TOOL

Substance Use Navigation at UC Davis Medical Center

OVERVIEW

In 2017, UC Davis Medical Center started their Medication Assisted Treatment (MAT) program with the support of one Substance Use Navigator (SUN). Overwhelming demand from patients and providers led to a 24/7 treatment program for Substance Use Disorders (SUD) across the Emergency Department (ED) and inpatient units.

In the program's initial year the SUN received up to 20-40 referrals a week with the number of referrals and community need steadily increasing month over month. In order to meet this demand, the hospital hired two additional SUNs.

With 3 full-time SUNs, the hospital has been able to expand their community outreach efforts. With SUN support at least two community-based clinics have developed their own MAT programs. In addition, SUNs serve in an advocacy role by engaging Sacramento County officials, Senators, and others on the importance of MAT in addressing the opioid epidemic. Due to the program's success UC Davis Medical Center serves as a model for other California hospitals and offers SUNs from other sites shadowing and other learning opportunities in an effort to accelerate access to MAT across the state.

SUN IMPACT

The SUNs have made a measurable impact on providers, staff, and patients, for example:

- **Increased** patient access to treatment for SUD to an average of 79 patients a month, with 60% of patients continuing treatment post-discharge.
- **Reduced** healthcare costs associated with SUD related care by 21% through ED Screening, Brief Intervention, and Referral to Treatment (SBIRT).
- **Decreased** hospital readmissions among high utilizers for SUD related care by 67%, e.g. care related to cellulitis, abscesses, endocarditis, withdrawal, etc.

About the UC Davis Medical Center Bridge Program

UC Davis Medical Center serves a 65,000-square-mile area that includes 33 counties and six million residents across northern and central California. The 625-bed acute-care teaching hospital admits more than 30,000 patients per year and handles nearly one million visits. The medical center's emergency room sees more than 210 patients per day on average.

In 2018, the rate of opioid-related deaths occurring in Sacramento County widely varies across its 55 zip codes, with several more than 3 times the California state average and others at or below. (source: California Opioid Overdose Surveillance Dashboard: https://skylab.cdph.ca.gov/ODdash/)

Structure

The program's three SUNs are integral members of the ED and inpatient care teams. The MAT program's SUN supervisor provides direct patient care, conducts community outreach, and supports two staff SUNs. The SUN supervisor reports to the hospital's Substance Use Intervention Team of physicians, pharmacists, social workers, case managers, and police officers.

Community MAT Education

In addition to direct patient care, the SUN supervisor at UC Davis spreads awareness of their MAT program and how to refer patients to this service through staff huddles, meetings with the community provider network and coaching other hospitals, SUNs, and local healthcare organizations on how to develop and implement their own MAT program.

Workday

The SUNs work Monday through Friday, 8:00 am to 5:00 pm. The two SUN staff alternate working on Saturdays. ED SUNs may adjust working hours to meet patients scheduled to initiate MAT in the ED. The SUN supervisor's schedule may change depending on other activities such as passing out harm reduction kits in the neighborhood, attending monthly team and committee meetings and assisting local police to address calls related to substance use.

Referral process

Physician and staff referral: A patient referral occurs once the ED and/or inpatient physician or other direct care provider has identified a patient as having SUD and seeking treatment. The physician or other direct care provider will request a SUN consultation using the hospital's electronic medical record. Any of the hospital's departments may also reach out to the SUN for support, for example, security will call the SUNs to help if patients in the lobby appear to have SUD.

Self-referral: SUNs receive about 10 calls a week directly from potential MAT patients who have obtained their number through the SUNs' community outreach activities. The SUN will determine if they are a candidate for MAT and direct them to the ED, where the ED SUN will meet with the patient upon arrival and hand-off treatment to the provider.

Other outside referral sources: The SUNs may also receive outside referrals, either by fax, email, or phone call, from primary care physicians, outpatient treatment clinics, health plans, and other hospitals.

SUN patient engagement

Once a patient is identified and referred, the SUN receives a consultation request via the hospital's electronic medical record. The ED SUN will respond immediately to ED referrals. The inpatient SUNs will review the day's consult list, review the patient's medical record, the projected date of discharge, and relevant insurance information (most have Medi-Cal) to prioritize referrals for immediate follow up.

The SUN meets with the patient to review treatment options and develop a personalized plan of care. For patients that are a good candidate for MAT, SUN will coordinate with the patient's provider to start treatment immediately while the patient is still in the hospital. MAT patients are discharged with a 2 week prescription for buprenorphine. The SUN coordinates follow-up care such as making an appointment for primary care services or outpatient mental health, securing placement at a residential treatment facility, or arranging transportation and in-home supportive services.

Patient follow-up

Providers and patients may choose to start MAT in the ED or inpatient units without a SUN consultation if the SUN is not available or if consultation is not otherwise needed. The ED SUN will follow up with the patient the following day via phone, while the inpatient SUNs will prioritize meeting with inpatients before discharge. If the SUN is not available to meet with a patient before they are discharged from the ED or inpatient units they will follow up with the patient via phone the following day to coordinate any additional care needs. All MAT patients will receive a follow-up phone call from the SUN at 5 and 30 days post-discharge to check-in, address any treatment barriers such as transportation or feeling unwell, and close gaps in care.