

Buprenorphine Induction from the ED
Maine Medical Center
Frequently Asked Questions

What is buprenorphine?

Buprenorphine is a unique schedule III opioid used for the treatment of acute and chronic pain, opioid withdrawal, and maintenance treatment of opioid addiction. The most common formulations are sublingual, used alone or in combination with naloxone.

Why are we doing this?

Emergency departments are on the front line of healthcare delivery. We are the medical safety net and we are where people go when they are in need. The opioid epidemic is profoundly impacting EDs, with 2018 data from the CDC indicating that there has been a 30% increase in visits for opioid overdose from 7/2016 – 9/2017. Addiction is a chronic, relapsing disease. People who present to the ED for other chronic diseases, like diabetes and asthma, are stabilized with medications and are then handed off for outpatient care. Individuals with opioid use disorder do best with a similar treatment plan.

Is this safe?

Yes. Although an opioid, adults using appropriate doses of buprenorphine are at low risk for respiratory depression. An important component of the Care Management evaluation will include discussion of the safety considerations for buprenorphine, including the risks of exposure in children. We will also discuss the risks of combining buprenorphine products with other drugs such as alcohol, other opioids, or benzodiazepines that can increase risk and result in respiratory depression or death.

Is this effective?

Early data from Yale is encouraging! A 2015 study published in the *Journal of the American Medical Association* found that twice as many patients were in treatment at 30 days (~80%) and used less illicit opioids in the last 7 days with ED-initiated buprenorphine compared with referral only or an interview and referral. There is also data showing that patients who receive buprenorphine while awaiting their follow-up use less illicit opioids than those untreated while awaiting appointment. More studies are underway to assess efficacy and the best ways to utilize buprenorphine in the ED.

Aren't we just replacing one drug for another?

It's not that simple. Buprenorphine treatment decreases withdrawal and craving. Patients who receive buprenorphine are less likely to experience overdose or death, to use illicit opioids, or to transmit Hepatitis C virus or HIV. They also have fewer injection drug use complications and contacts with the criminal justice system. They have a better chance to have a more functional, positive life. This is very different from illicit use of opioids.

Can't someone just keep coming back to get buprenorphine from the ED?

We are taking precautions to minimize the risk that this occurs. Part of the Care Management assessment includes checking the PMP for prescriptions for buprenorphine within the last 30 days. In addition, as we will have an electronic record documenting the encounter, there is minimal risk that patients will have multiple visits for buprenorphine induction within the MaineHealth system.

What are the contraindications to treatment with buprenorphine in the emergency department?

There are few contraindications to the use of buprenorphine in the ED. The primary contraindication is the presence of methadone in the urine. This is because giving buprenorphine in the presence of methadone can cause precipitated withdrawal, making the patient feel worse. Another contraindication is the use of buprenorphine for pain. These patients will need to follow-up with own provider for further care.

Active psychosis, suicidal or homicidal ideation are all contraindications for ED-initiated buprenorphine.

A possible contraindication would be concern for significant, concomitant alcohol or benzodiazepine use disorder as these may increase the risk of respiratory depression or death. This will be at the discretion of the treating provider.

Pregnancy is not a contraindication for buprenorphine induction and we would encourage pregnant women to engage in treatment for both their own health and the health of their unborn child.

How is someone identified as possibly benefiting from buprenorphine?

There are many ways that a patient can be identified. Someone may self-present specifically for concerns relating to withdrawal. Also, there are certain medical presentations that may trigger us to be concerned about substance use disorder (abscess, etc.).

Anyone (Nursing, Care Management, Providers) may identify someone as a possible buprenorphine patient. The provider taking care of the patient should be notified to start the process.

What is the process for initiating buprenorphine from the ED?

Once the provider has been notified, an initial order for a Clinical Opioid Withdrawal Scale (COWS) assessment will be placed. At that time, Care Management will be consulted to begin their assessment help determine the patient's eligibility for ED induction. This will be about a 15-20 minute discussion to assess readiness for treatment, resources, substance use history, etc.

The patient will have a screening medical exam, and screening labs as needed.

If there is no contraindication and the COWS score is greater than 8, the patient will be given buprenorphine/naloxone in an effort to attenuate withdrawal to a COWS of less than 8. Once withdrawal is controlled, the patient will be discharged with a prescheduled appointment for follow-up, generally within 1 business day. If the patient presents over the weekend or on a holiday, they will be provided with a small prescription for the number of doses needed to bridge them until their appointment.

If the patient does not meet criteria for ED induction or if we are unable to control their withdrawal, they will not be given a prescription for buprenorphine; however, they will still leave with a prescheduled appointment for follow-up at a community substance use disorder provider. **Nobody will leave without at least community follow-up for rapid evaluation of their opioid use disorder.**

What if they want treatment but their COWS is less than 8?

We can observe these patients in the emergency department for an hour or two to determine whether their withdrawal symptoms worsen. Alternatively, they can be discharged if they have no other acute needs. They can be provided with a referral for prescheduled follow-up at one of our community partners or they can return to the ED the next day for reevaluation and possible induction.

Will they need a prescription for buprenorphine/naloxone at discharge? What if they have no insurance or money?

Our goal is to get everyone follow-up the next business day. This will limit the need for prescriptions; however, if someone presents on a Friday or a holiday, they will be provided with a small prescription (up to 3 days) to bridge them until their appointment.

Buprenorphine is covered by many commercial insurance plans as well as MaineCare. If it is determined that the patient has no ability to pay for the prescription, The Pharmacy at Maine Medical Center has agreed to supply the medication at no cost to the patient.

What if there is no Care Management available?

If there is no Care Management available, a provider may still, at their discretion, start induction of buprenorphine without the specific Care Management assessment. This assessment gives us valuable information about the patient's level of readiness for change, PMP history, resources, etc., as well as assistance in coordinating their outpatient appointment.

We recommend that patients remain in the department to participate in the Care Management process. It is important to explain that findings of the Care Management evaluation will help to determine whether or not the patient meets criteria for ED induction and receipt of a buprenorphine prescription.

Can all providers administer and/or prescribe buprenorphine in the ED?

Any provider can and order and have buprenorphine administered in the ED whether an APP, resident, or attending. There does not need to be a waived provider to initiate buprenorphine

induction from the ED. Patients can be given buprenorphine to decrease their withdrawal while in the ED for up to 3 days (72 Hour Rule). Because of our agreement with our community partners to see our patients as soon as possible (hopefully one business day), there will be many cases that will not require an outpatient prescription for buprenorphine.

An **X-waver** is an addition to a provider's DEA license that allows for **prescribing** of buprenorphine for the treatment of opioid use disorder. If we do an induction on a Friday or holiday and a patient needs an outpatient prescription, there needs to be an X-waivered provider to write that script.

What if there is no waived provider in the department?

Currently more than 60% of our attending physician providers are waived to be able to write prescriptions for buprenorphine! We are hopeful that more of our physicians and advanced practice providers will obtain their waivers from the DEA. If there is a rare situation that there is no X-waivered provider in the department, the patient can be brought back to the ED for up to 3 days to administer a dose of buprenorphine. Hopefully, this will require only one extra visit and either there will be an X-waivered provider available or the patient can get follow-up the following day and will not need a script.

Who will our patients follow-up with out-patient?

We have partnered with multiple community resources, all of whom have committed to seeing our patients in a timely manner, most within one business day. We anticipate that many of our patients will be referred to the South Portland Maine Behavioral Hub; however, we can also refer to Discovery House, Greater Portland Health, ENSO Recovery, and possibly others moving forward.

Will they need to return to our ED for medication if they come in on a Friday?

No. If we are able to control their withdrawal, an X-waivered provider can give them a prescription for up to 3 days, bridging the patient until they are able to be seen.

What if the patient is pregnant?

Pregnancy is not a contraindication to treatment with buprenorphine! Quite the contrary, pregnant women with substance use disorder should be encouraged to engage in treatment to decrease the possibility of adverse events for themselves and their unborn child. Everything is the same as it is for non-pregnant patients except that we provide ED induction with buprenorphine monotherapy, rather than buprenorphine/naloxone in combination.

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 Clinical Opioid Withdrawal Scale (COWS) and treat according to withdrawal severity. Remember to always ask about and test for methadone exposure, and if the individual has methadone in their system, we will not proceed with ED induction. Some patients may be good candidates for unobserved home induction, if they are ready for treatment and are adequately supported.

Is there a risk of diversion with prescribing buprenorphine in the ED?

Yes. Buprenorphine is bought and sold on the street routinely; however, diverted buprenorphine is generally used for its intended purpose – avoiding dope-sickness and cravings. People who have used “street” buprenorphine have longer retention times in treatment, perhaps because they have experienced what buprenorphine does to increase stability and therefore are even more motivated when it comes to treatment. We will try to limit this with PMP, chart review, and discussion.

What if I have any questions?

You are encouraged to ask questions! Reach out to Tammi Schaeffer (tschaeffer@mmc.org, 662-7222) or Matt Glazer (mglazer@mmc.org, 662-1859) with any questions, concerns, or comments.

We are proud of Maine Medical Center and MaineHealth for their commitment to patients with opioid use disorder. We believe that this important program has the potential to save lives and improve quality of life for many in our community and we are pleased to partner with you in this effort!