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# Focus Study: Medication for Opioid Use Disorder (MOUD) Treatment

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## Description

There is an extreme need to expand and make more accessible opioid use disorder (OUD) treatment in the United States, as only one in 10 people with substance use disorder (SUD) receive treatment (Indicator Dashboards Opioid Dashboard, n.d.). Connecting people who experience a non-fatal drug overdose with treatment is crucial to preventing additional overdoses. It is estimated that about one in 20 people who receive medical treatment in an emergency department (ED) for a non-fatal overdose will die within a year. About two-thirds of those deaths can be linked to an opioid overdose (Weiner, et al).

However, despite commendable efforts within healthcare systems, interventions to address SUD treatments often occur in silos, lacking a coordinated, system-wide approach. This fragmentation can lead to duplication of efforts, inefficiencies, and most crucially, gaps in care that hinder the patient's journey to recovery through the continuum of care. Given that patients with OUD often have time-limited circumstances when they seek and obtain care, and that rapid, low threshold access to care is related to better engagement and retention, there is a belief that a more integrated care coordination effort between acute and outpatient settings, fostered through cross-departmental collaboration and coordination, would significantly improve the quality and effectiveness of the services provided.

Opioid use disorder is increasingly recognized as a chronic, relapsing medical condition. Additionally, many individuals with OUD also have other medical and psychiatric comorbidities that are often sub-optimally managed. Individuals with OUD have high rates of ED visits and hospital admissions/readmissions. When OUD is not treated, individuals have high rates of injury, disability, and death.

According to Center for Disease Control's (CDC) Drug Overdose Surveillance and Epidemiology (DOSE) system dashboard for Minnesota, which outlines both ED and inpatient statistics, the annual number of non-fatal opioid overdose ED visits in 2021 was 2,555 and the annual rate of ED visits for non-fatal opioid overdoses per 100,000 persons in 2021 was 44.7. There were 769 non-fatal opioid overdose inpatient hospitalizations in 2021 with an annual rate of 13.5 non-fatal opioid overdoses per 100,000 persons in 2021. Additionally, the Minnesota Electronic Health Record (EHR) Consortium, which provides a dashboard to trend substance-involved ED visits in Hennepin County, shows the annual number of ED and hospital visits that involved opioids was 10,236 in 2022 and 10,356 in 2021 compared to 9,488 in 2020 and 8,413 in 2016. Non-fatal opioid overdoses occurred in 2,334 of these visits in 2021 and in 1,309 visits in 2016.

In addition to the high rate of OUD related ED visits and hospitalization, a concerning gap exists in the continuum of treatment for patients with OUD. According to research by Kilaru et al., published in 2020, only 16.6% of patients obtained follow-up treatment within 90 days after being discharged from the ED following a non-fatal opioid overdose. Similarly, a 2016 study by Naeger et al. revealed that only 17% of patients engaged in SUD treatment within 30 days of a hospital discharge. These statistics suggest that, even when life-saving interventions are successfully employed in ED settings, the majority of patients do not continue to receive the critical ongoing care needed for recovery post-discharge. The failure to bridge this gap not only places these individuals at heightened risk for relapse, overdose, and other adverse outcomes, but it also highlights an urgent need for integrated, long-term solutions. [i]

### *Focus Study Questions*

1. What barriers exist within current healthcare settings that prevent effective coordination of care for members accessing care for opioid use disorder?

2. What interventions can address these barriers?

## Process and Documentation

This study utilizes the ongoing findings of the Hennepin Health reinvestment initiatives championed by physician researchers at Hennepin Healthcare System (HHS) in the SUD access and treatment area. “Improving Inpatient to Outpatient Care Coordination for Medication for Opioid Use Disorder” is championed by Sarah Lexcen, PA-C, MPH—Division of General Internal Medicine and Xin Piao, APRN, CNP—Division of General Internal Medicine.

The findings of these complimentary interventions, using the PDSA methodology, are being analyzed and synthesized to assess the effectiveness of processes and structural changes to elicit sustainable improvements to SUD treatment access. This study reviews a comprehensive overview of workflow practices specifically looking at areas for efficiency and stability. A survey was conducted as part of the project.

### *Sample Size and Study Methodology*

Provider champions from within HHS conducted key interviews with staff from Addiction Medicine, Emergency Medicine, and the inpatient setting as well as partners in community service organizations. These interviews were conducted to identify barriers as well as facilitators for patients with SUD transitioning from acute to outpatient settings. A program evaluator then identified key themes of the interviews and highlighted recommendations for workflow changes to improve transitions of care.

## Analysis

### *Data Limitations*

As these initiatives are still in the early stages and utilize the PDSA-cycle of continuous improvement, conclusions at this time are limited. Initial results are promising; however, additional provider cohorts will need to be trained on the interventions, and additional time is needed to see the changes in practice and patient outcomes. Hennepin Health will continue to monitor HEDIS® rates of SUD follow-up care for additional systemic evidence of intervention effectiveness.

### *Results*

The survey findings have been divided into three key areas of focus: patient access, operational barriers, and scheduling.

Patient access to this program is crucial. A walk-in culture facilitates access to care in Addiction Medicine department and at the 1800 Chicago facility. This is not the current system in General Internal Medicine (GIM). There needs to be widespread community knowledge about what services are available and how to access care. Administrative silos prevent both the GIM and Addiction Medicine departments from providing a full array of SUD and primary care services. Improving the transition from acute to outpatient care remains to be a challenge for all stakeholders. Restrictions within Epic®, the electronic health record system, prevent care coordinators and connection center staff from scheduling GIM SUD reserved appointments. The Addiction Medicine department has a direct phone number which patients/referrers can call to schedule SUD appointments. The typical process to schedule a general primary care appointment at the GIM’s Clinic and Specialty Center (CSC) clinic is to call the HHS Connection Center, but scheduling agents do not have a mechanism to know which providers have expertise in treating SUDs. Because general primary care appointments are often booked out weeks in advance, GIM providers at the CSC created private appointment time slots dedicated for urgent access to provide care for patients with SUDs. Although keeping these appointment slots private prevents them from being scheduled for non-SUD related needs, this restriction significantly minimizes the staff that have knowledge of these slots and permissions to schedule them. As such, these dedicated slots are not optimally utilized to increase access to SUD care.

Widespread knowledge of what clinical services are available at different locations and how to access them are essential for ensuring patients can utilize available services. For example, Hennepin County's Behavioral Health Center (aka 1800 Chicago) is well-known in the community as a place for patients to receive acute withdrawal management, and the HHS Addiction Medicine department has a publicly available scheduling telephone number which facilitates direct connection to services. The availability of SUD appointment slots in GIM's CSC clinic is relatively new and less widely known. Emergency Department, hospital inpatient, and community service providers voiced a desire for easier access to the SUD appointment slots and greater transparency in how to help patients access these appointments.

Addressing these challenges began with increasing availability of next-day appointments in primary care with a future goal created to facilitate same-day walk-in access. The clinic was able to effectively create and use dedicated SUD appointment slots by ensuring that schedulers and coordinators could access clinic templates as well as creating new ways to utilize newly implemented collaborative care model and care coordination to facilitate care connections. Education was provided to internal providers via departmental meetings and weekly updates. Patient-facing pamphlets were created to promote this service and distributed to both internal providers and community partners. Workflows were also created to allow referrals directly from Epic® to outpatient care.

Operational barriers including administrative silos and continuity-of-care challenges from acute settings to outpatient care were identified. Several administrative and legal barriers exist that limit the sharing of patient information in order to access care. There are logistical barriers to fully integrating primary care into the Addiction Medicine Clinic. For example, because the Addiction Medicine Clinic is in a different building from the majority of CSC outpatient clinics, it is more difficult to access the clinical laboratory or medications that are stored at the CSC, like vaccines. At the same time, there are barriers to integrating all addiction medicine services into primary care. For example, federal regulations require that methadone only be administered in the opioid treatment program setting, and some medications, like long-acting buprenorphine (Sublocade), have special safety storage requirements currently limiting its storage and administration to the Addiction Medicine Clinic.

Overcoming identified scheduling barriers requires changes to the Epic® charting system and creating ease of access through direct telephonic scheduling—omitting routing of telephone calls through the Connection Center. Timely access is critical. Interviewees working in multiple care settings highlighted the logistical barriers to coordinating follow-up primary care upon discharge from the hospital or the ED. Specifically, although there are dedicated appointment slots reserved for patients who need SUD treatment in a primary care setting at the CSC Internal Medicine clinic, the care coordinators for inpatient units and the ED do not have bandwidth for coordinating follow-up appointments for all patients. Furthermore, for the subset of higher risk patients for whom care coordinators do schedule follow-up care, the care coordinators do not have authorized Epic® permissions to schedule in the reserved private slots. This results in a mismatch where GIM SUD slots are underutilized and patients needing follow-up care have many barriers to accessing appointments in a timely manner. Patients and community providers are not able to call to make a SUD related appointment in primary care and cannot access the reserved slots without going through the HHS telephone system, which increases the barriers for timely access to an appointment.

## Recommendations and Next Steps

Outlined below are the next steps for this project.

1. Increase availability of next-day appointments: When patients with a SUD are discharged from the ED or the hospital, they frequently have both physical and behavioral health needs and are discharged with a small supply of medications and are advised to follow-up in an outpatient setting for ongoing care. A priority identified is a clear pathway to rapid access care at a pivotal time in behavior change readiness. An area where GIM can significantly increase capacity to support treatment retention for SUDs in HHS is through scheduled next-day appointments for patients leaving acute settings. Increasing the availability of next-day

appointments in GIM's CSC clinic would also open capacity at the Addiction Medicine Clinic for patients with more complex SUD management needs and would allow patients for whom it is appropriate to receive primary and SUD care in the same appointment.

2. Advertise availability of SUD care in GIM: Within HHS and in the wider community, there are several SUD care providers that are well known (e.g., Addiction Medicine, 1800 Chicago, Red Door). What is less well known is that the CSC GIM clinic has providers who have the expertise and training to provide SUD care and have reserved appointment slots for doing so. Internally, project champions should consider promoting this newer service availability by publishing in the HHS Scanner, presenting at Departments of Medicine, Emergency Medicine, and Psychiatry monthly meetings, and adding a public facing website for SUD care at GIM, similar to the pages for weight management and adult gender and sexual health. In addition, GIM should create printed promotional materials that highlight the availability of SUD care at the GIM clinic and how to schedule an appointment for distribution internally to HHS departments (e.g., ED, Acute Psychiatry Services, jail, Psychiatry, Addiction Medicine) as well as to patients and community partners.
3. Reduce technical barriers to scheduling GIM SUD appointments: If the health system increases the availability of same-day and next-day appointments for SUD treatment in primary care and promotes these service availabilities to patients and community providers, it is also essential to ensure that the care coordinators in acute settings have the specific Epic® permissions to schedule appointments in the CSC GIM SUD appointment slots. Furthermore, if informational technology resources are prioritized to create a specific visit type for SUD care, schedulers in the Connection Center would also be able to make appointments for patients calling the main phone number.

Hennepin Health will continue to monitor SUD-related HEDIS® measures going forward, with attention paid to the Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) measure for follow-up care after receiving high-intensity care for SUD and the Follow-Up After Emergency Department Visit for SUD (FUA) measure which measures follow-up care received after ED visits for SUD. Outpatient follow-up and utilization can be measured. As these initiatives progress, Hennepin Health will make determinations as to the impact these initiatives have on the rates versus other contributing factors.

As the initiatives continue and more detailed data analysis becomes possible, Hennepin Health will receive quantifiable results for assessment per the terms of the Reinvestment Initiative program. While quantitative data are not yet robust enough for formal analyses, the qualitative data currently available suggest that providers are receptive and interested in these new tools and processes that have been developed and continue to be refined. By assessing long-term utilization rates of EHR SmartSets, building out formal scheduling processes for SUD patients, developing formal mechanisms for interdisciplinary practice across care environments, and monitoring follow-up quality metrics, this study shows promise to demonstrate effective and sustainable methods of process improvement with regard to SUD treatment access.

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