

Recommendations for Components of Emergency Department Discharge Protocols

Background

Maryland, like many other states, is in the midst of an opioid crisis. In 2016, 89 percent of all intoxication deaths in the state were related to opioids.¹ Further, between 2015 and 2016, opioid-related deaths increased by 70 percent, and have almost quadrupled since 2010.² The state government has dedicated more than \$22 million to fight the heroin and opioid epidemic with initiatives related to prevention, enforcement, and treatment.³ Hospitals are often on the front lines in prevention and treatment for patients with substance use disorders, including those with opioid overdose. As such, it is an important time for hospitals to assess their policies and guidance related to this patient population.

In 2015, the Maryland Hospital Association's (MHA) Council on Clinical and Quality Issues (CCQI) developed provider-focused opioid prescribing guidelines which were voluntarily adopted by every Maryland hospital. These guidelines consisted of eight recommendations designed to promote a general standard on opioid utilization and prescribing within Maryland. For example, they recommend that emergency department (ED) providers consult the Maryland Prescription Drug Monitoring Program before writing an opioid prescription, advise prescribing no more than a short course and minimal amount of opioid analgesics lasting no more than three days, encourage hospitals to develop a process to share the ED visit history of patients with other providers and other hospitals, and discourage ED providers from providing prescriptions for lost, destroyed or stolen substances.⁴ While the recommendations were focused on the hospital ED, it was acknowledged that a comprehensive effort that includes providers beyond emergency medicine is needed to effectively address this problem.

MHA continued to assess implementation of the prescribing guidelines and convened conversations about additional opportunities to address the state's opioid crisis, which by March 2017, was the subject of a State of Emergency declaration by the governor. MHA supported the Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017, which among other provisions aimed at mitigating Maryland's crisis, requires that hospitals have a discharge protocol in place for patients treated for an overdose or identified as having a substance use disorder. Hospitals must report these protocols to MHA beginning in 2018. MHA clarified with the Senate sponsor that the legislative intent was for hospitals to have these discharge protocols in place for patients treated in

¹ Maryland Department of Health and Mental Hygiene, Alcohol and Drug Abuse Administration. *Drug- and Alcohol-Related Intoxications Deaths in Maryland, 2016*. June 2017.

² Ibid.

³ *Changing Maryland for the Better*. One pager distributed at the September 26, 2017 Legislative Briefing to the Joint Committee on Behavioral Health and Opioid Use Disorders.

⁴ Maryland Hospital Association. *Maryland Emergency Department Opioid Prescribing Guidelines*. 2015.

emergency departments. Accordingly, MHA is requesting that hospitals, at a minimum, submit their discharge protocols within the scope of their emergency departments. Hospitals are encouraged to also share discharge protocols for the inpatient setting for this patient population if they are available.

To support hospitals' efforts to meet this requirement, MHA convened a series of Clinical Conversations in the fall of 2017, during which hospital ED and clinical leaders met to develop a consensus on recommended components for an ED discharge protocol. As a result of these forums, hospital representatives agreed that it is important to include components related to universal screening, naloxone access, referrals to treatment, and use of non-clinical personnel.

This paper provides a summary of the key takeaways from these forums, including recommendations, considerations, and resources intended to support the development of a hospital's ED discharge protocol for patients treated for an overdose, or identified as having a substance use disorder. Consideration and implementation of the recommendations should be done in collaboration with medical staff, clinical leadership, and legal counsel.

While hospitals must begin submitting protocols to MHA in 2018, it is understood that protocols will likely be revised over time, depending on their implementation experience, availability of resources and patient outcomes. There was widespread recognition that the manner in which these components are incorporated into a protocol will vary to account for a hospital's patient population and substance use epidemiology, and access to community and hospital-based resources.

Recommendations and Discussion

- 1. To the extent possible, hospitals should universally screen for substance use disorder among patients who present in the ED.** Hospitals agreed that screening -- defined as the application of a simple test to determine whether a patient is at risk for or may have an alcohol or substance use disorder -- is an important piece of the ED admission and discharge process. Screening will help providers make patient-specific treatment decisions and recommendations for follow-up care and/or monitoring.

Of the hospitals that currently screen universally in the ED, there were differences in the types of screening tools used. It was agreed that providers should use evidence-based screening tools that are most meaningful for their patient populations. One evidence-based process used in some hospitals is SBIRT (Screening Brief Intervention and Referral to Treatment), which aims to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs.⁵ General information on this program and links to free training can be found here:

<https://bha.health.maryland.gov/Pages/SBIRT.aspx>

There were also differences in the ages at which hospitals started screening patients for substance use disorder -- some started as young as 12, while others started at 16. It was noted

⁵ SAMHSA-HRSA Center for Integrated Health Solutions. *SBIRT: Screening, Brief Intervention and Referral to Treatment. Opportunities for Implementation and Points for Consideration.*

that several validated screening tools for youth exist, such as CRAFFT,⁶ as well as others that are designed to capture other factors, such as drug use in the household.

Challenges	Possible Mitigation Strategies
Some hospital representatives expressed concerns that the additional time it takes to screen patients would further lengthen ED wait times, which is at odds with forthcoming payment policy seeking to reduce wait times.	<p>Representatives from hospitals that universally screen in the ED noted that screening could be incorporated into the existing electronic medical record questionnaires that nurses administer in triage. Examples of brief, evidence-based screening tools -- consisting of only one to a few questions -- were shared by hospital representatives who noted that they did not take much additional time.</p> <p>Hospital representatives also noted the importance of having an advocate on their leadership team champion a universal screening effort.</p>

Several billing codes allow physicians to be reimbursed for screening and brief intervention services: http://www.integration.samhsa.gov/sbirt/Reimbursement_for_SBIRT.pdf.

Additional information about alcohol and drug use screening tools and hospital experience with universal screening can be found here: <http://www.mhaonline.org/docs/default-source/Resources/Opioid-Resources-for-Hospitals/webinar-series-september-12-2017.pdf?sfvrsn=2>

- Hospitals should offer naloxone to patients who present in the ED with an opioid overdose, and to patients deemed to be at risk for opioid use disorder, either by dispensing directly from the ED or by providing a prescription.** Hospitals agreed that a patient who presents in the ED with an opioid overdose should receive naloxone. The group also reached consensus that patients who screen positive for opioid use disorder during the ED visit should receive at least a prescription for naloxone. Some hospitals directly dispensed naloxone, which was generally preferred over writing a prescription. Hospital interpretation of scope of practice varied on which staff can provide naloxone -- specifically, some do not allow nurses to dispense it. It was noted that prescriptions for naloxone may also be appropriate for patients taking opioids for chronic pain.

Challenges	Possible Mitigation Strategies
The cost of naloxone may serve as a barrier to patients filling a prescription. Rising costs were also identified as a barrier to dispensing from the ED.	Of the hospitals that dispense naloxone, representatives discussed how they either look for lower cost formulations, obtained the drug from their local health department, or have used

⁶ CRAFFT is a behavioral health screening tool for use with children ages 12-18 and is recommended by the American Academy of Pediatrics' Committee on Substance Abuse with adolescents. It consists of a series of 6 questions developed to screen adolescents for high risk alcohol and other drug use disorders simultaneously. It is a short, effective screening tool meant to assess with a longer conversation about the context of use, frequency, and other risks and consequences of alcohol and other drug use is warranted.

<p>Grant funding, which some hospitals used to support take-home kits, is not sustainable.</p> <p>Some retail pharmacies in certain areas did not keep naloxone in stock, which prevented patients from filling a prescription quickly.</p> <p>Some hospitals cited physical space, time, and staffing constraints associated with providing training to patients on naloxone use.</p> <p>Patients often do not want to stay in the ED long enough to get training and/or the naloxone prescription.</p>	<p>grants to purchase it. Strategies include using local health departments to train hospital ED staff, which enabled them to train patients and/or family members. Other hospitals use peers to deliver patient education while others use a training video on a laptop for patients and/or family members.</p>
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Additional information about naloxone prescribing and dispensing, including hospital experiences with naloxone in the ED, can be found here: <http://mhaonline.org/docs/default-source/Resources/Opioid-Resources-for-Hospitals/july-11-presentation.pdf?sfvrsn=4>

- 3. Hospitals should refer patients who screen positive for substance use disorder to treatment, ideally using a facilitated referral approach if possible.** Hospitals agreed that referrals to treatment are an essential component to the discharge protocol for this patient population. Ideally, a facilitated referral is preferred to simply providing a patient with a list of treatment centers at discharge. A facilitated referral can involve a range of tasks that are designed to encourage a patient to go to his or her first appointment at the treatment center after being discharged. These tasks may be as basic as staff placing follow up calls to the patient and or the treatment center, or as involved as partnering to arrange for the next provider to meet the patient prior to discharge, or to arrange for patient transportation to treatment. Substance use disorder patients should receive treatment similar to that of a heart attack patient who, once stable in the ED, would receive a facilitated referral to a cardiologist.

<u>Challenges</u>	<u>Possible Mitigation Strategies</u>
<p>Hospitals may not have the staffing needed to refer patients to treatment using a facilitated referral approach.</p> <p>Referring patients to treatment on the weekends and at night can be especially challenging given staffing constraints and available treatment center hours.</p> <p>A hospital’s ability to provide a facilitated referral can largely be dictated by the resources it has available to it in its</p>	<p>To the extent possible, hospitals may want to use non-clinical personnel, such as peer recovery counselors, to execute the referral to treatment. If peer recovery counselors are unavailable, social workers or case workers may be used for referral services.</p> <p>Hospitals should ensure that they have fostered relationships with treatment centers in their surrounding communities. The first step may</p>

surrounding community. There are vast differences in the number of treatment centers available to hospitals depending on location.	be working with the health department to make these connections. In cases where treatment resources are sparse, telehealth may be an option.
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4. **To the extent possible, hospitals should incorporate the use of non-clinical personnel into their processes for treating and discharging patients treated for an opioid overdose, and those identified as having a substance use disorder.** Hospital representatives saw value in using non-clinical personnel, such as peer recovery counselors and community health workers in the treatment and discharge process for these patients. Specifically, in addition to referring patients to treatment, non-clinical personnel were typically used to explain screening results to patients, to provide them with information on safe use, to assess their readiness to change, and to advise them on how to change.

<u>Challenges</u>	<u>Possible Mitigation Strategies</u>
Hospitals cited cost, training staff, limited availability, liability concerns, and retention as barriers. Grants used to fund peer recovery counselors will expire, leaving the hospitals to devise another way to finance the cost of sustaining them.	Among the hospitals that used peer recovery counselors, including those participating in the state’s SBIRT or Overdose Survivors Outreach Program, many were doing so under a grant-funded initiative with training of peers provided by an outside group. Others were partnering with local health departments who employ the peers, who are then deployed at the hospital. Other hospitals discussed leveraging existing social work or case management staff to support components of the protocol.
Non-clinical personnel, including peer recovery counselors and community health workers, are not typically available to hospitals 24 hours a day.	Hospitals schedule peer recovery counselor shifts during peak times.

Other Potential Elements

Hospital representatives discussed additional potential elements of an ED discharge protocol, including doing a full behavioral health assessment, and administering an initial dose of buprenorphine in the ED.

- ***Providing a full behavioral health assessment.*** Behavioral health assessments include psychiatric tests performed to allow the ED staff to understand the patient’s mental health. One hospital’s protocol calls for ED physicians to order a psychiatric consult for patients suspected to have a substance use disorder or who are being treated for an overdose. However, among the few hospitals that did include behavioral health assessments in their discharge protocols, most seemed to rely on providers’ judgment about when a patient may need one. For example, an ED physician may not order a behavioral health assessment if the patient’s mental health status is already known in the system.

During the forums, representatives from a few hospitals talked about how they dedicate behavioral health staff to the ED for 24 hours daily, though most did not. One of the hospitals that followed this practice said that having the behavioral health staff readily available to deal with more complicated patients alleviated the strain on other ED staff, who could deal with other emergencies. This has lowered readmissions.

- ***Administering an initial dose of buprenorphine in the ED.*** A small but growing number of hospitals provide an initial dose of buprenorphine in the ED for patients indicating a willingness to enter into treatment. These hospitals consistently stressed the importance of access to treatment within 24 hours before the patient begins to experience withdrawal symptoms and is at greater risk of relapse. Hospitals that were initiating buprenorphine were either using waived providers or a regulatory exception known as the “three-day rule”.⁷ This rule allows a practitioner who is not in an outpatient treatment program or waived under DATA 2000, to administer (but not prescribe) an opioid agonist medication to a patient for the “purpose of relieving acute withdrawal symptoms,” under the following conditions:
 - No more than one day’s medication is administered or given to a patient at one time.
 - Treatment does not exceed 72 hours.
 - The 72-hour period cannot be renewed or extended.⁸

The intent of this regulatory exception is to offer an opportunity to provide relief from acute opioid withdrawal and allow time to arrange for referral and engagement into ongoing care. Hospitals not currently initiating buprenorphine in the ED cited the lack of treatment capacity in their surrounding communities as a key deterrent.

Additional information regarding the state program and experience of hospitals initiating buprenorphine can be found at: <http://www.mhaonline.org/docs/default-source/Resources/Opioid-Resources-for-Hospitals/webinar-series-november-14-2017.pdf?sfvrsn=2>

Operational Considerations

- As with the adoption of the opioid prescriber guidelines, hospitals are encouraged to assess their own population needs in developing their ED discharge protocols. It should be recognized that no recommendation can anticipate all circumstances. Patient clinical information, provider professional judgment, and access to community and hospital-based resources may dictate deviation from these recommendations. It should be noted that the evidence base for these recommendations for ED discharge protocols is still developing. As

⁷ CFR 21 (Part 1306.07(b))

⁸ See a June 6, 2017 memorandum from the Behavioral Health Administration to MHA which details the circumstances in which buprenorphine can be prescribed and or dispensed in an ED: <http://www.mhaonline.org/docs/default-source/Resources/Opioid-Resources-for-Hospitals/ed-prescribing-rules-june-2017---waiver-information-from-dhnh.pdf?sfvrsn=2>

more studies are conducted and the evidence base grows, hospitals should consider revising their ED discharge protocols accordingly.

- Data collection to track the implementation, and where possible, efficacy, of these components is encouraged. For example, hospitals that track the number of naloxone take-home kits that they distribute will help inform resource conversations and calls for funding support at the state and national levels. Other hospitals are tracking the number of patients screened, percent of positive screens that are referred to treatment, and patient adherence to treatment. This data collection and reporting is often done by peer recovery counselors.
- Each ED should identify at least one staff member as a champion who ensures that ED providers are educated and trained on each component in the protocol.
- Effective communication is essential between ED and inpatient providers. In cases when the patient will be admitted to the hospital, the ED and inpatient providers should coordinate so that patient expectations are managed, and treatment protocols are consistent throughout the patient's hospital encounter.

***Disclaimer:** This document should not be used to establish any standard of care. No legal proceeding, including medical malpractice proceeding or disciplinary hearings, should reference a deviation from any part of this document as constituting a breach of professional conduct. These recommendations are only an educational tool. All of the above recommendations should be considered in concert and collaboration with hospital counsel, public health entities and other relevant stakeholders.*

Additional Resources and Protocol Submission Instructions

MHA developed a “**SUD Resources**” SharePoint site for members to share information, literature, and helpful resources related to discharging patients with substance use disorders and/or an opioid overdose from the ED. The site is accessible at:

<https://mhaonline.sharepoint.com/SUDResources/default.aspx>.

MHA is using the **SUD Resources** SharePoint site to receive hospital discharge protocols. Please submit your hospital's approved ED discharge protocol per the requirements of the HOPE Act, by joining SharePoint and uploading the protocol in the “2018 DISCHARGE PROTOCOLS” folder. All protocols should be uploaded no later than January 31, 2018. If you need to gain access to the site, please send an email to Shamonda Braithwaite at sbraithwaite@mhaonline.org. You can also submit your hospital's approved protocol to MHA via [email](#).