FORTRESS

Data Driven DECISIONMAKING

Fatal Overdose Review Teams: Research to Enhance Surveillence Systems.

Contact Us

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OCTOBER 2 & 3 2025

INDIANA UNIVERSITY
SCHOOL OF MEDICINE

FORTRESS
Fatal Overdose Review Teams:
Research to Enhance Surveillance Systems

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October 2025

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Data Driven Decision Making Power Point Slide Deck

Additional Resources:

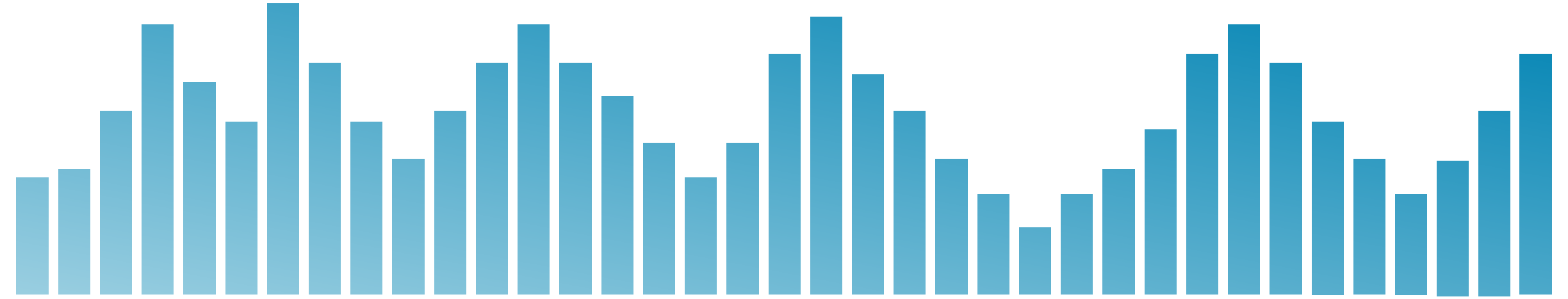
Fact Sheets for Naloxone and Syringe Services Programs

Evidenced Based Strategies for Preventing Opioid Overdose

ORCCA-Opioid Overdose Reduction Continuum of Care Approach

DOJ, Civil Rights Division: The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery

These materials are also available for download electronically under **"Training Materials"** at https://www.indianatouchpoints.org/

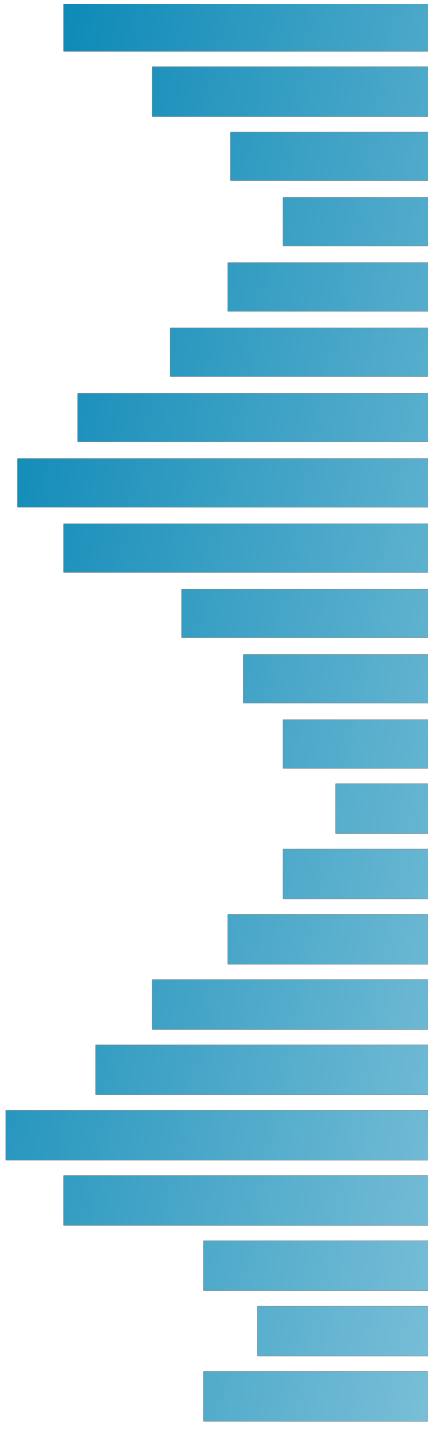


Fatal Overdose Review Team Research to Enhance Surveillance Systems

Data-Driven Decision Making

Welcome

- Introduction
- What *is* FORTRESS
- What *is* Data-driven decision making
- Intro to overdose touchpoints
- Intro to the FORTRESS overdose dashboard
- Data interpretation



Our Team

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Introduction

What's Your Name?

Where are you from?

What do you do for work?

What do you do for fun?

Why are you here?

What *is* FORTRESS?

What *is* Data-driven decision making?

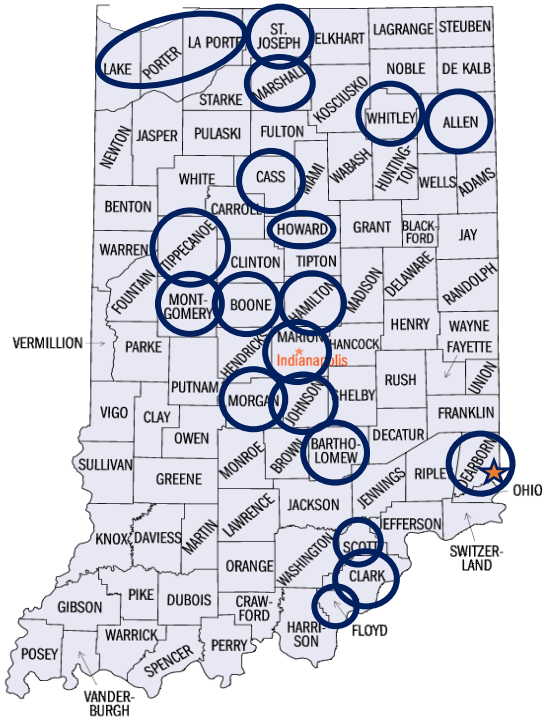
FORTRESS

Study Phase 1:

- Learn more about OFR teams
- Develop the Overdose Touchpoint dashboard
- Create and pilot training materials

Study Phase 2: (right now)

- Train three cohorts of six teams on how to use the dashboard
- Host Community of Practice Calls
- Provide technical support for the duration of the project
- Collect study data



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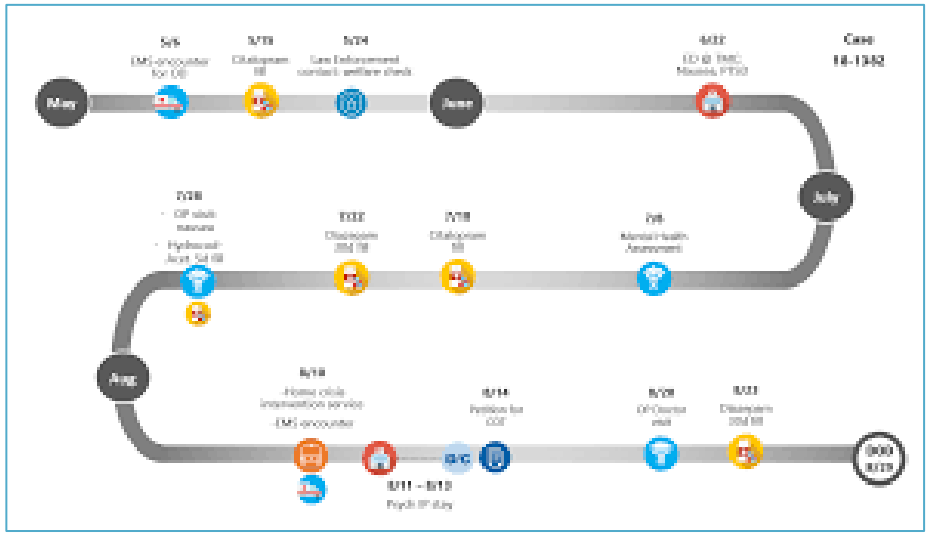
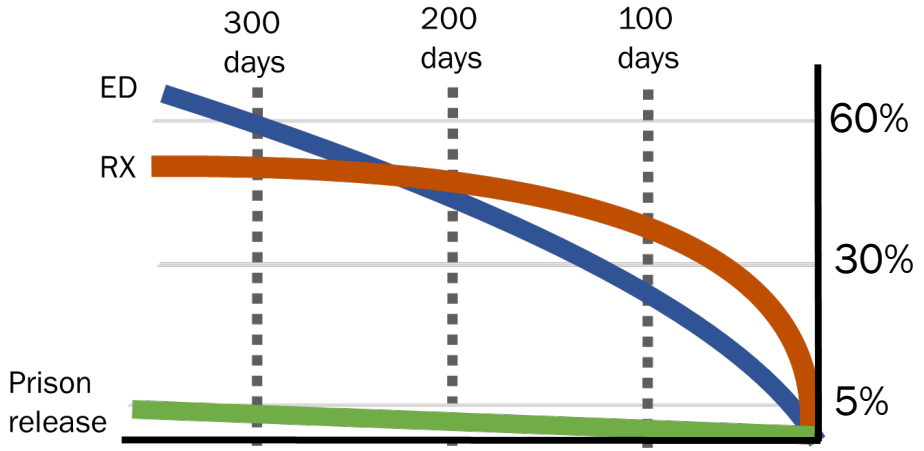
Traditional OFR

- Provides rich information on a single overdose death
- Helps identify “gaps” between systems



Enhanced OFR

- Add real-time, population-level trends in overdose deaths
- Identify *current* points for intervention



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Overcome barriers to data access

Monitor touchpoints in real-time

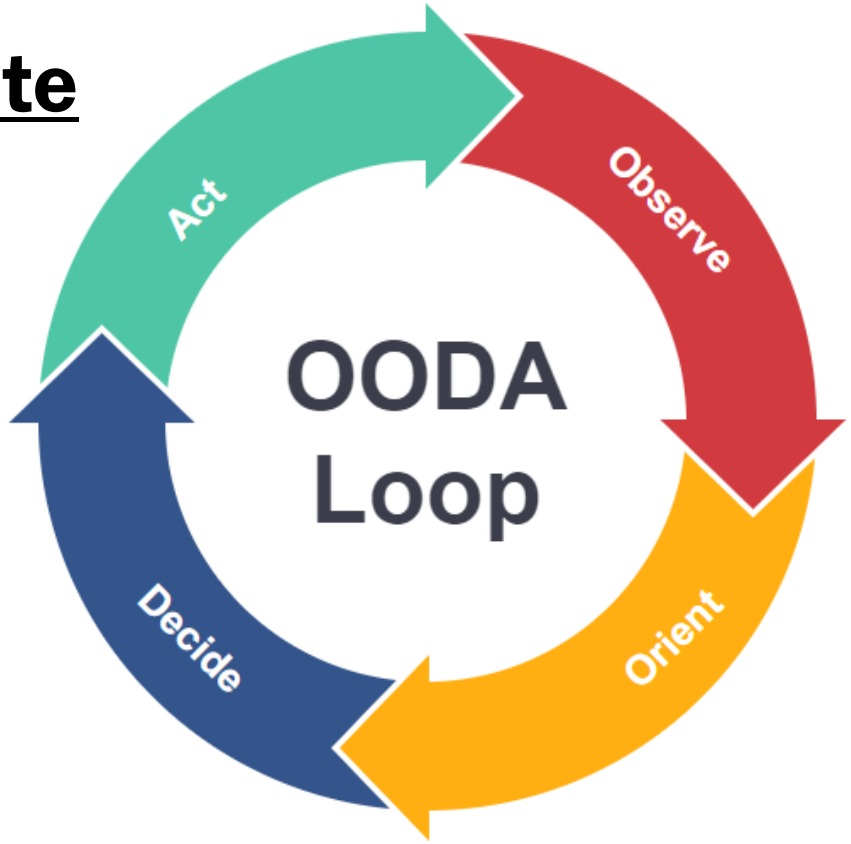
Create community-focused recommendations

Data-Driven Decision Making

- using facts, metrics, and data to guide strategic decisions that align with your goals, objectives, and initiatives (AKA 3DM).

Applying 3DM to OFR

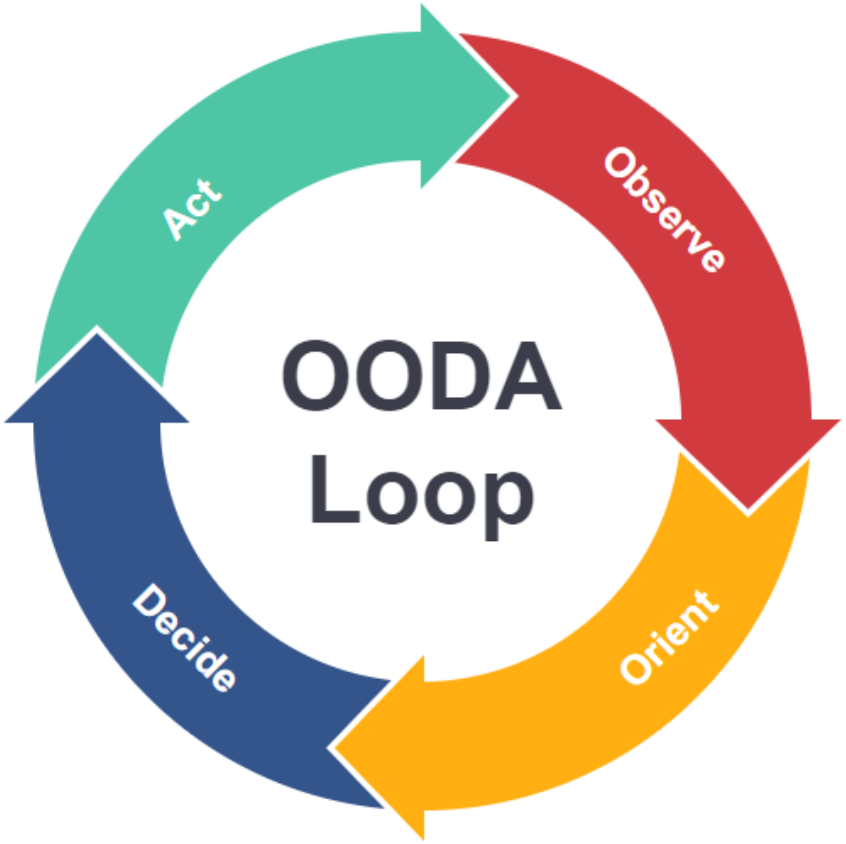
- ❑ **Observe: Identify current and accurate trends in overdose deaths**
- ❑ **Orient: Contextualize these trends within the local landscape**
- ❑ **Decide: Use these trends to inform where to target evidence-based overdose prevention services**
- ❑ **Act: Develop a strategy for implementing your recommendation**
- ❑ **Re-Cycle: Test and Reassess**



Source: https://www.cdc.gov/drugoverdose/pdf/phast-toolkit-508.pdf

Applying 3DM to OFR

Leveraging *clinical science* to craft recommendations that maximize the impact of your resources



Source: https://www.cdc.gov/drugoverdose/pdf/phast-toolkit-508.pdf

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Fatal Overdose Review Teams-Research to Enhance Surveillance Systems (FORTRESS)

Danny Galan, Senior Data Scientist
Kelsey Chance, Senior Director of Engagement and Analytics

Agenda

- Welcome & Introduction to MPH
- FORTRESS Project Overview & MPH's Role
- How We Link the Data
- Touchpoints: Defining Intervention Opportunities
- Agency Partners & Data Sources
- Key Metrics
- Dashboard Walkthrough
- Looking Ahead: The Future of FORTRESS
- Q&A and Discussion

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Who We Are

Indiana Management Performance Hub

MPH provides analytics solutions tailored to address complex management and policy questions enabling **improved outcomes for Hoosiers.**

We empower our partners to leverage data in innovative ways, facilitating **data-driven decision making** and **data-informed policy making.**

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Management Performance Hub

Our Data Partnerships

MPH **does not house any direct constituent services**; it's an agent of its state agency partners.

MPH **serves state agencies and external partners** and adds value by unlocking data, connecting and analyzing across disparate systems, and sharing with agencies and external partners.

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Connecting the Data
Using Record Linkage

MPH's Record Linkage algorithm based on a probabilistic approach.

- See the complete "*journey*" leading to overdose death
- Students and their outcomes out of high school
- Program evaluations on workforce development programs
- All data is de-identified and aggerated for all analysis

We do those across hundreds of millions of records to be able to begin creating new insights.

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What is FORTRESS
Project Overview

- Real-time dashboard displaying touchpoints an individual experienced prior to a fatal overdose
- Funded by National Institutes of Health (NIH) under the HEAL Data2Action Program (HD2A)
  - MPH: Dataset development, internal agreements, and dashboard development
- Primary Project Goal
  - To equip Overdose Fatality Review Teams (OFRTs) with a real-time dashboard that identifies touchpoints while simultaneously providing training on how to use these data to implement overdose prevention strategies

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What Are Touchpoints?

Defining System Interactions That Signal Risk

A touchpoint is a documented interaction between an individual and a system, i.e., healthcare, criminal justice, or social services. It represents a critical opportunity to deliver harm and reduction services or connect someone at risk to evidence-based treatment before a fatal overdose occurs.

ED Visit – Hospital emergency room encounters before fatal overdose
EMS Interaction – Ambulance/paramedic responses before fatal overdose
Jail Booking – Arrest and intake into county jail system
Release from a Prison – Discharge from correctional facility
Rx Dispensation – Filling prescriptions at pharmacies

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Where the Data Comes From

Agency Partners & Data Sources

Agency	Dataset	Touchpoint	Data Extracted
Indiana Dept. of Health	Vital Records	Fatal Overdose	Death certificate data including ICD-10 codes (X40–X44, X60–X64, Y10–Y14, X85), date of death, and demographic information.
	ESSENCE (Syndromic Surveillance System)	Emergency Department Visits	Date/time of ED visit, chief complaint/symptoms, patient age, sex, ZIP code, and hospital name.
Indiana State Police	CHRIS (Criminal History Repository Information System)	Jail Bookings	Date of jail booking events for individuals, including facility and offense-level details where available.
Indiana Dept. of Correction	Prison Release Records	Prison Releases	Date of release from state correctional facilities, including facility name and sentence completion status.
Indiana Board of Pharmacy	INSPECT (Rx Monitoring Program)	Prescription Medication Dispensation	Dates and types of controlled substances dispensed (excluding <72-hour supply and inpatient pharmacy fills), prescriber and pharmacy identifiers.
Indiana Dept. of Homeland Security	EMS Reporting (NEMSIS)	EMS Responses	Date/time of EMS dispatch and arrival, location, patient demographics, and suspected overdose indicators from pre-hospital care reports.

Connecting the Data
Using Record Linkage

The Challenge
Assume of the Following:

1. Jane Doe gets arrested
2. Visits the ER
3. Fills Prescription
4. Dies of Overdose

ISP: Jane Doe, DOB 1985, Arrest ID #1234
IDOH: J. Doe, DOB 1/1/1985, Patient #6789
PLA: Jane M. Doe, DOB 1/1/1985, RX # 4567

Four Separate data sets with no connection to the same person and the data may look something like this

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Building the Dashboard

The Data Infrastructure

The FORTRESS Overdose Touchpoint Dashboard was developed using modern data engineering stack some of those include the following:

Data Processing & Analytics

R – Primary analytical environment

SQL – Query language for creating complex queries

SAP HANA – Enterprise data warehouse platform

Orchestration & Automation

Redwood – Workflow orchestration and job scheduling

Misc.

Git Repos – code version control

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Building the Dashboard

What We Gained Along the Way

- More frequent data refresh from partner agencies
- Stronger relationships with partner agencies
- Enhanced infrastructure to validate and process data in near real-time

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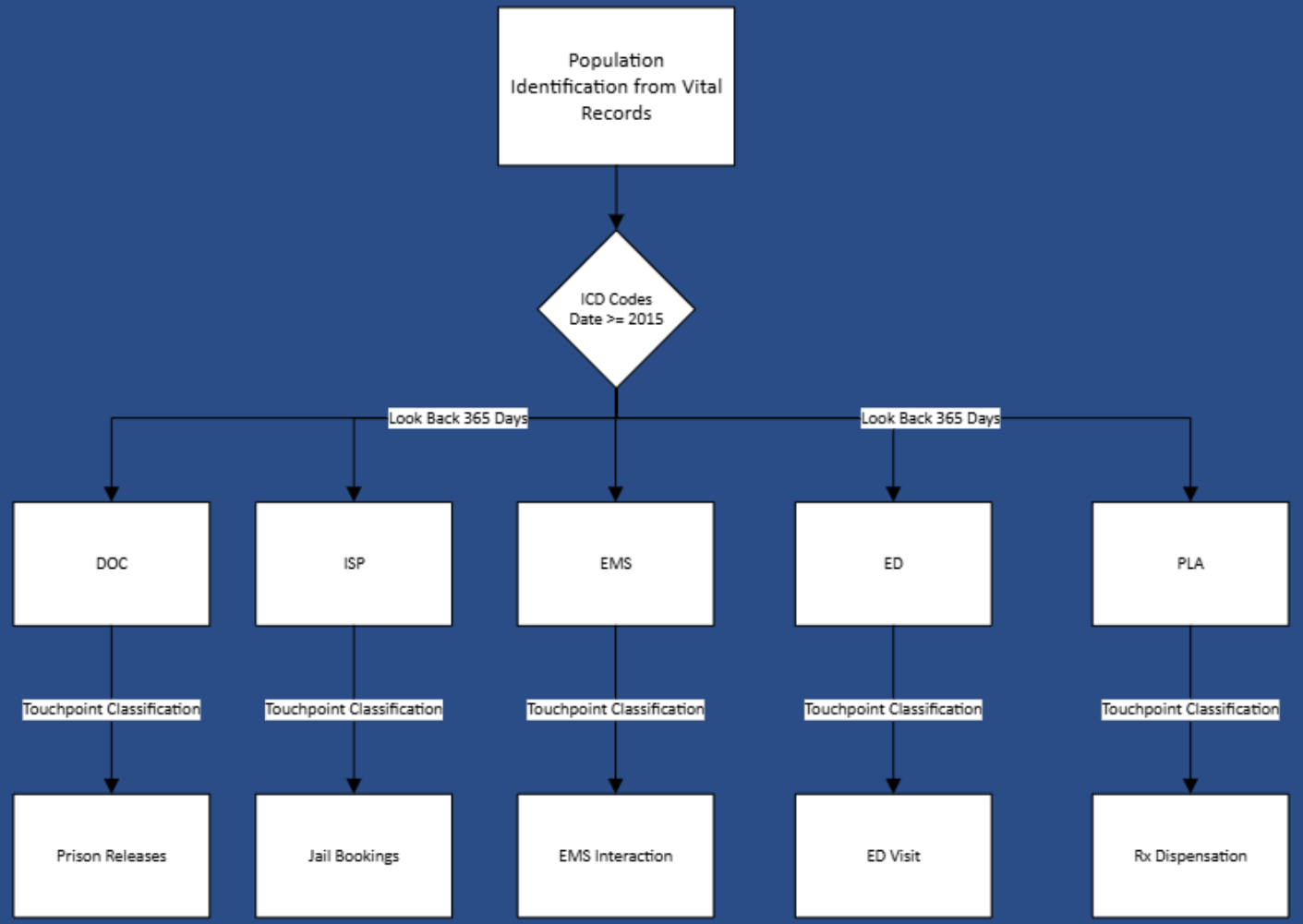
Assigning Touchpoints

How We Identify & Classify Interactions

The following process is how we assign touchpoints for individuals:



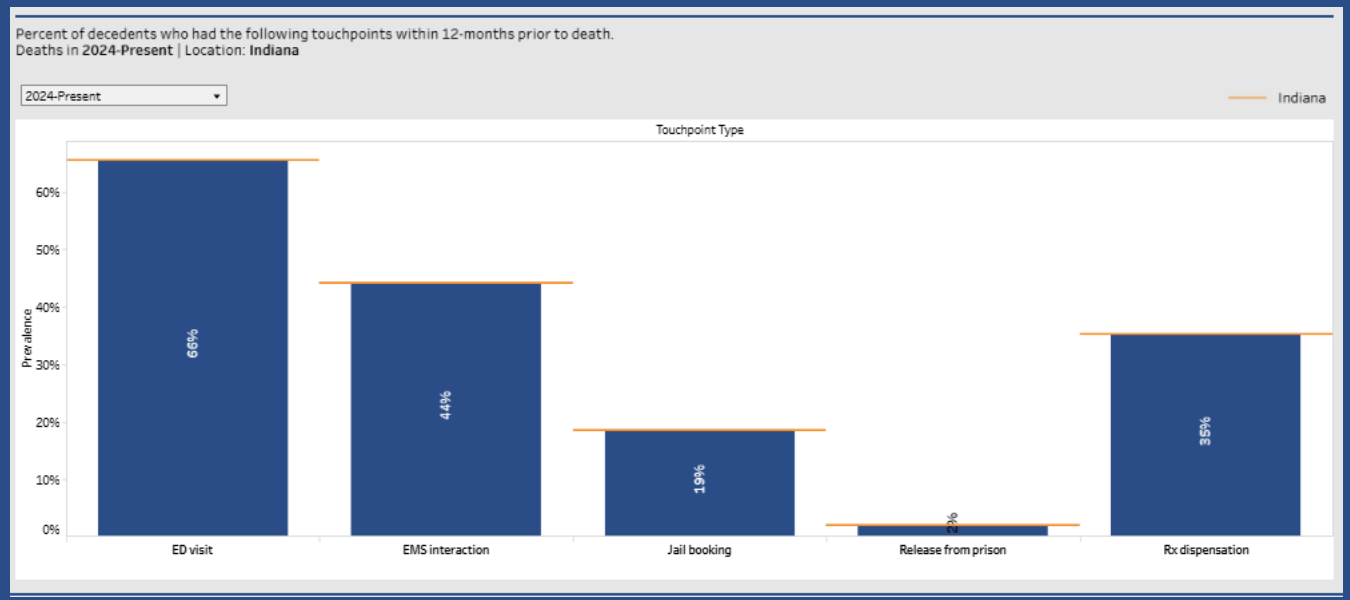
Key Metrics
Prevalence

Prevalence - How Common is a Touchpoint?

What percentage of people who died from overdose had this type of touchpoint?

How this is calculated:

$$\frac{Decedent\ Touchpoint\ Count}{Decedent\ Total\ Individual\ Count} * 100$$



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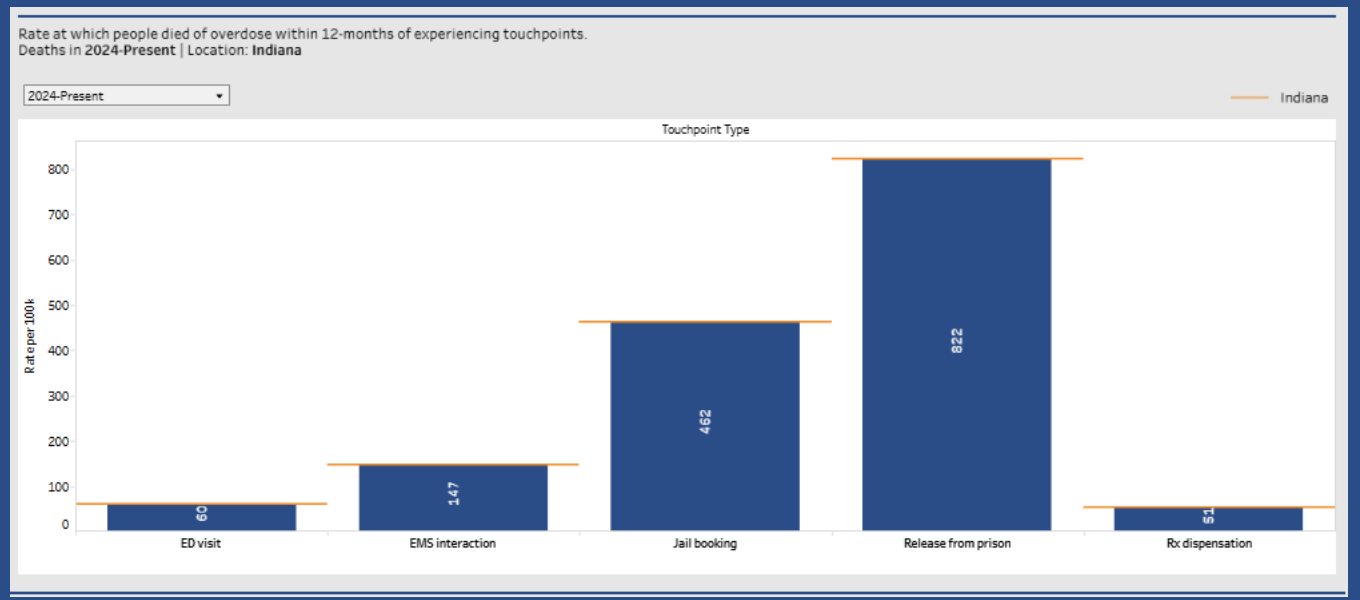
Key Metrics
Rate per 100K

Rate per 100K - How widespread is the impact?

How many people **per 100,000 residents** died from an overdose after experiencing this type of touchpoint?

How this is calculated:

$$\frac{Decedent\ Touchpoint\ Count}{Touchpoint\ Total\ Individual\ Count} * 100K$$



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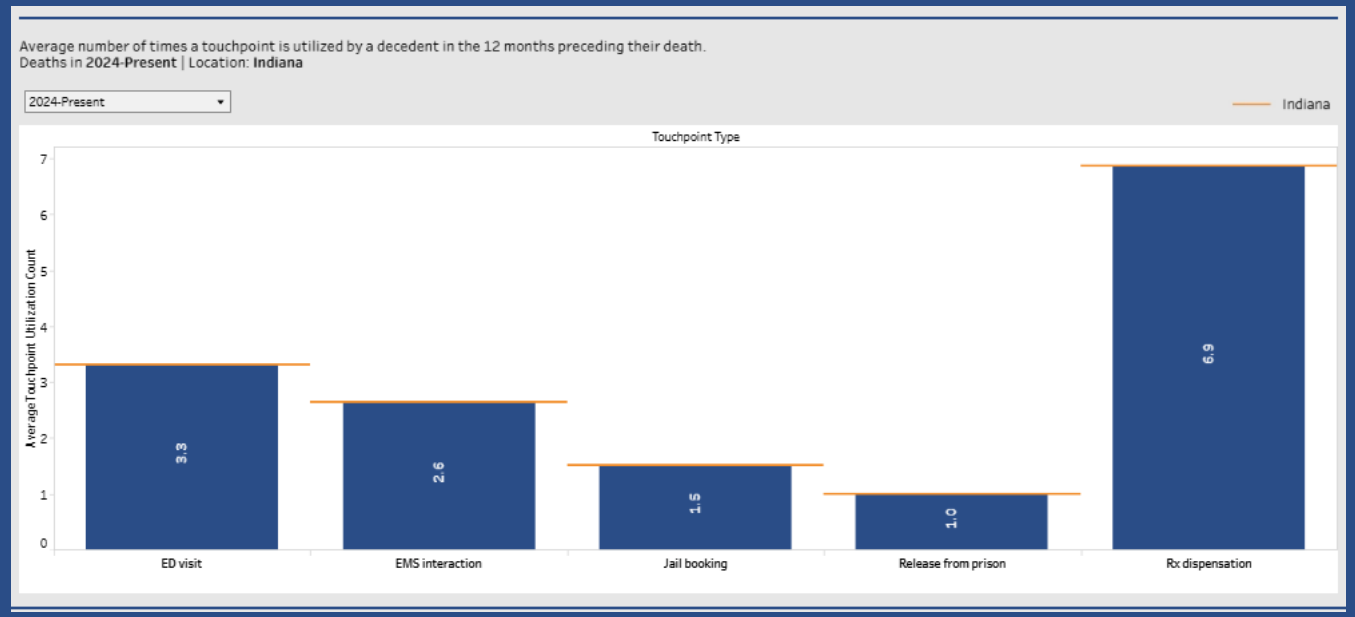
Key Metrics
Frequency

Frequency – How often did a touchpoint Occur?

On average, how many times did a person experience a specific touchpoint before their overdose death?

How this is calculated:

$$SUM\left(\frac{events\ within\ 1\ year\ before\ death}{COUNT(people\ with\ touchpoints)}\right)$$



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Key Metrics
Recency

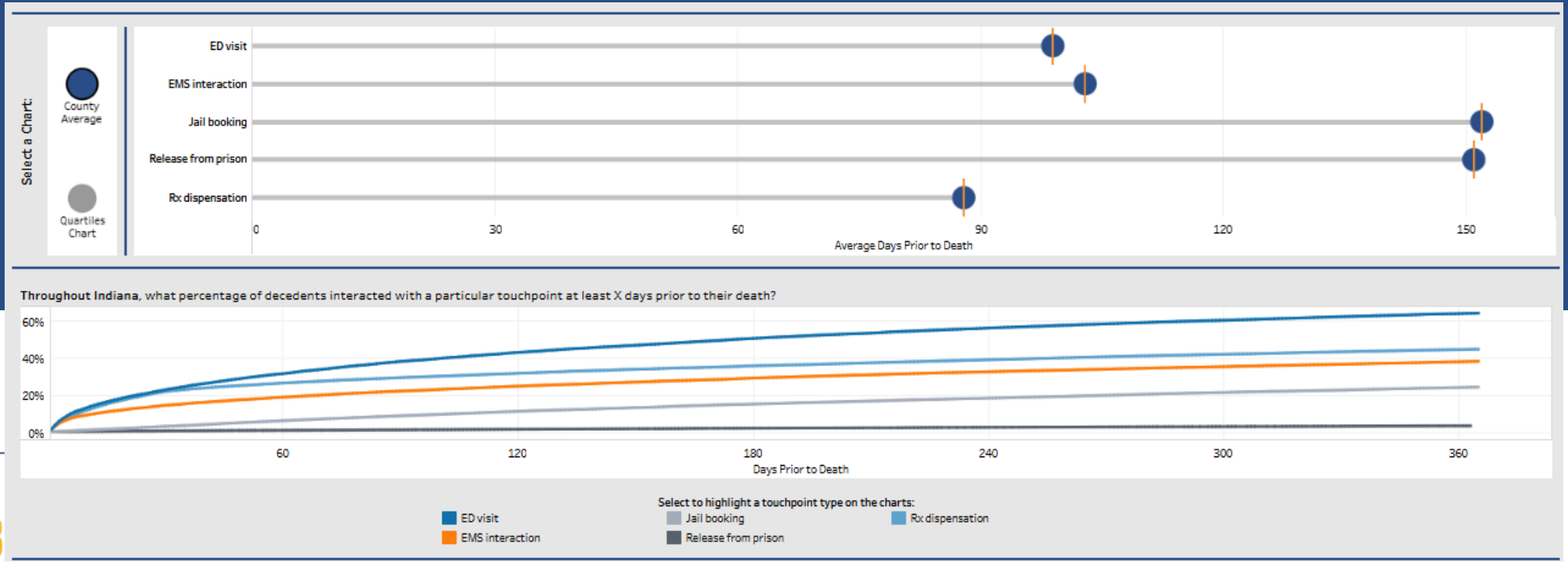
Recency – How close was the touchpoint to the date of death?

How many days before the overdose death did the last touchpoint occur?

How this is calculated:

$$date\ of\ death\ -most\ recent\ touchpoint\ date$$

*We calculate the 25th, median, **average**, and 75th percentile



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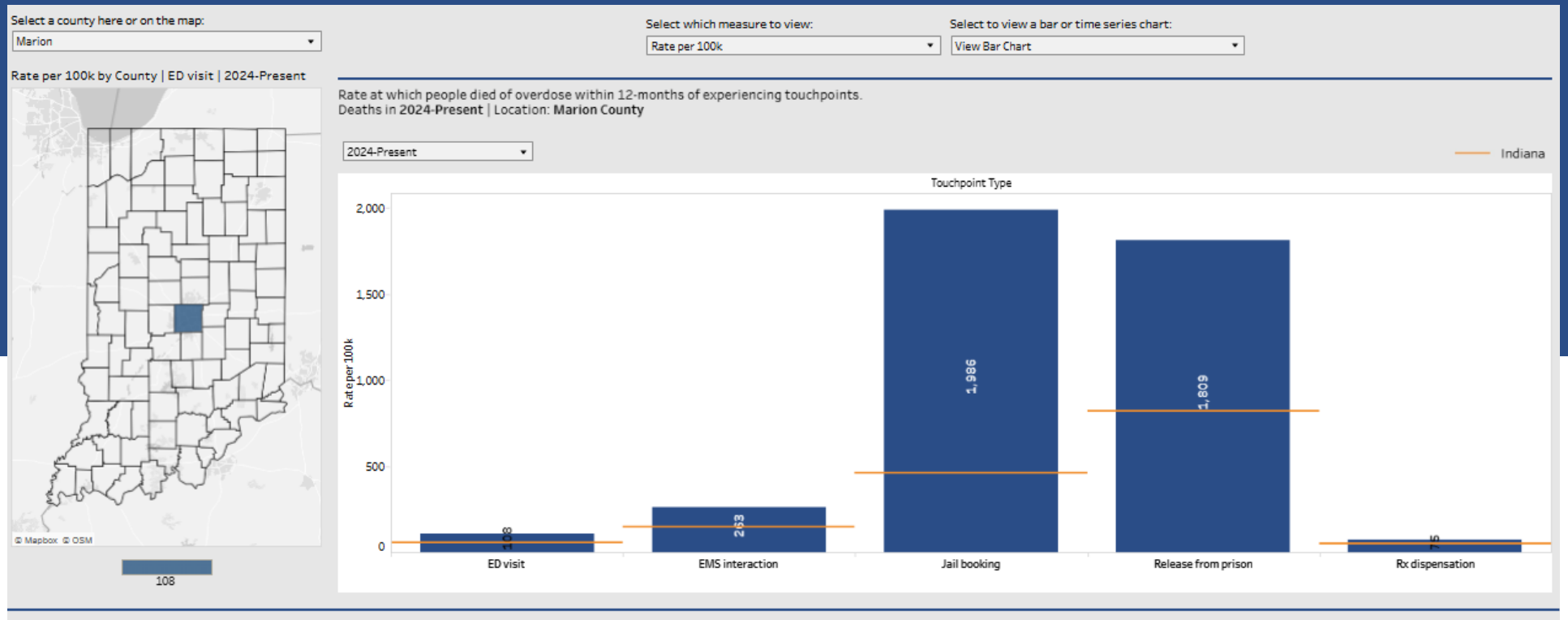
Geographic Insights
County Level View

Geography – Where the risk and opportunity are.

The dashboard allows users to filter by **county** to view local-level data for each metric.

County refers to the **location of death** as recorded in IDOH's Vital Records. However, the associated touchpoints may have occurred anywhere in the state, not necessarily in the same county where the death was recorded.



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Dashboard Demo

MPH: Fatal Drug Overdose Touchpoints

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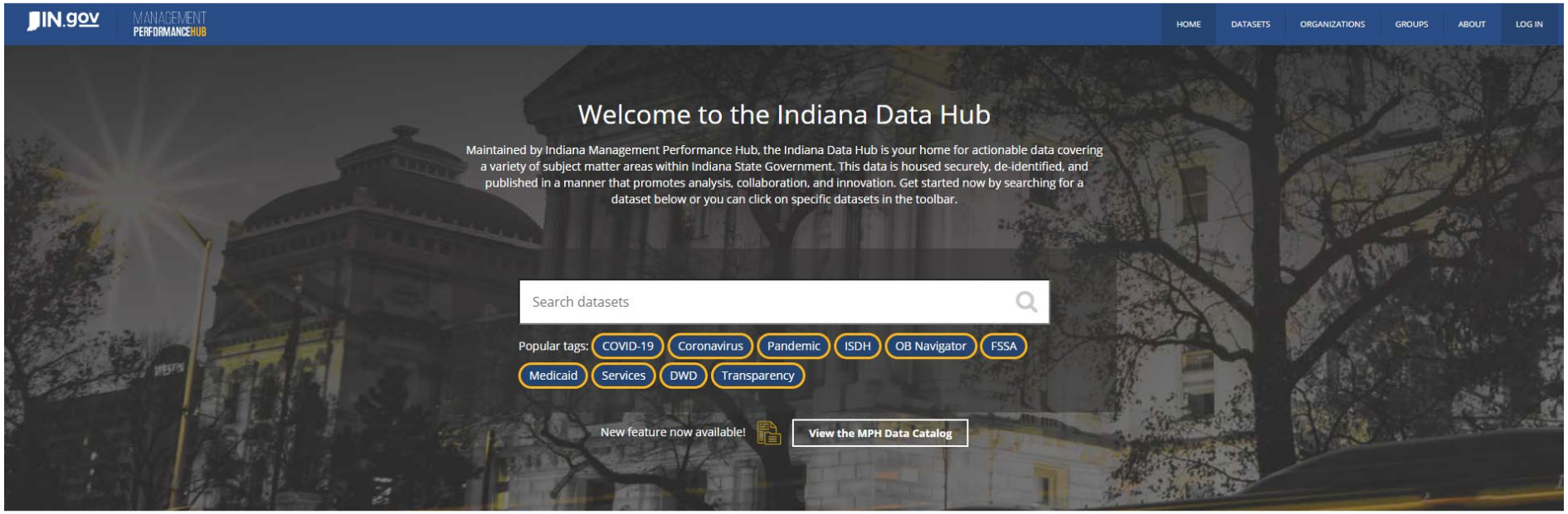
Indiana Data Hub



[OD Touchpoints: Recency and Reach]

[OD Touchpoints: Prevalence, Frequency, and Recency]

hub.mph.IN.gov
Indiana Data Hub

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What's Next?
MPH's Future with FORTRESS

- Ongoing Dashboard Maintenance and Refinement
- Advanced Analysis of Indiana Touchpoints in MPH's Enhance Research Environment (ERE)

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Questions?

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Contact Us

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Dashboard demo

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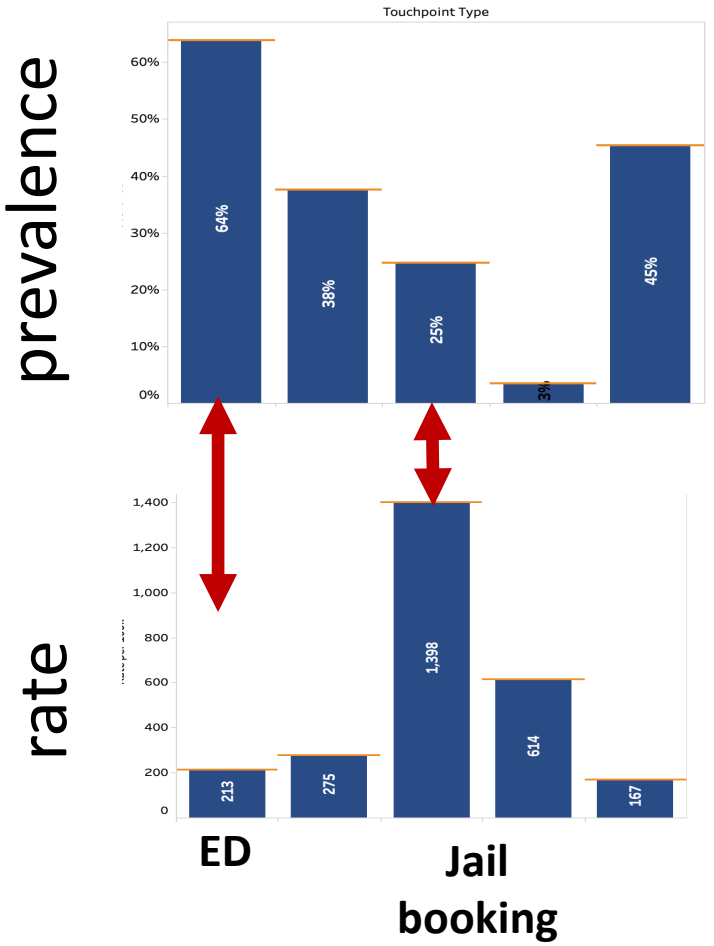
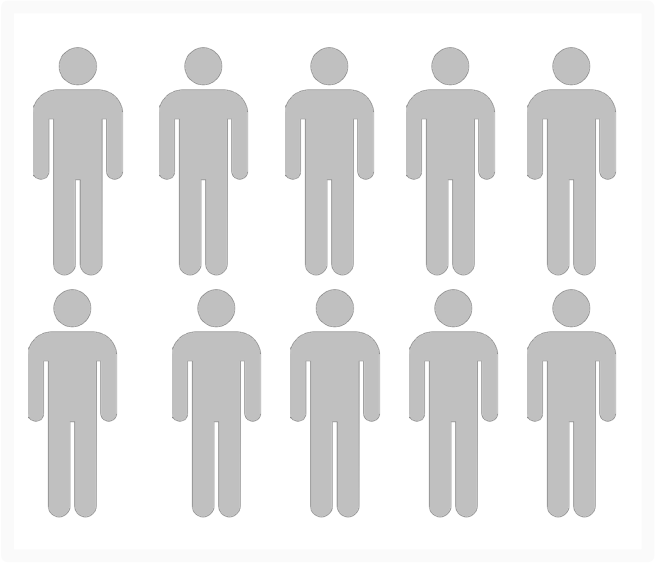
Interpreting touchpoints data

Making sense of ***prevalence*** vs. ***rate***

Prevalence: Percent of decedents who interacted with the touchpoint

Rate: Fraction of touchpoint users who end up dying of overdose

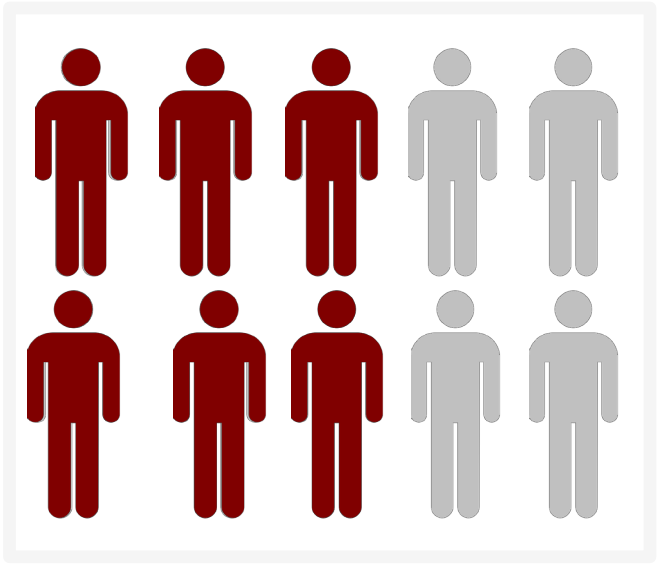




10 people who
died of overdose

6 visited the **ED**
in the year before
their overdose

(**60%** prevalence)



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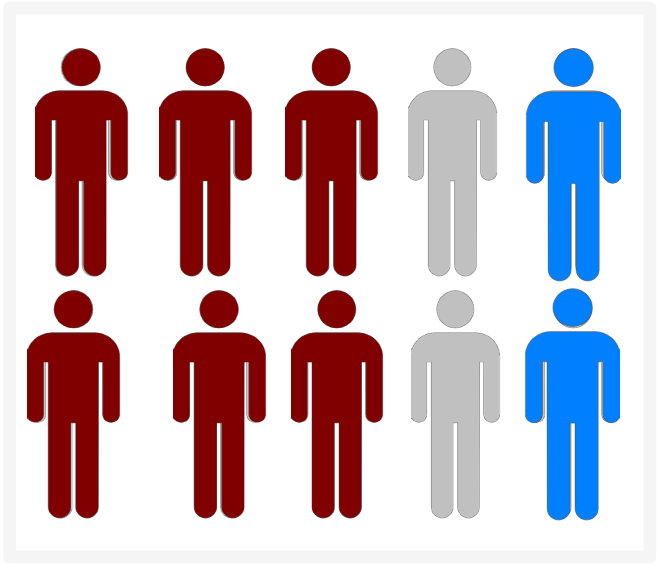
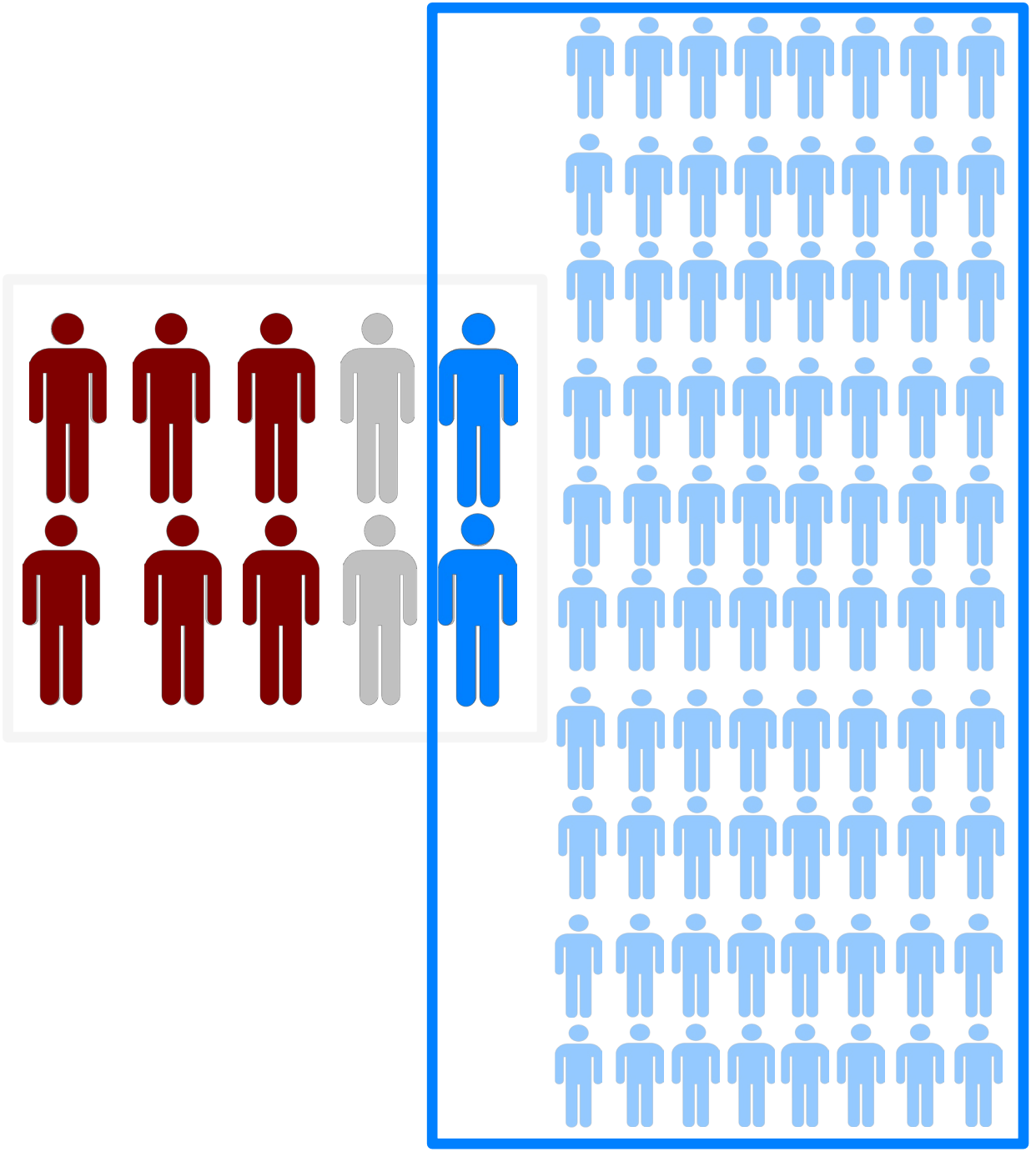
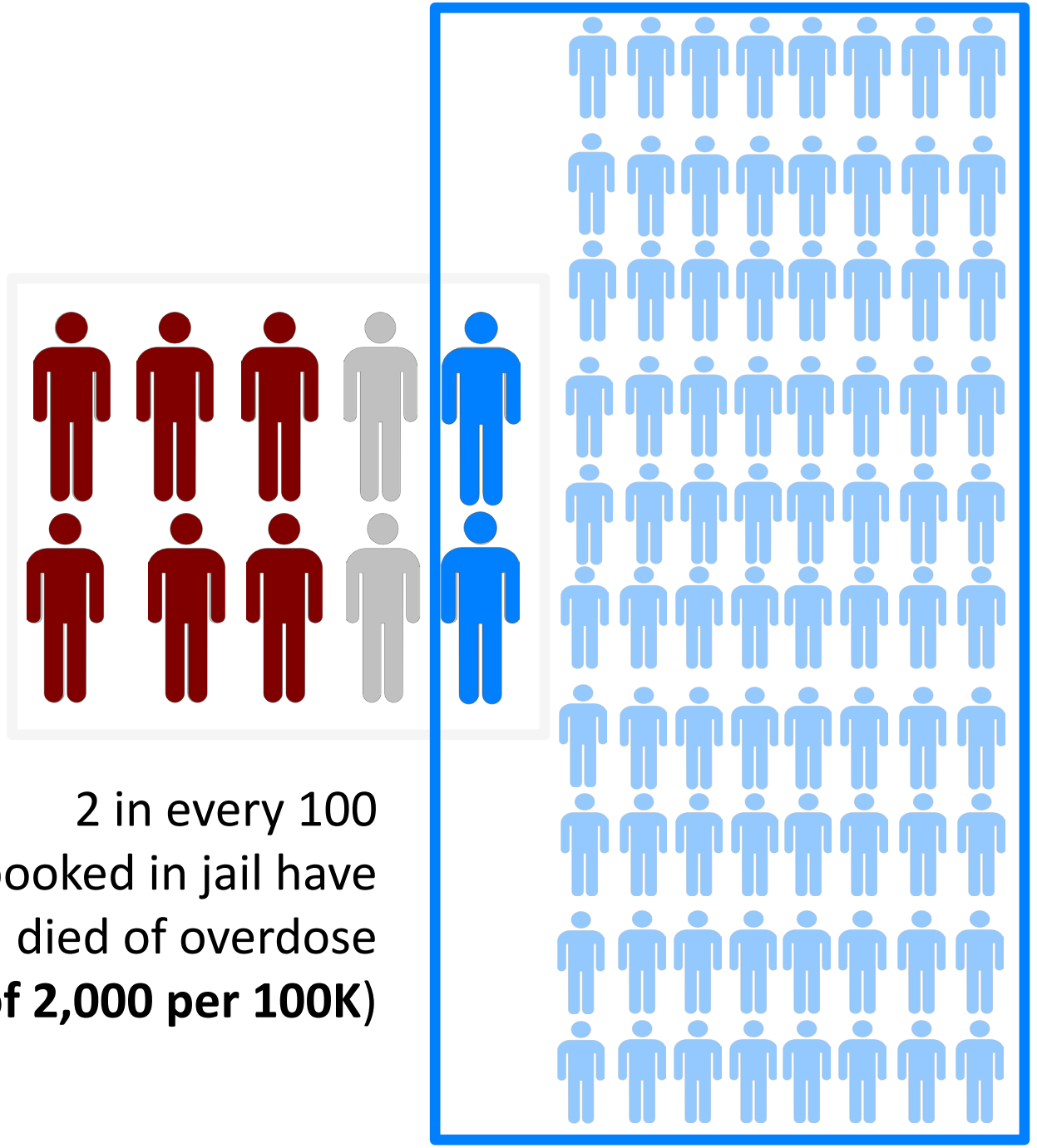
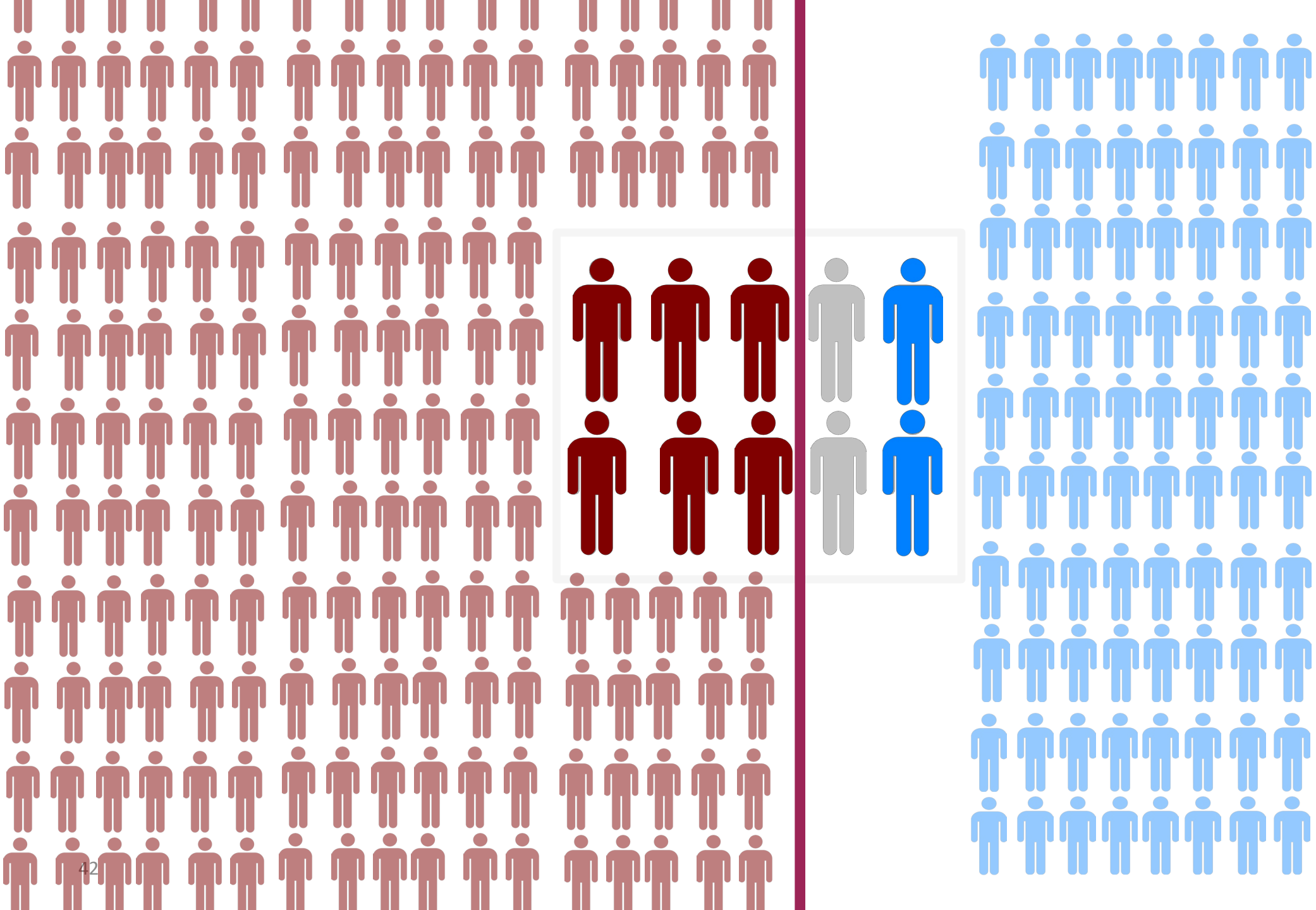


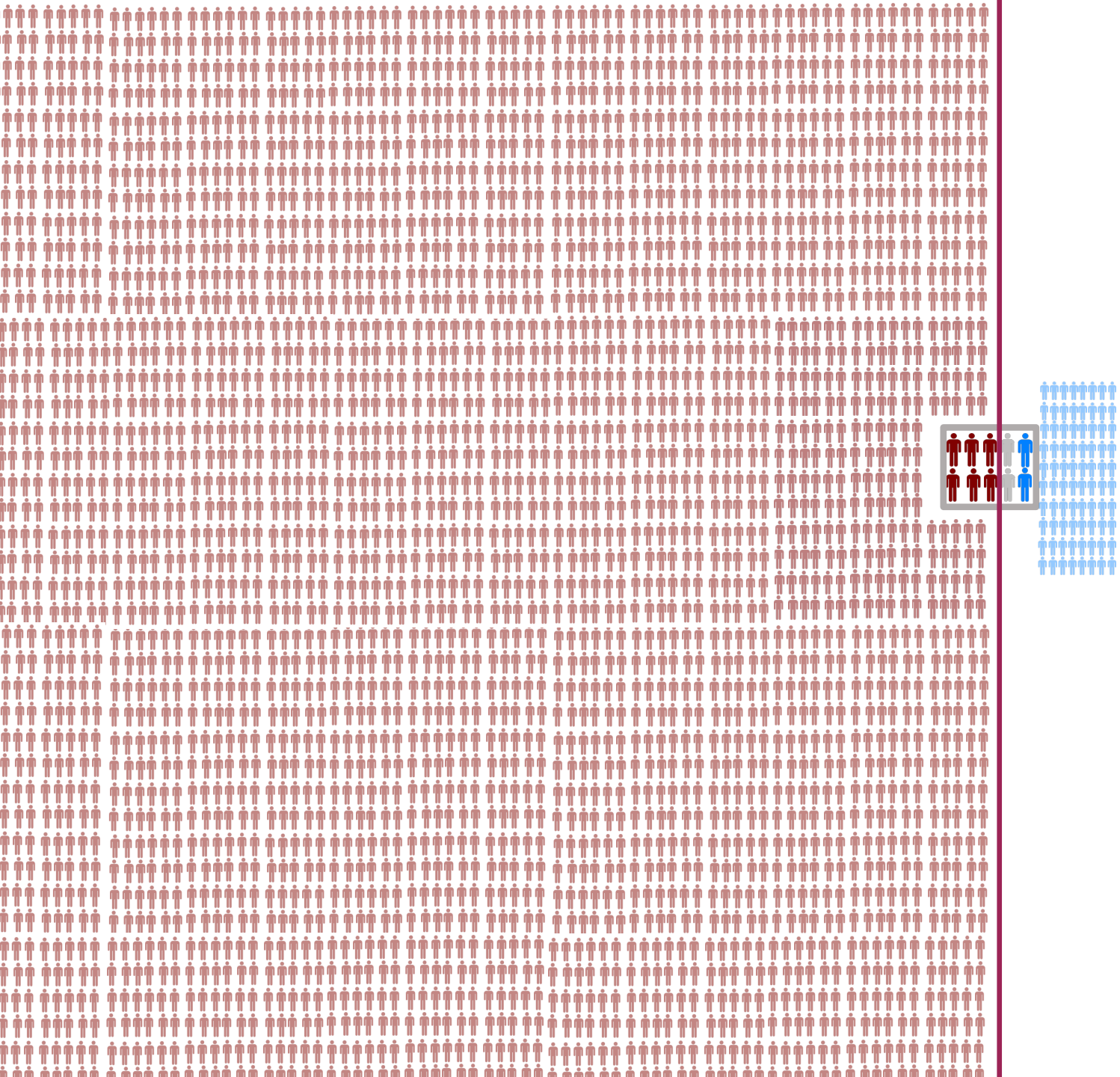
2 were **booked in jail**
(20% prevalence)

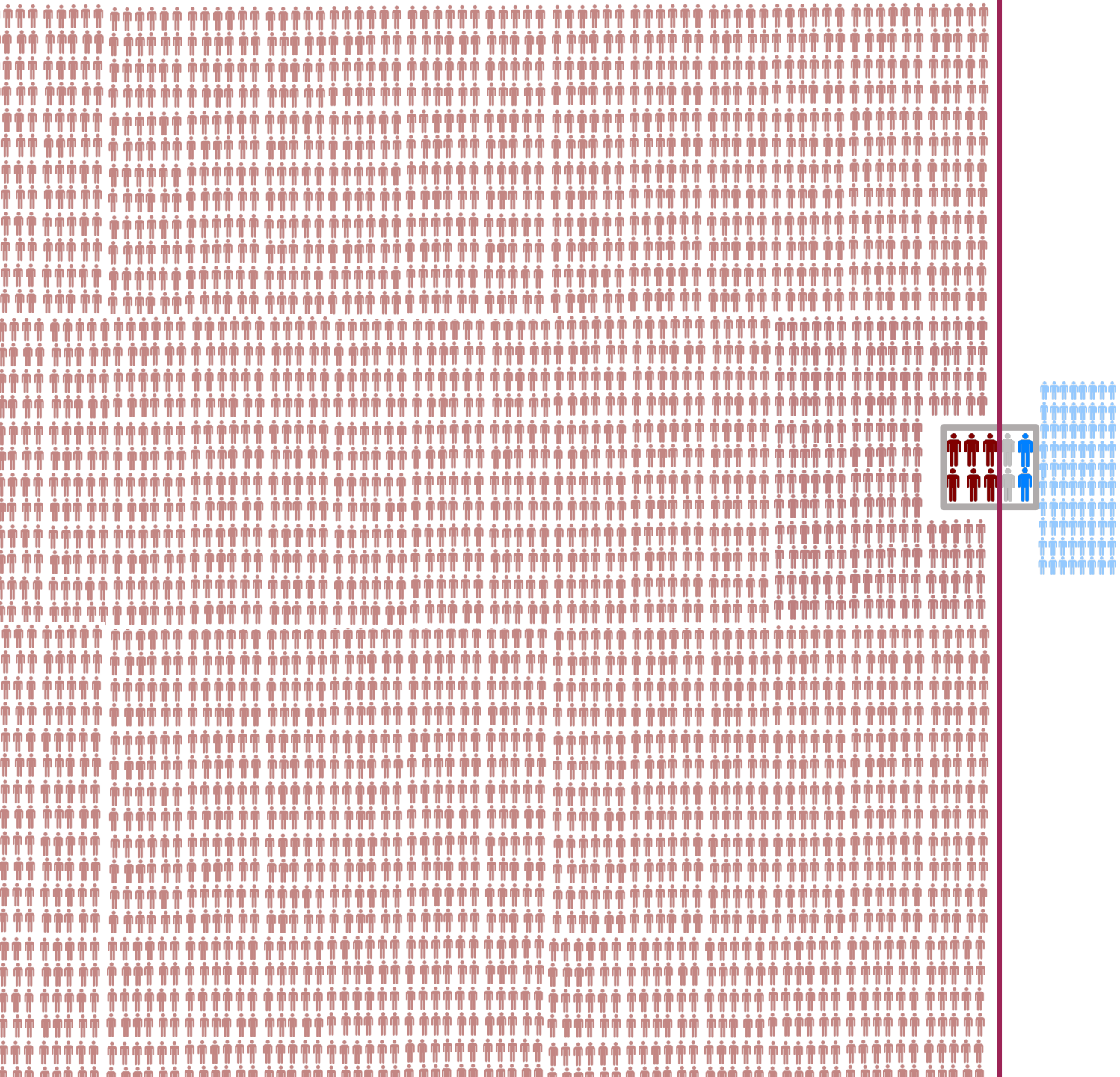




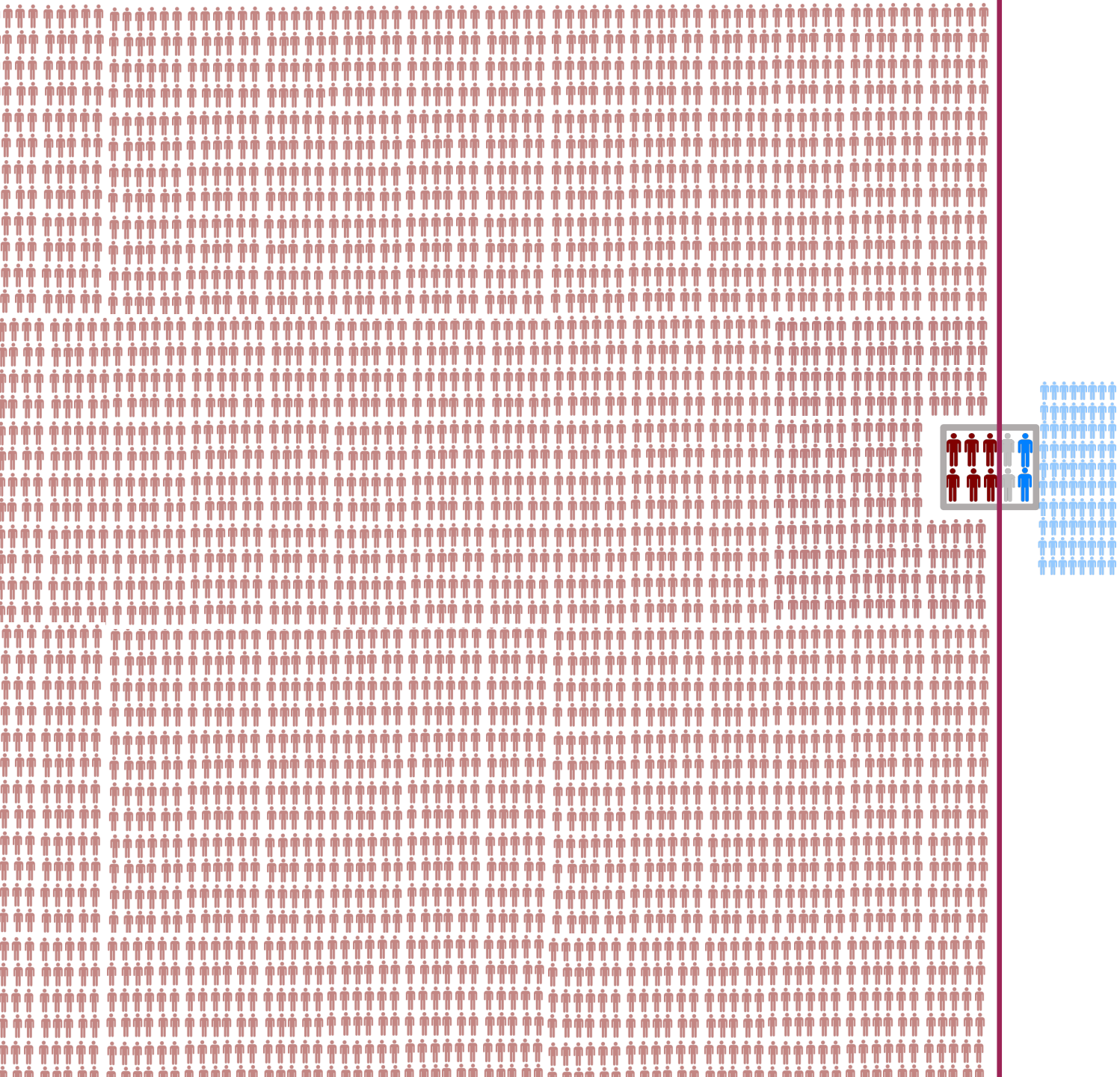
2 in every 100
people booked in jail have
died of overdose
(**rate of 2,000 per 100K**)





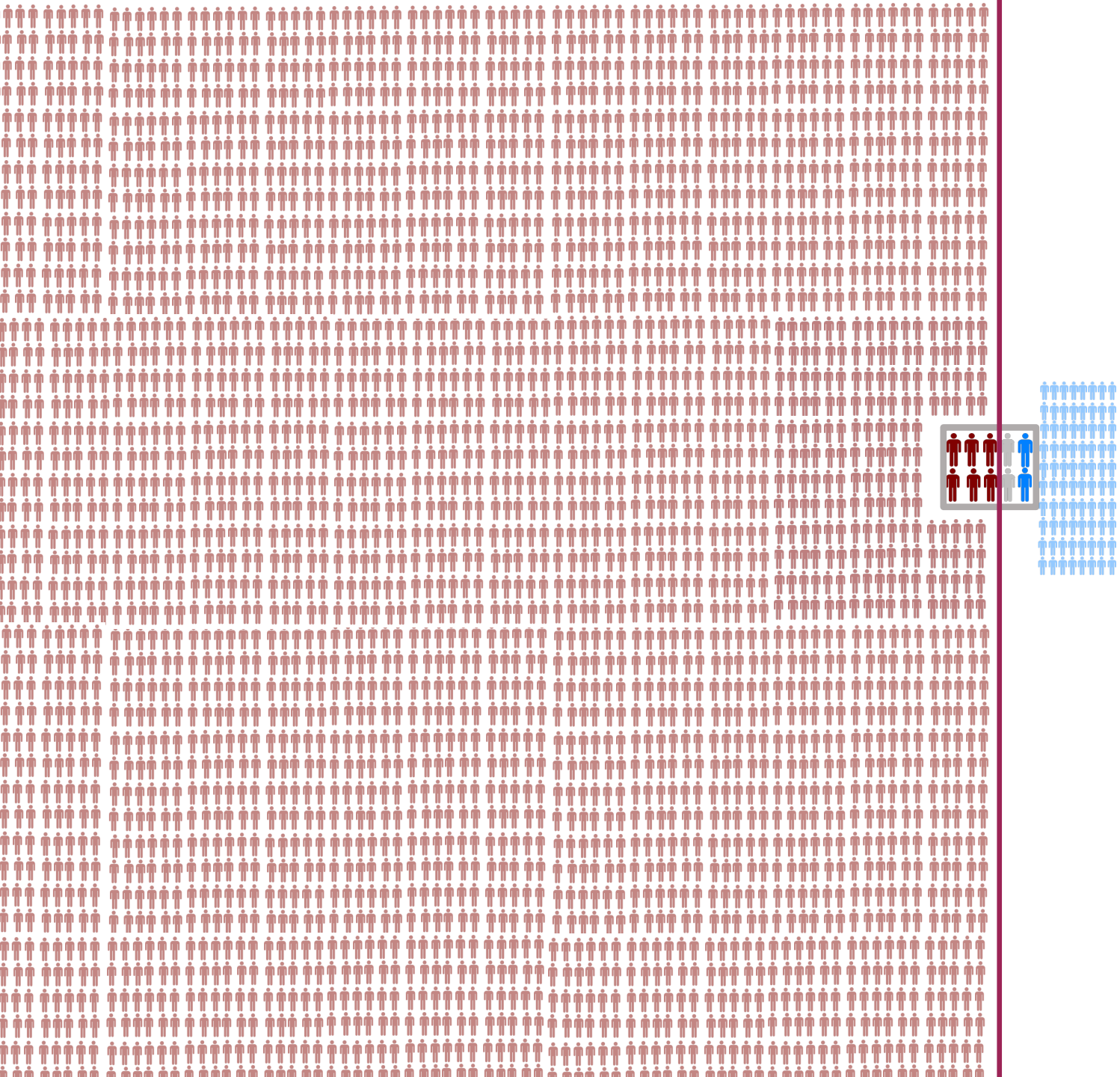


ED overdose rate = **100** per 100K



Jail-booking rate = **2,000** per 100K

ED overdose rate = **100** per 100K



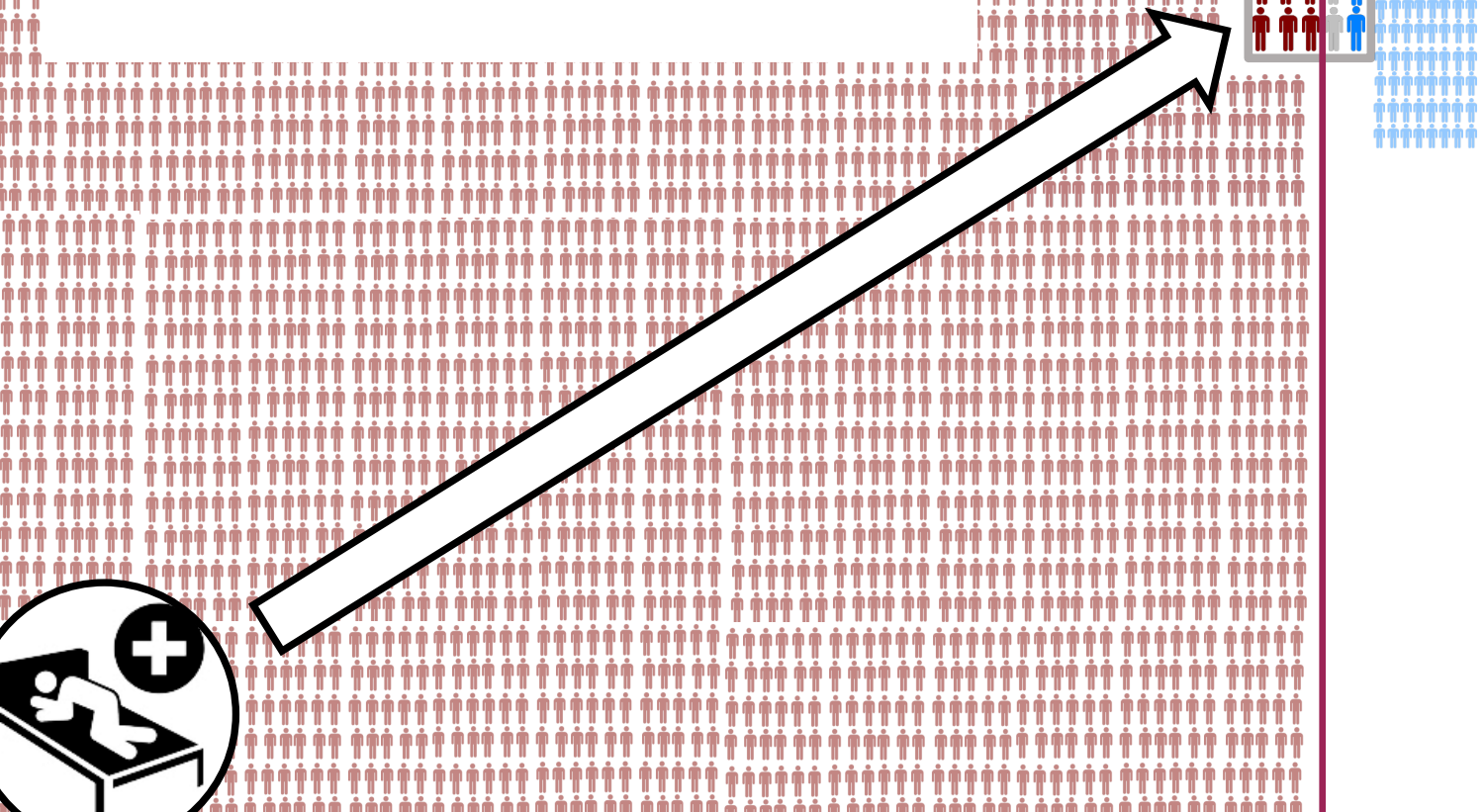
An average person who is booked for jail has a relatively ***high risk*** of overdosing in the next year

Jail-booking rate = **2,000** per 100K

ED overdose rate = **100** per 100K

Programs / interventions implemented at the ED need to be **more efficient in targeting** those who are truly at risk of overdose

If done effectively can reach **60%** of at-risk individuals



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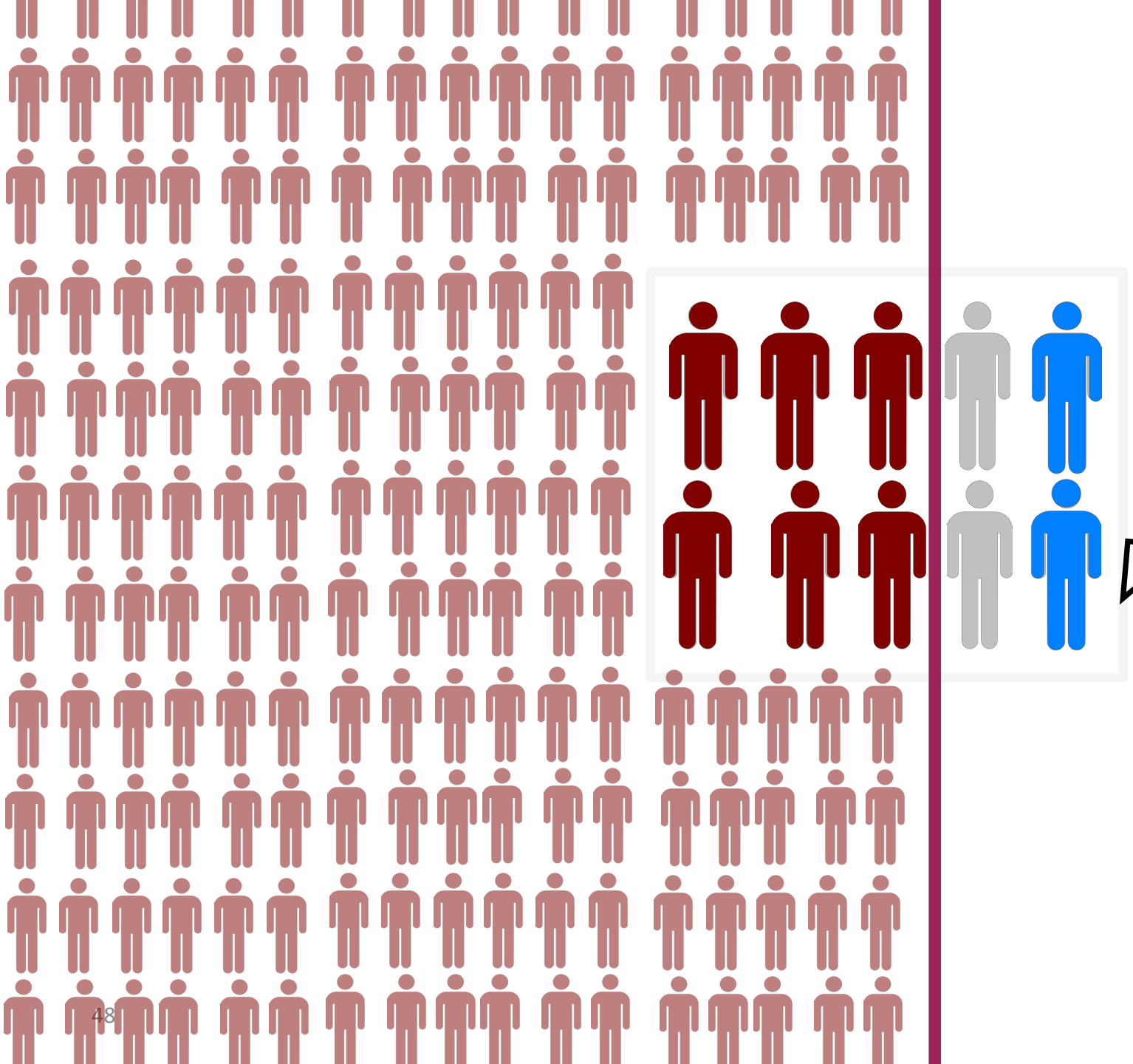
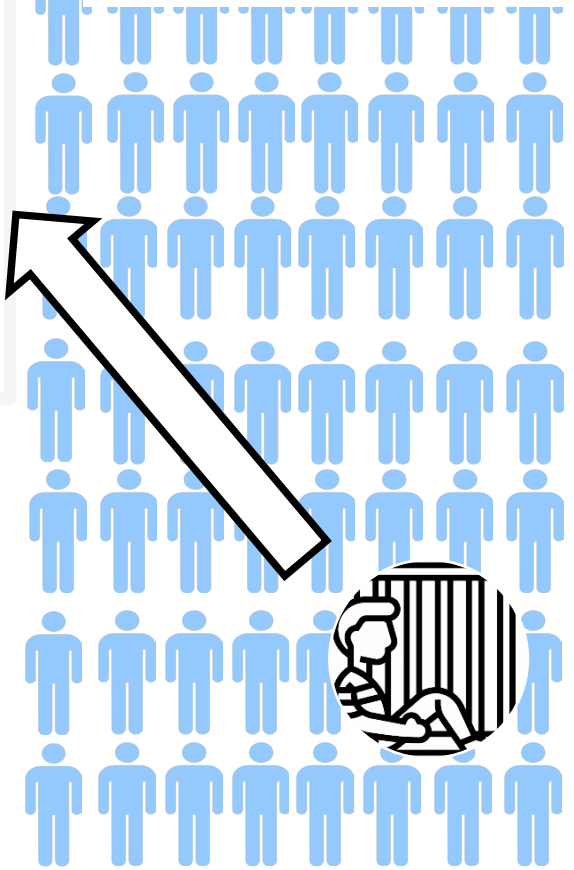


Easier to target at-risk individuals through **jails**

Reaching up **20%** of those who will overdose



Interpreting touchpoints data

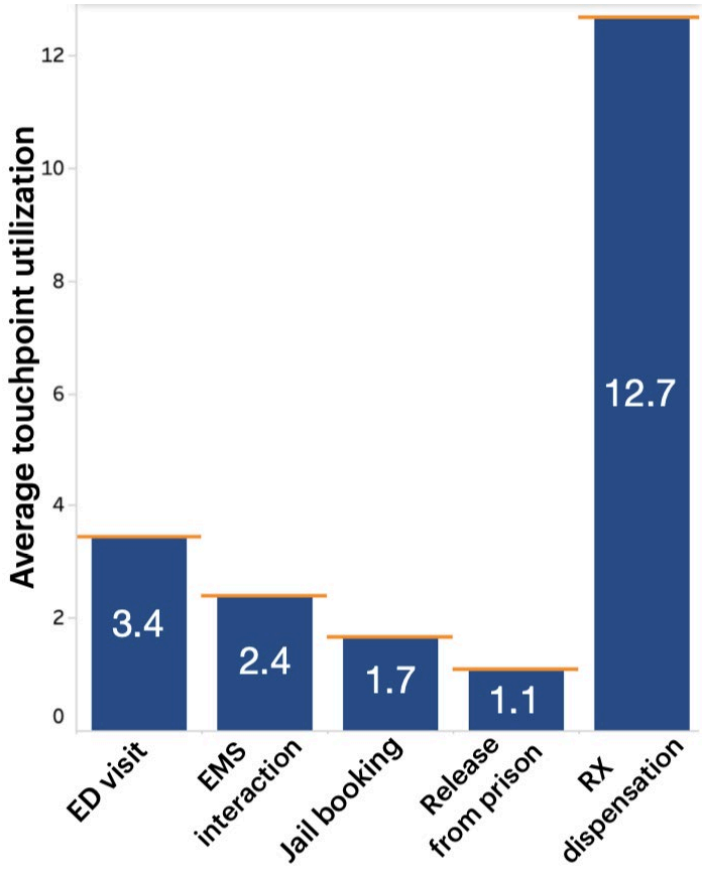
Touchpoint *recency* and *frequency*

Interpreting touchpoints data

Touchpoint *recency* and ***frequency***

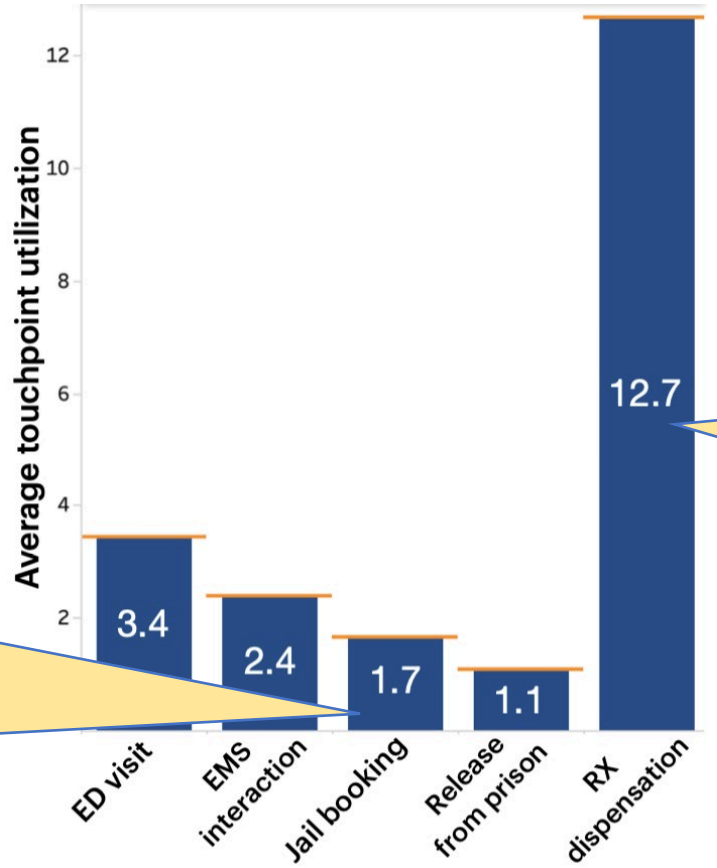
Interpreting touchpoints data

Touchpoint *recency* and ***frequency***



Interpreting touchpoints data

Touchpoint *recency* and ***frequency***



Interventions should be designed to make an **impact with fewer** interactions

More chances to connect with at-risk individuals before overdose

Interpreting touchpoints data

Touchpoint ***recency*** and *frequency*

Interpreting touchpoints data

Touchpoint ***recency*** and *frequency*

Interpreting touchpoints data

Touchpoint ***recency*** and *frequency*

Interpreting touchpoints data

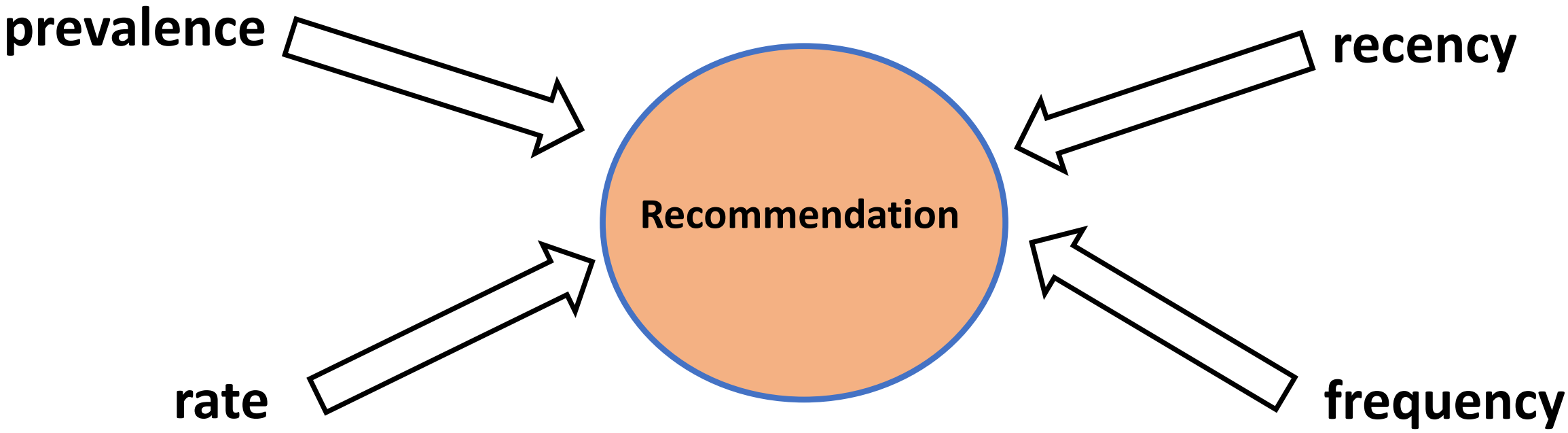
Touchpoint ***recency*** and *frequency*

Services could target **near term** (2 – 3 months)

Recommendations should focus on **longer-term** support (6 months – 1 year)

Touchpoints present a multi-dimensional decision scenario

Consider these 4 data features when making a recommendation



Prevalence: what percentage of at-risk individuals can we reach with touchpoint?

> ***Higher*** **prevalence** = ***more*** **individuals can be reached** with touchpoint

Rate: how efficient/selective do we need to be in order to reach people who are truly at-risk?

> ***Higher*** **rate** = ***easier*** **to target at-risk individuals** (e.g., *Jails*)
>
> *Lower* rate = need to think about ways to separate individuals who are at risk of overdosing from all other touchpoint users (e.g., all *ED visitors*)

Recency: What's the time window between the last touchpoint interaction and overdose?

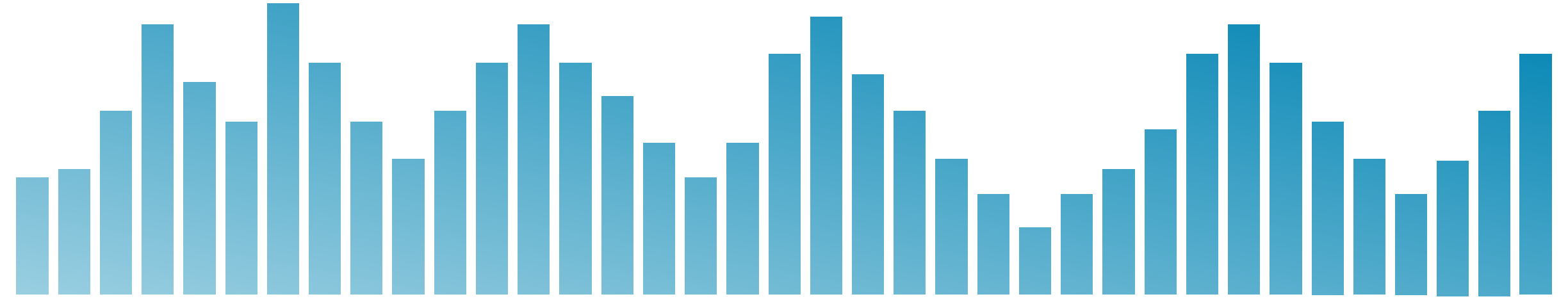
Longer period = need *longer-term* support strategies

Shorter window = opportunity for *rapid* intervention to avert overdose

Frequency: how often do individuals interact with a touchpoint?

Higher frequency = more opportunities to engage individuals

Lower frequency = interventions need to be designed to make an impact with fewer interactions



Fatal Overdose Review Team Research to Enhance Surveillance Systems

Data-Driven Decision Making

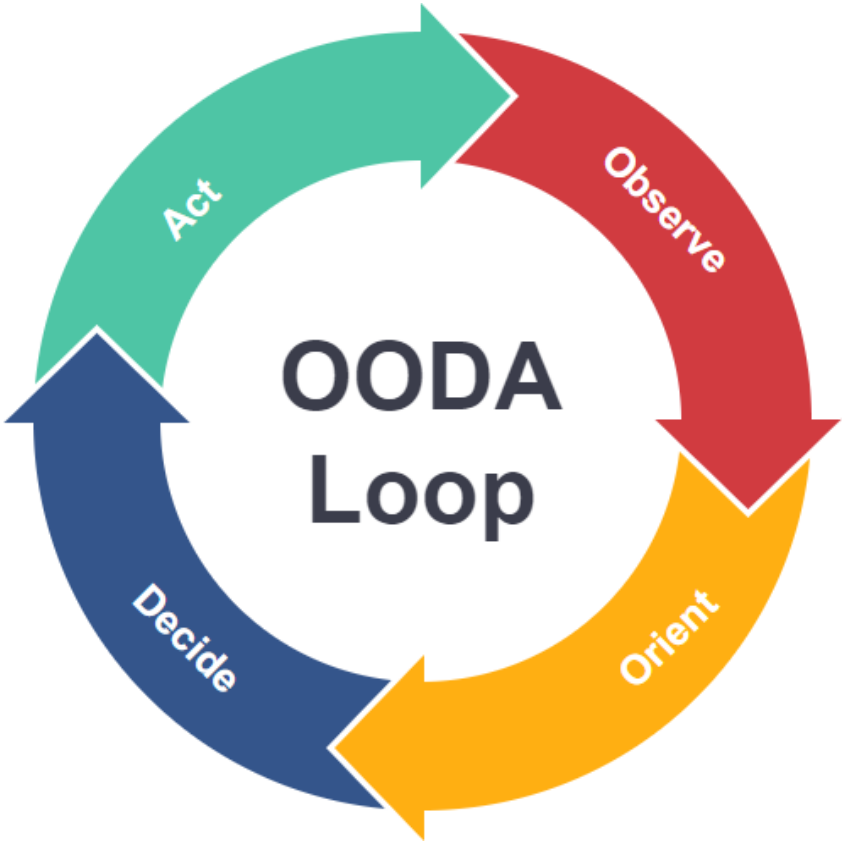
Welcome

- Recommendation Strategies
- What makes a good recommendation?
- Using the dashboard to make recommendations
- Other uses of the dashboard
- What to expect next

All Overdose Deaths are Preventable

Applying 3DM to OFR

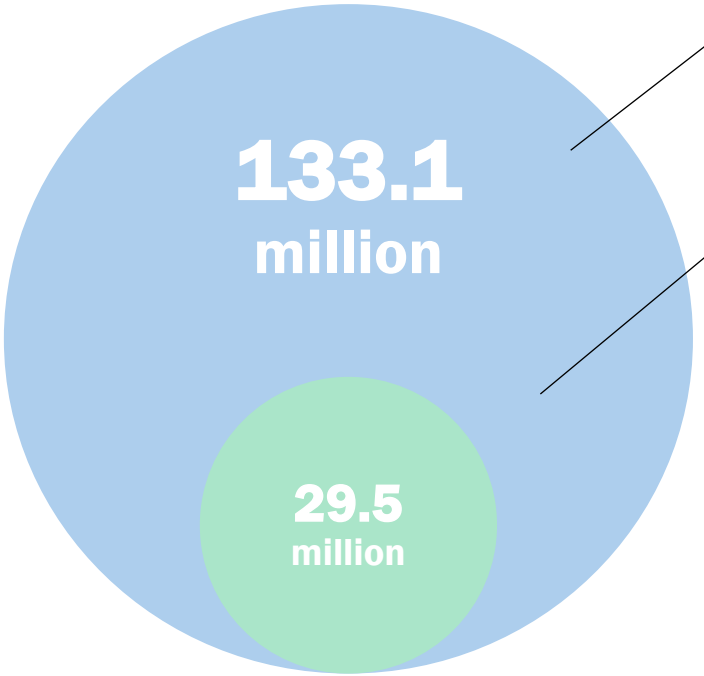
Leveraging *clinical science* to craft recommendations that maximize the impact of your resources



Source: https://www.cdc.gov/drugoverdose/pdf/phast-toolkit-508.pdf

Goal is to focus on increasing recommendations and community strategies that focus on preventing overdose deaths, not just addiction or substance use disorder

Alcohol use vs. Alcohol use disorder



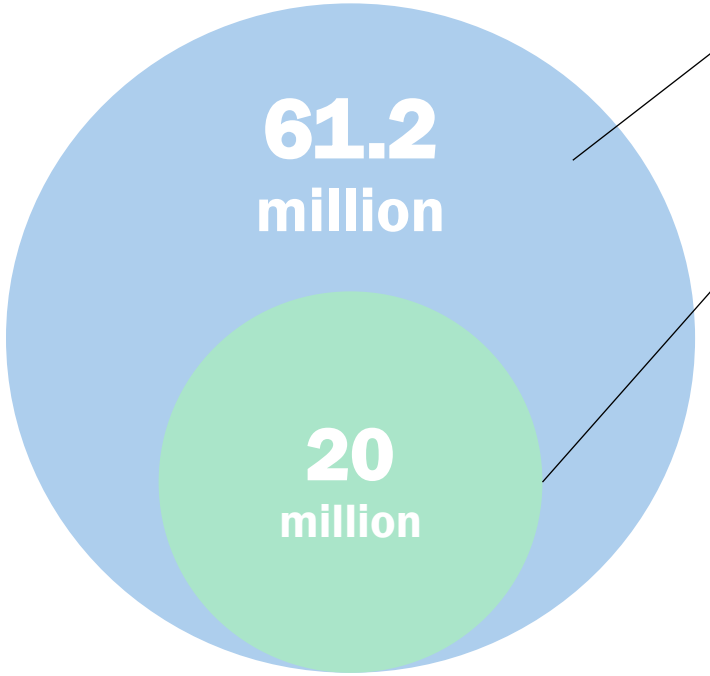
People who reported drinking alcohol in the past month in 2021

People who reported having an alcohol use disorder in the past year in 2021

Not everyone who drinks alcohol has a use disorder

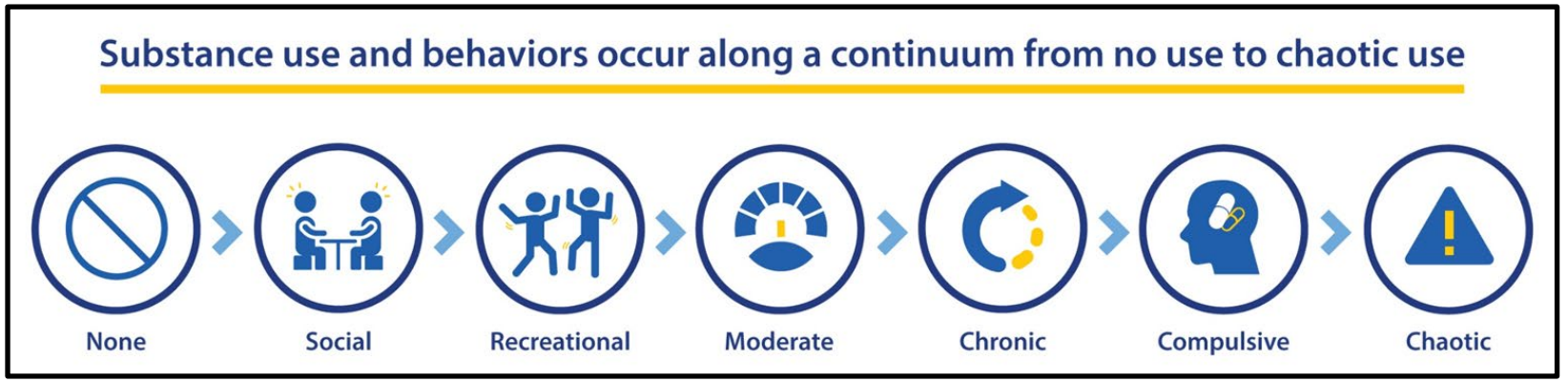
Reference: Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-reportt

Substance use vs. Substance use disorder



People who reported using illicit drugs in the past year in 2021

People who reported having a drug use disorder in the past year in 2021

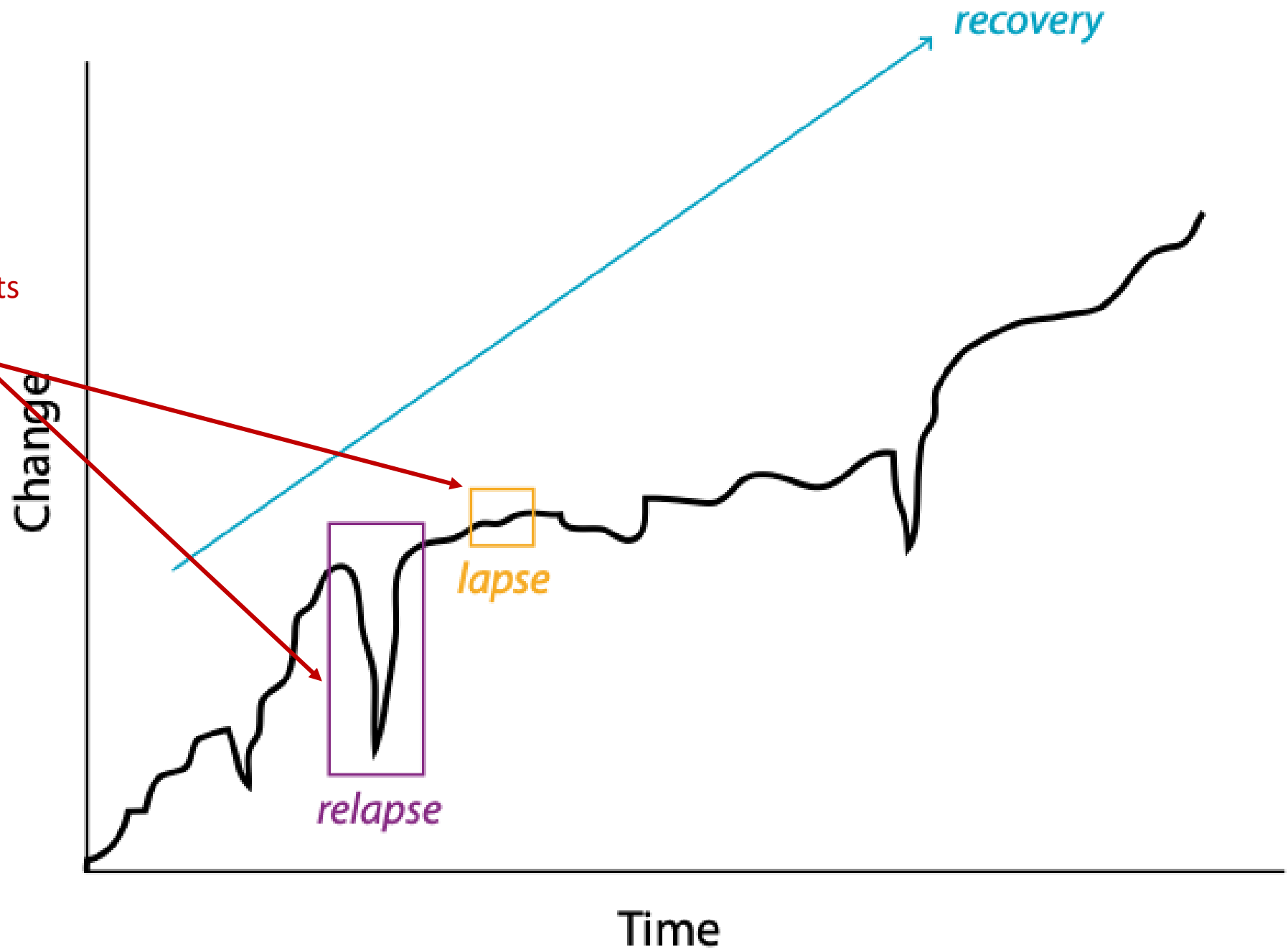


Reference: Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report; Bozarth, M. A. (1990). Drug addiction as a psychobiological process. In Warburton, D. M. (Ed.), Addiction controversies (pp. 112-134). London: Harwood Academic Publishers.

FORTRESS: focus on overdose death, NOT addiction (even though that's of course important!)

1. Addiction or use disorder is not a necessary criteria for overdose (i.e., not all overdoses are a result of addiction)
2. Treatment for substance use disorder is not a solution for preventing *all overdose deaths*

Many available behavioral treatments prevent relapse but do not provide adequate



Evidence-Based Practices for Overdose Prevention

- **Overdose Education and Naloxone Distribution**
  - Evidence-based curriculum
- **Medications for Opioid Use Disorder**
  - Methadone and Buprenorphine
- **Safer Opioid Prescribing**
- **Peer Recovery Support Services**

Medications for Opioid Use Disorder (MOUD

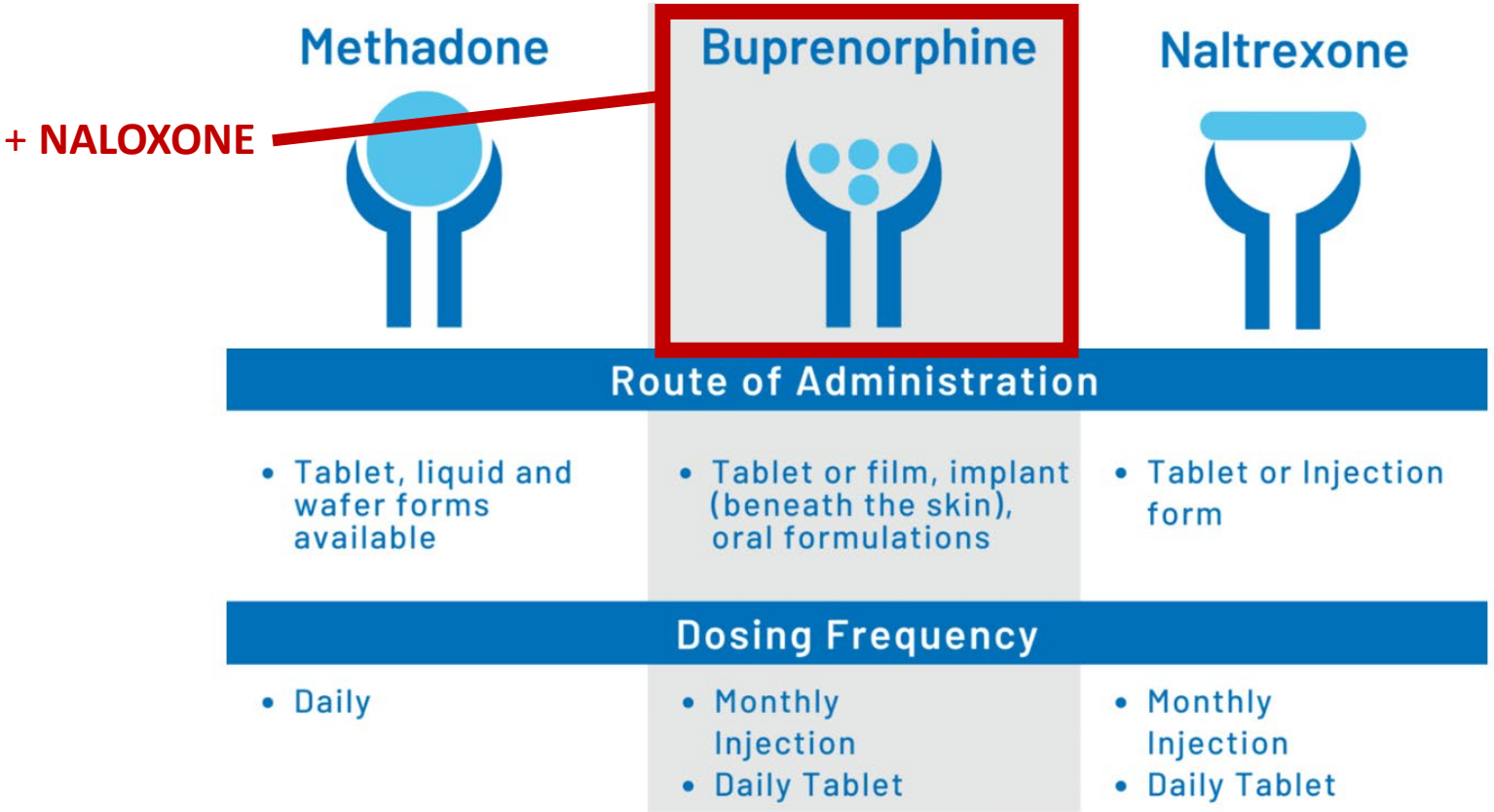
Methadone	Buprenorphine	Naltrexone
		
How it Works		
Full Agonist	**Partial Agonist**	**Antagonist**
• Activates opioid receptors in the body • Reduces opioid cravings and withdrawal symptoms	• Only allows for partial activation of the opioid receptor • Reduces opioid cravings and withdrawal symptoms	• Binds to the receptor blocking any opioid effect • May help reduce cravings

Medications for Opioid Use Disorder (MOUD

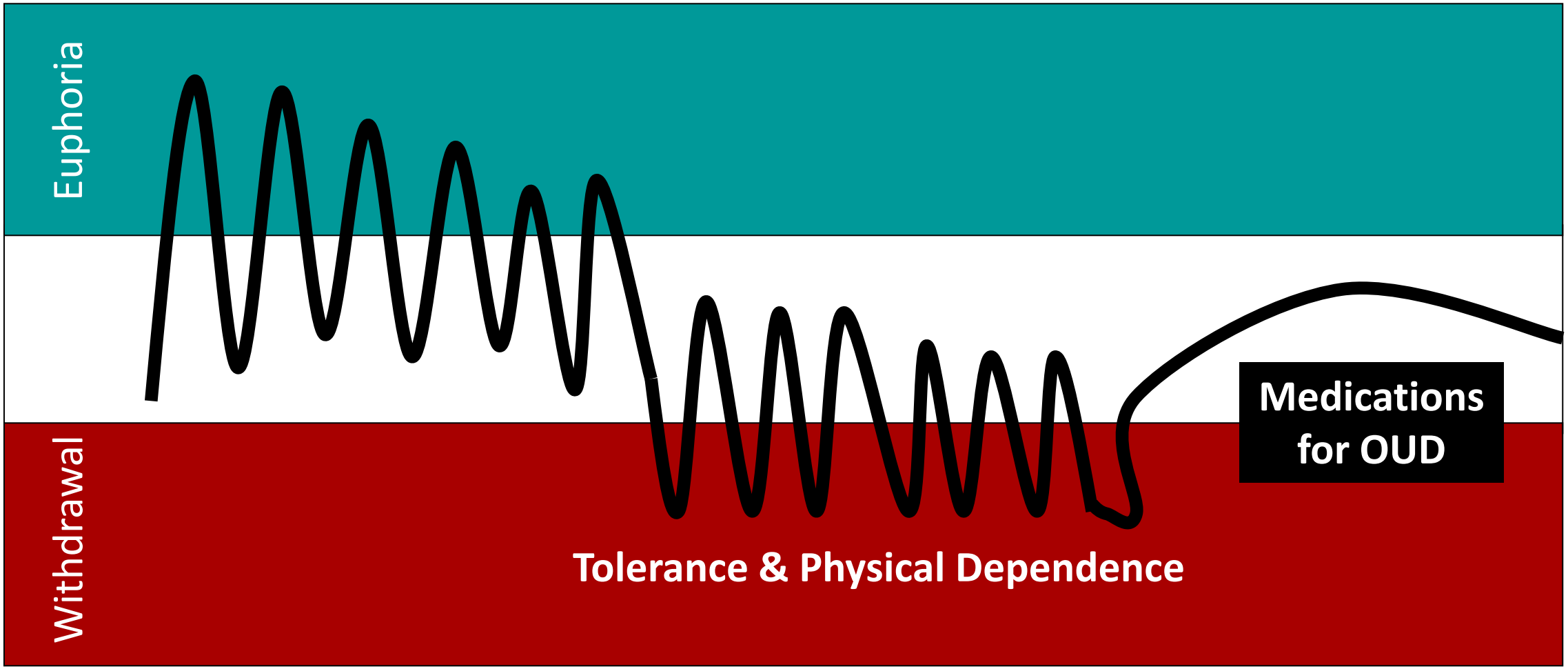
	Methadone	Buprenorphine	Naltrexone
			
Route of Administration			
	• Tablet, liquid and wafer forms available	• Tablet or film, implant (beneath the skin), oral formulations	• Tablet or Injection form
Dosing Frequency			
	• Daily	• Monthly Injection • Daily Tablet	• Monthly Injection • Daily Tablet

What about overdose risk?

Suboxone:
Buprenorphine + **NALOXONE**



Trajectory of Opioid Use to Disorder



Reference: Alford DP. http://www.bumc.bu.edu/care/

Low-threshold or medications-first approach

An approach to offering buprenorphine that focuses on rapid treatment initiation, patient autonomy, flexible care plans, harm reduction, nontraditional care settings, and reduced barriers.

Traditional	Low-Threshold
☐ Multiple office visits	☐ Same day prescription
☐ Office-based induction	☐ Home induction
☐ Programmatic rules prioritized	☐ Patient goals prioritized
☐ Abstinence is primary goal	☐ Reduction in opioid use in primary goal
☐ Buprenorphine is discontinued for co-use	☐ No treatment cessation for co-use
☐ Intensive counseling required	☐ Intensive counseling recommended
☐ Referral to buprenorphine provider	☐ Buprenorphine provider on site

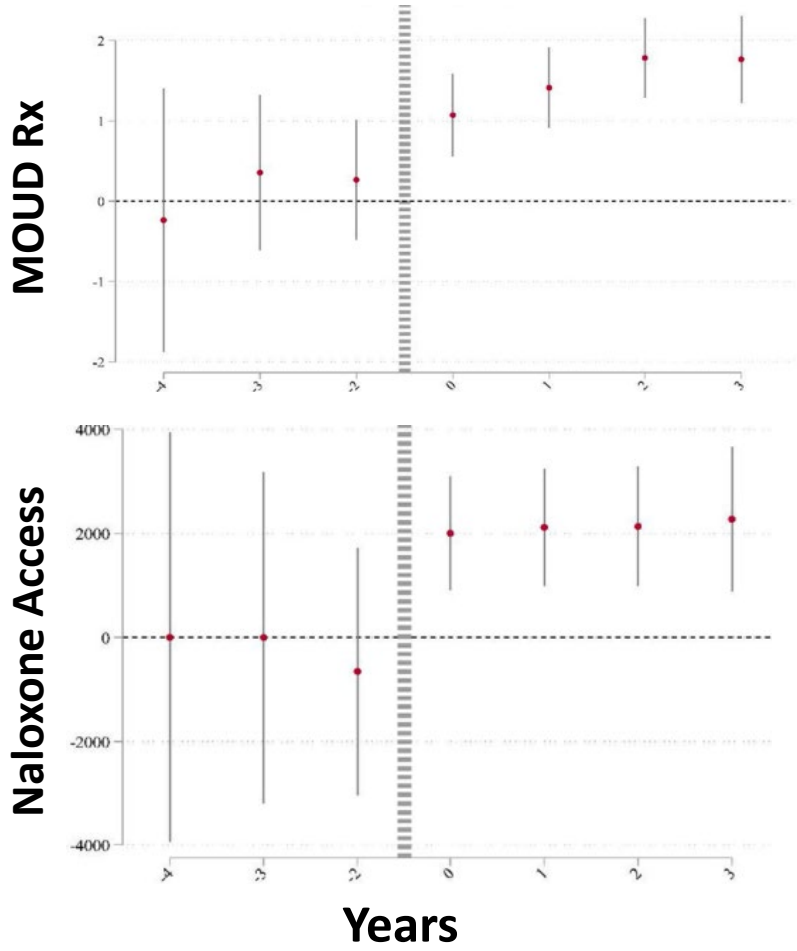
Reference: Jakubowski A, Fox A. Defining Low-threshold Buprenorphine Treatment. J Addict Med. 2020;14(2):95-98. doi:10.1097/ADM.0000000000000555

Prevention in the ED

Embed recovery coaches in the ED

- Link people to MOUD treatment
- Provide naloxone & harm reduction education
- Investigate barriers to accessing treatment

Passive Naloxone Distribution in the ED



Source: Watson et al., 2021

Prevention through EMS

Naloxone Leave-behind program

- Distribute naloxone to overdose survivors/friends and families

Upwards of 35% of people refuse Ambulance Transport following an OD

Prehospital Bupe Induction

- 6-fold increase in MOUD treatment after 30 days
- No adverse effects observed
- Buprenorphine after naloxone "blocks" other opioid agonists

Source: Herring et al., 2019

OVERDOSE PREVENTION HELPLINE

1-800-972-0590

WHAT IT IS

- A helpline to call while using substances so you never have to use alone. The operator will only ask your location.
- Medical services are only called if you become unresponsive.
- You will share what substance you are using to determine call length.
- When the call ends, you can go about your day!

WHO IT IS

- Staffed by Harm Reduction workers and people with lived experience.
- Created by someone with lived experience with overdose.
- The goal of the helpline is to prevent overdoses. Substance use treatment will **never** be pushed.

TIPS FOR CALLING

- Have your substance and supplies ready to go before calling. The call length begins when the substance is first used. Being ready to go makes the call as brief as possible.
- Put away other substances or safe use supplies. If EMS is called, it is good to have all drug-related personal items out of sight.

GOOD TO KNOW

- You can refuse transport to the hospital after overdosing if you are conscious.
- MOPH operators are not mandated reporters.
- Location data is never stored.
- Conversation is not required - only confirmation that you are still alert and aware.

Prevention at Jail and Prison

Naloxone vending machines

- Passive naloxone dispensation

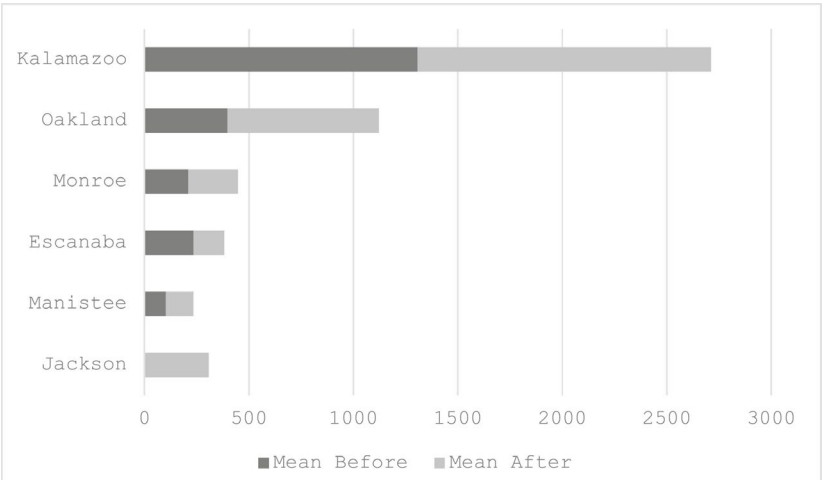
MOUD Continuation

- Twice as likely to engage in MOUD treatment within 30 days of release

MOUD induction

- 5-fold increase in MOUD engagement within 30 days of release

Number of Naloxone boxes pre/post vending machine



Source: Krawczyk et al., 2024

Prevention at the Pharmacy

Academic detailing

- Educational outreach by trained professionals to pharmacists & prescribers
- Tailored training & technical assistance

Pharmacy-based Naloxone Distribution

What makes an impactful recommendation?

EVIDENCE BASED.

ACTIONABLE.

ASSIGNED.

TIME-BOUND.

DATA-INFORMED.

Example of Impactful Recommendations

Install a naloxone vending machine at Clark County Jail

Establish a buprenorphine induction program through the Scott County EMS

Embed peer recovery coaches at the Martinsville IU Health Emergency Department

What types of recommendations do Indiana OFRTs make?

Recommendation coding

- 2022 recommendations submitted to IDOH across all OFRTs

Contents lists available at ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

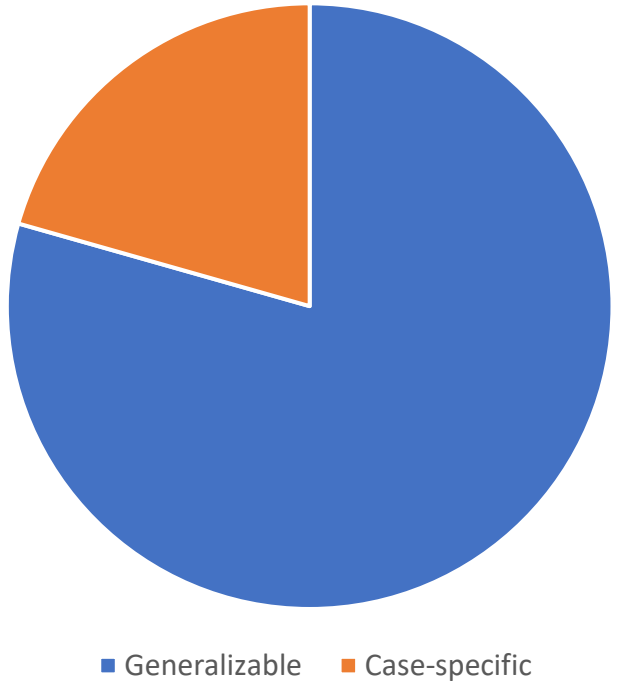
Descriptive analysis of recommendations made by county-level overdose fatality review teams in indiana to combat the opioid epidemic

Allyson L. Dir [a,b,*], Logan Gillenwater [b,c], Melvin Wao [b,c], Jamie Smith [d], Caitlyn Short [d], Katherine Schwartz [b,c], Khairi Reda [e], Matthew C. Aalsma [b,c], Bradley Ray [f]

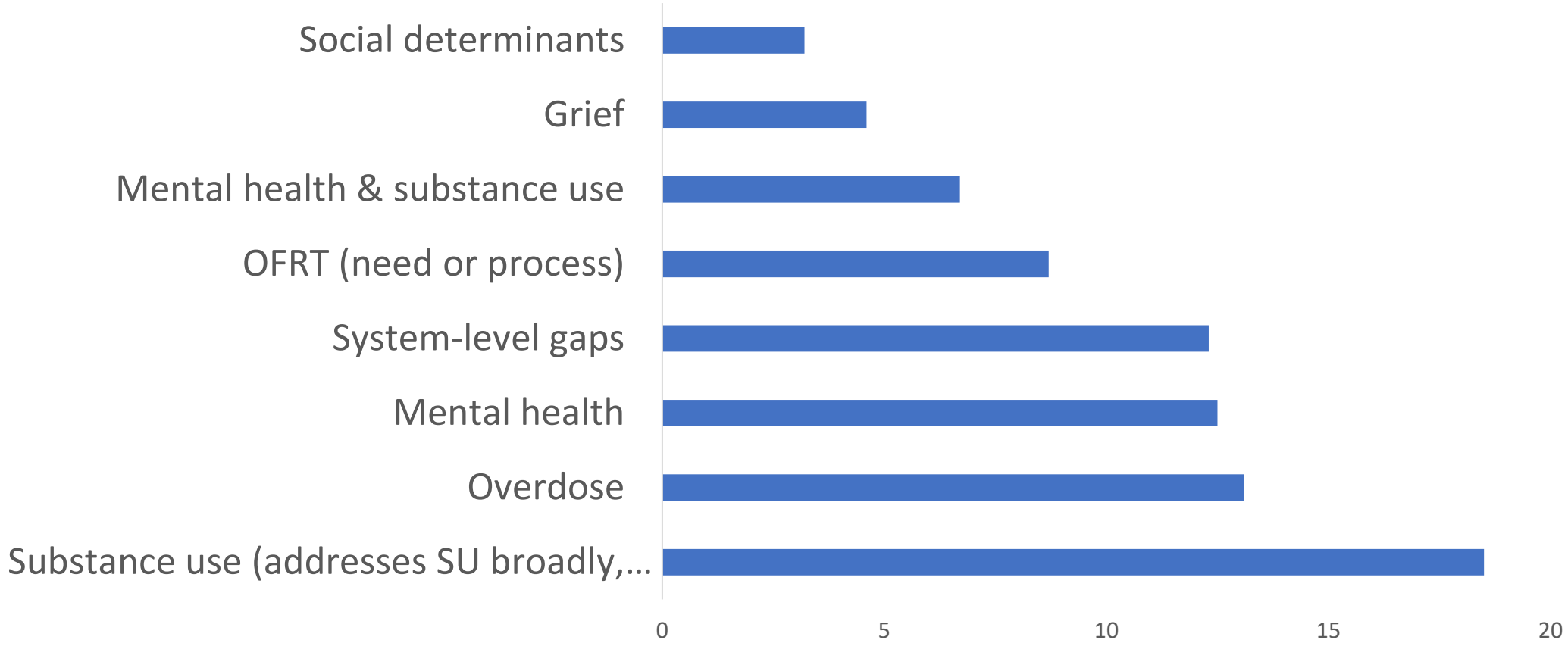
[a] Department of Psychiatry, Indiana Univeristy School of Medicine, Indianapolis, IN, USA
[b] Adolescent Behavioral Health Research Program, Indiana University School of Medicine, Indianapolis, IN, USA
[c] Department of Pediatrics, Indiana University School of Medicine, Indianapolis, IN, USA
[d] Indiana Department of Health, Indianapolis, IN, USA
[e] Luddy School of Informatics, Computing, and Engineering, Indiana University Purdue University – Indianapolis, Indianapolis, IN, USA
[f] RTI International, Research Triangle Park, NC, USA

Recommendation coding

1,413 recommendations made by OFRTs in 2022 based on 291 fatal overdose cases



Recommendation topics



Recommended Actions

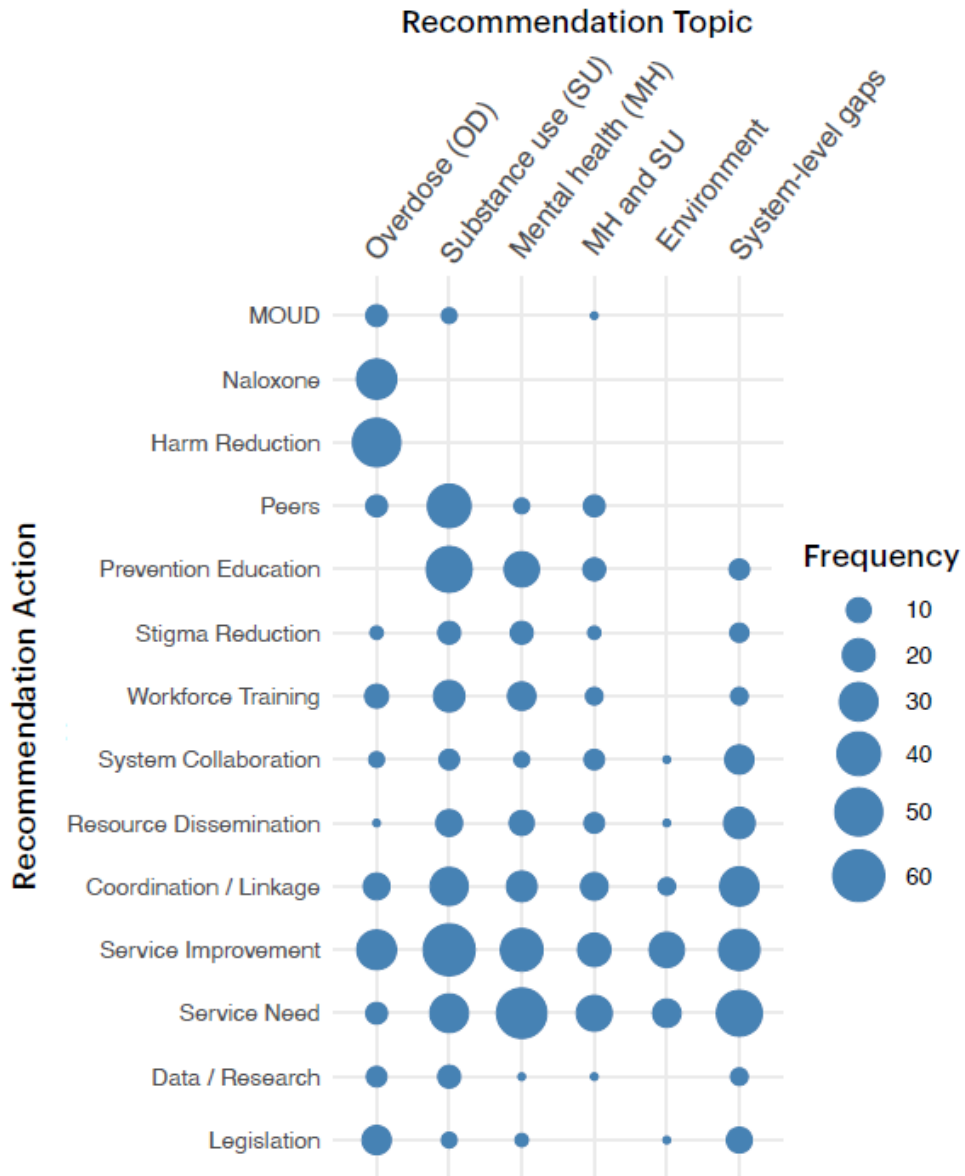
Service Improvement Improving quality or processes of existing services (e.g., improving SU screening) or agencies.	210 (14.9)
Service Need Non-existing service/program or workforce need.	177 (12.5)
OFRT Addresses OFRT need.	123 (8.7)
Care coordination/Linkage Services/procedures entailing service referral/linkage and care coordination (follow-up, retention)	106 (7.5)
Prevention education. SU or MH prevention or harm reduction – NOT overdose specific	83 (5.9)
Grief support Providing grief and bereavement support to loved ones of overdose victims.	65 (4.6)
Peer support services Services specific to peer specialists (e.g., peer recovery coach).	57 (4.0)
Harm reduction Harm reduction (non-naloxone) strategies/ education specific to overdose prevention	51 (3.6)

Recommended Actions

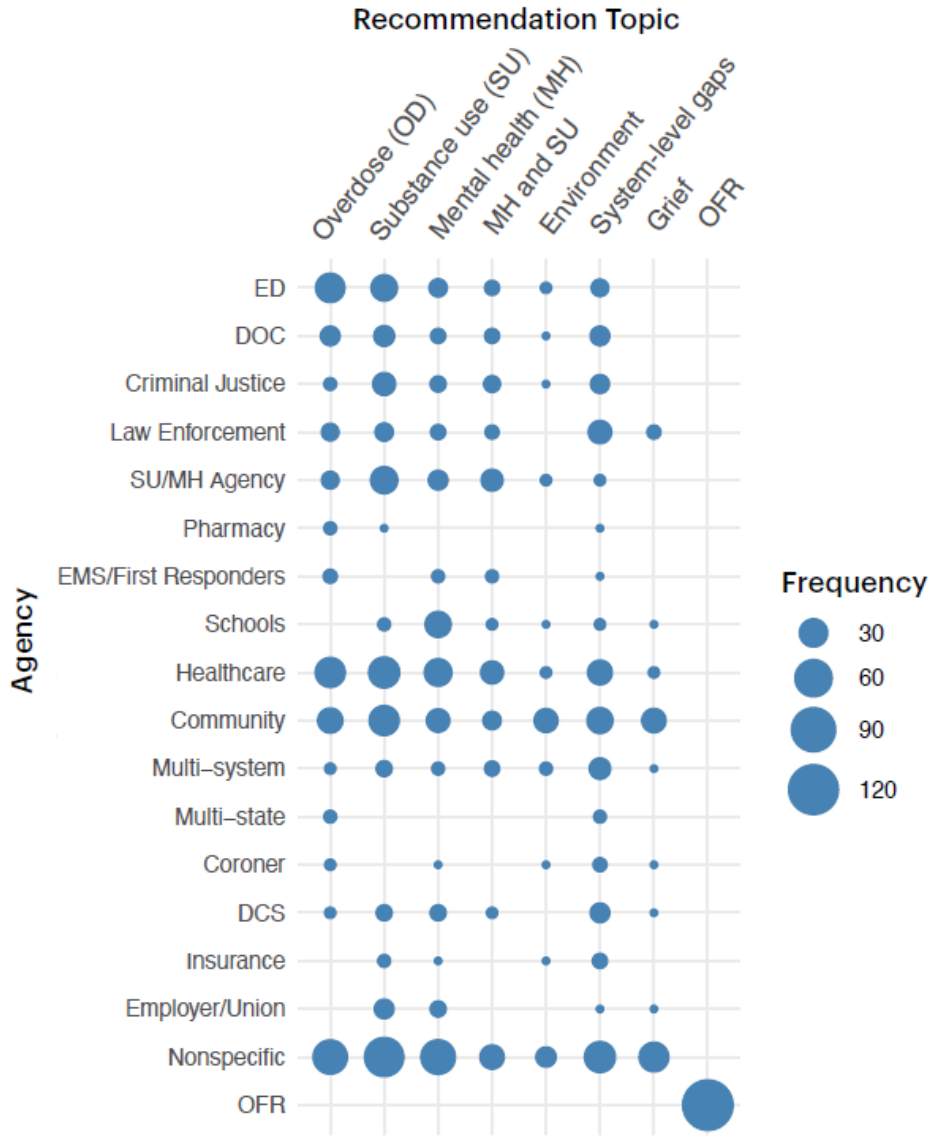
Workforce training Education for healthcare field in practices and policies relevant to mental health and addiction.	49 (3.5)
Resource dissemination Distribution of information or promotion of available community resources and services.	49 (3.5)
System Collaboration Communication and collaboration across systems/agencies (e.g., information sharing).	34 (2.4)
Naloxone access / distribution	33 (2.3)
Legislation Addresses need for or changes to state or local legislation or policy-level changes.	32 (2.3)
Stigma reduction	25 (1.8)
Data / Research Field need for research or better data collection system-wide (e.g., tracking overdose deaths).	12 (1.4)
MOUD (medications for opioid use disorder) Specific to MOUD services, policies, and procedures.	11 (0.8)

Agencies Targeted

Agency	N (%)
Nonspecific	273 (14.6)
Healthcare system	142 (7.6)
Community agencies	116 (6.2)
OFRT	109 (5.8)
Emergency department	82 (4.4)
Substance use / mental health agency	65 (3.5)
Law Enforcement	49 (2.6)
Department of Corrections (DOC) (jail, prison)	45 (2.4)
Criminal justice system (probation, court)	44 (2.3)
Multi-system / Multi-state	36 (1.9)
Schools	32 (1.7)
Child welfare system	28 (1.5)
Employer/Union	19 (1.0)
Emergency medical / first responders	11 (0.6)
Insurance	10 (0.5)
Coroner	9 (0.5)
Pharmacy	5 (0.3)


Recommendation Topic
Overdose (OD)
Substance use (SU)
Mental health (MH)
MH and SU
Environment
System-level gaps
Recommendation Action
MOUD
Naloxone
Harm Reduction
Peers
Prevention Education
Stigma Reduction
Workforce Training
System Collaboration
Resource Dissemination
Coordination / Linkage
Service Improvement
Service Need
Data / Research
Legislation
Frequency
10
20
30
40
50
60

Recommendation topic x agency



Recommendation Specifics

- Substance use (19%)
  - Service improvements: improving screening & assessment for SUD (primary care, ED)
  - Service needs: peer specialist services (ED, jails)
  - Prevention education: school-based education

County differences: rurality

- Overdose-related recommendations: 12.9% of urban recs > 8.1% of mixed > 6.3% of rural recs
- Social determinants: 8.5% of rural recs vs. 3% of urban & rural recs
- Rural counties focused on service needs vs. urban/mixed county focus on service improvements
- Urban counties focus on workforce training vs. rural counties focus on stigma reduction

Deep Dive: Strategies for Successful Implementation along Touchpoints

The Issue

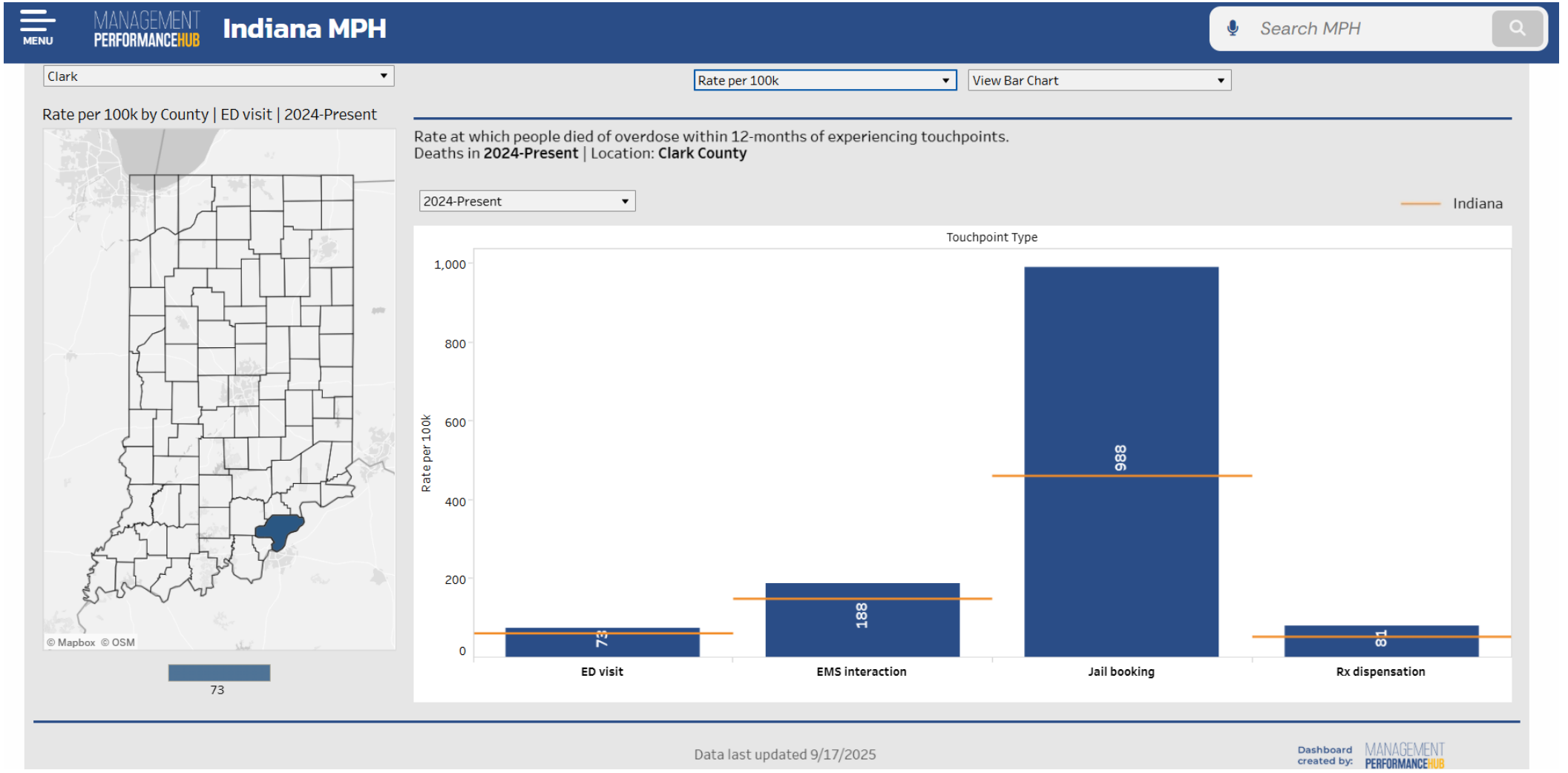
- Traditionally, the prevalence of OUD and risk of fatal overdose is significantly higher in persons who are incarcerated than the general population

- Risk of fatal overdose persists after release, with estimates as high of **47% of fatal overdoses** including persons who were formerly incarcerated

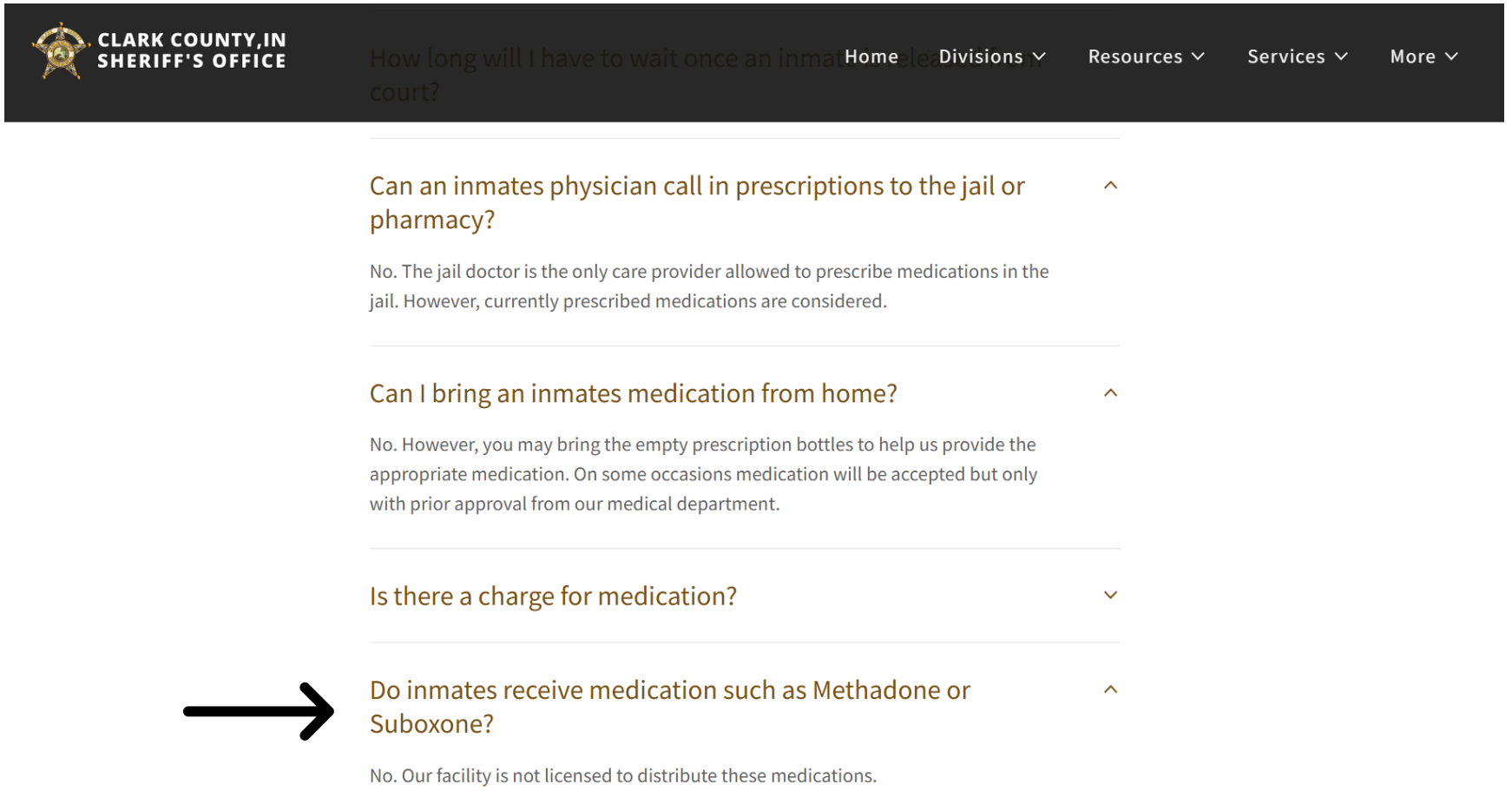
- Jail is a frequent touchpoint discussed in OFR meetings and has population level data displayed on the dashboard.

Sources
Dowell D, Brown S, Gyawali S, et al. (2024). Treatment for opioid use disorder: population estimates — United States, 2022. MMWR Morb Mortal Wkly Rep 2024; 73:567-74.
Friedmann, PD., Wilson, D., Stopka, TJ, et al. (2025). Medications for Opioid Use Disorder in County Jails—Outcomes after Release. New England Journal of Medicine, 393(10), 994-1003.
Maruschak LM, Minton TD, Zeng Z. (2023). Opioid use disorder screening and treatment in local jails, 2019. Washington, DC: Department of Justice. https://bjs.ojp.gov/document/oudstlj19.pdf.
Saloner B, Chang H-Y, Krawczyk N, et al. (2020). Predictive modeling of opioid overdose using linked statewide medical and criminal justice data. JAMA Psychiatry, 77:1155-62.

Example in Clark County-Jail Booking Rate



Is MOUD Available?



Sources

Clark County Sherrif's Office. (n.d.). FAQS. https://clarkcosheriff.com/faq-2.

Example Evidenced Based Solution: Continue MOUD Prescriptions In Jails

- MOUD in correctional settings improves outcomes during and after incarceration reduces risks of:
  - Fatal overdose
  - Nonfatal overdose
  - Death from any cause
  - Reincarceration

Sources
Saloner B, Chang H-Y, Krawczyk N, et al. (2020). Predictive modeling of opioid overdose using linked statewide medical and criminal justice data. JAMA Psychiatry, 77:1155-62.
Friedmann PD, Wilson D, Stopka TJ, Bernson D, Pivovarova E, Ferguson W, Hoskinson RA Jr, Rottapel RE, Bovell-Ammon B, Gaba A, Morgan JR, Senst T, Hayes E, Evans EA; MassJCOIN Research Hub. Medications for Opioid Use Disorder in County Jails - Outcomes after Release. N Engl J Med. 2025 Sep 11;393(10):994-1003. doi: 10.1056/NEJMsa2415987. PMID: 40929634.

How to Enact Change

- FORTRESS is public-facing, so you can show decisionmakers the dashboard to highlight the problem
- DOJ guidance (2022): People with OUD are protected under the Americans with Disabilities Act
- Denial of MOUD access may constitute discrimination
- Legal requirement to ensure treatment continuity and equal access to healthcare in jail settings

Sources
U.S. Department of Justice. (2022). Justice Department Issues Guidance on Protections for People with Opioid Use Disorder under the Americans with Disabilities Act.
Treating opioid addiction in jails improves treatment engagement, reduces overdose deaths and reincarceration
https://www.justice.gov/archives/opa/pr/justice-department-issues-guidance-protections-people-opioid-use-disorder-under-americans.

Legal Support of MOUD in Jails

- There have been several successful lawsuits against local, state, and federal jails and prisons who have denied persons access to MOUD (e.g., Pesce v. Coppinger, Smith v. Aroostook Cty)

- Result
  - MOUD legally recognized as a necessary treatment for OUD
  - Access to MOUD has expanded on local, state, and national levels

Sources
Legal Action Center. (2025). Cases Involving Discrimination Based on Treatment with Medication for Opioid Use Disorder (MOUD). https://www.lac.org/assets/files/Cases-involving-denial-of-access-to-MOUD.pdf.

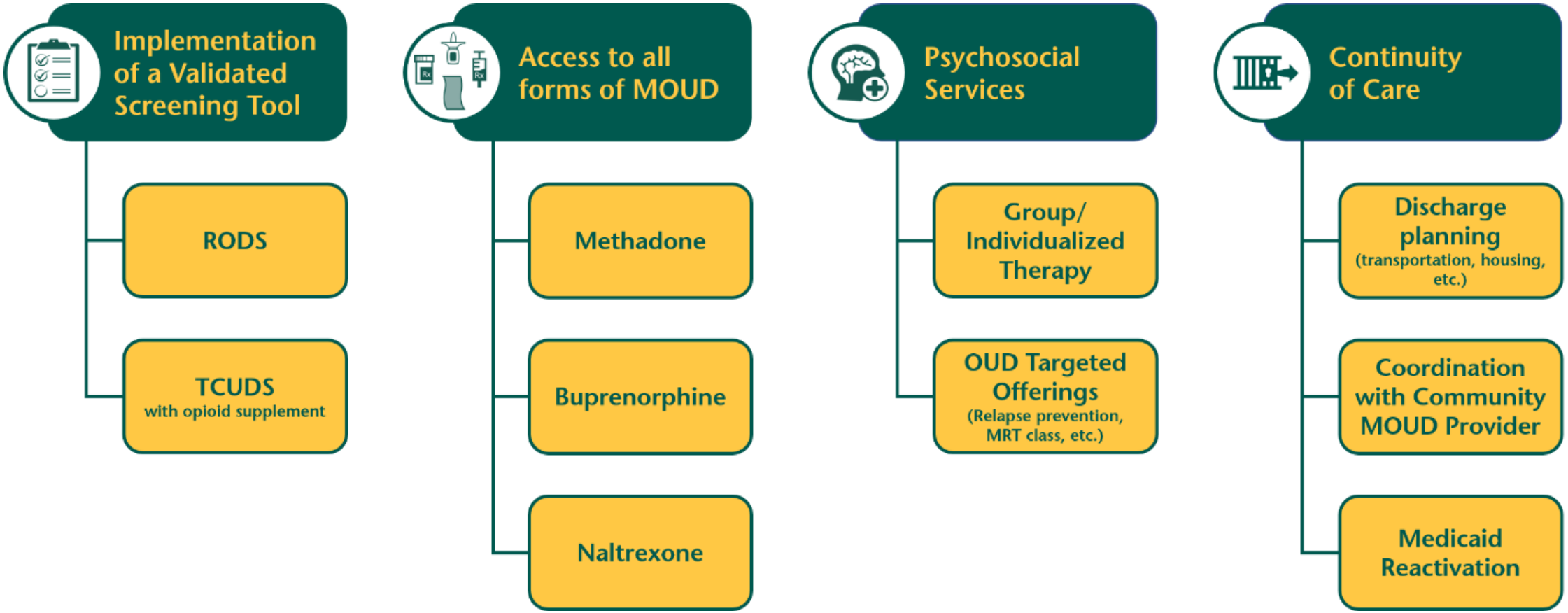
MOUD in Jail Model

- Developed by the Center for Behavioral Health and Justice

- Uses multiple evidence-based practices to ensure persons in jails/prisons are provided with appropriate OUD treatment, included but not limited to, MOUD

Sources
Wayne State University. (n.d.). MOUD in Jail Fidelity Assessment.

MOUD in Jail Model



Sources
Wayne State University. (n.d.). MOUD in Jail Fidelity Assessment.

MOUD in Jail Model

MOUD Implementation Tracker for All OTE Sites

County Name	Validated Screen	Methadone: Cont.	Methadone: New	Bupreno-orphine: Cont.	Bupreno-orphine: New	Naltrexone: Cont.	Naltrexone: New	BH Services Available	BH Services for OUD	Re-Entry Plan	MOUD Appt. Scheduled	Medicaid Reactivation	Naloxone Distribution
Jackson	✓	✓		✓		✓		✓			✓	✓	✓
Kent	✓	✓		✓				✓	✓	✓	✓	✓	✓
Muskegon	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓
Monroe	✓	✓		✓		✓	✓	✓	✓	✓	✓	✓	✓
Washtenaw	✓	✓		✓		✓	✓	✓					
Wayne	✓					✓	✓	✓	✓	✓	✓	✓	✓

	Jackson			Kent		Muskegon		Monroe		
% People Screened	67% (8/8/19-9/8/19)	11%* (11/3/19-12/30/19)	28%** (1/14/20-3/13/20)	13% (10/1/19-10/3/19)	15% (3/1/20-3/31/20)	91% (8/6/19-9/5/19)	20%*** (11/1/19-1/23/20)	28% (8/1/19-9/1/19)	33%**** (1/23/20-3/11/20)	36%***** (3/12/20-4/23/20)
Number of People Screened	n=375 (8/8/19-9/8/19)	n=106* (11/3/19-12/30/19)	n=274** (1/14/20-3/13/20)	n=210 (10/1/19-10/3/19)	n=149 (3/1/20-3/31/20)	n=624 (8/6/19-9/5/19)	n=327*** (11/1/19-1/23/20)	n=111 (8/1/19-9/1/19)	n=215**** (1/23/20-3/11/20)	n=45***** (3/12/20-4/23/20)
% Usable Screens	65% (8/8/19-9/8/19)	9%* (11/3/19-12/30/19)	28%** (1/14/20-3/13/20)	13% (10/1/19-10/3/19)	15% (3/1/20-3/31/20)	90% (8/6/19-9/5/19)	20%*** (11/1/19-1/23/20)	28% (8/1/19-9/1/19)	33%**** (1/23/20-3/11/20)	36%***** (3/12/20-4/23/20)
Number of Usable Screens	n=360 (8/8/19-9/8/19)	n=92* (11/3/19-12/30/19)	n=268** (1/14/20-3/13/20)	n=210 (10/1/19-10/3/19)	n=149 (3/1/20-3/31/20)	n=617 (8/6/19-9/5/19)	n=326*** (11/1/19-1/23/20)	n=111 (8/1/19-9/1/19)	n=215**** (1/23/20-3/11/20)	n=45***** (3/12/20-4/23/20)

Sources

Wayne State University. (n.d.). MOUD in Jail Fidelity Assessment.

MOUD in Jail Model

MOUD Implementation Tracker for All OTE Sites

Validated Screen	Using Validated Screening Tool at Booking
% People Screened	% of Persons Booked with Usable or Refused Screening
% Usable Screens	% of Persons Booked with Usable Screening
Methadone: Cont.	Methadone - Continuation
Methadone: New	Methadone - New Inductions
Buprenorphine: Cont.	Buprenorphine - Continuation
Buprenorphine: New	Buprenorphine - New Inductions
Naltrexone: Cont.	Naltrexone - Continuations
Naltrexone: New	Naltrexone - New Inductions
BH Services Available	BH Services Provided to MOUD Patients
BH Services for OUD	BH Services Targeted Towards OUD
Re-Entry Plan	Detailed Re-Entry Plan for MOUD Patients
MOUD Appt. Scheduled	Appt. Made with MOUD Prescriber in Community Pre-Release
Medicaid Reactivation	Medicaid Reactivation Pre-Release
Naloxone Distribution	Naloxone Kits at Release

*MH Clinician quit her position during this time period and did not submit all RODS to the CBHJ (it is unknown how many RODS are missing from this batch); Other RODS batches may overlap with this time period also, which could alter results

**Other RODS batches likely overlap with this time period; Thus, results will likely change.

***Other RODS batches may overlap with this time period, which could alter results

****Other batches of RODS may slightly overlap with this time period, which could slightly alter results

*****Batch of RODS recieved after this batch has 3 unique screens with a date administered that falls within this batch's time period (included these cases in analysis). However, that batch has not yet been fully cleaned and verified so it is possible that results may slightly change

Sources

Wayne State University. (n.d.). MOUD in Jail Fidelity Assessment.

Meeting People Where They Are

- Strategies for successful implementation:
  - Implement naloxone distribution and training
  - Expand access to MOUD (methadone, buprenorphine, naltrexone)
  - Develop diversion & deflection programs
  - Partner with community-based initiatives like SHIELD
  - Integrate services at critical touchpoints (jails, reentry, community)

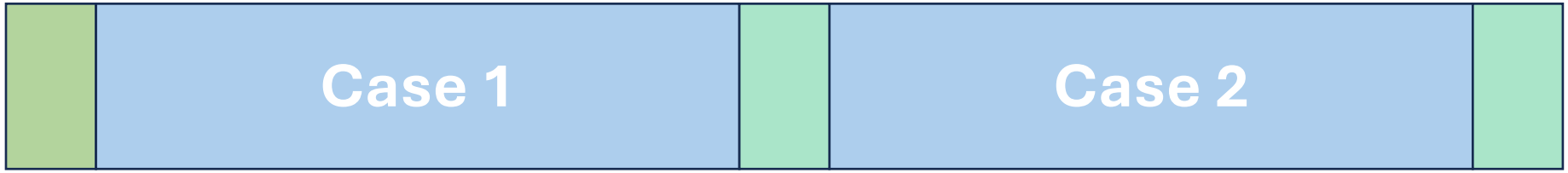
How will you plan to use the dashboard?

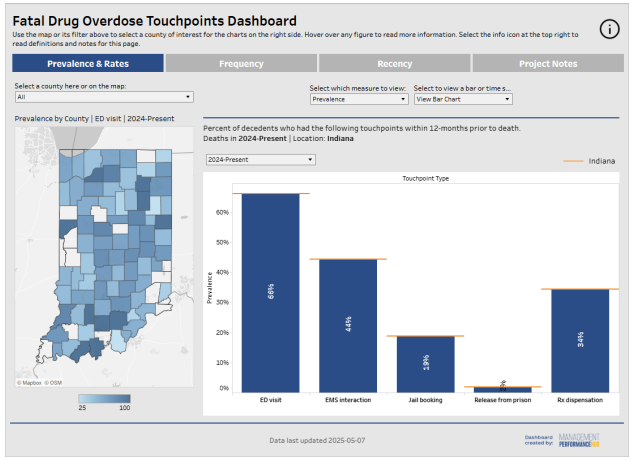
Option 1: Pull up the dashboard during case review as a data source reflecting trends in the county

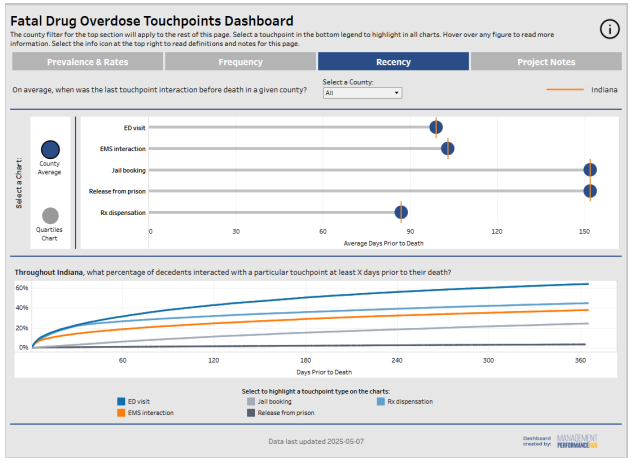
Introduction

Recommendations

Recommendations





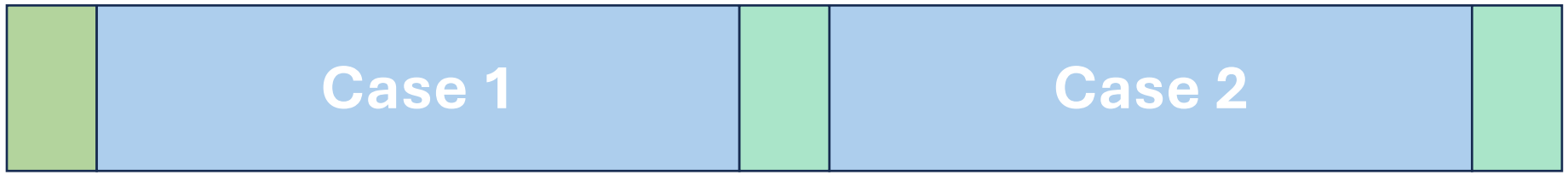


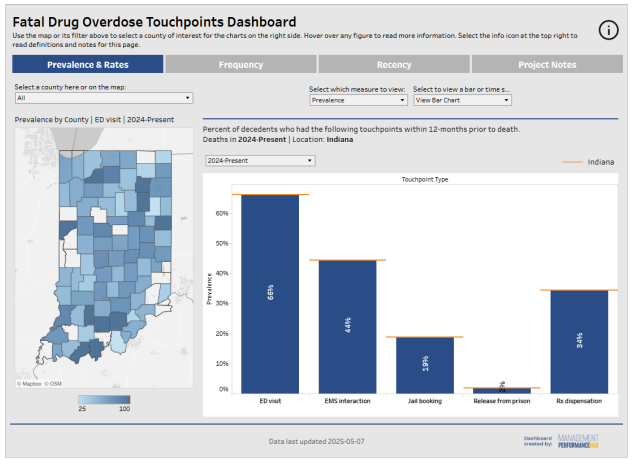
Option 2: Pull up dashboard during the recommendation-making process

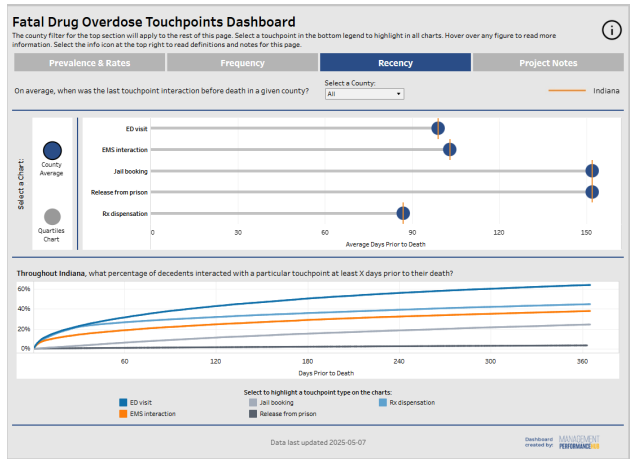
Introduction

Recommendations

Recommendations







Activity: Case discussion and recommendation making with dashboard data

Consider the following case:

Jane Doe, a 32-year-old female from Marion County, with a history of opioid use disorder, died of an accidental overdose involving fentanyl in a motel room (12/2024).

She had multiple **ED visits** due to face laceration (2012), skull fracture (2015), *non-fatal overdose (2022), and pain (2022, 2023)*

Had an active hydrocodone **prescription** (last filled 35 days before death).

Booked in jail in 2021 for theft (released on probation) and DUI (2023, served 6-months in prison)

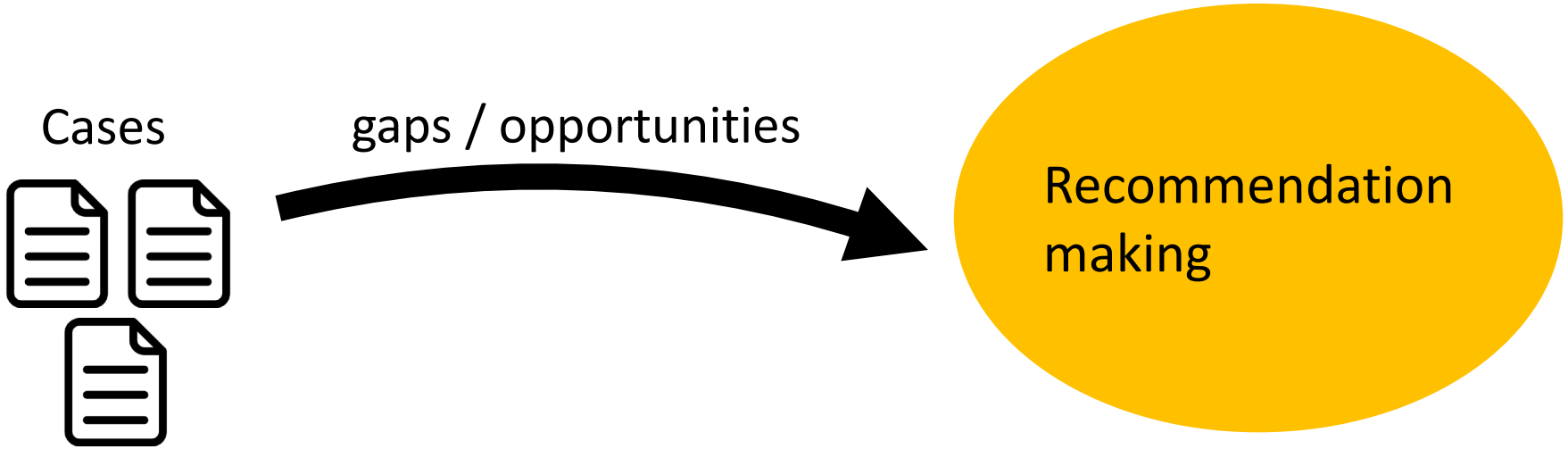
Released from prison 3/2024 (8 months prior to death).

Activity: Case discussion and recommendation making with dashboard data

- Discuss the case in groups
- What recommendations can you make from this case?

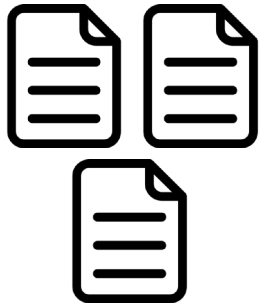
- **Now consult the dashboard**
  - What percentage of at-risk individuals will be impacted by each of your recommendations?
  - How feasible is it to effectively target individuals who are truly at risk through your proposed program changes/services?
  - Over what time frame should the recommended programs be sustained to meaningfully impact individuals?
  - Given the dashboard data, can you identify any opportunities to improve your recommendations?

Integrating the dashboard into OFR process



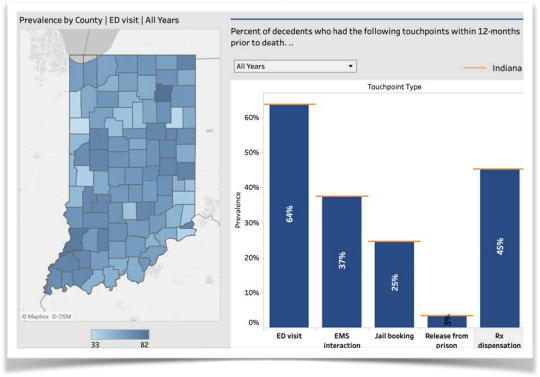
Integrating the dashboard into OFR process

Cases



gaps / opportunities

Recommendation making

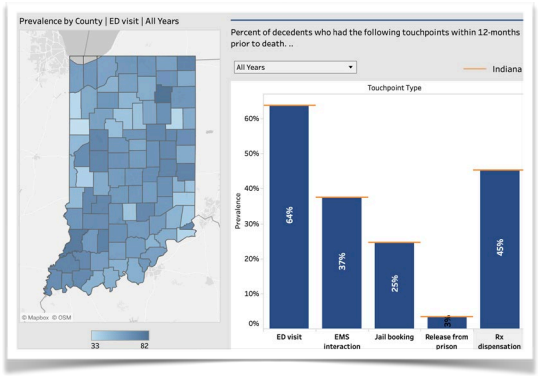


Touchpoints Dashboard

Integrating the dashboard into OFR process

Cases

gaps / opportunities



Touchpoints Dashboard

Recommendation making

prioritize, tailor, set expectation

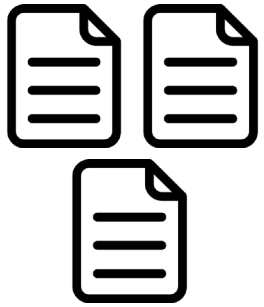
How many people are likely to benefit from program/policy change? (Touchpoint *prevalence*)

How easy is it to implement a program to target at-risk people? (touchpoint *rate, frequency*)

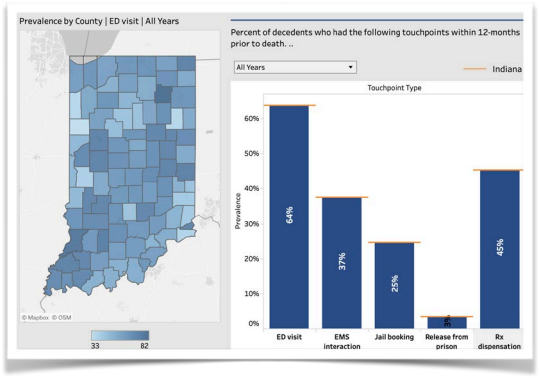
Over what time period should the program be implemented/targeted? (*recency*)

Integrating the dashboard into OFR process

Cases



Recommendation making



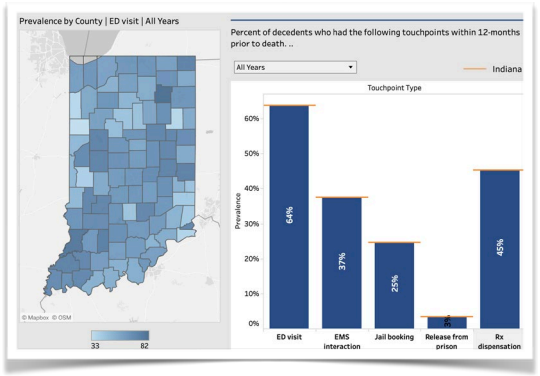
Touchpoints Dashboard

Assess the impact of programs.
Monitor touchpoint utilization

Dashboard for outreach and funding justification

Population-level touchpoint trends

Communicate with stakeholders / community members



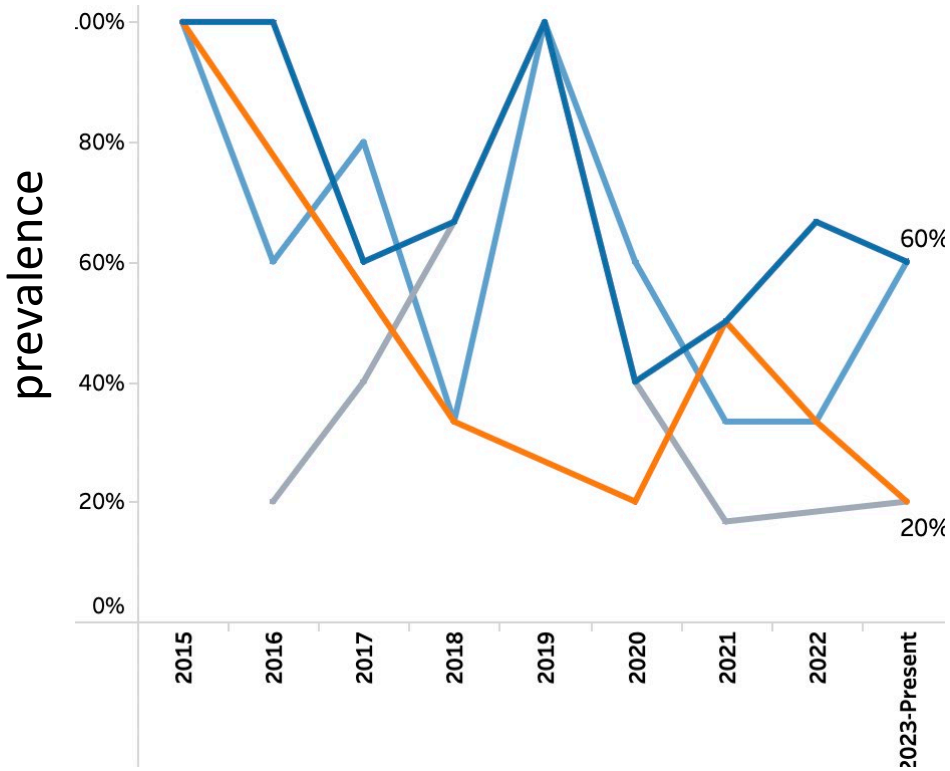
Touchpoints Dashboard

Touchpoint utilization (*prevalence*)

Fund raising / program justification

Pitfalls / limitations

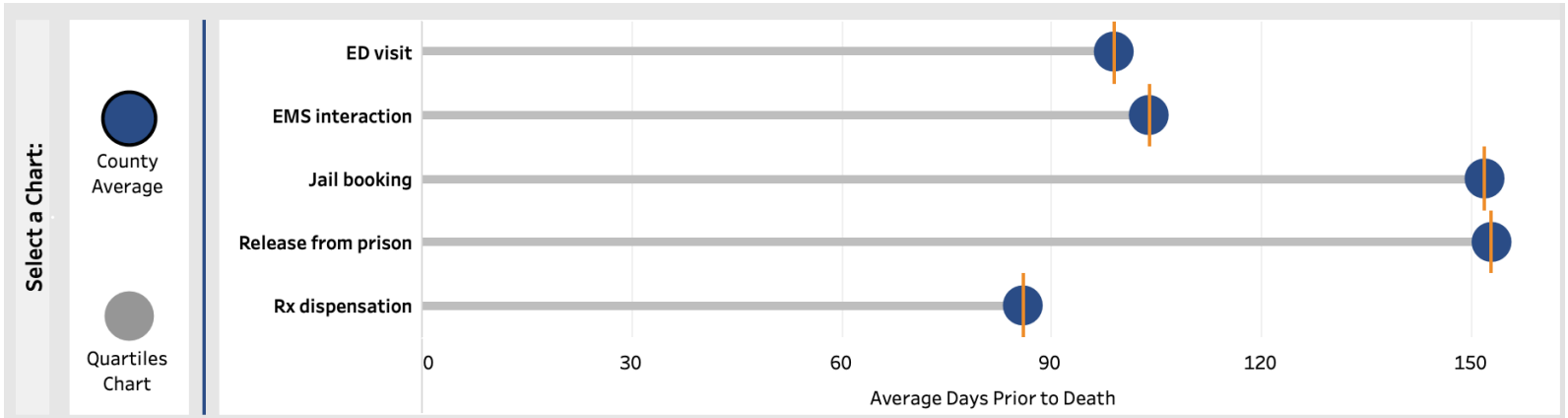
Real spike or fluke?



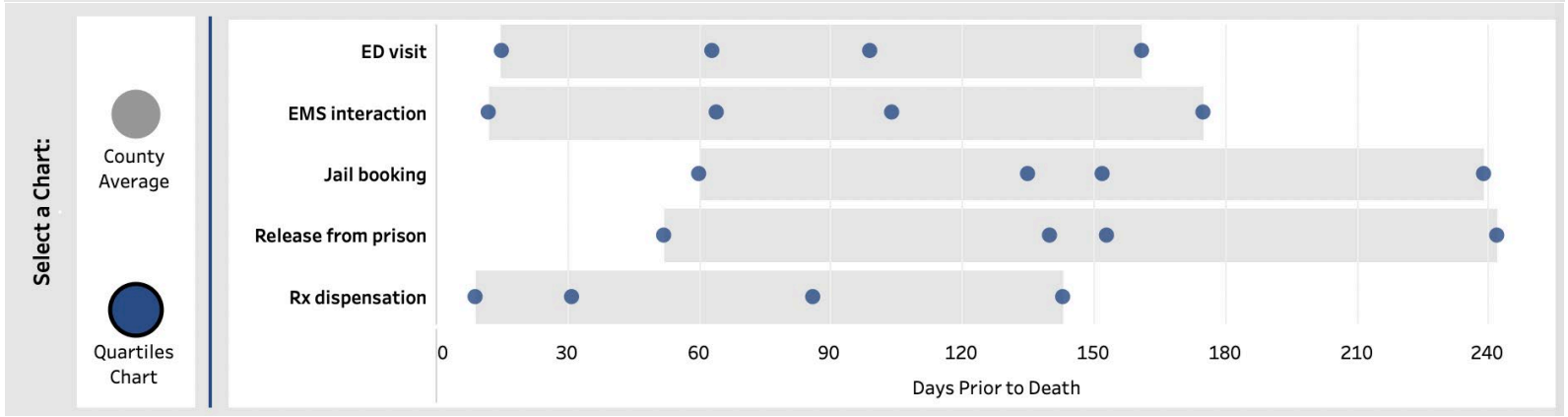
Fewer data points = higher variability

The decedent count in X is less than 20. This statistic should be interpreted with caution

Pitfalls / limitations



Average



Quartiles

Pitfalls / limitations

Table 1. Data types and attributes as identified by experts and featured in the dashboard.

Data type and attribute	Identified by expert panel?	Included in dashboard?
Touchpoint		
Jail booking	No	Yes
Release from prison	Yes	Yes
Visit to the ED[a]	Yes	Yes
Encounter with EMS[b]	Yes	Yes
Interaction with residential treatment services	Yes	No
Prescription dispensation for scheduled drugs, including opioid analgesics and MOUD[c]	No	Yes
Social determinants		
Demographics	Yes	No
Educational level	Yes	No
Poverty	Yes	No
Access to harm reduction services	Yes	No
Housing	Yes	No
Access to transportation	Yes	No
Adverse childhood experiences	Yes	No

Provided by dashboard

Not currently available

What would we like you to do?

Use the dashboard

- Show the data in meetings
- Communicate with people outside of meetings
- Secure grant funding
- ??

Dashboard use during OFR Meeting to improve recommendation-making

FORTRESS
Training Videos

Assessment (for FORTRESS team)

- How are you using the dashboard with your teams?
- Does it measurably impact the quality of recommendations?
- Is the dashboard user-friendly? Are there changes that can make it more usable/informative to OFRs

What to expect next

- Fidelity Monitoring and Feedback Form
- Community of Practice Calls
- FORTRESS team support
  - REDCAP data entry, etc.
- More surveys (wave 4 upcoming)

Community of Practice Calls

- We will add you to the invites, feel free to forward to OFR members
- Upcoming:
  - Oct: FORTRESS and Record Linkage-MPH
  - Nov: Use FORTRESS to Support Grants for Opioid Settlement-Dr. Brad Ray
  - Dec: Experience Passing OFR Legislation-Dr. Beth Keeney, Clark Co OFR

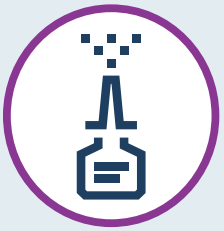
FIN

When to Offer Naloxone to Patients

Only 1 naloxone prescription is dispensed for every 70 high-dose opioid prescriptions. As a healthcare professional, you play a critical role in ensuring patients receive naloxone.[1]

Offer naloxone to all patients prescribed opioids, particularly to patients who are at an increased risk for opioid overdose. In addition, offer naloxone to a patient's family and caregivers and direct them to resources that will teach them how to administer naloxone.

Three forms of naloxone products are available: nasal spray, injection, and auto-injection. Refer to the Substance Abuse and Mental Health Administration's (SAMHSA) Opioid Overdose Prevention Toolkit to educate patients, caregivers, and the community about the benefits of having naloxone readily available, the different forms and how to use them. For example, if household members, including children, or other close contacts accidentally ingest or experience an opioid overdose having naloxone nearby is critical. Helping people identify places that dispense naloxone can increase the number of people who carry it.



Far too little naloxone is being dispensed in the United States.[1]

- **In 2018, rural counties had the lowest dispensing rates and were nearly 3 times more likely to be low-dispensing counties compared to metropolitan counties.**
- **Primary care clinicians wrote only 1.5 naloxone prescriptions per 100 high-dose opioid prescriptions—a marker for opioid overdose risk.**
- **Over half of naloxone prescriptions required a copay.**

Dispensing naloxone in areas hardest hit by the opioid overdose epidemic can increase the number of lives saved and the opportunity to link people to treatment.[1]

Visit Prescribe to Prevent for resources about prescribing naloxone in primary care settings.

Some situations and conditions may make an opioid overdose more likely. The following factors increase risk of opioid overdose:[2]

- A history of overdose
- Patients with sleep-disordered breathing
- Patients taking benzodiazepines with opioids
- Patients at risk of returning to a high dose for which they have lost tolerance (e.g., patients undergoing tapering or recently released from prison)
- Patients taking higher dosages of opioids (e.g., ≥50 MME/day)
- A history of substance use disorder

For more information and resources on naloxone, visit cdc.gov/opioids/naloxone, and for drug overdose prevention, visit cdc.gov/drugoverdose.

[1]https://www.cdc.gov/vitalsigns/naloxone/index.html
[2]https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_w

When to Offer Naloxone to Patients in the Emergency Department

As a healthcare professional working in the emergency department, you play a critical role in ensuring patients receive naloxone,[1] by offering overdose prevention education and related training for patients, family members, and friends.

When caring for a patient who has experienced an overdose, make an effort to determine how the overdose occurred.

For example, was the patient a household member that experienced an accidental ingestion? Or does the patient have a history of OUD? Depending on the cause, you might prescribe naloxone in the event of future overdoses[2] and/or initiate treatment with buprenorphine in the emergency department and transition to ongoing treatment using a "warm handoff".[3]

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

LEARN MORE: cdc.gov/opioids/naloxone

When prescribing opioids, everyone is at risk for opioid overdose and should be offered naloxone. However, some situations and conditions may make an opioid overdose more likely. The following factors increase risk of opioid overdose:[4]

- A history of overdose
- Patients with sleep-disordered breathing
- Patients taking benzodiazepines with opioids
- Patients at risk of returning to a high dose for which they have lost tolerance (e.g., patients undergoing tapering or recently released from prison)
- Patients taking higher dosages of opioids (e.g., ≥50 MME/day)
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For more information and resources on naloxone, visit cdc.gov/opioids/naloxone, and for drug overdose prevention, visit cdc.gov/drugoverdose.

[1] https://www.cdc.gov/vitalsigns/naloxone/index.html

[2] https://www.fda.gov/drugs/drug-safety-and-availability/fda-recommends-health-care-professionals-discuss-naloxone-all-patients-when-prescribing-opioid-pain

[3] https://www.annemergmed.com/article/S0196-0644(19)30606-7/fulltext

[4] https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_w

How and When to Use Naloxone for an Opioid Overdose

Naloxone saves lives because it can quickly restore normal breathing to a person whose breathing has slowed or stopped as a result of overdosing on prescription opioid medications, heroin, or drugs that are adulterated and contaminated with an opioid like fentanyl (e.g., cocaine, methamphetamine).[1]

What are the signs of an opioid overdose?

During an overdose, a person's breathing can be dangerously slowed or stopped, causing brain damage or death. It's important to recognize the signs and act fast, even before emergency workers arrive. Signs of an overdose may include:[2, 3]

- Small, constricted "pinpoint pupils"
- Falling asleep or loss of consciousness
- Limp body
- Slow, shallow breathing
- Choking or gurgling sounds

Naloxone (Narcan®) temporarily reverses the effects of overdose from drugs made from opium or opioids, including:[1]

- heroin
- morphine
- oxycodone (OxyContin®)
- methadone
- fentanyl
- hydrocodone (Vicodin®)
- codeine
- hydromorphone
- buprenorphine

If you give naloxone to a person who has not taken an opioid medicine, it will not hurt them.[1] To learn about training on how to give naloxone, visit getnaloxonenow.org.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Side effects of naloxone

Naloxone can (but does not always) cause withdrawal symptoms, unpleasant physical reactions, when an individual stops using a substance that they depend on. Withdrawal symptoms may be uncomfortable but are not life-threatening.[1]

Withdrawal symptoms may include:

- Fever
- Nausea
- Feeling restless or irritable
- Fast heart rate
- Sweating
- Vomiting
- Shaking

What to do if you think someone has overdosed on opioids

1. Call 911 immediately.
2. Give naloxone as quickly as possible, if available. Do not wait for emergency workers to arrive before giving naloxone.
3. Try to keep the person awake and breathing.
4. Lay the person on their side to prevent choking.
5. Stay with the person until emergency workers arrive.
6. Naloxone is a temporary treatment. More than one dose might be needed under some circumstances, especially if an overdose event involves illicitly manufactured fentanyl and fentanyl-related substances.[4]

Remember, naloxone is a safe medicine. By carrying naloxone, you can save a life.[5] After naloxone is used or if it is expired, make sure to let your clinician or pharmacist know so you can get more.

For more information and resources on naloxone, visit cdc.gov/opioids/naloxone, and for drug overdose prevention, visit cdc.gov/drugoverdose.

[1] https://www.drugabuse.gov/publications/drugfacts/naloxone
[2] https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/opioid-overdose
[3] https://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/recognizing-opioid-overdose/
[4] https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf
[5] https://www.hhs.gov/surgeongeneral/priorities/opioids-and-addiction/naloxone-advisory/index.html

What You Need to Know About Naloxone

Side effects of naloxone

Naloxone can (but does not always) cause withdrawal symptoms, unpleasant physical reactions, in people who are physically dependent on opioids. Withdrawal symptoms are not life-threatening[1] and may include fever, anxiety and irritability, rapid heart rate, sweating, nausea, vomiting, and tremors.

Naloxone saves lives because it can quickly restore normal breathing to a person whose breathing has slowed or stopped as a result of overdosing on prescription opioid medications, heroin, or drugs that are adulterated and contaminated with an opioid like fentanyl (e.g., cocaine, methamphetamine).[1]

Three forms of naloxone products are available: nasal spray, injection, and auto-injection. The Substance Abuse and Mental Health Administration's (SAMHSA) Opioid Overdose Prevention Toolkit can help you learn about the different forms and how to use them.

Naloxone can be given safely to people of all ages, from infants to older adults. This includes a child who may have accidentally taken an opioid pain reliever or medicine to treat opioid use disorder.[2]

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

LEARN MORE: cdc.gov/opioids/naloxone

How much does naloxone cost?

The cost varies depending on where and how you get it, as well as your health insurance. People with insurance should check with their insurance company to see what the cost is, while individuals without insurance can check with their local pharmacies. **Contact your local health department to learn about community programs that may provide naloxone for free or for a reduced cost.**

General advice to prevent overdose[2]

- Only take opioids as prescribed.
- Lock up opioids to keep them away from children, prevent them being taken accidentally, or being taken without permission (stolen).
- Follow the naloxone package instructions that come with the product and check the expiration date,[1] so it can be replaced before it expires.
- Dispose of opioids properly.
- Have naloxone readily available if needed in an emergency.

Remember, naloxone is a safe medicine.[1] By carrying naloxone, even when you are away from home, you can save a life.[3] Let others you are with know you have it, where it is, and how to use it.

Where can you get Naloxone?

If you or someone you know takes opioids or was prescribed an opioid medication, you can go to a pharmacy or community-based program to get trained to use naloxone and receive naloxone.[4] For example: ***"I think I need naloxone because I'm worried my [friend/family member] could overdose, or my doctor recommended that I get it."***[1]

Currently all 50 states, the District of Columbia, and Puerto Rico allow pharmacists to dispense naloxone without a prescription.[5]

For more information and resources on naloxone, visit cdc.gov/opioids/naloxone, and for drug overdose prevention, visit cdc.gov/drugoverdose.

[1] https://www.drugabuse.gov/publications/drugfacts/naloxone

[2] https://www.fda.gov/drugs/drug-safety-and-availability/fda-recommends-health-care-professionals-discuss-naloxone-all-patients-when-prescribing-opioid-pain

[3] https://www.medscape.com/viewarticle/919515?src=par_cdc_stm_mscpedt&faf=1#vp_1

[4] https://www.hhs.gov/surgeongeneral/priorities/opioids-and-addiction/naloxone-advisory/index.html

[5] http://dx.doi.org/10.15585/mmwr.mm6831e1

Pharmacists' Role in Naloxone Dispensing

As a pharmacist, you can reduce risks of overdose deaths by educating patients and their caregivers on the benefits of naloxone, the three forms available (nasal spray, injection, and auto-injection), how to administer it, and how to recognize an opioid overdose.[1]

Far too little naloxone is being dispensed in United States.[2]

- **In 2018, rural counties had the lowest dispensing rates and were nearly 3 times more likely to be low-dispensing counties compared to metropolitan counties.**
- **Primary care clinicians wrote only 1.5 naloxone prescriptions per 100 high-dose opioid prescriptions—a marker for opioid overdose risk.**
- **Over half of naloxone prescriptions required a copay.**

Ensure naloxone is always available in your pharmacy.[3]

Currently all 50 states, the District of Columbia, and Puerto Rico allow pharmacists to dispense naloxone without a prescription.[3]

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

LEARN MORE: cdc.gov/opioids/naloxone

Everyone prescribed opioids is at risk for opioid overdose and should be offered naloxone. However, some situations and conditions may make an opioid overdose more likely. The following factors increase risk of opioid overdose:[4]

- A history of overdose
- Patients with sleep-disordered breathing
- Patients taking benzodiazepines with opioids
- Patients at risk of returning to a high dose for which they have lost tolerance (e.g., patients undergoing tapering or recently released from prison)
- Patients taking higher dosages of opioids (e.g., ≥50 MME/day)
- A history of substance use disorder

Collaborate with the health department and health systems in your local community to help educate patients, caregivers, and the community about how they can request naloxone from a pharmacist and the benefits of having naloxone readily available if they know someone who uses drugs and are likely to witness or experience an overdose.[5]

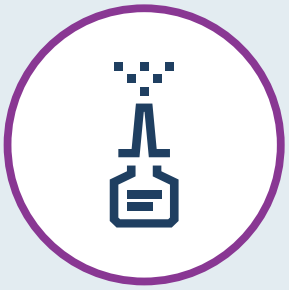
For more information and resources on naloxone, visit cdc.gov/opioids/naloxone, and refer to the Substance Abuse and Mental Health Administration's Opioid Overdose Prevention Toolkit. For drug overdose prevention, visit cdc.gov/drugoverdose.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5331002/
[2] https://www.cdc.gov/vitalsigns/naloxone/index.html
[3] http://dx.doi.org/10.15585/mmwr.mm6831e1
[4] https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_w
[5] https://www.hhs.gov/surgeongeneral/priorities/opioids-and-addiction/naloxone-advisory/index.html

Increase Naloxone Prescribing in Your Health System

Naloxone is a life-saving medication that can temporarily reverse the effects of an opioid overdose, whether from prescription or illicit opioids including heroin and fentanyl.[1]

It is available in three forms: nasal spray, injection, and auto-injection. When sprayed into the nose or injected into the muscle, it quickly reverses the harmful effects of opioids during an overdose.[2] However, only 1 naloxone prescription is dispensed for every 70 high-dose opioid prescriptions.[1]



Did you know?

Far too little naloxone is being dispensed in the United States.[1]

- In 2018, rural counties had the lowest naloxone dispensing rates and were nearly 3 times more likely to be low-dispensing counties compared to metropolitan counties.
- Primary care clinicians wrote only 1.5 naloxone prescriptions per 100 high-dose opioid prescriptions—a marker for opioid overdose risk.
- Over half of naloxone prescriptions required a copay.

As a healthcare executive, you play a critical role in supporting naloxone and opioid use disorder training and education for clinicians.[3]

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

LEARN MORE: cdc.gov/opioids/naloxone

Here are some tips for increasing naloxone prescibing in your health system for patients at risk for opioid overdose:[3]

1. **Support education for healthcare clinicians and pharmacists** related to the benefits of naloxone, when to prescribe it, and how to talk to patients and families about naloxone in a non-judgmental manner.

   Learn more: https://store.samhsa.gov/system/files/sma18-4742.pdf

2. **Establish practice-wide quality improvement measures** to assess electronic health record data and track the percentage of patients on long-term opioid therapy who were counseled on the purpose and use of naloxone, and either prescribed or referred to obtain naloxone.[3]

   Learn more: https://www.cdc.gov/opioids/healthcare-admins/qi-cc.html

3. **Build in electronic health records clinical reminders** at the point of care to increase naloxone prescribing. Consider proactive approaches such as integrating clinical decision support tools into your electronic health records system.

For more information and resources on naloxone, visit cdc.gov/opioids/naloxone, and for drug overdose prevention, visit cdc.gov/drugoverdose.

[1] https://www.cdc.gov/vitalsigns/naloxone/index.html
[2] https://www.fda.gov/consumers/consumer-updates/having-naloxone-hand-can-save-life-during-opioid-overdose
[3] https://www.medscape.com/viewarticle/919117

Syringe Services Programs (SSPs) Fact Sheet

The opioid crisis is fueling a dramatic increase in infectious diseases associated with injection drug use.

Reports of acute hepatitis C virus (HCV) cases rose 3.5-fold from 2010 to 2016.[1]

The majority of new HCV infections are due to injection drug use.

Over 2,500 new HIV infections occur each year among people who inject drugs (PWID).[2]

Syringe Services Programs (SSPs) reduce HIV and HCV infections and are an effective component of comprehensive community-based prevention and intervention programs that provide additional services. These include vaccination, testing, linkage to infectious disease care and substance use treatment, and access to and disposal of syringes and injection equipment.

Helps prevent transmission of blood-borne infections

For people who inject drugs, the best way to reduce the risk of acquiring and transmitting disease through injection drug use is to stop injecting drugs. For people who do not stop injecting drugs, using sterile injection equipment for each injection can reduce the risk of acquiring and transmitting infections and prevent outbreaks.

SSPs are associated with an estimated 50% reduction in HIV and HCV incidence.[3] When combined with medications that treat opioid dependence (also known as medication-assisted treatment), HCV and HIV transmission is reduced by over two-thirds.[3,4]

SSPs serve as a bridge to other health services, including HCV and HIV testing and treatment and medication-assisted treatment for opioid use disorder.[5]

Helps stop substance use

The majority of SSPs offer referrals to medication-assisted treatment,[6] and new users of SSPs are five times more likely to enter drug treatment and three times more likely to stop using drugs than those who don't use the programs.

SSPs prevent overdose deaths by teaching people who inject drugs how to prevent overdose and how to recognize, respond to, and reverse a drug overdose by providing training on how to use naloxone, a medication used to reverse overdose. Many SSPs provide "overdose prevention kits" containing naloxone to people who inject drugs.[7-12]

Helps support public safety

SSPs have partnered with law enforcement, providing naloxone to local police departments to help them respond and prevent death when someone has overdosed.[13]

SSPs also protect first responders and the public by providing safe needle disposal and reducing the presence of discarded needles in the community.[14-19]

In 2015, CDC's National HIV Behavioral Surveillance System found that the more syringes SSPs distributed per the number of people who inject drugs in a geographic region, the more likely the people who inject drugs in that region were to dispose of used syringes safely.[20]

Studies in Baltimore[21] and New York City[22] have also found no difference in crime rates between areas with and areas without SSPs.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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Evidence-Based Strategies for Preventing Opioid Overdose:

What's Working in the United States

An introduction for public heath, law enforcement, local organizations, and others striving to serve their community

Authors:
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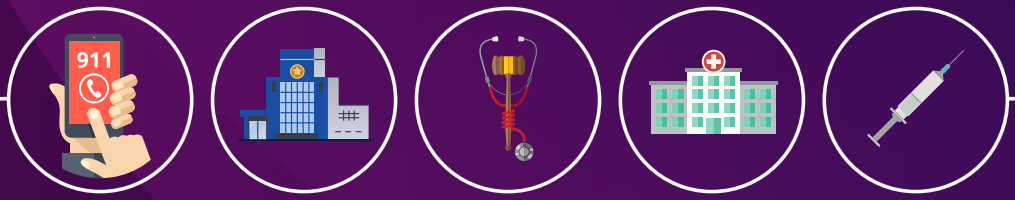

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Contents

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Introduction and Overview

Who is this document for?

This document is to assist community leaders, local and regional organizers, non-profit groups, law enforcement, public health, and members of the public in understanding and navigating effective strategies to prevent opioid overdose in their communities.

How can readers use this document?

Readers can use this document as a general reference for evidence-based practices that have been successfully implemented in the U.S. and are effective in reducing rates of opioid overdose. This document also provides readers with straightforward explanations of how and why these strategies work, summaries of major research on these topics, and examples of organizations from across the U.S. that have excelled at putting these strategies into practice.

How was this document created?

The selection of evidence-based strategies included in this document began with a systematic search of scientific literature on the prevention of opioid overdose in the context of prescription opioid misuse or use of illicit opioids. To be considered for inclusion in this document, strategies must have been successfully implemented in at least one jurisdiction in the U.S. as evidence for this document was being reviewed (between April and August 2017) AND meet one of the following evidentiary criteria: (1) meta-analyses or systematic reviews have found the strategy to be effective at reducing overdose and/or factors that increase overdose risk; (2) evidence from a scientifically rigorous experimental study, such as a randomized controlled trial, demonstrates the strategy's effectiveness in reducing overdose and/or factors that increase overdose risk; or (3) multiple observational studies from U.S. settings indicate the strategy's ability to reduce overdose or mitigate and reduce factors that increase overdose risk. In order to provide the broadest possible scope of evidence for guiding the implementation of overdose prevention strategies in the U.S., research that has been conducted in international settings that examines strategies also well-studied and proven feasible in U.S. settings are included in this document as well.

Based on these criteria, strategies identified can be considered promising or effective in reducing opioid overdose.

Over the course of several months, researchers, public health professionals, and subject matter experts were consulted to refine the list of strategies considered into a collection of those interventions with the strongest evidence of efficacy AND with demonstrated feasibility in U.S. settings. These contributors, including physicians, epidemiologists, sociologists, medical anthropologists, harm reductionists, and more, offered individual input based on their own research and experiences working at the forefront of the opioid crisis.

This is not an exhaustive list of overdose prevention strategies. Many countries—such as Canada, Portugal, The Netherlands, Germany, Switzerland, Norway, Australia, and Uruguay, just to name a few—have implemented overdose-prevention policies and programs that have never been used in the U.S. Even within the U.S., many local organizers and advocates have developed unique, locally appropriate strategies too numerous to name here.

In sum, the strategies laid out in this document are well known, evidence-based actions that U.S. states and municipalities can take **today** to prevent new overdoses **tomorrow.**

Why evidence-based?

Opioid use disorders and opioid overdose are complex phenomena shaped by numerous social, biological, and psychological factors. Due to this complexity—and the natural complexity of all human beings—fully understanding and accounting for all of these factors in an overdose prevention activity is a significant challenge. Often, ideas that once looked promising fail to pan out as expected.* There are also strategies that at first glance appeared counter-intuitive or wrong but were ultimately shown to be very effective in preventing fatal overdose. Subjecting overdose prevention interventions to scientific testing and evaluation is the only way to know for sure whether these intuitions are correct.

In acknowledgement of this pressing need, a practice is considered both "locally appropriate" and "evidence-based" if it has been designed in accordance with three key sources of information: (1) high quality scientific research; (2) the professional opinions and experiences of clinical

and public health experts; and (3) the preferences, priorities, and values of the individuals who will be targeted or affected by that practice.[1] By offering this summary of the current "best practices" for overdose prevention, based on a thorough review of existing research and expertise from a diverse array of medical and public health professionals, this document aims to fulfill areas 1 (scientific research) and 2 (expert opinions). Area 3, the preferences and priorities of those affected (in this case, individuals who use opioids or are otherwise at risk of opioid overdose), must be sought anew in each new community context. This combination of evidence, expertise, and community dialog will lay the groundwork for truly effective opioid overdose prevention strategies across the U.S.

* Research shows that some opioid use and overdose prevention interventions have harmful effects on individuals at risk. Some have even been shown to increase the risks of opioid overdose. The causes of these harms often include the sharp reduction of opioid tolerance during periods of high risk for relapse; the inadvertent promotion of riskier drug use practices through inattention to structural risk factors; and the exposure of at-risk individuals to additional trauma. Examples of strategies shown ineffective by research and data include: arrest and incarceration, compulsory treatment, rapid detox without opioid agonist/antagonist medication assistance, inappropriately implemented school-based education (e.g. short sessions focused on knowledge improvement and resistance only, mixing students from different risk groups), and inappropriately implemented drug court systems (e.g. low quality service provision, improper participant selection, lack of program evaluation).

Guiding Principles

Below are four overarching principles, lessons gleaned from previous public health emergencies, such as the HIV/AIDS crisis in the 1980s and 1990s. These principles serve as a guide for the design and implementation of effective overdose prevention strategies.

1. Know your epidemic, know your response

First advanced by UNAIDS as a guiding principle for global HIV prevention and control, the mantra "know your epidemic, know your response" originally spoke to the mismatch between strategy and reality that hindered HIV control efforts in the first years of the epidemic. In a 2008 Lancet article, Drs. David Wilson and Daniel Halperin championed the "know your epidemic, know your response" principle with their observation that "there is no single HIV Epidemic, but a multitude of diverse epidemics" that differ according to "who gets infected and how."[2]

Similarly, opioid overdose is driven by a multitude of mechanisms and human experiences, and people may follow a variety of paths toward opioid misuse and overdose. The realities faced by people who use drugs may be common across regions or vary within tight social groups.

"Know your epidemic, know your response" reminds us that we must have a clear understanding of the causes and characteristics of local public health problems before we can know how to tackle them. It reminds us that our choices must be driven by evidence and data; that we must employ strategies we know to be effective; and that we must remain vigilant in maintaining a holistic and grounded understanding of who is at risk of fatal overdose, how that risk is constructed, and what can be done to reduce that risk as much as possible.

2. Make collaboration your strategy

Effective solutions to the opioid overdose crisis will only emerge from strong partnerships across governmental, legal, medical, and other community stakeholders. Collaboration between public health and public safety is especially important, as the impact of illicit opioid use and prescription opioid misuse is great on both of these fronts.

Overdose prevention strategies will only be successful if the role of each player is well designed, reasonable, and clear—and only if those players take on those roles in deliberate coordination with each other. Accomplishing this requires much more than sharing data and intelligence. The implementation of a proven public health approach such as a 911 Good Samaritan Law may be ineffective if law enforcement officers are not included in the planning and design of its implementation or if public safety protocols at the scene of an overdose are not discussed in tandem with the law. Similarly, the successful police take-down of a clinician or facility operating as an illegal "pill mill" may achieve long-term gains at the expense of creating short-term dangers if a public health strategy to support the patients suddenly cut off from this supply of opioids is not put into place ahead of time.

Effectively responding to the opioid overdose crisis requires that all partners be at the table and that we "make collaboration our strategy" by ensuring that all community entities are able to fulfill their necessary roles.

3. Nothing about us without us

The phrase "nothing about us without us"[3] reflects the idea that public policies should not be written or put into place (officially or unofficially) without the direction and input of the people who will be affected by that policy. This mantra has been used by persons living with disabilities as they fought for recognition as independent persons who know their needs better than anyone else.[4] It has been used by numerous at-risk groups in the U.S. to defend their place at the table in the planning of HIV prevention strategies.[5,6]

In the context of today's opioid overdose epidemic, "nothing about us without us" speaks to the fact that prevention strategies need to take into account the realities, experiences, and perspectives of those at risk of overdose. Those affected by opioid use and overdose risk should be involved in the design, implementation, and evaluation of interventions to assure those efforts are responsive to local realities and can achieve their desired goals.

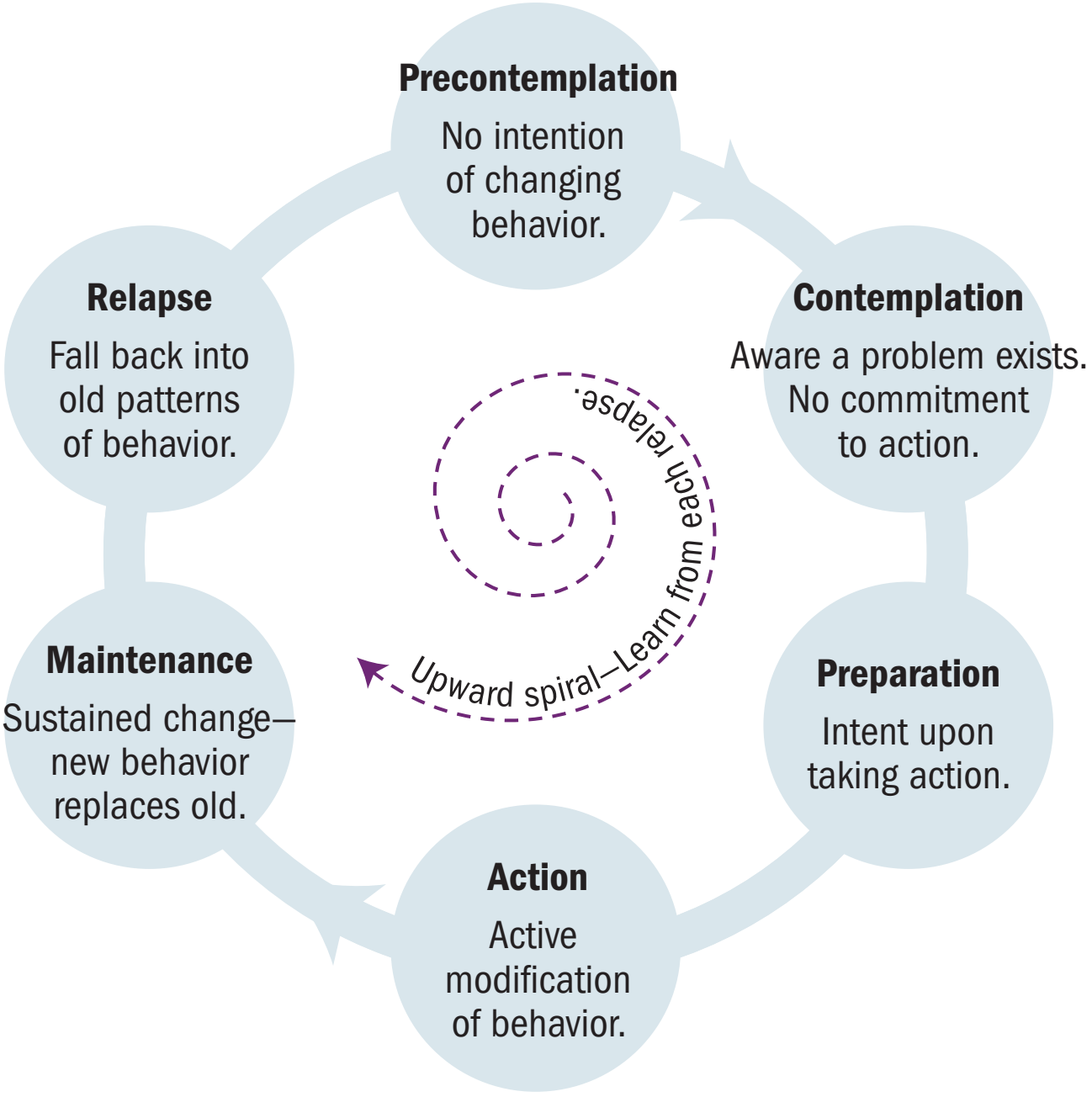
4. Meet people where they are

Meeting people where they are requires understanding their lives and circumstances, what objectives are important to them personally, and what changes they can realistically make to achieve those objectives. For example, abstinence may not be immediately achievable by all who use illicit substances; however, many smaller changes may be feasible and could bring substantial benefit, such as reducing the spread of infectious disease, lowering overdose risk, and improving overall physical or mental health.

The Transtheoretical Model, also called the Stages of Change model,[7] describes how such behavior change often occurs. The model emphasizes the need to understand the experience of the person we are trying to reach in order to help them. To promote change, interventions must be provided that are appropriate for the stage in the process that people are in.[8]

The guiding principle of "meeting people where they are" means more than showing compassion or tolerance to people in crisis. This principle also asks us to acknowledge that all people we meet are at different stages of behavior change. Furthermore, recognition of these stages helps us set reasonable expectations for that encounter. For example, a person who has experienced an overdose who is precontemplative and has not yet recognized that their drug use is a problem may be unlikely to accept treatment when they are revived, but may benefit from clear, objective information about problems caused by their drug use and steps they can take to mitigate them. Unrealistic expectations cause frustration and disappointment for patients, providers, family, caregivers, and others touched by the event. Someone who is already preparing for action, however, may be ready for treatment, support, or other positive change. A positive, judgement-free encounter with first responders may provide the impetus and encouragement needed to get started. When we "meet people where they are," we can better support them in their progress towards healthy behavior change. Recognizing the progress made as a person moves forward through the stages of change can help avoid the frustration that arises from the expectation that they will achieve everything at once.

The Transtheoretical Model of Behavior Change



This image is adapted from Prochaska & DiClemente, 1983.

Evidence-Based Strategies

Targeted Naloxone Distribution

Naloxone is an opioid antagonist that can quickly and safely reverse the potentially fatal effects of an opioid overdose. Targeted distribution programs seek to train and equip individuals who are most likely to encounter or witness an overdose—especially people who use drugs and first responders—with naloxone kits, which they can use in an emergency to save a life. There are many different approaches to distributing naloxone to people at high risk of experiencing or witnessing an overdose. Effective approaches include community distribution programs, co-prescription of naloxone, and equipping first responders.

Why this strategy works

Naloxone is a drug that carries no risk of abuse and has no effect on individuals who do not already have opioids in their system. It does not generate physical dependency. It produces no neurological or psychological effects or euphoria. It also poses negligible risk of harm if misused. The people who most often witness and respond to an overdose are other persons who use drugs. By equipping these individuals with naloxone and training them to identify and respond to an overdose, the potential delay between the onset of an opioid overdose and the delivery of life-saving care can be reduced from hours to seconds. This is especially true in rural areas, where residents may experience longer EMS response times.[9] With powerful opioids, like fentanyl and fentanyl analogs, appearing in the U.S. drug supply, higher doses of naloxone may be needed. Therefore, ready access to naloxone among members of the lay community and first responders is key for saving lives.

Targeted naloxone distribution programs work best when:

- Naloxone is provided to people at high risk of experiencing or witnessing overdose.[10]
- Outreach workers, harm reduction staff, and trusted clinicians are properly educated and comfortable distributing naloxone to those using illicit opioids or receiving a high-risk opioid prescription.[11]
- People who use drugs and first responders are well informed as to the potential effects and actions of naloxone. Comfort with carrying and administering naloxone is crucial.[12]

TRAILBLAZERS

Naloxone has been carried by hospitals and emergency medical services since it was approved by the FDA in 1971.

Large-scale naloxone distribution for people who use drugs was first pioneered by staff at the Chicago Recovery Alliance in 1996.

In 2003, the DOPE Project in San Francisco began distributing naloxone via prescription from Nurse Practitioners working with the project. In 2010, California's standing order for naloxone prescription from the Medical Director of the local Department of Health was put in place, allowing the DOPE project to more readily distribute naloxone to program participants and expand their reach.

In 2013, Walgreens Pharmacy expanded a pilot naloxone access project in Rhode Island, making the overdose-reversing medication available at the pharmacy without having to first see a prescriber, thus beginning the first such statewide pharmacy-based naloxone program.

Targeted naloxone distribution—What the research says

- A nation-wide study found that more than 80% of overdose reversals with naloxone in the U.S. were carried out by individuals who also use drugs.[13] A similar study carried out in Massachusetts found that nearly 90% of overdose reversals with naloxone were carried out by bystanders who also use drugs.[14]
- An observational study of a naloxone distribution program in British Columbia recorded the distribution of 836 naloxone kits to people who use drugs and 85 reported overdose reversals from among those trained and equipped with naloxone by the program, indicating that at least one in every ten kits distributed had saved a life.[15]
- An observational study in Ohio found that increases in the number of law enforcement officers trained and carrying naloxone was associated with a reduction in opioid overdose deaths and an increase rate of survival among opioid overdose victims in the surrounding area.[16]
- A retrospective review of all program enrollee information collected by the Massachusetts Department of Public Health Overdose Education and Naloxone Distribution Program found that family members of persons at risk of overdose comprised nearly 30% of the program's enrollees and were responsible for 20% of all recorded rescue attempts. Some of those rescues were performed on someone other than the relative these participants were originally concerned about. These findings indicate that naloxone distribution across families and social networks can have life-saving, synergistic effects.[17]
- An observational study of nearly two thousand individuals who had received an opioid prescription over a two-year period found that those individuals who were co-prescribed naloxone along with their opioid analgesic prescription had 47% fewer visits to the emergency department in the 6 months after receiving the prescription and 63% fewer emergency department visits after 1 year.[18]

Medication-Assisted Treatment (MAT)

MAT is a proven pharmacological treatment for opioid use disorder. The backbone of this treatment is FDA approved medications. Agonist drugs, methadone and buprenorphine, activate opioid receptors in the brain, preventing painful opioid withdrawal symptoms without causing euphoria; naltrexone blocks the effects of opioids. MAT is effective at reducing use and helping people to lead normal lives.

Why this strategy works

The World Health Organization has called MAT "one of the most effective types of pharmacological therapy of opioid dependence."[19] Numerous studies have shown that MAT contributes to significant reductions in opioid use, criminal activity, overdose, and other risky behaviors.[20,21] MAT quells cravings and allows patients receiving it to stabilize their physical dependency. This stability allows MAT patients to achieve healthy social, psychological, and lifestyle changes.

A note about the three FDA-approved medications for opioid use disorder:

While all three medications (methadone, buprenorphine, and naltrexone) can be effective in the treatment of opioid use disorder, decades of research support the efficacy of opioid agonist medications (methadone and buprenorphine) in preventing overdose. We are now learning about the overdose prevention capabilities of long-acting, injectable naltrexone. Early research indicates that long acting naltrexone may share methadone and buprenorphine's overdose prevention effects.[22] Though naltrexone has also proven effective, research has shown that this medication is harder to initiate in some patients[23] and that less effective attenuation of withdrawal symptoms during the first days of treatment may predict treatment drop out.[24] Differences in treatment response and outcomes with naltrexone are actively being researched. Medications, therefore, should be selected carefully and tailored to the needs of each individual patient.

MAT works best when:

- It is combined with ancillary treatment strategies like counseling and social support with fixed, safe, and predictable doses of medications.[25,26]
- Public awareness of MAT as an effective medical intervention is promoted by local leadership. This helps to reduce stigma against MAT that discourages people from seeking this form of care.
- Entry into treatment is voluntary. Compulsory treatment programs through legal and social welfare systems are less effective than voluntary treatment.[27]
- Patients have access to a variety of medication options. All patients are different, and treatment is best when individualized. Some people fare significantly better on buprenorphine than on methadone, and vice versa. Some may need to try several treatment options before discovering what works best, and some may not have access to all MAT medications.[28]
- The challenges of receiving MAT are understood and mitigated. Many individuals face hurdles in receiving approval for MAT from their health insurance provider. Many methadone clinics require patients to attend daily to receive treatment. This can mean long, burdensome commutes at odd hours, which can conflict with professional, familial, or care-giving responsibilities.[29] Those who live in rural areas, for example, may have to drive hours to receive care. Treatment is more successful when these obstacles are not placed in the way.

TRAILBLAZERS

Methadone, which originally was synthesized by German scientists in the 1930s, was first used as a medication for opioid dependency in the 1960s, when heroin-related mortality was the leading cause of death for adults between 15 and 35 years old in New York City.[30]

Methadone was approved by the FDA for use in MAT in 1972, followed by buprenorphine in 2002. The U.S. Substance Use and Mental Health Services Administration (SAMHSA) released guidelines for the clinical management of buprenorphine-based MAT in 2004.[31]

Medication-assisted treatment—What the research says

- A meta-analysis that included eleven different studies of methadone as a medication for opioid use disorder found that methadone was more effective at treating opioid use disorder and reducing illicit opioid use than non-pharmacological treatments.[20]
- A 2014 review of all available evidence on buprenorphine as a treatment for opioid use disorder found it to be effective in retaining patients in care and just as effective as methadone in reducing illicit opioid use among those retained in care.[21]
- A longitudinal study that followed MAT patients for more than four years found both methadone and buprenorphine to be effective long-term treatments for opioid use disorder throughout that follow-up period.[32]
- Two studies, one conducted in Australia and one conducted in Washington state, have found higher death rates among patients receiving oral naltrexone compared to patients receiving long-acting injectable naltrexone[33] or methadone,[34] respectively.
- A meta-analysis concluded that participation in pharmacological treatment for opioid use disorder, such as MAT, improves HIV treatment across the entire continuum of care, increasing coverage of antiretroviral treatment by 54%, increasing enrollment into antiretroviral treatment by 87%, increasing antiretroviral treatment adherence by nearly 200%, increasing rates of viral suppression by 45%, and reducing antiretroviral treatment discontinuation by 23%.[35]
- A study that followed MAT patients for a year after initiating treatment found that MAT patients experienced a significantly improved quality of life during the course of their treatment.[36]
- In a clinical trial of more than 300 criminal justice-involved individuals with opioid use disorder, long-acting injectable naltrexone was compared to basic counseling with no medication. During the 24-week study period, there were no overdose events among the 153 individuals offered long-acting naltrexone and 7 overdose events among the 155 individuals offered no medication.[22]

Academic Detailing

"Detailing" is a structured educational strategy developed by commercial manufacturers of medical and pharmaceutical technologies to market these products to prescribers and pharmacists. "Academic detailing" consists of structured visits to healthcare providers by trained professionals who can provide tailored training and technical assistance, helping healthcare providers use best practices.

Why this strategy works

The purpose of commercial detailing, the sales strategy upon which academic detail is based, is the targeted marketing of pharmaceutical products to healthcare providers who are best positioned to prescribe them, which, depending on state law, includes physicians, physician assistants, nurse practitioners, and pharmacists. Academic detailing takes the most effective practices of this commercial marketing and applies them to the "marketing" of evidence-based practices to healthcare providers and other community stakeholders. In the context of overdose prevention efforts, academic detailing has been used to assist physicians in reducing potentially risky opioid prescribing practices, to prepare pharmacists to effectively distribute naloxone to the public, and many other innovative and community-based initiatives designed to deliver new skills to those individuals poised to make an impact on the rate of overdose in their communities.

Academic detailing works best when:

- Dedicated and trained detailing teams are deployed for all academic detailing activities, as this strengthens the detailing approach and fosters consistency within the project.[37]
- The individuals who receive academic detailing possess the means and resources to put their newly gained knowledge to use. For instance, physicians who treat patients receiving opioid medications often benefit from additional staff support, as evidence based opioid prescribing requires additional patient follow-up activities and administrative tasks.[38]

TRAILBLAZERS

Since 2013, the New York City Department of Health and Mental Hygiene, in collaboration with the U.S. Centers for Disease Control and Prevention (CDC), has actively undertaken two academic detailing campaigns: one to support providers of buprenorphine-based MAT with additional training and assistance, and the other to train and support clinic staff in adopting safe opioid prescribing practices.

The San Francisco Department of Public Health recently sponsored the CIAO (California Intervention for Academic Detailing on Opioids) study, which supported rural counties in developing and implementing academic detailing for primary care providers on safe opioid prescribing, overdose prevention, and buprenorphine-based MAT.

The Veterans Health Administration has made academic detailing a key component of its national Opioid Overdose Education and Naloxone Distribution program.

Academic detailing—What the research says

- A recent review found that commercial detailing is so effective in prompting behavior change among healthcare providers that its effects are overpowering those of traditional academic information sources. One major factor behind this pattern is that researchers who produce and seek to disseminate scientific medical knowledge are rarely trained in effective communication strategies. Academic detailing corrects this disparity by "marketing" new science to healthcare providers in a compelling and efficacious manner.[39]
- Academic detailing has been used to improve physician practices across a variety of medical spheres, including opioid prescribing,[40] proper medication dosing for patients with limited renal function,[41] and the timely screening of pregnant women for high-risk infections.[42]
- In a recent study on the effects of academic detailing on general practitioners, those who received detailing significantly improved their clinical management of refractory labored breathing. Further, more than 80% of those physicians who did not receive detailing lacked confidence in their knowledge of and ability to manage this condition.[43]
- A 2013 overdose prevention intervention carried out on Staten Island used targeted educational sessions with medical providers to reduce rates of inappropriate opioid prescribing and overdose death. The intervention resulted in a 29% decrease in prescription opioid overdoses on Staten Island, even as overdose rates remained unchanged in New York City's other boroughs.[44]
- Recent efforts to increase the rate of naloxone prescription by general practitioners through academic detailing have shown remarkable results. A study in San Francisco found an eleven-fold increase in the rate of naloxone prescription among physicians who received a half-hour-long academic detailing session.[45] Further, a large scale academic detailing effort in the Veterans Health Administration was able to reach more than 7,000 physicians in less than a year.[46] This effort resulted in a three-fold increase in naloxone prescription one year after the intervention and a seven-fold increase two years later, indicating that physicians were enabled to improve their clinical practice independently even after the academic detailing had taken place.[47]

Eliminating Prior-Authorization Requirements for Medications for Opioid Use Disorder

In this scenario, health insurance providers cover the cost of MAT as a standard benefit and all requirements that a physician contact the insurance provider for approval prior to writing the prescription (a process called "prior authorization") are removed. Without these prior authorization requirements, prescriptions for MAT medications to treat opioid use disorder can be written and filled as soon as a physician deems this treatment necessary, free from artificial delays.

Why this strategy works

Prior authorizations may take up to several days to process with insurance providers. This processing time creates an immediate barrier to a patient's initiation onto treatment. This delay forces patients to leave their provider's office without receiving potentially life-saving medication, only to return again to receive it several days later. During that time, treatment can be derailed. A patient may lose interest, lose access to their doctor, lose transportation, suffer an injury, or even die from an overdose.

The removal of prior authorization requirements allows a patient to be initiated onto treatment the same day they see their doctor. This immediate initiation reduces the patient's risk of overdose in the subsequent days and increases the likelihood that they will successfully engage in and remain connected to treatment.

Due to regulations governing the provision of methadone, buprenorphine and naltrexone are the only FDA-approved medications for opioid use disorder potentially subject to prior authorization requirements.

Removing prior authorization requirements works best when:

- Policy makers and healthcare providers work collaboratively with health insurance companies and state Medicaid programs to design and implement these policy changes.[48]

TRAILBLAZERS

In 2016, an investigation of barriers to treatment for opioid use disorder in New York prompted Cigna to voluntarily remove all prior authorization requirements for policy holders seeking prescription buprenorphine. Anthem Inc. also removed these requirements a few months later.

In March 2017, Aetna removed all prior authorization requirements for its private insurance plans.

In Rhode Island, the Governor's Overdose Prevention Task Force brought insurance company representatives to the table to help coordinate statewide overdose reduction measures. Following these collaboration efforts, Neighborhood Health Plan of Rhode Island and United Healthcare, the state's two Medicaid managed care providers, along with Blue Cross Blue Shield and Tufts Health Plan, two private health insurance providers, removed prior authorization for prescription buprenorphine for all of their policyholders to better support the state's overdose prevention efforts.

Eliminating prior-authorization requirements for medications for opioid use disorder—What the research says

- In 2014, prior authorization for prescription buprenorphine was still required for 35% of Health Maintenance Organizations (HMOs), 36% of Preferred Provider Organizations (PPOs), and more than half of Consumer Driven Products (CDPs).[49]
- Self-treatment with diverted (i.e. misused) opioid medications is common among individuals with opioid use disorder who have recently experienced barriers to or delays in starting buprenorphine-based MAT.[50,51,52]

Screening for Fentanyl in Routine Clinical Toxicology Testing

The standard panel of substances included in routine clinical drug screens (carried out in hospitals, clinics, treatment centers, etc.) should include screening for fentanyl exposure, particularly in jurisdictions where fentanyl is known to be prevalent in the local illicit drug market.

Why this strategy works

Because it is such a highly potent and fast acting opioid, and because it is often difficult—if not impossible—to identify prior to consumption, the presence of fentanyl in illicit drug supplies changes the landscape of opioid overdose dramatically. Harm reduction, risk reduction, and opioid overdose prevention efforts all need to be informed by an awareness of fentanyl exposure in the populations served in order to continue affording maximum safety and protection to community members who are navigating a fentanyl-contaminated drug supply.

The addition of fentanyl testing in routine clinical toxicology tests allows for early warnings of supply contamination and provides one of the best sources of routine surveillance for fentanyl in the local drug supply. The results of fentanyl screens may also have implications for the clinical management of substance use disorder for fentanyl-exposed individuals and for public health responses to opioid use and overdose.

Fentanyl testing in routine drug screens works best when:

- Adjustments are made to funding streams, standard lab procedures, and electronic medical records systems to accommodate and standardize this change in practice.[53,54]
- Trends in the results of fentanyl screens are shared effectively across public institutions with the capacity to intervene amongst those who intentionally or unintentionally consume fentanyl and reduce the risk of overdose.[55]

TRAILBLAZERS

In 2017, Lifespan, the parent company of the largest hospital network in Rhode Island, instituted a new policy mandating that fentanyl be added to the panel of drugs screened for among patients who are in the emergency department following an overdose. This practice ultimately became part of the state's Standard of Care for the Treatment of Opioid Addiction and Overdose in Emergency Departments and Hospitals.

Some outpatient methadone-based MAT programs have also begun testing for fentanyl in all urine screens, identifying individuals who were struggling in treatment and may not have known they were at risk of fentanyl-related overdose.[56]

Screening for fentanyl in routine clinical toxicology testing—What the research says

- A study conducted in Vancouver, British Columbia, that tested urine samples from 242 people who inject drugs found that 29% of all participants (only 59% of whom reported using heroin) tested positive for fentanyl. Of those who tested positive for fentanyl, nearly 75% did not report using fentanyl in the past three days, indicating that they were not aware they had been exposed. The same study also found that people who reported using methamphetamine had 6-times the odds of testing positive for fentanyl, compared to those who did not report using methamphetamine. At the time, this was a counter-intuitive finding, which would have likely not been discovered without adding fentanyl screening to these drug testing procedures.[55]
- A recent study conducted in the Detroit area found that 38% of clients receiving methadone-based MAT tested positive for fentanyl in standard monthly drug screenings at least once between January 2015 and May 2016. Clients who tested positive for cocaine were more likely to test positive for fentanyl as well.[57]
- Data collected from more than 700 medical records at a methadone-based MAT clinic in Rhode Island revealed that approximately one in seven methadone patients tests positive for fentanyl each month, and nearly two-thirds of new patients initiating methadone-based MAT tested positive for fentanyl at intake.[56] Each of these factors may shape a patient's experience of treatment and individual needs while receiving care.

911 Good Samaritan Laws

The term "911 Good Samaritan Law" refers to local or state legislation that may provide overdose victims and/or overdose bystanders with limited immunity from drug-related criminal charges and other criminal or judicial consequences that may otherwise result from calling first responders to the scene. The scope of 911 Good Samaritan Laws varies across U.S. states, but each is written with the goal of reducing barriers to calling 911 in the event of an overdose.

Why this strategy works

Frequently, individuals who witness an overdose have been using opioids themselves. Calling 911 for an overdose victim is an inherently risky thing for such bystanders to do. Emergency medical services are often accompanied by the police, and police have the discretion to execute warrants, search the premises, and arrest bystanders for drug-related charges that are coincidental to the overdose emergency at hand. When facing the risk of arrest, detention, prosecution, and potentially prison time, bystanders are forced to weigh their own wellbeing against the wellbeing of the person who is in crisis in front of them.

By providing limited immunity from drug charges arising from evidence found at the scene of an overdose, 911 Good Samaritan Laws defuse this conflict, allowing a bystander to seek emergency care for an overdose victim without putting themselves at risk of arrest.

Good Samaritan Laws are most effective when:

- Immunity is extended to all bystanders on the scene, not only to the individual in crisis and the individual who called 911.[58]
- Bystanders are protected from parole violations and warrant searches in addition to receiving immunity from criminal charges. Any perceived risk to the freedom or safety of the bystander reduces the probability that 911 will be called.[58,59]
- Police officers and other first responders are well informed as to their liabilities and responsibilities when responding to an overdose as outlined in their state's 911 Good Samaritan Law and other state and local regulations.
- People who use drugs are well informed about the 911 Good Samaritan law and have reason to trust that those protections will be consistently afforded to them when they call 911.[60]
- The hospital experiences of people who use drugs are strengthened and improved. Individuals in crisis will not call for emergency care if they don't want to be transported to the hospital due to previous maltreatment.[61]

TRAILBLAZERS

In 2007, New Mexico became the first state to pass a 911 Good Samaritan Law for overdose prevention—extending immunity from criminal liability for drug possession to victims of an overdose crisis and for those who seek help.

As of May 2018, all but five states have enacted similar legislation.

911 Good Samaritan Laws—What the research says

- A large study of overdose scenarios in Baltimore found that 911 was called during only one in five overdoses witnessed, and that the presence of more than four bystanders statistically decreased the probability that 911 would be called.[58]
- An evaluation of 911 Good Samaritan Law education efforts in New York City found that awareness of this law statistically increased the likelihood that a bystander would call 911 in the event of an overdose. This finding was true for all participants across race, age, and gender.[60]
- Multiple studies in the U.S. and Canada have observed that bystanders of an overdose are concerned that they will be arrested or have negative police interactions if 911 is called, which effectively deters many bystanders from making the call.[62,63]
- A large study of opioid using parolees in Alabama found that a number of bystanders (about 30%) will try to find help through means other than calling 911, such as dropping off the overdose victim at a hospital. Though it may be done with good intentions, this response could mean a fatal delay in care for the overdose victim.[64]
- Many police officers, when first introduced to the idea of 911 Good Samaritan Laws, experience concern about jurisdictional issues and liability surrounding the carry and administration of naloxone.[65] However, simple trainings and informational tools have been shown to quickly increase police officer familiarity and comfort with overdose response.[61]
- Young adults who report using opioids in Rhode Island have poor awareness of the local Good Samaritan law, indicating that targeted awareness raising may be needed for these laws to be effective across the entire community.[66]

Naloxone Distribution in Treatment Centers and Criminal Justice Settings

Naloxone distribution programs in criminal justice and treatment facilities (both inpatient and outpatient) target individuals who are about to be released from supervision and/or cease treatment to receive overdose response training and naloxone kits prior to their exit from the program or facility.

Why this strategy works

Individuals with a history of incarceration are, in general, at higher risk of overdose. Periods immediately following release from supervision or treatment, when a person's opioid tolerance is low, are especially dangerous: an individual is more than twenty-five-times more likely to overdose in the first weeks following the cessation of treatment than during treatment,[67] and release from incarceration, also defined by abrupt reintegration in the context of lowered opioid tolerance, places individuals with opioid dependency at similar risk.[68] Naloxone distribution programs operated within treatment and correctional settings are an effective way to train and equip this extremely high-risk group—as well as their friends and family members—with life-saving naloxone.

Naloxone distribution in treatment centers and criminal justice settings works best when:

- Coverage of these distribution programs is universal, providing all individuals leaving criminal justice settings or treatment with the opportunity to be trained and receive a naloxone kit. This is preferable to opt-in programs that require inmates to request special services to receive naloxone.[69]
- Training is provided in a way that refrains from making negative judgments about drug use and focuses instead on the importance of every person's safety and wellbeing even in the context of drug use.[70]
- Close contacts of the individual (family, partners, and children) are also trained in naloxone administration and overdose response.[10]
- Naloxone distribution in treatment centers and criminal justice settings works best when there is certainty in the supply chain and in funding. In treatment settings, an individual's insurance can cover the cost of naloxone.[71]

TRAILBLAZERS

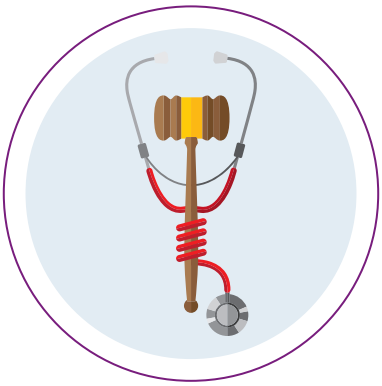
The first pilot programs for overdose prevention for incarcerated individuals took place in jails in Pittsburg and New York City, where naloxone was provided to incarcerated persons upon release or to caregivers visiting the detainees.

Since 2005, Rhode Island's adult prison system has trained inmates on overdose prevention. The prison then began providing naloxone to inmates at release in 2010, a model that other states have since adopted.

Baltimore area jails began distributing naloxone to at-risk individuals in 2016, following a recommendation from Maryland's Heroin and Opioid Emergency Task Force.

Naloxone distribution in treatment centers and criminal justice settings— What the research says

- A nationwide study of more than 10,000 individuals exiting specialized drug treatment settings in the U.S. found that rates of overdose death were twenty-six times higher in the first month following the cessation of treatment compared to the rate of overdose death while individuals were in treatment.[67]
- A similar study of more than 5,000 individuals ceasing outpatient MAT for substance use disorder found that overdose death rates were nine times higher than baseline in the first two weeks following treatment cessation, eight times higher in weeks three and four following treatment cessation, and approximately 1.9 times higher in the second month.[72]
- A large meta-analysis of data from several different nations found that individuals released from incarceration experience a three to eight-fold increase in the rate of overdose death in the first two weeks after release compared to weeks three through twelve following release.[73]
- A study carried out by the Massachusetts Department of Public Health found that individuals recently released from incarceration in the Commonwealth are 56 times more likely to overdose than members of the general public, indicating urgent need to scale up overdose prevention services for this population both before and after release.[74]
- Scotland's National Naloxone Programme, which started providing naloxone at release to inmates in 2011, was associated with a 36% reduction in the proportion of opioid- related deaths that occurred within the first four weeks following an individual's release from prison.[75]



MAT in Criminal Justice Settings and Upon Release

In this intervention, MAT should be made available as a standard of care for incarcerated individuals with opioid use disorder. Those receiving MAT when they enter a criminal justice setting may continue receiving this treatment, and those who are not on treatment may initiate and continue this form of care while incarcerated and then be linked with appropriate care providers to continue MAT upon release.*

Why this strategy works

MAT is one of the most effective forms of treatment available for opioid use disorders. MAT has been shown to lower rates of illicit drug use, lower risk of overdose, lower rates of drug-related crime, and increase engagement with many other essential forms of healthcare.

Providing MAT in jails and prisons not only brings healthcare in correctional facilities in line with current medical standards for the treatment of this medical disorder, it also improves the likelihood that incarcerated persons will engage in care in the future and lowers the likelihood of relapse, problem opioid use, and risky opioid use after release.

MAT in criminal justice settings works best when:

- MAT is uninterrupted for those who were receiving care prior to incarceration.[76]
- MAT can be initiated in criminal justice settings.[69]
- Individuals have access to all available forms of MAT medication. This choice is essential, as some individuals fare much better (or worse) on one of these drugs than on the other.[28]
- An effective system for referral and linkage to care is in place so that individuals on MAT can receive a "warm handoff" to providers who are able to continue their care upon release.[77] Otherwise, recently released individuals are forced to choose between enduring painful opioid withdrawal and quickly finding another source of opioids. The quickest and easiest sources of opioids are illicit ones.

*Medicare and Medicaid generally do not pay for services rendered to individuals in custodial settings. Applicable statutory and/or regulatory exclusions will apply.

TRAILBLAZERS

Rikers Island Correctional Facility, New York City's jail, has been offering MAT with opioid agonist medication to inmates since 1987. Today, the facility provides both methadone and buprenorphine.

Vermont began piloting MAT care with methadone and buprenorphine at two of its jails in 2014.

In 2016, Rhode Island became the first state to implement a program offering buprenorphine, methadone, or naltrexone to all incarcerated persons (in jail or in prison) with substance use disorder, both maintaining those who became incarcerated and initiating many into MAT care for the first time.

MAT in criminal justice settings and upon release—What the research says

- Multiple studies have found that MAT in correctional facilities is associated with decreased heroin use, decreased levels of syringe sharing, decreased criminal activity, and a significantly higher probability of engaging with treatment upon release.[78–81]
- A study conducted among nearly 300 incarcerated persons in Rhode Island concluded that forced withdrawal from methadone upon incarceration (among those who were receiving methadone prior to incarceration) reduces the likelihood that an individual will engage in care after release.[82] Forced withdrawal is required in correctional facilities where MAT is not available.
- A study conducted at Rikers Island found that individuals given buprenorphine-based MAT during a 10–90-day incarceration were more likely than those given methadone-based MAT to continue treatment after release.[83]
- A Baltimore study found that incarcerated individuals who received methadone stayed in treatment for an average of 166 days in the year following their release, whereas those who received only counseling but no MAT engaged in treatment for an average of 23 days following release and were more likely to test positive for opioids at 12 months after release.[84]
- Within one year of initiating its new MAT program in all state adult correctional facilities, the state of Rhode Island observed a 60% decrease in the proportion of recently incarcerated individuals who suffered a fatal overdose. The state also observed a 12% overall decrease in overdose fatalities compared to the previous year, which can be attributed to the deaths prevented by the prison's MAT program.[85]

Initiating Buprenorphine-based MAT in Emergency Departments

Patients receiving care in emergency departments who have untreated opioid use disorder are referred to a provider for long-term buprenorphine-based MAT. This referral is accompanied by initial doses of buprenorphine or a short-term prescription that can be filled right away. The patient can begin treatment immediately, instead of waiting several days for their appointment with a new provider.

Why this strategy works

Even if a patient in the emergency department is very eager to begin MAT, receiving a referral and possibly waiting several days to begin care greatly decreases the likelihood that this patient will successfully engage in care. Providing an initial dose of buprenorphine in the emergency department eliminates these delays in care and allows the patient to begin experiencing the benefits of MAT immediately. Subsequent daily doses provided by the hospital (either by prescription or by supervised consumption at the hospital pharmacy) serve as a "bridge," providing the patient with care on a temporary basis, if necessary, while a referral and "warm hand off" to a physician who can continue to provide MAT is carried out.

Initiating buprenorphine-based MAT in emergency departments works best when:

There is no broadly accepted "best practice" for initiating patients onto buprenorphine-based MAT in an emergency department. This intervention is very new, and researchers are still studying how best to serve patients' needs and assist them in engaging with care. Patients who are initiated in the emergency department are very likely there because they have experienced an overdose crisis. It can be expected that such an experience may change the meaning of treatment for these patients, and the value of treatment may change in an inconsistent or counter-intuitive way over time.

What we do know, however, is that each instance of engagement in MAT, even if the patient eventually drops out of care, predicts higher success the next time treatment is sought. Furthermore, providing "bridging" doses of MAT medications to individuals seeking treatment greatly improves patient engagement in MAT care during treatment initiation—a key moment for those with opioid use disorder, when maintaining trust and stability is of utmost importance.[86,87]

TRAILBLAZERS

Yale University Hospital in New Haven, Connecticut, was the first institution to begin initiating MAT in their emergency department in 2015. They found that patients who started MAT in the emergency department were twice as likely to be in engaged in treatment 30 days after discharge.

Boston Medical Center operates the Faster Paths to Treatment program in a similar way. The program also initiates patients with opioid use disorder hospitalized for other conditions and people in residential treatment programs in the community who request or would benefit from MAT. Patients are immediately stabilized on buprenorphine or connected to a methadone program and then actively transitioned to a primary care provider or other provider of long-term care. Patient navigators assist patients in connecting with and continuing care.

Initiating buprenorphine-based MAT in emergency departments—What the research says

- A 2010 study conducted in a location with very long wait lists (6 months or more) for MAT provided those who were seeking treatment through a personal physician or a licensed opioid treatment program with immediate access to buprenorphine via prescription while they waited for a slot in a formal treatment program. Compared to those who were not offered this medication immediately, these individuals reported significant reductions in illicit opioid use, opioid withdrawal symptoms, and opioid cravings, even before they began wrap-around treatment. The medication adherence rate was 99%, indicating almost no medication diversion.[86,87]
- Yale University Hospital conducted a randomized controlled trial to test the effect of initiating patients on buprenorphine in the emergency department and then continuing that MAT in primary care. Two months later, those patients who received buprenorphine prior to a referral for MAT were more likely to be engaged in care and had lower rates of illicit opioid use. Six months later, the study's findings were less encouraging, which indicates that patients initiated onto MAT in the emergency department may need additional supports to remain engaged in care.[88] The hospital now employs patient navigators and counselors to support patients who may be struggling to maintain their treatment.

Syringe Services Programs

Sometimes called "needle exchange" or "syringe exchange," syringe services programs provide access to clean and sterile equipment used for the preparation and consumption of drugs as well as tools for the prevention and reversal of opioid overdose, such as naloxone training and distribution, fentanyl testing strips, and more. Comprehensive syringe services programs also provide additional social and medical services such as: safe disposal of syringes and needles; testing for HIV and hepatitis C infection and linkage to treatment; education about overdose and safer injection practices; referral and access to drug treatment programs, including MAT; tools to prevent HIV and other infectious disease, such as condoms, counseling, or vaccinations; and linkage to medical, mental health, and social services.

Why this strategy works

Syringe services programs are a key component of overdose prevention strategies, because they can facilitate access to and uptake of services and interventions for reducing overdose, enhancing health and wellbeing, and improving public health and public safety.

First, some, but not all, people who use drugs experience homelessness, poverty, and other social or financial insecurities that make acquiring clean injection equipment challenging, even in locations where syringes can be purchased without a prescription. The free distribution of clean injection equipment lowers the frequency of syringe sharing and re-use,[89–91] with major protective impacts on the rates of infectious diseases like HIV and hepatitis C as well as other injection-related infections or soft tissue injury.[92,93] Individuals who participate in syringe services programs are also more likely to seek treatment for a substance use disorder.[94]

Second, syringe services programs provide people who use drugs a non-judgmental environment in which they are able to build supportive and trusting relationships, talk freely about their needs and concerns, and re-enforce feelings of self-worth, empowerment, and control. Relief from the shame and judgment carried by the stigma associated with drug use gives people the freedom to think objectively about the risks their drug use may pose to themselves and others and to strategize steps they can take to mitigate those risks. For people who are socially marginalized and have internalized stigma about their drug use, these services can substantially benefit their safety and chances of survival.

Third, if and when someone who uses drugs chooses to seek medical care, naloxone access, or substance abuse treatment, syringe services programs and their staff are able to help their participants connect with and navigate these services, making syringe services programs a key component of overdose prevention efforts on all fronts.

Syringe services programs work best when:

- They provide an adequate supply of sterile syringes. Limiting the number of syringes an individual may receive reduces the effectiveness of the intervention. Programs with one-for-one exchange policies, for example, allow participants only as many syringes as the number of used syringes they return, thus undercutting the program's own effectiveness.[95] When no limits are set on the number of syringes distributed, participants are more likely to have clean syringes on hand when they need them, and they can provide syringes to many more people than can attend the program themselves, thus multiplying the program's effectiveness. This also increases participants' incentive to visit the program and interact with staff and counselors.[96]
- The needs and concerns specific to the local drug using community are addressed and accommodated by the program.[97]
- Program participants who are seeking treatment for opioid use disorder or for other physical or mental health concerns are offered assistance in accessing appropriate care.[98,99]

Syringe services programs—What the research says

- Syringe services program participants are five times more likely to enter drug treatment and 3.5 times more likely to cease injecting compared to those who don't utilize these programs.[100]
- Syringe services programs are more effective at preventing disease and maximizing service coverage when distribution rules are less restrictive, such as when the program is distribution-based, not exchange-based, and when distribution limits are high.[95,101]
- A key element to the success of syringe service programs in reducing disease and overdose and in connecting more participants with care is the refocusing of public responses to drug use away from criminal justice approaches, which discourage safer drug use behaviors and requests for help, to public health approaches focused on the underlying drivers of these risks.[102] Law enforcement officials can play an important role as partners in this shift by directing people found using illicit drugs to treatment programs rather than arresting and detaining them.
- A recent study found that individuals who use drugs who were recently incarcerated are at significantly higher risk of overdose and are more willing than their non-incarcerated peers to receive training for and administer naloxone when this is offered by a syringe services program, making syringe service programs a particularly important intervention for assisting these high-risk individuals.[103]
- Some regions have begun implementing syringe access and disposal services at pharmacies and have achieved success in decreasing syringe sharing and reuse.[104] However, a study in San Francisco found that more than 65% of interviewees who used drugs regularly disposed of syringes at syringe service programs, and almost none disposed of syringes at pharmacies, indicating that pharmacies alone cannot fill the role played by these programs with respect to syringe disposal.[105]

TRAILBLAZERS

The concept of syringe access was borne from local efforts to prevent hepatitis B in the 1980s in Rotterdam, Holland.

In the 1990s, the U.S. government funded several studies that demonstrated the effectiveness of syringe services programs, leading then-Secretary of HHS Donna Shalala and NIDA Director Nora Volkow to herald the efficacy of these programs.

By 2014, syringe services programs were operating in nearly 200 U.S. cities.

In 2015, Congress lifted a ban on federal funding for syringe services programs, allowing federal funds to be used to support syringe service programs and the wrap-around services that are a part of the program; however, federal funds cannot be used to purchase the actual syringes distributed.[106]

In 2015, Kentucky opened numerous syringe service programs across the state. These programs offer all participants referrals to drug treatment, case management, HIV and hepatitis C testing and referral to treatment, syringe access, and safe syringe disposal services. In the first six months of operation, these programs served more than 1400 unique individuals and distributed more than 128,000 clean syringes. A similar syringe service program run by the Cabell-Huntington Health Department in West Virginia helped reduce the proportion of their clients sharing syringes from above 25% to below 10% between September 2015 and March 2016.

The People's Harm Reduction Alliance, a community organization that provides syringe services to communities across western Washington and northern Oregon, employs a variety of methods for reaching individuals in need of services including stationary or "brick and mortar" locations and supply delivery on demand by car, by bike, or on foot. Since 2007, the organization has distributed more than 10,000 naloxone kits and has recorded more than 5,000 overdose reversals based on client reports.

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OPIOID-OVERDOSE REDUCTION CONTINUUM OF CARE APPROACH (ORCCA)

PRACTICE GUIDE 2023

NIH National Institute on Drug Abuse

SAMHSA Substance Abuse and Mental Health Services Administration

Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) Practice Guide

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NIH HEAL INITIATIVE
HEALing Communities Study

Released 2023

Contents

Key Terms

TERM	DEFINITION
Addiction	Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases. See American Society of Addiction Medicine Definition of Addiction
Behavioral Health	The term "behavioral health" means the promotion of mental health, resilience, and well-being; the treatment of mental health conditions and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.
Continuum of Care	An integrated system of care that guides and tracks a person over time through a comprehensive array of health services appropriate to the individual's need. A continuum of care may include prevention, early intervention, treatment, continuing care, and recovery support.
Evidence-Based Practice (EBP)	Evidence-based practices are interventions that are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the persons receiving the services that promote individual-level or population-level outcomes.
Harm Reduction	Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of people who use drugs, especially those in underserved communities, in these strategies and the practices that flow from them. See SAMHSA–Harm Reduction
Intersectionality	The complex, cumulative intertwining of social identities that result in unique experiences, opportunities, and barriers. People may use "intersectionality" to refer to the many facets of our identities and how those facets intersect. Some use the term to refer to the compound nature of multiple systemic oppressions.
Justice-Involved	This descriptor indicates past or current involvement in the criminal legal system, typically indicating the person has experienced one or more of the following: an arrest, prosecution, incarceration in a jail or prison, and/or community supervision.
Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex + (LGBTQI+)	Lesbian, gay, bisexual, transgender, queer, those who are questioning their sexual orientation or gender identity, and others who are not cisgender or straight/heterosexual. LGBTQI+ is used interchangeably with "sexual and gender minority."

TERM	DEFINITION
Medication for Opioid Use Disorder (MOUD)	This term refers to the class of medications that are FDA-approved for the treatment of opioid use disorder (OUD). They are often used in combination with counseling and other behavioral therapies to provide a whole-patient approach to the treatment of OUD. This class of medications includes buprenorphine, methadone, and naltrexone in different formulations. See SAMHSA Medications, Counseling, and Related Conditions
Peer Distribution	Peers are people with lived experience from the community. In a peer distribution program, peers distribute naloxone to others within the community outside of formal settings (e.g., medical offices, harm reduction agencies).
Peer Support Workers	Peer support workers are people with lived or living experience who help others experiencing similar situations.
Peer Recovery Support Services	Services provided by peer support workers may include emotional (e.g., mentoring), informational (e.g., parenting class), instrumental (e.g., accessing community services), and affiliational (e.g., social events) support. See SAMHSA Peer Support Workers for those in Recovery
People with Lived Experience (PWLE)	People who currently use or formerly used opioids, or their family members.
Recovery	Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery: • Health: overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being. • Home: having a stable and safe place to live. • Purpose: conducting meaningful daily activities and having the independence, income, and resources to participate in society. • Community: having relationships and social networks that provide support, friendship, love, and hope. See SAMHSA Recovery and Recovery Support
Social Determinants of Health	Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The Social Determinants of Health cover five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. See Healthy People 2030: Social Determinants of Health
Stigma	Stigma arises from the negative feelings that many individuals harbor against people struggling with mental and/or substance use disorders, and their beliefs that poor personal choices, "moral failing," and defects of character are to blame for the disease. Stigma can reduce willingness of policymakers to allocate resources, reduce willingness of providers in non-specialty settings to screen for and address mental health conditions and substance use disorders, impact a person's standing in their community, limit access to employment or housing, and may limit willingness of individuals with these conditions to seek treatment. Some people object to this term as it may perpetuate a negative connotation. Others favor "prejudice and discrimination" as the societal attitudes and actions that reinforce negative stereotypes and policies.

TERM	DEFINITION
Telemedicine	"Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment… [Medicaid] does not recognize telemedicine as a distinct service." See SAMHSA CCBHCs Using Telehealth or Telemedicine
Telehealth	By contrast, telehealth is usually used as a broader term. Telehealth typically includes not only telemedicine but also other forms of telecommunication, including asynchronous or "store and forward" systems, which transfer a patient's data or images for a physician or practitioner at another site to access at a later time. With these systems, the patient and provider do not have to be present at the same time. See SAMHSA CCBHCs Using Telehealth or Telemedicine
Trauma	SAMHSA describes individual trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." See SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach
Trauma-Informed Approach	A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization. Referred to variably as "trauma-informed care" or "trauma-informed approach," this framework is regarded as essential to the context of care. See SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Acronyms

ASAM	American Society of Addiction Medicine
ASTHO	Association of State and Territorial Health Officials
CDC	Centers for Disease Control and Prevention
CME	Continuing medication education
CTH	Communities That HEAL
CTN	Clinical Trials Network
DEA	Drug Enforcement Administration
EBP	Evidence-based practice
FDA	U.S. Food and Drug Administration
HCS	HEALing Communities Study
MAT	Medication-Assisted Treatment
MOUD	Medication for opioid use disorder
OBAT	Office-Based Addiction Treatment
OEND	Opioid overdose prevention education and naloxone distribution
ORCCA	Opioid-Overdose Reduction Continuum of Care Approach
OTP	Opioid treatment program
OUD	Opioid use disorder
PAARI	Police Assisted and Addiction Recovery Initiative
PCSS	Providers Clinical Support System
PDMP	Prescription drug monitoring program
PWLE	People with lived experience
PWUD	People who use drugs
SAMHSA	Substance Abuse and Mental Health Services Administration
SSP	Syringe service program
SUD	Substance use disorder
TTC	Technology Transfer Center
VA	U.S. Department of Veterans Affairs

1. Overview

This guide includes **(1)** a menu of evidence-based practices for reducing opioid overdose deaths and **(2)** real-world tips for implementing the evidence-based practices.

What is the Purpose of this Practice Guide?

This guide was developed to help the workforce, community members, and volunteers that provide opioid use disorder (OUD) treatment, harm reduction and recovery services respond to the opioid crisis in their communities.

Who is This Guide For?

This guide was developed for the Substance Abuse and Mental Health Services Administration (SAMHSA) Technology Transfer Centers (TTC) program and other providers of technical assistance as a resource for individuals working to end the opioid crisis. These individuals include community coalition members, professional treatment providers, recovery support specialists, people with lived experience, policymakers, recovery program administrators, and many others working to prevent, treat, and support recovery from substance use disorders. This guide is particularly designed for individuals at the front lines of the opioid response.

Evidence-based practices are approaches that have been shown, through research and evaluation, to be effective in decreasing opioid overdose deaths.

Care continuum is the span of care across prevention, diagnosis, engagement, and retention in OUD treatment.

Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives. (SAMHSA).

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

How Was This Guide Developed?

This guide is based on the Opioid-Overdose Reduction Continuum of Care Approach (ORCCA), which was developed as part of the HEALing Communities Study (HCS). In this study, researchers worked with community coalitions to implement the Communities That HEAL (CTH) intervention, which created data-driven action plans for reducing opioid overdose deaths by implementing evidence-based practices across the care continuum.

See **Appendix B** and the following website for more information about the study: https://hcs.rti.org

To create this practice guide, an eight-person technical expert panel reviewed key ORCCA content and made recommendations for translating ORCCA content into a resource for TTC networks. The panel included people with lived experience, experts from recovery and harm reduction agencies, SAMHSA, National Institute on Drug Abuse, and the HCS. All experts provided input on the guide and reviewed the final product. A companion practice guide, "Engaging Community Coalitions to Decrease Opioid Overdose Deaths," features tools and real-world examples that can be used to build and strengthen community coalitions that work to reduce opioid overdose deaths.

See **Appendices C and D** for more information on technical expert panel members.

What Is in This Guide?

This practice guide includes **guidance**, **resources**, and **insights** from the study sites and subject matter experts on implementing strategies from the ORCCA to reduce opioid overdose deaths.

Throughout this guide, we highlight **"Stories from the Field,"** in-depth examples of the challenges coalitions implementing the CTH intervention faced, their solutions, and their lessons learned.

Section 2 introduces the ORCCA and menu strategies. **Section 3** provides guidance on how to identify higher risk populations and priority settings and assess community needs and assets to inform EBP selection. **Section 4** reviews opioid overdose prevention education and naloxone distribution strategies, including the rationale, supporting research, challenges and solutions related to the strategies, and implementation resources. **Section 5** reviews medication for opioid use disorder strategies, including the rationale, supporting research, challenges and solutions related to the strategies, and implementation resources. **Section 6** reviews safer prescribing and medication disposal strategies, including the rationale, supporting research, challenges and solutions related to the strategies, and implementation resources. **Appendices** present additional information about the HCS study, biographies for the technical expert panel, and additional details on guide development.

2. Introduction

WHAT IS THE ORCCA?

The Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) is designed to help communities reduce opioid overdose deaths. Created by a workgroup of experts from four research sites implementing the Communities That HEAL intervention, the ORCCA menu features a selection of evidence-based practices across **three** overarching "menu" categories:

1

Opioid overdose prevention education and naloxone distribution in higher risk populations

2

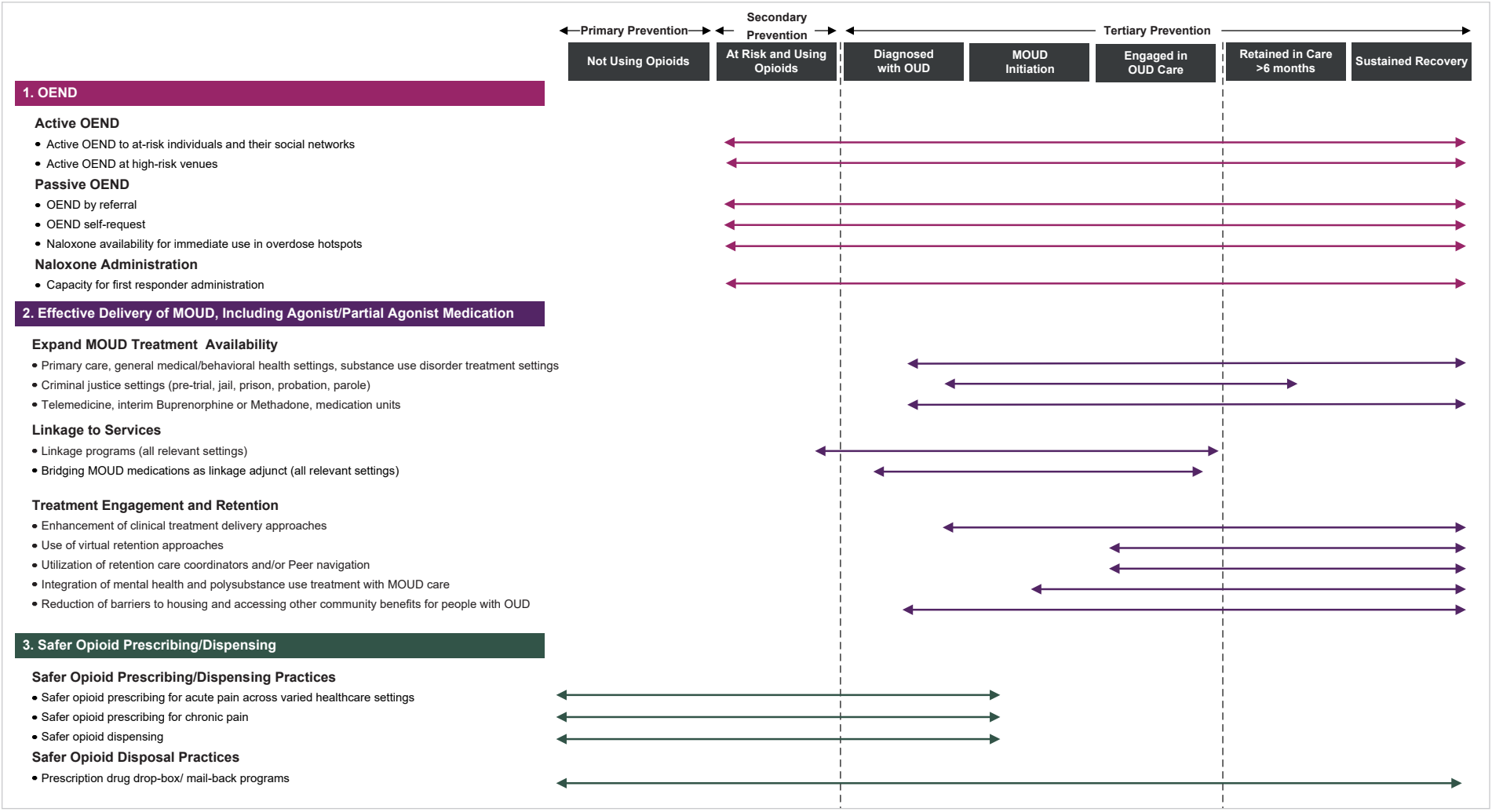
Effective delivery of medication for opioid use disorder treatment with outreach and delivery to higher risk populations

3

Safer opioid prescribing and dispensing

The ORCCA was adapted from the Cascades of Care for OUD developed by Williams and colleagues[1] and is purposefully designed to overlap strategies to reduce opioid overdose fatalities across a continuum of care.

Figure 1. The HEALing Communities Study Opioid-Overdose Reduction Continuum of Care Approach with Sample Strategies



3. Tips for Data-Driven Strategy Selection

Data-driven strategy selection means using community data to guide the selection and implementation of evidence-based practices (EBPs). Communities impacted by the opioid overdose crisis are best positioned to identify what assets or barriers exist that might impact strategy implementation. So, community members should be **front and center** in making the decisions about how to respond to the opioid crisis in their community.

This section of the guide provides tips and resources to help you complete key steps in the data-driven strategy selection process:

1. Engage **community experts**
2. Conduct a **community assessment**
3. Identify **priority populations** (people at higher risk of opioid overdose)
4. Prioritize **settings** (settings used by priority populations)

Engage Community Experts

Ensuring that people most affected by the opioid overdose crisis and those at higher risk of opioid overdose have an **active** role in selecting and implementing strategies will maximize the impact of your opioid overdose interventions.

People with lived experience (PWLE) and people who use drugs (PWUD) include people who currently use or formerly used opioids or their family members. These people can provide key insights on treatment experiences, harm reduction approaches, community-held beliefs that might affect the reach of EBP strategies, and anticipated challenges and facilitators for implementing strategies.

Our expert panel and research sites shared the following best practices for working with PWLE and PWUD:

Prioritizing the Voices of PWLE/PWUD

Harm reduction, considered a social policy and public health model, was born out of grassroots efforts by PWUD and community activists. PWUD play a critical role in identifying emerging issues, particularly in the evolving drug supply and associated health behaviors and outcomes.

PWUD are the only population at risk for overdose and therefore are the very people our work must prioritize and protect. We need their expertise and lived experience to be successful.

KEY INSIGHTS

- Recognize publicly and privately that their knowledge is valuable.
- Allow people to decide how to introduce themselves and their story. Accept that “PWUD” or “PWLE” may not be what experts want to be called.
- Avoid tokenism, or only inviting a person from an underrepresented group to participate to give the appearance that the coalition is diverse and inclusive.
- Foster an environment of listening and open-mindedness.
- Model respectful, person-first language and discuss the impact of stigmatizing terms.
- Advocate that health and wellness is deserved by everyone, including those actively using.
- Don’t assume that one person or a few people can speak for an entire group of people. Seek out multiple perspectives.
- Emphasize that the knowledge and insights of PWLE/PWUD will be incorporated meaningfully into strategy selection, implementation, and evaluation.

Please see the companion practice guide "Engaging Community Coalitions to Decrease Opioid Overdose Deaths" for additional guidance on how to successfully engage PWLE/PWUD in a way that protects their well-being and insights into building and maintaining coalitions to decrease opioid overdose deaths.

Members of local organizations that deliver services to people at higher risk of opioid overdose (e.g., syringe service programs [SSPs], addiction treatment organizations) in your community can share information about how different strategies have worked or might work in their settings. These members can share patient and provider experiences with EBP strategies to date.

Additional resources for engaging people with lived experience

- International Network of People who Use Drugs
- National Harm Reduction Coalition
- National Harm Reduction Technical Assistance Center: offers access to free help in providing or planning to provide harm reduction services

Conduct a Community Assessment

A community assessment seeks to determine what is currently being done to address the opioid crisis in your community, including where services are provided and the extent to which services are reaching people at higher risk for overdose. This information informs the selection and implementation of EBPs. For example, you may decide to expand existing services or select strategies that help fill gaps in services.

Work with community experts to conduct the community assessment **(Tool 1)**. PWLE and service providers can identify service gaps and opportunities for enhancing existing services. You can also use online search tools, such as Google, to gather information about opioid use disorder (OUD) prevention and treatment services in your community.

When seeking community expertise to inform strategy selection, consider your community's:

- Sociodemographic characteristics (race, ethnicity, age distribution, etc.)
- Sociocultural characteristics (political climate, religion, country of origin, languages spoken)
- History of opioid overdose–related work within the community and key leaders

The most successful efforts will establish buy-in and build trust among community members and community leaders.

Tool 1: Guiding Questions for a Community Assessment

Instructions: The following interactive worksheet can be used to answer questions regarding your community. You must download and save the file to your computer before filling it out. Completing the form within your web browser will not save your work.

FOCUS & GUIDING QUESTIONS
Existing Services
» What are existing services for people at higher risk of opioid overdose in our community? – What substance use treatment services are available?
– Recovery support?
– Social services? (refer to the "prioritize settings" subsection for a full list of settings to consider)
Information sources: » Speak with community members about available services, including: – PWLE, including PWUD; Recovery support service providers; Staff at harm reduction agencies; Treatment providers » Search online for community resources » Search for providers using SAMHSA's Buprenorphine Practitioner Locator

continued

Tool 1: Guiding Questions for a Community Assessment (*continued*)

FOCUS & GUIDING QUESTIONS
Service Gaps
» What are the most pressing gaps between existing and needed services?
» What services have people at higher risk of overdose sought out and haven't been able to locate?
» What are the greatest needs expressed by community experts?
» What populations are underserved?
Information sources: » Community members » Recovery support service providers » Staff at harm reduction agencies » Treatment providers

continued

Tool 1: Guiding Questions for a Community Assessment (*continued*)

FOCUS & GUIDING QUESTIONS
Feasibility
» What level of resources (staff, facilities, materials, and funding) are available?
» What time is available to implement the strategy?
» What is community buy-in (i.e., is there support for harm reduction services or new treatment services)?
» How could community factors affect implementation of EBPs?
Information sources: » Available funding opportunities, including grants and opioid settlement funds » Community members and service providers » Local news reports or media coverage on the opioid overdose crisis to assess community buy-in

continued

Tool 1: Guiding Questions for a Community Assessment (*continued*)

FOCUS & GUIDING QUESTIONS	
Potential Impact	
» How can we have the largest potential impact on decreasing opioid overdose deaths in the community?	
» Who is overdosing (e.g., age, race/ethnicity)?	
» Where are overdoses occurring (e.g., which neighborhoods)?	
» In what settings are people overdosing (e.g., shelters, public restrooms, motels, residential settings)?	
Information sources: » Public health department surveillance data on overdose and overdose fatalities: NEMSIS nonfatal overdose dashboard » Mortality data from the coroner/medical examiner's office » 911 call records and 311 data from emergency medical services (EMS)	» Hospital emergency department (ED) data » Police reports of drug arrests » Local drug treatment centers » Harm reduction agencies » State level: NVSS Provisional Drug Overdose Death Counts

continued

Tool 1: Guiding Questions for a Community Assessment (*continued*)

FOCUS & GUIDING QUESTIONS
Sustainability
» What is the plan for sustainability?
» How will success be measured?
» What is the goal timeline for evaluation?
» What populations are underserved?
Information sources: » Available funding opportunities, including grants and opioid settlement funds » Potential evaluation strategies

When implementing the Communities That HEAL (CTH) intervention, research sites engaged communities in EBP strategy selection and implementation through coalitions. Coalitions followed a **phased intervention process** that included conducting community assessments and identifying priority populations and settings for EBP strategies).[2] Additional resources related to community engagement, the phased intervention process, and EBP implementation will be added to the dissemination website as the study winds down.

Identify Priority Populations

To have the biggest impact on opioid overdose deaths, EBP strategies must **reach people who are most at risk of overdose**. This step should not be connected to any criminal legal purpose; this should be emphasized when working with community members and partner organizations, including law enforcement.

Once priority populations are identified, you can select strategies that are most likely to reach priority populations. For example, if community data show that younger people who inject drugs make up most opioid overdose–related deaths in your community, you may consider working with harm reduction agencies to reach this priority population.

When identifying priority populations, consider groups at higher risk of opioid overdose, groups experiencing health inequities, and groups that face racism and discrimination in addition to stigma associated with drug use.

Higher risk populations include people who:

- have had a prior opioid overdose;
- have reduced opioid tolerance (e.g., from completing medically supervised or socially managed withdrawal or upon release from institutional setting such as jail, residential treatment, or hospital);
- use other substances (e.g., alcohol, benzodiazepines, cocaine, or amphetamine-like substances);
- have OUD and major mental illness (e.g., major depression, bipolar disorder, schizophrenia, anxiety disorders);
- have OUD and major medical illness (e.g., cirrhosis, chronic renal insufficiency, chronic obstructive pulmonary disease, asthma, sleep apnea, congestive heart failure; infections related to drug use); or
- inject drugs.

To promote health equity, it is critical to identify and work to reach populations that experience disparities in OUD services and outcomes. Underserved communities have been and remain disproportionately affected by opioid overdose and premature mortality because of substance use, exclusion from access to high-quality care, and criminalization. It is of added importance to tailor strategies with **cultural humility to address racial and ethnic inequities** Some best practice tools for integrating equity into strategy selection and implementation include the following:

- The Opioid Crisis and the Black/African American Population: An Urgent Issue
- Racial Equity and Social Justice Process Guide
- Equitable Hiring Tool
- Fast Track Equity Analysis Tool
- Comprehensive Equity Analysis Tool

Be mindful of intersectionality when identifying groups and tailor strategies to better reach them. Intersectionality impacts people who use substances and have multiple other parts of their identity that are stigmatized. This can lead to compounded challenges in protecting oneself and barriers to accessing and staying in care. Consideration and assessment of the impact on health outcomes for these people is warranted.

Although these special populations may not be specifically prioritized, and technical guidance unique to their identities may be unavailable, **acknowledging membership in these special groups and the discrimination and unique challenges they face** can help to ensure that interventions and programs are inclusive and more equitable. These populations include the following:

- Adolescents
- Pregnant and postpartum women
- People without stable housing, rural populations without transportation, and other populations impacted by factors related to poverty
- Veterans
- Non–English-speaking populations and immigrants
- People with mental health disorders and mental/physical disabilities
- People who use multiple substances
- People involved in transactional sex
- People who have chronic pain
- People who are lesbian, gay, bisexual, transgender, or queer (LGBTQI+)

Approaches to identify higher risk populations

Higher risk populations can be identified through

1. screening in settings where higher risk people seek services,
2. conducting outreach, or
3. using surveillance and other data sources.

Screening in priority settings. Priority settings include SSPs, EDs, hotlines, first responder stations, and other settings (full list in the Prioritize Settings section). People accessing these services can be screened using existing tools (see box to the right). Note that screening within service venues identifies higher risk people who initiate contact with a service venue and self-report their risk. It will *not* identify higher risk people who are not connected to a venue where screening occurs or do not disclose their risk. Outreach is recommended to identify these people.

Potential screening criteria:

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

Single-item Drug Screening Question

TAPS Tool (Tobacco, Alcohol, Prescription Medication and Other Substance Use)

Rapid Opioid dependency screen (RODS)

Brief Screener for Tobacco, Alcohol, and other Drugs (BSTAD)

Outreach and identification within field settings. Outreach can be used to identify people who do not attend a service venue or who may not disclose their risk, for example, using peer support workers for outreach in neighborhood hotspots to identify people with OUD, post-overdose public health outreach,[4] or mobile vans.[6]

Surveillance systems and other data sources. Another way to identify people who do not initiate contact at priority settings or self-disclose risk is to use surveillance and other data sources. Rapid and proactive use of existing data can also be used to detect overdose "outbreaks." Potential data sources include medical records to identify frequent users of specific health services, substance use treatment records, or records of people with criminal legal system involvement. Please note that using nonfatal overdose records (911 calls/EMS; 311 calls, ED records) and records of people having called hotlines to conduct outreach can have a paradoxical effect (see below), and use of 911 records is *not* a recommended approach.

Approaches and field settings for outreach

- Peers and social networks
- Family members
- Community outreach events
- Mobile vans[5]
- Drug checking
- Media outlets (awareness campaigns)
- Local business leaders
- Barbershops and hair salons
- Elected officials
- Libraries
- Colleges, universities, and trade schools
- Religious organizations and houses of worship

Efforts to identify and reach out to high-risk people should be mindful of the stigma and barriers that many face when seeking care or self-identifying as a person who uses opioids. Guidance on how to conduct post-overdose outreach and follow-up is shared in this SAMHSA guide, which states: "*Visits rest on a foundation of consent and respect for privacy and confidentiality. Outreach teams that include law enforcement should make every attempt to minimize fear of arrest.*" Identification efforts can have the paradoxical effect of making people less likely to seek care if respect for people who use opioids is not considered.

For example, using 911 call records[7] to identify people at higher risk often furthers suspicion of authorities and can lead to people being less willing to call 911 in the future. Therefore, use of 911 record data is not recommended for outreach purposes. Using records of people who have recently discontinued substance use treatment may lead to distrust in the medical system. Working with PWLE in your community can help ensure that the methods of identification and outreach are conducted in a way that engages and empowers those you are seeking to help.

Implementation resources for identifying people at higher risk of opioid overdose

- Screening for Drug Use in General Medical Settings: This NIH toolkit provides guidance on screening for drug use.
- Guide to Developing and Managing Syringe Access Programs: This is a 92-page manual from the Harm Reduction Coalition that describes the process of implementing a Syringe Access Program.
- SAMHSA "Now What? The Role of Prevention Following a Nonfatal Opioid Overdose": This is a 9-page document that describes ED screening and engaging with people following nonfatal overdose.

Prioritize Settings

Based on what you learned from the community assessment, identify priority settings for implementing EBP strategies. Also, consider which settings have the highest potential for reaching priority population groups. In the CTH, communities worked to implement EBP strategies in multiple settings across four sectors: behavioral health, healthcare, the criminal legal system, and the community (**Tool 2**).

Tool 2: Potential Settings for Strategy Implementation

SECTION	SETTING
Behavioral Health	» Syringe service programs » Addiction treatment and recovery facilities » Mental/behavioral health treatment facilities » Homeless shelters » Recovery housing » Department of Community-Based Services » Domestic violence programs
Health Care	» Emergency department » Health department » Pharmacy » Inpatient service » Outpatient clinics » Ambulatory surgery » Dental clinics

continued

SECTION	SETTING
Criminal Legal	» Jails » Community Supervision programs » First responder stations » Pretrial services » Drug courts or other specialty courts
Community	» Media outlets » Chamber of Commerce » Barbershops and hair salons » Libraries » Colleges, universities, and trade schools » Religious organizations and houses of worship » Restaurants/bars » Gas stations

Implementation resources for prioritizing settings

- Position Paper on Community Strategies for Post Opioid Overdose Interventions: This is a 15-page paper written by the New York State Department of Health detailing the development of a Post Opioid Overdose outreach program. It features information about the creation of an outreach team, how to share information, legal issues, and how to conduct a post-overdose outreach visit and program evaluation.
- Kraft Center for Community Health Mobile Addiction Services Toolkit: This toolkit provides a comprehensive overview of how to launch and operate a mobile addiction program following the Community Care in Reach® model. Included are sample protocols, best practices, and lessons learned.
- Police Assisted and Addiction Recovery Initiative (PAARI): This is a website for law enforcement agencies to develop non-arrest pathways to treatment and recovery. This may be useful for developing programs where people are taken to treatment environments rather than being arrested.

Selecting Strategies

Strategy selection and implementation should be tailored to the needs and assets of your community, be informed by local experts (including PWLE), and focus on priority populations and settings. To select EBP strategies, decision-making approaches like a Strengths, Weaknesses, Opportunities, and Threats analysis; developing SMART goals; or other decision-making tools can be helpful. Several example tools developed by sites implementing the CTH intervention are included in **Appendix A**. In general, EBPs that are both high impact and highly feasible should have top priority for selection.

Discussion Guide for Community Leaders: Preventing Opioid Overdose Deaths in Your Community

Prompt: Brainstorm! Think about your community: what you've experienced, what you have learned from your community, and what you envision for the future. Answer the questions below and jot down your thoughts.

Instructions: The following interactive worksheet can be used to answer questions regarding your community. You must save the file to your computer first and then fill it out. Do not complete the form within your web browser or your data will not be saved.

What are we doing well?

What could we do better?

What are our priority populations?

Where can we best engage our priority populations?

Increasing Opioid Overdose Prevention Education and Naloxone Distribution (OEND)

What OEND services already exist?

Who needs OEND in our community?

Where in our community should OEND services be provided?

Community OEND Goals:

1.

2.

3.

4.

continued

Discussion Guide for Community Leaders: Preventing Opioid Overdose Deaths in Your Community (continued)
Enhancing Delivery of Medication for Opioid Use Disorder (MOUD)
What are we doing well regarding MOUD provision?
What MOUD services already exist?
What are the gaps in MOUD care in our community?
Where in our community should MOUD services be expanded?
Where in our community can we reach people with OUD who are not receiving MOUD?
What services does our community need to engage people more effectively in and support people in treatment for OUD?
Community MOUD Goals:
1.
2.
3.
4.

continued

Discussion Guide for Community Leaders: Preventing Opioid Overdose Deaths in Your Community (continued)
Improving Prescription Opioid Safety
What are we doing well in terms of prescription opioid safety?
What prescription opioid safety concerns does our community have?
Who in our community needs to be engaged to improve prescription opioid safety (e.g. organizations, provider specialties, patient groups)?
Community Prescription Opioid Safety Goals:
1.
2.
3.
4.

4. Evidence-based Strategies to Increase Opioid Overdose Prevention Education and Naloxone Distribution

RATIONALE

Naloxone administration reverses an opioid overdose if administered in time. Naloxone is a medication that can be given as a nasal spray (Narcan®) or injected into the muscle, under the skin, or into the veins. Opioid overdose death is unlikely when another person is present and equipped with naloxone. Overdose prevention education is typically coupled with naloxone distribution and includes clear, direct messages about how to prevent opioid overdose in the first place and rescue a person who is overdosing. Opioid overdose prevention education and naloxone distribution (OEND) empowers trainees to respond to overdoses and can be successfully implemented at multiple venues among diverse populations. Community-level implementation of OEND directly to people who use drugs (PWUD) has been associated with reduced community-level opioid overdose mortality.

On March 29, 2023, the U.S. Food and Drug Administration (FDA) approved Narcan (nasal spray) for over-the-counter, nonprescription use.[8] This allows Narcan to be sold directly to consumers in drug stores, convenience stores, groceries, gas stations, and online. However, the retail cost of over-the-counter Narcan will likely be too expensive for many people at higher risk for opioid overdose.[9] Therefore, community distribution of naloxone directly to PWUD at no cost is a central component to an evidence-based response to the opioid crisis.

Goals: The OEND menu is designed to increase the number of:

1. Naloxone doses distributed
2. Overdose events where naloxone is administered
3. Opioid overdose prevention education programs

Active OEND

Active OEND is proactive distribution of overdose prevention and response education and naloxone rescue kits to **higher risk populations and their social networks (Tool 3)**. Examples of an active OEND program include distribution of naloxone through peers (people with lived experience from the community), providing naloxone kits to people upon release from a correctional facility, and first responders leaving behind a naloxone kit when responding to an emergency call related to an opioid overdose. Active OEND programs can be tailored to priority populations or located at venues where higher risk populations are likely to be engaged.

Overdose Education and Naloxone Distribution Outreach Manual

HCS-KY staff at the State Capitol for Overdose Awareness Day in Franklin County, Kentucky

This manual provides a blueprint for sustaining or launching successful OEND outreach programs based on lessons learned from the HEALing Communities Study in Kentucky.

Among its many features are venue outreach and scheduling ideas, a supply checklist, and a breakdown of program costs.

You can download the manual from this website: https://fw.uky.edu/HEALKYResources

Peer-reviewed literature to support OEND strategies

Key messages

- Naloxone administration by bystanders during an overdose significantly increases the odds of survival compared with no naloxone administration (Giglio et al.)
- Communities with enrollment in OEND programs distributing directly to PWUD had lower rates of opioid overdose deaths (Naumann et al., Walley et al.)

Key citations

- Giglio RE, Li G, DiMaggio CJ. Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis. Injury Epidemiology. 2015 Dec; 2:1-9.
- Naumann RB, Durrance CP, Ranapurwala SI, Austin AE, Proescholdbell S, Childs R, Marshall SW, Kansagra S, Shanahan ME. Impact of a community-based naloxone distribution program on opioid overdose death rates. Drug and Alcohol Dependence. 2019 Nov 1; 204:107536.
- Walley AY, Xuan Z, Hackman HH, Quinn E, Doe-Simkins M, Sorensen-Alawad A, Ruiz S, Ozonoff A. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ. 2013 Jan 31; 346.

OEND History and Harm Reduction

1961
Created in 1961, naloxone hydrochloride (naloxone) was approved by FDA to reverse opioid overdose.

1990s
Through the 1990s, naloxone was used exclusively by medical personnel in hospital settings.

1996
In 1996, the Chicago Recovery Alliance began distributing naloxone to people who used syringe services, beginning the world's first coordinated naloxone distribution program.

1996–present
Since then naloxone distribution has been a cornerstone of harm reduction, and people have reported using naloxone to revive friends, peers, partners, bystanders, neighbors, and family members.

Source: https://remedyallianceftp.org/pages/history

Multiple sequential doses of naloxone are more likely to be needed because of synthetic opioids: Many overdose reversals now require more than two doses of naloxone to reverse the overdose. During training, provide information on how circumstances surrounding the overdose can impact the way people respond to naloxone and that multiple doses may be necessary. Guidance should be to wait 2–3 minutes between administrations and that people can continue administering every 2–3 minutes until they run out of naloxone, the person becomes responsive, or EMS arrives.

This increased need also has implications on the frequency that naloxone will need to be restocked and the number of kits distributed per person.[10; 11]

Tool 3: Active OEND Strategies

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Active OEND for higher risk people and their social networks	• Are there existing programs in your community that could offer naloxone but don't? • Do the criminal legal venues in your community offer OEND? • What program or person could deliver OEND programming?	• **Identify gaps** in overdose prevention education programs that incorporate naloxone distribution • **Identify organizations to deliver the program** (e.g., community health educators, pharmacists, first responders), provide training on delivery of identified prevention program • **Implement** an overdose prevention education program	• Number of naloxone units distributed in communities through venues or community organizations • Number of jails providing OEND	• Criminal legal venues (jails, prisons, etc.) • Contacts within service venues • Public health department • Community organizations distributing naloxone

Implementation resources for active OEND strategies by priority setting	
Criminal legal settings	» Overdose Prevention in Community Corrections: An Environmental Scan: A 49-page toolkit developed by the National Council for Mental Wellbeing. The toolkit explores information regarding recovery-led practices for people under supervision of community corrections agencies.
Syringe Service Programs	» Harm Reduction Coalition Guide to Developing and Managing Syringe Access Programs: A five-module manual broken down into planning and design, key operational concerns, organizational considerations, external issues, and population-specific considerations. » Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation: A 33-page technical package of strategies to develop and implement SSPs. The document is for use by health departments, community-based organizations, and diverse stakeholders.

continued

Tool 3: Active OEND Strategies (continued)

Implementation resources for active OEND strategies by priority setting	
ED or acute care settings	» Prescribe to Prevent page for Emergency Medicine Providers: Includes sample ED policies and guidance.
"Leave-behind" programs at sites of overdose	» No toolkits currently available; refer to case example at the end of the chapter for details on how one community implemented a leave-behind program. » Research articles: • A scoping review of post opioid-overdose interventions • Post opioid overdose outreach by public health and public safety agencies: Exploration of emerging programs in Massachusetts » Example Leave Behind Protocol for EMS
Primary care, pain management, mental health, and addiction treatment settings	» Prescribe to Prevent page for Primary, Chronic Pain, and Palliative Care: Includes clinician guidance, materials to support naloxone prescribing, and opioid safety materials. » MA Practice Guidance for Integrating Overdose Prevention into Addiction Treatment: Outlines guidance for implementing opioid overdose prevention strategies into addiction treatment. The document should be used in addiction treatment centers and outlines how centers may update policy, change operations, training, and delivery to patients.

Passive OEND

Passive OEND is overdose prevention and response education and naloxone rescue kit distribution to **people referred by other care providers or for those seeking OEND on their own (Tool 4)**. Examples of a referral would be giving a prescription for naloxone to a higher risk person to pick up at a pharmacy or at a community OEND program. Examples of facilitating naloxone distribution include pharmacy standing order programs and community meetings that distribute naloxone rescue kits to people who ask for them.

Passive OEND **also includes programs that make naloxone publicly available for emergency use** in overdose hotspots where overdoses commonly occur, such as public restrooms and addiction treatment programs.

Naloxone administration includes opioid overdose response and rescue by first responders, such as **police, fire, and emergency medical technicians**.

Tool 4: Passive OEND Strategies

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
OEND by referral (e.g., prescription refill at a pharmacy, OEND dispensing program)	• What pharmacies stock naloxone? • What pharmacies don't stock naloxone? • What barriers exist for accessing naloxone at pharmacies? • How to best facilitate the prescription and dispensation of naloxone by providers (e.g. co-prescribing mandates, insurance and copay support and opt-out offers by pharmacists)? • Who can provide education to prescribers on naloxone?	• **Identify pharmacies** with/without naloxone in stock • **Advocate** with state boards of pharmacy to support stocking of naloxone • **Educate prescribers** to prescribe naloxone • **Facilitate** access to prescription naloxone at pharmacies • **Develop and implement** proactive prescribing and dispensing (e.g., co-prescribing mandates, insurance and copay support and opt-out offers by pharmacists) of naloxone among prescribers and pharmacies	• Number of naloxone units distributed in communities through pharmacies	• Pharmacies • Addiction treatment and recovery facilities
OEND by self-request (e.g., at pharmacy, community meetings, or public health department)	• What venues stock naloxone? • What venues don't stock naloxone? • What venues have standing naloxone protocols? • Who can provide naloxone guidance to venues?	• **Identify venues** with and without naloxone available • **Identify venues** with and without standing naloxone protocols • **Provide trainings and increase access** to naloxone at venues	• Number of naloxone units distributed in communities through pharmacies • Number of naloxone units distributed in communities total	• Pharmacies • Addiction treatment and recovery facilities • Community organizations
Naloxone availability for immediate use in overdose hotspots	• Where should naloxone be readily accessible (e.g., locations based on geographic analysis of population density or overdose frequency from local overdose data)? • What protocols need to be in place (e.g., naloxone monitoring and restocking protocols and agreements)?	• **Identify candidate locations** (e.g., based on geographic analysis of population density or overdose frequency) • **Establish** naloxone monitoring and restocking protocols, and agreements • **Secure** naloxone storage boxes • **Implement** naloxone storage container placement, monitoring, and restocking protocol	• Number of locations with naloxone readily available	• Contacts within service venues • Public health department

continued

Tool 4: Passive OEND Strategies (continued)

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Naloxone administration (e.g., increasing first responder administration)	• What are the reported barriers to first responder administration of naloxone in your community? • What protocols are needed to improve first responder administration (e.g., implementation strategy, evaluation measures, procedures)? • Who can provide trainings to first responders?	• **Identify gaps in access** to naloxone and develop protocol including implementation strategy and evaluation measures/procedures • **Provide training** to first responders (as necessary) • **Implement** first responders naloxone program	• Number of emergency medical services (EMS) naloxone administration events • Number of EMS runs for opioid-related incidents/overdoses	• 911 call records and 311 data from EMS • Hospital ED data

Implementation resources for passive OEND strategies by strategy

OEND by referral (e.g., prescription refill at a pharmacy, OEND dispensing program)	» Prescribe to Prevent: Information to prescribe and dispense naloxone (Narcan) rescue kits. Created by prescribers, pharmacists, public health workers, lawyers, and researchers working on overdose prevention and naloxone access. There are links to training materials, overdose prevention and response videos, online training modules, and a research blog that includes updated data summaries of naloxone-related studies. » Prevent & Protect (Agency Outreach): A resource kit that aims to support pharmacists support to expand access to naloxone. Includes a guide to help organizations (e.g., local pharmacy, clinic, substance use disorder (SUD) treatment program, shelter) establish a naloxone standing orders. » Promoting the Importance of Naloxone: Centers for Disease Control and Prevention (CDC) webpage providing links to training, mini modules, interactive patient cases and factsheets for clinicians, health care administrators, family members, caregivers, and pharmacists.
OEND by self-request (e.g., at pharmacy, community meetings, or public health department)	» GetNaloxoneNow: The website includes links and resources regarding drug use, treatment, and ways to obtain naloxone and training for both bystanders and first responders. Community members may complete the Opioid Overdose Prevention, Recognition, and Response Bystander Module. The module is 56 slides and takes approximately 20–30 minutes to complete. The module reviews opioid overdose recognition and opioid overdose response. There is a certificate available for download for a $10 donation. » NEXT Naloxone: An online opioid overdose responder training site that includes mail-based naloxone distribution at no cost to PWUD or people most likely to be first responders in an opioid overdose incident. It has state-specific resource pages with information on how to obtain naloxone locally.

continued

Tool 4: Passive OEND Strategies (continued)

Implementation resources for passive OEND strategies by strategy	
Naloxone availability for immediate use in overdose hotspots	» Prevent & Protect Safety Policy: Page that includes sample policies for staff training and onsite overdose response management.
Naloxone administration (e.g., increasing first responder administration)	» SAMHSA: Opioid Overdose Prevention Toolkit: Five Essential Steps for First Responders: This document outlines the recommended steps first responders can take during an opioid overdose emergency. It can be used for talking points with first responders. » GetNaloxoneNow: See description above.

Cost Considerations and Resources

The cost of implementing OEND strategies is often reported as a barrier by communities interested in expanding access to naloxone. **Tool 5** presents estimated costs for one-time startup costs and ongoing operating costs from a study by Behrends et al. (2022)[12] using 2017–2019 data from programs in New York City. Startup costs included training sessions for staff, developing training materials, and developing an inventory database. Note that these costs exclude naloxone kits (which typically cost $20–$60) and overhead costs (equipment, supplies, consultants, and administrative support).

Research is currently underway to estimate costs associated with specific OEND strategies to enhance MOUD delivery (e.g., EMS leave-behind) implemented in communities implementing the CTH. These studies will be shared (https://hcs.rti.org) over the coming months.

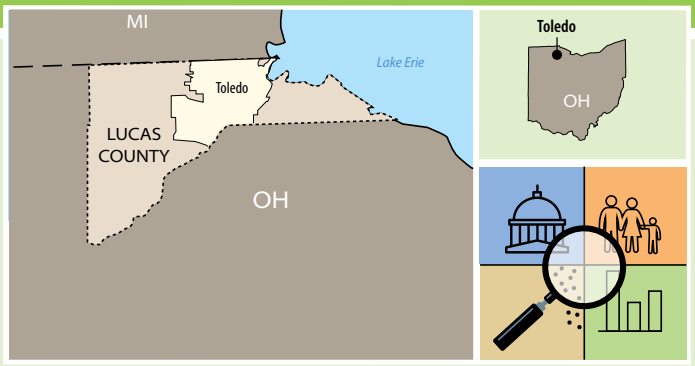
Tool 5: Reported Costs of OEND Programs[25]

Strategy	One-time startup costs (median cost in US$)	Ongoing operating costs (median cost in US$)	Median number of kits distributed per month (range)
Syringe service program (SSP)	$1,024 (range: $522–$5,481)	$1,579 per month	80 (27–187)
Non-SSP with multiple sites (large healthcare systems)	$7,635 ($2,600–$76,858)	$1,959 per month	52 (13–58)
Non-SSP with a single site (including substance use treatment programs, community health centers, other community-based organizations)	$2,403 ($821–$3,800)	$2,737 per month	89 (37–196)

The estimated median cost per unit dispensed was $25 for SSP-based programs and $43 for non-SSP programs, including overhead costs. Costs varied by program and the number of sites. Authors note that startup costs could be reduced by providing virtual or onsite trainings. The following resources may be helpful in informing cost estimates for OEND strategy implementation (**Tool 6**).

Tool 6: Cost Considerations and Resources for OEND Strategy Implementation

Cost consideration	Resource
Free or low-cost source of naloxone for harm reduction programs	» Remedy Alliance/For the People: Buyer's club for harm reduction service programs. Programs can complete an application to receive access to a catalog and have naloxone shipped directly to the program, if eligible.
Free or low-cost OEND training	» Prescribe to Prevent: Includes links to training materials, overdose prevention and response videos, online training modules, and a research blog that includes updated data summaries of naloxone-related studies. » Prevent & Protect (Agency Outreach): A resource kit that aims to support pharmacists to expand access to naloxone. Includes a guide to help organizations (e.g., local pharmacy, clinic, SUD treatment program, shelter) establish a naloxone standing orders.
NaloxBox cost	» $200-$400 per unit, https://naloxbox.org/collections/all » NaloxBoxes are only one option—there may be other, more affordable, options available.
Naloxone vending machine cost	» ~$13,000 » Similar in size and design to snack vending machines, a naloxone vending machine enables people to acquire naloxone anonymously and free of charge.



STORIES FROM THE FIELD

Providing community members with naloxone via EMS Leave-Behind programs

LUCAS COUNTY, OHIO

COMMUNITY PROFILE

Lucas County, Ohio, and the Opioid Crisis

Lucas County, in the northwest corner of the state, experienced 296 deaths from opioid-related overdoses in 2020. This is a 12% increase from the previous year, according to the county coroner's toxicology lab. There were 2,800 opioid overdose Emergency Medical Services (EMS) runs in 2021 alone.[13]

This spike was largely attributed to the COVID-19 crisis. According to the Centers for Disease Control and Prevention, US drug overdose deaths increased from 17,415 in 2000 to 72,151 in 2019 to 100,306 in 2021 (a 39% increase from 2019).[14]

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EMERGENCY MEDICAL SERVICES AGENCIES

The EMS agencies of Toledo, Ohio, the largest city in Lucas County and fourth largest in the state, frequently respond to 911 calls for opioid overdose or other conditions affecting people with opioid use disorder.

EMS plays an integral role in overdose care. For example, patients who refuse transport to a hospital, which is common, are at much greater risk of a subsequent nonfatal overdose.

Lucas County EMS Leave-Behind Program

Community coalitions in Ohio working to address the opioid crisis identified 22 agencies in six counties, both urban and rural, that had the desire and need for the EMS naloxone leave-behind intervention. Lucas County was identified as one of these counties.

Challenge: Individuals who overdose often are treated at the site of the overdose but are not transported to the hospital

Nontransport to the hospital prevents any emergency-department-based efforts, such as Overdose Education and Naloxone Distribution (OEND), medication for opioid use disorder (MOUD), or linkage to care. Consequently, individuals would benefit from receiving naloxone, even if not transported for hospital-based care, by keeping them alive in case of a subsequent overdose and allowing for the future possibility of MOUD and linkage to care.

Strategy Approach:

Lucas County's EMS Leave-Behind programs were modeled after the successful 2015 launch of the Colerain Township Quick Response Team in Hamilton County, Ohio. This was an EMS leave-behind and linkage-to-care initiative, which resulted in a 42% decrease in EMS overdose calls between 2017 and 2019.

The Colerain Township Assistant Fire Chief/EMS Leave-Behind Coordinator, Chief Will Mueller, who championed those efforts, subsequently provided invaluable expertise to Lucas County to develop and implement their own naloxone leave-behind programs.

The Toledo Fire & Rescue Department (TFRD) partnered with the Lucas County Health Department to develop a protocol and implement procedures for leaving naloxone with individuals who are at risk, particularly when

not transported to an emergency department for further care. Additionally, the initiative worked to streamline data collection to better inform accurate and timely reporting of overdose information and naloxone distribution.

A consistent, free supply of naloxone is provided by the Health Department through Project DAWN (Deaths Avoided With Naloxone), an Ohio Department of Health initiative that ensures naloxone availability across the state.

As a result, in June 2020, TFRD personnel arriving on the scene of an overdose began to "leave behind" intranasal naloxone with individuals who sign an Against Medical Advice order after an overdose reversal. Fire crews that reverse an opioid overdose with naloxone also educate the person or family/friends and provide educational materials about caring for someone who is experiencing an opioid overdose.

According to the State of Ohio Board of Pharmacy Protocol, from August 5, 2022, Ohio EMS agencies are permitted to personally furnish naloxone under Ohio law to any of the following:

1. An individual who there is reason to believe is experiencing or at risk of experiencing an opioid-related overdose.
2. A family member, friend, or other person in a position to assist an individual who there is reason to believe is at risk of experiencing an opioid-related overdose.

To do this, EMS agencies must adhere to the Board of Pharmacy Protocol, which includes the following:

1. Update the organization's protocol to include the authorization for EMS personnel to personally furnish naloxone (sample protocol: Personally Furnishing Naloxone by Emergency Medical Service Personnel).
2. Comply with Board of Pharmacy labeling requirements.
3. Comply with Board of Pharmacy recordkeeping requirements.

> *That is the selling point. Fifty lives have been positively impacted by having one of the naloxone kits TFRD handed out.*
>
> —Lieutenant Zakariya Reed, TFRD, EMS Bureau Supervisor

OUTCOMES AND OTHER BENEFITS

In addition to protocol and procedure development, data collection, dissemination guidance, and connection to a sustainable naloxone supply, other EMS agency efforts include staff training assistance, computer tablet purchases for data collection, and IT assistance with ESO (prehospital electronic patient care reporting system) software or ODMAP (Overdose Detection Mapping Application Program) to provide real-time overdose data and allow for targeted interventions.

Two new programs emerged from the TFRD strategy. First, the Toledo Police Department followed TFRD's lead by partnering with the Lucas County Health Department to develop their own naloxone leave-behind program.

Second, TFRD developed a novel program called Medics on Bikes (MOB). The MOB team is used during large-scale, open-air events to provide emergency care and harm reduction to citizens. The smaller vehicles, which include bicycles and an all-terrain vehicle, can maneuver through large crowds to an emergent situation in ways that the typical EMS vehicle cannot. They are equipped with lifesaving equipment and medications and are capable of stabilizing critical patients following an overdose. The MOB team also provides OEND by distributing leave-behind naloxone kits, educational materials, and information about treatment facilities.

TFRD has documented incidents where patients are (almost) alert and oriented by the time EMS arrive on scene.

AS OF MARCH 2023, TFRD HAS DISTRIBUTED

580 kits, with about **50 kits**

being used in the field after repeat overdoses.

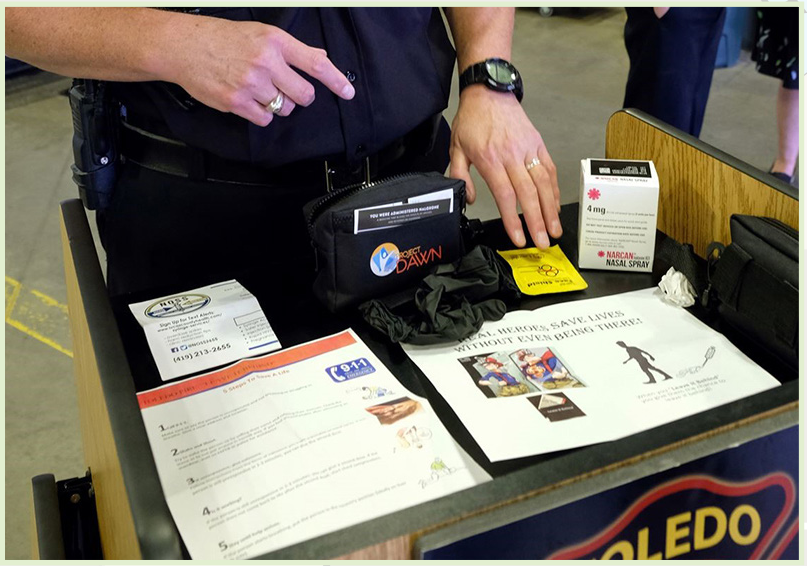
> *One life saved by this simple act [of naloxone leave-behind] is unmeasurable success! A simple idea during the height of COVID has turned into inspiration for fire departments all over the state, and further (Pennsylvania and North Carolina). I am proud of that!*
>
> —Lieutenant Zakariya Reed

Not only do they leave behind naloxone at the site of an overdose, but TFRD has also hosted at least one naloxone giveaway event and participates in other community events when possible, providing naloxone kits, drug deactivation bags to safely dispose of leftover medications, and educational materials to the community.

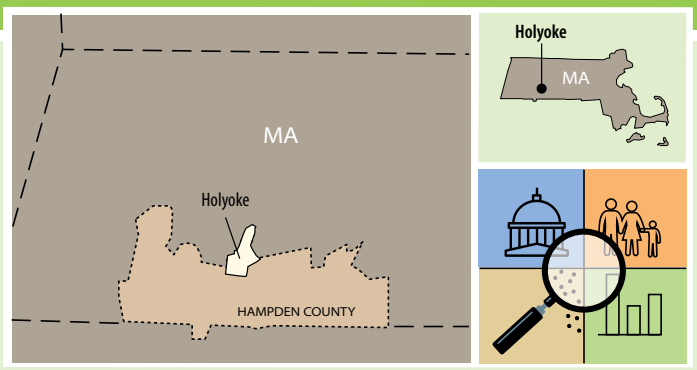
These efforts in Lucas County and other Ohio counties have spread across the state and beyond, into Pennsylvania and North Carolina.

TIPS FOR YOUR COMMUNITY

- Identify a **leave-behind program champion** in a well-respected department/agency.
- Make it simple for the EMS crew, even if it is complicated for administrators. **Use existing processes and technology** as much as possible to limit the barriers to leaving behind naloxone.
- **Initial trainings should be led by the program champion** (can also be co-taught with a physician), but it is useful for agencies to see that it is "their" program.
- **Do not record trainings** because it limits open discussion about stigma that tends to come up.
- Focus the discussion on **stigma during training, toward the end**, after it has naturally come up during training. Helpful resources and guidance can be found in the Anti-Stigma Toolkit: A Guide to Reducing Behavioral Health Disorder Stigma.
- If an agency has staff who are the main point of contact to hand out **naloxone kits**, have the agency leadership/ medical director do **"check ins"** on their well-being because it can be hard for staff to hear the many heartbreaking tales of opioid addiction and its wide-ranging impact on families and communities.



Source: The Blade: Toledo Fire & Rescue announces "Leave It Behind" naloxone program, 9/10/2020



STORIES FROM THE FIELD

Providing cash stipends to peers (people with active drug use) to distribute naloxone and provide harm-reduction services within their social networks

HOLYOKE, MASSACHUSETTS

Holyoke, Massachusetts

Holyoke is a small urban community in Western Massachusetts with an ethnically diverse population of about 38,000. The largest ethnic group in Holyoke is Hispanic (52.25%), including those who identify as White (Hispanic) (38.9%), two or more race categories (Hispanic) (8.24%), and Other (Hispanic) (5.11%). This is followed by White (non-Hispanic) (41.1%) and Black or African American (non-Hispanic) (2.4%). A majority of people who identify as Hispanic are of Puerto Rican descent. In fact, Holyoke has the largest number of Puerto Rican residents per capita in the continental United States. However, only 5.8% of Holyoke's population is foreign born.[15]

As of 2020, 78.4% of Holyoke residents were high school graduates or greater, 54.7% were employed in the civilian workforce, and 96.4% had health insurance coverage. The median income is $45,045, with 26.5% of residents living at or below the poverty level.[15]

Author: Erin Gibson, MPH, Associate Director of Research Operations, MA-HCS

RATE OF FATAL OPIOID OVERDOSES

From 2018 to 2021, the rate of fatal opioid overdose among Holyoke residents aged 18 or older increased 71.5%, from 45.6 to 78.2 per 100,000 residents. However, the change in the overdose death rate in Holyoke varied by race and ethnicity. Among Hispanic/Latino residents 18 years or older, the opioid overdose death rate increased 249.8%, from 27.3 to 95.5 deaths per 100,000 residents. Meanwhile, both the non-Hispanic Black and non-Hispanic White populations' rates remained the same at 225.5 deaths per 100,000 residents and 54.9 deaths per 100,000 residents, respectively.[16]

HOLYOKE COMMUNITY COALITION

Our coalition in Holyoke engaged in a data-driven decision-making process to assess existing resources and gaps in regard to reducing opioid-related overdose, including community naloxone distribution.

Challenge: How to increase naloxone distribution to people who use drugs (PWUD) not reached by current street outreach efforts

As a result of this approach, our priority was to increase naloxone distribution to PWUD—specifically to people who do not tend to access services at Tapestry Health, the community's brick-and-mortar Syringe Service Program (SSP), and were not being reached by the existing street outreach efforts. This included people who do not use opioids and might not see themselves as at risk for overdose. However, with the increasing presence of fentanyl and other illicit substances, the coalition made expanding harm-reduction outreach the priority.

Our coalition proposed a peer-based outreach strategy to reach people who

do not access services, especially those who live and use drugs in homeless encampments and who tend to avoid services because of fear and mistrust. The strategy provided weekly cash stipends to peers who were identified as people who use drugs and have access to these hard-to-reach individuals as part of their social network. In Holyoke, the peers included people experiencing homelessness, who did not speak English, or who identified as engaging in transactional sex. The coalition emphasized the importance of providing stipends in the form of cash to fairly compensate peers without stigmatizing constraints (e.g., lack of a bank account and/or identification to be able to cash a check) and to avoid formal contracting, disclosure of a social security number, or criminal offender record information.

Because of its trusted reputation and long history of providing harm-reduction services to the Holyoke community, we selected Tapestry Health to coordinate the program. Tapestry is a state-funded Overdose Education and Naloxone Distribution (OEND) program that receives funding and naloxone at no cost through the Bureau of Substance Addiction Services (BSAS) at the Massachusetts Department of Public Health.

Strategy Approach:
Coalition-driven, peer-based outreach

Tapestry Health invited interested peers to meet one on one with the Harm Reduction Specialist at the brick-and-mortar service location. During this meeting, the Harm Reduction Specialist provided an overview of the program and assessed peers' commitment to the goal of expanding naloxone distribution to people who are at risk and who otherwise might not have access. Originally, peers signed up to distribute naloxone for a 4-week period. However, peer feedback recommended a shift to a 1-week commitment at a time.

- Each Monday, Tapestry Health assigned peer naloxone distribution spots to the first two approved peers to arrive at Tapestry to pick up their five naloxone kits
- At the end of the week, the peers returned to Tapestry to report on their activities and receive the cash stipend of $5 per kit distributed ($25 maximum)
- Tapestry requested that peers report the number of naloxone kits distributed by week, general descriptions of where distribution occurred, and specific information for BSAS reporting

- Peers submitted this information weekly via a paper form prior to receiving their stipend payment
- Peers also shared their observed insights on the successes and challenges, and ideas to expand distribution

To provide multiple peers the opportunity to participate in this program, each peer was limited to 4 consecutive weeks of naloxone distribution, at which point they would give their spot to another peer. However, peers were welcome to reenroll with Tapestry and wait their turn to participate in the program again.

> *It is easier for the peer distributor to engage with a PWUD.*
>
> —Erika Hensel, Harm Reduction Specialist & Peer Naloxone Distribution Program Coordinator at Tapestry Health

PROGRAM COMPONENT	DETAILS
Hosting Syringe Service Program	Tapestry Health
Duration of program funding	March 2021–June 2022 (15 months)
Program Manager	Harm Reduction Specialist
Identification of peers	Preapproved list based on peer interest
Duration of peer participation	4 consecutive weeks, with option to reenroll
Cash compensation per week	Up to $25 cash per peer per week ($5 per naloxone kit distributed)
Supplies distributed	Naloxone kits
Average program cost per month	$219
Total program cost	$3,510

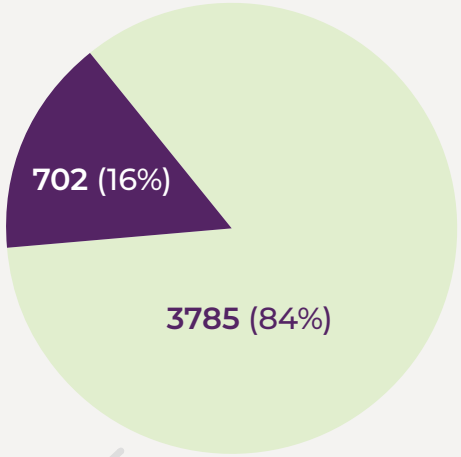
OUTCOMES AND OTHER BENEFITS

Despite staffing and operational challenges posed by COVID-19, Tapestry Health's program to invite peers to distribute naloxone to hard-to-reach individuals who were at high risk engaged an average of five peers per month. The peers' efforts resulted in 702 naloxone kits distributed over 15 months (March 2021–June 2022), equaling 16% of the agency's total naloxone distribution.

Monthly counts of naloxone kit distribution ranged from 10 to 85 kits during this time, with an average of 44 kits per month. Past research in Massachusetts has shown that annual OEND training of >100 potential overdose bystanders per 100,000 residents was associated with a 46% reduction in the opioid overdose death rate compared to communities that did not implement OEND training strategies.

This program achieved a naloxone distribution rate of 109 kits per 100,000 residents, indicating a potential to achieve clinically meaningful reductions in opioid overdose deaths.

Holyoke's Naloxone Distribution, March 2021–June 2022



> *Ninety-five percent of the peer distributors are homeless and I did not want to create further barriers for them. Also, I believe that people should be paid cash for their work, and they did not want a gift card where their earned money was limited.*
>
> —Erika Hensel, Harm Reduction Specialist & Peer Naloxone Distribution Program Coordinator at Tapestry Health

TIPS FOR YOUR COMMUNITY

- **Engaging and providing a stipend for peers** to distribute naloxone and provide other harm reduction services to hard-to-reach populations at high risk in their social network is a feasible, effective, and low-cost approach.
- PWUD have a long history of caring for each other. Given the opportunity, they are willing and uniquely effective at reaching and providing **harm-reduction materials** to their peers at high risk.
- **Cash stipends** provide an accessible, equitably available form of compensation that shows respect for peers' autonomy and unique expertise.
- **Securing long-term funding** for novel naloxone distribution models can be challenging.
- Coalitions seeking funding support for naloxone may **consider collaborating** with local agencies, with OEND programs, and other state funding, such as departments of public health.

Local artwork in Holyoke honoring Tim Purington, public health advocate and a driving force behind harm reduction programs for drug users, such as the first needle exchange program in Western Massachusetts. The mural represents the Holyoke community's strong commitment to harm reduction and care for people who use drugs.

5. Evidence-based Strategies to Enhance Delivery of MOUD Treatment, Including Agonist/Partial Agonist Medication

Rationale

Three medications are approved by the U.S. Food and Drug Administration (FDA) for the treatment of opioid use disorder: methadone (a full *mu* opioid agonist), buprenorphine in several formulations (a partial *mu* opioid agonist), and extended-release naltrexone (a *mu* opioid antagonist). Increasing the number of people with opioid use disorder receiving medication for opioid use disorder (MOUD)-based treatment is at the center of the nation's efforts to address the opioid crisis.

During the COVID-19 pandemic, increased flexibility around MOUD prescribing policies was introduced including telehealth visits to initiate buprenorphine and, for patients in opioid treatment programs, take-home methadone. Despite this increased flexibility, there was no concurrent increase[17] in the proportion of overdose deaths involving buprenorphine or methadone.[18]

Peer-reviewed literature to support MOUD strategies

Key messages

- Methadone and buprenorphine reduced overdose and opioid-related morbidity compared to other OUD treatment modalities (Wakeman et al.)
- Use of methadone and buprenorphine increases retention in treatment and saves lives (LaRochelle et al.; Sordo et al.)
- MOUD decreases opioid use and crime (Bukten at al., Marsh et al., Molero et al.)

Key citations

- Bukten A, Skurtveit S, Gossop M, Waal H, Stangeland P, Havnes I, Clausen T. Engagement with opioid maintenance treatment and reductions in crime: a longitudinal national cohort study. Addiction. 2012 Feb;107(2):393-9.

Considering this evidence and other support for more equitable and low-barrier access MOUD treatment, the federal requirement for prescribers of buprenorphine to have a Drug Addiction Treatment Act waiver (also referred to as the "X-waiver") was removed as of January 2023.[19] Therefore, many more health care providers can now prescribe MOUD. However, significant barriers including lack of awareness, financial constraints, and lack of training have limited the potential impact of this action.[20] In addition, some health care providers and pharmacists hold stigmatizing beliefs around MOUD treatment. People interested in MOUD treatment may have difficulty finding a nonstigmatizing provider or a pharmacy that is willing to fill a prescription for MOUD. Incorporating anti-stigma training and increasing knowledge around the efficacy and purpose of MOUD treatment within provider and pharmacist educational content can help address these barriers.

In summary, strategies to expand MOUD treatment availability, increase linkage to MOUD treatment programs, and improve MOUD treatment engagement and retention can significantly reduce the risk of opioid overdose death.

Goals: The MOUD menu is designed to increase:

1. The number of new settings and opportunities for implementing and expanding MOUD
2. The number of settings expanding MOUD
3. The number of people receiving MOUD
4. MOUD retention rates

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- Marsch LA. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behavior and criminality: a meta-analysis. Addiction. 1998 Apr; 93(4):515-32
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- Sordo L, Barrio G, Bravo MJ, Indave BI, Degenhardt L, Wiessing L, Ferri M, Pastor-Barriuso R. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ. 2017 Apr 26;357.
- Wakeman SE, Larochelle MR, Ameli O, Chaisson CE, McPheeters JT, Crown WH, Azocar F, Sanghavi DM. Comparative effectiveness of different treatment pathways for opioid use disorder. JAMA network open. 2020 Feb 5;3(2):e1920622-.

Expanding MOUD Treatment Availability

Strategies to add or expand MOUD treatment in healthcare settings (e.g., primary care, mental health settings), specialty addiction/substance abuse disorder treatment settings, and criminal legal settings can significantly increase the number of people receiving MOUD (**Tool 7**). Example strategies include the following:

- **Adding or expanding MOUD treatment in healthcare settings** (primary care, behavioral or mental health treatment settings, general medical settings, addiction treatment programs).
- **Adding or expanding MOUD treatment in criminal legal settings** by working with local correctional facilities (e.g., jails, prisons).
- **Expanding access to MOUD treatment** through supporting healthcare providers in their capacity to provide telehealth prescriptions of buprenorphine, interim buprenorphine, or methadone, and through medication units. Please note that interim methadone or interim buprenorphine treatment and medication units are specific to licensed opioid treatment programs (OTPs).
  - **Interim methadone or buprenorphine treatment** at an OTP means that medication (methadone or buprenorphine) is dispensed to patients (*not* prescribed) for up to 120 days without comprehensive ancillary services. Interim treatment can only occur when there are waitlists and must be approved at the state level and by the Substance Abuse and Mental Health Services Administration (SAMHSA). After 120 days of interim treatment, the OTP must transition patients to comprehensive treatment.
  - **Medication units** are ancillary sites associated with a specific OTP where only medication is dispensed and urine is drug-tested.

Don'ts around MOUD prescribing

- **Don't** mandate counseling as a requirement for prescribing MOUD or continuing MOUD treatment (SAMHSA Treatment Improvement Protocol)
- **Don't** require a person to try abstinence-based treatment before prescribing MOUD (SAMHSA Treatment Improvement Protocol)
- **Don't** withhold MOUD from someone because they are also prescribed benzodiazepines (FDA guidance)

MOUD Treatment Guidelines

- SAMHSA Tip 63: Medications for Opioid Use Disorder
- SAMHSA: Clinical Use of Extended-release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide
- A Guide to DEA Narcotic Treatment Program Regulations
- SAMHSA Opioid Response Network

Tool 7: Expanding MOUD Treatment Availability Strategies

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Adding/expanding MOUD treatment in healthcare settings	• Where can people with OUD access MOUD treatment in your community? • What healthcare settings could offer MOUD but don't? • What do these settings require (i.e., trained staff, resources, anti-stigma training) to expand or offer MOUD treatment?	• **Identify barriers and opportunities** for implementing and expanding MOUD • **Identify potential settings** for MOUD integration and expansion • **Train staff** on MOUD • **Implement** an MOUD integration and expansion program	• Number of people receiving MOUD • Number of people receiving buprenorphine for treatment of OUD • Number of people receiving methadone • Number of people receiving naltrexone (injectable, combined injectable/oral) • Number of people with OUD receiving MOUD • Number of providers who prescribe buprenorphine for the treatment of OUD	• Search for providers using SAMHSA Buprenorphine Practitioner Locator • State level: National Survey of Substance Abuse Treatment Services, publicly available • IQVIA data (costs involved) • Electronic health record review from healthcare setting (requires permission/access)
Adding/expanding MOUD treatment in criminal legal settings	• Can people experiencing incarceration access MOUD within local correctional facilities? • Are there limitations to who can receive treatment (e.g., pregnant women only, people previously prescribed or diagnosed with OUD)? • What would these settings require (i.e., trained staff, resources, anti-stigma training) to expand or offer MOUD treatment? • Are people with OUD linked to MOUD treatment within the community upon release?	• **Identify barriers** and opportunities for implementing or linking to MOUD • **Identify potential settings** for MOUD integration/linkage • **Train staff** on MOUD • **Implement** a MOUD integration and expansion program	• Number of people provided MOUD while incarcerated • Number of jails or prisons that will initiate MOUD treatment (for those who are not prescribed upon entry) • Number of inductions on buprenorphine during incarceration or immediately prior to release • Number of inductions on methadone or immediately prior to release • Number of inductions on naltrexone during incarceration or immediately prior to release • Number of criminal legal settings that link to MOUD upon release • Number of people released from prison and linked to MOUD within 14 or 28 days	• Contacts from local correctional facilities • Program data from linkage programs (if existent)

continued

Tool 7: Expanding MOUD Treatment Availability Strategies (continued)

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Expanding access to MOUD treatment through telemedicine, interim buprenorphine or methadone, or medication units	• Are there licensed opioid treatment programs (primary care or addiction treatment) with waiting lists where interim buprenorphine or methadone or telemedicine could expand access? • Are there programs or regions in your community with geographic barriers indicating that telemedicine or medication units could expand access? • Are providers trained on telemedicine prescription or interim buprenorphine and methadone?	• **Contact** local OTP programs offering to expand access to MOUD • **Train program staff** on procedures required to initiate interim buprenorphine or methadone or telemedicine • **Implement** a program to expand MOUD through interim buprenorphine/ methadone • **Implement** medication units as offshoots of OTPs • **Engage** telemedicine providers to prescribe buprenorphine	• Number of people receiving buprenorphine for treatment of OUD • Number of people receiving methadone	• Electronic health record review from OTP (requires permission/access) • State level: National Survey of Substance Abuse Treatment Services, publicly available • IQVIA data (costs involved)

Implementation resources for strategies expanding MOUD treatment availability by setting

General resources

» Providers Clinical Support System (PCSS) SUD 101 Core Curriculum: For healthcare providers spanning prevention, assessment, and treatment of substance use disorders and co-occurring mental health disorders; includes 22 modules (approximately 1 hour each) with free inter-professional continuing education credits.

» Brandeis Opioid Resource Connector: Helps communities in mounting a comprehensive response to the opioid crisis. It is a product of the Brandeis Opioid Policy Research Collaborative. The site provides a curated collection of community-focused programs, tools, and resources to help stakeholders choose, design, and implement essential interventions.

» AHRQ Six Building Blocks: A Team-Based Approach to Improving Opioid Management in Primary Care: A toolkit for organizations that have already completed opioid management improvement work or intend to engage in a more targeted effort. The website and corresponding materials describe the six building blocks that make up the program and how to implement them in a primary care setting.

» Buprenorphine Quick Start Guide: A six-page checklist for prescribing buprenorphine for OUD.

continued

Tool 7: Expanding MOUD Treatment Availability Strategies (continued)

Implementation resources for strategies expanding MOUD treatment availability by setting	
Primary care settings	» Boston University School of Public Health HRSA Integrating Buprenorphine Treatment for OUD in Primary Care: A 34-page document to aid clinicians who are implementing buprenorphine in a primary care setting. » Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings: This guide provides information to primary care providers and practices on how to implement opioid use disorder treatment using buprenorphine. Specifically, this resource documents step-by-step tactics to support buprenorphine implementation and how to identify and address barriers.
Addiction and recovery treatment programs	» Boston Medical Center OBAT Clinical Guidelines: A 167-page clinical guideline about the Nurse Care Manager Model of Office-Based Addiction Treatment (OBAT), broken into sections including (1) OBAT introduction and team requirements; (2) program requirements; (3) treatment agreement and policies; (4) treatment initiation, stabilization, and maintenance; (5) addressing substance use treatment; and (6) treating specific populations. » OBAT Clinical Tools and Forms (Boston Medical Center): This website offers a listing of various tools for providers in OUD. There are downloadable forms to aid with clinic visit documentation, such as patient forms and short informational videos. » MAT in Residential Treatment Facilities: A toolkit for residential treatment facilities.
Criminal legal settings	» Medication-Assisted Treatment (MAT) for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit: This toolkit, supported by funding from CDC and Bloomberg Philanthropies, provides correctional administrators and healthcare providers recommendations and tools for implementing MOUD in correctional settings and strategies for overcoming challenges. Informed by real-world practice, the toolkit provides examples from the field that can be widely applied and adapted. » Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings: This guide focuses on policies and practices that can be implemented to intervene during a person's time in the correctional system and upon release that moderate and mitigate the risk of overdose for people with OUD after release. This document contains five chapters: a brief of the field, an assessment of current evidence, some examples of MAT in justice settings, a discussion of how to identify and address the challenges of implementing programs in criminal justice settings, and resources to support the use of MAT in criminal justice settings. » Medication for Opioid Use Disorder (MOUD): Correctional Health Implementation Toolkit, August 2022: A 74-page document authored by the New York State Department of Health detailing how to implement an MOUD program in a correctional setting.
Telemedicine	» US Department of Health and Human Services: Telemedicine and Prescribing Buprenorphine for Treatment of OUD: This document discusses the Drug Enforcement Administration (DEA) statement concerning exemption from in-person medical evaluation if engaging the patient in the practice of telemedicine, a case example of effective use of this practice, and links to additional resources about telemedicine and regulations for general telemedicine. » Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders: This guide helps health care providers, systems, and communities support recovery from substance use disorders via employment mechanisms. It describes relevant research, examines emerging and best practices, identifies knowledge gaps and implementation challenges, and offers resources. » Telehealth for Opioid Use Disorder: Guidance to Support High-Quality Care: A 21-page toolkit focusing on real-time videoconferencing, buprenorphine, and adjunctive psychotherapy treatment.

continued

Tool 7: Expanding MOUD Treatment Availability Strategies (continued)

Implementation resources for strategies expanding MOUD treatment availability by setting	
Interim buprenorphine/ methadone	» Federal Guidelines for Opioid Treatment Programs – A 79-page document providing detailed rules, standards, and guidance regarding many facets of treatment for opioid use disorder. Pages 57–58 provide an overview of the rationale, requirements, and regulations governing interim treatment. » Code of Federal Regulations: Opioid Treatment Program Certification – Brief legal document that outlines requirements on how to become certified as a licensed OTP; Item G highlights who you need to contact and how to begin the process to seek approval to dispense buprenorphine or methadone to patients for up to 120 days.
Medication units	» Federal Guidelines for Opioid Treatment Programs – A 79-page document providing detailed rules, standards, and guidance regarding many facets of treatment for opioid use disorder. Pages 12–13 and 66–67 provide a general overview of Medication Units and how a licensed OTP can open one. » Code of Federal Regulations: Opioid Treatment Program Certification – A brief legal document that outlines requirements on how to become certified as a licensed OTP. Item I details how licensed OTPs can establish medication units, including what forms to complete.
Considerations for special populations	» Pregnant women: IHR Maternal Opioid Use During Pregnancy Toolkit » Co-occurring Disorders: – SAMHSA Tip 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders – American Psychological Association: The Opioid Guide » Multiple substances: SAMHSA EBP Guidebook on Treatment of Stimulant Use Disorder » Persons living with HIV: Integrating BUP treatment in HIV primary care settings

Interventions to Link to MOUD

People in need of MOUD are often located in the field or other service settings where MOUD is unavailable. This section outlines the associated resources and toolkits for linking those people to definitive addiction care (**Tool 8)**. The most basic, and least preferred, option is referral only. More advanced linkage support includes formal care coordination, often assisted by peer navigation, peer recovery support services, or provision of bridging MOUD medications in the time window between initial

identification and later engagement in care. Co-locating MOUD within a syringe service program (SSP) or harm reduction agency is another strategy to improve linkage to MOUD for people at higher risk of overdose. Example strategies include the following:

- **Linkage programs** in priority settings (SSPs, harm reduction agencies, emergency departments (EDs), post-overdose, recovery organizations)
- **Bridging MOUD medications** as a linkage adjunct in priority settings

Tool 8: Strategies to Improve Linkage to MOUD

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Linkage programs in priority settings	• What post-overdose outreach currently exists? • How can post-overdose outreach be improved or expanded? • Who can provide trainings on MOUD linkage to community outreach workers (including peers, first responders, law enforcement)? • Do local prisons/jails offer linkage to MOUD treatment following release? • What do these settings require (e.g., trained staff, resources) to offer linkage to MOUD?	• **Identify and engage peers** to be trained in MOUD outreach. • **Develop messaging and referral plan** with trained peer members. • **Implement or enhance** post-overdose outreach programs. • **Establish cross-sectoral communication and collaboration** involving law enforcement, harm reduction services, MOUD providers, and people who use drugs to support post-overdose outreach programs. • **Implement or enhance law enforcement trainings** to prevent adverse encounters and engage at-risk people and deflect them from criminal legal involvement.	• Number of people linked to MOUD following overdose • Number of opioid-related visits following linkage to MOUD post-overdose • Number of jails or prisons that link to MOUD upon release • Number of people released from prison and linked to MOUD within 14 or 28 days • Number of people linked to MOUD following an opioid-related ED visit • Number of people linked to MOUD following an opioid-related ED visit within 30 days • Number of withdrawal programs that initiate MOUD	• Electronic health record review from healthcare setting (requires permission/access) • IQVIA data (costs involved) • Contacts from local correctional facilities • Program data from linkage programs (if existent)

continued

Tool 8: Strategies to Improve Linkage to MOUD (continued)

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Bridging MOUD medications in priority settings	• Where can people quickly start MOUD? • What protocols are in place on quick start and linkage to MOUD treatment in priority settings in your community? • How can linkage to MOUD treatment from EDs or inpatients settings be improved? • Do local prisons/jails offer induction onto MOUD treatment? • What are medication aftercare protocols upon discharge from settings?	• **Develop medication quick start and linkage implementation protocols** (including evaluation measures and plan) • **Train staff** on quick start medication and linkage • **Implement or enhance** quick start medication or linkage program	• Number of people receiving MOUD following opioid-related ED visit • Number of people receiving MOUD during or following opioid-related inpatient stay • Number of jails/prisons that induct MOUD in the month prior to release • Number of jails or prisons that will initiate MOUD treatment (for those who are not prescribed upon entry) • Number of inductions on buprenorphine during incarceration or immediately prior to release • Number of inductions on methadone or immediately prior to release • Number of inductions on naltrexone during incarceration or immediately prior to release • Number of criminal legal settings that link to MOUD upon release • Number of people released from prison and linked to MOUD within 14 or 28 days	• Electronic health record review from health care setting (requires permission/access) • IQVIA data (costs involved) • Contacts from local correctional facilities • Program data from linkage programs (if existent)

continued

Tool 8: Strategies to Improve Linkage to MOUD (continued)

Implementation resources for strategies linking or bridging MOUD treatment by setting	
General overview of linkage programs	» Linking People with Opioid Use Disorder to Medication Treatment: A Technical Package of Policy, Programs, and Practices: Provides guidance for initiating OUD treatment and examples of linkage in primary care, ED, inpatient settings, SSPs, and prenatal and postpartum care. The technical document also includes best practices for linkage to OUD for people with justice-involvement, adolescents, people with past trauma, transgender and gender minority populations, sex workers, and tribal communities and indigenous people. » Police Assisted and Addiction Recovery Initiative (PAARI): This website is for law enforcement agencies to develop non-arrest pathways to treatment and recovery. It describes how PAARI was created in Massachusetts and includes links for technical assistance. » Innovative EMS Response to Overdoses: Beyond Naloxone: A webinar describing the nontraditional role of emergency medical services (EMS) agencies in the opioid epidemic and how Quick Response Teams can add to the care EMS provides and discusses the barriers to implementing these programs.
Bridging MOUD medications: Peer navigators	» PCSS Webinar: Collaboration in Crisis: Utilizing Peer Recovery Coach Support in the ED to Maximize Patient Outcomes: Webinar describing best practices for integrating Peer Support in the ED for Linkage to Treatment.
Bridging MOUD medications: EDs	» Yale School of Emergency Medicine EM: ED-Initiated Buprenorphine: This is a website that can be used for providers who wish to initiate a buprenorphine delivery program in the ED. There is a 43-slide presentation that describes buprenorphine in the ED, the clinical pathway, assessments for screening, interviewing, home induction information and how to set up a buprenorphine program. The website includes example assessments, algorithms for the ED and home induction one-pagers. » PCSS Webinar "Treatment of Opioid Use Disorder in the Emergency Department: Should it be a Choice?": A recorded webinar describing the role of the ED in treating OUD. » FAQ about Buprenorphine in the Emergency Department: Webpage of the Kentucky HEALing Communities Study that provides answers to Frequently Asked Questions about the use of buprenorphine in the ED.
Bridging MOUD medications: Inpatient settings	» CA Bridge: Blueprint for Hospital OUD Treatment: This blueprint provides step-by-step guidance on how to set up a MAT program in an acute care hospital following the CA Bridge model.
Bridging MOUD medications: Home induction	» NIDA Home Induction One-Pager: A one-page guide for reviewing when to start buprenorphine and dosing information for at-home induction.

Strategies to Improve MOUD Treatment Engagement and Retention

This section outlines strategies delivered in conjunction with MOUD to enhance implementation of MOUD and improve retention in care on MOUD (**Tool 9**). These include behavioral interventions such as Motivational Interviewing or Contingency Management, digital (web- or app-based) tools, the care coordination service delivery strategy, treating co-occurring psychiatric disorders, and reducing barriers to essential community resources such as housing, transportation, and childcare.

Tool 9: Strategies to Improve MOUD Treatment Engagement and Retention

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Enhancement of clinical delivery approaches that support engagement and retention	• What are the most reported clinical conditions that impair MOUD engagement and retention (e.g., psychiatric and other comorbidities)? • What clinical delivery approaches, including trauma-informed care, care navigation, case management, transportation and payment programs, and recovery support services, are currently offered in priority settings? • What barriers exist to enhancing clinical delivery approaches? • What approaches are most likely to be successful? • Who can provide trainings on clinical delivery approaches?	• **Identify** barriers and facilitators currently impacting service delivery. • **Develop strategy** to address identified factors impairing treatment retention (e.g., lack of robust recovery support, lack of transportation). • **Implement or enhance** a program to improve engagement and retention.	• Number of people with OUD receiving case management • Number of people with OUD receiving peer support • Number of people receiving buprenorphine for the treatment of OUD retained 6 months following initiation • Number of people receiving methadone retained 6 months following initiation • Number of people receiving naltrexone retained 6 months following initiation • Number of people receiving any MOUD retained 6 months following initiation • Number of person-months actively on MOUD over a set period of time (e.g., 6 months, 1 year)	• Electronic health record review from healthcare setting (requires permission/access) • IQVIA data (costs involved) • Programmatic data from priority setting (e.g., case management services, peer support services)

continued

Tool 9: Strategies to Improve MOUD Treatment Engagement and Retention (continued)

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Use of virtual retention approaches (mobile, web, digital therapeutics)	• What barriers currently exist for following up with patients with OUD who have been lost to care? • Are virtual approaches to enhance retention currently in place? • What would be the most acceptable virtual retention approach for the priority setting? • Who can provide support for developing the virtual retention approach?	• **Identify gaps** in current procedures to facilitate retention. • **Identify** the preferred virtual retention approach to implement. • **Implement** an enhanced virtual retention program.	• Number of people receiving buprenorphine for the treatment of OUD retained 6 months following initiation • Number of people receiving methadone retained 6 months following initiation • Number of people receiving naltrexone retained 6 months following initiation • Number of people receiving any MOUD retained 6 months following initiation • Number of person-months actively on MOUD over a set period of time (e.g., 6 months, 1 year)	• Electronic health record review from healthcare setting (requires permission/access) • IQVIA data (costs involved)
Use care coordinators	• Do priority settings offering MOUD have case management or peer support services available? • If not, what are the perceived barriers to offering case management or peer support? • What resources (trained staff, funding, etc.) are required to improve care coordination?	• **Identify gaps** in care coordination services • **Develop** clinical protocols for retention coordinators and evaluation measures • **Determine strategies** to use retention care coordinator services • **Implement or expand** a retention care coordinator program	• Number of people with OUD receiving case management • Number of people with OUD receiving peer support • Number of people receiving any MOUD retained 6 months following initiation • Number of person-months actively on MOUD over a set period of time (e.g., 6 months, 1 year)	• Programmatic data from priority setting (e.g., case management services, peer support services)

continued

Tool 9: Strategies to Improve MOUD Treatment Engagement and Retention (continued)

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Mental health and polysubstance use treatment integrated into MOUD care	• Do settings offering MOUD integrate mental health or polysubstance treatment into care? • If not, what are the perceived barriers to offering these services? • What resources (trained staff, funding, facilities) are required to offer integrated care? • What is the community capacity for existing mental health and polysubstance treatment providers that can be integrated into the MOUD care providers?	• **Identify gaps** and need to integrate MOUD, mental health, and polysubstance treatment. • **Develop new mental health** and polysubstance abuse treatment services for MOUD providers. • **Train MOUD providers** in integrated care. • **Implement** integrated care.	• Number of people with OUD receiving behavioral health treatment by treatment intensity: inpatient/American Society of Addiction Medicine (ASAM) levels 3-4, intensive outpatient/ level 2, outpatient ASAM level 1 • Number of people with OUD receiving case management • Number of people with OUD receiving peer support • Number of people receiving any MOUD retained 6 months following initiation • Number of person-months actively on MOUD over a set period of time (e.g., 6 months, 1 year)	• Programmatic data from priority setting (e.g., case management services, peer support services) • Electronic health record review from healthcare setting (requires permission/access) • IQVIA data (costs involved)
Reducing barriers to housing, transportation, childcare, and access to other community benefits for people with OUD	• What are the most significant barriers to MOUD retention (lack of housing, transportation, childcare, etc.) reported by persons with OUD? • What social services currently exist for persons with OUD? • What social services are most needed? • What resources are needed to expand these services?	• **Identify gaps and need** for housing, transportation, and childcare for people on MOUD. • **Determine existing capacity** for social services. • **Train MOUD provider**s on how to access existing services and implement new community services. • **Implement the integration** of these community benefits into existing MOUD treatment services.	• Number of people on MOUD receiving community benefits (housing, transportation, childcare, etc.) • Number of people receiving any MOUD retained 6 months following initiation • Number of person-months actively on MOUD over a set period of time (e.g., 6 months, 1 year)	• Programmatic data from priority setting (e.g., sharing community benefit information, case management services, peer support services) • Electronic health record review from healthcare setting (requires permission/access) • IQVIA data (costs involved)

continued

Tool 9: Strategies to Improve MOUD Treatment Engagement and Retention (continued)

Implementation resources for strategies linking or bridging MOUD treatment by setting	
Enhancement of clinical delivery approaches that support engagement and retention	» Developing a Behavioral Treatment Protocol in Conjunction with MAT (Revised): Providers Clinical Support System (PCSS) PowerPoint presentation covering four basic principles of empirically supported behavioral treatments for substance use disorders—coping skills, competing reinforcers, how people talk about their change plan, and using social supports. » Promoting Awareness of Motivational Incentives (PAMI): This online training program provides practical guidance on how to implement Motivational Incentives or Contingency Management, where rewards or prizes are awarded to patients, contingent on evidence of abstinence (drug-negative urine tests) or other desirable target behaviors such as attendance at treatment. The program is an outgrowth of two community-based, multisite trials of Motivational Incentives conducted in the NIDA-funded Clinical Trials Network.
Use of virtual retention approaches (mobile, web, digital therapeutics)	» The Center for Behavioral Health Technology: Program Reviews: This web-based review summarizes available technology-based programs for mental health, addiction, and dual diagnosis patients. Each technology-based program is reviewed in a page summarizing the intervention, the evidence of its efficacy, and a link to each program's site for further information about access.
Use care coordinators	» BMC SUD Continuum of Care ECHO: A 12-part telemonitoring training on SUD treatment for providers including but not limited to acute treatment services, opioid treatment programs, long-term residential programs, primary care, and psychiatry.
Mental health and polysubstance use treatment integrated into MOUD	» PCSS Webinars: The PCSS is made up of a coalition of major healthcare organizations dedicated to addressing the opioid overdose crisis. PCSS's mission is to increase health care providers' knowledge and skills in the prevention, identification, and treatment of substance use disorders with a focus on opioid use disorders. You do not have to be an member to create a new user account for free. » SAMHSA Treating Concurrent Substance Use Among Adults: The guidebook presents three evidence-based practices that can engage and improve outcomes for people with concurrent substance use disorders. » TIP 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders: This March 2020 TIP is intended to provide addiction counselors and other providers, supervisors, and administrators with the latest science in the screening, assessment, diagnosis, and management of co-occurring disorders.
Reducing barriers to housing, transportation, childcare, and access to other community benefits for people with OUD	» SAMHSA Homelessness Programs and Resources: A webpage with access to many articles, videos, trainings, webinars, and other resources with the intent to facilitate prevention and eradication of homelessness, particularly among patients with mental health and substance use conditions. » Substance Use Disorders Recovery with a Focus on Employment and Education: This guide helps healthcare providers, systems, and communities support recovery from substance use disorders via employment mechanisms. » Ryan White HIV/AIDS Medical Case Management: Resources on a core medical patient-centered service that links and engages patients living with HIV/AIDS to healthcare and psychosocial services. Medical case management aims to provide other services like housing and transportation for patients. It also includes routine assessment of service needs, development and implementation of the plan, patient monitoring to evaluate the efficacy of the plan, and periodic reevaluation and adaptation of the plan.

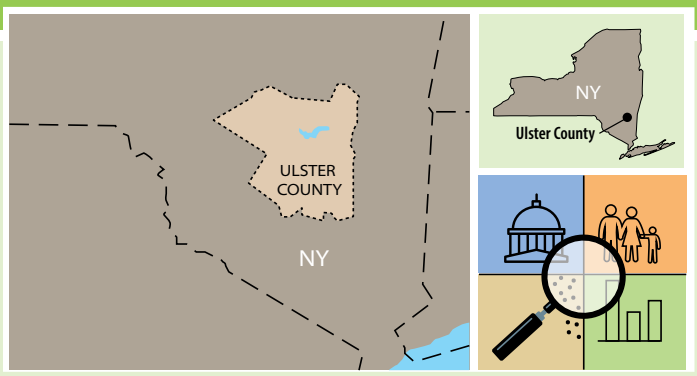
Cost Considerations and Resources

Communities, program planners, and providers considering these strategies will likely have questions regarding reimbursement, insurance coverage, and sample business plans. The following resources are recommended to provide information on these cost considerations (**Tool 10**).

Research is currently underway to estimate costs associated with specific strategies to enhance MOUD delivery (e.g., emergency department linkage program) implemented in HCS communities. These studies will be shared via the HCS Dissemination website (https://hcs.rti.org) over the coming months.

Tool 10: Implementation Resources for Considering Costs of MOUD Strategies

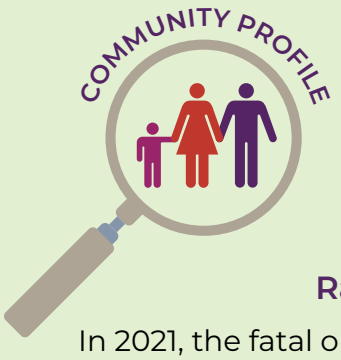
Implementation Resource	Description
2018 SAMHSA and National Council for Behavioral Health Report: Medicaid Coverage of MOUD for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose	This is a detailed report that outlines state-specific summary information on Medicaid coverage and financing of medications to treat alcohol and opioid use disorders.
PCSS and National Association of Community Health Centers: Business Plan for Medication-Assisted Treatment (MAT)	This report includes information on determining organizational readiness, a potential implementation timeline, and a financial plan, including information on billing and coding.
PCSS: Financing Factors for Implementing Medication-Assisted Treatment	A PowerPoint presentation addressing MOUD financing and overcoming financial barriers. Identifies financial considerations for successfully implementing and sustaining MAT in a primary or behavioral health practice setting and describes common models to implement and finance MAT in practice settings.
Billing and Coding Guidance for Treatment of OUD	A three-page summary from PCSS titled “Prescriber Billing for Office-based Treatment of Opioid Use Disorder” summarizing billing and diagnostic codes.
SAMHSA-funded Opioid Response Network (ORN), State Targeted Response (STR) Technical Assistance (TA), (STR-TA) Grant	Provides free training and technical assistance via local experts across the country around OUD prevention, treatment, and recovery support services.
American Society of Addiction Medicine Live and Online CME Trainings	Live and online continuing medication education (CME) opportunities for healthcare professionals focusing on the care and treatment of patients with substance use disorders.



STORIES FROM THE FIELD

Providing emergency housing to support entry into and reentry from treatment for opioid use disorder: A behavioral health and law enforcement crisis response team collaboration

ULSTER COUNTY, NEW YORK



Ulster County, New York

Ulster County in New York State sits along the Hudson River. With more than 182,000 residents. Ulster County's population is 87% White, 7% Black, and 6% other or two or more races, with 11% of the population reporting Hispanic ethnicity.[15]

Rate of Fatal Opioid Overdoses

In 2021, the fatal opioid overdose rate was 27 per 100,000, which was higher than the New York State (excluding New York City) average rate of 24 per 100,000.[21]

Authors: Jillian Nadiak-Bruck, Community Engagement Coordinator, Opioid Prevention, Ulster County Department of Health; Juanita Hotchkiss, Director of Community & Incarcerated Services, Ulster County Sheriff's Office; Kelly Perry, Data Surveillance Coordinator, Opioid Prevention, Ulster County Department of Health; Julianah Abimbola Ogundimu, Ulster County, Opioid Use Disorder System Specialist, HRMT/ORACLE; Tim Hunt, PhD, Co-Investigator & Intervention & Community Engagement Investigative Lead, Columbia University

HEALING COMMUNITIES STUDY (HCS) ULSTER COUNTY OPIOID STRATEGIC ACTION TEAM (OSAT)

Left to right: Left to right: Frankie Wright, Giff Liewa, Kevin Lundell, Julianah Abimbola Ogundimu (ORACLE), Michael Berg, Tamara Cooper, and Susan Carroll (Family of Woodstock) at the Roadway Inn Motel in Kingston, NY

A taskforce was formed in 2018 to provide strategic coordination, partnership, and resources to raise awareness about opioid misuse and harm reduction and to improve access to care for people experiencing opioid use disorder (OUD).

The taskforce is a coalition of 50 agencies and diverse community members. It has the full support of the Commissioners of the Departments of Health and Mental Health and the Ulster County Executive. The taskforce evolved into the HCS Ulster County OSAT and was tasked with implementing the Communities That HEAL intervention.

The coalition strives to mobilize the power of community members, organizations, and policymakers in finding solutions to the opioid use problems in the county. Its activities include

- providing education and training,
- establishing treatment and recovery options,
- developing data-driven strategies to identify areas of need,
- implementing evidence-based interventions, and
- evaluating progress toward achieving the stated goals.

Challenge: How to help individuals experiencing housing instability better cope with OUD

Access to safe and stable housing is one of the critical social determinants of health that can significantly impact a person's ability to cope with OUD. Navigating the complex system of care for individuals experiencing housing instability can present a significant challenge for individuals coping with OUD because they lack a safe place to store their belongings and find rest.

By providing temporary housing, individuals can concentrate on getting into treatment, connecting with necessary services, and achieving stability while preparing for the transition back into the community, as opposed to figuring out where they are going to find safety each night.

This housing solution serves as a critical support system after individuals complete the initial phases of treatment, and many work toward securing more permanent housing options.

When this strategy was developed, Ulster County was in the middle of a severe housing crisis. This problem was made worse by the sudden influx of people from New York City during the COVID-19 pandemic. Rents skyrocketed, as did the cost of purchasing a home. Consequently, we needed an immediate solution for individuals who did not meet the requirements from the Ulster County Department of Social Services (DSS) to get temporary housing.

Left to right: Tamara Cooper (Family of Woodstock), Frankie Wright, and Julianah Abimbola Ogundimu (ORACLE) showcase food items in a care package provided for every individual who stays at a motel through the housing voucher program.

Strategy Approach:
Use existing systems and collaborate with community pharmacy partners

Through the use of community impact funds, temporary housing was contracted and a voucher provided by the lead agency, Family of Woodstock, Inc. (FOW), for individuals in need of safe housing while seeking OUD treatment or awaiting inpatient treatment following release from incarceration.

FOW is a not-for-profit network of paid and volunteer individuals whose mission is to provide confidential and fully accessible crisis intervention, information, prevention, and support services to address the needs of individuals and families. Vouchers were also provided to individuals returning from inpatient treatment while they sought more permanent housing.

FOW worked with the Opioid Response as County Law Enforcement (ORACLE) initiative to set up response teams to address these housing challenges. The ORACLE initiative, selected by the Rural Justice Collaborative and the National Center for State Courts as one of the country's most innovative rural justice programs, is a crisis-intervention and recovery-response program based out of the Ulster County Sheriff's Office.

The response team includes crisis intervention officers, a mental health and substance use social worker, two peer-recovery advocates, and a care manager for people at high risk. Two individuals from this team were assigned as point persons for referrals in the strategy to be available Monday through Friday, 9:00 am to 9:00 pm. The point person worked with FOW to gather the information necessary to provide the best housing option. The referring agency was responsible for arranging transportation to the hotel and maintaining contact with the individual through the duration of their stay. Emergency referrals were accepted after hours and on weekends using the FOW hotline. Case reviews were conducted weekly during High-Risk Mitigation Team (HRMT) meetings, with required attendance for referring agencies.

Individuals who qualified for the program were

- individuals who are living with OUD (diagnosed or assessed) and experiencing housing instability, and
- individuals who are experiencing housing instability (with no other options) and are returning from inpatient treatment.

Referring agencies were responsible for certifying that individuals referred to this program did not currently have housing and did not qualify for DSS emergency housing assistance. Individuals could not use vouchers for more than 14 days upon return from treatment, and no more than 28 days total for the life of program participation.

OUTCOMES AND OTHER BENEFITS

From October 2020 through January 2023, a total of 1,221 vouchers (nights) were issued to 140 individuals.

Although demographics were not captured for recipients of housing vouchers, names were cross-referenced with the ORACLE HRMT database, which showed that 87 of the 140 individuals served were 37% female and 63% male, and that 87% were White, 9% Black, 3% mixed or other race, and 9% Hispanic.

> *The HEALing Community Program – Emergency housing has made an immense impact on individuals struggling with opioid use disorder by providing a safe place to transition into treatment programs and more importantly, integrating back into the community and accessing needed services.*
>
> —Julianah Abimbola Ogundimu, Ulster County, Opioid Use Disorder System Specialist, HRMT/ORACLE

HOW HAS THIS PROGRAM BRIDGED A GAP?

The program has helped bridge gaps by

- assisting with navigating clients with substance use disorder (SUD) for linkage to treatment programs;
- providing a safe place to locate clients for client-centered care;
- facilitating easy client communication and accessibility;
- helping address urgent housing and food needs, including unanticipated jail discharges;
- providing a reliable and consistent housing option; and
- providing access to peer support and navigation.

WHAT IMPACT HAVE YOU SEEN AS A RESULT?

The key impacts of the program include

- increasing successful admission into SUD treatment,
- improving open communication between clients and support services of the ORACLE team,
- addressing housing instability in Ulster County and supporting DSS,
- providing alternative and safe temporary housing for people with SUD who may not qualify for DSS temporary assistance, and
- increasing successful reentry and retention in care post inpatient treatment.

SUCCESS STORIES

Program successes include

- using housing vouchers for transitional housing for an individual following release from jail and prior to admission into long-term SUD treatment—the individual is currently engaged with a long-term treatment facility and making positive progress in recovery;
- using housing vouchers to provide a client safe housing until a detox bed at a treatment facility became available—the individual was housed for 3 nights in the motel, successfully picked up from the motel by Medicaid Transportation, and brought to treatment where they successfully completed and currently maintain recovery; and
- using a housing voucher for an individual who is a Veteran but could not connect with VA services in time to get safe housing the night they returned home from treatment—the individual contacted ORACLE requesting assistance with housing and we were able to place them in the motel for the night and get them connected to the VA the following day, who then connected them with long-term housing.

TIPS FOR YOUR COMMUNITY

- **Referrals.** Initially, organizations made their own referrals, but it was difficult to check each referral for eligibility against the voucher criteria. To simplify the process and collect data, we designated a point person within the organization to assess referrals for voucher criteria and link them to Family of Woodstock for voucher processing.
- **Partnership with DSS.** After someone completes their treatment program, emergency housing can typically be obtained from DSS. If we provide assistance for people in completing their application within a reasonable timeframe, DSS will cover housing costs.
- **Emergency housing vouchers.** Using an organization that already processes emergency housing vouchers through the county's DSS is efficient. Having a 24/7 hotline is important for off hours.
- **HRMT case review.** An HRMT case review meeting was useful to problem solve the barriers to getting individuals into treatment.
- **Transition to treatment.** Initially, there were no limits on the number of housing vouchers available to individuals. A specific time frame was introduced to encourage a speedier transition into treatment. If someone needed more time to prepare, they could apply for recertification to extend the time limit.
- **Care packages.** Individuals were leaving the motels because of lack of food and basic necessities. To prevent this from happening, care packages were provided to the individuals to help them settle in and avoid leaving, which could increase risks. These care packages were funded by HCS.

> *The HEAL Motel Voucher program has saved countless lives. When people do not feel safe, have food, shelter, and compassion, they are unlikely to work on their recovery. We have successfully linked 64 individuals to inpatient treatment in one year due to this incredible program!*
>
> —David McNamara, Executive Director, Samadhi

6. Evidence-based Strategies to Improve Prescription Opioid Safety

Rationale

The pharmaceutical opioid supply is a source of opioid exposure, contributing to OUD and the opioid overdose crisis. Specific prescribing practices, including excessive prescribing for acute or postoperative pain, prescribing high morphine-equivalent daily dose (e.g., ≥ 90 MME/day) for chronic pain, or co-prescribing opioids and benzodiazepines, increase the risk of opioid overdose. Promoting safer, more judicious opioid prescribing, dispensing, storage, and disposal practices can increase opioid safety, reduce the excess opioid supply in communities, and decrease the risk of overdose from prescribed opioids.

At the same time, there is increased recognition that misapplication of opioid prescribing guidelines (including sudden discontinuation of opioid prescriptions) can lead to significant harm. Therefore, strategies to improve prescription opioid safety should be mindful of current guidance on gradual, individualized tapering and evidence-based pain management guidelines.

Peer-reviewed literature to support prescription safety strategies

Key messages

- 8.7 million people misused prescription opioids in 2021 (NSDUH 2021)
- 45% of people who misused prescription opioids obtained them from a friend or relative (NSDUH 2021)
- Specific prescription features such as a high dose or long initial duration increase the likelihood of unintentional overdose and long-term use (Dowell et al., 2022)

Key citations

- Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. MMWR Recomm Rep. 2022 Nov 4;71(3):1-95. doi: 10.15585/mmwr.rr7103a1.
- Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). 2022.

Goals: This menu is designed to:

1. Reduce high-risk opioid prescribing
2. Encourage appropriate opioid prescribing for acute conditions
3. Reduce opioid prescriptions from multiple prescribers or pharmacies
4. Increase appropriate medication disposal

Communities and healthcare facilities should carefully review state and local regulations before implementation of opioid prescribing, dispensing, and disposal strategies. State prescription drug monitoring programs (PDMPs) can provide prescribers with both patient-specific information regarding opioid use and aggregate prescribing data to assist both in clinical decision-making and development of safer prescribing practices and protocols.

Safer Opioid Prescribing for Acute and Chronic Pain

This section addresses safer opioid prescribing for acute and chronic pain and safer opioid dispensing **(Tool 11)**. Activities to encourage safer opioid prescribing include **offering an academic detailing service** (one-on-one education outreach visits and other engagement activities to improve prescriber decision-making and patient care) for healthcare professionals in primary care, urgent care/EDs, pharmacists, and dentists and **outreach to hospitals' opioid stewardship teams** and colleges of nursing, medicine, and pharmacy.

Other activities for improving opioid safety could include **continuing education** and **PDMP review**.

Pain Management Guidelines

2022 CDC Guideline for Prescribing Opioids for Pain

Tool 11: Strategies for Safer Opioid Prescribing

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Safer opioid prescribing for acute pain across settings (inpatient service, emergency/ urgent care, outpatient clinics, ambulatory surgery, dental clinics)	• What current protocols are in place around prescribing opioids for acute pain? • What could be improved (including use of PDMPs)? • What are the expressed goals around prescribing practices and patient education?	• **Obtain leadership support and identify a champion(s)** for opioid prescribing practices. • **Select and prioritize** guideline recommendations to implement. • **Establish protocol** to enhance providers' use of guidelines for opioid use. • **Train team** on best practices and new protocols. • **Implement** prescribing enhancement protocols and adapt as needed. • **Ongoing monitoring** of use and refresher training of new protocols.	• Number of new high-risk opioid prescriptions for acute pain (e.g., ≥ 90 MME/day) • Number of new opioid prescriptions for acute pain for over 31 days • Number of new prescriptions for acute pain using extended-release or long-acting opioids • Number of new prescriptions for an opioid with an overlapping benzodiazepine for at least 31 days • Percent of prescriptions limited to a 7-day supply of all new opioid prescriptions for acute pain • Number of opioid prescriptions from multiple prescribers or pharmacies	• PDMP data • Electronic health record review from healthcare setting (requires permission/ access) • IQVIA data (costs involved)
Safer opioid prescribing for chronic pain (adherence to Centers for Disease Control and Prevention (CDC) guidelines, patient-centered opioid tapering)	• What current protocols are in place around prescribing opioids for chronic pain? • What could be improved (including use of PDMPs)? • What are the expressed goals around prescribing practices and patient education?	• **Obtain leadership support and identify a champion(s)** for opioid prescribing practices. • **Select and prioritize** guideline recommendations to implement. • **Establish protocol** to enhance providers' use of guidelines for opioid use. • **Train team** on best practices and new protocols. • **Implement** prescribing enhancement protocols and adapt as needed. • **Ongoing monitoring** of use and refresher training of new protocols.	• Number of new high-risk opioid prescriptions for chronic pain (e.g., ≥ 90 mg/day) • Number of new prescriptions for chronic pain using extended-release or long-acting opioid • Number of new prescription for an opioid with an overlapping benzodiazepine for at least 31 days • Number of new prescriptions for an opioid with a naloxone co-prescription • Number of opioid prescriptions from multiple prescribers or pharmacies	• PDMP data • Electronic health record review from healthcare setting (requires permission/ access) • IQVIA data (costs involved)

continued

Tool 11: Strategies for Safer Opioid Prescribing (continued)

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Safer opioid dispensing (such as use of PDMPs and NARx score, improved communication with prescribers, and naloxone co-prescription)	• What settings can offer pharmacy education (e.g., schools of pharmacy, pharmacies within the community)? • What protocols are currently in place? • What could be improved (including use of PDMPs)? • What training is needed for pharmacists?	• **Develop pharmacist education** and outreach strategies to promote safe opioid dispensing practices. • **Develop patient education** materials on safer opioid use for pharmacists to use during counseling. • **Develop tools** for monitoring pharmacist outcomes and efficacy of materials. • **Train pharmacists**. • **Ongoing monitoring** and refresher trainings.	• Number of new prescriptions for an opioid with a naloxone co-prescription • Number of naloxone units distributed through pharmacies • Number of opioid prescriptions from multiple prescribers or pharmacies	• PDMP data • Review of pharmacy data (requires permission/access)

Implementation resources for strategies for safer opioid prescribing

Safer opioid prescribing for *acute* pain: **pain management guidelines**	» Guideline for Discharge Opioid Prescriptions after Inpatient General Surgical Procedures: A 2017 guideline for postoperative patients. Indicates that postdischarge opioid use is best predicted by usage the day before discharge and predicts that 85% of patients' postoperative home opioid requirements would be satisfied using their guideline. » Opioid-Prescribing Guidelines for Common Surgical Procedures: An Expert Panel Consensus): A 2018 guideline from the American College of Surgeons: Opioids After Surgery Workgroup. For 20 surgical procedures reviewed, the minimum number of opioid tablets recommended by the panel was 0. Ibuprofen was recommended for all patients unless medically contraindicated. The maximum number of opioid tablets varied by procedure (median 12.5 tablets), with panel recommendations of 0 opioid tablets for 3 of 20 (15%) procedures, 1 to 15 opioid tablets for 11 of 20 (55%) procedures, and 16 to 20 tablets for 6 of 20 (30%) procedures. » Dental Guideline on Prescribing Opioids for Acute Pain Management: A 2017 guidance developed by the Bree Collaborative and Washington State Agency for Medical Directors Group. An easy-to-use reference to help dentists and oral surgeons follow a set of clinical recommendations to align opioid prescribing with current evidence. » The Treatment of Acute Pain in the Emergency Department: A White Paper Position Statement Prepared for the American Academy of Emergency Medicine: A 2018 guideline that provides resources for the safe use of opioids in the ED and pharmacological and nonpharmacological alternatives to opioid analgesia. Emphasizes that care should be tailored to the patient based on their specific acute painful condition and underlying risk factors and comorbidities.

continued

Tool 11: Strategies for Safer Opioid Prescribing (continued)

Implementation resources for strategies for safer opioid prescribing	
Safer opioid prescribing for *acute* pain: **prescriber education**	» Opioid Prescribing Best Practices: Warning Signs, Tapering Strategies, and Alternatives. A two-part video interview with Dr. Arwen Podesta from Psych Congress Network. » Safer Post-Operative Prescribing of Opioids: This continuing medication education (CME) activity shares best practices in postoperative opioid prescribing to reduce the number of excess opioids left over following a surgery. » Education for Clinicians Treating Patients with Opioids for Chronic Pain: An animated video that focuses on four key strategies: Reducing Risk for Development of OUD and Avoidance of Misuse, Identification of Risk Factors, Safety Planning, and Overdose Rescue Preparation.
Safer opioid prescribing for *acute* pain: **academic detailing and consult services**	» Best Practices in Academic Detailing for Opioid Safety: Links to materials for conducting academic detailing campaigns generally and specifically targeting opioid safety. Developed at Brigham & Women's Hospital, Division of Pharmacoepidemiology. » Academic Detailing Service - Pain & Opioid Safety Initiative (OSI) Materials: U.S. Department of Veterans Affairs (VA): Pain resources for providers, including a pain management and opioid safety quick reference guide, dose and taper tools, and a chronic pain and suicide factsheet. Patient-facing resource related to risk of combining opioids and benzodiazepines. » PCSS Mentoring Program: National program connecting clinicians with one-on-one mentoring about pain management or addiction, or offers participation in clinical forums.
Safer opioid prescribing for *acute* pain: **patient education resources**	» Pain Education Toolkit for Patients: Patient handouts from Oregon Pain Guidance cover topics such as how pain works, sleep hygiene for pain, and videos that address questions like, "How does mood affect your pain?" "Why does activity help with pain?" and "Why should I think about reducing my pain medication?" Handouts are available in English, Spanish, Russian, Vietnamese, and Zhuang. » CDC Information for Patients: Information for patients about pain treatment, expectations for opioid therapy, and preventing misuse and overdose. Includes handouts and infographics about the CDC guideline, promoting safer and more effective pain management, and preventing overdose.
Safer opioid prescribing for *chronic* pain: **prescriber education**	» SCOPE of Pain Core Curriculum: A series of online or in-person CME activities designed to help practitioners safely and effectively manage patients with chronic pain, when appropriate, with opioid analgesics. » Safe and Competent Opioid Prescribing: Optimizing Office Systems: A CME activity to help clinicians reengineer office systems to reduce the potential for opioid misuse, addiction, or diversion while ensuring safe evidence-based care of patients with chronic pain. » SCOPE of Pain supplemental training: Includes online activities for opioid prescribing in special populations, naloxone co-prescribing, opioid tapering, and state-specific training for practitioners in New York and Massachusetts. » PCSS: Extensive resource provided by SAMHSA, including free CME and mentorship. A 13-module course "Management of Chronic Pain: A Core Curriculum for Primary Care Providers" covers key topics in chronic pain assessment and management, opioid risk assessment and management, opioid use disorder (OUD) in patients with chronic pain, and communication strategies.

continued

Tool 11: Strategies for Safer Opioid Prescribing (continued)

Implementation resources for strategies for safer opioid prescribing	
Safer opioid prescribing for *chronic* pain: **tapering guidelines and resources**	» CDC Pocket Guide for Tapering Opioids for Chronic Pain: A high-level overview of when and how to taper opioids for chronic pain. » Tapering Guidance & Tools: Includes a tapering flowchart and the BRAVO protocol for patient-centered opioid tapering. » VA Opioid Taper Decision Tool: A guide developed by VA to help clinicians determine when a taper is indicated and how to perform the taper and support patients throughout the taper. » RxFiles Opioid Tapering Template: Information for providers and patients to help guide opioid tapering, including a template for writing out a suggested opioid taper over time and managing symptoms of opioid withdrawal.
Safer opioid prescribing for *chronic* pain: **naloxone co-prescribing**	» PrescribetoPrevent.org: This website provides information for providers, pharmacists, and patients and families about how to prescribe, obtain, and use naloxone to prevent fatal opioid overdose.
Safer opioid prescribing for *chronic* pain: **pharmacist education**	» Scope of Pain: Series of online or in-person CME activities designed to help practitioners safely and effectively manage patients with chronic pain, when appropriate, with opioid analgesics.

KEY INSIGHTS

A qualitative study interviewing community members across the sites implementing the CTH intervention identified the following themes related to opioid prescribing practices:[22]

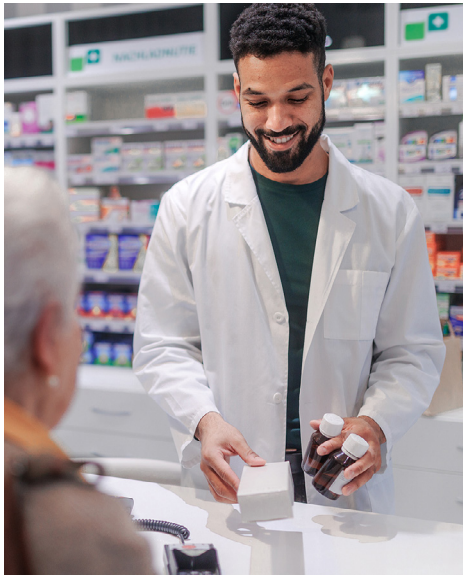
1. **Acknowledging progress** by recognizing that healthcare providers are part of the solution, provider educational opportunities, and use of PDMP.
2. **Emergent challenges** related to physician nonadherence to guidelines, difficulty identifying appropriate use of opioids, and concerns about accelerating the progression from opioid misuse to drug abuse.
3. **Opportunities for change** through patient, prescriber, and pharmacist education, changing expectations around completely eliminating pain, and expanding access and insurance coverage for non–opioid-based pain management.

Need to expand education to dentists and veterinarians:

> *We never really include dentists in the conversation. And we have been doing surveys with the community and asking people about like getting opiate prescriptions. And a lot of time they're saying they got them from their dentist. And I don't think that's a group that we often include in our conversation. And we've also heard from some rural residents that people are diverting medications that they receive from the vet for their animals. I feel like we don't think about dentists and veterinarians at the table when we're talking about reducing prescriptions."*
>
> —Community member within criminal legal sector in New York

Changing unrealistic expectations around pain:

> *I think the consequences of [over prescribing]...are lagged, they're gonna just be affecting us, I think, for a long time in terms of initiation of those behaviors because those are the broader challenges with prescribing universally and prescribing practices for opioids. Demand for them especially among, I think, older adults who are in pain, have been told for the last 30 years or so that they shouldn't be in pain, it's a vital sign, and that there's drugs to help. So I think [it's] the legacy of availability."*
>
> —Educator in New York



Safe Disposal Practices

Leftover (unused) prescription opioids are a potential source for opioid misuse and accidental poisoning. Providing safe, convenient, and environmentally appropriate options for disposing of unused prescription opioids can help reduce opioid supply within communities and prevent access by children, adolescents, and other vulnerable populations.

The three recommended means of drug disposal are

a. **Drug take-back events** sponsored by law enforcement agencies
b. **Permanent drug drop-box kiosks** in law enforcement, pharmacy, and other healthcare locations
c. **Take-home disposal mechanisms** such as mail-back envelopes, which are typically sold or provided by participating pharmacies

This section outlines the associated resources and toolkits for decreasing community opioid supply through more robust drug disposal programs **(Tool 12)**. Communities wishing to expand drug disposal options should identify current drug disposal locations, weigh the costs and benefits of each type of program, and review state and local regulations concerning drug disposal prior to implementation.

Tool 12: Strategies for Safe Disposal

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Drug take-back events, prescription drug drop-boxes, and mail-back programs	• Where in the community can people dispose of leftover opioids? • Are local pharmacies receptive to hosting a prescription drug drop-box? • What are potential barriers to implementing a safer disposal program (e.g., lack of community buy-in, lack of awareness)?	• **Establish partnerships** with key governmental officials, law enforcement, pharmacies. • **Identify** potential settings for prescription drug disposal. • **Implement** prescription drug disposal program and adapt as needed.	• Number of drug take-back events over 1 year • Number of prescription drug drop-boxes • Number of mail-back programs in place • Pounds of medication incinerated	• Local pharmacies • Law enforcement • Community organizations

continued

Tool 12: Strategies for Safe Disposal (continued)

Implementation resources for strategies linking or bridging MOUD treatment by setting	
Identification of current drug disposal locations	» DEA Controlled Substance Public Disposal Locations Search Utility: A public database contains locations that have registered with the Drug Enforcement Administration (DEA) for controlled substance disposal, searchable by ZIP code or city/state up to a 50-mile radius. Does not contain law enforcement–affiliated drug disposal locations. » NABP AwareRx Drug Disposal Locator: A public database of permanent U.S. drug disposal sites for consumers, searchable by ZIP code or city/state up to a 100-mile radius. Contains law enforcement–affiliated drug disposal locations; does not contain all DEA-registered facilities. Maintained by the National Association of Boards of Pharmacy. » National Drug Take Back Day: Information on DEA's national drug take-back day events in April and October. Includes a "Partnership Toolkit" with PSAs, posters, handouts, and other materials to promote National Prescription Drug Take-Back Day. » Safe Drug Disposal: A Guide for Communities Seeking Solutions: A 14-page guide written by Partnership for Drug-Free Kids to "help community officials and organizers design a safe drug-disposal program for their community." Focuses on three elements of drug disposal: collection, destruction, and promotion of the drug disposal service. Includes links to federal agencies involved in safe drug-disposal programs (DEA, FDA, EPA, and DOT). » Registrant for Drug Disposal: A website that includes link to get registered with DEA as a drug take-back receptor and to have receptacles installed at registered site.
Implementation of prescription drug disposal program	» National Drug Take-Back Day – Information on DEA's national drug take-back day events in April and October. – Includes a "Partnership Toolkit" with PSAs, posters, handouts, and other materials to promote National Prescription Drug Take-Back Day. » Safe Drug Disposal: A Guide for Communities Seeking Solutions – A 14-page guide written by Partnership for Drug-Free Kids to "help community officials and organizers design a safe drug-disposal program for their community." – Focuses on three elements of drug disposal: collection, destruction, and promotion of the drug disposal service. – Includes links to federal agencies involved in safe drug-disposal programs (DEA, FDA, EPA, and DOT). » How-to Guide for Drug Take-Back: Managing a Pharmacy-based Collection Program for Leftover Household Pharmaceuticals – A 40-page guide published by the Product Stewardship Institute to offer "step-by-step guidance" to pharmacies and other stakeholders wishing to set up a drug take-back program. – Provides details on modifying DEA registration to become a collector, selecting collection systems, setting up and operating the program, and promoting the service. – Appendix B includes a list of vendors to consider for take-back receptacles and disposal services. » Registrant for Drug Disposal – A website that includes link to get registered with DEA as a drug take-back receptor and to have receptacles installed at registered site

continued

Cost Considerations and Resources

Communities seeking to provide safer opioid prescribing education for healthcare providers and pharmacists can access free or low-cost educational trainings featured within the implementation resources shared above. Continuing education credits are often offered after completing these trainings, which can incentivize providers to participate. Free patient educational materials (e.g., posters, handouts) are available through CDC's Injury Center.

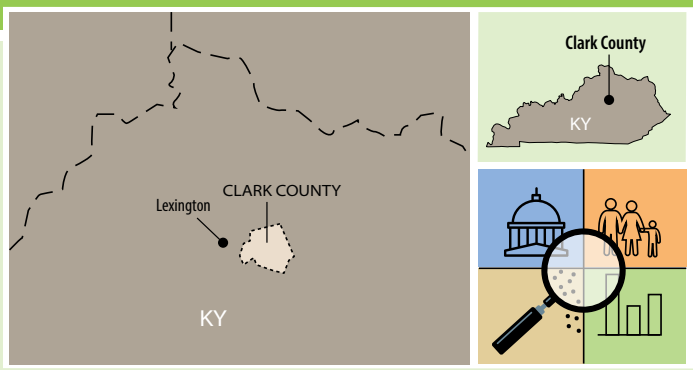
Costs associated with safe disposal strategies will vary depending on the approach used. This "Prescription Drug Take Back Toolkit" describes costs for a drug take-back event including hiring a law enforcement officer (~$30–$40/hour), costs of incinerating collected medications, and advertising. An alternative to organizing an event would be to publicize National Prescription Drug Take-Back Day and locations accepting leftover medications within the community.

Cost considerations for communities interested in establishing permanent drug disposal kiosks in law enforcement offices, pharmacies, and other healthcare settings are described in **Tool 13**. In a case study featured within the Product Stewardship Institute's How-to Guide for Drug Take-back, five rural pharmacies piloted a drug take-back program and calculated the total cost of promotion/outreach and collection materials (e.g., permanent drug drop-box, mail-back envelopes). The reported costs did not include employee time, which was determined to be minimal. The costs for the first year (i.e., pilot) of a drug take-back program for a pharmacy was $3,713 for independent pharmacies and $5,250 for a hospital-affiliated pharmacy. The five pharmacies collected around 300 pounds of leftover drugs.

The costs of implementing specific prescription drug safety strategies in HCS communities are still being researched and will be shared via the HCS Dissemination website (https://hcs.rti.org) over the coming months.

Tool 13: Permanent Drug Disposal Strategy Cost Considerations

Cost consideration	Estimated costs
Permanent drug drop-box kiosk (i.e., locking prescription drop-box)	~$300–$1,100 with varying sizes, available through medical supply websites
Drug deactivation and disposal pouch	~$2–$6 per pouch, available online
Raising awareness around permanent prescription drug take-back locations	This how-to guide includes in-pharmacy advertising strategies, social media guidance, and practical guidance on piloting a permanent drug drop-box



STORIES FROM THE FIELD

Using existing systems and collaborating with community pharmacy partners to create and promote medication drop-box/safe disposal locations

CLARK COUNTY, KENTUCKY

COMMUNITY PROFILE

Clark County, Kentucky

Clark County is a small, urban community in Central Kentucky that has been highly impacted by opioid overdose. Its systems, including the county jail and a syringe service program, could support adopting proven practices to reduce opioid overdose deaths.

Rate of fatal opioid overdoses

The 2020 age-adjusted opioid overdose death rate in Clark County was 73.5 per 100,000 residents,[23] which was higher than the national rate of 21.4 per 100,000.[24] Age-adjustment is a measure applied to rates that allows communities with different age structures to be compared.

Author: Laura K. Stinson, PharmD, HCS Academic Detailing Pharmacist

CLARK COUNTY COALITION

When looking at the Clark County community, there were no permanent pharmacy-based medication disposal options for controlled substances. These are drugs, such as prescription opioids, that are closely regulated by the government based on their potential for misuse and dependence. The nearest pharmacy with a place to dispose of these drugs was about 30 minutes away in a neighboring county. Because public transportation is not available to make this trip, this created challenges for people in Clark County without their own means of transportation.

Two local law enforcement agencies offered to dispose of controlled substances. But many people are not comfortable returning drugs—such as prescription opioids—to police departments or sheriff's offices. So these types of locations are not visited regularly by most people.

Information about the lack of disposal locations was shared with the Clark County Coalition. Pharmacists helped educate members of the coalition about the need for medication disposal for prescription opioid safety and options for increasing safe disposal to be available in their community.

Pharmacists highlighted the following:

- The number of prescription opioids that are not used
- The large portion of misused prescription pain relievers that are obtained from friends and relatives
- The increased chances of medication disposal when it is recommended by a healthcare provider, such as a pharmacist, and when the disposal site is in a convenient location, such as a community pharmacy

Challenge: How to create and promote medication drop-box/safe disposal locations

The Clark County Coalition saw the lack of convenient disposal options as a large gap with a high priority. Members also talked about medication take-back events held by law enforcement agencies. But low attendance at these events further emphasized the need for permanent disposal options for prescription opioids that are placed in convenient locations.

Based on the limited number of medication disposal locations and the fact that those available were associated with law enforcement, the community set a goal to increase the number of safe disposal locations within Clark County.

Strategy Approach:
Use existing systems and collaborate with community pharmacy partners

The Clark County Coalition identified possible priority community pharmacies as disposal sites based on their location and which patients they serve. Priority selection looked at people who are underserved and the convenience of locations. Coalition members who could help communicate with possible pharmacy partners were also identified.

Team members contacted all community pharmacies in Clark County—beginning with the priority locations—by phone, email, mail, virtual meeting, or in-person visit—with information about pharmacy-based disposal drop-boxes, an offer to provide a disposal drop-box and supplies, and instructions for ordering them. Team members worked closely with pharmacy owners, corporate offices, and pharmacy technicians to make the ordering process easier for all pharmacies that accepted. This included providing technical assistance when registering with the DEA to be able to collect controlled substances. Changing the DEA registration was a barrier in many locations, so team members worked with pharmacies to simplify the process.

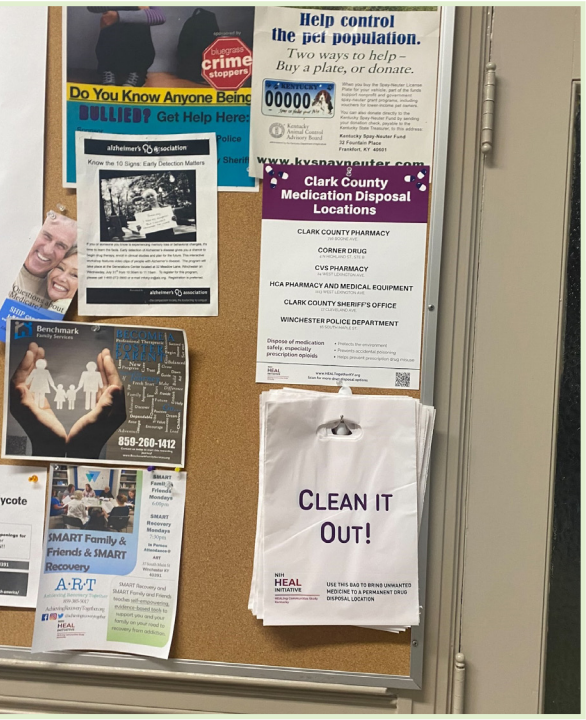
The following resources and support were also provided:

- Training on the disposal drop-boxes was offered to all pharmacy partners by virtual meeting, in person, or using a brief recorded video
- Follow-up calls or visits were made one month after the drop-box was installed and then every 3 months to identify challenges, report success, and offer assistance
- Public service radio announcements and ads in local publications promoted the importance of prescription opioid disposal and locations for disposal in the county
- Posters and bags encouraging medication disposal were placed in public locations, such as the public library, courthouse, and health department
- Community pharmacy partners reported new people visiting their pharmacy to use the disposal drop-box because of these efforts
- The Coalition looked at options for funding disposal drop-boxes over time and identified a local organization as a source for financial support
- Staff shared this information with pharmacy partners and also talked about the future costs and needs related to the drop-boxes, such as training, materials, and answering questions

> *It's a responsible thing to do for the community and there's always positive feedback from any patient who sees it.*
>
> —Local independent pharmacy owner and Clark County partner

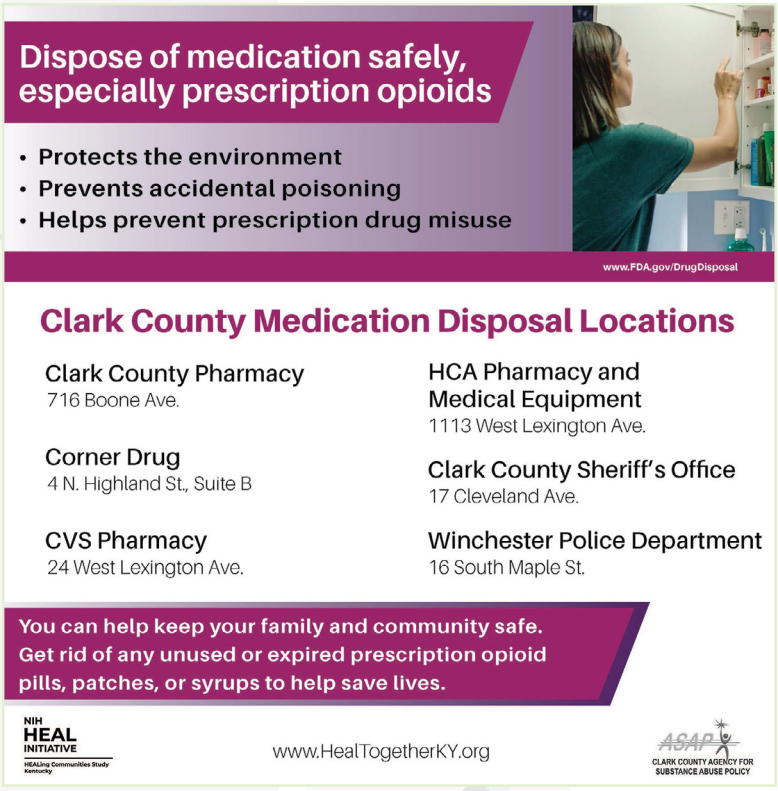
OUTCOMES AND OTHER BENEFITS

- We installed drop-boxes in four community pharmacies in Clark County (three independent pharmacies and one chain pharmacy). This exceeded our goal to have a permanent drop-box in about a third of community pharmacies in a county or one drop-box available for every 25,000 county residents.
- Two of the three priority locations identified by the coalition members agreed to install a drop-box. In interviews, participants reported that doing this did not create a big burden on pharmacy staff, the drop-box was convenient, and providing this service to their community was rewarding.
- The Coalition approved this approach in October 2020 and as of May 2023, the pharmacy partners in Clark County had returned 767 lbs. of medication to be incinerated, indicating that the approach is being sustained successfully.



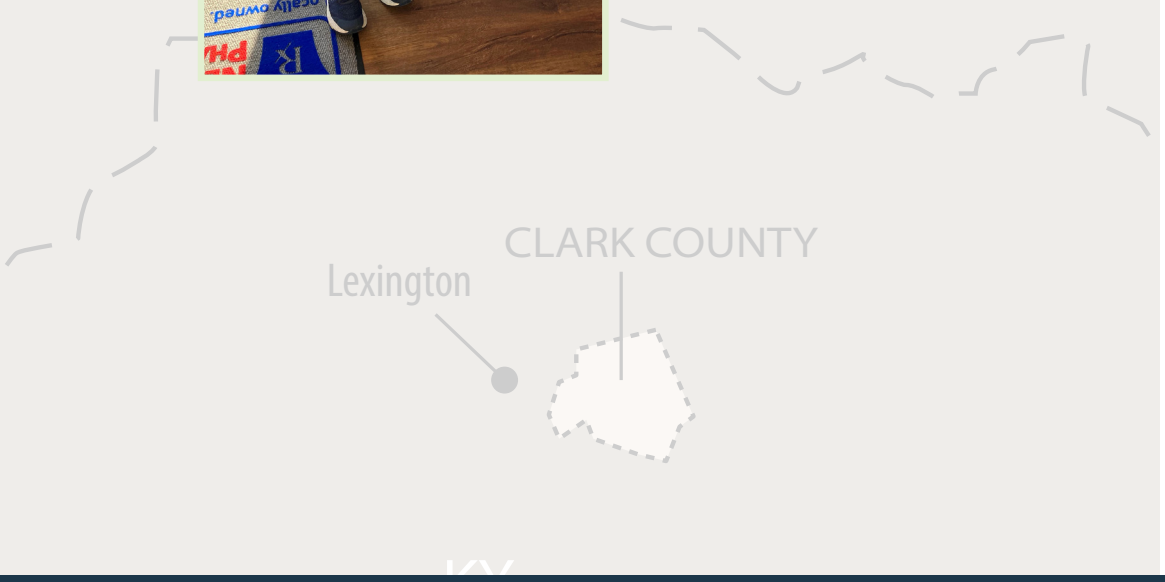
> *It's very user friendly, it's just been really great actually. It's very convenient for our customers.*
>
> —Clark County partner pharmacist

> *It's been really good … just being able to provide another service that people ask for so often.*
>
> —Clark County partner pharmacist



TIPS FOR YOUR COMMUNITY

- Overcoming barriers, such as cost and lack of information, increases acceptance of installing disposal drop-boxes in community pharmacies.
- The amount of medication that's been collected and destroyed from Clark County shows the previously unmet need for convenient disposal locations in this community.
- Community pharmacy partners can successfully carry out programs to increase prescription opioid safety when given the resources to overcome barriers.
- Promoting medication disposal and locations in a community using radio and newspaper ads can lead to increased use of disposal drop-boxes.



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Appendices

APPENDIX A. TOOLS FOR DATA-DRIVE STRATEGY SELECTION

Strategies to Increase Opioid Overdose Prevention Education and Naloxone Distribution (OEND)						
Strategy and Venue	**Current Activity**	**Size of Gap (Current Activity vs. Need)**	**Feasibility in <12 Months**	**Impact on Overdose Deaths**	**Potential reach with underserved populations**	**Priority Score**
From the ORCCA menu, brainstorm possible strategies to meet the community OEND goals. Record all strategies in this column.	Briefly summarize current activity in your community.	0. None 1. Small 2. Medium 3. Large	0. Extremely low 1. Low 2. Medium 3. High	1. Low 2. Medium 3. High	1. Low 2. Medium 3. High	Add previous four columns. If any column contains 0, priority score is 0.
Strategies to Enhance Delivery of MOUD Treatment, Including Agonist/Partial Agonist Medication						
Strategies to Improve Prescription Opioid Safety						

ORCCA Strategy Selection Tool

From your community assessment, what is the most urgent priority in your community regarding opioid overdose prevention?	
List a potential strategy from the ORCCA menu that your community wants to implement.	
Higher risk population prioritized:	
Setting engaged:	
What resources within this practice guide would be helpful as you plan and advance implementation?	
What data do you have to inform your choice?	
What data do you need to inform your choice?	
What technical assistance and training resources do you think may be needed?	
Who should be at the table to plan and advance this strategy?	

APPENDIX B. HEALing COMMUNITIES STUDY

NIH HEAL INITIATIVE
HEALing Communities Study

The National Institutes of Health and the Substance Abuse and Mental Health Services Administration launched the HEALing Communities Study to test the immediate impact of an integrated set of evidence-based interventions across healthcare, behavioral health, criminal legal, and other community-based settings to prevent and treat opioid misuse and opioid use disorder within highly affected communities.[25] The HCS tests the impact of the Communities that HEAL (CTH) intervention, which seeks integration of prevention efforts, overdose treatment, and medication-based treatment in select communities hard hit by the opioid crisis. The CTH contains three components: (1) a community-engaged coalition and data-driven process to facilitate the implementation of evidence-based practices;[26] (2) the ORCCA menu of strategies;[27] and (3) communication campaigns to address stigma and increase knowledge of, and demand for, evidence-based practices.[28] This comprehensive treatment model was tested in a coordinated array of settings, including primary care, emergency departments, and other community settings.

The goal of the HCS is to reduce opioid-related overdose deaths by 40 percent over the course of 3 years. Research sites partnered with 67 communities highly affected by the opioid crisis in four states to measure the impact of these efforts. The study looks at the effectiveness of coordinated systems of care designed to increase the number of people receiving medication to treat OUD, increase the distribution of naloxone, and reduce high-risk opioid prescribing. The study also supports harm reduction research to investigate the effectiveness of rapid-acting fentanyl test strips in modifying drug use behaviors and exploring drug checking needs in clinical settings.

Within the HCS study, community coalitions were required to select at least five ORCCA menu strategies with a minimum of (1) one strategy involving active OEND; (2) three strategies involving MOUD expansion, linkage, or retention; and (3) one strategy on safer opioid prescribing/dispensing practices. In addition, the study protocol required coalitions to implement

at least one EBP strategy in three key sectors (behavioral health, criminal legal, and healthcare). Coalitions were encouraged to consider EBP strategies focused on those most vulnerable to opioid overdose (e.g., people with a prior opioid overdose, people who inject drugs) and priority settings (e.g., correctional settings, syringe service programs). Additional detail on the development of the ORCCA menu can be found in Winhusen et al.[27]

Research grant awards were issued to the University of Kentucky in Lexington; Boston Medical Center in Boston; Columbia University in New York City; and Ohio State University in Columbus. The HCS is a multiyear study under a cooperative agreement supported by the National Institute on Drug Abuse, part of the National Institutes of Health. The study launched in 2019 and results will be shared in the summer of 2023. Technical details and specifics about study design and how intervention success was evaluated can be found in this overview of the HEALing Communities Study Consortium.[25]

APPENDIX C. ACKNOWLEDGMENTS

Technical Expert Panel Members

- **Laura Fanucchi**, MD, MPH, Associate Professor of Medicine, Division of Infectious Disease, University of Kentucky College of Medicine
- **Fernando González**, MD, MPH, Manager, EMS Opioid Prevention Program, UTHealth San Antonio/Project Vida
- **Chase Holleman**, LCSW, LCAS, Public Health Analyst, SAMHSA Center for Substance Abuse Prevention
- **Edward V. Nunes**, MD, Professor of Psychiatry, Columbia University Irving Medical Center
- **Richa Ranade**, MPH, Senior Director, Overdose Prevention, Association of State and Territorial Health Officials
- **Angelia Smith-Wilson**, EdD, MSW, Executive Director, Friends of Recovery-New York
- **Jessica Taylor**, MD, Assistant Professor of Medicine, Boston University School of Medicine, Boston Medical Center
- **John T. Winhusen**, PhD, Professor, Vice Chair of Addiction Sciences, University of Cincinnati, College of Medicine

HEALing Communities Study

- Continuum of Care Work Group
- Community Engagement Work Group

Substance Abuse and Mental Health Services Administration

- **Yngvild K. Olsen**, MD, MPH, Director of the Center for Substance Abuse Treatment
- **Karran Phillips**, MD, MSc, Deputy Director of the Center for Substance Abuse Treatment
- **Carter Roeber**, PhD, MA, Social Science Analyst, National Mental Health and Substance Use Policy Laboratory
- **Humberto Carvalho**, MPH, Project Officer, Center for Substance Abuse Treatment

National Institute on Drug Abuse

- **Redonna K. Chandler**, PhD, Director of the HEALing Communities Study
- **Jennifer Villani**, PhD, MPH, Associate Director of the HEALing Communities Study
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RTI Data Coordinating Center

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- **Rebecca Hipp**, BS, Senior Project Management Specialist
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- **Michelle Myers**, BS, Senior Editor

APPENDIX D. TECHNICAL EXPERT BIOGRAPHIES

Laura Fanucchi, MD, MPH, FASAM, is Associate Professor of Medicine at the University of Kentucky in the Division of Infectious Diseases and the Center on Drug and Alcohol Research. Dr. Fanucchi graduated from Emory University School of Medicine and completed a residency and chief residency in Internal Medicine at New York – Presbyterian Hospital/Weill Cornell. Dr. Fanucchi is board-certified in Internal Medicine and Addiction Medicine and is the founding Director of the University of Kentucky inpatient Addiction Consult and Education Service. Her research is focused on developing innovative approaches to current clinical problems in the treatment of opioid use disorder that translate to improved outcomes. Dr. Fanucchi is an NIH/NIDA-funded clinical researcher and has received support from AIDS United and the Kentucky Opioid Response Effort for clinical service expansion and improvement in addiction medicine. She is a Co-Investigator on the HEALing Communities Study – Kentucky, providing clinical expertise, training, and technical assistance to support increasing access to medications for treatment of opioid use disorder in communities highly impacted by the opioid epidemic.

Fernando González, MD, MPH, has more than 37 years of experience in Public Health work in the United States and Mexico, with emphasis in the United States-Mexico border. He graduated from medical school at the University of Juarez, Mexico and received an MPH degree from the UTHealth Houston School of Public Health. Dr. González currently serves as manager for the EMS Opioid Prevention Program at UTHealth San Antonio/Project Vida in El Paso, Texas. The program provides peer support and clinical response services and develops predictive analytic models for optimal resource allocation. For more than 16 years, Dr. González has collaborated as senior consultant for Links Global based in Rockville, MD. The company provides worldwide solutions across many sectors, including public health. He has developed ample professional experience in global health, working and collaborating in both the United States and Mexico with federal, state, and international agencies such as Ministry of Health, Mexico; Pan American Health Organization; CDC; Texas Department of Health; U.S.-México Border Health Commission, U.S.; and Mexico Border Health Association. Dr. González has publications on maternal and child health, tuberculosis, public health services, and infectious diseases and has received awards and recognition from several agencies in the United States and Mexico.

Chase Holleman, LCSW, LCAS, serves as a Public Health Advisor in the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention. As part of the Office of Prevention Innovation, Mr. Holleman serves in a lead role supporting harm reduction efforts within the Center and across the Agency as a subject matter expert. In his previous role as Assistant Professor at UNC-Greensboro, he cofounded and directed GCSTOP, a novel harm reduction services program that doubles as a clinical training site for undergraduate and graduate social work students.

Edward "Ned" Nunes, MD, is a Professor of Psychiatry at Columbia University Irving Medical Center and Research Psychiatrist at New York State Psychiatric Institute. He is an internationally recognized leader in research on treatments for opioid use disorder and other substance use disorders and on co-occurring psychiatric and substance use disorders. For the past 30 years with continuous funding from NIH, mainly National Institute on Drug Abuse (NIDA), including a series of Career Development Awards, he has led clinical trials on medication and behavioral treatments for cocaine and opioid use disorders.

Richa Ranade, MPH, leads the overdose prevention department of the Association of State and Territorial Health Officials (ASTHO). In this role, she oversees ASTHO's technical assistance and capacity building related to overdose prevention, preparedness, mortality data, and surveillance. These technical assistance and capacity-building efforts regularly convene public health agencies, behavioral health agencies, public safety partners, harm reduction professionals, and others to collectively advance the public's health and well-being. Prior to joining ASTHO, Ms. Ranade was a health policy advisor for the Maryland Department of Health, where she managed multiple maternal and child health training and technical assistance programs. Earlier in her career, she supported and led qualitative and quantitative public health research efforts that aimed to describe the role of social determinants of health in health disparities. She completed her Master of Public Health at the George Washington University and a Bachelor of Science degree at the Pennsylvania State University. Ms. Ranade is passionate about facilitating partnerships, implementing evidence-based programs, and supporting the public health workforce.

Angelia Smith-Wilson, EdD, MSW, brings over 20 years of human service and addiction experience to Friends of Recovery-New York. Her career spans across working with human service agencies that have served people with mental health, substance use, residential, and homeless issues. She has worked as an intensive case manager, a primary therapist, a director of client services and eventually progressing to level of vice president throughout the greater Rochester and Albany NY area. Dr. Smith-Wilson has centered her career around improving recovery and treatment outcomes for those in recovery and exploring research designed at substance use counselor development. Her doctoral dissertation, "Examining the Relationship between the Substance Abuse Counselor Knowledge of the Models of Disability and their self-assessment of cultural competence working with the Deaf Sign Language User," afforded her the opportunity to learn and study addictions from the counselor's perspective. Her research further led her to develop trainings centered around cultural humility and its application to working with people in recovery. Dr. Smith-Wilson has a BS in Psychology from SUNY Brockport, MSW from Roberts Wesleyan College, and EdD from St. John Fisher College. Dr. Smith-Wilson is adjunct

faculty at the School of Social Welfare, Graduate MSW Program, University of Albany, where she teaches Macro Practice Social Work in the MSW program and a variety of undergraduate courses. She is currently a member of Black Faces, Black Voices, and on the CAPRRS Advisory Committee for Faces and Voices of Recovery, and a founding board member of Girls Beyond Inc.

Jessica L. Taylor, MD, is an Assistant Professor of Medicine in General Internal Medicine at the Boston University School of Medicine (BUSM) and Boston Medical Center (BMC) and a board-certified Addiction Specialist. She attended Mount Sinai School of Medicine and completed internal medicine residency training at Beth Israel Deaconess Medical Center and Harvard Medical School, where she also served as a Chief Resident. Dr. Taylor's clinical work focuses on the care of patients with substance use disorders, HIV, and viral hepatitis. Her research interests include HIV prevention among people who inject drugs, HIV pre-exposure prophylaxis implementation, low-barrier substance use disorder treatment models, and overdose prevention. She is Co-Director of the Care Continuum Core for the Massachusetts site of the NIDA-funded Healing Communities Study, which aims to reduce fatal opioid overdose by 40 percent. Dr. Taylor is the Medical Director of Faster Paths to Treatment, Boston Medical Center's innovative, low-barrier substance use disorder bridge clinic and she codirects clinical services in a former hotel that offers low-threshold, transitional housing for people experiencing homelessness. She directs HIV Prevention Programs at BMC. Her educational roles include directing the HIV Pathway for internal medicine residents and serving as core faculty in BUSM's Addiction Medicine fellowship program.

John Winhusen, PhD, is a Professor and Vice Chair of Addiction Sciences in Psychiatry, and the Director for the Center for Addiction Research at the University of Cincinnati College of Medicine. He has been a continuously funded NIDA investigator for over 20 years with much of his career focused on conducting clinical trials evaluating medication and psychosocial interventions in "real-world" clinical settings. Most of this work has been accomplished through his roles as both a lead investigator (national PI) of multisite clinical trials and node PI in the National Drug Abuse Clinical Trials Network (CTN). The research that Dr. Winhusen conducts has the goal of improving public health by improving addiction treatment outcomes and has been largely influenced by the two "epidemics" that have occurred during his career—the crack cocaine epidemic and the opioid epidemic. Since 2014, he has led or co-led eight NIDA-funded opioid-focused studies. As co-chair of the NIDA CTN Prescription Opioid Task Force, Dr. Winhusen played a critical role in developing the CTN Opioid Research Task Force Report, which outlined research priorities for addressing the opioid use epidemic. He serves as the Co-PI for the Ohio Healing Communities Study (HCS) and leads the national HCS Care Continuum workgroup.

The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery

The opioid crisis poses an extraordinary challenge to communities throughout our country. The Department of Justice (the Department) has responded with a comprehensive approach prioritizing prevention, enforcement, and treatment. This includes enforcing the Americans with Disabilities Act (ADA), which prohibits discrimination against people in recovery from opioid use disorder (OUD) who are not engaging in illegal drug use, including those who are taking legally-prescribed medication to treat their OUD. This guidance document provides information about how the ADA can protect individuals with OUD from discrimination—an important part of combating the opioid epidemic across American communities. While this document focuses on individuals with OUD, the legal principles discussed also apply to individuals with other types of substance use disorders.

1) What is the ADA?

The ADA is a federal law that gives civil rights protections to individuals with disabilities in many areas of life. The ADA guarantees that people with disabilities have the same opportunities as everyone else to enjoy employment opportunities,[1] participate in state and local government programs,[2] and purchase goods and services.[3] For example, the ADA protects people with disabilities from discrimination by social services agencies; child welfare agencies; courts; prisons and jails; medical facilities, including hospitals, doctors' offices, and skilled nursing facilities; homeless shelters; and schools, colleges, and universities.

2) Does an individual in treatment or recovery from opioid use disorder have a disability under the ADA?

Typically, yes, unless the individual is currently engaged in illegal drug use. *See* Question 5.

The ADA prohibits discrimination on the basis of disability.[4] The ADA defines disability as (1) a physical or mental impairment that substantially limits one or more major life activities,

including major bodily functions; (2) a record of such an impairment; or (3) being regarded as having such an impairment.[5]

People with OUD typically have a disability because they have a drug addiction that substantially limits one or more of their major life activities. Drug addiction is considered a physical or mental impairment under the ADA.[6] Drug addiction occurs when the repeated use of drugs causes clinically significant impairment, such as health problems and or an inability to meet major responsibilities at work, school, or home.[7] People with OUD may therefore experience a substantial limitation of one or more major life activities, such as caring for oneself, learning, concentrating, thinking, communicating, working, or the operation of major bodily functions, including neurological and brain functions.[8] The ADA also protects individuals who are in recovery, but who would be limited in a major life activity in the absence of treatment and/or services to support recovery.[9]

3) Does the ADA protect individuals who are taking legally prescribed medication to treat their opioid use disorder?

Yes, if the individual is not engaged in the illegal use of drugs. Under the ADA, an individual's use of prescribed medication, such as that used to treat OUD, is not an "illegal use of drugs" if the individual uses the medication under the supervision of a licensed health care professional, including primary care or other non-specialty providers.[10] This includes medications for opioid use disorder (MOUD) or medication assisted treatment (MAT). MOUD is the use of one of three medications (methadone, buprenorphine, or naltrexone) approved by the Food and Drug Administration (FDA) for treatment of OUD;[11] MAT refers to treatment of OUD and certain other substance use disorders by combining counseling and behavioral therapies with the use of FDA-approved medications.[12]

Example A
A skilled nursing facility refuses to admit a patient with OUD because the patient takes doctor-prescribed MOUD, and the facility prohibits any of its patients from taking MOUD. The facility's exclusion of patients based on their OUD would violate the ADA.

Example B
A jail does not allow incoming inmates to continue taking MOUD prescribed before their detention. The jail's blanket policy prohibiting the use of MOUD would violate the ADA.

4) Does the ADA protect individuals with opioid use disorder who currently participate in a drug treatment program?

Yes. Individuals whose OUD is a disability and who are participating in a supervised rehabilitation or drug treatment program are protected by the ADA if they are not currently engaging in the illegal use of drugs.[13] *See* explanation in Question 5. It is illegal to discriminate against these individuals based on their treatment for OUD.

Example C
A doctor's office has a blanket policy of denying care to patients receiving treatment for OUD. The office would violate the ADA if it excludes individuals based on their OUD.

Example D
A town refuses to allow a treatment center for people with OUD to open after residents complained that they did not want "those kind of people" in their area. The town may violate the ADA if its refusal is because of the residents' hostility towards people with OUD.

5) Does the ADA protect individuals who are currently illegally using opioids?

Generally, no. With limited exceptions, the ADA does not protect individuals engaged in the current illegal use of drugs if an entity takes action against them because of that illegal drug use.[14] "Current illegal use of drugs" means illegal use of drugs that occurred recently enough to justify a reasonable belief that a person's drug use is current or that continuing use is a real and ongoing problem.[15] Illegal use, however, does not include taking a medication, including an opioid or medication used to treat OUD, under the supervision of a licensed health care professional.[16]

Example E
A mentoring program requires its volunteers to provide test results showing that they do not engage in the illegal use of drugs. The program dismisses a volunteer who tests positive for opioids for which the volunteer does not have a valid prescription. This does not violate the ADA because the dismissal was based on current illegal drug use.

In addition, an individual cannot be denied health services, or services provided in connection with drug rehabilitation, on the basis of that individual's current illegal use of drugs, if the individual is otherwise entitled to such services.[17] But a drug rehabilitation or treatment program may deny participation to individuals who engage in illegal use of drugs while they are in the program.[18]

Example F
A hospital emergency room routinely turns away people experiencing drug overdoses, but admits all other patients who are experiencing emergency health issues. The hospital would be in violation of the ADA for denying health services to those individuals because of their current illegal drug use, since those individuals would otherwise be entitled to emergency services.

Example G
A drug rehabilitation program asks a participant to leave because that participant routinely breaks a rule prohibiting the use of illegal drugs while in the program. This is not discrimination under the ADA because the program can require participants to abstain from illegal drugs while in the program.

6) Does the ADA protect individuals with a history of past opioid use disorder, who no longer illegally use drugs?

Yes. The ADA protects individuals with a "record of" disability. As explained above in Question 2, OUD typically qualifies as a disability. Therefore, individuals with a "record of" having OUD usually will be protected under the ADA.[19] Individuals would fall into this category if they have a history of, or have been misclassified as having, OUD.[20]

Example H
A city terminates an employee based on his disclosure that he completed treatment for a previous addiction to prescription opioids. The city may be in violation of the ADA for discriminating against the employee based on his record of OUD.

7) Does the ADA provide any legal protections for individuals who are regarded as having an opioid use disorder, whether or not they actually have an opioid use disorder?

Yes. The ADA protects individuals who are "regarded as" having OUD, even if they do not in fact have OUD.[21]

Example I
An employer mistakenly believes that an employee has OUD simply because that employee uses opioids legally prescribed by her physician to treat pain associated with an injury. The ADA prohibits an employer from firing the employee based on this mistaken belief.

8) Does the ADA protect individuals from discrimination based on their association with individuals who have opioid use disorder?

Yes. The ADA protects individuals from discrimination based on their known association or relationship with an individual who has a disability, such as a friend, coworker, or family member. The ADA also protects organizations, such as OUD treatment clinics, from discriminatory enforcement of zoning rules based on the organization's known association with or relationship to individuals with OUD. [22]

9) Can employers have a drug policy or conduct drug testing for opioids?

Yes. Employers may adopt or administer reasonable policies or procedures, including drug testing, designed to ensure that individuals are not engaging in the illegal use of drugs.[23] However, some individuals who test positive for an opioid, which may include MOUD, will be able to show that the medication is being taken as prescribed or administered and a licensed health care professional is supervising its use. These individuals may not be denied, or fired from, a job for this legal use of medication, unless they cannot do the job safely and effectively, or are disqualified under another federal law.[24]

10) What can I do if I believe I have been discriminated against because of my opioid use disorder or treatment for my opioid use disorder?

Individuals may file a complaint with the Department of Justice if they believe that a public accommodation or a state or local government is discriminating or has discriminated against them because of OUD. Individuals may also bring private lawsuits under the ADA.

Information about filing an ADA complaint with the Department is available at civilrights.justice.gov. More information about the ADA is available by calling the Department's toll-free ADA information line at 800-514-0301 or 800-514-0383 (TTY), or accessing its ADA website at ada.gov.

Complaints about a state or local government's programs, services, or activities relating to the provision of health care and social services can also be filed with the Department of Health and Human Services Office for Civil Rights (HHS OCR). Information about filing an HHS OCR complaint is available at hhs.gov/civil-rights/filing-a-complaint, by email at OCRMail@hhs.gov, by phone at 1-800-368-1019, or at 1-800-537-7697 (TTY).

Complaints about employment discrimination (called "charges") on the basis of disability can be filed with the Equal Employment Opportunity Commission (EEOC). Information about filing an EEOC charge is available at eeoc.gov or 800-669-4000, 800-669-6820 (TTY), or 844-234-5122 (ASL Video Phone). Additional EEOC resources regarding employees and opioid use are available at eeoc.gov/laws/guidance/use-codeine-oxycodone-and-other-opioids-information-employees and eeoc.gov/laws/guidance/how-health-care-providers-can-help-current-and-former-patients-who-have-used-opioids.

Individuals who believe they have been discriminated against under the ADA and would like to file a complaint should file as soon as possible. For instance, there are specific filing deadlines for a charge of employment discrimination, either 180 days or 300 days from the date of the alleged discrimination, depending on the jurisdiction where the charge is filed.

11) Where can I find treatment for opioid use disorder?

Information about treatment for opioid use disorder is available at hhs.gov/opioids, findtreatment.gov, samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator, and dpt2.samhsa.gov/treatment.

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[1] 42 U.S.C. §§ 12111-12117. The Equal Employment Opportunity Commission (EEOC) and the Department of Justice jointly enforce the ADA's ban on employment discrimination. For more information or to file a complaint of employment discrimination, visit eeoc.gov.

[2] *Id.* §§ 12131-12134.

[3] *Id.* §§ 12181-12189.

[4] *Id.* §§ 12112, 12132, 12182.

[5] *Id.* § 12102(1)-(2).

[6] 28 C.F.R. §§ 35.108(b)(2), 36.105(b)(2). Regulations implementing Title I of the ADA define the term "physical or mental impairment" as including "any physiological disorder or condition." 29 C.F.R. § 1630.2(h).

[7] *See* Substance Abuse and Mental Health Services Administration, *Mental Health and Substance Use Disorders*, samhsa.gov/find-help/disorders (last visited Apr. 1, 2022).

[8] 42 U.S.C. § 12102; 28 C.F.R. §§ 35.108(c)(1) (listing examples of major life activities, which include the operation of major bodily functions), 36.105(c)(1) (same).

[9] 28 C.F.R. §§ 35.108(d)(1)(viii), 36.105(d)(1)(viii).

[10] 42 U.S.C. § 12210(d); 28 C.F.R. §§ 35.104, 36.104.

[11] *See* Substance Abuse and Mental Health Services Administration, *TIP 63: Medications for Opioid Use Disorder*, store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002 (last visited Apr. 1, 2022); *see also* Health Resources and Services Administration, *Caring for Women with Opioid Use Disorder: A Toolkit for Organization Leaders and Providers*, hrsa.gov/sites/default/files/hrsa/Caring-for-Women-with-Opioid-Disorder.pdf (last visited Apr. 1, 2022).

[12] *See* Substance Abuse and Mental Health Services Administration, *Medication-Assisted Treatment (MAT)*, samhsa.gov/medication-assisted-treatment (last visited Apr. 1, 2022); *see also* Substance Abuse and Mental Health Services Administration, *MAT Medications, Counseling, and Related Conditions*, samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions (last visited Apr. 1, 2022).

[13] 42 U.S.C. § 12210(b)(2); 28 C.F.R. §§ 35.131(a)(2)(ii), 36.209(a)(2)(ii).

[14] 42 U.S.C. § 12210(a); 28 C.F.R. §§ 35.131(a)(1), 36.209(a)(1).

[15] 28 C.F.R. §§ 35.104, 36.104.

[16] 42 U.S.C. § 12210(d); 28 C.F.R. §§ 35.104, 36.104.

[17] 42 U.S.C. § 12210(c); 28 C.F.R. §§ 35.131(b)(1), 36.209(b)(1).

[18] 28 C.F.R. §§ 35.131(b)(2), 36.209(b)(2).

[19] 42 U.S.C. § 12102(1)(B); 28 C.F.R. §§ 35.108(a)(1)(ii), 36.105(a)(1)(ii).

[20] 42 U.S.C. § 12102(1)(B); 28 C.F.R. §§ 35.108(e), 36.105(e).

[21] 42 U.S.C. § 12102(1)(C); 28 C.F.R. §§ 35.108(a)(1)(iii), 35.108(f), 36.105(a)(1)(iii), 36.105(f); *see also* 42 U.S.C. § 12201(h); 28 C.F.R. §§ 35.130(b)(7)(ii), 36.302(g); 29 C.F.R. § 1630.2(o)(4) (noting that individuals who meet the definition of "disability" solely because they are "regarded as" disabled are not entitled to reasonable modifications or reasonable accommodations under the ADA).

[22] 42 U.S.C. § 12112(b)(4); 42 U.S.C. § 12182(b)(1)(E); 28 C.F.R. §§ 35.130(g), 36.205; 29 C.F.R. § 1630.8.

[23] 42 U.S.C. §§ 12114(b), 12114(d); 29 C.F.R. §§ 1630.3(c), 1630.16(c); *see also* 42 U.S.C. § 12210(b); 28 C.F.R. §§ 35.131(c), 36.209(c) (drug testing by Title II and Title III entities).

[24] *See, e.g.*, 42 U.S.C. § 12111(3); 29 C.F.R. §§ 1630.2(r), 1630.15(b)(2), 1630.15(e).

The Americans with Disabilities Act authorizes the Department of Justice to provide technical assistance to individuals and entities that have rights or responsibilities under the Act. This document provides informal guidance to assist you in understanding the ADA and the Department's regulations.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way. This document is intended to provide clarity to the public regarding existing requirements under the law or Department policies.