Ensuring Medication for Opioid Use Disorder (MOUD) Treatment through the Care Continuum Webinar Series

Role of the Emergency Department (ED) Physician in the Treatment of Patients with Opioid Use Disorder (OUD)

September 15, 2023

In partnership with all Quality Innovation Network-Quality Improvement Organizations

QIN-QIO Partnership to Address the Opioid Epidemic

This series is a collaboration of all Quality Innovation Networks–Quality Improvement Organizations (QIN-QIOs). National experts across the healthcare continuum provide robust educational content to address the opioid epidemic.

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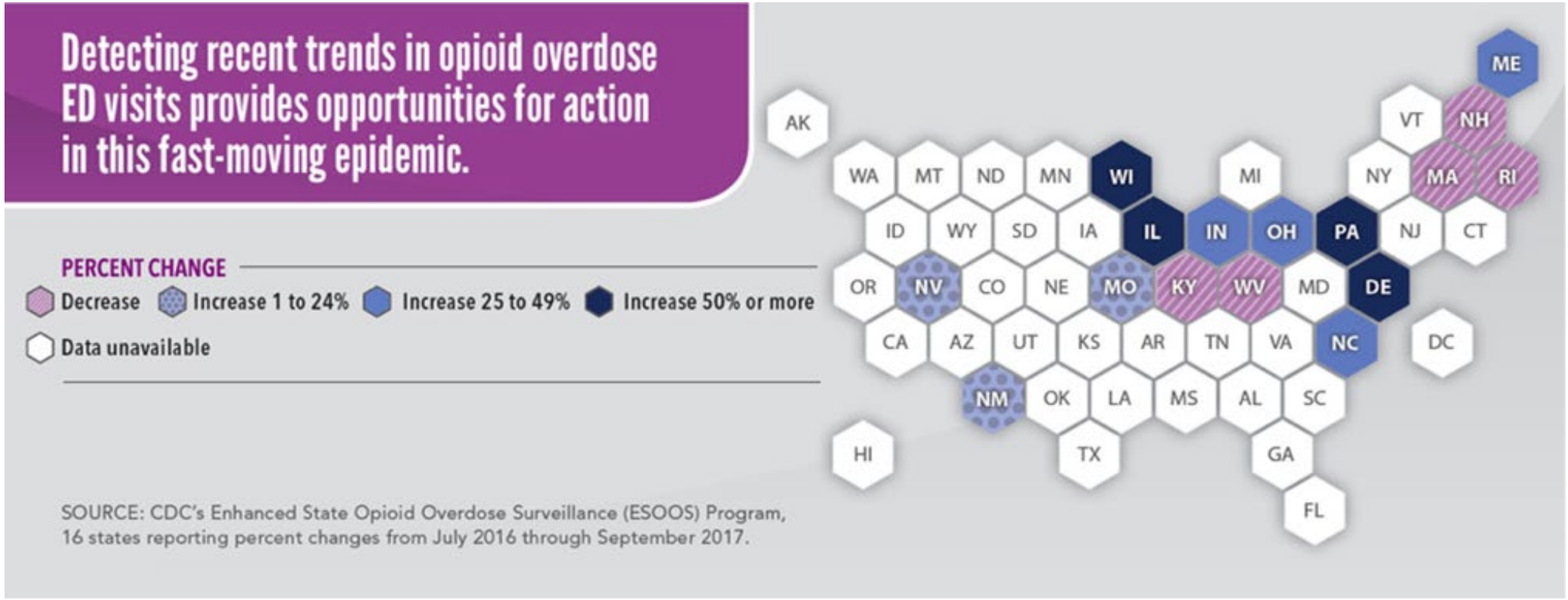
Learning Objectives

- Explain the evolving role of the ED in Medications for Opioid Use Disorder (MOUD).
- Review the mechanism of action and evidence base behind Buprenorphine MOUD.
- Review how the 2022 Consolidated Appropriations Act affects the X-waiver and MOUD training process.
- Describe the process of ED MOUD initiation and referral.

Guest Speaker

Bobby Redwood, MD, MPH, FACEP, has no financial relationships to disclose.

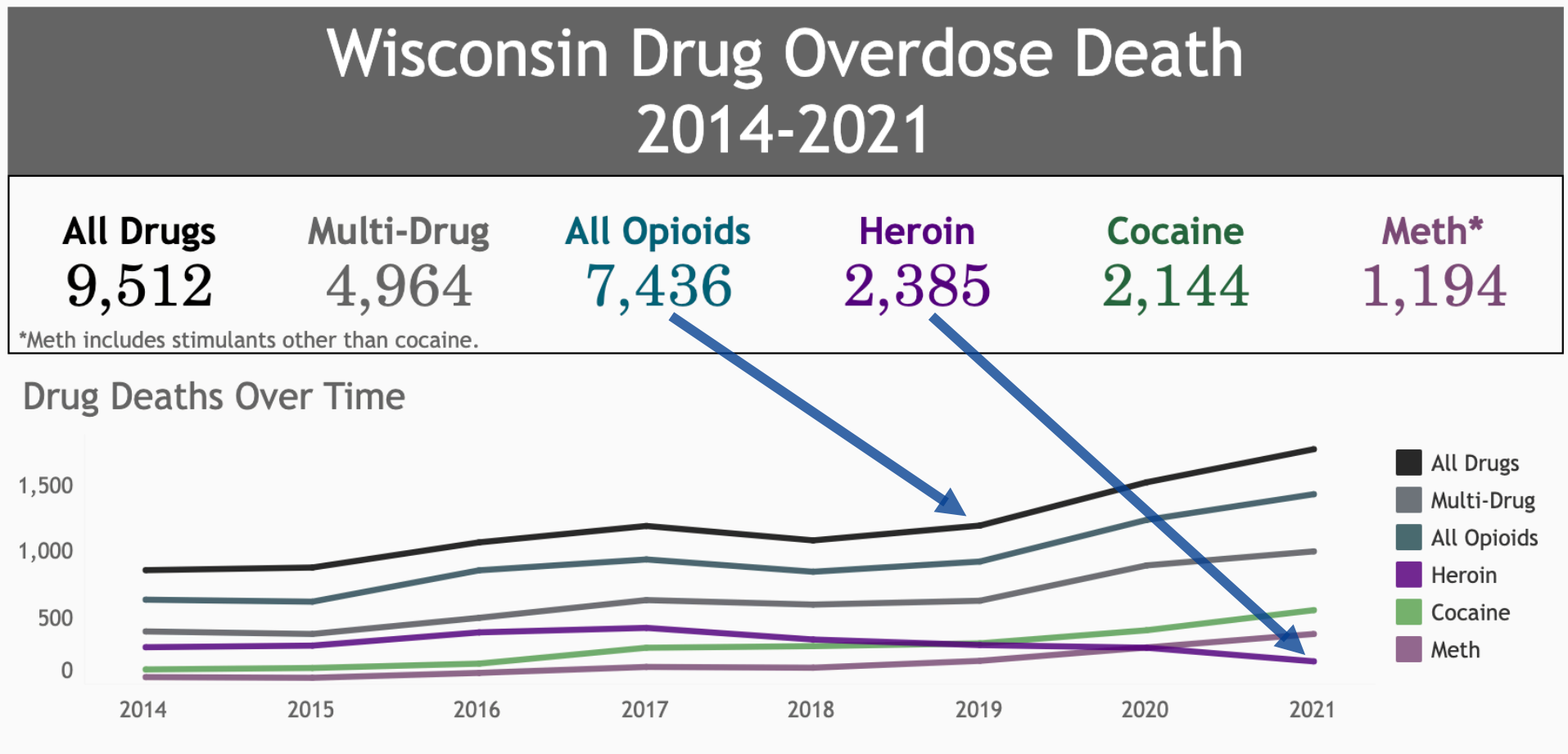
The Opioid Epidemic in the Upper Midwest



Wisconsin had a 109% increase in ED overdoses in 2017. Number one in the nation.

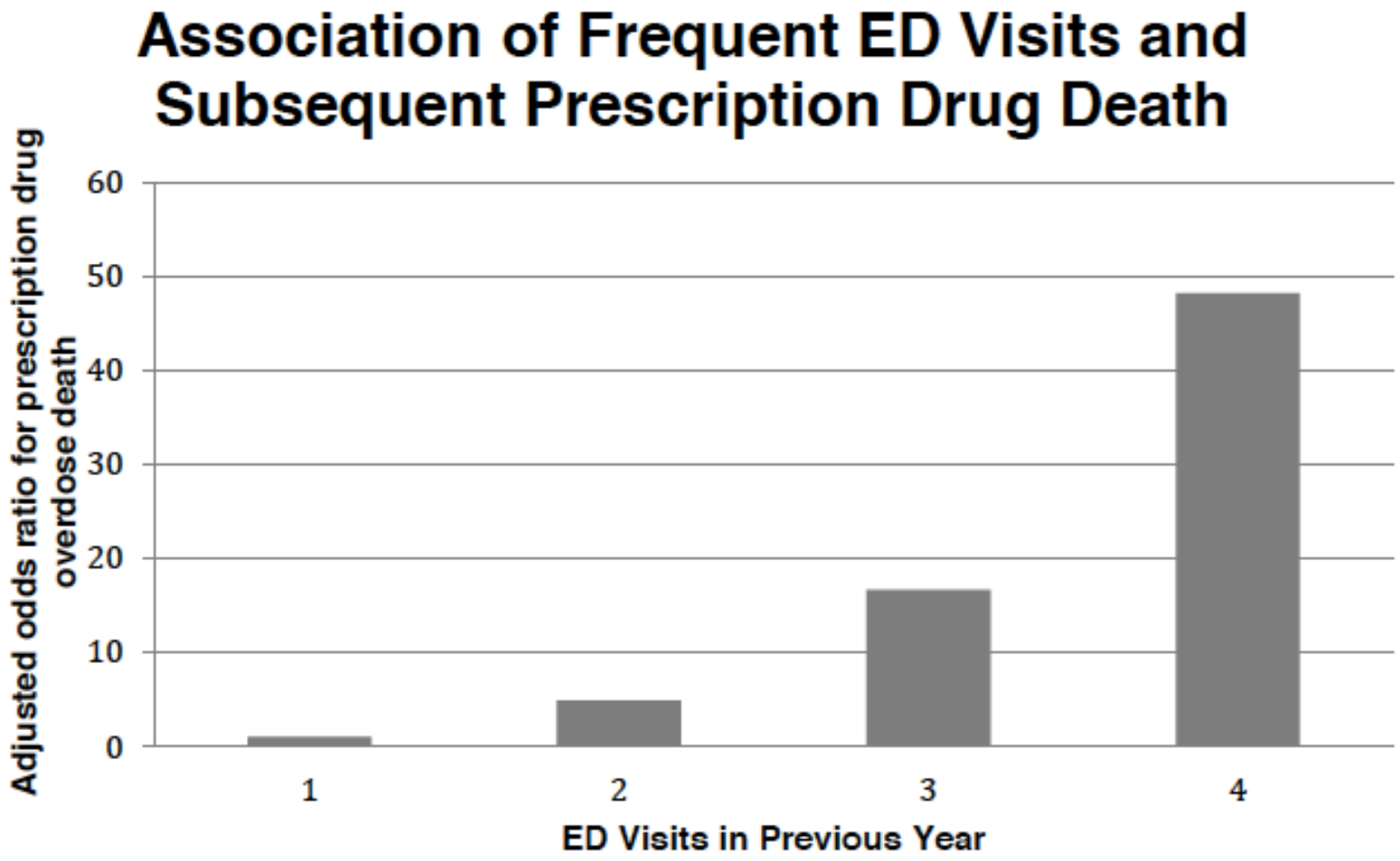
Source: CDC.gov

The Opioid Epidemic in the Upper Midwest



Source: CDC.gov

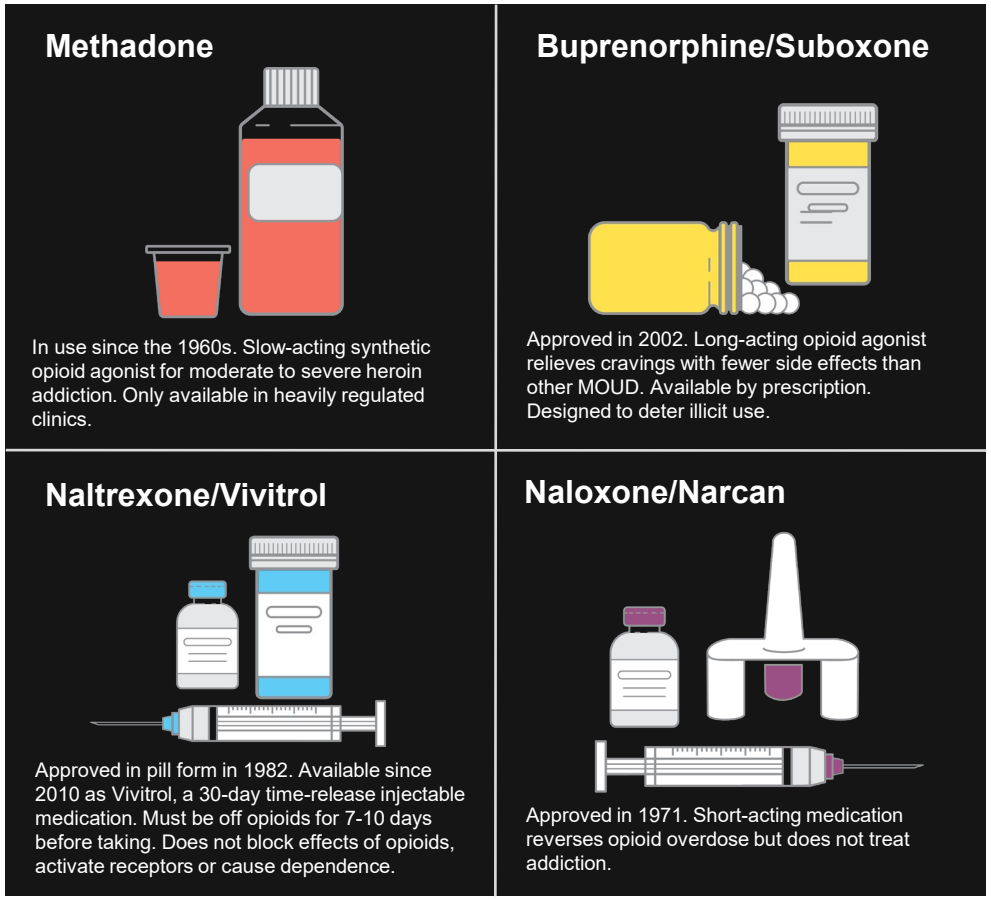
The Opioid Epidemic in the Upper Midwest (cont.)



Brady et al., "Emergency Department Utilization."

FDA-approved Varieties of MOUD

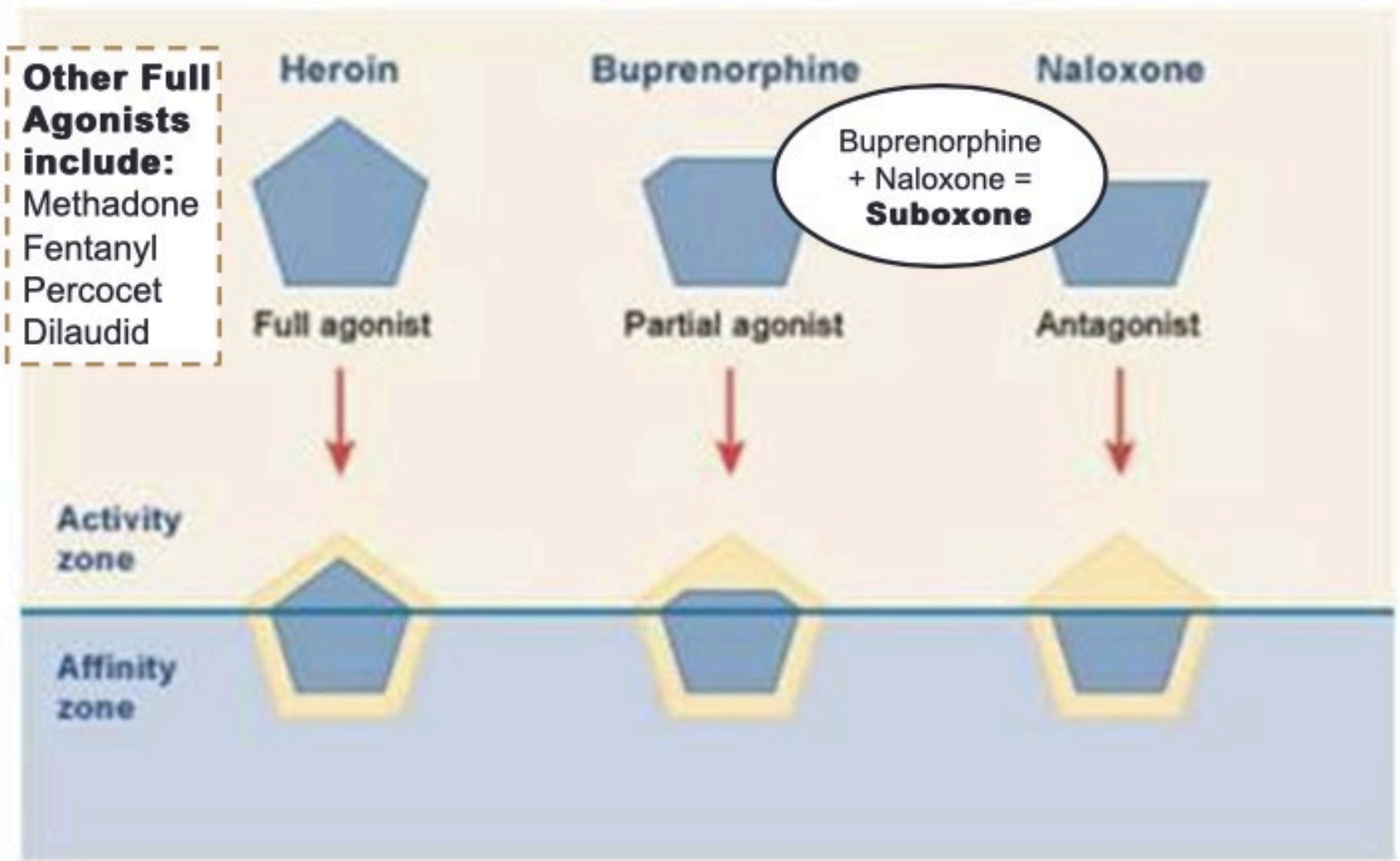
- Buprenorphine
  - Semi-synthetic partial mu agonist
  - Withdrawal and maintenance ($$ ☠☠)
- Methadone
  - Synthetic ‘full’ mu agonist
  - Maintenance ($ ☠☠☠☠)
- XR-Naltrexone
  - Synthetic 30-day injectable antagonist
  - Maintenance ($$$$)
- Naloxone
  - Synthetic, antagonist, multiple routes
  - Antidote for acute overdose ($$)



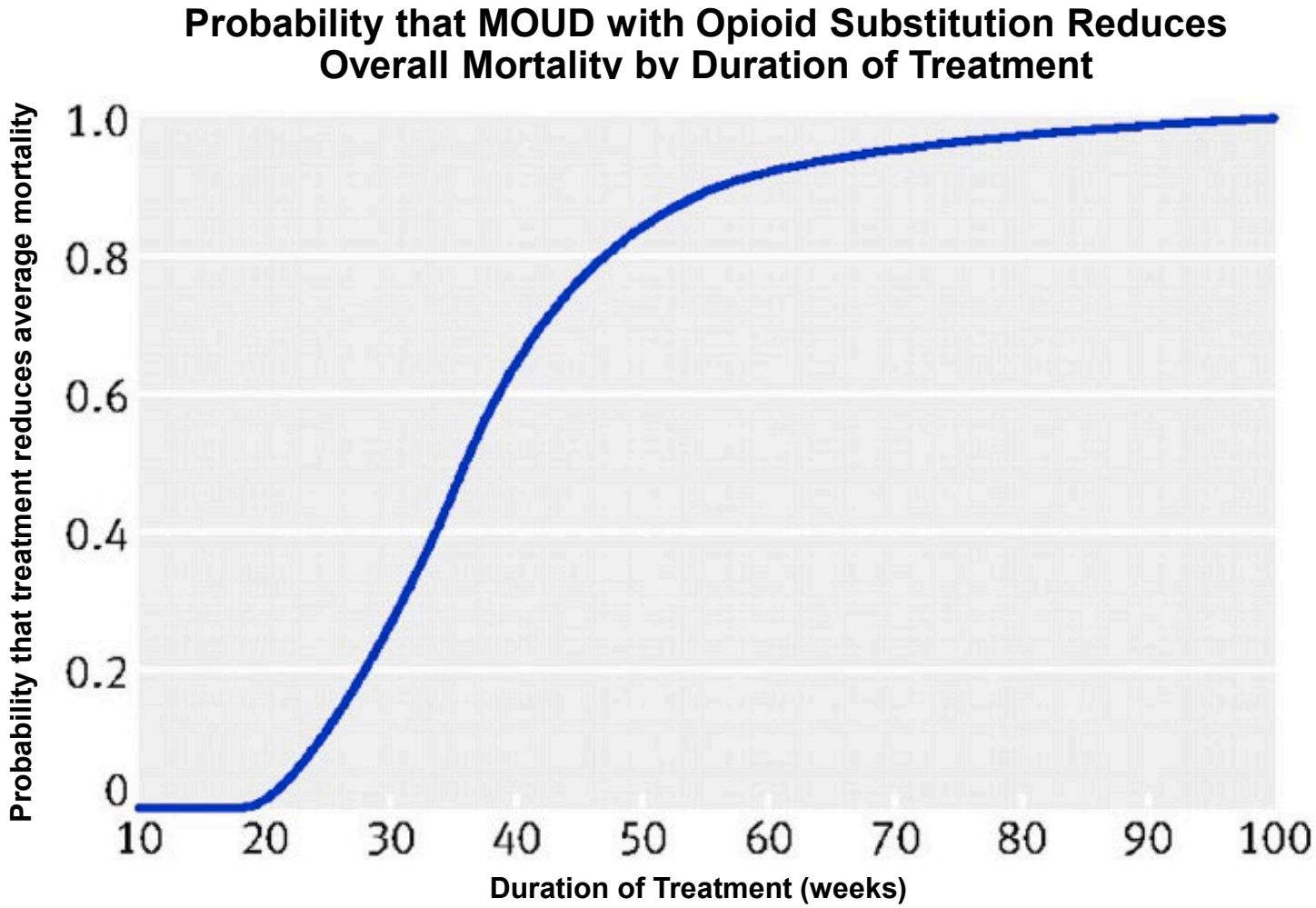
$ = COST

☠ = ABUSE POTENTIAL

Pharmacology of Buprenorphine MOUD

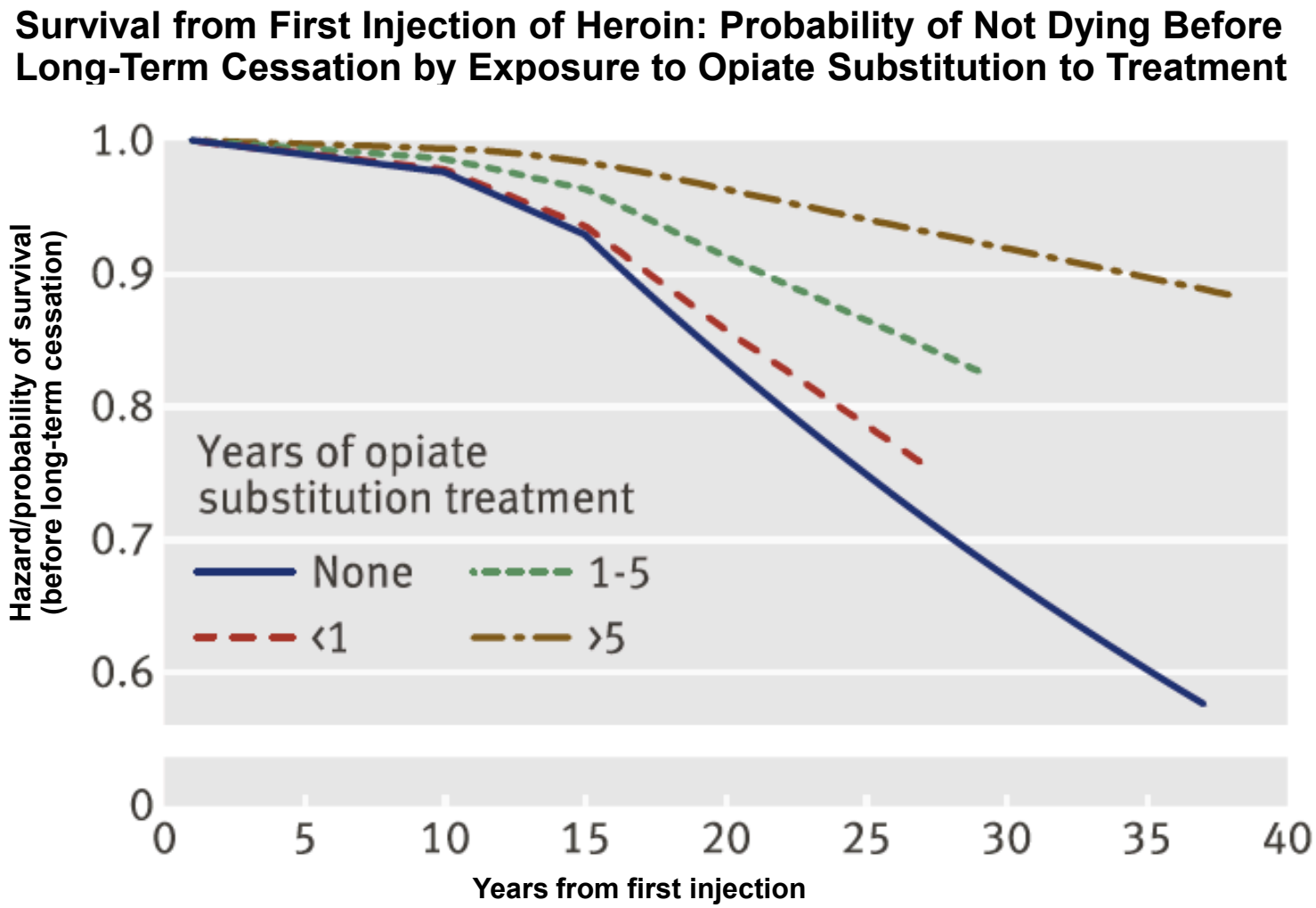


Does MOUD work?



Cornish et al., "Risk of Death"; Clark et al., "Evidence"; Kimber et al., "Survival and Cessation."

Does MOUD work? (cont.)



Cornish et al., "Risk of Death"; Clark et al., "Evidence"; Kimber et al., "Survival and Cessation."

Buprenorphine Safety Considerations

Common side effects

- Nausea
- Vomiting
- Constipation

Less common side effects

- Headache
- Insomnia
- Leg edema/itching

Special populations

Management of unexpected precipitated withdrawal

- Increase dose of buprenorphine
  - 2–4 mg oral every hour till symptoms have improved

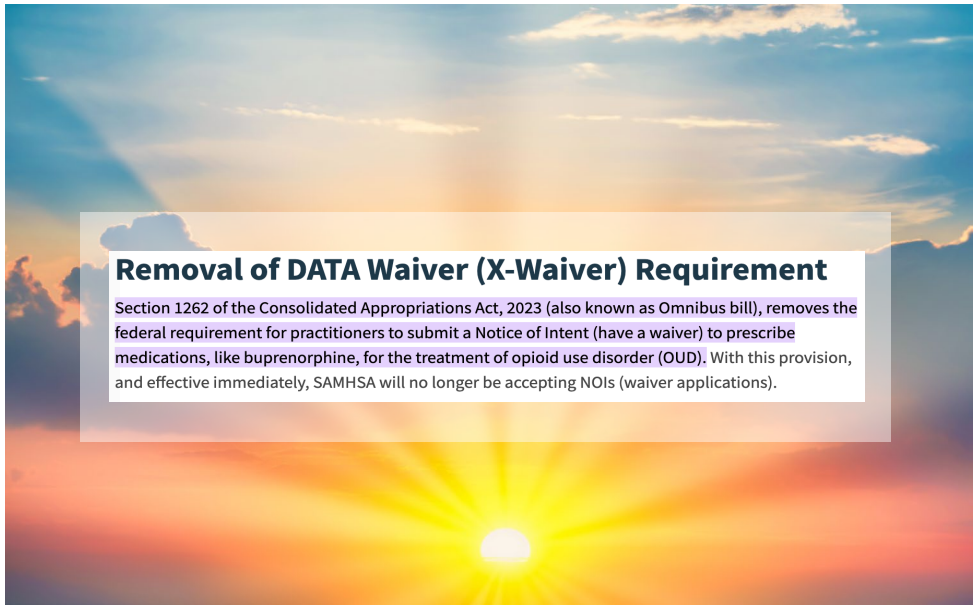
    OR
  - 0.3 mg IV or IM every 30 minutes till symptoms have improved

Legal Issues / X-Waiver

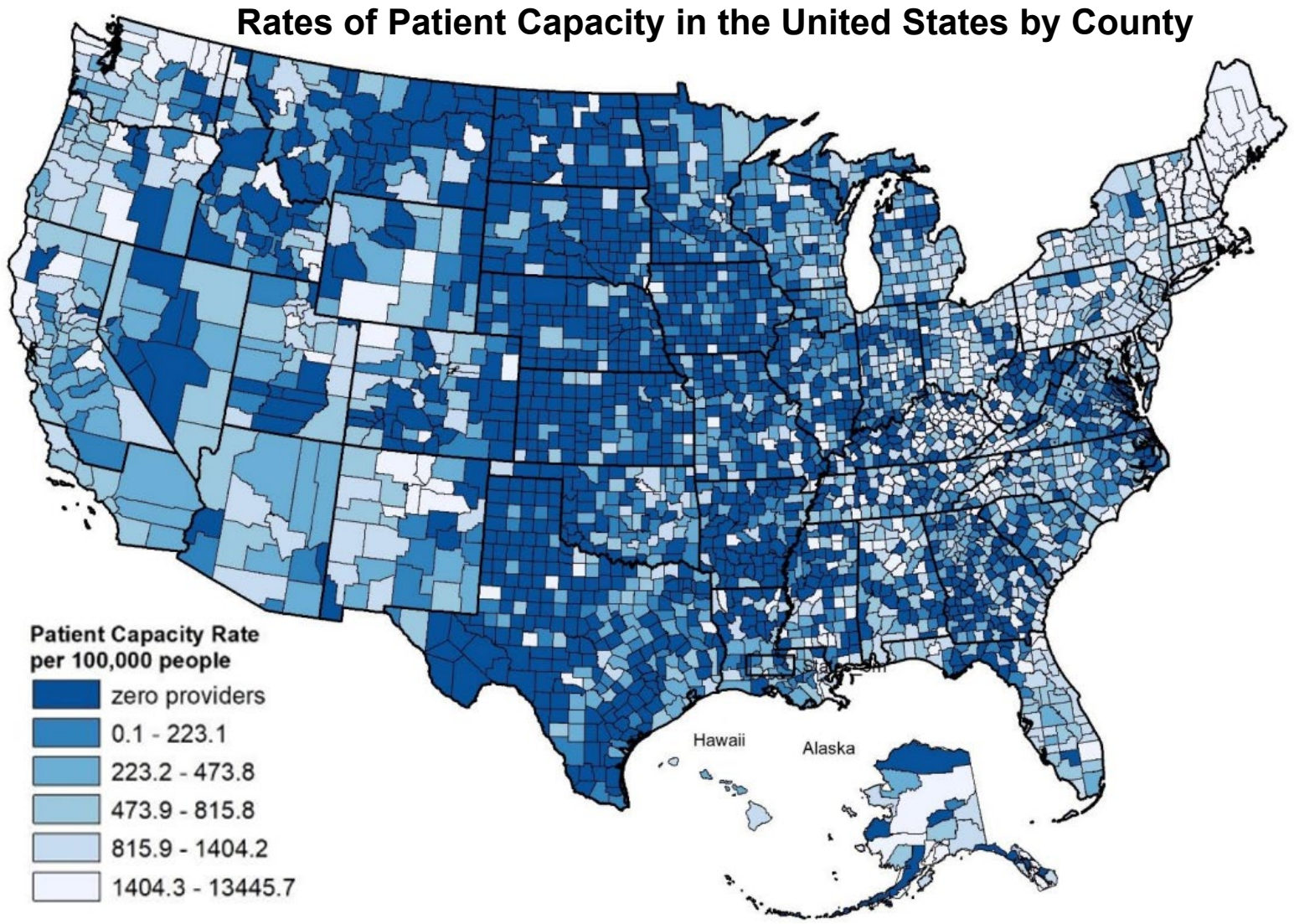
Buprenorphine

- DEA Schedule III narcotic
- X-waiver was required for prescribing / OBOT until 12/2022
- FDA approved formulations include
  - Oral buprenorphine plus naloxone
  - Sublingual buprenorphine
  - Buprenorphine implant
  - Extended-release buprenorphine

As of 12/2022, any opioid (including all FDA-approved formulations of buprenorphine) can be administered (and prescribed for) in the ED for the treatment of acute withdrawal without a DEA X-waiver.



MOUD Providers in the Upper Midwest



Source: OIG analysis of SAMHSA Buprenorphine Waiver Notification System data, 2018

Buprenorphine
Acute Unscheduled Care and Primary Care Roles

Emergency Provider Role

- Confirm diagnosis of substance abuse disorder (SUD)
- Screening labs for comorbid conditions
- Treatment of acute withdrawal symptoms
- Care coordination with PCP
- Ascertain maintenance dose
- Bridge therapy until PCP follow-up is available

Primary Care Provider Role

- Confirm appropriate maintenance dose (and adjust if needed)
- Monitor for misuse/diversion
- Ensure care coordination
- Relapse planning
- Check in regularly and taper dose appropriately (if applicable)

Buprenorphine

Acute Unscheduled Care and Primary Care Roles (cont.)

CHANGE CAN START WITH ONE ED DOCTOR AND ONE REFERRAL CLINIC.	Cultivate **CHAMPIONS** among clinicians, nurses, pharmacists, social workers, behavioral health staff, and administrators. 	Encourage clinicians to get **BUPRENORPHINE TRAINING**. 
Partner with **PHARMACISTS**. 	Build relationships with fellow **CLINICIANS** for ongoing cases. 	Collaborate with **BEHAVIORAL HEALTH SERVICES** where available. 
Develop a **TEAM-BASED APPROACH** involving the ED, inpatient services, and outpatient clinics. 	Integrate buprenorphine into **SAFE PRESCRIBING GUIDELINES** in the ED. 	Connect addiction treatment with the **TREATMENT OF WITHDRAWAL AND OVERDOSE**. 

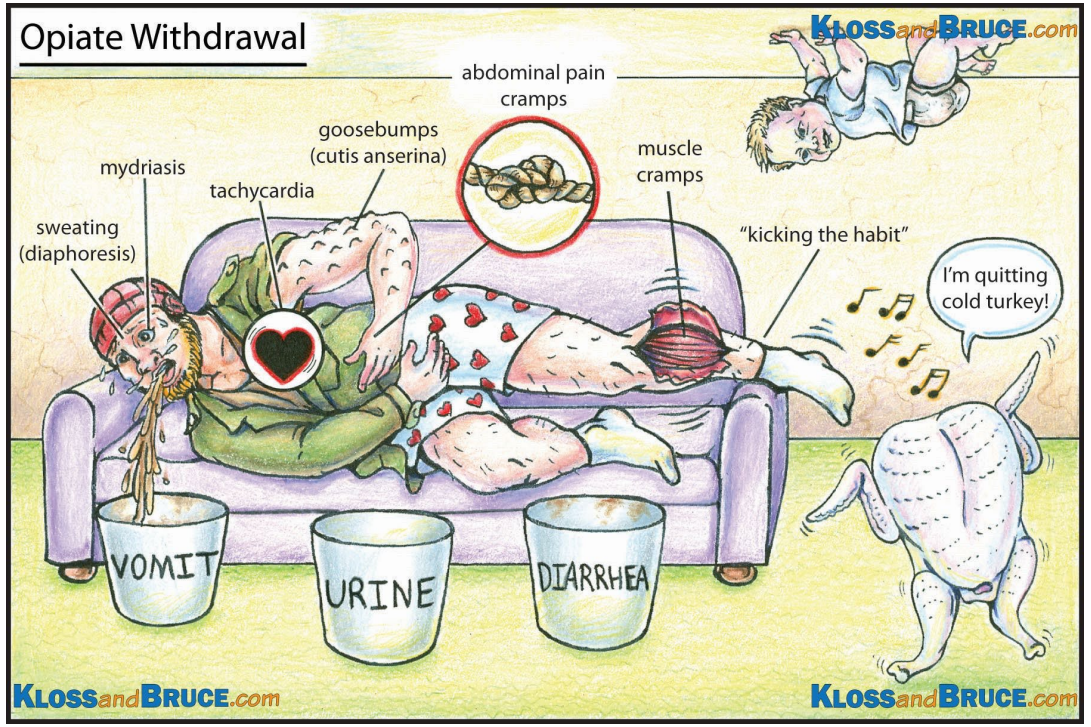
Source: https://wisconsinacep.wildapricot.org

Buprenorphine in the ED

Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: a Randomized Clinical Trial," *JAMA* 313 (April 28, 2015): 1636.

Operationalizing the “Yale Protocol”

1. Patient identification
2. Confirm patient has an opioid use disorder
3. Evaluate if the patient is in opioid withdrawal
4. ED screening orders
5. Buprenorphine administration
6. Buprenorphine prescription
7. Discharge instructions



Patient Identification

- Requesting assistance with opioid use disorder.
  (e.g., “I need help to get clean.”)
- Statement of intent to attempt abstinence.
  (e.g., “I am never using again.”)
- Admitted or clinically obvious history of injection opioid use
- Opioid overdose
- Opioid seeking behavior
  (e.g., requesting IV hydromorphone for chronic pain.)
- Admitted or obvious use of illicit opioids
- Clinical gestalt that an opioid use disorder may be present
- Patients with active alcohol, benzodiazepine, and/or psychiatric instability are generally NOT considered good candidates for treatment.

Confirm Patient has an Opioid Use Disorder

Two-minute Rapid Opioid Dependence Screen (RODS)

1. Have you ever taken any of the following drugs?

a. Heroin	○ Yes	○ No
b. Methadone	○ Yes	○ No
c. Buprenorphine	○ Yes	○ No
d. Morphine	○ Yes	○ No
e. MS Contin	○ Yes	○ No
f. Oxycontin	○ Yes	○ No
g. Oxycodone	○ Yes	○ No
e. Other opioid analgesics (e.g., Vicodin, Darvocet, etc.)	○ Yes	○ No

If any drug in question 1 is coded "yes", proceed to questions 2 to 8.

If all drugs in question 1 are "no", skip to end and code "no" for opioid dependent.

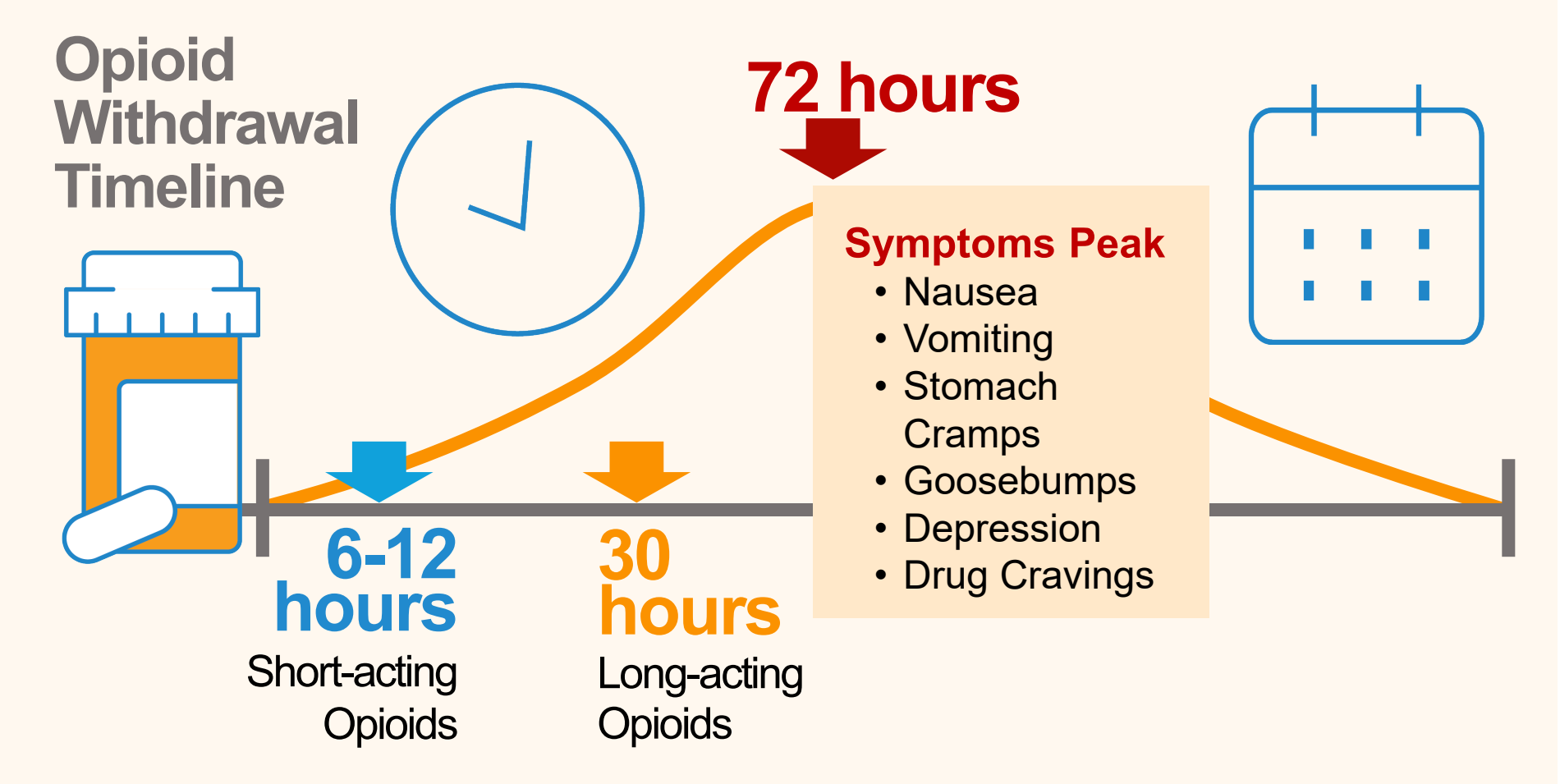
2. Did you ever need to use more opioids to get the same high as when you first started using opioids? ○ Yes ○ No
3. Did the idea of missing a fix (or dose) ever make you anxious or worried? ○ Yes ○ No
4. In the morning, did you ever use opioids to keep from feeling "dope sick" or did you ever feel "dope sick"? ○ Yes ○ No
5. Did you worry about your use of opioids? ○ Yes ○ No
6. Did you find it difficult to stop or not use opioids? ○ Yes ○ No
7. Did you ever need to spend a lot of time/energy on finding opioids or recovering from feeling high? ○ Yes ○ No
8. Did you ever miss important things like doctor's appointments, family/friend activities, or other things because of opioids? ○ Yes ○ No

Scoring Instructions: Add number of "yes" responses for questions 2 to 8. If total is > 3, code "yes" for opioid dependent. If total is < 2, code "no" for opioid dependent.

Opioid Dependent: ○ Yes ○ No

Wickersham JA, Azar MM, Cannon CM, Altice FL, Springer SA. Validation of a Brief Measure of Opioid Dependence The Rapid Opioid Dependence Screen (RODS). *Journal of Correctional Health Care*. 2015;21(1):12-26.

Evaluate if the Patient is in Opioid Withdrawal



Short-acting opioids (heroin, Norco, Percocet, morphine IR, snorted oxycodone) **wait 8-12 hours.**
Long-acting opioids (oxycodone, MS Contin) **wait 16-24 hours.**
Methadone wait at least 48 hours.

Adapted from: https://www.safeharborrecovery.com/opiate-withdrawal-timeline/

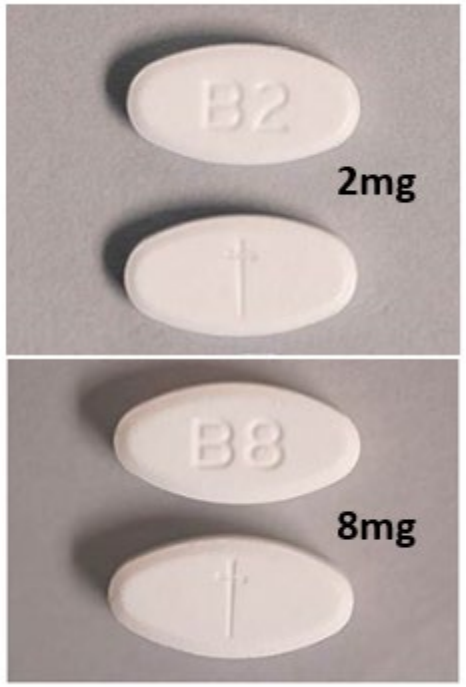
Evaluate if the Patient is in Opioid Withdrawal

Symptom	None	Mild	Moderate	Severe
Feeling sick	0	1	2	3
Stomach cramps	0	1	2	3
Muscle spasms or twitching	0	1	2	3
Feeling cold	0	1	2	3
Heart pounding	0	1	2	3
Muscular tension	0	1	2	3
Aches and pains	0	1	2	3
Yawning	0	1	2	3
Runny/watery eyes	0	1	2	3
Difficulty sleeping	0	1	2	3

SCORING	
< 10	**Don't give buprenorphine yet**
≥10	**Give buprenorphine now** (10-20) Moderate withdrawal (20-30) Severe withdrawal

Short Opioid Withdrawal Scale. Gossop M. The development of a short opiate withdrawal scale (SOWS). Addictive behaviors. 1990 Dec 31;15(5):487-90.

Common Buprenorphine Formulations



Buprenorphine

Buprenorphine/ Naloxone

Office-based Opioid Agonist Treatment (OBOT) — While in the ED

Screening Labs

- Urine pregnancy test
- Rapid HIV test
- Hepatitis A,B,C screening
- Liver function tests
- If possible: consultation with social worker and substance abuse counselor

For Patient in <u>Moderate to Severe</u> Withdrawal

- Buprenorphine 4mg or 8mg sublingual tablet x1 now

OR

- Buprenorphine/naloxone 4mg/1mg or 8mg/2mg sublingual tablet x 1 now

If Not Yet Withdrawing (ED Take Home Rx Option)

Buprenorphine

- Buprenorphine 2 mg sublingual tablet
- 1-4 tablets under the tongue
- Every 1-3 hours as needed for withdrawal
- Dispense #20 No Refills

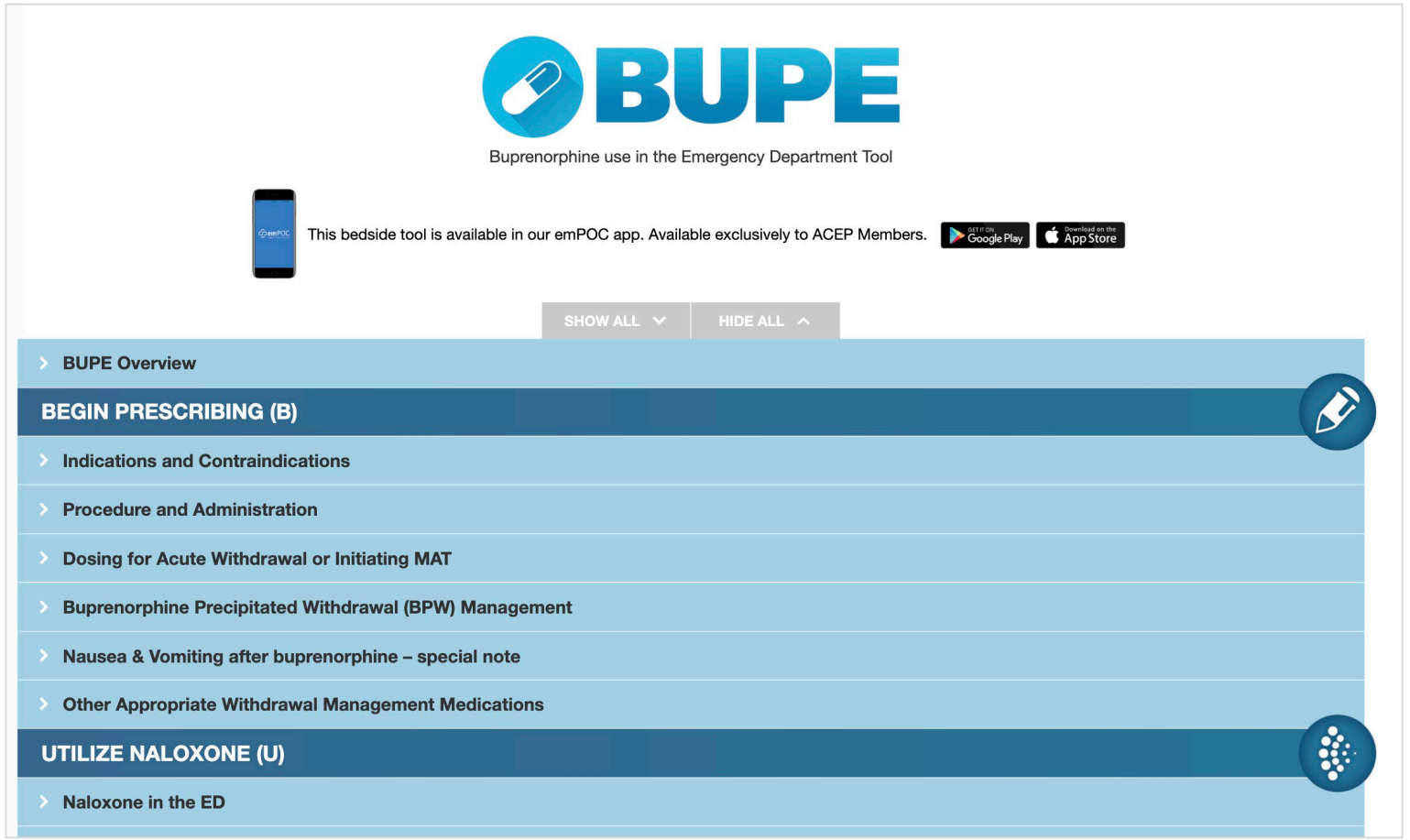
Buprenorphine/Naloxone

- Buprenorphine/naloxone 2mg/0.5mg sublingual tablet
- 1-4 tablets under the tongue
- Every 1-3 hours as needed for withdrawal
- Dispense #20 No Refills

Adjunct Therapy for Withdrawal

- Ibuprofen 400mg PO for body/bone aches
- Ondansetron ODT 4mg PO for nausea
- Clonidine 0.1 mg PO for tremors/chills
  - *[hold if BP < 90/60 or HR < 60]*
- Loperamide 4mg PO for diarrhea

The ACEP “BUPE” Tool



https://www.acep.org/patient-care/bupe/

Questions

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What's Next

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