Emergency Department Opioid Misuse Treatment Map

in withdrawal
desires treatment for opioid addiction

see emupdates.com/help for complete initiation pathway
exclusions from ED buprenorphine initiation
on methadone or extended-release opioids
on high dose (usually prescribed) opioids
very intoxicated (with other substances)
buprenorphine allergy

verifying adequate withdrawal is crucial
if inadequate withdrawal, buprenorphine will precipitate withdrawal
mdcalc.com/cows or your favorite resource
COWS should be ≥ 8, the higher the better

you do not need to be waivered to treat withdrawal with buprenorphine in the ED

buprenorphine 4-8 mg sublingual
the higher the COWS, the larger the bup dose
if unsure of withdrawal symptoms or borderline COWS, dose 2 mg q1h

observe in ED for 30-60 minutes
provide sandwich

optional testing during buprenorphine initiation
HCG, urine tox, BAL, LFTs, Hep C, HIV

unless patient will certainly get bup within 24h
second dose of bup: 8-24 mg

if waivered doc present, can d/c with prescription

advise on dangers of etoh/benzo use while on bup

refer to outpatient addiction care
the smaller the ED buprenorphine dose, the tighter the followup has to be, esp if no Rx
if administered or Rx bup, must dx OUD and document f/u plan

in withdrawal
does not desire treatment

consider buprenorphine anyway
alternative: methadone 10 mg IM or 20 mg PO
non-opioids much less effective, do not address cravings:
clonidine, NSAID, antiemetic, antidiarrheal, haloperidol, ketamine

refer to MAT clinic

harm reduction (see box)

not in withdrawal
desires treatment for opioid addiction

if waivered doc present, can prescribe buprenorphine for home initiation
emupdates.com/help for home initiation handout

alternatives: return to ED when withdrawing or hold in ED to await withdrawal

refer to MAT Clinic

Detox Is Dangerous
abstinence-based treatment is ineffective for most OUD patients, almost all relapse and relapse is very dangerous. Strongly encourage MAT, even though many patients/families/providers ask for rehab

Harm Reduction for all opioid misusers

Discuss overdose risk reduction strategies
Explain how to recognize and respond to overdose
Offer to screen for HIV, Hep C, pregnancy
Assess for shelter & food insecurity, comorbid medical & psychiatric dz

all patients at high risk for OD should receive take home naloxone
high risk: daily use of ≥90 MMEs, opioid therapy > 3 months, current or past opioid misuse
very high risk: ↓ tolerance (just incarcerated, detoxed), prior OD, concurrent use of BZD/alcohol

if IVDU, refer to local needle exchange and encourage safe injection practices
Do you lick your needles?
Do you cut your heroin with sterile water?
Do you discard your cotton after every use?
Do you inject with other people around?
Do you do a tester shot to make sure a new batch isn't too strong?

open door policy: if unwilling to be treated for addiction now, come back anytime, we're here 24/7

buprenorphine Rx

buprenorphine/naloxone 8/2 mg sublingual tabs
1 tab SL bid–dispense 14 tabs
bup patient info handout at emupdates.com/help

alternatively, **patient can return to ED** while awaiting followup: on days 2 and 3 dose 16 mg SL
x-waiver not required to dose in ED on days 2&3
however cannot continue beyond 3 days by law

not in withdrawal
does not desire treatment

engage, encourage
to move to treatment

refer to addiction care