CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

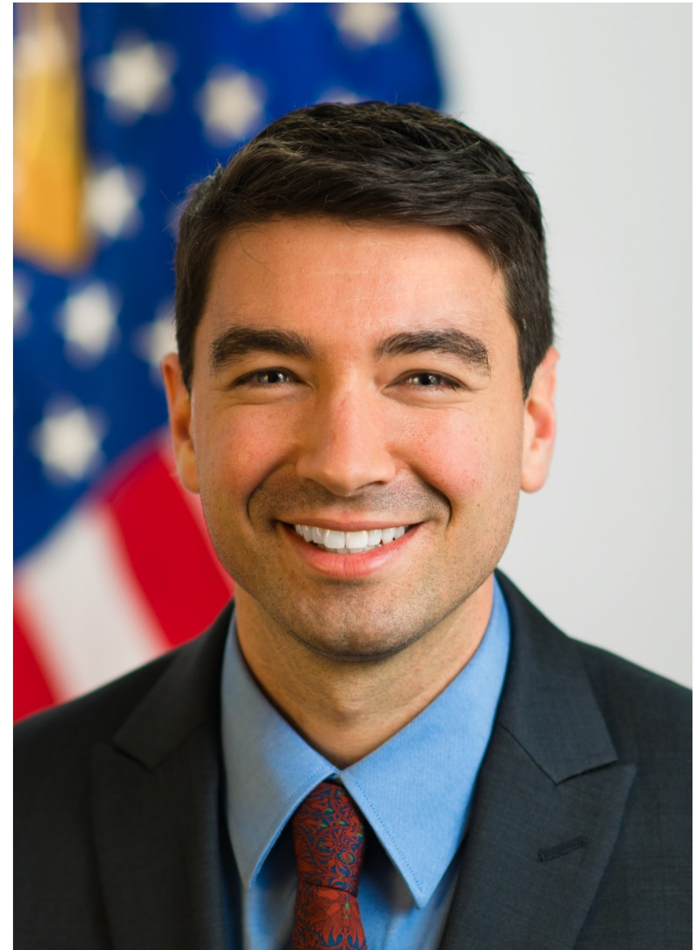
IAP | Medicaid Innovation Accelerator Program

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



Learning Objectives

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

Speaker

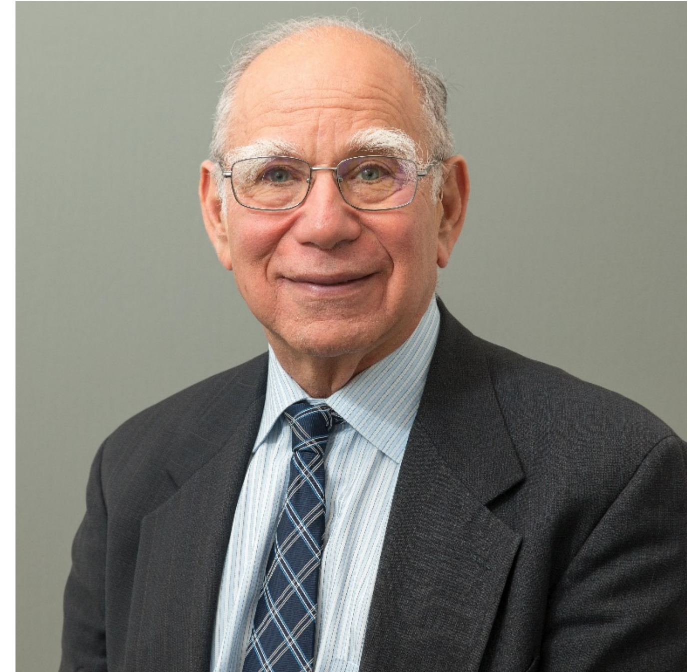
- **Kathryn Hawk, MD, MHS**
- Assistant Professor

  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



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Facilitator

- **John O'Brien, MS**
- Senior Consultant, Technical Assistance Collaborative

Opioid Use Disorder in the Emergency Department: Treatment Initiation & Linkage to Care

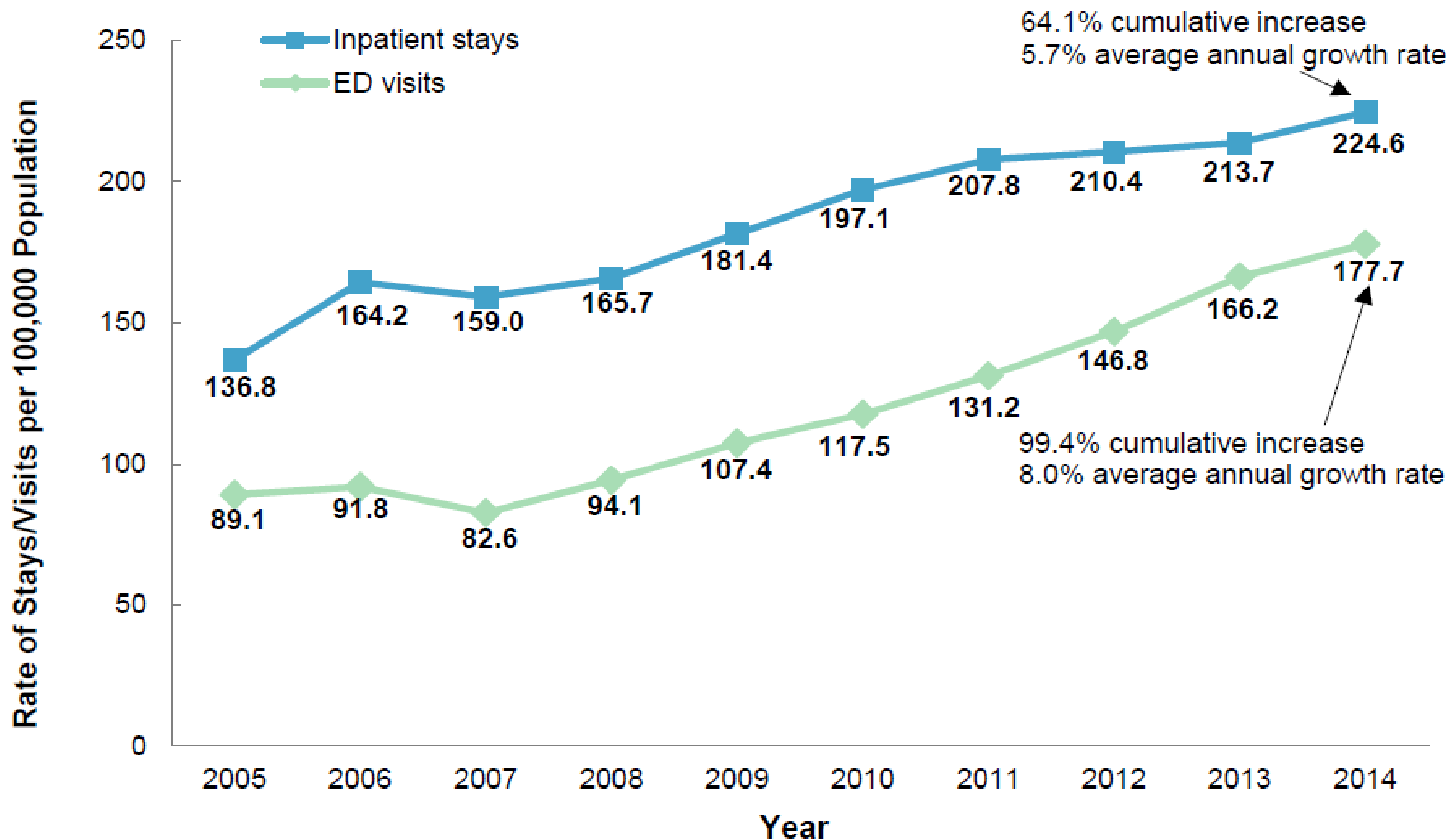
Kathryn Hawk, MD, MHS
Assistant Professor
Department of Emergency Medicine
Yale University School of Medicine

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

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Why focus on the ED?

Because that's where the patients are

Overdose

Seeking Treatment

Screening

Reducing Opioid-Associated Morbidity & Mortality

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

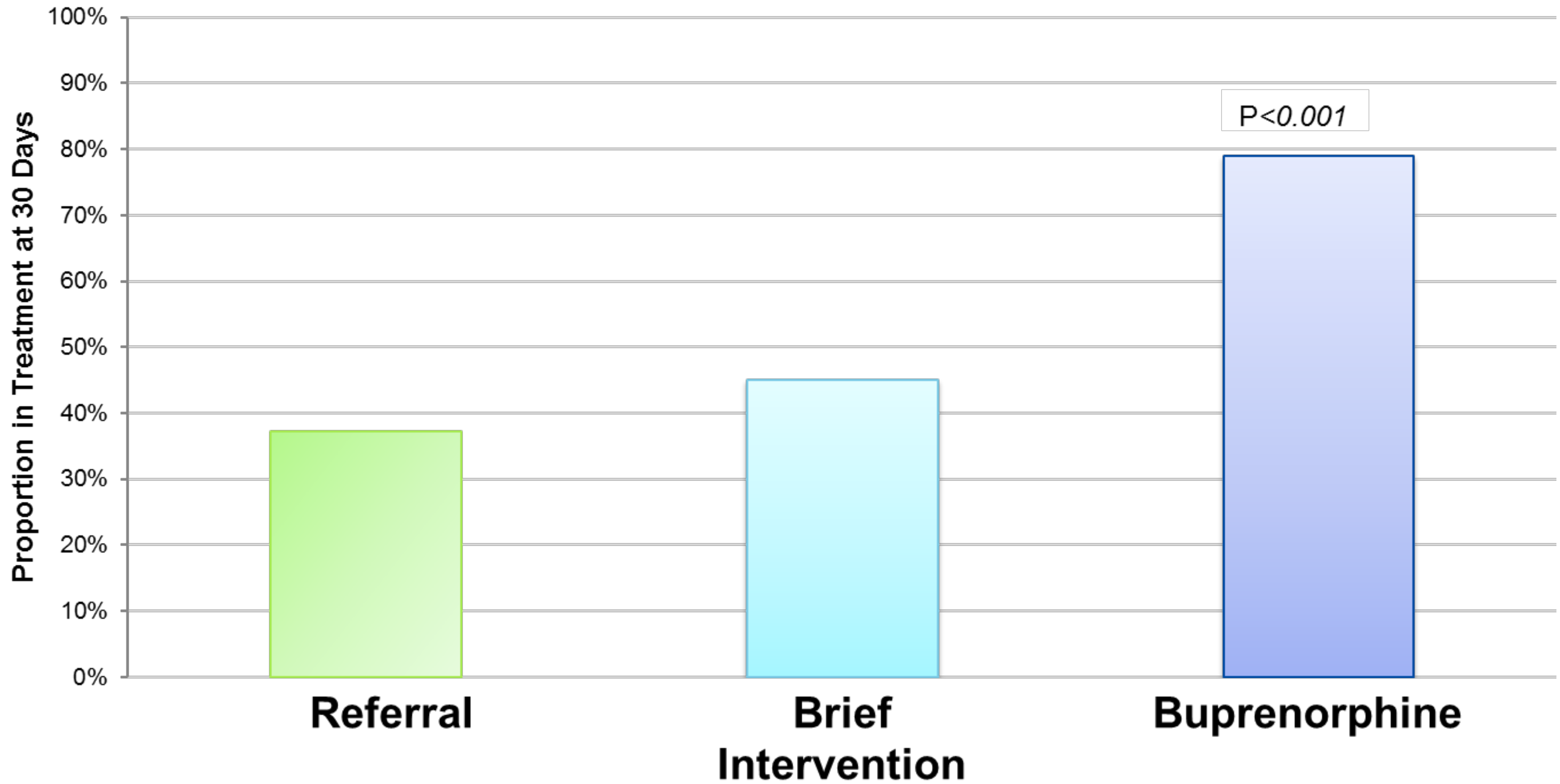
329 Patients were enrolled from April 2009 - June 2013

- ≥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



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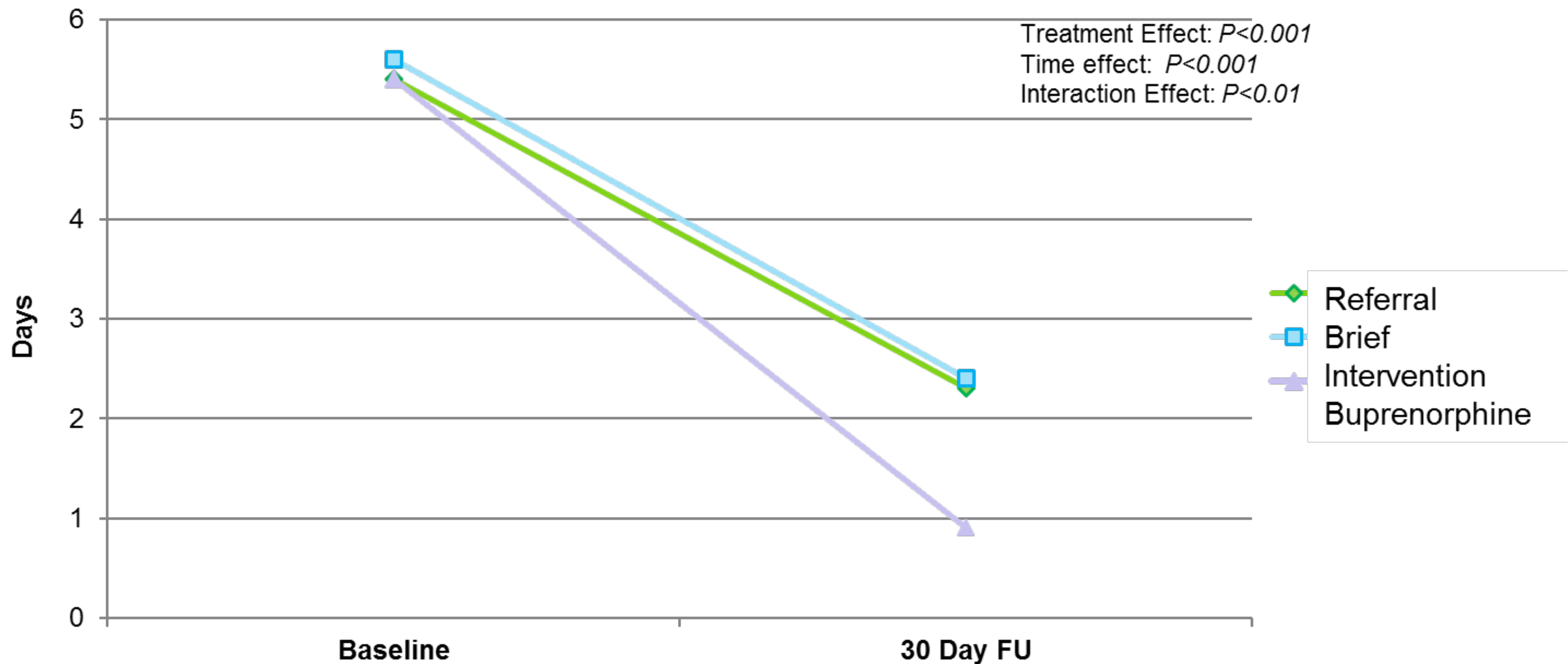
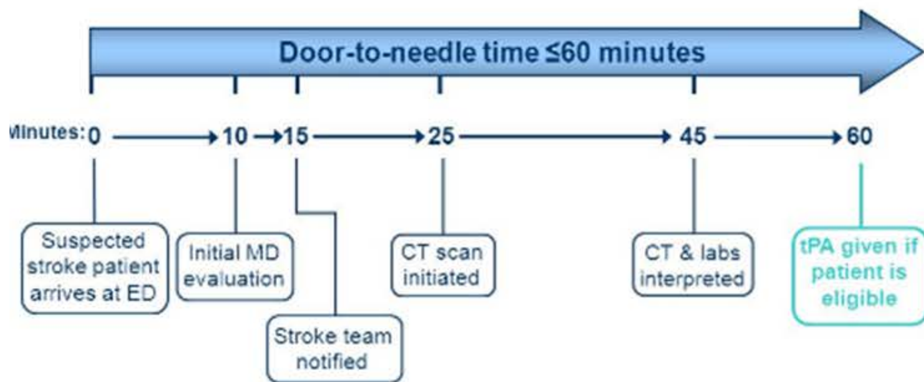
Less likely to Use Illicit Opioids Past 7-Day Use

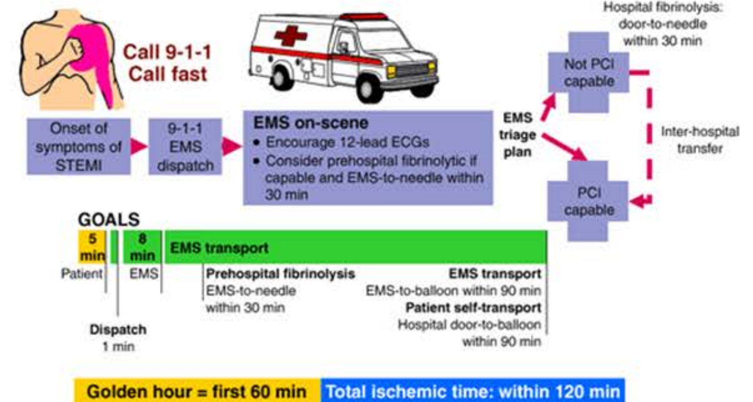


CASE

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

Examples of Acute Emergencies





Stroke

STEMI

ED Management of Opioid Use Disorder

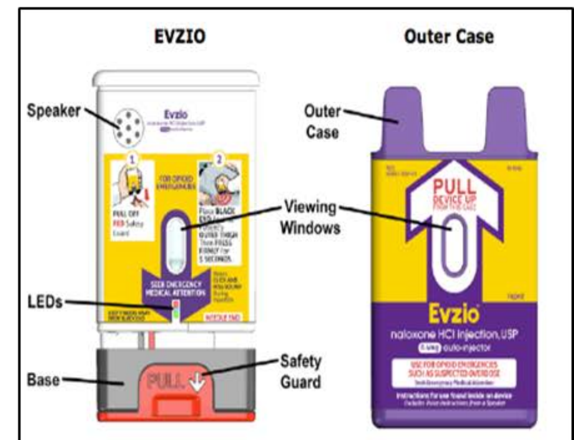
Overdose Prevention Education & Naloxone Distribution

ED-Initiated Buprenorphine & Referral for Followup

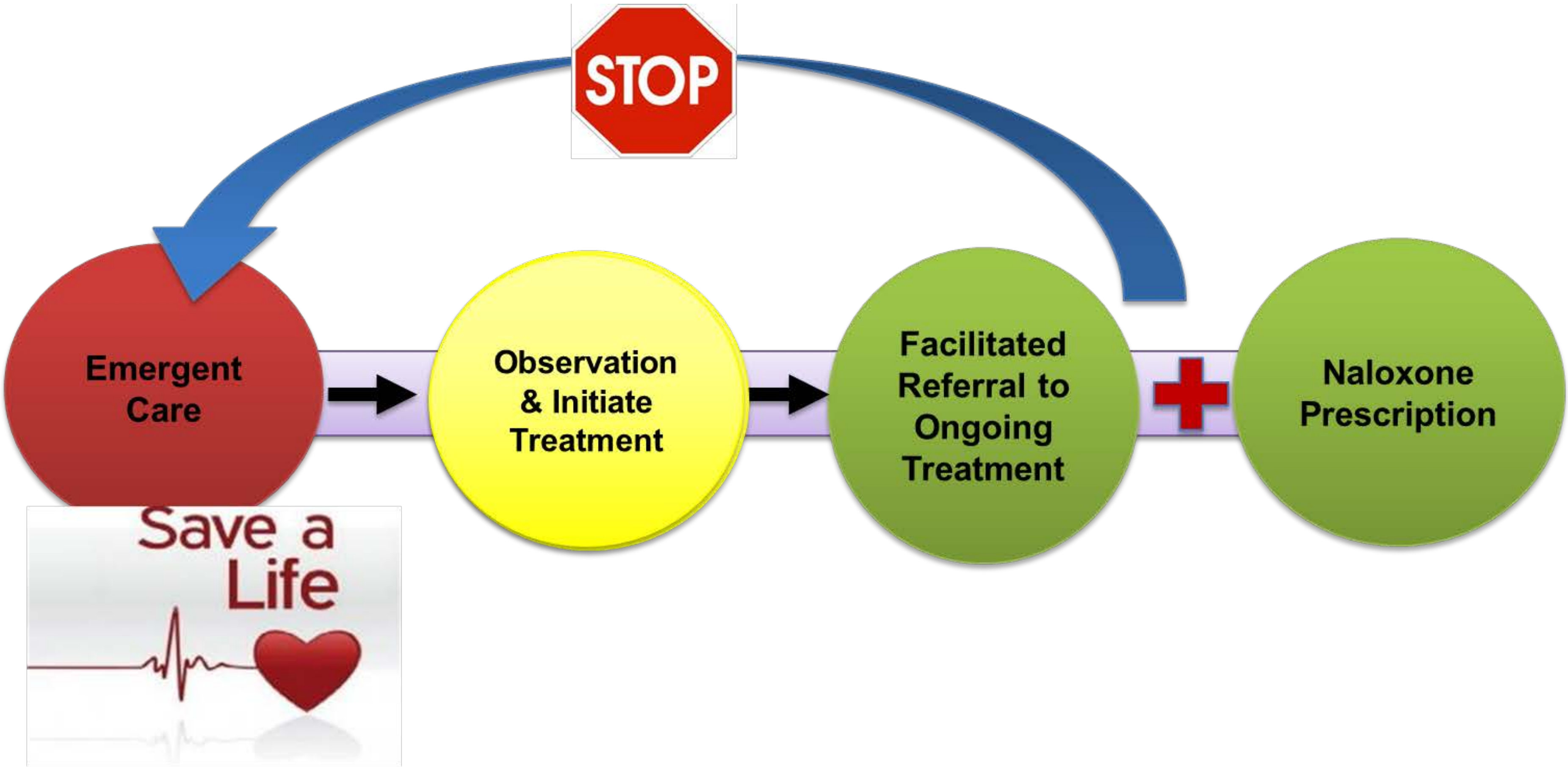
Project ASSERT

- 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



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)

Flowsheet 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.

Patient Name: ____________________ Date: __________

Buprenorphine Induction: ____________________

Enter scores at time zero, 30 minutes after first dose, 2 hours after first dose, etc. Times of Observation:				
Resting Pulse Rate: Record Beats per Minute Measured after patient is sitting or lying for one 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 observable 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 • 3 = frequent shifting or extraneous movements of legs/arms • 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 • 5 = 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 1 = mild diffuse discomfort • 2 = patient reports severe diffuse aching of joints/muscles • 4 = patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny Nose or Tearing Not Accounted for by Cold Symptoms or Allergies 0 = not present 1 = nasal stuffiness or unusually moist eyes • 2 = nose running or tearing • 4 = nose constantly running or tears streaming down cheeks				
GI Upset: Over Last 1/2 Hour 0 = no GI symptoms 1 = stomach cramps 2 = nausea or loose stool • 3 = vomiting or diarrhea • 5 = 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 • 2 = yawning three or more times 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 3 = piloerection of skin can be felt or hairs standing up on arms • 5 = prominent piloerection				

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

YaleNewHavenHealth
Yale New Haven Hospital

BUPRENORPHINE REFERRAL FORM FOR OPIOID USE DISORDER

YNHH Instructions: Buprenorphine/naloxone (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 ≤ 5x normal): ______________________________________
DSM MINI-SCID Score for opioid dependence (Score must be ≥3): _________________
COWS 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):** 203-503-3300 (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 Tetrault (clinic directors).
- **Fair Haven Community Health Clinic:** Call 201-809-3511 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 ☐

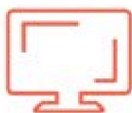
Buprenorphine referral form

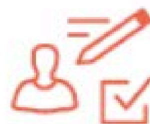
bupractice

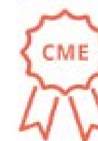
DATA 2000-QUALIFYING BUPRENORPHINE TRAINING

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

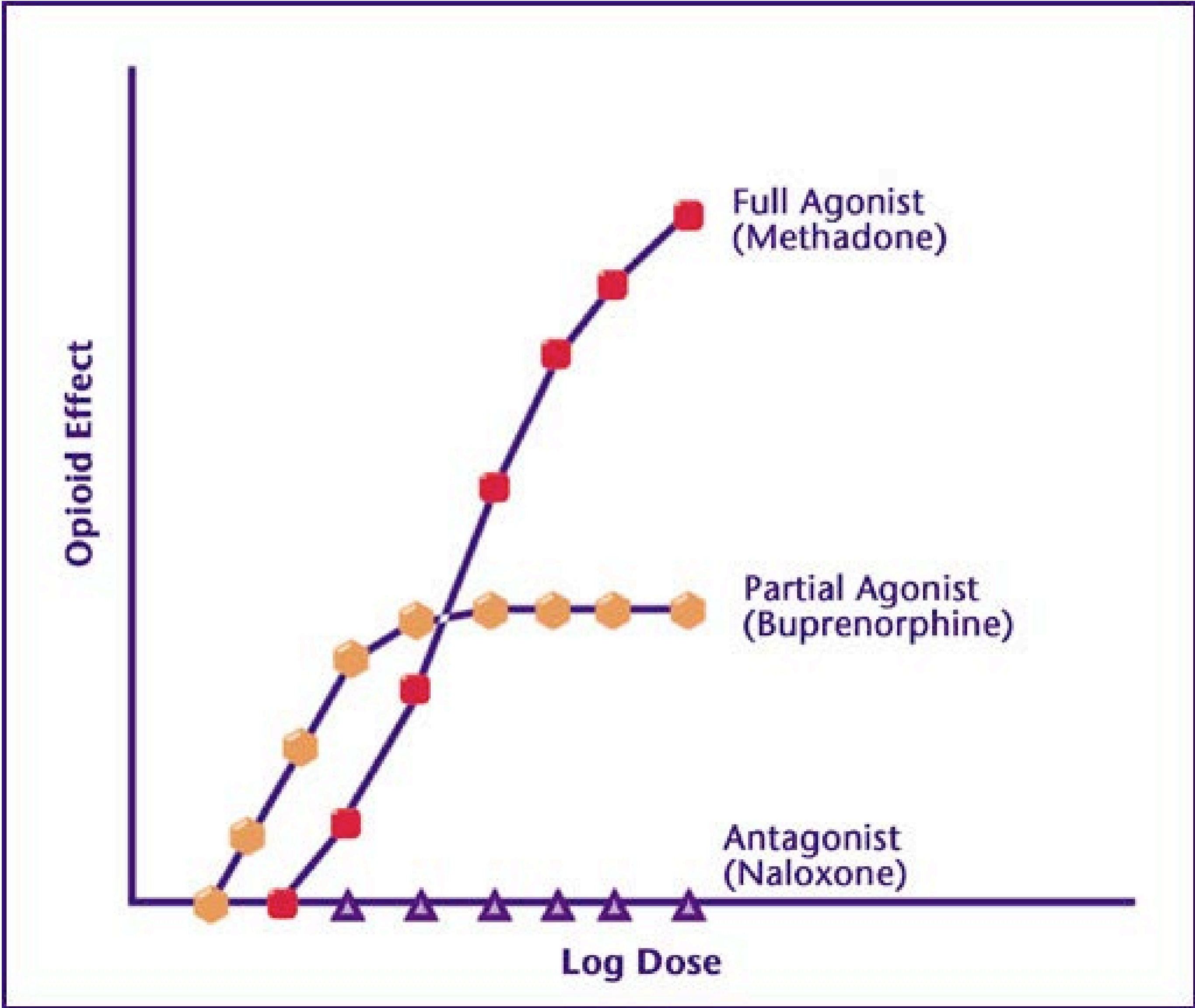
- Up to 9 *AMA PRA Category 1 Credit™*
- $199 user fee
- 10 modules, complete at your own pace
- Developed with funding from

For Physicians

Get DATA 2000 8 Hour Waiver Qualifying Buprenorphine Training.

Up to 9 *AMA PRA Category 1 Credit™*

$199 user fee


Full Agonist
(Methadone)
Partial Agonist
(Buprenorphine)
Antagonist
(Naloxone)
Opioid Effect
Log Dose

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

Proposal to MA Department of Public Health 11/17/15 and started 8/1/16

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 waivered prescribers, MDs)
  - In the inpatient hospital setting (Addiction Consult Service and SW & Project ASSERT Consults)

Funded in 1993 SAMHSA/CSAT;
1998 line item in BMC ED Budget

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

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

General Medical Setting	Screening for Health & Safety Needs	Empowerment through Brief Negotiation Interview/ BNI Compassionate/ curious Patient centered Respectful	Active Referral Network for Community Resources

Project ASSERT Model:

Brief Motivational Intervention by Peer Counselors

INJURY PREVENTION/ORIGINAL CONTRIBUTION

Ann Emerg Med August 1997;30:181-189.]

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

From the Department of Emergency Medicine, Boston University School of Medicine,* and Boston University School of Public Health,‡ Boston, MA; and Heller School, Brandeis University, Waltham,§ MA.

Edward Bernstein, MD*‡
Judith Bernstein, PhD‡§
Suzette Levenson, MPH‡

Received for publication

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.

ELSEVIER

Drug and Alcohol Dependence 77 (2005) 49–59

ALCOHOL DEPENDENCE

www.elsevier.com/locate/drugalcdep

Brief motivational intervention at a clinic visit reduces cocaine and heroin use

Judith Bernstein[a,c], Edward Bernstein[a,b,*], Katherine Tassiopoulos[b], Timothy Heeren[d], Suzette Levenson[e], Ralph Hingson[b]

[a] Department of Emergency Medicine, Boston University School of Medicine, 818 Harrison St. (Dowling 1), Boston, MA 02118, USA
[b] Department of Social and Behavioral Sciences, Boston University School of Public Health, Boston, MA 02118, USA
[c] Department of Maternal and Child Health, Boston University School of Public Health, Boston, MA 02118, USA
[d] Department of Biostatistics, Boston University School of Public Health, Boston, MA 02118, USA
[e] Data Coordinating Center, Boston University School of Public Health, Boston, MA 02118, USA

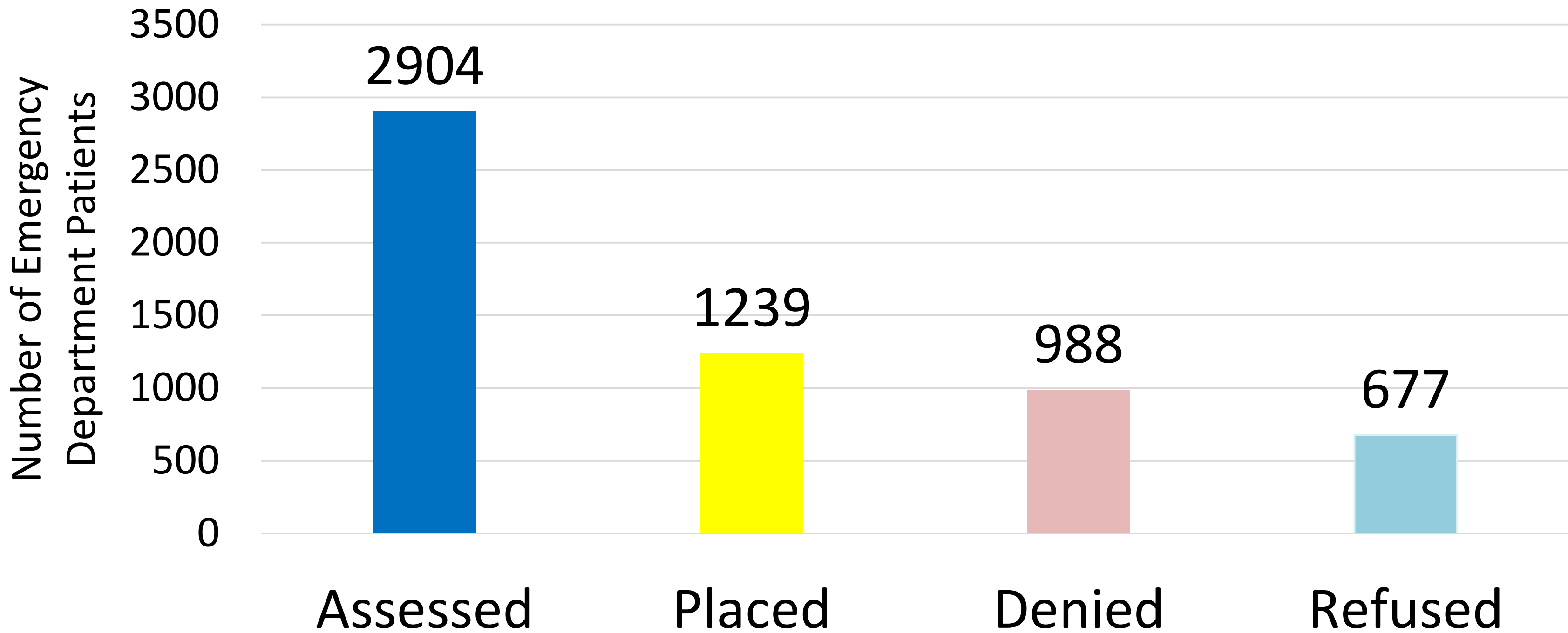
Received 4 February 2004; received in revised form 6 July 2004; accepted 7 July 2004

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 inner-city teaching hospital outpatient clinics with 3 and 6 months follow-up by

HTTPS://WWW.HHNMAG.COM/ARTICLES/8641-IMPROVING-THE-HOSPITAL-AND-EMERGENCY-DEPARTMENT-RESPONSE-TO-SUBSTANCE-USE-DISORDERS-A-PROJECT-ASSERT-CASE-STUDY

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



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

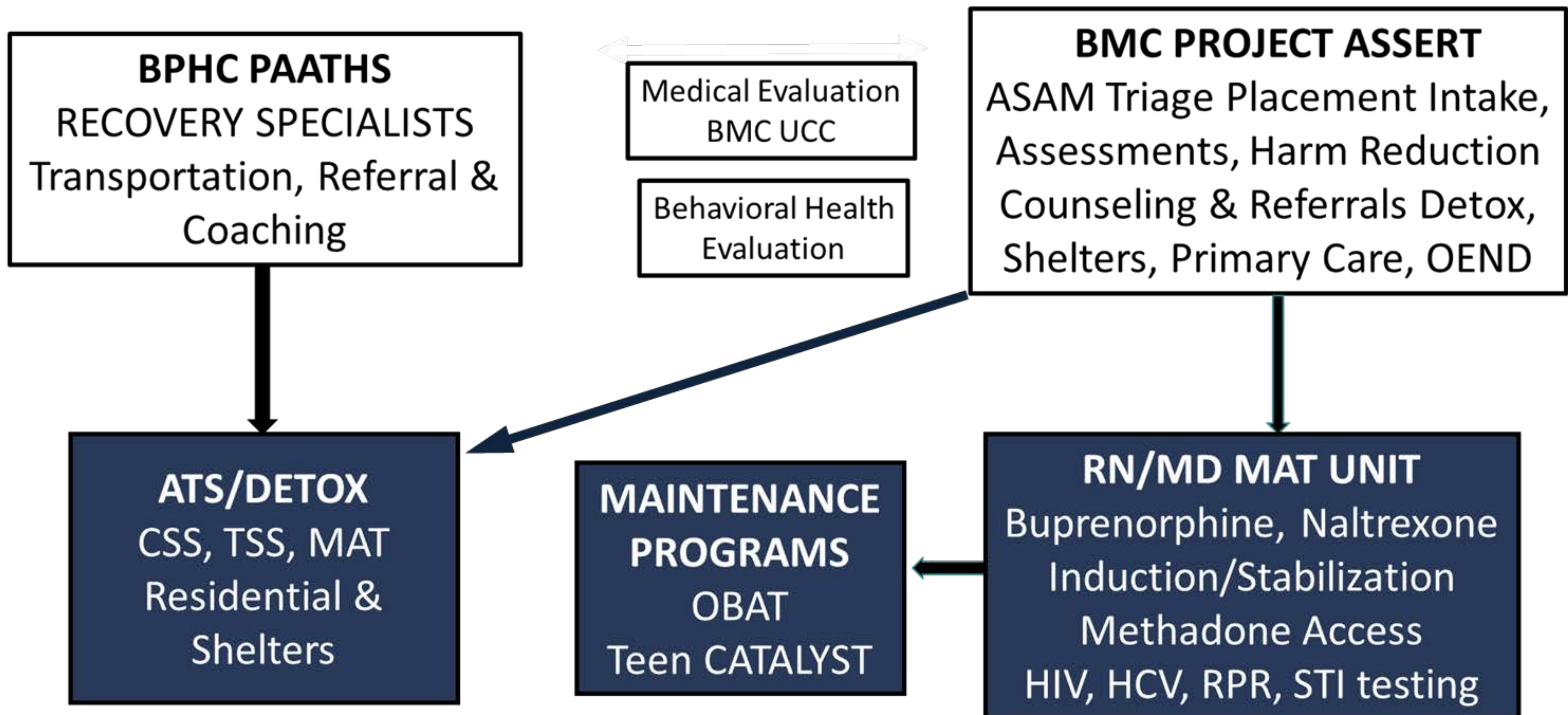
Inpatient Addiction Consult Service (ACS)

- 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



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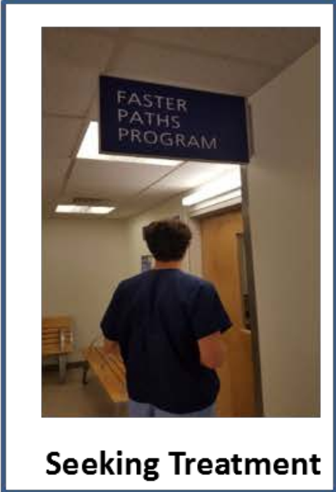
FASTER PATHS SERVICES

Co-Located With The ED Fast Track, Lab & Pharmacy



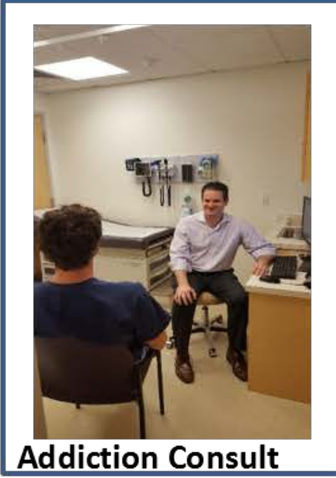
Seeking Treatment

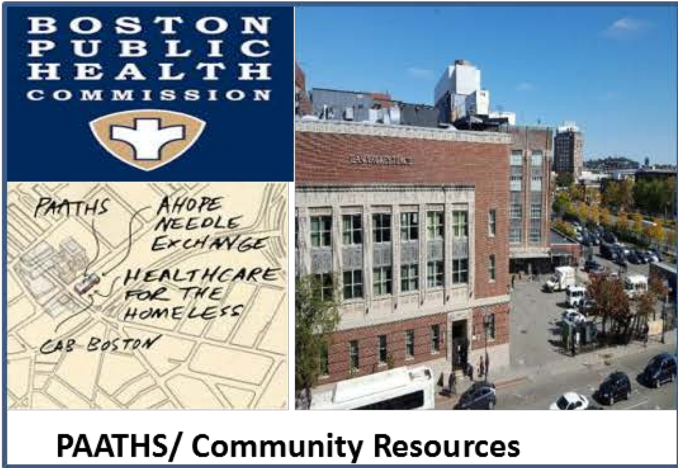
Registration

Project ASSERT LADCs Team

ASAM Triage, Assessment, Referrals, OEND, Follow up

Addiction Nurse


Addiction Consult



PAATHS/ Community Resources

Faster Paths to Treatment: August 1, 2016 - July 31, 2017

Total Unique Patients Served/ Total Visits	**1,275/ 4,635**
Total Addiction RN Medication Unit Visits	**2,056**
X waivered Physician Visits: diagnostic assessment, medical examinations, and medication therapy	**773**
LADCs Psych-social assessments, treatment planning & ASAM Level of Care Placement	**1,806**

Faster Paths to Treatment Services

MAT	MAT Rx	Transfers to OBAT or other programs	Placed in Detox	Other Services & Referrals: Shelter, PCP, ID, Ins. Food and Clothes NA/AA
407	1990	177	664	712

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

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Addiction consultation services - Linking hospitalized patients to outpatient addiction treatment. J Subst Abuse Treat. 2017 Aug;79:1-5. PubMed PMID: 28673521.

Discussion & Questions

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)

Contact Information

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