance Use Navigator\*](#)
- [\*SUN & Clinician Champion Collaboration\*](#)
- [\*Options to Support Substance Use Navigators in Emergency Departments\*](#)
- [\*Substance Use Navigator \(SUN\)\*](#)
- [\*Harm Reduction Strategies for the Hospital Setting\*](#)
- [\*CA Bridge Guide to Naloxone Distribution\*](#)
- [\*CA Bridge Substance Use Navigation Toolkit\*](#)
- [\*CA Bridge Nursing Toolkit\*](#)

### Skills-building Video Series

- [\*Buprenorphine In The Hospital: How Do We Do It?\*](#)
- [\*Treatment, Culture & Connection\*](#)
- [\*Substance Use Navigators\*](#)
- [\*Nurses Drive Care for Opioid Use Disorder\*](#)

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## Site Level Examples and Templates

- [Treatment Starts Here: Sign of the Times](#)
- [Signs template](#)
- [SUN Job Description Template](#)
- [Example MOU](#)
- [Clinical Opioid Withdrawal Score \(COWS\)](#)
- [Discharge Instruction Template: Buprenorphine](#)
- [Discharge Instruction Template: Harm Reduction for Patients Who Use Drugs](#)
- [Discharge Instruction Template: Bup XR](#)
- [Order set – Zuckerberg San Francisco General hospital](#)

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