Opioids in the ED Setting
June 13, 2017

Mark Hurst, MD
Medical Director
Unintentional Drug Overdoses & Distribution Rates of Prescription Opioids in Grams per 100,000 population, Ohio, 1997-2011\(^1-3\)

- **Opioid analgesic grams distributed**
- **Unintentional drug overdose death rate**

Figure 5. Number of Unintentional Overdose Involving Selected Drugs, by Year, Ohio, 2000-2015

* Prescription opioids not including fentanyl; fentanyl was not captured in the data prior to 2007 as denoted by the dashed line.

Source: Ohio Department of Health, Bureau of Vital Statistics; Analysis Conducted by ODH Injury Prevention Program.

Multiple drugs are usually involved in overdose deaths. Individual deaths may be reported in more than one category.
Substance Use Disorders are Brain Disorders

NEJM, 2016
Response to the opioid crisis

• Prevention
• Early intervention
• Treatment
• Life-saving measures
• Interdiction
Prevention

Start Talking!
Building a Drug-Free Future
Ohio Opioid Prescribing Guidelines

• Guidelines in Emergency Departments and Acute Care Settings
• Guidelines for Prescribing Opiates in Chronic Pain
• Guidelines for Management of Acute Pain Outside of Emergency Departments All are consensus guidelines developed by a broad representation of practitioners
• Rules for prescribing opioids in acute pain (proposed March 2017)
Ohio Opioid Prescribing Guidelines

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Ohio Guidelines for Emergency and Acute Care Facility Opioid and Other Controlled Substances (OOCs) Prescribing (2012; Revised 2014)

1. Prescribe only when deemed appropriate based on:
   - Presenting symptoms
   - Overall condition
   - Clinical examination
   - Addiction risk
   a. Parenteral doses not typically given for chronic pain or acute exacerbations of chronic pain
   b. Prescriptions not typically given if patient has previously presented with the same problem or has received a prescription in the past month
   c. Use of IV Meperidine discouraged
2. Emergency Clinicians will not routinely provide:
   a. Replacement prescriptions that were lost, destroyed or stolen
   b. Replacement doses of MAT (Buprenorphine, Methadone) for patients in a treatment program
   c. Long-acting or controlled release opioids:
      i. Oxycontin
      ii. Fentanyl patches
      iii. Methadone
      iv. Others
Ohio Guidelines for Emergency and Acute Care Facility Opioid and Other Controlled Substances (OOCS) Prescribing (2012, 2014)

3. Prior to making a final determination about providing a prescription:
   a. Search the OARRS database
   b. Consider checking photo ID to verify identity, and if none available, photograph patient and include this photograph in medical record
   c. Reserve the right to check UDS

4. Maintain a list of clinics that provide primary care and/or pain management services
Ohio Guidelines for Emergency and Acute Care Facility Opioid and Other Controlled Substances (OOCS) Prescribing (2012, 2014)

5. Prior to making a final determination about providing a prescription the emergency clinician should consider:
   a. Contacting the patient’s routine provider of care/prescriber of OOCS
   b. Consultation from palliative care/pain management service or subspecialty
   c. Case conferences for patients who frequently present with pain-related complaints
   d. Request medical/prescribing records from other providers, hospitals, etc.
   e. Sign a pain agreement
Ohio Guidelines for Emergency and Acute Care Facility Opioid and Other Controlled Substances (OOCS) Prescribing (2012, 2014)

6. Use available (electronic) medical resources to coordinate care of frequent utilizers to encourage information exchange within the facility, with other facilities, and with community care providers.

7. Limit prescriptions to a three-day supply and refer continuing pain needs to PCP/specialist for re-evaluation.

8. Provide detailed information to each patient leaving the facility with a OOCS prescription, including:
   a. Addictive nature of the medication
   b. Dangers of misuse
   c. Appropriate storage and disposal of the medication
Ohio Guidelines for Emergency and Acute Care Facility Opioid and Other Controlled Substances (OOCS) Prescribing (2012, 2014)

10. Following medical screening, provide the patient a handout outlining these guidelines that clearly states the facility position on prescribing of opioids and other controlled substances
Chart #5 - OARRS Queries, by Year

- 2011: 1.78
- 2012: 5.39
- 2013: 7.36
- 2014: 10.78
- 2015: 16.49
- 2016: 24.11

# of Queries in Millions vs Year
Chart #6 - Total Doctor Shoppers*, by Year

*In this chart, a doctor shopper is defined as an individual receiving a prescription for a controlled substance from five or more prescribers in one calendar month.
Chart #1 - Opioid Solid Doses Dispensed to Ohio Patients, by Year

# of Solid Oral Doses in Millions

Year


782  793  778  751  701  631

57 for every person in Ohio
Proportion of beneficiaries ages 12-24 with an opiate claim within 4 days of an ED visit.

*Excluding opiates provided in the ED and ED visits preceding hospitalization

Source: Medicaid Claims and encounter data for calendar years 2007-2015.
Evaluation of the Implementation of the Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCS) Prescribing Guidelines

Dr. Neil MacKinnon
Dean, James L Winkle College of Pharmacy
University of Cincinnati
Results: Demographics

163 hospitals with EDs were identified in Ohio and, of these, 150 EDs responded to the survey, giving a response rate of 92%. In total, 57% of respondents were from urban hospitals and 43% were from rural hospitals.

<table>
<thead>
<tr>
<th>Position</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Medical Director</td>
<td>119 (79.3%)</td>
</tr>
<tr>
<td>ED Physician</td>
<td>19 (12.7%)</td>
</tr>
<tr>
<td>Nursing Director</td>
<td>9 (6.0%)</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>3 (2.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>150 (100%)</td>
</tr>
</tbody>
</table>
Results: OOCS Policy

A third of hospitals (49/150) reported that their ED had an OOCS prescribing policy. Altogether, 75% (112/150) of hospitals had an OOCS prescribing policy, were adopting one, or were implementing guidelines without a specific policy.

<table>
<thead>
<tr>
<th>Hospitals with an opioid and other controlled substances prescribing policy</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a policy</td>
<td>49 (32.7%)</td>
</tr>
<tr>
<td>In the process of adopting one</td>
<td>8 (5.3%)</td>
</tr>
<tr>
<td>Implementing prescribing guidelines without adopting a specific policy</td>
<td>55 (36.7%)</td>
</tr>
<tr>
<td>Does not have a policy</td>
<td>32 (21.3%)</td>
</tr>
<tr>
<td>Not sure</td>
<td>6 (4.0%)</td>
</tr>
</tbody>
</table>
Results: Basis of Policy

Of the 112 emergency departments that had a policy, were adopting one, or were implementing guidelines without a specific policy, 72% based their practices on the Ohio Emergency and Acute Care Facility OOCs Prescribing Guidelines.

<table>
<thead>
<tr>
<th>Common Opioid Prescribing Guidelines</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances Prescribing Guidelines</td>
<td>81 (72.3%)</td>
</tr>
<tr>
<td>American College of Emergency Physicians guidelines</td>
<td>38 (33.9%)</td>
</tr>
<tr>
<td>CDC Guideline for Prescribing Opioids for Chronic Pain</td>
<td>32 (28.6%)</td>
</tr>
<tr>
<td>American Academy of Emergency Medicine guidelines</td>
<td>15 (13.4%)</td>
</tr>
<tr>
<td>Other</td>
<td>7 (6.3%)</td>
</tr>
</tbody>
</table>
Results: Perceived Impact of the Ohio OOCS Prescribing Guidelines

- Increased the use of the OARRS prescription monitoring program (n=106)
- Reduced inappropriate opioid prescribing (n=105)
- Reduced the conflict between patients and ED staff regarding opioids (n=106)
- Reduced the number of patients requesting opioids inappropriately (n=106)
- Increased physician satisfaction (n=105)
- Increased nurse satisfaction (n=105)
- Reduced inappropriate use of the ED (n=105)
- Allowed staff to focus more on emergent conditions (n=106)
Take-Home Points/Conclusions

- Although the guidelines are strongly supported by ED physicians, many believed more organizational responsibility, administrative assistance, and patient involvement were required to increase their implementation.
- Furthermore, patient satisfaction scores were reported to negatively impact efforts to reduce opioid prescribing in EDs.
Results: Naloxone practices for high risk opioid overdose patients

Naloxone to take home that is not part of a Project DAWN kit (n=131)

- 13%
- 17%
- 58%

Naloxone to take home that is part of a Project DAWN kit (Deaths Avoided With Naloxone) (n=133)

- 4%
- 7%
- 77%

A prescription for naloxone (n=132)

- 5%
- 81%

≥5% or patients
1-4% of patients
Never
Do not know
0% 20% 40% 60% 80% 100%
Hospitals and emergency departments in Ohio have various levels of resources to address drug overdoses and link patients to evidence-based treatment to address addiction.

Hospitals and emergency departments have an important role in the comprehensive approach to prevent unintentional deaths for drug overdose and facilitate entry into treatment, as an overdose event or emergency department visit for another drug-related medical problem can serve as a “change motivator” regarding drug use behavior.

Specific strategies can assist emergency departments in the assessment of patients who are treated for unintentional drug overdoses and link them to resources and care.
Conduct a global assessment of patients who present with suspected or confirmed overdose

- Safe housing
- Safe family and relationships
- Transportation availability
- Employment status
- Co-morbid mental health conditions
- Patient attitude toward the overdose event
- Patient attitude toward detox or treatment
- Opioid prescription history
- MAT history
- Opioid Use Disorder treatment history
- Health literacy re: opioids and overdose
- Major recent life events
- Human trafficking screening
- Insurance status; presumptive Medicaid eligibility
- Current opioid prescriptions
- Current signed pain agreement/contract
OARRS, Naloxone and Withdrawal Management

- Request and OARRS report for all patients who present with overdose
- Provide naloxone for every patient who presents with an overdose
  - A bystander is present in 70% of fatal overdoses (CDC, 2014)
  - Does not promote more drug use but encourages entry into treatment
- Provide patients experiencing withdrawal with a “comfort pack” to decrease likelihood of “self-medicating” withdrawal with illicit opioids
Use non-stigmatizing language internally and when addressing patients:

Overcoming Obstacles: Watch Your Language!
## Non-stigmatizing language:

<table>
<thead>
<tr>
<th>Say This.....</th>
<th>Not this.....</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person with substance abuse disorder; person with addiction; person who uses drugs</td>
<td>Addict, Drug abuser, Junkie, Druggie.....</td>
</tr>
<tr>
<td>Drug screen was positive (or negative) for specific drugs</td>
<td>“Dirty Urine”</td>
</tr>
<tr>
<td>Substance use disorder, Addictive disorder</td>
<td>Drug abuse, drug habit, substance abuse</td>
</tr>
<tr>
<td>Treatment failure</td>
<td>Treatment was not effective</td>
</tr>
<tr>
<td>Abstinent, in remission, in recovery</td>
<td>Clean, sober</td>
</tr>
<tr>
<td>Relapser, recidivist, frequent flyer</td>
<td>Person experiencing a recurrence</td>
</tr>
<tr>
<td>Medication assisted treatment, treatment</td>
<td>Opiate replacement therapy, substitution therapy</td>
</tr>
</tbody>
</table>
Patient Education and SBIRT

• Use Screening, Brief Intervention, and Referral to Treatment (SBIRT) approaches with patient presenting with overdose
• Provide overdose patients with harm reduction resources and education about blood-borne pathogen prevention and training
• Provide training on substance use disorders and overdose and effective approaches to engage and treat individuals affected with substance use disorders and their families
Refer patients who present with overdose to treatment and follow-up care

- Drug acute stabilization centers
- Inpatient and outpatient drug and addiction treatment facilities
- Providers of medication-assisted treatment (MAT)
- Patient and family support groups
- Mental and behavioral health care providers
- Housing assistance
- Domestic and sexual violence services
- Food assistance
- Employment assistance
- Ex-offender re-entry programs

The tighter the handoff, the better!
Evaluate all patients who present with overdose for medication-assisted treatment

• Options:
  • Buprenorphine
  • Methadone
  • Naltrexone
    • Long-acting injection
    • Oral
• All are demonstrated to:
  • Decrease relapse
  • Decrease mortality
  • Decrease incarceration
  • Increase employment
  • Improve family functioning
Overheard about MAT

- “It’s a crutch”
- “Why use a drug to treat a problem with a drug?”
Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence
A Randomized Clinical Trial

Gail D’Onofrio, MD, MS; Patrick G. O’Connor, MD, MPH; Michael V. Pantalon, PhD; Marek C. Chawarski, PhD; Susan H. Busch, PhD; Patricia H. Owens, MS; Steven L. Bernstein, MD; David A. Fiellin, MD
Initiating Buprenorphine in Emergency Departments (JAMA: D’Onofrio, 2015)

- 3 randomized groups:
  - Screening and treatment referral
  - SBIRT and referral
  - SBIRT, ED-initiated buprenorphine and referral to PCP for 10 week follow-up
Initiating Buprenorphine in Emergency Departments (JAMA: D’Onofrio, 2015)

• Results:
  – Engagement in tx after 30 days:
    • Screening/referral group: 37%
    • SBIRT group: 45%
    • BUP group: 78%
  – # of days/wk of illicit opioid use:
    • Screening/referral group: 5.6 days/wk baseline to 2.4 days/wk
    • SBIRT group: 5.4 days/wk baseline to 2.3 days/wk
    • BUP group: 5.4 days/wk baseline to 0.9 days/wk
  – Inpatient treatment use:
    • Screening/referral group: 37%
    • SBIRT group: 35%
    • Bup group: 11%
Specific recommendations for patients presenting in the ED for opioid-related substance use disorders

• Patients presenting with indication of opioid overdose
  • Utilization of naloxone
  • Obtaining information from first responders
  • Provision of naloxone kit or referral to source of naloxone
  • Information on community resources
  • Consideration of initiating pharmacological treatment of withdrawal
Patients presenting with conditions that may warrant prescribing of opioids or with history of opioid abuse:

- Check OARRS
- Refer to internal guidelines which have been developed
- Prescribe scheduled drugs after performing due diligence:
  - OARRS
  - Medication reconciliation
  - Pain medicine consultation
  - Adhere to pain protocols

Provide education to staff on management of OD, treatment of pain, treatment of SUDs, etc.

Develop internal protocols
Rhode Island Levels of Care for EDs and Hospitals in Treating Overdose and Opioid Use

**LEVEL 3**
1. Follows discharge planning per law
2. Administers standardized substance use disorder screening for all patients
3. Educates all patients who are prescribed opioids on safe storage and disposal
4. Dispenses naloxone to patients at risk, according to clear protocol
5. Offers peer recovery support services
6. Provides active referral to appropriate community provider(s)
7. Complies with 48-hour reporting of overdose to RIDOH
8. Performs laboratory drug screening that includes fentanyl on patients who overdose

**LEVEL 2**
Meets all criteria of Level 3 and:
1. Conducts comprehensive, standardized substance use assessment
2. Maintains capacity for evaluation and treatment of opioid use disorder using support from addiction specialty services

**LEVEL 1**
Meets criteria of Level 3 and Level 2 and also:
1. Maintains a Center of Excellence or comparable arrangement for initiating, stabilizing, and re-stabilizing patients on medication assisted treatment
   - Ensures transitioning to/from community care to facilitate recovery
   - Evaluates and manages medication assisted treatment
The 21st Century CURES Act was enacted by Congress in December 2016.

- It targeted $1 billion in funding for the opioid epidemic.
Training Overview

- Continuing Education
- ECHO Model Support
- Enhanced Training
- Initial Waiver Training
- Physician/PA/NPs
Initial Waiver Training

• Physicians practicing in 47 Tier 1 and Tier 2 communities will be encouraged to obtain their waiver. OHA, OSMA, OOA, managed care organizations (MCPs), and others will assist in recruitment.
  • Live trainings will be conducted by ASAM and OhioMHAS staff
  • Physicians will be reimbursed for their time lost
  • Free online trainings will be available for physicians in other parts of the state
Enhanced Training - ASAM

- Training will also be provided to help existing waived physicians increase their competency with ASAM guidelines.
  - Ten live ASAM trainings for 40 persons each will be held in Tier 1 counties
  - Free online trainings will be provided concerning ASAM multidimensional assessments and ASAM levels of care in other parts of the state
Enhanced Training - ED

• Training will also be targeted to prescribers in emergency departments to help them encourage continuity of care
  • Model 1: Induction of MAT in ED through specialists on staff. Handoff to interim PCP or OB until OBOT/OTP available
  • Model 2: Induction of MAT in ED through telemedicine; Handoff to interim PCP or OB until OBOT/OTP available
  • Model 3: Immediate warm handoff to PCP/OBOT/OTP
  • Model 4: Immediate withdrawal management in hospital or community
Development of expertise among newly waivered prescribers through ECHO model

- Year 1: Mentorship ECHO for physicians that meets once a week for three months per cohort
- Year 2: Mentorship ECHO for APNs and PAs that meets once a week for three months per cohort
Continuing education for specialist prescribers with a monthly ECHO that varies content throughout the month

- Week 1: General topics on opioid abuse and dependence relevant to prescribers (e.g., motivational interviewing and retention)
- Week 2: Emergency department physicians
- Week 3: Primary care physicians
- Week 4: Obstetric physicians
Continuing Education

- Develop 21-part curricula by a panel of experts that promotes understanding of MAT, substance abuse, and vicarious trauma.
  - Fundamentals of Addiction
  - Getting a Physician Practice Ready to Use the Waiver
  - Prescribing Best Practices Basics of MAT
  - MAT in Obstetric Settings
  - MAT and Non-Prescribing Professionals
  - Managing Pain in Patients with Opioid Use Disorders
  - Vicarious Trauma Overview
Community Rollout Strategy

1. Community Marketing
2. Enter county with Data 2000 Training
3. Follow-up 3-6 weeks later with ASAM training
4. Offer ECHO mentorship to waivered physicians
5. Offer Continuing education (Specialty ECHO, & C.E.)
Hospital Systems & CURES

• Adopt emergency department induction of MAT
• Grants will be awarded to 11 hospitals in the first year of CURES funding and 30 hospitals in the second year of CURES funding.
• Funds will be used for targeted case managers that can refer appropriate patients to treatment for substance use disorder.
Hospital Systems & CURES (cont.)

- General Grant Requirements
  - Using MAT induction in ED settings
  - or immediate handoff to someone who will do induction
  - Follow up with referral source and patient after admittance
- Accept Medicaid
- Quality improvement data
For more information

• Andrea Boxill, Deputy Director, Governor’s Cabinet Opioid Action Team (GCOAT)
  • mha.ohio.gov/gcoat
• Mark Hurst, MD, Medical Director, Ohio MHAS
• Rick Massatti, PhD, MSW, MPH, LSW, State Opiate Treatment Authority
• Ellen Augspurger, MAT
  SBIRT Project Director
• Sarah Smith, lead of “Start Talking” initiative
Find us on:

http://www.mha.ohio.gov/

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