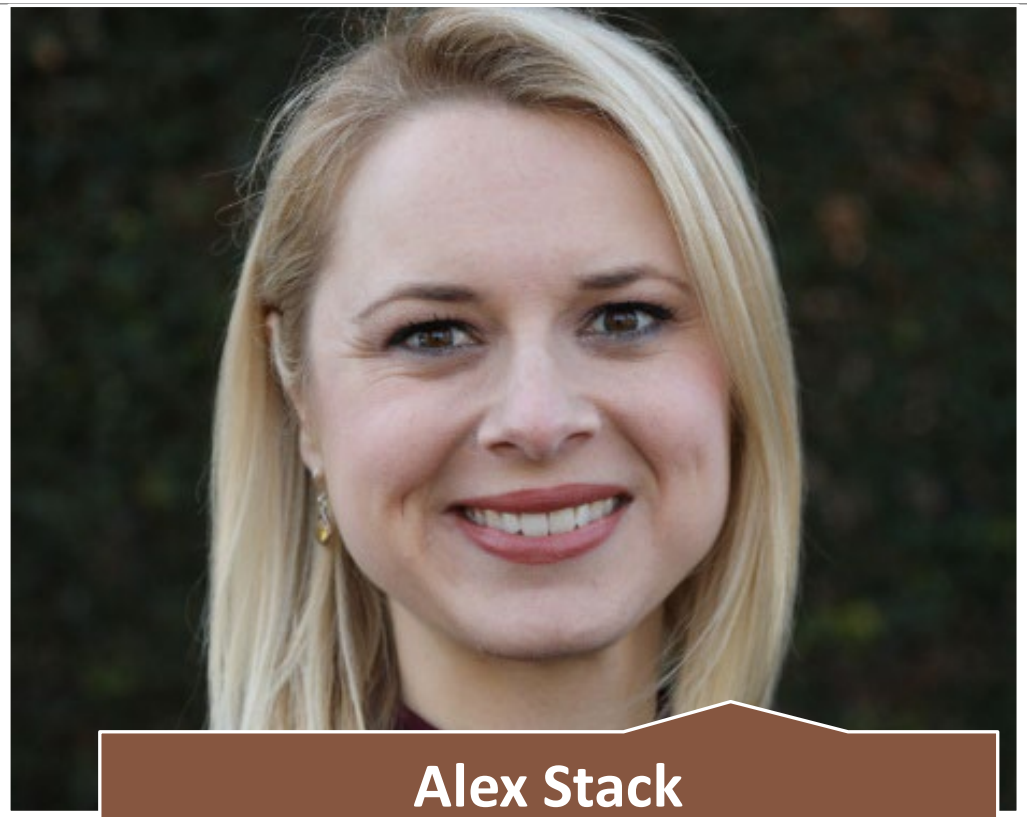
Opioid Care Honor Roll

2024 PROGRAM

AUGUST 23, 2023

Cal Hospital Compare

Facilitators

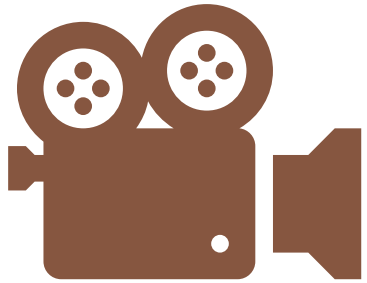


Alex Stack

Director, Programs & Strategic Initiatives, CHC

Using Zoom Meeting Platform

CHAT in your questions/comments



Webinar is being RECORDED

Please MUTE/UNMUTE your line as needed

DOWNLOAD resources

Meeting Objectives

1

Celebrate progress and share bright spots!

2

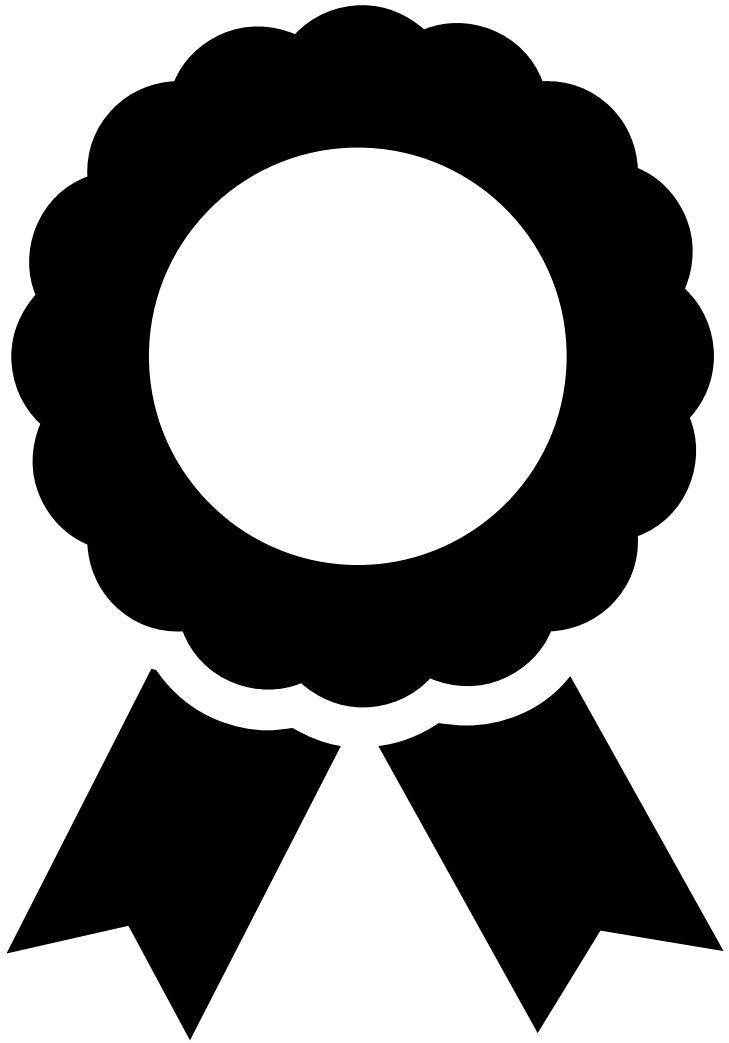
Review changes made to the 2024 Opioid Management Hospital Self-Assessment

3

Discuss how to apply and timeline

Programmatic Goals

- Activate hospitals to accelerate care redesign in service of reducing OUD related deaths
- Recognize hospitals for their performance & commitment to this effort
- Create the space for quality improvement & the sharing of best practices by connecting hospitals to key resources



Mission Hospital at Saddleback College: Naloxone Distribution & Education

Check out: https://app.criticalmention.com/app/#/report/b03f75c6-0ea9-41d2-b198-169946f91816

Chat Waterfall

In the chat box write your name, organization, and one thing you are proud of

HOLD onto your message until my signal

2023 Results

110 hospitals submitted their application!

Recognition Categories

Superior Performance: ≥ 34 points

Excellent Progress: 26 – 33 points

Most Improved: ≥ 5 points in comparison to 2021 results OR

Sustained Improvement: hospital achieves Superior Performance two years in a row

Participant: hospital scores between 0 and 20 points &/or does not fall into any other recognition category

Results

Superior Performance

- 42; with 31 hospitals sustaining the gains over the past 2 years

Excellent Progress

- 35

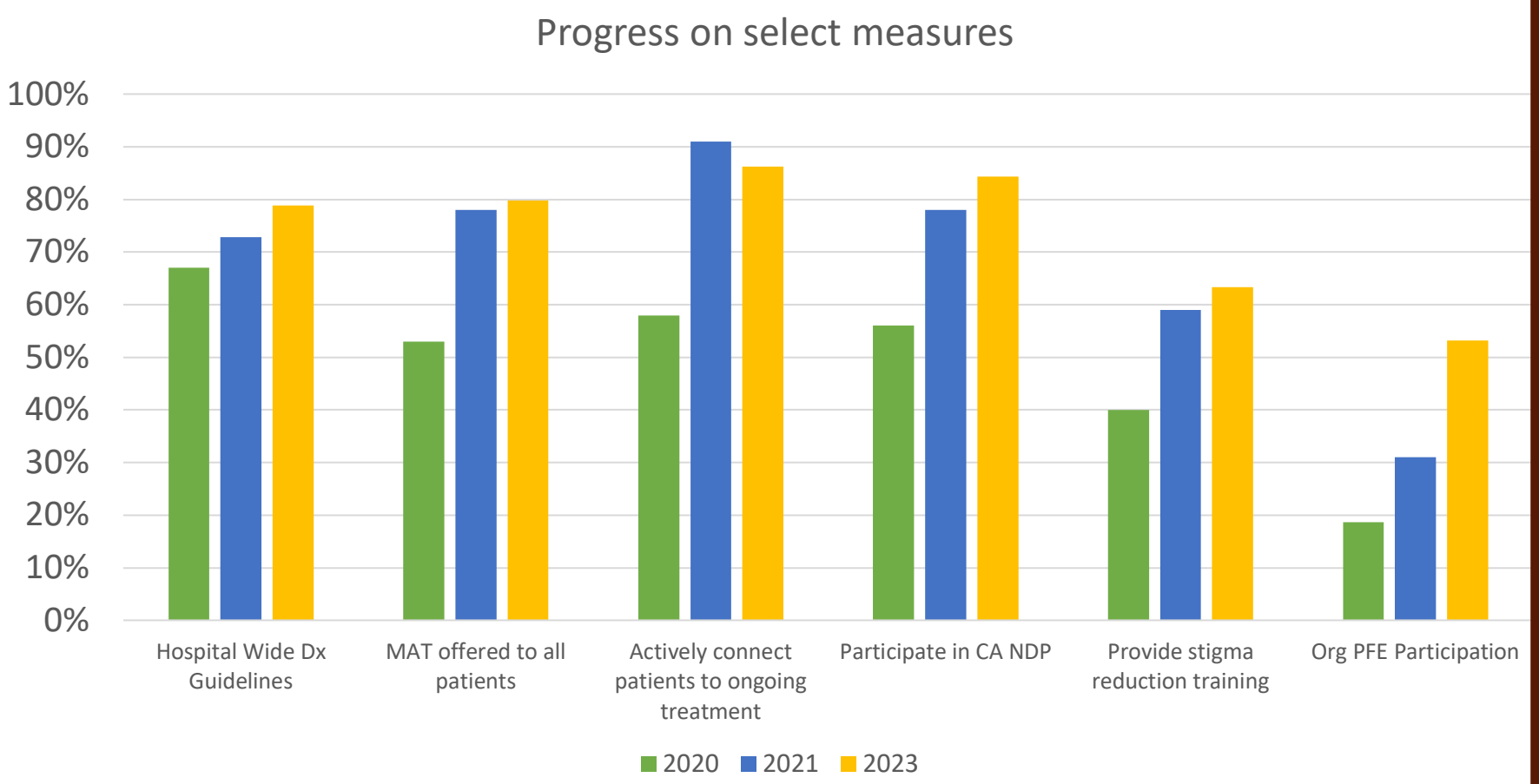
Most Improved

- 31

Program Participant

- 25

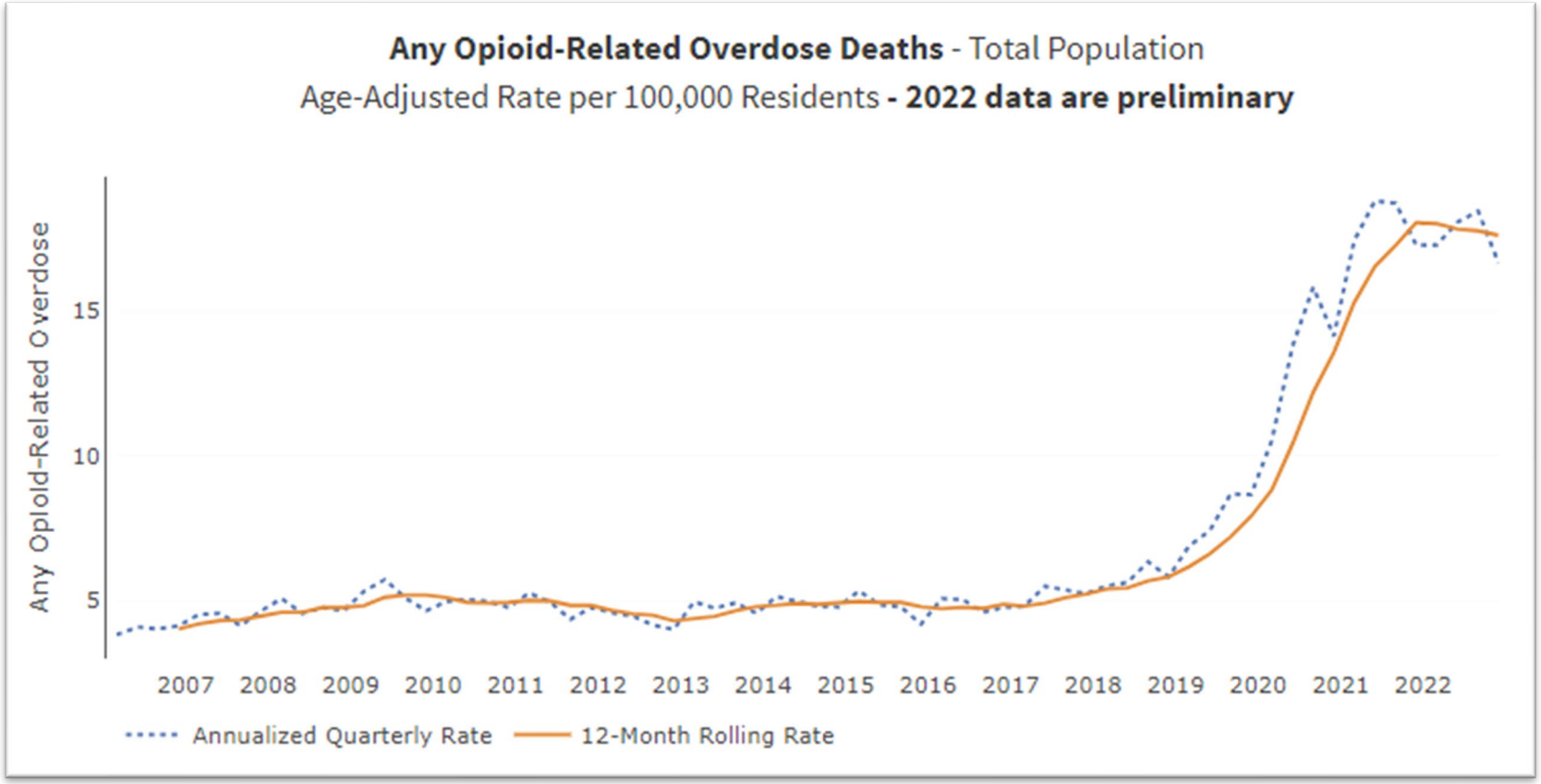
2023 Results



2023 Results Snapshot

- **79%** of hospitals have supportive pathways that promote a **team-based approach to identifying opioid alternatives**
- **49%** of hospitals provide **fentanyl test strips**, access to or information on safe syringe kits, and/or information on how to properly store and dispose of opioid medications
- **64%** regularly assess **stigma** and also provide some kind of stigma reduction training

California is making progress!



Source: California Overdose Surveillance Dashboard, accessed August, 2023

Peer to Peer learning

Opioid Care Honor Roll - Shared Learnings Summary Page

Thank you to the 109 hospitals who submitted their applications for the 2023 Opioid Care Honor Roll and for the opportunity for Cal Hospital Compare to recognize your work to address the opioid epidemic, and beyond, in your communities.

Hospitals were recognized based on the following categories:
- Superior Performance: ≥ 34 points
- Excellent Progress: 26 – 33 points
- Most Improved: ≥ 5 points in comparison to 2021 results
- Sustained Improvement: hospital achieves Superior Performance two years in a row

More about this year's program including a complete list of honor roll recipients can be found on the Cal Hospital Compare website - www.calhospitalcompare.org.

The Program Shared Learnings worksheet tab shows the results of the Opioid Care Honor Roll's Self-Assessment for those institutions that chose to share information. The interactive spreadsheet can be filtered, sorted and searched to review the self-assessment scores and free response narrative answers.

As a reminder, please take care to not share the information outside of your organization. Thank you.

Access Opioid Care Honor Roll – **Shared Learnings** **HERE**

Peer to Peer learning – Filter & Search!

Hospital Nam	City/To	Name:	Role:	Email Address:	Appropriate Prescri	Alternatives to Opioi	M	Timely F/ Ca	Naloxo	EC: Add'l Harm Reducti	Org Infrastructure	Address Stig	P	Sc	TOTAL SC	Briefly describe the steps your hospital has taken to improve opioid stewardship across the 4 domains assessed in the 2023 Opioid Management Hospital Self-Assessment.	What would you like to learn more about in 2024 that would help you to close a gap in your work?
Adventist Health Bakersfield	Bakersfield	Mandy Herrera	Substance Use Navigator	herrermd@ah.org	5	5	4	5	5	1	4	5	5	39	40	Hospital continues to monitor performance but providing free naloxone kits to patients and families. Continues to train appropriate providers and staff on, some combination of, the medical model of addiction, harm reduction principles, motivational interviewing and trauma informed care to normalize OUD and treatment	How to integrate harm reduction and approaches to identifying opioid alternatives.
Adventist Health Glendale	Glendale	Lisa Gunther, TENIA MIRZAIAN, MELANIA MIKHAEILYAN	Medication Safety Officer, Pharmacist Residents	gunthela@ah.org; mirzait@ah.org; mikhaem@ah.org	4	4	4	2	5	1	4	3	3	30	30	a.Collaboration with nurses, physicians and social workers with the execution of a substance use navigator (SUN) has allowed for access to Medication for Addiction Treatment (MAT), locating SUD treatment centers and learning more about reducing harm. By raising awareness for MAT such as buprenorphine and naltrexone, overdose rates can be reduced in the community and withdrawal symptoms blocked. Resources provided by the SUN have allowed for safe and effective opioid use upon teaching patients how to use only as needed and to be cautious of signs of overdose. Upon a visit to the Emergency Department at the onset of an acute event, Satellite Medication Dispensing Pharmacy has been actively providing treatment to patients with direct education provided upon dispensing. Narcan is not only provided to patients for free at the Emergency Room, but also furnished by pharmacists for patients who meet the eligibility criteria. Overdose prevention education is a crucial component of the interaction between a pharmacist and the patient at Adventist Health Glendale, whether it be behind the pharmacy counter or bedside before patient discharge from the hospital. In order to manage opioid use during admission, pharmacists are working diligently to identify patients who do not have naloxone ordered and addressing this barrier to opioid overdose prevention by implementing addition of it to the medication list. b.Implementation of safety net programs, such as VigiLanz, which alerts high risk/opioid naive patients who do not have an active naloxone order and an active hospital order, notify pharmacists to pay closer attention to this high risk population of patients. On the other hand, pharmacists regularly check for opportunities either by personal initiative or in response to VigiLanz notifications, in an effort to add naloxone orders to patient medication lists. Consequently, our end goal of reducing opioid related incidents in the hospital is met.	a.Given the opioid epidemic and development of technology, it would be a great opportunity to learn about new software and technological advancements that can aid hospitals to better navigate opioid use. Moreover, with recent FDA approved over-the-counter Narcan, expanded availability to patients at risk of an overdose will better promote supply distribution within the community and on a larger scale. Gaining information about community centers that provide free Narcan in addition to the services provided by our hospital can allow us to provide help to patients close to home.
																AHHM has successfully had the CA Bridge program for four years with a substance use	

Peer to Peer learning

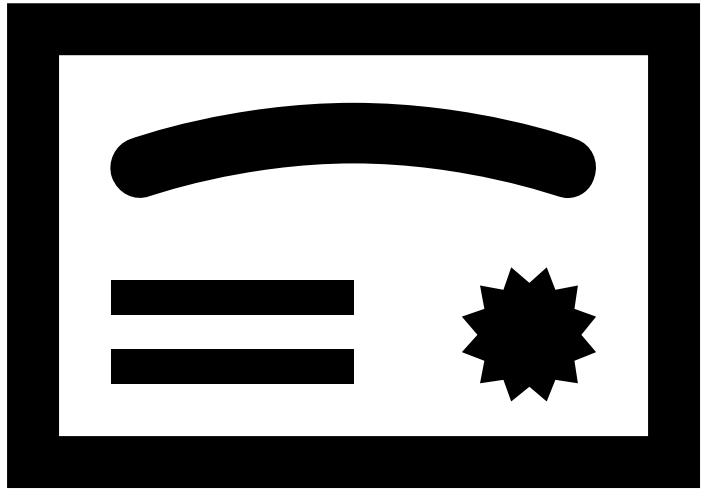
Upon a visit to the Emergency Department at the onset of an acute event, Satellite Medication Dispensing Pharmacy has been actively providing treatment to patients with direct education provided upon dispensing. Narcan is not only provided to patients for free at the Emergency Room, but also furnished by pharmacists for patients who meet the eligibility criteria. Overdose prevention education is a cru component of the interaction between a pharmacist and the patie at **Adventist Health Glendale**, whether it be behind the pharmacy counter or bedside before patient discharge from the hospital. In order to manage opioid use during admission, pharmacists are working diligently to identify patients who do not have naloxone ordered and addressing this barrier to opioid overdose prevention implementing addition of it to the medication list.

At **CHOMP** we assess stigma among providers and staff and give frequent feedback on patient interactions.
We have developed a Pain Management certificate program for pharmacists. This can be easily adapted to other provider types. We have also partnered with other agencies within our County (Public Health, Behavioral Health

Mercy General Hospital uses the Oasis dashboard to monitor opioid prescribing practices and follow up with the individual prescribers when needed. Metrics include opioid prescription count per 1000 discharges, opioid prescription percent by MME and by duration, number of opioid short-acting vs. long acting, number of MAT prescriptions given per month, number of concurrent benzo opioid prescription combo, percentage of prescriptions non-opioid vs. opioid. The hospital compares opioid rate to the CMS rate and to other hospitals in the CommonSpiritHealth system.

Patient and family engagement

- Since 2014, **Barton Health** has had an active PFAC. Their PFAC has been instrumental in helping the hospital meet the needs of their close-knit community. For example, the PFAC urged the hospital to become "baby friendly," implement patient friendly billing practices, and has given invaluable feedback on a number of patient education materials from brochures on infection prevention, falls, and where to access naloxone. The hospital's "Where can I find Narcan?" flyer, based on the PFAC's feedback, includes simple language with pictures that illustrate the signs of an overdose and how to use the spray, information on when Narcan is helpful (e.g., Narcan can only reverse an opioid related overdose), and where to put the flyers so that they would be accessible to the people who need it most (e.g., libraries, high schools, and the hospital's ED lobby).



Press release coming soon!

Cal Hospital Compare

CalHHS

Opioid Management Hospital Self-Assessment

FOR THE 2024 OPIOID CARE HONOR ROLL

4 Domains of Care

Safe & effective opioid use

Identification & treatment

Harm reduction

Cross cutting organizational best practices

Opioid Management Hospital Self-Assessment

Measure	Level 1 *Basic Mgmt.* (1 pt)	Level 2 *Hospital Wide Standards* (2 pts)	Level 3 *Integration & Innovation* (3 pts)	Level 4 *Practice Improvement* *(4 pts)*	Level 5 *Integration* *(5 pts)*
Safe & Effective Opioid Use • Appropriate opioid discharge prescribing guidelines • Alternatives to opioids for pain management			Harm Reduction • Harm reduction informed care		
Identification & Treatment • Medication Assisted Treatment (MAT) • Timely follow up care			Cross-cutting Opioid Management Best Practices • Organizational infrastructure • Address stigma with physicians & staff • Patient & family engagement		
Extra credit for “hon-rolling” a friend					

Identification & Treatment						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Level 5 (5 pts.)** *Integration*
Timely follow up care Hospital actively coordinates follow up care for patients initiating MAT within 72 hours, either in the hospital or outpatient setting.	Hospital identifies providers within the hospital and/or within the community that **routinely** prescribe buprenorphine Provides list of **community-based resources** for follow up care to patients, family, caregivers, and friends (e.g., primary care, outpatient clinics, outpatient treatment programs, telehealth treatment providers, mental health providers, etc.)	Hospital provides **support to practitioners in the ED and IP units with buprenorphine. prescribing** (e.g., provides updates on changes to x-waiver & DEA licensure process, provides education on how to prescribe buprenorphine in special populations, hospital's process for providing MAT etc.) Hospital is actively **building relationships and coordinating with outpatient, and long term care services to enhance care transitions**	Hospital has an agreement in place with **at least one community provider to provide timely follow up care**	**Actively refer and/or schedule** MAT and OUD patients with a community provider for ongoing treatment (e.g., primary care, outpatient clinic, outpatient treatment program, telehealth treatment provider, mental health provider, etc.) **Hospital actively partners with primary care and specialty clinics affiliated with the hospitals on** coordinating ongoing care and pain management in accordance with hospital policies	Your hospital is actively **measuring and developing strategies to improve** patient access to timely follow up care	Providing timely follow up care for MAT patients is **embedded** into clinical and operational workflows (e.g., care transitions for MAT patients are prioritized in the same way as all other high needs patients requiring timely follow up care, sustained performance on key performance indicators over a 12-month period, hospital continues to monitor performance, but this is not a standalone QI initiative) **Great job!**

Scenario 1:
Hospital actively encourages, educates, and counsels providers on bup. prescribing. Hospital reviews and collects data on bup. starts on a quarterly basis. (Level 2)

Choose words that matter to you

“What’s in a name? That which we call a rose by any other name would smell as sweet.

- William Shakespeare

Identification and Treatment						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Level 5 (5 pts.)** *Integration*
Medication Assisted Treatment (MAT) or Medications for Opioid Use Disorder (MOUD) Provide MAT for patients (adults and youth) identified as having OUD, or in withdrawal, and continue MAT for patients in active treatment. Components of a MAT program should include: • Identifying patients eligible for MAT, on MAT, and/or in opioid withdrawal • Treatment is accessible in the emergency department, and in all other hospital departments • Treatment is provided rapidly (same day) and efficiently in response to patient needs • Human interactions that build trust are integral to treatment *Guidelines on how to universally offer MAT • Do not screen select patients for OUD; quick screen of all patients is appropriate • Do not ask patients if they are interested in MAT services rather do let patients know that your site offers MAT during the exam so that patients can choose to disclose whether and when they need support • Do promote MAT services using signage in waiting and exam rooms, badge flare, and patient forms	Methadone and buprenorphine on hospital **formulary**	MAT is offered, initiated, and continued for those already on MAT in at least **1 service line** (ED, Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.) Hospital **provides support to care teams** in understanding **risk, benefits, and evidence of buprenorphine** in MAT for adults and youth	MAT is offered, initiated, and continued for those already on MAT in at least **2 service lines** (ED, Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.) Hospital **provides support to care teams** in understanding **risk, benefits, and evidence of buprenorphine** in MAT for adults and youth	MAT is **universally offered*** to all patients (adults and youth) presenting to the hospital One or more **hospital staff** has the time and skills to **engage with patients** (adults and youth) on a human level, motivating them to engage in treatment (e.g., a hospital employee embedded within either an ED or an inpatient setting to help patients begin and remain in addiction treatment – commonly known as a Substance Use Navigator, Case Manager, Social Worker, Patient Liaison, Peer Mentor, Chaplain, etc.)	Your hospital is actively **measuring and developing strategies to improve** access to MAT	MAT is **embedded** into clinical and operational workflows (e.g., substance use navigation is a core service, buprenorphine is a treatment option like insulin, or warfarin, sustained performance on key performance indicators over a 12-month period, hospital continues to monitor performance, but this is not a standalone QI initiative) **Great job!**

Scenario 2: Hospital provides substance use navigation since Jan 2020, follow up with all patients within 5 days post discharge. Hospital actively collects and reviews data.
(Level 4).

Refined the tool in key categories

Integration

- This is the goal of our work!
- Integration = sustainability
- Opioid stewardship is second nature and has a permanent place in our work

Harm Reduction

- Meet patients where they are
- Offer HR services and supplies
  - Overdose reversal education and training services
  - Substance use navigation
  - Free naloxone kits
  - Fentanyl test strips
  - Safe injection kits and or information on where to access
  - Information on how/where to dispose of opioids

Address Stigma

- Elevate providers and staff as champions and coaches
- Assess stigma & evaluate the impact of any interventions

Integration

Buprenorphine is a treatment option like insulin or warfarin

Opioid stewardship is standing agenda item at meetings

Resources are not dependent on grant funds

Hospital addresses stigma with physicians and staff across multiple diagnoses

Organization hires individuals with lived experience

Patients ask us for opioid alternatives

Learnings are spread to all departments and affiliated practices

Level 5 (5 pts.)
Integration

Appropriate opioid prescribing is **embedded** into clinical and operational workflows (e.g., the same attention is put on managing opioid prescribing as all other controlled substances, sustained performance on key performance indicators over a 12-month period, hospital continues to monitor performance, but this is not a standalone QI initiative)

Great job!

Harm Reduction						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Level 5 (5 pts.)** *Integration*
Hospital practices harm reduction informed care Hospitals meet patients where they are by practicing harm reduction (HR) informed care. In addition, hospitals provide patients and families access to no cost/low-cost HR services or supplies to lessen harms associated with drug use and related behaviors that increase the risk of infectious diseases, including HIV, viral hepatitis, and bacterial and fungal infections. HR principles: patients feel heard and take the lead in their care, care is tailored to patient's capacity and capability, patients understand the risk and benefits of their behaviors and all available treatment options. HR services/supplies may include one or more of the following: • Overdose reversal education and training services • Substance use navigation • Free naloxone via California Naloxone Distribution Project; we recommend this be an ED led process in collaboration with pharmacy (see Guide to Naloxone Distribution for details) • Fentanyl test strips • Safe injection kits and or information on where to access • Information on how/where to dispose of opioids	Hospital **does not practice HR reduction informed care** and does not provide HR services or supplies	**Educate providers and staff on HR principles**, your hospital's approach to HR, hospital-based HR services/supplies, and where patients can access HR services/supplies in the community. Education can be embedded in annual competencies, lunch and learns, CME opportunities, etc.)	**Creates a welcome and comfortable physical space for patients to receive stigma-free care** (e.g., ensure signage does not include stigmatizing language, providers and staff avoid using stigmatizing language, information on treatment and community services is readily available, any screening for substance misuse is provided appropriately and without judgement, etc.)	**Standing order** in place allowing providers and staff to provide HR supplies and services at no or low cost to all patients and families while in the healthcare setting (e.g., naloxone is co-prescribed with long term opioid prescriptions, patients are actively referred to low or no cost HR distribution centers, naloxone vending machine in place, providers/staff hand out free naloxone as needed, free access to fentanyl test strips, education provided on how to use harm reduction supplies, etc.)	Your hospital is actively **measuring and developing strategies to foster a HR culture and increase access** to HR services/supplies	Practicing HR informed care is **embedded** into clinical and operational workflows (e.g., HR informed care extends beyond patients with substance misuse, sustained performance on key performance indicators over a 12-month period, hospital continues to monitor performance, but this is not a standalone QI initiative) **Great job!**

Scenario 3: Hospital provides a number of HR services and supplies. Take active steps to foster a culture of HR by engaging with providers, staff, and patients on what this means to them. Hospital has a process to collect data and benchmark performance against publicly available data with sustained improvement/performance for over a year. (Level 5)

Harm Reduction Principles

Principle	Definition	Approaches
1. Humanism	• Providers value, care for, respect, and dignify patients as individuals. • It is important to recognize that people do things for a reason; harmful health behaviors provide some benefit to the individual and those benefits must be assessed and acknowledged to understand the balance between harms and benefits. • Understanding why patients make decisions is empowering for providers.	• Moral judgments made against patients do not produce positive health outcomes. • Grudges are not held against patients. • Services are user-friendly and responsive to patients' needs. • Providers accept patients' choices.
2. Pragmatism	• None of us will ever achieve perfect health behaviors. • Health behaviors and the ability to change them are influenced by social and community norms; behaviors do not occur within a vacuum.	• Abstinence is neither prioritized nor assumed to be the goal of the patient. • A range of supportive approaches is provided. • Care messages should be about actual harms to patients as opposed to moral or societal standards. • It is valuable for providers to understand that harm reduction can present experiences of moral ambiguity, since they are essentially supporting individuals in health behaviors that are likely to result in negative health outcomes.
3. Individualism	• Every person presents with his/her own needs and strengths. • People present with spectrums of harm and receptivity and therefore require a spectrum of intervention options.	• Strengths and needs are assessed for each patient, and no assumptions are made based on harmful health behaviors. • There is not a universal application of protocol or messaging for patients. Instead, providers tailor messages and interventions for each patient and maximize treatment options for each patient served.
4. Autonomy	• Though providers offer suggestions and education regarding patients' medications and treatment options, individuals ultimately make their own choices about medications, treatment, and health behaviors to the best of their abilities, beliefs, and priorities.	• Provider-patient partnerships are important, and these are exemplified by patient-driven care, shared decision-making, and reciprocal learning. • Care negotiations are based on the current state of the patient.
5. Incrementalism	• Any positive change is a step toward improved health, and positive change can take years. • It is important to understand and plan for backward movements.	• Providers can help patients celebrate any positive movement. • It is important to recognize that at times, all people experience plateaus or negative trajectories. • Providing positive reinforcement is valuable.
6. Accountability without termination	• Patients are responsible for their choices and health behaviors. • Patients are not "fired" for not achieving goals. • Individuals have the right to make harmful health decisions, and providers can still help them to understand that the consequences are their own.	• While helping patients to understand the impact of their choices and behaviors is valuable, backwards movement is not penalized.

From Harm reduction principles for healthcare settings

What harm reduction feels like…

Patients feel educated, engaged, empowered

Patients feel heard and take the lead in their care

Care is tailored to their capacity and capability

Patients understand the risk and benefits of their behaviors, and all available treatment options

Cross Cutting Opioid Management Best Practices						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Level 5 (5 pts.)** *Integration*
Address stigma with physicians and staff Hospital culture is welcoming and does not stigmatize substance misuse. Hospital actively addresses stigma, including but not limited to, through the education and promotion of the medical model of addiction, trauma informed care, motivational interviewing, and by offering harm reduction services across all departments to facilitate disease recognition, greater access to patient partnerships, and the use of non-stigmatizing language/behaviors (e.g., words matter).	Hospital **does not address stigma with** physicians and staff	Provides passive, **general education** on hospital opioid prescribing guidelines in **at least 2 service lines**, identification, and treatment, and overdose prevention to appropriate providers and staff (e.g., M&M, lunch and learns, flyers/brochures, CME requirements, RN annual competencies, etc.)	Provides **point of care decision making support** (e.g., MME flag for providers, automatic pharmacy review for long-term opioid prescription, auto prescribe naloxone with any opioid prescription, reminder to check CURES, flag concurrent opioid and benzo prescribing, etc.)	Trains appropriate providers and staff on, some combination of, the **medical model of addiction, harm reduction principles, motivational interviewing, and trauma informed care** to normalize OUD and treatment (e.g., stigma reduction training, M&M, lunch and learns, CME requirements, RN annual competencies, etc.) **Elevates** any providers and staff with training as program champions, peer to peer trainers, coaches, etc.	Your hospital is actively **measuring and developing strategies** to addresses physician and staff stigma towards OUD patients **Regularly assesses stigma** among providers and staff (e.g., audit of existing materials for stigmatizing language including signage and medical records, annual survey, focus groups, focused leader rounding, etc.)	Opioid stewardship program is **embedded** into clinical and operational workflows (e.g., hospital addresses stigma with physicians and staff across multiple diagnoses, organization hires individuals with lived experience, performance on key performance indicators over a 12-month period, hospital continues to monitor performance, but this is not a standalone QI initiative) **Great job!**

Scenario 4: Hospital promotes a patient safety culture but does not directly address stigma among physicians and staff. (Level 0)

Addressing Stigma

1. Elevate providers and staff as champions and coaches
2. Lean on storytelling and the patient experience to guide efforts
3. Model harm reduction informed care
4. Provide meaningful education on appropriate language, implicit bias, medical model of addition, etc.
5. Share data!

Stigma Research

A randomized controlled trial of an intervention to reduce stigma toward people with opioid use disorder among primary care clinicians

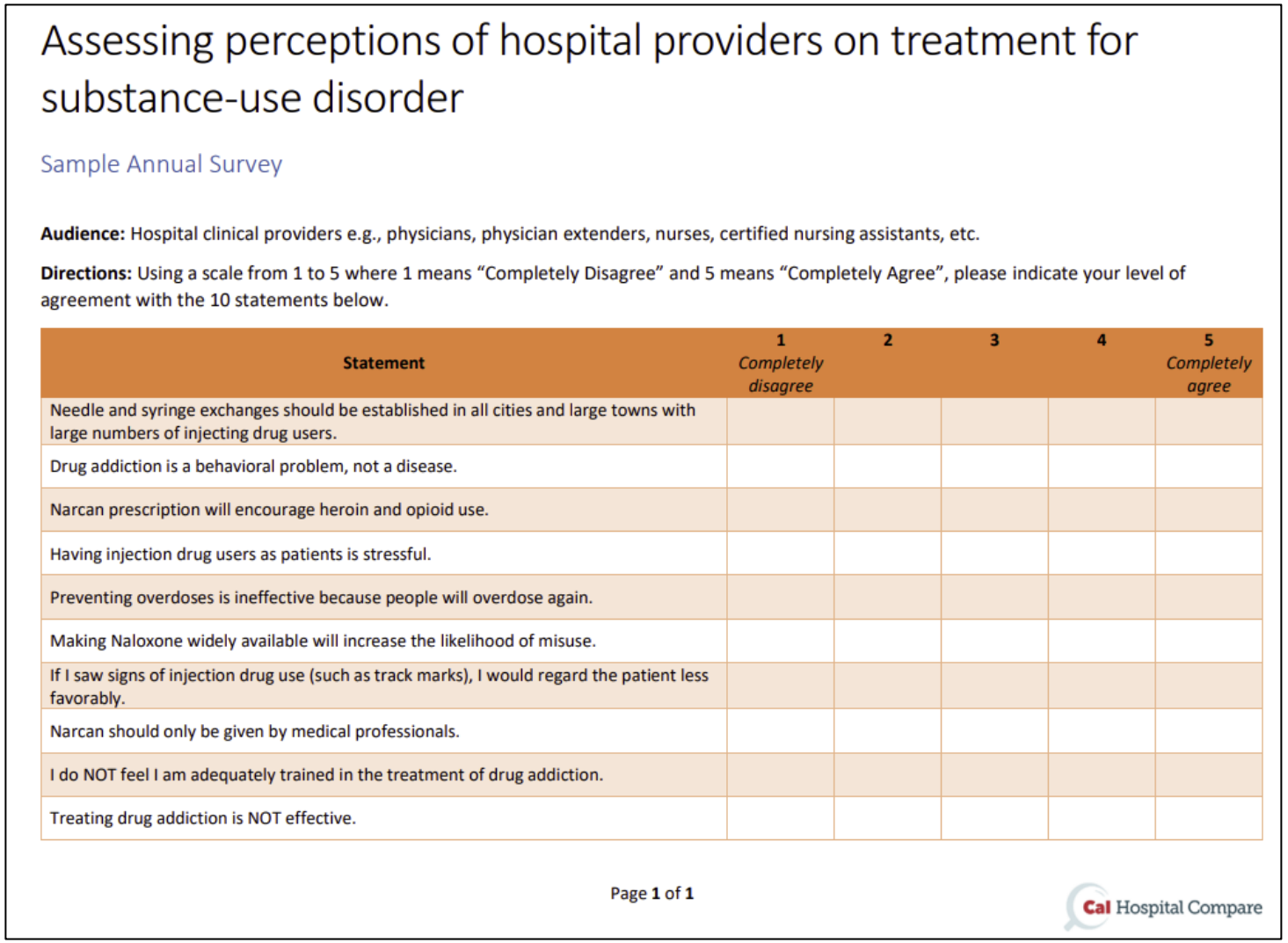
- Stigma toward people with OUD may require more robust intervention than this brief training was able to accomplish. However, stigma was related to lower intentions to treat people with OUD, suggesting stigma acts as a barrier to care.

The Impact of Stigma on People with Opioid Use Disorder, Opioid Treatment, and Policy

- This paper outlines the different levels of stigma and small steps that we can take to address stigma at the organizational and personal levlel

Stigma in health facilities: why it matters and how we can change it

- Provision of information" consisted of teaching participants about the condition itself or about stigma, its manifestations, and its effect on health.
- "Skills-building activities" involved creating opportunities for healthcare providers to develop the appropriate skills to work directly with the stigmatized group.
- Participatory learning" approaches required participants (health facility staff or clients or both) to actively engage in the intervention.
- "Contact with stigmatized group" relied on involving members of the stigmatized group in the delivery of the interventions to develop empathy, humanize the stigmatized individual, and break down stereotypes.
- An "empowerment" approach was used to improve client coping mechanisms to overcome stigma at the health facility level.
- "Structural" or "policy change" approaches included changing policies, providing clinical materials, redress systems, and facility restructuring.



Assessing perceptions of hospital providers on treatment for substance-use disorder

Sample Annual Survey

Audience: Hospital clinical providers e.g., physicians, physician extenders, nurses, certified nursing assistants, etc.

Directions: Using a scale from 1 to 5 where 1 means "Completely Disagree" and 5 means "Completely Agree", please indicate your level of agreement with the 10 statements below.

Statement	1 *Completely disagree*	2	3	4	5 *Completely agree*
Needle and syringe exchanges should be established in all cities and large towns with large numbers of injecting drug users.					
Drug addiction is a behavioral problem, not a disease.					
Narcan prescription will encourage heroin and opioid use.					
Having injection drug users as patients is stressful.					
Preventing overdoses is ineffective because people will overdose again.					
Making Naloxone widely available will increase the likelihood of misuse.					
If I saw signs of injection drug use (such as track marks), I would regard the patient less favorably.					
Narcan should only be given by medical professionals.					
I do NOT feel I am adequately trained in the treatment of drug addiction.					
Treating drug addiction is NOT effective.					

Page **1** of **1**

Cal Hospital Compare

Assessing Stigma

Source: [Assessing Stigma OUD Sample Annual Survey]

Additional file 2: Pre- and Post-Intervention Response Characteristics for OMS-HC

Item	
1	I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.
2	If a person with a mental illness complains of physical symptoms (e.g. nausea, back pain or headache), I would likely attribute this to their mental illness.
3*	If a colleague with whom I work told me they had a managed mental illness, I would be as willing to work with him/her.
4	If I were under treatment for a mental illness I would not disclose this to any of my colleagues.
5	I would be more inclined to seek help for a mental illness if my treating healthcare provider was not associated with my workplace.
6	I would see myself as weak if I had a mental illness and could not fix it myself.
7	I would be reluctant to seek help if I had a mental illness.
8*	Employers should hire a person with a managed mental illness if he/she is the best person for the job.
9*	I would still go to a physician if I knew that the physician had been treated for a mental illness.
10*	If I had a mental illness, I would tell my friends.

Assessing Stigma

Source: Opening Minds Stigma Scale for Health Care Providers (OMS-HC): Examination of psychometric properties and responsiveness

Other updates

Timely follow up care

- Spread information on new DEA licensure requirements
- Focus on educating and supporting providers with buprenorphine prescribing

Organizational infrastructure

- Engage affiliated practices, spread learnings, and leverage relationships to promote smooth care transitions
- Board engagement

Patient and family engagement

- Empower, educate, engage

How and when to apply

2023 Application Process (Jan – Mar 2024)

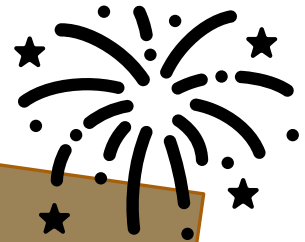
Download the 2024 Opioid Management Hospital Self-Assessment

Review & complete as a team. Block off 1 to 2 hours on your calendar.

Be sure to save a copy of your answers.

Jan – Mar 2024
submit your results; for progress made Apr 2023 – Mar 2024

Celebrate!



In partnership with California Health & Human Services, CHC will recognize honor roll awardees & participants summer 2024

Recognition

Superior Performance

- ≥Hospital scores at least **34 points**

Excellent progress

- Hospital scores **between 26 and 33 points**

Most Improved

- ≥ 5-point difference between 2023 and 2024

Sustained Improvement

- Superior performance two years in a row

Q&A

WHAT QUESTIONS DO YOU HAVE?

Timeline

August 2023: 2024 Opioid Care Honor Roll Program Launch!

- Check out the NEW Opioid Management Hospital Self-Assessment
- Check out "Shared Learnings" and reach out to your peers to learn more
- Celebrate your progress in tandem with our press release honoring hospitals for the 2023 Opioid Care Honor Roll program

September, October, & November: Fall Showcase

- Throughout the Fall we will highlight and share emerging best practices, virtual/on-demand resources, partner events, and other resources to support your opioid stewardship journey

February & March 2024: Office Hours (30 min.)

- Join our office hours for 1:1 coaching and to get your questions answered about how/why to apply for the honor roll

Resources & Follow Up Materials

2023

- Honor Roll Fact Sheet; with list of hospitals
- Methodology Primer
- Honor roll certificates
- Shared learnings excel spreadsheet for peer to pear learning

2024

- Updated Opioid Management Hospital Self-Assessment
- FAQ
- Measurement guide

Partner Resources

CA Bridge

- Recorded training & videos
- Resource library with clinical protocol & SUN/RN workflows
- Sign up for their newsletter to stay in the know

California Opioid Prevention Network

- Virtual events – next up 988 hotline & naloxone supply in CA
- Resource library with a focus on coalition building

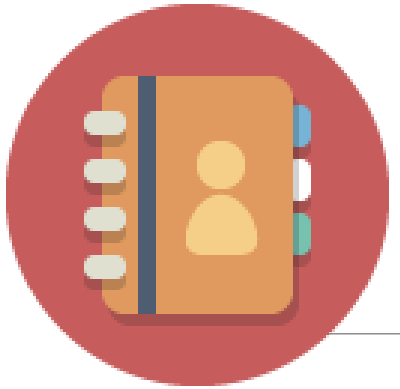
Partner Resources

Health Services Advisory Group

- Webinar Series Sept thru June
- Role of the Emergency Department Physician in the Treatment of Patients with OUD
- Role of the Pharmacist in the Treatment of Patients with OUD
- Seamlessly Transitioning Patients on MOUD to Nursing Homes
- Management of Patients on MOUD During the Nursing Home Stay
- Sustaining Recovery for Patients with MOUD
- Management of Patients on MOUD-Key Takeaways and Series Wrap Up

National Harm Reduction Coalition

- Their website has a number or resources that can help you define and outline your own harm reduction program and general information on how to implement services and supply distribution



Questions?

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Thank you!