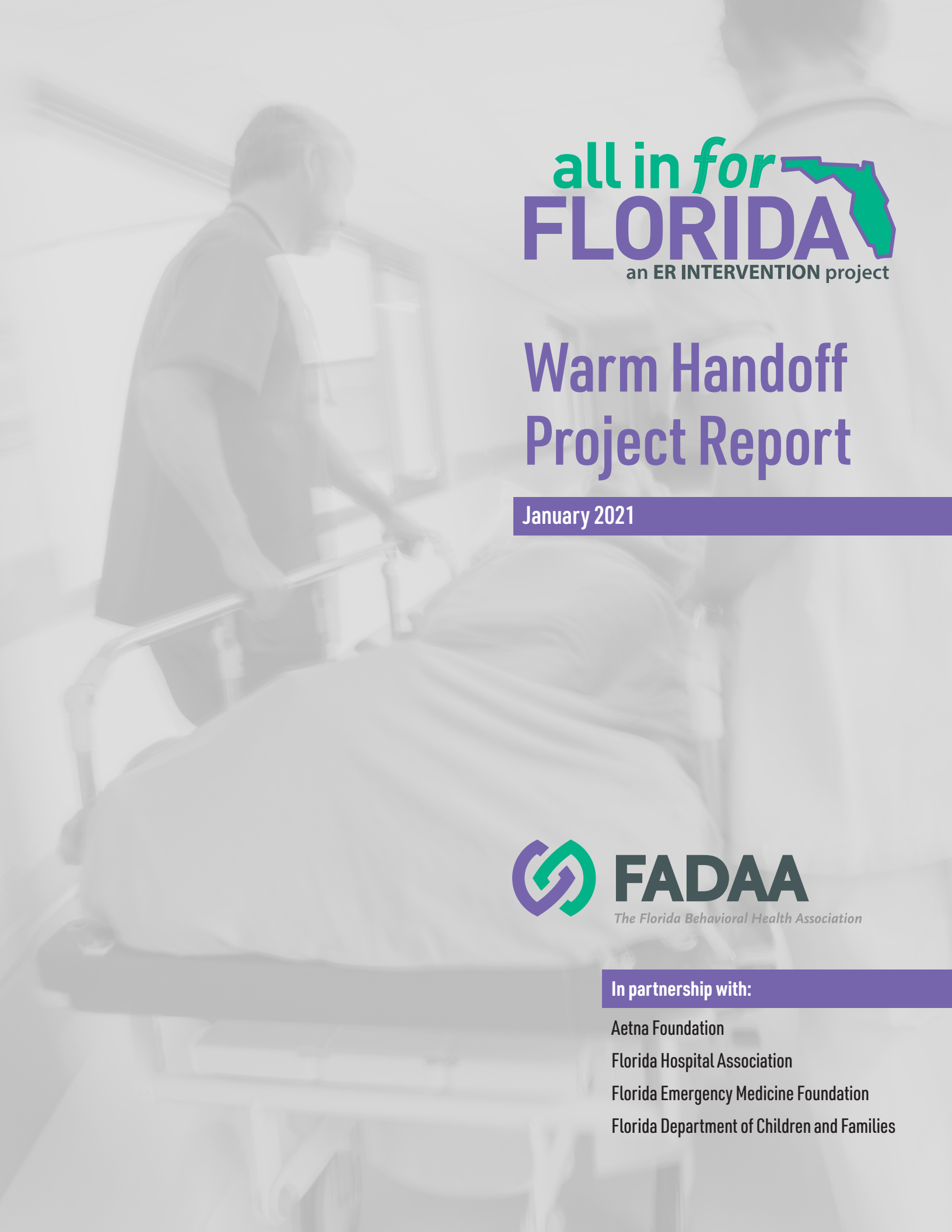

all in for FLORIDA
an ER INTERVENTION project

Warm Handoff Project Report

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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Implementing Warm Handoff Programs in Hospital Emergency Departments Project Report 2018-2020

INTRODUCTION

The *All in for Florida: ER (Emergency Room) Intervention Project* was a response to the opioid crisis. This project, funded through the generosity of the Aetna Foundation, aimed to develop new relationships between hospitals and community-based substance use disorder treatment providers to develop a person-to-person link, a warm handoff, for transitions between hospital emergency departments and community-based substance use disorder (SUD) treatment services for overdose victims and patients with an opioid use disorder (OUD). While hospital emergency departments provide the very best immediate care, substance use disorder treatment and rehabilitation programs provided the option for treatment, on-going MAT services, and transition into longer-term recovery support services.

The three-year project involved collaboration between the Florida Alcohol and Drug Abuse Association (FADAA), the Florida Hospital Association (FHA) and the Florida College of Emergency Physicians (FCEP) Emergency Medicine Learning & Resource Center (EMLRC). The goal of this project was to identify best practices for integrating behavioral health care with hospital emergency departments and to develop a toolkit that could be used to support expanding warm handoff programs across Florida. This project served as a blueprint for hospitals and community-based behavioral health treatment agencies to form collaborations and seamless transitions to strengthen continuity of care for individuals treated in hospital emergency departments for drug overdoses.

This report summarizes the efforts of FADAA and those of the project partners to support the development of warm handoff processes in hospital emergency departments across Florida through December 2020. The report also includes a discussion of the challenges, promising practices and approaches used during the implementation of the initiative.

FADAA appreciates all the support it received from the partners:

- Florida Hospital Association
- Florida College of Emergency Physicians, Emergency Medicine Learning & Resource Center
- Florida Department of Children and Families

This project was possible due to the generous support of the Aetna Foundation. Aetna is thanked for the support and resources that made this initiative possible.

OVERVIEW OF THE PROJECT

Background

Over the past four years, there has been growing awareness both in Florida and throughout the nation that opioid abuse has reached epidemic proportions. In 2017, the U.S. Department of Health and Human Services declared a public health emergency with regard to the opioid crisis.[1] In recent years, the consequences of the nationwide opioid epidemic have had a sobering impact on communities across the country. Florida has not been spared from this national health challenge. A *Palm Beach Post* article in November 2016 noted that the cost of the heroin epidemic was more than one billion dollars in Florida alone.[2] Since 2015, Florida has seen a mostly upward trend in the number of opioid-related deaths.[3]

In 2017, Florida's hospitals treated over 33,800 hospital emergency department (ED) patients with an unintentional/undetermined non-fatal drug overdose. [4] Of those, over 17,400 involved opioids.[5] While data is not readily available, some practitioners suspect that about 10 percent of those patients who presented due to an overdose were being treated for overdosing a second time or more.

Key stakeholders at every level have stepped up to address this emergency in a variety of strategic and effective ways. In Florida, stakeholders from various backgrounds have collaborated to create innovative solutions to address the problem. The *All in for Florida: An ER Intervention Project* is one of these initiatives. In this initiative three different professional associations came together to improve the continuum of care for individuals presenting at the emergency room as a result of an OUD: the Florida Alcohol and Drug Abuse Association (FADAA), the Florida Hospital Association (FHA) and the Florida College of Emergency Physicians (FCEP) Emergency Medicine Learning & Resource Center (EMLRC). The Aetna Foundation provided generous support for this project to meet their mission "to promote wellness, health, and access to high-quality health care for everyone, while supporting the communities we serve."[6]

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[1] Health and Human Services. (2017, October 26). HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis. Retrieved from https://public3.pagefreezer.com/browse/HHS.gov/31-12-2020T08:51/https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html

[2] Beall, P. & Stucka, M. Cost of heroin epidemic tops $1 billion a year in Florida. *Palm Beach Post.* December 17, 2016. https://tinyurl.com/y8ngjet6

[3] Florida Department of Law Enforcement (2015-2019) Drugs Identified in Deceased Persons by Florida Medical Examiners. Retrieved from http://www.fdle.state.fl.us/mec/publications-and-forms.aspx

[4] Florida Department of Health. (n.d.). Opioid Use Dashboard. Retrieved from http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.OpioidUseDashboard

[5] Ibid

[6] Aetna Foundation. (n.d.) Our Organization and Funding Strategy: Mission & Vision. Retrieved December 30, 2020 from https://www.aetna-foundation.org/organization-strategy/organization.html

Project Partners

This project mobilized a number of key partners working together to coordinate their efforts to create and support the momentum that led to warm handoff being implemented and practiced in almost 40 emergency department by the end of the project.

Florida Alcohol and Drug Abuse Association (FADAA)

The Florida Alcohol and Drug Abuse Association (FADAA) was incorporated in 1981. In 2019, FADAA merged with the Florida Council for Mental Health to form the Florida Behavioral Health Association (FBHA). FBHA is the state's largest trade association representing community treatment providers with a united voice. FBHA serves as a trusted source of information, it advances policy initiatives, and it advocates for better behavioral health for all Floridians.

FADAA remains as the service arm of FBHA. FADAA is a non-profit service association that supports prevention and treatment providers, managing entities, and community anti-drug coalitions that provide substance use disorder and mental health services. Its mission is to advance the use of evidence-based prevention and treatment practices, promote research to practice initiatives, support the development of a professional behavioral health workforce through professional development activities and distribution of resources, and informing the public regarding the impacts of addiction and mental health issues.

FADAA has developed an extensive portfolio of activities including hundreds of training and technical assistance events. Its board members and staff monitor and address policy issues related to emerging trends in the areas of substance use and co-occurring service delivery, healthcare reform, prevention, child welfare, criminal justice, veterans and their families, workforce issues, business and private sector changes and cultural diversity.

Florida Hospital Association (FHA)

Founded in 1927, the Florida Hospital Association (FHA) is the voice of Florida's hospital community. Through representation and advocacy, education and informational services, FHA supports the mission of its members to provide the highest quality of care to the patients they serve.

The mission of the Florida Hospital Association is to advocate proactively on behalf of hospitals at both the state and the federal level on issues that will assist members in their mission of community service and care to patients. FHA serves as a resource for demonstrating the community value of hospitals, for building consensus with other groups and for securing needed resources so its members can continue to provide high-quality, affordable care to their communities.

Florida College of Emergency Physicians (FCEP) Emergency Medicine Learning & Resource Center (EMLRC)

Established in 1990, The EMLRC is a non-profit organization advancing emergency care through advocacy and education. The Center provides continuing education to over 5,000 emergency care providers annually. EMLRC is accredited to provide continuing education for medical professionals including paramedics, EMTs, nurses and physicians through the Florida Department of Health, Bureau of EMS, and Continuing Education Coordinating Board for Emergency Medical Services, the Florida Board of Nursing, and the Accreditation Counsel for Continuing Medical Education.

Florida Department of Children and Families (DCF)

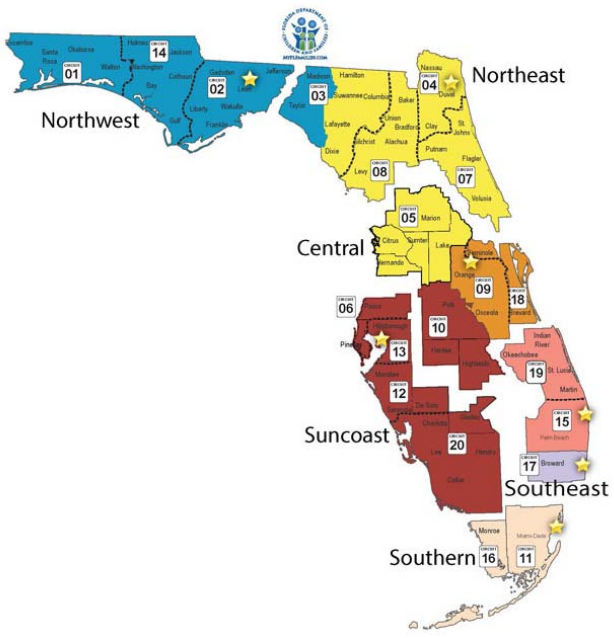
Florida Department of Children and Families (DCF) is the state agency that leads Florida's substance abuse treatment and prevention activities. DCF is the licensing agency for substance use disorder prevention and treatment services and serves as the designated Single State Agency (SSA). DCF as the SSA is the state agency eligible to receive federal assistance to the states. In an effort to improve responsiveness to local needs, DCF contracts for behavioral health services through regional systems of care called Managing Entities (MEs).

Florida is divided into seven Managing Entity regions. DCF manages state general revenue and federal block grant funding (non-Medicaid) for substance abuse and mental health treatment. The Department has targeted hospital emergency department interventions as part of the federal State Targeted Response and the State Opioid Response grant initiatives implemented across Florida.

Florida's Managing Entities

DCF contracts for behavioral health services through regional systems of care called Managing Entities (MEs). These entities do not provide direct services; rather, they allow the department's funding to be tailored to the specific behavioral health needs in the various regions of the State. The seven ME are:

- Big Bend Community Based Care, Inc. d/b/a NWF Health Network - Contract AHME1
  Serving Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington counties.
- Broward Behavioral Health Coalition - Contract JH343
  Serving Broward county.
- Central Florida Behavioral Health Network, Inc. - Contract QD1A9
  Serving Charlotte, Collier, DeSoto, Glades, Hardee, Highlands, Hendry, Hillsborough, Lee,



Manatee, Pasco, Pinellas, Polk and Sarasota counties.

Central Florida Cares Health System - Contract GHME1
Serving Brevard, Orange, Osceola and Seminole counties.

Lutheran Services Florida - Contract EH003
Serving Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union and Volusia counties.

South Florida Behavioral Health Network, Inc. d/b/a Thriving Mind South Florida - Contract KH225
Serving Miami-Dade and Monroe counties.

Southeast Florida Behavioral Health Network - Contract IH611
Serving Indian River, Martin, Okeechobee, Palm Beach and St. Lucie counties.

Figure 1. Florida Managing Entities Areas

Project Outline

The project's goal was to seek and promote best practices to intervene with individuals presenting at an emergency department with an opioid overdose. The project identified best practices for integrating behavioral health care with hospital emergency departments (EDS) and engage in a strategic effort to increase the number of Florida communities benefiting from a warm handoff for individuals with an OUD. The project was implemented in five stages:

Stage 1 – State of the State Report on Interventions
During this stage, FADAA researched warm handoff efforts in Florida and around the nation. The publication of the 2018 State of the State Report marked the end of this stage. The report chronicled the benefits of implementing evidence-based practices that link hospitals with community-based behavioral health providers and documented what projects were in operation at the time. The Florida project also identified similar initiatives in other states.

Stage 2 – Selection of Pilot Programs
Using data collected related to overdoses in the community, FADAA and FHA, in consultation with DCF, selected four (4) hospitals to participate in the project. These selected hospitals were matched with one or more community-based behavioral health treatment providers in the hospital catchment area. At the same time, DCF funded seven pilot projects at different hospitals through the State Targeted Response grant to combat the opioid crisis.

Each of the four community systems, composed of a hospital ED and community-based treatment provider(s), participated in targeted training on behavioral health integration, focusing specifically on transition from acute care for opioid overdoses to community-based treatment and community support for attaining and sustaining recovery. Both the hospitals and community providers agreed to collect data, attend face-to-face trainings and team-building meetings and share their experiences and materials such as operational policies, memoranda of agreement, job description, and data.

Stage 3 – Training and Other Supports

During this stage, implementation of the warm handoff programs took place. The partners brought their expertise to the table to support the development of warm handoff linkages. Targeted trainings, coaching calls, and other technical assistance efforts as needed by the participating hospitals and community-based behavioral health providers were delivered.

Stage 4 – Development of Best Practices

Through the implementation of the program, FADAA collected information on the experiences of the hospitals and the providers as well as samples of the tools they were using for implementation of a warm handoff protocol. Using lessons learned, a collaborative and comprehensive blueprint sensitive to the vast needs of Florida's communities was developed, along with recommendations to address barriers to integrating care across systems. The partnership developed and published a *Warm Handoff Implementation Toolkit*.

Stage 5 – Continuation of Data Collection

The initial goal was to collect a full 12 months of data following initiation of best practice protocols and interventions. However, the initiation of the several projects took longer than expected thus impacting the data collection. An analysis of the data is included in this final report. During this stage the State of the State report was updated to reflect the changes in this area as a result of this initiative and similar projects supported by DCF.

Specific Project Goals

The overall goal of the project was:

> *To improve Florida's system of care by linking hospital systems with community-based behavioral health programs to provide treatment, transitional support and other wrap-around services to prevent readmissions to hospital emergency departments due to opioid overdoses.*

Project partners identified the following short-term goals:

- Identify hospitals with effective transition of care models.
- Determine barriers to implementing transition of care programs.
- Collect baseline data on ED admissions due to opioid overdoses.
- Initiate collaborations to connect hospitals and community-based behavioral health providers in four (4) communities that lacked well-defined transition of care models.
- Develop Florida-specific best practices to transition opioid overdose patients from EDs to more cost-effective community-based settings.
- Provide technical assistance to hospitals, emergency department physicians and staff, and community-based behavioral health providers in implementing best practices.

Long-term project goals included the following:

- Increase in the number of patients referred to substance use disorder treatment following a medical intervention to treat an opioid overdose in hospital emergency departments.

- Increase in percentage of patients that complete their initial scheduled appointments.
- Decrease in ED readmissions for opioid overdoses for those patients who are successfully referred for treatment.
- Decrease in ED readmissions for those patients who successfully complete a treatment program.

SUMMARY OF THE PROJECT FINDINGS

Pilot Programs

The opioid epidemic created a new dynamic for the healthcare and SUD treatment system. Often the ED became the first contact point for an intervention after an opioid overdose. These individuals were no longer presenting for substance use disorder care in the traditional modes of referral, rather they were being delivered to hospital ED's on gurneys as a result of an overdose. Besides the need to provide an immediate healthcare intervention to deal with the drug overdose; it became clear that a more structured and non-traditional intervention was necessary to address the opioid use disorder being manifested. This reality became acutely relevant when the same individual returned to the ER for multiple overdoses in a short period of time.

A major goal of the Aetna project was to learn key dynamics of a successful ED warm handoff program. A key component was to identify and better understand the barriers that prevent such a program from being successful. At the time this project began there were only a handful of ED warm handoff programs in the state. As stated above, the goal of this project was to both support the implementation on warm handoff process in additional emergency departments and to build on the body of knowledge on what are the key dynamics of success for these programs. As a result of this initiative, five (5) warm handoff pilot programs were created in selected ED's across the state. The original plan was to work with four (4) hospitals but late in the program another hospital requested to be included. The hospitals in the program were:

- St. Joseph's Hospital/Baycare Health Systems – Tampa
- Lee Memorial Hospital – Ft. Myers
- Halifax Hospital – Daytona
- Advent Health/Orlando East – Orlando
- Broward Health – Coral Springs

The main accomplishments of this project are a result of the cooperative efforts among our partners and highly motivated physicians and staff members on the front line of the opioid epidemic. Weekly conference calls with project partners (FADAA, FHA, and EMLRC) provided continuous forward momentum and positive solutions. Monthly coaching calls with the Hospital ED Physician champions, Managing Entity and treatment providers offered an opportunity to share successes, identify challenges, and brainstorm solutions. On site targeted technical assistant visits were also held to assist and guide in the development of the transition of care program. Summarized below is a profile of each hospital's progress toward implementing a "warm hand off" program.

St. Joseph Hospital/Baycare Health Systems in Tampa Florida

St. Joseph's hospital initially partnered with DACCO Behavioral Health, a community substance use disorder provider in Hillsborough County. On April 11, 2019 the first patient was referred from the ED to treatment at DACCO. Initial challenges faced by this pilot program included addressing the stigma attached to an overdose and lack of medical staff with the credentials necessary to prescribe buprenorphine. Early in the project, the hospital reported that ED staff did not have appropriate training on how to engage the patient; implementing Motivational Interviewing (MI) training addressed this need. It also was recognized early on that a Peer Recovery Specialist (PRS), an individual with lived experience, or other substance abuse professional would be a valuable asset in the ED.

In addition, a second community SUD treatment provider, ACTS, was engaged in the pilot. ACTS hired a PRS and is currently providing services in St. Joseph's ED. It is reported that the RPS has been very helpful in engaging patients to pursue SUD treatment. DACCO also reports success in securing a RPS to participate in this initiative. Coordination was necessary to identify a schedule for the RPS from each partner to prevent overlap of services. A universal referral form was created to be used by both treatment providers (DACCO and ACTS).

A key ingredient of this pilot was the implementation of a MAT protocol in the ED. This protocol allows patients that agree to engage in treatment to begin MAT while in the ED before being transferred to a community provider for follow-up MAT services. St. Joseph reports that the ER physicians are becoming more comfortable with the MAT protocol but because the Opioid Overdose Crisis is no longer headline news, maintaining momentum for the project is a constant challenge. The hospital also continues work on the initiative to have Naloxone dispensed to patients with a high risk of overdose. A future goal of the project is to expand and bring the Inpatient Hospital on board with the program. This will involve training on the value of using buprenorphine as a MAT intervention and providing education regarding the peer recovery specialist resources available.

Lee Memorial Hospital at Ft. Myers, Florida

From the early stage of the effort, Lee Memorial Hospital partnered with two community-based treatment providers, Operation PAR and SalusCare, to implement the pilot program. The recruitment and onboarding process for the peer was difficult and lengthy. These providers have modified the proposed RPS work hours to make the job more appealing to applicants. Lee Health requires the peer to be certified upon hire creating a greater challenge in filling these positions. Seventy percent of all ER physicians in the ER have their DATA 2000 waiver for prescribing buprenorphine.

The effort was greatly supported by a champion who was serving as an ED physician and was able to lead the charge on diminishing bias and getting buy in from other physicians. Medical executives at Lee Health participated in a lecture specially designed for them promoting MAT as the Standard of Care for patients with an OUD. As a result of this efforts, Lee Health now requires all new physician hires, regardless of discipline, to complete the DATA 2000 waiver within two years of hiring. As a result of these efforts, Lee Memorial's Shipley Cardiothoracic Center has employed a RPS to work in their Endocarditis Unit. Part of this program included the initiation of a MAT clinic and the hiring of two addiction specialists who are board certified.

No data is yet available on patients impacted. Data collection has been a challenge for the hospital and provider. A RPS have recently been hired and is now working in the pilot program. The need was recognized to restart monthly meetings between the hospital and providers. Data collection is an on-going goal and expectation for this hospital and provider.

Halifax Hospital at Daytona Beach, Florida

Halifax Hospital partnered with Stewart-Marchman-Act (SMA) Behavioral Healthcare who provided a RPS to work at the ED for warm handoffs. This pilot was officially launched on October 28, 2019. The Hospital utilizes tele-health when the RPS is not on site and reports no difference noted in acceptance rates with the utilization of tele-health. One hundred percent of the ED physicians at Halifax have completed the DATA 2000 Waiver. The hospital is planning to expand the tele-health services to other facilities. Also under discussion is the proposed plan of a RPS conducting initial face to face screenings via tele-health and then providing in-person follow up based on patient need.

Future goals include collaborating with community partners regarding developing an intermediate care level for patients requiring longer hospital stay such as endocarditis and osteomyelitis patients. This would require protocols on how to initiate MAT in an inpatient setting. SMA reports that they are evaluating their programs and looking for ways to expand their MAT and behavioral counseling capacity. The plan is to continue the Halifax Daytona project and use teleconferencing to expand peer services to two additional Halifax Health ED locations in Deltona & Port Orange. SMA is working to identify additional funding sources to expand the warm handoff at Advent Health System hospitals in DeLand, Orange City, and New Smyrna Beach.

Since inception of the Halifax ED Intervention Project until June 2020, 89 patients have been screened and 19 patients were induced with buprenorphine. A total of 45 patients were referred to treatment and 41 of those patients were linked to a SUD treatment provider. The hospital did report that the COVID-19 pandemic had a negative impact on the program.

Advent Health/Orlando East in Orlando, Florida

Advent Health/Orlando East experiences the highest number of overdoses in Central Florida. Advent Health developed a partnership with Aspire Health Partners, a community-based behavioral health provider, to help them address the overdose problem. In April 2019, hospital leadership and medical staff from Advent Health, Aspire, FADAA, FHA and EMLRC met to explore how to facilitate warm hand off at the hospital. Aspire proposed sharing a peer the organization currently housed at a sister hospital. The hospital medical staff indicated the need for clear protocols between the doctors, hospital and the treatment provider. It was noted that a large number of individuals presenting with an opioid overdose were not interested in pursuing treatment for their OUD. Aspire is planning on expanding tele-health services by utilizing tele-health as the initial contact based on patient need. The partners contribute the success of the pilot to the peer integration into the ED setting and to the established relationship that already existed between the community facilities. Aspire has expanded services to several additional hospital organizations including Orlando Health and are in the initial discussions with Osceola Hospital.

Since inception of the ED Intervention Project, 2791 patients were screened throughout all hospitals in partnership with Aspire. Patients are not induced with buprenorphine at the hospital locations. The patients receive this service once enrolled into one of the community clinics operated by Aspire.

Broward Health Coral Springs in Coral Springs, Florida

Broward Health Coral Springs joined the project late but the hospital asked to have access to the project to participate in the technical assistance and peer calls. The hospital partnered with Banyan Health Systems, a community behavioral health agency. One key ingredient of this program is the partnership with the Coral Springs Fire Department. The Paramedicine Program is the model being implemented. The plan is to have the paramedic partner with the community SUD treatment provider to offer integrated MAT services. The process has been delayed due to legal and union-related concerns regarding safety. Meetings have been held to finalize the Memorandum of Understanding (MOU) along with policy and procedures. The goal was to implement the Paramedicine Program in March 2020. Unfortunately, the Covid-19 pandemic has delayed its implementation. All parties continue to meet in an effort to resolve all the conflicts. Since the program is yet to commence, no data is available at this time. Data collection will begin when the program is initiated.

Lessons Learned

The implementation of this project has not been without challenges or concerns. However, a lot was learned about the contingencies that must be addressed if a successful warm handoff program is going to be implemented. While not all hospitals or partnerships experiences the same challenges, some common issues emerged.

Coordinating Activities between Highly Regulated Healthcare Organizations

Both hospitals and behavioral health treatment providers are highly regulated entities. In Florida, hospitals are licensed and regulated by the Agency for Health Care Administration (AHCA). Substance use treatment providers are licensed and regulated by the Florida Department of Children and Families (DCF). In addition, there are federal and state regulations that govern parts of their operations and the credentialing of their staff. These entities also have different funding streams. The warm handoff requires that all these mandates and regulations be coordinated across the partners. Some of the steps taken to manage this challenge include:

- Involve legal and compliance staff in the early stages.
- Partners must learn and understand the regulations that govern the operations of all partners.
- Partners must identify areas where flexibility can allow coordination.
- Developing a patient flow chart to clearly understand where and how a warm handoff can be introduced into the operations of the ED. A visual representation adds clarity.
- Sharing forms, job descriptions, and protocols can help all the partners understand each other's operation.

Patient Management and Confidentiality Concerns

In addition to the entities regulating the operation of hospitals and treatment providers, patient management and confidentiality adds another layer of regulations that must be navigated when implementing a warm handoff. In this case, it is helpful that most of these regulations apply to all the partners, so all parties are familiar with them. The most overreaching regulations include:

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- The Patient Protection and Affordable Care Act (ACA)
- The Administrative Simplification Compliance Act (ASCA)
- 42 CFR Part 2 - Confidentiality of Substance Use Disorder Patient Records

The partners must take the time to address each of these concerns to ensure the program meets the requirements of the governing regulations. Pilot participants recommended that the hospitals and community partners include legal and compliance staff or departments early in the process. Many partnerships indicated that frequent dialogue with all partners involved proved to be beneficial in addressing these concerns.

Formalizing the Partnership

In any partnership, understanding each party's role is key to success. This is especially true in partnerships between complex, highly regulated systems such as hospitals and treatment providers. A vehicle such as a Memorandum of Understanding (MOU) serves to commit to writing the role of

each partner. While a MOU is not typically binding, it helps to communicate and clarify roles and responsibilities. One important role of an MOU is to secure a commitment on what data will be shared and how. Securing an MOU proved to be a difficult and lengthy process. As with earlier concerns, including legal and compliance staff/departments early in the process helped expedite the MOU process.

Prescriber Credentialing

Inducting patients using buprenorphine while in the ED has emerged as a promising practice in engaging patients into treatment. Prescribers must complete the DATA 2000 Waiver to prescribe buprenorphine.[7] Hospitals often identify the need for their physicians to secure this credential as a challenge. Qualified practitioners that can obtain a waiver include physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs), Certified Registered Nurse Anesthetist (CRNAs), and Certified Nurse-Midwifes (CNMs). Securing the waiver includes submitting a Notice of Intent (NOI) to SAMHSA and completing the required training. While the training is free, it is time consuming – 8-hrs for physicians and 24-hours for other qualified practitioners. There may be a fee for securing the waiver.

However, under certain conditions ED physicians may not be required to secure the waiver in order to administer buprenorphine. This exemption enables a physician 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:

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

While training and technical assistance was provided to the hospitals regarding the requirements and the exceptions, many hospitals identified the training as beneficiary to help their staff become more proficient on the nature and treatment of SUD. Some of the approaches to resolve this issue included:

- Provide financial incentives for eligible practitioners to secure the waiver.
- Implement requirements mandating that eligible practitioners secure the waiver within a reasonable timeframe.
- Develop protocols to allow dispensing of buprenorphine within the limits of the exemption.

Ongoing Treatment Capacity Concerns

Hospitals, especially those in areas with high incidence of opioid overdoses, express concerns in beginning a treatment protocol and then experience challenges placing the patient in treatment due to issues with capacity at the community-based treatment providers. This is of particular concern when the hospital uses buprenorphine induction at the ED and there is a possibility that a continuum of care will be disrupted. Some of the approaches used to manage this concern included:

- Frequent dialogue among all the partners to understand caseloads and trends of referral.

[7] Substance Abuse and Mental Health Services Administration (2021). Become a Buprenorphine Waivered Practitioner. Available at https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner.

- Involve the funding sources to secure their support when capacity may need to be expanded.
- Including more than one treatment provider to expand capacity.

While this is one of the most noted concerns, the number of referrals to treatment has not reached levels that could not be served during the pilot phase.

Using Technology

The effective use of technology proved critical in the development and operation of warm handoff process both in the coordination efforts to develop the program and in its implementation. At the development stage, technology allowed the partners to sustain frequent communications, share documents, and work together in the development of the protocols. During implementation, technology helps improve the success of the program. Many hospitals found that automation can help warm handoff to occur in a consistent basis regardless of the time of day, attending physician, diagnosis, and others. Process were developed to assist in the notification of the entire team when a patient presented with a drug overdose. Tele-health became a valuable resource to maximize the utilization of PRS during times when the peer was not personally at the ED. Projects worked with their information technology (IT) departments to create or modify existing platforms, programs and protocols as required. In one pilot, the hospital and the treatment provider are currently working to develop a process to allow access to the patient's Electronic Health Record to all parties involved in treating the patient.

Transportation

Transportation typically presents a challenge in Florida since the urban settings are not densely populated and public transportation is very limited. Transporting the patient from the ED to the receiving substance treatment center is not an exception. Typically, these patients were taken to the ED by emergency services and may or may not have a family or friend available for transport. Some solutions used to manage this challenge includes:

- Working with the patient to secure transportation assistance from friends and families.
- Using private transportation providers such as Medical Uber.
- Making a bus pass available to the patient.
- Using vehicles operated by the treatment provider.

Whether these solutions are available varies significantly around the state. Rural areas typically have less choices available.

Integrating the Peer into the Hospital Setting

The ED is a fast paced, often high energy and stressful environment. The ED teams develop their own rhythm to help them adapt and respond to the everchanging environment. Inserting a peer into this environment proved to be one of the most challenging parts of the implementation phase. The peers were not accustomed to the pace and stress of the emergency department and they were not familiar with the typical medical protocols that are commonplace for medical staff such as the use of personal protective equipment or the use of technology to both treat and document that treatment. Special attention must be invested in the onboarding process for peers. All partners can take steps to ease the process. The treatment provider can:

- Develop a proper job description that fully describes the expectations.
- Support certification and continuing education.
- Develop a relationship with the ED leadership team to ensure open communication.

The hospital and ED staff can:

- Make a concerted effort to introduce the peer to all the ED staff.
- Provide an opportunity for a walk-through of the ED by the peer.
- Include peer in staff meetings and daily or safety huddles.
- Provide a working space and tools for the peer.
- Include peer in the ED routines

The peer can:

- Be open to learn and respectful of the ED requirements.
- Share their story of recovery.
- Explain their role in engaging individual with a SUD into treatment.
- Share success stories.
- Maintain their own personal recovery.

Overcoming Stigma in the ED

Stigma remains the most significant barrier to people seeking care for mental health and substance use disorders. Stigma was identified as the number one barrier to success to implementing MAT and warm handoff protocols in the ED. It is important to recognize that stigma occurs in the individual with a SUD, in their families, and in the ED staff. The personal stigma can lead a patient to demy or hide their struggles with a SUD or miss-report their recent use. Public stigma, the negative attitude that people may have about SUD is often related to a lack of understanding of the problem.[8] This type of stigma can be managed with training and education. It is important to help staff understand addiction as a disease and not a moral failure. Some of the actions that EDs can take to reduce the impact of stigma are:

- Provide training opportunities for staff regarding addiction.
- Change the language used to describe addition and patients with SUD.
- Post signs that inform patients that help is available.

Peer specialists can play an important role in diminishing stigma. Peers can use their experiences to help others understand addiction and how treatment and recovery can improve the welfare of people with a SUD. RPS serve as an important part of a care transition team and are serve as “change agents” to reduce stigma surrounding addiction.

[8] Corrigan, Pw, Druss, BG, Perlick, DA. The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care. Psychological Science in The Public Interest. 2014, 15(2);37-70.

Promising Practices Identified

An important goal of the project was to identify those practices or approaches that proved more successful to aid the implementation of a warm handoff and supported successful implementation of this initiative. While data and evaluation are needed to validate warm handoff practices as an evidenced-based best practice, the project did identify some promising approaches and practices.

Role of Peer Recovery 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. A peer can also be a person who has at least two years of experience as a family member or caregiver of an individual who has a substance use disorder or mental illness.

Peer specialists have a desire to use their experiences to help others with their recovery and are willing to publicly identify as a person living in recovery for the purpose of educating, role modeling, and providing hope to others about the reality of recovery. While peers do not provide clinical or medical services, they serve as an important part of a care transition team and are key "change agents" to reduce stigma surrounding addiction. They have also proven to be effective agents in helping individuals experiencing an overdose make the decision to pursue SUD treatment.

The use of peers is an evidence-based practice recognized by the Substance Abuse Mental Health Services Administration, Centers for Medicare and Medicaid Services, and the U.S. Department of Health & Human Services and widely promoted through peer review journals.[9]

Initiating MAT in the Emergency Department

For opioid dependent patients receiving emergency care in the ED, treatment with buprenorphine initiated in the emergency department had significantly better results than a brief intervention and referral. These results included higher likelihood of receiving formal addiction treatment, reduced illicit opioid use (by self-report), and decreased use of inpatient addiction treatment services. However, initiating MAT in the emergency department did not significantly decrease the rates of urine samples that tested positive for opioids or of HIV risk, according to a study in the April 28, 2015 issue of *JAMA*[10]

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[9] 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

[10] JAMA Network. *Emergency department intervention improves rate of treatment for opioid dependence.* JAMA Network. April 25, 2015. https://media.jamanetwork.com/news-item/emergency-department-intervention-improves-rate-of-treatment-for-opioid-dependence/

Identifying Champions

The concept of a hospital champion often referred to as a change champion or change agent have been around for fifty years. Ideally, the lead champion is an emergency medicine physician with a DEA waiver to administer buprenorphine, but the lead champion could be any medical or hospital administrative professional. The lead champion works directly with the hospital's administrator to determine the protocols that best fit the needs of the hospital and surrounding community and work with the hospitals pharmacy on medication therapies such as buprenorphine and naloxone availability.

Building A Culture of Collaboration

Building of relationships requires scheduled meetings and frequent interventions to establish roles and responsibilities of the collaboration partners. This process has often taken hospitals six months to one year to establish effective dialogue and working relationships with the local community SUD treatment partners. Regular dialogue among the partners assists in addressing concerns that may arise regarding legal, compliance, capacity, and confidentiality issues. A MOU is highly recommended between the hospital and community SUD treatment provider. An effective MOU prevents misunderstandings and potential disputes by clearly laying out the expectations and responsibilities of all parties.

Challenges

As the hospitals and treatment providers endeavored to launch a warm handoff, challenges surfaced in many areas. Some of these challenges were forecasted by stakeholders such as lack of substance use screening tools in the hospital ED. This type of challenges were part of the development plan and as such were addressed early during the implementation. Other challenges were either mostly unexpected or proved to be bigger hurdles than expected. The following items remain a challenge.

Data collection

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. 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.

Recruiting Recovery Peer Specialists

The practice of using Recovery Peer Specialist (RPS) to facilitate the warm handoff has surfaced as a promising approach in this initiative. Typically, both hospitals and treatment providers require that these peers be certified. In Florida the certification requires that the peer meet a specific set of standards in the following categories:

- Formal Education
- Content-Specific Training
- On-the-Job Supervision
- Related Work Experience
- Professional Recommendations
- Examination
- Continuing Education Credits
- Renewal

In addition, hospitals and providers require that peers are cleared through a background screening. Often this requirement is based on regulations governing the operation of the facility or the treatment modality. The standard in Florida is a Florida Department of Law Enforcement (FDLE) Level 2 Background check. This is "a state and national fingerprint-based check and consideration of disqualifying offenses and applies to those employees designated by law as holding positions of responsibility or trust."[11] Often, peers struggle with securing this clearance due to past criminal behavior during their substance use. While there is an appeal process available in Florida, the process is slow and cumbersome.

Florida has a shortage of certified peers. Efforts are underway through other initiatives such as Recovery Community Organizations (RCO) to identify, recruit and support individuals in recovery on the path to become Certified Recovery Peer Specialist.

As programs were implemented, both hospitals and providers recognized that ED are high stress environments that may risk the recovery of peers. To manage this risk, it is important to properly train peers on ED practices, provide sufficient coaching and supervision, and monitor the peers continued engagement in their recovery efforts.

COVID-19 Pandemic

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

[11] FDLE (n.d.) Definitions. Retrieved on December 29, 2020 from https://www.fdle.state.fl.us/Background-Checks/VECHS-FAQs/Definitions.aspx#:~:text=Level%202%3A%20a%20state%20and,positions%20of%20responsibility%20or%20trust.

options such as telephone conversations and web-based telehealth. This had a negative impact on program success. For example, Halifax Hospital and the community treatment provider SMA 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.

MAJOR PROJECT ACTIVITES

This section summarizes the major activities and events of the project.

All in for Florida: An ER Intervention Project Launch

August 14, 2018 in Orlando Florida

A daylong event attended by over 100 individuals that included hospital administrators and medical staff, behavioral health providers, state employees, private physicians and law enforcement. This event sought to engage participants in a conversation about warm handoff, learn about what is happening in this space and energize the stakeholders to support these efforts. Event presentations included:

- Emergency Department Intervention: What it means to you
  Mark G. Stavros, MD, FACEP, ABAM – Medical Director, West Florida Hospital
- State of the State: Hospital Overdose Intervention Initiatives
  Houston Park – Director ER Intervention Project, FADAA
- Have We Moved the Needle in Opioid Use Disorder?
  Ute Gazioch – Director of Substance Abuse and Mental Health, DCF
- Understanding HB 21 Regulatory Changes
  Claudia Kemp – Executive Director, Board of Medicine
  Rebecca Poston, BPharm, MHL, FCCM – Program Director, DOH PDMP
- St. Vincent's Hospital Intervention: Case Study
  Ray Pomm, MD – Medical Director, Gateway Community Services
- Overcoming Roadblocks to ER Interventions for Opioid Overdoses
  Panel Moderator: State Representative Cary Pigman, MD
  Dennis Goodspeed – ED Lakeview BH, Baptist Health Systems
  Houston Park – ER Intervention Project, FADAA
  Raymond Pomm, MD – Medical Director, Gateway Community Services
  Shannon Robinson – Sr. VP of Medical Operations, Aspire Health Partners

Mark G. Stavros, MD, FACEP, ABAM – Medical Director, West Florida Hospital
Aaron Wohl, MD, FACEP – Staff Physician, Lee Emergency Physicians

The event was very well received. Participants agreed that the event provided them with new information about warm handoff processes and protocols.

State of the State Report Session at BHCon 2018

August 15, 2018 in Orlando Florida

In 2018, FADAA, in partnership with the Florida Council for Community Mental Health, hosted the Florida Behavioral Health Conference known as BHCon 2018. This is the largest behavioral health conference in the Southeast and attracts more than 1,400 professionals, executives, exhibitors, and volunteers each year. The conference provides attendees with opportunities to learn and apply the most current technology, research, and trends to their daily jobs and to network with other professionals.

The presentation described the goals and objectives of the *All in for Florida: An ER Intervention Project* in an effort to further inform the behavioral health professional community of the initiative and continue engaging stakeholders. The presentation included a discussion of the state of the State of Florida in regard to warm handoff efforts in hospital ED. The presenters included:

- Houston Park, Project Director, Florida Alcohol & Drug Abuse Association
- Kim Streit, VP Healthcare Research & Information, Florida Hospital Association

FADAA Opioid Bridge Program Summit

January 8, 2019 in Orlando, Florida

This was a one-day workshop developed specifically for hospital administrators, emergency department physicians, community based behavioral health care providers and managing entities. This was a statewide effort towards true integration between hospitals and behavioral health care providers to facilitate a warm handoff for individuals presenting with opioid use disorders. This meeting was attended by over 50 individuals representing both hospitals and community-based SUD treatment providers. Presentations included:

- All in for Florida: An ER Intervention Project Goals and Objectives
  Houston Park – Florida Alcohol and Drug Abuse Association
  Kim Streit, FACHE, MBA, MHS – Florida Hospital Association
- Peer programs
  Nancy McConnell MSW, MCAP, CRPS – Rebel Recovery
- MAT: Vivitrol, Methadone, Suboxone, Subutex the SAMSHA gold standard
  Dr. Robert Moran
- The Memorial Model
  Dr. Alberto Augsten – Memorial Health System
- First Responder Follow-up Programs with phones
  Lauren Young, LCSW
- Managing Entities and how they can support the program

Ann M. Berner - South Florida Behavioral Health Network, Inc.

- Prescriber Peer Mentors
  Mark Fontaine, MSW – Florida Alcohol and Drug Abuse Association
- Training and Continuing Educations Needs and Opportunities
  Beth Brunner, MBA, CAE – Emergency Medicine Learning and Resource Center
- Psychology a missing link in OUD treatment
  Dr. Rachel Needle – Palm Beach Sober Task Force

Workshop evaluations were very positive. The program was by invitation to ensure that representatives from the targeted hospitals, treatment providers, and managing entities were present. A seating chart was used to ensure that each table included a hospital and a SUD treatment provider in the same community to encourage conversation and partnership development.

Periodic Program Calls

Monthly during 2018-2020

On a monthly basis, the project hosted a call with the hospital and provider staff to promote sharing of success, challenges, and solutions being implemented. These calls also allowed the team to identify common and individual technical assistance needs. This information was used to develop trainings and technical assistance events. These calls were only available to the hospitals in the project. In mid-2019, the partnership decided that there was a need for a platform that allowed the hospitals to discuss issues specific to their operations. In the last half of the project, the calls alternated between hospital-only calls and hospital and treatment provider calls. Sometimes, the calls also included other parties to address specific issues. Special guests include peer organizations, ED physicians, and attorneys.

Implementing Warm Handoffs Webinar

June - September 2019, Web-based

In June 2019, the partnership released a Webinar specially designed for medical staff working in the hospital ED, *Implementing Warm Handoffs Between EDs and Treatment Providers for Patients with Opioid Use Disorder*. The training aimed to inform about OUD patients and recovery options using evidence-based research and case studies. Presenters discussed misconceptions about treatment and the disease of addiction; introduced the concept of warm handoffs between EDs and treatment providers; reviewed legal issues surrounding opioid overdose cases; and talked about the important role of peer specialists in recovery. The webinar included presentations from:

- Chief Judge Frederick J. Lauten
  Ninth Judicial Circuit Court of Florida
- Nancy McConnell, MSW, MCAP, CRPS-A,
  Chief Operating Officer/Program Director, Rebel Recovery Florida
- Mark Stavros, MD, FACEP
  Medical Director, Emergency Department, West Florida Hospital
  Education Director, Emergency Medicine, Florida State University College of Medicine
  Medical Director, Pensacola State EMT/Paramedic Program

– Aaron Wohl, MD, FACEP
  Medical Director, Opioid Use Disorder Treatment
  Department of Emergency Medicine, Lee Health

ER Intervention Panel at BHCon 2019

August 22, 2019 in Orlando, Florida

In 2019, FADAA, in partnership with the Florida Council for Community Mental Health, hosted the Florida Behavioral Health Conference known as BHCon 2019. The conference provided attendees with opportunities to learn and apply the most current technology, research, and trends to their daily jobs and to network with other professionals.

This workshop panel highlighted that care coordination interventions are a key strategy to improve the effectiveness of treating individuals who have overdose or with substance use disorders, especially at the intersection between emergency care and follow-up treatment. It also provided updates on project and offer approaches behavioral health providers can apply when working with their local hospitals and emergency care professionals. The panel included:

– Jill Gran, M.Ed. All in for Florida Hospital Project, FBHA
– Aaron Wohl, MD. Medical Director, Lee Health
– Deanna Obregon, MHA, LHRM, CPHQ, Chief Admin Officer, DACCO
– Shelley Katz, MSW MBA, Chief Operating Officer, LSF Health Systems

Peer Recovery Workshop, Survey, and Interviews

January 31, 2020 in Orlando, Florida

This workshop was planned and implemented in response to the partnerships identifying challenges finding peers to staff the warm handoff and preparing them to work in the hospital emergency department. This workshop provided an opportunity for networking and sharing of best practices and challenges impacting “warm handoff”. The goals of this event were to identify:

– strategies to promote a culture of peer support
– strategies to promote peer skills and leadership
– community opportunities to support peers
– approaches to overcome the stigma within the behavioral health care system

The meeting was attended by:

– 36 Peer Recovery Specialist,
– 3 representatives from the ME and treatment provider agencies,
– 1 guest speaker, and
– 3 FADAA staff and contractors

This activity also included a survey of the peers during the workshop and one-to-one interviews following the workshop. The main points discussed, and summary findings of these efforts are:

– Enhancing the Warm Handoff Process. Peers identified several critical skills, practices, and resources that underlie successful warm handoffs. In particular, peers emphasized the

importance of anticipating the needs of patients and familiarity with programs and services beyond that of the hospital or SUD treatment providers. Peers also highlighted the significance of efficacy in the handoff process, especially by streamlining screening requirements, recognizing the role of insurance (as appropriate), and arranging transportation.

- Supporting peer recovery specialists in their practice. Peers highlighted a number of challenges that impact their practice in hospitals. Chief among these challenges were logistical obstacles such as difficulty gaining access to clients through an established referral process, lack of designated workspace for peers in the ED, the duration of credentialing processes, and an apparent lack of knowledgeable about the role and purpose of peers among hospital staff.

- Promoting Peer Skills and Leadership. Peers expressed great interest in opportunities to enhance their professional contacts and capacity through the development of a peer network, the development of peer supervisor/manager positions, and cross-training in peer roles outside the hospital setting.

ED Peer Network

December 16, 2020 via Zoom Meeting

During the peer meeting in January the peers identified the need to develop a peer network as an activity that can support their work. Peers typically work as the only peer in the hospital and a peer network would allow them to connect with other peers and share their experiences. Plans to develop a network had to be put on hold during the summer because of the COVID-19 pandemic. The initiative was re-instated in the Fall of 2020.

Through another project supported by the Aetna Foundation, the All in for Florida: A Recovery Project, FADAA partners with Floridians for Recovery (FFR), and Recover Certified Organization that is growing to become the statewide RCO. In that effort, FADAA helped FFR apply for a SAMHSA grant. This effort resulting in a multi-year grant. In December, FADAA in partnership with FFR launched the ED Peer Network through a web-based meeting.

The meeting was attended by 12 peers who are currently working in a hospital ED and three (3) FADAA staff and contractors. Ms. Bobbie Rogers, Adult Program Supervisor for South Florida Wellness Network, shared her lived experience of developing relationships with hospital ER staff. Ms. Rogers recognized that:

- Stigma is a reality
- Many persons are without health insurance
- There is a need for increased resources for detox
- Hospital ED staffs are always changing; therefore, it is vitally important to maintain relationships and connections with the staff
- Self-care is vital for peer specialists.

The peers also discussed several contingencies impacting their work in the ED:

- COVID-19
- leadership training/support
- ED working space/environment
- Practices that work in the ED warm handoff

The peer network will continue to meet quarterly. This activity will be supported by the SAMHSA funded project after the Aetna program sunsets.

2020 ED Physician Survey

In March 2020, the project determined that it should survey ED physicians to determine their knowledge and attitudes towards individuals with a SUD, MAT, warm handoff and other contingencies that impact warm handoff. FADAA engaged the Florida College of Emergency Physicians (FCEP) to help design the survey and to launch the service to its membership. This approach was selected with the idea that it would improve response rates. FCEP sent a request to its membership to take the survey and also posted a link to the survey on in the membership magazine.

A total 94 responses were received. A response rate cannot be determined because the link was open to a large audience of physicians. Of the 94 respondents:

- 48 (51%) identified as Emergency Physicians and 35 (37%) as Physician Assistant/ARNP
- Seven (7) were Board-certified in Addiction Medicine
- 17 (18%) had completed the DATA2000 training for buprenorphine prescribing
- 13 (14%) had personally initiated MAT, in any form, in the ED

Among the most significant findings of the survey were the barriers to initiating medication assisted treatment in the ED. A summary of the responses is below:

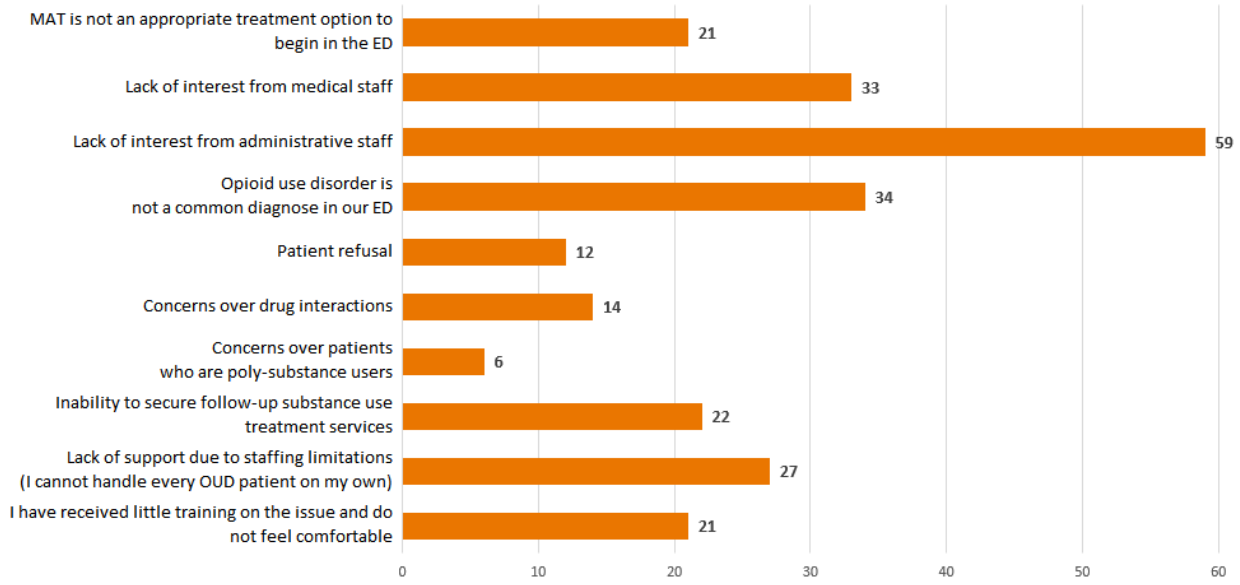

Figure 2. Barriers or concerns that impede MAT initiation in the ED. ED Survey 2020.

The information gathered in the survey is being used to develop training modules for hospital ED staff thought other funding with the goal of continue to support the expansion of warm handoff initiatives around the state.

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.

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.