Emergency Department Buprenorphine Induction to Recovery Guide

Table of contents

HSHS St. Nicholas Hospital

About HSHS St. Nicholas Hospital's Buprenorphine Induction to Recovery Service

This recovery guide details the procedures and workflows associated with HSHS St. Nicholas Hospital's Emergency Department buprenorphine induction to recovery program. HSHS St. Nicholas Hospital Emergency Department has expanded its emergency services to include an opioid recovery program. The project is funded by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) administered by the Wisconsin Department of Health Services, Division of Care and Treatment Services.

In order to enhance local emergency services and better meet the needs of Sheboygan and its surrounding communities, HSHS St. Nicholas Hospital Emergency Department has developed additional processes and protocols so patients can be assessed anytime, day or night. This is for those who may be overdosing, withdrawing or ready to start recovery from heroin or pain pills. Those seeking help may be started on a lifesaving medication to aid them on their path to recovery and be connected with recovery coaches. The medical team at HSHS St. Nicholas Hospital Emergency Department then coordinates treatment with the appropriate treatment center.

National experts in addiction medicine from Health Management Associates, as well as local experts in emergency care, addiction medicine, psychiatry, mental health, primary care and those working in the recovery community, collaborated to develop this improved offering at HSHS St. Nicholas Hospital.

The contents of this guide are subject to review and may change over time. If you have any questions, call Jeff Stumbras at (920) 272-1200.

What to do when a patient presents to the ED

When a patient presents to the emergency department with symptoms of withdrawal or overdose, the registrar informs the nurse of patient symptoms. The nurse greets client, obtains vitals and assesses the chief complaint. Recovery Services/Peer Support Specialists are contacted if the patient is suspected to have AUD, SUD or OUD. The nurse initiates a verbal order. COWS is conducted and recorded in EPIC. A provider enters the room and completes the assessment.

CHIEF COMPLAINT: OPIOID USE DISORDER TREATMENT (this will fire OUD tools such as COWS, recovery coach, LABS and discharge smart sets)

Ordering labs

While labs may vary, basic lab work must be completed before any potential medication-assisted treatment is administered, including but not limited to buprenorphine.

- Basic metabolic panel
- Liver function test
- Urine pregnancy (if applicable)
- Urine drug screen

Optional labs may include: Hepatitis C, Hepatitis B and/or HIV panel - based on discussion with the patient.

Positive toxicology results do not diagnose an opioid use disorder.

Eligibility for induction of buprenorphine in the ED

Once a patient has been medically cleared and is seeking recovery from an opioid use disorder, determine if any contraindications are present. Discuss the risks and benefits of medication-assisted treatment with the patient.

Contraindications and considerations

- COWS score is less than 8 and/or NOT in opioid withdrawal (or early in stages).
- Positive for methadone - buprenorphine can precipitate severe withdrawal.
- Concern for significant alcohol or benzodiazepine use disorder/withdrawal due to risk of respiratory depression.
- Actively suicidal, homicidal or psychotic.
- Pregnancy (not a contraindication but be sure to involve the patient's care team).
- DO NOT prescribe new or increased doses of sedatives when starting buprenorphine.

Withdrawal

Exposure to steady state level of a substance causes neuroadaptation; this leads to the spontaneous onset of withdrawal symptoms when the substance is abruptly stopped or greatly decreased

Opioid	**Onset**	**Peak**	**Duration**
Heroin	6 hours	By 3 days	4 to 7 days
Methadone	1 to 2 days	By 7 days	12 to 14 days
Fentanyl (short acting)	6 hours	Duration of withdrawal is dependent upon the duration of the drug being consumed.	
Fentanyl (long acting)	24 to 36 hours		

DSM-5 Criteria for identification of an opioid use disorder

Mild: 2 to 3 symptoms
Moderate: 4 to 5 symptoms
Severe: 6 or more symptoms

Criteria	Question about the past 12 months	YES (1)	NO (0)
Opioids are often taken in larger amounts or over a longer period of time than intended	Have you found yourself using more than you intended?		
There is a persistent desire or unsuccessful efforts to cut down or control opioid use	Have you wanted to stop or cut back on your use?		
A great deal of time is spent in activities necessary to obtain the opioid, use the opioid or recover from its effects	Have you spent a lot of time getting, using or thinking about using?		
Craving or a strong desire to use opioids	Have you had a strong desire or craving to use?		
Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home	Has your use caused you to miss school/work or be late because you were still intoxicated, high or recovering from the day/night before?		
Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids	Has your use caused problems with other people around you? Family/friends/coworkers		
Important social, occupational or recreational activities are given up or reduced because of opioid use	Have you had to give up or spend less time working, enjoying hobbies or being with others because of your use?		
Recurrent opioid use in situations in which it is physically hazardous	Have you ever used before a task that required coordination or concentration? Driving/boating/construction		
Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids	Have you continued to use even though you knew it was causing unwanted side effects? Depression/irritability/anxiousness		
Tolerance as defined by a need for markedly increased amounts of opioids to achieve intoxication or desired effect, or markedly diminished effect with continue use of the same amount of an opioid	Have you found you need to use more to get the same effect?		
Withdrawal as manifested by the characteristic opioid withdrawal syndrome	Have you experienced uncomfortable symptoms when you tried to cut down or stop using?		

Opioid risk tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management.

Mark each box that applies.

	Female	Male
Family history of substance use		
Alcohol	1	3
Illegal drugs	2	3
Prescription drugs	4	4
Personal history of substance use		
Alcohol	3	3
Illegal drugs	4	4
Prescription drugs	5	5
Age between 16 to 45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
SCORE TOTALS		

A score of 3 or lower indicates low risk for future opioid abuse.
A score of 4 to 7 indicates moderate risk for opioid abuse.
A score of 8 or higher indicates a high risk for opioid abuse.

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction. Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6): 432

COWS tool

The COWS (Clinical Opioid Withdrawal Scale) tool is used to assess withdrawal. This is a sample. COWS is embedded in EPIC.

SAMPLE ONLY. ACCESS THIS TOOL IN EPIC. Enter scores at start, 30 to 60 min after first dose, repeat as needed.		
Resting pulse rate: record beats per minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81 to 100 2 pulse rate 101 to 120 4 pulse rate greater than 120		
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		
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		
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		
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		
Runny nose or tearing: n*ot 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		
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		
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		
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		
Anxiety or irritability 0 none 1 patient reports increasingly irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult		
Gooseflesh skin 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection		
Total scores (include observer's initials) 5 to 12 mild 13 to 24 moderate 1 to 36 moderate to severe 36 and above severe		

Starting induction of buprenorphine

If COWS score is greater than or equal to 8, then complete the following steps:

- Labs.
- Full dose induction: Give 6 to 8 mg SL tablet.
- Reassess after 60 minutes.
    - If still in withdrawal, give additional 4 mg SL Tab (normal target 16 mg SL).
    - If worse, consider precipitated withdrawal, give second full dose: 6 to 8 mg SL Tab.
    - If better, document post induction COWS.
        - ***Buprenorphine-waivered providers*:** Discharge with RX for total dose received, daily SL tabs to cover no less than five business days for bridge to follow up. Include script for naloxone for added harm reduction.
        - ***Non buprenorphine-waivered providers*:** Instruct patient to return to the ED the next day and for additional days (no more than three in a row) for dispensing of buprenorphine. Provide naloxone kit for added harm reduction.

If COWS score is less than 8, then complete the following steps:

- Question the last time they used opioids.
    - If greater than 72 hours (already finished withdrawal):
        - Labs.
        - Low dose induction for craving prevention, 4 mg SL Tab.
        - If better, document post induction COWS.
            - ***Buprenorphine-waivered providers*:** Discharge with RX for total dose received, daily SL tabs to cover no less than five business days for bridge to follow up. Include script for naloxone for added harm reduction.
            - ***Non buprenorphine-waivered providers*:** Instruct patient to return to the ED the next day and for additional days (no more than three in a row) for dispensing of buprenorphine. Provide naloxone kit for added harm reduction.
    - If less than 72 hours (has not yet started withdrawal):
        - Discharge patient with instructions to return to ED when in withdrawal.

      OR
        - Consider home induction of buprenorphine (for patients previously prescribed buprenorphine).

Buprenorphine-waivered providers

For patients that may present to the ED already taking outpatient buprenorphine or buprenorphine-naloxone, buprenorphine waivered providers can do the following:

1. Confirm dose by calling their pharmacy or checking the PDMP.
2. Unless patient has a severe alteration in mental status or other contraindication (including missed doses), provider can continue patient's outpatient dose by writing a medication order. COWS is not necessary. Phone call to current prescriber encouraged.
3. Buprenorphine should typically be continued during acutely painful events, but buprenorphine alone will not control severe acute pain—see buprenorphine FAQ.
4. If patient has missed outpatient dosing and has not used opioid agonists in the interim, provider may order patient's full outpatient dose. Phone call to current prescriber encouraged.

5. If patient has missed >1 day of buprenorphine AND has used opioid agonists in the interim, use clinical judgement to determine whether they are at risk for precipitated withdrawal. If you are concerned for precipitated withdrawal – based on their period of time without buprenorphine, opioid use and lack of current objective withdrawal – please consider them a new induction and follow appropriate protocols.

Documentation requirements/Check list

- ☐ DSM 5 criteria and/or COWS score
- ☐ Labs
- ☐ Clinical impression/summary
- ☐ Recovery coach contacted
- ☐ Naloxone provided (take home or prescription)
- ☐ Follow up plan/referral

Discharge/Follow-up

***Buprenorphine-waivered providers*:**

- Discharge with RX for total dose received, daily SL tabs to cover no less than five business days for bridge to follow up.
- Include script for naloxone for added harm reduction.
- Document your DATA-waiver DEA number on the prescription.

***Non buprenorphine-waivered providers*:**

- Instruct patient to return to the ED the next day and for additional days (no more than three in a row) for dispensing of buprenorphine.
- Provide naloxone kit for added harm reduction.
- Encourage client to follow up with a recovery coach for additional support.

Referral to a buprenorphine provider

REF3: the referral order in EPIC that is specific to referral to HSHS St. Nicholas Hospital Emergency Department. This will allow the referral to fall into a monitored work queue for proper follow up. This will pop in as a suggestion if using the chief complaint *OPIOID USE DISORDER TREATMENT.*

Reminder: not all doctors can prescribe buprenorphine.

Determine best location/time for outpatient follow-up and provide options to patients.
Aurora Behavioral Health
1221 N 26th St., Sheboygan
(920) 453-3900

Clean Slate
2707 S. Business Dr., Sheboygan
(920) 783-0122

Sheboygan Comprehensive Treatment Center
2742 S. Business Dr., Sheboygan
(920) 547-3639

Prevea Health
1411 N. Taylor Dr., Sheboygan
(920) 457-4858

4810 Expo Dr., Manitowoc
(920) 717-0800

Prevea Behavioral Care
3425 Superior Ave., Sheboygan
(920) 458-5557

There are also free 24/7/365 helplines available in English and Spanish for individuals and family members facing mental and/or opioid use disorders. They provide referrals to local treatment facilities, support groups, recovery coaching and community-based organizations for further treatment.

WI Addiction Recovery Helpline:	211
SAMHSA's National Helpline:	1(800) 662-HELP (4357)
American Addiction Centers:	1(866) 436-9146
National Suicide Prevention Lifeline:	1 (800) 273-8255
Mental Health America:	1 (877) 605-5165
Lighthouse Recovery Community Center:	1(855) 449-4726 (HOTLINE - operates 7 days a week 8 a.m. to midnight) (920) 234-5016 (DO NOT use for recovery coach requests)

What is recovery coaching?
Recovery coaching is non-clinical, meaning it is not in the realm of treatment services. It's based on both training and lived experience, with the goal of engaging, educating and supporting an individual to successfully recover from substance use disorder or problematic substance use.

Peer recovery coaches act as a recovery and empowerment catalyst, providing hope and positive role-modeling, guiding the recovery process and supporting the individual's recovery choices, goals and decisions, while recognizing and appreciating that there are multiple pathways to recovery.

Appropriate for both individuals in recovery, or those impacted by another's addiction (friends and family), recovery coaching is a strengths-based peer support service to help individuals reach their full potential.

Recovery coaches offer support and help with obtaining community-based services and resources, while providing hope and positive role-modeling. Coaches promote recovery, help remove barrier to success, build recovery capital and encourage hope, optimism and wellness.

EPIC tools

Smart phrases
Use smart phrase: SNSBUPDCINSTRUCTIONS (the below will auto populate)

Buprenorphine treatment discharge instructions:
You have been prescribed buprenorphine while in the hospital/emergency department. Buprenorphine (BUP) is used to treat opioid use disorder. BUP stops withdrawal symptoms and cravings by acting on the same areas of the brain as the opioids you were taking. This makes it easier for you to cut down or even stop using, so that you can focus on other activities that are important to you. BUP is an opioid, but it is NOT the same as substituting one addictive drug for another. When used properly, BUP helps you feel normal, without feeling high, and does NOT create a new addiction.

The medication should be placed under your tongue where it will dissolve and be absorbed directly into your blood stream. If you swallow the medication it will not work as well.

You should not take any opiates or sedatives (including those prescribed by a doctor) while taking this medication. If you drink alcohol or use benzodiazepines, talk to your provider. Taking buprenorphine with alcohol or benzodiazepines may put you at an increased risk for overdose. If you received a first dose of Buprenorphine in the hospital/emergency department, you should take your next dose 12 hours later, and then continue to take one dose every 12 hours (unless otherwise prescribed).

If you miss a dose: Take a dose as soon as you remember. If it is almost time for your next dose, wait until then and take a regular dose. Do not take extra medicine to make up for a missed dose.

Keep yourself and others safe. Lock up your medication away from children and pets. If a child accidentally takes some, get medical help fast. BUP can be very dangerous in children. Store the medicine in a closed container at room temperature, away from heat, moisture, and direct light. Do NOT store in your vehicle. Keep the medication in the bottle it came in and don't share your medication with anyone.

BUP can make you feel drowsy at first; don't drive a car or operate dangerous machinery until you know how BUP affects you. Nearly all drugs have **potential side effects**. The following are some potential side effects of BUP: constipation, nausea or vomiting, headache, sweating, mouth or tongue pain/ numbness, heart palpitations, difficulty sleeping, lightheadedness, dizziness. This drug may cause harm to an unborn baby if you take it while you are pregnant. If you are pregnant or you get pregnant while taking this drug, call your doctor right away.

Be sure you know how to treat pain while you take this drug. Do not take opioid pain drugs unless your doctor tells you to. Pain drugs may not work as well while you take this drug. Do not take more pain drugs to try to get them to work. If you have an emergency, tell your healthcare provider that you take this drug. If you have questions, talk with your doctor.

Meeting with a counselor, support group, or a recovery coach (Lighthouse Recovery Community Center, formerly WIRCO, 920-234-5016) can also help you stop using opioids. With support you will learn about the motivations and behaviors that led to your opioid

addiction. You gain support and skills while working with others to manage your recovery long term. It can provide you with encouragement and motivation to stick to treatment. It can help you learn how to make healthy decisions, handle setbacks and stress, and move forward with your life.

Avoid people who use illegal drugs or think it is OK to use drugs without a medical need. This way you might be less tempted to use opioids. Learn how to deal with pressure from your friends. Take yourself out of places where you feel pressured to take drugs or drink alcohol. Try to find healthy ways to deal with your feelings and stress. Your doctor, counselor, or recovery coach can help with this. Relaxation methods like reflection, deep breathing, and muscle relaxation may be helpful. Things like yoga, exercise, and tai chi are also good.
Keep naloxone with you. This is a medicine that is used to treat opioid overdose. Make sure you, your family, and friends know how and when to use it.
Not all doctors can prescribe buprenorphine; BUP can only be prescribed by providers with a special license. Below is a list of resources to help find treatment for opioid use disorder or mental health needs:

WI Addiction Recovery Helpline:	211
SAMHSA's National Helpline:	1-800-662-HELP (4357) available 24/7/365 in English & Spanish
American Addiction Centers:	1-866-436-9146
National Suicide Prevention Lifeline:	1-800-273-8255
Mental Health America:	1-877-605-5165
Lighthouse Recovery Community Center (formerly WIRCO)	HOTLINE 1-855-449-4726 (operates 7 days a week 8 am to midnight)
Lighthouse/WIRCO Business line	920-234-5016
Prevea Behavioral Care:	920-458-5557
Prevea Health Care:	920-457-4858
Clean Slate:	920-783-0122
Comprehensive Treatment Center:	920-547-3639
Aurora Behavioral Health:	920-453-3900
St. Nicholas Hospital ED:	920-459-4760

EPIC handouts

Hospital Sisters HEALTH SYSTEM

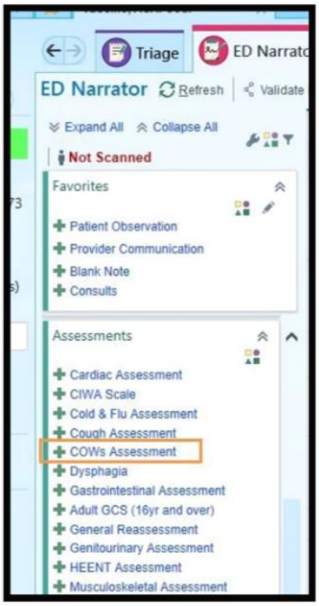
EPIC COMMUNICATION

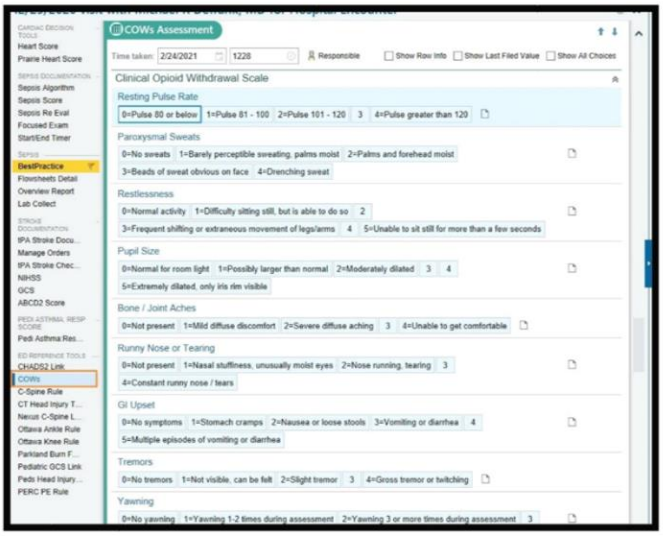
WEEKLY COMMUNICATION BULLETIN

AUDIENCE: ED PROVIDER, NURSE AND LEADERSHIP

Addition of Clinical Opioid Withdrawal Scale to ED Tools – Go Live 3/4/21

This change will give ED Nurses access to the COWS tool in their ED Nursing Narrator and the ED Providers Access to the COWS in their Decision Tools Navigator. A smartphrase has also been created (.COWS) to allow the total of this score to be easily added to their notes.





Epic HAND-OUT

ASAP-ED Recovery Coach Contact Information

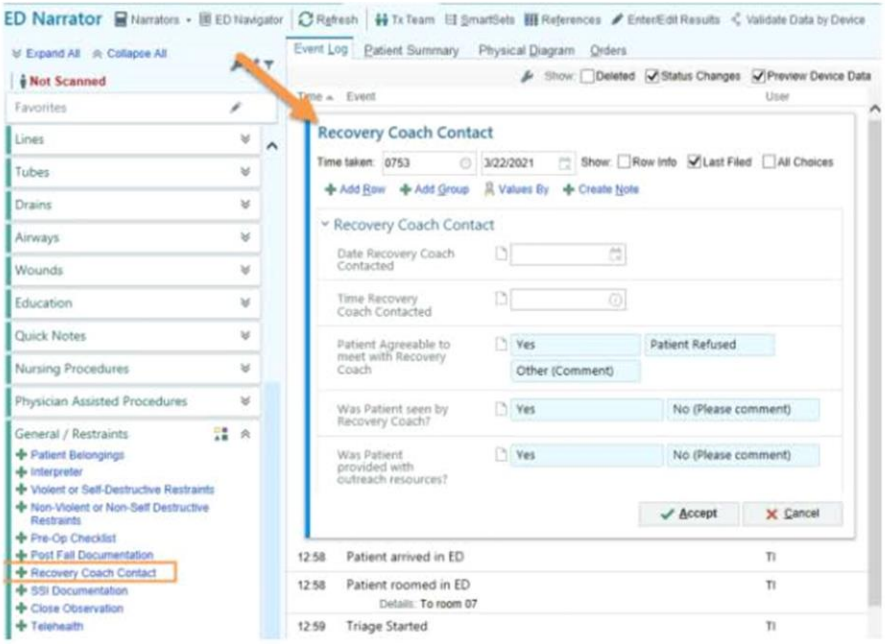
03/25/21

Audience: ED Nurses

A section has been added for ED Nurses to document the contact of a Recovery Coach. This has been added for those patients who may need this service due to substance abuse issues. It also aids in our report tracking of these patients.

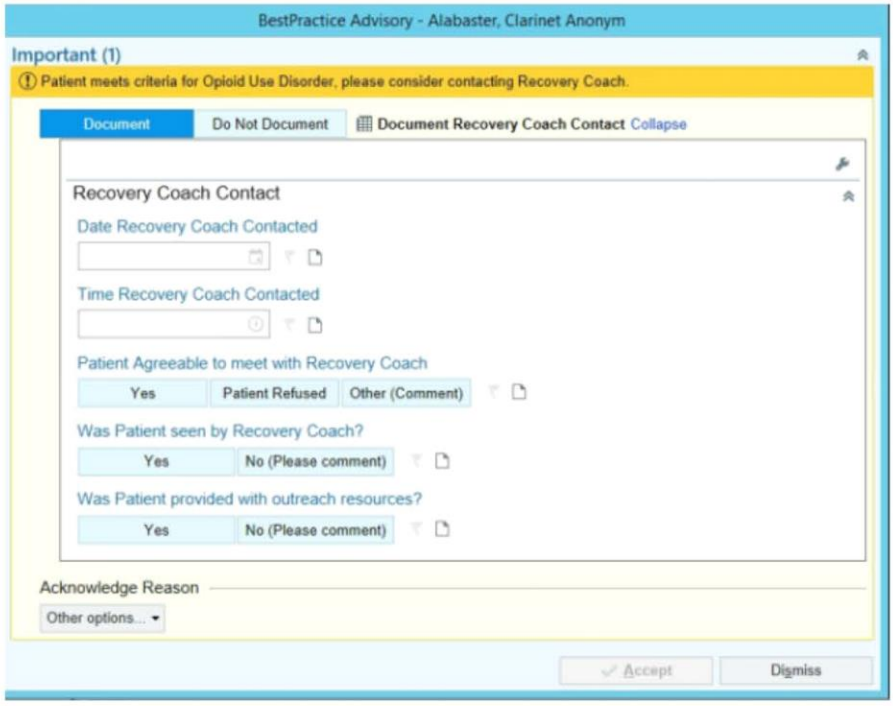
Let's Take a Look

The new Recovery Coach Contact section and documentation can be found in the **ED Nursing Narrator** under the **General/Restraints** section.



SNS ED Nurses ONLY

NOTE: AT SNS ONLY, ED nurses will see a BPA if a patient has a chief complaint of Substance Abuse or Opiate Withdrawal, has buprenorphine prescribed, or has a COWS completed and a recovery coach has not been contacted.



3/22/2021 2:52 PM (IMP)

Epic HAND-OUT

SNS ED Addition of Smartset and Orderset for Opioid Use Disorder

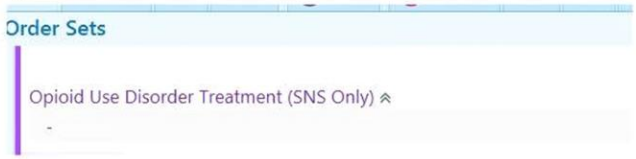
04/21/21

Audience: SNS ED Providers

Additional tools have been added to make the use of buprenorphine to treat opioid use disorder more streamlined and simplified for ED Providers.

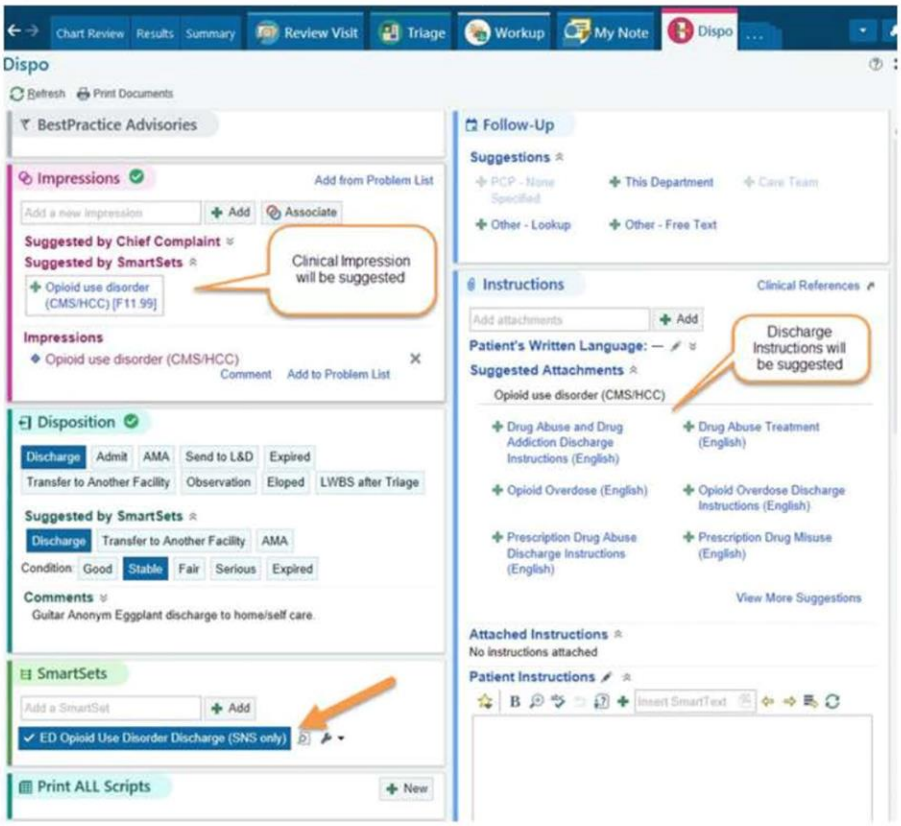
Let's Take a Look

A. A new ED Orderset has been added to the ED Orderset suggestions titled Opioid Use Disorder Treatment (SNS Only).

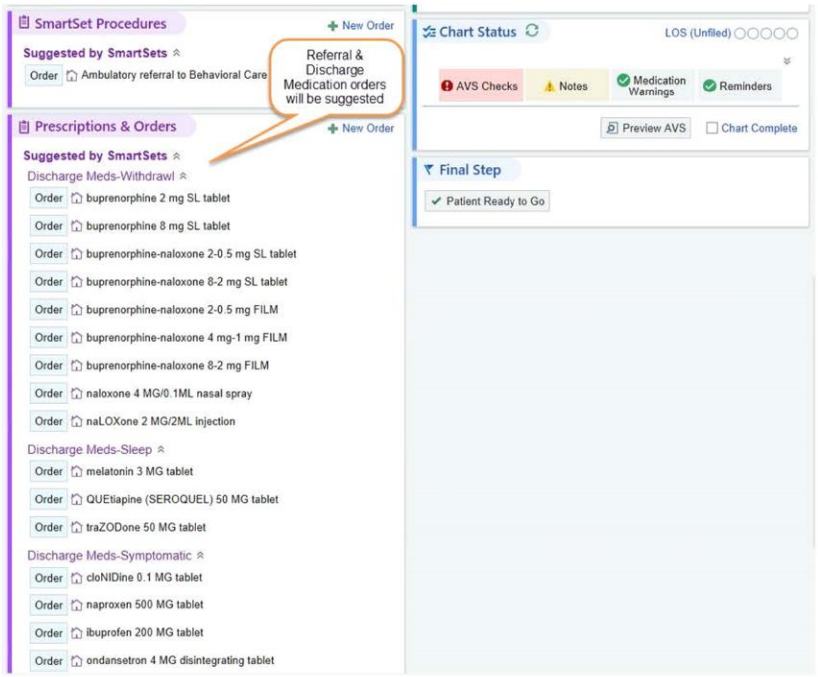


B. By Checking the box for the ED Opioid User Disorder Discharge, the following things will be suggested.

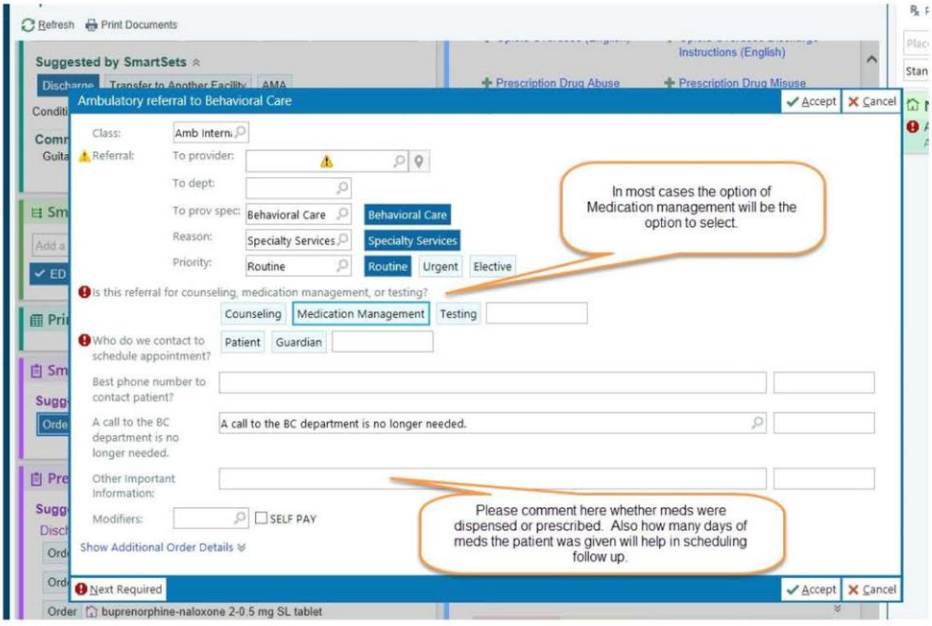
a. By selecting the **suggested Clinical Impression**, it will auto populate the suggestions for the Discharge Patient instructions as well.



b. **Discharge Medications** are broken out into categories for ease of ordering.



c. **The Ambulatory Referral** to Behavior Care will be suggested. This referral order assistes in scheduing the patient for follow up care as well as aiding in the communication between ED and follow up agency. Please see screenshot below for suggested comments.



MAT FAQ

What is Medication-Assisted Treatment (MAT)?
MAT is the use of FDA-approved medications in the treatment of substance use disorders.

What's the best way to address/talk to someone struggling with substance use?
Words are powerful. They can contribute to the opioid stigma and create barriers for these individuals when accessing effective treatment.

It's recommended to use person-first language when talking to someone struggling with substance use. Focus on the person, not the disorder. This change in language shows that a person "has" a problem, rather than "is" the problem.

When discussing opioid or other substance use disorders, consider the following.

Instead of:	**Use:**
Addict, user, drug abuse, junkie	Person with opioid use disorder or person with opioid addiction
Opioid abuse or opioid dependence	Opioid use disorder
Problem	Disease
Habit	Drug addiction
Clean or dirty urine test	Negative or positive urine drug test
Opioid substitution or replacement therapy	Opioid agonist treatment
Relapse	Return to us
Treatment failure	Treatment attempt
Being clean	Being in remission or recovery

Adapted from NIDA Words Matter: Terms to Use and Avoid When Talking About Addiction
https://www.asam.org/docs/default-source/default-document-library/nidamed_wordsmatter3_508.pdf?sfvrsn=5cf550c2_2

What medications can be used to treat opioid addiction?
The FDA approved the use of methadone, buprenorphine and naltrexone for the treatment of opioid dependence and addiction to short-acting opioids such as heroin, morphine and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone.

Who is medication-assisted treatment for?
MAT is primarily used to help individuals who are dependent on opioids such as heroin and prescription pain relievers that contain opiates.

How does MAT help?
The prescribed medication operates to normalize brain chemistry, block the euphoric effects of

alcohol and opioids, relieve physiological cravings and normalize body functions without the negative effects of the abused drug.

Is medication-assisted treatment replacing one drug for another?
No. Medications approved for medication-assisted treatment, like buprenorphine, are not opioid substitutes and do not provide feelings of getting "high" or extreme euphoria. It is a safe and effective medication method for treating opioid dependency and substance use disorder. Research has identified that patients undergoing buprenorphine treatment do not suffer the same social and behavioral destabilization that correlates in active drug addicts and abusers.

Buprenorphine FAQ

What is buprenorphine?
Buprenorphine is a schedule III medication approved by the FDA for the treatment of opioid use disorder, acute and chronic pain, and opioid withdrawal. Buprenorphine has been around since the 1970s. In early 2002, a safety profile sublingual buprenorphine was approved for opioid substitution treatment.

How does buprenorphine work?
Buprenorphine is an opioid partial agonist. When taken as prescribed it is safe and effective. It has unique pharmacological properties that diminish withdrawal symptoms and cravings.

What are the different formulations of buprenorphine?
The most common is SUBOXONE which is a combination of buprenorphine/naloxone 0.5mg. This preparation comes in SL tablets (generic) or film dissolved under the tongue. There are different brand names including ZUBSOLV tablets and BUNAVAIL film preparations.

Buprenorphine alone is available as SL tablet (SUBUTEX) without the naloxone that is often used in pregnancy to decrease risk of withdrawal symptoms.

What is the difference between buprenorphine and SUBOXONE?
SUBOXONE is the trademark name for buprenorphine and naloxone. The naloxone component is an abuse deterrent that is not active when taken sublingually. The naloxone is only active if injected.

Is giving buprenorphine replacing one drug for another?
No. Buprenorphine is a medication, prescribed by physicians and taken under supervision. 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.

Will patients flock to the ED if we start offering buprenorphine?
EDs that have ED-initiated buprenorphine protocols have not noted this to happen. 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.

Should I worry about diversion?
Diversion of buprenorphine is less than other opioids. 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.

When do you administer buprenorphine in the ED?
Buprenorphine will displace other drugs from opioid receptors, replacing the high-intensity stimulation from drugs like heroin or oxycodone, eliminating craving and withdrawal symptoms. Starting buprenorphine when patients are in moderate withdrawal provides immediate relief, stopping withdrawal discomfort without causing euphoria or sleepiness.

DO NOT start buprenorphine on opioid-dependent patients who are not in withdrawal as buprenorphine will cause withdrawal and will decrease the patient's desire to stay on or try buprenorphine again.

Do I need a buprenorphine waiver to administer buprenorphine in the ED?
No, buprenorphine may be dispensed or administered 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 physicians to administer narcotic drugs for the purpose of reliving acute withdrawal symptoms when necessary while arrangements are being made for referral to treatment.

Can I write a buprenorphine prescription for three days without a waiver?
No, the patient may come back to the ED for two subsequent days and you can administer a dose for up to three days in total. You cannot prescribe buprenorphine without a buprenorphine waiver.

How many days of a buprenorphine prescription should I prescribe if I have a waiver?
The goal is to develop relationships with providers within the community for follow up care. Offering a 7-day script allows them time to schedule proper follow up and not have a lapse in treatment.

What is the difference between administering and prescribing buprenorphine?
Administration of buprenorphine in any form is allowed for any ED provider. ED providers are allowed to administer dosing one day at a time consecutively for three days. A buprenorphine waiver is not required to administer buprenorphine, but having a provider with a buprenorphine waiver is recommended so prescribing buprenorphine is an option on discharge. A prescription of buprenorphine is restricted. A buprenorphine waiver is needed in order to provide a patient with a written prescription of buprenorphine for the treatment of opioid use disorder.

How does a provider give buprenorphine in the ED?
Generally, start with 4-8 mg sublingual tablet (Suboxone or Subutex) under the tongue. If the tablets are swallowed, very little buprenorphine gets absorbed. Repeat doses up to 32 mg SL can be administered depending on the clinical situation. A single 8 mg dose will have peak effect by about one hour and control withdrawal symptoms 6 to 12 hours.

What is the worst thing that could happen after I administer buprenorphine?
Not recognizing that (1) the patient has other opioids on board that will be displaced from the receptors by buprenorphine and you can precipitate withdrawal; (2) the patient was experimenting with an opioid and does not have a moderate to severe opioid use disorder, and may develop overdose symptoms.

How long do I need to wait to initiate buprenorphine after a naloxone reversal for opioid overdose?
In general, the recommendation is to wait two 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.

Do I have to worry if a patient is also taking benzodiazepines?
Many patients will be taking benzodiazepines and other substances along with their 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.

What's the best way to manage pregnant patients who are living with OUD?
All women of childbearing age should have a urine pregnancy sent for long term management. Theoretically, one would prescribe buprenorphine alone (Subutex) without naloxone to prevent withdrawal. However, in the ED with observed induction any formulation can be used.

Different protocols suggest dosing at different COWS scores. Does it matter?
The first principle related to dosing buprenorphine for moderate to severe opioid use disorder (OUD) is that the patient is in withdrawal. Since buprenorphine has a high affinity to the mu receptor it will displace any other opioid on the receptor and can therefore precipitate withdrawal. Therefore, the most important principle is that the patient is in withdrawal. A careful history regarding last use is important.

In general patients are in withdrawal 12 hours after last heroin use and 24 hours after oxycodone. For methadone, a long acting opioid, one should wait 48 to 72 hours. Knowing this, variations in COWS can exist; one needs to understand pharmacology.

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.

What mandatory versus 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 five 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.

How long does buprenorphine take to act and when does it peak?
Sublingual buprenorphine takes 15 minutes to act when held under the tongue and peaks in one hour.

How long do I need to observe a patient prior to discharge after a dose of buprenorphine?
Multiple studies have confirmed the safety and efficacy of home buprenorphine starts or unobserved starts. Low doses of buprenorphine should not cause respiratory depression in patients with known opioid tolerance. Monitoring following dosing inpatient or in the emergency department is only necessary for ensuring that the dose improved withdrawal, for about one hour. [11,12,13,14]

What if the buprenorphine induction causes opioid withdrawal?
Consider more buprenorphine and/or standard meds for supportive care such as clonidine, Zofran and loperamide.

What if my patient is still in withdrawal after re-dosing?
Consider other causes for withdrawal symptoms. Did the patient vomit, spit out or swallow induction dose? The strip or the tab should be left in the mouth until fully dissolved. It is also possible the patient has a high tolerance and may need more buprenorphine.

What steps should I take if I want to continue buprenorphine for a patient stabilized on an outpatient dose?
A call to the patient's pharmacy or checking PDMP can help confirm that a patient is prescribed buprenorphine and at what dose. Confirm with the patient directly that they have been taking their medication as prescribed. If they have not been taking it consistently and have used other opioids, treat this as a new induction and follow the appropriate guidelines.

What if the patient has pain or will have surgery?
Continue their outpatient dose. Home buprenorphine can be split TID or QID to improve pain control, and additional non-opioid and opioid analgesics should be used. If the patient is on buprenorphine, receiving additional opioids will not put them at risk for precipitated withdrawal.[11]

What if a patient presents on buprenorphine but is in pain?
You can increase the dose of buprenorphine for a short period to control pain. Due to strong binding affinity, most opioids will not work as well. Fentanyl has similar binding affinity as buprenorphine, so if parenteral opioid is needed this can be used. It is important to coordinate with the current prescriber of buprenorphine for discharge pain management.

How should an ED discharge a patient?
Always offer a naloxone prescription or kit. Provide referral to outpatient services and peer support recovery services.

- ***Buprenorphine-waivered providers*:** discharge with RX for total dose received, daily SL tabs to cover no less than five business days for bridge to follow up.
- ***Non buprenorphine-waivered providers*:** instruct patient to return to the ED the next day and for additional days (no more than three in a row) for dispensing of buprenorphine.

Adapted from CA Bridge https://cabridge.org/resource/buprenorphine-frequently-asked-questions/

Federal regulations for prescribing buprenorphine

What licensing do I need to prescribe buprenorphine for an inpatient?
Title 21, Code of Federal Regulations, Part 1306.07(b)

72 Hour Rule

(Title 21, Code of Federal Regulations, Part 1306.07(b), allows a practitioner who is not separately registered as a narcotic treatment program or certified as a "waivered DATA 2000 physician," to administer (but not prescribe) narcotic drugs to a patient for the purpose of relieving acute withdrawal symptoms while arranging for the patient's referral for treatment, under the following conditions: 1) not more than one day's medication may be administered or given to a patient at one time 2) this treatment may not be carried out for more than 72 hours and 3) this 72 hour period cannot be renewed or extended.)

Part 1306 — Prescriptions
General Information
§1306.07 Administering or dispensing of narcotic drugs.
(a) A practitioner may administer or dispense directly (but not prescribe) a narcotic drug listed in any schedule to a narcotic dependent person for the purpose of maintenance or detoxification treatment if the practitioner meets both of the following conditions:

(1) The practitioner is separately registered with DEA as a narcotic treatment program.

(2) The practitioner is in compliance with DEA regulations regarding treatment qualifications, security, records, and unsupervised use of the drugs pursuant to the Act.

(b) Nothing in this section shall prohibit a physician who is not specifically registered to conduct a narcotic treatment program from administering (but not prescribing) narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. Not more than one day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three days and may not be renewed or extended.

(c) This section is not intended to impose any limitations on a physician or authorized hospital staff to administer or dispense narcotic drugs in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction or to administer or dispense narcotic drugs to persons with intractable pain in which no relief or cure is possible or none has been found after reasonable efforts.

(d) A practitioner may administer or dispense (including prescribe) any Schedule III, IV, or V narcotic drug approved by the Food and Drug Administration specifically for use in maintenance or detoxification treatment to a narcotic dependent person if the practitioner complies with the requirements of §1301.28 of this chapter.

Patient FAQ

What is buprenorphine?
Buprenorphine (SUBOXONE) is a medication that treats addiction to opioids such as heroin, fentanyl or prescription painkillers (like Vicodin, Oxycontin or Percocet). It's a type of medication-assisted treatment or MAT.

How does buprenorphine work?
Buprenorphine stops withdrawal symptoms and cravings by acting on the same areas of the brain as the opioids you were taking. This makes it easier for you to cut down or even stop using, so that you can focus on other activities that are important to you. Buprenorphine is an opioid, but it is NOT the same as substituting one addictive drug for another. When used properly, buprenorphine helps you feel normal, without feeling high, and does NOT create a new addiction.

How does buprenorphine help?
A person with addiction can regain a healthy, productive life. Medication-assisted treatment gives you the chance to focus on getting back to healthy living. Buprenorphine helps you get through withdrawal and cope with cravings. You can take buprenorphine for as long as needed.

Why can't I quit "cold turkey"?
Addiction cannot be cured, but it can be effectively treated. Addiction is NOT a sign of weakness. It is difficult to stop using opioids after you have become addicted because the cravings are so strong and the fear of withdrawal is so great. Chronic drug use causes changes in the brain that put people at risk of returning to use. If you are like most people, you cannot walk away from addiction on your own. People who stop using opioids are extremely likely to return to use (relapse) and are at a very high risk of overdose and death when that happens. After you stop using opioids for a period of time (weeks or even days), a much smaller amount of opioid use can cause overdose death.

How do I take buprenorphine or SUBOXONE?
- Buprenorphine usually comes as a tablet or film that dissolves under the tongue in about 10 minutes. You must let the medicine dissolve under your tongue. Do not swallow it because it will not work. You may rinse the bitter taste from your mouth only after it is fully dissolved.
- If you miss a dose: Take a dose as soon as you remember. If it is almost time for your next dose, wait until then and take a regular dose. Do not take extra medicine to make up for a missed dose or without talking with your doctor first.

Do I need to be in withdrawal before starting buprenorphine?
Buprenorphine replaces other opioids (heroin, painkillers, methadone) on the receptors in the brain. The effect of buprenorphine is not as strong as these other opioids. If you take it before you are in withdrawal, the strong effect of the other opioids will go away very quickly and put you in instant withdrawal. You may become very sick.

Why does the medicine have naloxone in it?
Buprenorphine is often combined with naloxone to help prevent abuse. Naloxone will cause people to feel withdrawal symptoms if they inject their buprenorphine. As long as the medicine is taken correctly, the naloxone does not get absorbed and has no effect.

What to expect at follow up appointments?
Your doctor may adjust your medication in order to reduce cravings. Talk with your doctor about how you are feeling and your treatment goals.

How long do I need to take buprenorphine?
Everyone is different. Many people may benefit from a long-term treatment; your treatment goal will be discussed with your provider. There is no medical reason for you to stop taking buprenorphine as long as it is helping you.

What if I return to using?
Be honest. Talk with your health care provider. Never use alone. Carry naloxone and keep it handy. Don't mix drugs with other substances (alcohol, benzodiazepines or sedatives). Don't share needles and always clean injection sites. Remember people who return to use are at a very high risk of overdose and death, much smaller amounts will have great affect.

Buprenorphine safety precautions
Talk to your doctor about any medical problems you have, if you are pregnant or nursing, and what medications you are taking. Ask your doctor and pharmacist any questions you may have. All medications have potential side effects. Some potential side effects of buprenorphine are constipation, nausea or vomiting, headache, sweating, mouth or tongue pain/numbness, heart palpitations, difficulty sleeping, lightheadedness and dizziness. See the medication insert from the pharmacy for additional precautions and information.

Keep your medication in its original container. Do not share your medication with anyone. Lock up your medication and keep it away from children or pets. Buprenorphine can be very dangerous to children. Keep your medication away from heat, moisture and direct light. Do not store it in your vehicle.

1. **Avoid withdrawal symptoms**
   - Don't start buprenorphine until you are in withdrawal.
   - Don't inject or "shoot-up" buprenorphine; it has naloxone in it.
   - Don't stop taking the medication suddenly.

2. **Avoid overdose and death**
   - The effect of heroin or prescription opioids will not have the same effect while you are taking this medication. Do not try to over-ride the effect by taking high doses of illicit or prescription opioids. You may overdose.
   - Do not drink a lot of alcohol, use illegal drugs, or take sedatives, tranquilizers or other drugs that slow breathing. Talk to your doctor before taking any medications, especially medications for sleep, anxiety or pain.

3. **What to do in an Emergency**
   - ***Call 911 or go to your nearest emergency department.***
   - If people notice you have slowed breathing or problems waking up, they should call 911 and tell the emergency providers that you are taking buprenorphine. They should use a naloxone rescue kit as indicated.

We know drug use is complicated, scary and has many ups and downs. If you get sick, overdose or are withdrawing from drugs, the emergency department at HSHS St. Nicholas Hospital can help anytime. We are here with walk-in care 24/7, 365 days of the year.

ED workflows

Nurse workflow

- Registrar informs nurse of patient experiencing symptoms of withdrawal
- Nurse calls recovery coach/peer support specialist
- Nurse brings patient to a private room
- Nurse takes vitals and assesses chief complaint
- Nurse initiates verbal order
- Nurse conducts COWS assessment, recorded in EPIC
- Provider enters patient room
- Patient meets with recovery coach/peer support specialist (if consents)
- Patient is prepared for discharge
- Patient is told they will receive a phone call tomorrow from nurse
- Phone number is flagged in discharge instructions
- Patient is discharged from ED
- Nurse calls the patient the next day for follow up.

Physician workflow

- Nurse has seen patient, took vitals and got chief complaint; if the patient is in withdrawal assessed with COWS score (withdrawal of at least 8)
- Provider enters patient exam room and conducts and interview with the patient (provider follows script and protocols)
- Provider assess OUD-DSAM classification and conducts a medical screening exam
- Provider orders screening labs (urine prep, urine drug, hep b/c)
- Nurse draws blood for labs
- Provider orders buprenorphine, dispensed in about 15 minutes
- Provider starts induction protocol
- Patient is assessed every 30 to 60 minutes
- Provider writes continuation buprenorphine prescription
- Recovery coach/peer support specialist makes referral/follow-up for patient
- Patient receives naloxone

Naloxone is available for purchase without a prescription at the following pharmacies in our county:

- CVS North 14th, Sheboygan
- Pick N Save 25th St., Sheboygan
- Walmart North & South, Sheboygan
- Walgreens North 14th, Business Dr., Calumet Dr. and Kohler

FREE Naloxone boxes are mounted inside:

- Lighthouse Recovery Community Center (formerly WIRCO)
- The Bridge
- Days Inn (Sheboygan Falls)
- Plymouth Police Department
- The OtherSide gift shop (Plymouth)
- Big Apple Bagels (Sheboygan)

Provider resources

Substance Abuse and Mental Health Services Administration (SAMHSA) https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/buprenorphine

https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf

https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002

Suboxone https://www.suboxone.com/

Providers Clinical Support System (PCSS) Free Online Training https://pcssnow.org/medications-for-opioid-use-disorder/

National Clinician Consultation Center https://nccc.ucsf.edu/clinical-resources/substance-use-resources/

Provided by: Physician Clinical Support System, (877) 630-8812; PCSSproject@asam.org; www.PCSSmentor.org (scores)

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

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

References

Substance Abuse and Mental Health Services Administration. Treatment Improvement Protocol Tip 63: Medications for Opioid Use Disorder for Healthcare and Addiction Professionals, Policymakers, Patients, and Families. 2020. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf

Walsh SL, Eissenberg, T. The clinical pharmacology of buprenorphine: Extrapolating from the laboratory to the clinic. Drug and Alcohol Depend. 2003 May 21;70(2 Suppl): S13-27. doi: 10.1016/s0376-8716(03)00056-5

Walsh SL, Preston KL, Stitzer ML, Cone EJ, Bigelow GE. Clinical pharmacology of buprenorphine: ceiling effects at high doses. Clin Pharmacol Ther. 1994 May;55(5): 569-580. doi: 10.1038/clpt.1994.71

Englander H, Mahoney S, Brandt K, et al. Tools to support hospital-based addiction care: Core components, values, and activities of the Improving Addiction Care Team. J Addict Med. 2019 Mar-Apr;13(2): 85-89. doi: 10.1097/ADM.0000000000000487 FAQ: Buprenorphine, September 2020 More resources available www.CABridge.org 7

Greenwald MK, Comer SD, Fiellin DA. Buprenorphine maintenance and μ-opioid receptor availability in the treatment of opioid use disorder: implications for clinical use and policy. Drug Alcohol Depend. 2014 Nov 1;0: 1–11. doi:10.1016/j.drugalcdep.2014.07.035

Chutuape MA, Jasinski DR, Fingerhood MI, Stitzer ML. One-, three-, and six-month outcomes after brief inpatient opioid detoxification. Am J Drug Alcohol Abuse. 2001 Feb;27(1): 19-44. doi: 10.1081/ada-100103117

Jones HE, O'Grady KE, Malfi D, Tuten M. Methadone maintenance vs. methadone taper during pregnancy: maternal and neonatal outcomes. Am J Addict. 2008 Sept-Oct;17(5):372–386. doi: 10.1080/10550490802266276.

Herring AA, Perrone J, Nelson LS. Managing opioid withdrawal in the emergency department with buprenorphine. Ann Emerg Med. 2019;73(5): 481-487. doi: 10.1016/j.annemergmeed.2018.11.032

PART 1306 - Section 1306.07 Administering or dispensing of narcotic drugs. Drug Enforcement Administration: Diversion Control Division website. https://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_07.htm

Haber LA, DeFries T, Martin M. Things We Do for No Reason™: Discontinuing buprenorphine when treating acute pain. J Hosp Med. 2019 Oct;14(10): 633-635. doi: 10.12788/jhm.3265

Cunningham CO, Giovanniello A, Li X, et al. A comparison of buprenorphine induction strategies: Patient-centered home-based inductions versus standard-of-care office-based inductions. J Subst Abuse Treat. 2011 Jun;40(4): 349-356. doi: 10.1016/j.jsat.2010.12.002

Lee JD, Vocci F, Fiellin DA. Unobserved "home" induction onto buprenorphine. J Addict Med. 2014 Sep-Oct;8(5): 299-308. doi: 10.1097/ADM.0000000000000059

Gunderson EW, Wang XQ, Fiellin DA, Bryan B, Levin FR. Unobserved versus observed office buprenorphine/naloxone induction: A pilot randomized clinical trial. Addictive Behaviors. 2010 May;35(5): 537-540. doi: 10.1016/j.addbeh.2010.01.001'

Jagadheesan K, Muirhead D. Possible manic potential of buprenorphine. Aust N Z J Psychiatry. 2004 Jul;38(7): 560-561. doi: 10.1111/j.1440-1614.2004.01411.x

Are there exceptions when Subutex and Suboxone may be administered by a practitioner without the DATA 2000 waiver?. The National Alliance of Advocates for Buprenorphine Treatment website. https://www.naabt.org/documents/three-day-rule.pdf

ED Initiated Buprenorphine Gail D'Onofrio, M.D., Ryan P. McCormack, M.D., and Kathryn Hawk, M.D., M.H.S. December 27, 2018, N Engl J Med 2018; 379:2487-2490, DOI: 10.1056/NEJMp1811988