MAT in the ED

Michael Nelson MD, MS
12/17/2020

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Disclosures

- I have no financial relationships to disclose
- I will not discuss off-label use or investigational use of medications in my presentation

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Overview

- Emergency Department workflow
- Barriers to initiation
- Buprenorphine Evidence
- Develop plans for linkage to treatment
- Harm reduction resources
- Build capacity for hospitals and ED to initiate MAT

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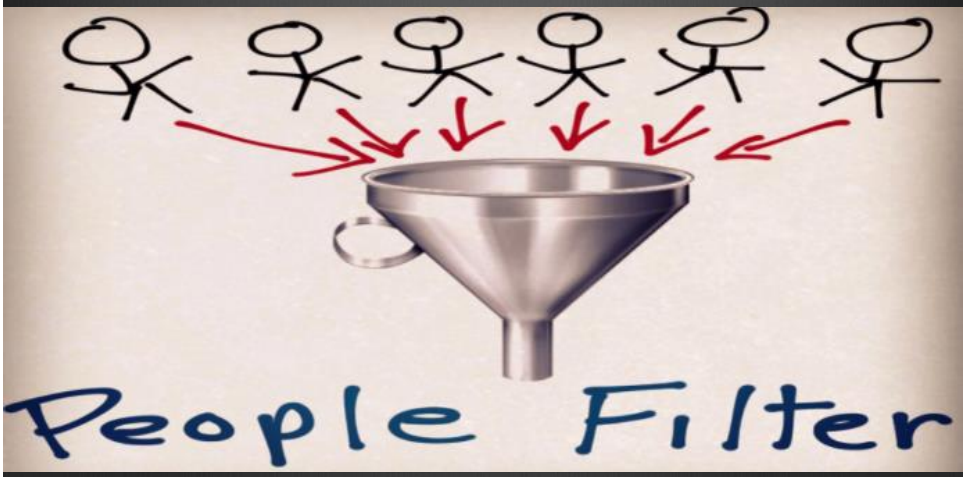
EDs are healthcare's and society's filter



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Misconceptions

- One stop shop
- Fix problems in 2 – 3 hours
- Get definitive answers
- On demand medicine
- Everyone has same knowledge base

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Reality

- Many resources but also limited
- Great to stabilize emergencies
- Bad at chronic or long term disease management
- Often risk stratification, not definitive answers
- Will move mountains for true emergencies
  - Non-emergencies will wait until resources available
- Different knowledge base amongst providers

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Knowledge base

- More than 135 specialties and subspecialties
- The ED physician knows a little something about a lot of those fields
- All these fields expect the ED to manage their patients just as they would
- Truly are masters at life threatening emergencies in these fields

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The demands have grown…

- Sepsis bundles
- CHF bundles
- Stroke protocols
- Door to doctor times
- Door to discharge times
- Door to floor times
- Patient satisfaction scores
- Door to balloon times
- Radiology ordering guidelines
- Documentation requirements
- Yearly CME (50+ hours)
- Certification requirements
- Click after click after click…

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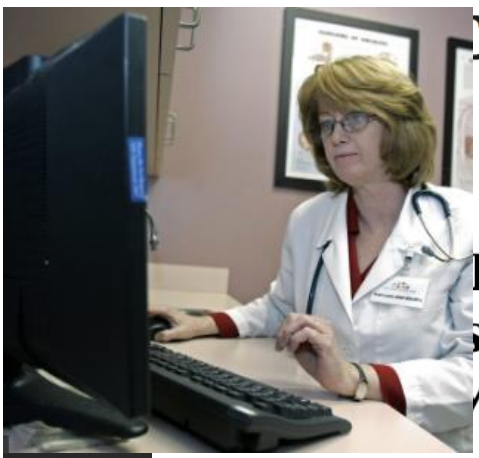
BOTCHED OPERATION

Death By 1,000 Clicks: Where Electronic Health Records Went Wrong



May 12, 2017 | By Drs. John Levinson, Bruce H. Price and Vikas Saini

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Organized chaos

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If you want things to work…

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At the end of the day

- Want to make a difference
- Want to improve health

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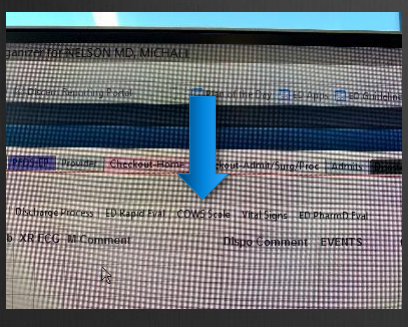
Documentation/EHR

- Decrease documentation burden
- Create templates
- Built in calculator (COWS score)
- Less time at the computer = more time with patient



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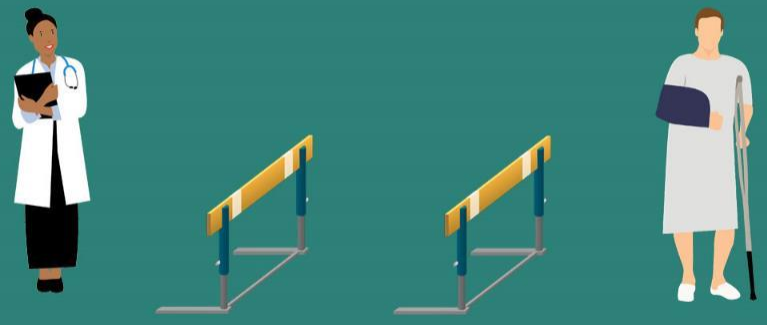
Barriers



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Am J Emerg Med. 2019 September ; 37(9): 1787–1790. doi:10.1016/j.ajem.2019.02.025.

Barriers and Facilitators for Emergency Department Initiation of Buprenorphine: A physician survey

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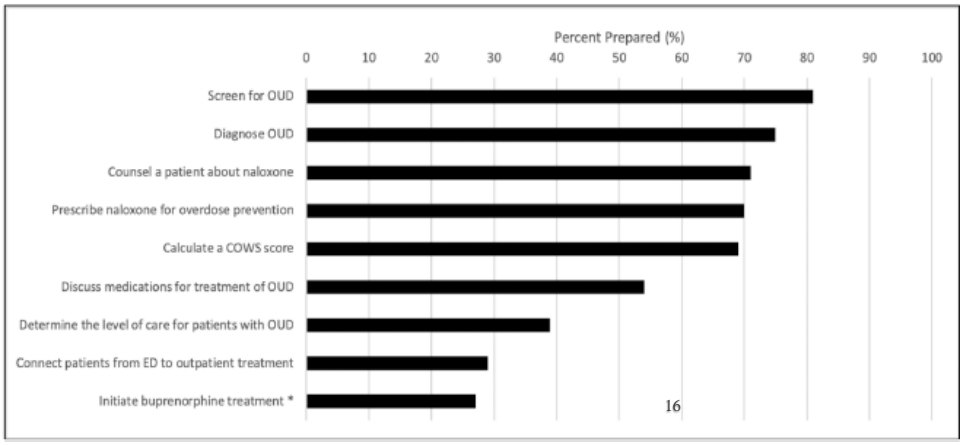

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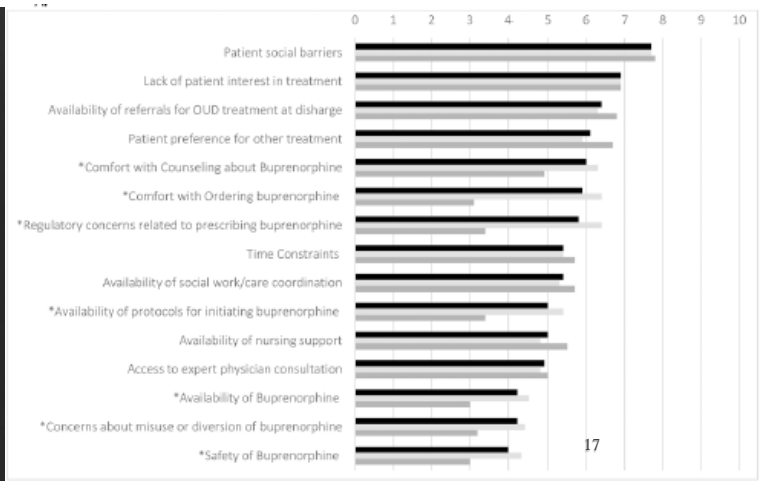

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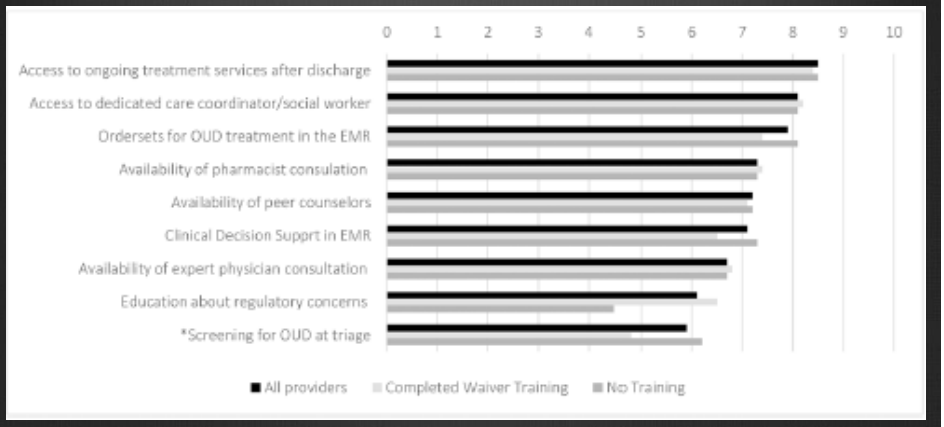

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Barriers to care

- Concern of induction logistics
- Reimbursement challenges
- Concern for diversion
- Lack of support for providers managing complex patients
- Lack of psychosocial support services
- Sustainability

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Barriers

- Financial
- Regulatory Restrictions
- Geographic
- Stigma
- Logistics
- Individual

- All lead to reduced access to care

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Financial barriers

- Fee-for-service
- Pay out of pocket
- Poor insurance/Medicaid re-imbursement
- Poor insurance coverage
- Prior-authorization

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Regulatory

- X-waiver requirement and limits
- OTP federal and state regulations
- Zoning regulations
- Required to have counseling

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Geographic

- MAT Deserts
- Lack of transportation
- In-person daily at OTP
- Lack of support for physicians in more rural regions

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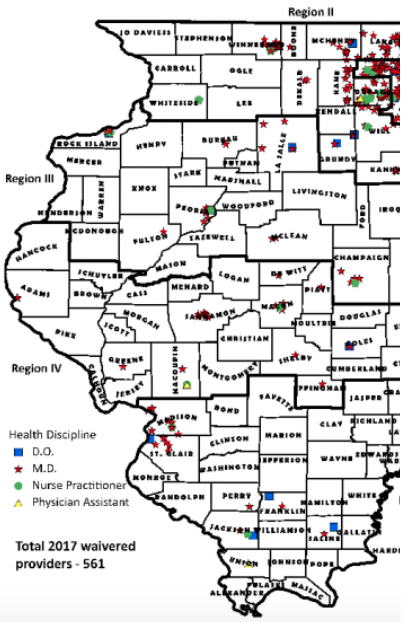
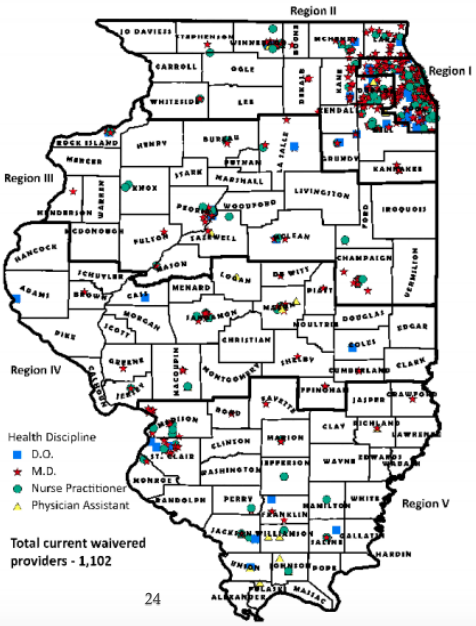
The Opioid Crisis in Illinois: Data and the State's Response

DATA-Waivered Illinois Providers with Buprenorph Prescribing Privileges – 2017



The Opioid Crisis in Illinois: Data and the State's Response

DATA-WAIVERED ILLINOIS PROVIDERS WITH BUPRENORPHINE PRESCRIBING PRIVILEGES – AUGUST 2019



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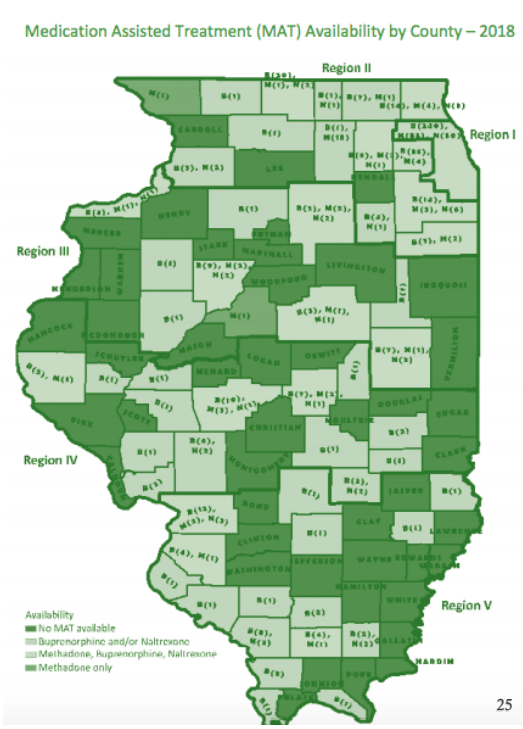

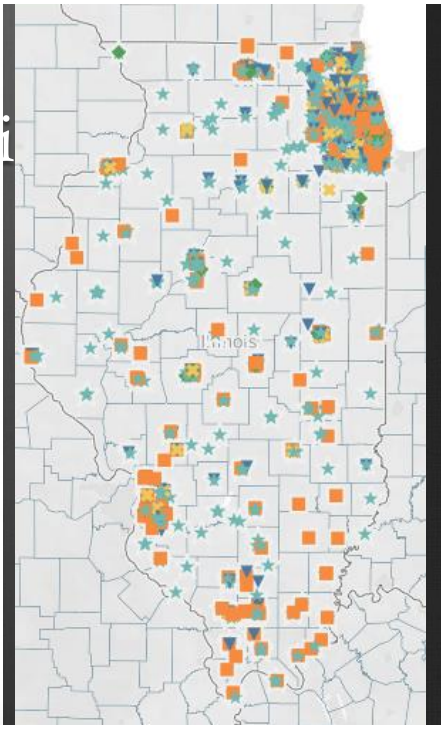

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Individuals

- Readiness to change
- Co-occurring diseases
- Individualized treatment plan
- Social support (family, living arrangements)
- Finances

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Logistics

- Lack of counseling available
- Coordination of care
- Wait-lists
- Lack of infrastructure for providers
- Time constraints on providers
- Poor re-imbursement

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Stigma

- "just another addict"
- "dirty urine", "addicted baby"
- Substituting one dependence for another
- They can "choose to just quit"
- Viewed as a moral failure

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Shift of focus

- Social problem to a medical one
- Chronic disease

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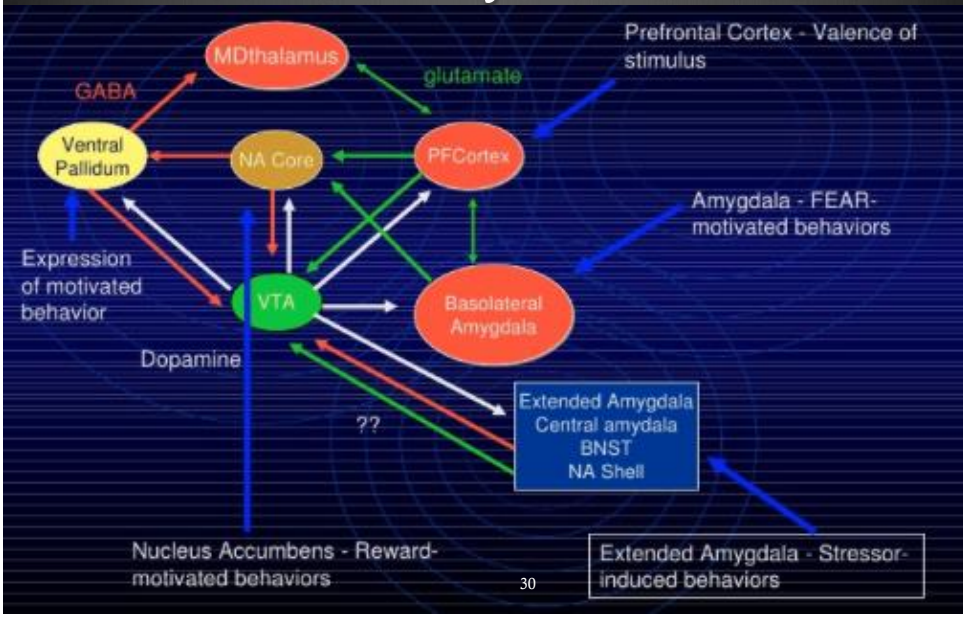
Neuroanatomy of addiction



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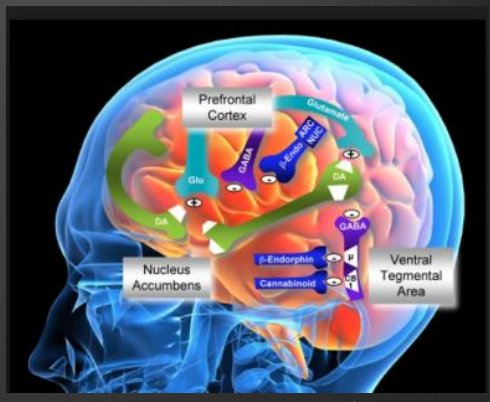
Basic

- Drug use stimulates DA reward pathways
- Nucleus accumbens, ventral tegmental area (VTA)
- Reinforcement
- Craving
- Tolerance
- Dependence
- Withdrawal



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Definition of Addiction

Definition:

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019

- Chronic disease = relapsing and remitting

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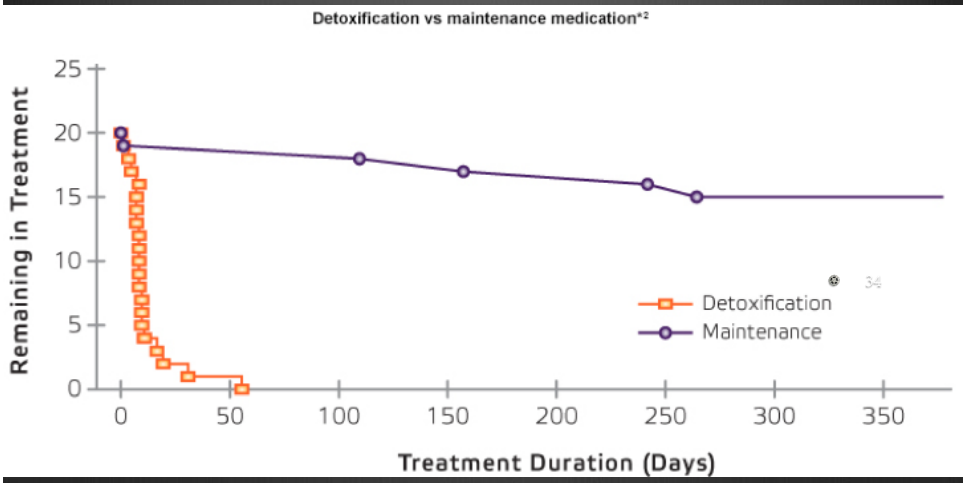
Detox and Discharge



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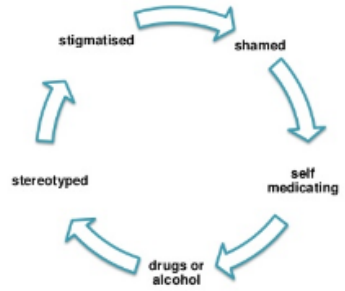
Viscous cycle



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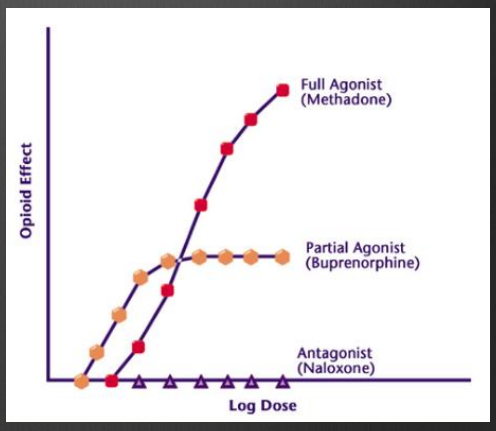
Buprenorphine

- Partial opioid agonist
- Low potency
- High Affinity
- Ceiling effect



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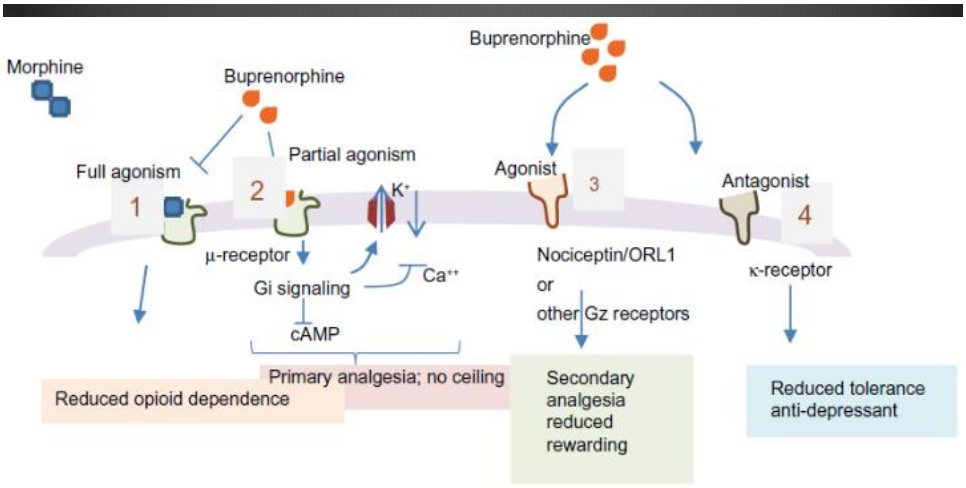

Opioid receptor	Ki (nM)	Agonist/antagonist
μ	1.5	Partial agonist
δ	6.1	Antagonist
κ	2.5	Antagonist
Nociceptin or ORL1	77.4	Agonist

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Goal

Increased retention in treatment

Decreased illicit opioid use

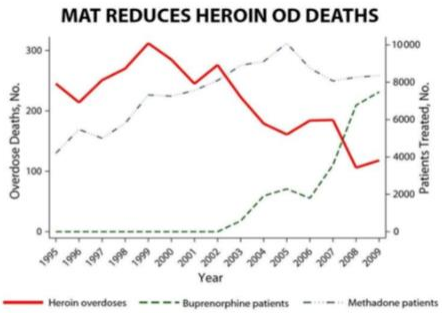
Decreased transmission of hepatitis C virus and human immunodeficiency virus

Reduced rates of incarceration

Increased employment

Increased survival

Not everything that can be counted counts.
Not everything that counts can be counted.



After buprenorphine became available in Baltimore, heroin overdose deaths decreased by 37 percent .[7]

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Published in final edited form as:
Drug Alcohol Depend. 2016 May 1; 162: 51–55. doi:10.1016/j.drugalcdep.2016.02.024.

NON-FATAL OVERDOSE AS A RISK FACTOR FOR SUBSEQUENT FATAL OVERDOSE AMONG PEOPLE WHO INJECT DRUGS

Alexander Caudarella[1], Huiru Dong[1], MJ Milloy[1,2], Thomas Kerr[1,2], Evan Wood[1,2,*], and Kanna Hayashi[1,2]

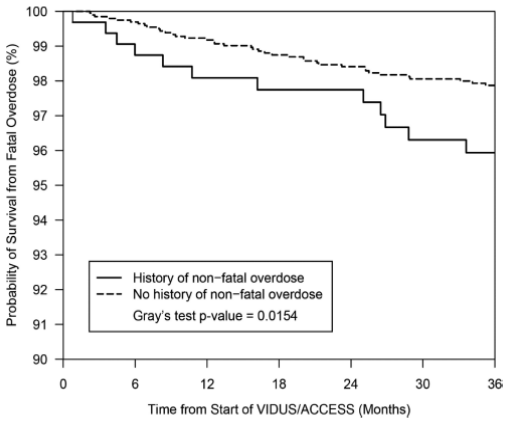
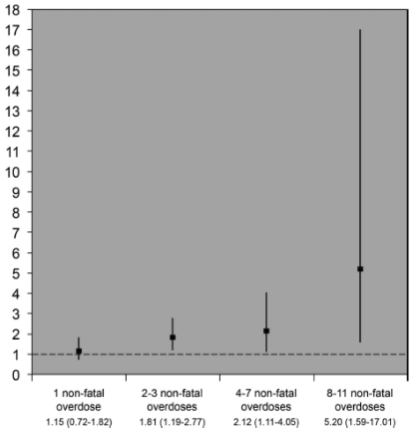


Figure 1.
Time to overdose mortality stratified by reporting non-fatal overdose in the last six months at baseline.



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Original Investigation

Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence
A Randomized Clinical Trial

Gail D'Onofrio, MD, MS; Patrick G. O'Connor, MD, MPH; Michael V. Pantalon, PhD; Marek C. Chawarski, PhD; Susan H. Busch, PhD; Patricia H. Owens, MS; Steven L. Bernstein, MD; David A. Fiellin, MD

- Those in addiction treatment at 30 days
  - 78% Buprenorphine
  - 45% Brief intervention
  - 37% Referral

Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention

Gail D'Onofrio, MD, MS[1], Marek C. Chawarski, PhD[1,2], Patrick G. O'Connor, MD, MPH[3], Michael V. Pantalon, PhD[1], Susan H. Busch, PhD[4], Patricia H. Owens, MS[1], Kathryn Hawk, MD, MHS[1], Steven L. Bernstein, MD[1], and David A. Fiellin, MD[3,4]

40 J Gen Intern Med 32(6):660–6

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Brief Report

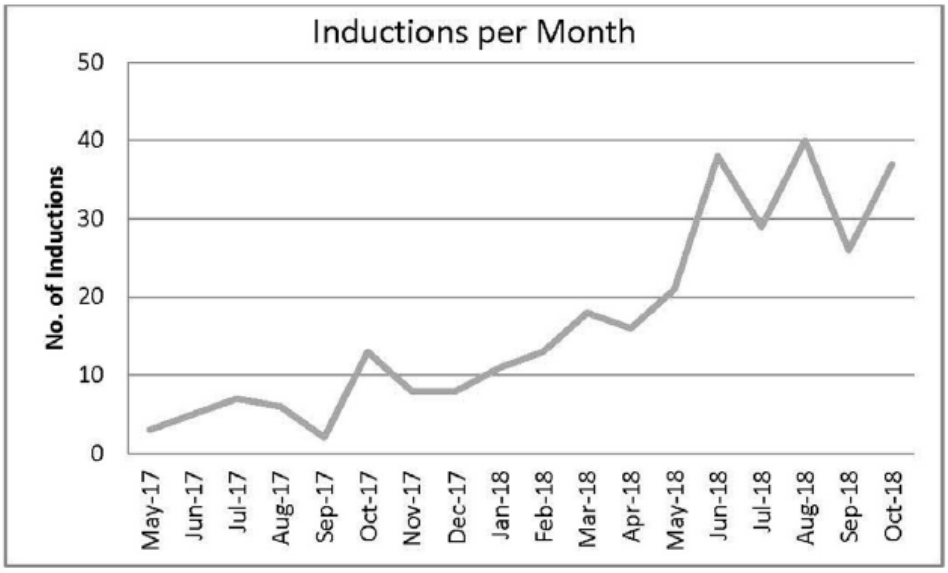

Fig. 2. Caption: Number of emergency department initiated inductions per month.

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Journal of Medical Toxicol
https://doi.org/10.1007/s1

POSITION STATEME

ACMT Positio in the Emerg

Paul M. Wax[1] · And · Lewis S. Nelson[6]

Check for updates

- The ED sees a large number of patients presenting with opioid overdose, opioid withdrawal, or OUD.
- For many patients at high-risk for overdose, the ED is their primary access point to health care and treatment.
- Evaluation in the ED represents an opportunity to engage patients in a discussion of OAT and harm reduction strategies to mitigate risk from the continued use of illicit drugs after discharge.
- Following initiation of buprenorphine in the ED, a bridge clinic or "warm handoff" to a treatment provider will improve engagement into long-term treatment.
- Screening for OUD in patients who present to the ED for other medical reasons provides an important opportunity to begin intervention immediately for those who screen positive.
- Buprenorphine is relatively safe even in high doses and has a substantially lower abuse potential than full agonist opioids [10].

ACMT supports the administration of buprenorphine in the ED as a bridge to long-term addiction treatment, and ACMT supports the administration of buprenorphine to ED patients to

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Treatment Engagement

Mean Costs and Outcomes (N=244)

	Mean (SD) [IQR]			Differences between groups * (95% confidence interval) (p-value)		
	ED-initiated Buprenorphine (N=93)	Brief Intervention (N=82)	Referral (N=69)	ED-initiated Buprenorphine versus Brief Intervention	Brief Intervention versus Referral	ED-initiated Buprenorphine versus Referral
Health care costs						
Intervention costs occurring during enrollment ED visit †	83	16	8	66	8	74
All other health care costs (US $)	1670 (2947) [498,1933]	1788 (3467) [0,1545]	1969 (3142) [0,1914]	−117 (−1096,913) p=.80	−166 (−1232,895) p=.76	−284 (−1174,666) p=.56
Total (US $)	1752 (2948) [5801,2015]	1805 (3467) [16,1561]	1977 (3142) [8,1923]	−51 (−1030,979) p=.90	−158 (−1224,903) p=76	−209 (−1100,740) p=.66
Effects						
Enrolled and receiving formal addiction treatment at 30 days	86% (35)	45% (50)	39% (49)	41% (28, 54) p<.001	6% (−10, 22) p=.46	47% (34, 60) p<.001
Change in days of self-reported illicit opioid use in the past 7 days (days)	4.43 (2.37) [3, 6]	3.23 (.50) [0, 6]	3.01 (2.94) [1, 6]	1.20 (.38, 2.01) p=.0044	.21 (−.76, 1.20) p=.66	1.42 (.59, 2.24) p=.0009
Incremental cost effectiveness ratios (ICERs)						
Cost per enrollment in formal addiction treatment at 30 days (%)				Brief intervention dominated. (Costs more/ fewer benefits)	Referral dominated. (Costs more/ fewer benefits)	Referral dominated. (Costs more/ fewer benefits)
Cost per change in days of self-reported illicit opioid use in the past 7 days (days)				Brief intervention dominated. (Costs more/ fewer benefits)	Referral dominated. (Costs more/ fewer benefits)	Referral dominated. (Costs more/ fewer benefits)

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J Gen Intern Med. 2019 Jun;34(6):871-877. doi: 10.1007/s11606-018-4807-x. Epub 2019 Jan 10.

Effect of Integrating Substance Use Disorder Treatment into Primary Care on Inpatient and Emergency Department Utilization.

Wakeman SE[1,2], Rigotti NA[3,4], Chang Y[3,4], Herman GE[5], Erwin A[6], Regan S[3,4], Metlay JP[3,4].

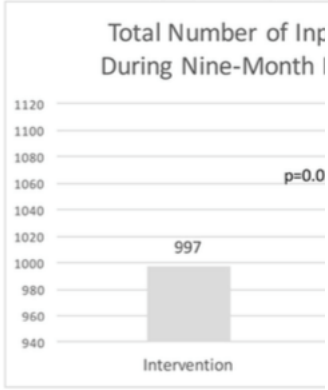

Fig. 1 Total number of inpatient … follow-up …

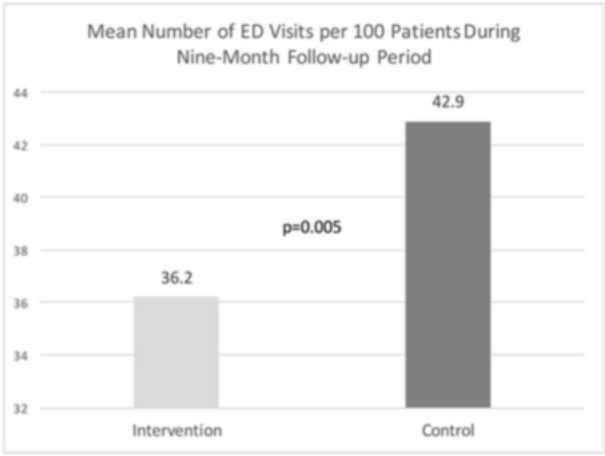

Fig. 2 Mean number of ED visits per 100 patients during the 9-month follow-up period.

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Impact of Medication-A
Medicaid Expenditures

Mary Kate Mohlman, Ph.D. [a,*],
Melanie Pinette, M.E.M. [b], Crai

[a] Vermont Blueprint for Health, NOB 1 South, 280 St
[b] Onpoint Health Data, 254 Commercial Street, Suite

Table 2
Adjusted average annual expenditures and utilization rates[†].

	MAT group	Non-MAT	Difference[‡]	P-value
Expenditures				
Total expenditures	$14,468	$14,880	−$412	0.07
Total expenditures without treatment	$ 8794	$11,203	−$2409	<0.01
Buprenorphine expenditures	$2708	−$47	$2755	<0.01
Total prescription expenditures	$4461	$2166	$2295	<0.01
Inpatient expenditures	$2132	$3757	−$1625	<0.01
Outpatient expenditures	$345	$604	−$259	<0.01
Professional expenditures	$674	$981	−$307	<0.01
SMS expenditures[*]	$2872	$4160	−$1288	<0.01
Utilization (rate/person)				
Inpatient days	1.54	3.00	−1.46	<0.01
Inpatient discharges	0.30	0.52	−0.22	<0.01
ED visits	1.44	2.48	−1.04	<0.01
Primary care physician visits	15.27	9.81	5.46	<0.01
Advanced imaging	0.29	0.54	−0.25	<0.01
Standard imaging	0.76	1.43	−0.67	<0.01
Colonoscopy	0.01	0.02	−0.01	<0.01
Echography	0.46	0.53	−0.07	0.002
Medical specialist visits	0.49	0.82	−0.33	<0.01
Surgical specialist visits	3.04	1.89	1.15	<0.01

[*] SMS refers to special Medicaid services and include transportation, home and community-based services, case management, dental, residential treatment, day treatment, mental health facilities, and school-based services.
[†] Multivariable regression analysis, adjusted for gender, age, calendar year, clinical risk groups, Medicaid in the prior year, hepatitis C virus (HCV) status, and pre- and perinatal care.
[‡] Difference = MAT – non-MAT.

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Number needed to treat

Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence (Review)

Mattick RP, Breen C, Kimber J, Davoli M

Mattick RP, Breen C, Kimber J, Davoli M.
Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence.
Cochrane Database of Systematic Reviews 2014, Issue 2. Art. No.: CD002207.
DOI: 10.1002/14651858.CD002207.pub4.

- NNT = 2 – 4
- For retention in treatment
- No mortality outcomes while in treatment

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Methadone vs. Buprenorphine

TABLE 5: Randomized controlled trials of buprenorphine as a maintenance treatment

TYPE OF STUDY	# PTS	RANDOMIZATION GROUPS				OUTCOMES
Double-blind double-dummy randomized trial[17]	162	Bup 8mg/day sublingual liquid	Methadone 20mg/day (low dose)	Methadone 60mg/day (high dose)		Retention in the program and percent negative urines. At the end of 17 weeks, 42% of the buprenorphine patients remained in the program vs 20% and 32% of low and high methadone patients. Urine screening showed similar results with the buprenorphine group having more negative urines than those in the methadone group.
Double blind randomized trial[18]	140	Bup 2mg/day Sublingual liquid	Bup 6mg/day Sublingual liquid	Methadone 35mg/day Methadone 65mg/day		The 6mg buprenorphine dose reduced illicit opioid use better than the 2mg dose but was not associated with better retention. Both methadone doses were associated with better retention than either buprenorphine dose.
Double blind double-dummy randomized trial[19]	162	Bup 8-16mg/day flexible; sublingual liquid	Methadone 50–90mg/ day flexible			Buprenorphine and methadone were equal in measures of treatment retention (56%) and counseling attendance. They had similar effects on opiate positive urines.
Double blind randomized trial[20]	225	Bup 8mg/day sublingual liquid	Methadone 30mg/day	Methadone 80mg/day		The 8mg/day buprenorphine dose was less effective than the 80mg methadone dose for treatment retention and negative opioid urines. It was comparable to the 30mg methadone dose.
Double blind randomized trial[21]	116	Bup 4mg/day sublingual liquid	Bup 12mg/day sublingual liquid	Methadone 20mg/ day	Methadone 65mg/ day	Both higher methadone and buprenorphine groups had better negative urine opioid positive results (45%, 58% vs 72%,77%). Treatment retention was similar in all groups.
Multi-site double-blind random trial[22]	736	Bup 1mg/day sublingual liquid	Bup 4mg/day sublingual liquid	Bup 8mg/day sublingual liquid	Bup 16mg/day sublingual liquid	The 8 and 16mg groups had significantly better rates of treatment completion. There was more sustained abstinence in the 16mg group.

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Methadone vs. Buprenorphine

- Dearth of studies
- Essentially similar in:
  - Treatment retention rates
  - Drug free days
- Differences:
  - High doses of methadone vs. ceiling effect buprenorphine
  - Daily structured visit (scheduled) at OTP vs. home/office based

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Buprenorphine facts

- "X" waiver for outpatient OUD management
- Do not need for use as inpatient
- Do not need for pain management
- "Three day rule" (21 CFR1306.07(b))

  - Not more than one day's medication may be administered or given to a patient at one time
  - Treatment may not be carried out for more than 72 hours
  - The 72-hour period cannot be renewed or extended

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Get waivered

- https://www.acep.org/education/ed-x-waiver-training-corps/
- Get 4 hours CME free

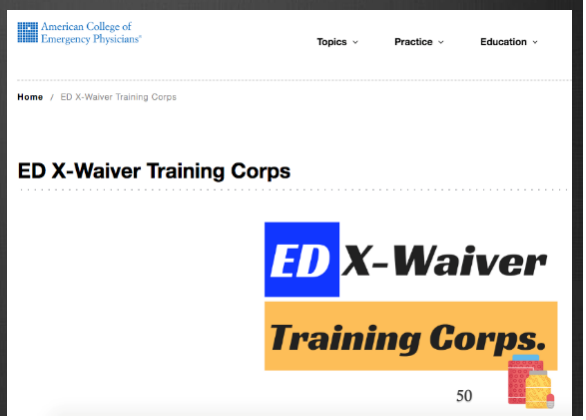

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Figure 3: Barriers and Facilitators to obtaining an X-waiver for emergency department physicians

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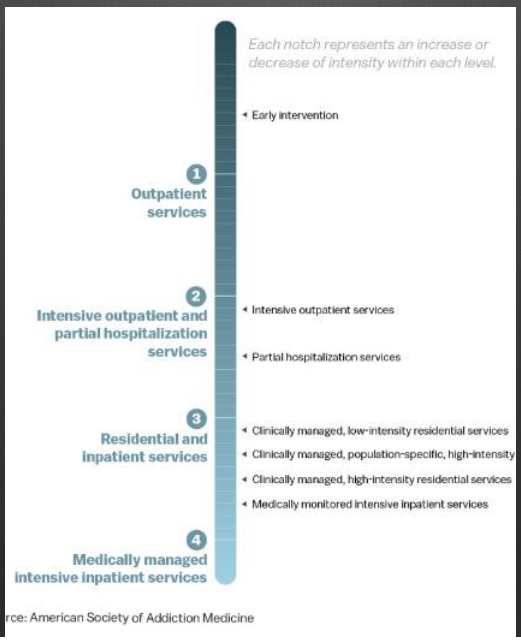
Levels of addiction treatment



rce: American Society of Addiction Medicine

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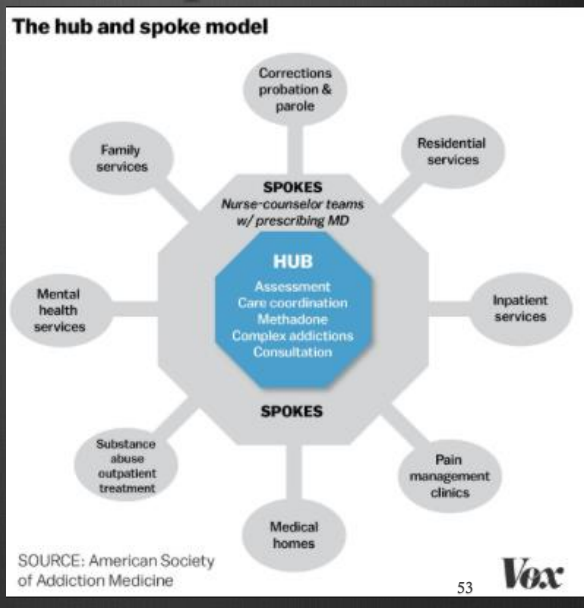
Hub and Spoke

- System of referral
- Levels of treatment
- Coordinated
  - PCP
  - ED
  - Hospital
  - Treatment facilities
- Lessens gaps



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Hub and Spoke

- Hub: regional opioid treatment center, complex SUD, co-occurring mental health conditions; methadone, buprenorphine, naltrexone
- Spoke: Primary care practice, specialty care practice, health center, co-ordinates care for patients with SUD; buprenorphine, naltrexone (no methadone)
- Support services: mental health, pain management, family support, life skills, job development, recovery support

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Vermont

- Services paid for Medicaid
- Hub: bills a monthly bundled rate
- Blueprint for health: distributes funds to spokes
- State provides oversight
- https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke

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Published in final edited form as:
J Addict Med. 2017 ; 11(4): 286–292. doi:10.1097/ADM.0000000000000310.

Vermont Hub-and-Spoke Model of Care For Opioid Use Disorder: Development, Implementation, and Impact

John R. Brooklyn, MD and **Stacey C. Sigmon, PhD**
Department of Psychiatry (JRB, SCS); Department of Psychology (SCS), University of Vermont, Burlington, VT

- 64% increase in X-waivered physicians
- Decrease in healthcare costs by 10%

- Among its Hub and Spoke patients, Vermont has achieved the following[23]:
  - 96-percent decrease in opioid use
  - 89-percent decrease in ED visits
  - 92-percent decrease in injection drug use
  - 90-percent reduction in illegal activity and police detentions/arrests
  - $6.7 million decrease in health care expenditures
  - Zero overdoses reported in the 90 days prior to patients' self-reporting, versus 25 percent who had overdosed within 90 days prior to entering treatment

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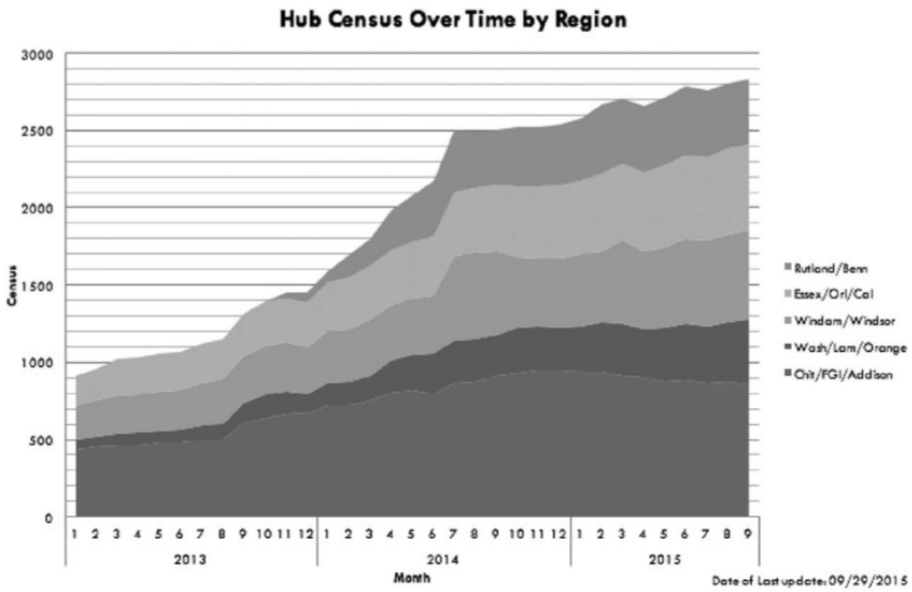

FIGURE 3.
Patient census data presented for Vermont's 5 regional hubs over time (January 2013–September 2015).

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Massachusetts

- MHA – guidelines for developing MAT in hospitals
- Law Chapter 208: requires acute care hospitals that have ED services to have the capacity to initiate buprenorphine and to connect them to treatment after discharge
- https://www.mhalink.org/MHADocs/MondayReport/2019/18-01-04MATguidelinesNEWFINAL.pdf

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Warm Handoff

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Recovery Coaches

- Lived experience
- Help monitor progress
- Help establish treatment linkages
- Model coping and self-help strategies
- Recovery planning

Replication of an emergency department-based recovery coaching intervention and pilot testing of pragmatic trial protocols within the context of Indiana's Opioid State Targeted Response plan

Dennis P. Watson[a,*], Krista Brucker[b], Alan McGuire[c,d], Nyssa L. Snow-Hill[a], Huiping Xu[e], Alex Cohen[f], Mark Campbell[g], Lisa Robison[a], Emily Sightes[h], Rebecca Buhner[i], Daniel O'Donnell[b], Jeffrey A. Kline[b]

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Recovery coaches

- Opioid Overdose Recovery Program, New Jersey
- Georgia Council on Substance Abuse
- Project POINT, Indiana
- Project Engage, Christiana Health System, Delaware
- Hartford HealthCare, Connecticut
- Anchor Recovery Services, Rhode Island
- Cook County Health, Chicago

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Anchor Recovery

230 survivors seen by recovery coaches

193 survivors, or 83%, have engaged in recovery supports after discharge from ED

Majority of survivors followed by Anchor Recovery Community Center with multiple recovery supports

36 survivors declined recovery support services; two remained in hospital care

Of the 230 survivors seen, only 12 (5%) have been seen in ER multiple times.

Recovery to Practice

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SAMHSA

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Recovery coaches

- Reductions in hospital readmissions
- Longer sobriety
- Increased hosing stability
- Improved mental health functioning

Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review

Ellen L. Bassuk, M.D. [a,b,*], Justine Hanson, Ph.D. [a], R. Neil Greene, M.A. [a], Molly Richard, B.A. [a], Alexandre Laudet, Ph.D. [c]

Journal of Substance Abuse Treatment 63 (2016) 1–9

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Need

- Integrated into work flow
- Automated, rapid, flexible referral system
- HIPAA and CFR 42 Part 2 compliant
- Urgent appointments at treatment facility
- Not disrupt work flow of treatment facility

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MAT Cash Clinics

- Cash only
- Pay for each visit
  - Often $200 – 500 for initial visit
  - Then often ~ $150 – 250 for follow up visit
- Can be financially constraining

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MAT "Bridge" Clinics

- Short term prescriptions
- See patient after ED visit typically in 1 – 2 days
  - Patient can receive dose of buprenorphine in ED
  - Be seen the next day in clinic
- Will monitor and treat until patient can be placed into appropriate level of care

66

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Treatment in prisons

Addiction. 2015 Dec;110(12):1975-84. doi: 10.1111/add.13073. Epub 2015 Sep 23.

A cost-effectiveness analysis of opioid substitution therapy upon prison release in reducing mortality among people with a history of opioid dependence.

Gisev N[1], Shanahan M[1], Weatherburn DJ[2], Mattick RP[1], Larney S[1,3], Burns L[1], Degenhardt L[1,4].

Addiction. 2017 Aug;112(8):1408-1418. doi: 10.1111/add.13779. Epub 2017 Mar 1.

Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England.

Marsden J[1], Stillwell G[1], Jones H[2], Cooper A[3], Eastwood B[3], Farrell M[4], Lowden T[3], Maddalena N[3], Metcalfe C[2], Shaw J[5], Hickman M[2].

PLoS One. 2012;7(5):e38335. doi: 10.1371/journal.pone.0038335. Epub 2012 May 31.

Retention on buprenorphine is associated with high levels of maximal viral suppression among HIV-infected opioid dependent released prisoners.

Springer SA[1], Qiu J, Saber-Tehrani AS, Altice FL.

Addiction. 2012 Mar;107(3):501-17. doi: 10.1111/j.1360-0443.2011.03676.x.

The effectiveness of opioid maintenance treatment in prison settings: a systematic review.

Hedrich D[1], Alves P, Farrell M, Stöver H, Møller L, Mayet S.

67

Telemedicine

Alcoholism & Drug Abuse Weekly. 2020 Apr 6; 32(14): 4–5. PMCID: PMC7161739
Published online 2020 Apr 3. doi: 10.1002/adaw.32680

DEA allows buprenorphine inductions based on telephone only

Alison Knopf

- Changes to Ryan Haight Online Consumer Protection Act
- Controlled Substances: need to do in-person evaluation
- https://www.deadiversion.usdoj.gov/fed_regs/rules/2020/fr0930_2.htm
- Then COVID…

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POWER Act

H.R.5176 - Preventing Overdoses While in Emergency Rooms Act of 2018
115th Congress (2017-2018)

BILL Hide Overview ✖

Sponsor: Rep. McKinley, David B. [R-WV-1] (Introduced 03/06/2018)
Committees: House - Energy and Commerce | Senate - Health, Education, Labor, and Pensions
Latest Action: Senate - 06/13/2018 Received in the Senate and Read twice and referred to the Committee on Health, Education, Labor, and Pensions. (All Actions)

Tracker:
Introduced | Passed House

- Grant program
- Develop protocols for discharging pt after drug overdose
- Enhance integration of post-discharge care for pt with SUD

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H.R.2281 - Easy MAT for Opioid Addiction Act
116th Congress (2019-2020) | Get alerts

- ED can dispense a three day supply of medication

Shown Here:
Passed House (11/17/2020)
Easy Medication Access and Treatment for Opioid Addiction Act or the Easy MAT for Opioid Addiction Act

This bill requires the Drug Enforcement Administration to revise regulations to allow a practitioner to administer up to a three-day supply of narcotic drugs to an individual at one time for purposes of relieving acute withdrawal symptoms while the individual awaits arrangements for narcotic treatment. Current regulations authorize up to a one-day supply of narcotic drugs for an individual at one time, for a total of up to three days.

H.R.2482 - Mainstreaming Addiction Treatment Act of 2019
116th Congress (2019-2020) | Get alerts

- Also, starting in 2021
  - Medicare will reimburse for MAT in the ED

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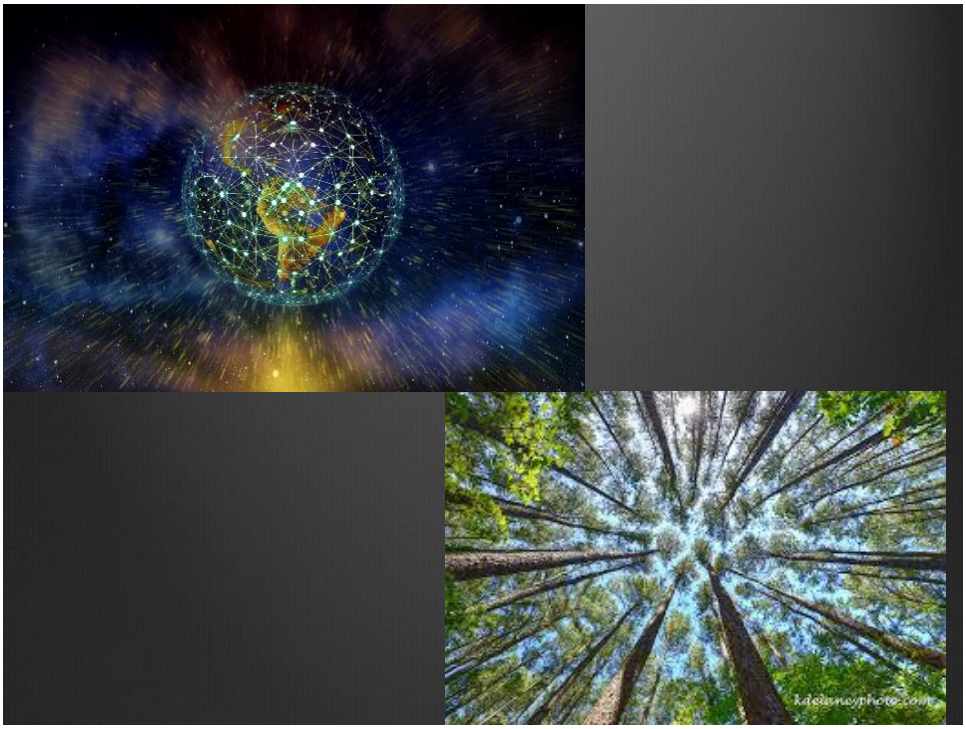

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200 WATT OK, DOC?
HEY! I'M NEXT!
YES, JUST HURRY!
CAN I SEE?
HOT PIZZA!
ALL SET, DUDE?
BAM
BATHROOM IN HERE?
EMT
E.R. (GOOD LUCK)

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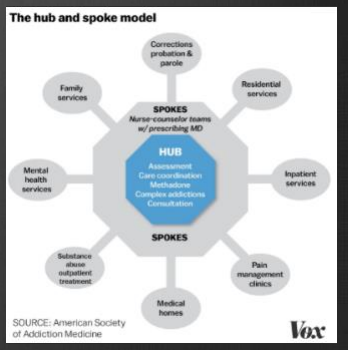
Summary

- Every ED provider needs the X-waiver
- Need to make work flow easy
  - EMR systems in place
  - Recovery coaches/"warm hand offs"
  - MAT clinics
- Need referral pattern in place



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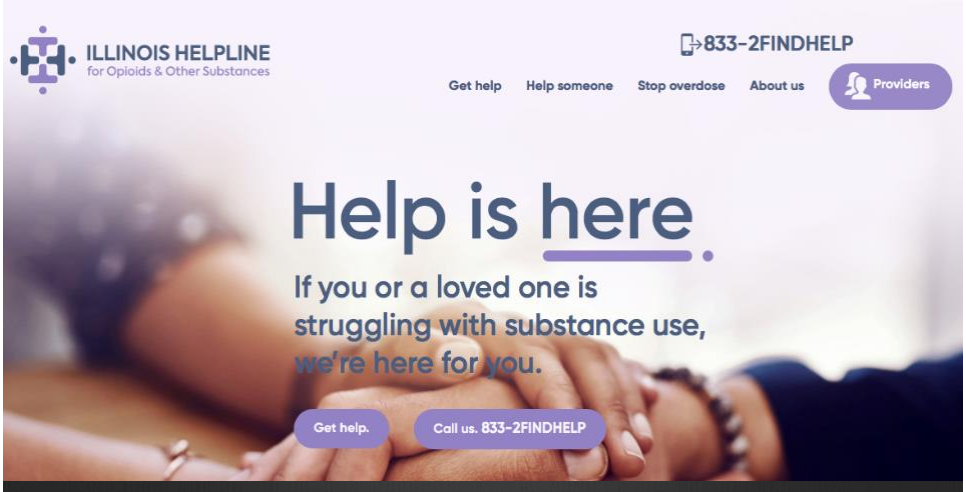
Illinois Helpline



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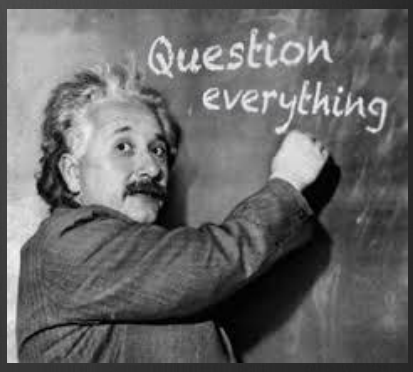
Thank you



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