Session I—Treatment for Opioid Use Disorder: Exploring Effective Approaches and Models of Care

Moderator: Mark McClellan, Duke-Margolis Center for Health Policy

Panelists:
- Colleen LaBelle, Boston Medical Center
- Kathryn Cates-Wessel, American Academy of Addiction Psychiatry
- Gail D’Onofrio, Yale Medicine
- Yngvild Olsen, Institute for Behavior Resources, Inc

Join the conversation at #OUDTreatment #EndTheStigma
Polling Question #2

What is the biggest challenge for health systems and/or providers that would like to implement a coordinated approach to OUD treatment? (Choose the best answer)

- Need for additional evidence on which models work
- Need for additional funding resources
- Need for additional training or education
- Need for additional institutional support
- Need for legal or regulatory changes
- Other

In person attendees—participate by entering the following URL into your web browser on your phone or laptop: [http://bit.ly/dukemargolis](http://bit.ly/dukemargolis)

Webcast—participate via chat box at the bottom right of your screen.
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Expanding Access to Effective Treatment for Opioid Use Disorder: Provider Perspective on Reducing Barriers to Evidence-Based Care
Duke-Margolis Center for Health Policy and U.S. Food and Drug Administration
September 20, 2018
DISCLOSURES

• I have no personal or financial conflicts of interest to disclose

Funding support provided by Massachusetts Department of Public Health, Bureau of Addiction Services
In 2003, Boston Medical Center developed the Nurse Care Manager model for Office Based Addiction Treatment (OBAT) in response to need for sustainable and effective addiction treatment in primary care settings.
BACKGROUND: Nurse Care Manager Model for OBAT

Nurse Care Managers increase patient access to treatment and retention in care

• Efficient and effective utilization of waived prescribers
• High quality management of chronic medical condition
• Able to address social determinants of health

What makes the NCM OBAT model successful?

Nurse care managers increase patient access to treatment!

- Frequent follow-ups
- Case management
- Able to address
  - positive urines
  - insurance issues
  - prescription/pharmacy issues
- Pregnancy, acute pain, surgery, injury
- Concrete service support
  - Intensive treatment, legal/social issues, safety, housing
- Brief counseling, social support, patient navigation
- Support providers with large case loads
Due to the success of the Nurse Care Manager OBAT Program at BMC…

..in 2007 the MA Department of Public Health (DPH) funded BMC to expand access to addiction treatment across the state using the nurse care manager or “Massachusetts Model”
RESULTS: NO. OF CHCs FUNDED BY MA DPH TO IMPLEMENT BMC OBAT MODEL BY YEAR
RESULTS: CUMULATIVE NO. OF PATIENTS TREATED BY YEAR AT MA DPH FUNDED SITES

Year | Number of Patients
--- | ---
2007 | 178
2008 | 1252
2009 | 2175
2010 | 3030
2011 | 4091
2012 | 5160
2013 | 5896
2014 | 6762
2015 | 7831
2016 | 9727
2017 | 12487
2018 | 16573
**RESULTS: HEALTH CARE UTILIZATION OUTCOMES MA OBAT SITES**
**JUL 1 2016 – JUN 30, 2017 (N=3,309)**

<table>
<thead>
<tr>
<th>% of patients in STATE OBAT Program</th>
<th>Inpatient, ED admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1+ night inpatient hospital (past 3 mos.)</strong></td>
<td>6.7% (In Tx ≤ 12 mos.)</td>
</tr>
<tr>
<td></td>
<td>4.8% (In Tx &gt;12 mos.)</td>
</tr>
<tr>
<td><strong>1+ ED visit (past 3 mos.)</strong></td>
<td>20.5% (P&lt;.01)</td>
</tr>
<tr>
<td></td>
<td>12.7% (In Tx &gt;12 mos.)</td>
</tr>
</tbody>
</table>

P-values:
- **P=.02** for In Tx ≤ 12 mos.
- **P=.02** for In Tx >12 mos.
**Results: Urine Toxicology Outcomes MA OBAT Sites**

Jul 1 2016 – Jun 30, 2017 (n=3,309)

<table>
<thead>
<tr>
<th>Substance</th>
<th>In Tx ≤ 12 mos.</th>
<th>In Tx &gt;12 mos.</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illicit opioids (past 3 mos.)</td>
<td>25.2%</td>
<td>10.7%</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Cocaine (past 3 mos.)</td>
<td>15.2%</td>
<td>8.9%</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Benzodiazepines (past 3 mos.)</td>
<td>23.0%</td>
<td>9.5%</td>
<td>&lt;.01</td>
</tr>
</tbody>
</table>

Retention in OBAT Positive urine toxicology screens
Retention in treatment at MA DPH funded OBAT Sites

- Retained in care ≤12 months: 44.8%
- Retained in care >12 months: 55.2%

**Results: Retention in Treatment July 2016 – June 2017**

(N=3,309)
We have shown success scaling in Massachusetts and are now sharing our learnings nationally.

NIDA CTN-0074: Primary Care Opioid Use Disorders Treatment (PROUD) Trial
• Testing BMC Nurse Care Manager Model against standard of care in 6 health systems nationwide in ~10,000 patients
AN EVOLVING EPIDEMIC REQUIRES…

✓ Investment in proven models of care and a workforce to implement them
✓ Flexibility
  • Responsive to current and changing needs
✓ Innovation

Nurses will continue to play key role in addressing the current epidemic of addiction and overdose deaths.
The Boston Globe
Salute to Nurses
Thank you for your time and attention

Colleen LaBelle
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617-797-6712
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Opioid Use Disorders: A Public Health Priority

American Academy of Addiction Psychiatry
Kathryn Cates-Wessel
AAAP CEO
Providers’ Clinical Support System (PCSS)

PCSS funded by SAMHSA to provide training and mentoring at NO COST to health professionals in evidence-based practices in the prevention, identification and treatment of substance use disorders with a focus on opioid use disorders.
PCSS Target Audience

- Primary Care Health Providers
  - Prescribers: physicians, psychiatrists, dentists, nurse practitioners, and physician assistants
  - Allied health professionals—nurses, social workers, psychologists, counselors, pharmacists, etc.
PCSS Partner Organizations

- Addiction Technology Transfer Center
- American Academy of Addiction Psychiatry
- American Academy of Family Physicians
- American Academy of Neurology
- American Academy of Pain Medicine
- American Academy of Pediatrics
- American College of Emergency Physicians
- American College of Physicians
- American Dental Association
- American Medical Association
- American Osteopathic Academy of Addiction Medicine
- American Psychiatric Association
- American Psychiatric Nurses Association
- American Society of Addiction Medicine
- American Society for Pain Management Nursing
- International Nurses Society on Addictions
- National Association of Community Health Centers
- National Association of Drug Court Professionals
- Association for Medical Education and Research in Substance Abuse
- Southeastern Consortium for Substance Abuse Training/ Mercer University
PCSS offers to health professionals **no-cost** training resources with continuing education directed to primary care, through several formats:

- **Webinars** (Live and On-demand)
- **Online Modules** - flipped classroom
- **Case Vignettes**
- **Podcasts**
- **Small Group Discussions**
- **MAT Waiver Trainings**
- **Clinical Coaching/Mentoring**
PCSS Highlights

PCSS Stats
Data as of Aug. 1 2013 – August 1, 2018

- 642 Webinars and online Modules
  119,064 Participants

- 896 MAT waiver trainings
  15,059 participants

- 468 clinicians have participated in Small Group Discussions

- 151 Mentors, 746 mentees and growing
7 State Initiative: “Connecting the Dots”
Pennsylvania Hospital Becomes OUD Treatment Model After Working with PCSS During Pilot Program

Hanover Hospital and its affiliated healthcare clinics has become a model for how a healthcare system that is fully engaged in embracing evidence-based treatment of opioid use disorders can make significant change.

A little more than a year ago, PCSS reached out to Hanover Hospital to participate in a five-state pilot program to create a medication assisted treatment (MAT) program. Since then, PCSS has worked closely with clinicians, administrators, and support staff to increase understanding of preventing, identifying, and treating OUD. [Read more]
On February 1, 2018, SAMHSA awarded the American Academy of Addiction Psychiatry (AAAP) and a coalition of 22 national healthcare and professional organizations a two-year grant to provide technical assistance to all U.S. states and territories to address the opioid crisis.
Partner Organizations and Individuals

- American Academy of Family Physicians (AAFP)
- American College of Emergency Physicians (ACEP)
- American College of Physicians (ACP)
- American Medical Association (AMA)
- Association for Medical Education and Research in Substance Abuse (AMERSA)
- American Osteopathic Academy of Addiction Medicine (AOAAM)
- American Psychiatric Association (APA)
- Boston Medical Center (BMC)
- Coalition of Physician Education (COPE)
- Council of Social Work Education (CSWE)
- National Association for Community Health Centers (NACHC)

- National Association of Drug Court Professionals (NADCP)
- National Alliance for HIV Education and Workforce Development (NAHEWD / AETC)
- National Council for Behavioral Health (NCBH)
- Physician Assistant Education Association (PAEA)
- Research Foundation for Mental Hygiene (Columbia)
- Strengthening Families
- Holly Echo-Hawk, PhD
- Karen Oliver, PhD
- Roger Chou, MD
TA Requests Across U.S.

May 1 - Sept. 4, 2018: 214 TA requests; 22 unique states; 6 unique territories

TA Requests by State
n = 200 (Aug 22, 2018)
Overview of the TA Request Workflow Steps

1. TA requested
2. TA logged in TA Management System (TAMARO)
3. Determination of Need (DON) conducted
4. Duplication Avoidance ensured
5. Intensive TA approved (if applicable)
6. Assignment of TA provider(s) made
7. Action Plan developed
8. TA services provided
9. TA request closed
Who Can Submit a Request?

Anyone!

If you need technical assistance to support evidence-based practices in the prevention, treatment and recovery of opioid use disorders in your community, submit a request to www.getSTR-TA.org.

www.getSTR-TA.org | str-ta@aaap.org | 401-270-5900
Across Projects Lessons Learned

- Local is key
- Stigma is HUGE — general community and within medicine
- SUD 101 required
- Collaboration is essential
- MAT is more than just prescribing
- MAT is NOT one medication
- Systems are needed — templates, workflow charts, business plans
Lessons Learned

- More than just educating prescribers
  - Multidisciplinary teams are vital (nurses, pharmacists, dentists, justice, counselors, psychologists, administrative/billing, CEO and the general community) are required

- One size does **not** fit all
- Mental health disorders cannot be ignored
- It takes time but vital to real change.
Together We Can Make a Difference

www.aaap.org
www.pcssNOW.org
www.getSTR-TA.org

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The 24/7/365-day Option
To Fight the Opioid Crisis
EDs and Emergency Physicians can...

- Identify patients with OUD
- Provide treatment
  - Initiate buprenorphine
  - Overdose education and naloxone distribution
- Directly link patient to continued opioid agonist therapy & preventative services
What is the Evidence?
A Randomized Trial of ED-Initiated Interventions for Opioid Dependence

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

D’Onofrio, G., O’Connor, P.G., Pantalon, M.V., Chawarski, M.C., Busch, S.H., Owens, P.H., Bernstein, S.L. and Fiellin, D.A.

Importance
Opioid-dependent patients often use the emergency department (ED) for medical care.

Objective
To test the efficacy of 3 interventions for opioid dependence: (1) screening and referral to treatment (referral); (2) screening, brief intervention, and facilitated referral to community-based treatment services (brief intervention); and (3) screening, brief intervention, ED-initiated treatment with buprenorphine/naloxone, and referral to primary care for 10-week follow-up (buprenorphine).

Design, Setting, and Participants
A randomized clinical trial involving 329 opioid-dependent patients who were treated at an urban teaching hospital ED from April 7, 2005, through June 25, 2013.

Interventions
After screening, 104 patients were randomized to the referral group, 111 to the brief intervention, and 114 to the buprenorphine group.
MAT: 2x More Likely to be Engaged in Addiction Treatment at 30 Days

Proportion in Treatment at 30 Days

- Referral
- Brief Intervention
- Buprenorphine

P < 0.001
Cost-effective acceptability curve: base case analysis.
(a) Willingness-to-pay for a 1 percentage point increase in the probability a patient is engaged in treatment 30-days post-enrollment.
(b) Willingness-to-pay for 1 additional opioid-free day in the past 7-days

Busch et al., Addiction 2017
The latest research shows that we really should do something with all this research.
Integrating Research Into Practice

Project Assert

Yale School of Medicine
An E.R. That Treats Opioid Use as an Emergency

By ABBY GOODNOUGH

OAKLAND, Calif. — Every year, thousands of people addicted to opioids show up at hospital emergency rooms in withdrawal so agonizing it leaves them moaning and writhing on the floor.

THE TREATMENT GAP
Help on Demand

Usually, they're given medicines that help with vomiting or diarrhea and sent on their way, maybe with a few numbers to call about treatment.

When Rhonda Hausworth arrived at the Highland Hospital E.R. here, retching and shaking violently after a day and a half without heroin, something very different happened. She was offered a dose of buprenorphine on the spot. One of three medications approved in the United States to treat opioid addiction, it works by easing withdrawal symptoms and cravings. The tablet dissolved under her tongue while she slumped in a plastic chair, her long red hair obscuring her ashen face.

Soon, the shakes stopped. "I could focus a little more. I could see straight," said Ms. Hausworth, 40. "I'll never heard of anyone going to an emergency room to do that."

Highland, a bustling big-city hospital where security wands constantly beep as new patients get scanned for weapons, is among a small group of institutions that have started initiating opioid addiction treatment in the E.R. Their aim is to plug a gaping hole in a medical system that consistently fails to provide treatment on demand, or any evidence-based treatment at all, even as more than two million Americans suffer from opioid addiction.

According to the latest estimates, overdoses involving opioids killed nearly 50,000 people last year. By providing buprenorphine around the clock to people in crisis — who may never otherwise seek medical care — these E.R.s are doing their best to ensure a rare opportunity isn't lost. "With a single E.R. visit we can provide 24 to 48 hours of withdrawal suppression, as well as suppression of cravings," said Dr. Andrew Herring, an emergency medicine specialist at Highland who runs the buprenorphine program. "It can be a revolutionary Continued on Page 20
BARRIERS

SOLUTIONS
Websites

https://medicine.yale.edu/edbup
https://www.drugabuse.gov/ed-buprenorphine
## Concerns, Reality & Solutions

<table>
<thead>
<tr>
<th>Concern</th>
<th>Reality</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction is a moral failing, patients keep coming back time and time again</td>
<td>Addiction is in fact a chronic and relapsing disease that can be effectively treated with opioid agonist therapies. EP’s often see a skewed sample of patients not in treatment.</td>
<td>Provide patient specific feedback to ED providers on success stories</td>
</tr>
<tr>
<td>Diversion of buprenorphine</td>
<td>There is less diversion of bup than other opioids. When bup is bought off the street it is often used to reduce withdrawal symptoms.</td>
<td>Limited supplies are offered, preferably 2-7 days, until a referral appt is made</td>
</tr>
<tr>
<td>Initiating buprenorphine is complicated and the ED is already crowded and chaotic</td>
<td>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.</td>
<td>Protocols integrated electronically into the ED workflow, can facilitate a streamlined process</td>
</tr>
<tr>
<td>Initiating buprenorphine will increase length of stay</td>
<td>Bup will decrease LOS and reduce the potential for violent behaviors. Instead of symptomatic cocktails, bup reduces withdrawal in 20-30 minutes.</td>
<td>Protocols &amp; knowledgeable staff can result treat and release times of 60-90 minutes</td>
</tr>
<tr>
<td>Concern</td>
<td>Reality</td>
<td>Solution</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Lack of referral sites</td>
<td>Most communities have treatment resources that the ED staff is unaware exist.</td>
<td>Developing relationships with community resources and health departments</td>
</tr>
<tr>
<td>Patients will return repeatedly for redosing</td>
<td>This has not happened at sites consistently offering buprenorphine.</td>
<td>Treatment plans can be developed. Withdrawal can be treated with bup &amp; referral</td>
</tr>
<tr>
<td>Patients will flock here for treatment</td>
<td>Patients with OUD are already in the ED. Sites with ED-initiated buprenorphine do not report an uptake of patients seeking treatment</td>
<td>Treatment protocols initiated at triage will promote rapid assessment, treatment and referral</td>
</tr>
<tr>
<td>Many patients do want treatment anyway.</td>
<td>The ED visit is a missed opportunity to engage patients who may be contemplating a positive change but need guidance and support.</td>
<td>Harm reduction strategies “OD prevention and naloxone distribution” can be life-saving. Positive behavior change is often incremental.</td>
</tr>
<tr>
<td>Obtaining a waiver is too burdensome</td>
<td>The training is online ½ day courses with ½ on line. Most trainings are free.</td>
<td>Resources identified on SAMHSA &amp; ASAM websites. Departments can offer faculty development or group learning</td>
</tr>
</tbody>
</table>
Policy Changes

• Shorter and enhanced training specific for ED providers to obtain x-waivers
• Ability to prescribe short courses from the ED without a waiver (up to 1-2 weeks)
• Availability of longer acting preparations
Need help with pain pills or heroin?

We want to help you get off opioids and started on Suboxone (Buprenorphine).

Ask here for more information.
The 24/7/365-day Option

Change the trajectory of the opioid epidemic
Questions?
Buprenorphine Integration Pathway

1. ED presentation
   - Seeking Treatment
   - Screen Positive
   - Complication of Drug Use
     - Withdrawal
     - Overdose
     - Infection
   - Identified during the course of the visit

2. Assess
   - Identification of OUD based on DSM-5
   - Clinical Opioid withdrawal Scale (COWS)

3. Treat
   - BNI Buprenorphine algorithm

4. Discharge & Refer to Treatment
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

(0-7) none - mild withdrawal
(≥8) mild - severe withdrawal

Dosing:
None in ED

Waivered provider able to prescribe buprenorphine?

YES

Unobserved buprenorphine induction and referral for ongoing treatment

NO

Referral for ongoing treatment

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
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 yawns
  - 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
  - Wait 45 minutes
  - 4mg
  - 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
  - Wait 6 hours
  - Still uncomfortable? Take last dose
  - Stop
  - Most people feel better after two doses = 8mg
  - Stop after this dose
  - Do not exceed 12mg on Day 1

DAY 2:
16mg of buprenorphine

- Step 3.
  - 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
ED Initiated Buprenorphine & Referral to Treatment
A brief guide for ED Practitioners

Why the ED?
Because that’s where the patients are!
The opioid epidemic is strongly impacting EDs, with 2018 data from the CDC indicating there has been a 30% increase in visits for opioid overdose from July 2016 - September 2017.
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.

What is the evidence?
A 2015 study (JAMA) found that twice as many patients were in OUD treatment at 30 days (~80%) with ED-initiated buprenorphine & a brief negotiation interview (BNI) compared with referral only or a BNI facilitated referral and used less illicit opioids in the last 7 days. 1

What do I need to know about buprenorphine?
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 HCV or HIV and have fewer injection drug use complications and contacts with the criminal justice system. 2
Since 2002 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.
Buprenorphine is a partial agonist at the mu opioid receptor, where it has a very high affinity but low intrinsic activity. Its high affinity means it will out-compete and displace full opioid agonists. It is administered when the patient exhibits withdrawal symptoms (COWS > 8). Its low intrinsic activity results in less euphoria and lower diversion potential.

How does it work?

RESPONDING TO THE OPIOID EPIDEMIC
Opioid-related ED visits are escalating and EPs are finding themselves on the front lines, with little preparation or tools to combat this crisis.
What can you do?
Prescribe opioids safely
• Identify patients receiving high doses of opioids
• Use prescription monitoring systems
• Avoiding drug combinations that might increase OD risk, especially benzodiazepines
Increase access to medication treatments
• Initiating buprenorphine and referral
Offer harm reduction strategies
• Overdose prevention education and training
• Prescribe Naloxone

Because that’s where the patients are!

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• Initiating buprenorphine and referral
Offer harm reduction strategies
• Overdose prevention education and training
• Prescribe Naloxone

Because that’s where the patients are!
# How to assess for OUD?

**Questions for identification of Opioid Use Disorder based on DSM-5**

1. Have you found that when you started using, you ended up taking more than you intended to?
2. Have you ever had to stop or cut down on using opioids?
3. Have you spent a lot of time getting or using opioids?
4. Have you missed work or school or often arrived late because you were intoxicated, high or recovering from the night before?
5. Have you used opioids even though other people such as family members, friends or people at work noticed a change in your behavior or appearance?
6. Have you had to keep repeating the same steps to get the desired effect?
7. Have you been in trouble with the law because of your drug use?
8. Have you forced yourself to get more opioids when you were not even in pain?
9. Have you continued to use even though you knew that the drug caused you problems like making you depressed, anxious, agitated or irritable?
10. Have you found you needed to use much more drug to get the same effect than you did when you first started taking it?
11. When you reduced or stopped using, did you have withdrawal symptoms or felt sick when you cut down or stopped using?

Moderate Opioid Use Disorder: 4–5 symptoms, Severe Opioid Use Disorder: 6 or more symptoms

## How to assess for withdrawal?

**Clinical Opioid Withdrawal Scale (COWS)**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restlessness</td>
<td>1-2 times (1)</td>
</tr>
<tr>
<td>Anxiety or irritability</td>
<td>3</td>
</tr>
<tr>
<td>Yawning</td>
<td>2</td>
</tr>
<tr>
<td>Pupil Size</td>
<td>Normal (1)</td>
</tr>
<tr>
<td>Runny Nose or Tearing</td>
<td>Not present (1)</td>
</tr>
<tr>
<td>Tremor</td>
<td>No tremor observed (1)</td>
</tr>
<tr>
<td>Sweating</td>
<td>No sweating (1)</td>
</tr>
<tr>
<td>Gooseflesh Skin</td>
<td>No gooseflesh skin (1)</td>
</tr>
<tr>
<td>Bone or Joint pain</td>
<td>No pain (1)</td>
</tr>
<tr>
<td>Glutop</td>
<td>No signs (1)</td>
</tr>
</tbody>
</table>

---

**How to start Buprenorphine in the ED**

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

---

**All Patients Receive:**

- Brief Intervention
- Overdose Education
- Naloxone Distribution

---

**Prescription:**

- 16mg dosing for each day until appointment for ongoing treatment.
- Consider return to the ED for 2 days of 16mg buprenorphine (72-hour rule).

---

**Scoring:**

- 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal
How do I motivate ED patients with OUD to accept treatment?

Step 1. Raise the Suspect/Reasonable Report
- Introduce yourself
- Raise the subject of opioid use
- Ask permission to discuss OUD
- Assess patients subjective level of physical discomfort (i.e., withdraw)

Step 2. Provide Feedback
- Review patients drug use and patterns
- Ask the patient about and discuss drug use and its negative consequences
- Make a connection (if possible) between drug use and ED visit or any medical issues
- Provide feedback on OUD diagnosis and treatment options (e.g., buprenorphine or other options, such as methadone maintenance, intensive outpatient program) and/or harm reduction strategies

Step 3. Enhance Motivation
- Assess readiness to change whichever of the above 3 target behaviors the patient chooses
- Buprenorphine, other treatment or harm reduction
- Enhance Motivation
  - Ask a series of open-ended questions designed to evoke “Change Talk” (or motivational statements) about their target behavior.
  - Reflect or reiterate the patient’s motivational statements regarding existing treatment.

Step 4. Negotiate & Advise
- Negotiate goal regarding the target behavior
- Give advice
- Provide feedback on OUD diagnosis and treatment options
- Give advice
- Route of
- Naloxone hydrochloride
- Buprenorphine
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How are the different buprenorphine formulations for OUD?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Route of Administration/ Form</th>
<th>Available strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine/ Naloxone</td>
<td>(Tables may be more expensive than films depending on insurance provider)</td>
<td></td>
</tr>
<tr>
<td>Suboxone</td>
<td>Sublingual film</td>
<td>2 mg/5 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 mg/5 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8 mg/2 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12 mg/3 mg</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Buccal film</td>
<td>2.1 mg/0.3 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.2 mg/0.7 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6.3 mg/1 mg</td>
</tr>
<tr>
<td>Naloxone hydrochloride</td>
<td>Sublingual tablet</td>
<td>0.7 mg/1.18 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.4 mg/3.36 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.9 mg/7.1 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.7 mg/14.3 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8.6 mg/2.1 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11.4 mg/3.9 mg</td>
</tr>
<tr>
<td>Generic combination product</td>
<td>Sublingual tablet</td>
<td>2 mg/3.5 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8 mg/2 mg</td>
</tr>
<tr>
<td>Buprenorphine/Alone</td>
<td>(Used with pregnant women to decrease potential fetal exposure to naloxone)</td>
<td></td>
</tr>
<tr>
<td>Suboxone</td>
<td>Sublingual tablet</td>
<td>2 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8 mg</td>
</tr>
<tr>
<td>Generic mono product</td>
<td>Sublingual tablet</td>
<td>2 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8 mg</td>
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</tbody>
</table>

How do I obtain a DATA 2000 waiver?

SAMHSA DATA 2000 waiver training for providers
Available at: https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training

References:

Educational Resources:
SAMHSA Opioid Overdose Prevention Toolkit: This toolkit offers strategies to help prevent opioid-related overdoses and deaths. https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA14-4743
Provider’s Clinical Support System for Medication-Assisted Treatment (PCSS-MAT) is a national training and clinical support system. The goal is to provide the most effective evidence-based clinical practices in the prevention, identification, and treatment of opioid use disorders. https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training

Yale GRIT website: https://medicine.yale.edu/grit
In the PAST YEAR, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

https://www.drugabuse.gov/taps/#!
Overdose Emergency

- Emergent Care
- Observation & Initiate TX
- Facilitated Referral
- Naloxone Prescription

GET A LIFE
Session I—
Treatment for Opioid Use Disorder: Exploring Effective Approaches and Models of Care

**Moderator:** Mark McClellan, Duke-Margolis Center for Health Policy

**Panelists:**
Colleen LaBelle, Boston Medical Center
Kathryn Cates-Wessel, American Academy of Addiction Psychiatry
Gail D’Onofrio, Yale Medicine
Yngvild Olsen, Institute for Behavior Resources, Inc

Join the conversation at #OUDTreatment #EndTheStigma
Yngvild Olsen, MD, MPH
Medical Director
Institutes for Behavior Resources, Inc./REACH Health Services
The Baltimore Buprenorphine Initiative (BBI)

- Original hub and spoke model
  - Integrated buprenorphine into drug-free outpatient specialty addiction treatment programs
  - Changed buprenorphine delivery model from short term “detox” to maintenance therapy
  - Supported integration of stable patients into primary care
  - Focused on improving quality of care with clinical guidelines
- Results since 2006:
  - All FQHCs have waivered prescribers
  - Number of patients treated increased from 577 in 2003 to 7479 in 2009
Reduced Mortality


Schwartz, et al. AJPH, 2013
Hub and Spoke 2.0

- Opioid Treatment Programs as hubs
- Access to both methadone and buprenorphine
- Creates primary care/specialist network
- Challenges:
  - No ability to transition stable patients on methadone to spokes
  - Limited medical services for complex patients better served in OTPs
  - Culture change
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