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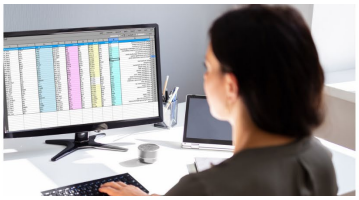


HARM REDUCTION AND OVERDOSE PREVENTION

50-State Survey

SUD-Related Emergency Department Mandates

Drug overdose is a nationwide epidemic that claimed the lives of approximately 90,000 people in the United States in 2020.[1] While many individuals with substance use disorder or who have experienced a nonfatal overdose do not seek treatment in hospital emergency departments (ED), nearly 975,000 nonfatal drug overdoses were treated in EDs in 2017.[2]

While emergency treatment for overdose is critical, EDs also present an opportunity to screen individuals for substance use disorder (SUD) and connect patients who might benefit from evidence-based treatment with appropriate follow-up services. Unfortunately, this opportunity is often missed. In Massachusetts, for example, only approximately one third of 18 to 45-year-olds who received hospital treatment for opioid overdose received any medication for opioid use disorder within the following 12 months.[3] This lack of continuing care may be part of the reason that overdose risk among people treated in the ED remains elevated. Recent research from England found that hospital discharge is associated with an increase in fatal opioid overdose,[4] and in the United States over 5% of people insured with Medicaid die and nearly 20% experience another opioid overdose in the year after experiencing a non-fatal overdose.[5]

Advocates have suggested that the failure of hospitals to identify patients at risk of substance-related harm and provide or refer them to treatment may violate one or more federal laws.[6] One way to ensure that EDs provide appropriate screening, referral, and treatment is for states to create legal mandates requiring them to do so.

We conducted a systematic legal review to determine the prevalence and characteristics of state laws that require some or all hospital emergency departments to create protocols to screen patients for substance use disorder as well as those that require that hospitals take specific actions when providing care to such individuals or individuals who have experienced an overdose. We excluded laws that do not apply to hospital EDs, as well as documents that do not have the force of law such as guidelines and best practice transmittals.[7] Where a law requires more than one activity, we list the law under the heading of the most expansive requirement.

We found a total of 14 states with legally enforceable mandates: Alaska, Connecticut, Massachusetts, Florida, Kentucky, Maryland, Missouri, New Jersey, New York, Rhode Island, Pennsylvania, Virginia, Washington, and Washington, D.C. A summary of the requirements in each state is listed below. The complete text of all relevant laws is attached as Appendix A.

Non-specific protocol or policy required

Alaska: “Guidelines or protocol for the treatment of and referral for substance abuse must be present and readily accessible in the emergency room”.[8]

Florida: Each hospital with an emergency department is required to “develop a best practices policy to promote the prevention of unintentional drug overdoses.”[9] This policy may include, but is not limited to, providing the patient with information regarding substance use disorder (SUD) treatment, guidelines for the prescription of medications for opioid use disorder, and the use of behavioral health professionals or peer specialists “to encourage the patient to seek substance abuse treatment.”[10]

Maryland: Each hospital is required to have a protocol for discharging a patient who was treated by the hospital for a drug overdose or who was identified as having an SUD. The protocol “may” include coordination with a peer recovery counselor who can conduct Screening, Brief Intervention and Referral to Treatment (SBIRT) and connect the patient to community services, as well as prescribing naloxone to the patient.[11]

Washington, D.C.: “Each hospital shall develop protocols governing the identification, treatment, discharge, and referral of patients with opioid use disorder, and submit the protocols to DOH."[12]

Provision of information or referral required

Kentucky: When a person is admitted to a hospital emergency department, for treatment of drug overdose, the person “shall be informed of available substance use disorder treatment services known to the hospital that are provided by that hospital, other local hospitals, the local community mental health center, and any other local treatment programs.”[13] The hospital is also permitted to contact those programs, with the consent of the patient or their representative, “to connect him or her to treatment.”[14]

Missouri: When an “overdose survivor” arrives in the emergency department of a hospital participating in the state’s Improved Access to Treatment for Opioid Addictions Program, a medical professional or recovery coach “shall, when reasonably practicable, meet with the overdose survivor and provide treatment options and support available to the overdose survivor.”[15]

New Jersey: If an opioid antidote is administered to a person believed to be experiencing a drug overdose and the person is admitted to a health care facility or receives treatment in the emergency department, a staff member must offer to provide them or a friend or family member an opioid antidote upon discharge, together with information concerning SUD treatment programs and resources, sterile syringe access programs, and resources. They may also, in collaboration with a health care practitioner, develop an individualized SUD treatment plan for the person.[16]

Pennsylvania: “A health care practitioner shall refer an individual for treatment if the individual is believed to be at risk for substance abuse while seeking treatment in an emergency department or urgent care center or when in observation status in a health care facility.”[17]

Virginia: State law requires the Board of Health to create regulations that require "each hospital with an emergency department to establish a protocol for the treatment and discharge of individuals experiencing a

substance use-related emergency…"[18] The regulations require each hospital with an emergency department to "establish a protocol for treatment of individuals experiencing a substance use-related emergency to include the completion of appropriate assessments or screenings to identify medical interventions necessary for the treatment of the individual in the emergency department." The protocol may also include a process for patients who are discharged directly from the emergency department for the recommendation of follow-up care following discharge, and may include instructions for distribution of naloxone, referrals to peer recovery specialists and community-based providers of behavioral health services; or referrals for pharmacotherapy for treatment of drug or alcohol dependence or mental health diagnoses.[19]

Screening or evaluation required

Connecticut: All short-term general hospitals, outpatient surgical facilities, and outpatient clinics must establish protocols for screening trauma patients for "alcohol and substance abuse," and "include in the record of each trauma patient a notation indicating the extent and outcome of screening for alcohol and substance abuse."[20] Separately, any hospital that treats a patient for a nonfatal opioid overdose "shall administer a mental health screening or assessment of the patient if medically appropriate, and provide the results of such screening or assessment to the patient if medically appropriate, or to the patient's parent, guardian or legal representative, as applicable, if medically appropriate."[21]

Medications required to be offered

Massachusetts: Massachusetts has two relevant laws. First, any person presenting in an acute care hospital or satellite emergency facility who the treating clinician reasonably believes to be experiencing an opioid-related overdose, or who has been administered naloxone prior to arriving at the facility, must be given an SUD evaluation within 24 hours. Findings from the evaluation as well as the treating clinician's determination of need for further treatment must be entered into the patient's medical record.[22]

Further, each acute care hospital that provides services in an emergency department must maintain protocols and capacity to provide "appropriate, evidence-based interventions prior to discharge that reduce the risk of subsequent harm and fatality following an opioid-related overdose including, but not limited to, institutional protocols and capacity to possess, dispense, administer and prescribe opioid agonist treatment, including partial agonist treatment, and offer such treatment to patients who present in an acute-care hospital emergency department or a satellite emergency facility for care and treatment of an opioid-related overdose."[23]

New York: General hospitals "shall include in their policies and procedures treatment protocols, consistent with medical standards, to be utilized by the emergency departments in general hospitals for the appropriate use of medication-assisted treatment, including buprenorphine, prior to discharge, or referral protocols for evaluation of medication-assisted treatment when initiation in an emergency department of a general hospital is not feasible." General hospitals are also required to "develop, maintain and disseminate, written policies and procedures, for the identification, assessment and referral of individuals with a documented substance use disorder or who appear to have or be at risk for a substance use disorder" and to "inform the individual of the availability of the substance use disorder treatment services that may be available to them through a substance use disorder services program."[24]

Rhode Island: Each hospital and freestanding emergency care facility is required to submit a comprehensive discharge plan to the state. The plan must include, for patients with indications of SUD, opioid overdose, or chronic addiction, a substance use evaluation, the administration of controlled substances to treat withdrawal, the provision of information regarding appropriate SUD services, and information about the availability of clinically appropriate services.[25] Per regulations, the hospital must also order a laboratory screening for overdose patients to determine which drug caused the overdose, provide education regarding illicit drug use and harm reduction strategies, the dispensing or prescribing of naloxone where indicated, and offer patients with SUD or who have overdosed the opportunity to speak with a peer recovery support specialist. The hospital must also provide information to the patient about treatment options and make a good faith effort to assist the patient in obtaining an appointment with a qualified licensed treatment professional.[26]

Washington: "A hospital shall provide a person who presents to an emergency department with symptoms of an opioid overdose, opioid use disorder, or other adverse event related to opioid use with opioid overdose reversal medication upon discharge, unless the treating practitioner determines in their clinical and professional judgment that dispensing or distributing opioid overdose reversal medication is not appropriate or the practitioner has confirmed that the patient already has opioid overdose reversal medication. If the hospital dispenses or distributes opioid overdose reversal medication it must provide directions for use."[27] Note that this law does not go into effect until Jan. 1, 2022.

SUPPORTERS

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[1] National Center for Health Statistics, *Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts*, *available at* https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.
[2] S. Liu, et al., *Nonfatal Drug and Polydrug Overdoses Treated in Emergency Departments - 29 States, 2018-2019*, 69 MORB MORTAL WKLY REP 1149 (2020).
[3] S. M. Bagley, et al., *Characteristics and Receipt of Medication Treatment Among Young Adults Who Experience a Nonfatal Opioid-Related Overdose*, 75 ANN EMERG MED 29 (2020).
[4] D. Lewer, et al., *Fatal opioid overdoses during and shortly after hospital admissions in England: A case-crossover study*, 18 PLOS MED (2021).
[5] M. Olfson, et al., *Risks of fatal opioid overdose during the first year following nonfatal overdose*, 190 DRUG ALCOHOL DEPEND 112 (2018).
[6] Legal Action Center, *Emergency: Hospitals are violating federal law by denying required care for substance use disorders in emergency departments* (2021).
[7] For example, Delaware law requires the Secretary of the Department of Health and Human Services to "create an overdose system of care to coordinate the treatment and care provided to individuals who have overdosed or require acute management of substance use disorder, including opioid use disorder" and to issue regulations to that effect, but no such regulations have been promulgated and the law contains no hospital requirements. *See* Del. Code tit. 16, § 9710. Similarly, we do not include laws that involve hospitals but do not require action from them, such as a law in

Vermont that directs the Department of Health to implement and expand hospital referral services for people treated for opioid overdose. *See* Vt. Stat. Ann. tit. 18, § 4240(b)(5). A listing of laws that were discovered through our legal search but that did not meet inclusion criteria is included in Appendix 2.

[8] Alaska Admin. Code tit. 7, § 12.870(c).
[9] Fla. Stat. § 395.1041(6)(b).
[10] Fla. Stat. § 395.1041(6)(b)(4).
[11] Md. Code, Health - General, § 19-310.3
[12] D.C. Code § 7-3203.
[13] Ky. Rev. Stat. Ann. § 216B.402(1).
[14] Ky. Rev. Stat. Ann. § 216B.402(2).
[15] Mo. Rev. Stat. § 630.875(9).
[16] N.J. Rev. Stat. § 24:6J-5.1.
[17] 35 Pa. Cons. Stat. § 873.4.
[18] Va. Code Ann. § 32.1-127(B)(27)
[19] 12 Va. Admin. Code § 5-410-280.
[20] Conn. Gen. Stat. §19a-490h.
[21] Conn. Gen. Stat. § 19a-127q(b).
[22] The treating hospital must also notify the patient's primary care physician, if known, of "the opioid-related overdose and any recommendations for further treatment." Mass. Gen. Laws ch. 111, § 51 ½.
[23] Mass. Gen. Laws ch. 111 § 25J ½.
[24] N.Y. Pub. Health Law § 2803-u.
[25] 23 R.I. Gen. Laws § 23-17.26-3(a).
[26] 216 R.I. Code R. 40-10-4.6(D).
[27] Wash. Rev. Code § 70.41.0001(1).

Appendix 1: Laws that mandate emergency departments take action with regard to patients who have experienced an overdose or may have substance use disorder

Alaska: Alaska Admin. Code tit. 7, § 12.870

(c) Guidelines or protocol for the treatment of and referral for substance abuse must be present and readily accessible in the emergency room.

Connecticut: Conn. Gen. Stat. Ann. § 19a-490h

(a) Each hospital licensed by the Department of Public Health as a short-term general hospital, outpatient surgical facility or outpatient clinic shall include in the record of each trauma patient a notation indicating the extent and outcome of screening for alcohol and substance abuse. For purposes of this section, “trauma patient” means a patient of sufficient age to be at risk of alcohol and substance abuse with a traumatic injury, as defined in the most recent edition of the International Classification of Disease, who is admitted to the hospital on an inpatient basis, is transferred to or from an acute care setting, dies or requires emergent trauma team activation.
(b) Each such hospital shall establish protocols for screening patients for alcohol and substance abuse.
(c) The Department of Mental Health and Addiction Services, after consultation with the Department of Public Health, shall assist each hospital required to conduct alcohol and substance abuse screening pursuant to subsections (a) and (b) of this section with the development and implementation of alcohol and substance abuse screening protocols.

Connecticut: Conn. Gen. Stat. Ann. § 19a-127q

(b) On and after January 1, 2020, any hospital licensed pursuant to chapter 368v that treats a patient for a nonfatal overdose of an opioid drug, as defined in section 20-14*o*, shall administer a mental health screening or assessment of the patient if medically appropriate, and provide the results of such screening or assessment to the patient if medically appropriate, or to the patient's parent, guardian or legal representative, as applicable, if medically appropriate.

Florida: Fl. Stat. Ann. § 395.1041

(6) Rights of persons being treated.--

(a) A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

(b) Each hospital with an emergency department shall develop a best practices policy to promote the prevention of unintentional drug overdoses. The policy may include, but is not limited to:

1. A process to obtain the patient’s consent to notify the patient’s next of kin, and each physician or health care practitioner who prescribed a controlled substance to the patient, regarding the patient’s overdose, her or his location, and the nature of the substance or controlled substance involved in the overdose.

2. A process for providing the patient or the patient's next of kin with information about licensed substance abuse treatment services, voluntary admission procedures under part IV of chapter 397, involuntary admission procedures under part V of chapter 397, and involuntary commitment procedures under chapter 394.

3. Guidelines for emergency department health care practitioners authorized to prescribe controlled substances to reduce the risk of opioid use, misuse, and addiction.

4. The use of licensed or certified behavioral health professionals or peer specialists in the emergency department to encourage the patient to seek substance abuse treatment.

5. The use of Screening, Brief Intervention, and Referral to Treatment protocols in the emergency department.

This paragraph may not be construed as creating a cause of action by any party.

Kentucky: Ky. Rev. Stat. § 216B.402

When a person is admitted to a hospital emergency department or hospital emergency room for treatment of a drug overdose:

(1) The person shall be informed of available substance use disorder treatment services known to the hospital that are provided by that hospital, other local hospitals, the local community mental health center, and any other local treatment programs licensed pursuant to KRS 222.231;

(2) The hospital may obtain permission from the person when stabilized, or the person's legal representative, to contact any available substance use disorder treatment programs offered by that hospital, other local hospitals, the local community mental health center, or any other local treatment programs licensed pursuant to KRS 222.231, on behalf of the person to connect him or her to treatment; and

(3) The local community mental health center may provide an on-call service in the hospital emergency department or hospital emergency room for the person who was treated for a drug overdose to provide information about services and connect the person to substance use disorder treatment, as funds are available. These services, when provided on the grounds of a hospital, shall be coordinated with appropriate hospital staff.

Maryland: Maryland Code, Health - General, § 19-310.3

In general

(a) On or before January 1, 2018, each hospital shall have a protocol for discharging a patient who was treated by the hospital for a drug overdose or was identified as having a substance use disorder.

Contents of protocol

(b) The protocol may include:

(1) Coordination with peer recovery counselors who can conduct a screening, a brief

intervention, and referral to treatment and connection of the patient with community services; and

(2) Prescribing naloxone for the patient.

Massachusetts: Mass. Gen. Laws ch. 111 § 25J ½

An acute-care hospital, as defined in section 25B, that provides emergency services in an emergency department and a satellite emergency facility, as defined in section 51 ½, shall maintain, as part of its emergency services, protocols and capacity to provide appropriate, evidence-based interventions prior to discharge that reduce the risk of subsequent harm and fatality following an opioid-related overdose including, but not limited to, institutional protocols and capacity to possess, dispense, administer and prescribe opioid agonist treatment, including partial agonist treatment, and offer such treatment to patients who present in an acute-care hospital emergency department or a satellite emergency facility for care and treatment of an opioid-related overdose; provided, however, that such treatment shall occur when it is recommended by the treating healthcare provider and is voluntarily agreed to by the patient. An acute-care hospital that provides emergency services in an emergency department, and a satellite emergency facility, shall demonstrate compliance with applicable training and waiver requirements established by the federal drug enforcement agency and the substance abuse and mental health services administration relative to prescribing opioid agonist treatment. Prior to discharge, any patient who is administered or prescribed an opioid agonist treatment in an acute care hospital emergency department or satellite emergency facility shall be directly connected to an appropriate provider or treatment site to voluntarily continue said treatment.

The department may issue regulations pursuant to this section.

Massachusetts: Mass. Gen. Laws ch. 111 § 51 ½

(b) A person presenting in an acute-care hospital or a satellite emergency facility who is reasonably believed by the treating clinician to be experiencing an opioid-related overdose, or who has been administered naloxone prior to arriving at the hospital or facility, shall receive a substance use disorder evaluation within 24 hours of receiving emergency room services. A substance use disorder evaluation shall conclude with a diagnosis of the status and nature of the patient's substance use disorder, using standardized definitions as set forth in the Diagnostic and Statistical Manual of Mental Disorders as published by the American Psychiatric Association a diagnosis of a mental or behavioral disorder due to the use of psychoactive substances, as defined and coded by the World Health Organization. Each patient shall be presented with the findings of the evaluation in person and in writing, and the findings shall include recommendations for further treatment, if necessary, with an assessment of the appropriate level of care needed. Findings from the evaluation shall be entered into the patient's medical record. No acute-care hospital or satellite emergency facility shall permit early discharge, defined as less than 24 hours after presentation or before the conclusion of a substance use disorder evaluation, whichever occurs sooner. If a patient does not receive an evaluation within 24 hours, the treating clinician shall note in the medical record the reason the evaluation did not take place and authorize the discharge of the patient. No clinician shall be held liable in a civil suit for releasing a patient who does not wish to remain in the emergency department after stabilization, but before a substance use disorder evaluation has taken place.

(c) During or after a substance use disorder evaluation conducted pursuant to subsection (b), treatment may occur within the acute-care hospital or satellite emergency facility, if appropriate

services are available, which may include induction to medication-assisted treatment. If the acute care hospital or satellite emergency facility is unable to provide such services, the acute care hospital or satellite emergency facility shall refer the patient to an appropriate and available hospital or treatment provider; provided, however, that nothing in this section shall relieve an acute care hospital or satellite emergency facility from the requirements of section 25J ½. Medical necessity for further treatment shall be determined by the treating clinician and noted in the patient's medical record.

If a patient refuses further treatment after the evaluation is complete, and is otherwise medically stable, the acute-care hospital or satellite emergency facility may initiate discharge proceedings; provided, however, that if the patient is in need of and agrees to further treatment following discharge pursuant to the substance use disorder evaluation, then the acute care hospital or satellite emergency facility shall directly connect the patient with a community-based program prior to discharge or within a reasonable time following discharge when the community-based program is available. All patients receiving an evaluation under subsection (b) shall receive, upon discharge, information on local and statewide treatment options, providers and other relevant information as deemed appropriate by the treating clinician.
(d) If a person has received a substance use disorder evaluation within the past 3 months, further treatment and the need for a further evaluation shall be determined by the treating clinician according to best practices and procedures.

(e) If a person under 18 years of age is ordered to undergo a substance use disorder evaluation, a parent or guardian shall be notified that the minor has suffered from an opioid-related overdose and that an evaluation has been ordered. A parent or guardian may be present when the findings of the evaluation are presented to the minor.

(f) Upon discharge of a patient who experienced an opioid-related overdose, the acute-care hospital or satellite emergency facility shall notify the patient's primary care physician, if known, of the opioid-related overdose and any recommendations for further treatment.

(g) Upon discharge of a patient who experienced an opioid-related overdose, the acute-care hospital, satellite emergency facility or emergency service program shall record the opioid-related overdose and substance use disorder evaluation in the patient's electronic medical record and shall make the evaluation directly accessible by other healthcare providers and facilities consistent with federal and state privacy requirements through a secure electronic medical record, health information exchange, or other similar software or information systems to: (i) improve ease of access and utilization of such data for treatment or diagnosis; (ii) support integration of such data within the electronic health records of a healthcare provider for purposes of treatment or diagnosis; or (iii) allow healthcare providers and their vendors to maintain such data for the purposes of compiling and visualizing such data within the electronic health records of a healthcare provider that supports treatment or diagnosis.

(h) Nothing in this section shall interfere with an individual's right to refuse medical care.

Missouri: Mo. Ann. Stat. § 630.875(9)

When an overdose survivor arrives in the emergency department, the assistant physician, physician assistant, or advanced practice registered nurse serving as a recovery coach or, if the assistant physician, physician assistant, or advanced practice registered nurse is unavailable, another properly trained recovery coach shall, when reasonably practicable, meet with the overdose survivor and provide treatment options and support available to the overdose

survivor. The department shall assist recovery coaches in providing treatment options and support to overdose survivors.

New Jersey: N.J. Stat. Ann. § 24:6J-5.1

a. If an opioid antidote is administered by a health care practitioner or a first responder to a person believed to be experiencing a drug overdose, an opioid antidote and information concerning substance use disorder treatment programs and resources and sterile syringe access programs and resources, including information on the availability of opioid antidotes, shall be provided to the person as follows:

(1) If the person is admitted to a health care facility or receives treatment in the emergency department of a health care facility, a staff member designated by the health care facility, who may be a social worker, professional counselor, licensed or certified alcohol or drug counselor, or other appropriate professional, shall offer to furnish the person, or a family member or friend of the person in attendance during the patient's admission or emergency department visit, with an opioid antidote upon discharge, along with information regarding the cost of the opioid antidote, and shall provide the information concerning substance use disorder treatment programs and resources and sterile syringe access programs and resources to the person at any time after treatment for the drug overdose is complete, but prior to the person's discharge from the facility. The designated staff member shall document the provision of the information and the dispensing of an opioid antidote to the person or to a family member or friend of the person, if an opioid antidote is dispensed, in the person's medical record, and may, in collaboration with an appropriate health care practitioner, additionally develop an individualized substance use disorder treatment plan for the person.

New York: N.Y. Public Health Law § 2803-u

1. The office of alcoholism and substance abuse services, in consultation with the department, shall develop or utilize existing educational materials to be provided to general hospitals to disseminate to individuals with a documented substance use disorder or who appear to have or be at risk for a substance use disorder during discharge planning pursuant to section twenty-eight hundred three-i of this article. Such materials shall include information regarding the various types of treatment and recovery services, including but not limited to: inpatient, outpatient, and medication-assisted treatment; how to recognize the need for treatment services; information for individuals to determine what type and level of treatment is most appropriate and what resources are available to them; and any other information the commissioner deems appropriate. General hospitals shall include in their policies and procedures treatment protocols, consistent with medical standards, to be utilized by the emergency departments in general hospitals for the appropriate use of medication-assisted treatment, including buprenorphine, prior to discharge, or referral protocols for evaluation of medication-assisted treatment when initiation in an emergency department of a general hospital is not feasible.

2. Every general hospital shall: (a) within existing or in addition to current policies and procedures, develop, maintain and disseminate, written policies and procedures, for the identification, assessment and referral of individuals with a documented substance use disorder or who appear to have or be at risk for a substance use disorder as defined in section 1.03 of the mental hygiene law;

(b) establish and implement training, within existing or in addition to current training programs, for all individuals licensed or certified pursuant to title eight of the education law who provide direct patient care regarding the policies and procedures established pursuant to this section; and

(c) except where an individual has come into the hospital under section 22.09 of the mental hygiene law, if the hospital does not directly provide substance use disorder services, then it shall refer individuals in need of substance use disorder services to and coordinate with substance use disorder services programs that provide behavioral health services, as defined in section 1.03 of the mental hygiene law.

3. Upon commencement of treatment, admission, or discharge of an individual with a documented substance use disorder or who appears to have or be at risk for a substance use disorder, including discharge from the emergency department, such hospital shall inform the individual of the availability of the substance use disorder treatment services that may be available to them through a substance use disorder services program.

4. The commissioner, in consultation with the commissioner of the office of alcoholism and substance abuse services, shall make regulations as may be necessary and proper to carry out the provisions of this section.

Pennsylvania: 35 Pa. Stat. Ann. § 873.4

"A health care practitioner shall refer an individual for treatment if the individual is believed to be at risk for substance abuse while seeking treatment in an emergency department or urgent care center or when in observation status in a health care facility."

Rhode Island: R.I. Gen. Laws § 23-17.26-3

(3) The discharge plan and transition process shall include recovery planning tools for patients with substance-use disorders, opioid overdoses, and chronic addiction, which plan and transition process shall include the elements contained in subsection (a)(1) or (a)(2), as applicable. In addition, such discharge plan and transition process shall also include:

(i) That, with patient consent, each patient presenting to a hospital or freestanding emergency-care facility with indication of a substance-use disorder, opioid overdose, or chronic addiction shall receive a substance-use evaluation, in accordance with the standards in subsection (a)(4)(ii), before discharge. Prior to the dissemination of the standards in subsection (a)(4)(ii), with patient consent, each patient presenting to a hospital or freestanding emergency-care facility with indication of a substance-use disorder, opioid overdose, or chronic addiction shall receive a substance-use evaluation, in accordance with best practices standards, before discharge;

(ii) That if, after the completion of a substance-use evaluation, in accordance with the standards in subsection (a)(4)(ii), the clinically appropriate inpatient and outpatient services for the treatment of substance-use disorders, opioid overdose, or chronic addiction contained in subsection (a)(3)(iv) are not immediately available, the hospital or freestanding emergency-care facility shall provide medically necessary and appropriate services with patient consent, until the appropriate transfer of care is completed;

(iii) That, with patient consent, pursuant to 21 C.F.R. § 1306.07, a 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 (3) days and may not be renewed or extended;

(iv) That each patient presenting to a hospital or freestanding emergency-care facility with indication of a substance-use disorder, opioid overdose, or chronic addiction, shall receive information, made available to the hospital or freestanding emergency-care facility in accordance with subsection (a)(4)(v), about the availability of clinically appropriate inpatient and outpatient services for the treatment of substance-use disorders, opioid overdose, or chronic addiction, including:

(A) Detoxification;
(B) Stabilization;
(C) Medication-assisted treatment or medication-assisted maintenance services, including methadone, buprenorphine, naltrexone, or other clinically appropriate medications;
(D) Inpatient and residential treatment;
(E) Licensed clinicians with expertise in the treatment of substance-use disorders, opioid overdoses, and chronic addiction;
(F) Certified peer recovery specialists; and

(v) That, when the real-time patient-services database outlined in subsection (a)(4)(vi) becomes available, each patient shall receive real-time information from the hospital or freestanding emergency-care facility about the availability of clinically appropriate inpatient and outpatient services.

Rhode Island: R.I. Admin. Code 40-10-4.6

D. Discharge Planning: Substance Use Disorder, Opioid Use Disorder, and Chronic Addiction

1. Evaluation

a. The hospital must administer a standardized evaluation to all patients with an indication of substance use disorder, opioid use disorder, or chronic addiction. If the patient declines evaluation this must be documented in the medical record. If the patient is determined after an evaluation to have a substance use disorder or opioid use disorder then appropriate medical services will be offered to the patient. Services offered to the patient shall include, but are not limited, to clinically appropriate inpatient and outpatient services.

b. Hospitals shall have a written policy for evaluation available upon request, inspection, or related to investigation of complaint.

2. Laboratory Screening

For every patient presenting to the hospital with an opioid overdose, the hospital must order a laboratory screening to determine what substance(s) caused the overdose. If the patient refuses the laboratory screening, the hospital is still in compliance as long as the test was ordered. If the patient declines screening this must be documented in the medical record.

3. Education

a. The hospital must educate all patients who are prescribed opioids on the risks and benefits of prescribed opioids as well as safe storage and disposal in accordance with the section titled “Patient Education/Consent” in Rules and Regulations for Pain Management, Opioid Use and the Registration of Distributors of Controlled Substances in Rhode Island.

b. When patients present with indications of illicit drug use (including but not limited to the use of illegal substances or the use of diverted prescription drugs), the hospital must educate such patients on illicit drug use, including evidence-based harm reduction strategies such as proper syringe disposal and how to obtain non-prescription syringes.

c. If the Department issues a health advisory (either statewide or for the particular geographic area in which the hospital is contained) regarding an increase in overdoses or overdose deaths, the hospital is required to educate illicit drug use and diverted overdose patients with evidence-based harm reduction strategies.

4. Naloxone

a. The hospital must have a written policy that outlines when a prescriber should dispense or prescribe naloxone to patients. This policy must include a list of conditions that would prompt the dispensing or prescribing of naloxone. A sample list of conditions is found in the Department's guidance document “Levels of Care for Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder.”

b. For patients meeting the conditions set out in the hospital's policy, a prescriber must dispense or prescribe naloxone.

c. For those patients who are dispensed or prescribed naloxone, education regarding how to administer naloxone shall be provided to patients prior to discharge.

d. Hospitals shall have a written policy for naloxone available upon request, inspection or related to investigation of complaint.

5. Peer Recovery

a. The hospital shall offer all patients the opportunity to speak with a peer recovery support specialist, if those patients:

(1) are diagnosed with substance use disorder or opioid use disorder using then [sic] evaluation protocol required by § 4.6.1(D)(1) of this Part, or
(2) are treated for an opioid overdose.

b. To fulfill the above requirement, at a minimum the hospital must inform the patient that the hospital will contact a peer recovery support specialist on the patient's behalf.
c. Hospitals shall have a written policy for peer recovery available upon request, inspection or related to investigation of complaint.

6. Treatment Services

a. The hospital shall provide information to patients about appropriate inpatient and outpatient services, including but not limited to medication assisted treatment and biopsychosocial treatment, if those patients:

(1) are diagnosed with substance use disorder or opioid use disorder using then [sic] evaluation protocol required by § 4.6.1(D)(1) of this Part, or
(2) are treated for an opioid overdose.
b. Hospitals must make a good faith effort to assist the patient in obtaining an appointment with a qualified licensed professional. To fulfill the above requirement, at a minimum the hospital must present a list of names, addresses, and phone numbers of appropriate inpatient and outpatient services. This list shall include information about medication-assisted treatment. If the patient declines to receive information or assistance about treatment services this must be documented in the medical record.
c. Hospitals shall have a written policy for treatment services available upon request, inspection or related to investigation of complaint.

7. Notification of Emergency Contact

a. Prior to discharge and with patient consent, the hospital will attempt to notify the patient's emergency contacts and peer recovery support specialist (if any of these individuals have been identified) pursuant to R.I. Gen. Laws § 23-17.26-3(iii). If the patient declines notification of an emergency contact or recovery coach, the treating provider will document this refusal in the medical record.
b. Hospitals shall have a written policy for notification of emergency contact available upon request, inspection, or related to investigation of complaint.

8. Right to Refuse Treatment

Pursuant to R.I. Gen. Laws § 23-17-19.1(4), a patient has the right to refuse any screening, treatment, or service described in §§ 4.6.1(D)(1) through (7) of this Part.

9. Overdose Reporting

Hospitals shall comply with the reporting requirements found in Rules and Regulations Pertaining to Opioid Overdose Prevention and Reporting (Part 20-20-5 of this Title).

Virginia: Va. Code Ann. § 32.1-127

B. Such regulations:
….
27. Shall require each hospital with an emergency department to establish a protocol for the treatment and discharge of individuals experiencing a substance use-related emergency, which shall include provisions for (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to identify medical interventions necessary for the treatment of the individual in the emergency department and (ii) recommendations for follow-up care following discharge for any patient identified as having a substance use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a) the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection X of § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or other opioid antagonist used for overdose reversal, including

information about accessing naloxone or other opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing order. Such protocols may also provide for referrals of individuals experiencing a substance use-related emergency to peer recovery specialists and community-based providers of behavioral health services, or to providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses.

Virginia: 12 VAC 5-410-280

J. Each hospital with an emergency department shall establish a protocol for treatment of individuals experiencing a substance use-related emergency to include the completion of appropriate assessments or screenings to identify medical interventions necessary for the treatment of the individual in the emergency department. The protocol may also include a process for patients who are discharged directly from the emergency department for the recommendation of follow-up care following discharge for any identified substance use disorder, depression, or mental health disorder, as appropriate, that may include:

1. Instructions for distribution of naloxone;
2. Referrals to peer recovery specialists and community-based providers of behavioral health services; or
3. Referrals for pharmacotherapy for treatment of drug or alcohol dependence or mental health diagnoses.

Washington: Wash. Code Ann. § 70.41.0001

(1) A hospital shall provide a person who presents to an emergency department with symptoms of an opioid overdose, opioid use disorder, or other adverse event related to opioid use with opioid overdose reversal medication upon discharge, unless the treating practitioner determines in their clinical and professional judgment that dispensing or distributing opioid overdose reversal medication is not appropriate or the practitioner has confirmed that the patient already has opioid overdose reversal medication. If the hospital dispenses or distributes opioid overdose reversal medication it must provide directions for use.

(2) The opioid overdose reversal medication may be dispensed with technology used to dispense medications.

(3) A person who is provided opioid overdose reversal medication under this section must be provided information and resources about medication for opioid use disorder and harm reduction strategies and services which may be available, such as substance use disorder treatment services and substance use disorder peer counselors. This information should be available in all languages relevant to the communities that the hospital serves.

(4) The labeling requirements of RCW 69.41.050 and 18.64.246 do not apply to opioid overdose reversal medications dispensed or distributed in accordance with this section.

Washington, D.C.: DC Code Ann. § 7-3203

(a) By October 1, 2019, and annually thereafter, each hospital shall develop protocols governing the identification, treatment, discharge, and referral of patients with opioid use disorder, and submit the protocols to DOH.

(b) By June 1, 2020, and annually thereafter, DOH shall submit an analysis of the sufficiency of each hospital's protocols to the chairperson of the Council committee with jurisdiction over matters related to health.

Appendix 2: Laws relevant to hospital SUD treatment that did not meet inclusion criteria

Delaware: Del. Code Ann. tit. 16, § 9710

(a) The Secretary shall create an overdose system of care to coordinate the treatment and care provided to individuals who have overdosed or require acute management of substance use disorder, including opioid use disorder.

(b)(1) The Secretary may adopt regulations, policies, and procedures to permit the Director of the Division of Substance Abuse and Mental Health to designate a facility as a stabilization center.
(2) A facility may be designated as a stabilization center if the facility meets federal and State requirements to receive a patient from Emergency Medical Services and can do all of the following:
a. Provide medical care and supervision after an overdose.
b. Provide medical care and supervision for acute management needs for substance use disorder.
c. Initiate medication-assisted treatment.
d. Refer individuals to other services.

(c)(1) The Secretary may adopt regulations, policies, and procedures to designate a facility as an overdose system of care center.
(2) The Secretary must use a guideline and evidence-based process as recommended by the Overdose System of Care Committee to determine designation criteria.

(d) The Secretary may adopt regulations, policies, and procedures to establish other distinct categories of care in the overdose care system as supported by evidence and recommended by nationally recognized guidelines and the Overdose System of Care Committee.

(e) The Secretary may suspend or revoke a designation under this section if a facility fails to meet the standards established under this section.

(f) The Director of the Division of Public Health may include an acute health care facility, hospital, freestanding emergency department, or emergency medical services provider in the overdose system of care if the entity does all of the following:
(1) Participates in the care of patients who have overdosed or require acute management for substance use disorder.
(2) Contributes data required by the Director of the Division of Public Health or the Director of the Division of Substance Abuse and Mental Health.
(3) Participates in overdose system of care quality improvement.

Vermont: Vt. Stat. Ann. § 4240

(b) For the purpose of addressing prescription and nonprescription opioid overdoses in Vermont, the Department shall develop and implement a prevention, intervention, and response strategy, depending on available resources, that shall:

(1) provide educational materials on opioid overdose prevention to the public free of charge, including to substance abuse treatment providers, health care providers, opioid users, and family members of opioid users;

(2) increase community-based prevention programs aimed at reducing risk factors that lead to opioid overdoses;
(3) increase timely access to treatment services for opioid users, including medication-assisted treatment;
(4)(A) educate substance abuse treatment providers on methods to prevent opioid overdoses;
(B) provide education and training on overdose prevention, intervention, and response to individuals living with addiction and participating in opioid treatment programs, syringe exchange programs, residential drug treatment programs, or correctional services;
(5) facilitate overdose prevention, drug treatment, and addiction recovery services by implementing and expanding hospital referral services for individuals treated for an opioid overdose; and
(6) develop a statewide opioid antagonist pilot program that emphasizes access to opioid antagonists to and for the benefit of individuals with a history of opioid use.

Wisconsin: Wis. Stat. Ann. § 46.482

(1) Definitions. In this section:
(a) “Overdose treatment provider” means an entity, including an emergency department of a hospital, that offers treatment or other services to individuals in response to or following a substance use overdose.
(b) “Peer recovery coach” means an individual described under s. 49.45(30j)(a) 2. and who has completed the training requirements specified under s. 49.45 (30j)(b) 4.

(2) The department shall establish and maintain a program to facilitate overdose treatment providers to do all of the following:
(a) Use peer recovery coaches to encourage individuals to seek treatment for a substance use disorder following an overdose.
(b) Provide access to medications to reverse overdose, as appropriate.
(c) Coordinate and continue care and treatment of individuals after an overdose, including through referrals to treatment services, to peer support, to community organizations that support recovery, to education, training, and employment services, to housing services, and to child welfare agencies. An overdose treatment provider may coordinate and continue care and treatment under this paragraph by establishing an integrated model of care for patients who have experienced an overdose that may include assessment, follow-up services, and transportation to and from treatment.
(d) Provide education to patients and families on preventing and reversing an overdose.
(e) Provide follow-up services for patients after overdose to ensure continued recovery and connection to support services.
(f) Collect and evaluate data on the outcomes of patients receiving peer recovery coach services and coordination and continuation of care services under this section.

(3) The department may establish policies and procedures to provide guidance on any of the following:
(a) The provision of medications that reverse an overdose and any other medications or biological products used to treat a substance use disorder.
(b) Continuation of, or referral to, evidence-based treatment services for patients with a substance use disorder who have experienced an overdose, for the purpose of supporting long-term treatment and preventing relapse or future overdoses.

(4) The department shall seek any funding available from the federal government, including grant funding under 42 USC 290dd-4, to establish and maintain the program under sub. (2) or

establish the policies and procedures under sub. (3). The department may satisfy the requirement under sub. (2) by encouraging or facilitating or providing funding to programs operated by nongovernmental overdose treatment providers.