Be the Voice

Breaking the Cycle of Addiction

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CALIFORNIA HOSPITAL ASSOCIATION
Center for Behavioral Health

No Wrong Door
Universal Access to Addiction Treatment

CA BRIDGE
TREATMENT STARTS HERE

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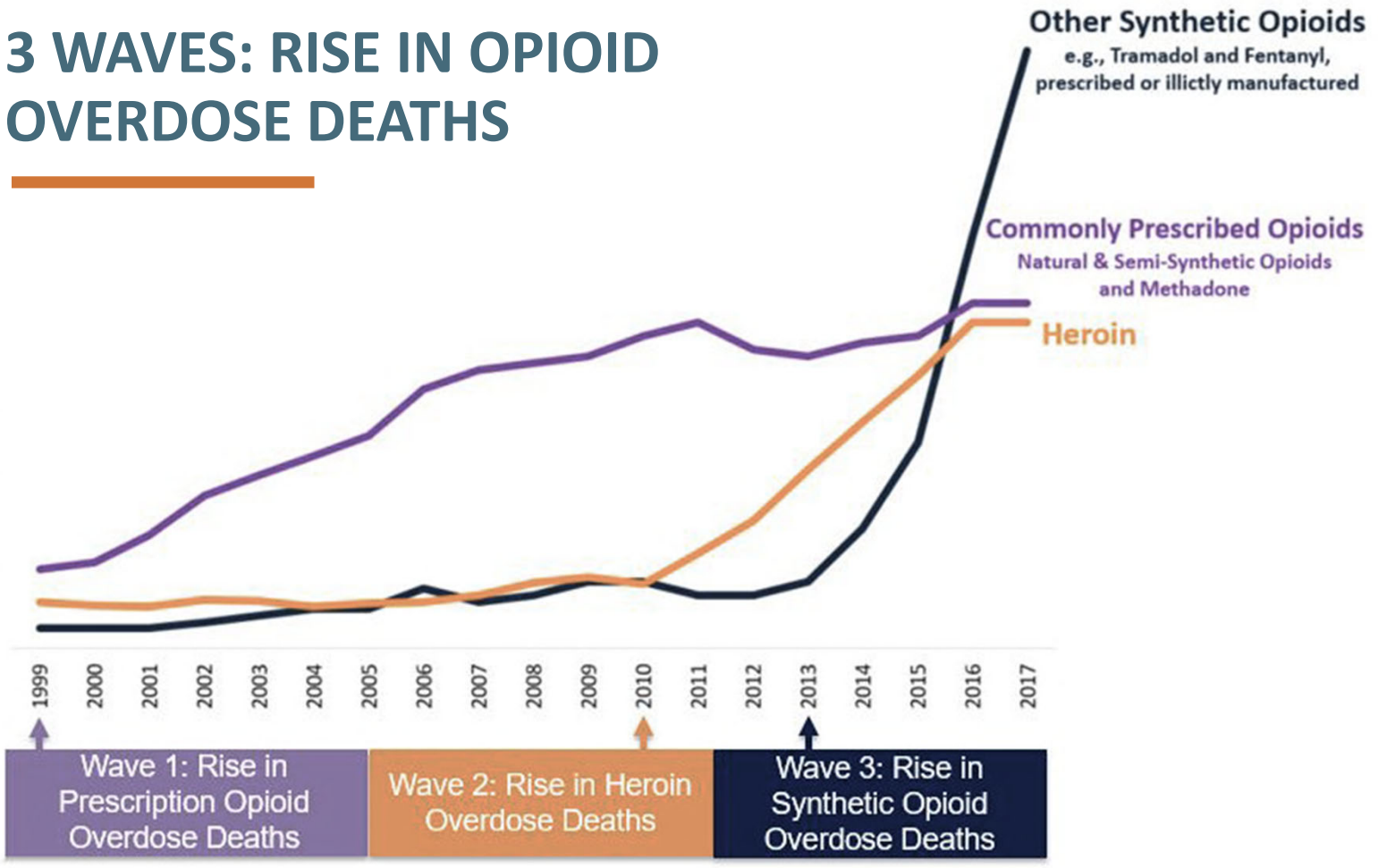
3 WAVES: RISE IN OPIOID OVERDOSE DEATHS

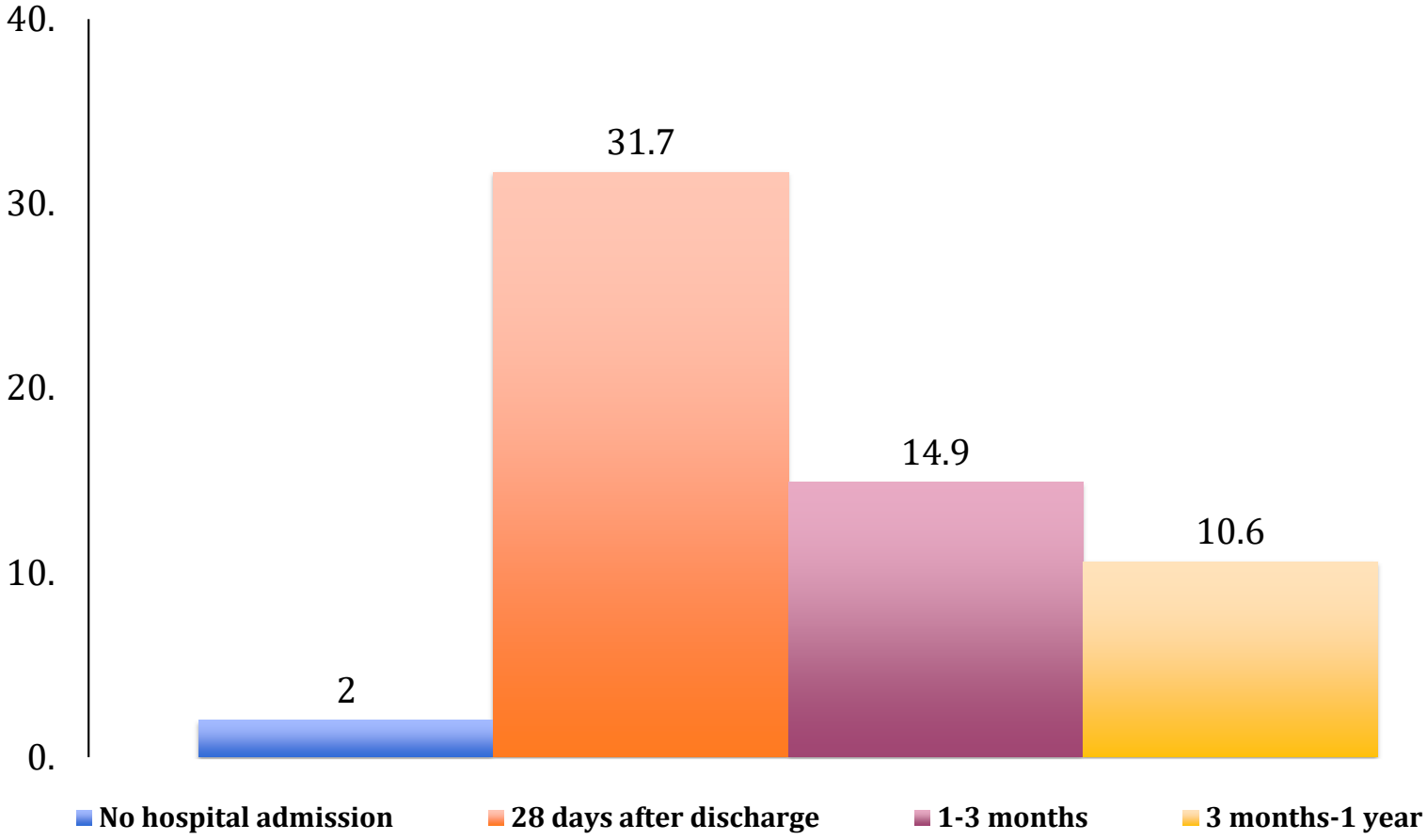


SOURCE: National Vital Statistics System Mortality File.

HOSPITAL ACQUIRED CONDITION

OVERDOSE

15 X OVERDOSE INCREASE IN MONTH AFTER DISCHARGE



THREE PRONGED APPROACH

1. Avoid chronic opioid starts
2. Treat addiction when present
3. Prevent overdose

CASE AH

23 year old female with a history of heroin use presents with feelings of hopelessness and suicidal thoughts.

CASE AH

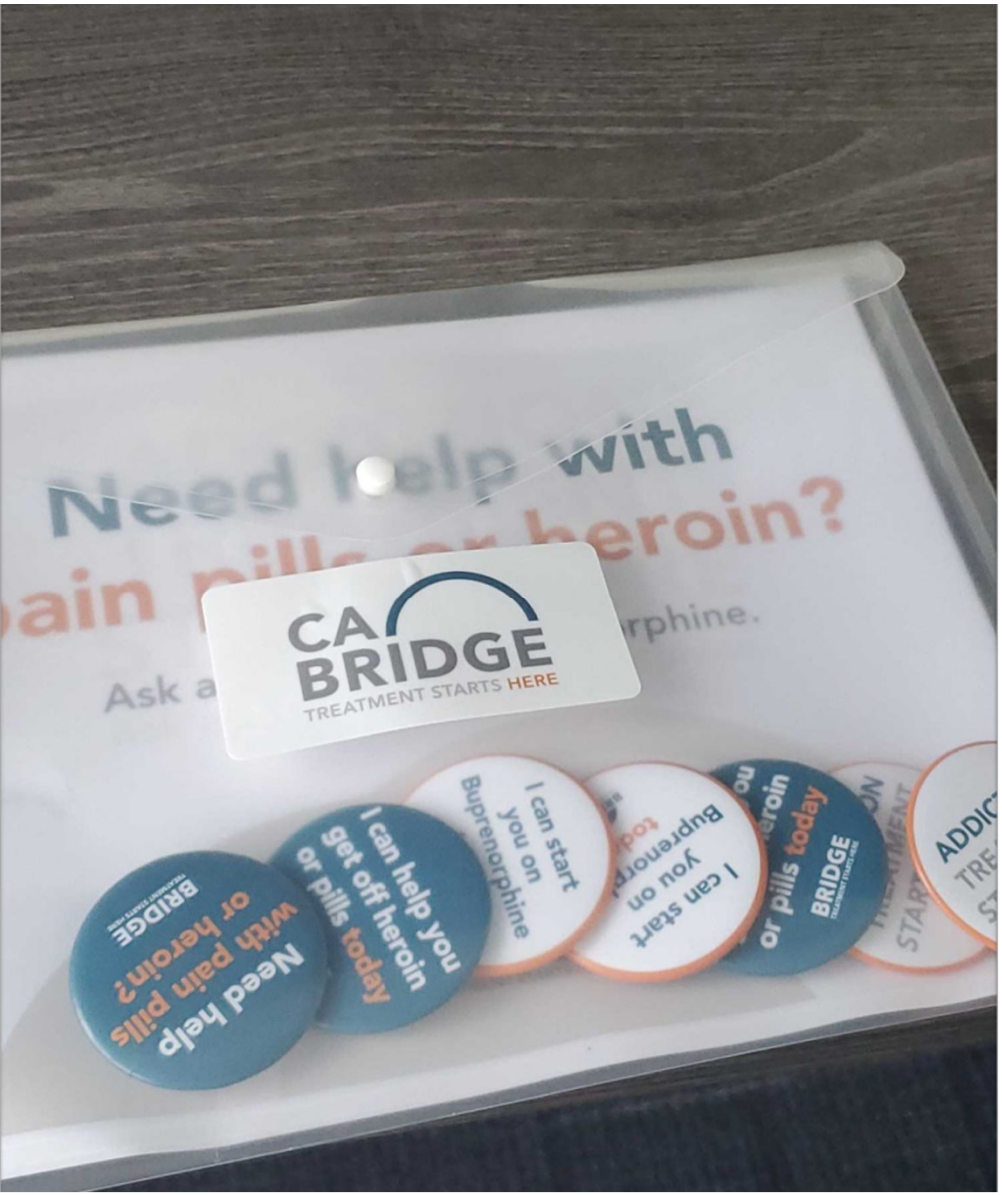
- AH is evaluated in the ED and placed on an involuntary hold for suicidal ideations associated with heroin use
- AH has opiate withdrawal and starts Buprenorphine in the ED
- AH transferred to inpatient psychiatric facility

CASE AH

- AH is taken off Buprenorphine at the inpatient psychiatric facility
- AH has nausea and vomiting from opiate withdrawal
- AH gets clonidine and ibuprofen for opiate withdrawal
- AH is still vomiting in opiate withdrawal
- and now hypotensive….

CASE AH

- AH is sent back to the ED for medical clearance
- AH is diagnosed with opiate withdrawal and treated with Buprenorphine
- AH discharged from ED to residential treatment program for opiate use disorder

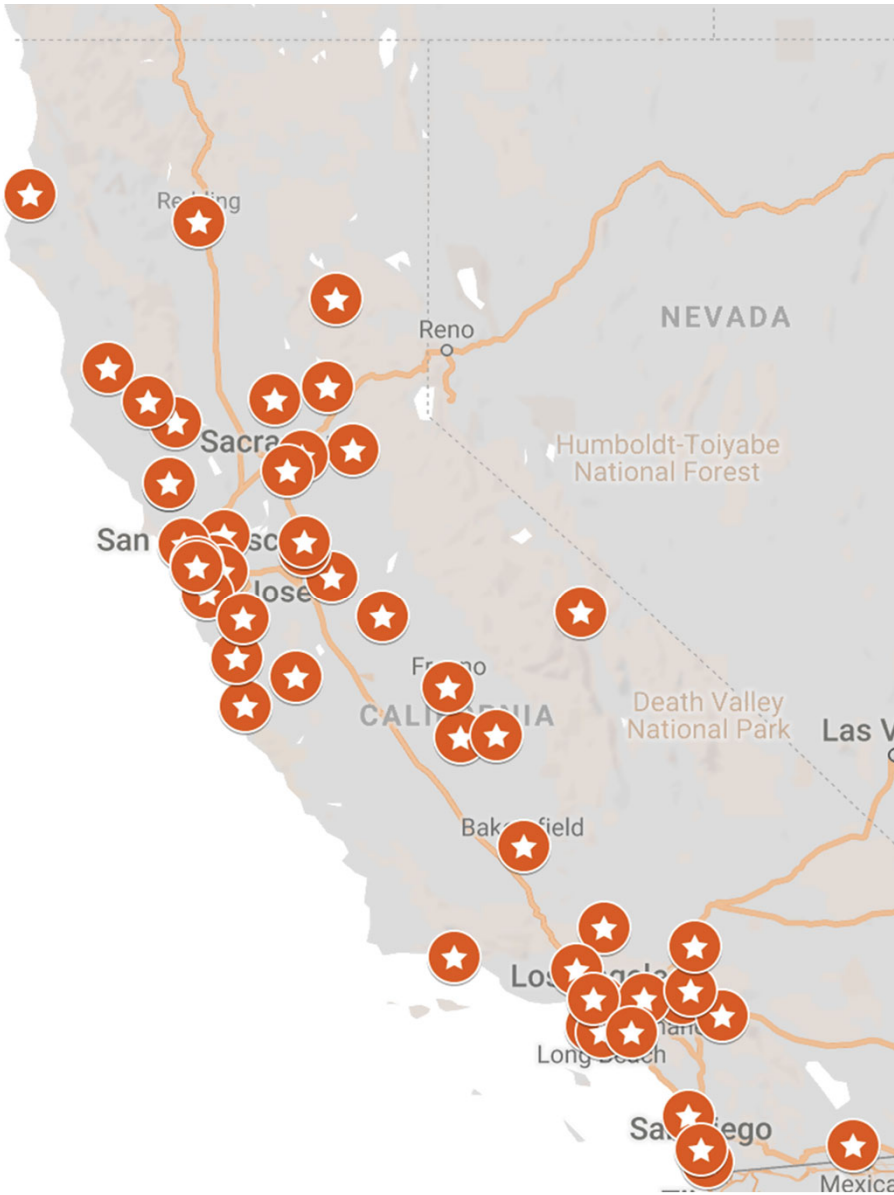


Treatment Starts HERE

CALIFORNIA BRIDGE PROGRAM

24-7 access to high quality treatment of substance use disorders in all California hospitals.

Now 50+ hospitals as the access point for patients with substance use disorders.



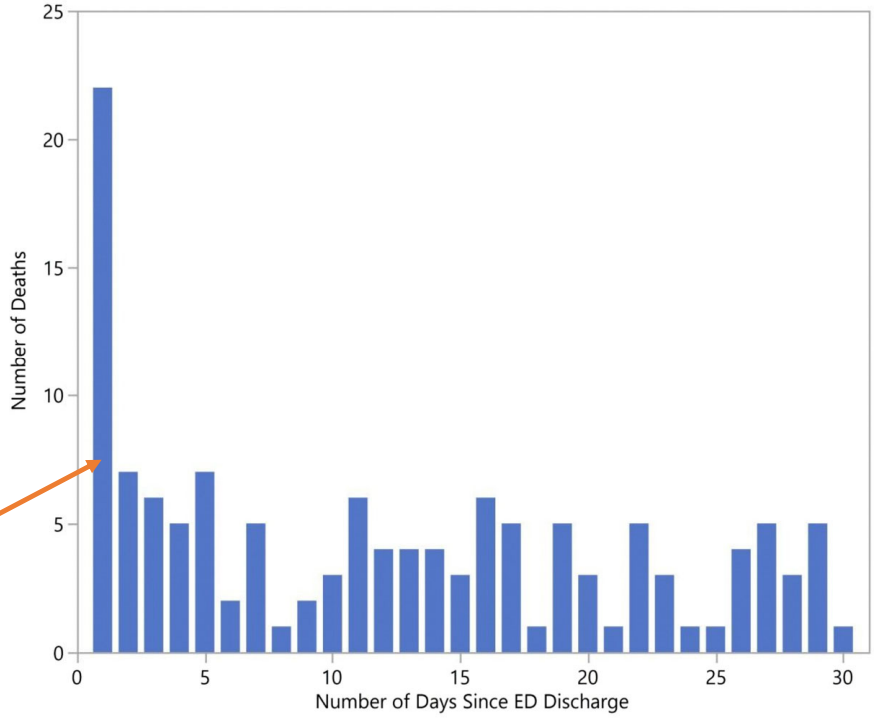
CA BRIDGE DELIVERS ADDICTION TREATMENT WHEN IT MATTERS MOST

One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose

Scott G. Weiner, MD, MPH[a,*], Olesya Baker, PhD[a], Dana Bernson, MPH[b], Jeremiah D. Schuur, MD, MHS[c]

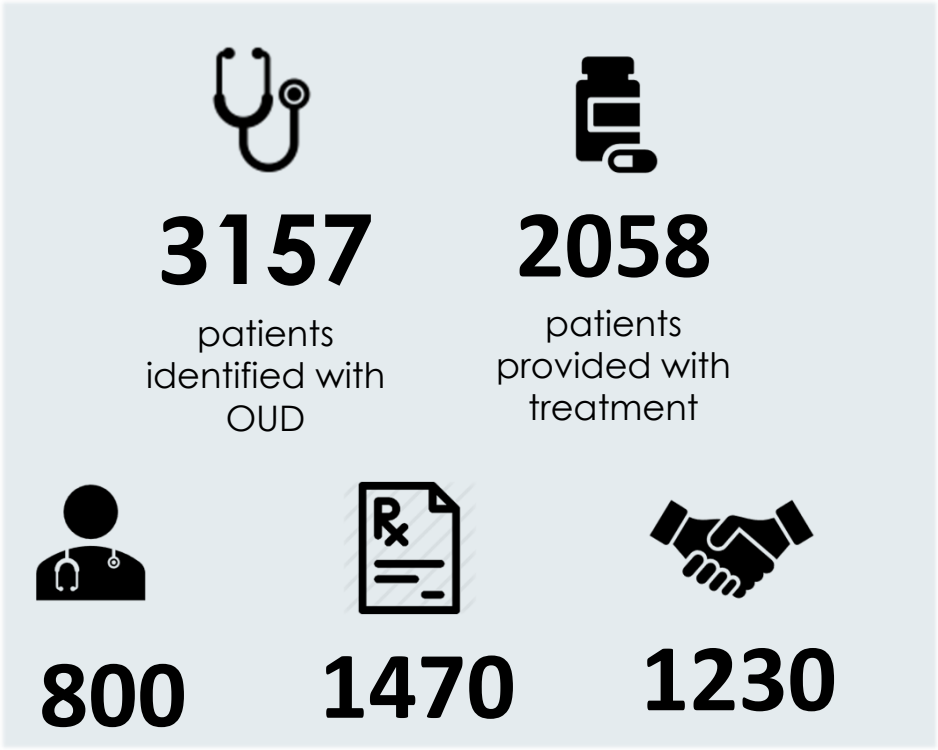
- Study of patients treated in Massachusetts EDs for opioid overdose 2011-2015
- Illustrates the short-term increase in mortality risk post-ED discharge
  - Of patients that died, 20% died in the first month
  - Of those that died in the first month, 22% died within the first 2 days

Number of deaths after ED treatment for nonfatal overdose by number of days after discharge in the first month (n=130)



Source: Weiner, Scott, et al.. *One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose*. Annals of Emergency Medicine. April 2, 2019.

CHANGING LIVES, CHANGING HEALTH CARE



OUD Opioid Use Disorder; **MAT** Medication for Addiction Treatment

BUPRENORPHINE

- Partial opioid agonist
- High affinity for the mu-Opioid receptor
- SL takes effect in 15min, Peak action 1 hour
- Approved for treatment of withdrawal, reducing physical cravings

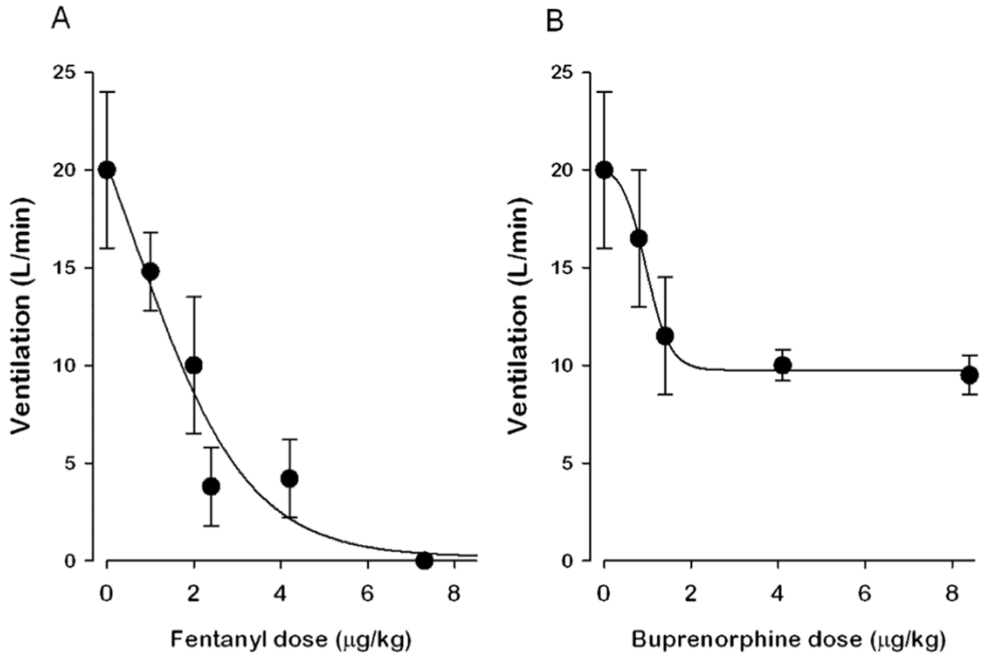
CEILING ON RESPIRATORY DEPRESSION

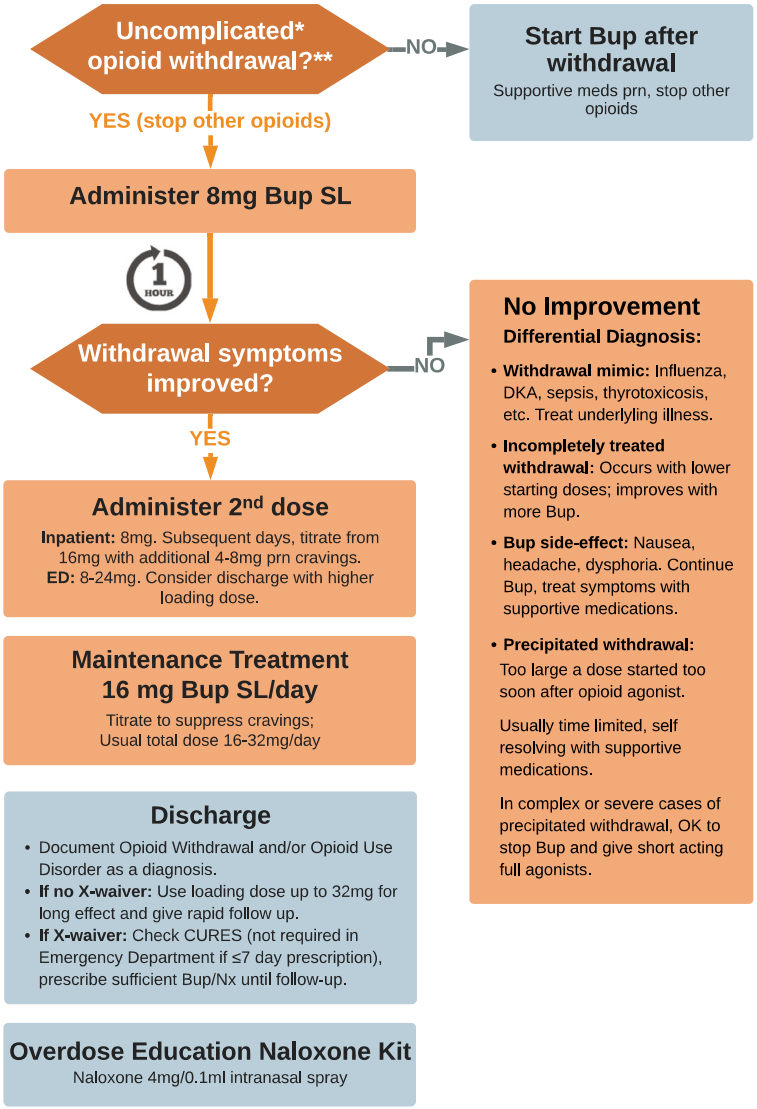
British Journal of Anaesthesia **96** (**5**): 627–32 (2006)
doi:10.1093/bja/ael051 Advance Access publication March 17, 2006

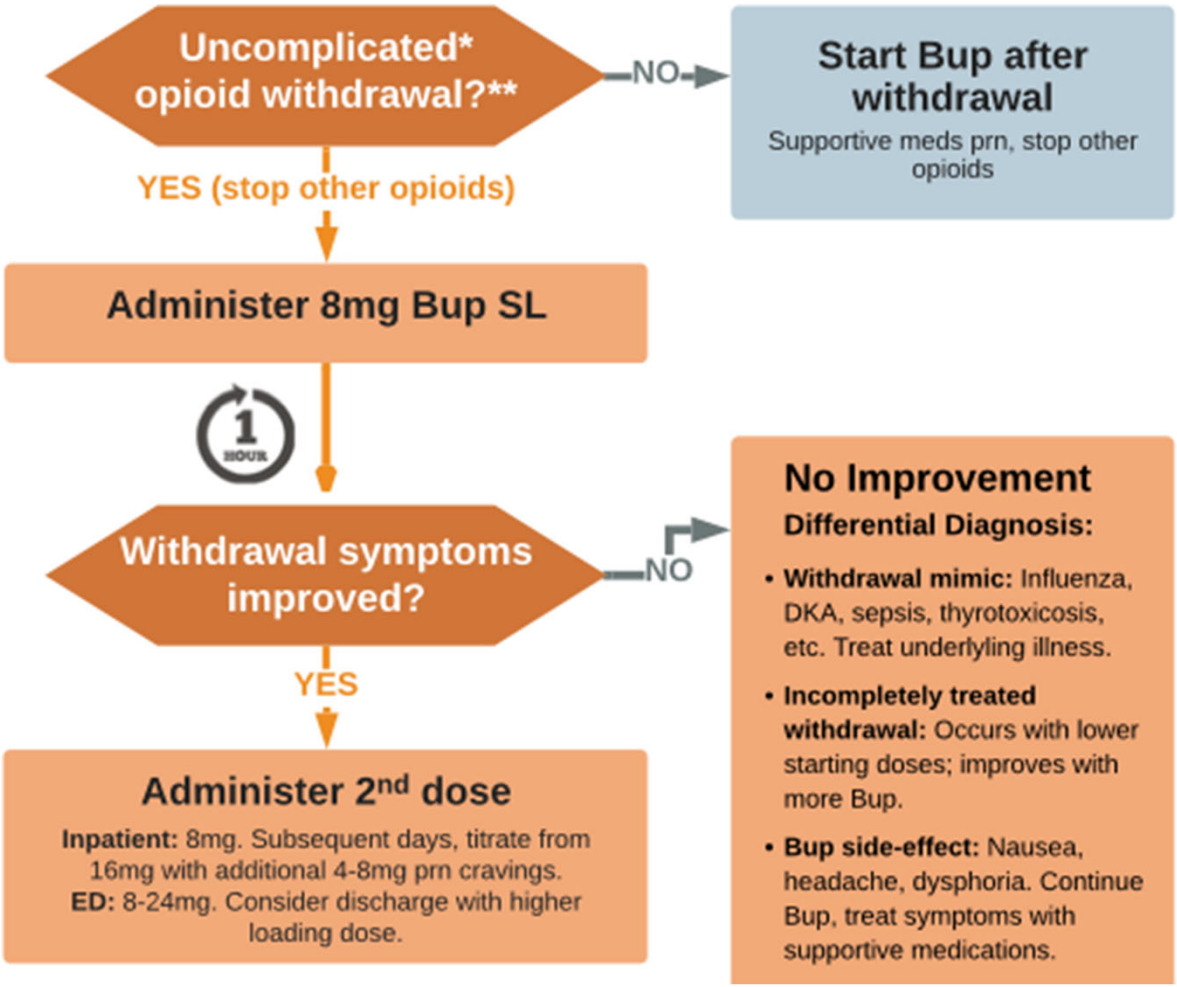
BJA

Buprenorphine induces ceiling in respiratory depression but not in analgesia

A. Dahan[1]*, A. Yassen[2], R. Romberg[1], E. Sarton[1], L. Teppema[1], E. Olofsen[1] and M. Danhof[2]




Uncomplicated* opioid withdrawal?**
NO
Start Bup after withdrawal
Supportive meds prn, stop other opioids
YES (stop other opioids)
Administer 8mg Bup SL
1 HOUR
Withdrawal symptoms improved?
NO
YES
No Improvement
Differential Diagnosis:
• Withdrawal mimic: Influenza, DKA, sepsis, thyrotoxicosis, etc. Treat underlying illness.
• Incompletely treated withdrawal: Occurs with lower starting doses; improves with more Bup.
• Bup side-effect: Nausea, headache, dysphoria. Continue Bup, treat symptoms with supportive medications.
• Precipitated withdrawal:
Too large a dose started too soon after opioid agonist.
Usually time limited, self resolving with supportive medications.
In complex or severe cases of precipitated withdrawal, OK to stop Bup and give short acting full agonists.
Administer 2nd dose
Inpatient: 8mg. Subsequent days, titrate from 16mg with additional 4-8mg prn cravings.
ED: 8-24mg. Consider discharge with higher loading dose.
Maintenance Treatment
16 mg Bup SL/day
Titrate to suppress cravings;
Usual total dose 16-32mg/day
Discharge
• Document Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.
• If no X-waiver: Use loading dose up to 32mg for long effect and give rapid follow up.
• If X-waiver: Check CURES (not required in Emergency Department if ≤7 day prescription), prescribe sufficient Bup/Nx until follow-up.
Overdose Education Naloxone Kit
Naloxone 4mg/0.1ml intranasal spray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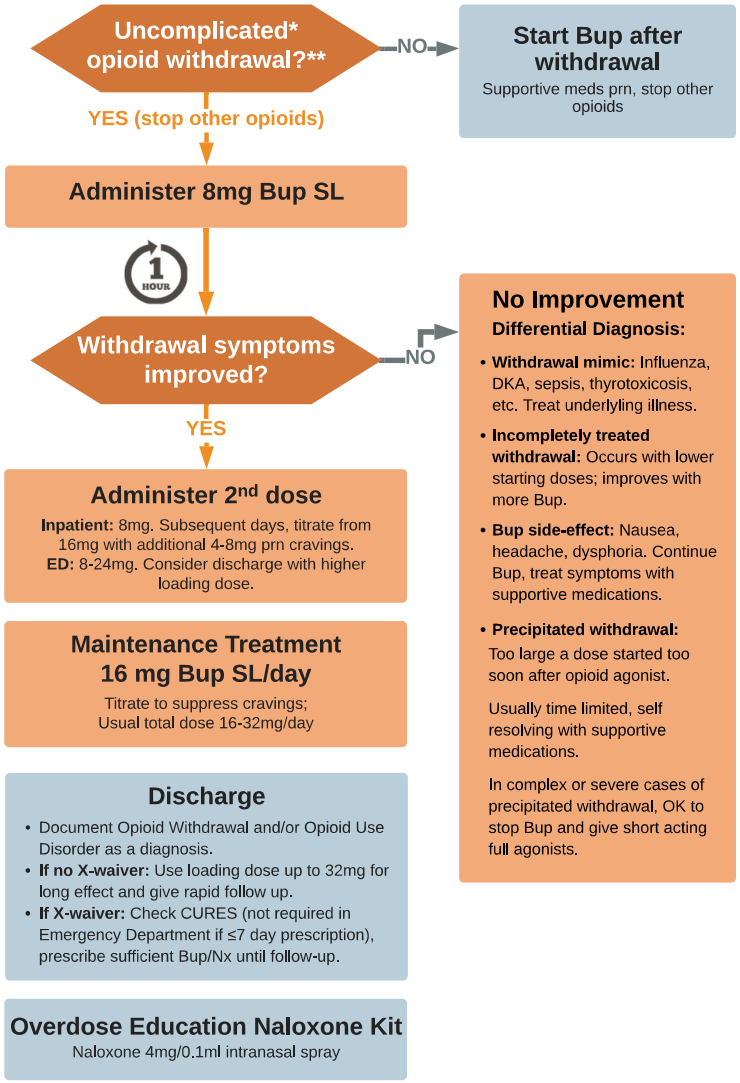
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OPENING DOORS TO TREATMENT

Substance Use Navigators:

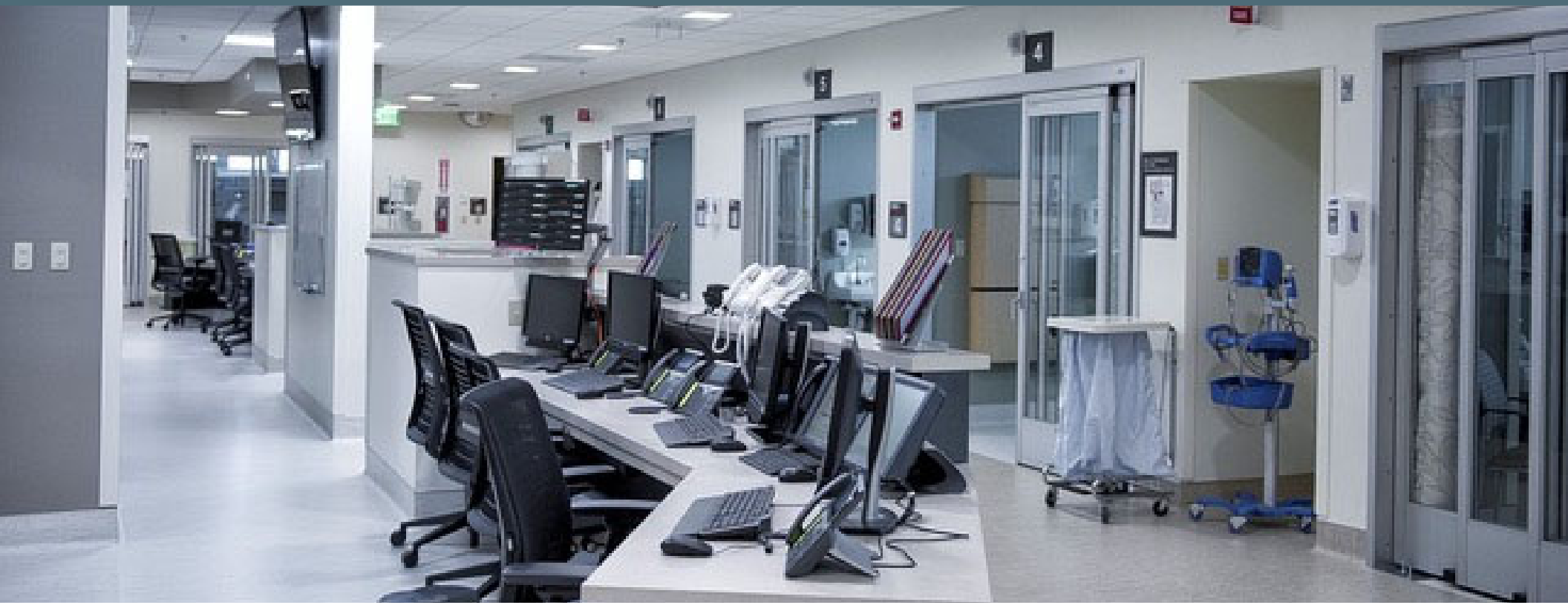
- Friendly face
- Similar experience
- Understand treatment resources

But isn’t this illegal…?

DEA REGULATIONS

- If patient is admitted for a medical or surgical reason other than opioid dependency:
  - Methadone and buprenorphine can be administered to maintain or detoxify, including new starts
- If the patient presents to ED or urgent care in withdrawal:
  - Legal to administer 72 hours of methadone or buprenorphine to treat withdrawal
- On discharge, regular rules apply

We don’t have any X waivered providers…



Saving Lives Building Community Resources

CA BRIDGE
TREATMENT STARTS HERE

Need help with pain pills or heroin?

We want to help you get off opioids and started on Suboxone (Buprenorphine).

Ask for more information here.

Thank You

Aimee Moulin
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Arianna Sampson
asampson@usacs.com

CALIFORNIA HOSPITAL ASSOCIATION
Center for Behavioral Health

Questions?

Raise your hand or submit a question at www.menti.com and enter code 95 34 60

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