North Carolina Department of Public Health // **Injury and Violence Prevention Branch**

POST-OVERDOSE RESPONSE TEAM (PORT) TOOLKIT

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health

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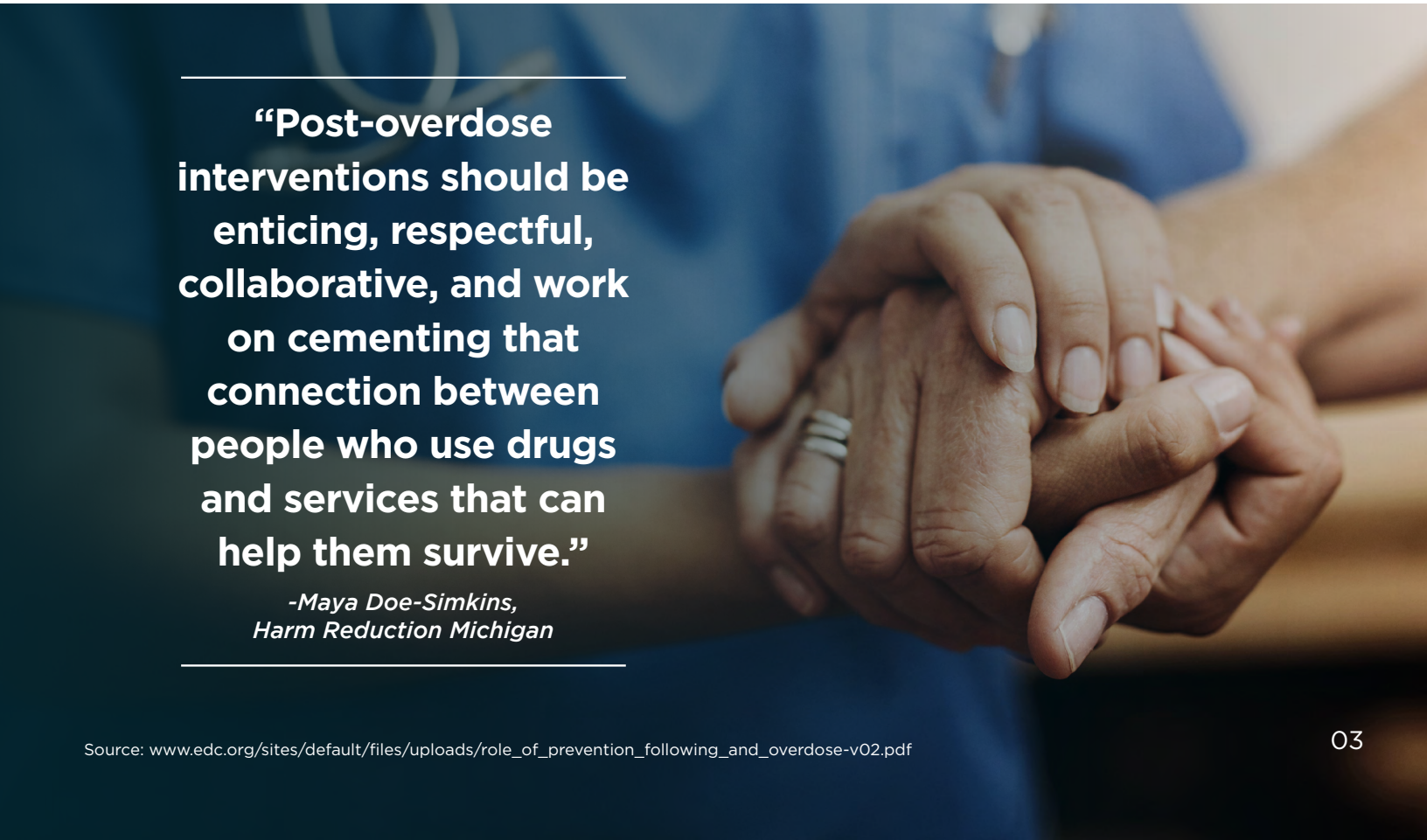


"Post-overdose interventions should be enticing, respectful, collaborative, and work on cementing that connection between people who use drugs and services that can help them survive."

-Maya Doe-Simkins, Harm Reduction Michigan

Source: www.edc.org/sites/default/files/uploads/role_of_prevention_following_and_overdose-v02.pdf

INTRODUCTION

A post-overdose response team (PORT) is an overdose follow-up program that provides holistic support through person-centered outreach directly following an overdose. The North Carolina Harm Reduction Coalition (NCHRC) explains that such follow-up visits conducted within days of a naloxone reversal provides multiple opportunities, including:

- Directing people to harm reduction services;
- Providing naloxone, overdose prevention training and materials; and
- Collaboration among partners in the overdose response field to work together to reduce overdose morbidity and mortality.

Teams have evolved to encompass broader functions related to addressing overdose and substance use in a community. They may initiate services at the scene of an overdose or meet a patient at the emergency room. They may provide "overdose prevention" services to high-risk groups by connecting to people who are unhoused, recently incarcerated, or referred by a partner agency. Because of this variability in program delivery, teams have established different names: Quick Response Teams, Opioid Response Teams, Outreach Teams.

The common element among these different types of programs are the importance of peer support specialists, naloxone distribution, and linkage to evidence-based addiction treatment and harm reduction services. But differences in team composition, services provided, and partnerships matter. Some PORT teams are based in EMS departments, others in health departments; some are run through hospital health care systems while others may run through community-based harm reduction organizations. Each community will decide which of these characteristics make the most sense for their PORT, because this will affect funding, data management, patient access, collaborative partnerships, independence, and resources.

Please direct any questions or requests for technical assistance related to Post-Overdose Response Teams to PORTNC@dhhs.nc.gov

Why PORT?

PORT (Post Overdose Response Teams) were created in response to the worsening overdose crisis, which traditional health care system – like hospitals and clinics – have failed to address. Many people who survive overdoses are at high risk of overdosing again. But stigma and poor treatment in emergency rooms often lead them to refuse care. Emergency services may be their only contact with the healthcare system.

Even when patients do go to the ED, they rarely get the most effective treatments, like naloxone or medications such as buprenorphine or methadone – which can cut overdose deaths by more than 40%. Instead, they're often just handed pamphlets and referrals, which don't solve real barriers like lack of transportation, insurance, stigma, or moments of crisis.

PORT programs fill these gaps. They bring care directly to people – anywhere, anytime – with skilled teams who help regardless of someone's ability to pay. Without PORT, communities end up spending more on emergency calls, health care, the justice system, and lost work productivity due to untreated addiction.

Language Matters

Language is powerful – especially when talking about substance use. Unlike most health conditions, substance use is often criminalized, which fuels stigma. Society tends to label people who use substances with harmful stereotypes, instead of recognizing substance use as a health issue often linked to trauma or lack of resources.

This stigma exists in both the justice and health care systems. Medical training on addiction is minimal, and funding for effective treatment is low. As a result, many providers show bias and treat patients poorly. This can change with education, and it starts with using respectful, non-stigmatizing language.

Words like "junkie," "addict," or "dirty urine" can subconsciously influence care and discourage people from seeking help. Over time, patients may even believe these labels, leading to hopelessness and worse health outcomes. The National Council on Mental Health offers a helpful guide on this: Language Matters Guide.

Respectful language saves lives.

ABOUT THE TERM MOUD

The older term **MAT** (Medication-Assisted Treatment) has been widely used for treating opioid use disorder. But this phrase wrongly suggests that medication is secondary to therapy. In reality, medications like methadone and buprenorphine are the most effective tools for saving lives.

Now, the preferred term is **MOUD** (Medication for Opioid Use Disorder), or **MAT** redefined as **Medication for Addiction Treatment.** Both terms put the focus on medication, where it belongs. In this guide, we'll use **MOUD.** See the appendix for more helpful terms and acronyms.

PORT Evidence-Based Practices to Reduce Substance Use, Prevent Overdose, and Save Lives

BUPRENORPHINE TREATMENT

Buprenorphine is an FDA-approved medication used to treat opioid use disorder. It works by easing withdrawal symptoms and cravings, but unlike other opioids, it doesn't cause dangerous breathing problems – even at high doses. Any DEA-registered provider can prescribe it, in person or via telehealth.

Buprenorphine lowers the risk of overdose death by 40 – 50%, but it must be used carefully. If a person still has opioids in their system when they take it, it can cause opioid withdrawal symptoms. That's why people must wait before starting it – usually 8–12 hours after short-acting opioids like heroin or oxycodone, and 16 – 24 hours after long-acting ones.

Fentanyl makes things more complicated. It stays in the body longer because it builds up in

fat tissue. Even after 12 – 24 hours, some people may still have enough fentanyl in their system to cause withdrawal when starting buprenorphine.

Despite this challenge, starting buprenorphine after a non-fatal overdose is a key opportunity. After receiving naloxone, people often go into withdrawal and want to use drugs again. Instead, paramedics can offer buprenorphine on the spot, giving fast relief without triggering withdrawal. This early treatment also helps reduce cravings for the next 24 hours.

PORT paramedic teams often continue buprenorphine treatment in the field and help transition patients to ongoing care. Starting treatment early has proven more effective than waiting. Since paramedics already handle complex medications, administering buprenorphine is well within their skill set – and it can make a big impact on both health and drug use outcomes.

Peer Support Services

Peer support, provided by trained individuals with lived experience, is a key part of any PORT team. These peer workers offer connection, mentorship, harm reduction tools, and support for solving problems. This kind of support is evidence-based and effective, no matter where someone is in their recovery journey.

Peer support doesn't replace formal treatment, but it can be a low-barrier first step and an ongoing source of support during recovery. It's linked to better treatment outcomes and reduced relapse. As peer support becomes more common, it's important to provide proper training, pay, and supervision. These roles are essential for the success of PORT teams.

For more, see: SAMHSA Peer Support Guide.

Targeted Naloxone Distribution

Getting naloxone into the hands of people most at risk of overdose is a proven way to save lives. While many communities now offer naloxone through nonprofits, health care providers, and even vending machines, targeted distribution is the most effective. Most overdoses are reversed by people who use drugs themselves, so efforts should focus on reaching this group directly.

PORT teams are well-positioned to do this, especially for those facing barriers like lack of insurance or transportation. Naloxone should be given alongside training on how to respond to an overdose and why it's safer not to use drugs alone.

A "compassionate overdose response" approach is also recommended. It includes:

- Using only as much naloxone as needed to restore breathing, not necessarily wakefulness
- Providing breathing support (ideally with oxygen)
- Keeping the survivor's environment calm and safe during recovery

This respectful approach improves outcomes and helps build trust.

Harm Reduction Services

Because substance use disorders often involve relapse, harm reduction is a key public health strategy. This includes providing supplies like syringes, cookers, smoking tools, and hygiene products. These tools help prevent diseases like HIV and Hepatitis C, reduce bacterial infections, and offer a connection to health care and support.

These programs do not increase drug use. In fact, they help people enter treatment more often. As more people smoke drugs instead of injecting them, programs must adapt to offer the right tools for modern drug use.

Harm reduction can also include:

- Sexual health services (condoms, lube, STI testing)
- Reproductive health services (contraceptives)

PORT teams should evolve to meet these changing needs.

Promising Innovations in Substance Use Care

Interventions like MOUD, naloxone distribution, peer support, and harm reduction have years of research evidence to support their efficacy. However, some newer PORT interventions don't yet have long-term research behind them but are showing promise:

1. WOUND CARE SERVICES

Infections and wounds are common among people who use drugs, especially with drugs like xylazine in the supply. Hospitals often don't treat both wounds and withdrawal, and shelters may turn away people with open sores. PORT teams can help fill this gap by providing wound care, supplies, and education.

2. DRUG CHECKING SERVICES

Unlike drug testing by police or doctors, drug checking lets people test their own drugs for dangerous substances like fentanyl or xylazine. Simple strips or more advanced lab tests can identify what's in a sample. PORT teams may offer supplies or partner with labs to make this service more available.

More info: UNC Drug Checking Lab

3. OUTREACH TO HIGH-RISK GROUPS

PORT teams don't just respond to overdoses – they also proactively reach out to people at high risk, including:

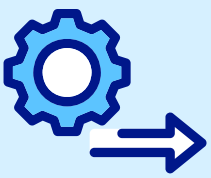
- People experiencing homelessness
- People recently released from jail or prison
- Marginalized communities (e.g., Black, Latiné, Native, LGBTQ+, pregnant/parenting)

These groups face more barriers to care and higher health risks. PORT programs can reduce these risks by offering targeted, culturally informed support. This includes hiring diverse staff and building strong community partnerships.

PHASES TO CREATING YOUR PROGRAM

There are four phases in the process of setting up a PORT in your community:

Assess your community.



Implement the program.

Design the program.

Evaluate the program and make improvements.

PHASE 1:
ASSESSMENT

Identify Community Needs

The first step in creating a PORT program is understanding how overdoses are affecting the community. This involves using data from several sources, such as death certificates, ER visit records, EMS overdose calls, and the number of people who refuse ER transport. You can also get helpful information – both statistics and stories – from local groups like harm reduction programs, syringe services, shelters, addiction treatment centers, doctors, recovery housing, and law enforcement.

Key data may include numbers of fatal and non-fatal overdoses, demographic details, and location-based trends. Setting up Data Use Agreements (DUAs) can help organizations share data and refer people more easily, making partnerships stronger.

Since overdose often happens when earlier chances for help are missed, it's important to understand the full recovery system in your area – like where people can get buprenorphine, detox services, peer support, or recovery housing. Also, look at what's getting in the way of care. Common barriers include lack of insurance, transportation problems, provider shortages, stigma, and pharmacies that don't carry needed medications.

PORT programs help by filling these gaps – preventing overdoses before they happen.

Gather Resources

To build an effective PORT program, you need to connect people with a wide range of community resources. Before starting your program, create a strong referral network and resource list. Focus on services that support overdose prevention, such as harm reduction programs for people who are actively using drugs. Also, learn what treatment and recovery services are available and how they're paid for.

Data Collection Opportunity:

Some of the data you might collect to illustrate the need in your community can include: the number of Emergency Department visits related to overdose response, the deaths due to overdose, and the lack of services addressing these health concerns.

Start by talking to health care providers, LME/MCOs, public health workers, and social workers – they may already have useful resource lists. Tracking this information is also important for future efforts to expand services. Collect data and work with your partners to evaluate needs and improve support.

1. PARTNERS

The NC Harm Reduction Coalition emphasizes building a strong team based on harm reduction. Include people with lived experience, peer support specialists, case managers, and patient navigators. Their input helps shape effective programs.

You should work with:

- People with lived experience (including family members)
- Public health workers
- Hospitals and clinics
- Treatment and recovery providers
- First responders (EMS, law enforcement, fire)
- Faith-based groups
- Community organizations
- LME/MCOs

Some partners may not fully understand evidence-based practices like medication for addiction treatment or syringe programs. Training can help build a shared

understanding. Be aware that poorly designed programs – especially those that involve coercion or lack trained staff – can cause harm. Among all partners, **peer organizations** are the most crucial because they have strong connections with people at highest risk.

2. CHAMPIONS

Find champions within partner organizations. These are people who support the PORT mission and can push for change, even if they're not in leadership roles. Meet with them regularly to plan referral systems, communication, and protocols.

3. TREATMENT & RECOVERY RESOURCES

Make a detailed list of treatment options that includes:

- Operating hours
- Insurance accepted
- Costs
- Location
- Type of treatment (e.g., medication-assisted, abstinence-only)

Keep this list up to date and build relationships with these providers. That way, your team can help participants get connected more smoothly. Existing resource guides can be found in Appendix C.

4. HARM REDUCTION RESOURCES

Everyone can benefit from harm reduction education – even those aiming for abstinence. Plans should also prepare for possible return to use. Tailor support to each person's unique situation.

Harm reduction services (like **Syringe Services Programs or SSPs**) provide:

- Unused drug use equipment like syringes/needles
- Hygiene supplies
- STD/STI testing and treatment
- Other health services: emergency contraception, condoms
- These programs help improve health, lower costs, reduce drug use, and save lives.

Data Collection Opportunity:

Data that can demonstrate the higher cost of Emergency Department (ED) visits due to overdose compared to the cost of preventive services can create additional buy-in for a PORT program. The NC IVPB Opioid Data Dashboard has monthly reports about the number of ED visits per county.

- Find SSPs in your area
- NC Harm Reduction Coalition: www.nchrc.org or call (336) 543-8050

5. SOCIAL SERVICES RESOURCES

Many overdose survivors also need help with **basic needs** like:

- Food
- Housing
- Jobs
- Clothing
- Transportation

Make a broad list of services for people with different financial situations. Don't assume what someone can or can't afford – give them options and let them choose what fits.

Tools like **NCCARE360** connect people to these services and track outcomes. While meeting basic needs can reduce overdose risk, these efforts don't replace core supports like medication treatment, peer services, harm reduction services, and naloxone.

6. FUNDING

Your PORT program will need funding to operate.

No matter how you start – with grants, private money, or other funds – you'll need a plan to keep it going long-term. Local support is key to sustainability.

Funding options include:

- Using opioid settlement funds and adding PORT costs to county or city budgets
- Getting support from local hospitals to reduce emergency room visits
- Applying for grants from foundations or government programs
- Partnering with LME/MCOs or other managed care organizations
- Housing the program in a local organization that includes it in their regular budget
- Sharing costs across multiple agencies

Some areas use opioid settlement money for start-up costs (training, hiring, equipment), and then show how the program saves money by reducing 911 calls, arrests, and ED visits. This helps make the case for ongoing funding from local budgets.

Health systems may also fund PORT programs since they pay for hospital stays caused by drug-related health issues, especially for uninsured patients.

Tips:

- Meet regularly with people at potential funding agencies – they may want input on the program's services and results.
- Some funders will only cover specific parts of the program, so combine different sources to fund the full budget.
- Ask: Is a PORT program financially realistic in your area? Since PORTs can save lives and money, it's often worth the investment.

Data Collection Opportunity:

Consider gathering anecdotal data from neighboring or similar counties to illustrate the benefits and challenges of creating and implementing a PORT program.

For more information about how communities are leveraging opioid settlement funds to support PORT programs, please visit ncopioidsettlement.org

COMMUNITY BUY-IN

Getting your community to support the PORT program is essential. Many people may need education about what PORT is and how it works.

Ways to build community support:

- Join or start a **Community Coalition for Substance Use**
- Share information at local government meetings or town halls
- Partner with faith communities
- Use the **annual county meeting about opioid settlements** to promote PORT
- Have one-on-one conversations to hear concerns and answer questions

Strong community support helps the program succeed – from finding participants to connecting with needed services.

PHASE 2:
DESIGN YOUR PORT

After you've confirmed your community needs a PORT and has support for it, you're ready to design the program. Every PORT will look different depending on local needs, but all should include these three parts:

CREATE YOUR TEAM

DEVELOP THE PROTOCOL

CREATE THE NECESSARY FORMS

Create Your Team

Choose who will lead your PORT – EMS, community paramedicine, fire department, health department, or a local organization. Involve people with **lived experience of drug use** from the beginning.

Your team should include:

- A mix of community partners
- People directly impacted by drug use
- Good relationships with service providers
- Respectful, non-judgmental interactions with people who use drugs
- A harm reduction approach

Avoid using untrained staff, forcing people into services, risking criminal justice involvement, or linking to treatment that isn't based on evidence – these can harm people.

OUTREACH WORK AND SUPPORT WORK

The PORT program has two types of work functions: Outreach and Support. The outreach work interfaces with patients and conducts visits.

Support work involves referrals into the PORT Outreach Team and out to partner agencies that provide treatment and prevention resources. PORT team members may contribute to one or both types of work; coordination is critical to success

OUTREACH TEAM MEMBERS

Outreach team members may include peer support specialists, community paramedics, outreach workers, and others. This team will connect participants with a variety of resources and act as system navigators. They should be skilled in:

- **System navigation** – Connecting people to services based on their needs, eligibility, and interest.
- **Building Trust** – Helping with what matters most to the participant builds stronger relationships.
- **Cultural Humility** – Respecting people's experiences, especially when stigma is involved. Peer supports are experts.
- **Harm Reduction** – Meeting people where they are, without judgment.

SUPPORT NETWORK – THE RECOVERY ECOSYSTEM

The PORT team relies on a community "ecosystem" – all the people and services that support the health of people who use drugs. No single program can do everything, so strong partnerships are key. This work often requires constantly updating information related to agencies, who to call when something is needed, streamlined ways of exchanging information, strategies for barriers to success like lack of insurance or lack of transportation, and active relationship building between partners.

Members of the support network may include:

- Directly impacted people (people who use drugs or family members)
- Harm Reduction providers
- Public health professionals
- Hospitals and health care providers
- Treatment providers and recovery networks
- LME/MCO representatives
- Community-based organization staff and stakeholders
- First responders (law enforcement/EMS/ community paramedicine/fire)
- Faith community members
- Homeless services providers, Recovery Housing and Transitional Housing providers
- Criminal Justice System Providers

DIRECTLY IMPACTED PEOPLE

People with lived experience of drug use offer valuable perspectives, helping identify needed services and appropriate language for program participants. They should be involved in planning, implementing, and evaluating programs.

One important thing to note is that people with lived experience or those who have been directly impacted by drug use all have unique experiences, so the PORT program should never assume that there is a "one-size fits all" path for everyone. Some people in recovery may have achieved their goals with specific treatment models, like 12-step programs, which may not be the desired strategy by all participants. It is important that ALL support network members, including people with lived experience, are open to all the ways recovery may look, and recognize that evidence-based strategies are likely to be most effective.

HARM REDUCTION PROVIDERS

Harm reduction providers, like syringe services and peer agencies, reduce substance use risks and refer new patients to PORT. They provide outreach and support, especially for high-risk individuals.

PUBLIC HEALTH

Local health departments support PORT by collecting data, coordinating with community partners, and sharing resources like staff and naloxone. They promote non-stigmatizing language, reduce access barriers, and support prevention through vaccinations, testing, and education.

HOSPITALS AND HEALTH CARE PROVIDERS

Hospitals and providers refer patients to PORT and deliver compassionate care. They should adopt cultural humility training to ensure positive experiences for participants and reduce barriers to care.

TREATMENT PROVIDERS AND RECOVERY NETWORKS

Perhaps the most important part of the recovery ecosystem, these groups offer treatment and recovery options for PORT participants. Strong relationships with them ensure clear communication about costs, insurance, and access to opioid agonist medications.

LME/MCOS

LME/MCOs manage state funds for Medicaid and uninsured clients, helping PORT participants access addiction treatment, behavioral, and medical health care services through their provider networks.

COMMUNITY-BASED ORGANIZATIONS

CBOs address social needs like food, clothing, and financial aid, especially in underserved areas.

Additionally, organizations that serve specific marginalized subpopulations, like LGBTQ, black/African

American, immigrant, unhoused, domestic violence survivors, or justice-involved, can refer into PORT and provide collaborative support to PORT clients.

FIRST RESPONDERS

Faith communities are often vital partners to have in the Support Network. Churches, mosques, temples, etc. often house a variety of resources from food and clothing assistance to recovery networks and harm reduction services. They also can act as facilitator of a community coalition as they can help bring a variety of different members of the Support Network together on common ground.

FAITH COMMUNITIES

Faith communities provide resources like food, clothing, and recovery networks.

While faith communities have historically been an important avenue to certain cultural groups, such as Black/African American and immigrant communities, they, like any member of the support network, can have non-evidence-based perspectives on substance use. Ongoing relationship building, with mutual learning and training opportunities, can develop partnerships based on a shared sense of effective strategies to improve community health. Of note, while overdose is broadly decreasing nationwide, this is mostly attributed to improvements in white populations; Black, Indigenous, and People of Color (BIPOC) communities are still seeing increases in substance use harm and have had specific lower rates of access to care and prevention resources.

HOMELESS SERVICES PROVIDERS, RECOVERY HOUSING AND TRANSITIONAL HOUSING PROVIDERS

People experiencing housing instability are at particular risk of negative health outcomes like overdose. Homeless services providers are an important source of referrals for PORT support and can also provide support for PORT clients with housing challenges. Recovery and transitional housing providers are key resources in a community for low-cost, low-barrier supportive housing for people who use drugs and people in recovery.

CRIMINAL JUSTICE SYSTEM PROVIDERS

This group of providers may not be the highest priority in mapping a recovery ecosystem, but people with justice system involvement are often at high risk for negative health consequences related to substance use and face numerous barriers to care. In particular, criminal justice system involvement can preclude access to housing, public benefits, employment, and social support, thus undermining recovery capital and increasing risk. While this system can increase harm and risk for people who use drugs, they are an undeniable status quo in most American communities and thus may be important sources of referral and coordination of services. They may include probation and parole officers, treatment courts, public defenders, prosecutors, jail providers, pretrial services staff, and more.

Determine What Direct Port Services to Offer

In general, directly providing services is more likely to be received than referring for services, but no PORT program can do everything, so each PORT will need to determine what services to provide based on local culture, resources, competing needs, hours of operation, available team members, and team members' skills. If there are large gaps in community services, such as naloxone distribution or syringe services programming, that may be useful to include in PORT programming. People with lived experience are critical to understanding community needs and service delivery.

Develop the Protocol

Protocols explain **how** your PORT will work v step-by-step processes and staff roles.

REFERRALS: HOW DOES SOMEONE GET INTO THE PROGRAM?

When a person overdoses, how will the PORT know? There could be multiple ways for your PORT program

to be alerted to potential participants. EMS, fire, and law enforcement are all first responders who may administer naloxone and reverse an overdose. Any of these first responders are good partners to include in the planning and implementation of the program and will be instrumental in providing data about participants to the outreach team. In addition, emergency departments are also often first contacts for people who have experienced an overdose. EDs can refer people to the PORT directly or relay information to the PORT to follow-up with patients. Lastly, many people who use drugs may avoid engaging with health care systems, law enforcement, and first responders due to previous stigmatization or criminalization, so referrals may also come from homeless service providers, recovery organizations, recovery housing, justice service providers, probation, LGBTQ organizations, syringe service programs, peer support programs, and BIPOC organizations. There are multiple ways in which this data can be shared.

EXAMPLES OF REFERRAL PROCESS AND ASSOCIATED FORMS

a. **In-house employee:** If a PORT team member works in EMS or the health department, they may already have access to records.

b. **Data-sharing agreements:** Legal documents allow outside partners to share data.

c. **HIPAA release forms:** First responders can ask participants to sign forms allowing data sharing after overdose recovery.

d. **Community Referrals:** CBOs can refer their clients through specific phone number, fax, or email.

Tip: Use digital forms and automatic systems to make this easier.

HOURS OF OPERATION

Overdose is not restricted to 9-5, but some teams are active only on certain hours/days, while others are able to function 24/7. Remember the goal is to follow up within 24-72 hours post-overdose, but some programs aim to intervene at the scene of the overdose or in the emergency room. Fatal overdose risk is highest in the hours and days after non-fatal overdose, so promptly providing overdose prevention education and/or MOUD will greatly reduce risk.

METHOD OF CARE MANAGEMENT

Much of the PORT work is similar to care management. Participants might have complicated follow-up needs requiring coordination with multiple resources or service providers. Some programs utilize care-management systems such as Goldie, a UNC-developed electronic health record platform custom-build for PORT teams, (see appendix A) to keep track of all this information. Other resources, like NCCARE360, can support referrals and case management.

An ideal system will provide methods for the following key functions:

- Referrals
- Patient data
- Forms and digital signatures
- Communications
- Tracking progress and quality improvement

Remember, participants may want frequent or occasional follow-ups – your system should support both.

Develop Forms for Your Port

PORTs deal with **private health information** – protect it carefully.

You'll need:

- **Patient forms:** HIPAA, 42 CFR (for substance use), Release of Information (ROI)
- **Field forms:** For collecting data during visits, and a leave-behind guide for participants
- **Team forms:** Data-sharing agreements between organizations

CONFIDENTIALITY

An overdose is traumatic. Don't push participants to sign forms immediately. Forced info sharing can make people drop out. Instead:

- Build trust with first responders
- Educate participants about what PORT is
- Let them know someone will be following up soon

PHASE 3:
IMPLEMENTATION

Now it's time to launch your PORT program. That means training your team, educating the community, spreading the word, and starting outreach visits.

Hold Training Sessions

Part of implementing the PORT is getting the outreach team, the support network, and the broader community on the same page, which requires education. Everyone involved on the Outreach Team should be taught about mental health, substance use, evidence-based treatment, MOUD pharmacology, efficacy of peer support and targeted naloxone distribution, harm reduction philosophy and practice, cultural competency, and the various legal considerations concerning overdose response (see Legality of the Opioid Response section below). Additionally, the community should be made aware of the program and educated about the benefits of having a PORT. Holding training and educational sessions for the community helps people see their role in supporting the PORT and lowering overdose deaths in their community. A good training to offer the community that can serve to both teach lifesaving skills and build support for your PORT is an overdose reversal/naloxone training. Teaching people a tangible skill like naloxone administration is good for public relations as well as the community's health!

LEGALITY OF THE OPIOID RESPONSE

In the last few years, North Carolina has passed a series of laws to support overdose response efforts. Training should include discussion of the following laws:

- **Good Samaritan Law** (G.S. 90-96.2 and G.S. 18B-302.2) – states that individuals who experience a drug overdose or witness an overdose and seek help for the victim cannot be prosecuted for possession of small amounts of drugs, paraphernalia, or underage drinking. The goal of this law was to encourage people to call 911 by removing the fear of criminal repercussions. This law helps to focus efforts on helping the victim.
- **Naloxone Access Law** (G.S. 90-12.7) – removes civil and criminal liabilities from doctors who prescribe, pharmacists who dispense, and bystanders who administer naloxone. Allows for organizations to distribute naloxone to the community under a distribution standing order. Authorizes the State Health Director write a standing order allowing pharmacists to dispense naloxone to persons in need.
- **Syringe Access Law** (G.S. 90-113.27) – allows for the legal establishment of syringe exchange programs. Any governmental or nongovernmental organization "that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors" can start a syringe exchange program. Also provides immunity for possession of drug paraphernalia received from a syringe exchange program.
- **Opioid Epidemic Response Act** (Session Law 2019-159) – allows state funds to be appropriated to syringe exchange programs. Decriminalizes the use of drug "testing equipment", such as fentanyl test strips, by people using drugs.

ADDITIONAL TOPICS FOR TRAINING

Depending on availability and capacity, additional topics for training include:

- Medication for Opioid Use Disorder (MOUD)
- Adverse childhood experiences (ACEs)
- Trauma-informed care
- Motivational interviewing
- Social determinants of health
- Science of SUD and overdose reversal
- Brain model of disease
- Transtheoretical/Stages of Change Model
- Harm Reduction

Press Release

Having a PORT is a wonderful resource in any community; let everyone know when you are ready to launch. Put out a press release, talk with local media, and try to spread the word about this new community resource.

THE ACTUAL VISIT

A PORT program may have different types of visits:

1. immediate post overdose visit – may take place at scene of overdose, at the emergency room, or within 24hours in the community
2. post-overdose outreach – 24-72 hrs. after overdose in the community
3. "pre-overdose" outreach – identify high-risk individuals (history of overdose, high-risk use, housing instability, post-incarceration) for intervention

Each type of visit has specific value, needed protocols, and resource requirements; all emphasize providing engagement and linkage to resources and care to reduce overdose risk. The post-overdose period can be an opportunity in which a person is thinking about the possibility of some sort of behavior change. During the visit, the outreach team member:

- Engages the person to develop trust and build rapport
- Educates and engages the family/friends/loved ones
- Assesses the person's needs by starting a dialogue
- Asks the person what they need, want, and what may be helpful
- Determine the person's stage of change (see Stages of Change Model in Appendix E)
- Provides linkages to care and resources, if desired

In some initial visits, not all these details will be collected. This visit should not feel like an interrogation or a massive collection of personal information. It is advised that only small notes are taken by the outreach team member, as opposed to filling out an entire assessment, which can be completed at a follow-up the visit.

KEY FACTORS OF VISIT

There are multiple factors to be aware of for the visit:

1. Who does the visit, and will that person be the main follow-up contact moving forward with the participant? Having the same person visit repeatedly helps with rapport and trust.

2. How soon does the visit happen? This visit should be within 24-72 hours post-overdose. Note that with crises, there is a window of opportunity. When the crisis passes, the window closes, so moving extremely quickly can help to build rapport and connect with individuals at a time where they may be thinking about a behavior change.

3. How much time will be spent with the client? Taking extra time may make all the difference.

COMPONENTS OF VISIT

The following should be provided, if possible and appropriate, during the initial post-overdose visit:

- **Naloxone kit and instructions**
- **Pamphlets explaining resources, such as crisis support, to leave with family members**
- **Contact information for:**
  - Syringe services program (SSP)/harm reduction (HR) services
  - LME/MCOs
  - Local treatment providers
  - Recovery supports
- If desired, linkage to MOUD services – actively facilitating access is better than simply providing information, because concrete barriers to linkage, like transportation, insurance, fear of stigmatized treatment, can be the difference between overdose and recovery. These barriers have solutions, and an effective PORT will actively solve them.
- Consider providing syringe supplies, drug checking supplies, wound care supplies, hygiene bag.

Referral services might include criminal justice navigation, dental clinics, domestic violence resources, family/peer/crisis support, financial assistance, food assistance, hospitals, medical clinics, mental health and addiction/substance use disorder (SUD) treatment options, prescription

assistance, shelters/homelessness resources, transportation, veteran's assistance, and more. NCCARE360 can facilitate case management and referrals for these community resources.

TREATMENT OPTIONS

Some PORT participants may be seeking treatment for substance use. It is important to present them with a complete list of options and not allow personal biases to get in the way of a participant's ability to choose their own path. Nevertheless, it is important to provide education on the research-proven benefits of opioid agonist treatments like buprenorphine and methadone, and the risks of abstinence or naltrexone-based care, with or without psychotherapy.

Consider the following questions when offering a variety of treatment options for participants:

- Do they offer MOUD (i.e. buprenorphine, methadone, etc.)?
- What are the requirements for MOUD?
- What kinds of insurance are accepted?
- What types of services are offered?
- Outpatient or inpatient?
- Where is the treatment located?
- What types of substances does the person want treatment for?
- Transportation needs?

It is important to remember that a lot of people you connect with will not be ready to access services. This initial visit is an important opportunity to build that connection for them to follow up the following week or six months later. Making that connection and letting them know you are there is the most important part of the visit.

PHASE 4:
EVALUATION

As you begin implementing your PORT program, you'll want to track and monitor your activities and progress. This is important both for reporting purposes and for your own knowledge and program improvement. Generally, you'll want to know whether you conducted your activities as planned, and whether they resulted in the outcomes you expected. You'll also want to know how much time, staff, money, and other resources you spent on each activity. Data that might help in communicating the success of and garnering continued support for your PORT program.

QUANTITATIVE DATA COLLECTION ON PROGRAM

Quantitative data is numbers. Some data that your PORT program can collect include:

- Number of naloxone kits (or other supplies, like testing strips) distributed by the program
- Number of referrals to the program following overdose reversal vs other referrals (justice referrals, community referrals, other agency referrals)
- Number of unique individuals served by the PORT
    - Demographics: race/ethnicity, gender, age range, zip code
    - Social – housing status, veteran status, insurance status
    - Clinical –substances used, recent overdose history, other health issues
- Number of total contacts with all participants of the program: initial vs follow-up
- Cascade of care:
    - Number of participants the program referred to resources, and specifically, evidence-based treatment (MOUD, peer support, syringe services)
    - Number of participants who attend first appointment for treatment
    - Number of participants still engaged in treatment after 30 days
- Number of buprenorphine initiations by PORT
- Amount of money, FTE (full time equivalent), and other resources the program is utilizing
- Amount of money the program is saving the county and /or other service organizations by prevention efforts

QUALITATIVE DATA COLLECTION ON PROGRAM

Qualitative data is just as important as quantitative data. Examples include changes in community member's knowledge, skills, and/or attitudes toward the PORT program, changes in participant's knowledge, skills, and/or attitudes regarding overdose prevention, and satisfaction level of program participants. Best practice is to gather direct feedback from participants. For example, the following questions could be asked of participants:

- "What was the most/least helpful resource option offered, and why?"
- "How did you feel about the timing of the follow-up visits? Would you prefer more/less frequent or differently spaced-out visits?"
- "Is there a service, resource, or referral option that you felt was missing?"
- "What are some ways we could improve our program to better meet your needs?"

MEASURES OF SUCCESS

Treatment is not the only end goal and programs should not measure success solely by the number of referrals to treatment providers. The goal is to connect participants with the resources that they need based upon their expressed opinions. Ultimately, your program will have to define success based upon your community needs and the unique gaps that your program fills. Any increase in healthy behavior is a win!

FOR HELP

Contact the Division of Public Health for resources and assistance:

beinjuryfreenc@dhhs.nc.gov. Remember, you don't have to recreate the wheel! In fact, reaching out and connecting with others, and asking for assistance is a great first step in creating your program. In addition, the North Carolina Technical Assistance Center has online webinars and resources and can provide tailored trainings and technical assistance on a variety of topics.

GLOSSARY

Any discussion of opioid response involves many acronyms. Here is a short list to help you navigate and understand this document:

ACE: adverse childhood experiences

CBO: community-based organization

CPSS: [North Carolina] Certified Peer Support Specialist

ED: emergency department

EMS: emergency medical services

HIPAA: Health Insurance Portability and Accountability Act

HR: harm reduction

LEA: law enforcement agency

LME/MCO: local management entities/managed care organizations

NCHRC: The North Carolina Harm Reduction Coalition

MAT: medication-assisted treatment or medication for addiction treatment

MCO: managed care organization

MOA: memorandum of agreement

MOU: memorandum of understanding

MOUD: medication for opioid use disorder

MI: motivational interviewing technique

OAT: opioid agonist treatment

OBOT: office-based opioid treatment

OTP: opioid treatment program

PORT: post-overdose response team

PWUD: people who use drugs

ROI: release of information

SDOH: social determinants of health

SEP: syringe exchange program

STD/STI: sexual transmitted disease/sexually transmitted infection

SUD: substance use disorder

TIC: trauma-informed care

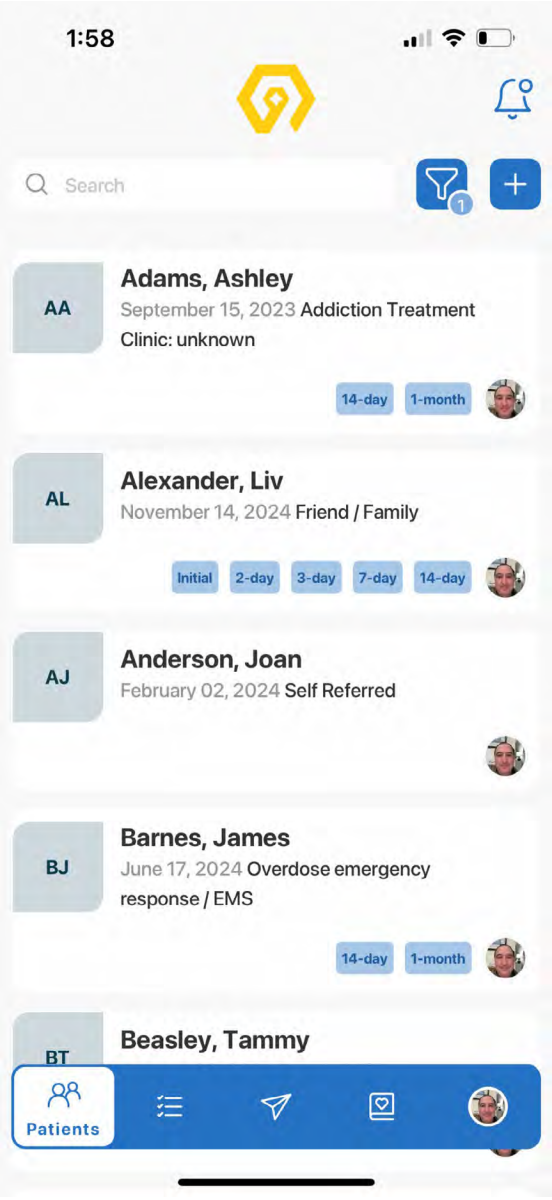
TTM: Transtheoretical Model also known as the Stages of Change

APPENDIX

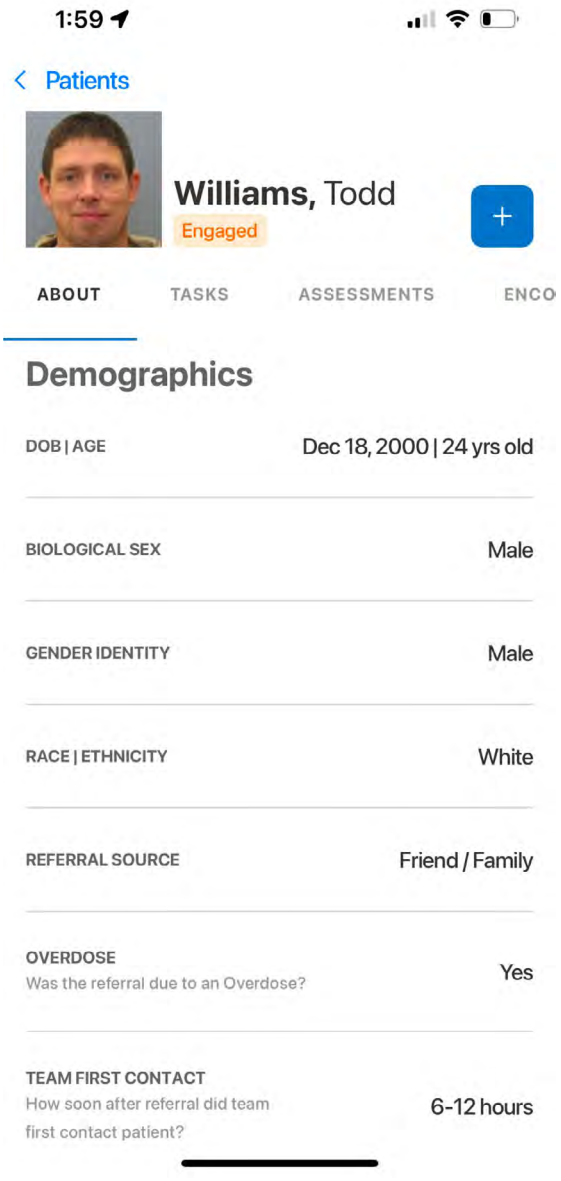
APPENDIX A: CARE MANAGEMENT

Appendix A contains an example of a mobile device-based care management system ("Goldie") developed by UNC Eshelman Innovation specifically for PORT programs.

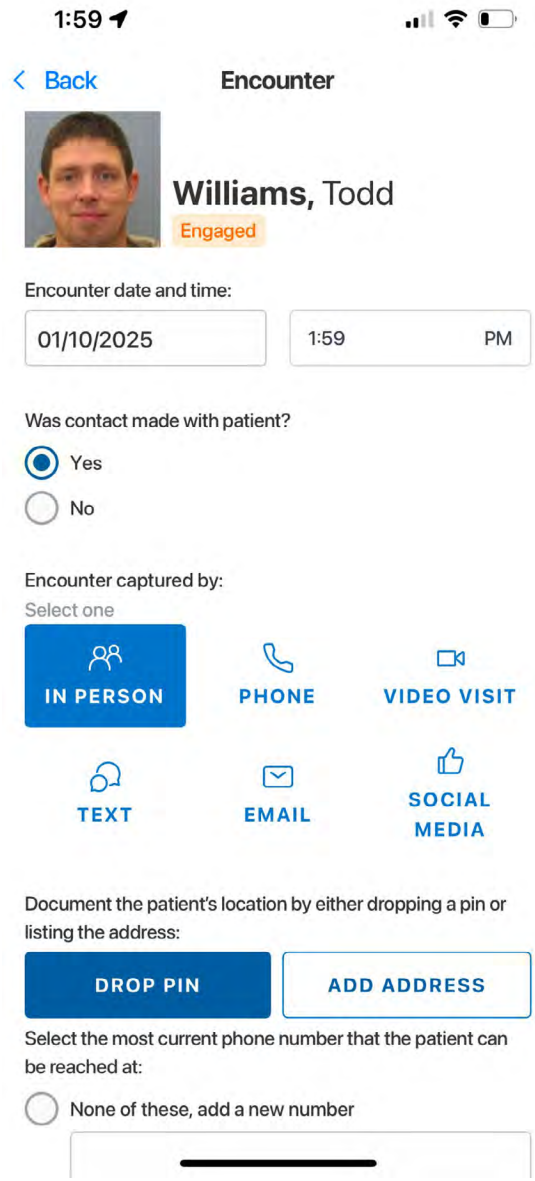
PATIENT LIST:



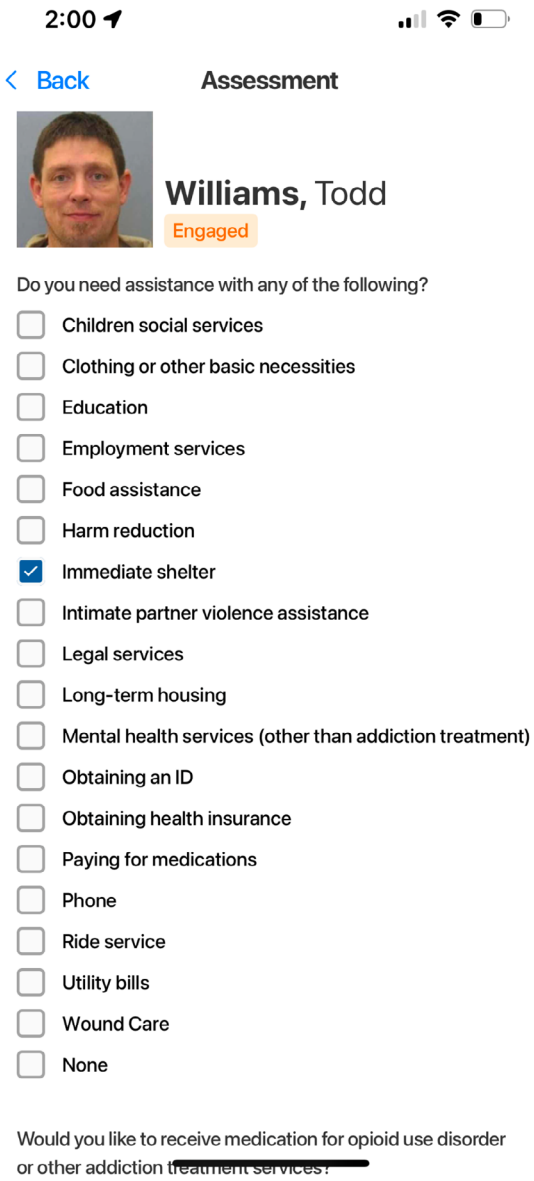
PATIENT FACE SHEET:



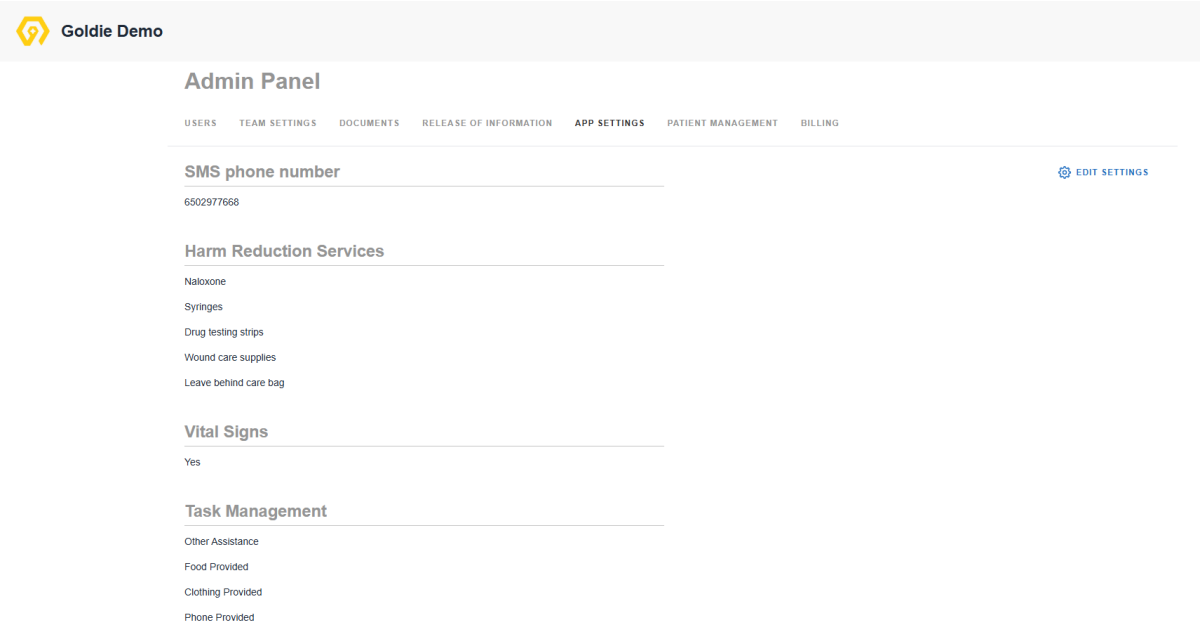
PATIENT ENCOUNTER NOTE:



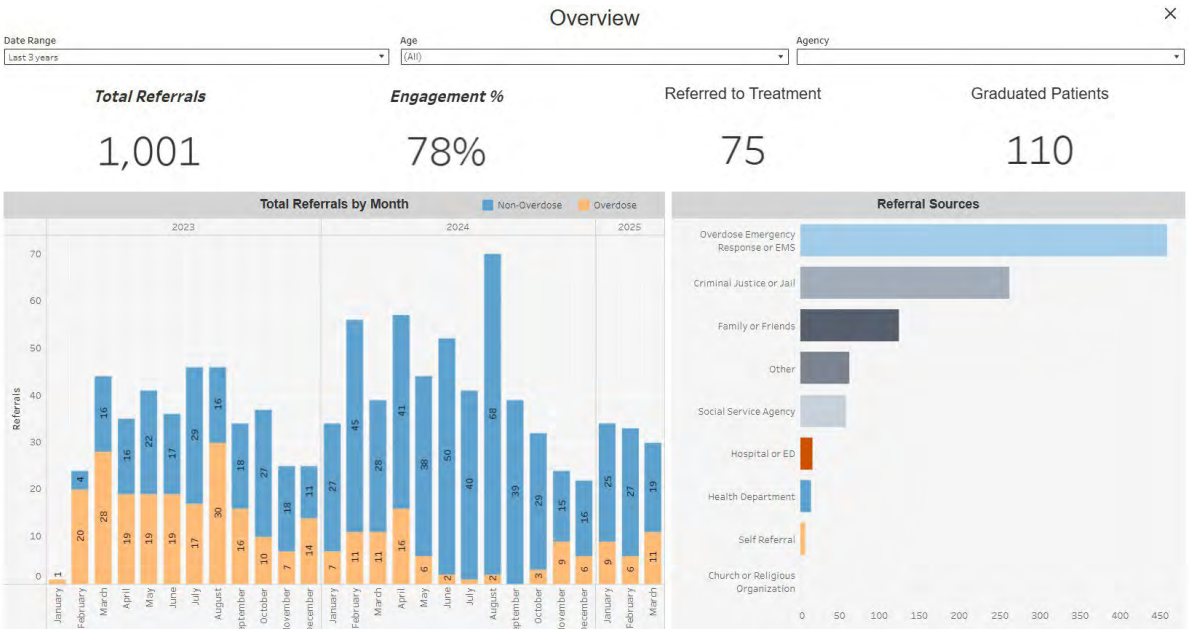
PATIENT ASSESSMENT:



ADMIN PORTAL:



ANALYTICS DASHBOARD:



APPENDIX B: PATIENT INFORMATION FORMS

Appendix B contains examples patient information forms including a sample HIPAA release form, a sample 42 CFR form, and two Release of Information forms from Forsyth County EMS

SAMPLE HIPAA RELEASE FORM:

MODEL HIPAA AUTHORIZATION FOR REFERRAL AND FOLLOW UP

I, <patient name>, give the health care provider named below and other employees at <health care institution> my permission to share my information with <name of community-based organization>. <Community-based organization> will use the information to contact me after I am discharged so that they can talk with me about getting connected to support and resources after an overdose. The information that will be provided to <community-based organization> will include, but may not be limited to, my contact information and information about my hospitalization(s) during which I received care for a substance use-related overdose.

I understand that I may refuse to sign this authorization. <Name of health care institution> may not condition my treatment or provision of services on my decision to sign this authorization form. I understand that I may revoke this authorization by letting <name of health care institution> in writing at any time except to the extent that action has been taken in reliance on it. Finally, I understand that the person(s)/organization(s) that I am authorizing to receive my patient information may not be covered by state/federal rules governing privacy and data security and may be allowed to further share the information that is provided to them.

Unless I revoke my consent earlier, this authorization will expire automatically one (1) year from the date on which it is signed, which is___ /___ /_____.

_____	_____
Patient name (print)	Name of health care provider (print)
_____	_____
Patient signature	Signature of health care provider
_____	_____
Date	Date

Date revoked: ___ /___ /_____ **Staff initials:** _____

SAMPLE 42 CFR FORM:

MODEL AUTHORIZATION FOR REFERRAL AND FOLLOW UP

This model authorization form has been drafted to comply with the requirements set forth under 42 C.F.R. Part 2, which establishes additional protections for patients receiving treatment for substance use disorder as well as additional criminal and civil liability for the unlawful disclosure of patient information. This form should be used when the individual or entity disclosing the patient information is a program as defined under 42 C.F.R. § 2.11 and when the information being disclosed is of the type described in 42 C.F.R. § 2.12(1)(1)(i).

I, <patient name>, give the health care provider named below and other employees at <health care institution> my permission to share my information with <name of *individual* at community-based organization who will receive the patient's information> at <name of community-based organization>. <Community-based organization> will use the information shared to contact me after I am discharged for the purpose of providing post-overdose support and/or connecting me to other resources. The information that will be provided to <community-based organization> will include, but may not be limited to, my contact information and information about my hospitalization(s) during which I received care for a substance use-related overdose.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I can refuse to sign this authorization and that <name of health care institution> may not condition my treatment or refuse to provide me services based on my decision to sign this authorization form. If I do sign this authorization then I must be given a copy of the form after it has been signed by me and my health care provider. I understand that I may revoke this authorization by letting <name of health care institution> know in writing at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this authorization will expire automatically one (1) year from the date on which it is signed, which is ___ /___ /_____.

_____	_____
Patient name (print)	Name of health care provider (print)
_____	_____
Patient signature	Signature of health care provider
_____	_____
Date	Date

Date revoked: ___ /___ /_____ **Staff initials:** _____

NOTICE TO RECIPIENT OF PATIENT INFORMATION

Each disclosure of patient information made with the patient's written consent must be accompanied by a notice on the prohibition against re-disclosure in accordance with 42 CFR § 2.32.

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

FORSYTH COUNTY EMS RELEASE OF INFORMATION FORMS:

Forsyth County Emergency Services
911 E. Fifth St. • Winston-Salem, NC 27101 • (336) 703-2750

CONSENT FOR RELEASE OF INFORMATION MEDICAL AND BEHAVIORAL HEALTH RECORDS

(This includes Mental Health, Substance Abuse and Intellectual/Developmental Disabilities)

Patient's Name:	Date of Birth	Social Security # **(last four)** XXX-XX-	Record #

LEGAL STATUS

Legally Responsible Person: ☐ Self ☐ Guardian ☐ POA (Printed Name):

SPECIFIC INFORMATION TO BE DISCLOSED (Initial all that apply)

_____ Admission/Transfer/D/C Summary	_____ Diagnosis(es)	_____ Presence/Participation in Treatment
_____ Assessment/Psych Eval/Psych Testing	_____ Educational Information/ Records	_____ Toxicology Reports/Drug Screens
_____ Behavioral & Medical Records	_____ Entitlements/Eligibility Info.	_____ Treatment History/ H & P
_____ Birth Records/Developmental Hx	_____ Laboratory/Scan Results	_____ Treatment Plan/Crisis Plan/ Care Plan
_____ Current Treatment Notes/Summary/ Update	_____ Legal Records	_____ Other: _____
_____ Demographic Information	_____ Medication Management Info.	_____ Other: _____

This consent/authorization is for **FORSYTH COUNTY EMERGENCY SERVICES** (FCES) to receive information from and release information to:
Name: Phone:

This consent/authorization will remain in effect: ☐ One year from the date signed
☐ Date Specified: ☐ Until the following event:

The purpose of this dual disclosure of information is: ☐ Continuity of Care ☐ Disability determination ☐ Insurance Processing
☐ Treatment Planning ☐ Legal Proceedings ☐ Benefits/Entitlements ☐ Other:

Form of Disclosure and Redisclosure

Unless specified in writing, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, facsimile or electronically to another medical facility or healthcare provider involved in the care of the patient or responsible for any part of the patient's charges. Health information is protected under HIPAA, 45 C.F.R. parts 160 & 164, but once the information is disclosed pursuant to this form, it may no longer be protected by HIPAA and further re-disclosure may occur.

I understand that my information may not be protected from re-disclosure by the requestor of the information. If this information is protected by Federal law 42 C.F.R. Part 2 (Federal Substance Abuse Confidentiality Regulations), the recipient may not re-disclose information related to substance abuse treatment information without my further written authorization unless otherwise provided for by state or federal law.

Expiration and Revocation:

I understand this authorization is valid for financial transactions indefinitely. I also understand that I may revoke this authorization at any time in writing by sending written notification to Forsyth County Emergency Services (FCES) ~ 911 E. Fifth St. ~ Winston-Salem, NC 27101. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding and it will not have any effect on any actions FCES took before it received the revocation.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol/ drug abuse, psychological/ psychiatric conditions, or genetic testing, this disclosure may include that information unless I request that this information be restricted. I also understand my signature is voluntary and that I may refuse to sign. I also understand that FCES cannot deny or refuse treatment if I refuse to sign.

☐ Check here if patient/client refuses to sign authorization. _____ Initial here to indicate receipt of duplicate copy.

☐ Signature of Patient/Client ☐ Signature of Parent/Guardian/Legal Representative — Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual:
☐ Power of attorney ☐ Healthcare surrogate ☐ Parent/Guardian ☐ Other: _____

Witness — Date

Original/White Sheet - Scan to PCR EMR — Duplicate/Yellow Sheet - Patient/Guardian

Release of Information Medical and Behavioral Health Treatment (Approved 12/21/2016)

Forsyth County Emergency Services
911 E. Fifth St. • Winston-Salem, NC 27101 • (336) 703-2750

CONSENT FOR RELEASE OF INFORMATION
MEDICAL AND BEHAVIORAL HEALTH RECORDS

(This includes Mental Health, Substance Abuse and Intellectual/Developmental Disabilities)

Patient's Name:	Date of Birth	Social Security # (last four) XXX-XX-	Date

This release is for **FORSYTH COUNTY EMERGENCY SERVICES** to receive and release information to and from:

☐ ARCA	☐ Forsyth County Public Health	☐ Samaritan Ministries
☐ Bethesda Center	☐ Forsyth County Sheriff's Dept.	☐ Senior Services
☐ Correct Care Solutions (Jail staff)	☐ GreenTree Peer Center	☐ Social Security Administration
☐ Cardinal Innovations Healthcare	☐ Insight Human Services	☐ Twin City Harm Reduction Collective
☐ City of Dwellings	☐ Kernersville Police Dept. ☐ Fire	☐ Veterans Administration
☐ Daymark Recovery Services	☐ Monarch Health Care	☐ VA Medical Center
☐ Empowerment Project	☐ Northwest Community Care/Emtiro	☐ Wake Forest Baptist Health
☐ Family Services	☐ Novant Health	☐ Winston-Salem Forsyth Co. Schools
☐ Forsyth County DSS	☐ Old Vineyard	☐ Winston-Salem Police Dept ☐ Fire Dept
☐ Forsyth County Judicial System/DOJ	☐ Salvation Army	☐ Other: _____

SPECIFIC INFORMATION TO BE DISCLOSED (Check all that apply)

☐ Mental Health Records	☐ Educational Records	☐ Pharmacy Records
☐ Substance Use Records including Assessment, Inpatient Record, H & P, Treatment, Meds, Labs, Discharge Info	☐ Entitlements & Housing Info	☐ Psychological Evaluations
	☐ Legal Info/Records	☐ Transportation
	☐ Medical Health/Labs (Including HIV and substance use related)	☐ Vocational Info
☐ Developmental Disability Records		☐ Other: _____
☐ Crisis Info, Plan, WRAP	☐ Medication Eval/History/ Orders	

This consent/authorization will remain in effect: ☐ One year from the date signed ☐ Date Specified:
☐ Until the following event:

The purpose of this dual disclosure of information is: ☐ Care Coordination ☐ Disability determination ☐ Insurance Processing ☐ Treatment Planning/Care Coordination ☐ Legal Proceedings ☐ Benefits/Entitlements ☐ Other:

Form of Disclosure and Redisclosure: Unless in writing, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, paper format, fax or electronically to another medical facility or healthcare provider involved in the care of the patient or responsible for any patient charges. Health information is protected under HIPAA, 45 C.F.R. parts 160 & 164, but once the information is disclosed pursuant to this form, it may no longer be protected by HIPAA and further re-disclosure may occur.

I understand that my information may not be protected from re-disclosure by the requestor of the information. If this information is protected by Federal law 42 C.F.R. Part 2 (Federal Substance Abuse Confidentiality Regulations), the recipient may not re-disclose information related to substance abuse treatment information without my further written authorization unless otherwise provided for by state or federal law.

Expiration and Revocation: I understand this authorization is valid for financial transactions indefinitely. I also understand that I may revoke this authorization at any time by initialing this notification (_____ **Initials**) and sending the form to Forsyth County Emergency Services (FCES) ~ 911 E. Fifth St. ~ Winston-Salem, NC 27101. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding and it will not have any effect on any actions FCES took before it received the revocation.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol/ drug abuse, psychological/ psychiatric conditions, or genetic testing, this disclosure may include that information unless I request that this information be restricted. I also understand my signature is voluntary and that I may refuse to sign. I also understand that FCES cannot deny or refuse treatment if I refuse to sign.

☐ Check here if patient/client refuses to sign authorization. _____ Initial here to indicate receipt of duplicate copy.

☐ Signature of Patient/Client ☐ Signature of Parent/Guardian/Legal Representative	Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual:
☐ Power of attorney ☐ Healthcare surrogate ☐ Parent/Guardian ☐ Other: _____

Witness Printed Name	Witness Signature	Date

Original/White Sheet - Scan to PCR EMR — Duplicate/Yellow Sheet - Patient/Guardian

Release of Information Medical and Behavioral Health Treatment (Approved 11/15/2017)

APPENDIX C: GENERAL PROTOCOL FORMS

Appendix C includes general forms that could be helpful in the field when doing initial or follow-up visits with PORT participants. A field data collection form was provided by Healing Transitions, and a pocket resource guide was provided by Wake County Health Department.

FIELD DATA COLLECTION FORM:

Healing Transitions

Rapid Response Data Collection Form

Date:_____

Name: _____

DOB:_____

Cell: _____

Family Involvement?: _____

Address: _____

City: _____

Gender: _____

Race/ Ethnicity: _____

Time of OD: _____

Date of overdose: _____

IV Use: _____

Prior Overdose: _____

Treatment Referral: _____

Pregnant: _____

Person is a Guardian of Minors: _____

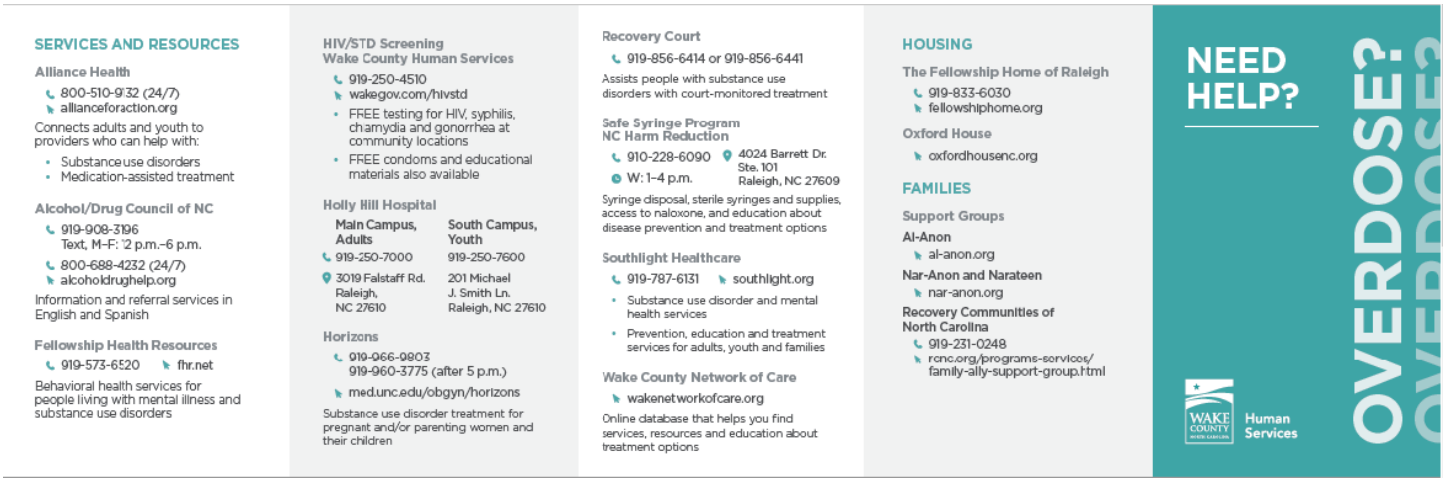
Employment: _____

Reliable Transportation: _____

Housing Situation: _____

Food Insecurity: _____

POCKET RESOURCE GUIDE:



SERVICES AND RESOURCES

Alliance Health
800-510-9132 (24/7)
allianceforaction.org
Connects adults and youth to providers who can help with:
- Substance use disorders
- Medication-assisted treatment

Alcohol/Drug Council of NC
919-908-3196
Text, M–F: 12 p.m.–6 p.m.
800-688-4232 (24/7)
alcoholdrughelp.org
Information and referral services in English and Spanish

Fellowship Health Resources
919-573-6520 fhr.net
Behavioral health services for people living with mental illness and substance use disorders

HIV/STD Screening
Wake County Human Services
919-250-4510
wakegov.com/hivstd
- FREE testing for HIV, syphilis, chlamydia and gonorrhea at community locations
- FREE condoms and educational materials also available

Holly Hill Hospital

Main Campus, Adults	South Campus, Youth
919-250-7000	919-250-7600
3019 Falstaff Rd. Raleigh, NC 27610	201 Michael J. Smith Ln. Raleigh, NC 27610

Horizons
919-966-9803
919-960-3775 (after 5 p.m.)
med.unc.edu/obgyn/horizons
Substance use disorder treatment for pregnant and/or parenting women and their children

Recovery Court
919-856-6414 or 919-856-6441
Assists people with substance use disorders with court-monitored treatment

Safe Syringe Program
NC Harm Reduction
910-228-6090 4024 Barrett Dr. Ste. 101 Raleigh, NC 27609
W: 1–4 p.m.
Syringe disposal, sterile syringes and supplies, access to naloxone, and education about disease prevention and treatment options

Southlight Healthcare
919-787-6131 southlight.org
- Substance use disorder and mental health services
- Prevention, education and treatment services for adults, youth and families

Wake County Network of Care
wakenetworkofcare.org
Online database that helps you find services, resources and education about treatment options

HOUSING

The Fellowship Home of Raleigh
919-833-6030
fellowshiphome.org

Oxford House
oxfordhousenc.org

FAMILIES

Support Groups

Al-Anon
al-anon.org

Nar-Anon and Narateen
nar-anon.org

Recovery Communities of North Carolina
919-231-0248
rcnc.org/programs-services/family-ally-support-group.html

NEED HELP?

OVERDOSE?

WAKE COUNTY NORTH CAROLINA Human Services

ADDITIONAL RESOURCE GUIDES FOR PEOPLE WHO USE DRUGS:

1. Disability Rights North Carolina – https://disabilityrightsnc.org/nc-statewide-opioid-use-disorder-and-substance-use-disorder-resources/
2. NCCARE360 – https://nccare360.org/
3. North Carolina Drug User Resource Guide - https://epi.dph.ncdhhs.gov/cd/hepatitis/DrugUserHealthResourceGuide.pdf

APPENDIX D: TEAM INFORMATION SHARING

Appendix D includes an example of a Protected Health Information Agreement between Wake Forest University Baptist Medical Center and an Outside Entity. These forms should be developed in partnership with your legal department and adapted to fit the needs of your programs.

SAMPLE PHI AGREEMENT:

WakeHealthLink

AGREEMENT FOR ACCESS TO PROTECTED HEALTH INFORMATION

BETWEEN WAKE FOREST UNIVERSITY BAPTIST MEDICAL CENTER

AND _____

THIS AGREEMENT for Access to Protected Health Information ("PHI") ("Agreement") is entered into between Wake Forest University Baptist Medical Center (hereinafter "WFUBMC") and _____ (hereinafter "Outside Entity").

WHEREAS, WFUBMC utilizes certain systems which allow users to remotely access patient electronic health records (the "System") among the WFUBMC facilities and other health care providers affiliated with WFUBMC;

WHEREAS, the System will allow certain authorized parties to view and retrieve the electronic health records ("EHR") of their patients for the purpose of treatment, payment, or certain health care operations to the extent permitted without authorization by applicable state law, the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996, and the rules and regulations promulgated thereunder, as may be amended from time to time (collectively, "HIPAA"), and further subject to the Recovery and Reinvestment Act of 2009 ("ARRA"), including its provisions commonly known as the "HITECH Act," and rules and regulations promulgated thereunder, as may be amended from time to time;

WHEREAS, WFUBMC believes that the proper use of the System by Outside Entity would substantially improve the quality of health care provided to patients and therefore desires to allow access to the System by Outside Entity, subject to the restrictions and other requirements set forth in this Agreement;

WHEREAS, Outside Entity provides professional or other medical services to WFUBMC patients, but does not otherwise have a contract with WFUBMC for access to the EHR;

WHEREAS, Outside Entity has agreed to use the System to improve the quality and efficiency of the medical services Outside Entity and WFUBMC provide to WFUBMC patients; and

NOW, THEREFORE, in consideration of the premises, the mutual agreements and covenants herein contained, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto do hereby agree as follows:

1. System Access.

A. Subject to the terms and conditions of this Agreement, WFUBMC hereby grants Outside Entity non-transferable and non-exclusive access to the System to permit the medical providers (each a "Medical Provider"), as defined and set forth in Exhibit A attached hereto, and their office administrators, secretaries and nurses (collectively "Authorized Users"), to electronically access and use the System solely for storing, processing and displaying medical records and other information, images and content related to the provision of healthcare to patients of such Medical Providers (the "System License"). Outside Entity understands and warrants that such access and use shall be limited to that achieved through unique access codes provided to each individual Authorized User granted access by WFUBMC, and that each Authorized User shall be prohibited from using another Authorized User's access code to access and/or use the System. Outside Entity further acknowledges and understands that WFUBMC may terminate Outside Entity's and/or individual Authorized Users' access and/or this Agreement at any time for any reason without penalty, regardless of any effect such termination may have on Outside Entity's operations.

B. Outside Entity acknowledges and agrees that any hardware, software, network access or other items (collectively, the "Components") necessary for Outside Entity to access and use the System must be obtained separately by Outside Entity. WFUBMC shall not be responsible for the procurement, installation or maintenance of any Components, and WFUBMC makes no representations or warranties regarding the Components whatsoever. Any fees associated with the Components shall be borne by Outside Entity and paid directly to the suppliers of the components.

C. Outside Entity acknowledges that WFUBMC does not guarantee constant or consistent availability of the System, and that the System may be periodically unavailable due to technical issues, security concerns, or hardware and software upgrades.

2. Use or Disclosure of PHI.

A. Outside Entity shall not use or disclose PHI received from WFUBMC in any manner that would constitute a violation of federal or state law, including, but not limited to, HIPAA. Outside Entity shall ensure that only its directors, officers, employees, contractors, and agents use or disclose PHI received from, or created or received on behalf of, WFUBMC only in accordance with the provisions of this Agreement and federal and state law. Outside Entity shall not disclose PHI in any manner other than as permitted by this Agreement. Outside Entity further agrees that all information accessed, viewed, or downloaded through the System will be maintained in the strictest confidentiality and, at a minimum, as required by state and federal law. In the event that the privacy and security standards employed by Outside Entity exceed state and federal requirements, Outside Entity shall protect such data in the same manner as Outside Entity safeguards the confidentiality of other patient care records. Outside Entity further agrees that it will implement all appropriate safeguards to prevent unauthorized use or disclosure of PHI.

B. Outside Entity agrees to implement and utilize the System and shall provide WFUBMC with access to a patient's EHR located on any system implemented or utilized by Outside Entity that are created, maintained, transmitted, or received using the System when such patient is also a patient of WFUBMC. WFUBMC agrees that such HER shall be used solely for the purposes of treatment, payment, or health care operations to the extent permitted without patient authorization by HIPAA. Outside Entity shall use the System in accordance with any policies issued by WFUBMC from time to time.

C. WFUBMC and Outside Entity shall comply in all material respects with the standards for privacy of individually identifiable health information of the Administrative Simplification subtitle of HIPAA. Outside Entity recognizes its status as a "covered entity" under HIPAA and agrees to carry out its responsibilities under this Agreement in accordance with such status.

3. Process for Requesting System Access.

A. Outside Entity shall provide WFUBMC with the name and direct contact information for its Privacy Officer, and shall properly notify WFUBMC prior to any change in such contact. Outside Entity shall also designate a liaison to coordinate user access (which person can also be the Privacy Officer). The liaison is responsible for managing the modification and termination of accounts that the Outside Entity is provided. Before accessing the System, each Authorized User shall agree to and sign the terms of a confidentiality statement (the "Confidentiality Statement") in the form provided herein as Exhibit B, attached hereto and incorporated herein by reference, as that form may be amended from time to time by WFUBMC. Outside Entity agrees to ensure that each Authorized User approved for access under this Agreement adheres to the requirements of this Agreement and the Confidentiality Statement. Each Authorized User shall also complete, in a form and in a manner to be determined by WFUBMC, training regarding the user requirements of the System.

B. For purposes of this Agreement, access to the System shall be permitted only for such employees of Outside Entity who have a reasonable need to access PHI of WFUBMC patients for purposes of carrying out their duties to such patients. The Authorized Users of Outside Entity who shall have access to the System are listed in Exhibit A of this Agreement, incorporated by reference herein. Outside Entity agrees to notify WFUBMC within 24 hours when any Authorized User is separated from employment of Outside Entity for any reason, including but not limited to retirement, termination or voluntary separation. Outside Entity further agrees that, on each anniversary date of this Agreement, or more frequently as requested by WFUBMC, it shall validate that each Authorized User listed in Exhibit A continues to have a reasonable need for access to the System and continues to be an employee or agent of Outside Entity.

4. Data Ownership.

Outside Entity acknowledges and agrees that WFUBMC owns all rights, interests and title in and to all data acquired, accessed, viewed, or downloaded through the System, and that such rights, interests and title shall remain vested in WFUBMC at all times. Outside Entity shall not compile and/or distribute such data or any analyses to third parties utilizing any data received from, or created or received on behalf of WFUBMC without express written permission from WFUBMC.

5. Reporting of Unauthorized Use or Disclosure of PHI.

A. Outside Entity shall, within twenty-four (24) hours of becoming aware of an unauthorized use or disclosure of PHI by any third party or by Outside Entity, its officers, directors, employees, contractors, agents or by a third party to which Outside Entity disclosed PHI, report any such disclosure to WFUBMC. Such notice shall be made by telephone call and by letter sent via a nationally recognized overnight carrier to the following:

Wake Forest University Baptist Medical Center
Medical Center Boulevard
Winston-Salem, NC 27157
ATTN: Privacy Office
(336) 716-4472

B. Potential Data Security Breach. If at any time Outside Entity has reason to believe that PHI transmitted pursuant to this Agreement may have been accessed or disclosed without proper authorization and contrary to the terms of this Agreement, Outside Entity will immediately give WFUBMC notice and take actions to eliminate the cause of the breach. To the extent WFUBMC deems warranted, in its sole discretion, WFUBMC will provide notice or require Outside Entity to provide notice to individuals whose PHI may have been improperly accessed or disclosed.

C. WFUBMC has the right, at Outside Entity's sole cost and expense, at any time, to monitor, audit, and review activities and methods in implementing this Agreement in order to assure compliance therewith, within the limits of Outside Entity's technical capabilities.

6. Availability of Books and Records.

Outside Entity agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from WFUBMC, or created or received on behalf of WFUBMC, available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining WFUBMC'S and Outside Entity's compliance with the HIPAA standards. Outside Entity shall promptly provide to WFUBMC a copy of any documentation that Outside Entity provides to the Secretary.

7. Investigations/Sanctions.

WFUBMC reserves the right to monitor, review and investigate reported and identified failures to comply with this Agreement and impose nonmonetary appropriate sanctions. Sanctions may include, but are not limited to, the termination of this Agreement or termination of individual Authorized User access. WFUBMC reserves the right to report unprofessional conduct to appropriate licensing or other regulatory authorities. Outside Entity agrees to cooperate with WFUBMC in order to adequately investigate complaints received involving the Outside Entity's employees or agents. Outside Entity agrees to have a sanctions policy, produce it upon request, and discipline their employees or agents for all breaches involving PHI in accordance with the HIPAA Privacy Rule.

8. Immediate Termination.

Outside Entity understands, acknowledges and agrees that WFUBMC may terminate this Agreement immediately without liability at any time, and for any reason, within the sole discretion of WFUBMC.

9. Indemnification.

Outside Entity agrees to indemnify and hold harmless WFUBMC, its governing board, officers, employees and agents, from and against any and all claims, costs, losses, damages, penalties, liabilities, expenses, demands, and judgments, including litigation expenses and attorney's fees, which may arise from Outside Entity's breach and/or performance under this Agreement or negligent acts or omissions of its subcontractors, agents, or employees, including, but not limited to, any penalties, claims or damages arising from or pertaining to a breach of this Agreement, or the violation of any state or federal law applicable to the use, disclosure or protection of PHI subject to this Agreement. Such indemnification shall include, but shall not be limited to, the full cost of any required notice to impacted individuals, including the costs to retain an outside consulting firm, vendor or outside attorneys to undertake the effort.

10. Insurance.

During the term of this Agreement, Outside Entity, at its sole cost and expense shall provide commercial general liability insurance on an occurrence basis in the minimum amount of $1,000,000. Such liability insurance coverage shall include "cyber liability" insurance coverage.

11. Entire Agreement.

This Agreement constitutes the entire agreement between the parties regarding access to the System, and supersedes all prior oral or written agreements, commitments, or understandings concerning the matters provided for herein.

12. Amendment.

This Agreement may be modified only by a subsequent written Agreement executed by the parties.

13. Governing Law.

The parties' rights or obligations under this Agreement will be construed in accordance with, and any claim or dispute relating thereto will be governed by, the laws of the State of North Carolina.

14. Waiver.

Neither the waiver by any of the parties hereto of a breach of, or a default under, any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasions, to enforce any of the provisions of this Agreement or to exercise any right or privilege hereunder, will thereafter be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any of such provisions, rights or privileges hereunder.

15. Term.

The term of this Agreement shall be one year, beginning on, and will continue thereafter from year to year unless terminated by either party.

IN WITNESS WHEREOF, WFUBMC and Outside Entity have caused this Agreement to be duly executed on the day and year first above written.

WFUBMC	Outside Entity
By:_____	By:_____
Name:_____	Name:_____
Title:_____	Title:_____

Exhibit A

1. Medical/clinical personnel including, but not limited to MD, RN, LPN, NA, PA, CMA, NP, PA

2. Billing and coding related personnel including, but not limited to Coders, Medical Records Clerk, Billing Clerks

Acknowledged by:

_____

Signature of individual authorized to sign for Outside Entity

Name: _____

Title: _____

Date: _____

APPENDIX E: STAGES OF CHANGE

Appendix E includes a Stages of Change diagram along with a sample treatment eagerness scale. Again, PORT participants should be leading the conversation about their individual wants and needs. This is to serve as a basis of understanding about the complexities of changing behavior.

STAGES OF CHANGE DIAGRAM:

SAMPLE TREATMENT EAGERNESS SCALE:

greenspace

Stages of Change Readiness and Treatment Eagerness Scale for Drugs (Socrates-8D)

Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drug use. For each statement circle one number from 1 to 5 to indicate how much you agree or disagree with it right now. Please circle one and only one number for every statement.

		NO! Strongly disagree	No Disagree	? Undecided or unsure	Yes Agree	YES! Strongly agree
1.	I really want to make changes in my use of drugs.	1	2	3	4	5
2.	Sometimes I wonder if I am an addict.	1	2	3	4	5
3.	If I don't change my drug use soon, my problems are going to get worse.	1	2	3	4	5
4.	I have already started making changes in my use of drugs	1	2	3	4	5
5.	I was using drugs too much at one time, but I've managed to change that.	1	2	3	4	5
6.	Sometimes I wonder if my drug use is hurting other people.	1	2	3	4	5
7.	I have a drug problem.	1	2	3	4	5
8.	I'm not just thinking about changing my drug use, I'm already doing something about it.	1	2	3	4	5
9.	I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern.	1	2	3	4	5
10.	I have serious problems with drugs.	1	2	3	4	5
11.	Sometimes I wonder if I am in control of my drug use.	1	2	3	4	5
12.	My drug use is causing a lot of harm.	1	2	3	4	5
13.	I am actively doing things now to cut down or stop use of drugs.	1	2	3	4	5
14.	I want help to keep from going back to the drug problems that I had before.	1	2	3	4	5
15.	I know I have a drug problem.	1	2	3	4	5
16.	There are times when I wonder if I use drugs too much.	1	2	3	4	5
17.	I am a drug addict.	1	2	3	4	5
18.	I am working hard to change my drug use.	1	2	3	4	5
19.	I have made some changes in my drug use, and I want some help to keep me from going back to the way I used before.	1	2	3	4	5