BALTIMORE CITY HEALTH DEPARTMENT

# Levels of Care for Baltimore City Hospitals Responding to the Opioid Epidemic

*Guide for Hospitals*

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# Introduction

Baltimore City has the highest age-adjusted opioid-related overdose fatality rate of any metropolitan county in the United States. The number of overdose deaths in the city quadrupled between 2011 and 2017, and it continues to increase.

The City has responded aggressively. Among other initiatives, Health Commissioner Dr. Leana Wen issued a blanket prescription for naloxone; the Baltimore City Health Department (BCHD) and Behavioral Health System Baltimore (BHSB) launched Maryland's first Stabilization Center, a 24/7 urgent care for behavioral health; and BCHD created a rapid response system that sends peer outreach teams to dispense naloxone and provide referrals to treatment in neighborhoods experiencing a spike in overdoses.

In addition, strong leaders within Baltimore's hospitals have effected significant improvements in their opioid-related services. With coordination from BCHD and BHSB, financial support from the Substance Abuse and Mental Health Services Administration and Maryland Department of Health's Behavioral Health Administration, and consultation from the Mosaic Group, almost all of the city's emergency departments screen patients for substance use, offer treatment on-demand for patients who screen positive for opioid use disorder, and employ peer recovery specialists to connect patients with ongoing care in the community.

On April 30, 2018, Mayor Catherine E. Pugh and Health Commissioner Dr. Leana Wen joined the leadership of Baltimore's eleven acute-care hospitals to launch an initiative that builds upon these early successes: the Levels of Care for Baltimore City Hospitals Responding to the Opioid Epidemic. Modeled on a similar project launched in Rhode Island, the Levels of Care serve as a call to action that highlights the central role that hospitals play in responding to the opioid crisis and encourages adoption of a shared framework to guide the expansion of comprehensive services for patients with opioid use disorder.

# Statement of Purpose

The Levels of Care initiative aims to recognize the breadth and depth of Baltimore City hospitals' response to the opioid crisis. It is intended as a shared framework for the establishment of services for patients with high-risk opioid use and/or opioid use disorder (OUD)—in emergency department (ED), inpatient, and outpatient settings—and policies to prevent new cases of OUD.

Hospitals will be certified by BCHD as having achieved one of three Levels of Care. Certification will be determined based on hospitals' ability to provide care elements described by evidence-based components. Hospitals will be certified as Level 3, Level 2, or Level 1—with the Level 1 designation indicating the most comprehensive set of services.

BCHD intends to assist all hospitals in the city to achieve a minimum of Level 3 certification. The Department will provide support that includes site visits, detailed feedback, and the provision of technical assistance, as requested by the institution.

This guide provides an overview of the component activities required for certification at each Level of Care.

# Definitions

Levels of Care refer to the comprehensiveness of services hospitals provide to patients with high-risk opioid use and/or OUD and of the steps they take to prevent new cases of OUD. The hospitals eligible for certification include the eleven acute-care hospitals in Baltimore City, listed below (inset).

Hospitals will be certified based on services available in their emergency departments, inpatient units, and on-campus outpatient clinics. Affiliated outpatient settings (e.g., surgical centers, community-based primary care offices, etc.) will not be considered part of a hospital and will not be expected to perform qualifying functions described by the Level of Care components. Services must be directly available at each hospital campus; unless otherwise determined by BCHD, a hospital may not qualify for certification based on services provided at another facility within the same university-based health system or private healthcare organization.

**Baltimore City Acute-care Hospitals**

Bon Secours Hospital
Johns Hopkins Bayview Medical Center
The Johns Hopkins Hospital
Mercy Medical Center
MedStar Good Samaritan Hospital
MedStar Harbor Hospital
MedStar Union Memorial Hospital
University of Maryland Medical Center
University of Maryland Midtown Campus
Sinai Hospital of Baltimore
St. Agnes Hospital

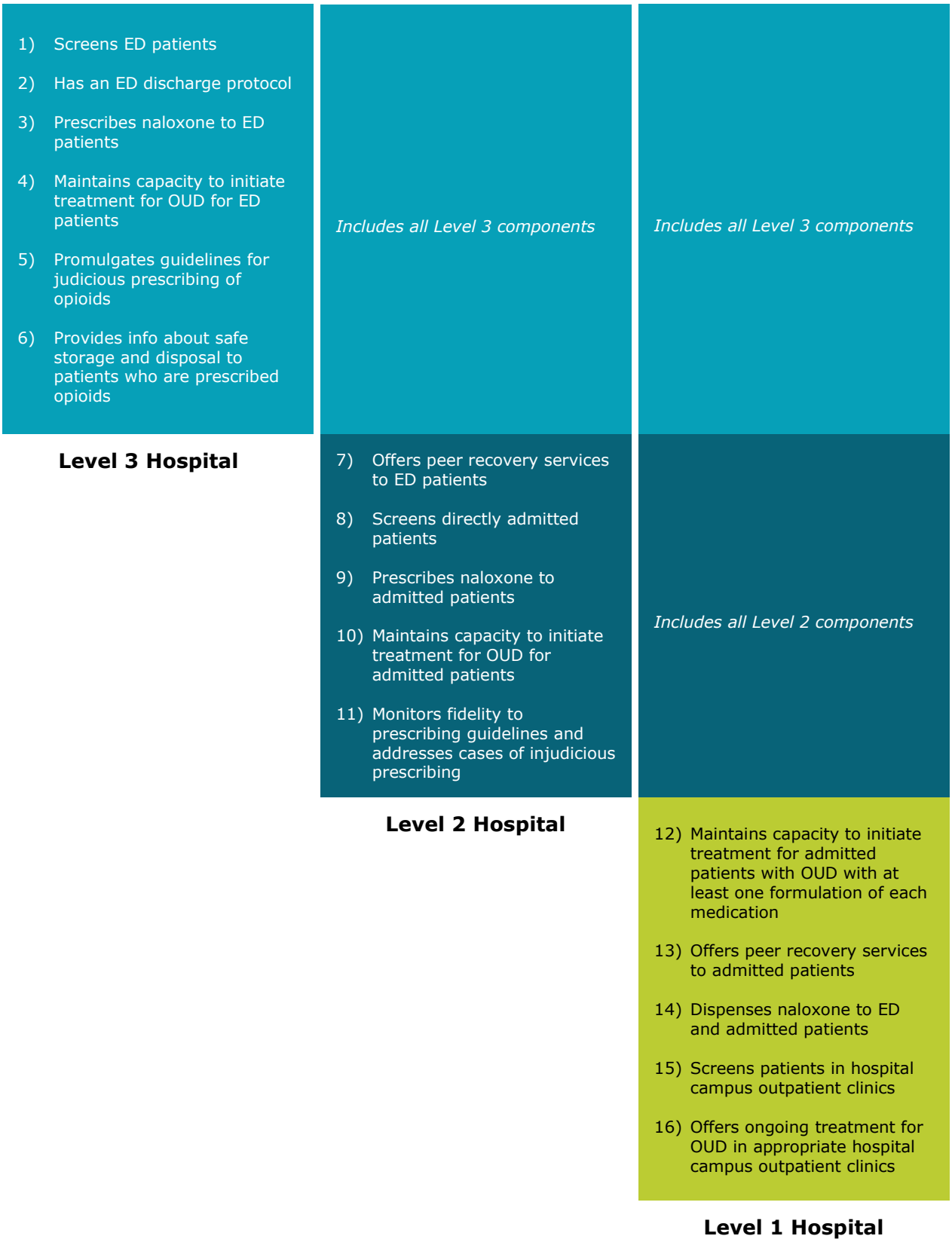
The three Levels of Care are delineated by the setting and complexity of care:

A **Level 3 Hospital** designation indicates that a minimum set of services are delivered to patients in the emergency care setting, including screening for and treating OUD, referring to community-based services, and prescribing naloxone. It also indicates the adoption of guidelines for judicious prescription of opioids throughout a hospital campus.

A **Level 2 Hospital** designation indicates that services are extended to the inpatient setting. Hospitals with this designation also possess augmented emergency department services and mechanisms for monitoring provider adherence to opioid prescribing guidelines.

A **Level 1 Hospital** designation indicates that services are provided in the outpatient setting with augmented emergency and inpatient services.

# Levels of Care Diagram



# Level 3 Components

## *1) Screens emergency department patients for at-risk substance use and substance use disorder*

Patients presenting to the ED who are not critically ill and are otherwise clinically appropriate should be screened for at-risk substance use and SUD. Screening should be performed as a standard procedure across patient types and regardless of chief complaint. Hospitals should maintain up-to-date written policies of the standard operating procedure for screening, specifying the screening instrument, personnel responsible for screening, and documentation procedures.

If a patient declines screening, it should be documented.

Screening tools for substance use and SUD should be evidence-based and available in English and Spanish. A variety of screening tools recommended by SAMHSA can be found online at:

https://www.integration.samhsa.gov/clinical-practice/screening-tools

Nearly all Baltimore City hospitals have adopted the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach to SUD screening. This approach offers the benefit of combining comprehensive substance use screening with both an intervention and a referral. These hospitals are specifically able to refer patients for whom they initiate treatment with buprenorphine to a "fast track" community-based provider that guarantees next day admission. The "fast track" program was established by the Mosaic Group.

More information on SBIRT (including training) can be found at:

https://sbirt.clinicalencounters.com/

Additional information regarding Maryland's SBIRT initiative (including clinical tools and referral resources) can be found at:

http://www.marylandsbirt.org/

## *2) Has an emergency department discharge protocol (as required by state law) that includes a referral to community-based treatment for patients with substance use disorder*

On April 10, 2017, the Maryland General Assembly passed the Heroin and Opioid Prevention Effort (HOPE) Act of 2017, which directed the expansion of treatment measures for patients with mental health and substance use disorders. The legislation requires hospitals in the state to develop and follow a protocol when discharging a patient treated for drug overdose or who was identified as having an SUD.

Pursuant to Maryland Statutory Code §19-310.3, such protocols may include:

- "Coordination with peer recovery counselors who can conduct a screening, a brief intervention, and referral to treatment and connection of the patient with community services"
- "[Prescription] of naloxone for the patient"

The Levels of Care initiative requires that hospitals are compliant with this law in order to attain certification as a Level 3 hospital. While the parameters of the discharge protocol intended by the law are not rigidly defined in the statutory language, it should contain the elements described above in order for the hospital to be certified as Level 3. It is intended that the patient discharge process will result in a facilitated referral for longer-term outpatient treatment of OUD (rather than detoxification alone).

## *3) Prescribes naloxone to emergency patients at high risk for opioid overdose*

In order to be certified as a Level 3 hospital, an institution must provide a written description of naloxone prescribing practices in their ED. Developing a written guideline for naloxone prescribing and developing the ability to monitor and report on naloxone prescriptions are encouraged but not required.

Such guidelines would direct providers to prescribe naloxone to patients at high risk for opioid overdose. Patients at high risk for opioid overdose include: patients who are treated for overdose; patients with OUD or who are identified as being at risk for OUD; patients with known non-medical opioid use or who are identified as being at risk for non-medical opioid use; and patients who are being discharged with a new or known combination of opioid and benzodiazepine prescriptions.

The guideline could describe indications for prescription of naloxone for patients who request naloxone or with conditions that may include, but are not limited to:

- current use of ≥ 50 morphine milligram equivalents (MME) per day
- current use of opioid with concomitant co-morbid condition potentially affecting cardiorespiratory status (e.g., smoking, Chronic Obstructive Pulmonary Disease, asthma, sleep apnea, respiratory infection, renal dysfunction, hepatic disease, cardiac illness, HIV/AIDS, etc.)
- a history of SUD or recovery management
- living with someone who meets any of the above descriptions

Dispensing naloxone is preferable when institutional resources allow. There are several formulations of naloxone that vary in price and ease of use. Evzio® (an intramuscular auto-injector) and Narcan® Nasal Spray are the two formulations approved by the U.S. Food and Drug Administration (FDA) for community use.

Emergency department staff should try to provide patient education about the use of naloxone. Education materials can be found at:

http://dontdie.org/

http://prescribetoprevent.org/patient-education/videos-for-download/

In 2015, Baltimore became the first Maryland jurisdiction to implement a "standing order" for naloxone: city residents can receive the medication at any pharmacy under that order without a prescription. Emergency department staff members are encouraged to inform patients of their access to naloxone as part of their discharge education.

## *4) Maintains capacity to initiate treatment for opioid use disorder for emergency department patients*

Effective treatment for OUD includes a medication. Alternatively referred to as medications for addiction treatment or medication-assisted treatment (MAT), three pharmaceutical agents are approved by the FDA for treating OUD: methadone, buprenorphine, and naltrexone. Determination of patients' appropriateness for MAT will likely require an institutional guideline to inform providers' decision-making. Hospitals are encouraged to develop and maintain a written guideline that specifies which patients are appropriate to receive MAT, personnel who will provide MAT, and appropriate support staff.

Examples of patients appropriate to receive MAT include individuals with OUD who present to the ED with an acute complaint unrelated to substance use (e.g., skin infection), screen positive, and indicate (after being asked) that they are willing to initiate treatment with buprenorphine. Other examples include patients who have not been able to access treatment for OUD and who present to the ED requesting treatment. Patients who present to the ED for an acute complaint unrelated to substance use (e.g., asthma exacerbation) but already receive MAT (e.g. buprenorphine) in the outpatient setting may need a prescription when discharged during off-hours after a prolonged stay in the ED for observation.

Some patients will not be candidates for immediate initiation of MAT; examples include patients who present to the ED for opioid overdose and subsequently receive multiple doses of naloxone until clinically stable. Furthermore, such patients may not be physiologically dependent on opioids (based on the duration and magnitude of their opioid use) and should not be treated with MAT. Any institutional guidelines for the provision of MAT will likely vary among Baltimore hospitals depending on the capabilities and resources available. It should be emphasized, however, that patients should be given the option of discharging to home with a prescription for buprenorphine if deemed clinically appropriate by the provider.

In order to maintain capacity to initiate MAT, hospitals could designate their staff (or house staff), establish (or augment) specialty services within their institution (e.g., specialized addiction medicine teams), or contract with appropriately qualified providers external to the institution. Regardless, hospitals are encouraged to provide training for their regular staff as part of their onboarding process and/or annual training curriculum.

Providers in the ED not waivered to prescribe buprenorphine may still provide the medication under a regulatory exception known as the "three-day rule." This rule allows a practitioner who is not in an opioid treatment program or waivered under the Drug Addiction Treatment Act of 2000 to administer (but not prescribe) an opioid agonist medication to a patient for the "purpose of relieving acute withdrawal symptoms," under the following conditions:

- No more than one day's medication is administered or given to a patient at one time
- Treatment does not exceed 72 hours
- The 72-hour period cannot be renewed or extended

Resources regarding MAT financing and training can be found at:

https://www.integration.samhsa.gov/clinical-practice/mat/mat-overview

## *5) Promulgates guidelines for judicious prescribing of opioid analgesics across the hospital system*

Prevention of new cases of OUD depends on reducing the number of new opioid prescriptions written and the volume dispensed when prescribing. Hospital guidelines for the judicious prescribing of opioids are a supply-side intervention to reduce the incidence of OUD that is based on a growing body of evidence.

While the Level 3 components described in this Guide generally pertain to the emergency care setting, guidelines should be developed or adopted to address opioid prescribing practices in all hospital campus settings, including the emergency department.

There are several examples of such guidelines:

> The Centers for Disease Control (CDC) has published guidelines intended for primary care providers:
>
> > https://www.cdc.gov/drugoverdose/prescribing/guideline.html
>
> Maryland Medicaid has published their own prescribing guidelines informed by the CDC's guidelines:
>
> > https://mmcp.health.maryland.gov/Documents/MMAC/2017/April/MMAC%20Drug%20Utilization%20Review%20Presenttion%20Apr%2017.pdf
>
> Guidelines intended for surgical prescribers were published in the article, "Opioid-Prescribing Guidelines for Common Surgical Procedures: An Expert Panel Consensus" by the Opioids After Surgery Workgroup:
>
> > https://www.journalacs.org/article/S1072-7515(18)31129-3/fulltext

Promulgation of guidelines should suit the capabilities of the hospital facility and could include a range of mechanisms: onboarding training, annual training, special training sessions, staff communication updates, etc.

## *6) Provides information about safe storage and disposal to patients who are prescribed opioids*

Patients receiving prescribed opioids as analgesic therapy must also receive education regarding its safe and prompt disposal when no longer needed. This should include:

- education regarding safe disposal options for controlled substances
- patient acknowledgement and plan for safeguarding all medications in a secure location

Hospitals should also consider educating patients regarding disposal of other controlled substances (e.g., benzodiazepines, amphetamines, etc.).

The FDA recommends specialized disposal practices for most drugs, but for certain "potentially dangerous" medications, the FDA recommends flushing in the absence of a take-back option. The list of medications—which includes many opioid agonists—can be found here:

> https://wayback.archive-it.org/7993/20180424065401/https://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm576167.htm

Take-back boxes are available in all Baltimore Police Department stations.

# Level 2 Components

## *7) Offers peer recovery specialist services or similar support services to emergency department patients*

A Level 2 hospital demonstrates the components required for Level 3 status, which include referrals to specialty treatment services. This component further specifies that patients receiving care in the ED at a Level 2 hospital will be offered peer-based recovery specialty services or similar support services.

If hospitals do not employ peer recovery specialists themselves, it is suggested that hospitals form active and durable relationships with entities that provide peer support services and that such relationships include the capacity for a reliable transition of care. Examples would include "warm hand-offs" from hospital case managers to peer-supported recovery services (or similar recovery services), post-discharge follow-up with recovery services, and, wherever possible, on-site or introduction to peer supports (prior to patient discharge from the ED).

If SUD treatment services are not immediately available through existing hospital services or relationships between hospitals and external entities, patients can be provided with the telephone number for the Baltimore City Crisis, Information, and Referral Line (410-433-5175). Hospital staff can also call the referral line on a patient's behalf as long as the patient is present, using it to provide a facilitated referral. The link below provides more information about this resource:

http://www.bhsbaltimore.org/for-individuals-and-families/crisis-services/

Additional information regarding Maryland's SBIRT initiative (including clinical tools and referral resources) can be found at:

http://www.marylandsbirt.org/

## *8) Screens directly admitted patients for at-risk substance use and substance use disorder*

A Level 2 hospital screens patients admitted to inpatient units who are clinically appropriate for screening and were not screened in the emergency department. The same screening process conducted in the emergency department could be used in the inpatient setting. Admitted patients should include all patients who were directly admitted to the hospital (i.e., not through the emergency department), including patients who are admitted for inpatient recovery following surgery, patients transferred from other hospitals, and patients admitted directly from outpatient clinics.

As nurses are typically the staff with direct initial contact with patients, hospitals should consider amending admission protocols performed by nursing to staff to include screening upon admission to the floor or other locations as appropriate (e.g., ICU, pre-operative locations, etc.).

## *9) Prescribes naloxone to admitted patients at high risk for opioid overdose*

A Level 2 hospital should extend the practice of prescribing naloxone at discharge to include clinically appropriate patients that are admitted to inpatient units. In order to be certified as a Level 2 hospital, institutions must provide a written description of naloxone prescribing practices in their respective inpatient units. Developing a written guideline for naloxone prescribing and developing the ability to monitor and report on naloxone prescriptions are encouraged but not required.

Such guidelines would direct providers to prescribe naloxone to patients at high risk for opioid overdose. Patients at high risk for opioid overdose include: patients who are treated for overdose; patients with OUD or who are identified as being at risk for OUD; patients with known non-medical opioid use or who are identified as being at risk for non-medical opioid use; and patients who are being discharged with a new or known combination of opioid and benzodiazepine prescriptions.

The guideline could describe indications for prescription of naloxone for patients who request naloxone or with conditions that may include, but are not limited to:

- current use of ≥ 50 morphine milligram equivalents (MME) per day
- current use of opioid with concomitant co-morbid condition potentially affecting cardiorespiratory status (e.g., smoking, Chronic Obstructive Pulmonary Disease, asthma, sleep apnea, respiratory infection, renal dysfunction, hepatic disease, cardiac illness, HIV/AIDS, etc.)
- a history of SUD or recovery management
- living with someone who meets any of the above descriptions

Dispensing naloxone is preferable when institutional resources allow. There are several formulations of naloxone that vary in price and ease of use. Evzio® (an intramuscular auto-injector) and Narcan® Nasal Spray are the two formulations approved by the U.S. Food and Drug Administration (FDA) for community use.

Emergency department staff should try to provide patient education about the use of naloxone. Education materials can be found at:

http://dontdie.org/

http://prescribetoprevent.org/patient-education/videos-for-download/

In 2015, Baltimore became the first Maryland jurisdiction to implement a "standing order" for naloxone: city residents can receive the medication at any pharmacy under that order without a prescription. Emergency department staff members are encouraged to inform patients of their access to naloxone as part of their discharge education.

## *10) Maintains capacity to initiate treatment for opioid use disorder for admitted patients*

As described in Component 4 of this Guide (p. 10), providers at a hospital designated Level 3 offer at least one FDA-approved medication (typically buprenorphine) for patients with OUD in the emergency care setting. To achieve Level 2 designation, a hospital should extend that service to the inpatient setting such that providers caring for admitted patients offer treatment for OUD.

The intention of this component is to ensure that hospital providers caring for admitted patients will offer at least one medication (again, typically buprenorphine) to clinically appropriate patients. Determination of patients' appropriateness for MAT is a complex process that could be described in a written guideline that delineates which patients are appropriate to receive MAT, personnel who will provide MAT, and appropriate support staff.

Initiation of MAT for admitted patients would require prescriber competencies across a range of specialty and subspecialty care teams. It may not be feasible that all provider teams caring for admitted patients will possess or develop these competencies. It may be necessary for hospitals to establish or augment specialty services within their institution (i.e., specialized addiction medicine teams) or contract with appropriately qualified providers external to the institution. Regardless, hospitals are encouraged to provide training for their regular staff as part of their onboarding process and/or annual training curriculum.

Resources regarding MAT financing and training can be found at:

https://www.integration.samhsa.gov/clinical-practice/mat/mat-overview

## *11) Monitors fidelity to prescribing guidelines and addresses cases of injudicious prescribing*

In addition to promulgating guidelines for judicious prescribing of opioid analgesics across the hospital campus, a Level 2 hospital demonstrates observance and active enforcement of those guidelines.

Hospitals should develop and maintain up-to-date written policies that identify optimal opioid prescribing practices in all hospital campus settings. There should be a mechanism for monitoring provider prescribing practices and regular reports to appropriate leaders within the hospital command infrastructure. If cases of injudicious prescribing of opioids are identified, there should be a standard procedure for investigating and remediating prescribers' practices.

As mentioned earlier in this Guide, policies should be incorporated into onboarding training for providers, annual training for providers, and/or special training sessions depending on the capability of each hospital facility. These policies should address prescribing practices of all providers affiliated with the hospital campus.

# Level 1 Components

## *12) Maintains capacity to initiate treatment for opioid use disorder for admitted patients with at least one formulation of each medication approved by the U.S. Food and Drug Administration for that purpose*

As described in Components 4 and 10 of this Guide (pp. 10 and 16), providers at a hospital designated Level 3 offer at least one FDA-approved medication (typically buprenorphine) for patients with OUD in the emergency care setting, and providers at a hospital designated Level 2 do the same for patients with OUD in the inpatient setting. A Level 1 hospital offers expanded treatment options for patients with OUD in the inpatient setting that includes all of the following:

- at least one formulation of methadone
- at least one formulation of buprenorphine
- at least one formulation of extended-release naltrexone

These options would be available when providers are initiating MAT for patients admitted to inpatient care units.

Determining which medication option to initiate is a medically driven process that could be described in a written guideline with appropriate accompanying protocols. The guideline would delineate which patients are appropriate to receive medications, clinical parameters for selecting and managing a particular medication, personnel who will initiate the process, appropriate support staff, and discharge planning needs.

Historically, hospitals have been hesitant to initiate opioid agonist therapies, particularly methadone, for the treatment of opioid use disorder without special DEA registration as an opioid treatment program. However, DEA regulations allow for the administration of methadone and buprenorphine in hospital settings for the treatment of opioid use disorder when that is as "an incidental adjunct to medical or surgical treatment of conditions other than addiction." (https://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_07.htm)

Forming relationships with community-based opioid treatment programs (OTPs) for seamless continuity of methadone treatment upon hospital discharge will be an important component for Level 1 hospitals.

Resources regarding MAT financing and training can be found at:

https://www.integration.samhsa.gov/clinical-practice/mat/mat-overview

## *13) Offers peer recovery support services or similar support services to admitted patients*

A Level 1 hospital extends the recovery support services already offered in their ED to patients admitted to any location within their facility. Again, the aim of this component is to support patients' decision-making process as they develop a recovery plan prior to discharge. Hospital case-managers working with admitted patients should engage in facilitated referrals. Examples would include "warm hand-offs" from hospital case-managers to peer supported recovery services (or similar recovery services), post-discharge follow-up with recovery services, and, wherever possible, on-site introduction to peer supports (prior to patient discharge from the inpatient setting).

If SUD treatment services are not immediately available through existing hospital services or relationships between hospitals and external entities, patients can be provided with the telephone number for the Baltimore City Crisis, Information, and Referral Line (410-433-5175). Hospital staff can also call the referral line on a patient's behalf as long as the patient is present, using it to provide a facilitated referral. The link below provides more information about this resource:

http://www.bhsbaltimore.org/for-individuals-and-families/crisis-services/

## *14) Dispenses naloxone to emergency department patients and admitted patients at high risk for opioid overdose*

A Level 1 hospital directly dispenses naloxone (prior to discharge) to patients in the emergency care and inpatient settings who are at risk for opioid overdose, as described in Components 3 and 9 of this Guide (pp. 11 and 17). Direct dispensation eliminates a barrier to accessing the medication: a recent study of patients with OUD presenting to the ED showed that less than 15% of take-home naloxone prescriptions were filled after discharge.[1]

If possible, hospital staff should try to provide patient education for the use of naloxone. Education materials can be found at:

http://dontdie.org/

http://prescribetoprevent.org/patient-education/videos-for-download/

[1] Lebin JA, Chen BC, Korab G, Jablonowski K, Whiteside LK. 254 Rates of Naloxone Prescriptions Following Implementation of a Take-Home Naloxone Program from the Emergency Department. Annals of Emergency Medicine. 2017 Oct 1;70(4):S101.

## *15) Screens patients in hospital campus outpatient clinics for at-risk substance use and substance use disorder*

Level 1 hospitals extend screening procedures to include patients in outpatient clinics located on the hospital campus. It is understood that the workflow and staffing infrastructure in the ambulatory setting will have distinctly separate and often limited capacity for screening compared to inpatient units. The aim of this component is for hospitals to direct their primary care and selected specialty clinics (e.g., HIV specialty care clinics) to develop written policies and procedures to screen patients in the ambulatory setting.

Such policies must be tailored to the unique patient populations seen in various outpatient clinics. For example, it would be appropriate to screen all patients in the high-risk population treated in an HIV specialty care clinic, whereas screening should be performed based on age-stratification in a pediatric clinic.

When formulating screening policies, clinical directors could look to their appropriate professional medical organizations' official recommendations with respect to screening for substance use. Selected recommendations include:

- American Academy of Family Physicians:

  https://www.aafp.org/afp/2013/0715/p113.html

- American Academy of Pediatrics:

  http://pediatrics.aappublications.org/content/138/1/e20161210

- American College of Obstetrics and Gynecology:

  https://www.acog.org/Clinical-Guidance-and-Publications/Guidelines-for Womens-Health-Care

While it would be ideal for larger private healthcare organizations or university-based healthcare organizations to maintain such policies at all free-standing and affiliated outpatient clinics, Level 1 designation requires compliance among only appropriate clinics that are located on the hospital campus and are considered "regulated space."

## *16) Offers ongoing treatment in appropriate hospital campus outpatient clinics, including clinics that do not specialize in the treatment of substance use disorder*

The defining feature of Level 1 designation is that hospitals offer comprehensive services for patients with OUD in the outpatient setting. This final component requires that hospitals offer MAT to patients in appropriate outpatient clinics. The appropriateness of a given outpatient clinic will be determined by the hospital; these determinations will be reviewed with BCHD during the application process. Examples of clinics include but are not limited to primary care clinics and specialty care clinics treating patients at high risk for OUD (e.g., HIV specialty clinics, adolescent care clinics, etc.).

The aim of this component is that at least one medication (typically buprenorphine) would be provided on an ongoing basis for patients with OUD. Provision of MAT would be available through enhanced provider training at clinics or availability of specialty care (e.g., providers trained in addiction medicine) to any clinic on a hospital campus.

While it would be ideal for larger private healthcare organizations or university-based healthcare organizations to maintain such policies at all their free-standing and affiliated outpatient clinics where ongoing MAT is clinically appropriate, Level 1 designation requires compliance among only appropriate clinics that are located on the hospital campus and are considered "regulated space."

As described in Component 4 and 10 of this Guide (pp. 11 and 17), determination of patients appropriate for MAT is a complex process that would require an up-to-date written protocol that delineates which patients are appropriate to receive MAT, personnel who will provide MAT, and appropriate support staff. Hospitals are encouraged to provide training for their regular clinic staff as part of their onboarding process and/or annual training curriculum.