

# Changing the ED

the role of the professional society

Sandra Schneider MD FACEP

Sr VP Clinical Affairs

American College of Emergency Physicians

# American College of Emergency Physicians ACEP

- 40,000 members – all 50 states, international
- >90% of emergency residents (EMRA)
- Education
  - Meetings
  - CME lectures
  - Webinars
  - Podcasts
  - Micro-education
- Other tools
  - Quality measures
  - Accreditation
  - Newsletters
  - Networking
    - Sections
    - Discussion boards
  - Point of care tools

# The ED environment

- It's a team
  - Short attention span
  - Work closely with law enforcement, EMS
- Short patient encounters
- Little to no follow up



Stigma

Harm reduction

Treatment

F/U

# Stigma

- Heavily embedded in EM culture
  - Years of role modeling, continuing
  - Lack of follow up, only see cases that fail
- Many believe addiction is a 'moral failing'; individuals can will themselves out of it
- Feel patients are manipulating or lying; feel 'duped' when they discover they gave opioids to a patient with SUD
- Monitoring of Practice Network shows improvement over time

# Stigma

- Conference 1/23/2020
  - Broad range of speakers, invitees
  - Multiple partners
  - Stigma paper on website -11 recommendations  
<https://www.acep.org/globalassets/new-pdfs/information-and-resource-papers/stigma-in-the-emergency-department.pdf>
- Video <http://vimeo.com/417656739>
- Funding for this initiative was made possible in part by grant no. 6H79T1080816 from SAMHSA



# Harm reduction

- Naloxone
  - Multiple policies supporting
    - <https://www.acep.org/patient-care/policy-statements/naloxone-prescriptions-by-emergency-physicians/>
    - <https://www.acep.org/patient-care/policy-statements/naloxone-access-and-utilization-for-suspected-opioid-overdoses/>
  - Resolutions this year
  - PACED <https://www.acep.org/paced/>
    - Major centers/hospital systems
    - IHS hospitals (grant from SAMSHA)

# Treatment

- Education – resident and practicing docs
- Point of care tool <https://www.acep.org/bupe>
- Consensus recommendations  
[https://www.annemergmed.com/article/S0196-0644\(21\)00306-1/fulltext](https://www.annemergmed.com/article/S0196-0644(21)00306-1/fulltext)
- State guide <https://www.acep.org/globalassets/sites/acep/media/by-medical-focus/opioids/opioid-guide-state-by-state.pdf>

# Treatment

- Point of care tool <https://www.acep.org/bupe>



Buprenorphine use in the Emergency Department Tool



This bedside tool is available in our emPOC app. Available exclusively to ACEP Members.



SHOW ALL ▾

HIDE ALL ▲

> BUPE Overview

## BEGIN PRESCRIBING (B)

> Indications and Contraindications

> Procedure and Administration

> Dosing for Acute Withdrawal or Initiating MAT

> Buprenorphine Precipitated Withdrawal (BPW) Management

> Nausea & Vomiting after buprenorphine – special note

> Other Appropriate Withdrawal Management Medications

## UTILIZE NALOXONE (U)

> Naloxone in the ED

> Forms of Naloxone for Patients/Community Use

## PROVIDE LINKAGE TO TREATMENT (P)

> Opportunity for Intervention



# Treatment

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> BUPE Overview

**BEGIN PRESCRIBING (B)**

> Indications and Contraindications

^ Procedure and Administration

Sublingual (SL) administration is most common, and usually effective (even in severe acute withdrawal). Should not be swallowed; sublingual bioavailability is ~ 50% (buccal and oral much less).<sup>8,10,11,12</sup>

IV access/IV fluids are usually NOT necessary:

- Unless acute opioid withdrawal is associated with severe dehydration, or exacerbates other chronic health conditions such as IDDM (DKA), epilepsy (seizures), heart failure, etc.<sup>12,18,19</sup>
- Most cases of N/V due to opioid withdrawal can be managed with oral antiemetics until the buprenorphine takes effect (Consider ondansetron ODT followed by buprenorphine SL).<sup>18</sup>

IV buprenorphine formulation (if available), "Buprenex" is effective, and indicated in cases of severe emesis (when patient can't absorb sublingual medication). IV buprenorphine not usually necessary, except in cases of severe dehydration or severe illness (when IV access is required).<sup>12</sup> The usual beginning dose is 0.3mg IV, effective in 2-5 minutes, peak effect in ~ 15 minutes.

Buprenorphine and Naloxone: mono drug, combination drug, and brand names. [See below for more information](#) ↓

> Buprenorphine and Naloxone: mono drug, combination drug, and brand names

> Dosing for Acute Withdrawal or Initiating MAT



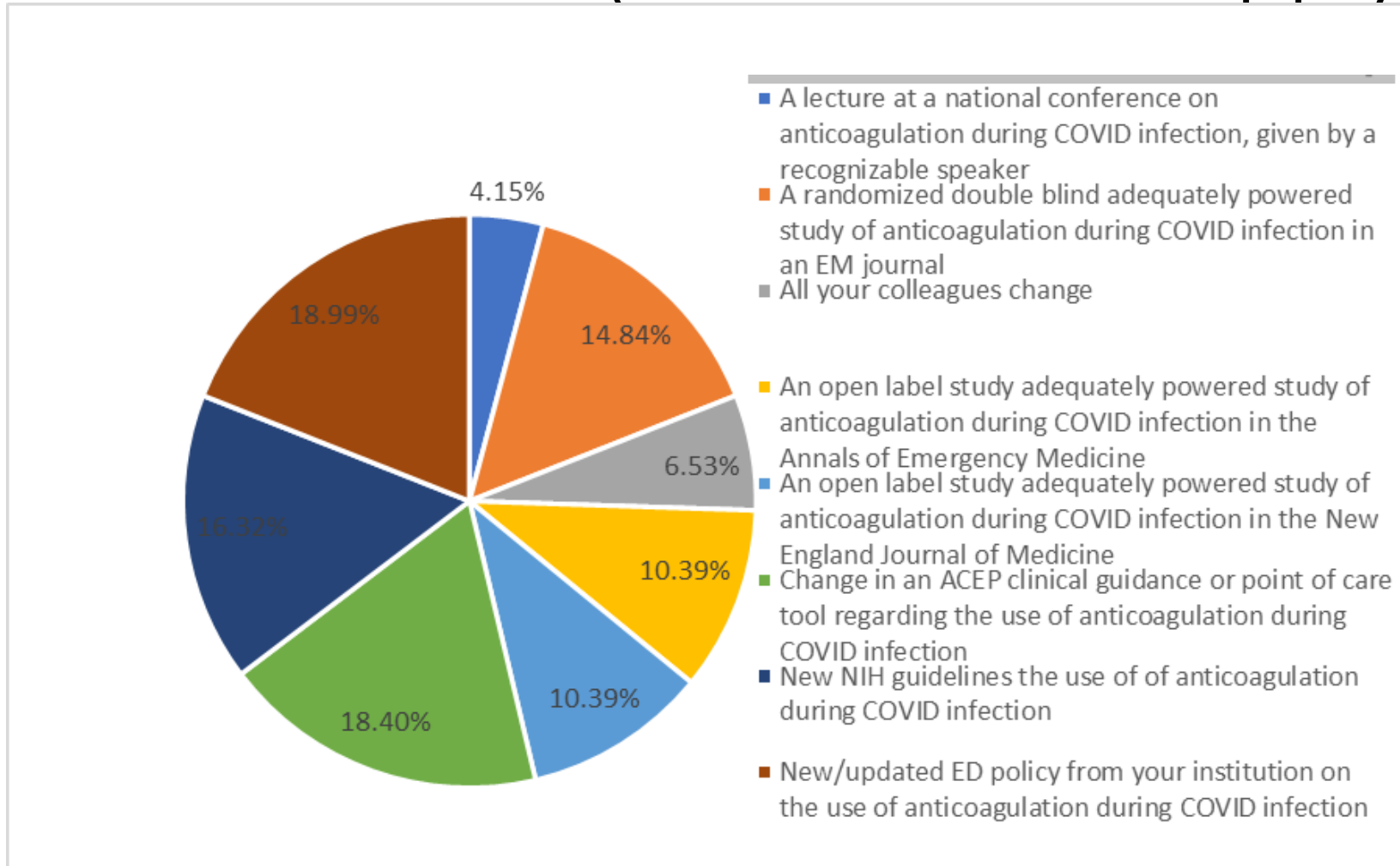
- PACED
- Hardest to find

# Change

- Why people change



# What would make you change your mind about a treatment? (check all that apply)



# Change

- Why people change
- Multifactorial- more than 1
  - NIH guidelines
  - Institutional policy
  - ACEP guidelines
  
- Randomized, double blind study (EM Journal)
- Open label study (NEJM)
- Open label study (Annals of Emergency Medicine)
- Peer change
- National lecture



# Research question: How do accelerate adoption? T3 and T4 research?

- Is dissemination/adoption as important as the research itself?
- Should there be a dissemination plan in all research?
- Should dissemination involve more than the docs?
- Should dissemination/adoption be rated/financed at an appropriate level as the original research?
- Which dissemination platform(s) creates the greatest change in practice?