



Emergency Discharge Protocols for Patients with Substance Use Disorders and Opioid Overdoses in Maryland's Hospitals

December 2018

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EXECUTIVE SUMMARY

The national opioid crisis has hit Maryland particularly hard. In 2016, Maryland was among the top five states with the highest rates of opioid-related overdose deaths. The number of opioid-related deaths has grown each year since 2010 — nearly quadrupling in the past eight years — largely due to the growing prevalence of synthetic opioids that are mixed into street drugs such as heroin, augmenting its potency. Hospitals are on the front lines of this crisis, often serving as a safety net for patients who overdose on opioids.

In June 2017, Maryland’s legislators passed the Heroin and Opioid Prevention Effort (HOPE) and Treatment Act, which requires hospitals to have a discharge protocol in place for patients treated for an overdose or identified as having a substance use disorder. Hospitals were required to report the protocols to the Maryland Hospital Association (MHA) starting in January 2018. To prepare for this requirement, MHA convened a series of Clinical Conversations, during which hospital emergency department (ED) and clinical leaders met to develop recommendations for ED discharge protocols. As a result of these forums, hospital representatives agreed that it was important to consider four core components in developing an ED discharge protocol:

- 1. Universal Screening:** To the extent possible, hospitals should universally screen for substance use disorder(s) among patients who present in the ED.
- 2. Naloxone Access:** Hospitals should offer naloxone, an antidote that rapidly reverses an opioid overdose by restoring breathing to normal, to patients who present in the emergency department with an opioid overdose, and to patients deemed to be at risk for opioid use disorder, either by dispensing directly from the emergency department or by providing a prescription.
- 3. Facilitated Referral:** Hospitals should refer patients who screen positive for substance use disorder(s) to treatment, ideally using a facilitated referral approach.
- 4. Peer Recovery Services:** To the extent possible, hospitals should incorporate peer recovery services into their processes for treating and discharging patients treated for an opioid overdose and those identified as having a substance use disorder.

MHA collected the discharge protocols and reviewed them for these elements. The results of the protocol review are in the table below. We also highlight key barriers to implementation.

<u>Protocol Element</u>	<u>Percentage of Hospital Protocols Detailing Intervention</u>	<u>Key Barriers to Implementation</u>
Universal Screening	80 percent	Additional time to screen could lengthen emergency department wait times
Naloxone Access	100 percent	Rising costs make it increasingly challenging to maintain stock for dispensing from the emergency department

Facilitated Referrals	84 percent	Lack of information about available treatment options (capabilities, quality) in the surrounding communities and limited supply of appropriate community providers and treatment options, particularly in rural areas
Peer Recovery Services	73 percent	Lack of 24/7 access to peer recovery coaches

Protocols were also reviewed for initiation of medication assisted treatment (MAT) in the ED, as hospital representatives agreed that it is an important consideration. Twenty-seven percent of hospitals indicated that they were providing an initial dose of buprenorphine in the ED to patients after it was determined that it was clinically appropriate. One of the key barriers to hospitals implementing MAT initiation is a lack of treatment capacity in their surrounding communities. That is why MHA’s focus in 2019 will be to work with our hospitals and community partners to increase patient access to all appropriate modalities of medication assisted treatment, whether in the hospital emergency department or in the community.

MHA remains committed to working with partners across the care continuum, as well as policymakers and state agencies, to mitigate barriers associated with hospital-based efforts and to support similar work in other care settings.

BACKGROUND

Maryland was among the top five states with the highest rates of opioid-related overdose deaths in 2016.¹ There were 2,009 opioid related deaths in 2017, representing 88 percent of all intoxication deaths in the state. The number of opioid-related deaths has grown each year since 2010, nearly quadrupling in the past eight years.²

The causes of opioid fatalities have changed over the last few years. In 2017, the number of heroin related deaths decreased by 11 percent in Maryland, and the number of prescription opioid-related deaths decreased by 1 percent. However, overall opioid-related deaths continue to rise due to fentanyl and carfentanil — highly potent synthetic opioids that are much stronger than heroin and increase the risk of overdose. Fentanyl sold on the street is typically mixed with other drugs such as heroin, augmenting its potency. Between 2016 and 2017 the number of fentanyl-related deaths in the state increased by 42 percent.³

Maryland's opioid scourge is one component of a larger behavioral health care crisis in the state. One in five people have a chronic behavioral health or substance use disorder and there is a lack of high quality, community-based behavioral health services to meet their needs. Hospitals often serve as a safety net for patients with behavioral health concerns, especially during a behavioral health emergency. Across the nation, and in Maryland, the number of opioid-related ED visits continues to rise. In 2014, Maryland was ranked among the states in the U.S with the highest rates of opioid-related ED visits across all age groups and genders.⁴ Between 2013 and 2016, hospital ED visits related to opioids jumped by 82 percent. In the fourth quarter of 2016, Maryland's rate of opioid related ED visits was 90 percent higher than that of the national average.⁵

In response, hospitals have assessed their policies and guidance to more effectively serve the needs of this patient population.

¹ National Institute on Drug Abuse. *Opioid Summaries by State*. Accessed on November 30, 2018. See: <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state>.

² Maryland Department of Health. *Unintentional Drug- and Alcohol-Related Intoxications Deaths in Maryland, 2017*. June 2018. Deaths related to carfentanil (a fentanyl analog) were first identified in 2017. In 2017 there were 60 carfentanil-related deaths, occurring among every age group, Whites and Blacks, men and women, and 13 jurisdictions in the state.

³ Ibid.

⁴ Weiss, Audrey J. et al. *Patient Characteristics of Opioid Related Inpatient Stays and Emergency Department Visits Nationally and by State, 2014*. Agency for Healthcare Research and Quality. Healthcare Cost and Utilization Project. Statistical Brief #224. June 2017.

⁵ HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). October 2018. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/faststats/opioid/opioiduse.jsp?radio3=on&location1=MD&characteristic1=01&setting1=ED&location2=US&characteristic2=01&setting2=ED&expansionInfoState=hide&dataTablesState=hide&definitionsState=hide&exportState=hide.

HOSPITALS IN ACTION

Opioid Prescribing Guidelines, Behavioral Health Roadmap Represent Steps toward Broader Solution

In 2015, the MHA developed provider-focused opioid prescribing guidelines that were voluntarily adopted by every Maryland hospital. These guidelines consist of eight recommendations to promote standardization of opioid utilization and prescribing in the state. For example, the guidelines recommended that emergency medicine providers consult the Maryland Prescription Drug Monitoring Program before writing an opioid prescription, advised prescribing no more than three days of a minimal amount of opioid analgesics, encouraged hospitals to use the Chesapeake Regional Information System for our Patients (CRISP) to share a patient's ED visit history with other providers and hospitals, and discouraged ED providers from providing prescriptions for lost, destroyed, or stolen substances.⁶ While the recommendations were focused on hospital emergency departments, it was acknowledged that a comprehensive effort that includes other providers is needed to effectively address this problem.

In addition, in recognition of Maryland's fragmented behavioral health care system, MHA's Behavioral Health Task Force, composed of hospital executives and experts in mental health and substance abuse disorders, in 2017 developed and distributed *A Roadmap to an Essential Comprehensive System of Behavioral Health Care for Maryland*.⁷ This document details key strategies for fighting the opioid epidemic, including recommendations on screening and referrals, access to care, workforce, and harm reduction services.

HOPE Act of 2017 Discharge Protocol Requirements

In March 2017, Gov. Larry Hogan declared a state of emergency in response to the state's opioid crisis. In June, the Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017, passed, mandating several provisions to mitigate Maryland's crisis, including a requirement that hospitals have a discharge protocol in place for patients treated for an overdose or identified as having a substance use disorder. The HOPE Act required hospitals to report these protocols to MHA beginning in 2018.⁸

To support hospitals' efforts to meet the requirements of the HOPE Act, in 2017 MHA convened a series of Clinical Conversations, during which hospital ED and clinical leaders met to develop consensus on recommended components for an ED discharge protocol. As a result of these forums, hospital representatives agreed that it was important to consider four core components in developing an ED discharge protocol:

⁶ Maryland Hospital Association. *Maryland Emergency Department Opioid Prescribing Guidelines*. 2015. <https://www.mhaonline.org/docs/default-source/Resources/Opioid-Resources-for-Hospitals/maryland-emergency-department-opioid-prescribing-guidelines.pdf>

⁷ Maryland Hospital Association. *A Roadmap to an Essential Comprehensive System of Behavioral Health Care for Maryland*. 2017. <https://www.mhaonline.org/docs/default-source/Resources/roadmap-to-an-essential-comprehensive-system-of-behavioral-health-care-for-maryland.pdf?sfvrsn=2>

⁸ HB 1329, (SB967), 19–310.3, *Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017* <http://mgaleg.maryland.gov/webmga/frmMain.aspx?id=hb1329&stab=01&pid=billpage&tab=subject3&ys=2017RS>

- 1. Universal Screening: To the extent possible, hospitals should universally screen for substance use disorder(s) 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 step within the ED admission and discharge process. Screening helps providers fully assess patients prior to making treatment decisions and recommendations for follow-up care and/or monitoring.
- 2. Naloxone Access: 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 agreed patients who screen positive for opioid use disorder during the ED visit should at minimum receive a naloxone prescription. Some hospitals have the capacity to directly dispense naloxone, which was generally preferred over writing a prescription.
- 3. Facilitated Referral: Hospitals should refer patients who screen positive for substance use disorder(s) to treatment, ideally using a facilitated referral approach.** Hospitals agreed that referrals to treatment are an essential component of the discharge protocols for this patient population. A facilitated referral may involve a range of tasks designed to assist the patient to attend his or her first appointment at the treatment center after being discharged.
- 4. Peer Recovery Services: To the extent possible, hospitals should incorporate peer recovery services into their processes for treating and discharging patients treated for an opioid overdose, and those identified as having a substance use disorder.** Peer recovery coaches use their lived experiences of recovering from addiction, as well as skills learned in formal training, to deliver services to patients that encourage their recovery.⁹ Specifically, in addition to referring patients to treatment, peer recovery coaches or other staff could provide patients with information on safe use, assess their readiness to change, and advise them on potential behavior changes under the guidance of licensed providers. Hospital representatives found it beneficial to include peer recovery coaches or other staff who are designated provide these services, such as community health workers or hospital social workers, in the discharge process.

Hospital representatives also agreed that in developing a discharge protocol, it is important to consider initiating MAT in the emergency department. There are three types of medications that have been approved by the Food and Drug Administration for the treatment of opioid use disorder: methadone, naltrexone, and buprenorphine. Federal law requires methadone only be dispensed through an opioid treatment program, and as such is not initiated by hospitals.¹⁰ Naltrexone can be

⁹ SAMHSA-HRSA Center for Integrated Health Solutions website. See: <https://www.integration.samhsa.gov/workforce/team-members/peer-providers>

¹⁰ 42 Code of Federal Regulations, part 8. Certification of Opioid Treatment Programs.

administered in the hospital setting, but requires patients to go through withdrawal under a doctor's care prior to starting it and can be challenging to administer in an ED setting. As such, hospital representatives agreed that it is ideal to administer MAT in the form of an initial dose of buprenorphine to patients in the ED if clinically appropriate and with patient consent, provided that the patient has access to next day treatment to receive the second dose.

MHA Review of ED Discharge Protocols

In January 2018, hospitals began submitting their ED discharge protocols to MHA. MHA received discharge protocols for 45 of our acute care inpatient hospitals with emergency room departments.¹¹ MHA reviewed these protocols for the four recommended elements on which hospital leaders came to a consensus during the Clinical Conversations series. MHA also reviewed the discharge protocols to track whether hospitals were initiating MAT in the ED. In May 2018, MHA hosted an ED Discharge Protocol Summit during which emergency medicine and clinical leaders discussed their experiences with the protocols.

The following sections detail the results of the protocol review and share relevant context for each of the core elements gleaned throughout the process. It is important to note that percentages reflected below are a point in time; hospital protocols will likely continue to evolve as hospitals gain experience implementing certain interventions and new resources become available. For example, an additional 14 hospitals will implement the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model in their EDs, and nine hospitals will adopt the model in their mother-baby units as part of the State Opioid Response grant awarded to Maryland. Hospitals in Baltimore City also are working with the Baltimore City Health Department to implement the Levels of Care initiative,¹² which provides a framework to guide the establishment of comprehensive services for patients with opioid use disorder. This effort covers the ED, inpatient, and outpatient settings. It also includes policies to prevent new cases of opioid use disorder, and hospitals are expected to add services over time to achieve different levels of care.

Recommendation 1: Universal Screening

To the extent possible, hospitals should universally screen for substance use disorder(s) among patients who present in the ED.

Most of the hospitals' protocols (43 of 45) include screening. Of these, most of the protocols (36 of 43) indicate universal screening, while only a handful of hospitals' protocols (seven) indicate that they screen for suspicion of substance use disorder

- Universal Screening: 80 percent of all hospitals' protocols collected
- Screening with suspicion: 16 percent of all hospitals' protocols collected

Of the hospitals that currently screen universally in the ED, there are differences in the methodologies and in types of tools used. See Appendix 1 for additional information.

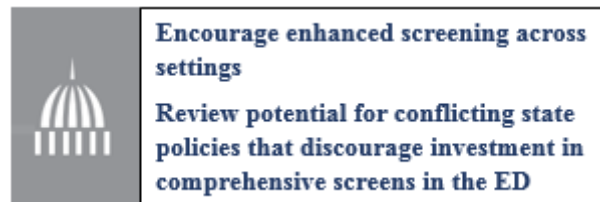
¹¹ McCready Memorial Hospital did not submit an ED discharge protocol, due to its small volume of inpatient discharges, averaging less than 1 per day.

¹² Baltimore City Health Department. *Levels of Care for Baltimore City Hospitals Responding to the Opioid Epidemic: Guide for Hospitals*. August 2018. <https://health.baltimorecity.gov/levels-care>

Universal Screening: What Maryland Needs

Maryland's hospitals support universal screening in appropriate settings across the care continuum.

While the majority of hospitals have implemented universal screenings into their emergency department discharge protocols, there was a recognition that screening could



be expanded more comprehensively in other settings of care, including settings outside of hospitals. This is consistent with the recommendations from MHA's *Roadmap to an Essential Comprehensive System of Behavioral Health Care for Maryland*. Patients should receive behavioral health screenings as part of their routine care regardless of setting. As such, universal screenings should be encouraged in primary care, specialty care, long-term care facilities, and all other health care settings.¹³ While implementation of the Maryland Primary Care Program will expand behavioral health screenings in primary care offices, a comprehensive focus is needed. Routine screening across the care continuum would result in earlier diagnosis and treatment, improved health outcomes, and reduced costs by limiting more expensive sequelae of untreated diseases.

Hospital representatives noted the additional time it takes to screen all patients and follow up on positive initial screens with more detailed full screening assessments could lengthen ED wait times at a time when state payment policy requires reducing wait times.

Recommendation 2: Naloxone Access

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 from the ED or providing a prescription.

The protocols for all 45 hospitals (100 percent) indicate that they either prescribe and/or dispense naloxone to patients with a substance use disorder or who were treated for an overdose at discharge. Specifically:

- 87 percent (39 of 45) prescribe naloxone
- 62 percent (28 of 45) dispense naloxone
- 49 percent (22 of 45) both prescribe and dispense naloxone

Some protocols specify that the hospital provides naloxone to people who are at risk for an opioid overdose, including those who use opioids to manage pain, or patients with a history of substance use disorder or overdose. All hospital protocols indicate that they educate patients and/or provide written information about the use of naloxone when prescribing or dispensing. Typically a nurse

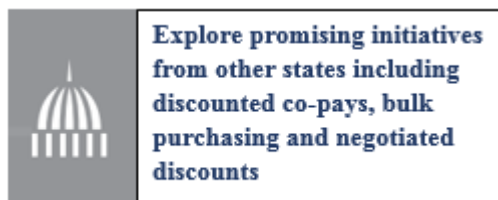
¹³ Maryland Hospital Association. *A Roadmap to an Essential Comprehensive System of Behavioral Health Care for Maryland*. 2017. <https://www.mhaonline.org/docs/default-source/Resources/roadmap-to-an-essential-comprehensive-system-of-behavioral-health-care-for-maryland.pdf?sfvrsn=2>

or other staff member will train the patient and/or family members. In some cases, hospitals require patients to watch an instructional training video before being discharged.

Naloxone Access: What Maryland Needs

Maryland’s hospitals support the state’s efforts to increase access to naloxone, including reducing the cost to users and providers.

During the Clinical Conversation series, Maryland’s hospital leaders said they had trouble securing the necessary staffing levels to provide the required training. Some hospitals partnered with local health departments to train hospital ED staff, enabling them to train patients and/or family members. Other hospitals use peer recovery coaches to deliver patient education or use a training video on a laptop. Even when training is available, hospitals note that some patients leave the ED prior to getting the training, the naloxone kit, or prescription.



One of the most significant challenges for Maryland’s hospitals — all of which operate under a fixed budget — is the rising cost of drugs. That’s why all hospitals raised concerns about dramatic increases in naloxone pricing — as much as 600 percent in some cases. These price increases make it more difficult for patients to fill prescriptions for the drug and affect a hospital’s ability to keep an adequate supply on hand. Hospital representatives have tried to adjust to higher prices by looking for lower cost formulations, partnering with local health departments to obtain naloxone, and using grants to purchase it. Despite these efforts, none of these solutions is sustainable, especially if drug manufacturers continue to maintain or increase prices. See Appendix 1 for more information on pricing.

In line with other states, earlier this year Gov. Hogan authorized Attorney General Brian Frosh to file suit against select opioid manufacturers and distributors on the grounds that they have misled the public and helped create the opioid addiction crisis in Maryland and throughout the country. Maryland joins several other jurisdictions, including municipal, county, and state-level government as well as the federal government, which also have sued opioid manufacturers in recent years, citing similar legal arguments.^{14,15} Hogan stipulated that 100 percent of any proceeds recovered in Maryland’s lawsuit must be directed toward new, innovative opioid treatment, prevention, and education programs.¹⁶ Some of the proceeds from the lawsuit could be dedicated to purchasing and distributing naloxone. However, given that recovering funds via the lawsuit is a

¹⁴ Lopez, German. “The growing number of lawsuits against opioid companies, explained.” Updated January 31, 2018. See <https://www.vox.com/policy-and-politics/2017/6/7/15724054/opioid-companies-epidemic-lawsuits>

¹⁵ The lawsuits, which number in the hundreds, have charged that opioid manufacturers made false representations of the addictiveness and effectiveness of their products and intentionally misled the state, prescribers, and the public. See Haffajee, Rebecca L., and Michelle M. Melo. “Drug Companies’ Liability for Opioid Epidemic.” *The New England Journal of Medicine*, 377:24. December 14, 2017.

¹⁶ “Hogan-Rutherford Administration Announces 2018 Anti-Opioid Initiatives” January 23, 2018. See <http://governor.maryland.gov/2018/01/23/hogan-rutherford-administration-announces-2018-anti-opioid-initiatives/>

long-term strategy, it is important that the state consider multiple options to increase availability of naloxone.

Other states have addressed naloxone access issues in ways that may help to inform Maryland's strategy. For example, New York state is the first in the nation to implement a naloxone co-payment assistance program.¹⁷ Other states have negotiated bulk purchasing arrangements to buy naloxone for municipal first responders at a discounted rate. In Massachusetts, the legislature established a bulk purchasing program,¹⁸ and in New Jersey the Office of the Attorney General negotiated with a drug manufacturer to reduce the costs for law enforcement and first responders.¹⁹

Recommendation 3: Facilitated Referrals

Hospitals should refer patients who screen positive for substance use disorder(s) to treatment, ideally using a facilitated referral approach.

- Eighty-four percent (38 of 45) of hospitals' protocols indicate that they are using a facilitated approach to referral.

Protocols outlining a facilitated approach to referral, sometimes referred to as a "warm handoff" detailed steps to connect patients to treatment post discharge. Most commonly, for people who screen positive for substance use disorder, facilitated referral activities entailed hospital social workers or peer recovery coaches making the patient's first treatment appointment at an outpatient facility before discharge, and following up with a call to the patient in the days following to ensure they made it to that appointment.²⁰

For patients who were treated for an overdose, at least 15 hospitals have implemented the Overdose Survivors Outreach Program (OSOP), an initiative funded by the Maryland Department of Health. After patients are treated for an overdose and discharged, peer recovery coaches maintain periodic contact with them in the days and weeks following, so the patient has a pathway to treatment and continued support. According to the Mosaic Group, which provided technical assistance to the majority of hospitals that implemented the program, between July 2017 and August 2018, over 75 percent of those referred to treatment through OSOP at 11 hospitals were successfully linked to a treatment program.²¹ See Appendix 1 for additional information about OSOP.

¹⁷ "Governor Cuomo Announces No-Cost or Lower Cost Naloxone Available at Pharmacies Across New York." August 7, 2017. <https://www.governor.ny.gov/news/governor-cuomo-announces-no-cost-or-lower-cost-naloxone-available-pharmacies-across-new-york>.

¹⁸ Massachusetts Department of Public Health. "2016 Municipal Naloxone Bulk Purchase Trust Fund Annual Report." October 2016. See <https://malegislature.gov/Bills/189/SD2733.pdf>.

¹⁹ State of New Jersey. The Office of the Governor. "Governor Christie Announces Agreement To Secure Discounts On Life-Saving Overdose Antidote For New Jersey First Responders." June 4, 2015.

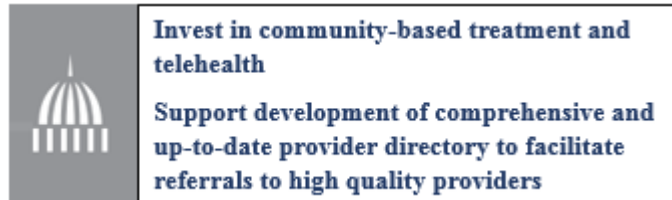
²⁰ MHA considered hospitals to have a facilitated approach to referral if they took steps to connect patients to treatment at discharge, doing more than providing patients with a list of treatment center contacts in the local community.

²¹ The Mosaic Group. Comprehensive Substance Use Response Program: Hospital Summary. Overdose Survivors Response Program data (July 2017-August 2018).

Facilitated Referrals: What Maryland Needs

Maryland's hospitals support initiatives that remove barriers to patients accessing treatment, including efforts to increase the number of treatment providers in underserved areas.

During the Clinical Conversations series, Maryland's hospital leaders spoke about the challenges of finding quality, evidence-based outpatient and residential treatment centers in their communities. Rural areas in particular have a limited number of treatment centers, and availability varies across the state.



Further, hospitals do not always have staff available in EDs to perform activities for a facilitated referral. Even among those that do utilize or employ peer recovery coaches or social workers that provide peer recovery services, these roles may not be staffed 24 hours/seven days per week. Referring patients to treatment on weekends and at night can be challenging due to staffing constraints and available treatment center hours.

Some hospitals used the local health department as a resource to connect patients to treatment or to provide peer recovery coaches. While these partnerships have helped, a more systematic effort to expand the availability of community-based treatment providers, including increased use and reimbursement for telehealth is needed. For example, the University of Maryland Medical Center has been focused on developing and implementing telemedicine programs in certain rural and underserved areas in the state. These programs, which include addiction consultation services and MAT, among resources, have been made possible through specific contracts and small grants. Additional state infrastructure would enable expansion of these services via a Center of Excellence in Telemental Health.

Finally, even when there are treatment centers in an area, some hospitals may not have current information about the services they provide or the insurance they accept. As such, Maryland's hospitals support the development of a provider directory that is kept up to date and readily accessible. At a minimum, such a directory should have location, services offered, and insurance accepted. Future capabilities should include standard quality metrics and eventually support appropriate and timely patient placement, ultimately including real-time bed inventory tracking and scheduling capabilities.

Recommendation 4: Peer Recovery Services

To the extent possible, hospitals should incorporate peer recovery services into their processes for treating and discharging patients treated for an opioid overdose, and those identified as having a substance use disorder.

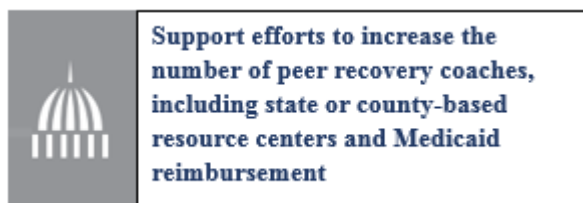
- 73 percent of hospitals (33 of 45) reference use of peer recovery coaches in their discharge protocols.²²
- An additional 13 percent of hospitals (six of 45) use other types of non-clinical personnel, such as a community health workers, to provide services that are typically provided by peer recovery coaches.

Hospitals typically use non-clinical personnel such as peer recovery coaches in the SBIRT process. After a patient screens positive for substance use disorder(s), peers are often used to provide a brief intervention during which they may identify which substances are used and assess the patient’s interest in a referral to substance use disorder treatment programs. Peers are often used to facilitate the patient’s referral to treatment. As previously mentioned, hospitals may also use peer recovery coaches to support individuals who have overdosed post-discharge through OSOP.

Peer Recovery Services: What Maryland Needs

Maryland’s hospitals support initiatives to increase access to peer recovery coaches.

As with facilitated referrals, one of the most pertinent challenges that hospitals associate with incorporating peer recovery coaches into their discharge protocol process is that they typically are not available 24 hours per day. To ensure coverage, hospitals have used other personnel, like social workers, to provide services typically provided by peer recovery coaches when a peer is not on duty or partnered with local health departments. However, some hospitals have been able to secure comprehensive access to peer recovery coaches.



Family advocate organizations have noted that the availability and frequency of training opportunities for those seeking certification as a peer recovery coach do not match the need. There are also insufficient grant funds available to community-based organizations to support these positions, particularly when those seeking certification are required to work under appropriate supervision.

Rhode Island makes peer recovery support services available 24/7 to hospitals through its partnership with the Providence Center, a community provider of mental health and substance use

²² If a hospital did not specifically reference the use of peer recovery coaches, but used overdose survivors outreach services, we considered them to use peer recovery coaches because they are an integral part of those services.

services.²³ By providing this resource to all hospitals, it mitigates the challenges hospitals may face in hiring peers. Maryland should explore the potential to establish partnerships with community providers that ensure 24/7 access to peer recovery support services. Recent legislation requiring a work group to study issues related to the reimbursement of certified peer recovery specialists, is a promising step in the right direction.²⁴ The ability to reimburse for these services may increase the number of peer recovery coaches and services available in the state— eliminating a significant barrier to accessing them.

Medication Assisted Treatment (MAT)

While initiation of MAT in the emergency department was not recommended to be included in every hospital’s discharge protocol it was agreed to be an important consideration.

- Twenty-seven percent of hospitals’ protocols indicated that they were providing an initial dose of buprenorphine in the ED to patients after it was determined that it was clinically appropriate.

Representatives from hospitals that initiate buprenorphine in the ED consistently stressed the importance of access to treatment within 24 hours. Some protocols detailed how the hospital “fast tracks” patients to treatment programs to continue treatment after the initial dose in the ED. By fast tracking patients, hospitals send buprenorphine patients to treatment providers for continued maintenance therapy the next day because they have established a network of providers ready and able to accept these patients.

Figure 1: Buprenorphine Fast Track Program Process



Source: The Mosaic Group. “Hospital Based Buprenorphine Induction in Maryland Hospitals” presentation included in the November 14, 2017 MHA Webinar on Buprenorphine in the Emergency Department.

²³ Rhode Island Department of Health. Department of Behavioral Healthcare and Hospitals Developmental Disabilities. *Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder*. March 2017.

²⁴ HB 772, (SB 765) *Maryland Department of Health - Reimbursement for Services Provided by Certified Peer Recovery Specialists - Workgroup and Report*. <http://mgaleg.maryland.gov/webmga/frmMain.aspx?pid=billpage&stab=02&id=hb0772&tab=subject3&ys=2018RS>

Medication Assisted Treatment: What Maryland Needs

Maryland’s hospitals support initiatives to expand the use of all appropriate modalities of medication assisted treatment, including efforts to increase the number of community-based MAT providers and efforts to support initiating MAT in the hospital.

Hospitals not currently initiating buprenorphine in the ED cited the lack of treatment capacity in their communities as a key deterrent because they are unable to get patients into necessary treatment within 24 hours. This concern was especially pronounced by hospitals in rural areas. Even when resources exist in communities, hospitals still may not be aware of the availability of treatment options. As such, MHA encourages information sharing initiatives to foster relationships among providers and hospitals, as well as tools that could be used to understand what services are available among providers – for example, an up-to-date directory of providers across the state.



Identify gaps in access to community-based medication assisted treatment

Roll-out comprehensive anti-stigma campaign

Educate providers about “three-day rule”

The hospitals that were administering buprenorphine in the ED either had enough waived staff or were using non-waived staff to administer buprenorphine under the regulatory exception known as the “three-day rule.”²⁵ This allows a practitioner who is not in an outpatient treatment program or who is not waived under the Drug Addiction Treatment Act of 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.²⁶

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 in ongoing care.

A continued effort to raise awareness about requirements to be waived as well as the availability of the “three-day rule” are encouraged. Further, incentive programs have shown to be effective. For example, in July 2018, the Baltimore City Health Department (BCHD) offered \$1,000 to any Baltimore hospital provider who completed the training required to prescribe buprenorphine. Physicians, nurse practitioners, and physician assistants were eligible. As a result, 156 providers from nine hospitals got the training and 133 of them were reimbursed by the BCHD.

²⁵ CFR 21 (Part 1306.07(b))

²⁶ 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-dhmf.pdf?sfvrsn=2>

Finally, the provider community must eliminate the stigma that some associate with opioid abuse. Studies show that some physicians do not view those suffering from opioid addiction as having a brain disorder requiring treatment and believe that medication assisted therapy is substituting one addiction for another.²⁷ It will be important to address these attitudes among health care providers and staff as MAT becomes more widely used.

While hospital-based MAT initiatives largely focus on buprenorphine, there was recognition that patients may prefer or be better suited for other modalities. MHA supports efforts to increase the availability of all treatment modalities so that patients have access to the most appropriate one for them.

CONCLUSIONS

Maryland's opioid crisis requires an "all hands on deck" approach. It was this spirit that drove all of Maryland's hospitals to sign the MHA's Emergency Department Opioid Prescribing Guidelines in 2015 and to develop consensus recommendations for discharge protocols, exceeding the requirements of the HOPE Act. Over 18 months, clinical leaders have shared evidence and lessons learned to support implementation of universal screening, enhanced naloxone access, facilitated referrals, and peer recovery services. Further, the number of hospitals initiating MAT is expected to nearly double as support from the state SOR grant is rolled out. Hospital emergency departments are an access point to treatment for many; therefore, this effort must be accompanied a sustained investment in community-based treatment. Maryland's opioid crisis demands a system-wide approach where providers, community organizations, and government agencies work together to provide a continuous and comprehensive support and treatment system for individuals with substance use disorder. Maryland's hospitals are committed to fulfilling their role.

²⁷ Wakeman, Sarah E, and Michael L. Barnett. "Primary Care and the Opioid-Overdose Crisis—Buprenorphine Myths and Realities". *New England Journal of Medicine*. July 5, 2018; 379:1-4.

Appendix 1

Universal Screening Tools and Methodologies

Some hospitals note that they screen all adults 18 and older for substance use disorder, while others begin universal screening of patients as young as 12 or 16. Certain hospitals qualify their universal screening process by specifying that they screen all patients who do not have a life- or limb-threatening problem. For example, a hospital will not screen a patient for substance use disorder who enters the ED in cardiac arrest. Regardless of whether a protocol mentioned a specific screening age, or if it specified exceptions for those with life threatening conditions, MHA considers a hospital to have universal screening if their protocol says that screening is done for all patients who visit the ED, not only when a provider suspects that the patient may have a substance use disorder.

Not all hospitals' protocols specify the screening tools they use. However, when screening tools were named, MHA found that hospitals often conducted an initial screening by pairing the Alcohol Use Disorders Identification Test (AUDIT-C) with the illegal drug use question from the National Institute on Drug Abuse (NIDA) Quick Screen tool. The AUDIT-C is a three question screening tool used to identify individuals who are hazardous drinkers or have active alcohol use disorders.

The NIDA Quick Screen tool is a single question instrument, which prompts the screener to ask patients about how often they used illegal drugs in the past year.²⁸ In addition, some hospitals that screen patients under the age of 18 specifically mention the use of the CRAFFT validated screening tool for adolescents in their protocols.²⁹ Other hospitals' protocols simply referred to "SBIRT screening tools," which may or may not be the AUDIT-C or the NIDA Quick Screen. SBIRT refers to the evidence-based process of Screening Brief Intervention and Referral to Treatment, which aims to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs.³⁰ If the patient screens positive as a result of the initial screen, the provider will often follow up with a more detailed full screening to assess the patient's condition.

AUDIT-C Questionnaire for Detecting Alcoholism
1. How often do you have a drink containing alcohol? <input type="checkbox"/> a. Never <input type="checkbox"/> b. Monthly or less <input type="checkbox"/> c. 2-4 times a month <input type="checkbox"/> d. 2-3 times a week <input type="checkbox"/> e. 4 or more times a week
2. How many standard drinks containing alcohol do you have on a typical day? <input type="checkbox"/> a. 1 or 2 <input type="checkbox"/> b. 3 or 4 <input type="checkbox"/> c. 5 or 6 <input type="checkbox"/> d. 7 to 9 <input type="checkbox"/> e. 10 or more
3. How often do you have six or more drinks on one occasion? <input type="checkbox"/> a. Never <input type="checkbox"/> b. Less than monthly <input type="checkbox"/> c. Monthly <input type="checkbox"/> d. Weekly <input type="checkbox"/> e. Daily or almost daily
<small>The AUDIT-C is scored on a scale of 0-12. Each AUDIT-C question has 5 answer choices. Points allotted are: a = 0 points, b = 1 point, c = 2 points, d = 3 points, e = 4 points Men, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. Women, a score of 3 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.</small>

²⁸ The NIDA quick screen question also asks about the patient's use of alcohol, tobacco and prescription drugs for non-medical reasons.

²⁹ 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.

³⁰ SAMHSA-HRSA Center for Integrated Health Solutions. *SBIRT: Screening, Brief Intervention and Referral to Treatment. Opportunities for Implementation and Points for Consideration.*

Naloxone Pricing

Naloxone can be administered through an intranasal plunger delivered into one of the patient's nostrils, or by a needle injection into the patient's muscle or fat.³¹ Researchers found that from January 2006 to February 2017, all formulations of naloxone increased in price except for Narcan Nasal spray. Specifically, these cumulative increases totaled 2,281 percent for the 0.4 MG single-dose products, 244 percent for the 2 MG single-dose products, 3,797 percent for the 4 MG multi-dose products, and 469 percent for the 0.4 MG Evzio auto-injector.³² In another study, researchers found the cost of a 0.4-mg-per-milliliter-dose increased by 129 percent in four years, from \$62.29 in 2012, to \$142.49 in 2016.³³ Furthermore, a 2018 United States Senate investigation into the price of naloxone found that the manufacturer of the Evzio auto injector increased the price by over 600 percent— from \$575 in July 2014 to \$4,100 in January 2017.³⁴

Facilitated Approach to Referral: Overdose Survivors Outreach Program (OSOP)

OSOP “seeks to create better pathways to treatment by creating closer collaboration between medical facilities, local health departments and treatment facilities.” Each hospital has customized its OSOP process. Some provide more details than others in the discharge protocols. For example, one hospital's protocol provides detail about how the program fits into the hospital's brief intervention and referral to treatment process using peer recovery coaches in the hospital and in the community (Community Recovery Coach, or OSOP CRC):

Example: All patients that receive a brief intervention should be scheduled for a minimum of one follow-up either by telephone or in the hospital if admitted

- a. *For overdose patients the follow-ups should be scheduled the following day.*
- b. *Opioid overdose patients that have been referred to OSOP will have follow-up conducted by the SBIRT PRC and the OSOP CRC.*

1. *The OSOP CRC is responsible for locating patients based on information provided on referral forms and during interventions. The OSOP CRC will conduct home visits, meet patients at community facilities or other institutions that they frequent, search for patients at places they hang out in the community, and conduct outreach via phone to the patient and any collateral contacts that were given.*

2. *The PRC may still schedule phone follow-ups and will notify the OSOP-CRC of any updates on the patient's location or status in the community.*

³¹ Naloxone can also be given by a medical professional intravenously. See: United States Senate. Permanent Subcommittee on Investigations. Committee on Homeland Security and Governmental Affairs. “Combating the Opioid Crisis: The Price Increase of an Opioid Overdose Reversal Drug and the Cost to the U.S. Health Care System”. Staff Report. Rob Portman, Chairman. Tom Carper, Ranking Member.

³² See Rosenberg, et al. “Trends and economic drivers for United States naloxone pricing” January 2006 to February 2017” *Addictive Behaviors*. Volume 86, pages 86-89. November 2018.

³³ In addition, the 1-mg-per-milliliter injections, the dose used off-label as a nasal spray, cost \$39.60 in 2016 after a two year 95 percent increase. See Gupta, et al. “The Rising Price of Naloxone – Risks to Efforts to Stem Overdose Deaths.” *The New England Journal of Medicine*. December 8, 2016.

³⁴ United States Senate. Permanent Subcommittee on Investigations. Committee on Homeland Security and Governmental Affairs. “Combating the Opioid Crisis: The Price Increase of an Opioid Overdose Reversal Drug and the Cost to the U.S. Health Care System.” Staff Report. Rob Portman, Chairman. Tom Carper, Ranking Member.