PCSS Providers Clinical Support System

Medication Assisted Treatment in the Emergency Room Setting

The VA Connecticut Model for Initiation of Buprenorphine in the PER

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Disclosures

- **I work as a consultant for the American Academy of Addiction Psychiatry (AAAP).**

Target Audience

- The overarching goal of PCSS is to train a diverse range of healthcare professionals in the safe and effective prescribing of opioid medications for the treatment of pain, as well as the treatment of substance use disorders, particularly opioid use disorders, with medication-assisted treatments.

Educational Objectives

At the conclusion of this activity participants should be able to:

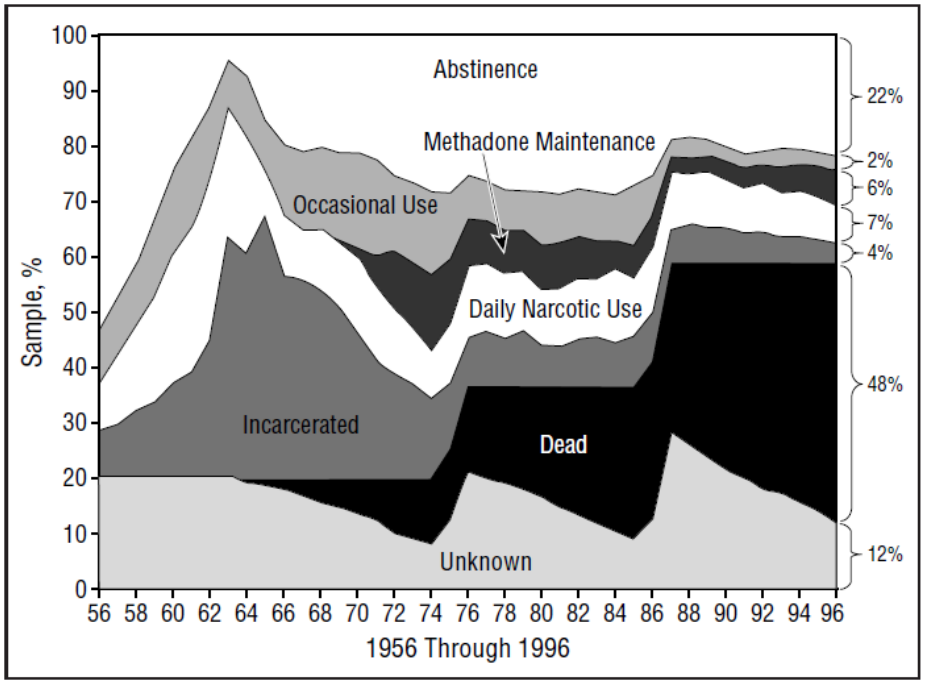
- Describe the severity of opioid use disorder
- Identify the various levels of care and how the emergency room can play a role
- Distinguish one model for the initiation of buprenorphine in a psychiatric emergency room setting

Opioid Use Disorder

- “U.S. Life Expectancy Drops Amid ‘Disturbing’ Rise in Overdoses and Suicides”
- “Fentanyl now America’s Deadliest Drug”

Opioid Use Disorder

- 581 males with OUD, mean age 25.4, followed for 33 years

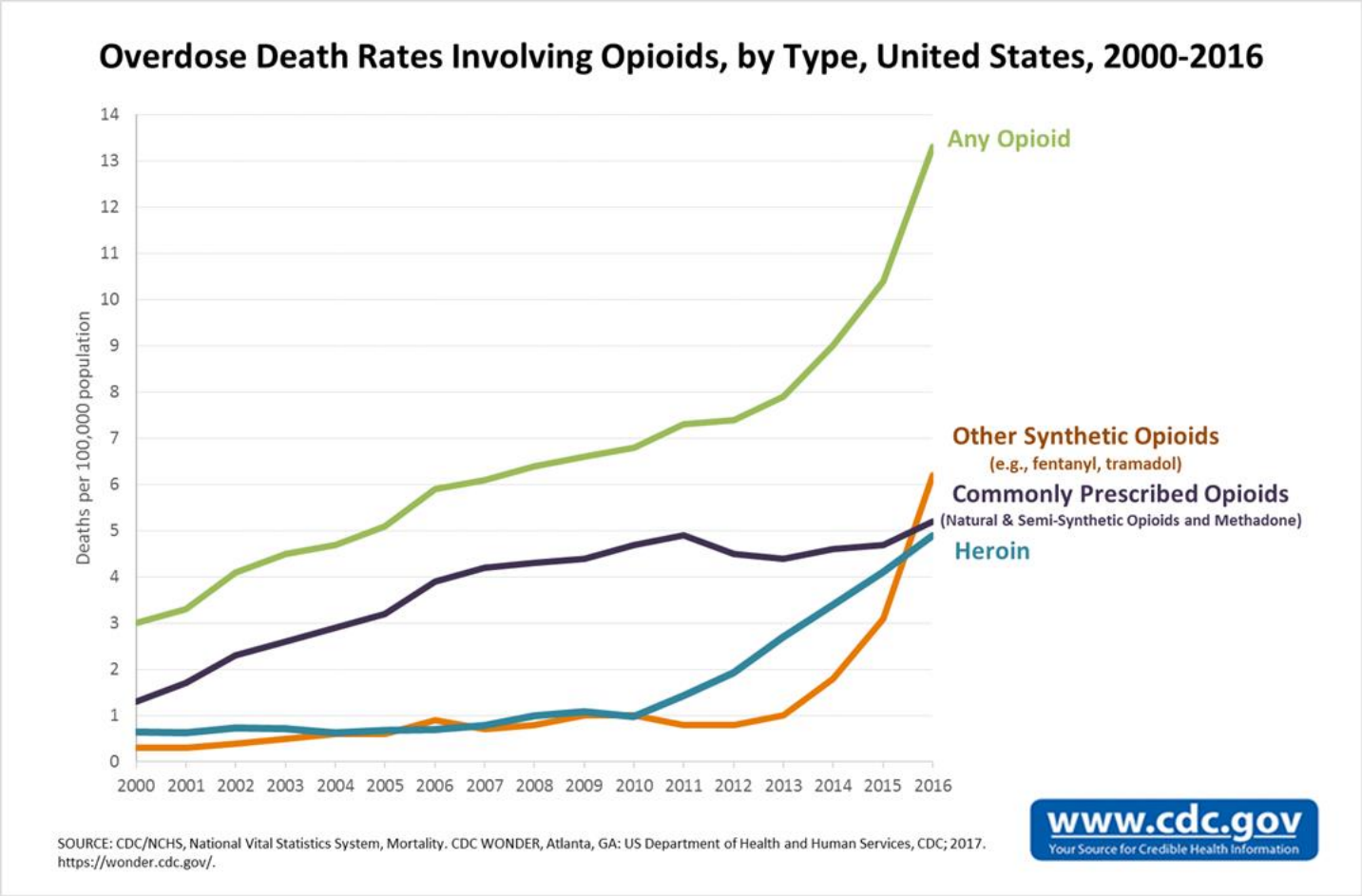


Hser, et. al. A 33-Year Follow-up of Narcotic Addicts. Archives of General Psychiatry, 2001;58:503-508

Opioid Use Disorder

- IV use
- Mixing with alcohol/benzodiazepines
- Previous Narcan administration

Overdose Death Rates Involving Opioids, by Type



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Fentanyl

	Fentanyl	Opioids	Cocaine
Total Urines	383	380	380
Positive	60	63	102
Percent Positive	15.67%	16.58%	26.84%

Fentanyl

- Fentanyl – Total positive = 60
- Of the 60, 41 positive for opioids = 68.33%
- Of the 60, 29 positive for cocaine = 48.33%
- Of the 60, 24 positive for opioids AND negative for cocaine = 40%
- Of the 60, 12 positive for cocaine AND negative for opioids = 20%
- Of the 60, 5 negative for cocaine AND negative for opioids = 8.33%

- Of the 63 positive for opioids, 41 positive for fentanyl = 65.08%
- Of the 102 positive for cocaine, 29 positive for fentanyl = 28.43%

- Of the 41 positive for opioids AND negative cocaine, 24 positive for fentanyl = 58.54%
- Of the 80 positive for cocaine AND negative opioids, 12 positive for fentanyl = 15%

Opioid Use Disorder

- “A key driver of the overdose epidemic is underlying substance use disorder. Consequently, expanding access to addiction treatment services is an essential component of a comprehensive response”

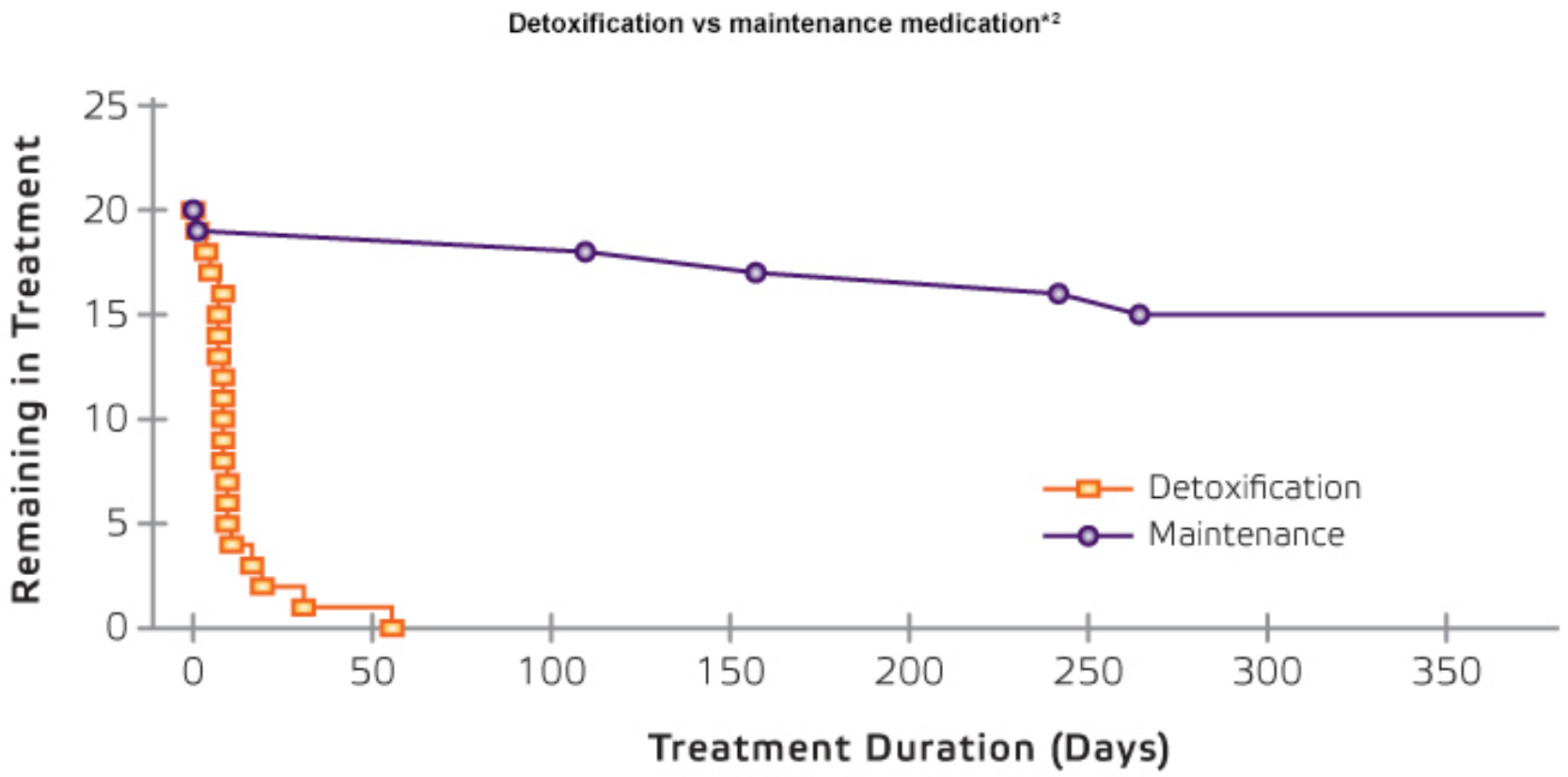
Volkow, Nora D., et al. "Medication-assisted therapies—tackling the opioid-overdose epidemic." *New England Journal of Medicine* 370.22 (2014): 2063-2066.

Opioid Use Disorder

- “Drug dependence generally has been treated as if it were an acute illness. Review results suggest that long term care strategies of medication management and continued monitoring produce lasting benefits. Drug dependence should be insured, treated and evaluated like other chronic illnesses.”

McLellan, A. Thomas, et al. "Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation." *Jama* 284.13 (2000): 1689-1695.

Medication Assisted Treatment



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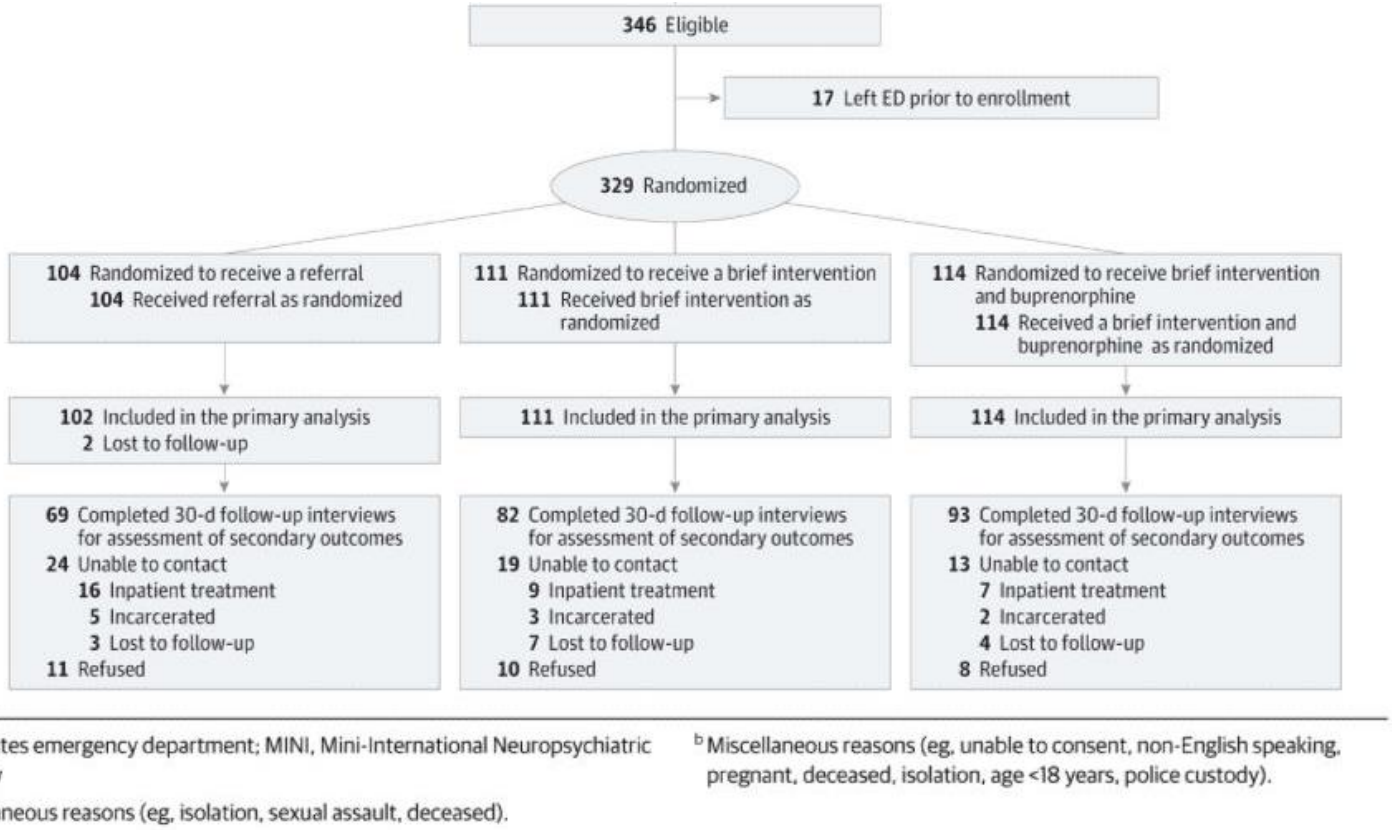
Medication Assisted Treatment



ED indicates emergency department; MINI, Mini-International Neuropsychiatric Interview

[a] Miscellaneous reasons (eg, isolation, sexual assault, deceased).

[b] Miscellaneous reasons (eg, unable to consent, non-English speaking, pregnant, deceased, isolation, age <18 years, police custody).

D'Onofrio, et. al. Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence. JAMA; 2015:313(16):1636-1644

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Medication Assisted Treatment

- Eighty-nine of 114 patients (78%; 95% CI, 70%-85%) in the buprenorphine group were engaged in treatment at significantly higher rates than the 38 of 102 patients (37%; 95% CI, 28%-47%) in the referral group or 50 of 111 patients (45%; 95% CI, 36%-54%) in the brief intervention group ($P < .001$).

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VA Connecticut PER

- Dedicated and locked, 24/7/365
- One of only several nationally at a VA
- Capacity of 14, able to provide extended observation
- Mostly voluntary patients
- Staffed by ~30 MDs, all required to have a buprenorphine waiver

VA Connecticut Resources

- Psychiatric emergency room
- Inpatient services
  - Inpatient psychiatric unit (16 beds)
  - Local inpatient psychiatric facilities
  - “Detox” service (inpatient and ambulatory)
  - Contracted “detox” facility
  - Local inpatient substance abuse treatment facilities
- Outpatient services
  - Substance abuse day program (PHP)
  - Opioid treatment program (methadone)
  - Buprenorphine clinic
  - Buprenorphine in primary care
  - Outpatient substance abuse clinic
  - Various groups and other therapies (CBT, CM)
- AA/NA referrals

Triage in the PER

- Hold in the PER
- Admit to inpatient “detox”
- Transfer to contracted “detox” bed
- Refer to inpatient substance abuse treatment
- Refer to substance abuse day program
- Refer to opioid treatment program
- Refer to ambulatory detox
- Refer to outpatient buprenorphine clinic
- Refer to outpatient substance abuse clinic
- Refer to 90 in 90, sponsor and step work
- Prescribe naloxone rescue kit

Initiation of Buprenorphine

- Hold in the PER, full history and PE, UDS, COWS
- 2-4mg driven by patient history or COWS
- Up to 8mg day 1 and 16mg day 2
- Patients typically stabilized by day 2 and we will often hold them in the PER until stabilized, even if it takes 2-3 days
- Our contracted “detox” facility generally does not detox patients with OUD, instead initiates and stabilizes on buprenorphine
- We then refer to buprenorphine clinic with ambulatory detox team to bridge the gap, if needed
- We generally will always recommend inpatient treatment or the day program

Case #1

- 25yo veteran presents to the PER seeking assistance with opioid use and sleep. He has no significant history of psychiatric or substance abuse treatment. Pt reports that 6 months ago he was prescribed an opioid for a shoulder injury. He realized that he started using the opioids to help him sleep and to get high. He started buying oxycodone on the street when he could no longer obtain prescriptions. He recently tried snorting though has never injected. He is currently using 1-2 times per week as that is all he can afford. He drinks alcohol occasionally. He wants to stop using opioids and is help-seeking.

Triage in the PER

- Hold in the PER – initiate buprenorphine
- Admit to inpatient “detox”
- Transfer to contracted “detox” bed
- Refer to inpatient substance abuse treatment (maybe)
- Refer to substance abuse day program
- Refer to opioid treatment program
- Refer to ambulatory detox (maybe)
- Refer to outpatient buprenorphine clinic (maybe)
- Refer to outpatient substance abuse clinic
- Refer to 90 in 90, sponsor and step work
- Prescribe naloxone rescue kit

Case #2

- 40yo male presents to the PER at the request of the buprenorphine clinic for continued opioid use. Pt reports that he has been on buprenorphine for 2 years and it has been very helpful. He admits to using occasional heroin off and on while on buprenorphine. He wishes to stay on buprenorphine. Pt has never been on methadone. He has been off buprenorphine for 2 weeks and last used IV heroin 5 days ago. Collateral from buprenorphine clinic reveals that they do not feel they can safely prescribe buprenorphine any longer.

Triage in the PER

- Hold in the PER – initiate buprenorphine
- Admit to inpatient “detox”
- Transfer to contracted “detox” bed
- Refer to inpatient substance abuse treatment
- Refer to substance abuse day program
- Refer to opioid treatment program (maybe)
- Refer to ambulatory detox
- Refer to outpatient buprenorphine clinic (maybe after treatment)
- Refer to outpatient substance abuse clinic
- Refer to 90 in 90, sponsor and step work
- Prescribe naloxone rescue kit

Case #3

- 27yo veteran with a 5 year history of opioid use disorder. He presents to the psych ER seeking opioid detox. He has been injecting approximately 10 bags of heroin daily with his last use being yesterday morning. He has also been using xanax 1-2mg daily and drinking sporadically. He denies medical problems. His parents have threatened to evict him if he does not stop using. He is interested in detox but not treatment because he does not want to miss work. He has never been on methadone or buprenorphine in the past. He denied psychiatric complaints.

Triage in the PER

- Hold in the PER – initiate buprenorphine
- Admit to inpatient “detox” (maybe)
- Transfer to contracted “detox” bed (maybe)
- Refer to inpatient substance abuse treatment
- Refer to substance abuse day program
- Refer to opioid treatment program
- Refer to ambulatory detox
- Refer to outpatient buprenorphine clinic
- Refer to outpatient substance abuse clinic
- Refer to 90 in 90, sponsor and step work
- Prescribe naloxone rescue kit

Case #4

- 31yo presents to the PER seeking assistance with opioid use and suicidal thoughts. He has a history of 3 recent suicide attempts, one involving crashing his car into a tree. He also has a history of IV heroin use with multiple near overdoses, some intentional, some unintentional. He has been through the day program and the inpatient substance use program in the past. He has been on buprenorphine off and on over the years but has not been on methadone. He has several inpatient psychiatric admissions as well. He has no medical problems. He is willing to be admitted for stabilization.

Triage in the PER

- Hold in the PER – initiate buprenorphine
- Admit to inpatient “detox” (likely needs a dual diagnosis bed, either at the VA or somewhere that can initiate buprenorphine)
- Transfer to contracted “detox” bed
- Refer to inpatient substance abuse treatment (after psychiatric inpt)
- Refer to substance abuse day program (after psychiatric inpt)
- Refer to opioid treatment program (maybe)
- Refer to ambulatory detox
- Refer to outpatient buprenorphine clinic (maybe)
- Refer to outpatient substance abuse clinic
- Refer to 90 in 90, sponsor and step work
- Prescribe naloxone rescue kit

Conclusions

- Psychiatric emergency rooms are often the initial point of care for patients with OUD
- Community physicians should be aware of the resources available to refer their patients to
- Buprenorphine is a potentially life-saving medication for a deadly illness

Hser, et. al. A 33-Year Follow-up of Narcotic Addicts. Archives of General Psychiatry, 2001;58:503-508

Kakko, Johan, et al. "1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomized, placebo-controlled trial." *The Lancet* 361.9358 (2003): 662-668.

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PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.
- PCSS Mentors are a national network of providers with expertise in **addictions, pain, evidence-based treatment including medication-assisted treatment**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

For more information visit:

https://pcssNOW.org/mentoring/

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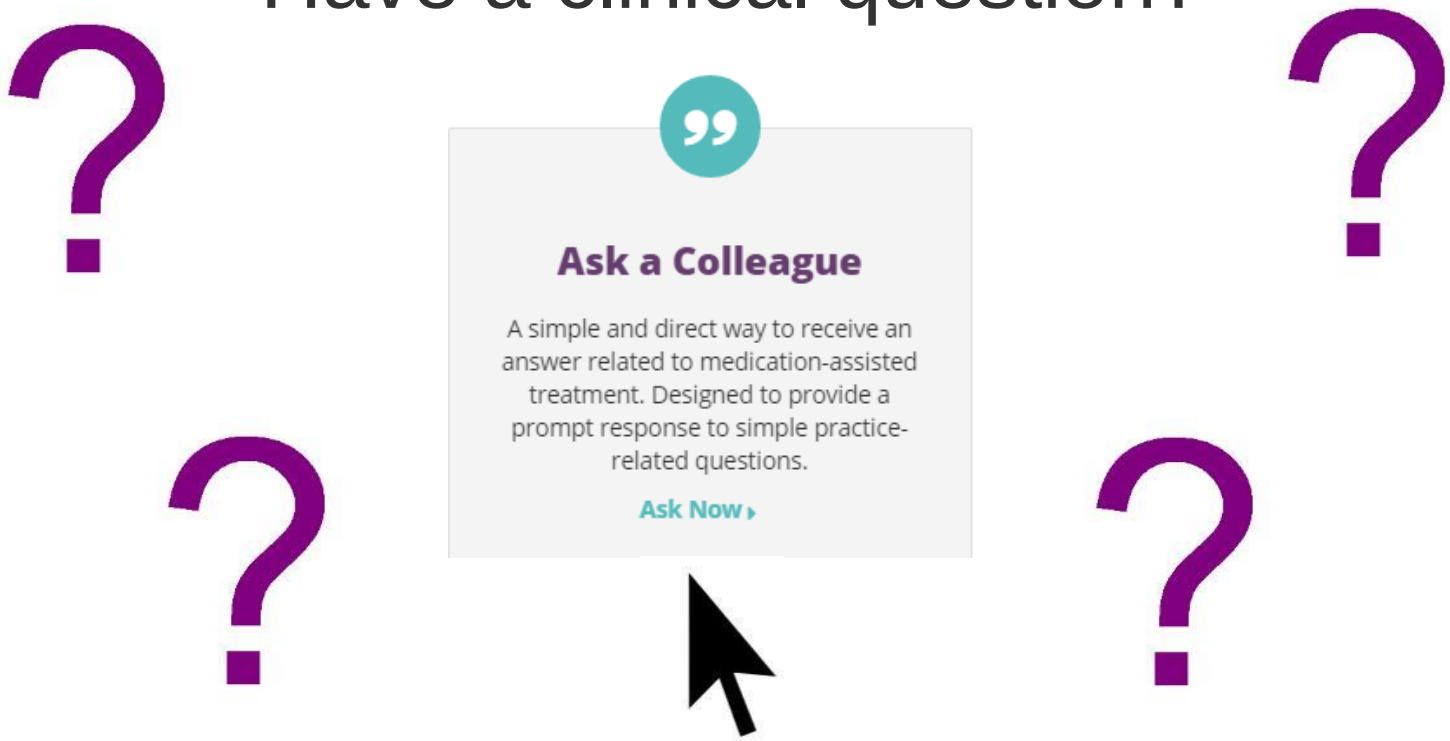
PCSS Discussion Forum

Have a clinical question?



http://pcss.invisionzone.com/register

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State Targeted Response-Technical Assistance Consortium (STR-TA)

- **Opioid Use Disorder Virtual Learning Collaborative (VLC)**
  - Translate your knowledge into action by joining one of our virtual learning collaboratives
  - Play a role in expanding the availability of medical for addiction treatment options for opioid use disorders
  - Each collaborative runs for 12-weeks and is lead by an experienced faculty advisor
  - Participants watch pre-recorded webinars, call into office-hours, engage with a virtual community and complete an individual project
  - Participants will earn up to 12 Continuing Medical Education (CME) credits
- Fill out our interest intake form at apapsy.ch/OpioidSTR. Contact Eunice Maize at emaize@psych.org for more information.

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Providers Clinical Support System

PCSS is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

American Academy of Family Physicians	American Psychiatric Association
American Academy of Neurology	American Society of Addiction Medicine
Addiction Technology Transfer Center	American Society of Pain Management Nursing
American Academy of Pain Medicine	Association for Medical Education and Research in Substance Abuse
American Academy of Pediatrics	International Nurses Society on Addictions
American College of Emergency Physicians	American Psychiatric Nurses Association
American College of Physicians	National Association of Community Health Centers
American Dental Association	National Association of Drug Court Professionals
American Medical Association	Southeastern Consortium for Substance Abuse Training
American Osteopathic Academy of Addiction Medicine	

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