

Proposed Changes to Existing Measure for HEDIS^{®1} MY 2022: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

NCQA seeks comments on proposed modifications to the HEDIS measure *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*.

The current measure assesses the percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), with a follow-up visit with a principal diagnosis of SUD. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days.
2. The percentage of ED visits for which the member received follow-up within 7 days.

The intent of this measure is to ensure coordinated care for members discharged from the ED who are at high risk due to a drug misuse event. To align the measure with the measure's intent and current evidence, NCQA proposes the following revisions:

- *Expand the denominator to include ED visits due to overdose of drugs with common abuse potential in "any" diagnosis position.*

Individuals who experience drug overdose are a particularly high-risk population that would benefit from timely follow-up. The addition of overdoses due to unintentional and undetermined intent fills an existing gap in the HEDIS care coordination measure suite.²

- *Expand the numerator to allow follow-up visits with SUD indicated in "any" diagnosis position.*

Recent qualitative analyses indicate that the order of listed diagnoses does not necessarily indicate the primary reason for the visit outside inpatient settings. NCQA wants to ensure that follow-up encounters where a diagnosis of substance use is included in any position on the claim is captured as appropriate follow-up.

- *Expand the numerator to include additional follow-up options that do not require a diagnosis of SUD.*

NCQA recommends adding additional follow-up options to align with updated clinical practice guidelines and account for individuals who may not have been diagnosed with SUD prior to or within 30 days of discharge from the ED:

- Dispensing or administration of pharmacotherapy for alcohol or opioid use disorder.
- Visits where a behavioral health assessment or screening is performed.
- Outpatient, observation or telehealth visits with a mental health provider.
- Any service defined as addressing substance use. (See the Alcohol and Drug Abuse Services Value Set, provided in the Value Set Directory, for the service codes and descriptions.)
- Any outpatient, intensive outpatient, partial hospitalization, observation and telehealth visit option currently included in the numerator specification for a diagnosis of drug "use" or overdose.
- Services provided by a peer recovery support specialist.

¹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

² Intentional overdoses are currently included in the *Follow-Up After Emergency Department Visit for Mental Illness* measure because they are considered intentional self-harm events.

Our expert panels supported the proposed changes. NCQA seeks general feedback on the measure revisions and on the following questions:

1. The addition of ED visits due to drug overdose intends to capture events that may be evidence of SUD. NCQA seeks feedback on recommended drugs for inclusion in the Drug Overdose Value Set. (Appendix, Table 1)
2. Stakeholders and literature support the addition of peer recovery support services as appropriate follow-up, as available evidence indicates that these services are associated with improved outcomes.³ Given the varying certification qualifications and billing practices across states, NCQA seeks additional feedback on the appropriateness of these encounters as follow-up, as well as on the service and diagnosis codes to bill for peer recovery support services. (Appendix, Table 2)
3. An example from a recent study indicates that the diagnosis of substance “use” on claims in outpatient or inpatient settings may be an appropriate way to identify follow-up services after overdose.⁴ NCQA seeks comment on the inclusion of substance “use” diagnoses to identify appropriate substance use follow-up when attached to outpatient, intensive outpatient, partial hospitalization, observation visit or telehealth visit claims. (See the AOD Use Disorders Value Set, provided in the Value Set Directory, for ICD-10 codes for substance “use.”)
4. Exclusion of ED visits followed by an inpatient admission uses the Inpatient Stay Value Set and is intended to capture inpatient stays as well as behavioral health residential treatment stays. NCQA seeks feedback on whether the Inpatient Stay Value Set currently captures residential behavioral health treatment stays and if NCQA should consider additional codes to specify this exclusion.

Supporting documents include draft measure specifications, evidence workup and performance data.

NCQA acknowledges the contributions of the Geriatric, Technical and Behavioral Health Measurement Advisory Panels and the Care Coordination Workgroup.

³Eddie, D., L. Hoffman, C. Vilsaint, A. Abry, B. Bergman, B. Hoepfner, C. Weinstein, & J.F. Kelly. 2019. “Lived Experience in New Models of Care for Substance Use Disorder: A Systematic Review of Peer Recovery Support Services and Recovery Coaching.” *Frontiers in Psychology* 10, 1052. <https://doi.org/10.3389/fpsyg.2019.01052>

⁴Kilaru, A.S., et al. 2020. “Incidence of Treatment for Opioid Use Disorder Following Nonfatal Overdose in Commercially Insured Patients.” *JAMA Network Open* 3(5). doi:10.1001/jamanetworkopen.2020.5852.

Appendix

Table 1. Proposed Drugs for Overdose Value Set

Note: This list captures unintentional and undetermined overdose events that may be evidence of SUD. Refer to the Drug Overdose Value Set, provided in the Value Set Directory, for associated ICD-10 codes.

ICD-10 Group	Substance	ICD-10 Group	Substance
T51	Ethanol	T41	Inhaled anesthetics
T40	Opium	T41	Intravenous anesthetics
	Heroin		Unspecified general anesthetics
	Other opioids		Other general anesthetics
	Methadone		Local anesthetics
	Fentanyl or fentanyl analogs		Unspecified anesthetic
	Tramadol		Therapeutic gases
	Other synthetic narcotics		T42
	Cocaine		Benzodiazepines
	Unspecified narcotics	T43	Unspecified psychostimulants
	Other narcotics		Amphetamines
	Cannabis		Methylphenidate
	Lysergide (LSD)		Ecstasy
	Unspecified psychodysleptics		Other psychostimulants

Table 2. Proposed Service Codes to Identify Peer Support Services

Code	Definition	Code System
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more) (G0177)	HCPCS
H0024	Behavioral health prevention information dissemination service (one-way direct or non-direct contact with service audiences to affect knowledge and attitude) (H0024)	HCPCS
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior) (H0025)	HCPCS
H0038	Self-help/peer services, per 15 minutes (H0038)	HCPCS
H0039	Assertive community treatment, face-to-face, per 15 minutes (H0039)	HCPCS
H0040	Assertive community treatment program, per diem (H0040)	HCPCS
H0046	Mental health services, not otherwise specified (H0046)	HCPCS
H2014	Skills training and development, per 15 minutes (H2014)	HCPCS
H2023	Supported employment, per 15 minutes (H2023)	HCPCS
S9445	Patient education, not otherwise classified, non-physician provider, individual, per session (S9445)	HCPCS
T1012	Alcohol and/or substance abuse services, skills development (T1012)	HCPCS
T1016	Case management, each 15 minutes (T1016)	HCPCS

Follow-Up After Emergency Department Visit for ~~Alcohol and Other Drug Abuse or Dependence~~ Substance Use (FUA)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Revised terminology from “alcohol or other drug abuse or dependence (AOD)” to “substance use” or substance use disorder (SUD)”.
- Added ED visits with a diagnosis of unintentional and undetermined drug overdose in the denominator.
- Revised diagnosis position requirement from a “principal” diagnosis to “any” diagnosis of SUD in the numerator.
- Added pharmacotherapy for alcohol and opioid use disorder follow-up options in the numerator.
- Allowed outpatient, observation visit and telehealth follow-up visits provided by a mental health provider, without a diagnosis of SUD, in the numerator.
- Allowed services defined as behavioral health assessments or substance use services, without a diagnosis of SUD, in the numerator.
- Added additional diagnosis options in the numerator to allow outpatient, intensive outpatient, partial hospitalization, observation and telehealth visits with a diagnosis of substance “use” or drug overdose.
- Added additional codes for partial hospitalization and intensive outpatient services in the numerator.
- Added peer support services, with a diagnosis for SUD, substance use or overdose, in the numerator.
- Clarified that members receiving hospice care are a required exclusion.

Description

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of ~~alcohol or other drug~~ substance use disorder (SUD/AOD), ~~abuse or dependence or any diagnosis of drug overdose, who had that received a follow-up visit for AOD.~~ Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Eligible Population

~~**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.~~

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Ages 13 years and older as of the ED visit. Report two age stratifications and a total rate:

- 13–17 years.
- 18 and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No gaps in enrollment. <u>None.</u>
Anchor date	None.
Benefit	Medical, and chemical dependency <u>and pharmacy.</u> <i>Note: Members with detoxification-only chemical dependency benefits do not meet these criteria.</i>
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence <u>SUD (AOD Abuse and Dependence Value Set) or any diagnosis of drug overdose (Drug Overdose Value Set)</u> on or between January 1 and December 1 of the measurement year, where the member was 13 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period, as described below.
Multiple visits in a 31-day period	If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. <i>Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.</i>
ED visits followed by inpatient admission	Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Identify the admission date for the stay. <p>These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.</p>
Required exclusions	<u>Members receiving hospice care are excluded from the eligible population (refer to General Guideline 17: Members in Hospice).</u>

Administrative Specification

Denominator The eligible population.

Numerators

30-Day Follow-Up A follow-up visit ~~with any practitioner, with a principal diagnosis of AOD or a pharmacotherapy dispensing event~~ within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

7-Day Follow-Up A follow-up visit ~~with any practitioner, with a principal diagnosis of AOD or a pharmacotherapy dispensing event~~ within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit:

- IET Stand Alone Visits Value Set, **with any** ~~principal~~ diagnosis of SUD AOD abuse or dependence (AOD Abuse and Dependence Value Set), drug substance use (AOD Use Disorder Value Set) or drug overdose (Drug Overdose Value Set) or a mental health provider.
- • OUD Weekly Non Drug Service Value Set **with any** ~~principal~~ diagnosis of SUD AOD abuse or dependence (AOD Abuse and Dependence Value Set), substance use (AOD Use Disorder Value Set) or drug overdose (Drug Overdose Value Set).
- • OUD Monthly Office Based Treatment Value Set **with any** ~~principal~~ diagnosis of SUD AOD abuse or dependence (AOD Abuse and Dependence Value Set), substance use (AOD Use Disorder Value Set) or drug overdose (Drug Overdose Value Set).
- • IET Visits Group 1 Value Set **with** IET POS Group 1 Value Set, **with and any** ~~principal~~ diagnosis of SUD AOD abuse or dependence (AOD Abuse and Dependence Value Set), substance use (AOD Use Abuse Disorder Value Set) or drug overdose (Drug Overdose Value Set) or a mental health provider.
- • IET Visits Group 2 Value Set **with** IET POS Group 2 Value Set, **with and any** ~~principal~~ diagnosis of SUD AOD abuse or dependence (AOD Abuse and Dependence Value Set), substance use (AOD Use Disorder Value Set) or drug overdose (Drug Overdose Value Set) or a mental health provider.
- • An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) **with** (Partial Hospitalization POS Value Set) **with any** diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (AOD Use Disorder Value Set) or drug overdose (Drug Overdose Value Set).
- • An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) **with any** diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (AOD Use Disorder Value Set) or drug overdose (Drug Overdose Value Set).
- • An observation visit (Observation Value Set) **with any a** ~~principal~~ diagnosis of SUD AOD abuse or dependence (AOD Abuse and Dependence Value Set), substance use (AOD Use Disorder Value Set) or drug overdose (Drug Overdose Value Set) or a mental health provider.

- A telephone visit (Telephone Visits Value Set), **with any principal**-diagnosis of SUD ~~AOD abuse or dependence~~ (AOD Abuse and Dependence Value Set), substance use (AOD Use Disorder Value Set) or drug overdose (Drug Overdose Value Set) or a mental health provider.
- An e-visit or virtual check-in (Online Assessments Value Set), **with any principal**-diagnosis of SUD ~~AOD abuse or dependence~~ (AOD Abuse and Dependence Value Set), substance use (AOD Use Disorder Value Set) or drug overdose (Drug Overdose Value Set) or a mental health provider.
- A pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) or medication treatment event (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).
- A peer support service (Peer Support Services Value Set) **with any diagnosis** of SUD (AOD Abuse and Dependence Value Set), substance use (AOD Use Disorder Value Set) or drug overdose (Drug Overdose Value Set)
- A behavioral health screening or assessment for SUD or mental health disorders (Behavioral Health Assessments Value Set).
- Substance use treatment (Alcohol and Drug Abuse Services Value Set).

Note

- Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (within 30 days after the ED visit or within 7 days after the ED visit).

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUA-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence Substance Use

Administrative	
Measurement year	✓
Eligible population	For each age stratification and total
<u>Number of required exclusions</u>	✓
Numerator events by administrative data	Each of the 2 rates for each age stratification and total
Numerator events by supplemental data	Each of the 2 rates for each age stratification and total
Reported rate	Each of the 2 rates for each age stratification and total

Follow-Up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA)

Measure Workup

Topic Overview

Measure Description

The *Follow-Up After Emergency Department for Alcohol or Other Drug Dependence (FUA)* measure assesses the percentage of emergency department (ED) visits for members age 13 years of age and older with a principal diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose, with a follow-up visit to address substance use within 30 days and 7 days. The intent of the measure is to ensure coordinated care for members discharged from the ED who are at high risk due to their drug misuse event.

Prevalence and Importance

SUDs are a serious public health issue and if left untreated, can lead to damaging effects on an individual's health, finances and overall well-being. SUD is characterized as impairment caused by the recurrent use of alcohol and/or other drugs, which may include health problems, disability and failure to meet major responsibilities (e.g., at work, school or home) (SAMHSA, 2020b). Commonly misused substances include alcohol, illicit drugs, marijuana, prescription pain relievers, cocaine, methamphetamine and heroin or other opioids (SAMHSA, 2020b).

Prevalence of SUD

In 2019, 20.4 million individuals in the U.S. age 12 or older (approximately 7.4% of the population) reported having an SUD within the past year (SAMHSA, 2020b). The overall prevalence of SUD among individuals 12 and older has remained relatively stable between 2015 and 2019 (SAMHSA 2020a; SAMHSA, 2020b).

Out of the 20.4 million people age 12 and older who reported having an SUD in 2018, 71.1% (14.5 million) had an alcohol use disorder, 40.7% (8.3 million) had an illicit drug use disorder and 11.8% (2.4 million) had a co-occurring alcohol and illicit drug use disorder (SAMHSA, 2020b).

ED use for drug use disorders or drug misuse

The use of ED services among individuals with an SUD or who have misused drugs is common and is growing among certain subpopulations. In 2007, one in eight ED visits in the U.S. were found to be related to SUDs and mental health disorders (Weiss et al. 2016). The Centers for Disease Control and Prevention (CDC) reports that between 2008 and 2017, the rate of ED visits for a primary diagnosis of substance abuse or dependence increased among patients 18–34 (from 45.4 visits per 10,000 individuals in 2008–2009 to 76.0 visits in 2016–2017) and remained relatively stable among patients 35 and older (27.2 visits per 10,000 in 2008–2009 to 24.6 visits in 2016–2017) (CDC, 2019b). Experts believe that many ED visits for people with SUD could be avoided if they had access to adequate outpatient care (Weiss et al. 2016).

In addition to ED visits for a documented SUD, many ED visits each year result from drug misuse. According to national surveillance data on ED visits due to overdoses of all drug types, excluding alcohol, there were 435,983 ED visits for nonfatal drug overdoses of unintentional or undetermined intent in 2016 (age-adjusted rate of 137.2 visits per 100,000 population) (CDC, 2019a). Notably, the most frequently occurring drug overdose events in the ED setting are related to opioids (183,147 visits per 100,000) (CDC, 2019a).

**Health
importance**

National syndromic surveillance data examining ED visits from 2017–2018 found that of suspected drug overdose-related visits, 42.5% were heroin-related, 27.3% were non-heroin opioid-related and 11.0% were due to opioid polysubstance misuse (Liu & Vivolo-Kantor, 2020).

SUD can have serious, irreversible effects on a person’s health and well-being. Substance use is associated with higher rates of motor vehicle accidents, HIV infection, interpersonal violence, unintentional injury and both intentional and accidental overdose (Hawk & D’Onofrio, 2018). The ED is an especially important care setting for individuals with an SUD or who have experienced a drug overdose event, as it represents an opportunity to connect individuals to appropriate services and supports following an acute event (Hawk et al. 2019).

Literature indicates that individuals who overdose once are at risk of having at least one additional overdose within a year (Suffoletto & Zeigler, 2020; Karmali et al. 2020). One study examining adult patients 18 and older from Kaiser Permanente Northern California found that from 2009–2016, approximately 7.2% of patients with an index nonfatal opioid overdose experienced a repeat opioid overdose within the following year (Karmali et al. 2020). Risk of subsequent death among ED patients seen for drug overdose is also high (Goldman-Mellor et al. 2020; Weiner et al. 2020). ED patients with nonfatal opioid or sedative/hypnotic drug overdose have increased mortality within the following year due to subsequent unintentional overdose, suicide and other causes (Goldman-Mellor et al. 2020).

A recent study found that approximately 1 in 20 patients treated in Massachusetts in the ED for a nonfatal opioid overdose died within one year of their visit (Weiner et al. 2020). One in 5 patients who died within a year did so within the first month, and patient deaths clustered around the first 2 days after being discharged (Weiner et al. 2020). Two-thirds of these deaths were directly attributed to subsequent opioid-related overdoses (Weiner et al. 2020).

The COVID-19 pandemic has created significant challenges for individuals with SUD, with many public health experts anticipating that the measures taken to manage the spread of the virus will exacerbate the opioid crisis. Though data for 2020 are limited, one study examined drug testing patterns at a national clinical laboratory before and after the pandemic began and found a 35% increase in positivity for non-prescribed fentanyl and a 44% increase in positivity for heroin (Niles et al. 2020). The Overdose Detection Mapping Application Program released a report in May 2020, describing a 20% increase in suspected overdose since the first reported case of COVID-19 when compared to the same period in the previous year (ODMAP, 2020).

Together, data indicate that individuals who are seen in the ED due to substance misuse are at high risk of adverse events, especially within the weeks and months following their ED visit. Individuals with SUD may require ongoing health services and supports following discharge from the ED care setting, and loss of contact with health care may begin a cycle of symptom deterioration, necessitating further crisis intervention in emergency settings (Kilaspay, 2007; Fischer, 2008; Jencks, 2009; Weiner et al. 2000). Health plans play a unique role facilitating care coordination for members following acute events and ensuring that members have access to high-quality post-ED care for the treatment of SUD.

Evidence

Evidence for ED follow-up

A strong body of evidence indicates that coordinated care for complex chronic conditions, such as SUD, positively influences disease trajectory (Duber et al. 2018). Multiple studies support the need for immediate treatment following ED discharge for patients with SUD and indicate that treatment engagement for SUD is linked to improved outcomes (Hawk & D’Onofrio, 2018; Weiner et al. 2020; Kilaru et al. 2020). As the primary provider of acute illness stabilization, timely diagnosis and links to appropriate care, the ED is uniquely positioned to improve care for patients with SUD and prevent overdose death (Samuels et al. 2019).

Studies have found that follow-up care is associated with remaining in the community for a longer period and avoidance of future emergency visits. A study of ED visits for patients with substance abuse and mental illness at a single hospital found that patients who failed to receive aftercare following their emergency psychiatric visit had six times higher odds of coming back to the ED within two months, compared with patients who received aftercare (Bruffaerts, 2005).

Medication-assisted therapy

For patients with opioid overdose and opioid use disorder (OUD), transitioning from the ED to outpatient settings requires carefully coordinated care to minimize potential opioid withdrawal and relapse. An important follow-up option to consider for this population includes medication-assisted therapy, often after initiation within the ED (Duber et al. 2018). Patients receiving maintenance buprenorphine for at least one year require fewer ED visits and hospitalizations compared to those who discontinue buprenorphine (Lo-Ciganic et al. 2016). Early initiation and maintenance of medication-assisted therapy for OUD patients can therefore significantly affect their health and acute health care use (Duber et al. 2018; Lo-Ciganic et al. 2016). Providing or coordinating appropriate counseling and social services is also important, as both are likely to lead to compliance with treatment and improved health outcomes (Duber et al. 2018).

Peer recovery support services

Use of peer recovery support services, including peer recovery coaches, is a growing trend for populations affected by SUD (Eddie et al. 2019). These individuals, who are paid staff or volunteers employed in a range of health care and social-service settings, are defined as individuals with “lived experience” of addiction and recovery, providing critical assistance and social support to underserved and vulnerable patients (McDaid, 2011). Although peer mentors typically do not have clinical training, they are uniquely positioned to help patients navigate the health system, access treatment and overcome barriers to recovery due to their own experience with SUD (Eddie et al. 2019). Existing research to date supports the use of peer recovery coaches in different SUD treatment settings, including hospital and medical settings, linking their services to improved outcomes such as reduced substance use and relapse rates, greater treatment satisfaction, higher treatment retention, greater housing stability and decreased criminal justice involvement (Eddie et al. 2019; ASTHO, 2020).

Timeliness of follow-up

Timeliness of follow-up and referral is also an important element of care transition from the ED, as delays are more likely to result in poor outcomes and entry into treatment (Duber et al. 2018). An observational study of patients with unhealthy alcohol and drug use in an urban ED found that patients who received direct referral were 30 times more likely to enroll in treatment compared to those who were discharged from the ED with an indirect referral (D’Onofrio and Degutis, 2010).

Literature indicates that follow-up may even be initiated within the ED, including screening, initiating psychosocial or pharmacotherapy treatment and directly linking patients to ongoing treatment (Hawk, D’Onofrio, 2018). One study found that with ED-initiated buprenorphine and brief negotiation interview (BNI), almost 80% of patients accessed OUD treatment within 30 days, compared to 37% with referral only or 45% with a BNI and facilitated referral (i.e., direct link to referral, including review of eligibility for services, insurance coverage and transportation arrangement) (D’Onofrio, 2015). ED-initiated buprenorphine is linked to better outcomes, including greater engagement in addiction treatment and decreased use of illicit opioids (D’Onofrio et al. 2017).

Evidence also indicates that a technique of Screening, Brief Intervention and Referral to Treatment (SBIRT) for SUD patients in the ED can lead to better outcomes (Bernstein & D’Onofrio, 2013). A study evaluating the effectiveness of this technique for excessive drinking found that patients who received this intervention reported less binge drinking and lower rates of drinking and driving than patients who received standard care (D’Onofrio et al. 2012).

Health Care Disparities and Quality Gap

Health care disparities

Age In 2016, nonfatal drug overdose-related ED visits (excluding alcohol) were highest among individuals 25–34 years of age (238.1 visits per 100,000) and individuals 20–24 years (219.3) (CDC, 2019a). For adults 65 and older, there were an estimated 77.1 per 100,000 ED visits for nonfatal drug overdose (CDC, 2019a).

SAMHSA data indicates that in 2019, among the 21.6 million people 12 or older who needed substance use treatment in the past year, only 12.2% received substance use treatment at a specialty facility (SAMHSA 2020b). A retrospective cohort study of commercially insured adult patients examined follow-up after an ED visit for opioid overdose between 2011 and 2016, and found that for each additional year of age, patients were 0.2% less likely to obtain follow-up (95% CI, –0.3% to –0.1%) (Kilaru et al. 2020).

Race/ethnicity and gender SAMHSA 2019 data indicates that across different racial and ethnic groups, past-year misuse of opioids among individuals 12 and older was most common among individuals identifying with two or more races (5.2%), followed by American Indian or Alaskan Native (5.1%), White (3.8%), Black or African American (3.4%) and Hispanic or Latino (3.7%) (SAMHSA, 2020a). Individuals identifying as Asian or Native Hawaiian or Other Pacific Islander reported the lowest past year misuse of opioids, at 1.6% and 2.8% respectively (SAMHSA, 2020a). Research has also shown that despite having a later age of first exposure and drinking less alcohol, African Americans—African American women in particular—tend to be at higher risk of experiencing adverse outcomes attributed to alcohol use disorders (Zapolski et al. 2014; Ransome et al. 2017; Williams et al. 2017).

A study examining the incidence of follow-up treatment following an ED discharge for non-fatal opioid overdose among commercially insured patients found that between 2011 and 2016, Black patients were half as likely to obtain follow-up compared to non-Hispanic Whites (absolute risk difference [ARD], –5.9%; 95% CI, –8.6% to –3.6%) (Kilaru et al. 2020). The same study found that women (ARD, –1.7%; 95% CI, –3.3% to –0.5%) and Hispanic patients (ARD, –3.5%; 95% CI, –6.1% to –0.9%) were also less likely to obtain follow-up.

Health insurance/SES Data from the 2017 National Survey on Drug Use and Health revealed that the percentage of alcohol dependence or substance use, including opioid use disorder and heroin use, was higher among individuals without health insurance and those with family income below 100% of the federal poverty level (SAMHSA, 2019a). Although literature has shown that the Affordable Care Act (ACA) and corresponding Medicaid expansion in some states have helped increase access to behavioral health treatment for vulnerable populations, disparities remain, particularly for substance use treatment (Creedon & Cook, 2016). Among individuals with past-year SUD, rates of SUD treatment remained low (around 7%) and did not change significantly before and after 2014 (when ACA-driven Medicaid expansion and private insurance Exchanges were initiated) (Creedon & Cook, 2016). One study found that Hispanic and Black individuals were more likely to have insurance in 2014, compared to 2011–2013; however, disparities in insurance access compared to Whites did not decrease (Creedon & Cook, 2016).

Gaps in care

ED follow-up Many patients leaving the ED fail to receive follow-up care. A retrospective analysis of commercial claims data found that for all members who had an ED visit for a diagnosis of SUD in 2004, only 13% received follow-up within 14 days of their ED visit (Breton et al. 2007). Within this 14-day follow-up time frame, an additional 36% of members were seen for an outpatient visit for a non-SUD behavioral health diagnosis (e.g., diagnosis coded included substance “use,” mental health or a nonpsychiatric medical disorder), which may suggest, but cannot confirm, appropriate follow-up care using current definitions (Breton et al. 2007). Patients diagnosed with alcohol abuse were less likely to receive follow-up services than patients diagnosed with other drug dependencies (Breton et al. 2007). A retrospective cohort study found that the majority of commercially insured patients who visited the ED for an opioid overdose did not receive timely follow-up care (Kilaru et al. 2020). Of the approximately 6,500 patients who visited the ED for an opioid overdose or other opioid-related medical complication between 2011 and 2016, only 16.6% of patients accessed treatment within 3 months of the ED visit. (Kilaru et al. 2020).

SUD treatment National survey data from 2019 indicates that of the 21.6 million people 12 years and older with an SUD, only 4.2 million received any substance use treatment in the past year (SAMHSA, 2020b). The ED is a critical access point to care for individuals with SUD; however, despite the promising findings around effectiveness of ED-initiated interventions, literature suggests that referrals from the ED to SUD treatment programs are uncommon (Samuels, 2016). Barriers can manifest at the individual, intra-organizational and cross-organizational levels (Blevins, Rawat, Stein, 2018).

At the individual level, literature shows that patients not only need to be motivated to seek care, but that access to care is influenced by perceived efficacy of treatment as well as individual social support and other social determinants (e.g., transportation challenges, language barriers and financial concerns) (Blevins, Rawat, Stein, 2018). At the organizational level, hospitals and treatment centers may face challenges such as limited staff and funding, which can make referral and delivery of substance use treatment more difficult (Blevins, Rawat, Stein, 2018).

Qualitative findings from a study examining barriers in the referral process included a total of 59 interviews with stakeholders (i.e., ED and primary care physicians, administrators and mental health advocates, among others) and revealed four primary themes: patient eligibility, treatment capacity, provider knowledge and communication (Blevins, Rawat, Stein, 2018). Under these themes, stakeholders referenced a number of challenges, including difficulty determining patient eligibility requirements for different programs, as some treatment centers have different criteria for admission (Blevins, Rawat, Stein, 2018). Other factors commonly cited included time and resources spent on determining program capacity and difficulties with referral confirmations (Blevins, Rawat, Stein, 2018).

Measure performance

Performance on the current FUA measure indicates that a gap in care continues to exist. Across commercial, Medicare and Medicaid product lines between measurement years 2017 and 2019, approximately only 8%–13% of patients with an ED visit for SUD received follow-up within 7 days of their ED discharge and approximately 12%–20% of patients received follow-up within 30 days.

Financial Impact

The economic burden of SUD on an individual or family can include resources spent on misused substances, as well as loss of income due to decreased productivity and job loss (Daley, 2013). At the health system level, data from the Healthcare Cost and Utilization Project indicate that in 2017, mental and substance use ED visits incurred a service cost of over \$5.6 billion, representing approximately 7% of the \$76.3 billion total ED costs for that year (Karaca & Moore, 2020). Alcohol-related visits to the ED were the costliest, representing 21.7% of total ED costs related to mental health or substance use (Karaca & Moore, 2020).

More broadly, the National Institute on Drug Abuse estimates the average health care costs for tobacco, alcohol, prescription opioids and illicit drugs to total approximately \$232 billion annually (NIH, 2020). This estimate increases to over \$820 billion when costs related to crime and lost work productivity are included with health care costs (NIH, 2020). This burden could potentially be decreased by “closing the treatment gap” and reducing costs related to hospital readmission rates, medical complications of SUDs, unintentional injuries and delayed or lack of interventions (Hawk & D’Onofrio, 2018; Bernstein & D’Onofrio, 2013). For example, SBIRT has emerged as a cost-effective option shown to be effective in ED settings for smoking, alcohol and marijuana use, with health care cost savings that range from \$3.81 to \$5.60 for every dollar spent (Bernstein & D’Onofrio, 2013).

Guidelines

Organization (Year)	Recommendation	Citation	Rating
American Psychiatric Association (2010)	<p>Assessments and Intervention: “It is clinically helpful when assessing patients to use a spectrum that includes use, misuse, abuse, and dependence. The latter two terms represent formal diagnostic categories. Use of a substance may or may not be clinically significant. If use of a substance is thought to be potentially clinically significant but does not meet diagnostic criteria for abuse or dependence, it may be characterized as “misuse,” although this is not a formal diagnostic category. Even when functional impairment is absent or limited, substance misuse can be an early indicator of an individual’s vulnerability to developing a chronic substance use disorder. Brief early interventions can effectively reduce this progression (1–3), although follow-up reinforcement appears necessary for sustained utility.” (15)</p> <p>Intervention After High-Risk Events: “Immediate intervention to provide safety to the patient in a medically monitored environment is recommended for individuals who present with high-risk intoxication or withdrawal states or altered mental states (e.g., psychosis, suicidality, agitation) that are associated with a risk of danger to self or others. After the patient is stabilized, the patient’s immediate needs regarding safety and stability should be addressed to prepare the patient to enter into comprehensive, long-term treatment of the substance use disorder and its associated conditions. Such acute interventions may be focused on goals such as preserving health, achieving financial security, and finding stable housing.” (15-16)</p> <p>Patients with Co-Occurring Psychiatric and SUD: “Once a patient’s acute psychiatric symptoms and intoxication or withdrawal states have been stabilized, the patient can be evaluated for treatment in an ongoing rehabilitative treatment program. When patients are being treated in a substance abuse treatment setting, their psychiatric symptoms should be monitored and addressed clinically through psychiatric medications, when appropriate, as well as through integrated psychosocial strategies (e.g., teaching patients mood management as part of relapse prevention therapy) and integrated treatment approaches for psychiatric disorders and substance use disorders (357). In a psychiatric treatment setting, it would be incorrect to assume that successful treatment of a psychiatric disorder will resolve the substance use disorder. The substance use disorder will require specific treatment even when it arises in the context of another psychiatric disorder, a situation that is quite common and that presents an opportunity for the prevention of a secondary disorder (358).”</p>	American Psychiatric Association. 2010. “Practice Guideline for the Treatment of Patients With Substance Use Disorders, Second Edition.”	See guideline for recommendation statements and ratings for the different substance use populations.

Organization (Year)	Recommendation	Citation	Rating
National Institute on Drug Abuse (NIDA) (2018)	“Treatment needs to be readily available: Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.”	NIDA. 2020. Principles of Effective Treatment. https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment Accessed on November 23, 2020.	NA
Veterans Affairs (VA)/Department of Defense (DOD) (2015)	SUD—Treatment Setting For patients with a diagnosis of a SUD, the Work Group suggests offering referral for specialty SUD care based on willingness to engage in specialty treatment.	Department of Veteran Affairs, Department of Defense. (2015). VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders. Washington DC: Department of Veterans Affairs, Department of Defense.	Weak For; Not reviewed, Amended
	Alcohol: For patients without documented alcohol use disorder who screen positive for unhealthy alcohol use, the Work Group recommends providing a single initial brief intervention regarding alcohol-related risks and advice to abstain or drink within nationally established age and gender-specific limits for daily and weekly consumption. AUD: For patients with moderate-severe alcohol use disorder, the Work Group recommends pharmacotherapy and psychosocial interventions.		Strong For; Reviewed, New-replaced
	ODU: For patients with opioid use disorder, the Work Group recommends pharmacotherapy, and psychosocial interventions with or without pharmacotherapy, considering patient preferences.		Strong For / Weak For / NA; Reviewed, New-replaced
	Cannabis Use Disorder: For patients with cannabis use disorder, the Work Group recommends psychosocial interventions as initial treatment considering patient preference and provider/training competence.		Strong For; Reviewed, New-added
	Stimulant Use Disorder: For patients with stimulant use disorder, the Work Group recommends psychosocial interventions as initial treatment considering patient preference and provider training/competence.		Strong For; Reviewed, New-replaced

Organization (Year)	Recommendation	Citation	Rating
ASAM (2020)	<p>“All FDA approved medications for the treatment of opioid use disorder should be available to all patients. Patients’ psychosocial needs should be assessed, and patients should be offered or referred to psychosocial treatment based on their individual needs. However, a patient’s decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacotherapy, with appropriate medication management. Motivational interviewing or enhancement can be used to encourage patients to engage in psychosocial treatment services appropriate for addressing individual needs.”</p>	<p>Kampman, K., Freedman, K. (2020). American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. Journal of Addiction Medicine; 14, no. 2S: 1–91, https://doi.org/10.1097/ADM.0000000000000633.</p>	<p>The methods used to search the literature and subsequently develop guideline statements were consistent with the RAM methodology employed for the 2015 publication. Criteria for inclusion in the focused update included new evidence and guidelines that were considered a) clinically meaningful and applicable to a broad range of clinicians treating addiction involving opioid use, and b) urgently needed to ensure the guideline reflects the current state of the science for the existing recommendations, aligns with other relevant practice guidelines, and reflects newly approved medications and formulations. Relevant evidence and current practices not meeting these criteria will be reviewed and incorporated into the full update as appropriate.</p>

Organization (Year)	Recommendation	Citation	Rating
Michigan Quality Improvement Consortium (2017)	<p>[For Patients with SUD or Risky Substance Use]</p> <p>Patient Education or Brief Intervention by PCP or Trained Staff (e.g. RN, MSW) [A]: If diagnosed with substance use disorder or risky substance use, initiate an intervention within 14 days. Frequent follow-up is helpful to support behavior change; preferably 2 visits within 30 days.</p>	Michigan Quality Improvement Consortium. (2017) Screening, diagnosis and referral for substance use disorders. Southfield (MI): Michigan Quality Improvement Consortium; Aug. 1p.	[A] Randomized controlled trials
	<p>[For Patients with SUD or Risky Substance Use]</p> <p>Referral (for high risk behavior, or symptoms): Refer to a substance abuse health specialist, an addiction physician specialist, or a physician experienced in pharmacologic management of addiction(2,3) [D]. Also consider referrals to community-based services (e.g. AA, NA, etc.), or an Employee Assistance Program.</p>		[D] Opinion of expert panel
Maryland Hospital Association (2018)	<p>Universal Screening: To the extent possible, hospitals should universally screen for substance use disorder(s) among patients who present in the ED. Hospitals agreed that screening—defined as the application of a simple test to determine whether a patient is at risk for, or may have, an alcohol or substance use disorder—is an important step within the ED admission and discharge process. Screening helps providers fully assess patients prior to making treatment decisions and recommendations for follow-up care and/or monitoring.</p> <p>Facilitated Referral: Hospitals should refer patients who screen positive for substance use disorder(s) to treatment, ideally using a facilitated referral approach. Hospitals agreed that referrals to treatment are an essential component of the discharge protocols for this patient population. A facilitated referral may involve a range of tasks designed to assist the patient to attend his or her first appointment at the treatment center after being discharged.</p> <p>Peer Recovery Services: To the extent possible, hospitals should incorporate peer recovery services into their processes for treating and discharging patients treated for an opioid overdose, and those identified as having a substance use disorder. Peer recovery coaches use their lived experiences of recovering from addiction, as well as skills learned in formal training, to deliver services to patients that encourage their recovery. Specifically, in addition to referring patients to treatment, peer recovery coaches or other staff could provide patients with information on safe use, assess their readiness to change, and advise them on potential behavior changes under the guidance of licensed providers. Hospital representatives found it beneficial to include peer recovery coaches or other staff who are designated provide these services, such as community health workers or hospital social workers, in the discharge process.</p>	Maryland Hospital Association. 2018. Emergency Discharge Protocols for Patients with Substance Use Disorders and Opioid Overdoses in Maryland's Hospitals.	NA

Organization (Year)	Recommendation	Citation	Rating
SAMHSA (2018)	“Recovering from opioid overdose: If the survivor’s underlying problem is pain, referral to a pain specialist may be in order. If it is addiction, the patient should be referred to an addiction specialist for assessment and treatment by a physician specializing in the treatment of opioid addiction in a residential treatment program or in a federally certified opioid treatment program.”	SAMHSA. 2018. SAMHSA Opioid Overdose Prevention Toolkit. https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf	NA
Women’s College Hospital (2017)	<p>ED Discharge & Referral Protocols for Alcohol- and Opioid-Related Presentations</p> <p>Alcohol Intoxication:</p> <ul style="list-style-type: none"> • Refer to rapid access addiction medicine clinic. • Refer to withdrawal management services if [at risk for withdrawal, or lacks social supports, is in crisis, want to start immediate treatment] • Consider reporting to Ministry of Transportation. <p>Alcohol Withdrawal:</p> <ul style="list-style-type: none"> • Refer to rapid access addiction medicine clinic. • Refer to withdrawal management services if withdrawal not fully resolved, lacks social supports, or in crisis. • See family doctor in 1–2 days. <p>Other Alcohol-Related Presentations:</p> <ul style="list-style-type: none"> • Alcohol-induced anxiety, depression, and suicidal ideation: If patient is intoxicated and suicidal, observe patient in ED until intoxication resolves. Refer patient to psychiatry if [patient is at risk]. • Trauma caused by alcohol intoxication: Screen for alcohol disorder. Inform patient that risk of trauma dramatically increases with each drink. Advise patient on harm-reduction strategies. • Alcohol use in the elderly: falls, confusion, depression, problematic failure to cope. Always ask about alcohol use in elderly patients presenting with falls, confusion, depression, problematic benzodiazepine use, or failure to cope. <p>Opioid Withdrawal: Administer buprenorphine/ naloxone if [clinically indicated].</p>	Women’s College Hospital. 2017. Emergency Department Protocols for Alcohol and Opioid Related Presentations. https://www.womenscolleghospital.ca/assets/pdf/MetaPhi/Emergency_department%20protocols_17.08.24.pdf	NA

Organization (Year)	Recommendation	Citation	Rating
	<p>Opioid Overdose:</p> <ul style="list-style-type: none"> • Refer patient to rapid-access addiction medicine clinic. • Prescribe buprenorphine/naloxone total amount dispensed in the ED (max 12 mg) as a single daily dose. • Prescription should last until next rapid access addiction medicine clinic. Refer patient to withdrawal management if transient housing, lack of social supports and/or high risk for relapse. • Provide high-risk patients with take-home naloxone. <p>Other Opioid-Related Presentations:</p> <ul style="list-style-type: none"> • Give take-home naloxone kit. • Give harm reduction advice. • If patient is not yet in withdrawal, prescribe buprenorphine/naloxone to take at home. • Refer to rapid-access addiction medicine clinic. • Refer to withdrawal management if transient housing, lack of social supports, and/or high risk for relapse. 		

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HEDIS Health Plan Performance Rates: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

Commercial Results: Tables 1–6

Table 1. HEDIS FUA Measure Performance—Commercial Plans (30 Day Rate—Total, All Ages)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2019*	417	312 (74.8)	14.8	7.5	7.2	10.1	13.5	17.5	23.3
2018	405	313 (77.3)	14.5	7.3	6.8	10.2	13.7	17.7	22.6
2017	406	327 (80.5)	14.3	7.1	6.8	10.0	13.3	17.6	22.0

*For measurement year 2019, the average denominator size for commercial plans was 383 individuals, with a standard deviation of 536.

Table 2. HEDIS FUA Measure Performance—Commercial Plans (30 Day Rate—13–17 Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2019*	417	75 (18.0)	10.5	10.5	2.9	5.2	8.5	13.9	17.3
2018	405	76 (18.8)	9.0	11.1	1.6	3.6	6.7	10.6	16.0
2017	406	96 (23.7)	9.5	10.3	2.6	5.2	7.5	10.7	16.7

*For measurement year 2019, the average denominator size for commercial plans was 74 individuals, with a standard deviation of 48.

Table 3. HEDIS FUA Measure Performance—Commercial Plans (30 Day Rate—18+ Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2019*	417	309 (74.1)	15.1	7.6	7.7	10.4	14.0	18.3	23.6
2018	405	307 (75.8)	15.0	7.4	7.3	10.5	14.0	18.2	22.8
2017	406	321 (79.1)	14.8	7.2	7.4	10.5	13.8	18.0	22.6

*For measurement year 2019, the average denominator size for commercial plans was 361 individuals, with a standard deviation of 501.

Table 4. HEDIS FUA Measure Performance—Commercial Plans (7 Day Rate —Total, All Ages)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2019*	417	315 (75.5)	10.9	6.4	5.1	7.2	9.8	13.6	17.8
2018	405	313 (77.3)	10.4	6.2	4.8	7.0	9.6	13.0	16.7
2017	406	327 (80.5)	10.4	6.4	4.6	6.8	9.7	12.9	16.7

*For measurement year 2019, the average denominator size for commercial plans was 384 individuals, with a standard deviation of 53.

Table 5. HEDIS FUA Measure Performance—Commercial Plans (7 Day Rate—13-17 Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2019*	417	76 (18.2)	7.9	10.1	2.1	2.9	5.6	9.6	14.7
2018	405	76 (18.8)	6.8	10.3	0.0	2.7	4.9	8.8	12.7
2017	406	96 (23.7)	7.0	9.5	1.3	3.2	5.4	8.4	13.2

*For measurement year 2019, the average denominator size for commercial plans was 73 individuals, with a standard deviation of 48.

Table 6. HEDIS FUA Measure Performance—Commercial Plans (7 Day Rate—18+ Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2019*	417	312 (74.8)	11.2	6.5	5.4	7.5	10.2	14.3	18.1
2018	405	307 (75.8)	10.8	6.2	5.0	7.2	10.0	13.2	17.2
2017	406	321 (79.1)	10.8	6.5	4.8	7.2	10.0	13.3	17.3

*For measurement year 2019, the average denominator size for commercial plans was 362 individuals, with a standard deviation of 499.

Medicaid Results: Tables 7–12

Table 7. HEDIS FUA Measure Performance—Medicaid Plans (30 Day Rate—Total, All Ages)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2019*	265	174 (65.7)	19.7	10.4	5.9	10.9	19.5	28.1	33.2
2018	256	157 (61.3)	19.3	10.1	6.8	10.9	17.9	26.7	33.3
2017	275	158 (57.5)	18.1	9.9	6.7	10.1	16.3	24.5	32.2

*For measurement year 2019, the average denominator size for Medicaid plans was 1,229 individuals, with a standard deviation of 1,583.

Table 8. HEDIS FUA Measure Performance—Medicaid Plans (30 Day Rate—13-17 Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2019*	265	90 (34.0)	10.7	8.1	3.3	5.0	8.8	13.9	21.9
2018	256	78 (30.5)	10.2	7.7	2.9	5.5	7.6	13.9	22.1
2017	275	83 (30.2)	11.9	10.3	2.9	5.1	8.9	16.7	22.2

*For measurement year 2019, the average denominator size for Medicaid plans was 95, with a standard deviation of 74.

Table 9. HEDIS FUA Measure Performance—Medicaid Plans (30 Day Rate—18+ Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2019*	265	173 (65.3)	20.2	10.5	6.4	11.7	20.4	28.4	33.9
2018	256	155 (60.6)	20.0	10.1	7.7	11.4	18.2	27.4	33.9
2017	275	157 (57.1)	18.5	10.0	6.7	10.4	16.6	25.6	32.3

*For measurement year 2019, the average denominator size for Medicaid plans was 1,181 individuals, with a standard deviation of 1,547.

Table 10. HEDIS FUA Measure Performance—Medicaid Plans (7 Day Rate—Total, All Ages)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2019*	265	175 (66.0)	13.4	7.8	3.4	7.1	12.7	18.2	24.0
2018	256	157 (61.3)	13.1	7.8	4.5	6.6	11.6	17.0	23.0
2017	275	158 (57.5)	12.2	7.7	4.3	6.9	10.4	16.7	21.9

*For measurement year 2019, the average denominator size for Medicaid plans was 1,225 individuals, with a standard deviation of 1,579.

Table 11. HEDIS FUA Measure Performance—Medicaid Plans (7 Day Rate—13–17 Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2019*	265	91 (34.3)	7.5	7.1	1.8	3.1	5.7	8.6	12.8
2018	256	78 (30.5)	6.9	6.2	1.8	2.9	4.8	9.1	14.5
2017	275	83 (30.0)	8.1	8.9	1.3	2.6	6.0	10.0	15.9

*For measurement year 2019, the average denominator size for Medicaid plans was 94 individuals, with a standard deviation of 73.

Table 12. HEDIS FUA Measure Performance—Medicaid Plans (7 Day Rate—18+ Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2019*	265	174 (65.6)	13.7	7.9	3.5	7.6	13.2	18.5	24.3
2018	256	155 (60.6)	13.5	7.9	4.9	7.0	12.0	18.4	23.3
2017	275	157 (57.1)	12.6	7.8	4.4	7.1	10.6	16.8	22.6

*For measurement year 2019, the average denominator size for Medicaid plans was 1,177 individuals, with a standard deviation of 1,543.

Medicare Results Tables 13–14

Table 13. HEDIS FUA Measure Performance—Medicare Plans (30 Day Rate—Total, All Ages)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018	525	238 (45.3)	12.6	7.8	4.8	7.6	10.9	15.8	22.0
2017	505	250 (49.5)	12.2	7.9	4.8	7.1	10.8	15.3	21.9

For measurement year 2018, the average denominator size for Medicare plans was 171 individuals, with a standard deviation of 223.

CMS eliminated requirements for the collection of HEDIS 2020 (MY 2019) data for Medicare advantage plans in response to COVID-19 and therefore are not included here.

Table 14. HEDIS FUA Measure Performance—Medicare Plans (7 Day Rate—Total, All Ages)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018	525	238 (45.3)	8.7	6.5	2.7	4.6	7.5	11.4	16.2
2017	505	250 (49.5)	8.4	6.1	2.8	4.8	7.0	10.6	15.6

For measurement year 2018, the average denominator size for Medicare plans was 171 individuals, with a standard deviation of 223.

CMS eliminated requirements for the collection of HEDIS 2020 (MY 2019) data for Medicare advantage plans in response to COVID-19 and therefore are not included here.