Emergency Department (ED) Initiated Buprenorphine & Referral to Treatment

A brief guide for ED Practitioners

Why the ED?

Because that's where the patients are!

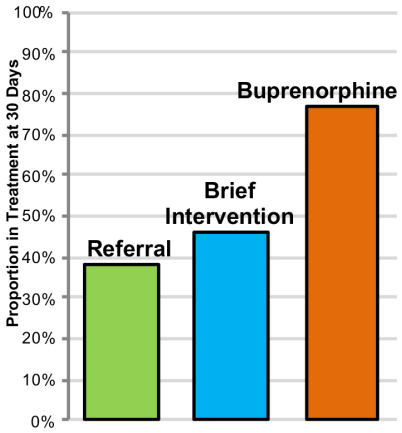
The opioid epidemic is strongly impacting EDs, with 2018 data from the CDC indicating that there has been a 30% increase in visits for opioid overdose from July 2016 – September 2017.[1]

Addiction is a chronic, relapsing disease, and a strongly stigmatized one. **It is NOT a moral failing.** People who present to the ED for other chronic disease like diabetes and asthma are stabilized with medications and handed off for outpatient care. Individuals with opioid use disorder (OUD) do best with a similar treatment plan.

What is the evidence?

A 2015 study (JAMA) found that twice as many patients were in OUD treatment at 30 days (~80%) with ED-initiated buprenorphine & a brief negotiation interview (BNI) compared with referral only or a BNI + facilitated referral and used less illicit opioids in the last 7 days.[2]

Engaged in Treatment at 30 Days



What do I need to know about buprenorphine?

It is NOT simply replacing one drug for another

Buprenorphine treatment decreases withdrawal and craving. Patients who receive buprenorphine are less likely to OD, die, use illicit opioids, spread HCV or HIV and have fewer injection drug use complications and contacts with the criminal justice system.[3]

Since 2002 ED physicians can administer buprenorphine in the ED for opioid withdrawal. Within 30-45 minutes patients will be much more comfortable. MDs, PAs and APRNs who complete the DATA 2000 waiver training, can prescribe buprenorphine with referral to ongoing treatment.

Buprenorphine is a partial agonist at the mu opioid receptor, where it has a very high affinity but low intrinsic activity. Its high affinity means it will out-compete and displace full opioid agonists. It is administered when the patient exhibits withdrawal symptoms (COWS ≥ 8). Its low intrinsic activity results in less euphoria and lower diversion potential.

Responding to the Opioid Epidemic

Opioid-related ED visits are escalating and EPs are finding themselves on the front lines, with little preparation or tools to combat this crisis.

What can you do?

Prescribe opioids safely

- Identify patients receiving high doses of opioids
- Use prescription monitoring systems
- Avoiding drug combinations that might increase OD risk, especially benzodiazepines

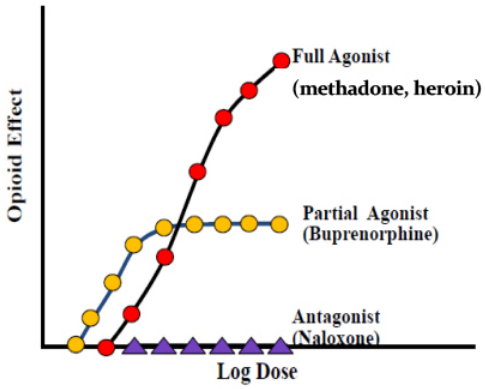
Increase access to medication treatments

- Initiating buprenorphine and referral

Offer harm reduction strategies

- Overdose prevention education and training
- Prescribe Naloxone

How does it work?



Comments or questions?

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How to Start Buprenorphine in the ED
(OUD Confirmed)

Assess for opioid type and last use
Patients taking methadone may have withdrawal reactions to buprenorphine up to 72 hours after last use. Consider consultation before starting buprenorphine in these patients

COWS

(0-7) none - mild withdrawal

Dosing:
None in ED

Waivered provider able to prescribe buprenorphine?

YES

Unobserved buprenorphine induction and referral for ongoing treatment

NO

Referral for ongoing treatment

All Patients Receive:
- Brief Intervention
- Overdose Education
- Naloxone Distribution

(≥8) mild - severe withdrawal

Dosing:
4-8mg SL*

Observe for 45-60 min
No adverse reaction

If initial dose 4mg SL repeat 4mg SL for total 8mg

Observe**

Waivered provider able to prescribe buprenorphine?

YES

Prescription 16mg dosing for each day until appointment for ongoing treatment

NO

Consider return to the ED for 2 days of 16mg dosing (72-hour rule) Referral for ongoing treatment

Notes:

*** Clinical Opioid Withdrawal Scale (COWS) ≥ 13**
(Moderate-Severe) consider starting with 8mg buprenorphine or buprenorphine/naloxone SL

** Patient remains in moderate withdrawal may consider adding additional 4mg and observation for 60 minutes

Warm hand-offs with specific time & date to opioid treatment providers/programs within 24-72 hours whenever possible

All patients should be educated regarding dangers of benzodiazepine and alcohol co-use

Ancillary medication treatments with buprenorphine induction are not needed

Tools & Assessments

How to assess for OUD?

Questions for Identification of Opioid Use Disorder Based on DSM-5

1. Have you found that when you started using, you ended up taking more than you intended to?
2. Have you wanted to stop or cut down on using opioids?
3. Have you spent a lot of time getting or using opioids?
4. Have you had a strong desire or urge to use opioids
5. Have you missed work or school or often arrived late because you were intoxicated, high or recovering from the night before?
6. Has your use of opioids caused problems with other people such as with family members, friends or people at work?
7. Have you had to give up or spend less time working, enjoying hobbies, or being with others because of your drug use?
8. Have you ever gotten high before doing something that requires coordination or concentration like driving, boating, climbing a ladder, or operating heavy machinery?
9. Have you continued to use even though you knew that the drug caused you problems like making you depressed, anxious, agitated or irritable?
10. Have you found you needed to use much more drug to get the same effect that you did when you first started taking it?
11. When you reduced or stopped using, did you have withdrawal symptoms or felt sick when you cut down or stopped using?

Loss of Control

Moderate Opioid Use Disorder: 4-5 symptoms, Severe Opioid Use Disorder: 6 or more symptoms

How do I motivate ED patients with OUD to accept treatment?

Step 1. Raise the Subject/Establish Rapport

- Introduce yourself
- Raise the subject of opioid use
- Ask permission to discuss OUD
- Assess patients subjective level of physical discomfort (i.e., withdrawal)

Step 2. Provide Feedback

- Review patients drug use and patterns
- Ask the patient about and discuss drug use and its negative consequences
- Make a connection (if possible) between drug use and ED visit or any medical issues
- Provide feedback on OUD diagnosis and treatment options (e.g., buprenorphine or other options, such as methadone maintenance, intensive outpatient programs) and/or harm reduction strategies.

Step 3. Enhance Motivation

- Assess readiness to change whichever of the above 3 target behaviors the patient chooses (i.e., Buprenorphine, other treatment or harm reduction)
- Enhance Motivation
  - Ask a series of open-ended questions designed to evoke "Change Talk" (or motivational statements) about their target behavior.
  - Reflect or reiterate the patient's motivational statements regarding entering treatment.

Step 4. Negotiate & Advise

- Negotiate goal regarding the target behavior
- Give advice
- Complete a referral/treatment or goal agreement, and secure and provide the actual referral for treatment (buprenorphine or other)

View video example:
https://www.aetna.com/health-care-professionals/patient-care-programs/impact-of-opioid-use-disorder.html

How to assess for withdrawal?

Clinical Opioid Withdrawal Scale (COWS)

Resting Pulse Rate				
80 or below (0)	81-100 (1)	101-120 (2)	>120 (4)	
Restlessness				
Sits still (0)	Difficulty sitting still (1)	Frequently shifting limbs (3)	Unable to sit still (5)	
Anxiety of irritability				
None (0)	Increasing (1)	Irritable/ anxious (2)	Cannot participate (4)	
Yawning				
None (0)	1-2 times (1)	3 or 4 times (2)	Several per/min (4)	
Pupil Size				
Normal (0)	Possibly larger (1)	Moderately dilated (2)	Only rim of iris visible (5)	
Runny Nose or Tearing				
Not present (0)	Stuffiness/ moist eyes (1)	Nose running/tearing (2)	Constant running/tears streaming (4)	
Tremor				
No tremor (0)	Felt-not observed (1)	Slight tremor observable (2)	Gross tremor/Twitching (4)	
Sweating				
No report (0)	Subjective report (1)	Flushed/observable (2)	Beads of sweat (3)	Streaming down face (4)
Gooseflesh Skin				
Skin is smooth (0)	Piloerection (3)	Prominent piloerection (5)		
Bone or Joint Pain				
None (0)	Mild (1)	Severe (2)	Unable to sit still due to pain (4)	
GI upset				
None (0)	Stomach cramps (1)	Nausea or loose stool (2)	Vomiting or diarrhea (5)	Multiple episodes (5)

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

What are the different buprenorphine formulations for OUD?

Medication	Route of Administration/form	Available strengths
Buprenorphine/ Naloxone (Tablets may be more inexpensive than film depending on insurance provider)		
Suboxone • **Buprenorphine hydrochloride** • **Naloxone hydrochloride**	Sublingual film	2 mg/0.5 mg 4 mg/1 mg 8 mg/2 mg 12 mg/3 mg
Bunavail • **Buprenorphine hydrochloride** • **Naloxone hydrochloride**	Buccal film	2.1 mg/0.3 mg 4.2 mg/0.7 mg 6.3 mg/1 mg
Zubsolv, • **Buprenorphine hydrochloride** • **Naloxone hydrochloride**	Sublingual tablet	0.7 mg/0.18 mg 1.4 mg/0.36 mg 2.9 mg/0.71 mg 5.7 mg/1.4 mg 8.6 mg/2.1 mg 11.4 mg/2.9 mg
Generic combination product • **Buprenorphine hydrochloride** • **Naloxone hydrochloride**	Sublingual tablet	2 mg/0.5 mg 8 mg/2 mg
Buprenorphine Alone (Used with pregnant women to decrease potential fetal exposure to naloxone)		
Subutex • **Buprenorphine hydrochloride**	Sublingual tablet	2 mg 8 mg
Generic mono product • **Buprenorphine hydrochloride**	Sublingual tablet	2 mg 8 mg

How do I obtain a Data 2000 Waiver?

SAMHSA DATA 2000 waiver training for providers

Available at:

https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training

Educational Resources

SAMSHA Opioid Overdose Prevention Toolkit: This toolkit offers strategies to help prevent opioid-related overdoses and deaths.
https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA16-4742

SAMSHA Treatment Improvement Protocol - TIP63: Medications for Opioid Use Disorders – Resources Related to Medications for Opioid Use Disorder.
https://store.samhsa.gov/product/SMA18-5063PT5

Provider's Clinical Support System for Medication-Assisted Treatment (PCSS-MAT) is a national training and clinical support system. The goal is to provide the most effective evidenced-based clinical practices in the prevention, identification, and treatment of opioid use disorders.
https://pcssnow.org/education-training/

Video series: Combating opioid use disorder
https://www.aetna.com/health-care-professionals/patient-care-programs/impact-of-opioid-use-disorder.html
Yale SBIRT website: https://medicine.yale.edu/sbirt/

Yale ED-Initiated Buprenorphine website: *https://medicine.yale.edu/edbup/*

NIDA ED-Bup Website: *https://www.drugabuse.gov/ed-buprenorphine*

References:

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2. D'Onofrio, G., O'Connor, P.G., Pantalon, M.V., Chawarski, M.C., Busch, S.H., Owens, P.H., Bernstein, S.L. and Fiellin, D.A., 2015. Emergency department–initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. *JAMA*, 313(16), pp.1636-1644.

3. 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