Strategy to Increase Follow-Up after Emergency Department Visit and Hospitalization for Opioid Use Disorder

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Learning Objectives

Understand need for hospital hand-off services for patients with OUD

Identify strategies to establish and maintain hospital hand-off programs

Gain information on the impact of warm hand-off services for patients with OUD

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Hospital Warm Hand-Offs for Patients with OUD

- A warm handoff is a seamless transition for patients experiencing an opioid-related ED visit or hospitalization to specialty substance use disorder treatment that improves their prospects for recovery.
- Warm hand-off models may include peers counselors and induction on medication to treat OUD
- Aims to reduce barriers for opioid users to access substance use disorder treatment, primary care services and enhance opportunities for long term recovery.

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The Need for Hospital Hand-Off Services

- Among the individuals who died of an opioid-related overdose:
  - 62% had at least one prior overdose;
  - 22% had at least two prior overdoses, and
  - 17% had experienced three to six prior overdoses
- 40% of patients who received hospital care for opioid-related conditions did not receive any follow-up services within 30 days of the hospitalization

http://onlinelibrary.wiley.com/doi/10.1111/j.1465-3362.2009.00057.x/full

https://www.samhsa.gov/data/sites/defualt/files/report_2117/ShortReport-2117.pdf

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The Need for Hospital Hand-Off Services

- Study published in Annals of Internal Medicine (Larochelle et al., 2018) found that just 3 in 10 patients revived by an EMT or in an emergency room received any form of medication assisted treatment following their overdose.
- The study followed 17,568 patients who overdosed on opioids from 2012 to 2014 in Massachusetts. It looked at survival rates over time and whether patients received medicines that treat addiction.
- Of the patients who did receive medication, 3,022 adults were on buprenorphine and 2,040 patients were on methadone. The buprenorphine group had a 40 percent lower death rate after one year, compared with those who did not receive any medication. The results for methadone were even stronger: a 60 percent lower death rate.

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The Need for Hospital Hand-Off Services

- The majority of commercially insured patients who visit the emergency department (ED) for an opioid overdose do not receive the timely follow-up care known to help prevent a future overdose or death, according to a new study from researchers at the University of Pennsylvania School of Medicine (Kilaru et al., 2020). Of nearly 6,500 patients treated in EDs nationwide for an overdose or other opioid-related medical complications, only 16 percent accessed opioid use disorder (OUD) medications or another form of treatment within three months of the ED visit.
- The lack of care was most pronounced among black patients, who were half as likely to receive post-overdose treatment as whites, even after adjusting for type of overdose (prescription or heroin), and other clinical characteristics.

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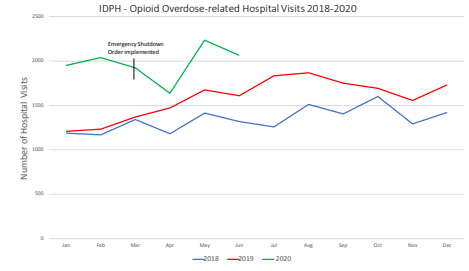

Source: Illinois Department of Public Health, Presentation to Opioid Advisory Council, August, 2020

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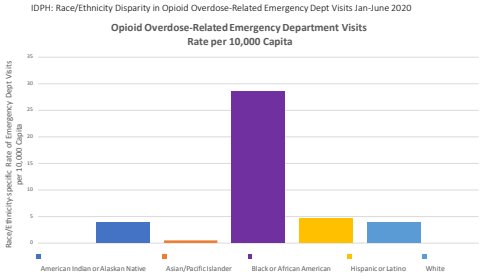

Source: Illinois Department of Public Health, Presentation to Opioid Advisory Council, August, 2020

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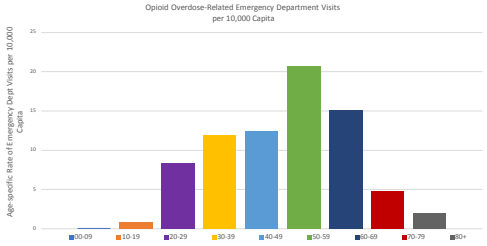
Age Demographics in Opioid Overdose-Related Emergency Dept Visits Jan-June 2020



- The highest rate of opioid overdose-related Emergency Department visits are in the 50-59 age group, followed by the 60-69 age group

Source: Illinois Department of Public Health, Presentation to Opioid Advisory Council, August, 2020

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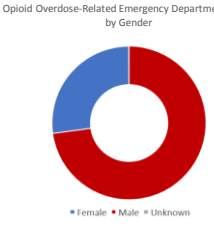
Gender Demographics in Opioid Overdose-Related Emergency Dept Visits Jan-June 2020



Source: Illinois Department of Public Health, Presentation to Opioid Advisory Council, August, 2020

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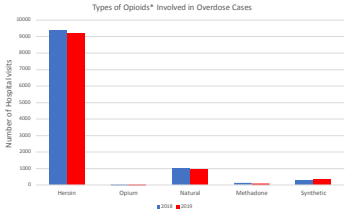
Types of Opioids Involved Overdose-Related Hospital Visits

- 2018: 13,658 hospital visits involving opioids
  - 3,151 visits did not record type
- 2019: 14,637 hospital visits involving opioids
  - 4,441 visits did not record type



*Different types of opioids are often mixed (ex. Heroin & fentanyl). One visit may include multiple types

Source: Illinois Department of Public Health, Presentation to Opioid Advisory Council, August, 2020

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Illinois Hospital-Based Withdrawal Management Services

- In SFY18, hospital-based withdrawal management (detox) services were reimbursed by Medicaid at 186 hospitals for a total of $36,242,523. Information on the utilization of these services includes the following:
  - A total of 9,730 unique patients received hospital-based detox services, with a total of 13,867 admissions and 46,581 days of care.
  - The average cost per day of care was $778
  - The top 7 hospitals (3.7%) accounted for 36% of the admissions; the top 15 hospitals (8.1%) accounted for 58% of the admissions.

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FGC Co-located Hospital Warm Hand-off Services for Persons with OUD

- FGC received grant award (7/1/17) from IDHS/SUPR to provide co-located hospital warm hand-off screening and referral services for patients with OUD at selected hospitals.*
- Partnerships were developed and expanded with the following hospitals: Methodist (Chicago), St. Bernard (Chicago), Silver Cross (Joliet), and Thorek (Chicago).

*These services were supported through an Opioid - State Targeted Response (STR) grant to the Illinois Department of Human Services, Division of Substance Use Prevention and Recovery from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (TI-080231).

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FGC Warm Handoff Model - Goals

1. Identify hospital detox and emergency room patients who are willing to accept the next appropriate level of substance use disorder treatment using the evidenced – based practice Stages of Change Model before discharge.
2. Work with the hospital's medical team to create a continuing care plan for individuals who present with heroin or other illicit opioid use.
3. Provide preliminary level of care placement for patients ready to enter community based treatment.
4. Link individuals with co-occurring mental health and substance use disorders to mental health services.
5. Transport willing patients from hospital site to substance use disorder treatment programs.
6. Link individuals to recovery support services.
7. Link individuals in SUD treatment to follow-up primary care services.
8. Provide Medication Assisted Treatment (MAT) as appropriate.

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Stages of Change
(Prochaska and DiClemente)

PRE-CONTEMPLATION

- At this stage, the patient may not recognize there is a problem. There are no thoughts about making any change at all. The impact of the problem has not become conscious and there is no consideration to make any adjustment to one's life.

CONTEMPLATION

- Adults in this stage are willing to consider that there might be a concern. However, their ambivalence is high. They haven't made a firm decision to change; rather, they know that the drinking or drug use is problematic and are willing to look at pros and cons to recovery. The counselor and patient might examine previous attempts to change in the past, causes for failure, and benefits and barriers to change.

DETERMINATION

- The hallmark of this stage is that a decision to change has been made. Although there continues to be some ambivalence, the determination to change is strong enough to outweigh any obstacles. There is a serious attempt to change with a realistic look at anticipatory problems, concrete solutions, and a sensible plan for recovery.

ACTION

- As the energy of determination continues to build, an individual takes action and chooses to implement his or her recovery plan. A person might make their commitment to change public by telling friends in order receive external validation for their efforts. As a recovery plan succeeds, emotional rewards might also become evident such as self-confidence, happiness, and optimism.

MAINTENANCE

- Although a recovery plan is in place, maintaining recovery can be challenging. This stage might even include incidents of returning to use, but the foundation for long-term recovery is becoming firm. The person in recovery is becoming more aware of old habits and is growing the ability to make healthier choices.

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FGC Warm Handoff Model

- The FGC Warm Hand-off counselors located on site at the hospitals, screen patients to determine readiness for change and willingness to enter substance use disorder treatment by utilizing the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). This instrument yields three scale scores: **Recognition**, **Ambivalence**, and **Taking Steps**. Client motivation for change is an important predictor of treatment compliance and eventual outcome. The SOCRATES assists the FGC clinicians with information necessary for treatment planning.
- For patients who are not willing to accept substance use disorder treatment, the FGC counselor provides Brief Intervention services during the patient's hospital stay and makes effort to follow up with these patients, especially upon any future admissions to the hospital.
- Brief Intervention is a distinct service intervention that seeks to help patients understand how their substance use puts them at risk and to encourage them to reduce or give up their substance use and to accept additional treatment.

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SOCRATES Assessment - Scales

- **Recognition** – At this state, a person is aware of the changes that he or she needs to make but has not taken any action toward this change.
- **Ambivalence** – This stage is marked by a high degree of ambivalence. There is a strong desire to change but as a person gets closer to action, the benefits of using drugs or drinking also become evident.
- **Taking Steps** – At this stage, a person has moved past the ambivalence and is taking action toward change.
- Having tools such as the SOCRATES assessment as well as the Stages of Change model can facilitate clinicians, families, and individuals in making decisions about entering treatment.

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FGC Warm Handoff Model

For patients who screen positively for readiness, the FGC counselor:

- Continues to provide Brief Intervention Services while the patient remains in the hospital;
- Completes a substance use disorder and mental health preliminary level of care assessment prior to discharge from the hospital;
- Directly provides or make arrangements for transportation from the hospital to the treatment program (immediately upon discharge);
- Makes arrangements for psychiatric evaluations, if necessary;
- Provides engagement support for patients at risk of relapse.

As patients transition from one level of care to another, the FGC counselor also:

- Secures recovery home services, if needed; and
- Secures other recovery support services, as needed.

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FGC Warm Handoff Model - Results

FGC Warm Hand-Off Services:

- St. Bernard Hospital: 677 patients
- Thorek Hospital: 566 patients
- Methodist Hospital: 498 patients
- Silver Cross Hospital: 23 patients

- Total of 1,764 unduplicated patients
- **Total of 1,496 (84.8%) began OMT services at FGC**

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FGC Co-located Hospital Warm Hand-off Services for Persons with OUD

- An opening data tool was completed for participating patients that collected demographic data and pre-discharge screening and referral service delivery information. This tool was completed when staff determined whether or not the patient followed through with the referral.
- A closing tool was completed that collected additional information regarding the results of post-discharge referrals. Staff were asked to complete this tool within 14 days following that date of first service.

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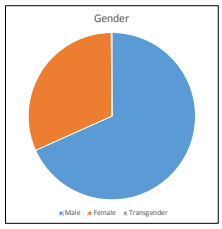
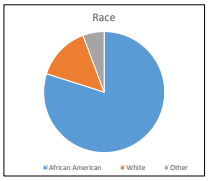
FGC Warm Hand-Off Clients



Average Age: 50.5 years old



Hispanic/Latinx Ethnicity: 5.0%

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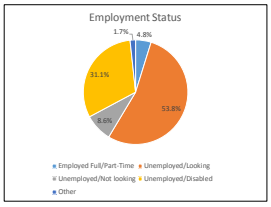
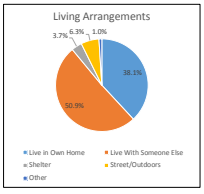
FGC Warm Hand-Off Clients



94.1% of Hand-Off Clients were covered by Medicaid



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FGC Warm Handoff Model - Results

Summary Patient Length of Stay Statistics (As of 09/15/2020)*

Average/Mean: 96.97
Minimum: 0
Maximum: 1,167
Percentiles: 25 - 31.00
50 - 163.00
75 - 473.00

*Source of Data: FGC SAMMS, 14.2% of Patients were still active in treatment at the time of the data extract.

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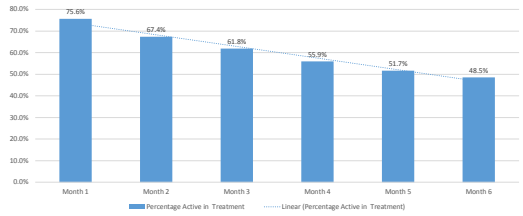
Retention in Treatment
Warm Hand-Off Patients Who Began Services at FGC
(N=1,496)



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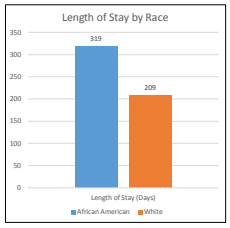
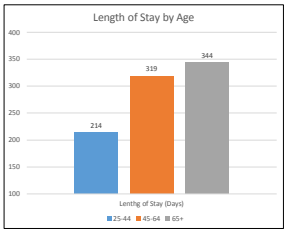
Warm Hand-Off Clients: Length of Stay by Race and Age





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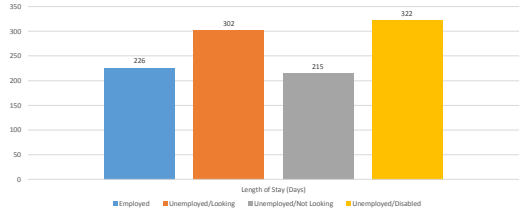
Warm Hand-Off Clients: Length of Stay by Employment Status



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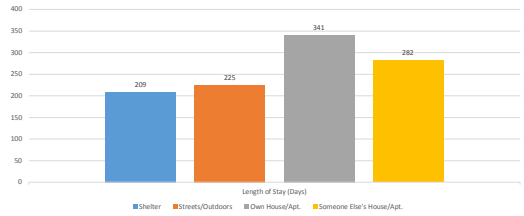
Warm Hand-Off Clients: Length of Stay by Housing Status



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Centers for Medicare and Medicaid Services (CMS) SUD Measures for 2020 Adult and Health Home Core Sets

- Improving outcomes for Medicaid beneficiaries with substance use disorders (SUDs) is a top priority for the Centers for Medicare & Medicaid Services (CMS). The opioid epidemic in particular continues to highlight the need for both preventing inappropriate prescribing and providing access to high quality treatment.
- CMS added new SUD measures to the 2020 Adult and Health Home Core The Use of Pharmacotherapy for Opioid Use Disorder (OUD) was added to both the Adult and Health Home Core Sets for Federal Fiscal Year (FFY) 2020 reporting. Additionally, the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) measure, which has been part of the Adult Core Set since FFY 2017, was added to the Health Home Core Set for FFY 2020.

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SUD Measures Included in the CMS 2020 Adult and Health Home Core Sets

NQF#	Measure Name	Adult	Health Home
0004	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD/IET-HH)	X	X
2940	Use of Opioids at High Dosage in Persons without Cancer (OHD-AD)	X	
3389	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	X	
3400	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD/OUD-HH)	X	X
3488	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD/FUA-HH)	X	X

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