

The Next Steps: Opioid Use Disorder Care After the ED

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STR-TA
Consortium
State Targeted Response
Technical Assistance

Working with communities to address the opioid crisis.

- ✧ SAMHSA's State Targeted Response Technical Assistance (STR-TA) Consortium assists STR grantees and other organizations, by providing the resources and technical assistance needed to address the opioid crisis.
- ✧ Technical assistance is available to support the evidence-based prevention, treatment, and recovery of opioid use disorders.

Funding for this initiative was made possible (in part) by grant no. 1H79TI080816-01 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.



Working with communities to address the opioid crisis.

- ✧ The STR-TA Consortium provides local expertise to communities and organizations to help address the opioid public health crisis.
- ✧ The STR-TA Consortium accepts requests for education and training resources.
- ✧ Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS) who is an expert in implementing evidence-based practices.

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Contact the STR-TA Consortium

✧ To ask questions or submit a technical assistance request:

- Visit www.getSTR-TA.org
- Email str-ta@aaap.org
- Call 401-270-5900

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Saving Lives: Bringing Buprenorphine to Emergency Care

Andrew A Herring, MD

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Medical Director Substance Use Disorder Program PI,

California Bridge Project

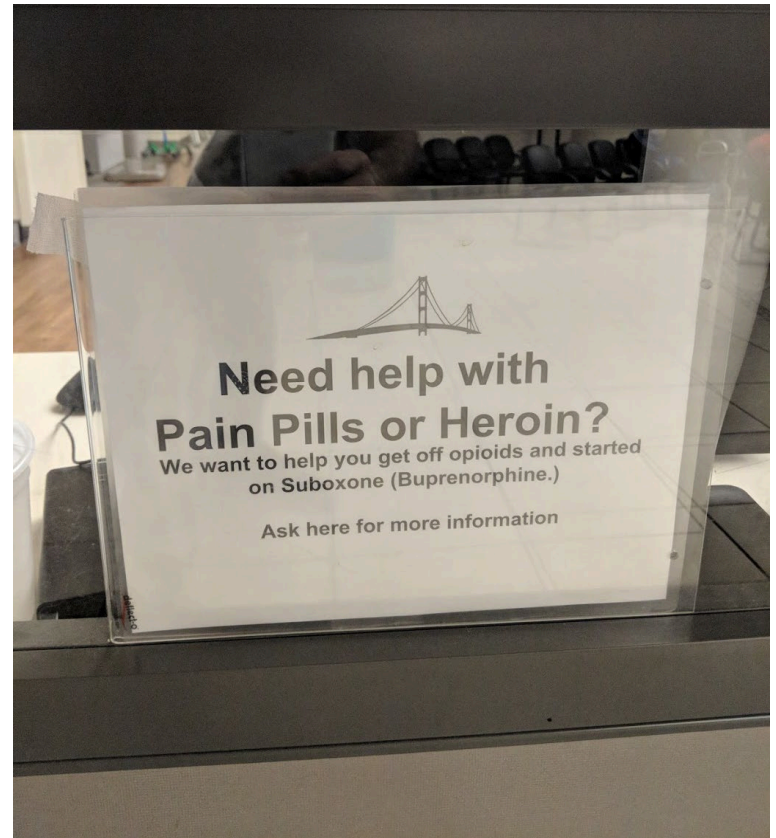
Highland Hospital—Alameda Health System

Assistant Clinical Professor of Emergency Medicine, UCSF

How can emergency services contribute to systems of care for people who use opioid drugs?

- ✧ The answer varies depending on:
 - The individual and unique needs of your community at any point in time during this rapidly evolving epidemic.
 - The capacity of healthcare and use disorder system outside of emergency department and hospital.





Emergency Access to Buprenorphine



Many sites of care for opioid use disorder lack capacity to:

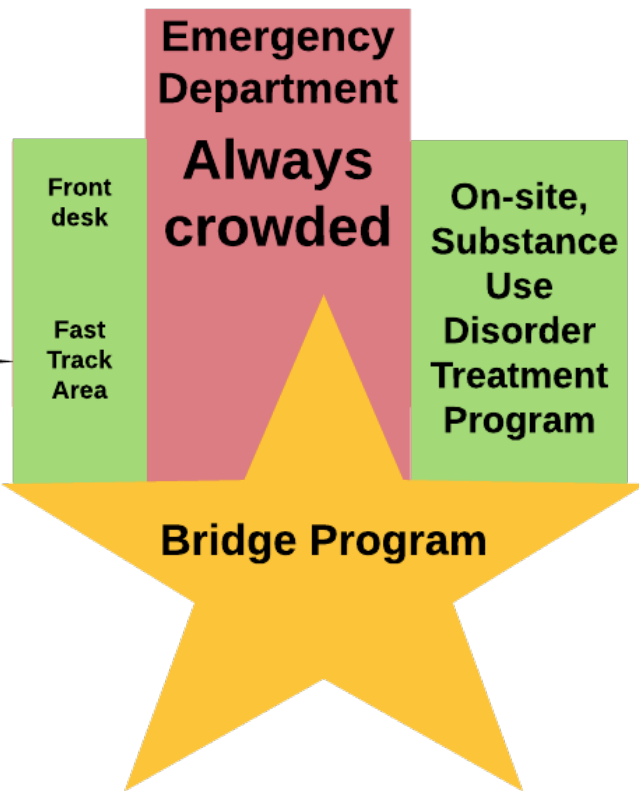
- 1) Start buprenorphine on demand 24-7.**
- 2) Arrange timely follow up after Buprenorphine has been started.**

The ED fills these gaps.

- no patient who wants treatment is abandoned*



Bridge Program Staffed By EM Attendings and Residents



Bridge Clinic
Care navigator M-F; 9-5
Weekly drop in Bridge clinic

Emergency Department attendings, residents and medical students staff Bridge Clinic

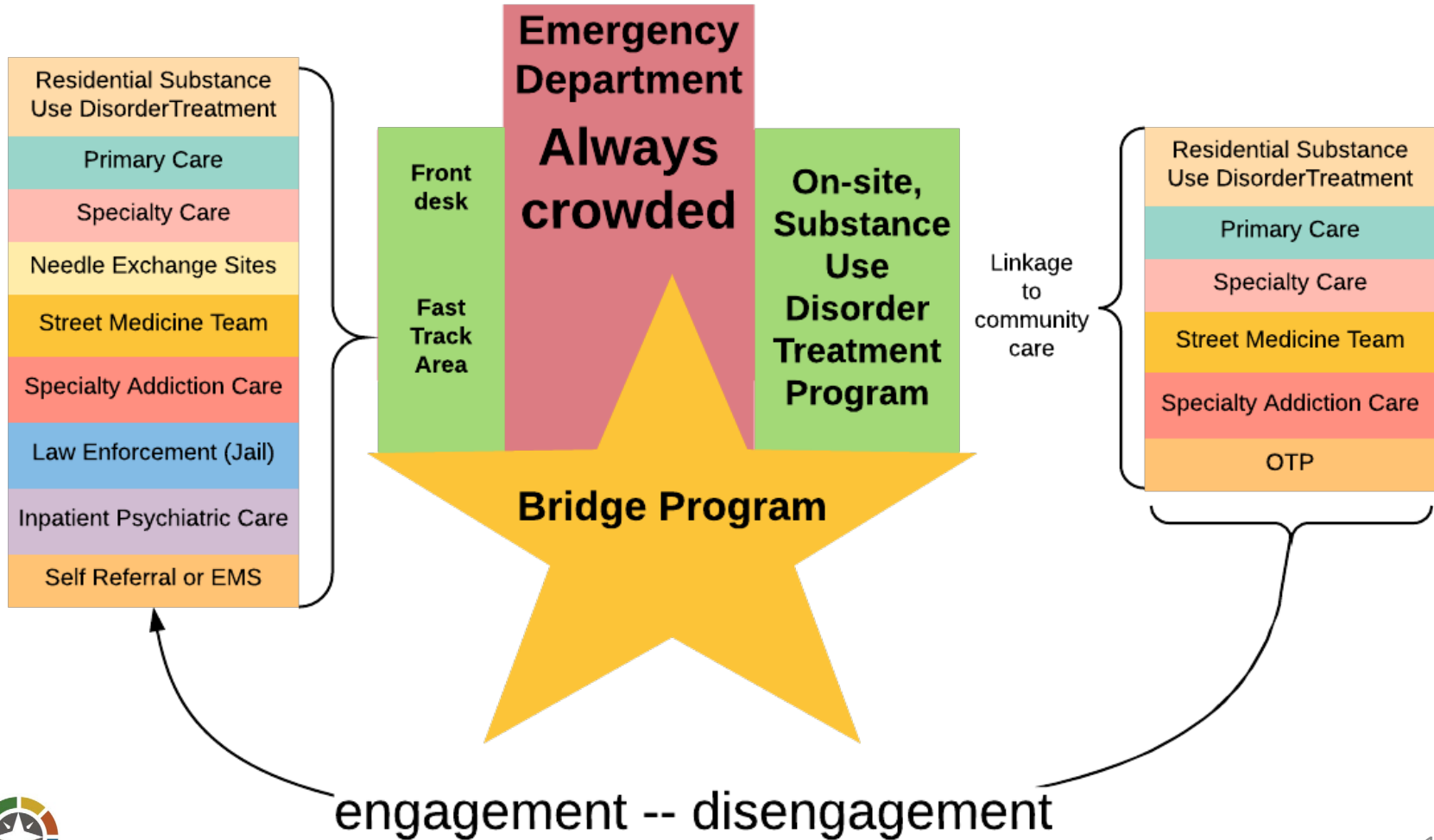
One day in bridge clinic = one day shift
All visits billed as outpatient visits



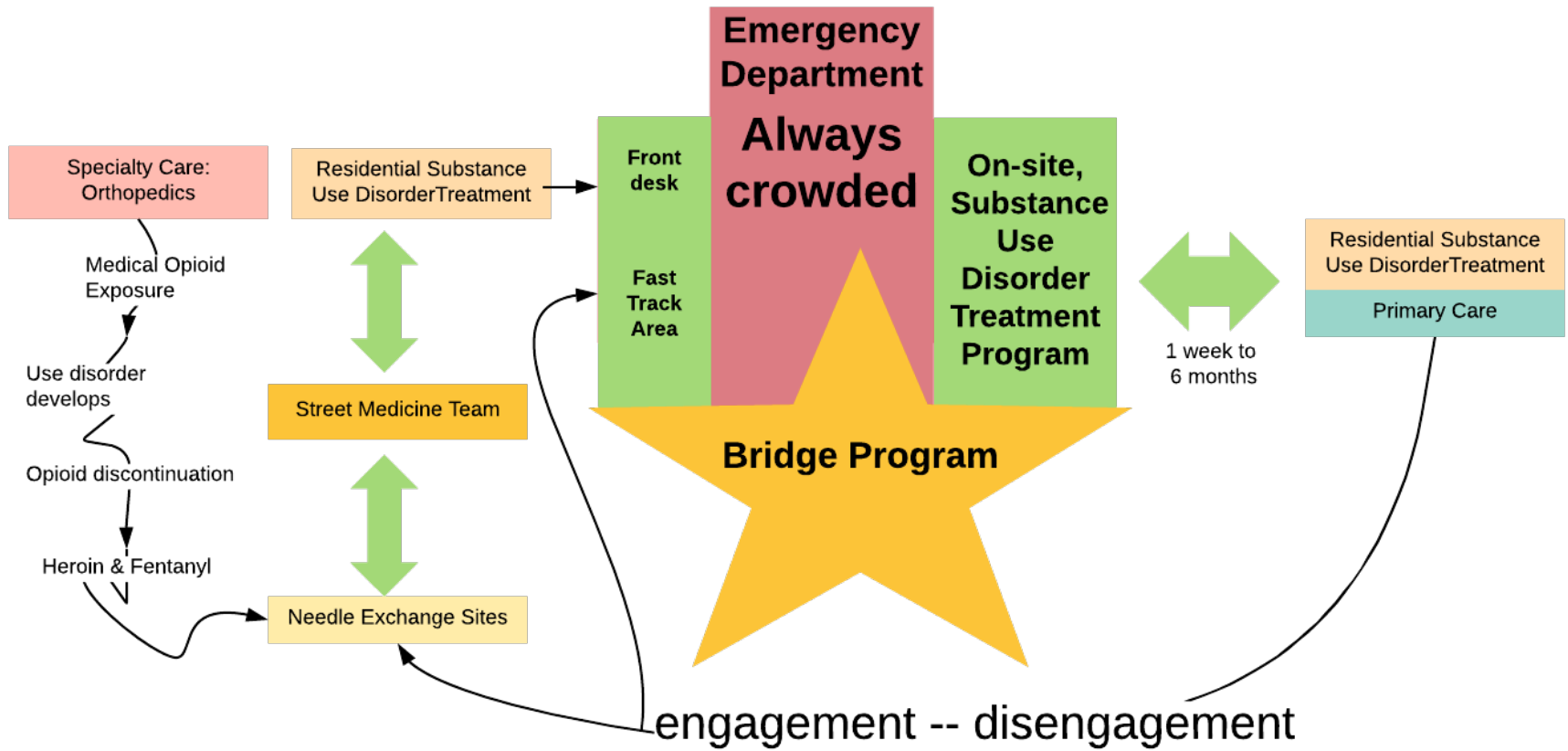
HIGHLAND EMERGENCY
DEPARTMENT OF EMERGENCY MEDICINE
ALAMEDA HEALTH SYSTEM - HIGHLAND HOSPITAL



Safety Net

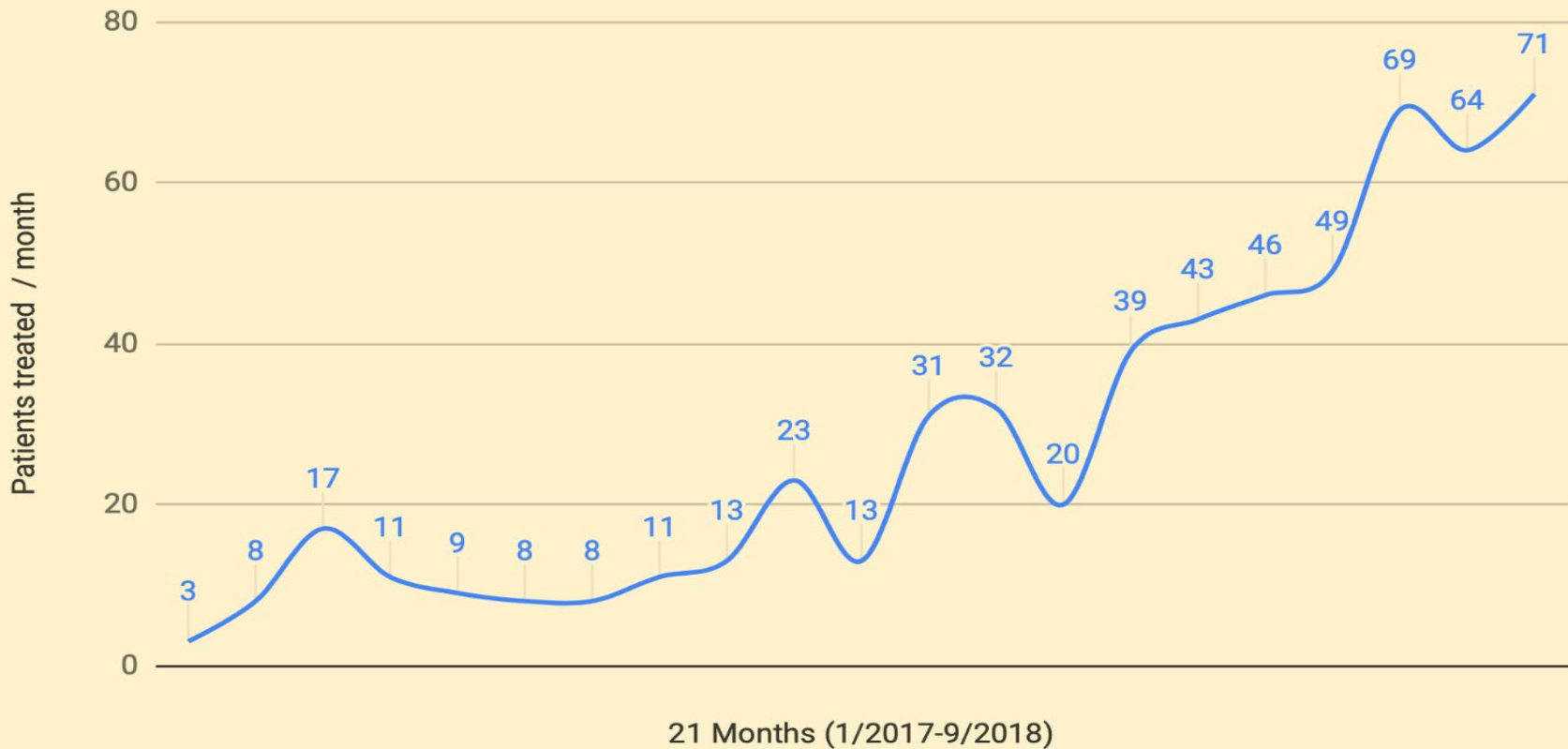


Case Example



Increased Utilization

Monthly Totals



HIGHLAND EMERGENCY

DEPARTMENT OF EMERGENCY MEDICINE
ALAMEDA HEALTH SYSTEM - HIGHLAND HOSPITAL



Changed Culture

574

Unique patients treated with buprenorphine

436

Made contact with navigator

297

68%

Accepted referral

249

84%

Arrived at follow up



HIGHLAND EMERGENCY

DEPARTMENT OF EMERGENCY MEDICINE
ALAMEDA HEALTH SYSTEM - HIGHLAND HOSPITAL





A Community Approach

Evan Schwarz FACEP, FACMT

Associate Professor of Emergency Medicine

Washington University School of Medicine

Barnes Jewish Hospital

Saint Louis, MO

Our Process

ED: Calls Central Agency



Recovery Coach

5 Treatment Centers in St. Louis
Receiving State Funds



Recovery Coach In the ED



Meets with patient. Gets additional 'buy-in'
Sets up follow up and arranges them getting there

Normally in 0-3 days

Gives them naloxone

Each patient receives a phone number to call

Fills buprenorphine prescription

Between 20-30 waived ED physicians



PATIENTS HAVE BEEN VERY RECEPTIVE TO THIS

If you have good insurance or financial resources?



ED Calls



Treatment Center
Follow up Obtained



Bup in the ED/
Naloxone prescription

Treatment Programs Contacted Us Once They
Saw That We Had This Interest
They Actually Want Our Referrals and Are
Willing to Work With Us



In Summary...

- ✧ Little burden on EM physician on shift
- ✧ Took time/effort to set up beforehand
 - Traditionally, no assistance from community
 - Now the centers are very engaged (*& costs us nothing*)
- ✧ Poorer patients receive meds, naloxone for free and wrap around services
- ✧ Those with resources are also directly connected
- ✧ Physicians, nursing, staff, social workers are all very supportive and process flows smoothly





Addiction Treatment at Brigham Health

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Director, Brigham Comprehensive Opioid Response
and Education (B-CORE Program)
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Department of Emergency Medicine
Brigham and Women's Hospital, Boston, MA

Thanks to Christin Price, MD

PHM Perspective: Becoming a Medicaid ACO

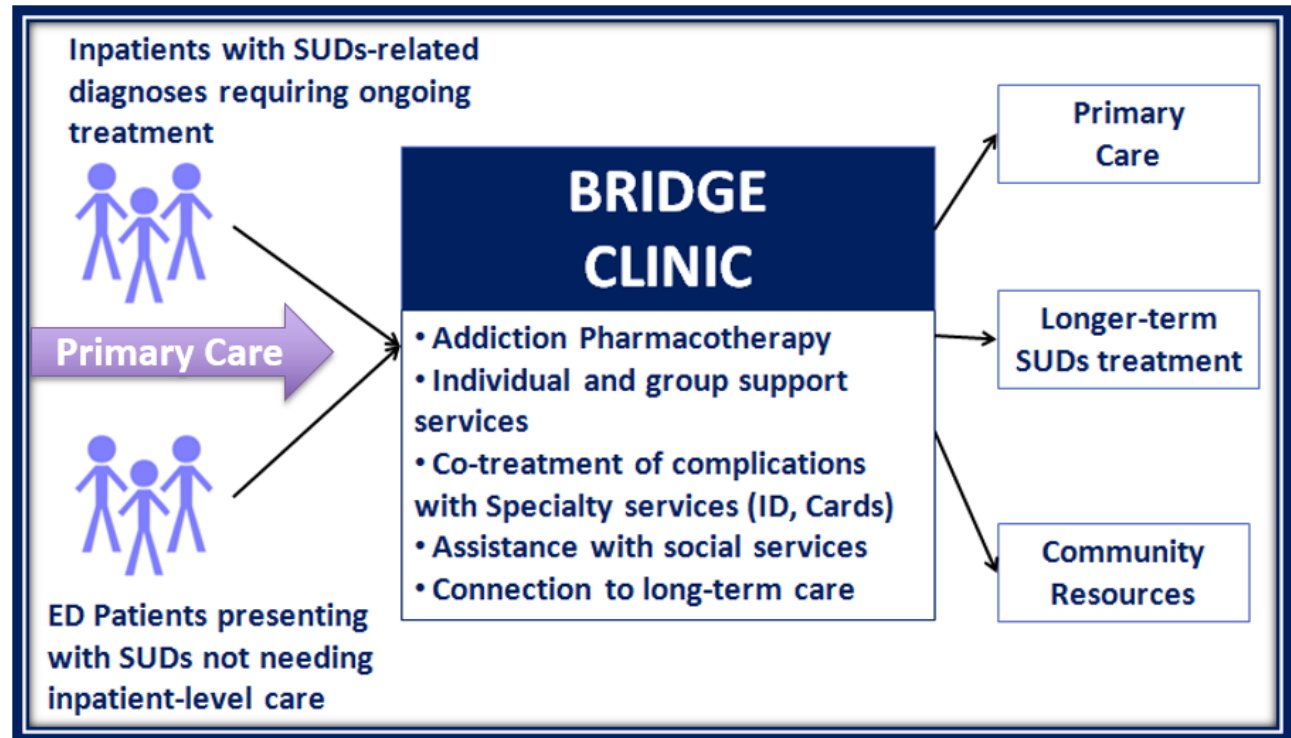
Table 4.3 - Prevalence of Top 10 Conditions by Members' Cost Group

Top 5% Highest Cost Members	Next 10% Highest Cost Members	85% Lowest Cost Members
Condition	Condition	Condition
Drug/Alcohol Abuse, (both Dependence and w/o Dependence) 41%	Drug/Alcohol Abuse, (both Dependence and w/o Dependence) 29%	Asthma 9%
Major Depressive, Bipolar, Paranoid 36%	Major Depressive, Bipolar, Paranoid 29%	Drug/Alcohol Abuse, (both Dependence and w/o Dependence) 8%
Hypertension 28%	Hypertension 20%	Hypertension 8%
Diabetes (w/ Complications and w/c Complications) 20%	Asthma 17%	Major Depressive, Bipolar, Paranoid 6%
Asthma 17%	Diabetes (w/ Complications and w/c Complications) 13%	Depression 5%
Depression 12%	Depression 12%	Attention Deficit Disorder 5%
Chronic Obstructive Pulmonary Disease 11%	Attention Deficit Disorder 10%	Diabetes (w/ Complications and w/c Complications) 3%
Disorders of Vertebrae/Spinal Discs 11%	Disorders of Vertebrae/Spinal Discs 8%	Disorders of Vertebrae/Spinal Discs 2%
Attention Deficit Disorder 9%	Chronic Obstructive Pulmonary Disease 4%	Osteoporosis and Other Bone/Cartilage 2%
Osteoporosis and Other Bone/Cartilage 8%	Osteoporosis and Other Bone/Cartilage 4%	Chronic Obstructive Pulmonary Disease 1%



Brigham Health Bridge Clinic

- Low barrier, **rapid access** clinic for patients with SUDs
- **Harm reduction approach** for patients in all stages of recovery
- Walk-ins accepted



Referrals: Types of patients

- ✧ Patients identified with any Substance Use Disorders (SUDs) or receiving care for medical complications related to substance use
 - Alcohol/Benzodiazepine dependence/withdrawal
 - Infections related to intravenous drug use
 - Opioid overdose +/- naloxone reversal
 - Ongoing cocaine, heroin, fentanyl use



BRIGHAM AND WOMEN'S
Physicians Organization

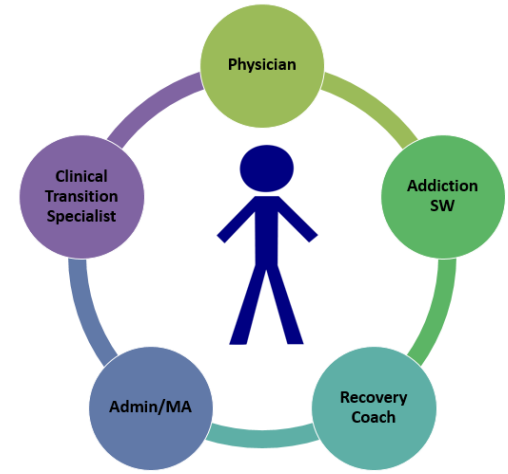


Life. Giving.
Breakthroughs.

Brigham Health Bridge Clinic

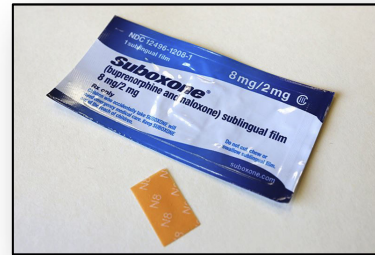
Roles and Services:

- **Addiction Psychiatry and Medicine physicians**
 - Perform intake, prescribe medications, monitor comorbid medical and mental health complications
- **Recovery Coach**
 - Provide peer support services; connect pts with long-term SUDs programs in community
 - Co-leads group sessions
- **Care Transition Specialist**
 - Screen for social determinants of health and connect pts with community resources (e.g., housing, food, transportation)



Available Medications:

- Buprenorphine (OUD)
- Oral Naltrexone (OUD, AUD)
- Intramuscular Vivitrol (OUD, AUD)



Goal: 100% Attending EPs Waivered

Friday, February 9, 2018

#GetWaivered

With limited resources and access to treatments for addiction, emergency rooms across the country have become the first point of contact for many people with substance use disorders, but the lack of opportunity for follow-up leaves many emergency providers powerless when a patient is ready to begin their path to recovery. To better equip providers in the MGH Emergency Department (ED) with more substantial and evidence-based options for treating these patients, many at the MGH are changing where and when recovery begins.

The #GetWaivered program – introduced by Alister Martin, MD, a resident in Emergency Medicine, and Ali Raja, MD, executive vice chair of Emergency Medicine – encourages providers to participate in the training necessary to prescribe buprenorphine – a medication that curbs opioid cravings and reduces the effects of opioid withdrawal in the hopes of helping patients stay in treatment longer – usually only prescribed by addiction medicine specialists.



A NEW APPROACH: MGH Emergency Department providers gather after receiving training.



Bridge Clinic: April – January 2019

- ✧ **277 patients** have been referred to the Bridge Clinic → **75%** presented for at least 1 appointment
- ✧ **Demographics:**
 - Ages: 23-70
 - Gender: 69% male, 31% female
 - Insurance: 60% MassHealth, 17% Medicare, 23% Commercial
- ✧ **Social Determinants:**
 - 28% Homeless
 - 23% have no phone
 - 20% have no Identification Card
- ✧ **SUDs diagnoses:**
 - 67% have OUD diagnosis (95% on buprenorphine)
 - 40% have AUD diagnosis (83% on naltrexone/Vivitrol)
 - 32% have polysubstance (most often cocaine or benzos)



Brigham Health Bridge Clinic (April – January 2019)

- ✧ **277 patients** have been referred to the Bridge Clinic → **75%** presented for at least 1 appointment
- ✧ Of the 207 patients that have engaged with the Bridge Clinic at least once:
 - **85% remain in treatment**—either at the Bridge Clinic or in longer-term care
 - **ED visits decreased by 66%** within the 3 months after referral**
 - **Inpatient admissions decreased by 60%** within the 3 months after referral**

***For patients with 3 months of follow-up after Bridge Clinic referral*

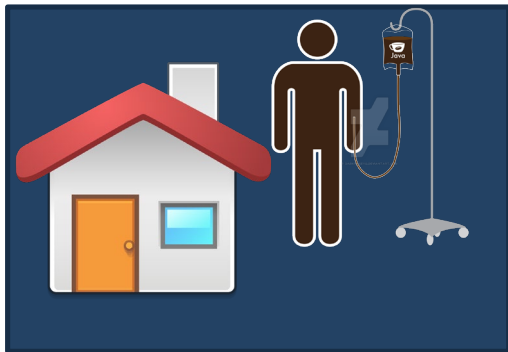


Bridge Clinic Outpatient Parenteral Antibiotic Therapy (OPAT) Program



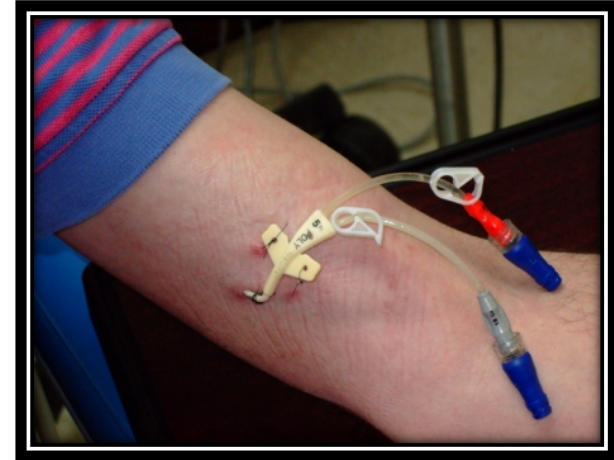
Creating Individualized Care Plans

- Safe housing
 - Ideally with sober support at home
 - No one at home is using intravenous drugs
- Engaged in treatment for substance use disorder
 - Suboxone or Methadone
 - Agrees to return to Bridge clinic twice/week while on IV antibiotics
 - Agrees to follow up in BWH ID clinic
- Not engaging in illicit substance use or violent behavior during latter part of hospitalization
- Multidisciplinary assessment confirms the patient is appropriate for discharge home



Bridge-OPAT patients (April – December 2018)

- 17 patients with OUD, history of IDU completed IV antibiotic course *at home* with close follow-up in the Bridge Clinic
 - 10 buprenorphine, 6 methadone, 1 N/A (cocaine use)
- All 17 have completed antibiotic course and PICC lines removed
 - Only 1 patient (on methadone) had readmission for a bloodstream infection, subsequently discharged on oral antibiotics
 - No other complications, relapses
- Collectively, for these 17 patients, **avoided 531 inpatient/rehab days.**



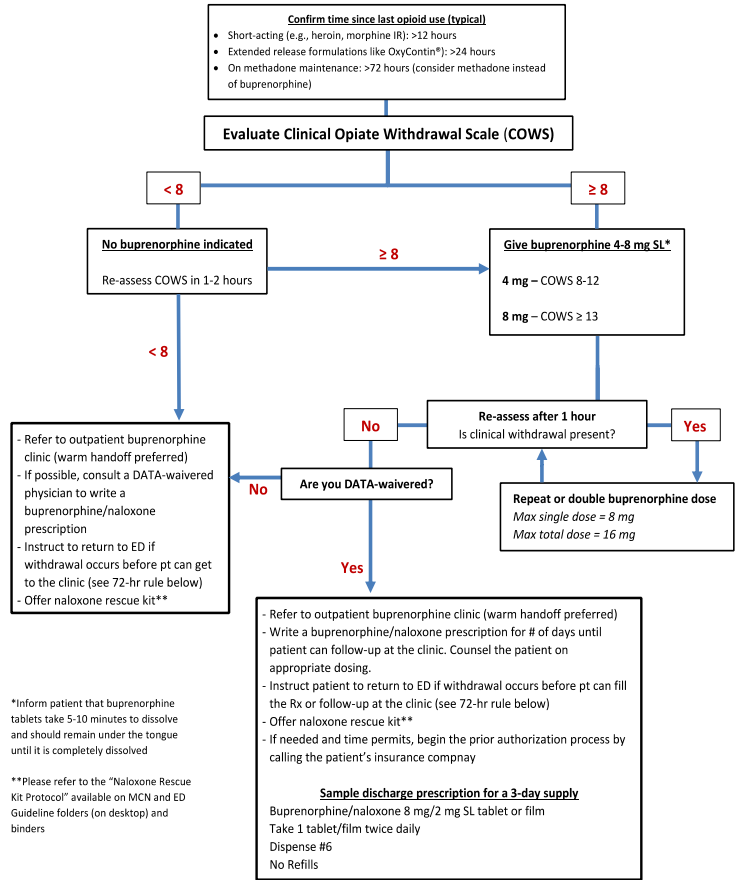


Assuring Addiction Treatment at a Safety Net Hospital

Lewis S. Nelson, MD

Professor of Emergency Medicine
Rutgers New Jersey Medical School
University Hospital of Newark
Newark, NJ

Buprenorphine Dosing Guideline for Acute Opioid Withdrawal



*Inform patient that buprenorphine tablets take 5-10 minutes to dissolve and should remain under the tongue until it is completely dissolved

**Please refer to the "Naloxone Rescue Kit Protocol" available on MCN and ED Guideline folders (on desktop) and binders

ADJUNCTIVE THERAPY - Consider if withdrawal persists after maximum dose of buprenorphine given

General withdrawal symptoms	Clonidine 0.1 mg PO Q4H PRN (hold for SBP < 90 mmHg)
Nausea and vomiting	Ondansetron 4 mg ODT/IV Q4H PRN
Diarrhea	Loperamide 4 mg PO, then 2 mg PO Q2H PRN (max total dose = 8 mg)
Myalgias and arthralgias	Ibuprofen 600 mg PO Q6H PRN

Guidelines are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines should be followed in most cases, but there is an understanding that, depending on the patient, setting, circumstances or factors, guidelines can and should be tailored to fit individual needs.



The Landscape

- ✧ Clinic half-day per week
 - 40% of overall patients are uninsured
 - Majority of the others are Medicaid
- ✧ No peer navigators, recovery coaches, or consistent social work support
 - Control arm for a peer navigator study
 - Developed student navigator program
- ✧ Naloxone distribution program
- ✧ Most physicians not waived
 - 6/35 with clear interest in addiction management
- ✧ Very collaborative relationship with addiction psychiatry



Suboxone (Buprenorphine) Clinic

Every Thursday, 12pm – 4pm

Behavioral Health Sciences Building (BHSB)

183 South Orange Ave, F-Level

Phone: 973-440-8179

We are located in the “BHSB” building as shown on the bottom of the map.

Tell the security guard you are going to F-level to see Dr. Zerbo.

Please call the phone number above if you have any questions.



 Search

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Emergency Narcotic Addiction Treatment

Get Email Updates:

The Drug Enforcement Administration (DEA) and Center for Substance Abuse Treatment (CSAT) have received numerous inquiries requesting clarification of the three- day (72 hour) exception to the separate registration requirement for maintenance or detoxification treatment. In addition, confusion continues to exist whether practitioners may prescribe Buprenex, a Schedule III **Schedule V** controlled substance for maintenance and detoxification treatment.

A practitioner who dispenses Schedule II narcotic drugs for maintenance and/or detoxification must obtain separate registration as a narcotic treatment program pursuant to the Narcotic Addict Treatment Act of 1974. This registration allows a practitioner to administer or dispense, but **not prescribe**, Schedule II narcotic drugs that are approved by the United States Food and Drug Administration (FDA) for the treatment of narcotic addiction. Methadone and levo-alpha-acetyl-methadol (LAAM) are the only drugs approved for use in maintenance and detoxification treatment. If a practitioner plans to use any other narcotic drug for addiction treatment, prior authorization must be obtained from FDA through an Investigational New Drug Application. Registration with DEA is contingent upon proper registration with the State Methadone Authority, and Health and Human Services.

An exception to the registration requirement, known as the "three day rule" (Title 21, Code of Federal Regulations, **Part 1306.07(b)**), allows a practitioner who is not separately registered as a narcotic treatment program, to administer (but not prescribe) narcotic drugs to a patient for the purpose of relieving acute withdrawal symptoms while arranging for the patient's referral for treatment, under the following conditions:

1. Not more than one day's medication may be administered or given to a patient at one time
2. This treatment may not be carried out for more than 72 hours and;
3. This 72-hour period cannot be renewed or extended

The intent of **21 CFR 1306.07(b)** is to provide practitioner flexibility in emergency situations where he may be confronted with a patient undergoing withdrawal. In such emergencies, it is impractical to require practitioners to obtain a separate registration. The 72-hour exception offers an opioid dependent individual relief from experiencing acute withdrawal symptoms, while the physician arranges placement in a maintenance/detoxification treatment program. This provision was established to augment, not to circumvent the separate registration requirement.

- Cases Against Doctors
- Chemical Control Program
- CMEA (Combat Meth Epidemic Act)
- Controlled Substance Schedules
- DATA Waived Physicians
- Drug Disposal Information
- Drug and Chemical Information
- E-commerce Initiatives
- Federal Agencies & Related Links
- Federal Register Notices
- National Prescription Drug Take Back Day
- NFLIS
- Publications & Manuals
- Questions & Answers
- Significant Guidance Documents
- Synthetic Drugs
- Title 21 Code of Federal Regulations
- Title 21 USC Codified CSA



Center of Excellence Grant



The Landscape

- ✧ Peer navigator program
- ✧ 5 weekday clinic availability
 - Incorporating our interested physicians
 - Insurance unimportant
- ✧ Funding for waiver training
- ✧ Very collaborative relationship with addiction psychiatry





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Moderated Discussion

- ✧ What hurdles have you faced in the development and implantation process?
 - How have you addressed them
- ✧ For the larger EM community, especially outside of academic medical centers, what additional hurdles should be anticipated?
- ✧ How important is the DATA waiver for emergency physicians?

