

Expanding Access to Opioid Use Disorder Treatment in Emergency Departments

Emergency departments (EDs) are often considered the “front door” of treatment for opioid use disorder (OUD) because their staff are among the first clinicians people recovering from an overdose see. They may also be the only providers people with infections and wounds related to the use of injectable drugs encounter, given that many don’t regularly access primary care.

For these reasons, EDs are a critical point of leverage in the nation’s efforts to end the opioid crisis. To prepare and support ED staff in offering evidence-based OUD treatment, FORE has funded three organizations that are working collaboratively to educate clinicians about the benefits of initiating medications for OUD (MOUD) in the ED and guiding patients to community providers who can provide ongoing care.

The National Emergency Medicine Consortium — made up of representatives of the [American College of Emergency Physicians \(ACEP\)](#)/Emergency Medicine Foundation, the [Get Waivered](#) campaign at Massachusetts General Hospital, and the Public Health Institute’s [California Bridge](#) program (CA Bridge) — is also providing technical assistance to clinicians and hospitals that are adapting their policies, procedures, and staffing to make OUD treatment more widely available.

Despite launching in March 2020, just as EDs were being inundated with COVID-19 patients, the consortium has made significant progress. This issue brief describes its approach and the policy and payment changes needed to make the initiation of OUD treatment in the ED and the handoff to outpatient care standard practice across U.S. hospitals.

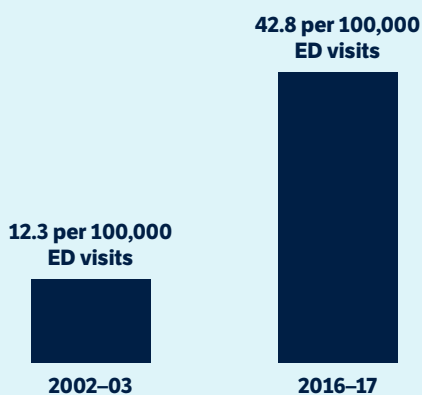
KEY TAKEAWAYS

- 1** Emergency departments are a critical point of leverage in the nation’s efforts to end the opioid crisis.
- 2** Research shows that initiating treatment for opioid use disorder in the ED improves outcomes, but many EDs have yet to adopt the standard of care: prescribing medication and connecting patients to follow-up care.
- 3** To accelerate the adoption of evidence-based practices, FORE grantees are providing education and technical support to EDs across the U.S.

CHANGING MINDSETS

Research has shown that prescribing buprenorphine, one of several MOUD, in the ED can be an effective way to engage people in treatment. One [study](#) found patients who received the medication in the ED and were given brief interventions and guided to outpatient providers for follow-up care — ACEP’s [recommendation](#) for treating opioid withdrawal — were twice as likely to be in treatment 30 days later compared with those who received only referrals or referrals and brief interventions. Three-quarters of those who received MOUD in the ED and warm handoffs to community providers were still in treatment, compared with 37 percent of those who only received referrals and 45 percent of those who also had brief interventions.

The rate at which buprenorphine is dispensed in EDs has increased over time.



Source: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7576404/>

Still, treatment has not kept pace with the rise in opioid overdoses.

Only 8.5%

The percentage of ED visits for opioid overdose that resulted in a buprenorphine or naloxone prescription, according to a [study](#) of 149,000 ED visits between August 2019 and April 2021.



Experts say small and rural hospitals are less likely than large academic medical centers to implement evidence-based practices for treating OUD.

Failing to intervene can have devastating consequences. The one-month and one-year mortality rates for people treated in the ED for non-fatal opioid overdoses are 1.1 percent and 5.5 percent, respectively.

The consortium has used a variety of strategies to persuade ED clinicians that delivering OUD treatment is a priority on par with treating heart attacks. The first is to counter the sense of being overwhelmed. “When people feel like ‘we can’t take on yet another thing,’ that’s an emotion that requires an emotional response,” says Arjun K. Venkatesh, M.D., M.B.A., M.H.S., who leads ACEP’s [Emergency Quality Network \(E-QUAL\) Opioid Initiative](#). The Opioid Initiative offers training and technical assistance to help ED clinicians assess and modify their practices for treating OUD patients and adopting harm reduction interventions such as prescribing naloxone to reverse overdoses. “We point out it’s one of the most impactful and effective things we can do as clinicians.”

MAKING IT EASY

Venkatesh says the fastest way to change ED practices is to make the process of prescribing buprenorphine and making referrals to outpatient care as easy as possible. At the outset of the pandemic, this meant helping clinicians navigate the changing and confusing regulations surrounding the DEA-X waiver.

The Get Waivered Campaign has sought to make the process transparent, guiding medical students, residents, and ED staff through the process of obtaining a DEA X-waiver to prescribe buprenorphine. It offers online training of varying lengths — from eight minutes to an hour — that covers the process of becoming waived and treatment protocols, including how to manage opioid withdrawal. Between March 2020 and July 2022, Get Waivered has trained more than 2,600 health care providers, Shuhan He, M.D., an emergency physician at Massachusetts General Hospital who leads Get Waivered’s digital operations, says the goal is to change the norm surrounding OUD treatment in the ED. “We want to make the process of getting waived as easy as possible with a website where people can go and with the click of a button get enrolled in a course,” He says.

Moving to a remote-only platform at the start of the pandemic enabled Get Waivered to scale quickly. “Rather than courses with 20 to 30 providers attending in person, we were able to enroll 1,200 in the May 2020 course, breaking the Zoom cap of 1,000 people,” He says.

Get Waivered continues to conduct outreach over social media and on clinical websites to recruit a corps of clinicians who are ready and willing to help. As part of that strategy, the campaign’s leaders have developed data visualization tools to make the prevalence of OUD in communities salient to clinicians. And, while waiver requirements have changed over the past year, ED clinicians still value the content of the training as information needed to provide good care.

CHANGING WORKFLOWS

The consortium has also sought to support busy EDs as they introduce or streamline processes for identifying, treating, and referring OUD patients to ongoing care. Through the CA Bridge program, the Public Health Institute offers technical assistance to clinicians, hospitals, and policymakers across the U.S. who are interested in expanding access to MOUD through EDs but concerned about the burden on staff and other impediments.



For many years, physicians were required to undergo eight hours of training to receive a waiver needed to prescribe buprenorphine, a requirement many believe deterred clinicians from treating OUD patients and perpetuated a stigma against those with addiction. In April 2021, the Biden Administration lowered this barrier by announcing that physicians, nurse practitioners, and physician assistants could treat up to 30 patients without additional training, provided they file a notice of intent to prescribe.

Any physician who wants to treat more than 30 patients must still complete the eight hours of training; nurse practitioners and physician assistants must undergo 24 hours. This rule rarely applies to ED clinicians because there are few circumstances under which they would treat 30 patients with OUD at a given time.

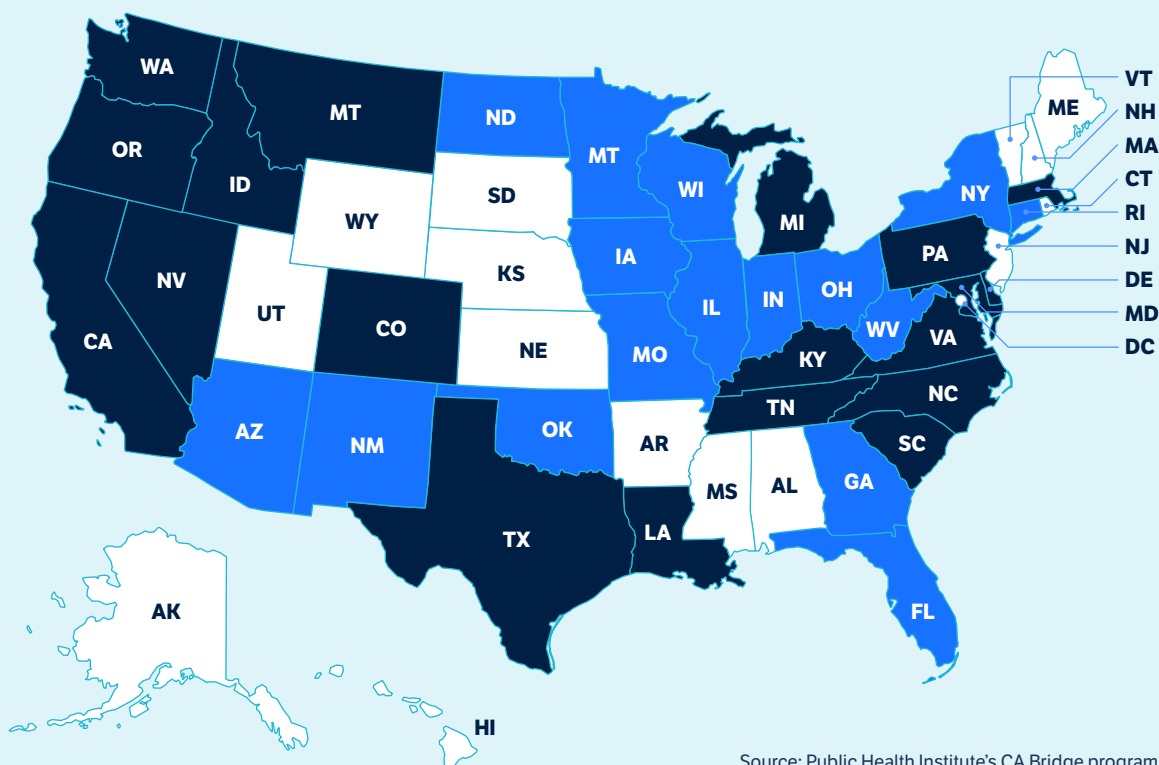
In California, CA Bridge has supported hospitals that are embedding “substance use navigators” in EDs to identify and assist people who need treatment for substance use disorders. “They are there ironing out all of these barriers to care that have been, unfortunately, a part of the system — from connecting to a pharmacy that carries buprenorphine to finding an outpatient prescriber who will continue to provide frictionless access to this lifesaving treatment,” says Arianna Campbell, a physician assistant who serves as co-principal investigator for the project. The salaries of the navigators, who now work in 194 of California’s 206 hospitals, were initially funded by state and federal grants and are now covered through the state Medicaid program’s new community health worker benefit.

Funding from FORE has also enabled CA Bridge to support hospitals around the country whose leaders are interested in expanding access to MOUD. Among other activities, CA Bridge has developed and disseminated protocols for initiating buprenorphine in the ED after an overdose reversal and delivering MOUD during pregnancy, as well as patient education materials. Program staff also offer education and support to clinicians via webinars, learning collaboratives, and one-on-one consultations.

CA Bridge’s National Reach

- Statewide assistance with strategy or implementation
- Provider and site level training or technical assistance

As of June 2022, the Public Health Institute’s CA Bridge program has consulted with hospitals, ED clinicians, and policymakers in nearly 40 states, helping them identify and overcome impediments to expanding access to MOUD in the EDs.



Source: Public Health Institute’s CA Bridge program

“We’ve been able to communicate the things that make a big difference, as well as the impact of utilizing a navigator within the ED,” Campbell says. Partnerships with community providers are also critical to ensuring no patient falls through the cracks. The ED at Placerville, Calif.–based Marshall Medical Center where Campbell works has forged a partnership with a nearby clinic that sees the ED’s OUD patients the next business day to continue treatment. Among OUD patients who were given treatment and referrals from the ED over the last four years, more than 90 percent followed up with community providers and roughly 40 percent have remained in treatment at one year, Campbell says.

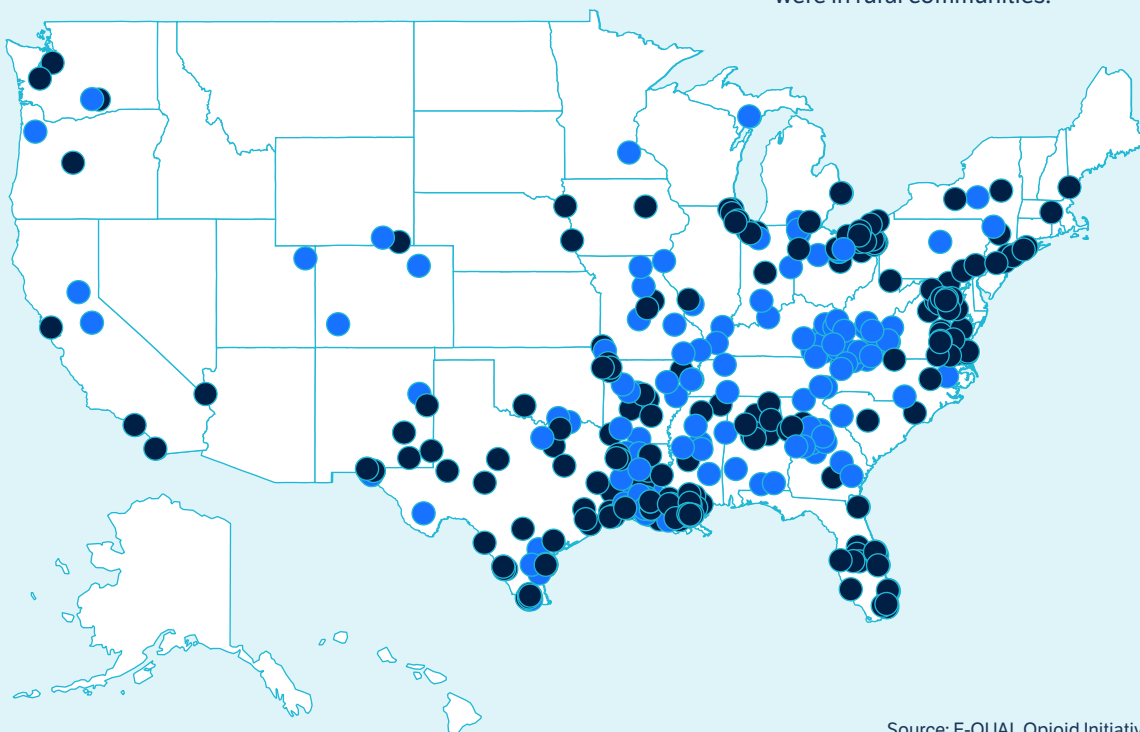
All of the California hospitals that CA Bridge partners with now have established relationships with community providers, including private clinics, federally qualified health centers, or telemedicine providers. With the rapid establishment of MOUD initiation in California’s EDs, CA Bridge is close to achieving its goal of universal access to on-demand treatment in the ED.

BENCHMARKING PROGRESS

The E-QUAL Opioid Initiative, run by the ACEP/Emergency Medicine Foundation, is helping EDs assess their effectiveness at delivering OUD treatment and harm reduction services. As part of a quality improvement project, EDs review charts to assess how frequently patients are evaluated for substance use and how often patients with OUD are offered treatment, naloxone, or referrals to ongoing care. Thirty-six percent of the 385 participating EDs are in rural areas, including some in critical access hospitals that have fewer training resources and quality improvement staff than academic medical centers.

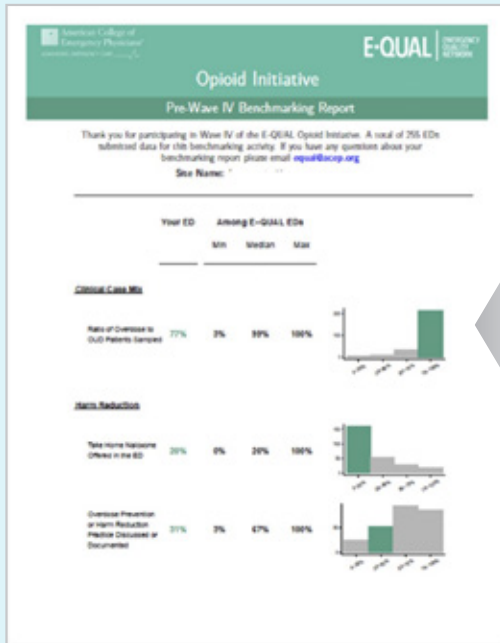
Map of EDs in the E-QUAL Network Opioid Initiative

● Urban ● Rural



Source: E-QUAL Opioid Initiative

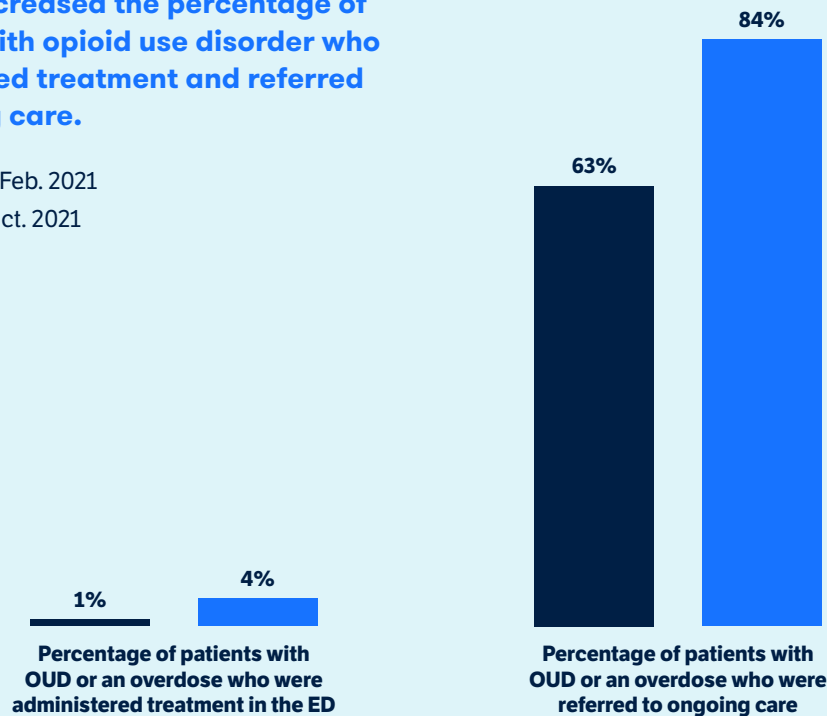
EDs participating in the E-QUAL Opioid Initiative benchmarked their performance on six metrics.



- Substance use evaluation in the ED
- Take-home naloxone offered in the ED
- Treatment administered in the ED
- Treatment prescribed at discharge
- Overdose prevention or harm reduction practice discussed or documented
- Referral to substance use disorder treatment offered

The EDs increased the percentage of patients with opioid use disorder who were offered treatment and referred to ongoing care.

■ Sep. 2020–Feb. 2021
■ Jul. 2021–Oct. 2021



Roughly 30 percent of the EDs reported they were able to offer patients with an opioid overdose access to a peer navigator and nearly 70 percent reported they could refer patients to outpatient OUD treatment. Fewer (6.3%) had a protocol to initiate buprenorphine in the ED. The latter can be “a tough nut to crack for people who have been doing things the same way for many, many years,” says Scott Weiner, M.D., M.P.H., co-lead of the E-QUAL Opioid Initiative and director of the Brigham Comprehensive Opioid Response and Education (B-CORE) Program at Brigham & Women’s Hospital in Boston.

Encouraging chart reviews and calling attention to successes — including counts of patients who have successfully transitioned to outpatient care — helps build staff investment. So does information about the mortality rates for patients who are not offered treatment. “The data really helps bring more people to the table,” says Kathryn Hawk, M.D., M.H.S., associate professor of emergency medicine at Yale University and co-lead of the E-QUAL Opioid Initiative.

LESSONS

Creating incentives and nudges

Each of the organizations in the consortium has pursued a similar strategy of pairing education on best practices with supports to address the challenges that inevitably arise as busy ED clinicians adopt new protocols. E-QUAL did so by providing tools and rapid feedback on a limited set of chart reviews, enabling providers to quickly identify areas for improvement. To encourage participation in its learning collaboratives, E-QUAL offers free continuing medical education credit to clinicians; their institutions can receive credit for the Centers for Medicare and Medicaid Services’ [Merit-Based Incentive Payment System](#).

Some states have used a top-down approach to encourage ED clinicians to increase access to MOUD. In 2018, Massachusetts passed [legislation](#) requiring all EDs to have the capability to initiate MOUD. Pennsylvania relies on incentives to spur changes in clinical practice. In 2019, the state offered hospitals participating in its [Opioid Hospital Quality Improvement Program](#) incentive payments for implementing one or more of the following clinical pathways: initiating buprenorphine treatment in the ED; making a warm handoff to outpatient treatment; referring pregnant patients for care; and initiating methadone or buprenorphine treatment on an inpatient basis. In the first year, hospitals that pursued all four were eligible for a \$193,000 payment. The state subsequently offered incentives to increase the rate of follow-up treatment for Medicaid beneficiaries within seven days of an ED visit for opioid-related illness.

Researchers [found](#) that while most hospitals participated in the program, only half pursued all four strategies. Qualitative interviews with hospital and health system staff [suggested](#) smaller and independent hospitals with lower volumes of OUD patients weren’t able to justify the investment despite the incentive payment.

Explicit financial supports could also help. Public and private payers could offer per-patient supplements to cover ED services for OUD patients. In California, the state helps to subsidize OUD care by covering the cost of the navigators who have proven instrumental to engaging patients and linking them to ongoing treatment.

At a minimum, states or local public health departments and payers could cover the cost of harm reduction supplies so that EDs have incentive to keep naloxone in stock. Funding for such supplies was disrupted during the pandemic, as many public health departments shifted their attention to the COVID-19 response, Venkatesh says.

Strengthening the care continuum

As EDs develop the capacity to initiate OUD treatment, they need a strong outpatient system to receive these patients — from pharmacies prepared to dispense buprenorphine and educate patients about MOUD to outpatient providers able and willing to provide ongoing buprenorphine treatment to patients for at least six months. “That’s the minimum duration of time we believe people need to be on buprenorphine for it to work,” says Bradley Stein, M.D., Ph.D., director of the Opioid Policies, Tools, and Information Center at RAND Corp.

Stein’s research suggests patients are falling through cracks in the system. He found three-quarters of patients (71.5%) who filled an initial buprenorphine prescription from an emergency physician did not fill subsequent prescriptions from other clinicians. Those who did tended to live in metropolitan counties (88.6%).

“

If you start someone in the ED but there’s no one to catch them, so to speak, you have a problem.”

– Bradley Stein, M.D., Ph.D., director of the Opioid Policies, Tools, and Information Center at RAND Corp

One way to encourage more outpatient providers to provide follow-up care would be to offer primary care providers an episode-based payment for doing so, Venkatesh says. Technology could also be leveraged: providers who offer OUD treatment via telemedicine could form a virtual bridge, assuming the role of helping patients find community-based providers during the vulnerable transition to long-term treatment.

“We know that when a person who has overdosed is admitted to the ED, it is a critical opportunity to offer and engage them in evidence-based treatment,” says Karen Scott, M.D., M.P.H., FORE’s president. “Our ED consortium grantees are showing concrete, collaborative ways to help ED clinicians and hospitals build a continuum of care for OUD treatment, reduce the stigma around addiction, and build a community of practice in which it is normal, and expected, to treat OUD patients.”



FORE is a national, private, grantmaking foundation focused on inspiring and accelerating action to end the opioid crisis.

We are committed to convening and supporting partners advancing patient-centered innovative, evidence-based solutions to make the greatest impact on the crisis.

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