Emergency Department Treatment and Follow-Up Strategies For Opioid Use Disorder

Reducing Substance Use Disorders: National Webinar Series

December 13, 2017
2:30pm – 4:00pm EST
Logistics

• Please mute your line & do not put the line on hold
• Use the chat box on your screen to ask a question or leave comment
  – Note: chat box will not be seen if you are in “full screen” mode
  – Please also exit out of “full screen” mode to participate in polling questions
• When spreadsheets are shared “full screen” mode is recommended
• Moderated Q&A will be held periodically throughout the webinar
  – Please submit your questions via the chat box
• Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience
Welcome and Overview

• Tyler Sadwith
• Medicaid Innovation Accelerator Program SUD Lead, Health Insurance Specialist, Disabled and Elderly Health Programs Group, CMS
Webinar participants will:

- Learn about successful strategies they can use to engage and facilitate treatment for opioid use disorders in emergency departments.
- Identify ways to scale effective hospital ED OUD practices, including effective approaches for initiating treatment and ensuring follow-up care.
Agenda

• Overview and Introductions
• Yale-New Haven Hospital’s Project ASSERT
• Q and A
• Boston Medical Center’s Faster Paths to Treatment program and Project ASSERT
• Q and A
• Final thoughts and Wrap-up
• Kathryn Hawk, MD, MHS
• Assistant Professor
Department of Emergency Medicine
Yale University School of Medicine
Speaker

- **Edward Bernstein, MD**
- Director, Faster Paths to Treatment, Boston Medical Center
- Professor of Emergency Medicine, Boston University School of Medicine
Facilitator

- John O’Brien, MS
- Senior Consultant, Technical Assistance Collaborative
Opioid Use Disorder in the Emergency Department: Treatment Initiation & Linkage to Care

Kathryn Hawk, MD, MHS
Assistant Professor
Department of Emergency Medicine
Yale University School of Medicine
Disclosures

I have no conflicts of interest or disclosures to report

Research Funding
National Rate per 100,000 Population of Opioid Related ED Visits 2005-2014

Abbreviation: ED, emergency department

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), HCUP Fast Stats, Opioid-Related Hospital Use (http://www.hcup-us.ahrq.gov/faststats/landing.jsp) based on the HCUP National (Nationwide) Inpatient Sample (NIS) and the HCUP Nationwide Emergency Department Sample (NEDS)
Only 1 in 5 Get Treatment
Why focus on the ED?

Because that’s where the patients are

Overdose

Seeking Treatment

Screening
Reducing Opioid-Associated Morbidity & Mortality
329 Patients were enrolled from April 2009 - June 2013

- >18 years of age
- Opioid dependent
- Urine toxicology with opioids
- ED presentation: overdose (9%), seeking treatment (34%), rest via

Referral  
Brief Intervention + Facilitated Referral  
BI+ Buprenorphine + PMD/Bup Referral

JAMA. 2015;313(16):1636-1644
Medication Assisted Treatment (MAT): 2x More Likely to be Engaged in Addiction Treatment at 30 Days
Less likely to Use Illicit Opioids
Past 7-Day Use

Treatment Effect: $P<0.001$
Time effect: $P<0.001$
Interaction Effect: $P<0.01$

Days

Baseline

30 Day FU

Referral
Brief
Intervention
Buprenorphine
CASE

28 year-old male is brought to the ED after heroin overdose

What happens next?

What could happen next?
Examples of Acute Emergencies

NIH-Recommended Emergency Department Response Times

The “golden hour” for evaluating and treating acute stroke

Door-to-needle time ≤60 minutes

Suspected stroke patient arrives at ED → Initial MD evaluation → CT scan initiated → CT & labs interpreted → tPA given if patient is eligible → Stroke team notified

Options for Transport of Patients with STEMI and Initial Reperfusion Treatment

Call 9-1-1 fast
- Onset of symptoms of STEMI
- 9-1-1 EMS dispatch

EMS on-scene
- Encourage 12-lead ECGs
- Consider prehospital fibrinolysis if capable and EMS-to-needle within 30 min

EMS triage plan
- Patient self-transport
- EMS transport: prehospital fibrinolysis
- EMS-to-needle within 30 min
- EMS-to-balloon within 90 min

Golden hour = first 60 min
Total ischemic time: within 120 min

Source: Cardiosource © 2008 by the American College of Cardiology Foundation

Stroke

STEMI
ED Management of Opioid Use Disorder

- Brief Intervention & Referral to Treatment
- Overdose Prevention Education & Naloxone Distribution
- ED-Initiated Buprenorphine & Referral for Followup
Project ASSERT

• ED-based based on Boston Medical Center model program since 1999
• Health Promotion Advocates (HPAs) provide screening, brief intervention, overdose prevention and referral to treatment
• Established relationships with local treatment providers
• Collaborate with & educate providers
• Directly refer patients to treatment
  – >2,000 ED patients with counseling, education, referrals in 2016
  – Services to >48,000 since 1999
Naloxone: Gateway to Treatment
Opioid Overdose Emergency

1. Emergent Care
2. Observation & Initiate Treatment
3. Facilitated Referral to Ongoing Treatment
4. Naloxone Prescription
72-Hour Rule
Title 21, Code of Federal Regulations, Part 1306.07(b)

Allows to administer (but not prescribe) opioid drugs for the purpose of relieving acute withdrawal symptoms while arranging for the patient's referral for treatment

- Not more than 1-day's medication may be administered or given to a patient at one time
- Patient must return to ED each day for no more than 72 hours
- This 72-hour period cannot be renewed or extended
Clinical Opiate Withdrawal Scale (COWS)

Flowchart for measuring symptoms over a period of time during buprenorphine induction.

For each item, write in 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 increased pulse rate would not add to the score.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine Induction:</td>
<td></td>
</tr>
</tbody>
</table>

**Resting Pulse Rate: Record Beats per Minute**
- 0 = pulse rate 80 or below
- 1 = pulse rate 81-100
- 2 = pulse rate 101-120
- 4 = pulse rate greater than 120

**Sweating: Over Past 1/2 Hour not Accounted for by Room Temperature or Patient Activity**
- 0 = no report of chills or flushing
- 1 = subjective report of chills or flushing
- 2 = flushed or observed moistness on face
- 3 = beads of sweat on brow or face
- 4 = sweat streaming off face

**Restlessness Observation During Assessment**
- 0 = able to sit still
- 1 = reports difficulty sitting still, but is able to do so
- 5 = Unable to sit still for more than a few seconds

**Pupil Size**
- 0 = pupils pinned or normal size for room light
- 1 = pupils possibly larger than normal for room light
- 2 = pupils moderately dilated
- 4 = pupils so dilated that only the rim of the iris is visible

**Bone or Joint Aches if Patient was Having Pain Previously; only the Additional Component Attributed to Opiate Withdrawal is Scored**
- 0 = not present
- 2 = patient reports severe diffuse aching of joints/muscles
- 1 = mild diffuse discomfort
- 4 = patient is rubbing joints or muscles and is unable to sit still because of discomfort

**Runny Nose or Coughing Not Accounted for by Cold Symptoms or Allergies**
- 0 = not present
- 2 = nose running or tearing
- 1 = nasal stuffiness or unusually moist eyes
- 4 = nose constantly running or tears streaming down cheeks

**GI Upset: Over Last 1/2 Hour**
- 0 = no GI symptoms
- 1 = nausea or loose stool
- 2 = vomiting or diarrhea
- 4 = multiple episodes of diarrhea or vomiting

**Tremor Observation of Outstretched Hands**
- 0 = no tremor
- 1 = tremor can be felt, but not observed
- 2 = slight tremor observable
- 4 = gross tremor or muscle twitching

**Yawning Observation During Assessment**
- 0 = no yawning
- 1 = yawning once or twice during assessment
- 4 = yawning several times/minute

**Anxiety or Irritability**
- 0 = none
- 1 = patient reports increasing irritability or anxiousness
- 2 = patient obviously irritable/anxious
- 4 = patient so irritable or anxious that participation in the assessment is difficult

**Gooseflesh Skin**
- 0 = skin is smooth
- 2 = patient reports increasing irritability or anxiousness
- 5 = prominent piloerection
- 3 = piloerection of skin can be felt or hairs standing up on arms

Score:
- 5-12 = Mild
- 13-24 = Moderate
- 25-36 = Moderately Severe
BUPRENORPHINE REFERRAL FORM FOR OPIOID USE DISORDER

YNNH Instructions: Buprenorphine (brand name Suboxone) helps treat opioid use disorder by decreasing cravings and suppressing withdrawal symptoms. When appropriate, patients with opioid use disorder should receive a prescription or first dose of buprenorphine in the hospital, along with a direct referral for buprenorphine maintenance. For referrals, please complete and fax this form to local treatment centers listed below.

Patient’s Name: __________________ Date of birth: ______/_____/______
Phone number: ( ) __________ Date of ED visit: ______/_____/______
Insurance: ☐ Medicaid/Medicare ☐ Commercial ☐ Self-pay
Presented to ED with opioid overdose: ☐ Yes ☐ No

Opioid Use History:
Age of first use: __________________ Primary type of opioid used: __________________________
Pattern of opioid use (average daily amount and frequency): __________________________

Substance Use History (beside opioids): Is the patient CURRENTLY using any of the following?
☐ cocaine ☐ PCP
☐ alcohol ☐ synthetic marijuana
☐ benzodiazepines ☐ other __________________________

Medical/Psychiatric History:
________________________________________

Critical actions required by the Emergency Department prior to buprenorphine induction:
Urine drug screen (list positive): __________________________
Liver function test (must be ≤ & normal): __________________________
DSM MINI-SCID Score for opioid dependence (Score must be ≥): __________________________
CDWS Score (Score must be ≥10): __________________________

Buprenorphine started in ED: ☐ Yes ☐ No Date first dose given in ED: ______/_____/______
Dose given: ______ Rx dose: ______ Sig: __________________________
Number of days@given Rx: __________________________

Name of referring ED provider: __________________________

Contact number: ( ) __________

Completed form faxed to: (please check one):
☐ South Central Rehabilitation Center (SCRC): 203-393-3300 (phone), 203-401-3352 (fax). Space permitting, patients started on buprenorphine in-hospital will be admitted to SCRC within the same day if possible. Otherwise, SCRC will contact the patient directly to schedule appointment within 24-48 hours of ED visit. Note: Takes all insurance types.
☐ APT Foundation Central Medical Unit (CMU): 203-781-4640 (phone), 203-781-4682 (fax). Please call first to check on available spots prior to faxing form. Note: Takes all insurance types.
☐ Addiction Recovery Clinic (ARC) at YNHH Chapel Street Campus: Send EPIC Inbox to Stephen Holt or Jeanette Ternatro (clinic director).
☐ Fair Haven Community Health Clinic: Call 203-809-3811 and leave message, note and upload form in EPIC. Patient will be seen within 3 business days; Note: Must live in Fair Haven Community, takes all insurance types.
☐ Multicultural Ambulatory Addictions Services (MAAS): 203-495-7710 (phone), 203-873-0987 (fax); Note: Medicaid or no insurance ONLY.

Follow up nurse discharge box: clicked to ensure linkage ☐ Yes ☐
DATA 2000-QUALIFYING BUPRENORPHINE TRAINING

Access 8 hrs of training required for a DEA waiver to prescribe

ACCESS TRAINING

DATA 2000 8 Hour Waiver Qualifying Buprenorphine Training

Supported by American Society of Addiction Medicine (ASAM)

Development funded by the

Online, Interactive, Case Based

- Up to 9 AMA PRA Category 1 Credit™
- $199 user fee
- 10 modules, complete at your own pace
- Developed with funding from

For Physicians

Get DATA 2000 8 Hour Waiver Qualifying Buprenorphine Training.

Up to 9 AMA PRA Category 1 Credit™

$199 user fee
Discussion & Questions
Innovation in the Hospital, and the Emergency Department’s Role in the Opioid Overdose and Use Disorder Epidemic

A Linkage Strategy To Primary Care, Behavioral Health, HIV/HCV and Substance Use Disorder Treatment

Edward Bernstein, MD
Director, Faster Paths to Treatment, Boston Medical Center
Professor of Emergency Medicine, Boston University School of Medicine
REGIONAL OPIOID URGENT CARE CENTER (OUCC) GRANT
FASTER PATHS TO TREATMENT

• A collaboration
  – Boston Medical Center (BMC)
  – Boston Public Health Commission (BPHC)
  – Massachusetts Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS)
Faster Paths to Treatment
What Can An Opioid Urgent Care Center Do?

• Evaluate, motivate, and refer patients with SUD to a comprehensive care network of inpatient and outpatient detoxification, treatment, and aftercare services integrated with mental health and medical care.

• Incorporate and build on existing addiction services provided by BMC and BPHC, filling gaps in care & strengthening the network to create a seamless continuum and provide more options.

• Provide weekday access to medication for addiction treatment in the Faster Paths Bridge Outpatient Unit/medical exams and appropriate lab, Hepatitis C, sexually transmitted infections and rapid drug testing.
Faster Paths to Treatment/Opioid Urgent Care Centers

- Referrals for Maintenance to Office Based Addiction Treatment (OBAT), Adolescent Clinic/CATALYST, HIV Clinic, Family Medicine, Addiction Psychiatry, Project Respect, FQHC
- Serve a large catchment area: Essex, Suffolk, Middlesex, and Norfolk Counties
Faster Paths to Treatment
Program Objectives

• Same-day access to American Society of Addiction Medicine (ASAM) Triage and Psych-social assessment and referral to SUD treatment
• Coordination and enhancement of services
• Economy of scale and Increased resources
• Divert ED patients seeking only SUD treatment services to OUCC
• Active collaboration with community agency partners, MA DPH Bureau of Substance Abuse Services, and the Boston Public Health Commission’s PAATHS (Providing Access to Addictions Treatment Hope and Support)
Faster Paths To Treatment
Building an Integrated Collaborative Model

• Over the last 23 years, BMC has developed and implemented a wide range of programs to address SUD
  – In the ED (Project ASSERT) March 1994 -- Peer Model/ LADC
  – In the clinics (OBAT/ CATALYST/ RESPECT, FM, GIM & Psych X- Buprenorphine waived prescribers, MDs)
  – In the inpatient hospital setting (Addiction Consult Service and SW & Project ASSERT Consults)
Health Promotion Advocates:
MA DPH Licensed Alcohol and Drug Counselors
Provide Assessments, Motivation, Navigation, Referrals and Follow-up Counseling for Faster Paths/OUCC patients
- focus on substance abuse in context of other health and safety issues
- offer info & health resources with emotional support & advocacy
- served over 80,000 patients in 23 years
- an ED SBIRT prototype

Funded in 1993 SAMHSA/CSAT; 1998 line item in BMC ED Budget
The Project ASSERT
Outreach Workers’ Role

- Recruited from the communities served by the hospital, provide “in-reach” services to bridge the gap between what patients needed & ED staff’s capacity.
- Bringing knowledge of community conditions and neighborhood life (the social determinants of health) to the emergency medicine practice.
- Serving as culture brokers by helping patients understand medical language and constructs while also helping medical professionals understand the complexity of patients’ lives, languages, priorities and choices.
The Project ASSERT Outreach Workers’ Role Cont’d

• Consulting with providers during daily rounds and engaging patients in respectful, compassionate and informed conversations about their health and safety.

• Conducting psych-social assessments & ASAM triage continuum placement criteria.

• Encouraging and motivating patients to seek help.

• Advocating for and facilitating access to an array of hospital and community resources and services.
## Project ASSERT Linkage Strategy

### Community Health Promotion Advocates

<table>
<thead>
<tr>
<th>General Medical Setting</th>
<th>Screening for Health &amp; Safety Needs</th>
<th>Empowerment through Brief Negotiation Interview/ BNI</th>
<th>Compassionate/curious</th>
<th>Patient centered</th>
<th>Respectful</th>
<th>Active Referral Network for Community Resources</th>
</tr>
</thead>
</table>
Project ASSERT Model: Brief Motivational Intervention by Peer Counselors

Project ASSERT: An ED-Based Intervention to Increase Access to Primary Care, Preventive Services, and the Substance Abuse Treatment System

Study objective: To test the feasibility and effectiveness of Project ASSERT, an innovative program developed by us to facilitate access to the substance abuse treatment system and to primary care and preventive services for emergency department patients with drug- and alcohol-related health problems.

Abstract
Background: Brief intervention is effective for alcohol misuse, but not adequately tested in the clinical setting with drug using patients. This study tested the impact of a single, structured encounter targeting cessation of drug use, conducted between peer educators and out-of-treatment cocaine and heroin users screened in the context of a routine medical visit.

Methods: A randomized controlled trial was conducted in seven inner-city urban hospital emergency clinics with 5-6 months follow-up.

The Acute Treatment Gap
(1/1/16 – 12/31/16)

1,239 BMC emergency department patients placed out of 2,227 requesting detox (56%)
Coach or PEERS Model for Overdose Education and Naloxone Kit Distribution

- **P** Page to bedside
- **E** Evaluate
- **E** Educate on overdose and distribute naloxone
- **R** Referral to Faster Path, detox or other
- **S** Safe discharge
Inpatient Addiction Consult Service (ACS)

- Staffed by faculty in the Section of General Internal Medicine, an Addiction Medicine fellow and 1-2 internal medicine or family medicine residents.
- Methadone or buprenorphine/naloxone induction in appropriate patients with opioid use disorder with referral to Faster Paths, methadone maintenance treatment and office-based addiction treatment.
- Prior to the ACS, these patients would have been offered detoxification during their hospitalization and information about opioid treatment programs, but not linkage to one, where the wait time is typically two weeks or more for new patients.
BPHC’s PAATHS: Providing Access to Addiction Treatment, Hope, and Support

- Recovery specialists/coaches
- Case management support
  - Referrals to community-based housing, education, job support
- Medical and social service navigation
  - Accompanying patients to pharmacies, social services, and medical or behavioral health appointments
- Chronic disease self-management support
  - Home visits for health education
  - Medication adherence support
- Support to initiate and engage in treatment
  - Placement & transportation to Acute Treatment Services, residential/inpatient services, MAT and other outpatient appointments; assist obtaining government IDs/$
  - Support group meetings; AA/NA and connecting with sponsors
Faster Paths: Continuum of Services

DROP-INS & REFERRALS FROM ED/UCC, BH, PCP, INPATIENT ACS, OUTSIDE AGENCIES AND WORD OF MOUTH

BPHC PAATHS
RECOVERY SPECIALISTS
Transportation, Referral & Coaching

BMC PROJECT ASSERT
ASAM Triage Placement Intake, Assessments, Harm Reduction Counseling & Referrals Detox, Shelters, Primary Care, OEND

Medical Evaluation
BMC UCC
Behavioral Health Evaluation

ATS/DETOX
CSS, TSS, MAT
Residential & Shelters

MAINTENANCE PROGRAMS
OBAT
Teen CATALYST

RN/MD MAT UNIT
Buprenorphine, Naltrexone Induction/Stabilization
Methadone Access
HIV, HCV, RPR, STI testing

IAP
Medicaid Innovation Accelerator Program
FASTER PATHS SERVICES

Seeking Treatment

Registration

ASAM Triage, Assessment, Referrals, OEND, Follow up

Addiction Nurse

Addiction Consult

PAATHS/ Community Resources

Project ASSERT LADCs Team
## Faster Paths to Treatment:
**August 1, 2016 - July 31, 2017**

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Unique Patients Served/ Total Visits</td>
<td>1,275/ 4,635</td>
</tr>
<tr>
<td>Total Addiction RN Medication Unit Visits</td>
<td>2,056</td>
</tr>
<tr>
<td>X waived Physician Visits: diagnostic assessment, medical examinations, and medication therapy</td>
<td>773</td>
</tr>
<tr>
<td>LADCs Psych-social assessments, treatment planning &amp; ASAM Level of Care Placement</td>
<td>1,806</td>
</tr>
</tbody>
</table>
# Faster Paths to Treatment Services

<table>
<thead>
<tr>
<th>MAT</th>
<th>MAT Rx</th>
<th>Transfers to OBAT or other programs</th>
<th>Placed in Detox</th>
<th>Other Services &amp; Referrals: Shelter, PCP, ID, Ins. Food and Clothes NA/AA</th>
</tr>
</thead>
<tbody>
<tr>
<td>407</td>
<td>1990</td>
<td>177</td>
<td>664</td>
<td>712</td>
</tr>
</tbody>
</table>

**IAP (Medicaid Innovation Accelerator Program)**
Lessons Learned and Challenges

• Partnership/collaboration: From grant to reality
• Blending medical with peer models, PAATHS with ASSERT culture
• Space and information technology build
• Filling prescription requires identification and can require prior approval
• Billing and finances
Lessons Learned and Challenges, Cont’d.

- Workforce and staffing
- Transferring patients to level of care: Medication maintenance
- Opioid overdose ED referrals and same day medications
- Patient access to mental health and addiction treatment system
- Establishing community linkage
References


Summary & Key Takeaways

• Innovative hospital and ED-based programs can play a crucial role in the opioid crisis—treat people where they are

• ED-initiated MAT and facilitated referral/follow-up services can increase treatment initiation and engagement

• Diffusing best practices can improve care, outcomes and quality in Medicaid (e.g., Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence quality measure)
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Thank you for joining us for this National Dissemination Webinar!

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