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Senate Bill 5195 Behavioral Health Agency Implementation Toolkit

Washington State Health Care Authority

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Contents

Introduction

Summary of Senate Bill (SB) 5195

The number of opioid overdose-related deaths in Washington State has significantly increased. In response, the legislature passed SB 5195, which requires licensed or certified behavioral health settings to distribute prepackaged opioid overdose reversal medication (i.e., naloxone) clients at risk of an opioid overdose for individual use or to assist clients in obtaining naloxone from a pharmacy. All licensed or certified behavioral health agencies (defined in **RCW 71.24.025** subsection 30) that provide treatment for mental health, treatment for substance use disorders, secure withdrawal management, evaluation and treatment, or opioid treatment programs are impacted by the requirements of SB 5195.

The purpose of the new law is increase community access to naloxone by ensuring that individuals at-risk of an opioid overdose leave qualifying behavioral health settings with naloxone in hand. Prescriptions alone for naloxone are not effective as they often remain unfilled. Naloxone in-hand has been proven effective and used widely to reverse overdoses in community settings, qualifying behavioral health settings are required to inform every client with symptoms of opioid use disorder (OUD) about the availability of naloxone, ask whether the client already has naloxone, and if they do not assist the client in obtaining it. The clients who receive naloxone are provided training on how to use naloxone, overdose prevention and reversal education, and information about harm reduction strategies and medications for opioid use disorder. Impacted organizations are also required to bill insurance for prepackaged naloxone as outlined in the legislation.

For the 5195 BHA requirement quick sheet please refer to **Appendix A - SB 5195 BHA Requirements - Quick Sheet**

Naloxone Overview

Naloxone is an opioid antagonist that preferentially binds to opioid receptors. In blocking the opioid receptors, naloxone can temporarily restore respiratory drive to patients who have experienced what may otherwise be a fatal overdose. Naloxone has a duration of 30-90 minutes, and when naloxone wears off overdose symptoms may return as opioid agonists re-bind to receptors. Observation and additional doses may be required following a successful reversal. In people with physical dependence on opioids, naloxone may cause withdrawal symptoms. Naloxone has no effect on a person who has not taken opioids and will not cause harm if administered to people have not used opioids. Naloxone will not reverse overdoses of non-opioid substances and may restore respiratory drive in a poly-substance overdose that includes opioids. Naloxone can be administered intranasally or intramuscularly and has been proven safe and effective when administered by non-clinical community members. Naloxone is a critical harm reduction and lifesaving tool for anyone who uses opioids, their family, friends, and individuals at risk of witnessing or responding to an overdose.

Harm Reduction

Harm reduction is a set of principles, policies, and practices that seek to reduce harm caused by drug use and the stigmatization of people who use drugs. Harm reduction recognizes drug use will always be a part of our society, that not all drug use is harmful, and that much of the harm associated with drug use can be attributed to stigma and bias as opposed to the drug itself[1]. Harm reduction accepts that not everyone is willing or able to practice abstinence and requires that all people are treated with respect and positive regard regardless of their relationship to drug use. Identified by the Department of Health and Human Services, harm reduction is one of the four critical interventions to combat the overdose crisis. Harm reduction is not a new principle and is already integrated into healthcare settings[2].

Existing examples of harm reduction include removing weapons from the home of a person expressing suicidal ideation, the use of multi-vitamins in the treatment plan of clients with eating disorders, or frequent testing in clients who are at risk for STIs. Approaching drug use from this perspective is not new either. Syringe exchange programs popularized during the AIDS crisis provided clear evidence that promoting and distributing clean needles reduced the transmission of HIV and Hepatitis C without increasing drug use or other risk behaviors. Harm reduction practices designed specifically for people who use drugs have typically taken place in community settings and are not yet standard in all behavioral health settings. The process of standardizing harm reduction services involves developing evidence-based protocols, focusing on treatments that reduce mortality rates, and acknowledging the damage caused by bias towards people who use drugs. Initial approaches to addressing bias in healthcare settings include adopting person-first language when discussing drug use.

Terms to Avoid	Replacement Terms
Addict, user, junkie, drug seeker	Person with substance use disorder, patient
Drug abuse, drug addiction, habit	Drug use, drug misuse
Clean	Person in recovery, abstinent

1 National Harm Reduction Coalition, 2021
2 Center for Disease Control, 2021

Another important consideration is viewing recovery on a spectrum that is defined by the individual and does not always include or require abstinence or participation in support groups. Recovery is defined by SAMHSA as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." Recovery from substance use disorder mirrors recovery from any other chronic illness. Recovery starts by making incremental positive changes and can include periods of remission and use. Examples of positive change may include carrying naloxone, practicing safer injection techniques, reducing use, initiating medications for opioid use disorder (MOUD), and developing a trusting relationship with a healthcare provider.

How to Use This Toolkit

This toolkit will provide guidance for creating an initial program that meets the requirements of Senate Bill 5195. This document is intended to be flexible, and adaptable, for settings starting a new naloxone distribution program and those with existing programs. While this toolkit outlines considerations and suggestions, it recognizes that success comes from leveraging existing program structures and finding the solutions that work best for your agency.

It may be helpful to identify a lead person, committee, or program manager to oversee the initial implementation of a naloxone distribution program that meets the standards set out in SB 5195. Ideally, this person or group will serve as the primary point of contact for this workstream and be well equipped to identify areas of process improvement and program updates. Initial considerations for program implementation may include determining who this program impacts. Examples include frontline staff, risk, regulatory, managers, social workers, providers, and clients. Developing a plan to communicate information to impacted groups can help to identify and resolve barriers, increase buy in, and support a smooth go-live. Communication techniques can include emails, education sessions, staff meetings, and/or distributing printed information sheets and FAQs. Dissemination to clients may be done via newsletters, online portal banners, highly visible client facing signage, or any other means that aligns with your organization's communication strategy.

Please refer to **Appendix B - administrative FAQ** and **Appendix C - Frontline staff FAQ**

Inclusion and Screening Criteria

SB 5195 Requirements

Clients who present with symptoms of an opioid use disorder (OUD), or who report recent use of opioids outside of legal authority.

The law identifies three, specific clinical opportunities, as appropriate, to identify and initiate the distribution of naloxone:

- Intake
- Treatment plan review, or
- Discharge

Exceptions are limited to the following:

- Provider judgement that it is not appropriate
- Client possesses naloxone
- Client declines medication

Screening and assessing for OUD

Objective and subjective signs and symptoms of OUD may include:

- Changes in physical appearance
- Small or constricted pupils
- Decreased respiratory rate
- Non responsiveness
- Drowsy or nodding off
- Reported loss or increase in appetite
- Marked weight loss or weight gain
- Intense flu-like symptoms (runny nose, watery eyes, gastrointestinal complaints, etc.)
- Wearing long-sleeves or hiding arms
- Change in attitude and/or affect
- Tendency to avoid contact with family and/or friends
- Change in friends, hobbies, activities and/or sports
- Drops in grades or performance at work
- Isolation or secretive behavior
- Moodiness, irritability, nervousness, giddiness

Screening and assessing for opioid use outside of legal authority

A client may endorse using an opioid or other substance that they got from the streets, a friend or family member, or on the internet. Due to the increase in highly potent opioids in the drug supply (e.g., fentanyl), any substances not distributed directly from a pharmacy or licensed cannabis dispensary in Washington State *may* contain synthetic opioids. It would be reasonable to include clients using any substance outside of legal authority in the scope of this program.

Additional resources on OUD screening is available at the following site: **Module 5: Assessing and Addressing Opioid Use Disorder (OUD) (cdc.gov)**

Resources on opioids outside legal authority, fentanyl, and the latest on the WA State drug supply can be found at: **Fentanyl | stopoverdose.org**

Integrating screening into workflow

Universal screening and assessment for opioid overdose risk during structured clinical activities (i.e., intake, client treatment plan review, or discharge) meets the criteria of the law, aligns with quality care, and occurs during a billable encounter. Universal screening at an intake provides an opportunity to assess client risk and strengths and may also serve to inform future treatment and discharge planning. For programs that see clients over time, universal screening at all three clinical activities is recommended. With new policy and protocol development, it may be important for your agency to account for how you will screen existing clients. For example, if your agency determines that you will universally screen clients at intake, this will likely prompt an additional protocol to screen, identify, and facilitate naloxone distribution to existing clients who completed intakes prior to January 1, 2022.

Sample screening and scripting

One approach to integrating screening into billable, clinical encounters is to develop a single question screening tool which can be universally added to standard intake, treatment planning, or discharge documentation. An example of a single question screener is as follows:

"In the last year, have you taken any pill(s), powders, or other substances that you obtained from the internet, a friend, or another person?"

An affirmative answer could be followed up by a transition into discussing naloxone. Examples of transition scripting is below, which may make discussing overdose risk feel more natural on the part of the clinician and client, especially in cases where substance use is not the primary focus of treatment.

"We ask everyone this question because any substance that was not obtained at a pharmacy or dispensary may contain fentanyl, which puts you at risk for an overdose. WA State now requires organizations to make sure people are aware of and have access to naloxone, an overdose reversal medication. Are you familiar with naloxone, sometimes referred to by the brand name, Narcan?"

"Do you have naloxone already? If not, I can help get you some."

If a client declines to discuss overdose risk and naloxone or does not feel that they are at risk, the clinician/staff member could still offer educational materials or resources and say something to the effect of,

"If you are ever interested in learning more, resources, or circling back to this- our agency can help and there are also ways of getting naloxone in the community."

Distribution and Client Education

SB 5195 Requirements

BHA's who identify clients meeting inclusion criteria must at the client's intake, treatment plan review, or discharge as appropriate do the following:

Inform the client about naloxone and ask whether the client has naloxone. If the client does not have naloxone, unless the provider determines in their clinical judgement that it is not appropriate, the provider must:

Prescribe the client naloxone or use the statewide naloxone standing order and assist the client in directly obtaining naloxone as soon as practical by:

- Directly dispensing naloxone if authorized by state law
- Partnering with a pharmacy to obtain naloxone on the client's behalf and distributing the naloxone to the client
- Assisting the client in utilizing a mail order pharmacy or pharmacy that mails prescription drugs directly to the BHA or client and distributing the naloxone to the client
- Obtaining and distributing naloxone through the bulk purchasing and distribution program (not yet operational)
- Using any other resources or means authorized by state law to provide naloxone
- Clients who receive naloxone in accordance with this law must be provided information and resources about medications for opioid use disorder and harm reduction services, which should be available in all relevant languages that the agency serves.
- The individual or entity that dispenses, distributes, or delivers naloxone in accordance with this law shall ensure that the directions for use are provided.

Providing a client with a prescription or ordering the medication to be filled and picked up at a pharmacy by the client does not meet the intent of the law, even if there is an on-site pharmacy. In cases where there is no prescriber the law allows for use of the statewide standing order. The standing order can be used as a prescription for naloxone in Washington State. Individuals may take this standing order to a pharmacy to get naloxone instead of going to a health care provider to get a prescription. Agencies and organizations may also use this standing order to get naloxone and dispense or distribute it to people who are at risk of opioid overdose or spending time with people at risk of opioid overdose. Using the standing order does not make naloxone over the counter.

Additional resources and information on the statewide standing order are outlined below and can also be found on the WA DOH Drug User Health webpage:

RCW 69.41.095: Opioid overdose reversal medication – Standing order permitted

A copy of the standing order to dispense naloxone

FAQ's: Frequently asked questions regarding the Statewide Standing Order to Dispense Naloxone (Spanish)

English versions of required client education materials are included as appendices in both trifold and electronic health record compatible formats. Translated materials and updated versions as published can be accessed from the HCA 5195 webpage. These materials cover the following educational domains:

- How to recognize and respond to an opioid overdose
- Opioid overdose risks
- Naloxone administration and directions for use
- Strategies and services to reduce harm and stay healthy
- An overview of medications for opioid use disorder and ways to learn more or access treatment

Another approach, as appropriate, is that a staff member and client watch a naloxone training video together, followed by reviewing the overdose prevention and directions for naloxone use sheet step by step. A QR code link to the video is printed on the HCA client trifold. Clients can

demonstrate understanding using the teach back method. Some clients will understand how to use naloxone and/or have reversed an overdose before and may have more expertise than the clinician. In this instance the education may start with the teach back method, with the clinician using video or printed materials to reinforce the clients existing knowledge.

For client education materials reference **Appendix G – sample staff competency**, **Appendix H – sample distribution signature sheet**, **Appendix I – overdose reversal quick sheet** and **Appendix J – patient education quick sheet**

Documentation

SB 5195 Requirements

The law does not give specific guidance on or requirements for documentation.

It is recommended that your agency include within your documentation the following:

- The client screening process
- The result of screening
- The distribution of naloxone and required education or the indications for client exclusion.

EHR integration can significantly increase the uptake of initiatives by clinical staff and improve compliance with policies and protocols. In the short-term or absence of EHR integration, checklist smart phrases can be created adapting screening questions and/or risk assessment tools. Smart phrases can also be created that cover exclusion criteria and workflow processes so that documentation of these elements exists within the EHR. Some agencies may choose to have a hard copy distribution signature sheet so that the patient can acknowledge receipt of overdose prevention medication in hand and confirm they have received and understood the required education and materials.

For sample smart phrases refer to **Appendix E - sample smart phrases** For sample distribution signature sheets refer to **Appendix H – sample distribution signature sheet**

Storage and Labeling

SB 5195 Requirements

Under SB 5195, the labelling requirements outlined in RCW 69.41.050 and RCW 18.64.246 are waived.

Allowance for naloxone storage is provided by RCW 69.41.095 (3) Any person or entity may lawfully possess, store, deliver, distribute, or administer an opioid overdose reversal medication pursuant to a prescription, collaborative drug therapy agreement, standing order, or protocol issued by a practitioner in accordance with subsection (1) of this section. The legislation permits variation from standard labelling, packaging, and storage standards for prepackaged overdose reversal medication. This can allow for kits to be distributed without a patient specific label on them.

Billing

SB 5195 Requirements

Until the naloxone bulk purchasing and distribution program is operational, if a BHA dispenses, distributes, or otherwise assists the client in directly obtaining naloxone such that the agency is the billing entity, the BHA must:

For clients enrolled in a medical assistance program, the agency must bill the client's Medicaid benefit for the patient's prepackaged naloxone using the appropriate billing codes established by HCA. This billing code must be separate from and in addition to the payment for the other services provided during the hospital visit.

For clients with available health insurance other than medical assistance (e.g., private or commercial insurance), the agency must bill the patient's health plan for the cost of the prepackaged naloxone.

For clients who are uninsured the agency must bill HCA for the cost of the client's prepackaged naloxone.

A pharmacy that dispenses naloxone through a partnership or relationship with the BHA must bill HCA for the cost of the client's naloxone for clients that are not enrolled in medical assistance under 74.09 and do not have any other available health insurance

The Washington State Health Care Authority (HCA) will establish a long-term mechanism to support naloxone distribution, known as the bulk purchasing and distribution program, as soon as feasible. Until this program is operational, behavioral health agencies will need to establish billing procedures based upon patient insurance status as outlined in the law. Currently, there is no identified state program to assist patients with co-payments. Organizations may elect to use existing charity care, existing co-payment programs, or dispense at no cost out of grant

funded or a pre-purchased supply.

Staff Education

This toolkit includes an editable sample power point that covers training elements and may be adapted by your facility and used in staff meetings, training sessions, or assigned via your learning management system. Records of staff competency may be kept using the sample competency forms. Suggested staff training domains include the following:

- How naloxone works
- Screening protocol and identification: which clients must receive naloxone
- General education on signs and symptoms of opioid overdose, opioid use disorder, adverse events related to opioid use
- Documentation
- Client education requirements for overdose reversal education and hard-copy materials (i.e., naloxone administration, medications for opioid use disorder, and harm reduction services and strategies)
- General education on signs and symptoms of opioid overdose, opioid use disorder, adverse events related to opioid use, and the Good Samaritan Law

Many of your clinical staff may have lived experience with substance use disorder; either themselves or someone close to them. This experience can carry with it complex emotions and deserves recognition as a part of training around substance use disorder assessment and interventions. It is possible to identify staff champions with lived experience who can promote the benefits of naloxone distribution and education.

Additional education and staff training on opioid use disorder and substance use disorder can help identify clients at risk of overdose. Approaching the clinician who may experience bias and reluctance to adopt evidence-based practice with compassion, not contempt, is a critical element of supporting them in adopting these policies and shifting the culture of care. Additionally, HCA is available to assist your agency in complying with SB 5195 by providing technical assistance and training to non-medical providers that covers distributing naloxone and providing education to patients about opioid overdose reversal medication.

For a sample staff training presentation refer to **Appendix F – sample staff training presentation**

Technical Assistance

The Health Care Authority will provide technical assistance to assist hospitals in complying with SB 5195. In addition to the provision of this toolkit and appendices, the Health Care Authority has made a webpage to consolidate resources and has identified points of contact for any questions or requests your organization may have. Live and recorded webinars will be available via the webpage.

- **HCA 5195 webpage**
- Training and implementation questions: **laura.meader@hca.wa.gov**
- Billing and pharmacy questions: **applehealthpharmacypolicy@hca.wa.gov**

The appendices that follow are intended to support the implementation of a naloxone distribution program in compliance with SB 5195. Appendices D-H are suggestions only. They are meant to be edited and amended to outline the specific processes established by your agency to meet the criteria of the law. Appendices A-C and I-L are not editable and are to be used as is. The complete toolkit as well as each appendix is available for download on the **HCA 5195 webpage**.

Appendix A - SB 5195 BHA Requirements - Quick Sheet

Inclusion Criteria[1]

Clients who present with symptoms of an opioid use disorder, or who report recent use of opioids outside of legal authority. Exceptions are limited to the following:

- Client declines medication
- Provider judgement that it is not appropriate
- Client possesses naloxone

Distribution and Client Education[2]

BHA's who identify clients meeting inclusion criteria must at the client's intake, treatment plan review, or discharge as appropriate do the following:

1. Inform the client about naloxone and ask whether the client has naloxone. If the client does not have naloxone, unless the provider determines in their clinical judgement that it is not appropriate, the provider must:
2. Prescribe the client naloxone or use the statewide naloxone standing order
3. Assist the client in directly obtaining naloxone as soon as practical by:
   - Directly dispensing naloxone if authorized by state law
   - Partnering with a pharmacy to obtain naloxone on the client's behalf and distributing the naloxone to the client
   - Assisting the client in utilizing a mail order pharmacy or pharmacy that mails prescription drugs directly to the BHA or client and distributing the naloxone to the client
   - Obtaining and distributing naloxone through the bulk purchasing and distribution program (not yet operational)
   - Using any other resources or means authorized by state law to provide naloxone
4. Clients who receive naloxone in accordance with this law must be provided information and resources about medications for opioid use disorder and harm reduction services, which should be available in all relevant languages that the agency serves.
5. The individual or entity that dispenses, distributes, or delivers naloxone in accordance with this law shall ensure that the directions for use are provided.

Storage and Labeling[3]

Under SB 5195, the labelling requirements outlined in RCW 69.41.050 and RCW 18.64.246 are waived.

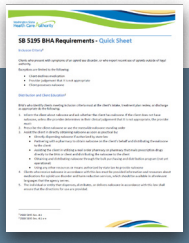
Billing[4]

Until the naloxone bulk purchasing and distribution program is operational, if a BHA dispenses, distributes, or otherwise assists the client in directly obtaining naloxone such that the agency is the billing entity, the BHA must:

- For clients enrolled in a medical assistance program, the agency must bill the client's Medicaid benefit for the patient's prepackaged naloxone using the appropriate billing codes established by HCA. This billing code must be separate from and in addition to the payment for the other services provided during the hospital visit.
- For clients with private or commercial insurance the agency must bill the patient's health plan for the cost of the prepackaged naloxone.
- For clients who are uninsured the agency must bill HCA for the cost of the client's prepackaged naloxone.

A pharmacy that dispenses naloxone through a partnership or relationship with the BHA must bill HCA for the cost of the client's naloxone for clients that are not enrolled in medical assistance under 74.09 and do not have any other available health insurance

1 2SSB 5195 Sec. 4.1
2 2SSB 5195 Sec. 4.1 a-e
3 2SSB 5195 Sec. 4.4
4 2SSB 5195 Sec 4.2-3



Appendix B - administrative FAQ

Can agencies utilize grant funded naloxone to meet the requirements of this program?

The intention of the law is for agencies to utilize insurance as a sustainable payment method for naloxone distribution. By using insurance, state supplies of grant funded naloxone will go to organizations that cannot bill insurance. Organizations may use any other resources or means authorized by state law to meet the requirements. There may be limited clinical scenarios where utilizing grant funded naloxone aligns with delivering optimal patient care.

Will we need to give a kit each time a client comes in for services?

If the client still has naloxone, it is not required that you distribute an additional kit.

Does the law require a specific screening process?

No, you can determine what is best for your agency and workflow if clients who meet inclusion criteria are reliably screened in. BHA inclusion criteria include any client presenting with symptoms of an opioid use disorder (OUD), or who report use of opioids outside legal authority. The toolkit includes a variety of possible screening protocols, frequency, and considerations.

What is the statewide standing order?

The standing order is a prescription. It is not different from a regular prescription. It is a statewide prescription that any individual or organization can use. It does not make naloxone over the counter. Please refer to the **RCW for more information**.

What are the exceptions to the in-hand naloxone distribution requirement?

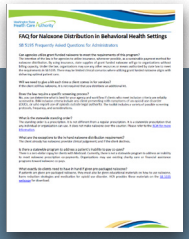
The client already has naloxone; provider clinical judgement; and if the client declines.

Is there a statewide program to address a patient's inability to pay co-pays?

There is a zero-dollar copay for clients with Medicaid. Currently, there is not a statewide program to address an inability to meet naloxone prescription co-payments. Organizations may use existing charity care or financial assistance programs toward naloxone co-pays.

What exactly do clients need to have in hand if given pre-packaged naloxone?

If patients are given pre-packaged naloxone, they must also be given educational materials on how to use naloxone, harm reduction strategies and medication for opioid use disorder. HCA provides these materials on the **SB 5195 webpage** for download.


FAQ for Naloxone Distribution in Behavioral Health Settings

SB 5195 Frequently Asked Questions for Administrators

Appendix C - frontline staff FAQ

Is naloxone safe and effective when used in community settings?

Yes, naloxone has been proven to effectively reverse opioid overdoses in community settings administered by people with no medical training. Naloxone will not cause harm if it is administered to someone who is not having an opioid overdose.

Does naloxone distribution encourage drug use?

No, the availability of naloxone does not correlate with an increase in drug use frequency or quantity. In fact, the distribution of naloxone combined with access to harm reduction services has been shown to have a positive impact on substance use behaviors.

Does naloxone help people get better, or does it just allow someone to stay alive and continue using drugs?

Many people who are at risk for an opioid overdose will reduce their risk over time and make positive changes, provided they are alive to do so. By distributing naloxone along with overdose prevention education, you are confirming that the lives of people who experience an opioid overdose are worth saving.

How will this affect my clinical practice?

Naloxone is a simple way to save lives. Offering naloxone to people at risk of opioid overdose can immediately shift the therapeutic relationship you have with your client. Often people who use opioids experience stigma and shame in their interactions with the health system. Building positive rapport and sharing resources on how to stay healthy may make the client's experience healing and your job more satisfying.

Where can I learn more about reducing the harms related to drug use?

There are a lot of resources out there, and **harmreduction.org** and **stopoverdose.org** are two good websites to start learning more. You can also connect with your local syringe services program, as they are experts in your community and refer to the Washington Department of Health Drug User Health Page: **https://www.doh.wa.gov/YouandYourFamily/DrugUserHealth**.

What words should I use and what words should I avoid when talking about drug use?

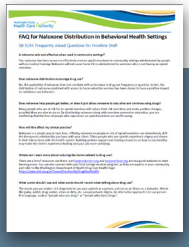
The words you use matter. It is important to see your patient as a person, and not as an illness or a behavior. Words like junky, addict, drug-seeker, clean or dirty, etc. can perpetuate stigma. An alternative approach is to use person-first language, such as "people who use drugs" or "people who inject drugs".

How can I help my clients "get sober"?

Many people who use drugs will end up on a path to recovery. Abstinence is only one way to recover from a substance use disorder. Collaborating with your client and identifying their recovery or use goals is also a way to orient conversations. Medications for opioid use disorder (MOUD), such as buprenorphine and methadone, are associated with a 50% reduction in mortality. Use of medication treatment is not replacing one drug with another and is one way of recovering from opioid use disorder. Providing information on MOUD and ways for client's to get and stay healthy are direct ways to support a client. Any positive change in how someone uses drugs is another way to start a recovery process. Patients who carry naloxone and reduce overdose risk are making positive change for themselves and others.

What are some effective ways to talk with people about overdose risk?

Approaching clients with curiosity and compassion may help facilitate conversations about overdose risk. In line with motivational interviewing, you can ask open ended questions, include the client's experiences and existing knowledge, and center them as the experts on their own use and lived experience. If you would like more structure, consider the following approach:


FAQ for Naloxone Distribution in Behavioral Health Settings

1. **Build rapport**
   I would like to take some time to talk about your risk of opioid overdose and naloxone. Can you tell me what you know about naloxone and how to use it?

2. **Pros and Cons**
   What do you do that might put you at risk for overdose? What actions do you currently take to reduce that risk?

3. **Provide information and get feedback**
   I have some additional information on overdose risk and how naloxone works, can we review it together?

4. **Assess readiness**
   So, on a scale of 0 to 10, how prepared do you feel to use naloxone / recognize an overdose / tell other people how to use it on you / etc.

5. **Make an action plan**
   Based on our conversation, what are some options that might work for you to help you stay healthy and safe? What supports do you have for making this change?

   Those are great ideas. I have a few more that be helpful (link to additional support, programs, telling people where the naloxone is stored, etc.)

Appendix D – SB 5195 sample workflow BHAs

Below is a sample workflow. This will look different depending on your agency's specific policies and procedures. The example below is of a workflow of a BHA that uses a combination of mail order pharmacy to deliver naloxone to the clinic and limited grant funded naloxone. This is the universal screening and distribution process at Intake.

Intake:

Screen for OUD or overdose risk

Negative Screen → no action needed
Positive Screen → inform and screen

Inform and Screen: Assuming client is clinically appropriate based on provider judgement

Inform client about naloxone and its availability

Ask if the client already possesses naloxone

Positive → document exception (see sample smart phrases for sample documentation), no further action required

A client possessing naloxone is an exception to distribution under SB 5195. Although your agency does not need to facilitate the distribution of naloxone under this circumstance, it is a clinical opportunity to inform treatment planning as well as highlight the client's positive behavior for already taking steps toward staying healthier by having a life-saving medication.

Negative → inform client that your agency can help facilitate naloxone distribution. It may make sense to integrate a way to inform clients of the naloxone distribution process and any logistical considerations at this point based on your agency's distribution channel/process. Some examples may include wait times or distribution timelines, possibility of co-payments, etc.)

Client declines naloxone distribution → document. No further action required*

Depending on why the client declines naloxone (not interested, bad experience with naloxone in the past, does not agree with assessed risk profile or utility, financial → staff can still offer resources and education and inform the client that if they ever change their mind or want naloxone, your agency can help.

Client consents to naloxone distribution → see below

Initiate naloxone distribution protocol

Using grant funded naloxone → client is unstably housed and unable to receive mail order directly or is not scheduled to come back on site for care

Retrieve naloxone kit and required educational materials in appropriate languages for teaching (HCA Opioid Overdose and Directions for Naloxone Use & HCA Harm Reduction & MOUD trifold). Review the DOH naloxone training video together if appropriate or preferred way for the client to learn.

Complete brief review of materials and training, provide additional resources as appropriate. Give physical materials to the client after review.

Document (see sample smart phrases for sample documentation) you can also have the client complete a signature sheet acknowledging education and receipt of naloxone.

Using pharmacy delivery to clinic for further distribution to client → the client has a follow-up appointment or comes to clinic for scheduled appointments

Complete client teaching and review of educational materials in appropriate languages (HCA Opioid Overdose and Directions for Naloxone Use & HCA Harm Reduction & MOUD trifold). Review the DOH naloxone training video together if appropriate or preferred way for the client to learn.

Collaborate with the client to pick up medication at the next scheduled appointment or at another set date (as clinically appropriate based on frequency of visits and logistical timing of naloxone delivery)

Document (see sample smart phrases for sample documentation)

At the follow up appointment → document naloxone distribution, have client complete a signature page acknowledging education and receipt of naloxone.

Other considerations:

If using telehealth staff can complete client education over the video by putting the documents up on the screen and reviewing them and/or watching a DOH training video together. Clinicians can also email, secure message or mail materials or links to materials to client, as appropriate. If in person, physical materials, or printed materials from the EHR may be given to clients.

Appendix E - sample smart phrases

OUD Screening

.oud

Client screened for signs and symptoms of opioid use disorder or use of opioids outside of legal authority based on the following question(s) *(insert screening tool/questions here with check boxes)* and based on client responses screened **in/out** for naloxone distribution. If client screened in for OUD and the provider deemed it appropriate, patient was offered naloxone and overdose prevention education, which the patient **accepted/declined.**

.oudexceptions

Client screened positive for signs and symptoms of opioid use disorder or use of opioids outside of legal authority based on the following question(s) *(insert screening tool/questions here with check boxes)* and based on client responses screened **out** for naloxone distribution due to the following exception(s):

- The client attested to having naloxone
- In the provider's clinical judgement, naloxone was not clinically appropriate due to (insert brief rationale)
- The client declined medication

Naloxone Distribution and Overdose Education

.oend

Client was provided a naloxone kit in hand that included 2 doses of naloxone, patient education brochures, and an overdose reversal information sheet.

.oendpickup

The client screened in for naloxone distribution and the following steps were taken in collaboration with the client:

☐ meets criteria and is clinically appropriate for naloxone distribution per (insert policy/procedure)

☐ Pharmacy protocol was initiated on (insert date)

☐ Client received naloxone kit in hand today, or

☐ Client will receive naloxone kit by:

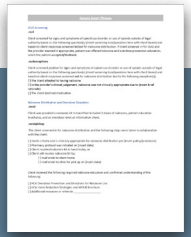
- ☐ mail order to client home
- ☐ mail order to clinic for pick up on (insert date)

Client received the following required naloxone education and confirmed understanding of the following:

☐ HCA Overdose Prevention and Directions for Naloxone Use

☐ HCA Harm Reduction Strategies and MOUD brochure

☐ Additional resources or referrals _____

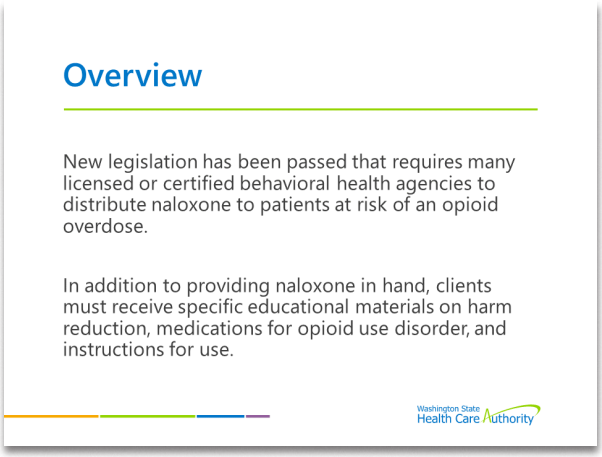


Appendix F – sample staff training presentation

Slide 1

BHA Staff Education SB 5195 Template

Updated December 2021

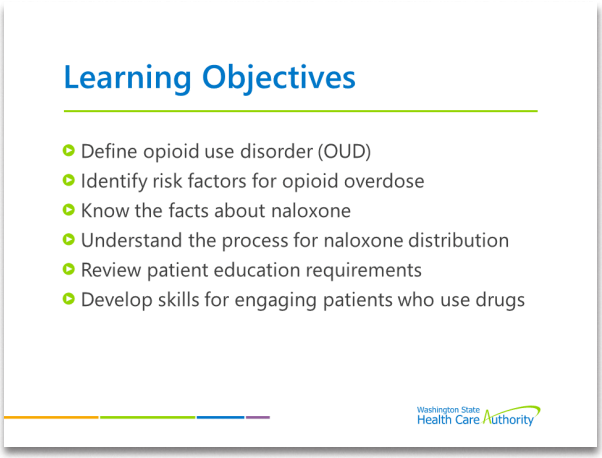


Slide 2

Overview

New legislation has been passed that requires many licensed or certified behavioral health agencies to distribute naloxone to patients at risk of an opioid overdose.

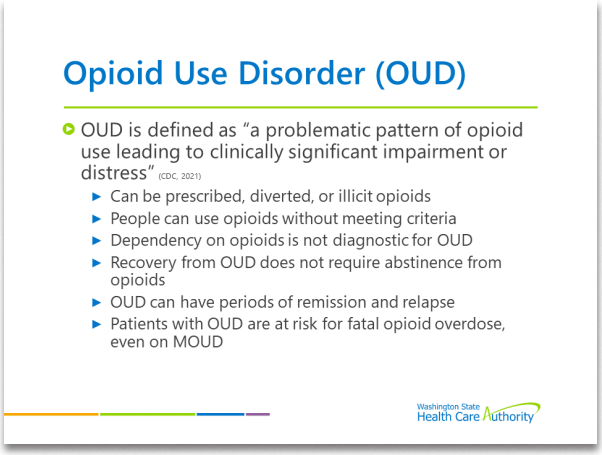
In addition to providing naloxone in hand, clients must receive specific educational materials on harm reduction, medications for opioid use disorder, and instructions for use.



Slide 3

Learning Objectives

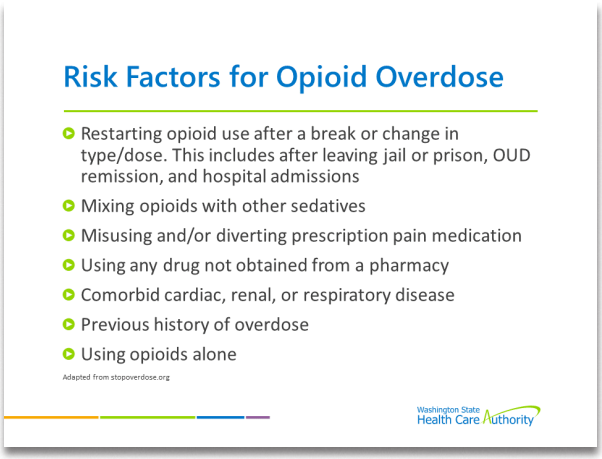
- Define opioid use disorder (OUD)
- Identify risk factors for opioid overdose
- Know the facts about naloxone
- Understand the process for naloxone distribution
- Review patient education requirements
- Develop skills for engaging patients who use drugs



Slide 4

Opioid Use Disorder (OUD)

- OUD is defined as "a problematic pattern of opioid use leading to clinically significant impairment or distress" (CDC, 2021)
  - Can be prescribed, diverted, or illicit opioids
  - People can use opioids without meeting criteria
  - Dependency on opioids is not diagnostic for OUD
  - Recovery from OUD does not require abstinence from opioids
  - OUD can have periods of remission and relapse
  - Patients with OUD are at risk for fatal opioid overdose, even on MOUD

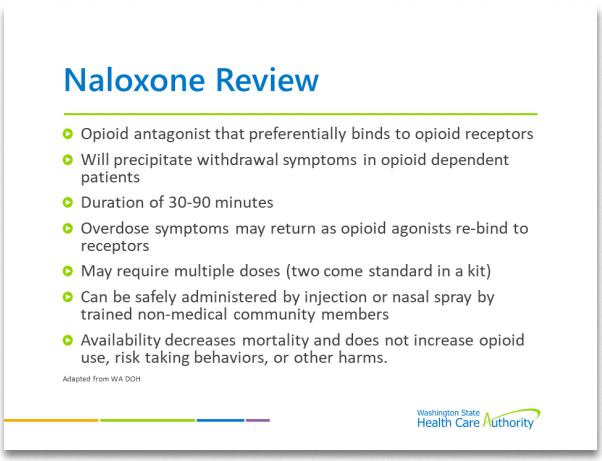


Slide 5

Risk Factors for Opioid Overdose

- Restarting opioid use after a break or change in type/dose. This includes after leaving jail or prison, OUD remission, and hospital admissions
- Mixing opioids with other sedatives
- Misusing and/or diverting prescription pain medication
- Using any drug not obtained from a pharmacy
- Comorbid cardiac, renal, or respiratory disease
- Previous history of overdose
- Using opioids alone

Adapted from **stopoverdose.org**

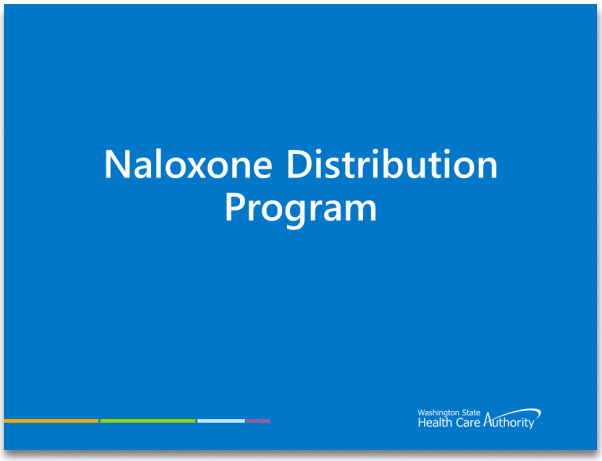


Slide 6

Naloxone Review

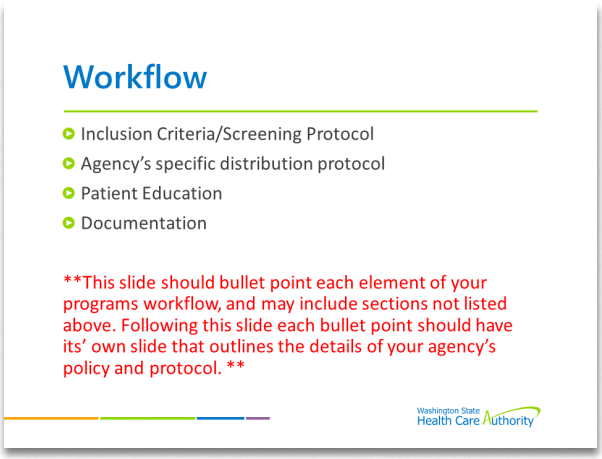
- Opioid antagonist that preferentially binds to opioid receptors
- Will precipitate withdrawal symptoms in opioid dependent patients
- Duration of 30-90 minutes
- Overdose symptoms may return as opioid agonists re-bind to receptors
- May require multiple doses (two come standard in a kit)
- Can be safely administered by injection or nasal spray by trained non-medical community members
- Availability decreases mortality and does not increase opioid use, risk taking behaviors, or other harms.

Adapted from WA DOH



Slide 7

Naloxone Distribution Program

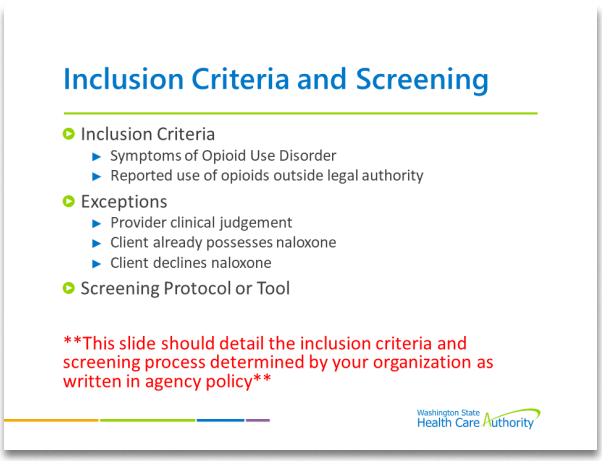


Slide 8

Workflow

- Inclusion Criteria/Screening Protocol
- Agency's specific distribution protocol
- Patient Education
- Documentation

**This slide should bullet point each element of your programs workflow, and may include sections not listed above. Following this slide each bullet point should have its' own slide that outlines the details of your agency's policy and protocol. **

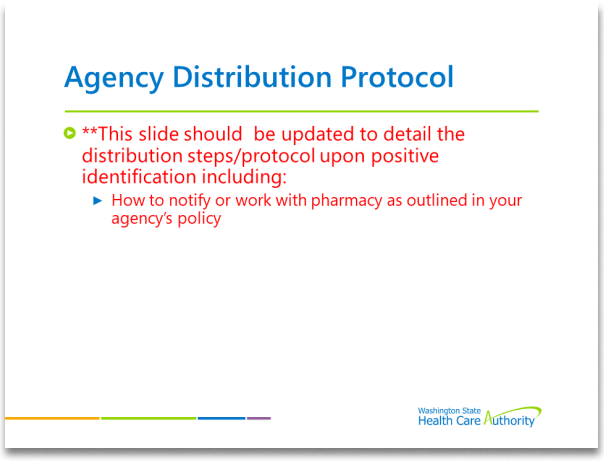


Slide 9

Inclusion Criteria and Screening

- Inclusion Criteria
  - Symptoms of Opioid Use Disorder
  - Reported use of opioids outside legal authority
- Exceptions
  - Provider clinical judgement
  - Client already possesses naloxone
  - Client declines naloxone
- Screening Protocol or Tool

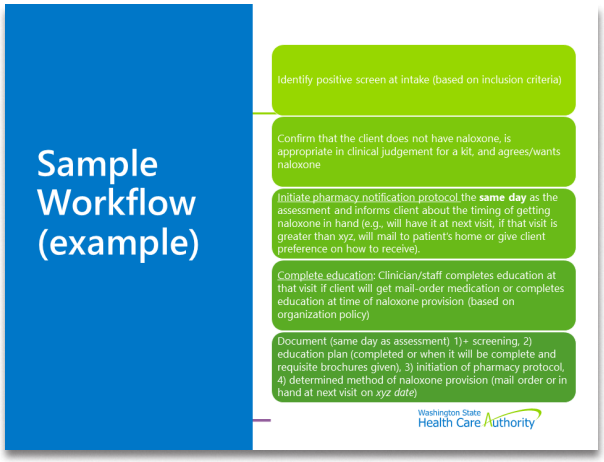
This slide should detail the inclusion criteria and screening process determined by your organization as written in agency policy



Slide 10

Agency Distribution Protocol

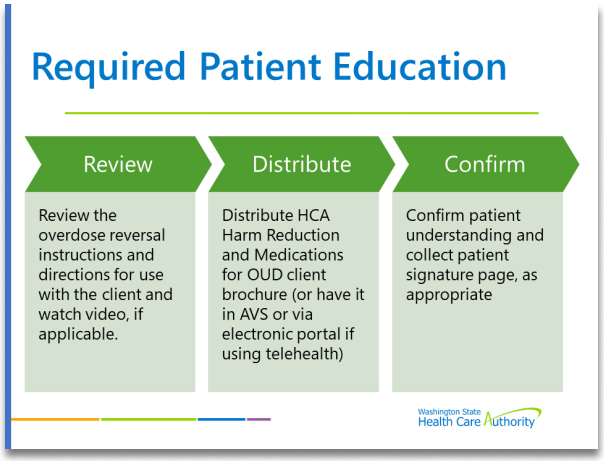
- **This slide should be updated to detail the distribution steps/protocol upon positive identification including:
  - How to notify or work with pharmacy as outlined in your agency's policy



Slide 11

Sample Workflow (example)

- Identify positive screen at intake (based on inclusion criteria)
- Confirm that the client does not have naloxone, is appropriate in clinical judgement for a kit, and agrees/wants naloxone
- Initiate pharmacy notification protocol the same day as the assessment and informs client about the timing of getting naloxone in hand (e.g., will have it at next visit, if that visit is greater than xyz, will mail to patient's home or give client preference on how to receive).
- Complete education: Clinician/staff completes education at that visit if client will get mail-order medication or completes education at time of naloxone provision (based on organization policy)
- Document (same day as assessment) 1)+ screening, 2) education plan (completed or when it will be complete and requisite brochures given), 3) initiation of pharmacy protocol, 4) determined method of naloxone provision (mail order or in hand at next visit on xyz date)



Slide 12

Required Patient Education

Review

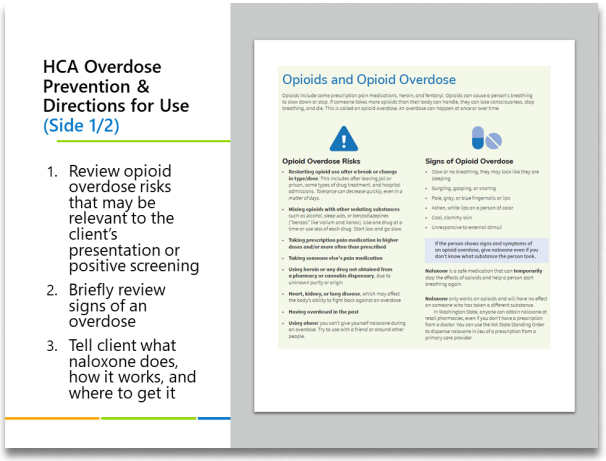
- Review the overdose reversal instructions and directions for use with the client and watch video, if applicable.

Distribute

- Distribute HCA Harm Reduction and Medications for OUD client brochure (or have it in AVS or via electronic portal if using telehealth)

Confirm

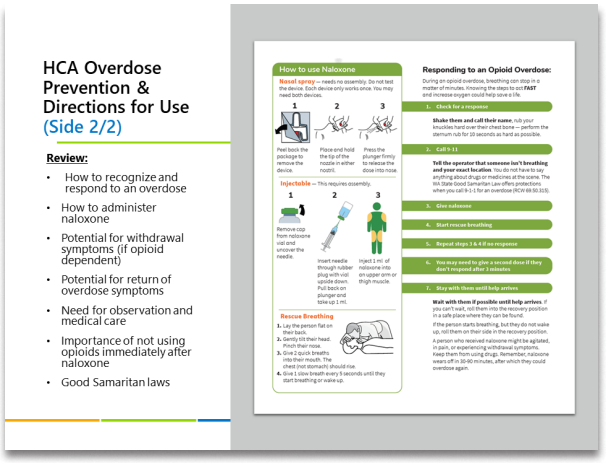
- Confirm patient understanding and collect patient signature page, as appropriate



Slide 13

HCA Overdose Prevention & Directions for Use (Side 1/2)

1. Review opioid overdose risks that may be relevant to the client's presentation or positive screening
2. Briefly review signs of an overdose
3. Tell client what naloxone does, how it works, and where to get it

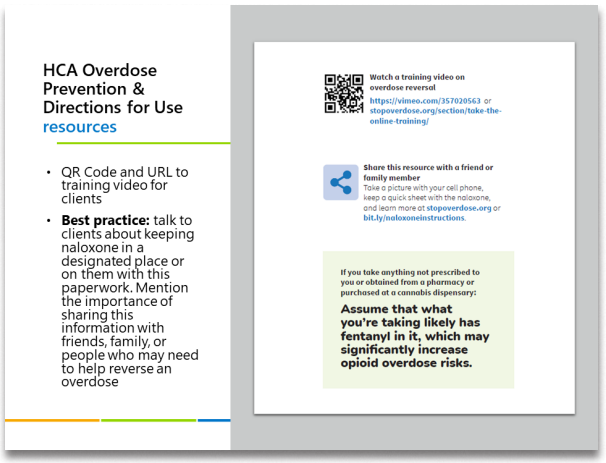


Slide 14

HCA Overdose Prevention & Directions for Use (Side 2/2)

Review:

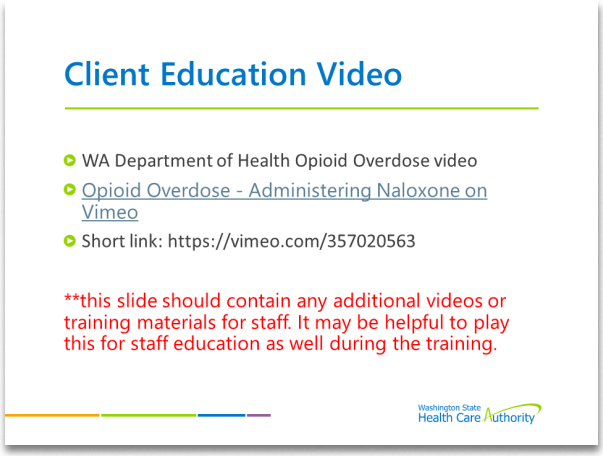
- How to recognize and respond to an overdose
- How to administer naloxone
- Potential for withdrawal symptoms (if opioid dependent)
- Potential for return of overdose symptoms
- Need for observation and medical care
- Importance of not using opioids immediately after naloxone
- Good Samaritan laws



Slide 15

HCA Overdose Prevention & Directions for Use resources

- QR Code and URL to training video for clients
- Best practice: talk to clients about keeping naloxone in a designated place or on them with this paperwork. Mention the importance of sharing this information with friends, family, or people who may need to help reverse an overdose

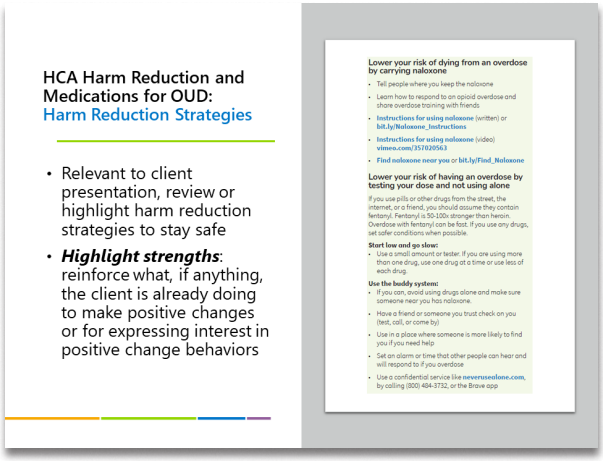


Slide 16

Client Education Video

- WA Department of Health Opioid Overdose video
- Opioid Overdose - Administering Naloxone on Vimeo
- Short link: https://vimeo.com/357020563

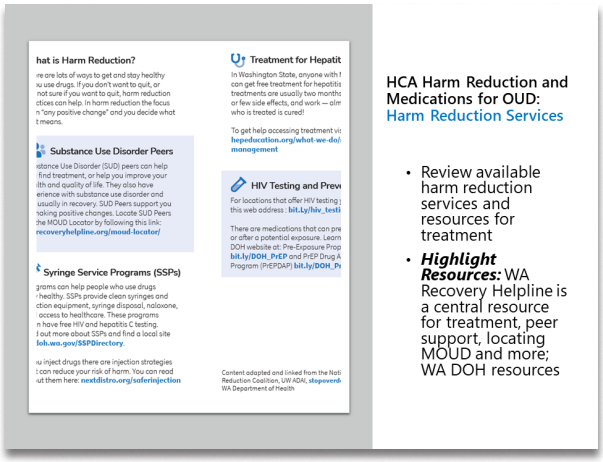
**this slide should contain any additional videos or training materials for staff. It may be helpful to play this for staff education as well during the training.



Slide 17

HCA Harm Reduction and Medications for OUD:Harm Reduction Strategies

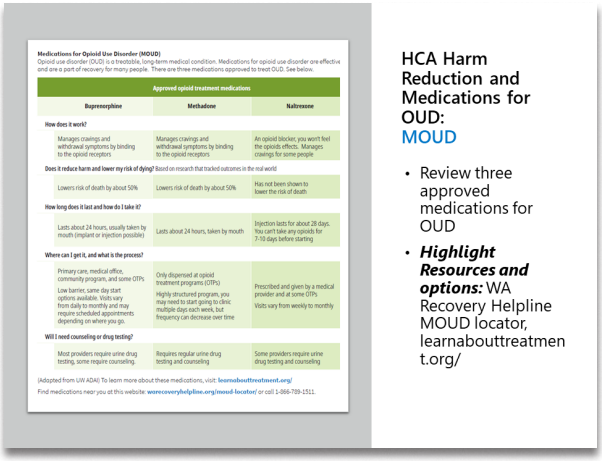
- Relevant to client presentation, review or highlight harm reduction strategies to stay safe
- **Highlight strengths:** reinforce what, if anything, the client is already doing to make positive changes or for expressing interest in positive change behaviors



Slide 18

HCA Harm Reduction and Medications for OUD:Harm Reduction Services

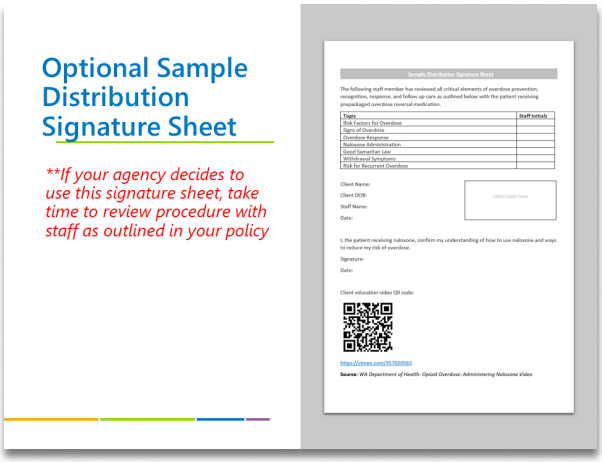
- Review available harm reduction services and resources for treatment
- **Highlight Resources:** WA Recovery Helpline is a central resource for treatment, peer support, locating MOUD and more; WA DOH resources



Slide 19

HCA Harm Reduction and Medications for OUD: MOUD

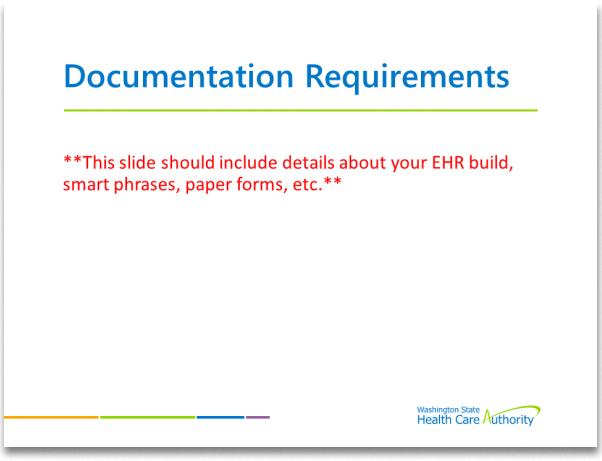
- Review three approved medications for OUD
- Highlight Resources and options: WA Recovery Helpline MOUD locator, learnabouttreatment.org/



Slide 20

Optional Sample Distribution Signature Sheet

**If your agency decides to use this signature sheet, take time to review procedure with staff as outlined in your policy



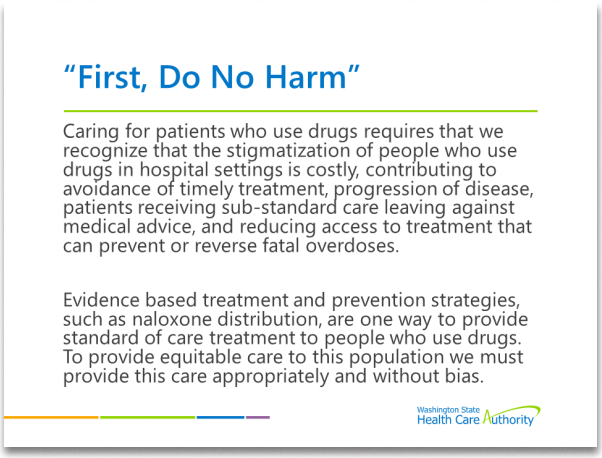
Slide 21

Documentation Requirements

This slide should include details about your EHR build, smart phrases, paper forms, etc.

Slide 22

Engaging and supporting people who use drugs

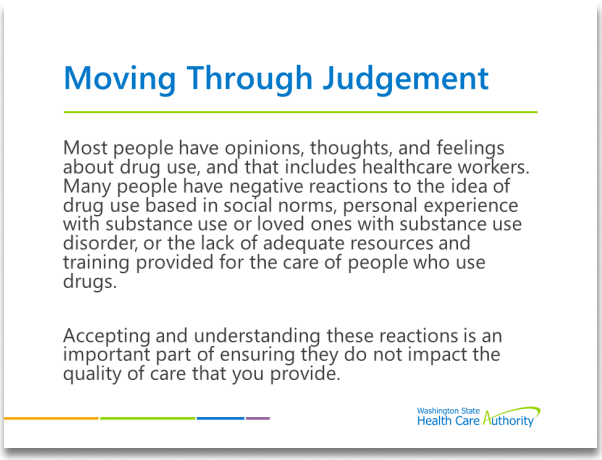


Slide 23

"First, Do No Harm"

Caring for patients who use drugs requires that we recognize that the stigmatization of people who use drugs in hospital settings is costly, contributing to avoidance of timely treatment, progression of disease, patients receiving sub-standard care leaving against medical advice, and reducing access to treatment that can prevent or reverse fatal overdoses.

Evidence based treatment and prevention strategies, such as naloxone distribution, are one way to provide standard of care treatment to people who use drugs. To provide equitable care to this population we must provide this care appropriately and without bias.

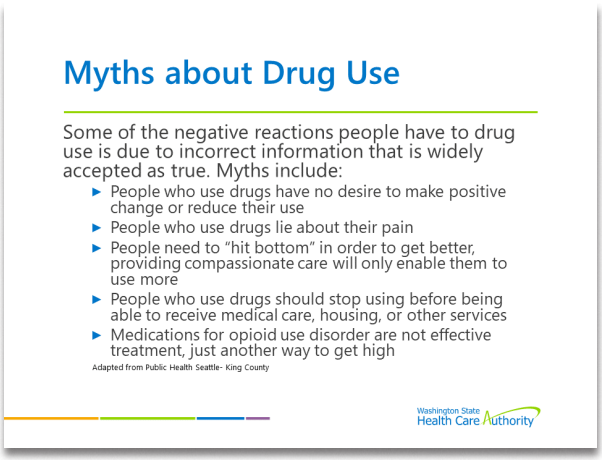


Slide 24

Moving Through Judgement

Most people have opinions, thoughts, and feelings about drug use, and that includes healthcare workers. Many people have negative reactions to the idea of drug use based in social norms, personal experience with substance use or loved ones with substance use disorder, or the lack of adequate resources and training provided for the care of people who use drugs.

Accepting and understanding these reactions is an important part of ensuring they do not impact the quality of care that you provide.



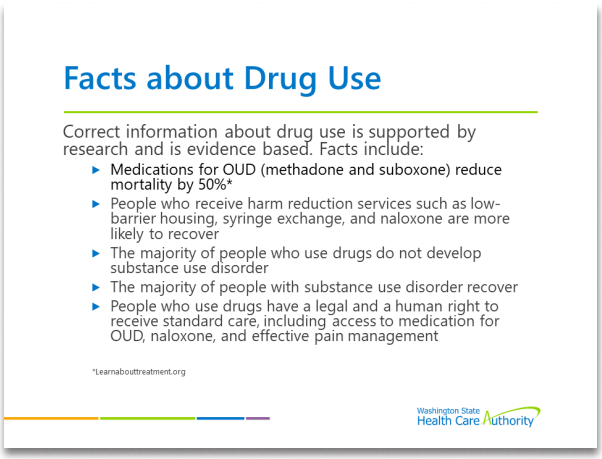
Slide 25

Myths about Drug Use

Some of the negative reactions people have to drug use is due to incorrect information that is widely accepted as true. Myths include:

- People who use drugs have no desire to make positive change or reduce their use
- People who use drugs lie about their pain
- People need to "hit bottom" in order to get better, providing compassionate care will only enable them to use more
- People who use drugs should stop using before being able to receive medical care, housing, or other services
- Medications for opioid use disorder are not effective treatment, just another way to get high

Adapted from Public Health Seattle- King County



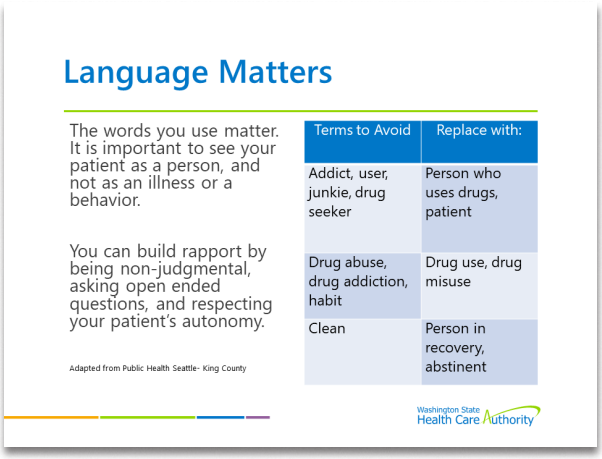
Slide 26

Facts about Drug Use

Correct information about drug use is supported by research and is evidence based. Facts include:

- Medications for OUD (methadone and suboxone) reduce mortality by 50%*
- People who receive harm reduction services such as low-barrier housing, syringe exchange, and naloxone are more likely to recover
- The majority of people who use drugs do not develop substance use disorder
- The majority of people with substance use disorder recover
- People who use drugs have a legal and a human right to receive standard care, including access to medication for OUD, naloxone, and effective pain management

***Learnabouttreatment.org**



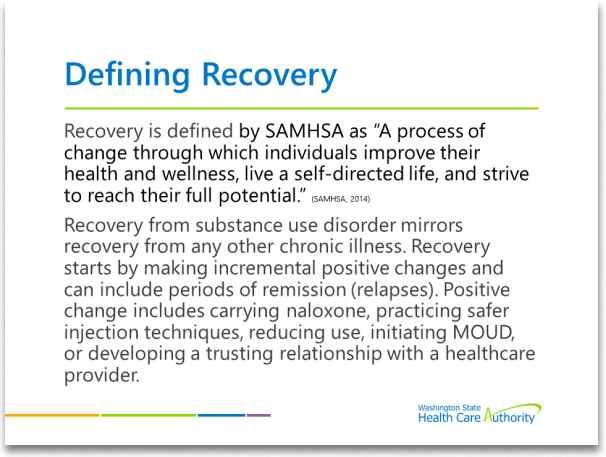
Slide 27

Language Matters

The words you use matter. It is important to see your patient as a person, and not as an illness or a behavior.

You can build rapport by being non-judgmental, asking open ended questions, and respecting your patient's autonomy.

Adapted from Public Health Seattle- King County

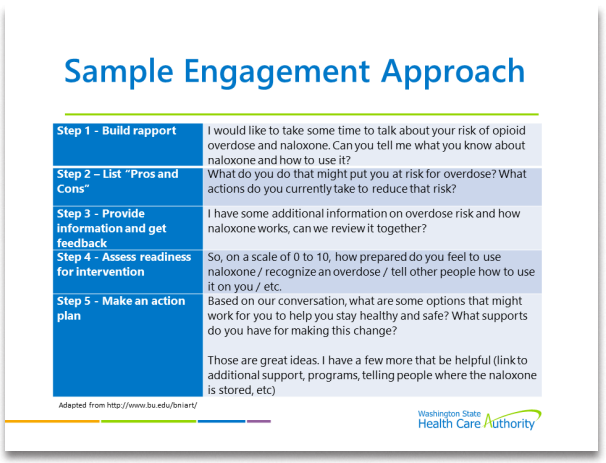


Slide 28

Defining Recovery

Recovery is defined by SAMHSA as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." (SAMHSA, 2014)

Recovery from substance use disorder mirrors recovery from any other chronic illness. Recovery starts by making incremental positive changes and can include periods of remission (relapses). Positive change includes carrying naloxone, practicing safer injection techniques, reducing use, initiating MOUD, or developing a trusting relationship with a healthcare provider.



Slide 29

Sample Engagement Approach

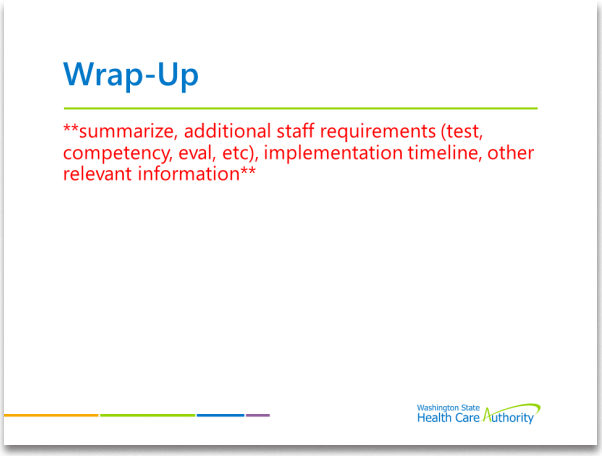
Step 1 - Build rapport I would like to take some time to talk about your risk of opioid overdose and naloxone. Can you tell me what you know about naloxone and how to use it?

Step 2 – List "Pros and Cons" What do you do that might put you at risk for overdose? What actions do you currently take to reduce that risk?

Step 3 - Provide information and get feedback I have some additional information on overdose risk and how naloxone works, can we review it together?

Step 4 - Assess readiness for intervention So, on a scale of 0 to 10, how prepared do you feel to use naloxone / recognize an overdose / tell other people how to use it on you / etc.

Step 5 - Make an action plan Based on our conversation, what are some options that might work for you to help you stay healthy and safe? What supports do you have for making this change? Those are great ideas. I have a few more that be helpful (link to additional support, programs, telling people where the naloxone is stored,



Slide 30

Wrap-Up

summarize, additional staff requirements (test, competency, eval, etc), implementation timeline, other relevant information

Slide 31

Questions?

Appendix G – sample staff competency

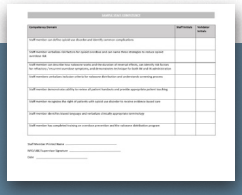
Sample staff competency

Competency Domain	Staff Initials	Validator Initials
Staff member can define opioid use disorder and identify common complications		
Staff member verbalizes risk factors for opioid overdose and can name three strategies to reduce opioid overdose risk		
Staff member can describe how naloxone works and the duration of reversal effects, can identify risk factors for refractory / recurrent overdose symptoms, and demonstrates technique for both IM and IN administration		
Staff members verbalizes inclusion criteria for naloxone distribution and understands screening process		
Staff member demonstrates ability to review all patient handouts and provide appropriate patient teaching		
Staff member recognizes the right of patients with opioid use disorder to receive evidence-based care		
Staff member identifies biased language and verbalizes clinically appropriate terminology		
Staff member has completed training on overdose prevention and the naloxone distribution program		

Staff Member Printed Name

Supervisor Signature

Date



Appendix H – sample distribution signature sheet

The following staff member has reviewed all critical elements of overdose prevention, recognition, response, and follow up care as outlined below with the patient receiving prepackaged overdose reversal medication.

Topic	Staff Initials
Risk Factors for Overdose	
Signs of Overdose	
Overdose Response	
Naloxone Administration	
Good Samaritan Law	
Withdrawal Symptoms	
Risk for Recurrent Overdose	

Client name

Client DOB

Staff Name

Date

Client Label here

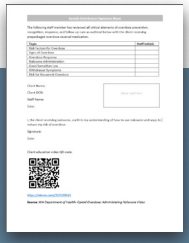
I, the Client receiving naloxone, confirm my understanding of how to use naloxone and ways to reduce my risk of overdose.

Signature

Date

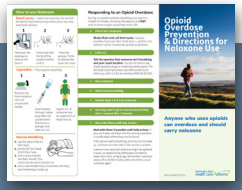
Patient education video QR code:

https://vimeo.com/357020563
Source: WA Department of Health- Opioid Overdose: Administering Naloxone Video



Appendix I – overdose reversal quick sheet

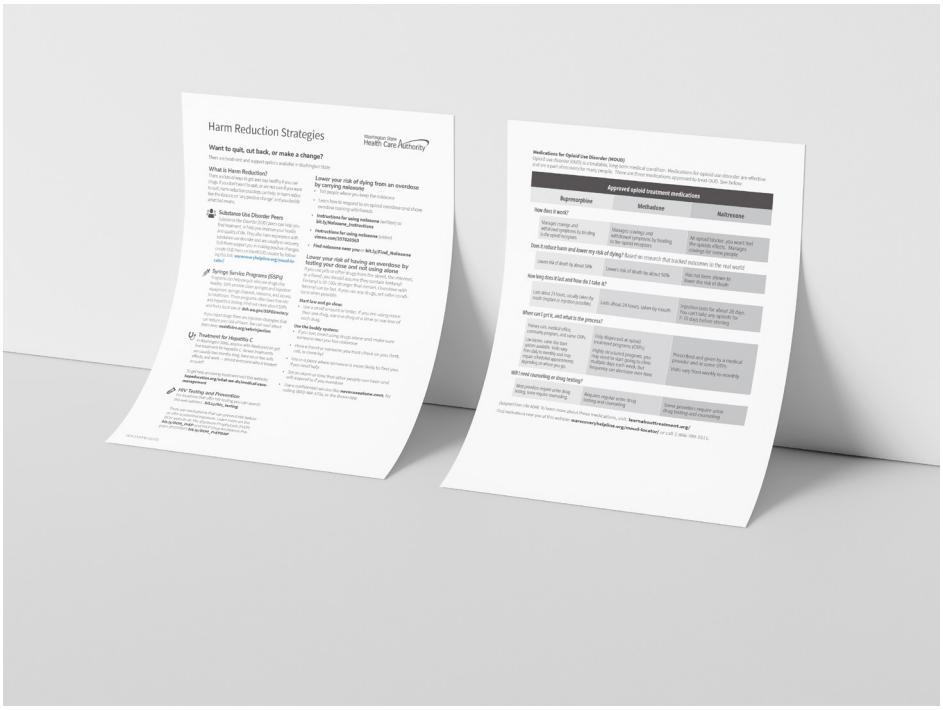
This information is available both as a trifold brochure or as a quick sheet for insertion into chart notes.



Visit **hca.wa.gov/opioid-toolkits** to download and use these documents

Appendix J – patient education quick sheet

This information is available both as a trifold brochure or as a quick sheet for insertion into chart notes.



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