



Financing Naloxone Dispensed from Illinois Emergency Departments

A Rapid Policy Assessment



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Executive Summary and Recommendations

Illinois faces an unparalleled overdose crisis. Two thousand two hundred thirty-three people died of an overdose in Illinois in 2019, nearly double the number of lives lost in 2010 and more than any other year on record. Many of these deaths would have been preventable with the administration of naloxone, a safe and effective medication that reverses opioid overdose if given in time.

The Illinois legislature has made numerous changes to increase access to this lifesaving medication. Based in part on these actions, pharmacies and community-based programs have provided tens of thousands of doses of naloxone, resulting in thousands of overdose reversals. Unfortunately, naloxone is still often not available when and where it is needed. According to the Department of Public Health's most recent Statewide Opioid Report, "further action is imperative to address the opioid epidemic afflicting the state."

Many people who overdose are treated in hospital emergency departments (EDs), either immediately after the overdose or for other conditions related to opioid use such as injection-related infections. Illinois ED visits for overdose have increased every year from 2013 to 2019, including a rise of nearly 22 percent from 2018 to 2019. Ensuring that individuals who have overdosed, as well as those who are likely to be present in the event of a future overdose, receive naloxone in the ED represents a critical opportunity to reduce overdose death and disability. Because many people who receive a prescription in the ED do not fill it, it is imperative that EDs provide the medication directly to patients.

The greatest challenges to implementing and expanding ED-based naloxone dispensing are financial. While some hospitals in Illinois have successfully integrated ED-based naloxone dispensing, lack of a statewide solution for affordable naloxone has left many of the most vulnerable Illinoisans without this lifesaving medication. To investigate how programs in other states with robust ED naloxone programs operate, the Illinois Public Health Institute conducted a series of interviews with key informants in eight states with ED naloxone distribution programs.

As a result of that survey as well as consultations with local Chicago clinical experts, we believe that there is an opportunity for Illinois to continue being a leader in this area by ensuring that everyone at risk of overdose leaves the emergency department with naloxone in hand. Specifically, we recommend:

RECOMMENDATION 1: Establish a fund within state government to purchase naloxone and provide that naloxone to hospitals for dispensing to individuals upon discharge from the emergency department.

RECOMMENDATION 2: Require or incentivize hospitals to offer naloxone to all patients at risk of future overdose upon discharge from the emergency department.

RECOMMENDATION 3: Require that all health insurers in Illinois cover naloxone dispensed to patients upon discharge from the emergency department.

Background



The United States continues to experience a crisis of opioid-related harm. Over 47,000 people died of opioid-related overdose in 2018, and the latest data show that more people died of drug overdose in the twelve months ending in June 2020 than in any other twelve month period on record.^{1,2} In Illinois, 2,233 people died of overdose in 2019, an increase of 3% from 2018 and nearly double the number in 2010.³

“There needs to be a publicly funded supply of naloxone that can be used to directly distribute from Emergency Departments, Hospitals and Clinics.”

– STEVEN E. AKS, DO

Many of these deaths are preventable with increased access to naloxone, a safe and effective medication that quickly reverses opioid overdose.² Numerous studies have demonstrated that increasing access to naloxone reduces fatal overdose.⁴ In fact, it is estimated that broader community naloxone access could prevent 21,000 deaths over the next decade.⁵

As recommended by the Centers for Disease Control and Prevention (CDC) and many other public health, medical, and governmental organizations, Illinois has made numerous legislative changes to increase access to this lifesaving medication, including requiring that most insurers pay for naloxone obtained from outpatient pharmacies. Based in part on these laws, pharmacies and community-based programs have provided tens of thousands of doses of naloxone to people at risk of overdose as well as friends, family, and community members. However, naloxone is still often not available when and where it is most needed. According to the Department of Public Health’s most recent Statewide Opioid Report, “further action is imperative to address the opioid epidemic afflicting the state.”

One promising initiative to get naloxone to those who need it most is ensuring that people who have been treated for overdose or related conditions in hospital EDs leave the hospital with the medication. Such emergency department naloxone programs have been initiated at several hospitals in Illinois, and many other hospitals are interested in dispensing naloxone from their facilities. Unfortunately, lack of stable financing hampers both initiation and sustainability of this promising source of increased naloxone availability.

This report briefly explains the importance of ED naloxone distribution, discusses lessons learned from other states, and provides legislative recommendations to address the lack of a statewide mechanism for funding the distribution of naloxone from those facilities.

The importance of hospital-based naloxone distribution


Many people who experience an opioid overdose are treated in hospital emergency departments, either for the overdose itself or related conditions such as injection-related infections. The latest available Illinois data show more EMS calls for opioid overdose responses in 2020 than in any previous year.³ Illinois ED visits for overdose have increased every year from 2013 to 2019, and rose nearly 22% from 2018 to 2019.³

One of the greatest predictors of fatal opioid overdose is a previous nonfatal overdose. Nationwide, nearly one in five people who are treated in the emergency department for opioid overdose experience at least one more overdose in the following year.⁶ As many as one-third of patients who die from an overdose interacted with the emergency medical system in the year prior to their death.^{7,8} Data from Massachusetts show that over 5% of people treated for overdose in the ED died within the first year after release; more than 1% died in the first month.⁹

Ensuring that these individuals receive naloxone when being discharged from the ED represents a critical opportunity to reduce future overdose death and disability.¹⁰ While some overdose

patients are prescribed naloxone in the ED, many do not fill those prescriptions due to financial inability or other barriers. In fact, in one study from Chicago, fewer than one in five individuals who were provided a prescription for naloxone in the emergency department filled that prescription.¹¹ In another study, 32% of patients who received naloxone in the ED reported using that naloxone to reverse an overdose.¹²

It is therefore critical that individuals who have overdosed are provided with naloxone in the emergency department.¹¹ In fact, the Director of the CDC's National Center for Injury Prevention and Control and the Surgeon General recently wrote that "...EDs should facilitate naloxone dispensing at discharge to at-risk patients or their families and loved ones."¹³

 "The desire to give out naloxone is there from all major hospitals, what is not there is the product itself. This roadblock can be eliminated simply by a central purchasing process."

- DIANA BOTTARI, DO

Financial barriers to hospital-based naloxone distribution in Illinois

In a 2020 report, the Illinois Hospital Opioid Treatment and Response Learning Collaborative [noted that](#) "dispensing naloxone at the bedside should be standard of care."¹⁴ Although a number of hospitals in Illinois have implemented some form of ED-based naloxone distribution, they experience a number of barriers to both scale-up and sustainability.¹⁵ The greatest challenge identified by members of the Collaborative related to sustainably financing naloxone dispensed in the emergency department. The group noted that a variety of measures have been attempted to address this limitation, including utilizing donated medication and charity care mechanisms. However, these individual solutions "are hard to scale and may not be sustainable."¹⁴

Similarly, a group of providers from seven Chicago-area hospitals with ED-based naloxone programs recently wrote that "securing a supply of naloxone for dispensing at no cost to the patient" is a critical step in building an ED-based take-home naloxone program.¹⁵ In the opinion of leaders from those seven hospitals, "Ideally, a central supply of naloxone would be publicly funded and provided to hospitals to address this public health crisis."¹⁵

Examples from other states



Addressing this problem is a critical and necessary step in the creation, expansion, and sustainability of ED naloxone distribution programs. The Illinois Public Health Institute funded this research to gain insight into how ED naloxone distribution programs outside of Illinois are funded, to determine best practices, and to make recommendations for Illinois.

Over late 2020 and early 2021, qualitative interviews were conducted with 18 individuals involved with ED naloxone distribution programs in eight states. The goal of these semi-structured interviews was to gain insight into funding mechanisms that might be adopted in Illinois. Interviewees were selected based on a review of the existing literature as well as snowball sampling from initial interviewees.

As in Illinois, hospitals in other states obtain naloxone through a variety of mechanisms. A few rely on grants or charity care, while others have designed solutions that permit insurance to be billed

for naloxone distributed at ED discharge. The most common, successful, and scalable option, however, appears to be naloxone funded by a state or local government agency. This frees hospitals from many of the burdens and uncertainty associated with obtaining naloxone from grant sources or relying on the goodwill of hospital systems and bypasses the often cumbersome and confusing processes involved in seeking payment from insurance. The following section briefly describes programs in these jurisdictions, highlighting potential avenues for increasing emergency department-dispensed naloxone.

1 Publicly funded ED naloxone distribution programs

Recently, two emergency department physicians, one from the Northwestern School of Medicine and another from Cook County Health, wrote in the *Journal of Addiction Medicine* urging the creation of a public funding stream for ED naloxone programs.¹⁶ Such a supply, they argue, would both increase penetration of take-home programs into underserved communities and create efficiencies in the procurement and distribution of the medication. The experience of ED naloxone programs in other states supports this view.

Indeed, all the highest-volume and most widespread programs interviewed utilize such a system. In California and New York City, hospitals are provided with naloxone through the same mechanism that the state or city uses to provide naloxone to community organizations and other distribution points. While in Michigan naloxone is provided through a program specific to emergency departments. All interviewees in these jurisdictions cited the publicly funded programs as a key component in the development and sustainability of their programs.

California

In California, most emergency department naloxone programs are coordinated by [California Bridge](#), a program of the Oakland-based

Public Health Institute that is funded by the California Department of Health Care Services (DHCS). California Bridge began as an initiative to advance the use of evidence-based medications for addiction treatment, particularly buprenorphine, in emergency departments. In October 2018 it expanded to include the provision of naloxone to patients in the ED as well as their acquaintances.

California Bridge receives naloxone through the California [Naloxone Distribution Project](#), which provides naloxone to eligible entities including law enforcement agencies, schools, and community organizations. This Project is funded by SAMHSA State Opioid Response funds and administered by DHCS. Since October 2018, the Project has distributed over 575,000 units of naloxone, all in the form of Narcan® nasal spray.

Emergency departments receive naloxone through a similar mechanism as other eligible entities. Emergency departments fill out an [online form](#), provide a copy of their standing order for naloxone distribution or pharmacy license for the facility, sign a [release](#), and provide their policies and procedures for distribution. After being approved, the state submits an order for Narcan® directly to the manufacturer, which ships the medication to the hospital and bills DHCS directly. Naloxone distributed through the Program and kept separate from other hospital naloxone inventory does not need to meet otherwise applicable prescription medication labeling requirements.

As of January 2021, 69 emergency departments in California participate in the DHCS program, and nearly 34,000 naloxone kits have been distributed.

New York City

Like California, emergency departments in New York City obtain naloxone from the same program that provides the medication to syringe service programs and other governmental and non-governmental entities that distribute it to at-risk individuals. The Department of Health and Mental Hygiene (NYC Health) pays for all naloxone distributed by the programs, termed [Opioid Overdose Prevention Programs](#). The funds for purchasing naloxone, approximately \$500,000 per year for all OOPPs in the city, come from appropriations to the agency from the City's general fund.

Registering as an OOPP is a straightforward process. Once a hospital has registered, a representative from NYC Health contacts the hospital to explain the program and set up training. The responsible person from the hospital then orders naloxone via a fillable PDF, which is signed by the program's clinical director and sent to NYC Health. NYC Health verifies the order and forwards it to New York Health + Hospitals, which purchases all naloxone provided to OOPPs. Health + Hospitals then ships the naloxone to each OOPP together with a breathing barrier, gloves, and a card containing administration instructions. Narcan® or injectable naloxone is provided, depending on the preference of the OOPP.

Approximately 20 hospitals in the city have registered as OOPPs and actively participate in the program, including all New York City Health + Hospitals hospital facilities. Several non-ED facilities such as inpatient psychiatric hospitals and outpatient clinics also participate, as do several private hospitals.

Michigan

In Michigan, the ED-based naloxone distribution program is an initiative of the Michigan [Opioid Prescribing Engagement Network \(OPEN\)](#) and the [Michigan Emergency Department Improvement Collaborative \(MEDIC\)](#). Both are based at the University of Michigan. The ED naloxone rescue kit project is currently funded by the state Department of Health and Human Services (DHHS) through September 2022, although an extension of funding is possible.

Emergency departments that receive naloxone through the program distribute a naloxone kit provided by OPEN/MEDIC. This kit contains a box of Narcan® together with a pair of gloves, a face shield for performing rescue breathing, instructions on how to administer the medication, and information on additional pharmacy standing order naloxone availability in the area. These kits are assembled by OPEN/MEDIC staff and volunteers on the University of Michigan's campus.

The ED naloxone distribution program began in the spring of 2020 with physician, nurse, and pharmacy champions from nine hospitals in the state. It was initially funded by the state DHHS, which provided a grant to OPEN/MEDIC to purchase boxes of Narcan® directly from a wholesaler at the public interest price of \$75 per box plus kit supplies. However, the initiative now obtains naloxone directly from DHHS through the same mechanism that the state uses to distribute naloxone to community organizations, law enforcement agencies, and other similar organizations. Staff time to administer the program is provided by OPEN, which has also created an [implementation guide](#) for interested hospitals.

Hospital organizations that wish to participate are required to sign a contract with the University of Michigan to participate and receive a small stipend. Because the project is part of a quality improvement initiative, each hospital agrees to collect and provide data on kits distributed to OPEN/MEDIC in exchange for receiving the naloxone and kits. By the end of 2020, the number of hospitals participating had more than doubled from the original nine to 19, largely because of word-of-mouth recruitment and the fact that the naloxone and kits are provided at no cost to the hospital. Over 2,000 kits have been distributed to nine hospitals, and over 800 have been distributed.

Washington

Several hospitals in Washington state also distribute naloxone purchased through a public financing model. We interviewed individuals at a hospital that is owned by King County and managed under contract by the University of Washington. The emergency department in this hospital previously distributed naloxone under a system whereby a physical prescription was generated and tubed to the outpatient pharmacy, which is physically connected to the ED. The pharmacy would fill the prescription and tube it back to the ED, where it would be distributed to the patient.

However, in summer 2020 the hospital began receiving Narcan® from the state health department. This naloxone is placed in the emergency department medication dispensing machine (a device that stores medications commonly used on hospital floors that

can be accessed by authorized medical staff), and is provided to patients who have overdosed or are at risk of overdose. Approximately 25 patients per month receive naloxone from this emergency department. Because of uncertainty regarding funding for the state naloxone program, it is currently unclear whether naloxone will continue to be provided to the hospital.

To help increase emergency department dispensing and greatly reduce uncertainty regarding naloxone financing, [a bill has](#) been introduced in the Washington legislature. Should it become law, it will require hospitals to dispense naloxone to a patient who has experienced an opioid overdose or who has opioid use disorder on discharge in most cases. It also requires Medicaid to reimburse hospitals for naloxone provided to such patients, and requires hospitals to bill the patient's insurance to the extent possible to receive reimbursement for dispensing or assisting with dispensing naloxone. Finally, it waives otherwise applicable labeling requirements for naloxone dispensed pursuant to the new mandate, although directions for use must be provided. On February 8, 2021, the bill was referred to the Ways and Means committee.

2 *Outpatient pharmacy*

In general, naloxone that is provided as part of inpatient care cannot be billed to the patient's pharmacy benefit insurance. Some hospitals have addressed this problem by having a prescription for naloxone sent to an on-site outpatient pharmacy that provides the medication to the patient at discharge. These programs are similar to "meds to beds" programs that ensure that patients leaving inpatient treatment have the medications they will need when they leave the hospital. However, these programs are generally only possible where the hospital has a co-located outpatient pharmacy, preferably one open 24 hours per day. They also require that either the patient has insurance that covers the naloxone prescription or that another source of funding is available, such as the hospital waiving the cost of the naloxone for uninsured patients.

Colorado

We interviewed providers at the University of Colorado Hospital, the region's only academic hospital. It receives approximately 110,000 visits per year, and is part of a broader UCHHealth system which together receive about one-third of all hospital visits in the state. The hospital has a 24-hour pharmacy co-located within the emergency department, that is able to dispense naloxone to patients as they leave the ED.

The ED's electronic health records system is programmed to default to prescribing naloxone to patients who are being started on buprenorphine as well as most patients on chronic opioid doses above 90 morphine milligram equivalent (MME). The prescription

Connecticut

In Connecticut, the Department of Public Health provides naloxone to the Yale New Haven Hospital emergency department on an as-needed basis. Naloxone is provided through the same program that provides naloxone to syringe service programs and other community organizations in the state. The naloxone is stored in the emergency department medication dispensing machine with other frequently accessed medications. Emergency department practitioners order naloxone through the EMR system, and the medication together with instructions on how to administer it is provided to the patient or other individuals who may be in a position to assist them. Since the medication is ordered through the EMR system, it must be associated with a current ED patient.

is automatically sent to the emergency department pharmacy. Most patients are either covered by Medicaid (~85 percent) or privately insured (~5 percent), and for those patients insurance is billed as with any other prescription. The emergency department has patient navigators who help people who are eligible for Medicaid sign up while in the ED. The hospital also maintains a stock of naloxone, provided by the state, that is dispensed to uninsured individuals at no charge. The pharmacy stocks both Narcan® as well as generic naloxone in vials. Approximately 40 prescriptions per month are filled, but the fill rate is low: the naloxone is not given directly to the patient but rather is available at a pharmacy as they leave, and approximately three out of every four prescriptions are not filled.

The Colorado legislature [passed a law](#), effective September 14, 2020, that mandates that health insurers that provide coverage for opioid antagonists like naloxone "shall reimburse a hospital for the hospital's cost of an opiate antagonist if the hospital gives a covered person an opiate antagonist upon discharge from the hospital." Perhaps because the law was passed so recently, neither respondent had insight into whether insurers had taken steps to ensure that this coverage was provided and whether any hospitals had expanded emergency department naloxone programs in response to it.

The state has also [created a fund](#) by which naloxone is purchased and distributed in bulk, but that program is not currently used to distribute naloxone to emergency departments. The fund receives money from grants and gifts as well as direct appropriations from the legislature. The legislature has appropriated funds through [allocating general revenues](#) and directing [CARES Act](#) money to the fund. It has also received money indirectly from SAMHSA State Opioid Response funds.

3 *Inpatient pharmacy*

One hospital in our survey utilized a model whereby naloxone is charged to Medicaid to enrollees in the state Medicaid program. However, this required a modification to the state Medicaid coverage to enable hospitals to receive reimbursement for ED-dispensed naloxone as an inpatient benefit.

Massachusetts

Like many sites, Boston Medical Center’s naloxone distribution program has gone through a series of iterations. At first, the Center received naloxone at no cost from the state health department, but that program ended in 2018. Beginning in September 2018, the ED began dispensing naloxone through the emergency department via an outpatient pharmacy mechanism. When indicated, an ED practitioner entered an order in the patient’s EHR, which generated a prescription for naloxone and was then signed.

Naloxone was then retrieved from an outpatient pharmacy space in the ED, which is available 24/7, and provided to the patient together with a brief training. However, the patient’s insurance was not verified or charged in real-time. Rather, the insurance claim was made retroactively by pharmacy staff on an approximately weekly basis. Where the patient’s insurance did not cover naloxone or a co-pay was required, the Center would cover the cost. In general, approximately 85 percent of prescriptions were covered by insurance and the cost of covering the other 15 percent was nominal.



Beginning April 1, 2020, the state [began reimbursing](#) acute outpatient hospitals \$125 for each box of Narcan® distributed through emergency departments to Medicaid enrollees.¹⁷ This policy change was explicitly designed to “encourage the appropriate distribution of nasal naloxone packages by [acute outpatient hospitals] through their EDs, and to enable MassHealth to identify patterns of distribution of those packages.”¹⁷ The hospital then modified its procedure to bill through this mechanism for all Medicaid enrollees. The ED currently dispenses approximately 50 Narcan® prescriptions per month.

Rhode Island

Emergency departments in Rhode Island began distributing naloxone to people at risk for opioid overdose in 2014.¹⁸ While the program started in one hospital system, distribution and/or prescribing naloxone after an opioid overdose has been expanded to all Rhode Island emergency departments following passage of a [comprehensive discharge planning law](#) for people treated for an opioid overdose.¹⁹ This law required the Rhode Island Department of Health and the Rhode Island Department of Behavioral Health, Developmental Disabilities, and Hospitals to establish hospital standards for the treatment of people with opioid use disorder and opioid overdose. [The standards](#) released by these state agencies require the distribution and/or prescribing of naloxone for all patients treated for an opioid overdose and individuals with opioid use disorder.^{20,21} Of the ten acute care hospitals in Rhode Island, six distribute naloxone directly to patients and four provide prescriptions.

Hospitals that distribute take-home naloxone purchase and provide the naloxone free of charge to patients as a community benefit. The hospital, which treats the majority of emergency department overdose visits, participates in the [340B drug pricing program](#). Pursuant to this program, the hospital pays \$64.95 for a two pack of intranasal Narcan® (naloxone). In 2019, 774 take-home naloxone kits or naloxone prescriptions were provided to patients upon emergency department discharge after an opioid overdose (approximately 47% of emergency department overdose visits in 2019).²²

“One large barrier is a lack of understanding of what is allowable for hospitals to provide at bedside when it comes to Naloxone. We need leadership and clear guidance so that hospitals can feel empowered without fear of punitive RIMS violations or any other penalty that would adversely affect patient care in their institutions. Everyone wants to do the right thing; we need to provide clear guidance and unambiguous legal support for hospitals to dispense Naloxone.”

– SUKHVEER BAINS, MD, MA

Summary and Recommendations

The experiences of these programs demonstrate that there are multiple pathways emergency department-dispensed naloxone programs can follow to ensure that everyone who is at risk of opioid overdose who wants to obtain naloxone is able to do so quickly, conveniently, and at no cost to them. While there is no one way to create such a system, many of the informants agreed that sustained, public funding is crucial to their success. This funding can come in several forms, including requiring that public and private insurers cover the cost of naloxone dispensed in the emergency department, as well as the direct provision of naloxone that is purchased in bulk and distributed to hospitals.

Given the extraordinary nature of the opioid overdose crisis and the differences in infrastructure and capability of hospitals throughout Illinois, we recommend an “all of the above” approach to financing naloxone dispensed through emergency departments in the state. We also recommend that the legislature consider coupling funding with a mandate that naloxone be offered or prescribed to individuals at risk of opioid overdose. Ten states have now passed laws that require prescribing or offering naloxone to some individuals in the outpatient setting, and they are associated with large increases in filled prescriptions.²³ Rhode Island requires all emergency departments to prescribe or provide naloxone via regulatory authority, and a bill has been introduced in Washington, D.C. to require that all emergency departments provide naloxone to at-risk individuals.

RECOMMENDATION 1: Establish a fund within state government to purchase naloxone and provide that naloxone to hospitals for dispensing to individuals upon discharge from the emergency department.

RECOMMENDATION 2: Require or incentivize hospitals to offer naloxone to all patients at risk of future overdose upon discharge from the emergency department.

RECOMMENDATION 3: Require that all health insurers in Illinois cover naloxone dispensed to patients upon discharge from the emergency department.



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