

Dr. Elizabeth Salisbury-Afshar: Welcome. This is ASAM Practice Pearls, a podcast series from the American Society of Addiction Medicine. I'm your host, Dr. Elizabeth Salisbury-Afshar. Today's episode is part of a four-part special series highlighting key sessions from ASAM's 56th Annual Conference.

In this episode, we'll focus on methadone initiation for opioid use disorder in the emergency department. It's a topic that's gaining momentum as EDs become more engaged with addiction care. I'm so excited to be here with three amazing emergency medicine physicians. I'm going to turn it over and let them introduce themselves.

Dr. Rachel Haroz: Thank you so much for having us. I'm Dr. Rachel Haroz. I'm an emergency medicine toxicologist and addiction specialist from Cooper University Hospital in Camden, New Jersey.

Dr. Bill Soares: Hi, everyone. My name is Bill Soares. I am an emergency and addiction medicine physician at UMass Medical Center, Baystate Campus in Springfield, Massachusetts.

Dr. Ryan McCormack: Hi, I am Ryan McCormick. I'm trained in emergency, internal, and addiction medicine and practice clinically at Bellevue Hospital as part of NYU School of Medicine, and I have been doing research in this field as well. It's a pleasure to be here.

Dr. Elizabeth Salisbury-Afshar: I'm so excited to be here with all three of you. I really want to talk a little bit about the fact that methadone hasn't historically been offered in emergency departments, and really, just to hear from you the factors that led all of you to thinking about doing this in your own settings.

Dr. Rachel Haroz: Yes. Thank you. So, we, in emergency medicine, haven't really done addiction well. In fact, I would say up until ten years ago, we didn't do addiction at all. We would treat overdose and then we would treat withdrawals, but not all withdrawal. We would treat alcohol and benzo, not much for opioids. And then we would send people out, and we didn't even send them out well; if they were lucky, they would get a piece of paper. And then the big paper was published in 2015, and Dr. D'Onofrio showed that, yes, you actually can start people on buprenorphine, you can be a part of the addiction pathway. And many of us pivoted, and we embraced it. We integrated it into our practices and this really took hold. And buprenorphine is a medication; it's easy to like. It was new, it's not really pronounceable, but we called it, affectionately, "bup." And the risk profile is great.

And so, many emergency physicians felt empowered to start this medication. But the problem was that the drug landscape was changing. And so, even though buprenorphine worked, especially for those patients using lower dose fentanyl or heroin, when you came to the high potency fentanyl, it just wasn't as easy to leverage in the emergency department. Even with the greatest interpersonal skills, it was difficult to start these patients. Patients didn't want it. Patients would literally say to

us, "I prefer methadone." And so, we had to pivot and start utilizing a medication that was actually, in many ways, in terms of the evidence, even more effective than buprenorphine and had really great retention data. And so, many of us turned to methadone as the next step.

I think that one of the hard things is, and I think that many people outside the ED don't realize this, but methadone is very much disliked in the emergency medicine community. It is a medication that's associated with patients that are difficult. And when EMS brings in a patient from the methadone clinic, nobody jumps up to see this patient. It's more of a 'not-it' situation. And so, bringing methadone to the ED was not just about the medicine; it was about overcoming the stigma that so many physicians feel so deeply regarding this one medication. I'm just going to say it's bonkers. Methadone itself is not inherently dangerous. As a physician, we use medications that are far more dangerous. As ED docs, we give TPA. I mean, we give insulin. A drop of insulin is infinitely more dangerous than methadone. But something about methadone, something about the way it is regulated, and all the stigma attached really makes emergency physicians shy away from it and literally feel distaste.

Dr. Elizabeth Salisbury-Afshar: As you were talking—I'm not an emergency medicine physician, but I work in outpatient setting, I work in the inpatient setting, on a consult team, and I think we all see the same stigma against methadone and people on methadone. So, just want to commiserate that it's not limited to your setting, it's something that we're all dealing with. And really appreciate you sort of walking us through how the drug supply changing is some of what's fueled the need to really do this. I'm curious, can one of you walk us through the steps you took to be able to offer methadone from the ED?

Dr. Bill Soares: Sure. It was a process that took a little while, and we did [it] in stages, and I encourage folks not to get hung up on some different stages. Everyone's stages are going to be a little bit different per your institution and per your guidelines. When I talk to other institutions that have implemented methadone, there's a lot of similarities that we share in our implementation strategies. And I think some of these really can be best practice.

The first, and I think most important, is having a clinical champion. Having someone who is going to push this forward, who's going to advocate. Ideally, if you're talking about in the emergency department, having someone who's based in the emergency department. We are, in a sense, tribal. We trust our own. We are suspicious of others outside of the emergency department. So, having someone who's advocating, who is part of that group, who understands the ebbs and flows of the ED, the requirements, the time pressures, and other things is really important to be able to first start a program.

Equally as important is having a partner OTP. We can do amazing things in the emergency department, but once our patients step outside, we kind of lose all our power. And so, having a partner OTP that can take that patient, can take that handoff, and continue great care and continue treatment is really important. And not

just identifying a place and saying, "Hey, we're just going to send everyone here," but really talking to them because this is going to be a partnership. You are working with them, and that OTP is putting trust in us as emergency physicians. They have to know that we can correctly identify and correctly dose patients and give them instructions, where we're going to hopefully set them up for a good outcome.

So, working with your OTP, talking to them; what do they do to start? Do they get an EKG? Do they not? What doses are they comfortable starting is really important and may shape your home protocols. Along with that, finding the people in the hospital who are going to be either clinical or nonclinical advocates. Support administration that you have to work with.

Some of the common ones that we've all worked with, working with your pharmacy department to talk about what their regulations are and how we can come to an understanding of what that means. Talking with nursing staff from a nonclinical standpoint; talking with your legal or compliance department; it's always good to talk before rather than talk after once they find out that this is going on, right? Clarify with them. Help them to understand some of the laws and regulations so that when this starts and there is a question about it, they understand and know and already have approved, hopefully, the program.

The only other things that I would say to start—a few other aspects. One is thinking about having a standard protocol. And in the show notes, we'll be able to link some of our own protocols, which you should all be able to copy and utilize and update. But having something—realizing that your standard emergency physician, depending on what hospital they're in, they may see one patient with opioid use disorder a day, they may see one patient a week, or maybe even less frequently. This may be a protocol that the standard emergency physician doesn't engage with on a daily basis. So having resources, a protocol, an order set, which makes it easy for people to do, even when they're not as familiar with what to do, is really important.

And then, the last thing I'll say is education. We really have not, as emergency physicians in our standard practice, been taught about methadone. There are some teaching aspects in terms of thinking about dosing, thinking about contraindications, and other aspects, which emergency physicians are happy to learn about. But definitely talking to your emergency physicians about methadone and doing a little bit of teaching goes a long way to avoid complications and give them a good experience, because ultimately, if your emergency physician has a good experience implementing this protocol, they're going to do it again.

Dr. Rachel Haroz: I'm going to add two more things. The first is your nurses. I think that the ED culture, a lot of times, rests with nursing. And so, the more you can bring them on board, the more you can empower them—they are often the first ones to see the patients. They are the ones that spend the most time with the patients. And if you can empower them to be a part of this process, that's half that battle. The other side of that is if they don't want to do that, it's never going to happen.

And then, the second part, to feed off that education, if you have a residency, bringing the residents on early. The residents, so many times, are the key to making anything happen, along with the nurses, of course. But if you teach them, a lot of the attendings will then learn from the residents, and the residents don't know any different, right? What they learn as residents is what they think is normal practice. And so, if they learn that as part of their regular curriculum and start doing that as part of their regular practice, they will carry it with them to wherever you go. And that's one way to change culture and to change this paradigm.

Dr. Elizabeth Salisbury-Afshar: One of the things that struck me as you both were talking was the importance of relationships. So, you talked about relationships with a clinical champion, relationships with a partner OTP. And maybe you didn't use the word "relationships" with hospital and admin support, but at the end of the day, a lot of what happens comes down to the relationships that we build, and then really the relationship with nursing overall being key components.

And so, thinking about our listeners, I'm aware some folks might be thinking, "I would love to partner with our emergency department, but I don't know who the clinical champion is." So, do you have suggestions on how someone, if they're not an EM physician, how they could find a partner? And then the second is, how do folks find a partner OTP if maybe they're not familiar, they don't have that clinical experience? Any thoughts or suggestions?

Dr. Ryan McCormack: I think this line of discussion is really important, and having top-down support, having grassroot bottom-up support, and then lateral support with other departments and multidisciplinary support is something that can't be overemphasized. And thinking about the context that you're going to—so a lot of the research that I've done has been implementing in different settings, whether it's a rural critical access hospital, a community center, or an academic center. And going in as an emergency medicine researcher was really important in places where there was a lot of resistance. Some of the people would say, "I wouldn't have trusted you if you weren't one of us," and I started this early in this paradigm shift, and we're not there. To suggest that buprenorphine has really penetrated across the country—it hasn't. There's still a lot of missing links and lack of access. And so, this is another step that we should be doing as well.

I think you have to strike the balance of the importance and also what's feasible. And translating something that's evidence-based to a new setting, particularly the emergency department—it needs to be practical. So, a local champion, you may be lucky and have somebody who's really interested in addiction or in this population who's had a personal experience or some other reason to have a personal interest. That's not always the case. In some of the settings, it was a top-down support where a chair or division director or a hospital leadership tasks somebody in the emergency department, they assign somebody.

And that doesn't always work so well. But it doesn't need to be somebody who is an expert in addiction. In emergency medicine, we have to be second best at everything.

There's always going to be someone who's more expert, and so you may not have an addiction-trained emergency physician or clinician there.

But fortunately, now there's an infrastructure. There are resources that exist. There are protocols that are linked to this podcast and that can exist in places like the ED Bridge site. There's this close-knit community of people who have implemented programs or who have programs that are more than willing and eager to help disseminate and implement this.

So, just to reiterate, some of the things that have been said already, having a protocol, you know, nobody needs to reinvent the wheel. There are protocols that exist, and it can be tailored. And partnering with your OTP, who may know some of the local resources. When I was implementing programs in these different contexts, nobody thought they had a place to refer people to, and that's because we've traditionally done such a poor job of referring people. Our referral list would be outdated, if they existed at all, and so it didn't take as much work as we would think. There are websites like the SAMHSA, and then your Department of Health, or you can call a local provider.

Dr. Rachel Haroz: I would also add that we are so separate in the ED from local governmental agencies, but most states will have either a combined Department of Health and Department of Mental Health and Addiction, or some states, like New Jersey, they're separate. But finding the representatives from there that can help identify your OTPs and all your other agencies that may support you.

And then there's also the SOTA. And I think a lot of people don't know what that is, but there's literally somebody whose entire role, there're the state opioid treatment authority, and they oversee all of the OTPs. And they're able to tell you where they are, what they do, how many people—they know all of those details, and they're able to connect you to the ones that are near you.

Dr. Elizabeth Salisbury-Afshar: As you all were talking, I was reminded of a personal experience when I moved to University of Wisconsin. I was really wanting to help support our emergency department to just implement buprenorphine. And I talked to Kate Hawk on the phone, who I'm guessing, you all know. And she said, "Elizabeth, you're never gonna do this. You gotta find a partner." I said, "I know, but how do I find them?" And so, I started emailing people, and I think I got passed around three or four times until I found the person who was willing to work with me.

And so, the other thing I might add is that if you have addiction medicine, you know, teams, if you don't have someone in your emergency department with addiction expertise, sometimes partnering in that way, we often have OTP relationships. And so, sometimes it takes a little bit to find the right fit, but we can all support each other.

Rachel, I want to go back. You were just mentioning the state opioid treatment authority, or the SOTA. Can you talk more about the federal methadone regulation and the strategies you employed to address both federal and state, and any additional regulatory hurdles at the local level?

Dr. Rachel Haroz: Yeah, so I will tell you, when I started learning about federal regs, I went down this crazy rabbit hole, because I was like, this can't possibly be true. Like, there are hundreds of pages of federal regulations, state regulations, some places have counties, some places have local, then they have the OTP that has another level of regs. At the beginning, I was completely overwhelmed. And the truth is, yes, there are a lot of these regs.

But at the end of the day, it's completely still doable. And the person who really can walk you through all the regs, because they are in charge of the way that the OTPs actually function, is your SOTA. And, hopefully, for you, your SOTA is kind and approachable and helpful.

I can't say enough about our SOTA in New Jersey. I have him on my cell phone. I ask him a lot of questions. He helps me get waivers through on the state level, and again, you can get waivers to overcome a lot of these regs. In fact, what a lot of people don't realize is the OTPs ask for waivers all the time when they have patients that are outside of the regular treatment protocols. And more often than not, these waivers are accepted because it's what's best for the patient.

So, I think partnering with your SOTA is really great. The one thing I will say about the SOTA is that the SOTA, actually, is not familiar with your local hospital protocols and cannot tell the hospital what to do outside of the regular state regs.

So, if there are specific state regs, like, for example, in New Jersey, we cannot dispense any controlled substance, and that comes from the OAG's office. None of us can overcome that. But otherwise, the SOTA cannot tell you how to do things in the hospital as long as you are within the regs.

Dr. Bill Soares: And I think, to take on what you said, Rachel, if there are emergency providers out there who are listening, it can be very overwhelming to think, "Oh, I have to go to the OTP. I have to look at the federal regulations and the state regulations," and even just starting small, starting with your hospital, because yes, ultimately, the goal is to have a program that links, that continues. But even thinking about practicing harm reduction and how you treat your patients with opioid use disorder, who have withdrawal and don't want buprenorphine, or have contraindications to buprenorphine. Even just starting to incorporate methadone for folks that are admitted with endocarditis or an abscess. Having a basic protocol saying, "we are gonna start you on a dose of methadone so that when the hospitalist sees you a few hours later, you're not in frank withdrawal."

There can be some other ways to start to introduce methadone, which maybe, for the emergency or hospital provider who's not addiction-trained feels a little less overwhelming than thinking about some of the regulations. The regulations are incredibly important, and we hope that folks will go on and explore exactly how you can connect people to the outside world, but also being able just to start in your hospital system can make a huge difference in getting your providers just comfortable being able to administer a dose of methadone for folks.

Dr. Ryan McCormack: I wanted to bring up a couple things. One is going back to the kind of multidisciplinary support and the different types of hospitals, you can really get buy-in from so many different people. I've implemented programs in dozens of places, and some, the champion is a clinical pharmacist or a nurse or a resident.

And it can really feel overwhelming, and sometimes it's not even being sure how to reach out to somebody at the OTP or how to create a linkage. But having people become engaged both within the emergency department and an OTP partner, once they see that you are trying to do something, and that your goals are relatively aligned, these partnerships really form.

And the same thing on a clinical side of things. I find that clinicians often need a lot of handholding. Because of the regulations, and I think it's actually, in some cases, worse with buprenorphine because of the existence of the X-waiver previously, is that people just had this assumption that both of these medicines were so risky and had the skewed perspective of the risk benefit ratio, that they were just overwhelmed and not doing it.

And when they started, a lot of times, people would come up to me like, "I had this person in withdrawal. I gave him medicine. He felt better. Did I do anything wrong?" And I was like, "No, it sounds great." And they're like, "Oh, thank you." And then, sometimes, some of the cases where people actually do well, and there aren't many things in emergency medicine that can be really transformative for patients. And having feedback of how patients do is a really critical piece of information. That just telling somebody, "Oh, that patient followed up in the OTP and is doing really well right now." That's the kind of thing that I've seen boost a clinician in the emergency department. And I'm thinking of a specific case where somebody was so resistant; literally said, "I'm going to do this to prove you wrong." And then I saw him two days later, and he told me this wonderful story about a patient, and he became the biggest clinical champion. And it really just can snowball like that.

And so, you don't always know who it's going to be. But it has to be low barrier, both for the patient and the clinician, and there has to be consistency. It doesn't have to be the perfect protocol, but you have to be consistent, and there has to be some general understanding of what exists and when and where it's going to exist and trying to get buy-in from your department.

Dr. Elizabeth Salisbury-Afshar: So, what I'm hearing is that this is doable, but it's also a lot of work. There are multiple steps. There are building relationships, both inside the hospital and outside the hospital. There are regulatory challenges at the federal, sometimes at the state, and even local level.

And then there are hospital challenges with systems and policies and protocols. I could see where some people might feel like, "Oh my goodness, this feels like way too much. Can't we just use buprenorphine?" And so again, I'd kind of love to go back to that first question and just say, if somebody's feeling like, "Wow, this is a little overwhelming," can you say more about why you think it's important to have more than one option?

Dr. Rachel Haroz: So, I think there's a couple things, and you know, in that first question, I sort of mentioned the drug landscape, but I didn't really get into some of the details. And definitely it varies across the country, but I think in a lot of the inner cities, the amount of fentanyl that is available and that people consume on a daily basis is striking. When we administer fentanyl in the emergency department, we do it in micrograms, 50 or a hundred mics really pushed at a time. But what we're finding is that a lot of these bags in the streets have milligrams of fentanyl. And patients don't just use one bag. They use many bags, sometimes bundles, and a bundle is 8 or 10 bags. Fentanyl has a lot of lipophilicity, and so it tends to stay in the body.

So, now you've taken a medication that has a very short half-life, and because it stays in the body, you've now turned it into this very long-acting situation. And we also know, from studies, that if you stop using fentanyl, it can stay in your urine up to a month. And so, it changes the entire playing field.

In medicine, we've always been in a place where we give the patients options. Sometimes, I don't even know if it's give or, we as a clinician, make a decision based on a lot of factors, and we use different modalities. So, whether it is different blood pressure medications, whether it's different antibiotics, we cater it to risk factors, to clinical situation, to background, to so many different factors.

It's not a great idea to use one medication as a panacea. Oh, it's got to be buprenorphine. What we should be doing is looking at a lot of these risk factors and background. And even the social factors like, can a patient get here? Can they get there? Are they able to keep this medication on them? What are all the different factors? And thus, enter methadone.

The other thing that I think is important is that patients don't have to be on one or the other just because you started in the emergency department—you're not committing them for a lifetime.

So, a perfect example is a patient that comes in, you know they're going to be admitted, whether they have cellulitis or endocarditis or something. But, like Bill had mentioned before, you may just be able to mitigate their symptoms by initiating that

methadone for that short period of time. I think the other thing that some physicians in the ED aren't aware of is that you can start the buprenorphine after they've been on the methadone. So, a lot of times, what inpatient consult services will do is they will just start the methadone, make the patient comfortable, and then have that conversation later. And if the patient then says, "Yes, you know what, actually buprenorphine suits me better. I'd like to do that," they can microdose it, and convert them from methadone to buprenorphine. But I think in order to have some of these options, you have to be willing to do either medication and feel comfortable with both medications.

Dr. Elizabeth Salisbury-Afshar: So, what I'm hearing is that, really, having multiple options is super important. Patient preference can also play a really important role.

As we think about future directions, are there policy shifts, guidelines, or other things that you could see really as necessary to expanding access to ED-initiated methadone?

Dr. Bill Soares: So, I think the emergency department is a place that there's constant pressure, and sometimes there can be the feeling of adding different things is just not feasible because we have so many other things. Part of that relates to the fact of what we are judged on, what we are graded on, what we are marked on.

So, for example, if you come in with a stroke. People are looking in the background at how quickly did I get the CT? How did I identify? Did I appropriately treat? If you come in with sepsis, I'm marked on at what point did I give antibiotics? Did I order the lactates?

As of right now, there aren't societies that are coming back to hospital administration and saying, "You had this many people with opioid use disorder through your emergency department. How many got offered medication? How many started medication?" Because really, as we get to a point where it becomes more important to regulatory bodies and to other agencies that, naturally, the hospitals pay attention to those, and there's the potential for more resources to be diverted to that.

So I'd say one of the best ways to do it is to make it important to those regulatory agencies and to others, because if it comes a point where it becomes something that is measured, and the hospital is valued upon, then that's going to help the hospital, overall, to think about what resources can we use to make this easier. Not only easier on the hospital itself, but easier on the provider.

Dr. Rachel Haroz: There's actually a lot of opportunities. So, Bill mentioned the code STROKE and the code STEMI, and all these things that we do—we don't have any of that. Somebody comes in after an overdose, and we don't have a protocol, we don't have metrics, we don't have any of that.

The metrics can be hospital-based, but they can also be state-based. So, there's a lot of state Medicaid incentives in place for different areas of medicine. Leveraging that to help guide and incentivize behavior on the hospital level, especially when it's tied to dollars, I think, can be impactful.

And then I think federally, shifting from this methadone model that we have, which is one of the most restrictive in the world. Other countries, the primary care provider prescribes methadone as a prescription that you pick up at the pharmacy, or they have methadone clinics that are limited. For example, in France it's 14 days that they stabilize you and then your primary care physician takes over.

So, there is one bill right now in Congress called MOTA, and the idea behind it is to give a lot of the methadone care to addiction physicians, which makes sense, right? This is literally what they do a fellowship in, and this is what they're boarded in, allowing them to prescribe and be able to treat patients.

And so, I think on legislative levels, on hospital levels, state levels, I think there's a lot of opportunity.

Dr. Ryan McCormack: It's also important that we get buy-in from our ED-based academic societies in trying to implement buprenorphine programs in various settings. I was really surprised to learn how influential having backing by American College of Emergency Physicians or other of our groups was in people saying, "I will do this."

There are some policy initiatives that we should be advocating for, but also, it's incumbent on us to also go to our academic societies, to express the need for support of not just buprenorphine but methadone, because not everything is a one-size-fits-all for everybody.

And also, to publish guidelines. Like, we have our own protocols published, but to have a consensus statement or publish guidelines from our societies would be really helpful as well.

Dr. Rachel Haroz: I just want to say one more thing, which is our job in the emergency department and wherever it is that we work, it takes up most of our day. We spent most of our day with patients. And I think finding meaning in what we do is so incredibly important.

And I can just say that this is so unbelievably meaningful. If nothing else, conveying to physicians how meaningful, like you gave that example of the physician that just, "Wow, like I can actually make a change and I can actually really help someone," and I think that's important.

Dr. Elizabeth Salisbury-Afshar: So, I really want to thank all three of you for being here today. I think that you will definitely inspire many others to start taking all the

steps that you've outlined to being able to work toward implementing methadone access in our emergency departments.

And I want to thank our listeners for tuning in to ASAM Practice Pearls. Today's session focused on methadone initiation for opioid use disorder in the emergency department, and that full recording of the annual conference session will be available in ASAM's e-Learning Center starting May 26th, so I would encourage everyone to check it out.

And finally, don't forget to subscribe and share this episode with colleagues who might find this information helpful. Thanks for listening, and we'll see you next time on ASAM Practice Pearls.