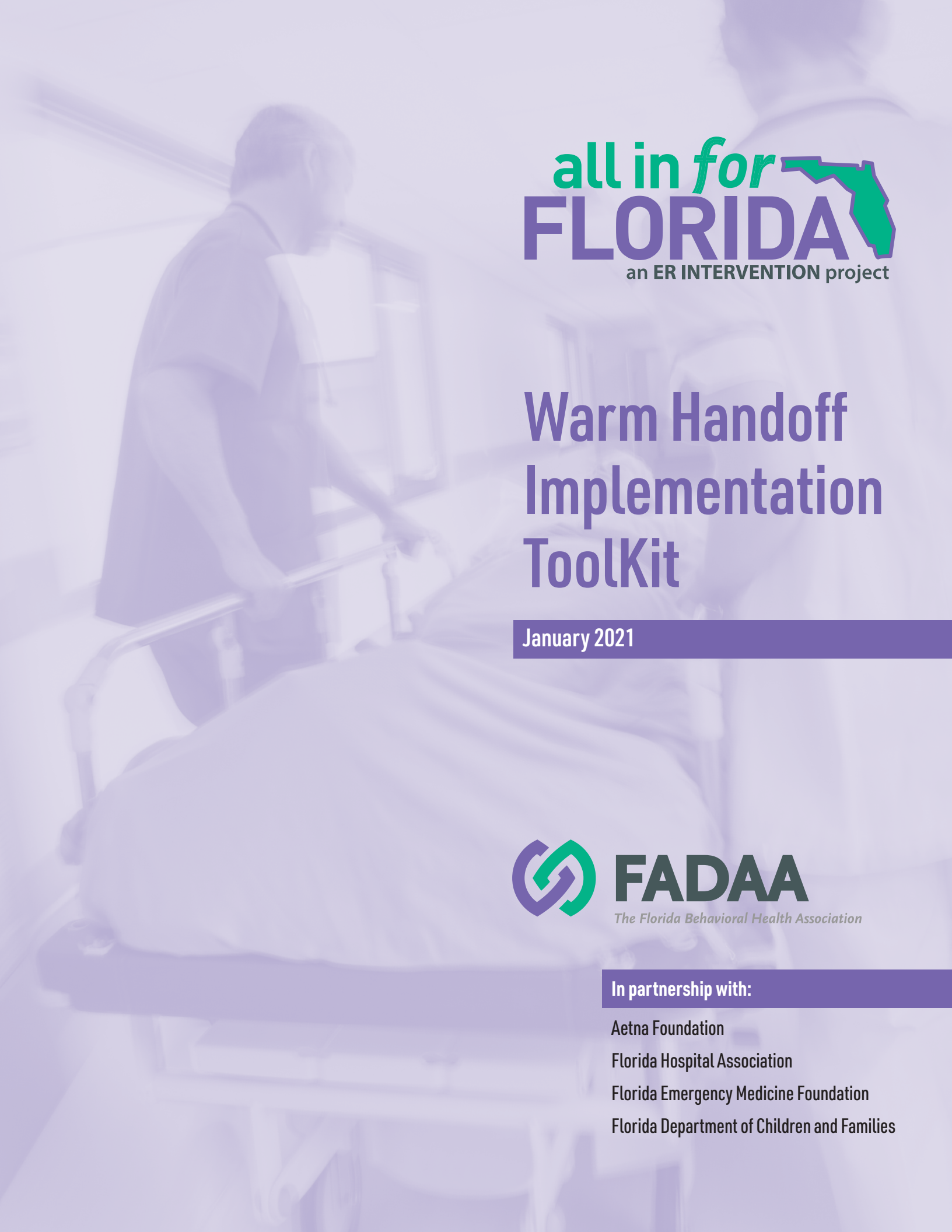

all in for FLORIDA
an ER INTERVENTION project

Warm Handoff Implementation ToolKit

January 2021

FADAA
The Florida Behavioral Health Association

In partnership with:

Aetna Foundation
Florida Hospital Association
Florida Emergency Medicine Foundation
Florida Department of Children and Families

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Warm Handoff Implementation Toolkit

A promising practice to improve engagement of individuals with a substance use disorder

Introduction

The opioid crisis in America has had a dramatic negative effect on individuals, families, communities, and the healthcare system. Individuals overdosing on opioids were delivered to hospital emergency departments (ED) for emergency care. Often these same individuals would return to the ED multiple times due to an overdose. It became clear early in the crisis that the ED was the ideal place to engage individuals with a substance use disorder into treatment. A paper referral or even a prescription for treatment are not typically successful strategies to engaging this population. A warm handoff, meaning a person-to-person transition from the hospital ED to a community-based treatment provider emerged as a promising practice. This approach is now recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA)[1] and the Florida Drug Policy Advisory Council.[2]

The Aetna Foundation recognized the value of this approach by awarding resources to the Florida Alcohol and Drug Abuse Association (FADAA) and its partners to implement the All in Florida: an ER Intervention Project. The focus of this effort was to build knowledge on effective strategies to implement warm handoff protocols that result in the warm hand-off transfer of individuals with an opioid use disorder to a community substance use disorder treatment agency for follow-up care. The by-product of this effort was the strengthening of partnership between the hospital and the community-based treatment provider.

The Warm Handoff Implementation Toolkit was created as a resource to hospitals and their emergency departments, and community substance use disorder treatment agencies. The toolkit was developed based on the project's experiences as the hospitals and community-based treatment providers endeavored to develop a warm handoff. It also includes information and samples collected both through the project and other sources identified during the life of the project. The Toolkit:

- provides guidance on how to develop and implement warm handoff programs,
- identifies the common barriers that arise when trying to implement a warm handoff program and the steps taken to resolve them, and
- offers numerous resources, forms, and checklists that can be used in the development and successful implementation of a warm handoff program.

[1] SAMHSA (2020). National Guidelines for Behavioral Health Crisis Care. Best Practice Toolkit. Available at https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[2] Statewide Drug policy Advisory Council (2020) 2020 Annual Report. Available at http://www.floridahealth.gov/provider-and-partner-resources/dpac/DPAC_11-30-20.pdf

Background

The Opioid Crisis

Since 2013, the US has been experiencing a wave of increased opioid overdose deaths and opioid-involved deaths. This concerning trend led the US Department of Health and Human Services to declare the opioid crisis as a public health emergency in October 2017.[3] Florida saw its highest number of opioid-related deaths in 2017 when 6,178 opioid-related deaths and 4,280 opioid-caused deaths were reported. This represented an eight (8) and nine (9) percent increase over 2016 reports, respectively.[4] While the data showed some improvement in 2018, the 2019 incidents indicated opioid-related deaths remained at the same levels experienced in Florida in 2017.[5] Since 2017, Florida has paid close attention to the opioid crisis impacting the state by passing laws and dedicating significant local, state, and federal dollars to address the epidemic. In May 2017, the opioid epidemic was identified as a statewide public health emergency by the governor.[6]

The Role of Hospital Emergency Departments

As public health professionals began to look at ways to combat the opioid crisis, the role of hospital emergency departments (ED) became apparent. The Delaware Overdose Fatality Commission published a report noting that more than half of the deaths in that state in late 2018 occurred within three months of a visit to the emergency room.[7] They recommended that patients displaying symptoms of opioid use disorders be linked with treatment while at the hospital. The possible impact of such a protocol can be understood given the number of nonfatal drug overdose ED visits. For example, the Centers for Disease Control and Prevention reported there were 967,615 such visits in 2017.[8] The authors of this study also recommended the implementation of post overdose protocols in ED. Hospital emergency departments can serve as critical entry points to prevent opioid overdose deaths and initiate proper interventions to reduce relapse, reduce overdose deaths, and reduce the cost of uncompensated care.

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[3] A copy of the determination by Acting Secretary Eric D. Hargan is available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/October_26_2017_Public_Health_Declaration_for_Opioids_Crisis.pdf

[4] Florida Department of Law Enforcement (2018) Drugs Identified in Deceased Persons by Florida Medical Examiners 2017 Annual Report available at http://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2017-Annual-Drug-Report.aspx

[5] Florida Department of Law Enforcement (2020) Drugs Identified in Deceased Persons by Florida Medical Examiners 2019 Annual Report available at http://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2019-Annual-Drug-Report.aspx

[6] Gov. Scott Directs Statewide Public Health Emergency for Opioid Epidemic. Available at http://www.floridahealth.gov/newsroom/2017/05/050317-health-emergency-opioid-epidemic.html

[7] Delaware Overdose Fatality Commission (2019) Delaware Drug Overdose Fatality Review Commission Report. Available at https://attorneygeneral.delaware.gov/wp-content/uploads/sites/50/2019/07/2019-Delaware-Drug-Overdose-Fatality-Review-Commission-Report-Final.pdf

[8] Vivolo-Kantor AM, Hoots BE, Scholl L, et al. Nonfatal Drug Overdoses Treated in Emergency Departments — United States, 2016–2017. MMWR Morb Mortal Wkly Rep 2020;69:371–376. Available at https://www.cdc.gov/mmwr/volumes/69/wr/mm6913a3.htm

The year 2018 saw a surge of efforts in Florida directed to improve the engagement into treatment of patients presenting to the ED with an opioid use disorder. The Florida legislature passed laws to increase the reporting of suspected overdoses by emergency medical service providers and required hospitals to develop best practices when treating patients presenting in the emergency department with a possible drug overdose.[9] Florida Alcohol and Drug Abuse Association (FADAA), through a generous grant from the Aetna Foundation and in partnership with the Florida Hospital Association (FHA) and the Florida Emergency Medicine Foundation (FEMF), launched a program to support the development of a warm handoff protocol at selected hospitals around Florida in 2018. At the same time, the Florida Department of Children and Families (DCF) launched a pilot program with similar goals. This Tool Kit is the result of those efforts and the lessons learned during the life of the project.

Best and Promising Practices

Understanding the disease of addiction, its impact on the brain, and the importance of deploying proper interventions go a long way to creating opportunities for successful interventions. Opioids change an individual's brain in ways that keep them from making logical decisions. Therefore, hospitals should treat opioid overdoses both as a toxicological problem and a psychological challenge. As a result, interventions beyond the usual "standard of care" are needed. Educating emergency physicians, emergency medical staff, and other professionals on best practices related to treating an overdose should precede any other protocol developed by a hospital.

Warm Handoff

The Agency for Healthcare Research and Quality defines a warm handoff as "a transfer of care between two members of the health care team, where the handoff occurs in front of the patient and family."[10] Hospitals have a vested interest to create proper interventions and care transitions such as warm handoffs for patients with opioid or substance use disorders (SUD) prior to discharge.

This approach is part of a collaborative care practice that is not unique to the treatment of substance use disorders. The warm handoff should be in person whenever possible and happen in front of the patient and/or family. It should include:

- introduction by ED staff to the community-based treatment provider
- a review of the discharge goals and plan
- a review of next steps and who is responsible for each step[11]

The warm handoff should provide an opportunity for all participants, including the patient and family, to question, clarify, and confirm information.[12]

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[9] *See* 395.1041(6)(b), Florida Statutes http://flsenate.gov/Laws/Statutes/2018/0395.1041

[10] Agency for Healthcare Research and Quality (2017) Warm Handoff: Intervention. Available at https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html#:~:text=A%20warm%20handoff%20is%20a,of%20the%20patient%20and%20family.

[11] Crew E, Chowfla A, DuPlessis H, Lee H, Main E, McCormick E, Oldini C, Smith H, Robinson R, Waller C, Wong J. (2020) Mother and Baby Substance Exposure Toolkit. Stanford, CA: California Maternal Quality Care Collaborative and California Perinatal Quality Care Collaborative. Accessed from https://nastoolkit.org/.

[12] Ibid.

The collaborative care team encourages the patient to engage in continued treatment, provides the patient with a clinical assessment, and immediately facilitates the transfer to a treatment program. The transition of care from the emergency room to a community substance use disorder treatment provider is expected to increase engagement, reduce stigma, and enhance continuity of care by improving communication between the healthcare team and the patient and family.[13] The goal is to make the referral process a gentle one.

The primary goal for hospitals that would like to engage in warm handoff for individuals with an SUD must be to link the patient to treatment and recovery. That may not happen on the day the patient is released from the hospital. While formal data is not yet available, anecdotal data indicate that though patients do not often transition directly from the ED to a treatment provider, linking them with a recovery peer, for example, will encourage engagement in treatment and recovery in the long term.

ED-Initiated Treatment

A 2015 study by researchers at the Yale School of Medicine tested three interventions for opioid-dependent patients who were treated in a hospital emergency department. The first group was given a handout with contact information for SUD treatment services. The second group received an interview about treatment options and assistance in connecting with treatment (including arranging transportation). The third group received the interview, plus a first dose of buprenorphine, take-home doses, and a scheduled appointment with a primary care provider within 72 hours. The study found that 78 percent of patients in the third group (buprenorphine) were still in treatment 30 days later, compared with 45 percent in the group that only got the interview and 37 percent who only got the handout.[14] This study and multiple others have shown that medication-assisted treatment is considered the gold standard in treating individuals with opioid use disorder.[15] Appendices F, G and H include sample ED Initiation Decision Trees. Appendix I includes a sample buprenorphine referral form for OUD developed by the Yale School of Medicine. Appendix J includes a sample buprenorphine treatment consent form.

Medication-Assistant Treatment

The Substance Abuse and Mental Health Services Administration (SAMHSA) describes Medication-Assisted Treatment (MAT) as "the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. Medications used in MAT are approved by the Food and Drug Administration (FDA) and MAT programs are clinically driven and tailored to meet each patient's needs."[16] This therapy has been

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[13] Agency for Healthcare Research and Quality (n.d.) Implementation Quick Start Guide: Warm Handoff. Available at https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/warm-handoff-qsg-letter.pdf

[14] Frazier W, Cochran G, Lo-Ciganic W, et al. (2017) Medication-Assisted Treatment and Opioid Use Before and After Overdose in Pennsylvania Medicaid. JAMA;318(8):750–752. Available at https://jamanetwork.com/journals/jama/fullarticle/10.1001/jama.2017.7818

[15] D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., Bernstein, S. L., & Fiellin, D. A. (2015). Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. JAMA, 313(16), 1636–1644. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4527523/

[16] https://www.samhsa.gov/medication-assisted-treatment

linked to improved outcomes.[17] Appendix C includes a description of the medications approved by the FDA for the treatment of opioid use disorders.

Developing Warm Handoffs at Your Hospital

Developing a warm handoff requires creating a bridge between the hospital and community-based SUD treatment providers. This process is not as difficult as it seems but does require foresight, planning, and relationship building. Based on Florida's experience, input from emergency department physicians, and information from sources such as the National Institute on Drug Abuse (NIDA),[18] implementing a warm handoff in the ED should follow a process such as:

Figure 1. Hospital ED Warm Handoff Implementation Process

Review the Data

Making sound business and policy decisions requires an understanding of both hospital and emergency department operations. This understanding requires an analysis of the data.[19] From a healthcare perspective, data helps drive practice improvement. Data will help the hospital and its partners understand the impact of substance use disorders on the operations of the ED as well as on other departments.

The Numbers

Hospitals have a large amount of data that can be utilized to describe much of their operation, including their patients, their costs, their liabilities. It is important to work with individuals who have the expertise to navigate through the numbers to provide an insight into the impact of substance use disorders. Some of the questions the hospital may seek to answer are:

- How many patients access the ED as a result of opioid or other drug overdoses?
- How many of those patients are visiting the ED repeatedly as a result of an overdose?
- How many of those patients have to be admitted due to drug use related diagnosis (e.g., endocarditis)?
- Who are the payors of the services provided to those patients?

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[17] National Academies of Sciences, Engineering, and Medicine. (2019). Medications for opioid use disorder save lives. National Academies Press. Available at https://www.careinnovations.org/wp-content/uploads/MOUD-Saves-Lives_NAS_2019.pdf

[18] National Institutes of Health, National Institute on Drug Abuse (n.d.) Medication Treatment for Opioid Use Disorder in the Emergency Medicine Setting. Available at https://www.drugabuse.gov/nidamed-medical-health-professionals/science-to-medicine/medication-treatment-opioid-use-disorder/in-emergency-medicine-setting

[19] Stobierski, T. (2019) The Advantages of Data-Driven Decision-Making. Harvard Business School Online. Available at https://online.hbs.edu/blog/post/data-driven-decision-making

- What is the cost of uncompensated care, either through uninsured or non-payment of claims?
- What is the 30-day readmission rate for drug overdoses at the hospital?
- Who is that patient (e.g., demographics data: age, gender, race)?

Obtaining data on the number of opioid overdoses may be complicated by the current coding practices of opioid overdoses at the ED. The reliance on diagnosis alone when examining ED data will likely underestimate the incidence of specific drug overdoses due to the frequent use of non-specific ICD-10 codes. Understanding the data will help make informed decisions as the facility develops hospital protocols and appropriate care transitions.

The Practice

Data is not limited to numbers. It is also important to review the practices, policies, and processes. All facilities are encouraged to review current practices, including discharge procedures for the opioid overdoses presenting at the Emergency Department. Hospitals should consider asking the following questions in this review:

- Do our discharge protocols consider substance use disorders?
- Do current referral protocols include linking to community-based treatment providers?
- If so, how current is our list of providers?
- How many physicians or other providers are trained and have hospital privileges to prescribe buprenorphine?
- What resources/funding are or could be available to assist in a warm handoff program?

The Staff

It is also important to understand both the knowledge and perceptions of all staff towards substance use disorders. These variables may be gaged through different venues, such as surveys, observations, and focus group meetings. The success of any change in policies and practices is driven by the engagement and commitment of the staff required to implement it. The hospital may want to understand:

- How do the medical professionals perceive individuals with a substance use disorder?
- How do hospital administrators perceive individuals with a substance use disorder?
- How does the hospital leadership (e.g., Board of Directors) perceive individuals with a substance use disorder?
- What concerns leadership when new processes and protocols are implemented (e.g. training, capacity)?

The Organization

Hospitals should not dismiss the fact that changes usually bring special operational concerns. Different departments in the system may have concerns that can delay or derail efforts to implement warm handoff protocols. Hospitals may want to determine:

- What are the identified legal and liability concerns?
- Are there rules or regulations that would impact a warm handoff protocol?
- What concerns regarding confidentiality may arise?
- Are there workload concerns?

Data can help hospitals understand where they are, what their needs are, and how to move forward. It helps establish a firm knowledge base to drive decisions and can diminish the impact of bias, false assumptions, and gut feeling or intuition.[20] Data can also help engage partners, as it demonstrates the need for and possible positive impact of the new protocol.

Build Support

Practice transformation requires efforts guided by a larger vision and commitment. This approach assures that individual changes fit together into a meaningful whole. In this case, the transformation is developing proper care transitions – warm handoffs – for patients treated in the hospital emergency department as a result of their substance use disorder into the larger operations of the ED and the hospital. The Florida experience supports the importance of a warm handoff champion that can serve the role of a change agent.

Warm Handoff Champion

The concept of a hospital champion often referred to as a change champion or change agent has been around for fifty years. These individuals can provide technical know-how, leadership, and social support for the new practice. The warm handoff champion is confident of the benefits of this approach and can effectively convey those benefits. This individual should also have good standing within the hospital that encourages trust from leadership and frontline staff.

There is no one position that is ideal to serve as a warm handoff champion. In Florida, these champions have been in the hospital leadership, in administration and/or emergency medicine physicians. The warm handoff champion should have access to all levels of hospital administration and leadership and the different departments, such as pharmacy and billing, that are likely to play a role in the treatment of patients with a substance use disorder. In Florida, the change agents that were most successful in implementing a warm handoff process in the ED were not appointed. Rather, they were individuals who took on the task to find ways to address the opioid crisis and determined that a warm handoff was something they could and should put in place in the hospitals.

Mobilize A Team

Warm handoffs will require a team of individuals and entities working together to engage individuals with a substance use disorder to pursue SUD treatment. Typically, the team could include:

- First responders
- Emergency department personnel
- Community-based treatment providers
- Peers specialists

[20] Miller, K. (2019) Data-Driven Decision Making: A Primer for Beginners. Northeastern University. Available at https://www.northeastern.edu/graduate/blog/data-driven-decision-making/#:~:text=Data%2Ddriven%20decision%20making%20(or,aims%20to%20be%20data%2Ddriven.

- Social service organizations[21]

Each of these parties can and should be an active participant in the engagement efforts.

First Responders

This group can include emergency medical technicians, law enforcement officers, firefighters, and 911 dispatchers. They have direct access to the patient and the community and bring a unique perspective to the team. Often, it is the first respondents who have first contact with an individual who has overdosed and can identify the individuals that are repeatedly overdosing. They can also provide information regarding the risk of a substance use disorder because of their knowledge of the community environment where the patient was engaged.

Emergency Department Personnel

This includes all hospital staff who are involved in the operation of the ED. The group likely includes administrators, legal counsel, care navigators, clinical leadership, and front-line workers. Some of these individuals may not interact with the patients but play a role in developing policies and protocols.

Community-Based Treatment Providers

A warm handoff requires a community-based treatment agency to transition the patient. A critical step of this process is to identify a reputable community-based SUD treatment provider within proximity of the hospital. Some areas may have more than one. Selecting this partner may be the most challenging task of developing a warm handoff process within the hospital. The criteria that should be part of the process to select a treatment provider should at least consider:

- **Licensing and Accreditation**. The first step is ensuring the entity is licensed by the appropriate state agency. In Florida, that is the Department of Children and Families. Accreditation typically indicates higher quality of care and an agency's commitment to quality care. Quality crediting entities in this field are the Commission on Accreditation of Rehabilitation Facilities (CARF) and The Joint Commission (TJC), formerly referred to JACHO.
- **Clinical Admissions Process**. The admissions process provides a glance into the practices of the agency. The process should include an addiction professional and consideration of the individual needs of the patient. The admission process must also align with the operations of the hospital.
- **Evidence-based Programs**. The use of evidence-based programs or practices (EBP) reflect a commitment to quality services. Practices such as Motivational Interviewing or Medication-Assisted Treatment have proven effective in treating addiction.[22]

Hospital staff, including the warm handoff champion, should make an effort to visit and tour the community-based treatment providers, gain an understanding of the services provided and determine the capacity to serve new patients.

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[21] Barnes, M. C. (2018, March). Warm Handoff Policies and Programs: Collaborative Efforts To Intervene and Treat Addiction. Presentation presented at the Addiction Executives Industry Summit, Ponte Vedra Beach, Florida. Retrieved from https://ptaccollaborative.org/wp-content/uploads/2018/05/Warm-Handoff-Policies-Barnes.pdf

[22] Bradley, B. F. (2017, September). Commentary: 5 Essential Tips to Finding Quality Addiction Treatment. Retrieved from https://drugfree.org/drug-and-alcohol-news/commentary-5-essential-tips-finding-quality-addiction-treatment/

Peer Specialists

Peer specialists are individuals who have lived experience, have been in recovery for at least two (2) years, and who can support the engagement, treatment, and recovery of individuals with a mental health or substance abuse disorder. In Florida, peers can become certified professionals. The Certified Recovery Peer Specialist (CRPS) designates competency in the domains of Recovery Support, Advocacy, Mentoring, and Professional Responsibilities.[23] Peers can take the perspective of "I have been in your shoes" and use this approach to engage individuals with a substance use disorder. While peers do not provide clinical or medical services, these individuals serve as an important part of a care transition team and help reduce addiction stigma. While it is not necessary to utilize peer services in care transition practices, their use is an evidence-based practice.[24]

Appendix M includes tips for hiring a peer specialist developed by the City of Philadelphia, Department of Behavioral Health and Intellectual Disability Services. Appendix N includes sample job descriptions for peer specialist and Appendix O sample job announcement for recruitment efforts. Appendix P includes a sample patient authorization for consultation with a peer.

Social Service Organizations

Individuals with a substance use disorder often need other supports beyond treatment such as housing, transportation, employment, and childcare, to list a few examples. Community-based organizations such as churches, not-for-profit organizations, local United Way, and similar entities can help support engagement into treatment by bringing additional resources to support the individual.

Build Relationships

Building of relationships between the ED and its community providers should be a deliberate effort that includes both formal and informal venues to engage the different players. The informal approach requires developing personal relationships with the players -the individuals that work at or with the needed partnership organizations. The sustainability of this effort will depend on engaging a network of allies, advisors, and partners and trusting them[25] to engage to help individuals with an SUD.

The formal aspect of the relationship-building effort requires scheduled meetings and open communication to establish clear roles and responsibilities for each partner. This process often takes six to 12 months. How this process develops will greatly depend on the ability of the warm handoff champion from the hospital to identify and engage similar champions at the target partner organizations. Each partner will have concerns pertinent to their operation and role in the

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[23] Florida Certification Board. (2019, June 11). Certified Recovery Peer Specialist (CRPS). Retrieved from https://flcertificationboard.org/certifications/certified-recovery-peers-specialist/

[24] Substance Abuse and Mental Health Services Administration. (n.d.). Peers Supporting Recovery from Substance Use Disorders [Infographic]. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-substance-use-disorders-2017.pdf

[25] Schwarting, T. (2018, March 9). Building Effective and Fulfilling Business Partnerships. Retrieved from https://www.forbes.com/sites/ellevate/2018/03/08/building-effective-and-fulfilling-business-partnerships/?sh=56d65c7e78c7

partnership (e.g., legal, liability, funding, compliance, capacity, confidentiality). These concerns have the capacity to derail the efforts if they are not properly addressed. A Memorandum of Understanding (MOU) or similar vehicle, is highly recommended between the hospital and community-based treatment provider and other partners. An effective MOU clearly delineates the role and responsibility of each partner and prevents misunderstandings and potential disputes. Key components of an MOU include:

- clearly identified parties
- time period covered by the agreement
- responsibilities of each party
- confidentiality of patient data
- disclaimers
- financial arrangements and responsibilities
- signatures of authorized agents from each party

Appendices K and L include both simple and comprehensive sample versions of MOU.

While the MOU defines the working arrangement of the program, successful warm handoff programs have implemented additional strategies to promote relationship building and maintaining those relationships such as:

- training of emergency room staff and other stakeholders on the treatment of SUD
- meeting regularly to evaluate the program and adjust when needed
- sharing data between partners
- including the peer recovery specialist in the emergency room daily huddles
- acknowledging the peer recovery specialist as part of the ED (e.g., providing a workspace, name badge, uniform)
- providing a designated phone number or secured text capability to the peer recovery specialist to receive referrals from the ED
- sharing success stories of patient engagement

Conveying the benefits of implementing a warm handoff process is key to developing and maintaining established partnerships. The champions must make every effort to ensure that the partners understand the benefits and importance of the proper transition of care, the warm handoff process, the reasoning behind the effort, and the value of evidence-based practices such as MAT and motivation interviewing in engaging individuals with a SUD.

Stigma remains the most significant barrier to people seeking care for mental health and substance use disorders. Healthcare is a critical partner in “humanizing” the disease of addiction and combating the disease’s negative stereotypes. All involved in the intervention can reduce stigma by engaging teams in education regarding addiction and changing the language and terms used to describe individuals with an opioid or substance use disorder. Changing language and improving understanding of the disease of addiction can help shift the mindset, enabling the healthcare team to engage with the patient with greater compassion, empathy, and support. Developing an understanding of substance use disorders will help the healthcare team identify the early signs of addiction and treat it in the early stages.

Develop ED Protocol for a Warm Handoff

The warm handoff protocol should define how a patient that has been identified as having an SUD will be linked to a treatment provider. The agency for Healthcare Research and Quality has developed a toolkit for warm handoff in primary care[26] that can be adapted for use in the hospital ED setting. The main steps are:

- Understand the current processes. It is important to understand how the staff currently treats patients with an SUD. Some of the areas the hospital may research is whether patients are assessed for substance use or provided any information about the risks of substance use, and treatment options. To understand current practices, the hospital should review the written policies and investigate what actually happens in the ED.
- Understand the current workflow. This requires an understanding of how the patient moves within the ED and which staff interact with the patient at each step. It is important to recognize that workflows do not always exactly match written protocols.
- Analyze the current workflow. This step will help identify points where the patient can be linked to treatment information and opportunities and what staff may be impacted by efforts to include a warm handoff to treatment.
- Seek the input of everyone affected by the new protocols. This step is important to secure buy-in from the affected staff and to develop effective processes. The ED staff likely know small details that are not written or apparent but may impact the implementation of a warm handoff to treatment. Developing these protocols with input from each of the team members will build awareness, commitment, and good practice.
- Identify potential challenges and possible solutions. Every effort should be made to identify possible roadblocks and challenges. Common challenges identified in Florida included legal concerns, coordination with the pharmacy department, and lack of understanding of the role and benefits of engaging a peer.
- Phase-in the warm handoff. Look for opportunities to test the warm handoff protocol before fully launching the initiative. This will allow the partners to grow more comfortable engaging in and supporting the warm handoff.

Appendix A provides a sample checklist for the implementation of a warm handoff process. The checklist should be edited to reflect the operation of the hospital and the treatment provider.

There are a set of questions that the hospital ED should consider while developing the protocol. These questions were identified by initiatives throughout Florida:

- Other than those individuals presenting with a drug overdose, how will staff identify patients with an SUD?
- When, in the treatment protocol, will the staff identified as facilitator for a warm handoff engage the patient?
- Is the facilitator for a warm handoff an individual or a team?

[26] Agency for Healthcare Research and Quality (n.d.) Implementation Quick Start Guide: Warm Handoff. Available at https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/warm-handoff-qsg-letter.pdf

- Who will serve as the facilitator for a warm handoff: Nurse Navigator, Peer/Recovery Coach, Social Worker, Community Paramedicine/EMS?
- How will the facilitator for a warm handoff be contacted (e.g., Electronic Medical Record, phone, fax, secured email)?
- What will the process flow look like when the facilitator for a warm handoff is not on-site?
- Will telehealth be incorporated into practice? The role of telehealth rose in importance beginning in March 2020 due to concerns over COVID-19.
- What are the identified inclusion and exclusion criteria for the warm handoff program?
- Will MAT be initiated in the Emergency Department?
- Will Narcan kits be distributed? If so, how will this be accomplished? Who will receive Narcan kits (e.g., patient, families, friends)?
- How will patient consent be secured?
- How will protected patient information be handled?
- How will the patient be transported to the treatment provider?
- What data will be shared between the partners?

It is often useful to develop a flow chart for the warm handoff and other related processes. Flow charts provide a simple "at-a-glance" view of the process to help all team members navigate the process. Appendix B includes a sample protocol developed by the Pennsylvania Department of Drug and Alcohol Programs in partnership with the Pennsylvania Department of Health and the Pennsylvania College of Emergency Physicians.[27] Appendices D and E include graphic representation of warm handoff processes.

There are some ancillary services that may become part of the warm handoff process. The most common ones are patient screening, initiation of medication-assisted protocols, and dispensing of overdose reversing medication.

Screening for Substance Use Disorders

While the prevalence of patients presenting with an overdose was the driver for the push for a warm handoff process in the ED, other patients that are accessing the ED may have or be at risk of a substance use disorder. There are a number of evidence-based SUD screening tools available for use in a warm handoff program. Florida encourages the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT). However, there are many other tools available, and hospitals should pick one that best fits their needs. When selecting a screening tool, the warm handoff team should consider the following:

- Who will perform the screening or be responsible for its completion?
- How will the screening be performed (e.g., staff or self-administered, on paper or tablet)?
- Where will the screening be performed (e.g., waiting room, triage area, patient room)?

[27] Pennsylvania Department of Drug and Alcohol Programs. (2019). Warm Hand-off Care map [Flowchart]. Retrieved from https://www.ddap.pa.gov/Documents/Agency%20Publications/Warm%20Hand-Off/Warm%20Hand-off%20Care%20Map.pdf

A short description of some of the most commonly used screening tools follows. Appendix R includes a comparison table of common Screening and Assessment Tools prepared by the National Institute on Drug Abuse.[28] The table includes links to more information on each tool.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is an evidence-based approach to identify patients who have a substance use disorder and those at risk of developing the disorder. SBIRT approach is recommended by the Institute of Medicine and endorsed by the Substance Abuse Mental Health Services Administration (SAMHSA).

Brief Negotiated Interview (BNI)

The BNI is a script to guide providers through a brief intervention for substance use with carefully phrased key questions and responses rooted in motivational interviewing (MI) techniques. It is specially designed for use in the emergency department and has been demonstrated to be effective in facilitating positive changes.

Clinical Opiate Withdrawal Scale (COWS)

COWS is a brief (11-item) scale designed to be administered by a clinician and can be used in both inpatient and outpatient settings. It is used to measure the severity of the patient's opiate withdrawal symptoms. The COWS can also be used to monitor these symptoms over time and to make inferences about the patient's physical dependence on opioids.

Current Opioid Misuse Measure (COMM)

The COMM is a brief (17 items), self-report measure of current aberrant drug-related behavior and may serve as a useful tool for those providers who need to document their patients' continued compliance and appropriate use of opioids for pain. The COMM is designed to address ongoing medication misuse by asking patients to describe how they are currently using their medication.

Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)

The TAPS Tool consists of a combined screening component (TAPS-1) followed by a brief assessment (TAPS-2) for those who screen positive. The test may be self-administered by the patient or as an interview tool by a health professional and is available as an online tool. It combines screening and brief assessment for commonly used substances, eliminating the need for multiple screenings and lengthy assessment tools.

Initiation of Medication-Assisted Treatment

Medication-assisted treatment (MAT) is an evidence-based practice that combines behavioral therapy and medications to treat substance use disorders.[29] MAT is currently available for the treatment of opioid and alcohol use disorders. In the ED environment, MAT refers to the treatment of opioid use disorders (OUD). The evidence suggests that the use of MAT at least doubles the rates of

[28] National Institute on Drug Abuse. (2020, August 17). Screening and Assessment Tools Chart. Retrieved from https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

[29] Substance Abuse and Mental Health Services Administration. (2020). Medication-Assisted Treatment (MAT). Retrieved from https://www.samhsa.gov/medication-assisted-treatment

opioid-abstinence when compared to those that do not receive MAT. There are three medications approved by the US Food and Drug Administration for use in MAT to treat individuals with an OUD:

- Methadone is a clinic-based opioid agonist that does not block other narcotics while preventing withdrawal while taking it. It is provided as a daily liquid dose dispensed only in regulated specialty clinics. Patients whom have a record of demonstrated compliance may be allowed take-home doses.
- Naltrexone is an office-based non-addictive opioid antagonist that blocks the effects of other narcotics. It is available as a daily pill or a monthly injection.
- Buprenorphine is an office-based opioid agonist and antagonist that blocks other narcotics while reducing withdrawal risk. It is available as a daily dissolving tablet, cheek film, long-acting injectable, or a 6-month implant under the skin.

As with other medications, there is no standard plan that can be used across all patients being treated for an OUD. Substance use history, level of addiction, drug use patterns, and patient motivation are all factors that guide the physician when selecting the appropriate MAT medication for each patient.

For patients with an OUD, MAT can be initiated at the hospital.[30] Buprenorphine induction is becoming the recognized best practice for use in a hospital ED. Buprenorphine has a favorable safety profile. Unlike methadone, buprenorphine has few drug-drug interactions, it is an opioid partial agonist, and it is not associated with a significant risk of respiratory depression. The unique pharmacological properties of buprenorphine lower the potential for misuse, diminishes the effects of withdrawal symptoms, and increases safety in case of an overdose. Appendices F, G and H include sample ED Initiation Decision Trees. Appendix I includes a sample buprenorphine referral form for OUD developed by the Yale School of Medicine. Appendix J includes a sample buprenorphine treatment consent form. Appendix Q includes a sample patient agreement that delineates the responsibilities of the patient as they are engaged in treatment.

Practitioners prescribing buprenorphine must obtain a separate registration under 21 U.S.C. Section 823(g)(1) or a DATA 2000 Waiver under 21 U.S.C. Section 823(g)(2). However, there are two exceptions that may apply in the ED:

- When admitted to a hospital for a primary medical problem other than opioid dependency, a patient may be administered opioid agonist medications such as methadone and buprenorphine to prevent opioid withdrawal that would complicate the primary medical problem.
- The “three-day rule” (Title 21, Code of Federal Regulations, Part 1306.07(b)) allows a practitioner to administer (but not prescribe) narcotic drugs to a patient for the purpose of relieving acute withdrawal symptoms while arranging for the patient’s referral for treatment under the following conditions:

[30] American College of Emergency Physicians. (n.d.). Initiating Opioid Treatment in the Emergency Department (ED). Retrieved from https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/mental-health-and-substance-abuse/initiating-opioid-treatment-in-the-emergency-department-ed-faqs.pdf

- Not more than one day's medication may be administered or given to a patient at one time
- Treatment may not extend beyond 72 hours
- The 72-hour period cannot be renewed or extended

When considering MAT initiation, the ED should include the pharmacy director in the development of medication protocols and in the education presented to the hospital treatment team. The pharmacy director can assist in ensuring buprenorphine is added to the hospital formulary.

It is recommended that the ED display signs that establish the ED as a safe place to reveal opioid use or dependence and seek help. Signs may read something like: "Need help with pain pills or heroin? We want to help you get off opioids. Ask us how."

Harm Reduction and Naloxone Distribution

Harm reduction efforts should be incorporated in the treatment of individuals with an SUD. Naloxone is one of the medications approved to treat opioid overdose. The Centers for Disease Control and Prevention (CDC) recommends that healthcare providers offer naloxone to patients at risk of overdose. The medication can be given by intranasal spray or intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection.

Florida has invested significant efforts to making naloxone readily available. The naloxone formulation Narcan® is available through the Florida Department of Health, the Florida Department of Children and families, and some pharmacies in Florida operating under non-patient specific standing orders. These standing orders allow people to purchase naloxone directly from a pharmacy without an individual prescription from their doctor. The Florida Department of Health issued a Statewide Standing Order for Naloxone in February 2019. Both patients and caregivers may access, store, and administer the medication in emergency situations, regardless of whether that person has a prescription. As funding allows, Narcan is available through the Department of Health Heroes Program for first responders and correctional and probation officers. To supplement, the Department of Children and Families provides free intranasal naloxone kits to those who request them. This is time-limited funding which was made available with federal State Targeted Response (STR) and State Opioid Response (SOR) grants. As of this writing, the funding to support this initiative is available until September 2022.

The Florida Legislature enacted legislation providing civil liability immunity to a person who possesses, administers, prescribes, dispenses, or stores opioid antagonists such as Naloxone. (see 318.887 F.S.)[31] The legislature also passed what is known as the "Good Samaritan" law limiting the

[31] The Florida Legislature. (2020). Public Health: General provisions. Emergency treatment for suspected opioid overdose. Retrieved from http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0381/Sections/0381.887.html

ability to arrest, charge, prosecute, or penalize individuals who seek medical assistance for themselves or another person when experiencing an overdose (see 893.21 F.S.)[32]

Appendix S includes sample discharge instructions and education on harm reduction for patients being discharged from the ED after an overdose. Appendix T includes training materials on harm reduction for care providers. Both these tools were developed by and ED physician.

Train Staff and Partners

Introducing the warm handoff process involves bringing change into the the hospital. The hospital should try to use *Change Management* techniques such as training to support the new initiative. Training is expected to improve innovative performance.[33] Working on developing the staff and partner competencies (knowledge, abilities, and attitudes) will help them support the shift into using a warm handoff process and improve the likelihood of successful implementation.[34] The training should cover three main topics:

- Addiction as a disease of the brain
- Description of the warm handoff initiative and how it can help improve outcomes for the patient and the hospital
- Warm handoff process and roles

Addiction is a Disease

Stigma remains the greatest barrier to people seeking care for mental health and addiction issues. Stigma prevents individuals with SUD from getting the help they need and caregivers and others from providing needed services. Stigma results in disparate treatment of those with an SUD by healthcare providers and leads to poorer outcomes.[35] Training can help all stakeholders understand addiction as a disease of the brain. In 2019 the American Society of Addiction Medicine wrote:

> "Addiction is a *treatable, chronic medical disease* involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.
>
> Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases."[36]

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[32] The Florida legislature. (2020). Drug Abuse Prevention and Control. Alcohol-related or drug-related overdoses; medical assistance; immunity from arrest, charge, prosecution, and penalization. Retrieved from http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0800-0899/0893/Sections/0893.21.html

[33] Sung, S. Y., and Choi, J. N. (2014). Do organizations spend wisely on employees? Effects of training and development investments on learning and innovation in organizations. J. Organ. Behav. 35, 393–412.

[34] Sartori R, Costantini A, Ceschi A and Tommasi F (2018) How Do You Manage Change in Organizations? Training, Development, Innovation, and Their Relationships. Front. Psychol. 9:313.

[35] Prevention Solutions at EDC, available at https://preventionsolutions.edc.org/sites/default/files/attachments/Words-Matter-How-Language-Choice-Can-Reduce-Stigma.pdf

[36] ASAM. (2019) Definition of Addiction. Available at: https://www.asam.org/Quality-Science/definition-of-addiction

All involved in the intervention must understand addiction as a disease. This can change how those with an SUD are approached in all stages of treatment. Language plays an important role in combating stigma. The terms used not only impact the person speaking them but also the patient's perception of whether the healthcare worker cares or can be trusted. Some resources to further understand stigma and how to address it are included in Appendix V. Appendix U includes a short pamphlet of terms that may lead to stigma and suggestions for new terminology.

The What and Why of the Warm Handoff Initiative

The stakeholders (e.g., staff, contractors) should understand the rationale that led the hospital to decide to launch the initiative. It should be presented and explained to the staffto help them engage as partners. Stakeholders should understand how the primary goal of the initiative to link the patient to treatment and recovery will:

- improve patient outcomes by supporting their recovery efforts,
- reduce repeat overdose visits to the ED, and
- improve hospital performance measures and metrics.

This is the value or inspirational part of the training.

Warm Handoff Process and Roles

The technical training on how the warm handoff will be implemented. Using flowcharts can help trainees understand the process and how the warm handoff will be incorporated into current practices. This training should also include how to use the tools that will be utilized in the warm handoff, such as assessment tools, referral forms, communication protocols, and others as applicable.

Buprenorphine Waivered Practitioner

A hospital may choose to support its practitioners to become buprenorphine waivered. Anecdotal data support that practitioners who complete this process have a better understanding of substance use disorders, medication-assisted treatment, and are more likely to support efforts such as warm handoff. The hospital can support its practitioners by providing time and supports for them to complete the process. The process, as defined by SAMHSA is below.

To receive a practitioner waiver to administer, dispense, and prescribe buprenorphine practitioners must notify SAMHSA's Center for Substance Abuse Treatment (CSAT), Division of Pharmacologic Therapies of their intent to practice this form of MAT. The notification of intent must be submitted to SAMHSA before the initial dispensing or prescribing of OUD treatment medication. Qualified practitioners include physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs), Certified Registered Nurse Anesthetist (CRNAs), and Certified Nurse-Midwifes (CNMs). [37]

Qualified practitioners can treat up to 100 patients using buprenorphine for the treatment of opioid use disorder (OUD) in the first year if they possess a DATA 2000 waiver and meet one of two conditions:

[37] Additional information is available at https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner

- The physician holds a board certification in addiction medicine or addiction psychiatry by the American Board of Preventive Medicine or the American Board of Psychiatry and Neurology
- The practitioner provides medication-assisted treatment (MAT) in a "qualified practice setting."

After one year at the 100-patient limit, qualifying practitioners who meet the above criteria can apply to increase their patient limit to 275.

Implement Warm Handoff

Implementation of a warm handoff protocol will depend on the operation of the hospital as well as the magnitude of the problem related to overdose cases experienced by the hospital. In Florida, those that embarked on this process followed one of the following approaches:

Build on Existing Procedures

Some Florida Hospitals had pre-existing relationships with community-based treatment providers. Most often, these relationships arose from managing patients who have been court-ordered to be assessed and treated for a substance use disorder (commonly referred to as “Marchman acted”) or for a mental illness (commonly referred to as “Baker acted”). They selected to build on that relationship. The benefit of this approach is that both organizations have knowledge and experience working together. In these cases, the hospital modified or expanded existing memoranda of understanding and protocols to include substance use disorders and overdoses. In these cases, the treatment provider engaged a certified peer who agreed to work in the ED. Current provider staff assisted with the onboarding and training of the new staff. The main benefit of this approach is that the organizations have experience working together. If that experience is positive, the new process can be easier to implement. See case Study 1.

Case Study 1

The hospital’s department of obstetrics had an existing agreement with a treatment provider to supply services to pregnant women using substances. The North Florida Regional Medical Center in Gainesville partnered with Meridian Behavioral Healthcare to expand this relationship, taking this bridge program live in the summer of 2019. Rather than a single hospital-based Peer, Meridian Peers rotated on-call responsibility for engaging patients in the hospital as need arose. The treatment provider was also able to receive patients under the Marchman Act as needed.

Launch as a Pilot

At least two hospitals launched or are in the process of launching warm handoff protocols as a pilot. There are some significant advantages to this approach:

- Permits the collection of data that can help to support the need for the program
- Allows testing of different processes to find the best-suited model
- Provides a finite implementation period that can help manage risk

The projects that used this process had funding from outside sources to support the program costs. This allowed the hospital and community-based provider to implement the program with limited financial risk. The longest standing and most replicated warm handoff process in Florida was launched as a pilot. See Case Study 2.

Case Study 2

This bridge program began as a six-month pilot championed in part by a Jacksonville City Council member. The proposal was developed between March and November of 2017. The pilot, funded by the city, was structured around a contract between the City of Jacksonville and Gateway Community Services, Inc. (GCS). Gateway subsequently established an MOU with Ascension St. Vincent's Riverside Hospital. Meetings with the hospital pharmacy and ED physicians, as well as training for the hospital nursing staff preceded implementation, with program initiation in the beginning of 2018.

Today, the program has expanded to all three of Ascension St. Vincent's Hospitals and to Memorial Hospital Jacksonville.

Direct Implementation

There were a few instances where a champion for warm handoff took on the challenge to develop the process, engage a team and ultimately implement a warm handoff. In those cases, the champion was an individual with good standing within the organization, knowledge of opioid use disorders, and the stamina to work through the process to take the steps necessary. In these cases, implementation took the form of a small program with limited hours of operation. This allowed the program to engage other supporters.

Case Study 3

After one year of planning, this program went live in October of 2019 as a bilateral partnership between the Halifax Health Hospital and SMA Healthcare with one Peer employed by SMA. The original scope included inpatient areas of the hospital, but the program was scaled down to the ED only in the early stages, out of concern for capacity and getting the model right. A certified peer was located in the ED from 10 am to 7 pm Monday through Friday. These extended hours, helpful to the ED, overlapped with SMA's hours of operations, ensuring that the Peer could routinely connect with colleagues at SMA. The Peer is notified of patients through an email alert ordered by hospital clinical staff.

In some cases, the champion was a part of the hospital staff. In other instances, this individual worked with a community-based provider in an area of the state with a high incidence of opioid overdose deaths. Regardless of where the original one was located, a champion was needed in both the hospital and the community-based provider. The champion at the hospital contributed knowledge of hospital operations and access to hospital leadership. The champion at the community-based provider contributed knowledge of substance use disorders and their treatment, access to peers and experience working with this type of professional, and access to funding streams that could support the program. See Case Study 3.

Monitoring and Evaluating Warm Handoff Initiatives

All initiatives in Florida identified access to accurate, valid data as the primary challenge to determine whether the program was meeting its objective of engaging individuals with a substance use disorder into treatment to reduce the number of overdose episodes and deaths. One common data concern was the coding of overdoses. Individuals presenting with an overdose likely have an array of conditions brought on by the overdose. Some programs noted that those patients were not being coded as overdoses. The main challenge was that the overdosing code had lower priority in the database that required the staff to scroll through several screens to find it. Some EDs, especially those in areas with high overdose incidence, made the decision to place the overdose codes higher in the list and provide additional training on coding to the medical staff.

Another challenge was that the hospital and the community-based providers operated separate and distinct data systems. These systems do not share the same unique identifier for each patient and do not communicate with each other. This barrier can be somewhat mitigated with periodic meetings to review data. The main data points needed from the hospital include:

- Number of opioid overdoses entering the ED and disposition status
- Number of physician orders for referral to treatment
- Number of cases with a warm handoff visit (typically from a peer)
- Number of patients who were offered SUD treatment and whether treatment was accepted
- Patients that were inducted into MAT (typically using buprenorphine)
- Number of readmissions within 30 days for opioid overdose

Other data points that were identified by hospitals involved in the warm handoff initiative include:

- Number of patients admitted/treated in the endocarditis unit
- Cost of overdose care (compensated vs uncompensated)

Community-based providers have been able to bridge some of the data challenges since they typically maintain detailed data systems that can document engagement, treatment type and length, and other socioeconomic information such as employment, family status, and involvement with the courts. The main data points needed from the community-provider include:

- Number of cases with a warm handoff visit (typically from a peer)
- Number of patients who were offered SUD treatment and whether treatment was accepted
- Patients that were inducted into MAT (typically using buprenorphine)

These data should be the same as that reported by the hospital. Once the individual is in the care of the provider, other important data points include:

- Treatment provided (MAT or other as appropriate for the substance of use)
- Length of treatment engagement
- Treatment outcome
- Socioeconomic data at the time of engagement and at the time of release from treatment

As with any new initiative, documenting outcomes is key to developing sustainability for the project.

Impact of COVID-19

The COVID-19 epidemic began in the US in early 2020. In March, cities began experiencing closures and stay at home orders. To safeguard both patients and staff, many hospitals began implementing restrictions as to who could access the facilities. The restrictions negatively impacted the ability of peers to remain in the ED and have a face-to-face interaction, or warm interaction, with individuals presenting with an overdose. Most hospitals replaced the in-person warm handoff with remote options such as telephone conversations and web-based telehealth. This had a negative impact on program success. For example, Halifax Hospital reported that from November 2019, when the program was started, to February 2020, the last time peers where in the ED, over 50 percent of eligible overdose patients providing consent led to a physician order for peer services. That number was reduced to less than 37 percent once the peers were not in the ED (March to June 2020). In the same periods the percent of patients transitioning into MAT enrollment went from 46 to less than 32 percent.

The key to the project and what makes it different from typical referral services lays in the "warm" aspect. Many struggle to provide that via web-based platforms. Peers also report that they often approach the patient with a snack, a hug or handshake, or other actions designed to communicate concern for the welfare of the patient. This is difficult to achieve via telehealth. The hospital that reported the findings above allowed the peers to return to the ED in July in an effort to regain the progress they had achieved before COVID-19.

Conclusion

The hospital emergency department provides a patient-centered, open-access setting that can provide an unparalleled combination of ease of access, ability to initiate treatment and transition to ongoing therapy. There is no specific transition care strategy that must be used for patients who present with an overdose in a hospital emergency department. The key is to educate hospital staff on addiction and find a strategy, or combination of strategies that work best in for each hospital and in each community. The major lessons learned include:

- Securing warm handoff champions within the hospital and the community-based provider is essential to support the implementation of the program.
- Helping all parties understand that substance use disorders in general and opioid use disorders specifically are a disease of the brain and as such, individuals with an SUD need appropriate treatment.
- Induction with buprenorphine can help patients be more amiable to engagement in treatment.
- Success will require that the process include other departments such as legal, compliance, pharmacy, data informatics, and Information technology.

All the projects reported use a peer as the bridge between the hospital ED and the community-based provider. It is important to remember that peers are also in recovery and the project must help the peer maintain their recovery. With that in mind, hospitals should consider:

- The ED is a highly charged, unpredictable, sometimes depressing and stressful environment

- An alternative work environment for peers may help them manage the ED environment (e.g., a desk in another area of the hospital)
- Take steps to ensure that the peer continues participation in recovery support services
- Allow peers access to hospital-based crisis counselors, if available.

More data and evaluation are needed to validate warm handoff practices as an evidenced-based best practice. Anecdotal data does support the case that warm handoff have secured positive outcomes for a number of patients even when engagement rates are low. It is important to remember that a patient engaged in treatment is one less patient that will present to the ED with an overdose.

Appendix A – Checklist for Implementing a "Warm Handoff" Program

Getting Started

- ☐ **Define the goals and objectives of the program**
- ☐ **Conduct Analysis of Current Processes**
  - ☐ Review current policies
  - ☐ Review current practices
  - ☐ Identify how many practitioners are trained and have hospital privileges to prescribe Buprenorphine
- ☐ **Identify available resources**

Planning and Designing

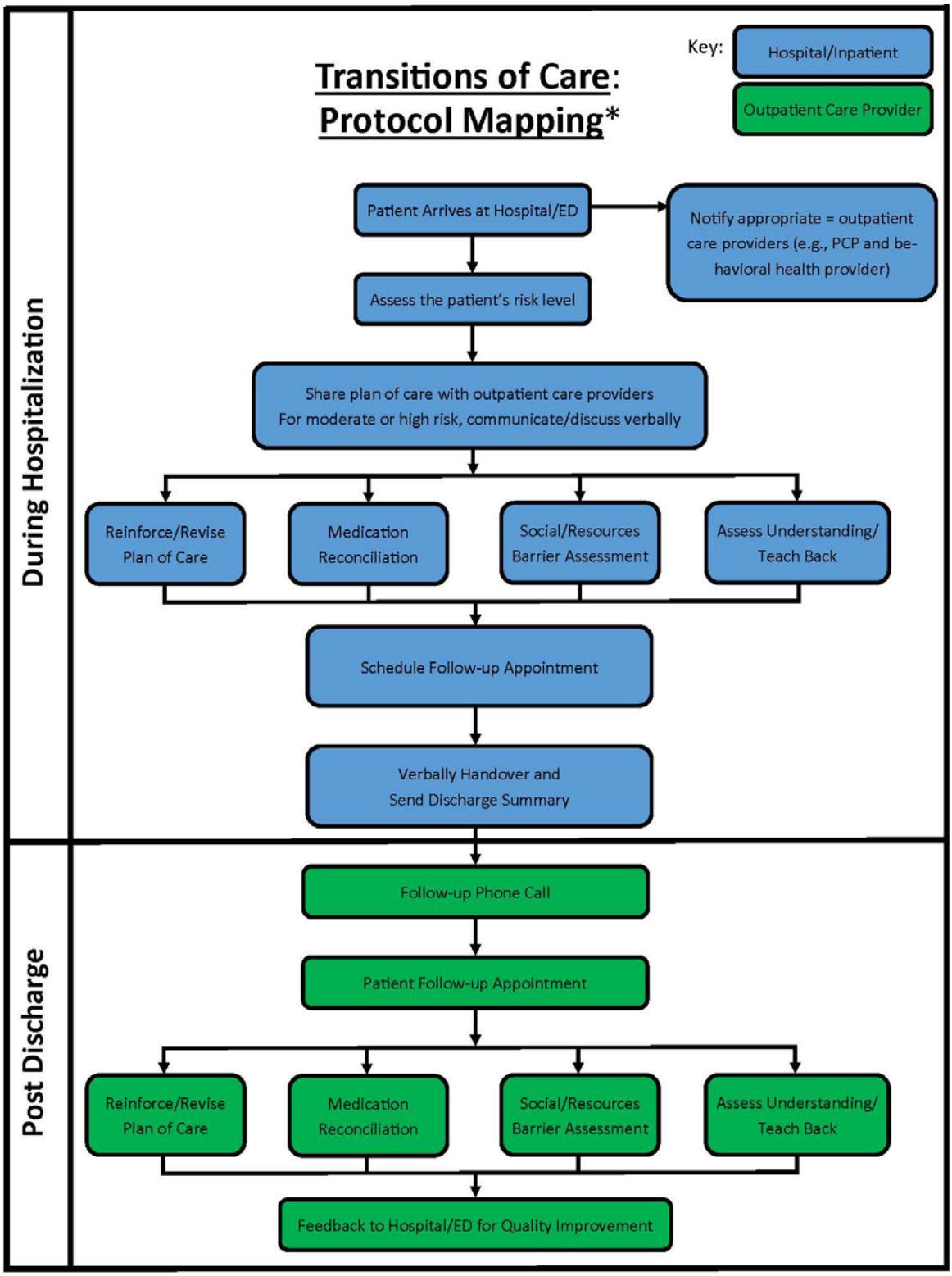
- ☐ **Establish Baseline Data**
  - ☐ Size of the problem (e.g., number of Opioid Overdoses presenting to the ER, readmissions)
  - ☐ Fiscal impact (e.g., payer breakdown, cost of uncompensated care)
- ☐ **Establish Organizational Readiness**
  - ☐ How does the hospital manage individuals with a substance use disorder?
  - ☐ What are the staff attitudes towards individuals with a substance use disorder?
  - ☐ What are the concerns of the hospital (e.g., liability, regulations)?
- ☐ **Build Support**
  - ☐ Hospital leadership
  - ☐ Identify a Warm Handoff Champion
- ☐ **Mobilize a Team**
  - ☐ First responders
  - ☐ Emergency department personnel
  - ☐ Community-based treatment providers
  - ☐ Peers specialists
  - ☐ Social service organizations
- ☐ **Establish a timeline and tasks to be completed**
- ☐ **Develop ED Protocol for a Warm Handoff**
  - ☐ Review current hospital practices
  - ☐ Review other warm handoff implementations
  - ☐ Review best practices (e.g., screening and assessments)
  - ☐ Identify what strategies best merge with hospital operations
  - ☐ Develop warm handoff protocol
    - ☐ Define Roles and Responsibilities for each team member
    - ☐ Develop/edits job descriptions
    - ☐ Write the protocol
  - ☐ Identify resources required: staffing, technical, financial
  - ☐ Develop implementation plan

Implementation

- ☐ **Engage partners through formal protocols such as Memorandum of Understanding or Agreement**
- ☐ **Train staff and partners**
- ☐ **Implement Warm Handoff**
- ☐ **Evaluate the implementation**
- ☐ **Make adjustments to the process as appropriate**

Appendix B – Transitions of Care: Protocol Mapping

A resource from the National Council for Behavioral Health available at https://www.nationalcouncildocs.net/wp-content/uploads/2018/03/Transitions-of-Care-Protocol-Mapping.pdf



*Adapted from: Wagner, C., & Hosken, R. (2017). *Reducing Readmissions: Care Transitions Toolkit*. Washington State Hospital Association - Partnership for Patients. Retrieved from https://leadingagewa.org/wp-content/uploads/WSHA-Care-Transitions-Toolkit-3rd-Edition-for-2017.pdf

Appendix C – Medicines for Treating Opioid Use Disorder

A resource from CA Bridge, a program of the Public Health Institute based in Oakland, California accessible at https://cabridge.org/resource/medicines-for-treating-opioid-use-disorder-what-you-need-to-know/

Medicines for Treating Opioid Use Disorder: What you need to know when choosing the best treatment for you

November 2019

Buprenorphine
(Suboxone®, Subutex®, Zubsolv®)

BENEFITS

- It is a well-studied medicine, and safe for long-term use.
- People who take buprenorphine are less likely to overdose or die than people who do not take it.
- It blocks cravings and prevents feeling "high" if you slip and use.
- It is more effective for chronic pain than methadone or naltrexone.
- It blocks withdrawal symptoms (unlike naltrexone or no medications).
- You can get to a comfortable dose in a couple of days (faster than with methadone).
- It does not produce a "high."
- Most people get it from a primary care doctor who can provide up to one month of medicine at a time—no need to go every day or go to a special clinic.
- Some people prefer the counseling and support of a methadone clinic—many clinics now also offer buprenorphine at the window.
- Safely used by patients who have employee health screens or on parole.
- It is covered by most health insurance programs.

CAUTIONS

- Side effects are rare AND less severe and less frequent than other opioids. All opioids can cause trouble sleeping, nausea, headaches, or overdose if mixed with other drugs.
- Some AA/NA groups, treatment programs, and police/judges may not support this.
- Usually, you should be in some withdrawal before you take the first dose.
- Stopping buprenorphine often is done slowly and with support of medical team.

Methadone

BENEFITS

- It is a well-studied medicine that is safe for long-term use.
- People who take methadone are less likely to overdose or to die than people who do not take it.
- It blocks cravings and prevents feeling "high" if you slip and use.
- It helps with chronic pain, but less than buprenorphine.
- It blocks withdrawal symptoms (unlike naltrexone or no medications) and may take longer to get to a comfortable dose than buprenorphine.
- It does not produce a "high" if taken at the right dose.
- Methadone users are less likely than those who don't take it to relapse, get HIV, or go to prison.
- Methadone clinics offer counseling and case management support.
- You do not need to go into withdrawal before starting it.
- It is covered by most health insurance programs.

CAUTIONS

- Side effects may include sleepiness (if dose is too high), constipation, or dangerous heart rhythms—these can be prevented by working with your medical team.
- If you take too much or mix with other drugs, you can overdose.
- It can only be taken by going to a methadone clinic daily.
- Stopping methadone must be done slowly and with support of medical team.

Naltrexone
(Vivitrol®)

BENEFITS

- It blocks opioid and alcohol cravings and stops you from feeling high if you use opioids.
- You only need to get the shot once a month.
- It is not an opioid and does not cause withdrawal symptoms if you stop taking it.
- Even though studies show buprenorphine and methadone are as helpful, some AA/NA groups, treatment programs, and police/judges may prefer naltrexone.

CAUTIONS

- Upon the first injection, if you have opioids in your system you will likely go into withdrawal. You must go through detox first and not use for 1-2 weeks.
- It can be very hard to start. Unlike methadone and buprenorphine, it does not help with withdrawal symptoms and can cause withdrawal for up to 2 weeks if taken too soon.
- It does not help with chronic pain.
- It can be expensive and hard to get; many insurance plans do not pay or only cover it after a long process.
- Your tolerance goes down when you don't take any opioid medicine. That means if you return to using, you may have a bigger risk of dying than if you took methadone or buprenorphine.
- If you need emergency surgery or have sudden bad pain, opioids will not work well.
- It is less well studied than buprenorphine and methadone. We don't know if it prevents overdose and deaths like those medicines do.

No Medication

BENEFITS

- Some patients prefer to be off all medicines, even when there is a higher risk of relapse and overdose.
- Medication side effects are avoided. The side effect of no medication is increased risk of relapse and overdose death.

CAUTIONS

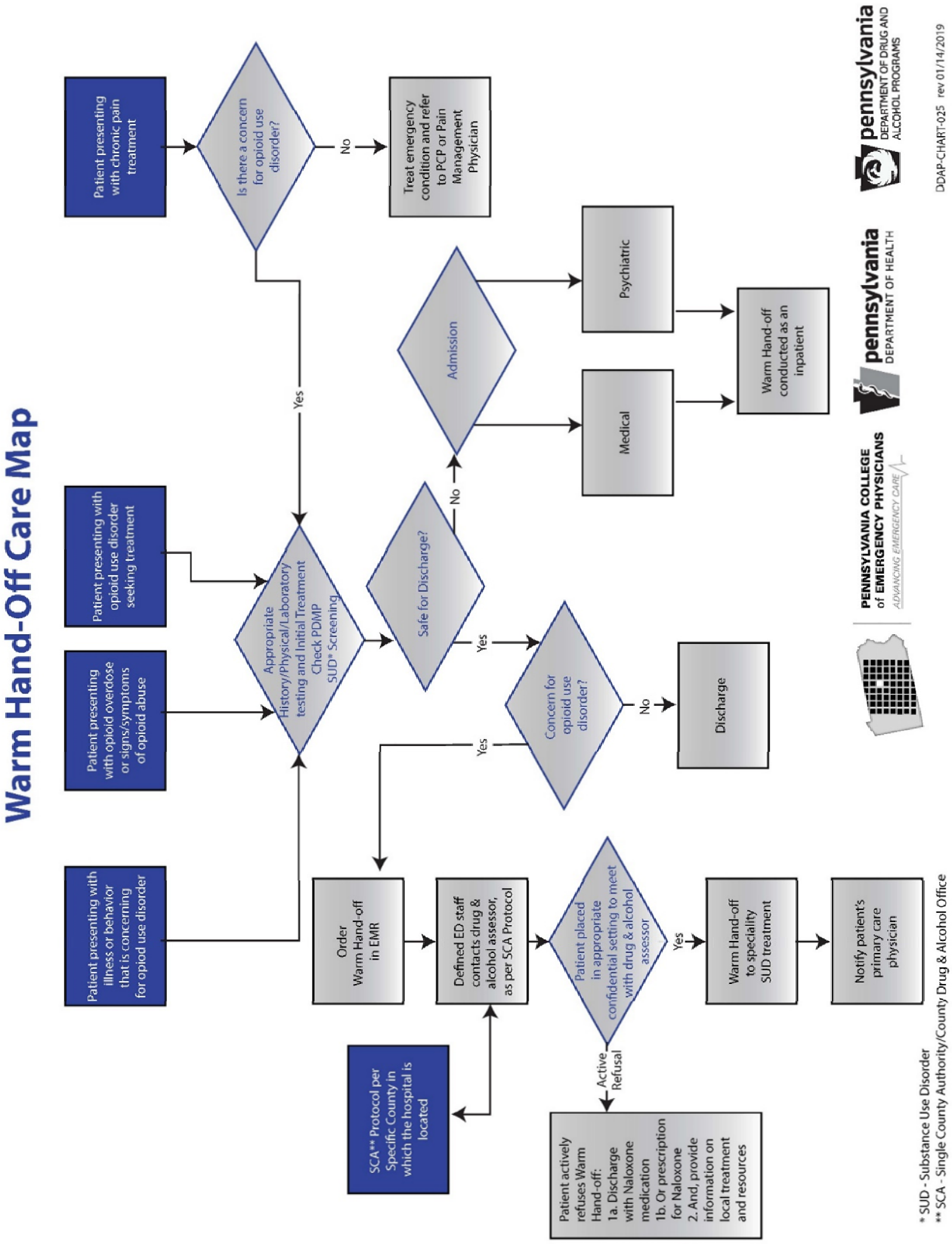
- You are much more likely to relapse, overdose, and die in comparison to results from buprenorphine or methadone.
- Cravings and withdrawal are not controlled when you are not taking medicines, and if you slip and use it can be much harder to stop.
- Your tolerance goes down when you don't take any opioid medicine. That means if you return to using, you have a bigger risk of dying than if you took methadone or buprenorphine.
- Because of increased risk of overdose death without medication, you should have naloxone rescue kit at home for your safety.

CA BRIDGE
TREATMENT STARTS HERE

California Bridge disseminates resources developed by an interdisciplinary team based on published evidence and medical expertise. These resources are not a substitute for clinical judgment or medical advice. Adherence to the guidance in these resources will not ensure successful patient treatments. Current best practices may change. Providers are responsible for assessing the care and needs of individual patients. Documents are periodically updated to reflect the most recent evidence-based research. Materials provided through the California Bridge may be utilized for the sole purpose of providing substance use disorder information. Such materials may be distributed with proper attribution from the California Department of Health Care Services, Public Health Institute, California Bridge Program. Questions may be submitted via email to info@BridgeToTreatment.org.

Appendix D – Warm Handoff Care Map

A resource from The Pennsylvania Department of Drug and Alcohol Programs accessible at https://www.ddap.pa.gov/Pages/Warm-Hand-Off.aspx



Appendix E – Warm Handoff Access Model

A resource from the ED Intervention Project at Halifax Health.

Peer Intervention Model

Emergency Room

- Stabilize Overdose Patient
- Provide Project Overview
- Attain Patient Consent
- Generate Physician Order for Peer Consult

SMA Certified Peer Specialist

- Receive Automated Email Alert
- Contact Assigned Unit Clerk as Directed
- Meet & Establish Relationship with Patient
- Register Patient in SMA System for MAT
- Provide follow up calls & transportation to program

Assigned ER Physician

- Provide Home Induction Education & Prescription

'After-Hour' Access Model

Emergency Room

- Stabilize Overdose Patient
- Provide Project Overview
- Attain Patient Consent
- Generate Physician Order for Peer Consult

SMA 24/7 Access Center

- Receive Automated Email Alert
- Contact Assigned Unit Clerk as Directed
- **Teleconference with Patient to establish Relationship**
- Register Patient in SMA System for MAT
- **Peer Specialist Provides Ongoing Follow-Up**

Assigned ER Physician

- Provide Home Induction Education & Prescription

Appendix F – Buprenorphine. Sample 1 ED Initiation Decision Tree

A resource from CA Bridge, a program of the Public Health Institute based in Oakland, California accessible at https://cabridge.org/resource/buprenorphine-bup-hospital-quick-start/

CA BRIDGE
TREATMENT STARTS HERE

Buprenorphine (Bup) Hospital Quick Start

- Any prescriber can order Bup in the hospital, even without an x-waiver.
- Bup is a high-affinity, partial agonist opioid that is safe and highly effective for treating opioid use disorder.
- If patient is stable on methadone or prefers methadone, recommend continuation of methadone as first-line treatment.

Uncomplicated* opioid withdrawal?**

NO → **Start Bup after withdrawal**
Supportive meds prn, stop other opioids

YES (stop other opioids)

Administer 8mg Bup SL

1 HOUR

Withdrawal symptoms improved?

NO → **No Improvement**

Differential Diagnosis:

- **Withdrawal mimic:** Influenza, DKA, sepsis, thyrotoxicosis, etc. Treat underlyling illness.
- **Incompletely treated withdrawal:** Occurs with lower starting doses; improves with more Bup.
- **Bup side-effect:** Nausea, headache, dysphoria. Continue Bup, treat symptoms with supportive medications.
- **Precipitated withdrawal:** Too large a dose started too soon after opioid agonist.

  Usually time limited, self resolving with supportive medications.

  In complex or severe cases of precipitated withdrawal, OK to stop Bup and give short acting full agonists.

YES

Administer 2nd dose

Inpatient: 8mg. Subsequent days, titrate from 16mg with additional 4-8mg prn cravings.
ED: 8-24mg. Consider discharge with higher loading dose.

Maintenance Treatment
16 mg Bup SL/day
Titrate to suppress cravings;
Usual total dose 16-32mg/day

Discharge

- Document Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.
- **If no X-waiver:** Use loading dose up to 32mg for long effect and give rapid follow up.
- **If X-waiver:** Check CURES (not required in Emergency Department if ≤7 day prescription), prescribe sufficient Bup/Nx until follow-up.

Overdose Education Naloxone Kit
Naloxone 4mg/0.1ml intranasal spray

Buprenorphine Dosing

- Either Bup or Bup/Nx (buprenorphine/naloxone) films or tab sublingual (SL) are OK.
- If unable to take oral/SL, try Bup 0.3mg IV/IM.
- OK to start with lower initial dose: Bup 2-4mg SL.
- Total initial daily dose above 16mg may increase duration of action beyond 24 hrs.
- Bup SL onset 15 min, peak 1 hr, steady state 7 days
- May dose qday or if co-exisiting chronic pain split dosing TID/QID.

*Complicating Factors

- Altered mental status, delirium, intoxication
- Severe acute pain, trauma or planned large surgeries
- Organ failure or other severe medical illness
- Recent methadone use

**Diagnosing Opioid Withdrawal

Subjective symptoms AND one objective sign

Subjective: Patient reports feeling "bad" due to withdrawal (nausea, stomach cramps, body aches, restlessness, hot and cold, stuffy nose)

Objective: ***[at least one]*** restlessness, sweating, rhinorrhea, dilated pupils, watery eyes, tachycardia, yawning, goose bumps, vomiting, diarrhea, tremor

Typical withdrawal onset:
≥ 12 hrs after short acting opioid
≥ 24 hrs after long acting opioid
≥ 48 hrs after methadone (can be >72 hrs)

If unsure, use COWS (clinical opioid withdrawal scale). Start if COWS ≥ 8 AND one objective sign.

If Completed Withdrawal:
Typically >72 hrs since last short-acting opioid, may be longer for methadone. Start Bup 4mg q4h prn cravings, usual dose 16-32mg/day. Subsequent days, OK to decrease frequency to qday

Opioid Analgesics

- Pause opioid pain relievers when starting Bup.
- OK to introduce opioid pain relievers after Bup is started for breakthrough pain. Do not use methadone with Bup.

Supportive Medications

- Can be used as needed while waiting for withdrawal or during induction process.

Pregnancy

- Bup monoproduct or Bup/Nx OK in pregnancy.
- Consider referencing buprenorphine in pregnancy guide.

The CA Bridge Program disseminates resources developed by an interdisciplinary team based on published evidence and medical expertise. These resources are not a substitute for clinical judgment or medical advice. Adherence to the guidance in these resources will not ensure successful patient treatments. Current best practices may change. Providers are responsible for assessing the care and needs of individual patients.

NOVEMBER 2019

PROVIDER RESOURCES

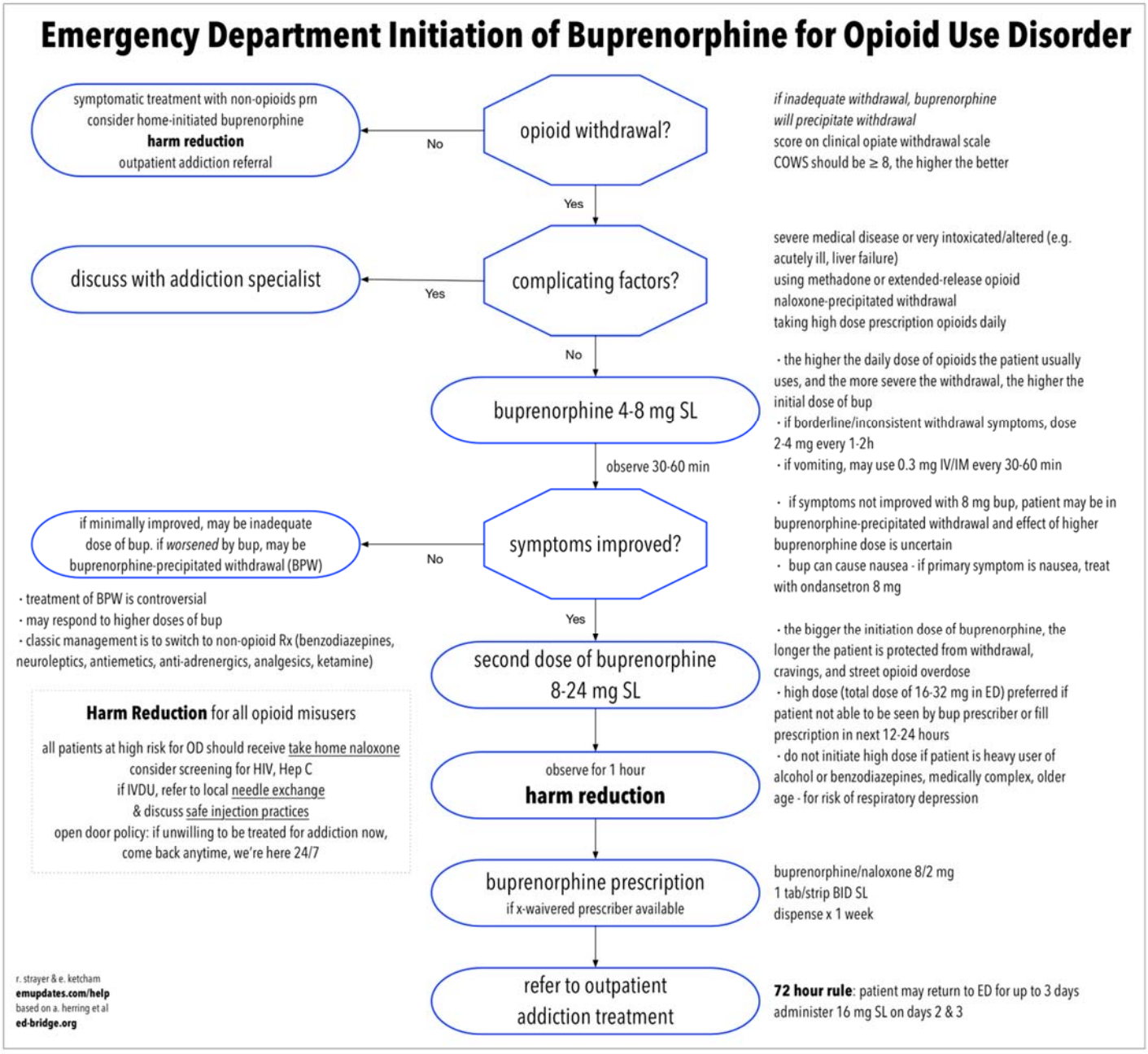
California Substance Use Line
CA Only (24/7)
1-844-326-2626

UCSF Substance Use Warmline
National (M-F 6am-5pm; Voicemail 24/7)
1-855-300-3595

Appendix G – Buprenorphine. Sample 2 ED Initiation Decision Tree

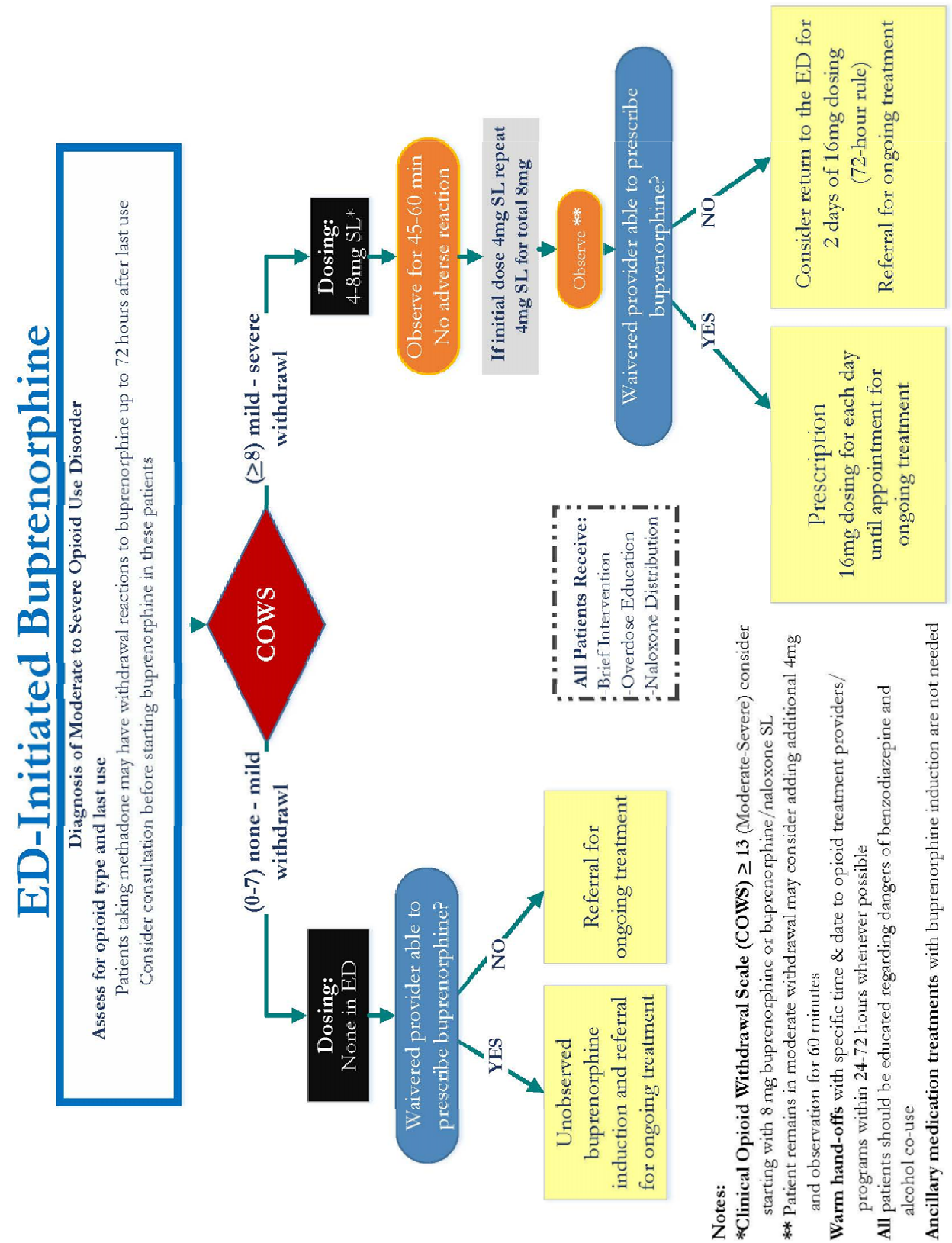
Retrieved from:

Strayer, R. J., Hawk, K., Hayes, B. D., Herring, A. A., Ketcham, E., LaPietra, A. M., ... & Nelson, L. S. (2020). Management of opioid use disorder in the emergency department: a white paper prepared for the American Academy of Emergency Medicine. Journal of Emergency Medicine, 58(3), 522-546.



Appendix H – Buprenorphine. Sample 3 ED Initiation Decision Tree

A resource from Yale School of Medicine available at
https://medicine.yale.edu/edbup/treatment/Algorithm_338052_284_42796_v2.pdf



Appendix I – Buprenorphine. Referral Form for Opioid Use Disorder

A resource from Yale School of Medicine available at https://medicine.yale.edu/sbirt/opioidusedisorders/

BUPRENORPHINE REFERRAL FORM FOR OPIOID USE DISORDER

Instructions: Buprenorphine/naloxone (brand name: Suboxone) helps treat opioid use disorder by decreasing cravings and suppressing withdrawal symptoms. When appropriate, patients with opioid use disorder should receive a prescription or first dose of buprenorphine in the hospital, along with a direct referral for buprenorphine maintenance. For referrals, please complete and fax this form to local treatment centers listed below.

Patient's Name: _____ **Date of birth**: _____/_____/_____
Phone number: (_____) _____-_____ **Date of ED visit:** _____/_____/_____
Insurance: ☐ Medicaid/Medicare ☐ Commercial ☐ Self-pay
Presented to ED with opioid overdose: ☐ Yes ☐ No

Opioid Use History:
Age of first use: _____ Primary type of opioid used: _____
Pattern of opioid use (average daily amount and frequency): _____

Substance Use History (other than opioids): Is the patient **CURRENTLY** using any of the following?

☐ cocaine ☐ PCP
☐ alcohol ☐ synthetic marijuana
☐ benzodiazepines ☐ other_____

Medical/Psychiatric History: _____
_____

Critical actions required by the Emergency Department prior to buprenorphine induction:
Urine drug screen (list positive): _____
Liver function test (must be ≤ 5x normal): _____
DSM 5 Score for opioid dependence (Score must be ≥3): _____
COWS Score (Score must be ≥8): _____

Buprenorphine started in ED: ☐ - Yes ☐ - No **Date first dose given in ED:** _____/_____/_____
Dose given: _____ Rx dose_____ Sig: _____
Number of days given (Rx):_____

Name of referring ED provider: _____

Contact number: (_____) _____-_____

Completed form sent by EHR, faxed etc. to (please check one): {List frequent referrals sites}

Note: For all treatment options include information on what insurance types are accepted and appointment times, availability or contact. Include walk in hours if available

Opioid Treatment Programs (list all in area)

Opioid Treatment Providers (list all in area)

Opioid Treatment Clinics (list all in area)

Some examples:

☐ **Opioid Treatment Program:** 203-733-1234 (phone), 203-788-5555 (fax). Note: Takes walk-ins Monday-Friday before noon; all insurance types.

☐ **Primary Care Center-** Call 204-123-3333 and leave message, note and upload form into EPIC. Patient will be seen within 3 business days, takes all insurance types

☐ **Southland Addiction Treatment Center:** Send EPIC inbox to Margaret Taft or John Page (clinic directors). Patient will be contacted with 24 hours, Medicaid or no insurance ONLY

Provide any relevant follow up capabilities e.g. Check Nurse follow up discharge box in EHR if available

Appendix J – Patient Buprenorphine/Suboxone Treatment Consent: Sample

This sample was shared by a program in Florida.

Patient Name: _____ Date: _____

Hospital/Treatment Provider SUBOXONE PARTICIPATION AGREEMENT

I, _____agree to participate in the Suboxone outpatient program provided by, Hospital/Treatment Provider. I attest to the following:

1. I will abstain from Mood altering chemicals while on the Suboxone program
2. I am not allergic to Suboxone
3. I have not nor will I ingest Methadone while on the Suboxone program

I acknowledge that my participation in this program is completely voluntary and understand I can terminate participation at any time

By signing this form, I am authorizing the above entities access to my protected health information related to this treatment.

I recognize that I can be terminated from the program for noncompliance with the above.

Signature of Patient: _____ Date: _____

Printed Name: _____

Appendix K – Memorandum of Understanding. Sample 1, Comprehensive

This sample was shared by a program in Florida.

("Agreement") is made and entered into effective as of the _____ day of _____, 20__, by and between [NOTE: Insert name of Hospital] ("Hospital"), and the [NOTE: Insert name of the Community PROVIDER] (“PROVIDER”).

WHEREAS, PROVIDER is a (non-profit corporation) with national accreditation that provides evidence-based treatment for substance use and or opioid use disorders;

WHEREAS, Hospital desires to reduce the rate of opioid or other drug overdoses through evidenced-based programs provided by PROVIDER and PROVIDER desires to provide evidence-based programs to Hospital patients/former patients/consumers (“consumers”) in a manner under the terms and conditions set forth in this document;

WHEREAS, PROVIDER desires and has the capacity to provide evidence-based programs and services to individuals with substance use or opioid use disorders who are stabilized through emergency medicine provided by the hospital;

WHEREAS, Hospital desires to improve health outcomes and reduce readmissions to Hospital that can be avoided in the interest of improving consumer health and welfare and reducing the cost of consumer care to consumers and to the health care system generally;

(option) WHEREAS, in order to accomplish those objectives, Hospital agrees to allow the use of a certified peer support specialist who is (employed by the Hospital, contracted through a third party, provided by the PROVIDER) to facilitate a transition of care to a PROVIDER for the delivery of evidence-based programs and services;

(option) WHEREAS, in order to accomplish those objectives, Hospital agrees to incorporate (nurse navigators or social workers) to contact PROVIDER staff to facilitate a transition of care to THE PROVIDER for the delivery of evidence-based programs and services; and

WHEREAS, Hospital and PROVIDER desire to set forth the terms of their agreement to provide evidence-based services according to the PROVIDER Evidence-Based program outlined in this Agreement in Exhibit A.

NOW, THEREFORE, Hospital and PROVIDER, in consideration of mutual covenants and promises of the parties, promise and agree as follows:

1. Term of Agreement. The term of this Agreement will begin on the date executed and continue in full force and effect until _____ [NOTE: insert time period] ("Initial Term") at which point the Agreement shall terminate unless extended by mutual agreement of the parties.
2. Termination. This Agreement may be terminated by either party at any time in writing with at least seven (7) days notification.:
3. Evidence-Based Services. Hospital hereby agrees to facilitate a transition of care for patients treated through emergency medicine for an opioid or drug overdose to PROVIDER to provide evidence-based treatment and services for substance use or opioid use disorder.
4. Representations by PROVIDER. PROVIDER hereby represents and warrants that: It is a non-profit corporation in good standing and licensed in the State of Florida to provide treatment and services for individuals with substance use or opioid use disorders.

   Explanatory Notes:
   i. PROVIDER employs professional staff and licensed or credentialed behavioral health workers that will perform services hereunder and that its employment of such personnel in its current model of organization is in compliance with the laws of the State of Florida.

ii. The services being provided as a part of PROVIDER's evidence-based programs, as defined in Exhibit A, are reimbursable by Medicare, Medicaid, other medical insurance programs, or state resources under identified billing codes.

5. Insurance and Indemnification.
   a. Professional Liability Insurance. PROVIDER agrees to provide general professional liability insurance for all PROVIDER staff members that will participate in the delivery of evidence-based program services and maintain at its own expense. PROVIDER's liability insurance policy shall cover all staff members providing services on behalf of PROVIDER hereunder and other PROVIDERs for all professional services performed by or on behalf of PROVIDER under this Agreement. PROVIDER agrees to deliver promptly to Hospital a copy of its certificate of insurance, and upon receipt, a copy of any notice of claim against PROVIDER involving its liability insurance; change or modification to the terms and conditions of PROVIDER's liability insurance that impact the ability to provide evidence-based services at the Hospital.
   b. Worker's Compensation Insurance. PROVIDER agrees to obtain and maintain worker's compensation insurance for PROVIDER employees as required by Florida law.
   c. General Liability Insurance. PROVIDER agrees to obtain and maintain a general liability insurance policy. PROVIDER's liability insurance coverage will remain in full force and effect for the entire period that PROVIDER provides the services defined in this agreement to Hospital.
   d. Proof of Insurance. Within ten (10) days of the execution of this Agreement, PROVIDER agrees to provide Hospital with applicable certificates of insurance with respect to all insurance policies required under this Agreement.
   e. PROVIDER Indemnification. PROVIDER shall indemnify and hold Hospital harmless from any and all claims, administrative investigations, actions, liability, fines, penalties and expenses (including, without limitation, costs of investigations, judgments, settlements, court costs and attorney's fees, regardless of the outcome of such claim or action) caused by, resulting from or alleging negligent, intentional or willful acts or omissions by PROVIDER, or any person acting on behalf of PROVIDER, in the performance of any duty or obligation imposed on the other, the breach of any representation or warranty, or any failure to comply with any obligation in this Agreement. PROVIDER shall have responsibility for the actions or omissions of any person performing services on behalf of PROVIDER under this Agreement. Upon notice from Hospital, PROVIDER will resist and defend the action at its own expense. Notwithstanding the foregoing, PROVIDER shall have the right to defend Hospital. PROVIDER's selection of counsel shall be with the advice of Hospital.
   f. Hospital Identification. Hospital shall indemnify and hold PROVIDER harmless from any and all claims, administrative investigations, actions, liability, fines, penalties and expenses (including, without limitation, costs of investigations, judgments, settlements, court costs and attorney's fees, regardless of the outcome of such claim or action) caused by, resulting from or alleging negligent, intentional or willful acts or omissions by Hospital, Hospital's employees, or any person acting on behalf of Hospital, in the performance of any duty or obligation imposed on the other, the breach of any representation or warranty, or any failure to comply with any obligation in this Agreement. Hospital shall have responsibility for the actions or omissions of any person performing services on behalf of Hospital under this Agreement. Upon notice from PROVIDER, Hospital will resist and defend the action at its own expense. Notwithstanding the foregoing, Hospital shall have the right to defend PROVIDER at its cost and expense with counsel of its selection. Hospital's selection of counsel shall be with the advice of PROVIDER.

6. Licenses, Certifications, and Registrations. Any employee or agent retained by PROVIDER to perform services pursuant to this Agreement must be licensed, certified or registered, as appropriate, for their area of professional experience as required by Florida law. PROVIDER shall provide Hospital proof of licensure, certification or registration for each PROVIDER employee or agent who performs services pursuant to this Agreement.

7. PROVIDER Staff. If Hospital is dissatisfied with any staff provided by PROVIDER, either as an employee or agent, Hospital will provide PROVIDER with written notice of the reasons for its dissatisfaction with the individual. PROVIDER will attempt to address Hospital's concerns. If Hospital's concerns cannot be resolved within a reasonable time period, Hospital may require PROVIDER to discontinue the use of that individual in providing services under the Agreement.

8. Consumer Grievances. If requested by Hospital, PROVIDER agrees to cooperate in responding to all consumer complaints and grievances, directed to the hospital, regarding any evidence-based program provided by PROVIDER.

9. Confidentiality. Each Party agrees to comply with the 42 C.F.R. Part 2 Confidentiality of Substance Use Disorder Patient Records, Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d ("HIPAA"), and any current and future regulations promulgated thereunder, including without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Part 142 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162, all collectively referred to herein as "HIPAA Requirements." Neither Party shall use nor further disclose any Protected Health Information (as defined in 45 C.F.R. § 164.501) or Individually Identifiable Health Information (as defined in 42 U.S.C. § 1320d), other than as permitted by 42 C.F.R Part 2, HIPAA, and the terms of this Agreement. Each Party shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the extent required for determining compliance with the Federal Privacy Regulations.

10. PROVIDER Reports to Hospital. PROVIDER will provide Hospital monthly reports containing an analysis of services provided under the Agreement.

11. Independent Contractor. The Parties agree that PROVIDER is an independent contractor to Hospital and at all times shall be performing as an independent contractor. Nothing contained in this Agreement is intended to or shall be construed to create an agency relationship or a joint venture relationship between the parties to the Agreement and their respective employee, agents and assigns. Hospital shall not have any control over the manner or method by which PROVIDER performs professional duties or responsibilities, provided, however, that PROVIDER shall render services in accordance with the Agreement, the bylaws, rules and regulations, standards and policies of Hospital and Medical Staff; as applicable. It is the sole responsibility of the hospital to provide any referenced regulatory or compliance documents to PROVIDER for review.

12. Proprietary and Confidential Information.
    a. For Purposes of this Agreement "Proprietary Information" shall mean any proprietary information relating to the business of PROVIDER or Hospital that has not previously been publicly released by duly authorized representatives of PROVIDER or Hospital, respectively, and shall include (but shall not be limited to) information encompassed in all proposals, marketing and sales plans, financial information, costs, pricing information, computer programs (including without limitation source code, object code, algorithms and models), customer information, customer lists, consumer information, consumer lists, consumer records and all methods, concepts, know-how or ideas in or reasonably related to the business of PROVIDER or Hospital.
    b. Hospital and PROVIDER agree to regard and preserve as confidential all Proprietary Information, whether it has such information as a memory or in writing or other tangible or intangible form. Hospital and PROVIDER will not, without written authority from the other Party to do so, directly or indirectly, use for its benefit or purposes, nor disclose to others, either during the term of this Agreement or thereafter, any Proprietary Information except as required by the conditions of this Agreement or pursuant to court order in which case the respective Party shall give the other prompt written notice so that the affected Party may seek a protective order or other appropriate remedy and/or waive compliance with the provisions of this Agreement. Hospital and PROVIDER agree not to remove from the premises of the other respective Party, except as specifically permitted in writing, any document or object containing or reflecting any Proprietary Information. Hospital and PROVIDER recognize that all such documents and objects, whether developed by PROVIDER or Hospital, are the exclusive property of the creator. In addition, any Proprietary Information is retained as the exclusive property of the organization that provided the Proprietary Information. Proprietary Information shall not include information which is presently in the public domain or which comes into the public domain through no fault of Hospital or PROVIDER or which is disclosed to Hospital or PROVIDER by a third Party lawfully in possession of such information with a right to disclose it.
    c. PROVIDER agrees that during and after the term of the Agreement its directors, officers, employees, agents and consultants will not without authorization from Hospital, divulge, disclose or otherwise communicate to any person or company any confidential or Proprietary Information pertaining to Hospital's business, functions, or operations, products, services, plan strategies, financial performance, customers, consumers, employees, or

contracts (collectively, "Confidential Information"), except in connection with the discharge of its duties hereunder, or pursuant to the order of a court of competent jurisdiction. . Subject to such record keeping and documentation requirements imposed by law, PROVIDER further agrees that upon termination of the Agreement with Hospital, PROVIDER will promptly return to Hospital all books and records of or pertaining to Hospital's business, and all other property belonging to Hospital which is in its custody or possession.

d. All documents, records, data, equipment and other physical property, whether or not pertaining to Proprietary Information, which are produced by and furnished to Hospital by PROVIDER or produced by and furnished to PROVIDER by Hospital will be and remain the sole property of the Party who produced and furnished the information. Each Party will return to the other promptly all such materials and property upon the termination of this Agreement or sooner if requested by either Party.
e. The Parties expressly agree that the covenants set forth in this section (Section 12 of this Agreement) are being given to PROVIDER and Hospital in connection with the Agreement and that such covenants are intended to protect Hospital and PROVIDER against competition by the other Party, within the terms stated, to the fullest extent deemed reasonable and permitted in law and equity. In the event that the foregoing limitations upon the conduct of the Parties are beyond those permitted by law, such limitations, both as to time and geographical area, shall be, and be deemed to be, reduced in scope and effect to the maximum extent permitted by law.

13. Injunctive Relief. The Parties acknowledge that the injury to each by the other from any violation of any of the covenants contained in this Agreement will be of such a character that it cannot be adequately compensated by money damages, and, accordingly, the Parties may, in addition to pursuing other remedies, obtain any injunction from any court having jurisdiction of the matter restraining any such violation.

14. Notices. All notices, requests, demands, and other communications required or permitted hereunder shall be in writing and shall be deemed to have been duly delivered if delivered in person or sent by registered or certified, first class mail, postage prepaid to:

Hospital: HOSPITAL/HEALTH PLAN NAME ADDRESS CITY, STATE, ZIP CODE
Attention: _____

PROVIDER: ORGANIZATION NAME ADDRESS CITY, STATE, ZIP CODE
Attention: _____

Either Party may from time to time change said address by written notice to the other Party, given as above provided.

15. Governing Law. This Agreement will be governed by the laws of the State of Florida.

16. Entire Agreement. This Agreement contains the entire agreement between the parties with respect to the transactions contemplated in this Agreement and supersedes all previous representations, negotiations, commitments, and writing with respect to those transactions. No change or amendment of any of the terms or provisions of this Agreement shall be binding unless in writing and signed by the Party against whom the same is sought to be enforced.

17. Severability. The provisions of this Agreement are severable. If any court of competent jurisdiction determines that any provision of this Agreement is invalid or unenforceable, then such invalidity or unenforceability shall have no effect on the other provisions hereof, which shall remain valid, binding and enforceable and in full force and effect, and such invalid or unenforceable provision shall be construed in a manner so as to give the maximum valid and enforceable effect to the intent of the parties expressed.

18. Waiver of Breach. The waiver by any Party to this Agreement of a breach of any provision of this Agreement shall not operate or be construed as a waiver of any subsequent breach by any of the parties to this Agreement.

19. Amendment or Alteration. No amendment or alteration of the terms of this Agreement shall be valid unless made in writing and signed by all of the parties to this Agreement.

20. Gender. Pronouns in any gender shall be construed as masculine, feminine, or neuter as the context requires in this Agreement.

21. Counterparts. This Agreement may be executed in any number of counterparts (including facsimile counterparts), each of which shall be an original, but all of which together shall constitute one instrument.

IN WITNESS WHEREOF, the parties below have executed this Agreement effective as of the date and year written on Page One (1) of this document.

[NOTE: Insert PROVIDER Name]
By: Printed Name: [Insert] Printed Title: [Insert]

[NOTE: Insert Hospital Name] By: Printed Name: [Insert]
Printed Title: [Insert]

EXHIBIT A EVIDENCE-BASED PROGRAMS
PROVIDER will provide evidence-based programs intended to improve the health outcomes of community residents and Hospital consumers. The following Evidence-Based Programs will be provided by PROVIDER, according to a schedule determined by PROVIDER and agreed upon by Hospital. [NOTE: List the services to be provided under this Agreement; the listing below is a SAMPLE only]

1. Peer Recovery Support Services
2. Behavioral Health Assessments by Qualified Professional

Care Transitions
It is the sole responsibility of PROVIDER to maintain current licensure agreements to offer and deliver the evidence-based programs covered by this Agreement. All staff training requirements are also the sole responsibility of PROVIDER. If Hospital wishes to have PROVIDER staff or contract members participate in the training, PROVIDER must agree. Hospital staff members must receive training on substance use disorders and implementation set forth in Exhibit C.

EXHIBIT B BUSINESS ASSOCIATE AGREEMENT
A Business Associate Agreement is required to comply with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). You can consult the following reference for more information regarding meeting the mandates of the HIPAA legislation, and then include your applicable agreement here as

Exhibit B:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

EXHIBIT C:
Process for implementing a warm hand off program from Hospital to PROVIDER.
Insert process here as agreed to by both parties.

Appendix L – Memorandum of Understanding. Sample 1, Simple

This sample was shared by a program in Florida.

THIS MEMORANDUM OF AGREEMENT is between *facility* and *provider*.

WHEREAS, both parties agree to coordinate resources to the best of their respective abilities in order to provide health services to patients within their service area.

NOW THEREFORE, for and in consideration of the benefits set forth, and for other good and valuable considerations, it is agreed among the Parties as follows:

1. Professional Liability Insurance

2. Services: *list services to be provided by the provider to the facility*

3. Services provided by: i.e. *Peer Recovery Specialist*

4. Scope of Services: *list of services provided by provider*

IN WITNESS THEREOF, the parties hereto have hereunto executed this instrument for the purpose herein expressed, the day and year written below.

ACCEPTED:

Provider

BY: _____ DATE: _____

Facility

BY: _____ DATE:_____

Appendix M – Peer Specialists. Tips for Hiring a Peer Recovery Specialist

These tips were excerpted from the Peer Support Toolkit published by the City of Philadelphia, Department of Behavioral Health and Intellectual Disability Services.

The Peer Support Toolkit is an interactive PDF that presents key information in brief reads, yet preserves the opportunity to delve deeper into subjects. The toolkit is organized in four modules, each addressing specific implementation issues relevant to agencies in various stages of integrating peer support services:

Module 1: Preparation
Module 2: Interviewing & Hiring
Module 3: Service Delivery
Module 4: Supervision & Retention

The complete toolkit is available at https://dbhids.org/wp-content/uploads/1970/01/PCCI_Peer-Support-Toolkit.pdf

Recruiting and Hiring Peer Staff

For the most part, the process for recruiting and hiring peer staff will be very similar to that used to hire other agency staff. Given their unique roles, however, there are important differences.

Practice 1. Expand Your Typical Search Activities

Consider posting the position at in different venues such as advocacy organizations, civic/nonprofit organizations, recovery ministries, online recovery support communities including bloggers and advocates, peer-run programs, faith communities, outreach events, treatment alumni groups, and youth centers.

Practice 2. Involve Non-Peer Staff and Organizational Leaders Throughout the

Practice 3. Write a Detailed Job Description

Providing clarity about the specific functions associated with the employment opportunity will minimize the number of applicants who are not a good fit and expedite the hiring process.

Be Clear about the Centrality of "Lived Experience"

The job posting need to explicitly address the applicant's comfort with sharing their own recovery story to engage, support, and inspire others

Practice 4. Define Optimal Peer Staff Qualifications

Consider the populations to be served and align the peer experience. For example, if the agency provides MAT, a peer with lived experience using MAT.

Practice 5. Include People Using Services on the Hiring Committee

Practice 6. Ensure that Hiring Staff Understand Relevant Employment Laws

Practice 7. Ensure that Hiring Staff Understand that Questions Related to Disability Cannot Be Asked During the Interview and Hiring Process

Practice 8. Use a Range of Interview Formats

Practice 9. Hire More Than One Peer Staff

Research indicates that having only one peer recovery specialist makes it extremely difficult to identify the organizational issues that inhibit their successful integration, as problems that arise are likely to be attributed to that individual rather than to the organizational culture.

Practice 10. Identify an Executive Champion

The executive champion understands and values the role of peer recovery specialist and is willing to advocate peer services at the executive level.

Practice 11. Offer Competitive Pay and Other Benefits

Practice 12. Ensure that Peer Staff Have Access to Resources

Practice 13. Understand and Manage Accommodations for Employees with Disabilities

Practice 14. Support Successful Candidates in Navigating Issues Related to Entitlements and Health Insurance

Practice 15. Create a Positive Onboarding Experience

During orientation, it will be important to expose the new Peer Recovery Specialist to as many facets of the organization as possible. In the initial days of employment, they may benefit from shadowing other members of their team to better understand their work context, their role and the roles of others, and opportunities for collaboration

Appendix N – Peer Specialists. Sample Job Descriptions

This is a collection of peer job descriptions from a number of hospitals that have implemented some version of a warm handoff. The name of the hospital and its location is included as a reference.

Shipley Cardiothoracic Center (Lee Health, Ft. Myers)

A Certified Recovery Peer Specialist (CRPS) helps to ensure client directed care by assisting people to build the skills and relationships needed to achieve and maintain recovery from substance use and/or mental health conditions. The CRPS achieves this goal by using their lived experience and professional preparation to mentor, monitor, and motivate others to achieve recovery. All tasks must reflect the perspective of the person served, meaning the CRPS must apply their skills to meet the individual needs of the client from where he or she is in recovery.

Requirements:
Education: High School or equivalent

Experience:
State of Florida Licensure Requirements: Valid Florida driver's license
Certifications/Registration Requirements: BLS and First Aid Certification within 90 days of hire, must pass background and fingerprinting checks. Eligibility for CRPS Provisional certification required

Other:
The CRPS has demonstrated competency through training and experience in the performance domains of:

- Advocacy
- Mentoring
- Recovery Support
- Professional Responsibility

Washington Hospital Center (Washington, DC)

Provides non-clinical services intended to aid patients in establishing recovery from high risk of dependent alcohol and drug use problems. Works with a team at MedStar Washington Hospital (MWHC) Center that provides peer support and motivation to encourage patients who are seeking treatment for alcohol or drug dependency and addiction issues. Assists in completing referrals to treatment services and developing service plans to promote successful linkage to treatment services. Services will be provided at MWHC with appropriate follow-up; and patient's nurse must be notified before visiting the patient.

Education:

- High School Diploma/GED required**.**

Experience:

- Actively in recovery with a minimum of two years of professional experience in a substance use disorder setting providing peer support/navigation; and/or Certified Peer Specialist through the DC Department of Behavioral Health; and/or a Recovery Coach.

Certification/Registration/Licensure:

- Peer Recovery Specialist certification preferred or preferably attained within 6 months of hire.

Howard University Hospital (Washington, DC)

The OSOP Community Recovery Coach is an integral part of the SBIRT team that is designated to conduct outreach and engagement to survivors of an opioid overdose after discharge and referral from the emergency department. This individual provides non-clinical services intended to aid patients in establishing recovery and reducing the risk associated with a subsequent overdose. The OSOP Community Recovery Coach will assist in completing referrals to recovery support and substance use treatment services as well as developing service plans to promote successful linkage to referred services. Services will primarily be provided in the community, however, the Coach may meet patients in the ED to assure successful continuity in care.

Essential Duties and Responsibilities

- Conducts street outreach to locate and engage with patients referred from hospital emergency departments.
- Conducts screenings to understand the patient's history of drug and/or alcohol use, treatment history, social service and other recovery support needs and motivation to change behavior.
- Facilitates patient's readiness for change and uses motivational interviewing techniques and other communication skills to support and encourage the patient to plan for reduction or elimination of drug and alcohol use.
- Assists patients in setting personal recovery goals.
- Works with healthcare team and patient to identify community supports and treatment services to promote recovery.
- Supports patients and families to understand how to access community resources.
- Assists patients in linking to community supports and treatment services, including helping secure transportation and other resources.
- Acts as a peer support after patient is discharged from the hospital. This involves face-to-face and phone engagement with patients in various community settings.
- Provides family members with recovery support materials.
- Provides education on risks of overdose and assures that patient and significant others have naloxone and are trained to use.
- Completes required reports and other necessary documentation accurately.

Qualifications:

High school diploma or G.E.D. is required. The candidate must be actively engaged in his/her own recovery with a minimum of two years demonstrated personal recovery experience from alcohol and/or drug use. The incumbent must be able to read, interpret documents and write routine reports. Basic computer skills are required. The OSOP Community Recovery Coach must demonstrate excellent interpersonal skills, the ability to relate to patients and health professionals, as well as good problem-solving skills. In addition, the candidate must demonstrate a willingness to learn and an interest in acquiring new skills. The incumbent should have a minimum of two years of professional experience in a substance use disorder setting providing peer support/navigation; and/or Certified Peer Specialist through the DC Department of Behavioral Health; and/or a Recovery Coach. Candidate must also have reliable transportation and valid driver's license.

Howard University Hospital/Emergency Department (Washington, DC)

The Peer Recovery Coach provides non-clinical services intended to aid patients in establishing recovery from high risk of dependent alcohol and drug use problems. The Peer Recovery Coach will work as part of the Emergency Department team to provide peer support and motivation to encourage patients who are seeking treatment for alcohol or drug dependency and addiction issues. The Peer Recovery Coach will assist in completing referrals to treatment services and developing service plans to promote successful linkage to treatment services. Services will be provided in the Emergency Department with appropriate follow-up.

Education/Experience:
High school diploma or G.E.D. is required. The candidate must be actively engaged in his/her own recovery program with a minimum of three years demonstrated personal recovery and sustained abstinence from alcohol and/or drug use.

License/Certification/Registration:
Actively in recovery with a minimum of two years of professional experience in a substance use disorder setting providing peer support/navigation; and/or Certified Peer Specialist through the DC Department of Behavioral Health; and/or a Recovery Coach.

Skills:
The Peer Recovery Coach must demonstrate excellent interpersonal skills, the ability to relate to patients and health professionals, as well as an ability to develop professional working relationships with partner agencies. The candidate must possess excellent listening, verbal and written communication skills, as well as good problem-solving skills. The incumbent must be able to read, interpret documents and write routine reports. Basic computer skills are required. In addition, the candidate must demonstrate a willingness to learn and an interest in acquiring new skills.

Primary Duties and Responsibilities:

- Conducts brief interventions to patients that screen positive for alcohol and/or drug use.
- Identifies patient's history of drug/alcohol use, treatment history, motivation to change behavior and other needs for community support services.
- Identifies patient's readiness to change and use motivational interviewing techniques and other communication skills to support a plan for reducing or eliminating harmful drug and/or alcohol use.
- Works with ED staff and social worker to identify community support services.
- Assists patient and family with understanding how to utilize these community services.
- Assists patients in linking to community support services and substance treatment services including securing appointment and transportation.
- Acts as a peer support throughout the hospitalization and post-discharge, as appropriate to facilitate attainment of goals.
- Provides family members with recovery support materials.
- Provides telephone outreach to patients to assist with linkages and continued peer support.
- Models coping techniques and self-help strategies.
- Participates in trainings to continually gain new skills.
- Attends required staff and other meetings.
- Completes required documentation and other reports.
- Acts as a resource to other clinical team members on recovery support.
- Consults with nursing staff, social work as requested, even if patient does not screen positive.
- Notifies patient's nurse before visiting the patient.
- Telephones treatment providers to verify patient showed up for appointment; and follow-up by telephone with any patient that misses an appointment.

Presbyterian Medical Center (Charlotte, NC)

The Peer Support Specialist-Hospital position is held by a team member who is or has been a recipient of mental health and/or substance abuse services. Due to their lived experience, they provide expertise with recovery, wellness self-management, self-advocacy, and resilience and share that expertise with colleagues and patients. The peer support specialist provides one to one peer mentoring with current patients in the behavioral health services of Novant Health system as well as group supports providing education, guidance, role modeling, and advocacy to promote the recovery of each patient.

The peer support specialist works as a fully integrated member of an interdisciplinary team. This position serves as a role model and recovery consultant with colleagues by providing essential expertise within the team to promote a culture in which each patient's point of view, preferences and needs are recognized, respected, understood, and integrated into treatment planning and rehabilitation services.

Qualifications

Education: High school diploma required.

Experience: A minimum of three years of experience in a professional, volunteer, or advocacy position in a human service related program preferred.

Licensure/certification/registration: Possess current NC PSS Certification required.

Additional skills required

- Must be a self-identified consumer of mental health and/or substance abuse services.
- Be able to share their personal history of recovery.
- Must be at least 21 years of age.
- Must submit to a criminal background screening.
- Must be able to maintain the highest level of ethical standards/boundaries and professional relationships.
- Must be able to avoid dual relationships with patients outside healthcare setting.
- Must possess good oral and written communication skills.
- Ability to interface with peers, colleagues, service providers, family members and community members in an empathic, professional manner.
- Presentation skills to large and small groups on mental health related topics, including sharing personal journey of recovery.
- Ability to represent Novant Health with a high level of professionalism in the workplace and in the community.
- Creativity, flexibility, and a positive support approach.
- Ability to remain solution focused.
- Ability to work independently and as part of a team.
- Ability to manage time, complete tasks accordingly, and be dependable and reliable.
- Possess understanding, belief, and commitment to the recovery process.
- Ability to resolve conflict, problem solve and respond calmly and appropriately under pressure.
- Possess excellent interpersonal skills, active and reflective listening, conflict resolution, mediation and negotiation skills, and demonstrated self-help skills.
- Ability to motivate and inspire others and promote self- advocacy.
- Ability to advocate on behalf of and with others.
- Ability to exercise discretion in handling confidential information.
- Ability to exercise sound judgment.
- Establish and maintain trusting relationships, show compassion, dignity, and respect.
- Have a clear sense of personal and professional limits and ability to communicate them to others including supervisor, colleagues, and peers.
- Willingness to utilize a Wellness Recovery Action Plan (WRAP) in daily life.
- Ability to use or learn computer software (Microsoft Word, Excel, and email programs).
- Ability to work variable shifts, including day, evening and weekends as needed. Knowledge of community resources, coping skills, and advocacy techniques.

Appendix O – Peer Specialists. Sample Job Announcement

These are sample job ads posted in Indeed.com. They were identified using the search term “Peer support Specialist”.

Job Announcement: Peer Support Specialist

This is a professional position and requires 2 years of lived recovery from substance use and/or mental health disorder, in which the incumbent provides non-clinical, evidence-based support services within the different locations by performing tasks designed to assist patients in wellness and recovery to promote self-advocacy. Under the supervision of the Recovery Connection Program Manager, the Recovery Support Specialist (RSS)/Recovery Peer Specialist (RPS) will serve as an advocate and function as a role model to peers; exhibiting competency in personal recovery and use of coping skills. The PSS is responsible for establishing a rapport with overdose survivors as well as to teach, lead, and mentor individuals to reach personal wellness and recovery goals. Incumbent will promote social learning through experiences; encourage patients to develop independent behaviors that are based on choice rather than compliance. Incumbent will assist patients to establish life skills, including personal care and social responsibility habits. They will assist patients to establish/reestablish and maintain healthy interpersonal relationships. Incumbent will help the patient develop an understanding of the holistic approach to wellness/recovery, which includes physical, mental, spiritual, and social wellness. Help the patient’s access information and resources necessary to make informed decisions to positively affect the patients’ overall wellness and recovery. Assist and motivate patients to navigate the array of services available to achieve and maintain recovery. Engage and assist patients to move through the stages of recovery and develop recovery and social capital.

QUALIFICATIONS:

Incumbent must have a High School diploma, GED or equivalent. Incumbent must be a Certified Recovery Peer Specialist through the Florida Certification Board Licensure or the ability to complete certification within first year of employment. This position will require the incumbent to drive to various locations so they must have a valid state of Florida driver’s license with safe driving record based on the agency’s insurance company. Be able to pass an agency driving test to drive a company vehicle to facilitate outings and events.

- Must be able to pass a level II DCF background screening
- Must be able to perform assigned work independently with minimal supervision
- Ability to relate to adolescents, adults, families, referral sources and internal Team Members and must possess requisite competencies to effectively understand and provide appropriate services to the patient population served
- Ability to maintain positive team approach
- Ability to work in fast-paced environment under stress situations
- Must have knowledge of the 12-step recovery process

Our agency is an Equal Opportunity Employer. It does not discriminate on the basis of race, religion, color, sex, gender identity, sexual orientation, age, non-disqualifying physical or mental disability, national origin, veteran status or any other basis covered by appropriate law. All employment is decided on the basis of qualifications, merit, and business need.

This Job Is Ideal for Someone Who Is:

- Dependable -- more reliable than spontaneous
- People-oriented -- enjoys interacting with people and working on group projects
- Adaptable/flexible -- enjoys doing work that requires frequent shifts in direction
- Detail-oriented -- would rather focus on the details of work than the bigger picture
- Achievement-oriented -- enjoys taking on challenges, even if they might fail
- Autonomous/Independent -- enjoys working with little direction
- Innovative -- prefers working in unconventional ways or on tasks that require creativity
- High stress tolerance -- thrives in a high-pressure environment

If you require alternative methods of application or screening, you must approach the employer directly to request this as Indeed is not responsible for the employer's application process.

Job Announcement: Senior Human Service Program Specialist

This position is for a Certified Peer Specialists. Certification through the Florida Certification Board can be obtained within one year of employment. The incumbent must be a person in recovery (e.g. "be a self-identified current or former user of mental health or co-occurring services who can relate to others who are now using those services").

Certified Peer Specialists work from the perspective of their lived experience to help build environments encouraging to recovery and will publicly share their recovery story for the purpose of educating, role modeling, and providing hope to others about the reality of recovery to others. They encourage hope, personal responsibility, empowerment, education, and self-determination in the communities where they serve. The incumbent will assist others in skill-building, problem-solving, individual sessions, peer support groups, and building self-directed recovery tools with the focus on supporting others in developing their recovery goals, and specific steps to reach those goals.

Examples of Tasks:

- Assist clients in articulating personal goals for recovery using one-to-one and group sessions
- Support vocational choices
- Recognize and document identified person-centered strengths, needs, abilities, and recovery goals; interventions to assist the client with reaching their goals for recovery; document progress made toward goals on the Recovery Plan.
- Utilize tools such as the Wellness Recovery Action Plan (WRAP) to assist clients in creating their own individual wellness and recovery plans.
- Assist clients in working with their case manager or treatment team in determining the steps he/she needs to take in order to achieve these goals and self-directed recovery.
- Attend treatment team meetings to promote consumer's use of self-directed recovery tools.
- Support staff in identifying program environments that are conducive to recovery; lend their unique insight into mental illness and what makes recovery possible.
- Assist in obtaining services that suit that individual's recovery needs by providing Community resources
- Support FSH's Recovery Oriented Systems of Care (ROSC) initiative by attending meetings, trainings, being an active participant, and building community partnerships.
- Advocate for change against policy that does not promote person centered treatment decisions.
- Maintain current training by the facility and increases knowledge of best practices and new techniques for service delivery. Provide role modeling and training for other staff as directed by supervisor.
- Other duties related to peer services within the Hospital setting

Knowledge/Skills/Abilities

- Knowledge of and ability to demonstrate The Substance Abuse and Mental Health Service Administration (SAMHSA) 10 guiding principals
- Knowledge of and ability to demonstrate Core Competencies for Peer Workers in Behavioral Health Science
- Knowledge, skills, and ability to use active listening and de-escalation techniques with individuals in various settings
- Ability to self disclose lived experience of a psychiatric diagnosis, extreme emotional states and/or trauma
- Ability to independently interview individuals to identify strengths, needs, abilities and preferences.
- Ability to prepare reports.
- Ability to plan, organize and coordinate work assignments.
- Ability to write progress reports/notes.
- Ability to communicate effectively.
- Ability to use computer, i.e., word processing
- Ability to establish and maintain effective working relationships with others.

Education/Certification

- High school diploma or equivalent
- Certification as a Peer Specialists through the Florida Board of Certification

- Applicants can become Certified within one year of employment

Background Screening Requirement: It is the policy of our entity that any applicant being considered for employment must successfully complete a State and National criminal history check as a condition of employment before beginning employment, and, if applicable, also be screened in accordance with the requirements of Chapter 435, F.S., and Chapter 408, F.S. No applicant may begin employment until the background screening results are received, reviewed for any disqualifying offenses, and approved by the Agency. Background screening shall include, but not be limited to, fingerprinting for State and Federal criminal records checks through the Florida Department of Law Enforcement (FDLE) and Federal Bureau of Investigation (FBI) and may include local criminal history checks through local law enforcement agencies.

Our entity is an Equal Opportunity Employer/Affirmative Action Employer and does not tolerate discrimination or violence in the workplace.

Candidates requiring a reasonable accommodation, as defined by the Americans with Disabilities Act, must notify the agency hiring authority and/or People First Service Center (1-866-663-4735). Notification to the hiring authority must be made in advance to allow sufficient time to provide the accommodation.

Our entity supports a Drug-Free workplace. All employees are subject to reasonable suspicion drug testing in accordance with Section 112.0455, F.S., Drug-Free Workplace Act.

Appendix P – Patient Authorization for Consultation with Peer Support Specialist

This sample was shared by a program in Florida.

Patient Name: _____ Date: _____

Assistance Available:

The Peer Support Specialist is available to assist patients that have experienced an overdose, or who have evidence of opioid use disorder/opioid withdraw symptoms, and provide peer support, education and information about local treatment services. The program is designed to provide a smooth and safe transition into available treatment services to reduce future overdoses and increases the number of individuals willing to access treatment.

This is not a condition of treatment for services received at, Facility name, and is completely voluntary. Consenting to a consult with a Peer Support Specialist will disclose your substance use to the Peer Support Specialist. Please be advised, treatment provider's name and the Peer Support Specialist will be provided at no cost to you and in no way automatically constitutes an agreement on your part to enter into any specific treatment program.

Authorization for Interview by Peer Counselor: Before the Peer Support Specialist can speak with you; we are required to have your authorization for the interview

I hereby voluntarily,

- o Agree
- o Refuse

To be visited by a Peer Specialist from treatment provider's name. I understand that if I agree, I will be contacted/visited by treatment provider's name Peer support Specialist assigned to facility's name.

This authorization shall expire upon your discharge from the, name of Hospital, Emergency Department.

Signature of Patient: _____ Date: _____

Printed Name: _____

Appendix Q – Patient Behavioral Contract

A resource from Lee Health located in Fort Myers, Florida.

Behavioral Contract

While Lee Health is committed to delivering quality and comprehensive care to the substance abuse patient we also feel that patients must be actively involved in the program and be responsible for their own recovery. Lee health will offer support through an interdisciplinary approach and staff will strive to provide a caring and therapeutic environment to facilitate recovery. I understand that I must be actively willing to participate and agree to follow the rules and regulations that will help to ensure my own safety as well as that of other patients, visitors and staff.

During your treatment, you accept responsibility as a patient to provide accurate and complete information about medications, hospitalization and any matter related to your health.

Your plan of care Includes agreeing and adding your initials to the following:

_____ **I agree to being weaned off any narcotics,** not including maintenance therapy.
I understand narcotics or other potentially addicting substances (such as benzodiazepines) will NOT be reordered (unless necessitated by a change in condition, at which time the plan of care will be updated according to individual patient needs}.

_____ **I agree to attend any support group meetings** and educational classes that may be offered/conducted in the hospital that are available to inpatients related to recovery (Narcotics Anonymous, etc.). I agree to participate in the therapy and counseling that is offered.

_____ **I agree to random urine drug screens** while hospitalized in this institution. If my urine drug screen is positive for substances other than what is ordered by the Physicians at Lee Health I understand that I may no longer be allowed to participate in the addiction treatment program and may be subject to administrative discharge.

_____ **I agree not to take any medications or substances that have not been ordered by the Physicians at Lee Health** while I am admitted. I understand that if I take any narcotics or other medications not ordered by a Lee Health Provider or any illegal substances while in the hospital this could lead to a very serious outcome which could include **respiratory/cardiac arrest, death, serious infections or sepsis.**

_____ **I agree to cooperate with all staff in a courteous and respectful manner.** I understand that screaming, abusive language and disruptive behavior including that which may affect other patients will not be tolerated and is grounds for administrative discharge.

_____ **I understand that there is a zero-tolerance policy** for any violations that involve violence, threats of violence, inappropriate sexual behavior or the possession or use of illegal drugs/substances/weapons. I understand that any infraction may lead to immediate discharge from the hospital and will be reported to the police

_____ **I agree to an initial search of my belongings** by security upon admission and if contraband is found, it will be confiscated. I understand further random room searches will be conducted throughout my hospital stay as deemed necessary by staff. If any further contraband is found it will be confiscated and I will be subject to discharge.

_____ **My door will remain open** and I agree to continuous observation, via a room equipped with video camera as available while I am in the hospital if deemed necessary by the physicians and staff.

_____ **I will follow** all **facility regulations.** I understand there is no smoking or vaping allowed in the hospital or on hospital grounds. If I need nicotine assistance Lee Health will provide me with a nicotine patch if appropriate. I understand that if I violate this rule, I may be subject to discharge from the hospital.

_____ **Tampering with my IV** is grounds for immediate discharge.

_____ Each time I am medicated my nurse will verify that I have appropriately **swallowed my medications.**

_____ I agree to speak to a case manager from Operation Par while I am hospitalized.

_____ **I agree that while** I **am receiving care that** I **must stay on the floor I'm assigned.** I am not allowed to wander in the hospital or leave the unit without permission from the nursing staff.

_____ If I **don't meet the expectations of this agreement£ a** patient care conference will be held and a determination will be made as to whether I will be allowed to remain hospitalized. I understand that I am expected to participate and be a productive member of these conferences.

VISITOR RULES

_____ I **understand and agree to the following:**
All visitors will be required to check with the nurse's station and leave bags and containers at the station, visitors will not be permitted to bring items into my room. Purses, briefcases and/or bags will not be allowed to be brought into the room. Food items must be in a sealed, unopened package. Take-out food must be delivered by an approved food delivery service and may not be brought in by visitors. Visitors must use visitor bathrooms and may not use the patient's bathroom.

Any visitors suspected of bringing in illicit drugs, weapons or other items that have the potential to impair my recovery or to cause injury to anyone will be escorted from the building by Lee County Sherriff's Office and will not be allowed to return to the hospital.

Any visitor exhibiting disorderly conduct, intoxication, and/or unusual or inappropriate behavior, including sexual relations of any kind will be asked to leave and will not be permitted to return. Law enforcement will be contacted as necessary to assist staff.

By my signature below, I acknowledge that I understand what is expected of me as a patient and I agree to adhere to these expectations for the remainder of my hospital stay.

Signature of Patient: _____ Date: _____

Printed Patient Name: _____ DOB: _____

Signature of Clinical Staff: _____ Date: _____

Appendix R – Screening and Assessment Tools Chart

A resource from the National Institute on Drug Abuse available at https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

Tool	Substance type		Patient age		How tool is administered	
	Alcohol	Drugs	Adults	Adolescents	Self-administered	Clinician-administered
Screens						
Screening to Brief Intervention (S2BI)	X	X		X	X	X
Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)	X	X		X	X	X
Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)	X	X	X		X	X
NIDA Drug Use Screening Tool: Quick Screen (NMASSIST)	X	X	X	See APA Adapted NM ASSIST tools	See APA Adapted NM ASSIST tools	X
Alcohol Use Disorders Identification Test-C (AUDIT-C (PDF, 41KB))	X		X		X	X
Alcohol Use Disorders Identification Test (AUDIT (PDF, 233KB))	X		X			X
Opioid Risk Tool (PDF, 168KB)		X	X		X	
CAGE-AID (PDF, 30KB)	X	X	X			X
CAGE (PDF, 14KB)(link is external)	X		X			X
Helping Patients Who Drink Too Much: A Clinician's Guide (NIAAA)	X		X			X

Tool	Substance type		Patient age		How tool is administered	
	Alcohol	Drugs	Adults	Adolescents	Self-administered	Clinician-administered
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)	X			X		X
Assessments						
Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)	X	X	X		X	X
CRAFFT (link is external)	X	X		X	X	X
Drug Abuse Screen Test (DAST-10)* *For use of this tool - please contact Dr. Harvey Skinner (link sends email)*		X	X		X	X
Drug Abuse Screen Test (DAST-20: Adolescent version) * *For use of this tool - please contact Dr. Harvey Skinner (link sends email)*		X		X	X	X
NIDA Drug Use Screening Tool (NMASSIST)	X	X	X			X
Helping Patients Who Drink Too Much: A Clinician's Guide (NIAAA)	X		X			X
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)	X			X		X

Appendix S – Overdose Discharge Instructions & Harm Reduction Education

A resource from Lee Health located in Fort Myers, Florida.

Opioid Overdose Discharge Instructions and Harm Reduction Education

By A. Wohl, MD
June 2019

What happened to me?

You overdosed on an opioid – heroin, fentanyl, Percocet (oxycodone), Vicodin (hydrocodone), methadone or some other combination of drugs. Overdose is a dangerous and deadly consequence of heroin (or any opioid) use. A large dose of an opioid (or a small dose of a potent opioid like fentanyl) slows your breathing so much that you cannot survive without immediate medical help. **With opioid overdoses, surviving or dying wholly depends on breathing and oxygen.** Fortunately, this process is rarely instantaneous or immediate; people slowly stop breathing, which usually happens *minutes to hours after* the drug was used. While people have been "found dead with a needle in their arm," more often there is time to intervene between when an overdose starts and before a victim dies. 10% of those that survive an overdose are dead within one year (because help didn't get there on time during another overdose event in the future).

How was I saved?

Someone called for help (or you were brought to the hospital in time) and you were likely given the antidote for opioids, Narcan, which saved your life. Naloxone (e.g., Narcan®) is a medicine used to reverse the effects of opioids in an overdose. It is available as a nasal spray or as an auto-injector. It must be given within a short few minutes after an overdose or you will stop breathing and die. If not given soon enough, you could survive but with some degree of brain damage as well.

Am I a bad person for using drugs?

You are not a bad person for using drugs, but it is a serious problem that needs to be addressed. Addiction is not a character flaw, but a chronic brain disease with both physical and mental symptoms. Abused substances cause physical changes to the brain's functioning, resulting in cravings, depression, difficulty with decision making, and other symptoms. Addiction is a disease that can affect anyone and can be better managed with medications and counseling therapy.

How can I get help?

The path to recovery is different for every individual. Very few are able to quit without the proper medical assistance and community support networks. If you are ready to quit using opioids, please ask your healthcare provider (doctor/nurse) about Lee Health's Medication-Assisted Treatment or ED Opioid Bridge. We can help and want to help you! If you are not ready for help now, we have an open door policy and we welcome your return for help. If you want, you may go to Operation PAR in North Fort Myers to start on medication-assisted treatment like buprenorphine (suboxone) or methadone or Vivitrol. They are located at 535 Pine Island Rd M, North Fort Myers, FL 33903 Phone Number is (239) 656-7700.

If I am not ready to stop using heroin/opioids, how can I make the process safer?

- Only smoke, snort or inject with others around who can monitor you and give the antidote Naloxone (Narcan), if needed, in case you overdose.
- Since street heroin has no quality control and is often mixed with other more potent drugs such as fentanyl, always do a tester snort/shot (a very small dose) if the supply is new or the quality is unknown.
- If injecting, always wash your hands and clean your work area prior to use with sanitizing wipes.
- Use only new, sterile needles and syringes. Avoid licking the needle tip or syringe (this introduces dangerous bacteria into your veins).

- If you are unable to get a new, sterile needle, all blood and dirt should be cleaned off of your current needle using tap water. Second, all parts of the equipment should be immersed in bleach water made with 1 tablespoon of household bleach in 1 gallon of tap water. After the parts are immersed for 15 minutes, let them air-dry fully. Assemble when dry and store in a clean container.
- Use alcohol swabs to sterilize the injection site on your skin before and after injection.
- Only use distilled, sterile water to dissolve the heroin. Any other water source (tap water, pond water, toilet water, etc.) or liquid will have impurities and if used may cause a **serious infection**. Do not draw water from someone else's source. Heat can be used to help dissolve the heroin/distilled water solution. No other liquid substance should be added to the injection.
- If you are unable to access clean, sterile water, **you may boil water on the stove for 2-3 minutes or microwave it until it boils and then allow it to cool**.
- Use .22 micron or cotton filters (these can be ordered from Amazon) to help remove impurities from your solution. **Never, ever** reuse the cotton filter as it can harbor bacteria, and cause severe health consequences. **Always dispose of the filter after a single use**. Do not squeeze the filter to get out more heroin since it may only introduce harmful bacteria. It is better to cut your filter smaller than to reuse a used filter.
- After sucking the solution into the syringe through the filter, make sure no air bubbles are present in the syringe barrel before the plunger is released. **Injecting large air bubbles into the bloodstream can easily result in fatal injury.**
- Properly dispose of used injecting equipment, especially needles. They should be stored in a thick walled plastic container, such as an empty orange juice jug, until they can be surrendered to a hospital or needle exchange program. Used sharps should never be discarded in standard trash or left as litter outside where someone could accidentally injure themselves by stepping on them or trying to dispose of them.

What other risks do I face if I continue to use heroin/opioids?
While intravenous (IV) injection is the most effective way to get an intense, nearly instantaneous rush of euphoria from heroin, all types of opioid users – shooting up (through veins, muscles, fat), snorting or smoking – pay for that rush by risking their health and livelihood in several ways:

- Exposure to blood-borne diseases (HIV, Hepatitis) and worsening withdrawal
- Damage to blood vessels and nerves, blood clots, severe heart valve infections, and sepsis (blood poisoning)
- Abscess or cellulitis formation, gangrene (which can result in loss of limbs)
- Economic ruin, incarceration, loss of family and friends, stroke, brain damage, and overdose death

Get regular STD, Hepatitis and HIV testing. If your injection site becomes red or tender, get it checked immediately at the closest emergency department. We want you to use safely even if you are not ready for a path toward recovery.

When should I return to the emergency department?
If your symptoms are not improving in 24 hours or worsens you should seek immediate medical care. Other concerning symptoms include the development of opioid withdrawal (nausea, muscle cramping, depression, agitation, anxiety and/or opiate cravings), fever, chest pain or shortness of breath.

In the event of an overdose, contacting EMS and rescue breathing are critical in addition to naloxone administration. If naloxone is given, then 911 should be called so that the person can be transported to an emergency department rapidly. Rescue breathing can keep the person alive until EMS arrives even if the naloxone was inappropriately administered or ineffective. If you are unsure about how to perform rescue breathing or administer naloxone please ask your emergency department healthcare provider.

Appendix T – Opioid Harm Reduction Education for Care Providers

A resource from Lee Health located in Fort Myers, Florida.

Opioid Harm Reduction Education for Care Providers

By A. Wohl, MD
June 2019

Harm reduction strategies can reduce morbidity and mortality in patients who continue to use opioids. We need to keep patients safe until they are ready for recovery. Using clean water, an alcohol pad and avoiding licking the syringe all decrease the risk of abscess and endocarditis. Educating patients on clean needle practices diminishes HIV and Hep C transmission and decreases the chance of endocarditis and bacteremia. Patients who overdose should almost always be provided with a prescription for naloxone as well.

- **How can we reduce morbidity and mortality in patients who continue to shoot opioids IV?** Patients with opioid addiction are likely to make decisions detrimental to their health. We can help them continue the unhealthy practices of addiction in a much safer way. Our job as healthcare providers is to protect and preserve human life, not to pass judgment.

- **Our patients don't always do what we tell them to.** It doesn't mean that you abandon these patients or stop trying to compassionately counsel them about maintaining their health. Just because patients are using IV drugs doesn't mean they don't care about their health.

- **IV drug use continues to be a huge cause of morbidity and mortality in the US.** It is the number one cause of mortality in patients under age 50. HIV and HCV transmission continues to spread in large part from IVDA. Patients with drug overdose are seen daily in emergency departments. We treat the immediate cause and then discharge them. We must end the practice of ignoring the problems of IV drug abuse. We can no longer afford to let these patients languish in shame and stigma. Also, for every dollar spent in Harm Reduction there is 4-7 dollars of treatment costs avoided. This is important for our community and the financial viability of our state and hospital safety network.

- **Harm Reduction.** This is a philosophy and commitment to meeting patients **where they are**. It realizes that addiction is a medical disease and not a moral failing. It is a practical set of strategies and ideas aimed at reducing the negative consequences associated with drug use. It emphasizes evidence and education over neglect. Telling people to just say "No" or to lecture them from a moral high ground about "making better choices" has been an abject failure. The majority of our IV drug users are not ready to quit on the day they see us in the emergency department. If our time and counseling is geared toward getting them to quit, we've set ourselves up for failure. How do we keep the patient safe until they are ready for recovery?

- **Every ED clinician needs to know how heroin is used safely and correctly.** We can teach safe practices that can avoid disease transmission and skin infections. We can refer patients to needle exchange programs (when they develop in our community, there is new legislation this year hopefully which will pass). This creates trust that can lead patients to come back to the physician when they are ready to quit. This is similar to HIV. Drug use and sex are stigmatized. Heroin is more addictive than sex. More people are dying from heroin overdoses than did from HIV. We can teach them and encourage them to use more safely.

- **Shooter abscesses are a common presentation.** Try to establish a good relationship with the patient. Let the patient know that using drugs doesn't make them a bad person, and that you care about helping them regain and maintain their health. Start talking with them about how they inject. Are they washing their hands? Are the syringe and needle new and sterile? What about the cooker, the spoon they mix the heroin in? How about the technique?

- There are multiple forms of heroin (such as unrefined black tar, various grades of powdered hydrochloride salts, freebase powder [so called "#4 heroin" which is more common in Europe and requires an acid to prepare for injection], and powder "China White" which may be very pure heroin hydrochloride salt but is more likely to be a mix of heroin and fentanyl or analogues of fentanyl--sometimes even pure fentanyl is sold as heroin or patients obtain pure fentanyl or fentanyl analogues from the dark web. Many patients also abuse prescription pills through crushing, dissolving and injecting them.
- **Each step is a potential portal for bacteria.**
- **The basics of injecting heroin.**
  - Powdered product is placed in a spoon or “cooker”.
  - Then water is added to the spoon.
  - The mixture is usually heated with a lighter to make the mixture blend more easily.
  - Then a “cotton” is put into the spoon (this is usually a cigarette butt) to serve as a filter.
  - Then the needle is placed into the cotton and the mixture is drawn up through the cotton.
  - Then they inject the mixture into a vein.

- **Important questions you need to ask your patients:**
  - “Where are you getting your water?” Common places include pond water, river water, toilet water or spit. You can recommend using clean water, an alcohol pad on the skin, don’t use spit or lick the syringe prior to injection.
  - How do patients respond? Most of the patients are incredulous and can’t believe a physician is talking with them to use more safely.
  - People often keep the cotton after they have injected it and will save it for a day they are out of their supply. They will rinse the cotton and heat the cotton up in the cooker. This becomes a repository for bacterial infections and hepatitis C. The cotton should be thrown away after every use. Medical grade cottons are often given with clean needles at exchange centers.

- **Patients presenting after an overdose.** These patients may be angry after naloxone reversal. Patients may want to sign out against medical advice. Heroin addicts fear withdrawal because they feel horrible. You can try to talk them down and counsel them if they will listen to you. If the patient has family or friends, you can help save the patients depending on what you tell the people in the room. Counsel everyone who overdoses to inject around other people. They should always try to have one sober person present. Talk with them about doing **tester shots**, especially with new product. Inject a small amount before the normal dose. This is important because heroin has no quality control and may range from 3% to 33%. Addition of fentanyl may result in more drastic differences. Embrace naloxone. Everyone who overdoses should go home with naloxone. We should counsel our patients and their friends and families on how to use it.
  - **Naloxone auto-injectors are really expensive.** The Evzio® auto-injector is $4500. However, if you prescribe the nasal spray or a vial of naloxone it is around $75-100. This is almost universally covered by Medicaid and insurers. There will also be Naloxone available to eligible patients via the ED MAT Pathway. We have free Naloxone to give to patients at Lee Health in cooperation with DCF!

- **IV drug use is the leading cause of hepatitis C transmission and the second leading cause of HIV transmission.** HIV testing depends on your institution. The CDC recommends screening patients for HIV. This is the right thing to do. You can counsel the patient, get them to stop sharing needles and get them into treatment. Preventing hepatitis C is more challenging as it can survive for long periods of time outside the body.

- **We need to change our approach to drug use.** Shame and stigmatization do not work.

- **Commonly heard criticisms include that this facilitates illegal behavior.** It does not. You have to do what is best for your patients. If we continue to neglect them, the death tolls will continue to rise. Does this enable people? We are enabling people who use drugs to protect themselves and their communities from HIV, hepatitis C and overdose. You are enabling them to take personal responsibility for their health and their futures.

Appendix U – Stigma. Words Matter

A resource from Yale School of Medicine available at
https://medicine.yale.edu/edbup/resources/WORDS%20MATTER%20handout%2010.17_338057_284_42920_v2.pdf

Words Matter

Words are powerful... They can contribute to stigma and create barriers to accessing effective treatment

Use person-first language; focus on the person, not the disorder

When Discussing Opioid or Other Substance Use Disorders...

Avoid These Terms:	Use These Instead:
Addict, user, drug abuser, junkie	Person with opioid use disorder or person with opioid addiction, patient
Addicted baby	Baby born with neonatal abstinence syndrome
Opioid abuse or opioid dependence	Opioid use disorder
Problem	Disease
Habit	Drug addiction
Clean or dirty urine test	Negative or positive urine drug test
Opioid substitution or replacement therapy	Opioid agonist treatment
Relapse	Return to use
Treatment failure	Treatment attempt
Being clean	Being in remission or recovery

Appendix V – Additional Resources

Addressing Stigma

By the American Hospital Association

According to the American Psychiatric Association, fear of stigma can lead patients to forego getting treatment, leading to poor health outcomes. This webpage housed a series of resources focus on understanding and addressing the stigma of opioid use disorder and treatment to ensure that patients have the medications and support they need.

https://www.aha.org/bibliographylink-page/2018-09-28-addressing-stigma

Model Act Providing for the Warm Hand-off of Overdose Survivors to Treatment

By the National Alliance for Model State Drug Laws

https://namsdl.org/wp-content/uploads/Warm-Hand-off-Model.pdf

Peer Support Workers in Emergency Departments: Engaging Individuals Surviving Opioid Overdoses – Qualitative Assessment

This issue brief highlights current and promising practices used to integrate peer support workers into ED settings. To understand the current practices and efforts underway to involve peer support workers in emergency department settings, the National Council conducted a cursory qualitative assessment involving an environmental scan and semistructured interviews with pertinent stakeholders. The emphasis of this work is to understand the placement, role, and promising practices of peer support workers in ED settings that assist individuals who have been revived from an opioid overdose.

https://www.thenationalcouncil.org/wp-content/uploads/2018/12/Peer-Support-Workers-in-EDs-Issue-Brief.pdf?daf=375ateTbd56

The Project RED Toolkit

By the Boston University Medical Center

The Re-Engineered Discharge (RED) Toolkit, funded by the Agency for Healthcare Research and Quality, can help hospitals reduce readmission rates by replicating the discharge process that resulted in 30 percent fewer hospital readmissions and emergency room visits. Developed by the Boston University Medical Center, the newly expanded toolkit provides guidance to implement the RED for all patients, including those with limited English proficiency and from diverse cultural backgrounds.

http://www.bu.edu/fammed/projectred/toolkit.html

Transitions of Care Planning Guide

By the National Council for Behavioral Health

The Transitions of Care Planning Guide is designed to support practices in strengthening their organizational capacity to safely and effectively transition clients between care settings. Practices can use the Guide to create and execute their own strategy to collaborate with other providers to identify the barriers to smooth transitions and identify, implement, and evaluate collective solutions. The overall aim is to increase the rates of follow-up care post-discharge, decrease avoidable readmissions, and improve the quality and experience of care for clients, families and provider organizations alike.

https://www.thenationalcouncil.org/wp-content/uploads/2020/03/Transitions-of-Care-Planning-Guide.pdf?daf=375ateTbd56

Use of Medication-Assisted Treatment in Emergency Departments

By the Substance Abuse and Mental Health Services Administration

This guide examines emerging and best practices for initiating medication-assisted treatment in emergency departments. It also reviews the existing literature and science of the topic, identifies gaps in knowledge, and discusses challenges of implementation.

https://store.samhsa.gov/product/use-of-mat-in-emergency-departments/pep21-pl-guide-5?referer=from_search_result

Words Matter - Terms to Use and Avoid When Talking About Addiction

By the National Institute on Drug Abuse

This page offers background information and tips for providers to keep in mind while using person-first language, as well as terms to avoid to reduce stigma and negative bias when discussing addiction. Although some language that may be considered stigmatizing is commonly used within social communities of people who struggle with substance use disorder (SUD), clinicians can show leadership in how language can destigmatize the disease of addiction.

https://www.drugabuse.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction