

August 2024

Levels of Care for Treating Overdose and Opioid Use Disorder in Utah Emergency Departments and Hospitals

Comagine Health

Acknowledgments

Comagine Health would like to acknowledge the Utah Advisory Council for Management of Opioid Use Disorder for their collaboration in, and contribution to, the development of the Levels of Care Guide for Treating Overdose and Opioid Disorder in Utah Emergency Departments and Hospitals. The guidance and support provided by this group of Emergency Department physicians, nurses, pharmacists, social workers and administrators was instrumental in achieving consensus on the best practices for Emergency Department care of individuals experiencing overdose or opioid use disorder in Utah. We would also like to thank the funder, the Utah Department of Health and Human Services Violence and Injury Prevention Program.

Table of Contents

Overview 4

Purpose/Goals 4

Definition: Levels of Care for Treating Overdose and Opioid Use Disorder 5

1. Follow discharge planning standards and organizational protocols 5

2. Standardized substance use disorder screening of patients presenting with susstance use related conditions 6

3. Educate all patients who are prescribed opioids on safe use, storage and disposal 7

4. Follow opioid prescribing laws and consider Utah and CDC guidelines and use of opioid alternatives 8

5. Dispense naloxone for patients who are at risk, according to a clear protocol 9

6. Offer peer support specialist services in the emergency department as available 10

7. Provide active referral to appropriate community providers 10

8. Comply with Utah requirements to report overdoses per Injury Reporting Rule R386-703 11

9. Perform laboratory drug screening that includes fentanyl on patients who overdose 11

10. Provide syringe exchange program or referral 12

11. Utilize the Utah Controlled Substance Database as required by Utah law and Administrative Code 12

12. Develop processes and or procedures for buprenorphine initiation 12

Level 2 Elements 13

1. Provides comprehensive assessment of SUD using a standardized tool 13

2. Offers addiction specialists or contracted providers who can fully evaluate and treat OUD 13

Level 1 Elements 14

1. Maintains a comprehensive program for management of OUD, including MOUD 14

Summary of Level Components 15

Overview

The Levels of Care for Treating Overdose and Opioid Use Disorder (OUD) in Utah Emergency Departments and Hospitals Guide is designed to organize recommendations and resources for evidence-based practices for overdose and OUD management into levels for emergency departments (EDs). This guidance seeks to standardize effective OUD management in the ED setting. The need for addressing individual clinical needs for patients is recognized.

The components of each level of care are outlined below, along with appropriate resources and tools that will assist facilities with implementing the corresponding level of care.

Purpose/Goals

The goal of the Levels of Care for Treating Overdose and OUD in Utah Emergency Departments and Hospitals Guide is to improve OUD harm reduction outcomes by promoting evidence-based OUD management in these secondary or tertiary care settings.

The standards of care described within this document are organized into three levels of care for Utah EDs and hospitals.

LEVEL 3:

1. Follow discharge planning standards and organizational protocols.
2. Standardized substance use disorder (SUD) screening of patients with substance use related conditions.
3. Educate all patients who are prescribed opioids on safe use, storage and disposal.
4. Follow opioid prescribing laws and consider Utah and Centers for Disease Control and Prevention (CDC) guidelines and use of opioid alternatives.
5. Dispense naloxone for patients who are at risk, according to clear guidelines.
6. Offer peer support specialist services in the ED as available.
7. Provide active referral to appropriate community providers.
8. Comply with Utah requirements to report overdoses per Injury Reporting Rule R386-703.
9. Perform laboratory drug screening that includes fentanyl on patients who overdose.
10. Develop processes for clean needle exchange referral or programs.
11. Develop processes for use of the Controlled Substance Database according to all applicable laws and rules.
12. Develop processes and or procedures for buprenorphine initiation.

LEVEL 2:

Incorporates all Level 3 services and provides:

- Comprehensive assessment of SUD using a standardized tool.
- Addiction specialists or contracted providers able to fully evaluate and treat OUD.

LEVEL 1:

Incorporates all Level 3 and Level 2 services, and in addition:

- Maintain a comprehensive program for management of OUD including medication for opioid use disorder (MOUD).
- Assess and administer medication for OUD programs.
- Maintain capability to transition patients to/from inpatient and outpatient programs as necessary.

Definition: Levels of Care for Treating Overdose and Opioid Use Disorder

LEVEL 3 ELEMENTS

Best Practices for Emergency Departments and Inpatient Clinical Settings

EDs are expected to maintain appropriate resources, capacity, and commitment to provide at least a Level 3 level of care. Inpatient units are encouraged to implement applicable processes as well.

Level 3 indicates that an organization has established a commitment to evidence-based care for treating overdose and OUD, including appropriate processes and or procedures, resources and capacity for treatment.

1. Follow discharge planning standards and organizational protocols.
2. Standardized SUD screening on all patients with substance use related conditions.
3. Educate all patients who are prescribed opioids on safe use, storage, and disposal.
4. Follow opioid prescribing laws and consider Utah and CDC guidelines and use of opioid alternatives.
5. Prescribe/dispense naloxone for patients who are at risk, according to a clear protocol.
6. Offer peer support specialist services in the ED as available.
7. Provide active referral to appropriate community providers.
8. Comply with Utah requirements to report overdoses per Injury Reporting Rule R386-703.
9. Perform laboratory drug screening that includes fentanyl on patients who overdose.
10. Develop processes for clean needle exchange referral or programs. (Optional element)
11. Develop processes for use of the Controlled Substance Database according to all applicable laws and rules.
12. Develop processes and or procedures for buprenorphine initiation.

1. Follow discharge planning standards and organizational protocols.

Discharge planning is a key element in providing care to patients who overdose or have OUD. The Centers for Medicare & Medicaid Services (CMS) requires discharge planning as a Condition of Participation CMS Regulations and Guidance for all patients with specific written processes and or procedures. Utah Rule R432-100-12 General Hospital Standards outlines important components: “Treatment services shall be coordinated with other hospital and community services to assure continuity of care through discharge planning and aftercare referrals. Counselors may refer patients or clients to public or private agencies for substance abuse rehabilitation, and employment and educational counseling.”

Discharge planning information drawn from CMS and the Utah Rule are summarized below.

- Evaluate post-discharge needs. (e.g., follow-up care, social, financial, emotional, etc.)
- Involve the patient and/or caregiver:
  - Discharge planning success incorporates the patient's goals and treatment preferences.
  - Key areas to address include health condition, medications, safety and need for follow-up care.
- When possible, with the patient's consent, involve the patient's support person.
- Contact a peer support specialist. (with patient consent) (see Step 6)
- Contact the patient's primary care provider to refer for follow-up care. This element may be completed via electronic communication from the E.H.R. If possible, schedule an appointment with the provider.
- Refer to community-based opioid management programs as appropriate. (see Steps 2 & 7)

2. Administer standardized substance use disorder screening on all patients.

Patients presenting to the ED should be screened for SUD. Substance abuse and opioid misuse may not be apparent upon presentation in the ED, and identification and treatment referral for these individuals has immense potential for improving outcomes (Strayer et al., 2020). If the patient declines screening, this should be documented in the medical record. The initial assessment may be conducted by the nurse, but nurses and practitioners should perform a more comprehensive screening of substance use to identify the specific substances the patient is using if the response to a single screening question is positive.

> **"Patients presenting to the ED should be screened for SUD. Substance abuse and opioid misuse may not be apparent upon presentation in the ED, and identification and treatment referral for these individuals has immense potential for improving outcomes (Strayer et al., 2020)."**

Screening tools can be found at the following links:

- Screening Tools and Prevention | National Institute on Drug Abuse (NIDA)
- Resource on Screening, Brief Intervention and Referral to Treatment (SBIRT) implementation | SAMHSA
- Opioid Risk Tool | NIH

Facilities may prefer a brief, single-question screening tool for substance use. In an ED setting, Strayer et al. (2020) and Hawk and D'Onofrio (2018) suggest considering use of the abbreviated NIDA Quick Screen, which uses a single question:

- "Do you smoke, do you use alcohol, do you use illicit drugs?"
- It is recommended that the nurse and/or practitioner should perform a more comprehensive screening of substance use to identify the specific substances the patient is using if the response to a single screening question is positive.

If “hazardous use” of substances is suspected according to results of patient screening, using principles of SBIRT would be considered best practice (Hawk & D’Onofrio, 2018; SAMHSA, 2017).

Utah law requires health care providers to complete 3.5 hours of continuing education on controlled substance prescribing. Recent changes to the law require 3.5 hours of continuing education on SBIRT, which can be used to meet the controlled substance prescribing law requirements. Continuing education is available from the Utah Medical Association here. SBIRT training, which includes information on billing codes for SBIRT and meets the 3.5 hours of continuing education credit, is available from the University of Utah here.

If the patient meets criteria for SUD, a referral to treatment is appropriate. Protocols should include expected steps in this process to promote consistency in care delivery.



3. Educate all patients who are prescribed opioids on safe use, storage and disposal.

All patients prescribed an opioid must receive education regarding safe use, storage and appropriate disposal once the medication is no longer needed. The education should be verbal and written to best increase patient’s understanding (Waszak et al., 2017). It should include at a minimum:

- Use of opioids as directed; dangers of using alcohol or depressants with opioids.
- Responsibility to safeguard all medications and store in a secure location.
- Safe disposal options for unused portions of a controlled substance.

Safe and prompt disposal of opioid prescriptions is essential for decreasing the risk of potential misuse and poisoning. Resources for finding safe medication disposal locations are listed below:

- Controlled Substance Public Disposal Locations - Search Utility | U.S. Department of Justice (DoJ)
- Disposal of Unused Medicines: What You Should Know | U.S. Food & Drug Administration (FDA)

Multiple resources are available for patient education materials. Materials are available at:

- About Prescription Opioids | Overdose Prevention | CDC
- Opioids - Patient Education Handouts | ACEP
- Opioid Overdose | stopoverdose.org

4. Follow opioid prescribing laws and consider Utah and CDC guidelines and use of opioid alternatives.

Clear guidelines for opioid prescribing should be implemented in the ED according to Utah law and considering CDC recommendations for pain management.

Avoiding the prescribing of opioid medications in favor of effective alternatives and following best practice prescribing guidelines are important primary prevention practices to help address the opioid epidemic in the ED setting. Utah law requires an opioid prescription not to exceed seven days in most circumstances. It also requires clinicians to discuss dangers and risks of opioids when issuing an initial opioid prescription, along with alternative treatments that could be used.

In 2023, the Consolidated Appropriations Act enacted a one-time, eight-hour education requirement for all DEA-registered practitioners on the treatment and management of patients with OUD and other SUDs. Information about this rule can be accessed here.

The State of Utah and the CDC have issued guidance for opioid prescriptions for chronic pain, which are also valuable to consider in ED settings. A few of the recommendations are listed here:

- Opioid alternatives are preferred, excepting for palliative care.
- Immediate release formulations at the lowest effective dose should be prescribed when opioids are selected for acute pain.
- Caution should always be used when prescribing opioids, considering expected benefits and potential harms.

The American Academy of Emergency Physicians (AAEP) has issued a list of suggested non-opioid and non-pharmacologic methods for chronic pain control in the ED setting, which can be accessed at the citation link (Strayer et al., 2020).

Prescribing laws and guideline links include:

- Title 58, Chapter 37, Section 6 of Utah Code | Utah State Legislature
- CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR

5. Prescribe/dispense naloxone for patients who are at risk according to a clear protocol.

Naloxone, which immediately reverses the effects of opioids, can be lifesaving for individuals who suffer critical respiratory depression because of opioid use or a combination of opioids and other substances.

Patients seen in the ED, meeting the criteria below, who are discharged from the hospital or ED should be prescribed naloxone prior to discharge. Other indications for prescribed naloxone include ACEP 2023 Policy Statement on Naloxone Access; Emergency Medicine (prescribetoprevent.org).

- Patients being treated as the result of opioid poisoning
- Patients receiving both benzodiazepines and opioids
- Patient is currently taking or being discharged with prescribed opioids of 50 or more morphine milligram equivalents (MME) per day, has been prescribed long acting or extended-release formulations or has been prescribed a rotating opioid regimen
- Patients taking opioids who also have a comorbid condition, such as smoking, lung disease, sleep apnea, respiratory infection or illness, kidney or liver disease, heart disease and/or HIV/AIDS
- Patient has a suspected or known history of SUD or OUD, is initiating MOUD, or is undergoing an opioid detoxification program
- Patient has recently been released from incarceration and has a history of opioid misuse
- Patient or caregiver request for naloxone
- Patient has a close associate with any of the above criteria

> **Timely administration of naloxone is a safe and effective way to reverse and stop an opioid overdose. In Utah, it is legal to have, is available from pharmacies without a written prescription and persons administering it in an emergency are protected from civil liability. Dispensing naloxone directly to a patient in the ED or hospital is a best practice (Strayer et al., 2020).**

Education, including written material about how to recognize an opioid overdose, safely administer Naloxone and seek necessary medical care should be given in the hospital or ED when naloxone is dispensed as required by Utah law. Resource options include:

- Utah Naloxone
- Patient Education Videos | Prescribe to Prevent



6. Optional element: offer peer support specialist services in the emergency department as available.

Peer support specialists (PSS) provide many types of social support to individuals experiencing SUD and can have a positive influence at any stage of an individual's recovery. In the ED setting, PSS can influence motivation to seek treatment and/or help facilitate a warm hand-off to treatment (SAMHSA, 2009). PSS have the personal experience to answer questions about the process of recovery from this chronic disease and are a valuable resource for patients.

In Utah, a peer support specialist is a person who has completed an approved training program and maintains ongoing certification as established by Utah Administrative Code Rule 523-5. Hours vary by location. To connect with a PSS in Salt Lake City, dial 385-210-0320, the contact number for Utah Support Advocates for Recovery Awareness (USARA). USARA offers services in five Utah locations. Hours vary by location. Patients identified as having SUD should be offered the opportunity to talk with a PSS before discharge, if available.

More information is available at:

- Utah Support Advocates for Recovery Awareness (USARA)
- Certified Peer Support Specialists | Utah Department of Health & Human Services
- 211 Utah

7. Optional element: provide active referral to appropriate community providers.

The "warm hand-off" or transition of care has been shown to increase the likelihood that a patient will follow up on a referral from one provider to another. "Warm" transitions involve more than just giving a patient a referral. It can also involve engaging the patient's support system and incorporate communicating relevant clinical information and recommendations to the next provider of care (AHRQ, n.d.).

For patients who have experienced an overdose or who have an OUD, "warm handoff" referrals and directing the transition of care to appropriate community providers and treatment options is best practice (Strayer et al., 2020). Warm handoffs to community providers are highly encouraged whenever possible. Appropriate providers may include those certified for medication for OUD, opioid treatment programs, primary care, counseling and biopsychosocial support. Optimizing the transition of care can reduce issues, such as patients resuming opioid misuse activities after discharge and being lost to follow-up.

For patients declining a direct referral for treatment, or when warm handoffs are not possible, clinicians should provide information on how to contact a treatment provider. Referral resources for treatment can be found at Utah 211 and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Staff involved in discharge instruction should be trained and provided with clear procedures for active referral to community care to be implemented whenever possible. Care transitions at discharge are critical for patient outcomes in the ED and inpatient settings. Warm handoffs can be accomplished utilizing the electronic medical record when direct communication with the provider is not feasible.

Additional resources are available at:

- SUMH | Utah Department of Health and Human Services - Substance Use and Mental Health

8. Comply with Utah requirements to report overdoses per Injury Reporting Rule R386-703.

The Injury Reporting Rule gathers information on serious injuries and death in Utah to provide data necessary to guide public health efforts in the state. Injuries where anyone involved in the incident was intoxicated with drugs or alcohol are included.

Applicable report requirements are described as:

- EDs treating a reportable injury must use the appropriate electronic format to submit ED logs to the Bureau of Emergency Medical Services. This will meet reporting requirements.
- If the patient dies as a result of the injury or poisoning, the death certificate submitted to the Bureau of Vital Records meets the reporting requirements.
- Reports must be submitted within 60 days.

Hospital processes and or procedures should outline the process of reporting.

9. Perform laboratory drug screening that includes fentanyl on patients who overdose.

Drug testing is an evidence-based tool which should be combined with patient report of drug use to determine an overall picture of what has led to an overdose (ASAM Appropriate Use of Drug Testing). The emphasis of drug testing should be on therapeutic use, including determining if the patient has been exposed to a substance they are not aware of, for appropriate risk mitigation to take place.

Protocols should be in place for patients who have suffered an overdose to receive a laboratory drug screen, which includes fentanyl and/or other high-risk substances suspected to be common in the community.

10. Optional element: provide syringe exchange program or referral.

Offering a syringe exchange program (SEP) whenever possible is a harm reduction strategy that lowers risk for HIV and Hepatitis C virus transmission in individuals who inject drugs. Programs provide education on overdose prevention, testing and prevention for blood-borne disease, safe disposal of used syringes, referral to treatment and naloxone kits in addition to the sterile syringes and needles provided free of charge at Syringe Services | Utah Epidemiology. SEPs have been established in Utah since the signing of legislation in 2016 providing legalization and guidance for programs. Hospitals and EDs may choose to implement their own SEP or refer patients to community programs.

Calendar of community SEPs and provider resources are available online at Utah Syringe Exchange Network. Links to laws, SEP schedules and educational material are online at the Utah Department of Health and Human Services. In addition, an extensive resource handbook is available from the Utah Department of Health and Human Services.

11. Utilize the Utah Controlled Substance Database as required by Utah law and Administrative Code.

The ED should develop processes and or procedures for use of the Controlled Substance Database (CSD) according to all applicable laws and rules. This type of database, generally called prescription drug monitoring programs (PDMP), is intended to collect data on prescribing practices for quality improvement education and to monitor patients for dangerous prescription-seeking behaviors to prevent opioid misuse.

Utah law requires a clinician to check the CSD when providing an opioid prescription to a patient for the first time, or to check the CSD occasionally when recurring prescriptions are provided to a patient.

Other elements of the law include:

- The CSD can be accessed by a registered designee of the provider.
- An electronic health record with the approved connection to the CSD can be accessed in place of the CSD.
- Exceptions are granted when the CSD is disrupted or when an emergency results in the inability to comply.

These and other aspects of the law are described in the Utah Department of Health and Human Services' Stop the Opidemic resource.

For more information, application forms for a CSD designee, instructions for how use the CSD and link to CSD, access the Division of Occupational and Professional licensing.

12. Develop processes and or procedures for buprenorphine initiation.

Buprenorphine, with well-established efficacy in community programs providing Medications for OUD, has strong evidence showing its value when initiated in the ED. Patients are far more likely to have continued engagement with treatment and significantly lower frequency of opioid misuse reported 30 days after being referred to a program when they received buprenorphine in the ED.

Buprenorphine initiation in the ED is endorsed by the American College of Emergency Medicine (ACEP) and the American Academy of Emergency Medicine (AAEM).

Buprenorphine can be utilized in the ED to relieve opioid withdrawal symptoms while arrangements are made for the willing patient to engage in a community treatment program.

Additional information and resources on buprenorphine use in the hospital setting are available from SAMHSA.

LEVEL 2 ELEMENTS

Best Practices for Emergency Departments and Inpatient Hospital Settings

The facility incorporates all Level 3 services and in addition provides:

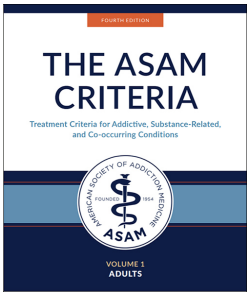
- Comprehensive assessment of SUD using a standardized tool.
- Addiction specialists or contracted providers able to fully evaluate and treat OUD.

Level 2 status indicates that an organization has established a larger commitment to comprehensive assessment and on-site treatment beyond buprenorphine initiation in the ED. Staff should be available at the facility with specialized training in SUD management. Patients identified with a quick screen, at risk for SUD, will receive a comprehensive assessment and be offered MOUD treatment if warranted. Patients will be included in decisions about their care as the comprehensive assessment results inform the best treatment options.

1. Provides comprehensive assessment of SUD using a standardized tool.

Level 2-certified facility SUD clinician will conduct comprehensive assessments of all patients identified as at risk for SUD or OUD. The specialist should use a tool that assesses holistic needs, such as those detailed in the six American Society of Addiction Medicine Criteria.

Additional screening tools are available from the National Institute on Drug Abuse.



2. Offers addiction specialists or contracted providers who can fully evaluate and treat OUD.

Medications for OUD, such as buprenorphine, may be initiated in the ED setting in Level 3 facilities, but a Level 2 facility will have inpatient or outpatient resources for continued treatment and counseling, with a provider available. Facility addiction specialists will be involved in identification of candidates for Medications for OUD and management of patients referred for treatment.

LEVEL 1 ELEMENTS

Best Practices for Emergency Departments and Inpatient Hospital Settings

The facility incorporates all Level 3 and Level 2 services, and in addition:

- Maintains a comprehensive program for management of OUD, including Medications for OUD.
- Addiction specialists or contracted providers able to fully evaluate and treat OUD.

Level 1 indicates the ability to provide the comprehensive and high-quality care necessary for management of complex patients in need of OUD management. Outpatient and inpatient care meets these requirements.

1. Maintains a comprehensive program for management of OUD, including MOUD.

The Level 1 facility maintains the ability to perform the following OUD management:

- The ability to assess patients for OUD, administer medication for OUD, and provide ongoing care.
- Maintains capability to transition patients to/from inpatient and outpatient programs as necessary to provide seamless care during stabilization and re-stabilization.

Processes and training should be in place to ensure leadership, staff and the health and human services department can achieve and verify compliance. Standardized tools, communication and incorporating alerts into electronic health record that streamline and promote high-quality interventions into normal workflow and is part of the Level 1 expectation. Established relationships with community treatment programs and the facility's ability to manage OUD are essential.

It is not expected in any of the levels that every patient identified as at risk of OUD be placed into treatment but rather that patients will be screened, those at risk assessed and treatment offered, including Medications for OUD and follow-up care when appropriate.

Summary of Level Components

References for All Levels

- A Quality Framework for ED Treatment of OUD | Annals of Emergency Medicine
- Acute Treatment and Stabilization for Overdose and Opioid Use Disorder | Rhode Island DoH
- Guidelines for Emergency Department Opioid Management | MA Hospital Association
- Management of OUD in the Emergency Department | Journal of Emergency Medicine

Level 3

Component	Required Elements	References
Follows discharge planning per law	Organization has developed processes that identify applicable federal, state laws, and provide implementation guidance.	**Laws and guidelines:** • State Operations Manual – Guidelines for Hospitals | CMS • Rules and Descriptions | Utah DHHS • R432-100-28. Substance Abuse Rehabilitation Services | Utah DHHS **Reference material:** • Acute Treatment and Stabilization for Overdose and Opioid Use Disorder | Rhode Island DoH
Substance use screening	Organization utilizes and implements a standardized SUD screening tool.	**SBIRT and short screen resources:** • SBIRT | SAMHSA • TAP 33: Systems-Level Implementation of SBIRT | SAMHSA • Toolkit for Opioid Prescribers | UT Dept. of Commerce **Utah law for provider education:** • Title 58, Chapter 37, Section 6 | UT Code **Links to continuing education:** • Online Learning Portal | UMA Foundation • SBIRT | Substance Education Institute **Reference material:** • Emergency Department Screening and Interventions for Substance Use Disorders | Addiction Science & Clinical Practice

Level 3

Component	Required Elements	References
Education	Organization educates all patients who are prescribed opioids on safe usage, storage, and disposal. Processes exist that outline the required elements of this education.	**Utah law:** • Title 58, Chapter 37, Section 6 | Utah Code **Educational tools:** • Drug Disposal: Drug Take Back Locations | FDA • Physician Guidance on Safe Storage, Disposal of Opioids | American Medical Association • About Prescription Opioids | CDC **Reference material:** • A Quality Improvement Project to Improve Education Provided by Nurses to ED Patients Prescribed Opioid Analgesics at Discharge | Journal of Emergency Nursing
Prescribing guidelines and use of opioid alternatives	The organization has developed and implemented clear guidelines for opioid prescribing according to law and considered Utah and CDC recommendations for pain management.	**Prescribing laws and guidelines:** • Medication Assisted Treatment | U.S. DEA Diversion Control Division • Title 58, Chapter 37, Section 6 | Utah Code • Clinical Practice Guideline for Prescribing Opioids for Pain | CDC **Reference material:** • A Country in Crisis: Opioid Sparing Solutions for Acute Pain Management | Modern Medicine • EMR-based interventions to encourage opioid prescribing best practices in the ED | American Journal of Emergency Medicine • Impact of Hospital "Best Practice" Mandates on Prescription Opioid Dispensing After an Emergency Department Visit | Academic Emergency Medicine
Naloxone protocols	Organization has developed and implemented clear guidelines for dispensing naloxone to patients at risk.	**Utah laws and resources:** • Rule 17b: Pharmacy Practice Act Rule | UT Office of Administrative Rules • Naloxone Access and Utilization for Suspected Opioid Overdoses | ACEP • Statewide Standing Order: Dispensing Naloxone for Opioid Overdose Prevention | UT DHHS **Reference material:** • Utah Naloxone • Prescribe To Prevent • U.S. Surgeon General's Advisory on Naloxone and Opioid Overdose | DHHS • Results of a Naloxone Screening Quality-Improvement Project in an Academic ED | Journal of Emergency Medicine • A Clinical Nurse Specialist-Led ED Naloxone Distribution Program | Clinical Nurse Specialist

Level 3

Component	Required Elements	References
Peer support	Wherever possible organizations have a list of resources for peer-to-peer support and a referral process.	**How to access Utah's peer support network:** • Utah Support Advocates for Recovery Awareness (USARA) • Certified Peer Support Specialist | UT DHHS • 211 Utah **Utah peer support law:** • Rule 5: Peer Support Specialist Training and Certification | UT Office of Administrative Rules **Reference material:** • What Are Peer Recovery Support Services? | SAMHSA • Responding to the Opioid and Overdose Crisis with Innovative Services: The Recovery Community Center Office-Based Opioid Treatment (RCC-OBOT) Model | Addictive Behaviors
Referral to community treatment provider(s)	Organization has developed and maintains a list of community OUD providers. Discharge processes outline the referral process.	**Links to find treatment providers:** • FindTreatment.gov • Mental Health Resources | 211 Utah • Toolkit for Opioid Prescribers | Utah Dept. of Commerce **Reference material:** • Responding to the Opioid and Overdose Crisis with Innovative Services: The Recovery Community Center Office-Based Opioid Treatment (RCC-OBOT) Model | Addictive Behaviors • Warm Handoffs: A Guide for Clinicians | AHRQ
Overdose reporting	Organization has developed processes and or procedures for overdose reporting.	**Utah injury reporting law:** • DAR File No. 41831 (Rule R386-703), 2017-13 Utah Bull. (07/01/2017)
Perform laboratory drug screening	Organization has developed processes outlining the requirement for screening all patients who overdose including screening for fentanyl.	**Reference material:** • Appropriate Use of Drug Testing in Clinical Addiction Medicine Consensus Document | ASAM

Level 3

Component	Required Elements	References
Syringe exchange	Organization has developed processes for clean needle exchange referral or program access wherever available.	**Utah Department of Health and Human Services resources:** • Utah Syringe Exchange Program Handbook • Syringe Services | Utah Epidemiology **Utah Syringe Exchange Administrative Rule 386-900** • Proposed 2023 General Session legislation affecting section 26-7-8: S.B. 41, 1st Sub. S.B. 41 • Rule 900: Special Measures for the Operation of Syringe Exchange Programs **Reference material:** • Syringe Services Programs | NIH
Controlled substance database	Organization has processes that define the requirements for reporting to the Utah Controlled Substance Database and can demonstrate that providers or their designees have obtained access.	**Utah laws and Administrative Rule:** • Title 58, Chapter 37f, Part 3, Section 304 | UT Code • Rule 37f: Controlled Substance Database Act Rule | UT Office of Administrative Rules **Reference material:** • Opioid Prescribing Laws and Emergency Department Guidelines for Chronic Non-Cancer Pain in Washington State | Pain Practice
Buprenorphine initiation	Organization has developed processes, and or, procedures for buprenorphine initiation.	**Reference material:** • The Case for Buprenorphine Initiation in the Emergency Department: Why, When, and How? | QIO Program • Advancing Emergency Department–Initiated Buprenorphine | JACEP Open • Initiating Buprenorphine Treatment in the Emergency Department | NIDA

Level 2

Component	Required Elements	References
Level 3 elements	Organization complies with all Level 3 elements.	See references in Level 3 table.
Comprehensive standardized substance use assessment	Organization employs or contracts with providers capable of completing a comprehensive assessment of patients experiencing OUD or overdose.	**National Institutes of Health (NIH) assessment tools:** • Screening and Assessment Tools Chart **Reference material:** • CA Bridge – Bridge to Treatment
Maintains capacity for evaluation and treatment	Organization employs, credentials or contracts with providers licensed and qualified to provide in-depth evaluation to patients with OUD and treatment of the disorder.	• Acute Treatment and Stabilization for Overdose and Opioid Use Disorder | Rhode Island DoH

Level 1

Component	Required Elements	References
Level 2 & 3 elements	Organization complies with all Level 2 & 3 elements.	
Maintains a comprehensive treatment center	Organization has implemented processes for initiating, stabilizing and re-stabilizing patients on medication assisted treatment.	• CA Bridge – Bridge to Treatment • Opioids Podcasts | ACEP

Level 1

Component	Required Elements	References
Transition to/from community care	Organization either provides or has an arrangement with outpatient organizations capable of providing ongoing care for patients experiencing OUD post-discharge.	
Evaluates and manages MOUD	Organization employs, credentials or contracts with providers capable of inpatient or outpatient medication management (i.e., buprenorphine).	• CA Bridge – Bridge to Treatment