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

Acknowledgments
This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under federal award number UM1DA049394-01S4 with the National Institute on Drug Abuse. The HEALing (Helping to End Addiction Long-term℠) Communities Study (HCS) was supported by the National Institutes of Health through the NIH HEAL Initiative under award numbers [UM1DA049394, UM1DA049406, UM1DA049412, UM1DA049415, UM1DA049417].

Disclaimer
The views, opinions, and content of this publication are those of the authors and do not necessarily reflect the views, opinions, or policies of SAMHSA, the National Institutes of Health, or its NIH HEAL Initiative. Nothing in this document constitutes a direct or indirect endorsement by SAMHSA, NIH, or NIH HEAL of any non-federal entity's products, services, or policies, and any reference to a non-federal entity's products, services, or policies should not be construed as such.

Electronic Access
This publication may be downloaded from https://store.samhsa.gov.

Recommended Citation
Substance Abuse and Mental Health Services Administration: *Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) Practice Guide*. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2023.

Originating Office
National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857. Published 2023.

Nondiscrimination Notice
The Substance Abuse and Mental Health Services Administration (SAMHSA) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). SAMHSA does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

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

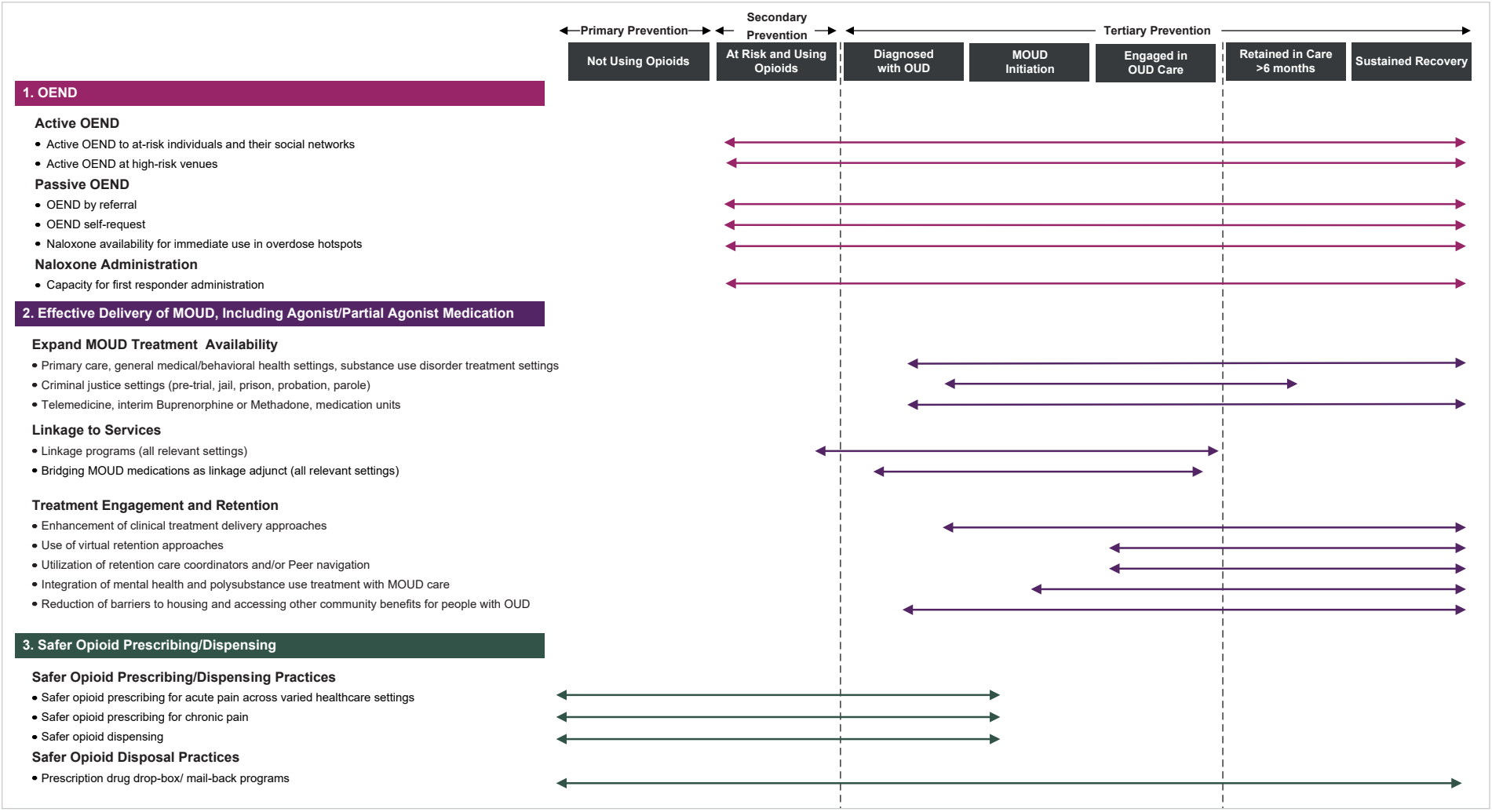
Effective delivery of medication for opioid use disorder treatment with outreach and delivery to higher risk populations

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.

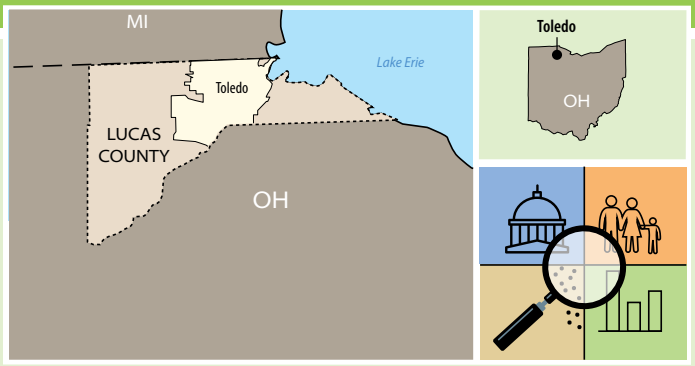
Tool 5: Reported Costs of OEND Programs[25]

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]

Authors: Jennifer L. Brown, PhD, Department of Psychological Sciences, Purdue University and Jason T. McMullan, MD, Department of Emergency Medicine, University of Cincinnati College of Medicine

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.

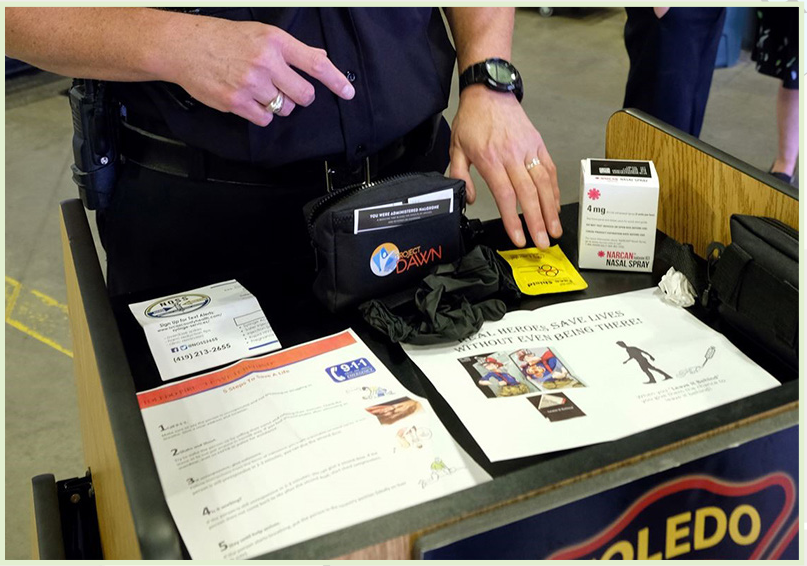
> *One life saved by this simple act [of naloxone leave-behind] is unmeasurable success! A simple idea during the height of COVID has turned into inspiration for fire departments all over the state, and further (Pennsylvania and North Carolina). I am proud of that!*
>
> —Lieutenant Zakariya Reed

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.

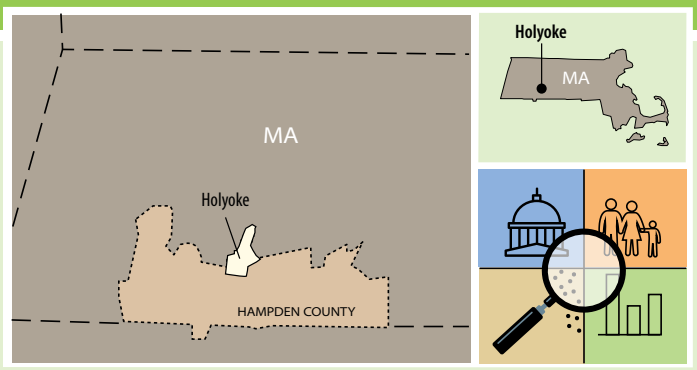
These efforts in Lucas County and other Ohio counties have spread across the state and beyond, into Pennsylvania and North Carolina.

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

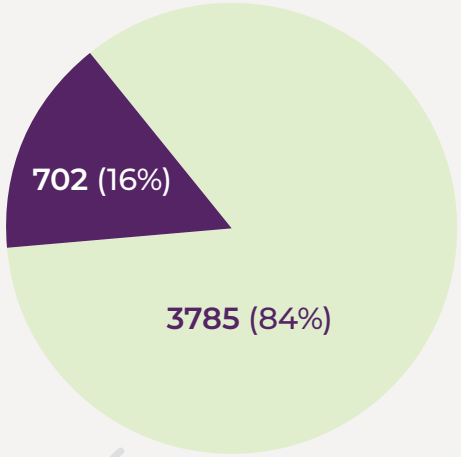
OUTCOMES AND OTHER BENEFITS

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

- Larochelle MR, Bernson D, Land T, Stopka TJ, Wang N, Xuan Z, Bagley SM, Liebschutz JM, Walley AY. Medication for opioid use disorder after nonfatal opioid overdose and association with mortality: a cohort study. Annals of Internal Medicine. 2018 Aug 7;169(3):137-45.
- 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
- Molero Y, Zetterqvist J, Binswanger IA, Hellner C, Larsson H, Fazel S. Medications for alcohol and opioid use disorders and risk of suicidal behavior, accidental overdoses, and crime. American Journal of Psychiatry. 2018 Oct 1;175(10):970-8.
- 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.

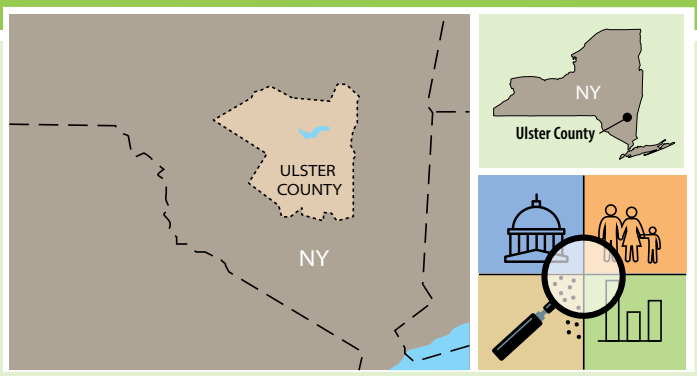
Cost Considerations and Resources

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

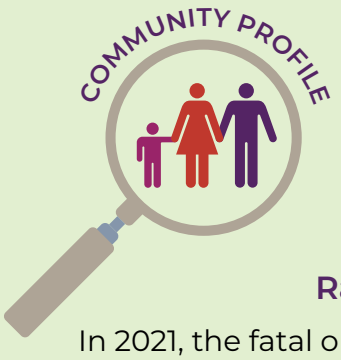
Implementation Resource	Description
2018 SAMHSA and National Council for Behavioral Health Report: Medicaid Coverage of MOUD for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose	This is a detailed report that outlines state-specific summary information on Medicaid 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]

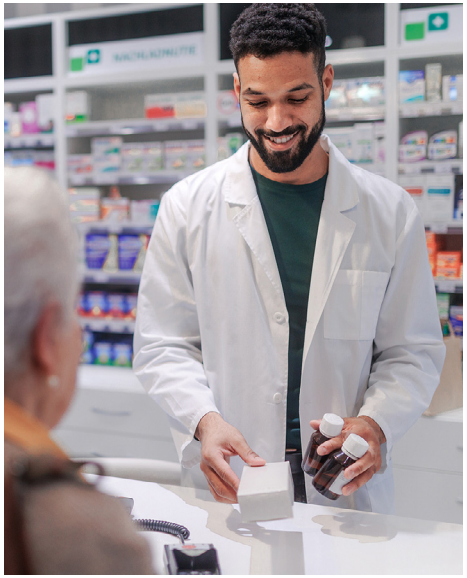
1. **Acknowledging progress** by recognizing that healthcare providers are part of the solution, provider educational opportunities, and use of PDMP.
2. **Emergent challenges** related to physician nonadherence to guidelines, difficulty identifying appropriate use of opioids, and concerns about accelerating 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.

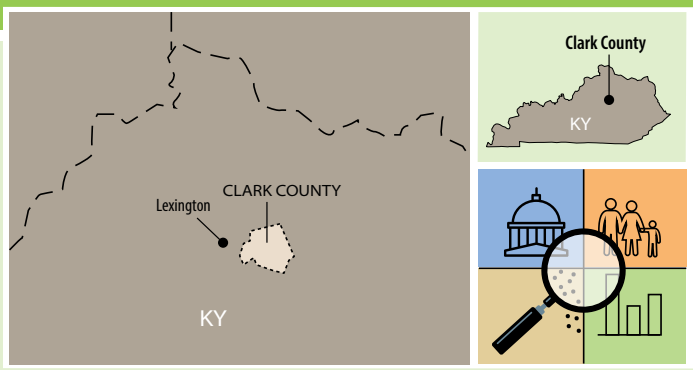
Costs associated with safe disposal strategies will vary depending on the approach used. This "Prescription Drug Take Back Toolkit" describes costs for a drug take-back event including hiring a law enforcement officer (~$30–$40/hour), costs of incinerating collected medications, and advertising. An alternative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

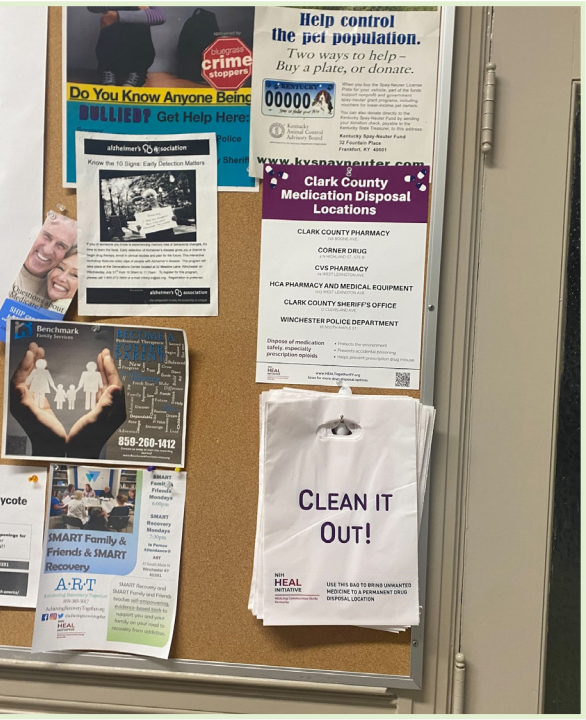
The following resources and support were also provided:

- 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

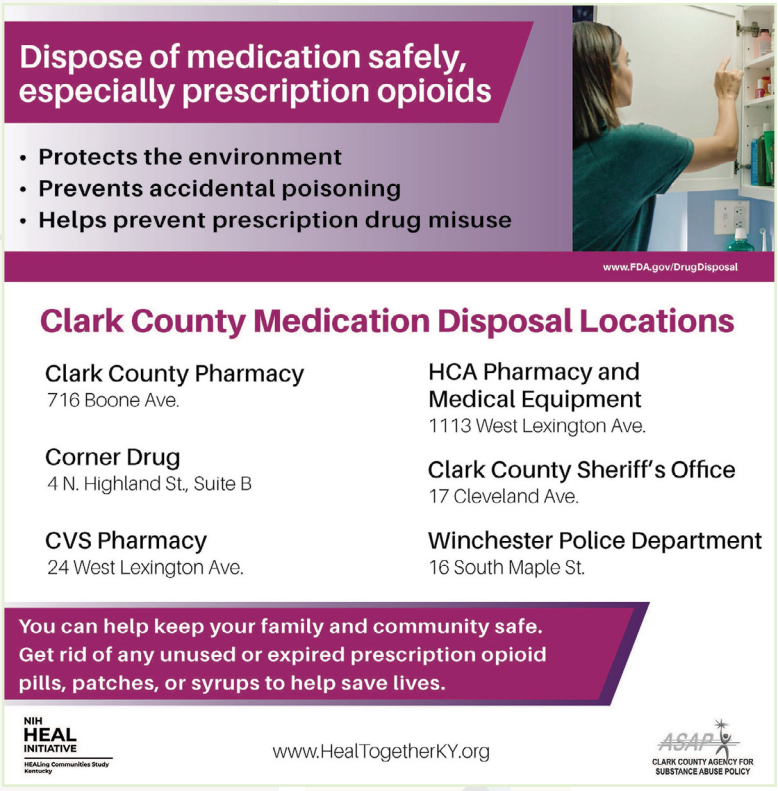
OUTCOMES AND OTHER BENEFITS

- 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.



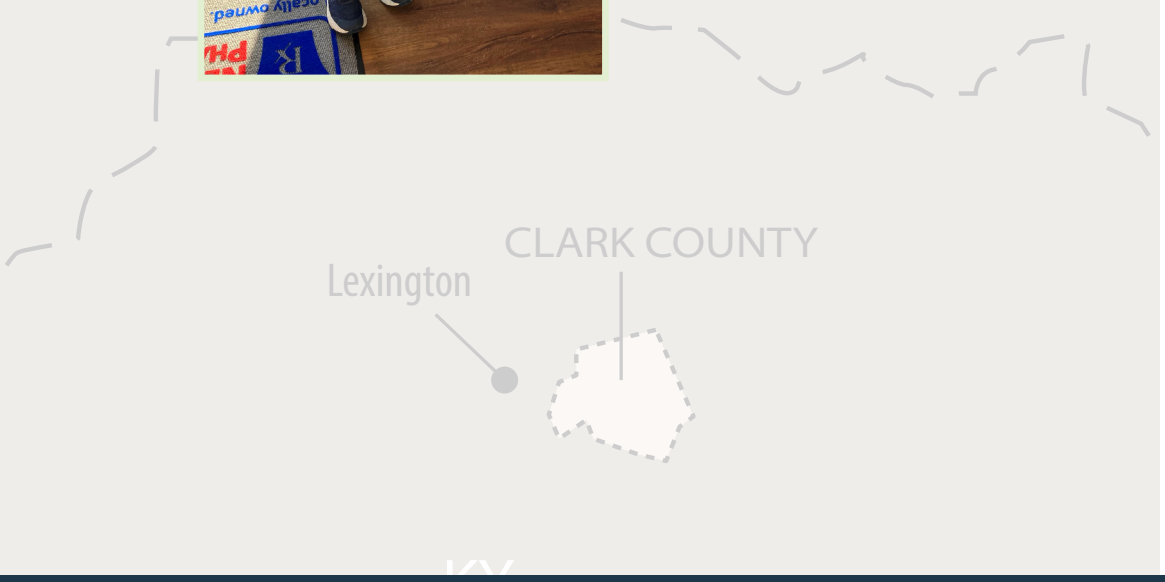
> *It's very user friendly, it's just been really great actually. It's very convenient for our customers.*
>
> —Clark County partner pharmacist

> *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.



References

1. Williams, A. R., Nunes, E. V., Bisaga, A., Pincus, H. A., Johnson, K. A., Campbell, A. N., Remien, R. H., Crystal, S., Friedmann, P. D., Levin, F. R., & Olfson, M. (2018). Developing an opioid use disorder treatment cascade: A review of quality measures. *Journal of Substance Abuse Treatment, 91*, 57-68. https://doi.org/10.1016/j.jsat.2018.06.001
2. Young, A. M., Brown, J. L., Hunt, T., Sprague Martinez, L. S., Chandler, R., Oga, E., Winhusen, T. J., Baker, T., Battaglia, T., Bowers-Sword, R., Button, A., Fallin-Bennett, A., Fanucchi, L., Freeman, P., Glasgow, L. M., Gulley, J., Kendell, C., Lofwall, M., Lyons, M. S., Quinn, M., Rapkin, B. D., et al. (2022). Protocol for community-driven selection of strategies to implement evidence-based practices to reduce opioid overdoses in the HEALing Communities Study: A trial to evaluate a community-engaged intervention in Kentucky, Massachusetts, New York and Ohio. *BMJ Open, 12*(9), e059328. https://doi.org/10.1136/bmjopen-2021-059328
3. Chan, B., Hoffman, K. A., Bougatsos, C., Grusing, S., Chou, R., & McCarty, D. (2021). Mobile methadone medication units: A brief history, scoping review and research opportunity. J*ournal of Substance Abuse Treatment, 129*, 108483. https://doi.org/10.1016/j.jsat.2021.108483
4. Formica, S. W., Waye, K. M., Benintendi, A. O., Yan, S., Bagley, S. M., Beletsky, L., Carroll, J. J., Xuan, Z., Rosenbloom, D., Apsler, R., Green, T. C., Hunter, A., & Walley, A. Y. (2021). Characteristics of post-overdose public health-public safety outreach in Massachusetts. *Drug Alcohol Depend, 219*, 108499-108499. https://doi.org/10.1016/j.drugalcdep.2020.108499
5. Godersky, M. E., Klein, J. W., Merrill, J. O., Blalock, K. L., Saxon, A. J., Samet, J. H., & Tsui, J. I. (2020). Acceptability and feasibility of a mobile health application for video directly observed therapy of buprenorphine for opioid use disorders in an office-based setting. *Journal of Addiction Medicine, 14*(4), 319-325. https://doi.org/10.1097/ADM.0000000000000608
6. Kraft Center for Community Health. (2019). *Mobile addiction services toolkit*. Retrieved from https://www.kraftcommunityhealth.org/wp-content/uploads/2020/01/Kraft-Center-Mobile-Addiction-Services-Toolkit.pdf
7. Wagner, K. D., Harding, R. W., Kelley, R., Labus, B., Verdugo, S. R., Copulsky, E., Bowles, J. M., Mittal, M. L., & Davidson, P. J. (2019). Post-overdose interventions triggered by calling 911: Centering the perspectives of people who use drugs (PWUDs). *PLoS One, 14*(10), e0223823. https://doi.org/10.1371/journal.pone.0223823
8. U.S. Food and Drug Administration (FDA). (2023, March 29). *FDA approves first over-the-counter naloxone nasal spray: Agency continues to take critical steps to reduce drug overdose deaths being driven primarily by illicit opioids*. FDA news release. Retrieved from https://www.fda.gov/news-events/press-announcements/fda-approves-first-over-counter-naloxone-nasal-spray
9. Hoffman, J. (2023, March 28). Over-the-counter Narcan could save more lives. But price and stigma are obstacles. *New York Times*. https://www.nytimes.com/2023/03/28/health/narcan-otc-price.html
10. Moss, R. B., & Carlo, D. J. (2019). Higher doses of naloxone are needed in the synthetic opioid era. *Substance abuse treatment, prevention, and policy, 14*, 1-6.
11. National Institute on Drug Abuse (NIDA). (2022). *What is naloxone?* Retrieved from https://nida.nih.gov/publications/drugfacts/naloxone
12. Behrends, C. N., Gutkind, S., Winkelstein, E., Wright, M., Dolatshahi, J., Welch, A., Paone, D., Kunins, H. V., & Schackman, B. R. (2022). Costs of opioid overdose education and naloxone distribution in New York City. *Substance Abuse, 43*(1), 692-698. https://doi.org/10.1080/08897077.2021.1986877
13. Scherzinger, A. (2022, March 24). Toledo fire department provides free naloxone to combat overdose deaths. *Toledo Blade*. https://www.toledoblade.com/local/city/2022/03/24/fire-department-provides-free-narcan-to-combat-overdose-deaths/stories/20220324144
14. Hedegaard, H., Miniño, A. M., Spencer, M. R., & Warner, M. (2021). *Drug overdose deaths in the United States, 1999–2020*. NCHS Data Brief, no 428. Hyattsville, MD: National Center for Health Statistics. https://stacks.cdc.gov/view/cdc/112340

15. United States Census Bureau. (2021). *American Community Survey.* Retrieved from https://data.census.gov/
16. MA Registry of Vital Statistics. (n.d.). *Statistics from death certificates.* Data not publicly available. MA Registry of Vital Records and Statistics.
17. Tanz, L. J., Jones, C. M., Davis, N. L., Compton, W. M., Baldwin, G. T., Han, B., & Volkow, N. D. (2023). Trends and characteristics of buprenorphine-involved overdose deaths prior to and during the COVID-19 pandemic. *JAMA Network Open, 6*(1), e2251856. https://doi.org/10.1001/jamanetworkopen.2022.51856
18. Jones, C. M., Compton, W. M., Han, B., Baldwin, G., & Volkow, N. D. (2022). Methadone-involved overdose deaths in the US before and after federal policy changes expanding take-home methadone doses from opioid treatment programs. *JAMA Psychiatry, 79*(9), 932-934. https://doi.org/10.1001/jamapsychiatry.2022.1776
19. Substance Abuse and Mental Health Services Administration (SAMHSA). (2023). *Removal of DATA Waiver (X-Waiver) requirement*. Retrieved from https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement
20. Linas, B. S., & Linas, B. P. (2023, February 14). The X-waiver for buprenorphine prescribing is gone. It's time to spread the word. *StatNews*. https://www.statnews.com/2023/02/14/x-waiver-buprenorphine-prescribing-gone-spread-the-word/
21. New York State Department of Health. (2023). *County opioid quarterly report*. Retrieved from https://www.health.ny.gov/statistics/opioid/data/pdf/nys_jan23.pdf
22. Walker, D. M., Childerhose, J. E., Chen, S., Coovert, N., Jackson, R. D., Kurien, N., McAlearney, A. S., Volney, J., Alford, D. P., Bosak, J., Oyler, D. R., Stinson, L. K., Behrooz, M., Christopher, M. C., & Drainoni, M. L. (2022). Exploring perspectives on changing opioid prescribing practices: A qualitative study of community stakeholders in the HEALing Communities Study. *Drug and Alcohol Dependence, 233*, 109342. https://doi.org/10.1016/j.drugalcdep.2022.109342
23. Steel, M., & Mirzaian, M. (2022). *Kentucky resident drug overdose deaths, 2017–2021*. Kentucky Injury Prevention and Research Center.
24. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. (n.d.). *Multiple cause of death 1999-2021. CDC WONDER Online Database*. Data are from the Multiple Cause of Death Files, 1999-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Retrieved from https://wonder.cdc.gov/mcd-icd10.html
25. HEALing Communities Study Consortium. (2020). The HEALing (Helping to End Addiction Long-term (SM)) Communities Study: Protocol for a cluster randomized trial at the community level to reduce opioid overdose deaths through implementation of an integrated set of evidence-based practices. *Drug and Alcohol Dependence, 217*, 108335. https://doi.org/10.1016/j.drugalcdep.2020.108335
26. Sprague Martinez, L., Rapkin, B. D., Young, A., Freisthler, B., Glasgow, L., Hunt, T., Salsberry, P. J., Oga, E. A., Bennet-Fallin, A., Plouck, T. J., Drainoni, M. L., Freeman, P. R., Surratt, H., Gulley, J., Hamilton, G. A., Bowman, P., Roeber, C. A., El-Bassel, N., & Battaglia, T. (2020). Community engagement to implement evidence-based practices in the HEALing communities study. *Drug and Alcohol Dependence, 217*, 108326. https://doi.org/10.1016/j.drugalcdep.2020.108326
27. Winhusen, T., Walley, A., Fanucchi, L. C., Hunt, T., Lyons, M., Lofwall, M., Brown, J. L., Freeman, P. R., Nunes, E., Beers, D., Saitz, R., Stambaugh, L., Oga, E. A., Herron, N., Baker, T., Cook, C. D., Roberts, M. F., Alford, D. P., Starrels, J. L., & Chandler, R. K. (2020). The Opioid-overdose Reduction Continuum of Care Approach (ORCCA): Evidence-based practices in the HEALing Communities Study. *Drug and Alcohol Dependence, 217*, 108325. https://doi.org/10.1016/j.drugalcdep.2020.108325
28. Lefebvre, R. C., Chandler, R. K., Helme, D. W., Kerner, R., Mann, S., Stein, M. D., Reynolds, J., Slater, M. D., Anakaraonye, A. R., Beard, D., Burrus, O., Frkovich, J., Hedrick, H., Lewis, N., & Rodgers, E. (2020). Health communication campaigns to drive demand for evidence-based practices and reduce stigma in the HEALing communities study. *Drug Alcohol Depend, 217*, 108338. https://doi.org/10.1016/j.drugalcdep.2020.108338

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
- **Andrea Czajkowski**, MBA, PMP, Program Analyst, HEALing Communities Study

RTI Data Coordinating Center

- **Joëlla W. Adams**, PhD, MPH, Research Epidemiologist
- **Lauren Farmer**, BA, Project Management Specialist
- **LaShawn Glasgow**, DrPH, MPH, Senior Director, Center for Program and Policy Evaluation to Advance Community Health
- **Craig LeFebvre**, PhD, MS, Communications Scientist
- **Emmanuel Oga**, MD, MPH, Senior Research Epidemiologist
- **Megan Hall**, MPH, Research Clinical Study Specialist
- **Beth Linas**, PhD, MHS, Research Epidemiologist
- **Mia Christopher**, MPH, Research Epidemiologist

RTI Editing and Design

- **Vivien Arnold**, MA, Senior Graphic Designer
- **Ally Elspas**, BA, Senior Graphic Designer
- **Rebecca Hipp**, BS, Senior Project Management Specialist
- **Claire Korzen**, BA, Editor
- **Shari Lambert**, BFA, Senior Graphic Designer
- **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.