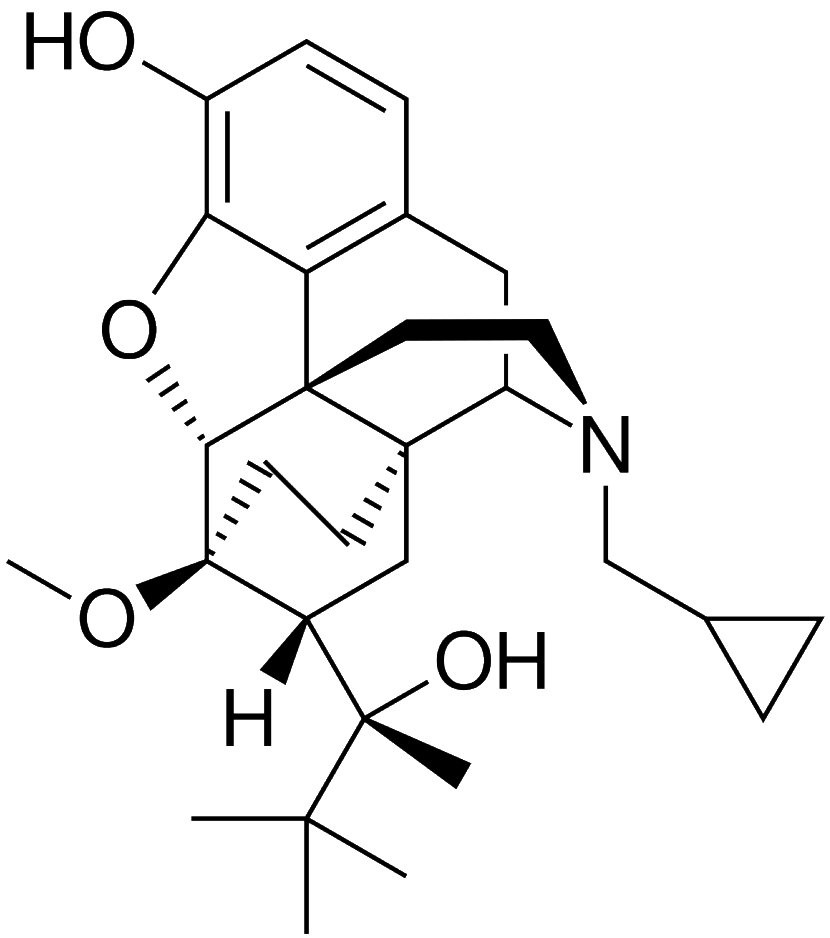


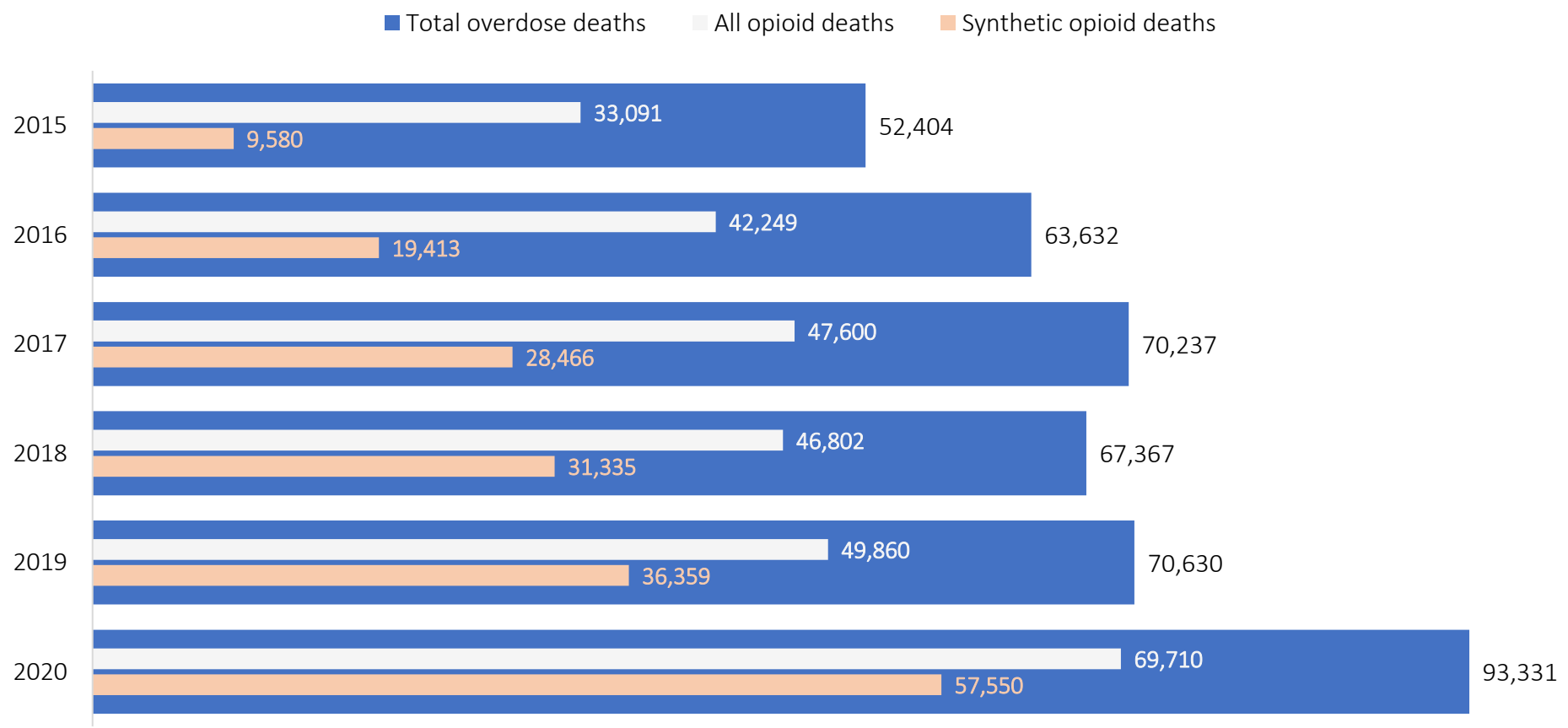
It's easier than you think: Helping patients with opioid use issues in the ER

Kent Tarro, MA

Macoupin County Public Health Department

Overdose deaths exploded to more than 90,000 in 2020, and synthetic opioids were involved in more than 60 percent of all overdose deaths.

Annual drug overdose deaths



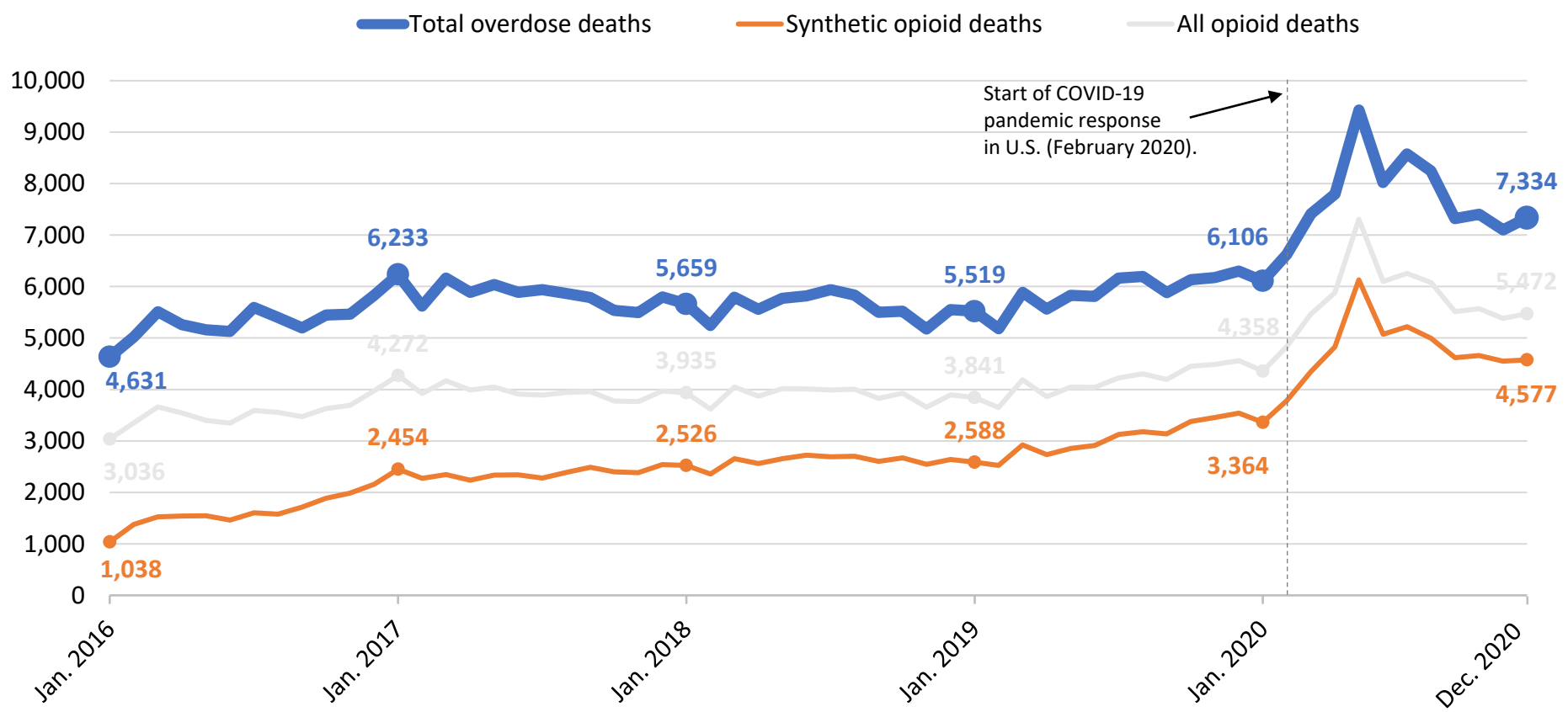
Note: Synthetic opioid deaths exclude those from methadone. Specific drug-class deaths are not mutually exclusive, as some deaths are attributable to multiple drug types.

Data: 2015–2019 — Final data from CDC WONDER; 2020 — National Vital Statistics System, Provisional Drug Overdose Death Counts, Dec. 2020 predicted totals (not final data, subject to change).

Jesse C. Baumgartner and David C. Radley, "The Drug Overdose Mortality Toll in 2020 and Near-Term Actions for Addressing It," *To the Point* (blog), Commonwealth Fund, July 15, 2021, updated Aug. 16, 2021.

Overdose deaths spiked at the start of the pandemic and stayed high through the end of 2020.

Monthly drug overdose deaths



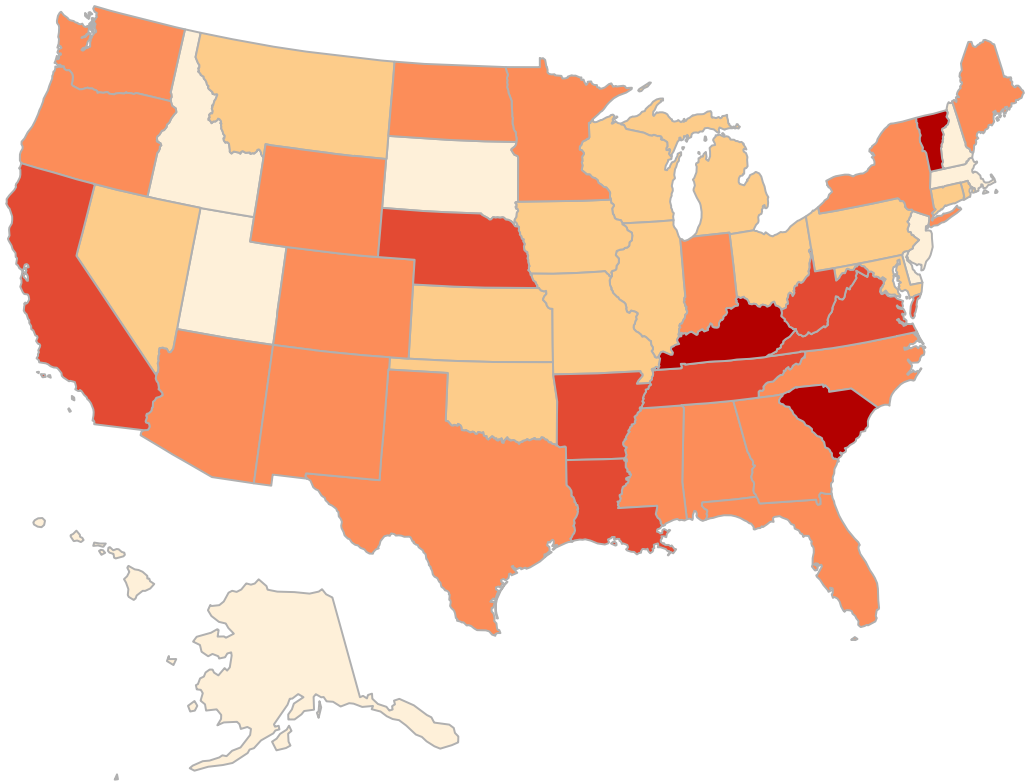
Note: Synthetic opioid deaths exclude those from methadone. Specific drug-class deaths are not mutually exclusive, as some deaths are attributable to multiple drug types.

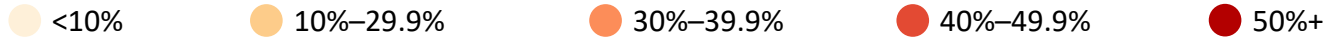
Data: 2016–2019 monthly totals — Final data from CDC WONDER; Estimated 2020 monthly totals — Calculations based on National Vital Statistics System, Provisional Drug Overdose Death Counts (see Data and Methods for details).

Jesse C. Baumgartner and David C. Radley, "The Drug Overdose Mortality Toll in 2020 and Near-Term Actions for Addressing It," *To the Point* (blog), Commonwealth Fund, July 15, 2021, updated Aug. 16, 2021.

Overdose deaths increased significantly in almost every state during 2020.

Estimated percent increase in provisional overdose deaths, Jan.–Dec. 2020 vs. Jan.–Dec. 2019





Note: Categories represent percent increase for provisional predicted overdose deaths in 2020 vs. 2019. Predicted totals from the Centers for Disease Control and Prevention are not final data and are subject to change. The District of Columbia had an estimated increase of 39%, South Dakota had an estimated decrease of –16%, and New Hampshire had an estimated decrease of –1%.

Data: National Vital Statistics System, Provisional Drug Overdose Death Counts.

Jesse C. Baumgartner and David C. Radley, "The Drug Overdose Mortality Toll in 2020 and Near-Term Actions for Addressing It," *To the Point* (blog), Commonwealth Fund, July 15, 2021, updated Aug. 16, 2021.

We are building a system of care

- Assessment and crisis care
- Medical Detox
- Residential/Inpatient
- Transitional/Recovery Housing
- Family Support
- Outpatient
- Recovery Services – Living Room Communities

Medical providers play a pivotal role

- Provide Buprenorphine, a schedule III opioid medication for opioid use disorder
- If have X-waiver/DATA 2000 license – prescribe buprenorphine for patient to take outside of the medical setting or administer buprenorphine within a medical setting, which are valid up to 6 months, can do up to 5 refills
  - They can add buprenorphine to hospital pharmacy formulary
- If don’t have X-waiver/DATA 2000 license – order buprenorphine for immediate administration while in emergency room settings

What does buprenorphine do for your patients?

- Many people say that their cravings and withdrawal go away, they feel “clear in the head,” and their chronic pain gets better.
- Every morning you put a pill or a film strip under your tongue and let it dissolve—don’t swallow it.
- People need to take it every day in most cases, and do feel sick if they stop taking it suddenly.
- Usually there are no side effects, but some people have headaches, stomach upset, or trouble sleeping.
- Many people keep taking it for years, or forever. If you want to stop taking it that is ok, but talk to your medical team first.
- The chance of an overdose on buprenorphine is very low, but if mixed with other drugs or alcohol overdose is possible.
- Some people take buprenorphine as a once a month shot under the skin of the belly. This is a great option if taking a medicine every day is hard for you.

Buprenorphine Options

- Takes about 15 minutes to act and peaks in 1 hour
- Rates of adverse events following initiation of buprenorphine very low bc has a “ceiling effect” but caution patients against also using benzodiazepine or alcohol
- Most common form are sublingual as mono-product (i.e., Subutex) or in combination with naloxone (Suboxone).
  - Suboxone includes naloxone component – a deterrant that becomes inert when the tablet is taken sublingually; naloxone is only active if the table is injected or snorted.
- Can also be transdermal for pain (i.e., Butrans), intravenous for pain (Burpenex), buccal for pain (Belbuca),
- Transmucosal or subcutaneous for opioid use disorder (Subocade)

Buprenorphine (Bup) Emergency Department Quick Start

CA BRIDGE

Abstinence and onset of withdrawal

Objective uncomplicated opioid withdrawal*

NO →

Rx self-directed ("home") start:
Wait for severe withdrawal then start with 8 mg SL. Rx per "Discharge" box below

Administer 8-16 mg bup SL

1 HOUR

Withdrawal improved?

NO →

If no improvement or worse consider:

Undertreated withdrawal: Occurs with lower starting doses and heavy tolerance; improves with more bup (add'l 8-16 mg SL).

Other substance intoxication or withdrawal: Stimulant intoxication, alcohol/benzo/xylazine/GHB withdrawal. Continue bup; manage additional syndromes.

Bup side-effects: Nausea, headache, dysphoria. Continue bup, treat side-effects with supportive medications.

Other medical/psychiatric illness: Anxiety, sepsis, influenza, DKA, thyrotoxicosis, etc. Continue bup, manage underlying condition.

If sudden/significant worsening, consider precipitated withdrawal: See box below.

YES

Administer 2nd dose
Additional 8-16 mg SL bup for total daily dose of 16-32 mg

Discharge

- **If prescriber has X-waiver:** Prescribe sufficient bup/nx until follow-up: e.g., buprenorphine/naloxone 8/2 mg SL films 2-4 films qday #32-64, 0 refills (may Rx more PRN). Notes to pharmacy: bill Medi-Cal FFS, ICD 10 F11.20, X DEA # ____.
- **If no X-waiver:** Use loading dose up to 32 mg SL for long effect and give rapid follow up (<72 h).
- **Dispense naloxone** from the ED (not just prescribed): e.g., naloxone 4 mg IN spray #2.
- **Document** Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.

Treatment of precipitated withdrawal

Precipitated withdrawal is a sudden, significant worsening of withdrawal after bup or full antagonist (e.g., naloxone).

Administer additional 16 mg SL bup immediately.
Reassess in 30-60 minutes. If continued distress remains: Repeat 8-16 mg bup SL.

If precipitated withdrawal not resolved by bup:

Consider alpha-2 agonists (clonidine or dexmedetomidine), antipsychotics (e.g., haloperidol), cautious use of benzodiazepines (e.g., 1-2 mg PO lorazepam x 1), high potency opioid (e.g., fentanyl 100-200 mcg IV q30 or infusion), or ketamine (0.3 mg/kg IV slow push q30 minutes or continuous infusion until calm). Once withdrawal is managed, continue daily bup dose.

We encourage shared decision making with patient for dosing.

*** Opioid Withdrawal:**

At least one clear objective sign (prefer ≥ 2): Tachycardia, mydriasis, yawning, rhinorrhea, vomiting, diarrhea, piloerection. **Ask the patient if they are in bad withdrawal** and if they feel ready to start bup. If they feel their withdrawal is mild, it is too soon.

If unsure, use COWS (clinical opioid withdrawal scale). Start if COWS ≥ 8 AND objective signs.

Typical withdrawal onset >12 hours after last short acting opioid use (excluding fentanyl); variable after last use of fentanyl or methadone (may be >72 hours).

Start protocol may vary for complicating factors:

- Altered mental status, delirium, intoxication
- Severe acute pain, trauma, or planned large surgery
- Organ failure or other severe medical illness (decompensated heart failure, respiratory distress, hemodynamically unstable, etc.)
- Recent methadone use
- Minimal opioid tolerance (consider lower dosing)

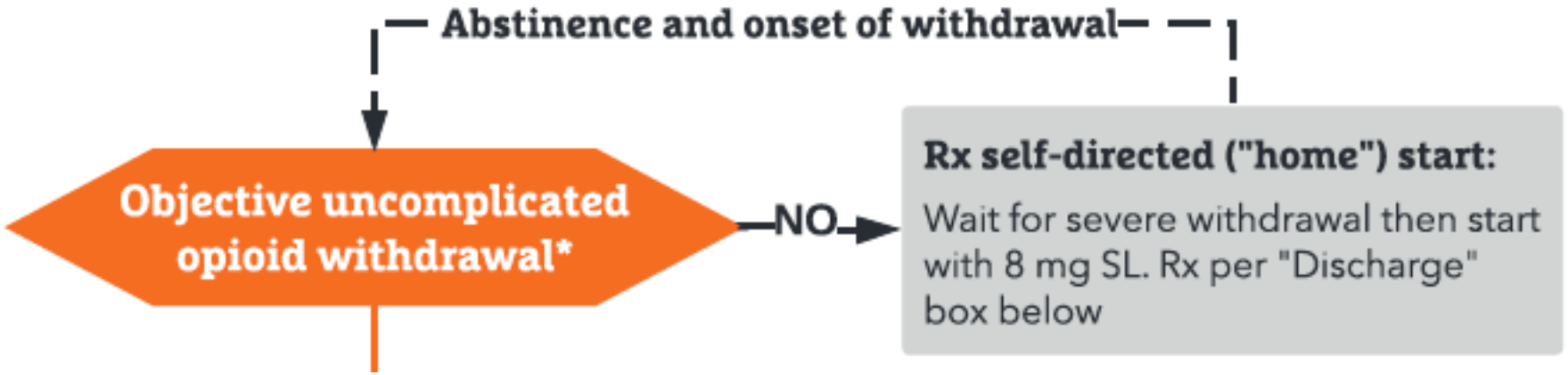
Most people who use fentanyl do well with starts following this guide. For fentanyl specific initiation questions, see Fentanyl FAQ.

If patient has already completed withdrawal (no longer symptomatic withdrawal, often >72 hrs from last use of opioids) and wants to start bup: give bup 8 mg SL q6h PRN cravings, usual dose 16-32mg/day. After first day, consolidate dosing to daily.

Bup dosing notes

This guidance is for the ED. We advocate for continuation & initiation of bup in inpatient and outpatient settings. Algorithms vary based on clinical scenario.

- Any prescriber can order bup in the ED/hospital. X-waivers are only needed for discharge Rx.
- Either bup or bup/nx (buprenorphine/naloxone) SL films or tab are OK. If chronic pain, may split dose TID-QID.
- Bup monoproduct or bup/nx OK in pregnancy. See Buprenorphine Quick Start in Pregnancy.
- Pause opioid pain relievers when starting Bup. OK to introduce opioid pain relievers after bup is started if patient has acute pain.



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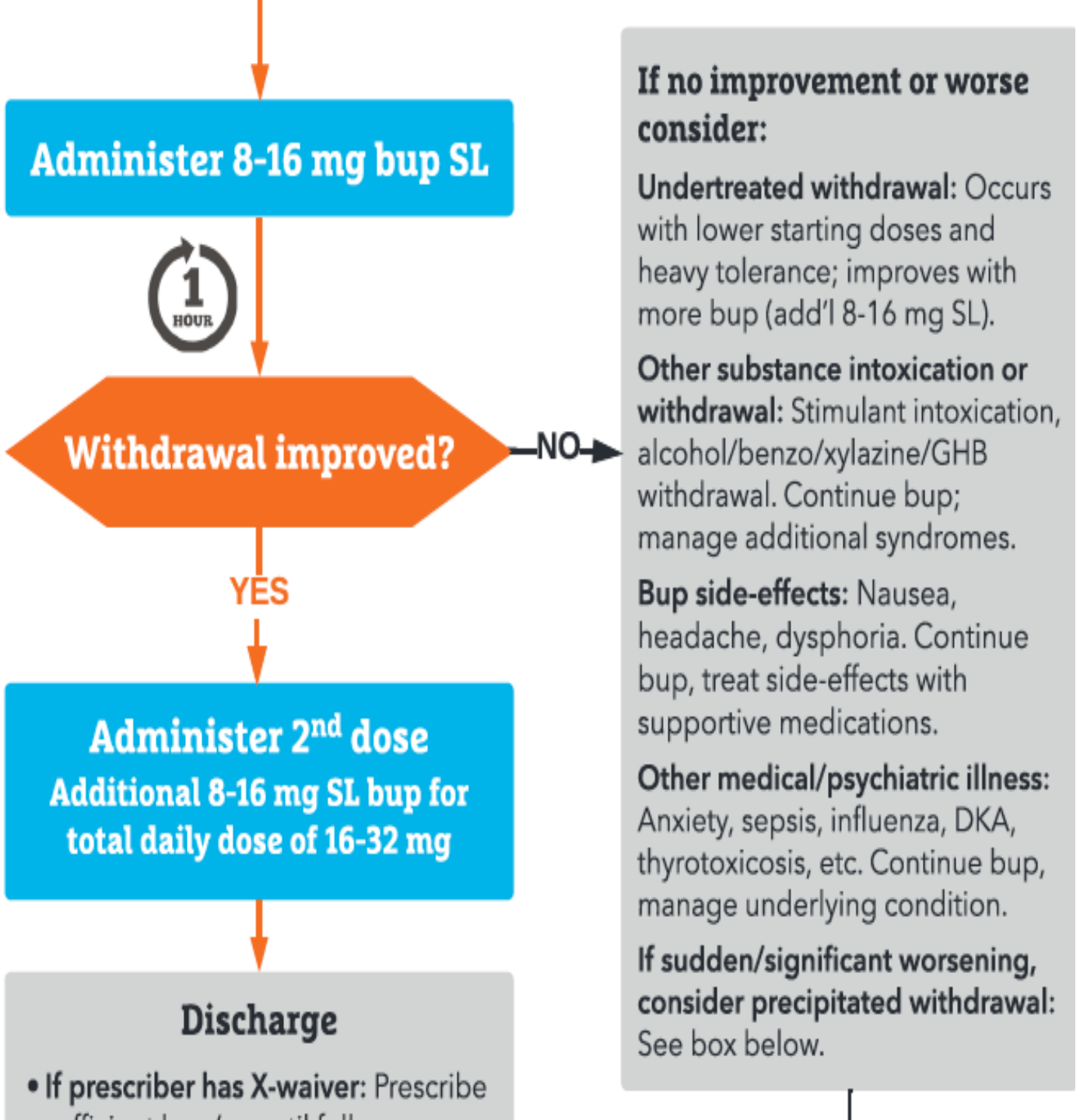
- Ask patient if they are in bad withdrawal and if they feel ready to start bup. If they feel their withdrawal is mild, it is too soon
- If unsure, use (COWS) clinical opioid withdrawal scale). Start if COWS=8+ AND objective signs
  - Resting Pulse Rate
  - Sweating
  - Restlessness
  - Pupil size, etc.
- Typical withdrawal onset >12 hours after opioid use and as much as 72 hours for fentanyl/methadone



Start protocol may vary for complicating factors

- Altered mental status, delirium, intoxication
- Severe acute pain, trauma or large surgery
- Organ failure or other severe medical illness
- Recent methadone use
- Minimal Opioid tolerance (consider lower dose)
- Fentanyl use

If patient already completed withdrawal (>72 h) and wants to start bup – give 8 mg SL q6h PRN

Bup dosing notes

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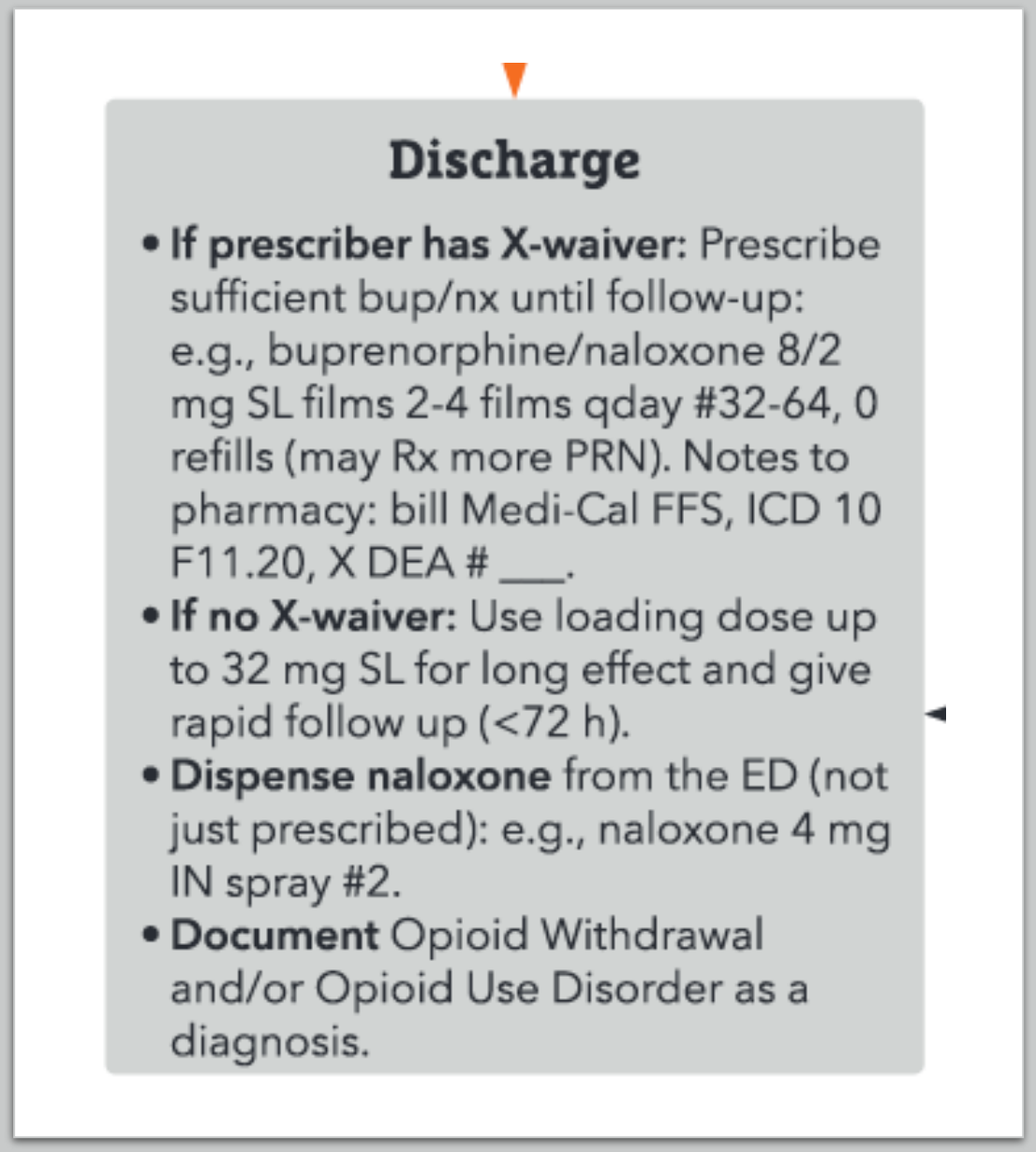

Treatment of precipitated withdrawal

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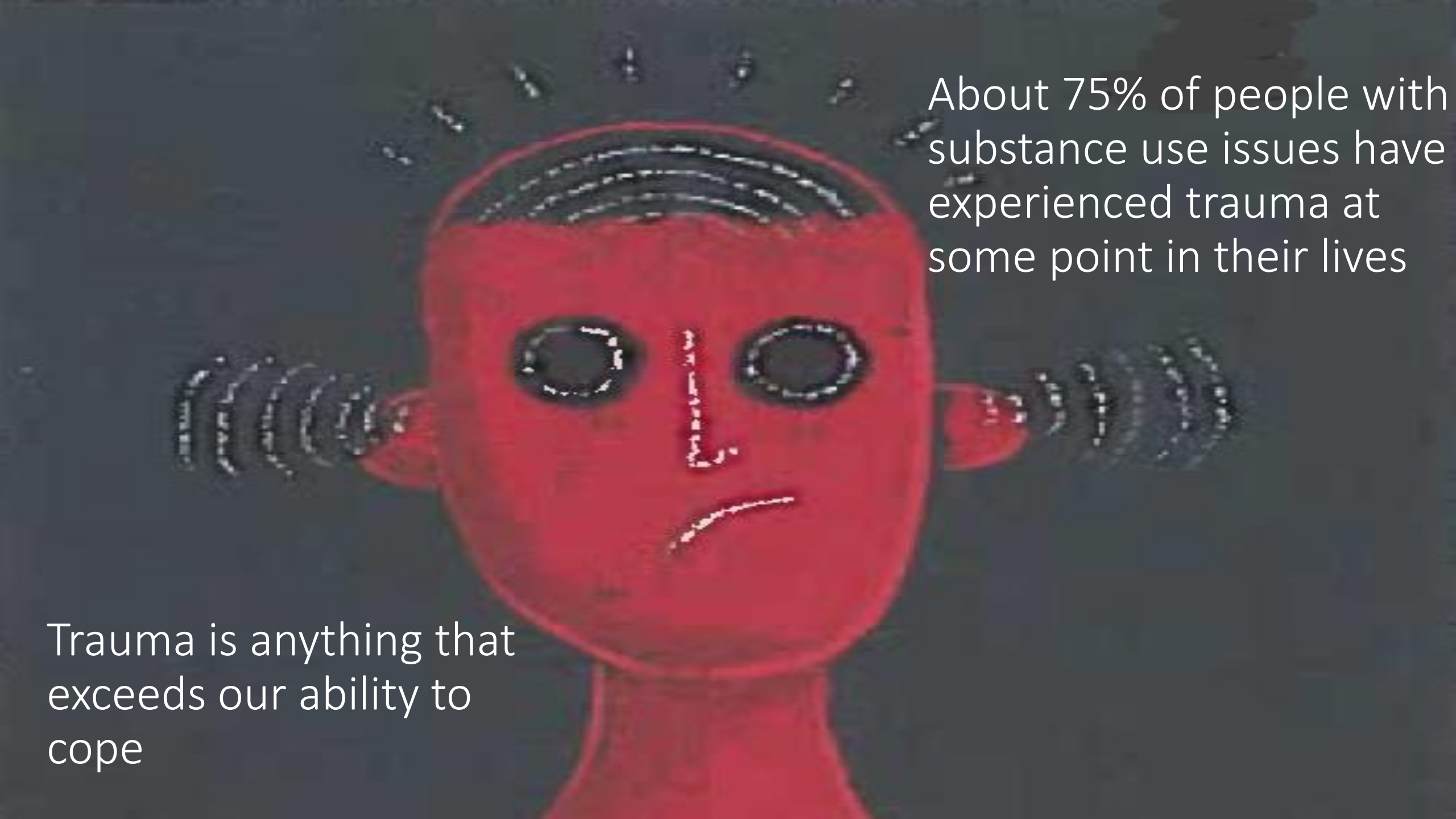
Consider alpha-2 agonists (clonidine or dexmedetomidine), antipsychotics (e.g., haloperidol), cautious use of benzodiazepines (e.g., 1-2 mg PO lorazepam x 1), high potency opioid (e.g., fentanyl 100-200 mcg IV q30 or infusion), or ketamine (0.3 mg/kg IV slow push q30 minutes or continuous infusion until calm). Once withdrawal is managed, continue daily bup dose.

OK, so what's next?

Client situation -



About 75% of people with substance use issues have experienced trauma at some point in their lives

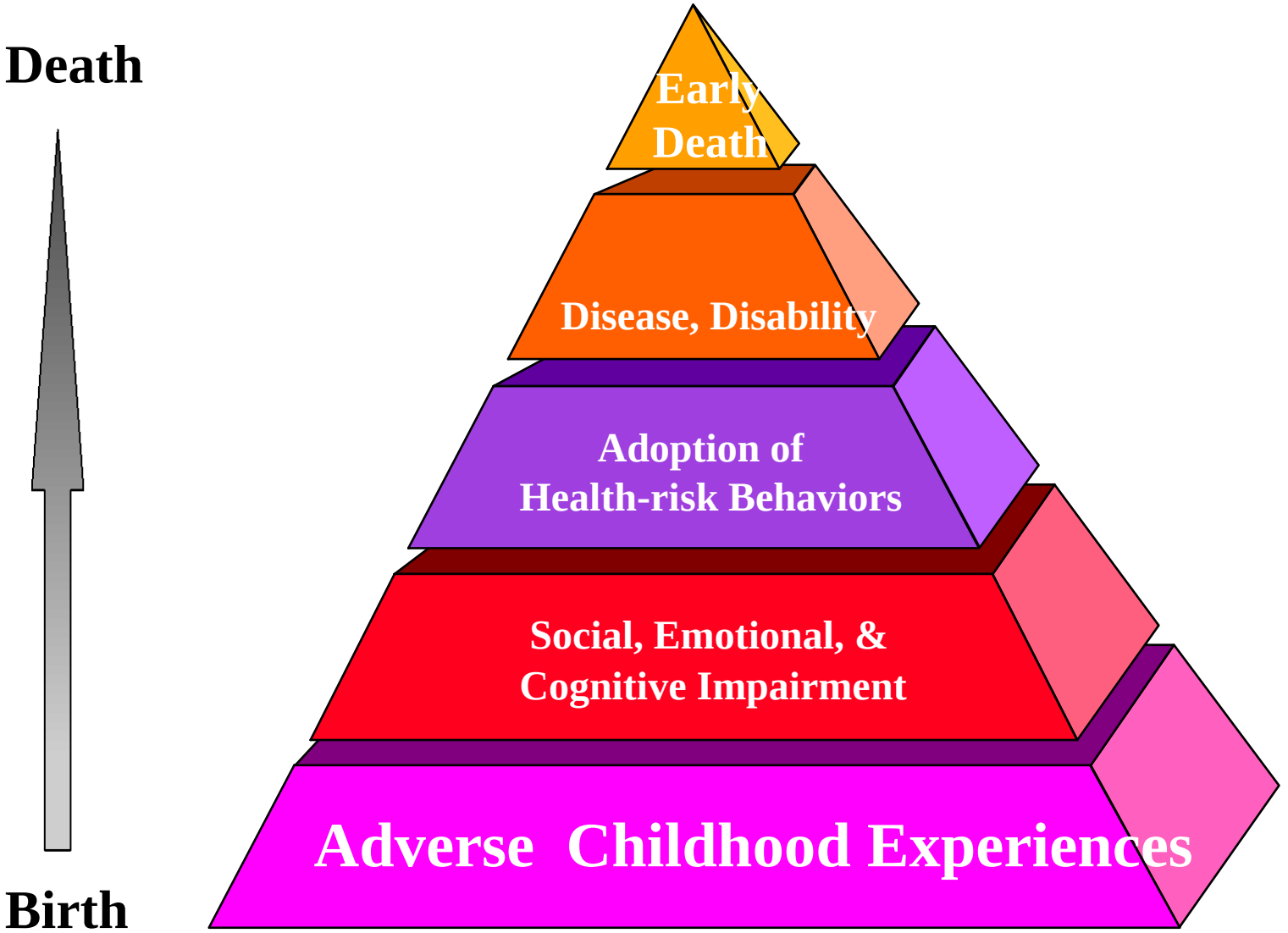
Trauma is anything that exceeds our ability to cope

- Acute Stress Disorder 1st month (6-33%)
- (80% go on to have PTSD)
  - Symptoms of chronic hyperarousal – a resetting of the way central nervous system responds to minor stress
  - Re-experiencing – flashbacks, memory problems
  - Avoidance – emotional numbing, avoiding anything that reminds you of the stressor

Why is trauma harmful?

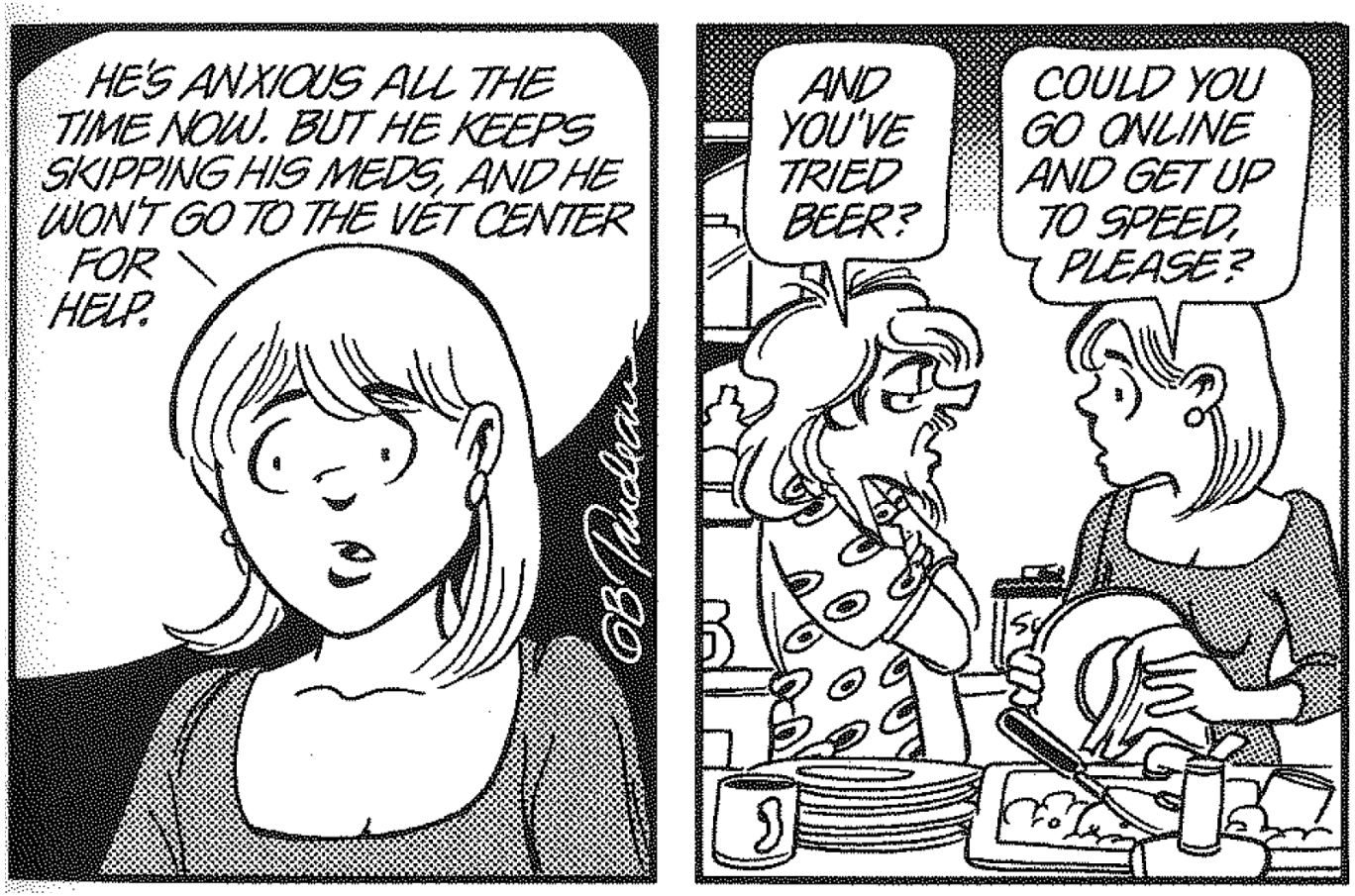
If you have PTSD you are:

- 6x more likely to have other psychiatric disorder
- 8x more likely to have 3 or more psychiatric disorders
- 90x to have somatization disorder
- 2-3 x more likely to have substance use problems



The Influence of Adverse Childhood Experiences Throughout Life

What about substance abuse clients?



Pathways between PTSD and Substance Use

Substance abuse → PTSD

- More common among illicit users – cocaine, herion because have to put self in dangerous situations
- Chronic substance use can also lead to higher levls of arousal, anxiety and sensitization of neurobiological stress symptoms which increases risk of PTSD

PTSD → Substance Abuse

- Self Medication Hypothesis – individuals use substances as a way to treat symptoms of mental disorders
- Traumatized pop use alcohol, marijuana, opioids, benzo to both deal with trauma and to alleviate symptoms of PTSD
- Traumatized individuals report escalation of substance and PTSD entertwined
- As these people attempt to withdrawl from substance use, physiological arousal prompts them to relapse back into patterns of self medicaiton

Self Medication hypothesis

Drinking is part of military culture and regarded as an instrument to cope with distress (Ames & Cunradi, 2004).

Well established that combat exposure associated with increased alcohol use and other mental health issues (See Carter & Capone, 2011 for review).

As many of 20% of American with PTSD use substances to self medicate. Alcohol is particularly effective in improving PTSD symptoms according to respondents (Leeis et al., 2010).

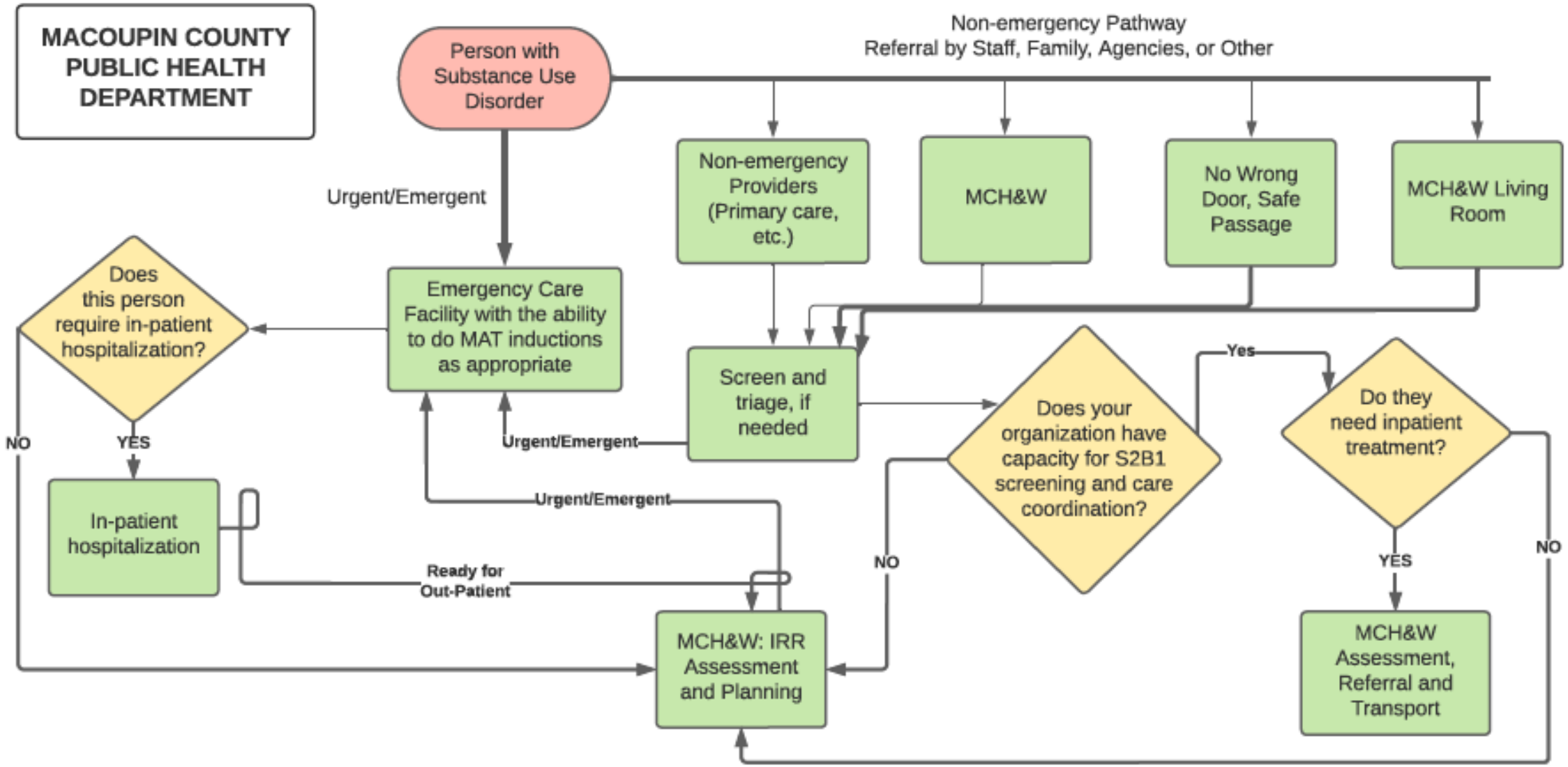
Studies also show that among Vietnam veterans, alcohol was used as a method of coping with fear and threat on the battlefield and enduring feelings of tension at post deployment (McFarlene, 1998).

Competing Neurobehavioral Decision System

- Competing regions of brain control decision making
- These regions become dysregulated by stressors like trauma
- When these regions are dysregulated, individuals have lowered capacity to inhibit impulses and thus are more likely to discount more readily
- Thus when given a choice between addictive substances (which make them feel good in the short term) and tx (which wll make them feel good in the long term), they are more likely to chose the former, especially when the trauma stressor is more recent.

But I don’t know how to handle all this? This is not in my scope of practice.

Solution: Call Safe Passages


MACOUPIN COUNTY PUBLIC HEALTH DEPARTMENT
Person with Substance Use Disorder
Non-emergency Pathway
Referral by Staff, Family, Agencies, or Other
Urgent/Emergent
Non-emergency Providers (Primary care, etc.)
MCH&W
No Wrong Door, Safe Passage
MCH&W Living Room
Does this person require in-patient hospitalization?
Emergency Care Facility with the ability to do MAT inductions as appropriate
Screen and triage, if needed
Does your organization have capacity for S2B1 screening and care coordination?
Yes
Do they need inpatient treatment?
NO
YES
Urgent/Emergent
Urgent/Emergent
In-patient hospitalization
Ready for Out-Patient
NO
YES
NO
MCH&W: IRR Assessment and Planning
MCH&W Assessment, Referral and Transport

What happens when I call safe passages?

- Screening for inpatient and outpatient treatment
- Transportation to treatment depending on need
- Crisis housing and recovery housing
- Mental Health Services
- Outpatient Substance Treatment
- Recovery coaching
- Living Room and Respite Care
- Involvement in a supportive recovering community

Macoupin and Montgomery County's Recovery Oriented System of Care

Local Hospitals	Mental Health Providers and Organizations	Health Departments	Health Centers and Clinics	Probation/Parole
Drug Courts	State's Attorneys	Law Enforcement	Schools	Local Businesses
Churches	Ministers/Faith Based Leaders	Addiction Treatment Providers	Recovery Providers	Local Government Officials
	Policy Makers	Substance Treatment Experts/Academics	People in Recovery	

Macoupin and Montgomery County's Recovery Oriented System of Care

Outpatient Treatment which includes individual/group therapy with behavioral health professionals and peer recovery specialists and medication assisted treatment

Safe Passage Program in partnerships with local law enforcement

No Wrong Door Program through other community partners

Recovery Support Groups

Volunteer Peer Recovery System

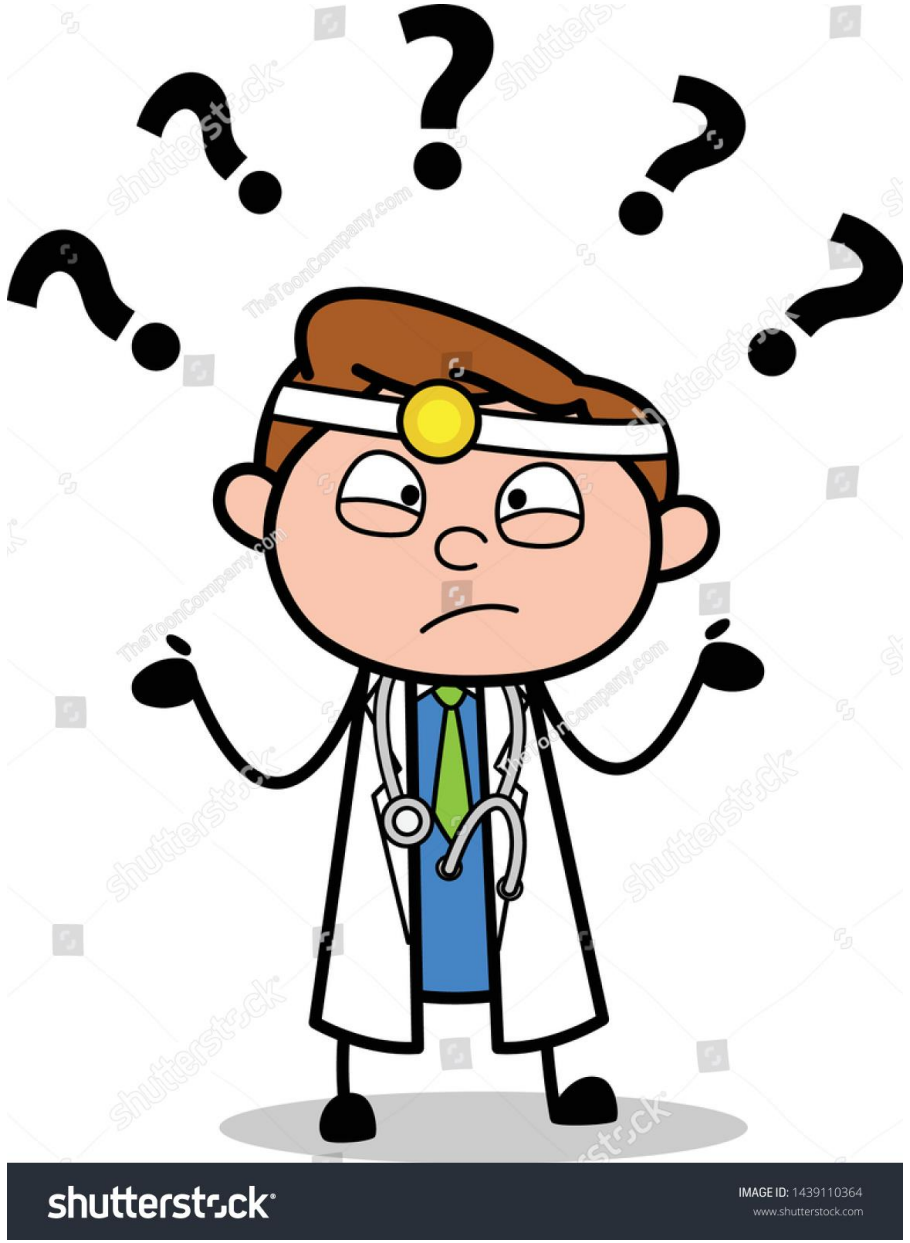
Living Room

Field Support Specialists

Living Rooms Will Act as Community Centers for Sober Living and Recovery

- Drop in setting for people to hang out and get support in treatment and recovery
- Place to rest, respite that removes community members from current stressors or triggers
- Staff will be on site to provide counseling and help connect clients to services
- Setting includes a library which has recovery literature, videos and webinars to assist people in maintaining successful recovery

But I don’t work in Macoupin or Montgomery County? Or anywhere close. What do I do?



https://www.dhs.state.il.us/page.aspx?item=117096

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Anyone, 5 years of age and older, is eligible to receive the COVID-19 vaccine. Find your nearest vaccination location at vaccines.gov.

IDHS Illinois Department of Human Services
JB Pritzker, Governor · Grace B. Hou, Secretary

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Illinois Recovery Oriented System of Care (ROSC) Councils

In 2018, IDHS/SUPR changed its name from the Division of Alcoholism and Substance Abuse (DASA) to the Division of Substance Use Prevention and Recovery (SUPR). In addition to removing stigmatizing language (substance abuse) from the Division's name, it supports the commitment of the Division for prevention of, and recovery from, substance use disorders. SUPR has made progress in reorienting the system from focusing solely on the traditional acute care approach to a chronic care approach. Shifting to a chronic care approach requires the entire system i.e., prevention, intervention, treatment and recovery management to embrace a recovery-oriented approach. Long term recovery from substance use disorders is dependent upon a continued connection to care and the delivery of services that are not only responsive to individuals' use of alcohol and other drugs, but their co-occurring trauma effects, mental health, physical health and ongoing recovery related concerns as well.

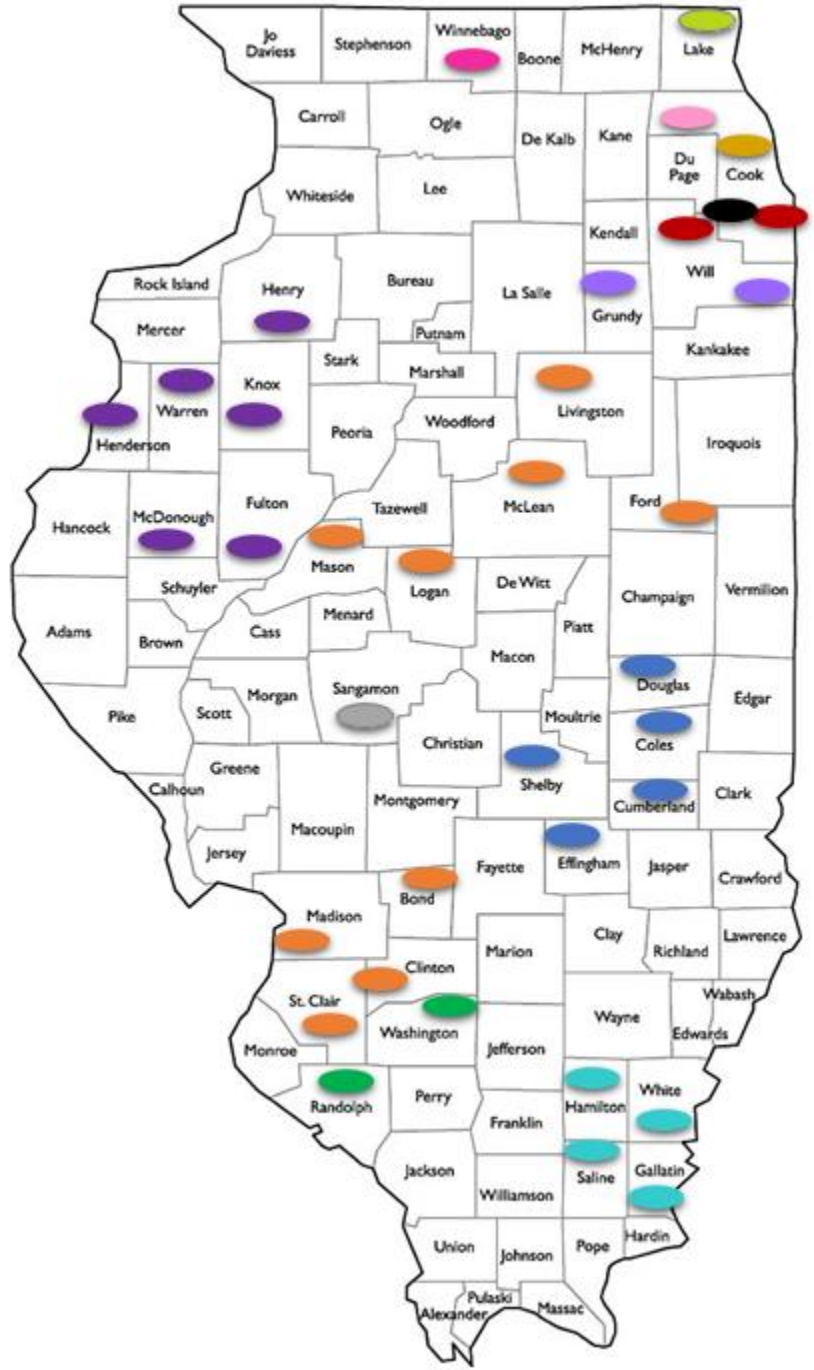
ROSC

Screenshot of rosc

ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve recovery and improved health, wellness, and quality of life for those with or at risk of substance use disorders. The central focus of a ROSC is to create an infrastructure, or "system of care", with the resources to effectively address the full range of substance use problems within communities. The goals of the Illinois ROSC include:

- Building a culture that builds and nurtures recovery

Illinois Recovery Oriented Systems of Care (ROSC)



Lead Agencies:

Bridgeway, Inc.: Knox, Warren, Henderson, Henry, Fulton, McDonough

Central East Alcoholism and Drug Council (dba Hour House): Effingham, Douglas, Shelby, Coles, Cumberland

Chestnut Heath Systems: Logan, Mason, Livingston, Ford, McLean, Madison, St. Clair, Bond, Clinton

Chicago Recovering Communities Coalition: Westside Chicago (Cook)

ComWell: Randolph, Washington

Cornerstone: Southern Cook, Northern Will

EDDR Foundation: Winnebago

Egyptian Health Department: Gallatin, Hamilton, Saline, White

Family Guidance Centers, Inc.: Sangamon

HeartLife Ministries: Will, Grundy

Kenneth Young Center: Palatine, Hanover Park (Cook)

Northern Illinois Recovery Community Organization: Lake

TEECH: Southwestern Cook

References

- ROSC: https://www.dhs.state.il.us/page.aspx?item=117096
- van der Kolk, *The Body Keeps Score*
- Harris, *The Deepest Well-Healing the Long Term Effects of Childhood Adversity*
- Ogden & Fisher, *Sensorimotor Psychotherapy: Interventions for Trauma and Attachment*
- National Suicide Prevention Lifelineexternal icon: 1-800-273-TALK (8255) for English, 1-888-628-9454 for Spanish, or Lifeline Chatexternal icon Disaster Distress Helplineexternal icon: CALL or TEXT 1-800-985-5990 (press 2 for Spanish). Get Help in a Crisis
- https://www.oxfordbrainstory.org/
- SAMSAH Trauma Informed Care Manual https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4816.pdf
- Gabor Mate Childhood Trauma creates addiction **https://www.youtube.com/watch?v=ojq-U13726E**
- NIDA - Common Comorbidities with Substance Use Disorders Research Report - https://www.drugabuse.gov/download/1155/common-comorbidities-substance-use-disorders-research-report.pdf?v=6344cb285ff0a098afa0909927de4512