SARATOGA HOSPITAL
DEPARTMENT OF EMERGENCY MEDICINE

OPIATE INITIATIVES

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ED Opiate Initiatives

- The rapid growth of use, abuse and dependence on Opiates reached a level in 2015-2016 that began to drive changes in the management of Opiates.
- Emergency Departments (ED) were initially blamed for a large part of the problem, although multiple subsequent studies proved this to be a false assumption.
- Saratoga Hospital's Department of Emergency Medicine elected to address the Opiate crisis through a number of avenues.
- These approaches were developed over several years.

ED Opiate Prescription Protocol

- Initiated May 6, 2016
- Based of CDC & ACEP Opiate Prescription Recommendations
- All Providers Enrolled in NYS I-Stop Prescription Monitoring System
- Continued a Comprehensive and Consistent Special Care Plan Approach
- Bi-Monthly Monitoring of ED Opiate Prescriptions
- Adoption of Opiate Prescription Guidelines

Specialized Care Plans

1. Meditech EMR allowed us the ability to attach care plans to the patient name / MRN.
2. Immediately identified patients registering in ED as have a Specialized Care Plan (SCP).
3. Worked with Primary Care Providers (PCP) / Specialists / Pain Management to draft plans for Opiate seeking patients.
4. SCP provided history, and consistent recommendations for treatment, pain management alternatives and prescriptions.
5. Available 24/7/365 no matter when a patient chooses to present to the ED.

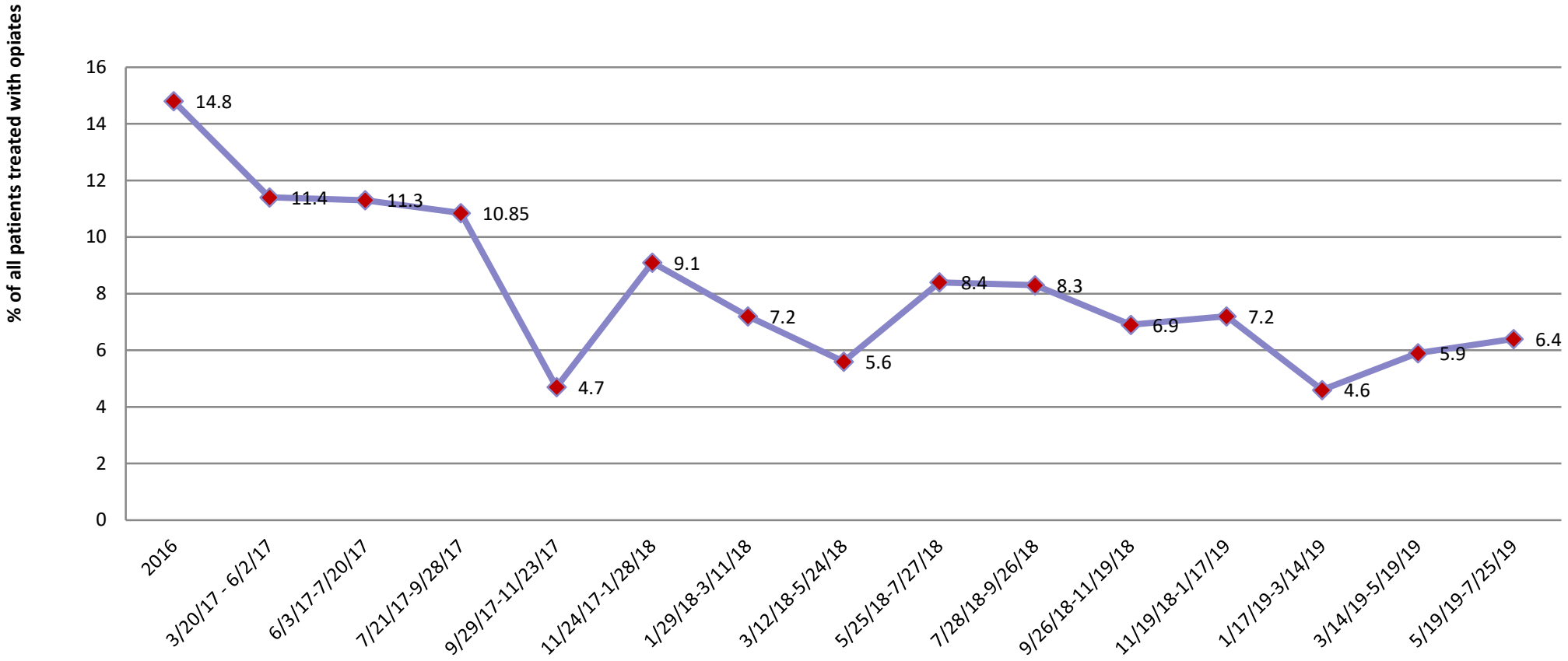
Opioid Prescription Guidelines

1. Consider non-narcotic medications when appropriate.
2. Use only short acting opiates for acute pain.
3. Start with lowest possible effective dose.
4. Prescribe only short course of treatment.
5. Avoid long acting or extended release formulas.
6. Assess for opioid abuse or addiction.
7. Address exacerbation of chronic pain with non-opioids, non-pharmacologic therapies and referral to pain management.
8. Provide comprehensive information on the risk of opioids to those prescribed them.

Results of Opioid Prescription Protocol

- Decrease in opioid prescriptions by 43% to 66% to ED patients.
- Duration of prescriptions decreased from 3.3 to 2.5 days; a decrease of 30%.

Saratoga Hospital Emergency Department Opiate Prescriptions



ALTERNATIVE TO OPIATES (ALTO) IN ED
Iroquois Healthcare Association
Opioid Alternative Project – NYS Grant

09/20/18 – Representatives of 14 hospitals meet in Syracuse and draft ALTO Guidelines

10/20/18 – Revision of Guidelines

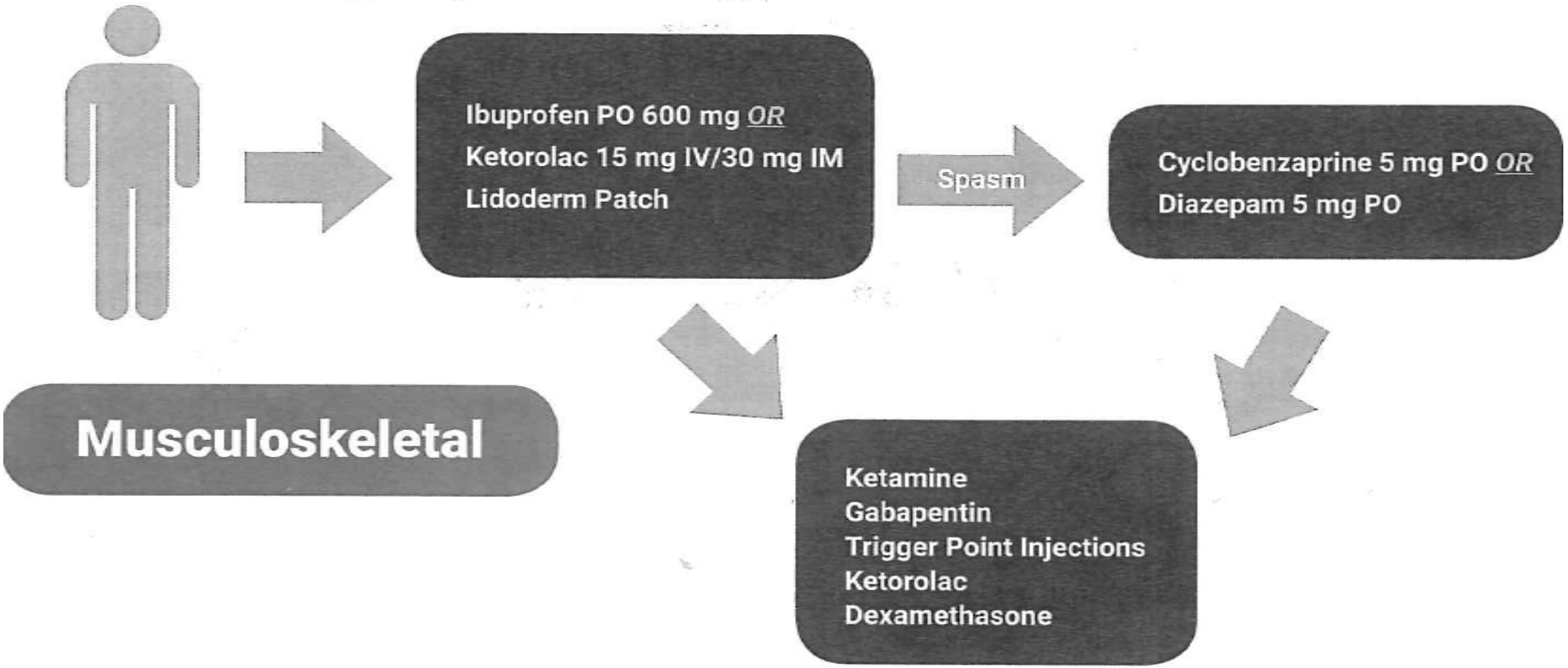
12/10/18 – Group re-meets in Albany, approves final protocols and educational plan

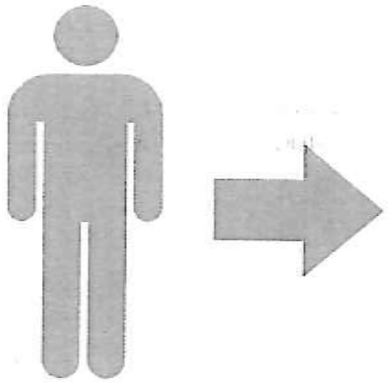
01/02/19 – Educational material provided to all SHED Staff

01/10/19 – ALTO order sets built and installed in EMR

ALTO PROJECT

- ALTERNATIVE approaches to treat common painful conditions in ED.
- Opioids not forbidden, but last resort after other treatments fail.
- Musculoskeletal (back)pain, headache, dental pain, renal colic (kidney stones) and abdominal pain (chronic/cyclical vomiting).


Ibuprofen PO 600 mg OR
Ketorolac 15 mg IV/30 mg IM
Lidoderm Patch
Spasm
Cyclobenzaprine 5 mg PO OR
Diazepam 5 mg PO
Musculoskeletal
Ketamine
Gabapentin
Trigger Point Injections
Ketorolac
Dexamethasone

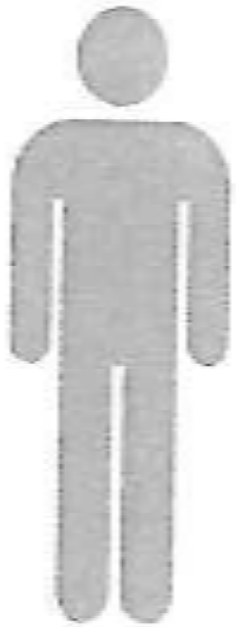


Headache

Prochlorperazine 10 mg PO / IV *OR* Metoclopramide 10 mg IV
Ketorolac 15 mg IV *OR* 30 mg IM
Sphenopalatine block, occipital block, or Trigger Point Injection
Acetaminophen 1000 mg PO + Ibuprofen 600 mg PO
1 L 0.9% NS + high-flow oxygen
Sumatriptan 6 mg SC

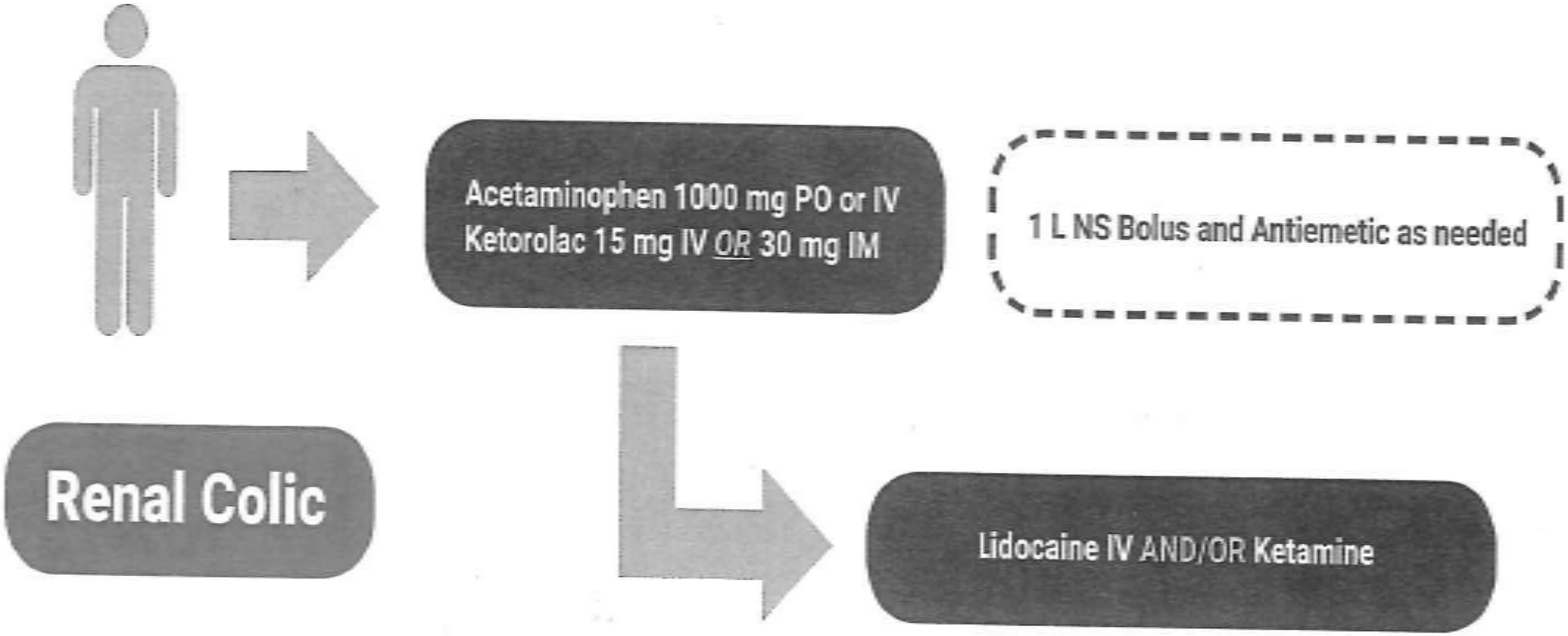
Lidocaine IV
Caffeine
Ketamine
Promethazine
Dexamethasone
Haloperidol
Magnesium
Valproic acid
Diprivan

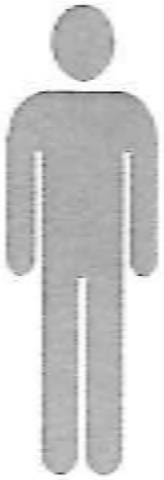
Diphenhydramine and 2nd dose of Metoclopramide at provider's discretion



Dental Pain

Acetaminophen 1000 mg PO
Ketorolac 30 mg IM
Dental Block


Acetaminophen 1000 mg PO or IV
Ketorolac 15 mg IV OR 30 mg IM
1 L NS Bolus and Antiemetic as needed
Renal Colic
Lidocaine IV AND/OR Ketamine



Abdominal Pain

Haloperidol 5mg IV
Acetaminophen 1000mg PO *OR*
Ketorolac 15 mg IV *OR* 30mg IM
Metoclopramide 10 mg IV
Prochlorperazine 10 mg IV
Diphenhydramine 25 mg IV
Dicyclomine 20 mg PO/IM

(Cannabinoid Hyperemesis)
Capsaicin Cream

Haloperidol
Ketamine
Lidocaine

Repeat First Approach drugs and diphenhydramine as secondary medication at provider's discretion

Buprenorphine Bridging Program

- Thrust upon ED mid 2018.
- Mechanism to provide daily doses of buprenorphine in the ED to control withdrawal and attempt to decrease likelihood of overdose.
- Title 2, Code of Federal Regulations Part 1306.076, allows a practitioner, who is not a Narcotics Treatment program or certified as a DATA 2000 waivered provider, to administer, but not prescribe narcotic medication to treat withdrawal while arranging for patients referral for treatment.

Buprenorphine Bridging Program

- May only dispense one day medications at a time.
- Treatment can only be provided for 72 hours.
- May not extend or renew after 72 hours.
- Patient must return to ED every 24 hours for subsequent dosing.
- Time frame usually sufficient to get into or be evaluated at a treatment program.

Buprenorphine Bridging Program

- ED treated 16 patients in < 6 months.
- Provide 30 doses Buprenorphine as Bridging Therapy.
- Helped to keep patients from using Heroin and prevented withdrawal – Harm Reduction.

ED Buprenorphine/Naloxone Induction Program

- Joint effort between ED/CHC-AM (Community Health Center – Addiction Medicine).
- Modeled after University of Buffalo “Buffalo Matters” program.
- Calls for ED Provides to initiate Buprenorphine/Naloxone in ED – if withdrawing.
- Or initiate at home if not withdrawing.

ED Buprenorphine/Naloxone Induction Program

- Requires adequate number of ED Providers to complete DATA 2000 X-Waiver training and submit applications to DEA for X-Waiver.
- This waiver legally allows provider to prescribe opiates to treat opiate use disorder and addiction.
- To date – 16 providers have completed training and received DEA X-Numbers.

ED Buprenorphine/Naloxone Induction Program

PROCESS

- Evaluate patient to determine if suitable for program.
- Opiate Dependence screening, Consent for Suboxone, Consent to Share Information.
- If withdrawing – initiate Buprenorphine in ED.
- If recently used, need to wait for adequate withdrawal to initiate Buprenorphine.
- Provide seven (7) days prescription for Buprenorphine/Naloxone.
- Refer to CHC-AM program.

ED Buprenorphine/Naloxone Induction Program

- CHC-AM reserves daily opening at 9:30am Monday-Friday.
- Comprehensive evaluation by Social Worker, CASAC (Credentialed Alcoholism and Substance Abuse Counselor) and Physician to determine best treatment program and options.
- Goal is program initiation in second quarter 2019 (actually began March 2019).

Results of ED Buprenorphine Induction Program

March 1, 2019 – August 22, 2019

11 patients started on Buprenorphine Induction Program

82% successfully had initial follow-up with our CHC-AM or another program

18% failed to follow-up

Narcan Distribution Program

- Provide Nasal Naloxone devices to those presenting with overdoses or seeking treatment for opiate use disorder or opiate abuse.
- Provide Nasal Naloxone to those patients on Buprenorphine Induction or bridging programs.
- Charge Nurses in the ED are educated on the program & necessary documentation and process.

Emergency Department Monitoring of Patient Volume with Opiate Related Presentations

- 2017 152
- 2018 172 (increase 13%)
- 2019 (Jan – July) 46 annualized to 79 (54% decrease)

Challenges to the Opiate Initiatives

1. Decreasing opiate prescriptions turned out not to be difficult, and regular feedback to all Providers has led to a consistent Opiate prescription rate of about 5%-6% of patients, down from 15%.
2. Changing attitudes of Providers to those with Opiate use disorder more challenging.
3. Successfully getting enough providers through required 8 hours (24 hours for APPs) of training and obtaining DEA X-Numbers.
4. Concern that once the community was aware of the Buprenorphine program, we would be inundated with patients seeking the drug.
5. Collaborating with addiction medicine to facilitate early follow-up for patients treated in the ED.
6. Efficacy of ALTO approach to pain management, and issues related to the use of Ketamine as an analgesic. RNs cannot push Ketamine in NYS, infusion required.

Saratoga Hospital Department of Emergency Medicine Opiate Initiatives

Questions?