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Clinical Practice Guidelines for Community-Based Resources for Substance Abuse Patients in an Emergency Department

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This is to certify that the doctoral study by

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Walden University
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Abstract

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MSN, Walden University, 2015

BSN, Ohio University, 2011

Project Submitted in Partial Fulfillment

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Abstract

Substance use disorder (SUD) has plagued the United States for decades and has been an ongoing issue in a Midwest hospital emergency department where SUD patients were provided discharge information that did not include SUD specific recovery and rehabilitation resources available in the community. The purpose of this project was to develop a clinical practice guideline (CPG) for nurses to use when discharging a SUD patient with an accompanying evidence-based recovery and referral resource list including Narcan, medication-assisted treatment, crisis hotlines, needle exchange programs, and treatment options. The Johns Hopkins Nursing Evidence-Based Practice framework was used to grade the levels of evidence found in the literature. The appraisal of guidelines for research and evaluation instrument was used by a three-member expert panel to assess the quality of the proposed guidelines, rating them using a 1–7 score range. Content expert scores ranged from 6.67 to 7 with the final score being 6.89, deeming the CPG to be of high quality. The use of the CPG by nurses with the recovery and rehabilitation resource list will promote positive social change for the nurses by providing them with the evidence-based knowledge to encourage SUD patients on means of success when seeking recovery and rehabilitation services and potentially decreasing ED visits and costs associated with ED SUD care. In addition, patients obtaining a measure of hope by understanding the resources available to them can lead to positive results for their health, thus improving the human condition.

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Section 1: Nature of the Project

Introduction

Substance use disorder (SUD) has been a well-known issue in the United States for decades (Helen, 2018). The Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (2020) defined SUD as: "when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."

As early as 1929, the Committee on Drug Addiction was established by the National Research Council's chair of the Medical Sciences Division (Mendelson, 1997). Over the years, public health officials and legislators have introduced an array of aggressive public health campaigns and policy changes related to SUDs. These changes were designed to increase public awareness and education regarding negative health and safety effects of substance misuse, as well as limit the availability or unregulated access to substances commonly prone to abuse—specifically, alcohol, illicit drugs, and prescription medications. Despite these efforts, recent data have indicated nearly 165 million of the U.S. population 12 years and older (60.2%) used a substance prone to substance abuse, an estimated 20.3 million Americans in the same age range suffer from addiction and substance abuse, and 21.2 million individuals in the United States entering substance abuse treatment facilities (SAMSA, 2019).

Substance abuse has been an ongoing and highly publicized issue. The lesser-known issue is the effect the condition has on emergency services and emergency

departments (EDs; Fahimi et al., 2015). Individuals admitted to the ED for treatment for regular medical conditions, overdose, withdrawal symptoms, or complications related to drug use increased wait times for all patients seeking ED treatment, creating challenges for nursing and provider staff and patient safety issues (Hawk & D'Onofrio, 2018; Morley et al., 2018). When SUD patients are discharged from the ED, discharge instructions do not acknowledge SUD specifically unless the condition was a part of the ED admission. Thus, resources available in the local community that may have assisted the patient were not provided as part of ED discharge instructions. Each SUD patient discharged from the ED needs a discharge process that includes the current instruction format and information on how to reach specific providers who deal with SUD, crisis lines, how to obtain and administer Narcan for overdose, caregivers who work with SUD populations, and means of transportation to and from appointments (Hawk & D'Onofrio, 2018).

At the project site, a clinical practice guideline (CPG) with a recovery and rehabilitation resource list (RRRL) for SUD patients was needed for nurses to facilitate patient access to resources in the community. A CPG is a systematically developed process to assist practitioners and patients with decisions about appropriate health care for specific clinical circumstances. The CPG guides nurses in assessing the needs of the patient, diagnosing what those needs are, providing discharge instructions with resources to meet those needs, and evaluating if the needs have been met (National Center for Complementary and Integrative Health, 2020).

Problem Statement

The problem identified in this doctor of nursing practice (DNP) project was the need for a CPG for nurses to provide information about evidence-based community resources to aid in SUD recovery and rehabilitation. The gap in practice was that the current discharge education did not include SUD recovery and rehabilitation resources available in the community. The director of the ED reported that although one third of patients seen in the project site have a SUD, the discharge instructions provided to these patients did not include community recovery and rehabilitation resources (personal communication, May 15, 2020). In addition, the nursing staff in the local ED were not knowledgeable about the specific resources available for SUD patients that could aid in their rehabilitation needs (personal communication, November 2020).

Discharge instructions provided to all patients in the ED include the diagnosis, how to self-administer medications, performance of self-care activities, appropriate diet or nutritional needs, and instructions to follow up with designated providers. Evidence-based research has shown that when SUD treatment and mental health services are not offered to SUD patients, this can create obstacles to successful care coordination for the patients (SAMHSA, 2016). Efforts are needed to support intervention, use of medications, and care coordination between general health systems and SUD treatment programs or services through discharge instructions (SAMHSA, 2016).

This project is significant to nursing practice because the ED has become a critical access point for providers to identify and link SUD patients to care when the patients typically have a poor quality of life and do not recognize a path to recovery.

Nurses can play a significant part in this process by providing patients with the available community resources and information about how to access and use them (Hawk & D'Onofrio, 2018).

Purpose Statement

The gap in practice was that the current discharge education at the project site did not include SUD recovery and rehabilitation resources available in the community. The purpose of this DNP project was to develop an ED CPG for the SUD patient that included a list of community resources specific to helping the patient access recovery and rehabilitation services. The practice-focused question was: Based on current evidence, what best practices should be included in a CPG and RRRL for ED nurses to support the SUD population?

Nature of the Doctoral Project

Evidence

The evidence to support this project came from the Walden University library databases and personal communication with the ED director. I obtained evidence-based articles using the search engines at Walden University library in ProQuest, PubMed, and Ovid. In addition, I obtained information from the Agency for Healthcare Research and Quality, Psychology Association, National Institutes of Health, Emergency Nurses Association (ENA), and SAMHSA. A comprehensive literature review strategy was used to search the Walden databases. Key search terms are: *substance abuse in the age range 15-35 due to most vulnerable age, emergency room discharge education with substance abuse, resources for substance abuse rehabilitation, clinical practice guideline structure,*

nursing knowledge, clinical practice guidelines for SUD in the ED setting, substance abuse patient education, discharge planning, SUD, clinical practice guidelines for SUD in the ED setting, substance abuse disorders patient education, and patient education upon discharge from the ED for substance abuse. Exclusion criteria include narrative reviews, blogs, commentaries, and letters. All articles will be within the last five years.

Approach

For this CPG and RRRL project I followed the steps in the Walden University Manual for Clinical Practice Guideline Development:

- Developed evidence selection criteria
- Described the systems used for recording, tracking, organizing, and analyzing the evidence—including any software used for these purposes.
- Outlined the procedures used to assure the integrity of the evidence, including approaches to managing outliers and missing information. c.
- Described analysis procedures used in the doctoral project to address the practice focused question(s) (e.g., coding, statistical analyses, etc.).
- Searched the literature.
- Critically appraised the evidence from the literature using GRADE.*
- Synthesized the evidence from the literature.
- Developed recommendations /guidelines.
- Identified an expert panel. The ED director identified three providers who participated in the expert panel to critically assess the content of the CPG.

- Using the AGREE II Instrument, the expert panel reviewed the guideline to validate content. The AGREE II instrument and users guide can be found at: https://www.agreetrust.org/resource-centre/agree-ii/
- The AGREE II instrument was scored per the instructions provided by the Agree Trust, those instructions can be found at the following website: https://www.agreetrust.org/resource-centre/agree-ii/
- The guideline was revised based on recommendations.
- Identified a group of key stakeholders/end-users.
- Presented the revised guideline to end-users/key stakeholders /local experts and discuss to validate content and ensure usability.
- Developed a final report.
- Disseminated the final report to ED program director and end users for use in the ED.

Significance

The DNP project contributed to nursing practice by providing information to the staff with the resources within their community that aids patients with SUD. The nursing staffs understanding of the evidence that supported the use of resources from the ED helped support the discharge efforts for the patient with SUD. Nurses became familiar with assessing the patient with SUD's needs and identifying emergent needs and other resources at their time of discharge. The CPG and RRRL provided the nurses with the information that was most current in their location, along with the location and contact information for each resource. The CPG and RRRL was shared with other agencies as

well. One example where the CPG and RRRL was shared was a primary care physician's office that dealt with SUD patients. The list of resources that was appropriate for their patient was then used at the physician's healthcare site. The CPG aided the nurses by providing the evidence-based information that the patient with SUD needed prior to discharge. The mission value by Walden University states that professionals will use their education to make a change in society for the better of the community As A DNP prepared nurse, translating evidence into a CPG supports the role of advance practice nurses in translating evidence for practice change.

Summary

Section 1 included a discussion of the problem for the need of a CPG and RRRL for SUD patients in the ED. The purpose and significance of the project and the evidence that was explored were discussed. The practice-focused question was: Based on current evidence, what best practices should be included in a CPG and RRRL for ED nurses to support the SUD population? Section 2 described the AGREE II model that framed the project, the evidence supporting the CPG and the nature of the project.

Section 2: Background and Context

Introduction

At the present time in a local ED in the midwestern region of the United States, nurses are giving patients their discharge instruction papers that indicate the reason the patient was seen, such as an injury, ailment, or overdose (AHRQ, 2017). There were no community resources for the ED nurses to provide when discharging patients with SUDs from the ED to support recovery and rehabilitation. The purpose of this DNP project was to develop an ED CPG for the SUD patient, including a list of community resources specific to helping the patient access recovery and rehabilitation services.

The practice-focused question was: Based on current evidence, what best practices should be included in a CPG and RRRL for ED nurses to support the SUD population? In this section, I discuss the Appraisal of Guidelines for Research & Evaluation (AGREEII) instrument, relevance of the project to nursing practice, local background and context, my role, and the role of the expert panel.

Concepts, Models, and Theories

The AGREEII instrument was developed to assess the methodological quality of practice guidelines that guides developers, policy makers, health administrator, program managers, and professional organizations. The tool has been used in nursing for the development of numerous CPGs (Levine & Ferrara, 2011). The instrument contains six domains encompassing 23 items that guide review of the CPG and RRRL. The six domains are (a) scope and purpose, (b) stakeholder involvement, (c) rigor of

development, (d) clarity of presentation, (e) applicability, and (f) editorial independence (Brouwers, et al., 2010).

Relevance to Nursing Practice

Nurses Knowledge About Substance Use Disorders

Nurses often have a lack of knowledge or under recognize appropriate treatment and care for patients with SUD (McNeely, Kumar, Rieckmann, 7 et al., 2018). Nurses have also been identified as having negative attitudes toward patients with SUD (Morgan, 2014). These negative attitudes may affect the quality of care delivered to patients with problems of SUD and the education they receive at the time of discharge (Morgan, 2014). Even if nurses have knowledge of SUDs, they often do not recognize the resources available for this population that can aid in rehabilitation. Nurses have a lack in knowledge about drugs due to a lack of training and lack of interest in the resources available (Juboori & Abbas, 2017). Until recently, there were no current guidelines that addressed the gap in practice on providing educational resources for patients with SUD and how they can aid in their own rehabilitation needs.

Community Resources for Substance Use Disorder

Community resources that aid the patient with SUD include recovery and rehabilitation programs that help the patient with either inpatient or outpatient services. Needle exchange programs, availability of Narcan, and crisis line phone numbers are important resources that should be readily available in the community (National Institute of Mental Health, 2021).

Discharge Instructions

Effective discharge education can reduce adverse drug events, unplanned hospital readmission, and post-discharge complications and mortality and result in increased patient satisfaction (Newman et al., 2017). Discharge education is necessary to ensure patients receive valuable information to aid in their recovery. The discharge process from the ED is an important part of a patient's care. The discharge instructions from the ED are the time patients receive education on the resources available to them in their area and how to contact the resources. Without this information, patients do not have the knowledge needed for follow-up care. Nearly 1 in 5 patients experience an adverse event during this transition from the ED to home, with a third of these being likely preventable if proper and comprehensive discharge education were given (Ashbrook et al., 2015).

Discharge Planning for Substance Use Disorder

Until recently, substance misuse problems and SUDs had been viewed as personal, family, or social problems best managed at the individual and family levels, sometimes through the existing social infrastructure, such as schools or places of worship (McLellan, 2017). With the rising number of patients seen with SUD in the ED, changes need to be made within the practice of ED's. National Survey on Drug Use and Health (NSDUH) data from 2016 show that of the 19.9 million adults seen in an ED who needed treatment for SUD, only 2.1 million, or 10.8%, received addiction treatment within the past 12 months (Hawk & D'Onofrio, 2018). The federal government acknowledged these numbers and formed substance abuse advisory boards to help treat these individuals. Patients presenting to the ED with a SUD have become more common but are not

receiving discharge teaching that prepares them for effective self-care management upon discharge (Hawk & D'Onofrio, 2018). ED practitioners may not recognize that they play a critical role in preparing the patient for self-care management, which may prevent nurses from providing an appropriate level of care to individuals experiencing SUDs, including lack of adequate preparation and experience (Compton & Blacher, 2020).

Opioid drug prevention programs are supported by an April 2018 advisory from Jerome Adams, the 20th U.S. surgeon general, that broadly supported clinicians to prescribe or dispense naloxone to individuals at risk of opioid overdose and their friends and family and to increase the awareness of rehabilitation options and resources available for the at-risk populations and broader communities (Hawk & D'Onofrio, 2018).

Clinical Practice Guidelines for Substance Use Disorders

CPGs have been developed by numerous agencies that support the care of patients with SUD. The American Psychiatric Association (APA) stated that assessment should occur while the patient is being seen, then a diagnosis should be made on their substance use. The provider or nurse should then use the feedback, responsibility, advising, menu, empathy, self-efficacy (FRAMES) approach. The specific elements of behavioral intervention under FRAMES include (a) providing feedback, (b) encouraging the patient to take responsibility, (c) advising to make change to behavior, (d) discussing a menu of options for change, (e) providing empathy for the condition of the patient, and (f) supporting self-efficacy for effecting the change upon discharge (Gaur, et al.,2019).

SAMHSA has provided practice guidelines for patients with SUD. SAMHSA (2019) practice guidelines emphasize that increasing access to medications to treat opioid

use disorder will help more people recover, enabling them to improve their health and live full and productive lives. Upon discharge from the ED, patients would be provided contact information for support groups that use medication-assisted recovery means. Improving access to treatment with outpatient medications is crucial to closing the wide gap between treatment need and treatment availability—especially considering the strong evidence of effectiveness for such treatments (SAMHSA, 2019).

The American Psychiatric Nurses Association (APNA) has provided the Emergency Nurses Association (ENA) position statement on protocols for discharging patients with SUD. The position statement states patients should have access to prevention, treatment, and rehabilitation services for those affected by substance abuse; treatment according to current standards of practice for those suffering from the disease of substance abuse and the consequences of substance abuse; education and programs through the ENA Institute for Quality, Safety, and Injury Prevention should be used; inclusion of substance abuse treatment in the benefits package planned under health care reform; and legislation to prevent injuries and fatalities due to substance abuse (ENA, 2020).

Local Background and Context

I work as a nurse practitioner within an ED located in the Midwest United States at a trauma center located in a metropolitan city, where the ED provides services to many patients with SUD. The local population is evenly divided among African Americans and Caucasians, with a small number of Hispanic individuals. The facility is a Level II trauma center with the ability to hold 1,003 inpatients. The daily average census is 212 patients

seen and approximately 33% of those have a SUD. The director of the ED identified that the discharge teaching provided to these patients on discharge is current; specific information related to post discharge drug abuse care is not provided (personal communication, May 15, 2020).

Until recently, nursing education did not provide nurses with information on resources for patients with SUD; therefore, many nurses were minimally equipped to address SUDs (Moody et al., 2017). Providing education to the nurses on resources that are available for patients with SUD will help this patient population find ways to reach out for rehabilitation needs. Limited understanding of treatment facilities, primary care physicians, or counselors who specialize in addiction rehabilitation have created a barrier for rehabilitation (Bunting et al., 2018). With education regarding the resources available for the patient, nurses felt less like they were minimally equipped to aid their patients.

Role of the DNP Student

As a nurse practitioner in the ED my role is to help educate patients with a SUD on ways to access resources to aid in rehabilitation. My role as the DNP student was to provide the expert panel with the CPG and based on their recommendations, develop a final CPG. Within my family I have lost a loved one to drug abuse. They had been seen in the ED and never given resources that would have provided guidance for the family member that accompanied the patient. A personal motivation was the need to see the CPG used in the ED setting. Any potential bias would have been, possibly directed toward the staff that may not feel that the CPG would work and not have a desire to promote the CPG.

Patients with SUD who are seen in the ED need discharge education that describes facilities, community resources, and physicians who can aid in the patient with SUD rehabilitation needs. As a nurse practitioner in the ED the role that was utilized was an advocate for the patient and a resource for administration. I have gained firsthand knowledge of how many people come to the ED with a SUD and need help and have observed that the help that was currently offered to patients was information that failed to direct the patient in finding resources for rehabilitation and promotion of self-care.

Role of the Expert Panel

The expert panel had experience and knowledge of patients with SUD. The expert panel consisted of three individuals, a peer counselor who had a degree in counseling, a nurse practitioner that had prior experience with SUD patients, and an ED physician. The role of the expert panel was to evaluate the proposed the CPG using the AGREE II scoring instrument. After the expert panel reviewed the information, recommended changes would be incorporated into the final guideline.

Summary

In Section 2, I described the AGREE II Instrument that was used to validate the CPG and RRRL. The evidence supporting the RRRL for the ED was discussed. The local background and context for this DNP CPG was introduced. I described my role and the role of the expert panel. In Section 3, I identified the practice focused question, provided the sources of evidence, identified participants involved in scoring the CPG and RRRL, protection of the participants, and the analysis and synthesis of evidence gathered.

Section 3: Collection and Analysis of Evidence

Introduction

The problem identified in this DNP project was the need for a CPG for nurses to provide information about evidence-based community resources to help patients with SUD recovery and rehabilitation. The purpose of the DNP project was to develop an ED CPG for the SUD patient that includes a list of community resources specific to helping the patient access recovery and rehabilitation services.

Practice-Focused Question

Patients with SUDs regularly access emergency care for numerous reasons from primary care needs to illnesses related to substance use. Although discharge instructions are given to the patient upon discharge, the instructions did not include resources for recovery and rehabilitation in the community, thus resulting in the gap in practice. The practice-focused question was: Based on current evidence, what best practices should be included in a CPG and RRRL for ED nurses to support the SUD population?

Sources of Evidence

I used two sources of evidence to develop the CPG. I used Walden University library databases and formative evaluations from key stakeholders and clinical experts. The expert panelists responded to questions in the AGREE II instrument. Selected articles were obtained by using key search terms as follows: *substance abuse in the age range 15–35, emergency room discharge education with substance abuse, resources for substance abuse rehabilitation, clinical practice guideline for substance use or substance abuse, nursing knowledge,* and *patient education upon discharge from the ED for*

substance abuse. Exclusion criteria included narrative reviews, blogs, commentaries, and letters. A combination of search terms was used to obtain multiple articles for research data. These search term combinations were entered in electronic databases, including ProQuest, PubMed, and Ovid, all from the Walden Library database. The following restrictions were placed on the research articles: all articles were within the last 5 years; age range between 15 and 35, which is the vulnerable age range; English language; and peer-reviewed articles. Articles deleted had no relevance to nursing education, discharge teaching, or patients with substance abuse. The evidence gained through research from the literature was used to develop the CPG and RRRL.

Participants

The CPG and RRRL were evaluated by the expert panelists using the AGREE II instrument. The experts included three individuals who were vested for the success of the CPG: a nurse practitioner who worked in the ED and has a specialty for substance abuse care, a counselor who also worked in the ED who helped patients with SUD, and an ED physician who created the policy to use the CPG and resource list.

Procedure

Upon approval from the Walden University Institutional Review Board (IRB; #07-22-21-0419735), the following steps were used to develop the CPG and RRRL for SUD patients discharged from the ED. The steps followed Walden University's Manual for Clinical Practice Guidelines Development in which I: (a) developed the CPG and RRRL and provided the product to the expert panel from the facility to evaluate for validity and useability using the AGREE-II instrument, (b) revised the CPG and RRRL

based on the expert panel's recommendations, (c) developed the final evidence-based practice CPG and RRRL, and (d) disseminated the final report to the administrator.

Protections

There were no patients included in this project. The project required approval from the IRB, which was received. The facility leadership signed the site approval documentation for the CPG and RRRL project. The names of the expert panel who evaluated the CPG were not identified in any reports of the project. The participants were provided with a disclosure to expert panelist form for their information, which did not require a signature. The questionnaires were presented to the participants via the AGREE website. The information on the AGREE site informed the participants that their completing the questionnaire acknowledged their consent to participate. The ED facility's identity was protected throughout the documentation of this project and was only identified by its region within the United States. All data collected for the project were kept confidential by use of the survey tool AGREE to avoid identifiers. The data will be stored for 3 years in my private files in my home with no access for others to review the collected information.

Analysis and Synthesis

The Johns Hopkins Nursing Evidence-Based Practice framework was used to categorize the levels of evidence. The levels of evidence were Level 1 quantitative study; Level 2 quasi-experimental study; Level 3 nonexperimental study and systematic review; Level 4 opinion of respected authorities; and Level 5 literature review and integrative reviews (Otten, 2008). The evidence was appraised for quality, and graded as high, good,

or low, according to JHNEBP. The synthesis of the evidence will support various topics that were included in the draft of the CPG with the RRRL which will be evaluated for validity and useability by the expert panel. The following instructions from the AGREE-II user manual were provided to each participant:

- Score of 1 (Strongly Disagree). There is no information that is relevant to the AGREE II item or if the concept is very poorly reported.
- Score between 2 to 6. The reporting of the AGREE II item does not meet the full criteria or consideration.
- Score of 7 (Strongly Agree). Full criteria and considerations in the User's Manual have been met with approval.

The maximum score was determined by taking the highest score of seven, multiplied by the number of items chosen in the domain, multiplied by the number of end-users who evaluated the CPG and RRRL quality score was calculated by using the scale from the total percentage. The scaled domain score was figured by using the obtained score minus the minimum possible score and dividing by the maximum score possible. The questionnaire also had a comment section where the experts could add their comments. After the review from the expert panel, the CPG and RRRL was revised based on their recommendations and presented to the ED administration and administrators who approved professional practice within the facility. Table 1 aligns the AGREE II tool with the project.

Table 1

AGREE II Tool Domains Alignment With Project

Domain	Description
1. Scope and purpose	Practice-focused question aligns with the proposed CPG to enhance patient care.
2. Stakeholder involvement	Three expert panelists to review the proposed CBG based on evidence-based practice.
3. Rigor of development	Best practices, current guidelines, and evidence used in development.
4. Clarity of presentation	CPG and resources were clear and supported with evidence-based practice.
5. Applicability	CPG and resources are universal for the target population.
6. Editorial independence	Each expert panelist completed their review and added their own thoughts and individual comments.

Summary

In Section 3, I described the sources of evidence, the procedures including participants, and protections as well as the analysis and synthesis of the evidence. In Section 4, I discussed the findings and implications, contribution of the doctoral project team, and the strengths and limitations of the project for the establishment of the CPG and RRRL that helped provide nurses and providers with specific ED discharge education to patients with a SUD.

Section 4: Findings and Recommendations

Introduction

Approximately 33% of the daily visits to the DNP project site ED were patients seen with a SUD. The ED provided the same standard discharge instructions for all patients, which did not include a community resource list for the SUD patient for recovery and rehabilitation in the outpatient community. Resources, such as treatment facilities, medication treatment, needle exchange, and crisis lines, were not offered and created a gap in practice. The purpose of this DNP project was to develop an ED CPG for the SUD patient including a list of community resources specific to helping the patient access recovery and rehabilitation services.

The practice-focused question for the study was: Based on current evidence, what best practices should be included in a CPG and RRRL for ED nurses to support the SUD population? Relevant articles demonstrating the needs for resources education and accurate information to be given to the SUD population were evaluated. To explore this literature, I used key words: *substance abuse in the age range 15-35 due to most vulnerable age, emergency room discharge education with substance abuse, resources for substance abuse rehabilitation, clinical practice guideline structure, nursing knowledge, clinical practice guidelines for SUD in the ED setting, substance abuse patient education, discharge planning, SUD, clinical practice guidelines for SUD in the ED setting, substance abuse disorders patient education,* and *patient education upon discharge from the ED for substance abuse.* Exclusion criteria included narrative reviews, blogs, commentaries, and letters. The articles were in the databases ProQuest,

PubMed, and Ovid, from the Walden Library databases and the journals the Agency for Healthcare Research and Quality, Psychology Association, National Institutes of Health, ENA, and SAMHSA. All articles were published in the last 5 years. The Johns Hopkins Nursing Evidence-Based Practice framework was used to grade the levels of evidence Dang & Dearholt, 2018).

Level I

Trowbridge et al. (2017) conducted a systematic review of the literature regarding initiating treatment for SUDs in the acute hospital setting. Results showed the proactive care to be feasible and effective, leading to better medical and substance use outcomes, including decreased emergency services use, increased completion of medical therapy, and transitioning to outpatient substance use treatment. Without education specific to the patients' needs, the patient population may return to a life of addiction. When diagnosed with addiction, providers need to be prompt with resources to aid in rehabilitation efforts.

Mäkinen et al. (2019) produced a systematic review with random controlled patients and distinguished between the professionals' and patients' view on what SUD issues need addressed at discharge from the ED. In the study, researchers stated that the providers and nursing staff should be able to conduct individual discharge education for each patient. The staff needs to be aware of the different circumstances that each patient may have and the resources available for the patient's needs. Providers should provide education in a format that is easy for the target patient population to understand and that they can access outside of the ED (Mäkinen et al., 2019). One example of education that

can be provided is informational sheets with phone numbers and addresses of facilities that can help the patient.

Pike et al. (2019) conducted a systematic review research study that addressed the loss of empathy or burnout among healthcare providers after seeing patients with SUD numerous times with no changes in behavior. Provider burnout decreased when interventions were provided by the ED staff that benefitted the patient with SUD. SUD patients benefit when the care received comes from the training of nonjudgmental, socially supportive caregivers or providers. Patients who experience this type of care may have less drug use due to having an empathetic person to hear their complaints and to guide them in the right direction.

Jalali et al. (2020) conducted two systematic reviews on ways to maximize availability of resources for patients with SUD. Evidence indicated that resources available for patients with SUD can be costly. Effective interventions and communication can be maximized to reduce the cost to the community (Jalali et al., 2020). One way to reduce this cost is to provide detailed discharge education to SUD patients so they have a means for self-help. Jalali et al. (2020) also found that maximizing the community resources resulted in increased growth in rehabilitation benefits in patients with SUD.

A systematic review from the *American Journal of Managed Care* was conducted to review11 controlled trials to see if medication management was helpful for SUD patients. In the controlled trial, the study demonstrated the effectiveness of medication assisted treatment for SUD patients, stating those who received MAT were less likely to require mental health hospitalization and ED visits and were more likely to adhere to

their psychotropic medications than those who did not receive MAT (*American Journal of Managed Care*, 2020). With medication-assisted treatment, patients are seen by a provider who specializes in addiction treatment and uses medication and therapy to help guide the SUD patient through rehabilitation and recovery. The SUD patient has an increased chance of staying with their recovery through the support of the medication and therapy when used and seen on a regular schedule.

Needle exchange programs are important to aid in SUD patient recovery. Patients who use intravenous (IV) drugs run the risk of contracting blood-borne pathogens from dirty needles. In a systematic review from BioMedical Central Public Health (2017), the rates of contracting blood-borne illnesses were reduced. People who inject drugs experience high levels of morbidity and mortality. Drug-related harm include overdose, drug-related deaths, and blood-borne infections such as human immunodeficiency virus (HIV), Hepatitis C (HCV), Hepatitis B, and bacteremia/sepsis (BioMedical Central Public Health, 2017). The findings from this study show that when clean needles are offered to patients who are IV drug users, there is a moderate reduction in HIV and HCV. In addition, the exchange of dirty needles to clean needles through needle exchange programs leads to fewer dirty needles accessible in the community.

Level II

Resnick and Rosenheck (2015) conducted a quasi-experimental study for SUDs and employed the use of people who have overcome drug addiction to be a peer to aid in recovery of those with SUD. Peer counselors can be effective contributors of mental health services (Resnick & Rosenheck, 2015). In the ED environment, the employment of

SUD peers has increased as a common staffing rubric. Patients with SUDs can feel comfortable when speaking to someone who had experienced similar difficulties and learned to cope and overcome their SUD.

McDonald and Strang (2016) completed a systematic review in which they studied the effects of teaching and providing Narcan or naloxone to patients with IV SUDs. The researchers studied the effects of teaching a layperson how to administer Narcan when a patient appeared to be experiencing an overdose. Results showed that the education on the use of Narcan or naloxone was highly effective in aiding the IV drug using community (McDonald & Strang, 2016). Improved survival rates were shown for the individuals who overdosed and were administered Narcan. This medication gives an individual with SUD the ability to survive and have the opportunity to pursue recovery. Without the use of Narcan in a patient who has overdosed, chances of survival are limited. The option to teach the public about Narcan and provide the intervention to the at-risk population is a choice that has a promising outcome for patients with SUD (McDonald & Strang, 2016).

Hoffberg et al. (2020) conducted a quantitative study to look at the effectiveness of crisis lines in a high-risk population. The study results revealed that 646 calls were received during a 1-week period, and with crisis line support for these individuals, 84% ended with a favorable outcome (Hoffberg et al., 2020). Crisis lines treat a high-risk population that needs support and empathy to aid in their recovery. Individuals knowledgeable in recovery and rehabilitation resources for the community can provide an

avenue for recovery to the person with SUD. Crisis lines are available from a national database and there are also local crisis lines that individuals can contact for help.

In a review conducted at the *Journal of Telemedicine and Telecare* (2015), the effectiveness of helplines that aid in the treatment of substance use was explored. Results showed approximately 23,000 calls were received monthly and services proved satisfaction in the service and uses of the service (*Journal of Telemedicine and Telecare*, 2015). The evidence gathered from the review showed that with the surveys conducted there was a high level of satisfaction from the patient with SUD during their time of need. During the phone calls, counselors are able to give resources to the SUD patient and to help them in the initial time of crisis form a plan or short-term goal.

Level III

Inanlou et al. (2020) reviewed articles to define addiction recovery and determine how to measure resources available for patients with SUD. The researchers reviewed 39 articles that address addiction recovery. Within the study there were five categories used: (a) client-based care, (b) learning healthy habits for change, (c) holistic treatment, (d) different levels of change, and (e) understanding that there are different levels or stages of addiction (Inanlou et al., 2020). The results of this study can help healthcare professionals understand what addiction recovery means and how it is incorporated into a client's care.

A meta-synthesis study on collegiate students with SUDs and themes related to their recovery was conducted by Ashford et al. (2018). Six major themes were found from the analysis of the study that aided in recovery: (a) social connectivity (internal,

external, friends, and family); (b) recovery supports (peer, staff, and programmatic); (c) drop-in recovery centers; (d) internalized feelings (stigma, identity, shame, and exclusion); (e) coping mechanisms of students in recovery; and (f) conflict of recovery status and college life (Ashford et al., 2018). The results show that, at the collegiate level, the six themes or stages are necessary for students to achieve recovery. Whether it is a student or patient from the ED, these six themes can be applied to both. A patient needs the social connection and coping mechanisms to understand what is expected from them and how this aids their recovery.

Level IV

A review from nine expert panelist was conducted to address the issue of opioid dependence and strategies to address the problem of addiction. Wright et al. (2016) researched strategies to address the misuse of opioids. The panel concluded that promotion of access to treatment and the use of product formulations are less likely to be misused and aid in recovery efforts. As an initial step, a broad range of strategies were defined, and in a systematic review of published literature, the panelists identified 37 highly relevant sources of evidence. Experts reviewed this evidence and ranked the list of strategies for effectiveness and ease of implementation based on their clinical experience (Wright et al., 2016). The final results were that products that could be abused should be limited for use within the home setting, healthcare professionals should be diligent in prescribing the medications for use, and strict policies should be in place in the pharmacy on the distribution of the medications (Wright et al., 2016).

In *The Journal of Addiction Medicine*, a committee shared a review stating that the response to an epidemic requires a balance between ideal and practical measures so that sufficient interventions can be delivered to at-risk people for SUD (Saxon et al., 2016). The recommendations for intervention would be that the patient must be assessed by a physician so that the physician would be able to prescribe the needed prescription. The patient would also need a psychological evaluation to ensure they understand what the recovery process entails and if they are ready (Saxon et al., 2016). These are necessary steps so that patients are medically cleared to start the treatment process.

Level V

A literature review conducted of 10 peer-reviewed research articles revealed that peer support groups that work within the addiction setting help patients with SUD recovery. The literature search revealed support for the use of peer support services that include peer support groups within addiction treatment to address substance use, treatment engagement, HIV/HCV risk behaviors, and secondary substance-related behaviors (Tracy & Wallace, 2016). When providing a patient with resources for recovery, each of these items must be addressed so the patient can achieve recovery and remain healthy. Within the patient's community, recovery groups can aid in addressing each item for the patient. Peer support groups are considered an important aspect of the addiction recovery process.

Table 2

Evidence Summary

	Number of sources	Overall quality rating
Level I	6	High quality
Level II	4	High quality
Level III	2	High quality
Level IV	2	High quality
Level V	1	Good quality

Note. Adapted from Dang, D., & Dearholt, S. L. (Eds.). (2018). Johns Hopkins nursing evidence-based practice: Model and guidelines (3rd ed.). Sigma Theta Tau International.

Findings and Implications

A panel of three experts evaluated the proposed CPG: a nurse practitioner who works in the ED and has a specialty for substance abuse care, a counselor who also works in the ED and focuses on advising patients with SUD, and an ED physician. Each member of the panel reviewed the CPG proposal and used the AGREE II to rate the proposed guidelines. The AGREE II tool consist of 23 criteria within six domains. Table 1 describes each domain and how the domain corresponds with the proposed CPG. The expert panel who participated in the assessment of the CPG used the AGREE II survey online (Brouwers et al., 2010). Criteria scored were appraised using a 7-point scale. Each domain's score was summed using the total of the individual items scored and dividing by the maximum score possible. The CPG is presented in Appendix A, and the RRRL is presented in Appendix B. The AGREE II scores from the panel are reported in Appendix C.

Three expert panelists completed the review of the proposed CPG using the AGREE II tool. The final overall score for the quality of the guideline was 6.89. The

expert panelists agreed and accepted the proposed CPG with the recommendations of keeping the resource list updated on a timely basis, continuing staff education on SUD, and continuing evidence-based research to aid patients with SUD and their recovery needs. After review of the scoring was complete, the expert panel found that the CPG for the SUD discharge resource list would be a benefit for the target population, SUD patients and their recovery needs. The RRRL will aid in SUD patients' self-help with rehabilitation needs, crisis numbers, places to turn for transportation needs, housing, and Narcan for possible overdoses.

Recommendations

Recommendations related to maintaining the CPG for the SUD population included ensuring that the CPG resources are updated in a timely manner for any changes that may occur. A second recommendation is to ensure that the staff are continually made aware of the resources and to encourage the staff to use the resource education for the target population. A third recommendation is to continue with evidence-based research to update the CPG as needed. The CPG was well accepted and will promote quality patient care by providing the target population with access to resources so that they can promote recovery and rehabilitation.

Contribution of the Doctoral Project Team

The doctoral project team consisted of three professionals who work with the SUD population and had unbiased opinions on the CPG. Each member of the team read the CPG and agreed that there is a need for increased education for the patients who are seen in the ED to aid in recovery if the patient desires that outcome. The project team

agreed that the ED discharge education at the present time lacked follow up resources for the SUD population which can create multiple visits to the ED for the patient with SUD to seek help. Suggestions from the project team included to place the resource list in a central location where all medical staff has access and to make sure that the resource list stay updated for accuracy.

The project team was able to provide additional resource options for the patient with SUD that were included in the CPG. One such resource was in home therapy options with counselors that come into the home to aid in support. The DNP doctoral project will be continued with additional resources being added as they appear and updates to contact information will be updated so that the patient with SUD can receive accurate information upon discharge from the ED.

Strengths and Limitations of the Project

The doctoral project had many strengths with the creation of the CPG. The educational resources provided for the SUD patient came from local resources that aligned with evidence-based research to aid the patient. Another strength of the project is the expert panel who reviewed the CPG have voiced their desire to continue the CPG and aid in promotion and implementation of the guideline. They will add new resource information to the guideline as they learn of the existence a beneficial program. A strength of the CPG is that the education will be provided for patients upon discharge when SUD is acknowledged. The RRRL will be in a preprinted packet that the nurse will give the patient and be able to discuss the resources that are included. The potential for

this CPG is to reduce ED admissions for patients with SUD be aiding in their self-help for recovery and rehabilitation.

Limitations in the use of the RRRL could be ensuring that the nursing staff ask the questions in triage regarding SUD and upon discharge they acknowledge the patients' needs. If the nursing staff is resistant or has a bias for patients with a SUD, then they may not provide the patient with the needed resource information. Limitations can occur from the patient with SUD not accepting help or agreeing that they have a SUD. The RRRL can be given to any patient with SUD yet only if the patient is ready to state that they have a problem and are ready for help will the CPG be a success.

Section 5: Dissemination Plan

The CPG with the accompanying RRRL was created for patients with SUD who are seen in the ED and discharged with reliable resources they can use for recovery and rehabilitation. The CPG was created with the local resources available for this specific patient population and placed on a resource handout to be distributed at the time of discharge. Dissemination of the CPG occurred by explaining the need for the information for this patient population and how accessing help can decrease return visits from this population. The CPG was created and distributed to the nurses to review and to become knowledgeable of the information provided. Upon discharge from the ED, nurses and providers were able to use the handout as a teaching tool describing the resources on the handout and how it could aid the SUD patient when they are ready.

Analysis of Self

Patients with a SUD may experience barriers to healthcare and may not know how to find rehabilitation and recovery paths. As a result, SUD patients may seek answers from ED's. The CPG project allowed me to gather the education and resources available in the area. Educating myself on these resources and the needs of SUD patients helped create an understanding of how the community is providing resources for patients. Nurses and providers in the ED need to be made aware of SUD patient needs and how to help guide them to resources that benefit their overall health.

Summary

The purpose of this CPG project was to provide patients who have a SUD specific information to aid in rehabilitation when they are discharged from the ED. The CPG

provides nurses and providers with an enhanced quality of care for this patient population. The CPG also provides improved communication between staff and patient. Dissemination of the information to staff and providers included providing area resources that can aid in patient recovery and rehabilitation, allowing patients to make choices in the process. Having the information in one place provides an ease of access for all staff. The information on the printed handouts allows SUD patients to take it with them for continued use to achieve recovery. The CPG was widely accepted by the staff and was placed into use by the ED administrator. I will pursue further dissemination of the information in the CPG to primary care offices in the local area.

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Appendix A: Clinical Practice Guideline Recommendations

1. Identify the patient with SUD. The Surgeon General's Report on Alcohol, Drugs, and Health addiction defines SUD as a dysfunctional relationship with substances, developed out of sane attempts to escape the inevitable and universal truth of one's own suffering, a from escaping pain, blame, shame, and loss (Ciovacco, & Hughes, 2021). SUD screening should be routinely performed upon admission to the ED. The triage note currently addresses the question and nurses need to be aware of how the patient answers the question. Every patient needs to be asked and they need to know that they should answer honestly. Persons with mental illness and addiction often feel discriminated against and stigmatized, leading to inadequate treatment (Mumba & Snow, 2017).
2. Discuss with the SUD patient if they would like education on recovery and rehabilitation needs. Open discussion between the patient and their nurse can lead to the patient feeling like they can be honest with their nurse on what they are feeling and what they would like to see happen in their post discharge care. The patient should be asked if they have thought of rehabilitation or recovery and how they feel they may go about starting that process.
3. Provide patient with resource information that will aid in recovery, such as, rehabilitation housing, transportation to and from housing and appointments. Patients with SUD may suffer from homelessness which can prevent their ability to seek care. Providing resources of the local rehabilitation centers and the number to call for admission will help. Patients should be supplied with the number to the local

transportation methods for this patient population and where phones are that they can make calls for help with, such as the City Mission, public library.

4. Provide patient with list of primary care providers who specialize in SUD for their care of acute or chronic health care needs and SUD. Primary care providers that provide care for the SUD patient must be provided. Patients may have success with recovery from prescribed medications to aid in healing such as, Suboxone.
5. Provide crisis line numbers. National hotline numbers and websites that the patient may use include findtreatment.gov, and 1-800-662-HELP (4357) which are provided by SAMSHA. Local phone numbers from the qualifying agencies will be provided.
6. Provide information on health department services for Narcan, the administration of the medication, needle exchange, and testing for viral illness, such as HIV and AIDS. Local health departments now conduct needle exchange so that the patient who uses IV drugs can obtain clean needles to decrease the rising numbers of dirty needle viruses. Address for the local health department will be provided. The local health department also offers Narcan for overdose. A provider is on site to show how and when to administer and provide the medication for outside of the clinic to the patient.
7. Provide information for peer counselors, social workers, and counselors to aid in the road to recovery. Three facilities in the area currently provide counselors and peer educators for the SUD patient to speak to. The peer counselors are graduates from a drug recovery program that can help the patient by understanding where they are and how to achieve success with recovery. The address and contact information will be provided.

8. Provide name, address, phone number of agencies that may help with state benefits for state funded insurance, clothing, and food vouchers while in recovery. The local health department has the resource that will provide the needed resources and application to receive these resources. The address and phone number will be provided.
9. The resource listRRRL will be printed for the patient for use. Transportation will be provided for the patient to return home or to the City Mission for emergency housing along with follow up information on what their next step for recovery is.
10. Provide follow up number to case manager in the ED that will be able to answer patient's questions after discharge if needed. Within the local ED's, there are always two case managers on duty. These case managers have the RRRL that aids patients with recovery and can answer questions for the patient that has been discharged.

Appendix B: Resources

Recovery and Rehabilitation Resources

If you have a substance use disorder and would like to seek treatment for recovery or rehabilitation theses resources can aid your path to healing.

Rehabilitation Facilities

Ohio Valley Physicians

Have inpatient and outpatient services for SUD needs including Suboxone, Vivitrol and inpatient therapy. You can reach out to a counselor at (304) 781-0076. **This line will be answered 24 hours a day 7 days a week for both inpatient and outpatient needs.**
601 20th Street Huntington WV 25703 - Outpatient Therapy and Suboxone treatment

OVP Recovery Center – Inpatient treatment services
335 Township Road 1026
South Point OH 45680

Prestera Treatment Center

Have both inpatient and outpatient services for SUD. **You can reach out to a counselor at (877) 399-7776 24 hours a day 7 days a week. Crisis line is also available by calling the number and pressing option 1.**

5600 US Route 60
Huntington WV 25705

Recovery Point of Huntington

This is an outpatient treatment facility that aids with SUD. **The number will be answered 24 hours a day 7 days a week (304)523-4673.** They offer group and private therapy.

2425 9th Avenue
Huntington WV 25703

ProACT

This is an outpatient treatment facility that aids with SUD including Suboxone and Vivitrol therapy. You can reach out to a counselor at (304) 696-8700 This line will be answered 24 hours a day 7 days a week for outpatient needs.

800 20th Street
Huntington WV 25703

Transportation Needs

Medical Transportation Services

If transportation is needed in the county of Wayne and Cabell in WV or Lawrence County Ohio, you can call for a ride to any inpatient treatment center or outpatient treatment facility. The services are 24 hours a day 7 days a week. The services are free covered by a Grant from the State of WV.

(304) 523-1000
2018 8th Avenue
Huntington WV 25703

West Virginia Medicaid for Medical Care

WVDHHR
To qualify for state funded insurance for healthcare, you can go to the office of the WVDHHR in Huntington for assistance for applying for the insurance and receiving immediate coverage. The state funded coverage does include inpatient and outpatient rehabilitation services. Also, at this office applications can be approved for the EBT services for food vouchers.

2999 Park Avenue
Huntington WV 25704
(304) 528-5000

Housing

Huntington City Mission

For immediate housing needs the Huntington City Mission provides housing for indefinite periods of time. At the City Mission, food is provided for three meals a day, phones are available for personal use to access needed resources. Dry warm clothing is also available along with social workers onsite. The city mission has placement for individuals along with family rooms if needed for displaced families.

62410th Street
Huntington WV 25701
(304) 523-0293

Harmony House

For immediate housing needs the Harmony House provides housing for indefinite periods of time. Food is provided for three meals a day and phones are available for personal use to access needed resources. Dry warm clothing is also available along with social workers onsite.

627 4th Avenue
Huntington WV 25703
(304) 523-2764

Cabell-Huntington Coalition

For immediate housing needs the Cabell-Huntington Coalition provides resources for housing. They have social workers onsite that can help apply for HUD housing or apartments. They provide resources for jobs and job training for those unemployed. They can aid with EBT services for food vouchers.

627 4th Avenue
Huntington WV 25701
(304) 523-2764

Needle Exchange Programs, Narcan

If needles are used drug use, clean needles can be obtained at the Cabell County Health Department. The program allows for 25 needles once a week. The program asks that dirty needles be returned to the needle boxes located outside the main door. The program is free of charge, and no one is denied access to the program.
Within the program one vial of Narcan is provided in case you see someone who was overdosed. The Registered Nurse at the clinic will provide you with the medication and show you how it is to be used. If it is used, you can return for another vial of Narcan as needed.

703 7th Avenue
Huntington WV 25701
(304) 523-6483

Phone Services

Huntington City Library

The local library provides an area where anyone can come in and make local calls free of charge. This service is to help aid patients who have no access to a phone make calls to help in recovery efforts.

455 9th Street
Huntington WV 25701
(304) 528-5700

Crisis Lines for Addiction

The national crisis line provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) is available 24 hours a day and 7 days a week. They can help people find recovery options no matter where they are located.

1-800-662-4357

Primary Care Physicians Who Aid in Acute and Chronic illness and SUD

The following primary care practices have providers that will treat your chronic medical conditions along with addiction needs.

Marshall Family Practice
1400 Hal Greer Blvd
Huntington WV 25701
(304) 526-1200

Valley Health
1301 Hal Greer Blvd
Huntington WV 25701
(304) 525-0572

OVP Health Systems
601 20th Street
Huntington WV 25703
(304)781-0076

Cabell Huntington Hospital Emergency Department

The emergency department is always available for your everyday needs or questions. If you have questions not answered in this flyer you can reach out to the ED Case Manager at (304)526-4550 for help with your recovery and rehabilitation needs. There is a case manager always on duty.

Appendix C: AGREE II Expert Panel Results

AGREE II Domain	AGREE II Criteria	SCORE 1-7 1 Strongly Disagree – 7 Strongly Agree 3 Expert Panel			Total
		1	2	3	
Scope and Purpose	The overall objective(s) of the guideline is (are) specifically described.	7	7	7	7
	The health question(s) covered by the guideline is (are) specifically described.	7	7	7	7
	The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.	7	7	7	7
Stakeholder Involvement	The guideline development group includes individuals from all relevant professional groups.	7	7	7	7
	The views and preferences of the target population (patients, public, etc.) have been sought.	7	7	7	7
	The target users of the guideline are clearly defined.	7	7	7	7
Rigor of Development	Systematic methods were used to search for evidence.	7	7	7	7
	The criteria for selecting the evidence are clearly described.	7	7	7	7
	The strengths and limitations of the body of evidence are clearly described.	6	7	7	6.67
	The methods for formulating the recommendations are clearly described.	7	7	7	7
	The health benefits, side effects, and risks have been considered in formulating the recommendations.	7	7	7	7
	There is an explicit link between the recommendations and the supporting evidence.	7	7	7	7
	The guideline has been externally reviewed by experts prior to its publication.	7	7	7	7
	A procedure for updating the guideline is provided.	7	7	7	7
Clarity of Presentation	The recommendations are specific and unambiguous.	7	7	7	7
	The different options for management of the condition or health issue are clearly presented.	7	7	7	7
	Key recommendations are easily identifiable.	7	7	6.67	6.67
Applicability	The guideline describes facilitators and barriers to its application.	7	7	7	7

AGREE II Domain	AGREE II Criteria	SCORE 1-7 1 Strongly Disagree – 7 Strongly Agree 3 Expert Panel			Total
		1	2	3	
	The guideline provides advice and/or tools on how the recommendations can be put into practice.	7	7	7	7
	The potential resource implications of applying the recommendations have been considered.	6	7	7	6.67
	The guideline presents monitoring and/or auditing criteria.	7	7	7	7
Editorial Independence	The views of the funding body have not influenced the content of the guideline.	7	7	7	7
	Competing interests of guideline development group members have been recorded and addressed.	7	7	7	7
Overall Guideline Assessment	Rate the overall quality of this guideline.	7	7	7	7
Overall Guideline Assessment	I would recommend this guideline for use.	7	7	7	7
	FINAL SCORE				6.69