STATE OF MAINE
GOVERNOR'S OFFICE OF POLICY INNOVATION AND THE FUTURE
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To: Maine hospital clinical and policy leadership, substance use treatment providers, and pharmacy communities

The Maine Opioid Response Clinical Advisory Committee consists of approximately 30 leaders in substance use disorder prevention, treatment and harm reduction in Maine including both prescribers and pharmacists.

As part of our efforts, we have been working on developing clinical recommendations related to the management of patients with substance use disorders, particularly as they encounter barriers within the existing health care delivery system. Access to medications for opioid use disorder (MOUD) in both the inpatient and emergency department (ED) settings has been associated with improved health outcomes.

Individuals seeking care at hospitals in Maine are at an increased risk of drug overdose death, as approximately 17% of fatal overdose decedents were found to have evidence of an inpatient stay or ED visit within the 30 days prior to their death. Despite the known benefits of MOUD, as well as an endorsement from the American College of Emergency Physicians and a recent consensus statement in the Journal of Hospital Medicine, buprenorphine initiation in the ED is still not consistently available in all Maine hospital EDs, and even fewer patients are started on MOUD during inpatient hospitalizations.

The purpose of this statement is to provide recommendations for the baseline level of care that should be available to individuals in Maine with OUD who seek care in hospital settings. We have also provided several policy recommendations that might facilitate enhanced access to MOUD in hospital settings in addition to a variety of clinical resources that may assist with MOUD implementation plans.

These recommendations are intended to enhance care and should not replace a provider's own clinical judgement. If you have any questions, please do not hesitate to contact us.

Sincerely,
Maine Opioid Response Clinical Advisory Committee

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Maine Opioid Response Clinical Advisory Committee: Proposed Position on Enhancing Access to Medications for Opioid Use Disorder for Patients in Hospital Settings

Background: More than 107,000 individuals died of drug overdose in the US during 2021, a 15% increase from 2020.[1] Similar increases have been seen in Maine, with over 700 drug overdose deaths expected to be reported for 2022. Additionally, we know that individuals seeking care at hospitals in Maine are at an increased risk of drug overdose death, as approximately 17% of fatal overdose decedents were found to have evidence of an inpatient stay or emergency department (ED) visit within the 30 days prior to their death. Despite the known benefits of medications for opioid use disorder (MOUD), as well as an endorsement from the American College of Emergency Physicians and a recent consensus statement in the Journal of Hospital Medicine[2,3], buprenorphine initiation in the ED is still not consistently available in all Maine hospital EDs, and even fewer patients are started on MOUD during inpatient hospitalizations.

Inpatient hospitalizations related to complications from opioid use disorder (OUD) have also been on the rise; the annual rate of OUD-related admissions more than quadrupled between 1993 and 2016.[4] Treatment using MOUD has been associated with a reduced risk of overdose and a reduction in serious opioid-related acute care hospitalizations.[5] Patients started on MOUD in the ED are less likely to use illicit drugs and are more than twice as likely to be engaged in MOUD treatment at 30 days when compared to those offered referral alone.[6] Individuals on MOUD at the time of inpatient hospital admission have 30-day and 90-day hospital readmission rates that are 53% and 43% lower than those with untreated OUD.[7]

Goal: The purpose of this statement is to provide recommendations for the baseline level of care that should be available to individuals in Maine with OUD who seek care in hospital settings. We believe that all facilities should provide at least a ***basic*** level of care to patients with OUD as a common foundation. We also recognize that some organizations have made the commitment to address the complex healthcare needs of patients with OUD and are able to provide a more ***advanced*** level of care. Finally, we provide policy recommendations that would potentially facilitate implementation of OUD treatment in hospital settings as well as a variety of helpful resources for providers.

Proposed Levels of OUD Care for Maine Hospitals

Basic: All hospital settings in Maine should provide at least a *basic* level of care for patients with OUD, including the following expectations:

- Annual training and education about substance use disorders (SUD) and stigma for all members of its staff. This includes the adoption of non-stigmatizing and trauma-informed policies as well.
- Process to identify high risk individuals (both inpatient and in ED) including patients who:
    - are opioid intoxicated/post-overdose or in opioid withdrawal
    - have pain that is unusually difficult to manage
    - have SUD-related complications such as endocarditis, osteomyelitis, sepsis, etc.
    - request treatment of a SUD
- Toxicology screening that is consistent with substances seen in the community (recognizing that point of care tests may be negative as a CLIA-waived fentanyl test is still unavailable) and provider knowledge of how to interpret the findings
- Buprenorphine available on the hospital formulary

- Buprenorphine initiation available in both the ED and inpatient hospital setting. Any ED or inpatient provider can initiate, continue, or prescribe buprenorphine at discharge as a DEA DATA-2000 X-waiver is no longer required to prescribe buprenorphine.
- Evidence-based best practices for treating patients on MOUD including:
    - MOUD should not be discontinued unless there is a clear contraindication to the use of MOUD. Discontinuation of MOUD requires patient consent
    - Pain management that is sensitive to the unique needs of patients with OUD
    - Direct linkage to a buprenorphine prescriber at hospital discharge including a scheduled appointment
    - Referrals to post-acute care facilities (e.g., skilled nursing facilities, nursing homes) that provide ongoing treatment with MOUD
    - Naloxone kit in hand at discharge (as well as a naloxone prescription sent to the pharmacy). An additional kit may be given to a family member/friend as appropriate.
- Wrap around services for individuals with OUD as appropriate including:
    - Screening for infectious complications of SUD such as Hepatitis B & C, HIV, sexually transmitted infections
    - Referral to:
        - Harm reduction services
        - Peer support services (an in-person or telehealth "warm hand off" is ideal)
        - Psychosocial supports, mutual support groups, and/or mental health treatment
        - Primary care provider
        - Services that meet social health needs including housing, shelters, food pantries, transportation assistance, as well as intimate partner violence, etc.

Advanced: Maine hospitals able to provide *advanced* OUD care should provide *basic* level of care for patients with OUD, as well as the following:

- A commitment to educate learners and providers in training (e.g., addiction medicine fellows, resident physicians, medical, nursing and pharmacy students, etc.) about the full spectrum of SUD care including prevention, screening, diagnosis, treatment, and harm reduction.
- Protocols and resources to utilize extended-release buprenorphine (XRB) in the ED and inpatient hospital setting
- Integrated inpatient care management and peer support
- Initiation of MOUD using methadone in the inpatient setting[8,9]

Policy Recommendations

To support these efforts from a **policy perspective**, we encourage leadership in Maine to consider identifying structures and funding to support the following:

- Inpatient interprofessional addiction teams, recognizing that comprehensive services delivered by such teams are often not reimbursed through traditional fee-for-service billing (e.g., SUD patient

navigator or peer support). Reimbursement for care coordination services such as those included in the OHH or MaineMOM model might be considered.

- Real-time 24-hour provider-to-provider support, in which addiction medicine experts are made available to support hospital generalists, likely through teleconsult or telehealth
- Regional bridge clinics that could support post-hospitalization transitions of care in prescribing MOUD (and other medications for SUD), care coordination, and transition to the appropriate next level of care

Helpful Resources:

- Stigma and bias training
    - The use of non-stigmatizing, person first language that is trauma informed is critical when engaging with patients with SUD.
        - We recommend: Maine Medical Association's *Words Matter Conversation Guide:* https://qclearninglab.org/wp-content/uploads/2022/06/Words-Matter-A-Substance-Use-Conversation-Guide-June-2022.pdf

- Buprenorphine initiation
    - During initiation of treatment, additional medications for opioid withdrawal should be provided as indicated and appropriate.
    - Any ED or inpatient provider can initiate, continue, or prescribe buprenorphine at discharge as a *DEA DATA-2000 X-waiver is no longer required* to prescribe buprenorphine.
        - Hospitals can also request permission from the DEA to dispense up to three days of buprenorphine at discharge from the ED or inpatient setting by emailing ODLP@dea.gov using the subject line: "request for exception to limitations on dispensing for OUD."
    - There are a variety of best practices buprenorphine initiation protocols in the ED and inpatient setting including:
        - Improving Addiction Care Team (IMPACT)- Oregon Health Sciences University: https://www.opioidlibrary.org/featured_collection/the-improving-addiction-care-team-impact/
        - California Bridge initiative: https://cabridge.org/resource/blueprint-for-hospital-opioid-use-disorder-treatment/
        - Maine Medical Association Center for Quality Improvement (MMA-CQI) MOUD in the ED Toolkit: https://qclearninglab.org/wp-content/uploads/2022/06/MOUD-in-ED-Toolkit-Revised-May-2022-Final.pdf
        - MMA-CQI MOUD in ED Toolkit Companion Guide: https://qclearninglab.org/wp-content/uploads/2022/06/MOUD-in-ED-Toolkit-Companion-Guide-May-2022-Final.pdf
    - Due to the potency of the illicit fentanyl in Maine, it can sometimes be difficult to initiate treatment with buprenorphine. Patients may require a low-dose or high-dose approach as opposed to traditional initiation protocols. These are outlined below:

        - Low-dose initiation protocol: https://cabridge.org/resource/starting-buprenorphine-with-microdosing-and-cross-tapering/
        - High-dose initiation protocols: https://cabridge.org/resource/buprenorphine-bup-hospital-quick-start/ OR https://oasas.ny.gov/system/files/documents/2022/07/low-high-dose-buprenorphine-initiation.pdf
    - Additional training on MOUD initiation is available at no cost through:
        - Maine's SUD Learning Community, https://mesudlearningcommunity.org/
        - Maine Medical Association Center for Quality Improvement's MOUD in the ED Toolkit: https://qclearninglab.org/wp-content/uploads/2022/06/MOUD-in-ED-Toolkit-Revised-May-2022-Final.pdf
        - Maine Medical Association's Maine Independent Clinical Information Service (MICIS): https://www.mainemed.com/MICIS

- Methadone initiation and maintenance
    - While federal regulations concerning the utilization of methadone are more complex, access to treatment with methadone is often critical, particularly as the opioid requirements of patients continue to rise due to the highly potent illicit fentanyl in the community. In addition, methadone, a full opioid agonist, does not carry significant risk of precipitated opioid withdrawal, but is complicated by higher risk of respiratory depression during initiation and significant medication interactions.
    - The US Code of Federal Regulations, § 1306.07, allows providers in a hospital setting to administer methadone "to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction."[9] Specifically, providers may:
        - *Maintain* patients who are already receiving methadone at a community-based federally licensed Outpatient Treatment Program (OTP). In these cases, the provider should verify the patient's daily dose with the OTP, collaborate with the OTP for ongoing treatment, and ensure referral back to the OTP upon discharge.
        - *Initiate* methadone treatment for the purposes of relieving acute withdrawal symptoms while arrangements are being made for referral to an OTP. There are no specific time limitations on the provider's ability to administer methadone in a hospital setting to maintain/detoxify a patient as an incidental adjunct to medical or surgical treatment of conditions other than the patient's OUD.[8,9] When patients are initiated on methadone in the hospital, the provider should begin collaborating with an OTP as soon as possible to create a transition plan at discharge. Access to OTPs is limited in some areas in Maine, especially those that are more rural. In addition, federal law does not allow hospital providers to write "bridge" prescriptions of methadone, which can create challenges as next-day appointments at the OTP are not necessarily available.
    - There are a variety of best practices methadone initiation protocols including:
        - California Bridge Initiative: https://cabridge.org/resource/methadone-hospital-quick-start/

        - Yale Addiction Medicine Program: https://medicine.yale.edu/intmed/genmed/addictionmedicine/yaleadm_covid19guidance_hospital-based%20addiction%20treatment_042020_384638_5_v1.pdf

- Evidence-based best practices for treating patients on MOUD including:
    - Pain management for patients with OUD:
        - Perioperative Management of Patients Prescribed Buprenorphine for Opioid Use Disorder (OUD): https://www.maine.gov/future/sites/maine.gov.future/files/inline-files/Perioperative%20Pain%20Mngmnt%20Guidance_ME%20Opioid%20Clinical%20Adv%20Comm_GOPIF_08-2020.pdf
    - Post-acute care of patients with OUD:
        - Ensuring Access to MOUD in Post-Acute Care Facilities: https://www.maine.gov/future/sites/maine.gov.future/files/inline-files/MOUD%20in%20Post-Acute%20Facilities.pdf
    - Resources about available treatment and harm reduction services:
        - Maine OPTIONS program, https://knowyouroptions.me/
        - Syringe service programs as appropriate, https://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/services/syringe-service-programs.shtml

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