Launching an ED MAT Program

Andrew Herring, MD

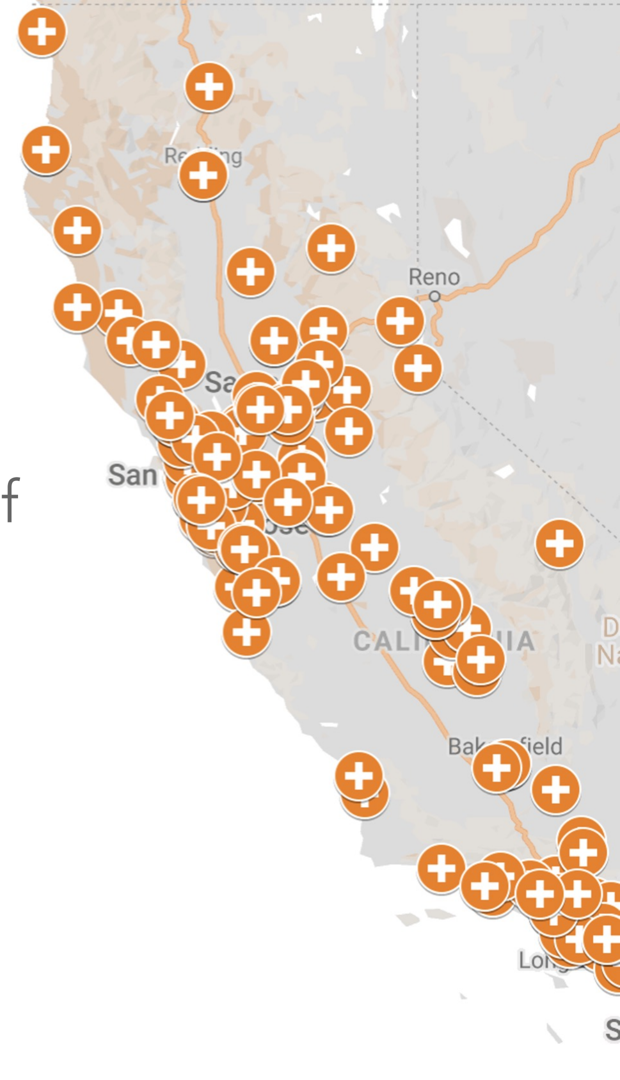
Addiction is NOT a moral failing.

It is a chronic disease that
requires medical treatment.

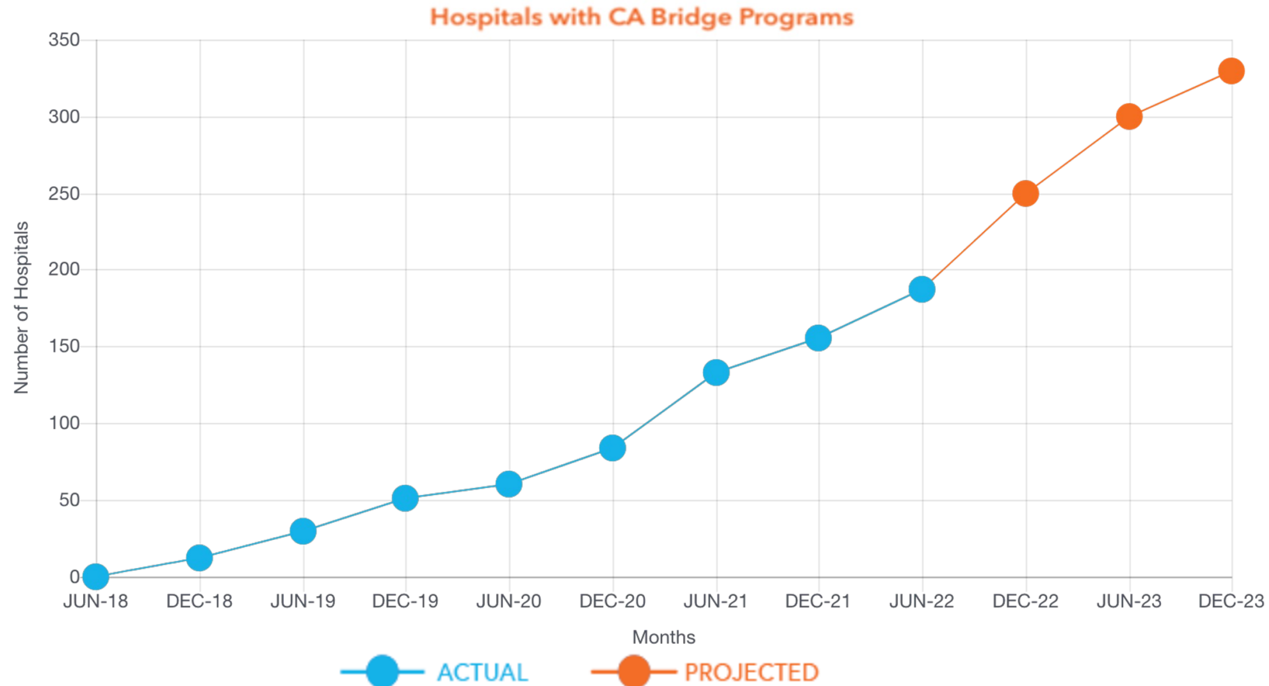
Behavioral Health Navigation

Partnering with community resources to meet the needs of our patients with substance use and mental illness

Goal: 24-7 access to high quality treatment of substance use disorders in all California hospitals by 2025.



Our goal is universal access to addiction treatment in all hospital emergency departments.



In 2018, the CA Bridge program began with just eight hospitals and today has expanded to 133.
By the end of 2023, we aim to see all hospital emergency departments treating opioid use disorder.

CA Bridge Model

Revolutionizing The System Of Care

Low-Barrier Treatment

Connection to Care and Community

Culture of Harm Reduction

The CA Bridge Model in Action

The CA Bridge Model in Action

The clinical champion provides assistance to staff so they can support the patient with medication

The navigator offers the patient guidance and linkage to ongoing treatment

The patient gets evidence-based care with better outcomes, and lower readmissions

Treatment starts here. Treatment starts now. cabridge.org

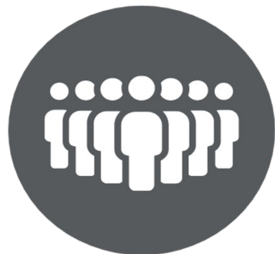
The Opioid Epidemic

107,622

people died from drug overdose during 2021 (1)

9.3 million

people misused prescription opioids in 2020 (2)



2.7 million

people had an opioid use disorder in 2020 (2)

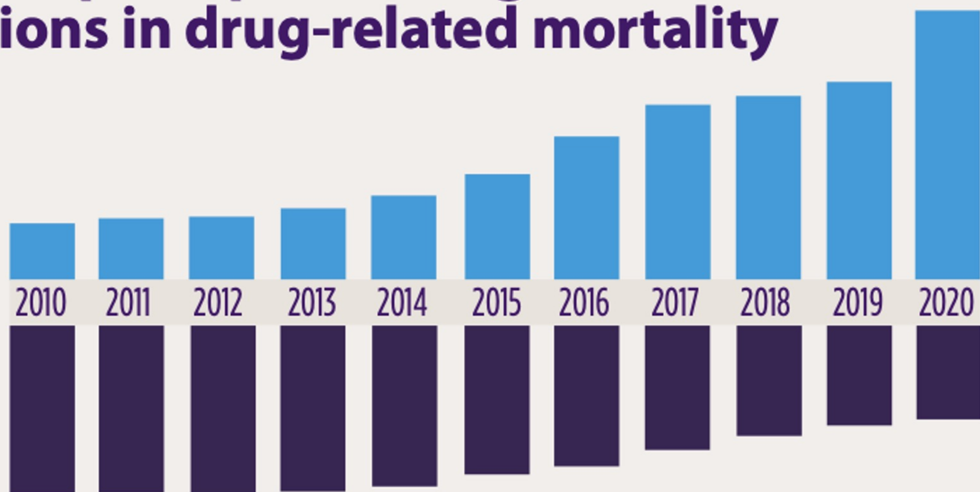
902,000

people used heroin in 2020 (2)

Sources

(1) Provisional data from CDC, National Center for Health Statistics
(2) 2020 National Survey on Drug Use and Health, 2021

As Opioid Prescribing Decreased, Overdose Deaths Increased



CA Bridge Impact: To-Date

Cumulative totals across all reporting CA Bridge sites (n = 196), April 2019-December 2021

0

patients seen for substance use disorders

0

patients identified with opioid use disorders

0

patients provided with buprenorphine

ED Medication Starts Save Lives

Original Investigation

Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence
A Randomized Clinical Trial

Gail D'Onofrio, MD, MS; Patrick G. O'Connor, MD, MPH; Michael V. Pantalon, PhD; Marek C. Chawarski, PhD;
Susan H. Busch, PhD; Patricia H. Owens, MS; Steven L. Bernstein, MD; David A. Fiellin, MD

37% vs 78%

CONCLUSIONS AND RELEVANCE Among opioid-dependent patients, ED-initiated buprenorphine treatment vs brief intervention and referral significantly increased engagement in addiction treatment, reduced self-reported illicit opioid use, and decreased use of inpatient addiction treatment services but did not significantly decrease the rates of urine samples that tested positive for opioids or of HIV risk. These findings require replication in other centers before widespread adoption.

Recognize that OUD is an EMERGENCY AND, this is our JOB

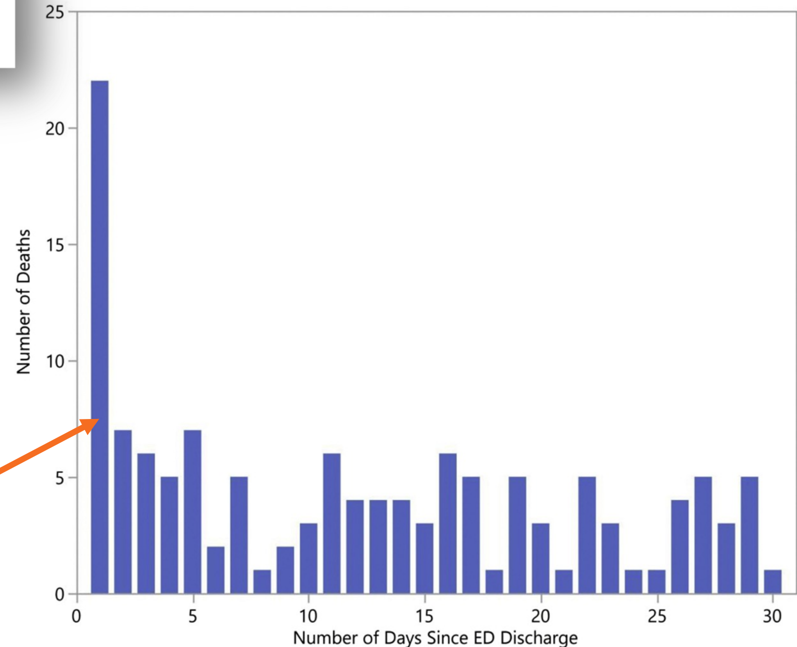
One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose

Scott G. Weiner, MD, MPH[a,*], Olesya Baker, PhD[a], Dana Bernson, MPH[b], Jeremiah D. Schuur, MD, MHS[c]

Study of patients treated in Massachusetts EDs for opioid overdose 2011-2015

- Illustrates the short-term increase in mortality risk post-ED discharge
- Of patients that died, 20% died in the first month
- Of those that died in the first month, 22% died within the first 2 days

Number of deaths after ED treatment for nonfatal overdose by number of days after discharge in the first month (n=130)



Source: Weiner, Scott, et al.. *One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose*. Annals of Emergency Medicine. April 2, 2019.

The Numbers for Success

Number Needed to Treat	
Aspirin in STEMI	**42** to save a life
Warfarin in Afib	**25** to prevent a stroke
Steroids in COPD	**10** to prevent tx failure
Defibrillation in Cardiac Arrest	**2.5** to save a life
Buprenorphine in Opioid Use Disorder	**2** to retain in treatment

https://clincalc.com/Stats/NNT.aspx

Pillars of Success

1. **Navigator has been hired for at least 50% FTE**
2. **Training**
   a. Navigator and clinical champion participation in at least one training together.
3. **Capacity Building**
   a. Clinical champion meets at least monthly with the navigator
   b. Clinical champion engages key hospital stakeholders in a workgroup to develop treatment and referral pathways for patients with SUD and behavioral health issues
4. **Navigation and Care Continuation**
   a. Navigator engages patients with SUD and links them with outpatient treatment providers that agree to follow up with patients and continue buprenorphine
   b. Clinical champion and navigator educate providers on local treatment and referral pathways for mental health conditions
5. **Reporting**
   a. Audit and Feedback - Success and challenges presented to hospital leadership

Example Data Metrics

METRIC	DESCRIPTION
1. # ED/hospital encounters where a patient was seen by the navigator for any reason.	The total number of encounters where a patient was served by the navigator(s). Include all meaningful patient encounters regardless of visit reason, diagnosis, or location where the patient was seen in the hospital (e.g., ED, inpatient, outpatient, virtual visit, phone encounter).
2. # ED/hospital encounters where a patient was diagnosed with opioid use disorder (OUD).	The total number of encounters in the ED or hospital where a patient received an OUD diagnosis. *Suggested ICD-10 codes:* F11.1*Opioid Abuse, F11.2* Opioid Dependence, F11.9*Opioid use
3. # ED/hospital encounters where a patient was discharged with a follow-up appointment with a substance use disorder (SUD) provider.	The total number of encounters in the ED or hospital where a patient was discharged and accepted a scheduled or drop-in appointment with any SUD provider (e.g., primary care, opioid treatment program, Federally Qualified Health Centers, residential treatment facilities, detox clinic, Bridge clinic, office-based opioid treatment, psychiatric addiction specialist).

Example Data Metrics

4.	# ED/hospital encounters where the navigator facilitates patient referral to follow-up mental health treatment.	The total number of encounters in the ED or hospital where a navigator connected a patient to ongoing treatment via referral to any mental health provider or follow-up mental health treatment (e.g., county mental health, therapist, primary care, crisis stabilization units).
5.	# ED/hospital encounters where a patient was treated with buprenorphine (administered and/or prescribed).	The total number of encounters in the ED or hospital that resulted in the administration or prescription of buprenorphine. This total is not limited to the ED.
6.	# ED/hospital encounters where a patient was diagnosed with overdose **and** seen by the navigator.	The total number of encounters in the ED or hospital where a patient received an overdose diagnosis and was served by the navigator during visit or post-discharge. This includes an overdose from any substance and is not limited to opioid overdose. *Suggested ICD-10 codes*: T40.0* Opium, T43.6* Psychostimulants, T40.1* Heroin, T40.2* Other Opioids, T40.3* Methadone, T40.4* Other synthetic opioids, T40.5* Cocaine, T40.6* Narcotics, T42.4* Benzodiazepines

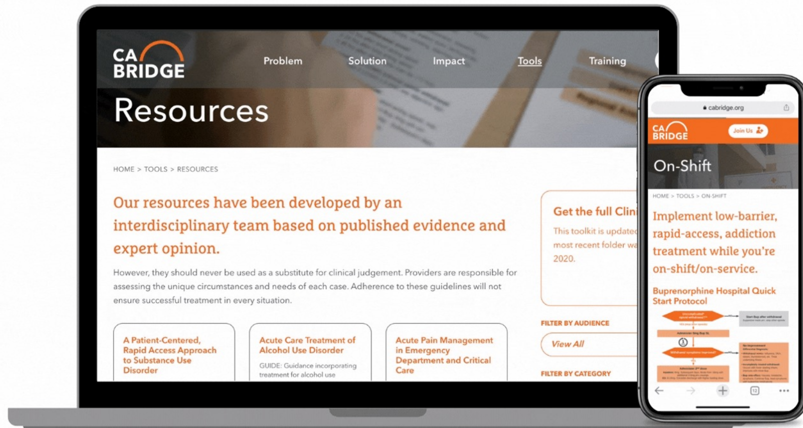
Next Steps

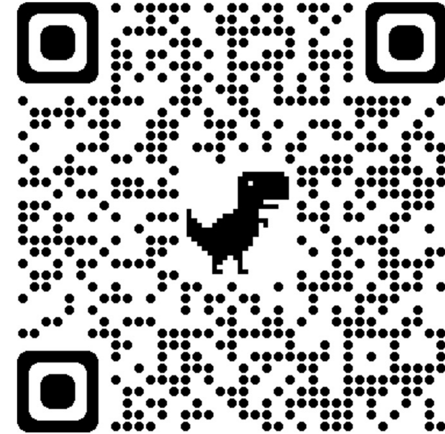
- ❑ Identify your Bridge team: clinical, administrative, pharmacy, SW/care management, outpatient linkage
- ❑ Navigator job posting, salary, supervision
- ❑ Buprenorphine on formulary
- ❑ Clinical protocols
- ❑ Get providers X-waivered
- ❑ Develop data reports
- ❑ Start treatment and linking to outpatient care

Sustainability

- ❑ ? reimbursement for Community Health Worker services
- ❑ MAT billing code G2213 for providers
- ❑ What matters to your hospital?
    - Decreased hospital utilization
    - Reduced ED length of stay
    - Increased staff satisfaction
    - What else?

CA Bridge Resources





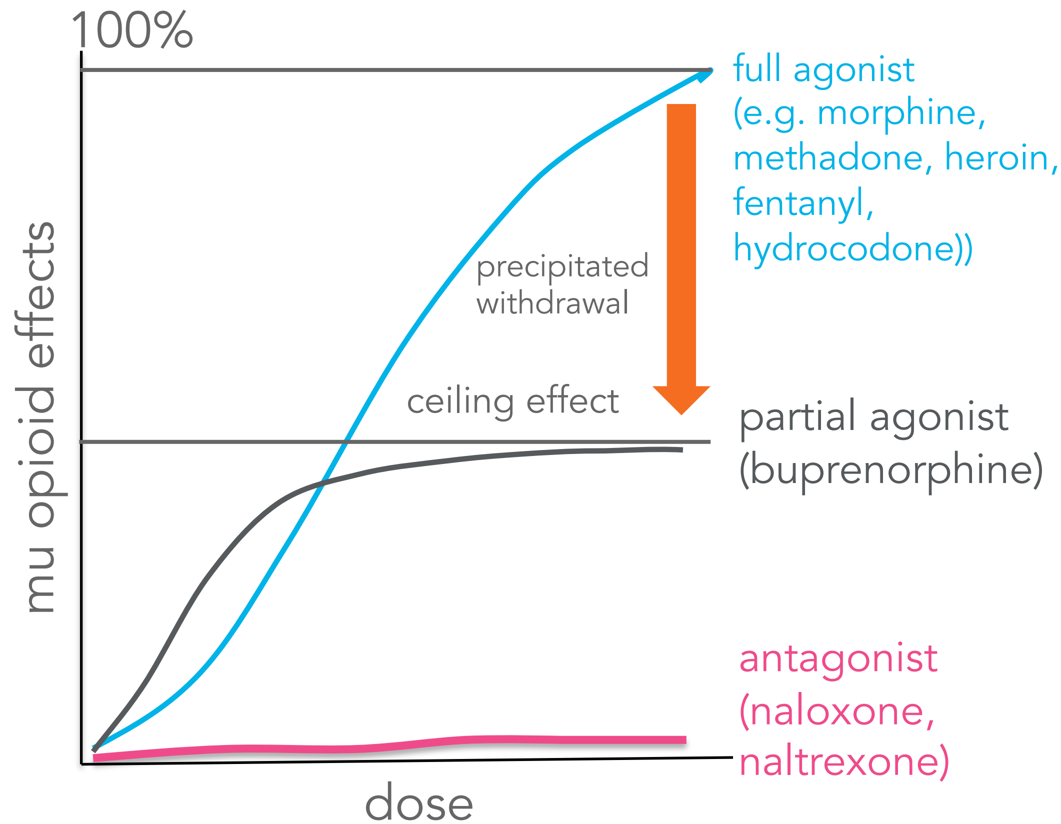
Visit our website for resources and more www.cabridge.org

Follow us on social media @BridgeToTx

Q&A

Get Your X-Waiver

Understanding Buprenorphine



Barriers To Treatment

Do not exclude a patient from appropriate treatment with buprenorphine for OUD because of:

- Polysubstances, stimulants, benzodiazepines, or alcohol
- Current or planned psychosocial support
- Contingencies on urine drug screen results or other labs

Patient Assessment is important

Look for objective signs only

Dilated pupils

Sweats

Tachycardia

Yawning

Piloerection

Vomiting

Diarrhea

Rhinorrhea, tearing

Do not score anxiety, restlessness

Caution about using time since last use given prevalence of fentanyl

Ask:

"Are you in bad withdrawal?"

"Do you think you are ready to start bup?"

COWS score can help identify withdrawal signs and symptoms

Buprenorphine (Bup) Emergency Department Quick Start

View or download on your device

Abstinence and onset of withdrawal

Objective uncomplicated opioid withdrawal*

NO → **Rx self-directed ("home") start:** Wait for severe withdrawal then start with 8 mg SL. Rx per "Discharge" box below

Administer 8-16 mg bup SL

1 HOUR

Withdrawal improved?

NO → **If no improvement or worse consider:**

Undertreated withdrawal: Occurs with lower starting doses and heavy tolerance; improves with more bup (add'l 8-16 mg SL).

Other substance intoxication or withdrawal: Stimulant intoxication, alcohol/benzo/xylazine/GHB withdrawal. Continue bup; manage additional syndromes.

Bup side-effects: Nausea, headache, dysphoria. Continue bup, treat side-effects with supportive medications.

Other medical/psychiatric illness: Anxiety, sepsis, influenza, DKA, thyrotoxicosis, etc. Continue bup, manage underlying condition.

If sudden/significant worsening, consider precipitated withdrawal: See box below.

YES

Administer 2nd dose
Additional 8-16 mg SL bup for total daily dose of 16-32 mg

Discharge

- **If prescriber has X-waiver:** Prescribe sufficient bup/nx until follow-up: e.g., buprenorphine/naloxone 8/2 mg SL films 2-4 films qday #32-64, 0 refills (may Rx more PRN). Notes to pharmacy: bill Medi-Cal FFS, ICD 10 F11.20, X DEA # ___.
- **If no X-waiver:** Use loading dose up to 32 mg SL for long effect and give rapid follow up (<72 h).
- **Dispense naloxone** from the ED (not just prescribed): e.g., naloxone 4 mg IN spray #2.
- **Document** Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.

We encourage shared decision making with patient for dosing.

*** Opioid Withdrawal:**

At least one clear objective sign (prefer ≥ 2): Tachycardia, mydriasis, yawning, rhinorrhea, vomiting, diarrhea, piloerection. **Ask the patient if they are in bad withdrawal** and if they feel ready to start bup. If they feel their withdrawal is mild, it is too soon.

If unsure, use COWS (clinical opioid withdrawal scale). Start if COWS ≥ 8 AND objective signs.

Typical withdrawal onset >12 hours after last short acting opioid use (excluding fentanyl); variable after last use of fentanyl or methadone (may be >72 hours).

Start protocol may vary for complicating factors:

- Altered mental status, delirium, intoxication
- Severe acute pain, trauma, or planned large surgery
- Organ failure or other severe medical illness (decompensated heart failure, respiratory distress, hemodynamically unstable, etc.)
- Recent methadone use
- Minimal opioid tolerance (consider lower dosing)

Most people who use fentanyl do well with starts following this guide. For fentanyl specific initiation questions, see Fentanyl FAQ.

If patient has already completed withdrawal (no longer symptomatic withdrawal, often >72 hrs from last use of opioids) and wants to start bup: give bup 8 mg SL q6h PRN cravings, usual dose 16-32mg/day. After first day, consolidate dosing to daily.

Treatment of precipitated withdrawal

Precipitated withdrawal is a sudden, significant worsening of withdrawal after bup or full antagonist (e.g., naloxone).

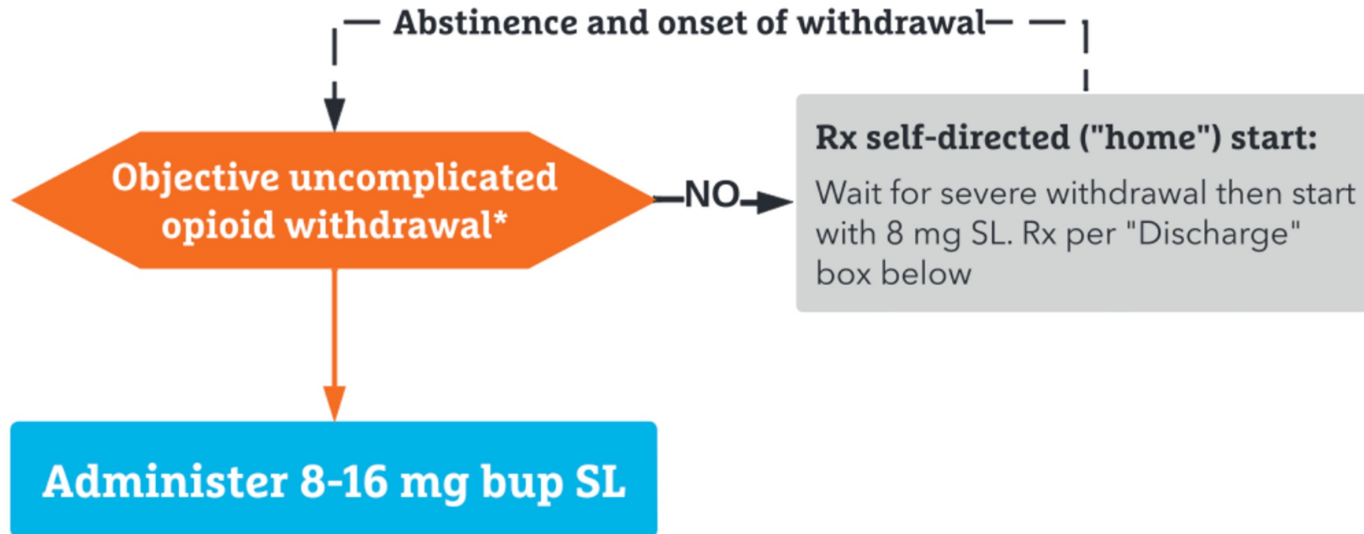
Administer additional 16 mg SL bup immediately.
Reassess in 30-60 minutes. If continued distress remains: Repeat 8-16 mg bup SL.

If precipitated withdrawal not resolved by bup:

Consider alpha-2 agonists (clonidine or dexmedetomidine), antipsychotics (e.g., haloperidol), cautious use of benzodiazepines (e.g., 1-2 mg PO lorazepam x 1), high potency opioid (e.g., fentanyl 100-200 mcg IV q30 or infusion), or ketamine (0.3 mg/kg IV slow push q30 minutes or continuous infusion until calm). Once withdrawal is managed, continue daily bup dose.

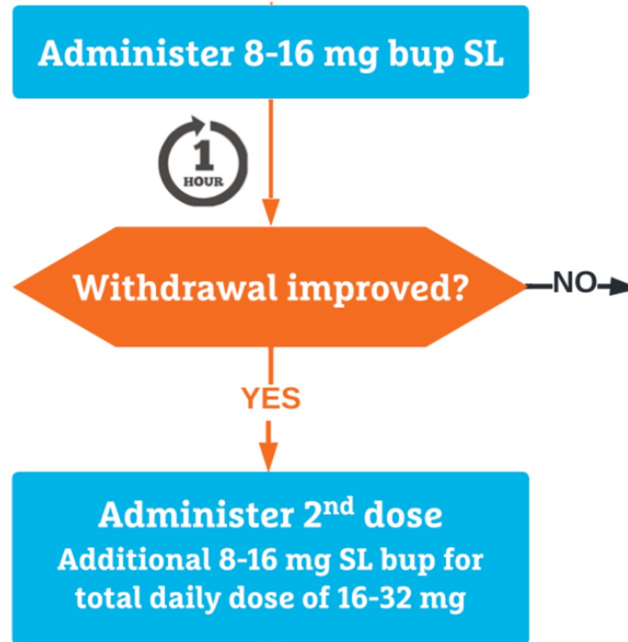
Step 1: Medication First Approach

- Pt in moderate to severe withdrawal?
- Wants help quitting illicit opioids?
- Give 8-16mg Buprenorphine sublingual.



Step 2: Wait 1 hr.

- Reassess.
- Better? Give another dose.
- No? Widen your ddx.



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Other medical/psychiatric illness: Anxiety, sepsis, influenza, DKA, thyrotoxicosis, etc. Continue bup, manage underlying condition.

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Step 3: Discharge Rx & Plan

Discharge

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Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

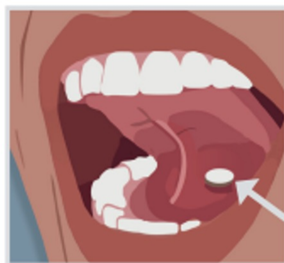
1. Plan to take a day off and have a place to rest.
2. Stop using and wait until you feel very sick from withdrawals (at least 12 hours is best, if using fentanyl it may take a few days).
3. Dose one or two 8mg tablets or strips UNDER your tongue (total dose of 8-16mg).
4. Repeat dose (another 8mg-16mg) in an hour to feel well.
5. The next day, take 16-32mg (2-4 tablets or films) at one time.

If you have started bup before:

- If it went well, that's great! Just do that again.
- If it was difficult, talk with your care team to figure out what happened and find ways to make it better this time. You may need a different dosing plan than what is listed here.

If you have never started bup before:

- Gather your support team and if possible take a "day off."
- You are going to want space to rest. Don't drive.
- Using cocaine, meth, alcohol or pills makes starting bup harder, and mixing in alcohol or benzos can be dangerous.



Place dose under your tongue (sublingual).