Suboxone Initiation in the Emergency Department and Hospital

Emily Kauffman, DO, MPH
Clinical Assistant Professor
Emergency Medicine/Internal Medicine – Assistant Program Director
Department of Emergency Medicine Department of Hospital Medicine
The Ohio State University Wexner Medical Center

Objectives

• The problem
• Description of Medication-Assisted Treatment (MAT)
• Role of the Emergency Department and Inpatient setting for initiation of MAT
• Protocols and how to initiate
• Role for Peer Support
Staggering National Statistics 1-6

- 1999-2017 >400,000 people died from an opioid overdose (OD) (700,000 all overdose deaths)
- 2016: >2 million U.S. residents have an Opioid Use Disorder (OUD)
- 47,600 opioid related deaths in 2017 (>5x increase since 1999)
  - Provisional data notes 5% nationwide decline in deaths for 2018
- 130 Americans die daily from an opioid overdose
- White males 25-44 y/o highest heroin death rate
- Major cause of decreased life expectancy since 2016

RISE IN OPIOID OVERDOSE DEATHS IN AMERICA

A Multi-Layered Problem in Three Distinct Waves

399,000 people died from an opioid overdose (1999-2017)

1990s marks a rise in prescription opioid overdose deaths

2010 marks a rise in heroin overdose deaths

2013 marks a rise in synthetic opioid overdose deaths

Rx OPIOIDS
Inhalants, semi-synthetic, and methadone can be prescribed by doctors

HERON
An illegal opoid

SYNTHETIC OPIOIDS
Such as fentanyl and tramadol are very powerful and can be illegally made

Learn more about the evolving opioid overdose crisis: www.cdc.gov/drugoverdose
2012: 81 scripts/100 people (>255 million prescriptions)

2017 decline to 59 scripts/100 people (191 million)

Nationwide decline since 2012

Some states still high: AL (107 scripts)

Ohio in 2017: 63.5 prescriptions/100 people

Prescription Drug Monitoring Program/OARRS queries up:

2016: 24 million
2017: 89 million

2017 Death Rate due to Drug Overdoses by State

1. West Virginia: 57.8/100,000
2. Ohio: 46.3/100,000
3. Pennsylvania: 44.3/100,000
4. District of Columbia: 44/100,000
5. Kentucky: 37.2/100,000
Ohio Overdose Data

- 1999-2011 death rate due to opioid related OD increased 440%
- >500,000 years of life lost from 2010-2016 (average lifespan in OH decreased by one year)
- 2018 **22% decline from 2017**
  - 3,764 deaths: 2,733 fentanyl
  - 10 deaths/day
  - 2018-19: Franklin County deaths on the rise

Costs Related to Opioid Overdose in Ohio and US

- **Ohio 2012**
  - $2 billion toward work loss and medical expenses
  - Inpatient hospital expenses: $39.1 million
  - $5.4 million/day
- **US 2018: $179 billion**
  - $73 billion related to mortality
  - $60 billion health care
  - $26 billion lost productivity
  - $11 billion criminal justice
  - $9 billion child and family
Opioid Use Disorder: Chronic Relapsing Condition that is Treatable!

- Medication-Assisted Treatment
  - Saves lives (harm reduction) and reduces infections
  - Increased engagement in recovery services and avoidance of illicit opioids
  - Decreases craving
  - Minimal euphoria, minimal respiratory depression
  - Allows the reward system to “lose” the hijacker and return to normal coping skills, rewire the maladaptive behaviors that are often lethal
  - Length of treatment variable—but may be lifelong
  - Abstinence based therapies and counseling alone are INEFFECTIVE (90% relapse rate) and DANGEROUS

What is Medication-Assisted Treatment (MAT)?

- **Buprenorphine** (semi-synthetic opioid) (2000)
  - Partial opioid agonist-antagonist with high affinity for the mu receptor; long acting, t½ 37 hours
  - Minimal respiratory depression and euphoria (decreases craving)
  - Often combined with naloxone (film/tab) to prevent misuse/diversion
  - Monthly injections (SC) or subdermal implant (6 months)
- **Methadone** (1947-approved 1972)
  - Long acting full mu agonist
  - Typically only obtained outpatient from federally sanctioned Narcotic Treatment Programs
- **Naltrexone** (Vivitrol)
  - Mu antagonist, monthly injection Vivitrol; abstinence 7-10 days prior
Buprenorphine Pharmacology

- Ceiling effect: lower risk of respiratory suppression
- Higher affinity for opioid receptors than other opioids which can precipitate withdrawal symptoms in patients who have recently used a full opioid agonist.


Sources: Cruciani & Knotkova, 2013; Goodman et al., 2006

### Buprenorphine

- 2 mg, 4 mg, or 8 mg, tabs or films SL
- Subutex (buprenorphine)
- *Suboxone* (buprenorphine-naloxone, 2-0.5 mg/8-2 mg)
  - $6000/year including twice weekly counseling
- Zubssolv, Bunavail (buprenorphine/naloxone)
- Probuphine (buprenorphine implant 6 months)
  - 2016
    - $5000/injection
- Sublocade (buprenorphine monthly SC injection): 2017
  - $1500-1600/month

### Suboxone Myths

- **Replacement of one addiction for another**
  - Addiction=compulsively taking a substance, despite harm;
  - taking a prescribed medication to manage a chronic disease
  - While buprenorphine has analgesic properties, very minimal euphoria
- **Too time consuming to initiate and the medication is “dangerous”**
  - Simple screening, determine if in withdrawal, dosing is not complicated and much easier to start than insulin; very few side effects;
- **Detoxification is “effective”**
  - NO! 90% relapse rate with detox alone; also increased rate of overdose
- **Decrease opioid prescribing will “fix” the problem**
  - Since 2012-13, prescribing patterns have declined, but death rate rising
Evidence for MAT 14-17

- Increases retention in recovery services
- Decreases rate of AMA and readmission
- Lowers mortality and morbidity
- Decreases use of illicit substances
- Decreases rate of transmission of HIV and Hep C

Why Target Patients in the ED?

- Frequent encounters with OUD given lack of primary care
- >50% of patients who died from an opioid OD had a health care encounter in the year before their death
- 50% ER admissions involve a substance use disorder
- 30% increased ER visits in 2017 for non-fatal opioid overdoses
- Barriers to care and treatment gap
  - 2016: 21.7 million with Substance Use Disorder: 2.35 million were able to access (10%)
Why Initiate MAT in the ED?

- *Journal of American Medical Association* 04/2015 D’Onofrio et al: *Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial*
  - 78% initiated on Suboxone (in ED or home) engaged in treatment at 30 days (compared to 37% for referral only group and 45% of brief intervention group)
  - Urine Drug Screen in prior 7 days more likely to be free of illicit opioids

Why Initiate MAT in the ED?

- *Annals of Internal Medicine* 08/2018 Larochelle: *Medication for opioid use disorder after nonfatal opioid overdose and association with mortality: a cohort study*
  - Large retrospective study of >17,000 ED visits for nonfatal opioid overdose
  - 4.9% all cause mortality and 2.2% opioid related mortality
  - If started on methadone or Suboxone, lowers to 2.5% for all cause mortality and 1.4% opioid related
ED Protocol

- Identification of Opioid Use Disorder
  - OD, medical complications, requesting detox, or other
  - Majority will have severe OUD, use DSMV for OUD for unclear cases for confirmation

- Withdrawal, timing of last use
  - Clinical Opiate Withdrawal Scale (COWS) or Subjective Opiate Withdrawal Scale (SOWS), typically approx. 12 hours

- Dosing (ED, inpatient, versus home) 4-8 mg

- Harm Reduction: narcan, Hep A vxn, HIV/STI, fentanyl strips

- Linkage and Peer Support
COWS:
Mild: 5-12
Moderate: 13-24
Mod Severe: 25-36
Severe: >36
COWS>8
Last Use: at least 12 hours
Post OD: 2-3 hrs

SOWS>10
Role of the Peer Coach

- Shared experience
- Transportation
- Facilitate transitions of care for recovery
- Legal Aid
- Social Determinants such as food, shelter, ID, insurance
- Finding case management
- Engaging bedside during ED/inpatient stay and may follow up to 12 months

Video: Peer Coaching

Testimonial from a Peer Coach
Evan Rooney
References

5. www.cdc.gov/drugoverdose/maps/rxrate-maps.html
6. www.cdc.gov/vitalsigns/pdf/2017-07-vitals July 2018
9. Franklin County Coroner and Office Press Release. 6/6/19 Dr. Anahi Ortiz

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Assistant Professor-Clinical
Department of Internal Medicine
Division of Hospital Medicine
The Ohio State University Wexner Medical Center

MAT in the inpatient setting

Outline

• Acute care medical settings: intersection of two epidemics
• OUD complicates inpatient care
• Why initiate medication assisted treatment in the hospital?
• OSU’s inpatient MAT consult team
• Specific issues related to inpatient MAT
Two epidemics: opioid overdose and IVDU related infections

• Ohio University study: more than 500,000 years of life lost in Ohio from opioid overdose deaths between 2010-2016. In 2016, opioid overdose deaths lowered the lifespan of an average Ohioan by 0.97 years.¹

• OSUWMC had over 5,400 ED visits and 5,700 inpatient hospital admissions for which OUD was a primary or secondary diagnosis in 2017²

Hall OT et al, “Years of Life Lost due to Opioid Overdose in Ohio: Temporal and Geographic Patterns of Excess Mortality”, Journal of Addiction Medicine 10/7/2019

Increase in intravenous and inhaled opioid and methamphetamine related infections

• UNC and NC Department of Public Health study¹:
  • 12-fold increase in hospital admissions for IVDU associated infectious endocarditis in North Carolina from 2010-2015
  • costs increased from $1.1 to $22.2 million

• 9% of new HIV cases and 64% of new HCV cases diagnosed in 2015 were attributed to illicit IVDU²

Call to Action: Annals of Internal Medicine 7/13/18

Action Steps:

• Implement screening for OUD in all relevant health care settings, in all persons evaluated in medical settings for overdose, endocarditis, bacteremia, skin abscesses, vertebral osteomyelitis, HIV and HCV

• For patients with positive screening results, immediately prescribe effective medication for OUD and/or opioid withdrawal symptoms

• Develop hospital based protocols that facilitate OUD treatment initiation and linkage to community based treatment upon discharge
Review of neurobiology of addiction

- Opiates binding to opiate receptors throughout reward pathway (ventral tegmental area, nucleus accumbens), causes release of dopamine throughout pathway, produces euphoria
- Brain tries to balance the frequent stimulation of dopamine transmitters by shutting down some receptors
- The same amount of drugs won’t cause the same degree of stimulation = tolerance

Volkow, et al. Copyright 2001 Society for Neuroscience

Natural History of OUD

Image retrieved from https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis
Changes in executive function

Neuroplastic changes throughout the limbic or dopamine reward pathway lead to:
- loss of coping skills
- more risky decision making
- anxiety and stress related to finding next dose to avoid dysphoria and withdrawal

Volkow et al., ASAM Principles of Addiction Medicine

OUD complicates hospitalizations

- 25-30% of patients leave against medical advice (AMA)\(^1\), \(^2\)
- Fear of mistreatment; financial, legal, and social pressures; craving and withdrawal
- Longer length of stay and high rate of readmissions (4 days longer in an OHSU 2015 study)\(^3\)
- Misuse of drugs during hospitalization\(^4\)
- Reduced adherence to medical recommendations increases risk for readmission\(^5\)-\(^7\)
- Complex interactions between nurses, providers and patients with OUD\(^8\)

\(^1\) Ti et al., 2015; \(^2\) Rosenthal et al., 2016; \(^3\) Englander et al., 2017; \(^4\) Ti & Ti, 2015; \(^5\) Moreno et al., 2029; \(^6\) Ronan & Herzig, 2016; \(^7\) Rosenthal et al., 2016; \(^8\) Englander et al., 2018a
**Inpatient Settings**

**An opportunity to engage**

- Hospitalization presents a “reachable moment” to initiate and coordinate OUD care in patients admitted for other medical-surgical reasons. Often first point of contact with medical providers.¹
- According to a needs assessment at Oregon Health Science University, the majority of hospitalized patients with OUD are interested in quitting or cutting down on opioids:²
- Patients emphasize importance of understanding substance use disorders, addressing fears of withdrawal, and caring, nonjudgmental staff.³

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**Goals of initiation of MAT during hospitalization**

- Management of withdrawal symptoms
- Harm reduction: patient more stable, more likely to stay in the hospital to undergo recommended medical treatment
- Start long term treatment for OUD
- Taper not advised: 80-90% chance of relapse if patient undergoes taper without MAT provided at discharge, with lowered tolerance -> high risk of overdose

Literature on starting inpatient MAT programs

MGH study found decreased 30- and 90-day readmission rates in patients with OUD taking buprenorphine during index hospital admission by 53% and 42% compared with patients with OUD not on buprenorphine.

BMC study found increased entrance into outpatient MAT therapy in patients discharged with buprenorphine and linkage appointment compared with detox and given information to make own appointments (72% vs 12%), improved adherence at 6 mos (17% vs 3%).
Prescribing buprenorphine inpatient vs. discharge

• For patients with opioid use disorder who are admitted to the hospital for a primary diagnosis other than opioid dependency, prescribers without a DEA-X waiver may initiate, maintain and/or adjust BUP/NX dose as an adjunct to patient management.
• Those without a DEA-X waiver cannot prescribe at discharge.

MAT consult team at OSUWMC

• Staffed by hospitalists with DEAX waivers and buprenorphine training
• Patients referred by primary attendings, seen by MAT consult attending and MAT social worker
• When patient agreeable and medical setting appropriate, patient is started on suboxone
• Patient counseled by MAT SW and follow up appointment made with outpatient provider. Warm handoff provided
• Bridge prescription for suboxone provided at discharge
• 35% decrease in AMA rates in patients seen by MAT team in first 7 months of consult service
Inpatient MAT and Psychiatry Consultation- Liaison Team collaboration

- Assessing decision making capacity and lethality risk
  - Leaving against medical advice
  - Consenting to procedures
- Behaviors that are difficult for staff to manage
  - Leaving the unit
  - Suspicious behavior
  - Crisis intervention for evolving behavioral emergencies
- Collaborative interventions to remove barriers to safe discharge
- Comorbidities: primary psychiatric illness, traumatic brain injury
- Complex withdrawal: concurrent use of EtOH or benzodiazepines

Longer length of stay in patients with OUD who need IV antibiotics

- Initiating MAT in OUD is the standard of care
- Initiating MAT may lead to decreased AMA and readmission rates
- If not leaving AMA, patients stay longer which costs the hospital and is typically not reimbursed
- Limited number of SNFs/LTACHs accepting patients with history of IVDU or OUD is major barrier to care
- Not receiving meaningful recovery counseling while inpatient
Cost saving opportunity
Combining antibiotic therapy with OUD treatment after discharge

- Study through Virginia Commonwealth Health System 2006-2011
- 205 patients (all types of addiction) with need for ongoing IV antibiotics discharged to a residential addiction facility contracted w/ the hospital
- Met medical stability criteria prior to discharge (cleared bacteremia, etc.)
- Not treated with MAT
- 73% antibiotic completion rate, 20% AMA
- Over 6 years saved $2.5 million for hospital, based on saved hospital days at $835 per bed-day

Solutions to aftercare for patients w/ IVDU needing IV antibiotics

- Bring counseling to skilled nursing facility
- Bring skilled nursing to counseling facility
- Provides expedited, robust OUD treatment for patients while completing their acute medical care
- Improves hospital length of stay for these patients, allowing OSUWMC to serve more patients and decrease ED wait times and boarding times
Treating acute pain in patients on buprenorphine

Buprenorphine and Mu Receptor Occupancy

- 2 mg daily: 41%
- 16 mg daily: 85-92%
- 32 mg daily: 94-98%

**Acute Pain Management Strategies**

- Continue buprenorphine and add full opioid agonists
- Continue buprenorphine but divide dose every 6-8 hours
- Discontinue buprenorphine and use full opioid agonists
- Discontinue buprenorphine and replace with methadone and full opioid agonists


**Considerations for Choosing a Strategy**

- Anticipated pain severity
- Emergent vs. Planned Surgery
- Risk for Relapse

Emergent vs. Planned Surgery

**Emergent**
- If I continue buprenorphine, how will the patient’s pain be controlled?
- If I stop buprenorphine, how will full agonists affect the patient?
- How long will buprenorphine act in the patient after the last dose?
- How will buprenorphine be reinitiated?

**Planned**
- What is the anticipated pain severity?
- Do I have time to taper and/or switch buprenorphine?
- Can care be coordinated to effectively taper and restart buprenorphine?

Risks with Discontinuing Buprenorphine

- Delay of procedures
- Requirement of increased visits for care coordination
- Re-initiation of buprenorphine risk of withdrawal precipitation
- Chance of no re-initiation
High risk of failure to re-initiate buprenorphine in perioperative patients

- Hospital buprenorphine continuation is associated with reduced opioid requirements, while not significantly impacting pain levels, functionality, or length of admission.
- Failure to reinitiate buprenorphine occurred in 31/57 patients (54.4%) in the discontinue group.

Houchard G, et al., Hospital Opioid Requirements Following Continuation Versus Discontinuation of Buprenorphine for Addiction – A Retrospective Cohort Study, Journal of Pain & Palliative Care Pharmacotherapy Volume 33, 2019 – Issue 3-4

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