

Statewide Emergency Department Needs Assessment Addressing Alaska's Opioid Epidemic

Part Two: Policy Review

PREPARED FOR:

State of Alaska Department of Health & Social Services

April 2020

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Summary: Policy Implications for Alaska

The Alaska Department of Health and Social Services (DHSS) contracted with McDowell Group to conduct a statewide emergency department (ED) needs assessment for addressing Alaska's opioid epidemic. The assessment, *Statewide Emergency Department Needs Assessment for Addressing Alaska's Opioid Epidemic, Part One: Needs Assessment (April 2020)*, provides a framework to identify equitable, feasible, and sustainable methods to support Alaska's EDs and those using the ED. The framework addresses six components:

1. **Upstream prevention** strategies promoting health and wellbeing of individuals with a focus on building resilience and reducing trauma and adverse childhood experiences.
2. **Reducing substance misuse and addition** through the Prescription Drug Monitoring Program (PDMP), Alaska ED Opioid and Controlled Substances Prescribing Guidelines, safe disposal approaches, and education.
3. **Harm reduction** strategies aimed at reducing negative consequences of substance misuse.
4. **Screening, referral, treatment, and substance use care coordination** strategies through systemic Screening, Brief Intervention, and Referral to Treatment (SBIRT); Medication Assisted Treatment (MAT); and linkages with other services.
5. **Relapse prevention** strategies to prevent additional episodes and support recovery.
6. **Surveillance and information exchange** strategies that collect and incorporate data to improve decisions and inform quality improvement.

This companion report focuses on ED related laws, policies, and procedures that address identified gaps related to core strategies recommended in the needs assessment. Multiple sources were reviewed for models of legislation, policies, and procedures, including federal legislation and policy, state legislature and executive office organizational databases, medical and academic policy reviews and journals, and medical associations (i.e., American College of Emergency Physicians (ACEP), American Society of Addiction Medicine, Alaska State Hospital and Nursing Home Association) policy reviews.

Recommended Policy Approaches

Based on the literature review, a summary of recommended policy approaches focused on core strategies to make optimal use of Alaska's ED resources for opioid misuse and addiction prevention and treatment include:

Establishing Overall System Standards

- Recognizing Alaska's network of EDs are embedded in a variety of hospital systems (i.e., tribal, military, and private) and serve diverse and disparate communities, establishing standard of care levels (core and enhanced) would allow for systemic and consistent policies to build and enhance over time. Rhode Island's Level of Care provides one model for this approach.

Upstream Prevention

- Alaska has established policy to support trauma-informed approaches to care. Policies that support organizational culture and training for ED providers to adopt these approaches will reduce stigma and improve quality of care.

Reducing Substance Misuse and Addiction

- Centers for Disease Control and Prevention Chronic Pain Guidelines, National Safety Council, and Alaska laws require medical providers to inform patients about the dangers of addictive opioid drugs before prescribing them and to promote potential non-opioid alternatives and authorizes penalties for providers who fail to comply. This policy could be enhanced through provider training and informational/educational tools.
- Changes that could improve the utility of PDMPs in EDs include: integrating PDMPs with electronic health records, implementing unsolicited reporting and prescription context, improving PDMP accessibility in the ED, improved data analytics and data sharing, and expanding the reporting scope of PDMPs inter- and intra-state. More effective use of PDMPs will also avoid opioid diversion.

Harm Reduction

- National Center on Addiction and Substance Abuse (NCASA) recommends increasing access to naloxone at all points of contact with individuals who may use opioids or be at risk of overdose, including the ED. ED organizational culture and stigma that may inhibit distribution of naloxone can be shifted with increased provider and ED staff training, and Medicaid and private insurance coverage of naloxone.

Screening, Referral, Treatment and Substance Use Care Coordination

- Drug Enforcement Administration allows providers without buprenorphine licenses to administer drugs like buprenorphine to a patient for the purpose of relieving acute withdrawal symptoms within 72 hours. Many hospital EDs have established referral programs where community services are available. However, instead of a treatment referral, Yale New Haven Hospital provides brief counseling, buprenorphine and connects patients to primary care following an overdose, with a warm hand-off or bridging the care for patients with Opioid Use Disorder.
- NCASA recommends states require EDs to screen all patients for SUD, provide appropriate interventions, including MAT, to those who screen positive, and develop a treatment plan and “warm hand-off” to a treatment program. States should also provide necessary resources and incentives, such as increased reimbursement rates, to help hospitals create capacity to provide such services.
- Alaska should continue its advocacy to the Secretary of Health and Human Services (HHS) to remove some privacy provisions in 42 U.S.C. § 290dd02 to permit opioid treatment programs (OTPs) to submit dispensing data to state PDMPs.
- NCASA recommends a comprehensive approach to prevention that includes SBIRT in EDs. A model program has been implemented by Connecticut and Massachusetts, Project ASSERT to help ED patients access treatment and care.

Relapse Prevention

- ACEP and others suggest PDMPs when implemented in an effective and easy-to-use manner, along with targeted screening of at-risk individuals may serve as an important tool to identify patients at risk for opioid misuse.

Surveillance and Information Exchange

- Policy supporting integration of PDMP with electronic health record (HER) is necessary for medical providers to have continuous access to prescription history information vital to safe prescribing and dispensing of controlled substances.
- Stable and adequate funding of PDMPs is essential for consistent operation and optimum use. Securing consistent long-term funding will provide a stable platform for PDMPs to operate, implement new technologies, and maintain suitable staffing levels. Adequate funding facilitates data access for authorized end-users, implementation of interoperability between PDMPs, and effective analysis and dissemination of prescription information.
- Policy, not necessarily technology, is limiting different hospital system platforms (such as EDIE, Epic, and Cerner) to communicate. If further investment is made, most platforms can transfer information or communicate across data systems and integrate with EHRs. These systems could notify ED providers of high-utilizer and complex-needs patients, improve communication and care coordination, and exchange information across hospital systems. They can also provide proactive, concise, and actionable data at the point of ED care and push notices within care provider workflow (anticipating provider needs). These systems also include dashboards that could communicate data to health plans, other hospitals, clinics, and care coordination organizations in real time.

Introduction and Methodology

The Alaska Department of Health and Social Services (DHSS) contracted with McDowell Group to conduct a statewide emergency department (ED) needs assessment for addressing Alaska's opioid epidemic. The assessment provides a framework for state efforts to identify equitable, feasible, and sustainable methods to support EDs and those using the ED (see *Statewide Emergency Department Needs Assessment for Addressing Alaska's Opioid Epidemic, Part One: Needs Assessment, April 2020*). The framework addresses six components:

7. **Upstream prevention** strategies promoting health and wellbeing of individuals with a focus on building resilience and reducing trauma and Adverse Childhood Experiences (ACEs).
8. **Reducing substance misuse and addiction** through the Prescription Drug Monitoring Program (PDMP), Alaska ED Opioid and Controlled Substances Prescribing Guidelines, safe disposal approaches, and education.
9. **Harm reduction** strategies aimed at reducing negative consequences of substance misuse.
10. **Screening, referral, treatment, and substance use care coordination** strategies through systemic Screening, Brief Intervention, and Referral to Treatment (SBIRT); Medication Assisted Treatment (MAT); and linkages with other services.
11. **Relapse prevention** strategies to prevent additional episodes and support recovery.
12. **Surveillance and information exchange** strategies that collect and incorporate data to improve decisions and inform quality improvement.

This report provides a literature review of relevant policy and legislation. These findings may be used to inform new strategies to support EDs as they address Opioid Use Disorder (OUD).

Methodology

This review of legislation and policy used multiple sources, including the following databases:

- National Council of State Legislatures' Statewide Prescription Drug Database (2015-present)
- Substance Use Disorder (SUD) Treatment Database, including eight categories related to SUD treatment:
 - Counseling and behavioral health
 - Medicaid
 - Medication Assisted Treatment (MAT)
 - Parity and Coverage
 - Recovery Support Services
 - Residential and Hospital-based Treatment
 - Telehealth
 - Other
- Injury Prevention Legislation Database

Other sources include the American Society of Addiction Medicine, Alaska State Hospital and Nursing Home Association (ASHNHA), American College of Emergency Physicians, *Annals of Emergency Medicine*, *Public*

Health Practice, Health Affairs, Western Journal of Emergency Medicine, as well as policy analyses for Rhode Island, Arizona, and Washington State, among others.

A multitude of documents address opioid-related policy. For example, the Arizona Department of Health produced *50 State Review on Opioid Related Policy* in 2017 reviewing more than 3,000 pages of federal and state guidance documents; state task force publications; academic articles; federal, state, and local laws; administrative rules; and stakeholder contributions.¹ The National Center on Addiction and Substance Abuse compiled *Ending the Opioid Crisis: A Practical Guide for State Policy Makers* (October 2017). The Centers for Disease Control and Prevention funded a *Compilation of Alaska Statutes Pertaining to Opioids/Heroin: Updated Through the 2019 Legislative Session* for DHSS. This compilation is a foundational component of this policy review, as are other Alaska documents, such as DHSS's *2018-2022 Statewide Opioid Action Plan* and the *Alaska Opioid Policy Task Force* reports.

This report focuses on ED related laws, policies, and procedure gaps as they relate to core strategies recommended in the *Statewide Emergency Department Needs Assessment for Addressing Alaska's Opioid Epidemic, April 2020*.

¹ <https://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/50-state-review-printer-friendly.pdf>. (Accessed February 12, 2020).

Alaska Policy Overview by Framework Component

The matrices below correspond with the six framework components identified in the *Statewide Emergency Department Needs Assessment for Addressing Alaska's Opioid Epidemic, April 2020*. For each indicator, examples of supportive policy in Alaska are presented. Indicators in bold correspond with core strategies recommended in the Needs Assessment. Notes highlight issues as these policies (or lack of policy) impact EDs and their integration into the continuum of care to address OUD in Alaska.

Table 1. Framework Component: Upstream Prevention

Indicator/Policy	Current Alaska Policy	Notes
Core Strategies		
Trauma-informed approach to care	<ul style="list-style-type: none"> AS 47.05.060: "It is the policy of the state to acknowledge and take into account the principles of early childhood and youth brain development and, whenever possible, consider the concepts of early adversity, toxic stress, childhood trauma, and the promotion of resilience through protective relationships, supports, self-regulation, and services." 2018-2022 Statewide Opioid Action Plan includes Strategy 1.1 Strengthen and support Alaskans and their communities by addressing trauma. 	<ul style="list-style-type: none"> The federal Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (H.R.6) changes state Medicaid and Medicare requirements to address SUDs, incorporates language on trauma-informed care in the health, early childhood, and education sectors. Alaska Opioid Policy Task Force recommendations emphasize upstream trauma prevention efforts and improved treatment and recovery supports. 2018-2022 Statewide Opioid Action Plan identifies "trauma-responsive" as a value in an integrated system and a guiding principal for action. Many Alaska EDs recognize trauma-informed approach as a best-practice to remove stigma associated with OUD and improve quality of service. Several EDs are working to shift ED cultures through training on trauma-informed and relationship development approaches.
Enhanced Strategies		
ACES screening for trauma	<ul style="list-style-type: none"> No policy addressing ACEs screening in the ED setting. 	<ul style="list-style-type: none"> EDs may not be the best setting to screen for ACEs. Screening policy may be better suited to primary care and treatment settings. With improved data systems integration, ED providers could access ACEs screenings done elsewhere.

Table 2. Framework Component: Reducing Substance Misuse and Addiction

Indicator/Policy	Current Alaska Policy	Notes
Core Strategies		
Availability of non-opioid pain management	<ul style="list-style-type: none"> Amended AS 8.36.355 requires medical providers to inform patients about the dangers of addictive opioid drugs before prescribing them and to consider non-opioid alternatives and authorizes penalties for providers who fail to comply. <i>2018-2022 Statewide Opioid Action Plan</i> includes Strategy 2.4 <i>Increase health plan participation in opioid control efforts</i> 	<ul style="list-style-type: none"> Currently, some EDs use <i>CDC Guideline for Prescribing Opioids for Chronic Pain</i>. The Alaska Opioid Task Force supports public and private health plan reimbursement for alternatives to narcotic pain management.
Prescription Drug Monitoring Program (PDMP) Use	<ul style="list-style-type: none"> AS 17.30.200; 7 AAC 120.100/114/12012 AAC 40.975, 12 AAC 52.320, 12 AAC 52.420/750/840/855/860/885/994 	<ul style="list-style-type: none"> <i>2018-2022 Statewide Opioid Action Plan</i> includes Strategy 3.2 <i>Promote responsible prescribing and dispensing policies and practices</i>. Includes engaging federal and Tribal healthcare entities to participate in PDMP reporting and use. Consideration of collaboration between Board of Pharmacy, Emergency Medical Services and Medical Examiner's office to notify prescribers after a patient experiences a fatal or non-fatal overdose. 42 C.F.R. Part 2 exempts Methadone clinics from reporting into the PDMP. Methadone or buprenorphine dispensed by opioid treatment providers is also not reported.
PDMP-EHR Integration	<ul style="list-style-type: none"> AS 17.30.200 Exemptions from PDMP usage include dispensing less than a 24-hour supply of a controlled substance at an ED (u); a controlled substance administered in an ED that has an inpatient pharmacy or administered before, during or after surgery; or a nonrefillable prescription for a less-than-three-day supply (k). 	<ul style="list-style-type: none"> Findings suggest PDMP programs are significantly underused by health care providers due to a variety of factors, including the cumbersome nature of accessing the system and privacy concerns.
"Safe prescribing" ED policies	<ul style="list-style-type: none"> AS 08.64, AS 08.64 Requires prescribers and pharmacists take a minimum of two hours of continuing education in pain management, opioid use, and addiction. DHSS promotes <i>Alaska Acute Pain Treatment Discussion Tool</i> to discuss management of acute pain. Alaska State Medical Board-issued <i>Guidelines Regarding Prescribing Controlled Substances</i> 	<ul style="list-style-type: none"> ASHNHA and the American College of Emergency Physicians' (ACEP's) jointly developed <i>Alaska ED Opioid & Controlled Substance Prescribing Guidelines</i> provide policy support for safe prescribing practices including lowest dosage and shortest time course, encourage use of nonopioid therapies, prohibit replacement prescriptions, and prohibit prescribing long-lasting or controlled-release opioids.

Indicator/Policy	Current Alaska Policy	Notes
Prescribing Practices	<ul style="list-style-type: none"> AS. 13.55.010: Voluntary Nonopioid Directive (VNOD) enables individuals decline future treatment with opioids. AS 17.30.200(q) Unsolicited Notifications authorizes the Board of Pharmacy to provide confidential, unsolicited notification if a patient has received one or more prescriptions for controlled substances in quantities or with a frequency inconsistent with generally recognized standards of care. AS 17.30.200(t) enables periodic unsolicited reports that detail and compare a practitioner's prescribing practice with other practitioners of the same occupation and similar specialty. The report is confidential and issued only to the practitioner. 	<ul style="list-style-type: none"> ASHNHA and ACEP's <i>Alaska ED Opioid & Controlled Substance Prescribing Guidelines</i> provide policy support for safe prescribing practices including lowest dosage and shortest time course, encourage use of nonopioid therapies, prohibit replacement prescriptions, and prohibit prescribing long-lasting or controlled-release opioids. HB 242 strengthens the Board of Pharmacy's role in credentialing, registration, and licensure of providers who prescribe opioids by establishing opioid prescription dosage standards and mandating practitioners check patients' prescription records before dispensing, prescribing, or administering a schedule II, III, or IV controlled substance under federal law.
Patient, Family & Caregiver Education	<ul style="list-style-type: none"> DHSS promotes <i>Alaska Acute Pain Treatment Discussion Tool</i> to discuss management of acute pain. AS. 13.55.010: Voluntary Nonopioid Directive (VNOD) enables individuals to decline future treatment with opioids. 	<ul style="list-style-type: none"> While no formal policy exists, there has been some movement in EDs to provide more information to patients at discharge, including outpatient services, community services, and dangers of opioid usage, etc.
Opioid Diversion (ED clinical policies/protocols safeguarding against diversion)	<ul style="list-style-type: none"> DHSS's Medication Assisted Treatment (MAT) Guide includes methods to avoid diversion. Buprenorphine-waiver training includes diversion avoidance. However, not all ED providers receive a buprenorphine waiver. 	<ul style="list-style-type: none"> 12 AAC.52.420: Article 4 of Chapter 52 the Board of Pharmacy contains general guidelines for pharmacies and pharmacists including "effective control against theft or diversion of drugs." ASHNHA and ACEP's <i>Alaska ED Opioid & Controlled Substance Prescribing Guidelines</i> provides policy support for safe prescribing practices, including prohibiting replacement prescriptions for controlled substances that are lost, destroyed, or stolen. <i>2018-2022 Statewide Opioid Action Plan</i> includes Goal 5: Strategy 2.4 <i>Increase diversion without incarceration and expand access to treatment and support services for those in contact with Law Enforcement and the legal system</i> (not intended for ED). There is no diversion alert program in Alaska.

Table 3. Framework Component: Harm Reduction

Indicator/Policy	Current Alaska Policy	Notes
Core Strategies		
Naloxone distribution policy	<ul style="list-style-type: none"> • Governor’s disaster declaration established a statewide Overdose Response Program, enabling wide distribution of naloxone. • DHSS’s “Project HOPE” has distributed more than 1,200 naloxone rescue kits and provided training on use to first responders. • <i>2018-2022 Statewide Opioid Action Plan</i> includes Strategy 2.1 <i>Increase cross-sector coloration and coordination for harm reduction</i>, and Strategy 4.2 <i>Decrease the incidence of overdose and overdose mortality</i>. 	<ul style="list-style-type: none"> • Stigma limits access to harm-reduction strategies like universal ED distribution of naloxone. • No regulations or procedures exist for consistent distribution across all systems and their EDs. • EDs may distribute naloxone; however, distribution practices vary among EDs and providers • Liability concerns persist – if kits do not work due to poor handling and storage – creating a barrier across all ED systems. • <i>2018-2022 Statewide Opioid Action Plan</i> supports public and private health plans to reimburse for access to naloxone, as well as continued training and distribution to all entities who work with or encounter individuals and their families with OUD (including EDs).
Enhanced Strategies		
Community Syringe Program	<ul style="list-style-type: none"> • <i>2018-2022 Statewide Opioid Action Plan</i> includes Strategy 3.1 <i>Increase safe medication disposal</i>, and Strategy 4.1 <i>Develop and implement education materials and outreach to address community benefits of syringe services</i>, and 4.3 <i>Work with Tribal and local authorities to reimburse and incentivize expansion of syringe exchange programs</i>. 	<ul style="list-style-type: none"> • Alaska law does not explicitly authorize or prohibit syringe service programs, or the sale or distribution of syringes. • Clean needle distribution occurs in Alaska through agencies working with high-risk HIV and HCV populations, but not through EDs. • Community resources are limited statewide. Needle exchange services are available in Anchorage, Juneau, Fairbanks, and Homer.
Addressing stigma	<ul style="list-style-type: none"> • <i>2018-2022 Statewide Opioid Action Plan</i> includes Goal 1: <i>Alaskans unite to reduce stigma and change social norms surrounding substance misuse and addiction</i>. 	<ul style="list-style-type: none"> • No specific policy is in place to address stigma among ED providers and caregivers. Some hospital systems have initiated training to shift cultures and inform staff about OUD.
ED Care Coordination: Children’s Services	<ul style="list-style-type: none"> • <i>2018-2022 Statewide Opioid Action Plan</i> includes Strategy 1.4: <i>Prioritize prevention efforts for at-risk Alaskans, where efforts will have the most impact</i> and Strategy 5.4 <i>Ensure screening, referral, and treatment is available for all Alaskans in need</i>. 	<ul style="list-style-type: none"> • Policy seeks to improve supports for children in/aging out of foster care. • Policy seeks to collaborate with hospitals to increase designated evaluation and treatment beds and improve services for children who need institutional care (not specific to EDs).

Table 4. Framework Component: Screening, Referral, Treatment & Substance Use Care Coordination

Indicator/Policy	Current Alaska Policy	Notes
Core Strategies		
Buprenorphine-waivered providers: ED & community	<ul style="list-style-type: none"> • Drug Enforcement Administration (DEA) waiver training available for providers delivering MAT services. • DEA exempts providers without waiver to administer drugs to a patient for the purpose of relieving acute withdrawal symptoms in first 72 hours (“three-day rule”) (Title 21, Code of Federal Regulations, Part 1306.7(b)). 	<ul style="list-style-type: none"> • Policy does not limit EDs’ ability to refer and coordinate with MAT programs; however, coordination and referral is limited by the availability of these programs in communities served by EDs.
SBIRT Protocol	<ul style="list-style-type: none"> • Healthy Alaskans 2020 supports a strategy to incentivize and promote SBIRT screening in outpatient hospitals. • Section 1115 Medicaid Waiver supports implementation of SBIRT in 10 hospital EDs. 	<ul style="list-style-type: none"> • Use of SBIRT limited or inconsistent use in Alaska’s ED.
Provider training & education	<ul style="list-style-type: none"> • ACEP, ASHNHA, ACPA, and other professional organizations provide training for MAT waivers, safe pain management, and cultural training. 	<ul style="list-style-type: none"> • There is widespread support for continued and comprehensive education for providers in identification/treatment of addiction, safe pain management, treatment, and recovery.
ED care coordination with:		
Judicial system/Alaska Dept. of Corrections	<ul style="list-style-type: none"> • No policy mandates for ED coordination with DOC • AS 17.30.200 (u) Correctional facilities are exempt from PDMP except when prescribing opioids to an inmate at the time of release. 	<ul style="list-style-type: none"> • DOC and drug/therapeutic court data are not integrated in PDMP. • DOC internal policy and protocol changes have improved care coordination with EDs and significantly reduced overdose deaths while incarcerated. • DOC has moved to an EHR platform.
Primary care provider	<ul style="list-style-type: none"> • No policy mandates for ED coordination with primary care providers 	<ul style="list-style-type: none"> • Many efforts are made by EDs to communicate and coordinate care with primary care providers; however, these efforts are not systemic and consistent. • ED care coordination works best when EHRs are integrated.
Behavioral health (BH) providers	<ul style="list-style-type: none"> • No policy mandates for ED coordination with BH providers 	<ul style="list-style-type: none"> • 42CFR inhibits improved coordination and integration of care. • Consistent ED concerns persist about available comprehensive BH services throughout Alaska and ability to coordinate with over-stretched BH services.
Enhanced Strategies		
Availability outpatient medication providers for OUD	<ul style="list-style-type: none"> • Primary care and treatment providers offer MAT waiver training through Alaska Primary Care Association and others. 	<ul style="list-style-type: none"> • Trained providers (i.e., those with MAT waivers) are not available in all outpatient settings across state.

Indicator/Policy	Current Alaska Policy	Notes
Enhanced Strategies (continued)		
Addiction medicine specialist consultation access		<ul style="list-style-type: none"> While policy mandates improved care coordination, the ability for EDs to coordinate with or access addiction medicine specialists depends on available organizational or community resources.
Community opioid treatment program and providers	<ul style="list-style-type: none"> ACEP and DHSS Division of Behavioral Health and others support a policy to link ED patients to primary care and behavioral health providers. 	<ul style="list-style-type: none"> ACEP/ASHNHA supports a policy of linking ED users to primary care and behavioral health providers within 96 hours after an ED visit. Success of this policy objective requires funding for referral systems (such as OpenBeds) and available treatment options throughout the state.
Hospital or community bridge programs		<ul style="list-style-type: none"> Some hospital EDs are piloting “bridge” programs between EDs and MAT clinics. Evaluation of program outcomes is still preliminary.
Linkages to care (peer support)	<ul style="list-style-type: none"> CMS approved the behavioral health component of the State of Alaska’s Medicaid Section 1115 Demonstration Project to address SUDs. 	<ul style="list-style-type: none"> While peer support is mostly aimed at community recovery, some EDs (i.e., Mat-Su Regional Medical Center) use peer support in their EDs. Medicaid 1115 waiver does not restrict reimbursement of peer support services in EDs.

Table 5. Framework Component: Relapse Prevention

Indicator/Policy	Current Alaska Policy	Notes
Core Strategies		
Screening for previous opioid dependence or addiction	<ul style="list-style-type: none"> Medicaid 1115 Section Waiver supports SBIRT in 10 hospitals in Alaska. 	<ul style="list-style-type: none"> Most EDs rely on self-disclosure.
Enhanced Strategies		
Recovery & Supports	<ul style="list-style-type: none"> Medicaid 1115 Section Waiver supports community recovery support programs with counselling and wraparound support for newly recovering people to prevent relapse and promote recovery. 	<ul style="list-style-type: none"> MAT programs provided by Opioid Treatment Programs do not provide data to PDMP thereby ED providers cannot access ED patient MAT treatment information. If a patient receives treatment out of state, ED providers can see no record for these components of treatment.

Table 6. Framework Component: Surveillance and Information Exchange

Indicator/Policy	Current Alaska Policy	Notes
Core Strategies		
ED Visits	<ul style="list-style-type: none"> Mandatory reporting under 7 AAC 27.660 to the Alaska Health Facilities Data Reporting (HFDR) Program, including ED visits. 	<ul style="list-style-type: none"> Data analytics ability within ED varies based on capacity and data systems infrastructure. Not all hospitals report consistently to HFDR. While HFDR Program compiles data, there is limited analysis across system. Not all EDs use the Emergency Department Information Exchange system to coordinate care across all EDs. The number of MAT-waivered ED providers cannot be determined under current PDMP data management system.
Enhanced Strategies		
Incidence & Prevalence, Mortality Data, and Neonatal Abstinence Syndrome	<ul style="list-style-type: none"> Currently collected. Alaska 1115 SUD Waiver Implementation supports creation of a data team that monitors metrics to generate reports to the Governor and to populate a public-facing opioid data dashboard, including deaths, naloxone statistics, prescription drug monitoring program, and neonatal abstinence syndrome. 	<ul style="list-style-type: none"> Data analytics ability within ED varies based on capacity and data systems infrastructure. Information is not directly used to inform ED system performance. PDMP data is not used to determine incidence and prevalence.
Opioid Use Surveillance	<ul style="list-style-type: none"> Alaska 1115 SUD Waiver Implementation supports creation of a data team that monitors metrics to generate reports to the Governor and to populate a public-facing opioid data dashboard, including deaths, naloxone statistics, prescription drug monitoring program, and neonatal abstinence syndrome. 	<ul style="list-style-type: none"> Training required for consistent coding to denote OUD (particularly when presented as a secondary diagnosis). While EDs are mandated to report to HFDR, quality of data is affected as not all facilities consistently enter data in the hospital facilities data reporting system.
OUD Treatment (including MAT)	<ul style="list-style-type: none"> Alaska 1115 SUD Waiver Implementation supports creation of a data team that monitors metrics to generate reports to the Governor and to populate a public-facing opioid data dashboard, including deaths, naloxone statistics, prescription drug monitoring program, and neonatal abstinence syndrome. 	<ul style="list-style-type: none"> Data analytics ability within ED varies based on capacity and data systems infrastructure. Information is not directly used to inform ED system performance. PDMP data is not used to determine incidence and prevalence.

Core Strategy Policy Review

This section highlights national and state policies related to ED use for opioid misuse and addiction prevention and treatment response. The analysis emphasizes policy that best addresses core strategies identified in the *Statewide Emergency Department Needs Assessment for Addressing Alaska's Opioid Epidemic, Part One: Needs Assessment, April 2020*.

The ED serves as a universal point of medical access, diagnosis, treatment, and linkage to definitive care. EDs function as access points to the health care system, yet linkage to OUD treatment has yet to become standard of care in many EDs. This may be in part due to stigma, lack of available outpatient addiction medicine resources, or gaps in provider knowledge and training.
– *Quality Framework for Emergency Department Treatment of Opioid Use Disorder (March 2019)*.

System Standards

Establishing Levels of Care to Standardize Care Across All EDs

The State of Rhode Island is recognized nationally as a model of quality care for ED response to Opioid Use Disorder (OUD) treatment. Even with the relatively compact geographic size of Rhode Island, it was recognized that each ED must assess its ability to address the opioid epidemic. Rhode Island established three levels with different care standards for ED clinical protocols, organizational policies, and required infrastructure. The Levels of Care established a minimum treatment standard for patients with OUD and those treated after an opioid overdose in Rhode Island EDs. This tiered approach requires each ED to evaluate its organizational approach and identify changes needed to ensure it meets the level of care consistent with its organizational culture, resources, and purpose.²

The document, *Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder (3/2017)*, outlines the components of each level of care, provides a self-assessment tool to help EDs organize information to submit to the Rhode Island Department of Health (RIDOH) and Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), and summarizes the certification process. Based on a self-assessment and a compliance and capability evaluation, each ED is certified as Level 1, 2, or 3. All facilities are expected to meet the criteria for Level 3 (the base level) and to have standardized protocols and written policies codifying their commitment to their level of care. Components for each level are:

LEVEL 3

1. Follow discharge planning standards as stated in current law.
2. Administer standardized substance use disorder screening for all patients.
3. Educate all patients who are prescribed opioids on safe storage and disposal.

² <https://health.ri.gov/publications/guides/LevelsOfCareForTreatingOverdoseAndOpioidUseDisorder.pdf> (Accessed March 2, 2020).

4. Dispense naloxone for patients who are at risk, according to a clear protocol.
5. Offer peer recovery support services in the ED.
6. Provide active referral to appropriate community provider(s).
7. Comply with requirement to report overdoses within 48 hours to RIDOH.
8. Perform laboratory drug screening that includes fentanyl on patients who overdose.

LEVEL 2

1. Meet all Level 3 components.
2. Conduct comprehensive standardized substance use assessments.
3. Maintain capacity for evaluation and treatment of opioid use disorder using support from addiction specialty services.

LEVEL 1

- Meet all Level 3 and 2 components.
- Maintain a Center of Excellence or comparable arrangement for initiating, stabilizing, and re-stabilizing patients on medication-assisted treatment (MAT).
 - Evaluate and manage MAT (in hospital or ED).
 - Ensure transition to/from community care to facilitate recovery.

Rhode Island Levels of Care Implementation Barriers

- Naloxone costs
- Outpatient treatment availability
- Availability of personnel for discharge planning and 48-hour reporting.
- Provider knowledge and training gaps about OUD medication and limited ability of community OUD treatment providers or clinic hours
- Pervasive stigma among providers and staff toward patients with OUD and about OUD medication, including reluctance to dedicate additional resources to patients and moralizing OUD as a personal flaw rather than a complex biopsychosocial disease.

Self-assessment is “yes” or “no” for each component and includes an explanation and documentation of organizational compliance with the required element. Technical assistance from RIDOH and BHDDH is available on request, depending on resource availability. A strategic workgroup led by the BHDDH Chief Medical Officer and the RIDOH Medical Director reviews materials and produces a report with the recommended designation. The review process includes a site visit to verify and evaluate compliance and assess technical support needs.

Level of care standards were issued in March 2017 and by June 2018, all Rhode Island licensed acute care facilities had implemented policies meeting the standards’ requirements. Rhode Island’s Levels of Care approach has standardized care for OUD; enhanced opioid overdose surveillance and response; and expanded linkage to peer recovery support, naloxone, and medication for OUD. While hospitals and EDs initially expressed skepticism about externally developed care standards, implementation was facilitated through interdepartmental collaboration, participation of hospital leadership, dedicated overdose reporting staff, and use of electronic medical records and reports. Costs of Rhode Island’s policy included naloxone purchasing, workforce time and effort, provider and staff training on new policy protocols and procedures, and electronic medical record

modifications. Next steps for policy expansion include incentivizing facilities to advance to higher levels of care and providing additional technical assistance for ED initiation of medications for OUD.³

Upstream Prevention

Promoting Trauma-Informed Care

Evidence links trauma and adverse childhood experiences (ACEs) to elevated risk of opioid addiction.^{4,5} Efforts to address the opioid epidemic will be only as effective as the ability to address the root causes of addiction.⁶

Studies have estimated 75% of individuals with SUDs have experienced trauma at some point in their lives; rates are even higher among populations seeking treatment for opioid addiction. Individuals who reported five or more ACEs were three times more likely to misuse prescription pain medication and five times more likely to engage in injection drug use.

The State of Alaska supports trauma-informed approaches to care and services as demonstrated in AS 47.05.060, relating to children the state serves. In 2018 the Alaska Legislature added statutory language stating, "It is the policy of the state to acknowledge and take into account the principles of early childhood and youth brain development and, whenever, possible, consider the concepts of early adversity, toxic stress, childhood trauma, and the promotion of resilience through protective relationships, support, self-regulation, and services."

The Alaska Opioid Policy Task Force has also recommended trauma prevention efforts. While no specific policy addresses Alaska's EDs, many ED representatives say they consider a trauma-informed or relationship development approach best-practice for treatment, and support changing the ED culture to remove stigma associated with OUD.

Reducing Substance Misuse and Addiction

Supporting Non-opioid Pain Management

The Centers for Disease Control and Prevention Chronic Pain Guidelines and National Safety Council recommendations highlight and underscore the need to use non-opioid pharmacologic therapies to treat chronic pain.⁷

³ "Emergency Department and Hospital Care for Opioid Use Disorder: Implementation of Statewide Standards in Rhode Island, 2017-2018." American Journal of Public Health, February 2019. <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2018.304847> (Accessed March 23, 2020).

⁴ Mills, K.L., Teeson, M., Ross, J., et al (2006) The costs and outcomes of treatment for opioid dependence associated with post-traumatic stress disorder. *Psychiatric Services*, 56(8), 940-945. (Accessed February 28, 2020).

⁵ Quinn, K., Boon, L., Scheidell, J.D., Mateau-Gelabert, P., Mcgorray, S. Sp., Beharie, N., Cottler, L.B., and Kahn, M.R. (2016) The relationship of childhood trauma and adult prescription pain reliever misuse and injection drug use. *Drug and Alcohol Dependence*, 169, 190-198.

⁶ Campaign for Trauma-Informed Policy and Practice, (June 2017) *Trauma-Informed Approaches Need to be Part of a Comprehensive Strategy for Addressing the Opioid Epidemic*. Policy Brief, www.ctipp.org. (Accessed February 28, 2020).

⁷ https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf, National Safety Council. (2016) *Prescription Nation 2016: Addressing America's Drug Epidemic*. <https://www.colorado.gov/pacific/hcpf/pain-management-resources-and-opioid-use>, <https://www.integrativepractitioner.com/whats-new/news-and-commentary/evidence-opens-medicaid-oregon-acupuncture/> (Accessed March 2, 2020).

Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, and Delaware have chronic pain guidelines that include providing alternatives to opioids for treating chronic pain. Ohio, Oregon, and Vermont provide Medicaid coverage for acupuncture, a non-pharmacotherapy form of pain management. Other states' task forces have recommended employing a variety of alternative approaches to treating chronic pain.

For example, Colorado formed the Colorado Opioid Safety Collaborative to improve opioid safety in Colorado EDs. The Collaborative established a goal to reduce administration of opioid medications by ED clinicians using the Alternative to Opioids (ALTO™) approach from the Colorado ACEP 2017 Opioid Prescribing and Treatment Guidelines (a similar program exists in New Jersey). These guidelines include:

1. Support use of non-opioid medications as first line of therapy.
2. Use opioids as second-line treatment or rescue therapy.
3. Multimodal and holistic approach to pain management.
4. Provide pathways from common ED pain presentations: kidney stones, low back pain, fractures, headache, and chronic abdominal pain.⁸

Between June 2016 and June 2018, the piloted ALTO™ approach resulted in a 63% reduction in opioid use in the ED. In 2018, the project expanded to 61 EDs. Colorado's Alternatives to Opioids (ALTO™) in the Emergency Department Act (HR 5197: S 2516) would provide grants to help emergency departments and hospitals implement non-opioid, evidence-based pain management. The measure passed the House awaits Senate approval.

Using PDMPs Effectively

Prescription Drug Monitoring Programs (PDMPs) have emerged as the leading intervention adopted by all states to address the opioid epidemic. An effective PDMP provides critical health information to ED and other health care providers about an individual's history of controlled substance prescriptions. This information can be used to avoid inappropriate prescribing and identify drug-seeking behavior and allows providers to intervene when there are signs of prescription drug misuse. PDMPs can provide emergency providers with comprehensive prescribing information to improve clinical decisions around opioids.

Regarding effective use of PDMPs, the American Society of Addiction Medicine (ASAM) recommends:

- Prescribers and dispensers should be required to enroll in and query the state's PDMP.
- States should ensure that PDMPs are functional, efficient, timely, user-friendly, and integrated into clinical workflow by integrating them as much as possible with EHR and pharmacy dispensation systems.

Physical therapy, occupational therapy, water therapy, acupuncture, yoga, T'ai Chi and massage are all recognized as effective interventions to treat chronic pain. Non-steroidal anti-inflammatory combination therapy (200 mg of ibuprofen combined with 500 mg of acetaminophen) is also recommended as a preferred alternative to prescribing an opioid for treating chronic pain.

⁸ http://coacep.org/docs/COACEP_Opioid_Guidelines-Final.pdf. (Accessed March 30, 2020).

- State PDMP data should be accessible only for clinical treatment and/or evaluation and for public health purposes by authorized clinicians and researchers.
- The Department of Veterans Affairs (VA), the Indian Health Service (HIS), and similar federal health care agencies should report and transmit data to state PDMPs.
- States should expand the medications reportable to the PDMP to include methadone and buprenorphine from opioid treatment providers (OTP), and cannabis obtained through a prescriber recommendation.
- PDMPs that report total opioid morphine milligram equivalents (MME) should not include buprenorphine or methadone used to treat opioid use in the calculation of MME.⁹

Despite evidence showing the effectiveness of PDMPs in reducing prescription drug-related death and injury, PDMPs remain underutilized. PDMPs vary tremendously in their accessibility and usability in the ED, which limits their effectiveness at the point of care. Potential solutions to improve the utility of PDMPs in EDs include:

- Integrating PDMPs with electronic health records
- Implementing unsolicited reporting and prescription context
- Improving PDMP accessibility
- Data analytics
- Expanding scope of PDMPs.¹⁰

Improving Access to PDMPs Within the ED

The American College of Emergency Physicians (ACEP) supports PDMPs that push prescription data to ED providers rather than requiring providers to sign into and pull the data from the PDMP.¹¹ Another common complaint from attending providers is the restriction allowing use of PDMPs only by licensed and practicing attending providers. Allowing other providers who work in the ED, such as nurses and technicians, access to PDMP data may amplify their effectiveness and use as a screening instead of a confirmation tool.¹²

Avoiding Opioid Diversion

Diversion occurs when drugs are diverted or sidetracked from their lawful (medical) purpose to illicit use.

Maine's Diversion Alert Program facilitates communication between law enforcement and health care providers with the goal of limiting drug-related harms and criminal behaviors. The Diversion Alert Program provides a unique data source for research, a harm-reduction tool for health care providers, and an informational resource for law enforcement.¹³

⁹ https://www.asam.org/docs/default-source/public-policy-statements/2018-statement-on-pdmps/406229472bc604ca5b7ff000030b21a.pdf?sfvrsn=63ba42c2_0 (Accessed March 2, 2020).

¹⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5851515/> (Accessed March 2, 2020).

¹¹ <https://www.acep.org/globalassets/uploads/uploaded-files/acep/advocacy/federal-issues/emergency-medicine-opioid-principles.pdf> (Accessed February 15, 2020).

¹² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5851515/> (Accessed March 2, 2020).

¹³ "Increasing heroin, cocaine, and buprenorphine arrests reported to the Main Diversion Alert Program," Forensic Science International 2019 October: 303. <https://www.ncbi.nlm.nih.gov/pubmed/31450173> (Accessed March 2, 2020).

The state-by-state patchwork of PDMP programs and policies makes coordination between states difficult, making it difficult to prevent cross-state “doctor shopping” and diversion.

Harm Reduction

Supporting Naloxone Distribution Policy

The National Center on Addiction and Substance Abuse (NCASA) recommends increasing access to naloxone to reduce opioid overdose deaths and other harmful consequences in alignment with a 2018 advisory from the office of the Surgeon General.¹⁴ Medicaid covers naloxone which helps defray its costs to some patients. Naloxone should be distributed at all points of contact with individuals who may use opioids or be at risk of overdose, including the ED. Establishing a clinical infrastructure that ensures naloxone provision before discharge requires a structured quality improvement program.

Rhode Island’s AnchorED Program helps individuals who overdosed and were brought to an ED by connecting them with a certified peer recovery coach. The coach helps facilitate treatment and recovery services, provides education about overdose and obtaining naloxone, and offers additional services to family members.¹⁵

Authorizing Community Syringe Programs

People who inject drugs and share needles, syringes, or other injection equipment are at increased risk for bloodborne infections such as human immunodeficiency virus (HIV) and hepatitis B and C viruses (HBV, HCV). Syringe service programs (SSPs), also called needle exchange programs, help prevent bloodborne infections associated with injection drug use (IDU) through use of new, sterile syringes for each injection, and by removing used and contaminated syringes from the community. Alaska law does not authorize or prohibit SSPs, nor does it prohibit or regulate the sale or distribution of syringes.¹⁶

Congressional appropriations language in fiscal years 2016–2018 permits use of funds from the Department of Health and Human Services (HHS), under certain circumstances, to support SSPs with the exception that funds may not be used to purchase needles or syringes. State, local, Tribal, or territorial health departments must first consult with CDC and provide evidence that their jurisdiction is experiencing or at risk for significant increases in hepatitis infections or an HIV outbreak due to injection drug use. CDC has developed guidance and consults with state, local, Tribal, or territorial health departments to determine whether they have adequately demonstrated need according to federal law. Decisions about use of SSPs to prevent disease transmission and support the health and engagement of people who inject drugs are made at the state and local level.¹⁷ SSPs serve as a bridge to other health services, including MAT. Many SSPs offer referrals to MAT and people who

At the recommendation of officials in Michigan, the state’s Prescription Drug and Opioid Abuse Commission endorsed the expansion of syringe services programs to help “reduce the impact of infectious disease, increase the rate of participants seeking treatment, reduce overdose deaths, and save lives.”

¹⁴ Adams J. Increasing naloxone awareness and use. *JAMA*. 2018; 319:2073–2074. <https://jamanetwork.com/journals/jama/article-abstract/2678206> (Accessed March 30, 2020).

¹⁵ <https://providencecenter.org/services/crisis-emergency-care/anchored> (Assessed March 2, 2020).

¹⁶ <http://epibulletins.dhss.alaska.gov/Document/Display?DocumentId=1942> (Accessed February 27, 2020).

¹⁷ <https://www.cdc.gov/ssp/syringe-services-programs-summary.html> (Accessed February 27, 2020).

inject drugs who regularly use an SSP are more than five times as likely to enter treatment for a substance use disorder and nearly three times as likely to report reducing or discontinuing injection as those who have never used an SSP.¹⁸

Local support is central to the success of state and local efforts to establish comprehensive harm reduction programs that offer syringe exchange. In some states, requiring local approval has helped overcome legislative barriers to authorizing syringe services programs, though the additional requirements can delay implementation. In Kentucky, the local approval process provides a forum for public health officials to educate communities about the benefits of syringe services programs and garner the support of business owners, health care providers, law enforcement and others needed to win local approval and ensure access. As of April 2019, syringe services programs have been approved in 60 of Kentucky's 120 counties, with multiple locations in some counties. With Kentucky's experience in mind, lawmakers in Alabama reintroduced syringe services legislation with a new requirement for approval from the county commission or city council. In response to stakeholder concerns, Utah revised its syringe services regulations to better ensure stakeholder engagement by requiring that new programs complete a readiness assessment in the communities where they seek to operate.¹⁹

Screening, Referral, Treatment and Substance Use Care Coordination

Improving ED care coordination

To improve the quality of addiction treatment, treatment needs to be well integrated with the health care system. There are multiple approaches to improving integration. NCASA recommends states require state-funded hospital EDs to screen all patients for substance use disorders, provide appropriate interventions including MAT to those who screen positive, and develop a treatment plan and "warm hand-off" to a treatment program for each patient who screens positive. NCASA also recommends states provide necessary resources and incentives, such as increased reimbursement rates, to help hospitals provide such services.

In 2018, Massachusetts adopted legislation requiring all EDs to be capable of initiating MAT. The measure also expands availability of MAT for prisoners, provide availability for behavioral health counselors, and allows partial filling of opioid prescriptions without penalty of additional co-pays.²⁰

Pennsylvania's *Integrated Care Management Program* awards incentive payments to providers treating individuals with serious persistent addiction, based on incremental improvements in performance measures related to treatment initiation, medication adherence, emergency room use, hospital readmissions, and utilization of patient care.²¹

¹⁸ Hagan H, McGough JP, Thiede H, Hopkins S, Duchin J, Alexander ER, "Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors", *Journal of Substance Abuse Treatment*, 2000; 19:247–252. (Accessed February 28, 2020).

¹⁹ <https://www.nga.org/wp-content/uploads/2019/05/NGA-Brief-State-Approaches-to-Addressing-Infectious-Disease-May-2019-002.pdf> (Accessed February 28, 2020).

²⁰ <https://www.acep.org/how-we-serve/sections/toxicology/news/september-2018/state-legislation-requiring-emergency-medication-assisted-therapy-for-opioid-use-disorder/> (Accessed February 28, 2020).

²¹ <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/20160411tlo13p4p.pdf> (Accessed March 2, 2020).

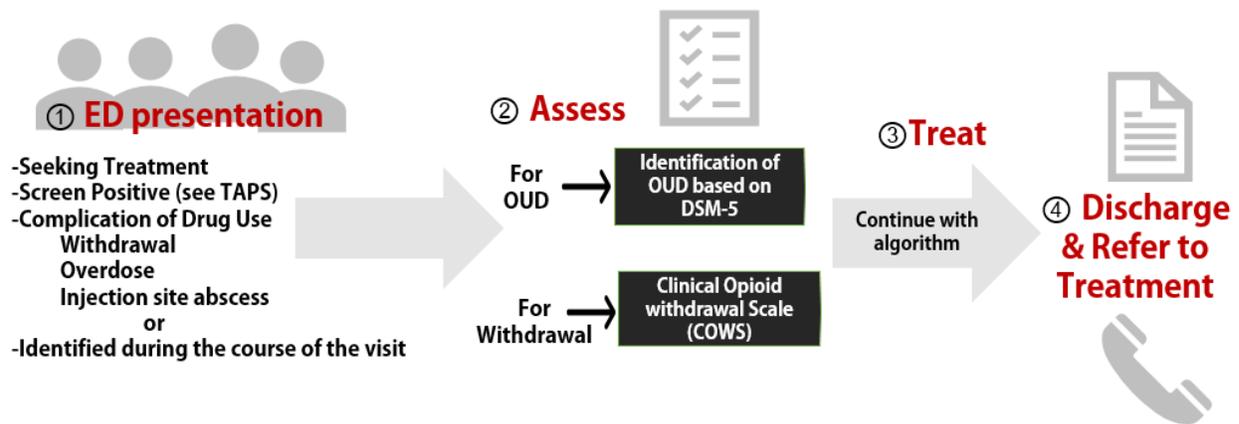
Boost Integration of Buprenorphine-waivered Providers in ED

One of the barriers to prescribing medication for OUD is that providers are not allowed to prescribe buprenorphine unless they have completed a training course and get a special license (called a waiver) from the federal Drug Enforcement Administration (DEA). DEA exempts providers from the waiver requirement for the purpose of relieving acute withdrawal systems for up to 72 hours (“three-day rule”). Yet one study found that only 47% of providers who obtained this waiver ever prescribed buprenorphine.²² One reason may be a time lag between development of new evidence-based practices and incorporation into everyday medical practice.

To ensure emergency providers know which patients may need addiction treatment, a best-practice advisory alert is built into an individual’s electronic health record to alert providers to a patient’s possible history of opioid dependence and lack of current treatment. The alert encourages providers to consider offering the patient medication for OUD in the ED if the patient is in withdrawal, or to refer the patient to a bridge clinic for ongoing treatment.

In Connecticut, Yale New Haven Hospital launched an innovative buprenorphine program to initiate treatment for opioid addiction in the ED following an overdose, instead of referring the patient for treatment. The Yale team provides brief counseling and buprenorphine and connects patients to primary care following an overdose. Patients initiated on buprenorphine in the ED and who continued to receive buprenorphine in a primary care setting were significantly more likely to remain in treatment than those who received a brief intervention or referral to treatment in the ED.²³ The figure below depicts the flow of the patient from ED presentation to discharge.

Figure 1. Yale New Haven Hospital ED Buprenorphine Integration Pathway



Source: <https://medicine.yale.edu/edbup/overview/>

²² <https://www.statnews.com/2019/11/27/changing-emergency-doctors-behaviors-promotes-treatment-opioid-use-disorder/> (Accessed March 2, 2020).

²³ <https://medicine.yale.edu/edbup/overview/> (Accessed March 2, 2020).

Requiring Opioid Treatment Providers to Submit Dispensing Data to PDMPs

Alaska's attorney general and 32 other state attorneys general signed a letter to the Secretary of Health and Human Services (HHS) seeking to remove some privacy provisions in 42 U.S.C. § 290dd02 to better ensure that individuals with SUDs receive comprehensive, safe, and efficacious treatment; and to reduce the diversion, misuse, and abuse of controlled prescription medications. The letter encourages HHS to revise the regulations to permit opioid treatment programs (OTPs) to submit dispensing data to state PDMPs.

Two kinds of prescription opioids are used to treat patients with OUDs: methadone and buprenorphine. Methadone is dispensed only at OTPs. Methadone may not be prescribed, so patients are not able to obtain it from a pharmacy. All OTPs are required to obtain certification from SAMHSA, and therefore meet the regulatory definition of "federally assisted drug abuse program." As such, they are not allowed to submit dispensing information to PDMPs. Critics of this policy point to several risks. ED providers may inadvertently prescribe medications for patients that harmfully interact with methadone. In addition, the policy may encourage individuals who intend to divert or abuse their medications to seek treatment at OTPs because they know they have less of a chance of being caught by their doctors.²⁴

While some believe confidentiality laws provide essential protection for patients seeking and receiving treatment for addiction, others (including the American Society of Addiction Medicine) argue that segregating addiction treatment records contributes to stigma and denies patients the clinical benefits of PDMPs.²⁵

The State of Washington (HB 1427) requires OTPs to review PDMP data before providing a patient's first dose of methadone or buprenorphine, at 1-year physical evaluation, and for cause.²⁶

Improving Care Coordination with Behavioral Health Providers

A "warm hand-off" is when the provider offers the patient a face-to-face introduction to the behavioral health/addiction treatment specialist instead of providing the patient with the name and contact information of the specialist and relying on the patient to initiate contact.

A comprehensive treatment strategy for patients with opioid use disorder involves medication-assisted treatment, psychological interventions, and social support or case management.²⁷ A rapid transition from an ED to outpatient care helps ensure patients receive these services. Some institutions have developed a "bridge" clinic that helps patients obtain next-day⁷ evaluations for continuation of therapy and appropriate referral. However, robust linkages to MAT are not available at many institutions. Commonly, there is little to no communication between EDs and treatment programs. These "cold handoffs" often result in delays in outpatient services, repeated assessments, gaps in MAT, and overall worse outcomes.

²⁴

https://www.nmag.gov/uploads/PressRelease/48737699ae174b30ac51a7eb286e661f/Methadone_Clinics_Should_Report_to_Prescription_Drug_Monitoring_Program_1.pdf (Accessed March 2, 2020).

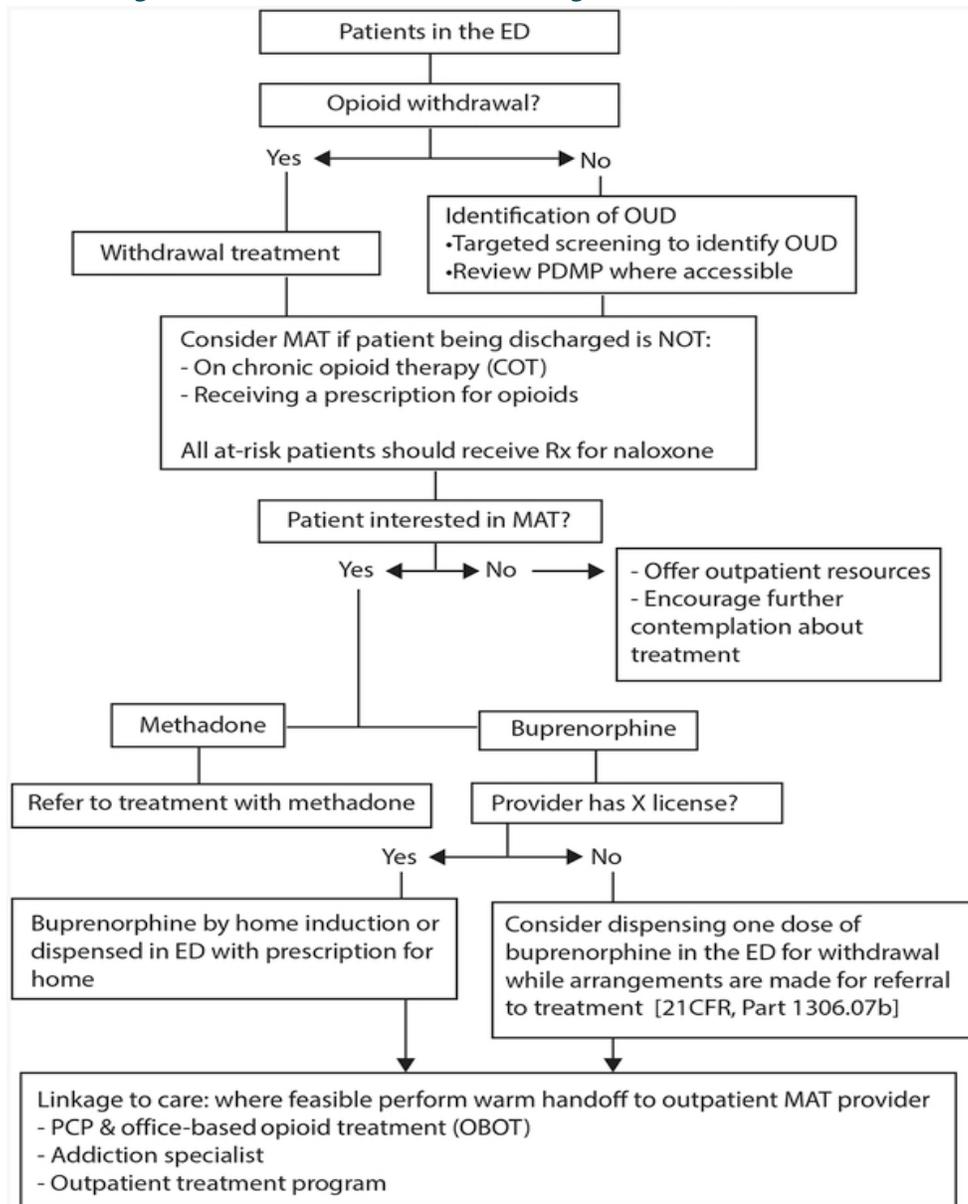
²⁵ https://www.asam.org/docs/default-source/public-policy-statements/2018-statement-on-pdmpsf406229472bc604ca5b7ff000030b21a.pdf?sfvrsn=63ba42c2_0 (Accessed February 15, 2020).

²⁶ https://oig.hhs.gov/oas/reports/region9/91802001_Factsheet.pdf (Accessed February 15, 2020).

²⁷ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6613583/> (Accessed March 2, 2020).

NCASA and others encourage hospitals to initiate MAT in EDs following an opioid overdose and to provide a “warm hand-off” to treatment. The National Alliance for Model State Drug Laws provides a *Model Act Providing for Warm Hand-off of Overdose Survivors to Treatment*.²⁸ The model law provides a mechanism for state and local agencies to develop a comprehensive state warm hand-off initiative. The goal is to ensure all reasonable measures are taken to have overdose survivors medically stabilized and transferred to a detoxification facility and support services according to an individualized plan. The act would also provide for Medicaid and private health insurance coverage for the warm hand-off initiative. The figure below (on the next page) provides an overview of the ED screening, treatment, and referral flow for patients with OUD.

Figure 2. Recommended ED Screening, Treatment, and Referral Flow



Source: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6613583/figure/F1/?report=objectonly>

²⁸ <https://namsdl.org/wp-content/uploads/Warm-Hand-off-Model.pdf> (Accessed March 3, 2020).

While EDs would ideally have a full menu of treatment options, including social support services and counseling, some communities may not have access to outpatient clinics capable of providing needed services, including MAT. In these cases, ACEP recommends the use of telemedicine for behavioral health specialists and addiction counselors.²⁹

The federal Preventing Overdoses While in the Emergency Room (POWER) Act (HR5176:S2610) provides grants to establish policies and procedures for initiating MAT in the ED and to provide a “warm hand-off” to appropriate community resources to keep patients engaged in treatment. The bill passed the House and has been introduced in the Senate.³⁰

NCASA recommends states require improved insurance coverage for addiction care. The State of Colorado requires insurance plans meet network adequacy standards for providers that specialize in addiction care.³¹ To demonstrate network adequacy, plans must meet specific standards related to wait times for emergency care.

Deploying SBIRT Services and Screening in EDs

NCASA published a policy study, *Ending the Opioid Crisis: A Practical Guide for State Policy Makers (October 2017)*, recommending a comprehensive approach to prevention that includes Screening, Brief Intervention, and Referral to Treatment (SBIRT) in EDs.³²

Connecticut and Massachusetts have long implemented Project ASSERT (Alcohol and Substance Abuse Services, Education and Referral to Treatment) that helps ED patients access treatment and care. The project is staffed by Health Promotion Advocates (HPAs) who are licensed drug abuse counselors who consult with ED clinicians to offer at-risk ED patients drug screening and intervention. HPAs are always present in the ED and initiate a motivational interviewing conversation with at-risk patients to explore how ready the patient is to make healthy changes, and to help develop a behavior change action plan. The HPA then helps connect the patient to a substance abuse treatment center and other needed community services, as well as referrals to primary services.³³

Relapse Prevention

Screening for OUD

Emergency providers need OUD screening tools that are accurate, reliable and easy to administer in the ED. Screening tools must be brief and integrate seamlessly into existing ED workflows to promote widespread use. Several screening tools are available (such as the Opioid Risk Tool, Revised Screener and Opioid Assessment for Patients with Pain, Current Opioid Misuse Measure, Addiction Behaviors Checklist, etc.) but not all have been

²⁹ <https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/models-for-addressing-transitions-of-care-for-patients-with-opioid-use-disorder.pdf> (Accessed March 2, 2020).

³⁰ <http://www.wvacep.org/default/index.cfm/e-newsletters/summer-2018/> (Accessed March 27, 2020).

³¹ Code of Colorado Regulations 3 CCR 702-4 Series 4-2, Section 5: Essential Health Benefits. <https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6485&fileName=3%20CCR%20702-4%20Series%204-2> (Accessed March 2, 2020).

³² <https://www.centeronaddiction.org/addiction-research/reports/ending-opioid-crisis-practical-guide-state-policymakers> (Accessed March 2, 2020).

³³ <https://www.bmc.org/programs/project-assert> (Accessed March 2, 2020).

validated for use in an ED environment. ACEP and others suggest PDMPs can serve as an important tool to identify patients at risk for opioid misuse. However, PDMPs do not capture data on patients who obtain opioids without a prescription, and there is no current evidence that PDMPs alone can identify individual patients with OUD.³⁴ Many states recommend or mandate judicious use of PDMPs along with targeted screening of at-risk individuals (i.e., reported history of opioid misuse, positive drug screen results) and individuals who will be discharged with opioids.³⁵

Surveillance and Information Exchange

Integrating the Prescription Drug Monitoring Program with Electronic Health Records

Making PDMP information available in health information systems like Electronic Health Records (EHR) can make it easier for ED providers and pharmacists to check a patient's prescription history before prescribing or dispensing opioids.

The ultimate goal is to provide secure PDMP data in real time to electronic records systems such that medical providers have continuous access to prescription history information vital to safe prescribing and dispensing of controlled substances. State public health agencies may be able to facilitate this integration.³⁶

While Alaska law requires prescribers to use the state PDMP system, integration of PDMPs with Electronic Health Records (EHR) and Health Information Exchange (HIE) systems has also been identified as a best practice. Integration would boost PDMP use by minimizing technical challenges and making prescribing information more readily available to health care professionals.

Currently, when clinicians access their hospital's EHR system, most have to open a web-browser and log in to a separate, secure page with a separate username and password. This cumbersome process deters widespread use of PDMP data. In the interest of time, physicians often resort to using prior EHR data to make determinations about possible drug-seeking behavior. Considering that EHR data are typically not shared between facilities, providers may base decisions on incomplete information. Indiana became the first state to merge an EHR with the PDMP. The integration was found to be highly effective, with 58% of physicians prescribing fewer opioids or smaller quantities following implementation.³⁷ Furthermore, integration of these systems could allow for improvements through unsolicited reporting "alerts" on the EHR for accessing providers.³⁸

The Washington PDMP is integrated with the statewide health information exchange (HIE), OneHealthPort, which allows health care organizations to exchange clinical information. If clinics and hospitals connect with the HIE, Washington prescribers can access PDMP information alongside other data in their EHRs without logging in to multiple systems. Additional integration allows threshold reporting through the Emergency Department

³⁴ <https://www.ncbi.nlm.nih.gov/pubmed/29880438> (Accessed March 1, 2020).

³⁵ <https://www.ncbi.nlm.nih.gov/pubmed/29880438> (Accessed March 1, 2020).

³⁶ <https://www.astho.org/Rx/Brandeis-PDMP-Report/>. (Accessed March 2, 2020).

³⁷ Connecting for Impact: Linking Potential Prescription Drug Monitoring Programs (PDMPs) to Patient Care Using Health IT. [Accessed on November 1, 2017]. Available at: <https://www.healthit.gov/PDMP> (Accessed March 2, 2020).

³⁸ Elder J, Pines J. Taking PDMPs Up a Notch. [Accessed on November 5, 2017]. Available at: <http://epmonthly.com/article/taking-pdmps-notch/> (Accessed March 2, 2020).

Information Exchange (EDIE), a proprietary software platform that automatically queries the PDMP and provides data to emergency department prescribers. Additionally, opioid treatment programs are required by Washington State rule to review PDMP data before the first dose of methadone or buprenorphine, at 1-year physical evaluation, and for cause.

Enhancing Data Analytics

Stable and adequate funding of PDMPs is essential for consistent operation and optimum use. Securing consistent, long-term funding will provide a stable platform for PDMPs to operate, integrate new technologies, and maintain sufficient staffing. Adequate funding facilitates data access for authorized end-users, implementation of interoperability between PDMPs, and effective analysis and dissemination of prescription information. Public health agencies can help ensure sustained and adequate PDMP funding.³⁹

Data analytics and data visualization may also help contextualize opioid prescriptions in a busy ED. For example, by linking prescriptions to a diagnosis, ED providers may greatly reduce the guesswork involved in prescription behavior. A patient with multiple prescriptions for both short- and long-acting opioid pain medications may appear to be an opioid abuser. However, by tying an explanatory diagnosis to such prescriptions, the patient could be found to have a condition warranting multiple prescriptions. Data analytics may thereby reduce the potential for misinterpreting data and provide quicker and better-informed emergency care.⁴⁰

The State of Washington's Health Care Authority uses its Analytics, Research, and Measurement (ARM) team; the Clinical Quality and Care Transformation Program Initiatives and Analytics team (in conjunction with a pharmacy team); and a program integrity team to conduct data analytics of Medicaid claims and PDMP. PDMP data are used to identify Medicaid beneficiaries paying with cash instead of using Medicaid and to validate the Medicaid data. The teams work with Washington's nine Accountable Communities of Health (ACHs) to provide analysis for the ACHs' opioid projects. The teams work closely with related groups, including Washington's Department of Health, State Hospital Association, and State Medical Association. The ARM team also supports managed-care organizations (MCOs) with data analytics. The Clinical Quality and Care Transformation Program Initiatives and Analytics team creates internal reports for quality control, internal policy development, and decision making and external reports for intervention purposes and to ensure patient safety and quality health care. Some data analysis is intended specifically for quality improvement interventions and other analysis is intended for internal policy development and decision making. For example, prescriber report cards are sent to prescribers based on data analytics for chronic use, high dose, and concurrent opioid and sedative prescribing. ED data are analyzed for nonfatal overdoses, and Washington sends overdose notification letters to the prescribers for those patients. Data analysis is also used to evaluate prescribers and patients, and patients identified as at-risk can be "locked into" seeing a specific primary care provider, hospital, or pharmacy.⁴¹

³⁹ <https://www.astho.org/Rx/Brandeis-PDMP-Report/>. (Accessed March 2, 2020).

⁴⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5851515/> (Accessed February 15, 2020).

⁴¹ https://oig.hhs.gov/oas/reports/region9/91802001_Factsheet.pdf (Accessed February 15, 2020).

Expanding Cross-System Scope of PDMPs

In Alaska, prescribers and pharmacists working with Tribal Health Organizations or the Indian Health Service (IHS), Veterans Administration (VA), military, or other federal employer may register with the PDMP under the authority of AS 17.30.200(f). Federal providers are not obligated to register by AS 08; however, the IHS and VA require employees to register with the State's PDMP. Registration and renewal fees do not apply to these federal providers. The state began distinguishing between federal and non-federal user roles in June 2018. In December 2018, the military launched its own controlled substance prescription database, the Military Health System Prescription Monitoring Program (MHS PMP) in collaboration with the National Association of Boards of Pharmacy (NABP) and the Defense Health Agency (DHA). The MHS PMP will contain global PDMP data issued by military prescribers and aims to connect with all state PDMPs in 2019. Alaska is exploring this bi-directional data, which will allow non-military registered users to view controlled substance prescriptions filled at military treatment facilities. Users will be able to obtain dual enrollment with the State and MHS PDMPs.⁴²

Expanding Cross-State System Scope of PDMPs

Practices that enable cross-state data sharing will increase the utility of PDMP data. Since doctor-shopping and other forms of prescription drug diversion often cross state lines, PDMP data from a single state are limited in their capacity to identify individuals potentially in need of intervention. Combining data from neighboring states and states known to be major sources of diverted prescription drugs will increase the capacity to identify diversion and doctor shopping. The same advantages accrue in discovery and investigation of "pill mills" and aberrant prescribing. Interstate epidemiological analyses of PDMP data hold potential for identifying cross-border and multi-state emerging trends in drug abuse and can help guide policy as well as interventions.⁴³

The Alaska PDMP shares data with seven other states through the National Association of Boards of Pharmacy's (NABP) PMP InterConnect program at no cost to the state under a partnership with the current PDMP vendor, Appriss Health. InterConnect provides a secure portal for data sharing between states; however, patient prescription information from other states cannot be stored in Alaska's PDMP, and vice versa. The state signed a memorandum of agreement in 2015 on the basis of AS 17.30.200(d)(3)(4) which authorizes practitioners not licensed in Alaska to access patient prescription information from the Alaska PDMP, so long as the practitioner holds a license in another state. States currently authorized to access information include practitioners licensed in Idaho, Massachusetts, Minnesota, Montana, Louisiana, North Dakota, and Rhode Island. Practitioners licensed in these states do not have full access to the Alaska PDMP and do not sign in using Alaska's AWAxE platform but rather using their state's AWAxE platform. Practitioners licensed in Alaska may likewise opt to include any or all seven states in a patient prescription history query.⁴⁴

Using funding from the Core State Violence and Injury Prevention Program, Oregon reformatted its PDMP to track schedule II–VI drugs prescribed within Oregon and to give providers access to PDMP data of bordering states. Such interstate sharing has shown to provide safer patient care. As sharing hubs such as those in Oregon,

⁴² https://www.commerce.alaska.gov/web/portals/5/pub/PHA_PDMP_2019_LegislativeReport.pdf (Accessed March 2, 2020).

⁴³ <https://www.astho.org/Rx/Brandeis-PDMP-Report/>. (Accessed March 2, 2020).

⁴⁴ https://www.commerce.alaska.gov/web/portals/5/pub/PHA_PDMP_2019_LegislativeReport.pdf (Accessed March 2, 2020).

Michigan, Indiana and Ohio are established, Electronic Prescription Services (EPS) may be better equipped to successfully identify drug-seeking behavior.⁴⁵

Expanded Use of ED Care Coordination and Information Exchange Tools

Software platforms like Emergency Department Information Exchange (EDIE), Epic, and Cerner track ED admissions, discharge and transfer data with other sources. These systems can identify patients with high ED use (often five or more visits a year) as soon as they are admitted. Some platforms, like EDIE, also provide a one-page report containing the most essential patient information for providers at the point of care, such as prescription management recommendations. This may include opioid guidelines for patients with a high risk of potential opioid abuse. EDIE can improve care coordination by prompting case managers to offer immediate referrals for patients whose care could be managed by a primary care provider.⁴⁶

While different hospital systems have invested in different platforms, most platforms can transfer information or communicate across data systems and integrate with EHRs. These systems could notify ED providers of high-utilizer and complex-needs patients, improve communication and care coordination, and exchange information across hospital systems. They can also provide proactive, concise, and actionable data at the point of ED care and push notices within care provider workflow (anticipating provider needs). These systems also include dashboards that could communicate data to health plans, other hospitals, clinics, and care coordination organizations in real time.

⁴⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5851515/> (Accessed February 15, 2020).

⁴⁶ <https://www.statnews.com/2018/01/19/opioid-epidemic-grassroots-approach/> (Accessed March 5, 2020).

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