

Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder



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INTRODUCTION

Far too many of our family, friends, and colleagues have been personally affected by addiction and opioid use disorder and far too many of us have personally experienced the tragedy of watching our loved ones suffer from this chronic disease. The 2016 Alexander C. Perry and Brandon Goldner Law, sponsored by Chairman Joshua Miller and Representative David Bennett, requires comprehensive discharge planning for patients with substance use disorders and requires insurers to cover expanded medication assisted treatment. It affords us a powerful opportunity and moral imperative regarding care for our loved ones at some of their most vulnerable moments.

Opioid use disorder and overdose represent life-changing health problems for patients. Opioid overdose may occur in individuals with an opioid use disorder, but may also occur as accidental poisoning in those receiving opioids, often in combination with other medications for pain management, or in those who ingest opioids and have little or no tolerance to these drugs.

Clinical protocols, organizational policies, and required infrastructure help to establish a strong framework for these diseases to be evaluated and managed at the appropriate level of care and clinical setting. It is incumbent upon each healthcare organization to evaluate their current organizational approach and embrace the needed changes described in this document, to ensure that they are meeting the described level of care most consistent with their organizational culture, resources, and purpose.

PURPOSE

The main goal of the **Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder** is to standardize humane, evidence-based care of patients with opioid use disorder in the state's emergency and hospital institutions.

It is expected that all of Rhode Island's emergency departments and hospitals will obtain a common foundation for treating opioid use disorder and overdose. This document endorses three Levels of Care and corresponding certification for emergency departments and hospitals.

The intent of this guide is to explain and define the three Levels of Care, and to delineate what is needed to demonstrate consistency with each Level. Included are:

- ▶ **definitions of the Levels' components;**
- ▶ **a Self-Assessment Form to help organize information to submit to the Rhode Island Department of Health (RIDOH) and the Department of Behavioral Healthcare and Hospitals Developmental Disabilities (BHDDH) in support of your institution's self-declared Level; and**
- ▶ **a summary of the certification process.**

DEFINITION OF LEVELS OF CARE

The expectations of Levels of Care apply to any hospital-based or freestanding emergency department or hospital. Based on a self-assessment and an evaluation for compliance with the statute and capability of treatment, each facility will be certified as Level 1, Level 2, or Level 3. It is expected that each facility will at least meet the criteria for Level 3 (the base level) and that organizations will have standardized protocols and written policies that codify their commitment to their self-declared Level of Care.

In Rhode Island, some emergency departments are free-standing, and others are part of a hospital or hospital system. The Level of Care certification for a free-standing emergency department is straightforward. The Level of Care certification for a hospital and attached emergency department reflects the successful demonstration of approved criteria for the combined facility. For example, if Hospital A has an attached emergency department and the emergency department demonstrates adherence to the approved criteria for Level 2 and the inpatient clinical setting adheres to the approved criteria of Level 3, then the institution achieves a designation of Level 3.

The state will work with all emergency departments and hospitals to ensure the provision of at least a Level of Care 3 to patients with opioid use disorder and overdose. Supports include site visits, detailed feedback, and the provision of technical assistance, as indicated and requested by the institution.

Level 3 represents a common foundation for all facilities that demonstrate a solid commitment to this healthcare problem by creating the required infrastructure and subject matter expertise to appropriately treat these patients.

Level 2 represents an organization that has actively integrated subject matter expertise and infrastructure and has made the commitment to this higher and more complex level of care.

Level 1 represents an organization which has made the commitment to establish itself as a Center of Excellence (as defined and certified by BHDDH), or another comparable arrangement as recognized by RIDOH or BHDDH, and has the requisite capacity to address appropriately the healthcare needs of the most complex patients with opioid use disorder and overdose.

LEVEL 3

1. Follows discharge planning per law
2. Administers standardized substance use disorder screening for all patients
3. Educates all patients who are prescribed opioids on safe storage and disposal
4. Dispenses naloxone to patients at risk, according to clear protocol
5. Offers peer recovery support services
6. Provides active referral to appropriate community provider(s)
7. Complies with 48-hour reporting of overdose to RIDOH
8. Performs laboratory drug screening that includes fentanyl on patients who overdose

LEVEL 2 Meets all criteria of Level 3 and:

1. Conducts comprehensive, standardized substance use assessment
2. Maintains capacity for evaluation and treatment of opioid use disorder using support from addiction specialty services

LEVEL 1 Meets criteria of Level 3 and Level 2 and also:

1. Maintains a Center of Excellence or comparable arrangement for initiating, stabilizing, and re-stabilizing patients on medication assisted treatment
 - Ensures transitioning to/from community care to facilitate recovery
 - Evaluates and manages medication assisted treatment

LEVEL 3 COMPONENTS

FOR EMERGENCY DEPARTMENTS AND INPATIENT CLINICAL SETTINGS

Emergency departments, whether freestanding or part of a larger institution, are expected to maintain at least a Level 3 designation. It is anticipated that at least one inpatient area of each hospital will achieve this designation as well, where applicable.

Level 3 indicates an organization has established standard protocols, capacity, and commitment to:

- 1. Follow the discharge planning standards as stated in current law**
- 2. Administer standardized substance use disorder screening for all patients**
- 3. Educate all patients who are prescribed opioids on safe storage and disposal**
- 4. Dispense naloxone for patients who are at risk, according to a clear protocol**
- 5. Offer peer recovery support services in the emergency department**
- 6. Provides active referral to appropriate community provider(s)**
- 7. Comply with requirement to report overdoses within 48 hours to RIDOH**
- 8. Perform laboratory drug screening that includes fentanyl on patients who overdose**

1. FOLLOW THE DISCHARGE PLANNING STANDARDS AS STATED IN CURRENT LAW*

An essential component of Level 3 is compliance with the 2016 Perry-Goldner law on discharge planning. In July of 2016, Rhode Island General Law 23-17.26.3 was amended specifically around requirements for free-standing and hospital emergency departments regarding discharge planning for patients who have a substance use disorder diagnosis. The requirements for the discharge plan are specific, and generally require the patient's consent.

This tool http://preventoverdoseri.org/wp-content/uploads/2016/10/ER-Handout_1up.pdf highlights the important parameters surrounding appropriate discharge. It can be printed and shared with the patient.

Specific requirements of the law include:

- ▶ **Involve the patient** – The patient and/or caregiver must demonstrate an understanding of relevant aspects of patient education (e.g., purpose of medication, how to administer, most common side effects, pending labs, x-rays, and phone number to call for questions) and a clear follow-up must be established. Documentation of patient involvement must be recorded in the medical record.
- ▶ **Contact patient's emergency contact** – Prior to discharge, the provider must contact the patient's emergency contact, with the patient's consent. If the patient does not consent to this, the provider must document the patient's refusal in the medical record.
- ▶ **Contact a peer recovery specialist** – Prior to discharge, the provider must contact a peer recovery specialist, with the patient's consent. If the patient does not consent to this, the provider must document the patient's refusal in the medical record.
- ▶ **Contact Primary Care Provider (PCP)** – Prior to discharge, the provider must contact the patient's primary care provider to help arrange follow-up care, preferably with an appointment being made. If there is no primary care provider, or discharge occurs after normal business hours, a good contact number or a reasonable list of PCPs should be provided. Documentation of attempt to contact must be recorded in medical record.
- ▶ **Refer to substance use care** – The patient shall be referred and transitioned, with the patient's consent, to an appropriate American Society of Addiction Medicine (ASAM) level of care for the patient's substance use disorder. If that ASAM level of care is not available, medically necessary care can be provided in an acute stabilization unit or the current clinical setting until transfer is completed or arranged. This emergency level of care cannot exceed three days.

***Required documentation includes written policies of the standard operating procedure for discharge of patients.**

2. ADMINISTER STANDARDIZED SUBSTANCE USE DISORDER SCREENING*

All patients who enter the emergency department or inpatient clinical setting should be screened for a substance use disorder. Screening for substance use disorder may uncover an important co-morbidity or principle diagnosis that may otherwise elude even the most astute clinician.

A variety of screening tools are available at:

<http://www.integration.samhsa.gov/clinical-practice/screening-tools>

Some facilities will find it more useful to select one tool to screen for drug-related issues, such as the Drug Abuse Screen Test (DAST-10) found at

<http://www.integration.samhsa.gov/clinical-practice/screening-tools>

Alternatively, facilities may prefer single-question screening tools for opioids. Sample questions include:

“How many times in the past year have you used an illegal drug?”

“How many times in the past year have you used a prescription medication for nonmedical reasons?”

Clinicians should perform additional screening and collect related history of drug use if the single question is positive. An assessment should be made as to whether the use is “hazardous use.” If so, employing the principles of Screening, Brief Intervention, Referral to Treatment (SBIRT) and considering a brief intervention would be expected. In cases where the individual appears to meet criteria for a substance use disorder, he or she should be provided a referral to treatment. Site-specific steps should be detailed in the written protocol so that the healthcare team can maintain consistency in care delivery.

If the patient declines screening for substance use disorder, this must be documented in the medical record.

***Required documentation includes written policies of the standard operating procedure for substance use disorder screening (specifying when, where, what instruments, and by whom).**

3. EDUCATE ALL PATIENTS WHO ARE PRESCRIBED OPIOIDS ON SAFE STORAGE AND DISPOSAL*

If an opioid is prescribed to a patient, the patient shall be educated regarding its safe and prompt disposal after it is no longer needed. This education will be communicated orally or in writing, depending on patient preference and shall include at a minimum:

- ▶ **acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and**
- ▶ **education regarding safe disposal options for unused portions of a controlled substance.**

Safe disposal of opioid medications reduces opportunities for diversion and their potential for misuse or unintentional poisoning. The Naloxone and Overdose Prevention Education Program of Rhode Island lists sites for medication disposal across the state: <http://noperi.org/drugdisposal.html>

Most drugs should not be flushed because of harm to the environment, however, the Food and Drug Administration recommends flushing certain prescription pain medications. To prevent accidental ingestion, these drugs should be immediately flushed when they are no longer needed. For a list of medicines recommended for disposal by flushing, visit: <http://bit.ly/2mJJ2qE>

***Required documentation includes written policies of the standard operating procedure for educating patients on safe opioid use, or any handouts or educational materials given to patients regarding opioid safety, overdose prevention, and storage.**

4. DISPENSE OR PRESCRIBE NALOXONE TO PATIENTS AT RISK, ACCORDING TO A CLEAR PROTOCOL*

Any patient who is treated for overdose, who is discharged home from the institution with a new or known combination of benzodiazepine and opioid prescriptions, or who is identified as being at risk for opioid misuse, dependence, or use disorder should be prescribed or dispensed naloxone prior to discharge from the emergency department or inpatient setting. In addition to these patients, other conditions may prompt the prescriber to dispense naloxone. These include, but are not limited to:

- ▶ **the patient is currently taking or being discharged with prescribed opioids of 50 or more morphine milligram equivalents (MME) per day;**
- ▶ **the patient is currently taking or being discharged with an opioid and has a documented diagnosis of a co-morbid condition, such as smoking, chronic obstructive pulmonary disease (COPD), emphysema, asthma, sleep apnea, respiratory infection other respiratory illness, renal dysfunction, hepatic disease, cardiac illness, and HIV/AIDS;**
- ▶ **the prescriber deems naloxone medically appropriate;**
- ▶ **the patient has a past history of substance use disorder or recovery management;**
- ▶ **the patient requests naloxone;**
- ▶ **there is known illicit opioid use; and**
- ▶ **the patient is associated with or living with someone who meets the above criteria.**

If it is not possible to dispense naloxone directly to the patient in the hospital or emergency department setting, a prescription should be provided.

Education about how to administer naloxone should be provided in the hospital or emergency department, as appropriate, prior to discharge. A web-based educational tool, such as <http://prescribetoprevent.org/patient-education/videos-for-download/>, or other online training module, can be a helpful supplement to in-person training.

While ensuring access to naloxone, prescribers should be made aware that combining an opioid and a benzodiazepine prescription represents a serious risk for adverse events and, in general, is not advised. The FDA has issued a Black Box warning about this combination.

(<http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm518697.htm>)

***Required documentation includes the electronic medical record order set (i.e., screenshot), written policies, or other documents indicating the standard operating procedure for patient education regarding provision of naloxone and overdose risk reduction.**

5. OFFER PEER RECOVERY SUPPORT SERVICES IN THE EMERGENCY DEPARTMENT OR HOSPITAL*

Patients who recover from an overdose or who are identified as having an opioid use disorder may be influenced to enter treatment if they can ask questions and talk to a peer who has a personal understanding of their chronic disease. Peer recovery support services are available 24/7 through The Providence Center (<https://providencecenter.org/services/crisis-emergency-care/anchored>) and are an integral resource in helping patients who have survived an overdose. It is expected that all patients in a Rhode Island hospital or emergency department who are treated for a drug overdose are offered the opportunity to speak with a peer recovery support specialist.

Contact a peer recovery support specialist at 401-415-8833 as soon as clinically appropriate, prior to discharge, to ensure that each overdose patient has the chance to benefit from this service.

Peer recovery support specialists:

- ▶ link individuals to treatment and recovery resources;
- ▶ provide education on overdose prevention and on obtaining naloxone (naloxone and training can be obtained at most pharmacies in Rhode Island and are usually covered by insurance, although some plans may have a co-pay);
- ▶ provide additional resources to individuals and family members; and
- ▶ contact the individual after he or she is discharged from the ED with a follow-up phone call or to schedule a visit to a local community center.

6. PROVIDES ACTIVE AND ENGAGED REFERRAL TO APPROPRIATE COMMUNITY PROVIDER(S)**

Establishing a “warm transition of care” for someone who has an opioid use disorder or has survived an overdose is expected. If a patient declines a referral to a qualified community health professional, it is expected that the clinician will provide the hotline number 401-942-STOP (942-7867) for referral to treatment of substance use, misuse, dependence, and opioid use disorder. Training staff, who are already involved in discharge of patients from emergency departments or inpatient settings, is expected.

The transition of care is a critical aspect of any discharge whether from an emergency department or inpatient clinical setting. Ideally, it includes referring the patient, with care coordination, to the appropriate level of care.

Achieving a seamless transition of care prevents the patient from being lost to follow up and going back to the situation that predisposed him or her to an overdose or other emergency department visit.

***Required documentation includes written policies of the standard operating procedure for utilization of peer recovery support services (specifying when, where, and by whom).**

****Required documentation includes written policies for medication assisted treatment along with treatment protocols, staff training and competency assessment, as well as examples of referral processes for safe transitions of care (specifying when, where, and by whom).**

A facility that achieves Level 3 designation will have their own staff that make active referral links and direct the transition of care to community providers to evaluate and manage patients for medication assisted treatment as well as biopsychosocial support.

It should be noted that often, the next stage of care will be outpatient MAT with coordinated counseling. This may occur at an opioid treatment program, or a local physician's office, depending on what is best for the individual patient.

The notion that a patient needs to be transferred to a facility with a "bed" is possible, yet not as frequent as it once was. Many patients do not require "detox" (medical withdrawal) or residential care, rather the treatment decision needs to incorporate outpatient services after a thorough biopsychosocial assessment and subsequent care coordination. The vast majority (80-90%) of people who go through "detox" relapse and are at even greater risk for overdose due to losing their tolerance during detox. This situation is unsafe and does not reflect the standard of care. If medical withdrawal is going to be considered, it should be noted this is unlikely to be successful in someone with relapsing disease. Additionally, injectable naltrexone, as well as ongoing counseling, should be part of a comprehensive treatment plan.

7. COMPLY WITH REQUIREMENT TO REPORT OVERDOSES WITHIN 48 HOURS TO RIDOH*

The Rhode Island Department of Health requires mandatory reporting of overdoses within 48 hours of discharge. Use this link to report all suspected opioid overdoses to RIDOH within the required timeframe:

<https://healthri.wufoo.com/forms/z19wu5a200231i5/>

8. PERFORM LABORATORY DRUG SCREENING THAT INCLUDES FENTANYL ON PATIENTS WHO OVERDOSE**

Patients who have survived an overdose may have been exposed to more than one substance. Patients often overdose on illicit substances and it is not unusual for a patient to have ingested a substance different than what they expected or a substance that may have been contaminated. Identifying the agent that caused an overdose may help the patient in overdose risk-reduction planning and in making informed decisions about treatment. The information will also be useful for subsequent treating providers. It is therefore expected that facilities will **conduct a blood or urine drug screen** that includes high-risk substances, such as fentanyl, that are known to be in the community.

***Required documentation includes evidence of compliance with RIDOH for completing the 48-hour mandatory reporting.**

****Required documentation includes evidence of a standard operating procedure that laboratory screening will be attempted in patients who have an overdose or opioid use disorder.**

LEVEL 2 COMPONENTS FOR EMERGENCY DEPARTMENTS AND INPATIENT SETTINGS

Facilities that achieve the Level 2 designation will include all Level 3 services as well as the following criteria:

- 1. Conduct comprehensive standardized substance use assessments**
- 2. Maintain capacity for evaluation and treatment of opioid use disorder using support from addiction specialty services**

An overarching concept of Level 2 includes the capacity to evaluate, diagnose, and treat patients who have opioid use disorder. Facilities that achieve a Level 2 designation have made a larger organizational commitment to engage and evaluate patients with opioid use disorder and consider how their organization can meet their treatment needs in a comprehensive manner. These facilities will have medical staff available that specialize in addiction medicine.

This evaluation and consideration of patients may include selective initiation of medication assisted treatment, as well as understanding the nuances of patients who are on medication assisted treatment for unrelated conditions, and the subsequent pharmacologic implications. All patients who present to the emergency department who have opioid use disorder can be evaluated for medication assisted treatment and, within Level 2 institutions, might even be able to be administered a dose in the emergency department if appropriate clinical protocols exist. Shared decision making with the patient that is informed by a standardized substance use disorder assessment is the expected context for Level 2.

Level 2
These facilities will have medical staff available that specialize in addiction medicine.

1. CONDUCT COMPREHENSIVE STANDARDIZED SUBSTANCE USE ASSESSMENTS*

Level 2 emergency departments and hospitals have staff, expertise, and resources to conduct comprehensive substance use assessments. Resources that might be used for a comprehensive assessment can be found courtesy of the Substance Abuse and Mental Health Services Administration (SAMHSA) (<http://www.integration.samhsa.gov/clinical-practice/screening-tools>). However, it is the expectation that a **comprehensive evaluation** would involve a **substance use disorder professional** who knows the standard of care for their profession and is familiar with the American Society of Addiction Medicine (ASAM) placement criteria. Facilities might have on-call staff with experience in addiction medicine for this evaluation or have consult staff available.

***Required documentation includes position descriptions of expert staff and materials used for assessment.**

2. MAINTAIN CAPACITY FOR EVALUATION AND TREATMENT OF OPIOID USE DISORDER USING SUPPORT FROM ADDICTION SPECIALTY SERVICES*

Medication assisted treatment (MAT) in the form of methadone, buprenorphine/naloxone, or injectable naltrexone will be administered, when clinically appropriate, in the emergency department or inpatient setting. Criteria for assessing clinical appropriateness for MAT should be clear and documented.

Administering medication assisted treatment in these settings requires thoughtful planning and recognizing the common clinical scenarios which would lead to the usage of MAT. For example, individuals with opioid use disorder who have been unable to access treatment and who experience an urgent need to obtain treatment may present at an emergency department. Such individuals should be accommodated and a Level 2 facility will need to be able to meet such needs. Similarly, individuals may be admitted to the hospital who have an existing opioid use disorder that then requires treatment as part of the patient's overall medical needs. Such patients will need a plan for ongoing treatment of opioid use disorder as part of their discharge plan.

Patients who have experienced an opioid overdose need careful assessment concerning whether they might be candidates for induction onto medication assisted treatment. Often such patients will have had multiple doses of opioids and naloxone in short succession. Opioid use disorder medications have not, to date, been utilized in such a context. Some individuals experiencing opioid overdose will not be physiologically dependent on opioids. Such individuals are not candidates for opioid therapies. These issues can be clinically complex and each facility must consider how these different clinical scenarios will be addressed.

If medication assisted treatment is to be administered, organizations need to decide if this will be done through contracted services provided by an outside entity (e.g., specialized addiction medicine teams contracted to provide addiction psychiatry services that augment hospital capacity), whether emergency department providers are going to care for the patients themselves, and whether the facility has a specialized subsection of an observation unit in which induction services could be performed.

Organizations are encouraged to have trained physicians in addiction medicine (or similar discipline) on their medical staff and readily available for real time consultation as needed. Medical staff trained in addiction medicine should also be available as needed for subject matter expertise in local policy development as well as ongoing clinical consultation.

Using MAT in the emergency department setting or inpatient clinical setting requires healthcare providers to become comfortable recognizing the signs and symptoms of withdrawal and providing appropriate non-opioid comfort measures and protocols for starting an induction with MAT, as well as next day follow up. The specifics of the law are here:

With patient consent, any physician in a hospital or freestanding, emergency-care facility, who is not specifically registered to conduct a narcotic treatment program, may administer narcotic drugs, including buprenorphine, to a person for the purpose of relieving acute, opioid-withdrawal symptoms, when necessary, while arrangements are being made for referral for treatment. Not more than one day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three days and may not be renewed or extended.

***Required documentation includes position descriptions, clinical protocols for MAT provision, and description of appropriate support staff.**

Ideally, patients who have overdosed are treated for their overdose, stabilized medically, and provided symptomatic relief to facilitate the substance use disorder assessment and consideration of MAT. If MAT is chosen, it can be provided for only three days and must be administered each day. Then the patient is transitioned to a more appropriate facility for maintenance care. Protocols should be in place for each type of MAT available through the emergency department.

LEVEL 1 COMPONENTS FOR EMERGENCY DEPARTMENTS AND/OR INPATIENT CLINICAL SETTINGS

Establishing and maintaining a Center of Excellence requires obtaining accreditation from BHDDH. Centers of Excellence are committed to high quality comprehensive care and have undergone the rigorous requirements to achieve this certification. Centers of Excellence have highly organized outpatient comprehensive care and are capable of caring for the most complex patients with opioid use disorder and overdose in outpatient settings. Centers of Excellence may also have inpatient care available depending on their organizational abilities.

Facilities that achieve the Level 1 designation will include all Level 3 and Level 2 services as well as the following criteria:



1. Maintain a Center of Excellence or comparable arrangement for initiating, stabilizing, and re-stabilizing patients on medication assisted treatment

- Evaluate and manage medication assisted treatment
- Ensure transitioning to/from community care to facilitate recovery

Level 1 sites incorporate all of the components of a Level 3 and 2 site including MAT induction. In addition, Level 1 sites are linked to a Center of Excellence or its equivalent to assure seamless transition of patients to outpatient care for their substance use disorder. As with Level 2, the expectation with Level 1 sites is not that every patient with opioid use disorder is immediately placed onto MAT. Rather, the standardization of assessment and offer of MAT is in place to support the hospital or emergency department in offering a Center of Excellence or its equivalent to patients with opioid use disorder.

It is expected that transition of care is seamless in organizations that achieve level 1 certification and are able to have patients connected in their own organization for most outpatient levels of care.

A Level 1 designation with a Center of Excellence or comparable program recognizes the long-term nature of medication assisted recovery. Although recovery might include medication assisted treatment, recovery encompasses other biopsychosocial aspects of health and reflects the lifelong commitment and healing that reflects a life in recovery. As a result, the capacity to transition to community care and to receive referrals back from community care for destabilizing is a critical element. Similar to diabetes or heart disease, addiction and opioid use disorder represent life-long disease that demands an understanding for the ups and downs that can occur during the journey of recovery. Behavioral services and social supports are required criteria to achieve Center of Excellence certification.

Approval process

Organization excellence is not random and requires local leadership to fully engage and create required infrastructure to facilitate successful organizational compliance that fulfills the criteria for Levels 3, 2, or 1. Facilities may have or will need to develop detailed policies to achieve such compliance. These policies should be available for staff and local leadership to implement as well as for regulators to verify compliance with the statute, where appropriate. The self-assessment form is provided to help you in this process.

Internal policies should clearly inform frontline staff what their role is and the expectations of leadership regarding incorporating their own organization culture, strategic plan and organization values to meet or exceed these requirements. Internal policies should address training requirements for initial compliance and ongoing compliance. Additionally, attention should be directed to possible communication tools, amending current documents and coordination with clinical staff to optimize the electronic health record and incorporate into the normal emergency department workflow is optimal.

1. MAINTAIN A CENTER OF EXCELLENCE OR COMPARABLE ARRANGEMENT FOR INITIATING, STABILIZING, AND RE-STABILIZING PATIENTS ON MEDICATION ASSISTED TREATMENT AND RECOVERY*

Establishing and maintaining a Center of Excellence requires obtaining accreditation from BHDDH. Centers of Excellence are committed to high-quality, comprehensive care and have undergone rigorous requirements to achieve this accreditation. Centers of Excellence have highly organized, comprehensive, outpatient care and are capable of caring for the most complex patients with opioid use disorder and overdose in outpatient settings. Centers of Excellence may also have inpatient care available depending on their organizational abilities.

- EVALUATE AND MANAGE MEDICATION ASSISTED TREATMENT**

Organizations that achieve Level 1 certification have a thorough and commanding understanding of the role of all forms of medication assisted treatment, serve as a repository of expert advice for other clinicians in the state regarding MAT, and are able to handle the most complex patients.

- ENSURE TRANSITIONING TO/FROM COMMUNITY CARE TO FACILITATE RECOVERY***

It is expected that transition of care is seamless in organizations that achieve Level 1 certification and that Level 1 facilities can manage patients in their own organization for most outpatient levels of care.

Facilities may have or will need to develop detailed policies to achieve compliance with the statute. These policies should be available for staff and local leadership to implement as well as for regulators to verify compliance with the statute. The [Self-Assessment Form](#) is provided to help you in this process.

Internal policies should inform frontline staff of their roles and of the expectations of leadership. Policies should address training requirements for initial and ongoing compliance.

*Required documentation includes Center of Excellence designation.

**Required documentation includes written policies for medication assisted treatment induction and clinical protocols for patients on MAT, as well as for re-stabilizing patients on MAT.

***Required documentation includes written policies and protocols for transitioning to or from community provision of care, as well examples of transition processes (specifying when, where, and by whom).

SELF-ASSESSMENT AND CERTIFICATION PROCESS

It is the expectation of BHDDH and RIDOH that all emergency departments and hospitals in the state will meet the minimum requirements regarding the standards of care for opioid use disorder and overdose and achieve a Level 3 certification.

To achieve certification in one of the three Levels of Care, the facility must submit a completed [Self-Assessment Form](#) and copies of relevant policies that address the statute.

To access the form, visit health.ri.gov/overdoseassessment

- ▶ **Technical assistance from RIDOH and BHDDH is available upon request, depending on resource availability.**
- ▶ **Materials will be reviewed by a strategic workgroup led by the BHDDH Chief Medical Officer and the RIDOH Medical Director.**
- ▶ **The BHDDH Chief Medical Officer and the RIDOH Medical Director will coordinate a site visit to verify and evaluate compliance and assess technical support needs.**
- ▶ **A report with the recommended designation will be issued to the Director of Health and the Director of BHDDH.**



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