TRANSCRIPT

Developing a Partner Network with Dr. Andrew Herring

Dr. Todd Mandell:

Welcome, Dr Herring. So, it seems that the emergency department is the point of entry to treatment for patients with opioid use disorder. How did this come about?

Dr. Andrew Herring:

The emergency department is a 24/7 open-access portal in the health care system where the community knows that whether or not you've got an appointment, whether or not you have insurance, whether or not you're a documented citizen, the emergency department is committed and there to provide you treatment, so it is an expected place for people to go in crisis.

Dr. Todd Mandell:

Why is starting buprenorphine treatment in the emergency department so important and how does California Bridge fit into this?

Dr. Andrew Herring:

Buprenorphine is this incredible medication that reduces your overdose risk, you know, 60 or more percent. It's immediate, it makes people feel good, it has, you know, excellent rates of retention after being initiated in the emergency department. It's incredibly safe; it's a medical technology that is our single most potent tool to move the needle on drug overdose deaths. There's just no question that buprenorphine is it.

The California Bridge Project basically begins with changing the narrative around opioid utilization in the emergency department where there's an initial wave of thinking that the primary place of the emergency department is to, the primary role of public health stakeholders is to assure that there's opioid stewardship in the ER, that there's not unconstrained prescribing of opioids leading to doctor shopping, and adding fuel to the fire of this escalating opioid epidemic.

The medication buprenorphine is effective and straightforward, yet has its own complexities, which is borne out by various providers being reticent or hesitant to jump into the pool, so to speak, and use it. So, our initial eight hospitals, this was kind of this radical revolutionary idea here in California. And then, to everyone's surprise, my own too, it just spread much more easily than I anticipated, and we went from seven to 52, and most recently, have contracted

with 278 hospitals in the state of California, making it a standard of care here that it is part and parcel of being an emergency department to develop the competency and capacity to provide 24/7 access to buprenorphine for people with opioid use disorders.

Dr. Todd Mandell:

Very interesting. Now does California Bridge provide guidance to hospitals on developing referral networks to community opioid use disorder treatment programs, as well?

Dr. Andrew Herring:

The goal of the Bridge is to create these partnerships, which really go one step beyond referral. They are actually based on people-to-people, they are friendships, they are a collective medical staff, they are emergency physicians who share narratives and treatment approaches and philosophies and goals for regional care with their ambulatory, clinic-based, and their hospital-based providers, so people getting admitted to the hospital for endocarditis or heart failure, whatever, the people running the clinics. That group of people all need to be friends and they all need to be constantly iterating, optimizing, redeveloping, and developing workflows that create this unified net that then pulls in these non-traditional touch points: jails, homeless housing support systems, street outreach teams, emergency medical services, are all kind of going into this sort of heart or core of integrated care between ambulatory emergency department and inpatient medicine.

California Bridge has built a really massive armamentarium of tools and resources, both easily downloaded PDFs on the nuts and bolts of how to do this, how do you dose buprenorphine, how do you treat precipitated withdrawal, how do you initiate methadone in the emergency department, as well as how do you talk with your partner clinic, how do you talk with administrators, how do you develop the shared understanding that leads to collective commitment to invest in a sustainable commitment to improving care for this really high-risk population.

The Bridge also backs up these resources with people: people who are in the trenches, on the ground, doing the work with tremendous experience on all of the myriad, unique ways that any given system needs to grow.

Dr. Todd Mandell:

Dr. Herring, could you please explain to our listeners how treatment for opioid use disorder gets integrated into regular medical care? Is it through establishing referral networks from emergency departments to the community?

Dr. Andrew Herring:

The networks, you know, again you know, that this, we really don't think of these as referral networks. We think of these as partnership networks. We think of this as creating this integrated continuum; that is, the more resources you can bring to bear to this condition, the better. So, providers in the community, clinic-based providers, are an incredible resource of humanity of care, of access to medications, and all the various resources that spoke off of that. Whether or not that's food assistance; whether that's care for interpersonal violence; whether that's associated medical conditions, hypertension, diabetes, etc.; whether that's mental health care; all of those resources are incredibly needed for people struggling with opioid use disorder, and any one individual can't do that on their own. They need a team, and that team needs to be as diverse and ever-present as possible.

When you establish programs that connect addiction medicine, you know, good science, so medical-based treatment of opioid use disorder with the human connection and pragmatic assistance to navigate the various complexities of eligibility and transport and logistics for care so the substance use navigator or the navigator, when you combine those two things, very predictably, you know you're going to see that people's utilization of the emergency department, utilization of hospitals goes down because they're stabilized in the outpatient setting.

The actual intervention itself is quite low cost. Buprenorphine is not particularly expensive. Navigation is also not a large expense, but the bang for your buck on a health system for the utilization piece is quite substantial. The additional aspect that shouldn't be overlooked is its impact on staff morale. By embracing treatment, that fills that gap, and it really lets providers express compassion and care and feel fulfilled and meaningful in their work around people struggling with opioid use disorder. The economies of it might be difficult to calculate, but the reality is right now in health care, we need motivated providers who believe in what they do, and this is just a low-hanging fruit to get people on board with this because we see such immediate and positive impacts of treatment.

Dr. Todd Mandell:

So, are there other programs that are sharing what they've learned with hospitals who want to start buprenorphine initiation in their emergency departments?

Dr. Andrew Herring:

Many other incredible programs are in progress around the country. Of course, you know Gail D'Onofrio and her Yale team with Project ASSERT. They really broke ground on this whole project, you know, decades ago and so they continue to lead with Project ASSERT and their program utilizing peers and navigators to connect the medical science of treatment with the human connection and navigation assistant to long-term care. The American College of

Emergency Physicians has been leading the medical profession in many ways with their E-QUAL Opioid Initiative that's really driving this into the core of standard practice of emergency medicine and combining the treatment with harm reduction and naloxone prescribing and providing resources that complement California Bridge very well to make this accessible to all emergency physicians that are interested in it.

A wonderful initiative that is really leveraging the potential of a state-level public health infrastructure, which is quite unique and really gives us a window into what you can do with a unified state partner is the MATTERS Network in New York, which creates this organized network for where anyone who presents to an emergency department can tap into that and find a clinic in their area with an automated set of supports to get to that clinic. It's really quite impressive. And finally, there's just simple things like MD Calc that are out there and enable you to learn about what it means to have opioid withdrawal, how to clinically evaluate it, and how to use that clinical evaluation to guide treatment with buprenorphine or methadone.

Dr. Todd Mandell:

So, to wrap up this chapter, what's the takeaway for hospital leaders?

Dr. Andrew Herring:

This is an easy win. If you create the high-level leadership support, you will see the staff really get behind these programs, then on the financial side of it, you build these structures, and this drives people into common-sense care and away from poorly reimbursed and less sensible access patterns of care. So, all of that adds up to a net huge win for the public, for the perception of the health care system, and for the internal sense of morale and fulfillment and reward in what people are doing. This is something that is literally affecting the life expectancy of American citizens and is a duty of all of us to step to the forefront and contribute in any way we can.

Dr. Todd Mandell:

So, to use a term that you brought up in this interview, opioid stewardship has really evolved to provide a pathway for treatment for patients with opioid use disorder with programs like the California Bridge and that can start in the emergency department. Thank you, Dr. Herring.

Dr. Andrew Herring:

Thank you so much.

Dr. Todd Mandell:

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