


Opioid Stewardship Program (OSP) Quickinar Session 5

Screening Patients for OUD Risk and Opioid Withdrawal

Claudia Kinsella, Quality Improvement Specialist

Jeff Francis, Quality Improvement Specialist

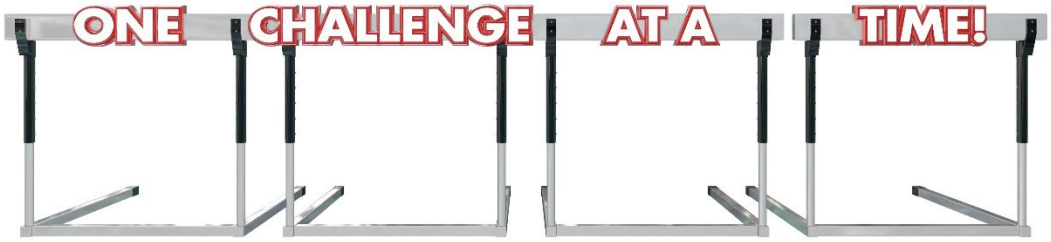
Thursday, January 13, 2022

HSAG HEALTH SERVICES ADVISORY GROUP

Last Session's Action Items

1. Review Dashboard Resources on the HSAG OSP Resource Page.

2. Identify quality metrics for your opioid dashboard.



Screening Patients for Opioid Use Disorder Risk and Opioid Withdrawal

Sandra A. Springer, MD
Associate Professor of Medicine
Department of Internal Medicine
Section of Infectious Diseases
Yale School of Medicine

InSTRIDE
Integrating Substance use Treatment Research with Infectious Diseases for Everyone

Dr. Springer's Disclosures

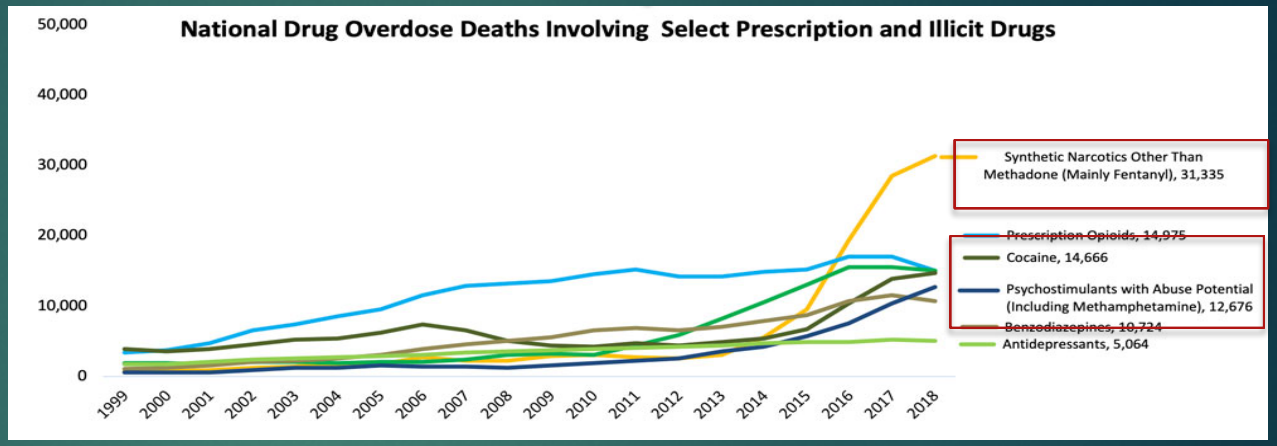
- Grant funding provided by:
  - NIH (NCATS, NIAAA & NIDA) & the VA
- Has received Extended-release Naltrexone (XR-NTX) donations in-kind from Alkermes Inc for NIH-sponsored research
- Has received Injectable Buprenorphine (Sublocade) donations in-kind from Indivior Inc for NIH sponsored research
- S. Springer has received paid honoraria for provision of expert discussion of published research that utilized XR-NTX and for review of Pathways Grants for Alkermes Inc

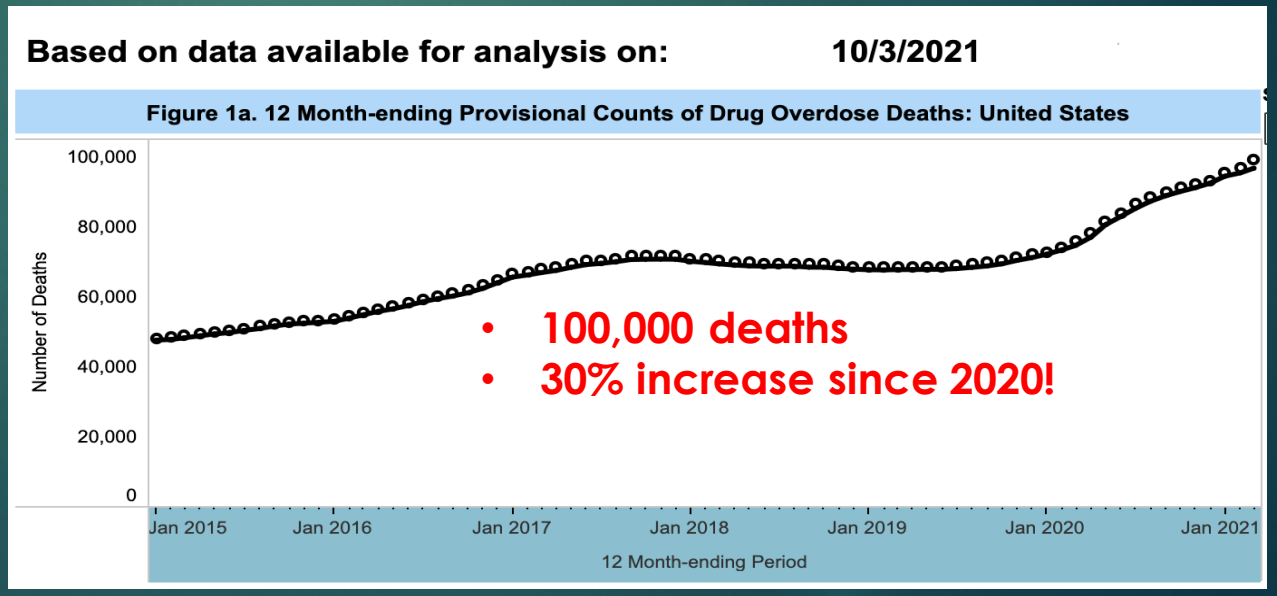
Persons who use drugs are dying at higher numbers now then ever before

We are not getting treatment & prevention of substance use disorders to PWUD

COVID19 showed the **failure of our healthcare** system

We have to change or more people will die





FDA-Approved Medications for Treatment of Opioid Use Disorder

Form of Treatment	Methadone	Buprenorphine	Extended-release Naltrexone
Mechanism of Action	Full μ agonist	Partial μ agonist Partial κ antagonist	Full μ antagonist
Delivery	Oral	Sublingual film/tablet, implant, injection	Injection
Frequency	Daily	Daily oral Monthly injection Implant 6 mos	Monthly
Setting	Licensed drug treatment program	Primary/HIV/HCV care setting (MD with 8 hr X-waiver training; PA/NP with 24 hr training)*	Primary/HIV/HCV care setting (no special licensing)

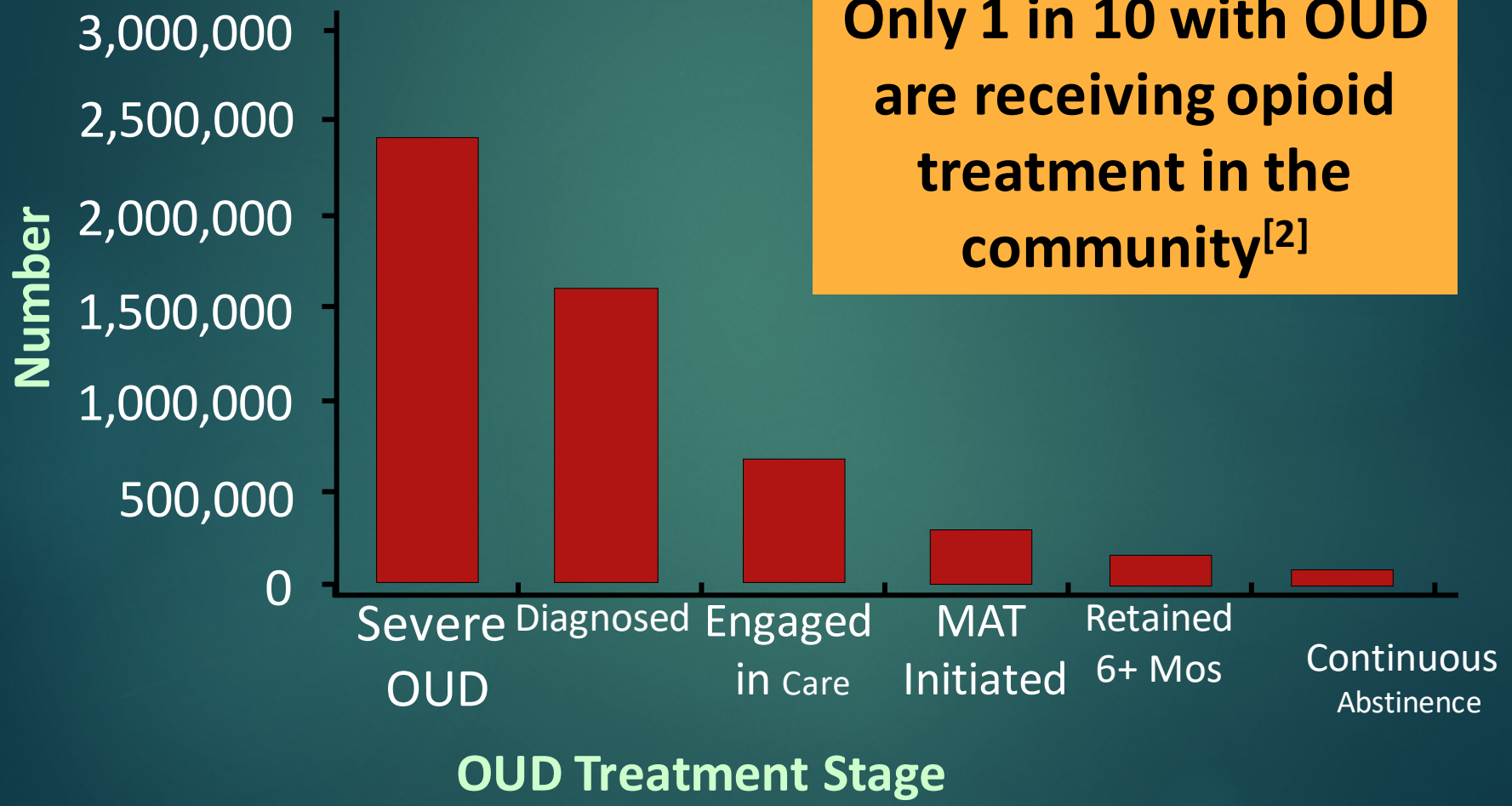
*NO training required now for X waiver for 30 patients but still need to apply for X-waiver

What do we know?... Well they work!

- **All 3 Forms of MOUD**:
  - Decrease opioid use, prevent OD, reduce mortality;
  - Decrease risk of transmission of infectious diseases like HIV & HCV;
  - Improve psychosocial outcomes (e.g. obtaining jobs, quality of life)
  - Decrease criminal behavior
- Buprenorphine and Methadone also treat opioid withdrawal and pain

But…Few Receive Medication Treatment for OUD and fewer are Retained on Treatment.

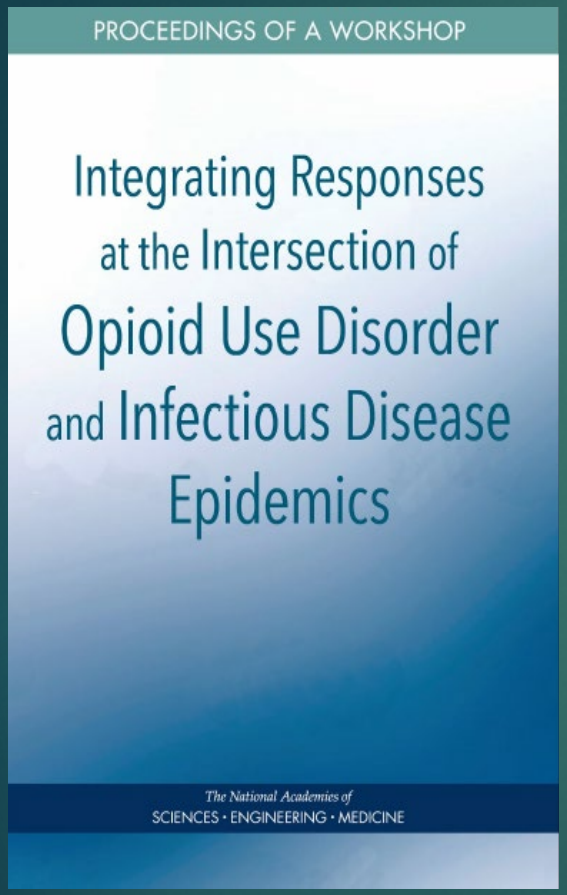
OUD Cascade of Care in United States: 2014 National Estimates



Only 1 in 10 with OUD are receiving opioid treatment in the community[2]

1. Williams. https://academiccommons.columbia.edu/doi/10.7916/D8RX9QF3.
2. O'Donnell. Mo Med. 2017;114:181

A Call to Action: Integrating Opioid Use Disorder Screening and Treatment With Infectious Disease

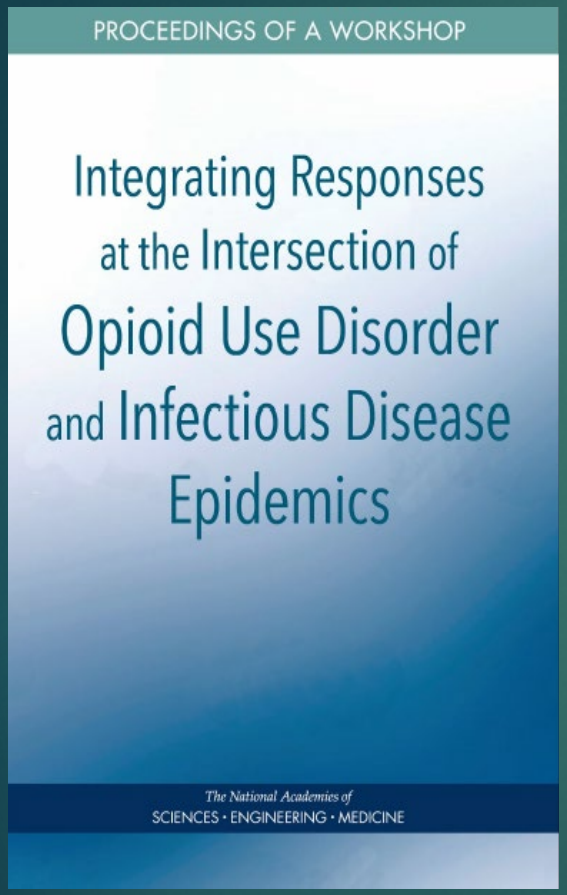


5 Action Items Identified:

- Universal screening for OUD in all healthcare settings, especially in patients with new HCV and HIV infections, opioid overdose, bacteremia, endocarditis, vertebral osteomyelitis, and skin abscesses
- Immediate treatment of OUD or opioid withdrawal symptoms with medication
- Enable OUD treatment using hospital-based protocols and link to community-based care upon discharge
- Increase training for OUD identification and treatment for physicians, residents, and students
- Improve access to healthcare and state funding to deliver effective OUD treatments

www.ncbi.nlm.nih.gov/books/NBK525635.

A Call to Action: Integrating Opioid Use Disorder Screening and Treatment With Infectious Disease



www.ncbi.nlm.nih.gov/books/NBK525635.

5 Action Items Identified:

- Universal screening for OUD in all healthcare settings, especially in patients with new HCV and HIV infections, opioid overdose, bacteremia, endocarditis, vertebral osteomyelitis, and skin abscesses
- Immediate treatment of OUD or opioid withdrawal symptoms with medication
- Enable OUD treatment using hospital-based protocols and link to community-based care upon discharge
- Increase training for OUD identification and treatment for physicians, residents, and students
- Improve access to healthcare and state funding to deliver effective OUD treatments

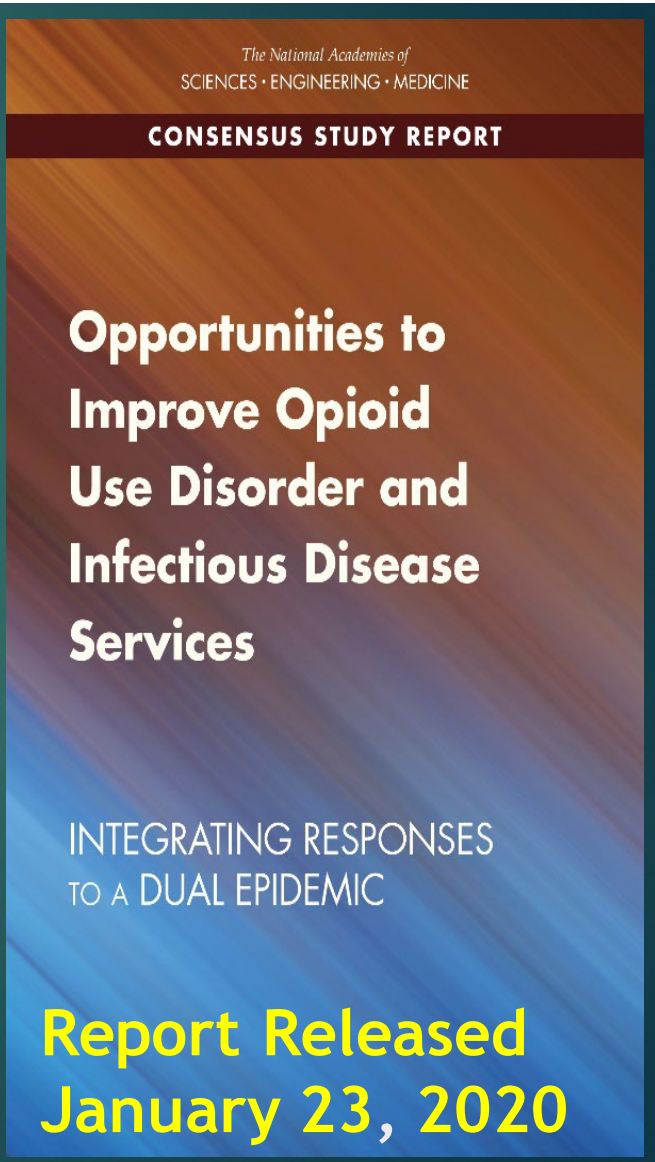
Annals of Internal Medicine IDEAS AND OPINIONS

Integrating Treatment at the Intersection of Opioid Use Disorder and Infectious Disease Epidemics in Medical Settings: A Call for Action After a National Academies of Sciences, Engineering, and Medicine Workshop

Sandra A. Springer, MD; P. Todd Korthuis, MD, MPH; and Carlos del Rio, MD

Annals of Internal Medicine. 2018

The National Academies of
SCIENCES • ENGINEERING • MEDICINE



The National Academies of
SCIENCES · ENGINEERING · MEDICINE

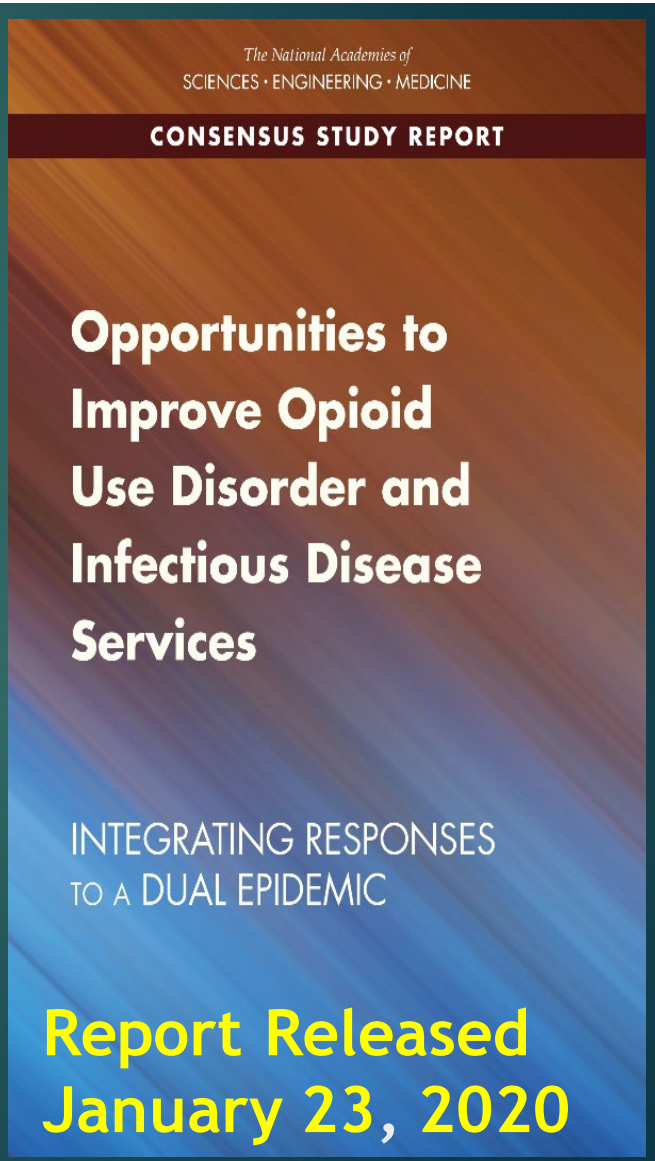
Opportunities to Improve Opioid Use Disorder and Infectious Disease Services: Integrating Responses to a Dual Epidemic

Committee Members:

1. Carlos del Rio (Chair)
2. Julie Baldwin
3. Edwin Chapman
4. Hannah Cooper
5. David Gustafson
6. Holly Hagan
7. Robin Newhouse
8. Jody Rich
9. Sandra Springer
10. David Thomas

* Ellen Eaton (NAM Omenn Fellow)

*NASEM staff: Rose Martinez and Andrew Merluzzi *



Report Released January 23, 2020

VIEWPOINT

Integrating Responses to the Opioid Use Disorder and Infectious Disease Epidemics

A Report From the National Academies of Sciences, Engineering, and Medicine

JAMA. March 2020

Sandra A. Springer, MD
Yale School of Medicine, Department of Medicine, Section of Infectious Disease, Yale AIDS Program, New Haven, Connecticut.

Andrew P. Merluzzi, PhD, MPA
Health and Medicine Division, Board on Population Health and Public Health Practice, National Academies of Sciences, Engineering, and Medicine, Washington, DC.

Carlos del Rio, MD
Division of Infectious Diseases, Department of Medicine, Emory University School of Medicine, Atlanta, Georgia.

The United States is in the midst of an opioid use disorder (OUD) epidemic,[1] with more than 2.1 million persons affected and more than 700 000 deaths since 1999.[2] In October 2017, President Trump declared the opioid crisis a public health emergency, and a national response was initiated. However, it is estimated that only 1 in 10 people with OUD are receiving needed treatment. The opioid epidemic also has contributed to an increase in bacterial and fungal infections as well as new HIV[3] and hepatitis C virus[4] outbreaks across many parts of the country.[5]

To guide the response to these dueling epidemics, the Department of Health and Human Services (DHHS) Office of Infectious Disease and HIV/AIDS Policy requested that the National Academies of Sciences, Engineering, and Medicine (NASEM) convene a committee that would (1) identify, highlight, and review programs within the United States that are achieving integration of OUD and infectious disease (ID) services; (2) identify and highlight barriers to integration and to suggest strategies to overcome barriers; and (3) provide conclusions and recommendations to inform existing and future projects that pro-

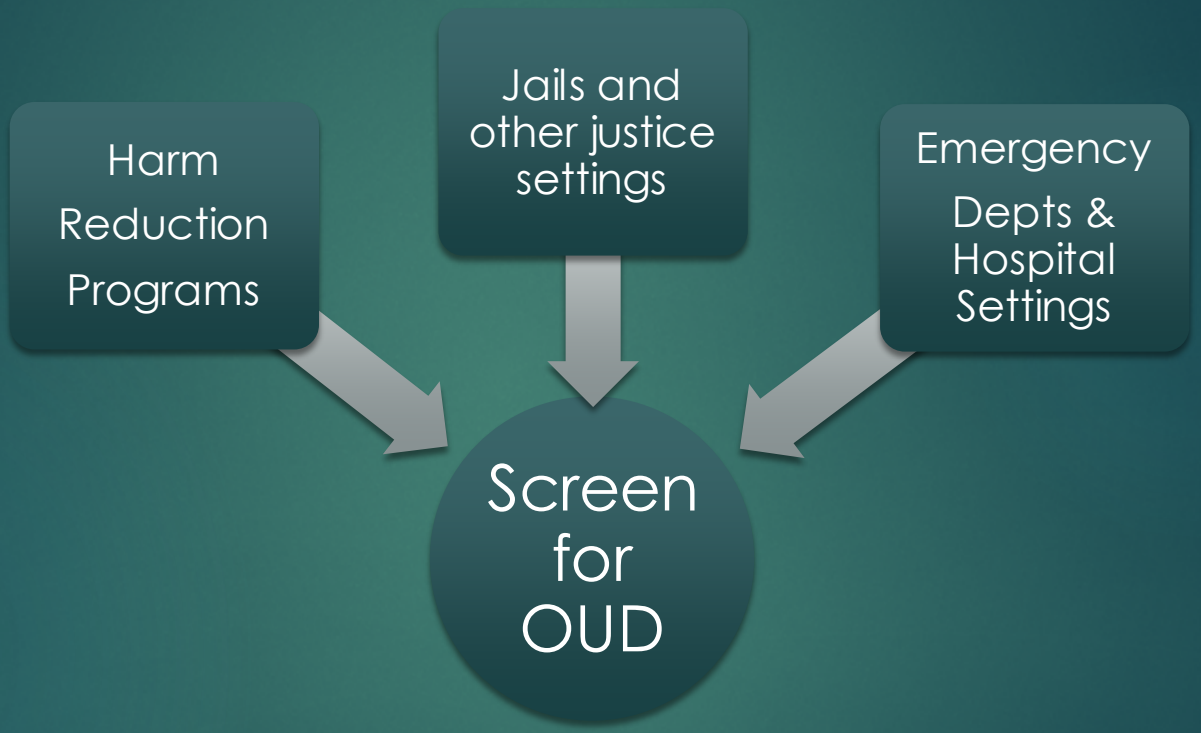
Same-Day Billing Restrictions

Some states have implemented restrictions on billing for both behavioral and physical health care visits on the same day.[8] These restrictions are intended to contain costs but often force patients to return to medical centers on a different day or require that the medical center incur financial loss for providing same-day care. The committee recommended that all states amend their policies to allow greater access to treatment for patients who need it.

Inadequate Data Sharing That Limits Integrated Care

Title 42, Part 2 of the *Code of Federal Regulations* (42 CFR Part 2) is a federal regulation that places strong protections around patients' substance use information and prevents sharing this information without explicit patient consent. The committee recognized that there is a balance between confidentiality and sharing of patient information related to substance use[9,10] and recommended that the Substance Abuse and Mental Health Services Administration (SAMHSA) engage with patients, advocacy groups, the general public, and legal experts to determine the benefits and costs of changing 42 CFR Part 2 and aligning it with the Health Insurance

SBIRT: Screening and Brief Intervention and Initiation/ Referral of Medication Treatment for OUD



Initiate Rapid Screening for OUD In high prevalence areas

Defining OUD: DSM-5 Diagnostic Criteria

- Diagnosis: ≥ 2 symptom criteria within a 12-mos period
- Severity: Mild 2-3 symptoms: Moderate 4-5 symptoms: Severe 6 or more symptoms

Category	Criteria
Loss of control	▪ Opioids are often taken in larger amounts or over a longer period than was intended ▪ There is a persistent desire or unsuccessful efforts to cut down or control opioid use ▪ A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects ▪ Craving, or a strong desire or urge to use opioids
Social problems	▪ Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home ▪ Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids ▪ Important social, occupational, or recreational activities are given up or reduced because of opioid use
Risky use	▪ Recurrent opioid use in situations in which it is physically hazardous ▪ Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
Pharmacologic problems	▪ Exhibits tolerance: need for a larger amount to achieve desired effect or diminished effect with same amount ▪ Exhibits withdrawal: occurrence of a characteristic opioid withdrawal syndrome or continued use of opioids or closely related substances to avoid withdrawal symptoms

Approaches to Screening for Substance Use Disorders

- Best in context of general health screening
  - Nonjudgmental, open-ended questions
- Single screening questions
  - Brief, validated in primary care
  - Easy to memorize, use in busy medical setting
- Standardized questionnaires
  - More difficult to administer/score
  - Provide information about severity/consequences

Single Screening Questions (SSQ)

- Brief, validated in primary medical care settings
  - 93% sensitive and 94% specific for any drug use
- "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?"

Source. Smith et al. 2010; 4. NIDA, 2014.

Standardized Screening Tools

- Best if computerized, automatic scoring
- Many provide information about severity
- Necessary if screening is part of Screening and Brief Intervention (SBIRT) protocol
- A positive single screening question can be followed by standardized screening

Standardized Screening Instruments for SUD/OUD

Measure	Characteristics
Drug Abuse Screening Test **(DAST)**	10 items, no information about drug of concern
Alcohol, Smoking and Substance Involvement Screening Test (**ASSIST)**	Up to 6 dozen items, depending on "skip outs"
Substance Use Brief Screen **(SUBS)**	4 items, preliminary testing in primary care
Rapid Opioid Dependence Screen **(RODS)**	8 items, good sensitivity/specificity
Michigan Alcohol Screening Test (**MAST)**	10 items, severity measure
Alcohol Use Disorders Identification Test **(AUDIT)**	10 items, well-validated

Need to screen and rapidly diagnose to treat OUD….

- Brief screeners for general drug use are good but for starting MOUD you have to know if they have moderate to severe OUD diagnosis
- If we could rapidly screen and diagnose OUD then could can rapidly start MOUD, similar to premise of Rapid ART start for HIV..

ADDICTION

SSA SOCIETY FOR THE STUDY OF ADDICTION

ADDICTION DEBATE

doi:10.1111/add.14546

Measurement-based care using DSM-5 for opioid use disorder: can we make opioid medication treatment more effective?

John Marsden[1], Betty Tai[2], Robert Ali[3], Lian Hu[2,4], A. John Rush[5,6,7] & Nora Volkow[2]

Addictions Department, Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK,[1] National Institute on Drug Abuse, National Institutes of Health, Rockville, MD, USA,[2] Discipline of Pharmacology, School of Medicine, The University of Adelaide, South Australia,[3] The Emmes Corporation, Rockville, MD, USA,[4] Duke-National University of Singapore, Singapore,[5] Department of Psychiatry, Duke University Medical School, Durham, USA[6] and Department of Psychiatry, Texas Tech Health Sciences Center, TX, USA[7]

Need to screen and rapidly diagnose to treat OUD….

- Brief screeners for general drug use are good but for starting MOUD you have to know if they have moderate to severe OUD diagnosis
- If we could rapidly screen and diagnose OUD then could can rapidly start MOUD, similar to premise of Rapid ART start for HIV..

ADDICTION

SSA SOCIETY FOR THE STUDY OF ADDICTION

ADDICTION DEBATE

doi:10.1111/add.14546

Measurement-based care using DSM-5 for opioid use disorder: can we make opioid medication treatment more effective?

John Marsden[1], Betty Tai[2], Robert Ali[3], Lian Hu[2,4], A. John Rush[5,6,7] & Nora Volkow[2]

Addictions Department, Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK,[1] National Institute on Drug Abuse, National Institutes of Health, Rockville, MD, USA,[2] Discipline of Pharmacology, School of Medicine, The University of Adelaide, South Australia,[3] The Emmes Corporation, Rockville, MD, USA,[4] Duke-National University of Singapore, Singapore,[5] Department of Psychiatry, Duke University Medical School, Durham, USA[6] and Department of Psychiatry, Texas Tech Health Sciences Center, TX, USA[7]

- through doing research to start buprenorphine , a screener was born….

Published in final edited form as:

J Correct Health Care. 2015 January ; 21(1): 12–26. doi:10.1177/1078345814557513.

Validation of a Brief Measure of Opioid Dependence: The Rapid Opioid Dependence Screen (RODS)

Jeffrey A. Wickersham, PhD[1], **Marwan M. Azar, MD**[1], **Christopher M. Cannon, MPH**[2], **Frederick L. Altice, MD**[1,3], and **Sandra A. Springer, MD**[1]

Published in final edited form as:

J Correct Health Care. 2015 January ; 21(1): 12–26. doi:10.1177/1078345814557513.

Validation of a Brief Measure of Opioid Dependence: The Rapid Opioid Dependence Screen (RODS)

Jeffrey A. Wickersham, PhD[1], **Marwan M. Azar, MD**[1], **Christopher M. Cannon, MPH**[2], **Frederick L. Altice, MD**[1,3], and **Sandra A. Springer, MD**[1]

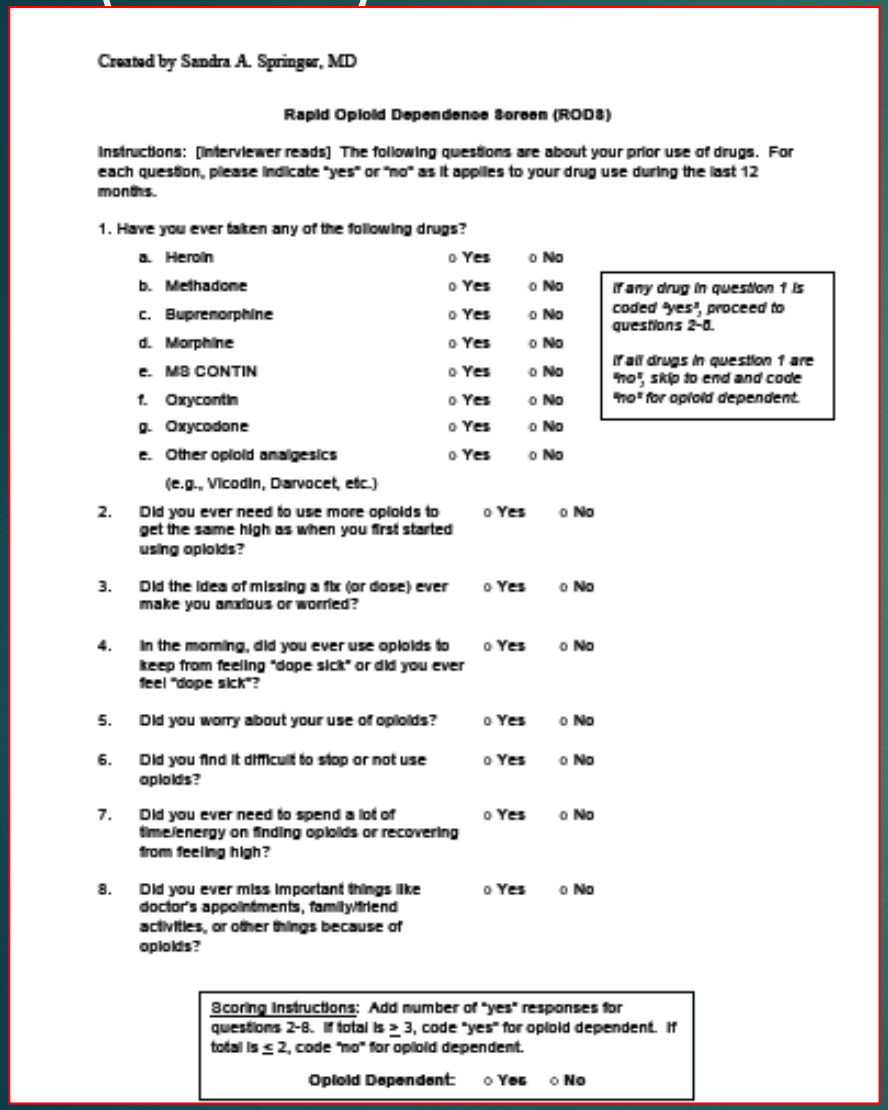
Journal of Correctional Health Care
2020, Vol. 26(2) 194

DOI: 10.1177/1078345820905750
journals.sagepub.com/home/jcx
SAGE

Erratum to Validation of a Brief Measure of Opioid Dependence: The Rapid Opioid Dependence Screen (RODS)

Wickersham, J. A., Azar, M. M., Cannon, C. M., Altice, F. L., and Springer, S. A. (2015). Validation of a Brief Measure of Opioid Dependence: The Rapid Opioid Dependence Screen (RODS). *Journal of Correctional Health Care.* 21(1), *12-26.* DOI: 10.1177/1078345814557513

Rapid Opioid Dependence Screen (RODS)



Created by Sandra A. Springer, MD

Rapid Opioid Dependence Screen (RODS)

Instructions: [interviewer reads] The following questions are about your prior use of drugs. For each question, please indicate "yes" or "no" as it applies to your drug use during the last 12 months.

1. Have you ever taken any of the following drugs?

a.	Heroin	o Yes	o No
b.	Methadone	o Yes	o No
c.	Buprenorphine	o Yes	o No
d.	Morphine	o Yes	o No
e.	MS CONTIN	o Yes	o No
f.	Oxycontin	o Yes	o No
g.	Oxycodone	o Yes	o No
e.	Other opioid analgesics (e.g., Vicodin, Darvocet, etc.)	o Yes	o No

If any drug in question 1 is coded "yes", proceed to questions 2-8.

If all drugs in question 1 are "no", skip to end and code "no" for opioid dependent.

2. Did you ever need to use more opioids to get the same high as when you first started using opioids? o Yes o No
3. Did the idea of missing a fix (or dose) ever make you anxious or worried? o Yes o No
4. In the morning, did you ever use opioids to keep from feeling "dope sick" or did you ever feel "dope sick"? o Yes o No
5. Did you worry about your use of opioids? o Yes o No
6. Did you find it difficult to stop or not use opioids? o Yes o No
7. Did you ever need to spend a lot of time/energy on finding opioids or recovering from feeling high? o Yes o No
8. Did you ever miss important things like doctor's appointments, family/friend activities, or other things because of opioids? o Yes o No

Scoring Instructions: Add number of "yes" responses for questions 2-8. If total is ≥ 3, code "yes" for opioid dependent. If total is ≤ 2, code "no" for opioid dependent.

Opioid Dependent: o Yes o No

- 8 questions created by Dr. Springer and used to assess opioid dependence, validated with the MINI[1]
- Used to safely initiate buprenorphine at time of release from prison or jail[1-3]
- Used to identify patients eligible to start extended-release naltrexone in prison or jail **before** release[4,5]

1. Wickersham. J Correct Health Care. 2015;21:12. 2. Springer. J Urban Health. 2010;87:592. 3. Springer. PLoS One. 2012;7:e38335.
4.. Springer. J Acquir Immune Defic Syndr. 2018;78:43 5. DiPaola. Contemp Clin Trials. 2014;39:256.

Initiation of Screening and diagnosis (RODS) of OUD leads to immediate access to MOUD!

Journal of Urban Health: Bulletin of the New York Academy of Medicine, Vol. 87, No. 4
doi:10.1007/s11524-010-9438-4

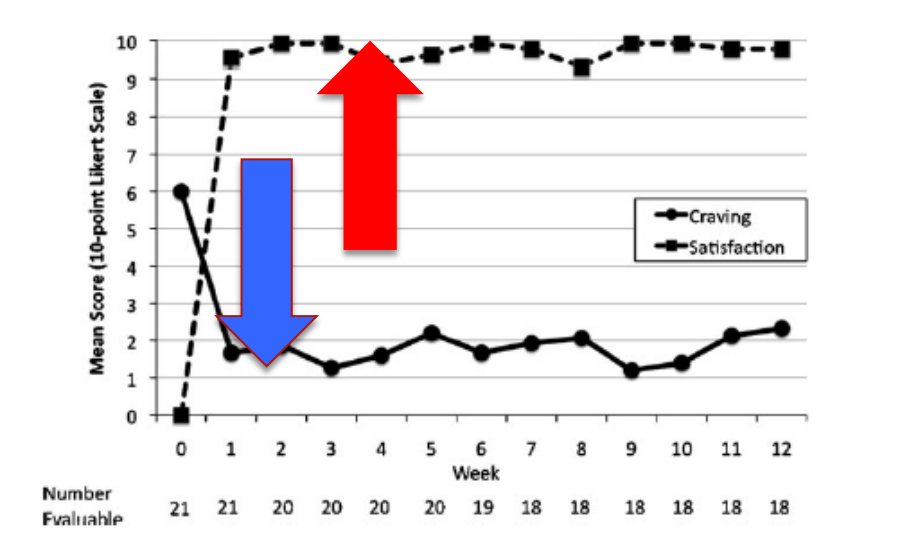
Improved HIV and Substance Abuse Treatment Outcomes for Released HIV-Infected Prisoners: The Impact of Buprenorphine Treatment

Sandra Ann Springer, Shu Chen, and Frederick L. Altice

OPEN ACCESS Freely available online PLoS one

Retention on Buprenorphine Is Associated with High Levels of Maximal Viral Suppression among HIV-Infected Opioid Dependent Released Prisoners

Sandra A. Springer[1*], Jingjun Qiu[1], Ali Shabahang Saber-Tehrani[1], Frederick L. Altice[1,2,3]



CLINICAL SCIENCE

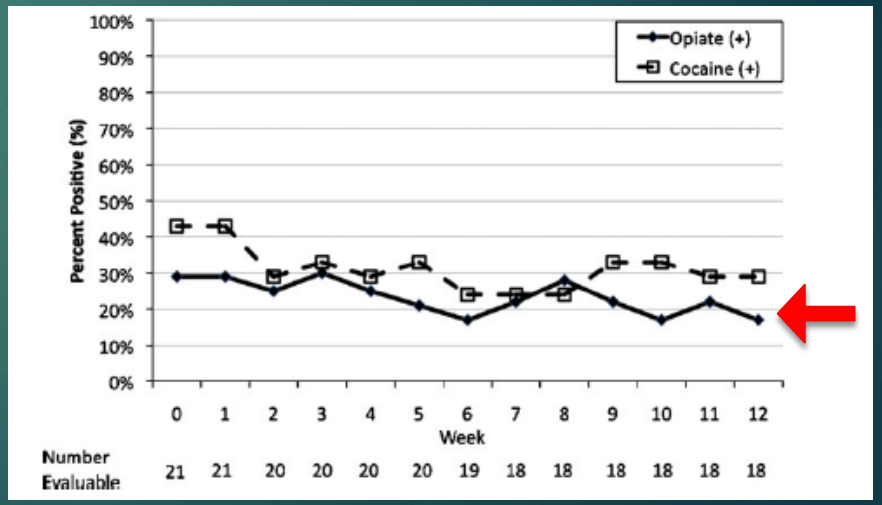
Extended-Release Naltrexone Improves Viral Suppression Among Incarcerated Persons Living With HIV With Opioid Use Disorders Transitioning to the Community: Results of a Double-Blind, Placebo-Controlled Randomized Trial

Sandra A. Springer, MD,† Angela Di Paola, MS,‡ Marwan M. Azar, MD,* Russell Barbour, PhD,† Breanne E. Biondi, MPH,* Maureen Desabrais, MEd,§ Thomas Lincoln, MD,§ Daniel J. Skiest, MD,§ and Frederick L. Altice, MD*†‖¶*

CLINICAL SCIENCE

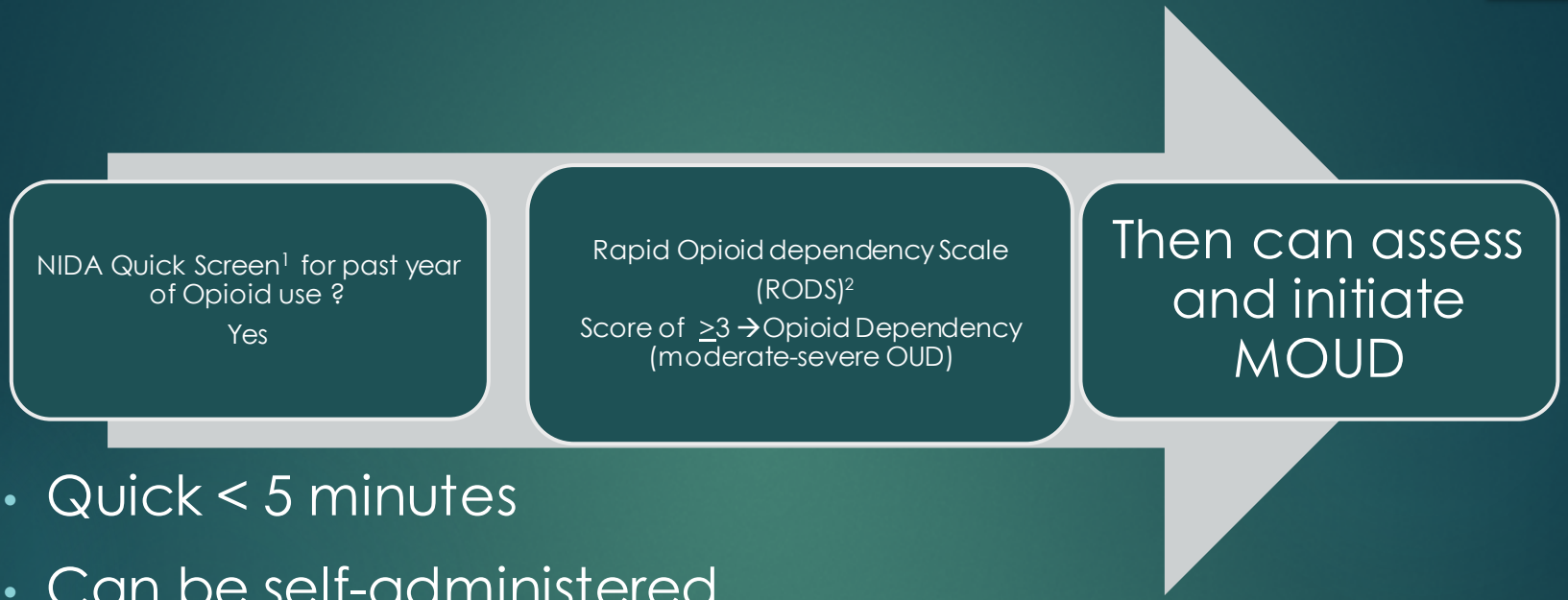
Extended-release Naltrexone Improves Viral Suppression Among Incarcerated Persons Living with HIV and Alcohol use Disorders Transitioning to the Community: Results From a Double-Blind, Placebo-Controlled Trial

Sandra A. Springer, MD,† Angela Di Paola, MS,‡ Russell Barbour, PhD,† Marwan M. Azar, MD,* and Frederick L. Altice, MD*†§‖*



And improved HIV outcomes!

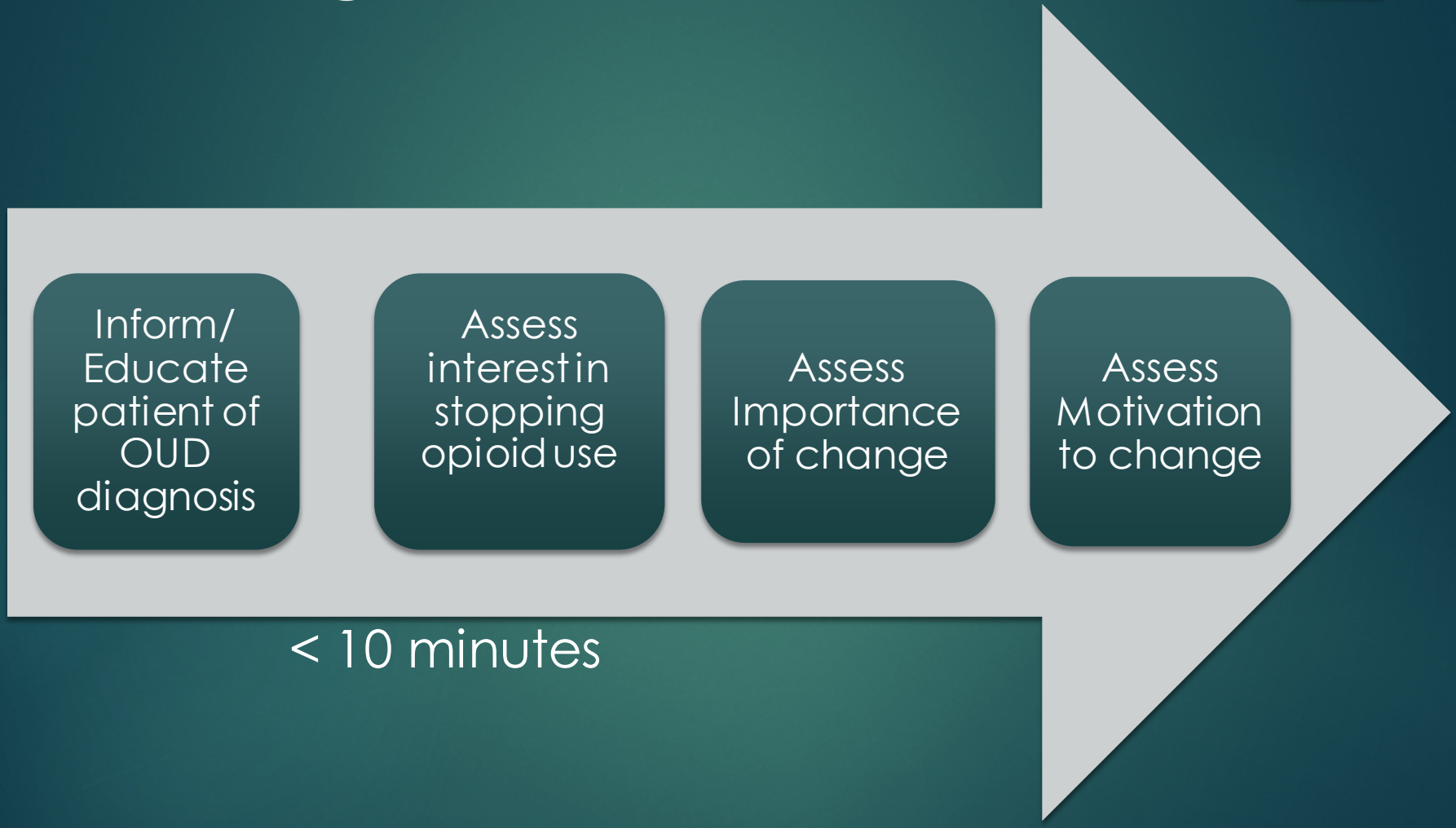
Screening for OUD Measurement Based Care (MBC)



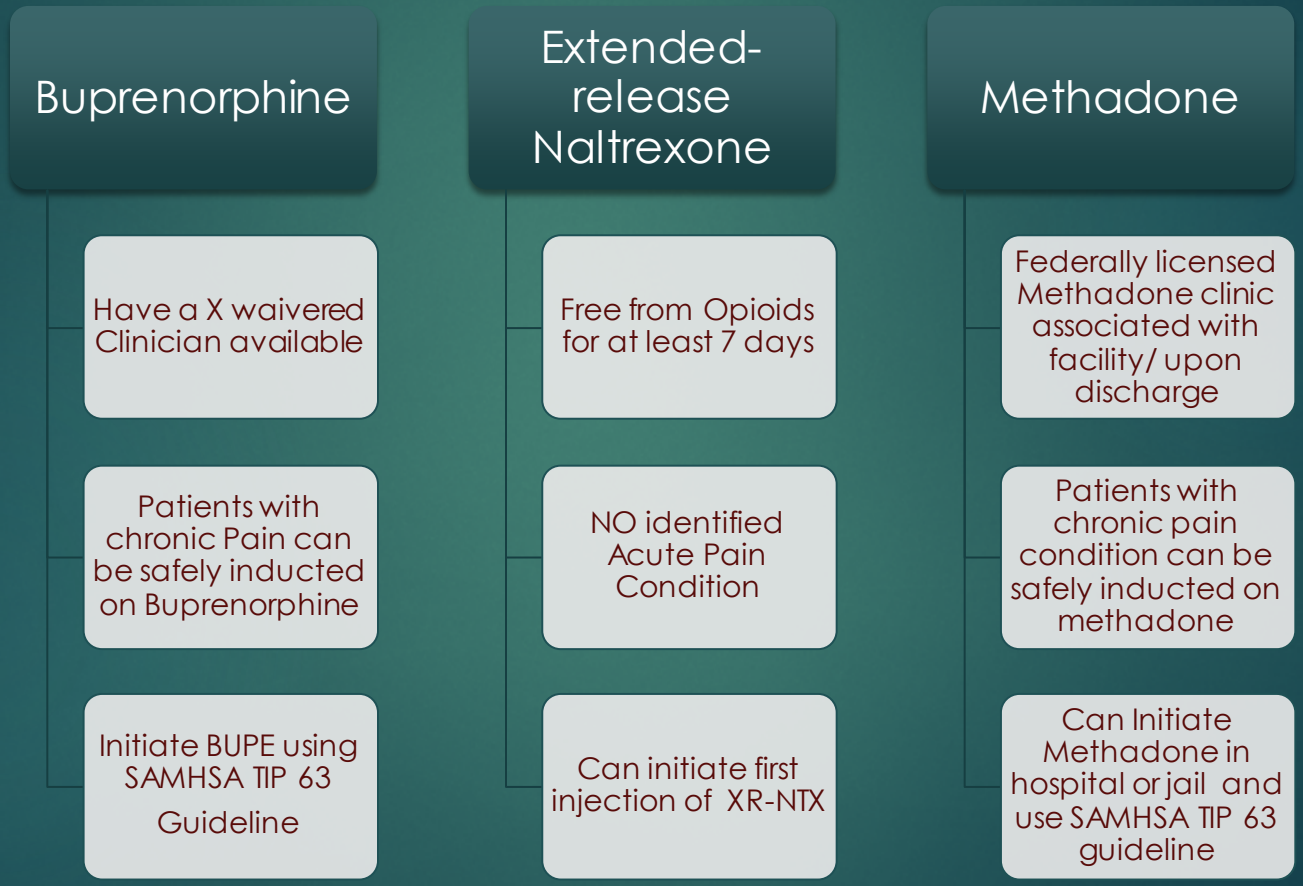
- Quick < 5 minutes
- Can be self-administered
- On iPad / paper / ACASI
- Used for BUP & XR-NTX initiation in jails/ prisons/ post-release/ hospitals[3-6]
- Now being used to start Sublocade in hospital settings

1/. NIDA. Resource Guide: Screening for Drug Use in General Medical Settings. 2012.; 2. Wickersham et al, **Springer** S. RODS. J J Correctional Health Care. 2014.; 3. Springer et al . JUH. 2010. 4; Springer et al. PLOS ONE. 2012. 5. Springer et al. JAIDS 2018; 66/ DiPaola a et al. Springer. CCT 2014 7. Marsden et al, Addiction. 2019

Brief Intervention: Assessing Readiness for MOUD



Treatment Initiation (or Referral) Selection of Form of MOUD

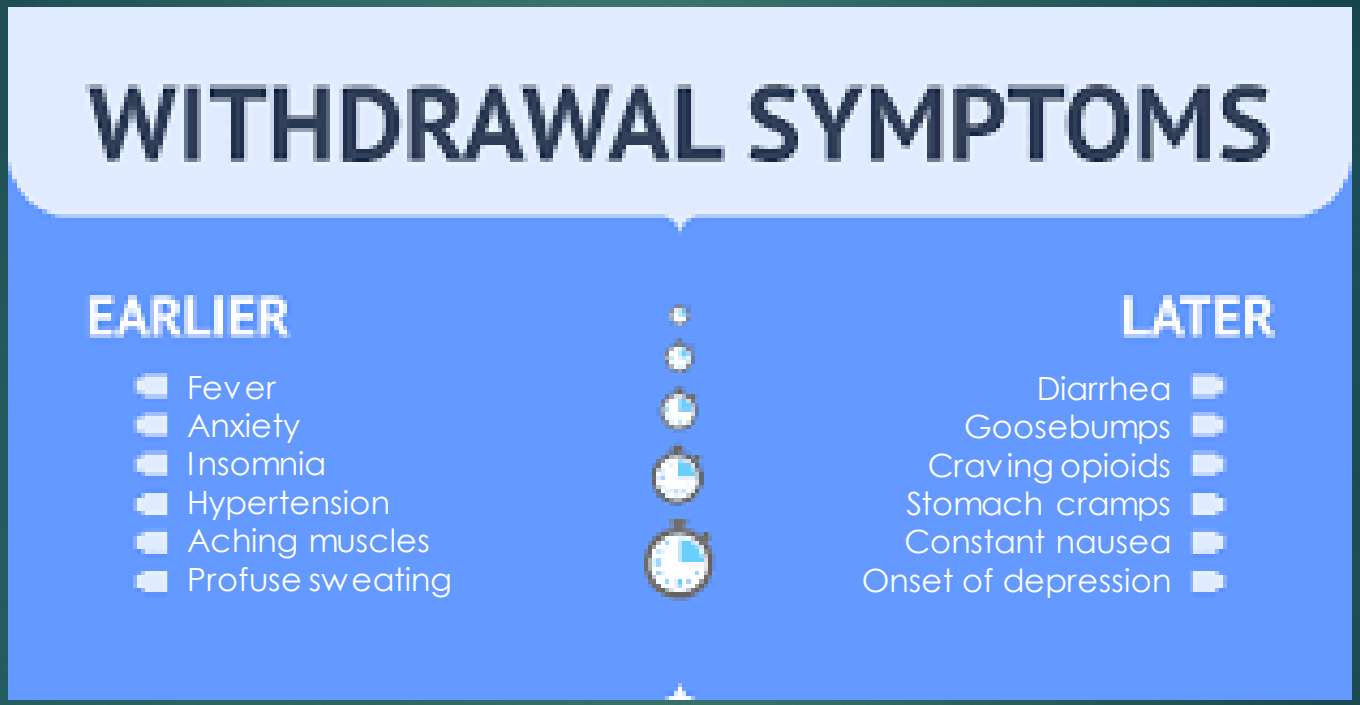


1. Liebschutz et al. JAMA Internal Medicine 2014. ; 2. Englander et al. J Hosp Med 2017.; 3. Trowbridge et al. JSAT 2017; 4. Springer et al. JUH; 5. Springer PLOS ONE; 6. Springer JAIDS . 2018

Not just OUD diagnosis but it is also critical to recognize opioid withdrawal and overdose

- Need to be able to recognize opioid withdrawal
- Start treatment with buprenorphine or methadone for withdrawal
- After acute withdrawal improved then can discuss maintenance treatment
- Also discuss in all situations additional harm reduction services like **overdose prevention** with **naloxone**, **safe injection procedures**
- Ensure they have naloxone prescription or actual preferably naloxone prior to discharge etc.

Opioid Withdrawal Signs

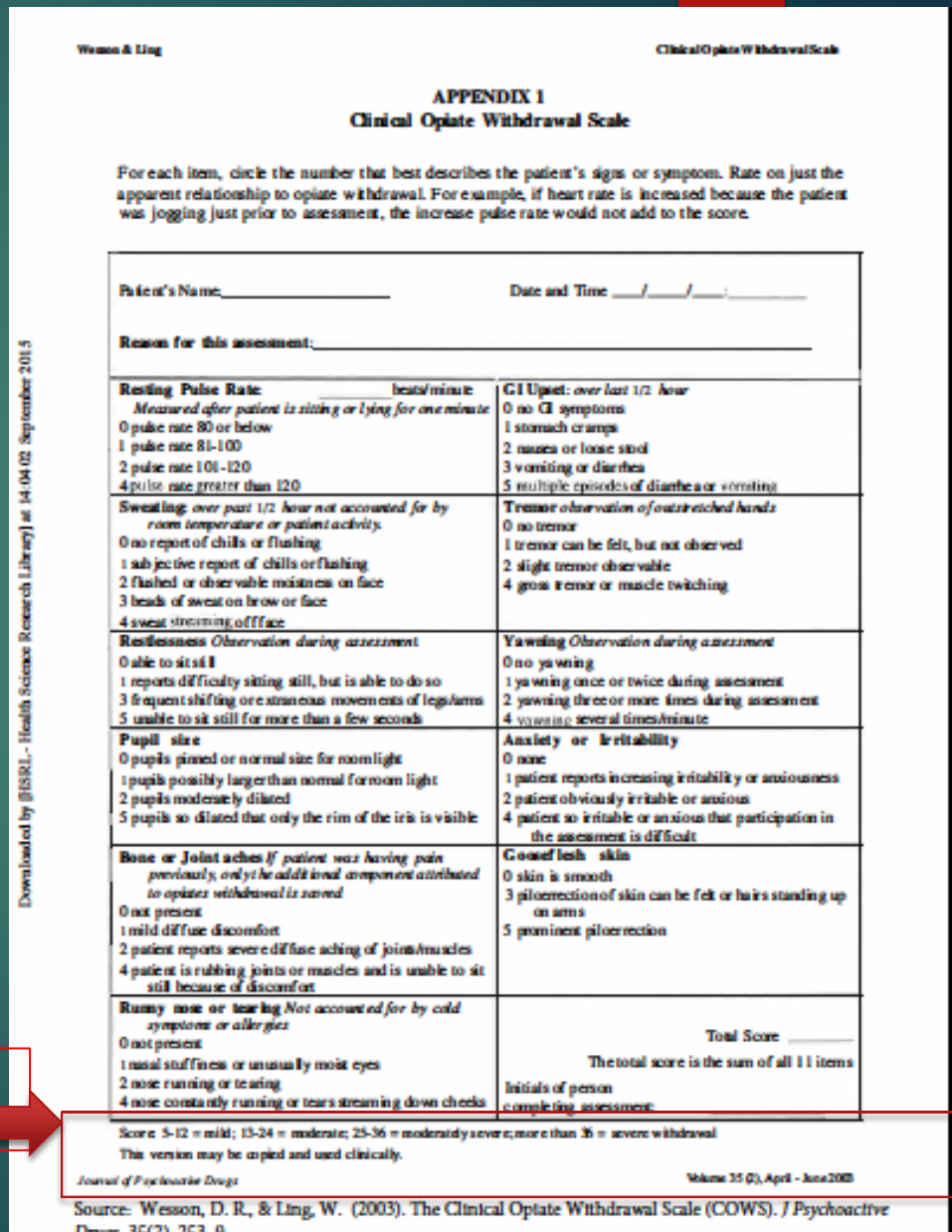


Clinical Opioid Withdrawal Scale (COWS)

- Validated scale to identify level of withdrawal from opioids
- Non-clinicians can use
- Easy scoring*
- Identifies who can start Buprenorphine/Methadone to treat withdrawal immediately

https://www.drugabuse.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf

Score ≥ 5= withdrawal



Wesson & Ling — Clinical Opiate Withdrawal Scale

APPENDIX 1
Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date and Time ___/___/___:_____

Reason for this assessment:_____

Resting Pulse Rate: _____ beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset:** *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment:

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

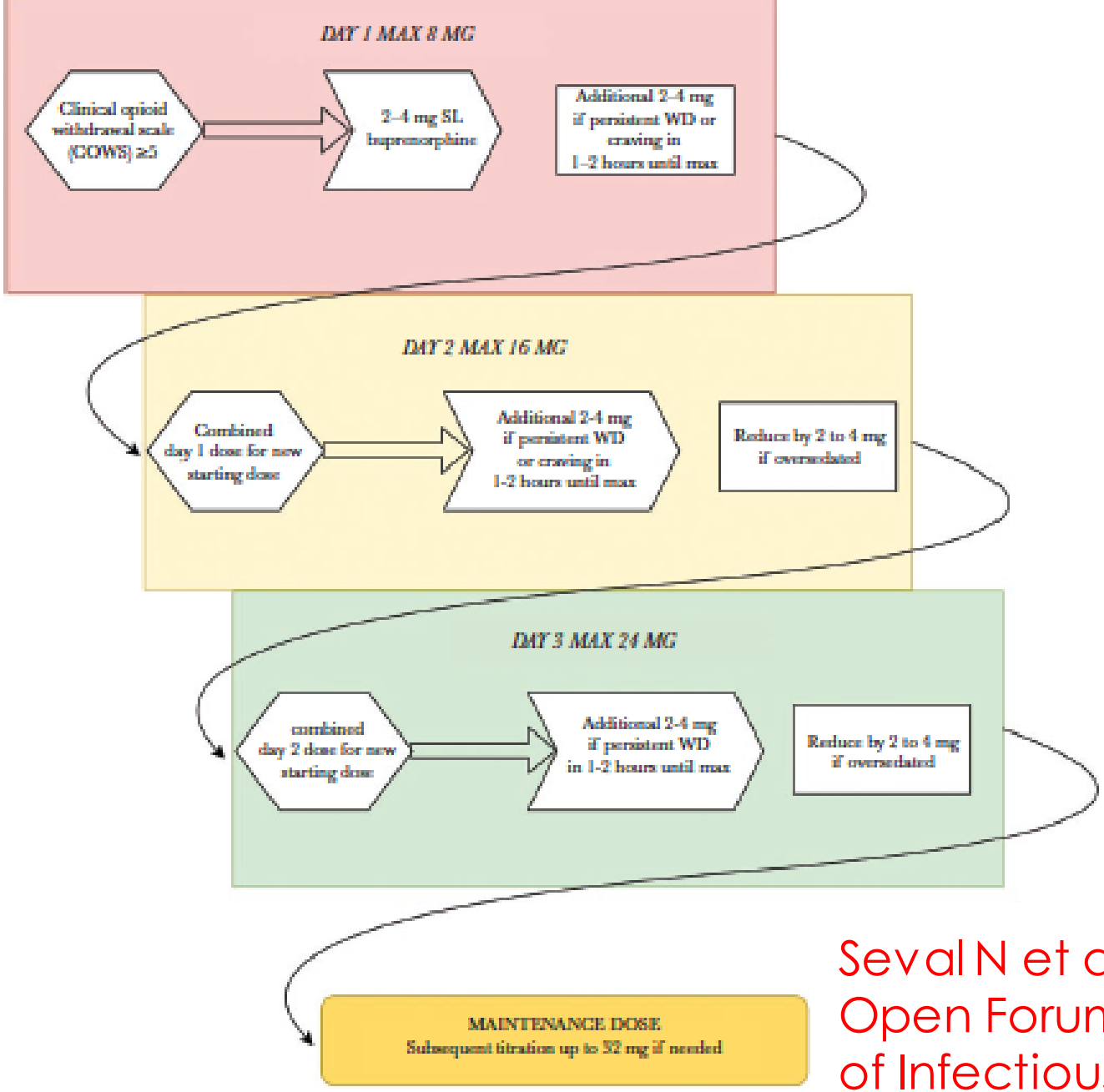
This version may be copied and used clinically.

Journal of Psychoactive Drugs Volume 35 (2), April - June 2003

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive*

Initiation of Withdrawal treatment

- Buprenorphine
- Methadone



Seval N et al Open Forum of Infectious Disease 2019

Figure 1. Flow diagram for sublingual buprenorphine induction in persons with active opioid addiction.

FREE Training Resources for Obtaining Buprenorphine X-Waiver

American Society for Addiction Medicine https://elearning.asam.org/buprenorphine-waiver-course

SAMHSA - Providers Clinical Support System https://pcssnow.org/medication-assisted-treatment/

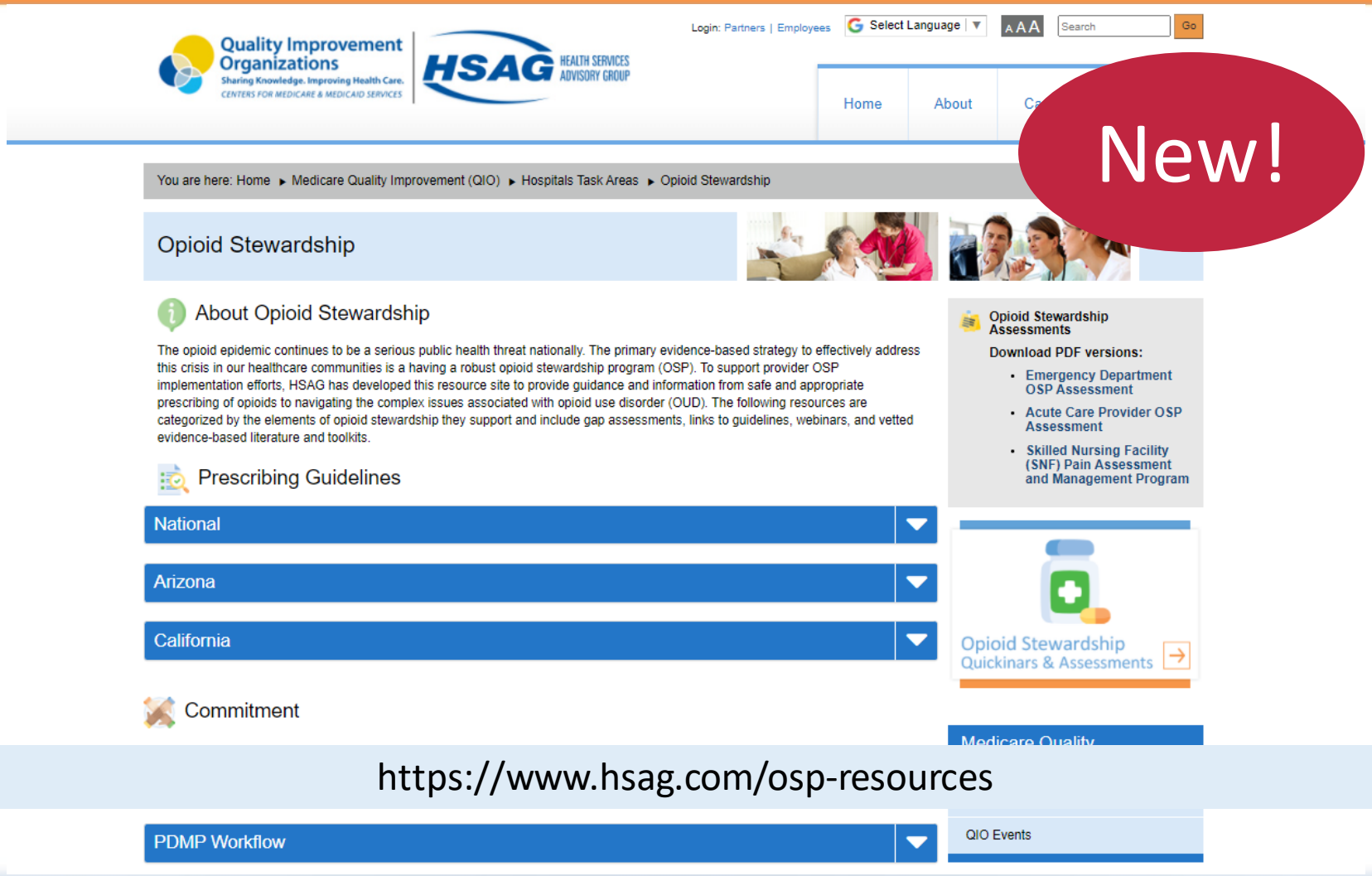
Summary

- Screening and Diagnosis of opioid use, withdrawal, OUD & overdose is critical in all settings
- Provide withdrawal treatment as a gateway to maintenance treatment
- Can be integrated in all settings
- Screening for opioid use can improve not only reduction in overdose but also improve other outcomes like HIV, HCV and other infectious disease outcomes.
- Include harm reduction with Naloxone, overdose education, safe injection procedures
- Meet people where they are at **WHERE EVER THEY** are

Thank you!

QUESTIONS?

Opioid Stewardship Resource Site

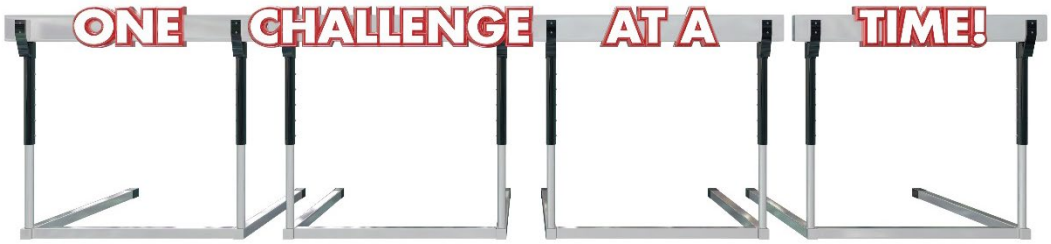


https://www.hsag.com/osp-resources

Action Items by Next Quickinar (1/27/2022)

1. Review and choose 2 screening/assessment tools for OUD (RODS, Opioid Risk Tool, COWS) best suited to your setting.

2. Trial the chosen tools with 5 patients.



OSP "Quickinar" Schedule: Mark Your Calendars

OSP Quickinar Kickoff: Introduction to Opioid Stewardship and Quickinar Format Thursday, October 21, 2021 | 10:30–11:00 a.m. PT	**Partnering with Pharmacists for ongoing Medication Management** Thursday, February 10, 2022 | 10:30–11:00 a.m. PT
OSP Assessment Overview Thursday, October 28, 2021 | 10:30–11:00 a.m. PT	**Double Trouble: Benzos and Opioids | Harm Reduction with Naloxone** Thursday, March 10, 2022 | 10:30–11:00 a.m. PT
Interpreting the OSP Assessment Results/Developing an Action Plan Thursday, November 18, 2021 | 10:30–11:00 a.m. PT	**MAT: Prescribing Buprenorphine** Thursday, April 14, 2022 | 10:30–11:00 a.m. PT
Developing a Dashboard Thursday, December 9, 2021 | 10:30–11:00 a.m. PT	**Getting Patient Buy-in through Education** Thursday, May 12, 2022 | 10:30–11:00 a.m. PT
Screening Patients for OUD Risk and Opioid Withdrawal Thursday, January 13, 2022 | 10:30–11:00 a.m. PT	**Reevaluating Your Program and Celebrating Success** Thursday, May 26, 2022 | 10:30–11:00 a.m. PT
A Good Discharge Plan for Pain Management with Opioids Thursday, January 27, 2022 | 10:30–11:00 a.m. PT	

Register for the entire OSP "Quickinar" series today!

bit.ly/OpioidStewardshipProgramQuickinars

HSAG Health Services Advisory Group

Please Take 5 Seconds and Let Us Know

We want this call to be meaningful to you, so we need your input.

At the end of the webinar, you will be asked **one question** to determine if this call equipped your organization to begin implementing opioid stewardship practices.

Thank you!

Claudia Kinsella: ckinsella@hsag.com

Jeff Francis: jfrancis@hsag.com




CMS Disclaimer

This material was prepared by Health Services Advisory Group (HSAG), a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. QN-12SOW-XC-01112022-01