Guidelines for the Identification and Management of Substance Use Disorders (SUD) and Opioid Use Disorders (OUD) in Inpatient Settings: A Comprehensive Treatment and Transition of Care Protocol

Developed by Summa Health, in partnership with BrightView Health.

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About the Guidelines

These guidelines were developed as part of a pilot project to improve access to Medication Assisted Treatment (MAT) and transitions of care for patients with Substance Use Disorders (SUD) and Opioid Use Disorders (OUD) in inpatient settings. Summa Health, a nonprofit integrated healthcare system based in Akron, Ohio, partnered with BrightView Health, an Ohio-based outpatient addiction treatment provider that specializes in comprehensive Medication Assisted Treatment (MAT). This document is intended to provide guidance and direction for the adoption of evidence-based clinical practice in inpatient health care settings. These protocols may need to be adapted to accommodate different patient populations, health system resources, or staffing availability.

For questions about the pilot project or the implementation and adaptation of the guidelines please contact:

Jaimie McKinnon, Vice President Behavioral Health Institute
Summa Health
mckinnonj@summahealth.org

Dr. Kelly Firesheets, Sr. Project Director
BrightView Health
k.firesheets@brightviewhealth.com
Implementation Guidance
# Recommended Outline and Timeline for Implementation

We recommend a 4-stage, 5-month process for the implementation of these protocols:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Planning, protocol review and adaptation: We recommend creating a small, interdisciplinary team to guide the implementation process from start to finish. The team should:</th>
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|       | ● Develop a timeline for the project (from start to finish)  
● Identify and communicate with major stakeholders in the target sites/units (provide timeline, goal, address concerns and resistance)  
● Select the sites/target units for implementation  
● Review screening instruments and update/replace if necessary  
● Convene a group of clinical staff to review protocols and update as necessary  
● Review education plan and update as necessary |
|       | 2 weeks |
| Stage 2 | Set up: The team should make sure all the infrastructure is in place for the pilot: |
|       | ● Staff receive the appropriate training, and there is a plan to provide education to new staff  
● The EMR is updated, or there are other work flow adjustments in place to accommodate the new practice  
● Front-line staff have appropriate resources and support to implement the new practice independently.  
● All stakeholders know what to expect and how to answer questions that come up |
|       | 6 weeks |
| Stage 3 | Pilot Period: The team should oversee the initial implementation: |
|       | ● Collect and review data on a regular basis (i.e., weekly) to assure that appropriate changes to the patient flow are occurring  
● Troubleshoot any issues or problems that arise during the pilot  
● Collect and review feedback and document lessons learned from the implementation |
|       | 8 weeks |
| Stage 4 | Review and Adjustment: Following the pilot period, the team should make any necessary changes to the protocols and process, or provide additional education to staff if needed |
|       | 4 weeks |
Key Elements of the Inpatient Intervention

We created an intervention that combined key elements:

1. **SBIRT (Screening, Brief Intervention and Referral to Treatment):** SBIRT is a structured screening protocol to help staff identify patients and plan for the most appropriate level of intervention.

2. **Medication Assisted Treatment/Medicated Withdrawal Management:** We adopted protocols to support the implementation of MAT and Medicated Withdrawal Management in the target inpatient units. These nurse-driven protocols allow for efficient patient care with support from nursing staff and addiction specialists.

3. **Peer Recovery Support:** Peers are available to provide additional support to patients who are struggling with addiction issues, and can provide consultation to staff who need guidance on how to manage or support patients.

4. **Referral to Care:** We created a system to facilitate referrals to the appropriate level of care upon discharge from the inpatient units. Providers on the target units have the option of referring patients to internal addiction treatment services, as well as community services. Peer Recovery Supporters help facilitate the referrals, and ensure that patients follow through.
Tips: Building an Interdisciplinary Team

It is ideal to create an interdisciplinary team to guide the implementation of the project. At a minimum, the team should include:

- Team Lead
- Administrative Assistant Support
- Physician Champion (Addiction Medicine)
- Nursing Champion
- Transitional Care - Social Work/RN
- IT and EHR Representative

Other members to consider if available within your institution:

- Process Engineer
- Physician leader within target unit
- Public relations/Community Outreach personnel

The team should report to an institutional leader (e.g., the campus/hospital president) who can help eliminate barriers or navigate challenges if needed.

Responsibilities of the Team Leader:

- Plan meeting schedule and agendas (with administrative support)
- Select and recruit team members for the project
- Create project timeline and ensure that the work stays on track
- Ensure that staff and leadership in the target units are updated on the project
- Keep hospital/site leadership updated on the status of the project
- Coordinate the collection of data, and ensure that the team reviews relevant information
- Facilitate institutional approval for parts of the project that may need further review prior to adoption (i.e., naloxone distribution protocol)

When selecting team members, the Team Lead should consider:

- Potential members’ knowledge of and passion for the project
- Team members’ ability to communicate to peers and colleagues regarding the importance of the project, as well as their credibility and influence with peers
- Team members’ ability to address resistance in the organization, or navigate the system
- Team members’ understanding of current processes and procedures
- The time and resources the potential team member will be able to commit
## Sample Meeting Schedule & Topics

<table>
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<tr>
<th>Week</th>
<th>Meeting Goal</th>
<th>Sample Agenda Items</th>
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<tbody>
<tr>
<td>Week 1</td>
<td>Introductions and Orient to the Project</td>
<td>● Team Introductions&lt;br&gt;● Review goal(s) of project&lt;br&gt;● Review and approve timeline&lt;br&gt;● Review list of stakeholders and create “communication” plan&lt;br&gt;● Review and discuss proposed sites</td>
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<tr>
<td>Week 2</td>
<td>Finalize Implementation Plan</td>
<td>● Review current patient flow in target units &amp; discuss proposed changes&lt;br&gt;● Review project plan and identify activities that will need additional organizational approval (i.e., new protocol for naloxone distribution, new order sets)&lt;br&gt;● Assign implementation tasks</td>
</tr>
<tr>
<td>Week 3</td>
<td>Patient Flow and EMR updates</td>
<td>● Review EMR and discuss updates to align with new processes&lt;br&gt;● Discuss timeline for EMR implementation</td>
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<tr>
<td>Week 4</td>
<td>Staff Training Plan</td>
<td>● Discuss staff training plan, revise as necessary&lt;br&gt;● Create a plan for implementation of new training</td>
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<td>Week 5</td>
<td>Stakeholder Communication</td>
<td>● Review and updates on stakeholder list - troubleshoot barriers</td>
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<tr>
<td>Week 6</td>
<td>Screening Instruments</td>
<td>● Review and discuss screening instruments for project.</td>
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<td>Week 7</td>
<td>Order Sets</td>
<td>● Clinical review and approval of order sets</td>
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<tr>
<td>Week 8</td>
<td>Referral Processes</td>
<td>● Review current resources for treatment referrals&lt;br&gt;● Identify additional resources, as well as a mechanism to facilitate referrals</td>
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<td>Week 9</td>
<td>Pilot Launch (invite all key stakeholders to meeting)</td>
<td>● Project Overview&lt;br&gt;● Plan for communication&lt;br&gt;● Plan for providing feedback</td>
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<tr>
<td>Weeks 10-16</td>
<td>Pilot Progress and Review</td>
<td>● Review pilot data&lt;br&gt;● Troubleshoot problems/challenges</td>
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<td>Meetings every week, or every other week as needed</td>
<td>Collect and review feedback</td>
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<td><strong>Week 17</strong></td>
<td><strong>Pilot Close Out</strong></td>
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<tr>
<td></td>
<td>• Review all data from pilot</td>
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<td>• Discuss lessons learned</td>
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<td></td>
<td>• Make a list of any necessary adjustments to process/protocol</td>
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<td></td>
<td>• Discuss and assign next steps</td>
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<tr>
<td><strong>Weeks 18-20</strong></td>
<td><strong>Follow Up Items from Pilot Close Out</strong></td>
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Project Management: Points to Consider

Assessing the culture within your organization

We recommend assessing the culture within your organization to determine potential areas of support and resistance. Surveying your leadership team as well as clinical staff of the target site would provide valuable insight into the stigma, beliefs, and motivation for SUD treatment initiatives. The surveys could lend direction to identification of educational needs about SUD and the institutional and population health benefits associated with SUD treatment initiatives. A post-survey would also provide valuable information regarding the success of the initiative in changing the culture within an organization and/or unit.

Assessing current addiction medicine resources/initiatives within your institution and community.

We recommend surveying your organization to identify all potential addiction treatment providers and initiatives within your system. Mapping out current and planned initiatives provides a framework for identifying internal gaps as well as an internal resource directory. We also recommend completing the exercise again for the community or markets your organization serves and overlapping with the internal map to identify community gaps in the treatment continuum.

Selecting Target Unit(s)

We recommend giving some thought to how you will select target units for the pilot. Ultimately, the decision-making process should be consistent with your system’s culture. However, there are several things to consider when selecting target unit(s):

- Is the unit leadership willing to be part of a pilot? Are they able to participate in the project team?
- Does the target unit have resources that support the pilot (e.g., nurses with behavioral health experience, access to physicians with a DEA Waiver)? If not, could resources be quickly deployed to support the pilot? Are there community resources that could permit MAT inductions internally with rapid transition to maintenance providers?
- Does data indicate that patients with OUD are naturally “clustered” in some units? If not, can they be?
• Does the target unit have competing initiatives that could cause delays or underperformance? Does the target unit have a high turnover rate that could result in continuous education needs and underperformance?

Key Stakeholders

A key stakeholder could be an individual (unit director) or a group of people (pharmacists). At the onset of the project, it is critical to identify the key stakeholders and develop a plan for communicating with those individuals/groups. While some key stakeholders will participate in the project team, others need notified and kept up to date on the progress of the work. As you generate a list of stakeholders, consider:

• Internal:
  ○ Pharmacy
  ○ Nursing
  ○ Physicians (Waivered)
  ○ Leadership in behavioral health (particularly for referrals and dually diagnosed)
  ○ Social work
  ○ EMR tech support
  ○ Finance/billing (related to new services)
  ○ Hospital leadership

• External:
  ○ Community addiction and mental health treatment partners
  ○ Local Alcohol, Drug, and Mental Health Board
  ○ Community Recovery Support Services
  ○ Local political officials, law enforcement, drug courts

EMR Updates and Revisions

Updating/modifying the EMR almost always takes longer than expected. If you anticipate making changes to your EMR, notify your EMR tech support as early as possible. Examine workflows from each discipline standpoint to minimize duplication of efforts, time required, and the number of handoffs. Providing workflows with tools facilitating ease of use will minimize the resistance and increase the quality of care provided.

Communication

It is important to have a plan for ongoing communication with key stakeholders, and to allow for feedback throughout the process. We recommend having one or two team members specifically responsible for providing information to unit staff,
and receiving feedback. This will help facilitate buy in, and allow the team to address issues quickly and efficiently.

Common Points of Resistance

Here are some common points of resistance that you may hear as you implement this project. We recommend you review these with your team and create “talking points,” so that everyone is prepared to address them consistently and effectively.

*We don’t have time for this*

Sample talking points:

- If we address addiction effectively here, we can prevent more serious issues later on.
- It’s always a challenge to adopt new procedures, but once they are integrated into the patient flow, we will be better able to serve these patients.
- Upon further discussions, the resistance is often due to the fear of the unknown which resolves with education and repetition

*Heroin/other opioids isn’t a problem here*

Sample talking points:

- # of the patients on these units that have opioid use disorder. These new policies will help us connect them to the treatment they need.
- Our health system is taking a number of steps to respond to the opioid crisis, and this is one of them.

*Why can’t social work do this? We treat medical conditions here.*

Sample talking points:

- Social work will be part of the team we use to address addiction on this unit. As patient advocates, we all need to do our part in treating all of the patient’s medical issues.
- Provide education on addiction as a disease and how all members of the patient care team need to be prepared to treat all chronic relapsing conditions, including addiction.
If we screen people, we will need to do something about the problem.

Sample talking points:

- We are already addressing the complications of addiction in our patients. We will be more effective if we address the source of the problems.
- We’re putting the resources in place to address the disease of addiction, and screening will help us provide care to more people.
Summa Health developed this education guide to organize staff education for this pilot project. Due to time constraints, the education modules for this project were developed and delivered in an online format. We found that this was cost effective and allowed for more flexibility for staff. However, there may be circumstances where in-person trainings are preferable. A few things to consider when choosing between online and in-person education:

1. How familiar are staff with behavioral health issues/addiction?
   
   Note: If staff are less familiar with addiction and behavioral health issues, it may be helpful to provide some training in person to allow individuals to ask questions.

2. How much time is available to support training and how much administrative support do you have for planning?
   
   Note: Online training is quicker to implement and requires less administrative support.

3. What is the cultural norm in your organization?
   
   Note: When possible, it is most effective to integrate education into the existing infrastructure and provide it in a way that is culturally consistent.

4. How much staff turnover do you expect/anticipate?
   
   Note: Any education/training should have a plan to accommodate staff turnover and onboarding for new staff (including resident physicians, if applicable).

5. Do you anticipate/need to plan for expansion of these practices?
   
   Note: Online training is generally easier and less expensive to replicate and scale.
Implementation Materials
Guidelines for Medication Assisted Treatment (MAT) Transition of Care Grant

A Comprehensive Treatment and Transitional Care Protocol for Inpatient Settings

CURRICULUM GUIDE

Jaimie McKinnon | February 11th, 2019
Module 1:  

Addiction 101: The Neurobiology of Addiction

Objectives:
- Provide an overview of the addictive process and its relationship with the brain
- Provide an explanation of addiction as a disease using the medical model
- Describe the various parts of the brain involved with addiction
- Provide understanding of the roles of neurotransmitters in the addicted brain

Addiction 101: Neurobiology of Addiction serves as the educational foundation for the entirety of the curriculum and is the first unit completed. Nicole T. Labor, DO, BCFP, BCABAM, Addiction Specialist, presents the latest research-based information on the neurobiology of addiction and evidence that addiction is a disease and should be treated as such, not as “weakness of character” or “moral failure.” Dr. Labors describes various parts of the brain involved with substance use and the roles of neurotransmitters, such as dopamine and serotonin in the disease. She also presents the pathophysiology behind relapse and cravings and the goal of dual modality treatment to restore the frontal cortex using behavioral therapy while addressing the craving derived from the midbrain with medications.

The target audience of the project included registered nurses and other providers working in the acute care setting on either a medical-surgical or telemetry unit who were tasked with screening for and treating opioid use disorders/substance use disorders. An understanding of addiction pathophysiology is crucial to remove stigma associated with patients with substance use disorders and support the delivery of effective and empathetic care. The training session is delivered via HealthStream, an electronic learning management system that provides its users with an efficient, asynchronous educational experience.
Addiction 101 (screenshots)
Module 2:  
Screening, Brief Intervention, and Referral to Treatment (SBIRT 101): A Comprehensive Care Model for Substance Use Disorders

Objectives:
- Introduce opioid use disorder (OUD) and substance use disorder (SUD).
- Briefly discuss the Opioid Epidemic and its effects on Ohio and Summit County.
- Explain the Screening, Brief Intervention, Referral to Treatment Model.
- Describe the Alcohol Use Disorders Identification Test (AUDIT) & the Drug Abuse Screening Test (DAST)
- Provide CarePath workflows of the SBIRT Model using the AUDIT & DAST

Once staff members have attained an understanding of addiction and its medical implications, they are ready to proceed with SBIRT education. The module developed by Chris Boros, MSN, RN provides employees with an overview of the SBIRT framework using the AUDIT and DAST, which guides the delivery of care provided to patients with OUD/SUD on the inpatient acute care units. Staff are provided with updated statistics regarding the Opioid epidemic and its effects on Ohio and Summit County as well as current statistics regarding SUD in general. Acute care clinical staff are informed of barriers to treatment for patients with SUD as they are educated on the need for seamless referrals to addiction treatment.
**What is SBIRT?**

1. “Comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders” (SAMHSA, 2017)

2. Consists of 3 main components
   - Screening
     - “a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting” (CIHS, n.d.)
   - Brief Intervention
     - “a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice” (CIHS, n.d.)
   - Referral to Treatment
     - “a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services” (CIHS, n.d.)

**AUDIT (Alcohol Use Disorders Identification Test)**

- 10-item screen
- Broad application across healthcare settings and demographics
- Clinicians should encourage patients to answer in terms of standard drinks

[Image of AUDIT form]
Module 3:  
SBIRT (Part 2): Ohio SBIRT 102 - Foundational Skills of MI

Objectives:
- Provide foundational skills of the evidence-based practice of Motivational Interviewing through the scope of Screening Brief Intervention and Referral to Treatment.
- Describe the technique and its efficiency in helping people change health behaviors.
- Illustrate examples of MI adherent patient interactions to demonstrate the various ways the skills can be utilized.

Because OHIO SBIRT 102 expands on the central tenets of the SBIRT model and provides an overview of motivational interviewing, the module should be completed after staff members have finished SBIRT 101.

Due to the increasing ubiquity of opioid use disorder in patients presenting to hospital inpatient settings, nurses must be able to therapeutically communicate with affected individuals from many demographic groups. Nurses must also possess an interpersonal skill set that allows them to effectively navigate the numerous pitfalls they are likely to encounter when broaching an often difficult subject. Armed with the tools of motivational interviewing, acute care RN’s can initiate and maintain productive conversations regarding changing unhealthy behaviors to improve the lives of those with OUD/SUD.

This training session is completed on the Ohio Department of Mental Health and Addiction Services website utilizing the free eBasedAcademy education platform.
OHIO SBIRT 102: Foundational Skills of MI (screenshots)
Module 4: Pharmacology: Alcohol & Opioid Withdrawal/MAT

Objectives:

- Explain the pathophysiology of substance withdrawal
- Describe the pharmacological interventions for detoxification of addictive substances
- Examine the principles of medication assisted treatment for opioid use disorder

Developed by Jessica Cather PharmD, students are provided a thorough tour through the pathophysiology of withdrawal from alcohol and opioids. Ms. Cather then provides detail on the use of medication treatments to facilitate detoxification from addictive substances. Additionally, medication assisted treatment – specifically buprenorphine (Suboxone, Subutex, and Sublocade) and naltrexone (Vivitrol) are discussed.

Preceded by Addiction 101 and SBIRT, Pharmacology of Withdrawal, Detoxification, and Medication Assisted Treatment enhances the clinical knowledge of the inpatient nurses while building upon the neurobiological and theoretical foundation instilled by the previous modules. Registered nurses are tasked with screening patients for SUD/OUD and dispensing pharmacological agents to treat its complications, which are key responsibilities highlighted in this presentation. Acute care staff will have tools to treat the whole patient, including their SUD, instead of focusing primarily on the medical co-morbidity of these conditions.

The training session is delivered via HealthStream.
Pharmacology: Alcohol & Opioid Withdrawal/MAT (Screenshots)

What is MAT?

- Any opioid addiction treatment that includes a FDA approved medication for the detoxification or maintenance treatment of opioid addiction
- Increases the likelihood for cessation of illicit opioid use or of prescription opioid abuse
- Is adversely affected by stigma
- 3 available agents: Methadone, Buprenorphine and Naltrexone

Buprenorphine

- Mu opioid Partial Agonist

Source: Mike Stillings, Reckitt Benckiser, Inc.

Science & Prac Perspectives. 2004;4-23.
Module 5:
SH Addiction Treatment Strategy: Clinical Withdrawal Protocols and Order Sets

Objectives:
- Describe the use of COWS and CIWA to assess substance withdrawal severity.
- Review the EHR workflow that accompanies use of the withdrawal assessment instruments.
- Describe the basic elements of the CarePath withdrawal order sets.

This module delivers an overview of the Summa Health Strategy for treating both alcohol and opioid withdrawal. A discussion on conducting assessments utilizing COWS and CIWA is offered. Fully expanded CarePATH withdrawal order sets are also provided.

Module 5 was developed by Jaimie McKinnon MBA, BSN, RN, NE-BC, Chris Boros MSN, RN, and the Summa Health CarePath Nursing Informatics Team. Because the course focuses on clinical application, registered nurses complete the module following Addiction 101 and SBIRT. The session may be disseminated concurrently with Pharmacology of Medication Assisted Treatment of Opioid Dependence and Withdrawal, as the content of both presentations is closely related.

The acute care registered nurses must be able to competently administer COWS and CIWA to provide adequate treatment to the SUD patient. Furthermore, they are required to spend significant periods of time navigating and documenting in the electronic health record, where the screens and order sets will be located. The module addresses both clinical and IT responsibilities for the clinical staff while familiarizing them with the assessment tools and order sets built within their EHR.

The training session is delivered via HealthStream.
Clinical Opiate Withdrawal Scale (COWS)

- Summa Health has adopted the COWS assessment as the standard tool for opiate withdrawal monitoring.
- COWS can be administered by any trained, licensed clinician.

1) Resting pulse rate (0-4)
2) Sweating over past half hour (0-4)
3) Restlessness (0-5)
4) Pupil dilated (0-5)
5) Bone or joint aches above baseline pain (0-4)
6) Runny nose or lacrimation (0-4)
7) GI upset over the past 30 minutes (0-5)
8) Tremor observation of outstretched hands (0-4)
9) Yawning (0-4)
10) Anxiety or irritability (0-4)
11) Piloerection or gooseflesh skin (0-5)

Withdrawal Categories - recheck
- no withdrawal (0-4) 4 hrs
- mild (5-12) 2 hrs
- moderate (13-24) 90 mins
- moderately severe (25-36) 60 mins
- severe withdrawal (> 36) 30 mins

Intervention
- Clonidine 0.1 mg and tramadol 50 mg
- Clonidine 0.1 mg and buprenorphine SL 2 mg

Assessment Frequency

- Assess patient using CIWA-Ar scale.
  - For scores <8 reassess every 8 hours X 72 hours and as needed.
  - For CIWA-Ar scores >8, assess patient 1 hours after each dose of medication.
Summa Health Addiction Treatment Strategy: Clinical Withdrawal Protocols and Order Sets (screenshots of order sets)

GEN Alcohol Withdrawal Focused Order Set

GEN Opiate Withdrawal Focused Order Set

Module 6:
ASAM Levels of Care/Transitions of Care

Objectives:

● Introduce the American Society of Addiction Medicine (ASAM) and their role in setting the standard of care for patients with SUD.
● Describe the 5 levels of the ASAM Continuum of Care
● Identification of barriers to aligning patients with the ideal level of care
● Review the levels of care available within Summa Health markets

The American Society of Addiction Medicine Levels of Care provide a standard nomenclature for describing the continuum of recovery-oriented addiction services. The 5 levels of service are reviewed in detail in the session by Chris Boros MSN, RN. Mr. Boros then provides an overview of the levels of care available within the Summa Health markets as well as the barriers identified in aligning patients with the ideal level of care.

The session is designed for staff who already possess a working knowledge of SUD/OUD and its treatment. Ideally, registered nurses complete ASAM Levels of Care after Addiction 101, SBIRT, Pharmacology, and Addiction Strategy. Transitioning the level of care of patients with OUD/SUD requires a multidisciplinary approach in order to navigate numerous potential hurdles, and the ASAM model has a proven track record of success.

The training session is delivered via HealthStream.
**ASAM Levels of Care/Transitions of Care (screenshot)**

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**Note:**
Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.
SBIRT Protocols
These protocols were developed to direct the implementation of SBIRT (Screening, Brief Intervention, and Referral to Treatment) in the inpatient setting. In this protocol, the SBIRT process is implemented by an RN leading to Social Work, Attending physician, and Addiction Specialist interventions.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Alcohol and Drug Protocols

1. Prior to initiating SBIRT, the RN must first “wrench” in the SBIRT documentation field into CarePATH, the electronic health record utilized by Summa Health (see Appendix A for visualization of “wrenching” process).

2. Once the SBIRT documentation field has been added, the RN begins the process by administering the alcohol and drug pre-screens. Both pre-screens are comprised of a single question; however, the alcohol pre-screen is sex-specific and contains two variations of the same question to account for sex-based physiological differences (see Appendix B for pre-screens as they appear in CarePATH).

3. If the alcohol pre-screen is positive (“1 or more”), the Alcohol Use Disorders Identification Test (AUDIT) cascades into view. If the drug pre-screen is positive (also “1 or more”), the Drug Abuse Screening Test (DAST) cascades into view (see Appendix C for AUDIT and DAST screens as they appear in CarePATH).

4. If a patient scores within a range of 0 to 6 on the AUDIT, the RN is not required to assess further or provide any type of intervention. A DAST score of 0 also requires no further intervention by the RN; however, this score is unlikely since the pre-screen question is similar to question 1 of the DAST.

5. The Alcohol Screening Intervention cascades in when the AUDIT score is 7 or more, and the Drug Screening Intervention cascades in when the DAST score is 1 or more (See Appendix D for alcohol and drug screening interventions as they appear in CarePATH).

6. An AUDIT score range of 7-19 requires the RN to complete the Alcohol Screening Intervention, and a DAST score range of 1-5 requires the RN to complete the Drug Screening Intervention. As the RN concludes the screening intervention(s), he or she will then provide the patient with a recommendation for follow-up by Social Work for additional consultation and resources. If the patient agrees to receive follow-up, the RN contacts the attending physician for a Social Work consult order. Please note that unlike the Alcohol Screening Intervention, the Drug Screening Intervention does not contain a documentation field prompting the clinician to offer more information or recommend a follow-up.
7. If a patient scores 20 or more on the AUDIT or 6 or greater on the DAST, a Best Practice Advisory is generated in CarePATH, which prompts the RN to notify the attending physician of the score(s). Please note that the RN must acknowledge the Best Practice Advisory by entering a comment indicating physician notification in order for it to be removed from view (see Appendix E for the Best Practice Advisory as it appears in CarePATH).

8. In addition to providing notification of the score(s), the RN will discuss the following with the attending physician:

   a. Medical management of current or anticipated signs and symptoms of withdrawal, e.g., CIWA/COWS protocol and medication orders for treating withdrawal symptomatology (see Appendix F for CarePATH withdrawal order sets).

   b. Addiction Medicine consult, if deemed necessary by the attending physician.

   c. Social Work consult (required) at discharge to facilitate referral for continued treatment. Social worker will facilitate additional treatment services utilizing ASAM Levels of Care placement guidelines (see Appendix G for internal and external provider list).
Appendix A

CarePATH: Wrenching in SBIRT

To permanently add (wrench) a flowsheet, click on the wrench icon in the top right-hand corner of the flowsheet activity.

Click on the checkbox next to Override Template Order. Find the first empty row and click on the magnifying glass.

The Select a Flowsheet Template dialogue box will display; it will default to the Preference List tab. Find SBIRT Screening and single click to highlight the row. Click the Accept button.
The SBIRT Screening flowsheet will now be permanently added to the Flowsheets activity.

Appendix B

Alcohol Pre-Screening/ Drug Pre-Screening
## Appendix C

### AUDIT/DAST

<table>
<thead>
<tr>
<th><strong>Alcohol Screening (AUDIT)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have a drink containing alcohol?</td>
</tr>
<tr>
<td>1 = Never</td>
</tr>
<tr>
<td>0 = No, you have 0 or more drinks containing alcohol per month</td>
</tr>
<tr>
<td>How many drinks containing alcohol do you have per occasion when you are drinking?</td>
</tr>
<tr>
<td>0 = Never</td>
</tr>
<tr>
<td>0 = Never</td>
</tr>
<tr>
<td>How often during the last year have you gone on a binge or drinking episode where you had noticeable physical or emotional problems, or drank when you were not able to do so because of the consequences of drinking?</td>
</tr>
<tr>
<td>0 = Never</td>
</tr>
<tr>
<td>How often during the last year have you made a physical or emotional recovery from drinking?</td>
</tr>
<tr>
<td>0 = Never</td>
</tr>
<tr>
<td>How often during the last year have you felt unable to control your drinking?</td>
</tr>
<tr>
<td>0 = Never</td>
</tr>
<tr>
<td>Have you ever been told by a relative, friend, doctor or other health care worker that you need to cut back on your drinking?</td>
</tr>
<tr>
<td>0 = No</td>
</tr>
<tr>
<td>TOTAL SCORE:</td>
</tr>
</tbody>
</table>
Drug Screening (DAST)

Have you used drugs other than those required for medical reasons?

☐ Yes ☐ No

Do you abuse more than one drug at a time?

☐ Yes ☐ No

Are you unable to stop using drugs when you want to?

☐ Yes ☐ No

Have you had "blackouts" or "flashbacks" as a result of drug use?

☐ Yes ☐ No

Do you ever feel bad or guilty about your drug use?

☐ Yes ☐ No

Does your spouse (or parent) ever complain about your involvement with drugs?

☐ Yes ☐ No

Have you neglected your family because of your use of drugs?

☐ Yes ☐ No

Have you engaged in illegal activities in order to obtain drugs?

☐ Yes ☐ No

Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?

☐ Yes ☐ No

Have you had medical problems as a result of your drug use?

☐ Yes ☐ No

TOTAL SCORE: [ ]
## Appendix D

### Alcohol Screening Intervention/Drug Screening Intervention

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would you mind if we talked for a few minutes about your alcohol use?</td>
<td></td>
</tr>
<tr>
<td>Are you aware that your drinking (and/or drug use) can be harmful to your health?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>On a scale of 0-10, how important is it for you to decrease your drinking?</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10</td>
</tr>
<tr>
<td>What makes you a _ and not a lower number?</td>
<td></td>
</tr>
<tr>
<td>On a scale from 0-10, how ready are you to decrease your drinking?</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10</td>
</tr>
<tr>
<td>On a scale from 0-10, how confident are you that you will be able to make the change?</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10</td>
</tr>
<tr>
<td>What is your next step, if any, to cut back on your use?</td>
<td></td>
</tr>
<tr>
<td>We can give you some more information and recommend a follow-up if you are interested.</td>
<td></td>
</tr>
</tbody>
</table>

[Image: screenshot of the Alcohol Screening Intervention/Drug Screening Intervention form]
Appendix E

Best Practice Advisory

<table>
<thead>
<tr>
<th>Best Practice Advisory</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If the patient has a score of 20 or greater on the AUDIT, the patient needs a referral to specialty chemical dependency treatment.</strong></td>
</tr>
<tr>
<td><img src="image_url" alt="Image" /></td>
</tr>
<tr>
<td><strong>If the patient has a score of 6 or greater on the DAST, the patient needs a referral to specialty chemical dependency treatment.</strong></td>
</tr>
<tr>
<td><img src="image_url" alt="Image" /></td>
</tr>
</tbody>
</table>
Appendix F

GEN Opiate Withdrawal Focused/GEN Alcohol Withdrawal Focused

Opiate Withdrawal Order Set

Summa developed the opioid withdrawal order set to support the implementation of MAT in its inpatient units. Clinical practice often varies from system to system or setting to setting. Therefore, we recommend that health systems review order sets with a small panel of clinicians before adopting them to ensure that clinicians are comfortable with the recommendations.
Gen Opiate Withdrawal Focused Order Set

Order Sets

Order Sets

Gen Opiate Withdrawal Focused

General

Notify Physician
- Notify physician
  - Routine, UNTIL, DISCONTINUED, Notify Physician for Clinical Opiate Withdrawal Score (COWS) of 15 or greater or SBP less than 90

Nurse Interventions

Opiate assessment
- Routine, ONE TIME, First occurrence today at 1400
  - Ascer patient using Clinical Opiate Withdrawal Scale (COWS). For scores less than 5, assess COWS every 4 hours for 24 hours and then every 6 hours. For scores greater than or equal to 5, assess COWS PRN and as directed within medication parameters.

Seizure precautions
- Routine, CONTINUOUS, Starting 3/26/19 Until Specified

Fall precautions
- Routine, CONTINUOUS, Starting 3/26/19 Until Specified

Medications

Nicotine Replacement

PATCH: Patients smoking less than 10 cigarettes/day, begin with 14 mg/day; patients smoking greater than 10 cigarettes/day, begin with 21 mg/day.

GUM: Patients who smoke their first cigarette within 30 minutes of waking should use the 4 mg strength, otherwise the 2 mg strength is recommended.

- nicotine (INCORET-CQ), 14 mg/24HR
  - 1 patch, Transdermal, Administer over 24 hours, DAILY

- nicotine (INCORET-CQ), 21 mg/24HR
  - 1 patch, Transdermal, Administer over 24 hours, DAILY

- nicotine polacrilex (NICORET) gum
  - 2 mg, Oral, EVERY 2 HOURS PRN, Smoking cessation; Patient may chew 1 piece of gum when urge to smoke occurs. If strong or frequent cravings are present after 1 piece of gum, may use a second piece within the hour, Do not chew continuously one piece after another.

Clinical Opiate Withdrawal Scale Medication Intervention

- tramadol and clonidine
- buprenorphine and clonidine

Symptom Management

- Melatonin ER tablet
  - 2 mg, Oral, NIGHTLY

- dicyclomine (BENTYL) tablet
  - 20 mg, Oral, EVERY 6 HOURS PRN, Abdominal Cramping

- ibuprofen (ADVIL/MOTRIN) tablet
  - 800 mg, Oral, EVERY 6 HOURS PRN, Myalgia, Administer with Food

- gabapentin (NEURONTIN) capsule
  - 300 mg, Oral, EVERY 6 HOURS PRN, Neuropathic Pain

- hydroxyzine (Vistaril) capsule
  - 50 mg, Oral, EVERY 6 HOURS PRN, Anxiety, Laxation, Rhinorrhea

- promethazine (PHENERGAN) tablet
  - 25 mg, EVERY 6 HOURS PRN, Nausea, Restless Leg Symptoms

Insomnia

- trazodone (Desyrel) tablet
  - 50 mg, Oral, NIGHTLY PRN, Sleep

- diphenhydramine (BENADRYL) tablet
  - 25 mg, NIGHTLY PRN, Sleep

- quetiapine (SEROQUEL) tablet
  - 50 mg, Oral, NIGHTLY PRN, Sleep

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**Notify Physician**
Notify physician

Notify physician for Systolic BP less than 90, pulse less than 60, CIWA score greater than 20, seizures, delirium tremens, or inadequate reduction in CIWA with maximum withdrawal treatment medication dose.

**Nurse Interventions**
- Alcohol and or drug assessment
- Seizure precautions
- Fall precautions
- Assault precautions
- Observation
- Search Patient
- Sitter at bedside

Routine, ONE TIME, Starting today
Assess patient using CIWA scale:
For CIWA score less than 8, reassess patient every 8 hours for 72 hours and as needed.
For CIWA score greater than or equal to 8, reassess patient 1 hr after each dose of medication and prn.
Q15 minute checks and suicide precautions

**Respiratory Interventions**
- Initiate Oxygen Therapy Protocol
- Nasal Cannula oxygen
- Venti-mask oxygen
- Nonrebreather mask oxygen
- Incentive spirometry
- Encourage deep breathing and coughing every two hours while awake
- Pulse Oximetry Spot Check
- Pulse oximetry, continuous

Routine, DAILY (RT)
Routine, DAILY (RT), Initial Flow Rate (L/MIN): 2SpO2
Initial FiO2: 31%, SpO2 Goal (%): 92%
SpO2 Goal (%): 92%, Initiate Oxygen Titration: Yes
Routine, DAILY (RT)
Routine, DAILY (RT)
Routine, UNTIL DISCONTINUED
Routine, ONE TIME
Routine, CONTINUOUS WITH Q4H RT CHECKS

**Medical Consults**
- Inpatient consult to Critical Care
- Consult to Intensivist
- Consult to Pulmonology
- Consult to Hospitalist
- Consult to Psychiatry

Reason for Consult? Provider Contacted?
Chemistry
- Basic Metabolic Panel
- Comprehensive Metabolic Panel
- Hepatic function panel
- Potassium
- Lactic acid, plasma
- Magnesium
- Calcium, Ionized
  Routine, TOMORROW AM,

Hematology
- CBC
- CBC auto differential
- Hemoglobin and hematocrit, blood
- Platelet count
- Protime – INR
- APTT
  Routine, TOMORROW AM, Starting tomorrow

Microbiology
- CULTURE BLOOD #1
- CULTURE BLOOD #1
  STAT, ONE TIME, Starting today

Microbiology - Other
- Respiratory Culture
  Routine, ONE TIME, Starting today

Urine - Drug Level
- Drug screen barbiturate urine
- Drug screen multi urine
  Routine, ONE TIME

Lab - Other
- HCG Qualitative, Serum
- Blood alcohol level
- Osmolality Serum (HMHP Only)
- Osmolality
- Acetaminophen Level
- Salicylate
  Routine, ONE TIME, Starting today For 1 Occurrences.
  To be completed on all females upon admission who have not had a hysterectomy or tubal ligation.

Detox Labs
- Phosphorus
- Calcium, Ionized
- Ammonia
- Amylase
  Routine, TOMORROW AM
- Lipase
- Vitamin B12
- TSH without Reflex
- Hemoglobin A1C
- POCT Glucose

Routine, TOMORROW AM
Routine, TOMORROW AM
Routine, TOMORROW AM
Routine, TOMORROW AM
Routine, ONE TIME, Starting today

**Imaging - Chest**

- XR CHEST STANDARD (2 VW)  
  Routine, Reason for exam:, Portable?
- X-ray chest PA only  
  Routine, Reason for exam:, Portable?
- X-ray chest AP portable  
  Routine, Reason for exam:, Portable?

**Cardiac Studies**

- EKG 12 lead  
  Routine, Starting today, Reason for Exam?

**IV Fluids**

- 0.9 % sodium chloride infusion
- KCl 20 mEq in dextrose 5 % and 0.45 % sodium chloride infusion
- 0.45 % sodium chloride infusion
- 0.9 % sodium chloride
- lactated ringers infusion
- Saline Flushes
- sodium chloride 0.9 % flush (scheduled)

Routine, at 125 mL/hr, CONTINUOUS
Routine, at 100 mL/hr, CONTINUOUS
Routine, at 75 mL/hr, CONTINUOUS bolus 500
Routine, at 1000 mL/hr, for 30 Minutes, ONCE
Routine, at 125 mL/hr, CONTINUOUS
10 mL, Intravenous, EVERY 12 HOURS
10 mL, Intravenous, PRN, Line Care,
Intravenous, CONTINUOUS

**Multivitamins - Infusion, IV, Oral**

- folic acid, thiamine, MVI in NaCl 0.9% Infusion  
  Intravenous, at 100 mL/hr, DAILY, For 3 Doses
- thiamine tablet 100 mg  
  100 mg, Oral, DAILY
- thiamine (B-1) injection 100 mg/mL  
  100 mg, Intramuscular, DAILY
- folic acid (FOLVITE) tablet 1 mg  
  1 mg, Oral, DAILY
- multivitamin (TAB-A-VITE) tablet  
  1 tablet, Oral, DAILY

**Nicotine Replacement**

- nicotine (NICODERM CQ) 14 MG/24HR  
  1 patch, Transdermal, for 24 Hours, DAILY
- nicotine (NICODERM CQ) 21 MG/24HR  
  1 patch, Transdermal, for 24 Hours, DAILY
- nicotine polacrilex (NICORETTE) gum  
  2 mg, Oral, EVERY 2 HOURS PRN, Smoking Cessation

**Medications for Alcohol Withdrawal**

**LORazepam (ATIVAN)**

- LORazepam (ATIVAN) tablet  
  1 mg, Oral, EVERY 1 HOUR PRN alcohol withdrawal. For CIWA score 8 to 10. Reassess CIWA one hour after each dose of medication and prn.

- LORazepam (ATIVAN) injection  
  1 mg, Intravenous, EVERY 1 HOUR PRN, For alcohol withdrawal. For CIWA score 8 to 10. If both oral and intravenous CIWA medications ordered, use intravenous if unable to tolerate oral equivalent. Reassess CIWA one hour
after each dose of medication and prn.

- **LORazepam (ATIVAN) tablet**
  2 mg, Oral, EVERY 1 HOUR PRN For alcohol withdrawal.
  For CIWA score 11 to 15. Reassess CIWA one hour after each dose of medication and prn.

- **LORazepam (ATIVAN) injection**
  2 mg, Intravenous, EVERY 1 HOUR PRN For alcohol withdrawal.
  For CIWA score 11 to 15. If both oral and intravenous CIWA medications ordered, use intravenous if unable to tolerate oral equivalent. Reassess CIWA one hour after each dose of medication and prn.

- **LORazepam (ATIVAN) tablet**
  3 mg, Oral, EVERY 1 HOUR PRN For alcohol withdrawal.
  For CIWA score 16 to 20. Reassess CIWA one hour after each dose of medication and prn.

- **LORazepam (ATIVAN) injection**
  3 mg, Intravenous, EVERY 1 HOUR PRN For alcohol withdrawal.
  For CIWA score 16 to 20. If both oral and intravenous CIWA medications ordered, use intravenous if unable to tolerate oral equivalent. Reassess CIWA one hour after each dose of medication and prn.

- **LORazepam (ATIVAN) tablet**
  4 mg, Oral, EVERY 1 HOUR PRN For alcohol withdrawal.
  For CIWA score greater than 20. Reassess CIWA one hour after each dose of medication and prn.

- **LORazepam (ATIVAN) injection**
  4 mg, Intravenous, EVERY 1 HOUR PRN For alcohol withdrawal.
  For CIWA score greater than 20. If both oral and intravenous CIWA medications ordered, use intravenous if unable to tolerate oral equivalent. Reassess CIWA one hour after each dose of medication and prn.
Naloxone Distribution and Harm Reduction Strategies

Due to policy for Naloxone distribution from the ED and acute care areas being delayed in P&T Committee, Naloxone Distribution policy and procedures upon DC to next level of care were not included in the guidelines. Providing Naloxone to OUD patients after detoxification or induction on MAT is the standard of care and will be added to SH’s protocols once finalized. Current practice is to provide a prescription to the patient which can be filled at one of our outpatient pharmacy locations. Attached is the ED dispensing policy being presented for approval.
Department of Pharmacy

# 4057 Medication Sent Home with the Patient

<table>
<thead>
<tr>
<th>Author:</th>
<th>Karen Eckley</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Sponsor:</td>
<td>Dr. David Custodio, Summa Health System-Akron Campus</td>
</tr>
<tr>
<td>Gate Keeper:</td>
<td>Karen Eckley, Project Pharmacist</td>
</tr>
<tr>
<td>Approved by:</td>
<td>John Feucht, System Director of Pharmacy</td>
</tr>
</tbody>
</table>

Policy Type

☐ Entity Governance Policy
☒ Entity Policy
☐ Entity Departmental Policy
☐ System Governance Policy
☐ System Policy
☐ System Departmental Policy
☐ Home Office Policy

Policy Scope

☐ Summa Health (Corporate)
☒ Summa Health System (Hospitals)
☐ Summa Health Network
☐ New Health Collaborative
☐ Summa Health Medical Group
☐ SummaCare
☐ Department:____________

ORIGINAL: 03/11
REVIEWS: ...2012, 2013, 2014, 02/15, 04/16, 04/17
REVISED: 01/18
1.0 **Purpose:**
1.1 To ensure medications to be sent home with the patient are properly labeled when supplied to Summa entities by the pharmacy.

2.0 **Scope:**
2.1 Summa Health System (Hospitals)

3.0 **Definitions:** N/A

4.0 **Policy:**
4.1 All medications prepared to be dispensed to the home going patient will be labeled in accordance with the legal requirements of the Ohio Board of Pharmacy.

5.0 **Procedure:**
5.1 Emergency Department Albuterol Inhalers

5.1.1 Prior to placing albuterol inhalers in the Emergency Department automated dispensing machine, the pharmacy department will attach a preprinted label containing the following:

5.1.1.1 Hospital name and address
5.1.1.2 Directions for use
5.1.1.3 Drug name and strength
5.1.1.4 Designated line for the patient’s name
5.1.1.5 Designated line for the prescriber’s name
5.1.1.6 Designated line for the date dispensed

5.1.2 Addition of the patient’s name, date of dispensing and prescriber’s legible name will be completed by the prescriber or his designee.

5.1.3 The prescriber (as per OAC 4729-5-17) will be responsible for the final check of the medication prior to dispensation to the patient. This final check will be signified by initialing the medication label.

5.2 Emergency Department Naloxone

5.2.1 Prior to placing naloxone in the Emergency Department automated dispensing machine, the pharmacy department will attach a preprinted label containing the following:

5.2.1.1 Hospital name and address
5.2.1.2 Directions for use
5.2.1.3 Drug name and strength
5.2.1.4 Designated line for the patient’s name
5.2.1.5 Designated line for the prescriber’s name
5.2.1.6 Designated line for the date dispensed

5.2.2 Addition of the patient’s name, date of dispensing and prescriber’s legible name will be completed by the prescriber or his designee.

5.2.3 The prescriber (as per OAC 4729-5-17) will be responsible for the final check of the medication prior to dispensation to the patient. This final check will be signified by initialing the medication label.

5.2.4 A prescriber or designee will provide verbal counseling and written educational materials to the patient for whom naloxone is dispensed, appropriate to the dosage form of naloxone dispensed including, but not limited to, the following:

5.2.4.1 Risk factors of opioid overdose
5.2.4.2 Strategies to prevent opioid overdose
5.2.4.3 Signs of opioid overdose
5.2.4.4 Steps in responding to an overdose
5.2.4.5 Information on naloxone
5.2.4.6 Procedures for administering naloxone
5.2.4.7 Proper storage and expiration of naloxone product dispensed
5.2.4.8 Information on where to obtain a referral for substance abuse treatment (i.e. Ohio Department of Mental Health and Addiction Services treatment information and referral hotline (877-275-6364))

5.3 Insulin Syringes initiated in the hospital
5.3.1 Insulin syringes are relabeled for home going use by the inpatient pharmacy.
5.3.2 A prescription must be received for the patient prior to relabeling
5.3.2.1 Labels will be generated from the pharmacy computer system(s)

5.4 Indigent Medications
5.4.1 Indigent medications will be filled by the retail pharmacy when it is open.
5.4.2 When the retail pharmacy is closed, indigent medication prescriptions will be filled by the inpatient pharmacy.
5.4.2.1 A prescription must be received for the patient prior to relabeling
5.4.2.2 Labels will be generated from the pharmacy computer system(s)

5.5 Multiple Dose Medications Initiated in Surgery
5.5.1 Refer to Policy 3391 – Medications Used in Surgery Sent Home with the Patient

6.0 Responsibilities and Authorities:

6.1 The System Director of Pharmacy has responsibility for and authority over this policy.
6.2 Any prescriber or pharmacist dispensing a medication for home going use is responsible to comply with the elements of this policy.
6.3 Failure to abide by these procedures will result in disciplinary actions up to and including termination.

7.0 Records:
7.1 Prescriptions are retained for three years
7.2 See Summa Health Record Retention Policy

8.0 References:
8.1 OAC 4279-5-17
8.2 Policy 4163 – Indigent Medication Acquisition by Social Work
8.3 Policy 3391 – Medications Used in Surgery Sent Home with the Patient

9.0 Key Words or Aliases (Optional):
9.1 Take home medication
9.2 Home going medication
9.3 Prescriber dispensing
ED-Narcan-To-Go Patient Education

1. Risk factors of opioid overdose and prevention
   a. Mixing Drugs: mixing heroin or prescription opioids with alcohol and/or benzodiazepines
      i. Don’t mix opioids with other drugs or alcohol. Take prescribed opioids and benzodiazepines only as directed.
   b. Tolerance: tolerance builds over time, but decreases rapidly when patients take a break from an opioid. They are then at an increased risk of overdose.
      i. If you are using opioids after a period of abstinence, start at a lower dose.
   c. Physical health: patients with asthma or other breathing problems are at an increased risk of overdose due to opioids impacting the ability to breathe.
   d. Previous overdose: those with history of a non-fatal overdose are at risk of a fatal overdose in the future
      i. Teach family and friends how to respond to an overdose.

2. Signs of opioid overdose
   a. Slow breathing (less than 1 breath every 5 seconds) or no breathing
   b. Vomiting
   c. Face is pale and clammy
   d. Blue lips, fingernails or toenails
   e. Slow, erratic, or no pulse
   f. Snoring or gurgling noises while asleep or nodding out
   g. No response when you yell the person’s name or rub the middle of their chest

3. Steps in responding to an overdose
   a. Try to wake the person up by yelling their name or preforming a sternum rub
   b. Call 911 immediately and indicate the person has stopped breathing or is struggling to breathe
   c. Make sure the person’s airway is clear, if breaths are slow or breathing has stopped, perform rescue breathing.

4. Information on Naloxone, storage and expiration
   a. Naloxone is a prescription medication that can reverse an overdose caused by an opioid. It stops the action of opioids on the brain and restores breathing. Naloxone is harmless if given to a person who is not experiencing an opioid overdose, but may cause withdrawal in someone who is. Store Naloxone at room temperature and away from light. It is good for approximately 2 years.

5. Procedures for administration
   a. Refer to package and Ohio State Board of Pharmacy brochure. Insert naloxone delivery device into nasal passage and instill spray. Repeat in 3 minutes if needed.

6. Info for referral for substance abuse treatment
   a. Ohio Department of Mental Health and Addiction Services treatment information and referral hotline (877-275-6364)
   b. For additional education materials please visit www.prescribetoprevent.org