A Survey of Emergency Department Opioid-related Practices in Georgia: Opportunities for Prevention and Intervention

Background:

As frontline providers, emergency physicians save lives by reversing the effects of opioid overdose. These providers are also uniquely positioned to prevent future overdoses through primary measures such as safe prescribing, and secondary measures such as provision of naloxone and linkage to clinical/behavioral health care, yet many patients are discharged without these interventions. In 2018, within a nationwide opioid epidemic, over 5,000 Emergency Department (ED) visits for opioid-involved overdoses were reported to the Georgia Department of Public Health (DPH). The Department of Public Health (DPH) conducted a survey to ascertain opioid-related practices among EDs in GA, and to identify gaps in evidence-based recommendations.

Methods:

Using Georgia Healthcare Association records, 130 emergency departments were identified in GA as potential participants. A web-based survey was created in DPH's State Electronic Notifiable Disease Surveillance System (SendSS). Questions were developed based on evidence-based guidelines for use of the Prescription Drug Monitoring Program (PDMP), safe opioid prescribing and education, screening and evaluation of overdose patients, use of medication assisted treatment (MAT), and linkage to care activities in an ED setting, as recommended by federal, state, and emergency medical society guidelines. Likert scale responses included *strongly agree, agree, neutral, disagree, strongly disagree*, or *nearly always, often, sometimes, not often, almost never, never*. One survey, to be completed by the Medical Director or a staff member with comparable clinical involvement, was requested per ED. Email reminders and telephone outreach was used to encourage participation. The survey was live from February through June 2019.

Results:

1. Respondent Profile:
   A total of 62 EDs (48%) participated in the survey (Table 1). Thirty-two of the respondents (52%) were physicians serving as Medical Directors of their respective EDs, while 26 (42%) were registered nurses serving as ED Directors or Managers. Four respondents (6%) held other staff positions (Physician's Assistant, Chief Nursing Officer, Director of Pharmacy, Director of Nursing). Most respondents (50/62, 81%) were in their current position for at least one year, with a mean of 4.9 years and a range from 1-20 years.

2. Emergency Department Demographics:
   a. *ED Location*
      Participating EDs were widely distributed geographically and located in 52 of the 159 counties in GA (Figure 1). All but one of 18 Public Health Districts had participating EDs, ranging from 7 in District 6 (East Central) to 0 in District 3-4 (Gwinnett-Newton-Rockdale). Population areas ranging from large metropolitan to non-core (less than 10,000 persons per county) were represented by participating EDs (Figure 2).

   b. *ED Capacity*
      Participating EDs varied in size with a reported a range in number of ED beds from 3-90 with a median of 25. Annual patient visits per ED ranged from 1,200 – 145,000, with a median of 36,000. In the event of an overdose cluster, the number of naloxone doses available for ED use ranged from 5-507 with a median of 30 (mean 69). The number of portable ventilators available for ED use ranged from 1-64 with a median number of 4 (mean 7).

3. Use of the Prescription Drug Monitoring Program:
The Prescription Drug Monitoring Program (PDMP) is a tool enabling prescribers to review a patient's prescription history and ensure safe and appropriate prescribing of controlled substances. Since January 1, 2018, all Georgia practitioners with a Drug Enforcement Agency (DEA) license have been required to register in the PDMP. Since July 1, 2018, all prescribers have been required to check the PDMP before prescribing schedule II opioids and cocaine derivatives, or benzodiazepines. Certain exceptions exist, such as that prescribers are not required to check the PDMP before prescribing opioids at low dosages (≤ 3 days and ≤ 26 pills).

- 73% (45/62) of survey respondents indicated that their system did not allow direct access to the PDMP through the electronic medical record system but necessitated entry through a separate site.
- 92% (56/61) of respondents *agreed* or *strongly agreed* that information obtained through the PDMP served to effect provider decisions when prescribing opioids in their respective ED.
- When an opioid prescription was written for more than 3 days or 26 pills, 65% (40/62) of EDs had a policy enforcing that the PDMP was checked prior to prescribing by requiring documentation in the electronic medical record. Eighty one percent of Medical Directors (26/32) answered yes to this question compared with 47% of other respondents (14/30).
- When prescribing a low opioid dosage (≤3 days and ≤ 26 pills) 69% (43/62) of respondents reported *nearly always* or *often* still checking the PDMP in this circumstance (despite no legal requirement). This decision was reported to be most influenced by the physicians' clinical assessment of the patient's risk for opioid abuse, not based on use of a screening tool to determine this risk.

4. Safe Opioid Prescribing:
Survey respondents were asked how familiar they were with guidelines on opioid prescribing for pain management such as those developed by the American College of Emergency Medicine (ACEP) and the Centers for Disease Control.
    - 90% (56/62) of respondents reported being either *very familiar* or *somewhat familiar* with these guidelines
    - 55% (34/62) of respondents reported that their ED implemented a policy around safe opioid prescribing guidelines.
    - Policy was most influenced by ACEP guidelines, followed by the American Academy of Emergency Medicine, and less by CDC's guidelines for chronic pain management. Most were based on more than one source.

    The survey addressed safe prescribing practices for a variety of pain scenarios seen in the ED, such as acute pain, acute exacerbation of chronic pain, and chronic pain, since specific guidelines vary by presentation type (Table 2).

    When treating acute pain
    - 97% (59/61) of EDs reported their physicians *nearly always* or *often* strongly considered non-opioid therapy before prescribing an opioid
    - 88% (52/59) of EDs reported their physicians *nearly always* or *often* prescribed short-acting opioids
    - 98% (58/59) of EDs reported their physicians *nearly always* or *often* prescribed the lowest effective opioid dose
    - 59% (34/58) of EDs reported having a policy that limited the duration of treatment for acute pain to a 3-day supply; 3% (2/58) reported a policy that limited duration of treatment to 7 days; and 38% (22/58) reported having no policy limiting the duration of treatment.

When treating an acute exacerbation of chronic pain

- 29% (17/58) of EDs reported their physicians *nearly always* or *often* conducted a substance abuse screening prior to prescribing an opioid
- 67% (39/58) reported their physicians *nearly always* or *often* avoided IV/IM opioid administration whenever possible 80% (47/59) reported their physicians *nearly always* or *often* checked the PDMP before prescribing an opioid
- 95% (57/60) reported their physicians *nearly always* or *often* avoided opioid prescribing if a patient was already on a controlled substance for pain 88% (51/60) reported their physicians *nearly always* or *often* prescribed short-acting opioids only 95% (55/58) reported their physicians *nearly always* or *often* prescribed the lowest effective dose of opioid 90% (52/58) reported their physicians *nearly always* or *often* prescribed the shortest course of an opioid i.e., ≤ 3day supply

When treating a patient with chronic pain already on opioid pain medication

- 87% (53/61) EDs reported their physicians nearly always or often denied the replacement of an opioid prescription, if a patient reported it as lost, destroyed, or stolen (87%)

5. Opioid-specific Education:
   When a patient was discharged with an opioid prescription, 25% (14/59) of EDs provided no opioid-specific education of any kind. If provided, education was most likely to cover the dangers of opioid misuse (88%) and the importance of secure medication storage (78%), with safe disposal of opioids (49%) and substance abuse resources (38%) less likely to be discussed. Of EDs that provided some opioid education on discharge, 51% (23/45) provided both written and verbal instructions.

6. Perception of Opioid Use Disorder:
   The survey included questions on provider perception of patients with opioid use disorder. Seventy seven percent (48/62) of respondents *strongly agreed* or *agreed* that opioid use disorder is a significant problem among the patient population in their ED. This response was more prevalent among Medical Directors as opposed to non-physician ED staff. Sixty one percent (38/62) of respondents *strongly agreed* or *agreed* with the perception that “Opioid use disorder warrants access to treatment services in the ED similar to diabetes or cardiac disease”, though non-physician staff were more neutral in their response.

7. Screening and Evaluation for Opioid Use Disorder:
   Only 20% (12/61) of EDs have a policy that required that all patients undergo a standardized screening i.e., using standardized question(s) for substance use when presenting for care. Fifteen percent (9/62) of EDs that participated had a policy to conduct a urine drug screen on all patients suspected of opioid overdose or opioid use disorder. Ten percent (6/62) of EDs reported the ability to conduct drug testing in their hospital that included fentanyl. Among respondents, 48% (30/62) reported having staff available to their ED that were specifically trained to conduct behavioral health and substance use assessments and referral to treatment.

8. Linkage to Care Resources and Actions:
   A certified peer specialist in addictive diseases is a trained individual who has had personal experience with substance abuse and recovery and can provide recovery coaching in EDs for patients willing to accept such services. Only 11% (7/62) of EDs had peer recovery coaches available to meet with patients in their facility. Fifty eight percent (36/62) of respondents were not aware of the concept of peer recovery coaches or their potential as an ED resource. Similarly, only 12% (7/60) of EDs surveyed referred patients to the CARES warmline, an instate support service available 7 days a week for persons in need for addiction assistance.

No EDs surveyed offered ED-initiated medication-assisted treatment (MAT) to opioid dependent patients, although 49% (30/61) of respondents were *familiar* or *very familiar* with this treatment intervention. Respondents *agreed* or *strongly agreed* that the reasons EDs are not offering MAT included a lack of awareness among ED staff about MAT as an ED-initiated treatment option in 71% (39/55), a lack of waivered ED physicians trained in this type of treatment in 78% (42/54), and a shortage of outpatient support available to continue MAT in their community in 79% (42/53). Only 33% (18/54) of respondents *strongly agreed* or *agreed* that they had reimbursement concerns regarding ED-initiated MAT therapy. Overall, 69% (37/54) *strongly agreed* or *agreed* that there was interest in developing an ED-initiated MAT program if the local community was able to support it.

Sixty two percent of respondents (38/61) *strongly agreed* or *agreed* that their staff felt comfortable and knowledgeable when talking to patients about substance use challenges and linkage to appropriate care. Sixty six percent (40/61) of respondents felt their ED staff were aware of local substance abuse services available for opioid use disorder. Multiple resources were used to link opioid overdose patients with care after discharge including crisis stabilization units (80%), inpatient detox centers (60%), community service boards (33%), residential detox centers (27%), MAT (20%), other (10%), or none (3%).

The term “warm hand-off” was defined as the direct transfer of an overdose survivor from the ED to a drug treatment provider, with confirmation that follow up, such as a direct admission to a drug treatment facility, outpatient appointment, or other referral has been arranged for the patient, and that any barriers such as transportation or childcare needs, have been addressed before the patient is discharged. ED respondents indicated that overdose survivors undergo an assessment by trained staff to determine their motivation to accept treatment 78% (47/60) of the time (*nearly always* -40%, *often* - 20%, and *sometimes* - 18%) in their respective EDs. Overdose survivors get a “warm hand-off” if they consent to treatment, up to 69% (37/54) of the time (*nearly always* -24%, *often* - 22%, *sometimes* - 22%). Overdose survivors reportedly do not get a “warm hand-off” due to barriers to care up to 65% (37/57) of the time. Overdose survivors receive information on local resources if they refuse treatment up to 94% (49/52) of the time (*nearly always* - 37%, *often* - 35%, *sometimes* - 23%).

9. <u>Access to Naloxone and Overdose Prevention Education</u>:
Naloxone can reverse the effects of opioids and save lives in an overdose situation. Most health insurance plans, including Medicaid and Medicare plans, will cover at least one form of naloxone (nasal spray, injection, auto-injection). A standing order allowing for the purchase of naloxone at pharmacies in GA without a prescription was issued by DPH in 2017 and remains in place.

Eighty four percent (51/61) of EDs had no policy for providing access to naloxone for overdose survivors at the time of discharge, either by prescription, dispensation, or pharmacy referral (Figure 3). Education on overdose prevention was defined as information on how to obtain naloxone, how to administer it, and/or providing awareness on GA’s 911 Amnesty Law – which states that anyone seeking medical assistance for themselves or someone else for a drug overdose can't be charged if evidence of a drug violation results solely from seeking such medical assistance. Ninety two percent (55/60) of respondents reported that their ED staff did not provide discharge education on overdose prevention with naloxone or on the 911 Amnesty Law to overdose survivors (Figure 4).

Table 1: Respondent Profile

ED Staff Position	n (%)	Position more than 1 year	Mean (yrs)	Range (yrs)
Medical Director (MD)	32 (52)	24	4.2	1-11
ED Director (RN)	10 (16)	9	5.0	1-13
ED Manager (RN)	16 (26)	13	5.9	1-20
Other*	4 (6)	4	5.5	5-6
Overall†	**62**	**50**	**4.9**	**1-20**

*Physicians Assistant, Chief Nursing Officer, Director of Pharmacy, Director of Nursing
†Includes 7 with <1 yr, 5 with years unspecified

Figure 1: Participating Emergency Departments by Location and Number of Patient Visits per Year

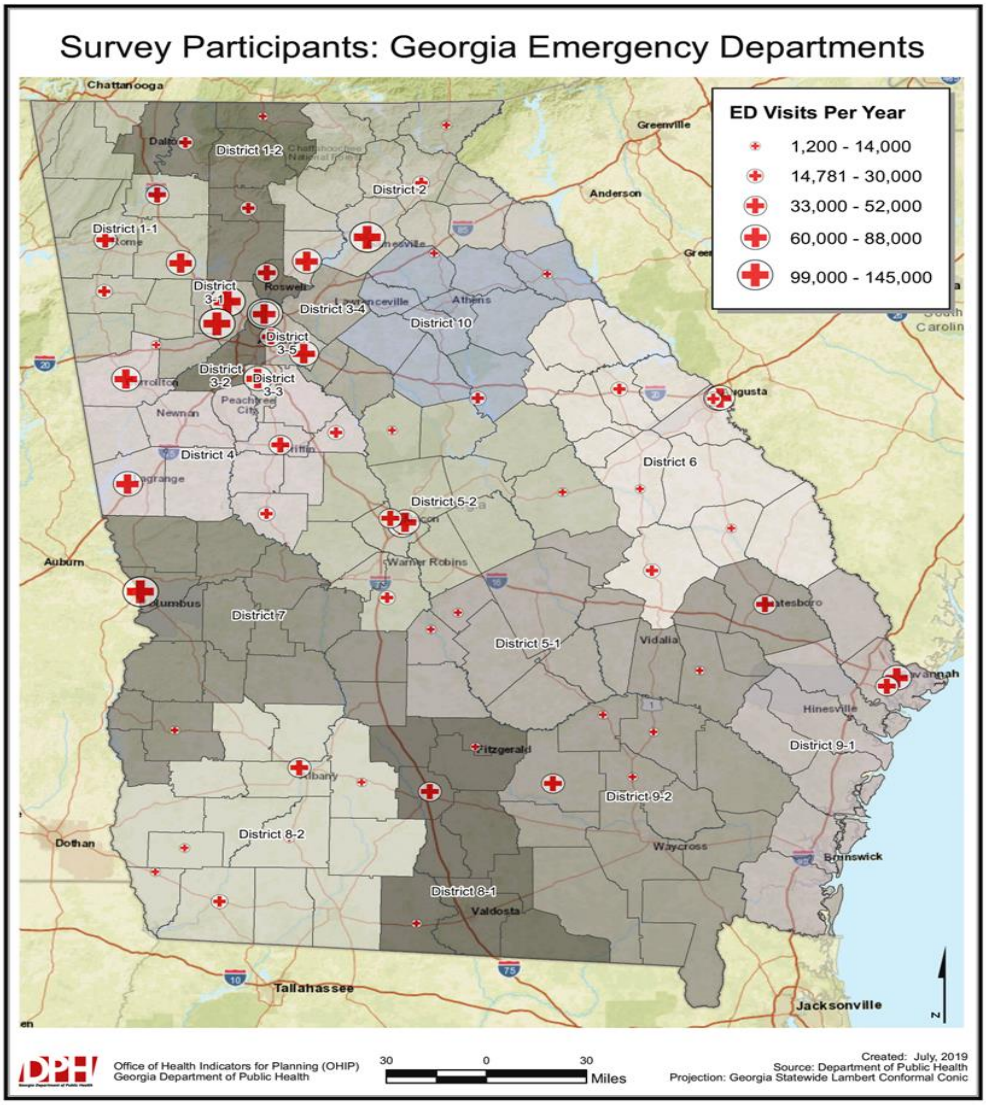


Figure 2: Distribution of Participating Emergency Departments by County Population
*National Center for Health Statistics, 2013 population data and classification

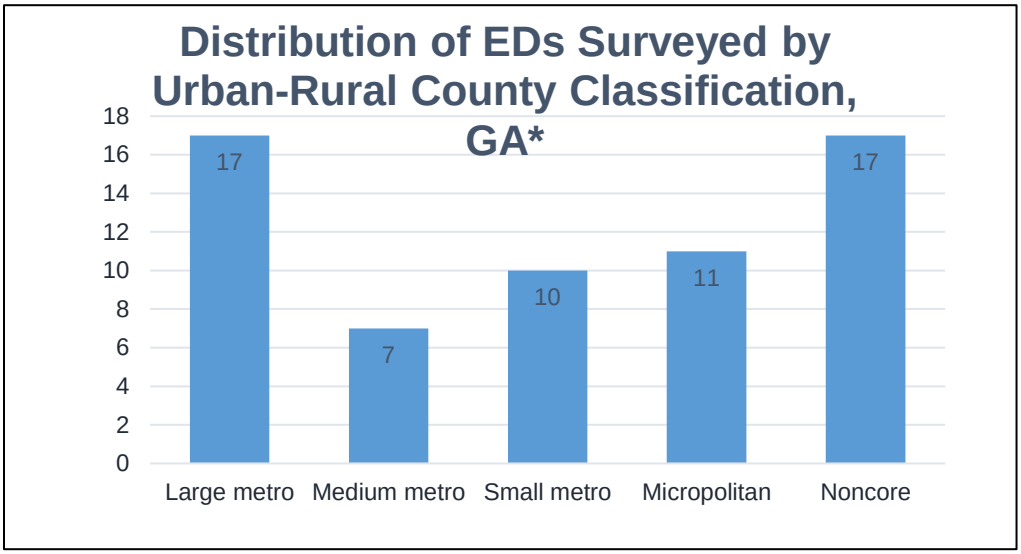


Table 2: Emergency Department survey responses to safe opioid prescribing practice statements

Pain Type	Safe Opioid Prescribing Practice Statement	Nearly always + often	n
Acute	Strongly consider non-opioid therapy before prescribing an opioid	97%	61
	Prescribe only short-acting opioids, if necessary	88%	59
	Prescribe lowest effective dose of opioid, if necessary	98%	59
Acute exacerbation of chronic	Conduct substance abuse screening prior to prescribing an opioid	29%	58
	Avoid IV/IM opioid administration whenever possible	67%	58
	Check the PDMP before prescribing an opioid	80%	59
	Avoid prescribing an opioid if already on controlled substance for pain	95%	60
Chronic	Deny replacement of an opioid prescription if lost, destroyed, or stolen	87%	61

Figure 3: ED survey responses regarding policies for providing naloxone

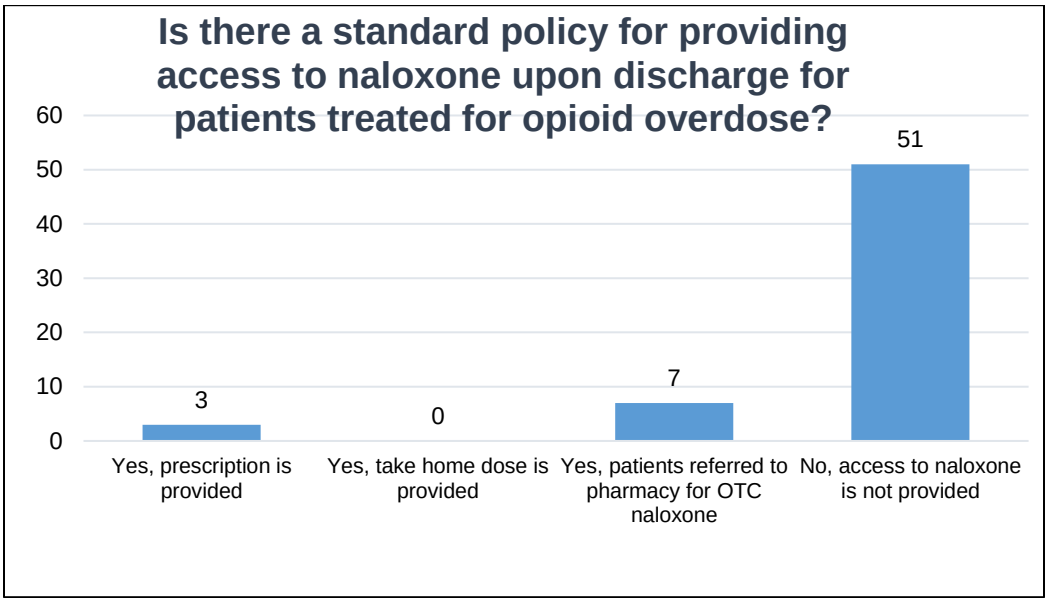
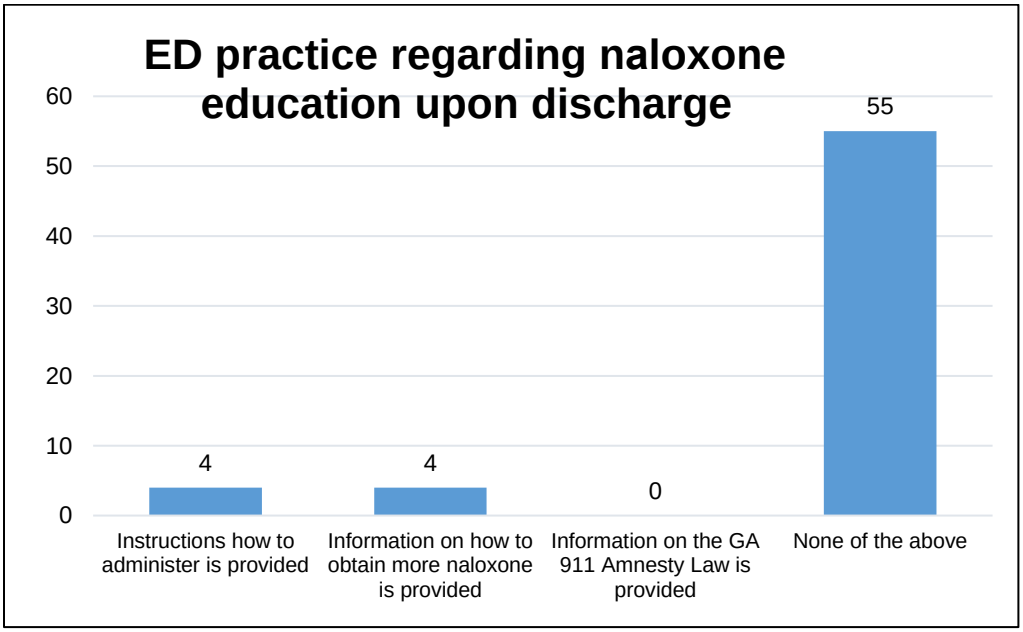


Figure 4: ED survey responses regarding naloxone education upon discharge



Summary

The Georgia Department of Public Health (DPH) surveyed all 130 Emergency Departments (EDs) in Georgia from February – June 2019 to ascertain opioid-related practices among emergency physicians, and to identify areas where gaps in evidence-based practices may exist. Questions were based on current evidence-based guidelines for use of the Prescription Drug Monitoring Program (PDMP), safe opioid prescribing, screening and evaluation for opioid misuse, linkage to care practices including the use of medication-assisted treatment (MAT), and overdose prevention education.

Sixty-two (48%) GA EDs participated in the survey. Of the respondents, 32 (52%) were Medical Directors. Participating EDs varied in size (3-90 beds per ED) and geographic distribution, representing all levels of population density around the state. Survey results indicated that most ED providers viewed the PDMP as a valuable tool when making opioid prescribing decisions. Most EDs had a policy requiring documentation of PDMP use when prescribing higher dosages of opioids, though the PDMP was often referenced even when not required. Direct access to the PDMP through electronic medical record systems was lacking in the majority of EDs.

Most respondents reported familiarity with safe opioid prescribing guidelines, yet only half implemented prescribing policies. Safe prescribing guidelines were followed for a variety of pain treatment scenarios, though when discharging a patient with an opioid prescription few providers offered education on misuse, safe storage, and disposal. Most respondents, particularly Medical Directors, considered opioid use disorder (OUD) a significant problem in their ED - and one that warrants access to medical treatment like other chronic diseases. Few EDs conduct standardized screening for substance abuse, drug screens for opioid use disorder, or have the capacity for fentanyl testing.

Only half of EDs had staff available that were trained to conduct behavioral health and substance use assessments on such patients, a prerequisite for treatment referral. Although interested in possibly developing a program for ED-initiated MAT, none of the responding EDs offered it, citing a lack of training and a shortage of outpatient support in the community to provide this treatment. Few respondents had knowledge of or access to peer recovery coaches as an ED resource. Although many overdose survivors were often assessed as to their motivation to accept treatment, warm handoffs were often impeded by barriers to care. Discharge education on overdose prevention such as how to obtain naloxone, how to administer it, and/or awareness of GA's 911 Amnesty Law was not provided.

This survey of opioid-related practices in GA EDs reveals potential missed opportunities for both primary and secondary prevention of opioid misuse at a critical - and for some patients only access point to healthcare. Primary prevention of opioid misuse through adherence to evidence-based prescribing practices can limit the potential for patients to transition from taking opioids for acute pain to addiction. Employing non-opioid therapies for pain, and limiting opioid prescriptions to those of low dose, short-action, and brief duration should be emphasized, though never supersede medical judgement. The PDMP should be accessible within the electronic medical record and should be used for early identification of patients at high risk of opioid abuse, in conjunction with a drug use screening tool if possible. EDs should deliver, within their capacity, secondary prevention measures which should include transitioning patients with OUD to care using a post-overdose protocol that provides naloxone access, overdose prevention education, contact with peer recovery support services, and active referral to appropriate community providers for treatment including MAT. Consideration for the developing the capacity to initiate MAT in the ED. Such a system of care is urgently needed to improve the outcome for patients with opioid addiction, and will require innovation and collaboration between medical providers, community-based services, and public health.

Recommendations for Emergency Departments

Prescription Drug Monitoring Program:

- The PDMP should be used to assist with appropriate and safe prescribing of opioids, and with identifying patients at risk i.e., those with prescriptions from multiple providers, or prescribed high morphine milliequivalent dosages (> 50 MME per day).
- The PDMP should be accessible directly through hospital electronic medical record systems to promote ease of use in the ED. DPH is currently funding all setup and licensing fees for any facility wanting to integrate access into their EMR which can be requested here: https://info.apprisshealth.com/georgiagatewayintegrationrequest

Safe Opioid Prescribing:

- ED providers should be familiar with opioid prescribing guidelines for pain and assess whether non-opioid therapies for pain would be adequate. ED providers should prescribe the lowest dose of shortest-acting opioid for < 1 week. Routine prescribing of opioids for acute exacerbation of chronic non-cancer pain, use of extended-release opioids, and combined prescribing of opioids and benzodiazepines should be avoided. Use of such guidance is not meant to supersede medical judgement.
- Consideration should be given to a hospital-based policy for safe opioid prescribing recommendations to ensure consistent practices among staff.

Opioid-specific Education:

- Upon discharge with an opioid prescription, patients should be educated on the risks of opioid analgesics and the importance of taking medication as prescribed.
- Patients should be instructed to keep opioid medication in a secure location, and safely dispose of unused doses, to reduce opportunities for misuse, diversion, and unintentional poisoning.

Screening and Evaluation for Opioid Use Disorder:

- Targeted screening for individuals at risk for OUD, such as those with a history of misuse, a positive drug screen result, or those who will be discharged with opioids, using a standardized screening tool should be conducted in conjunction with use of the PDMP when feasible. A single-question screening tool for drug use which has been validated in the primary care setting (though not in the ED) such as “How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons” may be preferable, with additional screening if positive. Other available screening tools include the NIDA-modified ASSIST, the TAPS-2, and the DAST-10) though not developed or validated for use in the ED, may identify patients who are obtaining opioids without a prescription.
- Laboratory drug screening which includes fentanyl should be considered on patients who overdose if a novel or emerging drug threat is suspected in the community. The Georgia Public Health Laboratory will be offering drug testing for fentanyl and fentanyl derivatives to EDs and hospitals in GA on request.

Linkage to Care:

- ED staff should receive education on addiction, the effect of stigma on patient experience, motivational interviewing, and how to develop a culture of recovery when caring for substance abuse patients.
- ED staff should become familiar with the role of peer recovery coaches and their potential application in the ED setting as an accessory to medical and social interventions. Efforts should be made to establish a relationship with local Recovery Community Organizations and determine what resources such as peer recovery coaches are available.
- Patients should be provided with telephonic resources. The CARES Warm Line (1-844-326-5400) provides addiction support. The Georgia Crisis & Access Line (1-800-715-4225) provides mental health, and substance abuse crisis intervention and referral 24-7.
- Consideration should be given to initiating Medication Assisted Treatment (MAT) in the ED and linking patients to outpatient MAT. Programs and providers in the community that support MAT should be identified and a referral system developed.

Naloxone and Overdose Prevention Education:

- A protocol should be developed for dispensing or prescribing naloxone for patients at increased risk of opioid overdose prior to discharge from the emergency department. Patients at *increased risk of opioid overdose* include those who:
  - Use illicit drugs – either opioids or drugs potentially contaminated with opioids;
  - Have a history of a substance use disorder;
  - Misuse prescription opioids;
  - Take opioids with benzodiazepines;
  - Are currently under treatment for opioid use disorder, including MAT wit methadone, buprenorphine, or naltrexone
  - Are on a high-dose opioid prescription (≥ 50 MME per day)
  - Have a respiratory condition such as chronic obstructive pulmonary disease (COPD) or obstructive sleep apnea and are on an opioid
- Education on how to administer naloxone should be provided prior to discharge when appropriate.
- Providers should become familiar with the GA 9-1-1 Amnesty law and educate patients with opioid use disorder on this law prior to discharge.
- EDs should collaborate with local pharmacists to ensure that pharmacies to which patients are referred for naloxone keep it in stock.

Resources for GA Emergency Departments

General:

CDC's Work to Prevent Opioid Overdose Deaths
https://www.cdc.gov/drugoverdose/index.html

Opportunities for Prevention and Intervention of Opioid Overdose in the Emergency Department
https://doi.org/10.1016/j.annemergmed.2018.01.052

Opioid Overdoses Treated in Emergency Departments – Identify Opportunities for Action
www.cdc.gov/vitalsigns/opioid-overdoses/

Georgia Department of Public Health Drug Surveillance Unit
https://dph.georgia.gov/drug-surveillance-unit

Prescription Drug Monitoring Program (PDMP):

Georgia Department of Public Health Prescription Drug Monitoring Program (PDMP)
https://dph.georgia.gov/pdmp

Information and request for DPH Supported PDMP Integration
https://dph.georgia.gov/pdmp/pdmp-integration

Safe Opioid Prescribing:

American Academy of Emergency Medicine White Paper on Acute Pain Management in the ED
https://www.aaem.org/resources/statements/position/white-paper-on-acute-pain-management-in-the-emergency-department

CDC guideline for prescribing opioids for chronic pain
https://www.cdc.gov/drugoverdose/prescribing/guideline.html

New York City Emergency Department Discharge Opioid Prescribing Guidelines
https://www1.nyc.gov/assets/doh/downloads/pdf/basas/opioid-prescribing-guidelines.pdf

Pennsylvania College of Emergency Physicians - Prescribing Guidelines for Pennsylvania
https://www.health.pa.gov/topics/Documents/Opioids/Emergency Department (ED) Prescribing Guidelines.pdf

Medical Association of Georgia – Think About It Initiative
https://www.mag.org/georgia/tai - pamphlets can be requested by mail for patient education

Georgia State Attorney General – Information on Safe Storage and Take Back in GA
https://doseofrealityga.org/

Georgia Prescription Drug Abuse Prevention Initiative
https://dbhdd.georgia.gov/bh-prevention

Georgia Department of Behavioral Health and Developmental Disabilities
https://dbhdd.georgia.gov/bh-prevention

Screening, Evaluation and Linkage to Care:

Screening Tools for Substance Abuse
https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

Georgia Council on Substance Abuse Peer Recovery Coach Program / CARES Warmline
https://gasubstanceabuse.org/cares-program/
https://gasubstanceabuse.org/cares-warm-line/

SAMHSA Resources for Medication Assisted Treatment
https://www.samhsa.gov/medication-assisted-treatment

ACEP - Buprenorphine Use in the Emergency Department Tool
https://www.acep.org/bupe

Identification, Management, and Transition of Care for Patients with Opioid Use Disorder in the ED
https://doi.org/10.1016/j.annemergmed.2018.04.007

Naloxone and Overdose Prevention:

ACEP Policy Statement on Naloxone Prescribing by ED Physicians
https://www.acep.org/globalassets/new-pdfs/policy-statements/naloxone-prescriptions-by-emergency-physicians.pdf

Life-Saving Naloxone from Pharmacies – More Dispensing Needed Despite Progress
www.cdc.gov/vitalsigns/naloxone

SAMHSA Opioid Overdose Prevention Toolkit
https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-4742

Educational videos for patients on naloxone administration
https://prescribetoprevent.org/patient-education/videos-for-download/

ED-based overdose education and naloxone prescription/distribution programs
https://prescribetoprevent.org/prescribers/emergency-medicine/

911 Georgia Medical Amnesty Law - § 16-13-5 - Immunity from arrest or prosecution when seeking medical assistance for drug overdose
http://www.legis.ga.gov/Legislation/20132014/144369.pdf