

Addiction Treatment Starts Here + California Bridge Program

The ED and Health Center:
Learning From Two Effective Partnerships

June 17, 2020



Webinar Reminders

1. Everyone is muted.

 *6 to **unmute**

 *6 to **re-mute**

2. Use the chat box for questions and to share what you're working on.

3. **This webinar is being recorded.** The slides and webinar recording will be emailed and posted to the ATSH program page and the California Bridge website.

Today's Agenda

- Introductions
- Overview of two partnerships: Santa Barbara and Orange County
- Substance Use Navigators (SUNs): Roles and Responsibilities
- Panel Discussion: Improving Coordination Between the Emergency Department and Health Centers
- Coming Attractions

ED-Health Center Collaboration



Introductions

Joe Sepulveda, MD
Facilitator

Family Health Centers of San Diego

Santa Barbara Partnership

Santa Barbara
Neighborhood Clinics
• Nancy Tillie

Cottage Hospital
• Armando Rivera
• Camilla Lettini

Orange County Partnership

KCS Health Center
• Stella Kim

UC Irvine Hospital
• Tiffany Hwang

Overview

Santa Barbara

- ED referrals per month: **10 (OUD only)**
- MOU between SBNC and Cottage: **Yes**
- Data sharing between SBNC and Cottage Hospital: **Cottage Hospital is view-only for SBNC**
- X-waivered prescribers:
 - # at SBNC: **8**
 - # at Cottage ED: **11**
- Open access/walk-ins at SBNC: **Yes**
- Patients with post health center ED visits: **10 total (3 with OUD)**

Orange County

- ED referrals per month: **13**
- MOU between KCS and UCI: **No**
- Description of data sharing between UCI and KCS: **Sharing MRN, DOB, Insurance, Follow-Up Info**
- X-waivered prescribers:
 - # at UCI: **34**
 - # at KCS: **4**
- Open access/walk-ins at KCS: **Currently appointment only (due to COVID-19)**
- Patients with post health center ED visits: **6**

Substance Use Navigators (SUN): Role

- Liaison, bridge, navigator, advocate, coordinator → Many titles, one meaning:
 - With compassion and understanding, help the vulnerable population of people connect to the treatment they want, need, and deserve, while fostering a harm reduction approach, and ensuring access to life-saving naloxone.
- Know what resources are in your community
- Utilize motivational interviewing (SBIRT) and educate
- Collect data
- Remain a support system on a patient's recovery journey

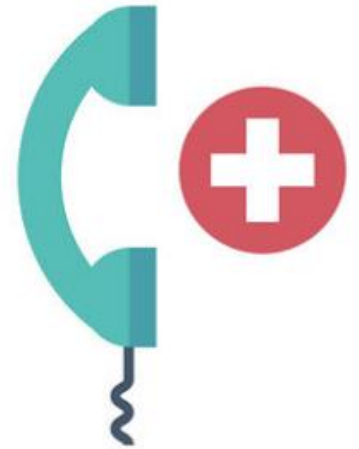


Discussion



Access and Capacity Issues

- What are the biggest challenges in connecting patients to ongoing care after discharge from the ED?
- How have you addressed these challenges in your partnership?



Warm Hand-Offs



Describe the value of and process for a warm hand-off from the ED to a health center.



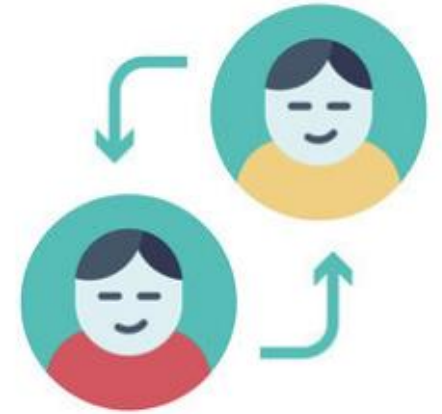
What challenges do you face in transitions in care for populations such as patients who don't have stable housing, those being released from detention centers, etc.? How can you improve those care transitions?

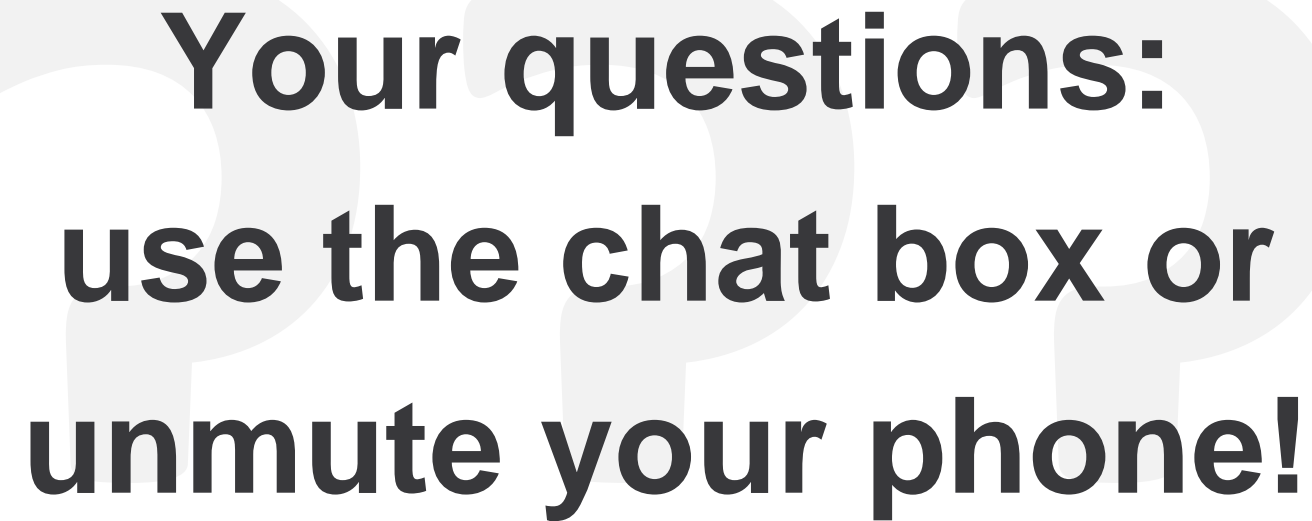


What data sharing and communication facilitates that warm hand-off (e.g., having health center forms at ED to be completed in advance)?

Planning Process

- Describe the planning process for establishing coordination between the ED and health center.
- What expectations did you set (e.g., around workflow, data sharing, etc.)
- Where do you recommend that EDs and health centers begin if they haven't yet started to coordinate?





**Your questions:
use the chat box or
unmute your phone!**

Poll

- On a scale of 1-5, please select the number below that best represents your overall experience with today's session.
- Please select the number below that best represents your response to the statement: Today's session was a valuable use of my time.



ATSH Coming Attractions + Resources



July 23: Learning Session Webinar 3
(Managing Pain, Patients Without
Stable Housing, SBIRT, etc.)



ATSH COVID-19 Resource Hub –
federal/state guidance
documents, tools and more!

CA Bridge Program Coming Attractions + Resources



**June 23: Augmenting Pain Control
for People with OUD**

Questions? Contact . . .



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Thank you!

