TRANSITIONS IN CARE AND LINKAGE TO TREATMENT FROM THE ED

I HAVE NO RELEVANT FINANCIAL OR PERSONAL MATTERS TO DISCLOSE

ROSS W. SULLIVAN MD

ASAM American Society of Addiction Medicine

Objectives

- 1) To understand the scope of the opioid epidemic with relation to Emergency Departments
- 2) To gain insight into some emerging Emergency Medicine solutions to the Opioid Epidemic
- 3) To learn about the Upstate Emergency Opioid Bridge Clinic and other engagement opportunities

U.S. opioid-related emergency department visits

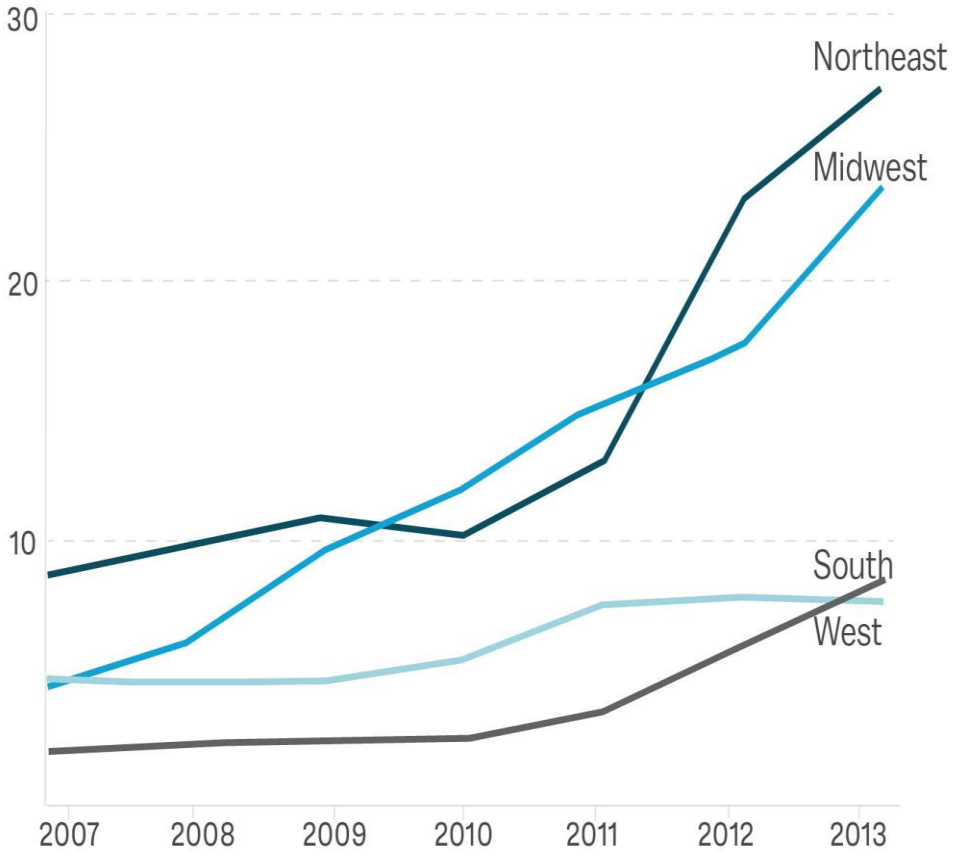
Rate of visits per 100,000 population for the United States

Source: Healthcare Cost and Utilization Project

@latimesgraphics

Heroin ER visits vary by region and are largely on the rise

Rate of heroin ER admissions for every 100,000 cases



Source: Jay Unick, NRDAH Presentation

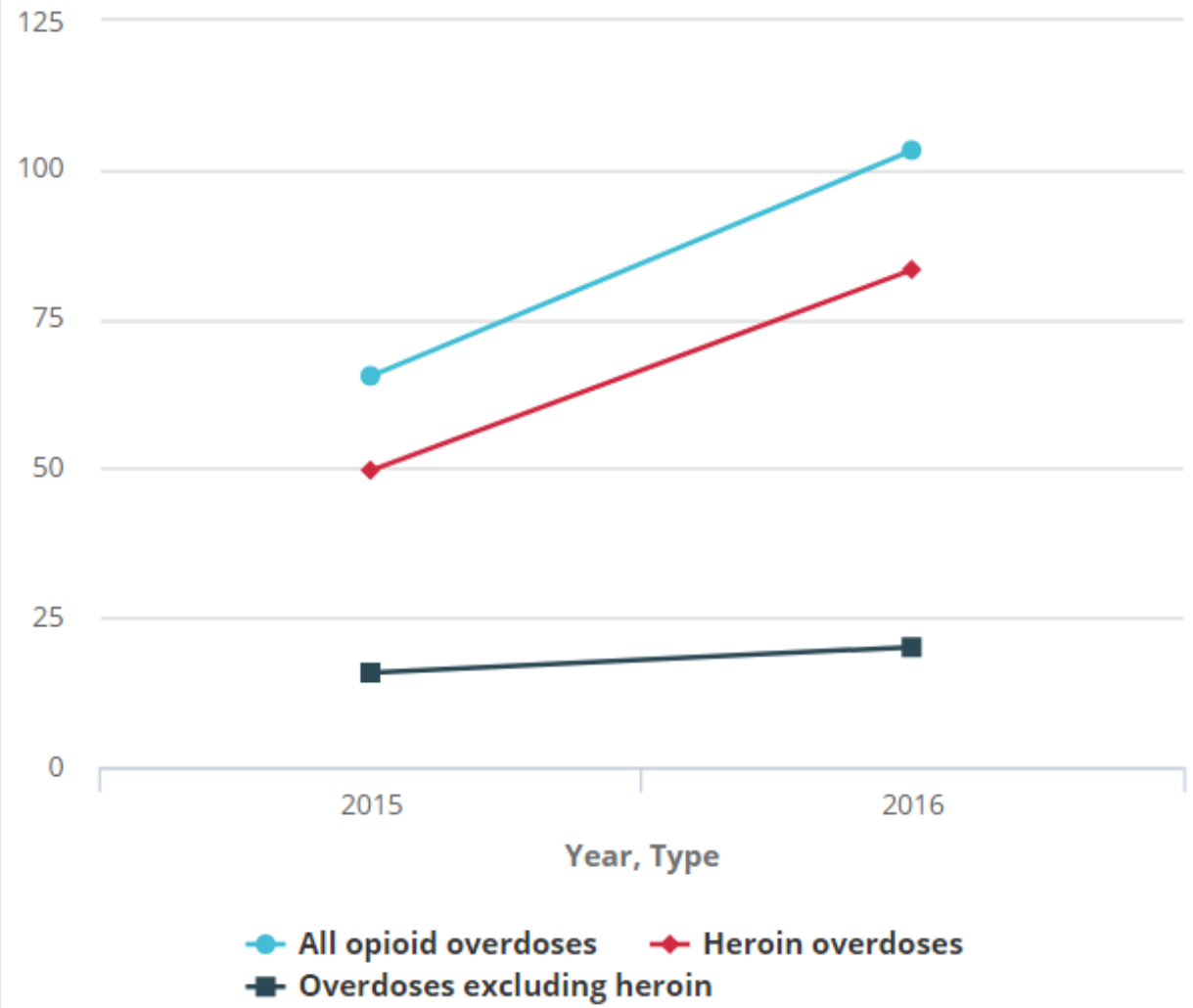
Credit: Sarah Frostenson

Vox

Opioid overdoses in the ED

Figure 4: Opioid Overdose Emergency Department Visits Per 100,000 Population, Onondaga County, 2015 & 2016

Source:
New York State-County Opioid Quarterly Report Published October 2017



ASAM American Society of Addiction Medicine

Case #1

- A 25 year old male presents to the ED with nausea, vomiting, diarrhea.
- PE shows a patient with a pulse of 115 bpm. Other vitals are stable. The patient is diaphoretic, tremulous, and anxious.
- The patient reports he has been using IV heroin/fentanyl for several months now and his last use was yesterday.

Questions

- What are some options for treating this patient's symptoms?
- Can buprenorphine be used? If so, what are some thoughts on how to

  do so.
- What are some options for follow up?

Case 2

- A 46 year old female presents to the ED for a med- refill
- She states that she just moved here (Anytown, USA) from Florida. She has been maintained on 16 mg Buprenorphine daily for 3 years due to pain pill abuse.
- She has had trouble establishing a provider maintenance. He last dose was 2 days ago and she is requesting a prescription.
- Other than some mild withdrawal symptoms, the patent is asymp.
- Her medical hx includes RA, LUPUS, FIBROMYALGIA, MIGRAINES, OPIATE USE DISORDER ON AGONIST THERAPY.

- Can you give this patient a dose of bup in the ED
  - If not, why?
  - If so, why?
- What are options for prescribing to this person?
- What are some follow up options for this patient?

Scope of the Problem

- Opioid related problems at UHED
  - Increased 50 %
    - Pts requesting opioid pain medications
    - Pts post heroin/fentanyl OD
    - Pts in opioid withdrawal
    - Pts/families seeking help
    - EMS transports increased about 50 %
    - Increased medical complications
      - Infective endocarditis
      - Abscess/epidural-abscess
    - Upon discharge pts receive a list of provider phone numbers to call

Scope of problem

- Average wait time to detox
  - 3-14 days
- Average wait time to inpatient
  - 3-14 days
- Average wait time to outpatient
  - Walk-ins
  - Wait time to buprenorphine
    - About 14-28 days
- Wait time to methadone
  - 14 days – 1 month
- Wait time to Primary Care buprenorphine providers
  - 1-2 months

ED Options

ASAM American Society of Addiction Medicine

FEBRUARY 2017

INNOVATION SPOTLIGHT:
AnchorED Rhode Island

Demonstrating Success

In the first 29 months of the program, over 1,400 people have met with a peer recovery coach in the emergency department through AnchorED, and of those, more than 80 percent engaged in recovery support services upon discharge. These results suggest that AnchorED may be an effective way to encourage people to seek treatment and begin recovery.

ASAM American Society of Addiction Medicine

Research

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

Summary - D'Onofrio et al. screened all adult patients presenting to their ED for opioid dependence and randomized them to either buprenorphine treatment, brief intervention and referral, or referral only. **The rate of engagement in addiction treatment was 78%, 45%, and 37% at 30 days for each group respectively.**

1) ***** They had staff available to complete an approximate 15 minute screen to identify patients with opioid dependence and then complete a brief intervention that lasted an average of 10.6 minutes.

2) *****All of their ED providers have completed training for and are licensed to provide buprenorphine.

3)***** In addition, they have a hospital based primary care center with physicians who are also all licensed to prescribe buprenorphine to whom they could refer patients for immediate follow up from the ED **within 72 hours**

Upstate Hospital Emergency Bridge Clinic (UHEBC)

- Emergency Department

- Aims to alleviate the emergency department and Upstate hospital influx of opioid addicted patients.
- Patients in the ED for issues related to opioid use will be seen by me or other ED qualified personnel to assess the patients' ailment.
- The patients will be treated for their withdrawal and or overdose accordingly.
  - Buprenorphine given in the ED by myself or other
- Patients will then be referred to the UHEBC within days to continue the treatment of their opioid addiction and or withdrawal and are given naloxone or Narcan NS prescription upon d/c

In the Clinic

1. Patient will see myself/NP
    1. Be subject to Urine Drug screen and I-STOP identification
    2. Be prescribed (when appropriate) buprenorphine
    3. Other medical conditions may be addressed
2. Patient will see a PEER Specialist
    1. Address the social needs of the patients.
    2. Assess the patient and available treatment options
    3. Offer valuable support

**** Together, we provide warm handoffs and referrals to the appropriate level of care. These patients will remain under the clinics' care until they engage in their next level of care ****

PEER Specialists

- Peers are people in recovery, usually a significant amount of time
- In some systems, at least a high school diploma
- Other programs require at least a 2 year degree
- CRPA (certified recovery peer advocate)
  - Usually 1 week of training, and then an exam
  - In NYS, can bill (if in a clinic)
- Must have the personal characteristics that aim towards helping others
- May have other helpful hx, but need to know the resources in the community , and truly understand the pt and what their needs are and matching unique personalities with the appropriate resources


NEW YORK STATE
Office of Alcoholism and

Demographics/FINDINGS

- Total number referred
  - 250 pts
    - 122 ED (no care)
    - 127 C (waiting for MAT)

Total number seen in the clinic

200

200 of 250 **(80% appointment retention)**

81% of ED pts – (99 of 122)

79% of C pts (100 of 127)

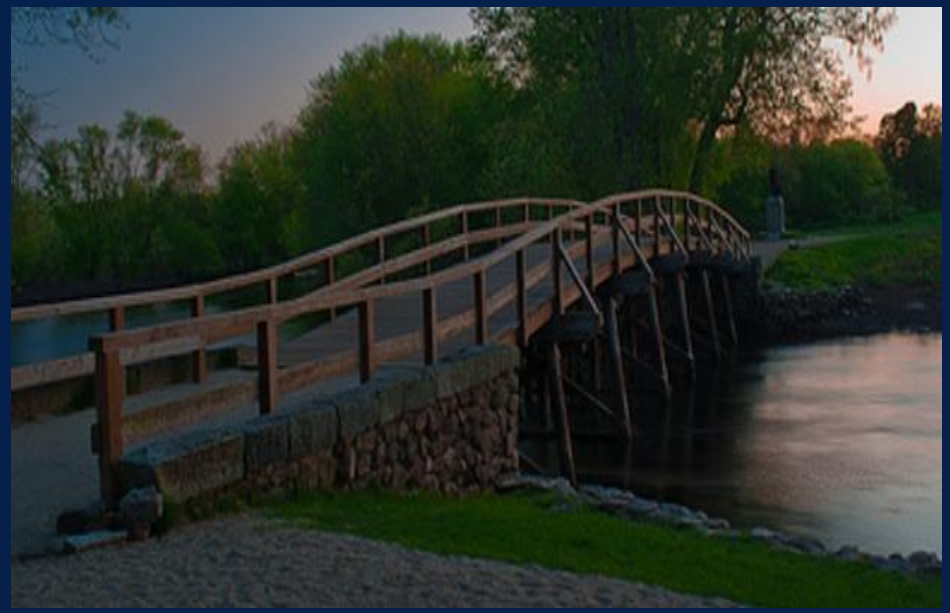
Demographics/FINDINGS

- 200 pts seen in clinic
  - 40 % male
  - 60% female
  - Age range
    - 19-64 yrs
  - Average age
    - 41.5 yrs
  - 33% homeless or Rescue Mission
- % of pts with PCP (on EMR)
  - 49
- % of pts with no PCP
  - 51
- % of pts with Medicaid/Medicare
  - 70
- % of pts with Private insurance
  - 5
- % of pts with no insurance
  - 25

Findings

- # of pts from C (OTPT) referred for bup. Bridge

74/100
(74%)



Findings

- # of patients from ED with no prior Tx that get successfully linked to treatment

85/99pts (86% linkage rate)
- **7 inpt/detox**
- **72 outpt**
- **7 PCP**

- # of patients from ED who get linked to Tx and then successfully receive MAT with bup

75/99 pts (76% bup rate)

Future

- Continue to increase pt numbers
  - Increase linkage from outside treatment centers
  - Potential linkage with discharged inmates
- Secure funding sources
  - Training of SW providers and PEERS
  - Clinic Staff
  - Physical space
- Increase buprenorphine prescribing from the ED with education/credentialing of ED attendings as well as community health care providers