Utilizing Telehealth to Expand Access to Medications for Opioid Use Disorder (MOUD) in a Rural Emergency Department (R-ED)

Suzanne Lane, MSHI[1], Sarah Gainey, MSW[1], Lindsey Jennings, MD[2] Angela Moreland, PhD[1] Alexandra Duncan, BS[1], Keia V.R. Hewitt, MD, MBA, MPH, FACEP[3], Jared Hayes, RN[3], Dustee Rivers[3], RN, Taylor Riner, RN[3], Karen Hartwell, MD[1,4], Louise Haynes, MSW[1] Kathleen Brady, MD[1]

1. Medical University of South Carolina, Department of Psychiatry, 2. Medical University of South Carolina - Charleston Division, Department of Emergency Medicine, 3. Medical University of South Carolina - Catawba Division, Department of Emergency Medicine, 4. Ralph H. Johnson VA Medical Center

AIM

Evaluate the feasibility and acceptability of Peer Recovery Specialist (PRS) services provided via telehealth utilizing existing PRS teams to expand access to patients in vulnerable areas.

BACKGROUND

- Opioid-involved deaths continue to rise, exceeding 100,000 for the first time in 2021.
- Patients provided ED-initiated buprenorphine (EDIB) are twice as likely to remain in treatment at 30-days compared to patients provided only treatment referral upon discharge.[1]
- Patients receiving MOUD have a decreased mortality risk[2] and experience better treatment outcomes.
- Rural (R)-ED access to PRS services is limited due to lower patient volumes and the need for almost constant PRS availability.

METHODS

Study Population

Individuals who presented to an urban (U) or rural (R) ED and screened positive for risky substance use between October 20, 2022, and October 18, 2023.

Procedure

- Screening, Brief Intervention and Referral to Treatment (SBIRT) model: screening occurs in triage, PRS perform a brief intervention (BI) and refer to treatment
- U-ED: PRS provide on-site clinical services
- R-ED: PRS provide tele-peer clinical services
  - Same team of 4 PRS provide services at both U & R-ED
- PRS track attempted and completed BIs via HIPPA-compliant survey software
  - Connectivity challenges recorded by PRS

Evaluation

- Feasibility: assessed by examining the number of times peer services were employed relative to the number of patients who screened positive and percentage of appropriate patients receiving EDIB
- Acceptability of the Intervention: patients complete validated Acceptability of Intervention Measure (AIM)[3] survey when possible

RESULTS

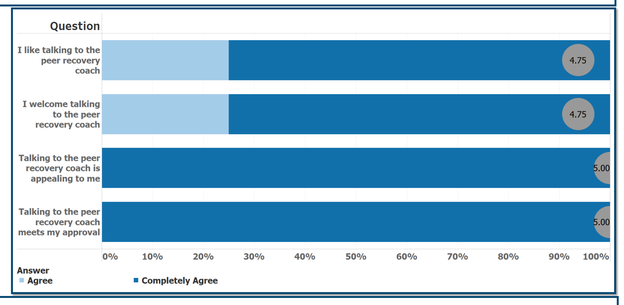
- U-ED:
  - 2831 Positive SBIRT Screens
  - 553 (20%) received in-person peer BI
  - 553/642 (86%) attempted BIs completed
  - 42/117 (36%) appropriate patients with OUD received EDIB
- R-ED:
  - 1016 Positive SBIRT Screens
  - 26 (3%) received tele-peer BI
  - 26/162 (20%) attempted BIs completed
  - 6/10 (60%) appropriate patients with OUD received EDIB

Top Reasons BI Not Conducted

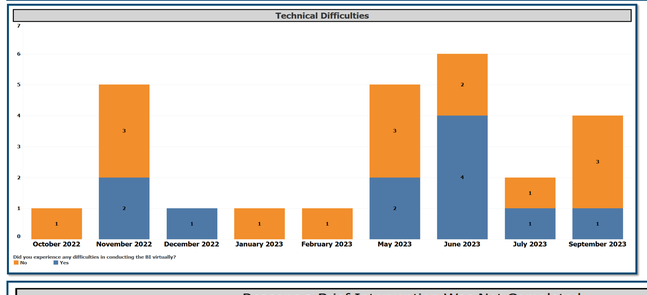
- U-ED
  - Patient too intoxicated (25%)
  - Patient declined PRSS services (25%)
  - Medical issues (19%)
- R-ED
  - PRSS unable to contact ED staff (24%)
  - Patient too intoxicated (15%)
  - Patient declined PRSS services (14%)

R-ED Acceptability of Intervention Measure

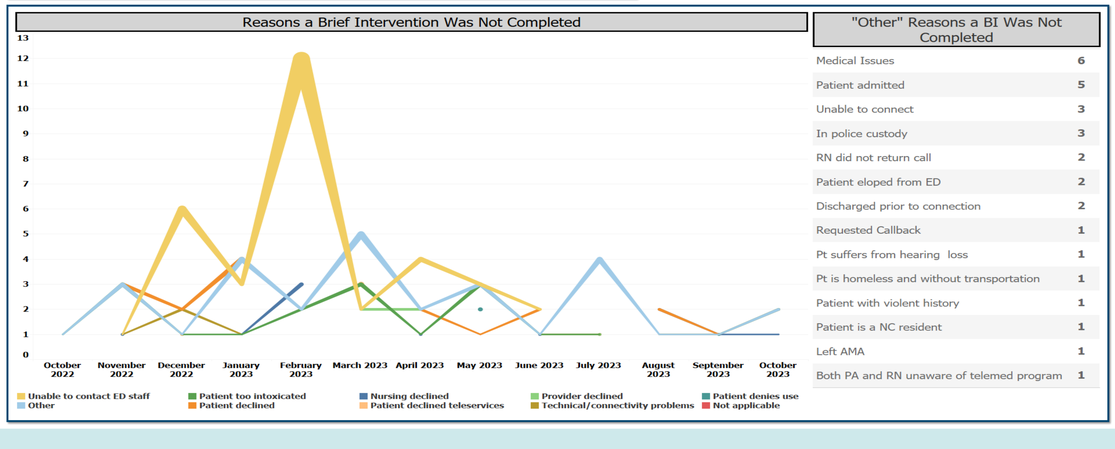
- Survey completed in 4/26 (15%) of BIs
- Patients agreed:
  - The BI met their approval
  - The BI was appealing
  - They liked talking to the PRSS
  - They welcomed talking to the PRSS



R-ED Technical Difficulties



- Experienced in 42% of completed BIs
- Causes of technical difficulties include:
  - Connecting to patient via tablet
  - Performing a referral
  - PRSS being flagged
  - Connecting to nurse
  - Connecting to provider



"Other" Reasons a BI Was Not Completed	
Medical Issues	6
Patient admitted	5
Unable to connect	3
In police custody	3
RN did not return call	2
Patient eloped from ED	2
Discharged prior to connection	2
Requested Callback	1
Pt suffers from hearing loss	1
Pt is homeless and without transportation	1
Patient with violent history	1
Patient is a NC resident	1
Left AMA	1
Both PA and RN unaware of telemed program	1

CONCLUSIONS

- Tele-peer services were implemented into a R-EDIB program.
- Tele-peer services are more difficult to implement than on-site peer services in the ED.
- Reasons a BI was not conducted were similar between the U-ED and R-ED
- Patient acceptability of services appears high.
- Data collection is ongoing to determine feasibility.

REFERENCES

1. D'Onofrio G, O'Connor PG, Pantalon MV, et al. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. *JAMA*. 2015;313(16):1636-1644.
2. Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ*. 2017;357:j1550. Published 2017 Apr 26.
3. Weiner, BJ, Lewis, CC, Stanick, C, et al. Psychometric assessment of three newly developed implementation outcome measures. *Implement SCI,* 12(1), 108.

DISCLOSURES

- Funded by: South Carolina Department of Health and Human Services (SCDHHS) and Health Resources and Services Administration (HRSA).
- Development of presentation supported in part by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of the National Telehealth Center of Excellence Award (U66 RH31458).
- Contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.
- The authors have no financial relationships that relate to the topic of this presentation