

LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

MODEL SUBSTANCE USE DISORDER TREATMENT IN EMERGENCY SETTINGS ACT

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SECTION I. SHORT TITLE.

This Act may be cited as the “Model Substance Use Disorder Treatment in Emergency Settings Act,” the “Act,” or the “Model Act.”

SECTION II. LEGISLATIVE FINDINGS AND PURPOSE.

(a) Legislative findings.—The legislature finds that:

(1) Drug and alcohol-related morbidity and mortality in [STATE]¹ has reached epidemic proportions. Since 2000, over one million people in the U.S. have lost their lives to a drug overdose,² including [NUMBER] in [STATE]. The Centers for Disease Control and Prevention (CDC) reported an average of 140,000 alcohol-attributable deaths per year in the U.S. from 2015-2019,³ including [NUMBER] in [STATE]. Additionally, the economic costs of excessive alcohol and substance use have totaled over \$[XXX] in [STATE] due to lost workplace productivity, health care expenses, crime, and other factors.⁴

(2) Further, individuals and families often seek treatment in emergency departments for drug and alcohol-related medical conditions such as overdose, infection, or accidents. In 2021, the national Drug Abuse Warning Network identified 141,529 drug-related emergency department visits from 52 participating hospitals.⁵ Of these visits, nearly 40 percent were related to alcohol, and fentanyl-related visits were growing at the fastest rate.⁶

(3) Research indicates that patients in need of substance use disorder treatment are more

¹ This Act contains certain bracketed words and phrases (e.g., “[LEGISLATURE]”). Brackets indicate instances where state lawmakers may need to insert state-specific terminology or facts.

² See Holly Hedegaard et al., *Drug Overdose Deaths in the United States, 1999–2020*, CTRES. FOR DISEASE CONTROL & PREVENTION (Dec. 2021), <https://www.cdc.gov/nchs/products/databriefs/db428.htm>; *Drug Overdose Deaths in the U.S. Top 100,000 Annually*, CTRES. FOR DISEASE CONTROL & PREVENTION (Nov. 17, 2021), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

³ *Alcohol and Public Health: Alcohol-related Disease Impact (ARDI)*, CTRES. FOR DISEASE CONTROL & PREVENTION (last visited July 27, 2022), https://nccd.cdc.gov/DPH_ARDI/Default/Report.aspx?T=AAM&P=612EF325-9B55-442B-AE0C-789B06E3A8D5&R=C877B524-834A-47D5-964D-158FE519C894&M=DB4DAAC0-C9B3-4F92-91A5-A5781DA85B68&F=&D=.

⁴ See Jeffrey J. Sacks et al., *2010 National and State Costs of Excessive Alcohol Consumption*, AM. J. PREVENTIVE MED. e73 (Nov. 2015); Feijun Luo et al., *State-level Economic Costs of Opioid Use Disorder and Fatal Opioid Overdose — United States, 2017*, 70 MORBIDITY & MORTALITY WEEKLY REP. 541 (2017).

⁵ PRELIMINARY FINDINGS FROM DRUG-RELATED EMERGENCY DEPARTMENT VISITS, 2021, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (2022).

⁶ *Id.*

likely to experience subsequent overdoses and have a greater risk of mortality after discharge from the emergency department.⁷

- (4) Research indicates that between 5.5–7.2 percent of patients experiencing substance use-related emergencies die within one year of discharge from the emergency department.⁸
- (5) Research indicates that fewer than half of the physicians in emergency departments feel prepared to deliver evidence-based substance use disorder treatment, determine the needed levels of care for patients with substance use disorders, or connect patients with outpatient treatment upon discharge.⁹ A 2017 poll conducted by the American College of Emergency Physicians of over 1,200 emergency physicians revealed that 57 percent believed that “detox” and “rehab” treatment centers are never or rarely accessible for patients with opioid use disorder in need of follow-up care.¹⁰ In the same survey, just 5 percent of physicians reported that their emergency departments provided medications for addiction treatment to patients.¹¹
- (6) Further, the CDC has reported that the number of substance use-related emergency department visits in the U.S. for people aged 18–34 has increased from 45.4 visits per 10,000 people in 2008–2009 to 76.0 visits in 2016–2017.¹²

⁷ Leslie W. Suen et al., *National Prevalence of Alcohol and Other Substance Use Disorders among Emergency Department Visits and Hospitalizations: NHAMCS 2014–2018*, 37(10) J. GEN. INTERNAL MED. 2420–2428 (Sep. 13, 2021).

⁸ See Geoff Jackson et al., *National Hospital Care Survey Demonstration Projects: Opioid-involved Emergency Department Visits in the National Hospital Care Survey*, 141 NAT’L HEALTH STAT. REP. 1 (2020); Scott G. Weiner et al., *One-year Mortality of Patients after Emergency Department Treatment for Nonfatal Opioid Overdose*, 75 ANNALS EMERGENCY MED. 13 (2020).

⁹ See Kathryn F. Hawk et al., *Barriers and Facilitators to Clinician Readiness to Provide Emergency Department–initiated Buprenorphine*, 3 JAMA NETWORK OPEN e204561 (2020); Margaret Lowenstein et al., *Barriers and Facilitators for Emergency Department Initiation of Buprenorphine: A Physician Survey*, 37 AM. J. EMERGENCY MED. 1787 (2019).

¹⁰ AM. COLL. OF EMERGENCY PHYSICIANS, 2017 ACEP EMERGENCY PHYSICIAN POLL: OPIOID PATIENTS IN THE EMERGENCY DEPARTMENT (2017), <https://www.emergencyphysicians.org/globalassets/files/pdfs/opioid-poll-results-acep17.pdf>.

¹¹ 2017 ACEP Emergency Physician Poll: Opioid Patients in the Emergency Department, AM. COLL. OF EMERGENCY PHYSICIANS (2017), <https://www.emergencyphysicians.org/globalassets/files/pdfs/opioid-poll-results-acep17.pdf>.

¹² Pinyao Rui & Alicia Ward, *QuickStats: Number of Emergency Department Visits, for Substance Abuse or Dependence per 10,000 Persons Aged ≥18 Years, by Age Group — United States, 2008–2009 and 2016–2017*, 68 MORBIDITY & MORTALITY WEEKLY REP. 1171 (2019).

- (7) Research indicates that emergency department patients are significantly less likely to obtain follow-up care after discharge if they screen positive for “alcohol misuse.”¹³
- (8) Research indicates that stimulant-related emergency department visits, often the result of cocaine and psychostimulants such as methamphetamine, are more often identified as cardiovascular and psychiatric emergencies and are less often identified as substance use-related emergencies in comparison to opioid-related emergency department visits.¹⁴
- (9) Further, data from the CDC’s National Syndromic Surveillance Program showed that between March and October 2020, on average, each week 15,000 Americans sought emergency department care for an overdose, with average overdose-related emergency visits greatly increasing week over week; in contrast, emergency department visits for other mental health conditions decreased during that time.¹⁵
- (10) Inadequate assessment, screening, and discharge planning, including immediate referral to a treatment provider, in emergency department settings is life-threatening and costly.¹⁶
- (11) Further, a 2015 study found that 78 percent of patients who were offered access to emergency department-initiated substance use disorder treatment and coordinated follow-up care continued engagement in outpatient treatment after discharge; additionally, this group’s illicit opioid use following discharge declined from nearly six days per week to only one day per week.¹⁷

¹³ Bryan Borg et al., *Alcohol Misuse and Outpatient Follow-up after Hospital Discharge: A Retrospective Cohort Study*, 13(24) ADDICTION SCIENCE & CLINICAL PRACTICE (Dec. 14, 2018), <https://ascjournal.biomedcentral.com/articles/10.1186/s13722-018-0125-1>.

¹⁴ Leslie W. Suen et al., *Emergency Department Visits and Trends Related to Cocaine, Psychostimulants, and Opioids in the United States, 2008–2018*, 22(19) BMC EMERGENCY MEDICINE (Feb. 4, 2022), <https://bmccemergmed.biomedcentral.com/articles/10.1186/s12873-022-00573-0>.

¹⁵ Kristin M. Holland et al., *Trends in US Emergency Department Visits for Mental Health, Overdose, and Violence Outcomes before and during the COVID-19 Pandemic*, 78 JAMA PSYCHIATRY 37 (2021).

¹⁶ Stacey C. Tobin, *Many People Treated for Opioid Overdose in Emergency Departments Die within 1 Year*, NAT’L INST. ON DRUG ABUSE: NIDA NOTES (April 2, 2020), <http://nida.nih.gov/news-events/nida-notes/2020/04/many-people-treated-opioid-overdose-in-emergency-departments-die-within-1-year>.

¹⁷ Gail D’Onofrio et al., *Emergency Department–initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial*, 313(16) JAMA NETWORK 1636-1644 (Apr. 28, 2015).

- (b) Purpose.—It is the intent of the Legislature through this Act to expand emergency department-initiated substance use disorder treatment in [STATE], to include referral to care and other critical health connections, which would both save lives and reduce health care costs.

Commentary

Since 2000, over one million people in the United States have lost their lives to a drug overdose, and overdose deaths continue to rise year after year.¹⁸ Provisional data from the National Center for Health Statistics at the CDC indicate that there were 107,622 drug overdose deaths in the United States in 2021.¹⁹ The CDC has also reported an average of 140,000 alcohol-attributable deaths in the U.S. per year from 2015-2019.²⁰

Adequate, ongoing, and sustainable funding is essential to ensure that emergency rooms and community-based providers are able to fulfill the requirements of this Act in the long term. In Sections XI, XII, and XIII, this Act provides opportunities for state governments to develop mechanisms for support. Notably, there are also opportunities at the federal level that states should utilize. For example, numerous components of the 2018 Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) can be leveraged to support the provisions of this Act: for instance, the SUPPORT Act authorizes new demonstrations to help states increase Medicaid substance use disorder treatment provider capacity and awards planning grants and payments to states to support these increases.²¹ States can utilize this funding to increase and maintain provider capacity and coordinate with hospitals and freestanding emergency departments to ensure that there is a sufficient number of community-based providers to meet community needs. States should work collaboratively with hospitals and freestanding emergency departments, as well as community-based programs, to identify all sources of funding to develop, launch, and maintain support for the provisions of this Act. The drafters emphasize that ongoing, sustainable funding is essential to accomplish the objectives of this Act.

There are significant disparities in access to substance use disorder prevention, treatment, harm reduction, and recovery services across demographic groups. In July 2022, the CDC reported that drug overdose deaths increased 30 percent in the U.S. from 2019 to 2020, generally.²² This same report indicated that death rates increased by 44 percent for non-Hispanic

¹⁸ Hedegaard, *supra* note 2; CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 2.

¹⁹ *U.S. Overdose Deaths in 2021 Increased Half as Much as in 2020 – But Are Still Up 15%*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 11, 2022), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm.

²⁰ CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 3.

²¹ Substance Use-disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, Pub. L. No. 115-271 § 6042.

²² Mbabazi Kariisa et al., *Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020*, 71 MORBIDITY & MORTALITY WEEKLY REP. 940 (2022).

Black people and 39 percent for non-Hispanic American Indian or Alaska Native people.²³ Likewise, a review from 2019 found that women are the fastest-growing population of substance users in the U.S.²⁴ Studies have shown that access to buprenorphine is drastically different between white and Black populations;²⁵ these disparities have increased during the COVID-19 pandemic.²⁶ Research indicates that people in socioeconomically vulnerable populations rely disproportionately on emergency departments as a result of their limited access to interventions offered in primary care settings.²⁷ As such, it is vital from a standpoint of health equity that emergency care settings present the opportunity for substance use disorder treatment and that services are delivered in a way that ensures equity of access to care for all populations.

Emergency medical settings can be critical access points for preventing drug and alcohol-related deaths. People with substance use disorders and other comorbidities, such as poverty and homelessness, often seek care in emergency medical settings.²⁸ Further, people are presenting to emergency rooms with substance use-related emergencies with greater frequency. The CDC reviewed trends in emergency department visits from 2006–2014 and found that mental health and substance use-related emergencies have risen, from 14.1 per 1,000 visits in 2006 to 20.3 per 1,000 visits in 2014.²⁹ Among these visits, alcohol-related disorders were the most frequent diagnoses in 2014, totaling 1.5 million visits.³⁰

There exists a vast corpus of compelling clinical research that has provided important guidance in the development of this Act. Rates of post-discharge deaths among emergency department patients presenting with substance use-related emergencies range from 5.5–7.2 percent.³¹ The fatality rate for patients discharged following a substance use-related emergency room visit is six times higher than that for patients visiting the emergency room for any other cause.³² In a 2020 study conducted in Massachusetts emergency departments, researchers found that, of 11,557 patients presenting to the emergency department with an overdose, 635 died within one year of discharge, 130 died within one month, and 29 died within two days.³³

²³ *Id.*

²⁴ Nassima Ait-Daoud et al., *Women and Addiction: An Update*, 103 *MED CLINICS N. AM.* 699 (2019).

²⁵ Pooja A. Lagisetty et al., *Buprenorphine Treatment Divide by Race/Ethnicity and Payment*, 76 *JAMA PSYCHIATRY* 979 (2019).

²⁶ Thuy Nguyen et al., *Racial and Ethnic Disparities in Buprenorphine and Extended-Release Naltrexone Filled Prescriptions during the COVID-19 Pandemic*, 5 *JAMA NETWORK OPEN* e2214765 (2022).

²⁷ David Powers et al., *Evaluating the Utility of Emergency Department Encounter Data and Examining Social Determinants of Emergency Department Utilization in Utah*, U.S. CENSUS BUREAU (June 8, 2021), <https://www.census.gov/library/working-papers/2021/demo/SEHSD-WP2021-07.html>.

²⁸ See Catherine A. Marco et al., *Access to Care among Emergency Department Patients*, 29(1) *EMERGENCY MED. J.* 28, 29 (Jan. 2012); and Paul Sacamano et al., *Emergency Department Visits in a Cohort of Persons with Substance Use: Incorporating the Role of Social Networks*, 53(13) *SUBSTANCE USE & MISUSE* 2265–2269 (Apr. 19, 2018).

²⁹ Brian J. Moore, Ph.D. et al., *Healthcare Cost and Utilization Project, Trends in Emergency Department Visits, 2006–2014*, AGENCY FOR HEALTHCARE RSCH. & QUALITY 6 (2017), <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf>.

³⁰ *Id.* at 1.

³¹ Jackson, *supra* note 8; Weiner, *supra* note 8.

³² Noa Krawczyk et al., *Predictors of Overdose Death among High-risk Emergency Department Patients with Substance-related Encounters: A Data Linkage Cohort Study*, 75 *ANNALS OF EMERGENCY MED.* 1 (2019).

³³ Weiner, *supra* note 8.

Likewise, lack of screening for problematic alcohol use is correlated with an increased risk for hazardous alcohol use.³⁴

The purpose of this Act is to establish and align mechanisms for maximizing emergency medical settings as intervention points for people who experience a substance use-related emergency, people with substance use disorders, and their families. This Act intends to do so by addressing the barriers to implementing protocols in emergency medical settings that would ensure evidence-based treatment of patients with substance use-related emergencies. The Act also intends to address barriers to expedited connection to the appropriate level of care following discharge. As such, the Act is crafted in accordance with guidance from subject matter experts, including emergency health care physicians, addiction medicine specialists, legislators, insurance providers, and people with lived experience. It also incorporates best practices and promising innovations from interdisciplinary research analyzing protocols for emergency medical care delivery for the people most at risk of dying after emergency room discharge. Importantly, this Act seeks to address all substance use disorders, including opioid use disorder, alcohol use disorder, and stimulant use disorder.

There is sound research supporting the development of legislation that would connect people with substance use disorders to treatment, prevention, recovery, and harm reduction services upon discharge from the emergency department. Generally, emergency department-initiated interventions for people with substance use disorder can result in a decrease in negative consequences associated with use, as well as a decline in repeat visits to the emergency department.³⁵ For example, a study examining the effectiveness of interventions at an urban emergency department found that the screening, brief intervention, and referral to treatment (SBIRT) model can be implemented in daily care and can be effective in reducing alcohol intake among patients.³⁶ A literature review focusing on studies examining brief interventions that targeted alcohol misuse among adults admitted into the emergency department found optimal conditions for brief interventions in emergency department settings.³⁷ Likewise, a large-scale data analysis of one million emergency department visits between July 2014 and November 2018 supported the scalability of SBIRT in hospital emergency departments.³⁸

Emergency department-initiated substance use disorder treatment may also include connecting patients to medications for addiction treatment, such as buprenorphine or methadone for opioid use disorder, as well as providing immediate access to naloxone, an opioid antagonist that can reverse overdoses. One study analyzing 155 adult patients who received a take-home supply of buprenorphine-naloxone from an urban emergency department showed that dispensing

³⁴ Merel van Loon et al., *Routine Alcohol Screening in the ED: Unscreened Patients Have an Increased Risk for Hazardous Alcohol Use*, 37(4) EMERGENCY MED. J. 206-211 (Apr. 2020).

³⁵ Isabel A. Barata et al., *Effectiveness of SBIRT for Alcohol Use Disorders in the Emergency Department: A Systematic Review*, 18(6) WEST. J. OF EMERGENCY MED. 1143-1152 (Oct. 2017).

³⁶ Merel van Loon et al., *Evaluation of Screening and Brief Intervention for Hazardous Alcohol Use Integrated into Clinical Practice in an Inner-city Emergency Department*, 24(3) EUR. J. OF EMERGENCY MED. 224-229 (June 2017).

³⁷ Caitlin J. Davey et al., *A Realist Review of Brief Interventions for Alcohol Misuse Delivered in Emergency Departments*, 4(45) SYSTEMATIC REVS. (Apr. 9, 2015).

³⁸ Laura B. Monico et al., *One Million Screened: Scaling Up SBIRT and Buprenorphine Treatment in Hospital Emergency Departments across Maryland*, 38(7) AM. J. OF EMERGENCY MED. 1466-1469 (July 2020).

these take-home kits resulted in continuation of outpatient buprenorphine treatment in almost half of the patients.³⁹ Another study evaluating the long-term outcomes at two, six, and 12 months following emergency medical interventions, found that emergency department-initiated buprenorphine was associated with increased engagement in addiction treatment and reduced illicit opioid use.⁴⁰ Similarly, a retrospective chart review found that initiation of buprenorphine by emergency medical providers in rural, community-based settings was associated with lower 12-month emergency department visit and all-cause hospitalization rates.⁴¹ Numerous other studies have yielded similar results, showing that using emergency medical settings as an opportunity to provide patients with buprenorphine-naloxone reduces the risk of future emergency department utilization and overdose deaths.⁴²

Studies indicate that, beyond treatment initiation, patients should also be connected with community resources outside the emergency department. A comprehensive literature review of research from 1980 to 2019 on interventions targeting opioid use disorder showed that emergency departments can be an appropriate setting for initiating treatment, but there should be community-based follow-up and support to ensure long-term treatment retention.⁴³ Likewise, research has shown that emergency departments can effectively utilize the expertise of social workers to drive buprenorphine initiation in emergency departments and coordinate outpatient medication referrals.⁴⁴

Effective utilization of community resources includes incorporating harm reduction. Harm reduction is an important concept in preventing future overdoses and deaths, and studies show that including harm reduction services, and adopting a harm reduction framework, can yield greater health outcomes for patients. One clinical article examining the specific health complications of injection drug use and reviewing the evidence base for syringe service programs and overdose prevention sites determined that emergency clinicians can improve health outcomes by promoting the use of harm reduction programs in the community to reduce viral transmission and other risks of injection drug use by providing information about these services to emergency department patients.⁴⁵ Another retrospective evaluation of the

³⁹ James R. Krenz et al., *Continuation of Outpatient Buprenorphine Therapy after Dispensing Buprenorphine-naloxone from the Emergency Department*, 60(4) CLINICAL TOXICOLOGY (PHILA., PA.) 429-432 (Aug. 2021).

⁴⁰ Gail D’Onofrio et al., *Emergency Department-initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes during and after Intervention*, 32(6) J. OF GEN. INTERNAL MED. 660-666 (June 2017).

⁴¹ Tinh Le et al., *Healthcare Use after Buprenorphine Prescription in a Community Emergency Department: A Cohort Study*, 22(6) W. J. OF EMERGENCY MED. 1270-1275 (Sept. 24, 2021).

⁴² See, e.g., Hannah Snyder et al., *Rapid Adoption of Low-threshold Buprenorphine Treatment at California Emergency Departments Participating in the CA Bridge Program*, 78(6) ANNALS OF EMERGENCY MED. 759-772 (Dec. 2021); Ross W. Sullivan et al., *Bridge Clinic Buprenorphine Program Decreases Emergency Department Visits*, 130 J. OF SUBSTANCE ABUSE TREATMENT, Nov. 1, 2021; and Tianyu Sun et al., *Early Buprenorphine-naloxone Initiation for Opioid Use Disorder Reduces Opioid Overdose, Emergency Room Visits, and Healthcare Cost Compared to Late Initiation*, 48(2) AM. J. OF DRUG & ALCOHOL ABUSE 217-225 (Nov. 15, 2021).

⁴³ Janusz Kaczorowski et al., *Emergency Department-initiated Interventions for Patients with Opioid Use Disorder: A Systematic Review*, 27(11) ACAD. EMERGENCY MED. 1173-1182 (Nov. 2020).

⁴⁴ Timothy Kelly et al., *A Novel Social Work Approach to Emergency Department Buprenorphine Induction and Warm Hand-off to Community Providers*, 38(6) AM. J. OF EMERGENCY MED. 1286-1290 (June 2020).

⁴⁵ Wendy Macias-Konstantopoulos et al., *Between Emergency Department Visits: The Role of Harm Reduction Programs in Mitigating the Harms Associated with Injection Drug Use*, 77(5) ANNALS OF EMERGENCY MED. 479-492 (May 2021).

implementation of low threshold emergency department buprenorphine treatment showed that this treatment, implemented with a harm reduction approach and active navigation to outpatient services, was successful in achieving buprenorphine retention in diverse California communities.⁴⁶ In sum, access to medication, referral for subsequent long-term treatment engagement, and community partnership are key components of an effective strategy for addressing the overdose crisis.⁴⁷

Interventions may be integrated into emergency department protocols in a way that is both feasible and effective.⁴⁸ One report by a multidisciplinary team of experts found that point of care naloxone distribution is feasible and yields a rate of obtainment significantly higher than previous studies in which naloxone was prescribed instead of provided in-hand at the emergency department.⁴⁹ An article describing the cost-effectiveness of SBIRT when applied to emergency department patients with substance use and behavioral disorders recommends adopting SBIRT broadly to help coordinate care.⁵⁰ In a paper investigating the economic impact of SBIRT using data from a multisite, randomized controlled trial, it was shown that implementation of the SBIRT program made no significant changes in the main economic outcomes of the emergency departments.⁵¹ Another study seeking to evaluate the health care costs and health care utilization associated with SBIRT services in the emergency department found further support that such programs are cost-effective and cost-beneficial approaches to substance use disorder management.⁵² Such programs are feasible in a number of settings, including rural areas, provided that there is sufficient institutional support.⁵³

Despite the effectiveness and feasibility of emergency department-initiated substance use disorder services, numerous barriers still exist that prevent access for people in need of this lifesaving care. Some barriers identified include a shortage of qualified prescribers and the poor availability of community-based resources. The recent elimination of the federal X-waiver removed one of the legal and regulatory barriers to treatment.⁵⁴ Researchers also identified stigma, lack of community outreach, and appropriate follow-up as significant barriers.⁵⁵

⁴⁶ Snyder et al., *supra* note 42.

⁴⁷ Lauren A. Walter et al., *Development of an Emergency Department-based Intervention to Expand Access to Medications for Opioid Use Disorder in a Medicaid Nonexpansion Setting: Protocol for Engagement and Community Collaboration*, 10(4) JMIR RSCH. PROTOCOLS e18734 (Apr. 29, 2021).

⁴⁸ van Loon et al., *supra* note 34.

⁴⁹ P. Quincy Moore et al., *Point-of-care Naloxone Distribution in the Emergency Department: A Pilot Study*, 78(4) AM. J. OF HEALTH-SYS. PHARMACY 360-366 (Feb. 8, 2021).

⁵⁰ Steven L. Bernstein & Gail D'Onofrio, *A Promising Approach for Emergency Departments to Care for Patients with Substance Use and Behavioral Disorders*, 32(12) HEALTH AFFS. PROJECT HOPE 2122-2128 (Dec. 2013).

⁵¹ Brady P. Horn et al., *Benefit-cost Analysis of SBIRT Interventions for Substance Using Patients in Emergency Departments*, 79 J. OF SUBSTANCE ABUSE TREATMENT 6-11 (Aug. 2017).

⁵² Janice L. Pringle et al., *Screening, Brief Intervention, and Referral to Treatment in the Emergency Department: An Examination of Health Care Utilization and Costs*, 56(2) MED. CARE 146-152 (Feb. 2018).

⁵³ Carolyn Bogan et al., *Implementation of Emergency Department-initiated Buprenorphine for Opioid Use Disorder in a Rural Southern State*, 112 J. OF SUBSTANCE ABUSE TREATMENT 73-78 (Mar. 2020).

⁵⁴ Gideon Logan et al., *Physician-perceived Barriers to Treating Opioid Use Disorder in the Emergency Department*, 13(11) CUREUS e19923 (Nov. 2021).

⁵⁵ Noah K. Rosenberg et al., *Barriers and Facilitators Associated with Establishment of Emergency Department-initiated Buprenorphine for Opioid Use Disorder in Rural Maine*, 38(3) J. OF RURAL HEALTH 612-619 (Sept. 1, 2021).

Implementation of this care also requires utilizing a standard of care for treatment and referral, increasing buprenorphine prescribing capacity, creating a central repository for streamlined referrals and follow-up, and supporting low-barrier scheduling and navigation.⁵⁶ Development of this Act was based, in part, on addressing these identified barriers.

The available research also identifies facilitators to establish these services in emergency medical settings, such as supportive hospital leadership, peer mentorship among emergency department professionals, adequate resources, and institutional support.⁵⁷ Another qualitative case study of care delivery in six hospital emergency rooms in Pennsylvania found common themes that influenced buprenorphine and “warm handoffs” across sites, including supporting interdisciplinary care champions, addressing knowledge gaps and biases, and having adequate data systems to capture care and integrate clinical protocols.⁵⁸ These studies, too, informed the development of this Act.

This Act reflects the wealth of research on this topic, as well as the input of stakeholders from all disciplines and the existing legislation addressing the need for emergency department-initiated substance use disorder services. The critical takeaways from this research are the following: (1) every hospital and freestanding emergency department should act as a point of intervention for patients with substance use disorder through the establishment of a set of evidence-based protocols for treating every patient presenting with a substance use-related emergency; (2) each facility’s protocols must reflect community need, facility resources, and best practices; (3) state-level guidance and oversight will ensure accountability and cohesiveness within the broader public health and substance use disorder treatment systems; and (4) the legislature and state executive must prioritize, support, and facilitate these services by leveraging all available funding sources.

As such, Sections IV, V, and VI of the Act require the development of achievable, effective, and evidence-based protocols and practice standards in emergency health settings, such that there will be a measurable improvement in health outcomes for those discharged from emergency rooms following substance use-related emergencies. Sections VII, VIII, IX, X, and XI establish oversight and enforcement mechanisms that would ensure consistent data collection and compliance assurance by state actors, thus ensuring constant improvement of health care delivery. Finally, Sections XII, XIII, and XIV of the Act create and activate a variety of funding levers in order to promote improved protocols and dismantle barriers to improving quality of care.

⁵⁶ Callan Elswick Fockele et al., *Improving Transitions of Care for Patients Initiated on Buprenorphine for Opioid Use Disorder from the Emergency Departments in King County, Washington*, 2 J. AM. COLL. EMERGENCY PHYSICIANS OPEN e12408 (2021).

⁵⁷ Rosenberg et al., *supra* note 55; Bogan et al., *supra* note 53.

⁵⁸ Esita Patel et al., *Implementation of Buprenorphine Initiation and Warm Handoff Protocols in Emergency Departments: A Qualitative Study of Pennsylvania Hospitals*, 136 J. OF SUBSTANCE ABUSE TREATMENT 108658 (Nov. 2021).

SECTION III. DEFINITIONS.

- (a) Academic medical center.—“Academic medical center” means a facility that consists of three related enterprises: a medical school that trains physicians; research activities involving laboratory science, clinical investigation, or both; and a system for delivering health care services that may include one or more hospitals, satellite clinics, and a physician office practice.⁵⁹
- (b) Adverse childhood experience.—“Adverse childhood experience” means a potentially traumatic experience that can have a profound impact on a child’s developing brain and body and lasting impacts on a person’s health and livelihood across their lifetime.⁶⁰
- (c) Buprenorphine.—“Buprenorphine” means a partial opioid agonist that is approved by the U.S. Food and Drug Administration (FDA) for the treatment of opioid use disorder. This definition can include products containing a combination of buprenorphine and naloxone.
- (d) Community health worker.—“Community health worker” means a member of the community who works in association with the local health care system in both urban and rural environments. Community health workers usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve.⁶¹
- (e) Emergency department.—“Emergency department” means any department or facility of a hospital, or any health care facility, licensed by [STATE] under [REGULATION] for the provision of medical and surgical care to patients in need of immediate care.
- (f) Evidence-based.—“Evidence-based” means an activity, practice, program, service, support, or strategy that meets one of the following evidentiary criteria: (1) meta-analyses or systematic reviews have found the strategy to be effective; (2) evidence from a scientifically rigorous experimental study, such as a randomized controlled trial, that demonstrates that the strategy is effective; or (3) multiple observational studies from U.S. settings indicate the strategy is effective.⁶² As used in this definition, “effective” means

⁵⁹ Henry J. Aaron, *The Plight of Academic Medical Centers*, BROOKINGS (May 15, 2000), <https://www.brookings.edu/research/the-plight-of-academic-medical-centers/>.

⁶⁰ A.B. 1644, 2015-2016 Reg. Sess. (Ca. 2016).

⁶¹ *Role of Community Health Workers*, NAT’L HEART, LUNG, & BLOOD INST. (last updated Dec. 16, 2020), <https://www.nhlbi.nih.gov/education/heart-truth/CHW/Role>.

⁶² Jennifer J. Carroll et al., *Evidence-based Strategies for Preventing Opioid Overdose: What’s Working in the United States*, CTRS. FOR DISEASE CONTROL & PREVENTION (2018) <https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf>.

an activity, practice, program, service, support, or strategy that helps individuals avoid the development and progression of substance use disorders and/or drug-related harms; reduces the adverse consequences of substance use among persons who use substances; or manages, slows the progression of, or supports recovery from a substance use disorder or co-occurring mental health disorder.

- (g) Federally Qualified Health Center.—“Federally Qualified Health Center” means a health center as defined in section 1905(l)(2)(B) of the Social Security Act, codified at 42 U.S.C. § 1396d(l)(2)(B).
- (h) Freestanding emergency department.—“Freestanding emergency department” means a state-licensed facility that is structurally separate and distinct from a hospital and provides emergency care, regulated under [STATE REGULATION].⁶³
- (i) Harm reduction.—“Harm reduction” means a public health framework that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission; improves the physical, mental, and social wellbeing of those served; and offers low threshold options for accessing substance use disorder treatment and other health care services.⁶⁴ Harm reduction services address conditions that give rise to substance use, as well as the substance use itself, and may include, but is not limited to, syringe service programs, naloxone distribution, and education about Good Samaritan laws.
- (j) Harm reduction services provider.—“Harm reduction services provider” means an organization authorized by [STATE] to provide a range of services designed to lessen the negative social, emotional, medical and/or mental health consequences associated with drug use without an expectation that individuals whom they serve will cease drug use. A harm reduction services provider might also be a substance use disorder treatment provider.

⁶³ *Freestanding Emergency Departments*, AM. COLL. OF EMERGENCY PHYSICIANS (rev. April 2020), <https://www.acep.org/patient-care/policy-statements/freestanding-emergency-departments/>.

⁶⁴ *Harm Reduction*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (last updated Aug. 16, 2022), <https://www.samhsa.gov/find-help/harm-reduction>.

- (k) Health care clinic.—“Health care clinic” means an organized medical service offering diagnostic, therapeutic, or preventive outpatient services, as regulated under [STATE] law.⁶⁵
- (l) Health care practitioner.—“Health care practitioner” means a person licensed, registered, certified, or otherwise authorized by [STATE] to provide health care to individuals.⁶⁶
- (m) Hospital.—“Hospital” means an institution providing medical and surgical treatment and nursing care for sick or injured people, as regulated under [STATE REGULATION].⁶⁷ For the purposes of this Act, this definition is limited to only hospitals that have emergency departments.
- (n) Low threshold treatment.—“Low threshold treatment” means treatment that (1) includes same-day buprenorphine or methadone initiation; (2) utilizes a harm reduction approach; (3) utilizes flexibility and a patient-centered approach in requirements for medication pick up, psychosocial counseling, or attendance at mutual aid groups; and (4) does not require abstinence from drugs or alcohol.⁶⁸
- (o) Medications for addiction treatment.—“Medications for addiction treatment” means medications approved by the FDA for treating substance use disorder, including opioid use disorder and/or alcohol use disorder. This includes medications for opioid use disorder.
- (p) Mental health provider.—“Mental health provider” means a health care practitioner or social and human services provider authorized by [STATE] to diagnose and/or treat mental health disorders and address patients’ mental health needs.
- (q) Methadone.—“Methadone” means an opioid agonist medication that has been used to treat opioid use disorder by reducing opioid craving and withdrawal and blunting or blocking the effects of opioids.⁶⁹

⁶⁵ Harold Scarborough et al., *Clinic*, BRITANNICA (last updated Apr. 2, 2020), <https://www.britannica.com/science/clinic>.

⁶⁶ *Definitions*, NATIONAL PRACTITIONER DATA BANK (last visited Jul. 28, 2022), <https://www.npdb.hrsa.gov/guidebook/CDefinitions.jsp>.

⁶⁷ *Hospital*, LEXICO (last visited June 7, 2022), <https://www.lexico.com/en/definition/hospital>.

⁶⁸ Andrea Jakubowski & Aaron Fox, *Defining Low-Threshold Buprenorphine Treatment*, 14 J. OF ADDICTION MED. 95 (2020).

⁶⁹ *Methadone*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (last visited Oct. 4, 2022), <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/methadone>.

- (r) Naloxone.—“Naloxone” means an opioid antagonist medication approved by the FDA that is used to reverse an opioid overdose.⁷⁰
- (s) Opioid treatment program.—“Opioid treatment program” means a program that offers methadone and other community-based outpatient substance use disorder treatment licensed under [STATE LAW] for individuals diagnosed with an opioid use disorder.⁷¹
- (t) Overdose.—“Overdose” means a condition, including, but not limited to, extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death resulting from the consumption or use of a substance that requires medical attention, assistance, or treatment, and clinical suspicion for drug overdose, such as respiratory depression, unconsciousness, or altered mental status, without other conditions to explain the clinical condition.⁷²
- (u) Patient consent.—“Patient consent” means the legally valid written, informed consent given by a patient or legal guardian that authorizes intervention or treatment services from a licensed facility or provider and that documents agreement to participate in those services and knowledge of the consequences of withdrawal from such services. For the purposes of this law, informed consent means that the patient or legal guardian has voluntarily given consent after being adequately informed of any relevant facts regarding treatment as required by federal and state law and regulation.
- (v) Patient-facing staff.—“Patient-facing staff” means any person employed as a staff member at a hospital or freestanding emergency department that interacts directly with patients, including front desk workers conducting intake.
- (w) Peer support.—“Peer support” means non-clinical care and assistance that encompasses a range of activities and interactions between people who share similar experiences of navigating substance use disorder in an effort to aid persons in long-term recovery. Peer support helps individuals get connected and stay connected to both services and community. These activities include, but are not limited to: (1) supporting persons in

⁷⁰ *Naloxone*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (last visited Jul. 28, 2022), <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/naloxone>.

⁷¹ NEBRASKA DEP’T OF HEALTH & HUMAN SERVS., OPIOID TREATMENT PROGRAM.

⁷² FLA. STAT. § 401.253 (2021).

seeking recovery; (2) sharing resources and building skills; and (3) building community and relationships.

- (x) Peer support professional.—“Peer support professional” means an individual with the lived experience of recovery from a substance use disorder who is authorized or certified by [STATE] or approved national certification body to provide non-clinical, strengths-based support to others experiencing similar challenges.
- (y) Recovery.—“Recovery” means a process of change through which individuals with substance use disorders improve their health and wellness, live a self-directed life, and strive to reach their full potential.⁷³
- (z) Recovery support services.—“Recovery support services” means non-clinical professional support, including peer support as well as a range of other social supports and services, often provided by individuals with lived experience with substance use disorder that assist individuals in initiating and sustaining recovery from substance use disorder, mental health disorder, or co-occurring disorders.⁷⁴ Recovery support services can include, but are not limited to, recovery community organizations, peer support services, recovery housing, recovery high schools, and collegiate recovery programs.
- (aa) Recovery support system.—“Recovery support system” means voluntary, non-professional, non-clinical support from the patient’s informal social network, including family and friends, that assist individuals in initiating and sustaining recovery from substance use disorders, mental health disorders, or co-occurring disorders.
- (bb) Stabilization.—“Stabilization” means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.⁷⁵ For the purposes of this Act, material deterioration of a patient’s substance use disorder includes overdose, near-future symptoms of withdrawal, and other related health issues that arise when a patient with a substance use disorder

⁷³ SAMHSA’S WORKING DEFINITION OF RECOVERY, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (2012).

⁷⁴ *What are Recovery Support Services?*, NEW JERSEY COAL. FOR ADDICTION RECOVERY SUPPORT (last visited Jul. 28, 2022), <https://nj-cars.org/about/what-are-recovery-support-services/>.

⁷⁵ 42 U.S.C. § 1395dd(e)(3)(A-B).

does not receive evidence-based treatment, including with medications for addiction treatment.

(cc) Substance use disorder.—“Substance use disorder” or “SUD” means a pattern of substance use leading to clinical or functional impairment, in accordance with the definition in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) of the American Psychiatric Association or in any subsequent editions.⁷⁶

(dd) Substance use disorder treatment.—“Substance use disorder treatment” means an evidence-based approach to intervene upon, care for, manage, slow progression of, or support recovery from a medical or health related event, including from a substance use disorder or co-occurring mental health disorder. Substance use disorder treatment can include behavioral therapy (such as cognitive-behavioral therapy or contingency management), medications, or their combination.⁷⁷

(ee) Substance use disorder treatment provider.—“Substance use disorder treatment provider” means an individual or entity who is licensed or authorized within [STATE] to treat substance use disorders, an opioid treatment program, an addiction specialist physician, a prescriber otherwise licensed or approved to prescribe buprenorphine, or a clinic providing low-threshold treatment.

(ff) Substance use-related emergency.—“Substance use-related emergency” means a health emergency that arises from, or is related to, concurrent substance use. This may include, but is not limited to, an injury sustained from impairment caused by the influence of alcohol or other substances, an overdose, alcohol poisoning, and withdrawal symptoms. It also includes a request for treatment and services initiated by the patient or patient’s guardian.

(gg) Telemedicine.—“Telemedicine” means the delivery of health care services, including diagnosis, consultation, treatment, and prescribing, through the use of interactive remote conferencing technology, such as audio, video, or other electronic media.

⁷⁶ AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION, 2013.

⁷⁷ *What is Drug Addiction Treatment?*, NAT’L INST. ON DRUG ABUSE (last visited Jul. 28, 2022), <https://nida.nih.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/what-drug-addiction-treatment>.

Commentary

The definitions provided in this Act come from a variety of sources. The drafters selected and developed these definitions based on what would best suit the intent behind this model Act. For example, the definition of “recovery” used is the one that the federal Substance Abuse and Mental Health Services Administration (SAMHSA) developed, and it was chosen because the drafters felt it best expressed the term as it is intended to be used throughout the Act. The drafters also used some of the definitions from previous model laws developed by the Legislative Analysis and Public Policy Association, while modifying other definitions to best suit the needs of this Act.

The medication buprenorphine may be combined with naloxone in some forms. Further, buprenorphine and methadone may be indicated for pediatric, pregnant, and other patient populations. Expert reviewers noted the importance of peer support professionals to be trained in the principles of harm reduction and the benefits of medications for addiction treatment.

SECTION IV. SUBSTANCE USE DISORDER TREATMENT IN HOSPITALS AND FREESTANDING EMERGENCY DEPARTMENTS.

- (a) In general.—Every hospital or freestanding emergency department shall offer a suite of services to patients presenting with a substance use-related emergency that includes:
- (1) Stabilization, as defined in this Act;
 - (2) Initiation of treatment with buprenorphine or methadone for patients with opioid use disorder, and initiation of treatment with medications for addiction treatment for patients with other types of substance use disorders;
 - (3) Information about options for substance use disorder treatment, mental health treatment and support, peer support services, harm reduction services, overdose prevention hotline(s) such as the “Never Use Alone” hotlines; and recovery support services;
 - (4) Comprehensive discharge planning that includes:
 - (A) A timely virtual or in-person appointment with a substance use disorder treatment provider;
 - (B) For patients with opioid use disorder, a sufficient supply of buprenorphine or methadone, dispensed in accordance with 21 CFR § 1306.07(b), to last until the patient’s appointment with a substance use disorder treatment provider or until a medication plan can be implemented;

- (C) Affirmative connection to a peer support professional through an in-person meeting, by phone, electronically, or virtually, before the patient is discharged;
 - (D) Facilitation of transportation to the scheduled appointment with the substance use disorder treatment provider, either by the peer support professional or other means;
 - (E) Naloxone in hand and instructions on use;
 - (F) Referral to a harm reduction services provider;
 - (G) Referral to a mental health provider, if clinically indicated; and
 - (H) Communication with the patient’s emergency contact, current substance use disorder treatment provider, recovery support system, and/or primary care provider(s), as applicable and permitted under state and federal laws, to coordinate post-discharge follow-up care.
- (5) Any other standards developed by the [STATE HEALTH AUTHORITY] pursuant to Section VI of this Act.
- (b) SUD checklist.—Every hospital or freestanding emergency department shall develop standardized protocols and a “checklist” for the stabilization, initiation of treatment, and discharge planning of patients presenting with a substance use-related emergency.
- (1) Protocols shall comport with guidelines or guidance issued by national medical organizations with physician membership that have expertise in emergency medicine and addiction medicine, such as the American College of Emergency Physicians and American Society of Addiction Medicine, and best practice standards developed by the [STATE HEALTH AUTHORITY] pursuant to Section VI of this Act.
 - (2) Protocols shall include considerations and practices for special populations, including, but not limited to, pregnant and parenting people; adolescents and children at risk of adverse childhood experiences; unhoused populations; members of the LGBTQ+ community; non-English speaking persons; people with disabilities including Deaf individuals; racial and ethnic minorities; current and former members of the military; patients who are incarcerated, in custody, or otherwise involved in the criminal-legal system; and any other marginalized groups.

- (c) Capacity to administer medications.—Every hospital and freestanding emergency department shall ensure capacity to administer and prescribe medications for addiction treatment and naloxone. Every hospital and freestanding emergency department shall:
- (1) Ensure there are a sufficient number of prescribers who possess a valid registration from the United States Drug Enforcement Administration (DEA) and [STATE] medical license and are trained in buprenorphine initiation available to meet patient need;
 - (2) Ensure that a sufficient supply of medications for addiction treatment and naloxone are stocked in the hospital pharmacy;
 - (3) Establish protocols for dispensing medications for addiction treatment and naloxone in the emergency department and for admitted patients; and
 - (4) Have a variety of formulations of buprenorphine on the facility’s formulary, including long-acting injectable buprenorphine.
- (d) Agreements with substance use disorder treatment providers.—Every hospital and freestanding emergency department shall enter into formal agreement(s) with a range of substance use disorder treatment providers that encompass all levels of care, for connecting patients to appointments upon discharge, including local providers and providers delivering services through telemedicine. Such agreement(s) must ensure:
- (1) That there are a sufficient number of providers to allow for timely appointments; and
 - (2) That there is a sufficient range of providers to meet clinical needs, such as types of medication, residential treatment, outpatient treatment, and those of special populations.
- (e) Procedures to implement the SUD checklist.—Every hospital and freestanding emergency department shall develop and implement procedures for:
- (1) Obtaining patient consent or documenting patient refusal for providing the services described in Section IV(a) of this Act;
 - (2) The use of telemedicine;
 - (3) Documentation of the completion of the SUD checklist in each patient’s record;
 - (4) Incorporating the checklist into the facility’s electronic health record system;
 - (5) Collecting patient data, as outlined in Section IX;

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- (6) Billing for the services outlined in Sections XII and XIII; and
 - (7) A process for engagement with the hospital SUD ombudsman program, established pursuant to Section VIII of this Act.
- (f) Initial and ongoing training.—Every hospital or freestanding emergency department shall establish and implement initial and ongoing training, at least annually, for all patient-facing staff and clinicians focused on evidence-based practices, respect for patients, destigmatization of substance use disorder, trauma prevention, patient rights, harm reduction, and improved care for patients with substance use disorder or who use substances and their families.
- (1) Training shall include special considerations and practices for high-risk populations, including, but not limited to, pregnant and parenting people; adolescents and children at risk of adverse childhood experiences; unhoused populations; members of the LGBTQ+ community; non-English speaking persons; people with disabilities including Deaf individuals; racial and ethnic minorities; current and former members of the military; patients who are incarcerated, in custody, or otherwise involved in the criminal-legal system; and other historically marginalized populations.
 - (2) The training shall also include presentation(s) from individual(s) with lived experience and family member(s).
- (g) Continuous quality improvement.—Every hospital and freestanding emergency department shall develop continuous quality improvement (CQI) processes that shall:
- (1) Include periodic and annual review and updates to the SUD checklist and protocols.
 - (2) Incorporate:
 - (A) Input and feedback from patient-facing staff, professionals, and organizations providing peer support professionals, substance use disorder treatment providers, patients, and patients’ family members;
 - (B) Program evaluations, performed by representatives of [STATE HEALTH AUTHORITY]; and
 - (C) Findings and recommendations from previous internal CQI evaluations.

- (3) Prioritize:
- (A) Adherence to SUD checklist and protocols;
 - (B) Compliance with standards of medical care, as developed by national medical organizations with physician membership that have expertise in emergency medicine and addiction medicine, such as the American College of Emergency Physicians and the American Society of Addiction Medicine;
 - (C) Timely and thorough completion of protocols, such that patients are not retained in the emergency department for extended periods of time where not clinically indicated;
 - (D) Fostering a culture of mutual respect and culturally appropriate care and treatment;
 - (E) Reducing negative health outcomes for patients upon discharge, including, but not limited to, return to use, return to emergency care for substance-related emergencies, discontinuing treatment, and substance-related morbidity and mortality;
 - (F) Evaluation to ensure that all patients are afforded the same access to emergency treatment regardless of demographic characteristics, history of substance use, or ability to pay; and
 - (G) Any other requirements developed by [STATE HEALTH AUTHORITY].
- (h) Reporting.—Every hospital and freestanding emergency department shall provide an annual report to [STATE HEALTH AUTHORITY] with the following de-identified data points:
- (1) Number and demographic information of patients presenting with a substance use-related emergency;
 - (A) Demographic information shall include, but not be limited to:
 - (i) Age
 - (ii) Gender;
 - (iii) Race;
 - (iv) Ethnicity;
 - (v) Military background;
 - (vi) Status as a pregnant and/or parenting person;

- (vii) Housing status;
 - (viii) Status as a member of the LGBTQ+ community;
 - (ix) Criminal justice involvement; and
 - (x) Co-occurring disabilities.
- (2) Number and demographic information of patients stabilized and provided with comprehensive discharge planning per the institution's SUD checklist;
 - (3) Number and demographic information of patients offered medications for addiction treatment and demographic information;
 - (4) Number and demographic information of patients offered peer support services and demographic information;
 - (5) Number and demographic information of patients who refused any of the services offered in Section IV(a) of this Act and demographic information;
 - (6) Number of individuals with an SUD diagnosis who returned to the facility within 30 days;
 - (7) Number of individuals who were those offered medication for addiction treatment who returned to the facility within 30 days; and
 - (8) Any other data required by [STATE HEALTH AUTHORITY].

Commentary

The purpose of Section IV of this Act is to ensure each hospital and freestanding emergency department establishes a checklist of evidence-based protocols for treating patients who present at these facilities with substance use-related emergencies. Under this Act, each hospital or freestanding emergency department would develop a set of protocols unique to the facility because the abilities and resources of each emergency medical facility are different. This requirement is based on existing law in various states, including in Alaska,⁷⁸ Connecticut,⁷⁹ and North Dakota.⁸⁰

The inaccessibility of adequate treatment for patients with substance use disorders in emergency medical settings, including treatment using medications for opioid use disorder where clinically indicated, may constitute a violation of the Americans with Disabilities Act and/or the Emergency Medical Treatment and Active Labor Act.⁸¹ Patients with substance use disorders

⁷⁸ ALASKA ADMIN. CODE tit. 7, § 12.870 (2022).

⁷⁹ CONN. GEN. STAT. ANN. § 19a-490h (West 2022).

⁸⁰ N.D. ADMIN. CODE 33-07-01.1-25 (2022).

⁸¹ See Americans with Disabilities Act, 42 U.S.C. § 12102; Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd; *The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against*

often receive disparate treatment in emergency medical settings; for example, research has shown that important components of emergency care, such as screening for substance use and related mental health needs, may occur less frequently than screening for other health-related social needs.⁸² With this Section, hospitals and freestanding emergency departments will be required to develop and offer a full suite of services that would ensure adequate care for patients with substance use disorders. While it is critical that patients be offered the care they need while in emergency medical settings, the drafters of this Act use the word “offer” throughout this Section to indicate the importance of patient consent.

The development of this Act has been guided by existing, exemplary programs and initiatives. Following the adoption of Rhode Island’s 2016 Perry-Goldner Act, which requires comprehensive discharge planning for emergency room patients with substance use disorders, researchers evaluating the program’s influence determined the law has improved naloxone distribution, behavioral counseling, and referral to treatment at hospitals without previously established opioid overdose services.⁸³

In New York, the Medication for Addiction Treatment and Electronic Referrals (MATTERS) Network assists people with opioid use disorder by providing a range of services, including providing an online referral database to connect emergency room patients to outpatient providers post-discharge.⁸⁴ A clinical evaluation of the MATTERS network determined that the program serves as “compelling evidence” of the scalability of an initiative that provides emergency department-initiated buprenorphine and connects individuals with outpatient follow-up care.⁸⁵

In California, the CA Bridge program utilizes a model featuring low threshold buprenorphine treatment access, active patient navigation from emergency medical care to outpatient treatment, and harm reduction interventions to connect patients to care following emergency room discharge.⁸⁶ The program partners with 52 hospitals dispersed across California “with substantial cultural, economic, and health system diversity.”⁸⁷ Through this partnership, these hospitals have “rapidly and successfully implemented [emergency department] buprenorphine programs.”⁸⁸ Because of these efforts, thousands of patients have been connected

People in Treatment or Recovery, U.S. DEP’T OF JUSTICE (2022), https://www.ada.gov/opioid_guidance.pdf; Sika Yeboah-Sampong et al., *EMERGENCY: Hospitals Can Violate Federal Law by Denying Necessary Care for Substance Use Disorders in Emergency Departments*, LEGAL ACTION CTR. (2021), <https://www.lac.org/resource/emergency-hospitals-can-violate-federal-law-by-denying-necessary-care-for-substance-use-disorders-in-emergency-departments>.

⁸² Margaret E. Samuels-Kalow et al., *Screening for Health-related Social Needs of Emergency Department Patients*, 77(1) ANNALS OF EMERGENCY MED. 62-68 (Jan. 2021).

⁸³ Elizabeth A. Samuels et al., *Rhode Island’s Opioid Overdose Hospital Standards and Emergency Department Naloxone Distribution, Behavioral Counseling, and Referral to Treatment*, 78(1) ANNALS OF EMERGENCY MED. 68-79 (July 2021).

⁸⁴ *MATTERS Network Services*, MATTERS (last visited Sept. 9, 2022), <https://mattersnetwork.org/>.

⁸⁵ Brian M. Clemency et al., *Implementing a Novel Statewide Network to Support Emergency Department-initiated Buprenorphine Treatment*, W. J. OF EMERGENCY MED., July 2022, at 451.

⁸⁶ Snyder et al., *supra* note 42.

⁸⁷ *Id.*

⁸⁸ *Id.*

to substance use disorder treatment, including those living in rural communities.⁸⁹ A study evaluating the CA Bridge program concluded “large-scale implementation of low-threshold [emergency department] buprenorphine, navigation to outpatient addiction treatment, and a harm reduction approach” appeared both effective and feasible.⁹⁰ Since 2018, this program has expanded to 155 hospitals.⁹¹

The American College of Emergency Physicians (ACEP) develops and compiles guidelines for emergency medical practitioners to utilize for strategies to address substance use disorder in emergency departments.⁹² These tools, as well as the efforts by ACEP to implement best practices across the country, have made a significant impact on emergency medical care.

A partnership and collaboration between state government and hospitals and freestanding emergency departments is essential to maximize the effectiveness of this Act. The role of the state in this area of the law is not limited to the provisions of this Act. A state may choose to provide further support; for example, by issuing an “All-facilities Letter” to all state-licensed health care facilities, including hospitals,⁹³ explaining that buprenorphine and methadone can be legally dispensed under facilities’ licenses in accordance with state laws. States can further facilitate access to the latest federal and regulatory guidance on medications for addiction treatment. Beyond advising on federal law, states may examine the full range of states’ legal and regulatory frameworks, including reimbursement structure, related to access to medications for addiction treatment in pharmacies and update regulations, issue guidance, and maximize reimbursement to ensure and incentivize access to medications for addiction treatment and naloxone in hospital and community pharmacies. States may also choose to further examine their scope of practice laws to align with federal law, which permits a wide range of practitioners to prescribe buprenorphine. Specifically, under federal law, nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives can all be authorized to prescribe buprenorphine.⁹⁴ In addition, states may choose to expand access to methadone by investing in additional opioid treatment programs, examining, updating and removing unnecessary barriers to admission, reimbursement, and provision of methadone, buprenorphine, and other community-based services. For example, states can clarify that the “physical examination” portion of methadone initiation, which is required to be done in person, can be done in an emergency department setting. This can be followed by a referral to an opioid treatment program whereby the services can be provided thereafter via telemedicine and without the need for a physical examination on site at the opioid treatment program. Finally, states can amend statutory and regulatory language to facilitate greater access to care by maximizing telemedicine.

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Impact*, CA BRIDGE (last visited Sept. 9, 2022), <https://cabridge.org/impact/>.

⁹² *Mental Health and Substance Use Disorders*, AM. COLL. OF EMERGENCY PHYSICIANS (last visited Sept. 9, 2022), <https://www.acep.org/by-medical-focus/mental-health-and-substanc-use-disorders/>.

⁹³ *See, e.g., All Facilities Letters – Library*, CAL. DEP’T OF PUB. HEALTH (last visited Sept. 28, 2022), <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL.aspx>.

⁹⁴ 21 U.S.C. 823(g)(2)(H)(i)(II).

The purpose of limiting the scope of these services to patients with substance use-related emergencies, as defined in Section III(ee) as a health emergency that arises from, or is related to, concurrent substance use, is to make these requirements manageable for emergency medical professionals. Subject matter experts emphasized the importance of prioritizing efficiency, and so the language of this Act includes those patients who present with emergencies that raise an immediate inference of substance use disorder, such as an overdose, as well as those that may be less obvious, such as an injury sustained while intoxicated. The drafters feel that this strikes the appropriate balance between preventing unnecessary screenings for patients with emergencies unrelated to substance use while still ensuring that patients who may be less frequently screened for a substance use disorder, such as those injured while under the influence of alcohol, receive this care.

Section IV(a)(3) of this Act requires that hospitals and freestanding emergency departments provide information to patients about substance use disorder treatment, harm reduction services, and other critical opportunities for better health outcomes. To meet this requirement, hospitals and freestanding emergency departments may deliver a package of already-published resources, such as those developed by federal and state agencies. Hospitals and freestanding emergency departments need not develop their own materials if there exist sufficient resources already.

The discharge planning components of Section IV(a)(4) build upon requirements in existing legislation, particularly Rhode Island's Perry-Goldner Act of 2016.⁹⁵ This provision ensures that patients leaving the emergency room will have access to community-based health care and support after discharge. Section IV(a)(4)(B) ensures critical continuity of care. The drafters of this Act acknowledge that delivery of certain medications described in this Section, such as methadone, may be limited by certain federal laws, and states may guide hospitals and freestanding emergency departments on these limitations. Affirmative connection to a professional prior to discharge—through either virtual or in-person introduction—will ensure that patients can access follow-up care after leaving the emergency room. Patients will also have critical medications, such as naloxone, on hand when they leave, thus reducing the likelihood of further overdose deaths. Because of the prevalence of fentanyl in the drug supply, the frequency of polysubstance use, and the need for preparedness at all times during this epidemic, this Act requires that all patients presenting with substance use-related emergencies be provided naloxone upon discharge, even those not presenting with opioid use-related emergencies.

In developing this Act, the drafters solicited input from numerous subject matter experts on barriers and facilitators to providing high quality emergency medical care to patients presenting with substance use-related emergencies. Experts explained that having some form of peer recovery support available to patients was a critical component of a successful model for emergency department-initiated substance use disorder care. These assertions are supported by clinical research, which shows that incorporating peer support services in emergency

⁹⁵ 2016 Perry-Goldner Act, R.I. Session Laws.

departments improves health outcomes for patients and is feasible.⁹⁶ In addition, the inclusion of peers in developing these initiatives has been shown to facilitate programs' success.⁹⁷ While peer support professionals serve an integral role, the drafters of this Act note that use of peer support services should not serve as a substitute for buprenorphine initiation. Subject matter experts have indicated that peers struggle to link people to treatment if they are not started on medication before discharge from emergency rooms.⁹⁸ Similarly, experts highlighted the importance of peer support professionals in emergency medical settings. As such, the drafters of this Act included Section IV(a)(4)(C) to ensure integration of peer support professionals into hospital and freestanding emergency departments' suite of services.

Perhaps the most significant component of this Act is the creation of the SUD "checklist" in Section IV(b). The purpose of requiring that each hospital develop a checklist of protocols for patients presenting with substance use-related emergencies is to ensure that the entire scope of necessary care—from stabilization to discharge planning—is integrated into every hospital and freestanding emergency department's system of care delivery. This Act seeks to utilize the existing guidance on treating substance use-related emergencies and create a legal basis upon which patients are guaranteed complete care. Expert reviewers noted the importance of incorporating best practices and the "checklist" into the electronic health record to ensure it becomes an established part of emergency department practice.

Section IV(c) of this Act requires that hospitals and freestanding emergency departments have the capacity to "administer" medications. The drafters of this Act note that it would be ideal for hospitals to be able to dispense these medications. This Act uses the term "administer," because some current state laws prevent hospitals and freestanding emergency departments from dispensing these medications and/or hinder these facilities from receiving reimbursement for this service. States adopting this Act may add a requirement here for dispensing, but may then need to update their pharmacy laws, regulations, and reimbursement schema to ensure cohesion.

The drafters note that the term "levels of care" in Section IV(d) of this Act will be state-specific when applied. The drafters note that some states utilize the levels of care developed by the American Society of Addiction Medicine, while other states have their own set of tools and definitions.

Continuous and culturally competent training is critical to ensuring an emergency medical workforce that can empathize with, and respond properly to, the needs of patients presenting with substance use-related emergencies. The drafters spoke at length with people with lived experience about their involvement with emergency medical settings; these conversations evince the need for Section IV(f) of this Act. The drafters wish to note, in particular, the importance of destigmatizing language in emergency medical settings, which can make a

⁹⁶ See Christine Ramdin et al., *The Impact of a Peer-navigator Program on Naloxone Distribution and Buprenorphine Utilization in the Emergency Department*, 57(4) SUBSTANCE USE & MISUSE 581-587 (2022); and Alex K. Gertner et al., *Universal Screening for Substance Use by Peer Support Specialists in the Emergency Department is a Pathway to Buprenorphine Treatment*, 14 ADDICTIVE BEHAV. REPS. 100378 (Dec. 2021).

⁹⁷ Rosenberg et al., *supra* note 55.

⁹⁸ Allyson L. Dir et al., *Barriers Impacting the POINT Pragmatic Trial: The Unavoidable Overlap Between Research and Intervention Procedures in "Real-World" Research*, 22 TRIALS 114 (2021).

significant difference in the experiences of people presenting with substance use-related emergencies. Stigma against people with substance use disorders commonly manifests in the form of punitive measures, including in emergency medical settings. Research has found that some clinicians hold negative attitudes against people who use drugs and may decide against providing evidence-based treatments because of these biases.⁹⁹ For example, patients who use or possess illicit substances are commonly administratively discharged from hospitals, despite needing continued treatment.¹⁰⁰ In developing this Act, the drafters received feedback from numerous subject matter experts, including those with lived experience, about the stigma that people face when entering emergency medical settings because of a substance use-related emergency. This Act responds to stigma in emergency medical settings with Section IV(f), which requires anti-stigma training for all patient-facing staff and clinicians.

This Act requires consistent data collection in order to be able to track quality of care. Feedback from subject matter experts indicates that tracking data and consistently reviewing the efficacy of hospital protocols is necessary to improve health outcomes for emergency department patients. Additionally, it is critical that states develop guidelines on data collection, so that the information that the state health authority receives is uniformly presented, thus enabling the health authority to consistently evaluate all data provided by hospitals and freestanding emergency departments statewide. Therefore, this Act includes Sections IV(g) and (h), which require continuous observation and collection of data to ensure that quality of care is monitored and improved.

Subject matter experts expressed concerns about capacity, specifically with regard to connecting individuals to community-based care. Regarding rural settings in particular, many experts worried that transition from emergency care to another form of treatment may be stymied by a lack of resources. For this reason, the Act includes Section IV(e)(2), which requires procedures for the use of telemedicine. The Act also includes Section IV(d), which requires hospitals and freestanding emergency departments to maintain formal agreements with local substance use disorder treatment providers that encompass all levels of care for the purpose of connecting patients to same-day and next-day appointments upon discharge. These agreements must ensure that there is a sufficient number of available providers in the community in which the hospital or freestanding emergency department is located. The drafters developed this requirement in lieu of requiring that the state develop a database of the daily availability of community-based providers due to concerns by subject matter experts that the creation and maintenance of such a database would be too burdensome. While the drafters chose to require collaboration at the community level, they also recognize that such a database can be created and successfully maintained. An example of a successful database, the MATTERS Network refers patients with opioid use disorder to community-based clinics after discharge from referral sites such as emergency departments.¹⁰¹

⁹⁹ Honora Englander et al., “We’ve Learned It’s a Medical Illness, Not a Moral Choice”: *Qualitative Study of the Effects of a Multicomponent Addiction Intervention on Hospital Providers’ Attitudes and Experiences*, 13(11) J. OF HOSPITAL MED. 752-758 (2018).

¹⁰⁰ Honora Englander & Corey S. Davis, *Hospital Standards of Care for People with Substance Use Disorder*, 387 NEW ENGLAND J. OF MED. 672-675 (2022).

¹⁰¹ MATTERS, *supra* note 84.

This Act also uses the term “sufficient” throughout this Section in reference to available community providers and medication because the drafters understand that capacity and need varies across states, and the term “sufficient” may carry different meanings in different communities. Likewise, the terms “timely and thorough” and “extended,” in Section IV(g)(3)(C) which references wait times is intentionally ambiguous because emergency room wait times are variable, and the drafters did not intend to proscribe a time limit on medical care that may render the Section impractical. As such, the drafters found it prudent to leave the language intentionally ambiguous so that states, hospitals, and communities could determine sufficiency.

The drafters of this Act heard concerns from numerous subject matter experts about the inclusion of other state actors, such as the child welfare system, in the “checklist” of protocols. The drafters ultimately chose not to address these concerns in this Act, due in part to many complexities surrounding the involvement of child welfare agencies in cases concerning parents with substance use disorders. As such, the drafters recommend a separate initiative that includes further addressing the unique needs and rights of pregnant and parenting people that present to emergency departments with substance use-related emergencies.

SECTION V. NETWORK OF PROVIDERS.

- (a) In general.— [STATE HEALTH AUTHORITY] and [SINGLE STATE AGENCY] shall develop guidance and requirements to facilitate and ensure engagement of substance use disorder treatment providers with hospitals and emergency departments for the purpose of accepting timely referrals of patients presenting with a substance use-related emergency.
- (b) Low-threshold treatment.— [STATE HEALTH AUTHORITY] and [SINGLE STATE AGENCY] shall develop and support network of providers to provide low threshold treatment, including buprenorphine initiation and short or long-term prescribing.
- (1) Low threshold treatment settings.—Low threshold treatment may be provided in a clinic licensed under [STATE LAW/REGULATION] or may be provided by primary care provider offices, Federally Qualified Health Centers, Certified Community Behavioral Health Centers, academic medical centers, syringe services programs, substance use disorder treatment providers, community pharmacies, recovery community organizations, or any other setting approved by [STATE HEALTH AUTHORITY].
- (2) Mobile treatment.—Low threshold treatment may be mobile.
- (3) Reimbursement.—[STATE HEALTH AUTHORITY] shall develop appropriate reimbursement codes to support and incentivize low threshold treatment.

- (c) Regulatory review.— [STATE HEALTH AUTHORITY] and [SINGLE STATE AGENCY] shall review and amend their regulations related to providers to identify and address barriers to the provision of low-threshold treatment, timely admission, and acceptance of referrals for all patients, regardless of referral source. Such regulatory review shall include amendments to add incentives for the provision of low threshold treatment and timely admission for services.

Commentary

The purpose of Section V of this Act is to ensure an adequate network of providers for patients to access following discharge from the emergency room, including low barrier treatment opportunities and harm reduction services. The aim of this Section is to make all forms of care as accessible as possible, particularly for patients living in rural or underserved communities. Access to treatment and harm reduction services after discharge is an essential element of maximizing emergency medical settings as intervention points for people with substance use disorders. Even if a facility follows each of the requirements detailed in Section IV of this Act, inability to connect people to community-based care will serve as a barrier to achieving the desired impact of this Act. As such, this Section facilitates collaboration among health care providers and removes barriers to low threshold treatment.

Substance use disorder treatment is extremely limited in the United States; research indicates that only about a quarter of all people in need of treatment for opioid use disorder are receiving it.¹⁰² Treatment access is even less accessible for members of historically marginalized groups, such as people of color living in highly segregated communities.¹⁰³ Subject matter experts providing guidance on this Act have described the many barriers patients face with accessing treatment after emergency room discharge: patients seeking to fill prescriptions struggle with pharmacies that do not carry certain medications. Legal limitations on prescribing and dispensing medications for addiction treatment, particularly methadone and buprenorphine, restrict access. Some opioid treatment programs that dispense methadone only offer intake on certain days of the week, which may not align with patient need. Further, subject matter experts emphasized the importance of state collaboration in ensuring a robust network of providers. Without state involvement, providers will encounter barriers to achieving the needed coordination with community-based providers. As such, Section V(a) of this Act empowers state agencies to ensure collaboration and engagement between emergency medical providers and other providers that are in patients' communities and available via telemedicine.

¹⁰² Pia M. Mauro et al, *Use of Medication for Opioid Use Disorder among US Adolescents and Adults with Need for Opioid Treatment*, 2019, 5 JAMA NETWORK OPEN e223821 (2022).

¹⁰³ William C. Goedel et al, *Association of Racial/Ethnic Segregation with Treatment Capacity for Opioid Use Disorder in Counties in the United States*, 3 JAMA NETWORK OPEN e203711 (2020).

The availability of low threshold services is also a critical component of ensuring widely available community-based health care. Low barrier treatment is an alternative approach to providing health care “that attempts to remove as many barriers to treatment as possible.”¹⁰⁴ This approach is guided by the principles of same-day treatment entry, following a harm reduction framework, flexibility, and widespread availability where people with opioid use disorder tend to go.¹⁰⁵ During the development of this Act, subject matter experts emphasized the importance of addressing capacity issues by utilizing low threshold treatment options.

One example of a successful provider of low threshold treatment is the REACH program¹⁰⁶ which owns and operates low threshold, harm reduction medical practices in Ithaca, New York.¹⁰⁷ REACH facilities offer same-day access to buprenorphine, primary care, behavioral health care, harm reduction services such as naloxone trainings, and a myriad of other services in an environment that prioritizes respectful, equitable access to compassionate healthcare.¹⁰⁸ Clinical research has found this program to be “innovative” and effective in reducing stigma for people who use drugs.¹⁰⁹ As such, this Act requires that state agencies support low threshold treatment by developing a network of providers. In addition, this Act requires the development of a reimbursement structure in Section V(b)(3) and also includes providers of low threshold treatment as eligible candidates for grant funding in Section XI(d). The Act further requires that state agencies conduct a review of regulations that may serve as unnecessary barriers to the provision of low threshold treatment.

This Section also applies the evidence supporting incorporation of low threshold treatment and harm reduction services into community-based treatment for patients discharged after substance use-related emergencies.¹¹⁰ As such, this Section requires that state health authorities incorporate low threshold treatment, and that such treatment be reimbursable, thus increasing accessibility. In Section V(d), the term “appropriate reimbursement codes” is intentionally ambiguous due to the variability of reimbursement schemes in state Medicaid programs.

States and hospitals should also evaluate patients’ abilities to begin methadone treatment, and legal barriers to accessing methadone should be reevaluated. The drafters of this legislation acknowledge that this issue is outside the scope of this Act, but it is a critical issue, nonetheless.

¹⁰⁴ Jakubowski & Fox, *supra* note 68.

¹⁰⁵ *Id.*

¹⁰⁶ Home, REACH (last visited Sept. 9, 2022), <https://www.reachprojectinc.org/>.

¹⁰⁷ *Id.*

¹⁰⁸ *Our Services*, REACH (last visited Sept. 9, 2022), <https://www.reachprojectinc.org/our-services>.

¹⁰⁹ Shashi N. Kapadia et al., *A Harm Reduction Approach to Treating Opioid Use Disorder in an Independent Primary Care Practice: A Qualitative Study*, 36 J. OF GENERAL INTERNAL MED. 1898 (2021).

¹¹⁰ Macias-Konstantopoulos et al., *supra* note 45.

SECTION VI. EMERGENCY DEPARTMENT PRACTICE STANDARDS.

- (a) In general.—[STATE HEALTH AUTHORITY] shall publish practice standards for hospitals and freestanding emergency departments.
- (b) Practice standards.—Practice standards shall include:
- (1) Best and promising practices for stabilization, treatment, education, transfer, discharge, and referral for patients experiencing a substance use-related emergency;
 - (2) Trauma-informed training for patient-facing hospital staff; and
 - (3) Guidance for hospitals and freestanding emergency departments with limited resources, such as those in rural and frontier areas.
- (c) Collaboration with state medical organizations.—Practice standards shall be developed in collaboration with state medical organizations with physician membership that have expertise in emergency medicine and addiction medicine, such as state affiliates of the American College of Emergency Physicians and American Society of Addiction Medicine.

Commentary

The purpose of Section VI of this Act is to create practice standards and resources for hospital and freestanding emergency departments to use as guidelines for the protocols developed pursuant to Section IV. These standards reflect similar requirements in Rhode Island General Laws Section 23-17.26-3(a)(4), which ensure that the director of the Rhode Island Department of Health develop and disseminate to all hospitals and freestanding care facilities standards for substance use evaluation; pre-admission, admission, and discharge; and a voluntary transition process for patients with substance use disorders, those recovering from opioid overdose, or those with “chronic addiction.”¹¹¹ As such, this Act likewise requires that the relevant state health authority publish practice standards for hospitals and freestanding emergency departments.

¹¹¹ R.I. GEN. LAWS ANN. § 23-17.26-3 (West 2022).

SECTION VII. COMPLIANCE.

- (a) In general.—[STATE HEALTH AUTHORITY] shall work with the relevant regulatory and/or inspection agencies to regularly inspect hospitals and freestanding emergency departments to ensure compliance with the Act and applicable regulations and standards developed pursuant to Sections VI and XIV.
- (b) Corrections of violations.—If the [STATE HEALTH AUTHORITY] finds, upon inspection or through information in its possession, that a facility is not in compliance, the [STATE HEALTH AUTHORITY] shall order the facility to correct such violation by issuing a corrective action order, which shall provide the facility notice, in writing, of each violation.
- (c) Corrective action order.—In such corrective action orders, the [STATE HEALTH AUTHORITY] shall specify a reasonable time, not to exceed [NUMBER] days after receipt thereof, by which time the facility shall remedy or correct each violation cited therein; provided, that, in the case of any violation which, in the opinion of the department, is not capable of correction within [NUMBER] days, the department shall require only that the facility submit a written plan for correction of the violation in a reasonable manner.
- (d) Modification.—The [STATE HEALTH AUTHORITY] may modify any nonconforming plan upon notice, in writing, to the facility.
- (e) Reconsideration.—Within [NUMBER] days of receipt, the affected facility may file a written request with the department for administrative reconsideration of the order or any portion thereof.
- (f) Sanctions for noncompliance.—Facilities that fail to maintain compliance with this Act may be subject to enforcement action, including, but not limited to, plans of correction, civil monetary penalties, fines, denial of payment, or termination from [STATE’s] Medicaid reimbursement system.
- (g) Rules for exemption.—[STATE HEALTH AUTHORITY] shall publish proposed rules implementing a reasonable exemption procedure by [DATE].

- (h) Staff reports of noncompliance.—[STATE HEALTH AUTHORITY] shall create a procedure for hospital and freestanding emergency department staff to report non-compliance with this law and applicable regulations and standards.

Commentary

The purpose of this Section is to establish mechanisms for ensuring compliance with Section IV of the Act. This Section requires that relevant state health authorities perform the necessary oversight to determine whether hospitals and freestanding emergency departments have established protocols pursuant to Section IV that match the best practice standards developed pursuant to Section VI. Subject matter experts that guided the drafting of this Act repeatedly emphasized the importance of regular oversight. This Section was developed to allow for states to perform oversight in accordance with any existing protocols; for example, the use of the term “regularly” in Section VII(a) may be interpreted in a way that best reflects each state’s existing processes overseeing health care delivery. Likewise, Section VII(f) was drafted based on the presumption that states had existing schedules of fines and an existing protocol for corrective action orders that could be updated with the requirements of this Section. The drafters of this Act note that these compliance and enforcement measures are separate from, and do not supersede, other federal requirements, such as the Emergency Medical Treatment and Active Labor Act and the Americans with Disabilities Act, or state enforcement mechanisms.

SECTION VIII. OMBUDSMAN PROGRAM.

- (a) In general.—[STATE HEALTH AUTHORITY], in collaboration with [STATE ADDICTION TREATMENT AUTHORITY], shall establish a hospital substance use disorder (SUD) ombudsman program for the purpose of facilitating complaints about hospital and freestanding emergency department protocols as they relate to treatment for substance use-related emergencies. To the extent possible, the ombudsman program shall include staff or volunteers with lived experience and family members.
- (b) Ombudsman duties.—Such ombudsman program shall have the following duties, including, but not limited to:
- (1) Establishing a complaint delivery structure based in [STATE] that includes a toll-free telephone hotline, an interactive website, and availability of in-person, telephone, and email access to ombudsman program staff or volunteers;
 - (2) Identifying, investigating, referring, and resolving complaints made by [STATE AGENCIES] and by, or on behalf of, private individuals;

- (3) Educating individuals on their rights with respect to access to services provided by hospitals and freestanding emergency departments in the event of substance use-related emergencies; and
 - (4) Collecting, tracking, and quantifying complaints and inquiries encountered by individuals and [STATE AGENCIES].
- (c) Reporting.—The ombudsman program shall submit a report within twelve (12) months after the adoption of this statute and annually thereafter to the [STATE HEALTH AUTHORITY]:
- (1) Describing the activities carried out by the ombudsman program during the prior calendar year;
 - (2) Containing and analyzing data relating to complaints and investigations for the purpose of identifying and resolving common and significant problems, including an examination of any recurring complaints to determine if there are systemic issues in specific hospitals and freestanding emergency departments as well as demographic information of such patients;
 - (3) Describing barriers and facilitators to improving substance use disorder treatment in hospitals and freestanding emergency departments in [STATE] based on data collected pursuant to this Section;
 - (4) Containing recommendations for appropriate state legislation, rules and regulations, and other action based on data collected pursuant to this Section, if deemed necessary by representatives of the ombudsman program;
 - (5) Describing any organizational conflicts of interest in the ombudsman program that have been identified and the steps taken to remove or remedy such conflicts;
 - (6) Containing all complaints received by the ombudsman program during the prior calendar year; and
 - (7) Any other matters as the ombudsman program, in consultation with [STATE AGENCIES], determines to be appropriate.
 - (8) Such report shall be reviewed by the board of the organization and signed by the leadership of the hospital.

Commentary

The purpose of this Section is to create an additional opportunity for oversight and resolution for individuals who receive inadequate care in hospitals and freestanding emergency departments. The language of this Section was largely derived from an ombudsman program in New York related to accessing mental health and substance use disorder treatment coverage by insurance. It is contemplated that the hospital SUD ombudsman program can be either state-operated or state-funded (and operated by not-for-profit organizations or other entities), and that the authority, duties and responsibilities of this ombudsman program can be folded into existing ombudsman programs and services.

SECTION IX. COLLECTION AND PUBLICATION OF RELEVANT DATA.

- (a) In general.—Within one year of the adoption of this Act, and annually thereafter, [STATE HEALTH AUTHORITY] shall:
- (1) Collect, maintain, evaluate, and publicly publish de-identified data reported pursuant to Section IV(h) of this Act; and
 - (2) Collect, maintain, evaluate, and publicly publish data on the number of providers in [STATE] that prescribe buprenorphine to more than thirty (30) patients per month.

SECTION X. ANNUAL EVALUATION AND REPORT.

- (a) In general.—Within one year of the adoption of this Act, and annually thereafter, [STATE HEALTH AUTHORITY] shall publicly publish a report with data, findings, and recommendations related to the requirements of this Act.
- (b) Data.—[STATE HEALTH AUTHORITY] shall include data reported by hospitals and freestanding emergency departments and the hospital SUD ombudsman program.
- (c) Barriers to care.—[STATE HEALTH AUTHORITY] shall evaluate state laws, regulations, guidance and practices to identify barriers to patient access and prescriber dispensing of medications for addiction treatment in emergency department settings, hospital settings, pharmacies, community-based settings, and other relevant settings, and include findings and recommendations for addressing barriers in its annual report.
- (d) Input for report.—[STATE HEALTH AUTHORITY] shall seek input from patients, prescribers, and payors in conducting its evaluation and developing recommendations.
- (e) Implementation.—[STATE HEALTH AUTHORITY] shall implement recommendations of each report.

Commentary

The purpose of Sections IX and X of this Act is to establish data collection, publication, evaluation, and dissemination protocols.

Collection and analysis of data regarding hospital protocols developed pursuant to Section IV of the Act is crucial to determining ongoing barriers and facilitators to improving health outcomes for patients with substance use-related emergencies. Furthermore, publishing this data publicly will ensure transparency and accountability. The public will be able to identify how the provisions of this Act are facilitating better health outcomes over time.

Section IX(a)(2) reflects input from subject matter experts that prescribers with more than 30 buprenorphine patients per month, known as “high capacity prescribers,” are crucial to increasing access to buprenorphine. Because of this feedback, this Act includes a provision requiring the state health authorities to monitor the number of high capacity prescribers in their state, with the intention of increasing this number.

Section IX, therefore, requires state health authorities to collect de-identified patient data, as well as prescriber data, that will be made available by hospitals and freestanding emergency departments and to evaluate, maintain, and publicly publish this information.

Section X further requires that state health authorities annually analyze this data and report on the results of this analysis.

SECTION XI. GRANTS TO IMPLEMENT THE PROVISIONS OF THIS ACT.

- (a) In general.—Subject to available funding, [STATE HEALTH AUTHORITY] shall award grants to create or support efforts to increase access to emergency department-initiated addiction treatment. [STATE HEALTH AUTHORITY] shall begin to operate the grant program beginning ninety (90) days after the effective date of the Act.
- (b) Federal and nongovernmental grants.—[STATE HEALTH AUTHORITY] may contract with the federal government and/or any nongovernmental entity that it considers appropriate to administer the grant program.
- (c) Eligible grant activities.—Eligible grant activities include, but are not limited to:
 - (1) Purchasing and distributing naloxone;
 - (2) Hiring and training staff to implement the requirements of this Act;
 - (3) Supporting a robust network of addiction medicine consultong services conducted by board-certified physicians, physician-to-physician mentorship, and peer support mentorship and professional development;
 - (4) Developing shared learning modules to implement the requirements of this Act;

- (5) Purchasing and upgrading technology to implement the requirements of this Act;
 - (6) Planning, technical assistance, and convening of key stakeholders;
 - (7) Developing an IT infrastructure to support the requirements of this act, such as telemedicine, electronic health records, and related staff and training;
 - (8) Providing vouchers for transportation;
 - (9) Providing resources and technical assistance to exempted hospitals and freestanding emergency departments, so that they may meet the requirements of this law and applicable regulations and practice guidelines; and
 - (10) Any other uses approved by [STATE HEALTH AUTHORITY].
- (d) Eligible grant recipients.—Eligible grant recipients include hospitals and freestanding emergency departments; providers of low threshold treatment; harm reduction services providers; recovery support services, including peer support professionals and recovery community organizations; Federally Qualified Health Centers; Community Behavioral Health Providers; academic medical centers; tribal health clinics; and substance use disorder treatment providers to implement the requirements of this Act.

Commentary

The purpose of Section XI of this Act is to ensure that the state provides resources to hospitals, freestanding emergency departments, and community-based providers in need of additional funding to implement the provisions of this Act. Although subject matter expertise and clinical research indicate that providing the suite of services detailed in Section IV of this Act would be feasible and may, in fact, save money from fewer re-admissions to emergency rooms and reduced economic impacts of substance use disorder, the drafters of this Act acknowledge that hospitals and freestanding emergency departments may require additional funding for these services at the outset. In this Section, the term “available funding” is intentionally ambiguous so that it may encompass all funds that a state may use to establish this program, including, but not limited to, opioid litigation proceeds, federal grants, and monies appropriated from state budgets. Beyond hospitals and freestanding emergency departments, this Section also includes community-based providers as eligible grant recipients, because these actors are equally important in ensuring continuity of care for patients upon discharge. While the provisions of this Section create two main groups of grantees—emergency medical treatment providers and community-based providers—the drafters of this Act leave it to states’ discretion with regard to how this grant program may be organized.

SECTION XII. MEDICAID.

- (a) In general.—[STATE MEDICAID AGENCY] shall create ongoing billing and other permanent support mechanisms to reimburse hospitals, freestanding emergency departments, substance use disorder treatment providers, peer support professionals and recovery support services, harm reduction services providers, and other providers for the services required under this Act.
- (b) Required coverage.—[STATE MEDICAID AGENCY] shall provide coverage to Medicaid beneficiaries for “Screening, Brief Intervention, and Referral to Treatment” (SBIRT), medications for addiction treatment and affiliated services and referrals, and peer support.
- (c) Prohibition on utilization management, including prior authorization.—The [STATE] Medicaid program and Medicaid managed care providers [if applicable] shall not engage in utilization management, including prior authorization, for: naloxone, any buprenorphine products, methadone, or long-acting injectable naltrexone for withdrawal management or treatment of a substance use disorder prescribed in accordance with generally accepted national professional guidelines for the treatment of substance use disorder.
- (d) Reimbursement.—[STATE MEDICAID AGENCY] shall develop and implement a methodology and reimbursement rate to support and incentivize provision of the services in this Act by establishing an adequate rate for all protocols listed in [Section IV(A)] of this Act, including but not limited to initiation of treatment, provision of peer support services, and discharge planning services, including transportation;
- (e) Billing codes.—[STATE MEDICAID AGENCY] shall develop and implement a code or codes for initiating medication for addiction treatment in hospitals and freestanding emergency departments identical to the federal Medicare code, Healthcare Common Procedure Coding System G2213, for provision of medications for opioid use disorder.
- (f) State Medicaid plan and 1115 Waiver.—[STATE MEDICAID AGENCY] must submit a revised state Medicaid plan and 1115 Waiver request, as applicable, to reflect any necessary changes to the plan based on this Section; and

- (g) Medicaid managed care model contract.—[Where applicable,] [STATE MEDICAID AGENCY] shall amend the [STATE] managed care contract so that:
- (1) Medicaid managed care organizations must contract with a sufficient number of prescribers of buprenorphine for opioid use disorder in their network to meet patient need;
 - (2) Each Medicaid managed care organization must contract with sufficient in-network providers to provide emergency care, and non-emergency substance use disorder treatment.
 - (3) Medicaid managed care organizations receive fines and other penalties for failure to comply.
- (h) Reimbursement for dispensation of medications from hospitals and freestanding emergency departments.—[APPROPRIATE STATE AGENCY] shall amend [STATE] pharmacy regulations that prohibit the reimbursement for dispensation of medications from emergency departments and hospitals.

Commentary

The purpose of Section XII is to leverage Medicaid dollars to support the provisions of this Act. The subject matter experts providing guidance on this Act acknowledged the importance of public insurance and the possible opportunities for integration of addiction care into emergency settings using Medicaid as a lever. The subject matter experts that informed the development of this Act recommended the prohibition of utilization management and prior authorization, development of reimbursement methodologies, and updating billing codes, which have been translated into policy in Sections XII(c)-(e). Subject matter experts were emphatic that adequate, stable reimbursement included in law is essential; otherwise, many emergency rooms, especially those serving underserved and/or rural populations, will not be able to meet the other requirements in the legislation. Equally essential are billing mechanisms for peers, and/or the extension of existing billing mechanisms to apply for the emergency department, including access to the same codes, and cannot have requirements for pre-authorization, an established diagnosis, or a registered treatment plan.

Section XII(b) of this Act requires that state Medicaid beneficiaries receive coverage for medications for addiction treatment. The drafters identified numerous opportunities for states to establish rates, such as by bundling services or adding to existing bundles. Ultimately, the drafters determined that state Medicaid agencies knew best how to establish rates, so the requirements of Section XII(b) leave open the opportunity for individual agencies to make their own determinations. Section XII(e) reflects feedback from subject matter experts that state Medicaid agencies should create a billing code identical to the federal Medicare code Healthcare Common Procedure Coding System G2213 for initiation and referral related to medications for

addiction treatment in an ED setting.¹¹² This billing code was originally developed for Medicare “to account for the resource costs involved with initiation of medication for the treatment of opioid use disorder in [emergency medical settings] and referral for follow-up care.”¹¹³ This code, therefore, reimburses providers for initiation of medication for opioid use disorder in emergency medical settings; the code includes assessment, referral to ongoing care, and arranging access to supportive services.

Section XII(g) of this Act requires that state Medicaid agencies submit revised state Medicaid plans and, as applicable, 1115 Waiver requests. Although this Act does not contemplate a requirement that states re-open their Medicaid plans and 1115 Waivers specifically for the purpose of submitting these changes, unless they choose to do so, it is critical that States update and provide billing codes immediately to enable reimbursement for the services and activities required under this Act.

The public health research conducted about opportunities for expanding Medicaid coverage resulted in Sections XII(f)-(g), which address revising state Medicaid plans and managed care contracts. The provisions of this Section are intentionally ambiguous so that the language may be adaptable for the distinct Medicaid schemes of all jurisdictions. This Section would ensure optimal participation by Medicaid; with this participation, emergency healthcare providers will be more inclined to provide care that they know will be covered by insurance. States may choose to go beyond the provisions of this Act; for example, a state could also require managed care organizations contracting with Medicaid to conduct quality improvement projects tied to substance use disorder treatment and recovery measures. The drafters of this Act leave this to the discretion of state Medicaid agencies but encourage additional support of substance use disorder treatment, prevention, recovery, and harm reduction services through improvements to state Medicaid structure and protocols.

Subject matter experts also expressed that state laws prohibiting reimbursement for medications dispensed in emergency medical settings would serve as a barrier to implementing the requirements of this Act. Therefore, Section XII(h) of this Act requires states to examine and amend these regulations to ensure reimbursement for this service. States can also include additional incentives and levers within their Medicaid managed care infrastructure; for example, they may offer value-based payment arrangements, pay for performance incentives, and other incentives to increase services such as buprenorphine prescribing and peer support.

¹¹² MEDICARE PROGRAM; CY 2021 PAYMENT POLICIES UNDER THE PHYSICIAN FEE SCHEDULE AND OTHER CHANGES TO PART B PAYMENT POLICIES, DEP’T OF HEALTH & HUM. SVCS., CTRS. FOR MEDICARE & MEDICAID SVCS., <https://www.federalregister.gov/documents/2020/12/28/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part>.

¹¹³ *Id.*

SECTION XIII. STATE INSURANCE LAW.

- (a) In general.—[STATE INSURANCE AGENCY] shall create ongoing billing and other permanent support mechanisms to reimburse hospitals, freestanding emergency departments, substance use disorder treatment providers, peer support professionals and recovery support services, harm reduction services providers, and other providers for the services required under this Act.
- (b) Required coverage.—[STATE INSURANCE AGENCY] shall require coverage for “Screening, Brief Intervention, and Referral to Treatment (SBIRT), medications for addiction treatment and affiliated services and referrals, and peer support by commercial health plans authorized under [STATE INSURANCE LAW].
- (c) Prohibition on utilization management, including prior authorization.—Every health insurance entity that provides an insurance contract, plan or policy that is delivered, issued for delivery, amended, or renewed in this state and commercial health plans authorized under [STATE INSURANCE LAW] shall not engage in utilization management, including prior authorization, for naloxone, any buprenorphine products, methadone, or long acting injectable naltrexone for withdrawal management or treatment of a substance use disorder prescribed in accordance with generally accepted national professional guidelines for the treatment of substance use disorder.

Commentary

The purpose of Section XIII of this Act is to remove barriers in state insurance law to make the services required in Section IV more accessible and affordable. Input from subject matter experts indicated that removing prior authorization requirements for medications for addiction treatment would make the dispensing and prescribing of these medications significantly easier. Therefore, this Section removes this barrier in order to make critical, life-saving medication more easily accessible.

SECTION XIV. PROMULGATION OF RULES BY [STATE HEALTH AUTHORITY].

On or before [DATE], [STATE HEALTH AUTHORITY] shall develop regulations to implement the requirements of this legislation.

SECTION XV. SEVERABILITY.

If any provision of this Act or application thereof to any circumstance is held invalid, the remaining provisions of this Act shall not be affected nor diminished.

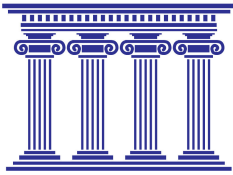
SECTION XVI. EFFECTIVE DATE.

This Act shall be effective on [specific date or reference to normal state method of determination of the effective date].

ABOUT THE LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

Based in Washington D.C., and led by and comprised of experienced attorneys, the Legislative Analysis and Public Policy Association is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorders, and the criminal justice system.

LAPPA produces timely model laws and policies that can be used by national, state, and local public health, public safety, and substance use disorder practitioners who want the latest comprehensive information on law and policy as well as up-to-the-minute comparative analyses, publications, educational brochures, and other tools ranging from podcasts to fact sheets. Examples of topics on which LAPPA has assisted stakeholders include naloxone laws, law enforcement/community engagement, alternatives to incarceration for those with substance use disorders, medication-assisted treatment in correctional settings, and the involuntary commitment and guardianship of individuals with alcohol or substance use disorders.



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