Virginia ED Bridge to Treatment Replication: FAQs session - January 14th, 2022

ED Bridge team: John H. Burton, MD, Chair, ED
Cheri W Hartman, PhD, Administrator, Office-based opioid treatment, OBOT; ED Bridge Quality Improvement Project Manager; David W Hartman, MD lead physician of the OBOT, Psychiatry Department Carilion Clinic, Roanoke, VA
Closed Captioning Service

- Automated CC is available for this event with realtime captions that will run simultaneously with the presentation.
- The streaming text is available through: [https://www.streamtext.net/player?event=HamiltonRelayRCC-0114-VA3213](https://www.streamtext.net/player?event=HamiltonRelayRCC-0114-VA3213)
- We recommend opening a second window with the link provided and resizing it in such a fashion that it appears below the webinar screen. This allows the viewer to see both the webinar and its associated text/graphics while also being able to comfortably view the realtime captions.
- If you have any questions about this service please send an email to CivilRightsCoordinator@DMAS.Virginia.Gov
Welcome and Meeting Information

• We have an ‘open’ meeting format to allow participation and questions

• Please make sure your line is muted if you are not speaking
  • We will mute all lines if there is a lot of background noise

• If you are having issues with audio, please type questions or comments in the chat box.

When the microphone icon looks like this, you are muted

When the microphone icon looks like this, you are unmuted
SUPPORT Grant - NEW Winter 2022 Webinar Schedule

- **FREE** webinars for anyone who serves Medicaid Member
- Registration is now open. Use links in schedule to register and access the webinars.

### New Topic: Substance Use Disorder Treatment for Adolescents
Presented on: March 22nd and March 24th

**Revisiting Topics:**
- Opioids, Stimulants & Cannabis
- ASAM Criteria Assessment Dimensions 1 - 6 (Five part series)**
- Urine Drug Screenings: Purpose & Practice
- Suicide Assessment
- SUD & Trauma
- Co-Occurring Disorders (Two parts series)

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
<th>Presenter(s)</th>
<th>Links to Register and Access the Webinar</th>
<th>Remote Conference Captioning (RCC) Links</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>January 2022</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday, January 18th</td>
<td>10:00 AM-11:00 AM</td>
<td>Opioids, Stimulants &amp; Cannabis</td>
<td>Paul Brasler</td>
<td><a href="https://covaconf.webex.com/covaconf/j.php?MTID=m1218b615d7dc1009b00466413001f67">Link</a></td>
<td><a href="https://www.streamtext.net/player?event=HamiltonRelayRCC-0118-VA3241">Link</a></td>
</tr>
<tr>
<td>Thursday, January 20th</td>
<td>1:00 PM - 2:00 PM</td>
<td>Opioids, Stimulants &amp; Cannabis</td>
<td>Paul Brasler</td>
<td><a href="https://covaconf.webex.com/covaconf/j.php?MTID=md29d357cfb2b0ae79357b5216bc171e">Link</a></td>
<td><a href="https://www.streamtext.net/player?event=HamiltonRelayRCC-0120-VA3243">Link</a></td>
</tr>
<tr>
<td>Tuesday, January 25th</td>
<td>10:00 AM-11:00 AM</td>
<td>ASAM Criteria Assessment Dimensions 1 &amp; 2</td>
<td>Paul Brasler</td>
<td><a href="https://covaconf.webex.com/covaconf/j.php?MTID=m24ac38b3f27e2194fb97ad56a09e00d">Link</a></td>
<td><a href="https://www.streamtext.net/player?event=HamiltonRelayRCC-0125-VA3242">Link</a></td>
</tr>
<tr>
<td>Thursday, January 27th</td>
<td>. 1:00 PM - 2:00 PM</td>
<td>ASAM Criteria Assessment Dimensions 1 &amp; 2</td>
<td>Paul Brasler</td>
<td><a href="https://covaconf.webex.com/covaconf/j.php?MTID=ma01d1756d4d08957308d541fa66bb69d">Link</a></td>
<td><a href="https://www.streamtext.net/player?event=HamiltonRelayRCC-0127-VA3240">Link</a></td>
</tr>
</tbody>
</table>

Webinar Schedule and Slide Decks are available on the SUPPORT grant website:
Today’s Agenda

• Introduce VA ED Bridge Replication Project and Carilion Clinic.
• Answer questions that have arisen to date.
• Answer your questions today.
• Invite you to receive further information about upcoming resources we will be sharing: “Guidelines” and ED Bridge Training Toolkit
Key players in ED Bridge at Carilion

- 49 waivered physicians in ED
- ED Chair: jhburton@carilionclinic.org
- Psychiatry OBOT care coordinators (6) led by Michelle Diehl, 3 therapists (intake specialist: Leanna Stone, LCSW)
- Prescribers led by David Hartman, nurses, administrative support
- OBOT contact: cwhartman1@carilionclinic.org
- Peers embedded in the ED supporting transitions (supervised by Kimberly Hunt, C-CPRS)
  Peer Recovery Center (540) 853-9152

Team meets monthly
VA ED Bridge Replication Project

Funded through VDH and VA DMAS resources
(ED Linkages to Care; SUPPORTAct Grant)

“Early implementers” interested in implementing an ED Bridge to Treatment – contact Dr. Cheri Hartman at Carilion Clinic. (540)- 981-7099

cwhartman1@carillionclinic.org

Consultative/TA is offered; no implementation requirements imposed on the hospitals; no cost beyond time and effort.

Monthly meetings are provided.
Getting waived no longer requires training: Question: should we encourage MAT training?

Dr. John Burton: “Education around MAT was needed to address a critical knowledge deficit: not understanding disease of addiction, needing education on buprenorphine as a straightforward medical tool, well within scope of practice of ED. Training on MAT has demystified it and provided a tool to be used by ED physicians.”

Myths debunked: detox = treatment; residential care is the “go to.”

Training is available at following link through March 23rd, 2022. It satisfies VA Board of Medicine requirement for all prescribers of any opioid to complete a 2-hour course on opioid prescribing:

https://drive.google.com/file/d/12t1RtgBTvdwsWwPALj9jW560FGL1gHZQ/view

CME survey: http://carilion.ca1.qualtrics.com/jfe/form/SV_54P4VbvEk8mXjf?COURSE=Project+ECHO+-+INTERNET+BASED+-"Medications+for+Opioid+Use+Disorders+-+Initiating+and+Prescribing+Best+Practices"+-+David+Hartman,+MD&PROVIDER=Carilion+Clinic&DATE=12-23-2021&SPONSOR1=Paula+Robertson&SPONSOR1_EMAIL=pgrobertson@carilionclinic.org&
Question: waiver is NOT needed to initiate buprenorphine in the ED; up to 3 consecutive days of buprenorphine may be administered in the ED. Is writing a prescription (that does require getting waivered) really necessary? The prescription serves as the medical bridge to ensure continuity of care from acute ED setting to the follow up site, a transition that can take at least a week. Transitions are vulnerable periods when probability of overdose is most high; the prescription can be lifesaving. If patient is not in withdrawal, a home induction with instructions can be used in combination with the prescription.
Question: Getting waivered to prescribe buprenorphine: is it a hassle?

• NOT REALLY: Federal regulations shifted such that clinicians prescribing buprenorphine for < 30 patients at a time do not have to complete the waiver training (8 hr for physicians; 24 hrs for ACPs) – instead process just involves the Notice of Intent (NOI) “application” to SAMHSA submitting your license # and DEA #.

Go to: Become a Buprenorphine Waivered Practitioner | SAMHSA

Recent Practice Guidelines have allowed for an alternative NOI for those seeking to treat up to 30 patients: The customary NOI requires eligible providers to undertake required training activities prior to their application to prescribe buprenorphine; the alternative type of NOI allows those providers who wish to treat up to 30 patients to forego the training requirement, as well as certification to counseling and other ancillary services (i.e., psychosocial services). Practitioners utilizing this training exemption are limited to treating no more than 30 patients at any one time (time spent practicing under this exemption will not qualify the practitioner for a higher patient limit). This exemption applies only to the prescription of Schedule III, IV, and V drugs or combinations of such drugs, covered under the CSA, such as buprenorphine.

• SAMHSA DATA Waiver
• the first step of the process involves verification of credentials (you submit your license # and DEA #) (numbers and letters only – no spaces or dashes)
• When you proceed to the next form to apply, make sure you select the “exempted” waiver option to treat fewer than 30 patients in order to be exempted from submitting a training certificate.

• Follow up question: Are incentives needed to motivate physicians to apply for their waiver? IF so, what might work?
Question: ED Bridge Protocol – how complicated is it to adopt this protocol?

- Patient assessed in ED for a moderate to severe opioid use disorder using the **DSM-5 criteria to diagnose OUD**
- Check the PMP for controlled substances prescription history
- Baseline Urine Drug Screen: don’t wait for results…make available to outpatient clinic
- Labs: Urine Pregnancy, LFTs, Hepatitis A/B/C – exclude patients who have severe liver disease, an active alcohol or benzodiazepine use disorder
- **COWS** Score in chart: moderate/severe withdrawal, score of 13 or above, then start patient on 8 mg/2mg – can go up to 16 mg/4 mg on Day One; if not in withdrawal, consider home induction (Wesson and Ling, 2003) combined with the prescription (7 to 10 day)
- Screening for suicidality or psychosis and link with appropriate care
- Peer Counselor consult obtained – important facilitator of the referral (warming up handoff)
- Prescribe Naloxone
- Social Work/Case Management: ED case managers help patients with problem-solving Rx issues, explaining referral instructions on the discharge papers
- Use discharge handout with phone numbers and instructions for accessing OBOT care coordinators for intake (typically next day phone appointment is arranged upon referral) and patient’s chart is shared with the lead prescriber of the OBOT (Dr. David Hartman).
Question: how would you handle a precipitated withdrawal response to the initial dose?

- Most likely:
  - Go up another 8 mg

Dr. John Burton...on this topic and how to prevent precipitated withdrawal response...
Buprenorphine in the ED: Bridge to .... Where? Question: what tips have been learned about creating outpatient partner(s) for the rapid handoff?

Being able to refer trusted outpatient partner(s) offering rapid access to follow up care = vital.

Establish in advance parameters/lines of communication to get on the same page ...

Example of breakdowns:

(1) Expectations by outpatient partner: regarding requests for consult services: Keep it simple; ED agrees to seek consult with Peer Recovery Specialists to facilitate transitions; if outpatient partner requires more consults, the expedited referral process could get bogged down.

(2) Expectations about labs: only certain labs are considered necessary for OUD tx referral

(3) Set up cross-departmental or cross-agency regular meetings (at first monthly, later quarterly).
Question: what about the patient, not appropriate for the OBOT (outpatient) level of care?

Assessment and triage is done by the follow up care clinic (Carilion’s Psychiatry) using ASAM criteria (six dimensions) to assess if patient is appropriate or needs a higher level of care. If not appropriate for office-based opioid treatment (OBOT), care coordinators work (with peers) to support patient’s transition to follow up care.

Recently iPADS in the ED are used (by peer recovery specialist) to link patient with the outpatient social worker, who conducts the intake assessment even before the patient leaves the ED. This has strengthened the bridging transition. Either the patient is then admitted into the OBOT or is referred to a higher level of care with the support of a Psychiatry OBOT care coordinator and a peer recovery specialist.

Recommendation: rapid access to the intake assessment is crucial with quick access to the appropriate level of care.
What is an OBOT, as created by DMAS’ ARTS Initiative? An OBAT?

- The OBOT (office-based opioid treatment) program = integrated comprehensive, patient-centered care, preferred model of care in Virginia for Medicaid members. Co-located therapy provides integration of the psychosocial interventions with the Medications for Opioid Use Disorders (MOUDs) – treating addiction as a biopsychosocial disease, grounded in evidence-based care per the American Society of Addiction Medicine (ASAM).

- Care coordinators play a key role in monitoring the interdisciplinary plan of care; tracking patient needs (medical, psychiatric, addiction/recovery, environmental: housing, relationship issues, transportation, child welfare, legal involvement) in the various domains affecting recovery. Care is interdisciplinary and team-based.

- The OBAT expands the OBOT model of care to all types of addiction, not just the opioid use disorder. These sets of policies apply to Medicaid members. OBAT = office-based addiction treatment

- Ashley Harrell has a resource on OBOTs through Virginia.
Are the CSB’s potential partner sites for the outpatient “shoreline?”

• Success was achieved through the Piedmont CSB partnership with Carilion’s Franklin Memorial Hospital (Monica Flora of Piedmont has led the way to partner with the ED).

• CSB’s can do the intake assessments and placement in appropriate level of care for the follow up services; they provide peers to support transitions; they offer various levels of care – not just OBOT outpatient care.
Question: Will it open the flood gates, increasing return ED visits?

“Will it open the flood gates?”

NO – though recently there has been an increase in return ED visits, the number does not surpass pre-bridge levels for addiction-related presentations to ED.

Likely to be fewer of the frequent ED “users.”

How to reduce these ED return visits?
Maintain communications with outpatient clinic – an FYI notification alerts ED physicians to NOT re-issue a script to patients turning the ED into their treatment clinic instead of coming to the OBOT site for follow up care.

Another benefit of the ED Bridge:
The ED Bridge reduces “pivoting” to suicidal ideation admissions. Hospitalizations are less likely as a result of the ED Bridge.
Telemedicine/teletherapy/virtual care

Question: how helpful is this for creating an ED Bridge?

- If there is no waivered prescriber in the ED, virtual linkage can provide access.
- Patients benefit from easier access to intake and to telemedicine without needing transportation.
- Patients have increased, faster access to OBOT care coordinators through virtual care— we use Google phones that patients can use to directly contact their care coordinators Monday – Friday (9-5); consents to treatment, IPOCs, releases – are still being signed virtually.
VA Replication of ED Bridge

• Cadre of early implementers will have access to consultation/TA services from Carilion Clinic’s team through July 2022

• Resources: The Guidelines for ED Bridge Replication; ED Bridge Training Toolkit will be released and made available in the public domain (once approved).

• Dept of Health Professionals has released a “go to” summary of best practices for ED interventions – required by HB 2300 (General Assembly, 2021) (Allison-Bryan, 2021)
Best Practices for Opioid-related Emergencies (Allison-Bryan, 2021)

1. Identify a multidisciplinary team to establish and champion training, protocols, and continuous improvement.
2. Avoid stigma and promote trust.
3. Ensure that Emergency Department providers understand the DEA x-waiver.
4. Build an inventory of outpatient (and residential) referral resources.
5. Implement Peer Recovery Specialists into triage, treatment, and follow-up services.
6. Use the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) criteria and the Virginia Prescription Monitoring Program (PMP) patient query to screen patients.
7. Screen for withdrawal using the Clinical Opiate Withdrawal Scale (COWS).
8. Offer/discuss Medication for Opioid Use Disorder (MOUD) treatment using buprenorphine.

When the patient presents to the ED in withdrawal and consents: induce with buprenorphine and define specific follow up. In the best scenario, patients would have follow up with an outpatient-based opioid treatment (OBOT) clinic within 24-48 hours of induction. However, if that is not possible, a definite appointment time within 7 days should be secured and a “bridge” prescription for buprenorphine/naloxone given. Educate and refer to harm reduction. Consider screening laboratory tests consistent with harm reduction. Dispense a naloxone kit.

If the patient refuses MOUD induction: refer directly to outpatient-based opioid treatment (OBOT) and harm reduction. Dispense a naloxone kit. If the individual is not in withdrawal upon ED presentation: refer within 24-48 hours to an OBOT. Educate and refer to harm reduction services. Dispense a naloxone kit. Consider prescription for buprenorphine/naloxone with instructions for home induction if clinically appropriate.

9. Refer seamlessly to outpatient services best suited to the patient and the encounter. Give the patient a specific appointment time and location. Virtual appointments may increase availability of services.
10. Every encounter stemming from an opioid emergency should include distribution of naloxone. A prescription alone does not represent best practice.
11. Understand and promote harm reduction.
Thank you!
Dr. Cheri Hartman: cwhartman1@carilionclinic.org
Dr. John Burton jhburton@carilionclinic.org