Poll: Help Us Get to Know You

1. I am from:
   a. An ED
   b. A primary care practice
   c. A specialty practice
   d. A behavioral health practice

2. How engaged are you or your practice in OUD treatment?
   a. Not part of my practice
   b. A small part of my practice
   c. Becoming a large part of our care delivery
   d. Its all I do
Lunch & Learn Webinar

“Breaking Down Silos: Enhanced Referrals between the ED and ARC”
Tuesday, May 15, 2018
12pm-1pm EST

A Tri-State Collaborative Program
Managed by Maine Quality Counts
The Opiate Problem

“Emergency Department – Addiction Resource Center Collaborative at Mid Coast Hospital”
Mission

Maine Quality Counts is a member driven nonprofit located in Manchester, Maine.

We are working to improve the health of all Maine people (and beyond) by transforming the way healthcare is delivered.
Priorities

QC Brings Together the People Who Give, Get and Pay for Healthcare to Address Shared Priorities:

- Improve the alignment of healthcare systems to transform health for all Maine people
- Provide quality improvement assistance to practices
- Engage consumers in health care
- Promote the integration of physical and behavioral health
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This Webinar is Made Possible by:

The NNE-PTN project - is supported by FONCMS- 1L1CMS331446-03-00 from the U.S. Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.
Welcome!

The Northern New England Practice Transformation Network (NNE-PTN) will make the transition to Value-Based Care seamless for you, your practice, and your patients.
NNE-PTN Organizational Partners

Larry Clifford
Executive Directors
Maine Quality Counts

Catherine Fulton, MS, CPHQ
Executive Director
Vermont Program for Quality in Healthcare, Inc.

Jeanne Ryer, MS
Director
New Hampshire Citizens Health Initiative
Important Webinar Notes

1. You are in listen-only mode.
2. Please use the Q&A function (top of the screen) to ask questions or make comments. The chat function is disabled.
3. Should you want to ask a question using your audio, please use the “Raise Your Hand” function on your top left zoom dashboard. Webinar host will “promote” you to a panelist so you can ask your question.
4. Video screen size and location are adjustable.
5. In two days you’ll receive an email with links to:
   - Slides and recordings
   - Online CME survey
Disclosure

Today’s speakers have no relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider of commercial services discussed in this CME activity.
Today’s Presenters

Ranjiv Advani, MD, FACEP
Emergency Physician
Medical Director – Mid Coast Hospital Emergency Department
Vice President, Medical Staff – Mid Coast Parkview Health
Board of Managers, BlueWater Emergency Partners

Dr. Advani graduated from the University of Michigan Medical School in 2000 and completed residency training in Emergency Medicine at Maine Medical Center in 2003. For the past 8 years has worked clinically at Mid Coast Hospital and is a founding partner of BlueWater Emergency Partners.

Dr. Advani is the Medical Director of the Mid Coast ED and leads a team of 15 physicians, 11 APPs, and 2 APP Fellows. Special areas of interest include Medical Error and Cognitive Bias, Tribalism in Medicine, Provider Resilience, and Substance Use Disorder.

Leah Bauer, MD
Psychiatrist
Medical Director, Addiction Resource Center, Mid Coast Hospital

Dr. Bauer graduated from the University of Cincinnati College of Medicine in 2009 and went on to complete residency training in adult psychiatry at Massachusetts General/McLean Hospital in 2013. She’s been at Mid Coast Hospital’s Addiction Resource Center for 3 years, where she works clinically on the front lines as a buprenorphine provider, while also helping lead the charge towards systemic change to address the opioid crisis across the Mid Coast system. She also serves as a consulting psychiatrist to Bowdoin College. Areas of interest include perinatal addiction treatment, co-occurring disorders, college mental health, and medication assisted treatment.
Breaking Down Silos:
Enhanced Referrals from the Emergency Department to the Addiction Resource Center
Outline

• Opioid Crisis Update
• MCPH ARC and ED
• Prior state of SUD treatment in the ED
• Yale Study
• Pathway Development
• Results to date
• Challenges and Lessons Learned
• Summary and Next Steps
Deaths in Maine

- 418 deaths in 2017

- Overdose deaths
- Motor vehicle deaths
Drug deaths in Maine

The number of overdose deaths hit a record 418 in 2017. Opioids, both illicit and prescription, were responsible for the vast majority of fatal overdoses. In many cases, more than one drug was listed as a cause of death or significant contributing factor.

SOURCEs: Office of the Maine Attorney General

STAFF GRAPHIC | MICHAEL FISHER
The Fentanyl Problem
Drug Overdoses in Maine: 2017

- Opioid Related: 85%
- Fentanyl Related: 59%

Portland Press Herald, 2/22/18
MAT reduces heroin deaths

(Schwartz, Am J Public Health, 2013)
Maintenance is needed for success

Approx. 75% of sample retained in maintenance
All participants who were medically withdrawn (control) dropped out of study by 60 days

20% of control group died

(Kakko, Lancet, 2003)
Mid Coast Hospital Addiction Resource Center (ARC):
- Across town from main hospital campus
- Satellite campus in Damariscotta
- 4 physicians, 2 nurses, ~10 masters level clinicians
- Day/evening IOP, aftercare groups, group based MAT program
- ~250 MAT patients between both campuses
- 25-45 patients in IOP in a given week
- Rapid ACCESS is our priority
MCH EMERGENCY DEPARTMENT
Mid Coast Hospital Emergency Department (ED):
- 15 physicians, 10 APPs, 75 RNs
- 36 hours MD, 17 hours APP Coverage Per Day
- 20 beds +3 BH Obs beds
- 31,000 visits/year – 81 patients per day
- 6% Visits – Behavioral Health
  - Many with co-occurring Substance Use Disorder
- Maine Behavioral Healthcare
- Psychiatry on staff at Hospital
- No Inpatient Substance Use Disorder/Detox Program
Substance Use Disorders - ED

- Increased Incidence
- Decreased inpatient and outpatient resources
- Lack of Crisis support
- Time Consuming
Substance Use Disorders – Prior State

• Interventions:
  – Call for inpatient bed
    • Usually no beds available
  – Phone number for outpatient treatment
  – Ad hoc outpatient withdrawal treatment:
    • Benzodiazepine Taper
    • Opiate Comfort Meds
How it all began....

- Yale study (D’Onofrio, JAMA, 2015)

- A pregnant woman walked into the ER on a Friday afternoon...
YALE (D’ONOFRIO) STUDY
D’Onofrio G, JAMA, 2015

• ED Patients with OUD

• 3 Study Groups
  – Traditional Referral (104)
  – Brief Intervention and Referral (111)
  – ED Initiated Buprenorphine (114)

• Primary Outcome:
  Engagement in treatment at 30 days
D’Onofrio G, JAMA, 2015

% Pts in Therapy at 30 Days

- Buprenorphine
- Referral
- Brief Intervention
D’Onofrio G, JAMA, 2015

# Days of Use/Wk

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<td>Referral</td>
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D’Onofrio G, JAMA, 2015

Study population:

- **reason for index visit**
  - Seeking Tx: 34%
  - Post-OD: 8.8%
  - ID'd by screening: 34%
Goals

• Defined Pathways to standardize
  – Screening
  – Clinical care
  – Communication

• Consistent, seamless, accessible

• Improve communication and collaboration bi-directionally between ED and ARC

• “Warm Handoff and Soft Landing” at ARC
Process

• Team met monthly Winter/Spring 2017
• MBH Crisis Involvement
• Drafts of Protocols: refined over time
• Introduced slowly to the ED Team
• Rollout Sept 2017
  – ED provider and nursing education
• Team now meets quarterly
  – Review cases: spreadsheet
  – Continue to refine protocols
Pathways

- ED Initiated Buprenorphine/Naloxone
- ED Initiated Opioid Withdrawal Treatment
- ED Initiated Alcohol Withdrawal Treatment
Buprenorphine Pathway

• Inclusion
  – Clear History of OUD
  – UDS positive for opioids or buprenorphine
  – Current Withdrawal – COWS > 7
  – Willing to engage in treatment

• Exclusion
  – Daily alcohol or daily illicit benzo use
  – UDS positive for Methadone
Buprenorphine Pathway

1. ED work-up and observation
2. MBH Consultation
3. Communication to ARC on call
4. Suboxone Induction
Buprenorphine Pathway

• Medication
  – Buprenorphine/naloxone 4/1 SL x1
  – Monitor 1-2 hrs and ensure COWS decreasing
  – If needed, dispense additional 4/1 mg after 2 hours
  – Order 8/2 daily for up to 3 days if needed
    • Nurse visit
Regulatory FAQ’s

• Do the ER providers need an x-waiver?
  – NO!
• Is that legal?
  – YES!
• How does that work?
  – Dispense vs prescribe
  – “3 day rule”
    - Ok to dispense daily for up to 72 hours
• For more info:
Opioid Withdrawal Pathway

• Medications
  – Clonidine -0.1mg q8hrs for 3d, q12h for 3 d (#15)
  – Dicyclomine (Bentyl) – 20 mg q 6h prn (#20)
  – Promethazine (Phenergan) 25mg q 6h (#20)
  – Ibuprofen
Alcohol Detox Pathway

• Inclusion
  – Alcohol use disorder + withdrawal
  – Willing to engage in treatment
  – Requires < 2mg lorazepam or 50 mg Librium PO to achieve stable VS
  – Sober Support Person Involved

• Exclusion
  – Prior withdrawal seizures or DTs
  – Significant Psychiatric or Medical Co-Morbidity
  – CIWA score >15
  – Failed past outpatient detox
Alcohol Detox Pathway

• Medications on Discharge
  – Librium
    • 50 mg q8h for 2d
    • 25mg q8h for 2d
    • 25 mg qd for 2d
“Warm Landing” at ARC

- If not overnight, patient leaves ED with appt time for next Mon/Tue/Thurs
- Reserved intake slots at ARC for ED pts
  - Intake with clinician
  - Physician “pops-in” for brief assessment during intake, then schedules more extensive visit soon thereafter
- Flexibility is key!
RESULTS TO DATE
Results – First 7 months

• Screened Many Patients

• ARC Referrals
  – 7 patients started on Buprenorphine
  – 3 on Non-Bup Opioid Pathway to ARC
  – 13 Alcohol Pathway

• Others on Opioid or EtOH pathway treated without referral

• Stories…
CHALLENGES AND LESSONS LEARNED
Anticipated Concerns

- Patients will flood the ER
  - Challenge to ED Flow and Occupancy
- Patients would return over and over again
- Security concerns $\rightarrow$ stigma
- Staff acceptance of program
  - Providers
  - RNs
- Part time ARC Physician
- Regulatory and risk management issues
Actual Challenges

Hospital Level
• Some providers less comfortable with protocols than others, implementing protocols takes time and effort
• Lack of enthusiasm from nurses
• Can’t gather staff at one time to disseminate info
• Coding and Billing the ED return visits

Patient Level
• Many patients not presently ready for treatment
• Transportation/financial barriers limit patient follow up
• Not as many patients as we anticipated
Lessons Learned

• Many patients not interested in treatment  
  – Plant a seed…
• Few initial concerns turned out to be barriers
• Our initial criteria excluded too many people
• ED induction works well for pregnant women
• Change happens slowly
• Communication between ARC and ED has never been better!
• Relationships are the most important thing!
Guiding Principles

• Opportunity to Intervene
• Give the ED Provider Tools
  – Standard Defined Pathways
  – Standard Expectations
• Alter the ED Paradigm
• Involves ED Crisis Team
• Warm Handoff to ARC
• Patient Leaves with Meds, Appointment Time/Place
Impact

• Low Volume - High Impact
• Patient
  – Increased access to treatment
  – Increased engagement with treatment
• Provider
  – Empowered – Have a solution
  – Less Judgmental
  – This is my job
Next steps

• Improve engagement of patients in ED
• Enhanced screening for OUD
• Low threshold for initial dose post-OD
• Involvement of peer support in the ED
• Education on bias/stigma for ED and security staff
• X-waiver training
• Spreading the word!
References

Thank you!

Questions?

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lbauer@midcoasthealth.com
Poll: Leaving In Action

1. Explore opportunities to coordinate OUD treatment in my community
2. Participate in x waiver training
3. Participate in alternate waiver training
Tools for Success: QCLearninglab.org

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<th>Tools From PTN</th>
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<tr>
<td>Tools From PTN Online Learning Module Opportunities (CME available):</td>
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<tr>
<td>- &quot;The PTN Basics&quot;</td>
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<td>- “Using the Practice Plan Tool”</td>
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<td>- “Finance and Business Skills for Transformation”</td>
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<td>- “Improving Patient outcomes with Cost of Care Conversation in the Clinical Practice”</td>
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<td>- “Get a Grip on Change”</td>
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<td>- “Systems Thinking”</td>
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<td>- “Coordinating Person-Centered Care Transitions in Your Medical Neighborhood”</td>
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<td>- “Spend Your Health Care Dollars Wisely”</td>
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<td>- “NNE-PTN Claims Data Report Suite Training”</td>
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<td>- “Steps for Improving Hypertension Care”</td>
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<td>- “Interpersonal Skills”</td>
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[Click here to Access Modules]
Tools for Success (con’t)

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<tr>
<th>Upcoming Webinar</th>
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<tr>
<td>Webinar “Conflict Management”</td>
<td>May 29th @12:00pm EST</td>
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<td>Presenter: Derek Ahl and Sarah Lawrence with the Daniel Hanley Center for Health Leadership</td>
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<tr>
<td>Webinar “Enhancing Cost-Of-Care Conversations for Low Back Pain Treatment Using Publicly Reported Cost Information “</td>
<td>May 30th @12:00pm EST</td>
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<tr>
<td>Presenter: Kimberly Fox Senior Research Associate at the Muskie School of Public Service at the University Of Southern Maine</td>
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This project is supported by FON CMS- 1L1-15-003 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.