Developing an ED-Initiated Buprenorphine Program

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Yale SCHOOL OF MEDICINE

Disclosure Statement

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The Science Of Drug Abuse & Addiction

CDC

National Drug Abuse Treatment
Clinical Trials Network

Aetna

Provided funding for filming & production of videos displayed on our interactive web portal

A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration

The 24/7/365-day Option

To Fight the Opioid Crisis

Yale SCHOOL OF MEDICINE

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

Research

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

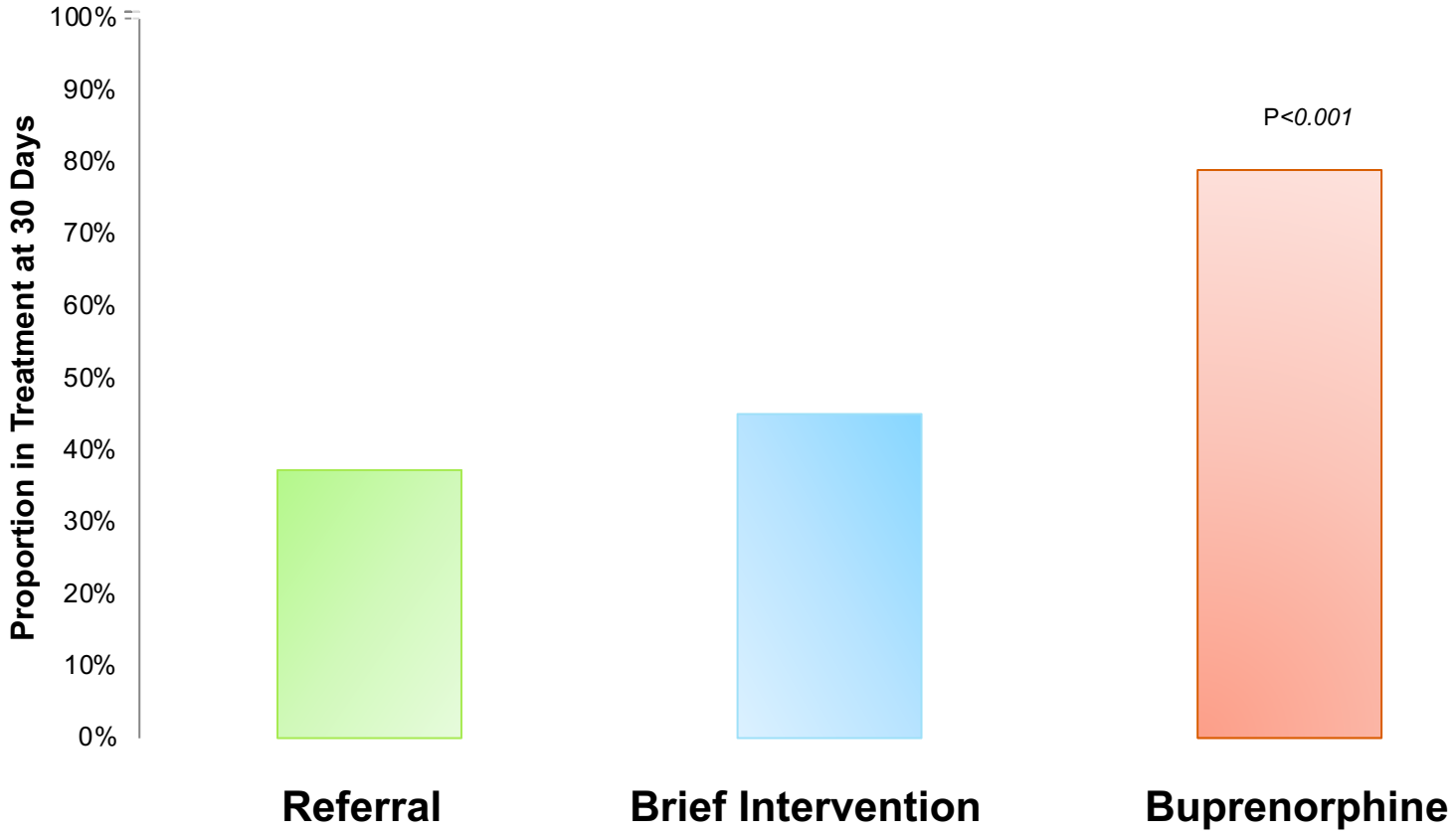
JAMA Report Video and Author Video Interview at jama.com

CME Quiz at jamanetworkcme.
CME Questions p

NIDA 5R01DA025991

JAMA. 2015;313(16):1636-1644.

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



Translating Research into Practice

Resources

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

https://medicine.yale.edu/edbup/

Facts for Medication

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[1]. Addition is a chronic, relapsing disease, and strongly stigmatized one. **It is NOT a moral failing.** People wh 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 b 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 w referral only or a BNI + facilitated referral and used less illicit opioids in the last 7 days.[2]

What Do I Need to Know About Buprenorphine?

It is NOT simply replacing one drug for another.

Buprenorphine treatment decreases withdrawal and craving

KEY DOCUMENTS

- Buprenorphine Algorithm
- Identification of OUD based on DSM-5
- Clinical Opioid Withdrawal Scale (COWS)
- Buprenorphine Referral Form
- Home Buprenorphine Initiation

RESEARCH UPDATES

ONLY THREE IN TEN PEOPLE WHO SURVIVE AN OVERDOSE RECEIVE MEDICATION TREATMENT

The researchers identified 17,568 cases where an adult in Massachusetts survived an overdose between 2012 and 2014. There was a 59% reduction in mortality for individuals taking methadone compared to those not taking medication, and a 38% reduction in mortality for those treated with buprenorphine. The was no change in morality associated with naltrexone. Despite these gains relative to morbidity, in the 12 months following the OD, only 34% of individuals received any medication for OUD: 11% received methadone maintenance treatment (median of 5 months); 17 received buprenorphine (median of 4 months); 6% received naltrexone (median of 1 month).

Treatment with opioid agonist therapy (methadone and buprenorphine) is associated with a reduction in all-cause and opioid-related mortality. Only a minority of overdose survivors received treatment.

Larochelle et al., Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality. Annals Of Internal Med, 2018.

ED-Initiated Buprenorphine

The Yale Department of Emergency Medicine is pleased to provide this website as a comprehensive resource for any provider seeking information on ED-initiated buprenorphine. Please check back often as we will be continuously updating the materials provided here.

Overview

Read More

Assessments & Tools

Read More

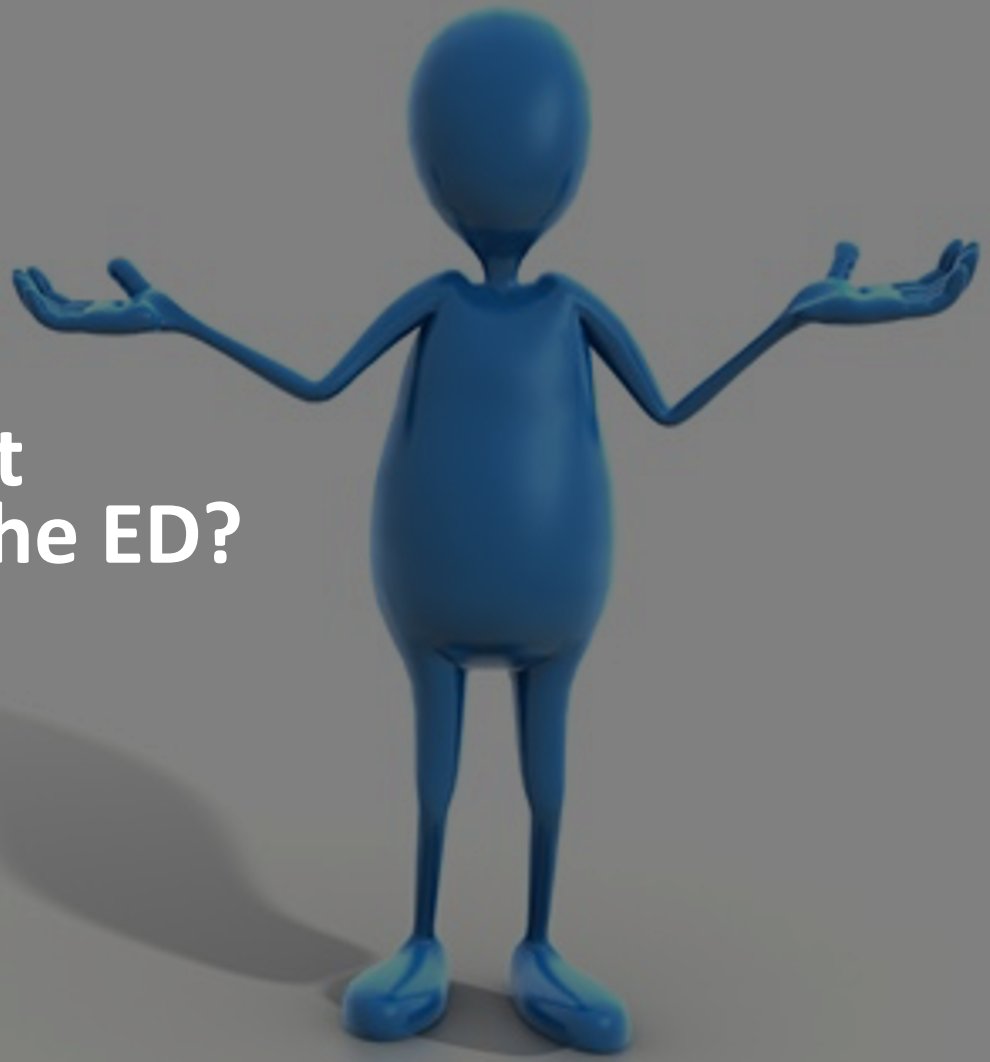
Treatment: Buprenorphine Algorithm & BNI

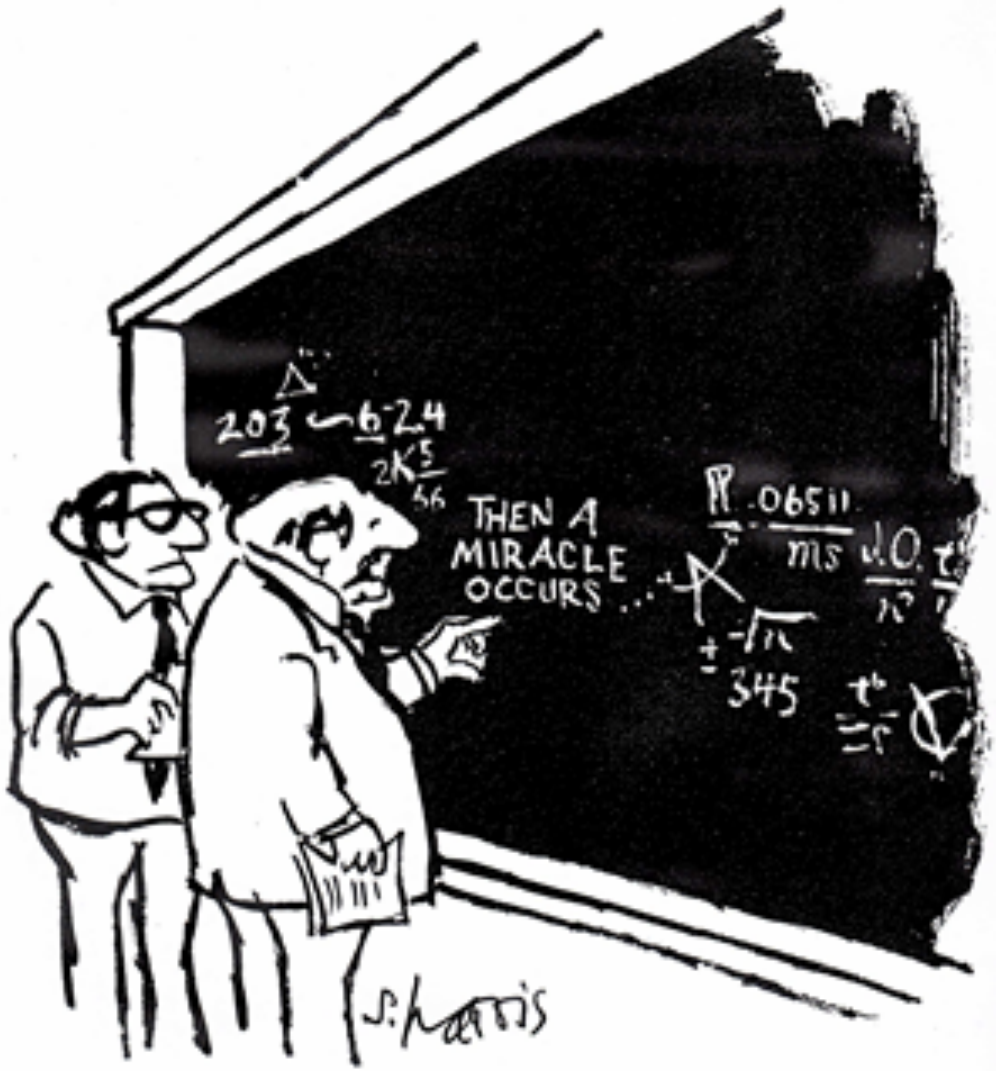
Read More

Discharge and Treatment Referral

Read More

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

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For OUD → Identification of OUD based on DSM-5

For Withdrawal → Clinical Opioid withdrawal Scale (COWS)

③ Treat

BNI Buprenorphine algorithm

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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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COWS

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Score:
5-12= Mild
13-24= Moderate
25-36= Moderately Severe

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⑥ Provide formal referral for ongoing medication assisted treatment

Anyone Can Treat Opioid Withdrawal with Buprenorphine

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72-hour rule

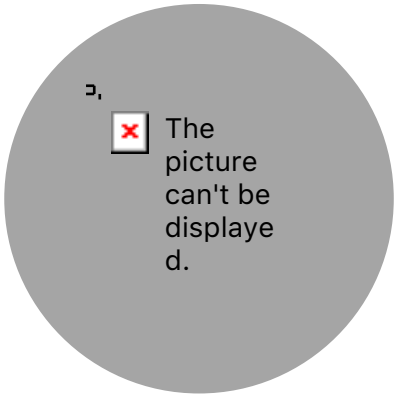
Title 21, Code of Federal Regulations, Part 1306.07(b)

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

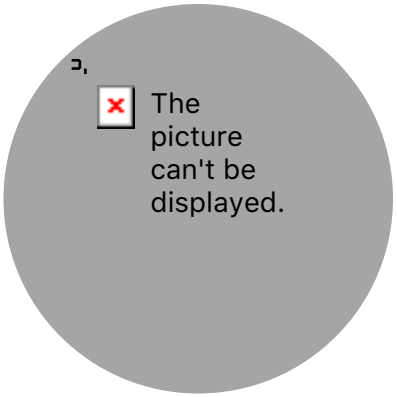
- **Not more than 1-day's medication may be administered or given to a patient at one time**
- **Patient must return to ED each day for no more than 72 hours**
- **This 72-hour period cannot be renewed or extended.**

How do you motivate patients to accept treatment?

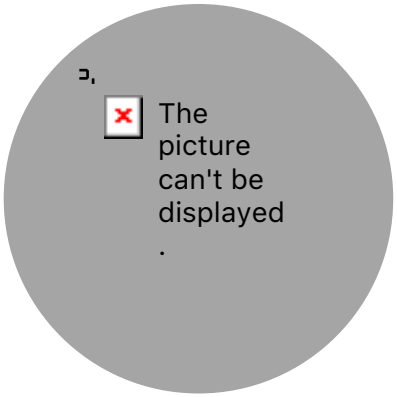
What makes people take action?



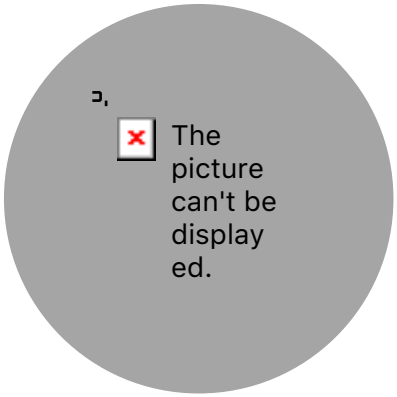
Autonomy (freedom)



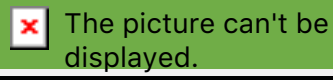
Engaging Talk



Hearing Themselves



Making a Plan



People only really listen to

1 person…

THEMSELVES!

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Algorithm

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① Formally assess for opioid use disorder

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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)

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Buprenorphine referral form

How do I set up a program?

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Local champions

Community Partners

Leadership Buy-In

Anticipate Barriers

Protocols

Success Stories

Know your Resources

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

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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”


Access to MAT
Reduce OD Risk
Reducing the stigma
Reduce
OD Deaths
Safe prescribing
Data Sharing
Increase Access to Naloxone

Barriers & Myths

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“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”

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Opportunity

Embrace science based treatments

Engage emergency practitioners

Change the trajectory of the opioid epidemic

Questions?

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