

Opioid-Overdose Reduction Continuum of Care Approach

A Guide for Policymakers for
Implementing Evidence-Based Strategies
that Address Opioid Overdose

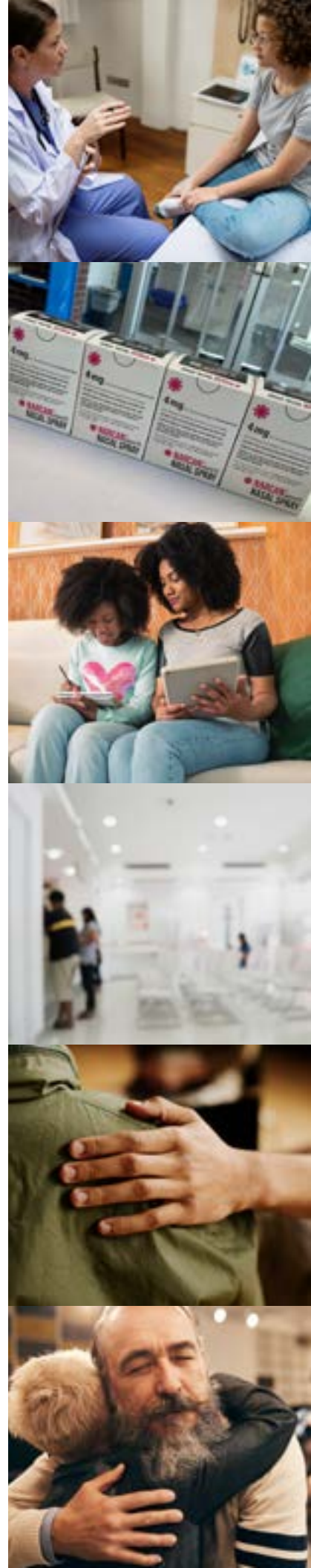


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Opioid-Overdose Reduction Continuum of Care Approach

The Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) guides system- and practice-level changes to reduce opioid overdose deaths. The HEALing Communities Study, a multi-site research study, tested the impact of an integrated set of evidence-based practices across healthcare, behavioral health, justice, and other community-based settings. HEALing Communities is funded by the National Institutes of Health (NIH) Helping to End Addiction Long-term (HEAL) Initiative®—a trans-agency effort to speed scientific solutions to stem the national opioid crisis.

This publication is intended to aid policymakers, communities, and key stakeholders in developing comprehensive, multi-system strategies that address the opioid crisis.



“The ORCCA menu represents evidence-based practices with years of research demonstrating their ability to reduce overdose deaths and improve other outcomes. Investing in these practices represents the best opportunity for policy makers to save lives, reduce substance use and support recovery, and strengthen communities.”

Redonna K. Chandler, PhD,
Director, HEALing Communities Study,
National Institute on Drug Abuse (NIDA)

ORCCA outlines the priority populations and 19 essential evidence-based interventions to reduce opioid overdose deaths:

1. Prioritize delivery of services to those who need them most in criminal legal settings and other venues
2. Implement field-based population detection methods
3. Use data sources to target intervention to those who need services
4. Engage individuals with lived experience in decision-making process
5. Implement active overdose education and naloxone distribution (OEND) programs for people who use opioids and their social networks
6. Implement active OEND at venues where overdoses are more likely to occur
7. Include passive OEND strategies
8. Build OEND capacity among first responders
9. Expand medications for opioid use disorder (MOUD) capacity in healthcare, criminal legal settings, and through telemedicine
10. Initiate on-site MOUD in community-based settings
11. Create linkage programs and protocols
12. Enhance MOUD engagement and retention
13. Expand peer recovery support and peer services
14. Remove barriers to housing services
15. Expand transportation initiatives for patients with opioid use disorder (OUD)
16. Address barriers to needed resources, including insurance coverage, food security, childcare, and employment
17. Remove barriers to supplemental behavioral health services
18. Ensure safer opioid prescribing
19. Implement safe and effective opioid disposal

A 2020 article by Winhusen et al. in *Drug and Alcohol Dependence*¹ explains the ORCCA strategies and their evidence base.

Prioritize Individuals at Heightened Risk for Opioid Overdose

The first step in preventing overdose deaths is reaching populations at the highest risk for overdose. A substantial proportion of people who have died from opioid-involved overdose had no interaction with the healthcare system in the preceding year.² Reducing overdose deaths requires getting overdose prevention interventions and effective OUD treatment services to those who need them. Communities can focus on increasing the number and proportion of individuals most at risk for opioid overdose who are identified and thereby become potential candidates for programs and services. Overdose risk is substantially elevated for individuals who:

- Have had a prior opioid overdose
- Have reduced opioid tolerance (i.e., people who have completed withdrawal from opioids, or who have been released from institutional settings such as jail, residential treatment, hospital)
- Use other substances (e.g., alcohol, benzodiazepines, cocaine, and amphetamine-like substances)
- Have a concomitant major mental illness (e.g., major depression, bipolar disorder, schizophrenia, anxiety disorders)
- Have a concomitant major medical illness (e.g., cirrhosis, chronic renal insufficiency, COPD, asthma, sleep apnea, congestive heart failure, infections related to drug use)
- Inject drugs

There are also striking racial disparities to consider in prioritizing populations with a high risk for overdose. Communities of color remain disproportionately affected by opioid overdose and premature mortality due to substance use, exclusion from access to high-quality care, and criminalization. Overdose deaths among Black and Indigenous communities are growing faster than among White individuals across the United States. A recent study showed a 40 percent increase in the opioid overdose death rate for Black individuals relative to non-Hispanic White individuals.³ Indigenous Americans have experienced a five-fold increase in opioid overdose fatalities over the past two decades.⁴ Communities are encouraged to tailor interventions with cultural humility to address racial

and ethnic inequities when implementing evidence-based practices and policies.

ORCCA delineates three approaches to identifying populations with higher risk of overdose:

1. Identifying individuals in criminal legal settings and venues where people who use drugs seek services
2. Employing field-based outreach, including point-of-contact for emergency response
3. Using data sources to locate individuals who likely need intervention

“Providing services to people at the greatest risk for overdose, for example those with a prior overdose or reduced opioid tolerance, is the best investment for communities seeking to reduce overdose deaths. These individuals can most efficiently be engaged by providing interventions at venues where high-risk populations are likely to be encountered, for example emergency departments and jails. Engagement in medication for opioid use disorder, particularly buprenorphine or methadone, and the provision of naloxone to these individuals and their loved ones should be a priority.”

T. John Winhusen, PhD,
Professor,

University of Cincinnati College of Medicine

Prioritize delivery of services to those who need them most in criminal legal settings and other venues

Communities can implement programs in venues that frequently come into contact with individuals with OUD. The staff of embedded programs can help identify individuals and connect them to services. Example venues include:

- Criminal legal settings
- Syringe service programs
- Healthcare facilities
- First responder stations (e.g., police and fire stations)
- Addiction treatment and recovery facilities
- Mental/behavioral health treatment facilities
- Community-based social service agencies

1

Implement field-based population detection methods

Field-based initiatives involve real-time community outreach to individuals within existing programs and systems, including:

- Point of contact during 911 calls
- Peer/social networks and families
- Community outreach initiatives and events
- Mobile medical services vans
- Drug checking
- Media outlets
- Local businesses/chambers of commerce
- Barbershops and hair salons
- Elected officials
- Libraries
- Colleges, universities, and trade schools
- Religious organizations and houses of worship

2





Use data sources to target intervention to those who need services

Rapid and proactive use of existing data can help identify populations at higher risk of overdose and detect hot spots for opioid overdose. Communities can create new records systems or population detection programs using existing records systems. Useful data include:

- Non-fatal overdose records from 911 calls and emergency medical personnel
- Emergency department encounters
- Records of frequently-accessed service systems, hotlines, or other health services
- Substance use disorder/mental health treatment center records
- Records of individuals encountering law enforcement
- Data from fatality review boards

3

Engage individuals with lived experience in the decision-making process

Individuals with lived experience are considered experts within their diagnosis or health condition. The phrase “Nothing About Us Without Us” is frequently used to convey the idea that members of the groups who will be impacted by policies should be fully involved. People who have lived experience can play a variety of roles in the SUD community, including serving as advisors in policy, treatment development, and education. Communities can ensure that those with lived experience, and individuals representing identified populations at higher risk of overdose, are included in decision-making processes and activities locally.

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Hamilton County Justice Center: Innovations to Address Substance Use Disorders for Justice-Involved Populations

The growing rates of substance use and overdose deaths, especially related to opioids, have significantly impacted the U.S. justice system. Almost half of all individuals under correctional supervision meet the criteria of having a substance use disorder (SUD),^{1SH} with 17% reporting regular opioid use.^{2SH} A study showed that individuals returning to the community from incarceration are 129 times more likely to die of a drug overdose compared to the general public, making justice-involved populations with substance use disorders one of the most at-risk populations to serve.^{3SH} In Hamilton County, Ohio, 76% of the people who overdosed in 2021 had a history of incarceration at the Hamilton County Justice Center (HCJC), the county jail.

Research shows that starting medications for opioid use disorder (MOUD) prior to release and continuing them during reentry reduces the risk of overdose death by 75%.^{4SH} To align with best practices, jail systems have worked to expand the availability of MOUD and wraparound services to improve health and treatment outcomes, reduce overdoses, and prevent recidivism.



PHOTO COURTESY HAMILTON COUNTY SHERIFF'S DEPARTMENT

A MULTIMODAL MODEL

Through the HEALing communities study (HCS), HCJC has expanded multimodal treatment for individuals entering and exiting the jail. The team expedited the development of protocols and procedures to launch the MOUD program with input from the HCS Intervention Design Team, technical experts, and input from other jurisdictions with MOUD programs, including Kenton County, KY jail and Cuyahoga County, OH jail.

“The Sheriff and key leadership across the county came together to provide the best evidence-based interventions to one of our most at-risk populations — incarcerated individuals with substance use disorders.”

Tina Ernst,
Intervention Facilitator,
HEALing Communities

SPOTLIGHT

Hamilton County Justice Center: Innovations to Address Substance Use Disorders for Justice-Involved Populations

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The HCJC model includes induction of MOUD for individuals with an opioid use disorder (OUD) and utilization of peer recovery coaches, and peer-mentors to assist individuals upon release. The key community partners in operationalizing the MOUD programs were Sheriff Charmaine McGuffey, NaphCare, Talbert House, Hamilton County Mental Health & Recovery Services Board, and the Addiction Services Board. “In thinking about what we were able to do together in Hamilton County, it’s a lot like meeting an individual with addiction issues where they are,” explained Tina Ernst, an intervention facilitator for HEALing Communities. “We had to meet the system where it was at the time.”

ACCESS TO MEDICATIONS

Using a chronic-care approach, HCJC’s MOUD program provides incarcerated individuals with OUD with an opportunity to begin MOUD treatment during their incarceration or to continue their medications

if previously inducted in the community. When an individual enters the HCJC, they are screened for treatment eligibility and substance use. The program offers buprenorphine, a medication to treat OUD that reduces cravings and withdrawal symptoms. In addition, the University Hospital will provide methadone to pregnant women when appropriate. Participants also receive addiction education, counseling and peer support.

Staff in the MOUD program are comprised of members of the internal addiction response team, a MOUD nurse, the Sheriff’s Command Staff, an Addiction Services Coordinator, pretrial service staff, and a peer mentor. If a client expresses interest in MOUD treatment, the Addiction Services Coordinator, a Licensed Chemical Dependency Counselor, conducts an assessment and, if eligible, sends the referral to the NaphCare and Community Medical Services staff, the independent health-care

PHOTO COURTESY LIZ DUFOUR/THE ENQUIRER



Hamilton County Justice Center: Innovations to Address Substance Use Disorders for Justice-Involved Populations

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provider at the HCJC who administer and monitor medications. Providers start the patients' treatment within 48 hours of receiving the referral.

The program has expanded and hired a full-time registered nurse to oversee the medication administration and the program is now able to screen an additional 600 clients and induct an additional 138 clients per year.

PEER MENTORS AND REENTRY SERVICES

When it is time for participants to be released, HCJC pairs them with peer mentors who help with connections to community treatment providers, transportation, and support. The mentors arrive as early as 4 a.m. to drive participants to their first appointments and provide support to the individuals returning throughout their transition back into the community.

HCJC has built relationships with over 40 treatment agencies providing individualized care in the community, including intensive outpatient programs, outpatient MOUD, residential treatment programs, and recovery housing programs. HCJC staff and peer mentors directly link participants to the appropriate community provider to ensure continuity of care.

Peer mentors have been key to the program's success. "The peer navigator serves a dual purpose for peer support and case management and linkage to community care. We realized that our peers are extremely knowledgeable in the community treatment provider availability and recovery housing availability and get people into those programs. We permitted our peers to drive the people to their first appointment because we lose people once they walk out of the door. Too often they don't make it to their appointment," shared Lisa Mertz, CEO of the Addiction Services Council in Cincinnati.

OUTCOMES AND NEXT STEPS

The Hamilton County program is evidence that by embedding treatment and recovery options into criminal legal settings, communities can effectively target their programming to high-risk individuals as they pass through the system. Hamilton County reported a 16% reduction in overdose deaths in 2022, the first decrease in overdose deaths in four years.^{55H} "The Hamilton County Justice Center's comprehensive treatment program equates to expedited treatment, longer sustained recovery, and reduced recidivism rates," shared Sheriff Charmaine McGuffey. "The program is generating long-term cost savings for the county, safer communities, and improved outcomes for those struggling with substance use disorders."

"The Hamilton County Justice Center's comprehensive treatment program equates to expedited treatment, longer sustained recovery, and reduced recidivism rates. The program is generating long-term cost savings for the county, safer communities, and improved outcomes for those struggling with substance use disorders."

Sheriff Charmaine McGuffey,
Hamilton County Sheriff's Office

SPOTLIGHT

Opioid Overdose Prevention Education and Naloxone Distribution (OEND)

Naloxone administration reverses an opioid overdose if administered in time. Overdose education and naloxone distribution (OEND) includes education about overdose risk factors and how to recognize and respond to an overdose, as well as how to administer naloxone, as well as providing naloxone or full rescue kits. OEND can be successfully implemented at multiple venues for diverse populations. The education component empowers trainees to respond to overdoses. Community-level implementation of OEND has been associated with reduced opioid overdose mortality. The best evidence for reducing overdose through OEND has been seen in communities that proactively make OEND accessible.⁵

The best evidence for reducing overdose through OEND has been seen in communities that proactively make OEND accessible.

“In the battle against the overdose death crisis, overdose education and naloxone distribution (OEND) isn’t just a choice; it’s a necessity. It’s the bridge that connects every community and every family to the power to save lives. Naloxone can give people who use opioids the chance to live and potentially connect to recovery services when they are ready. Our HCS communities worked with New York’s already strong existing statewide naloxone distribution infrastructure to find ways to reach community saturation, battle stigma, and get naloxone in the hands of vulnerable populations and their social networks.”

Nabila El-Bassel, PhD,
Professor, Columbia University



PHOTO COURTESY HAMILTON COUNTY, OH QUICK RESPONSE TEAM

Communities can implement OEND at multiple venues for diverse populations. Several OEND interventions increase naloxone dose distribution, completed rescues, and opioid overdose prevention education. Key evidence-based practices for overdose education and naloxone distribution include:

Implement active OEND for people who use opioids and their social networks

Proactive OEND and distributing naloxone rescue kits to people who use opioids and their social networks reduces overdose fatalities.⁶⁻⁹ Active OEND programs can target specific populations or venues where people at higher risk for overdose are likely to be. Such populations include people released from incarceration¹⁰ and people with chronic pain who are treated with chronic opioid therapy through community health centers.¹¹

5

Implement active OEND at venues where overdoses are more likely to occur

Active OEND at high-risk venues has been shown in numerous studies to reduce overdose fatalities, from syringe service program workers providing OEND to people who inject opioids,¹² emergency department staff providing OEND to patients seen for opioid-use complications,¹³ to jail and prison staff equipping people released from incarceration with naloxone.¹⁴

6

Passive OEND strategies

Passive OEND denotes education and naloxone rescue kit distribution to individuals referred by other care providers or who have sought out OEND on their own. For example, a patient can access over-the-counter naloxone at a local pharmacy, or a provider could write a prescription for naloxone that their patient fills at a pharmacy or community OEND program. There are also 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—places where overdoses commonly occur, such as public restrooms and addiction treatment programs.

7

Build OEND capacity among first responders

OEND programs can increase overdose response training for first responders such as police officers, fire fighters, and emergency medical technicians, and equip them with naloxone rescue kits.

8

New York Peer Engaged Overdose Education and Naloxone Distribution (OEND)

Peer distribution for naloxone and education on its use enhances partnerships between medical researchers, law enforcement, public health leadership, and activist groups in order to achieve the shared goal of reducing fatal overdose. Research on goals of naloxone saturation has galvanized interest in designing strategies with people with past or current experience with drug use that effectively target distribution efforts to ensure kits are in the hands of those most likely to observe an overdose and who can share needed messages of hope and health to those in need.

This can be accomplished by integrating people who use or have used drugs along a continuum of recovery, with or without professional certifications, into public health approaches. This policy approach potentially provides new avenues for participation, solidarity, and citizenship.^{1SN} “Peer distribution of naloxone is most effective at getting the lifesaving

resource to those most likely to witness or experience an overdose through trusted relationships and direct knowledge of their community,” shared Dr. Timothy Hunt, Research Scientist at Columbia University School of Social Work. “Getting naloxone to those most likely to see or experience an overdose is critical. Those with direct experience who are trusted in communities are most effective for overdose messaging and naloxone distribution, needed to stem the epidemic... getting naloxone to the right place at the right time.”

Currently, over 1,000 registered programs exist in New York State (NYS) offering training and provision of naloxone directly and at no cost to persons they have trained. Trained responders include individuals who are at risk for an overdose, their family and friends or partners, individuals working for agencies providing services to those at risk for an overdose, and others in the community who may be positioned to intervene in an overdose, including first responders.^{2SN}

Through the HEALing Communities Study, peer-led organizations have expanded services to champion low threshold, 24/7 engagement of people in need of support and access to harm reduction and pathways to recovery based on a client-centered and mutual aid approach.



PHOTO COURTESY MONROE COUNTY IMPACT TEAM



SPOTLIGHT

New York Peer Engaged Overdose Education and Naloxone Distribution (OEND) (continued from previous page)

Common across peer-led strategies is personal commitment to saving lives, a non-judgmental approach, flexibility to adapt to the multiple needs of those they serve, and availability to intervene day and night. Support for those with lived experience through appropriate salaries, and needed supervision and resources are core elements of an effective peer-driven approach to overdose prevention. One example of a peer bill of rights was developed by the Peer Network of NY and can be utilized as a guide when designing programs and partnerships.^{3SN}

Engaging communities and prioritizing people with lived experience and highly impacted by overdose is foundational to getting to solutions efficiently and to building trust to support implementation and sustainability for selected strategies for OEND.^{4SN}

Successful peer-led OEND programs statewide include:

MONROE COUNTY, NY IMPACT TEAM MODEL

In 2020, the Monroe County Department of Public Health, with the support of the County Executive, established Monroe County's first Addiction Services Division, known community-wide as the Monroe County Improving Addiction Coordination Team (IMPACT). Monroe County IMPACT comprises 22 Outreach and Public Health professionals who provide numerous services, including: Narcan distribution; training and education; support and connection to treatment and resources for individuals who have experienced an overdose or who use substances; street-level, data-driven outreach to the community; naloxone box maintenance and supply; 24/7 hotline support and community engagement. "When an overdose happens in Monroe County, we respond. One of our IMPACT team members is there within 48 hours, offering compassion, support, resources and guidance to overdose survivors and their loved ones," states Dr. Tisha Smith, Director of Addiction Services.

Present in photo, Front Row: Kim Niles, Dr. Tisha Smith, Michelle Walker, Andrew Bynoe; Middle Row: Rhiannon Rossi, Kelly Robinson, LaToya Manhertz, Shawanda Green, Deanna Appleton, Jessica O'Connor, Malik Smith, Wendy Tisdale, Alex Benitez; Back Row: Kyle Englert, Joshua Devine, Curtis Childs, Patrick Meagher



PHOTO COURTESY MONROE COUNTY IMPACT TEAM

New York Peer Engaged Overdose Education and Naloxone Distribution (OEND) (continued from previous page)



Front row, left to right: Jaclyn Grey, Chino Garcia; Back row, left to right: Pablo Angelus Ulloa, Christopher Abert, Michael Motchnik
PHOTO COURTESY NYRA

NY RECOVERY ALLIANCE (NYRA), ROCHESTER, NY

Monroe County Department of Public Health and the HEALing Communities Monroe County Coalition partnered with NY Recovery Alliance to distribute naloxone to unhoused individuals and do community outreach in parks. Each week — rain, snow, or shine, and without shame or judgment — a dedicated team of outreach volunteers both onsite, and in the community, assist anyone facing substance use disorder, mental illness, and/or homelessness. In addition to providing health and recovery resources, basic needs, and nourishment, NYRA deploys a cleanup team to safely dispose of used needles in “hot zones,” (public spaces such as parks, parking lots, and playgrounds) and make wellness checks on unhoused neighbors who have sought refuge in vacant lots or abandoned properties. NYRA also has a specialized team that provides certified Narcan training and community education. “One size does not fit all. We aim to help our neighbors locate the type of treatment that they believe will work for them. Seeking treatment can be intimidating and overwhelming, but we can offer perspective from our own personal experience, and assist with any barriers they may encounter along the way” shared Chris Abert, Executive Director, NYRA.

SAMADHI RECOVERY CENTER, ULSTER COUNTY, NY

Samadhi is a recovery center founded in 2018 to end the suffering associated with addiction and help individuals overcome obstacles to recovery through compassionate, person-centered care and treatment. Their community-based Outreach Center provides individuals and families services such as peer-led addiction and recovery support groups for both the individual and the family. They offer life skills training, overdose education and naloxone distribution, collaboration with community resources, trauma-informed care (EMDR and Somatic Experiencing), fitness, health, mindfulness based and wellness activities, and community service opportunities. Executive Director David McNamara shared: “The compassion and dedication of those with lived experience in the healing of those in active addiction is an amazing thing to experience.” Additionally, to address housing insecurity the Samadhi Refuge Program’s central mission is to provide safe, secure, emergency housing and supports to adults struggling with Substance Use Disorder (SUD) who lack suitable housing. While providing emergency housing, they work to find each person safe alternative housing or permanent housing elsewhere, as well as provide each resident with appropriate supports in their recovery.



PHOTO COURTESY SAMADHI

SPOTLIGHT

New York Peer Engaged Overdose Education and Naloxone Distribution (OEND) (continued from previous page)

NICK'S RIDE 4 FRIENDS, CAYUGA COUNTY, NY

Founded in 2016 in honor of Nick Campagnola, who lost his fight with addiction at just 20 years of age, Nick's Ride 4 Friends is a local, grassroots, 501(c)(3) not-for-profit organization whose mission is *Empowering individuals towards recovery, through sharing lived experience and promoting community connections*. Nick's Ride 4 Friends relies upon a peer support model that is client-centered, trauma-informed, and non-judgmental. The organization promotes the importance of developing authentic relationships in combination with embedding harm reduction strategies into all areas of prevention, treatment, and recovery services to engage with people who use drugs. Additionally, the organization advocates for social justice and health equity by promoting education, raising awareness, and celebrating recovery.

Nick's Ride 4 Friends Inc. offers free, peer-based, non-clinical recovery support services. Certified peers leverage their unique personal experiences to engage, connect, and establish trusting rapport with people who use drugs and those already in recovery, supporting all on their personal wellness journeys. Peer services include: one-on-one peer support, transportation services, same-day linkages to treatment, including linkages to medications for opioid use disorder (MOUD), assistance navigating community resources and treatment services,

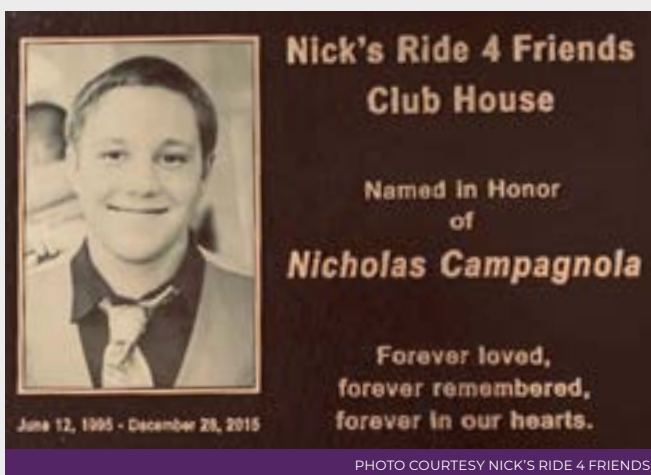
advocacy for individuals who are court-involved or currently incarcerated, empowerment and recovery coaching. Peers work out of the organization's headquarters, located at 13 Chapel Street in Auburn, New York, in a community-based setting and conduct street outreach. The organization runs both a drop-in center on the first floor and a recovery clubhouse on the third floor, a safe haven where individuals and friends gather for fellowship in the fight to recover from addiction. Sandwiched between their two floors is the home to the first and sole Opioid Treatment Program (OTP) in Cayuga County, expanding access to MOUD.

EXPANDING PEER-LED OEND

Integrating people who use drugs or those with substance use disorders along a continuum of recovery, with or without professional certifications, into public health approaches potentially provides new avenues for participation, solidarity, and citizenship.^{15N}

Addressing barriers to the expansion of these programs can include:

- Improving protections for responders to an overdose through Good Samaritan Laws to reduce fears that may inhibit naloxone administrations and calling 911 after overdose.
- Addressing reimbursement and grant funding for the provision of outreach, navigation, peer recovery coaching, or case management. Staff and volunteers in peer-led organizations have a range of lived and living experience and professional certifications, and agencies can expand positions with adequate funding and reimbursement for diverse roles and positions.
- Enhancing volunteer opportunities for people with substance use disorder or who use drugs to build support and self-efficacy and promote their own personal growth while contributing to the care of their communities and networks.



SPOTLIGHT

Enhance Delivery of Medications to Treat Opioid Use Disorder

Improved access to evidence-based MOUD treatment can significantly reduce the risk of overdose death.¹⁵ MOUD helps stabilize brain chemistry, reduce or block the euphoric effects of opioids, and relieve cravings. Available MOUDs include methadone (a full opioid agonist), buprenorphine in several formulations (a partial opioid agonist), and extended-release naltrexone (an opioid antagonist). Experts recommend expanding access to full and partial agonist therapies based on the strong evidence of decreased mortality rates for methadone and buprenorphine patients. Antagonist therapies have less evidence for reducing opioid-involved overdose,¹⁶ although clinical trials suggest extended-release injection naltrexone can be effective for relapse prevention if adherence is secured.¹⁷

“Medication for opioid use disorder is our most important tool for reducing overdose. MOUD helps people gain control over their lives, engages them in treatment, and reduces harmful substance use. We need to rise to the challenge of making MOUD more accessible so more people with opioid use disorder are able to start and continue on MOUD.”

Jeffery Samet, MD, MA, MPH,
Professor, Boston University



Key evidence-based practices to enhance the delivery of MOUD include:

Expand MOUD capacity in healthcare and criminal legal settings, and through telemedicine

There is overwhelming evidence that MOUD reduces overdose fatalities and improves patient outcomes. In a national study of 40,885 individuals with OUD who were treated with buprenorphine or methadone, MOUD was associated with a 76 percent reduction in overdoses at three months and a 59 percent reduction in overdoses at 12 months.¹⁸ Despite the evidence, medications are still underutilized in most communities. Common barriers to MOUD access include inadequate treatment availability, failure to identify and engage high-risk populations in MOUD, and poor treatment retention.¹⁹

Healthcare settings

MOUD expansion in healthcare can include integration into various settings from primary care, emergency medicine, other general medical and behavioral/mental health settings, and in specialty addiction or substance use disorder (SUD) treatment settings and recovery programs. Expansion increases capacity and reduces treatment barriers for patients. Historically, addiction treatment has been isolated from general medical and mental healthcare settings in the U.S., and MOUD treatment has been omitted from the care provided in primary care, hospitals,²⁰ emergency departments,²¹ general mental health, and many SUD treatment programs.²²

Criminal legal settings

Improving the availability of MOUD in criminal legal settings, including the pre-trial period, jail, prison, probation, and parole, is a critical opportunity to reduce opioid-involved overdose deaths. Research shows that providing medications for addiction treatment prior to and during reentry cuts the risk of death by 75 percent.²³ In Rhode Island, the Department of Corrections implemented a program to provide FDA-approved MOUD (methadone, buprenorphine, or naltrexone) during and after incarceration. They saw a decrease in overdose fatalities by nearly 61 percent, despite the availability of fentanyl.²⁴

Telemedicine, interim buprenorphine or methadone, and medication units

Evidence-based practices to reduce overdose fatalities in people 18 and older include:

- Telemedicine models for buprenorphine treatment were expanded during the COVID-19 pandemic to allow greater flexibility of MOUD treatment. Telemedicine is an important tool to support treatment access.
- Interim treatment with methadone or buprenorphine refers to medication dispensed directly to patients without a prescription at licensed opioid treatment programs, which are heavily regulated at a federal and state level and require comprehensive ancillary services (e.g., on-site counseling). When programs have waiting lists, they may receive regulatory approval to provide medication for up to 180 days while patients await the full array of non-medication services. This interim treatment is superior to waiting lists for multiple outcomes including illicit opioid use and treatment retention.²⁵
- A medication unit is a satellite to a licensed opioid treatment program that primarily provides medication dispensing to make treatment more accessible to patients.²⁶ Medication dispensation must be supervised for the first 90 days of treatment, which makes transportation a barrier to treatment if the program is located far from the patient. Medication units offer a way to extend the availability of methadone treatment over a wider geographic region.



On-site MOUD initiation in community-based settings

On-site MOUD initiation strategies can occur across multiple community-based settings including emergency departments and hospitals, where patients may present with complications of untreated OUD, such as an opioid overdose or infection related to intravenous opioid injection. Starting MOUD in these venues is safe, feasible, and can significantly increase a person's likelihood of continuing MOUD treatment.²⁷

10

Create linkage programs and protocols

Along with starting MOUD at the venue where the patient is, it is important to link patients to longer-term MOUD treatment and care. Begin by identifying quick-start medication settings that don't currently link individuals to ongoing MOUD treatment. Creating a linkage implementation protocol includes establishing evaluation measures and procedures, and training staff on quick-start medication and the protocol itself.

11

Enhance MOUD engagement and retention

MOUD retention for individuals with OUD beyond six months is challenging,²⁸ but critical to saving lives. Research is clear that MOUD treatment retention is strongly associated with decreased mortality from overdose and other causes, with risk of overdose increasing dramatically after discontinuation of MOUD.²⁹ Comprehensive strategies to improve retention in MOUD treatment include addressing each individual's treatment needs, which may also involve treatment for comorbid mental health and non-opioid substance use disorders. Examples of strategies that can improve engagement and retention in treatment include:

- Shared decision-making
- Active case management
- Legal assistance and advocacy
- On-site psychiatric services and psychosocial recovery support
- Insurance navigation
- Behavioral interventions such as contingency management for comorbid non-opioid SUDs³⁰
- Technology-delivered therapies³¹

The ORCCA identifies four evidence-based strategies to improve treatment retention: 1) enhancement of clinical delivery approaches to support engagement and retention; 2) use of virtual retention approaches; 3) retention care coordinators; and 4) mental health and polysubstance use treatment integrated into MOUD care.

12

Massachusetts Bridge Clinics

Effective treatments for substance use disorder (SUD) can substantially improve patient outcomes. First-line medications like buprenorphine and methadone can decrease opioid fatality rates, infectious disease transmission, and other adverse health consequences,^{1SM} yet barriers to accessing these medications persist, from insufficient program capacity, long wait times, to inadequate support during high-risk transitions, such as emergency department discharge and release from prison and jail.

These challenges have spurred interest in the creation of new, low-barrier models to streamline the induction of medications to treat opioid use disorder (OUD) induction and SUD care delivery, such as bridge clinics.

BRIDGE CLINIC MODEL

Usually based in emergency departments or outpatient settings, bridge clinics provide rapid initiation of medications for OUD (MOUD), stabilization during high-risk transitions, harm reduction services, and linkage to long-term treatment providers.^{2SM} Patients seeking medication to treat OUD—specifically buprenorphine or methadone, which can be difficult to access in the



PHOTO COURTESY BOSTON UNIVERSITY SCHOOL OF MEDICINE

“Bridge clinics reduce the barriers to starting medication for substance use disorders by offering evidence-based treatment on demand. They work by making the treatment work for the patients, instead of making the patients work for the treatment.”

Dr. Alex Walley,
Professor,
Boston University School of Medicine

outpatient setting—and other SUDs can schedule same-day and next-day appointments through a bridge clinic, which increases utilization and retention compared to treatment programs that require scheduling further out. “Bridge clinics reduce the barriers to starting medication for substance use disorders by offering evidence-based treatment on demand,” shared Dr. Alex Walley, Professor at Boston University School of Medicine shared. “They work by making the treatment work for the patients, instead of making the patients work for the treatment.”

MASSACHUSETTS

SPOTLIGHT

Massachusetts Bridge Clinics

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Staff in bridge clinics typically comprise interdisciplinary teams that may include addiction medicine physicians, psychiatrists, nurse practitioners, nurse care managers, social workers, psychologists, case managers, patient navigators, peer recovery coaches, or pharmacists. Some bridge clinics also offer integrated behavioral health services or collaborative referrals to other long-term care settings. Karen Haessler, a PA-C, explained, “As a provider for an inpatient Addiction Consult Service, my relationship with the local Bridge Clinic is invaluable. It allows me to treat the whole person and start them on the lifesaving medications of Methadone or Suboxone while they are in a safe place and open to recovery. Knowing they will get good care and their medications will not be interrupted while they are waiting for an appointment at a standard Office-Based Addiction Treatment program or other addiction medicine provider allows me to treat the patient’s addiction immediately and not just treat their withdrawal and hope they can find a place for treatment after discharge.”

Research shows patient preference and endorsement for the bridge clinic model, citing the welcoming clinical environments, flexibility to be seen without an appointment, utilization of harm reduction principles, access to knowledgeable providers who approach addiction care with compassion, and linkage to ongoing care, including peer recovery coaches.^{3SM}

In addition to MOUD, bridge clinics generally offer pharmacotherapy for other types of SUD, such as naltrexone and acamprosate for alcohol use disorder. Some bridge clinics incorporate human immunodeficiency virus (HIV), viral hepatitis, and sexually transmitted infection (STI) screening, treatment, and prevention services like HIV pre-and post-exposure prophylaxis (PrEP, PEP).^{2SM}

When patients are ready, they can be linked to other long-term programs, like office-based addiction programs in primary care clinics.

In order to make treatment truly accessible, bridge clinics often collaborate with other providers and

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Massachusetts Bridge Clinics

(continued from previous page)

services, such as housing programs, residential addiction treatment, and pharmacies, to reduce barriers. Dr. Walley explained, “If a medication isn’t easily accessible through the pharmacy because a patient doesn’t have an ID, then the bridge clinic team will work to resolve this, by clarifying the regulations around ID requirements and their exceptions, finding a pharmacy willing to work with their patients, making a relationship with that pharmacy, and having an ongoing relationship with them. Further, they will work with the patient to obtain the ID to reduce future barriers.”

BRIDGE CLINIC MODELS EXPAND THROUGHOUT MASSACHUSETTS

In Massachusetts, the Bridge Clinic at Boston Medical Center (BMC) is an inspiring example of the difference that compassionate, patient-centered continuity of care can make for those with OUD. Through the New York HEALing Communities Study, the BMC bridge clinic model was expanded statewide, creating a low-barrier treatment-on-demand access point for individuals with opioid use disorder in a variety of general medical settings.



PHOTO COURTESY BOSTON UNIVERSITY SCHOOL OF MEDICINE

“[My] relationship with the local Bridge Clinic is invaluable. It allows me to treat the whole person and start them on the lifesaving medications of methadone or Suboxone while they are in a safe place and open to recovery.”

Karen Haessler, PA-C
Physician Assistant - Addiction,
High Risk Intervention Team at
Beth Israel Lahey Health

MA communities in both Wave 1 and Wave 2 have chosen to develop bridge clinics through HEALing Communities, establishing an innovative treatment-on-demand statewide framework that utilizes evidence-based treatment options.

Dr. Jessica Taylor, Assistant Professor at Boston University School of Medicine, explained, “Bridge clinics fill a key gap for patients who need to start addiction treatment or address other addiction-related needs urgently. In the era of fentanyl, which is driving unprecedented rates of opioid overdose death in Massachusetts, OUD treatment needs to be available on demand, as soon as someone is ready to start it, and bridge clinics are designed to deliver on rapid access to medications. Bridge clinics also support those who might otherwise fall through the cracks of a fractured system during transitions of care. They make the entire continuum of care work better for people with SUD.”

SPOTLIGHT

Massachusetts Bridge Clinics

(continued from previous page)

New bridge clinics launched in many different medical settings:

- In Lowell, Massachusetts, a city of 115,000 in northeastern Massachusetts, Lowell General Hospital started a Bridge Clinic, convenient to their Emergency Department, to help patients get started onto medications for opioid use disorder right away. Patients might come in after being referred by their primary care provider, be walked over by homeless encampments by outreach workers, or walk over from the Emergency Department in order to connect to the Bridge team. The staff there engaged in innovative clinical work, such as using microdosing protocols to transition patients from active fentanyl use to buprenorphine, but also excelled at expressing compassion, offering food, clothes, and a warm, dry place for often stigmatized individuals trying to engage in addiction care.
- In nearby Lawrence, Massachusetts, the Greater Lawrence Family Health Center and the Lawrence

Comprehensive Treatment Center (the methadone clinic in town) have partnered to create a bridge program on a mobile health unit. A buprenorphine prescriber sits on the mobile unit along with a clinician from the methadone program who can complete an intake form and walk a patient over to the methadone program to receive their first dose on that same day. This mobile unit-based bridge program has already started enrolling patients, and staff from both programs are enthusiastic about early successes.

- In Gloucester, Massachusetts, the Addison Gilbert Hospital team with Beth Israel Lahey Health developed a bridge clinic to provide immediate outpatient follow-up to patients who started buprenorphine in their emergency department and received an ED buprenorphine take-home kit. The bridge clinic also collaborates closely with a patient navigator based at the Gloucester Family Health Center and with outreach teams from One Stop, a harm reduction program, to provide rapid access to medication for other patients.
- In Salem, Massachusetts, Salem Hospital created an outpatient bridge clinic that collaborated closely with their expanded inpatient Addiction Consult Service, offering interim visits for patients started on buprenorphine during their hospitalization who could not see a long-term outpatient buprenorphine provider right away after discharge. These services supported the growth of inpatient addiction care delivery, giving clinical teams the confidence to start medication knowing that patients would be able to continue it after discharge even if they encountered challenges seeing a long-term outpatient prescriber right away.

Bridge clinics are increasingly recognized as integral components of the care continuum for people with SUD.

“In the era of fentanyl, which is driving unprecedented rates of opioid overdose death in Massachusetts, OUD treatment needs to be available on demand, as soon as someone is ready to start it, and bridge clinics are designed to deliver on rapid access to medications.”

Dr. Jessica Taylor,
Assistant Professor,
Boston University School of Medicine

SPOTLIGHT

Remove Barriers to Critical Resources

Addressing the availability of external resources a person with an OUD can access in support of their recovery process can improve outcomes and enhance treatment retention.³² Comprehensive strategies

include reducing barriers to critical needs, such as housing, transportation, insurance coverage, food security, childcare, employment, and psychosocial and community services.

“Individuals suffering from opioid use disorder often face myriad barriers both to entering treatment and to remain in treatment once they’ve started receiving care. One of the most common barriers is the lack of reliable transportation — needed both to attend treatment but also to be able to get to their job so they can keep their health insurance and/or earn money to pay for treatment. Other common barriers include the lack of a valid ID (sometimes required for prescriptions), court fines, past utility bills that prevent new service, unstable housing and lack of child care. Through provision of support to remove these barriers to care, including innovative transportation programs, more individuals may be able to access and stay in treatment improving overall outcomes and recovery.”

Sharon Walsh, PhD,
Professor,
University of Kentucky College of Medicine



Expand peer recovery support and peer services

Peer support involves an individual with lived experience providing non-clinical assistance and practical guidance to support long-term recovery from substance use disorders. Peers provide a range of supports and can be integrated into care teams across numerous settings for long-term recovery management. Emerging research shows that peer support is effective in supporting recovery from substance use disorders. Peer community support programs have been shown to reduce relapse rates and improve access to social support.³³ Barriers to the expansion of peer professionals in the care continuum include stigma; lack of resources and compensation; and inadequate training. Communities can address these barriers and expand peer placement in recovery community centers, recovery residences, criminal legal settings, emergency departments, child welfare agencies, homeless shelters, public health departments, specialty treatment, MOUD treatment programs, and primary care settings.

13

Remove barriers to housing services

A person's ability to recover from SUDs depends heavily on having stable housing. Homelessness, unstable housing, and associated stress can trigger the recurrence of use and relapse. Communities should determine what new capacity can be developed for housing people receiving MOUD.

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Expand transportation initiatives for patients with OUD

Research indicates that shorter travel distances and access to transportation are associated with better retention in SUD treatment.³⁴ Travel presents a specific barrier for rural clients who may live a significant distance from treatment and care facilities and have few, if any, public transportation options. Providing transportation to patients receiving medication for OUD can increase retention in treatment. Communities can implement transportation services to help clients, such as forming partnerships with ride services or dedicated transportation services with peers or recovery coaches.

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Address barriers to and capacity for needed resources, including insurance coverage, food security, childcare, and employment

Social determinants of health such as unemployment, housing instability, food insecurity, and lack of healthcare significantly impact OUD treatment outcomes. Recommended steps to address gaps in these services include determining existing capacity, planning for expansion of services to meet needs, training MOUD providers on how to access existing and new community benefits, and implementing the integration of these community benefits into existing MOUD programs.

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Remove barriers to supplemental behavioral health services

SUDs and other mental health disorders are frequently co-occurring, which can result in worse treatment outcomes, higher mortality rates, higher treatment costs, and increased risk for homelessness and incarceration. Multiple SUDs are also prevalent in the U.S. Many MOUD and other treatment facilities may have limited capacity to provide the psychosocial services that can be successful in addressing co-occurring disorders and other SUDs in addition to OUD. Communities can work to integrate mental health and polysubstance use treatment into MOUD care,³⁵ provide on-site psychiatric services and psychosocial recovery support, and expand behavioral interventions such as contingency management for comorbid non-opioid SUDs.

17

Kentucky Transportation Program Opens the Road to Treatment

Even the best opioid use disorder (OUD) treatment programs can't succeed if people can't get to them. Limited public transportation systems, nonexistent ride share and weekend service, and routes that don't extend beyond city limits into rural areas can create significant barriers to treatment access and stable recovery. Even people who have cars often can't afford the fuel needed to reach distant appointments daily.



PHOTO COURTESY VOICES OF HOPE

"When someone lives in a place without a bus line, who doesn't have a car, where there's no Uber or Lyft, and you have to go every single day — it can seem almost impossible" reflected Amanda Falli-Bennett, HCS Community Engagement faculty and co-founder of Voices of Hope, an organization dedicated to helping people stay in recovery. "A lot of people have no idea how hard you have to work to be on methadone because of all the barriers."

Community coalitions in Kentucky identified transportation as one of the biggest barriers to accessing and continuing on medications for OUD (MOUD). While some programs provide transportation to residential or 12-step programs, transportation services did not exist for daily drives

"Participants are just so ecstatic to have these rides every day, and they've been very successful in treatment. Some have become peer support specialists themselves after getting stable in their treatment."

Clinton Underwood,
Transportation Program Coordinator

to access MOUD. In rural counties with no opioid treatment programs, the drive time to access life-saving methadone can be over an hour each way daily. Once a dose is missed and a person suffers withdrawal, retention in the program becomes difficult, and a return to use is likely, which makes accessible and affordable transportation a critical need.

FLEXIBLE OPTIONS SMOOTH THE WAY

The Kentucky HEALing Communities Study (HCS) took on this challenge, creating flexible options and encouraging innovative approaches to address transportation barriers.



SPOTLIGHT

Kentucky Transportation Program Opens the Road to Treatment (continued from previous page)

The Kentucky HCS team provides several transportation assistance options across 16 counties participating in HEALing Communities to help people attend their treatment appointments consistently, prioritizing flexibility and accessibility. Kentucky HCS employs different funding models to meet agencies' varying and specific needs. Similarly, the model allows participants to tailor their transportation service based on their location and available services. This ensures rural patients who face heightened barriers to access MOUD treatment receive transportation services. Several of the participating sites distribute fuel cards to patients to help those with cars pay for gas expenses. Other agencies make available bus passes and vouchers for cabs, and Uber/Lyft rides where those services exist. The state has also supported a new model for transportation assistance that employs peers through recovery support programs and organizations to transport individuals in need of treatment.

“When someone lives in a place without a bus line, who doesn’t have a car, where there’s no Uber or Lyft, and you have to go every single day — it can seem almost impossible

A lot of people have no idea how hard you have to work to get methadone because of all the barriers.”

Amanda Fallin-Bennett,
HCS Community Engagement faculty
and Co-founder of Voices of Hope

PHOTO COURTESY VOICES OF HOPE



SPOTLIGHT

Kentucky Transportation Program Opens the Road to Treatment (continued from previous page)

One of the peer-driver programs in Kentucky is Voices of Hope (VOH), which created a specialty ride share service that employs individuals in recovery to serve as drivers, using their own cars or vans to take people to any kind of recovery-related appointments. “These drivers are up at 3:30 every morning transporting people to and from their appointments,” notes Clinton Underwood, Transportation Program Coordinator. “They are consistent; they always show up.”

As their service grew, the VOH leaders quickly recognized the extent of the need and hired additional drivers. Underwood continues, “Participants are just so ecstatic to have these rides every day, and they’ve been very successful in treatment. Some have become peer support specialists themselves after getting stable in their treatment.” Additionally, patients often shared the benefit of having drivers, who were often recovery coaches with lived experience, as the drivers supplied the patients with added support during the drive to and from the appointments. These coaches shared their personal experiences of recovery and

remission in addition to the transportation support. Also, the recovery coaches sent text reminders about appointments and rides.

As of August 2023, VOH drivers logged over 400,000 miles, supplying nearly 10,000 rides to 239 individuals. “It’s been pretty impactful,” reflects Underwood. In a recent three-month period, the wider HCS transportation team distributed nearly 400 bus passes, more than 2,300 fuel cards, and covered about 70 Uber rides to individuals across the 16 supported Kentucky counties. Plus, in-house service agencies provided 126 individuals with rides through their vehicles.

THE NUMBERS REVEAL CLEAR IMPACT

“The lack of transportation is a primary reason that individuals are not able to remain in treatment with medications for opioid use disorder,” shared Jennifer Miles, the Executive Director for the Kentucky HEALing Communities Study (HCS-KY). “Through our multi-faceted approach we connected over 4,000 patients with transportation services in Kentucky.”

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Jennifer Miles,
Executive Director,
Kentucky HEALing Communities Study

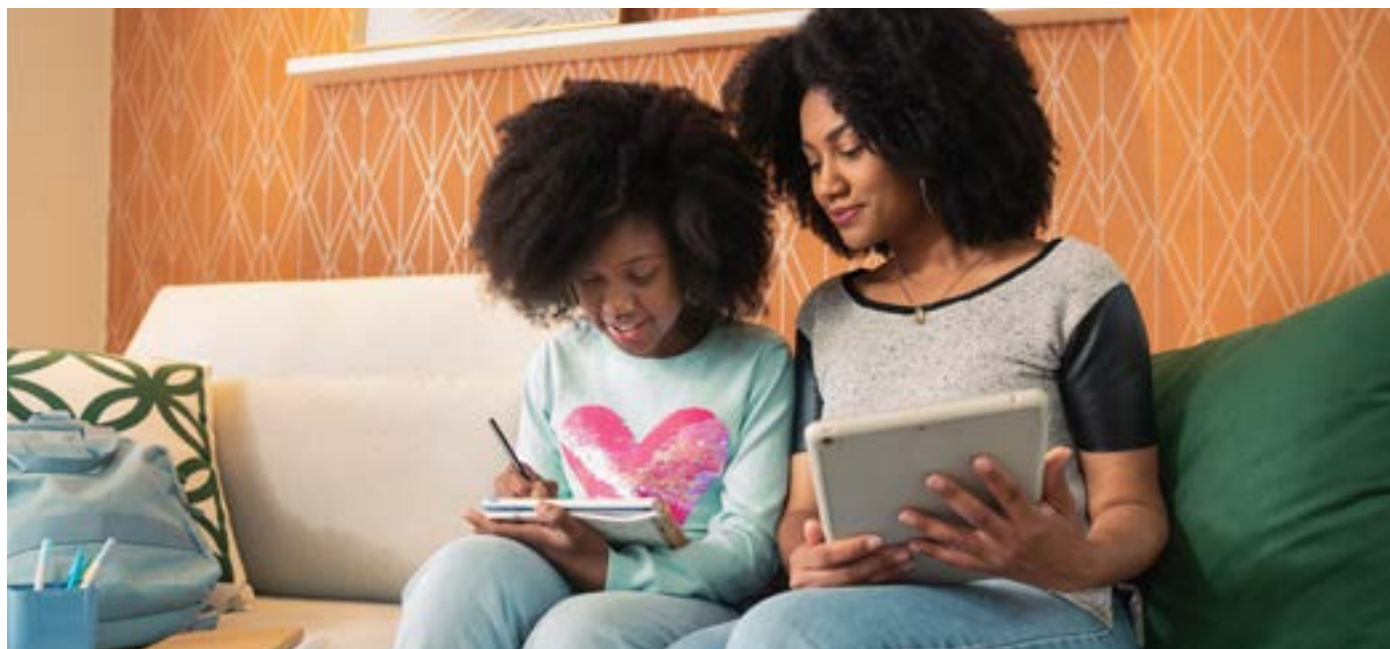
SPOTLIGHT

Safer Opioid Prescribing, Dispensing, and Disposal Practices

A variety of approaches have been effective in promoting safer opioid prescribing. For example, opioid prescribing changes were observed following the implementation of the CDC Clinical Practice Guideline for Prescribing Opioids for Pain in 2022.³⁶ Three strategies that can be implemented by communities include: 1) safer opioid prescribing for acute pain across healthcare settings, such as inpatient services, emergency departments, outpatient clinics, ambulatory surgery, and dental clinics; 2) expanded prescriber education; or 3) disposal initiatives.

“Over 9 million Americans ages 12 and older misused prescription opioids in 2021, according to SAMHSA’s National Survey on Drug Use and Health, and the CDC reports that nearly 17% of all overdose deaths involved a prescription opioid in that same year. This means strategies to promote safer opioid prescribing and ensuring people have access to and know how to safely dispose of unwanted opioids remain important tools in our collective overdose response efforts.”

Yngvild Olsen, MD, MPH,
Director of the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA)





Ensure safer opioid prescribing for acute pain across healthcare settings

Research shows that online and in-person continuing education improves healthcare providers' knowledge about, attitudes toward, confidence in, and use of safer opioid prescribing.³⁷ Academic detailing, an interactive one-on-one educational outreach by a healthcare provider to a prescriber to provide unbiased, evidence-based information to enhance patient care, has been applied successfully to improve opioid prescribing behavior.³⁸

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Implement safe and effective opioid disposal

Providing safe, convenient, and environmentally appropriate ways to dispose unused prescription opioids can reduce excess opioid supply in communities and prevent access by children, adolescents, and other vulnerable individuals. According to a recent study, only 30% of people who received an opioid prescription in the previous two years disposed of their unused opioid medication; however, over 80% indicated they would be more likely to do so in the future if there were disposal kiosks in a location they visited frequently.³⁹ Communities can promote safe disposal practices in a variety of ways, including:

1. Having law-enforcement agencies sponsor drug take-back events
2. Installing permanent drug drop-box kiosks in law-enforcement, pharmacy, and other healthcare locations
3. Promoting at-home disposal practices by providing mail-back envelopes, which are typically sold or provided by participating pharmacies

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Resources

Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) Practice Guide 2023

This [guide](#) from the Substance Abuse and Mental Health Services Administration (SAMHSA) was drawn from HEALing Communities Study (HCS) learnings to-

date and expert insights to provide guidance regarding implementation of ORCCA menu strategies.

Overdose Education and Naloxone Resources

[Harm Reduction Coalition](#): This website includes information on developing and managing overdose prevention and take-home naloxone projects, naloxone kit assembly, training webinars regarding community naloxone distribution, and sample materials.

[SAMHSA: Opioid Overdose Prevention Toolkit](#): This document describes the problem and provides community resource information and strategies to prevent overdose deaths.

[Protect & Prevent](#): This website provides tools for organizations conducting overdose prevention and naloxone advocacy, outreach, and communication campaigns.

A Primer for Implementation of [Overdose Education and Naloxone Distribution in Jails and Prisons](#): This primer outlines strategies for developing, coordinating, monitoring, and evaluating jail- and prison-based programs, and builds on lessons learned from two National Institute on Drug Abuse-funded studies, *Preventing Overdose Mortality among People Exiting Incarceration*, and *Optimizing Overdose Education and Naloxone Distribution Delivery in the United States*.

[Bureau of Justice Assistance Law Enforcement Naloxone Toolkit](#): This online toolkit is searchable by topic, resource type, or contributor. Law enforcement agencies can use it to help them establish or expand naloxone administration and distribution protocols.

[University of Kentucky How to Use Naloxone Training Video](#): These videos in English, Swahili, Spanish, and Arabic teach the general public what to do in case of an opioid-related emergency or overdose, and how to administer naloxone.

[NaloxBox](#): This online resource provides information on naloxone availability for immediate use in overdose hotspots. NaloxBox units are transparent polycarbonate surface-mounted enclosures that provide organizations access to lifesaving naloxone in an easy-to-recognize cabinet placed in a central location in high-traffic or high-risk buildings and organizations.

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.



MOUD Expansion

[National Academies of Science, Engineering, and Medicine — Medications for Opioid Use Disorder Save Lives](#): This 2019 report of findings and conclusions from an expert committee that examined the evidence base for medications to treat OUD and identify barriers that prevent people from accessing safe, effective, medicine-based treatment.

- [Highlights](#)
- [Conclusions](#)

[Protecting Others and Protecting Treatment](#): This four-page pamphlet explains the dangers to children who may be exposed to buprenorphine, including step-by-step guidance in case of exposure and prevention. The national poison control number is on the front of the pamphlet. This pamphlet can be used by community members and healthcare providers.

[Project Shout Webinar on Telemedicine and MOUD Treatment](#): Webinar 7 is approximately one hour and discusses how telemedicine can ease MOUD initiation.

[Telehealth for Opioid Use Disorder — Guidance to Support High-Quality Care](#): This 21-page toolkit focuses on real-time videoconferencing, buprenorphine, and adjunctive psychotherapy treatment. The toolkit is intended for clinicians, administrators, and policy makers.

Remove Barriers to Services

[SAMHSA Homelessness Programs and Resources](#)

- 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.
- Some key resources include specific links to: case management, self-care for providers, housing and shelter, employment, trauma, social inclusion, and youth.

[Ryan White HIV/AIDS Medical Case Management](#)

- Ryan White HIV/AIDS Medical Case Management (MCM) is a core medical patient-centered service that links and engages patients living with HIV/AIDS to healthcare and psychosocial services like substance use and mental health counseling.

[Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders](#): This guide helps healthcare providers, systems, and communities support recovery from SUDs via employment mechanisms. It describes relevant research, examines emerging and best practices, identifies knowledge gaps and implementation challenges, and offers resources.

[Buprenorphine Quick Start Guide](#): This is a six-page checklist for prescribing buprenorphine for OUD.

[Brandeis Opioid Resource Connector](#): The Opioid Resource Connector assists communities in mounting a comprehensive response to the opioid crisis that spans the continuum of care.

[National Sheriff's Association & National Commission on Correctional Healthcare Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field](#): This is a national resource to support jail administrators in providing effective MOUD for persons with OUD. It lists best practices associated with developing, implementing, and sustaining a jail-based medication for addiction treatment / MOUD program.

- MCM provides other services like housing and transportation for patients. It also includes routine assessment of service needs, development and implementation of plan, patient monitoring to evaluate the efficacy of the plan, and periodic reevaluation and adaptation of the plan.
- It boosts the collaborations at state, regional, and individual service delivery levels to identify and eliminate barriers to HIV care and improve access to treatment.

[Substance Use Disorders Recovery with a Focus on Employment](#)

This guide helps healthcare 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.

Safer Prescribing

[CDC Guideline for Prescribing Opioids for Chronic Pain](#). The 2022 edition of the guideline includes 12 recommendations for prescribing opioids for adults with acute, subacute, or chronic pain. It includes recommendations for determining whether to initiate opioids, for selecting opioids and dosages, for deciding treatment duration and conducting follow-up, and for assessing risk and addressing harms of opioid use.

[FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering](#). Advisories Warning against Misapplication of Opioid Prescribing Guidelines.

[Acute Pain Management: Meeting the Challenges: A VA Clinician's Guide](#). 2017 guide was created as a tool for providers at U.S. Department of Veterans Affairs facilities but contains information broadly applicable to prescribing in emergency, urgent care, and primary care settings.

[Guideline for Discharge Opioid Prescriptions after Inpatient General Surgical Procedures](#). 2017 guideline for postoperative patients.

[Opioid-Prescribing Guidelines for Common Surgical Procedures: An Expert Panel Consensus](#). 2018 guideline from the American College of Surgeons: Opioids After Surgery Workgroup.

[Prescribing Opioids for Postoperative Pain – Supplemental Guidance](#). 2018 guidance developed by the Bree Collaborative and Washington State Agency for Medical Directors Group.

[Dental Guideline on Prescribing Opioids for Acute Pain Management](#). 2017 guidance developed by the Bree Collaborative and Washington State Agency for Medical Directors Group.

[The Treatment of Acute Pain in the Emergency Department: A White Paper Position Statement Prepared for the American Academy of Emergency Medicine](#). 2018 guideline provides resources for the safe use of opioids in the ED as well as pharmacological and nonpharmacological alternatives to opioid analgesia.



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