Medications for Opioid Use Disorder in the Emergency Department Setting

Middle Tennessee Regional Event
April 23rd, 2024

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Disclosures:
• I have no financial disclosures to report.
• The content of this presentation is for informational purposes and not legal advice or intended to dictate clinical practice.

Special Thanks:
• Tennessee Department of Health’s Overdose Response Coordination Office (ORCO)
• CDC Overdose Data to Action in States Grant (OD2A-S)
Where are we going today?

Addressing OUD in the ED:
- Why buprenorphine?
- Is this evidence-based?
- What is needed to do this?
What is recovery?
Recovery is ...
... being honest with myself
... being able to enjoy life without drinking or using drugs like I used to
... living a life that contributes to society, to your family or to your betterment
... being the kind of person that people can count on
... about giving back
... striving to be consistent with my beliefs and values in activities that take up the major part of my time and energy.

(ASAM, 2014)
Why buprenorphine?

Buprenorphine:
• Improved treatment retention (Lee, 2018)
• Reduced risk for overdose (Wakeman, 2020)
• Reduced risk of death (Larochelle, 2018)
Why buprenorphine?

Opioid Antagonist: Naloxone and Naltrexone
0% Intrinsic Activity

Opioid Partial Agonist: Buprenorphine
40% Intrinsic Activity

Full Opioid Agonist: Methadone
100% Intrinsic Activity

(Wyatt, 2017)
Why buprenorphine?

Results of simulation study: probabilities of apnea and decrease in ventilation.

Simulations in a representative ("typical") individual with chronic opioid use showing the effect of 4 subsequent fentanyl iv doses (0.25, 0.35, 0.50, and 0.70 mg/70 kg) on top of a buprenorphine plasma concentration of 0 (placebo), 1, and 5 ng/mL. (A-C) Fentanyl and buprenorphine plasma concentrations (Cp). (D-F) Fentanyl and buprenorphine receptor occupancy. (G-I) Ventilation.

(Olofsen E., et al., 2022)
Addressing Opioid Use Disorder in the Emergency Department:

A Changing Landscape
PubMed Search Results: (Buprenorphine) AND (Emergency Department)
Why buprenorphine in the ED?

• Improved retention to outpatient follow-up (D’Onofrio, 2015) (Jennings, 2021)

• Reduced re-admission and hospitalizations (Le, 2021)

• A lifeline at the highest risk time for a fatal overdose (Weiner, 2020)
10% of individuals with a substance use disorder receive specialty treatment (2016).
What do you think is a significant barrier to individuals with a SUD obtaining treatment?
Figure 45. Perceived Need for Substance Use Treatment: Among People Aged 12 or Older with a Past Year Substance Use Disorder (SUD) Who Did Not Receive Substance Use Treatment at a Specialty Facility in the Past Year; 2020

- 211,000 felt they needed treatment and made an effort to get treatment (0.5%)
- 737,000 felt they needed treatment and did not make an effort to get treatment (1.9%)
- 37.5 million did not feel they needed treatment (97.5%)

38.4 million people with an SUD who did not receive substance use treatment at a specialty facility

(SAMHSA, 2021)
The Ascension
Saint Thomas
Rutherford
Pilot Program
Elements of a Successful ED Buprenorphine Program

Planning and Evaluation
- Champions and project manager engaged
- Evaluation based on objective data and subjective feedback

Identification
- Effective and consistent screening for OUD
- Screening elicits reliable response.

Warm Handoff
- Referral to recovery resources placed for interested patients
- Strong community connections
- Follow-up contact with patients after discharge
- Naloxone in hand at discharge or prescription
- Discharge education includes harm reduction information

Warm Welcome
- Stigma addressed with nursing and physician team members
- Peer navigators provide compassionate welcome

Harm Reduction

Withdrawal Management
- Buprenorphine administered in a timely fashion to appropriate patients
# COMPARISON CHART

Four urban academic medical centers as described in the November, 2022 publication of *Annals of Emergency Medicine*.

**Source:** [https://doi.org/10.1016/j.annemergmed.2022.05.010](https://doi.org/10.1016/j.annemergmed.2022.05.010)

<table>
<thead>
<tr>
<th>CHARACTERISTICS</th>
<th>BALTIMORE, MD 70,000</th>
<th>NEW YORK, NY 90,000</th>
<th>CINCINNATI, OH 75,000</th>
<th>SEATTLE, WA 66,000</th>
<th>MURFESBORO, TN 84,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approximate ED Census/Yr.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program launch year</td>
<td>2018</td>
<td>2018</td>
<td>2018</td>
<td>2019</td>
<td>2020</td>
</tr>
<tr>
<td>Protocol for ED initiated buprenorphine in place?</td>
<td>●</td>
<td>●</td>
<td>•</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Bup. in automated med dispensing system in ED?</td>
<td>●</td>
<td>●</td>
<td>•</td>
<td>●</td>
<td>● (checkmark)</td>
</tr>
<tr>
<td>Pharmacist in the ED?</td>
<td>●</td>
<td>●</td>
<td>•</td>
<td>●</td>
<td>● (checkmark)</td>
</tr>
<tr>
<td>Peer navigator in the ED?</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>● (checkmark)</td>
</tr>
<tr>
<td>Screening questions in EMR?</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>● (checkmark)</td>
</tr>
<tr>
<td>Usual referral process for outpatient care</td>
<td>Care manager or peer coach/tailors referral to pt. need</td>
<td>Health educator offers brief intervention &amp; coordinates care</td>
<td>Peer, counselor, or ED provider can refer to walk-in for next-day care</td>
<td>Clinic w. OUD care integrated into primary care on hosp. campus</td>
<td>Peer navigator available to tailor referral to patient needs</td>
</tr>
<tr>
<td>Funding for peer navigators</td>
<td>Funded by grant and hospital</td>
<td>Funded by grant and hospital</td>
<td>Funded by grant and hospital</td>
<td>N/A (Peer navigation not in ED)</td>
<td>Funded by OJSHA grant (TN DoH and DMMHSA joint partnership)</td>
</tr>
<tr>
<td>Avg. turn around for f/u appt.</td>
<td>1-4 days</td>
<td>1-4 days</td>
<td>1-4 days</td>
<td>1-4 days</td>
<td>1-4 days (based on recent navigator experiences)</td>
</tr>
</tbody>
</table>

Created by: Kayla Williams-Mehr, PMHNP, TDMHSAS
Additional growth from the pilot:

• Technical assistance to other interested hospitals and communities
• Quarterly calls
• Shared learning as we go
• Community connections
TDMHSAS and THA ED MOUD Partnership Project
Where to start?

• One willing or interested clinician
• Buprenorphine located in the emergency department dispensing machine
• A referral location
• An ally pharmacy
Lessons Learned
Moving the needle:

- The space between starting and change is difficult but important
- Before measured change occurs energy, time, and trial and error are needed
- Stay the course or make change?
Only one meter?
What does a body scan look like on a systems level?

• Taking a step back to observe

• Noticing the parts:
  • Is someone or something missing?
  • Is an adjustment needed?
  • How are these parts interacting?

• Listening to stakeholders without judgment

• Applying compassion
References:


Questions?
TECHNICAL AND EDUCATIONAL ASSISTANCE

Kayla Williams Mehr, PMHNP
Medications for Opioid Use Disorder
Clinical Specialist

Topics
- Medication options for Opioid Use Disorder
- The Tennessee Nonresidential Buprenorphine Treatment Guidelines and CDC Prescribing Opioids Guidelines
- Screening, diagnosis, and linkage to care for individuals with substance use disorders
- Motivational interviewing, stigma, and trauma informed care

Purpose
The purpose of these services is to provide education and training to healthcare clinicians. This can be carried out in the form of 1:1 virtual or in person discussions, presentations to groups, or drop-in informational sessions.

This service is at no cost to your organization, and travel can be arranged to organizations outside of the middle Tennessee area.

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