Rancho Los Amigos National Rehabilitation Center
OUTPATIENT SERVICES: MOBILE CLINIC POLICY AND PROCEDURE

SUBJECT:	**Housing for Health Mobile Clinic Medication for Addiction Treatment (MAT) Services**	**Policy No.:**	**100**
		Supersedes:	**New**
		Revision Date:	**February 2, 2022**
		Page:	**1 of 18**

PURPOSE:

The purpose of this policy is to describe the process by which mobile clinic units will provide medications for addiction treatment (MAT) services for patients with substance use disorders (SUD). It will also describe the roles and responsibilities of different mobile clinic staff members involved in MAT services.

DEFINITIONS:

Medications for addiction treatment (MAT) – Evidence-based medications used to treat substance use disorders, sustain recovery, and prevent overdose.

Buprenorphine waivered provider – Provider with the X-waiver to administer, dispense, and prescribe buprenorphine for opioid use disorder treatment.

Direct dispensing / furnishing – Process in which mobile clinic staff provide patients with a supply of medications from the mobile clinic unit's medication stock.

Mobile clinic – Mobile units that provide various health care services to persons experiencing homelessness.

MAT staff – Mobile clinic staff involved in the MAT service such as SUD counselors, physicians, nurse managers, psychiatrists, and clinical pharmacists.

MAT group – Group education sessions conducted by SUD counselors

Modified Office-Based Opioid Treatment (OBOT) Stability Index – OBOT Stability Index modified for purposes of mobile clinic MAT program. Tool will be used to identify patients requiring closer follow-up and/or additional support. See Attachment A

Treatment Needs Questionnaire (TNQ) – Tool used to stratify patients based on their severity, complexity, and treatment response. See Attachment B

PROCEDURE:

I. Training and License Requirements

A. All mobile clinic team members involved in MAT services will complete training requirements relevant for the mobile clinic MAT program.

II. Provided Services
- A. MAT prescription and refills
- B. Harm reduction education and provision of harm reduction materials
- C. Physical assessment and labs including screenings for Hepatitis B/C, HIV, STDs, pregnancy test, and liver function test
- D. Primary care including chronic disease management

III. Staff and Responsibilities for MAT Services
- A. Provider Relations Representative (PRR)
  - i. Schedule initial and follow up visits.
  - ii. Check in and check out patients from visits.
  - iii. Register/empanel patients as needed.
- B. RN
  - i. Triage patients with SUD from overall mobile clinic referrals to SUD counselors.
  - ii. Collect patient vitals.
  - iii. Review controlled substances inventory log and submit report of directly dispensed controlled substances to DEA CURES.
- C. CMA and LVN
  - i. Support PRR in checking patients in and out for visits as needed.
  - ii. Support RN in triaging patients, collecting patient vitals, and reviewing controlled substances inventory log as needed.
- D. SUD counselors
  - i. Assess and document patient's substance use and risk level.
  - ii. Screen patients for eligibility for MAT.
  - iii. Review MAT program expectations and policies with patients.
  - iv. Educate patients on harm reduction (e.g. naloxone for opioid overdose, fentanyl education) and provide harm reduction kits.
  - v. Assess patients' responses to treatment in follow up visits.
  - vi. Triage patients requiring additional support to appropriate MAT staff.
  - vii. Make direct referrals or connect patients with MCW for placement in higher level of care as needed.
  - viii. Conduct MAT groups.
  - ix. Connect patients to PRR as needed for registration.
- E. CHW
  - i. Conduct baseline needs assessment and triage to appropriate MAT and non-MAT mobile clinic staff to meet patient's needs.
  - ii. Support patients in scheduling and attending MAT-related appointments as needed.
  - iii. Support MAT staff in monitoring patients' substance use and prioritizing those at high risk.
  - iv. Advocate for patients by providing input to MAT staff responsible for patients' care as needed.
  - v. Help pick up and deliver medications to patients as needed.
  - vi. Make direct referrals or connect patients with MCW for placement in higher level of care as needed.

F. Physicians
    i. Document patient's SUD diagnosis.
    ii. Prescribe MAT for patient's SUD treatment.
    iii. Conduct physical assessments including evaluation for injection drug-related infections (endocarditis, cellulitis, abscess, etc.).
    iv. Order and assess baseline and follow-up labs.
    v. Provide primary care services.
    vi. Refer patients requiring additional support to appropriate MAT staff as needed.
    vii. Submit report of directly dispensed controlled substances to DEA CURES in absence of RN.
G. Senior clinical social workers (SCSW)
    i. Assess complex psychosocial needs of high-risk patients identified by TNQ and/or other provider's clinical judgment.
    ii. Develop treatment plan to address patients' psychosocial needs and document interventions and patient progress.
H. Psychiatrists
    i. Provide consults for patients with severe and persistent mental illness (SPMI) or need for psychotropic regimen.
I. Clinical pharmacists
    i. Provide consults and/or medication management for patients per Mobile Clinic P&P on MAT Services by Clinical Pharmacy.

IV. Referrals

Referrals shall be made per Mobile Clinic P&P on Referral Process to Behavioral Health Team

V. Patient Eligibility
A. Current empanelment or initiated empanelment with mobile clinic physician for primary care services
B. Meets criteria for a SUD
    i. Alcohol use disorder (AUD)
    ii. Opioid use disorder (OUD)
    iii. Stimulant use disorder (StUD)
    iv. Tobacco use disorder (TUD)
C. Agrees to expectations of MAT services (See Attachment C)

VI. Treatment Phases and Corresponding Visits
A. Initiation Phase
    i. Intake visit with SUD counselor
        1. Complete ASSIST and TNQ tools to assess patient's substance use history and level of care needed. If patient's substance use and psychosocial history are documented from a previous intake assessment by the behavioral health team, date of the previous intake assessment and any changes since that assessment should be documented.
        2. Harm reduction education and provision of harm reduction kits as needed
        3. Education on MAT/non-pharmacologic treatment options for patient's SUD

4. Review of expectations for patient participation in MAT services (Attachment C)
5. If patient agrees to MAT services expectations, collection of patient consent to treatment (if not previously completed) and referral to physician for prescriptions
6. Referral to other MAT staff or higher level of care as needed

ii. Initial visit with physician
1. Document patient's SUD diagnosis on ORCHID based on ASSIST tool completed by SUD counselor
2. Prescribe MAT for patient's SUD
3. Assess for and treat injection drug-related infections as needed
4. Assess for other primary care needs

iii. As needed visit with other MAT staff
1. Patients with TNQ >10 should be seen by SCSW
2. Patients with SPMI or other psychotropic needs should be seen by psychiatrist
3. Patients meeting criteria outlined in Mobile Clinic P&P on MAT Services by Clinical Pharmacy should be seen by clinical pharmacist

B. Stabilization Phase
i. Follow up with SUD counselor
1. Assess and document response to prescribed MAT regimen
2. Administer modified OBOT Stability Index for patients with OUD and refer to other MAT staff as needed
3. Refer to prescribing provider if poor response/side effect to MAT regimen

ii. As needed visit with prescribing provider
1. Adjust MAT regimen based on patient's response/tolerance

C. Maintenance Phase
i. MAT groups conducted by SUD counselor
1. Monitor and document patient's substance use
2. Continue providing harm reduction education and kits

ii. Individual follow up visits with SUD counselor as needed
1. Schedule individual visits based on input from CHW and other MAT staff
2. Administer OBOT Stability Index for patients with OUD and refer to other MAT staff as needed

iii. Follow up visits with prescribing provider
1. Prescribe refills for MAT
2. Monitor labs as needed
3. Provide primary care services as needed
4. Triage to other MAT staff as needed

iv. Follow up visits with other MAT staff as needed

D. See Appendices A-D for treatment guidance.

E. Patients who miss 3 attempts of follow-up by MAT staff will be considered lost to follow-up. Patients will need to complete a new intake visit to re-enroll for MAT services.
i. During initiation or stabilization phase, MAT staff will attempt to reach the patient at least once every 2 weeks via phone or encampment visit
ii. During maintenance phase, MAT staff will attempt to reach the patient at least once monthly via phone or encampment visit

VII. Urine Toxicology Screen
- A. Urine toxicology screen should be collected whenever initiating or restarting patients on naltrexone to ensure patient is opioid-free.
- B. Physicians and clinical pharmacists may order toxicology screens if they suspect non-adherence, diversion, other aberrant behaviors, or as clinically indicated.
- C. Physicians and clinical pharmacists may order a repeat screen if they have questionable urine results. Positive screens may be sent to lab for specific gravity testing and confirmation at the discretion of the provider. (See Attachment D for list of order sets)

VIII. High-Risk Patients
- A. Patients who meet following criteria are recommended to be discussed with a multidisciplinary team:
  - i. Concern for diversion
  - ii. Lost to follow up
  - iii. Failed treatment (See Attachment E)
  - iv. Other patients deemed high-risk based on staff's judgment
- B. A multidisciplinary team consisting of patient's MAT provider, SCSW, SUD counselor, and other mobile clinic staff as indicated will discuss and develop recommended plan for high-risk patients.

IX. Naloxone Provision
- A. Naloxone should be provided for all patients with OUD and at risk of opioid overdose unless patient has a contraindication including but not limited to hypersensitivity to naloxone.
- B. A maximum of 2 naloxone kits should be furnished per patient and prescriptions with refills should be ordered by physician for additional supply. Patients should also be provided with a naloxone fact sheet.

X. Prescriptions for Controlled Substances
- A. Patients should be prescribed with enough quantity and refills to last until the next visit.
- B. Patients without state-issued identification should be provided with a letter for proof of treatment signed by the physician to present at the pharmacy for medication pick-up (See Attachment F). If a mobile clinic staff is delivering the medication to the patient, the staff should be given a staff version of the letter (See Attachment G).

XI. Direct Dispensing of Medications
- A. Medications will be stocked and maintained per Sections III and IV of DHS Policy 329.023.
- B. If a patient is unable to pick up medications from a pharmacy and the mobile clinic team is unable to deliver the medication to the patient within reasonable time, the medication may be directly dispensed to the patient.
- C. MAT staff will follow the process for direct dispensing outlined in Section VIII of DHS Policy 329.023.
- D. Quantity of medications dispensed should be limited to maximum of 1 week supply.

XII. Procedure for CURES reporting

A. Each mobile clinic unit will be registered with the DEA as a dispensing entity and the RN or physician will be responsible for submitting reports to the DEA CURES
B. Any supply of controlled substances (e.g. buprenorphine/naloxone, chlordiazepoxide) that were directly dispensed to patients must be reported to CURES within one business day
C. If no controlled substances were directly dispensed in a specific week, a Zero Report should be submitted to CURES
D. See Attachment H for information needed for CURES reporting

REFERENCES:

American Society of Addiction Medicine. The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management. *J Addict Med*. 2020 May/Jun;14(3S Suppl 1):1-72.

DHS Expected Practices: Outpatient Management of Alcohol Withdrawal. DHS Clinical Care Library - Addiction Medicine - Outpatient Management of Alcohol Withdrawal 5-20-21.pdf

DHS Expected Practices: Outpatient Medication Management of Alcohol Use Disorder. DHS Clinical Care Library - Outpatient Medication Management of Alcohol Use Disorder.pdf

DHS Expected Practices: Medication Management of Opioid Use Disorder in Ambulatory Care Settings. DHS Clinical Care Library - Addiction Medicine - Outpatient Medication Management of Opioid Use Disorder Expected Practice 10-28-19.pdf

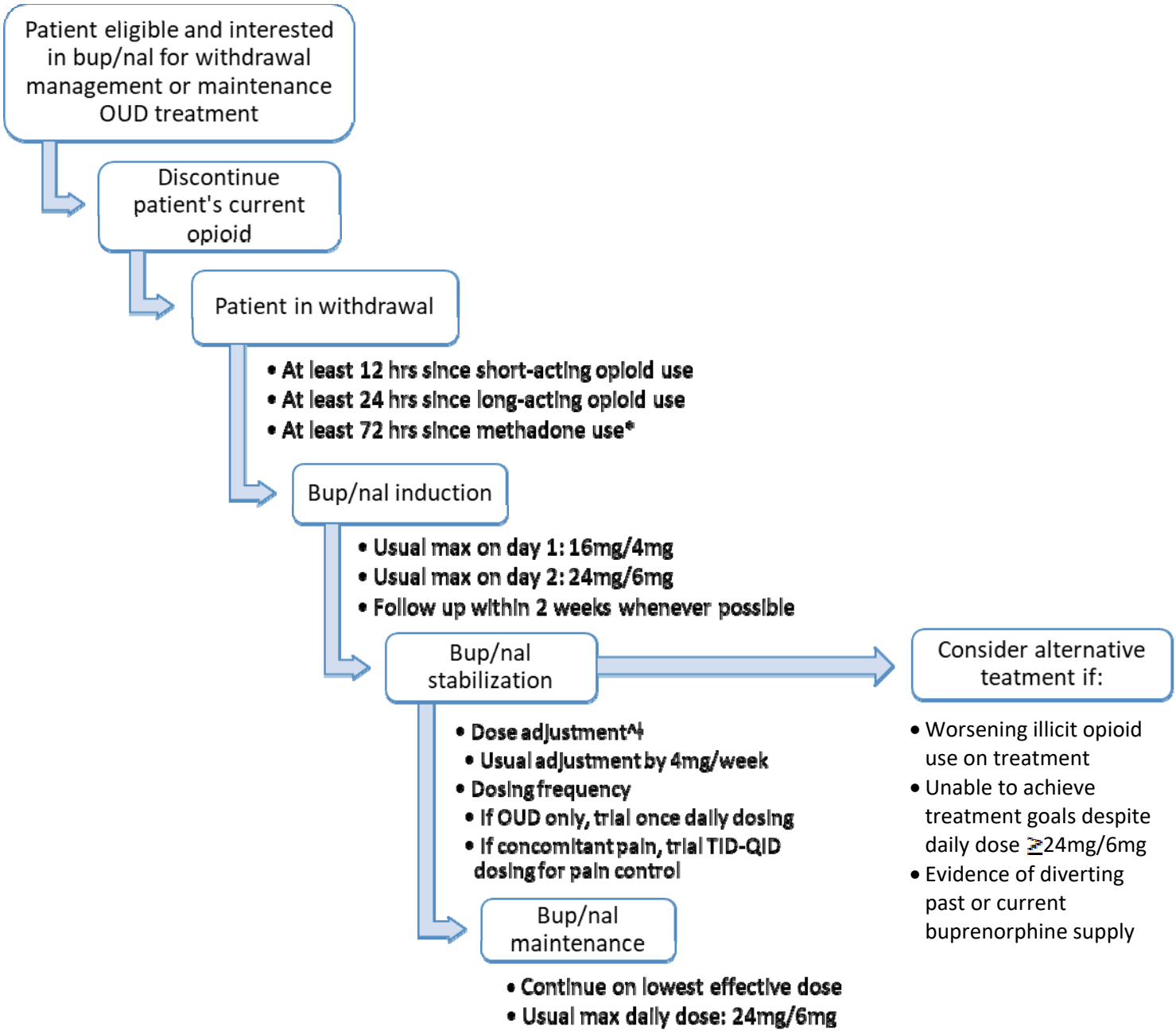
DHS Expected Practices: Treatment of Smoking and Tobacco-Related Product Use. DHS Clinical Care Library - Addiction Medicine - Treatment of Smoking and Tobacco-Related Product Use Expected Practice.pdf

Sigmon SC, Bisaga A, Nunes EV, O'Connor PG, Kosten T, Woody G. Opioid detoxification and naltrexone induction strategies: recommendations for clinical practice. *Am J Drug Alcohol Abuse.* 2012 May;38(3):187-99.

Srivastava AB, Mariani JJ, Levin FR. New directions in the treatment of opioid withdrawal. *Lancet*. 2020 Jun 20;395(10241):1938-1948.

Substance Abuse and Mental Health Services Administration. Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63. HHS Publication No. (SMA) 18-5063EXSUMM. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018

Appendix A: Recommended Buprenorphine/naloxone (Bup/nal) Treatment Algorithm for OUD

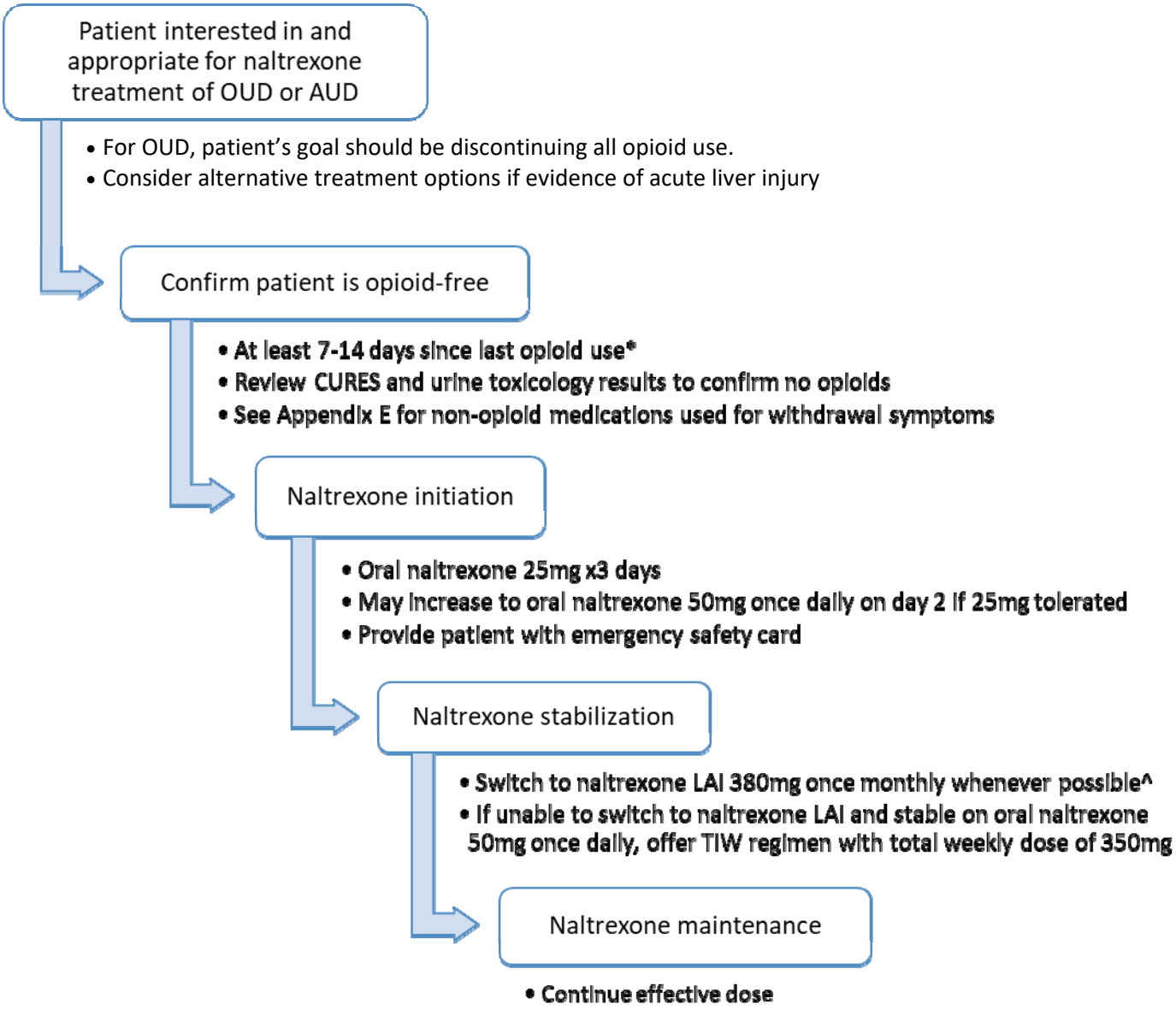


*Methadone dose should be 30-40mg before discontinuation and switch to buprenorphine

^Consider increasing dose if patient continues to use illicit opioids or experience withdrawal symptoms, cravings, and/or euphoria from illicit opioid use. Psychosocial treatment should be considered for improving symptoms as well.

‡ Consider decreasing dose with signs of dose toxicity (e.g. sedation or rare, clinically relevant LFT increase). Consider holding dose in acute alcohol or benzodiazepine intoxication.

Appendix B: Recommended Naltrexone Treatment Algorithm for OUD or AUD



*Patients who were on buprenorphine or methadone should wait at least 14 days before initiating naltrexone

^Relative contraindications for naltrexone LAI include BMI >40 kg/m2 and severe coagulopathy or thrombocytopenia

Appendix C: Non-Opioid Treatment Options for Management of Opioid Withdrawal

Withdrawal Symptom	Suggested Treatment Options
Pain	Ibuprofen 400mg tablets, 1 tablet TID PRN pain Acetaminophen 325mg tablets, 1-2 tablets q4-6h PRN pain, max 3gm/day
Nausea/Vomiting	Ondansetron 4mg tablets, 1 tablet TID PRN nausea or vomiting
Insomnia	Diphenhydramine 25mg capsules, 1 capsule QHS PRN insomnia Hydroxyzine 25mg tablets, 1-2 tablets QHS PRN insomnia Trazodone 50mg tablets, 1-2 tablets QHS PRN insomnia
Diarrhea	Loperamide 2mg capsules, 1 capsule after each unformed stool, max 16mg/day
Anxiety	Hydroxyzine 25mg tablets, 1-2 tablets QID PRN anxiety

Appendix D: Smoking Cessation Pharmacotherapy Reference Chart

From DHS Expected Practices for Treatment of Smoking and Tobacco-Related Product Use

DHS Pharmacotherapy Options	Recommended Dose		Adverse Effects	Duration
NICOTINE REPLACEMENT THERAPY (NRT)				
Nicotine Transdermal Patch *Can be safely combined with nicotine gum & lozenges and bupropion. Do not combine nicotine patches and varenicline.*	**Heavy Smoker:** Smoking history > 10 cigarettes/day	One 21 mg patch/day for 4-6 weeks, then One 14 mg patch/day for 2 weeks, then One 7 mg patch/day for 2 weeks	Local skin reaction Sleep disturbance	Up to 10 weeks
	Light Smoker: Smoking history ≤ 10 cigarettes/day	One 14 mg patch/day for 6 weeks, then One 7 mg patch/day for 2 weeks		
Nicotine Polacrilex Gum *The nicotine gum or lozenge should be offered in addition to the nicotine patch or varenicline, and can also be used in patients who decline nicotine patches or varenicline. Nicotine replacement medications can also be safely combined with bupropion.*	**Heavy Smoker:** Smokes first cigarette ≤ 30 minutes after waking	1 piece of 4 mg gum every 1-2 hr prn cravings for weeks 1-6, 1 piece of 4 mg gum every 2-4 hr prn cravings for weeks 7-9, 1 piece of 4 mg gum every 4-8 hr prn cravings for weeks 10-12	Mouth soreness Dyspepsia	Up to 12 weeks Maximum 24 pieces per day
	Light Smoker: Smokes first cigarette >30 minutes after waking	1 piece of 2 mg gum every 1-2 hr prn cravings for weeks 1-6, 1 piece of 2 mg gum every 2-4 hr prn cravings for weeks 7-9, 1 piece of 2 mg gum every 4-8 hr prn cravings for weeks 10-12		
Nicotine Polacrilex Lozenge *The nicotine gum or lozenge should be offered in addition to the nicotine patch or varenicline, and can also be used in patients who decline nicotine patches or varenicline. Nicotine replacement medications can also be safely combined with bupropion.*	**Heavy Smoker:** Smokes first cigarette ≤ 30 minutes after waking	1 piece of 4 mg lozenge every 1-2 hr prn cravings for weeks 1-6, 1 piece of 4 mg lozenge every 2-4 hr prn cravings for weeks 7-9, 1 piece of 4 mg lozenge every 4-8 hr prn cravings for weeks 10-12 *Use at least 9 lozenges/day for the first 6 weeks	Nausea Hiccups Heartburn Insomnia	Up to 12 weeks Maximum 20 pieces per day
	Light Smoker: Smokes first cigarette >30 minutes after waking	1 piece of 2 mg lozenge every 1-2 hr prn cravings for weeks 1-6, 1 piece of 2 mg lozenge every 2-4 hr prn cravings for weeks 7-9, 1 piece of 2 mg lozenge every 4-8 hr prn cravings for weeks 10-12		
Special Circumstances: 1. patients who smoke only a few cigarettes daily: consider Gum or Lozenge only 2. Combination of Nicotine Patch with either Gum or Lozenge has been shown to improve outcomes 3. Clinicians may consider using longer-term (>24 weeks) therapy in patients who require longer term smoking cessation medication maintenance to sustain remission from tobacco use disorder.				
Bupropion XL				
Bupropion extended release oral tablet *Can be safely combined with nicotine medication or varenicline.*	150 mg orally q AM for 3 days, then increase to 300 mg orally daily for total 7-12 weeks Begin one week before the patient stops smoking		Insomnia Dry mouth	7 to 12 weeks Maintenance may be required up to 6 months
Varenicline				
Varenicline oral tablet – *Restricted to patients for whom NRT hasn't been successful, wasn't tolerated, or was declined by the patient. Do not use with nicotine patches, but can be safely combined with nicotine gum/lozenges and/or bupropion.*	.5 mg orally daily for days 1-3, then 0.5 mg orally BID for days 4-7, then 1 mg BID for 11 weeks		Nausea Sleep disturbances	12 weeks Maintenance may be required up to 6 months

Attachment A: Modified OBOT Stability Index

Housing for Health Mobile Clinic
Modified OBOT Stability Index

1. Is the patient using sedative-hypnotic drugs (i.e. benzodiazepines) or admitting to alcohol use?	Yes	No
2. Does the patient report drug craving that is difficult to control?	Yes	No
3. Does the patient endorse having used illicit substances in the past month?	Yes	No
4. Does the query of the CURES show evidence of unexplained, unadmitted, or otherwise concerning provision of controlled substances?	Yes	No
5. Is there any other evidence of the patient using illicit substances in the past month?	Yes	No
6. Did the patient report their last prescription as being lost or stolen?	Yes	No
7. Did the patient run out of medication early from his/her last prescription?	Yes	No

If NO to all, the patient can be seen monthly for follow up and prescriptions.

If YES to any of the above, consider more frequent follow up visits with patients and notify patient's prescribing provider.

Reference: Vermont's Office-Based Opioid Treatment Stability Index. Shared as supporting material to an IAP webinar "Clinical Pathways & Payment Bundles for Medication Assisted Treatment" on January 17, 2017.

Attachment B: Treatment Needs Questionnaire

TREATMENT NEEDS QUESTIONNAIRE

Patient Name/ID: _____ Date: _____

Ask patient each question and circle answer for each.	Yes	No
Have you ever used a drug intravenously?	2	0
If you have ever been on medication-assisted treatment (e.g. methadone, buprenorphine) before, were you successful? (If never in treatment before, leave answer blank)	0	2
Do you have a chronic pain issue that needs treatment?	2	0
Do you have any significant medical problems (e.g. hepatitis, HIV, diabetes)?	1	0
Do you ever use cocaine, even occasionally?	2	0
Do you ever use benzodiazepines (e.g. lorazepam, alprazolam), even occasionally?	2	0
Do you have a problem with alcohol? Have you ever been told that you have a problem with alcohol or have you ever gotten a DWI/DUI?	2	0
Do you have any mental health conditions (e.g. major depression, bipolar disorder, severe anxiety, PTSD, schizophrenia, personality subtype of antisocial, borderline, or sociopathy?)	1	0
Are you currently going to any counseling, AA or NA?	0	1
Are you motivated for treatment?	0	1
Do you have a partner that uses drugs or alcohol?	1	0
Do you have 2 or more close friends or family members who do not use alcohol or drugs?	0	1
Is your housing stable?	0	1
Do you have access to reliable transportation?	0	1
Do you have a reliable phone number?	0	1
Did you receive a high school diploma or equivalent (e.g. did you complete >12 years of education)?	0	1
Are you employed?	0	1
Do you have any legal issues (e.g. charges pending, probation/parole, etc)?	1	0
Are you currently on probation?	1	0
Have you ever been charged (not necessarily convicted) with drug dealing?	1	0

Totals +

= _____

Total possible points is 26

Scores >10: Refer patient to Senior Clinical Social Worker

Reference: Vermont's Treatment Needs Questionnaire. @2015 JR Brooklyn & SC Sigmon, Licensed under CC BY-NC-ND 4.0 version 1/21/16

Attachment C: Expectations for participating in Mobile Clinic MAT Services

Expectations for Participation in the Mobile Clinic MAT Services

Visits

1. Participants will be expected to attend scheduled visits with their MAT provider.
2. If a participant is late to their scheduled visit, they may be asked to reschedule out of consideration for other participants utilizing the clinic.
3. If a participant presents for an unscheduled, walk-in visit, they may have to wait for several hours for a provider to be available or be scheduled for an available visit on another day.

Labs

1. Participants will be expected to complete laboratory and diagnostic tests necessary to ensure appropriate medical care.
2. Providers may ask for urine tests to ensure safety of participants' medications and to provide participants with support needed for continued substance use.

Prescriptions

1. Participants will be expected to take their medications as prescribed.
2. Providers will work with the participants to find the right medication for the participants, but the provider will make the final decisions about the medication prescribed. The participants should respect their providers' clinical judgment and decisions.
3. Participants should let their provider know if they get controlled medications from someone other than their provider. This will allow their provider to give the participants appropriate treatment.
4. Participants will be expected to safely store their medications to the best of their ability.

Lost or Stolen Medications

1. If a participant's medications are lost or stolen, the participant should work with their provider and/or other mobile clinic staff to prevent future loss or theft.
2. The provider may ask for a urine test if a participant reports medication loss or theft.
3. The provider may prescribe fewer days supply of a participant's medications until the participant has a plan for preventing future loss or theft.

Destroyed or Damaged Medications

1. If a participant's medications are destroyed or damaged, they should bring them to show their provider.
2. The participant should work with their provider and/or other mobile staff to prevent future destruction or damage of their medications.
3. The provider may prescribe fewer days supply of a participant's medications until the participant has a plan to prevent future destruction or damage of their medications

Attachment D: Order sets for urine toxicology screens

U Pain Management, Opiates Expanded, Quantitative-SO
- Tests for codeine, hydrocodone, hydromorphone, morphine, norhydrocodone, noroxycodone, oxycodone, and oxymorphone

U Pain Management, Methadone Metabolite, w/out Confirmation-SO
- Tests for methadone

U Pain Management, Buprenorphine, Quant-SO
- Tests for buprenorphine

Attachment E: Examples of Possible Indicators for Failed Treatment

- Continued use of illicit substances or cravings despite adherence to maximum recommended dose of MAT
- Request for early refills for prescriptions of MAT at maximum recommended dose
- SUD-related hospitalization or ED visit while on MAT
- Substance-related overdose while on MAT
- Intolerance to MAT preventing dose titration to recommended maintenance dose range
- Non-adherence to prescribed MAT

Attachment F: Letter for Proof of Treatment for Patient

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NATIONAL REHABILITATION CENTER

7601 .Imperial Highway
Downey, CA 90242

Tel: (562) 385-7022
Fax (562) 803-5876

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

Health Services
www.dhs.lacounty.org

Dear Pharmacist,

The patient presenting this letter is under my care at the Housing for Health mobile clinic with the Department of Health Services (DHS). Because the patient is experiencing homelessness and currently does not have a state-issued ID, I am the writing to confirm the patient's identity and the source of the patient's prescription. The patient's name, date of birth, and address are as follows:

Name: _____

Date of Birth: _____

Address: _____

The Housing for Health mobile clinics and our partners are working to reduce barriers for people experiencing homelessness (PEH) in accessing medications. This includes controlled medications for substance use disorders such as buprenorphine-naloxone (Suboxone).

We are sure you are aware that opioid overdose is the most common cause of death in PEH. Through a partnership with DHS' Housing for Health mobile clinic teams and Addiction Medicine team, we are implementing an evidence-based and life-saving *Medication First* approach for our most vulnerable patients.

This letter is to assure you that:

- The prescriptions are from a trusted source.
- We are actively working to help the patient regain appropriate ID. Please accept this letter and any supportive information from the patient as proof that the person presenting the letter is the correct patient.

Thank you for your support in our efforts. Please feel free to contact me for more information.

Warmly,

Physician's name and title
Physician's contact information

Attachment G: Letter for Proof of Treatment for Mobile Clinic Staff

RANCHO LOS AMIGOS
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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

Health Services
www.dhs.lacounty.org

Dear Pharmacist,

I am writing to inform you that the Community Health Worker (CHW) presenting this letter is working with the Department of Health Services (DHS) and our partners to provide support to people experiencing homelessness (PEH). Part of that support work is helping to reduce barriers for PEH in accessing medications, including buprenorphine-naloxone (Suboxone) for opioid use disorder treatment.

This letter is to assure you that:

- The prescriptions are from a trusted source.
- This CHW is a trusted person to pick up medications for the patient (see patient's signed consent below).
- This CHW can help you with any trouble shooting or put you in contact with the appropriate persons if they do not know the answers.
- If there are any issues with the patient's identification, the CHW is actively working to help the patient regain appropriate ID. Please accept the CHW's ID and any supportive paperwork from the patient as proof that the CHW is presenting for the correct patient.

Thank you for your support in our efforts. Please feel free to contact me for more information.

Warmly,

Physician's name and title
Physician's contact information

Patient Consent for Prescription Pick-up by CHW:

Patient's Name: _____

Patient's DOB: _____

I give consent for the CHW to pick up my prescription on my behalf.

Patient's signature: _____

Date: _____

Attachment H: Required Information for DEA CURES Report

1. Full name, address, and, if available, telephone number of the ultimate user, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.
2. The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of a prescriber using the federal controlled substance registration number of a government-exempt facility.
3. National Drug Code (NDC) number of the controlled substance dispensed.
4. Quantity of the controlled substance dispensed.
5. Number of refills ordered.
6. Whether the drug was dispensed as a refill of a prescription or as a first-time request.
7. Prescribing date of the prescription.
8. Date of dispensing of the prescription.