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

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VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS
9960 MAYLAND DRIVE, SUITE 300
HENRICO, VIRGINIA 23233-1463
(804) 367-4400
WWW.DHP.VIRGINIA.GOV
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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, if 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. People with a substance use disorder who experience stigma have poorer outcomes. 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.

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

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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.

7 Ibid.
The SAMHSA website has a treatment locator. 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 and a provider search system facilitated by the Virginia Department of Behavioral Health and Disability Services (DBHDS).

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. 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. They are able to serve as health advocates or navigators in the ED and can assist with motivating patients toward treatment. 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

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the Association for Addiction Professionals or be certified by another state, national or Veterans Administration process.) The individual then registers with the Virginia Board of Counseling. An application Handbook is available online. 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.

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. There is a fourth Narx Score: the overdose risk score which represents the risk of unintentional overdose death.

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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.

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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

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.

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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.


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:

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

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.\(^\text{22}\) 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).\(^\text{23}\) 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.\(^\text{24}\)

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

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\(^\text{22}\) Virginia Statewide Standing Order for Naloxone  

https://www.dhp.virginia.gov/Pharmacy/guidelines/110-44.pdf

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. In addition to “needle exchange,” all comprehensive harm reduction sites refer clients to OBOT, employ individuals at various stages of recovery and PRSSs, 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

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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.

WORKGROUP MEMBERS

Barbara Allison-Bryan, MD  
Chief Deputy Director, Virginia Department of Health Professions

Scott Hickey, MD  
Medical Society of Virginia

Diana Jordan, RN, MS, ACRN  
Virginia Department of Health

Ginny Lovitt  
Chris Atwood Foundation

Jason Lowe, MSW  
Virginia Department of Medical Assistance

Kelly Branhm McAllister, PharmD. MBA, BCPS  
Emergency Department Pharmacist, Carilion Clinic

Elizabeth Mikula  
HCA, Division VP of Quality (VHHA rep)

F. Gerald Moeller, MD  
Virginia Commonwealth University, Professor and Division Chair, Addiction Psychiatry

Jessica Nguyen, MD  
VA College of Emergency Physicians

Natalie Nguyen, PharmD, MSHA  
VCU Pharmacist, Virginia Society Health-System Pharmacists

Beth O’Halloran, RPh  
Deputy Executive Director, Virginia Board of Pharmacy

Ruthanne Risser  
Virginia Department of Health

Charlie Tarasidis, PharmD  
Pharmacist, Carilion Clinic  
Virginia Pharmacy Association

Elaine Yeatts  
Senior Policy Analyst, Virginia Department of Health Professions

Mike Zohab  
Virginia Department of Behavioral Health and Disability Services