Implementation Resource Kit for Health Engagement Programs for People Who Use Drugs

"Direct from the field" protocols, guidelines, and tools for providing community based, integrated health care for people who use drugs

ADAI
ADDICTIONS, DRUG & ALCOHOL INSTITUTE

CENTER FOR COMMUNITY-ENGAGED DRUG EDUCATION, EPIDEMIOLOGY, AND RESEARCH

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ABOUT CEDEER

The **Center for Community-Engaged Drug Education, Epidemiology, and Research** joins research with the "real-world" to generate innovative, evidence-based, and person-centered responses to the use of opioids, stimulants, and other illicit substances.

Our goal is to collect and share knowledge gained from research, local data, clinical expertise, and personal lived experiences of people who use drugs. We use this knowledge to improve policies and services to reduce substance-related harms and improve the lives of people impacted by substance use.

CEDEER is part of the Addictions, Drug & Alcohol Institute (ADAI), Department of Psychiatry and Behavioral Sciences, School of Medicine at the University of Washington.

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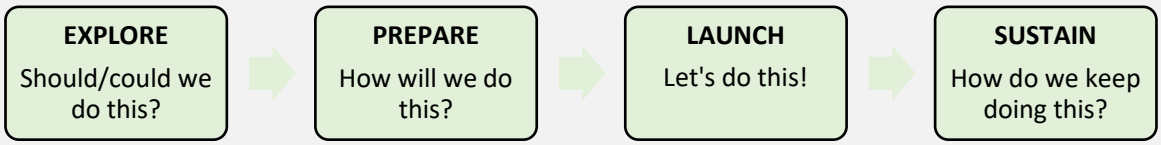
INTRODUCTION

This resource kit is for community organizations that want to implement a health engagement program to provide integrated health care, harm reduction, and substance use services for people who use drugs. Here you will find a number of tools to help plan, implement, and sustain this unique service mix. For those seeking WA State Health Care Authority "Health Engagement Hub" funding, be sure to review their requirements.

The Resource kit includes:

- An **Implementation Roadmap** to guide you through the four phases of project implementation:



- **Sample protocols, policies, and staffing documents**.
- **Templates** for planning budgets, service flow, and training agendas.
- Other tools such as **training manuals, client materials**, and **data collection forms**.

This toolkit and materials are available for download here: https://adai.uw.edu/cedeer/health-engagement-programs/.

Additional information about low-barrier buprenorphine models, other clinical support tools, and information about opioid and stimulant use disorders can be found at www.learnabouttreatment.org.

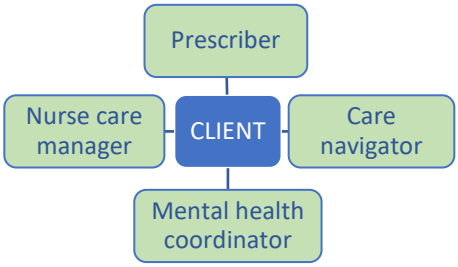
THE HEALTH ENGAGEMENT PROGRAM MODEL

Health engagement program is a broad term for a range of models providing low-barrier substance use treatment, harm reduction, and basic medical services for people who use drugs (primarily opioids and stimulants). This includes low-barrier buprenorphine programs at harm reduction programs, "drug user health hubs," WA State's Health Engagement Hub model[1], and post-overdose recovery centers. Health engagement programs are ideally co-located with syringe services programs (SSPs) and/or housed within and operated by community-based programs grounded in harm reduction philosophy and practice. In Washington State this model evolved in part from drop-in buprenorphine clinics at the Public Health-Seattle & King County syringe services program[2] and the Olympia Bupe Clinic[3].

The central goal of this model is to provide a range of coordinated services in a single, easy to access point of care where clients can build trusting relationships that encourage them to engage—and stay engaged—with health care and support services to make progress towards health and life goals.

Health Engagement Program Care Philosophy:

- Provide services where people who use drugs feel welcome and by people they trust.
- Offer services on a walk-in basis, no appointments required.
- Clients are welcome to use any service, any time they feel ready.
- The goal is to engage and support, even if drug use continues. "Keep coming back."



The particular health engagement program model featured in this resource kit uses a care team or "health support team" of a prescriber, nurse care manager, care navigator(s), and a mental health coordinator, all working together with the client. The original version of this model (called "Community-Based Meds First") was launched through ADAI in 2019 at six sites across WA State. Initially a resource for same-day access to buprenorphine to treat opioid use disorder (OUD), the model expanded in 2021 (then called "Health Support Teams") to offer Contingency Management to support people who wanted to reduce stimulant use and low-barrier mental health support and linkage with mental health treatment. These models helped inform the WA Substance Use Recovery Services Advisory Committee's recommended model for health engagement hubs in 2022[1]. WA State legislation in 2023 funded Health Engagement Hub pilots[4]. WA State Health Care Authority in collaboration with the Department of Health oversees the funding process and has specified numerous services and staffing requirements including access to primary care and behavioral health care that are outside of the scope of this resource kit. These requirements should be reviewed by those considering seeking HCA Health Engagement Hub funding [5].

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[1] https://www.hca.wa.gov/assets/sursac-plan-recommendation-seven.pdf Substance Use and Recovery Services Plan Recommendation – Establishing Health Engagement Hubs

[2] https://pubmed.ncbi.nlm.nih.gov/31403907/ Engaging an unstably housed population with low-barrier buprenorphine treatment at a syringe services program: Lessons learned from Seattle, Washington

[3] https://apnews.com/article/aafba4beec89c0cd8fd9d6bed386098e Walk-in clinics for opioid addiction offer meds first, fast. Associated Press 12/18/2019

[4] Health engagement hubs pilot program. https://apps.leg.wa.gov/rcw/default.aspx?cite=71.24.112

[5] https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/health-engagement-hub

Many of the resources, reports, and research provided here will reference the "Meds First" or "Health Support Teams" name.

Health Engagement Program services often include, but are not limited to:

- Screening and referrals for primary care, infectious diseases, substance use disorder treatment, mental health treatment, and recovery supports.
- Screening and referrals for HIV, hepatitis C, sexually transmitted infections (particularly syphilis), vaccinations or other medical services.
- Minor wound care; triage and referral for more acute medical conditions.
- Medications for opioid use disorder.
- Education to understand options and make informed, shared decisions about substance use and/or mental health treatment.
- Care navigation to assess needs for other services (e.g., housing, employment, legal, recovery supports) and to help clients connect and stay engaged with these services.
- Mental health screening and care coordination, either in-person or via telehealth options.
- Medication management for common mental health conditions.
- Behavioral health support approaches including incentives or Contingency Management.
- Emotional support and brief harm reduction counseling in 1-1 sessions or small groups.

I have been in and out of treatment my whole life and you are the first people who ever treated me well. That's why I come back and why I've been bringing my friends.

-Community-Based Meds First client

Implementing the Health Engagement Program model

The health engagement program model is adaptable to client needs, organizational capacity, and funding. An organization could implement a "full model" or take a more incremental approach to scale up staffing and services as resources and client demand increase.

Full model example	**Incremental "Ramp Up" options**
• Full services • 20-40 hours/week • 100% FTE for nurse care manager, care navigator, and mental health coordinator/counselor. • Partial FTE for prescriber(s) and program manager.	• All services but for fewer hours/week. • Fewer services but for more hours/week and/or offer them fewer hours/week. • Fewer services.

Primary care and/or behavioral health services could be added, either directly onsite or through carefully coordinated services with dedicated clinical partners in the community.

A note about Contingency Management

In the Health Support Team model implemented through ADAI, we adapted some of the tools and approaches used in traditional, treatment-based Contingency Management to work more flexibly in a harm reduction environment. These tools are not included in this Resource Kit. A summary of qualitative research on the acceptability and uptake of Contingency Management in health engagement programs is available[6] with additional research forthcoming. For more information, please contact Dr. Caleb Banta-Green at calebbg@uw.edu.

Other resources:

Contingency Management factsheet from WA State Health Care Authority:
https://www.hca.wa.gov/assets/program/fact-sheet-contingency-management.pdf

SAMHSA Guide for Treatment of Stimulant Use Disorder:
guide https://store.samhsa.gov/sites/default/files/pep20-06-01-001.pdf

To learn more about the "Meds First/Health Support Team" health engagement program model, go to learnabouttreatment.org to find:

- descriptions of low-barrier buprenorphine models.
- webinar on the Community-Based Meds First model.
- published research on the Meds First model.[7] [8]
- Care Navigation at Harm Reduction Programs: Meds First Preliminary Data Report.

[6] Winstead T, Singh S, Floyd AS, Banta-Green CJ. Contingency Management for Methamphetamine Use: Qualitative Interviews at Harm Reduction Programs. Seattle, WA: Addictions, Drug & Alcohol Institute, Department of Psychiatry & Behavioral Sciences, School of Medicine, University of Washington, March 2024 https://www.learnabouttreatment.org/wp-content/uploads/2024/04/CM-for-Meth-Use-Qualitative-Interviews-2024-3.pdf

[7] https://pubmed.ncbi.nlm.nih.gov/35799210/ The Community-Based Medication-First program for opioid use disorder: a hybrid implementation study protocol of a rapid access to buprenorphine program in Washington State

[8] https://adai.uw.edu/wordpress/wp-content/uploads/community-based-meds-poster-2023.pdf Community Based Medications First for Opioid Use Disorder- Care utilization and mortality outcomes

IMPLEMENTATION ROADMAP

Phase 1: EXPLORE → Prepare → Launch → Sustain

The questions below can help your organization determine if it has the essential elements needed to implement a health engagement program. When your organization has these elements – or a clear, achievable plan to get them – you are ready to move forward!

Essential element	Questions to consider	Further action needed
Staff support	• How interested is our staff in providing/adding this model of care to our services? This includes front desk, security, counselors, care navigators, health care providers, and administrators. • How well does the staff understand and embrace a blended harm reduction-substance use treatment philosophy? • How can this model benefit clients AND staff? • What concerns do staff have?	
Leadership support	• Does this fit within the organization's mission and capacity? • What other competing programs or service needs do we have?	
Community partners	• **Who could be our necessary community partners?** ○ These include: a pharmacy, programs who can refer clients, providers who can offer support services (housing, behavioral health, primary/specialty/pregnancy care).	

Accessible location	• **How well are we located? How accessible is our location?**
	  ○ Clients need access to nearby buses/transportation.
	  ○ Partner pharmacy should be close by and welcoming to your clients.
	  ○ Being close to harm reduction services may improve referrals and support promotion through word of mouth.
	  ○ When locating near an SSP, some clients may not wish to see drug paraphernalia or other people using the SSP. A private entrance may be preferable.
	• How will business and residential neighbors react to increased client traffic?	

Physical space, technology, and security infrastructure	• **Do we have enough infrastructure? If not, can we get it?**
	  ○ Space needs include private exam room, workspaces for all team members.
	  ○ Space needs must match client volume.
	  ○ Tech needs: HIPAA compliance.
	  ○ Security: Locked areas for supplies.	

Staffing potential	• **Do we have adequate staff? If not, will we be able to hire additional staff?**
	  ○ Internal and external talent pool.
	  ○ Consider what level of FTE/benefits is needed to attract and retain local talent.
	  ○ Consider administrative staff support for meetings, reporting, creating forms and databases, invoicing.	

Financial resources/funding	• **How much will this cost, and do we have adequate funding?**
	  ○ Depending on which services you provide and how often, staffing levels and any one-time start-up expenses, the average cost of this model can run about $500,000 per year.
	• **Main expenses include:**
	  ○ Salary and benefits (care team and admin).
	  ○ Lease, insurance, utilities, office furniture, security upgrades.
	  ○ Electronic health records.
	  ○ Malpractice and liability insurance.
	  ○ Basic medical supplies (exam table, wound care, etc).
	  ○ Developing and printing promotional materials.
	  ○ Training.
	• **Funding sources may include:**
	  ○ State/local requests for proposals.
	  ○ Private grants.
	  ○ Accountable Communities of Health funding.
	  ○ Medicaid billing (in some instances).	

IMPLEMENTATION ROADMAP

Explore → **Phase 2: PREPARE** → Launch → Sustain

Use this checklist to plan activities and set key target dates for completion. Revisit this checklist regularly to check your progress.

Task	Considerations and Resources	Action Needed or Completed ✓
PROCESS AND TIMELINE		
Choose a start date and develop planning timeline.	• Give yourself three months to plan and prepare.	
Schedule weekly planning meetings.	• Include clinical and administrative staff.	
ENGAGEMENT		
Meet with senior leadership/Board of Directors to keep them informed and address concerns.	• Create internal "project brief" for Board other potential partners.	
Identify key community partners ("champions") who might be part of your planning team.	• Pharmacy. • Primary care providers. • Harm reduction programs/SSPs. • Homeless case management. • Substance use disorder programs.	
INFRASTRUCTURE		
Plan and set up office spaces.	• Explore real estate options for new space if needed and sign rental agreements. • Workspace for each staff role, client waiting area, wound care area, storage.	
Identify and set up technology.	• Computers, printer, copier, fax, Internet. • Ask other programs what they use.	
Assess and plan for extra security needs.	• Locked cabinets, staff safety issues.	
Secure appropriate malpractice and liability insurance.	• Current programs might have recommendations.	

WORKFLOW		
Plan each step in the care flow.	• Flow: Inform clients about services→ enrollment→ clinical assessment→ care navigation support→ follow-up. • Staffing and Service Plan Template. (also in Appendix)	
Identify plan to generate referrals into the program.		
Develop clinical protocols (e.g., buprenorphine protocols, medication diversion plan, clinical follow-up plans, suicide risk protocol, overdose response).	• Sample buprenorphine protocols. • Sample Medication Diversion Control Plan. • WA Health Care Authority Buprenorphine Treatment Guidelines. • American Society of Addiction Medicine Guideline pages about buprenorphine. • Massachusetts Nurse Care Manager model articles and PowerPoints. • Overdose training resources: https://stopoverdose.org.	
Set up e-prescribing with local pharmacies.		
Determine what outcomes you need for quality improvement, basic program monitoring, or reporting required by funders.	• 2023 Health Support Team Evaluation Report by ADAI/CEDEER describes methods and data variables that might be useful.	
Develop a registry/spreadsheet/tracking system that will collect and provide those data.	• Client characteristics- demographics, housing status • Substances used frequently and related diagnoses. Routes of ingestion could be important for both clinical issues and harm reduction education. • Track service utilization by staff type if possible. • Sample Registry (see below)	

Decide on an electronic health record system. HIPAA compliance includes telehealth and email.	• EHR considerations:
	  ○ HIPAA compliance.
	  ○ Upfront and ongoing costs.
	  ○ Data security and user access.
	  ○ In-house expertise to make revisions.
	  ○ Integration with billing, communications, pharmacy, and other needs.	

	○ Ability to view both active and inactive client caseloads. ○ Ability to export data for reporting. ○ It can be difficult, time-consuming, and expensive to change data fields inside an EHR platform, so consider how the system will align with other data collection needs.	
Identify what client education materials you need and a plan to create or adapt those.	• Medications for Opioid Use Disorder brochure (available in English and Spanish) and companion guide for shared decision making. • High Dose Bupe Patient Handout. • Low Dose Bupe Patient Handout.	
Develop plans to support uninsured clients.	• Help with insurance enrollment. • How to cover prescriptions until insurance is active.	
STAFFING		
Create a staffing plan for each staff role (clinical, admin support, program manager).	• Staff hired or under contract? • Include a plan for turnover.	
Identify and hire/contract with appropriate prescribers.	• Prescribers who are willing to: ○ prescribe higher dosage levels. ○ prescribe without mandating counseling. ○ partner with a nurse care manager who takes lead on medication management.	
Develop job descriptions for each staff role. Establish clinical supervision roles.	• Sample Job Descriptions (also in Appendix).	
Schedule full team meetings to train on the care model, protocols, EHR and registry, record keeping, etc.	• Sample Training Agenda (also in Appendix). • Care Navigator Manual.	
Schedule role-specific trainings for staff.	• See list in *SUSTAIN* section.	
Support new staff in with orientation trainings.	• Organization materials (e.g., mission statement, human resource policies).	
FINANCING		
Develop budget.	• Sample budget worksheet (also in Appendix).	

Begin planning how you might fund this program long-term (sustainability planning).	• Examples:
	  ○ reimbursement opportunities.
	  ○ Building in Medicaid billing.
	  ○ connecting clients to insurance.
	  ○ building relationships with payors.
	• Potential and Recommended Billing Codes.	

MARKETING AND COMMUNICATIONS		

Develop marketing materials to advertise the program such as brochures, flyers, online content.	• Different audiences will need different materials:
	  ○ Potential clients.
	  ○ Referral sources.
	  ○ Community stakeholders.
	Meds First Program brochure.	

Introduce the program to community partners.	• Update your website. • Email blasts to relevant listservs. • Announcements and updates at regular service provider/stakeholder meetings. (And if they don't exist, consider starting one to build awareness, relationships and a more complete continuum of care.) • Schedule an open house – virtual or in person.	

A **registry to track client care** can be used during regular team meetings to track client care and maintain follow up and engagement with clients. Useful items to include are: contacts, buprenorphine induction details, demographics, prescription dates including when filled, care navigator services (e.g., help with housing, insurance), and other process of care measures. Below is a sample registry (additional registry examples are available from CEDEER).

Organization Name
Reviewed by:
Meds First/Rapid Induction onto Bup Program

Client	Medicaid	1st Contact	Initiation	Inducted	Medication type	Age	Gender	R/E	Comp Assess	Acuity	County	Housed?	Proper documentation? Insurance card? photo ID?	Most recent prescription fill date	Notes	Reinduction?	CM Services? (e.g., housing/rent/MH/ insurance)

IMPLEMENTATION ROADMAP

Explore → Prepare → **Phase 3: LAUNCH** → Sustain

This phase requires regular and frequent communication across the team to quickly identify and resolve unexpected needs and issues in your service delivery. Hiccups and adjustments are a normal part of new service roll-out, so don't feel discouraged! This is also a critical time to make sure your data collection and reporting mechanisms are working well.

Task	Considerations and Resources	Action Needed or Completed ✓
TEAM COMMUNICATION		
Establish regular meeting times to review *clinical/client-level* concerns.	• Daily care team "huddles" before clinic opens. • Weekly case consult/caseload review meetings. • Twice-a-month team meetings to discuss service flow.	
Establish regular meeting times to review *administrative* concerns.	• Weekly or bi-weekly meetings with full team to identify and resolve operational and data collection issues.	
PROGRAM MONITORING - DATA		

Create a timeline for any required reporting and process for how data will be compiled.	• Who will want reports from you? Consider how they may be curious about different outcomes or require different data.
	  ○ Funders.
	  ○ Board of Directors/leadership.
	  ○ Community partners.	

Review electronic health records weekly to ensure data are correct and consistent.		
Review other record keeping on a weekly basis to ensure data are correct and consistent.	• Are intake and retention data updated regularly?	

It's never too early to think about what you will need to maintain or scale up your program in the long-term.

Task	Considerations and Resources	Action Needed or Completed ✓
MEASURING SUCCESS		
Continue regular meetings to review and revise work plan to address challenges and changes.	• Track client care and outcomes and review at regular team meetings.	
Create process for soliciting and integrating client input into program development.	• Focus groups, 1-1 interviews, anonymous surveys.	
SUPPORTING STAFF		
Provide ongoing training webinars, shadowing etc.	**Useful topics:** • Harm reduction. • Motivational Interviewing. • Trauma-informed Care. • Suicide Prevention (e.g., All Clients Safe). • Range of substance use disorder topics: https://pcssnow.org/education-training/sud-core-curriculum/.	
Join technical assistance or learning collaborative groups.	• Contact CEDEER or WA State Health Care Authority for suggestions.	
SUSTAINABILITY		
Maintain community partnerships and relationships.	• Attend local/regional workgroups, network meetings, etc.	

Continue sustainability planning.	• Consider how you might:
	  ○ bill for services.
	  ○ connect clients to insurance.
	  ○ build relationships with insurance payors.	

APPENDIX

The following resources are available for download at: https://adai.uw.edu/cedeer/health-engagement-programs/

- Staffing and Service Plan Template
- Sample Buprenorphine Protocols
- Medication Diversion Control Policy
- 2023 Health Support Team Evaluation Report
- Medications for Opioid Use Disorder brochure and Companion Guide for shared decision making
- High Dose Bupe Patient Handout
- Low Dose Bupe Patient Handout
- Sample Job Descriptions
- Example Training Agenda
- Care Navigator Manual
- Sample Budget Worksheet
- Potential and Recommended Billing Codes
- Meds First Program Brochure

Staffing and Service Plan Template

STAFFING PLAN

Role	Name	Licensure/certification (as relevant)	FTE
Nurse care manager	---	RN	1.0
Care navigator	---	Peer	1.0
Care navigator	---	Peer	1.0
Mental health coordinator	---	BA Psychology, MSW	1.0
Prescriber	---	MD	.2
Site supervisor	---		.1
Other roles….			

SERVICE MODEL

Days and hours of clinic Mon – Fri 4:00-7:00pm	**Days and hours of SSP:** Wed 3:00-5:30pm
Name of electronic health records system	Practice Fusion
Do all staff enter activity into this EHR?	**YES**
Staff person responsible for monthly reporting	CM
How often does the full team meet to discuss program and client issues? Weekly	
How do NEW CLIENTS flow through their first visit? (e.g., which staff do they see and in what order, what steps/activities does each staff person conduct?)	
• Care Navigator (CN) meets client at the door, helps complete paperwork. • CN creates profile and checks them in. Then has client provide UA. • CN rooms client, gives overview of clinic, starts relationship building/goal development. • Nurse completes screening. • CN addresses non-medication needs and continues relationship building/goal development. • Provider meets with client, diagnoses, and prescribes as appropriate. • Care Navigator sets follow up appointment	
How do RETURNING CLIENTS flow through follow up visits?	
• CN greets client, rooms, and gets urinalysis if needed. • CN continues relationship building, addresses immediate needs, follows up on goal progress. • Nurse screens client. • Provider meets with client, reviews diagnosis, treatment plan, prescribes. • CN schedules follow up visit and provides any follow up info required.	
How do you integrate mental health services into this service flow for NEW and RETURNING clients?	
Mental Health Coordinator is stationed at clinic during regular hours and can engage clients at three different points depending on staffing/volume. 1) Greet clients as they come in. 2) Participate in initial intake and follow-up. 3) Receive a warm hand-off from care navigator, nurse, or prescriber as needed.	
How do you conduct outreach at your SSP and link SSP participants into the clinic?	
Each SSP staff is trained to offer referrals to the clinic. Mental Health Coordinator will also join the weekly SSP outreach in order to meet, engage, and assess participants with referral in mind.	

Sample Job Descriptions

CARE NAVIGATOR JOB DESCRIPTION

The Care Navigator will work to initiate treatment services and support treatment success for health engagement program clients. This position serves as a client advocate, supporting the client in OUD treatment and providing referrals to a range of social service and health care providers. The Care Navigator works collaboratively with an interdisciplinary care team, including prescribing providers, care managers and/or other care navigators. Building rapport and trust with clients, the care team and other community supports is crucial for success in this position.

Skills and General Responsibilities

- Conduct outreach to agencies and individuals to identify appropriate referrals into the program.
- Help clients understand and select medication treatment options.
- Work with clients to assess other health care, SUD treatment and psychosocial needs. Provide direct referrals to agencies agreeable to the client to address these concerns.
- Help clients connect to these services (can include making referrals, facilitating or directly providing transportation, coordinating and accompanying clients to appointments, etc.)
- Follow up and attempt to reconnect with clients who have disengaged from services.
- Provide client education about health, mental health, OUD treatment, harm reduction and general wellness. Assist clients in becoming effective self-advocates in the healthcare system.
- Coordinate closely with clients' care team to support engagement with care.
- Directly facilitate transition to other care settings or more intensive services as needed. Follow up to ensure transitions have been successful.
- Document all care navigation activities as required by hiring agency (in electronic health records, treatment plans, other tracking systems, etc.).
- Liaise with other community service providers and stay knowledgeable about community resources.

Qualifications

- High school diploma or GED required. Certificate in Chemical Dependency, AA or BA in human services/psychology/social work desirable. Personal experience may also substitute for education.

Other Useful Skills and Experience

- Experience working with individuals experiencing mental illness and/or substance use disorders.
- Thorough understanding of substance use disorders and expertise negotiating health care systems.
- Strong communication and interpersonal skills.
- Experience in forging effective collaborations with individuals and agencies.
- A nonjudgmental, person-centered focus and ability to work with people from different backgrounds.
- Ability to maintain appropriate personal and professional boundaries.
- Experience using electronic health records or other health information tracking tools.
- Valid driver's license.

NURSE CARE MANAGER JOB DESCRIPTION

The nurse care manager clients receiving medications to treat opioid use disorder. Duties include assessment, intake/admission, evaluation, triage, teaching, medication induction and stabilization, and monitoring of clients. The nurse care manager collaborates with prescribers, care navigators and mental health coordinators to assist clients and support their referral needs.

Skills and General Responsibilities

- Assess and monitor clients with substance use disorder in the induction, stabilization, and maintenance phases of treating clients with medications for opioid use disorder.
- Ongoing management of clients receiving treatment medications. Assessment of signs and symptoms of opioid withdrawal using opioid withdrawal scales.
- Ongoing client education and support in all phases of treatment including toxicology screens, routine labs, medication teaching, monitoring, observed dosing, and medication refills.
- Follow Federal and State guidelines for opioid use disorder treatment, including but not limited to: HIPPA, SAMHSA, DEA, and WAC/RCW.
- Confidential use of the Washington State Prescription Drug Monitoring Program database.
- Ongoing coordination of client care plans with the Health Support Team to address complex, co-occurring/co-morbid client needs.
- Collect and report pertinent program data using appropriate assessment techniques.
- Provide referral, transfer, and/or warm hand-off to other community services including addiction, mental health, and primary care.
- Communicate effectively and professionally with external healthcare teams (i.e., Physicians, Healthcare Providers, and Healthcare Professionals).
- Work with clients with special needs, non-English speaking, emotionally distressed, experiencing homelessness, and their families.
- Demonstrates strong communication skills and clinical proficiency in managing complex situations; ability to perform triage functions, take substance use and medical history.
- Demonstrates professional conduct, flexibility, reliability, and accountability.
- Demonstrates leadership ability and has experience and willingness to lead change.
- Provide stage one and two wound care using standard infection control techniques.

Care Management Duties and Responsibilities

- Analyze data and monitor client progress over time. Revise care plan as needed.
- Utilize client communications strategies, e.g., motivational interviewing. Involves the client in developing a plan of care, goals, or other specific measures pertinent to their health condition.
- Assess client readiness for change and collaborates with client to develop self-management goals.
- Actively participate in all leadership team activities.
- Act as a liaison between clinics, hospitals, and community resources, as needed.
- Serve as an educational resource and provide consultation.
- Maintain job specific licensure and certifications.

MENTAL HEALTH COORDINATOR JOB DESCRIPTION

The Mental Health Coordinator (MHC) helps clients who use opioids and/or stimulants to initiate and stay engaged with mental health services, including in-person and telehealth options. A great MHC has a harm reduction approach and a nonjudgmental, person-centered focus, the ability to work with people from different backgrounds, and a knowledge of a variety of mental health treatment approaches. This position works collaboratively with an interdisciplinary care team, including prescribing providers, psychiatric consultants, care managers, care navigators, and staff of syringe service programs. Building rapport and trust with clients, the care team, and other community supports is crucial for success in this position.

Duties and Responsibilities

- Support the mental and physical health care of clients on an assigned client caseload. Closely coordinate care with the client's medical provider and, when appropriate, other mental health providers.
- Screen and assess client for common mental health and substance use concerns. Facilitate client engagement and follow-up care.
- Provide client education and decision-making support on treatment options for mental health and substance use concerns.
- Provide or facilitate in-clinic or outside referrals to care as clinically indicated.
- Provide emotional support and brief behavioral interventions using a harm reduction framework and evidence-based techniques such as Contingency management and/or incentives, motivational interviewing, behavioral activation, problem-solving skills, or other skills as appropriate.
- Support psychotropic medication management as prescribed by medical providers, focusing on treatment adherence monitoring and effectiveness of treatment.
- Participate in regularly scheduled (usually weekly) caseload consultations.
- Document client progress and care recommendations in EHR and other required systems.
- Attempt to reconnect with clients who have disengaged from clinical and/or social services.

Qualifications

- High school diploma or GED required.
- Substance Use Disorder Professional (SUDP) or Substance Use Disorder Professional Trainee (SUDPT) certification, BA/BS or MA in human services/psychology or BSW/MSW desirable. Personal experience may also substitute for advanced education.

Other Useful Skills and Experience

- Strong communication and interpersonal skills.
- Experience in forging effective collaborations with individuals and agencies.
- Enthusiasm to work with underserved and oppressed populations.
- Commitment to addressing stigma and structural racism.
- Experience using electronic health records or other health information tracking tools.
- Valid driver's license.

Example Training Agenda

In-person training agenda example:

TIME	SESSION TITLE	PRESENTER
9:00 – 9:30	Introductions, Project Overview	
9:30 –10:15	Roles of the Care Navigator, Nurse Care Manager, Mental Health Coordinator	
10:15 – 10:30	**Break**	
10:30- 11:30	Medications for Opioid Use Disorder	
11:30 – 12:30	Client Engagement and Motivational Interviewing	
12:30 - 1:30	**Lunch**	
1:30 - 2:30	Treatment Decision Making	
2:30 - 2:45	**Break**	
2:45 – 3:15	Work Flow	
3:15 – 3:45	Break outs: case study discussions	
3:45 – 4:00	Wrap Up & Evaluations	
4:00	**Adjourn**	

Sample Budget Worksheet

ALL TOTALS BELOW ARE EXAMPLES. Actual costs will vary						
Salary	**Base**	**% effort**	**Salary**	**Fringe %**	**Fringe $**	**Tot Sal + FB**
Program Manager	$ 90,000	10%	$9,000	35.0%	$3,150	$ 12,150
Prescriber	$125,000	100%	$125,000	35.0%	$43,750	$ 168,750
Nurse Care Manager	$80,000	100%	$80,000	35.0%	$28,000	$ 108,000
Care Navigator	$70,000	100%	$70,000	35.0%	$24,500	$ 94,500
Mental Health Counselor	$75,000	100%	$75,000	35.0%	$26,250	$ 101,250
					Salary Costs Total	**$ 484,650**
Services						
Insurance						$ 8,000
Printing						$ 500
EHR renewal						$ 5,000
Total Services						**$ 13,500**
Lease						
Office Space	$2,000/mo*12 mo					**$ 27,000**
Client Direct Support						
Client Assistance	(phones, food, emerg vouchers,etc)					$ 1,000
Client Travel Assistance						$ 500
Total Direct Support						**$ 1,500**
Travel	staff, @ 0.54/mile					**$ 108**
Supplies						
Office Supplies						$ 3,000
Medical supplies						$ 4,000
Contingency Mgmt incentives						$ 5,000
Total Supplies						**$ 12,000**
					Direct Costs Total	**$ 538,758**
Indirect Rate 10%						**$ 53,876**
					Total Costs	**$ 592,634**