Effective Strategies for Hospitals Responding to the Opioid Crisis
AUTHORS:

Michael Botticelli, MEd: Executive Director, The Grayken Center for Addiction at Boston Medical Center

Maia Gottlieb, MPH: Project Manager, The Grayken Center for Addiction at Boston Medical Center

Mara Laderman, MSPH: Senior Director, Innovation, Institute for Healthcare Improvement

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- Sarah Wakeman, MD, Medical Director, Substance Use Disorders Initiative, Massachusetts General Hospital; Program Director, Addiction Medicine Fellowship, Massachusetts General Hospital; Assistant Professor of Medicine, Harvard University
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The Grayken Center for Addiction at Boston Medical Center (BMC) serves as the umbrella for all of BMC’s work in addiction and is a national resource for advancing addiction treatment and education, replicating best practices, and providing policy, advocacy, and thought leadership to the field. With more than 25 years of experience developing treatment approaches, teaching medical professionals, and researching new care advances, the experts at Boston Medical Center are proving every day that long-term recovery for people with substance use disorders can be a reality. Learn more at www.bmc.org/addiction.
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Executive Summary

Since the emergence of the opioid epidemic in the United States at the beginning of the 21st century, more than 400,000 Americans have died as the result of an opioid overdose. As of 2018, the Substance Abuse and Mental Health Services Administration estimates that more two million people have an opioid use disorder. With the rate of opioid-related inpatient stays and the number of opioid-related emergency department visits continuing to rise dramatically in the US, hospitals have the opportunity to make a major impact in reducing morbidity and mortality related to opioid use.

This document provides system-level strategies that hospitals can implement immediately to address the challenges of preventing, identifying, and treating opioid use disorder. Specific improvement ideas for the strategies are accompanied by case examples describing how some hospitals have approached this work, in addition to supporting source literature and resources.
Introduction

Every day, hospitals experience the effects of opioid and substance use disorders. According to the Agency for Healthcare Research and Quality, in 2016 the rate of opioid-related inpatient stays in US hospitals rose to about 300 per 100,000 population — almost double the rate in 2008.\(^1\) At the same time, the number of opioid-related emergency department visits more than doubled from 2008 to 2017.\(^2\)

In response to the growing volume of inpatient admissions and outpatient visits for individuals with a substance use disorder, hospitals are the primary point of care for many patients in need of comprehensive substance use care. Fortunately, hospitals also have the opportunity to make a major impact in reducing morbidity and mortality related to opioid use, from prevention to screening, to treatment, to engaging with communities to reduce harms. They are also in a position to confront racial and ethnic disparities in care, which is particularly important as the opioid crisis evolves and opioid use patterns and demographics shift.

Five System-Level Strategies

This document provides hospital and health system administrators and leaders with specific improvement ideas for five system-level strategies that address the challenges of preventing, identifying, and treating opioid use disorder.

- Identify and Treat Individuals with Opioid Use Disorder at Key Clinical Touchpoints
- Modify Opioid Prescribing Practices to Minimize Harm and Maximize Benefit
- Train Stakeholders on the Risks of Opioid Use Disorder and How to Reduce Stigma
- Identify and Screen Individuals at High Risk of Developing Opioid Use Disorder
- Reduce the Harms of Substance Use Disorder

The strategies do not provide clinical guidance; rather, they are system-level improvements hospitals can implement immediately. Brief case examples provide an opportunity to learn from other hospitals’ approaches. Each strategy includes source literature and additional resources, including cost savings data, where applicable. To arrive at the improvement ideas and case examples, we conducted a literature review of relevant topic areas as well as a synthesis of state, federal, and organizational guidance documents.

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Strategy 1: Identify and Treat Individuals with Opioid Use Disorder at Key Clinical Touchpoints

<table>
<thead>
<tr>
<th>Specific Improvement Idea or Project</th>
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<tbody>
<tr>
<td>• Implement screening and referral to treatment protocol in EDs and medication for opioid use disorders (MOUD) initiation where appropriate.</td>
</tr>
<tr>
<td>• Where necessary, establish urgent care opioid clinics, providing MOUD until a bridge to further long-term pharmacotherapy or inpatient care is established.</td>
</tr>
<tr>
<td>• Providers in the ED should be trained to treat acute opioid withdrawal.</td>
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</table>

Case Examples

Emergency Department Care

• Yale-New Haven Hospital: Implemented three levels of intervention for patients with an opioid use disorder presenting to the emergency department: 1) screening and referral to treatment; 2) screening, brief intervention, and facilitated referral to community organization; or 3) all of the above as well as an ED-initiated treatment with buprenorphine, and referral to primary care for a 10-week follow up. The results showed that the third-level intervention was most effective in retaining patients in treatment, and after the study the ED continued to use buprenorphine.


• Boston Medical Center Project ASSERT (Alcohol & Substance Use Disorder Services, Education, and Referral to Treatment): The first nationally published program in an ED to deploy peer counselors/educators as motivators and navigators to identify and intervene with patients with unhealthy alcohol and drug use.


Opioid Urgent Care Clinics

• Faster Paths to Treatment. Boston Medical Center. https://www.bmc.org/programs/faster-paths-to-treatment


ED-BRIDGE: Supports emergency departments throughout California to develop and implement plans for 24/7 access to buprenorphine for patients with opioid use disorder. [https://ed-bridge.org/](https://ed-bridge.org/)

### 1B. Identify and treat individuals with opioid use disorder in inpatient settings.

**Specific Improvement Idea or Project**
- Develop an addiction consult service to engage patients during acute hospitalizations to provide screening for opioid use disorder, initiation of MOUD, brief behavioral interventions, counseling, and referrals to treatment.
- Incorporate peer services and case management where needed.
- Connect individuals with a Bridge Clinic (a transitional outpatient addiction clinic for discharged hospital and ED patients who are not yet connected to outpatient care).

**Case Examples**

- **Johns Hopkins Bayview Medical Center Inpatient Addiction Consult Service:** With fellows, faculty, and peer support available, the service provides consultation for inpatients identified as having alcohol, tobacco, or other substance use disorder. The service, available in all areas of the hospital (including the medical, trauma, and surgical units), provides brief behavioral interventions and counseling, guidance on clinical management, brief buprenorphine/naloxone bridges, education, and facilitates linkages. An early study found that the Consult Service made patients less likely to have more than three ED episodes and more likely to have more than one ambulatory care visit. [https://www.hopkinsmedicine.org/johns_hopkins_bayview/medical_services/specialty_care/addiction_medicine/index.html](https://www.hopkinsmedicine.org/johns_hopkins_bayview/medical_services/specialty_care/addiction_medicine/index.html)


- **Boston Medical Center:** Established an addiction consult service to engage patients in addiction care during acute hospitalizations. A review of relevant care needs concludes that addiction consult services have the potential to decrease readmissions and utilization costs for medical systems, improve substance use outcomes for patients, and increase provider knowledge.


• Massachusetts General Hospital Substance Use Disorders Initiative: Created a multidisciplinary addiction consult team, including peers in recovery, to provide comprehensive evaluation, treatment recommendations, and connections to community resources. Validated substance use disorders screening tools are now part of the hospital’s standardized initial admission assessment. [https://www.massgeneral.org/substance-use-disorders-initiative.aspx](https://www.massgeneral.org/substance-use-disorders-initiative.aspx)

• Oregon Health Sciences University Improving Addiction Care Team (IMPACT): Created a team-based inpatient addiction consult to assess patient needs and initiate MOUD where needed, as well as developed rapid-access pathways to community services. [https://www.aha.org/system/files/content/17/opioid-ohsu-case-study.pdf](https://www.aha.org/system/files/content/17/opioid-ohsu-case-study.pdf)


1C. Integrate addiction care into primary care and other care settings, where appropriate.

<table>
<thead>
<tr>
<th>Specific Improvement Idea or Project</th>
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<tr>
<td>• Encourage primary care providers and infectious disease providers to incorporate MOUD into their treatment options.</td>
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<tr>
<td>• Incorporate nurse care manager models to provide consistent follow up.</td>
</tr>
</tbody>
</table>

Case Examples

Primary Care

• Massachusetts Bureau of Substance Abuse Services (BSAS) and Boston Medical Center (BMC): BSAS worked to disseminate the BMC Massachusetts Model of the office-based opioid treatment with buprenorphine (OBOT-B) for primary care doctors at community health centers in Massachusetts. Employing a collaborative care model with a central role for nursing enabled implementation of effective treatment for patients with an opioid use disorder at community health centers throughout Massachusetts while effectively engaging primary care physicians.


• Boston University School of Public Health and Albert Einstein College of Medicine: Together, these two organizations developed an integration manual for the implementation of office-based buprenorphine treatment delivered in primary care clinics.
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**Infectious Disease**

- Beth Israel Deaconess Medical Center: In the *New England Journal of Medicine*, experts from Beth Israel describe how an infectious disease practice is actively providing medication for opioid use disorder (MOUD) to patients hospitalized with infectious complications of injection drug use.


- NASEM Action Steps on “Integrating Infectious Disease Considerations with Response to the Opioid Epidemic”: In response to a request from the US Department of Health and Human Services, the National Academies of Sciences, Engineering, and Medicine (NASEM) convened a workshop on integrating infectious disease work into substance use treatment, resulting in five key action steps, including screening, the use of medication, hospital-based protocols, increased training, and increased access to addiction care.


**Family Medicine**

- Bridgton Family Practice: A rural Maine family practice physician set up MOUD in his primary care practice, paired with counseling or cognitive behavioral therapy.


- AMA and RIMS Guidance for Family Physicians: In an effort to help family medicine physicians treat opioid use disorder, the American Medical Association (AMA), Rhode Island Medical Society (RIMS), and officials from the Rhode Island Department of Health and the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals announced a partnership to develop and distribute a statewide educational toolbox for health care providers to help reverse the state’s opioid epidemic. The program is being piloted in Rhode Island and Alabama.


1D. Enhance specialty addiction treatment programming.

Specific Improvement Idea or Project

- Develop connections to specialty addiction treatment programs for certain groups of people, including adolescents, young adults, pregnant women, and new parents or, where necessary, create in-house programs to support these populations.

Case Examples

Pregnant and Postpartum Women and Babies

- Boston Medical Center and Boston University School of Medicine Project RESPECT (Recovery, Empowerment, Social Services, Prenatal care, Education, Community and Treatment): A high-risk obstetrical and addiction recovery medical home in Massachusetts that provides a unique service of comprehensive obstetric and substance use disorder treatment for pregnant women and their newborns. The article referenced below reviews evidence for opioid agonist treatment (OAT) and best practices for comprehensive care of pregnant women.

Substance Use Disorder and Pregnancy. Boston Medical Center.
https://www.bmc.org/obstetrics/pregnancy/addiction


- Massachusetts General Hospital HOPE Clinic (Harnessing support for Opioid and substance use disorders in Pregnancy and Early childhood): Provides comprehensive care for pregnant women with substance use disorder, their partners, and their infants, from conception through early childhood.

https://www.massgeneral.org/obgyn/services/treatmentprograms.aspx?id=2039

- Behavioral Treatment at Yale-New Haven Hospital or Bridgeport Hospital: In this pilot study, a behavioral therapy with components of motivational interviewing and cognitive therapy was administered concurrent with routine prenatal care at inner-city maternal health clinics in Connecticut and found feasible.


Adolescents and Young Adults

- Boston Medical Center CATALYST (Center for Addiction Treatment for AdoLescent/Young adults who use SubsTances) Clinic: Provides access to a wide range of services, including primary care, behavioral health, and support resources, for patients up to age 25 and their families. The program directors review evidence in favor of medication treatment for youths and young adults.

https://www.bmc.org/catalyst-clinic

Massachusetts General Hospital Addiction Recovery Management Service (ARMS): Specializes in supporting teenagers and young adults between the ages of 14 and 26 and their parents as they deal with substance use and related problems. [https://www.massgeneral.org/psychiatry/services/treatmentprograms.aspx?id=2090](https://www.massgeneral.org/psychiatry/services/treatmentprograms.aspx?id=2090)


### Specific Improvement Idea or Project

- Every provider should have baseline knowledge and competencies in: 1) fundamentals of addiction; 2) modern treatment of opioid use disorder, including utilization of buprenorphine; and 3) addressing stigma.
- Educate providers about how to treat substance use disorder, including pharmacotherapy and behavioral support, at every point in their training: medical school, residency, and maintenance through CME courses throughout career.
- Educate providers to provide culturally competent care that is cognizant of how racial or ethnic background may affect the type of care patients receive.
- Expand the availability of medication for opioid use disorder in office-based settings (e.g., buprenorphine/naloxone, naltrexone).
- Establish a plan to incentivize and expand the number of medical providers, medical students, residents, and fellows to take the necessary course to become waivered to prescribe buprenorphine for treating opioid use disorder. (Note: Medical students and residents can take the course but cannot be waivered until they have a full medical license.)

### Case Examples

Massachusetts General Hospital: Developed a “Get Waivered” training (to help ED physicians obtain a waiver to prescribe buprenorphine to patients with opioid use disorder) and campaign, complete with posters, publicity, and a gold pin to designate and honor those who complete the training. An anonymous donor provided money so that doctors could take the course while at work. [http://getwaivered.com/about/](http://getwaivered.com/about/)

### Guidance on Treating Individuals with Opioid Use Disorder


• Apply for a Buprenorphine Practitioner Waiver. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver


• Medical Education Core Competencies for the Prevention and Management of Prescription Drug Misuse and Suggested Education Modules. Massachusetts Medical Society. http://www.massmed.org/corecomp/#.XQ1A8NJKiUl

Addiction Consult Service


Primary Care


Cost Savings


Strategy 2: Modify Opioid Prescribing Practices to Minimize Harm and Maximize Benefit

2A. Improve opioid prescribing practices for patients with acute and chronic pain.

Specific Improvement Idea or Project
For clinical guidance on opioid prescribing, please refer to the CDC and pharmacy guidelines below.

Acute Pain Management:

- Opioids are not first-line medications for many types of acute pain. Try alternative medications and treatments before prescribing opioids.
- Opioids may be indicated for severe acute pain for a short period of time (i.e., 3 days or less is often sufficient; more than 7 days is rarely needed).

Chronic Pain Management:

- Opioids are not first-line medications for new patients experiencing chronic pain and have limited short-term effectiveness (i.e., up to 3 months). The effectiveness of opioids for more than 6 months has been inadequately studied. Long-term opioids should generally be avoided for chronic pain, especially chronic axial back pain, fibromyalgia, and headaches.
- Other considerations also apply for the management of patients already on high-dose chronic opioids, including shared decision making and focus on risk reduction. Involuntary and abrupt opioids tapers are inappropriate.
- Try multimodal non-opioids and non-pharmacological treatments before starting opioids. Note that these recommendations are for treating adult patients outside of active cancer treatment, palliative care, and end-of-life care.
- When prescribing opioids, employ universal precautions by using patient-provider agreements (i.e., informed consent and plan of care) and monitor for adherence and safety by checking the prescription drug monitoring program, instituting urine drug testing, and conducting pill counts.

Case Examples

- Michigan Opioid Prescribing Engagement Network (OPEN): Founded to develop a preventative approach to the opioid epidemic in Michigan through a focus on acute care prescribing (surgery, dentistry, emergency medicine, and trauma). [http://michigan-open.org](http://michigan-open.org)

- Brigham and Women’s Hospital (BWH): Created an organizational opioid stewardship program (OSP) to develop a multidisciplinary approach to the opioid epidemic. As part of the OSP, a Prescribing Task Force established safe prescribing guidelines, and a peer review committee addresses high-frequency opioid prescribers. With these elements in place, BWH successfully reduced the number of opioid prescriptions and, in particular, the number of high-dose opioid prescriptions.


- Duke University Health System: Updated their approach to pain management in many ways, including creating one uniform pain agreement for all patients, providing relevant CME, and hosting workshops to help patients self-manage their pain without opioids. [https://www.dukehealth.org/treatments/pain-management](https://www.dukehealth.org/treatments/pain-management)
• Dartmouth-Hitchcock Medical Center: Studied the number of opioids prescribed after surgery and found that the number prescribed exceeded the number used. After implementing an educational intervention with surgeons, which recommended that surgeons encourage patients to use a nonsteroidal anti-inflammatory drug (NSAID) and acetaminophen before using opioids, the number of initial opioid prescriptions after surgery was significantly reduced.


• Massachusetts General Hospital/Massachusetts General Physicians Organization Opioid Task Force: Developed best practices for clinicians prescribing opioids for patients with acute or chronic pain. The task force has overseen the hospital-wide distribution and implementation of the guidelines and is developing training for all clinicians prescribing opioids. “The guidelines help clinicians communicate openly with patients about the risks and concerns of opioids, while helping patients manage their pain effectively and responsibly.” [http://mgpo.massgeneral.org/fsp/2016/fsp-201606/OpioidPrescribingGuidelines.pdf](http://mgpo.massgeneral.org/fsp/2016/fsp-201606/OpioidPrescribingGuidelines.pdf)

• Boston University School of Medicine SCOPE of Pain: A series of continuing education activities designed to help effectively manage patients with acute and/or chronic pain, when appropriate, with opioid analgesics. It is intended for physicians, nurse practitioners, registered nurses, physician assistants, nurses, dentists, pharmacists, and allied health professionals whose practices manage acute and chronic pain. Includes modules on a patient-centered approach to opioid tapering, safer postoperative opioid prescribing, optimizing office systems, safer opioid prescribing for dental pain, and naloxone co-prescribing. [https://www.scopeofpain.org/about-us/](https://www.scopeofpain.org/about-us/)


• Southcentral Foundation: Opioid Guidelines describe the components of improving their prescribing practices, including a pain assessment by a behavioral consultant, establishing an opiate review committee, a multidisciplinary pain team, and a medication agreement and wellness plan.


• Partnership HealthPlan of California: Began its Managing Pain Safely program in 2014, implementing prescriber education, particularly for rural prescribers, additional reinforcement for ongoing technical assistance, formulary changes, and new benefits like alternative pain treatment.

2B. Improve opioid dispensing practices.

Specific Improvement Idea or Project

Pharmacy:
- Require checking the prescription drug monitoring program (PDMP) before dispensing opioids and incorporate referral to treatment where appropriate.
- Use existing data (e.g., claims, payment form, location of prescription fills, PDMP) to identify patients, providers, and prescribers who may be inappropriately using or prescribing opioids.
- Empower pharmacists to question prescribing practices (aka, “corresponding responsibility”) and address concerns to prescribing clinician or higher authority (e.g., boards of registration).
- Ensure that patients prescribed opioids for chronic pain have access to naloxone.

Payers:
- Require pharmacies and clinicians to check PDMP to be able to prescribe covered opioids. (Frequency of PDMP checks may be required by state laws.)
- Conduct claims data surveillance to identify patients, providers, and prescribers who may need additional investigation.
- Consider adding “pharmacy lock” so that opioids can only be prescribed by one provider and dispensed from one pharmacy.
- Change reimbursement to cover multimodal non-pharmacologic treatments (e.g., acupuncture, cognitive behavioral therapy, chiropractor services).
- Change reimbursement for different types of opioids (e.g., preference for abuse-deterrent formulations).
- Institute formulary controls for new opioid starts and dose escalation: type of opioid to be dispensed, number of pills per covered prescription, refill frequency.
- Cover payment for safer disposal products like Dispose Rx, Deterra, or other similar bags.
- Support clinician education on safer opioid use for acute and chronic pain.
- Change reimbursement to cover most (if not all) patient costs for naloxone.

Case Examples

- Geisinger Health System: Trained pharmacists are already embedded in primary care clinics to become pain management and addiction specialists. After just one year, the pharmacists were able to manage 1,233 patients with chronic, non-cancer pain and reduce ED visits by 20 percent.

- Kaweah Delta Medical Center: Implemented a pharmacy-directed pain management service (PPMS) to optimize analgesic pharmacotherapy, minimize adverse events, and improve patient experience of pain management. This led to decreases in high-risk opioid medications, total institutional opioid use, and rapid response team (RRT) and code blue events associated with opioid-induced oversedation.
• Boston University School of Medicine SCOPE of Pain: A series of continuing education activities for health professionals designed to help effectively manage patients with acute and/or chronic pain, when appropriate, with opioid analgesics. [https://www.scopeofpain.org/about-us/](https://www.scopeofpain.org/about-us/)

• University of Utah: All adult patients with an appointment for chronic pain who were prescribed >50 morphine milligram equivalents (MMEs) per day had charts reviewed by a pharmacist before each appointment; recommendations were sent electronically to the provider before the appointment. After four months of implementation, each patient’s chart was manually reviewed. When comparing outcomes before and after the intervention, the mean MMEs per day decreased by 14 percent (P < .001), with no change in pain scores (P = .783).


<table>
<thead>
<tr>
<th>2C. Prevent diversion of opioids (i.e., the transfer of legally prescribed opioids from the individual for whom they were prescribed to another person for any illicit use).</th>
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<tbody>
<tr>
<td><strong>Specific Improvement Idea or Project</strong></td>
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<tr>
<td>• Educate the public/patients about the risks of becoming addicted to prescription opioids and the link between prescription opioids and future prescription opioid misuse and illicit opioid use.</td>
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<tr>
<td>• Educate the public/patients about the risks of opioid diversion, how to safely store opioid medication, and how to properly dispose of unused medication.</td>
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<tr>
<td>• Pharmacists have locked boxes/bags available to ensure that patients can securely store opioids at home.</td>
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<tr>
<td>• Pharmacists dispense opioids with Dispose Rx, Deterra, or similar devices for safe disposal.</td>
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<tr>
<td>• Install permanent, bin-based safe drug disposal sites in community spaces such as pharmacies, police stations, and social service agency offices.</td>
</tr>
<tr>
<td>• Organize and publicize community-wide drug take-back days to encourage people to safely dispose of unused opioids and other medications.</td>
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</table>

**Case Examples**

• The Mayo Clinic: Created a new position, the Medication Diversion Prevention Coordinator (MDPC), within the Department of Pharmacy. With input from multiple participants, a “best practices” list was created that identified 77 specific points to create the best possible system to date to prevent controlled substance diversion.


• Washington University School of Medicine and Barnes Jewish Hospital: Researchers found that adult patients who received a new patient education brochure describing safe disposal practices for unused pain pills were twice as likely to properly dispose of their opioids than those who did not receive the brochure.

2D. Enhance the availability of multimodal pain management strategies.

### Specific Improvement Idea or Project

**Clinicians:**
- Improve clinician training in pain management, particularly for primary care clinicians.
- Increase clinician knowledge about effective, non-opioid treatments for different types of chronic pain such as NSAIDs, acetaminophen, adjuvant therapies (e.g., antidepressants, anticonvulsants), physical therapy, acupuncture, massage therapy, exercise, yoga, and cognitive behavioral therapy (CBT).

**Payers:**
- Provide adequate benefit coverage and reimbursement for non-opioid pain management options to increase uptake, including the options mentioned above. For specific interventions, see link below for Consortium Pain Task Force White Paper.
- Incentivize use of non-opioid pain treatments.

### Case Examples

- **St. Joseph’s Health: The Alternatives to Opiates (ALTO) program** uses targeted non-opioid medications, trigger-point injections, nitrous oxide, and ultrasound-guided nerve blocks to tailor patients' pain management needs and avoid opioids when possible. [https://www.stjosephshealth.org/clinical-focuses/item/1861 Alternatives to Opiates (ALTO) Program](https://www.stjosephshealth.org/clinical-focuses/item/1861). St. Joseph's Regional Medical Center; 2016.

  *St. Joseph’s Health: The Alternatives to Opiates (ALTO) Program.* St. Joseph’s Regional Medical Center; 2016. [https://www.aha.org/system/files/content/16/16behavhealthcaseex-stjosephs.pdf](https://www.aha.org/system/files/content/16/16behavhealthcaseex-stjosephs.pdf)

- **The Mayo Clinic:** A review by the Mayo Clinic found that the following complementary approaches for pain management had positive evidence: acupuncture and yoga for back pain; acupuncture and Tai chi for osteoarthritis of the knee; massage therapy for neck pain, with adequate doses and for short-term benefit; and relaxation techniques for severe headaches and migraine.


- **National Center for Integrative Primary Healthcare (NCIPH):** Their purpose is to advance the incorporation of competency- and evidence-based integrative health curricula and best practices into primary care education and practice. They developed core competencies, an educational curriculum open to all providers, and resources for patients and the public. [https://nciph.org/](https://nciph.org/)

### Guidance for Limiting the Supply of Opioids

- **Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016.** *MMWR Recommendations and Reports.* 2016 Mar;65(No. RR-1):1–49. [https://www.cdc.gov/mmwr/volumes/65/rr/rr6501et1.htm](https://www.cdc.gov/mmwr/volumes/65/rr/rr6501et1.htm)


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- **HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics.** US Department of Health and Human Services; September 2019. [https://www.hhs.gov/opioids/sites/default/files/2019-10/8-Pages%20version_HHS%20Guidance%20on%20Dosage%20Reduction%20or%20Discontinuation%20of%20Opioids.pdf](https://www.hhs.gov/opioids/sites/default/files/2019-10/8-Pages%20version_HHS%20Guidance%20on%20Dosage%20Reduction%20or%20Discontinuation%20of%20Opioids.pdf)


- Pharmacist Resources. National Association Board of Pharmacy. [https://nabp.pharmacy/initiatives/pharmacist-resources/](https://nabp.pharmacy/initiatives/pharmacist-resources/)


- **State Criteria for Mandatory Enrollment or Query of PDMP.** Prescription Drug Monitoring Program Training and Technical Assistance Center; July 2016. [http://www.pdmpassist.org/pdf/Mandatory_conditions.pdf](http://www.pdmpassist.org/pdf/Mandatory_conditions.pdf)


- State Profiles. Prescription Drug Monitoring Program Training and Technical Assistance Center. [http://www.pdmpassist.org/content/state-profiles](http://www.pdmpassist.org/content/state-profiles)

**Cost Savings**

### Strategy 3: Train Stakeholders on the Risks of Opioid Use Disorder and How to Reduce Stigma

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<thead>
<tr>
<th>3A. Educate health care professionals, patients, and the public about the risks of taking opioids.</th>
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<tr>
<td><strong>Specific Improvement Idea or Project</strong></td>
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<tr>
<td>- Educate health care professionals on the risks of prescription opioid misuse and developing an opioid use disorder.</td>
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<tr>
<td>- Educate the public, particularly adolescents and young adults, about the risks of opioid use, appropriate usage (e.g., taking opioids in ways other than prescribed carries risks of addiction, overdose, and death), and safe medication storage and disposal.</td>
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<tr>
<td>- Provide clear information on addiction risk to patients prescribed opioids.</td>
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</table>

**Case Examples**

- Intermountain Healthcare: Provides a set of opioid patient education documents: before taking opioids; taking opioids for acute care, perinatal care, and chronic care; and guidance on disposal. [https://intermountainhealthcare.org/services/pain-management/patient-education/](https://intermountainhealthcare.org/services/pain-management/patient-education/)

- Boston University School of Medicine SCOPE of Pain: A series of continuing education activities for health professionals designed to help safely and effectively manage patients with acute and/or chronic pain, when appropriate, with opioid analgesics. [https://www.scopeofpain.org/about-us/](https://www.scopeofpain.org/about-us/)


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<tr>
<th>3B. Reduce stigma around substance use disorders.</th>
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<tr>
<td><strong>Specific Improvement Idea or Project</strong></td>
</tr>
<tr>
<td>- Increase public and provider awareness to reframe substance use disorders as a chronic disease rather than a moral failing, to be managed like other chronic conditions such as diabetes.</td>
</tr>
<tr>
<td>- Use clinically indicated rather than judgmental language.</td>
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<tr>
<td>- Use evidence-based approaches to develop stigma reduction campaigns and continuously evaluate efficacy.</td>
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<tr>
<td>- Use diverse imagery and language (using multiple languages, where indicated) to reach different populations.</td>
</tr>
</tbody>
</table>

**Case Examples**

- Boston Medical Center: Created a list of stigmatizing and non-stigmatizing language around addiction, in addition to a pledge that explains the importance of committing to using clinically appropriate and medically accurate terminology. [https://www.bmc.org/addiction/reducing-stigma](https://www.bmc.org/addiction/reducing-stigma)

- Kaiser Permanente: Through ongoing awareness-building by senior leaders and the “Find Your Words” campaign, Kaiser Permanente is aiming to reduce mental health stigma in the workplace. [https://findyourwords.org/](https://findyourwords.org/)
IHI Open School: The Recover Hope campaign includes a “Change the Narrative Pledge,” a month-long friendly competition to encourage commitment to stop stigma surrounding substance use disorders, and free online resources and trainings, including ideas for taking local action. 
http://www.ihi.org/education/IHIOpenSchool/Recover-Hope-Campaign/Pages/default.aspx

Guidance on Training Stakeholders

• Helpful Materials for Patients. Centers for Disease Control and Prevention. 
https://www.cdc.gov/drugoverdose/patients/materials.html


Strategy 4: Identify and Screen Individuals at High Risk of Developing Opioid Use Disorder

4A. Screen patients at high risk for developing opioid use disorder and provide education on addiction risks.

Specific Improvement Idea or Project

• Screen all patients who are being prescribed opioids for risk of misuse and substance use disorder. Screening efforts should focus on those with a co-occurring substance use disorder, a history of substance use, adolescents and young adults, and those with significant needs regarding their social determinants of health.

• Provide clear information to patients being prescribed opioids about the risk of addiction.

Case Examples

• Christiana Care Health System: Project Engage, an early intervention program, screens people with signs of substance use disorder and connects them with trained specialists. The program led to an increased acceptance of treatment and has been implemented in Christiana and Wilmington hospitals’ emergency departments, Christiana’s patient care units, Christiana Care’s primary care practices, and Christiana Care’s women’s and children’s services. 
https://christianacare.org/services/behavioralhealth/project-engage/


• Screening, Brief Intervention, and Referral to Treatment (SBIRT): An evidence-based practice used to identify, reduce, and prevent problematic use and dependence on alcohol and illicit drugs. It can be integrated into primary care. While it is primarily effective for alcohol use disorder, it can also be used for other substance use disorder screening.

Guidance for Identifying and Screening Individuals at Risk for Opioid Use Disorder


- Screening Tools:

  Drug Abuse Screening Test (DAST-10). National Institute on Drug Abuse. https://cde.drugabuse.gov/instrument/e9053390-ee9c-9140-e040-bb89ad433d69


Strategy 5: Reduce the Harms of Substance Use Disorder

<table>
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<tr>
<th>5A. Enhance the availability of supportive social services and connections to long-term, ongoing, comprehensive treatment (medication-assisted treatment + behavior-based therapy).</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Specific Improvement Idea or Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Collaborate with local communities, private and public addiction treatment facilities, to support the continuum of care.</td>
</tr>
<tr>
<td>• Enhance transitions to other levels of substance use care such as Clinical Stabilization Services (CSS), Transitional Support Services (TSS), and residential treatment programs.</td>
</tr>
<tr>
<td>• Increase access to and availability of social services often required by those in recovery to support continued recovery and prevent relapse, including affordable housing, employment support, and child care.</td>
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</tbody>
</table>

Case Examples

- Vermont Hub-and-Spoke Model: Vermont’s five geographic regions each have a “hub clinic” organized around an existing opioid treatment program (OTP) with prescriptive authority to dispense buprenorphine along with methadone (MTD) under its existing OTP licensure. Hub staff assess patients’ medical and psychiatric needs at intake and determine the most appropriate treatment placement (e.g., in the OTP with MTD or buprenorphine, with spoke providers for office-based opioid treatment). Entry points into the hubs also include hospitals and emergency departments (especially after an overdose reversal or medical treatment for injection-related diseases), residential programs, Department of Corrections, and community mental health programs. The hub-and-spoke model supported a substantial increase in Vermont’s opioid use disorder treatment capacity.

- Cuyahoga County Opiate Task Force: Launched an extensive collaborative, long-term campaign in Ohio aiming to increase awareness of the dangers associated with the misuse of opioids as well as to implement strategies and policies that will have a positive impact. Partners include local health plans and hospitals. [http://opiatecollaborative.cuyahogacounty.us](http://opiatecollaborative.cuyahogacounty.us)

Dayton and Montgomery County Community Overdose Action Team: Established in Fall 2016 to address the opioid/heroin epidemic in Ohio’s Montgomery County, including a Steering Committee of 60 community leaders from numerous public and private organizations throughout the county. The goal is to reduce the number of fatal overdoses. [https://www.phdmc.org/coat](https://www.phdmc.org/coat)

- Oregon Health State University Hospital: This three-county collaborative involved 14 hospitals from four health systems, two coordinated care organizations, and four health departments working together to develop a community standard to reduce the use of and addiction to opioids.


- The Northern Shenandoah Valley Substance Abuse Coalition: Speakers share how this community in rural Virginia coalesced to develop strategies to effectively respond to the challenge of heroin and opioid use. Initiatives include “Breaking the Code of Silence,” an educational campaign to highlight awareness; development and access to transitional care after incarceration; establishment of a drug treatment court; and use of a peer recovery network.


- Katherine Shaw Bethea (KSB) Hospital and Dixon Police Department Safe Passage Initiative: An addiction recovery initiative in Illinois that allows people seeking treatment to contact police without fear of arrest, as long as they don’t have any outstanding warrants. The hospital and police department partner with treatment centers in and outside of Illinois to coordinate care and treatment for participants. Since September 2015, they’ve placed more than 60 individuals into treatment and have been able to secure a treatment bed for a participant within two hours. Illinois Medicaid paid for treatment for the majority of participants; scholarships and private insurance also have been utilized.

Intervention Strategies for Hospitals Responding to the Opioid Crisis

- Intermountain Healthcare Opioid Community Collaborative: A consortium of community leaders in Utah sponsored and funded by Intermountain to help prevent opioid abuse, has several initiatives, including medication disposal drop boxes, distribution of naloxone rescue kits, increased caregiver training, and adoption of MOUD. [https://intermountainhealthcare.org/about/who-we-are/trustee-resource-center/newsletter/newsletter-archive/intermountain-leaders-address-utahs-opioid-epidemic/](https://intermountainhealthcare.org/about/who-we-are/trustee-resource-center/newsletter/newsletter-archive/intermountain-leaders-address-utahs-opioid-epidemic/)

### 5B. Develop and promote harm reduction to optimize safety in people with addictions.

**Specific Improvement Idea or Project**
- Increase prescribing and other access to naloxone kits, including among pharmacists, community and family members, and non-paramedic first responders. Ability to do this varies by state (see resources below). State governments and payers should cover naloxone with little or no cost to the individual.
- Initiate naloxone co-prescribing processes for high-risk patients, for example, when prescribing opioids or buprenorphine.
- Providers offer comprehensive harm reduction services (including syringe exchange, safe use instructions, and harm reduction kits) and preventive care.
- Consider fentanyl testing.

**Case Examples**

- Massachusetts General Hospital Kraft Center for Community Health CareZONE: A mobile health initiative deploys caregivers to “hotspots” of opioid overdose, providing low-threshold access to treatment-on-demand and a nontraditional combination of clinical and harm reduction services to vulnerable populations. [http://www.kraftcommunityhealth.org/CareZONE](http://www.kraftcommunityhealth.org/CareZONE)


- NYC Health + Hospitals/Lincoln: The health system was the first to distribute naloxone kits to all patients served by the emergency room for behavioral health and chemical dependency, and has now opened a hospital-based naloxone kit distribution center to make naloxone available free to the community at large and without a prescription.

- A review of community opioid overdose prevention and naloxone distribution programs: This review investigated publications on the effectiveness of community-based opioid overdose prevention programs and finds suggestive evidence that bystanders (mostly opioid users) can and will use naloxone to reverse opioid overdoses when properly trained, and that this training can be done successfully through opioid overdose prevention programs.


Guidance on Reducing the Harms of Substance Use Disorder


- Prescribe to Prevent. [https://prescribetoprevent.org/](https://prescribetoprevent.org/)


Cost Savings


Appendix: General Guidance Resources


- *Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder.* Rhode Island Department of Health, Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals; 2017. [http://health.ri.gov/publications/guides/LevelsOfCareForTreatingOverdoseAndOpioidUseDisorder.pdf](http://health.ri.gov/publications/guides/LevelsOfCareForTreatingOverdoseAndOpioidUseDisorder.pdf)

- Levels of Care for Baltimore City Hospitals Responding to the Opioid Epidemic. Baltimore City Health Department. [https://health.baltimorecity.gov/levels-care](https://health.baltimorecity.gov/levels-care)