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featuring  
**OPIOID EPIDEMIC**

As part of AHC Media's ongoing coverage of opioids, the October issue of *ED Management* focuses on the opioid epidemic.

**AHC** Media

## New Initiative Slashes Opioid Prescriptions, Boosts Community Response

*Emergency providers take a leading role in developing pain management guidelines, linking patients to care for underlying issues*

**T**he Monterey County Prescribe Safe Initiative (MCPSI) is a multi-agency collaborative conceived in February 2014 as a way to address the problem of prescription opioid misuse in Monterey County, CA. The idea for the initiative originated at Community Hospital of Monterey Peninsula (CHOMP), but the effort has now grown to include 17 organizations, including all four hospitals in the region, urgent care centers, primary care and mental health providers, advocacy groups, and law enforcement.

While the name of the initiative implies a focus on prescribing, the initiative actually includes multiple interventions that address different aspects of the opioid crisis, and emergency providers have taken a leading role in driving these interventions.

"It was just a matter of trying to figure out how to get patients the care they need in a safe way," explains **Reb Close**, MD, an emergency physician at CHOMP and one of the physician

leaders of MCPSI. "At the time the initiative began, the epidemic was becoming much more understood and more appreciated, and so Anthony Chavis, [MD, MMM, FCCP, the vice president and chief medical officer at Montage Health, CHOMP's parent company], and I started brainstorming about it and coming up with how to address it. And it has just spider-webbed in so many different directions because so many different people are affected by this."

### Address Underlying Issues

The results of MCPSI thus far are impressive. They include a 59% reduction in ED visits and a 47% reduction in variable cost avoidance in a population of recurrent visitors that are under biopsychosocial care management. Additionally, the initiative has more than halved the number of narcotic pills prescribed at primary care clinics in the

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region. Perhaps most notable is the reality that providers are beginning to think about both addiction and their role in treating patients who present with addiction problems in a new way.

For instance, physician leaders at CHOMP are not fans of the term “drug seeking” to describe patients who recurrently present to the ED to fill prescriptions for narcotics.

“That is a particularly loaded and challenging term,” observes **Casey Grover**, MD, an emergency physician at CHOMP who also has taken a leading role in MCPSI. “These patients may be looking to get a medication, but there is another reason that is bringing them to the ED.”

Such a patient may experience uncontrolled pain, suffer from an uncontrolled mental health condition, or may have an addiction, Grover notes. “It is not so much that the patients are doing something bad or wrong if they have an untreated illness ... and repeatedly going to the ED isn't fixing it,” he says. “So [under CHOMP's recurrent visitors program] these patients are given a plan of care, and usually what that is designed to address is the underlying issue. Is it that they need a real pain specialist? Is it that they need to see our recovery center, [the hospital's associated outpatient addiction clinic]? Is it that they need to see a psychiatrist? Those are all meant to address the underlying illness that is making them show up to the ED requesting or seeking various medications.”

Grover allows that the idea of addressing addiction in the emergency setting initially raised some eyebrows in some quarters, primarily because this just adds to emergency providers' long to-do list.

“There has been research that we

should do HIV screening in the ED and we should do domestic violence screening and depression screening,” he says. “It was one more thing that people are expecting us to do, but then as we have gone through the data, people realize that if you treat [patients] with the right medications for what is a disease, namely addiction, people have fewer ED visits and they are likely to get better faster.”

Emergency providers all went into medicine to help people get better, Grover adds.

“You present the data and people kind of put the barriers down and think that maybe they can provide better care for patients this way,” he says.

## Establish a Pathway for Addiction

While the motivation to address addiction is there, the way emergency providers at CHOMP treat patients who present with an opioid addiction is in flux, Close notes.

“Previously, we had reasonable access in our county to the recovery center for all patients,” she explains. “If someone presented with an opioid addiction and was interested in recovery, we would start them on a single shot of buprenorphine in the ED, and then we would refer them to our recovery center where they would be seen basically the next day and [continued] on medication-assisted treatment [MAT].”

The approach seemed successful, Close observes. However, funding difficulties forced the ED to alter its approach.

“The availability for patients to see a MAT-prescribing physician in rapid fashion was non-existent, so we couldn't use buprenorphine

anymore in the ED.”

To get around this problem, emergency providers have had to adjust their addiction pathway to accommodate a longer wait time for access to MAT.

“So we give patients a prescription for a five-day course of medication with tapers [including clonidine, gabapentin, tramadol, and ondansetron], and then refer them to an addiction clinic for ongoing care. The addiction clinic can’t get them medications for treatment rapidly, but it can give them addiction services rapidly,” Close explains. “That is the model we are using right now.”

However, Close stresses that ED administrators hope to restart their earlier approach soon, involving the administration of buprenorphine while patients are still in the ED along with the referral to an appropriate outpatient setting in which patients will receive immediate chemical and dependency support services. Other hospitals in California are considering implementing a similar protocol, Close observes.

“We are using expertise throughout the state to formalize how we can do these plans for patients,” she says.

Close acknowledges that there still is plenty of resistance in the emergency medicine community to the idea of providing buprenorphine to patients with addictions while they are in the ED.

“We treat these patients every single day, so [it’s a matter of] reminding providers that these patients are already in their EDs and that they have a tool that can help them more safely and more effectively than any other tool they have,” she explains. “These patients are agitated, sweaty, uncomfortable, angry, and frustrated. And you give them a shot of buprenorphine and then come back

## EXECUTIVE SUMMARY

The Community Hospital of Monterey Peninsula (CHOMP) has spearheaded a multi-agency collaborative that has been successful at more than halving the prescriptions for narcotics in the region and trimming ED visits among frequent users. Known as “Prescribe Safe,” the approach can be credited, in part, with nudging emergency providers to view addiction as a disease and to reevaluate their role in linking patients with needed treatment.

- Under its recurrent visitors program, emergency providers at CHOMP reject the term “drug seeking,” instead focusing on addressing the underlying reasons for a patient’s addiction problem.
- A centerpiece of the Prescribe Safe initiative is county-wide implementation of pain management protocols for the ED, coupled with provider and patient education initiatives about these guidelines and why they are important.
- Physician leaders of the Prescribe Safe initiative note that networking with community partners has produced alliances with law enforcement on drug take-back events and a more effective response to drug diversion and prescription forgery.
- By making safety the ultimate goal of the initiative, patient-provider conflict over prescribing choices has been minimized.

in 20 minutes, and they are calm and pleasant. They thank you, and they feel so much better.”

A centerpiece of MCPSI is county-wide implementation of pain-management protocols for the ED, but Grover acknowledges that crafting guidelines does not guarantee adherence. Nonetheless, he notes that CHOMP has been able to achieve effective compliance with these guidelines by initiating broad educational initiatives to both providers and the public.

“We had a CME [continuing medical education] event for our providers — a big lecture on safe pain care. We also educated them about use of California’s prescription drug monitoring program [the Controlled Substance Utilization Review and Evaluation System, or CURES],” Grover explains. “Then we also educated the public that this is what the county believes is safe, and it is in all of our county EDs. In our particular hospital, every patient,

no matter what they come in for, gets a copy of these guidelines at discharge, so the public knows what to expect and what we think is safe.”

There has been a general misconception that if a physician prescribes narcotics, such drugs must be safe, Grover adds.

“Between the medical side and the community side, there is a big movement to educate the whole group that these medicines can be really dangerous, so be careful, and let’s monitor them closely,” he says.

As part of this education process, providers receive advice on how to teach patients most effectively about opioids, the potential hazards associated with them, and how to minimize any negative effects, Close adds. Providers also learn about more effective responses when patients report that they need something for pain.

“The reflex is not to write a prescription for [a narcotic]; it is to talk to them about what this means,” she

explains. “There are all these different treatment options, and teaching the physicians and the patients that there is not just one answer has really changed all of our practices.”

It is still up to the treating provider ultimately to make decisions about what to prescribe, but now when a decision is made that is counter to the pain management guidelines, a provider generally will approach ED physician leaders to explain why an exception was needed in this particular case. Close notes that there are valid reasons to deviate from the guidelines. For instance, the physician may report that the patient experienced a surgical emergency and he or she thought it was in the patient’s best interest to prescribe an opiate.

Close notes that the issue of opioid prescribing comes up regularly during emergency group monthly meetings, and plans are in the works to study the impact of the opioid guidelines on prescribing and provider decision-making.

## Network with Community Partners

Development of the guidelines for the ED at CHOMP was actually a good starting point for more community-wide participation in the overall initiative, Close observes.

“Those guidelines were very well thought out and put together, and we gave them to our physicians, and then we said, ‘Hey, the clinics need them,’ and so we took the ED framework and shared it with the clinics, and then we shared [the guidelines] with the community,” she explains. “There was not one person I contacted out of the blue that questioned why we were doing this, so getting people involved ... and getting those

ED guidelines, I think, for us, was a big hurdle that really made a difference.”

The original networking that took place to disseminate the guidelines created many other avenues to pursue to tackle the opioid crisis, Grover explains.

“Our contacts with the sheriff’s office turned into us being able to work with them to sponsor drug take-back events,” he explains. Such events provide an opportunity for the public to safely dispose of unused narcotics, ensuring these dangerous medications don’t fall into the hands of people who should not use them.

THE ORIGINAL NETWORKING THAT TOOK PLACE TO DISSEMINATE THE GUIDELINES CREATED MANY OTHER AVENUES TO PURSUE TO TACKLE THE OPIOID CRISIS.

Similarly, contacts with the district attorney’s (DA) office have enabled emergency providers to take a firm stand on prescription forgery and prescription drug diversion, which already has paid dividends, Grover explains.

“The license and DEA number belonging to one of our providers were taken by a patient, and medications were fraudulently called in,” he says. “The DA investigator for healthcare fraud in Monterey Coun-

ty had been through the process with us, so we knew how to advise this provider, and it just all of a sudden made things so much easier to move forward.”

## Make Safety the Priority

The physician leaders of the MCPSI discovered that much of the work that they wanted to pursue was already underway in some fashion in the county — they just needed to knit all these efforts together, Grover explains.

“Doing all this work in the name of safety has been very important. It is not telling a patient that [he or she] is addicted. It is offering to treat a medical disease, and make decisions to choose medicines that are the safest,” he says. “That really inspires people that this is a good program for the community.”

Grover adds that the approach also reduces conflict when a patient presents to the ED with an addiction problem, and the provider conveys that he or she will not refill a prescription for narcotics because the provider is concerned about the patient’s safety.

“The family member will look at you and you look them in the eye and say that you are really concerned for their safety. They know you mean it and they know it is for the right reasons,” he explains.

Whereas prescribing used to be a point of considerable disagreement between patients and providers, “we have now all unified ourselves under the greater goal of safety,” Grover adds.

While MCPSI has slashed prescriptions for narcotics and strengthened the community’s response to the opioid crisis, charting the initiative’s effect on drug overdoses has been

difficult. Part of the problem is that the electronic medical record (EMR) system at CHOMP does not facilitate such tracking, Grover explains.

“I am currently keeping a list of all the overdoses because we are planning, as one of the next steps in this project, to start alerting providers that are prescribing scheduled substances when one of their patients overdoses,” he says. “Anecdotally, I have not seen a fatal drug overdose in quite a while, and I can tell you that

in 2013 we had around 50 fatal overdoses in Monterey County related to scheduled medications. So, anecdotally, we are seeing fewer overdoses.”

Grover stresses that he is only able to chart the overdoses that people tell him about or those of which he is personally aware, so it is hardly a perfect system. MCPSI leaders hope to devise a better way of tracking such events in the future.

*Editor’s note: For more information about the MCPSI, including access to*

*the prescribing guidelines for the ED and other resources, please visit: <http://bit.ly/2ccanMw>. ■*

## SOURCES

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# A Second Look at ED-initiated Buprenorphine for Opioid Addiction

While many emergency providers remain hesitant to start patients on medication-assisted treatment (MAT) for an identified addiction to opiate medications while such patients are still in the ED, there is growing interest in this approach. This is in part due to research published in 2015 showing that starting these patients on buprenorphine, a drug that helps with withdrawal symptoms, at the time of their ED encounter considerably increases the chances that patients will remain in treatment.<sup>1</sup>

Researchers at Yale New Haven Hospital in New Haven, CT, studied 329 people with opioid addictions who presented to the ED for any reason. One-third were referred to an addiction treatment center, another one-third received 10 minutes of counseling about treatment and were referred to an addiction treatment center, and the final one-third immediately received a dose of buprenorphine in addition to the 10 minutes of counseling and referral to an addiction treatment center.

One month following the ED

encounter, researchers reported that 78% of the patients in the buprenorphine group were enrolled in a formal addiction treatment program,

“ED-INITIATED BUPRENORPHINE IS SOMETHING THAT ONLY WORKS IF YOU HAVE LOCAL COMMUNITY PROVIDERS THAT CAN TAKE OVER CARE OF THE PATIENT.”

while just 45% of those who received counseling and referral were enrolled in treatment, and just 37% of those who received referral for treatment were actively enrolled.

Since these findings were reported, administrators at Yale New

Haven Hospital have worked to bolster infrastructure in the ED to initiate buprenorphine for patients who present with opiate addictions and are candidates for MAT, explains **Kathryn Hawk**, MD, an instructor in emergency medicine and a K12 research fellow on drug abuse, addiction, and HIV in the Yale Department of Emergency Medicine.

“We have established a collaboration with multiple local buprenorphine providers that offer services in the area,” she says. “We have also developed protocols and we are in the process of implementing them on a larger scale for getting people the treatment they need, starting in the ED.”

## Provide Education, Training

Hawk notes that she has not observed any resistance to this treatment approach from emergency providers at Yale New Haven Hospital, but she acknowledges that implementing this type of addiction

pathway typically requires education and training.

“I think that any initial push-back or concern is because this is not something emergency providers are familiar with,” she argues. “Also, ED-initiated buprenorphine is something that only works if you have local community providers that can take over care of the patient. In New Haven, we don’t have any kind of a waiting list now, but that is not the case everywhere.”

Nonetheless, Hawk observes providers want to help and are keeping an open mind about new approaches.

“Physicians want to help people, they want to do the right thing for them,” she says. “What is happening with the opioid epidemic ... and the deaths associated with it over the past several years has really gotten the attention of a lot of emergency medicine physicians, and people who wouldn’t necessarily have considered doing this a couple of years ago ... are more willing to learn about it and figure out how to integrate it into their practice. But you have to have the infrastructure in place in order to do it. That is one of the biggest barriers.”

At Yale New Haven Hospital, there are a couple of different mechanisms in place to transition patients with addiction problems into ongoing care. For instance, the hospital’s “Project Assert” program leverages health workers to find beds for patients and even go so far as to arrange for transportation, if that is needed.

“These are health promotion advocates who specialize in linking patients with drug and alcohol disorders with addiction treatment,” Hawk explains. “These are people who provide motivational interviewing, they assess willingness to engage

in treatment, they look at patient insurance status, and they call treatment centers.”

The hospital also has a second system in place in which emergency medicine physicians can fill out a one-page form for referral that can be expedited to one of several treatment centers in New Haven. The form includes medical information that treatment providers typically request, including the results of urine toxicology and liver enzyme tests, Hawk says.

**“IT IS IMPORTANT TO KNOW YOUR COMMUNITY RESOURCES AND TO DISCUSS THEM WITH YOUR PATIENTS, WHETHER THESE RESOURCES INCLUDE BUPRENORPHINE AND MAT OR NOT.”**

“The form then just gets faxed over to these treatment centers that have agreed to take patients that we send over,” she says. “[The patients] will get a phone call the next morning to arrange to be seen in the next couple of days.”

To successfully implement a model like the one used at Yale New Haven Hospital, providers first must identify local partners who can provide long-term care for patients suffering from addiction.

“It is important to know your

community resources and to discuss them with your patients, whether these resources include buprenorphine and MAT or not,” Hawk observes.

Also important is patient education about factors that increase the risk of overdose, such as taking opioids with benzodiazepines, alcohol, or other sedatives. A previous overdose or recent periods of abstinence also can increase the risk of overdose, Hawk notes.

“One thing that all emergency providers can do is prescribe take-home naloxone, which is something that is supported by the CDC, the AMA, and the Office of National Drug Control Policy at the White House,” Hawk says. “While naloxone does not necessarily treat addiction, it can help keep people alive so they can get to the ED and get referred to treatment. It gives people a chance.”

Hawk advises emergency providers find out which pharmacies in their region stock naloxone, and share that information with patients.

“The thing about this is people [with addictions] get better,” she says. “If we can help them access the treatment to get better, it is a win for all of us.” ■

## REFERENCE

1. D’Onofrio G, O’Connor PG, Pantalon MV, et al. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence. *JAMA* 2015;313:1636-1644.

## SOURCE

- **Kathryn Hawk**, MD, Instructor, Emergency Medicine; K12 Research Fellow, Drug Abuse, Addiction, and HIV, Yale Department of Emergency Medicine, New Haven, CT. Email: [Kathryn.hawk@yale.edu](mailto:Kathryn.hawk@yale.edu).

# Guide Patients into Treatment Through Outreach Visits

*A community approach leverages law enforcement, medical personnel, and addiction treatment providers, bringing resources to patients and families who are struggling with an addiction problem*

Clinicians and social workers at Beth Israel Deaconess Hospital in Plymouth, MA, (BID-Plymouth) have found that by working closely with the Plymouth Police Department and other community partners, they can connect many more patients with treatment for their opioid addictions than they have in the past. In fact, the Integrated Health Care and Substance Use Collaborative, as their program is called, began with recognition by law enforcement that something needed to change in the way the community dealt with its opioid abuse problem.

**Michael Botieri**, Plymouth's chief of police, explains that the opioid crisis became so alarming back in 2014 that he requested to hire nine officers so that he could create a division to deal with the issue.

"We looked at it as having a front row seat to the problem since we were the police and we were going out on all these calls [involving drug overdoses]," Botieri notes.

But the officers responding to these calls saw a clear need to do more on the treatment side.

"Traditionally, in law enforcement, we go to a scene, and we hope things are better when we leave," Botieri explains. "We wanted to be more engaged and more involved in that rehab piece."

Consequently, the police department prepared a brochure that outlined all the different alternatives and treatment providers in the region that patients and families could consider in getting help for an

opioid addiction, and officers began handing out the brochure when they responded to calls related to opioids. This effort didn't solve the problem, but it started the community down the path toward a more comprehensive approach.

"It took the collaboration of different stakeholders," Botieri observes. "We started sharing best practices, and trying to figure out how we can deal with this."

## Develop an Outreach Team

One of the stakeholders involved

with these discussions was BID-Plymouth. In October 2015, the hospital developed a behavioral health (BH) team to work with overdose patients who present to the ED. The team, which is embedded in the ED, consists of nurse practitioners and substance abuse clinicians, explains **Sara Cloud**, LICSW, the director of social work at BID-Plymouth.

"We do a substance abuse disorder evaluation while patients are in the ED. We also meet with the family, offer support, and offer to connect them with appropriate levels of care based on the assessment and the findings of the evaluation," she

## EXECUTIVE SUMMARY

By working with the police department and area addiction treatment centers, Beth Israel Deaconess Hospital in Plymouth, MA, (BID-Plymouth) has been able to persuade many more patients who present to the ED with addiction problems to seek needed treatment. The approach involves the creation of an outreach team that visits patients in their homes within a day of discharge from the hospital following an overdose.

- A behavioral health team embedded in the ED sees all patients who present to the ED with addiction issues. While the vast majority of these patients reject addiction treatment alternatives at this stage, administrators have found patients to be much more amenable to accepting treatment once patients have returned home.
- In the first nine months of the program, roughly 80% of patients with addiction problems agreed to seek treatment following an outreach visit.
- A police officer always accompanies clinicians on outreach visits and can help the team work around confidentiality issues.
- Emergency providers at BID-Plymouth have devised opioid guidelines to ensure prescriptions are used only when appropriate. By sharing information with providers about how their own prescribing practices compare with the prescribing practices of their peers, administrators have produced significant declines in opioid prescribing.

explains. “We offer them printed materials in terms of resources, and we follow up with them the next day ... to see if they got linked, whether there are any barriers, and if there are any problems we can help them with.”

While the BH team provides a big assist in helping emergency personnel manage the increasing volume of patients with opioid addictions, administrators note that the vast majority of these individuals decline treatment referrals while they are in the ED. However, rather than give up on connecting these patients with addiction treatment services, BID-Plymouth and the Plymouth Police Department have formed an outreach team that will visit these patients at home.

“We have a much higher success rate of people accepting treatment from that vantage point in the community than when they are in the ED and they are signing out against medical advice,” Cloud observes. “Because we have clinicians right there on the scene doing the opioid follow-ups, we can do an assessment of what people need. If it is inpatient detox ... the detectives can drive them there if they need or want that. Others may be much more appropriate for medication-assisted treatment [MAT] on an outpatient basis. We have flexibility based on what is needed, what we can link them to, and what they might be agreeable to.”

This aspect of the program, called Project Outreach, is a collaboration of not just the police and hospital, but also substance abuse treatment providers in the region.

“The Plymouth Police Department really worked on pulling together a team of collaborators and meeting that charge,” Cloud notes. “That was effortless on our part.

They had done all that work.”

The goal of the outreach team is to visit patients in their homes within 12 to 24 hours of their discharge from the hospital.

“We started on Dec. 1, 2015, and the statistics are good,” Botieri explains. “We are going to measure our success in small doses, but roughly 80% of the people we visit are [accepting treatment] ... within a week or two of the visit.”

There definitely is a law enforcement component to this approach, Botieri explains.

“We make sure that the person [who overdosed] is not wanted for anything. If they are, we take care of that first. We make an arrest, bring them to court, and try to get them help through that process,” he says. “If they aren’t [wanted for anything], then we can do a follow-up the next day.”

Another important role for law enforcement has to do with confidentiality.

“The way the program is structured, first responders identify a case and confirm that Narcan [naloxone] was administered. They flag the case for the police department and the police department then sends a response that [outreach] is needed. Then we go out,” Cloud explains. “When we go into the community, we are going with a detective, and the detective is the one telling the family that we are there because their son overdosed last night. The detective is disclosing that information based on the information he or she received from the first responders.”

As a hospital employee, Cloud notes that she is not revealing the information from the hospital medical records, which would be problematic from a patient privacy standpoint.

“The first responders are sharing that information. They have a lot

more flexibility and leeway than we would have as healthcare providers,” she explains.

The confidentiality piece was one of the thornier issues the collaborators had to work through in designing the outreach approach, Botieri acknowledges.

“We are basically making the introduction. We are taking the confidentiality piece out, and saying it is public safety,” he explains. “That is why we are there. We actually have someone with us who can talk about the options and actually put [the person in need of addiction treatment] in a bed.”

## Leverage Specialized Skills, Expertise

To succeed with such an approach, both the hospital and the community partners involved need to break down silos, Cloud stresses.

“The team has representatives from a very specialized area. We have representatives from MAT programs, we have recovery coaches, we have the hospital, and we have detox facilities,” she explains. Other stakeholders include mental health agencies and the drug court in the region, as well as the school department, Cloud adds.

On the hospital’s part, embedding a new behavioral health team within the ED came with some growing pains, acknowledges **Peter Smulowitz**, MD, the associate chief in the department of emergency medicine at BID-Plymouth.

“As we brought in some new providers, there was some getting used to who they are, what they are offering, and what their role is, but I would say that was a fairly short-lived process of trying to understand the team, and once that was all

in place, I think it has been only positive,” he explains. “Emergency providers are incredibly busy trying to manage everything that is coming through our doors, and we want to give these folks who are really needing and sometimes seeking treatment the best treatment that we can provide.”

Employing staff members who are specially trained at handling patients with behavioral health issues, not just addiction, but all behavioral health issues, has been a big gain for the department, Smulowitz adds.

“They are able to spend time with patients and provide resources that we just don’t have the expertise in, so we really rely [on the behavioral health team] at this point and look to the team as a huge success.”

While much of the impetus for the creation of the embedded behavioral health team was the opiate problem, the team works with all behavioral health presentations as well as social work needs, Cloud notes.

“If someone comes in who is homeless or there is a question of abuse or neglect, we help,” she says. “We work with a full range of need in the ED.”

Smulowitz explains that the substance abuse piece of this intervention is very connected to the mental health piece.

“We have two psychiatric nurse practitioners who are with us Monday through Friday from 9 a.m. until 5 p.m. who are really dedicated to helping the patients with mostly mental health issues, although obviously substance use dovetails into that as well,” he says. “They’re helping to expedite dispositions to the extent possible.”

Cloud notes that colleagues interested in developing a similar ED-based behavioral health team should think through the logistics

thoroughly beforehand.

“I think having frequent meetings, transparency, and really defining the roles as clearly as possible are the best words of advice in terms of the transition and culture shift within the ED itself,” she says.

## Address Opioid Prescribing

Emergency providers at BID-Plymouth have decided that one thing they will not do is start patients with opiate addictions on MAT in the ED.

“We decided not to do that piece of it, and there are a variety of reasons why,” Smulowitz says. “I think the main thing is that if we start treatment, then we basically need to have the patients connected with [an addiction treatment] provider the very next day to continue that treatment, and, logistically, that is challenging.”

Further, in terms of providing prescriptions for medications such as buprenorphine, ED leaders were concerned about the potential for abuse because of the street value of such drugs. They also were concerned about the effect on patient volume.

“We weren’t prepared because we are already overloaded with patients that we are trying to help. We were concerned about the if-you-build-it-they-will-come phenomenon of offering treatment and then people coming that would max out our resources,” Smulowitz explains. “Our main goal is to connect these patients to the next stage of treatment.”

However, one step emergency providers have taken to address the opioid abuse problem is developing their own opioid prescribing guidelines.

“They largely speak to the conditions upon which we don’t think it is appropriate for us to provide prescriptions, and to give providers some support for not providing opioids in these cases,” Smulowitz explains.

The guidelines primarily focus on the appropriate management of acute non-chronic exacerbations of pain, not treating chronic pain with opiates, and not refilling lost or stolen medications, Smulowitz says.

“We’re trying to rein in what we thought was potentially inappropriate access to opioid utilization,” he explains. “The next step is we engaged in a project where we have shared prescribing information with our providers as to their individual prescribing practices as compared to their peers.”

While formal data from this project will not be available for a month or two, Smulowitz notes the project has produced a significant reduction in opioid prescribing.

“People like to compete,” he says. “We started off sharing blinded information so the providers didn’t know who they were being compared with, and now everyone is asking for the information to be non-blinded. They are comfortable looking to see how they are performing among their peers.” ■

## SOURCES

- **Michael Botieri**, Chief, Police Department, Plymouth, MA. Phone: (508) 830-4218.
- **Sara Cloud**, LICSW, Director of Social Work, Beth Israel Deaconess Hospital, Plymouth, MA. Email: scloud@bidplymouth.org.
- **Peter Smulowitz**, MD, Associate Chief, Department of Emergency Medicine, Beth Israel Deaconess Hospital, Plymouth, MA. Email: psmulowi@bidmc.harvard.edu.

# Warm Handoffs Connect Substance Abuse Patients to Vital Services

Although there are varying perspectives on whether emergency providers should place substance abuse patients on medication-assisted treatment (MAT) while such patients are still in the emergency setting, there is wide agreement that linking all such patients to treatment is important. This mechanism, often referred to as a “warm handoff,” ensures patients can turn to a resource for help in dealing with their substance abuse problem immediately.

Of course, the specifics involved in this transition are critical. That’s why emergency providers at Reading Hospital in West Reading, PA, work closely with the Council on Chemical Abuse (COCA), a non-profit organization that focuses on issues involving substance abuse in Berks County, PA, to develop an effective warm handoff approach.

“We developed the program based on feedback that we received from multiple sources, including COCA and our mental health services, as well as emergency providers and the staff here,” explains **Kristen Sandel**, MD, associate director of emergency medicine at Reading Hospital.

The resulting warm handoff program includes several components, all designed to ensure patients with addiction problems are connected to a treatment plan as soon as their medical emergency has been addressed.

At first, the program was targeted specifically toward patients who had overdosed on heroin because there was an epidemic of heroin overdoses in Berks County and surrounding areas, Sandel observes.

“As the program evolved, we recognized that there are many more patients who could benefit from these

services, so we approached COCA to see if we could offer the same program to patients who wanted assistance with their addictions involving other opioids,” she explains. “We have not been able to extend it to other

THE RESULTING WARM HANDOFF PROGRAM INCLUDES SEVERAL COMPONENTS, ALL DESIGNED TO ENSURE PATIENTS WITH ADDICTION PROBLEMS ARE CONNECTED TO A TREATMENT PLAN AS SOON AS THEIR MEDICAL EMERGENCY HAS BEEN ADDRESSED.

substances beyond opioids at this point, but our successes with the program thus far have made it clear that this may be a program we can expand in the future.”

The new program, which has been up and running since February, has gained steam.

“Initially, it was a little bit slow,

and we had a few glitches, but as the program has become more robust and more mature, our providers have been very active in offering these services,” Sandel says. “We are averaging one patient [taking part in the warm handoff program] every two days ... and it is a resource that didn’t used to be available.”

## Treat Addiction as a Disease

What happens when a patient with an addiction problem presents to the ED?

“The initial focus is stabilization of the patient and treatment of their acute, life-threatening medical condition,” Sandel notes. “At that point, we have a frank discussion with the patient about the reason he or she is in the ED if it was a heroin overdose, or we ask the patient about his or her substance use history and social history, and if we see that this person has an issue with a controlled substance, including opioids or heroin, then we offer the program.”

Sandel emphasizes that emergency providers are instructed to treat these patients like they would treat any patient with any other medical condition, whether it is a heart attack or appendicitis.

“Addiction is a disease, and part of the treatment is offering recovery, just like we would offer a cardiac catheterization to a patient having a heart attack or medication for a patient who is having a stroke,” she offers.

The warm handoff program is voluntary, so patients certainly can decline, but if they do accept the warm handoff, the provider will contact a

mental health liaison and a hospital social services representative.

“At that point, the mental health liaison will call the consultant/recovery expert from COCA,” Sandel explains. “In most cases, they will come to the ED within 30 minutes to an hour to meet with the patient before they are discharged home, or [the patient] will be offered an inpatient treatment program if that is the best option.”

## Alert Providers to the Approach

To make sure emergency providers were aware of the warm handoff program, administrators inserted a prompt into the electronic referral process.

“When someone consults our mental health services regarding a patient, the first question that is asked is whether this is a warm handoff,” Sandel says. “The provider has to answer that question, so it is always in the forefront of their mind: Do I need to offer this patient warm handoff services for an opiate or heroin addiction?”

If the provider says, “yes,” that triggers the mental health worker to recognize not only the mental health issues that the patient may have, but also the substance abuse issue, Sandel explains.

“The reason we put the hard stop in [the electronic process] was to ensure that our providers are thinking about [substance abuse] and asking patients about it,” she says.

Additionally, administrators held an information session with emergency providers to explain the warm handoff process and to review the types of conversations in which providers might engage with substance abuse patients. Sandel stresses com-

munication with patients is key.

“This isn’t just an option that patients can take or not. It is something that could change their lives,” she says. “It is telling a patient that he almost died today or that he lost his heartbeat and wasn’t breathing, and that you had to provide lifesaving treatment to ensure that you could be having this discussion.”

At the same time, it is important to convey that you are there to help and that addiction is a disease, Sandel adds.

“We are not pointing fingers or blaming patients for this. We want to help them, and many times the best option is getting them into a recovery program, whether that is in an inpatient setting or an outpatient setting with the help of recovery specialists,” she explains. “That communication piece, where we actually have the discussion with the patient or the patient and their family, is critical.”

## Nurture Ties with Treatment Providers

For the warm handoff process to work, there must be treatment providers in the region ready to accept patients. That was not always the case in Berks County, Sandel notes.

“In the past, when patients wanted to go into recovery, if we didn’t have a bed or we couldn’t find a bed somewhere in one of the surrounding areas, we would discharge a patient

with a phone number or an address,” she explains. “It really was a disjointed effort, and one of the reasons was because there were limited resources.”

Pennsylvania authorities have been improving access to recovery programs, including both outpatient and inpatient approaches.

“The state is also looking at both mental health and substance use because they are so intertwined and making sure we have the resources to meet both the mental health needs and substance use issues,” Sandel notes.

While it’s important to build relationships with treatment providers, you also have to finesse how the ED will communicate and interact with these services, Sandel advises.

“We had some growing pains [in this area] in the beginning, but once we worked those out, it has been a very smooth process,” she says.

Another critical element of success is making sure that everyone is on board with the process, from the physicians and nursing staff to mental health services, social services, and allied staff throughout the ED.

“This is a process where everyone has a piece,” Sandel says. ■

### SOURCE

- **Kristen Sandel, MD**, associate director of emergency medicine at Reading Hospital, West Reading, PA. Email: [Kristen.Sandel@readinghealth.org](mailto:Kristen.Sandel@readinghealth.org).

## CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Apply new information about various approaches to ED management;
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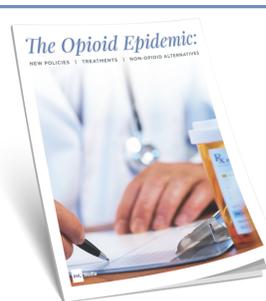
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## CME/CE QUESTIONS

1. **ED-initiated buprenorphine is something that only works if you have:**
  - a. local community providers that can take over care of the patient.
  - b. an on-site addiction recovery program.
  - c. a psychiatrist who can oversee prescribing.
  - d. All of the above
2. **When patients present to the ED with addiction problems, the main goal of emergency providers is to:**
  - a. start patients on medication-assisted treatment.
  - b. notify law enforcement.
  - c. move patients through the care process quickly.
  - d. connect patients to the next stage of treatment.
3. **Emergency providers at Reading Hospital are instructed to treat patients who present with substance use problems:**
  - a. as expeditiously as possible.
  - b. with great caution.
  - c. like they would treat any patient with any other medical condition.
  - d. as potential drug seekers.
4. **For Reading Hospital's warm handoff process to work, there must be:**
  - a. an on-site addiction counselor.
  - b. addiction treatment providers in the region ready to accept patients.
  - c. a full medical workup beforehand.
  - d. All of the above



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