EMERGENCY: Hospitals are Violating Federal Law by Denying Required Care for Substance Use Disorders in Emergency Departments

Evidence-Based Care, Legal Protections for Patients, Improving Hospital Practices

LEGAL ACTION CENTER

Breaking Barriers. Defending Dignity.

Breaking Barriers. Defending Dignity.

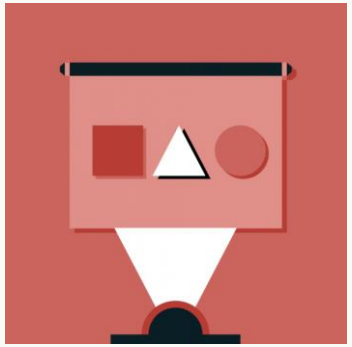
The Legal Action Center (LAC) uses legal and policy strategies to fight discrimination, build health equity, and restore opportunity for people with criminal records, substance use disorders, and HIV or AIDS.

How LAC Works

Direct Legal Services

Impact Litigation

Policy Advocacy



Training, Technical Assistance & Education

Coalitions & Collaboration

Why Focus on Emergency Departments

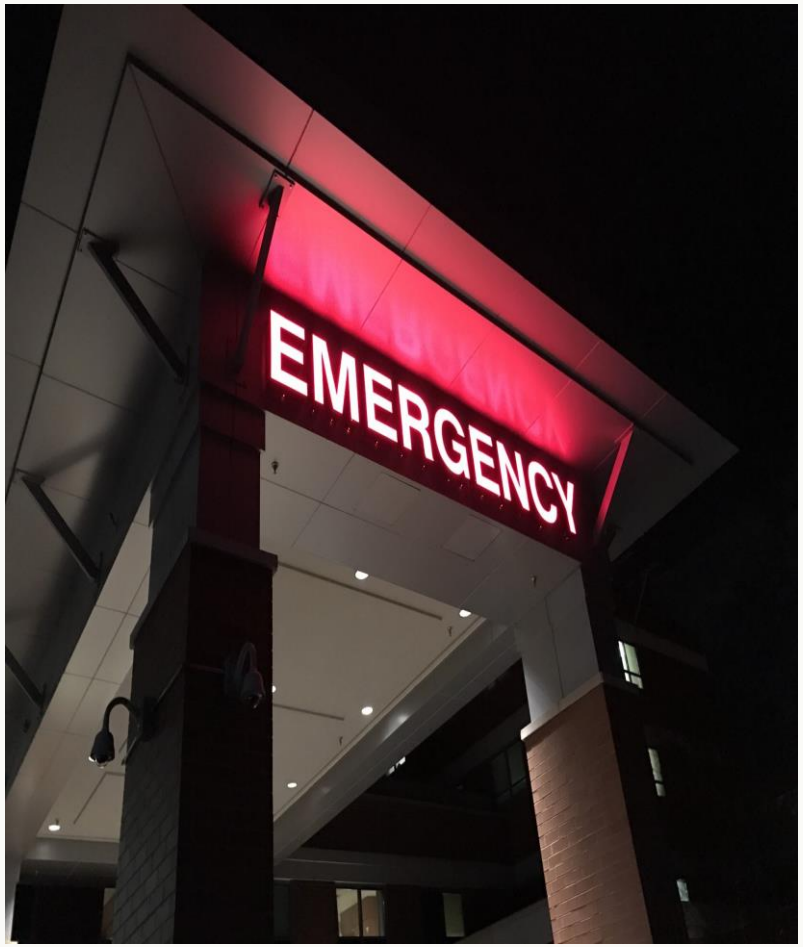
- Key access point to substance use disorder care
  - People who use drugs often visit EDs for withdrawal, post-overdose treatment, accidents, and infections
  - Point of access to medical care for people with lower incomes and for Black and Brown people.
- Overdose deaths at unprecedented numbers and disparate racial impact
  - Nationally – 105,752 (year ending Oct. 2021) – 40% increase previous 12-month period
  - Maryland – 2792 (year ending Oct. 2021) – 16% increase previous 12-month period
- Disparate Racial Impact – Overdose and Access to Care for OUD
  - Nationally – Overdose rates have increased faster among Black and Latino people than white people and Indigenous people have highest rates of SUD and opioid misuse.
  - Maryland – opioid-related fatal overdose increased substantially among Black individuals (+12.5%) and decreased marginally among white individuals (-8%) (Q2 2021 v. Q2 2020).
  - Black patients with opioid use disorder 77% less likely than white patients to receive buprenorphine. (Lagisetty, et al. Buprenorphine Treatment Divide by Race/Ethnicity and Payment (2019)
  - Post ED, black patients with commercial insurance were 50% less likely that white patients to receive follow-up care. (Kilaru, et al. Incidence of Treatment for Opioid Use Disorder Following Nonfatal Overdose in Commercially Insured Patients (2020))

Why Focus on Emergency Departments

- ED Role: “A universal point of medical access, diagnosis, treatment and linkage to definitive care.” (Samuels et al. A Quality Framework for Emergency Dept. Treatment of Opioid Use Disorder (2017).
- Best Practices Exist for SUD Care
  - Screening and diagnostic assessment based on medical diagnostic criteria (DSM-5)
  - Offer to administer medication for opioid use disorder
  - Facilitated referral to treatment and naloxone dispensing or prescription at discharge
- But Most EDs Are Not Adopting
  - **1 in 12 patients** (8.5%) receive buprenorphine prescription within 30 days
    - Only 3.9% of prescriptions were among the 90% of patients who had no prior buprenorphine dispensing → low rate of ED prescribing.
  - **1 in 13 patients** (7.4%) received naloxone prescription within 30 days of visit
    - Substantially lower than epinephrine prescribing rate (48.9%) for ED visit for anaphylaxis

Chua, et al. Naloxone and Buprenorphine Prescribing Following US Emergency Dept. Visit for Suspected Overdose: August 4, 2019 to April 3, 2021 (national study of 148,966 ED visits for opioid overdose)

Common ED Practice



Flo overdoses while using heroin, and her neighbor calls 911 asking that EMS come immediately to save a friend who has overdosed.

At the ED, hospital staff:

- Administer more naloxone
- Monitor respiratory function
- Rehydrate and give medication for withdrawal symptoms

Flo's neighbor tells the ED doctor that she has overdosed many times and needs treatment. They asks the doctor to give her buprenorphine. The doctor says he can't and, after Flo seems alert, discharges her with a list of local treatment programs.

Later that evening, Flo's neighbor finds her unresponsive and Flo dies on the way to the ED.

Session Overview

- Evidence-Based Practices – Patients with Substance Use-Related Conditions
- Failure to Implement – Common Reasons
- Federal Laws Requiring Evidence-Based Practices and Hospital ED Practices that Violate Laws
- Enforcing Individual Rights and Strategies for Reform
- Questions

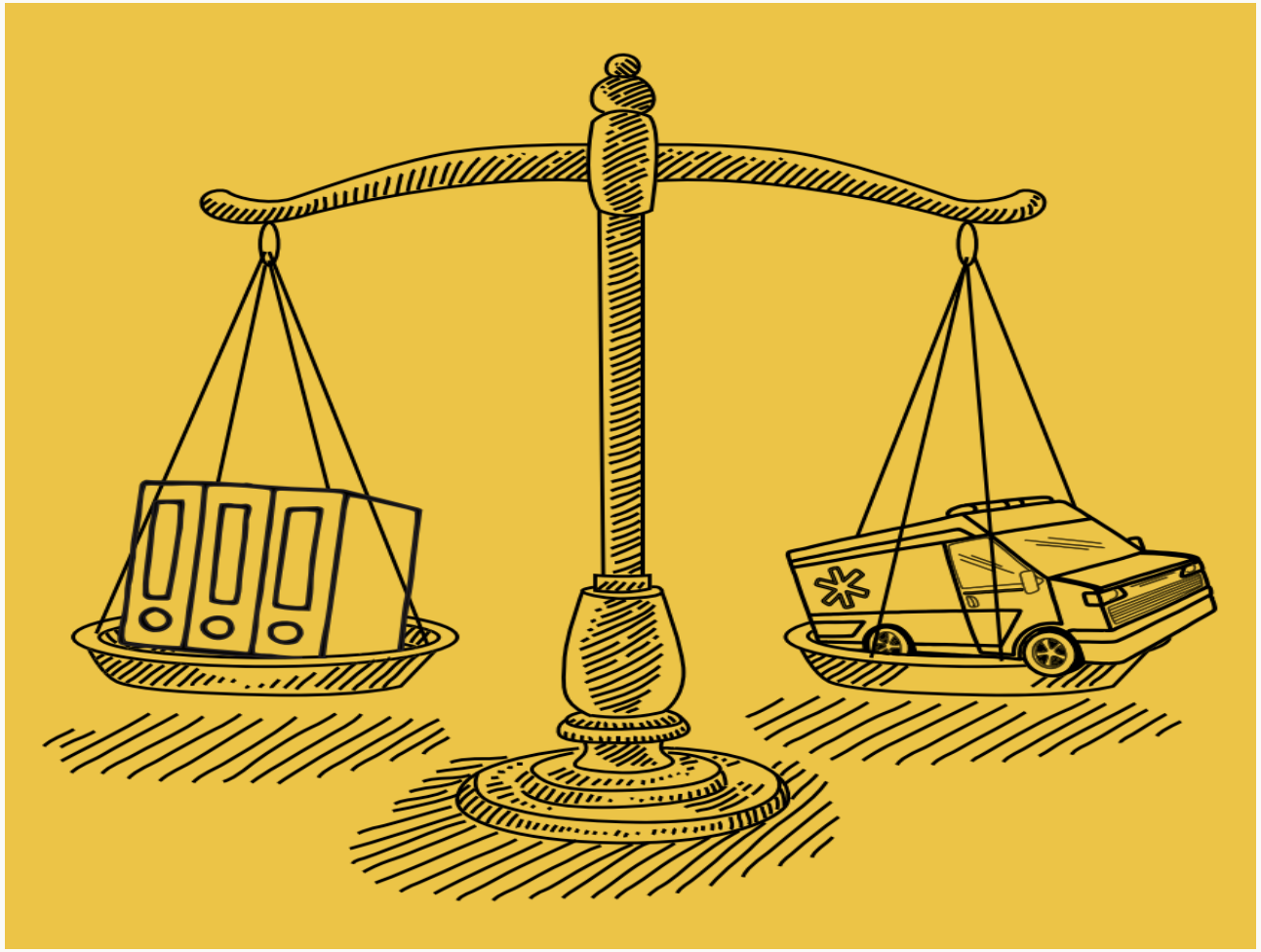
Evidence-Based SUD Services Implemented in EDs

- Research and recommendations support 3 evidence-based practices for individuals presenting to ED with substance-use related conditions.
  - Screening for and diagnosis of SUD
    - *ED Role*: Determine whether patient has a SUD that could pose a life-threatening condition
    - *Screening*: is presenting condition (accident, infection, other symptoms) related to substance use and requires diagnostic assessment
      - SBIRT for alcohol use – American College of Emergency Physicians; Am. College of Surgeons Comm on Trauma
    - *Diagnostic assessment*: physical exam, medical and substance use history based on DSM-5 criteria
  - Offer to administer buprenorphine to patients in opioid withdrawal and/or untreated moderate to severe opioid use disorder
    - *ED Role*: treat life-threatening conditions
    - Treat opioid withdrawal, suppress cravings and avert opioid overdose (reduces mortality by 50%)
  - Facilitated referral to community-based SUD treatment along with naloxone for patients using opioids or drug with which opioid can be combined
    - *ED Role*: Linkage to definitive care for chronic conditions
    - Direct, specific referral with appointment time to a provider that takes patient's insurance and meets needs with assistance from staff (peers, social worker, advocate) to navigate entry to care

Failure to Adopt Evidence-Based Practices

Rationale	Response
Not ED Role • Treat life-threatening not chronic conditions	• Untreated OUD/SUDs is life-threatening • Patients who survive opioid OD – 100% more likely to die by drug OD in following year and 18% more likely to die by suicide compared to general public. • Linkage to care for common chronic conditions – asthma, diabetes
Stigma and Stereotype • Drug use is choice not medical condition • Medication substitutes one drug for another • “Difficult and disruptive” patients	• Research establishes nature and etiology of SUDs and efficacy of medication for OUD • Failure to provide effective care leads to patient’s withdrawal and discomfort in ED resulting in irritability, continued use and return to ED
Limited Time and ED Resources	• SUD diagnostic criteria can be incorporated into electronic health record • Buprenorphine initiation within time limitations for ED patient care • Proper care reduces likelihood of patients returning to ED • Appropriate assistance available from non-medical, affiliated staff
X-Waiver to Prescribe Buprenorphine	• No waiver required under 3-day rule – dispensing 3-days of medication • Can treat up to 30-patients without meeting education and service requirements
Reimbursement	• Insurance law limitations on access to buprenorphine – violate Parity Act • State laws barring insurance reimbursement for injuries sustained while intoxicated • EMTALA bars hospitals from denying services based on insurance status
Limited Community Providers	• Increased collaboration with community-based providers will identify existing services and lay foundation for more

ED Legal Obligations to Offer Evidence-Based Services



Federal Law Protections – Evidence-Based Services for Patients with Substance Use-Related Conditions

- Emergency Medical Treatment and Labor Act (EMTALA)
  - Requires most EDs to examine patients for an emergency medical condition and stabilize those with such a condition before discharge or transfer
- Americans with Disabilities Act (ADA) and Rehabilitation Act
  - Prohibit discrimination on basis of disability including persons with current alcohol use disorder, history of illegal drug use disorder and those regarded as having a SUD
  - Prohibits denial of health care to individuals based on current illegal use of drugs
  - ADA applies to most public and private hospitals; Rehab Act applies to those getting federal financial assistance
- Title VI of the Civil Rights Act of 1964 (Title VI)
  - Prohibits discrimination on the basis of race or ethnicity
  - Applies to most public and private hospitals (must receive federal financial assistance).

EMTALA – EDs Must Identify Medical Emergencies

1. CONDUCT MEDICAL SCREENING EXAMINATION

- Identify *emergency medical condition*
  - "acute symptoms of sufficient severity" that absent immediate medical attention could "reasonably be expected" to seriously jeopardize health or impair bodily functions
  - Symptoms of "substance abuse" or "psychiatric disturbances" defined as acute symptoms
- For patients with substance use-related conditions, a diagnostic assessment determines if patient has a SUD and one of sufficient severity to jeopardize health
  - Untreated SUD can result in respiratory failure, brain or other organ injury, death
- ED has broad discretion to establish its "medical screening" protocols and can vary based on ED's capability

WHAT VIOLATES OBLIGATION

- Does not conduct *any* diagnostic assessment to determine if patient presenting with acute symptoms of alcohol or drug use has an SUD – "failure to screen."
- Fails to provide same level of "screening" to all patients presenting with similar medical complaints associated with substance use-related condition.
- Some courts will consider if ED screening procedure is so cursory/inadequate as to amount to no "appropriate medical screening."
- *Misdiagnosis or failure to identify all medical emergency conditions is not an EMTALA medical screening violation.*

EMTALA – ED Must Stabilize Patients with Emergency Medical Conditions

2. STABILIZE PATIENT WITH *IDENTIFIED* EMERGENCY MEDICAL CONDITION

- Provide medical treatment that, with reasonable medical certainty, will prevent "material deterioration" of patient's condition following discharge or transfer to another hospital
  - Must be tailored to patient's individual condition (not just uniform treatment)
  - Must resolve the medical emergency
  - Does not need to treat underlying condition
- For patients with untreated moderate or severe SUD, ED staff know that patients will continue to use alcohol or drugs in potentially life-threatening way if withdrawal symptoms and cravings are not effectively treated.
- "Material deterioration" foreseeable" at discharge and specific care and assistance required to prevent.

WHAT VIOLATES OBLIGATION

- For patients with untreated OUD, failure to offer opioid agonist medication to treat withdrawal, suppress cravings an prevent overdose (buprenorphine)
- Failure to help arrange treatment for SUD through a facilitated referral
- Failure to provide naloxone for patients who use opioids or drugs that can be mixed with opioid

EMTALA Case Study

Flo overdosed on heroin and is being treated in the ED.

Before discharging Flo, ED staff:

- *Restored her respiratory function*
- *Rehydrated her with fluids and treated some withdrawal symptoms resulting from naloxone*
- *Gave her a list of local SUD programs*

Flo uses heroin within hours of discharge to mitigate withdrawal symptoms. She fatally overdoses.

1. Has ED screened Flo for SUD?

   No, potential screening violation if did not conduct diagnostic assessment to identify OUD

   Diagnostic assessment required to identify emergency medical condition and triggers stabilization obligation.

2. Has ED stabilized Flo's SUD?

   No, staff did not offer to:

   - *Administer buprenorphine*
   - *Arrange follow-up care at a specific treatment program that could deliver care to Flo.*

3. Proof of harm that results from ED violation is required.

ADA and Rehabilitation Act Prohibited Actions by EDs

- Discriminating against people because of or on the basis of disability.
  - Actions are based on stereotypes and generalizations about people with SUDs rather than legitimate, individualized medical reason.
    - Reason for not providing evidence-based practices often based on stigma or not grounded in objective individualized facts.
  - Administering “program” in a manner that has the purpose or effect of discriminating on basis of disability.
- Denying health care services to people who currently use drugs illegally because they use drugs.
- Refusing a request for a reasonable accommodation - modifications to policy or practice that would allow for access to health services.
  - Requested policy change does not “fundamentally alter” the ED’s service or impose “undue burden”

ADA/Rehab Act Case Study

During Flo's ED visit, her friend tells ED doctor that Flo needs treatment and asks the doctor to give her buprenorphine.

ED doctor tells Flo that ED does not offer buprenorphine and he does not have the permission to administer it. Instead, he gives Flo medications that are less effective in treating opioid withdrawal and do not suppress cravings.

Before discharge, ED staff gives Flo a list of local SUD treatment programs- standard practice for patients in need of SUD treatment – and instructs

Flo to have naloxone on hand.

1. Does ED denial of buprenorphine to Flo violate the ADA/Rehab Act.
   - Yes likely
     - Hospital policy to not offer buprenorphine is a "method of administration" that has the effect of discriminating – denying health services to – person who uses opioids.
     - Denial could be disparate treatment on basis of stereotypes about people with OUD, not legitimate reason (i.e. offering buprenorphine will "attract drug users;" involves too much DEA oversight; doctors must have x-waiver; takes too much time).
     - Could be denial of a request for a reasonable accommodation – modification of ED's "no buprenorphine policy"
2. Does ED failure to provide a direct referral to SUD treatment violation the ADA/Rehab Act.
   - Yes likely
     - Lack of effective referral could be disparate treatment based on stereotype (i.e. individuals with SUD don't want to stop using or won't follow through)
     - Method of administration – providing general list rather than specific referral – has the effect of discriminating in delivery of health services.
     - Failure to provide reasonable accommodation if patient requests direct referral.

Title VI – Prohibited ED Discrimination Race and Ethnicity

- INTENTIONAL denial of specific services because of the patient's race or ethnicity
  - Individuals must show race/ethnicity was a substantial and motivating factor in ED's decision/action
  - Direct and indirect proof of race/ethnicity-based decision making
- FAILURE to offer services has a disproportionate negative impact on patients of specific race or ethnicity
  - Federal Office of Civil Rights must bring this type of claim
  - Race/ethnicity data needed
  - Causal link between ED practice and disparate racial/ethnic group impact
- PROVISION of services in a manner that has a disproportionate negative impact on patients of specific race or ethnicity.
  - Same as above

Title VI Case Study

Flo is Black. Flo's friend tells ED doctor that Flo needs treatment and asks the doctor to give her buprenorphine.

ED doctor tells Flo that ED does not offer buprenorphine. Instead, he gives Flo medications that are less effective in treating opioid withdrawal and do not suppress cravings.

Before discharge, ED staff gives Flo a list of local SUD treatment programs. The list does not indicate whether any offer medication for opioid use disorder.

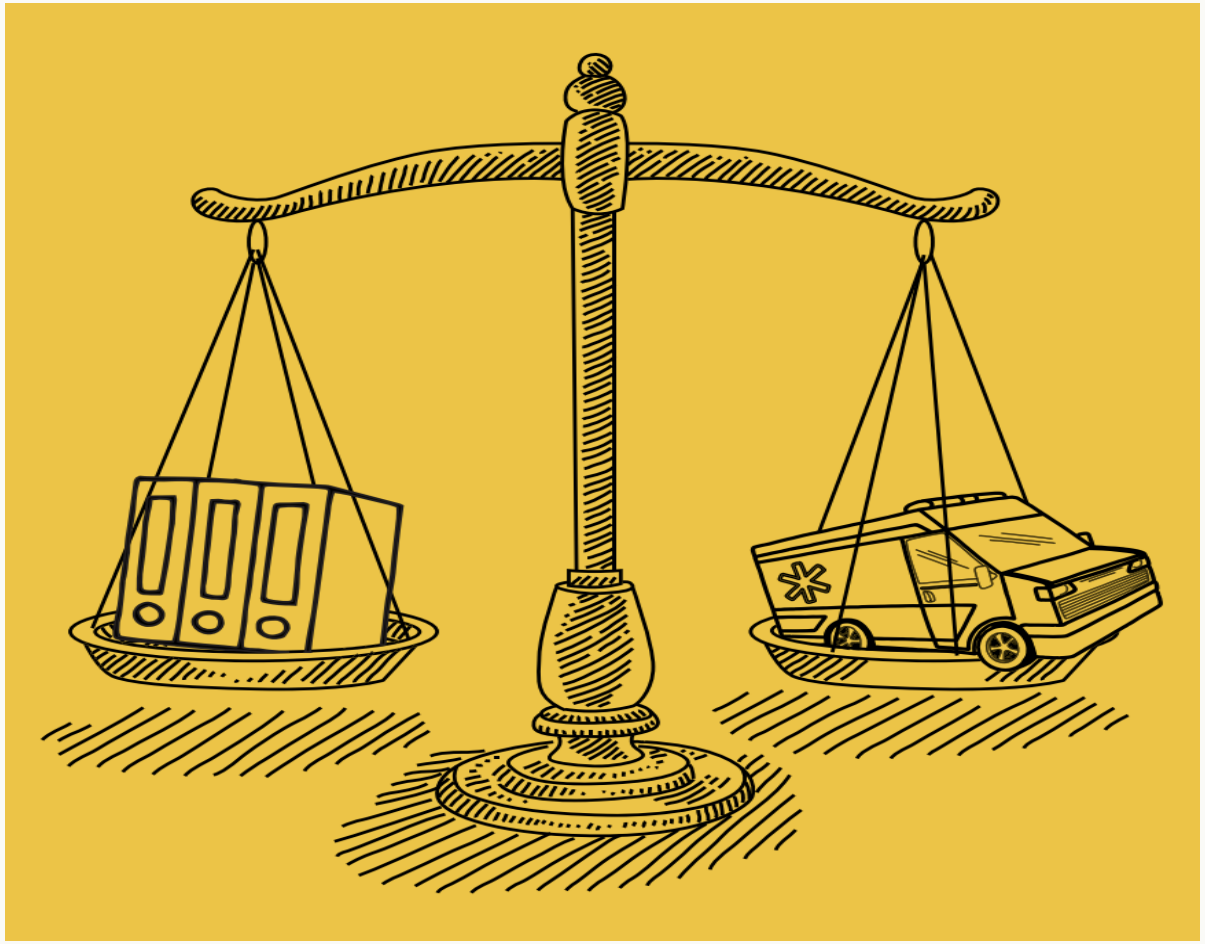
1. Did ED deny Flo buprenorphine because of her race?
   - More information is needed – evidence of racial bias/race-based decisions
     - ED staff overheard saying "she'd probably sell her buprenorphine" or "Black people are better off on methadone or no medication"
     - Flo's friend knows a white patient who was offered buprenorphine by the ED
     - Hospital system is piloting a buprenorphine initiation program in an ED with a predominantly white population, but not a hospital serving a predominantly Black community.
     - What is ED's "legitimate, non-discriminatory" rationale

Title VI Case Study

2. Does this ED's practice of not providing buprenorphine to patients disparately impact Black patients like Flo?

- More information is needed, such as…
  - Is percentage of Black individuals in city/community with OUD who need buprenorphine dramatically higher than white population in need?
  - Is opioid or SUD overdose rate higher for Black residents than white residents in area served by hospital?
  - What is racial breakdown of patients served by ED, diagnosis of SUD/OUD, and treatment referral patterns?
- OCR can gather and analyze race data for disparate impact
  - Hospital would offer non-discriminatory reasons for disparate impact and lack of causal connection.
  - Can OCR make case that decision to not offer buprenorphine or offer targeted referral to MOUD has a foreseeable disparate impact based on high utilization ED services by Black residents?

Enforcing Individual Rights and Improving ED Policies +Practices



Multiple Strategies to Ensure Implementation of Evidence-Based Care

√ Education
- Consumers and Providers
- Hospital Administrators
- Regulators

√ Federal and State Action
- Legislative Requirements and Funding Incentives
- State Professional Associations and Hospital Practices

√ Individual Complaints → Federal agency investigations

Federal and State Policy Action

- Biden Administration's Unity Agenda – Addressing Addiction and Overdose Epidemic
  - Universal access to medication for opioid use disorder (MOUD) by 2025, including removing unnecessary barriers to practitioner prescribing
  - Recommendations for hospital overdose care and care coordination and model state law (within year)
  - "Hospital emergency departments (EDs) offer a unique setting to initiate treatment, provide naloxone and connect patients with peer support services."

- Funding Incentives (Payer models and Grants)
  - CMS – Medicare billing codes to reimburse hospitals for ED OUD assessment, medication initiation, referral to care and access to supportive services.
- Regulatory Investigations
  - Office of Civil Rights – examine delivery of ED SUD services from health equity frame.

Federal and State Policy Action

State Action

- Legislation
  - Massachusetts (H4742 – 2018) – Acute care hospital EDs must have protocols and ability to provide evidence-based practices, including buprenorphine or methadone for patients who have overdosed. MA Health and Hospital Assoc. and MA ACEP issued recs for implementing.
- Funding Incentives
  - Pennsylvania – since 2019 funding incentives for hospitals to implement buprenorphine initiation with warm-handoff to treatment and direct warm-handoff to all community-based care.
- Medical Professional Guidance
  - American College of Emergency Physicians – Buprenorphine Use in the Emergency Dept. Tool BUPE
  - Colorado Am. College of Emergency Physicians, *Opioid Prescribing & Treatment Guide*lines (2017)
- Individual Hospital Practices
  - CA Bridge
  - Maryland Hospital Models

Maryland ED Practices

- Heroin & Opioid Prevention Effort (HOPE) & Treatment Act of 2107
  - Hospitals required to have a discharge protocol for patients treated for overdose or identified as having a substance use disorder
- Maryland Hospital Association Report (Dec. 2018)
  - Compiled hospital protocols (Jan. 2018)
  - Recommended 4 core components
    - Universal screening for SUD – all presenting patients
    - Naloxone access – dispense directly or prescription for patients presenting with opioid overdose or at risk for OUD
    - Facilitated referral to treatment – patients who screen for SUD (ideally using facilitated referral)
    - Peer recovery services – incorporate into treating and discharging patients
  - Examined but did not recommend initiation of medication for OUD
    - 27% reported initiating buprenorphine as clinically appropriate
    - Lack of treatment capacity in community cites as key barrier
    - MHA -2019 focus – work with hospitals and community partners to increase patient access to MOUD in EDs and community.

Individual Complaints and Federal/State Agency Investigations

- Patients and providers may file complaints with relevant federal agencies
  - EMTALA Complaints – Centers for Medicare and Medicaid Services (CMS Regional Offices)
  - ADA/Rehab Act – Department of Justice (DOJ)
  - Title VI – Office of Civil Rights, Dept. of Health and Human Services (OCR)
- Marylanders may file complaints about specific hospital practices with Maryland Dept of Health, Office of Health Care Quality (OHCQ).
  - OHCQ Complaint Report Form
  - CMS Regional Offices recommend filing EMTALA complaints with State departments of health
- Individuals may share stories with Legal Action Center
  - Email Stories to er@lac.org
  - LAC preparing Consumer Guide and other materials for education

Contact Information

Ellen Weber
Legal Action Center
www.lac.org
eweber@lac.org