EMS Focus Webinar FAQ: EMS Harm Reduction and SUD Treatment

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The following answers are provided by:

- **Kate Elkins**, Emergency Medical Services/911 Specialist, NHTSA's Office of EMS (moderator)
- **Gerard Carroll, M.D**., EMS Medical Director, Cooper University Health Care; Division Head of EMS/Disaster Medicine; and Program Director, EMS Fellowship Program
- **John Ehrhart**, Paramedic; EMS Manager, San Diego Health Connect; Co-Founder, California Paramedic Foundation; and Founder, Mission Critical Protocols
- **Simon Taxel**, Paramedic Crew Chief and Public Safety Diver, Pittsburgh Bureau of EMS; Bloomberg Fellow, Johns Hopkins Bloomberg School of Public Health

1. How do you maintain connections with the unhoused population? If they don't respond, have you found other approaches to staying connected? What are your thoughts on Emergency Medical Services (EMS) transporting individuals to rehabilitation centers instead of emergency rooms?

Following up with unhoused people is a persistent problem for us. Unfortunately, we have yet to develop an effective strategy.

2. What is your take on alternative destinations for SUD's and first responders?

For some patients this could be a really useful tool. That said, there are significant challenges that need to be addressed including reimbursement, liability and a transfer of care at the destination that meets current regulatory standards. Additionally, there would need to be robust mechanisms in place to ensure that patients are not under triaged and then transported to the alternative destination.

3. How are EMS personnel able to do induction of pre-hospital buprenorphine? Does a prescriber need to be on board as a prescriber in advance of these cases? Is it only if the patient is going directly to a hospital or if there is no transport?

We contact the online medical command and consult with a faculty physician to administer the buprenorphine. Now that the X-waiver requirement has been removed, any command physician can authorize. Transport or refusal after administration is at the patient's discretion.

4. Is it possible for individuals to attend a Suboxone clinic while still misusing opiates? Put differently, how feasible is it for someone to abuse illicit drugs while also undergoing Suboxone treatment?

It is not easy, but possible. Most patients taking regular buprenorphine attain long term recovery.

5. Given the critical role of Narcan in various settings, including emergency response, why do pharmacies opt to charge for it instead of states providing it free of charge to those who require it for survival or to rescue others?

This is because of local politics and funding.

6. Is there a role for opioid antagonists with greater potency than a 4 mg nasal spray of Naloxone?
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There is absolutely no evidence to support the use of high dose naloxone products, even in the context of a drug marketplace dominated with synthetics like fentanyl. They are likely to cause a significant amount of harm.

7. What measures are implemented when introducing a new protocol to mitigate the financial implications for the Fire agency? How do we balance the costs with the benefits and explore avenues for securing continuous, sustainable funding?

Grant money is always great, but we train this as part of general orientation and the medication itself is not expensive. One Glucagon will pay for the year of buprenorphine in most programs.

8. What's being done to help people get into long-term treatment? For example, it's often hard to find spots in places with more intense care or detox centers when needed quickly.

This is an area in need of more work. Low barrier walk-in clinics, after hours clinics, home visits, mobile units and community paramedics are all being explored and hopefully the data will lead the way.

9. How does the person circumvent the system to abuse both substances?

We do not observe patients abusing buprenorphine, however some patients struggling with recovery will use less buprenorphine than prescribed in order to be able to use other opiates.

10. Do users of illicit opiates commonly reduce their consumption of Suboxone?

Certainly there are cases where utox + of illicit opiates makes further prescribing impossible. However, a 100% negative utox rule is too prescriptive in my medical opinion.

11. Stigma and bias surrounding substance use disorder has always been challenging. How have you educated EMS providers or other healthcare professionals to continue pushing this great and important initiative?

This is difficult, but crucial to tackle for EMS. I had to face my own biases before being successful in this space. I try to help EMS understand that this is a chronic disease and help them understand the pathophysiology of OUD and how that disease process makes these patients so difficult to interact with and to treat.

12. What are the concerns associated with withdrawal from more potent opioid antagonists? Can you provide evidence-based data or statistics related to these concerns?

Only anecdotes, no publications. I do not feel we need the higher dose naloxone products from what I am seeing in the field/hospital.

13. Could someone have an allergic reaction to buprenorphine?

It is certainly possible, but I have never seen it nor seen it published.

14. Is there a drug screening process they continue throughout their suboxone treatment?

Most clinics use drug screening to help track patients' success in recovery. I find it essential in my own practice.

15. If the patient continues to go to their scheduled treatment, should they be clean of illicit drugs?

If patients are taking a therapeutic amount of buprenorphine in their measured urine testing, but are still using illicit opiates - I will continue treating them. But this will be considered an unstable patient requiring close follow-up and monitoring.

16. Locally where I am, Southern IL, the suboxone prescribing care provider makes patients take a UA. If it shows opiates they will not refill the patient's suboxone, they test monthly and have to have a face to face appointment.

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17. Do you work with any non-profit organizations that currently see participants with substance use disorder? Those that do syringe exchange, hand out fentanyl test strips, naloxone leave behind, and other harm reduction measures?

Yes. In Ventura, CA a harm reduction non-profit performs substance use navigation in addition to those resources. They are now partnering with EMS to get their buprenorphine protocol in place. The program is very effective overall.

18. For the programs that provide outreach and navigators, is there additional follow-up between navigators and participants?

Yes. In California, the goal is for a warm hand-off to substance use navigators. The SUN teams provide follow-up with the patient beyond the emergency episode. We are working on technology to close the loop back to EMS providers so they can see the downstream effects of their field buprenorphine and referral work.

19. What is SUN team?

Substance Use Navigators. Usually hospital-based or community based substance use staff that help a patient get follow-on care.

20. I'm an EM resident in Seattle working with our team for our recent start of our EMS-bupe pilot. Are you seeing any significant differences in outcomes based on where the next touch point is after their initial bupe induction (ED vs the outpatient linkage to care)?

Dr. Carroll's program in NJ has fairly high release in the field number and has proven very effective. In CA, programs have a much higher transport rate. The success level lies in the ability to get accurate contact information and make warm referrals that are followed up with.

21. Is there a certificate for attendees?

We do not have a mechanism for certificates at this time.

22. What level of providers? Is it only Paramedics?

Buprenorphine is typically only administered by paramedics. But it is important to have EMTs trained in the program and participating.

23. Can we have the contact information for the speakers?

Kate Elkins, katherine.elkins@dot.gov

Gerard Carroll, M.D., carroll-gerard@cooperhealth.edu

John Ehrhart, john@caparamedic.org

Simon Taxel, taxels1@gmail.com