THE UNIVERSITY OF ARIZONA

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Center for Rural Health

Comprehensive Center for Pain & Addiction

Opioid Stewardship Program Site Implementation Guide

Version 2: 2025

18-month version

Implementation of the *2022 Centers for Disease Control and Prevention's Clinical Practice Guideline for Prescribing Opioids for Pain* in emergency departments and acute care hospitals in rural Arizona

Contents

University of Arizona Land Acknowledgement

"We respectfully acknowledge the University of Arizona is on the land and territories of Indigenous peoples. Today, Arizona is home to 22 federally recognized tribes, with Tucson being home to the O'odham and the Yaqui. The University strives to build sustainable relationships with sovereign Native Nations and Indigenous communities through education offerings, partnerships, and community service."

Summary

Pain and substance misuse continue to be public health priorities. Rural, underserved, and under resourced populations consistently show disparities in healthcare access, quality, and outcomes. Yet, rural populations have resilience and community capital that can be harnessed to address these complex issues. Opioid Stewardship Programs (OSPs) are one way to support rural healthcare organizations. OSPs are set of interrelated organizational interventions that aim to (1) address pain, (2) reduce opioid misuse through prescribing practices and monitoring, and (3) provide treatment for those who develop an opioid use disorder.

In 2020 personnel from the Arizona Center for Rural Health (AzCRH) began examining the level of OSP implementation in rural Arizona hospitals. This guide is a culmination of this work to offer rural healthcare organizations a model for implementing interventions aligned with *2022 Centers for Disease Control and Preventions Clinical Practice Guideline for Prescribing Opioids for Pain* (herein referred to as the Guideline). This is achieved at all levels of the organization's ecological context with a foundation of trauma informed principles and prioritizing health equity.

This implementation guide is divided into three parts: (1) overview of the implementation intervention, approach, theory, and strategies, (2) procedures for a site to develop an implementation plan, and (3) the expected results of participation.

Purpose and Intended Audience

The purpose of this implementation guide is to offer healthcare organizations (herein referred to as sites) with a plan and tools for implementing one OSP intervention which is aligned with the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain. It was written for the site-level OSP Leadership Team (see discussion).

Our ultimate goal is to help rural healthcare organizations increase their capacity for offering evidence-based pain and addiction treatment; thereby saving lives and improving quality of life.

Table 1. Definitions

Term/Acronym	Definition
CDC	Centers for Disease Control and Prevention
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare and Medicaid Services Framework for Healthy Communities
EHR	Electronic Health Record
Facilitator	University of Arizona personnel trained to support sites to implement OSPs.
Feedback reports	A report the site receives three times throughout the research. This report provides organizational and community strengths, challenges, and progress towards OSP implementation.
FHC	Framework for Health Communities
IF	Implementation Facilitation
IFT	Implementation Facilitation Team
OSP	Opioid Stewardship Program
OSP-LT	Opioid Stewardship Program – Leadership Team
Site	An Arizona rural healthcare organization
Innovation	An evidence-based policy, practice, process, or program.
Intervention	An intervention is a policy, practice, process, or program that the healthcare organization implements or improves.
Strategy	Ways the healthcare organization can work towards implementing the OSP interventions.
UA	University of Arizona

Part 1: Overview

Relevance

Pain is pervasive in the United States with 20% of adults living with chronic pain.[1] Untreated or poorly treated chronic pain has individual and societal costs.[1] Excessive prescribing of opioids has led to opioid overdose and opioid use disorder (OUD).[1] Changes in prescribing practices have left patients with unmanaged pain, withdrawal symptoms, and OUD potentially turning patients to unregulated drug markets.[2] Pain, addiction, and infectious disease are public health prevention priorities.

Opioid Stewardship Programs (OSPs) are a set of interrelated organizational interventions that aim to (1) address pain, (2) reduce opioid misuse through prescribing practices and monitoring, and (3) provide treatment for those who develop an opioid use disorder.[3] Like the positive effect that antibiotic stewardship has on infectious disease management, OSPs offer coordinated advancements in the management of pain and addiction. Both OSPs and antibiotic stewardship programs function under the principle that a particular medication can serve an appropriate function "in the right patient at the right time."[4] Some hesitancies surrounding OSPs are directed towards the concern of inadequate pain control and "withholding" medications for patients who are in pain and may need it.[5] However, the goal of OSPs is not to take away medicine from patients who are in pain–rather, they aim to strategize and develop individualized plans for patients requiring pain medications both in hospital settings and in long-term management.

Despite their strong endorsement by professional organizations, OSP implementation rates are low.[6] OSPs are feasible and acceptable to implement in hospital settings. They show decreases in adverse events and opioid exposure without increases in pain scores.

Preliminary Work

In 2020 personnel from the Arizona Center for Rural Health (AzCRH) began examining the level of OSP implementation in rural Arizona hospitals. [7] Rural hospitals indicated some level of OSP implementation but the plurality were in the planning stages. Additionally, AzCRH personnel began developing OSP implementation tools.[8] These tools were piloted with two critical access hospitals (herein referred to as sites). Pilot sites indicated the process was feasible and acceptable and offered suggestions for improvement.[8] Subsequently, we updated our implementation interventions to align with *2022 Centers for Disease Control and Preventions Clinical Practice Guideline for Prescribing Opioids for Pain* (herein referred to the Guideline) and enhanced our implementation strategies.

Orientation to the Implementation Guide

This implementation guide is divided into three parts: (1) overview of the implementation intervention, approach, theory, and strategies, (2) procedures for a site to develop an implementation plan, and (3) the expected results of participation. To begin, we provide an overview of the key definitions followed by a discussion of each.

- OSP **intervention** are the five recommendations in practice area four of the 2022 Clinical Practice Guideline.[1]
- OSP implementation **approach** is the six trauma-informed principles developed by the Substance Abuse and Mental Health Services Administration and used by the Center for Disease Control and Prevention.[9] These principles will be infused throughout all aspects of this research. The principles include:
    1. Safety
    2. Trustworthiness and transparency
    3. Peer support

4. Collaboration and mutuality
5. Empowerment voice & choice
6. Cultural, historical, and gender issues

- OSP **theory** is the Social Ecological Model which posits that change efforts must be nested in numerous contexts to identify facilitators and overcome challenges.[10]
- OSP **strategies** in five areas include:
  - Personnel:
    - Developing organizational level OSP Leadership Team.
    - Supporting the OSP Leadership Team by the Implementation Facilitation Team (IFT).[11]
    - Community health workers/representatives
  - Organizational:
    - Increasing use of Motivational Interviewing[12] and Screening, Brief Intervention, and Referral to Treatment (SBIRT)[13] framework.
    - Implementing the Centers for Medicare and Medicaid Services Framework for Healthy Communities.[14]
    - Financing structures.
  - Clinical/practice:
    - Toxicology screening.
    - Initiating and monitoring treatments for opioid withdrawal and use disorder.
    - Co-prescribing naloxone.
  - Technology:
    - Utilizing the Arizona Controlled Substance Prescription Drug Monitoring Program (AzPMP).
    - Using the Arizona social determinants of health referral system.
  - Educational:
    - Breakthrough Series Collaboratives.[15]

OSP Intervention

2022 Clinical Practice Guideline: Rationale for Focusing on Practice Area Four

In 2022, the CDC released updated guidance regarding prescribing opioids for pain. There are 12 recommendations in four practice areas. Through the preliminary work conducted on OSP we found a consistent gap in practices associated with screening, intervening, and referring for risks and potential harms associated with opioids. To fill this gap and increase implementation in practice area four, our OSP intervention is to increase the uptake of the Guideline recommendations 8-12 (Figure 1).

Figure 1 2022 Clinical Practice Guideline – Practice Area 4 Recommendations 8-12.[1]

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone
9. When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose.
10. When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances.
11. Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants.
12. Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder. Detoxification on its own, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death.

OSP Approach

In the post-COVID era, increasing focus is being placed on resilience in all healthcare workers. It has been demonstrated that physician burnout can lead to career disengagement, healthcare inefficiency, and decreased quality of patient care.[16] Additionally, the toll of emotional exhaustion continues to perpetuate the feelings that lead healthcare workers towards burnout. In the setting of the opioid crisis, the development and implementation of OSPs aim to alleviate the stresses placed on healthcare providers and diversify management of patients across various specialties. At the institutional level, organizational leadership is paramount to creating meaningful change in regard to physician burnout.[17] Effective leaders have the power to provide team collaboration, direction, and policy management while delegating tasks. Physicians endure stressful situations given their workload;[16] therefore, utilizing OSPs and dividing work among several team members may alleviate burdens of physicians and offer coordinated care to ensure patients and their families receive quality services and support for managing pain and addiction.

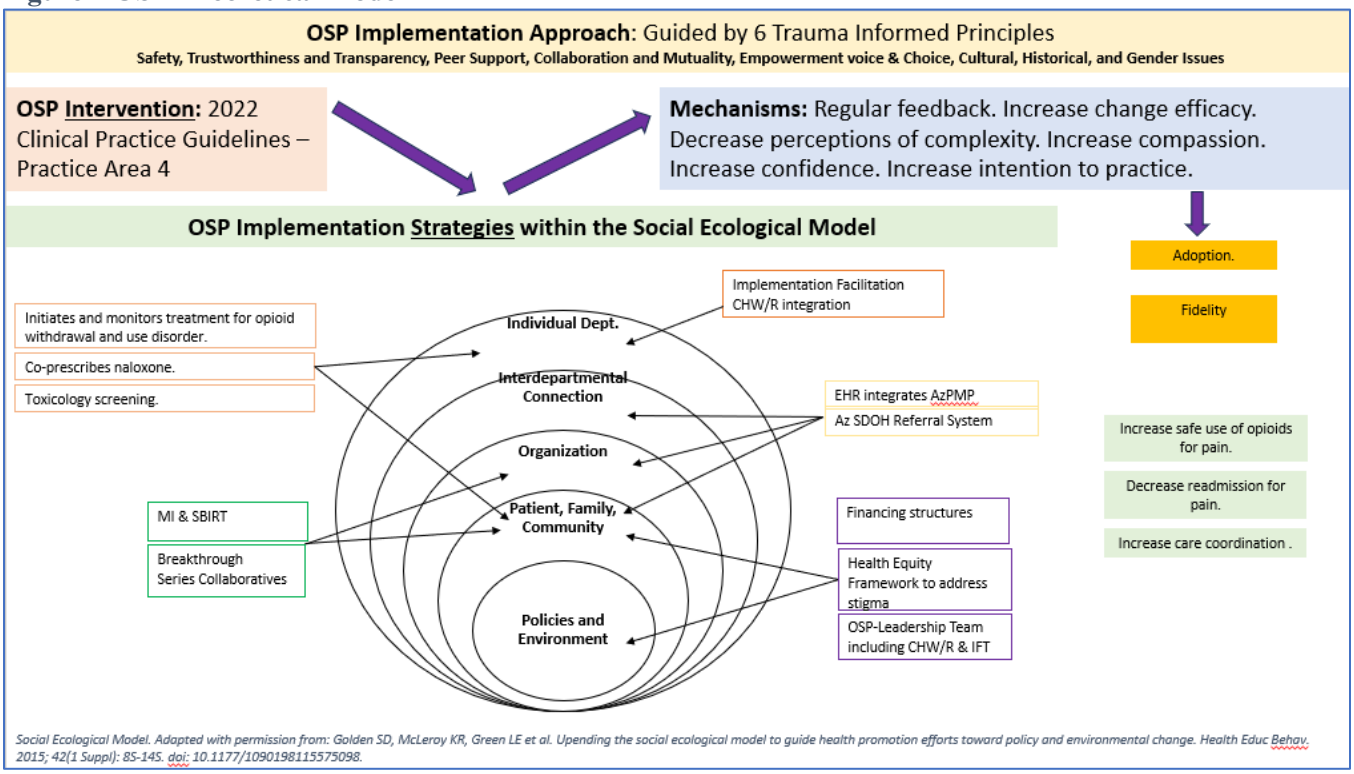
One barrier to successful treatment of physician burnout in the realm of OSP implementation may be "lack of community infrastructure or support" [6] within a hospital or community population. That is, rural healthcare organizations may have limited infrastructure (e.g., payment structures; technology), personnel (e.g., knowledgeable, skilled, and able), and community resources (e.g., treatment options; referral sources) to address pain and addiction. Moral distress due to lack of administrative support can further exacerbate feelings of burnout and may lead physicians and ancillary staff to abandon OSP projects altogether. It is essential for administrative leadership to support the efforts of OSP leadership teams and promote the wellbeing of the physicians and other healthcare workers that make up these multidisciplinary teams. The quality of healthcare and likelihood of adverse health events is significantly affected by physician burnout,[16] and therefore we will promote and encourage individual and organizational well-being throughout our implementation process.

Our OSP implementation approach recognizes the stresses encountered by patients, families, and healthcare professionals alike particularly in a post-pandemic era. We use a trauma-informed approach to our implementation to ensure we are engaging with healthcare organizations and professionals within the context of their environments and policies. Trauma-informed approaches aim to engage participants in the process of implementation, avoid trauma exposure, and create safety in community.[9]

OSP Theory

The Social Ecological Model[10] recognizes the nested contexts of individuals and organizations and how these interact to support or hinder a variety of issues including change processes. Figure 2 shows our theoretical model for implementing OSPs in rural healthcare settings. It shows developing and supporting OSP leaders who can champion the implementation of the intervention throughout all contexts so that increases in the assessment of risks and addressing potential harms can occur without decreasing quality of care. Our OSP will support sites in creating guidelines and workflows for the assessment and treatment of pain and opioid misuse, withdrawal, and opioid use disorder.

Figure 2 OSP Theoretical Model



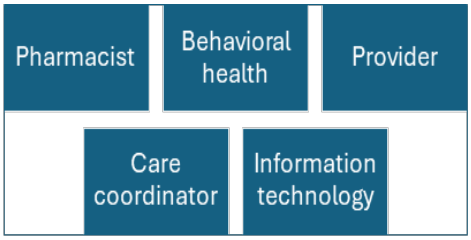
OSP Strategies

Personnel

OSP Organization-Level Leadership Team

The **OSP Leadership Team** (OSP-LT) are personnel from the healthcare organization and are critical to accelerating OSP implementation. The purpose of the OSP-LT is to (a) offer guidance, support, and monitoring for implementing the OSP intervention within their organization with a specific focus on the organizational policies, environment, and context (b) support the health and wellness of the organizations workforce, (c) meet regularly with the Implementation Facilitation Team (IFT) (see below), and (d) complete forms and surveys for

the research. The OSP-LT can be comprised of various roles within the healthcare organization, but organizations should consider two to five personnel who may fill one or multiple roles such as:



It's understood that small rural healthcare organizations may have one person who fills two or three roles. If possible, their participation is particularly important. One person should be identified as the lead and the main point of contact for the IFT. Over the course of 18 months, the OSP-LT will:

- ✓ Focus on implementation facilitators and challenges with the organizational environment and policies.
- ✓ Attend implementation facilitation meetings and learning collaboratives.
- ✓ Model and instill best practices for creating and supporting healthy organizational culture.
- ✓ Communicate implementation processes and provide support to hospital staff using feedback reports.
- ✓ Ensure project charter, implementation plan, and feedback reports are reviewed and discussed.
- ✓ Complete research forms.
- ✓ Host one meeting with organizational personnel to communicate achievements and lessons learned.

Supporting the OSP Leadership Team by the Implementation Facilitation Team (IFT)

The **Implementation Facilitation Team (IFT)** are personnel that are part of the external research team. The IFT is dedicated to supporting the OSP-LT in achieving their implementation goals. The IFT will be comprised of a lead facilitator and co-facilitator. Their primary purpose is to support the OSP-LT by (1) documenting and tracking progress towards implementation goals, (2) helping the OSP-LT stay focused on the original goals and providing relevant resources, (3) preparing and discussing regular feedback reports, (4) engaging and encouraging the OSP-LT to recognize successes and identify solutions to challenges. The IFT also aims to support the OSP-LT by demonstrating compassion, addressing challenges, and celebrating organizational change efficacy.

The OSP-LT can expect the IFT to:

- Provide regular feedback reports that highlight progress and identify improvement areas.
- Dedicate time to support implementation.
- Support managing multiple priorities.

Sites will participate in 60-minute IF meetings. The frequency of these meetings depends on the site's progress. The purpose of the IF meetings are to (1) acknowledge progress made towards achieving implementation goals, (2) identify challenges and solutions, and (3) create plans for the following months. These meetings will be guided by the site's implementation plan (see detailed discussion in part 2).

Meetings may follow this type of agenda:

1. Welcome, land acknowledgement, introductions, and mindfulness moment (5-minutes).
2. Update on new information contextual information (something interesting from the literature; policies; organization) relevant to the OSP intervention (5 minutes).
3. Review implementation plan goals, progress, and provide feedback (30 minutes):
   - What worked well this month?

- What were the challenges?
- What are the potential solutions for next month?

4. Create a plan for the subsequent month and confirm the date/time of next meeting (10 minutes).
5. Recognize the good things done by yourself, a teammate, and what was achieved as a team (10 minutes)

Community Health Workers/Representatives

CHW/Rs will be integrated into the healthcare setting to screen patients for issues related to the social determinants of health and support coordination of care. Healthcare organizations may have a CHW/R already on staff or have someone who may be interested. Through this research process, we will be able to provide some salary dollars to pay CHW/Rs for work related to the research (e.g., training, data collection). If healthcare organizations do not have a CHW/R identified, we will work with the site to help identify someone who may be interested.

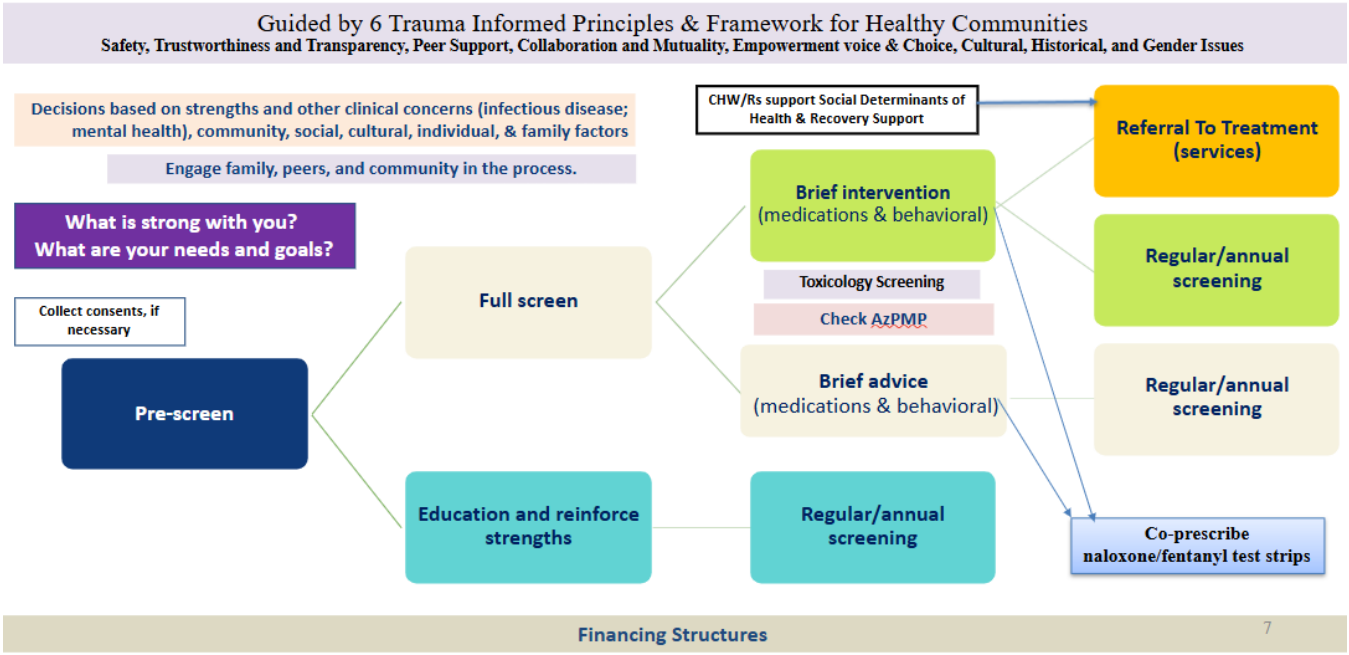
Organizational

Motivational Interviewing (MI) & Screening, Brief Intervention, and Referral to Treatment (SBIRT)

MI is a person-centered approach for working with patients with various health conditions.[12] MI engages patients in a non-directive conversation about health behaviors that they may be ambivalent about changing. MI can be implemented in healthcare settings to help patients determine how their current behaviors are supporting and/or hindering them in achieving their goals.[12] Fundamentally, MI is a strength-based and person-centered communication style that helps patients build intrinsic motivation for change.

SBIRT is a public and population approach to identifying and intervening on issues of substance use, misuse, and addiction. SBIRT starts with a universal approach to screening all patients about alcohol, tobacco, and other drug use. Ultimately, SBIRT is a prevention and early intervention approach to address substance use, mental health, and infectious disease issues before they become severe. Yet, it also identifies patients who may need medications and specialty care. Based on pre-screening results, a full screening may be conducted and/or brief interventions or referral to specialty care (Figure 3 – sample workflow). For our purposes, we aim to take a strength-based approach to all aspects of SBIRT implementation. This means supporting the healthcare workforce to implement a trauma informed approach that considers the strengths of the patient and their family/support system.

Figure 3 Sample SBIRT Workflow



CMS Framework for Healthy Communities

Studies show people who use drugs or are in recovery may be reluctant to use the healthcare system because of stigma,[18] lack of resources,[18] or concerns about treatments. As such, we will use the Centers for Medicare & Medicaid Services Framework for Healthy Communities[19] to ensure we are striving to increase access to quality care for people with pain and addiction. This may include conducting a scan of the language, terminology, and treatment recommendations used in the healthcare setting for people with pain and/or addiction.

The CMS Framework for Healthy Communities has five priority areas:

- Priority 1: Expand the collection, reporting and analysis of standardized data.
- Priority 2: Assess opportunities to close gaps in CMS programs, policies, and operations.
- Priority 3: Build capacity of health care organizations and the workforce.
- Priority 4: Promote language access, health literacy, and the provision of person-centered services.
- Priority 5: Increase access to health care services for individuals living with a disability.

While we develop the implementation plan, we will ask sites to select one priority area and develop one way they will further this priority for people with pain and substance use concerns (See Part 2).

Financing structures

It is essential for healthcare organizations to have financing structures in place to pay for care. Inadequate reimbursement can lead to OSP implementation never starting or moving slowly. There are payment structures for pain treatments including those related to opioid withdrawal, treatment, and recovery support.

Sites may elect to assess and expand their use of payment structures for offering pain and addiction treatments. Together the OSP-LT and IFT will collaborate to develop tools, systems, and training for paying for pain and addiction services.

Clinical/practice

Toxicology screening.

Toxicology screening is one strategy for detecting therapeutic uses of opioids, reducing risks, and assessing patient needs related to pain and substance use. In healthcare, numerous biological screenings are used to detect, prevent, and manage numerous conditions. Yet, recognizing the ways healthcare professionals introduce, collect, and communicate results is important. Patients who use or have used drugs may have had toxicology screenings that were a punitive measure (e.g., employment; probation/parole requirement) and/or reexperience trauma because of the way it was collected (e.g., observed).

Sites may elect to increase the use of toxicology screening to assess risk as part of their implementation plan. Together the OSP-LT and IFT will collaborate to develop tools, workflows and training and procedural activities to increase trauma informed toxicology screening.

Initiating and monitoring treatments for opioid withdrawal and use disorder.

Effective Food and Drug Administration (FDA) approved medications exist for managing opioid withdrawal and use disorder. There are also effective and reimbursable psychosocial and behavioral interventions. Yet, these are underutilized in healthcare for a variety of reasons.

Sites may choose to increase their use of treatments for opioid withdrawal and use disorder. Together the OSP-LT and IFT will collaborate to identify/develop tools, workflows, training, and procedural activities to increase use of effective treatments.

Co-prescribing naloxone.

Naloxone is a lifesaving drug that can reverse an opioid overdose. Yet, rates of co-prescribing naloxone when an opioid is prescribed are low. There are numerous factors associated with this including policies, availability of the product, cost, and clinical and individual issues.

Sites may choose to increase their co-prescribing of naloxone. Together the OSP-LT and IFT will collaborate to identify/develop tools, workflows, training, and procedural activities to increase co-prescribing of naloxone.

Technology

Utilizing the Arizona Prescription Drug Monitoring Program (AzPMP)

The AzPMP is a technology tool that can identify risks and potential harms associated with prescribing an opioid. While there are high rates of use of the AzPMP, integration into the EHR is lower in rural as compared to urban areas.

Sites may choose to increase their integration of the AzPMP into the EHR. Together the OSP-LT and IFT will collaborate to identify/develop tools, workflows, training, and procedural activities to support sites in integration the AzPMP into their EHR.

CommunityCares, Arizona Social Determinants of Health Referral System (SDOH Referral System)

Arizona has a single statewide referral system specifically around the social determinants of health. The goals are to coordinate care, connect communities, improve health with a whole person care mindset which leads with a data driven approach. The system includes screening and assessment of needs and can be integrated into the EHR.

Sites may choose to increase their use of the SDOH referral system. Together the OSP-LT and IFT will collaborate to identify/develop tools, workflows, training, and procedural activities to support sites in integrating and using the SDOH referral system.

Educational

Breakthrough Series Collaboratives (Learning Collaboratives)

The Institute for Healthcare Improvement developed the Breakthrough Series Model as a method for improving healthcare quality.[15] Beginning immediately, sites can participate in learning collaboratives. The purpose of learning collaborative is to allow sites to exchange ideas, best practices, resources, and develop action steps for dissemination and implementation. The monthly learning collaboratives are designed to offer healthcare organizations didactic information about a topic and opportunities to interact. These are open to everyone at the organization. Learning collaboratives will be focused on solutions, best practices, and actions.

The IF facilitators will host monthly learning collaboratives. We'd like sites to attend all learning collaboratives but recognize that is unrealistic. Therefore, we ask sites to attend a minimum of 6 out the 16-learning collaborative's during their 18-months of participation. After they participate in a learning collaborative, we will ask them to select one action item to take back to their organization for dissemination.

Structure and topics might include:

Structure:

Welcome, sign in, mindfulness moment, and reminding of collaborative/purpose 5 minutes
Topic speaker and expert 15 minutes (5 slides)
Interactive discussion 25 minutes
Dissemination plans 10 minutes

- One way you will discuss this learning collaborative with others in your organization.
- By when?
- What do you hope to achieve?

Potential Topics:

Personnel

- Substance use, misuse, and addiction – Challenging (some) current practices.
- We're stressed out and not in a healthy way. Strategies for organizational and individual post traumatic growth.
- Hiring peer/family support specialists and/or community health workers/representatives.
- We'd love to help but no one is here. Addressing workforce issues such as turnover, presenteeism, specialty providers.

Organization

- Creating trauma informed, culturally and linguistically responsive systems of care.
- Motivational Interviewing and Screening, Brief Intervention, and Referral to Treatment
- When ethical standards collide – what are some approaches for making informed decisions?
- Prevention through a SBIRT framework.
- Increasing access – concrete strategies for systemic change.
- Naloxone and fentanyl test strips – standardizing harm reduction practices into care.
- Getting reimbursed for complementary pain care and substance use services.

Clinical/practice

- Celebrating people who use drugs or are in recovery and their families.
- Strategies to engage people who use drugs or are in recovery into care.
- Pain – Opioids and complementary treatments.
- Addressing syndemics – pain, substance use, mental health, and infectious disease.

- Compassionate and safe ways of interacting with people who may be intoxicated.

Technology
- Continuum of care – identifying, reviewing, and working with other service or support organizations.
- Integrated behavioral healthcare.
- Information technology in healthcare.

Part 1: Summary

OSPs are feasible and acceptable to implement in hospital settings. They are recommended by numerous professional organizations but are underutilized. The CDC issued a practice guideline for prescribing opioids for pain in 2022. A needs assessment, literature review, and survey highlighted the potential for practice improvement in area 4 – assessing risks and addressing potential harms using a trauma-informed approach and multiple strategies within each sphere of the Social Ecological Model. Part 2 walks through the specific implementation process and plan.

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Part 2: Concrete Implementation Steps

Site Participation Overview

This research aims to engage rural healthcare organizations to participate in an 18-month research project (Figure 4). Based on the work of Ritchie et al.[11] the research is in three phases to participation: (1) ***pre-implementation***, (2) ***implementation***, and (3) ***post-implementation***. Figure 4 and Table 2 provide an overview of the timeline below and components of the project. These are discussed in greater detail throughout this guide.

Figure 4 OSP Site Level Implementation Timeline

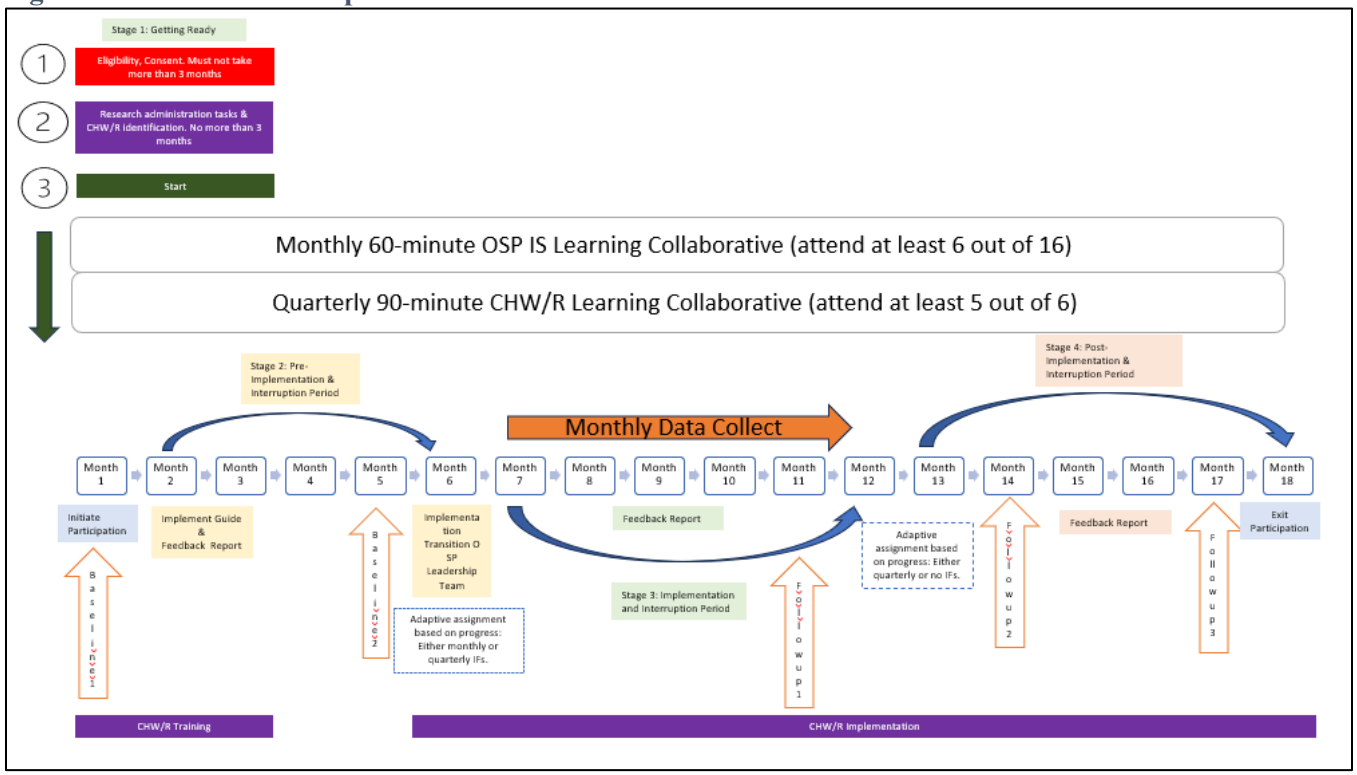


Table 2. Key Steps By Implementation Phase

Step	Activity
	Pre-Implementation
Step 1.	Communicate interest in participating by completing the interest and eligibility form. Complete research forms and baseline 1 which includes implementation assessment (month 1)
Step 2.	Receive welcome packet from IFT. Review and begin developing project charter, and implementation plan. (month 2)
Step 3.	Select at least 6 out of 16 learning collaboratives to attend and begin attending. (month 2)
Step 4.	Identify CHW/R who can work on the project. Support initial and ongoing training (by month 3)
Step 5.	Complete project charter and implementation plan and begin implementation. Review feedback report (month 3)

Step	Activity
Step 6.	Initial meeting with IF facilitators. Review project charter, implementation plan and progress. Schedule subsequent IF meetings. (month 5)
Step 7.	Complete baseline 2. (month 5)
Implementation	
Step 8	Participate in IF meetings as designated by implementation progress and continue implementation (months 7-12)
Step 9	Review feedback report and adjust implementation plan if necessary (month 9)
Step 10	Complete monthly data collection (months 7-12)
Step 11	Complete follow up 1 (month 11)
Post Implementation	
Step 12	Participate in IF meetings as designated by implementation progress (months 13)
Step 13	Continue implementation (months 13-18)
Step 14	Complete follow up 2 (month 14)
Step 15	Complete follow up 3 (month 17)
Step 16	Host one meeting within the organization to communicate achievements and lessons learned (months 15-17)
Step 17	Final research meeting (month 18)

Opioid Stewardship Program Implementation Project Charter & Plan

This section provides a template and instructions for developing the project charter and implementation plan. This will be available so sites can complete and update this electronically (Research Electronic Data Capture [REDCap][20]). They will be able to download the template and completed document for their reference.

[ORG NAME]

Purpose

To offer Arizona hospitals and their affiliates a project charter and plan for implementing or enhancing an Opioid Stewardship Program (OSP). Ultimately, we aim to increase access to quality care for all patients with chronic pain and substance use concerns.

Intended Audience

This template should be completed by the OSP Leadership Team (OSP-LT) as defined by the organization. The OSP-LT may need to collect information from other personnel in the organization.

This document is divided into two sections:

1. **Project Charter.** A project charter lists key personnel, the purpose of the OSP, what would be considered a success and what is and isn't within the scope of the project.
2. **Implementation Plan**
    a. Review and update—This section provides the organization's results from the implementation survey and requests updates reflecting any recent changes to OSP strategy implementation levels.
    b. Implementation planning—This section walks through elements to consider when developing the plan for implementation.
    c. Planning to action—This is the actual implementation plan.

Project Charter Template

The project charter provides general contact information, a shared understanding of the purpose of implementing the OSP intervention, and timelines.

Contact Information

Site Name		OSP Leadership Team Members Name	Email
Site Lead Name			
Email			
Phone			
Organization			

Purpose of Project

Problem or issue trying to address	
Success indicators	
What is within the scope of this project	
What is outside the scope of this project	

Activities and Timelines

Milestones	**Expected Start Date**	**Expected Complete Date**
OSP Leadership Team formed		
Finalized implementation plan		
Data collection		
Participate in monthly OSP IF meetings		
Participate in monthly learning collaboratives		
Adopt OSP intervention		

Who would you like us to add to our research listserv? This provides information about implementation and learning collaboratives. You may add as many people as you'd like. Once subscribed, individuals can modify subscription services and/or leave at any time.

Name	**Email**	**Role**

Implementation Plan

Determining Implementation Stage

Implementation science tells us it is relevant to understand the stage of implementation when initiating any change process. We wouldn't want to say as part of the CDCs recommendation 8, all organizations must select a screening tool to start. Some organizations may have a screening tool that is accepted among practitioners, is regularly used, and integrated into the EHR. In this instance, another implementation strategy might be to increase use of the screening results for implementing brief interventions. Understanding the implementation stage is important for selecting the best strategies, monitoring progress, and examining research results.

Table 3 provides some general guidance on the five implementation stages.

Table 3. Implementation Stage Definitions

Implementation Stage	Definition
1. Not implemented/no plan.	The healthcare organization may have thought about implementing the intervention but do not have a plan or start date.
2. Plan to implement/no start date.	The healthcare organization has developed a plan and but no start date set.
3. Plan to implement/ start date set	The healthcare organization has a plan and date they will start implementation but haven't started yet.
4. In place less than 6 months.	The healthcare organization has started and has been implementing the intervention for less than 6-months.
5. In place longer than 6 months.	The healthcare organization has started and has been implementing the intervention for more than 6-months. ***This is considered adoption.***

Implementation Assessment

The questions that follow are part of the OSP implementation strategies. Please answer the questions by considering this stem…. *Based on the last 12-months our organization has {…} for pain and then addiction*

1 = Not implemented/no plan
2 = Planned to implement/no start date
3 = Planned to implement/start date set
4 = In place less than 6 months
5 = In place more than 6 months

Domain Area and Strategies	ED Pain	ED Addiction	Acute Care Pain	Acute Care Addiction
Screening and Assessment Based on the last 12-months our organization has {…} for pain and addiction				
Valid screening/assessment tools (Rec. 8, 10, 11, 12).				
Conducted toxicology screening (Rec 10)				

Domain Area and Strategies	ED Pain	ED Addiction	Acute Care Pain	Acute Care Addiction
Checked the AzPMP for all patients receiving opioid prescription and/or on opioid therapies (Rec 9).				
Screening/assessment tools integrated into the EHR (Rec 8, 9, 10, 11, 12)				
Payment/financing structures for screening/assessment (Rec 8, 9, 10, 11, 12)				
Implementation Score Low = 5 High = 25 Rec 8 – possible = 3 Rec 9 – possible =3 Rec 10 – possible = 4 Rec 11 – possible = 3 Rec 12 – possible = 3				
Intervention & Treatment				
Used multimodal peri/postoperative pathways for recovery after surgery (Rec 8, 11, 12)				
Co-prescribed naloxone with opioid prescriptions (Rec 8, 10, 11, 12)				
Offered patient and family education. (Rec 8, 9, 10, 11, 12)				
Offered brief intervention/treatment (Rec 8, 10, 11, 12)				
Provided treatment for withdrawal (Rec 12)				
Provided treatment for OUD (Rec 12)				
Provided medications to treat OUD (Rec 12)				
Incorporated CHW/R, peers/family specialist, navigators into workflow (Rec 8, 10, 11, 12)				
Developed opioid risk, benefit, and exit plans with patients (Rec 8, 9, 10, 11, 12)				
Payment/financing structures for intervention/treatment (Rec 8, 9, 10, 11, 12)				
Implementation Score Low = 10 High = 50 Rec 8 – possible = 7 Rec 9 – possible = 3 Rec 10 – possible = 6 Rec 11 – possible = 7 Rec 12 – possible = 10				
Referral & Linkage to Care				
Agreements with community or specialty pain care (Rec 9, 10)				
Agreements with community or specialty OUD care (Rec 9, 10)				

Domain Area and Strategies	ED Pain	ED Addiction	Acute Care Pain	Acute Care Addiction
Agreement with community or specialty care for infectious disease. (Rec 9, 10)				
Incorporated CHW/Rs, peers/family specialist, or navigators into the referral/linkage process (Rec 8, 11, 12)				
Payment/financing structures for referral and linkages to care. (Rec 8, 9, 10, 11, 12)				
Implementation Score Low = 5 High = 25 Rec 8 – possible = 2 Rec 9 – possible = 4 Rec 10 – possible = 4 Rec 11 – possible = 2 Rec 12 – possible = 2				
Score of # endorsed by Guideline Recommendations Implementation Score Low = 20 High = 100 Rec 8 – possible = 12 Rec 9 – possible = 10 Rec 10 – possible = 14 Rec 11 – possible = 12 Rec 12 – possible = 15				

Note. Rec means recommendation from the Guideline. Number in parenthesis corresponds to the recommendation number.

Now please consider these Guideline recommendations as our OSP interventions:

- 8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone.
- 9. When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose.
- 10. When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess prescribed medications as well as other prescribed and nonprescribed controlled substances.
- 11. Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants.
- 12. Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder. Detoxification on its own, without medications for opioid use disorder,

is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death.

Selecting OSP Interventions and Strategies

Please refer to pages below for some examples of how you might operationalize the intervention with the strategies.

Using the implementation assessment, feedback report, and knowledge of the organizational context, the OSP-LT will select one OSP intervention and one strategy as part of this research.

- For sites in implementation stage 2. The site will review the implementation guide, considering the feasibility of implementing the OSP interventions and strategies. Then they will finalize the implementation plan and set a start date for implementation within 60-days.
- For sites in implementation stages 3. The site will review the implementation guide and consider what, if any changes to their plan necessary for OSP intervention and begin implementing within 30-days. They will set an implementation date within 30-days.

Based on the implementation assessment and the context of your site, which **one** OSP intervention would your organization like to focus on starting or moving forward? ____ ____

Thinking about the OSP intervention you want to implement, which one strategy from the list above that has an implementation stage of 1-2 do you think your organization could work on and which setting (there are examples below)?

Strategy		Setting (ED/ACH)	

Organizational Factors

Current organizational factors may serve as facilitators or challenges for implementing your OSP intervention strategies. Organizational factors may include leadership, written policies/protocols, technological, personnel, financial issues, etc. Please identify the facilitators and challenges that may be relevant to implementing the OSP intervention and strategy.

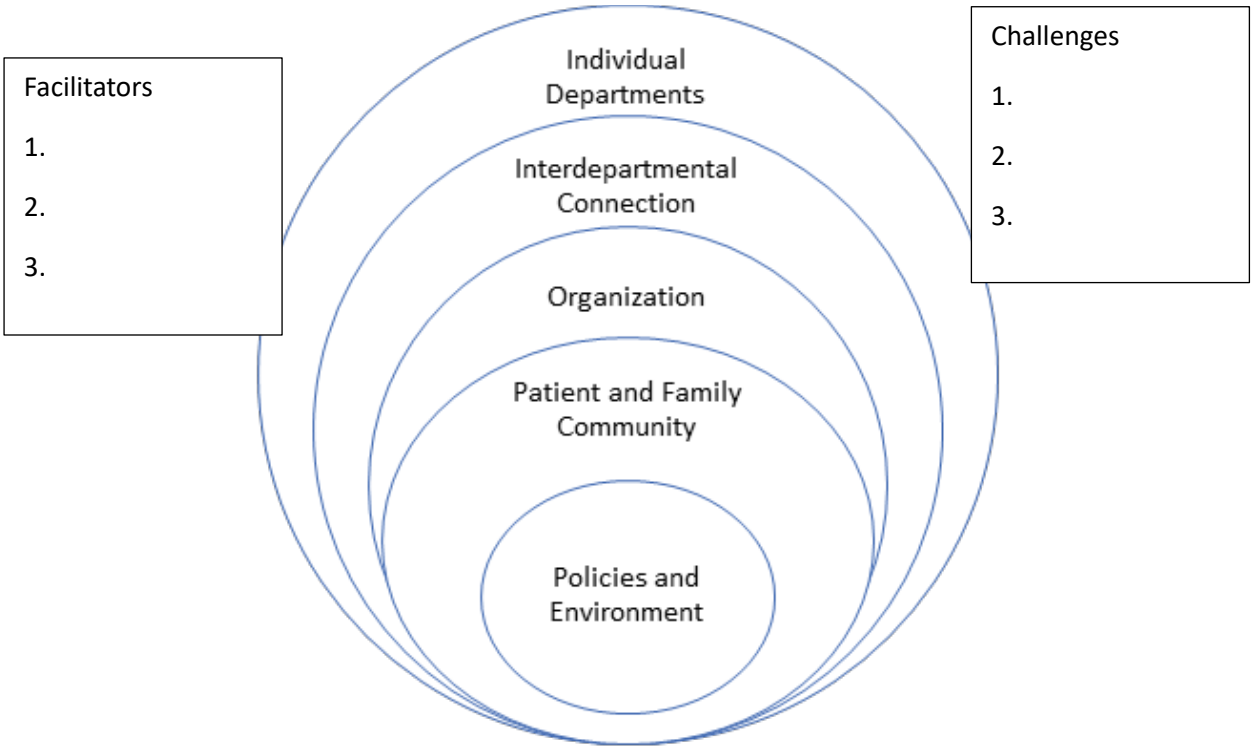


Figure above: Social Ecological Model. Adapted from: Golden SD, McLeroy KR, Green LE et al. Upending the social ecological model to guide health promotion efforts toward policy and environmental change. Health Educ Behav. 2015; 42(1 Suppl): 8S-14S. doi: 10.1177/1090198115575098.

What are three potential solutions for the challenges above?

1. _____
2. _____
3. _____

Framework for Healthy Communities

The FHC has five priorities.

- Priority 1: Expand the collection, reporting and analysis of standardized data.
- Priority 2: Assess opportunities to close gaps in CMS programs, policies, and operations.
- Priority 3: Build capacity of health care organizations and the workforce.
- Priority 4: Promote language access, health literacy, and the provision of person-centered services.
- Priority 5: Increase access to health care services for individuals living with a disability.

These are examples of how sites might implement FHC with OSPs:

Figure 5 Potential Health Strategies Aligned with OSP interventions.

Priority 1: Expand the collection, reporting and analysis of standardized data.	Secure the necessary forms such as consents, releases.
	Utilize data to ensure prescribing and treatment recommendations are fair for all patients.
	Track and report toxicology tests offered and taken by patient characteristics.
	Assess the language used in data systems to ensure it doesn't preciptate stigma and bias.
Priority 2: Assess opportunities to close gaps in CMS programs, policies, and operations.	Verify workflows and processes don't inadvertently introduce bias in care.
	Consider issues of historical trauma and toxicology screening. Ensure patients are informed and their concerns are addressed.
	Consider multiple measures of perceptions of pain to ensure treatment recommendations are fair for all patients.
	Consider the language used throughout the health care setting which may inadvertantly preciptiate stigma and bias.
Priority 3: Build capacity of health care organizations and the workforce.	Secure the necessary forms such as consents and releases.
	Provide training and tools to reduce bias in prescribing and treatment.
	Engage family members in the care planning process.
	Ensure toxicology protocols are presented and discussed in a similar way as other healthcare tests (e.g., cholesterol; glucose) using medically accurate terminology and chronic care management models
	Provide ongoing training on substance use, misuse and addiction to ensure latest evidence is communicated to personnel.
Priority 4: Promote language access, health literacy, and the provision of person-centered services.	Ensure screening and other resources are available in the language used by the patient population and considers the social determinants of health
	Ensure patient safety education is developed and delivered in an appropriate and understandable in the patients preferred way.
	Consider social determinants of health resources for positive toxicology screening.
	Plan to incorporate language assistance in workflows.
	Use updated language when discussing substance use, misuse, and addiction throughout all aspects of care.
Priority 5: Increase access to health care services for individuals living with a disability.	Ensure policies, processes, and programs are accessible
	Visit referral sources to ensure they offer culturally and linguistically responsive services.
	Make conflict resolution or grievance processes for personnel, patients, and families easy to understand and accessible.

Based on your OSP intervention and strategy what is one FHC strategy your site will implement?

Table 4. FHC Implementation Strategies

FHC Priority #	Strategy

Healthcare Environment and Workforce

- Tell us one organizational policy, practice or process that you consider an organizational strength.
- What three words would you use to describe the current healthcare environment.
- What three words would you use to describe the current healthcare workforce.

As part of the implementation plan, we want to ensure we are using a trauma informed approach. Here are some examples of ways organizations can implement strategies:

What one trauma informed approach fits best within your organization: _____

What is one trauma informed activity your organization can start or improve _____

Putting it all together. Planning to Action

Implementation Plan and Progress Feedback

The purpose of this section is to develop an 18-month action plan for implementing the OSP intervention and strategies.

1. Implementation plan developed date:
2. Implementation plan finalized date:
3. Planned Implementation start date OSP strategy:
4. Planned Implementation start date FHC strategy:
5. Planned Implementation start date trauma informed approach:

Identifying the OSP Intervention and Strategies to focus on for 6-12 months.

OSP Intervention			
OSP Strategy		FHC Strategy	
Trauma Informed Approach			

Each month we will identify action steps for the next month. These will be reviewed during IF meetings.

Each action step should be SMART: Specific, Measurable, Achievable, Relevant and Timebound.

This is an ***example*** of a SMART Goal for an organization in stage 2 of implementation:

- By March 2026, we will identify and select one screening tool to use with patients in the emergency department.
- By March 2026, we will determine if there are costs associated with using the screening tool with patients in the emergency department.
- By March 2026, we will determine if the screening tool is available in language(s) used by most of our patients in the emergency department.

Month 1 (Date) - Action Steps:

	SMART Goal	**Who's Responsible?**
Action Step 1		
Action Step 2		
Action Step 3		

Month 2 (Date) - Action Steps:

	SMART Goal Progress from Last Month	**Changes, modifications, updates**	**Who's Responsible?**
Action Step 1			
Action Step 2			
Action Step 3			

Month 3 (Date) - Action Steps:

	SMART Goal Progress from Last Month	**Changes, modifications, updates**	**Who's Responsible?**
Action Step 1			
Action Step 2			
Action Step 3			

Month 4 (Date) - Action Steps:

	SMART Goal Progress from Last Month	**Changes, modifications, updates**	**Whose Responsible?**
Action Step 1			
Action Step 2			
Action Step 3			

Month 5 (Date) - Action Steps:

	SMART Goal Progress from Last Month	Changes, modifications, updates	Who's Responsible?
Action Step 1			
Action Step 2			
Action Step 3			

Month 6 (Date) - Action Steps:

	SMART Goal Progress from Last Month	Changes, modifications, updates	Who's Responsible?
Action Step 1			
Action Step 2			
Action Step 3			

Month 7 (Date) - Action Steps:

	SMART Goal Progress from Last Month	Changes, modifications, updates	Whose Responsible?
Action Step 1			
Action Step 2			
Action Step 3			

Month 8 (Date) - Action Steps:

	SMART Goal Progress from Last Month	Changes, modifications, updates	Who's Responsible?
Action Step 1			
Action Step 2			
Action Step 3			

Month 9 (Date) - Action Steps:

	SMART Goal Progress from Last Month	Changes, modifications, updates	Who's Responsible?
Action Step 1			
Action Step 2			
Action Step 3			

Month 10 (Date) - Action Steps:

	SMART Goal Progress from Last Month	Changes, modifications, updates	Who's Responsible?
Action Step 1			
Action Step 2			

Action Step 3			

Month 11 (Date) - Action Steps:

	SMART Goal Progress from Last Month	Changes, modifications, updates	Who's Responsible?
Action Step 1			
Action Step 2			
Action Step 3			

Month 12 (Date) - Action Steps:

	SMART Goal Progress from Last Month	Changes, modifications, updates	Who's Responsible?
Action Step 1			
Action Step 2			
Action Step 3			

Month 13-18 (Start and End Date) - Action Steps:

	SMART Goal Progress from Last Month	Changes, modifications, updates	Who's Responsible?
Action Step 1			
Action Step 2			
Action Step 3			

Implementation Progress Measurement			Notes
Start Implementation Stage (months 1-3)	Mid-term (9-months) Implementation Stage	End Implementation Stage (month 18)	

Overall progress measurement please use this scale.

1=Plan to implement/start date set
2=Start date set but delayed or postponed (brief description of reasons)

3=Implementation is in progress
5=In place less than 6 months
6=In place more than 6 months

While you are welcome and we encourage you to attend as many Learning Collaboratives as possible, we recognize that it may be difficult. We would like you to attend at least 6 over the course of this research. Which 6 Learning Collaborative Sessions will your site attend?

Date: Title

Date: Title

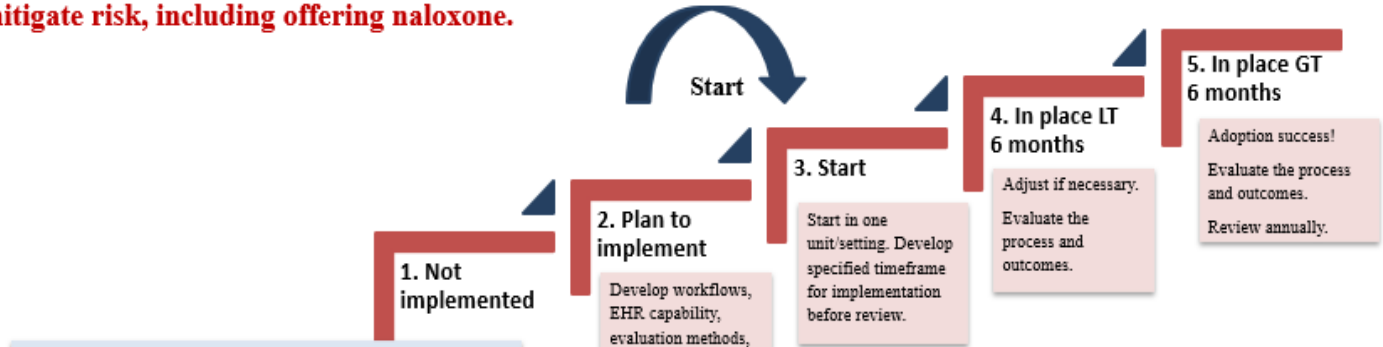
Date: Title

Date: Title

Date: Title

Date: Title

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone.



Screening/Assessment

Determine the validated tools to screen for and assess mental health/substance use concerns currently in use.

Integrate screening tools into EHR.

Identify current processes for using the PMP.

Determine needs for conducting toxicology screening.

Intervention & Treatment

Examine the types of education currently provided to patients/caregivers.

Compile resources for naloxone co-prescribing.

Compile list of referral sources for specialty care.

Referral & Linkage to Care

Engage CHW/Rs and/or navigators.

Considerations for a Healthy Community

Verify workflows and processes don't inadvertently introduce bias in care (Priority 2).

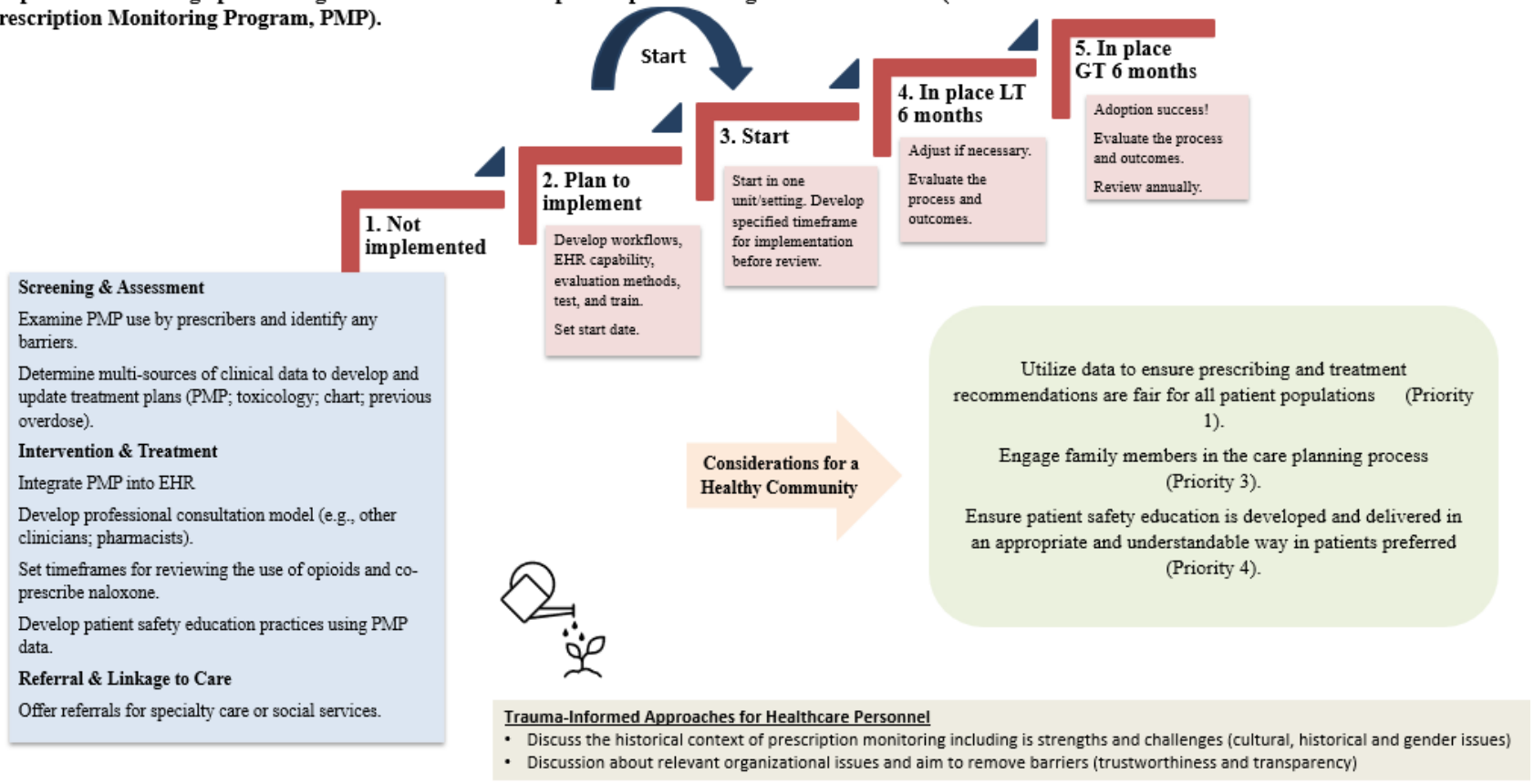
Provide training and tools to reduce bias in prescribing and treatment (Priority 3)

Ensure screening tools reflect the social determinants of health (Priority 4)

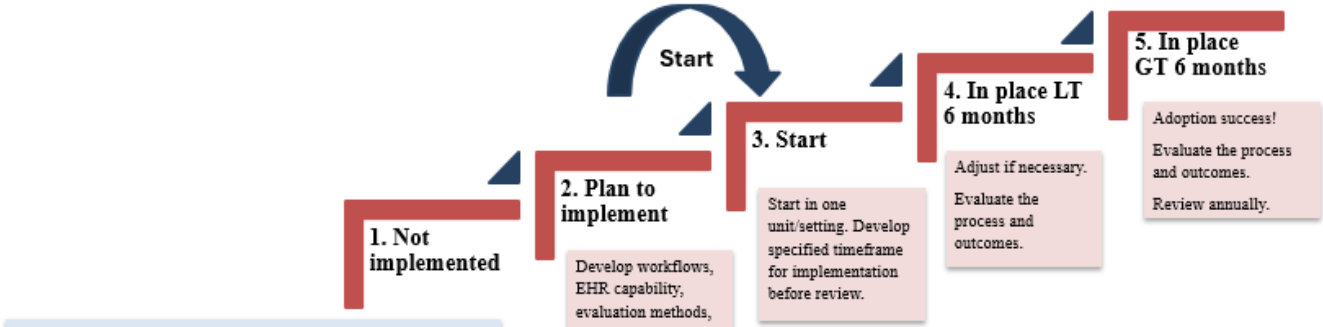
Trauma-Informed Approach for Healthcare Personnel

- Ensure personnel have a safety plan in case these topics are upsetting (safety).
- Provide mentoring opportunities for personnel on starting the conversation with patients (peer support).

9. When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose (in Arizona it's called Controlled Substance Prescription Monitoring Program, PMP).



10. When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances.



Screening/Assessment

Prepare strength-based protocols for introducing, collecting, and reporting results of toxicology screens.

Consider frequency of toxicology screening.

Determine how/if confirmatory toxicology screens will be used.

Examine costs/payment associated with toxicology screening.

Intervention & Treatment

Develop plans and resources for patients (e.g., naloxone; treatment).

Offer strength-based advice or intervention.

Referral & Linkage to care

Offer referrals for specialty care or social services.

Considerations for a Healthy Community

Track and report toxicology test offered and taken by patient characteristics (Priority 1)

Consider issues of historical trauma and toxicology screening. Ensure patients are informed and their concerns are addressed (Priority 2).

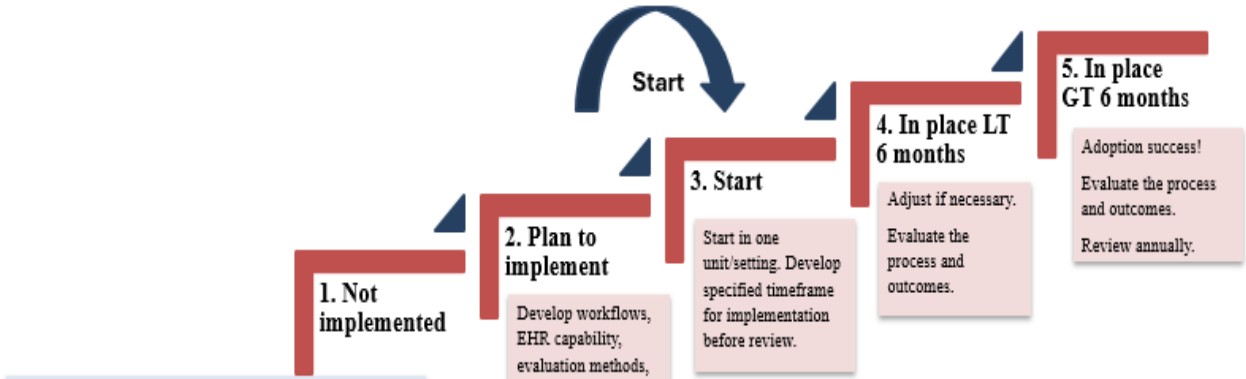
Ensure toxicology protocols are presented and discussed in a similar way as other healthcare tests (e.g., cholesterol; glucose) using medically accurate terminology and chronic care management models (Priority 3).

Utilize results from social determinants of health screening to offer resources for positive toxicology screening (Priority 4).

Trauma-Informed Approaches for Healthcare Personnel

- Discuss the context of toxicology testing for controlled substances (cultural, historical and gender issues)
- Engage personnel in identifying multiple strategies for conducting toxicology screening (empowerment voice and choice)

11. Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants.



Screening/Assessment

Screen for factors associated with mental health concerns or social determinants of health that may be influencing pain severity.

Develop a decision-making tree for weighing risks and benefits of concurrent prescribing of opioids and other central nervous system depressants.

Intervention and Treatment

Offer behavioral or other types of treatments.

Develop tapering plans that consider individual factors such that they don't cause negative outcomes (e.g., withdrawal, rebound symptoms).

Referral and Linkage to Care

Engage CHW/Rs or navigators.

Considerations for a Healthy Community

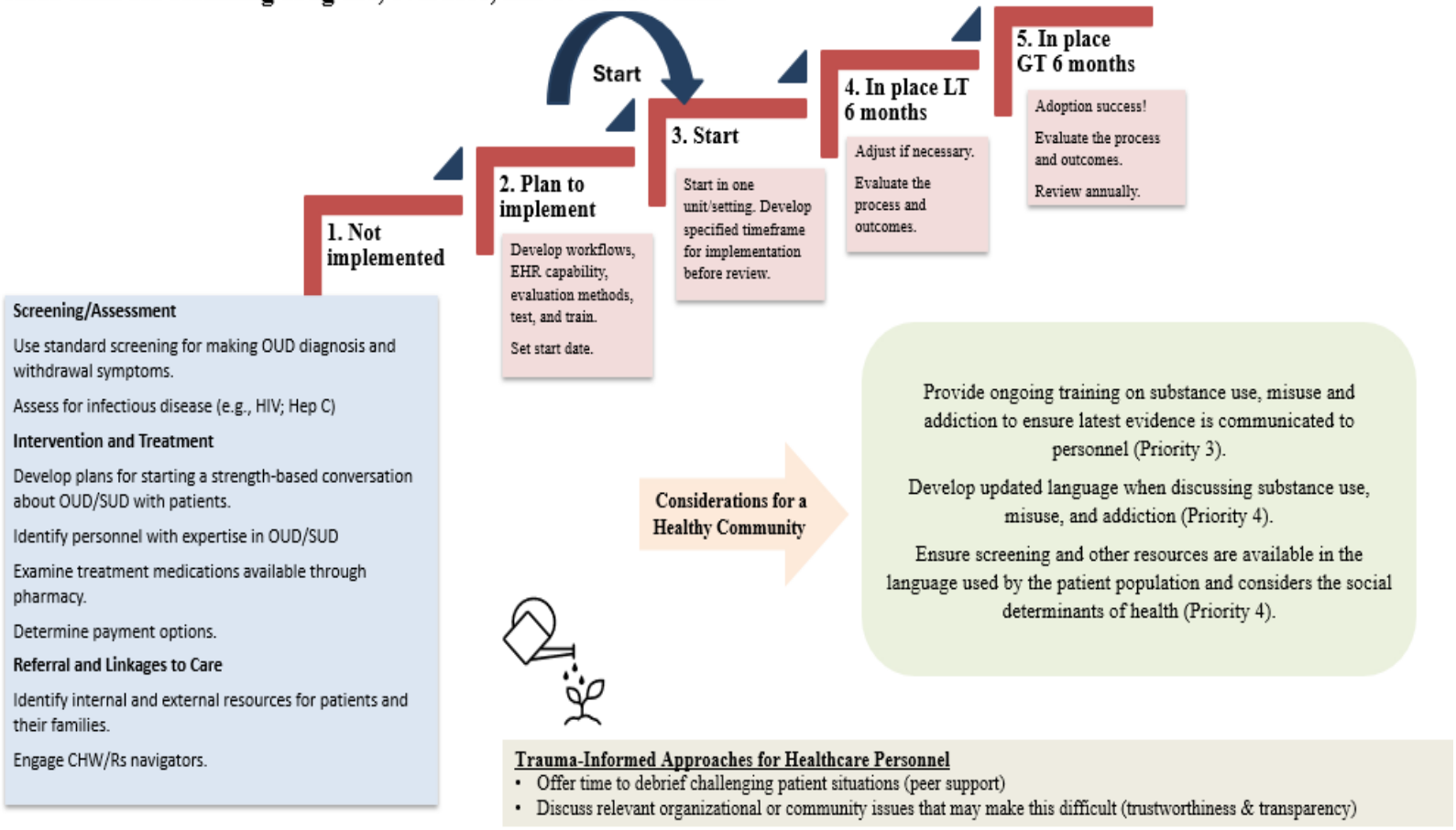
Consider multiple measures of perceptions of pain to ensure treatment recommendations are fair for all patients (Priority 2).

Plan to incorporate language assistance in workflows (Priority 4).

Trauma-Informed Approaches for Healthcare Personnel

- Discuss protocols to keep personnel and patients safe (safety)
- Engage personnel in shared decision making strategies about the best way to respond to patients (collaboration & mutuality)

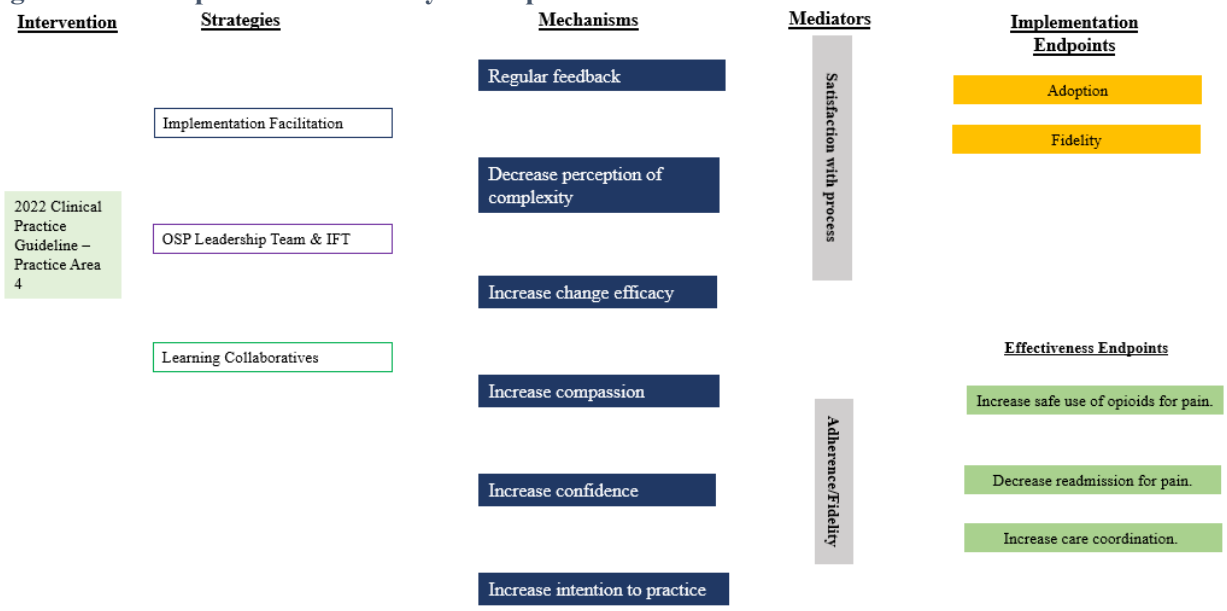
12. Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder. Detoxification on its own, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death.



Part 3: Expected Results

We want to share our conceptual model for how we think the intervention and strategies will lead to implementation and effectiveness (Figure 6). We do not expect sites to do anything with this information, we just want to provide it for anyone who may be interested. The surveys and other data we collect will help us determine if this model supports the implementation and effectiveness endpoints.

Figure 6 OSP Implementation Study Conceptual Model.



As a result of the OSP study, organizations can expect these short, immediate, and long-term outcomes. Table 3 (next page) provides the expected short, immediate, and long-term outcomes for sites.

Table 3 Expected Site Level Outcomes (18 months)

Expected Outputs	Short-term outcomes	Intermediate Outcomes	Long-term Outcomes
Identify OSP leadership team within 3 months of project start.	OSP Leadership Team is identified, and implementation plan developed by month 3	OSP Leadership Team has begun implementation by month 6.	OSP-LT has led efforts to implement one OSP intervention for 13 months.
Develop OSP implementation plan.	Identification of one OSP intervention that will be implemented using implementation plan by month 3	Meet the milestone goals identified in the implementation template by month 7.	OSP intervention has been fully implemented for at least 6 months without support by month 17.
Collaboration by OSP-LT & IFT.	OSP-LT and IFT will be introduced, and roles/expectations defined by month 2.	OSP-LT and IFT will establish perceptions of mutuality by month 6.	OSP-LT and IFT will develop a safe, trusting, and satisfying working relationship by month 12.
Adoption of one OSP intervention.	By month 6, one OSP intervention will be selected implementation started.	By month 12, the OSP intervention will be fully implemented as indicated on the implementation plan.	By month 17 the OSP intervention will be adopted.
Fidelity to OSP implementation	By month 3, fidelity measures will be identified.	By month 7, the OSP intervention will be implemented with fidelity.	By month 12, the OSP intervention will be fully implemented as intended (with fidelity)
Increase safe use of opioids opioid safety.	By month 5, conduct baseline.	By month 12, demonstrate either no change or increase in safe use of opioids.	By month 18, demonstrate increases in safe use of opioids.
Decrease readmissions for pain.	By month 5, conduct baseline.	By month 12, demonstrate either no change or decrease in readmissions for pain.	By month 18, demonstrate either decrease in readmissions for pain.
Increase care coordination.	By month 5, conduct baseline.	By month 12, demonstrate either no change or increase in care coordination.	By month 18, demonstrate either no change or increase in care coordination.

Institutional Ethics Statement. This project has been reviewed and approved by the University of Arizona's Institutional Review Board and determined this research to minimal risk.

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Contributions. Murphy conceptualized and wrote version 2 of the OSP implementation guide. Falls provided a review of the document and wrote paragraphs in the relevance and approach sections.

Suggested citation. Murphy BS. Opioid stewardship program site implementation guide version 2. The University of Arizona, Mel & Enid Zuckerman College of Public Health, Health Promotion Sciences. Tucson, Arizona, 2025.