MHA's Opioid Crisis Meeting with Emergency Department Leadership

March 29, 2017

Summary
Over fifty emergency department leaders from Maryland's hospitals attended a statewide meeting to discuss hospitals' role in addressing Maryland's opioid crisis. Maryland Deputy Secretary for Public Health Dr. Howard Haft, Opioid Operational Command Center Director Clay Stamp, and Baltimore City Health Department Director of Opioid Overdose Prevention and Treatment Mark O'Brien, participated in the meeting. The meeting provided a forum to discuss barriers to implementation as well as best practices for the following interventions:

- Increasing access to Naloxone (prescribing and dispensing directly)
- Universal screening for substance use disorder; specifically Screening, Brief Intervention, and Referral to Treatment (SBIRT)

MHA anticipates convening future meetings of emergency department leaders, which may include information on additional interventions such as peer or other therapy referrals/contacts from/in the ED; medication assisted treatment in the ED; and the use of community and local health department services.

Opioid Crisis background information provided by Dr. Haft:

- CY2016 overdose deaths are higher than CY2015, and Q1 of 2017 overdose deaths are higher than Q1 of 2016. (unpublished DHMH data)
- Opioid overdose is projected 4th leading cause of death in Maryland, after cancer, stroke, and heart attacks
- 3.5 million opioid prescriptions each year;
    - 65 percent of prescriptions written for more than 7 days in Maryland; CDC guidelines recommend 3 days but no more than 7 days' worth of prescription
- Dr. Haft called Maryland's hospitals to action for a field-wide commitment prescribing and/or dispensing naloxone and universal SBIRT and requested feedback on what support was needed from DHMH to support hospitals' efforts

Supporting Access to Naloxone

Example of Hospitals' Approach

- Standardize process for high-risk patients by creating SMART discharge set in EPIC which includes prescription for Naloxone
- Distribute Naloxone Kits (also referred to as Red Bags) which include Naloxone, training instructions, face shield, and information on Good Samaritan laws; if patient refuses bag, then it is given to family members. Patients who receive Naloxone[1] are tracked via

1 The group discussed a recent journal article that reported a two-thirds ED take-home naloxone acceptance rate in patients using opioids. See Kestler A et al. Factors associated with participation in an emergency department–based take-home naloxone program for at-risk opioid users. Ann Emerg Med 2016 Oct 10.

hospital EMR to track utilization, including if they come in as an accidental overdose again
- Participate in BHA's Overdose Survivor Outreach Program[2]
- Partner with Local Health Departments to educate ED staff on Naloxone

Barriers

While there was recognition of the life-saving value of Naloxone, participants felt strongly that a significant investment in treatment and community resources was necessary to ensure high-risk patients have access to a comprehensive recovery pathway. Barriers to prescribing and dispensing Naloxone included:

Cost

- Cost of Naloxone is on the rise as demand increases; non-340B hospitals pay more
- Some hospitals were relying on foundation or grant funds to purchase Naloxone

Education

- Education needed for ED staff, including physicians on flexibility provided under Naloxone standing order for prescribing and dispensing as well as Good Samaritan Law
    - Clarification needed on roles for physicians and nurses re: dispensing

SBIRT

Example of Hospitals' Approach

- Use of SBIRT for every nursing evaluation; peer support personnel receives a report every hour on patients that may need an intervention/referral and the health department will reach out if peer not available
    - Future effort to have peer response to overdose with EMS to initiate contact with patient earlier
- Track the percent of patients that get screened, those that get connected to a peer recovery coach, and the percent of those patients who are ultimately connected to treatment. The patient is given an opportunity to start Medication Assisted Treatment if ready to connect to treatment within a day
- Use of limited (20 hrs./day) SBIRT grant supports rapid referral (from addiction counselors) to treatment programs and will hold patients if needed during night shift until SBIRT staff come in the morning to cover the 4 hour gap if needed

[2] The Overdose Survivors Outreach Program is an initiative to improve health outcomes for overdose survivors or those at risk for overdose by collaborating with hospitals and local health departments to facilitate interventions by Peer Recovery Specialists in the emergency department. If a patient has overdosed, or is at risk for overdose, the peer will work with the patient to assist them in enrolling in treatment or support services. If she or he is not interested in treatment, the peer will obtain consent to refer them to an outreach peer at the local health department, who will contact them via phone or field call a day or two after presenting in the emergency department, and will periodically check in to assess their needs and willingness to enter treatment. As of December 2016, four hospitals in Baltimore City and two in northern Anne Arundel County are participating in the program, with plans to expand post-discharge outreach services for multiple other hospitals in the coming months.

- Partner with treatment providers for same day referral and the hospital will cover transportation costs

Additional Feedback

While the conversation was initially focused on Naloxone dispensing and prescribing and use of SBIRT screening, additional ED-based interventions were identified including the need to limit the amount of opioids prescribed, more effectively using the Prescription Drug Monitoring Program, and prescribing lidocaine patches or alternative pain management treatment such as physical therapy, massage, etc. In addition, some hospitals reported success going dilaudid free while others were starting Buprenorphine in the emergency department.

Regulatory Relief for General Opioid Prescribing

- There is a need to add alternate pain management reimbursement for Medicaid such as physician therapy, massage therapy, etc. Lidocaine patches can be an alternative to opioid prescribing and should be added to the preferred drug list

Next Steps

MHA will disseminate a meeting summary and additional information on the policies and programs discussed with all participants. As was discussed at the meeting, the Naloxone and SBIRT barriers and strategies that were identified at the meeting will be shared with MHA's Behavioral Health Task Force with the goal of developing best practices for field-wide adoption. MHA's Council on Clinical and Quality Issues will review the recommendation and consider it for approval. Finally, MHA will work with Dr. Haft and his team to schedule a future meeting of emergency department leadership to discuss additional interventions and opportunities for collaboration.