Emergency Department Initiation of Medication-Assisted Treatment for Opioid Addiction: Strategies for Success

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Access to treatment for opioid addiction is a national health priority — only 10% of patients who need treatment can get it. Emergency departments (EDs) can be one effective access point for patients needing treatment. EDs already see patients with addiction, but currently have little to offer short of reversing overdoses and discharging patients, a course of treatment with high risk for repeated events. Just as other patients with uncontrolled chronic diseases are treated and stabilized in the ED, and referred to other providers for ongoing care, patients with addiction can be treated with buprenorphine in the ED, and once stabilized, can be transferred to ongoing outpatient care.

Addiction experts and experienced clinicians identified several common strategies for successful initiation of medication-assisted treatment (MAT) programs in EDs. (See *Emergency Care for the Opioid Epidemic: Leaders Discuss Medication-Assisted Treatment in the ED*.)

Cultivate Champions

While EDs treat patients with some form of addiction nearly every day, the concept of treating addiction with buprenorphine may be new to many ED staff. Any ED embarking on a MAT program should develop champions and supporters among physicians, nurses, pharmacists, social workers, behavioral health staff, and administrators. Champions help promote a consistent vision and case for change, build enthusiasm and partnerships, address fears and concerns, solve problems, and overcome barriers. Champions can provide or facilitate initial staff training and be an ongoing resource for staff education and guidance.

Support Emergency Physicians in Obtaining Buprenorphine (DATA 2000) Waivers

At least two (and preferably several) ED physicians, nurse practitioners, and physician assistants[1] should have waivers to prescribe buprenorphine. Because patients with addiction may present at any time, it is not practical for any single clinician to cover all needs; multiple clinicians with the capacity to prescribe buprenorphine will help distribute the workload. Training with other clinicians can promote peer support and build camaraderie in this challenging work environment, to work through barriers and to strategize on how to adapt practices.

Partner with Pharmacy Staff

A successful ED MAT program requires working with both inpatient and outpatient pharmacies to ensure that formulations of buprenorphine (sublingual, IV, and transdermal) are on formulary and accessible to ED physicians. Pharmacy staff may need to be trained on how to submit Medi-Cal and commercial claims.

DEA audits are inevitable and will require that the ED produce simple reports of the dates and amounts of buprenorphine prescribed. In most scenarios, the ED will not maintain an ongoing caseload of patients on buprenorphine, and DEA limits on the number of patients managed by one physician should not be a concern. It is important, however, for ED staff to work with the organization's IT team and pharmacist to ensure that prompt production of a report on ED buprenorphine prescribing is possible.

1. Recovery Enhancement for Addiction Treatment Act (TREAT Act), H.R.2536, 114th Congress (2015-2016), www.congress.gov.

Partner with Outpatient Buprenorphine Prescribers

The ED is one of the few settings where providers can reach patients in crisis due to severe withdrawal or near-overdose and therefore be available when a patient may be particularly receptive to the idea of addiction treatment. It is essential to have a close working relationship with clinic providers interested in taking on new patients: a buprenorphine induction clinic (for initial stabilization and referral for ongoing treatment), a primary care physician accepting referrals for buprenorphine, an opioid treatment program, or a pain clinic. Patients should not be started on buprenorphine without clear access to ongoing treatment.

Collaborate with Behavioral Health Service Providers, Where Available

Behavioral health staff in the ED can help engage patients and ensure ongoing behavioral health treatment. Depending on community resources, this may involve on-site or remote (phone or telemedicine) behavioral health staff, or established connections with outpatient ongoing treatment. Partnering with 12-step or other peer-to-peer groups may also help increase access to support services, as long as those groups are accepting of MAT.

While support services and addiction counseling are recommended for long-term treatment success, on-site behavioral health is uncommon in many EDs, and the lack of such services should not be considered a barrier to starting an ED MAT program.

Cultivate a Team-Based Approach

The ED intersects with virtually all aspects of the health care system; therefore, ED MAT programs may impact a wide range of providers. Early communication and engagement with inpatient and outpatient providers will help promote acceptance of ED MAT programs and help prevent confusion or opposition. Inpatient hospitalist and surgical teams may want to develop protocols for buprenorphine initiation. Outpatient providers will need education on how to appropriately refer patients to the ED for buprenorphine initiation, and may appreciate reassurance that patients will be referred to them through a coordinated hand-off.

The needs of patients new to MAT are diverse and potentially quite complex. A team model enables the ED, inpatient hospital services, and outpatient clinics to provide wraparound, coordinated care. In particular, some patients may benefit from intensive complex care management beyond the scope of ED care. Developing a broad base of partnerships helps meet the needs of ED MAT patients and prevents overburdening ED staff.

Integrate ED MAT with ED Pain Management Initiatives

EDs are undergoing rapid change in the standards of practice around pain assessment and treatment. Partnering with hospital and community-wide efforts to promote safe opioid prescribing may help recruit resources to support an ED MAT program. For ED staff, understanding the limitations of opioid analgesia is a convenient bridge to understanding the fundamental concepts of opioid addiction. In particular, understanding opioid addiction as a cause of physical pain and psychological distress can motivate interest in treating the underlying addiction, versus more superficial symptom management.

Buprenorphine is an effective and underused analgesic that can be used in the ED by any provider with DEA opioid prescribing authority, without a buprenorphine waiver. Increasing the use of buprenorphine for pain may help hesitant or skeptical providers directly witness the effect of buprenorphine on patients before they commit to initiating patients into long-term MAT.

Integrate ED MAT with ED Treatment of Withdrawal and Overdose

EDs treat opioid overdose and opioid withdrawal routinely. Developing a set of interventions that integrate ED initiation of buprenorphine with treatment of overdose and withdrawal is a convenient way to link ED MAT to a well-established role for the ED. Buprenorphine should be viewed as a first-line treatment for opioid withdrawal, as it has significant advantages over alternatives such as morphine or hydromorphone: less euphoria, longer duration of action, and reduced risk of respiratory depression. If ED staff grow accustomed to treating withdrawal with buprenorphine, initiating MAT becomes an easy next step. ED physicians commonly see patients with active or historical addiction present with severe pain or injury; buprenorphine for pain is a safer alternative than other opioids. Finally, a patient with opioid overdose seen in the ED is at extremely high risk for death after discharge. After initial reversal with naloxone, patients can be transitioned onto buprenorphine instead of other potentially more harmful opioids such as morphine, hydromorphone, or illicit opioids.

Develop an Adaptable and Tailored Approach to ED MAT

There are several strategies for integrating MAT into ED care. The simplest approach involves an ED clinician partnering with an outpatient site willing to accept ED-initiated patients. This model is limited in its potential scope of impact but can be a practical first step to get a program up and running in preparation for larger-scale work. In this model, patients are identified and recruited in the ED with a warm hand-off to a buprenorphine clinic within three days. More comprehensive models explore the potential of the ED as a hub and portal for systemwide access to treatment for addiction. Flexibility and creativity in tailoring a program to the opportunities and challenges in a particular community will promote successful, sustainable programs.

Other Resources on Buprenorphine

Buprenorphine: Questions and Answers
Answers to common questions about buprenorphine for addiction and pain: who can prescribe, what formulations, and how to manage inductions
www.chcf.org (PDF)

UCSF Substance Use Warmline
Free clinical advice on addiction treatment
Monday to Friday, 7 am to 3 pm PST
855.300.3595
nccc.ucsf.edu

Providers Clinical Support System MAT Mentorship Program
Resources and online mentorship for providers new to prescribing buprenorphine
pcssmat.org

Recovery Within Reach: Medication-Assisted Treatment Comes to Primary Care
Discussion of models of integration of buprenorphine into primary care
www.chcf.org

California Health Care Foundation

For more information, visit www.chcf.org.

LAUNCHING
OPIOID ADDICTION TREATMENT
In Emergency Departments

Improving access to treatment for opioid addiction is a national health priority. Emergency departments (EDs) can be an important access point for patients needing help. Addiction experts and experienced clinicians offer strategies for successful initiation of medication-assisted treatment in EDs.

Change can start with one ED doctor and one referral clinic.

TO BUILD A PROGRAM IN THE ED:

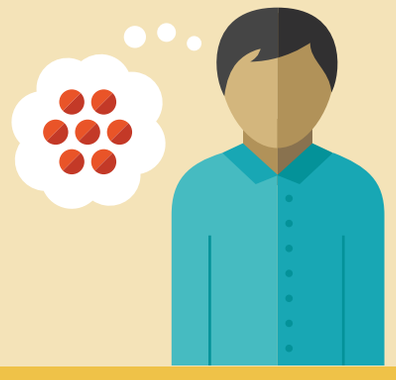
Cultivate **CHAMPIONS** among clinicians, nurses, pharmacists, social workers, behavioral health staff, and administrators.

Encourage clinicians to get **BUPRENORPHINE TRAINING.**

Partner with **PHARMACISTS.**

Build relationships with **CLINICIANS** for ongoing care.

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 **TREATMENT OF WITHDRAWAL AND OVERDOSE.**

For details on these strategies, see the full report:
www.chcf.org/ED-opioid