CardinalCare
Virginia's Medicaid Program

Building Bridges: OAA and DMAS' Partnership to Strengthen Connections to Substance Use Disorder Treatment

Opioid Abatement Authority Academy
October 23, 2025

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ARTS Program Manager

RIGHT HELP. RIGHT NOW.
Transforming Behavioral Health Care for Virginians

DMAS

Medicaid Fast Facts

• Medicare is a federal health insurance for anyone over 65, and some under 65 with certain disabilities or conditions. Medicaid is a joint federal/state program that provides health coverage to eligible people with limited income and includes children, pregnant people, and people with disabilities.

• Medicaid is the single largest payer of behavioral health services both nationwide and in the Commonwealth of Virginia.

How it Started? OAA, DMAS, and Bridge

- 2019- 2022: The Department of Medical Assistance Services (DMAS, also known as Virginia Medicaid) utilized funds from the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act to strengthen Bridge Programs at two locations:
  - Carilion Clinic
  - Virginia Commonwealth University (VCU)

How it Started? OAA, DMAS, and Bridge

- **Carilion Clinic:Emergency Department Bridge Clinic**
  - Expanded and enhanced existing Bridge Clinic services
  - Added new Bridge Clinic staff, including licensed social worker and peer recovery specialist
  - Developed a curriculum for bridge clinic implementation based on quality improvement work done in partnership with Virginia Department of Health

How it Started? OAA, DMAS, and Bridge

- **VCU Emergency Department (ED) Bridge Clinic**
  - Interacted with more than 500 individuals post-overdose and linked them to community-based treatment options
  - Dispensed naloxone to individuals at high-risk of overdose upon ED discharge

VCU Health

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Facing rising overdoses, VCU Health strengthens bridge between urgent ER care and long-term addiction services

July 14, 2021

How's it going? OAA, DMAS, and Bridge

- The Department of Medical Assistance Services (DMAS) applied to the Opioid Abatement Authority (OAA) to continue the expansion of Emergency Department Bridge Clinic (EDBC) Programs.
- Program goals are to provide:
  - Funding to support hospitals and health groups to create/expand bridge clinics
  - Technical assistance to hospitals implementing/expanding EDBCs
  - Training to reduce stigma around substance use disorder (SUD) and educate about EDBCs and their impact

How's it going? OAA, DMAS, and Bridge

- OAA awarded funds to DMAS for EDBC project
  - Period of Performance (PP) 2023-2024 - $150,000
    - EDBC Project delayed
    - Funds carried over to PP2024-25
  - PP2024-25 - $150,000 carried over from PP 23-24
    - DMAS contracted with Carilion Clinic, pioneer in EDBC in Virginia
    - Carilion provided 10 webinars attended by more than 900 professionals

Where we're headed? OAA, DMAS, and Bridge

- OAA awarded funds to DMAS for EDBC project
  - Period of Performance (PP) 2025-2026 - $1,050,000
    - Funding for Hospitals and Health Groups - $900,000
      - Request for proposals being developed for procurement
      - Award funding to 2-4 hospitals, depending on proposals
    - Training and Technical Assistance - $150,000
      - Continued training on EDBC and stigma reduction
      - Targeted technical assistance for funding recipients

Where we're headed? OAA, DMAS, and Bridge

- DMAS intends to continue to request similar funding amounts in subsequent periods of performance to continue expansion
- DMAS will be working with:
  - Evaluation partners to ensure successful projects
  - Research partners to identify opportunities for growth
- DMAS will be rebranding EDBC to *Discharge Bridge Programs*, allowing for expansion to other settings to respond to needs of members with SUD

Thank you!

DMAS sincerely appreciates its partnerships with the OAA, Carilion Clinic, Virginia Commonwealth University, and other partners in this joint effort.

It is our honor to work together with these partners to address the needs of members with substance use disorders in the Commonwealth.

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Thank you!

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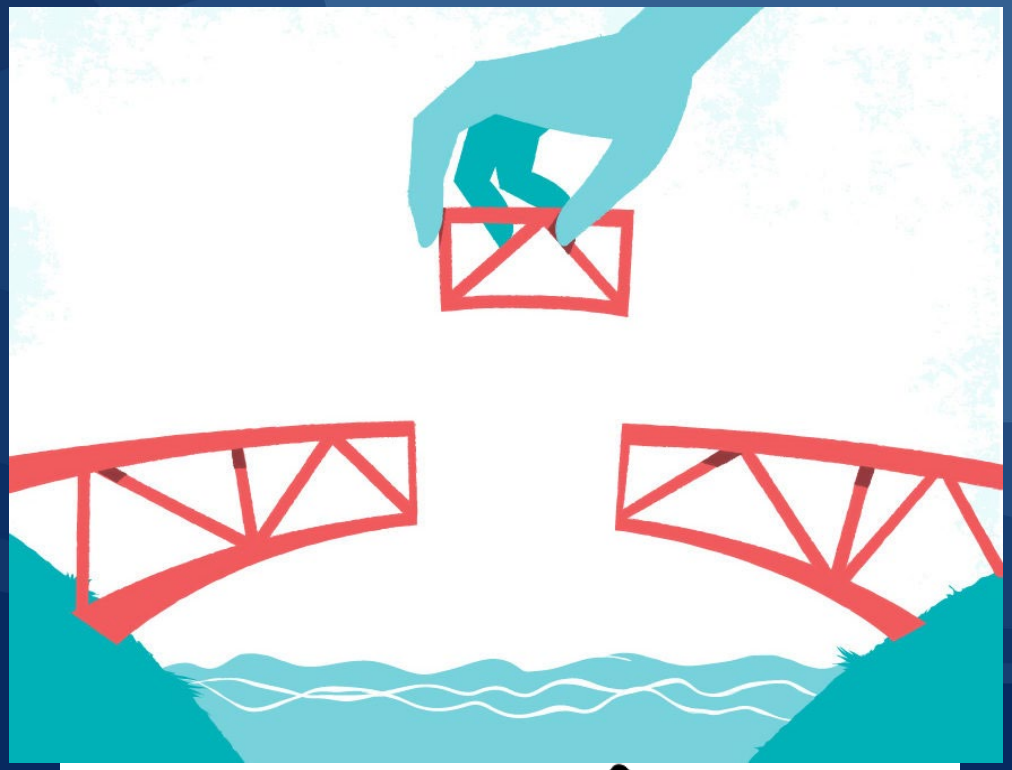
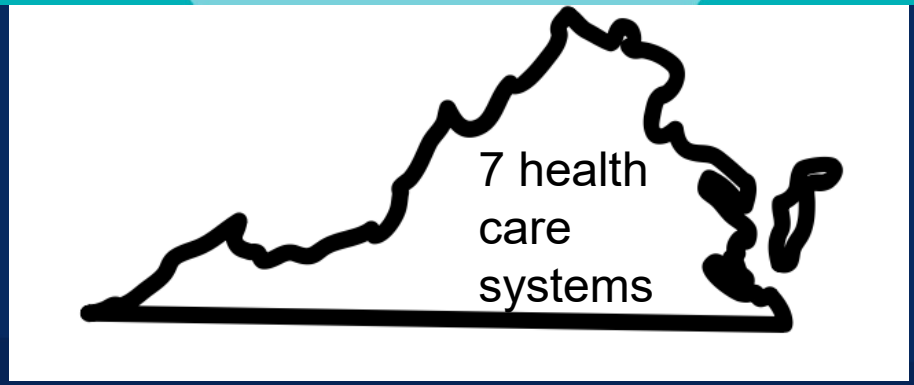
DMAS

The Carilion ER Bridge to Treatment
Virginia Expansion Project: VDH + Va DMAS/OAA sponsors





Introducing the Carilion team …

- Drs. David and Cheri Hartman are employed in Carilion Clinic's Mental Health Department in Roanoke, Va Together they played a key role in developing Carilion's OBAT (office-based addiction treatment program), both serve on the faculty of the VA Tech Carilion School of Medicine; they co-founded Carilion's ED Bridge to Treatment program with Dr. John Burton.
  - Cheri Hartman, PhD has served as the Virginia ER Bridge to Treatment Expansion Project Lead; she has conducted evidence-based program replication in the fields of teen pregnancy prevention, substance use disorder treatment dropout and violence prevention among adolescents, as well as leading the quality improvement study of Carilion's ER Bridge to Treatment project. Cheri convenes and provides trainings on ED Bridge best practices.
  - David W Hartman, MD is boarded in psychiatry, sub-certified in Addiction Medicine; X-waivered for 16 years; he brought MOUD to Carilion, researching key outcome measures like treatment retention, ED Bridge transition outcomes, benefits of MOUD on prenatal care, and the START NOW manualized group therapy impact on patients' treatment. David has provided trainings on Medications for Opioid Use Disorder (MOUDs) for the VA Tech Carilion School of Medicine, statewide ECHO sessions, and the ED Bridge webinars funded by the OAA.
- Gabe Anderson, MS is the full-time Project Consultant on the Virginia ER Bridge to Treatment Expansion Project. He has worked with "CONNECT", crisis services at Carilion Clinic before serving as a project consultant for the ER Bridge project.

Opioid Crisis hit Roanoke and all of Virginia hard: what can we do???

- **Only about 20% of persons with OUD get into treatment (access to treatment needs to improve).**
- **The untreated overdose.**
- **Fentanyl has been driving fatalities to tragically high levels.**
- **Recently, decreases in overdose fatalities are significant across the country, including Virginia – however, as Dr. Petros Levounis (a past President of ASAM) has stated about the current state of addressing the opioid epidemic *"it is far from doing WELL" when nationally, more than 82,000 Americans lose their lives in a 12 month period from ODs; ODs remain the leading cause of death among 18 to 44 year olds.***

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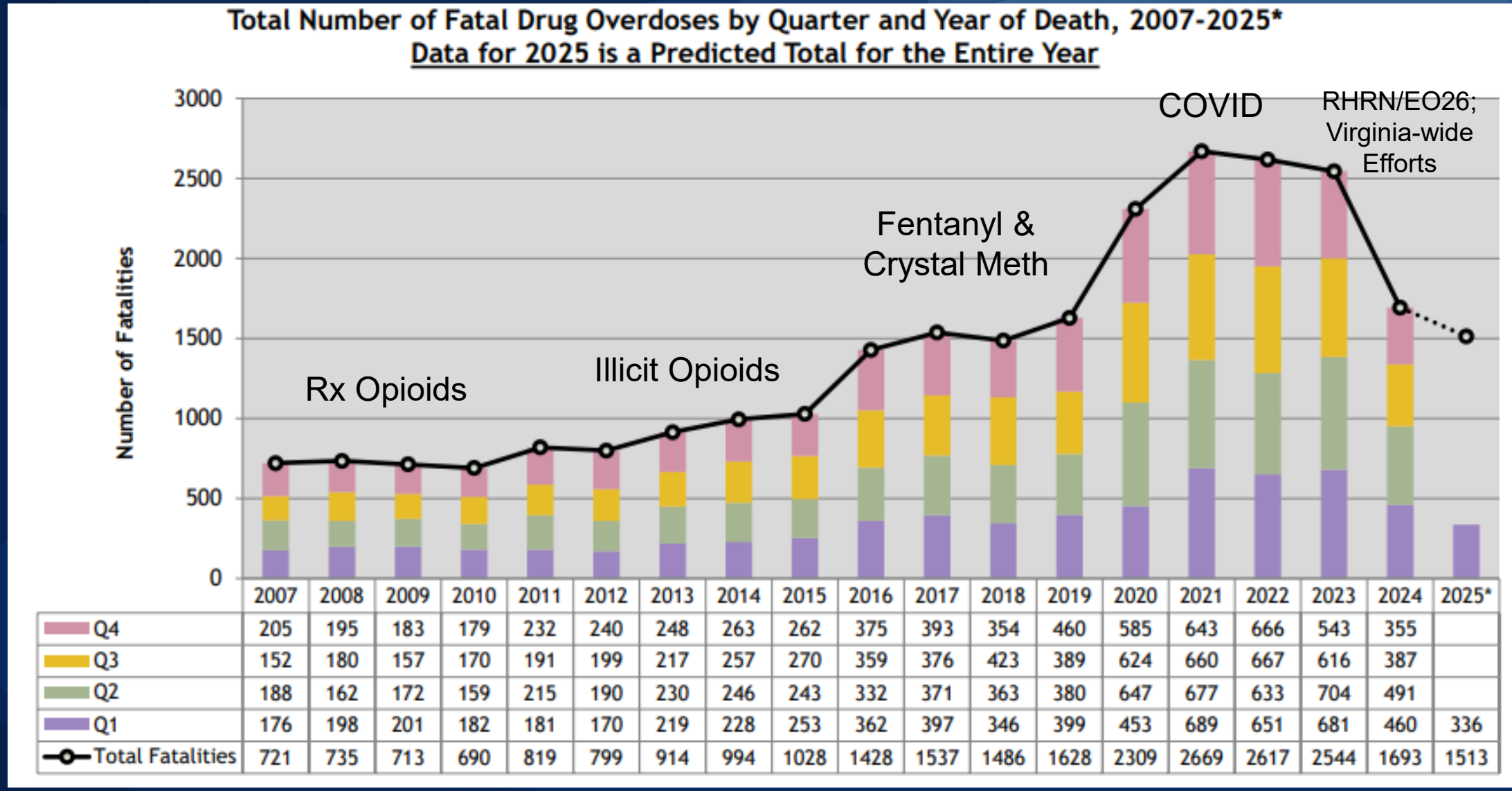
Fatal ODs in Virginia, All Drugs: History



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025*
Q4	205	195	183	179	232	240	248	263	262	375	393	354	460	585	643	666	543	355	
Q3	152	180	157	170	191	199	217	257	270	359	376	423	389	624	660	667	616	387	
Q2	188	162	172	159	215	190	230	246	243	332	371	363	380	647	677	633	704	491	
Q1	176	198	201	182	181	170	219	228	253	362	397	346	399	453	689	651	681	460	336
Total Fatalities	721	735	713	690	819	799	914	994	1028	1428	1537	1486	1628	2309	2669	2617	2544	1693	1513

33.5% drop from 2023-24; 36.6% drop from 2021 peak to 2024

Fentanyl involved in 64.6% of OD deaths, down from 76.2% in past years

Source: Office of the Chief Medical Examiner, https://www.vdh.virginia.gov/content/uploads/sites/18/2025/04/Quarterly-Drug-Death-Report-FINAL-Q1-2025.pdf

Prevalence of the Disease: Epidemic Scale

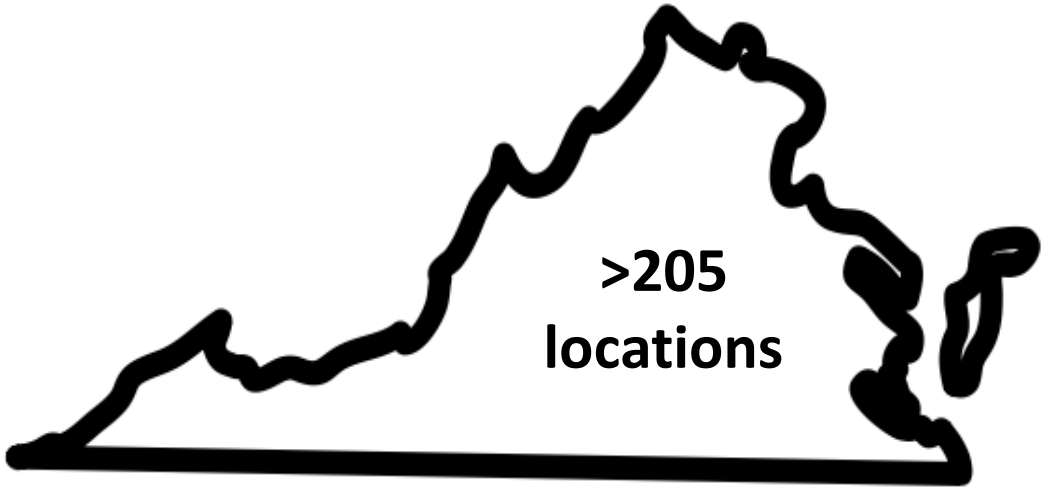
- People with OUD Nationwide: 2.1-6.1 million[1] (0.6-1.8%)
- Virginia's proportional share: 55,000-150,000
- Estimates are: 65%-80% have received no treatment in the last year[2]
- Some 20,000 may be incarcerated at any one time[3]
- Higher risk groups for fatal OD:[4,5]
  - Ages 25-64 (85% of total)
  - Male > Female
  - Black > White > Hispanic >> Asian (varies somewhat by locality)
  - Recently released from ED, hospital, incarceration
  - Cocaine, methamphetamine users

1. NIH, 2024; DEA Est 6.1M. 2. Jones C et al. *JAMA Network Open* 2023;6(8):e2327488. 3. VADOC data. 4. VDH, 2023, data at https://www.vdh.virginia.gov/drug-overdose-data/overdose-deaths/.
5. https://www.kff.org/other/state-indicator/drug-overdose-death-rate-per-100000-population-by-race-ethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Increased Access to Office-Based Addiction Treatment (OBATs) resulted from the 2017 Virginia Addiction and Recovery Treatment Services (ARTS) Initiative by DMAS

Leveraging the Evidence-Based model for OUD by the VA Department of Medical Assistance Services

- **Settings:** Primary care clinics, outpatient health system clinics, psychiatry clinics, Federally-Qualified Health Centers (FQHC), Community Services Boards (CSB), and physician offices



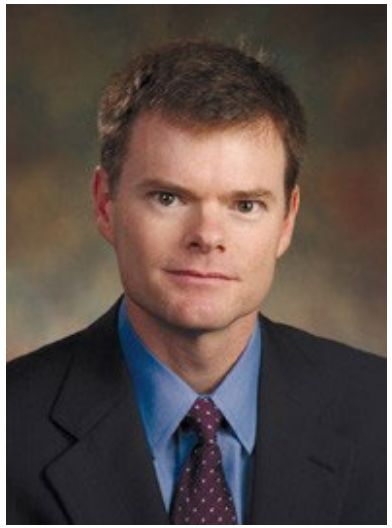
Virginia's ARTS policies made it possible to provide comprehensive integrated care in many settings and get reimbursed.

THIS INCREASED CAPACITY – DID NOT PUT A LID ON THE OPIOID EPIDEMIC AND OVERDOSE EPIDEMIC.

TOO FEW ARE ACCESSING TREATMENT….

ED Bridge Expansion Project is in turning the ER into a pivotal touchpoint in Virginia – improving access to care for persons struggling with an opioid use disorder

- In 2018 the Carilion OBOT (office-based opioid treatment) outpatient clinic was well established – access to this treatment asset was leveraged by:
- Dr. John Burton as Chair of the Emergency Medicine Department at the Carilion Clinic in Roanoke , Virginia, attended a conference featuring Dr. Gail D'Onofrio who shared her seminal study on STIR: the successful model of Screening, Treatment Initiation(onto buprenorphine) and Referrals (rapid access to follow up care)
- This is where the story takes off …



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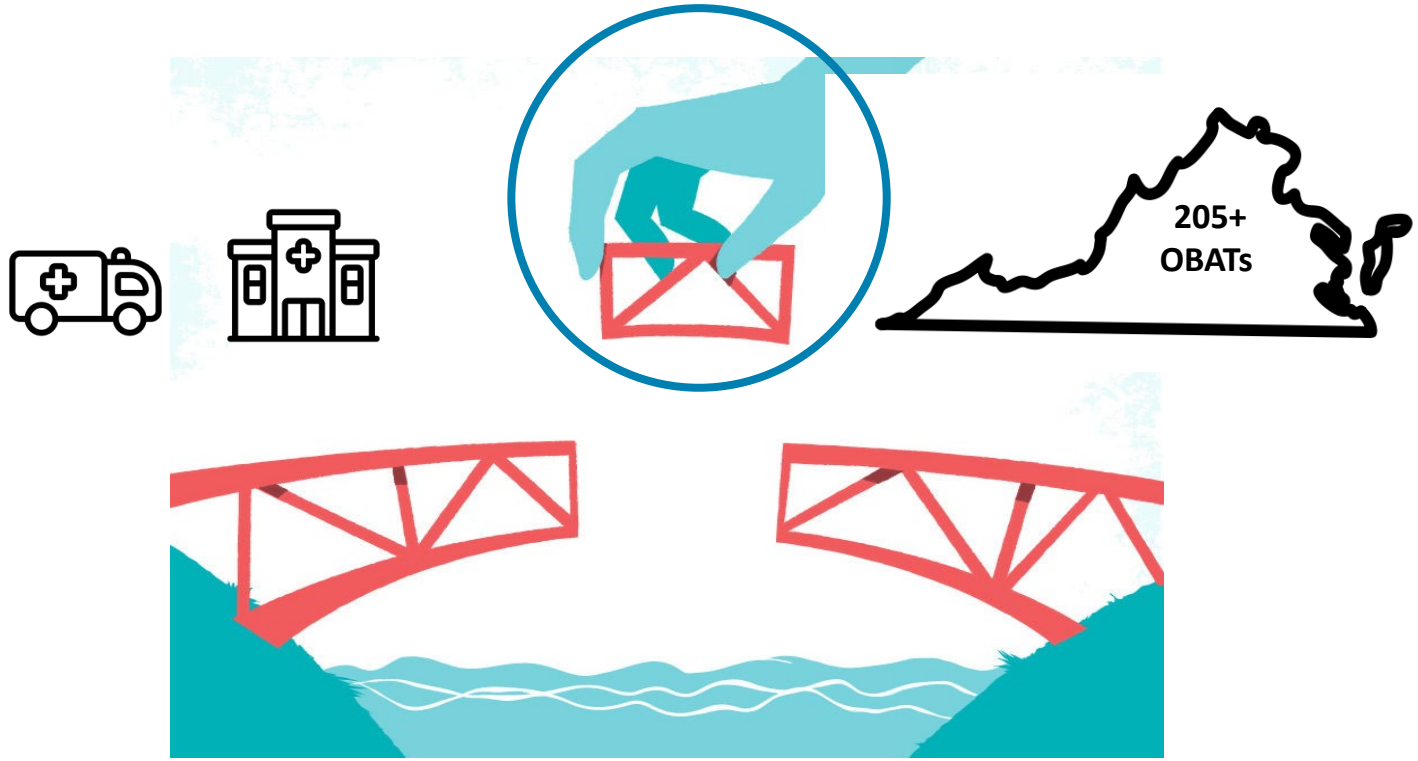
Dr. Gail D'Onofrio's seminal research: created ED Bridges to Care Using Buprenorphine Initiation in the ED and Successful Linkages to Outpatient Care

- RCT Buprenorphine ED Patients: *Likelihood of receiving outpatient follow up buprenorphine care at 30 days post ED discharge*
  - Buprenorphine Initiation + Brief Intervention (motivational interviewing) + Rapid Referral: **78%**

    got into follow up care post ED visit
  - (motivational interviewing) Brief Intervention + Referral: **45% got into follow up care**
  - Referral Alone: **37% got into follow up care**

Source: D'Onofrio G et al. Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial. JAMA. 2015.

“Bridge” Program: Identify OUD, Administer Buprenorphine to Tx Withdrawal Provide Rx – as Medical Bridge… and Refer for Follow Up Care w/ Rapid Access



American College of Emergency Physicians®

Recommends that emergency physicians offer to initiate opioid use disorder treatment with buprenorphine in appropriate patients and provide direct linkage to ongoing treatment for patients with untreated opioid use disorder.

“Pre-ED Bridge” Circumstances: Dr. Burton reported the challenges at Carilion

- Patients with opioid use disorder (OUD) felt ignored and discounted.
- ED doctors felt annoyed and frustrated with this patient population.
- Disease of addiction not well understood.
- There was often a lack of trust between doctors and patients.
- Patients were referred to detox, but not referred to best practice treatments.
- There were, in fact, limited places to refer patients with opioid use disorder prior to 2017 – when the Virginia ARTS Initiative (based on DMAS policies) incentivized the development of office-based addiction treatment sites and Carilion’s Mental Health Department created it Office-based Opioid Treatment (OBOT) clinic.

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Starting Dec 2018: Carilion ED doctors got waivered to treat the opioid use disorder

- Dr. Burton incentivized ED doctors to get waivered in the use of buprenorphine to treat the opioid use disorder (8 hours of previously required training- led doctors to understand this disease and treatment best practices)
- Patients were given COWS to assess withdrawal; if 12 or above, they are initiated on buprenorphine in the Emergency Room. (now the threshold is 8 or above)
- ED protocol was developed and implemented following Dr. Andrew Herring's model
- Patients were given first a 1 week then later as much as a 2 week long script for buprenorphine/naloxone to bridge them to follow up medical treat for their OUD.
- Patients were paired with a peer recovery specialist who could support their referral to treatment (usually to Carilion's OBOT clinic in Years 1 – 3 especially).
- Our outpatient clinic ensured that we would see the patient within a week to 2 weeks. RAPID ACCESS TO TREATMENT for continuity of medical care.

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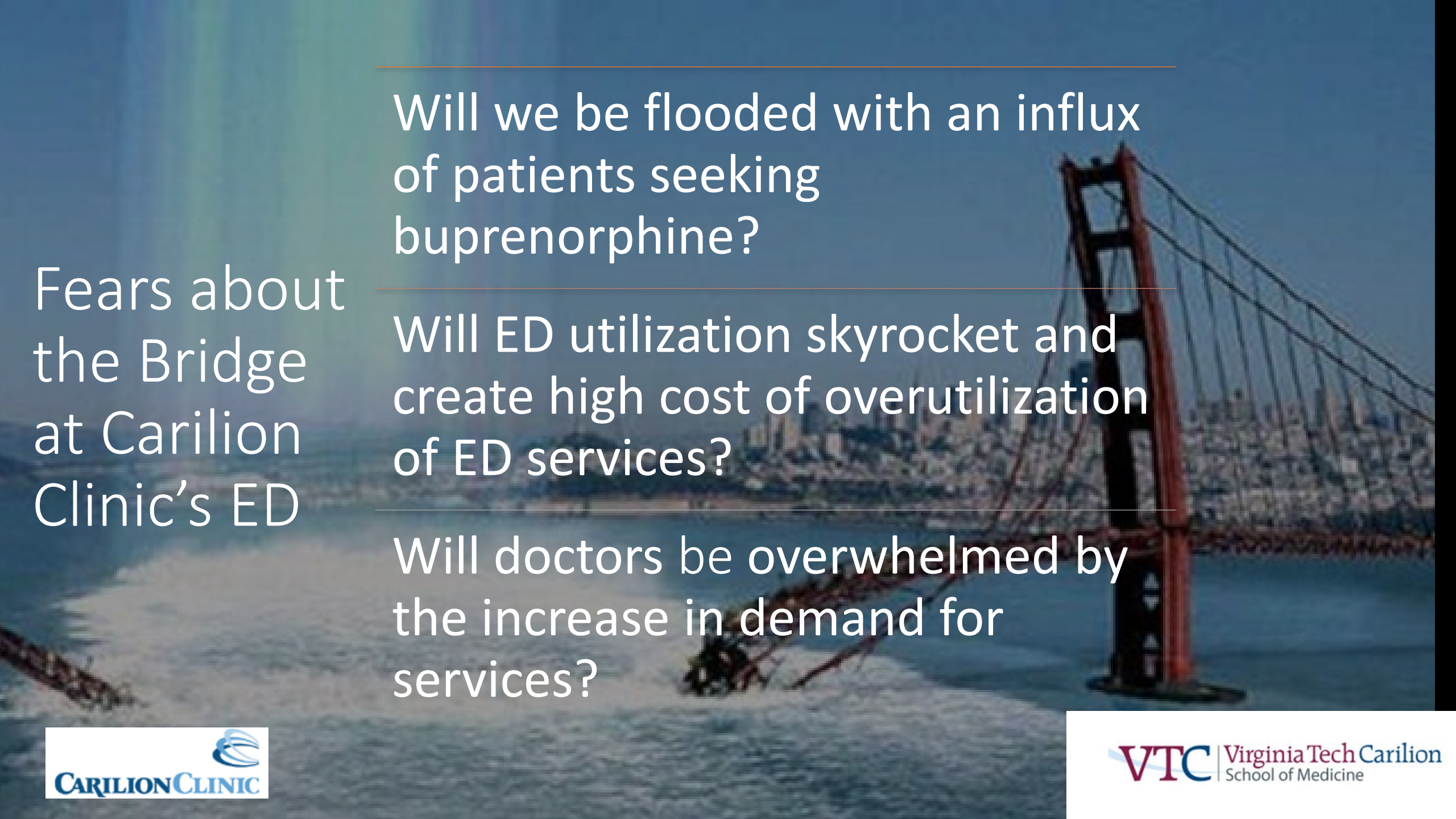

Fears about the Bridge at Carilion Clinic's ED

Will we be flooded with an influx of patients seeking buprenorphine?

Will ED utilization skyrocket and create high cost of overutilization of ED services?

Will doctors be overwhelmed by the increase in demand for services?

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After ED doctors were waivered/trained to treat the opioid use disorder (OUD)…

fears were replaced with a rewarding experience.

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ED doctors **understood better** the disease of addiction, showing more compassion, increased confidence in working wOUD patients.

ED doctors **had tools for treating** these patients and **no longer felt helpless and frustrated.**

ED doctors had **a clear plan** in order to treat these patients.

Patients were **less likely** to return repeatedly to ED for opioids.

Therefore; **use of ED decreased** rather than increasing.

Patients were **more likely to get into treatment** post ED visit.

Patients felt better understood and were **more open and honest.**

Patients reported experiencing compassionate care, rather than feeling humiliated.

Protocol overview for ED Bridge

- Diagnose OUD using DSM-5 criteria (moderate to severe) (11 criteria: 2 needed for dx)
- Identify withdrawal symptoms (using COWS) plus history of last use (score >8)
- The Clinical Opiate Withdrawal Scale (COWS) - PubMed (nih.gov)
- In ED: appropriate medication to initiate would be buprenorphine unless patient already is receiving treatment with methadone or prefers full antagonist of naltrexone. Latter requires 7 days of abstinence to initiate. (Check Prescription Monitoring Program for current scripts.)
- If withdrawal is <8, rely on home induction with written instructions and provide prescription.
- Initial dose of buprenorphine is 8/2 mg unless patient is naïve to buprenorphine. Rx written for the combined product: buprenorphine + naloxone (brand name = Suboxone).
- If person never has taken buprenorphine, initiate with 4 mg. (Rx = 4/1 mg)
- Prescribe a "medical bridge" usually 8/2 mg 2x/day for 7 days
- Prescribe Narcan and/or distribute it from the ED.
- Link with peer recovery specialist in the ED); after hours give peer phone #
- Discharge instructions has information re: dropping in for care M –F
- or how to call Carilion Clinic OBAT intake phone # - care coordinators help support transition.

Disease of Opioid Use Disorder: diagnosis

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities to obtain, use or recover from the opioid.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use results in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by opioids.
7. Important social, occupational, or recreational activities are given up or reduced due to use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a) A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
    b) A markedly diminished effect with continued use of same amount of opioid. Note: This criterion is not considered met if taking opioids solely under appropriate medical supervision.
11. Withdrawal, characteristic opioid withdrawal syndrome

Severity Scoring: Mild: 2-3 symptoms Moderate: 4-5 symptoms Severe: 6 or more symptoms Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (2013)

Link to NIDA's posted "Questions for Identification of Opioid Use Disorder based on the DSM-5:"

https://www.drugabuse.gov/nidamed-medical-health-professionals/your-discipline/emergency-physicians-first-responders/questions-identification-opioid-use-disorder-based-dsm-5

COWS Clinical Opiate Withdrawal Scale

Wesson & Ling, J Psychoactive Drugs. 2003 Apr-Jun;35(2):253-9.

Resting Pulse Rate _____ beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81–100 2 pulse rate 101–120 4 pulse rate greater than 120	**GI Upset** *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating *over past ½ hour not accounted for by room temperature or patient activity* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil Size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint Aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh Skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny Nose or Tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	**Total Score** _____ *The total score is the sum of all 11 items.*

Scoring of withdrawal

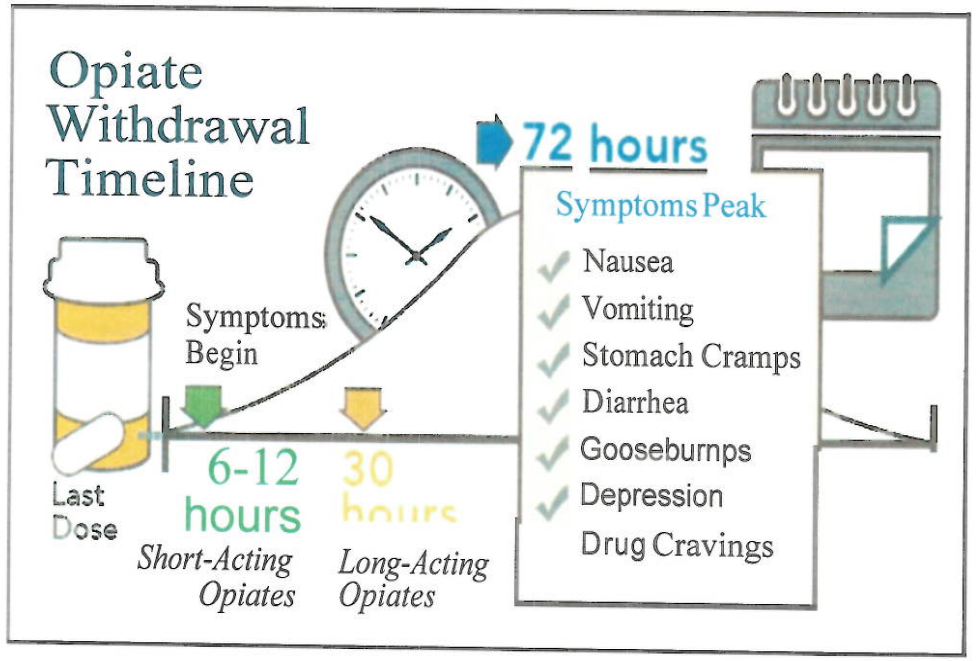
5-12 = mild

13-24 = moderate

25-36 = moderately severe

>36 = severe

Evaluate if the patient is in opioid withdrawal



Onset of withdrawal:

Short-acting opioids (Heroin, Oxycodone, Percocet, Morphine IR): wait 8-12 hours

Long-acting opioids (Oxycontin, MS Contin): wait 16-24 hours

Methadone: wait at least 48 hours

Why is buprenorphine so effective and recommended for ED initiation?

- Buprenorphine's biochemical properties:
  - Strongly adheres to the mu receptor blocking other opioids- protective
  - Relieves withdrawal symptoms
  - Decreases cravings for opioids
  - Safer as a partial agonist – only partially activating the neuron and hitting a ceiling effect making overdose very unlikely unless there is a drug X drug interaction with a benzodiazepine or with alcohol
  - Functioning does not appear to be impaired for a person taking buprenorphine; in fact, it enhances recovery and quality of life
  - Retention on buprenorphine is important as substance use disorders are chronic diseases; medication is not a cure but facilitates disease management and the achievement of recovery: access to our clinic was assured for continuity of care.
  - NOT substituting one toxin for another.

Quality Improvement Study: types of presenting problems

Patients' presenting problem categories:

1) Withdrawal level (>8) or clinically identified "in withdrawal" by ER clinician
2) Overdose survivor (revived in the ER, revived prior to ER arrival)
3) Seeking to initiate treatment (they have recently used and are not in withdrawal)

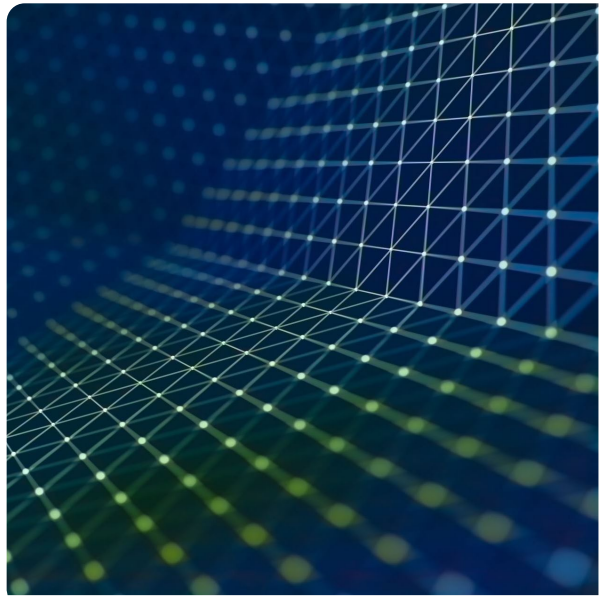
Process objectives of the Quality Improvement study (2019 – 2022)

Protocol fidelity:

How many patients in withdrawal were administered buprenorphine in the ER? Average dose?

How many patients provided a prescription for buprenorphine? On what dose? Duration of the prescription? (prescription = medical bridge from the ER to follow up care)

How many patients were linked with a peer in the ER?



Study's outcome objectives: success measurements

How many patients successfully "crossed the bridge" from ER to the intake/assessment session or provider visit?

How many patients were identified as appropriate for Carilion Clinic's outpatient program vs requiring a referral to a higher level of care (intensive outpatient – IOP or residential), a program closer to home, or a public program that could provide sponsored medications for the uninsured and help with homelessness – due to lacking insurance)?

How many patients remained in treatment at least for a month?

Results across 4 years of QI Study: Data Drove Statewide Expansion Led by Carilion

Year 1: **82% (63/77)** pts seen in ER "crossed bridge" to OBOT (office-based opioid treatment) clinic (seen w/n 4 days, ave. ER script = 4 days) (86% retained in OBOT) (Mar 2019 – Aug 2019)

Year 2: **78% (155/198**) of pts seen in ER "crossed bridge" to OBOT clinic's intake session (seen w/n 8 days; ave. ER script = 8 days) (81% retained in OBOT) (Sept 2019 – Aug 2020)

Year 3: **71% (108/152)** of pts seen in ER "crossed bridge" to OBOT clinic's intake session (seen w/n 8 days; ave. ER script = 7 days) (59% retained in OBOT) (Sept 2020 – Aug 2021)

Year 4: **55% (102/184)** of pts seen in ER "crossed bridge" to OBOT clinic's prescriber visit (seen w/n 9 days, ave. ER script = 8 days) (**51% retained in OBOT**) (Sept 2021- Aug 2022)

(*Years 3 and 4: increased #s referred elsewhere, as capacity increased in other OBOT clinics and Carilion doctors were approaching their limits due to retention in treatment; patients were increasingly likely to be polysubstance users in need of higher levels of care than the OBOT; we tended to retain patients with psychiatric co-morbidities)

Year 4: fewer patients presented in withdrawal in Year 4 (32%) (**more presented "seeking treatment"** – due to recent use they were not in withdrawal-as a result fewer patients were initiated in ER onto buprenorphine: 49% in Year 3 vs. 69% in Year 1; however, if not in withdrawal, prescriptions were still provided and comprehensive discharge planning led to placements in treatment clinics who provided care coordination.

"Carilion Clinic ED Bridge Quality Improvement Study" results: successful transitions in care

Key factors associated with successful "crossing" from ER to follow up care (attending ambulatory clinic intake):

- Suboxone (buprenorphine + naloxone) initiation in ED when patient is in withdrawal per COWS' score (measure of withdrawal) > 8
- Peer Recovery Specialist direct linkage during ED visit doubled chances of successful transition from ER into ambulatory care in the OBOT clinic in Year One; continued to have significant impact in further years (2,3,4)
- Rapid access to follow up care assuring continuing of medication from acute setting to the clinician appointment
- Carilion trained the Emergency Medicine clinicians in OUD treatment best practices (50 of Carilion ER physicians got waivered in 2017)

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Treatment shoreline partners: Office-based addiction treatment (OBAT) clinics combine MOUD with Comprehensive Care

Rapid access to appropriate level of care is the goal of the ED Bridge to Treatment. At Carilion a preliminary intake screening is done by a care coordinator for identifying appropriate placements in the OBAT. If not appropriate; care coordinators and peers support a warm handoff. Our clinic offers level 1.7 (medically managed outpatient care) using the Virginia preferred OBAT model.

To address patient complexity in a comprehensive manner, patients have access to integrated care in the OBAT:

- co-located therapy: groups, individual, family, psychiatry
- MOUDs: usually buprenorphine combined product, also injectable naltrexone;
- care coordinators help remove barriers to recovery and link patients with primary care physicians and relevant specialists (Hep C tx., family planning)
- peer recovery specialists support the recovery process.

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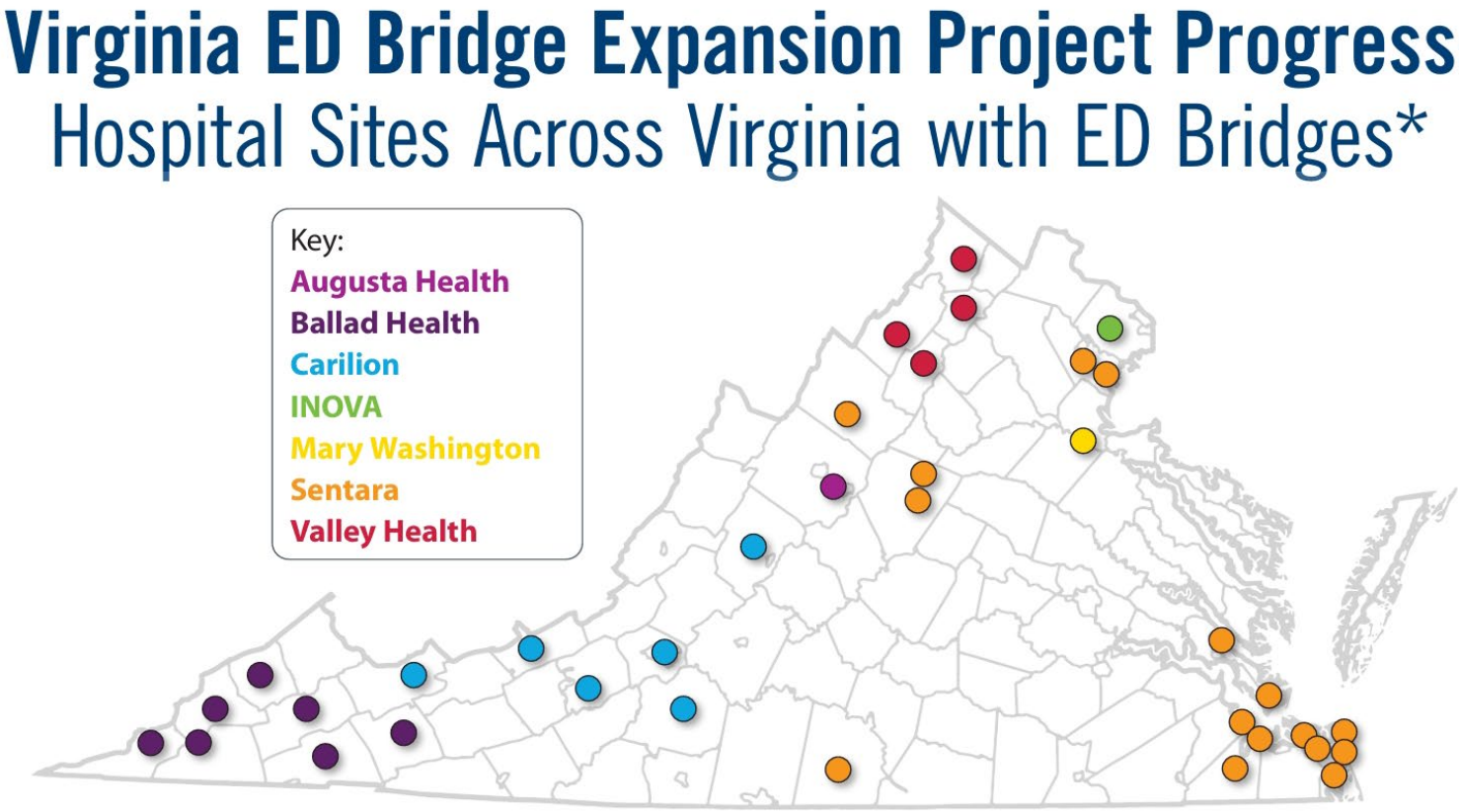
“Seven early implementer” health care systems recruited to date; Carilion leads monthly OAA funded webinars

- Augusta Health
- Sentara
- Valley Health
- INOVA
- Ballad Health
- Mary Washington Healthcare
- Carilion’s six Emergency Rooms
- ER Bridge best practice webinars are offered to hospital ER leaders and clinicians throughout Virginia, some of whom we hope to recruit for further expansion – with the aim of bringing on board 4 additional ER Bridge program hospitals in 25-26.

Virginia ED Bridge Expansion currently has involved these hospital sites (see map) across the state during the Phase I recruitment of early implementer health care systems, who receive educational support thanks to OAA funding of the webinar series and they have benefitted from on site training and analytics' coaching plus direct clinical technical assistance (targeted outreach is funded by VDH).



CRMH EMERGENCY SERVICES

Bridge to Treatment Protocol

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Identify opioid use disorder individual who consents to buprenorphine-naloxone

Consult Community Health and Outreach (PRS)
Order UDS, POC preg – results not required.

Subjective sx + objective opioid withdrawal[(A)] → **NO[(AA)]**

Administer STAT SL bup-nlx 8-2 mg.[(B)]
Wait 30-45 minutes

Withdrawal improved? → **NO**

YES

Discharge:

1. Send AMB Referral to ADDICTION SERVICES.
2. Prescribe BID to Bridge to outpatient appt or 7d with naloxone Rx.
3. Discharge instructions (.EDBUPDC)
4. ED use only: Take Home Naloxone Order, dispense Narcan with survey (.EDNARCAN .EDDCNARCAN)
5. Update correct phone # in chart
6. Final impression: Opioid Use Disorder

Pregnant:

- Send AMB Referral to ADDICTION SERVICES
- Choose: Pregnancy with substance use disorder
- Location: OB Highland, Ste. 303, 540-985-9715
- Wed. Perinatal SUD clinic, acute visits available
- Safe to use bup-nlx in pregnancy
- Referrals: 540-510-0913

Other considerations if withdrawal persists:

- Undertreated withdrawal: initiate second 8-16 mg dose with adjunctive meds, document medical necessity with up to 24 mg on day 1.[(D)]
- Other diagnoses to consider: alcohol withdrawal, meth intoxication, benzo withdrawal or other comorbid medical diagnosis
- Precipitated withdrawal[(C)] is a rare complication of bup induction with opioid dependence, COWS increases by 6 or more.

(A) Withdrawal:

- Objective opioid withdrawal includes dilated pupils, HR>100, yawning, runny nose, restless, diarrhea, vomiting
  - Or COWS ≥ 8
- (AA) Not ready = no withdrawal with dependence-Rx w/guide (.BUPHOMEINDUCT)
  - OUD, no recent use (4-5 days), no dependence, no withdrawal ex. jail release - can start bup-nlx

(B) Prior to dosing or Rx:

- Check PDMP for abnormal Rx activity
- 2 refills from ED in 4 months allowed through PDMP or per MD discretion. Contact below for an appointment and dose in ED
- Dose higher (16 mg) initially with documented severe withdrawal and high tolerance with IV heroin/fentanyl use
- Bup naïve with low opioid use, 2-4 mg SL with BID Rx at dc
- If hx of anaphylaxis to bup-nlx, only indication for bup mono-product
- Ask the patient usual dose of bup-nlx to guide dc Rx

(C) Precipitated withdrawal: treat with more bup-nlx (16 mg), reassess. May administer up to 24 mg with documentation.

- IV ketamine 0.2 mg/kg, kappa antagonist may help withdrawal
- IV bup 0.6mg-0.9mg, if intolerance to SL

(D) Adjunctive medications for withdrawal symptoms:
ondansetron, clonidine, gabapentin, hydroxyzine, ibuprofen, dicyclomine, acetaminophen, trazodone/mirtazapine

Carilion Addiction Services Program:
2017 S. Jefferson St, M-F 8:30 a.m. - 4:30 p.m.
Office: 540-981-8025 Fax: 540-853-0511 Referrals: 540-510-0913

Reference: *CA ED Bridge Department Start Guide 9/23*

CARILION CLINIC

Virginia's ED Bridge to Treatment: "Training Toolkit"

by Dr. Cheri Hartman
(author, Virginia ER Bridge to Treatment Expansion project consultant) in collaboration with Carilion Clinic's team:
Dr. John Burton, Dr. Annie Ickes, Dr. David Hartman, and Gabe Anderson

August, 2025

CARILION CLINIC

VTC | Virginia Tech Carilion School of Medicine

Lessons Learned: C

High level endorsement matters from your hospital leaders!

Recommendation #3: **Create/share with hospital leaders a YouTube of your health care system's President and CEO (or share this one by Carilion's retired CEO, Nancy Agee) endorsing an anti-stigma message to set the stage for system-wide open-mindedness about the value of treating addiction.**

2018-19 AHA Past President and Carilion Clinic's retired CEO, Nancy Agee: message produced for AHA:

Video #3: https://youtu.be/l2my7rq7Uyc

CARILION CLINIC

VTC | Virginia Tech Carilion School of Medicine

Recommendation #27: *Accept Our Invitation …*

An ED Bridge to Treatment is not rocket science, it is relatively painless to establish with tremendous gains as a cost effective and life-saving intervention.

"Starting a Buprenorphine Program: Our Community ED Experience" by Herring et al. (2018)

"Starting our program at Sutter Delta was surprisingly painless. After presenting the efficacy and safety data around buprenorphine, it was easy to get buy-in from hospital, ED, pharmacy, and nursing leadership….We trained physicians, advanced practice providers, and nurses how to assess withdrawal and give buprenorphine. When an eligible patient arrives in the ED, they are seen and treated from fast-track … Codifying the referral process in detail may be the most important component of starting a program. Initial quality improvement follow-ups have found that these patients have all started addiction treatment and are happy with the care they received." (Herring et al., 2018)

Recommendation #27: AN INVITATION -- Build Your ED Bridge to Treatment -- Reach out to Virginia's ED Bridge Builders for technical assistance (from the Carilion Clinic – whose replication efforts are sponsored by the Virginia Department of Health).

ED Bridge Replication Coordinator is Dr. Cheri Hartman with Carilion Clinic (cwhartman1@carilionclinic.org) or call: (540) 981-7099

CARILION CLINIC

VTC Virginia Tech Carilion School of Medicine

Thank you!

- For more information, contact:
  - Dr. Cheri Hartman at (540)-798-7984 or via e-mail at cwhartman1@carilionclinic.org
  - or Gabe Anderson: gwanderson@carilionclinic.org

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Virginia Naloxone Project

Take-Home Kits from The ED

Brandon Wills, DO, Chair, The Virginia Naloxone Project
Ryan Tsipis, MPH, Senior Project Manager
Dr. Don Stader, Founder & Executive Director TNP
Nikki King, MSW - National Project Manager

Why this matters

US drug OD deaths > 100K in 2022 (most are related to fentanyl)[1]

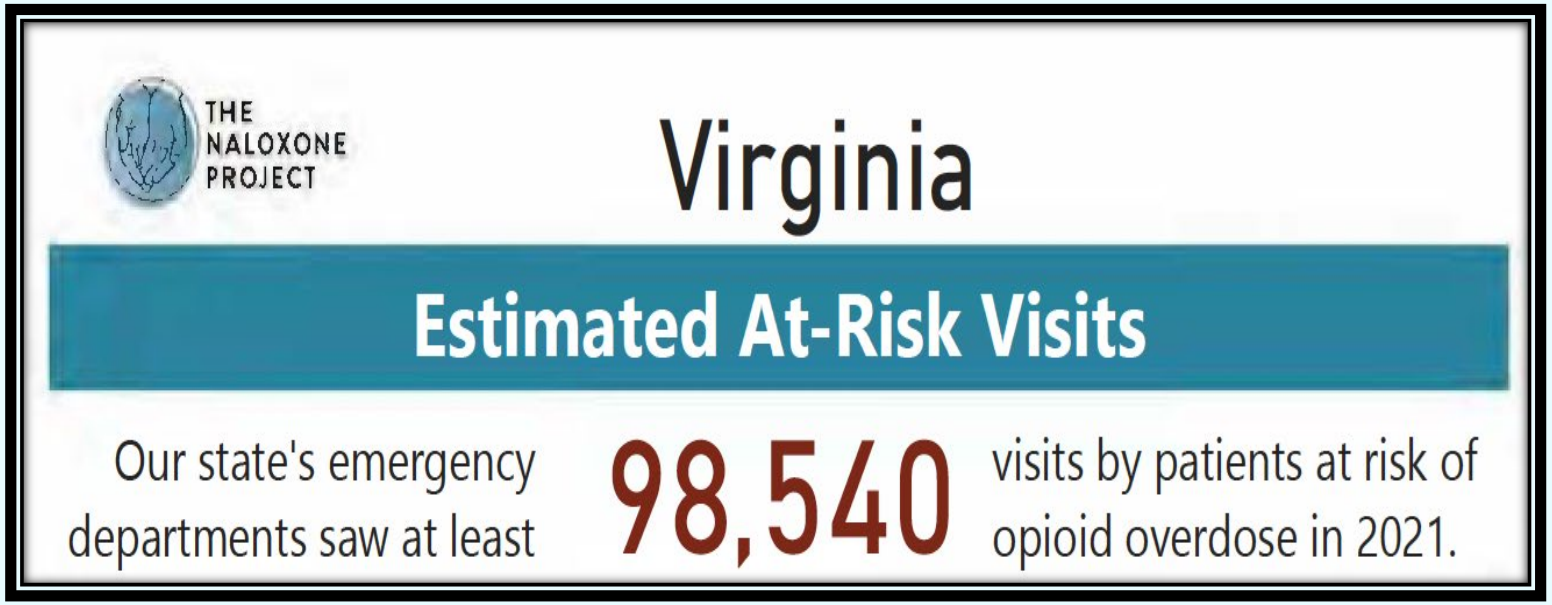
Approx 1,000,000 non-fatal OD are treated in US ED's annually[2]

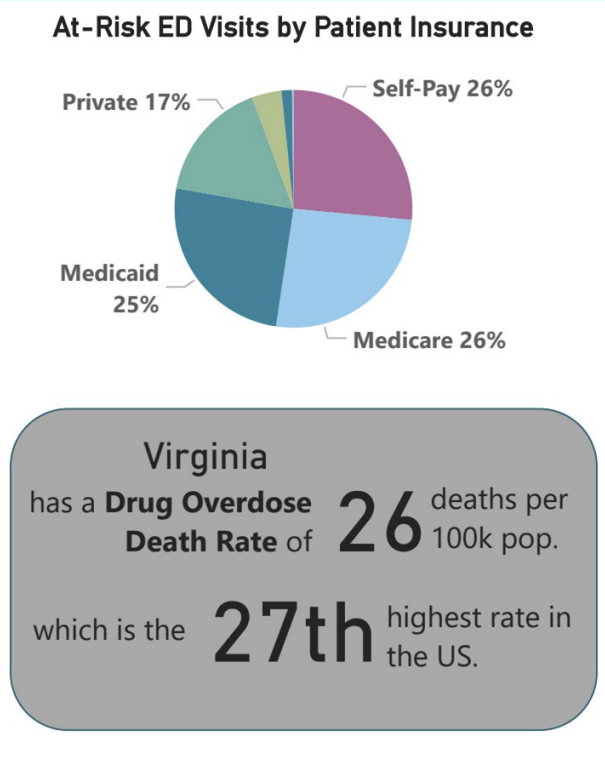
Non-fatal overdose has significant risk of death after discharge[3]

ED take-home naloxone is associated with ↓ ED OD and death[4]

1. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm
2. PMID: 32240125
3. PMID: 37033158
4. Heliyon Volume 11, Issue 6e42967March 20, 2025

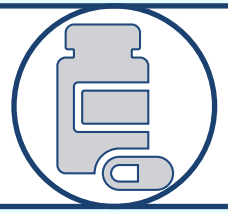
Virginia OD Risk





Challenges to getting naloxone to ED patients

Clinician awareness/ willingness



Patient Rx fill rates are very low

VA pharmacy regulations= barrier to dispensing

The Naloxone Project

The Naloxone Project is a 501c3 organization devoted to ending the opioid overdose crisis through education and naloxone distribution in hospital settings.

Our mission is:

To create a medical system and society that has no stigma, provides naloxone, and saves lives. One that is equitable and sustainable.

Our goal is:

For all hospitals, labor and delivery units, and emergency departments to distribute naloxone to at-risk patients, placing naloxone in patients' hands prior to their departure from the hospital.

The Naloxone Project
VNP ED Needs Assessment Survey

Only 5 of 65 surveyed VA EDs were distributing Naloxone.

Virginia Naloxone Project Collaboration

Phase I — Initiation

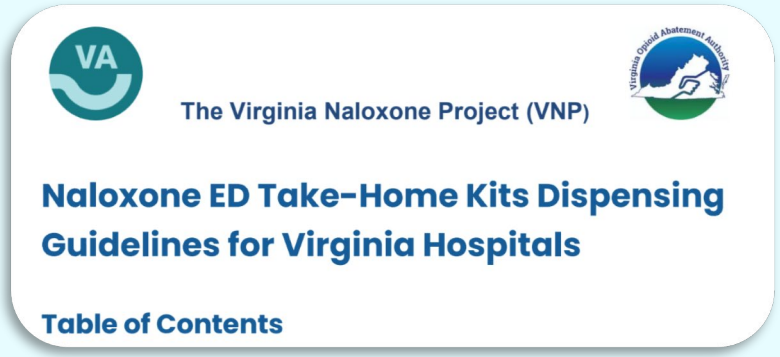
Phase II — Dissemination

Phase III — Sustainability

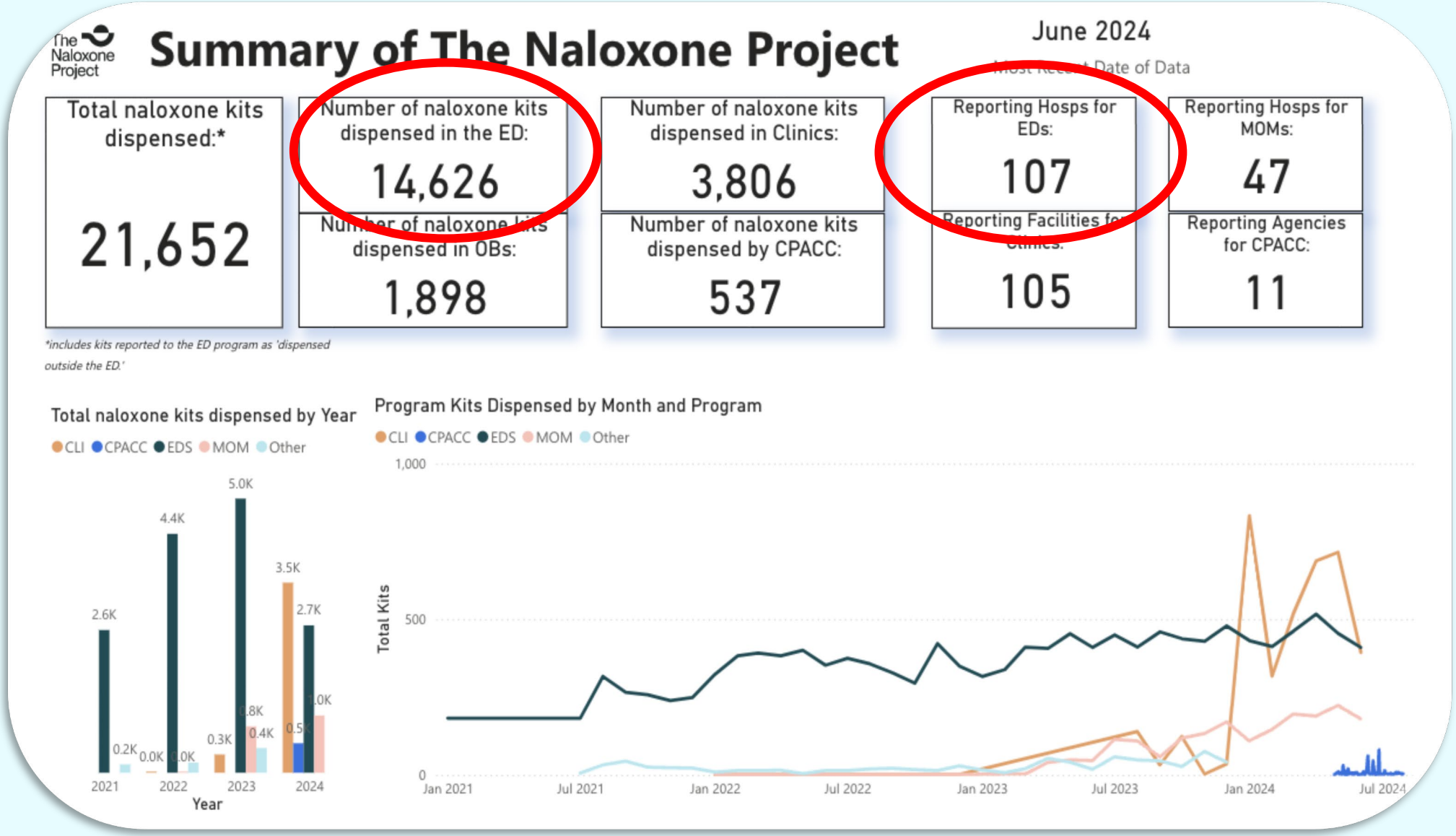
Virginia Naloxone Project

With OAA Funding…

- VNP Project Manager (Ryan Tsipis)
- Expertise to develop VNP Toolkit
- Provide naloxone kits to EDs



Colorado Naloxone Project



Example Progress Report for Hospital System

Facility KPI Chart

This chart shows the **most recent month of submitted data** and a YTD trend of dispensing naloxone kits. We are working towards the goal of dispensing naloxone kits to an estimated 50% of at-risk visits in the ED. **Red** is <25% visits covered, **Yellow** 25-49%, and **Green** is 50% or more. You are not submitting at risk data for

As of Date	Facility	Dispensed Kits	At-Risk Visits	% At-Risk Visits Covered	At Goal?	YTD Facility Trend of Dispensed Kits
September 2023	Good People Medical Center	2	9	22%		
September 2023	Blue Spruce Medical Center	11	63	17%		
September 2023	Candy Valley Medical Center	3	11	27%		
September 2023	Saint Hannukah Hospital	19	40	48%		
September 2023	Sacred Heart Medical Center	15	10	150%		

COLORADO NALOXONE PROJECT

Emergency Department Progress Report for Example System

Since the program began, we have dispensed 10,791 naloxone kits to at-risk patients seen in the ED.

This month, we have dispensed 450 naloxone kits to at-risk patients seen in the ED.

We hope to have all hospitals reaching an estimated 50% of at-risk visits with naloxone. We understand there are many reasons why a patient may not receive a naloxone kit during a visit. This report is meant to help you understand your general trends and where there may be opportunity.

	# of Kits Dispensed	At-Risk Visits	Est. At-Risk Visits Covered	Kits needed to reach goal
This Month	50	133	38%	17
YTD	384	1,136	34%	184


Rx Only
NDC 45802-811-84
Naloxone HCl
Nasal Spray
4 mg
Important: FOR USE IN THE NOSE ONLY.
Use Naloxone HCl Nasal Spray for known or suspected opioid overdose in adults and children.
Do not remove or test the Naloxone HCl Nasal Spray until ready to use.
TWO PACK
This box contains two (2) 4-mg doses of naloxone HCl nasal spray.
0.1 mL intranasal spray per unit
For use in the nose only
CHECK PRODUCT EXPIRATION DATE BEFORE USE.
N HERE FOR QUICK START GUIDE
oid Overdose Response Instructions
4 mg
Naloxone HCl Nasal Spray
NALOXONE
SAVES LIVES.
The Naloxone Project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4 mg
Naloxone HCl Nasal Spray
WE PROVIDE
NALOXONE
HERE
The Naloxone Project

Contact Us

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brandon.wills@vcuhealth.org