Draft

Emergency Department & Hospital Standards for Rhode Island

Traci C. Green, PhD, MSc
Associate Professor of Emergency Medicine & Community Health Sciences
Boston University School of Medicine
Adjunct Associate Professor of Emergency Medicine & Epidemiology
Warren Alpert Medical School of Brown University
Why?

Healthcare institutions regularly care for people with acute and chronic pain conditions, and people with substance use disorders

- 59% of overdose victims in MD had been to ED <12 mos of death
- 18% (10-39%) of annual hospitalizations in one MA hospital billed a substance use code
- Almost one-quarter of hospitalized nonsurgical patients in US were exposed to high dose opioid prescriptions, had increased risk of severe opioid-related adverse drug events

Healthcare institutions are a source of opioids

- 91% of RIH trauma service patients discharged home with an opioid

Healthcare institutions contribute to proliferation of opioids in the environment, to diversion, and to iatrogenic risk of addiction and overdose

Focus has been on community, outpatient setting, primary care

Become less of the problem

Lower prescribing high dose of opioids, co-prescribing benzodiazepines and opioids

Become more of the solution:

Increase identifying and treating SUD, prescribing naloxone, offering MAT

---

Charge

Goal

Develop a standard of care for Rhode Island to address opioid use disorders and overdoses in hospital, clinic, urgent care, and ED settings

Objective

Prepare draft best practice standards for emergency departments and hospitals for the treatment of opioid addiction and overdose
Essential Attributes  (May 2016 Task Force meeting)

- Focus on repeat overdose visits; consider scaled response
- Create and sustain engagement
- Co-locate services at high volume locations
- Ability to learn from events
- Opportunity for improving care coordination
- Use information technology advances to support and facilitate standards and care delivery (e.g., EDiE system)
- Consider multiple sentinel events and other interactions with the healthcare system as opportunity to screen for SUD and extend offer of evidence based treatment
- See that the recovery planning tool is utilized for all patients presenting, especially for those refusing to have a contact by a peer recovery coach
- Evaluate ways to better engaged families for additional support
Process

- Task force discussions, Workgroup recommendations
- ED/Hospital standards
- Independent expert review of current practices, proposed standard
- Review of relevant literature, expert input
- Public comment, discussion
Becoming more of the solution: Building on Efforts Underway & Nearby Innovations

ED Discharge planning legislation

Anchor ED program

Safer Opioid Prescribing Protocol (SOPP) Study

Nearby Innovations

◦ Transitional Opioid Program (TOP) study & Liebschutz et al., 2014
◦ Addiction consult service
◦ Faster PATHS to Treatment
Perry and Goldner Discharge Planning Law, 2016

All hospitals to develop a comprehensive discharge plan for people with substance use disorders
RIDOH to develop model discharge plan guidelines and send them to hospitals, urgent care facilities, and health care centers

Comprehensive discharge planning and information to be shared with patients transitioning from the hospitals care:

- Providing in-hospital education prior to discharge, to include the utilization of a recovery plan
- Ensuring patients, caregivers have a point of contact for follow-up questions
- Identifying patients’ primary care providers, assisting with scheduling post-hospital follow-up appointments prior to discharge
**Efforts Underway: Recovery Planning Tool card**

<table>
<thead>
<tr>
<th>Step</th>
<th>Question</th>
</tr>
</thead>
</table>
| 1    | What can you do right now, to not have that next high?  
(Example: I can delete toxic phone numbers from my phone right now, I can stay with a safe friend temporarily, or I can call someone to remove anything toxic that is still at my house, including alcohol) |
| 2    | Do you have a non-toxic place where you can sleep tonight? |
| 3    | Is there someone safe you can call for a ride and maybe even agree to stay with you? |
| 4    | Are you willing to consider methadone or buprenorphine to help your recovery?  
If “yes” where have you been in the past? |
| 5    | Do you need any help making or getting to your first appointment? |
| 6    | Will you be willing to let someone, who has traveled the road you’re on, just talk to you or maybe help get you into treatment? |
Emergency Department-specific activities

3-day prescription limit for opioid medications

Anchor ED—EMS- or ED-initiated

Hotline for referrals 942-STOP

Community treatment provider referrals

LOOP (Lifespan Opioid Overdose Prevention) Program: naloxone in RIH ED for overdose and other opioid-involved emergencies

Buprenorphine/naloxone: take home and observed doses
Methadone observed doses

-up to 3 days’ supply with follow up visit appointment secured
Safer Opioid Prescribing Protocol Study (SOPP) (Baird 2016): becoming more of the solution

Universal and targeted intervention for trauma patients discharged to home with prescription for opioid analgesics

• Identification of unintentional prescription opioid risk factors among injured trauma patients- checklist
• Prescription of naloxone where indicated
• Education on naloxone use
• Education on safe opioid use and storage

*Incorporated into institutional electronic medical record system of Lifespan Trauma Service*

Evaluation

• Pre and post implementation medical record reviews on injured trauma patients
• Survey discharged injured patients, survey providers on pre SOPP practices
Documented Risk Among Trauma Patients: Retrospective Chart Review

<table>
<thead>
<tr>
<th>Co-morbidity</th>
<th>RIH</th>
<th>BMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Disease</td>
<td>9 (4.7%)</td>
<td>12 (7.2%)</td>
</tr>
<tr>
<td>Renal Disease</td>
<td>2 (1.0%)</td>
<td>2 (1.5%)</td>
</tr>
<tr>
<td>Cardiac Disease</td>
<td>6 (3.1%)</td>
<td>3 (1.9%)</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>12 (6.3%)</td>
<td>1 (0.62%)</td>
</tr>
<tr>
<td>Alcohol/Substance Abuse (last 12 months)</td>
<td>8 (4.2%)</td>
<td>5 (3.1%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SedativeHomeMedication_Risk</td>
<td>41 (21.5%)</td>
<td>1 (0.62%)</td>
</tr>
<tr>
<td>SedativePrescribed to Take home_Risk</td>
<td>30 (15.7%)</td>
<td>4 (2.5%)</td>
</tr>
<tr>
<td>Both Home and Prescribed to take home Risk</td>
<td>10 (5.2%)</td>
<td>10 (6.2%)</td>
</tr>
<tr>
<td>Benzodiazapene Use</td>
<td>18 (9.4%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Methadone/Buprenorphine Use</td>
<td>7 (3.7%)</td>
<td>3 (1.9%)</td>
</tr>
<tr>
<td>Opioid Dose &gt; 100 (Mev)</td>
<td>61 (31.9%)</td>
<td>4 (2.5%)</td>
</tr>
<tr>
<td>Home Medication Prescription Opioid Use</td>
<td>18 (9.4%)</td>
<td>15 (9.3%)</td>
</tr>
</tbody>
</table>

No naloxone prescribed
Survey Shows Little Safe Opioid Advising: Becoming less of the problem

<table>
<thead>
<tr>
<th>Safe Medication use during discharge from hospital’s trauma service (RIH, N=51):</th>
<th>No %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anyone reviewed prescription pain med with you</td>
<td>10</td>
</tr>
<tr>
<td>Advised about not using pain medications with alcohol</td>
<td>40</td>
</tr>
<tr>
<td>Advised about taking pain medication with other medications</td>
<td>47</td>
</tr>
<tr>
<td>Discussed not sharing pain medications with others</td>
<td>42</td>
</tr>
<tr>
<td>Discussed safe storage</td>
<td>62</td>
</tr>
<tr>
<td>Discussed safe disposal</td>
<td>87</td>
</tr>
<tr>
<td>Discussed unintentional prescription overdose</td>
<td>87</td>
</tr>
<tr>
<td>Discussed about naloxone/Narcan</td>
<td>96</td>
</tr>
<tr>
<td>Given a prescription for naloxone/Narcan</td>
<td>100</td>
</tr>
</tbody>
</table>
Best Practice Advisories (BPAs) in EMR can guide care

<table>
<thead>
<tr>
<th>Opioid discharge prescription strength</th>
<th>Risk for overdose, naloxone recommendation</th>
<th>Patient Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>For providers ordering any discharge opioid</td>
<td>Appears in discharge navigator for providers</td>
<td>Appears for nurses in the shift or discharge navigators</td>
</tr>
<tr>
<td>Serves as a reminder of dosing equivalents, also contributes to overdose risk based on user response</td>
<td>Suggests intranasal naloxone Rx when patient meets risk criteria</td>
<td>Reminder to add opioid safety and/or naloxone education</td>
</tr>
</tbody>
</table>
Morphine Equivalent Value (MEV) BPA

- Appears when an opioid is selected in the discharge med/rec

- Currently only applies to inpatients on the trauma service

- Response required to continue

- An answer of “Yes – MEV >= 100 mg” contributes to calculated overdose risk
BPA Alert

This patient is at risk for unintentional opioid overdose. A **naloxone/narcan** prescription is recommended.

For prescriptions filled in Rhode Island, use the single order below. For prescriptions filled out of state, select the two separate orders below:

- **Opiate Equianalgesic Chart (see page 2)**
- **RI Prescription Monitoring Program**

Preferred Pharmacy Address:
Providence VA Medical Center Pharmacy
330 Chalkstone Avenue
Providence RI 02908-4799
Phone: 401-273-7100 Fax: 401-525-2507

**Meds that increase risk:**
- **sertraline (ZOLOFT) tablet 25 mg** 25 mg, Oral, Daily
- **bupropion (WELLBUTRIN) 75 MG tablet** 75 mg, Oral, 3 times daily

**Dx that increase risk:**
- **COPD (chronic obstructive pulmonary disease)**

**Order** | **Do Not Order**
--- | ---
- For Rhode Island prescriptions - naloxone (NARCAN) kit (2 Syringes + Atomizer)
- For out of state prescriptions - naloxone (NARCAN) kit (2 Syringes + Atomizer)

Follow-up orders Consolidated from 3 items to 2

Activity links removed d/t minimal use

Cleaner layout

Qualifying patient data displayed
SOPP Early Implementation: becoming less of the problem and more of the solution:

- Discharged home with opioid medications: Pre > Post
- Sent home with High Dose Prescription opioids (>100MME): Pre > Post
- Prescribed naloxone: Pre < Post
- Patient educations on opioid safety: Pre < Post

Pre, Post, and Post-As % of patients with high dose opioids
Becoming more of the solution: Integrating Medication Assisted Treatment into the Hospital Setting
Acute Care Hospital Utilization Among Medical Inpatients Discharged With a Substance Use Disorder Diagnosis

Alexander Y. Walley, MD, MSc; Michael Paasche-Orlow, MD, MA, MPH, Eugene C. Lee, BA, Shaula Forsythe, AM, MPH, Veerappa K. Chetty, PhD, Suzanne Mitchell, MD, and Brian W. Jack, MD

(J Addict Med 2012;6: 50–56)

A Transitional Opioid Program to Engage Hospitalized Drug Users

Christopher W. Shanahan, MD, MPH1,2, Donna Beers, RN, BSN, CARN2,4, Daniel P. Alford, MD, MPH4,2, Eileen Brigandi4, and Jeffrey H. Sarnet, MD, MA, MPH1,2,3,4

BACKGROUND: Many opioid-dependent patients do not receive care for addiction issues when hospitalized for other medical problems. Based on 3 years of clinical

Optimising health and safety of people who inject drugs during transition from acute to outpatient care: narrative review with clinical checklist

Kinna Thakrar,1 Zoe M Weinstein,2 Alexander Y Walley2

Buprenorphine Treatment for Hospitalized, Opioid-Dependent Patients

Jane M. Liebschutz, MD, MPH; Denise Crooks, MPH; Debra Herman, PhD; Bradley Anderson, PhD; Judith Tsui, MD, MPH; Lidia Z. Meshesha, BA; Shermaz Dossabhoy, BA; Michael Stein, MD

Published online June 30, 2014.
Substance use is pervasive across inpatient populations

### Adult discharges with billed substance use code during visit

*Percentage of annual discharges*

<table>
<thead>
<tr>
<th>Specialization</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID</td>
<td>38.8%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>33.8%</td>
</tr>
<tr>
<td>MICU</td>
<td>31.6%</td>
</tr>
<tr>
<td>Hospitalist</td>
<td>31.6%</td>
</tr>
<tr>
<td>Internal Medicine - Hip Fracture</td>
<td>29.6%</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>20.6%</td>
</tr>
<tr>
<td>CCU</td>
<td>20.4%</td>
</tr>
<tr>
<td>Cards CHF</td>
<td>17.1%</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>15.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>14.6%</td>
</tr>
<tr>
<td>Neurology</td>
<td>13.4%</td>
</tr>
<tr>
<td>Heme / Onc</td>
<td>12.8%</td>
</tr>
<tr>
<td>CT Surg</td>
<td>12.5%</td>
</tr>
<tr>
<td>Gyn</td>
<td>12.4%</td>
</tr>
<tr>
<td>Gen Cards</td>
<td>11.5%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>11.0%</td>
</tr>
<tr>
<td>Plastics</td>
<td>10.8%</td>
</tr>
<tr>
<td>Renal</td>
<td>10.7%</td>
</tr>
<tr>
<td>Vascular</td>
<td>10.4%</td>
</tr>
<tr>
<td>Other</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

- Across all adult discharges, **17.5%** had a substance use code billed during their hospitalization.
- Likely **undercounts true demand**, as substance use is frequently a complicating, but **not primary, diagnosis**.
Studies Starting MAT During Hospitalization

Hospitalization as a “reachable moment”

80% of opioid-dependent individuals relapse within 1 year of detoxification\(^1,2\)

**TOP Study** (Shanahan et al., 2010; observational)
Model: Identify hospitalized out-of treatment, opioid-dependent patients, improve their health and drug use outcomes, promote low-threshold access to engage reluctant patients

1) interim opioid agonist therapy with methadone;
2) individualized case management;
3) group public health education;
4) principles of motivational interviewing and harm reduction

**Liebschutz et al.** (JAMA Internal Medicine 2014; randomized controlled trial)
Randomized out of treatment hospitalized patients with opioid use disorder to:

a) Detox group: 5-day taper buprenorphine + referral to outpatient treatment
b) Linkage group: buprenorphine maintenance induction with bridging doses at discharge + transition to outpatient therapy at primary care clinic

**Results:** More in Linkage group entered buprenorphine treatment within 6 months vs. Detox group (>70% vs. 12%), and reported less illicit drug use at 6 months post hospitalization

---

Hospital-based Addiction Consult Service

Boston Medical Center ACS started July 17, 2015

Goals:
- Improve care quality for inpatients, including initiating evidence-based medications, prescribe naloxone
- Link to outpatient chronic care services
- Reduce readmission, optimize length of stay
- Improve hospital staff satisfaction and trainee knowledge/skills

Offers consultation Monday-Friday to all inpatient services. **Team:**
- Medicine attending (afternoons)
- Addiction Medicine Fellow (when available)
- 1-2 Internal medicine or family medicine residents full-time (when available)
- Nurse/RN 0.5FTE
- Daily coordination with Social Work and Project ASSERT (LADC, peer recovery coaches)
- Weekly joint rounds with Psychiatry C/L on Wednesdays
Patients Seen: July 17, 2015 – January 17, 2016

Substance Use Disorders Diagnosed

<table>
<thead>
<tr>
<th>Substance</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids</td>
<td>271</td>
</tr>
<tr>
<td>Alcohol</td>
<td>130</td>
</tr>
<tr>
<td>Cocaine</td>
<td>96</td>
</tr>
<tr>
<td>Benzos</td>
<td>29</td>
</tr>
<tr>
<td>Marijuana</td>
<td>4</td>
</tr>
<tr>
<td>Meth</td>
<td>9</td>
</tr>
</tbody>
</table>

Data provided by A. Walley, presented at the Annual meeting of the College on Problems of Drug Dependence, La Quinta, CA, June 2016
Treatments Initiated: July 17, 2015 – January 17, 2016

Medically-Assisted Treatment Recommendations

Number of Patients

- Methadone: 72
- Suboxone: 44
- Naltrexone - OUD: 5
- Naltrexone - Both: 8
- Naltrexone - AUD: 35
- Acamprosate: 12
- Disulfiram: 6
- Topiramate: 2
Linkage to Care: July 17, 2015 – January 17, 2016

Follow-up by Medication

Number of Patients

<table>
<thead>
<tr>
<th>Medication</th>
<th>FAST PATH</th>
<th>OBAT</th>
<th>Psychiatry</th>
<th>PCP</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suboxone</td>
<td>35</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Naltrexone - OUD</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Naltrexone - Both</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Naltrexone - AUD</td>
<td>35</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Acamprosate</td>
<td>15</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disulfiram</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Topiramate</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
**Linkage to Care: July 17, 2015 – January 17, 2016**

<table>
<thead>
<tr>
<th>Referral Program</th>
<th>Referrals</th>
<th>Showed</th>
<th>No Showed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone Maintenance at CSAC</td>
<td>N=66</td>
<td>79% (52)</td>
<td>21% (14)</td>
</tr>
<tr>
<td>Buprenorphine at BMC</td>
<td>N=37</td>
<td>49% (13)</td>
<td>51% (18)</td>
</tr>
<tr>
<td>Naltrexone at BMC</td>
<td>N=16</td>
<td>25.0% (4 – all AUD)</td>
<td>75.0% (12)</td>
</tr>
</tbody>
</table>

Data provided by A. Walley, presented at the Annual meeting of the College on Problems of Drug Dependence, La Quinta, CA, June 2016
<table>
<thead>
<tr>
<th></th>
<th>Referred for outpatient linkage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Methadone Maintenance at CSAC</strong></td>
<td>N=52</td>
</tr>
<tr>
<td>Still Dosing, &lt;30 Days at Clinic</td>
<td>7.7% (4)</td>
</tr>
<tr>
<td>Still Dosing at &gt;30 Days</td>
<td><strong>65.4% (34)</strong> – 52.8% (38/72)</td>
</tr>
<tr>
<td>No Longer at Clinic</td>
<td>26.9% (14)</td>
</tr>
<tr>
<td><strong>Buprenorphine at FAST PATH</strong></td>
<td>N=13</td>
</tr>
<tr>
<td>Still at FAST PATH</td>
<td>23.1% (3)</td>
</tr>
<tr>
<td>Transitioned from FAST PATH</td>
<td><strong>53.8% (7)</strong></td>
</tr>
<tr>
<td>Lost to Follow-up</td>
<td>23.1% (3)</td>
</tr>
</tbody>
</table>
Subsequent readmissions, admissions, and ED use decrease after Addiction Medicine consult, LOS increases slightly.

**Admission rate**
*Average admissions per year*

- Pre-consult: 2.92
- After consult: 2.12

**30d readmission rate**
*Average admissions per year*

- Pre-consult: 44.3%
- Index visit: 12.2%
- After consult: 26.8%

**ED utilization rate**
*Average ED visits per year*

- Pre-consult: 10.0
- After consult: 6.6

**Inpatient length of stay**
*Average length of stay, excluding outliers*

- Pre-consult: 4.6
- Index visit: 5.9
- After consult: 5.5

Source: Internal BMC data; January 2015-December 2015. Slide provided by A Walley
Faster Paths To Treatment: Opioid Urgent Care Center
(Boston Medical Center, Bernstein 2016)

- Rapidly evaluate, motivate, and refer patients with substance use disorders to a comprehensive care network of inpatient and outpatient detoxification, treatment, and aftercare services integrated with mental health and medical care.

- Incorporate and build upon the existing addiction services provided by Boston Medical Center (BMC) and Boston Public Health Commission (BPHC), filling the gaps in care to create a seamless continuum. 
  - recovery coaching, overdose prevention and naloxone, SBIRT, OBOT

- Provide daily access to Medication Assisted Treatment (MAT) in the new Faster Paths Outpatient Clinic
  - co-located with ED & urgent care clinic
Faster Paths to Treatment: Continuum of Services

BPHC PAATHS RECOVERY SPECIALISTS
Transportation, Referral & Coaching

BMC PROJECT ASSERT
CENTRAL INTAKE
Registration, Harm Reduction, Motivation & Referral

Medical Evaluation
BMC UCC

Behavioral Health Evaluation

ATS/DETOX
CSS, TSS, MAT
Residential & Shelters

RN/MD
MAT CLINIC
Buprenorphine, Naltrexone Induction/Stabilization Methadone Access

OBAT Maintenance Programs
Becoming more of the solution: RI Centers of Excellence in MAT

First one opening by end of the year
In community
Hospital-affiliated
Geographically dispersed
Electronic Medical Record based and linked
<table>
<thead>
<tr>
<th></th>
<th>Inpatient</th>
<th>ED</th>
<th>Center of Excellence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Standardized assessment, check PDMP</td>
<td>• Standardized assessment, check PDMP</td>
<td>• One-stop assessment, intake on 2nd visit for hotline referrals, walk-ins</td>
</tr>
<tr>
<td></td>
<td>• Universal safe opioid use, storage, disposal, pain alternatives counseling + OEND for patients prescribed &gt;50 MME, opioid+benzo</td>
<td>• Universal safe opioid use, storage, disposal, pain alternatives counseling + OEND for patients prescribed &gt;50 MME, opioid+benzo</td>
<td>• Referrals from ED, inpatient: continue or begin induction</td>
</tr>
<tr>
<td></td>
<td>• Addiction consult service: initiation or continuation of MAT, patient centered</td>
<td>• Addiction consult service: initiation of MAT, hotline referral</td>
<td>• Patient Centered MAT, urine drug screen/check PDMP for safety</td>
</tr>
<tr>
<td></td>
<td>• Anchor ED</td>
<td>• Anchor ED + OEND for overdose survivors</td>
<td>• Transition to community providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discharge planning per law</td>
<td>• Recovery coach + OEND</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Summary & Recommendations

- Many missed opportunities in hospital, ED settings to engage those out of treatment
- Importance of patient safety, recovery focused and harm reduction oriented services
- Access to MAT providers (e.g., Centers of Excellence) critical to creating and maintaining high standard of care
- There are essential, replicable components to high quality care provision in ED, hospital for people prescribed opioids for pain and people with opioid use disorder, with huge potential for benefit
- Recommend leveled approach
Proposed Voluntary Designation Levels for Hospitals

**Level 1**
- Maintains a Center of Excellence or comparable program for inductions, re/stabilizing patients on MAT, transitioning to/from community care

**Level 2**
- Initiates MAT (methadone, buprenorphine, naltrexone) in ED and inpatient, and provides active referral to community provider

**Level 3**
- Standardized SUD assessment, check PDMP
- Universal safe opioid use, storage, disposal patient education
- Naloxone for high dose opioids, opioid+ benzodiazepine, hx of SUD, post-overdose
- Anchor ED, Anchor inpatient
- Discharge planning per law
- Hotline/referral to treatment in community

Voluntary process, self-declaring
Public, transparent documentation of components
**All hospitals should be at least Level 3**
There’s Work to Be Done

Thank you!

Traci.c.green@brown.edu
tcgreen@bu.edu