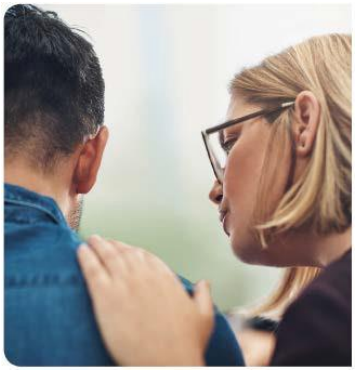
Buprenorphine/Naloxone (Bup-Nal) Initiation in Emergency Departments in Alberta

# A Brief Guide for Emergency Department Physicians, Nurses & Staff

version 2.2 July 2021

## Why the Emergency Department (ED)?

### Because that's where the patients are!



The opioid crisis is strongly impacting EDs. There has been a 58% increase in the rate of ED visits related to opioid use and substance misuse from Jan 1, 2015 to March 31, 2018. Furthermore, 13% of those who had accidental deaths related to fentanyl had an ED visit related to opioid/substances of misuse within 30 days before death.[i]

Addiction is a chronic, relapsing disease that is strongly stigmatized. **It is NOT a moral failing**. People who present to the ED for other chronic diseases like diabetes and asthma are stabilized with medications and handed off for outpatient care. Individuals who live with opioid use disorder (OUD) do best with a similar treatment plan.

## What do I need to know about buprenorphine?

### It is NOT simply replacing one drug with another.

Buprenorphine treatment decreases withdrawal and cravings. Patients who receive buprenorphine are less likely to overdose, die, use illicit opioids, spread HCV or

## Responding to the Opioid Crisis

Opioid-related ED visits are escalating and emergency physicians, nurses, and staff are finding themselves on the front lines, with little preparation or tools to combat this crisis.

### What can you do?

**Prescribe opioids safely**

- Identify patients receiving high doses of opioids
- Use prescription monitoring systems
- Avoid drug combinations that might increase OD risk, especially benzodiazepines

**Increase access to medication treatments**

- Initiate bup-nal and referral

**Offer harm reduction strategies**

- Overdose prevention education and training
- Distribute take home naloxone (Narcan®) kits

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HIV and have fewer injection drug use complications and contacts with the criminal justice system.[ii]

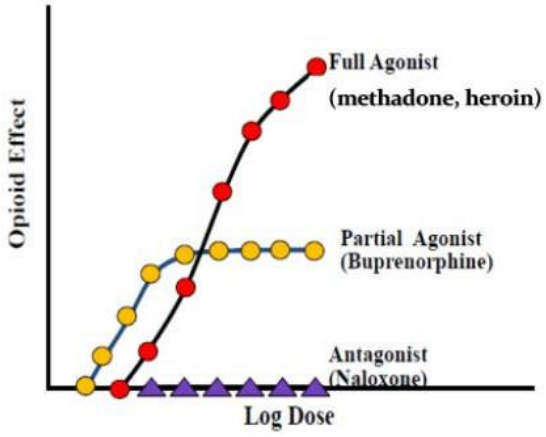
Effective July 15, 2019, CPSA has moved buprenorphine/naloxone products from Type 1 to Type 2 Triplicate Prescription Program (TPP) Alberta status. This means registration with TPP Alberta and use of a secure TPP prescription pad are no longer required when writing prescriptions for them. Further info is available on the CPSA website.

Buprenorphine is a partial agonist at the *mu* opioid receptor, where it has a very high affinity but low intrinsic activity. Its high affinity means it will out-compete and displace full opioid agonists. It is administered when the patient exhibits withdrawal symptoms (Clinical Opiate Withdrawal Scale [COWS] ≥ 12). The low intrinsic activity results in less euphoria and lower diversion potential.

## What is the evidence?

A 2015 study (Journal of the American Medical Association) found that twice as many patients were in OUD treatment at 30 days (~80%) with ED-initiated buprenorphine and a brief negotiation interview (BNI) compared with referral only or a BNI plus facilitated referral. The ED-initiated group also had used less opioids in the last 7 days.[iii]

## How does it work?



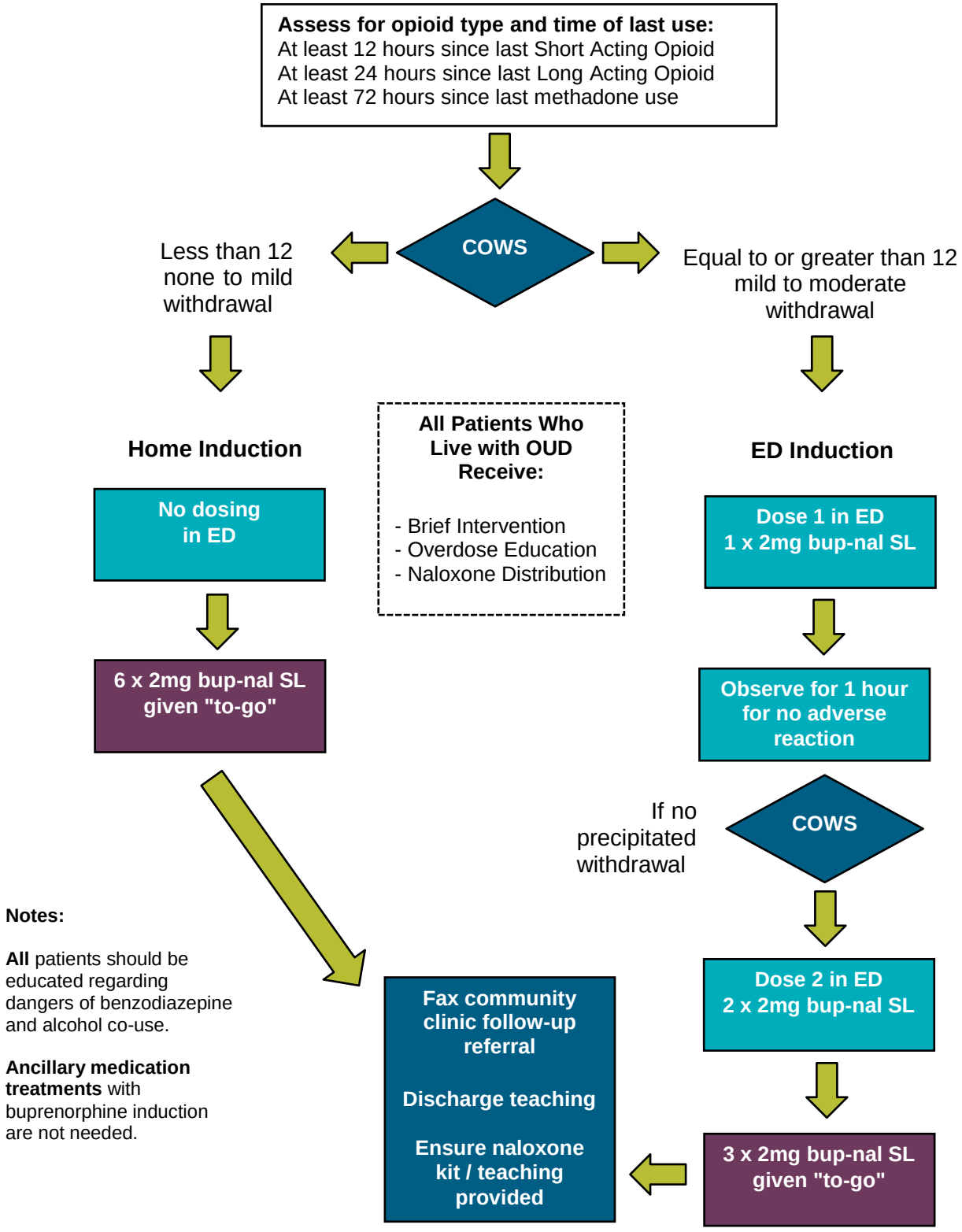

## Comments or questions?

emergency.scn@ahs.ca

**Reference for Left:** The National Alliance of Advocates for Buprenorphine Treatment. Thorough Technical Explanation of Buprenorphine. Retrieved from: https://www.naabt.org/education/technical_explanation_buprenorphine.cfm.

This ED program does not provide definitive care for patients who live with OUD. Rather, it is an opportunity to identify patients who live with OUD, provide harm reduction teaching, and for eligible candidates, initiate bup-nal medication combined with a rapid and effective follow-up in the community for titration and continued patient care.

# How to Start Bup-Nal in the ED (OUD Confirmed)




**Notes:**

**All** patients should be educated regarding dangers of benzodiazepine and alcohol co-use.

**Ancillary medication treatments** with buprenorphine induction are not needed.

# Tools & Assessments

## How do you assess for OUD?

**Questions for Identification of Opioid Use Disorder Based on DSM-5** (American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders: DSM- 5. 5th ed. Arlington, WA: American Psychiatric Publishing, Inc.)

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

Loss of Control

**Moderate Opioid Use Disorder: 4-5 symptoms, Severe Opioid Use Disorder: 6 or more symptoms**

## How do I motivate ED patients who live with OUD to accept treatment?

Some patients who live with OUD may not be ready for or interested in medication such as bup-nal. Harm reduction teaching and referrals to community clinics can still be provided.

**Step 1. Raise the Subject/Establish Rapport**

Introduce yourself
Raise the subject of opioid use
Ask permission to discuss OUD
Assess patients subjective level of physical discomfort (i.e., withdrawal)

**Step 2. Provide Feedback**

Review patients drug use and patterns
Ask the patient about and discuss drug use and its negative consequences
Make a connection (if possible) between drug use and ED visit or any medical issues
Provide feedback on OUD diagnosis and treatment options (e.g., buprenorphine or other options, such as methadone maintenance intensive outpatient programs) and/or harm reduction strategies.

**Step 3. Enhance Motivation**

Assess readiness to change whichever of the above 3 target behaviors the patient chooses (i.e., Buprenorphine, other treatment or harm reduction)
Enhance Motivation Ask a series of open-ended questions designed to evoke “Change Talk” (or motivational statements) about their target behavior.
Reflect or reiterate the patient’s motivational statements regarding entering treatment.

**Step 4. Negotiate & Advise**

Negotiate goal regarding the target behavior
Give advice
Complete a referral/treatment or goal agreement, and secure and provide the actual referral for treatment (buprenorphine or other)

**View video example**

**Reference**

## How do you assess for withdrawal?

**Clinical Opioid Withdrawal Scale (COWS).**

| Patient's Last Name | Patient's First Name | Date *(yyyy-Mon-dd)* | Time *(24hrs)* |
|---|---|---|---|
| Reason for this assessment | | | |

| | |
|---|---|
| **Resting Pulse Rate**: _____beats/minute<br>*Measured after patient is sitting or lying for one minute*<br>☐ 0 pulse rate 80 or below<br>☐ 1 pulse rate 81 - 100<br>☐ 2 pulse rate 101 - 120<br>☐ 4 pulse rate greater than 120 | **GI Upset**: *over last 1/2 hour*<br>☐ 0 no GI symptoms<br>☐ 1 stomach cramps<br>☐ 2 nausea or loose stool<br>☐ 3 vomiting or diarrhea<br>☐ 5 multiple episodes of diarrhea or vomiting |
| **Sweating**: *over past 1/2 hour not accounted for by room temperature or patient activity.*<br>☐ 0 no report of chills or flushing<br>☐ 1 subjective report of chills or flushing<br>☐ 2 flushed or observable moistness on face<br>☐ 3 beads of sweat on brow or face<br>☐ 4 sweat streaming off face | **Tremor** *observation of outstretched hands*<br>☐ 0 no tremor<br>☐ 1 tremor can be felt, but not observed<br>☐ 2 slight tremor observable<br>☐ 4 gross tremor or muscle twitching |
| **Restlessness** *Observation during assessment*<br>☐ 0 able to sit still<br>☐ 1 reports difficulty sitting still, but is able to do so<br>☐ 3 frequent shifting or extraneous movements of legs/ arms<br>☐ 5 unable to sit still for more than a few seconds | **Yawning** *Observation during assessment*<br>☐ 0 no yawning<br>☐ 1 yawning once or twice during assessment<br>☐ 2 yawning three or more times during assessment<br>☐ 4 yawning several times/minute |
| **Pupil size**<br>☐ 0 pupils pinned or normal size for room light<br>☐ 1 pupils possibly larger than normal for room light<br>☐ 2 pupils moderately dilated<br>☐ 5 pupils so dilated that only the rim of the iris is visible | **Anxiety or Irritability**<br>☐ 0 none<br>☐ 1 patient reports increasing irritability or anxiousness<br>☐ 2 patient obviously irritable or anxious<br>☐ 4 patient so irritable or anxious that participation in the assessment is difficult |
| **Bone or Joint aches** *if patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*<br>☐ 0 not present<br>☐ 1 mild diffuse discomfort<br>☐ 2 patient reports severe diffuse aching of joints/muscles<br>☐ 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort | **Gooseflesh skin**<br>☐ 0 skin is smooth<br>☐ 3 piloerrection of skin can be felt or hairs standing up on arms<br>☐ 5 prominent piloerrection |
| **Runny nose or tearing** *Not accounted for by cold symptoms or allergies*<br>☐ 0 not present<br>☐ 1 nasal stuffiness or unusually moist eyes<br>☐ 2 nose running or tearing<br>☐ 4 nose constantly running or tears streaming down cheeks | Total Score _____<br>Total score is the sum of all 11 items<br><br>Initials of person completing assessment: _____ |

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

[i] Alberta Health Report. (2018) Opioids and substances of misuse, 2018 Q1. May 29, 2018, pp. 1, 15.
[ii] Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database of Systematic Reviews 2014, Issue 2. Art. No.: CD002207. DOI: 10.1002/14651858.CD002207.pub4.
[iii] D'Onofrio, G., O'Connor, P.G., Pantalon, M.V., Chawarski, M.C., Busch, S.H., Owens, P.H., Bernstein, S.L. and Fiellin, D.A., 2015. Emergency department–initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. *JAMA*, 313(16), pp.1636-1644.