Draft
Emergency Department & Hospital Standards for Rhode Island

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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 [1]
- 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 [2]

Healthcare institutions are a **source of opioids**

- 91% of RIH trauma service patients discharged home with an opioid [3]

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

1 A Walley, Developing an Addiction Medicine Consult Service, Addiction Medicine Fellowship Directors meeting, Baltimore, MD; April 2016. 2 Herzig SJ, Rothberg MB, Cheung M, Ngo LH, Marcantonio ER. Opioid utilization and opioid-related adverse events in nonsurgical patients in US hospitals. J Hosp Med. 2014 Feb;9(2):73–81. 3 J Baird, SOPP Study Preliminary Findings, Boston Medical Center IPC Grand Rounds, April 2016.

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

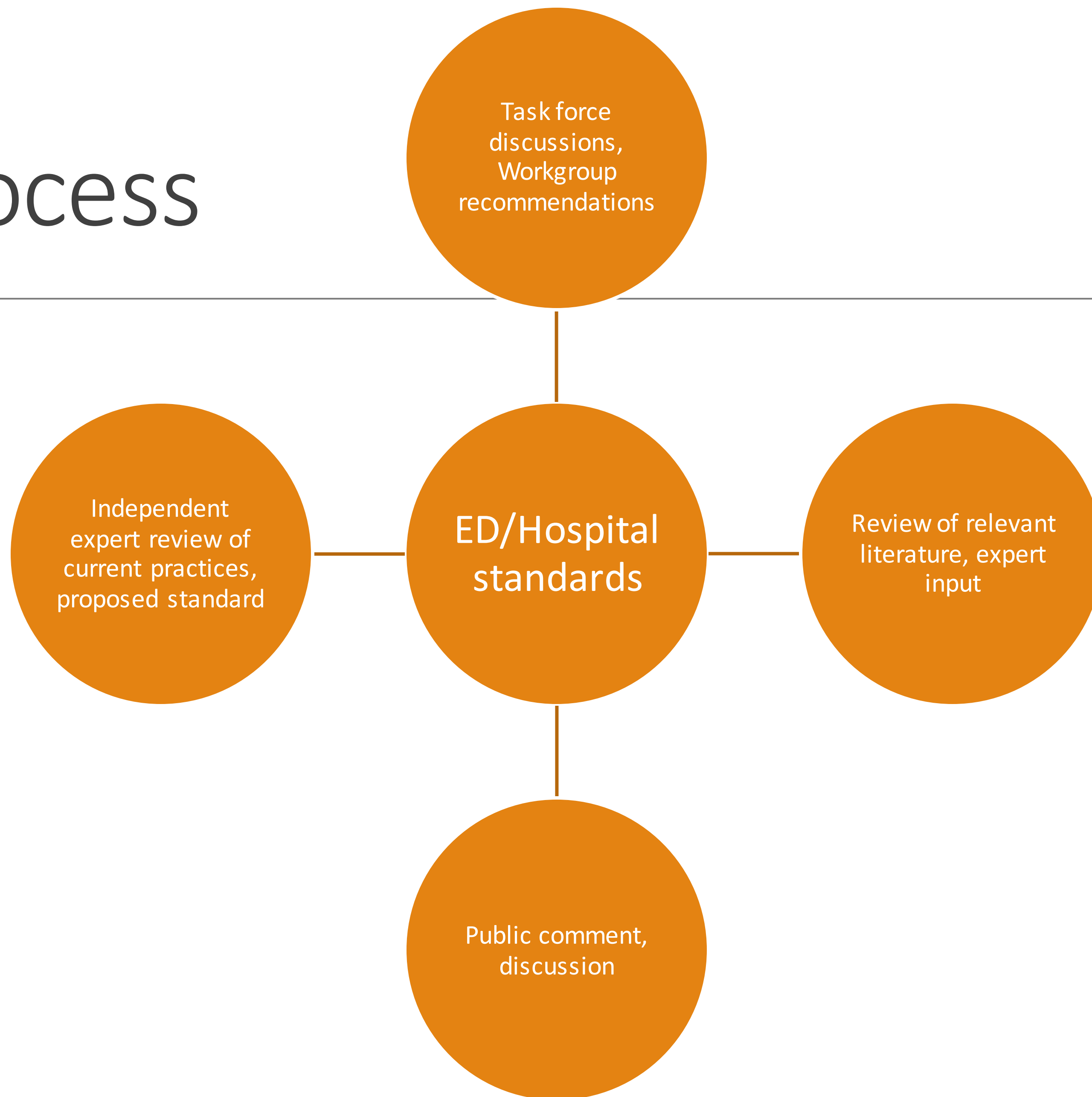
Objective

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



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

We're concerned about your next use and the serious danger for you.

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

Co-morbidity	RIH	BMC
Respiratory Disease	9 (4.7%)	12 (7.2%)
Renal Disease	2 (1.0%)	2 (1.5%)
Cardiac Disease	6 (3.1%)	3 (1.9%)
Liver Disease	12 (6.3%)	1 (0.62%)
Alcohol/Substance Abuse (last 12 months)	8 (4.2%)	5 (3.1%)
Medication		
SedativeHomeMedication_Risk	41 (21.5%)	1 (0.62%)
SedativePrescribed to Take home_Risk	30 (15.7%)	4 (2.5%)
Both Home and Prescribed to take home Risk	10 (5.2%)	10 (6.2%)
Benzodiazapene Use	18 (9.4%)	0 (0.0%)
Methadone/Buprenorphine Use	7 (3.7%)	3 (1.9%)
Opioid Dose > 100 (Mev)	61 (31.9%)	4 (2.5%)
Home Medication Prescription Opioid Use	18 (9.4%)	15 (9.3%)

No naloxone prescribed

Survey Shows Little Safe Opioid Advising:
Becoming less of the problem

Safe Medication use during discharge from hospital's trauma service (RIH, N=51):	No %
Anyone reviewed prescription pain med with you	10
Advised about not using pain medications with alcohol	40
Advised about taking pain medication with other medications	47
Discussed not sharing pain medications with others	42
Discussed safe storage	62
Discussed safe disposal	87
Discussed unintentional prescription overdose	87
Discussed about naloxone/Narcan Given a prescription for naloxone/Narcan	96 100

Best Practice Advisories (BPAs) in EMR can guide care

Opioid discharge prescription strength

For providers ordering any discharge opioid

Serves as a reminder of dosing equivalents, also contributes to overdose risk based on user response

Risk for overdose, naloxone recommendation

Appears in discharge navigator for providers

Suggests intranasal naloxone Rx when patient meets risk criteria

Patient Education

Appears for nurses in the shift or discharge navigators

Reminder to add opioid safety and/or naloxone education

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

BestPractice Advisory - Traumaseven,Cmm

Care Guidance (Advisory: 1)

You are ordering an discharge prescription for an opiate. Please refer to the table below and respond whether or not the medication has a Morphine Equivalent Value of >= 100 mg.

Prescribed Drug	**Dose in mg**	**Frequency/maximum time per days**	**Amount** (Dose X max frequency)	**Morphine equiv. value**
oxycodone	2.5	Q 2 hrs (max = 12 times/day)	30	**45**
oxycodone	2.5	Q 4 hrs (max = 6 times/day)	15	**22.5**
oxycodone	2.5	Q 3 hrs (max = 8 times/day)	20	**30**
oxycodone	5	Q 3 hrs (max = 8 times/day)	40	**60**
oxycodone	7.5	Q 3 hrs (max = 8 times/day)	60	**90**
oxycodone	10	Q 3 hrs (max = 8 times/day)	80	**120**
oxycodone	15	Q 3 hrs (max = 8 times/day)	120	**180**
oxycodone	20	Q 3 hrs (max = 8 times/day)	160	**240**
oxycodone	2.5	Q 4 hrs (max = 6 times/day)	15	**22.5**
oxycodone	5	Q 4 hrs (max = 6 times/day)	30	**45**
oxycodone	10	Q 4 hrs (max = 6 times/day)	60	**90**
oxycodone	15	Q 4 hrs (max = 6 times/day)	90	**135**
oxycodone	5	Q 6 hrs (max = 4 times/day)	20	**30**
oxycodone	15	Q 6 hrs (max = 4 times/day)	60	**90**
oxycodone	5	Q 8 hrs (max = 3 times/day)	15	**22.5**
Percocet (oxycodone + acetaminophen)	5	Q 4 hrs (max = 6 times/day)	30	**45**
Percocet (oxycodone + acetaminophen)	5	Q 6 hrs (max = 4 times/day)	20	**30**
Percocet (oxycodone + acetaminophen)	10	Q 4 hrs (max = 6 times/day)	60	**90**
hydrocodone/acetaminophen	5	Q 4 hrs(max = 6 times/day)	30	**30**
hydrocodone/ acetaminophen	10	Q 4 hrs(max = 6 times/day)	60	**60**
hydromorphone	6	Q 4 hrs(max = 6 times/day)	36	**144**
hydromorphone	4	Q 4 hrs(max = 6 times/day)	24	**96**
hydromorphone	2	Q 4 hrs(max = 6 times/day)	12	**48**
morphine	30	Q 3 hrs (max = 8 times/day)	240	**240**

Acknowledge Reason

Yes - MEV >= 100 mg | No - MEV < 100 mg

Accept

BPA Alert

Care Guidance (Advisory: 1)

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
830 Chalkstone Avenue
Providence RI 02908-4799
Phone: 401-273-7100 Fax: 401-525-2507

Meds that increase risk:

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

Acknowledge Reason

Does not meet criteria | Patient declines | Not prescribed at this time | Discharge to nursing home

Apply Selected

Cleaner layout

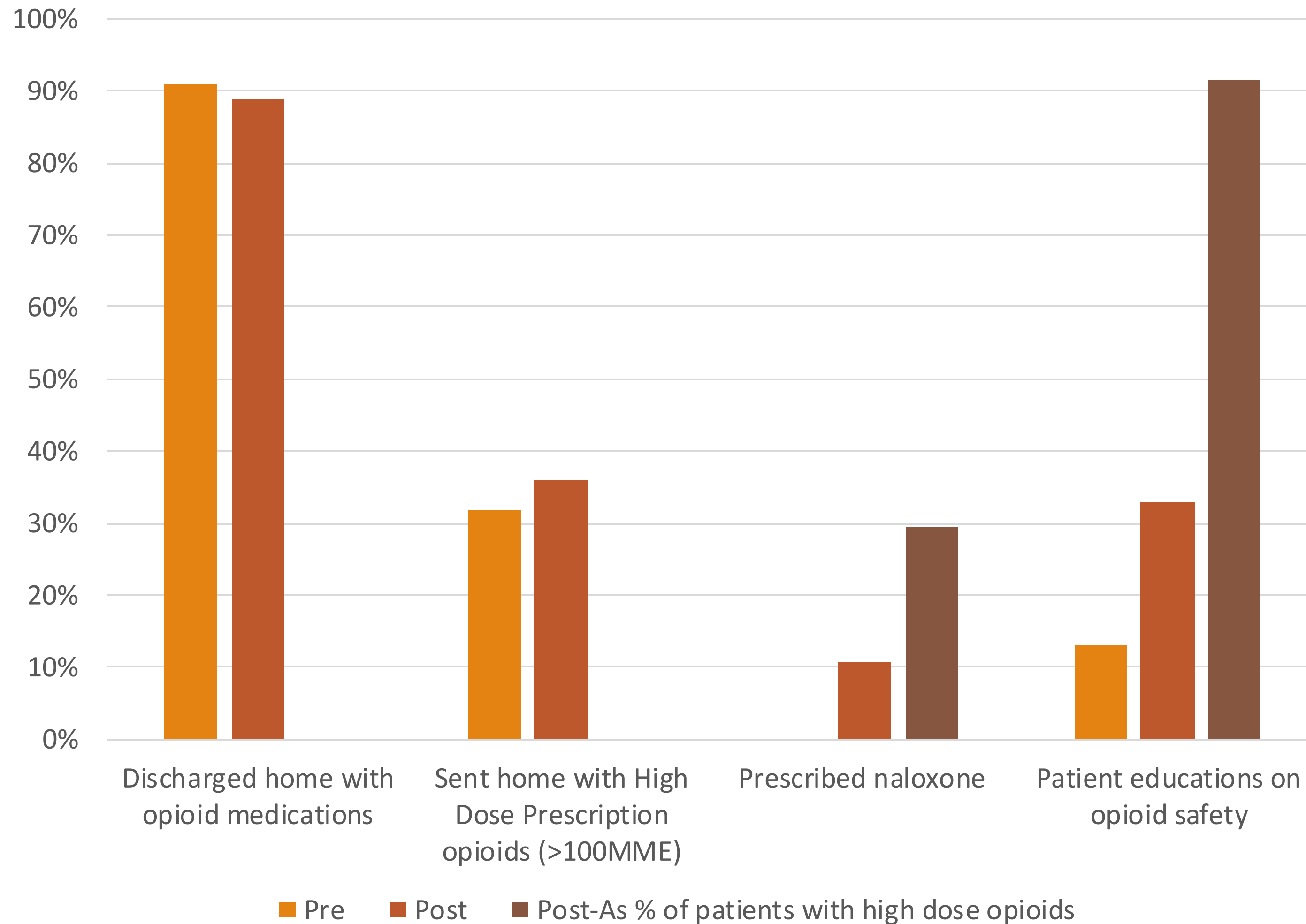
Qualifying patient data displayed

Follow-up orders Consolidated from 3 items to 2

Activity links removed d/t minimal use

SOPP Early Implementation:

becoming less of the problem and more of the solution:



Examples in Nearby Hospitals

Becoming more of the solution:

Integrating Medication Assisted Treatment into the Hospital Setting

ORIGINAL RESEARCH

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, MPH[1,2], *Donna Beers, RN, BSN, CARN*[2,4], *Daniel P. Alford, MD, MPH*[1,2], *Eileen Brigandi*[4], *and Jeffrey H. Samet, MD, MA, MPH*[1,2,3,4]

[1]Clinical Addiction Research and Education (CARE) Unit, Section of General Internal Medicine, Department of Medicine, Boston University School of Medicine, Boston, MA, USA; [2]Boston Medical Center, Boston, MA, USA; [3]Department of Social and Behavioral Sciences, Boston University School of Public Health, Boston, MA, USA; [4]Division of Substance Abuse Prevention and Treatment Services, Boston Public Health Commission, Boston, MA, USA.

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

KEY WORDS: harm reduction; opioid dependence; methadone; addiction treatment.
J Gen Intern Med 25(8):803–8

Research

Original Investigation

Buprenorphine Treatment for Hospitalized, Opioid-Dependent Patients
A Randomized Clinical Trial

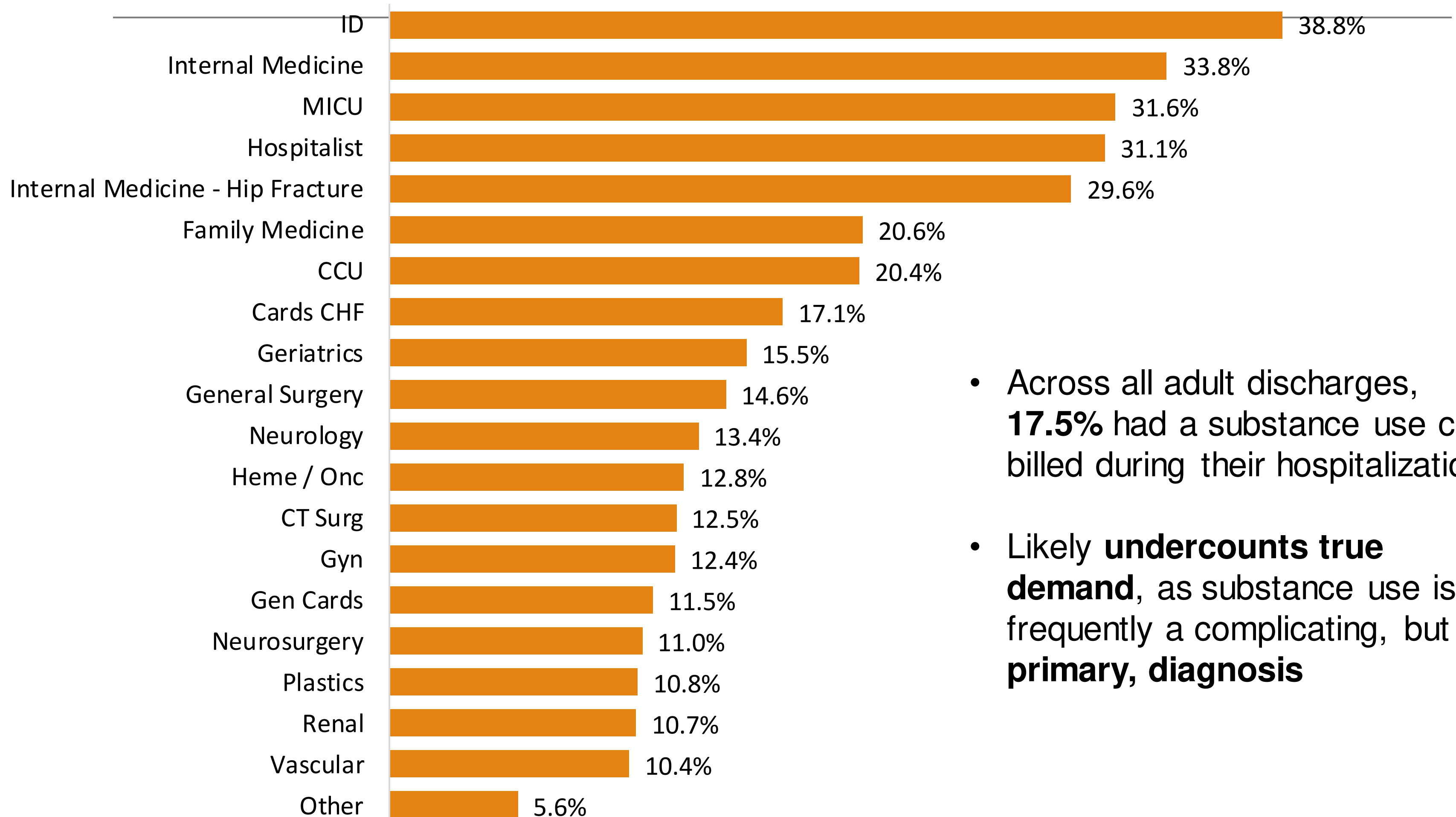
Jane M. Liebschutz, MD, MPH; Denise Crooks, MPH; Debra Herman, PhD; Bradley Anderson, PhD; Judith Tsui, MD, MPH; Lidia Z. Meshesha, BA; Shernaz Dossabhoy, BA; Michael Stein, MD

JAMA Intern Med. 2014;174(8):1369-1376. doi:10.1001/jamainternmed.2014.2556
Published online June 30, 2014.

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

Kinna Thakarar,[1] Zoe M Weinstein,[2] Alexander Y Walley[2]

Substance use is pervasive across inpatient populations



- 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

1 States. *Simpson DD, Savage LJ.* Treatment re-entry and outcomes of opioid addicts during a four-year follow-up after drug abuse treatment in the United *Bull Narc. 1980;32(4):1-10.*; 2 *Simpson DD.* Treatment for drug abuse. Follow-up outcomes and length of time spent. *Arch Gen Psychiatry. 1981 Aug; 38(8):875-80.*

Hospital-based Addiction Consult Service

Boston Medical Center ACS started July 17, 2015

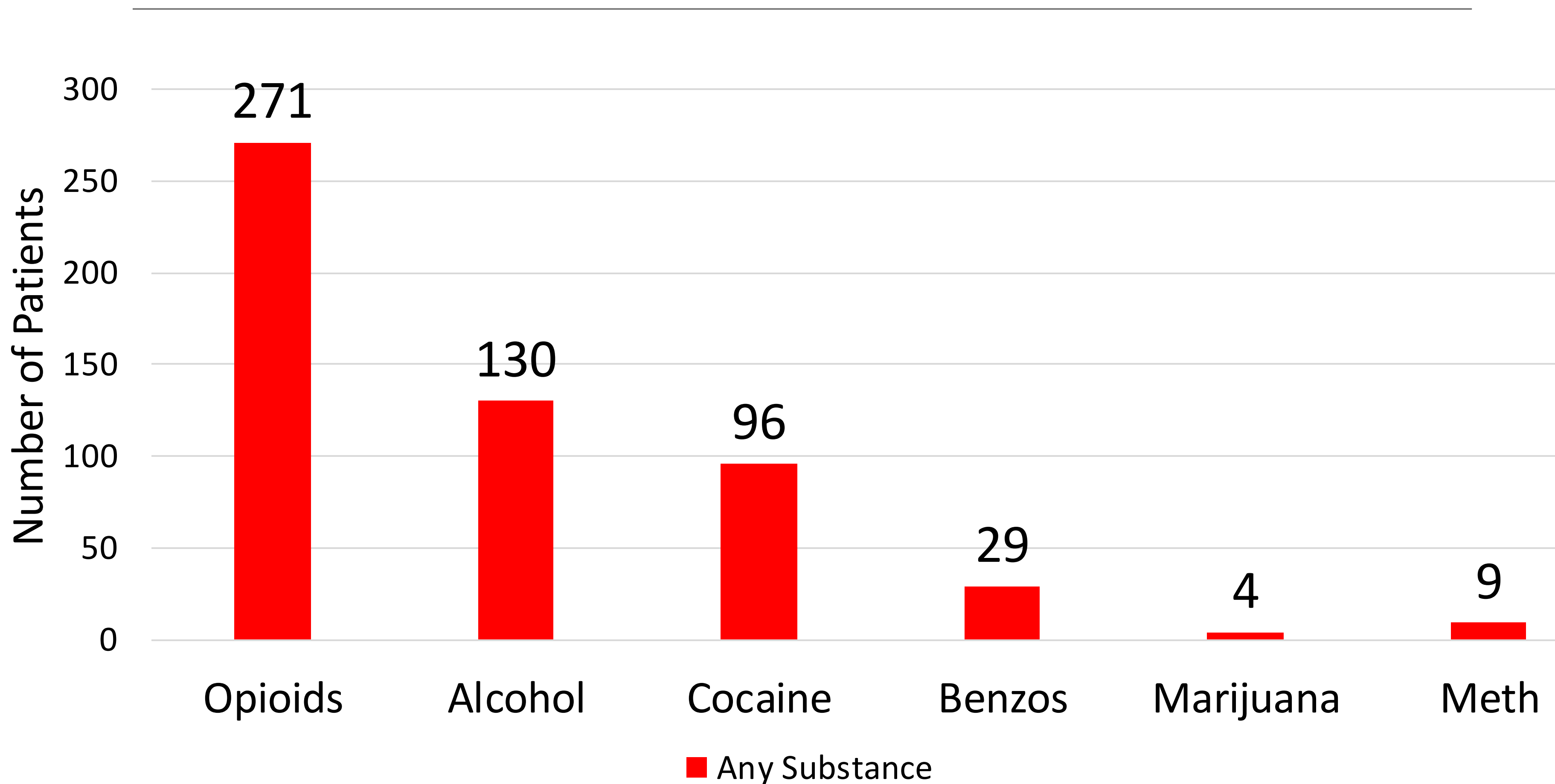
Goals:

- 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:

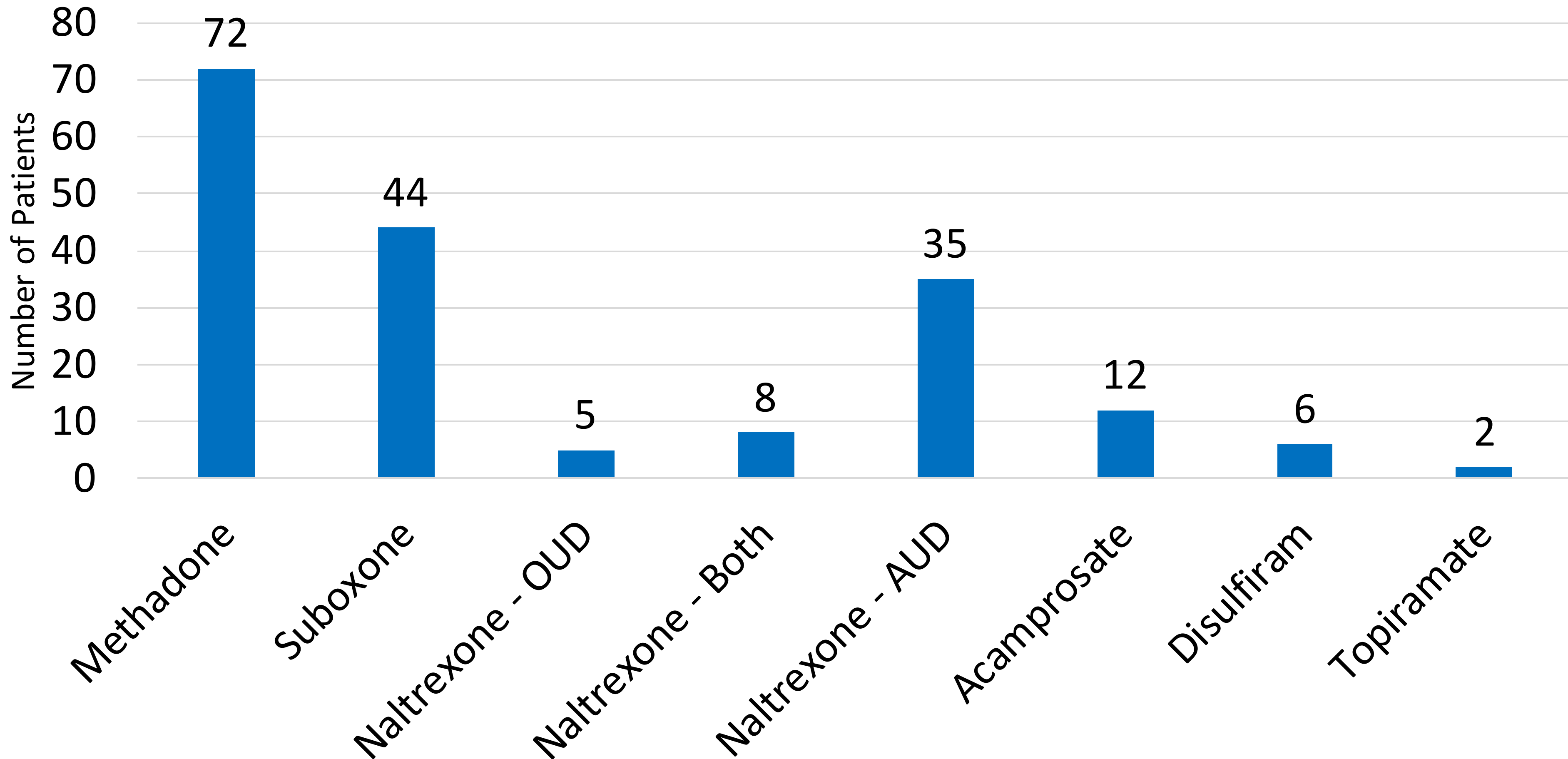
- Medicine attending (afternoons)
- Addiction Medicine Fellow (when available)
- 1-2 Internal medicine or family medicine residents full-time (when available)
- Nurse/RN 0.5FTE
- Daily coordination with Social Work and Project ASSERT (LADC, peer recovery coaches)
- Weekly joint rounds with Psychiatry C/L on Wednesdays

Patients Seen: July 17, 2015 – January 17, 2016

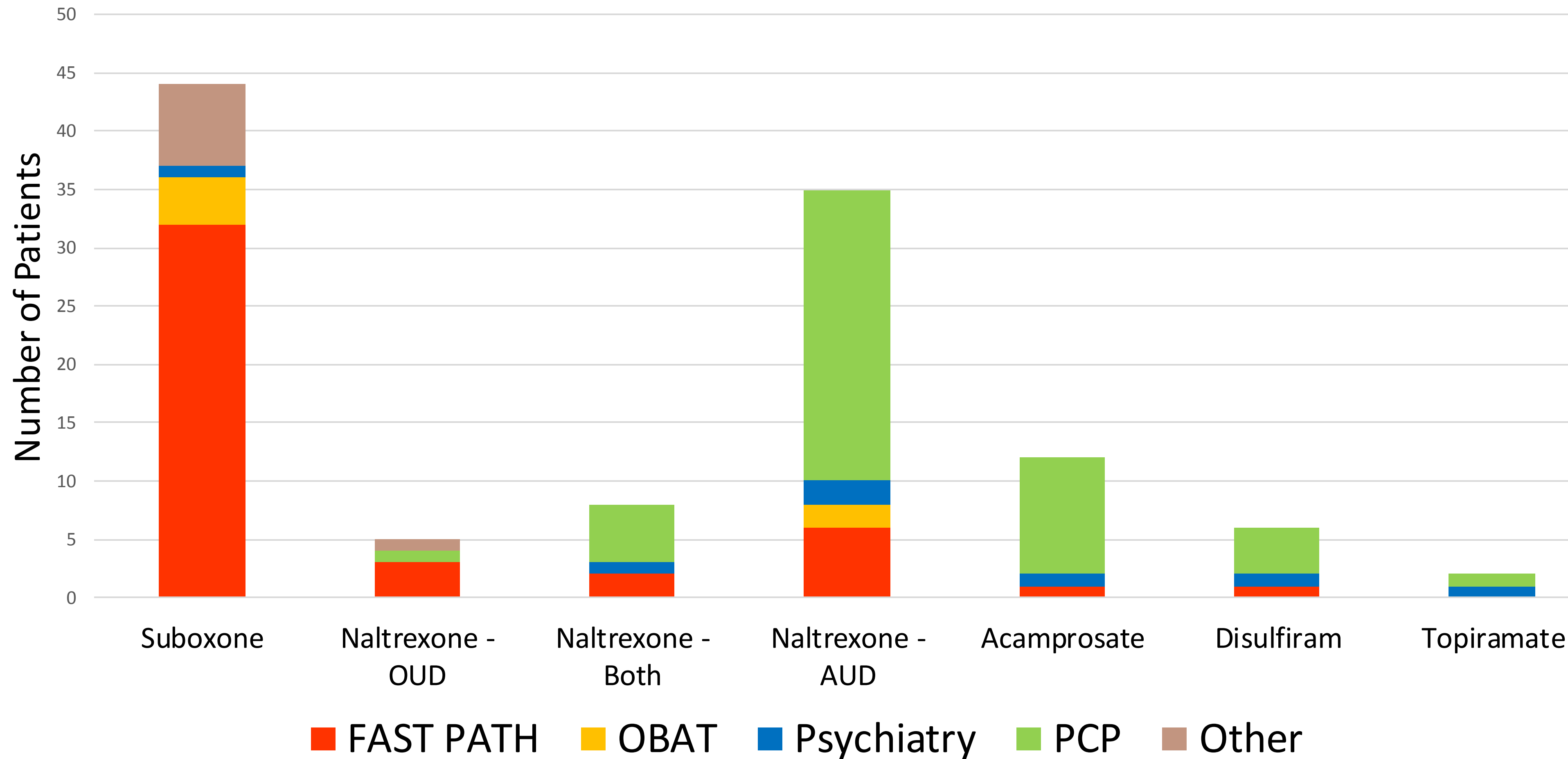


Data provided by A. Walley, presented at the Annual meeting of the College on Problems of Drug Dependence, La Quinta, CA, June 2016

Treatments Initiated: July 17, 2015 – January 17, 2016



Linkage to Care: July 17, 2015 – January 17, 2016



Linkage to Care: July 17, 2015 – January 17, 2016

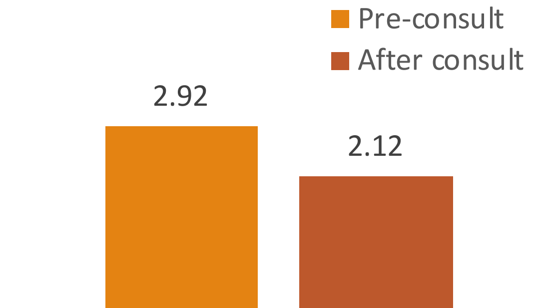
	Referred for outpatient linkage
Methadone Maintenance at CSAC	N=66
Showed	**79%** (52)
No Showed	21% (14)
Buprenorphine at BMC	N=37
Showed	49% (13)
No Showed	**51%**(18)
Naltrexone at BMC	N=16
Showed	25.0% (4 – all AUD)
No Showed	**75.0%** (12)

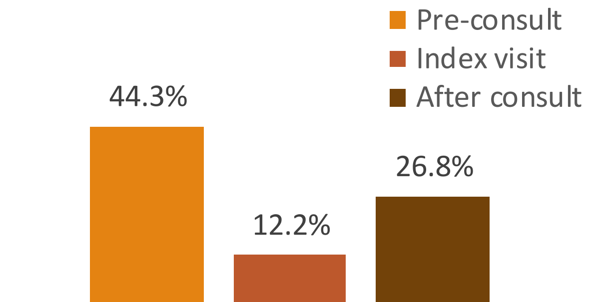
Data provided by A. Walley, presented at the Annual meeting of the College on Problems of Drug Dependence, La Quinta, CA, June 2016

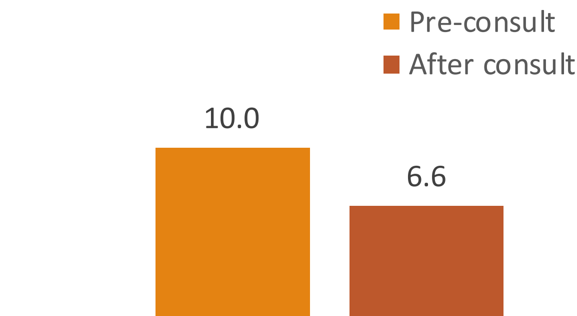
Follow-up:
July 17, 2015 – January 17, 2016

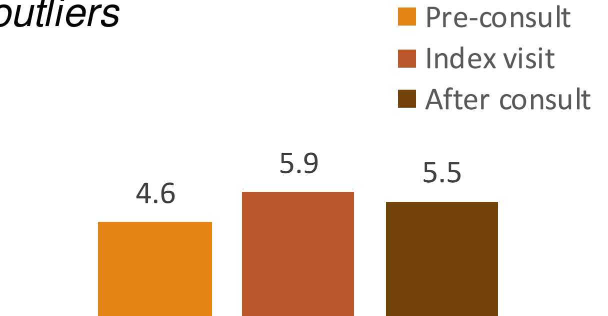
	Referred for outpatient linkage
Methadone Maintenance at CSAC	N=52
Still Dosing, <30 Days at Clinic	7.7% (4)
Still Dosing at >30 Days	**65.4% (34) –** 52.8% (38/72)
No Longer at Clinic	26.9% (14)
Buprenorphine at FAST PATH	N=13
Still at FAST PATH	23.1% (3)
Transitioned from FAST PATH	**53.8% (7)**
Lost to Follow-up	23.1% (3)

Subsequent readmissions, admissions, and ED use decrease after Addiction Medicine consult, LOS increases slightly









Source: Internal BMC data; January 2015-December 2015. Slide provided by A Walley

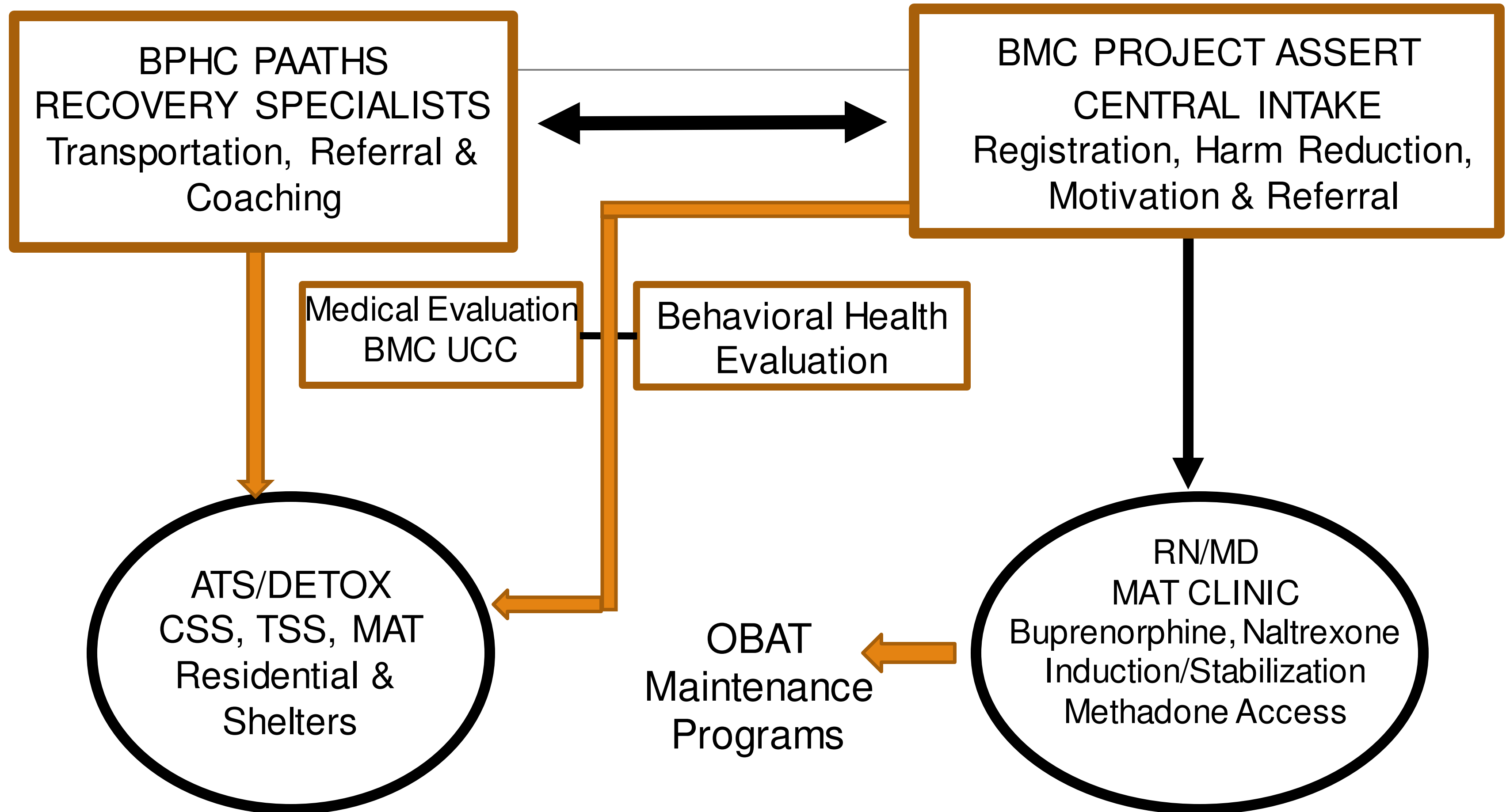
Faster Paths To Treatment: Opioid Urgent Care Center
(Boston Medical Center, Bernstein 2016)

- **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



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

- Standardized assessment, check PDMP
- Universal safe opioid use, storage, disposal, pain alternatives counseling +OEND for patients prescribed >50 MME, opioid+benzo
- Addiction consult service: initiation or continuation of MAT, patient centered
- Anchor ED

ED

- Standardized assessment, check PDMP
- Universal safe opioid use, storage, disposal, pain alternatives counseling +OEND for patients prescribed >50 MME, opioid+benzo
- Addiction consult service: initiation of MAT, hotline referral
- Anchor ED+OEND for overdose survivors
- Discharge planning per law

Center of Excellence

- One-stop assessment, intake on 2nd visit for hotline referrals, walk-ins
- Referrals from ED, inpatient: continue or begin induction
- Patient Centered MAT, urine drug screen/check PDMP for safety
- Transition to community providers
- Recovery coach + OEND

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 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

Level 2

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

Level 1

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

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!

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