Community-Based Medication-First Program Guide to Care Navigation for Individuals with Opioid Use Disorder

ADAI
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Welcome!

This manual starts by giving care navigators a foundation of information on opioid use disorder (OUD) and medications as an evidence-based treatment. Strategies for building rapport to create productive, client-centered working relationships while helping them to navigate care will be detailed. This information will equip care navigators to effectively help individuals with OUD overcome barriers to stabilizing medication and seeking other care. Included in this manual are sections on:

1 Introduction to Care Navigation for OUD:
Provides a brief overview of the role of care navigators in helping individuals seek care to manage their OUD.

2 Evidence-based Care for OUD:
Describes the background information on OUD, and their treatments.

3 Role of Care Navigators:
Details the responsibilities of the care navigator, what is in and out of scope, communicating with clients, anticipating barriers and problem-solving strategies, and addressing stigma.

4 Care Navigator Tasks:
Presents the continuum of care for helping individuals to manage their OUD, including building the referral network and getting to know the community, onboarding individuals to medications, providing ongoing care coordination and case management.

5 Tools:
Includes checklists for specific tasks for care navigators.

Program Philosophy

OUD is a life-long relapsing brain disease that can be effectively managed through ongoing, long-term client-centered care. The Community-Based Meds-First program follows a client-centered philosophy and uses a team-based model to support the client in making treatment-related decisions. The primary priorities of the program are to a) engage individuals with OUD in care who are not seeking treatment, b) reduce barriers to initiating and sustaining care, c) help them to improve their lives in ways that are important to them, and d) provide them the tools, skills, and resources to manage their OUD treatment. The ultimate goals of this program are to help stabilize clients on medications for OUD, and if possible, transfer their ongoing care to primary care providers in the community or a primary care-based lower intensity maintenance model of care within the same organization. This will free services for the next group of clients.

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Introduction to Care Navigation

This section introduces the foundational information that care navigators can use to inform their daily tasks and help answer questions for clients and other care providers.

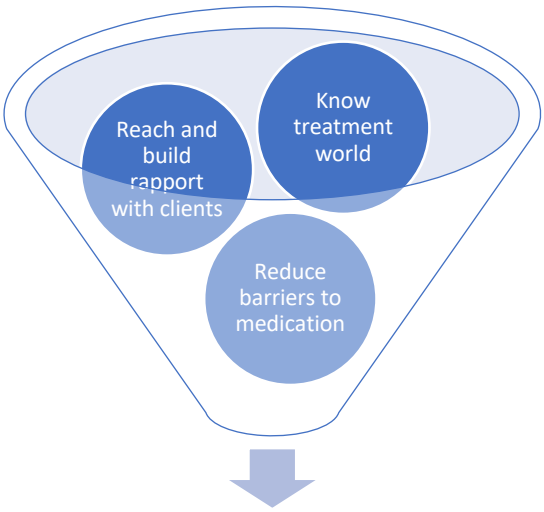
Why Is Care Navigation Important?

The United States is experiencing an opioid crisis: Every day, 130 people die from an opioid overdose and prescription opioid misuse alone costs nearly $80 billion a year, including costs related to not working, costs to healthcare, and costs due to the criminal legal system. Medications are an integral part of the solution to the opioid crisis because they significantly lower individuals' risk of fatal overdose from opioids and can help stabilize their lives.

Unfortunately, individuals experience numerous barriers to starting and continuing medications for the treatment of their opioid use disorder (OUD) even though most want to stop or reduce their use[1]. Some barriers include not being welcomed by many providers, not knowing where to go for medications, not having insurance or other means for paying for medication, and internal and external stigma. Care navigators can be essential in partnering with individuals to help them start and stay on medication for OUD (MOUD) with as few barriers as possible, which helps to address the opioid epidemic.

Role of Care Navigator

Care navigators are important allies for individuals with OUD. Your role includes knowing the relevant healthcare systems (Community-Based Meds-First and community providers), building a positive relationship with clients, and helping them to manage their OUD by accessing medications and other sources of care with as few barriers as possible. When possible, this process begins by having a treatment decision making conversation and then helping them start and stay on medication, and seek any needed additional care for their OUD.



Care Navigation

Build rapport to help clients start and stay on medication

Eligible Clients: Individuals with OUD

Individuals with OUD can include those who only use opioids as well as those who use opioids and other substances, such as methamphetamine, alcohol, and cannabis. Individuals also may present with co-occurring mental health or medical concerns, such as PTSD and/or Hepatitis C. Starting eligible individuals on medication for their OUD can help stabilize them and make it easier for them to seek out and engage with additional care.

[1] Interest in Getting Help to Reduce or Stop Substance Use Among Syringe Exchange Clients Who Use Opioids. J Addict Med. 2018 Nov/Dec;12(6):428-434.

2
Evidence-Based Care for OUD

This section provides a brief overview of the clinical evidence that is used to inform recommendations about using medications to treat individuals with OUD.

What Are Opioids?

Opioids are drugs that bind to and activate opioid receptors in the brain. These include heroin, fentanyl, and other pharmaceutical type opioids including morphine, oxycodone, and hydrocodone.

Heroin is derived directly from the opium poppy plant. Heroin can be smoked or injected alone, or combined with other drugs, such as methamphetamine ("goofballs") or cocaine ("speedballs").

Fentanyl is a newer synthetic opioid that is similar to morphine, but is 50 to 100 times more powerful. It can be prescribed as a pain reliever and can be administered via a shot, patch, or lozenge. More recently fentanyl has been manufactured illicitly. Because it is cheap to manufacture, it can be mixed into fake prescription pills that are sold on the street as Xanax, "Oxys", or other medications – this increases individuals' risk of overdose, because people may not know that they are mixing drugs and ingesting fentanyl, which is so much stronger than other opioids. It may be mixed into or sold as other drugs as well. Sales and deaths associated with illicit fentanyl are increasing in Washington State.

Prescription opioids can go by their generic or brand name. They can be taken orally via a pill or liquid, smoked, used rectally, or crushed up and snorted or injected.

Generic Name	Brand Name
Hydrocodone	Vicodin
Morphine	Kadian / MS Contin
Hydromorphone	Dilaudid
Oxycodone	OxyContin / Percocet / Percodan
Fentanyl	Duragesic / Actiq
Buprenorphine (partial opioid)	Suboxone / Subutex / Sublocade
Methadone	Methadose / Dolophine

What Is OUD?

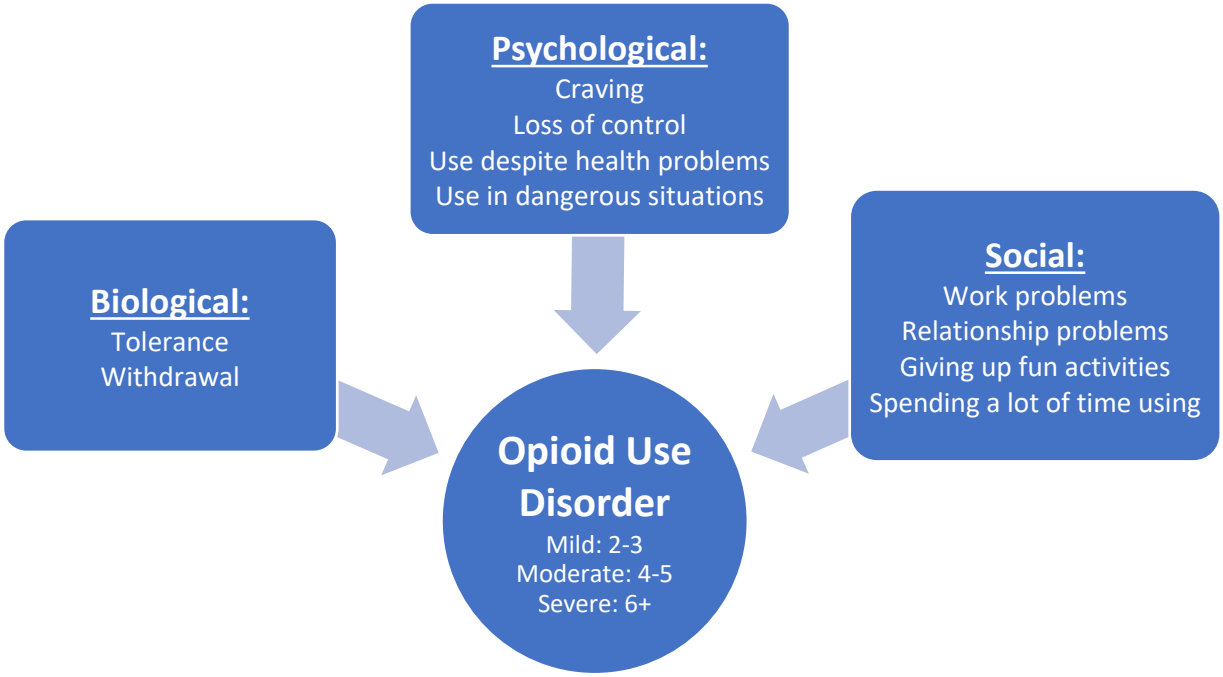
There is an important distinction between physical dependence and OUD. Similar to taking other medications, our bodies acclimate to consistent use of opioids, which results in biological changes. Namely, these biological changes include tolerance, needing more to get the same effect, and withdrawal symptoms when discontinuing or decreasing the use of opioids.

Although OUD includes these biological components (tolerance and withdrawal), they are just one piece of OUD. OUD includes other psychological and social consequences of opioid use, as described below in the bio-psycho-social model of OUD.

*An individual does **not** meet criteria for opioid use disorder if they take their opioid medication as prescribed, even if they experience both tolerance and withdrawal.*

The formal diagnosis of OUD is derived from the Diagnostical and Statistical Manual of Mental Disorders – 5th Edition (DSM-5) which defines OUD as meeting at least two of 11 criteria (see figure below) for a given 12-month period, with a current OUD being in the last 12 months. However, an individual does not meet criteria for OUD if they take their opioid medication as prescribed (for the medical indications of pain or OUD), even if they experience both tolerance and withdrawal.

Note that it is not the role as a care navigator to assess for or diagnose OUD. If a person self-reports problematic opioid use that is sufficient to have an initial conversation with them and connect them with the medical providers for an assessment.



The 11 biological-psychological-social criteria for the DSM-5 definition of OUD.

Why Are Medications Recommended to Treat OUD?

☐ Medications: Reduce mortality, drug use, and treatment dropout

Multiple studies, including large comprehensive reviews of research on treatments for OUD, have shown that buprenorphine and methadone lead to improvements in quality of life and healthcare utilization (e.g., for infectious disease), reduced risk of arrest, reduced financial costs, and significantly decreased risk of overdose and death. [1-10] Death rates are reduced for all-cause mortality, including injuries and infectious disease, as well as directly from drug overdoses.

A newer medication approved by the FDA for the treatment of OUD, long-acting naltrexone ("Vivitrol"), has preliminary evidence showing it reduces illicit opioid use; however, this medication also has lower rates of initiation and retention compared to buprenorphine and methadone and has not been shown to reduce mortality in actual practice.[11-13] As a newer medication it has less research on its use in real world situations.

The above research is the rationale for talking with individuals about the range of potential options of medications for the treatment of their OUD. Current clinical guidelines do not specify that individuals have to be 1) completely abstinent from alcohol or drugs or 2) be engaged in other therapy (e.g., counseling) to start and continue medications for their OUD.[14] However, addiction or mental health counseling may be helpful if indicated by the client or assessments.

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Evidence-based Care: Medications

Currently, there are three FDA-approved medications for the treatment of OUD:

Methadone

- A full opioid medication. The more one takes the more one feels the effects.
- Manages cravings and withdrawal by binding to opioid receptors.
- Lasts about 24 hours and is taken by mouth.
- Provided only at opioid treatment programs. It is generally given by daily observed dosing.
- Requires regular urine drug testing and counseling.

Buprenorphine

- A partial opioid medication. Above a certain dose you stop feeling more opioid effect.
- Manages cravings and withdrawal by binding to opioid receptors.
- Lasts about 24 hours, usually taken by mouth or injection.
- Can be prescribed by a medical provider and picked up at a pharmacy.
- Can also be dispensed at some opioid treatment programs that offer more structure and counseling.

Naltrexone

- An opioid blocker. It is not an opioid.
- It can manage cravings for some people.
- An injection that lasts for about 28 days. Individuals should not use any opioids for 7-10 days before taking naltrexone.
- Prescribed and administered by a medical provider who may require urine drug testing and counseling.

3
Role of Care Navigator

This section provides a general description of the care navigator's role in the Community-Based Meds-First program, their relationship with clients, and their responsibilities in helping navigate care.

Care Navigators: What You Do and What You Do Not Do

Your primary tasks are to establish a positive and functional relationship with clients, and to facilitate their initiation and continuation of medications for the treatment of OUD (as long as they want to stay on medications). While this process may involve flexing in and out of other roles (e.g., providing some light case management), this depends on your needs and availability, and policies outlined by your supervisor and your agency. The Community-Based Meds-First model is based on most care navigators providing the services listed under the category of "always" most and perhaps all of the time. The tasks listed under things you "can" do should be done infrequently. These additional tasks can be very important, but if a person requires a high level of case management, outside resources/services should be sought.

What You **Always** Do	What You **Can** Do (when time allows)	What You **Do Not** Do
☐ Build community connections	☐ Light case management	☐ Discuss medication dosing or contra-indications
☐ Build rapport with clients and be their advocate	☐ Accompany clients to outside appointments	☐ Therapy
☐ Maintain professional boundaries	☐ Problem solve barriers to other treatment (addiction, medical)	☐ Act as a sponsor
☐ Receive referrals of clients		☐ Full case management
☐ Discuss medication options		☐ Billing
☐ Connect w/ other providers		☐ Develop *personal* relationships with clients
☐ Remind clients of visits		
☐ Problem solve barriers to medications		
☐ Help clients sign up for insurance		
☐ Actively follow-up with clients who have been lost to care		
☐ Reconnect clients to care if they experience a recurrence of use		
☐ Help clients connect to a long-term MOUD care provider		

Person-Centered Care

Person-centered care is an effective approach to partnering with clients that is based on respecting their autonomy and caring for them on their own terms. The fundamental principles of person-centered care include:

- Building a true partnership among the client, their provider, and their friends/families (when appropriate)
- Promoting a client/provider relationship that promotes client self-management and collaborative decision making
- Delivering care that is individualized to clients' needs

Clients' needs and preferences should be considered the primary drivers of care, with agency and provider needs secondary (when possible). This is in contrast to previous models of treatment that may have employed a confrontational or expert-to-novice care model.

Your role is to assist the client in advocating for themselves and understanding the choices open to them. This is to prepare the client for making treatment decisions based on their own personal needs, preferences, and goals. It also requires encouraging and supporting the client to take a much more active role in their treatment than they may be normally accustomed to and helping them feel self-empowered in their recovery journey. This approach helps clients adhere to *their* treatment plan, improves communication, and helps build positive relationships.

Communicating with Clients

☐ Three Parts of Communication

Active Listening

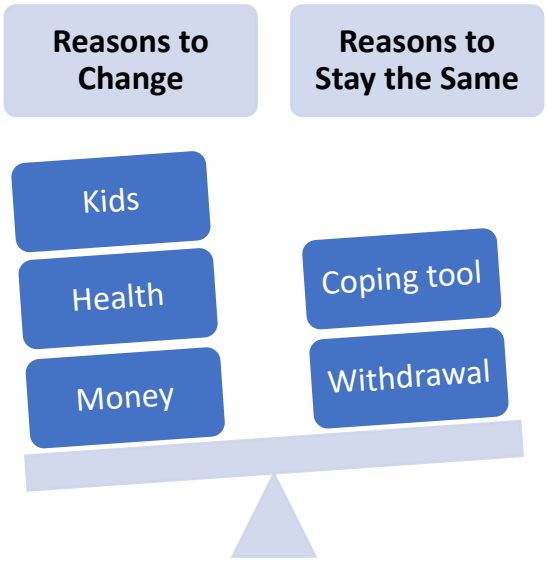
Active listening is an essential part of building a positive and trusting rapport with your clients. In addition to improving your relationship with your client, taking the time to listen to their concerns and preferences ultimately will make you more efficient and better prepared to help them. Active listening involves focusing on what your client is saying, giving them space to speak, and not rushing to talk next. Some ways that you can let your client know that you are listening are:

- Nodding your head
- Waiting to respond
- Reflect what they say
- Listening noises ("mmhmm", "right", "uh huh")

Asking

Open-ended questions are questions that cannot be answered with a "Yes" or "No" response and are a helpful tool for asking about their thoughts on their opioid use and preferences for treatment. Open-ended questions can include:

- *How are things going for you?*
- *What have you heard about different medications?*
- *Why do you want to change?*
- *What's made it hard to change?*
- *What would you miss or lose if you stopped using?*
- *What's worked for you in the past?*



When talking to clients about their opioid use, thoughts on medications, and other goals, it is important to both explore their reasons for wanting to change their behaviors as well as reasons for wanting to stay the same. Identifying individuals' reasons to stay the same can help you problem-solve barriers to changing with them. For example, if an individual uses heroin as a coping tool to deal with childhood trauma, you may refer them to mental health counseling; or if they continue to use to avoid withdrawal, you can discuss with them the benefits of medications or other services.

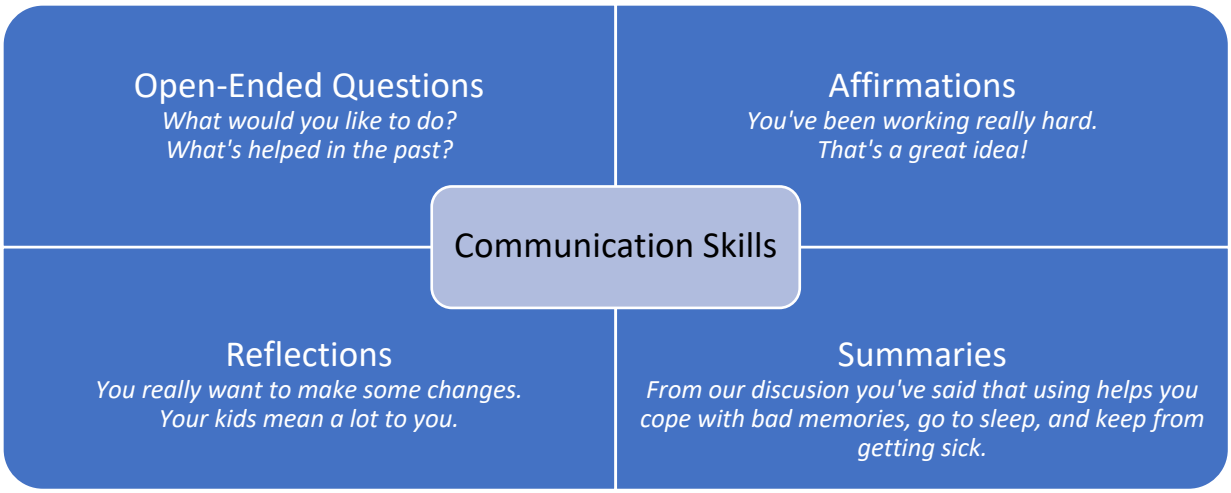
Informing with Permission

Is it okay if I share some information with you?

You bring important expertise to the interactions with your clients, including accurate information on medications to treat OUD, navigating the process of getting and staying on these medications, and how to seek related care. It can be helpful to provide this information to your client after first getting their permission, which is consistent with a person-centered approach. You do not have to ask for permission every time, but doing it every so often helps to balance the power dynamic and support your clients in feeling confident and able to make medical decisions.

Communication Skills

You can use these and other skills within the three parts of communication to actively listen to clients, ask them about their experiences and preferences, and offer helpful information.



Addressing Stigma

Unfortunately, the reality is that individuals with OUD may experience stigma from a variety of sources, including friends and family, healthcare providers, and others in their communities. Stigma can create enormous barriers to accessing care and be a disincentive to staying in care. You play a role in helping to address and reduce the stigma experienced individuals with OUD by:

- Engaging with clients early and often to convey that you are an ally to them
- Taking a person-centered approach
- Listening respectfully and nonjudgmentally to your client
- Advocating for them to others in your agency and in your community
- Supporting them in finding self-help groups (e.g., AA, NA) that do not discriminate against medications for OUD
- Educating others about OUD and evidence-based treatment (if they express concerns about friends or family undermining them being on medications, see if their medical provider is willing to talk with friends/family about the importance of medications)
- Exploring clients' own stigmatized thinking about MOUD and abstinence, and how labels can impact their treatment compliance (e.g. you're just swapping one addiction for another by being on an opioid-based treatment medication)
- Exploring your own biases about MOUD and abstinence

Anticipating Barriers and Problem-Solving Strategies

Barriers to Medications	Potential Strategies for Care Navigators
Recurrence of disease	• Understand open door policy "I'll work with you whether or not you relapse" • Do intensive follow up of disengaged clients- policy of set number of follow up calls, letters, actual outreach contact efforts • Learn strategies to help clients proactively avoid return to use, and what to do if they do use again
Polysubstance use	• Describe agency policy that use of other substances does not prevent them from accessing care • Identify referral resources for intensification of treatment with outside provider if warranted
Client distrust of healthcare system	• Spend time building/repairing rapport with client and understanding his/her concerns • Reiterate your role as your client's ally and advocate • Remind client of agency policies and goals (e.g., our goal is to do everything we can to keep providing you care) • Join the client in attending initial outside appointments
Paying for treatment	• Have familiarity with Medicaid and other resources and paperwork: how to restart someone who's been jailed, how to help someone get ID if necessary, how to connect with appropriate eligibility staff
Pharmacy challenges/ payment	• Understand the nuances of different pharmacies, know which are reliable, carry the medication, approved by insurance • Establish professional relationships with nearby pharmacies to streamline the process of helping clients when difficulties arise
Attending MOUD visits – transportation issues	• Have contact with local resources for transportation • Understand agency policy around transportation services and potential to use taxis/shared rides
Attending MOUD visits – remembering/punctuality	• Understand no-show policy, reminder calls/texts, follow up calls after visit, some programs offer flexibility/walk-in appts • Consider beginning to coach clients in attending appointments
Losing medications/ suspected diversion	• Understand agency policy • Get lock boxes • Strategize with client • Be aware of pill count policies and rationale for this
Housing	• Have good knowledge of local referral networks and personal contacts to refer client to • Help set realistic expectations with clients that waitlists for public housing may be long
Mental health comorbidity	• Understand access issues, have contacts with local resources • Accompany client to first appointments (whenever possible)
Health comorbidity	• Understand access issues • Have personal contacts with local resources • Help educate client on being an effective patient • Can accompany client to first appointment if necessary

	• Get releases signed • Follow up on progress
Social support	• Have knowledge of local recovery support resources, peer supports in community, MAT/MOUD friendly AA and NA groups • See if the medical provider is willing to talk with friends/family who are hesitant of MOUD about the importance of medications
Transitioning MOUD to long-term community provider	• Engage in treatment decision making conversation with the client from the beginning of their time with the Meds-First Program to identify where they would like to eventually transfer their MOUD • Identify and problem-solve potential difficulties with transfer to receiving provider (e.g., difficulty discontinuing other drug use, making scheduled appointments) • Emphasize the benefits of transferring to a long-term MOUD provider (e.g., comprehensive care if at primary care) • Help the client schedule initial appointment with receiving provider, give reminders, and offer to attend appointment if able

Preventing Burnout

☐ Setting Personal Boundaries

One of the more challenging parts in the role of the care navigator can be setting personal boundaries with clients. This is because of a desire to help clients however possible and seeing clients in complex, difficult situations. Setting boundaries early and consistently can help prevent burnout. Boundaries also are helpful for clients – it is less confusing for clients if they get consistent responses within this program and learning the kinds of responses that they will get from other healthcare providers. This will help them to eventually transition to other settings. It can also provide a model for them as they learn to set boundaries in their personal life.

Setting boundaries can also help you be consistent in your approach as we are often tempted to provide additional attention and services for those with "easier" personalities and those in crisis - this can help protect you from real or perceived favoritism.

By setting the same boundaries and keeping them consistently, we are better able to provide equitable care to all clients.

If I make an exception for one client, I really have to think about why I'm doing it:

Why them? Why now? Why not for other clients?

☐ Setting Limits – Time & Tasks

Receiving calls/texts off-hours	•Do not respond off-hours. Clarify what your hours are. Set this boundary early and stay consistent •Provide local 211 information/wallet card if appropriate
Family member calls	•Have client sign ROI for family members in advance •Do not provide information to family member without an ROI •Acknowledge family members' input without commenting on it
Driving clients	•Talk to your agency •There may be travel funds to help clients get to the pharmacy for the first time without having to drive them (this is for safety reasons)
Providing a job reference	•Do NOT provide job references for any clients •Doing this may put the care navigator in a difficult position
Going to court with client	•Talk to your agency •Discuss with care team if appropriate
Responding to clients in a crisis (e.g., suicidality)	•Refer the client to the crisis hotline in the area or call 911 •Care navigators should not be put in the position to provide therapy or safety planning
Responding to clients on social media	•Be clear with clients that this is not a platform for communication and that this is consistent with all clients (and is not personal)
Responding to inappropriate behaviors from clients	•Discuss boundaries with client •If not responsive, seek additional consultation from supervisor

4
Care Navigator Tasks

This section describes in more detail tasks related to learning about your agency and community to help identify community resources, onboarding clients to medication, help them stay on these medications, and engage in needed care coordination.

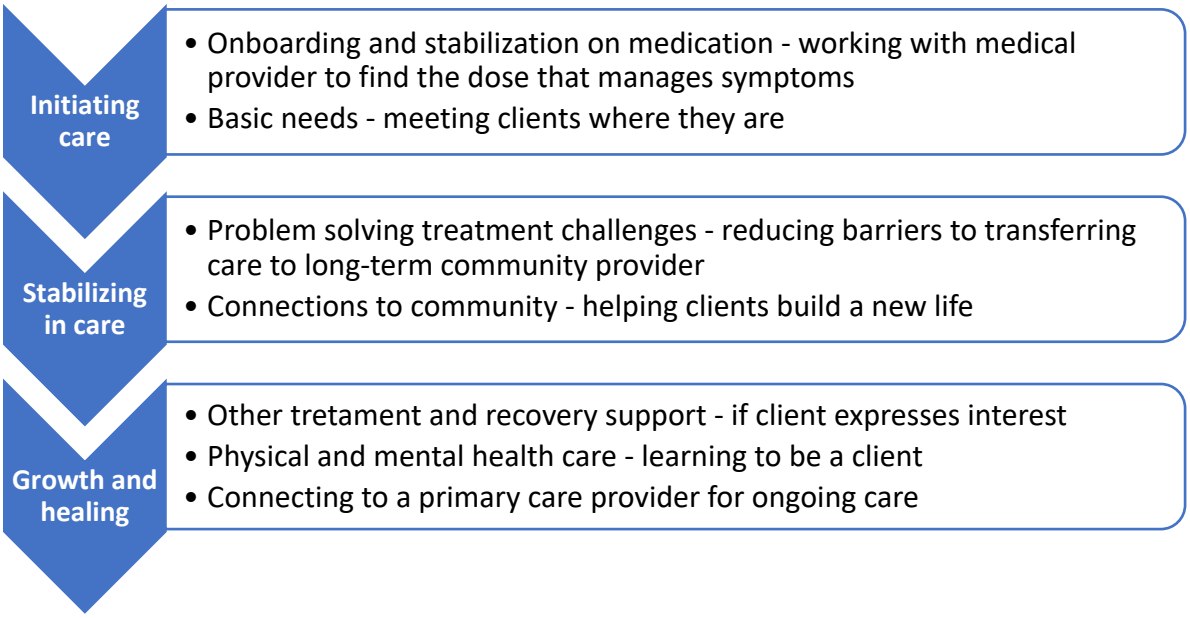
Building Referral Network

Onboarding

Ongoing Care Coordination

Helping Clients across the Care Continuum

Overall, it can be helpful to think about the care navigator tasks across a client's continuum of care in the following three phases:



Building a Referral Network & Getting to Know Your Community

☐ Learn Your Agency

You are now a representative of your organization, so you will want to connect with your administrator to learn more about your program and make sure that you are efficient and an accurate representative of your program when establishing relationships with others in the community.

In addition to meeting with your administrator, you should introduce yourself to other staff members at your agency and tell them of your role as a care navigator and provide a brief description of clients who would be appropriate referrals (individuals who may have OUD with any interest in medications).

It is important that you build relationships with others in your agency and community – this will facilitate referrals and help you in coordinating client's care.

It also will be necessary for you to familiarize yourself with:

- **Agency philosophy**: What is the approach to addressing OUD taken by your agency?

- **Agency flow**: Where/when/how do clients first come in contact with someone at your agency? What kinds of services are provided at your agency?
- **Staffing**: What kinds of staff and providers are there at your program? What staff members might see individuals with an OUD (i.e., who may be a potential referral source)?

☐ Learn Your Community

In the beginning and throughout your time as a care navigator, an important task is to connect and build relationships with potential referring providers in your community – this includes both those providers who may refer potential clients to you as well as providers to whom you would refer clients.

You should prioritize establishing relationships with primary care providers and other opioid treatment programs who may be able to deliver ongoing care to clients.

Because the ultimate goal is to transition clients to providers who can manage their medications long-term, you should prioritize establishing relationships with primary care providers and other opioid treatment programs who may be able to deliver this long-term care. Forming these relationships early will help make that transition easier for clients down the road.

You also should identify other potential outside referring and referral providers by asking other staff members for recommendations, documenting where you have received referrals, and by exploring other nearby agencies. Think creatively about the types of organizations that may serve people who would do well in the Community-Based Meds-First program (see examples in the table below). You may reach out to them directly or by contacting the director of the agency, and either by phone or email. It may be most beneficial to offer to visit them in-person to help establish a better working relationship, provide a description of the program and appropriate referrals, and answer any questions that they may have.

Potential Providers/Agencies Who May Refer Clients to You	Potential Providers/Agencies to Whom You May Refer Clients
Primary care physicians	Primary care physicians
Emergency departments	Specialty medical treatment
Hospital inpatient units	Syringe exchange programs
Syringe exchange programs	Substance use counseling/counselors
Substance use counseling/counselors	Mental health counseling/counselors
Mental health counseling/counselors	Substance use detoxification
Substance use detoxification	Opioid Treatment Programs
Jails	
Housing/Homeless service providers	
Police and Emergency Medical Services	

Map of Community Resources

It likely would be beneficial to create an interactive map of local resources, which could include public services, housing and shelters, food backs, and other treatment sites. For example, you can do this through Google Maps by saving these locations and categorizing them. This will help you to orient yourself to your community and be a useful tool with clients.

Figure 1. Example Map of Service Providers

☐ Forming Relationships

It is helpful to get to know the resources in your community in a personal way so you can give a good endorsement of the resource to your client and encourage your client's successful participation through your "inside knowledge" and personal links.

Some ways to develop relationships with other agencies might include:

- Getting introduced to referral agency personnel from your own personal and professional networks
- Offering the referral source the opportunity to present their program to your agency
- Partnering in joint endeavors
- Joining advocacy or other community groups together
- Visit the agency to personally to share your own program resources and information on OUD including brochures and wallet cards
- Arranging joint trainings or formal working agreements

Thinking of referral as active collaboration with community partners is a way of building "authentically connected networks" for your clients, rather than thinking of referral sources as being merely a list of phone numbers to give out.

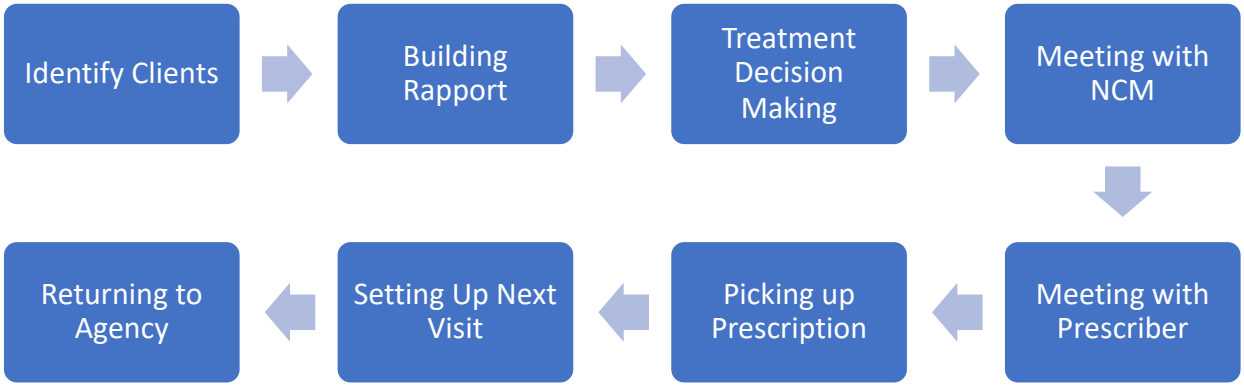
It is very challenging for clients to successfully link to resources they are not familiar with. The strength of your relationship with other providers in the community can be the bridge that helps them get the services they need. Best practices to consider include:

- Normalizing help seeking for your client
- Explore client's misgivings and doubts, encourage self-advocacy
- Ensure client eligibility at receiving agency
- Offering a "warm hand off" to the other agency by accompanying client to their first visit, or at least calling together to make the first contact
- Closing the loop - checking in with client and agency staff to follow up on how the referral went

☐ Learn How to Access Basic Resources in Your Area

Your clients likely will need other support services to help them stay on medications and stabilize their lives. Therefore, it will be necessary for you to learn the other basic resources in your area so that you can be prepared when clients' present with difficulties such as:

- Housing/shelters/Section 8 housing
- Food/food banks/food stamps
- Cell phones (e.g., "Obama phones") and getting minutes
- Clothing
- Getting on social security/disability
- Unemployment offices
- JobCorps/employment services/felony-friendly employers
- Vocation rehabilitation (DVR)
- Help with creating resumes and doing interviews
- Child care resources
- Foreclosures and refinancing
- Paying utility bills
- Low-cost sources for recurring medical supplies (e.g., diabetes test strips)
- United Way referral services
- How to get birth certificate/identification



Onboarding Clients to Medication

☐ Identifying Clients

While this should not be a priority for care navigators, there are multiple ways to do outreach to identify clients, such as:

- Placing posters/brochures/wallet cards in the waiting rooms at your agency
- Receiving referrals from other providers and staff within your agency
- Connecting with providers in community agencies, including hospitals, inpatient and outpatient mental health and addiction treatment centers, nearby jails, prisons, and probation/parole departments

Referrals can come from numerous sources, such as needle/syringe exchange programs, primary care physicians, hospital emergency rooms, inpatient drug treatment programs, and self-referrals.

☐ Building Rapport

When you've identified a potential client, it is essential to build rapport throughout your interaction, particularly at the beginning. This will increase the likelihood that clients will come back. Some helpful tools for building rapport include:

Early **engagement** is one of the most important tasks for care navigators.

- Validating the individual's struggles with their use and navigating the healthcare system
- Being neutral and nonjudgmental (e.g., "I am not here to judge you if you use alcohol or drugs, I'm here to help however I can")

- Affirming clients' desires and efforts to improve different aspects of their life
- Focusing on your client when you are with them
- Asking open-ended questions
- Positive body language and appropriate tone of voice
- Reflecting on and summarizing client experiences
- Understanding client health literacy, using appropriate language and materials
- Helping to ensure client privacy and confidentiality
- Shared problem solving
- Maintaining appropriate boundaries

Keeping in Contact with Clients

Having regular contact with clients will help with building and maintaining rapport. You can start with more regular and consistent contact at the beginning and then begin to space out contact throughout your six months of working together.

Time Period	Intensity of Contact
Day 1	Engagement with Community-Based Meds-First Program, treatment decision making conversation, and check-in with clients after their initial medical visits
Days 2 and/or 3	Check-in with clients (e.g., by phone) to ask how they are doing on the medications – physically, emotionally.
	Help clients plan for their first few follow-up visits, problem-solve potential barriers to returning. This can be done on the first day and/or by phone prior to their next visit.
Month 1	Make weekly contact with clients (or more, if needed)
Months 2-3	Make contact with clients at least every other week (or more, if needed)
Months 4-6	Make contact with clients at least one per month (or more, if needed)

☐ Treatment Decision Making: Talking about Medications

Once you have built initial rapport, determined that the individual meets criteria for OUD, and is interested in medications, it is helpful to continue with a nonjudgmental conversation about treatment decision making and potential options.

Some clients may present already having decided that they want to start buprenorphine, and may not be interested in having a more in-depth discussion about other medication options (e.g., if they are in active withdrawal). Offer to have this conversation now or at any point, and remain open if they want to stop or change medications at any point.

> *"Sounds like you already have had a positive experience with bupe and are interested in starting today. Let me know if it ever would be helpful to go over the other meds now or in the future."*

Ask

When having a Treatment Decision Making conversation with a client, start by asking about their specific goals, interest, and experience with trying to cut back or stop their opioid use. If they give a vague answer like "get healthy," ask them "what that would look like for you?" Try to use the same language they use to talk about their goals for cutting back or stopping. Language like "treatment" or "recovery" may be helpful for some clients and not for others.

Explore and Educate

Many individuals already have experience with treatment/counseling and/or medications for OUD. Talking about past experiences is important to understand their perspective and to identify any misperceptions or gaps in understanding. You can then provide accurate information and correct any misconceptions about medications for OUD.

Questions that may be helpful to ask about their past experiences with *each type* of medication:

- *How was it helpful?*
- *How did you feel emotionally/physically when you used this medication in the past?*
- *How did your friends/family/others in your social network react to you being on medication?*
- *How did being on the medication fit in with your recovery?*
- *Did you get this medication from a doctor or off the streets?*
  (Note, this is not to judge the client's behavior, rather, may start a discussion about whether or not they were on the right dose for a consistent amount of time)
- *How convenient was it to get the medication* (e.g., location, times, pharmacy pick-up)*?*

Let them know that you are just providing an introduction to the care settings and medications. You can't provide any medical advice of any kind, they'll need to talk with a medical provider about whether a medication is right for them.

Walk clients through the brochure, one point at a time, allowing space for questions or discussion. Do not just read the brochure to them; look for their reactions- confusion, skepticism, interest- and check in with them about what they are thinking about the information you are sharing. If you see them looking at a particular section, ask them if they would like to go over information in that section first- people like information presented in different ways and the brochure purposefully has the information organized in different ways (e.g., by treatment setting vs. by medication).

Individuals will often want to talk about medication doses, how medications interact with other medications they are on, or other health conditions. In every instance re-state that you are providing basic information so that they can pick out a reasonable next step to pursue. You

could help them organize their medical questions by writing them down so they remember to ask their provider about all the concerns and questions they have.

Support and Empower

Let the client know that you are there to help support whatever decision they make. Let them know you will be there to help them access services at this time, or later if they are not ready. If they start care, and decide to stop, or relapse, you will be there for them.

Encourage them to fully explore what will work for them and how they will move forward with their personal plan.

Sample script:

What types of things have you done in the past to cut back on your use? What has worked well and what has not?

I'd like to talk to you about treatment options and what types of treatment you would like to try. There are new medications, new places, and new ways to get care.

We'll talk about:

- *What exactly OUD is*
- *Different medication options*
- *Your preferences*
- *Some of the pluses and minuses of options from your perspective*

If there is an option you want to try, I will work with you to find treatment near you. If you're interested in medications, you'll need to meet with a medical provider to find out if a particular medication is appropriate for you.

After today, I will continue to be available to work with you to talk about how medication is going, and help you get back on treatment if you stop.

I will keep working with you whether or not you relapse. Treating OUD is like treating other health conditions. It may be that different treatments need to be tried until the one that works best is found.

Treatment Options

When talking about medications, feel free to use the brand names Suboxone and Vivitrol. Ask if they are familiar with these medications or have heard them called other names (Subs, Bupe etc.).

Washington State Medicaid pays for all medications. Other insurers pay for most of them. Exploring medication options with payers and pharmacies when setting up a program is important to ensure smooth starts on medications.

For some individuals, the setting where they receive care is the most important factor, followed by the medication(s) they're interested in.

Ask about their preference for:

- How often they want to go
- Counseling requirements or availability
- How much structure they want.

Some care most about being on a specific medication, with the care setting being secondary, for them you can start with discussing medications and *then* discuss the 3 different treatment settings.

Remember not all care setting options will be available in your community and care navigation services only are for clients who opt for care at your agency (office-based buprenorphine, naltrexone). This is because other care settings will have their own support services (e.g., required counseling for methadone in Opioid Treatment Programs); however, care navigators can help bridge clients to Opioid Treatment Programs.

Things to Consider at the End of the Conversation

- Good chance to ask, "What have you learned that's new? What questions do you have? What options interest you?" Help them identify which settings and/or medications are of interest.
- Clients may express interest in counseling or other treatment that does not involve medications. Acknowledge that counseling or social supports are valuable to many people.
- If they discuss treatment options that prohibit or may not be supportive of medications, point that out to them and encourage them to pursue supportive services that let them make their *own* decisions about what types of care they want now and in the future. Let them know that you support them in any decision they make.

☐ Connecting Clients to Healthcare Team: Meeting with Nurse Care Manager (NCM)

For clients interested in starting medications, provide the client with a warm handoff by walking them to their meeting with the NCM if possible.

Medical Screening

When meeting with the NCM, the NCM will do an initial medical screening, including collecting information about current medications, and any immediately relevant medical, addiction, and mental health histories; and conducting any needed physical examinations. The NCM will assess for OUD, opioid withdrawal (if recent use), and determine eligibility for medications.

☐ Connecting Clients to Healthcare Team: Meeting with Physician or Provider

Diagnosis

Providers will confirm an OUD diagnosis and the client's fit for medication.

Prescription

If the provider finds that the client is appropriate for MOUD, the provider either will: 1) write a prescription for buprenorphine (the duration will depend on the client and situation), 2) refer the client to an Opioid Treatment Program (OTP) for methadone or buprenorphine (on-site or nearby, if available), or 3) provide instructions to the client about steps to get a naltrexone injection. If a client will be prescribed buprenorphine, the provider or NCM will discuss the steps for office or at-home induction.

If available, the care navigator should be waiting to meet with the client immediately following their meeting with the provider/NCM. The care navigator will then discuss referrals to an OTP or other clinic for naltrexone, or help the client problem solve how to get their first buprenorphine prescription.

If care navigation services are not provided by the same agency as the medical care (i.e., if you do not work under the same agency), clients should sign a universal release of information between medical care and care navigation to facilitate coordination.

☐ Picking Up the First Prescription

Insurance

It will be necessary for clients to have insurance and have this verified in advance to ensure that their medications can be paid for. Check with your agency to see if or who might be able to confirm this. If there is no identified staff person to help with this, you should identify other places in the community where individuals may go to enroll in Medicaid or explore other insurance option (e.g., county-funded insurance for non-US citizens).

Helping to Navigate Pharmacy Pick-Up

Because most agencies do not have an on-site pharmacy, it will be necessary to help the client to find a pharmacy that carries their medication and problem-solve transportation. If possible, accompanying the client to the pharmacy can increase the probability that the client will start the medication as indicated. Some pharmacies will deliver medications and this option should be explored as it may be ideal for some or all clients/agencies.

☐ Setting up Next Medical Visit

Schedule Next Visit

After the client meets with the NCM and provider, make sure to check-in with the client about any remaining questions that they have and find out when they are scheduled to come back.

It also may be helpful to collect additional contact information from clients and verify at other visits. Collected contact information may include (be sure to describe that providing this contact information assumes permission to use it):

- Personal phone number and mailing address
- Phone number(s) and mailing address(es) of spouses/partners and family member(s)
- Names, phone numbers, and mailing addresses of community agencies where client may frequent (e.g., homeless shelter, day centers)

Site-Specific: Nurse Care Manager Check-In Call

Depending on the site protocol, the NCM may reach out to the client after their initiation appointment to see how they are feeling since starting buprenorphine, including side effects and any other aversive reactions, such as:

- Mouth numbness, redness, or pain
- Headache
- Dizziness
- Numbness or tingling
- Drowsiness
- Sleep disturbances
- Stomach pain, vomiting, constipation
- Feeling intoxicated or trouble concentrating

The NCM also can remind the client of their next visit – this is to provide multiple reminders to increase likelihood that the client comes to their visits.

☐ Returning to the Agency

Reminder Call for Visits

> *Reminder calls also can be a nice opportunity to check-in with clients: "How are things going? Anything I can help with?"*

Given the potential that clients will be experiencing instabilities in their lives, maintaining a connection with them and reminding them of visits will be helpful – this may include reminding them of their medication-related visits as well as other appointments (e.g., other medical appointments).

Depending on the regulations of your agency and clients' documented permissions, reminders may be made via telephone calls, text messaging, or email. You likely will start to understand the needs of your individual clients and whether they need multiple reminders (e.g., day before and day of) or just one reminder prior to their visit. Note that some programs will not have specific visit times, but rather drop-in times.

This is very important for the returning for the first follow up visit and may well be important for most or all of their early medical visits.

Adjusting Medication Dosing as Needed

At their follow-up visits with the NCM or providers, clients will discuss how they are doing on the medication, any side effects, and other indications that providers may consider when adjusting medication doses.

Picking Up New Prescription

Once the clients have met with the NCM or provider, they will receive a new prescription. If possible, you can check in the client after these visits and help them problem-solve transportation to their previous pharmacy or find a new one, if needed.

If Clients Miss Their Visit(s)

> *Reinforce to clients early and often that missing visits does not disqualify them from services or medications.*

At the beginning of your services and throughout your interactions with clients, it is helpful to reinforce that missing visits will not disqualify them from services or medications. Rather, if they miss their initial follow-up visit(s), this signifies that the client may be in a crisis and requires more emergent and intensive responses. This may look like repeated phone calls, texts, and other contact attempts; and/or trying to find the client physically (if this is permitted by client).

☐ Site-Specific / After 1+ Weeks: Psychosocial Evaluation

Once clients have been initially stabilized on their medication, are not going through withdrawals, and have returned to the agency multiple times, care navigators should do a more thorough clinical/psychosocial evaluation with clients. Conducting this evaluation with clients who are still going through withdrawal and/or are otherwise struggling may irritate them and/or hurt rapport, which may make individuals less likely to return to your agency and continue their medication.

The purpose of the psychosocial evaluation is to inform ongoing care navigation. Consult with your agency for any additional information that is required to collect; however, a formal evaluation is not necessary for the Community-Based Meds-First Program.

Ongoing Care Coordination & Case Management

☐ Continuing Medication

Ongoing Visits for Adjustments to Medication Dosing as Needed

Clients will meet with the NCM and their prescribing provider regularly within their first few months of starting buprenorphine. These visits will be used to check in with the client about any new side effects or other medical issues, ongoing symptom (e.g., cravings) or side effects, and, if necessary, adjustments to medication dosing or type. Decreasing the frequency of these visits will be a team-based decision.

Clients also may need to provide a urine sample. Depending on your agency policy, these urine samples may or may not be randomly screened for buprenorphine and other drugs. Screening for buprenorphine will help to identify any potential diversion of medications and screening for other drug use will be used to inform clinical care (e.g., needing to increase medication dosing) – screening positive for other drugs will not result in the client being discharged from the program.

Providing reminders for all visits will help to ensure that clients come to their necessary visits and can continue their medications.

At the end of the clients' visit, clients will be provided with a prescription that will last them until their next visit. If available or necessary, check in with the client to see if they need additional assistance with getting to their previous pharmacy or finding a new one.

If Unable to Make/Keep Contact with Clients

Given the complexity of some clients' lives, it may be that some will become difficult to keep in contact. For example, some clients may have difficulty paying for their cell phones and will have them shut off or be "couch surfing" and difficult to locate. This is why it will be important to collect multiple points and modes of contact during the initial visits with clients and to verify contact information on an ongoing basis.

☐ Making the Care Plan – After Initiating and Stabilizing on Medications

A great care plan is created by the client in partnership with the care team and it is something they feel full ownership over. It is an action plan that will assist them in achieving their unique personal goals in their recovery journey. Elements to include are:

- Assessment of the clients' strengths and past successes and inclusion of these. Any needs assessment should be reviewed and updated regularly
- Involvement of important family, friends, and other helpers indicated by the client
- Articulation of short- and long-term goals with measurable and realistic objectives to improve quality of life and eventually help the client transition care
- Clear assignment of roles and responsibilities to both the client and the treatment team
- Effective discernment of how the client really wants to proceed

*The goals for every care plan should include stabilizing on medications and **transferring care to a community***

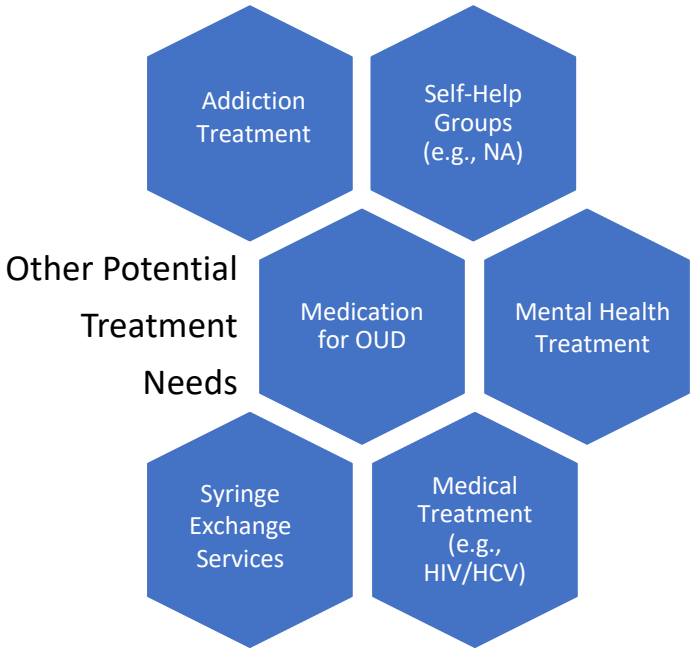
It is helpful to always give the client a copy of the plan and to have it available so that all members of the care team can access it. A key role for navigators is communicating the care plan to the team and updating team members with any challenges or barriers to progress in the care plan.

☐ Other Care Coordination

If your client is ready to start other drug treatment services and/or peer support groups, work with them to identify concrete action steps. This can include:

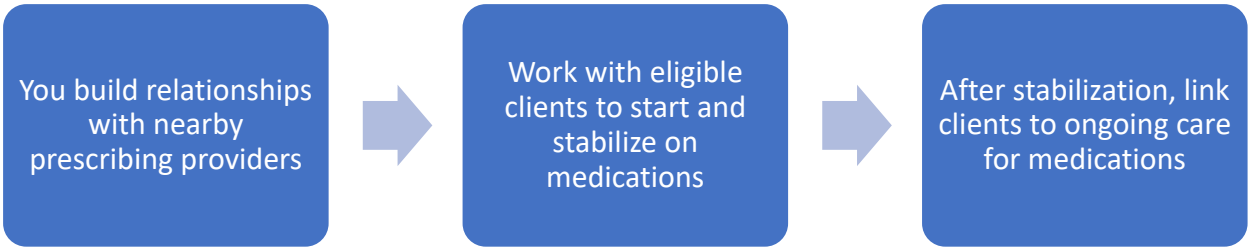
- Calling the Washington Recovery Help Line with them, or referring them to the Help Line to find an appropriate provider or peer support groups that do not discourage MOUD: http://www.warecoveryhelpline.org/moud-locator/
- Offer to help them set up an appointment with a provider and/or take them (if able to)
- Go with them to the program If they are still processing what they need to do, encourage smaller steps. Offer to call or text them in a few days, or set up a follow up

appointment. Help them make a specific plan that includes next steps and short-term goals for addressing their OUD.



☐ Connecting Clients to Ongoing Community Primary Care / Opioid Treatment Provider

After the client has been stabilized on medications of their OUD, a goal may be to connect the client with a primary care physician or other provider for longer-term opioid treatment. This is to help free available space at your agency and with you so that new clients can be helped. Additionally, connecting clients with a primary care physician will help to integrate them into the larger healthcare system, establish a relationship with a provider for ongoing monitor, and get any other services as needed. This may mean a referral to an outside agency, in some agencies it is possible that a step down in care can occur within the same clinic.



If Clients Do Not Want to Transition or Return to Your Agency

Some clients likely will be apprehensive to transition their care to a new primary care provider in the community or will return to your agency after transitioning. This may be related to concerns with meeting a new provider, being familiar with and/or attached to you and your agency, and with other clinics' procedures (e.g., discontinuing clients' medications after screening for polysubstance use, missing appointments, etc.). It will be important for you to familiarize yourself and establish relationships with other community providers so that you will know who will be most receptive to receiving your clients and anticipate any difficulties.

Some tips to help with this transition are:

- Meet with community providers in advance to know who will be most receptive to clients on medications for OUD and learn their clinic procedures. Then, relay these procedures to clients so they know what to expect when they transition.
- Assist community providers with understanding the Community-Based Meds-First Program policies around ongoing other substance use. Inform them that the FDA has issued guidance encouraging care with buprenorphine regardless of benzodiazepine use (licit or illicit). Share with them the initial study of King County's Buprenorphine Pathways project that found good retention and low mortality rates for those who continued with other substance use including illicit substances.
- Clients appreciate when expectations are clear to them. Be clear from the beginning that the goal of this program is to eventually move them to someone else in the community who can provide ongoing care. Or another model of care within the same agency if that is an option.
- Remind clients that a significant benefit of moving to a community provider is so that the client can establish a long-term relationship with that provider – both for ongoing medication if/as needed, as well as monitoring of other current and future health concerns
- When possible, transition clients to a new community provider within the first few months so that there is remaining time to provide care navigation service while they are in the new setting. This is helpful for the client and the new provider.

Documentation

☐ Clinical Documentation

Check with your agency about if/how you are required to document clinical interactions in an electronic health record.

Additionally, you will document all client interactions using the provided Windows Access tracking database, including outreach attempts and completed phone calls, text interactions, letters, emails, etc.

You do not need to separately enter each outgoing/receiving text or missed calls, but capture the full scope of that interaction in one entry. For example, if you call a client and leave a voicemail, and they call you right back, this can be entered as one entry as you making an attempt to reach them.

For each client interaction, you will document the date, minutes spent on interaction (i.e., time talking on the phone, or total amount of time spent texting back and forth), and areas of concern that arose during that interaction (you will include all that apply):

- Drugs-using
- Drugs-thinking about/craving
- Medication treatment-enrollment
- Medication treatment-retention barriers
- Medication treatment-dosing concerns
- Addiction counseling treatment-enrollment
- Addiction counseling treatment-retention barriers
- Mental health counseling treatment-enrollment
- Mental health counseling treatment-retention barriers
- Peer support (12-step, self-help)
- Social support-retention barriers
- Family-partner/spouse
- Family-children/childcare
- Family/other issues
- Money
- Housing
- Transportation
- Employment/School/Training
- Illegal behaviors
- Consequences of crime
- Health-physical
- Health-mental
- Appointment reminder
- Insurance
- Primary care transition

Depending on what your agency decides, it is expected that you will interact with other program clinical team members on a regular basis. This likely will include at least weekly onsite team meetings (e.g., including the NCM, providers, care navigators, community counselors) and monthly meetings with full program participants, including onsite clinical teams, care navigators, and research staff.

5
Tools

This section including a checklist for onboarding clients to medication, and general checklists of daily and weekly tasks.

Onboarding Checklist

- ☐ Prescreening
    - ☐ Assessing OUD
- ☐ Screening
    - ☐ Verify insurance
- ☐ Meeting with nurse care manager (NCM)
- ☐ Meeting with prescriber
- ☐ Picking up prescription (or getting if delivered)
    - ☐ Research enrollment
- ☐ Setting up next visit
- ☐ Returning to the agency
    - ☐ Reminder call for visit
    - ☐ Picking up new prescription
    - ☐ Clinical evaluation

Daily Tasks Checklist

Identify Clients for Needed Follow-up:

- ☐ Identify clients with no upcoming visits scheduled
- ☐ Review caseload of clients for missed visits from previous day
- ☐ Check for clients with upcoming visits for reminder calls

Phone Calls:

- ☐ Call referral resources to monitor successful attendance of client at visit
- ☐ Call individuals referred from other agencies
- ☐ Call clients with upcoming/missed visits

Documentation:

- ☐ Update case notes
- ☐ Update care navigator tracking log

Weekly Tasks Checklist

- ☐ Staff complex cases at agency team meetings
- ☐ Reach out to community agencies to partner, including emails, calls, site visits
- ☐ Check local and neighboring jail rosters weekly for current clients