

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.



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

Detecting recent trends in opioid overdose ED visits provides opportunities for action in this fast-moving epidemic.

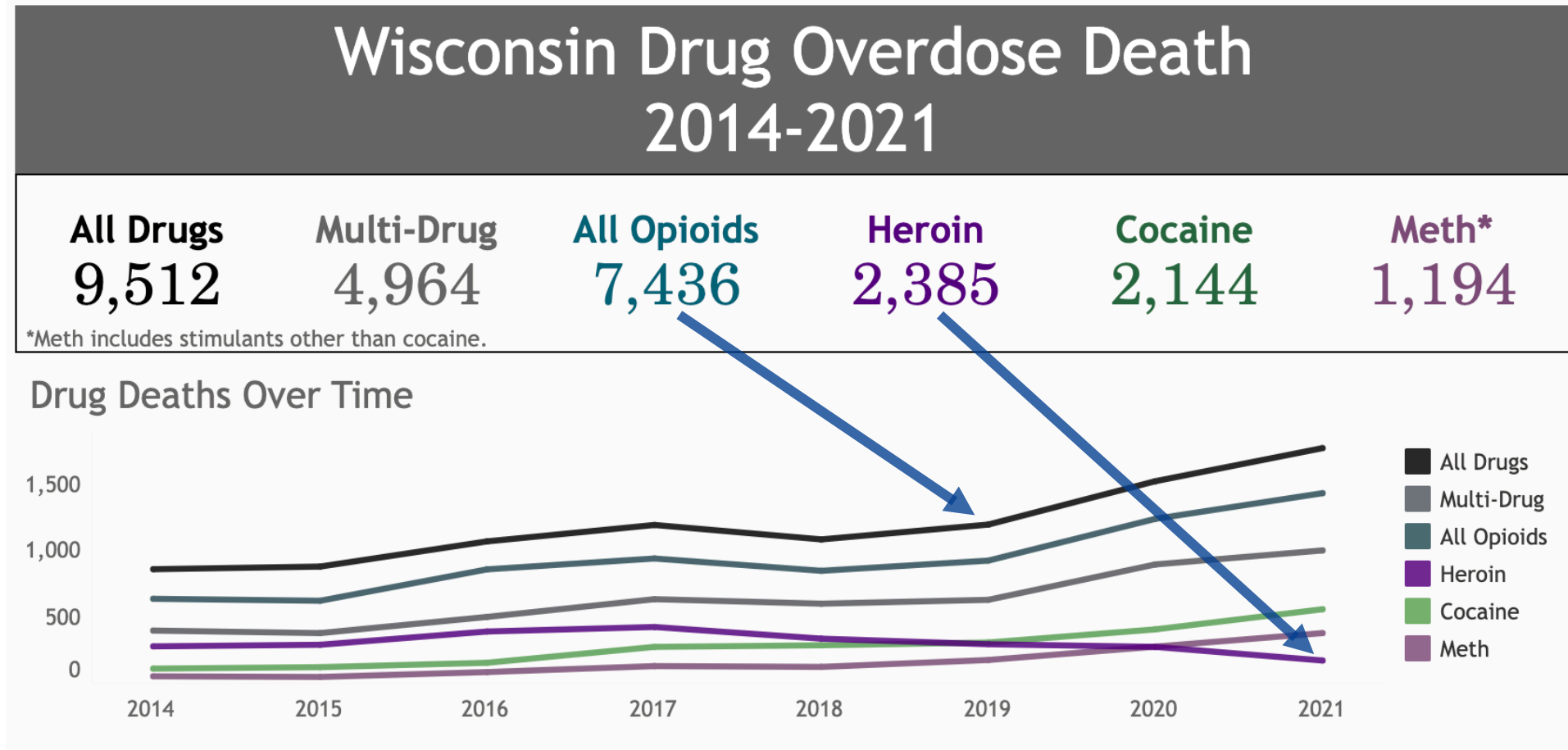


SOURCE: CDC's Enhanced State Opioid Overdose Surveillance (ESOOS) Program, 16 states reporting percent changes from July 2016 through September 2017.

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

Source: CDC.gov

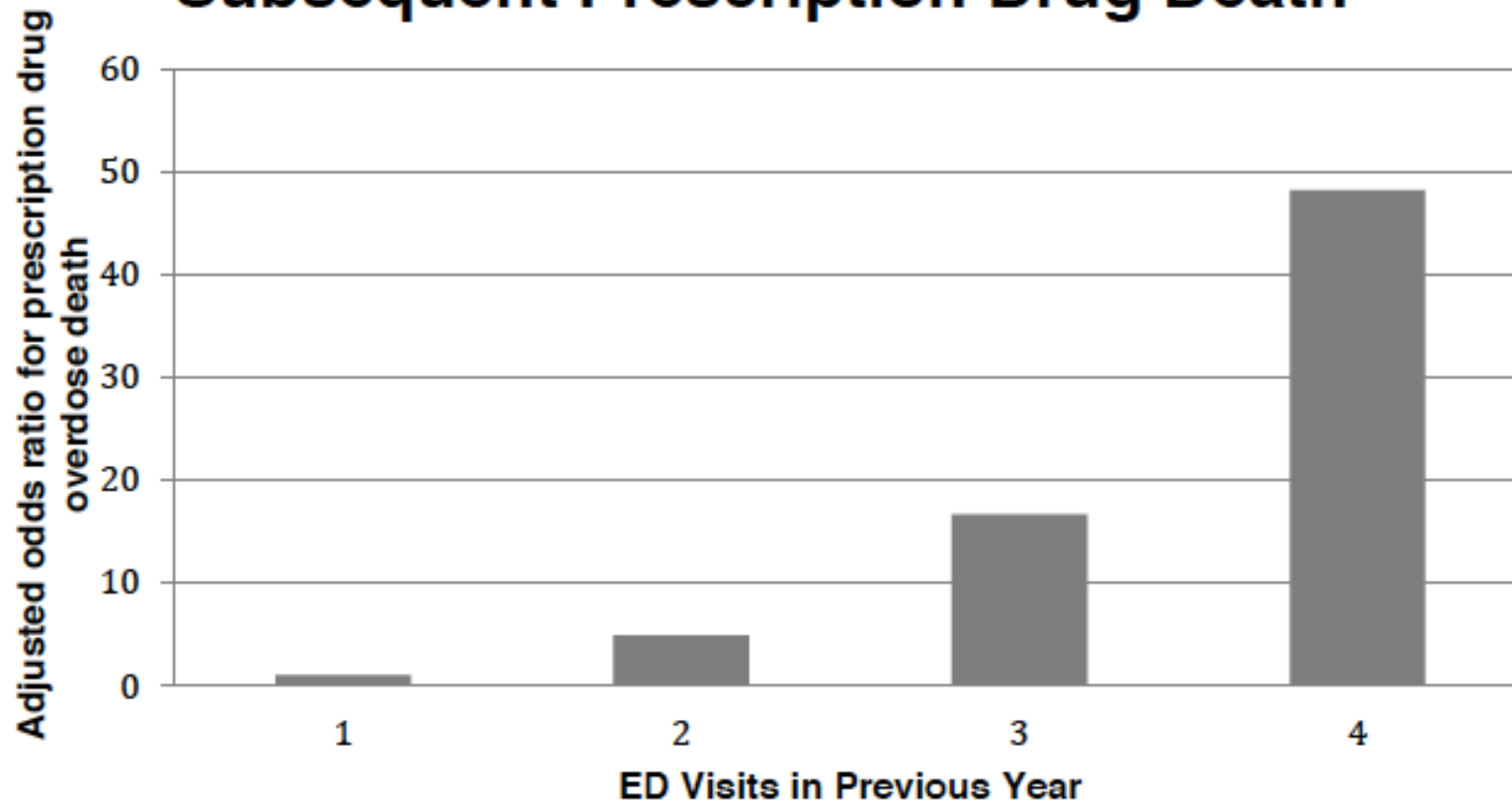
The Opioid Epidemic in the Upper Midwest



Source: CDC.gov



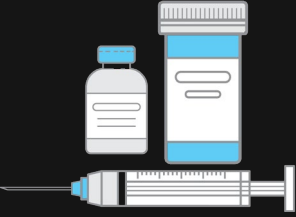
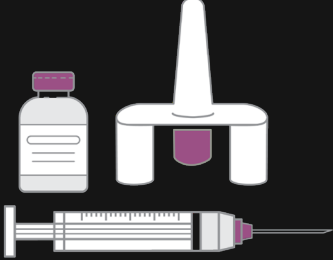
The Opioid Epidemic in the Upper Midwest (cont.)

Association of Frequent ED Visits and Subsequent Prescription Drug Death



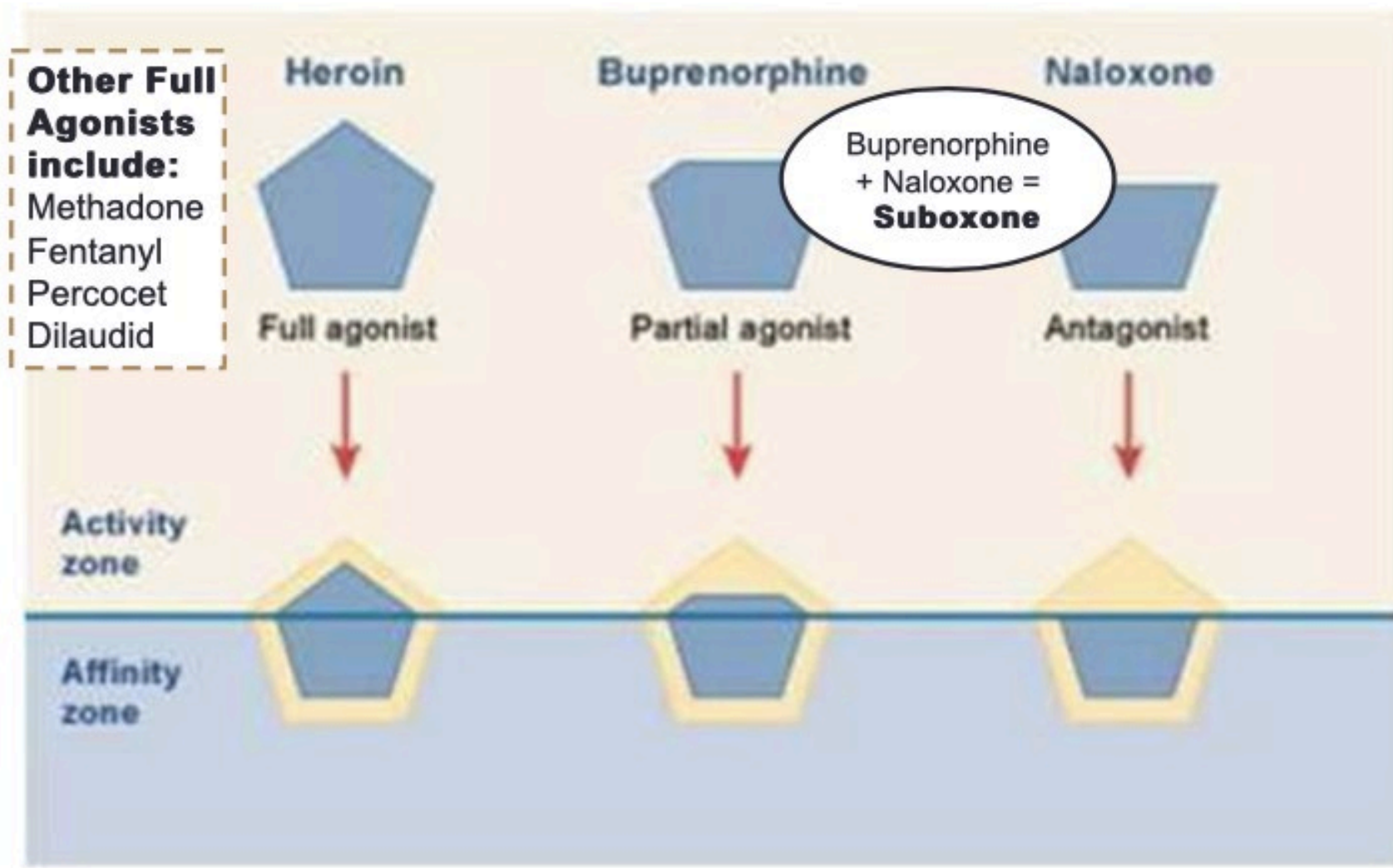
FDA-approved Varieties of MOUD

- 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 (\$\$)

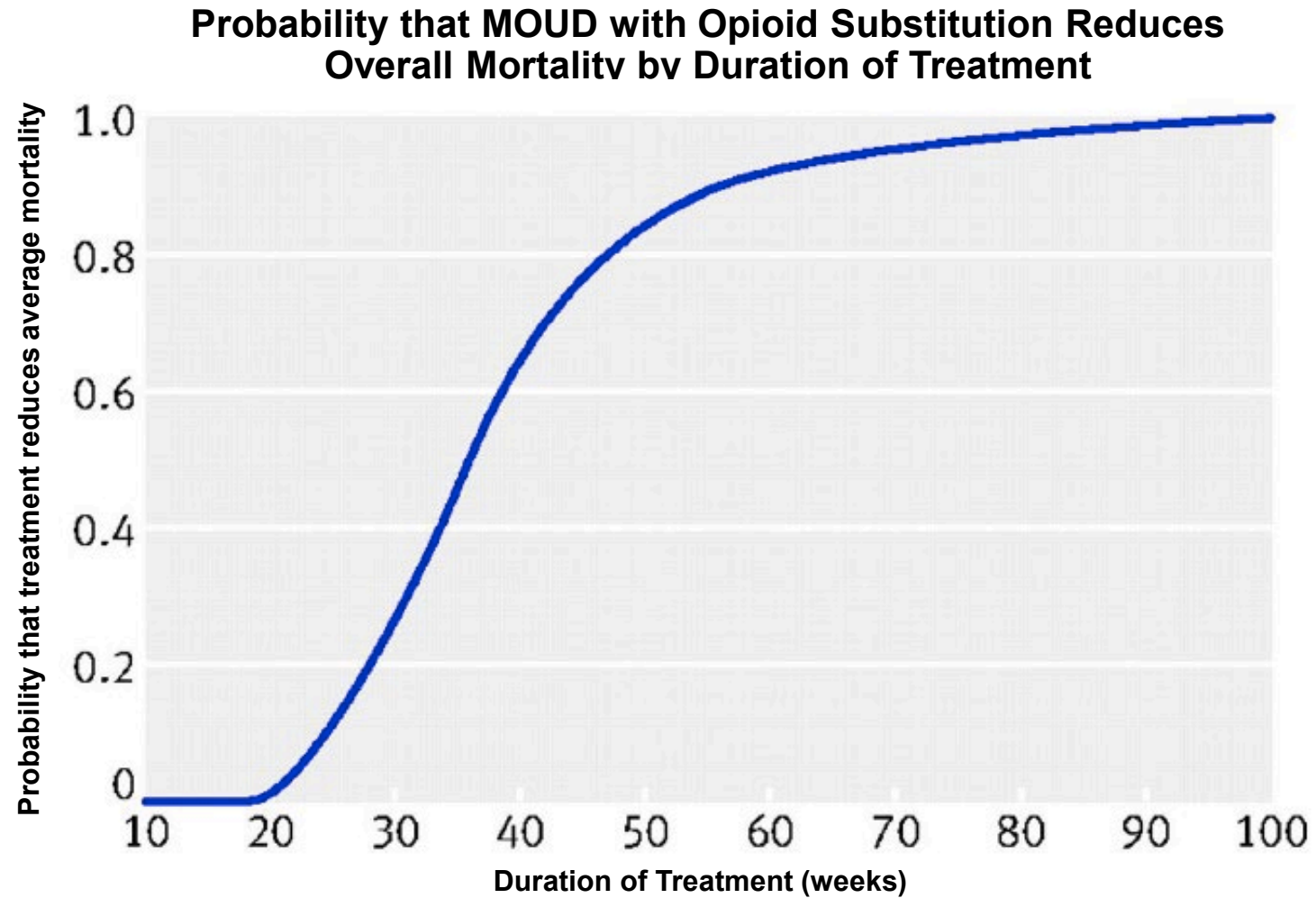
<p>Methadone</p>  <p>In use since the 1960s. Slow-acting synthetic opioid agonist for moderate to severe heroin addiction. Only available in heavily regulated clinics.</p>	<p>Buprenorphine/Suboxone</p>  <p>Approved in 2002. Long-acting opioid agonist relieves cravings with fewer side effects than other MOUD. Available by prescription. Designed to deter illicit use.</p>
<p>Naltrexone/Vivitrol</p>  <p>Approved in pill form in 1982. Available since 2010 as Vivitrol, a 30-day time-release injectable medication. Must be off opioids for 7-10 days before taking. Does not block effects of opioids, activate receptors or cause dependence.</p>	<p>Naloxone/Narcan</p>  <p>Approved in 1971. Short-acting medication reverses opioid overdose but does not treat addiction.</p>

\$ = COST
☠ = ABUSE POTENTIAL

Pharmacology of Buprenorphine MOUD



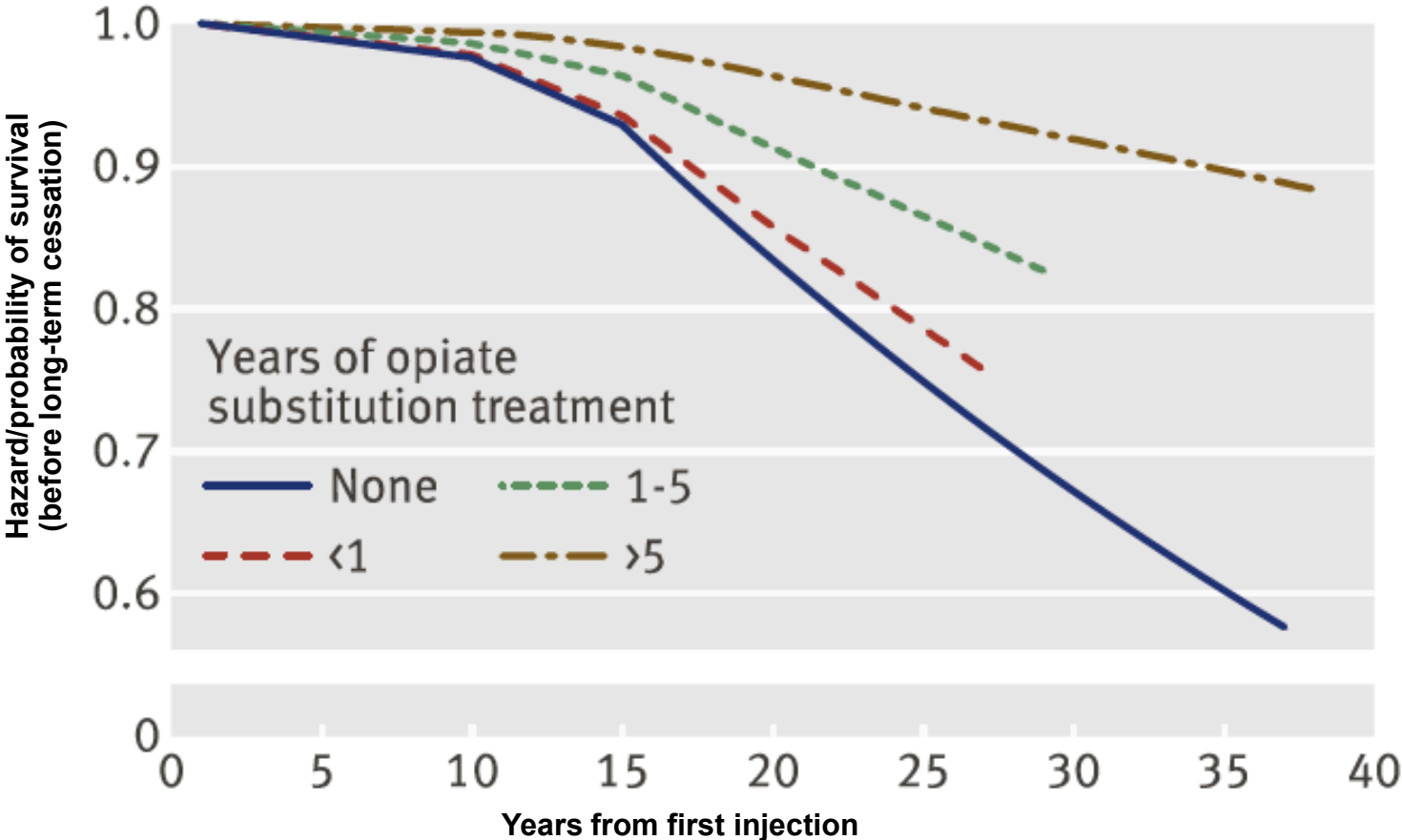
Does MOUD work?



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

Does MOUD work? (cont.)

Survival from First Injection of Heroin: Probability of Not Dying Before Long-Term Cessation by Exposure to Opiate Substitution to Treatment



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

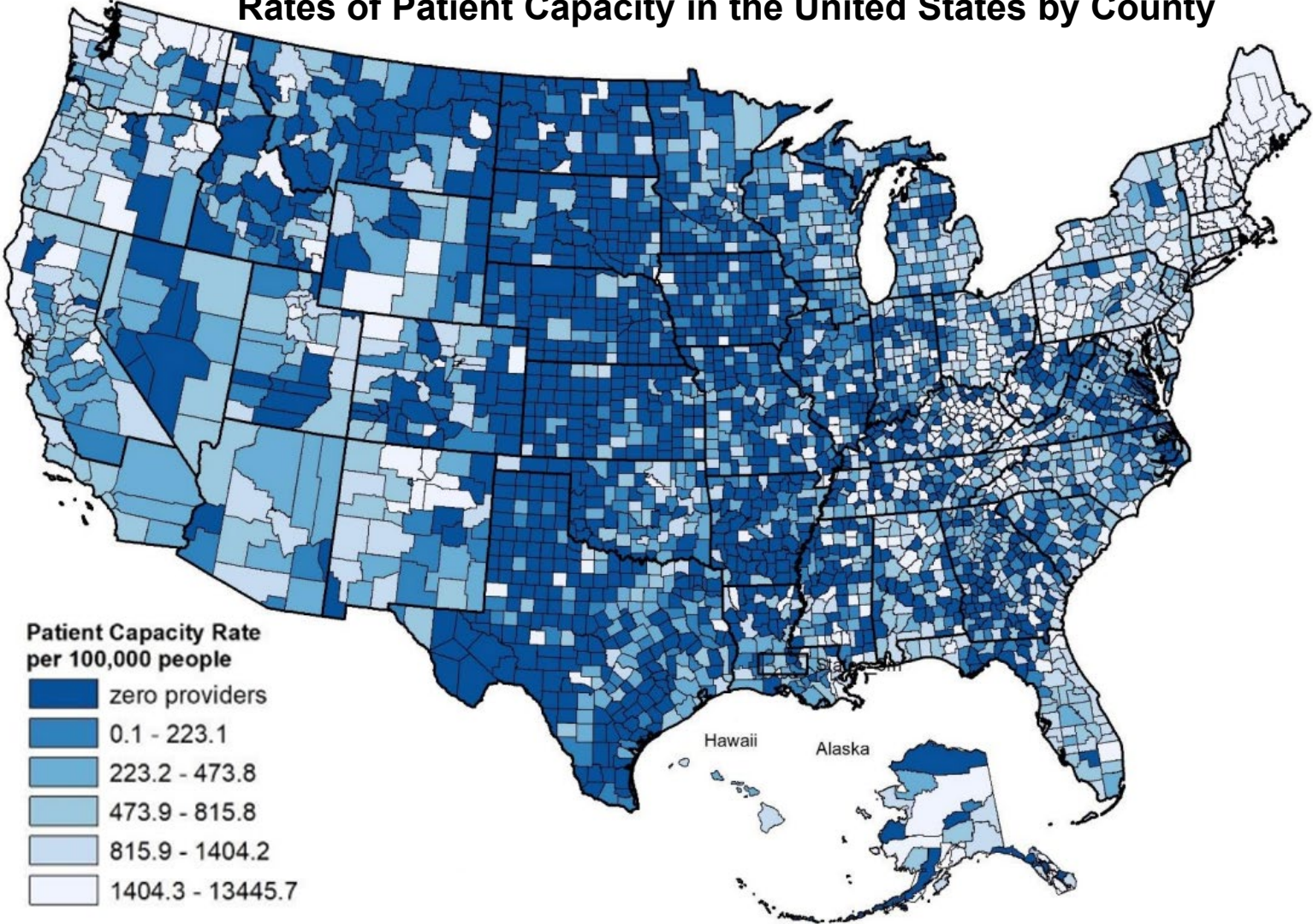
As of 12/2022, any opioid (including all FDA-approved formulations of buprenorphine) can be administered (and prescribed for) in the ED for the treatment of acute withdrawal without a DEA X-waiver.

Removal of DATA Waiver (X-Waiver) Requirement

Section 1262 of the Consolidated Appropriations Act, 2023 (also known as Omnibus bill), removes the federal requirement for practitioners to submit a Notice of Intent (have a waiver) to prescribe medications, like buprenorphine, for the treatment of opioid use disorder (OUD). With this provision, and effective immediately, SAMHSA will no longer be accepting NOIs (waiver applications).

MOUD Providers in the Upper Midwest

Rates of Patient Capacity in the United States by County



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**.



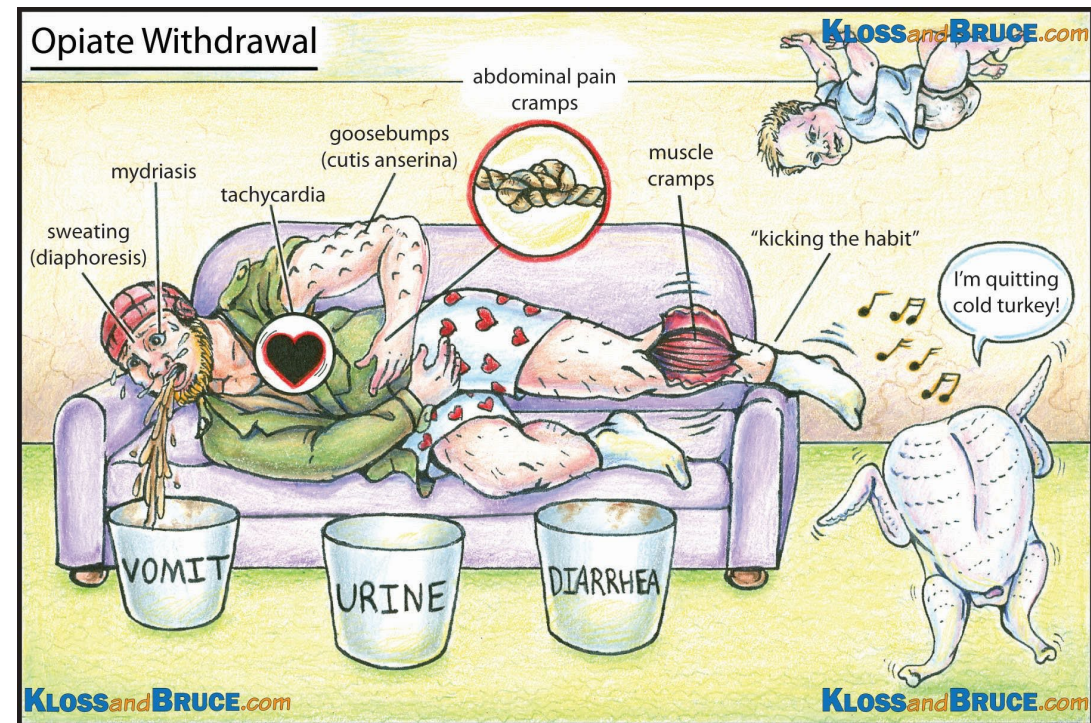


Buprenorphine in the ED

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 | <input type="radio"/> Yes | <input type="radio"/> No |
| b. Methadone | <input type="radio"/> Yes | <input type="radio"/> No |
| c. Buprenorphine | <input type="radio"/> Yes | <input type="radio"/> No |
| d. Morphine | <input type="radio"/> Yes | <input type="radio"/> No |
| e. MS Contin | <input type="radio"/> Yes | <input type="radio"/> No |
| f. Oxycodone | <input type="radio"/> Yes | <input type="radio"/> No |
| g. Oxycodone | <input type="radio"/> Yes | <input type="radio"/> No |
| e. Other opioid analgesics
(e.g., Vicodin, Darvocet, etc.) | <input type="radio"/> Yes | <input type="radio"/> 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.

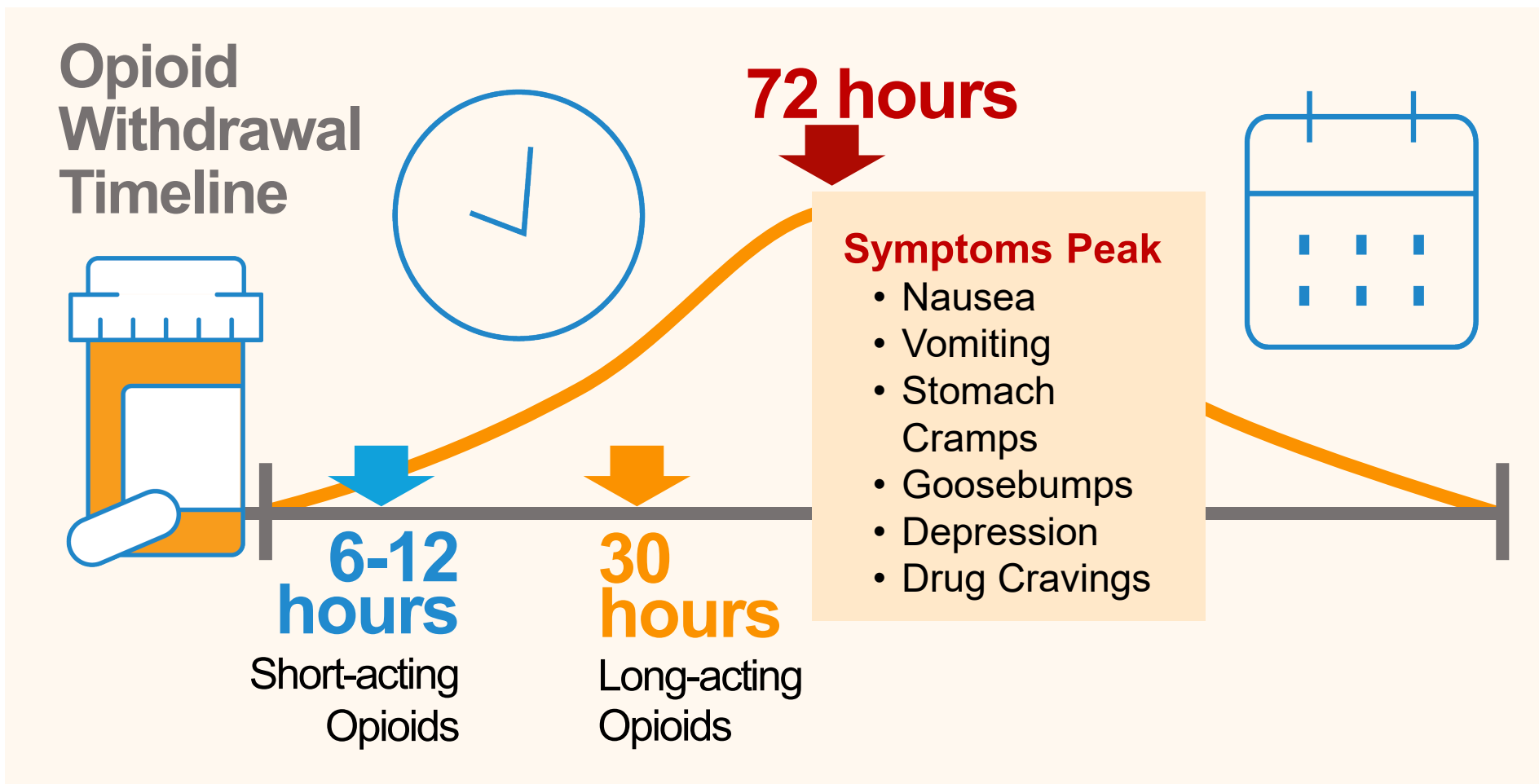
- | | | |
|---|---------------------------|--------------------------|
| 2. Did you ever need to use more opioids to get the same high as when you first started using opioids? | <input type="radio"/> Yes | <input type="radio"/> No |
| 3. Did the idea of missing a fix (or dose) ever make you anxious or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

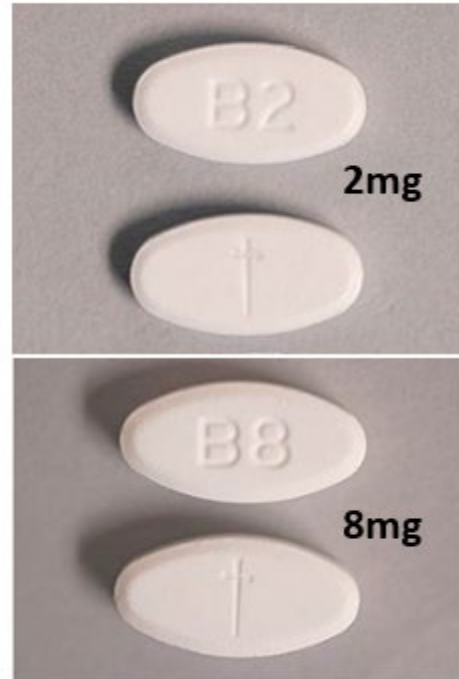
Evaluate if the Patient is in Opioid Withdrawal

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 Moderate to Severe 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

BUPE
Buprenorphine use in the Emergency Department Tool

This bedside tool is available in our emPOC app. Available exclusively to ACEP Members.

SHOW ALL ▾ HIDE ALL ▲

- > BUPE Overview
- BEGIN PRESCRIBING (B)**
- > Indications and Contraindications
- > Procedure and Administration
- > Dosing for Acute Withdrawal or Initiating MAT
- > Buprenorphine Precipitated Withdrawal (BPW) Management
- > Nausea & Vomiting after buprenorphine – special note
- > Other Appropriate Withdrawal Management Medications
- UTILIZE NALOXONE (U)**
- > Naloxone in the ED

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

Questions

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What's Next

Join us for the next session on Oct. 13, 2023:
Role of the Pharmacist in the Treatment of Patients with OUD

Register at:

bit.ly/MOUDthroughCareContinuumSeries

Recordings, slides, and resource links are posted for on-demand access 72 hours after every session.

<https://www.hsag.com/qiocollabopioidseries>



QIO Collaborative Op...

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

More than 1 million of Medicare beneficiaries had a diagnosis of opioid use disorder in 2020.¹

However, fewer than 1 in 5 Medicare beneficiaries with an opioid use disorder diagnosis received medication to treat this condition. In addition, the number of patients who stay in treatment after hospital discharge decrease drastically during the transition of care.²

This series of webinars is a collaboration of all of the Quality Improvement Organizations and will provide strategies, interventions, and targeted solutions to ensure access to treatment and facilitate the continuity of care through the continuum.

Please join us to hear from leading national experts monthly on Fridays from September 2023 through June 2024 at 12 noon ET, 11 a.m. MT and CST, 9 a.m. PT.

Register for this no-cost series at:
<https://bit.ly/MOUDthroughCareContinuumSeries>

A general certificate of attendance will be provided for continuing education/contact hours. Attendees are responsible for determining if this program meets the criteria for licensure or recertification for their discipline.

Session 1—September 15, 2023	▼
Session 2—October 13, 2023	▼
Sessions 3 (Part 1) and 4 (Part 4)—November 17, 2023, and January 12, 2024	▼
Sessions 5 and 6—February 9, 2024, and March 8, 2024	▼
Sessions 7 and 8—April 12, 2024, and May 10, 2024	▼
Session 9—June 7, 2024	▼

Certificate of Attendance

Continuing Education Credits and Contact Hours for Health Professionals

- This series may meet continuing education requirements for your discipline. You may use this certificate as proof of attendance. It is your responsibility to determine if the series fulfills that requirement.
- The link to request a certificate of attendance is below and will be included in the follow-up email sent directly to you by Webex.
 - New User Registration Link: <https://lmc.hshapps.com/register/default.aspx?ID=c6529490-8887-49e0-90de-be7150faef52>
 - Existing User Link: <https://lmc.hshapps.com/test/adduser.aspx?ID=c6529490-8887-49e0-90de-be7150faef52>





Thank You

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