The Louisiana Bridge Program (LA Bridge), modeled after the nationally recognized Bridge, makes evidence-based addiction treatment and naloxone accessible through Emergency Departments (ED). The program creates a compassionate pathway to effective addiction treatments through three critical components:

1. **Evidence-based treatment for SUD:** Making medication for addiction treatment (MAT) accessible in the emergency department and all hospital departments without complicated restrictions and procedures.
2. **Connection to Care and Community:** Trained Substance Use Navigators connect patients to ongoing care in the community providing a warm walk through services as well as take home naloxone.
3. **Culture of Care:** Creating a welcoming hospital culture that offers treatment without stigma, building trust, and leading with respect.

LA Bridge Tiers Overview

The LA Bridge Tier Framework establishes a clear, progressive roadmap for hospitals to implement and sustain evidence-based care for patients with opioid use disorder (OUD). The framework is organized into four tiers—Bronze, Silver, Gold, and Platinum—with each tier building on the prior level and requiring full achievement of defined metrics to qualify for advancement. Performance is measured relative to overall emergency department and hospital volume.

LA Bridge FAQ's

What leadership support is needed to implement LA Bridge?

Successful programs require visible executive support, pharmacy alignment, and clinical champions. Leadership endorsement signals institutional commitment, facilitates policy adoption, and supports sustainability planning and quality improvement.

Low Barrier Naloxone Distribution

Goal: Hospital provides low barrier naloxone distribution in the Emergency Department

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What are the essential features of a hospital naloxone policy?

A hospital naloxone template should establish a low-barrier policy that authorizes 24/7 naloxone distribution in the ED without restrictive criteria. Naloxone must be stocked and readily accessible, provided at no cost, and available to patients, families, and anyone requesting it. Distribution should be documented and tracked in the required format to support quality monitoring and reporting requirements.

A copy of an implemented naloxone policy is required for tier level verification.

Is distribution of community naloxone against the hospital licensing regulations, pharmacy regulations, or board of nursing regulations?

No. The Louisiana Board of Pharmacy and the Louisiana State Board of Nursing both passed resolutions clarifying that RS 40:978.2 supersedes existing board regulations. The Louisiana Board of Nursing formally supports the distribution of naloxone to community members at risk of experiencing or witnessing an overdose. The resolution stipulates that the naloxone must be stored separately from the pharmacy inventory, must have policies and procedures, and must keep a log to track the doses distributed. The resolution also specifically says that naloxone being provided to the community as part of a harm reduction may be dispensed by a nurse directly to a community member or patient of a hospital if supplied at no charge. LDH adopted an Emergency Rule allowing widespread availability and distribution of OTC naloxone to patients and/or non-patients who present in a hospital and sent a memo to all Louisiana Licensed Hospitals on April 19, 2024. There are no known legal or regulatory barriers that prohibit community naloxone distribution at a hospital.

Who can distribute naloxone at the hospital?

Anyone who agrees to abide by the standard operating procedure can participate. Hospital and ED leaders should identify staff who are best suited to begin community naloxone distribution. Since this is a community distribution program, EDs are permitted to use any employee category for this program, including navigators, clinicians, ED techs, nurses, social workers, or volunteers.

Can I distribute take-home naloxone kits to visitors in the ED lobby/waiting area?

Yes. If an individual is not seeking medical care, they are not required to register as a patient to receive community naloxone. You can simply document distribution on your log sheet. If the individual is also seeking emergency medical care, they would then need to be registered and be afforded a medical screening exam per EMTALA regulations. This approach assures the low barrier environment that makes community distribution of naloxone so successful in saving lives.

Can naloxone kit recipients remain anonymous?

Yes. People with opioid use disorder are often subject to shame and stigma, so requiring identifying information can be a significant barrier to the highest risk populations. Your naloxone distribution program can and should be designed to facilitate anonymous distribution.

Can community naloxone be distributed to minors?

Yes. There is no age restriction on distribution of naloxone in Louisiana. Minors who are not patients (i.e. visitors, friends, or family), can receive community naloxone without age restriction. If the minor is a patient, Louisiana minor consent and confidentiality laws apply.

Should our ED have signs in the lobby identifying the ED lobby/waiting area as a place people can receive free naloxone?

Yes. Most people will be unaware that free naloxone is available. Increasing awareness will help your program succeed. Advertising the availability of free naloxone will not have a significant impact on your staff workload other than decreasing the number of overdoses treated by your ED.

Naloxone I ordered through the Louisiana Department of Health has passed its expiration date. What should I do?
Numerous studies have demonstrated that naloxone retains its potency long past its expiration date, even when kept in less-than-ideal conditions. If you have expired or nearly expired naloxone kits, please reach out to your local community naloxone source for support with handling the expired kits and getting a new supply as soon as possible. There is proposed legislation that, if passed, will provide immunity for the use of expired naloxone and extend the shelf-life which will help with sustaining our community distribution programs.

Is a standing order still needed for naloxone distribution?
Since naloxone is now an over-the-counter product, a standing order is no longer needed.

My pharmacy is telling me that all naloxone must go through the pharmacy. Is this true?
No. *Community Distributed Naloxone* obtained through the Louisiana Department of Health or another source such as Opioid settlement funds, is not a therapeutic or pharmaceutical that will be used for medical care in your hospital. Selling, providing patient care or fulfilling prescriptions with the community distributed naloxone supply is prohibited. Even though the pharmacists in your hospital will not be the ones tracking or distributing community naloxone, it's important to include them as you educate your team and get your program started. This naloxone program is very different from the way all other medications are handled in the hospital. This naloxone cannot be billed to patient insurance and is not subject to regulations from CMS, The Joint Commission, the Louisiana Board of Pharmacy, or LDH.

Do naloxone doses from the community distribution program need to be labeled?
No. Naloxone obtained for community distribution to the public is exempt from labeling requirements. It can be given to the patient exactly how it arrives. Many hospitals opt to add custom stickers to the boxes that provide information on navigator services, overdose prevention and risk reduction resources, as well as and mental health support.

Is a hospital policy required to distribute community naloxone?
Yes. Regulatory entities may require that your hospital have a policy. Surveyors may request copies of your policy and procedure or log sheets during a site survey. The Louisiana State Board of Nursing resolution also expresses that for nurses to participate in community naloxone distribution, there must be a hospital policy. In addition, a policy helps to ensure that your team is properly tracking distribution, following the same process, knows where the community naloxone is stored, and ensuring that community doses are not incorrectly handled (such as storing with the pharmacy inventory, using for medical purposes, or billing for doses).

Are individuals who are receiving community naloxone required to receive training?
Yes. According to Louisiana law (RS 40:978.2), training should address recognizing signs of an opioid overdose, how to store and administer naloxone, and emergency follow up procedures including activating emergency medical services via 911. There is no required documentation of training, and training can be done by simply reviewing the instructions on the box flap of each kit which covers all of these points.

What are the essential features of a naloxone sustainability plan?
A sustainability plan should describe how the hospital will continue naloxone distribution without relying solely on federally supplied naloxone. At minimum, the plan identifies alternative funding sources. The plan should include basic tracking of units distributed and assign responsibility for ongoing supply management. Sustainability strategies may include obtaining naloxone using Opioid Settlement funds from your local parish government or sheriff's office, applying for grants to support naloxone sustainability and purchasing from a distributor like Padagis, which is affiliated with The Naloxone Project and has a unique local reinvestment strategy.
A copy of a naloxone sustainability plan is required for tier level verification.

Medications for Addiction Treatment
GOAL: Hospital provides MAT for patients identified as having OUD and/or patients in withdrawal, and continues MAT for patients in active treatment.

What are the essential components of a MAT program in the Emergency Department?
Components of a MAT program should include:

- Identifying patients eligible for MAT, on MAT, in withdrawal, or admitted as a result of an overdose/acute poisoning - Quick screen of all patients is appropriate but not required.
- Treatment is accessible in the emergency department, and in all other hospital departments
- Treatment is provided rapidly (same day) and efficiently in response to patient needs

Do ED clinicians need special waivers or certifications?
No special waiver is required to administer or prescribe buprenorphine for opioid use disorder. Hospitals should ensure prescribers receive basic training on buprenorphine initiation and withdrawal management, consistent with onboarding and continuing education expectations.

What are the required features of opioid withdrawal protocols?
Withdrawal protocols must be evidence-based and embedded in the EHR as standardized order sets. Protocols should include buprenorphine initiation and continuation and provide guidance for managing precipitated withdrawal, naloxone induced withdrawal following overdose and general opiate withdrawal that may present to your hospital ED due to lack of access or attempts to quit using opiates in nonmedical setting.

A copy of an implemented opioid withdrawal protocol is required for tier level verification.

Is stocking buprenorphine sufficient, or must it be accessible 24/7?
Formulary inclusion alone is insufficient for advancement beyond early tiers. Scoring prioritizes operational access at all hours, reflecting whether clinicians can reliably initiate or continue treatment without pharmacy-related delays.

Are we required to give buprenorphine to all patients with OUD diagnoses?
Hospitals must ensure buprenorphine is offered when clinically appropriate. Tier scoring reflects availability and use, not forced treatment or patient acceptance.

Do patients already on methadone count toward MOUD metrics?
Yes. Continuation of methadone during hospitalization and appropriate coordination with OTPs reflects adherence to best practices and supports higher-tier expectations, even though buprenorphine metrics are tracked separately.

Bridge to Care and Substance Use Navigation

GOAL: Hospital actively coordinates follow up care for patients initiating MAT within 72 hours, either in the hospital or outpatient setting. Hospital ED provides SUD Navigation services to support the recognition, linkage to care & ongoing treatment for SUD

What if a hospital's volume is too low to require a 1.0 FTE Substance Use Navigator?
Hospitals may meet this requirement using a 1.0 FTE SUN shared with other hospitals as long as they are present in the ED for a set amount of time each week and integrated into the ED clinical team.

Where can I find resources and details on how to develop Substance Use Navigator position(s) at my hospital?
The Louisiana Bridge Team is currently working on developing state-specific materials. In the meantime, the National Bridge website has excellent, descriptive resources, including a SUN toolkit (https://bridgetotreatment.org/resource/substance-use-navigation-toolkit/)

Clinical Champion

GOAL: Clinician champions are knowledgeable on MOUD, start treatment, help ensure adequate education for their team, and serve as a resource on-shift when others have questions. Champions help orient a navigator to the hospital environment and culture and introducing them to department heads and nurse leaders

Where can I find the required trainings?
1 hour Bridge basics:
Review 3 toolkits below (including watch videos)
https://bridgetotreatment.org/resource/what-emergency-department-clinical-teams-need-to-know/
https://bridgetotreatment.org/resource/critical-access-toolkit-what-hospital-leaders-need-to-know-about-naloxone/
https://bridgetotreatment.org/resource/critical-access-toolkit-what-hospital-leaders-need-to-know/

1 hour Buprenorphine 101:
Bup Basics: MAT as the Emergent Standard of Care for Opioid Use Disorder
https://cabridge.academy.reliaslearning.com/Bup-Basics-MAT-as-the-Emergent-Standard-of-Care-for-Opioid-Use-Disorder--1732650.aspx

The Louisiana Bridge Team is currently working on developing state-specific materials. Trainings are free but registration is required. We will update our website with additional acceptable training programs/videos/materials as they become available.

What happens if our EHR cannot easily generate required metrics?
Hospitals are still responsible for accurate reporting. Manual tracking is acceptable initially, but higher tiers expect increasing automation and data reliability.

Does LDH conduct site visits as part of tier verification?
Tier verification is primarily document- and data-based, but LDH may request additional clarification or conduct targeted follow-up if submissions raise questions.

Can tier status be used in hospital marketing or community reporting?
Yes, once finalized and approved by LDH. Hospitals should use accurate language that reflects the tier achieved and the scope of services provided.