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Opioid Podcast Series, Season 2, Episode 1: Role of the ED Physician in the Treatment of Patients With OUD

National experts across the healthcare continuum will provide robust educational content to address the opioid epidemic. Today's session is entitled The Role of the Emergency Department Physician in the Treatment of Patients with Opioid Use Disorder (OUD). You'll be hearing from two guests today, Dr. Bobby Redwood and Jocelyn Hubbard, who is an MSW. Dr. Redwood is a physician improvement advisor for the Wisconsin Hospital Association. His quality improvement portfolio includes opioid stewardship, medications for opioid use disorder, and reducing stigma around substance use disorder. Jocelyn Hubbard is an E.R. navigator with Saint James Intermountain Health in Butte, Montana. Dr. Redwood

Hey, Candy, thank you for that warm introduction. It's a pleasure to be here with all of you. We've always had a role in opioid use disorder, but traditionally the role has been to resuscitate people, to administer naloxone and resuscitate people, or if they come in withdrawal, to mitigate withdrawal symptoms. And there really is a nationwide movement, and that movement is to actually start medication-assisted treatment for opioid use disorder in the emergency department. And so, I'm a clinical emergency physician. It would be odd that I work a shift without seeing some sort of complaint related to opioid use disorder. It's just that common, and it really is a pleasure to have something to offer patients, you know, a bit of hope besides a resuscitation and treating the withdrawal symptoms.

Let's actually manage your cravings. Let's actually get you on the right path so you can build a life, so you can, you know, start on the path to wellness here. And so, the focus of the presentation today is going to be the actual nuts and bolts of how we administer medication for opioid use disorder in the emergency department. And we started attacking this epidemic in multiple ways. The four-prong approach that I think most of you are used to is first to just limit the number of opioids out there. So, we got to get these medications out of the medicine cabinets. 50% of opioids are diverted. So, when you prescribe oxycodone to grandma, half the time it doesn't go to grandma. It goes to the 17-year-old who's living in the house. The second after that is alternatives to opioids. And so, you know, we see acute pain all day, every day in the ER. Our approach is that opioid is a last resort. So, it's no it's not no opioids whatsoever. If you have a broken bone, if you have cancer pain, if you're getting surgery, opioids may well be appropriate in that situation. But for a sprained ankle, tension headache, for a tooth pain, you know, are we really going to prescribe opioids in that? There's a lot of literature that that initial taste of opioids, especially in the teens and twenties era, can lead to opioid use disorder pretty rapidly on average, in 1.6 years, actually, after a prescription. There's harm reduction, that's the third prong. Harm reduction is naloxone is keeping people alive. There's other very varieties of harm reduction, like safe needle exchanges, like drug disposal situations, you know, there's peer support, specialist things like that. But when people say harm reduction, they're largely talking about reversing overdoses with naloxone. And then, of course, medication for opioid use disorder, primarily buprenorphine. We have actually seen heroin on the decline and then fentanyl on the increase. And this is really meaningful because prior to this wave of fentanyl, you know, people visited the 7 times with overdose before they died. And I haven't seen new literature yet, but I suspect with the fentanyl epidemic, it's getting fewer visits before the people actually die. And so that means fewer chances for us to save their lives. And it's all the more urgency, all the more reason to embark on this journey of emergency physicians and emergency providers starting buprenorphine in the ED so that we can at least sustain people and get them into therapy and counseling and all the other aspects of comprehensive treatment for opioid use disorder. You know, I actually look at this when I see somebody come in with opioid use disorder, I check and see how many times they've been in the emergency department in the last year. And if I see two, three, four or five visits, I think to myself, for goodness gracious, this person is at very high risk for death from opioid use disorder, death from overdose, and we need to spring into action. And my role is to really start the maintenance therapy, get that prescription for buprenorphine in their pocket, but get them on the road to wellness, which really takes a village. Now, it's not only

buprenorphine, there are other FDA approved varieties. So, buprenorphine is semi-synthetic. It's a partial mu agonist and it's, it's relatively inexpensive, which is wonderful. And then it's not a preferred drug of abuse. It is possible to abuse buprenorphine if you're opioid naive. But for patients who already have opioid use disorder, they don't get euphoria from buprenorphine. It really just manages the cravings. And so, what I would say is the main part of that is just to screen to make sure the patient has opioid use disorder. You don't want to prescribe buprenorphine, obviously, to someone who is opioid naive or seeking it to sell on the street, but for some reason were unable to get it through the formal clinic setting. Methadone is a synthetic full mu agonist, and so it has high potential for abuse and it's extremely affordable. But the reason there's methadone clinics is because of that abuse potential. And so, it's usually an observed administration of methadone. And methadone is a tried-and-true treatment. I don't mean to belittle that in any way, but it's really inconvenient to go to a methadone clinic day after day. It's hard to hold a job. It's hard to get your kids to daycare. All these things, all the things that we have to do to build a real, meaningful life where we have support systems. And I think buprenorphine is, you know, it helps you facilitate some of those other aspects of life so that you can actually stay in the maintenance therapy longer. Extended-release Naltrexone is a 30-day injectable. It's prohibitively expensive right now. It has not yet gone generic. I think that will be a key component of treatment for opioid use disorder in the future. But right now, I'm not seeing a lot of naltrexone and it was of course originally used for alcohol use disorder actually and so I think it's kind of crossing into that sphere. And then naloxone is considered medication for opioid use disorder. But again, this is a full antagonist and it's essentially used as the antidote for overdose. And the cravings are what ruin people's lives. The cravings are what causes people to lie, to miss work, to steal from others, to get in trouble with law enforcement. It is this insane desire for these medications and really a physical discomfort. I mean, it is a exquisitely painful state to have these cravings. And so, whether it's, you know, you see the medications across the top, there's heroin, there's buprenorphine, there's naloxone. All of those are going to fill that binding site. Buprenorphine is trying to hit that sweet spot where you're not in withdrawal, you're not having cravings, but you're also not having euphoria. And that's kind of the role of this partial agonist. Now, does MOUD really work? There is so, so, so much literature that MOUD is highly effective. There are actually natural experiments in other countries like France just went full court press on MOUD study and saved so many lives. But essentially, if you look at the duration of treatment, the bottom access in weeks and the probability of reducing mortality, the longer you are on maintenance therapy with buprenorphine, the more likely you are to survive. And it does take a while. You know, it looks like it's 20 weeks first. And so, there are people who have fits and starts on this medication, but you really have to stick with it. And there are many people who are on buprenorphine for life. This is lifelong maintenance therapy to maintain the cravings so you can participate in daily life and build social support, build meaningful connections with others, and take care of your other medical problems. You know, people with opioid use disorder often rake up a lot of other medical problems that need maintenance from IV drug use and other things. Now for safety considerations. I would say buprenorphine is extremely safe. Some of the side effects are the actual side effects of opioids because it is a partial agonist. Nausea, vomiting, constipation. I see those mostly if somebody is on the wrong dose, if they're on a little bit too large of a dose initially, or if somebody was opioid naive taking this medication. And then less common side effects are headache, insomnia, like leg edema and itching. I think these side effects are, quite honestly, trivial to actual opioid use disorder and the risk of overdose and death. And then if someone is starting it for the first time and we'll talk about this in depth, but in the ED, it's possible that you could actually throw someone into withdrawal. So, you have to be sure that somebody is like really withdrawing before you start buprenorphine therapy. And if they're too soon, like especially with long-acting opioids, like methadone, that's in your system for 72 hours. If you're starting buprenorphine too soon, someone can actually go into withdrawal. Interestingly, the treatment is more buprenorphine, so for buprenorphine induced withdrawal, you administer more medication. So legal issues. Buprenorphine is a schedule three narcotic. And prior to December 2022, an X-waiver was required for prescribing office-based outpatient treatment for opioid use disorder. And that was a major barrier. And the states with some of the worst opioid use disorder rates also had the fewest prescribers of buprenorphine. We can all prescribe buprenorphine now. You know, there is some training. It's a, you know, a self-monitored system for training. But you don't have to get an X-waiver anymore. You don't have to pay additional fees or go through those additional hoops. And so, it's really

revolutionized the treatment of opioid use disorder. And now we're at the point where we just have to spread the word. I hope some of your emergency providers I hope some of you are case managers or social workers or quality improvement professionals. That liaison with the emergency department, please send them this, because this is a step-by-step method of how you can prescribe buprenorphine for opioid use disorder, and you can do it this shift. You know, if someone has never done it before, they can walk out there, this shift with this knowledge in hand. And if someone comes in withdrawal, they can prescribe buprenorphine and really potentially save a life. I always think about when you prescribe opioids, the number needed to kill for an opioid prescription, and we always talk about number needed to harm. This is the number needed to kill is 50. So, for every 50 opioid prescriptions that I give, one person will die. And it's on average in 2.5 years of opioid use disorder. That's from the medical literature. And so, you know, obviously, we want to we want to not kill people. We want to prescribe fewer opioids, but we also want to save people. And this is an opportunity to prolong people's lives so they can get engaged with counseling and outpatient therapy and, you know, and take care of the cravings while they get off of the opioids. We are all potential prescribers of buprenorphine. You just have to take that leap and really prescribe it the first time. I think that's the biggest leap for people is they've never done it before. And when in fact the cure for opioid use disorder is much easier to prescribe, I think, than the actual opioids. I think opioids have more side effects than the buprenorphine does, which is a partial agonist. Now here's how I see the two roles of buprenorphine, because we are talking about a seamless transition of care. So, you're going to be starting in the emergency department. Obviously, buprenorphine can be started in a clinic. It can be started in an outpatient clinic for opioid use disorder as well. But let's be real. A lot of patients come into the emergency department. They are not on a 9 to 5 schedule. They come in on Sunday night. They come in, you know, Friday at two in the morning, and we want to be there for them. So, I see the emergency provider role as confirming that there's a substance use disorder happening. You know, you don't want someone, a scoundrel coming into to get opioids to sell on the streets. You want to make sure they actually have opioid use disorder screening labs just to make sure they're this is, again, harm reduction opportunity, honestly. But we check liver enzymes, we check for HIV to make sure there are no comorbid conditions, especially affecting the liver. And then we want to make sure the patient actually has acute withdrawal symptoms. You don't want to start this medication until there are withdrawal symptoms. Ideally, care coordination with the PCP, and then we find out the maintenance dose while the patient is in the ED and give them a prescription so they can get to their outpatient appointment. That's sort of the game plan for the emergency department and then for the primary care physician. You know, we're doing that warm handoff. Ideally, our handoff with social work, the patient's got a pretty prompt appointment and they confirm that the maintenance dose is actually correct. How are you feeling? How are your cravings? Maybe it's too much. Maybe it's too little. That dose would be adjusted as needed. Then the primary care physician will continue to monitor for misuse or diversion, which is a thing that we have to look out for ensure care coordination with outpatient therapy, with specialists, if they need to, if they have co-morbidities from injection use or opioid use disorder. And then I love this one is relapse planning? You know, this isn't perfect. You don't always start buprenorphine and have no relapses. We expect relapses and we have a plan in place for when that patient does relapse. Obviously, ideally, they don't, but I don't think that's the norm. And then eventually, usually when people are on this medication for months or years, we can start talking about tapering. If you have a community plan, that's great, but you just need one primary care provider who's willing to prescribe buprenorphine and one emergency physician who willing to get it started. You know, emergency departments often get asked to be put in that public health role and some people view our primary diagnosis, their primary mission as diagnosing and stabilizing emergencies. And that's it. As you know, I like population health. I think of this as a population wide emergency. If we're losing 100,000 young people per year, which is what we're on track to lose this year from opioid use disorder if opioid deaths are outnumbering car crash deaths, we've you know, we've got to step in this. We've got to get into the ring and start treatment. And so, with my colleagues, I do shoulder-to-shoulder learning and I'll kind of look at the emergency department track board and see when somebody comes in withdrawal or someone comes in with an opioid related issue and I'll check in with my colleague, I'll say, hey, have you prescribed buprenorphine before this patient be appropriate? And a lot of times that's actually an opportunity for shoulder-to-shoulder learning. Think about who might not have prescribed buprenorphine yet. That might be an

opportunity to be a mentor and really save some lives, you know, exponentially, right. If you teach a colleague and they teach two colleagues and so on and so forth, we're going to have this covered across the nation. All right. Let's dive right into it. This is what I do when someone comes into the ED with opioid use disorder or opioid withdrawal. This is what someone looks like when they come in with opioid use disorder. It's truly a state of suffering. So, they feel like they're crawling on the ceiling, they're vomiting, they're having diarrhea, they've wet themselves, they've got goosebumps all over their skin, shaking, very irritable. These patients are not pleasant to be around. Let's be real here. They might yell at the nurses; they might yell at you. They might be snappy and demanding. It's not a personality trait, it's opioid use disorder and acute withdrawal. It is an extreme state of suffering. And it's pretty gratifying, actually, to give buprenorphine and see that suffering, be relieved when the patient comes in, though. These are the steps we talked about before, and I'm going to go through just one by one of what it actually means to idea of patient, what it actually means to confirm opioid use disorder. There's evidence-based tools for each of these steps, and we'll go through them right now. So, for patient identification, a lot of times the patients just come in asking for medication assisted treatment. I would say that as my most usual patient, as they say, hey, I've been on buprenorphine in the past or I've heard things about it. I need help. Can you help me, Doctor? It's usually quite obvious, to be honest with you. You might see a patient who's actually in an overdose state. And so, an overdose state, we want to resuscitate them, obviously, but that those patients are often hospitalized or observed in the ED. And so, you may have a chance to have that conversation. Once they're out of the in that initial overdose state, you might see a patient complaining that they're of withdrawal symptoms. You know, they're not ready to admit yet that they have opioid use disorder. May have they been using on the sly, maybe a coworker reported them. But you look at them and they've got goosebumps all over. They're yawning throughout the visit. They've got their vomiting bag in hand. And you say, hey, have you ever had issues with opioids. So, there is that kind of a withdrawal that comes in. And then, you know, you may see classic things like opioid seeking behavior. And, you know, that's still that's was a phenomenon a little more of five or ten years ago when we were still overprescribing. I think prescribing has been reigned in significantly. But you will definitely see people coming in asking for medications by name, asking for injectable medications. Maybe that's your opening to start talking about opioid use disorder and maintenance therapy. And there is actually a two-minute screening tool. It's called the RODS Tool. I use this initially and now quite honestly, it's kind of just committed to memory and you can go through it with the patients. But it's similar to the CAGE questionnaire that you use for alcohol use disorder. So, you know, talk about your cravings. Do you ever get upset if you don't have an opioid? Are you misusing your prescription? Are you running out early? All of these questions and you know, I have no affiliations. This is a free website, but MD calc is what most of us use and it has all of these scoring tools on it. So, you can just have that on your desktop and use evidence-based screening tool to confirm opioid use disorder. Once you get used to this, once you've done it five, ten times, you'll probably stop using the screening tool, to be honest with you. But it's a great thing to have documented in the chart to really let the next provider know what you're dealing with next. Next, you want to evaluate that the patient's actually in opioid withdrawal. I find that patients are very forthcoming about which medications they've been using, especially if you have an approaching manner and you are not approaching the patient from a place of stigma. So, when you think of opioid use disorder as a disease process, you know when you're not saying, are you clean? When did you last use? Are you an addict? Are you know, and you know, things like that, that stigmatizing language that will really turn people off and you will find that they are less forthcoming about their use behaviors. But when you say, you know, come with empathy, and say, oh my goodness, I can see that you're suffering opioid withdrawal. Opioid use disorder is such a terrible disease. How long have you been suffering from it? Tell me, what are you using lately? When did you last use? You'll get a pretty accurate description of what people are using and how long it's been. The upshot of this slide is really that you want to be sure that their last use kind of corresponds with their withdrawal symptoms. And it's tricky when people are using everything. When it's a big mixture, that's when it becomes tricky. But for those patients who are on oxycodone, essentially when they're on short acting pills, you can expect withdrawal to kick in in 6 to 12 hours. And there are a lot of fentanyl pills out there. There's a lot of fake pills now. And so, people think they're using oxycodone, but they're using fentanyl that but that's a similar 6 to 12 hours. When you're talking about OxyContin and extended-release opioids, that's more like 30 hours. So now the patient has to

have not been using for more than a day. And if they did use earlier that day, you've got to be careful. You could have that buprenorphine induced withdrawal. It's not the end of the world if withdrawals induced. I've been there. You do give more buprenorphine as we'll talk about, but that is kind of a tricky situation. And then when patients are on methadone, that's a 72-hour withdrawal. I get a little bit squirrely here. I'm becoming more comfortable with it. But multiple times I've sent patients into acute withdrawal with buprenorphine and then needed pretty large doses to get them back to a maintenance state. So again, it is possible in an ED setting, but the withdrawal timeline gets muddier there and it might be most appropriate in an outpatient setting where they're kind of more familiar with methadone and buprenorphine, use it on a daily basis. You might want to tell someone, you know, essentially just give them medications to manage symptoms until they can get into clinic the next day, bright and early, 8 a.m., and start their buprenorphine, they call it microdosing, but kind of a gradual introduction to the medication as they withdraw. So, it can be the process can be done smoothly. But in ED, we sometimes have time constraints. That's the one patient population I've gotten, I wouldn't say gotten into trouble with, but maybe gotten some surprise symptoms with. And then there's two different scoring systems that people use. This is the SOWS score. There's also the COWS score. It's an opioid withdrawal scale. OWS This one's a little bit faster for the ED setting, and our nurses are very facile with it. It's built into our ER, so we use the SOWS, other places use COWS. They're functionally identical. COWS is just a little bit longer, but you're just going through the withdrawal symptoms. Are you feeling sick of stomach cramps, muscle spasms, or you having cold or chills? Is your heart pounding or a rapid heart rate for that matter? Do you have aches and pains? Have the patient yawning? Are their eyes running? Are they having difficulty sleeping? And when patients come in an opioid withdrawal, I mean, it's pretty odd that someone would have less than ten. They're usually more like 20 plus. So opioid withdrawal comes on fierce. The time when I see people more in that 10 to 15 ranges or 10 to 20 range is when they're actually trying to self-maintain at home. So, they're taking smaller and smaller doses and trying to self-withdraw and then they feel like they're essentially failing, withdraw and come to the emergency department for help. These are the common formulations of buprenorphine. So, there's regular buprenorphine, which is eight milligram and two milligram dose, I have to say, in the era of fentanyl, I hardly ever use those two milligrams in the ED setting. I think there is a clinic protocol where you're going to and two and two and gradually working up there in the emergency department and really starting with four or eight and then the buprenorphine naloxone. This one's interesting. This is not what I use in the ED, but it's what I prescribe. So, buprenorphine naloxone combination medication has naloxone in it and cannot be as easily misused. So, if you're opioid naive and you take the buprenorphine naloxone combination, the chance of you having euphoria is very low. And so, in the ED, when I'm finding someone's maintenance dose, I'll start with buprenorphine alone, and then I'll actually prescribe the buprenorphine naloxone combination so it can't be diverted or would not be successfully diverted. There are also sublingual tablets of this is where a sublingual like dissolving strips of this as well. And those are equivalent to the to the pills. And the sublingual dissolving strips are nice because a lot of times patients are actually quite nauseous. So, here's the you know, now we've confirmed that the patient has opioid use disorder. We've confirmed that they're in withdrawal. We've asked them if they're interested in medication for opioid use disorder and to reduce those cravings and to essentially start maintenance therapy. And they are. So, what are our next steps? You do want to confirm that the patient isn't pregnant. That complicates things in the state of pregnancy. Pregnancy is by no means a contraindication to maintenance therapy. But again, you just want closer follow up. You want OB involved. It's a little more complicated. You sent for a rapid HIV test, especially if there's a direct injection drug use, as well as a hepatitis panel and liver function tests So these medications are processed by the liver and then there's just a lot of co-morbidity out there with injection drug use. And so, if you're, you know, there's more disease and liver disease going on, that's something else you want to address as you start medication assisted treatment. That might actually be a reason to hospitalize someone. We typically do not hospitalize patients for opioid withdrawal, and these are usually discharged patients. But if they had hepatitis that they had active HIV, that would change things. And then, if possible, you also want to do a consultation with social work or substance use counselor or peer support specialist, someone else to get started with the mental health aspect of all this because there is active opioid use withdrawal and the physical symptoms but much deeper than that are the guilt, shame, and the life disorder that go along with these cravings. And it's just such a complicated disease and

there's so much to it. And the sooner that you can get the counseling started, the sooner that you can get the peer support started, the more likely that person is going to have success. It's buprenorphine four milligrams or eight milligrams once and then an additional dose. I do every 30 minutes to an hour, depending on severity until you reach that maintenance dose. And on that dosing, it can be buprenorphine naloxone. There's no contraindication to buprenorphine naloxone in an emergency department. It just depends on what you have on formulary. I know buprenorphine alone is significantly less expensive, and these patients are often uninsured. To be real with you and the hospitals tend to stock buprenorphine. So, if you have buprenorphine naloxone, that's wonderful. You can use that as well. And then once the patient is no longer withdrawing and they'll tell you, they say, no, I'm good, doctor. I'm feeling better once they are no longer withdrawing. It's time to get that patient home with a prescription. And the prescription is these two milligram sublingual tablets or the eight mg tablets. If you're into the big doses and then you dispense 20 of them without refills, assuming that they can get in to see their substance abuse counselor or their primary care doctor within 1 to 3 days. And then I'll talk about adjunct medications for withdrawal as well. But sometimes a withdrawal can start creeping in and they've already had their buprenorphine and so they want to take them ondansetron for nausea, or they want to take some atavan for irritation. These are perfectly safe and acceptable as well. Here are the adjunct therapies. I'm a big fan of scheduled ibuprofen. It is very painful. They call them bone aches to be an opioid withdrawal. And so, 4 to 600 milligrams by mouth ibuprofen every 8 hours. And you can just schedule that through your withdrawal period. You're going to be needing it. If when you when you give buprenorphine, it should take away most of the nausea. But ondansetron oral dissolving tablets four milligrams by mouth every 4 to 6 hours for nausea is a perfect adjunct. And I always tell people to don't jump for a bacon cheeseburger or something like that. Like these patients are drinking broth, Jello, white rice, really bland stuff. Their stomachs are just so upset. Clonidine can really help for the tremors or chills. I mean, sometimes when patients come in, we're trying to get an EKG on, and we can't even see the EKG because the tremors are just that severe. And so, if it's a patient with really severe tremors, this clonidine medication can really help as well. That's an alpha antagonist for the emergency physicians out there. And then you can prescribe loperamide four milligrams by mouth for diarrhea. And then, you know, what are the chances you're going to remember all this first time? Zero. But if you are in the emergency department, the American College of Emergency Physicians has a lot of free clinical decision aids out there, clinical tools that you can use at the bedside. Again, these are this is not marketing. These are completely free. They're developed for quality of patient care. But the BIPE tool you can just search be BUPE ASAP on Google, and this will come up. It's an app for your cell phone as well. And everything I said in this presentation will be included in that in some form. It's a dropdown menu. It's just extremely convenient. And if you don't have a department protocol in place yet, I would encourage you to get one. When we get protocols in place, then things really happen. The quality work is sustained, and it'll happen not just on your shift, but the next shift afterwards and when your colleagues come on. But until you get that protocol in place, use a buprenorphine tool. It's just extremely useful. A dropdown menu and everything is laid out for you, exquisitely clear in that tool. So, I wanted to leave time for my colleague Joslin to talk more about the care, coordination, and social work aspect of it. Just to remind you that Joslin is an ER navigator with St. James Intermountain Health. She's an MSW and she works out of Butte, Montana. Thank you and thank you, Dr. Redwood. So, I just wanted to touch base on a little bit of how we have seen success with initiation of the buprenorphine out of our emergency room here in Butte, Montana. And part of that really started with stigma, education, and reduction training for all staff, including not only our providers, but our nurses, our front admitting people. We went through training on how to how to talk to people, what language to use, understanding more of what substance use disorder is and how it impacts lives. But of course, in the E.R., they knew this. But I think, you know, we had some doctors who had been practicing for 30 years, and they'd always kind of similar to what Dr. Redwood had mentioned, you know, treating the symptoms. And we would discharge them sometimes as a piece of paperwork that would give them a list of follow up clinics or primary care providers to follow up with, but not necessarily treating them. And so, it was just really trying to change the mindset of our providers. How do we get our providers to buy in? At first it was, you know, this is helping support my salary. We had a grant. And if you want social work in the ER, then you need to kind of buy in. So that, to be honest, that was the start of it. Secondly, our providers then, once they started to do this, they realized that their patients were

spending less time in the emergency room, they were returning less, and they were easier to deal with when they were here. So that was a big thing for our doctors. You know, we were we were seeing some of these people less and less when they were here. They were here for fewer times, shortening our length of stay. And then also, they were more pleasant to all of our staff when they were here. Because we were, we were, helping them. And so, what we do, we try to, and we also wanted to make sure people were aware of the personal biases. We all have those. So, we did discussions around that and how that looks and how well we're treating patients. Part of the role of the social worker in the emergency room is not only helping my doctors to understand in my nurses what's going on, but also to talk with the patients. And sometimes, you know, I know Dr. Redwood mentioned a lot of his patients come in and they're asking for it and they're identifying that they need this help. Sometimes it's talking to patients about their use. And for us to get to the point that they understand that, yes, I do have a problem. Initially, I was prescribed this after a knee surgery and now, you know, I, I can't stop or, you know, so it's talking to them about that. We talk a lot about that. This is a disease, right? We treat diabetes a certain way. We treat heart attacks and strokes. This is substance use is a disease. And so how do we do that? And we do it with empathy and compassion and we try to talk to everyone the way that we would want to be treated or talked to and our patients. And we reduce barriers where big harm reduction as well. So, we will give naloxone out of our emergency room. Actually, it's kept in our Omnicell. We're able to give it to anybody who comes in post overdose who our EMR flags as high risk because of medications that they're prescribed from, you know, if they're given a benzo and an opiate or high doses of opiates that are prescribed, they still might be at risk. So, we try to give them the naloxone directly out of the ER to reduce stigma or reduce any barriers going to pick it up. We also do the starter packs out of the ER for Suboxone. So, we have created buprenorphine. So, when it's prescribed, we have them here in our in-house pharmacy. We give them to patients who are not, again we reduce in that area from them getting somewhere. Sometimes transportations issues, sometimes it's Medicaid or finances to pick the prescription up. So, we are able to give back to them and along with their naloxone and we give those, we also make appointments. So, when I'm here, I try to schedule time with them. But we also have made a partnership with a community health provider here in town. And so, we have some standing appointments. So unfortunately, they don't come in Monday through Friday to 8 to 5 when I'm here. Sometimes they come in at, you know, 2:00 in the morning or Sunday nights. And so, we have times available so we can our doctors can take those times and tell someone to follow up. We've also reduced I know Dr. Redwoods showed, you know, 20 pills. We try our providers try to only prescribe 2 to 3 days' worth because we're able to get them in so quickly with our community provider. And that has taken a little bit of the fear and worry from our providers. Initially, when they first started prescribing, they felt more comfortable, only prescribing a couple of days. So, when we were able to have that partnership where they were able to get directly into an appointment that made that much better. And then also, if they've done that on a Sunday night, when I come in Monday, I am notified of that through a process we have here, and I try to follow up with them. And that's just a phone call. And sometimes I'm successful and sometimes I'm not. But my hope is that they see that someone is calling, someone cares. Sometimes that goes a long way. And so, when I talk to them, I just ask them if they have any questions about the medication they started. If they did, I can have them talk to the ER doc on or a pharmacist. Do they have any barriers to getting to their appointments? Are they able to make that appointment? Do they need anything else, do they have any questions? And so, you know, really just wrapping around and treating the whole person. You know, we are always our partner, our community partner who we get follow up appointments. They do have mental health therapy down there. They encourage it as well. But it's not mandatory that people are in either substance use or LAC addictions therapy or mental health. But it's encouraged. So, you know, we just try to talk to people trying to help them and then understanding that sometimes it's successful, but they might we might see them in two months, the same thing. And we can start this again, an understanding that, you know, this is going to be a lifelong disease that they're working with. And so, just again, that compassion and empathy is what we stress. Do you want to take us through some questions that we have in chat? Yes. So perinatal patients, buprenorphine and methadone, completely safe in pregnancy, in fact, encouraged by the American College of Obstetricians. And so, this is this is standard of care in terms of caring for pregnant mothers with opioid use disorder. It is also care for neonatal abstinence syndrome. So, this is relatively new. But just like there's a COWS scale and a SOWS scale,

there's an NAS scale or NOWS scale, I'm sorry, now which is for neonatal abstinence syndrome. And yeah, the idea is to get people on maintenance therapy. I have always done this in consultation with OB. OB does tend to send them home from the emergency department that they do tachometry. So, they do monitoring of the fetus depending on how long the pregnancy, how far along the pregnancy is. And in my experience, expectant mothers with opioid use disorder are coming in closer to delivery. I'm not sure why that is, if that's a bit anecdotal, I guess, but it tends to be third trimester that I'm actually seeing the patients in the emergency department. Things are getting real. They're starting to think about delivery. Maybe they're starting to have contractions and they want to be sure that baby is healthy. But yeah, this is this is acceptable treatment. And I would say a little more high maintenance because you are now treating two patients and you have the issue of contractions to deal with And so I do it in consultation with my OB providers. I think if you were in like a in a hospital setting where you just see this very frequently and felt comfortable and this might be something an emergency physician would do solo, but I guess I'd see it a little less frequently and like to ask a colleague for help. Our next question is there is a recent article that shows there is not a dramatic increase of buprenorphine initiated since the removal of the X-waiver. Any other recommendations except the peer to peer learning you mentioned to get more physicians engaged? Yeah. Well, I'm not surprised at all that there's not a big uptake. Medicine moves, like, you know, like not like a sailboat, like a battleship. Right? And so we're all members of quality improvement organizations. This is the idea of implementation science is we take these best practices and actually try to bring them to the bedside, and it is not easy. The number one thing I would say is true mental health parity in terms of funding. I'm going to be real with you. These patients are not paying their bills, you know, and so there is this fear, I would say, among hospital administrators, among physicians, that if you build it, they will come. If you start offering medication for opioid use disorder, there's going to be this tsunami of nonpaying patients filling up your emergency departments with withdrawal symptoms. And first of all, bring it on. This is a life-threatening disease that we need to get in the fray and start saving lives here. But you know why? Why isn't there parity? You know, Joslin was talking about stigma here. We need to compensate people for the work they do, whether it's opioid use disorder or whether it's diabetes. I mean, these are patients who are suffering. They're dying on us. We need to treat them. And that, you know, there's been legislation for mental health parity, but it doesn't pan out. It's not real yet in terms of Medicaid and Medicare reimbursement. So honestly, I think that's probably a huge one to get health systems on board. That's the same reason all mental health is undertreated in terms of the kind of nuts and bolts you want to make it easy for providers. So, you want to have a protocol in place. So, if you're sitting there at your hospital saying, oh, why aren't we doing this? Check if there's a protocol, if you have a protocol in place, how do we treat opioid use disorder? How do we start medication assisted treatment? When you have a protocol in place, when you get case management and social worker involved, when you have PCPs raising their hands to see these patients the next day, it's going to become much more easy. It's going to become streamlined. It's going to become part of your DNA. You want to make it easy for physicians, so you want to have an order set in the emergency in the in the HER electronic health record. You know, if I have to look up how to prescribe buprenorphine every time, that's going to be a barrier for me. If there's a quick list, ED order set which all emergency departments have this quick list. Right. We have our common orders. Just have a little dropdown menu for opioid related stuff. We already have naloxone in there. You know, we have the buprenorphine in there as well for opioid use disorder and withdrawal. And standard discharge instructions just kind of build it into your program and then really you want to have a champion at your shop. So, if you don't have a champion yet, I would encourage everyone on this webinar to think about becoming your champion. You can do it as a social worker, as a quality improvement professional, as a nurse, as a PA, as an NP, as a physician. Anyone can be a champion for this program. And like I said, you want to just I mean, you can ask your medical director to pull some charts, pull the opioid withdrawal charts, and see how many people were started on buprenorphine. Look at who treated them and why not. I mean, this could be a tidy little quality improvement project, but it has to start somewhere and that would be a great thing to have. A departmental meeting is to come and say, look, we had 30 people come in with opioid withdrawal and only two were started on medication for opioid use disorder. Let's have a talk about it. Here's an article that you can read. I have a little journal club and get the conversation going. But medicine, you know, we don't just change for best practices overnight. We need to be cajoled and prodded and everything else. And that's

part of the reason that these QIOs exist is to get that's best practice to the bedside. Joslin, did you want to weigh in on that at all and the other reasons why this has not taken off like wildfire yet? My experience has just been that there was hesitation with the X-waiver. And now even though it's been removed, I think providers who have been in practice for a while are still nervous and hesitant around that. So, it's just training and education. And my experience is doctors listen best to other doctors. So, peer to peer. But, you know, just reminding them and then, you know, the more I can show them, I like to go to our ER provider meetings and do follow up and so letting them know, you know, this patient we had seen four times prior to this doctor starting and now we have not seen her and I checked in and she's been going to her primary care and so things like that definitely excite our providers and getting them to buy into this program. And it obviously is saving lives too. Our last question, just to be clear, we no longer need to take a course before we can provide buprenorphine, right. Correct. So, before there was a mandatory 8-hour training that was very pharmacology heavy. I did it myself and found it hard to get through. To be honest with you. And that was required. You had to pay a fee and then you had to have a special X-waiver on your DEA number. So, your DEA had to start with an X. That has all gone away. There is still a when you sign up for your or your DEA number. Now, though, there is a box to click that says that you got your opioid training, and it is now a blanket expectation that all DEA holders have training on safe opioid prescribing, including buprenorphine. And it's an audit system. So, when I get my DEA, I just check I have done my education and then if I were to get audited, I would have to provide proof that I did that education. And that proof is things like this webinar, for example, a lot of specialty societies have done their own. So, if you're for example, we talked about obstetrics, if you're in obstetrics, ACOG now has opioid education, mandatory opioid education that would account for this. And so that I would encourage you to check your own specialty and see what they have available, make sure that it fits the training requirement. I have yet to hear of anyone be audited, but it is possible. But you just have to click a box that you've done your opioid education and it's much less prescribed now. It's not the SAMHSA mandatory 8-hour course, but it's rather self-directed courses that are can be specialty specific. Does buprenorphine also treat pain. So great question. Yes, sometimes people need additional pain relief. But yeah, buprenorphine does treat pain. It is an analgesic. And anyone who's been in this acute pain space knows that pain is really it's really complex. So, there's you can, you know, opioids essentially trick your brain into thinking there's less pain. So, the Mu receptor is in the brain, it tricks your brain into thinking there's less pain, but ibuprofen treats the pain at the source. So, when your muscles are literally spasming, it's an anti-inflammatory that works at the muscle level. You know when we talk about Ativan, there's or Lorazepam, it's a benzodiazepine. That is the anticipation of pain. So, some people know that the pain is coming and then they get this kind of wind-up phenomena where they are so scared of the pain and they're anticipating it so much that they actually feel more severe pain And so the name of the game in pain control is multimodal low doses. That's kind of what we're going for. And everybody's opioid withdrawal experience is different. I have definitely had patients where buprenorphine alone just takes away all their symptoms. You just you just, you know, fill those Mu receptors and they feel 100% better. And then I have patients who don't. I have patients where I'm up to 24 milligrams. I'm kind of feeling like I don't want to go higher. They seem okay. Their vital signs of normalized, they're no longer vomiting. But when I ask them how they feel, they say I still feel terrible. And so that's when I use some of those adjunct medications. But yeah, unfortunately it's not it's not like a cookie cutter algorithmic process. It's one of those talk to the patients about their goals of care for their pain, talk about their functional goals, see what medications work for them, what medications don't, you know, if they're having a lot more anxiety, I may be leaning towards the Lorazepam. If they're having a lot more muscle aches, I might be leaning towards ibuprofen. There's no one size fits all. Do you see that this treatment protocol is being activated during labor? And do you have some case managers are going to be assigned to these patients as a follow up? In a lot of emergency departments don't have the don't have the resources to fund case management, let alone 24/7 case management. In my shop, we have 9 to 5 case management. Absolutely. And pretty much anyone with mental health issues sees case management in my shop. And then we have an order in place where if it's after hours, you can place an order and the case manager will follow up with them via phone. And so, it depends on how high resource you're setting is. I know a lot of rural emergency departments don't have case management like that, but that would be the ideal for sure. And then, yes, medication for opioid use disorder can be started during labor. All right. Well, thank you

so much, both of you. This was just such a rich conversation. And we really appreciate you both bringing your expertise to the group. So, thank you so much for joining us today.

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