

Models for Addressing Transitions of Care for Patients with Opioid Use Disorder *An Information Paper*

In addition to implementing a medication-assisted treatment (MAT) program for patients with opioid use disorder (OUD) in the emergency department (ED), a variety of complementary interventions in the ED setting can also improve short-term outcomes. However, the ability to develop and implement such interventions is likely to vary considerably based on a given ED's capacity, resources, and patient volume. This report outlines potential interventions EDs should consider in order to facilitate the transition of patients with OUD to the outpatient setting.

One idealized model might start with a behavioral health professional providing a Screening, Brief Intervention, and Referral to Treatment (SBIRT). The Brief Negotiation Interview (BNI) is a structured SBIRT focused specifically on patients with opiate addiction. Appropriately selected patients would then be administered a dose of buprenorphine in the ED. Further education, such as training in naloxone use or on safe injection techniques, could be provided. An outpatient appointment would be made for the patient while in the ED, and other resources, such as needle exchange programs, could be provided. The patient would be discharged with a prescription for naloxone or naloxone in hand. After discharge, the patient would receive a call from the ED behavioral health professional to assist the patient in overcoming unanticipated barriers in following up with the clinic.

Utilizing Allied Health Professionals

Facilitating these interventions has the potential to be time consuming, making it difficult for ED providers to buy-in to such process. However, ancillary staff may be incredibly helpful in facilitating and/or performing many of these tasks. It is, therefore, critical that emergency physicians have an understanding of other care team members who might perform these tasks:

- **Social workers** are licensed professionals who could provide counseling and connect patients to outpatient MAT resources. Different social workers have different backgrounds, such as medical, mental health, or substance abuse. Social workers can bill for services. While specifics vary from state to state, there are three categories:
 - LICSW – licensed independent clinical social workers able to practice independently
 - LAICSW – licensed associate independent clinical social workers are recent graduates required to do several years of supervised work prior to becoming truly independent
 - LCSW – licensed clinical social workers who cannot practice independently and need to be associated with an agency

- **Case managers** frequently have a nursing background and are focused on care coordination and discharge planning. Case managers have a strong background in care navigation and understanding outpatient resources but might not have the same counseling background as social workers. Case managers cannot bill for services.
- **Peer counselors** are unlicensed individuals who have personal experience with addiction. While they lack formal training or certification, their lived experience can provide significant credibility and motivation.
- **Care navigator** is a loosely defined term applied to individuals focused on connecting patients to outpatient resources and potentially following up via phone to ensure the patient has connected with outpatient resources. Any of the above roles can serve as care navigators.

Naloxone Prescribing

Examples of resources with key considerations for [emergency department naloxone distribution in the ED is provided at the Prescribe to Prevent web site](#). It includes a Naloxone product comparison chart, instructions for healthcare professionals, billing information, and a reference to the ACEP's EQUAL materials on key considerations and implementation strategies for Naloxone distribution in the ED, as well as a sample policy.

Hand-off from Emergency Department to Outpatient Setting

Emergency departments may choose to have various means of transitioning patients whom they have started on MAT into the outpatient setting. This is, again, dependent on resources available to the individual department or system. Some models that have been used include:

- **Warm hand-offs:** This is a transfer of patient care from the emergency department into the next steps of care. In some cases, this may mean that the patient goes directly to a facility where inpatient treatment or detox can be continued. In others, there is an appointment set up for the patient to go after discharge from the ED.
 - Many systems that have developed purely warm handoffs utilize case managers, peer counselors, or LICWs to facilitate the transition (see above for definitions).
 - Some areas have developed electronic resources to maintain up-to-date availability of follow-up care that can be accessed by patients or ED staff.
 - Some organizations offer telemedicine services to help transition ED patients into their outpatient care network.
- **Cold handoffs:** These encompass situations when no direct communication between ED provider and outpatient follow-up occurs. In these cases, patients are often given a list of referrals to locations where they can seek next steps in care. Warm hand-offs are likely more effective than cold hand-offs.

Transitioning to Outpatient Care

In general, the goal is to obtain follow up within 1-3 days. However, even this can be flexible depending on the type of follow-up system available within a given community. In health systems where there are

resources for the patient to go either directly to an outpatient care provider or have a next-day appointment set up, ED providers may only need to dispense buprenorphine when a patient presents with active withdrawal. If a same or next-day appointment is not available, the ED should have a plan for providing patients with subsequent doses of buprenorphine for those started in the ED, and home induction for those who do not present in moderate to severe withdrawal. In some cases, this may be a prescription for buprenorphine, which can only be prescribed by providers who have received their DEA X-waiver license. In other cases, it may be instructing the patient to return to the ED for their next dose under the 72-hour rule. Yet another option is to refer patients to so-called “low-barrier” clinics where eligible patients can immediately be initiated on buprenorphine. Other facilities have successfully established a transition clinic capable of continuing patients initiated on buprenorphine in the ED while a definitive long-term care plan is arranged.

Ideally, follow-up locations should provide a full menu of treatment options, including social support services and counseling. However, some communities may not have rapid access to outpatient clinics capable of MAT and/or provide limited services. Therefore, patients may need to be referred to additional facilities for services, such as counseling, and innovative approaches, including telemedicine, may need to be explored. EDs without established MAT programs will need to look carefully at the resources in their community as they develop programs, forging relationships to establish firm follow-up pathways in which these patients are transitioned to the outpatient setting. Although many partnering organizations may exist, several to consider include:

- Federally Qualified Health Centers (FQHCs)
 - There are options available via FQHCs for MAT but may be more challenging to find in rural areas - <https://onlinelibrary.wiley.com/doi/10.1111/jrh.12260>
- Rehabilitation/detox facilities
 - Opioid treatment centers (residential/outpatient/recovery clinics)
 - Methadone clinics
 - NA/AA (are options to assist with behavioral component of treatment)
- Private clinics
 - Primary care clinics accepting referrals for buprenorphine treatment (may be limited by patients having a funding source)
 - Pain clinics
 - Low barrier MAT clinics
 - Methadone clinics
 - SAMHSA Behavioral Health Treatment Services Locator - www.findtreatment.samhsa.gov
 - Consider specialty clinics for those with comorbidities such as HIV and for pregnant patients
- Telemedicine
 - Behavioral health specialists to address psychiatric component of care
 - Addiction counselors
 - Apps
 - FDA approved app provides cognitive behavioral therapy as adjunct to their treatment process, shown to increase compliance with treatment
<http://contemporaryclinic.pharmacytimes.com/news-views/outpatient-treatment-app-available-for-adults-with-oud>

Assessing Success of MAT Programs

Evaluation of interventions for the management of OUD patients can be evaluated on three levels: patient focused outcomes, provider focused outcomes, and system level outcomes. Implementation of a MAT program should begin with an assessment of the size and scope of the problem, as well as the collection of data from the pre-intervention period in order to ascertain the scope of effect. This is particularly true in settings where resources are tightly controlled, and the demonstration of economic viability is essential to obtaining funding for a long-term MAT program.

Patient-focused outcomes include:

1. Patient satisfaction with the program
2. Patient outcomes (death, 30-day return visits, etc)
3. Availability of patient support services (social worker, peer counseling, case management, etc)
4. Relapse rate for patients enrolled in the MAT program
5. Availability of naloxone training and dispensing

Provider-focused outcomes include

1. Ease and availability of provider training programs
2. Provider satisfaction with the MAT intervention processes
3. Availability of ancillary OUD support services (social worker, peer counseling, case management, etc.)
4. Availability of professional compensation of MAT initiation

System level outcomes include:

1. Frequency opioid related deaths
2. Frequency of opioid related ED visits and hospitalizations
3. Cost of care for OUD visits
4. Cost of expanded OUD ancillary services (social work, etc.)
5. ED and hospital throughput impact
6. Rate of successful follow up from ED to outpatient (short term, long term)
7. Percent of qualifying OUD patients who enroll that qualify (including the potential loss of opportunity if the process isn't available 24/7)
8. Availability of funding sources for hospital and community-based interventions

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