Medication for Opioid Use Disorder in the Emergency Department (MOUD in the ED)

Implementation Toolkit

March 2023

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Introduction

With support from Maine DHHS, the Maine Medical Association Center for Quality Improvement (MMA-CQI) has worked with clinical experts to create the "Rapid Induction Starting in the ED" (RISE) project to provide education and assistance on best practices for initiating buprenorphine in hospital Emergency Departments (EDs) for individuals with opioid use disorder (OUD) who are interested in engaging in treatment.

This toolkit provides training materials, recommended protocols, and resources to EDs interested in implementing an opioid use disorder treatment program focusing on initiating buprenorphine. The use of the term buprenorphine in this document is referencing the buprenorphine/naloxone combination product unless specified otherwise.

MAT in the ED Toolkit Team

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Acronym List

Acronym	Phrases, Words, etc.
ED	Emergency Department
DEA	Drug Enforcement Administration
MOUD	Medication for Opioid Use Disorder
RISE	Rapid Induction Starting in the ED
SUD/OUD	Substance Use Disorder/Opioid Use Disorder
EMR	Electronic Medical Record
COWS	Clinical Opioid Withdrawal Scale

Implementing an ED Program

A complete ED Program to address opioid use disorder (OUD) is required to not only reduce the risk of acquiring the disorder but also to treat the patient in a clinically appropriate way. The following is a checklist of recommended guidelines that each ED should consider. The remainder of this document focuses on initiation of medication for opioid use disorder (MOUD).

Four Pillars of an ED Program

Decrease Opioid Prescribing	Alternatives to Opioids	Risk Reduction	Treatment of Addiction
• ED guidelines for discharged patients that meet regulatory requirements and best practices • ED Guidelines around filling lost or stolen opioid prescriptions • Tracking clinician prescribing practices	• Non-opioid management of acute and chronic pain guidelines (pharmacologic and non-pharmacologic)	• Guidelines for dispensing and prescribing Narcan • Patient education to decrease the risk of complications of ongoing opioid use	• MOUD initiation protocols • Compassionate treatment guidelines for those not involved with MOUD • Referral systems

Readiness Checklist

- Availability of buprenorphine and naloxone kits in ED (Pyxis)
- Create order sets for streamlined care
    - Buprenorphine initiation orders, medication orders including buprenorphine, naloxone kits, and comfort medications
- All providers can now prescribe buprenorphine upon discharge (the DEA DATA 2000 X-waiver is no longer required)
    - Providers/hospitals may also choose to email the DEA for permission to dispense 3 days of buprenorphine at discharge
- Assure appropriate billing procedures with hospital/ED billing department
- Provider and nursing education
- Define role of crisis services/case management/social work/peer support
- Development of discharge instructions
- Identify outpatient follow-up services and agreed upon warm hand off procedures

Tracking Measures to Consider

- Cases in which buprenorphine was administered/dispensed/prescribed, and patient was referred to recovery center or MOUD prescriber
- Number of patients attending first recovery center or MOUD prescriber appointment
    - Denominator: Number of patients started on buprenorphine in the ED
- Number of patients in treatment 30 days after buprenorphine induction in the ED
    - Denominator: Number of patients started on buprenorphine in the ED

Sample Planning Process

- Monthly team planning meetings
- Concept introduced to the ED team
- Drafts of protocols refined over time
- ED provider and nursing education
- Program rollout
- Quarterly team process review meetings

Regulatory FAQs: How can ED clinicians provide MOUD in the ED?

There are three possible options: PRESCRIBING, DISPENSING and ADMINSTERTING

PRESCRIBING OPTION

- As part of the Consolidated Appropriations Act of 2023, Congress eliminated the DATA-Waiver Program. Any provider able to prescribe Schedule III medications can now prescribe buprenorphine. There are no limits/caps on the number of patients a prescriber may treat for OUD with buprenorphine. ***Prescribing is the simplest way to continue patients on buprenorphine following ED discharge and it is the recommended clinical pathway.*** In Maine, Chapter 488 still requires providers to include the diagnosis and exemption code on buprenorphine prescriptions (i.e., F11.20 OUD, Exemption D, Chronic).

DISPENSE OPTION

- In accordance with 21 CFR 1307.03, a DEA-registered provider working in a hospital, clinic, or ED, or any DEA-registered hospital/clinic that allows providers to operate under their registration number as per 21 CFR 1301.22(c), *may request an exception to the one-day supply* limitation currently imposed pursuant to 21 CFR 1306.07(b). Consistent with Pub. L. 116-215, the DEA will grant such requests to allow a provider to dispense up to a three-day supply of the medication under the circumstances described in subsection 1306.07(b). *Requests for exception must be emailed to: ODLP@dea.gov. Please add the following to the subject line: Request for Exception to Limitations on Dispensing for OUD.* This may be the simplest way to provide buprenorphine to a patient unable to get to a pharmacy and/or after hours when the pharmacy might be closed.

ADMINISTER IN ED OPTION (i.e., "THE 72 HOUR RULE")

- Emergency Departments can also ADMINISTER buprenorphine for up to 72 hours after the patient's initial visit to the ED for buprenorphine initiation. This allows patients to return to the ED for subsequent dosing of buprenorphine after being seen by a provider. ***This is no longer a recommended pathway as it is creates significant barriers for patients and is labor intensive for hospital staff***.

Using Buprenorphine

Buprenorphine Formulations

- Buprenorphine/Naloxone Tablets
- Buprenorphine/Naloxone Films
- Buprenorphine Tablets

Common Side Effects

- Dizziness, drowsiness, blurred vision, trouble concentrating
- Withdrawal symptoms (if opioids are in an individual's system)
- Tongue pain, redness, or numbness inside your mouth
- Nausea, vomiting, constipation
- Headache, back pain
- Fast or pounding heartbeats, increased sweating
- Sleep problems (insomnia)

Effects of Buprenorphine

- Decreases craving for drugs
- Prevents opioid withdrawal symptoms
- Less likely to cause respiratory suppression in overdose than other opioids

Tips for Sublingual Use of Buprenorphine

There is a specific approach to sublingual administration that will improve absorption of buprenorphine. Below are some tips you can provide to your patients when taking sublingual buprenorphine. Advise patients that:

Each buprenorphine tablet or film will take some time to dissolve under their tongue, but the film dissolves more quickly than tablets.

- The mean time for tablets to fully dissolve is 7 to 12.4 minutes; the mean time for the film to dissolve is 5 to 6.6 minutes.
- Patients should grasp the film by the edges and place it under their tongue at the base, just to the side of the center.
- While the medication is dissolving, they should not talk, drink, or swallow.
- While the tablet is dissolving, they will salivate a lot, so they may need to tilt their heads forward to avoid swallowing the saliva.
- Suggest patients rinse their mouth or eat a mint before taking buprenorphine to help with the taste.
- To improve absorption, have patient avoid smoking 15 minutes before and after taking buprenorphine.

Sublingual Administration

Recommended Protocols

Sample Guidelines

Please see companion guide for a site-specific example

1. Patient at risk of accidental overdose as evidenced by patient history of daily opioid use despite harmful consequences or presentation after naloxone reversal following opioid overdose
2. No evidence of alcohol intoxication or withdrawal
3. Lack of medical or psychiatric condition that indicates need for inpatient admission
4. Patient understands the following:
    a. Buprenorphine is a partial opioid agonist that helps with cravings and withdrawal. Once started, it should not be discontinued abruptly, or withdrawal will occur. It is risky to use buprenorphine if the patient is misusing alcohol or benzodiazepines as this may lead to respiratory suppression and/or death.
    b. Follow up at an outpatient treatment program is necessary for continued buprenorphine treatment and an individualized treatment plan will be developed
    c. ED buprenorphine induction is not a guarantee of continued buprenorphine treatment at the outpatient treatment program
5. Initiate order set for induction
    a. Labs: Consider urine drug screen (UDS) and urine pregnancy test. Be aware that the absence of opioids/oxycodone on UDS is common as fentanyl is not detected by most ED UDS. Providers can include other basic labs if requested by the outpatient treatment program (i.e., hepatitis panel, HIV, LFTs).
    b. Consult to crisis services/case management/social work/peer support
    c. Nursing orders for COWS score

*Pregnancy is not a contraindication to buprenorphine induction. You may receive a flag cautioning against the use of buprenorphine in pregnancy. It is safe to proceed as the benefits outweigh the risks. The buprenorphine/naloxone combination product (or the buprenorphine monoproduct) can be used in pregnancy.

*If the patient's age is under 18, a specific pathway should be developed to ensure appropriate follow up and treatment. Adolescents and young adults are at risk of opioid overdose and death; therefore, age should not be a contraindication for initiating treatment.

ED Induction Guidelines

Please see companion guide for site specific example

1. Offer patient a peer recovery coach if available (or enter referral for outpatient follow up)
2. Calculate COWS score
    - If COWS greater than 12 with one objective sign of withdrawal (tachycardia, mydriasis, tearing, yawning, sweating, diarrhea), proceed to #3.
    - If these criteria are not met, patient is not in adequate level of withdrawal necessary to induce onto buprenorphine. Consider a "home Induction" (using the guideline below) after either dispensing (if approved) or writing a prescription for buprenorphine (a DEA X-waiver is no longer required). See #5 for more information. Alternatively, the patient can be observed until an adequate COWS score is reached to begin induction.
3. Order buprenorphine 8 mg sublingual. The buprenorphine/naloxone combination product can be used. The nurse should educate the patient regarding sublingual administration as the medication should not be swallowed.
4. Observe the patient for 60 minutes. If the patient's symptoms have improved and the patient is comfortable, proceed to #5 and #6. If the patient is not improving or worsening, proceed to #7.
5. Initiate discharge plan which may include:
    - Prescription for buprenorphine/naloxone 16 mg daily sublingual for up to 7 days (a DEA X-waiver is no longer required to prescribe buprenorphine). As prescribing buprenorphine is now simpler, having the patient return to the ED for daily administration of buprenorphine is no longer a recommended pathway.
    - Dispensing of buprenorphine/naloxone 16 mg daily sublingual up to 3 days of medication (if provider has been granted DEA permission – see page 5).
    - Patient follow up instructions should include clear plan (ideally with an appointment time/day at an outpatient treatment program but may also include how the patient should contact the treatment program or when the patient will be contacted for appointment time). Patient should also be given a number to call if they have questions related to their ED visit.
6. Discharge with a dispensed naloxone kit.
7. If, after the initial dose of buprenorphine, the COWS score is increasing, this may represent worsening or precipitated withdrawal. Administer adjuvant medications as needed and continue administering buprenorphine 8 mg sublingual every hour up to 24 mg. If, after up to 24 mg is administered, the COWS score improves and the patient is stable, proceed to step #5 and #6. If, after administering the maximum dosing of up to 24 mg, the COWS score is worsening, consult an addiction medicine specialist and/or request patient admission to hospital.

Home Induction Guideline

If the patient presents to the ED and has used opioids in the last 12 hours, they will likely not be an ideal candidate for ED induction without a long period of observation. Consider discharge home with one of the follow plans:

1. A prescription can be written for buprenorphine/naloxone 16 mg daily for up to 7 days (as a DEA X-waiver is no longer required). The patient should be provided with the following home induction instructions.
2. Alternatively, up to 3 days of buprenorphine/naloxone 16 mg daily can be dispensed to the patient if the DEA has granted the provider/hospital permission to do so (see page 5). The patient should be provided with the following home induction instructions.

If patients are prescribed/dispensed buprenorphine/naloxone, it is critical that they are discharged with clear instructions for follow up at an outpatient treatment program, a phone number to call with questions, referral to a peer recovery coach and with a naloxone kit dispensed.

Subjective Opiate Withdrawal Scale

Today's date: _____

These are some symptoms that you may be feeling after you stop using opioids. For each symptom, circle the number that best represents how you are feeling. Then, add up the numbers.

Symptom	Not at All	A Little	Moderately	Quite a Bit	Extremely
I feel anxious	0	1	2	3	4
I feel like yawning	0	1	2	3	4
I am perspiring	0	1	2	3	4
My eyes are tearing	0	1	2	3	4
My nose is running	0	1	2	3	4
I have goosebumps	0	1	2	3	4
I am shaking	0	1	2	3	4
I have hot flashes	0	1	2	3	4
I have cold flashes	0	1	2	3	4
My bones and muscles ache	0	1	2	3	4
I feel restless	0	1	2	3	4
I feel nauseous	0	1	2	3	4
I feel like vomiting	0	1	2	3	4
My muscles twitch	0	1	2	3	4
I have stomach cramps	0	1	2	3	4
I feel like using now	0	1	2	3	4
Total					

Add each column up in the bottom row that says total. Then, add these numbers together for your withdrawal score. Your score should be over 17 before you start buprenorphine.

Mild withdrawal: score of 1-10

Moderate withdrawal: 11-20

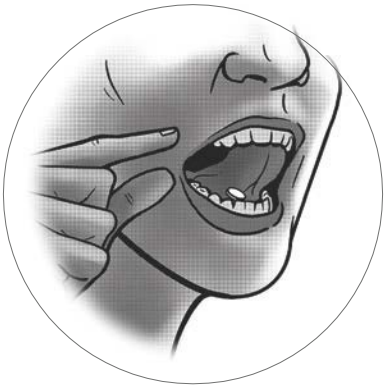
Severe withdrawal: 21-30

If you have questions about your score or symptoms, please contact your prescriber.

Source: *Handelsman L, Cochrane KJ, Aronson MJ, Ness R, Rubinstein KJ, Kanof PD. Two New Rating Scales for Opiate Withdrawal. 1987. American Journal of Alcohol Abuse 13, 293-308.*

How to Start Your Buprenorphine Treatment at Home

Buprenorphine treatment is a safe and effective way to stop using opioids. This guide will help you start taking buprenorphine at home. Your treatment will be more successful if you prepare and make a plan.



Before starting your buprenorphine treatment

You will need to stop using opioids before you start taking buprenorphine. Stopping will make starting treatment easier. You will have opioid withdrawal symptoms when you stop. Buprenorphine will help with this.

- Stop using heroin/fentanyl/methadone at least 48 hours before your first dose of buprenorphine.
  - » For example: Stop mid-day on Thursday if you are starting buprenorphine on Saturday.
- Before you start buprenorphine, review the Subjective Opioid Withdrawal Scale (SOWS) on the back. Your SOWS score should be over 17 before starting buprenorphine. You will feel lousy, like you have the flu.
- Use caution if you recently used alcohol or benzodiazepines as it can be unsafe to take buprenorphine at the same time.

If you have questions about your score or symptoms, please contact your prescriber.

Record the amounts and times you take buprenorphine each day in the tables provided.

Continued

Day 1

Buprenorphine comes in 8 mg tablets or films (“strips”). You can use scissors or a pill splitter to divide the medication.

1. Start by taking 4 mg, or half of an 8 mg tablet or strip, by placing it under your tongue (see the picture at the top of the first page for an example). Let it fully dissolve under the tongue. Do not swallow it. It does not work if it is swallowed.

2. Wait one hour.

If starting buprenorphine makes you feel much worse than you did before you took the medication: Call your prescriber’s office.

If you feel better: Do not take more buprenorphine today.
If you do not feel better: If you still have withdrawal such as hot or cold flashes, “creepy crawly” skin, or muscle aches, follow these instructions:

3. Take another 4 mg by placing it under your tongue and waiting for it to dissolve.

4. Wait 1-2 hours.

If you feel better after the second dose: Do not take more buprenorphine today.

If you do not feel better after the second dose: Repeat steps 3 and 4.

Do not take more than 12 mg (3 doses) on the first day.

Record the amounts and times you took buprenorphine on Day 1 here. Fill in the chart for 2nd or 3rd dose only if you needed to take it.

Day 1 Dose Summary

Dose	Amount	Time
1st dose	4 mg	
2nd dose	4 mg	
3rd dose	4 mg	
Total mg on Day 1		

2

Day 2

Record your total buprenorphine dose on Day 1 (yesterday) here:_____mg

1. Take your total dose from Day 1 as a single dose first thing in the morning.

- For example: If you took a total of 8 mg on Day 1, take 8 mg as one dose first thing in the morning.

2. Wait 1-2 hours

If you feel better: Do not take more buprenorphine today.

If you do not feel better: If you still have withdrawal symptoms such as hot or cold flashes, "creepy crawly" skin, anxiousness, or muscle aches, follow the instructions below:

3. Take another 4 mg by placing it under your tongue and waiting for it to dissolve.

4. Wait 1-2 hours.

If you feel better: Do not take more buprenorphine today.

If you do not feel better: Repeat steps 3 and 4.

Do not take more than 16 mg on Day 2.

Record the amounts and times you took buprenorphine on Day 2 here. Fill in the chart for 2nd and 3rd dose only if you needed to take it.

Day 2 Dose Summary

Dose	Amount	Time
First morning dose = Day 1 total dose	mg	
2nd dose	4 mg	
3rd dose	4 mg	
Total mg on Day 2		

Day 3 and beyond

Record your total buprenorphine dose on Day 2 (yesterday) here:_____mg

1. Take your total dose from Day 2 as a single dose first thing in the morning.
   - For example: If you took a total of 12 mg on Day 2, take a 12 mg dose first thing in the morning for Day 3.

If you feel like you still have withdrawal or that maybe you took too much medication, call your prescriber's office.

Continued

What Is Stigma and Where Does It Come From?

Stigma can be:

Stigma can also present in various ways when we are referring to OUD/SUD. There can be institutional stigma, social stigma and self-stigma.

Institutional Stigma	• Doctors have not listened to me • Pharmacists look at me suspiciously
Social Stigma	• My family looks down on me • My AA sponsor says I'm not really sober if I am on MOUD
Self Stigma	• I struggle with people offering me help. I still think that I'm not worthy of it - Graham • Once we start something good, we feel guilty because we feel like we don't deserve it - Diane

Training on stigma, bias, and language is a critical component of successful implementation. ED teams are strongly encouraged to include training and competencies for these crucial domains for improved care and outcomes. Sustainability of this work is best when providers, nursing, registration, and security are included.

It's sometimes helpful to picture how stigma could present if we use the example of diabetes, another chronic condition. Would we say or imply things like:

- **Elevated blood glucose makes blood "dirty"?**
- **Plan to treat with insulin for only 2 years, then insist on changing lifestyle enough to taper off?**
- **Discharge patients from treatment if they choose to eat poorly or persistently have high blood sugar?**
- **Or decline to treat at all?**

OPTIONS Rack Card

The Overdose Prevention Through Intensive Outreach Naloxone and Safety (OPTIONS) initiative is a coordinated effort of the Maine Office of Behavioral Health and other state agencies to improve the health of Mainers using substances through harm reduction strategies, helping them on the road to recovery, and dramatically reducing the number of fatal and non-fatal drug overdoses. For more information on the OPTIONS program visit https://knowyouroptions.me/

Contact Information

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