U.S. Department of Veterans Affairs
Veterans Health Administration
PBM Academic Detailing Services

Emergency Department (ED) and Buprenorphine/Naloxone Treatment

Why the Emergency Department?

The ED is positioned to intervene at a critical moment in the addiction cycle.[1] Opioid use disorder (OUD) is a chronic disease, not a moral failing. Just as we stabilize and refer to outpatient care for other chronic diseases like diabetes and asthma, we have the opportunity to offer Veterans access to addiction treatment in the ED.[2]

Buprenorphine is a gold standard treatment for OUD—it saves lives.

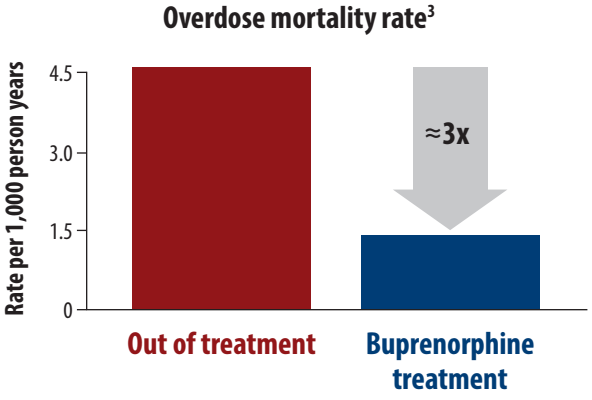
Buprenorphine decreases withdrawal and craving and helps patients engage in their treatment. Patients who receive buprenorphine are less likely to have complications related to drugs (overdose, communicable diseases, criminal justice system encounters). They live longer and are more likely to get back to work.[2]

- ED prescribers who have a DEA registration can **administer** buprenorphine in the ED for treatment of opioid withdrawal.
- All providers with an active DEA registration can **prescribe** buprenorphine to Veterans upon discharge to bridge until outpatient care is available. X-waiver registration is no longer needed. There are no additional requirements to prescribe buprenorphine, however trainings are available at: Provider Clinical Support System (PCSS), pcssnow.org/medications-for-opioid-use-disorder.

Buprenorphine is a partial agonist at the μ opioid receptor.

- High affinity (displaces full opioid agonists)
- Low intrinsic activity (less euphoria and lower diversion potential)
- Can be administered in the ED during opioid withdrawal (Clinical Opiate Withdrawal Scale [COWS] ≥ 8)

Buprenorphine dramatically lowers the risk of death.



In a meta-analysis of 122,885 patients, **buprenorphine reduced the overdose mortality rate nearly 3-fold** compared to those out of treatment.[3]

Additionally, the all cause **mortality rates were twice as high** for patients out of treatment compared to those on buprenorphine.[3]

STEP 1 Use *OUD/Opioid Dependence Buprenorphine Initiation Note*

to document Steps 2-4 below and ensure the Buprenorphine Transmucosal Products for Opioid Dependence (BTOD) check list is followed: www.accessdata.fda.gov/scripts/cder/rems/index.cfm?event=RemsDetails.page&REMS=9.

STEP 2 Determine OUD severity

DSM-5 criteria for OUD

Treatment begins > 2 symptoms; Mild-moderate: 2-5 symptoms; Severe OUD: 6 or more symptoms

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

*Per DSM-5, a disorder characterized by loss of control of opioid use, risky opioid use, impaired social functioning, tolerance, and withdrawal. Tolerance and withdrawal do not count toward the diagnosis in people experiencing these symptoms when using opioids under appropriate medical supervision.[4]

STEP 3 Assess for withdrawal

Clinical Opiate Withdrawal Scale (COWS)

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

Resting pulse rate

80 or below	81-100	101-120	> 120
0	1	2	4

Restlessness

Sits still	Difficulty sitting still	Frequently shifting limbs	Unable to sit still
0	1	3	5

Anxiety or irritability

None	Increasing	Irritable/ anxious	Cannot participate
0	1	2	4

Yawning

None	1-2 times	3 or 4 times	Several times/min
0	1	2	4

Pupil size

Normal	Possibly larger	Moderately dilated	Only rim of iris visible
0	1	2	5

Runny nose or tearing

Not present	Stuffiness/ moist eyes	Nose running/ tearing	Constant running/ tears streaming
0	1	2	4

Tremor

No tremor	Felt-not observed	Slight tremor observable	Gross tremor/ twitching
0	1	2	4

Sweating over past 1/2 hour*

No report	Subjective report	Flushed/ observable	Beads of sweat	Streaming down face
0	1	2	3	4

Gooseflesh skin

Skin is smooth	Piloerection	Prominent piloerection
0	3	5

Bone or joint pain

None	Mild	Severe	Unable to sit still due to pain
0	1	2	4

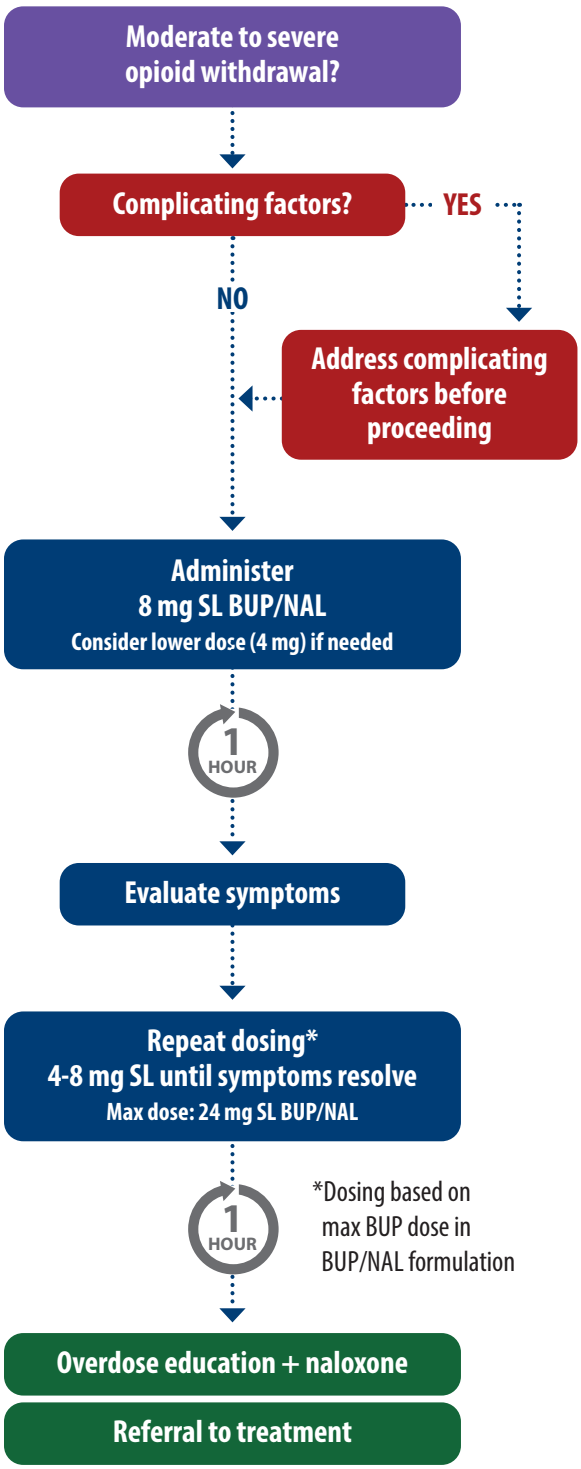
GI upset over past 1/2 hour

None	Stomach cramps	Nausea or loose stool	Vomiting or diarrhea	Multiple episodes
0	1	2	3	5

*Not due to room temperature or activity.

STEP 4 Treatment administration pathway

See content to the right for more details.



BUP/NAL = buprenorphine/naloxone;
SL = sublingual;
BUP = buprenorphine

Adapted from CA Bridge Program: Buprenorphine (Bup) Hospital Quick Start, Nov 2019

Considerations during initiation

MODERATE TO SEVERE OPIOID WITHDRAWAL

Use clinical judgment to determine moderate to severe withdrawal.

- COWS scale recommended
- If using COWS, the score should be ≥ 8
- Document: which opioid was used, time of last use
  - F11.20 Opioid Dependence, unspecified (if withdrawal symptoms are not present)
  - F11.23 Opioid Dependence with withdrawal

COMPLICATING FACTORS

Identify and manage complicating factors prior to proceeding. The only absolute contraindication is allergy to BUP/NAL. Consider consultation if needed.

- Clinical suspicion of acute liver failure
- ≥ 20 weeks pregnant
- Intoxicated/altered with substances other than opioids

DOSING CONSIDERATIONS

- Mild withdrawal, consider lower dose 4 mg
- Repeat dosing until symptoms resolve
- If symptoms have not resolved after 24 mg, consult addiction specialist

RE-EVALUATION TIME INTERVALS

Time to SL BUP/NAL onset is typically 15 minutes; peak clinical effect is typically within 1 hour.

- Re-evaluate patient 1 hour after BUP/NAL doses
- Observe for 1 hour after the final dose before discharge

REFERRAL TO TREATMENT/FOLLOW-UP OPTIONS

Arrange for urgent follow-up treatment, preferably within 3 to 7 days, and provide the Veteran with a buprenorphine prescription to bridge them until outpatient care is available. Discharge the Veteran with a written plan for follow up, such as:

- Walk-in or scheduled Substance Use Disorder (SUD) clinic*
- Other clinic (e.g., primary care, pain, etc.)

* Ideally a standardized approach should be developed with your local SUD treatment program.

DISCHARGE

- Provide opioid overdose education and naloxone
- Daily dosing is total dose given for induction (e.g., if 16 mg SL given in the ED for initiation, then patient should receive 16 mg daily for up to 1 week until definitive care is established)

VISN 19 real evidence sharepoint

- Videos of providers sharing how they got started
- Frequently asked questions
- Link to SharePoint: dvagov.sharepoint.com/sites/VHAV19Pharmacy/ADS/SitePages/Emergency-Management-of-Opioid-Use-Disorder.aspx

***Doctors Who Care, Treating Opioid Addiction in the Emergency Department*: https://youtu.be/JEx-PQTTJiQ**

#ItIsMyJob

"If someone is struggling with dependence, they may be out on the street or doing desperate things. There can be dire consequences from delaying treatment. As a psychiatrist, I see Veterans return to their jobs, their families, and become functional in society again. However, the road to recovery can be difficult to navigate and filled with stigma. I don't want to be a barrier. I want every door to be the right door to recovery."

Larissa Mooney, MD, Chief of Addiction Medicine
VA Greater Los Angeles Healthcare System

Buprenorphine care: Then and now[5]

Historically	New findings and current recommendations
Initiation of buprenorphine must be done in a medical setting.	Home initiation of buprenorphine is safe and effective.[4]
Taking a benzodiazepine and buprenorphine together is toxic.	Patients prescribed a benzodiazepine can still be candidates for OUD treatment using buprenorphine.[4,6]
If the patient relapses while on buprenorphine, it means the patient is unfit for buprenorphine-based treatment.	A return to use is not a treatment failure. It indicates the current OUD treatment strategy needs to be adjusted, reinstated, or changed in order to move toward recovery.[7,8]
Patients receiving medication treatment for OUD must participate in a 12-step program.	Medications for OUD should not be withheld if patients do not participate in psychosocial interventions.[4,8]
Drug testing can be used as a tool to discharge patients from buprenorphine treatment.	Drug testing is a tool to better support recovery and improve treatment safety.[9]
If the patient uses other substances while on buprenorphine, they should be discharged from treatment.	Buprenorphine treatment does not directly affect other substance use. Discuss risks of other substances and offer treatment as indicated.[7,8]
Buprenorphine should only be used short-term to treat OUD.	OUD often requires long-term treatment. Buprenorphine should be used as long as the patient continues to benefit.[4,8]

Chart adapted from Martin SA et al. The Next Stage of Buprenorphine Care for Opioid Use Disorder. *Ann Intern Med.* 2018 Nov 6;169(9):628-635.

REFERENCES: 1. CSAM. *Use of Buprenorphine-Naloxone in the Emergency Department.* Jan 2018. **2.** NIDA. Initiating Buprenorphine Treatment in the Emergency Department. www.drugabuse.gov. **3.** Sordo L et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ*. 2017;357:j1550. **4.** SAMSHA. *TIP 63: Medications for Opioid Use Disorder.* www.samhsa.gov. **5.** Martin SA et al. The Next Stage of Buprenorphine Care for Opioid Use Disorder. *Ann Intern Med.* 2018 Nov 6;169(9):628-635. **6.** FDA Drug Safety Communication: FDA urges caution about withholding opioid addiction medications from patients taking benzodiazepines or CNS depressants. 2017. www.fda.gov/Drugs/DrugSafety/ucm575307.htm. **7.** Kampman K, Jarvis M. American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. *J Addict Med.* 2015 Sep-Oct;9(5):358-67. **8.** The Management of Substance Abuse Disorders Work Group. *VA/DOD Clinical Practice Guideline for the Management of Substance Use Disorders.* VA/DoD. 2021; Version 4.0:1-187. **9.** Jarvis M et al. Appropriate Use of Drug Testing in Clinical Addiction Medicine. *J Addict Med.* 2017 May/Jun;11(3):163-173.