OREGON HEALTH LEADERSHIP COUNCIL

Opioid Use Disorder (OUD) Treatment in the Emergency Department (ED)

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Agenda

1. OUD Treatment in the ED Toolkit

- Background
- ED survey
- Toolkit information

2. Local Examples

- CODA
- Columbia Memorial Hospital
- Adventist Health Tillamook

Background - OHLC

OHLC 2.0

SHARED VISION

MISSION

to co-create **A HEALTHCARE SYSTEM** that is accessible, equitable, affordable, sustainable and high-quality for all people in Oregon

STRATEGIC FOCUS

- PROMOTING WHOLE-PERSON CARE
- REDUCING HEALTHCARE COSTS
- FOSTERING A THRIVING WORKFORCE

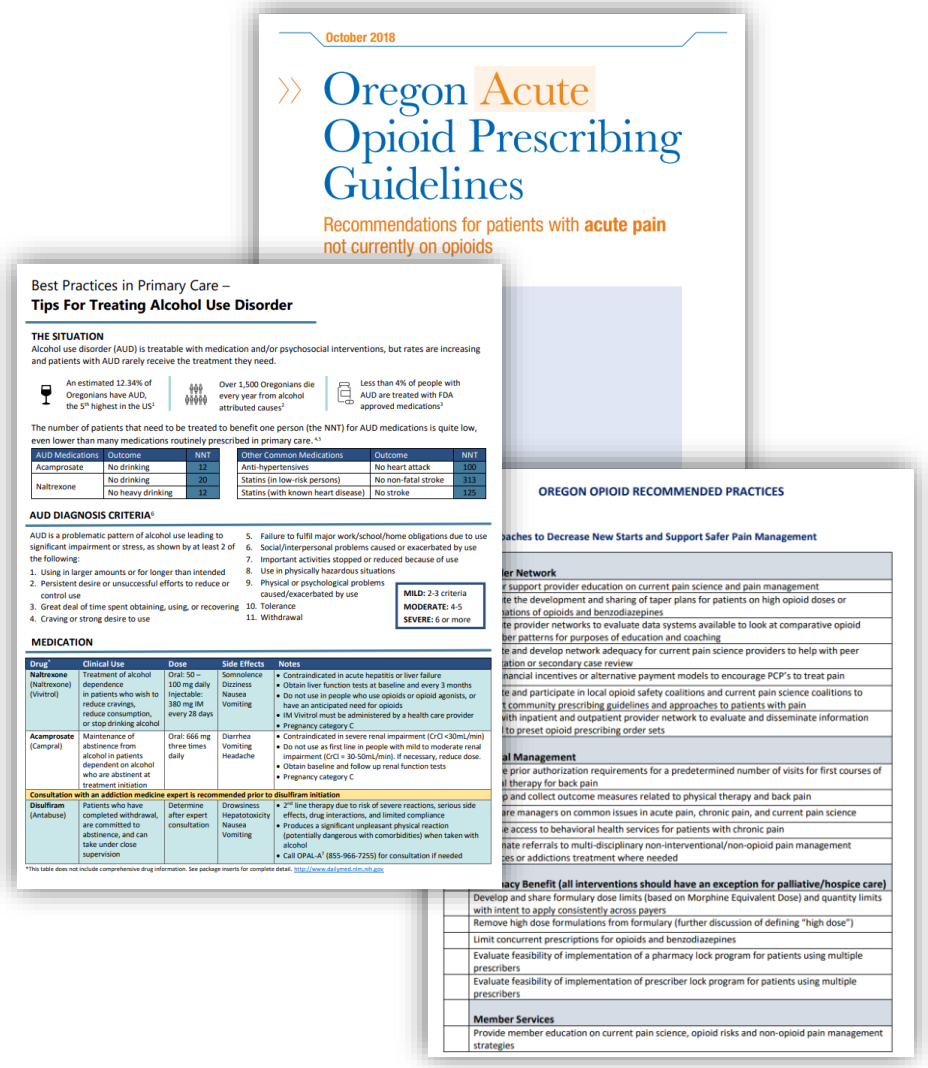
OHLC Members:

- Adventist Health
- Aetna
- Asante
- CareOregon
- Cigna
- HealthNet/Trillium
- Health Share of Oregon
- Kaiser Permanente NW
- Legacy Health
- Moda Health
- OAHHS
- OHSU
- OHSU Hillsboro Medical Center
- Oregon Medical Association (OMA)
- Oregon Primary Care Association
- PacificSource Health Plans
- Portland Coordinated Care Association
- PeaceHealth
- Providence Health and Services
- Regence
- Salem Health
- Samaritan Health Services
- St. Charles Health System
- The Oregon Clinic
- UnitedHealthCare

Background - SUD Workgroup

Purpose: To develop, align, and communicate recommendations for policies, procedures, and benefit methodology that support best practice management of substance use disorder in Oregon

- **Members:** SUD experts from CCOs, health systems, community SUD treatment, public health, pharmacy
  - We are always accepting new members!
- **Chair:** Safina Koreishi, MD, Columbia Pacific CCO
- **Initiatives:**
  - Best Practice Guidance
  - Reporting & Analysis
  - Support & inform other statewide SUD projects



OUD in the ED Toolkit

OUD in the ED Toolkit provides a basic framework for emergency departments (EDs) that want to build or strengthen their Opioid Use Disorder (OUD) treatment programs and offers Oregon-specific resources and examples that can help support their success.

Why?: Oregon's EDs have a unique opportunity to intervene during a crucial moment of a patient's life; to not just stabilize and discharge, but to provide the medications and connections people need to start down a new and healthier path**. We do not currently have a reliable system to ensure this is happening**.

Content gathered from:

OUD in the ED – Survey

ED Survey

- **Purpose:**
  1. Collect current ED approaches to OUD treatment, including medications, harm reduction services, and referral practices
  2. Understand barriers to treatment & needs in Oregon EDs
  3. Inform content/areas of focus for the Toolkit
- **Conducted:** Mar-Apr 2022, Aug 2022 by Comagine Health
- **Response rate:** 24/54 hospitals completed the survey

Full survey report can be found at: https://orhealthleadershipcouncil.org/wp-content/uploads/2023/01/MOUD-in-the-ED-Survey-Results-Report-Updated-8-2022.pdf

OUD in the ED – Survey

Of the 24 EDs that responded:

- Most (96%) have buprenorphine on their hospital's formulary
- Most (79%) are either both dispensing and prescribing **naloxone** (46%) or only prescribing naloxone (33%)
- Some (50%) have staff or volunteers who help with **care navigation** for patients with SUD
- Some (32%) have providers who routinely **prescribe buprenorphine** (of these, an average of 24% of providers in their ED routinely prescribe, range = 5% to 75%)
- Few (21%) have a **protocol for initiating buprenorphine** (another 21% are in progress of developing a protocol)
- Few (21%) have trained staff who can perform **treatment agreements** with patients prior to initiating buprenorphine
- Few (4%) provide a **telehealth option** for follow-up medication services for patients initiated on buprenorphine

OUD in the ED – Survey

What **barriers** has your organization experienced or do you anticipate experiencing related OUD treatment in the ED?

- Linkages to follow-up care for outpatient treatment especially in rural areas
- Trained staff comfortable providing medications for OUD
- Cost of dispensing naloxone
- Other

"**Education/knowledge** of specifics on treating opioid use disorder"

"**Rural practice** with limited outpatient treatment options"

"**Institutional comfort** with managing OUD in the ED"

"Our pharmacy will not give **naloxone** start packs to patients at discharge because the **cost is too high**"

"Ongoing **staffing issues** in small critical access hospital setting make launching a new program challenging"

"Ongoing **hesitancy and low self-efficacy** in initiating MOUD treatments"

"Many [providers] **don't believe this is the role of an emergency department**"

"there is minimal utility in starting someone on a medication if they **cannot get follow up**"

OUD in the ED – Survey

What **information, resources, tools, and training do you wish were available** to help with implementation?

- Additional outpatient resources for follow-up care
- More resources, education, and training
- Tools for developing workflows and protocols

"**Workflows** on who to consider initiating in. **Protocols** with dosing & counseling points"

"Workforce of **peer navigators available 24/7** online or in person"

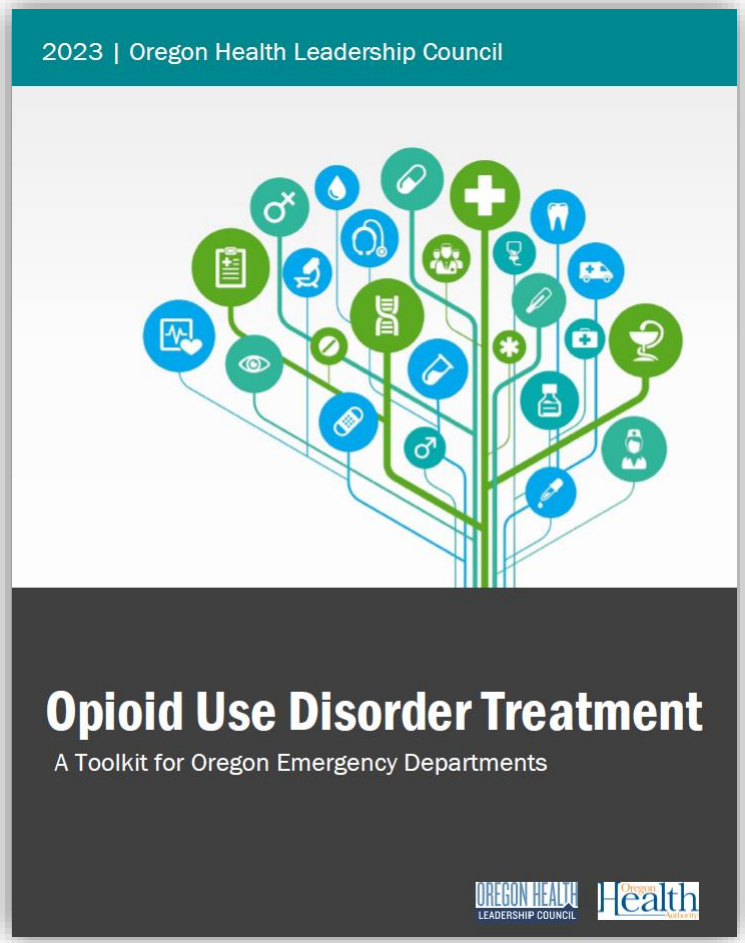
"Info regarding **insurance billing, logistics and protocols** for treatment, multi-disciplinary team"

"**training that is short and available** for busy clinical staff"

"I wish that we had an **easy referral process** for outpatient therapy"

"What free **resources are available** and how people access them"

OUD in the ED Toolkit



Toolkit Contents

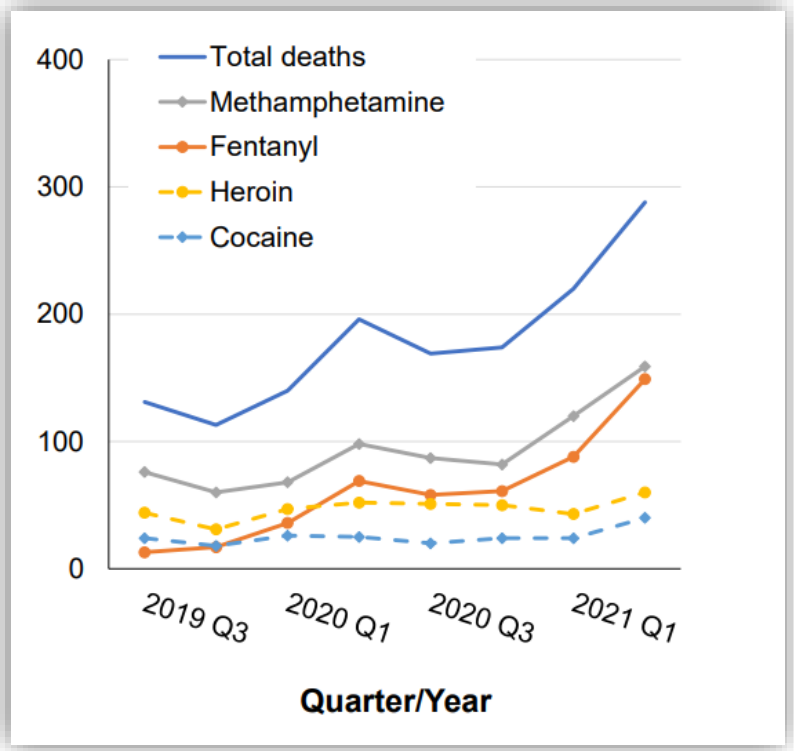
1. Background & rationale
2. Developing a successful program
3. Establishing best practice workflows
4. Provider focused treatment recommendations
5. Maintaining endurance

Full Toolkit can be found at: https://orhealthleadershipcouncil.org/wp-content/uploads/2023/02/OUD-Toolkit-final.pdf

1. Background & Rationale

- **Oregon is 1st (worst) in the nation for:**
  - % of population with prescription opioid misuse in the last year
  - % of population with illicit drug use disorder in the last year
  - People needing but not receiving treatment for SUD
- **Hospitalizations and deaths due to fentanyl and heroin are rising**
  - ED visits for overdoses increased in all Oregon regions from Q3 2021 to Q3 2022, particularly in the Southern Coast (30.6% increase) and Valley regions (24.9% increase)

Unintentional drug overdose deaths, Oregon, July 2019-June 2021*



*Source: Oregon Health Authority, Unintentional Drug Overdose in Oregon: The Current & Potential Impacts of the Covid-19 Pandemic, May 2022

Sources: Mental Health & Addition Certification Board of Oregon. Oregon Data extracted from the national Survey on Drug Use and Health, released December 2021.
Oregon Health Authority. Prescribing and Drug Overdose Data Dashboard.
Apprise Health Insights Quarterly EDIE Analytics Dashboards

1. Background & Rationale

- **There is strong evidence for the effectiveness of ED-initiated MOUD in addition to a secured plan for follow-up services**
  - "significantly increased engagement in addiction treatment, reduced self-reported illicit opioid use, and decreased use of inpatient addiction treatment services"
  - OUD treatment is achievable in all ED settings (small, large, rural, urban, etc.)
  - "Most likely to be cost effective compared to brief intervention or referral to community-based treatment alone"
- **EDs are an essential place of service to initiate medications and facilitate appropriate treatment for patients with OUD**
  - Patients who survive an opioid overdose are at high risk of death from several causes within the first 2 days after ED discharge
  - Since many patients do not have PCPs, ED participation in this service fills a significant gap in the current system of care and allows **the only access point that many patients may have to receive treatment**

2. Developing a successful program

Address the barriers

Two types:

Logistical barriers

- Need for training, referral partners, protocols/procedures, support staff, etc.
- How? Use the information and resources in the Toolkit

Perceived barriers

- Concerns such as “initiating OUD treatment is not the role of the ED”, “buprenorphine will be misused or sold”, “more patients will come to the ED seeking treatment”
- How? Strong leadership, champions, education…

2. Developing a successful program

Build Foundational Elements

Leadership Involvement
& ED Champions

OREGON Spotlight: ED Champion

"My experience as an SUD champion in the ED has been incredibly rewarding on a personal and professional level. The ED is one of the most common access points that people who use substances have with the health care system. For too long, the status quo has been to treat an overdose or abscess and discharge without further discussing substance use. I have found that my team and I, through the work that I and an RN champion have done, are changing how we interact with patients with SUD. We feel more comfortable having open conversations about a person's use and either starting treatment in the department or having up-to-date treatment information, discussing harm reduction and referrals to peers. **Change can be slow, and there are always bumps along the way, but having a steady team of champions to work through these issues and keep the momentum going, is vital.** I have seen growth and less burnout in myself and my teammates by changing the stigma around SUD and how we communicate with people who use substances. Hopefully, this change will be noticed by the community we serve and rebuild the trust with health care providers."

- *Melissa Willitzer, PA-C*
  ED Lead APP: Adventist Health, Hillsboro Medical Center, & Columbia Memorial Hospital

PROMOTE A CULTURE

- Communicate to the ED team that **OUD treatment is a priority** and that there is a **duty and moral obligation** to offer it to patients
- Uphold the position that **OUD treatment is a skill that belongs within emergency medicine** and is necessary to meet the needs of patients who may not seek care elsewhere
- Provide instruction on **trauma-informed care and harm reduction**

DEDICATE TIME AND RESOURCES

- Arrange time and space for the **collaborative development of policies**, procedures, practice guidelines, and patient materials related to OUD treatment
- Hire and train the **multi-disciplinary staff** needed to support clinicians and facilitate efficient and effective OUD treatment services

FACILITATE EDUCATION

- Arrange **department-wide training** in the areas of addiction medicine, opioid use disorder, pain science, stigma reduction, etc. (see page 7 for education resources)
- **Incentivize providers to obtain continuing education** through offering on-site training, training during shift, or reimbursement for time

2. Developing a successful program

Build Foundational Elements

Education

- Department-wide trainings for the **entire ED team** (providers, nurses, techs, administrative staff, and other support staff)
- Training should focus on both:
  - **Clinical practices** - including foundational knowledge of addiction, medication for addiction, evidence regarding the safety and effectiveness of buprenorphine
  - **Stigma reduction** - including trauma-informed care, harm reduction strategies, brief counseling for patients with OUD, and understanding OUD as a disease

OREGON EDUCATION RESOURCES
Oregon ECHO Network: Substance Use Disorders in Hospital Care
Opioid Response Network
Oregon Pain Guidance
Trauma Informed Oregon
Mental Health & Addiction Certification Board of Oregon (MHACBO)
NATIONAL EDUCATION RESOURCES
Providers Clinical Support System (PCSS)
American Society of Addiction Medicine (ASAM)
National Harm Reduction Coalition

2. Developing a successful program

Build Foundational Elements

Community Relationships & Referral Networks

It is especially important that EDs build strong ongoing relationships with their local referral partners

- Establish referral agreements with local community treatment sites and/or PCPs
- If possible, use an electronic referral network
- Utilize telehealth options when possible

REFERRAL NETWORKS
Connect Oregon
211info Coordination Center

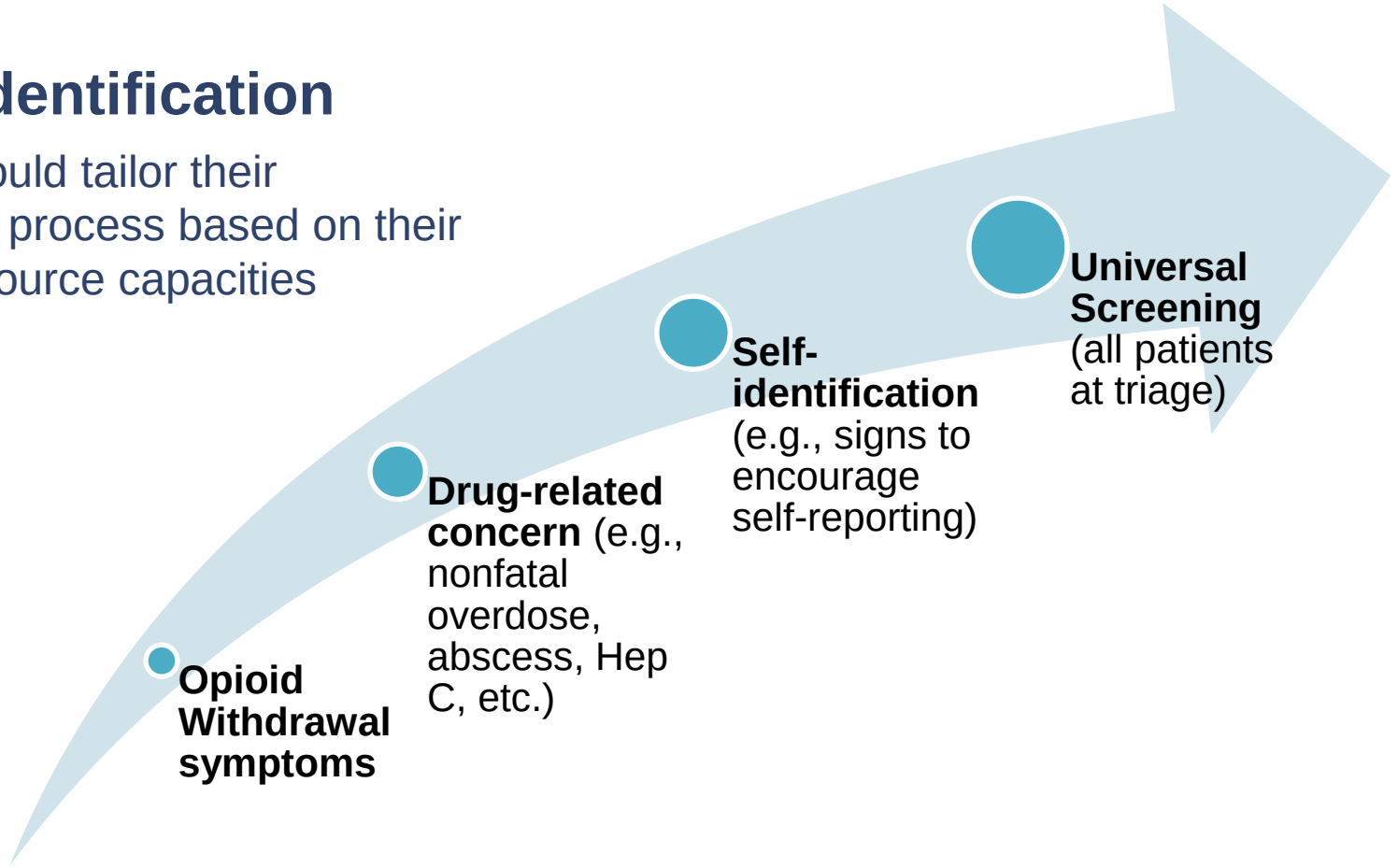
OREGON PROVIDER & COMMUNITY SUPPORT LOCATOR RESOURCES
OHA SUD Services Directory
211info
Oregon Overdose-Related Services & Projects Summary
Coast to Forest

CLINIC	DESCRIPTION
HRBR Clinic	Low-barrier, on-demand access to people who are interested in cutting back or stopping their alcohol or drug use. Services include MAT, disease screening, peer support, and connections to longer-term care. Accepts any and no insurance. Located at OHSU.
Boulder Care	Comprehensive, long-term virtual telehealth treatment for opioid and alcohol addiction treatment. Services include MAT, peer support, case management, care advocacy, as well as mental and physical health services. Referrals can be made 24/7 via their website.

3. Establishing best practice workflows

Patient identification

Each ED should tailor their identification process based on their time and resource capacities



3. Establishing best practice workflows

Informed Consent

Prior to initiating buprenorphine, **patient-centered** informed consent conversations should be completed. Including:

- How buprenorphine works
- Expected results
- Benefits of initiation
- Associated risks
- Safety precautions
- Alternative treatments
- Potential consequences of declining treatment

Specialist Consult

Consultation with an addiction medicine specialist can be beneficial **when treating complex patients**. If there is not an available specialist in your system, it is recommended that EDs establish a consultation process with a local treatment organization

The OHSU Addiction Consult Line provides free same day services to medical professionals in Oregon. Information available at https://www.ohsu.edu/health/ohsu-improving-addiction-care-team-impact

Electronic Order Sets

EHR-embedded order sets, clinical decision support tools, and narrative templates can **make it easier for providers** to follow treatment protocols:

- Buprenorphine dosing
- COWS assessment
- Supportive medications
- Lab tests
- Opioid withdrawal management
- Discharge medications
- PDMP review

3. Establishing best practice workflows

Harm Reduction Strategies

Compassionate care and an OPEN-DOOR POLICY

- All team members recognize addiction as a chronic disease
- Patients are cared for thoughtfully & without bias
- Patients are welcomed back if and when they are ready for treatment

Distribute NALOXONE

- Naloxone kits or prescriptions, as well as accompanying education, are provided to all patients at risk for an overdose

Offer LAB SCREENINGS

- Encourage patients with OUD to undergo testing for Hep C, HIV, and pregnancy

Teach SAFER INJECTION PRACTICES

- Provide education and materials
- Refer to a needle exchange program if appropriate

3. Establishing best practice workflows

Discharge Planning

1. **Referral –** Ideally a follow up appointment will be schedule prior to discharge. As this is not always feasible, an electronic referral or direct communication with the outpatient facility from the ED can help ensure an appointment is made.
2. **Buprenorphine prescription** – with the elimination of the x-waiver, any clinician with a DEA registration can write a prescription to bridge the gap until outpatient care is established
3. **Naloxone** – all patients at risk for an opioid overdose should be discharged with a naloxone kit (preferred) or prescription
4. **Discharge instructions** – Should be written at a 5th grade reading level and available in the patient's primary language

RESOURCE	DESCRIPTION
ColoradoMAT	Sample discharge instructions
CA Bridge	Sample discharge instructions, available in multiple languages and includes a customizable template

3. Establishing best practice workflows

Enhanced Care Teams

- Multiple titles and licenses/certifications - Peer support specialists, care navigators, care managers, care coordinators, and substance use navigators.
- All can provide logistical support, emotional support, and advocacy for patients, while minimizing the workload and time commitment for ED providers

OREGON Spotlight: Enhanced Care Teams

"In **St. Charles Bend/Redmond** emergency department, **BestCare's peer team** often works with patients with opioid use disorder, having just experienced an overdose, or other medical issues. Our peers can help the patient with immediate access to resources such as rapid access intakes into detox, medication supported recovery (MSR) or medications for addiction treatment (MAT) clinics, Narcan, as well as basic needs. These basic needs include transportation, food, tents, sleeping bags, and referrals to PCP's and mental health services.

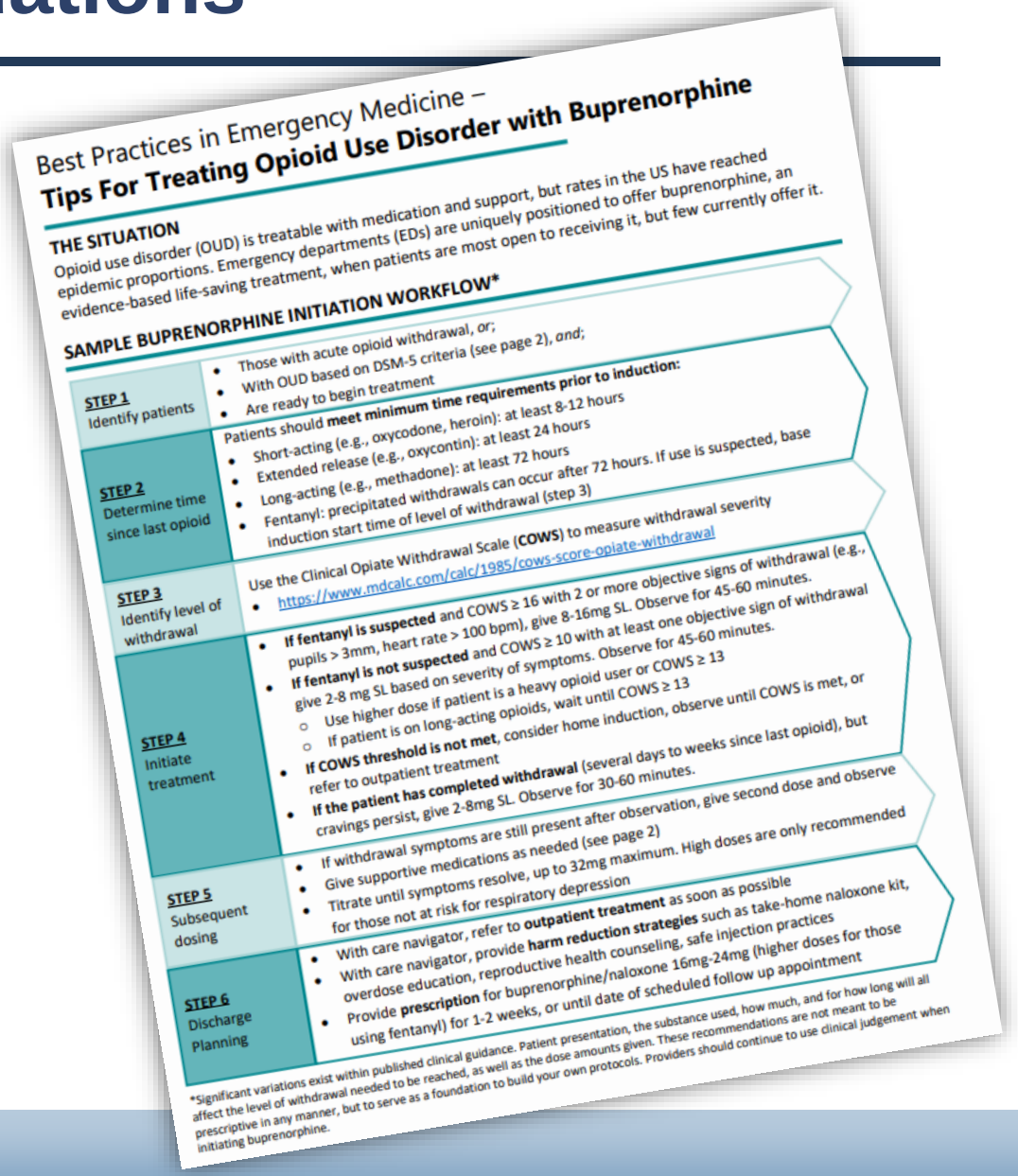
Our lived experience as peers helps us to build a unique connection with the patients we serve that leads to long lasting trust and rapport. The patients we see in the ED are often not ready to quit but continue to communicate with our peers for harm reduction support, and basic needs. For those patients that are ready to stop using opioids, we are able to complete the intake and assessment process to get them into SUD treatment almost immediately."

- *Lynette Espinoza*
  BestCare Peer Supervisor

4. Treatment recommendations

Tips for Treating OUD with Buprenorphine

- Can be used as separate provider focused document
- Includes:
  - Sample initiation workflow
  - OUD diagnosis criteria
  - Supportive medications
  - Additional considerations
  - Fentanyl information
  - Resources



Best Practices in Emergency Medicine –

Tips For Treating Opioid Use Disorder with Buprenorphine

THE SITUATION

Opioid use disorder (OUD) is treatable with medication and support, but rates in the US have reached epidemic proportions. Emergency departments (EDs) are uniquely positioned to offer buprenorphine, an evidence-based life-saving treatment, when patients are most open to receiving it, but few currently offer it.

SAMPLE BUPRENORPHINE INITIATION WORKFLOW*

STEP 1 Identify patients
- Those with acute opioid withdrawal, *or*;
- With OUD based on DSM-5 criteria (see page 2), *and*;
- Are ready to begin treatment

STEP 2 Determine time since last opioid

Patients should **meet minimum time requirements prior to induction:**
- Short-acting (e.g., oxycodone, heroin): at least 8-12 hours
- Extended release (e.g., oxycontin): at least 24 hours
- Long-acting (e.g., methadone): at least 72 hours
- Fentanyl: precipitated withdrawals can occur after 72 hours. If use is suspected, base induction start time of level of withdrawal (step 3)

STEP 3 Identify level of withdrawal

Use the Clinical Opiate Withdrawal Scale (**COWS**) to measure withdrawal severity
- https://www.mdcalc.com/calc/1985/cows-score-opiate-withdrawal

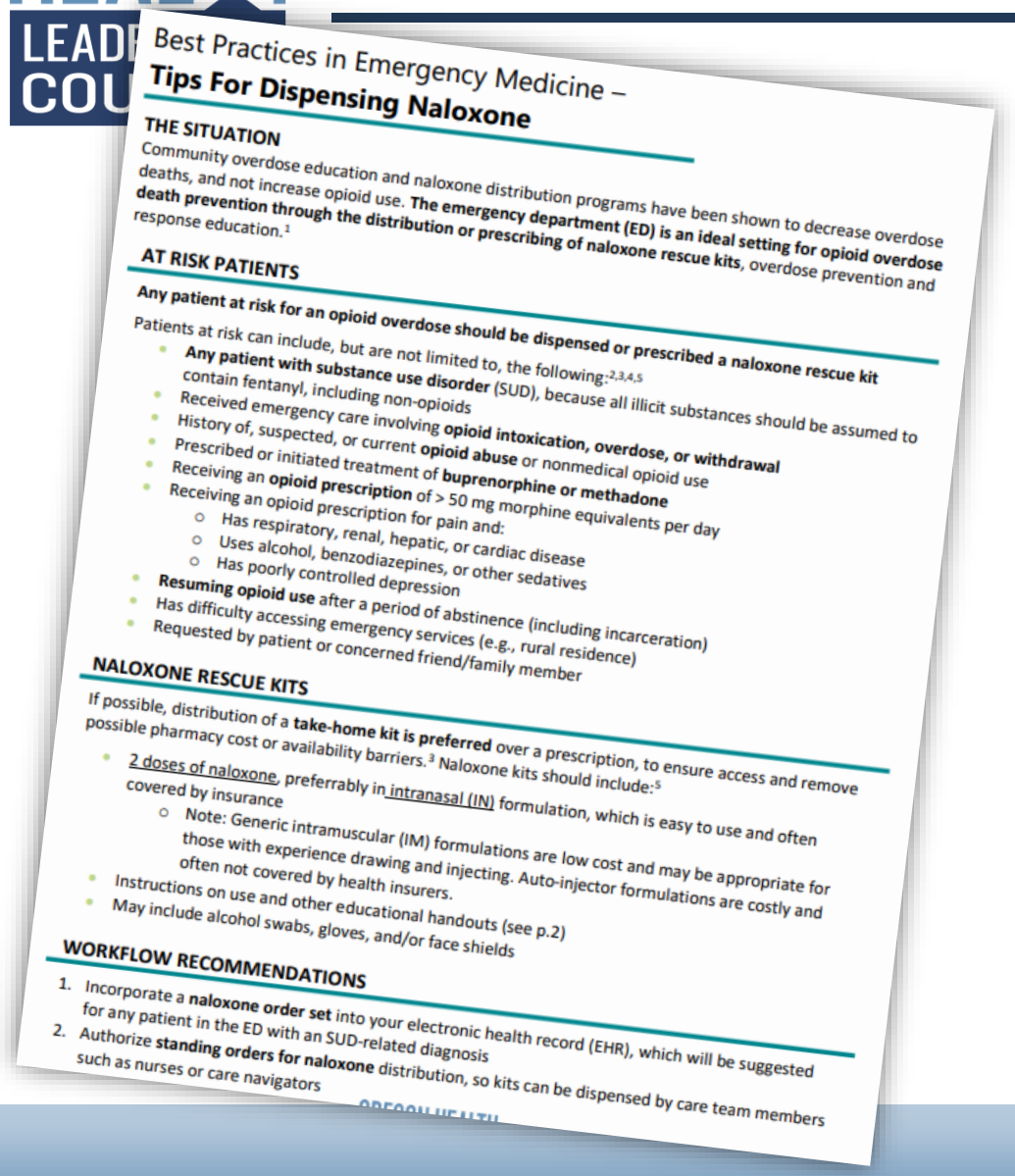
STEP 4 Initiate treatment
- **If fentanyl is suspected** and COWS ≥ 16 with 2 or more objective signs of withdrawal (e.g., pupils > 3mm, heart rate > 100 bpm), give 8-16mg SL. Observe for 45-60 minutes.
- **If fentanyl is not suspected** and COWS ≥ 10 with at least one objective sign of withdrawal give 2-8 mg SL based on severity of symptoms. Observe for 45-60 minutes.
  - Use higher dose if patient is a heavy opioid user or COWS ≥ 13
  - If patient is on long-acting opioids, wait until COWS ≥ 13
- **If COWS threshold is not met**, consider home induction, observe until COWS is met, or refer to outpatient treatment
- **If the patient has completed withdrawal** (several days to weeks since last opioid), but cravings persist, give 2-8mg SL. Observe for 30-60 minutes.

STEP 5 Subsequent dosing
- If withdrawal symptoms are still present after observation, give second dose and observe
- Give supportive medications as needed (see page 2)
- Titrate until symptoms resolve, up to 32mg maximum. High doses are only recommended for those not at risk for respiratory depression

STEP 6 Discharge Planning
- With care navigator, refer to **outpatient treatment** as soon as possible
- With care navigator, provide **harm reduction strategies** such as take-home naloxone kit, overdose education, reproductive health counseling, safe injection practices
- Provide **prescription** for buprenorphine/naloxone 16mg-24mg (higher doses for those using fentanyl) for 1-2 weeks, or until date of scheduled follow up appointment

*Significant variations exist within published clinical guidance. Patient presentation, the substance used, how much, and for how long will all affect the level of withdrawal needed to be reached, as well as the dose amounts given. These recommendations are not meant to be prescriptive in any manner, but to serve as a foundation to build your own protocols. Providers should continue to use clinical judgement when initiating buprenorphine.

4. Treatment recommendations



Best Practices in Emergency Medicine –

Tips For Dispensing Naloxone

THE SITUATION

Community overdose education and naloxone distribution programs have been shown to decrease overdose deaths, and not increase opioid use. **The emergency department (ED) is an ideal setting for opioid overdose death prevention through the distribution or prescribing of naloxone rescue kits**, overdose prevention and response education.[1]

AT RISK PATIENTS

Any patient at risk for an opioid overdose should be dispensed or prescribed a naloxone rescue kit

Patients at risk can include, but are not limited to, the following:[2,3,4,5]

- **Any patient with substance use disorder** (SUD), because all illicit substances should be assumed to contain fentanyl, including non-opioids
- Received emergency care involving **opioid intoxication, overdose, or withdrawal**
- History of, suspected, or current **opioid abuse** or nonmedical opioid use
- Prescribed or initiated treatment of **buprenorphine or methadone**
- Receiving an **opioid prescription** of > 50 mg morphine equivalents per day
- Receiving an opioid prescription for pain and:
  - Has respiratory, renal, hepatic, or cardiac disease
  - Uses alcohol, benzodiazepines, or other sedatives
  - Has poorly controlled depression
- **Resuming opioid use** after a period of abstinence (including incarceration)
- Has difficulty accessing emergency services (e.g., rural residence)
- Requested by patient or concerned friend/family member

NALOXONE RESCUE KITS

If possible, distribution of a **take-home kit is preferred** over a prescription, to ensure access and remove possible pharmacy cost or availability barriers.[3] Naloxone kits should include:[5]

- 2 doses of naloxone, preferrably in intranasal (IN) formulation, which is easy to use and often covered by insurance
  - Note: Generic intramuscular (IM) formulations are low cost and may be appropriate for those with experience drawing and injecting. Auto-injector formulations are costly and often not covered by health insurers.
- Instructions on use and other educational handouts (see p.2)
- May include alcohol swabs, gloves, and/or face shields

WORKFLOW RECOMMENDATIONS

1. Incorporate a **naloxone order set** into your electronic health record (EHR), which will be suggested for any patient in the ED with an SUD-related diagnosis
2. Authorize **standing orders for naloxone** distribution, so kits can be dispensed by care team members such as nurses or care navigators

Tips for Dispensing Naloxone

- Can be used as a separate provider focused document
- Includes:
  - Identifying at risk patients
  - What to include in a naloxone kit
  - Workflow recommendations
  - Patient education
  - How to access naloxone
  - Resources

5. Maintaining Endurance

Continual Quality Improvement

OUD treatment programs should continue to be evaluated and refined over time. Collecting, analyzing, and sharing data is an essential part of understanding the impact and identifying areas in need of improvement

Collect Data

1. Quantitative (EHR, dx codes, pharmacy records)
2. Qualitative (pt & staff satisfaction & barriers)
3. Follow-up data (referral outcomes)

Track Measures (examples)

- # of pts seen with an OUD-related diagnosis
- # of patients prescribed buprenorphine
- % of patients referred to follow-up treatment

Share Outcomes

- Data summaries
- Achievements and areas in need of improvement
- *Patient success stories*

5. Maintaining Endurance

Future needs in Oregon

Our group identified 4 primary recommendations for future focus areas in the state:

Increase post-discharge treatment options

We recommend continued focus on the need to fund and develop additional follow-up treatment options, including expansion of telehealth-based treatment, as well as inpatient facilities that can medically manage complex SUD patients.

Develop access to expert consultation

We recommend the development of regional addiction medicine consult lines, available 24/7 for all providers treating patients with substance use.

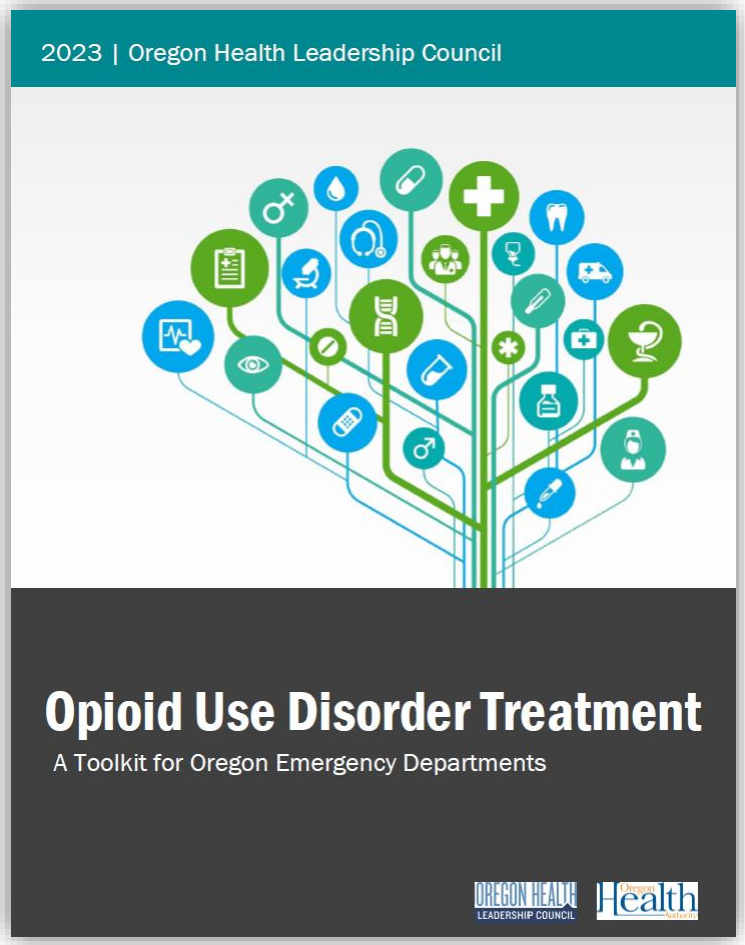
Address cost of naloxone take-home kits

We recommend statewide collaborative action to secure sustainable funding and reduce the cost of naloxone distribution through the ED, as well as educate all parties on the benefit of continued investment in take-home naloxone.

Expand access to peer support

We recommend that all Oregon hospitals embed peer support personnel into the ED, allowing low-barrier access to services for patients with substance use disorders.

OUD in the ED Toolkit



Takeaways

- Our hope is that the Toolkit is used as a catalyst to help facilitate change – to create a local sense of empowerment and duty to provide these services.
- Remember EDs don't need to do *everything* all at once. Start somewhere and take it slow. Build as time and resources become available.
- Our biggest hurdle is the culture shift – changing how EDs view their role in treatment of people with SUD and understanding the benefits of medication and a harm reduction approach.
- **This will take time, training, and strong leadership. We want to help support this change.**