ED-initiated buprenorphine

expanding the scope of emergency care during an addiction epidemic

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ED management of pain and misuse during an epidemic

1. prevent opioid naive patients from becoming misusers by your prescription

calculate benefit: harm whenever opioid Rx considered
if opioid Rx, small number of low dose, lower-risk pills

2. for existing opioid users

2a. revealed, willing
"I'm an addict, I need help"
aggressive move to treatment
ED-initiated buprenorphine
arranged speciality followup

2b. revealed, unwilling
"I overdosed"
harm reduction, LowThreshBup
supportive stance, open door

2c. partially revealed
"I have chronic pain and need meds"
avoid opioids in ED or by prescription
opioid alternatives for pain
express concern that opioids are causing harm

2d. unrevealed
"I have acute pain and need meds"
risk stratify with red & yellow flags
PDMP - move positives to willingness

MAT: medication assisted treatment
is the best treatment for opioid addiction

OAT: opioid agonist treatment
OST: opioid substitution treatment
is the treatment for opioid addiction

abstinence does not work

abstinence does not work
for opioid addiction

detox does not work
rehab does not work
12-step does not work
NA does not work
counseling does not work

27% relapse on day of discharge from rehab
65% relapse at one month
90% relapse at one year

very dangerous

abstinence.
does not work.
for opioid addiction.

MAT: naltrexone
methadone
buprenorphine

MAT: medication assisted treatment
buprenorphine

partial opioid agonist
ceiling effect: much safer, less euphoriant

higher receptor affinity than almost any other opioid
will precipitate withdrawal if not in withdrawal

less abuse-prone and blocks more abuse-prone opioids

bup is uniquely suited to treat opioid addiction: less dangerous, less abuse-prone vs. methadone, more likely to abolish craving, protects users from OD by more dangerous opioids

MAT: medication assisted treatment

buprenorphine

buprenorphine + naloxone = Suboxone
naloxone additive is inert unless injected
naloxone component only prevents IV abuse

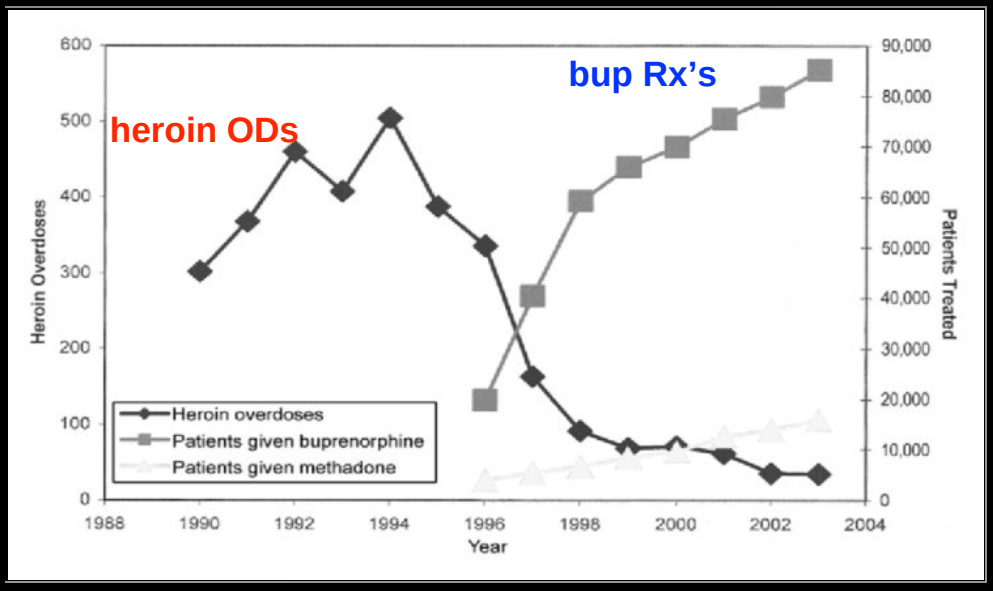
slow acting & long-acting

reduces abuse potential +ceiling effect = long dosing intervals

everyone can use buprenorphine to treat withdrawal but an X-waiver is required to prescribe for addiction

ACEP X Waiver course for emergency docs

in 1996, France responded to its heroin overdose epidemic by training/licensing GP's to prescribe buprenorphine



Auriacomb 2004

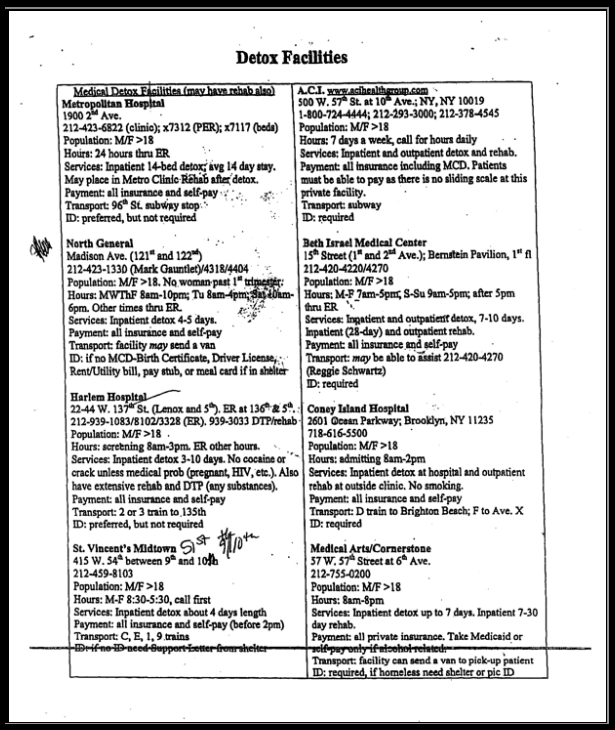
opioid addiction

desperate need to avoid withdrawal
constant debilitating cravings
perpetual cycling of highs/lows
normal functioning impossible
acquisition harms: poverty, crime, frantic behavior
injection harms: local infections, HIV/Hep C, endocarditis
street drug harms: accidental overdose/death

prescribed
opioid agonist

opioid dependence

scheduled opioid consumption
freedom from addiction harms
normal life possible



Detox Facilities

Medical Detox Facilities (may have rehab also)

Metropolitan Hospital
1900 2nd Ave.
212-423-6822 (clinic); x7312 (PER); x7117 (beds)
Population: M/F >18
Hours: 24 hours thru ER
Services: Inpatient 14-bed detox; avg 14 day stay. May place in Metro Clinic Rehab after detox.
Payment: all insurance and self-pay
Transport: 96th St. subway stop
ID: preferred, but not required

North General
Madison Ave. (121st and 122nd)
212-423-1330 (Mark Gauntlet)/4318/4404
Population: M/F >18. No woman past 1st trimester.
Hours: MWThF 8am-10pm; Tu 8am-4pm; Sat 10am-6pm. Other times thru ER.
Services: Inpatient detox 4-5 days.
Payment: all insurance and self-pay
Transport: facility *may* send a van
ID: if no MCD-Birth Certificate, Driver License, Rent/Utility bill, pay stub, or meal card if in shelter

Harlem Hospital
22-44 W. 137th St. (Lenox and 5th). ER at 136th & 5th.
212-939-1083/8102/3328 (ER). 939-3033 DTP/rehab
Population: M/F >18
Hours: screening 8am-3pm. ER other hours.
Services: Inpatient detox 3-10 days. No cocaine or crack unless medical prob (pregnant, HIV, etc.). Also have extensive rehab and DTP (any substances).
Payment: all insurance and self-pay
Transport: 2 or 3 train to 135th
ID: preferred, but not required

St. Vincent's Midtown
415 W. 54th between 9th and 10th
212-459-8103
Population: M/F >18
Hours: M-F 8:30-5:30, call first
Services: Inpatient detox about 4 days length
Payment: all insurance and self-pay (before 2pm)
Transport: C, E, 1, 9 trains
~~ID: if no ID need Support Letter from shelter~~

A.C.I. www.acihealthgroup.com
500 W. 57th St. at 10th Ave.; NY, NY 10019
1-800-724-4444; 212-293-3000; 212-378-4545
Population: M/F >18
Hours: 7 days a week, call for hours daily
Services: Inpatient and outpatient detox and rehab.
Payment: all insurance including MCD. Patients must be able to pay as there is no sliding scale at this private facility.
Transport: subway
ID: required

Beth Israel Medical Center
15th Street (1st and 2nd Ave.); Bernstein Pavilion, 1st fl
212-420-4220/4270
Population: M/F >18
Hours: M-F 7am-5pm; S-Su 9am-5pm; after 5pm thru ER
Services: Inpatient and outpatient detox, 7-10 days. Inpatient (28-day) and outpatient rehab.
Payment: all insurance and self-pay
Transport: *may* be able to assist 212-420-4270 (Reggie Schwartz)
ID: required

Coney Island Hospital
2601 Ocean Parkway; Brooklyn, NY 11235
718-616-5500
Population: M/F >18
Hours: admitting 8am-2pm
Services: Inpatient detox at hospital and outpatient rehab at outside clinic. No smoking.
Payment: all insurance and self-pay
Transport: D train to Brighton Beach; F to Ave. X
ID: required

Medical Arts/Cornerstone
57 W. 57th Street at 6th Ave.
212-755-0200
Population: M/F >18
Hours: 8am-8pm
Services: Inpatient detox up to 7 days. Inpatient 7-30 day rehab.
Payment: all private insurance. Take Medicaid or ~~self-pay only if alcohol related~~.
Transport: facility can send a van to pick-up patient
ID: required, if homeless need shelter or pic ID

“A great part of the tragedy of this opioid crisis is that, unlike in previous such crises America has seen, we now possess effective treatment strategies that could address it and save many lives, yet tens of thousands of people die each year because they have not received these treatments.”

Volkow 2018

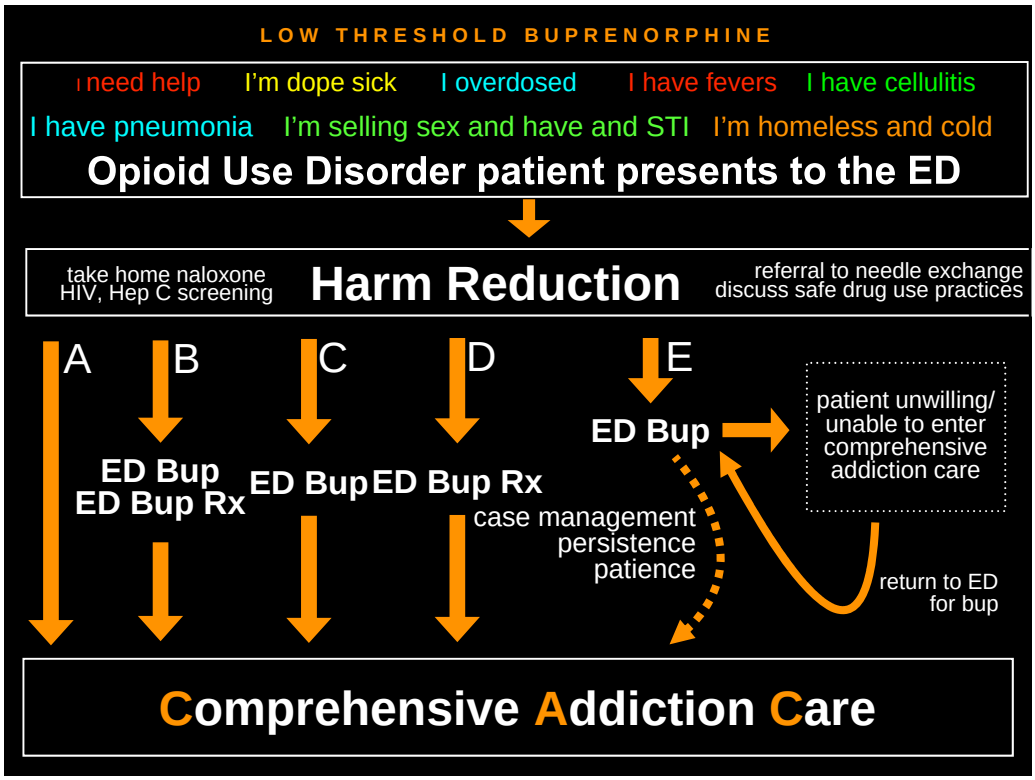
Discharging a person addicted to opioids who is in withdrawal is more dangerous than any discharge we would ever consider in any other context

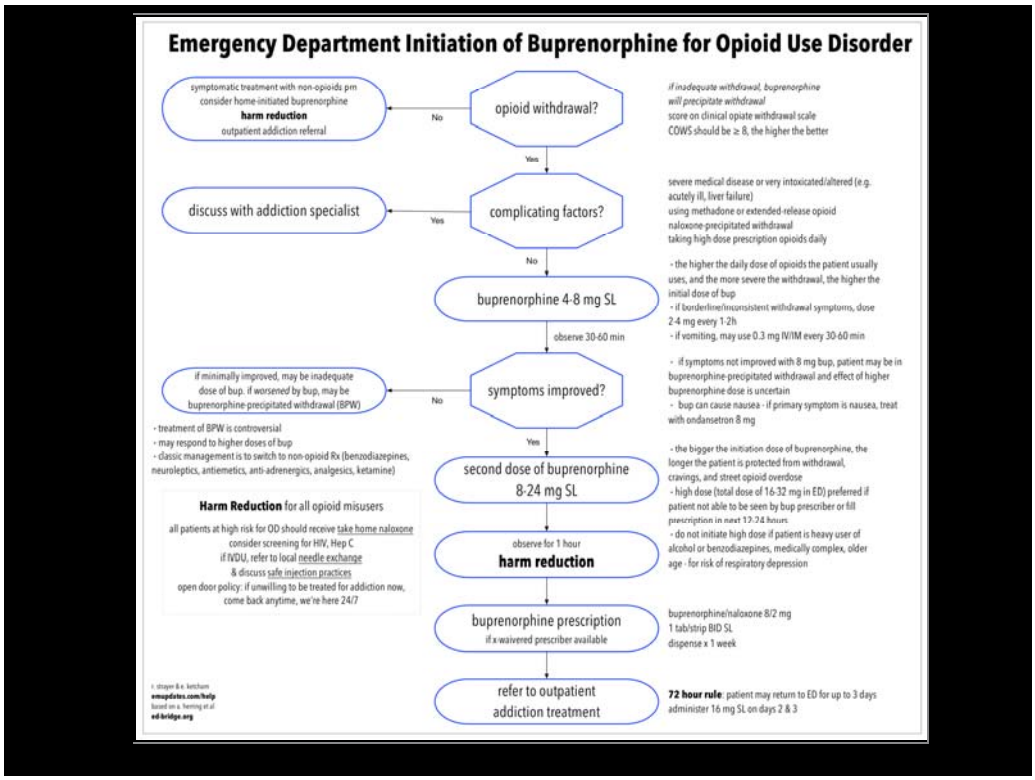
“The history of medicine is, in part, the history of physicians stretching the scope of their practice to answer the pressing needs of their times.”

Rapoport & Rowley, *NEJM*, 2017

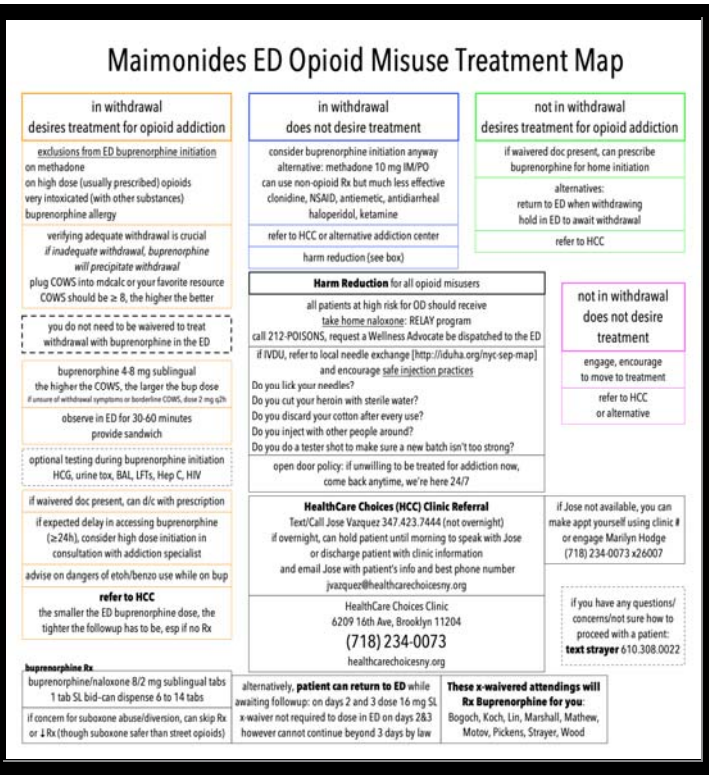
I need help
I’m dope sick
I overdosed
I have fevers
I have cellulitis
I have pneumonia
I was assaulted
I was arrested
I was in jail
I’m selling sex and have an STI
I’m homeless and cold

the emergency department is where these patients are


LOW THRESHOLD BUPRENORPHINE
I need help
I'm dope sick
I overdosed
I have fevers
I have cellulitis
I have pneumonia
I'm selling sex and have and STI
I'm homeless and cold
Opioid Use Disorder patient presents to the ED
take home naloxone
HIV, Hep C screening
Harm Reduction
referral to needle exchange
discuss safe drug use practices
A
B
C
D
E
ED Bup
ED Bup Rx
ED Bup
ED Bup Rx
ED Bup
patient unwilling/ unable to enter comprehensive addiction care
case management
persistence
patience
return to ED for bup
Comprehensive Addiction Care


Emergency Department Initiation of Buprenorphine for Opioid Use Disorder
opioid withdrawal?
symptomatic treatment with non-opioids prn
consider home-initiated buprenorphine
harm reduction
outpatient addiction referral
No
Yes
if inadequate withdrawal, buprenorphine will precipitate withdrawal
score on clinical opiate withdrawal scale
COWS should be ≥ 8, the higher the better
complicating factors?
discuss with addiction specialist
Yes
No
severe medical disease or very intoxicated/altered (e.g. acutely ill, liver failure)
using methadone or extended-release opioid
naloxone-precipitated withdrawal
taking high dose prescription opioids daily
buprenorphine 4-8 mg SL
observe 30-60 min
- the higher the daily dose of opioids the patient usually uses, and the more severe the withdrawal, the higher the initial dose of bup
- if borderline/inconsistent withdrawal symptoms, dose 2-4 mg every 1-2h
- if vomiting, may use 0.3 mg IV/IM every 30-60 min
symptoms improved?
if minimally improved, may be inadequate dose of bup. if worsened by bup, may be buprenorphine-precipitated withdrawal (BPW)
No
Yes
- if symptoms not improved with 8 mg bup, patient may be in buprenorphine-precipitated withdrawal and effect of higher buprenorphine dose is uncertain
- bup can cause nausea - if primary symptom is nausea, treat with ondansetron 8 mg
- treatment of BPW is controversial
- may respond to higher doses of bup
- classic management is to switch to non-opioid Rx (Benzodiazepines, neuroleptics, antiemetics, anti-adrenergics, analgesics, ketamine)
second dose of buprenorphine 8-24 mg SL
- the bigger the initiation dose of buprenorphine, the longer the patient is protected from withdrawal, cravings, and street opioid overdose
- high dose (total dose of 16-32 mg in ED) preferred if patient not able to be seen by bup prescriber or fill prescription in next 12-24 hours
- do not initiate high dose if patient is heavy user of alcohol or benzodiazepines, medically complex, older age - for risk of respiratory depression
Harm Reduction for all opioid misusers
all patients at high risk for OD should receive take home naloxone
consider screening for HIV, Hep C
if IVDU, refer to local needle exchange
& discuss safe injection practices
open door policy: if unwilling to be treated for addiction now, come back anytime, we're here 24/7
observe for 1 hour
harm reduction
buprenorphine prescription
if x-waivered prescriber available
buprenorphine/naloxone 8/2 mg
1 tab/strip BID SL
dispense x 1 week
refer to outpatient addiction treatment
72 hour rule, patient may return to ED for up to 3 days
administer 16 mg SL on days 2 & 3

Maimonides EDIB Protocol



we don't want to be a suboxone clinic / suboxone abuse

EDs that have started bup programs have not seen significant bup abuse
bup is not nearly as abuse prone as full agonists
patient visits may **decrease** - these patients are coming to the ED anyway
non-prescribed bup exposure potentiates successful treatment
buprenorphine overdose is comparatively safe
even diversion may not be a bad thing, in an era of superfentanyls
high dose bup initiation: prescription less important

CHS Opioid Prevention Program

Christopher C. Raio, MD MBA FACEP
Chief, Emergency Medicine CHSLI
Chairman, Emergency Medicine GSHMA

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Catholic Health Services of Long Island

- Integrated Health Care Delivery System serving Eastern Queens, Nassau and Suffolk Counties
- **Mission driven organization under the sponsorship of the DRVC & leadership of Bishop John Barres and President & CEO Dr. Alan Guerci**
- 6 Hospitals, 3 SNF's, Home Care, Hospice, Palliative Care Substance Abuse/ Detox and Rehabilitative Services
- 1,928 certified hospital beds
- 790 nursing home beds
- Approximately 17,500 employees
- More than 4,300 medical staff
- More than 4,000 nursing staff
- Almost 3,000 volunteers
- More than $2 billion in revenues
- *2017 statistics

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Multifactorial Complex Issue:

Social and Economic Factors

- Economic variability across long island with some communities experiencing loss of social capital
- Economic Distress
- Work related injuries
- Increase in illicit drug trafficking

Initial Incongruent Public Policy and Awareness/Education

- Excellent changes made in NYS medical prescribing and tracking policies/requirements (I-STOP)
- Initial lack of additional legislation to increase criminal charges against criminal illicit drug traffickers
- Lack of Effective Public Health education and campaigns
- Education failures and risks in schools

Clinical, Big Phamra and Payor

- **Irresponsible marketing of opioid medications to providers. (Oxycontin, Purdue Pharma)**
- **Irresponsible prescribing by health care providers**
- **Pain is the 5th vital sign**
- **Center for Medicare and Medicaid Services Patient Experience "Pain" Domain and penalties**

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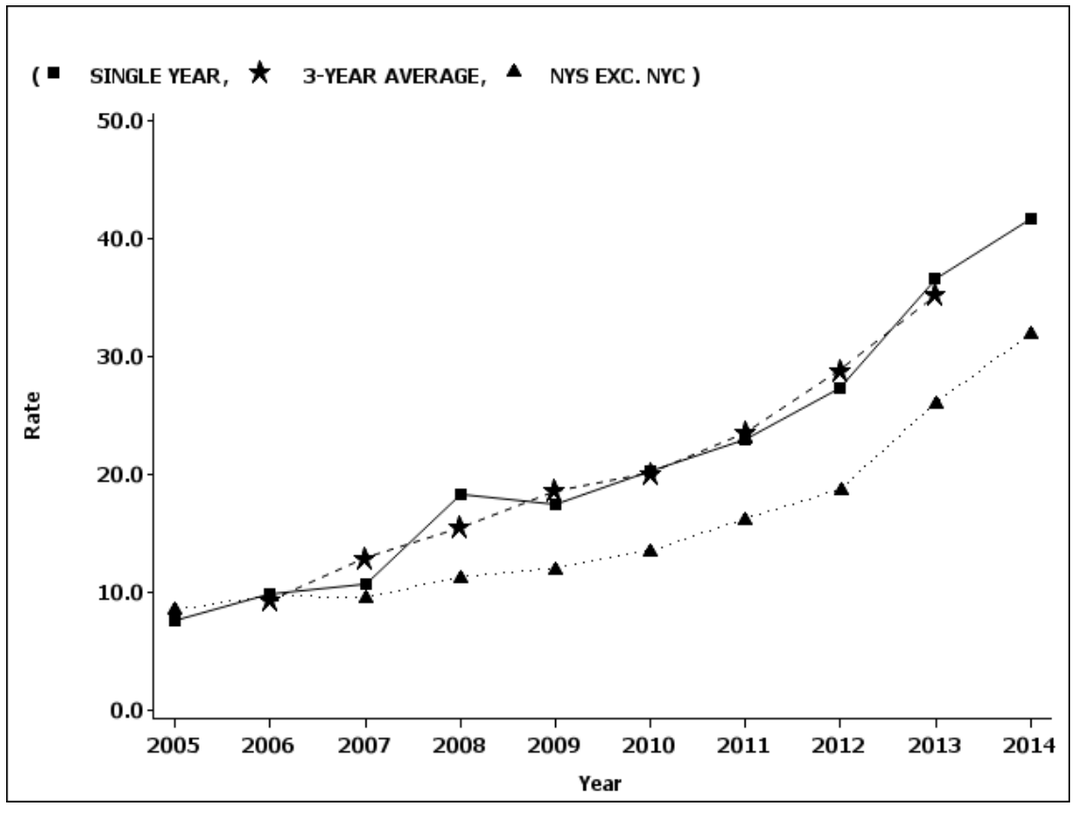
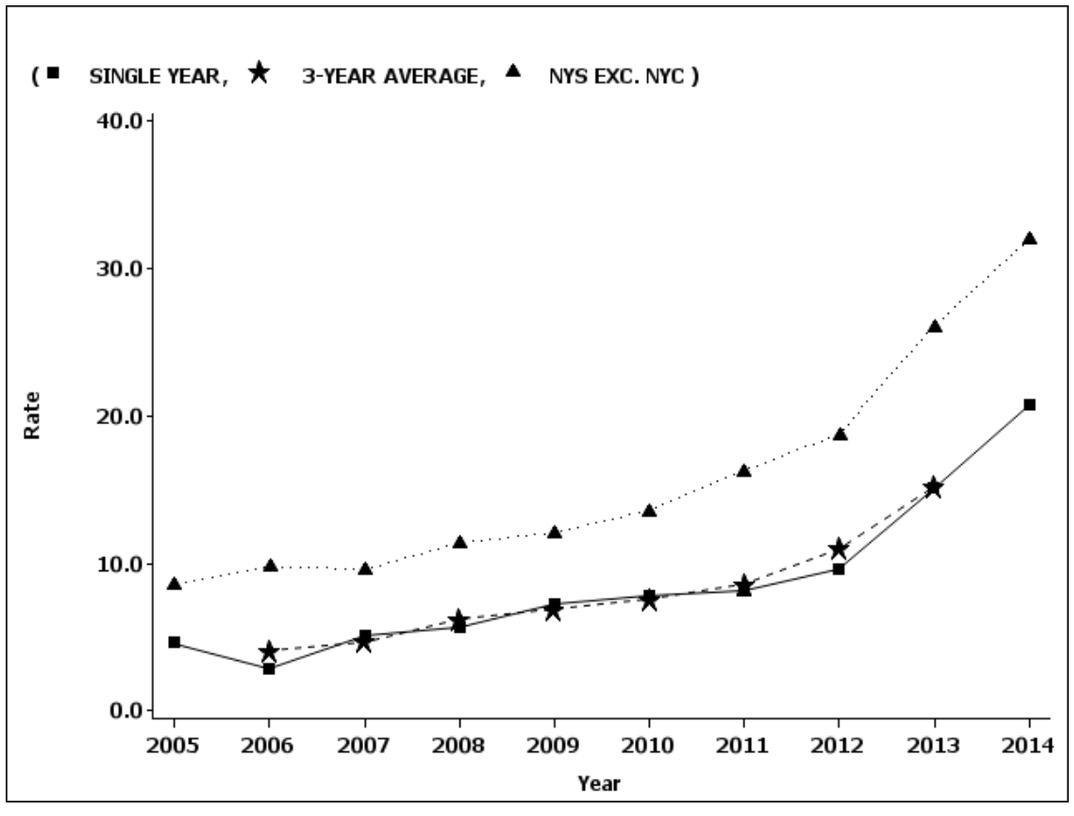
Opioid Overdose ED Visit Rates – Suffolk/Nassau County

Suffolk County Outpatient emergency department visits involving any opioid overdose, age-adjusted rate per 100,000 population



Nassau County Outpatient emergency department visits involving any opioid overdose, age-adjusted rate per 100,000 population



Source: NYSDOH - https://www.health.ny.gov/statistics/opioid/data/e2_47.htm

Source: NYSDOH - https://www.health.ny.gov/statistics/opioid/data/e2_28.htm

We have a tough climb ahead……

CHS Internal Data
Why MAT/Sherpa (CHS:FCA Joint Program) and why GSHMC?

Source: Epic Reporting

CHS: Catholic Health Services

FCA: Family and Children's Association

GSHMC: Good Samaritan Hospital Medical Center

2016-2017 Naloxone Doses Dispensed from Pyxis*

2016	SFH	GSH	SCS	MMC	SCH	SJH	System Total
Naloxone doses dispensed from Pyxis	80	283	35	69	48	1	**516**
Excluding ED department	49	97	35	28	17	1	**227**
ED Department	31	186	0	41	31	0	**289**

2017	SFH	GSH	SCS	MMC	SCH	SJH	System Total
Naloxone doses dispensed from Pyxis	79	358	60	82	63	18	**660**
Excluding ED department	45	119	39	18	29	18	**268**
ED Department	34	239	21	64	34	0	**392**
% CHANGE	**SFH**	**GSH**	**SCS**	**MMC**	**SCH**	**SJH**	**System Total**
Naloxone doses dispensed from Pyxis	-1.3%	26.5%	71.4%	18.8%	31.3%	N/A	27.9%
Excluding ED department	-8.2%	22.7%	11.4%	-35.7%	70.6%	N/A	18.1%
ED Department	9.7%	28.5%	N/A	56.1%	9.7%	N/A	35.6%

**SJH does not dispense Naloxone from Pyxis System. System data does not include medication dispensed from sources other than Pyxis (crash cart, etc.).*

Overview

- High priority initiative: engaged CHS leadership
- Collaborative: across disciplines, service lines, departments, specialties
- Resourced: Administrative, Education, Staffing, etc.
- *Multiple overlapping programs*

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Current Processes

- CHS Opioid Prescribing Guidelines
- Narcan distribution program (Suffolk County)
- Increased availability of social work at some sites
- SBIRT
- NYS Mandatory Training
- ED Peer/Family Navigator Program (SHERPA)
- ED Buprenorphine

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CHS Opioid Prescribing Guidelines

- Guidelines for ED prescribing of controlled substances
  - Adresses prescriptions
  - Adresses in-ED pain management
  - Adresses medication selection
  - Adresses care coordination
  - Adresses substance abuse screening/Narcan
  - Clearly states CHS support of provider professional judgement

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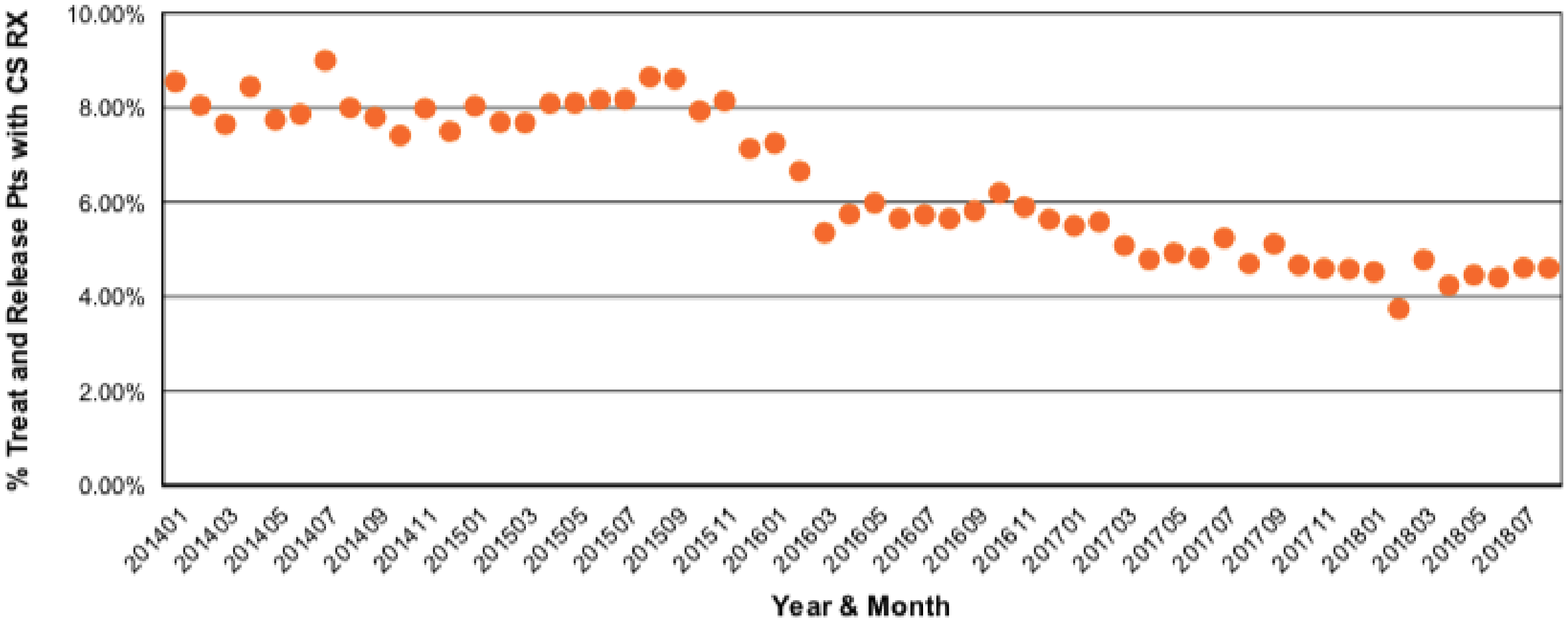
CHS_RX Controlled Substance Treat and Release Patients

For contact dates from 1/1/2014 through 8/31/2018

Controlled Substance Patients

For All EDs



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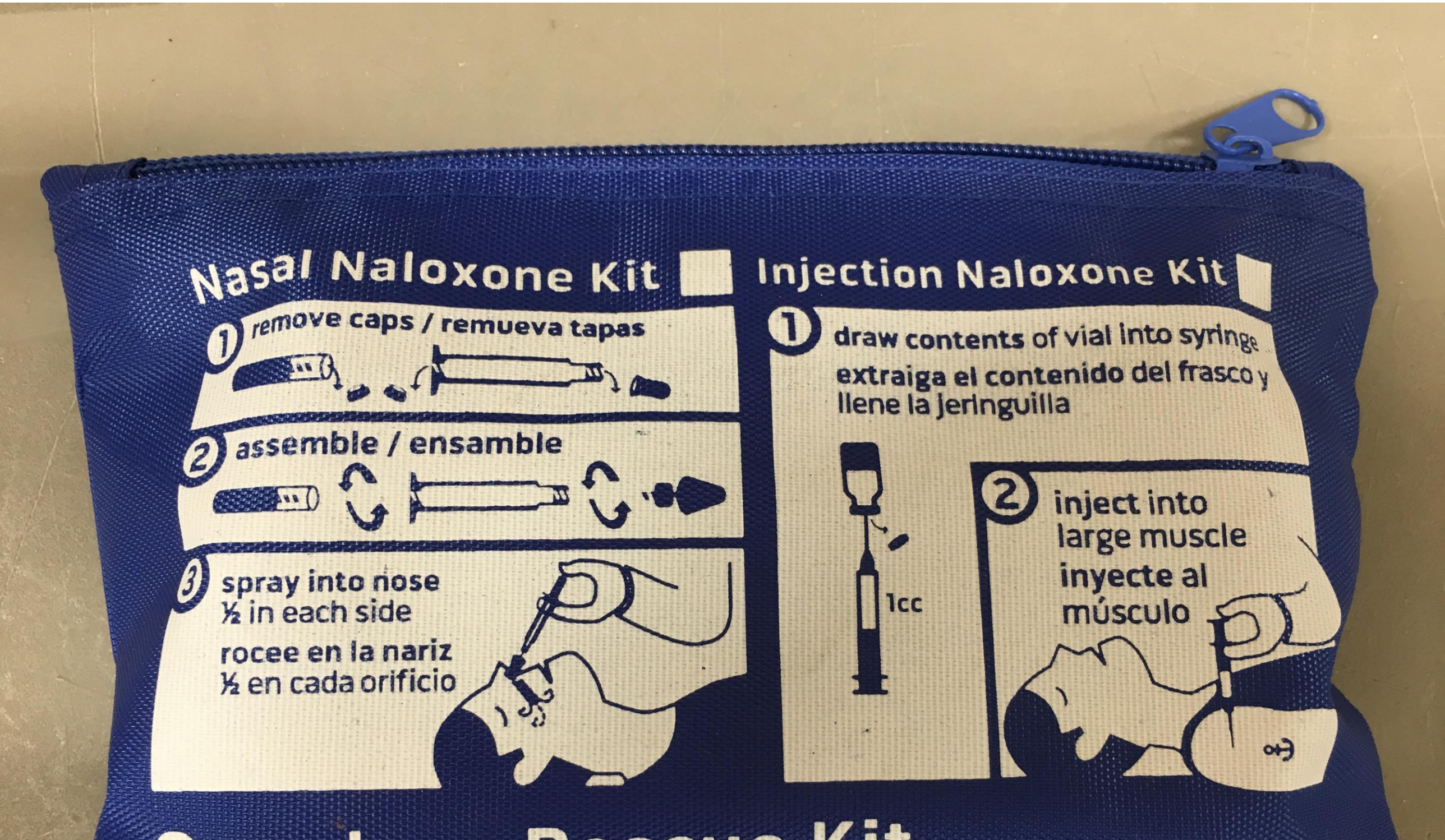
CHS_ED CS Prescribing in ED By Last Attending

For contact dates from 12/1/2017 through 12/31/2017

Facility Name [Number] / Last Attending Provider Name [ID]	Num Patients	CS Scripts	PerCnt CS	Avg Qty	Num Psyc DX	PerCnt Psyc
GSH EMERGENCY GER[10100097]						
	277	1	0.36%	2	1	0.36%
	207	8	3.86%	12	1	0.48%
	251	10	3.98%	9	8	3.19%
	198	10	5.05%	13	10	5.05%
	197	5	2.54%	14	1	0.51%
	334	41	12.28%	16	6	1.80%
	253	0	0.00%		1	0.40%
	158	17	10.76%	7	4	2.53%
	170	2	1.18%	11	2	1.18%
	195	9	4.62%	9	4	2.05%
	239	12	5.02%	10	7	2.93%
	200	16	8.00%	10	1	0.50%
	154	12	7.79%	10	3	1.95%
	107	4	3.74%	8	4	3.74%
	44	0	0.00%		0	0.00%
	331	15	4.53%	17	8	2.42%
	163	5	3.07%	6	0	0.00%
	110	0	0.00%		0	0.00%
	93	0	0.00%		0	0.00%
	125	1	0.80%	12	3	2.40%
	227	3	1.32%	10	3	1.32%
	236	0	0.00%		5	2.12%
	100	1	1.00%	10	3	3.00%
	138	6	4.35%	10	2	1.45%
	209	0	0.00%		1	0.48%
	313	0	0.00%		2	0.64%
	69	5	7.25%	18	3	4.35%
	5,098	**183**	**3.59%**	12	**83**	**1.63%**
	5,098	**183**	**3.59%**	12	**83**	**1.63%**

Narcan Distribution Program



Good Samaritan Hospital Medical Center

Opioid Overdose Prevention Training Program

Good Samaritan Hospital Medical Center

Emergency Department

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ED Peer/Family Navigator Program (SHERPA)

Good Samaritan Hospital Medical Center Sherpa Program Workflow

*The primary target for this program is opiate overdose survivors in the emergency department. Participants may also be at risk for overdose or misusing substances other than opiates.

IDENTIFIY

Patient at risk of addiction or status post overdose is identified by emergency medicine physician or any member of the clinical team.

CONSULT

As per protocol social work and Psychiatry consult is placed in electronic medical record (EPIC).

Social work evaluation is completed as per current protocols.

Peer navigator services are discussed. If services are accepted by patient, social worker obtains consent and places consult through LICADD.

LICADD Hotline:

631-979-1700

Family navigator services are discussed with patient's family or close contacts/friends. If services are accepted, social worker places consult through LICADD.

Identified navigator will present within 30 minutes

Note: in person eval available 10am-10pm

Identified navigator will present within 30

Peer navigator will listen and build trust, identify strengths and openings for change, discuss risks\options\harm reduction, and ask the patient if they are willing to attend treatment options.

Family navigator will provide ongoing peer support, help family members navigate SUD treatment system, and educate family members to refer to other supportive outpatient services.

If peer navigator services are declined for any reason, traditional referral pathways and follow-up resources are given to the patient. If the patient is already engaged in addiction treatment, will refer patient back to outpatient provider. Narcan kits will also be provided when appropriate.

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CHS Physician Partners
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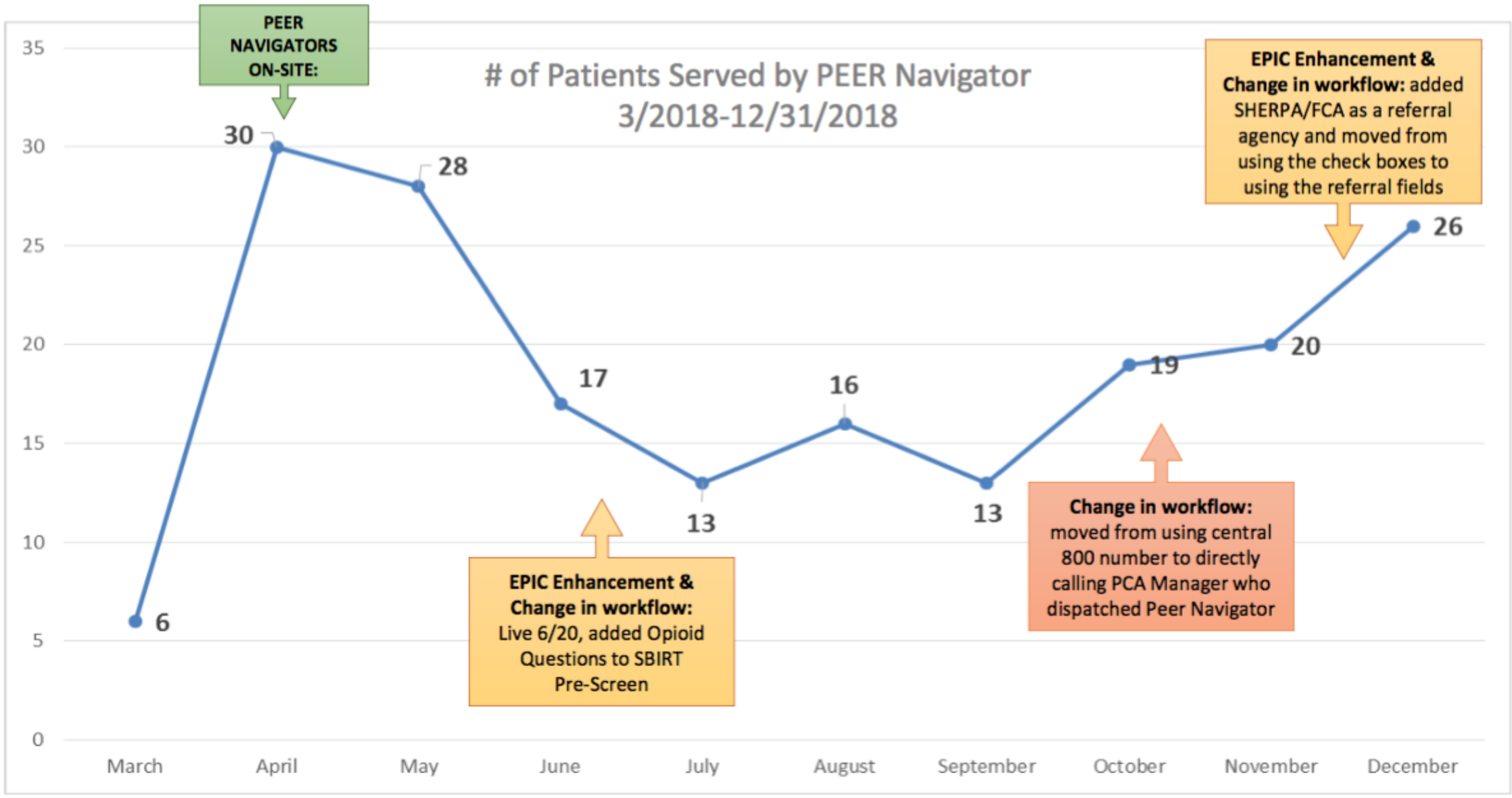
Outcomes Update: SHERPA – GSH
Data Source: FCA



Patients Served = 188

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CHS Physician Partners
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Outcomes Update: SHERPA – GSH
Data Source: Eligible Patients; EPIC / Enrollment Info; FCA

SHERPA Data: Total of **188** patients served by PEER Navigator from **3/19/2018 to 12/31/2018**

- Eligible: **183** patients (Answered YES to Opioids)
  - **19/183 = ~11% have been enrolled**
- Excluded: **4** patients (No Referral Needed)
- Enrolled: **184** patients (Consented to FCA)

- Primary SUD:
  - Alcohol: 111
  - Heroin: 44
  - Opioids: 13
  - Other: 16
- Secondary SUD:
  - Alcohol: 8
  - Heroin: 2
  - Opioids: 4
  - Primary Alcohol/Secondary None: 71
  - Primary Heroin/Secondary None: 10
  - Primary Opioids/Secondary None: 5

- Diagnosed/Self Identified Mental Health Challenges:
  - Yes: 11
  - No: 3

- Other Data Collection Expanded to:
  - Admissions
  - Gender
  - Age Bracket
  - Race
  - Ethnicity
  - Overdose/Morbidity Rates
  - Family Involvement
  - PEER Navigator
    - Volume / TAT (Call > Dispatch > Arrival)
    - Outcomes

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Outcomes Update: SHERPA – SCS
Data Source: FCA

Patients Served = 188

# of Referrals Accepted by Patients: 133 (~71% of Patients Served)

Referral Rates

	30 Days		60 Days		90 Days	
	Engaged in Treatment	*Engaged with Peers*	*Engaged in Treatment*	*Engaged with Peers*	*Engaged in Treatment*	*Engaged with Peers*
Yes	38%	48%	11%	17%	6%	11%
No	18%	8%	11%	5%	11%	6%
N/A	26%	26%	42%	42%	50%	50%
Unable to Reach	50%	50%	72%	71%	72%	71%
Unkown	8%	8%	4%	4%	2%	2%

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Narcan Policy

- Morbidity and mortality post Narcan administration
- No clear guidelines
- Will allow for further engagement with high-risk patients

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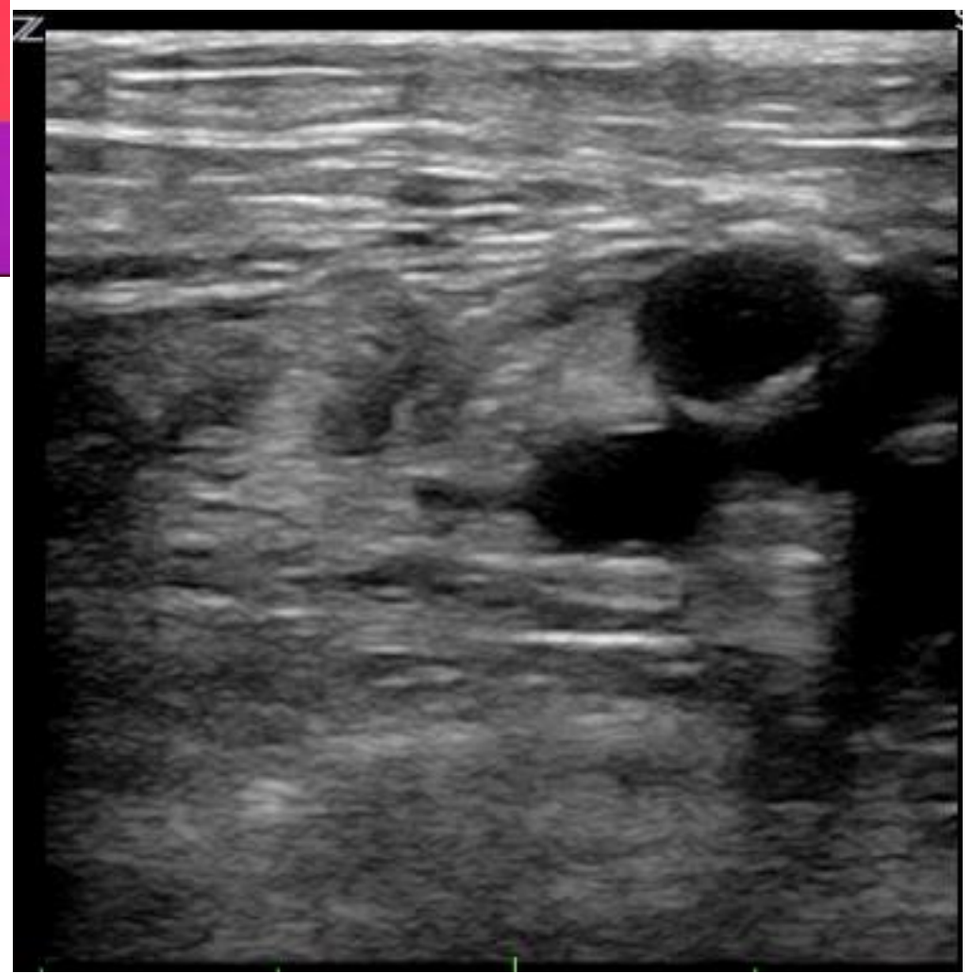
ALTO Program

Pain Syndrome	Inpatient (in the ED) Parenteral Opioid Alternatives	Outpatient (at discharge) Oral Opioid Alternatives
Abdominal Pain (non-traumatic)	1. IV Ketorolac 10-15 mg or IV Diclofenac 75 mg IV or IV Metamizole 1g (as a single agent OR in combination with number 2,3,4) 2. IV Acetaminophen (Paracetamol) 1g over 15 min* 3. IV Lidocaine -1.5 mg/kg of 2% Lidocaine (preservative free) over 10-15min (more data needed for patients with cardiac disease) 4. IV Ketamine-0.3 mg/kg over 10 min, + IV drip at 0.15 mg/kg /hr	PO Ibuprofen 400 mg q8h x 3-5 days or PO Acetaminophen (Paracetamol) 1g q6h x 3-5 days OR a combination of two
Abdominal Pain (traumatic)	1. IV Acetaminophen(Paracetamol) 1g over 15 min* 2. IV Ketamine-0.3 mg/kg over 10 min + IV drip at 0.15 mg/kg /hr	PO Ibuprofen 400 mg q8h x 3 -5 days or PO Acetaminophen (Paracetamol) 1g q6h x 3-5 days OR a combination of two
Back Pain (non-radicular)	1. IV Ketorolac-10-15 mg or Ibuprofen 400 mg PO or IV Diclofenac 75 mg IV or IV Metamizole 1g (a single agent OR in combination with number 2,3,4) 2. Trigger point injection 10 ml 0.5% Bupivicaine or 20 ml of 1% Lidocaine to site of maximal pain 3. IV Acetaminophen (Paracetamol) 1g over 15 min* 4. IV Lidocaine -1.5 mg/kg of 2% Lidocaine (preservative free) over 10-15 min 5. IV Ketamine-0.3 mg/kg over 10 min, + IV drip at 0.15 mg/kg /hr	PO Ibuprofen 400-800 mg q8h PO Acetaminophen (Paracetamol) 1g q6h PO Methocarbamol 500 mg-1500 mg q6h PO Diazepam-5 mg q8h Topical Diclofenac Gel 3% q8h Physical Therapy Acupuncture
Burns	1. IV Ketamine-0.3 mg/kg over 10 min, + IV drip at 0.15 mg/kg /hr 2. IV Lidocaine 2% 1.5 mg/kg (preservative free) over 10-15 min, + continuous infusion at 1.5.-2.5 mg/kg /hr 3. IV Dexemedetomidine 0.2-0.7 mcg/kg/hr drip OR 4. IV Clonidine-0.3-2 mcg/kg/hr drip	Lidocaine 5% cream PO Ibuprofen 400 mg q8h x 3 -5 PO Acetaminophen (Paracetamol) 1g q6h

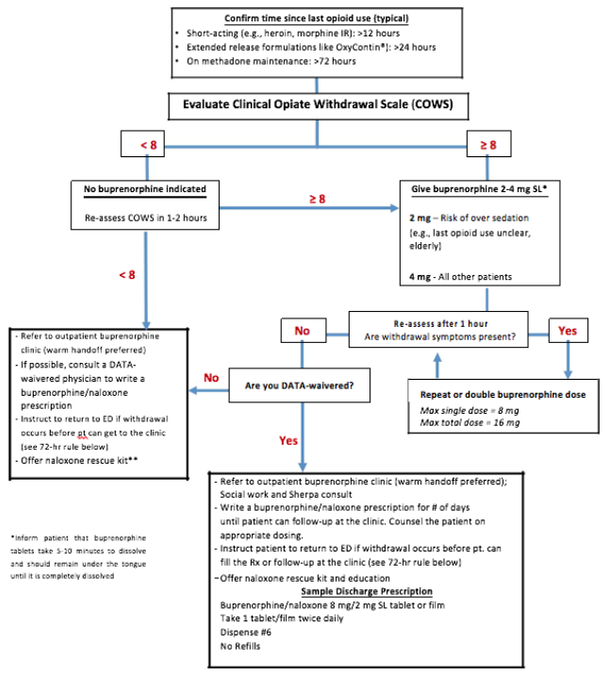


MAT in the ED

- 96% ED Attendings waiver trained at GSHMC
- Initiative will go system-wide

Good Samaritan Hospital Medical Center
Catholic Health Services
At the heart of health

Buprenorphine Dosing Guideline for Acute Opioid Withdrawal



ADJUNCTIVE THERAPY - *Consider if symptoms persist after maximum dose of buprenorphine given*

General withdrawal symptoms	Clonidine 0.1 mg PO Q4H PRN (hold for SBP < 90 mmHg)
Nausea and vomiting	Ondansetron 4 mg ODT/IV Q4H PRN
Diarrhea	Loperamide 4 mg PO, then 2 mg PO Q2H PRN (max total dose = 8 mg)
Myalgias and arthralgias	Ibuprofen 600 mg PO Q6H PRN

Guidelines are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines should be followed in most cases, but there is an understanding that, depending on the patient, setting, circumstances or factors, guidelines can and should be tailored to fit individual needs.

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Challenges…Pre

- Volume
- Resources-within hospital and outpatient
- Expertise, waiver training

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of Long Island
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Challenges…Post

- Individual beliefs re:MAT
- MAT education
- Confidence in connection to longitudinal care
- Lack of appropriate patients for MAT
- Momentum with Sherpa program
- Data
- Transportation

Catholic Health Services
of Long Island
At the heart of health

Thank You

Christopher C. Raio MD MBA

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Catholic Health Services
of Long Island
At the heart of health

Emergency Medicine Service Line

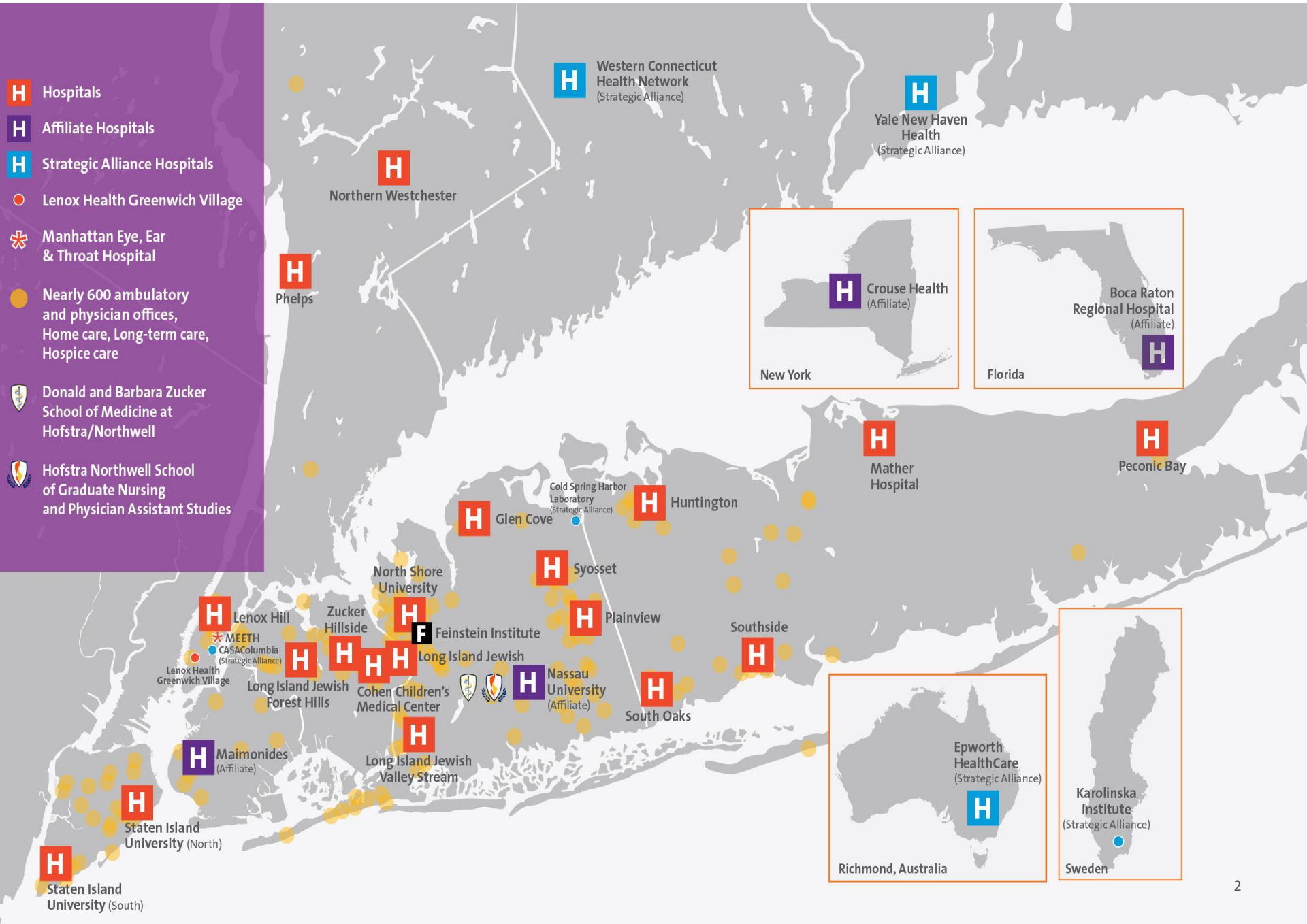
ED Opioid Collaborative

John D'Angelo, MD, FACEP
Executive Director & Senior Vice President
Emergency Medicine Service Line
Northwell Health

January 30, 2019

Northwell Health℠

Northwell Health



Our Strategy

approach in a ***layered*** fashion – setting a foundation and utilizing it as a framework to continually enhance our clinical offerings

DONALD AND BARBARA
ZUCKER SCHOOL *of* MEDICINE
AT HOFSTRA/NORTHWELL

NAL-SAT
NALOXONE SATURATION CAMPAIGN

MAT in the ED

Project CONNECT

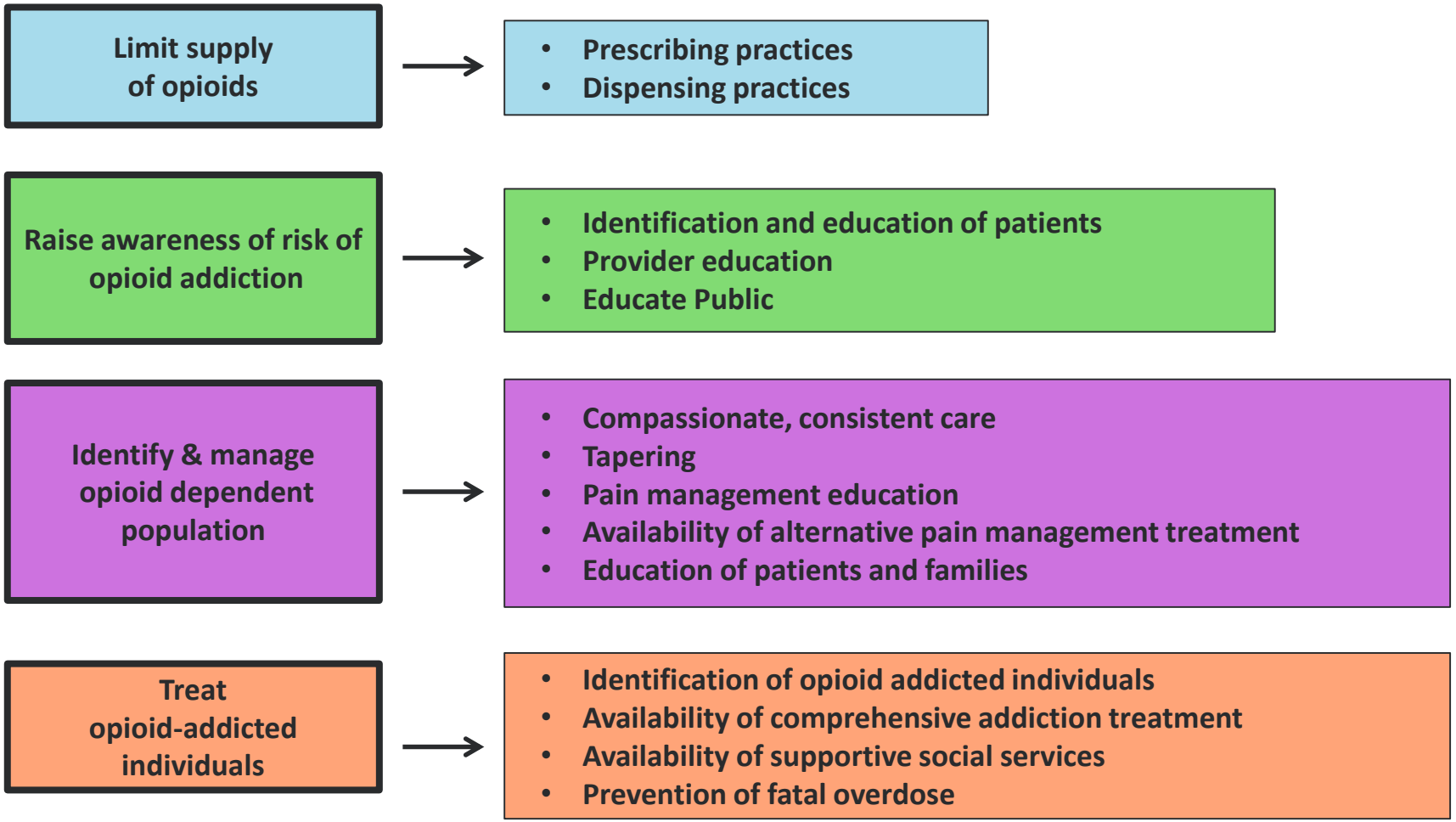
Northwell Health

Northwell Health Opioid Management Steering Committee

Addressing the Opioid Crisis

Chair: Jay Enden, MD

Exec Sponsor: Mark Jarrett, MD



There is Help

Realization

With the mindset that Addiction is a CHRONIC Illness, like so many others we are familiar with, treatment can start in our EDs

Layer #3

Initiating Addiction Treatment

MAT in the ED

- Relied on experiences and support from others
  - Yale study
  - Maimonides ED (Dr Motov and team)
  - Buffalo Matters (Dr Lynch)
  - NYS OASAS, NYS DOH, Northwell SUD, Community Based Organizations
- Dynamic layer requiring more ***Action*** and ***Ownership***
- Similar approach as other Northwell initiatives (SBIRT/NAL-SAT)
  - Multiple Stakeholders and Collaborators
    - SUD Services, Toxicology, EM, IM, Psychiatry, SBIRT, Administration, Legal, etc.
  - Team-Based clinical workflows
  - Wide-spread training and education

Layer #3

Initiating Addiction Treatment

MAT in the ED

3 Northwell ED sites identified (Suffolk, Nassau, Staten Island)

- 2 pilots began in July 2018 (LIJ and SIUH)
- 3rd pilot to begin in Feb 2019 (Southside Hospital)

Emergency Department process:

- Team-based identification, assessment , education (SBIRT/NAL-SAT)
  - *Confirming if patient is motivated, willing, & agreeable to treatment initiation and handoff*
- Potential induction with Bupenorpherine 4mg + 4mg (if needed)
- In-house team-based care navigation to ensure "handoff" is completed

Northwell Health SUD Treatment Provider process:

- Acceptance of referral and **OUTREACH** Protocol initiated
- Confirmation of arrival + Re-Navigation if deemed necessary
- **Longitudinal collection of data for 120 days → shared with whole team**

Layer #3

Initiating Addiction Treatment

MAT in the ED

Current Model:

Inductions and confirmed warm-handoff

Status:

62% pts induced in ED engaged to care in our SUD Tx Center

Of those patients who met the 30 day and 60 day mark:

@ 30days, 52% pts engaged to care in our SUD Tx Center

@ 60days, 45% pts engaged to care in our SUD Tx Center

Important to note that patients may have engaged into care in other non-partner SUD Tx facilities, may have been transferred, and/or discharged

Northwell Health℠

Thank You

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