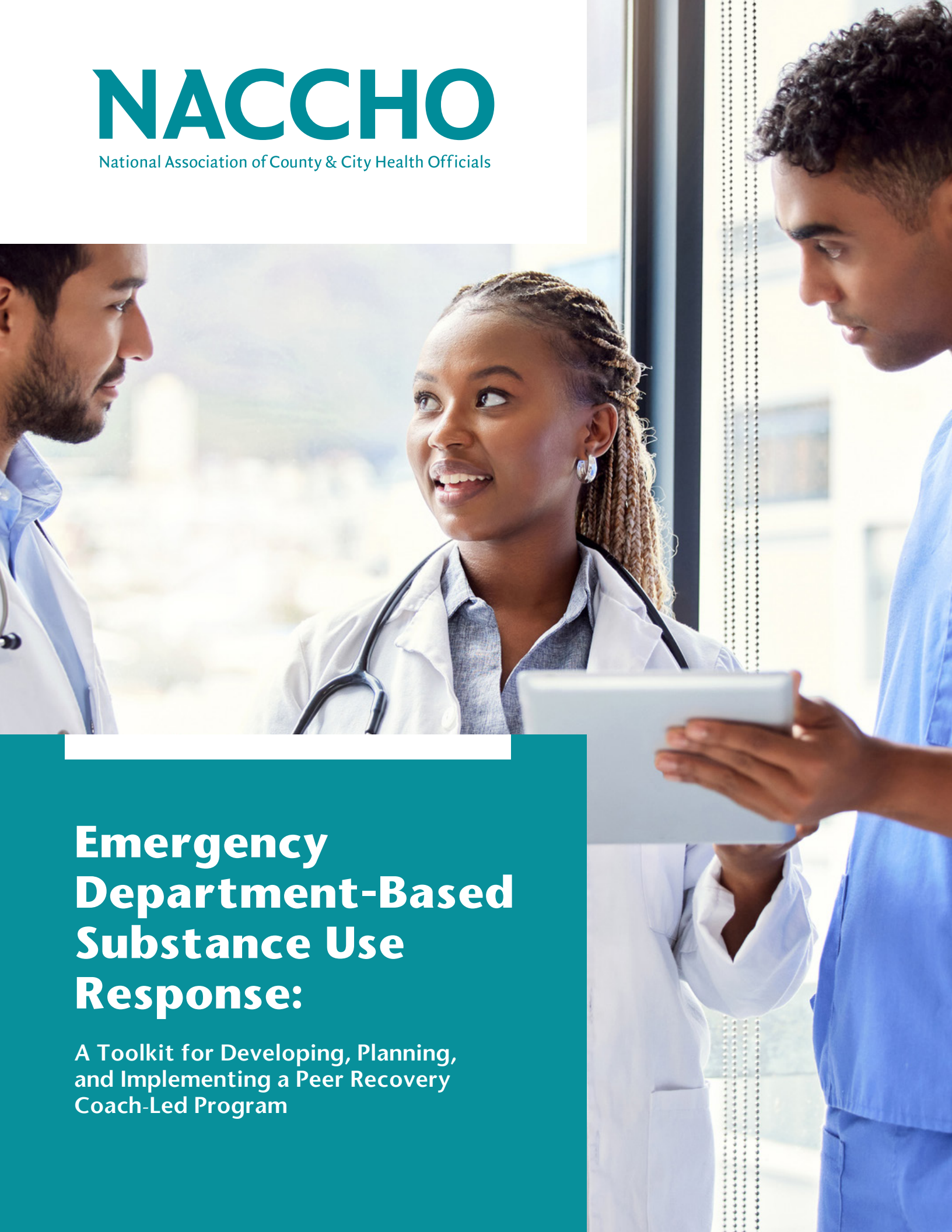
NACCHO

National Association of County & City Health Officials



Emergency Department-Based Substance Use Response:

A Toolkit for Developing, Planning, and Implementing a Peer Recovery Coach-Led Program

TABLE OF CONTENTS

39

APPENDIX

COMMONLY USED ACRONYMS

GENERAL

- Protocol Development Considerations
- Myths vs. Truths on Pharmacological Interventions in the ED
- The Legal Foundation for ED-Based Response to Substance Use

MOUD GUIDANCE

- DEA Registrant Letter Eliminating DATA-Waiver Program
- Summary of Solutions in Mainstreaming Addiction Treatment Act
- Clinical Opiate Withdrawal Scale (COWS) Assessment Tool
- Considerations for Development of MOUD protocol

ROLES AND JOB DESCRIPTIONS

- Peer Job Description
- OSOP Job Description
- Champion Role Description
- Planning Committee Composition
- Peer Supervisor Role Description
- References/Resources

ACKNOWLEDGEMENTS

This toolkit was developed by The Mosaic Group with support from the National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). The project team would like to thank all of the partner hospitals nationwide that have implemented ED-based peer programming and all of the key leaders and staff who generously devoted their time and insights to inform this resource.

Project Team

Marla Oros, RN, MS, FAAN
President
The Mosaic Group

Yewande Kotun Davis, MBA, MHA
Senior Advisor, Population Health
The Mosaic Group

Madeline Masog, MPH
Program Analyst, Overdose, Injury, and Violence Prevention
National Association of County and City Health Officials (NACCHO)

Sadie Smith, MSW
Managing Director
The Mosaic Group

Francis Higgins, MSc
Senior Program Analyst, Overdose, Injury, and Violence Prevention
National Association of County and City Health Officials (NACCHO)

The Mosaic Group is a nationally recognized healthcare management consultant firm, specializing in behavioral health integration and overdose prevention and response strategies.

The National Association of County and City Health Officials (NACCHO) represents the country's nearly 3,000 local health departments including city, county, metropolitan, district, and tribal agencies across the country. NACCHO's subject matter expertise and resources help local health department leaders to develop public health policies, programs, and services to ensure that people in their communities are protected and prepared.

Financial support provided by the Centers for Disease Control and Prevention under cooperative agreement OT18-1802 "Strengthening Public Health Systems and Services Through National Partnerships to Improve and Protect the Nation's Health."

Recommended Citation; Oros, M; Smith, S; Davis, Y; Higgins, F; Masog, M. "Emergency Department-Based Substance Use Response: A Toolkit for Developing, Planning, and Implementing a Peer Recovery Coach-Led Program ." NACCHO, 1 Feb. 2024.

INTRODUCTION

PURPOSE

The Emergency Department-Based Substance Use Response Toolkit was created out of recognition of both the severity of the ongoing overdose epidemic and the unique and critical role healthcare systems play in the identification of and support for individuals most at risk of overdose. This toolkit is meant for health systems and their partners, such as state or local health departments, who are interested in developing emergency department (ED) based programs to reduce the harms associated with substance use and prevent future overdose. This toolkit will equip readers with tools to identify those most at risk, allowing them to share important resources and support patients to make safer choices and meet self-directed goals related to drug use. While much of the information provided may be usefully applied across in-patient settings, it is most appropriately meant to provide a roadmap for implementation in EDs.

While the number and type of interventions aimed at reducing overdoses is necessarily varied, this toolkit focuses on providing hospitals and health departments a roadmap to:

Systematize the screening of patients who present in the emergency department for substance use

Integrate interventions led by Peer Recovery Coaches[1] for patients who positively screen for substance use

Provide access to medication for opioid use disorder (MOUD) as an evidence-based mechanism for harm reduction and recovery support

Develop relationships with community based MOUD clinicians, as well as harm reduction and recovery organizations, to provide ongoing support for people who use drugs (PWUD) after leaving the emergency department or other medical settings

It is important to also note that, while the overdose epidemic is largely driven by opioid use, considerations should be given to broader identification and response to substance use to capture the nuances of different patient populations, respond to unique community needs, and reflect the reality of a complex and shifting drug supply.

BACKGROUND

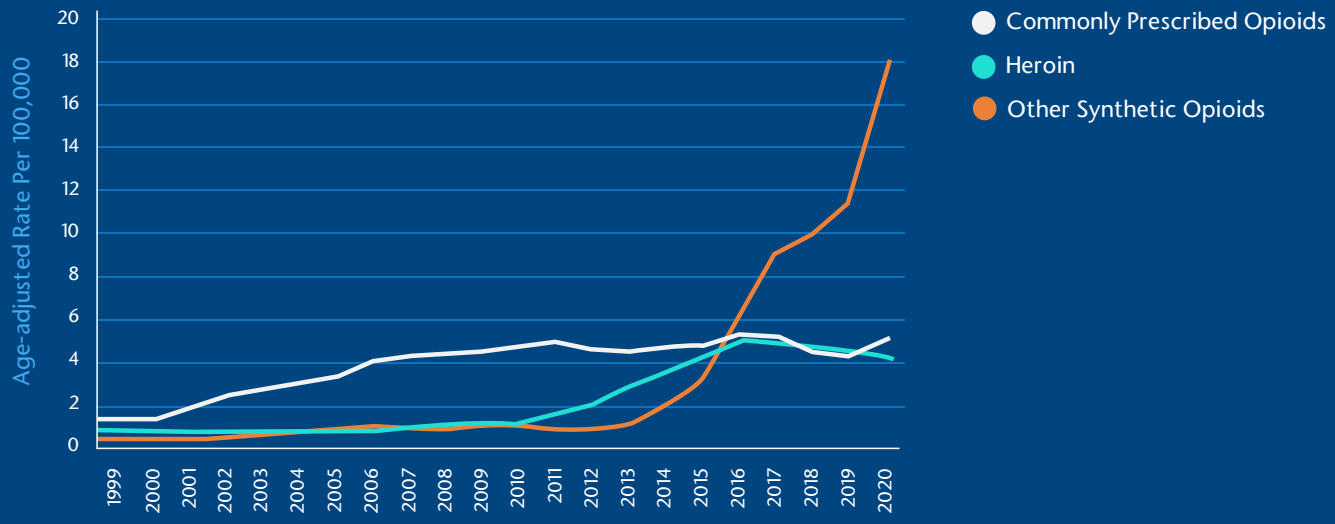
Drug overdose continues to be the number one cause of injury related death in the U.S, outpacing car accidents and gun-related deaths combined.[2] While increasing overdose deaths has long been a major public health concern, a number of factors have contributed to an unprecedented rise in deaths since the beginning of 2021. Unintentional drug overdoses increased by over 50% from December 2019 through

1 Peer Recovery Coaches may have a number of titles (Peer Recovery Specialist, Wellness Advocate, etc.) but broadly refer individuals with lived experience of drug use who have completed a formal training regimen.
2 https://injuryfacts.nsc.org/all-injuries/preventable-death-overview/odds-of-dying/

December 2022, rising from approximately 71,130 to 108,500.[3] This has in large part been driven by steep increases in illicitly manufactured fentanyl-involved overdoses, which, along with overdoses caused by other synthetic opioids, were over 18 times more common in 2020 than 2013.[4] The number of polysubstance overdoses, such as incidents where both opioids and methamphetamine or opioids and cocaine were involved, have also risen precipitously in recent years.[5] While this may in part be driven by individuals intentionally engaging in polysubstance use, the drug supply has also become increasingly contaminated, either in an intentional effort to increase profit or unintentionally due to unsafe practices at drug processing centers.[6] Finally, there has been a dangerous increase in the number of pills purporting to be legitimate prescription opioids, such as oxycodone, entering the drug market, which may in part explain the precipitous rise in adolescent overdose deaths since 2020.[7,8] Taken together, these recent trends have significantly increased the risk of overdose and expanded the populations most at risk beyond those of previous associated with the overdose epidemic.

Three Waves of the Rise in Opioid Overdose Deaths

Source: Center for Disease Control and Prevention, CDC WONDER Online Database, February 2022
Available at http://wonder.cdc.gov/mcd-icd10.html



Apart from the human cost of the overdose epidemic, ongoing challenges related to alleviating the associated harms of substance use produce over $13 billion in hospital costs annually,[9] straining hospital capacity and the healthcare delivery system. Despite the funds expended in response to the epidemic, access to drug and alcohol use treatment is still a challenge for many. The COVID-19 pandemic further intensified the access gap by both disrupting existing treatment options and limiting the types of treatment interventions available during a time when overdoses were rising rapidly.[10]

3 https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
4 https://www.cdc.gov/opioids/basics/fentanyl.html
5 https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates
6 https://www.dea.gov/sites/default/files/2018-07/BUL-039-18.pdf
7 https://www.sciencedirect.com/science/article/abs/pii/S0376871622001351
8 https://jamanetwork.com/journals/jama/fullarticle/2790949?guestAccessKey=c6551d85-8488-4716-887d-a598dae6d048&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=0412229 (Peterson, Li, Xu, Mikosz, & Luo, 2021)
9 (Peterson, Li, Xu, Mikosz, & Luo, 2021)
10 https://substanceabusepolicy.biomedcentral.com/articles/10.1186/s13011-022-00499-7

According to the 2021 Survey on Drug Use and Health, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that more than 26 million people ages 12 and older report having a substance use disorder (SUD).[11] However, historical data shows that only 10% of these individuals typically receive specialized care.[12] For individuals with co-occurring chronic illness and substance use disorders, the treatment gap is even more significant. Substance use often complicates co-occurring medical conditions, and research shows that these patients have higher rates of other medical conditions like hypertension, injury, and psychiatric disorders.[13] Most specialty treatment facilities lack the capacity to manage both chronic medical conditions and substance use. As a result, some of the most complex and vulnerable patients rely on hospital emergency rooms as their primary source of healthcare.

While hospital EDs are equipped to provide interventions for a broad range of chronic conditions like heart disease, diabetes, and hypertension, many fail to address or even identify chronic substance use. Only 1 in 10 people with a substance use disorder receive any type of specialty treatment[14] despite the well documented success of interventions like buprenorphine, a MOUD. Additionally, there are proven harm reduction techniques that limit the risk associated with drug use that are not implemented to the degree that the crisis demands.[15] As with any other chronic health condition, hospitals should normalize early identification, intervention, harm reduction, and treatment for those with substance use disorders in order to address gaps in access and save more lives.

While integrating substance use response in the ED is both important and necessary, it would be remiss to not acknowledge the realities of the ED environment. EDs can be challenging, busy, and unpredictable at times, and new programming cannot be implemented haphazardly or in a silo. For this work to be successful, system level resources and support are necessary to drive care transformation and ensure practice adoption. Only by fulling integrating this work into their overall workflow can EDs address the critical needs of PWUD.

The Emergency Department is a critical access point for SUD intervention.

Unlocking the Emergency Department's Potential

According to the CDC, hospital emergency departments across the nation provide over 131 million visits to patients each year,[16] including 38 million visits classified as being due to injuries.[17] Analysis of health care data indicates that ED visits contribute to about half of all hospital-associated medical care delivered in the US.[18] This analysis also points to the ED's role as a safety net for vulnerable and underserved populations and highlights higher ED utilization for African American people, women, Medicaid and Medicare beneficiaries, and individuals with lower socioeconomic status. Additionally, patients who frequent EDs are more likely to present with drug and alcohol, mental health, and other chronic illnesses. Often, they depend on hospital EDs to bridge the gap in access to health care caused by limited access to quality, timely care in the community. While EDs treat hundreds of thousands of nonfatal overdose survivors each year, many fail to respond in a systematic way to mitigate the risk of recurrence.[19]

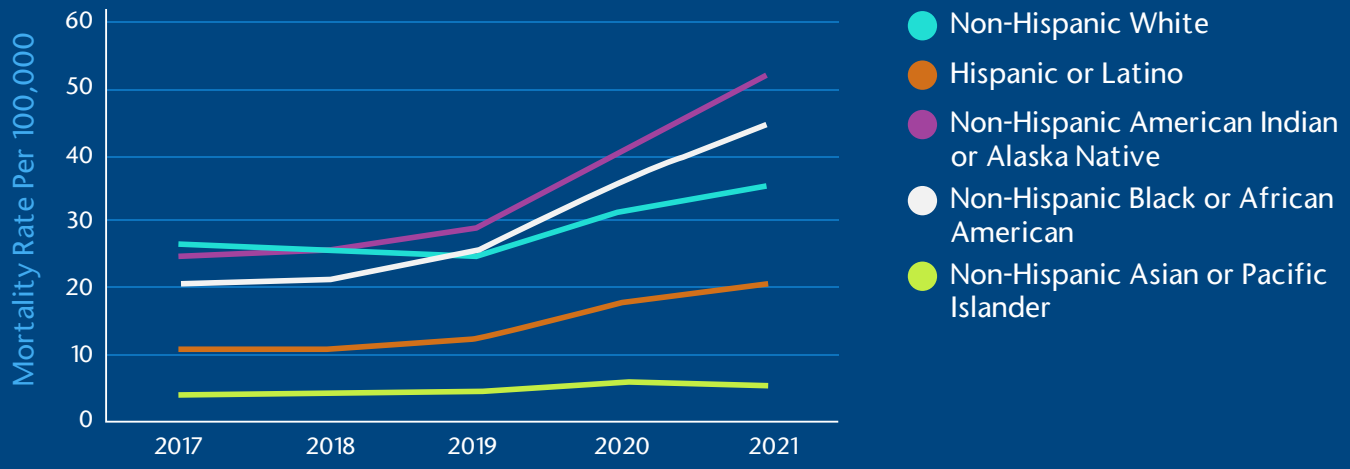
11 (Substance Abuse and Mental Health Services Administration, 2021)14 (US Office of the Surgeon General , 2016)
12 (Jack, Oller, Kelly, Magidson, & Wakeman, 2018)
13 (US Office of the Surgeon General , 2016)
14 (US Office of the Surgeon General , 2016)
15 (Substance Abuse and Mental Health Services Administration, 2022)
16 (Centers for Disease Control and Prevention, 2022)
17 (Centers for Disease Control and Prevention, 2022)
18 (Marcozzi, Carr, Liferidge, Baehr, & Browne, 2017)
19 (Substance Abuse and Mental Health Services Administration, 2021)

A growing body of research shows that people who survive a nonfatal overdose are at an increased risk of a subsequent fatal overdose. According to the National Institute on Drug Abuse (NIDA), about 1 in 20 patients treated for a nonfatal opioid overdose in an emergency department died within 1 year of their visit, many within 2 days.[20] Retention in MOUD is strongly associated with reduction in risk of overdose, and hospital initiation of MOUD can be a key facilitator of care linkage and retention.[21] This finding undergirds the necessity for EDs to maximize their unique opportunity to systematically screen and intervene with individuals engaging in high-risk substance use.

The American College of Emergency Physicians (ACEP) has defined the minimum evidence-based practices for hospitals to appropriately respond to people who use drugs and alcohol.[22] According to ACEP, hospitals should routinely (1) screen and diagnose SUDs, (2) offer opioid agonist medications for patients with Opioid Use Disorder (OUD), and (3) facilitate referrals to treatment for patients with any SUD and offer naloxone to those whose drugs may contain opioids. This last point has become progressively more relevant as the overall drug supply has been increasingly contaminated by fentanyl.

US Drug Overdose Deaths per 100,000 by Race, 2017-2011

Source: Center for Disease Control and Prevention, CDC WONDER Online Database, February 2022
Available at http://wonder.cdc.gov/mcd-icd10.html



Despite this, there are a number of factors[23] contributing to the slow uptake or complete resistance of hospitals to adopting interventions in the ED for people who use drugs, including:

- Limited perception regarding the depth of opioid and substance use beyond acute symptoms
- Concerns about safety of patients and staff
- Misinformation about insufficient hospital and community resources

20 (Weiner, Baker, Bernson, & Schuur, 2020)
21 (Nordeck, Welsh, Shwartz, Mitchell, O'Grady, & Gryczynski, 2022)
22 (Hawk, et al., 2021)
23 (Lowenstein, Perrone, Hemmons, Abdel-Rahman , Meisel, Delgado)

Unfortunately, the consequences of not aligning the provision of care with the best available evidence are borne not only by the inadequately served patients, but also by the hospitals themselves. By failing to identify and address substance use in the ED, hospitals directly contribute to many of the issues they hope to prevent, such as continued health disparities, avoidable utilization of ED, and lengthy hospital inpatient stays.[24]

Given the extreme toll the overdose epidemic has had on PWUD, their support networks, and society at large, the potential impact of adopting a systemic response to opioid and substance use in EDs is great. There are several interventions that hospitals may offer to PWUD, and each has demonstrated improvements in patient outcomes and decreased healthcare costs. Now, more than ever, it is vital that health systems prioritize strategies to strengthen their response to the overdose crisis. To do so, leadership must be committed to the end goal, creative in meeting the unique needs of their communities, and resilient in the face of setbacks and challenges.

24 (Yeboah-Sampong, Weber, & Friedman, 2021)

HOW TO USE THIS TOOLKIT

This toolkit is organized to help hospital systems plan for and implement interventions related to substance use and overdose response initiatives. Within each section, guiding elements inform planning and implementation efforts, as described in the table below.

KEY CONSIDERATIONS	Critical planning and implementation strategies to consider when exploring opportunities to implement evidence-based options.
CALLOUTS	Information and quick insights into approaches and ideas for planning and implementation.
TOOLS	Tools and resources to guide implementation efforts.
CASE STUDY	Real-world examples of how strategies are being implemented in the field.
IMPORTANT QUESTIONS TO ASK	Questions and answers related to key planning and implementation considerations.

PART I: EVIDENCE-BASED OPTIONS FOR SUD CARE IN THE EMERGENCY DEPARTMENT

Overview

Option I: Universal Screening
Option II: Engaging Patients with High-Risk Substance Use
Option III: Pharmacological Interventions
Option IV: Overdose Response
Option V: Facilitated Referral to Treatment

The evidence-based strategies in the following sections, when considered separately or in combination, present EDs with opportunities to strengthen care for patients who use drugs. Before moving forward with any of these strategies, health systems should take the formative steps of securing leadership buy-in and determining how the each intervention aligns with the needs of their patient population. Committed leadership is necessary for embedding these strategies into the ED's workflow, rather than just tacitly encouraging them. EDs and their partners should consider this information within the context of their own environments to make informed decisions that will have the broadest impact in their communities. While it might not be feasible for EDs to adopt all the presented strategies at once, simply choosing to start can grow the synergy necessary for ongoing and future expansion.

UNIVERSAL SCREENING

Universal screening enables systematic identification of patients who may be at risk of developing a substance use disorder or experiencing harms or death related to substance use. By adopting universal screening practices, hospitals can close the gap and identify individuals who may need additional support.[25] Universal screening ensures ED staff have the opportunity to identify all patients who may benefit from substance use-related education and resources. Furthermore, universal screening normalizes the conversation around substance use and makes it a routine part of care, catalyzing a shift in perceptions and allowing clinicians to treat SUD as a chronic condition, rather than a moral failing.

Given the volume of patients that come through EDs, hospitals should use (a) validated screening tool(s). Validity is important because validated tools have been proven to measure what they claim to measure in a specific population. Validated screening tools are evidence based and have high sensitivity, specificity, reliability, and high positive predictive value and negative predictive value. This means that validated tools are highly likely to detect those who truly have the condition when administered to the intended population. There are a variety of validated screening tools that can be used to evaluate the use of specific substances, and hospitals should make a two-fold determination about which validated tool is best. First, hospitals should consider which tool most *efficiently* captures the necessary information, considering the fast-paced ED setting. Second, hospitals should consider which tool most *effectively* captures necessary information so that patients can be connected to evidence-based care. Tools such as NIDA's Screening and Assessment Tool Chart[26] can be used to determine which validated tool(s) might best serve a hospital's patient population.

VALIDATED SCREENING TOOLS

Screening tool	Description (Primary Population)	# Questions	Administration
TAPS	Tobacco, Alcohol, Prescription medication, and other Substance Use (Adults)	4-item questionnaire (Part 1)	Self- or clinically-administered
DAST	Drug Abuse Screening Test (Adults)	10- or 20-item questionnaire	Self- or clinically-administered
CRAFFT 2.0	Car, Relax, Alone, Forget, Friends/ Family, Trouble (ages 12-20)	9-item questionnaire	Self- or clinically-administered
S2BI	Screening to Brief Intervention (ages 12-17)	7-item questionnaire	Self- or clinically-administered

The above list of validated screening tools[27], while not exhaustive, presents alternatives to assist hospitals to assess potentially high-risk substance use. While there is some overlap in the substances and conditions that they can identify, each tool is tailored to a specific patient population as reflected in the questions.

25 (Gertner, Roberts, Bowen, Pearson, Jordan, 2021)
26 (National Institute on Drug Abuse, 2022)
27 ((National Institute on Drug Abuse, 2022)

ENGAGING PATIENTS WITH HIGH-RISK SUBSTANCE USE

Once patients are identified as eligible for intervention based on screening results, a number of different staff can potentially engage them. Physicians and nurses can provide the clinical expertise to treat patients with high-risk substance use. They understand the pharmacologic and other medically necessary interventions to care for patients in need. However, other patient needs may be complex and call for further intervention by a social worker, care navigator, or Peer Recovery Coach (PRC). PRCs—individuals with lived experience with SUD— are a key emerging workforce with the experience and training to develop a connection with the patient and assist in identifying and addressing their relationship to substance use.[28] Regardless of who engages the patient around their substance use, it is important to recognize that recovery is not a monolith and can look quite different from one person to the next. When engaging a patient around their substance use behavior, the intervention is the opportunity to identify the patient's goals, meet them where they are in terms of how they define personal health and success, and provide support and coaching to achieve these goals.

MOTIVATIONAL INTERVIEWING

A commonly used method when engaging patients who use drugs and alcohol is motivational interviewing. Motivational interviewing (MI) is an effective, evidence-based technique used to help patients resolve ambivalence about behaviors that prevent change. The core goals of MI are to express empathy and elicit patients' reasons for and commitment to changing substance use and other high-risk behaviors.[29,30] Through the use of open-ended questions, affirmations, and reflective listening, hospital staff can help coach patients toward their self-directed goals, including engaging in active recovery. Again, it is important to reiterate that recovery support looks different for everyone. For some, it may be a facilitated referral to treatment, while for others, it may be support for reduced or safer use of drugs and alcohol. Nonetheless, motivational interviewing allows peers and other health professionals to engage patients who use drugs and alcohol in a non-judgmental manner that centers patient autonomy.

PEER SUPPORT

While there are many names for Peer workers—Recovery Coach, Peer Specialist, Peer Advocate, Recovery Specialist, Peer Mentor—the premise is that a peer is an individual with personal lived experience with SUD.[31] Peers are quickly becoming an essential workforce for engaging patients who use drugs and alcohol because they connect with patients through shared experience. Patients often trust peers and are more likely to engage with them in conversations around their substance use than clinicians or other care providers without this personal experience.[32] This trust, coupled with techniques like motivational interviewing, can help a peer to coach patients with various levels of interest in recovery support. In addition, peers serve as a positive example of recovery, which can both encourage patients and help reduce stigma among hospital staff. In a 2019 study, Devin Collins et al provided a qualitative review of peer interventions in hospitals.[33] They identified peers as "cultural brokers" with the unique ability to draw from personal experience to contextualize patient experiences for hospital providers while also "translating" provider recommendations

28 (Reif, Braude, Lyman, Dougherty, Daniels, Ghose, Salim, Delphin-Ritton, 2014)
29 (Miller & Rollnik, 2012)
30 (Substance Abuse and Mental Health Servies Administration, 2021)
31 (Substance Abuse and Mental Health Servies Administration, 2021)
32 (Lennox, 2021)
33 (Collins, et al., 2019)

in a way that connects with patients. The example below demonstrates the potential impact of using peers in the hospital. Additional benefits of integrating a peer model include increased buy-in from hospital staff, the improved ability to provide integrated health care, increased likelihood of patient use of community support services, and increased patient engagement in substance use treatment.

Peer Mentors (PM) Effect on Hospitalization for Patients with SUD

"If It Wasn't for Him, I Wouldn't Have Talked to Them": Qualitative Study of Addiction Peer Mentorship in the Hospital [34]

HOSPITAL

Peer Mentor Action		Cultural Brokerage		Outcomes
• Share life experiences • Perform small, humanizing gestures • Support patient autonomy • Offer patient resources • Bring patient perspectives to IMPACT Team • Translate care plans to patients • Vouch for IMPACT team	→	• Transfer patient trust & legitimacy towards IMPACT • Contextualize patient experiences to IMPACT providers • Improved understanding between patients and providers	→	• Increased patient-centered care • De-escalate crises • Reduce staff stigma • Make patients more amenable • Make hospitalization more tolerable • Offer patients positive experience with healthcare sytem

Although hospitals may view hiring peers as a shortcut to better engagement with patients who use drugs and alcohol, there is a steep learning curve for both peers and hospital staff when it comes to effectively integrating the peer role in the ED. In the experience of the Mosaic Group, considerations when hiring peers include:

While peer recovery roles do not necessarily require licensure, they do require training and often certification. As professionals, peer recovery support workers should be paid a livable wage.

The concept of recovery is highly personal and may not follow a linear pathway. Employers should be prepared to respect and embrace the experience that peers' diverse pathways to recovery bring to the table and make every effort to support them in their own journey.

34 (Collins, et al., 2019)

When considering an individual with personal, lived experience with substance use, it is important to be considerate of the work environment and any related stigma against substance use. As with other chronic conditions, there are circumstances that can trigger or exacerbate a return to use. Employers should ensure that peers have the support they need to maintain their recovery, and in the case of a return to use, the support they need to seek help without the immediate risk of losing employment. While this may be nuanced, there should be the opportunity to evaluate and provide accommodations on a case-by-case basis.

Additional modifications to the onboarding process may need to be in place regarding a prospective candidate's background check. This, too, should be evaluated on a case-by-case basis depending on the severity and timing of criminal infractions.

Separate from employer considerations, peers may have not been in a hospital or healthcare setting as employees. The Mosaic Group has observed that this can be an intimidating and difficult to navigate environment, especially initially. In the experience of the Mosaic Group, considerations when integrating peers into healthcare settings include:

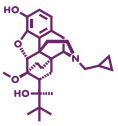
- The rigid professional hierarchy of hospitals, and how that might impact someone who has not encountered a comparable work environment
- The frequent rotation of clinicians and presence of trainees, which requires peers to effectively manage themselves and others while operating in a complex environment
- The potential for the peer to encounter stigma from colleagues and staff toward people with SUD
- The fast pace and high demands of hospital care and high patient acuity, which can cause additional stress

Once acclimated to the hospital environment, peers can play a significant role in partnering with patients to help them identify and meet their goals.

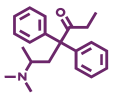
PHARMACOLOGICAL INTERVENTIONS

In addition to screening and peer engagement, there are pharmacological interventions that hospitals can and should integrate to reduce overdose and support patients interested in treatment and recovery. There are several pharmacological interventions for treatment of SUD, but for the purposes of this toolkit, only medication for opioid use disorder, or MOUD, and opioid overdose reversal medication will be discussed.[35] MOUD is an approach to opioid use treatment that utilizes FDA-approved drugs as a standalone regimen to achieve recovery for people diagnosed with opioid use disorder. MOUD can be utilized in combination with counseling and behavioral therapies for people diagnosed with opioid use disorders to provide patients with a whole-person approach.[36] MOUD that is approved by the FDA include buprenorphine, methadone, and extended-release naltrexone.

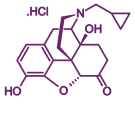
35 (Substance Abuse and Mental Health Services Administration, 2021)
36 (Substance Abuse and Mental Health Services Administration, 2021)



Buprenorphine is a partial opioid agonist that can help diminish desire for, and physical dependency on, opioids. Due to being a partial opioid agonist,buprenorphine is subject to less onerous treatment regulation than full agonists, such as methadone. It is also the first medication to treat OUD that can be prescribed or dispensed in physician offices. For these and other reasons, buprenorphine is the most common pharmacological intervention provided and initiated in the ED.[37]



Methadone is a full opioid agonist that reduces opioid craving and withdrawal and blocks the effects of opioids. Taken daily, methadone regimens are individually tailored to the patient and, due to federal regulations, can only be dispensed from a certified opioid treatment program and must be taken under the supervision of a practitioner.[38]



Naltrexone is not an opioid, but works by blocking the pleasurable side effects of alcohol or opioid use. It can be used to treat both alcohol use disorder (AUD) and OUD. However, there is increased risk of overdose during the required extended period of abstinence prior to starting the medication. Patients are also at increased risk of overdose if they stop taking naltrexone and resume use, due to significantly reduced tolerance.[39]

Naloxone is a safe and effective medication approved by the FDA for the rapid reversal of an opioid overdose. As an opioid antagonist, it can reverse an overdose by temporarily binding to opioid receptors and blocking the effects of opioids such as heroin, oxycodone, and even synthetic opioids like fentanyl. Naloxone is a critical overdose response tool and should be made available to anyone likely to witness or experience an overdose.[40]

For hospitals looking to make a measurable impact on the overdose crisis, MOUD should be made available to all patients. Buprenorphine is an evidence-based medication with the most demonstrated success in ED settings. Unfortunately, there are several misconceptions about MOUD and its use in the ED setting that have historically prevented widespread practice adoption. Now that legislation has expanded clinician capabilities even further to prescribe MOUD, education on when and how MOUD can be utilized in the ED is paramount for myth-busting and to encourage clinician buy-in.

Prior to 2023, many ED clinicians could only administer MOUD like buprenorphine directly in the ED, due to the DEA requirement of a DATA 2000 (X-waiver) to prescribe the medication to be taken after leaving the ED. In addition, clinicians that did have an X-waiver could only prescribe to a limited panel of patients at one time. In January 2023, the Consolidated Appropriations Act, 2023 removed the X-waiver requirement, immediately increasing access to utilization of MOUD. As a result, any clinician with a standard DEA registration with Schedule III authority can both administer and prescribe buprenorphine, and there are no longer patient caps related to prescribing it. The DEA does note that existing state laws or regulations may still apply.[41] Nonetheless, hospitals and clinicians now have the ability and opportunity to offer a suite of MOUD options to patients to address the overdose crisis. Promoting practice adoption will require addressing barriers, such as myths and misconceptions surrounding the medication, and enhancing clinician readiness through training, education, and the development of departmental protocols.[42] Several options for ED-based buprenorphine interventions have been outlined below to support hospitals with practice adoption.

37 (Substance Abuse and Mental Health Services Administration, 2021)
38 (Substance Abuse and Mental Health Services Administration, 2021)
39 (Substance Abuse and Mental Health Services Administration, 2021)
40 (Substance Abuse and Mental Health Services Administration, 2021)
41 DEA announces important change to registration requirement (usdoj.gov)
42 (Hawk, D'Onofrio, Chawarski, O'Connor, Cowan, Lyons, Richardson, Rothman, Whiteside, Owens, Martel, Coupet, Pantalon, Curry, Fiellin, & Edelman, 2020)

OPTIONS FOR BUPRENOPHINE INTERVENTION

Interventions well suited for the ED for patients ready to enter treatment include initiation and bridge prescribing.

INITIATION

A patient who is ready for treatment for OUD may be initiated, or induced, on buprenorphine in the ED to manage withdrawal, suppress cravings, improve linkage to treatment, and prevent future overdose. Because the MOUD is only started in the ED, patients need to be connected to ongoing care in the community. Ideally, patients should be connected to ongoing care within a day of hospital discharge to minimize withdrawal symptoms or cravings and increase their likelihood of attendance.[43] While next-day appointments may be difficult in both rural and urban settings depending on the supply and demand for MOUD care, hospitals should mitigate potential difficulties by forging partnerships with treatment clinicians in the community that can assist with the patient's ongoing treatment. When next-day appointments are not available, a prescription should be considered to bridge the patient between discharge and their appointment.

BRIDGE PRESCRIBING

Buprenorphine bridging is made to fill the gap in care for patients with OUD who are motivated to continue treatment and when next day referral from the ED to treatment cannot be arranged. Bridge prescriptions are meant to help patients manage withdrawal between hospital discharge and follow up with a treatment clinician in the community. Bridging can be facilitated either by an ED clinician while a patient is in the ED, or through a bridge clinic, when available. Bridge clinics typically offer low-threshold MOUD treatment with same-day access for new patients and on-demand drop-in appointments.[44] While bridge clinics are an excellent resource, they might not be available or accessible to all communities. When this is the case, ED clinicians should work with patients to provide them with a bridge prescription appropriate to their needs. As a practice, these prescriptions should ideally be given when treatment is arranged prior to discharge, and a follow up plan should always be implemented by PRCs or other responsible staff until linkage to an ongoing prescriber is confirmed. In rural communities, bridge prescribing can be especially helpful if timely treatment for OUD is difficult to access. Now that regulatory changes have broadened the pool of clinicians able to prescribe MOUD, bridge prescribing can be leveraged to fill the gap after MOUD initiation if a community clinician is not immediately available to continue the medication.

43 (D'onofrio, et al., 2015)
44 (Taylor, J. L., Wakeman, S. E., Walley, A. Y., & Kehoe, L. G., 2023)

WITHDRAWAL MANAGEMENT

Buprenorphine can also be used to alleviate withdrawal symptoms in patients presenting to the ED. This can facilitate treatment of other medical issues and reduce the number of patients leaving hospitals against medical advice (AMA),[45] which may increase the ability of EDs to connect patients with peer interventions. While it is best practice and the aim of these programs to have patients continue MOUD treatment after discharge, patients not ready to commit to ongoing treatment may benefit from having their acute withdrawal symptoms alleviated. In the case of this case, eligible patients typically receive just enough buprenorphine to stave off withdrawal symptoms while they are in the ED.

MERITUS MEDICAL CENTER: A STAGED APPROACH TO MOUD TREATMENT IN THE ED

Meritus Medical Center, located in Washington County, Maryland, integrated universal screening, peer recovery interventions and community-based support in 2018 after the Governor declared a State of Emergency due to the overdose crisis. In previous years, the rural area served by the hospital had seen significant increases in opioid use and overdoses. Despite some initial staff discomfort and hesitation due to lack of experience with MOUD, the need within the community was so great that Meritus incorporated MOUD initiation into the ED workflow to allow for one dose of buprenorphine to be provided to patients who were ready to begin treatment and continue with ongoing, community-based care.

By 2022, Meritus recognized that there were still significant gaps in care associated with patients accessing MOUD. Clinicians recognized that although initiation is effective, it is not always inclusive, namely for patients that do not meet the criteria to be dosed in the ED and those who receive an initial dose in the ED but are unable to attend a next-day appointment. This led to patients who were motivated for treatment leaving the ED without the benefit of medication to manage withdrawal or cravings, and unable to receive the treatment that they desired. Leveraging the momentum of the ED MOUD initiation work and the positive shift in attitudes towards the use of MOUD, Meritus decided to expand their protocol to allow for patients to receive bridge prescriptions upon discharge.

An important final consideration for adopting pharmacological interventions in the ED is the provision of naloxone to prevent death in the event of an opioid overdose. In all cases, patients who use drugs, including those who are administered, dispensed, or prescribed buprenorphine, should be offered or prescribed naloxone prior to discharge. Further details related to overdose prevention and response will be addressed in the next section.

45 (Srivastava, Mariani, & Levin, 2020).

OVERDOSE RESPONSE

In order to prevent fatal overdoses, hospitals should adopt practices that address the range of patients who may be at risk for overdose. Considerations should be made for overdose prevention, overdose response, and the risk of subsequent overdose outside of the hospital. As with the previous strategies, the following overdose prevention strategies are most effective when combined with other elements such as pharmacological interventions and peer involvement. Harm reduction is the core of overdose prevention. There is a continuum of harm reduction offerings, and hospitals should consider which strategies best fit the needs of their patient population.

NALOXONE FOR PREVENTION

Naloxone is a life-saving drug that reverses an opioid overdose when administered properly and quickly.[46] The medication is easy to use and requires no medical training to administer. While access to naloxone can vary by location, it can be obtained from clinicians, public health departments, harm reduction programs, and pharmacies, among other locations.

In March 2023, for the first time, the FDA approved Narcan®, a name-brand naloxone nasal spray, for over the counter (OTC) use. Shortly after that, the FDA approved ReVive, another naloxone nasal spray, for OTC use. EDs should plan how to provide take-home naloxone to prevent overdose. Providing naloxone on the spot ensures patients have immediate access, but, if procurement for this kind of distribution is not possible, clinicians can prescribe it for pick-up outside of the ED or direct patients to other available sources. Local Health Departments (LHDs) often already have mechanisms to procure naloxone directly, so partnering with LHDs is a promising strategy to ensure patients have immediate access. For rural communities, this can be especially helpful and mitigate barriers to accessing medication outside of the ED. While naloxone is most commonly provided to individuals who use prescribed or illicit opioids, the contamination of the overall drug supply, particularly due to fentanyl, has made it important to have naloxone available to anyone who uses drugs.[47]

While many see the provision of naloxone for patients who use opioids as an opportunity to discuss treatment or drastic behavior change, many individuals may not be ready to stop using drugs even after a nonfatal overdose. In all cases, harm reduction is a trusted approach to engage patients in conversations around their substance use risk and provide education on strategies to reduce the risk of fatal overdose regardless of their interest in treatment.

HARM REDUCTION

Harm reduction refers to a range of strategies and concepts designed to lessen adverse outcomes related to substance use. Harm reduction is a baseline level of support that meets patients where they are in order to prevent overdose fatality or other harms due to drug use. While the term "harm reduction" is commonly associated with syringe and needle exchange initiatives, its scope actually encompasses a much wider range of approaches to to improve health outcomes for PWUD. It is important to consider the broad continuum of harm reduction interventions when determining how to best align with the needs of a patient population.[48]

46 (Taylor, J. L., Wakeman, S. E., Walley, A. Y., & Kehoe, L. G., 2023)
47 (Nolan, Shamasunder, Colon-Berezin, Kunins, Paone, 2019)
48 (Drucker, Anderson, Haemmig, Heimer, Small, Walley, Wood, & van Beek, 2016)

Examples of harm reduction can include:[49]

- Coaching around reduced and/or safe use
- Wound care to prevent infection or illness
- Preventive testing and education for common infectious diseases, such as HIV and Hepatitis C
- Provision of naloxone and training
- Provision of fentanyl test strips and other drug checking strategies
- Provision of syringe services, meetings, and other recovery supports

Harm reduction acknowledges that drug use is a fact of life and that not everyone is interested in abstinence or treatment. Because of its embrace of goals other than abstinence, harm reduction offers an opportunity to expand the availability of substance use and overdose prevention services to the whole spectrum of PWUD. Many harm reduction resources, information, and materials can be offered within the ED.

RAPID RESPONSE FOR PATIENTS WHO PRESENT WITH AN OVERDOSE

While prevention is an important practice to adopt for all patients, it should also be the expectation that hospitals have routine standards to respond when patients present to the ED after a nonfatal overdose. Often, a rapid response is required to first stabilize the patient before educating and supporting nonfatal overdose survivors, as they are at extremely high risk for subsequent overdose post-discharge.[50]

Rapid response for patients who present with an overdose includes these steps:

STEP 1

Medical stabilization and withdrawal management with MOUD (if the patient is eligible)

STEP 2

Harm reduction education through provision of naloxone, fentanyl test strips, coaching around safe and/or reduced use

STEP 3

Naloxone distribution to any patient whose drugs may contain opioids (i.e., fentanyl) as well as family members and friends who may be present, when possible

STEP 4

Referral for community recovery support at a harm reduction or treatment facility or with a peer in the community, as appropriate

49 (Substance Abuse and Mental Health Services Administration, 2022)
50 (National Institute on Drug Abuse, 2020)

Step four is critical to ensure patients receive ongoing support in the community. Considerations for patients who are interested in harm reduction or treatment are discussed in the coming sections. While there are many pathways to recovery and not every patient will be interested in treatment, hospitals can still leverage the peer workforce to provide outreach and person-centered support.

COMMUNITY OUTREACH

For patients who survive an opioid overdose, peer outreach in the community can be lifesaving. Experience has shown that patients may face several difficulties in the ED after surviving a nonfatal overdose, such as inadequate management of withdrawal symptoms and medications, stigma and shaming from healthcare clinicians, traumatic experiences with EMS, or triggers of past trauma with the medical system[51,52] — all of which can curtail their ED stay, leaving them without the necessary tools for harm reduction and/or connection to recovery support prior to leaving that hospital. However, linkage to a peer that can follow patients into the community can address gaps through ongoing coaching and recovery support in a more familiar environment.

OPIOID OVERDOSE SURVIVORS OUTREACH PROGRAM

The Opioid Overdose Survivors Outreach Program (OSOP) is a model originally designed by the Mosaic Group to respond to opioid overdoses in Maryland Emergency Departments and has since been expanded nationally. Through OSOP, patients who survive an opioid overdose receive highly structured and intensive community outreach from a peer for up to 90 days. Recovery support includes consistent access to naloxone, education related to the risks of subsequent overdose, ongoing coaching related to substance use, linkage to treatment if desired, as well as connection with resources to address social needs.

OSOP OVERVIEW

Patient in ED following opioid overdose is seen by a peer

↓

ED Peer works to:

1. Provide overdose prevention education
2. Discuss heightened risk of overdose fatality with subsequent overdose
3. Introduce OSOP Peer, if available

↓

OSOP Recovery Coach connects with patient within 24 hours in order to help the patient:

1. Connect with recovery support services
2. Connect to substance use treatment programs
3. Coordinate care/services to prevent subsequent overdose

51 (Elliott, Bennett, & Wolfson-Stofko, 2019)
52 (Hawk, et al., 2021)

Community outreach—especially for individuals who survive an overdose—can support recovery and help prevent future overdoses for PWUD. Oftentimes, navigating health-related social barriers such as housing instability or access to healthy food coupled with substance use is difficult and discouraging. However, making peers available to follow patients into the community to provide more robust recovery support can help build positive, trusting relationships, and connect patients with necessary resources related to their health and life goals.

FACILITATED REFERRAL TO TREATMENT

For patients ready for treatment, facilitated referrals to care help build on the momentum gained in the ED around SUD engagement. A facilitated referral to care consists of an individualized treatment plan or referral that addresses barriers to care as well as the patient's range of needs around recovery support and treatment. A comprehensive referral addresses substance use, social determinants, and takes chronic care management into account. As a result, a comprehensive referral can include linkage to a primary care physician (PCP), SUD treatment program, community peer support, and/or referrals to address social barriers to care. Comprehensive referrals can take time, so it is important to have dedicated staff to help facilitate them. It is also important to note that referrals can and should be a team effort since patient transition planning often includes individuals from several disciplines. Bidirectional communication and collaboration can help to appropriately manage responsibilities and ensure that patients' needs are met.

Referral partnerships are often key to ensuring timely access to treatment for patients with SUDs. In addition, having clear knowledge of which programs best serve certain populations (e.g., women with children, people who speak a language other than English as their primary language) as well as the general effectiveness of their program interventions can help referring hospital staff to connect patients with treatment options that are most supportive of patients' recovery goals. Experience has also shown that in-person visits by hospital staff to treatment facilities for tours and "meet-and-greets" can help to cement relationships that can ultimately be leveraged on behalf of patients.

Since comprehensive referrals may not be limited to substance use treatment, it is vital to also build partnerships across the care continuum to eliminate barriers. For example, having a clear understanding of which PCPs are accepting new patients can assist patients in need of additional chronic disease management. Experience has also shown that placement for patients facing complex medical conditions can be exceedingly difficult—especially since most treatment facilities are ill-equipped to provide complex medical care.

SNF OPAT CENTERS OF EXCELLENCE PILOT AT JOHNS HOPKINS BAYVIEW

After both observing and experiencing barriers to quality care when referring patients with both SUD and co-occurring medical conditions to skilled nursing facilities (SNFs), a couple of physicians—an addiction medicine clinician and an infectious disease clinician—at Johns Hopkins Bayview Medical Center partnered to find a solution. Through collaboration with the hospital's population health leadership, they identified the opportunity to build a strategic partnership with a handful of SNFs to provide whole health care, inclusive of substance use treatment, for patients on outpatient parenteral antibiotic therapy (OPAT).

Through the partnership, patients were actively enrolled in an opioid treatment program (OTP) or office-based opioid treatment (OBOT) prior to hospital discharge in order to receive MOUD while living at the SNF. Once at the SNF, they received weekly support from a Peer Recovery Coach along with complex case management from a dedicated nurse, who also collaborated with the addiction medicine clinician behind the scenes. As necessary, the infectious disease clinician and addiction medicine clinician also collaboratively planned patient care with the SNF Medical Director. Additional education and training facilitated by the addiction medicine clinician and the peer for SNF staff helped to ease fears and stigma related to treating patients with SUDs. As a result, OPAT patients were able to receive well-coordinated whole person care in a safe environment, several barriers to treatment were addressed, and a measurable financial impact was demonstrated by avoided hospital and ED utilization. Today, this pilot has evolved into a novel program called OUD Meets.[53]

BARRIERS TO TREATMENT

In order to successfully facilitate referrals to treatment for patients ready for this step, EDs must understand and build capacity, both internally and externally. Hospitals and health systems with behavioral health services should have a clear understanding of what services are available, referral criteria, and how best to facilitate warm handoffs when possible. It is also recommended that hospitals establish or strengthen partner referral networks with their local health department, community outpatient treatment programs, behavioral health clinics, primary care clinicians, and community resources that address social barriers to care.

Often, patients need assistance with structural barriers to treatment access. It is recommended that, in addition to treatment partnerships, hospital referring staff also have partnerships, resources, or at least a clear understanding of how to help patients access treatment and other services. When staff can help to mitigate barriers to treatment, patients more successfully engage in care for their SUD.[54]

UTILIZATION OF UBER HEALTH AT MEDSTAR HEALTH SYSTEM

After difficulty successfully transporting patients to treatment from the hospital using taxis and buses, Medstar Hospital System recognized the opportunity to leverage Uber Health to ensure patient linkage to treatment. Uber Health is timely, trackable, and more affordable than taxis, while allowing for patient PHI to remain protected. When a peer at Medstar refers a patient to treatment from the hospital, they log into Uber Health to track the patient's ride. A few minutes after the patient has arrived, the peer calls the treatment program to confirm their attendance at their intake appointment. A comparison between the Medstar hospitals with Uber Health and those without shows significantly higher rates of linkage to treatment for patients in the former group.

53 (Tassey, et al., 2022)
54 (Farhoudian, Razaghi, Hooshyari, Noroozi, Pilevari, Mokri, Mohammadi, Malekinejad, 2022)

PART II: HOW TO IMPLEMENT EVIDENCE-BASED OPTIONS IN THE EMERGENCY DEPARTMENT

Overview

Strategy I: Gauge Readiness
Strategy II: Integrate Routine Screening
Strategy III: Develop MOUD Protocol
Strategy IV: Integrate Peers for Recovery Support
Strategy V: Leverage Technology for Practice Adoption
Strategy VI: Define and Measure Success

GAUGE READINESS

Prior to adoption and implementation of any of the substance use response interventions, there are three key preliminary steps that hospitals should not miss in order to gauge readiness and ensure success. First, hospitals and their partners should establish an understanding of the community's needs and which interventions best align with those needs. Second, they should assess their organization's readiness to move forward with the interventions that align with the community's needs. Third, they should gain leadership buy-in and make the case for adoption of the identified interventions. Each preliminary step will be discussed in more detail in the following sections.

1 UNDERSTAND THE NEEDS OF THE COMMUNITY

In order to understand the needs of the community, hospitals should assess trends in substance use, available resources, and potential gaps in care for patients who use drugs and alcohol. To gain this level of understanding, hospitals should look at both publicly available and hospital-specific data, survey the community if appropriate, and spend time on the ground observing the community in real-time. The community assessment also presents an ideal opportunity for hospitals and health departments to partner to collect and evaluate data.

The below guide provides several questions that hospitals can ask in order to better understand what is happening in their community.

Topic	Important questions to ask	Helpful resources
Primary patient population	• What are the general characteristics of the patient population in the hospital's primary service area? • What is the quality of life related to housing, employment status, poverty status? • What is the overall health status of the community?	Hospital demographics data, local and state health department data, census data
Substance use trends in the hospital service area	• What is the current overdose rate? • To which substance(s) are overdoses being attributed? • What is the nature of substance use (e.g., prescription drug misuse, underage drinking)? • What is the rate of drug use? Alcohol misuse? • Who is experiencing these substance use trends and related behaviors? For example, are they male, female, youth, adults, or members of certain cultural groups? • Is marijuana legal in any form?	National Survey on Drug Use and Health, Local and state health department data
Access to substance use treatment	• What treatment options are available in the community for people who use drugs and alcohol? • What gaps in care exist? For which populations?	SAMHSA Treatment Locator (online), Findhelp.org

2 ASSESS ORGANIZATIONAL READINESS

As hospitals prepare to deploy interventions to identify and engage more intentionally with people who use drugs and alcohol, they should also understand their own readiness and capacity to respond. There are many aspects of readiness to consider such as available resources and personnel, technological capabilities, and impact on current practices. The goal of this organizational assessment of readiness is to identify whether the key components associated with implementation of the program are achievable. Based on the organizational assessment, hospitals should be able to discern their level of readiness to move forward. The following is a sample internal assessment questionnaire:

Internal Capability Assessment

1. What is the volume of ED patients on a monthly basis?
2. What services (social work, care management, community health, etc.) are available to patients who come to the ED? Are peer recovery coaches available?
    a. When are these services available?
    b. How do patients access these services?
3. Who might help to champion this work?
4. What current practices, if any, are in place to identify, treat, and facilitate referral to treatment for patients who use drugs and alcohol? Is SUD status documented in the patient record?
5. What resources do we currently have, and what resources do we currently need to better serve our patient population with SUD?
6. What are the organization's population health goals related to this work?
7. Do we currently stock buprenorphine and naloxone in our medication dispensing system?
8. If necessary, can we make changes to our EHR to support new programming? Consider cost and time of potential changes.
9. How willing are our ED clinicians to consider the use of MOUD to manage and treat patients with OUD?
10. What does success look like for this program, and how will it be measured?

3 GAIN LEADERSHIP BUY-IN

Once the organization is ready to move forward, it is time to build momentum through leadership buy-in. Experience in SUD program implementation shows a direct correlation between leadership support and the success of practice adoption and program implementation across care settings. For leadership to fully buy-in, there needs to be a clear understanding of the alignment between the mission, business plan, and goals of an organization, along with clear commitment from senior leadership. This creates an effective case when working to socialize new ideas across the organization. It is also important to include clinical and administrative leadership for a sense of ownership during future planning. For small or rural hospitals, it may even be helpful to gain buy-in from important members of the community. In all cases, hospitals should be thoughtful about framing the program in a way that aligns with and reflects hospital and population health goals. The context of why the programming is important and how it fits in the broader hospital and community landscape can help to make the case for leadership support.

In addition to broad leadership support, hospitals should identify a champion to help drive the transformation. The project champion is the change agent within the ED or hospital responsible for leading the SUD integration efforts. This leader is most vital during the planning process to help build and sustain buy-in from leadership an d clinical staff. The champion should also be able to demonstrate the alignment of SUD response services with the organization's mission and business plan and work with leaders to ensure that they are committed and willing to allocate the personnel and other support necessary for effective implementation of the interventions into routine care. Additionally, the champion should be in a position of influence to help support movement on all planning activities on the proposed timeline, and willing to dedicate the time and resources necessary for effective, sustainable implementation.

Who should be involved in planning and implementation?

- An Executive-level leader, such as the Chief Medical Officer, Chief Nursing Officer, and/or the Chief Operating Officer
- ED Nursing Director
- ED Administrator
- ED Medical Director
- Behavioral Health leadership (if applicable)
- Case management/Social work leadership
- Population health/Community health leadership
- Pharmacy
- Informatics/IT and EHR vendor (if possible)
- Human resources

In addition, if the hospital plans to integrate a peer workforce, a peer supervisor will need to be identified. Initially, the planning group will be needed to actively participate in workflow analysis, protocol development, data review and development of a sustainability plan. Once implementation commences, ED nursing and medical leadership are engaged as needed and at a minimum, monthly to review data dashboards along with other key leaders.

INTEGRATE ROUTINE SCREENING

Once all of the key team members are in place and the organization is deemed ready to move forward, it is time to embark on the work. As discussed, none of the program interventions move without first implementing a screening protocol to identify and stratify patients that hospitals would like to engage. An important consideration when implementing a screening protocol is the capacity to respond. Hospitals must establish the expected course of action once a patient screens positive. It is also important to assess the feasibility of the expected course of action and take measures to fulfill those actions prior to making the commitment to systematically screen for high-risk substance use.

Integration of screening results should be used as an opportunity to consider how drug and alcohol use might impact a patient's overall wellbeing. When implementing universal screening, hospitals should ensure that screening results are available across disciplines and considered as a part of the patient's whole health picture. Since integration is also an important aspect of this work, and routine review of drug and alcohol screening results help to normalize conversations related to the full picture of the patient's health. To further integration and transparency, hospitals should leverage technology in order to reduce the risk of human error and hardwire workflows as often as possible. Building the validated screening tool(s) into the EHR can assist with more precise documentation, promote communication and coordination across care settings, and allow for seamless monitoring and reporting.

Key considerations for universal screening in the ED

- Patient population
- Capacity to respond
- Population health goals
- Ability to incorporate tools into EHR

UNDERSTANDING EXISTING WORKFLOWS: CONDUCT A WALK THROUGH

True practice adoption in any large system or department requires thoughtful integration and ease of practice. As hospitals prepare to implement new programming, it is critical to understand the current landscape and patient flow to promote synergy between the existing programming and the new components. Conducting a walkthrough of key departments to understand the patient flow and experience, inclusive of process, operations, documentation, and personnel involved can support improved planning as hospitals make decisions on the how and where of new program components. It is important to understand the entire patient experience from registration to discharge and spend time learning how different clinical teams and support staff interact with patients.

Questions to ask during the ED walk-through

- Who greets patients and does registration? What information is collected and what is documented in the EHR?
- Who conducts triage, where is it conducted, and what takes place? What questions are asked and how do the patients' answers inform next steps?
- Are clinical support staff involved in patient care during the encounter? What education or support do they typically offer? How are they notified about patients in need?
- Are there clinical considerations that change a patient's flow through the department (i.e. substance use or suicidal ideations)?
- How are referrals made?
- How is check-out/discharge handled?

Additional workflow questions to consider prior to protocol development

- Can patients complete the screening on their own or does the tool need to be administered?
- How much time do clinicians typically spend with each patient?
- Are behavioral health staff available as part of the team?
- What is the best way to assure that patient referrals are personalized and linkage can occur?
- What is the best way to institutionalize SUD services as a routine part of care?

DEVELOP A SCREENING PROTOCOL

Protocol development serves as the foundation for system level change, which is necessary to integrate practices as a routine part of care. This step immediately follows the walkthrough and workflow analysis. The screening tool and methods of screening will vary across sites and settings. EDs should choose ONE screening tool that will best serve the target population and the frequency with which it will be administered.

Guiding questions for development of a screening protocol include:

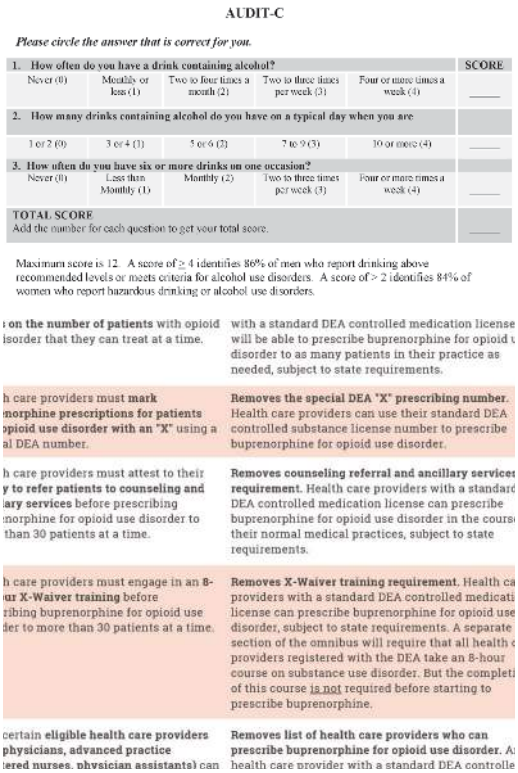
1. Who will conduct the screening?
2. Which tool will be used?
3. Are there additional questions that need to be added based on our patient population?
4. Where will the screening results be documented?
5. How frequently will screening occur?
6. What are the triage care options based on patient risk level?
7. What defines our high risk population in need of intervention?
   a. Is there a clear way to identify these populations within the EHR documentation?
8. What patient populations may need to be excluded from screening?

While universal screening is the goal, there will be instances that patients need to be excluded from screening. For example, trauma patients, patients suspected of an overdose, or patients experiencing a psychiatric emergency may not follow the typical patient flow for screening due to the inability to answer questions or the nature of the ED. For some, screening may be revisited at a later time, while for others, screening cannot be prioritized until they are stable.

EXAMPLES OF VALIDATED SCREENING TOOLS

NIDA Quick Screen Questionnaire

The NIDA Quick Screen questionnaire is an evidence-based tool to assist clinicians to identify high-risk substance use. The clinically administered tool is quick, efficient, and is most useful in primary care settings.



AUDIT-C

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?					SCORE
Never (0)	Monthly or less (1)	Two to four times a month (2)	Two to three times per week (3)	Four or more times a week (4)	____
2. How many drinks containing alcohol do you have on a typical day when you are					
1 or 2 (0)	3 or 4 (1)	5 or 6 (2)	7 to 9 (3)	10 or more (4)	____
3. How often do you have six or more drinks on one occasion?					
Never (0)	Less than Monthly (1)	Monthly (2)	Two to three times per week (3)	Four or more times a week (4)	____
TOTAL SCORE Add the number for each question to get your total score.					____

Maximum score is 12. A score of ≥ 4 identifies 86% of men who report drinking above recommended levels or meets criteria for alcohol use disorders. A score of > 2 identifies 84% of women who report hazardous drinking or alcohol use disorders.

on the number of patients with opioid isorder that they can treat at a time.	with a standard DEA controlled medication license will be able to prescribe buprenorphine for opioid disorder to as many patients in their practice as needed, subject to state requirements.
h care providers must **mark morphine prescriptions for patients pioid use disorder with an "X"** using a al DEA number.	**Removes the special DEA "X" prescribing number.** Health care providers can use their standard DEA controlled substance license number to prescribe buprenorphine for opioid use disorder.
h care providers must attest to their **y to refer patients to counseling and lary services** before prescribing morphine for opioid use disorder to than 30 patients at a time.	**Removes counseling referral and ancillary services requirement.** Health care providers with a standard DEA controlled medication license can prescribe buprenorphine for opioid use disorder in the course their normal medical practices, subject to state requirements.
h care providers must engage in an **8-ur X-Waiver training** before ribing buprenorphine for opioid use der to more than 30 patients at a time.	**Removes X-Waiver training requirement.** Health ca providers with a standard DEA controlled medicati license can prescribe buprenorphine for opioid use disorder, subject to state requirements. A separate section of the omnibus will require that all health providers registered with the DEA take an 8-hour course on substance use disorder. But the completi of this course is not required before starting to prescribe buprenorphine.
certain **eligible health care providers physicians, advanced practice tered nurses, physician assistants)** can	**Removes list of health care providers who can prescribe buprenorphine for opioid use disorder.** A health care provider with a standard DEA controlle

The AUDIT-C questionnaire is a brief three question alcohol screen that identifies persons who have moderate- to high-risk drinking habits.The tool is scored on a scale of 0-12, and the higher the score, the more likely that the patient's drinking is affecting their safety. Based on the validity of the tool, the threshold for a "positive" alcohol screen is typically a score of 4 or above. Scores of 4-7 are considered moderate risk and 8 or above is high-risk alcohol use. Hospitals that use the AUDIT-C for screening may choose to implement a formal intervention for patients who score 7 or higher. In order to capture high-risk drug use, hospitals can insert drug questions from the NIDA Quick Screen,

"In the last year, how often have you used prescription drugs for nonmedical reasons? Illegal drugs?"

Any variation of a "yes" to this screening for illicit drug use is considered a positive screen and reason for additional intervention related to substance use.

DEVELOP MOUD PROTOCOL

It is beneficial for Emergency Departments to establish MOUD as an option for patients who may benefit from it, as an evidence-based practice for OUD. Most commonly, use of order sets is recommended to encourage appropriate dosing and to ensure that patients also receive naloxone. Typical order sets can include guidance on buprenorphine dosing for withdrawal management, initiation, and bridge prescriptions when applicable, to be administered to patients based on the results of the Clinical Opioid Withdrawal Scale (COWS) assessment. It is also important to note that conventional buprenorphine initiation protocols that are successful for most individuals with opioid use disorder may not be the best approach for individuals using fentanyl due to risk of precipitating withdrawal.

For patients initiated on MOUD, a referral to ongoing treatment in the community should be confirmed prior to discharge. Hospitals should develop a clear understanding of the capacity of their treatment partners to plan their approach to provision of MOUD. For example, if the average time for intake at a treatment program is 5 days, the ED clinician may routinely provide patients with a bridge prescription to last 5 days until their appointment. In many cases, it is also helpful for hospitals to develop fast-track partnerships with treatment clinicians in the community to minimize the time between hospital discharge and linkage to treatment after MOUD initiation. Experience has shown that establishing partnerships can help patients access SUD treatment within 1-2 days, greatly improving their chance of moving towards recovery. In any case, patients newly initiated on MOUD in the ED should have a confirmed follow up appointment or plan and, when necessary, a bridge prescription or linkage to bridge clinic to ensure continuity of care.

Key considerations for universal screening in the ED

- Order set options and accessibility
- Availability and capacity of MOUD treatment partners in the community
- Willingness of ED clinicians to prescribe in addition to dispense an initial dose of medication
- Identification and development of fast-track partnerships
- Considerations for patients using fentanyl
- Discharge instructions, including naloxone

INTEGRATE PEERS FOR RECOVERY SUPPORT

Peers are dedicated staff who can systematically respond to patients that present to the ED and screen positive for high-risk substance use. The success of many ED-based programs is based on the integration of peers in the emergency department to deliver motivational conversations with patients and help facilitate linkage to harm reduction and treatment for motivated patients. While peers are highly capable partners and valuable resources, they are not clinically trained. Therefore, it is important for hospitals to clearly define the professional bounds of the PRC role. While it is at the discretion of the hospital on how peers may be deployed, experience has shown that peers are most effective when they can serve in the previously described "broker" role while also embracing motivational interviewing techniques to coach patients to and through recovery.

Peers often couple MI conversations with their own lived experience to build trust and rapport with patients. This allows them to connect with patients in a way that clinicians or individuals without lived experience with SUD cannot. It is also important to note the stages of change and recognize that every patient who is engaged will not be immediately motivated for treatment. Peer skillsets should be developed to not only move patients into treatment, but to also offer broader recovery support and encourage methods of harm reduction.

Important questions to ask related to the integration of a peer workforce include:

1. How will the peer program be funded, including salaries and benefits, the cost of a supervisor, and an allowance for supplies and materials?
   a. How can funding be used to prioritize paying peers a living wage?
2. What is the scope of the peer role?
3. Who will be the clinical champion for their work?
4. Will typical hiring policies and protocols need to be modified to successfully hire and onboard peers? For example, some candidates may have a legal record related to their previous lived experience with SUD, and some may need to attend regular methadone or other recovery-related appointments during typical working hours.
5. What are the traits required to succeed in the peer role?
6. What training and continued education opportunities can be offered for the peer(s)? Will certification be required? How long does a peer have to achieve certification upon employment?
7. How will the peer staff be introduced and integrated with existing ED staff?
8. What coordination will be needed with other care team members, including behavioral health and crisis response?
9. What is the most appropriate supervision structure?
10. What polices, practices, and resources will help support the peers' continued recovery? For example, what vacation, other leave, and employee assistance programs can the hospital offer?
11. Can protocols be established to support, rather than fire, peers who return to use? What recovery supports will be availablefor peers who return to use?

STAFFING THE ED WITH PEERS

Since most EDs are 24/7, it is important to understand the flow of patients—especially those with SUD—through the ED in order to plan for staffing. A heat map like Example 1 can be used as a tool to determine the ideal staff coverage schedule necessary to address a majority of patients with SUD. It can also help hospitals identify which substances are most common for their patient population, as well as the incidence of overdose. Based on the sample heat map in Example 1, this ED should at least provide coverage between the hours of 6 AM and midnight if around-the-clock coverage is not possible.

Example 1: ED Heat Map for All Substances for 1 Week

ALL SUBSTANCES							
Time	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
12:00:00 AM	2	4	1	2	6	0	1
1:00:00 AM	1	5	3	2	2	2	1
2:00:00 AM	1	3	3	2	0	4	1
3:00:00 AM	2	1	2	4	6	1	1
4:00:00 AM	2	0	2	1	3	2	0
5:00:00 AM	1	5	2	1	1	4	2
6:00:00 AM	1	4	1	0	1	3	1
7:00:00 AM	5	0	2	1	1	1	3
8:00:00 AM	4	2	3	2	3	0	2
9:00:00 AM	5	4	6	6	6	5	6
10:00:00 AM	8	4	10	7	2	4	6
11:00:00 AM	3	12	10	3	9	6	4
12:00:00 PM	10	6	5	7	4	4	7
1:00:00 PM	4	10	9	7	8	7	2
2:00:00 PM	10	3	5	3	4	3	7
3:00:00 PM	5	6	6	3	4	2	8
4:00:00 PM	8	4	7	4	10	4	5
5:00:00 PM	2	4	6	7	3	3	7
6:00:00 PM	9	9	7	3	1	3	3
7:00:00 PM	2	3	3	3	14	3	6
8:00:00 PM	6	3	2	6	6	2	7
9:00:00 PM	4	2	2	3	5	0	4
10:00:00 PM	3	3	3	6	2	5	3
11:00:00 PM	3	6	7	0	2	1	6
SUM	101	103	107	83	104	69	93
Opioid	11	15	13	12	8	7	7
Stimulant	18	27	22	18	21	12	20
OD	6	7	2	4	8	1	2

Additional questions to consider when staffing the ED with peers include:

- How long will shifts be for available staff, e.g., 8, 10, 12 hours?
- How many staff will be needed to provide daily coverage?
- How much overlap, if any, will be needed for staff handoffs?
- Who will supervise and manage the staff?
- Will staff be available on weekends?
- What is the plan for coverage after hours or if no staff is onsite?

Key considerations when integrating peers

- Available budget and hiring plan
- Staff skillset and training needs
- Peer supervision
- Potential HR concessions
- Schedule and coverage of available staff

LEVERAGE TECHNOLOGY FOR PRACTICE ADOPTION — INTEGRATION WITH ELECTRONIC HEALTH RECORDS

Regardless of the breadth of SUD services offered, EHR integration is essential. Practice adoption and institutionalization of programming relies heavily on EHR integration, so it is highly recommended that hospitals have a relationship with their EHR vendor so that changes and modifications can be made to fully integrate processes and protocols, and documentation can take place within a patient's medical record.[55]

EHR integration can help foster:

- Universal screening
- Completed workflows based on established protocols
- Patient brief interventions captured within the primary care encounter
- Facilitated referrals to treatment and documentation of linkage
- Communication and care coordination across care settings and disciplines
- Practice integration within the workflow of the health care setting, making interventions a part of the workflow and not a "set aside" process
- Facilitates billing for services
- Easeful use and access to order sets and clinical decision making tools
- Trustworthy quality improvement and data reporting

EHR AND BILLING

While billing capabilities vary by personnel and services provided, hospitals can leverage their EHR to help facilitate the billing process using the following method:

1. Identify the codes within the specific state and setting that will be used to code for service delivery.

2. Work with IT and staff to modify EHR to support service billing and reimbursement. This step is critical in integrating SUD service codes into the existing EHR system. There must be a fluid process of designating when SUD services are completed and the subsequent billing designation.

3. Continually monitor the billing process to ensure service reimbursement is occurring.

55 (The Office of the National Coordinator for Health Information Technology, 2023)

THE REVERSE THE CYCLE (RTC) MODEL

Reverse the Cycle is a comprehensive response to substance use and consists of three core components:

1. Universal screening and peer intervention
2. Outreach to patients who have survived an opioid overdose (OSOP)
3. Initiation of medications for opioid use disorder (MOUD)

In 2014, the Mosaic Group implemented universal screening and peer intervention, an essential component of Reverse the Cycle (RTC), in its first Maryland hospital emergency department. Over the past decade, Mosaic Group has expanded RTC to over 70 hospitals across the country in rural, urban and suburban communities. RTC has been shown to be effective and sustainable in large urban academic health centers as well as small critical access hospitals. The RTC model is a proven method to systematically screen and identify for high-risk substance use and provide interventions that are medically necessary and socially appropriate.

The following video provides a glimpse of the impact of RTC from one of Mosaic's partner hospitals:

How Peer Recovery Coaches Save Lives in the Emergency Department

DEFINE AND MEASURE SUCCESS

The use of EHRs for documentation and subsequent data collection can greatly influence the ease (or burden) of data analysis and program evaluation. Once success is defined, metrics and goals can be identified in order for hospital EDs to understand the effectiveness of its interventions. Once goals are defined, it is also recommended that the data be tracked on a monthly basis, at minimum. Hospital champions and accountable stakeholders should work with IT to ensure that the source and methodologies for collecting data are clear.

Proper data depends heavily on properly trained staff, as they will often provide the inputs that will later be extracted and analyzed.

Suggested monthly data points to assess effectiveness:

- Number of screens conducted (compare to target population to be screened)
- Number of positive screens
- Appropriate number of interventions for positive screens
- Number of facilitated referrals to SUD treatment and recovery support
- Number of confirmed linkages to SUD treatment
- Types of facilitated referrals and recovery support
- Number of patients eligible vs. referred for MOUD initiation
- Number of naloxone prescriptions and/or kits provided
- Number of suspected overdoses

USING DASHBOARDS

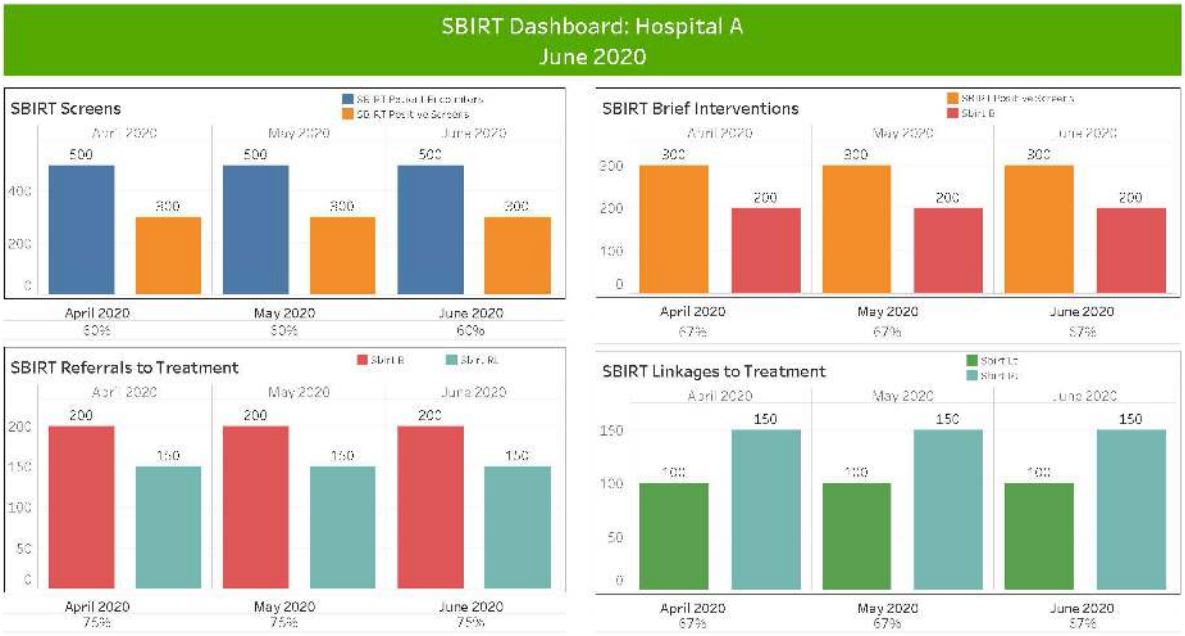
Dashboards can be invaluable for monitoring program performance and measuring success. It is recommended that, when modifying the EHR to capture workflows, hospitals also work closely with IT and other necessary parties to design and build a dashboard that can provide both global and detailed views to demonstrate the effectiveness of the intervention(s). When designing a dashboard, hospitals should ensure that the data is timely, accurate, and allows for decision making.

DATA-DRIVEN DECISION MAKING

The first 3-6 months of implementation are critical to understanding the effectiveness of SUD program or service integration. When initial data is collected and discrepancies are revealed, more focused data collection may be necessary to provide an explanation and ultimate correction. Dashboard reports can be useful to illustrate trends in data over time so that interventions can be adjusted as necessary. Dashboard findings can also reveal the need for staff to be (re)trained, protocols to be modified, or additional interventions to be adopted for emerging patient populations.

FLEXIBILITY is KEY: Even the best laid plans may need to be changed. Allow the data to guide your decision making.

Dashboard for universal screening and peer intervention program



Universal screening and peer intervention is an evidence-based approach for delivering early intervention and treatment services to people with, or at risk of developing, substance use disorders.[56] This hospital-based model is designed to provide universal screening for all patients in the ED to identify individuals with high-risk substance-use behavior, then providing motivational conversations utilizing a peer who can assist in the coordination of referrals to treatment, when appropriate.

RTC CASE STUDIES

LOGAN REGIONAL MEDICAL CENTER

Logan Regional Medical Center (LRMC) is a 132-bed acute care facility located in the rural area of Logan, West Virginia that partnered with Mosaic Group in August 2021 to integrate RTC. At the time of the program's launch, Logan County had the second highest rate of fatal overdoses in the nation (191 fatalities per 100,000 residents).[57] Prior to RTC, the ED was not routinely screening for substance use (however, approximately 1.2% of all ED patient encounters were related to overdose).[58] Mosaic Group spent several months working with a planning committee comprised of hospital and departmental leadership and community partners, such as the Southwestern Regional Day Report Center (SDRC), to develop customized protocols to address the needs and improve health outcomes for patients engaging in substance use. After 9 months of implementation of RTC, the ED had screened a cumulative total of 13,920 patients for substance use (approximately 91% of all encounters) and linked 378 patients

56 (The Office of the National Coordinator for Health Information Technology, 2023)
57 (The West Virginia Department of Health and Human Resources (DHHR), 2023)
58 (The West Virginia Department of Health and Human Resources (DHHR), 2023)

with high-risk use to peer support, offering referrals to treatment and other vital resources for reducing the risk of harm or death related to substance use, and ongoing follow-up support from the peer team, post-discharge. While 378 patients might seem like a low number, the subject of substance use in this rural area is often seen as taboo and something that is deeply stigmatized. The true success at LRMC has been how the RTC team has normalized the conversation around substance use and provided patients with a safe and nonjudgmental space to discuss their use and access a variety of supports both within the ED and in the wider community. ED staff and hospital leadership have expressed a markedly positive shift in perceptions and attitudes towards patients engaging in substance use and patients have made statements such as, "this was the first time I felt like I could talk honestly about my drug use" and "[the peer] was the first person to treat me like a human-being and believe in me". As a result of the positive integration of RTC, LRMC expanded the program beyond the ED, offering peer services across all hospital departments, and deemed confronting the substance use epidemic as one of their top priorities. LRMC has developed a committee specifically focused on strengthening data collection on substance use and on expanding the program to improve access to care.

APPALACHIAN REGIONAL HEALTHCARE (ARH)

Appalachian Regional HealthCare (ARH) is a not-for-profit health system serving more than 400,000 residents across Eastern Kentucky and Southern West Virginia, an area known as the epicenter of the nation's overdose epidemic. They are the largest clinician of care in southeastern Kentucky and operating 14 hospitals, multi-specialty physician practices, home health agencies, HomeCare Stores and retail pharmacies. In an effort to confront the alarming rate of overdoses in this region, ARH partnered with Mosaic Group in 2019 to integrate RTC into two of their hospitals. As of 2023, they have expanded RTC to an additional 7 hospitals (9 in total) and now employ more than 18 Peer Recovery Coaches across the system. ARH RTC data demonstrates that more than 78% of patients who are engaged by a peer, and referred to substance use treatment, successfully link to their treatment appointments. Additionally, more than 77% of overdose patients who present to an ARH ED participating in the RTC program, are successfully linked to intensive outreach via the Overdose Survivors Outreach Program (OSOP), and another 93% of patients eligible for buprenorphine induction receive buprenorphine in the ED. The program's expansion and successful implementation has largely been the result of a high-degree of buy-in from leadership and staff both at the system and local level. Not only do all staff receive regular training on RTC protocols, ARH has a dedicated team of system and hospital-level leaders who regularly audit program data and engage in quality improvement activities to strengthen RTC outcomes across the system.

CONCLUSION

With the guidance provided in this toolkit, hospitals and their partners should feel equipped to embark on the work associated with full practice adoption of SUD interventions in the ED. Each intervention represents another opportunity for hospitals to make positive impactful change in their communities. Each implementation strategy lays out the major considerations that may impact how the work is carried out in different settings. As trusted institutions, the onus is on hospitals and their partners to help improve the overall health of their communities. Through universal screening and systematic response to care for people who use drugs and alcohol, hospitals and their partners can contribute to alleviation of the overdose crisis and save lives.

APPENDIX

COMMONLY USED ACRONYMS

GENERAL
Protocol Development Considerations
Myths vs. Truths on Pharmacological Interventions in the ED
The Legal Foundation for ED-Based Response to Substance Use

MOUD GUIDANCE
DEA Registrant Letter Eliminating DATA-Waiver Program
Summary of Solutions in Mainstreaming Addiction Treatment Act
Clinical Opiate Withdrawal Scale (COWS) Assessment Tool
Considerations for Development of MOUD protocol

ROLES AND JOB DESCRIPTIONS
Peer Job Description
OSOP Job Description
Champion Role Description
Planning Committee Composition
Peer Supervisor Role Description
References/Resources

COMMONLY USED ACROYNMS

ACRONYM	MEANING
SUD	Substance use disorder
PWUD	Person/people who use drugs
OUD	Opioid use disorder
ED	Emergency department
MOUD	Medications for opioid use disorder
SSI*	Systematic Screening and Intervention
OSOP	Opioid Overdose Survivors Outreach Program
PRC	Peer recovery coach
MI	Motivational interviewing
COWS	Clinical Opioid Withdrawal Scale
AMA	Against Medical Advice
EMTALA	Emergency Medical Treatment and Labor Act
EHR	Electronic health record
PCP	Primary care physician
CDC	Centers for Disease Control and Prevention
SAMHSA	Substance Abuse and Mental Health Services Administration
NACCHO	National Association of County and City Health Officials
DEA	Drug Enforcement Agency
NIDA	National Institute on Drug Abuse
FDA	Food and Drug Administration
ADA	Americans with Disabilities Act
HHS	US Department of Health and Human Services

*While the term SBIRT (Screening, Brief Intervention, and Referral to Treatment) is commonly used to describe this patient screening and intervention programs, the evidence base for SBIRT is particular to its use as an intervention for patients with alcohol-use disorder.

PROTOCOL DEVELOPMENT CONSIDERATIONS

Developed by Mosaic Group

SYSTEMATIC SCREENING & INTERVENTION CONSIDERATIONS:

a. Who will screen?

b. When will screening take place?

c. Where will screening appear in EHR?

d. Marijuana use – medical marijuana exclusion for trigger?

e. PRC notification

f. Peer Interventions for patients in crisis/psych

g. Peer Intervention: Patients using marijuana for medical purposes without medical marijuana Card

h. Peer coordination with community-based peers through LHD

i. IT Questions (if relevant or can be saved for EMR/IS meeting)

   a. Use of Shift Report

   b. System functionality and communication for follow-ups

OVERDOSE SURVIVORS OUTREACH PROGRAM

a. Who is in the eligible patient population?

b. Will documentation occur beyond 30 days?

c. Protocol for naloxone distribution?

MOUD INITIATION IN THE ED CONSIDERATIONS:

a. Bridge dosing on weekends/holidays?

b. Medication – Mono-product (buprenorphine) or combination product (8/2 buprenorphine/naloxone)

EXCLUSIONARY CRITERIA/CAUTIONARY CRITERIA

MYTHS VS. TRUTHS: THERE ARE NO REGULATORY OR PHARMACOLOGICAL BARRIERS TO PROVIDING ED-BASED SUD SERVICES

MYTH	TRUTH
 **Substance use treatment should be kept separate from mental health and traditional health care.**	Well-supported scientific evidence shows that the separation of substance use disorder treatment and mental health services from traditional health care has created obstacles to successful care coordination.[59,60] There is an increased move toward integrating general health, behavioral health and mental health needs to help patients achieve whole health, and peer support workers can often play a role in bridging gaps that may otherwise threaten a patient's recovery.[61]
 **Substance use disorders are not medical conditions. They are individual moral and social failures.**	According to the National Institute of Mental Health, substance use disorder is a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, medications, or alcohol.[62] Substance use disorders change the brain's circuits that produce long-term behavioral effects. When people take drugs, the brain is flooded with chemicals that stimulate the reward system. This, in turn, can lead to strong cravings and continued use and the building of tolerance that requires more drugs in order to feel the same effect.[63] Separately, there is research around the impact of social determinants of health including community environmental factors that can directly influence the prevalence of substance use and addiction.[64,65] According to Deborah Furr-Holden, Dean of New York University's School of Global Public Health, environmental risk may be a stronger predictor of high-risk behaviors, including drug and alcohol use and violence, than individual risk factors. A deeper look into social and structural determinants of health can help to educate those who misunderstand the overdose crisis as an individual issue.

59 (Substance Abuse and Mental Health Services Administration (US), 2016)
60 (US Office of the Surgeon General , 2016)
61 (Collins, et al., 2019)
62 (National Institute of Mental Health, 2021)
63 (Centers for Disease Control and Prevention, 2022)
64 (National Institutes of Health, 2016)
65 (Menis, Stahler, & Mason, 2016)

MYTH	TRUTH
Substance use disorders cannot be effectively treated in a traditional healthcare setting.	Well-supported scientific evidence shows that substance use disorders can be effectively treated, with recurrence rates no higher than those for other chronic illnesses such as diabetes, asthma, and hypertension. With comprehensive continuing care, recovery is an achievable outcome.[66]
Insurance does not cover SUD services.	Insurance coverage for substance use disorder services is becoming more robust as a result of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act. The Affordable Care Act also requires non-grandfathered individual and small group market plans to cover services to prevent and treat substance use disorders.[67]
As a clinician, I must be waivered in order to administer buprenorphine in the ED.	Several studies have now shown the benefit of initiating buprenorphine in the emergency department rather than just referring to treatment.[68] ED clinicians have always had the ability to administer buprenorphine. Prior to federal Omnibus legislation at the end of 2022, clinicians had authority to administer a daily dose for up to three days in an emergency setting (DEA 3-day rule), but there were limitations on who could prescribe buprenorphine based on a clinician's DATA 2000 (X-waiver) status. The federal Consolidated Appropriations Act of 2023 removed this step to prescribing medications like buprenorphine.[69] Now, any clinician with current DEA registration with Schedule III authority can both administer and prescribe medications like buprenorphine.[70] This paradigm shift creates the opportunity for increased access to MOUD across the care continuum, including the emergency department.

66 (National Institute on Drug Abuse, 2022)
67 (Beronio, Po, Skopec, & Glied, 2013)
68 (National Institute on Drug Abuse, 2019)
69 (End Substance Use Disorder, 2022)
70 (Substance Abuse and Mental Health Services Administration, 2023)

MYTH	TRUTH
 **MOUD is "replacing one drug with another."**	Buprenorphine is an FDA-approved medication for the treatment of opioid use disorder. It is a partial opioid agonist, which means that it produces effects such as euphoria or respiratory depression but to a much weaker degree than other opioids. As a partial agonist against the mu opioid receptor and full antagonist on the kappa receptor, buprenorphine can help diminish physical dependency on opioids, increase safety in cases of overdose, and lower potential for misuse.[71] The opioid effects of buprenorphine increase with each dose until they taper off at moderate doses. This phenomenon is called a "ceiling effect," which lowers the risk of respiratory depression from buprenorphine as compared to other opioids. Additionally, methadone has a long history of efficacy and safety and may be preferred by some patients. Some innovative emergency departments have successfully integrated use of methadone into their treatment plan, providing patients another option for care.[72] Patients treated with buprenorphine or methadone are less likely to use illicit substances, less likely to overdose, have fewer injection drug use or STI-related health complications, and have reduced contact with the criminal/legal system.[73]

71 (Substance Abuse and Mental Health Services Administration, 2022)
72 (UAMS Psychiatry Research Institute , 2022)
73 (National Institute on Drug Abuse, 2019)

THE LEGAL FOUNDATION FOR ED-BASED RESPONSE TO SUBSTANCE USE

Many myths related to hospital-based substance use response are rooted in stigma and misinformation. A 2021 report by the Legal Action Center (LAC) sought to articulate a strong legal basis for hospital EDs to adopt evidence-based practices in response to the overdose epidemic. According to LAC, there are four federal laws that require hospitals to indiscriminately provide specific services to patients with substance use disorders.[74] The report calls out reasonable defenses for EDs that may be resistant to evidence-based practices, addresses concerns about safety and limited resources, and provides suggestions for how to mitigate concerns related to each law. A brief description of each law and the potential violations that EDs could face, according to the LAC 2021 report, are listed below:

FEDERAL LAW	POTENTIAL VIOLATION(S)
EMTALA • Imposes affirmative medical care requirements for EDs to conduct a medical screening examination of every individual to identify if a condition exists which, absent immediate medical attention, poses a serious threat to the patient's health exists. • Hospitals must stabilize that condition before the patient's discharge or transfer to another medical facility.	• **Medical screening obligation** *when lack of screening can be attributed to harm* • **Stabilization requirement** *when moderate or severe SUD is identified, but not appropriately treated with medically necessary intervention such as buprenorphine* • **Requirement to secure necessary provisions prior to discharge,** *such as naloxone and/or offer to facilitate referral to recovery support*
The ADA and Rehabilitation Act • Both Acts prohibit disability-based discrimination and require state and local hospitals to treat individuals [with substance use disorders and other disabilities] equally and fairly, based on an objective evaluation of their qualifications for services.	• **Disparate treatment discrimination** *due to withholding of evidence-based practices based on personal bias or the decision not to institute life-saving practices* • **Failure to provide reasonable accommodation** *if patient requests an evidence-based practice, such as a facilitated referral to treatment and it is not provided*
Title VI of the Civil Rights Act of 1964 • Bars federally funded hospitals from discriminating on the basis of "race, color, or national origin."	• **Disparate treatment (intentional) and disparate impact (unintentional) discrimination** *if ED denies a patient access to evidence-based practices for SUD. Given the rising number of overdose deaths for Black, Brown and Indigenous people and the well-documented racial inequities in access to care for substance use disorders, an ED's failure to use evidence-based practices will likely have a disproportionate impact on these communities*

74 (Yeboah-Sampong, Weber, & Friedman, 2021)

DEA REGISTRANT LETTER (2023)

U.S. Department of Justice
Drug Enforcement Administration

Office of the Administrator *Springfield, VA 22152*

January 12, 2023

Dear Registrants:

On December 29, 2022, with the signing of the Consolidated Appropriations Act of 2023 (the Act), Congress eliminated the "DATA-Waiver Program."

DEA fully supports this significant policy reform. In this moment, when the United States is suffering tens of thousands of opioid-related drug poisoning deaths every year, the DEA's top priority is doing everything in our power to save lives. Medication for opioid use disorder helps those who are fighting to overcome opioid use disorder by sustaining recovery and preventing overdoses. At DEA, our goal is simple: we want medication for opioid use disorder to be readily and safely available to anyone in the country who needs it. The elimination of the X-Waiver will increase access to buprenorphine for those in need.

- Going forward, all prescriptions for buprenorphine only require a standard DEA registration number. The previously used DATA-Waiver registration numbers are no longer needed for any prescription.
- There are no longer any limits or patient caps on the number of patients a prescriber may treat for opioid use disorder with buprenorphine.
- The Act does not impact existing state laws or regulations that may be applicable.

Separately, the Act also introduced new training requirements for all prescribers. These requirements will not go into effect until June 21, 2023. The DEA and SAMHSA are actively working to provide further guidance and DEA will follow up with additional information on these requirements shortly. Importantly, these new requirements do not impact the changes related to elimination of the DATA-Waiver Program described above.

Sincerely,

Anne Milgram
Administrator

For information regarding DEA's Diversion Control Division, please visit https://www.DEAdiversion.usdoj.gov. Please contact the Diversion Control Division Policy Section at ODLP@dea.gov if you seek additional assistance regarding this or any other matter.

MAINSTREAMING ADDICTION TREATMENT ACT (H.R. 1384 / S. 445)

SUMMARY OF SOLUTIONS INCLUDED IN THE FY 2023 OMNIBUS

CURRENT FEDERAL RULES	MAT ACT CHANGES INCLUDED IN THE OMNIBUS
Health care providers must **apply for an "X-Waiver"** from SAMSHA and the DEA before prescribing buprenorphine for opioid use disorder.	**Removes the X-Waiver registration requirement.** All health care providers with a standard DEA controlled medication license will be able to prescribe buprenorphine for opioid use disorder without separate registration, subject to state requirements.
Health care providers must adhere to **strict limits on the number of patients** with opioid use disorder that they can treat at a time.	**Removes the patient limits.** All health care providers with a standard DEA controlled medication license will be able to prescribe buprenorphine for opioid use disorder to as many patients in their practice as needed, subject to state requirements.
Health care providers must **mark buprenorphine prescriptions for patients with opioid use disorder with an "X"** using a special DEA number.	**Removes the special DEA "X" prescribing number.** Health care providers can use their standard DEA controlled substance license number to prescribe buprenorphine for opioid use disorder.
Health care providers must attest to their **ability to refer patients to counseling and ancillary services** before prescribing buprenorphine for opioid use disorder to more than 30 patients at a time.	**Removes counseling referral and ancillary services requirement.** Health care providers with a standard DEA controlled medication license can prescribe buprenorphine for opioid use disorder in the course of their normal medical practices, subject to state requirements.
Health care providers must engage in an **8-24-hour X-Waiver training** before prescribing buprenorphine for opioid use disorder to more than 30 patients at a time.	**Removes X-Waiver training requirement.** Health care providers with a standard DEA controlled medication license can prescribe buprenorphine for opioid use disorder, subject to state requirements. A separate section of the omnibus will require that all health care providers registered with the DEA take an 8-hour course on substance use disorder. But the completion of this course is not required before starting to prescribe buprenorphine.
Only certain **eligible health care providers (e.g., physicians, advanced practice registered nurses, physician assistants)** can prescribe buprenorphine for opioid use disorder.	**Removes list of health care providers who can prescribe buprenorphine for opioid use disorder.** Any health care provider with a standard DEA controlled medication license can prescribe buprenorphine, subject to state requirements.

For more information, please contact us at erin@endsud.org
www.endsud.org/mat-act

END SUBSTANCE USE DISORDER

CLINICAL OPIATE WITHDRAWAL SCALE

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment the increased pulse rate would not add to the score.

Patient's Name:	**Date and Time:** / / :
Reason for this assessment:	
Resting Pulse Rate: *Beats/minute* *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset:** *Over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *Over last 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor:** *Observation of outstretched hands* 0 no tremor 1 tremor can be felt but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness: *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning:** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three a more times during assessment 4 yawning several times/minute

Pupil Size:	**Anxiety or Irritability:**
0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint Aches: *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored.*	**Gooseflesh Skin:**
0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny Nose or Tearing: *Not accounted for by cold symptoms or allergies.* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	**Total Score:** The score is the sum of all 11 items Initials of person completing assessment:

Score: 5-12 = mild; 13-24 = moderate; 25-36= moderately severe; more than 36 = severe withdrawal.
Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs. 35(2), 253-9.

MEDICATION FOR OPIOID USE DISORDER INITIATION IN THE ED

PROTOCOL CONSIDERATIONS

Developed by Mosaic Group for use in Reverse the Cycle contracted hospital systems

Your hospital is planning for Reverse the Cycle, including integration of Peer Recovery Coaches and the ability to dispense and/or prescribe buprenorphine to patients who are using opioids and motivated for treatment. Mosaic Group has outlined several considerations and recommendations for your clinical team. These are outlined below.

QUALIFYING CRITERIA

The evidence is clear that medication for opioid use disorder (MOUD) is now the standard of care and provides the best chance for long term recovery. There may be several factors that impact a patient's ability to connect with an MOUD clinician upon their release from the hospital which include, but are not limited to:

1. Patient values and beliefs about the use of MOUD in recovery
2. Timeliness of access to ongoing MOUD in the community
3. Patients' willingness to meet program requirements to receive MOUD with prescribing clinician or program

When a patient with OUD is motivated for treatment, the ED peer recovery coach will assist the patient in obtaining an appointment for intake with an appropriate treatment clinician. Patients that present to the ED in withdrawal or begin to experience a level of withdrawal symptoms while in the ED may be eligible to receive a dose(s) of buprenorphine that will assist them in addressing their withdrawal symptoms after discharge and support linkage to ongoing MOUD. Patients that do not experience withdrawal symptoms after discharge show up at the scheduled intake appointment at statistically significant higher rates than those not medicated with buprenorphine according to research studies (Donofrio, G, JAMA).

Please note that conventional buprenorphine induction protocols that are successful for most individuals with opioid use disorder may not be the best approach for individuals using fentanyl. Lower dose buprenorphine doses in the emergency room that are increased over the duration of the patient's stay may reduce the risk of precipitated opioid withdrawal for individuals using fentanyl.

Mosaic Group recommends that hospitals adopt a protocol to evaluate any patient that is scheduled for an intake appointment for substance use treatment for buprenorphine initiation, regardless of the referring treatment modality.

EXCLUSION/CAUTIONARY CRITERIA

Buprenorphine has been clinically proven to be a safe and effective medication for the long-term treatment of opioid use disorder. The MOUD Initiation protocols that are developed for hospital emergency departments are designed to dispense clinically appropriate dose(s) of medication to the patient prior to ED discharge. Given these factors, there are very few exclusion criteria for consideration in the MOUD Initiation protocol. Mosaic Group recommends the following be considered in discussion at the Reverse the Cycle Planning Team meeting with clinical leadership and others for development of the MOUD Initiation order set:

1. Clinician will determine if patient is approved for buprenorphine administration in the ED:

   a. Exclusion Criteria
      i. Patient reports that they are on long-acting opioids
      ii. Evidence of liver disease
      iii. Acute psychiatric illness
      iv. Allergy to buprenorphine or naloxone

   b. Cautionary Criteria:
      i. Prescribed or illicit benzodiazepine use
      ii. Patient reports that they are pregnant

Mosaic Group does not recommend that patients be given a urine toxicology screen as part of the order set.

BRIDGE DOSING CONSIDERATION

In some communities where the Reverse the Cycle program is being implemented, there may not be available Fast Track capacity 7 days a week or on holidays. Mosaic Group works diligently to build capacity in the community and continues this work throughout the implementation phase of their work with hospitals to create a robust network of clinicians with on-demand access.

When next-day access is not available 24/7, hospitals should consider bridge dosing. The Consolidated Appropriations Act, 2023 grants prescribing authority to any clinician with DEA registration and Schedule III authority. Whether the hospital has a robust network of ED clinicians who have their X waiver, or uses an on-call service, the patient may receive a prescription to continue home dosing until the date of their appointment.

ADDITIONAL CONSIDERATIONS FOR MOUD BRIDGE PRESCRIBING PROTOCOL DEVELOPMENT

1. How many of the ED clinicians are willing to prescribe MOUD? Will leadership require all ED DEA licensed clinicians to prescribe according to the order set, or will it be optional?
2. Will a prescriber be available to cover all shifts?
3. Who is the target population that is eligible for a bridge prescription? Will all patients who are being referred to MOUD treatment post-discharge be given a bridge prescription, or only those that are unable to go to treatment the same or next day?

4. What will be the number of days on the bridge prescription?
   a. Will there be a standard number of days for all patients?
   b. Will the days be determined based on time until treatment appointment?
   c. Will patients be able to request a bridge prescription?
   d. What are the minimum or maximum number of days for a bridge prescription?

5. How will you manage medication and home induction patient instructions? Considerations include:
   a. Discharge instructions on home induction and medication administration
   b. Role of the clinician, nurse, peer coach and/or other staff that support patient instructions related to discharge
   c. Patient education material needs

6. Do you need a follow-up protocol?
   a. Consider support for patient in filling prescription and home induction
   b. Consider support for patient to link to treatment within bridge timeframe

7. What are the staff training needs?

REVERSE THE CYCLE

ED-BASED PEER RECOVERY COACH JOB

Developed by Mosaic Group for use in Reverse the Cycle contracted hospital systems.

JOB TITLE: Peer Recovery Coach (Emergency Department)

JOB SUMMARY: The Peer Recovery Coach provides non-clinical services intended to aid patients in establishing recovery from high risk of drugs and alcohol. The Peer Recovery Coach will work as part of the Emergency Department team to provide peer support and motivation to encourage patients who would benefit from treatment and/or recovery support for alcohol or drug use. The Peer Recovery Coach will assist in completing referrals to treatment services and developing service plans to promote successful linkage to treatment services. Services will be provided in the Emergency Department with appropriate follow-up.

EDUCATION, EXPERIENCE: High school diploma or G.E.D. is required. The candidate must be actively engaged in his/her own recovery program with a minimum of two years demonstrated personal recovery.

LICENSE/CERTIFICATION/REGISTRATION: N/A

SKILLS: The Peer Recovery Coach must demonstrate excellent interpersonal skills, the ability to relate to patients and health professionals, as well as an ability to develop professional working relationships with partner agencies. The candidate must possess excellent listening, verbal and written communication skills, as well as good problem-solving skills. The incumbent must be able to read, interpret documents and write routine reports. Basic computer skills are required. Must be able to demonstrate patience and tact when dealing with patients, families, and other staff, to integrate Continuous Quality Improvement principles for service and organization work improvements.

Ability to work with people of all social, economic, and cultural backgrounds; be flexible, open-minded and adaptable to change; to develop collaborative relationships with physicians, families, patients, interdisciplinary team and other community agencies. In addition, the candidate must demonstrate a willingness to learn and an interest in acquiring new skills.

PRIMARY DUTIES & RESPONSIBILITIES:

1. Conducts brief interventions for patients that screen positive for alcohol and/or drug use.
2. Identifies patient's history of drug/alcohol use, treatment history, motivation to change behavior and other needs for community support services.
3. Identifies patient's readiness to change and use motivational interviewing techniques and other communication skills to support a plan for reducing or eliminating harmful drug and/or alcohol use.
4. Works with ED staff and social worker to identify community support services.
5. Assists patient and family with understanding how to utilize community services.
6. Assists patients in linking to community support services and substance treatment services including securing appointment and transportation.
7. Acts as a peer support throughout the hospitalization and post-discharge, as appropriate, to facilitate attainment of goals.
8. Provides family members with recovery support materials.
9. Provides telephone outreach to patients to assist with linkages and continued peer support.
10. Models coping techniques and self-help strategies.
11. Demonstrates ability to meet the productivity requirements set in accordance with program goals.
12. Participates in trainings to continually gain new skills.
13. Attends required staff and other meetings.
14. Completes required documentation and other reports.
15. Acts as a resource to other clinical team members on recovery support.
16. Consults with nursing staff, social work as requested, even if patient does not screen positive.
17. Notifies patient's nurse before visiting the patient.
18. Telephones treatment clinicians to verify patient showed up for appointment; and follow-up by telephone with any patient that misses an appointment.
19. Demonstrates competencies for position within the first 90 days of employment.
20. Satisfactorily meets requirements of position during periodic and annual evaluations.

REPORTS TO: On-Site Supervisor

OVERDOSE SURVIVOR'S OUTREACH PROJECT (OSOP)

COMMUNITY RECOVERY COACH – COMMUNITY OUTREACH

Developed by Mosaic Group for use in Reverse the Cycle contracted hospital systems.

JOB TITLE: OSOP Community Recovery Coach

SUMMARY OF POSITION: The OSOP Community Recovery Coach is an integral part of the team that is designated to conduct outreach and engagement to survivors of an opioid overdose after discharge and referral from the emergency department. This individual provides non-clinical services intended to aid patients in establishing recovery and reducing the risk associated with a subsequent overdose. The OSOP Community Recovery Coach will assist in completing referrals to recovery support and substance use treatment services as well as developing service plans to promote successful linkage to referred services. Services will primarily be provided in the community; however, the Coach may meet patients in the ED to assure successful continuity in care.

QUALIFICATIONS: High school diploma or G.E.D. is required. The candidate must be actively engaged in his/her own recovery with a minimum of four years demonstrated personal recovery experience from alcohol and/or drug use. The incumbent must be able to read, interpret documents and write routine reports. Basic computer skills are required. The OSOP Community Recovery Coach must demonstrate excellent interpersonal skills, the ability to relate to patients and health professionals, as well as good problem-solving skills. Must be able to demonstrate patience and tact when dealing with patients, families, and other staff, to integrate Continuous Quality Improvement principles for service and organization work improvements. Ability to work with people of all social, economic, and cultural backgrounds; be flexible, open-minded and adaptable to change; to develop collaborative relationships with physicians, families, patients, interdisciplinary team and other community agencies. In addition, the candidate must demonstrate a willingness to learn and an interest in acquiring new skills.

PRIMARY DUTIES & RESPONSIBILITIES:

1. Conducts street outreach to locate and engage with referred OSOP patients from hospital emergency departments.
2. Conducts screenings to understand the patient's history of drug and/or alcohol use, treatment history, social service and other recovery support needs and motivation to change behavior.
3. Facilitates patient's readiness for change and uses motivational interviewing techniques and other communication skills to support and encourage the patient to plan for reduction or elimination of drug and alcohol use.
4. Assists patients in setting personal recovery goals.
5. Works with healthcare team and patient to identify community supports and treatment services to promote recovery.
6. Supports patients and families to understand how to access community resources.

7. Assists patients in linking to community supports and treatment services, including helping secure transportation and other resources.
8. Acts as a peer support after patient is discharged from the hospital. This involves face-to-face and phone engagement with patients in various community settings.
9. Provides family members with recovery support materials.
10. Provides education on risks of overdose and assures that patient and significant others have naloxone and are trained to use it.
11. Completes required reports and other necessary documentation accurately.
12. Demonstrates competencies for position within the first 90 days of employment.
13. Satisfactorily meets requirements of position during periodic and annual evaluations.

REPORTS TO: On-Site Supervisor

REVERSE THE CYCLE HOSPITAL SUBSTANCE USE RESPONSE PROGRAM

CHAMPION

Developed by Mosaic Group for use in Reverse the Cycle contracted hospital systems.

Mosaic Group works with health systems to integrate SSI (systematic screening and intervention), OSOP (Overdose Survivors Outreach Program) and MOUD Initiation in the Emergency Department. A planning team is organized at the start of our work and meets continuously throughout the planning process to develop protocols, enhance workflows and support a successful implementation. The RTC Champion is defined as an individual who works closely with the primary Mosaic consultant to move the team and staff through system transformation as they integrate the interventions.

The RTC Champion is most vital during the planning process to help create buy-in from leadership and clinical staff. The Champion should be in a position of influence to help support movement on all planning activities on the proposed timeline. Other key characteristics important to a successful Champion include the following:

PROJECT UNDERSTANDING AND OWNERSHIP: The Champion should be a team member in the hospital that has a thorough understanding of the emergency room operational environment in order to help guide the planning process to support successful RTC integration. The Champion will assume responsibility for ultimate approval of the decisions made by the planning team and help the team and Mosaic Group assess and analyze the set of issues associated with critical decisions in the planning process. The Champion must be able to confidently embrace the systems change requirements of program integration and understand how/who this practice change impacts in their guidance, direction and support of the integration process.

POSITION OF TRUST AND RESPECT: Hospital leadership places a high degree of trust and confidence in the identified Champion to carry out the planning and implementation requirements for successful program integration in the ED. As a result, the Champion will be able to gain the confidence of the planning team and other ED/hospital staff to assume a leadership role in the practice transformation process. They must believe the Champion is balancing their interests along with the business, clinical and other operational needs of the Department, and that their voice is being heard.

COMMUNICATION: Supporting effective communication with Mosaic Group, the partners, the planning team and other hospital staff will be essential to the planning and implementation process. The Champion is a conduit for both formal and informal communication and these messages need to come from and go to the Champion. The Champion will need to be prepared to communicate up to senior leadership as necessary, with other departmental leaders and ED staff.

CHAMPION ROLES & RESPONSIBILITIES:

1. Identify planning team members and convene planning team meetings – Approximately 4 to 5 during planning and then quarterly after launch.
2. Work with Mosaic Group to facilitate planning team meetings as the process moves through protocol development and other decisions are made.
3. Identify an appropriate person to conduct a walk-through of the ED with Mosaic Group.
4. Support Mosaic Group in answering key questions throughout the planning process.
5. Support Mosaic Group in identification of key hospital and partner staff that need to be involved and engaged if not on the planning team.
6. Help facilitate, with Mosaic Group, the partner relationships vital to integrating interventions.
7. Work with Mosaic Group to ensure that Peer Recovery Coaches are processed through hospital HR and the credentialing process within the project timeline.
8. Work with Mosaic Group and key hospital leadership to help advance key project planning tasks in order to meet launch objective.
9. Review and approve the protocols.
10. Help Mosaic Group plan training for nursing, physician and other key staff necessary prior to project launch.
11. Review monthly data with Mosaic Group and support identification and implementation of program improvements.
12. Serve as the primary point of contact throughout the planning and implementation period.

REVERSE THE CYCLE HOSPITAL SUBSTANCE USE RESPONSE PROGRAM

PROGRAM PLANNING TEAM COMPOSITION

Developed by Mosaic Group for use in Reverse the Cycle contracted hospital systems.

The planning team is an essential group of committed hospital and community partner stakeholders that will work together with Mosaic Group to guide integration of Systematic Screening and Intervention (SSI), initiation of Medication for Opioid Use Disorder (MOUD) in the ED and the Overdose Survivor's Outreach Program. The team will meet bi-weekly, approximately five times over the planning period to provide vital input into the final protocol development and implementation process.

Representation from individuals of influence and leadership in the hospital and other community agencies from the following areas are recommended:

DEPARTMENT	RECOMMENDED PARTICIPANT
Emergency Medicine/ General Medicine	Chief Medical Officer, ED Medical Director
Nursing, ED Nursing	Senior leader in Nursing Administration and ED Nursing Director
Social Work/Care Navigation	Director of Social Work/Care Management or designated leader
Behavioral Health	Director of Psychiatric ED, Inpatient Psych manager or designated leader
Legal/Risk Management	Director or manager
Information Systems/ Business Intelligence	Director, EMR Analyst, Specialist or other designated team member. Also need representation from the report-build team, if separate.
Human Resources	HR Specialist. Helpful to have the HR team member assigned to recruit and support project.
Pharmacy	Director or manager
Population Health	Director or manager
Community Behavioral Health Partner	Director or manager of local health department and/or addiction authority
Other Public Health Partner Agencies integral to the program	

REVERSE THE CYCLE HOSPITAL SUBSTANCE USE RESPONSE PROGRAM

SUPERVISOR

Developed by Mosaic Group for use in Reverse the Cycle contracted hospital systems.

The Reverse the Cycle Program Supervisor plays a vital role in the success of the program within the organization. An effective supervisor will build a professional relationship with the Peer Recovery Coaches (PRC), empowering them to be successful in their role. This includes providing guidance and direction around topics such as ethics, boundaries, recovery and wellness, advocacy, mentoring and education, time management, professionalism, and self-care. The Supervisor should be regularly available to provide both scheduled and non-scheduled supervision to the PRC, as needed.

The Supervisor is responsible for the day-to-day performance of the RTC project and the PRCs that are assigned to this project. During the implementation phase of the program, the Supervisor should be able to commit 2-4 hours weekly to the PRC team and Reverse the Cycle programming. Beyond the Mosaic TA, the Supervisor should be available at least 2 hours weekly to support the team.

RESPONSIBILITIES:

1. Participates with Mosaic Group and the hospital leadership team in the planning and implementation of the RTC program.
2. Supports the integration of Peer Recovery Coaches into the hospital emergency department and facilitates a positive working relationship.
3. Monitors performance of Peer Recovery Coaches including delivery of brief interventions, referrals to treatment and consistent follow-ups.
4. Provides mentoring and coaching to the Peer Recovery Coaches related to job performance.
5. Meets regularly with the PRCs to assess program success, challenges and provide consultation on patient issues, as needed.
6. Conducts chart audits to verify all information documented by the Peer Recovery Coaches is completed appropriately.
7. Oversees the collection of data and assures provision of reports/updates according to established timelines.
8. Maintains relationships with community treatment clinicians and resource sites to ensure adequate treatment capacity in support of program goals.
9. Identifies additional education and/or training needs for the Peer Recovery Coaches.
10. Assures compliance with program protocols.
11. Participates in quality improvement activities, as needed, to ensure the program is meeting the established goals.

REFERENCES

Beronio, K., Po, R., Skopec, L., & Glied, S. (2013, 2013 19). *affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans.* https://aspe.hhs.gov/reports/affordable-care-act-expands-mental-health-substance-use-disorder-benefits-federal-parity-protections-0: ASPE, US Department of Health and Human Services. Retrieved from ASPE: https://aspe.hhs.gov/reports/affordable-care-act-expands-mental-health-substance-use-disorder-benefits-federal-parity-protections-0.

Bridge, C. (2022). Bridge Clinics High Volume, Low-Barrier MAT Clinics Partnering with Emergency Departments. Retrieved from https://bridgetotreatment.org. https://bridgetotreatment.org/resource/bridge-clinics/.

Centers for Disease Control and Prevention. (2022, December 30). *FastStats Homepage.* Retrieved from National Center for Health Statistics: https://www.cdc.gov/nchs/fastats/emergency-department.htm.

Centers for Disease Control and Prevention. (2022, September 7). *Lifesaving Naloxone.* Retrieved from Stop Overdose: https://www.cdc.gov/stopoverdose/naloxone/index.html.

Centers for Disease Control and Prevention. (2022, September 26). *National Center for Health Statistics.* Retrieved from Stop Overdose: https://www.cdc.gov/stopoverdose/naloxone/index.html.

Cisewski, D., Santos, C., Koyfman, A., & Long, B. (2019). Approach to buprenorphine use for opioid withdrawal treatment in the emergency setting. *Journal of Emergency Medicine,* https://doi.org/10.1016/j.ajem.2018.10.013.

Collins, D., Alla, J., Nicolaidis, C., Gregg, J., Gullickson, D. J., Patten, A., & Englander, H. (2019). "If It Wasn't for Him, I Wouldn't Have Talked to Them": Qualitative Study of Addiction Peer Mentorship in the Hospital. *Journal of General Internal Medicine*, https://doi.org/10.1007/s11606-019-05311-0.

Courtney D. Nordeck, a. C. (2022). Opioid agonist treatment initiation and linkage for hospitalized patients seen by a substance use disorder consultation servicex. *Drug and Alcohol Dependence Reports.*

D'onofrio, G., O'Conner, P., Pantalon, M., Chawarski, M., Busch, S., Owens, P., . . . Fiellin, D. (2015). Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial. JAMA, 313(16):1636–1644. doi:10.1001/jama.2015.3474.

Drucker, E. A. (2016). Treating addictions: Harm reduction in clinical care and prevention. *Journal of Bioethical Inquiry,* 239-249.

Drug Enforcement Administration . (2022). *DEA's Commitment to Expanding Access to Medication-Assisted Treatment.* https://www.dea.gov/press-releases/2022/03/23/deas-commitment-expanding-access-medication-assisted-treatment: DEA.

Elliott, L., Bennett, A., & Wolfson-Stofko, B. (2019).
Life after opioid-involved overdose: Survivor narratives and their implications for ER/ED interventions. *Addiction, https://doi.org/10.1111/add.14608.*

End Substance Use Disorder. (2022, December 23). *MAT Act Passage- Overview of Provisions in Omnibus.* Retrieved from End Substance Use Disorder: https://drive.google.com/file/d/1OwOAvy3oEs5DUtKAToS8irT4ZWApdezV/view.

Farhoudian A, R. E. (2022).
Barriers and Facilitators to Substance Use Disorder Treatment: An Overview of Systematic Reviews. *Substance Abuse: Research and Treatment.* doi:10.1177/11782218221118462

Gertner AK, R. K. (2021). .
Universal screening for substance use by Peer Support Specialists in the Emergency Department is a pathway to buprenorphine treatment. 2021 Sep 25;14:100378. doi: 10.1016/j.abrep.202. *Addictive Behavior Reports.*

Hawk, K. F., & Edelman, E. J. (2020).
Barriers and facilitators to clinician readiness to provide emergency department–initiated buprenorphine. *JAMA Network Open.*

Hawk, K., Hoppe, J., Ketcham, E., Stader, D., Wilson, M., & D'Onofrio, G. (2021).
Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department. Annals of Emergency Medicine, https://www.annemergmed.com/article/S0196-0644(21)00306-1/fulltext#secsectitle0050.

Huhn, A., & Dunn, K. (2017).
Why aren't physicians prescribing more buprenorphine?. *Journal of Substance Abuse Treatment*, https://www.jsatjournal.com/article/S0740-5472(17)30029-6/fulltext.

Jack, H., Oller, D., Kelly, J., Magidson, J., & Wakeman, S. (2018).
Addressing Substance Use Disorder in Primary Care: The Role, Impact, and Integration of Recovery Coaches. Substance Abuse, https://doi.org/10.1080/08897077.2017.1389802.

Lennox, R. L. (2021).
Peer support workers as a bridge: a qualitative study exploring the role of peer support workers in the care of people who use drugs during and after hospitalization. *Harm Reduction Journal.*

Marcozzi, D., Carr, B., Liferidge, A., Baehr, N., & Browne, B. (2017).
Trends in the Contribution of Emergency Departments to the Provision of Hospital-Associated Health Care in the USA. *International Journal of Health Services,* https://doi.org/10.1177/0020731417734498.

Menis, J., Stahler, G., & Mason, M. (2016).
Risky Substance Use Environments and Addiction: A New Frontier for Environmental Justice Research. International Journal of Environmental Research and Public Health, https://doi.org/10.3390/ijerph13060607.

Miller, W., & Rollnik, S. (2012).
Motivational Interviewing: Helping People Change. New York: The Guilford Press.

National Institute of Mental Health. (2021, March).
Substance Use and Co-Occurring Mental Disorders. Retrieved from NIMH: https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health.

National Institute on Drug Abuse. (2019, September 20).
Frequently Asked Questions about ED-Initiated Buprenorphine. Retrieved from National Institutes of Health: https://nida.nih.gov/nidamed-medical-health-professionals/discipline-specific-resources/emergency-physicians-first-responders/initiating-buprenorphine-treatment-in-emergency-department/frequently-asked-questions-about-ed-initiated-buprenorphine.

National Institute on Drug Abuse. (2020, April 2).
Many People Treated for Opioid Overdose in Emergency Departments Die Within 1 Year. Retrieved from NIDA: NIDA. 2020, April 2. Many People Treated for Opioid Overdo https://nida.nih.gov/news-events/nida-notes/2020/04/many-people-treated-opioid-overdose-in-emergency-departments-die-within-1-year.

National Institute on Drug Abuse. (2022, March 21).
Screening and Assessment Tool Chart. Retrieved from National Institute on Drug Abuse: https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools.

National Institute on Drug Abuse. (2022, March 22).
Treatment and Recovery. Retrieved from National Institutes of Health: https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery.

National Institutes of Health. (2016, Februrary 25).
How the Built Environment Influences Violence and Drug and Alcohol Abuse. Retrieved from NIH: https://obssr.od.nih.gov/news-and-events/news/how-built-environment-influences-violence-and-drug-and-alcohol-abuse#:~:text=What%20do%20place%20and%20the%20built%20environment%20have,a%20predictor%20of%20behavior%20in%20highly%20disordered%20environments.

Nolan, M. L.-B. (2019).
Increased presence of fentanyl in cocaine-involved fatal overdoses: Implications for prevention. Journal of Urban Health, 49-54.

Nordeck, C. D. (2022).
Opioid agonist treatment initiation and linkage for hospitalized patients seen by a substance use disorder consultation service. *Drug and Alcohol Dependence Reports, 2.*

Peterson, C., Li, M., Xu, L., Mikosz, C., & Luo, F. (2021).
Assessment of Annual Cost of Substance Use Disorder in US Hospitals. *JAMA network open,* https://doi.org/10.1001/jamanetworkopen.2021.0242.

Reif S, B. L.-R. (2014).
Peer recovery support for individuals with substance use disorders: assessing the evidence. *Psychiatric Services.*

Srivastava, A. B. (2020). New directions in the treatment of opioid withdrawal. The Lancet.

Substance Abuse and Mental Health Services Administration. (2022, September 27). *Peer Support Workers for Those in Recovery.* Retrieved from SAMHSA: https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers.

Substance Abuse and Mental Health Services Administration (US). (2016). Office of the Surgeon General. In U. D. Services, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (pp. Chapter 6, Healthcare Systems and Substance Use Disorders). https://www.ncbi.nlm.nih.gov/books/NBK424848/.

Substance Abuse and Mental Health Services Administration. (2020). *National Survey on Drug Use and Health.* Retrieved from SAMHSA: https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health.

Substance Abuse and Mental Health Services Administration. (2021, July). *Tip 63: Medications for Opioid Use Disorder.* Retrieved from SAMHSA: https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf.

Substance Abuse and Mental Health Services Administration. (2022, April 21). Become a Buprenorphine Waivered Practitioner. Retrieved from SAMHSA: https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner.

Substance Abuse and Mental Health Services Administration. (2022, September 27). Buprenorphine. Retrieved from SAMHSA: https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/buprenorphine.

Substance Abuse and Mental Health Services Administration. (2022, August 16). *Harm Reduction.* Retrieved from SAMHSA: https://www.samhsa.gov/find-help/harm-reduction.

Substance Abuse and Mental Health Services Administration. (2022, September 27). *Methadone.* Retrieved from SAMHSA: https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/methadone.

Substance Abuse and Mental Health Services Administration. (2022, September 27). *Naltrexone.* Retrieved from SAMHSA: https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/naltrexone.

Substance Abuse and Mental Health Services Administration. (2022, August 12). *Screening, Brief Intervention, and Referral to Treatment (SBIRT).* Retrieved from SAMHSA: https://www.samhsa.gov/sbirt.

Substance Abuse and Mental Health Services Administration. (2023, January 25). *Naloxone.* Retrieved from US Department of Health & Human Services: https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/naloxone.

Substance Abuse and Mental Health Servies Administration. (2021). *SAMHSA Advisory.* Retrieved from Using Motivational Interviewing in Substance Use Disorder Treatment: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-02-014.pdf.

Tassey, T., Ott, G., Alvanzo, A., Peirce, J., Antoine, D., & Buresh, M. (2022).
OUD MEETS: A novel program to increase initiation of medications for opioid use disorder and improve outcomes for hospitalized patients being discharged to skilled nursing facilities. *Journa of Substance Abuse Treatment,* https://pubmed.ncbi.nlm.nih.gov/36215913/.

Taylor, J. L. (2023).
Substance use disorder bridge clinics: Models, evidence, and future directions.
Addiction Science and Clinical Practice, 18.

Technology, T. O. (2023, September 30).
What are the advantages of electronic health records? Retrieved from HealthIT.gov:
https://www.healthit.gov/faq/what-are-advantages-electronic-health-records.

The West Virginia Department of Health and Human Resources (DHHR), O. o. (2023).
Data Dashboard. Retrieved from West Virginia Office of Drug Control Policy Data Dashboard:
https://dhhr.wv.gov/office-of-drug-control-policy/datadashboard/Pages/default.aspx.

UAMS Psychiatry Research Institute. (2022).
What is Buprenorphine? Retrieved from UAMS Psychiatry Research Institute:
https://psychiatry.uams.edu/clinical-care/cast/buprenorphine/

US Food and Drug Administration. (2020, August 12).
New Recommendations for Naloxone. Retrieved from FDA:
https://www.fda.gov/drugs/drug-safety-and-availability/new-recommendations-naloxone

US Office of the Surgeon General. (2016).
Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC:
https://www.ncbi.nlm.nih.gov/books/NBK424857/pdf/Bookshelf_NBK424857.pdf.

Volkow, N. (2020).
Stigma and the Toll of Addiction. New England Journal of Medicine,
https://www.nejm.org/doi/full/10.1056/NEJMp1917360?query=recirc_curatedRelated_article.

Weiner, S., Baker, O., Bernson, D., & Schuur, J. (2020).
One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose.
Annals of Emergency Medicine , https://www.annemergmed.com/article/S0196-0644(19)30343-9/fulltext.

Yeboah-Sampong, S., Weber, E., & Friedman, S. (2021).
Emergency: Hospitals are Violating Federal Law by Denying Required Care for Substance Use Disorders in Emergency Departments. https://www.lac.org/assets/files/LAC-Report-Final-7.19.21.pdf: Legal Action Center.

ADDITIONAL RESOURCES

Removal of DATA Waiver (X-Waiver) Requirement | SAMHSA
USING MOTIVATIONAL INTERVIEWING IN - Advisory 35 (samhsa.gov)
Harm Reduction Model in Substance Use - Addiction Group
Addressing Stigma and Health Disparities | National Institute on Drug Abuse (NIDA) (nih.gov)
CDC's Clinical Practice Guideline for Prescribing Opioids for Pain | Guidelines | Healthcare Professionals | Opioids | CDC