Virginia Department of
Health Professions

REPORT ON BEST PRACTICES FOR OPIOID-RELATED EMERGENCIES IN THE EMERGENCY DEPARTMENT: HB2300

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Table of Contents

I. Executive Summary ... 1

II. Recommendations ... 2

1. Identify a multidisciplinary team to establish and champion training, protocols, and continuous improvement ... 3
2. Avoid stigma and promote trust ... 3
3. Ensure that Emergency Department providers understand the DEA x-waiver ... 4
4. Build an inventory of outpatient (and residential) referral resources ... 4
5. Implement Peer Recovery Specialists into triage, treatment, and follow-up services ... 5
6. Screen patients for opioid use/misuse using the DSM-5 and the PMP ... 6
7. Screen for opiate withdrawal using the COWS ... 8
8. Offer medication for opioid use disorder treatment ... 9
9. Refer to outpatient services best suited to the patient and the configuration of the ED ... 10
10. Naloxone dispensation ... 10
11. Understand and promote harm reduction ... 11

III. Summary ... 12

I. EXECUTIVE SUMMARY

Pursuant to the enactment clause of HB 2300 (2021) a working group assembled by the Department of Health Professions met to recommend best practices for the treatment and subsequent discharge of patients presenting to Emergency Departments (EDs) with an opioid-related emergency. The report, required to be submitted to the General Assembly, serves as an implementation resource for hospitals and emergency department providers across the Commonwealth.

What follows is a list of the group's recommendations for the:

…*treatment and discharging of patients in emergency departments experiencing opioid-related emergencies, including overdose, which…include recommendations for best practices related to (i) performing substance use assessments and screenings for patients experiencing opioid-related overdose and other high-risk patients; (ii) prescribing and dispensing naloxone or other opioid antagonists used for overdose reversal; (iii) connecting patients treated for opioid-related emergencies, including overdose, and their families with community substance abuse resources, including existing harm reduction programs and other treatment providers*.[1]

These best practice recommendations promote patient-centered, wrap-around care for individuals with an opioid-related emergency or opioid use disorder who present to an Emergency Department. The care must be free of stigma and include the initiation of medication for opioid use disorder (MOUD) whenever possible. The "bridge" from ED care to outpatient treatment must be seamless, direct, and defined. A person with lived experience, specifically a Peer Recovery Specialist, can facilitate the encounter and the disposition. It is a best practice to dispense a naloxone kit to any ED patient who experiences an opioid emergency at the time of discharge.

In addition to discussing and coming to consensus on best practice recommendations, the workgroup identified two barriers to naloxone distribution, cost and delivery to point of care sites. The group also summarized existing harm reduction practices and identified Comprehensive Harm Reduction programs in the state.

[1] HB2300 (2021) https://lis.virginia.gov/cgi-bin/legp604.exe?211+ful+HB2300H1

II. RECOMMENDATIONS

Best Practices for the treatment and discharge of individuals in an Emergency Department experiencing an opioid-related emergency:

1. Identify a multidisciplinary team to establish and champion training, protocols, and continuous improvement.
2. Avoid stigma and promote trust.
3. Ensure that Emergency Department providers understand the DEA x-waiver.
4. Build an inventory of outpatient (and residential) referral resources.
5. Implement Peer Recovery Specialists into triage, treatment, and follow-up services.
6. Use the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) criteria and the Virginia Prescription Monitoring Program (PMP) patient query to screen patients.
7. Screen for withdrawal using the Clinical Opiate Withdrawal Scale (COWS).
8. Offer/ discuss Medication for Opioid Use Disorder (MOUD) treatment using buprenorphine.
    i. When the patient presents to the ED in withdrawal and consents: induce with buprenorphine and define specific follow up. In the best scenario, patients would have follow up with an outpatient-based opioid treatment (OBOT) clinic within 24-48 hours of induction. However, it that is not possible, a definite appointment time within 7 days should be secured and a “bridge” prescription for buprenorphine/naloxone given. Educate and refer to harm reduction. Consider screening laboratory tests consistent with harm reduction. Dispense a naloxone kit.
    ii. If the patient refuses MOUD induction: refer directly to outpatient-based opioid treatment (OBOT) and harm reduction. Dispense a naloxone kit.
    iii. If the individual is not in withdrawal upon ED presentation: refer within 24-48 hours to an OBOT. Educate and refer to harm reduction services. Dispense a naloxone kit. Consider prescription for buprenorphine/naloxone with instructions for home induction if clinically appropriate.
9. Refer seamlessly to outpatient services best suited to the patient and the encounter. Give the patient a specific appointment time and location. Virtual appointments may increase availability of services.
10. Every encounter stemming from an opioid emergency should include distribution of naloxone. A prescription alone does not represent best practice.
11. Understand and promote harm reduction.

Recommendations expanded:

1. Identify a multidisciplinary team to establish and champion training, protocols, and continuous improvement.

   Physicians, nurses, pharmacists, social workers, peer recovery specialists, and administrators have important roles to play. The team is encouraged to use the best practices detailed in this report to promote training, establish protocols, and identify and build relationships with referral centers. The team is responsible for identifying specific educational objectives required to ensure success and for establishing methods for measuring success. The team is encouraged to meet monthly, review cases, and adapt algorithms and protocols as necessary.

2. Avoid stigma and promote trust.

   Substance use disorder is one of the most stigmatizing conditions in the Commonwealth. Individuals with substance use disorder report feeling especially stigmatized during health care interactions. This can lead to distrust and the unwillingness to either seek or continue medical care.[2] People with a substance use disorder who experience stigma have poorer outcomes.[3] Best practices for avoiding stigmatizing an individual include ready and immediate peer recovery specialist (PRS) support, an environment that is supportive and infuses cultural and clinical humility, and the use of patient-centered, professional, objective language. The chart below offers some examples of patient-centered words and those they replace.

Patient-centered	Stigmatizing
Person with a substance use disorder	Addict, junkie, druggie
Drug use/misuse	Drug abuse
Person living in recovery	Ex-addict, clean
Recurrence	Relapse
Maintained recovery	Stayed clean
Testing positive for substance use	Dirty screen
Used needle	Dirty Needle
Utilizes services and supports when necessary	Frequent Flyer

[2] Paquette CE, et al. Stigma at every turn; health services experiences among people who inject drugs. *Int J Drug Policy.*2018; 57:104-110.

[3] Brener, L., von Hippel, W., von Hippel, C., Resnick, I., & Treloar, C. (2010). Perceptions of discriminatory treatment by staff as predictors of drug treatment completion: utility of a mixed methods approach. Drug and Alcohol Review, 29(5), 491-497.

3. Ensure that Emergency Department providers understand the DEA x-waiver.

   Data 2000 permitted physicians to obtain a DEA DATA waiver after completing an 8-hour SAMHSA-approved course to treat patients with opioid use disorder using buprenorphine. The Comprehensive Addiction Recovery Act of 2016 allowed for qualifying nurse practitioners and physician assistants to obtain x-waivers after completing 24 hours of approved coursework.[4] There are patient limits incorporated into both laws, but they refer only to the longitudinal care of outpatients and hence are not likely to pose a limitation to prescribing from the ED.[5] In April 2021, the Department of Health and Human Services released new practice guidelines allowing DEA-registered clinicians to treat up to 30 patients at one time without completing the 8-hour (or 24-hour) DATA 2000 training previously required.[6] Important: prescribers must still apply for an x-waiver by filing a Notice of Intent with SAMHSA.[7]

4. Build an inventory of outpatient (and residential) referral resources.

   Every individual treated for an opioid emergency should be provided with a direct, specific referral with an appointment time (if possible) when discharged from the Emergency Department. To accomplish this, each ED must build an inventory of available resources. Resources may include local Community Service Boards, local office-based opioid treatment (OBOT) practices, local x-waivered practitioners including psychiatrists and addiction medicine specialists, intensive outpatient programs, partial hospitalization programs, and residential treatment programs. In addition, the value of local coalitions, community recovery organizations, and harm reduction programs cannot be underestimated and any comprehensive list of referral options must include these. Virtual appointments offer the potential to use treatment providers outside the local geographic area when availability, individual preference, or insurance coverage dictates. Members of the multidisciplinary team should make direct connections and establish relationships with each potential referral resource to ensure a willingness to accept the Emergency Department's referrals, to delineate how the referral will be made, how the appointment can be guaranteed, and the like.

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[4] US Department of Health and Human Services. HHS Expands Access to Treatment for Opioid Use Disorder. Accessed October 4, 2021. https://www.hhs.gov/about/news/2021/01/14/hhs-expands-access-to-treatment-for-opioid-use-disorder.html

[5] The American College of Emergency Physicians. Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department. Accessed October 4, 2021. https://www.annemergmed.com/article/S0196-0644(21)00306-1/fulltext

[6] Federal Register: Practice Guidelines for Administering Buprenorphine for the Treatment of Opioid Use Disorder. Accessed October 4, 2021. https://www.federalregister.gov/documents/2021/04/28/2021-08961/practice-guidelines-for-the-administration-of-buprenorphine-for-treating-opioid-use-disorder

[7] Ibid.

The SAMHSA website has a treatment locator.[8] While a reasonable place to start, it is not always complete or accurate. Another place to begin is Virginia's *Curb the Crisis* website which provides both a list of Virginia's Community Service Boards[9] and a provider search system facilitated by the Virginia Department of Behavioral Health and Disability Services (DBHDS).[10]

The Department of Medical Assistance Services (DMAS) Addiction and Recovery Treatment Services (ARTS) also has a list of ARTS network providers including Preferred OBOTs and Opioid Treatment Programs.[11] The Commonwealth also has a statewide contract with the Unite Us platform through VDH, which other states have used to make closed loop referrals with substance use disorder treatment providers.

5. Implement Peer Recovery Specialists into triage, treatment, and follow-up services.

To the extent possible, hospitals should incorporate peer recovery services into their processes for triaging, treating, and discharging patients who have experienced an opioid-related emergency. A Peer Recovery Specialist (PRS) is a self-identified person with lived experience with a mental illness and/or substance use disorder who is in ongoing recovery from the challenges of their disease. These individuals use their lived experience to support health activation among individuals interested in treatment and recovery options prior to discharge and support another person's recovery journey. The PRS provides non-clinical, person-centered, strengths-based, wellness-focused, and trauma-informed support to another in the development of their wellness-recovery plan.[12] They are able to serve as health advocates or navigators in the ED and can assist with motivating patients toward treatment.[13] They are able to maintain contact with discharged patients through telephone follow-up.

In Virginia, to ensure both compliance (e.g. with HIPPA) and payment for a PRS working in the ED, the peer needs to be trained, certified, and subsequently registered with the Department of Health Professions, Board of Counseling. To begin the certification and registration processes, a PRS successfully completes the 72- Hour DBHDS Peer Recovery Specialist Training. They must secure 500 hours of Peer Recovery Work Experience to qualify as a Certified Peer Recovery Specialist (CPRS) with the Virginia Certification Board. (Alternatively, a PRS may meet requirements for certification as a National Certified Peer Recovery Support Specialist (NCPRSS) with

[8] US Department of Health and Human Services SAMHSA Treatment Locator. Accessed October 4, 2021. https://www.findtreatment.gov/
[9] *Curb the Crisis*. Accessed October 4, 2021. https://curbthecrisis.com/get-help/
[10] Provider Search System, DBHDS. Accessed October 4, 2021. http://lpss.dbhds.virginia.gov/lpss.aspx
[11] DMAS Information and Provider Map. Accessed October 12, 2021. https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/
[12] Virginia Peer Recovery Specialist Network. Accessed October 4, 2021. https://virginiapeerspecialistnetwork.org/getting-started/
[13] The American College of Emergency Physicians. Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department.

the Association for Addiction Professionals or be certified by another state, national or Veterans Administration process.)[14] The individual then registers with the Virginia Board of Counseling. An application Handbook is available on line.[15] There is a growing trend to adopt PRSs within addiction and mental health services. Current literature supports the inclusion of peer support workers in the mental health care workforce to improve patient engagement, to instill hope, and to promote better clinical outcomes.[16]

6. Screen patients for opioid use/ misuse using the DSM-5 and the PMP.

   EDs disproportionately provide care to patients with opioid use disorder (OUD) who may present for emergency care with concerns directly related or tangentially related to their opioid use. Identifying OUD in ED patients when opioid misuse is not explicit in their presentation allows the ED provider to consider comprehensive treatment and follow-up services. A variety of opioid misuse screening tools are available, but the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) criteria are uniquely able to both quickly screen the patient and estimate the severity of the illness. The criteria, which are copied on the next page, are easily incorporated into the provider's electronic medical record as a favorite phrase.

   The use of the DSM-5 criteria is enhanced by a query of the patient's prescription history through the Virginia Prescription Monitoring Program (PMP). The PMP collects prescription data into a central database. The information collected in the PMP is maintained by the Department of Health Professions. Prescribers and dispensers query the database to access both two years of prescription data and the patient's Narx Scores. A Narx Score is a numeric reflection of a patient's controlled drug use. The Narx Score quantifies risk with a three digit number ranging from 000 to 999. The score offers a composite risk index computed separately for narcotics, sedatives, and stimulants. The distribution of scores is such that in any given population 75% fall below 200, 5% are above 500, and 1% are above 650. The higher the number, the higher the risk. The last digit in the score represents the number of active prescriptions.[17] There is a fourth Narx Score: the overdose risk score which represents the risk of unintentional overdose death.

[14] DBHDS Virginia PRS Certification and Registration Pathways. Accessed October 4, 2021. https://dbhds.virginia.gov/assets/doc/recovery/certification-and-registration-pathways-final.pdf

[15] Department of Health Professions, Board of Counseling. Online Application Handbook for QMHP and RPRS. Accessed October 4, 2021. https://www.dhp.virginia.gov/Forms/counseling/Online_Application_Handbook_QMHP.pdf

[16] Shalaby and Agyapong. Peer Support in Mental Health: Literature Review. *JMIR Mental Health.* June 2020. Accessed October 4, 2021. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7312261/

[17] Department of Health Professions, Prescription Monitoring Program. *How to Utilize NarxCare.* Accessed October 4, 2021. https://www.dhp.virginia.gov/media/dhpweb/docs/pmp/NarxCare%20Factsheet.pdf

Diagnostic Criteria (Substance use disorder requires at least 2 criteria be met within a 12 month period)	Meets Criteria? Yes	 No	Notes/supporting information
1. Substance often taken in larger amounts or over a longer period than intended.			
2. There is a persistent desire or unsuccessful efforts to cut down or control the substance use.			
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.			
4. Craving or a strong desire to use the substance.			
5. Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home.			
6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.			
7. Important social, occupational or recreational activities are given up or reduced because of substance use.			
8. Recurrent substance use in situations in which it is physically hazardous.			
9. Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.			
10. *Tolerance, as defined by either of the following: a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect. b. Markedly diminished effect with continued use of the same substance.			
11. *Withdrawal, as manifested by either of the following: a. The characteristic withdrawal for the substance. b. The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.			

*This criterion is not considered to be met for those individuals taking prescription opiates solely under medical supervision.

Severity: Mild: 2-3 symptoms, Moderate: 4-5 symptoms, Severe: 6 or more symptoms.

Signed ______________________________ Date ______________

Criteria from American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.* Washington, DC, American Psychiatric Association page 541.

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Screening may also include a mental health/suicide risk assessment and laboratory tests: liver function tests, urine pregnancy test, urine drug screen, HIV screen, and a hepatitis panel. There is no need to wait for the results to return prior to treatment. While the ED provider will review the results when they come back, it is prudent to have the results copied to the outpatient provider who will follow the patient upon discharge from the ED and for the team-building the referral inventory to have secured that relationship officially.

7. Screen for opiate withdrawal using the COWS.
   The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician. The tool can be used to reproducibly rate common signs and symptoms of opiate withdrawal and to monitor them over time. The summed score can be used to help providers determine the stage or severity of opiate withdrawal.[18]

   A patient with a COWS score of 5-12 is in mild withdrawal, from 13-24 moderate withdrawal, 25-36 moderately severe withdrawal, and over 36 severe withdrawal. A copy of the COWS scoring sheet is reproduced below.

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:____________________	Date and Time ___/___/___:_________
Reason for this assessment:______________________	
Resting Pulse Rate: _________beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset:** *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score ________ The total score is the sum of all 11 items Initials of person completing assessment: ______________

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

Journal of Psychoactive Drugs Volume 35 (2), April - June 2003

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs*, 35(2), 253–9.

[18] Clinical Opiate Withdrawal Scale. Accessed October 4, 2021. https://www.drugabuse.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf

8. Offer medication for opioid use disorder treatment.

   Although specific protocols will vary among EDs, the patient with moderate to severe opioid use assessed through questions derived from the DSM-5 criteria and experiencing at least moderate withdrawal on the COWS should be offered treatment with buprenorphine in the ED. COWS scores of 8-13 are a minimum for starting buprenorphine in the ED.

   Sample protocols may be useful for the hospital developing the protocol for the induction of medication for opioid use disorder in their own ED.

   - Yale School of Medicine: ED-Initiated Buprenorphine[19]
   - Management of Opioid Use Disorder in the Emergency Department: A White Paper prepared for the American Academy of Emergency Medicine[20]

   Best practice protocols include:

   - Offering buprenorphine induction to individuals experiencing withdrawal or those who seek MOUD
   - Implementing and engaging peer recovery services
   - Verified, scheduled in-person or virtual appointment for out-patient treatment
   - Prescriptions for buprenorphine/naloxone to “bridge” the period from hospital discharge to out-patient appointment
   - Naloxone kit dispensed directly to the individual (2 doses of naloxone, risk factor information, directions for use)
   - Harm reduction strategies offered

   If the patient is not in withdrawal as measured by the COWS score, refer to outpatient treatment with a specific appointment time, offer PRS services, consider a virtual appointment especially for weekends and holidays and provide harm reduction including a naloxone kit. Discuss outpatient induction with buprenorphine.

   Some patients who are not in withdrawal upon presentation to the ED may be candidates for home induction. While the ED provider is equipped to educate and provide the prescription for buprenorphine/naloxone, most commonly, the outpatient follow-up provider monitors the home induction. Yale School of medicine has a sample protocol.[21]

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[19] Yale School of Medicine: ED-Initiated Buprenorphine. Accessed October 5, 2021. https://medicine.yale.edu/edbup/

[20] Strayer, et al. Management of Opioid Use Disorder in the Emergency Department: A White Paper prepared for the American Academy of Emergency Medicine, *The Journal of Emergency Medicine*, 58:3 pp522-546, 2020.

[21] Yale University School of Medicine: A Guide for Beginning Buprenorphine Treatment at Home. Accessed October 8, 2021. https://medicine.yale.edu/edbup/Home_Buprenorphine_Initiation_338574_5_v1.pdf

If the patient refuses treatment in the ED, give an appointment with an outpatient provider and provide harm reduction including dispensing a naloxone kit. A PRS can reconnect by phone after the discharge.

9. Refer to outpatient services best suited to the patient and the configuration of the ED.

   One of the most important aspects of the treatment of opioid emergencies in the ED is how the patient is discharged. The referral to outpatient opioid treatment services is often called the "bridge" to services. The more intentional, directed, and defined the handoff is, the more likely the patient will remain in treatment or seek treatment. This is the reason that the preliminary work defined in this report includes the development of a referral network inventory and the establishment of relationships with outpatient providers that "warm" the handoff.

   Large medical centers and hospitals that are part of a healthcare network may have the opportunity to refer "vertically." That means that providers dedicated to the outpatient-based treatment of OUD are directly connected to the ED either by a shared contract or perhaps through electronic medical record (EMR) access. Both VCU and Carilion Clinic, who are represented on the workgroup, refer vertically. VCU has established its "MOTIVATE" Clinic and Carilion has a dedicated OBOT which accepts referrals and continues ED-initiated care. They also can refer the patient for methadone induction and treatment when that is appropriate.

   Most EDs will not have access to an outpatient program within the hospital or hospital system. The "bridge" must be constructed horizontally. The referral inventory and relationships built between the ED and outpatient providers are the foundation for the "warm handoff" of the patient from the ED. The patient should be given the name, location, and date/time of the appointment at discharge. If there is more than 24 hours before the scheduled appointment, "bridge" prescriptions for buprenorphine/naloxone should be given. Virtual visits are now more common. A virtual visit expands the referral catchment area and may be especially useful on a weekend or holiday.

10. Naloxone dispensation.

    Every patient seen in the ED who screened in for OUD/SUD should leave the ED with a naloxone kit. Providing only a prescription for naloxone is not best practice.

Naloxone typically dispensed from healthcare settings includes:

Intranasal Naloxone Kit		Intranasal Naloxone Spray
• 2 naloxone 1mg/ml 2ml (2mg total) prefilled syringes • 2 mucosal atomization devices (MAD) • Directions for assembly and use • Risk factor information • Referral information to harm reduction services	OR	Twinpack of two naloxone intranasal sprays (4mg each)

The Virginia Commissioner of Health has issued a standing order for naloxone which authorizes Virginia pharmacies to dispense naloxone without a prescription and expands authority to dispense intranasal or auto injector formulations to certain other individuals.[22] While not all naloxone is reported to the PMP, in the second quarter of 2021, just under 15,000 naloxone prescriptions were dispensed through a pharmacy; 5% of the those total dispensations were through the standing order.

The Virginia Board of Pharmacy revised its Naloxone Protocols in February 2021 and recommended that the 8mg dosage form of naloxone be added to its protocols in September 2021 (currently in the comment period).[23] The protocols delineate who is able to prescribe and dispense the drug and the required training to do so. The two biggest barriers to naloxone availability appear to be cost (estimated to be $125-$150/dose) and access at the immediate point of care. The cost of injectable naloxone, which requires the medication to be drawn up into a syringe and injected either into a muscle or subcutaneously, is significantly less than the nasal preparations (about $15). The Chris Atwood Foundation has distributed over 50,000 doses at no charge through the mail to individuals who have qualified by watching an 8 minute training video and answering a short quiz.[24]

Hospital pharmacies are accountable for the distribution and dispensing of naloxone within the health-system environment. Updates to the Naloxone Protocols by the Virginia Board of Pharmacy remove some operational challenges by establishing a feasible approach to the dispensing of naloxone to patients from ED settings. For instance, with regards to labeling requirements, the Naloxone Protocols do not

[22] Virginia Statewide Standing Order for Naloxone https://www.vdh.virginia.gov/content/uploads/sites/4/2016/11/Standing-Order-w-o-DEA-FINAL.pdf

[23] Virginia Board of Pharmacy 110-44 Protocol for the Prescribing and dispensing of Naloxone. Accessed October 5, 2021. https://www.dhp.virginia.gov/Pharmacy/guidelines/110-44.pdf

[24] The Chris Atwood Foundation. Get Free Naloxone Mailed Straight to You. Accessed October 5, 2021. https://www.thecaf.org/get-narcan

require the patient's name to be on the dispensed naloxone. A best practice within the healthcare environment is to provide medications in the most ready-to-use form.

Thus, the intranasal naloxone spray is the preferred dosage formulation as it requires minimal preparation and less steps to administer. As stated previously, this dosage formulation carries a higher cost, and is recognized as a barrier. The workgroup opined that there may be a way for VDH to distribute pre-purchased naloxone to a hospital pharmacy. Addressing the operational and financial considerations facilitates a practical pathway for hospital pharmacies to implement this best practice recommendation.

11. Understand and promote harm reduction.

    Harm reduction refers to the policies, programs, and practices that aim to minimize the negative health, social, and legal impacts associated with drug use. It is grounded in principles that improve public health and protect the dignity of the individual. Harm reduction includes education, screening laboratory tests such as liver function tests, hepatitis panels, pregnancy tests, screening for HIV, and the like. It includes the provision of appropriate vaccinations and medications such as those used to treat Hepatitis C and pre and post-exposure HIV.

    Comprehensive harm reduction (CHR) in the Commonwealth includes the provision of sterile injection equipment and equipment exchange. There are currently six comprehensive harm reduction programs in Virginia.[25] In addition to "needle exchange," all comprehensive harm reduction sites refer clients to OBOT, employ individuals at various stages of recovery and PRSs, offer or refer for laboratory tests, and dispense naloxone. CHR program participants are protected from prosecution for possession of paraphernalia acquired through the program. Since 2018, CHR programs have served 3800 participants who report using naloxone to reverse 1,950 overdoses.

III. SUMMARY

The Emergency Departments in the Commonwealth are an appropriate venue to address the escalating opioid crisis. Individuals presenting to an ED with a life-threatening condition such as overdose or who seek treatment for withdrawal symptoms can access the care they need. The ED visit provides an opportunity to identify individuals experiencing an opioid-related crisis, offer motivational strategies to enhance the acceptance of treatment, initiate evidence-based treatment interventions, and provide

[25] CHR services are located in the Lenowisco health district, the Mount Rodgers health district, and through Health Brigade, the Council of Community Services, Strength in Peers, and the Chris Atwood Foundation. Contact information is on the VDH webpage accessed October 6, 2021. https://www.vdh.virginia.gov/disease-prevention/chr/

direct linkages for ongoing medical management (including naloxone) and community support services.

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