Developing an ED-Initiated Buprenorphine Program

Kathryn Hawk, MD, MHS
Gail D’Onofrio, MD
Department of Emergency Medicine
Yale University School of Medicine
Disclosure Statement

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Provided funding for filming & production of videos displayed on our interactive web portal.
The 24/7/365-day Option
To Fight the Opioid Crisis
Why focus on the ED?

Because that’s where the patients are

Overdose

Seeking Treatment

Screening
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 & preventive services
A Randomized Trial of ED-Initiated Interventions for Opioid Dependence

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.

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

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, 2009, through June 25, 2013.

INTERVENTIONS After screening, 104 patients were randomized to the referral group, 111 to


NIDA 5R01DA025991
ED-Bup: 2x More Likely to be Engaged in Addiction Treatment at 30 Days

The proportion in treatment at 30 days for different interventions is as follows:

- Referral: 30%
- Brief Intervention: 50%
- Buprenorphine: 90%

The difference is statistically significant with $P < 0.001$. 

P<0.001
Translating Research into Practice

Initiating Treatment

Direct Linkage
Resources

https://www.drugabuse.gov/ed-buprenorphine

Why the Emergency Department (ED)?

That is Where the Patients Are! The opioid epidemic is strongly impacting EDs, with 2018 data from the CDC indicating that there has been a 30% increase in visits for opioid overdose from July 2016 – September 2017. Addiction is a chronic, relapsing disease, and is strongly stigmatized one. It is NOT a moral failing. People will 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 not present 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 to referral only or a BNI + facilitated referral and used less illicit opioids in the last 7 days.

What Do I Need to Know About Buprenorphine?

It is NOT simply replacing one drug for another. Buprenorphine treatment decreases withdrawal and craving.
How do I start buprenorphine in the ED?
"I think you should be more explicit here in step two."
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**
   - For OUD
     - Identification of OUD based on DSM-5
   - For Withdrawal
     - Clinical Opioid withdrawal Scale (COWS)

3. **Treat**
   - BNI Buprenorphine algorithm

4. **Discharge & Refer to Treatment**
① Formally assess for opioid use disorder
② Formally assess the severity of opioid withdrawal (COWS)
③ Assess patient willingness for BUP
④ Provide ED-initiated buprenorphine (ED or home induction)
⑤ Overdose education and naloxone distribution (OEND)
⑥ Provide formal referral for ongoing opioid agonist treatment
DSM-5 criteria for diagnosis of Opioid Use Disorder

At least 2 criteria must be met within a 12 month period

1. Take more/longer than intended
2. Desire/unsuccessful efforts to quit opioid use
3. A great deal of time taken by activities involved in use
4. Craving, or a strong desire to use opioids
5. Recurrent opioid use resulting in failure to fulfill major role obligations
6. Continued use despite having persistent social problems
7. Important activities are given up because of use.
8. Recurrent opioid use in situations in which it is physically hazardous (e.g. driving)
9. Use despite knowledge of problems
10. Tolerance
11. Withdrawal

Severity
Presence of Symptoms
Mild: 2-3
Moderate: 4-5
Severe: >6
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Score:
5-12 = Mild
13-24 = Moderate
25-36 = Moderately Severe
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Anyone Can Treat Opioid Withdrawal with Buprenorphine

72-hour rule
Title 21, Code of Federal Regulations, Part 1306.07(b)

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

- 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.

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How do you motivate patients to accept treatment?
What makes people take action?

- Autonomy (freedom)
- Engaging Talk
- Hearing Themselves
- Making a Plan
People only really listen to 1 person…

THEMSELVES!
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Algorithm
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Those at Highest Risk for Overdose

- Prior non-fatal opioid overdose
- Opioid use disorder leaving controlled settings (e.g. residential treatments, detoxification, incarceration) who have lowered opioid tolerance
- Prescribed doses of opioid analgesics greater than 90 milligram morphine equivalents (MME) per day
- Taking (co-prescription or co-use) opioids and benzodiazepines
- Alcohol and opioids
- Injecting opioids
- Exposed to high potency opioids (fentanyl, W-18)
- Low levels of physical tolerance (new initiates)
- Sleep disordered breathing (e.g. sleep apnea)
① Formally assess for opioid use disorder

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Buprenorphine referral form
How do I set up a program?
Community Partners

- Is there an OTP, primary care practice, resident clinic, FQHC that will take a “warm handoff”?  
  - What services do they offer? 
  - Insurance? 
  - Waitlist or mandatory waiting period?

- Anyone willing to run a Bridge or Transition Clinic?
Local Champions

• Administration, Faculty, Residents, Nursing...
  – How are you going to get providers waivered?
  – How are you going to get waivered providers to prescribe?
  – Do you need to consider other models?

• Know your allies
  – In the hospital and out
  – Social work/navigators/Health Promotions Advocates
  – Pharmacy!
Anticipate Challenges

• Buprenorphine
  – Waiver Requirements
  – Formulary/ED Pyxis
  – Insurance Prior Authorization?
  – Local pharmacy

• Patient
  – ID
  – Insurance
  – Transportation
Additional Challenges

• Anticipate resistance, particularly around ANY increased workload across all staff
  – How can you offload some of the work?
  – What motivates different key players?
    • Reducing repeat ED visits or psych holds
    • Staff safety
    • LOS
    • Patient satisfaction
Making Progress

- Engaging stakeholders helps change culture
- It will not happen overnight
- Perfect is the enemy of good
  - Don’t wait for a perfect protocol or system!
- Make is as easy as possible for providers and patients

“This is about improving patient care”
Reduce OD Deaths

- Access to MAT
- Reduce OD Risk
- Safe prescribing
- Reducing the stigma
- Data Sharing
- Increase Access to Naloxone
Barriers & Myths

“Drug use is a moral failing”

“You are just substituting one drug for another”

“I'm just going to add more drugs to the community, they have enough”

“Patients are going to flock here if we start offering medications like Bup”
Opportunity

Embrace science based treatments

Engage emergency practitioners

Change the trajectory of the opioid epidemic
Questions?

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kathryn.hawk@yale.edu
gail.donofrio@yale.edu