The Opioid Crisis and Emergency Department Intervention

Sponsored by the Florida Alcohol and Drug Abuse Association and the Florida Department of Children and Families
Mark Stavros, MD, FACEP, FASAM
Medical Director, West Florida Hospital Emergency Services
Education Director, Emergency Medicine Florida State University
By participating in this webinar, participants will:

• Learn about the opioid crisis and its impact.
• Develop an understanding about addiction and the medications used for opioid use disorder (OUD).
• Become knowledgeable about the importance of initiating medication assisted treatment and support services in the emergency department.
• Be able to discuss the concern, realities and solutions for initiating MAT for opioid use disorder in hospital emergency rooms.
Opioid Crisis
The Crisis: National Overdose Death Rates

In 2017, there were **70,237** overdose deaths (9.6% higher than 2016)

Evolution of the Opioid Crisis

Overdose Fatalities

- Prescription
- Heroin
- Fentanyl

Source: Centres for Disease Control and Prevention
Doctors Continue to Prescribe Opioids for Ninety-one Percent of Overdose Patients

In a study of 2848 patients who had a nonfatal opioid overdose during long-term opioid pain treatment:

- 63% of high-dose opioid patients were still on a high dose 31-90 days after overdosing.
- 17% of high-dose patients overdosed again within two years.

Epidemic of Deaths

Opioid related Emergency Room (ER) visits in Florida increased 32.3% between 2009 and 2014

Nationally, opioid-related ER visits increased 99.4% between 2005 and 2014

USA -146 deaths a day in 2016 (60% from opioids)

Florida – 14 + deaths a day in 2016 and for every death – 27 non-fatal overdoses

2017 – Nationally, death rate still increasing >120 deaths/day opioid related

Florida Medical Association, 2019
Illicit drug use in the United States is estimated to have cost the U.S economy more than $750 billion due to lost productivity at work, health care fees, and costs associated with the criminal justice system (National Safety Council).

Only 5% of the cost is related to treatment. Medication-assisted treatment has been proven to significantly reduce these costs.
Understanding Addiction
After decades of research it is now thought that addiction is a disease of the **BRAIN**.

**Definition:** Primary, chronic disease of **brain reward, motivation, memory and related circuitry**

There is a dysfunction of the circuitry and individuals pathologically pursue rewards and/or relief by substance use or other behaviors.

Like other chronic diseases, addiction often involves **cycles of relapse and remission**. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.
Areas of the Human Brain that are Especially Important in Addiction

**Prefrontal Cortex**
- Role:
  - Decision making
  - Thinking
  - Reasoning
  - Learning

**Reward Circuit (Cortex/Limbic System)**

**Basal Ganglia**
- Nucleus Accumbens – “Motivational Motor”
  - get us to act, to pursue goals, gives us a motive to go toward something, experience reward

**VTA** – “Fuel Tank”/dopamine machine – it supplies DA to the NA and tells us how important something is and if we need to pursue it and at what cost

**Ext. Amygdala**
- Stress response
- Fight/Flight
- Regulate negative emotions (unease, anxiety, irritability
- Withdrawals

The limbic system controls such basic needs as eating, drinking, mating and protecting children and family.
Prefrontal Cortex (DAMAGED)

**ONCE function is decreased, disrupted or damaged:**
- Causes the loss of the crucial behavioral guidance system
- Responses are impulsive and inappropriate
- Deficits of self-regulation

Also leads to:
- Premature, risky, poorly conceived actions/sensation seeking
- Emotional crisis and or
  - Emotions inappropriate to the situation
- Insensitivity to consequences
  - risk going to prison to use “just one more time”
  - risk losing medical license or pharmacy license
  - risk losing children

You would say, what were they thinking, exactly, they really weren’t thinking.

*NOT an Excuse*
Midbrain: Limbic (REWARD) System

Role:
- Motivation and drive for survival, (30 seconds)
  - Food – Hunger/Thirst
  - Fight – Flight/Defend
  - Procreation/Sex
- Experience of Reward and Pleasure
Hijacking of the Reward Pathway

Drugs such as Opioids specifically hijack or hack into our limbic system by binding directly to brain receptors that cause release dopamine.

- messenger that our limbic system uses in order to understand which activities in life are salient – most important.
- generates pleasurable reactions in the limbic system
- Prioritize which drives are most essential to life

Once the Brain Has Been Hijacked,

✓ It will force the individual to search for drugs with the same strength as if it were food or even greater – and the rational brain is unable to stop it. *(hungry/thirsty?)*

✓ And in severe opioid use disorder, when stressed, or in withdrawal or craving - it can cause one to pursue the reward/ drug at the cost of everything in their life, even possibly to the point of death.
Our Brains are wired to ensure that we will repeat life-sustaining activities by associating them with reward.

Drug is more important than other drivers of survival.
Circuits Involved in Addiction

Pleasure-seeking overrides reason, taking over motivation/drive. Former strong connections between judgement and motivation shrink.
Without Treatment – Difficult to Attain Abstinence

**Interventions**
- Psychosocial Therapies
- 12 Step Programs
- Monitoring

**Interventions (stabilization)**
- Agonist Medications
- Antagonist Medications
Medication Assisted Treatment (MAT)
Medication Assisted Treatment

The use of medication in combination with other behavioral therapies used in the treatment of Opioid Use Disorder (OUD)

Not unlike the use of medication in combination with behavioral therapies in other chronic diseases like Hypertension, Diabetes and Asthma
MEDICATION ASSISTED TREATMENT

- Achieve full prevention of both signs and symptoms of withdrawal for 24 hours
- The dose should reduce or eliminate drug hunger or craving
- Block reinforcing effects of illicit opiates: should see significant decrease of opiate positive UDS
- Tolerance to any sedative effects of MAT

METHADONE

BUPRENOPHINE

NALTREXONE
MAT Benefits

In combination with counseling, MAT:
Decreased overdose rate
Increases patient retention
Decreases drug use
Decreases sexual disease transmission
Decreased health care costs
Decreases criminal activity
Decreased criminal justice system cost

NIDA 2012
How Does MAT Work?

Long acting opioids that:

• Occupy brain receptor sites affected by heroin & other opioids
• Normalize brain chemistry
• Relieve physiological cravings
• Prevent withdrawal
• Normalize bodily functions
• Dosing is an individualized medical decision
• Does not impair functioning
• No negative effect on intelligence, mental capability, physical functioning, or employability
Initiating Treatment in the ED

Buprenorphine:
- Partial agonist at the mu opioid receptor
- Very high affinity but low intrinsic activity – will out compete and displace full opioid agonist
- Low intrinsic activity results in less euphoria and lower diversion potential
Source: ASAM. The Review Course in Addiction Medicine
Emergency Department Intervention
Why Focus on the Emergency Department (ED)?

Because that is where the patients are!!

Open 24 hours, 7 days / week

Treat patients for opioid overdose and withdrawal
Emergency Departments

Screen and Identify Patients with Opioid Use Disorder (OUD)

Provide Treatment
- Initiate MAT – Buprenorphine
- Education for overdose (OD) prevention
- Naloxone distribution

Link Patient with Ongoing Treatment
JAMA--2015

Addiction is a chronic, relapsing disease, and a strongly stigmatized one.

It is NOT a moral failing.

People who present to the ED for other chronic disease like diabetes and asthma are stabilized with medications and handed off for outpatient care. Individuals with opioid use disorder (OUD) do best with a similar treatment plan.
D’Onofrio, JAMA, 2015

- ED Patients with OUD

- 3 Study Groups
  - Traditional Referral (104)
  - Brief Intervention and Referral (111)
  - ED Initiated Buprenorphine (114)

- Primary Outcome:
  Engagement with Therapy at 30 days
D’Onofrio, JAMA, 2015

# Days of Use/Wk

- Buprenorphine: 0.9
- Referral: 2.3
- Brief Intervention: 2.4
Initiating Treatment in the ED

It is NOT simply replacing one drug for another. Buprenorphine treatment decreases withdrawal and craving. Patients who receive buprenorphine are less likely to OD, die, use illicit opioids, spread Hepatitis C Virus (HCV) or Human Immunodeficiency Virus (HIV) and have fewer injection drug use complications and contact with the criminal justice system.

NIDA. Initiating Buprenorphine Treatment in the Emergency Department
MAT Reduces Heroin Deaths

Regulatory FAQs

- Do the ER providers need an x-waiver?
  - No!

- Wait...is that legal?
  - Yes!
  - Administer vs. prescribe
  - 3-day rule: OK to *administer* daily for up to 72 hours

- For more information:
Initiating treatment in the ED

ED physicians can administer buprenorphine in the ED for opioid withdrawal. Within 30-45 minutes patients will be much more comfortable. MDs, PAs and APRNs who complete the DATA 2000 waiver training, can prescribe buprenorphine with referral to ongoing treatment.

72 hour rule
--Allows to administer (but not prescribe) narcotic drugs for the purpose of relieving acute withdrawal symptoms while arranging for the patient's referral for treatment
--Patient must return to ED each day for another day's dose up to 72 hours
--The 72 hour rule may not be extended or renewed
Title 21, CFR, Part 1306.07(b)
Primary Goal?

Keep the patient alive!!
To attain long term recovery maintained with or without medication and provide protection from overdose and death while improving physical, emotional and psychological health.
Emergency Department Evaluation

• Patient presents with signs and symptoms of drug use (opioid withdrawal, OD, infection) or seeking treatment

• Urine Drug Screen (UDS) positive for opioids or buprenorphine **NOT Methadone**

• Make the diagnosis of OUD. Patient is screened for OUD (Diagnostic and Statistical Manual V) and withdrawal severity – 2 min Rapid Opioid Dependence Screen (RODS)

• Withdrawal assessment - Clinical Opioid Withdrawal Scale (COWS)
Emergency Department Evaluation

• Brief Negotiation Interview (BNI) + Medication treatment initiated in the ED if patient is willing
• Refer to treatment or “Warm Hand-off”
• Peer Support evaluates patient in the ED and arranges outpatient follow-up
• Offer take-home naloxone kit to patient and family
Overdose Triad

- Pinpoint Pupils
- Respiratory Depression
- Unconscious

Relationships:
- Pinpoint Pupils to Respiratory Depression
- Respiratory Depression to Unconscious
- Unconscious to Pinpoint Pupils
NALOXONE

You hear about it all the time, but you never think it’ll be you. I just remember coming round. My boyfriend was holding me up, I couldn’t even feel my legs. I fought to stand up but couldn’t. He was crying, I thought I was dead. He saved my life. It’s made me think about keeping myself safe from now on.

NALOXONE CAN TEMPORARILY REVERSE THE EFFECTS OF OPIOID OVERDOSE.

For more information on being supplied with and trained to use naloxone, ask at your local drug service or needle exchange.

www.naloxone.org.uk / www.sdf.org.uk

The ONLY thing Narcan enables is breathing.
Confirm the Diagnosis of Opioid Use Disorder (DSM-V)
Opioid Use Disorder Criteria:

A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, 4-5 is moderate, and 6-7 is severe.

#10 and 11 must be accompanied by other criteria to make the diagnosis of OUD
1. Taking the opioid in larger amounts and/or for longer or more frequently than intended.
2. Wanting to cut down or quit but not being able to do so.
3. Spending a lot of time obtaining the opioid, under the influence, or recovering from the effects of it.
4. Craving or a strong desire to use opioids.
5. Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
6. **Continued use despite** persistent or recurring social or interpersonal problems caused or made worse by opioid use.

7. **Stopping** or reducing important social, occupational, or recreational activities due to opioid use.

8. Recurrent use of opioids in physically hazardous situations.

9. **Consistent use** of opioids despite acknowledgment of persistent or recurrent **physical or psychological difficulties** from using opioids.

10. **Tolerance** as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount.

11. **Withdrawal** manifesting as either characteristic syndrome or the substance is used to avoid withdrawal.
RODS

Takes about 2 minutes

doi:10.1177/1078345814557513
Withdrawal screening

COWS scale
- **Mild**—no medication
- **Moderate**—initiate medication
- **Severe**—initiate medication and extended observation and possible more medication

Post overdose resuscitation patients
## Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient’s signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time (military):</th>
</tr>
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<table>
<thead>
<tr>
<th><strong>Resting Pulse Rate:</strong></th>
<th>beats/minute</th>
</tr>
</thead>
<tbody>
<tr>
<td>0...pulse rate 50 or below</td>
<td>1...pulse rate 80-100</td>
</tr>
<tr>
<td>2...pulse rate 101-120</td>
<td>4...pulse rate greater than 120</td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>GI Upset:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Over past 1/2 hour</td>
</tr>
<tr>
<td>0...no GI symptoms</td>
</tr>
<tr>
<td>1...stomach cramps</td>
</tr>
<tr>
<td>2...nausea or loose stool</td>
</tr>
<tr>
<td>3...vomiting or diarrhea</td>
</tr>
<tr>
<td>4...multiple episodes of diarrhea or vomiting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Sweating:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Over past 1/2 hour not accounted for by room temperature or patient activity</td>
</tr>
<tr>
<td>0...no report of chills or flushing</td>
</tr>
<tr>
<td>1...subjective report of chills or flushing</td>
</tr>
<tr>
<td>2...flushed or observable moisture on face</td>
</tr>
<tr>
<td>3...beads of sweat on brow or face</td>
</tr>
<tr>
<td>4...sweat streaming off face</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Tremor:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation of unthreatened hands</td>
</tr>
<tr>
<td>0...No tremor</td>
</tr>
<tr>
<td>1...tremor can be felt, but not observed</td>
</tr>
<tr>
<td>2...slight tremor observable</td>
</tr>
<tr>
<td>3...gross tremor or muscle twitching</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Restlessness:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation during assessment</td>
</tr>
<tr>
<td>0...able to sit still</td>
</tr>
<tr>
<td>1...reports difficulty sitting still, but is able to do so</td>
</tr>
<tr>
<td>2...frequent shifting or extraneous movements of legs/arms</td>
</tr>
<tr>
<td>3...Unable to sit still for more than a few seconds</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Pupils:</strong></th>
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<tbody>
<tr>
<td>0...pupils pinned or normal size for room light</td>
</tr>
<tr>
<td>1...pupils possibly larger than normal for room light</td>
</tr>
<tr>
<td>2...pupils moderately dilated</td>
</tr>
<tr>
<td>3...pupils so dilated that only the rim of the iris is visible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Yawning:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation during assessment</td>
</tr>
<tr>
<td>0...no yawning</td>
</tr>
<tr>
<td>1...yawning once or twice during assessment</td>
</tr>
<tr>
<td>2...yawning three or more times during assessment</td>
</tr>
<tr>
<td>3...yawning several times/minute</td>
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<table>
<thead>
<tr>
<th><strong>Mental Status:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>0...alert</td>
</tr>
<tr>
<td>1...somewhat drowsy</td>
</tr>
<tr>
<td>2...drowsy</td>
</tr>
<tr>
<td>3...confused</td>
</tr>
<tr>
<td>4...unoriented</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>Bone or Joint aches:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>0...not present</td>
</tr>
<tr>
<td>1...mild diffuse discomfort</td>
</tr>
<tr>
<td>2...patient reports severe diffuse aching of joints/muscles</td>
</tr>
<tr>
<td>3...patient is rubbing joints or muscles and is unable to sit still because of discomfort</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Runny nose or tearing:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not accounted for by cold symptoms or allergies</td>
</tr>
<tr>
<td>0...not present</td>
</tr>
<tr>
<td>1...nasal stuffiness or unusually moist eyes</td>
</tr>
<tr>
<td>2...nose running or tearing</td>
</tr>
<tr>
<td>3...nose constantly running or tears streaming down checks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Dry mouth:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>0...not present</td>
</tr>
<tr>
<td>1...mild dryness</td>
</tr>
<tr>
<td>2...moderate dryness</td>
</tr>
<tr>
<td>3...severe dryness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Goose flesh:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>0...skin is smooth</td>
</tr>
<tr>
<td>1...piloerection of skin can be felt or hairs standing up on arms</td>
</tr>
<tr>
<td>2...patients feel discomfort</td>
</tr>
</tbody>
</table>

| **The total score is the sum of all 13 items:** |

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Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

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Provided by: Physician Clinical Support System, (877) 630-8872; PCSSproject@asan.org; www.PCSSmonitor.org
ED Treatment

1. Brief Negotiation Interview
2. Buprenorphine Sublingual
   - must be in moderate (COWS>8) to severe withdrawals
   - can be administered in ED but no prescription unless waived provider (72 hour rule)
3. Overdose Education Kit
4. Referral or Warm Hand off with Peer Support
Brief Negotiating Interview (BNI)

**Raise the Subject**
- Establish rapport
- Raise the subject of drug use
- Assess comfort

**Provide Feedback**
- Review patient’s substance use and patterns
- Make connection between substance use and negative consequences (e.g., impaired judgement leading to injury, unprotected sex/sharing needles)
- Make a connection between substance use and ED visit
Assess Readiness to Change

On a scale of 1 to 10 how ready are you to stop using, cut back or enroll in a program???

(Why didn’t you pick a lower number?)
MAT: MEDICATION ASSISTED TREATMENT
BUPRENORPHINE

Partial opioid agonist
Ceiling effect: much safer, less euphoriant

Higher receptor affinity than almost any other opioid:
Will precipitate withdrawal if not in withdrawal

Less abuse-prone and blocks more abuse-prone opioids

Buprenorphine is uniquely suited to treat opioid addiction: less dangerous, less abuse-prone vs. methadone, more likely to abolish craving, protects users from OD by more dangerous opioids
ED-Initiated Buprenorphine

Diagnosis of Moderate to Severe Opioid Use Disorder

Assess for opioid type and last use
Patients taking methadone may have withdrawal reactions to buprenorphine up to 72 hours after last use
Consider consultation before starting buprenorphine in these patients

(COWS)

Dosing: None in ED
Waivered provider able to prescribe buprenorphine?

YES

Unobserved buprenorphine induction and referral for ongoing treatment

NO

Referral for ongoing treatment

(0-7) none - mild withdrawl

(Dosing: 4-8mg SL*)
Observe for 45-60 min
No adverse reaction

If initial dose 4mg SL repeat 4mg SL for total 8mg

Observe **

Waivered provider able to prescribe buprenorphine?

YES

Prescription
16mg dosing for each day until appointment for ongoing treatment

NO

Consider return to the ED for 2 days of 16mg dosing (72-hour rule)
Referral for ongoing treatment

Notes:
*Clinical Opioid Withdrawal Scale (COWS) ≥ 13 (Moderate-Severe) consider starting with 8 mg buprenorphine or buprenorphine/naloxone SL.
** Patient remains in moderate withdrawal may consider adding additional 4mg and observation for 60 minutes
Warm hand-offs with specific time & date to opioid treatment providers/ programs within 24-72 hours whenever possible
All patients should be educated regarding dangers of benzodiazepine and alcohol co-use
Ancillary medication treatments with buprenorphine induction are not needed.

Source.drugabuse.gov
A Guide for Patients Beginning Buprenorphine Treatment at Home

Before you begin you want to feel very sick from your withdrawal symptoms

It should be at least...
- 12 hours since you used heroin/fentanyl
- 12 hours since snorted pain pills (Oxycontin)
- 16 hours since you swallowed pain pills
- 48-72 hours since you used methadone

You should feel at least three of these symptoms...
- Restlessness
- Heavy yawning
- Enlarged pupils
- Runny nose
- Body aches
- Tremors/twitching
- Chills or sweating
- Anxious or irritable
- Goose pimples
- Stomach cramps, nausea, vomiting or diarrhea

Once you are ready, follow these instructions to start the medication

**DAY 1:**
8-12mg of buprenorphine
Most people feel better the first day after 8-12mg. (Dosing depends on how early on the first day you started)

**Step 1.**
Take the first dose
- 4mg
- Wait 45 minutes
- Put the tablet or strip under your tongue
- Keep it there until fully dissolved (about 15 min.)
- Do NOT eat or drink at this time
- Do NOT swallow the medicine

**Step 2.**
Still feel sick?
- Take next dose
- Still uncomfortable?
- Take last dose
- Most people feel better after two doses = 6mg
- Stop

**Step 3.**
Wait 6 hours
- Stop after this dose
- Do not exceed 12mg on Day 1

**DAY 2:**
16mg of buprenorphine
Take one 16mg dose
- Most people feel better with a 16mg dose
- Repeat this dose until your next follow-up appointment

If you develop worsening symptoms while starting buprenorphine before your scheduled outpatient appointment return to the emergency department.

Source.drugabuse.gov
<table>
<thead>
<tr>
<th>Carrying</th>
<th>Carry Naloxone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using</td>
<td>Never Use Alone</td>
</tr>
<tr>
<td>Don’t Combine</td>
<td>Don’t Combine Opioids with Other Substances (alcohol, benzodiazepines, or other sedatives)</td>
</tr>
<tr>
<td>Diverting</td>
<td>Divert Low Level Crimes from the Criminal Justice System to Community Based Treatment Services</td>
</tr>
<tr>
<td>Do Not SHARE</td>
<td>Do Not SHARE Injection/Snorting or Smoking Equipment</td>
</tr>
</tbody>
</table>
Prescribe or Distribute Naloxone

**Naloxone Nasal Spray**

- Food and Drug Administration (FDA) Approval – November 2015, 4 mg in 0.1 mL
- Single dose, one nostril
- Very rapid delivery
- Repeat within 2-3 minutes as needed

*Price: low (<$100, 2 pack) & free or insurance covered in many states*

**I Save Florida**

Naloxone Locator, Resources and Toolkit [https://www.isavefl.com](https://www.isavefl.com)
Naloxone Kits – Resource for EDs

Amanda Muller
Overdose Prevention Coordinator
Office of Substance Abuse and Mental Health
Florida Department of Children and Families
1317 Winewood Blvd., Bldg. 6, Room 219
Tallahassee, FL 32399
Office: (850) 717-4431
Cell: (850) 631-0212
Amanda.Muller@myflfamilies.com
Referral or Warm Hand off with Peer Support

- Know Your Local Resources
- Is there an Opioid Treatment Program (OTP), Primary Care Practice, Residential Clinic, Federally Qualified Health Center (FQHC) that will take a “warm hand off?”
- Insurance/funding?
- Champions in the ED /Waivered Physicians
- Social Work
- Peer Support
Peer Support

• Literally a person that has a history of OUD that is in recovery to physically come to the ED and start talking with the patient
• Help educate about treatment options and harm reduction
• Help facilitate ongoing treatment after leaving the ED

A growing body of evidence suggests that peer support workers can effectively connect individuals suffering from opioid use disorder with proper treatment and recovery interventions, often to greater effect than primary care or clinical behavioral staff.

Anticipate resistance, particularly around ANY increased workload across all staff

What motivates different key stakeholders?

- Reducing repeated ED visits or psych holds
- Staff safety
- Length of stay
- Patient Satisfaction

Change culture by engaging all stakeholders

It takes time for change
Don’t wait for a perfect protocol or system? Just start somewhere – even if it is education

Make it as simple as possible for providers and patients

“This is about improving patient care”
Concerns, Realities and Solutions Regarding OUD and Buprenorphine Treatment in the ED
CONCERN: Addiction is a moral failing; patients keep coming back to the ED time and time again.

REALITY: Addiction is a chronic and relapsing disease that can be effectively treated with opioid agonist therapies. Emergency physician often see a skewed sample of patients not in treatment.

SOLUTION: Provide patient-specific feedback to ED providers on success stories regarding engagement in treatment.
CONCERN: Providing buprenorphine to patients will lead to diversion.

REALITY: There is less diversion of buprenorphine than of other opioids. Buprenorphine bought off the streets is often used to reduce withdrawal symptoms. Every buprenorphine pill taken is one less opportunity for overdose, complication of injection drug use or death.

SOLUTION: Offer limited supplies, preferably 2-7 days’ worth of treatment, until an appointment with a community provider or program can be arranged.

Emergency Departments – A 24/7/365 Option for Combating the Opioid Crisis. Gail D’Onofrio, MD, Ryan P. McCormack, MD and Kathryn Hawk, MD, MHS
CONCERN: Initiating buprenorphine treatment is complicated and the ED is already crowded and chaotic.

REALITY: Buprenorphine is safer and more predictable than many medications used in routine ED practice. Treatment can be accomplished in less time than an urgent care visit.

SOLUTION: Integrate protocols electronically into the ED workflow from triage to discharge that engage all providers in order to facilitate a simplified and streamlined process. Identify a cadre of champions available to treat new prescribers.

Emergency Departments – A 24/7/365 Option for Combating the Opioid Crisis. Gail D’Onofrio, MD, Ryan P. McCormack, MD and Kathryn Hawk, MD, MHS
CONCERN: There is a lack of referral sites for patients who have initiated buprenorphine treatment.

REALITY: Most communities have treatment resources of which the ED staff are unaware.

SOLUTION: Partner and develop relationships with community resources and local health departments to permit efficient referral and feedback. Hire an ED staff member such as a health promotion advocate, which is helpful and cost-effective.
CONCERN: Patients will flock to the ED for treatment.

REALITY: Patients with OUD are already in the ED. Sites with ED-initiated buprenorphine do not report an uptake of patients seeking treatment.

SOLUTION: Initiate treatment protocols at triage to promote rapid assessment, treatment and referral.
CONCERN: Many patients don’t want treatment anyway.

REALITY: Some patients, often after an overdose are not ready for treatment after a brief psychosocial intervention, but discussion may lead to a change in motivation in the future. The ED visit is often a missed opportunity to engage patients who may be contemplating a positive change but need guidance and support.

SOLUTION: Introduce harm reduction strategies such as overdose prevention and naloxone distribution. Establish rapport to facilitate improved outcomes.
**CONCERN:** Obtaining a waiver to prescribe buprenorphine is too burdensome.

**REALITY:** The training required to obtain a waiver can be done all online or as half-day courses coupled with half-day online services. Most training is free and similar to other required learning and counts toward CME requirements for specialty certification, recertification and licensing in many states.

**SOLUTION:** Identify resources online and at institutions using the Substance Abuse and Mental Health Services Administration and American Society of Addiction Medicine websites.
30,000 annual visits

APC wanted to make a difference with OUD

Created relationship with local OUD clinic

In-service on buprenorphine induction in ED

No X-waiver required
Results

Slow going—14 months

-35 patients
-94% made it to first aftercare visit
-70% still in treatment at 30 days

“These are low-volume but high-risk and high-impact situations. Compare this to stroke. In our emergency department last year, we gave tissue plasminogen activator 15 times. Like many of you who are medical directors in emergency departments, I have spent an amazing amount of time working on systems of care for our stroke patients, with perhaps much more doubtful impact than recovery can have on a life.”
Benefits and Development

Clear **benefits** to patients – lives saved

Less recidivism in ED

Rewarding for ED physicians

- “While patients with OUD can sometimes be ‘difficult,’” I would argue that much of the stigma and bias surrounding these patients come from our frustration with the situation.”

- Not just giving a phone number, but starting life saving treatment in the ED
Benefits and Development

Development:

- Need partnerships with local recovery centers
- Standard protocols for screening, dosing, and referral should be in place to make the process easy for providers and patients
Summary

1. We are in the midst of an Opioid Crisis
2. OUD is a Chronic Disease of the Brain
3. Medication Assisted Treatment improves many outcome measures
4. There are interventions that can be initiated in the Emergency Department for patients with OUD