

# Addressing Opioid Use in Rural Communities: Examples from Critical Access Hospitals

Flex Monitoring Team  
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## KEY FINDINGS

- Critical Access Hospitals' (CAHs') opioid strategies align with key areas of hospital activity including quality improvement, service expansion, population health, and community benefit.
- Data from prescription drug monitoring programs, electronic health records, and providers can help CAHs identify problematic opioid prescribing practices and meet the needs of patients presenting with opioid use disorders (OUDs).
- CAHs can improve their quality of care and reduce the supply of opioids in their communities by implementing prescribing guidelines and oxy-free emergency departments (EDs).
- Efforts to reduce the amount of opioids prescribed by hospital providers are improved by the development of alternative pain management treatment options.
- Medication-assisted treatment (MAT), an evidence-based intervention, can be implemented by CAHs in their primary care practices and EDs to improve care for patients with OUDs.

## INTRODUCTION

The opioid epidemic continues to have a devastating impact in the U.S., especially in rural areas disproportionately affected by a lack of infrastructure that provides treatment for opioid use disorders (OUDs).<sup>1,2</sup> Critical Access Hospitals (CAHs), often the hubs of local systems of care, can play an important role in addressing OUDs. Using the substance use framework developed for the Flex Monitoring Team's earlier study of CAH substance use strategies (Figure), this brief highlights examples of strategies adopted by CAHs to combat opioid use in their communities. It also identifies resources that State Flex Programs can use to support CAHs in their efforts with this challenging population health issue.

## BACKGROUND

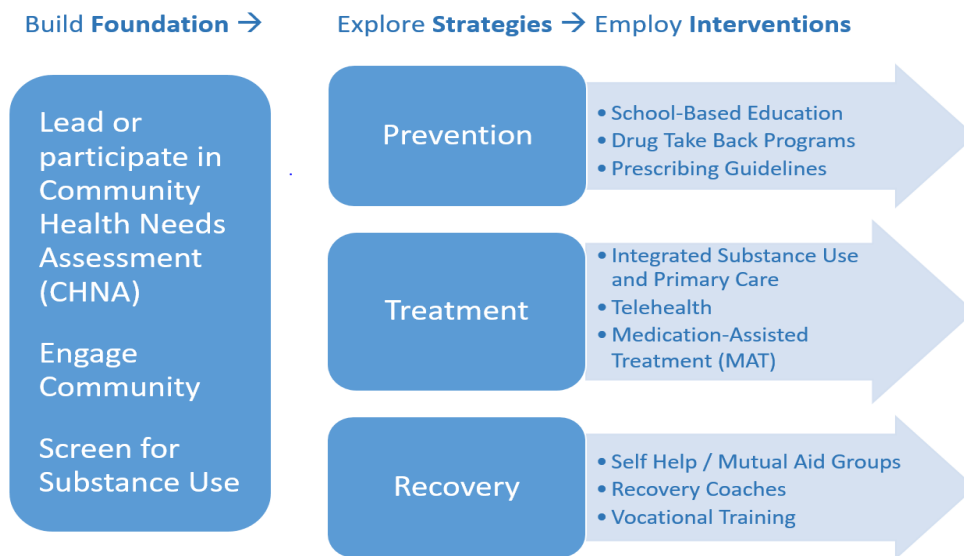
Overprescribing and non-medical use of opioids has contributed to a public health epidemic across all communities. Rural areas, in particular, have reported an increased prevalence of opioid use, with accompanying increases in heroin, illicitly manufactured fentanyl and other synthetic opioids, polysubstance use involving opioids, benzodiazepines, and methamphetamine.<sup>3-6</sup>

Rural areas suffer from chronic shortages of OUD treatment services, including a shortage of providers approved to prescribe buprenorphine, a partial opioid agonist medication widely recognized as an evidence-based standard for the treatment of OUDs.<sup>7-9</sup> As a result, rural residents have limited access to OUD treatment, travel farther to access care, and have fewer choices when selecting providers.<sup>9-12</sup> At the same time, hospitals contribute to the opioid problem through the overuse of opioid pain medications for pain issues and the underuse of alternative pain medications and treatment.<sup>21</sup>

In the recent Flex Monitoring Team briefing paper, *Engaging Critical Access Hospitals in Addressing Rural Substance Use*,<sup>13</sup> we laid out a framework (Figure) that encompasses three foundational activities (assessing and prioritizing community health needs, engaging the community, and screening for substance use) and a three-pronged set of prevention, treatment,

and recovery strategies for CAHs to address substance use. This framework applies equally to opioid use. Prevention programs focus on reducing the initiation of opioid use and working holistically with those at-risk for using opioids. Treatment programs provide care for individuals with OUDs and include medication-assisted treatment (MAT), behavioral therapies and counseling, and integrated substance/opioid use and primary care services. Recovery programs offer education, peer recovery support, vocational training, social opportunities, transportation, and housing to intervene in the patterns of high-risk behavior that exacerbate opioid use and offer affected persons a way to overcome their dependence.

**Figure:** Critical Access Hospital Substance Use Framework



Source: Gale, J, Kahn-Troster, S, Croll, Z, First, N. *Engaging Critical Access Hospitals in Addressing Rural Substance Use.*<sup>13</sup>

## METHODOLOGY

To identify participants for this study, the Flex Monitoring Team used a convenience sample of CAHs engaged in opioid initiatives. Hospitals were selected based on input from staff at State Flex Programs (SFPs) and State Offices of Rural Health (SORHs), as well as from extensive online searches of hospital websites and community health needs assessments, news articles, government sources, and research literature. From the resulting list of over 70 CAHs, we narrowed to a final cohort of 11 hospitals (Appendix A) by prioritizing programs that (1) had already launched versus those still in planning stages; (2) were geographically diverse (representative of all U.S. Census Bureau regions); and (3) showed significant depth, innovation, and potential to be adopted by other CAHs. We conducted telephone interviews with key informants that included hospital administrators, clinicians, and program staff using semi-structured protocols. When relevant, we gathered additional data through email correspondence, hospital websites, peer-reviewed literature, and program implementation plans.

## FINDINGS

For this study, we focused on a subset of the substance use framework activities: community engagement; programs and guidelines to manage and improve opioid prescribing (prevention); MAT and alternative pain management services (treatment); and peer coaching services

(recovery). These are programs that can be implemented by CAHs as part of their quality improvement initiatives (prescribing guidelines), service mix (MAT and alternative pain management programs), and population health and community benefit activities (community engagement and recovery services).

### **Community Engagement**

The following examples describe strategies developed by two CAHs to engage key stakeholders and community members, leverage local resources, and reduce duplication and overlap across services.

*Prairie Ridge Health (Prairie Ridge), Columbus, Wisconsin*, spearheaded Project C.L.E.A.N. (Community Leaders Eliminating the Abuse of Narcotics) in 2012 to reduce opioid use through open conversations and education about the safe use of prescription opioids. Responding to data from Prairie Ridge's Emergency Department (ED) showing high prescribing rates for patients with low levels of pain, a group of providers and team members formed a coalition to reduce the misuse of prescription opioids and enhance education to patients and the communities about the safe use of prescription opioids. Project C.L.E.A.N. team members, led by an ED physician, the ED manager, and a representative from law enforcement, make presentations to area high schools on the risks of opioid use and share videos of community members whose lives have been impacted by OUDs. Project C.L.E.A.N. also conducts ongoing community education for adults.

*Summit Pacific Medical Center (Summit Pacific), Elma, Washington*, leads the Grays Harbor County Opioid Response Consortium in its efforts to address OUDs and associated social determinants of health. The consortium was founded under a 2018 Health Resources and Services Administration (HRSA) Rural Community Opioid Response Program (RCORP) Planning Grant, which continued with an RCORP Implementation Grant in 2019. The Summit Pacific-led consortium consists of four treatment centers, an in-home service provider, a syringe exchange program, a district hospital, a community health clinic, a correctional center, and a child and family advocacy center, that engages with over 45 other county organizations. The consortium identified nine project areas during its planning year to guide its work:

- education and community outreach;
- continuing education/training (e.g., helping providers obtain buprenorphine waivers);
- harm reduction (e.g., replacing an RV used to provide mobile syringe exchange services);
- workforce development (e.g., funding interns obtaining behavioral health degrees);
- transportation (e.g., providing patients with bus passes to get to their appointments);
- housing (e.g., assisting those in the drug court system to find stable housing);
- peer support (e.g., operating recreational recovery support groups);
- legislative regulations (e.g., educating policy makers/legislators); and
- collaboration/communication between partners.

### **Prevention Strategies**

Successful prevention strategies address modifiable risk and protective factors and are adapted to the unique characteristics of the rural communities in which they are implemented. Five CAHs

in our study developed prevention strategies to reduce the prescription opioid drug supply by implementing prescribing guidelines in their EDs and other clinical settings and/or creating an oxy-free ED to change provider prescribing habits and reduce the prescribing of opioids for patients with chronic pain.

*Clearwater Valley Hospital and Clinics (Clearwater), Orofino, Idaho*, participated in the Six Building Blocks pilot program, a team-based primary care safe prescribing program designed to facilitate changes in opioid prescribing behaviors.<sup>14</sup> The six building blocks are:

- demonstrate leadership support and develop consensus;
- revise and implement policies, patient agreements, and workflows;
- proactively track and monitor patient care;
- implement planned, patient-centered visits;
- identify and develop resources to care for complex patients; and
- measure implementation success.

To help manage patients on chronic opioid therapy, Clearwater providers participated in Project ECHO-based calls and webinars with physician pain specialists from University of Washington's School of Medicine.<sup>1</sup> Opioid improvement team members held monthly meetings to generate support from the primary care physicians (PCPs) and develop consensus on the importance of reducing patient opioid use and the opioid supply in local communities. Clearwater's opioid improvement team, which included a full-time clinician and the chief strategy officer, worked with its clinics to standardize workflows and processes and develop metrics to monitor performance. The hospital provides alternatives for patients seeking to reduce their opioid use, including occupational therapy, MAT, and integrative behavioral health. Community health workers conduct training programs on living with chronic pain. Clearwater expanded the Six Building Blocks program to an affiliated CAH and clinics following the initial pilot study.

*LincolnHealth Miles Campus (LincolnHealth), Damariscotta, Maine*, developed a program in 2011 to reduce opioid prescribing and increase the use of alternative treatments for ED patients presenting with dental pain. The ED team, led by a physician champion, implemented refresher trainings in opioid alternatives, particularly nerve blocks. The goal was to stabilize patients' acute pain until they could see a dentist to address the underlying problems. Written guidelines on the use of opioids for dental pain were implemented. These guidelines, which all staff were expected to follow, also supported providers experiencing pushback from patients. Six months after implementing the new guidelines, LincolnHealth saw a 17 percent decrease in opioid prescriptions for dental pain in the ED.<sup>15</sup> The number of ED visits for dental pain also declined from 26 to 21 per 1,000 compared to the previous year. Staff suggested these changes may indicate a decrease in drug-seeking behavior.

In 2017, *Gunnison Valley Health (Gunnison), Gunnison, Colorado*, participated in the Colorado Opioid Safety Pilot spearheaded by the Colorado Hospital Association (CHA). The pilot, now known as the Colorado ALTO (Alternatives to Opioids) Project, sought to reduce ED opioid

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<sup>1</sup> Project ECHO (Extension for Community Healthcare Outcomes) is a tele-mentoring program that connects rural providers with subject matter experts using videoconferencing technology, brief lecture presentations, and case-based learning. The goal is to improve the skills of rural providers and their ability to treat complex conditions.

prescriptions by 15 percent among the 10 participating hospitals by promoting alternative pain medications and educating patients about the risks of opioid use. CHA provided the hospitals with training materials outlining alternatives to opioids for 10 different types of pain typically seen in an ED. Gunnison's pharmacist reviewed these alternatives with ED providers to help them understand the best options for specific patient complaints. Providers were expected to use these recommended alternative pain medications as a first line of treatment for ED patients. Opioids were to be prescribed only as a last resort if the alternatives proved insufficient for the level of pain. Prior to receiving opioids, patients were required to undergo an addiction risk assessment. Gunnison's ED opioid prescribing rate declined by 31 percent during the pilot period compared to the previous year and by close to 70 percent for conditions associated with higher rates of opioid misuse. Accompanying these declines was an increase in use of alternative pain treatment options.

*Prairie Ridge's* safe prescribing program implemented prescribing restrictions in the ED. Prairie Ridge collaborated with providers to develop a tapering tool to assist patients in reducing their use of opioids. Prairie Ridge worked with their contracted ED physician group to reduce opioid prescribing by reviewing patient records to identify patients who had visited an ED (either Prairie Ridge or surrounding hospitals) more than 10 times in the past year. The records for those patients were reviewed to determine the appropriateness of prescribing practices and care. Following this review, patients received a letter outlining the purpose of the review, its results, and the extent to which patients might be better served by accessing care in settings other than the ED. Prairie Ridge reported a decrease in the number of patients seeking opioid prescriptions through the ED following receipt of these letters.

*McKenzie Health System (McKenzie), Sandusky, Michigan,* implemented an oxy-free ED policy in 2012, based on a model developed in Washington state and successfully piloted at Swedish Health Services in Seattle.<sup>16</sup> McKenzie developed the program in response to concerns raised by their ED providers about the number of patients seeking opioids through the ED. Their goal was to restrict the prescribing of narcotics, such as Oxycodone and Oxycontin, for chronic pain complaints. McKenzie reached out to local mental health agencies, the department of health, pharmacies, and law enforcement to inform them of the new oxy-free ED program, and launched a media campaign to generate awareness of the new policy emphasizing patient safety and compassionate care. The hospital developed signs for patient rooms that highlighted their oxy-free policy and informed patients that they might be prescribed alternative medications, particularly for chronic pain. McKenzie worked with local PCPs to help patients develop and adhere to pain contracts intended to curb opioid-seeking behaviors. McKenzie reported that adherence to the policy is a key to successful implementation of an oxy-free ED. As a result, it is a mandatory condition of employment for their ED providers.

### ***Treatment Strategies***

We focused on a subset of treatment strategies that can be implemented in CAH primary care and ED settings. In particular, we focused on the development of MAT which has been described as the most common and effective opioid treatment.<sup>17</sup> Three participating CAHs described the development of outpatient MAT, each with its own distinct integration strategy. We also included a CAH that developed an alternative pain management program with a partner hospital using telehealth and on-site services.

*Summit Pacific's* low-barrier walk-in MAT clinic started in February 2019 with support through Washington State Health Care Authority's State Opioid Response funding. Led by the hospital's medical director, the clinic provides buprenorphine and naltrexone initiation services to walk-in clients during established weekday hours. After initiating treatment, the clinic refers patient to staff physicians, the majority of whom have completed the Substance Abuse and Mental Health Services Administration approval process to prescribe buprenorphine. Summit Pacific's clinic uses a nurse care manager model in which a registered nurse conducts assessments and screenings and the provider team administers care under the direction of the hospital's medical director.<sup>18</sup> Patients also receive support from a care navigator to address other factors that may impact their opioid use or its treatment such as housing and transportation. Demand exceeded expectations during the first several months and Summit Pacific has received another HRSA grant to expand and move its services to the primary care clinic.

*WVU Medicine Barnesville Hospital (Barnesville), Barnesville, Ohio* provides MAT through Addiction Services of Eastern Ohio (ASEO), a collaboration founded in 2017 between Barnesville and four regional providers to serve adults with OUDs and other SUDs. Housed at Barnesville and funded by a HRSA grant, ASEO's outpatient program integrates MAT with harm reduction and withdrawal management services. All MAT clients receive naltrexone injections and must participate in regular outpatient counseling, generally provided on site. Staff are sourced largely from ASEO's consortium partners, which include Barnesville, a Federally Qualified Health Center (FQHC), a counseling and addiction service agency, a nonprofit health care provider, and a local mental health and recovery board. In its first three years, ASEO served over 100 clients annually. With funding ending in September 2020, ASEO plans to apply for new grants to continue its outpatient program and possibly expand to inpatient detox services.

*Bridgton Hospital (Bridgton), Bridgton, Maine* developed MAT services for pregnant women in 2011 through a partnership between two family practice physicians at Bridgton and a local counseling center. The program combined buprenorphine treatment with comprehensive maternity care, off-site therapy at the counseling center, and a support group for opioid-dependent mothers. The program scheduled joint appointments for coordinated MAT/obstetrical care, and supported 25 births annually with women on buprenorphine. A small number of the hospital's maternity and obstetric providers, along with a local case manager, provided additional support. The program's two founding physicians moved out of state in 2019, which led to a temporary pause in services. The program will resume in 2020 under the direction of a board-certified addiction medicine physician. Bridgton expects to see a reduction in patient recidivism. Patients will benefit by having multiple needs met during a single visit.

*Martha's Vineyard Hospital (MVH), Oak Bluffs, MA* has operated a successful telehealth-based pain management clinic since 2013, providing specialty consultation to island residents, thus reducing travel time and costs.<sup>19</sup> MVH contracts with the Center for Pain Management at Massachusetts General Hospital (MGH) to evaluate patients via video-conferencing four and a half days a month. MGH's providers make recommendations to patients' PCPs about procedures and pain management techniques, including physical therapy and non-opioid medications. Specialists from MGH work on-site at MVH two days per month to perform procedures such as epidural steroid injections and nerve blocks. The clinic maintains a full caseload with most follow-up care conducted by non-physician clinic staff to free physician time. The clinic provides

consultation to local PCPs on opioid tapering strategies and alternative pain management treatments. Through the mutual agreement of both hospitals, MVH handles all billing and receives the revenue generated for the telehealth visits and procedures.

### ***Recovery Strategies***

We focused on two CAHs that work collaboratively with other organizations to offer peer recovery coaching programs that help individuals with OUDs to live healthy and productive lives.

*Copley Hospital (Copley), Morrisville, Vermont* began its partnership with the North Central Vermont Recovery Center (NCVRC) in February 2019, with NCVRC providing peer recovery coaches to work with patients in Copley's ED. Within the first eight months, 100 successful referrals to peer recovery coaches were made. NCVRC coordinates the staffing of the service and has several coaches trained specifically to work in the ED. When ED patients present with signs of overdose or other opioid-related concerns, or express interest in recovery support, staff page NCVRC and a peer recovery coach arrives on-site generally within 30 minutes. These coaches provide peer support and assistance to connect patients to community support services such as housing, transportation, or food assistance. The business arrangement with NCVRC includes patient record sharing which allow Copley to flag high-risk or repeat patients. Two additional partners facilitate peer recovery efforts. A local FQHC provides embedded case management and a regional transportation agency transports patients to their appointments. State and local grants cover the costs associated with peer recovery training and wages.

*Shenandoah Memorial Hospital (Shenandoah), Woodstock, Virginia* provides peer recovery services in its ED through a longstanding partnership with the Northwestern Community Services Board (NCSB). Although traditionally supported through grant funding, NCSB has begun to bill Medicaid for peer recovery services to provide a revenue stream to sustain the program once the grant ends. ED patients presenting with opioid or substance use concerns can be referred to an on-call certified peer recovery specialist, who will follow up with the patient by phone or in person. The peer support service is driven by the needs of the patient and the specialist acts as a bridge to connect patients to available resources. NCSB employs peer recovery specialists on a full-time basis.

## **LESSONS LEARNED**

Several themes emerged from our interviews with the CAHs regarding the development and implementation of projects targeting opioid use, including alignment with hospital activity areas, communication, staff and provider buy-in, use of data, and collaboration.

### ***Alignment with Hospital Activities***

The CAHs in this study have developed successful opioid response strategies that align with ongoing hospital activities and obligations. For example, hospital efforts to implement prescribing guidelines fall within their quality improvement strategies. CAHs have a direct role to play in reducing the supply of prescription opioids in their communities by implementing opioid prescribing guidelines for common conditions that present in EDs (e.g., dental pain) and primary care settings (e.g., chronic pain). Similarly, alternative pain management services provide a way to help reduce opioid prescribing by offering non-opioid options for pain management. CAHs can integrate MAT and other OUD/SUD services into their primary care and ED settings



to increase access to this important treatment modality. The other strategies we reviewed in this study—community engagement and collaboration initiatives and the development of peer recovery coaching services—align with the population health and/or community benefit portfolios of CAHs. These services and programs address the population health needs of patients, support ongoing hospital activities and obligations, and demonstrate the leadership role that CAHs play in their communities.

### ***Patient and Community Communication***

Staff from Gunnison, MVH, McKenzie, and Summit Pacific emphasized the importance of communicating changes to opioid prescribing practices so that patients are aware of how new policies will affect them and referring providers understand the change in prescribing policies. McKenzie noted the need to be compassionate with patients, while holding firm to opioid prescribing policies. MVH and Clearwater spoke of the need to set clear expectations with patients about their pain, their ability to function, and any improvement they might see after introducing alternative pain management treatment.

### ***Staff and Provider Buy-in***

Several hospitals cited the need to secure “buy-in” from staff and providers as a critical component in successful program implementation. Many of the initiatives implemented by the study hospitals involved changing practice and/or prescribing patterns. Key informants reinforced the need to engage staff and providers in the development of new initiatives and to secure their ongoing support. Five CAHs noted the crucial role that in-house advocates or champions, particularly physicians, played in securing the active engagement of CAH leadership, providers, and staff. McKenzie delayed implementation of their oxy-free ED to increase support by working with clinical staff on appropriate messaging and conducting role-playing scenarios. Bridgton, Summit Pacific, and Gunnison spoke of the challenges of convincing other providers of the need for their opioid initiatives. Respondents from these CAHs highlighted staff concerns about the difficulty of working with OUD patients and their reluctance to prescribe buprenorphines. Finally, some key informants found it necessary to educate providers, staff, board members, and community leaders about the depth and causes of the opioid crisis in their communities and the need for their hospitals’ interventions.

### ***Using Data to Support Opioid Initiatives***

A number of study participants discussed the use of data to identify the need for opioid interventions, develop support for them, and monitor their impact over time. McKenzie used ED data to document the need for their oxy-free ED. Data helped Gunnison to identify the role of other providers’ prescribing practice in fueling the local opioid crisis. LincolnHealth used data to identify high opioid prescribing patterns for ED patients with dental pain and develop its prescribing guidelines. McKenzie and LincolnHealth encouraged prescribers to use data from state prescription drug monitoring programs and their electronic health records to inform their opioid prescribing practices. Summit Pacific and Gunnison used data to demonstrate the impact of their programs on the health of their communities.

### ***Collaboration***

Collaboration with community stakeholders and other partner organizations was a common element of many of the initiatives we reviewed. Shenandoah and Copley recommended working

with existing programs and services to determine best use of scarce resources, save time, and avoid “reinventing the wheel.” Respondents noted that good relationships with community partners helped identify the need for OUD treatment initiatives and ensure their success. Through their community consortium, Summit Pacific recognized the specific needs of the community and developed prevention, treatment, and recovery strategies to respond to those needs. Although respondents stressed the importance of collaboration, they noted that the process of collaboration and engagement can be difficult and time consuming, particularly when lead organizations cannot mandate that other participating organizations change.

## **ROLE OF STATE FLEX PROGRAMS AND OFFICES OF RURAL HEALTH**

SFPs can play an important role in helping CAHs and their communities by sharing the examples in this study to inform the development of their own opioid initiatives. Depending on their CAHs’ needs, this work can directly align with specific State Flex program areas:

- 1: CAH Quality Improvement (e.g., opioid prescribing guidelines)
- 3: CAH Population Health (e.g., community engagement, opioid consortiums, recovery coaching, and/or MAT services)

SFPs and SORHs can work with CAHs to secure grant funding to support community-based OUD initiatives. For example, the Federal Office of Rural Health Policy (FORHP) has outlined a number of tasks that SORHs (which typically house SFPs) can undertake in relation to RCORP grant funding:<sup>20</sup>

- apply for, and/or serve as a consortium member on, an RCORP grant;
- help connect organizations in your state so that they can apply as a consortium;
- inform FORHP on the status of SUD/OUD in your state;
- disseminate RCORP funding opportunities to rural stakeholders; and
- participate in RCORP site visits

As part of broader collaborations with SORHs, SFPs have participated in RCORP grants<sup>21</sup> and in the Rural Opioid Overdose Reversal program.<sup>22</sup> For example, a number of SORHs (Delaware, Michigan, Minnesota, Montana, Oregon, South Carolina, Texas, and Virginia) served as the lead organizations or partners in RCORP grants.<sup>23</sup> Seven SFPs received supplemental funding in 2017 to engage CAHs in opioid prevention and treatment activities.<sup>24</sup> Strategies included a CAH educational summit (Kentucky); naloxone trainings for nurses and law enforcement (Alabama); and increased training and capacity for rural EMS to prevent opioid-related overdoses (Arizona).

## **CONCLUSIONS**

This briefing paper describes a number of opioid interventions and strategies targeting prevention, treatment, and recovery that CAHs and other rural hospitals can implement to address opioid issues in their communities. SFPs can support the efforts of CAHs to address opioid use issues by sharing this information and providing technical assistance to CAHs interested in developing their own initiatives. A number of resources that can be used by SFPs to help CAHs address OUD locally are listed in Appendix B. For more resources on substance use, please refer to *Engaging Critical Access Hospitals in Addressing Rural Substance Use*.<sup>13</sup>

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*For more information on this study, please contact John Gale at [john.gale@maine.edu](mailto:john.gale@maine.edu)*

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## **APPENDIX A.** Critical Access Hospital Respondents

### **Bridgton Hospital, Bridgton, ME**

Website: [cmhc.org/bridgton-hospital/](http://cmhc.org/bridgton-hospital/)

Dr. Peter Leighton, Addiction Medicine

### **Clearwater Valley Hospital & Clinics, Orofino, ID**

Website: [smh-cvh.org/](http://smh-cvh.org/)

Dr. Kelly McGrath, Chief Medical Officer

Christine Packer, Chief Transformation Officer & Director of Process Improvement

### **Copley Hospital, Morrisville, VT**

Website: [copleyvt.org/](http://copleyvt.org/)

Michael Brigati, Director of Emergency Services and Clinical Life Safety

### **Gunnison Valley Health, Gunnison, CO**

Website: [gunnisonvalleyhealth.org/](http://gunnisonvalleyhealth.org/)

Rob Santilli, CEO

Amy Magnus, Medical Staff/Risk Coordinator

Sherilyn Skokan, Director of Patient Care Services

Melinda M. Sandgren, Director of Care Management

### **LincolnHealth – Miles Campus & Hospital, Damariscotta, ME**

Website: [mainehealth.org/lincolnhealth/locations/lincolnhealth-miles-campus-hospital](http://mainehealth.org/lincolnhealth/locations/lincolnhealth-miles-campus-hospital)

Dr. Timothy Fox, Emergency Medicine

### **Martha's Vineyard Hospital, Oak Bluffs, MA**

Website: [www.mvhospital.com/](http://www.mvhospital.com/)

Cheryl Kram, RN, BSN, BC Nurse Manager

Pamela Thomas, RN, BSN, Martha's Vineyard Hospital Center for Pain Management

### **McKenzie Health System, Sandusky, MI**

Website: [mckenziehealth.org/](http://mckenziehealth.org/)

Steve Barnett, DHA, CRNA, FACHE, President & CEO

Dr. Mark Hamed, Medical Director

### **Prairie Ridge Health, Columbus, WI**

Website: [prairieridge.health/en/](http://prairieridge.health/en/)

Emily Dilley, Director of Marketing

### **Shenandoah Memorial Hospital, Woodstock, VA**

Website: [valleyhealthlink.com/shenandoah-memorial-hospital/](http://valleyhealthlink.com/shenandoah-memorial-hospital/)

David Cash, Peer Recovery Program Supervisor, Northwestern Community Services Board

Tim May, Substance Use Disorder Program Manager, Northwestern Community Services Board

April McClain-Clower, Director of Inpatient Nursing

### **Summit Pacific Medical Center, Elma, WA**

Website: [summitpacificmedicalcenter.org/](http://summitpacificmedicalcenter.org/)

Dr. Shawn Andrews, Medical Director

Aaron DeBard, MBA, Project Coordinator

### **WVU Medicine Barnesville Hospital, Barnesville, OH**

Website: [barnesvillehospital.com/](http://barnesvillehospital.com/)

Danica Haverty, MPA, Project Director, Addiction Services of Eastern Ohio, Barnesville Hospital

## APPENDIX B. Opioid Resources for CAHs and State Flex Programs

Source	Resource Description	Links
AffirmHealth	<i>Opioid Prescribing Guidelines: A State by State Overview</i> : Provides links to prescribing guidelines and opioid-response state and national resources.	<a href="https://affirmhealth.com/blog/opioid-prescribing-guidelines-a-state-by-state-overview">affirmhealth.com/blog/opioid-prescribing-guidelines-a-state-by-state-overview</a>
Agency for Healthcare Research and Quality	<i>Medication-Assisted Treatment for Opioid Use Disorder Playbook</i> : Provides a practical guide for implementing MAT in primary care and other ambulatory care settings, with a focus on rural areas.	<a href="https://integrationacademy.ahrq.gov/products/mat-playbook/medication-assisted-treatment-opioid-use-disorder-playbook">integrationacademy.ahrq.gov/products/mat-playbook/medication-assisted-treatment-opioid-use-disorder-playbook</a>
Centers for Disease Control	<i>Opioid Overdose</i> : Provides evidence-based strategies for prevention, treatment, and recovery, trainings, data, and information resources.	<a href="https://cdc.gov/drugoverdose/index.html">cdc.gov/drugoverdose/index.html</a>
Centers for Medicare and Medicaid Services (CMS)	<i>CMS Roadmap: Strategy to Fight the Opioid Crisis</i> : Highlights CMS efforts to address opioid use, and includes some information relating to rural areas.	<a href="https://cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf">cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf</a>
Health and Human Services	<i>National Opioid Crisis: Help and Resources</i> : Describes models for opioid use prevention, treatment, and recovery, as well as news and resources to get help.	<a href="https://hhs.gov/opioids/">hhs.gov/opioids/</a>
Maine Rural Health Research Center	<i>Rural Opioid Abuse Prevention and Treatment Strategies: The Experience in Four States</i> : Presents strategies for dealing with the opioid crisis in Indiana, North Carolina, Vermont, and Washington.	<a href="https://digitalcommons.usm.maine.edu/behavioral_health/27/">digitalcommons.usm.maine.edu/behavioral_health/27/</a>
Maine Rural Health Research Center	<i>Engaging Critical Access Hospitals in Addressing Rural Substance Use</i> : Describes an evidence-based framework to assist Critical Access and other rural hospitals in understanding the role that they can play in addressing substance use issues in their communities and developing appropriate interventions. The framework includes foundational activities (community assessment and engagement as well as patient screening) and prevention, treatment, and recovery strategies.	<a href="https://3jzjstox04m3j7c-ty2rs9yh9-wpengine.netdna-ssl.com/wp-content/uploads/2020/06/fmt-bp-44-2020.pdf">3jzjstox04m3j7c-ty2rs9yh9-wpengine.netdna-ssl.com/wp-content/uploads/2020/06/fmt-bp-44-2020.pdf</a>
National Organization of State Offices of Rural Health	<i>Rural Opioid Educational Resources</i> : Provides training resources and examples strategies implemented by CAHs and rural hospitals.	<a href="https://nosorh.org/rural-opioid-resources/">nosorh.org/rural-opioid-resources/</a>
National Rural Health Resource Center	<i>Oxy Free Emergency Department (webinar)</i> : Features representatives from McKenzie Health System discussing the implementation of their oxy-free ED.	<a href="https://ruralcenter.org/events/help-webinars/oxy-free-emergency-department">ruralcenter.org/events/help-webinars/oxy-free-emergency-department</a>

Source	Resource Description	Links
NORC at the University of Chicago	<i>National Opioid Misuse Community Assessment Tool</i> : Allows the creation of county maps to show the relationship between community and population demographics and fatal drug overdoses—including opioids—in the United States.	<a href="http://opioidmisusetool.norc.org/">opioidmisusetool.norc.org/</a>
Office of National Drug Control Policy	<i>Rural Community Action Guide</i> : Provides an overview of the opioid crisis in rural communities, describes the impact of addiction, and offers resources and tools for opioid use prevention, treatment, and recovery.	<a href="http://usda.gov/sites/default/files/documents/rural-community-action-guide.pdf">usda.gov/sites/default/files/documents/rural-community-action-guide.pdf</a>
Rural Opioid Federal Inter-agency Working Group (IWG)	<i>Rural Community Toolbox</i> : Serves as a guide to the resources that can help make a difference in rural communities. It offers tools to empower rural community leaders to assess the causes and impact of substance use disorder and find federal programs to help them build strong healthy drug-free rural communities.	<a href="http://ruralcommunitytoolbox.org/">ruralcommunitytoolbox.org/</a>
Project Lazarus	<i>Project Lazarus</i> : Offers resources to support community engagement and program development to reverse opioid overdose deaths.	<a href="http://projectlazarus.org/">projectlazarus.org/</a>
RHHub	<i>Rural Response to the Opioid Crisis</i> : Provides links to information, toolkits, and studies on rural opioid use, including examples of prevention, treatment, and recovery strategies.	<a href="http://ruralhealthinfo.org/topics/opioids">ruralhealthinfo.org/topics/opioids</a>
RHHub	<i>Telebehavioral Health and Opioid Use Disorder</i> : Provides resources to support rural provider in using telehealth to expand access to opioid use treatment.	<a href="http://ruralhealthinfo.org/toolkits/telehealth/2/specific-populations/behavioral-health/opioids">ruralhealthinfo.org/toolkits/telehealth/2/specific-populations/behavioral-health/opioids</a>
Rural Communities Opioid Response Program (RCORP)	<i>RCORP's Technical Assistance website</i> : Provides articles and publications; templates, samples, and forms; and training materials for grantees of the RCORP program as well as opioid treatment providers. RCORP funding opportunities are available on the Health Resources and Services Administration's website.	<a href="http://rcorp-ta.org/index.php/resources">rcorp-ta.org/index.php/resources</a> <a href="http://hrsa.gov/rural-health/rcorp">hrsa.gov/rural-health/rcorp</a>
Rural Opioid Federal Inter-agency Working Group	<i>Rural Community Toolbox</i> : Provides a clearinghouse for information, resources, funding, and technical assistance from 16 federal agencies to address opioid use in rural communities.	<a href="http://ruralcommunitytoolbox.org/">ruralcommunitytoolbox.org/</a>
University of Washington School of Medicine	<i>Six Building Blocks: A Team-Based Approach to Improving Opioid Management in Primary Care</i> : Describes an evidence-based QI process to improve the management of patients on long-term opioid therapy and includes a self-assessment tools, an implementation guide, and links to helpful resources.	<a href="http://depts.washington.edu/fammed/improvingopioidcare/6-building-blocks/">depts.washington.edu/fammed/improvingopioidcare/6-building-blocks/</a>
Peer-reviewed article	Study on the development of opioid ED prescribing guidelines. (Neven, DE, Sabel, JC, Howell, DN, Carlisle, RJ. The development of the Washington state emergency department opioid prescribing guidelines. <i>J Med Toxicol</i> . 2012;8(4):353-359.)	<a href="http://ncbi.nlm.nih.gov/pmc/articles/PMC3550252/pdf/13181_2012_Article_267.pdf">ncbi.nlm.nih.gov/pmc/articles/PMC3550252/pdf/13181_2012_Article_267.pdf</a>

Source	Resource Description	Links
Peer-reviewed article	Study on the impact of mandated opioid prescribing policies in the ED in Washington State. (Sun, BC, Lupulescu-Mann, N, Charlesworth, CJ, et al. Impact of hospital "best practice" mandates on prescription opioid dispensing after an emergency department visit. <i>Acad Emerg Med.</i> 2017;24(8):905-913.)	<a href="https://onlinelibrary.wiley.com/doi/epdf/10.1111/acem.13230">onlinelibrary.wiley.com/doi/epdf/10.1111/acem.13230</a>
Peer-reviewed article	Study on a performance improvement project to reduce ED opioid prescriptions for dental pain in rural hospitals in Maine. (Fox, TR, Li, J, Stevens, S, Tippie, T. A performance improvement prescribing guideline reduces opioid prescriptions for emergency department dental pain patients. <i>Ann Emerg Med.</i> 2013;62(3):237-240.)	<a href="https://pubmed.ncbi.nlm.nih.gov/23374416/">pubmed.ncbi.nlm.nih.gov/23374416/</a>
Peer-reviewed article	Research brief on the development of a telemedicine-based pain management program at a rural critical access hospital. (Hanna GM, Fishman I, Edwards DA, et al. Development and Patient Satisfaction of a New Telemedicine Service for Pain Management at Massachusetts General Hospital to the Island of Martha's Vineyard. <i>Pain Med.</i> 2016;17(9):1658-1663.)	<a href="https://ncbi.nlm.nih.gov/pmc/articles/PMC6281046/pdf/pnw069.pdf">ncbi.nlm.nih.gov/pmc/articles/PMC6281046/pdf/pnw069.pdf</a>