NIH HEAL INITIATIVE
HEALing Communities Study Kentucky

FAQ Initiating Buprenorphine in the Emergency Department

How do we change culture in a healthcare facility and ED?

Get everyone on board, from registration to the pharmacy used at discharge. Often the first step to changing the culture is changing the language we use when discussing the care of people living with OUD. Some other key steps for culture change include promoting harm reduction practices , avoiding negative labels for people who use drugs, posting signs inviting patients to seek treatment in the ED and waiting areas, and practicing patient-centered trauma-informed care that focuses on empathy and human connection. Highlight some successes also so the staff see that their treatment helped.

What is the best strategy for buprenorphine dosing?

The traditional dosing recommendations may not always work well in every ED. Be flexible and focus on the needs of the patient. Buprenorphine is safe and has a ceiling effect for respiratory depression, sedation, and other subjective measures.
Micro and macro dosing can have a role in the ED. Try to avoid doses in the middle that could lead to precipitated withdrawal.
If there are concerns about adverse effects with higher doses, keep in mind that these will happen quickly. The patient will most likely still be in the ED.

How do you initiate buprenorphine after a patient has received naloxone?

In general, the recommendation is to wait 2 hours after a naloxone reversal to perform the COWS and treat accordingly. Remember to always ask about methadone and if the individual has methadone on board, waiting longer is more prudent.

Should we implement universal screenings for OUD?

Universal screening does not have strong enough data to support widespread use. Patients may hesitate to reveal information with standard screening and there is a history of using screening for illicit drug use to harm patients in racially biased ways rather than for clinical reasons to treat an illness. Lead the conversation with why you are trying to determine if the patient could have a SUD or OUD and tell them how they can benefit from receiving buprenorphine. Offer patients a solution.

What if the patient does not want buprenorphine?

Some individuals may not want treatment, especially after an overdose. Try to find out what the patient needs at the time. Start with harm reduction and screenings (e.g., hepatitis C, HIV). They might need information on how to access their local syringe service program, education about injection technique, or guidance about Pre-exposure Prophylaxis (PrEP).
If an individual is not ready for buprenorphine, this does not mean they will not change their mind in the future. This highlights the need for harm reduction strategies and easily available treatment when they are ready.

How do you overcome the barrier of working with physicians who are skeptical of initiating buprenorphine in the ED?

Having a clear path for patients helps. If providers know there is a place where a patient can go for follow up, they will be more likely to have a favorable outlook. Sharing successes can also be helpful. Hearing about a patient they started on buprenorphine several months ago who's in remission can encourage providers who struggle with seeing patients in active addiction not get the care they need.

WHAT IS THE BEST PROTOCOL TO USE?

There is no best protocol. Protocols should be adaptable. Treatment, including the starting dose for buprenorphine, can vary and should be based on patient characteristics and response. Protocols can be customized based on resources available in a healthcare facility and the surrounding community. It is helpful to think about the needs of the patients who use the ED. Keep in mind that successful protocols may look different based on the characteristics of a community (e.g., rural vs. urban). Examples are available from existing programs.

HOW SHOULD COWS BE USED?

COWS should not be used as a screening tool to determine with 100% validity (sensitivity and specificity) that opioid withdrawal is present or absent. Remember that people can be using multiple substances that can mask some opioid withdrawal and other illnesses may look like opioid withdrawal also even if the person has never used opioids. There is variability in COWS results based on the provider who is administering. COWS is a helpful tool though – it can be used to confirm or help make decisions but not as a requirement for buprenorphine initiation. Look at the patient. Ask them how sick they feel and if they feel ready to begin buprenorphine now. COWS may not be necessary, and these questions can be a valid measurement tool.

Patients are typically in withdrawal 12 hours after last heroin use, 24 hours after oxycodone, and 48-72 hours after methadone, a long acting opioid. Information about last use and pharmacology are important since variation in COWS can exist. For example, if an individual is 12 hours out of last use of heroin and his COWS is 8, then one can initiate a dose of buprenorphine. With the use of methadone one should wait until more moderate withdrawal such as a COWS of 13-15.

WILL PATIENTS FLOCK TO THE ED IF WE START OFFERING BUPRENORPHINE?

EDs that have ED-initiated buprenorphine protocols have not noted this to happen. In fact, the patients with OUD are already in the ED whether presenting with life-threatening illness such as overdose or less urgent, such as skin infections or withdrawal. Treatment with linkage to ongoing care can prevent the frequent flyer from continuously coming to the ED. If a person is coming in frequently because of withdrawal and injection-related infections, treatment can stop that cycle and the ED will see less of the person.

WHAT DO YOU DO IF A PATIENT HAS RECEIVED BUPRENORPHINE BUT STILL FEELS BAD?

Look for other things that could be going on. Benzodiazepines, alcohol, or methamphetamines could be involved, or the patient could have an underlying medical illness that needs to be treated.

Many patients take other substances along with opioids and this is not a reason to withhold treatment. If co-use is suspected you should counsel the patient regarding the higher risk of overdose when using benzodiazepines, alcohol or other sedatives with buprenorphine.

HOW CAN EMS PLAY A ROLE IN BUPRENORPHINE INITIATION?

Many individuals who experience an overdose refuse transport to a healthcare facility. Providing buprenorphine on an ambulance can be a way to reach these individuals as well as bystanders. They can serve as a touchpoint for the community. EMS can be integrated into the ED program and can be advocates for offering buprenorphine induction in the ED.

HOW LONG DO YOU OBSERVE THE PATIENT?

You will notice a major improvement after 20 to 30 minutes. Some protocols suggest 45 to 60 minutes. The ED visit that includes assessment of OUD, administering buprenorphine, counseling regarding overdose, buprenorphine treatment and providing a specific referral can be accomplished within 60-90 minutes, which is in guidelines for an urgent visit.

WHAT CAN I TELL PROVIDERS THAT DON'T WANT TO SUBSTITUTE ONE OPIOID FOR ANOTHER?

Acknowledge that they are correct in that buprenorphine is another opioid, but it is very long-acting and a partial opioid agonist instead of a short-acting full opioid agonist like heroin, most pain pills, and fentanyl. The risks of use are low compared to other opioids that the patient may take. Emphasize that we want the patient to survive and they will have a better chance of doing so and moving forward with their life if they are taking buprenorphine instead of heroin, etc.

Buprenorphine is prescribed by a healthcare provider and used under supervision. The medication has been chosen for its sublingual (instead of intravenous) route of administration, daily dosing, and lack of euphoria. Addiction is about loss of control, compulsive use, and continued use despite adverse consequence. In this case of opioids, addiction is about engaging in behaviors associated with obtaining and taking opioids illegally or differently than prescribed.

Treatment with buprenorphine and methadone, both opioid agonists, is effective in reducing withdrawal symptoms, cravings, HIV transmission and other infectious diseases, interactions with the judicial system, as well as improving social relationships and becoming functional members of society.

WHAT IS AN OPIOID RECEIVING CENTER?

An opioid receiving center is an ED that is equipped to deal with opioid overdose, similar to a trauma care model. For example, EMS knows if they have an acute STEMI / stroke they try to get those patients to EDs who have specialty care to address those life-threatening conditions. EMS who are familiar EDs that have special services for opioid overdose can help direct patients to these facilities where they can receive appropriate care and have the option to begin buprenorphine and be connected with a bridge clinic or follow-up program.

WHAT DO YOU RECOMMEND FOR BUPRENORPHINE INDUCTION WHEN FENTANYL IS INVOLVED?

Fentanyl is not just a substance. It can be a marker of disease severity. It is very feasible to still induct persons on buprenorphine who are using fentanyl. Rapid induction has been successful. If there are challenges with the induction, there may be other substances or underlying medical issues involved. Listening to patient's past experiences can be helpful in navigating a challenging induction when fentanyl is being used. Knowing what worked (or didn't work!) for them in the past can guide you moving forward.

HOW DO YOU TREAT PRECIPITATED WITHDRAWAL?

The best form of treatment is prevention – reserving buprenorphine induction for patients in moderate to severe withdrawal as assessed using the COWS. Care for patients with precipitated withdrawal is supportive, and driven by management of the patient's symptoms. Optimal management will be driven by consideration of the most recent opioid type, quantity and the duration of time before buprenorphine exposure along with the dose of buprenorphine that precipitated the withdrawal.

Adjuvants such as clonidine may make examination of the patient more difficult. Use a higher dose of buprenorphine. You can't make the effects of precipitated withdrawal worse. Giving more buprenorphine will help the patient. Effective treatment of withdrawal symptoms has been reported with additional buprenorphine to fully occupy the mu opioid receptor. Low dose benzodiazepines can be added. This can help with the feeling of panic that can be induced by precipitated withdrawal and will help the patient feel better.

MANY INDIVIDUALS WHO WORK WITH PATIENTS IN SUD TREATMENT ARE ALSO IN RECOVERY OR HAVE LIVED EXPERIENCE. WHAT APPROACH SHOULD BE TAKEN IF THESE INDIVIDUALS RELY TOO HEAVILY ON THEIR EXPERIENCES WHEN ADVISING PATIENTS?

It is going to be hard. It is important to remember and remind others that what works for one person may not be the best fit for someone else. There are many different paths. Trying to push someone along a path that is not working for them may result in the patient dropping out of treatment and returning to substance use. But having a peer who has made it and supplies hope and support can be very, very valuable to the person who is just starting to think about and initiate treatment and their own recovery path.

WHAT IS THE BEST TIMEFRAME FOR FOLLOW UP AFTER BUPRENORPHINE INITIATION IN THE ED?

ASAP! Intake does not have to be complex. With a good system, return visits to the ED will decrease. The goal is to develop agreements with community providers and opioid treatment programs so that follow-up can occur quickly. However, in some communities, access may be difficult and you may need to provide buprenorphine for up to 7 days to ensure that there is not a gap in treatment.

WHEN DO YOU USE HIGHER DOSES OF BUPRENORPHINE FOR RAPID INDUCTION?

CA Bridge most often use higher doses. It is important to ask patients about their substance use. Those with heavy use may benefit from higher doses. Others that may benefit include individuals who have greater challenges to success and those who may have trouble obtaining buprenorphine after discharge. High dose is not a good option for older adults or patients experiencing a COPD exacerbation.

SHOULD I WORRY ABOUT DIVERSION?

Do you worry about diversion of every opioid you prescribe? Diverted buprenorphine is less reinforcing than diverted full agonist opioids that cause greater euphoria and respiratory depression. When individuals are obtaining buprenorphine off the street they are almost always trying to reduce withdrawal. Every time there is one less use of injection drugs there is one less opportunity for overdose and death.

DO I NEED A DATA WAIVER TO ADMINISTER BUPRENORPHINE IN THE ED?

No. Buprenorphine can be provided in the ED to treat opioid withdrawal symptoms. Buprenorphine may be dispensed by a non-waivered practitioner for up to 72-hours. "The 72-hour rule" (Title 21, Code of Federal Regulations, part 1306.07(b)) allows appropriate providers to administer narcotic drugs for the purpose of reliving acute withdrawal symptoms when necessary while arrangements are being made for referral to treatment"

You cannot write a prescription for "up to 72 hours" without a DATA 2000 waiver. Each dose of buprenorphine during the 72-hour period must be administered in the ED. By obtaining a DATA 2000 waiver, clinicians can prescribe buprenorphine for short or long periods of time.

In April 2021, the Department of Health and Human Services (HHS) issued The Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder which provides eligible physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives, who are state licensed and registered by the DEA to prescribe controlled substances, an exemption from certain statutory certification requirements related to training, counseling and other ancillary services (i.e., psychosocial services) related to buprenorphine prescribing. State regulations, however, can be more restrictive and still require training.

WHAT MANDATORY/OPTIONAL LAB TESTS DO YOU NEED FOR ED INITIATED BUPRENORPHINE?

There are no mandatory tests needed if you are sure that the patient has OUD. A pregnancy test is helpful in terms of referral and deciding on whether to administer or prescribe buprenorphine with or without naloxone. If there is concern regarding methadone use you may check a urine sample, but methadone can be in the urine for longer periods of time. Buprenorphine is metabolized in the liver and may be a problem if the LFTs are greater than 5 times normal. However, obtaining LFTs is not essential in the first visit but may be helpful for the receiving referral site. Other tests such as hepatitis C and HIV can be done at the referral site. Urine drug screening can be used in the ED setting. If there are concerns that this can slow things down, rapid point-of-care testing can provide results in approximately 5 minutes.

References: Cisewski DH, et al. *Am J Emerg Med*. 2019;37(1):143-150; https://www.drugabuse.gov/nidamed-medical-health-professionals/discipline-specific-resources/emergency-physicians-first-responders/initiating-buprenorphine-treatment-in-emergency-department/frequently-asked-questions-about-ed-initiated-buprenorphine; https://medicine.yale.edu/edbup/resources/; Herring A. HCS Learning Collaborative: Emergency Department-initiated buprenorphine for opioid use disorder: Building a bridge to remission and recovery. May 3, 2021; Kunzler NM, et al. *J Emerg Med*. 2020;58(2):245-253; https://cabridge.org/resource/blueprint-for-hospital-opioid-use-disorder-treatment/; SAMHSA: Use of Medication-Assisted Treatment in Emergency Departments. HHS Publication No. PEP21-PL-Guide-5 Rockville, MD; ASAM. *J Addict Med*. 2020;14(2S Suppl 1):1-91; Tompkins DA, et al. *Drug Alcohol Depend*. 2009;105(1-2):154-159.