Medications for Opioid Use Disorder in the Emergency Department

Baseline survey results

Comagine Health

September 2022

INTRODUCTION

Oregon Health Leadership Council's (OHLC) Best Practice Committee recommends and executes statewide best practice strategies aimed at improving healthcare quality, value, patient outcomes, and provider satisfaction. As part of those efforts and efforts to address the overdose crisis in Oregon, OHLC's Substance Use Disorder (SUD) Workgroup is developing a toolkit to support emergency departments build and sustain medications for opioid use disorder (MOUD) initiation programs. Comagine Health, in collaboration with OHLC and Oregon Health Authority, developed and administered a survey to better understand Oregon's emergency departments current approaches related to MOUD initiation, naloxone distribution, connections with community-based treatment providers, and support for care navigation. OHLC will use the survey results to guide and inform areas of support to meet the needs of Oregon's emergency departments.

SURVEY

The survey was conducted from March to April of 2022. A secondary data collection effort was made in August 2022 to increase response rates. Comagine Health invited emergency department leadership or hospital level representatives to participate in a survey to assess current practices in providing MOUD in emergency departments across Oregon. A unique survey link was emailed to emergency department leadership or hospital level representative, and they were encouraged to complete the survey, once per organization, in consultation with other key staff. To increase survey response rates, Comagine Health staff followed-up with contacts via phone and LinkedIn. Participation in the survey was voluntary and took approximately 5 minutes to complete. Respondents did not receive compensation for completing the survey.

The purpose of the baseline survey was:

- To collect information about current approaches to provide MOUD and refer people with SUD to treatment and harm reduction services and
- To help inform what should be included in the toolkit and what areas OHLC should focus their technical assistance.

Respondents were asked about anticipated and experienced barriers initiating MOUD and dispensing naloxone in emergency departments and information, resources, tools, and trainings they are interested in to help with implementation.

EXECUTIVE SUMMARY

The baseline survey was sent to 54 Oregon hospital/emergency department leadership and/or administrative representative and **24 (44%)** completed the survey.

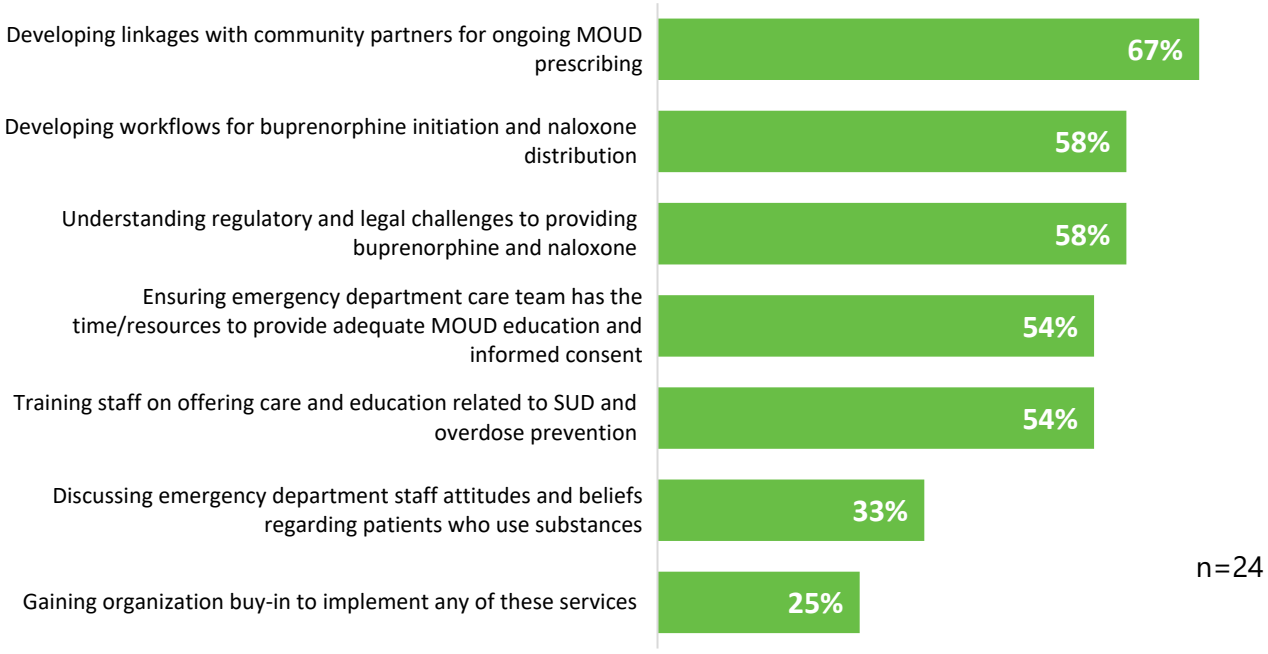
- **Most (79%)** respondents said their emergency department is either both dispensing and prescribing naloxone **(46%)** or only prescribing naloxone **(33%)**
- **Most (96%)** respondents said buprenorphine (i.e., Subutex, Suboxone) is on their hospital's formulary
- **Some (32%)** of respondents said their emergency department has providers who routinely prescribe buprenorphine
- **Some (42%)** of respondents said they do have or are in progress of developing a protocol for initiating buprenorphine
- **Few (21%)** respondents have trained staff who can perform treatment agreements with patients prior to initiating buprenorphine
- **Some (50%)** respondents currently have any staff or volunteers who help with care navigation for patients with SUD
- **Most (58%)** respondents have an adequate referral system to ensure appropriate care and follow-up post-emergency department discharge
- **Few (4%)** of the respondents provide a telehealth option, for follow-up medication services, for patients initiated on buprenorphine
- Respondents were in most need of further information or support in:
  - Developing linkages with community partners for ongoing MOUD prescribing **(67%)**
  - Understanding regulatory and legal challenges to providing buprenorphine and naloxone **(58%)**
  - Developing workflows for buprenorphine initiation and naloxone distribution **(58%)**
  - Ensuring emergency department care team has the time/resources to provide adequate MOUD education and informed consent **(54%)**
  - Training staff on offering care and education related to SUD and overdose prevention **(54%)**

DETAILED RESULTS

The table below provides responses for each survey item. Questions 1, 2 and 4 prompted additional follow up questions depending on if eligible responses were selected. Follow-up questions are signified by rows in light green.

#	Item	Responses	%
1	Is your emergency department currently dispensing and/or prescribing naloxone? (N = 24)	Dispensing	0%
		Prescribing	33%
		Both	46%
		Neither	21%
1a	*If only dispensing, only prescribing, or both was selected*, does your emergency department have a protocol to identify which patients should receive naloxone at discharge? (N = 19)	Yes	32%
		No	68%
2	Is buprenorphine (i.e., Subutex, Suboxone) on your hospital's formulary? (N = 24)	Yes	96%
		No	4%
3	Does your emergency department have providers who routinely prescribe buprenorphine? (N = 24)	Yes	38%
		No	63%
3a	*If yes,* approximately what percent of emergency department providers routinely prescribe buprenorphine? (N = 9)	*Median 10%* *Average 24%*	range 5 to 75
4	Does your emergency department have a protocol for initiating buprenorphine? (N = 24)	Yes	21%
		In progress	21%
		No	58%
4a	*If yes or in progress,* does your emergency department have a protocol to identify which patients should be screened for buprenorphine initiation? (N = 10)	Yes	40%
		In progress	40%
		No	20%
5	Does your emergency department have trained staff who can perform treatment agreements with patients prior to initiating buprenorphine? (N = 24)	Yes	21%
		No	79%
6	Does your emergency department currently have any staff or volunteers who help with care navigation for patients with SUD? This could include peer recovery support specialists, community health workers, care coordinators, care navigator, etc. (N = 24)	Yes	50%
		No	50%
7	Does your emergency department have an adequate referral system to ensure appropriate care and follow-up post-emergency department discharge? (N = 24)	Yes	58%
		No	42%
8	For follow-up medication services, does your emergency department provide a telehealth option for patients initiated on buprenorphine? (N = 24)	Yes	4%
		No	96%

Respondents were asked to select which of the following topics their emergency department is in most need of further information or support:



**Percentages do not equal 100% because participants could suggest more than one option*

Open-Ended Questions and Responses

What barriers has your organization experienced or do you anticipate experiencing related to MOUD initiation in the emergency department, naloxone distribution at discharge, connections with community-based treatment providers, and support for care navigation? **(N = 18)**

Linkages for follow-up care with outpatient treatment providers especially in rural areas
• Availability of follow-up for the patients, there is minimal utility and starting someone on a medication if they cannot get follow up.
• Lack of community resources, transportation, transition of care coordinators that are ED based.
• Limited availability of outpatient follow-up resources.
• Our biggest concern remains the continuity of outpatient follow-up, though resources are improving every day.
• Rural practice with limited outpatient treatment options.
• There is no outpatient support for these programs in our rural community.

- We have difficulty arranging follow up for patients that we start on suboxone. So, there is a hesitation to start these medications, as we worry that patients won't be able to follow up with an outpatient prescriber.

Trained staff comfortable in providing MOUD

- Education/knowledge of specifics on treating opioid use disorder. Need guidance with protocols.
- Enough trained staff to help. Providers need special training and licensing to prescribe Suboxone and that's a big barrier.
- Getting x-waiver and education.
- Institutional comfort with managing OUD in the ED.
- Ongoing hesitancy and low self-efficacy in initiating MOUD treatments. Lack of consistency and standardization in assessment and conversations with patients who may benefit from OUD.

Naloxone dispensing cost

- Cost of Naloxone has been an issue for providing it to patients therefore we are only prescribing it currently and I'm sure most of those prescriptions are never filled. Our buprenorphine protocol is only to provide a one-time bridge dose to treat withdrawal we are not prescribing long term courses of buprenorphine or suboxone.
- Our pharmacy will not give naloxone start packs to patients at discharge because the cost is too high.

Other

- Limited patient need
- Physician engagement. There is very little incentive for providers to take the additional training and licensure to prescribe buprenorphine to patients. Many don't believe this is the role of an emergency department.
- Remote location restricts access to specialty care and social resources. Ongoing staffing issues in small critical access hospital setting make launching a new program challenging.
- We have a psychiatrist who will consult on, give Rx and see the patient within 24 hrs if buprenorphine is indicated. Thus, the reason our providers don't give the Rx. SUD is through our CHD [county health department] within the county.

What information, resources, tools, and training do you wish were available to help with implementation? (N = 12*)

*Open-ended responses covering multiple topic areas were broken out into the relevant section.

More outpatient resources for follow-up care

- I wish that we had an easy referral process for outpatient therapy. I think more providers would prescribe suboxone if we had confidence in the follow up process.

• Out-patient follow up at rehabilitation center guaranteed within 72 hours if requested by this ED. • Resources of local Providers or Resources for treatment of opioid use disorder. • We need follow up services in the community. It feels like there are none.
Additional resources, education, and training
• Education • Online resources, printable material that is useful for houseless population, training that is short and available for busy clinical staff. • Short training videos for all staff (Providers, nurses, etc.) on medications for opioid use disorder • What free resources are available and how people access them.
Tools for workflows and protocol
• Standalone addiction management clinic/primary care provider who is has special training and interest in developing a local program. Recruiting such a person and funding the program/employees would be challenging. Info regarding insurance billing, logistics and protocols for treatment, multi-disciplinary team (psych, dental, non-pharmacologic pain control methods, support group, etc.). Social support during treatment for patients to meet basic needs during removal from addiction cycle. • Standardized Epic / EHR dot phrases and discharge order sets. Workforce of peer navigators available 24/7 online or in person to make a warm handoff to follow up clinics and treatment. Appointment slots that can be filled from the ER side or guaranteed walk-in slots for MOUD. • Workflows on who to consider initiating in. Protocols with dosing & counseling points • Workflows for initiation of buprenorphine
Other
• Do not mandate that ED's provide this care • Provider engagement incentives to obtain additional licensure for prescription of buprenorphine.

RECOMMENDATIONS

- Compile contact lists of community-based X-waivered practitioners, opioid treatment programs (OTP), and telehealth buprenorphine providers (e.g., Boulder care) by region to share with emergency department staff.
- Support emergency departments in developing linkages to follow-up care with community-based treatment providers (e.g., OTP, X-waivered practitioners) and strategize ways to build relationships and connections between emergency department and outpatient providers.
- Encourage emergency departments to hire or partner with care navigators, peer recovery support specialists, community health workers, and care coordinators to support people

with OUD and connect them with resources in community, including setting up follow-up appointments in community.

- Promote continuing education for physicians, nurse practitioners, and physicians assistants to complete Provider Clinical Support System X-waiver training to improve confidence and self-efficacy in performing treatment agreements with patients and initiating and prescribing buprenorphine.
- Collaborate with emergency department leadership and staff to develop workflows and protocols to efficiently initiate and prescribing patients MOUD, including processes for identifying and educating qualified patients.
- Encourage emergency departments to continue to dispense and prescribe naloxone for patients at risk of an overdose.

REFERENCES

- Implementation of emergency department-initiated buprenorphine for opioid use disorder in a rural southern state (2020)
- Rapid Adoption of Low-Threshold Buprenorphine Treatment at California Emergency Departments Participating in the CA Bridge Program (2021)
- CA Bridge: Blueprint for Hospital Opioid Use Disorder Treatment