Appendix 6

Example of activities to be conducted in healthcare settings:

Prevention Strategy	Example Activities

1A. Linkage to and retention in care	• Implementing universal screening and linkage to care protocols via multidisciplinary teams, including navigators and case management for SUDs, across clinical settings including emergency departments, inpatient settings, infectious disease clinics and through primary care.
	• Building bidirectional connections across clinical, social/behavioral service settings, and public safety.
	  ○ Building capacity to broadly screen, diagnose, and connect hospitalized patients to OUD/StUD care in the community upon hospital discharge.
	  ○ Expanding options for patient-centered long-term access to outpatient OUD/StUD care for adolescents and adults, including building connections to provide MOUD as well as behavioral health linkages and long-term recovery.
	• Enhancing telehealth capabilities in local healthcare sites to broaden access to care especially for underserved populations and those at higher risk of overdose.
	• Developing electronic resource hubs such as a comprehensive database of clinicians and facilities offering treatment located within the local jurisdiction and adjourning localities, a complete listing of behavioral health networks located within the jurisdiction and possibly also adjourning localities, locations of local syringe service programs (SSPs) as well as other harm reduction service providers, including an inventory of services available at each facility.

2A. Harm reduction	• Partnering with clinicians to ensure persons at high risk of an opioid overdose have access to naloxone, either via a prescription or direct provision.
	• Providing access to harm reduction services in health systems.
	  ○ Providing fentanyl test strips to PWUD engaging in healthcare
	  ○ Co-locating SSPs in health systems
	• Ensuring clinicians understand local SSP resources and understand how to help PWUD access services.
	• Equipping clinicians with education on safer use practices (e.g., safer injection, using with others, etc.) to enhance counseling for PWUD.

3A. Stigma reduction (optional)	• Implementing anti-stigma education for clinicians to address stigma about PWUID, harm reduction services, and recovery.
	• Organizing and integrating clinician and health system training on the role of stigma for the provision of pain management and SUD care, including how stigmatizing practices may exacerbate inequities in care access and delivery, and to implement anti-stigma didactic education.
	  ○ Training for healthcare personnel to ensure person-first and anti-stigmatizing language when engaging with patients with SUDs.
	  ○ Training incorporating engagement with people with lived experience of SUDs to reduce stigma and humanize the lived

	experience of people living with SUDs among healthcare personnel. • Examination of policies and protocols for potentially unfair or discriminatory treatment of people with pain and/or OUD to ensure that access to pain medication and treatment for SUDs is equitable across the healthcare system.
4A. Clinician and health systems best practices	• Advancing clinician best practices for acute, subacute, and chronic pain treatment including opioid prescribing, as described in the *CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022.* o Developing health system- or practice-level policies that align with the 2022 Guideline recommendations. • Identifying and addressing inequities in pain management practices, SUD diagnosis and care. • Building comfort and confidence among clinicians to support provision of pain care as well as MOUD. • Training, implementation, and adoption of trauma-informed practices into health system and clinical staff policies and standards. • Expanding fundamental knowledge of screening and care for polysubstance use, OUD, and StUD, with special attention paid to raising awareness of specific community/local options for care.
5A. Health IT enhancements (optional)	• Building formal frameworks and mechanisms to facilitate actionable and computable sharing of state-collected data for local implementation and integration into health system EHRs. • Supporting creation of electronic CDS tools and/or quality improvement measures to bring tailored data into EHRs in an actionable and computable format for clinicians thereby streamlining clinical workflow. Examples may include but are not limited to: o Morphine milligram equivalent calculators; o EHR prompts and order sets to prescribe/offer naloxone; o Templates for clinical notes and referrals to SUD care.