California Health Care Foundation

July 2016

Meeting Summary

Emergency Care for the Opioid Epidemic:
Leaders Discuss Medication-Assisted Treatment in the ED

The April 2016 death of the musician Prince highlighted an all-too-common scenario: Patients are rescued from an opioid overdose in the emergency department (ED) but are not immediately connected to addiction treatment. Another overdose — often fatal — can follow.

The opioid epidemic is strongly impacting EDs, where for every overdose death, there are 35 visits related to opioid overuse, according to the CDC.[1] Both overdose deaths and opioid-related ED visits are steadily increasing each year in California.[2] In response, EDs across the state have implemented American College of Emergency Physician prescribing guidelines[3] to encourage judicious prescribing and to help ED providers avoid inappropriate prescriptions. However, there has been much less guidance on what EDs should do with patients who present with signs and symptoms of addiction — other than just saying no to a prescription request.

Addiction is considered a chronic disease, but it is an intensely stigmatized one. People who present at the ED for care for other chronic diseases — like diabetes — are stabilized with medications and handed off for outpatient care. For opioid addiction, there is only one published study that looks at outcomes for the same protocol: Gail D'Onofrio, MD, MS, of Yale University found that twice as many patients remained in treatment at 30 days (78% versus 37%) if they received a dose of buprenorphine[4] in the ED and a facilitated outpatient referral, compared to facilitated referral alone.[5]

There has not yet been a focus on what to do with ED patients who present with symptoms of addiction — other than just saying no to a prescription request.

To understand the potential role of EDs in treating addiction, CHCF convened emergency physicians, addiction specialists, behavioral health providers, and policy experts on March 10, 2016, to examine current models of ED addiction treatment and to discuss what it would take to spread these models in

I Feel Normal

When my patient — a very large man with PTSD, severe knee pain, and a lot of irritability — first showed up at the treatment program, it looked like he would soon be using a wheelchair. He had started opioids years earlier and found that by crushing and snorting the medication, he was able to get more pain relief. When the medication was changed to prevent that, he migrated to heroin.

There was a lot of tragedy in his life. He saw his wife die in a car accident when he had been too intoxicated to drive. His children had addiction problems. He was bordering on homelessness. But he wanted to get off opioids and also get better pain relief.

When we started him on buprenorphine, the effect was nothing short of miraculous. Within 30 minutes his symptoms improved 50% to 60%. After a few days of treatment he said, "I feel just like I did before I used opioids. I feel normal."

He was still having knee pain, so we titrated the dose, and then he could finally sleep through the night. He was able to get into VA-sponsored housing and get his life together.

As he got control over his addiction, he began to reconnect with people, engaging with the treatment community and helping out other veterans. They find him to be incredibly kind and giving. I see him as a gentle giant whose transformation is the best sort of advertising for this kind of drug treatment.

— David Kan, MD, president-elect and chair, Opioid Committee, California Society of Addiction Medicine

California. The meeting focused mostly on the use of buprenorphine in opioid use disorder and injectable naltrexone for alcoholism, globally referred to here as medication-assisted treatment (MAT).

An Underdeveloped Opportunity

Andrew Herring, MD, an ED physician at Alameda Health System's Highland Hospital, described the current landscape of practices and evidence related to MAT in the ED. Emergency physicians are in a difficult position, said Herring: "We are stuck in the middle between undertreatment and overtreatment with opioids." As the epidemic has swelled across the country, he said, EDs have been pressured to reduce opioid prescribing, although they are responsible for less than 5% of the opioid prescriptions in most communities.[6] As a result of an intensive educational effort, he said, there was a 50% reduction in these prescriptions in Highland Hospital's ED between 2010 and 2016.

"Now we're on the other side of that shift," he continued, "and it seems like a hollow victory." Many patients with opioid use disorder continue to use the ED as their primary source of care. While ED physicians "want to make a difference for patients and not spend their time battling about opioids," Herring said, the prevailing model of care is to address these patients' immediate symptoms without addressing the addiction itself. "The level of conflict starts to take over our shifts," he said. "It burns people out."

At the same time, Herring indicated, policymakers, payers, and others have emphasized the need to prevent inappropriate ED visits, despite evidence that for many low-acuity patients, the ED setting is not significantly more expensive than alternatives.[7] More importantly, for patients in the throes of addiction, he said, scheduling an appointment at 3 PM three weeks from now is not feasible. He asserted that the ED is a round-the-clock shop where, if systems were in place, patients could walk in when ready for treatment or could be encouraged to seek treatment when presenting for pain. Herring believes that ED visits should not be considered a "failure of the system, but instead an underdeveloped opportunity to engage otherwise difficult-to-reach patients such as those struggling with substance use disorder." With its 24-hour accessibility and capacity for complex care, he said, the ED can potentially serve as a hub for effective, patient-centered care for people with addiction — enabling ED clinicians to do more than just "treat and street."

"I've had a very long love affair with buprenorphine. I became a true believer when I saw a long-time heroin user who failed every other treatment become stabilized."

— David Kan, MD, president-elect and chair
Opioid Committee, California Society of Addiction Medicine

But the mindset that the ED could be an appropriate — even desirable — place to start patients with uncontrolled addiction on MAT is not yet part of the culture of most EDs, said Herring. Typically, ED physicians do not have waivers to prescribe

buprenorphine, and many of those with waivers do not use them. (Buprenorphine treatment can be done only within a certified drug treatment program, unless a physician has a waiver from the DEA authorizing buprenorphine prescribing, obtained after taking an eight-hour online or in-person class.)

Herring and the meeting participants discussed some of the challenges to achieving this vision, including:

- The requirement for waiver training and maintaining licensure to prescribe buprenorphine
- A patient population that can be uncooperative and difficult to treat
- Provider uncertainty about where patients fall on the continuum or "gray zone" of addiction and chronic pain, or trying to distinguish between "real pain" and "fake pain" or the "good patient" and the "bad patient"
- Uncertainty about treatment protocols and possible liability if treatment is initiated without sufficient follow-up in place
- Unavailability of a reliable path for referring patients for monitoring and follow-up

Herring said that D'Onofrio's study proves that these problems can be overcome. "These complex patients are already coming to our EDs, and we are treating them inefficiently, in ways that frustrate the patients, providers, and staff," he said. When ED providers hear a compelling narrative about why this works — the science and the patient success stories — the culture shifts. An ED can get started using buprenorphine with just one physician champion and a referral arrangement. "But we need a whole system to make this work," Herring said, "and that involves working with the staff and the nurses to treat addiction differently than we are right now."

California Innovations

A number of initiatives in California were described and discussed, including the following.

Community Hospital Monterey Peninsula (CHOMP). Lee Goldman, MD, medical director of Chemical Dependency Services in Monterey, described the hospital's process for serving opioid- and alcohol-dependent patients in the ED. While at the time of the meeting their MAT program was on hold due to challenges linking patients to ongoing outpatient care, CHOMP and the Central California Alliance for Health are collaborating to find new options. Goldman described the processes CHOMP has used in the past and that he aims to restart and build upon.

- Most of the patients self-refer or are brought in by family members; others are identified as frequent ED users and are assessed for opioid use disorder.
- ED physicians and nurses partner to identify, educate, and administer medications to patients.
- Patients in withdrawal are given the first dose of buprenorphine in the ED; patients not in withdrawal are given medications for home induction and a five-day stabilizing dose. Typically, their providers have used intramuscular (IM) buprenorphine (for patients with both addiction and pain diagnoses), since only one provider currently has a license to prescribe sublingual buprenorphine (whose use is restricted to addiction).
- Patients are referred to community organizations for ongoing treatment.

Goldman said that it is very rewarding when people come back and their lives are changed. "They'll say, 'I don't know what it is, doc. I don't have cravings. I don't think about it a lot. I feel normal again.'"

"Three years ago, we didn't test for HIV in the ED at LAC+USC, and now we do. Cultures change. Providers will change their behaviors rather quickly if they get what they need — not just information, but someone to manage a warm handoff for their patients."

— Michael Menchine, MD, MPH, associate professor of Clinical Emergency Medicine and research director Los Angeles County / University of Southern California

County of San Mateo Behavioral Health and Recovery Services (BHRS). Mary Taylor Fullerton, MA, MFT, BHRS supervisor, described the San Mateo County program, which began with using injectable naltrexone for people with chronic alcohol use frequently using San Mateo Medical Center ED and psych ED services, or interacting with law enforcement. (The program is expanding to include buprenorphine for patients with opioid use disorder later in 2016.)

The program, involving intensive case management and monthly injectable naltrexone, was piloted in 2013 with 18 patients and resulted in large cost savings due to reduction in ED use. The cost data were

used to establish a formal partnership with the Health Plan of San Mateo and create the county's first MAT program, which began in 2015. Key features include:

- A behavioral health alcohol and drug services case manager is available onsite at the San Mateo Medical Center ED and Psychiatric ED seven days a week, and in satellite primary care clinics Monday through Friday; a case manager is also available in the field — jails and substance use disorder treatment programs — Monday through Saturday.
- The program has priority access to 15 residential withdrawal management beds as well as a sobering station for use up to 18 hours.
- The local Medi-Cal health plan pays for the program, and care is provided almost exclusively to Medi-Cal health plan members and those with no insurance.
- Program staff include eight case managers, a psychiatric/addiction specialist, a program analyst, a benefits analyst, and a supervisor; contracted partners include inpatient detox (withdrawal management), a new MAT clinic with basic primary care, and MAT services as well as peer coaching and supports.

"We have reached out to 1,000 patients since July 1, [2015,] mostly through the ED," Fullerton said. "Many are frequently seen in the ED, psych ED, and jails, and most are homeless." The program got a list of the health plan's frequent services users, then reached out to the first 75. Because most of the patients struggle to keep appointments, the program acquired a vehicle and can now transport people to their appointments. Also, a case manager can contact patients even when they are in a shelter without a phone. "To have that monitoring at the beginning is really important," Fullerton said. "The crucial thing is the warm handoff."

"I have heard doctors express concern about the idea of addiction treatment in the ED — resenting one more thing put on the busy ED provider. But the truth is, we are seeing these patients anyway, often again and again. We can see them and continue not to address all of their needs, or we can do the right thing and actually try to treat their disease."

— Maria Raven, MD, associate professor
Emergency Medicine, UCSF

Zuckerberg San Francisco General Hospital (ZSFGH). Based on information sent by leaders who could not attend the convening, CHCF's Pfeifer described four ZSFGH initiatives: inpatient buprenorphine; inpatient naloxone; ED naloxone; and inpatient naltrexone for alcoholism. (The naloxone program does not treat addiction, but dispenses and teaches high-risk patients the use of this antidote.) She provided details about the inpatient buprenorphine program, since learnings from this model can be applied to the ED setting as well.

- If providers identify an inpatient with opioid use disorder, they assess the patient's appropriateness for and interest in methadone or buprenorphine, following a defined protocol.
- The appropriate drug is started during the hospitalization. Methadone recipients are discharged to the care of a local methadone clinic, while buprenorphine patients receive enough medication from the discharge pharmacy to last through their follow-up appointment at San Francisco's OBIC (Office-based Buprenorphine Induction Clinic).
- Once buprenorphine patients are stabilized, they are discharged back to their primary care or other physician for ongoing medication maintenance.
- All ZSFGH family medicine residents are trained in the use of buprenorphine, although obtaining the waiver is not mandatory.

Yale Model Points to Results

D'Onofrio, who chairs the Department of Emergency Medicine at Yale-New Haven Hospital, talked with participants by phone about Yale's experiences initiating buprenorphine treatment in the ED, and described a randomized clinical trial comparing three levels of intervention for patients with opioid use disorder.[8]

The three levels included: (1) screening and referral to treatment (giving patients a pamphlet and a phone number); (2) screening, brief intervention, and facilitated referral to community-based treatment services (calling the community organization,

arranging transportation for the patient, and providing a warm handoff); and (3) screening, brief intervention, ED-initiated treatment with buprenorphine, facilitated referral to community-based treatment, and referral to primary care for 10-week follow-up, all done from the emergency department. The primary measure of success, D'Onofrio said, was being enrolled in and receiving addiction treatment after 30 days.

The results showed that 78% of patients in the buprenorphine treatment group were still in treatment at 30 days, compared to 45% of the brief intervention group, and 37% of patients in the referral group. D'Onofrio noted that robust outpatient follow-up with life coaches was an important aspect of the program.

After the conclusion of the study, D'Onofrio said, buprenorphine is still used routinely in the ED. There are four prescribers and about 15 to 20 faculty who have completed part of the required training to prescribe. "So many doctors are training for this, it's kind of exciting," she said.

In response to questions from the meeting participants, she said that getting staff on board was not difficult. "They see these patients every day," said D'Onofrio. "Staff were happy that they had something to do for them." She stressed the importance of feedback. "I always get back to the other physicians and ED staff to let them know how patients are doing," she added.

What Is Needed for Spread

Pfeifer led a discussion of how to best proceed with the creation of pilot initiatives for providing MAT in the ED, focused on four elements that would support pilots and spread:

1. **A compelling narrative** with both an emotional appeal, such as inspiring patient stories and feedback to providers about how their patients are doing after treatment, and a rational appeal, such as sharing evidence of success in the literature and facts about cost-savings and other return-on-investment advantages.

2. **Protocols** that would clarify what is needed to proceed at three levels, depending on leadership commitment and resources:

   a. *MAT in the ED 1.0, or basic level.* A single champion prescriber with an arrangement for outpatient handoffs.

   b. *MAT in the ED 2.0, or mid-level.* A champion, a few doctors waivered to treat with buprenorphine, and some engagement of support staff (such as a case manager) helping with referrals and follow-up.

   c. *MAT in the ED 3.0, or robust level.* Most or all ED prescribers waivered to prescribe buprenorphine; established protocols in place for patient education, evaluation for treatment, and referral to outpatients services; and all staff trained to treat addiction without stigma. All addictions are addressed, not just opioids.

"I have a vision that there's a continuum of care beginning in the ED and followed up in primary care with comprehensive behavioral health services."

— John Bachman, PhD, behavioral health director
El Dorado Community Health Center

3. **Policy backing** including official technical guidance from organizations like the American Society of Emergency Physicians (ASEP) and the California Society of Addiction Medicine (CSAM) to clarify who can prescribe what forms of buprenorphine for what conditions, with and without the waiver. Helpful policy changes might include a focus on sustainable funding for MAT.

4. **Mentoring** of physicians, nurses, and others through services like the Clinician Consultation Center Warmline (see box) and Providers' Clinical Support System (PCSS).

Primary Care Doctors' Warmline

The Substance Use Warmline (855) 300-3595. provides clinician-to-clinician consultation on managing substance use disorders every weekday (7 AM to 3 PM). Run by the Clinician Consultation Center at the University of California, San Francisco, the Warmline is staffed by experts in pharmacotherapy options for opioid use. See nccc.ucsf.edu.

A Task List for California

Participants had numerous ideas about what could be done to move ED-based addiction treatment forward in California. Some of the following activities are already in progress at certain locations.

Assess Needs and Build on Current Assets

- Start by defining a target geography and assessing existing capacity for addiction treatment that could manage urgent referrals. Launch pilots in all (or most) hospitals in the area so that one hospital doesn't become the only option.
- Work with local safety coalitions already working on MAT access, or create a planning group with partners among community providers, pharmacies, hospitals, and county systems.
- Connect with directors of area opioid treatment programs (e.g., methadone clinics) and residential treatment facilities. Explore the option of referrals to treatment programs that offer both buprenorphine and methadone.
- Connect with county or regional planning and implementation efforts for Drug Medi-Cal Organized Delivery System.

Explore and Facilitate Easier Access to Services

- Consider different models for MAT in outpatient settings and explore funding options, to allow more options for referral after ED treatment.
  - *Induction clinics paired with a network of primary care providers for opioid addiction.* Induction clinics offer intensive behavioral health support and can see new patients frequently. In this model, the induction clinic starts patients on treatment and follows them closely until they are able to manage with monthly visits. At that point, the patients are referred to primary care providers for buprenorphine maintenance.
  - *Residential facility partnerships.* This model, in use in Contra Costa County, allows clients in residential addiction treatment facilities to go to the ED on a pre-arranged basis for buprenorphine induction; the follow-up visits for buprenorphine maintenance occur in the county clinic.
- Explore alternative induction strategies, such as home induction, or the use of transdermal opioids (fentanyl or buprenorphine) to "bridge" patients through the induction with no or minimal withdrawal symptoms. **Note:** Fentanyl and buprenorphine can be prescribed only for patients with a pain diagnosis, since these products are indicated for pain, not addiction. Buprenorphine can be prescribed for pain by any clinician without a waiver, as long as the clinician has a DEA license to prescribe controlled substances. (See *Buprenorphine: Questions and Answers* for examples of bridge protocols at www.chcf.org.)
- Promote the inclusion of buprenorphine on commercial health plan formularies, with fewer authorization restrictions (commercial plans only; buprenorphine for addiction is available on Medi-Cal without authorization, while buprenorphine for pain does require Medi-Cal authorization).
- Work with local pharmacies to keep medications for addiction treatment in stock, and ensure they know how to bill insurance. **Note:** For Medi-Cal, the claims need to go to the state fee-for-service Medi-Cal system, not the local Medi-Cal plan.
- Develop an ED entryway for vulnerable patients, with more stable patients directed to outpatient facilities. Use case managers to identify vulnerable patients and then prioritize them.

Build Skills and Knowledge

- Research existing models and protocols, and create standardized procedures, workflows, and training modules for nurses, case managers, social workers, and primary care doctors. Share broadly.
- Create a frequently asked questions (FAQ) document for ED physicians who are not familiar with buprenorphine (e.g., Do patients get high from buprenorphine? What are the licensing implications of using buprenorphine? What is a DEA X-license?).
- Offer incentives for ED physicians to be trained and waivered to prescribe buprenorphine.
- Research options for a website to house protocols related to MAT in the ED.

Look for Creative Ways to Manage Financial Challenges

- Seek federal and local grants to support the establishment of pilots and programs.
- Work with hospital pharmacies to build MAT into the formulary. Generic buprenorphine without naloxone, for example, is cheaper than the brand-name combined product.
- Work with health plans, which have financial incentives to better manage patients with addiction and high resource use.

The conference participants recommended working with natural allies such as the American College of Emergency Physicians, the California Society of Addiction Medicine, the California Medical Association, the California State Association of Counties, the California Nurses Association, and others.

"The ED is the right source of entry and re-entry for a lot of people, and an important source of referrals. We currently have about 250 patients on buprenorphine several of whom were evaluated and whose inductions began in the ED."

— Ken Saffier, MD
Contra Costa Regional Medical and Health Centers

Beyond Binary Thinking

In closing the gathering, Pfeifer spoke about necessary changes to the clinical mindset. "In the past, we've had a binary notion in our approach to these patients," she said. "They are sober or not sober. If they are not sober, treatment has failed and they have failed."

It makes more sense for addiction to be treated like any chronic disease, she said. "If a patient with diabetes binges on sugar and gets into trouble, they can be treated in the ED, stabilized, and sent home. We don't say they have failed treatment and take away their insulin. Yet if someone with addiction makes a mistake, it can result in lost access to buprenorphine, jail time, or losing children to foster care." It can take considerable time for people to recover fully, she said, because the brain chemistry is altered, and because habits are hard to change.

Despite the considerable obstacles to establishing MAT as routine care in California EDs, there is growing interest throughout the state. Several meeting participants stressed that physicians are won over when they see how patients respond within 20 minutes to their first dose of buprenorphine. "You're only going to convince the skeptics when they've seen how this works," said Pfeifer. "Seeing patients get better is the best cure for cynicism."

About the Author

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About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

Resources

Buprenorphine: Questions and Answers
www.chcf.org (PDF)

Changing Course: The Role of Health Plans in Curbing the Opioid Epidemic
www.chcf.org

Opioid Safety Coalitions Network
www.chcf.org/oscn

Recovery Within Reach: Medication-Assisted Treatment of Opioid Addiction Comes to Primary Care
www.chcf.org

Webinars:

Expanding Access to Buprenorphine in Primary Care Practices
www.chcf.org

Opioid Safety Coalitions: Is Buprenorphine for Pain a Safer Alternative to High-Dose or Long Term Opioid Use?
www.chcf.org

Endnotes

1. "The DAWN Report: Highlights of the 2009 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits," Substance Abuse and Mental Health Services Administration, December 28, 2010, www.samhsa.gov.
2. "Understanding the Epidemic Through Data," California Health Care Foundation, Opioid Safety Coalitions Network, www.chcf.org/oscn/data.
3. "Safe Prescribing," California American College of Emergency Physicians, californiaacep.org.
4. Buprenorphine is a medication proven effective for both opioid addiction and pain; patients on buprenorphine have much lower death rates and higher retention in treatment than drug-free treatment models. "Induction" is the process of starting a patient on buprenorphine. Naltrexone, also discussed in this report, has been proven effective in alcoholism, and has benefit in some subpopulations of opioid use disorder.
5. Gail D'Onofrio et al., "Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial," *JAMA* 313, no. 16 (April 28, 2015): 1636-44, doi:10.1001/jama.2015.3474, www.ncbi.nlm.nih.gov.
6. Laura Governale, "Outpatient Prescription Opioid Utilization in the U.S., Years 2000-2009," archived US Food and Drug Administration presentation July 22, 2010.
7. Robert M. Williams, "The Costs of Visits to Emergency Departments," *New England Journal of Medicine* 334 (March 7, 1996): 642-6, doi:10.1056/NEJM199603073341007; Thomas J. Sugarman, "Time to Focus on Improving Emergency Department Value Rather Than Discouraging Emergency Department Visits," *Western Journal of Emergency Medicine* 14, no. 6 (October 2013): 617-8, doi:10.5811/westjem.2013.8.19100.
8. See endnote 5.