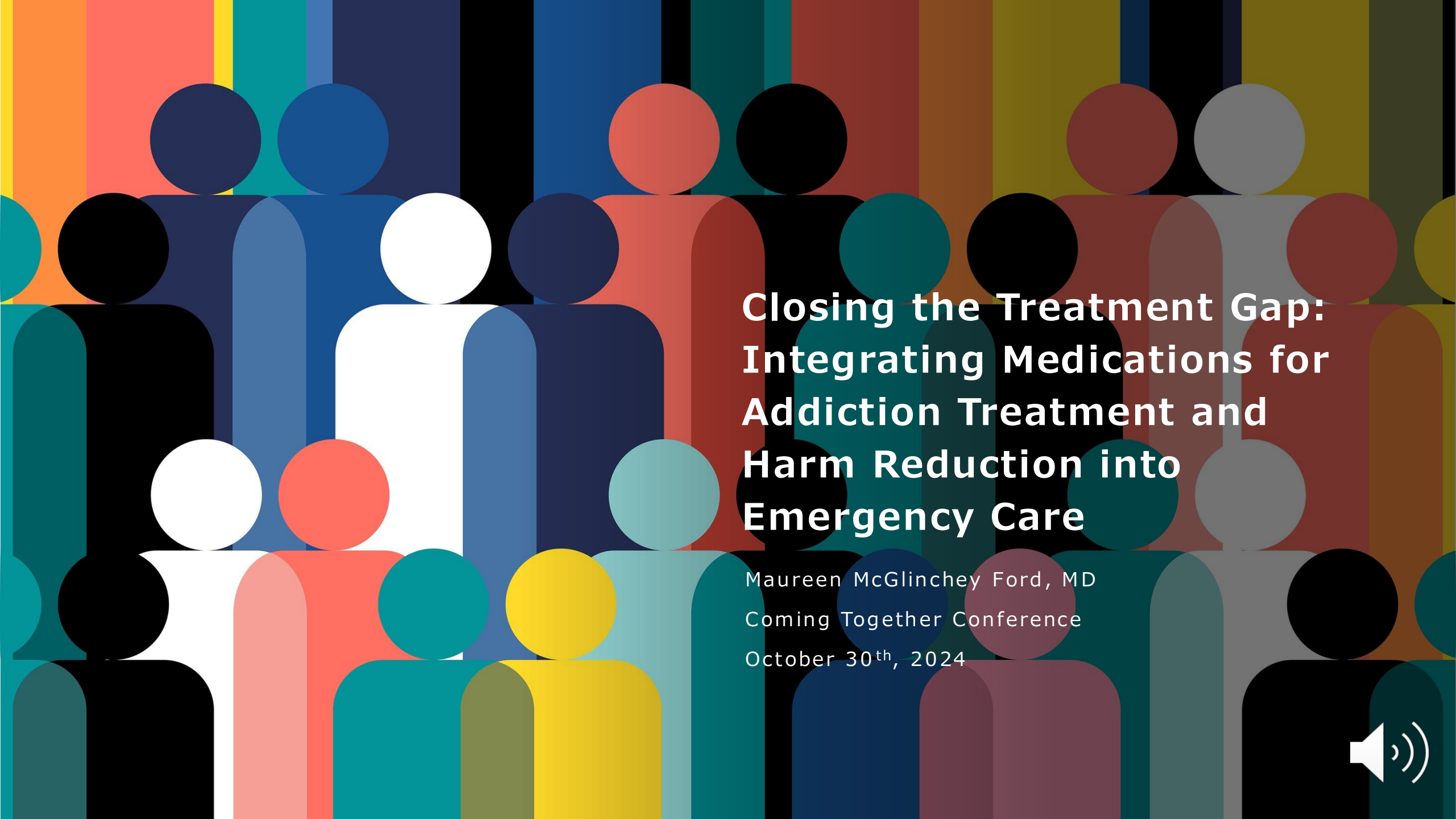


Closing the Treatment Gap: Integrating Medications for Addiction Treatment and Harm Reduction into Emergency Care

Maureen McGlinchey Ford, MD

Coming Together Conference

October 30th, 2024

Disclosures: None

ADDICTION IS A DISEASE

It has been nearly 70 years since the science and medical community have defined addiction as a chronic brain disease. Still today, many think it is a moral failing.

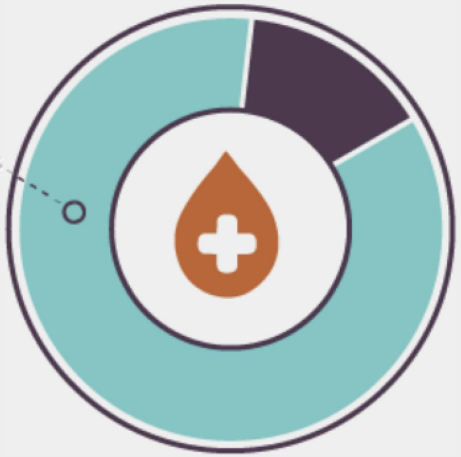
10

Most doctors receive fewer than 10 hours of addiction training in medical school.

SUBSTANCE USE DISORDERS

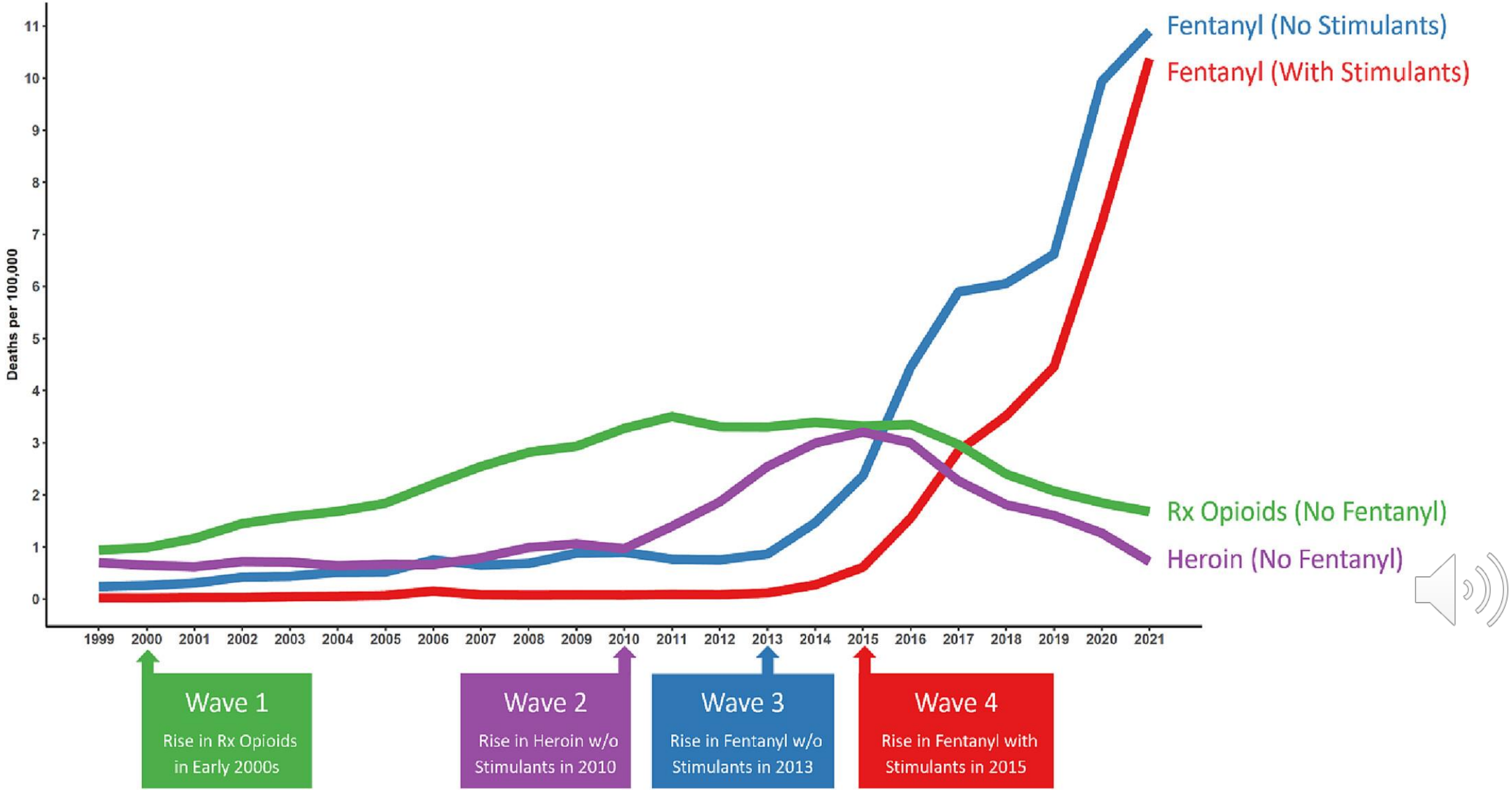
- **23 million** Americans (ages 12+) need treatment for substance abuse disorders
- Only **10%** receive the treatment they need

By contrast, **85%** of the **29 million** people in the U.S. with diabetes receive treatment



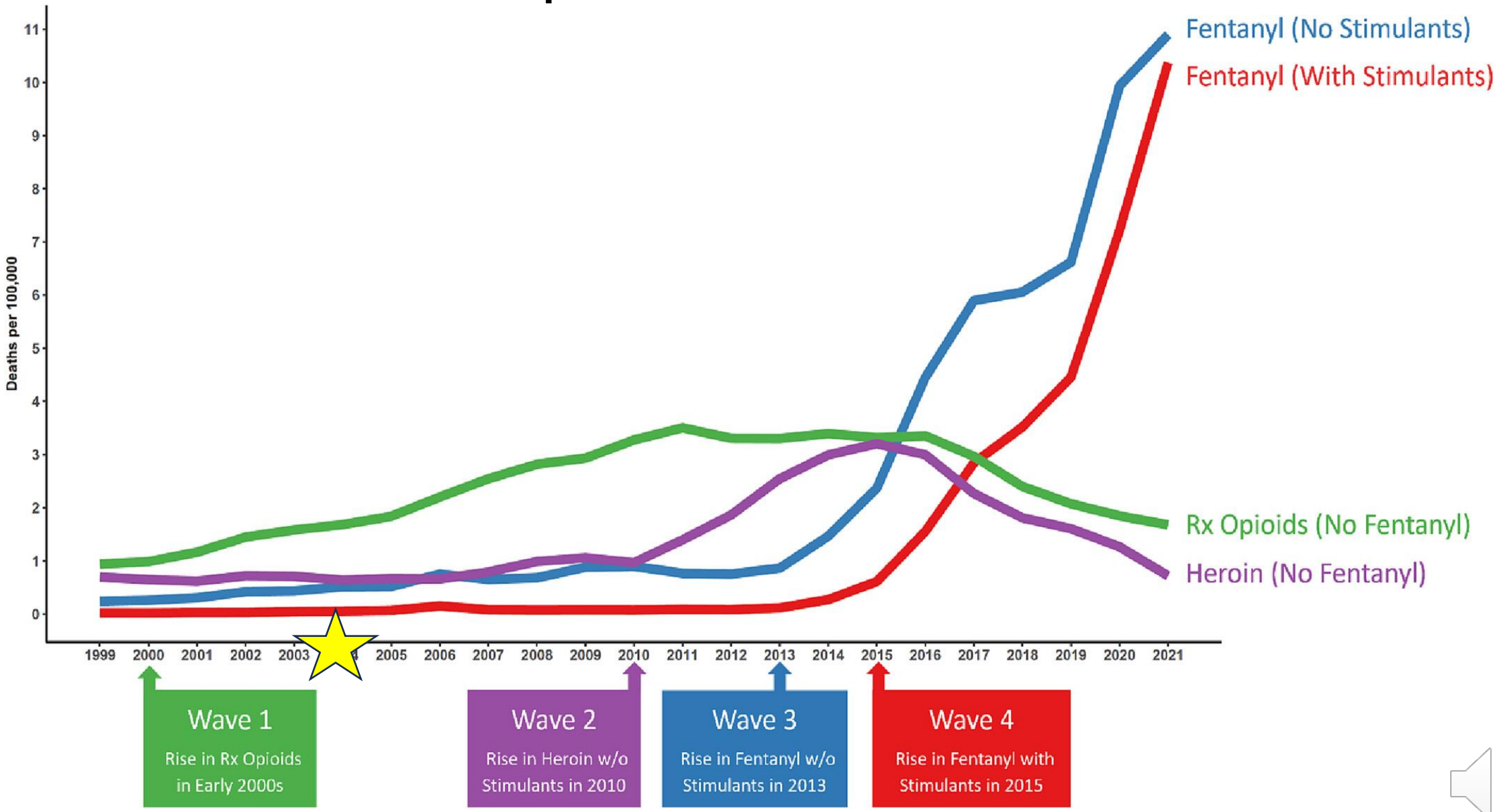
Sources: CDC, 2014; JAMA Psychiatry 2015

Four Waves of Opioid Overdose Deaths



Addiction, Volume: 118, Issue: 12, Pages: 2477-2485, First published: 13 September 2023, DOI: (10.1111/add.16318)

Four Waves of Opioid Overdose Deaths



Addiction, Volume: 118, Issue: 12, Pages: 2477-2485, First published: 13 September 2023, DOI: (10.1111/add.16318)

Impact of Alcohol and Opioids in the United States

Alcohol

Past-Year Use % of population

174,339,000

62.3%

DSM-5 Alcohol Use Disorder (AUD)

% of population

29,544,000

10.6%

Emergency Department Visits

1,714,757

Primary reason

4,936,690

All alcohol-related

Deaths

140,557

Annual deaths

58,277 Acute (e.g., injury)

82,279 Chronic (e.g., liver disease)

Opioids

Past-Year Misuse % of population

9,236,000

3.3%

Opioid Use Disorder (OUD)

% of population

5,559,000

2.0%

Emergency Department Visits

408,079

Primary reason

1,461,770

All opioid-related

Deaths

80,411

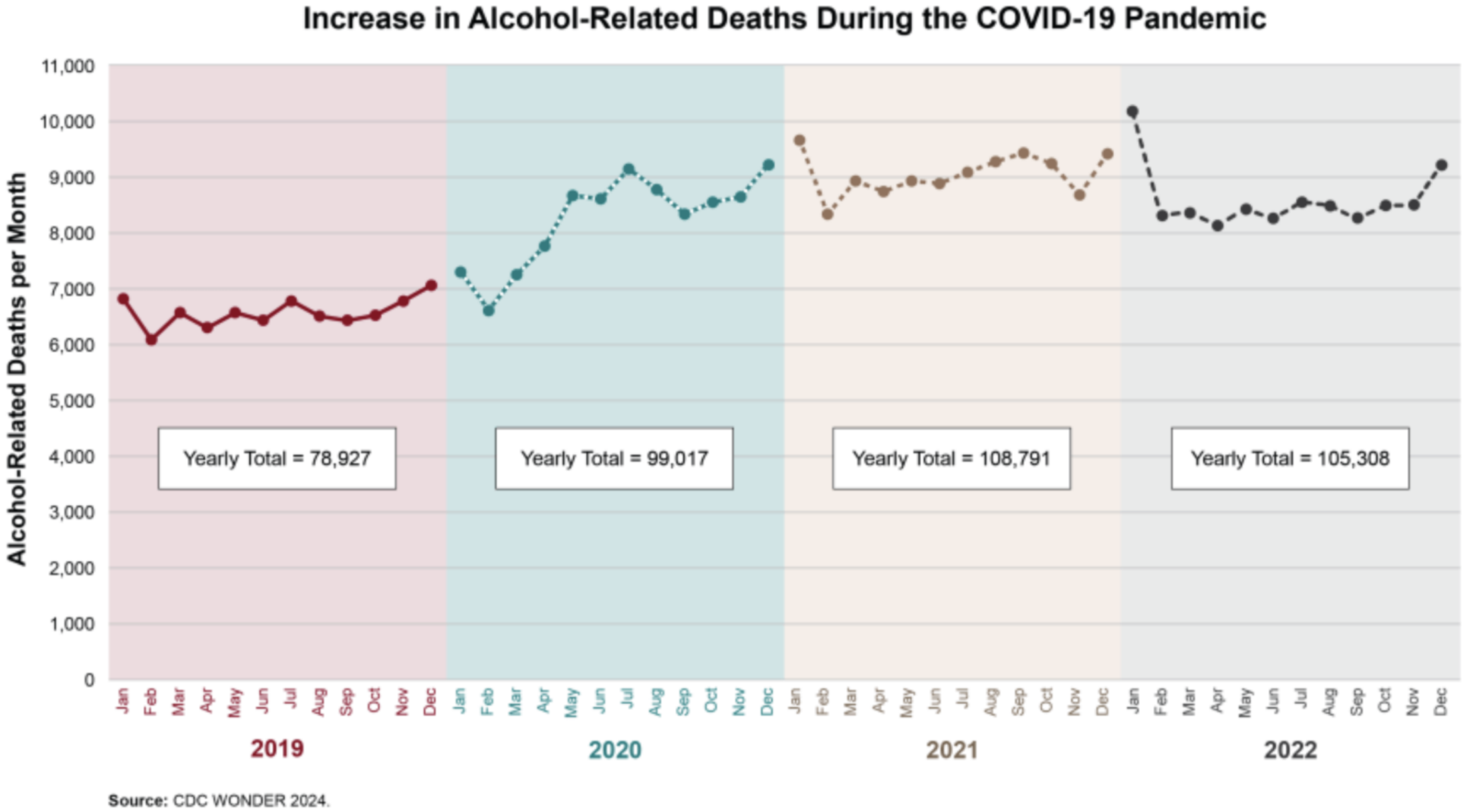
2021 overdose deaths

70,601 Synthetic opioids

9,173 Heroin

16,706 Rx Opioids

[Alcohol-Related Emergencies and Deaths in the United States]



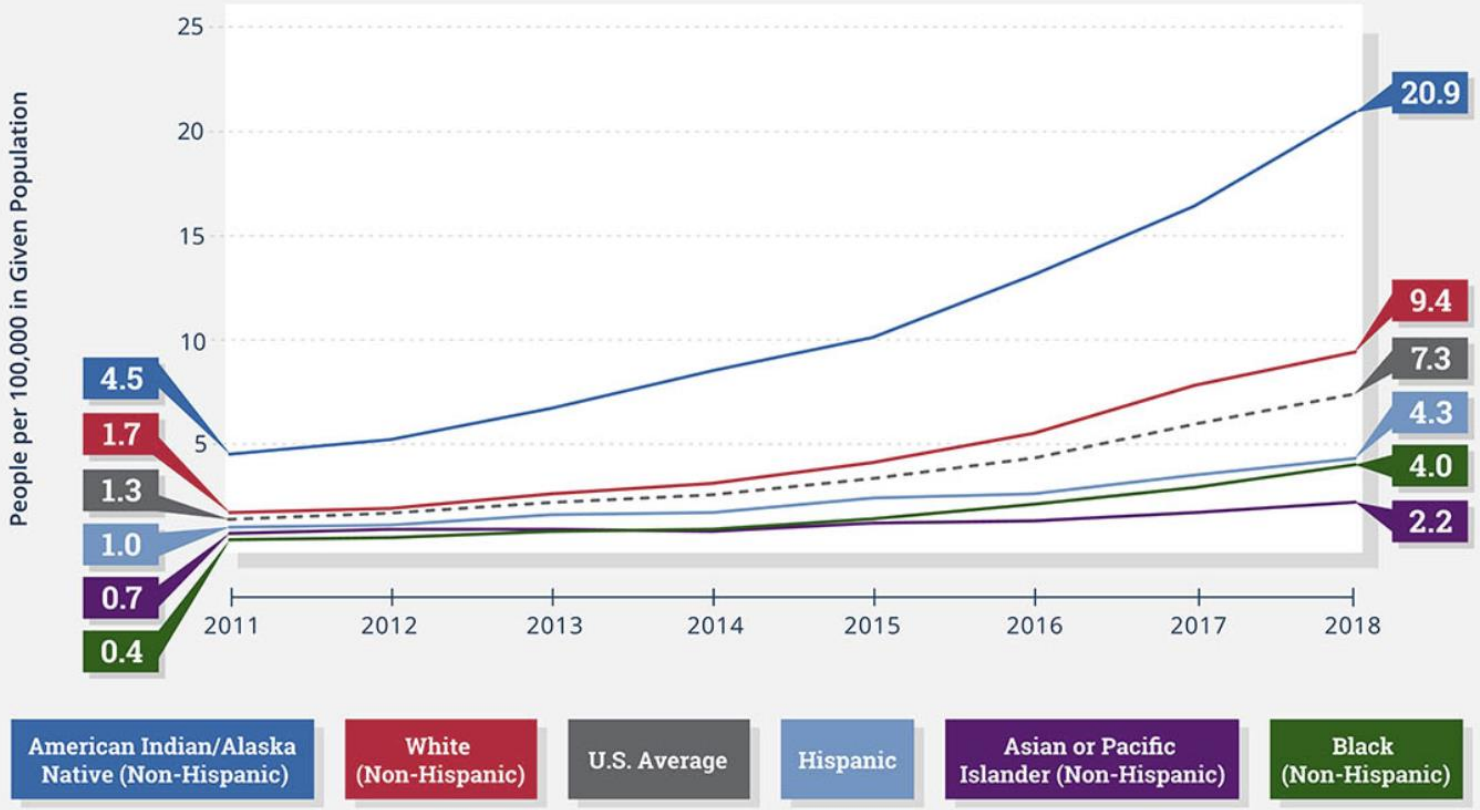
Alcohol-Related Emergencies and Deaths in the United States

Esser MB, Sherk A, Liu Y, Naimi TS. Deaths from Excessive Alcohol Use — United States, 2016–2021. MMWR Morb Mortal Wkly Rep 2024;73:154–161. DOI: http://dx.doi.org/10.15585/mmwr.mm7308a1

Deaths and Disease in the U.S. from Tobacco Use

People who die each year from their own cigarette smoking or exposure to secondhand smoke.	approx. 480,000+
People in the U.S. who currently suffer from smoking-caused illness	16 million+

U.S. Overdose Deaths Involving Methamphetamine in People Ages 25 – 54*



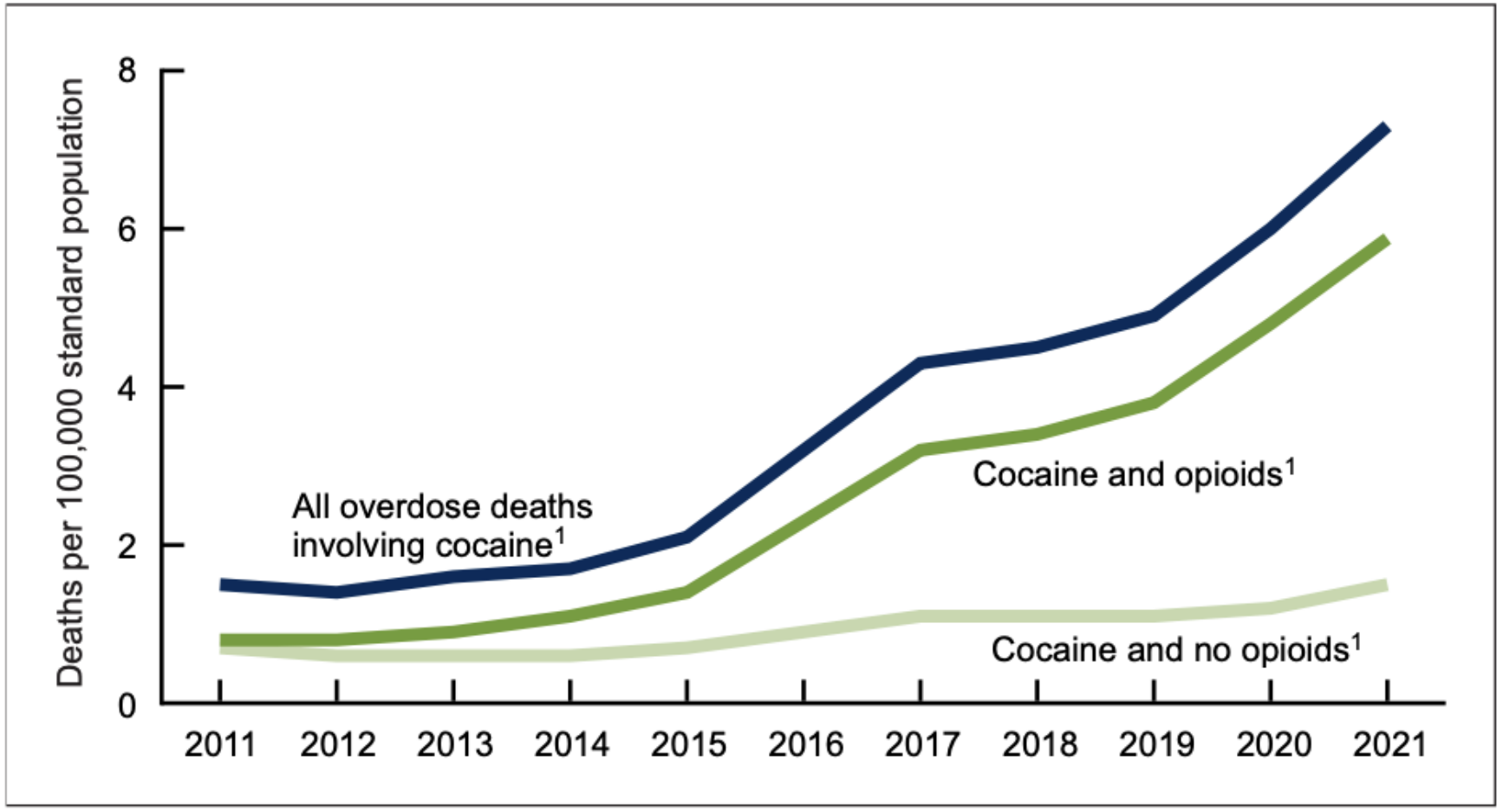
*Recent national data show that most people who use methamphetamine are between 25 and 54 years old, so investigators limited analysis to this age group.

NIH National Institute on Drug Abuse

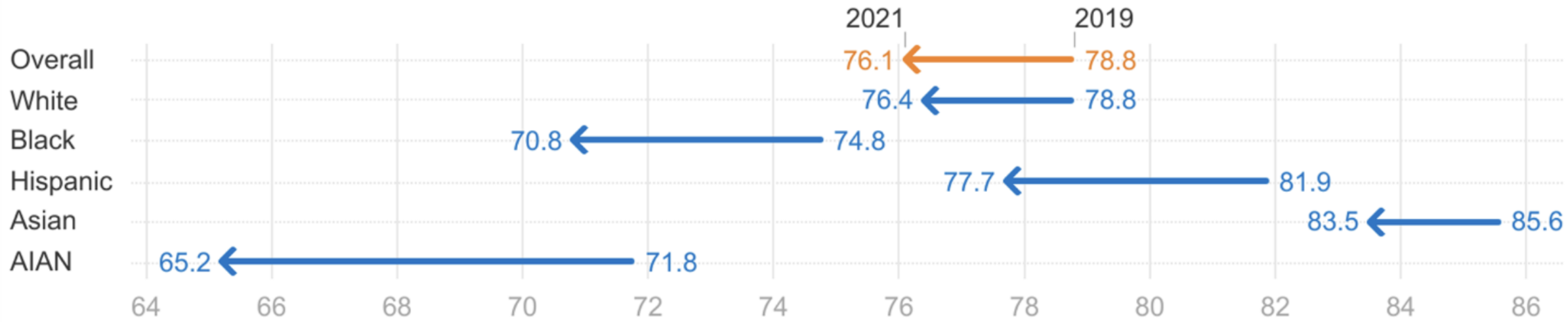
drugabuse.gov

For 2011–2021, the rate of drug overdose deaths involving both cocaine and opioids increased more quickly than the rate of overdose deaths involving cocaine without opioids.

Figure 1. Age-adjusted rate of drug overdose deaths involving cocaine, by co-involvement of opioids: United States, 2011–2021



Life Expectancy and Race/Ethnicity 2019-2021



NOTE: Estimates based on provisional data for 2021 and final data for 2019 life expectancy at birth. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

SOURCE: Arias E, Tejada-Vera B, Kochanek KD, Ahmad FB. Provisional life expectancy estimates for 2021. Vital Statistics Rapid Release; no 23. Hyattsville, MD: National Center for Health Statistics. August 2022. DOI: https://dx.doi.org/ 10.15620/cdc:118999.

KFF


EMERGENCY

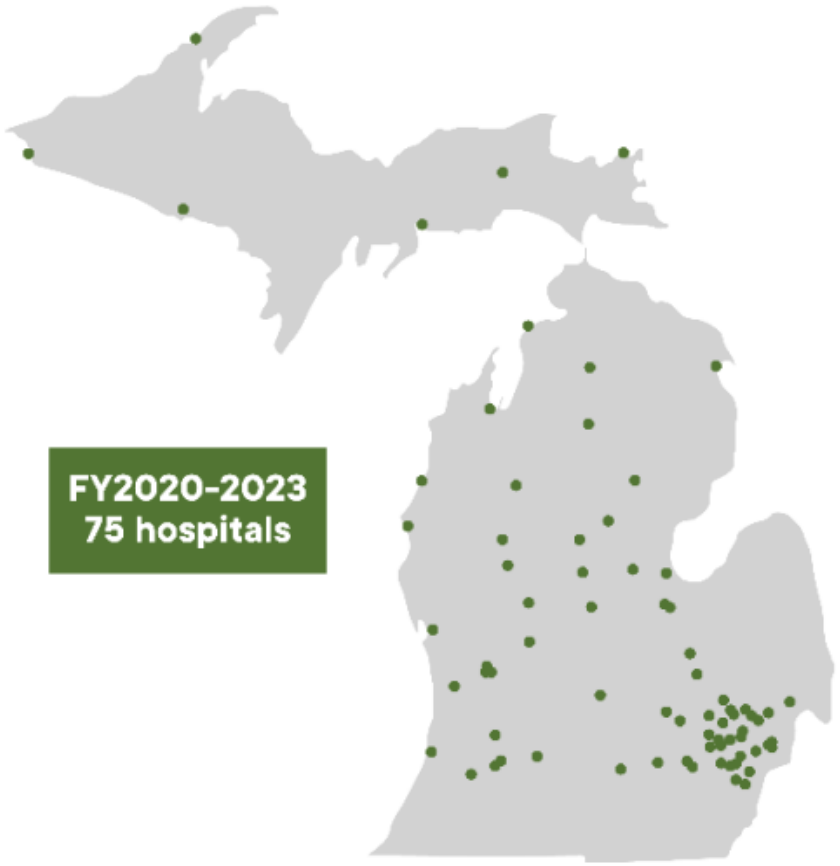

TOGETHER WE
LEARN

MICHIGAN OPIOID PARTNERSHIP

Between 2019 and 2023, the ED MOUD initiative successfully engaged half of Michigan's emergency departments. Participation occurred statewide and represented **all ten prepaid inpatient health plan regions**.

Hospitals received grant funding and technical assistance from local subject matter experts. The funding was primarily used for staff time to set up protocols, train providers, and make technology updates.

cfsem.org/wp-content/uploads/2023/09/The-Case-for-ED-MOUD-in-Michigan-Full-Report.pdfION



50%

Of Emergency Departments Statewide

Between 2019 and 2023, the ED MOUD initiative successfully engaged half of Michigan's emergency departments. Participation occurred statewide and represented **all ten prepaid inpatient health plan regions**.

Hospitals received grant funding and technical assistance from local subject matter experts. The funding was primarily used for staff time to set up protocols, train providers, and make technology updates.

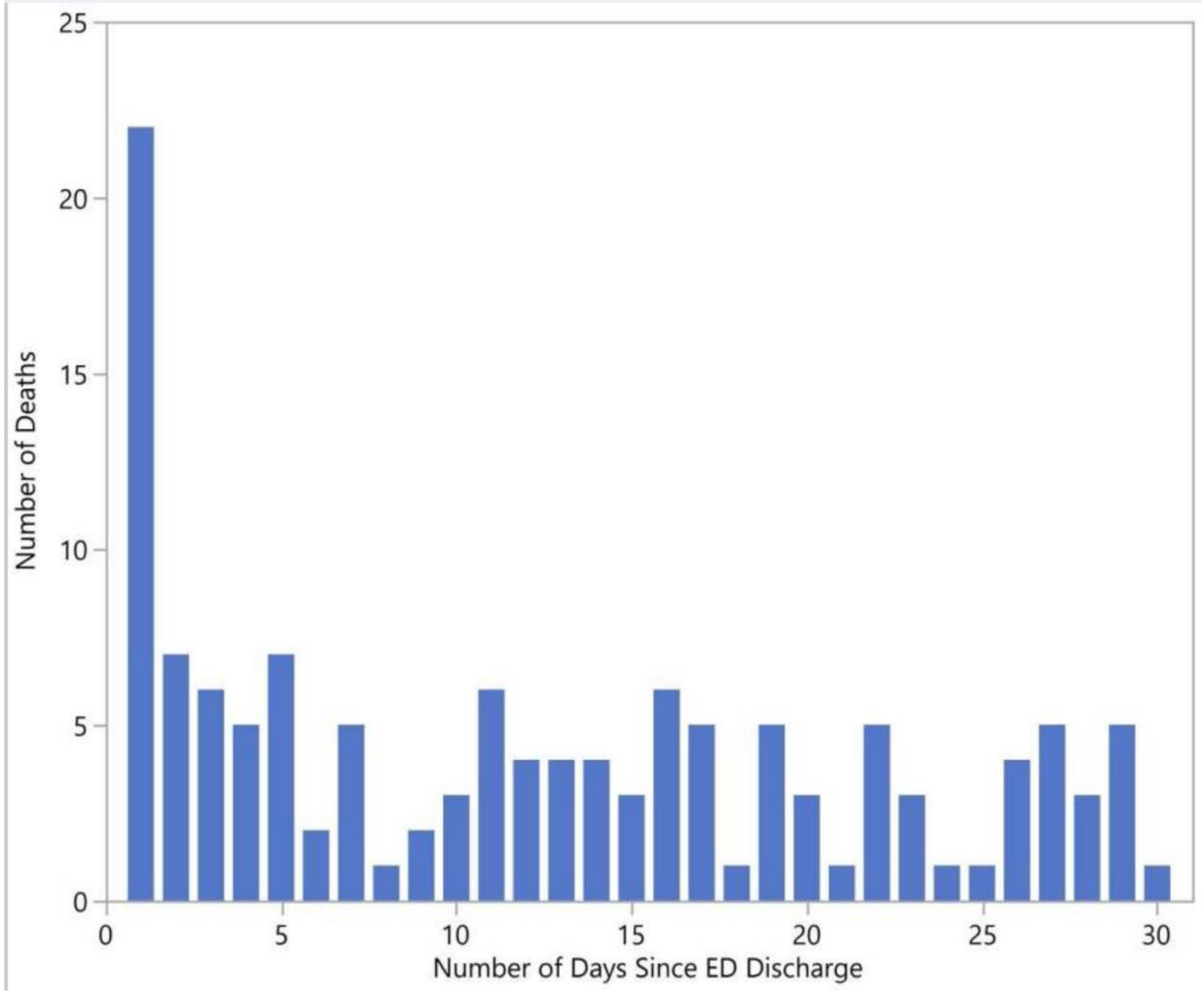
Why in the ED?

Cohort of 11,557 patients seen in ED after overdose

630 patients (5.5 percent) died within a year

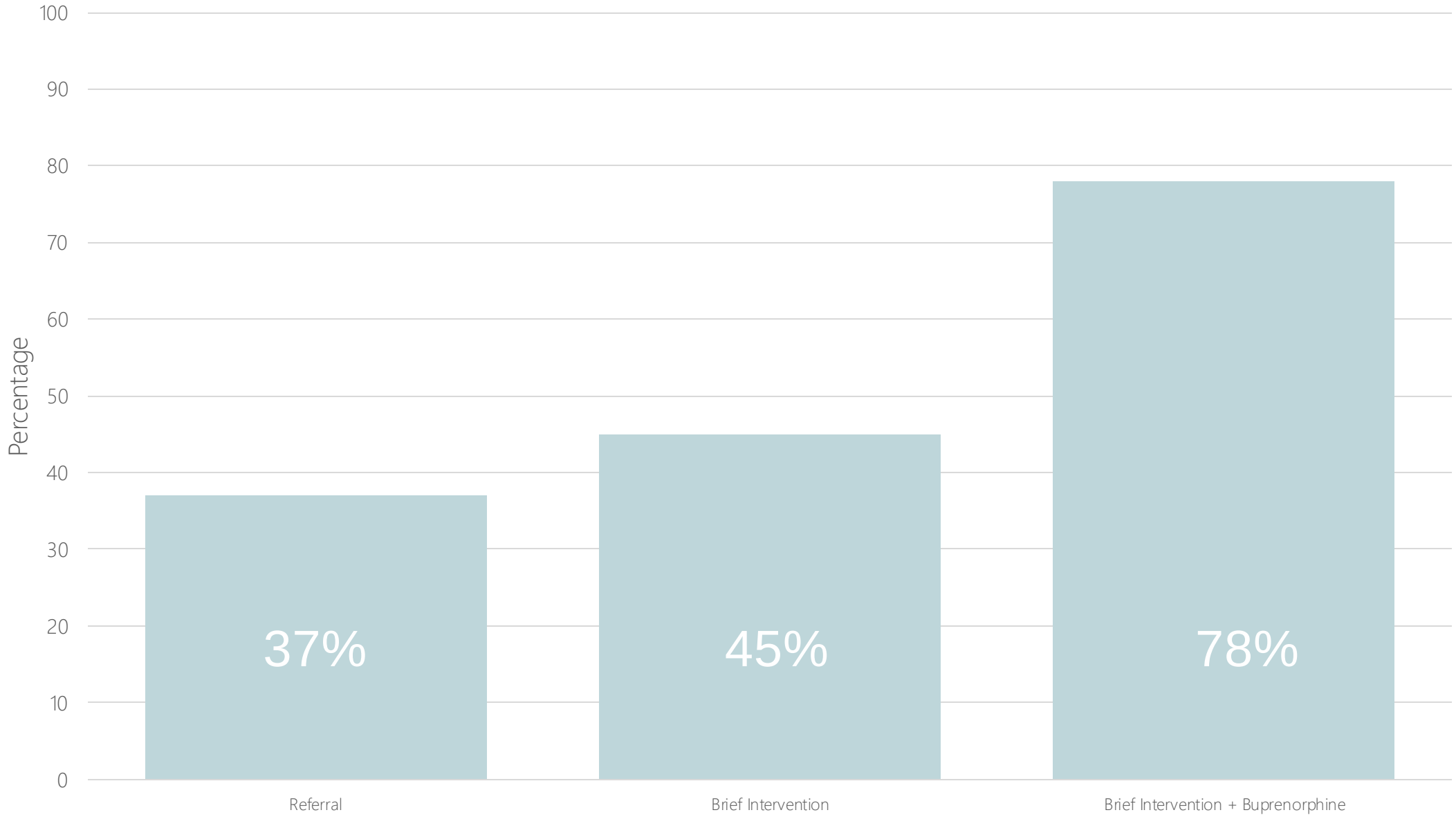
Of those that died within that year:
1 in 5 (20%) died within the first month

Of those that died in the first month:
1 in 5 (20%) died within the first 2 days



Weiner SG, Baker O, Bernson D, Schuur JD. One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose. *Ann Emerg Med*. 2020 Jan;75(1):13-17.

Engagement in Treatment at 30 Days (RCT 329 ED patients with OUD)



D'Onofrio G, O'Connor PG, Pantalon MV, Chawarski MC, Busch SH, Owens PH, Bernstein SL, Fiellin DA. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. JAMA. 2015; 313(16):1636-44.

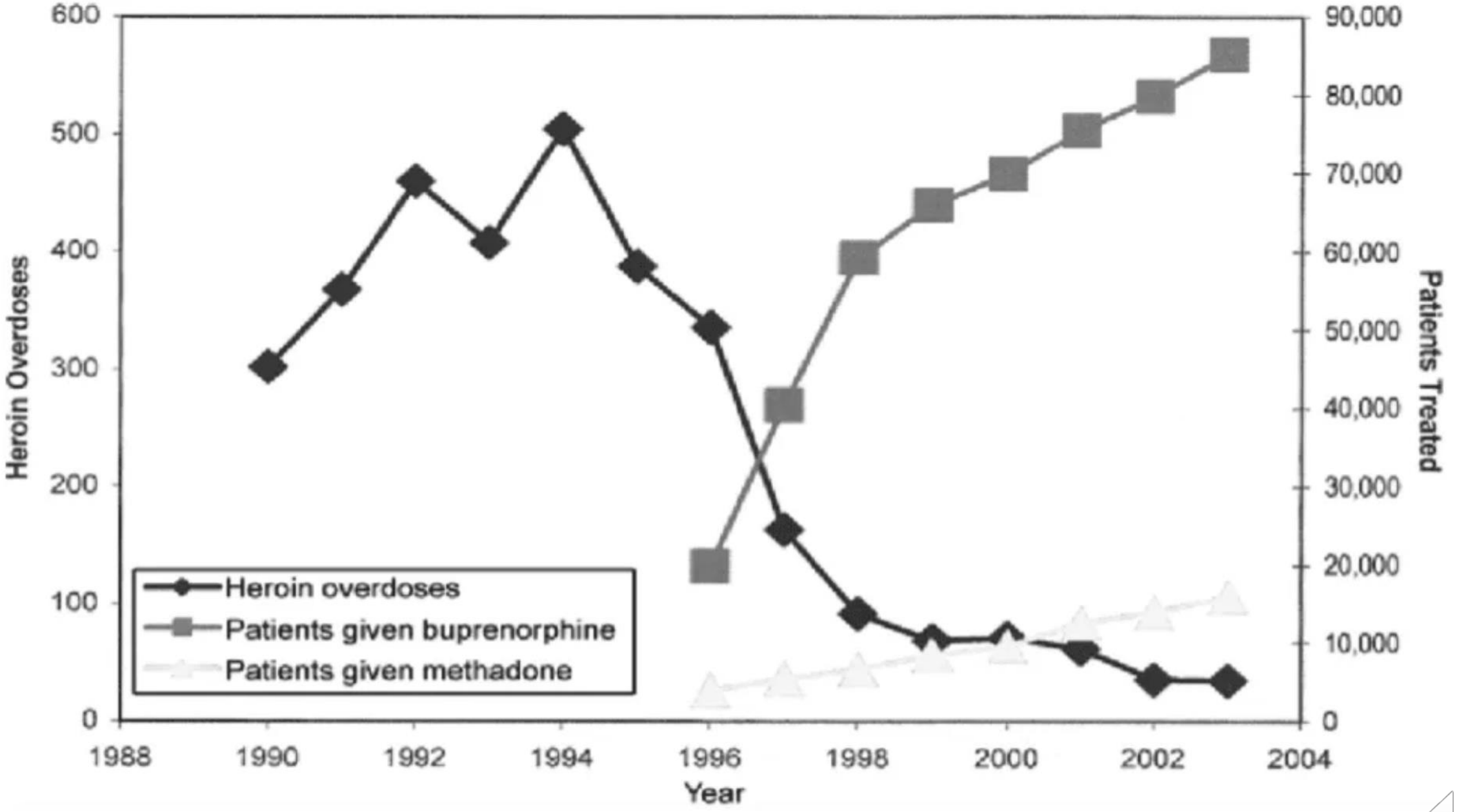


Figure 2. From: Carrieri, Maria Patrizia, et al. "Buprenorphine use: the international experience." Clinical Infectious Diseases 43.Supplement 4 (2006): S197-S215.

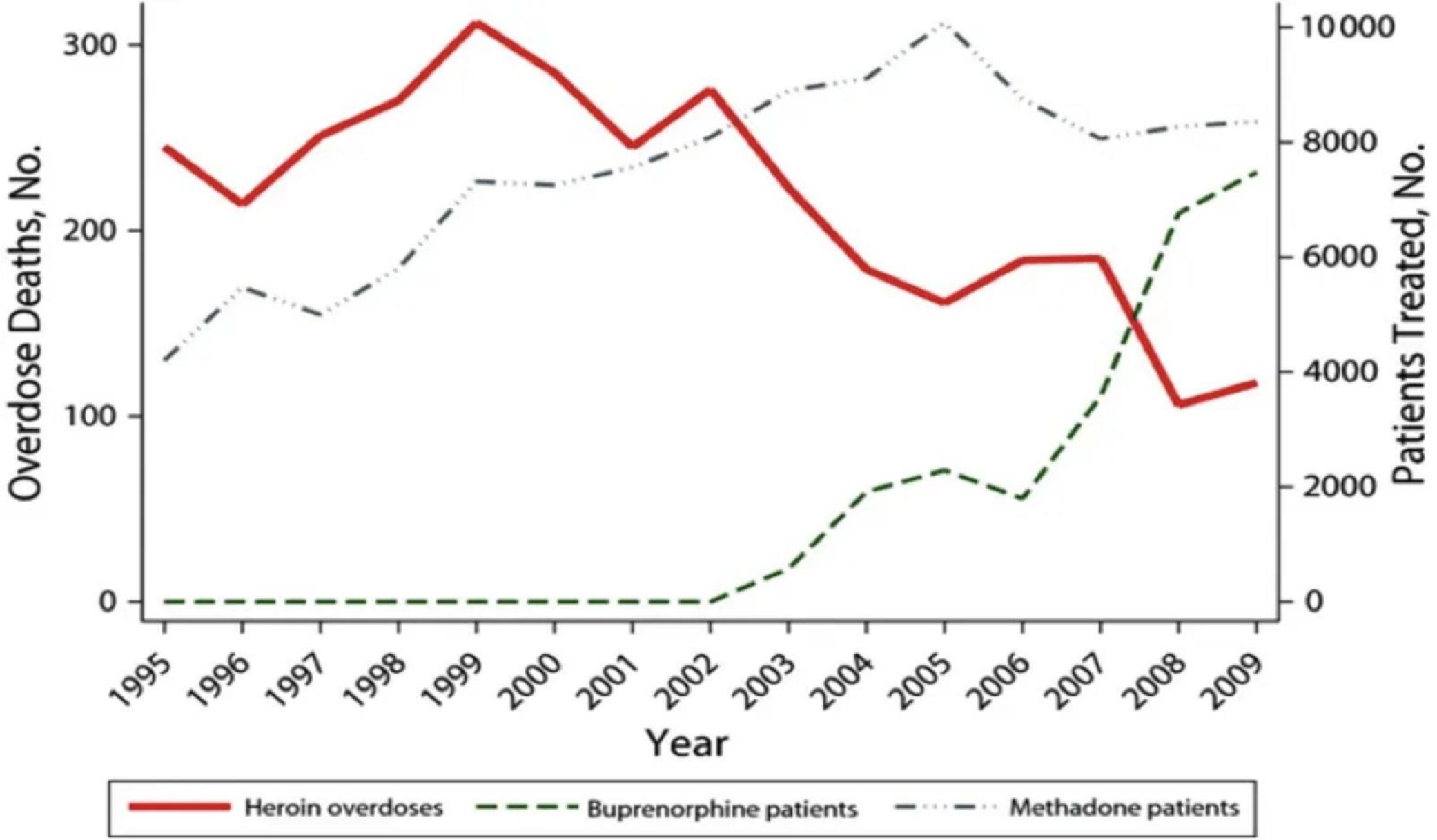


Figure 3. Schwartz, Robert P., et al. "Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995–2009." American journal of public health 103.5 (2013): 917-922.

2 for retention in treatment (using high-dose buprenorphine, ≥ 16 mg)

Benefits in Percent	
4	25% using low-dose buprenorphine (2 to 6 mg) had retention in treatment
3	33% using medium-dose buprenorphine (7 to 16 mg) had retention in treatment
2	50% using high-dose buprenorphine (≥ 16 mg) had retention in treatment

Harms in Percent	
	No study-related medication mortality was reported
	Uncertain adverse effects

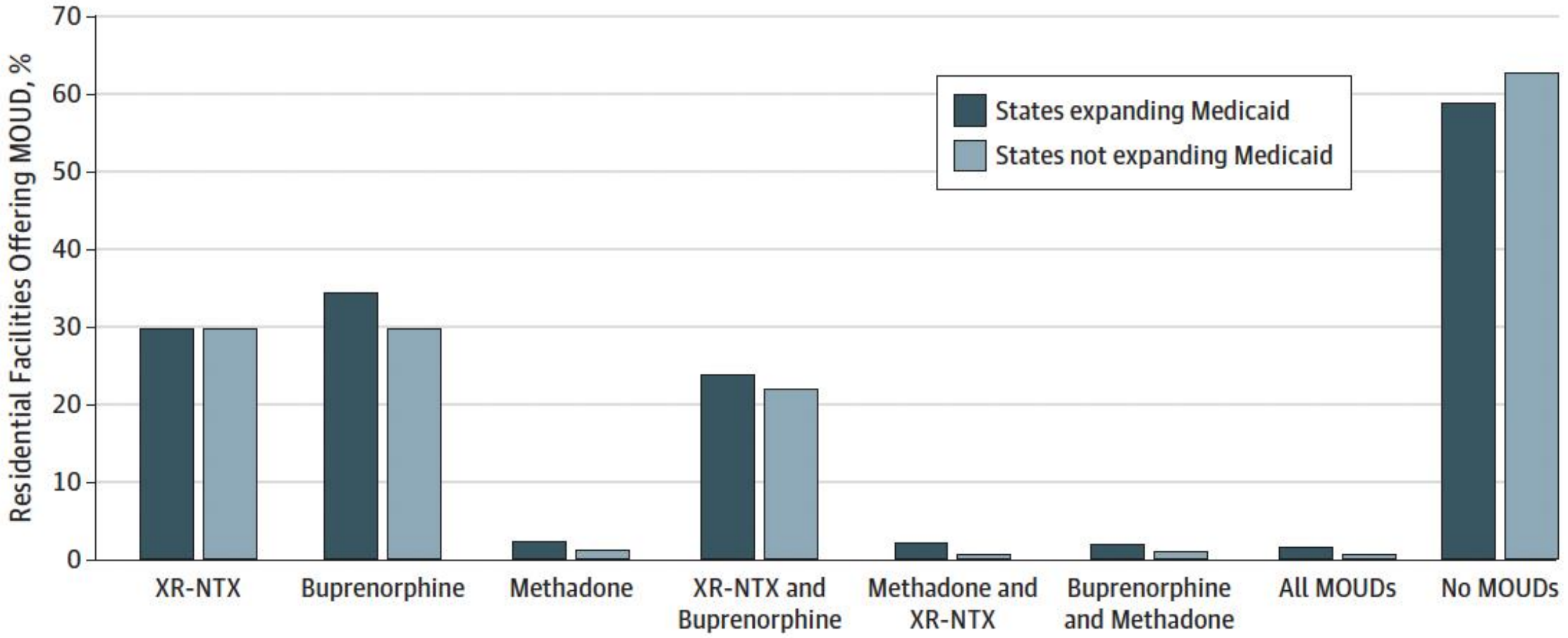
View As: NNT %

Treatment without medication is more dangerous than no treatment at all.

	Relative Risk of Death	Percent increase or reduction
MOUD-Methadone	0.62	↓ 38 %
MOUD-Buprenorphine	0.69	↓ 31 %
No Treatment	ref	ref
Treatment without MOUD	1.77	↑ 77 %

Heimer, R. etal. Receipt of opioid use disorder treatments prior to fatal overdoses and comparison to no treatment in Connecticut, 2016–17, Drug and Alcohol Dependence,Volume 254, Jan. 2024. https://doi.org/10.1016/j.drugalcdep.2023.111040.
https://news.yale.edu/2023/12/19/treating-opioid-disorder-without-meds-more-harmful-no-treatment-all

Figure 2. Availability of Medications for Opioid Use Disorder (MOUDs) and Combinations of MOUDs in Residential Treatment Facilities, by State Expansion of Medicaid



Huhn AS, Hobelmann JG, Strickland JC, Oyler GA, Bergeria CL, Umbricht A, Dunn KE. Differences in Availability and Use of Medications for Opioid Use Disorder in Residential Treatment Settings in the United States. JAMA Netw Open. 2020 Feb 5;3(2):e1920843. doi: 10.1001/jamanetworkopen.2019.20843. PMID: 32031650; PMCID: PMC8188643.

For the few who receive medication for opioid use disorder **(MOUD)** or residential treatment after detox, mortality was reduced over the next 12 months

RETROSPECTIVE POPULATION COHORT, MASSACHUSETTS PUBLIC HEALTH DATA WAREHOUSE (2012-2014)

30,681 patients
admitted to a facility for medically managed opioid withdrawal (detox)

Most patients received no further treatment in the month after discharge from detox	All-cause mortality rate with relative risk reductions
No Treatment (65%)	2 of 100 people who received no treatment were dead at 1 year
Residential (17%)	↓ 37%
MOUD (15%)	↓ 66%
MOUD + Residential (3%)	↓ 89%

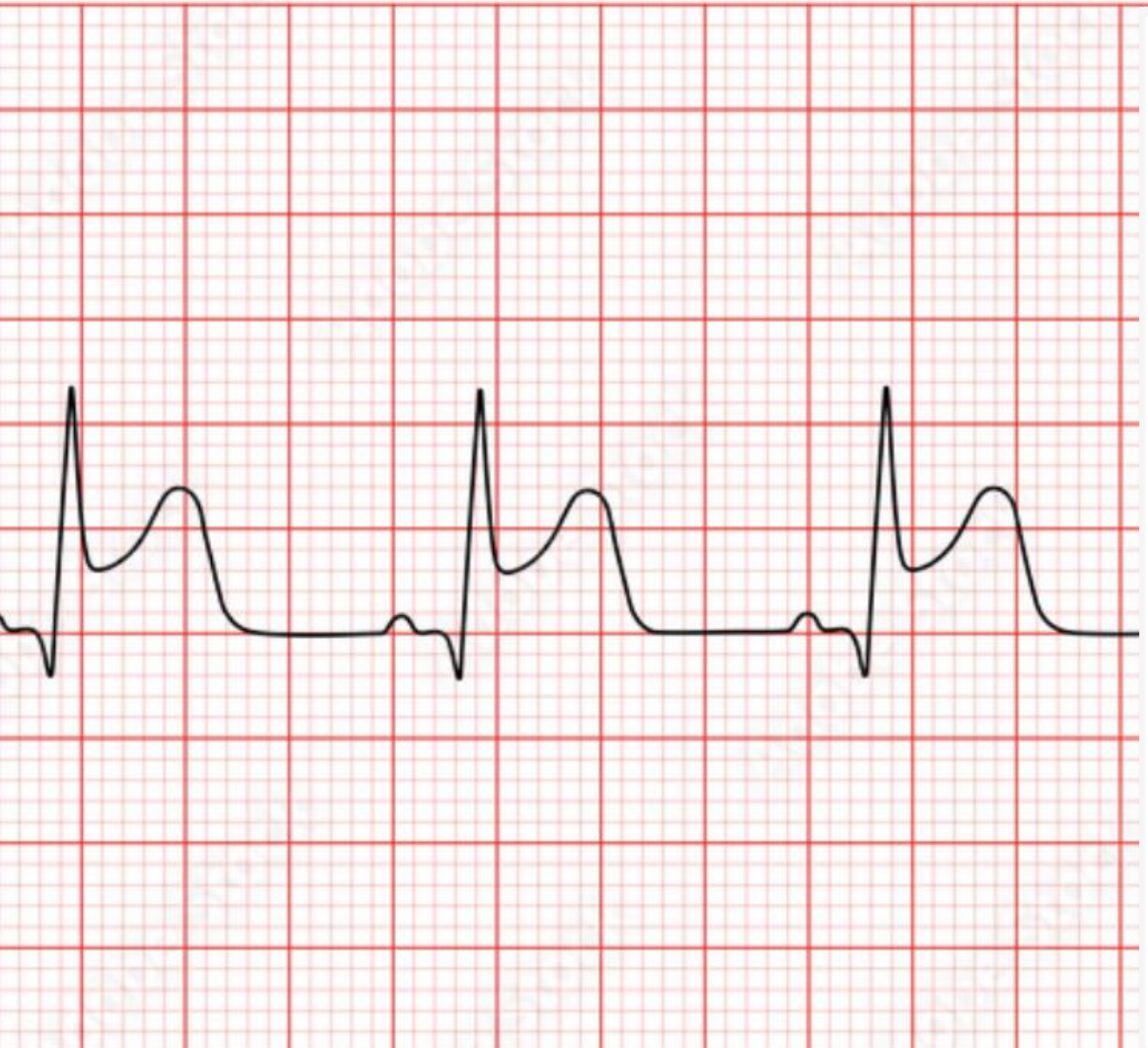
Grayken Center for Addiction

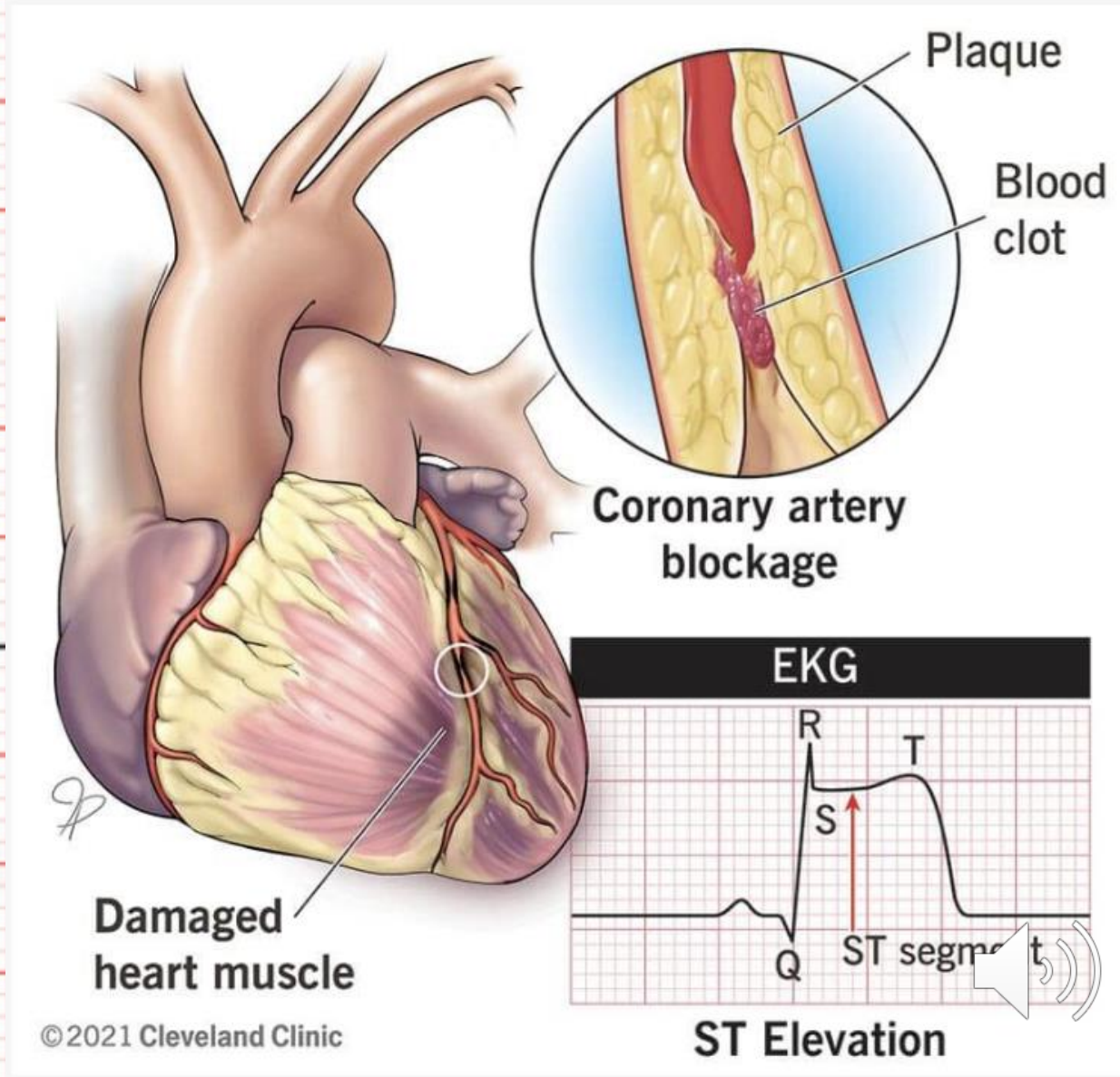
Walley et al. Addiction. 2020.

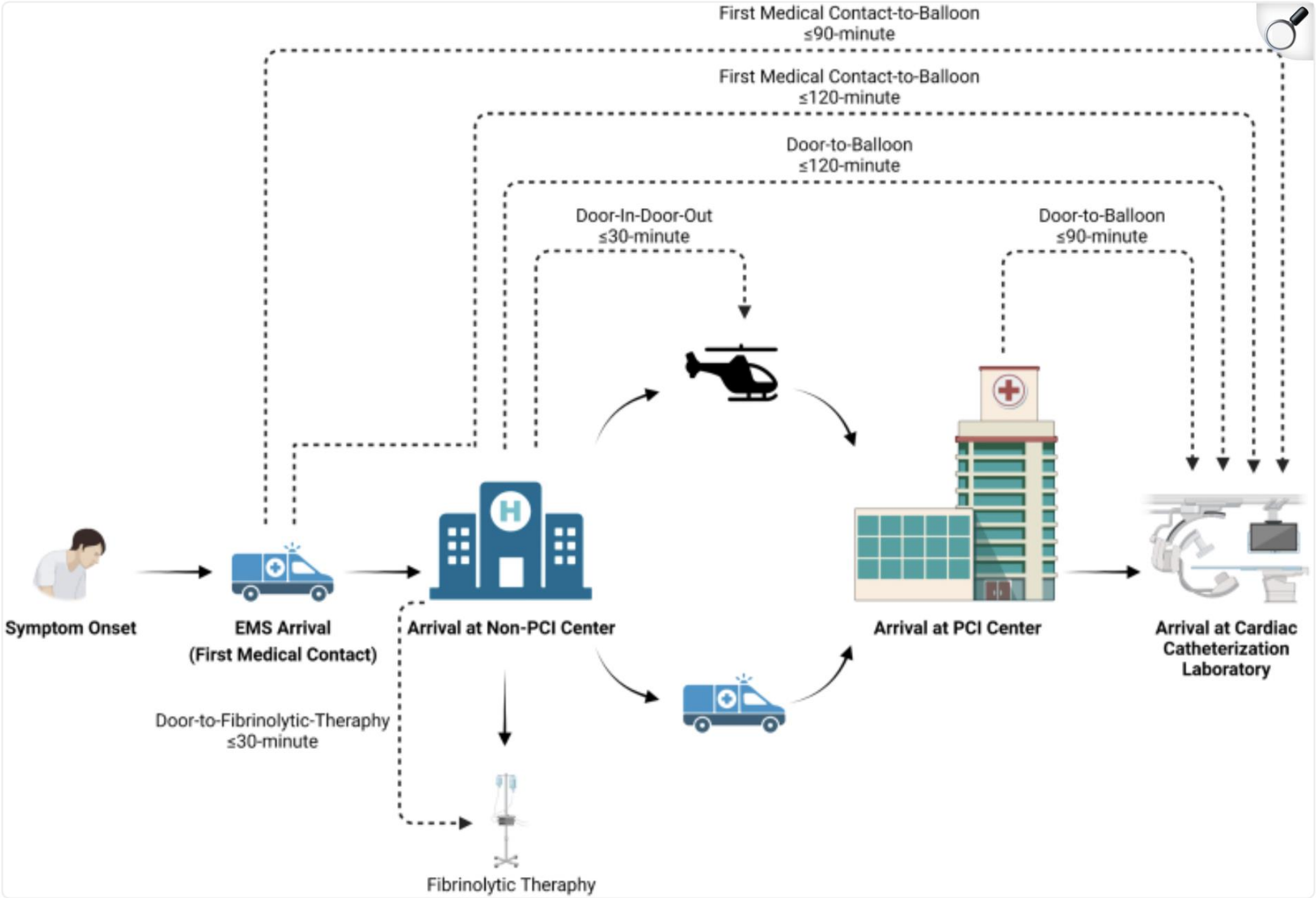

EMERGENCY


Mortality Rate at 1 year
8
7
6
5
4
3
2
1
0
STEMI
Nonfatal Opioid Overdose

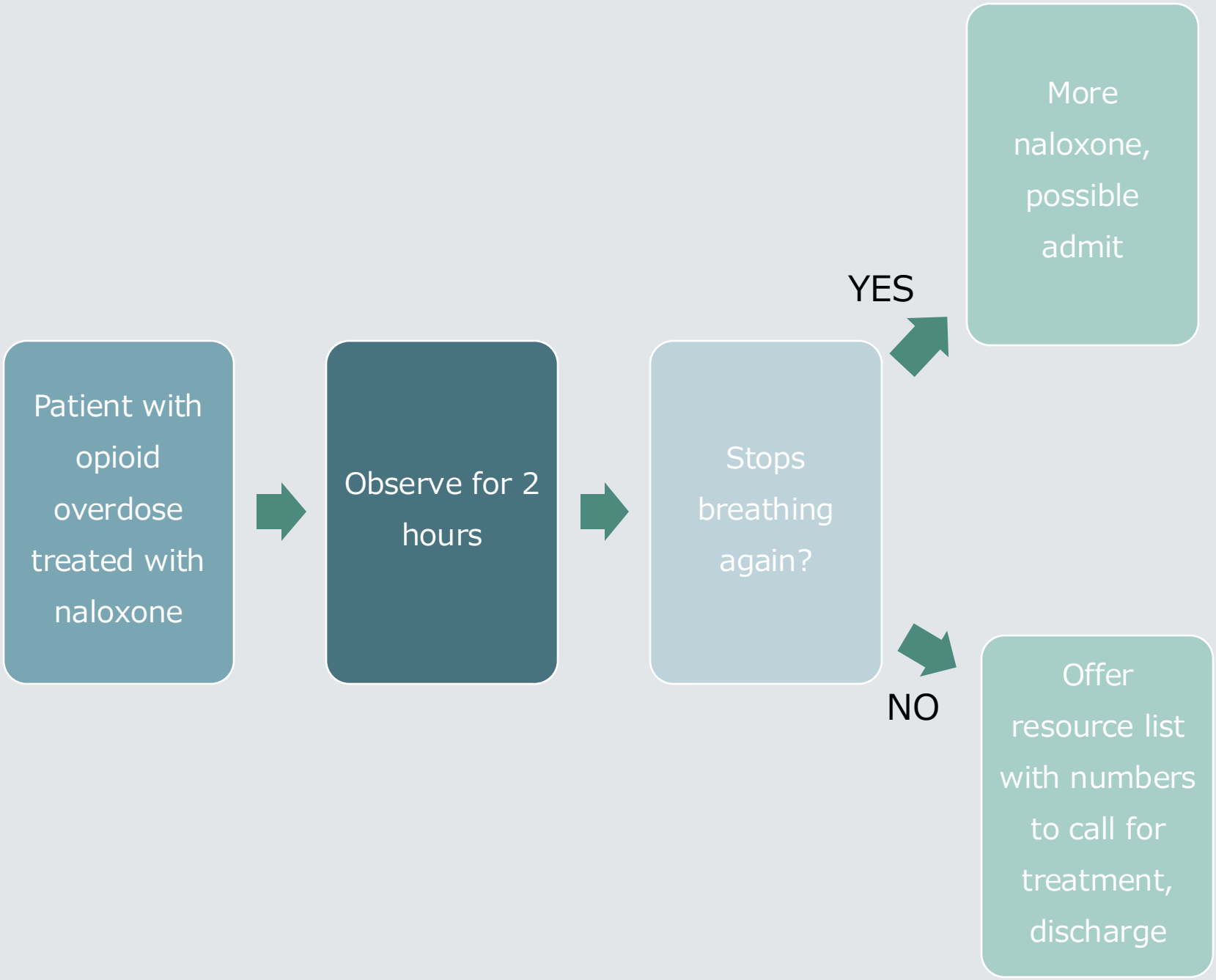
ST Elevation Myocardial Infarction (STEMI)






First Medical Contact-to-Balloon
≤90-minute
First Medical Contact-to-Balloon
≤120-minute
Door-to-Balloon
≤120-minute
Door-In-Door-Out
≤30-minute
Door-to-Balloon
≤90-minute
Symptom Onset
EMS Arrival
(First Medical Contact)
Arrival at Non-PCI Center
Arrival at PCI Center
Arrival at Cardiac
Catheterization
Laboratory
Door-to-Fibrinolytic-Theraphy
≤30-minute
Fibrinolytic Theraphy


80
98
120
80
37.1
36.5


Patient with opioid overdose treated with naloxone
Observe for 2 hours
Stops breathing again?
YES
More naloxone, possible admit
NO
Offer resource list with numbers to call for treatment, discharge

ED-MOUD

1. Identify Patients with OUD

2. Start MOUD during the ED encounter

3. Connect To community-based care

1. Identify Patients with OUD

- Post overdose/OUD Complications
- Reporting Opioid Withdrawal
- Screening question at triage
- Encourage self-disclosure to ED staff

Are pain pills or heroin affecting your life?

We care about your safety and health.

Ask us about medicines and Community resources that can help.

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MICHIGAN OPIOID PARTNERSHIP

Communication sent to all team members notifying people what action to take if patient asks for help.

- 2. Begin ED MOUD during an ED Encounter

Creation of ED buprenorphine dosing protocol for ED and home starts

Creation of ED MOUD Orderset (contains buprenorphine dosing and naloxone at discharge)

Build COWS scale into nursing documentation/import to provider note

Creation of .EDMOUD Smartphrase for ED buprenorphine starts

Patients identified with OUD discharged with Naloxone in hand

ED Staff Education

Bronson ED Buprenorphine Initiation for Opioid Withdrawal

Objective opioid withdrawal (COWS ≥8)?
(from abstinence or naloxone reversal)

NO → **Home Buprenorphine Induction**
Click here for instructions

YES ↓

Administer 8 mg sublingual buprenorphine* (SL bup)
*If vomiting: May use IM bup 0.3 mg

↓ 30-60 min ↓

Withdrawal improved?

NO → **If no improvement or worse, consider:**

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

Other substance intoxication or 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 mg SL bup

↓ Observe 30 min ↓

Discharge

- **Prescribe sufficient buprenorphine/naloxone** until follow-up:
  - Goal total daily dose = 8-32 mg of bup, split BID for doses >8 mg/day. Adjust up/down based on patient experience. Doses >24 mg/day have not shown additional clinical advantage.
  - For home induction: Prescribe bup/naloxone 4mg/1mg SL films. See example dosing here.
  - Pause opioid pain relievers when starting bup.
  - Bup and bup/naloxone are both OK in pregnancy
- **Consult MSW +/- Recovery Coach or enter discharge referral** for outpatient follow-up (< 7 days) at:
  - BMH: Family Health Center / Family Medicine
  - BBC: Summit Pointe / First Step
  - BLH & BSH: InterCare Community Health Ntwk
- **Dispense (preferred) or prescribe (if not available) intranasal naloxone** from the ED.

Precipitated withdrawal:

- Administer additional 16 mg of bup ASAP. Reassess in 30-60 minutes.

- If continued distress remains: Repeat 8-16 mg bup. Max = 32 mg total dosage.

- If precipitated withdrawal is not resolved by bup: Consider clonidine, antipsychotics (e.g., haloperidol), cautious use of benzodiazepines, high potency opioid (e.g., fentanyl 100 mcg IV), or ketamine (0.3 mg/kg IV over 10-20 min).

- Once withdrawal is managed, initiate daily buprenorphine prescribing.

Opioid Withdrawal:

Start buprenorphine if COWS score ≥ 8 AND objective signs

Objective signs: tachycardia, yawning, mydriasis, rhinorrhea, vomiting, diarrhea, piloerection

Typical withdrawal onset:
- >12 hr after last short-acting opioid
- >24 hr after last sustained-release opioid
- Variable onset after last methadone use (may be >72 hours)

Do NOT start bup if:
- Patient taking methadone and <72 hr from last dose
- Benzodiazepine or other sedative/ intoxicant suspected
- Unable to comprehend risks and benefits
- Severe medical illness (sepsis, respiratory distress, etc.) suspected

BRONSON

Order Sets

Orders

Clear All Orders

ED Adult Opioid Use Disorder / Withdrawal Treatment Orders

Manage User Versions | Remove Order Sets

Provider Information:

- ***For more detailed algorithm and link to additional resources:*** *Bronson ED Buprenorphine Initiation for Opioid Withdrawal.pdf (bronsonhg.org)*
  - ***Link to Clinical Opiate Withdrawal Score (COWS) Calculator:*** *COWS Score for Opiate Withdrawal*
  - ***Link to DSM-5 Criteria for Opioid Use Disorder (OUD):*** *DSM-5 Criteria for OUD*

Inclusion Criteria for Buprenorphine Treatment:

- ***Mild-to-Moderate Acute Opioid Withdrawal and Opioid Use Disorder***

Exclusion Criteria for Buprenorphine Treatment:

- ***Patients whose last methadone dose was in the past 72 hours. Patients taking methadone may have withdrawal reactions to buprenorphine up to 72 hours after last use.***
- ***Benzodiazepine or other sedative/intoxicant suspected***
- ***Unable to comprehend potential risks and benefits for any reason***
- ***Severe medical illness such as sepsis, respiratory distress, organ failure present or suspected***

GENERAL

Initial Orders

- [x] Clinical opiate withdrawal scale
  ASAP, Until discontinued, Starting today at 1434, Until Specified
  Before and 30-60 minutes after each buprenorphine/clonidine dose is administered. Document in Scoring Scales.
- [x] Nursing communication
  ASAP, Once, today at 1434, For 1 occurrence
  Notify provider if the patient experiences excessive sedation or decreased respiratory rate of less than 12 BPM.
- [x] IP consult to Social Work
  Reason for Consult? Other (comment)
  Other (see comments): Opioid use disorder and withdrawal

LABS

No labs required prior to initiating therapy. Any labs needed for follow-up therapy should be completed in the outpatient setting.

OUD/Withdrawal Labs

Click for more

Peer Recovery Coaches

- Peer Recovery Coaches (PRCs) are individuals in long term recovery from addiction that are trained in motivational interviewing and other skills to use their lived experience to help patients in active addiction.
- PRCs are experts in navigating the complex world of outpatient clinics, inpatient rehab regardless of insurance, county of residence for ongoing treatment

Bronson Battle Creek	Summit Pointe
Bronson Methodist Kalamazoo	Integrated Services of Kalamazoo
Bronson Lakeview	COPE Network / Intercare
Bronson South Haven	COPE Network / Intercare

3. Support care continuity by connecting patients to outpatient MOUD services in the community

Upon ED discharge

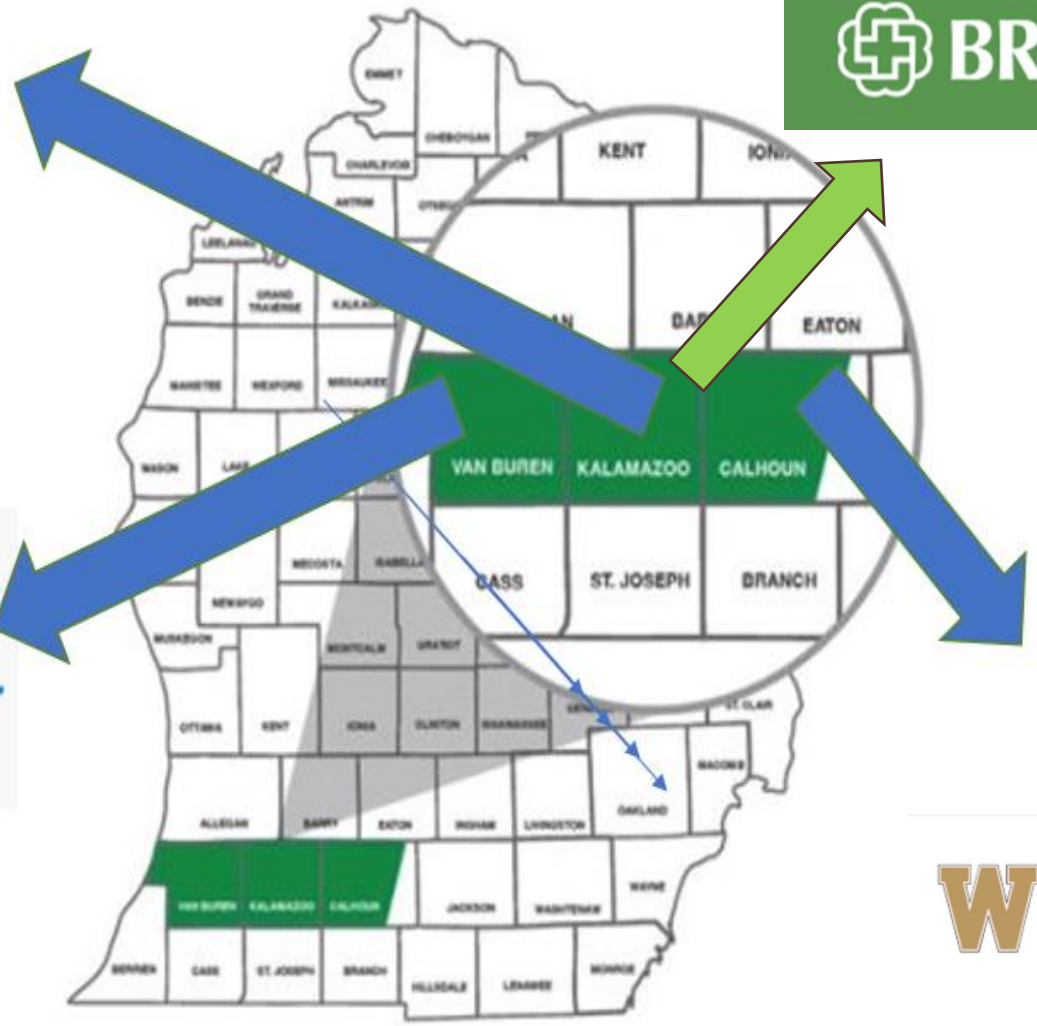
Upon Hospital discharge

Warm Handoffs/close follow up are a key to patient survival and success

FAMILY HEALTH center

BRONSON

Western Michigan University — Homer Stryker M.D. SCHOOL OF MEDICINE



InterCare Community Health Network

Summit Pointe

Western Michigan University — Homer Stryker M.D. SCHOOL OF MEDICINE

Patients initiated on buprenorphine in the ED will have follow up with one of our community partners within 7 days

Bronson ED-MOUD Warm Handoffs/ED Follow-up Grid

Establishing supported, early ED follow-up for patients with further MOUD services is key to patient survival and success!	
Bronson Battle Creek	Summit Pointe/First Step Recovery Center • Clinic Hours: 24 hours/7 days per week • Address: 175 College Street, Battle Creek, MI 49037 • Ph: 269-966-1460 (call 24/7)
Bronson Methodist - Kalamazoo	Family Health Center – Paterson • Office-Based Addiction Treatment Clinic Hours: M-F, 8:00AM - 5:00PM • Address: 117 West Paterson Street, Kalamazoo, MI 49007 • Ph (OBAT Clinic): 269-349-2641, ext. 515 - If after hours, leave a message which will be returned the next business day. WMed Family Medicine – Crosstown Parkway • Clinic Hours: M-F, 8:00AM - 5:00PM • Address: 555 W Crosstown Pkwy, Suite 200, Kalamazoo, MI 49008 • Ph: 269-585-0200 Bronson Family Medicine - The Groves: Office-Based Addiction Treatment • Clinic Hours: M-F, 7:00AM - 5:00PM • Address: 6938 Elm Valley Drive, Suite 101, Kalamazoo, MI 49009 • Ph: 269-552-4233 - Front desk will schedule follow up within 7 days. If warm handoff is needed, ask to speak with social worker.
Bronson Lakeview - Paw Paw **Bronson South Haven**	InterCare Community Health Network • Clinic Hours: M-F, 8:30 AM - 5:00PM • Address: InterCare Community Health Network (MOUD Services available at all locations) • Ph: Business Hours = 269-251-3128. If after hours, leave a message for next-day follow-up.
• ED Social Work/Case Manager consult / Peer Recovery Coach consults are preferred for every patient. • If Social Worker/Case Manager/Peer Recovery Coach is not available, ED Provider/Nurse/Clerk can call and leave a message with patient contact information.	


Summit
Pointe


BRONSON


FAMILYHEALTH
center


Dedicated to Quality of Care
Southwestern Michigan
EMERGENCY SERVICES, P.C.


WESTERN MICHIGAN UNIVERSITY
Homer Stryker M.D.
SCHOOL OF MEDICINE


LANDMARK
RECOVERY


STREET
MEDICINE
KALAMAZOO


Ascension


COPE
network


grace
HEALTH


INTEGRATED
Services of Kalamazoo

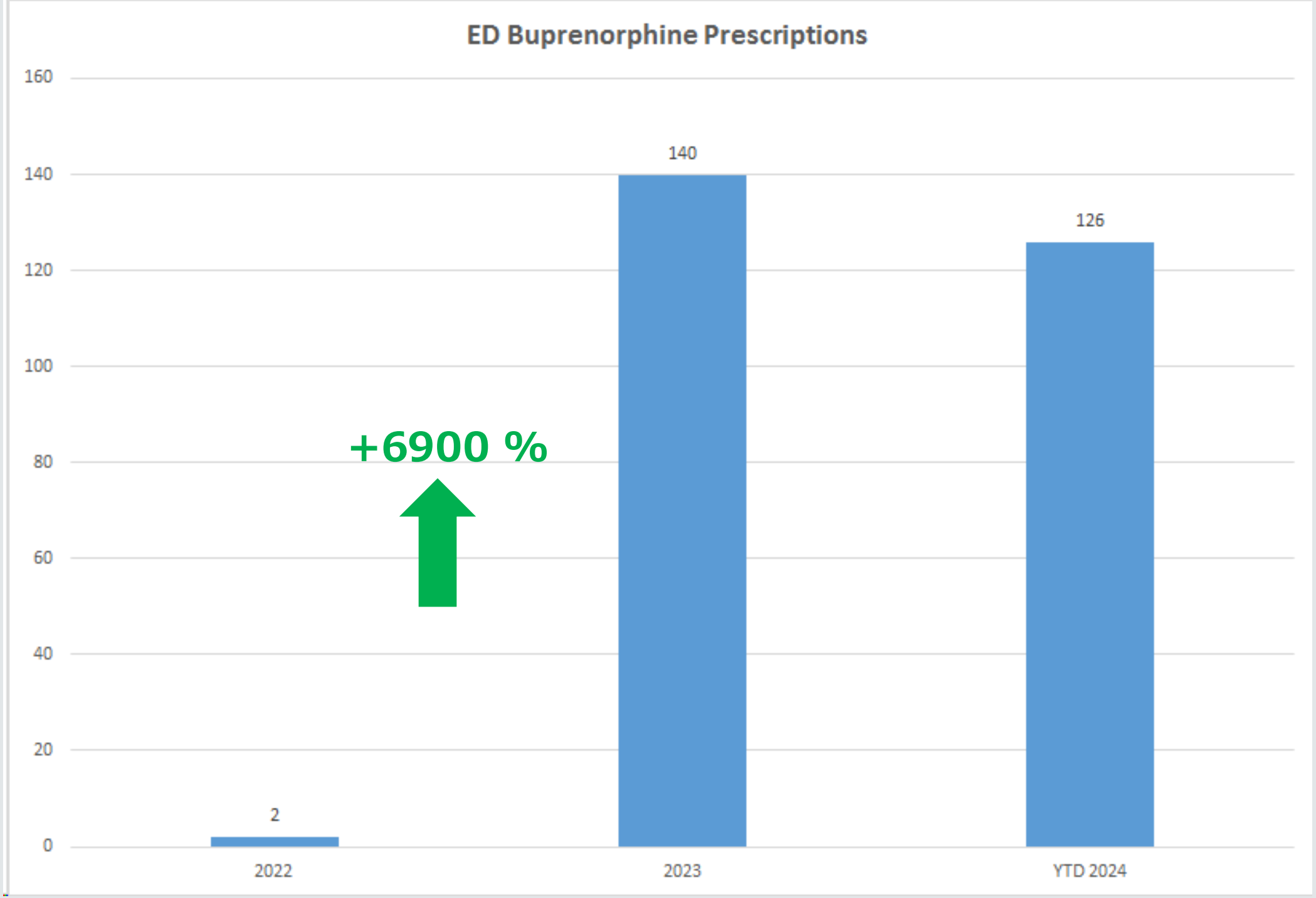

InterCare
Community Health Network


Community
Foundation
FOR SOUTHEAST MICHIGAN


MICHIGAN OPIOID
PARTNERSHIP


VICTORY CLINICAL SERVICES


Van Buren
Community
Mental Health

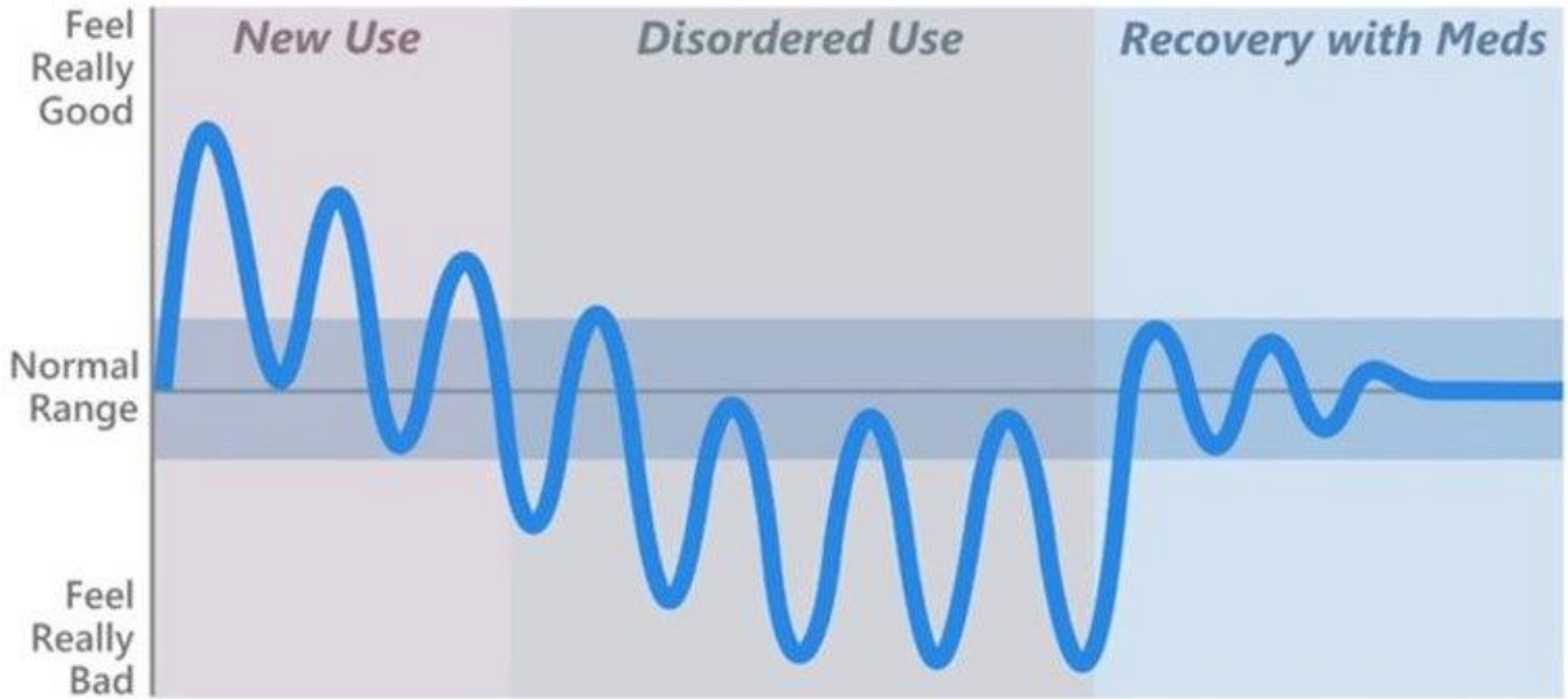

ED Buprenorphine Prescriptions
160
140
120
100
80
60
40
20
0
140
126
2
+6900 %
2022
2023
YTD 2024

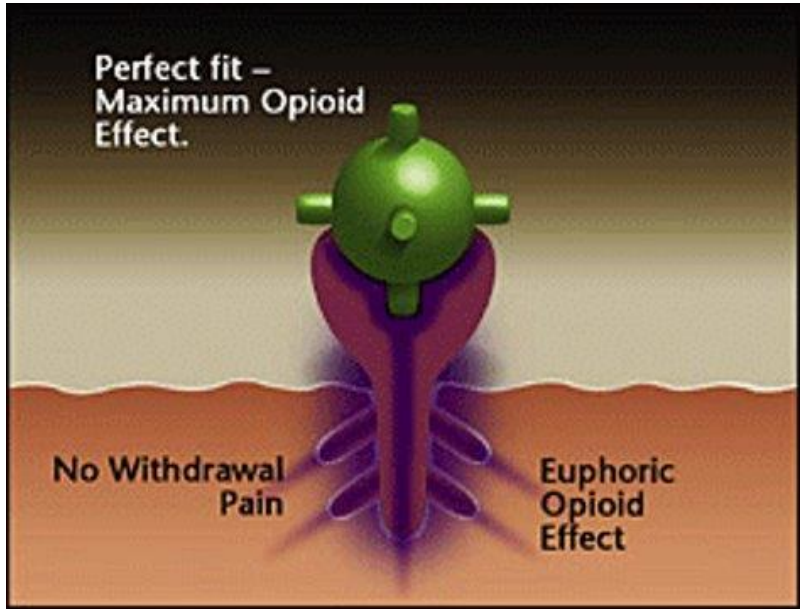
Benefits of MOUD

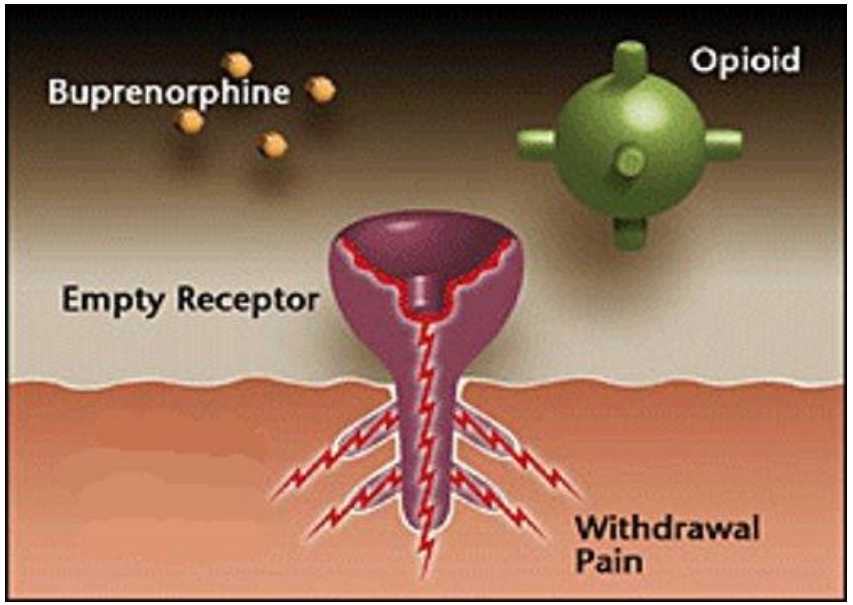
- Decreases opioid specific and all-cause mortality
- Decreased ED visits
- Decreased Hospitalizations
- Less Infectious disease transmission (HIV, Hepatitis)
- Decrease involvement with criminal justice system

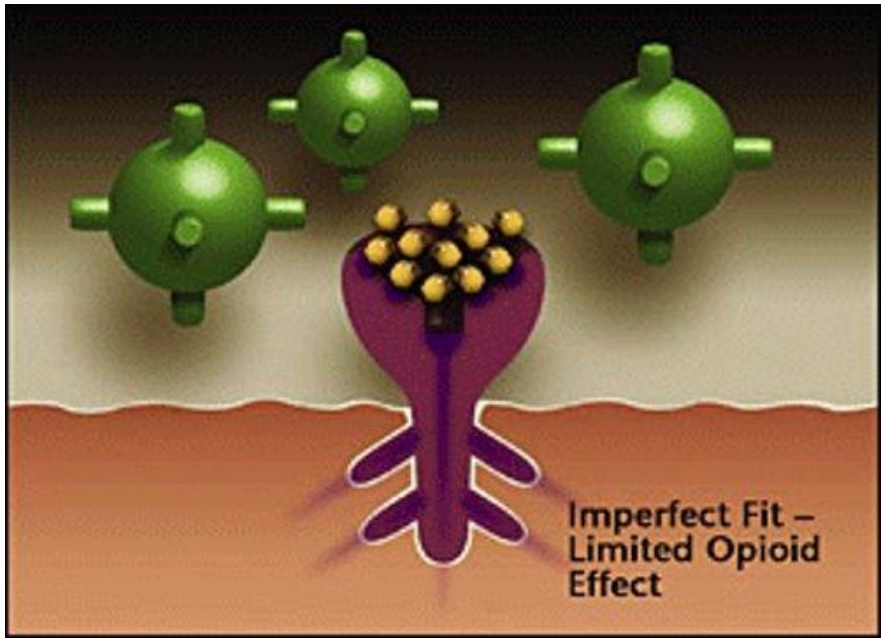
Larochelle MR, et al. Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality: A Cohort Study. *Ann Intern Med*. 2018;169(3):137-145.
Lo-Ciganic WH, etal. Association between trajectories of buprenorphine treatment and emergency department and in-patient utilization. Addiction. 2016 May;111(5):892-902.
Sordo L, etal. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ. 2017 Apr 26;357:j1550.
Holloway KR, Bennett TH, Farrington DP. The effectiveness of drug treatment programs in reducing criminal behavior: a meta-analysis. Psicothema. 2006 Aug;18(3):620-9. PMID: 17296096.

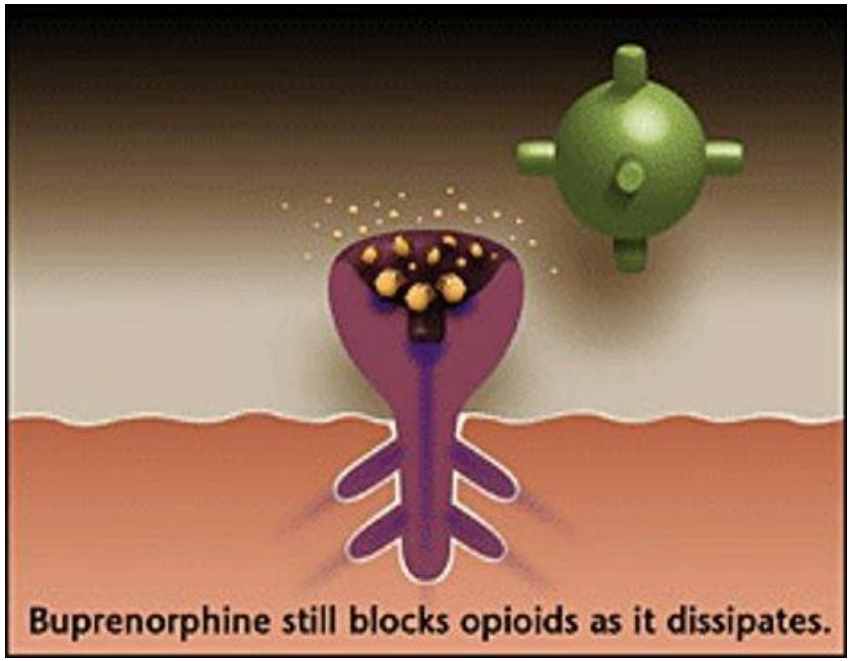
Opioid Use Disorder











https://www.naabt.org/education/buprenorphine_treatment.cfm

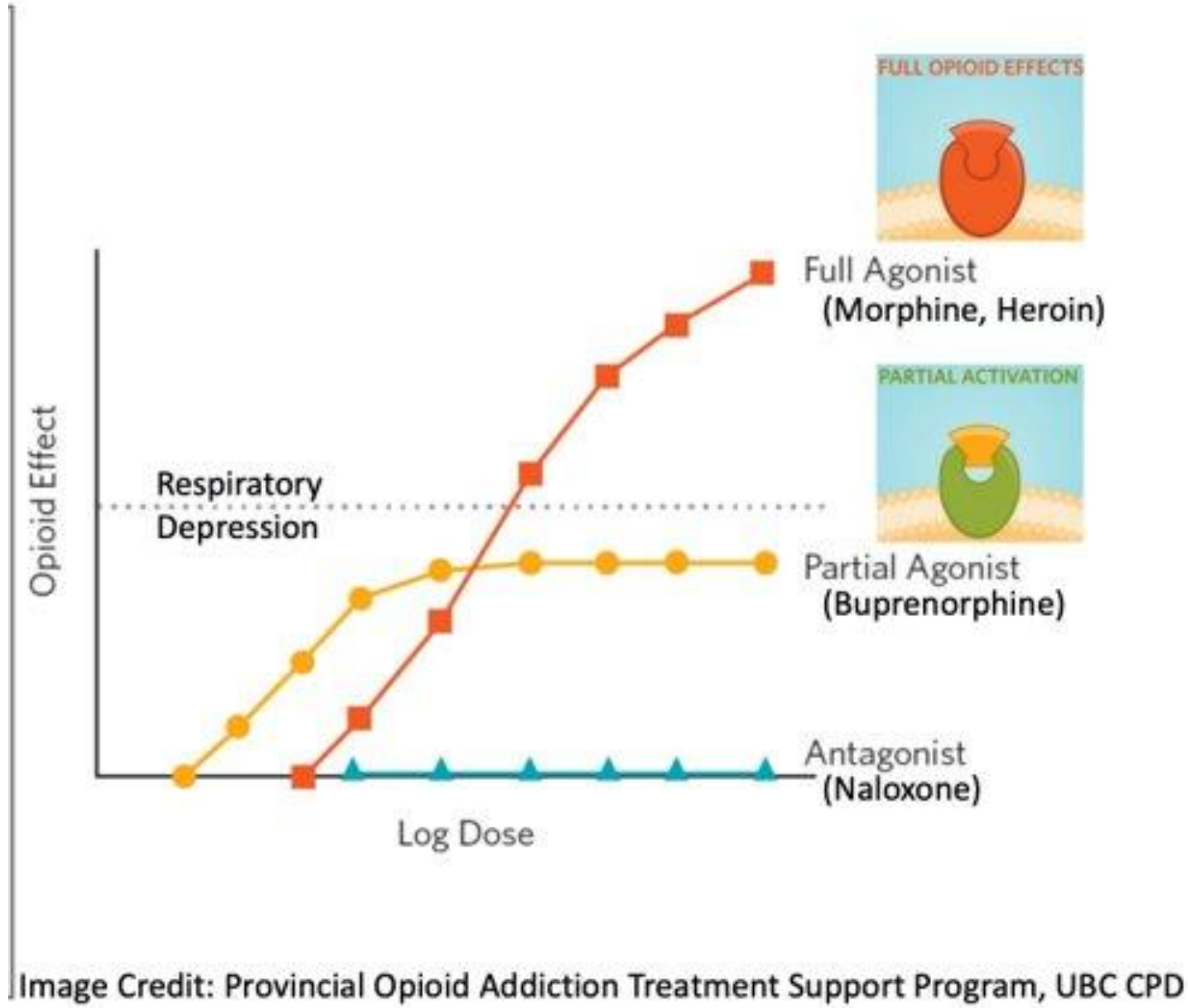


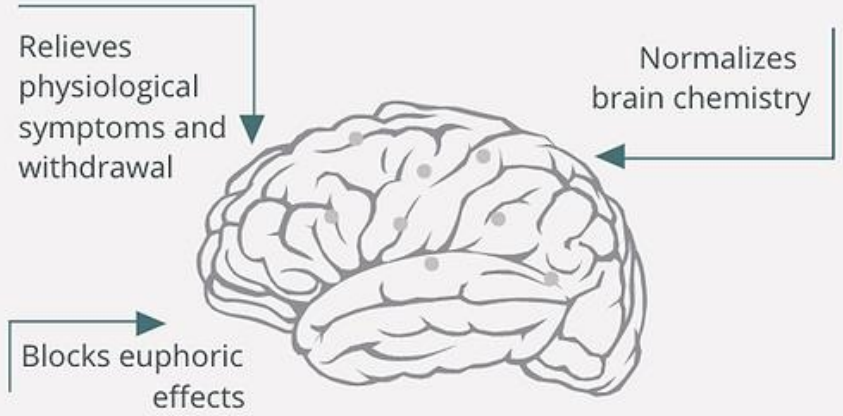
Image Credit: Provincial Opioid Addiction Treatment Support Program, UBC CPD

[Buprenorphine Basics. British Colombia Center on Substance Use]

ADDICTION POLICY FORUM

Medications for Opioid Use Disorder (MOUD)

How It Works

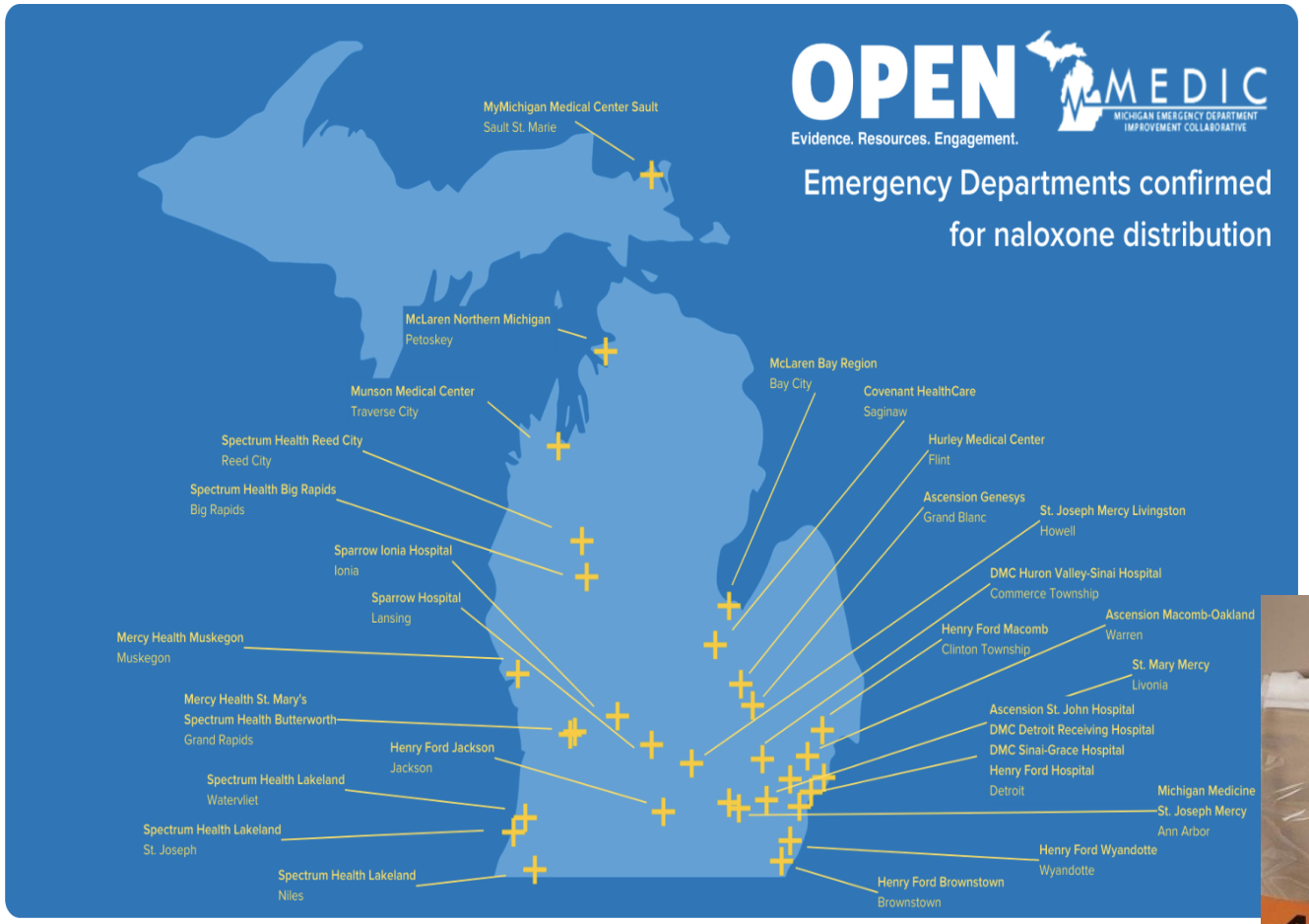


Types of Medications

Full agonist tightly attaches to opioid receptors

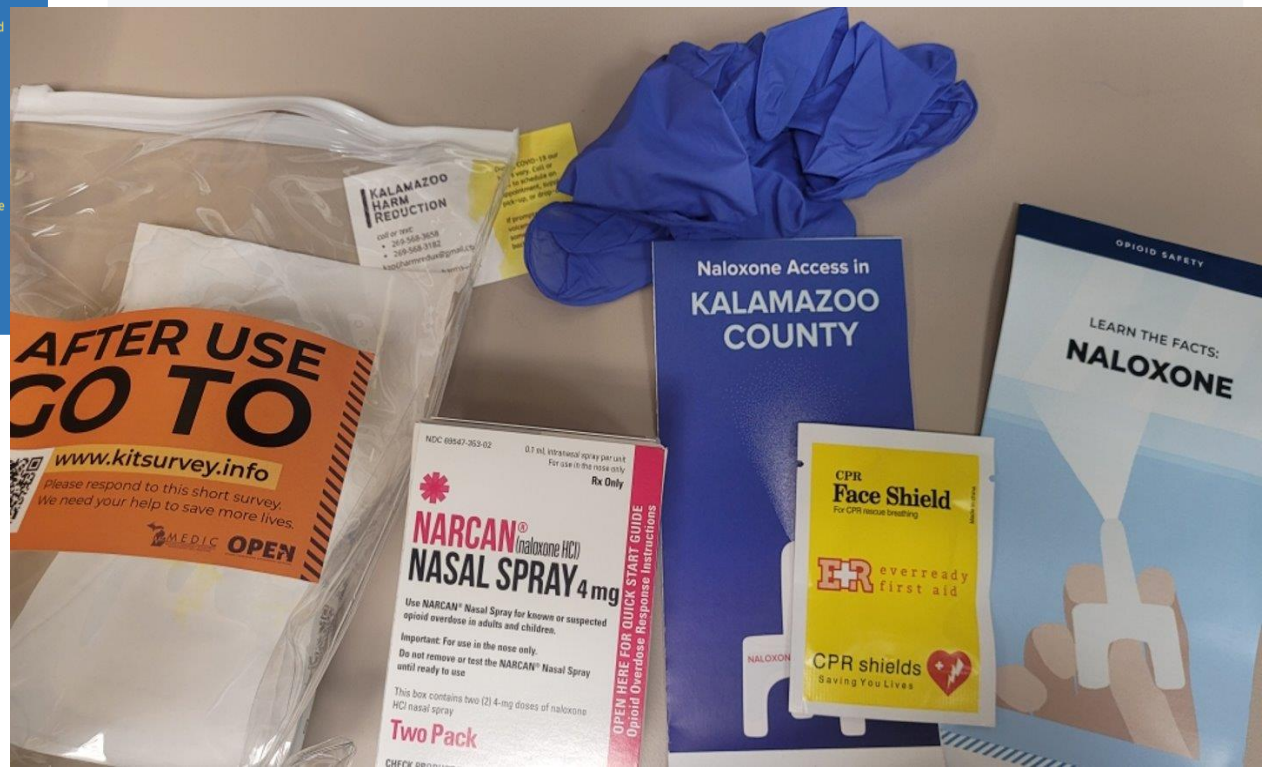
Partial agonist activate opioid receptors to a lesser extent

Antagonists block the effects of opioids



25 percent

25 percent of opioid deaths could be prevented by increasing naloxone availability by 30 percent



Michigan Overdose Data to Action Dashboard

Home

Explore Data

Current Trends

Helpful Tips

Technical Notes

Frequently Asked Questions

Data Notes
Deaths and ED Visits represent all drug overdoses. EMS Responses represent probable opioid overdoses only. Due to the differences in how frequently each data source is updated, the time period shown may vary by indicator.

Select Data Source

Death | Emergency Healthcare | EMS | Opioid Rx

Select Geographic Category: 5-Region

Select Sub-Category: Southwest

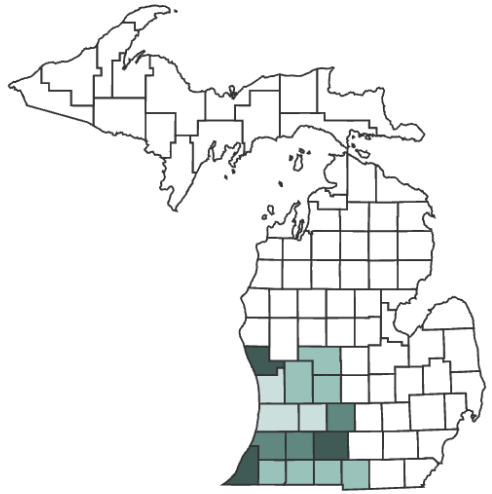
For historical data, go to mitracking.state.mi.us

Prior and Most Recent 12-Month Counts:

512	503
Q4 2021 - Q3 2022	Q4 2022 - Q3 2023

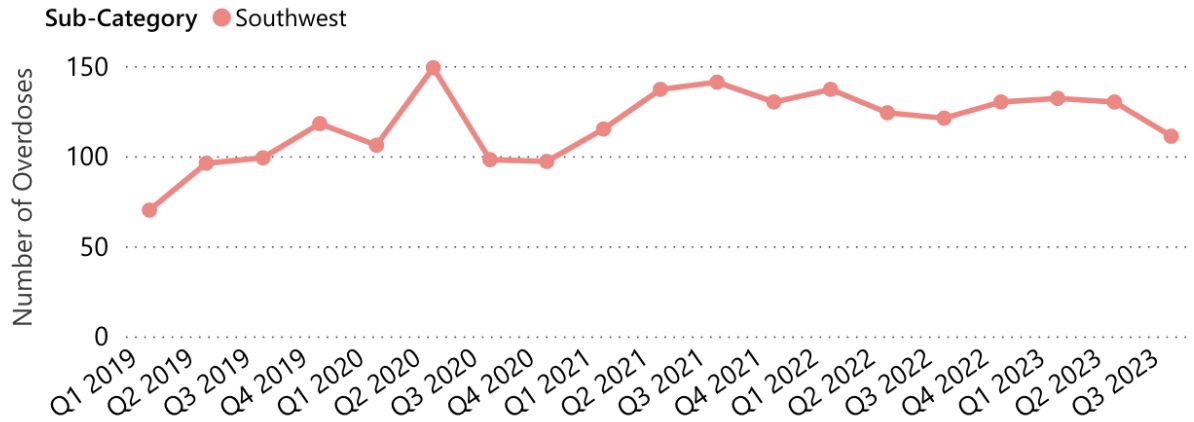
Provisional 3-Year Avg. Overdose Death Rate per 100,000, Q4 2020 - Q3 2023

0-14 15-19 20-29 30+

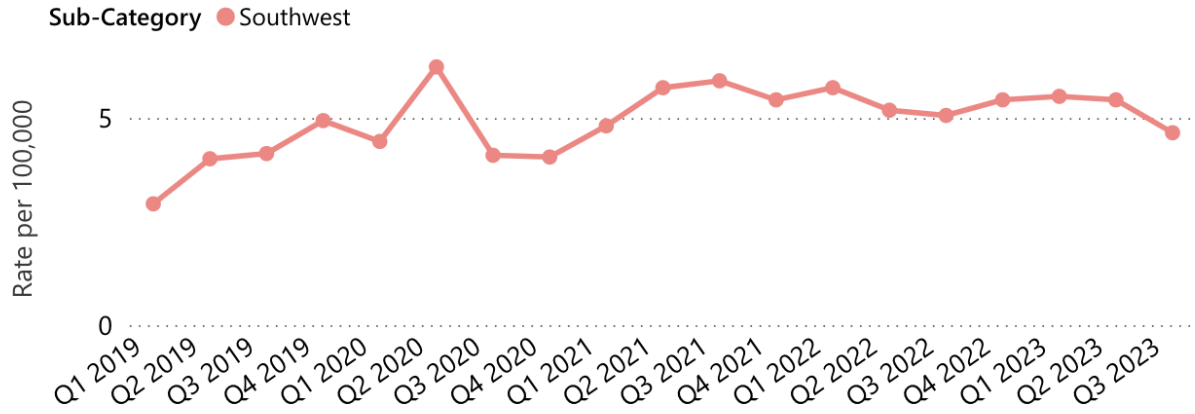


Underlying table shows '9999' for suppressed data. 3-year rate used to avoid suppressing significant numbers of rural counties.

Provisional Number of Overdose Deaths by Quarter



Provisional Overdose Death Rate by Quarter



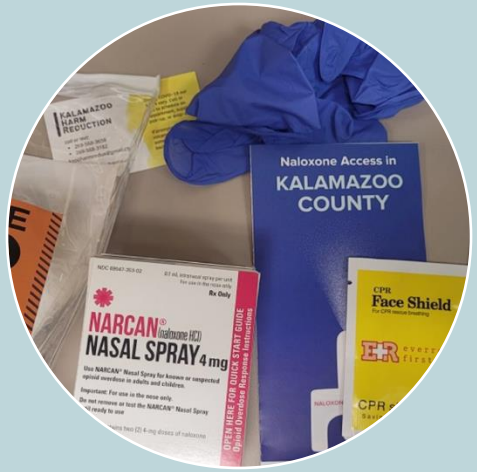
Data Suppression: On the quarterly graphs, county-level counts between 1-5 are suppressed to protect confidentiality. Additional counts (including some 0 counts) may be suppressed to prevent back-calculation. All rates are suppressed when the numerator is between 1-5 to ensure statistical stability.

NOTE: Michigan is one of several states experiencing longer than usual delays in drug overdose death data reporting, October-December 2023 data are subject to change.

Naloxone Distribution

Naloxone Distribution

Porch Boxes



Health Care Environments

EMS Leave Behind

NALOXONE NURSING PROTOCOL

YOU MAY NOW ASSESS PATIENTS AND ACTIVATE THIS PROTOCOL

82%

WHO WOULD BENEFIT FROM NARCAN DON'T RECEIVE IT.

Assess the patient for any of the following:

- **Illicit drug use including:**
  - STIMULANTS (METHAMPHETAMINES, COCAINE-DUE TO RISK OF FENTANYL CONTAMINATION)
  - OPIOIDS (HEROIN/FENTANYL/PILLS NOT PRESCRIBED TO THEM)
- **History of drug overdose (current visit or in lifetime)**
- **Combination of opioids with other sedating drugs**

If yes to any: dispense a Naloxone ED discharge kit

If no, but you think your patient might benefit from one, notify provider who can order kit for broader indications.

Purpose: To quickly identify patients at risk for opioid overdose, and to facilitate distribution of lifesaving naloxone.

KITS

Contains naloxone, gloves, face shields, and QR/physical cards for support and help.

Identify patients at risk during initial assessment, activate nursing driven protocol, and then patient will receive naloxone before discharge. This can all be done at initial screening using the protocol.

IDENTIFY PATIENTS AT RISK

ACTIVATE PROTOCOL USING ORDER SET

PATIENT WILL GO HOME WITH NALOXONE.

COPE network

KALAMAZOO HARM REDUCTION

KALAMAZOO COUNTY GOVERNMENT
Health & Community Services Department

INTEGRATED Services of Kalamazoo

BRONSON

Questions? Contact
bodenbpa@bronsonhg.org

LEAVE-BEHIND NALOXONE PROTOCOL

EXPANDING NALOXONE ACCESS IS THE MOST IMPACTFUL INTERVENTION IN REDUCING OPIOID OVERDOSE DEATH

1 IN 3
OVERDOSES HAVE BYSTANDERS PRESENT

Offer naloxone if:
- **Patient has received naloxone with IMPROVEMENT**
- **Any suspected substance use disorder**
- **Concern for recent loss of opioid tolerance (incarceration, rehab, etc)**

Consider offering safe needle disposal
Offer naloxone to bystanders on scene
Offer resources for opioid/substance use disorder treatment

Expanding harm reduction services does NOT increase risky substance use

KITS

Contain naloxone, gloves, face shields, and QR/physical cards for links to treatment and harm reduction resources and naloxone education use.

Opioid overdose response program (OORP): recovery coaches 24/7 at 269-226-3366, option # for OORP

COPE/Kalamazoo Harm Reduction: 269-568-3658

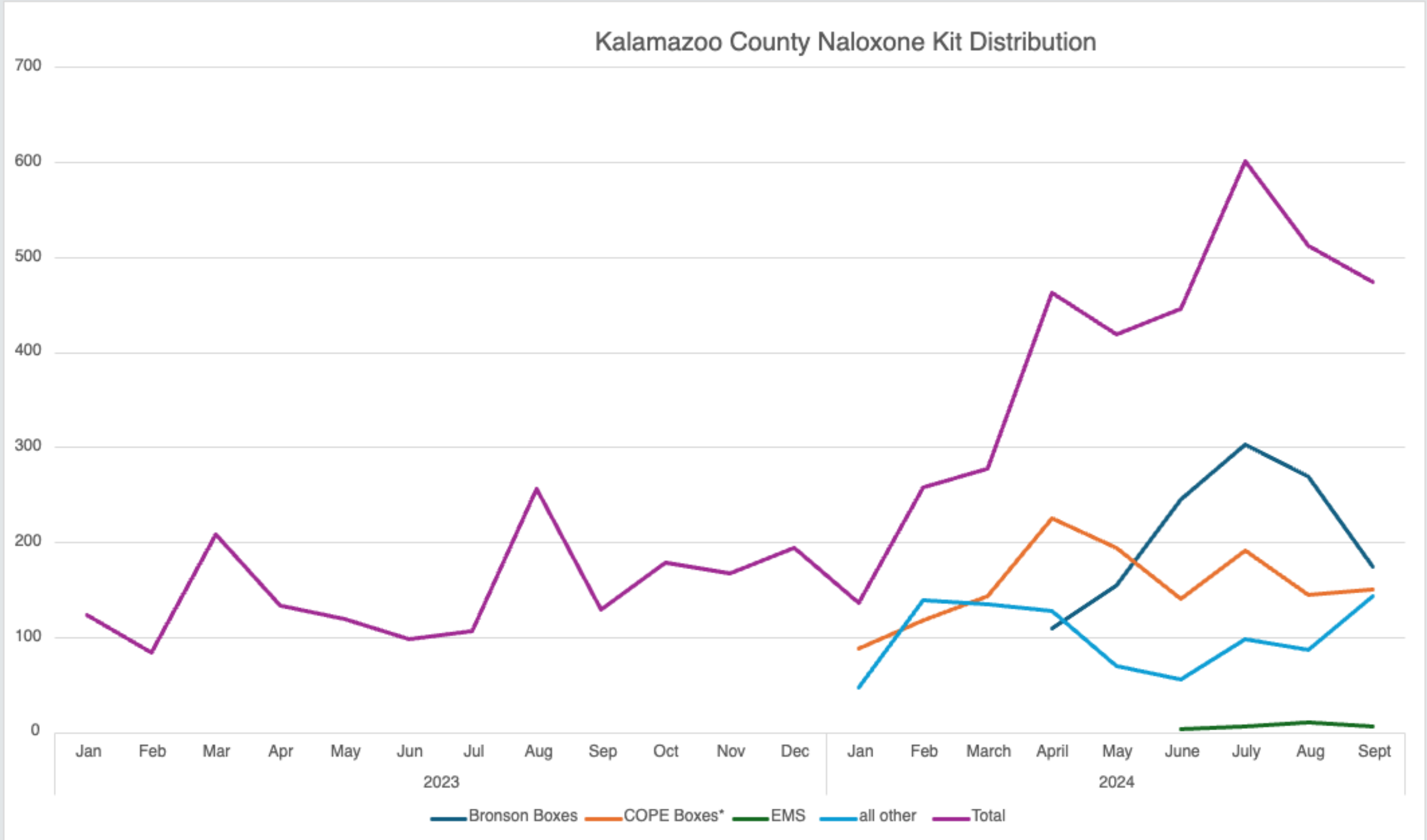
IDENTIFY PATIENTS AT RISK

OFFER NALOXONE TO PATIENT/ BYSTANDER

CONNECT WITH HARM REDUCTION RESOURCES

BRONSON · Ascension · LIFE ems · KALAMAZOO COUNTY GOVERNMENT Health & Community Services Department · INTEGRATED Services of Kalamazoo · WMU Homer Stryker M.D. SCHOOL OF MEDICINE · COPE network · KALAMAZOO HARM REDUCTION

Questions? Contact Saraswati.keeni@wmed.edu


Kalamazoo County Naloxone Kit Distribution
700
600
500
400
300
200
100
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2023
Jan
Feb
March
April
May
June
July
Aug
Sept
2024
Bronson Boxes
COPE Boxes*
EMS
all other
Total

Naloxone

- Bystanders are present in more than 1 in 3 overdoses involving opioids
- CDC recommends carrying and keeping naloxone for anyone at increased risk for opioid overdose, including prescription opioid doses >50MME prescribed by providers
- Naloxone co-prescription with other medication for OUD reduces number of overdoses in a community
- Overdose education and naloxone distribution (OEND) is an evidence-based strategy to reduce opioid related mortality
- Expanding access to naloxone in communities is among the most impactful interventions in decreasing opioid overdose deaths[1,2]
- Despite this evidence, nearly every state in the US is under-saturated with naloxone[3]

1. Irvine , etal. Modelling the combined impact of interventions in averting deaths during a synthetic-opioid overdose epidemic. *Addiction.* 2019;114(9):1602–1613.
2. Rao, etal. Effectiveness of policies for addressing the US opioid epidemic: a model-based analysis from the stanford-lancet commission on the North American opioid crisis. *Lancet Regional Health Am.* 2021;3 doi: 10.1016/j.lana.2021.100031.
3. Irvine, etal. Estimating naloxone need in the USA across fentanyl, heroin, and prescription opioid epidemics: a modelling study. *Lancet Public Health.* 2022

EMS leave behind naloxone protocol

Consider leave behind naloxone for patients over 18 and	Have received naloxone with IMPROVEMENT in condition
	Opioid use disorder
	Any substance use disorder (meth, cocaine)
	Recent loss of opioid tolerance (incarceration, inpatient rehab, etc.)

Providing naloxone kit does not preclude standard treatment protocols. Primary goals are oxygenation, ventilation, and restoration of respiratory drive. Transport to an emergency department is preferred

-Continue to expand naloxone distribution through EMS, ED and other health care units, and porch box distribution.

-Promote referral for harm reduction from health care environments (Syringe exchange, fentanyl test strips)

System Wide MOUD

Identify Patients with SUD

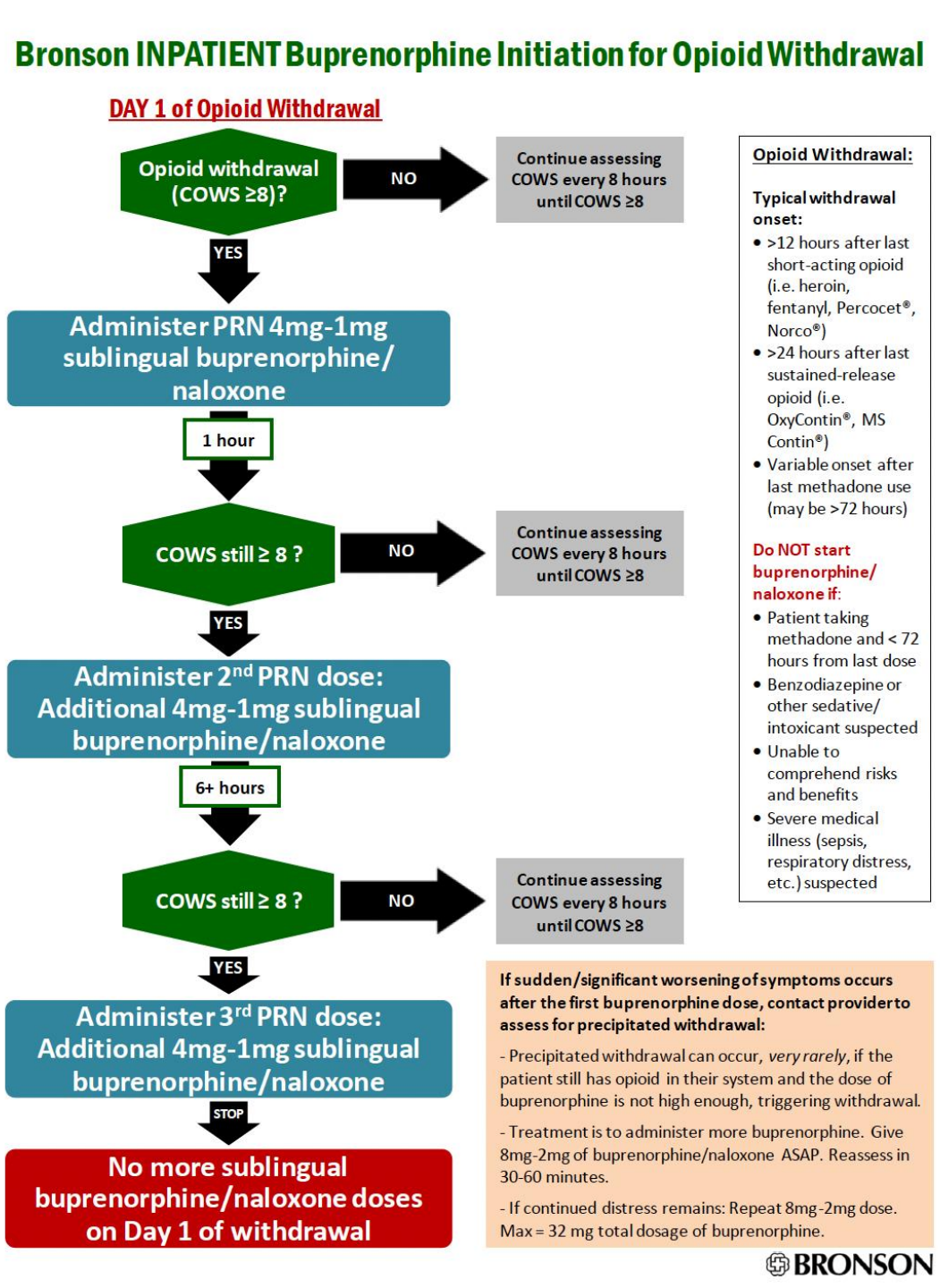
Start MAT during the health care encounter

Connect To community-based care

Next Steps

-Michigan Health Endowment Fund Support to increase MOUD prescribing and referral for close follow up throughout our Bronson Health System.

-Identify physician clinical champions in other units.

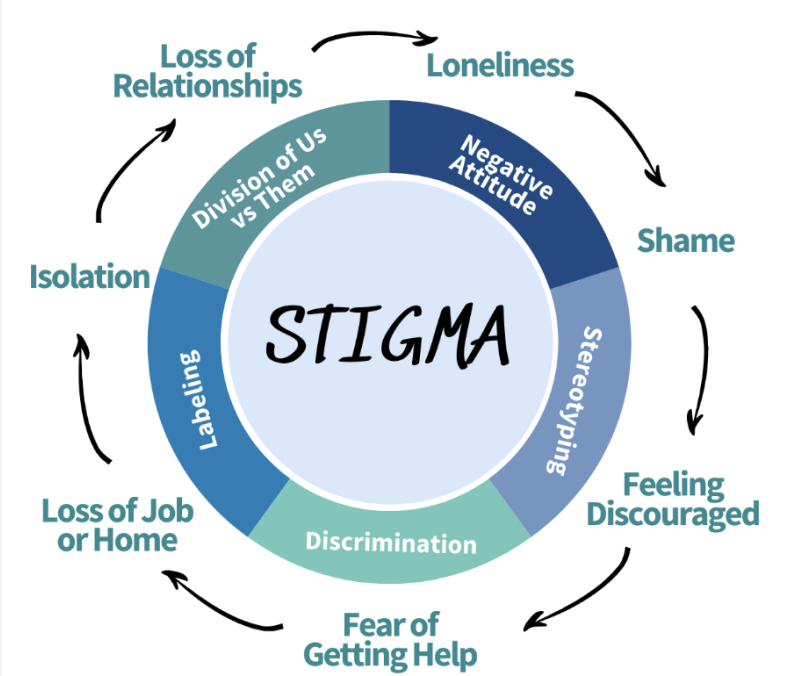


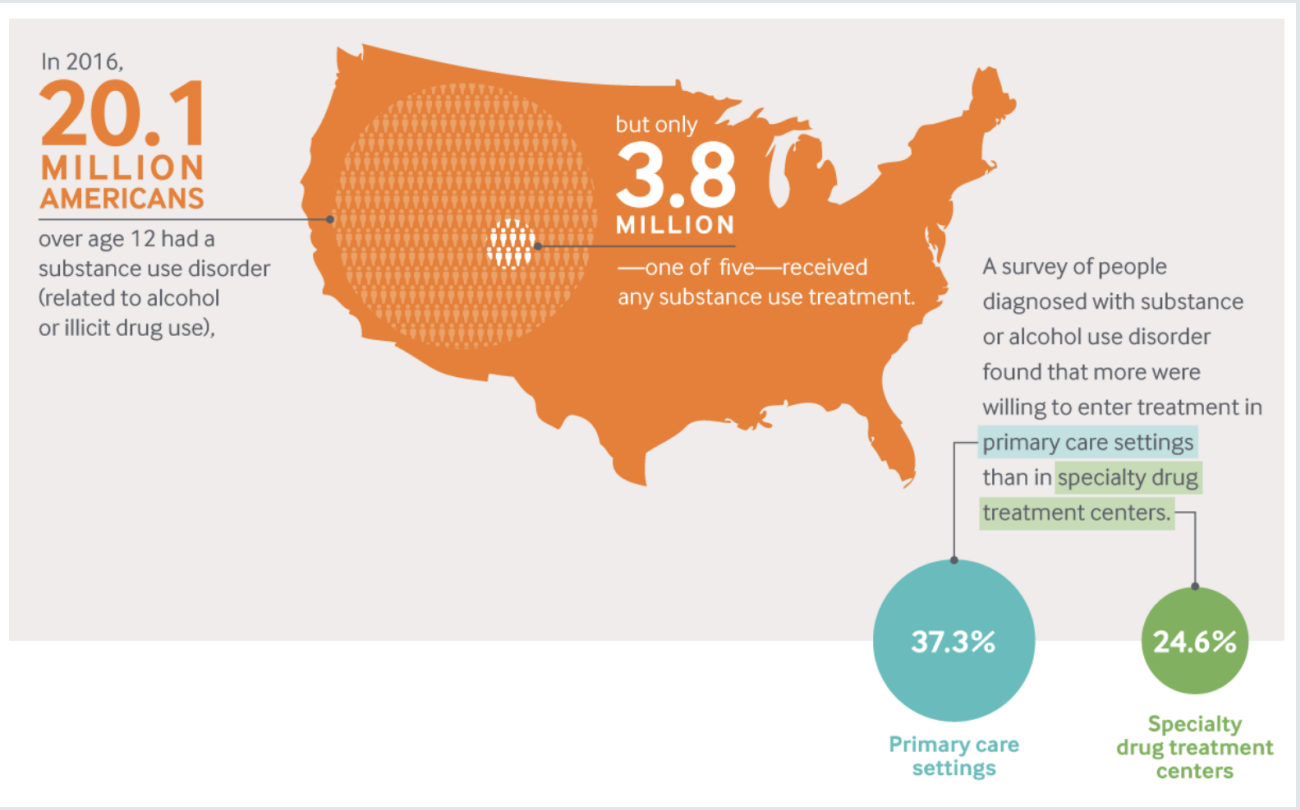
Naltrexone	Opioid Use Disorder, Alcohol Use Disorder	Maintain abstinence from opioids or alcohol	Tablet, injection(c)
Acamprosate	Alcohol Use Disorder	Maintain abstinence from alcohol	Tablet
Disulfiram	Alcohol Use Disorder	Maintain abstinence from alcohol	Tablet
Nicotine replacement therapy	Tobacco Use Disorder	Maintain abstinence from tobacco use	Inhaler, nasal spray(d
Bupropion sustained release (SR)	Tobacco Use Disorder	Maintain abstinence from tobacco use	Tablet
Varenicline	Tobacco Use Disorder	Maintain abstinence from tobacco use	Tablet

Next Steps

-Calhoun County Opioid Settlement Fund Support Stigma Reduction and Medications for Addiction Training for Healthcare workers (OUD, AUD, TUD).

-Submitted request to Kalamazoo County for similar funding with plans to approach other counties.





Next Steps

-Building the foundation for an Addiction Medicine Fellowship at WMed to train residency trained physicians to become addiction medicine specialists.

-Integrating more SUD education medical student curriculum at WMed.

In Focus: Expanding Access to Addiction Treatment Through Primary Care

Medication for Opioid Use Disorder in the Emergency Department

FREE Technical Assistance & Learning Opportunities

Are you interested in learning how to best care for patients with opioid use disorder in an emergency department?

#1 Connect with a team of emergency medicine providers for free, individualized technical assistance and subject matter expertise.

The Michigan Opioid Partnership's clinical consultant team is made up of providers who all have first-hand experience establishing opioid use disorder (OUD) care protocols in Michigan emergency departments. They are available to answer questions, lead training sessions, review protocols, speak at department meetings, and more for free.

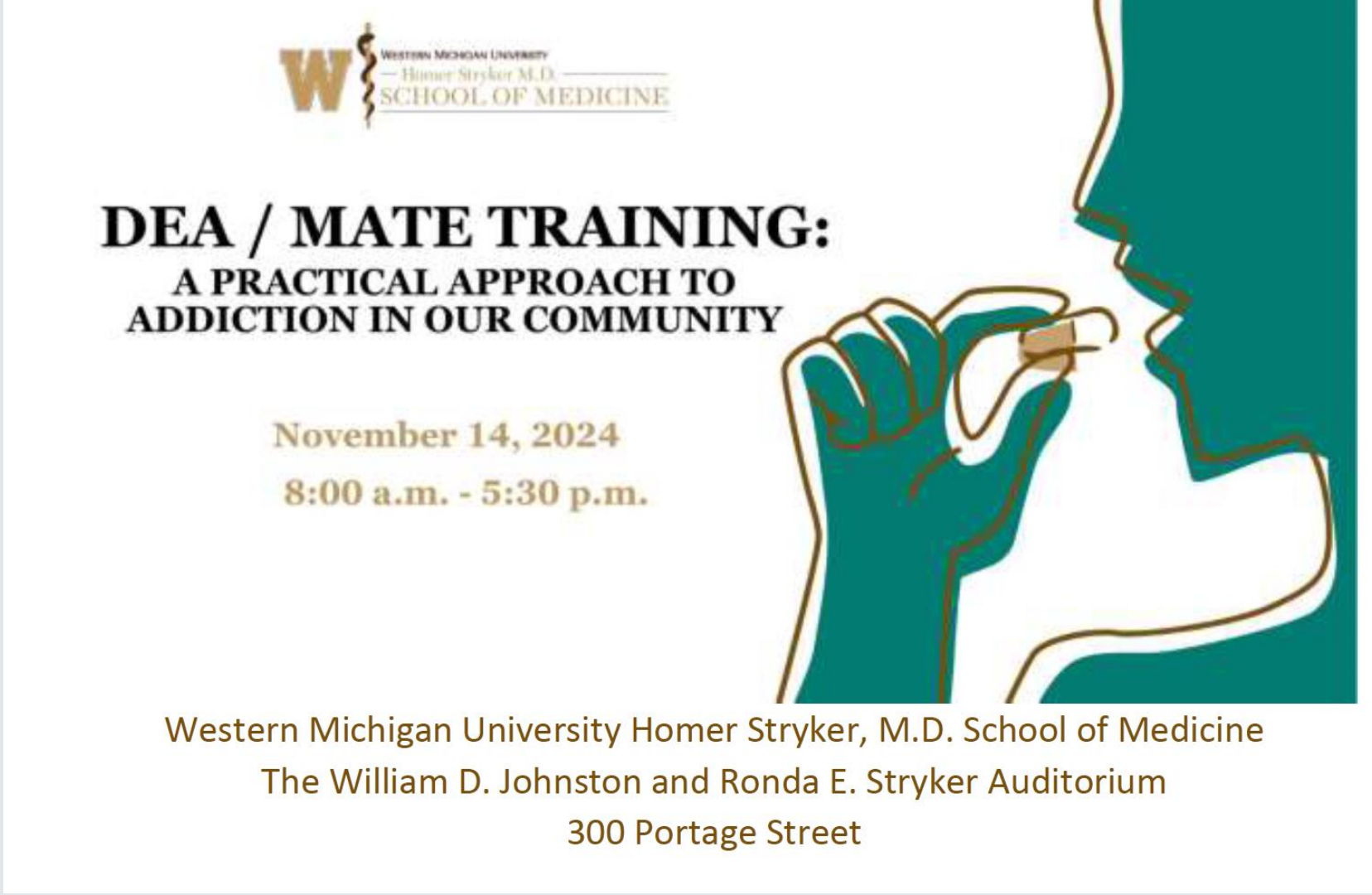
Michigan Collaborative Addiction Resources & Education System

MICARES

-Outreach to residencies and medical schools throughout the state for SUD education.

Next Steps

-Addiction Medicine Clinic within WMed Family Medicine Crosstown Clinic for specialty addiction care integrated with primary care.



Click here to register!

Registration is open until November 8, 2024.

This event will feature expert keynote speakers, small group breakout sessions, community resources, and a recovery coach panel.

This event will help practitioners applying for a new or renewed DEA registration meet the eight-hour training requirement on opioid or other substance use disorders.

Feedback?

What else should I be doing?

THANK YOU !

Questions ?

Maureen.ford@wmed.edu
269-365-3999