**HOSPITAL OVERDOSE PREVENTION AND ADDICTION TREATMENT SYSTEMS OF CARE PROGRAM**

**PHASE 1 PLANNING GRANT APPLICATION**

**March – August 2021**

**\*\*Please note:** This application is only for the planning grant (Phase 1) which includes funding for six months. Continued funding for implementation (Phase 2) will include a separate application process that will take place in July and August of 2021.

Completion of this application will require some initial collaboration between hospitals and community partners. Hospitals and community partners are encouraged to convene virtually to clarify aspects of the application. Please refer to Appendix H for a program description intended for hospital applicants to share with community partners as the application for this planning grant is completed.

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| **Applicant Information** | |
| **Healthcare Organization Legal Name** |  |
| **Doing Business As**  (if applicable) |  |
| **Street Address** |  |
| **City, State, Zip Code** |  |
| **Mailing Address, If Different** |  |
| **Primary Contact for the Application**  (one of the individuals identified below) | **Name:**  **Title:**  **Email:**  **Phone:** |

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| **Applicant Representatives** | |
| **Hospital** | |
| **Contract Representative**  (Individual responsible for agreement processing and negotiations) | **Name:**  **Title:**  **Email:**  **Phone:** |
| **Program Lead**  (Individual leading the implementation)  \*\*This role could be filled by a variety of positions including but not limited to program manager or social worker | **Name:**  **Title:**  **Email:**  **Phone:** |
| **Leadership Champion**  (Individual with leadership and decision-making authority for hospital) | **Name:**  **Title:**  **Email:**  **Phone:** |
| **Authorized Signatory**  (Individual authorized to sign on behalf of the hospital) | **Name:**  **Title:**  **Email:**  **Phone:** |

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| **Hospital Information – ED and Inpatient** | **YES** | **NO** |
| Are emergency department medical services provided through a contracted entity? |  |  |
| If medical (physician and mid-level provider) ED services are provided through a contracted entity, please provide the name of the entity. Additionally, this entity must provide a letter of commitment. | | |
| On the inpatient side, describe the medical staffing model and describe who would offer MOUD. | | |

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| **Community Partners**  (Entities working with the applicant on the program. Note: At least two partners are required) | |
| **Community Partner 1** | |
| **Organization Name:** |  |
| **Contract Representative**  (Individual responsible for agreement processing and negotiations) | **Name:**  **Title:**  **Email:**  **Phone:** |
| **Program Lead**  (Individual leading the implementation) | **Name:**  **Title:**  **Email:**  **Phone:** |
| **Leadership Champion**  (Individual with leadership and decision-making authority for organization) | **Name:**  **Title:**  **Email:**  **Phone:** |

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| **Community Partner 2** | |
| **Organization Name:** |  |
| **Contract Representative**  (Individual responsible for agreement processing and negotiations) | **Name:**  **Title:**  **Email:**  **Phone:** |
| **Program Lead**  (Individual leading the implementation) | **Name:**  **Title:**  **Email:**  **Phone:** |
| **Leadership Champion**  (Individual with leadership and decision-making authority for organization) | **Name:**  **Title:**  **Email:**  **Phone:** |

**I. Program Rationale**

1. In 2-3 sentences, describe why your hospital is interested in this program.

**II. Hospital Patient Characteristics**

1. Briefly describe (1-2 paragraphs) the patient population served by the hospital and their needs related to opioid-involved overdose/opioid use disorder. Discuss any unique populations this work may impact and include demographic data if possible.
2. What is the payor mix in the hospital?

|  |  |
| --- | --- |
| **Payor Type** | **Percent of Patient Population** |
| Medicare |  |
| Medicaid |  |
| Private Insurance |  |
| Self-Pay |  |
| Other: |  |

1. Provide the following information about the volume of opioid-related cases (Please refer to Appendix A for description of how to calculate and report these).
   1. Number of ED visits for opioid-related diagnoses (Calendar Year 2019): \_\_\_\_\_\_\_\_\_
   2. Number of opioid-related overdoses presented in ED (Calendar Year 2019): \_\_\_\_\_\_\_\_\_
   3. Number of opioid-related hospital admissions (Calendar Year 2019): \_\_\_\_\_\_\_\_\_

**III. Hospital Background Information**

The following questions are not related to your hospital’s eligibility. Rather, this will be used as background information to help IPHI and the Review Committee understand the context in which you’ll be working and planning during Phase 1. Because funding under this RFA is intended to address infrastructure needs, there is **NOT** an expectation that hospitals have all the following elements in place to apply.

1. Please select all the medications for opioid use disorder (MOUD) your hospital currently has listed on its formulary:

□ Methadone □ Buprenorphine/Suboxone □ Naltrexone/Vivitrol

1. Please select all of the ways your hospital provides naloxone to patients:

□ Administer only □ Prescribe for take-home □ Dispense at bedside for take-home

1. Does your hospital currently have any staff who help with care coordination in the ED? This could include community health workers, case managers, peer recovery workers, care coordinators, social workers, etc.

Yes: \_\_\_\_ No: \_\_\_\_

If yes, how many? \_\_\_\_\_

1. Does your hospital currently have any staff who help with care coordination on the inpatient floor? This could include community health workers, case managers, peer recovery workers, care coordinators, social workers, etc.

Yes: \_\_\_\_ No: \_\_\_\_

If yes, how many? \_\_\_\_\_

1. Does your hospital have providers with a buprenorphine waiver?

Yes: \_\_\_\_ No: \_\_\_\_

If yes, how many? \_\_\_\_\_

**IV. Program Description**

Please provide brief responses (1-2 paragraphs) to each of the questions in the narrative sections A-C below.

**A. Hospital Team**

1. Who will be involved in the planning process on the hospital side? In the table below, list team member names and roles. In addition to the program lead and leadership champions identified above, the team must include, at minimum, a prescriber from the emergency department AND inpatient unit, a staff member who manages ED operations, and a pharmacist. An asterisk (\*) has been placed by the required team member roles. Other members may include, IT, behavioral health providers, quality improvement and other staff. Applicants can add additional rows to this table as needed.

|  |  |
| --- | --- |
| **Team Member Name** | **Team Member Role** |
|  | \*Lead clinician prescribing from ED: |
|  | \*Lead clinician prescribing from Inpatient: |
|  | \*Pharmacist: |
|  | \*Staff member managing ED operations: |
|  | Other (optional): |
| *(add additional rows as necessary)* | Other (optional): |

1. What is the commitment of the hospital team to the overall goals of the program? Describe the team’s readiness and/or willingness to lead efforts to increase access to MOUD, naloxone, and warm handoffs to community-based treatment for patients with OUD. Describe possible barriers to engaging colleagues in this effort.

**B****. Strategy and Work Plan**

Goal 1: Planning to advance hospital infrastructure development in the emergency department around best practices (i.e. initiation of MOUD, take-home naloxone) for treating and addressing opioid use disorder (OUD)

1. Please describe your hospital’s strategy for accomplishing Goal 1 of the program. Please include a brief description of the anticipated impact.
2. Use the work plan template below to outline your plan for accomplishing Goal 1 of Phase 1 program planning activities and deliverables over the six-month planning period (March – August 2021). Please refer to “Phase I Program Planning Activities and Deliverables” on p.3 for guidance related to the goal. Refer to Appendix B for ED-specific infrastructure development examples. Insert additional rows as needed.

**High-Level Workplan**

Goal 1: Planning to advance hospital infrastructure development in the emergency department around best practices (i.e. initiation of MOUD, take-home naloxone) for treating and addressing opioid use disorder (OUD).

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Activity/Milestone** | **Person(s) Responsible** | **F** | **M** | **A** | **M** | **J** | **J** |
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| (*add more rows as necessary)* |  |  |  |  |  |  |  |

**C. Partnerships and Continuity of Care Plan**

Goal 2: Plan for developing hospital-to-community collaborations to better support continuity of care (i.e. warm handoffs) outcomes for people with OUD with at least two community partners.

1. Describe your continuity of care plans based on the community partners identified in your letters of commitment. Please include a brief description of the anticipated impact.

How will the hospital work with community partners to connect interested patients to community-based MOUD treatment programs to ensure continuity of care after discharge?

*As mentioned above, hospital applicants may choose to work with more than two community partners and/or may propose an alternative model that still meets the requirements of including a methadone and a buprenorphine provider. If an alternative model is of interest, please describe this alternative model here, including how the alternative model meets the requirements outlined in this RFA.*

1. Use the work plan template below to outline your plan for accomplishing Goal 2 of Phase 1 program planning activities and deliverables over the six-month planning period (March – August 2021). Please refer to “Phase I Program Planning Activities and Deliverables” on p.3 for guidance related to the goal. Refer to Appendix B for ED-specific infrastructure development examples. Insert additional rows as needed.

**High-Level Workplan**

Goal 2: Plan for developing hospital-to-community collaborations to better support continuity of care outcomes (i.e. warm handoffs) for people with OUD with at least two community partners.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Activity/Milestone** | **Person(s) Responsible** | **F** | **M** | **A** | **M** | **J** | **J** |
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| (*add more rows as necessary)* |  |  |  |  |  |  |  |

**V. Required attachments**

1. Letters of commitment from each community-based MOUD provider who will partner with your hospital on this program and participate in planning and implementation meetings with your team. Please refer to Section E “Application Requirements.” Refer to Appendix H for a program description to share with community partners.
2. If the hospital is applying for funding for an emergency department-focused program and ED medical services are provided by an outside contractor, a letter of commitment from the ED physician group is required that includes a commitment from at least one ED physician who will participate in the program. Please refer to Section E “Application Requirements”.
3. Budgets and narratives of how funds will be spent from each organization (e.g. Hospital and 2 community partners = 3 budgets). Refer to Appendix C for budget templates and budget narrative instructions and to section D, Funds and Available Uses for guidance on allowable use of funds. Refer to Appendix H for a program description to share with community partners.
4. A letter of commitment from the hospital’s Inpatient Director, Hospitalists Director or Chief of Staff stating a commitment to work with the program team to support development within the ED and any subsequent transitions of care to the inpatient floor. The letter should state that the inpatient floor will continue medication initiated in the ED for any patients who are admitted and that the inpatient team will ensure a smooth transition to a community partner for continued care and medication management upon hospital discharge.

**VI. Signatory Page**

I certify that to the best of my knowledge that the information included in this application is complete and accurate.

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| --- | --- |
| **Hospital: Authorized Signatory** | |
| **Signature:** | |
| **Name and title:** | **Date:** |

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| **Hospital: Leadership Champion** | |
| **Signature:** | |
| **Name and title:** | **Date:** |

|  |  |
| --- | --- |
| **Hospital: Program Lead** | |
| **Signature:** | |
| **Name and title:** | **Date:** |

**Appendix A**

Please use the diagnoses described below to calculate the number of visits/hospitalizations reported in Section II.3 of this application.

**Number of ED visits for opioid-related diagnoses other than overdose (Calendar Year 2019)**

ED discharges that include any ICD-10 CM code of F11.XXX should be included except F11.21 (opioid use disorder in remission)

**Number of ED encounters for opioid overdoses (Calendar Year 2019)**

ED discharges that include any of the following diagnosis codes should be included in this total:

T40.0X1A-T40.0X4A, T40.1X1A-T40.1X4A, T40.2X1A-T40.2X4A, T40.3X1A-T40.3X4A, T40.4X1A-T40.4X4A, T40.601A-T40.604A, T40.691A-T40.694A

**Number of opioid-related hospital admissions (Calendar Year 2019)**

Any hospital discharges that include the following codes should be included:

Any F11.XXX except F11.21 (opioid use disorder in remission)

Any ICD-9-CM: 965.00, 965.01, 965.02, 965.09, E850.0, E850.1, E850.2

Any ICD-10-CM: T40.0X1A-T40.0X4A, T40.1X1A-T40.1X4A, T40.2X1A-T40.2X4A, T40.3X1A-T40.3X4A, T40.4X1A-T40.4X4A, T40.601A-T40.604A, T40.691A-T40.694A

\*Some patients may have both a T-code and an F-code. They should not be double-counted.

**Appendix B**

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| **Hospital Emergency Department Infrastructure Development Examples Across the 3 Best Practice Areas** |
| **NALOXONE: Hospital Initiation of Take-home Naloxone Outputs** |
| 1. Develop a uniform protocol for training clinical and program staff on overdose prevention and naloxone dispensing from the ED. 2. Work with outpatient pharmacy to implement a standing order to allow for naloxone dispensing without a prescription (if hospital has an outpatient pharmacy). 3. Develop workflow for naloxone dispensing from the ED for patient take-home. 4. Develop a clinical decision support mechanism in the EHR to prompt the ordering of naloxone. 5. Develop a uniform protocol for training patients on overdose prevention and naloxone dispensing from the ED who have a history of overdose and/or opioid use. |
| **MEDICATION FOR OPIOID USE DISORDER (MOUD): Hospital Initiation of MOUD Outputs** |
| 1. Ensure buprenorphine and methadone are listed on the hospital formulary & that buprenorphine is in the pyxis in the ED. 2. Increase number of waivered providers who can prescribe buprenorphine in the ED by \_\_\_ %. 3. Develop a workflow for initiating buprenorphine for patients with OUD from the ED. 4. Ensure that hospital policies and procedures allow all prescribers (even those without DEA waiver) to be able to order buprenorphine to be administered onsite. 5. If not all ED providers have a waiver to prescribe buprenorphine, develop policies and protocols around bridge prescription management. |
| **CONTINUITY OF CARE: Hospital Initiation of Linkage to Community-based Treatment Outputs** |
| 1. Identify ED-based staff to support linkage to community-based MOUD treatment (e.g. peer recovery specialists, social workers, community health workers, peer navigators). 2. Establish formal arrangements between ED and community-based MOUD treatment providers via MOUs for linkage to care beyond hospital discharge and HIPAA compliant release forms to allow EDs to share basic information about dosing and Rx duration. 3. Develop protocol to support transportation services for patients receiving warm handoffs to community-based MOUD treatment. 4. Develop follow-up protocols to ensure patient successfully gained access to community-based MOUD treatment and remains engaged in care. |

**Appendix C**

**Budgets and Budget Narratives**

**Budget period: March 1, 2021 – August 31, 2021**

*Hospitals.*

Hospitals may propose a budget of $30,000 - $40,000 (amount awarded will depend on the number of projects funded).

\*\*Please refer to Section D. Funds Available and Uses for a list of allowable and non-allowable use of grant funds.

|  |  |  |
| --- | --- | --- |
| **Hospital Budget** | | |
| Category | From IPHI | In-kind |
| **Personnel** |  |  |
| Salaries |  |  |
| Fringe |  |  |
| **Total Personnel** |  |  |
|  |  |  |
| **Other Direct** |  |  |
| Consulting/Contractual |  |  |
| Supplies |  |  |
| Travel |  |  |
| Training |  |  |
| Other (printing, meeting costs, etc.) |  |  |
| **Total Other Direct** |  |  |
|  |  |  |
| **TOTAL DIRECT COSTS** |  |  |
| Indirect Costs |  |  |
| **GRAND TOTAL** |  |  |

Hospital Budget Narrative:

* 1. Please provide a budget narrative for each line item explaining how it was calculated. For personnel, please provide anticipated FTEs for each staff person included in the budget as well as those that will be participating in-kind, and their role in the project.
  2. Please include what resources (if any) you currently have to fund this work. If an investment is currently underway, please describe how this grant will supplement existing investment/funds.
  3. If you anticipate being able to initiate implementation/begin transitioning patients to community-based care during Phase 1, please include an explanation of how you will provide transportation support for patients who need it, and include a line item for transportation in your budget.

*Community Partners.*

Each funded community partner must also provide a budget and budget narrative. A minimum of 2 community-based MOUD partners is required. The amounts awarded will depend on the number of projects funded and the number of community partners involved.

* $40,000 - $50,000 TOTAL is available for community partners, e.g. with 2 community partners, each would receive $20,000 - $25,000;
* If more than 2 funded partners are proposed, please ensure the total across all partners does not exceed the range of $40,000 - $50,000.

\*\*Please refer to Section D. Funds Available and Uses for a list of allowable and non-allowable use of grant funds.

|  |  |  |
| --- | --- | --- |
| **Community Partner 1 Budget** | | |
| Category | From IPHI | In-kind |
| **Personnel** |  |  |
| Salaries |  |  |
| Fringe |  |  |
| **Total Personnel** |  |  |
|  |  |  |
| **Other Direct** |  |  |
| Consulting/Contractual |  |  |
| Supplies |  |  |
| Travel |  |  |
| Training |  |  |
| Other (printing, meeting costs, etc.) |  |  |
| **Total Other Direct** |  |  |
|  |  |  |
| **TOTAL DIRECT COSTS** |  |  |
| Indirect Costs |  |  |
| **GRAND TOTAL** |  |  |

Community Partner 1 Budget Narrative:

* 1. Please provide a budget narrative for each line item explaining how it was calculated. For personnel, please provide anticipated FTEs for each staff person included in the budget as well as those that will be participating in-kind, and their role in the project.

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| **Community Partner 2 Budget** | | |
| Category | From IPHI | In-kind |
| **Personnel** |  |  |
| Salaries |  |  |
| Fringe |  |  |
| **Total Personnel** |  |  |
|  |  |  |
| **Other Direct** |  |  |
| Consulting/Contractual |  |  |
| Supplies |  |  |
| Travel |  |  |
| Training |  |  |
| Other (printing, meeting costs, etc.) |  |  |
| **Total Other Direct** |  |  |
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| **TOTAL DIRECT COSTS** |  |  |
| Indirect Costs |  |  |
| **GRAND TOTAL** |  |  |

Community Partner 2 Budget Narrative:

* 1. Please provide a budget narrative for each line item explaining how it was calculated. For personnel, please provide anticipated FTEs for each staff person included in the budget as well as those that will be participating in-kind, and their role in the project.

**Appendix D**

Federally Qualified Health Centers (FQHCs) with buprenorphine maintenance programs

Please note: This list may not be exhaustive. Rather this is a list of FQHCs we know either currently have or previously had an active buprenorphine maintenance program.

\*\*\*Considerations when reaching out to FQHCs for potential partnerships\*\*\*

Please make sure to confirm the following:

1. The FQHC has an active outpatient buprenorphine maintenance program.
   1. FQHCs often provide programming at multiple sites so be sure you know which locations provide MOUD services.
2. The FQHC has capacity to receive new patients within 1-2 weeks’ time.
   1. Buprenorphine/Suboxone prescribers have caps on the number of patients they can prescribe to. Both the number of prescribers a program has and the length of time the prescribers have been practicing may impact a program’s ability to take on new patients.

\*\*If your hospital needs support connecting to a program, please email the IPHI team at [MATDemo@iphionline.org](mailto:MATDemo@iphionline.org) and we will do our best to help connect you.

|  |  |
| --- | --- |
| **FQHC Name** | **FQHC Location** |
| Access Community Health Network | Multi-site. Refer to the [website](https://www.achn.net/) to find the location nearest you. |
| Aunt Martha's | Multi-site. Refer to the [website](https://www.auntmarthas.org/) to find the location nearest you. |
| Cook County Health Clinics | Multi-site. Refer to the [website](https://cookcountyhealth.org/our-locations/) to find the location nearest you. |
| Chicago Family Health Centers | Multi-site. Refer to the [website](https://chicagofamilyhealth.org/) to find the location nearest you. |
| Christian Community Health Centers | Multi-site. Refer to the [website](https://cchc-online.org/) to find the location nearest you. |
| Erie Family Health Centers | Multi-site. Refer to the [website](https://www.eriefamilyhealth.org/) to find the location nearest you. |
| Esperanza Health Centers | Multi-site. Refer to the [website](https://www.esperanzachicago.org/) to find the location nearest you. |
| Heartland Alliance Health | Multi-site. Refer to the [website](https://www.heartlandalliance.org/heartland-alliance-health/) to find the location nearest you. |
| Heartland Health Centers | Multi-site. Refer to the [website](https://www.heartlandhealthcenters.org/) to find the location nearest you. |
| Howard Brown Health Centers | Multi-site. Refer to the [website](https://howardbrown.org/) to find the location nearest you. |
| Lawndale Christian Health Centers | Multi-site. Refer to the [website](https://lawndale.org/) to find the location nearest you. |
| PCC Community Wellness Centers | Multi-site. Refer to the [website](https://www.pccwellness.org/) to find the location nearest you. |
| Prime Care Community Health Centers | Multi-site. Refer to the [website](https://www.primecarehealth.org/) to find the location nearest you. |
| Near North Health | Multi-site. Refer to the [website](https://www.nearnorthhealth.org/) to find the location nearest you. |

**Appendix E**

Opioid Treatment Programs (OTPs) with established methadone maintenance programs

licensed by the Illinois Department of Human Services (IDHS),

Division of Substance Use Prevention and Recovery (SUPR)

Please note: This list may not be exhaustive. Some programs were excluded because they self-identified as being at capacity and not able to take on new patients.

\*\*\*Considerations when reaching out to OTPs for potential partnerships\*\*\*

Please make sure to confirm the following:

1. The OTP is licensed by IDHS/SUPR
2. The OTP has capacity to receive new patients within 1-2 weeks’ time.
   1. Methadone programs sometimes have waitlists for new patients.

\*\*If your hospital needs support connecting to a program, please email the IPHI team at [MATDemo@iphionline.org](mailto:MATDemo@iphionline.org) and we will do our best to help connect you.

|  |  |
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| **OTP Agency Name** | **OTP Agency Location** |
| Caritas Central Intake/OMAT | 140 N. Ashland Ave, Chicago, IL 60607 |
| Center for Addictive Problems | 609 N. Wells St, Chicago, IL 60654 |
| Cermak Health Services - Cook County Jail | 2800 S. California Ave, Chicago, IL 60608 |
| Chicago Treatment and Counseling Center, Inc. | 3520 S. Ashland Ave, Chicago, IL 60609 |
| Elite Treatment Center | 395 W. Lincoln Hwy, Chicago Heights, IL 60411 |
| Eva Mae Recovery Hope, Inc. | Multi-site. Refer to the [website](http://cdph.purplebinder.com/locations/caritas-central-intake/outpatient-medication-assisted-treatment-omat) to find the location nearest you. |
| Family Guidance Centers, Inc. | Multi-site. Refer to the [website](https://www.fgcinc.org/) to find the location nearest you. |
| Fola Community Action Services, Inc. | 8014 S. Ashland Ave, Chicago, IL 60620 |
| Garfield Counseling Center, Inc. | 4132 W. Madison St, Chicago, IL 60624 |
| Healthcare Alternative Systems/NEXA | 210 N. Ashland Ave, Chicago, IL 60607 |
| Human Resources Development Institute, Inc. | Multi-site. Refer to the [website](https://www.hrdi.org/home.html) to find the location nearest you. |
| Ijeba Community, Inc. | 1950 E. 75th St, Chicago, IL 60649 |
| Katherine Boone Robinson Foundation | 4100 W. Ogden Avenue, 1st Fl, Chicago, IL 60623 |
| New Age Services Corporation | 1330 S. Kostner Ave, Chicago, IL 60623 |
| New Hope Community Service Center | 2559 W. 79th St, Chicago, IL 60652 |
| Nuway Community Services, Inc. | 110 E. 79th Street, Chicago, IL 60619 |
| PDSSC – Chicago | 2260 N. Elston Ave, Chicago, IL 60614 |
| Pilsen Wellness Center/Pilsen - Little Village CMHC | 2319 S. Damen Ave, Chicago, IL 60608 |
| Renewed Hope Community Services | 626 E. 71st St, Chicago, IL 60619 |
| Rincon Family Services | Multi-site. Refer to the [website](https://www.rinconfamilyservices.org/) to find the location nearest you. |
| Strive to Serenity | 7124 W. Grand Ave, Chicago, IL 60707 |
| Sundance Methadone Treatment Center, Inc. | 4545 N. Broadway Ave, 3rd Fl, Chicago, IL 60640 |
| The Women's Treatment Center | 140 N. Ashland Ave, Chicago, IL 60607 |

**Appendix F**

**Phase 2: Program Implementation**

Timeline: September 2021 – August 2022

**Goal: Implementation of hospital-to-community collaborations to better support continuity of care outcomes (i.e. warm handoffs) for people with OUD with at least two community partners.**

Program teams (includes hospital teams and community-based MOUD partner teams) will be expected to complete the following during Phase 2:

* Amend subcontract and MOUs to reflect the Phase 2 implementation work plan.
* Implement linkage/warm handoff workflows and conduct quality improvement (Plan, Do, Study, Act (PDSA) cycles) as needed.
* Develop a sustainability plan for long-term implementation.
* Continued participation in program team meetings and program cohort collaborative sessions.
* Submission of monthly progress reports and participation in evaluation activities.

**Goal: Implementation to advance hospital infrastructure development in the emergency department around best practices (i.e. initiation of MOUD, take-home naloxone) for treating and addressing opioid use disorder (OUD)**

Hospitals will be expected to complete the following during Phase 2 independent of their full program teams:

* Implement workflows and conduct quality improvement (Plan, Do, Study, Act (PDSA) cycles) as needed.
  + Naloxone dispensing workflow implementation in the ED.
  + MOUD initiation workflow implementation in the ED.

**Appendix G**

**Cohort Collaborative**

Timeline: March 2021 – August 2022

The cohort collaborative is part of the HOPATSC Program and will begin in March of 2021. IPHI will work with the UI Health Mile Square team to facilitate this collaborative. The purpose of this collaborative is to provide cohort-level technical assistance support, capacity building and peer-to-peer learning as teams move through the program and execute their team’s work plans.

Key collaborative design components include:

* Cohort-based, open only to program grantees
* Cross-sectoral, involving all hospital teams plus the community-based MOUD providers
* Every other month meeting frequency
* Required attendance from all grantees and their partner teams
* Virtual convenings (until meeting in person is once again feasible)
* Focus on practical application, problem-solving, case presentations, and system workarounds

Content areas will likely include, but not be limited to:

* Hospital leadership buy-in
* Guidelines, workflows, and clinical decision supports
* MOUD Initiation across hospital settings (e.g. ED, inpatient)
* Co-prescribing and naloxone dispensing
* Linkage to care: MOUs, workflows, referring to different community service providers
* Harm reduction, stigma reduction, and syringe service programs
* Peer recovery models
* SDOH and treatment retention; How to connect with systems in your hospital overseeing the CHNA process
* Capacity limitations with limited staffing and hours of operation
* Meeting the needs of pregnant persons with OUD

**Appendix H**

**Program Description for Community Partners**

Hospital Overdose Prevention and Addiction Treatment Systems of Care (HOPATSC) Program

Six-Month Planning Grant

(March – August 2021)

**Background & Rationale**

As opioid overdose fatalities reach unprecedented levels, continued funding and focus on Chicago hospital capacity to better serve people with an opioid use disorder (OUD) is both necessary and urgent. The increased utilization of emergency medical services from overdose incidents, particularly in key West and South Side community areas, demands a concentrated effort to support hospitals to provide overdose prevention support, initiate medication for opioid use disorder (MOUD) services, and link patients to ongoing treatment services. However, hospitals cannot do it alone, and must integrate their response into a robust system of care.

The Illinois Public Health Institute (IPHI) is seeking applications from West and South Side Chicago hospitals to participate in a capacity building program that seeks to strengthen transitions of care between hospitals and community-based MOUD providers. Many individuals with OUD cycle in and out of hospital emergency rooms, often without a clear plan for continued care beyond the hospital setting. Given the overdose risk for persons with OUD following any period of abstinence or any loss of tolerance that often follows hospital admission, returning to the community with a service connection plan that also respects patient preferences, is critical.

Funding support for this program is provided by the Chicago Department of Public Health (CDPH) and the Centers for Disease Control and Prevention (CDC). IPHI is managing the program development, implementation, and grantee selection.

**Program Overview**

The purpose of the HOPATSC program is two-fold:

* To advance hospital infrastructure development in the emergency department around best practices (i.e. initiation of MOUD, take-home naloxone, and warm handoffs) for treating and addressing opioid use disorder (OUD), and
* To bolster hospital-to-community collaborations to better support continuity of care outcomes for people with OUD.

The HOPATSC program will focus on expanding capacity in the city’s hardest hit communities through a localized and team-based approach that includes one area hospital and at least two community-based MOUD provider partners. Teams (1 hospital, 2 community partners) will work together to develop a program that improves transitions of care from the hospital to the community. This program will utilize training and technical assistance and cross-sector peer learning to advance these goals. Hospital applicants will focus program development in the emergency department (ED).

The HOPATSC program will be broken up into two phases, a planning phase (Phase 1) and an implementation phase (Phase 2). The phases are sequential and intended to build off one another. Each phase requires a separate application process. This RFA is for Phase 1 planning grants only. Phase 2, implementation, is expected to begin September 2021 and is not automatically guaranteed to grantees who receive Phase 1 planning grants.

Applicants for Phase 2 grants will be evaluated on their performance in Phase 1. In addition, fewer grantees may be awarded for Phase 2 implementation than are awarded during Phase 1 of planning. A shorter application and review process will take place at the end of Phase 1 to determine Phase 2 grantees before the next cycle begins.

**Community Partners – Roles and Requirements**

This program is intended to improve outcomes for people with OUD and people at risk of an opioid overdose by increasing the uptake of best practices and improving hospital-to-community linkage to care. Therefore, the community partners must be able to provide evidence-based treatment known for reducing morbidity and mortality related to opioid use for persons with OUD. Community partners must include at least one licensed buprenorphine/Suboxone program and at least one licensed methadone program. If community-based partners are also providing Vivitrol/naltrexone, counseling services, or other additional services, these services will be viewed as supplemental and cannot be substituted for the requirement of having at least one buprenorphine/Suboxone maintenance program and at least one methadone maintenance program.

*Phase 1: Program Planning Activities and Deliverables*

Timeline: March – August 2021

Teams (includes hospital teams and community partner teams) will be expected to complete the following during Phase 1:

* Subcontracts, MOUs, work plans for Phase 1, team-based meeting schedule, workflow, protocol development and discharge planning based on a Plan-Do-Study-Act (PDSA) cycle.
* Participate in a program cohort collaborative. The cohort collaborative is intended to build capacity, engage participants in cross-sector peer learning, and provide critical technical assistance around best practices and infrastructure development.
* Develop work plans for Phase 2.

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| **Phase 1 Meetings and Time Commitment** | | | | |
| **Meeting Type** | **Required Stakeholders** | **Meeting Purpose** | **Duration** | **Frequency** |
| Program Team Meetings | * Hospital Team assigned to program * Community Partner 1 Team assigned to program * Community Partner 2 Team assigned to program | Develop linkage workflows; Engage in team-based planning and implementation work; Participate in workflow testing for QI | TBD by your program team | Once per month |
| Program Cohort Collaborative | * All awarded hospitals and community partners | Participate in a learning and technical assistance collaborative | 90 minutes | Every other month |
| *\*\*Please note that teams are expected to meet as often as is needed to accomplish program goals.* | | | | |

**While the hospital will serve as the lead applicant in this process, the following information is required from each community partner:**

* A letter of commitment from each community partner stating they are agreeing to participate in this program within the stated time frame (March – August 2021).
* Contact information from each community partner including the contract representative, the program lead and the leadership champion.
* A budget and budget narrative from each community partner outlining how monies will be spent.