Care Navigation at Harm Reduction Programs:
Community-Based "Meds First" Buprenorphine Program Preliminary Data

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Key Findings

- Care navigation fits flexibly and productively within community-based harm reduction programs.
- Participants of harm reduction programs want—and use—care navigation services, especially in-person support.
- Providing opioid use disorder treatment with a harm reduction orientation supports honest conversations about drug use.
- Care navigation services could be an important feature of a broader, low-barrier, "one-stop" model of health care available at harm reduction programs for people who use drugs and are not adequately served by traditional health care or addiction treatment settings.

Introduction

Syringe services programs (SSPs) are well known for their success in engaging people who use drugs (PWUD), especially those who inject or smoke opioids and/or stimulants, by providing safer drug use equipment to prevent infection and disease transmission. Most SSPs also provide additional health services including onsite testing (and, in some cases, treatment) for HIV and viral hepatitis, vaccinations, reproductive health resources, and referrals or direct linkage to health and social services, including substance use treatment. Most recently, many SSPs now also offer onsite access to buprenorphine to treat opioid use disorder (OUD). Other harm reduction programs with similar services include day service programs for those who are unhoused and community health clinics with an overt harm reduction mission.

In 2019, the Addictions, Drug & Alcohol Institute (ADAI) at the University of Washington launched the Community-Based "Meds First" program to provide onsite, low-barrier access to buprenorphine in partnership with six harm reduction programs (HRPs) across Washington State.[1] **A key component of the service model was the addition of care navigation to support client engagement and retention in OUD treatment.** While care navigation is commonly used in health care, substance use treatment, housing, and mental health settings, it is rarely funded and available at SSPs and other HRPs.

This report:

- Describes the role of care navigators in buprenorphine treatment at HRPs.
- Provides preliminary data on the type, length, and content of care navigation activities.
- Discusses lessons learned and the potential opportunities and challenges to expand this service model.

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The Community-Based Meds First model of care

The Community Meds First model of care is defined by these essential characteristics:

- Service provided within or adjacent to syringe services programs/harm reduction programs.
- Care team with a prescriber, nurse care manager, and at least one care navigator.
- Walk-in, same-day access to buprenorphine.
- Six months of follow-up care as a bridge to longer-term OUD treatment, onsite or in the community.
- Ongoing substance use seen as an opportunity for further engagement, not as treatment failure or reason for discharge.
- Shared decision making for medications for opioid use disorder.
- Counseling offered but not mandated.

Six sites launched services at different times between June 2019 through May 2020. The SSP and OUD treatment services were located in a variety of settings, either in the same physical space or in adjacent locations (see Appendix 1).

Care navigation

All care navigators and nurse care managers participated in an initial, full-day training on topics including the background intent of the model of care, staff roles, OUD medications, client engagement, shared treatment decision making, and Motivational Interviewing. In addition to regular meetings with the site care team (e.g., daily team huddles, weekly clinical review), care navigators also met twice monthly with other sites' care navigators and nurse care managers for cross-learning and case consult, led by a licensed clinical psychologist and licensed social worker from ADAI.

Across the six sites, care navigators had diverse personal experience with substance use and varied professional education and training, ranging from state-certified peer recovery coaches to graduate-level social workers.

Through kind, consistent, and nonjudgmental engagement, care navigators helped clients identify and link with any number of social, emotional, and health care supports they needed to stay meaningfully engaged in their treatment for opioid use disorder (see job description in Appendix 2). In general, this work of care navigation fell into two categories:

- Client-focused activities (building rapport, visit reminders, needs assessment, service linkage, etc.).
- Administrative activities (documentation, staff meetings, etc.).

What is a care navigator?

Care navigators help individuals find their way (i.e., "navigate") through often complicated social and health service systems to connect with needed services. Care navigators are commonly used in health care, substance use treatment, housing, and mental health settings where they may also be referred to as peer navigators, patient navigators, or peer recovery coaches. Navigators may or may not have personal lived experience with substance use and can have a range of education or professional training.

Care navigators documented detailed information about their client-focused activities each day in electronic health records and other online databases and reported the following monthly to ADAI in aggregate form:

- Number and type of care navigation activities (i.e., "encounters").
- Length of time spent in each type of encounter activity.
- Main topics of each encounter.

Preliminary data on Meds First care navigation

New client initiations on buprenorphine were offered from June 2019 through September 2021 with six-month care periods ending on March 31, 2022. Data presented in this report reflect care navigation activities through the end of this period. Some sites began or ended services on different months within this period.

Client demographics

Between June 2019 and September 2021, 1,325 individuals began medication for OUD (1,323 on buprenorphine, 2 on naltrexone) with an average of 47 initiations per month. The average number of initiations at individual sites ranged from 2-20 initiations per month, influenced by factors such as staffing capacity and the number of days and hours the SSP operates (which were also impacted at times by COVID-19 restrictions).

Participants beginning OUD medications were majority male (54%), under the age of 40 (64%), and White (79%) (Table 1). The demographics of clients resembled those of the broader population of SSP participants as documented in the *2021 WA State Syringe Services Program Health Survey*.[2]

Table 1. Demographics of Meds First clients, n=1,325

Gender			Age			Race/ethnicity		
Male	718	54%	**<20**	28	2%	**White**	1,045	79%
Female	539	41%	**20-29**	330	25%	**Hispanic/Latino**	98	7%
Transgender/other	1	<1%	**30-39**	485	37%	**Black/African American**	65	5%
missing	*67*	*5%*	**40-49**	249	19%	**American Indian/Alaska Native**	38	3%
			50-59	133	10%	**Asian**	10	<1%
			60+	60	5%	**Other/multiple**	408	31%
			missing	*40*	*3%*	**Unknown**	82	6%

Types and duration of care navigation activities

Care navigators documented 12,812 client-focused activities during this period, with 41% of these activities being in-person meetings with clients (Table 2). Communicating (or attempts to communicate) with clients by texts and phone calls was common, while email was used far less often. While care navigators accompanied clients on very few appointments with outside providers (n=26), there may have been fewer opportunities to actually do so due to COVID-19 restrictions. Overall, care navigators documented **an average of 10 care navigation activities (any type) per client** during a typical six-month care navigation period.

Naturally, direct meetings with clients were the most time-consuming, whether in person (26 minutes/encounter), via videoconference (18 minutes/encounter), or while accompanying clients at outside appointments (56 minutes/encounter). On average, care navigators documented **over two hours (143 minutes) of care navigation time per client**.

[2] https://adai.uw.edu/wordpress/wp-content/uploads/ssp-health-survey-2021.pdf.

Table 2. Types and time length of client-focused care navigation activities				
	Activity type		**Total minutes**	**Average length of encounter (minutes)**
Met client in person	5,257	41%	134,076	26
Sent text, no reply received by end of shift	1,589	12%	4,784	3
Made phone call, left message	981	8%	4,399	4
Made phone call, talked with client	905	7%	8,162	9
Spoke with professional on client's behalf	828	6%	11,733	14
Received phone call, spoke with client	779	6%	5,597	7
Sent text, received reply	749	6%	4,757	6
Received text, sent response	595	5%	3,737	6
Met client via videoconference	493	4%	8,845	18
Made phone call, unable to leave message	455	4%	1,529	3
Sent email, no reply received by end of shift	89	1%	584	7
Received email, sent reply	30	<1%	236	8
Accompanied on outside appointment	26	<1%	1,464	56
Sent email, received reply	23	<1%	154	7
Sent text, received reply after shift	13	<1%	63	5
	12,812		**190,120**	**15**

Main topics of care navigation activities

Care navigators documented the main topics of each activity. Most often, care navigation activities focused on **general retention support**—texts and phone calls to remind or follow up on clinic visits or conversations to generally engage, build rapport, and strengthen relationships to encourage clients to stay connected with the care team (Table 3). Care navigators documented primary and secondary topics which are presented together in the table.

"My mission is to make sure people know that they can come in any time, for any reason, no matter what they did or didn't do. It can take a while for people to trust that we really do care about them."
-Meds First care navigator

Table 3. Main topics of care navigation activities		
Meds First program retention (staying connected, follow up on missed visits)	3,036	15%
Current drug use (polysubstance use, ongoing or recurring opioid use)	2,313	11%
Appointment/visit reminder or follow up	2,189	11%
Housing	1,615	8%
Physical health	1,497	7%
Thinking about/craving drugs (building skills to cope with cravings)	1,322	7%
Family (children/childcare, spouse/partner, other)	1,074	5%
Meds First enrollment	929	5%
Mental health	874	4%
Employment/school/training	872	4%
Money	710	4%
Buprenorphine dosing concerns	674	3%
Transportation	613	3%
Planning transition to OUD maintenance care, establishing primary care	420	2%
Other concerns	1,978	9%
	20,116	

Drug use was another common theme and included topics such as use of other substances while stabilizing on buprenorphine, ongoing or recurring opioid use, struggles with drug craving, or building skills to cope with relapse triggers.

Care navigation activities frequently focused on specific **challenges or barriers faced by clients**, especially those that made it difficult for clients to start or stay on OUD medication; lack of stable housing was the most common of these barriers. Care navigation time was spent discussing these issues with clients, identifying resources, and helping clients link to resources, all with the goal of easing the way for clients to remain on OUD medication and be successful in their other substance use or quality of life goals.

Care navigators were not asked to document if or when the main topic was raised by the client or by the care navigator. Therefore, the frequency of these topics likely reflects both client priorities and care navigator preferences or comfort level with certain topics.

What can we learn from these data?

1. Care navigation fits flexibly and productively within diverse community-based harm reduction programs.

Care navigators were able to conduct their work in a variety of indoor and outdoor settings, alongside SSP/HRP staff, and within fixed site and mobile operations. The stigma-free, "all doors always open" harm reduction philosophy creates an atmosphere that allows clients to access care navigation services when and as they need. It also allows care navigators to engage and support clients in a familiar, safe space.

> *"It's great having a care navigator right here to talk to a participant when they need to. That window opens so randomly and only stays open for a second. We would miss that chance completely if we had to say "Well, come back on Wednesday at 3:00." -SSP staff person*

SSPs/HRPs are productive places for care navigation because of their role as connecting points for people who use drugs and who may not be seeking substance use or health care services elsewhere. Care navigators are able to build on relationships initially established at the SSP/HRP to help participants access OUD medications and other supportive services.

2. Participants of harm reduction programs want—and use—care navigation services, especially in-person support.

In the 2019 WA State Syringe Service Program Health Survey,[3] nearly half (44%) of participants whose main drug was heroin indicated that they wanted "someone to help navigate services" (Figure 1). The high number of in-person meetings with care navigators, largely initiated by clients on a drop-in basis, demonstrates how important interpersonal connection may be for these individuals. Even during the COVID-19 pandemic when face-to-face connection was physically limited at times, participants still came to sites (often repeatedly) for one-on-one, in-person meetings with their care navigators.

[3] https://adai.uw.edu/wa-state-syringe-exchange-health-survey-2019-results/.

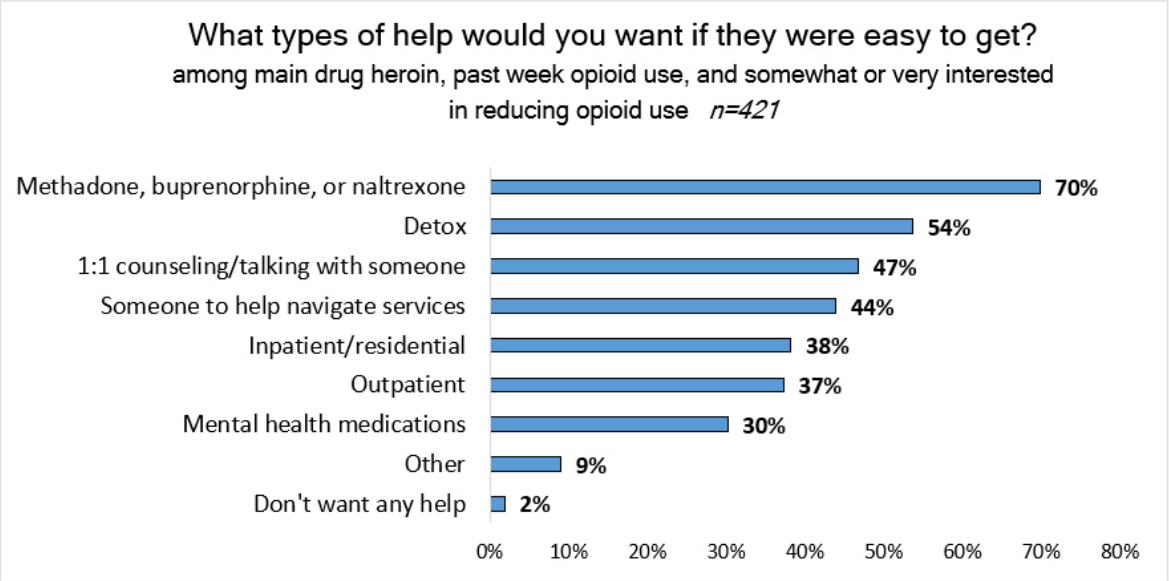

Figure 1. Interest in services to help stop or reduce opioid use. 2019 WA State SSP Health Survey

3. Substance use treatment with a harm reduction orientation supports honest conversations about drug use.

Care navigation conversations about polysubstance use and drug craving were frequent. This suggests that Meds First clients felt safe to discuss ongoing drug use without fear of losing services. This is different from traditional substance use treatment and health care settings where clients may be discharged, lose services, or be penalized in some other way for any ongoing drug use. Locating substance use treatment services in a program using a harm reduction approach (i.e., an approach that allows clients to set their own goals and that does not pre-set abstinence as a goal) creates a service mix where there is "something for everyone" and a culture that prioritizes continuity over adherence to rigid one-size-fits-all treatment regimens.

> *"You can't imagine how it feels to finally not have to lie or cheat to hide my drug use just to get some help. Here, they actually want to know about it! That seemed crazy to me at first but that's just really how it ought to be, isn't it?" -Meds First client*

4. Data collection is essential to show the scope and depth of care navigation work.

While care navigation is increasingly discussed as an important service that should be more widely available, the research literature specific to supporting people with substance use is limited. Data specific to Washington State are also extremely limited. These results show that relatively simple data collection procedures and data elements can provide rich and useful information to help fill this gap.

The data presented here show the frequency and nature of interactions between care navigators and clients. Care navigation utilization was high, and the service mix and topics of conversation appear highly relevant for people working to improve their overall health. The topics were an important mix of both harm reduction and treatment topics, implying that these services can and do co-exist.

These data also provide important evidence for health care administrators, payors, and policy makers that care navigators in harm reduction programs can successfully engage people with OUD who face significant challenges in their social determinants of health such as a lack of housing. A subgroup of those who received Meds First services (n=834) agreed to enroll in a research project (Banta-Green, Principal Investigator) that will document

health and social outcomes via multiple measures. Data analysis will be conducted late in 2022 with a research manuscript to follow.

Considerations for scaling up SSP care navigation

Care navigation located at syringe services programs and other harm reduction programs, especially in connection with low-barrier buprenorphine access, **is an adaptable, high-demand service that provides a crucial "first foot through the door" opportunity** for many PWUD to get services they might not otherwise access. Expanded easy access to methadone is also needed as it is a more effective medication for some people with OUD.

While these data quantify the *amount* of time care navigation can entail, they do not measure the effort required to connect people to care, which can often feel fruitless when outside community resources do not exist, are too difficult to use, or feel stigmatizing. Care navigators regularly reported how clients felt too discouraged to engage in outside services like primary care or ongoing OUD treatment that are traditionally structured on appointments, complete abstinence, or lengthy waitlists. In the 2017 WA State Syringe Exchange Health Survey, 59% of non-King County respondents reported they had needed medical care in the prior year but did not access it, largely due to distrust of providers who had treated them poorly in the past.[4] **Care navigation can have greater impact when there is a fuller array of low-barrier community services available.** Of note, this model of care was expanded to address methamphetamine use and related mental health issues in 2021.

> *"It's discouraging to see how much time we spend trying to get housing for clients with such little progress to show for it. We really need so much more money invested in housing resources."*
> *-Meds First care navigator*

Where possible, **integrating low-barrier, "one stop" health care and social service hubs at SSPs/HRPs is ideal**. SSPs and other low-barrier harm reduction programs provide culturally appropriate and trusted settings in which to provide these services to people who use drugs, have complex needs, and experience significant health outcomes and care access disparities. Recognizing that physical and behavioral health are inextricably linked, care navigation at harm reduction programs should be expanded beyond buprenorphine access to include the variety of health and social service navigation needs of clients and to help them progress toward their self-defined health and wellness goals.

There are several **financial considerations** in scaling up care navigation at SSPs/HRPs:

- Care navigation requires funding for dedicated staffing. Few SSPs have enough funding to pay for even basic operations staffing let alone care navigators. Many SSPs are run by staff who are loaned out from other agency or health department programs to staff the SSP a few hours per week. Current funding to support SSPs is largely allocated for harm reduction supplies, and even that funding is inadequate to cover the full need.
- Options for reimbursement for care navigation services through third party, behavioral health payors are also limited. This leaves SSPs dependent on grant and public funding to provide care navigation. Making

[4] https://adai.uw.edu/pubs/pdf/2017syringeexchangehealthsurvey.pdf

care navigation services at SSPs a reimbursable service by Medicaid, local and private dollars would substantially expand access to this popular service.

There is little published research on the role of care navigation at SSPs and its impact on client engagement, linkages, and service retention. Similarly, while there is published literature on the implementation of low-barrier buprenorphine programs at SSPs, the use and outcomes of care navigation in SSP buprenorphine programs has been largely undocumented. **Integrating care navigation into more harm reduction programs will generate opportunities to create an evidence base for care navigation** and provide insight into questions such as:

- What defines "success" in care navigation and what influences success?
- What factors enable care navigators to do their best work and flourish in their roles?
- What can SSP/HRP care navigation models and other health system care navigation models learn from each other?
- What potential partnerships or funding mechanisms can be used to build on the model and provide health engagement hubs for medical and behavioral health services?
- Can care navigation be shown to improve engagement and health outcomes and therefore be justified as a reimbursable health care expense?

Citation:

Kingston S, Banta-Green C.J. Care Navigation at Harm Reduction Programs: Community-Based "Meds First" Buprenorphine Program Preliminary Data. Seattle, WA: Addictions, Drug & Alcohol Institute, Department of Psychiatry & Behavioral Sciences, School of Medicine, University of Washington, June 2022.
URL: https://adai.uw.edu/care-navigation-2022

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Appendix 1. Location of Meds First services

Location of Meds First services				
Site	**Service providers**	**SSP services located:**	**OUD services located:**	**Care navigator located:**
Tacoma	• Tacoma Needle Exchange/Dave Purchase Project • Tacoma Pierce County Health Department	Parked van outside health department. Later inside an adjacent building	Inside health department	Van, inside SSP, inside health department
Spokane	• Spokane Regional Health Department needle exchange • Frontier Behavioral Health • Compassionate Addiction Treatment (CAT)	Inside health department and CAT	Inside health department and CAT	Inside all locations. Provided by Frontier Behavioral Health.
Centralia	• Gather Church	Mobile van	Inside agency	SSP van and inside agency
Walla Walla	• Blue Mountain Heart to Heart (BMHTH)*	Inside agency	Inside agency	Inside agency
Kennewick*		Inside agency	Inside agency	Inside agency
North Seattle	• Neighborcare Health • Aurora Commons • SSP outreach/delivery by People's Harm Reduction Alliance	Nearby street outreach, mobile delivery	Inside adjacent primary care clinic and later also at community drop-in center	At both indoor locations
*BMHTH also operates a mobile SSP van with referrals into the Meds First.				

Appendix 2: Meds First Care Navigator Job Description

The Care Navigator works closely with patients to identify and successfully utilize these resources as appropriate. The focus is on helping individuals to identify their needs and to connect them with appropriate resources that help them stay engaged with clinical care and other social and/or community-based services. This position works collaboratively with an interdisciplinary care team, including prescribing providers, care managers, and/or other care navigators. Building rapport and trust with patients, the care team, and other community supports is crucial for success in this position.

A great Care Navigator has a nonjudgmental, person-centered focus, the ability to work with people from different backgrounds, a knowledge of a variety of treatment approaches, and comfort with working in partnership with a variety of colleagues and agencies. Care Navigators are energetically driven to serve people experiencing opioid use disorder (OUD), motivated to maintain appropriate personal and professional boundaries, and embraces opioid treatment medications and rapid access to treatment services as a key part of recovery.

Duties and Responsibilities

1. Help clients assess their interest in and readiness for OUD treatment and to understand their OUD treatment options. (Shared treatment decision making)
2. Work with clients to assess other health care, SUD treatment, and psychosocial needs and provide direct referrals to agencies agreeable to the client to address these concerns.
3. Help clients directly connect to these services (can include making referrals, facilitating, or directly providing transportation, coordinating and accompanying clients to appointments, etc.).
4. Follow up and attempt to reconnect with patients who have disengaged from clinical and/or social services.
5. Provide education about health, mental health, OUD treatment, harm reduction, and general wellness to clients. Assist client in becoming an effective self-advocate in the health care system.
6. Coordinate closely with clients' care team to support engagement with care.
7. Help client successfully transition to other care settings or more intensive services as needed.
8. Document all care navigation activities as required by hiring agency (in electronic health records, treatment plans, other tracking systems, etc.)
9. Liaise with other community service providers and collaborate in local advocacy efforts on behalf of people affected by SUD, becoming knowledgeable about community resources

Qualifications

High school diploma or GED required. Certification as a Substance Use Disorder Professional, AA or BA in human services/psychology/social work desirable. Personal experience may also substitute for advanced education

Other Useful Skills and Experience

- Experience working with individuals experiencing mental illness and/or substance use disorders
- Strong communication and interpersonal skills
- Experience in forging effective collaborations with individuals and agencies
- Enthusiasm to work with underserved and oppressed populations
- Commitment to maintaining cultural competency
- Experience using electronic health records or other health information tracking tools.
- Valid driver's license

Appendix 3: Additional reading

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