METAPHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

Approach to Patients With Opioid Use Disorder in the ED

Patient presents with opioid withdrawal, overdose or complication of opioid use (skin/soft tissue infection, abscess, endocarditis)

Contact ED substance use navigator/hospital to home coordinator if available.

Offer buprenorphine. Does the patient want buprenorphine treatment?

NO
- Offer RAAM referral/harm reduction resources
- Provide naloxone kit
- Consider opioid withdrawal symptom management: clonidine 0.1mg TID

YES

SEE ED ORDER SET

Is the patient in moderate withdrawal? (COWS ≥13)

NO
- Rapid worsening of symptoms is likely precipitated withdrawal
- **DO NOT** give another dose of buprenorphine in the ED
- **DO NOT** give additional opioids
- Offer symptomatic treatment and home buprenorphine start
- Patient handouts on buprenorphine treatment
- Home start

YES

Is timing of last opioid use appropriate?
>12 hours since short-acting opioid
>18 hours since intermediate-acting opioid
>48 hours since fentanyl

NO

OPTIONS:
- ☐ Offer home buprenorphine start
- ☐ Offer microinduction buprenorphine start
- ☐ Offer return to ED when in withdrawal for buprenorphine treatment
- ☐ Patient handouts on buprenorphine treatment
- ☐ Home start
- ☐ Naloxone kit

YES

Initiate buprenorphine
- Usual starting dose 4mg
- Elderly/patients on BZDs/unsure of last opioid use 2mg

Reassess in one hour

Symptoms improved or the same?

NO

Give another 2-4 mg

YES

PATIENTS ON METHADONE SHOULD NOT BE CHANGED TO BUPRENORPHINE IN THE ED.
- Consider dosing in the ED or a bridging Rx of their usual dose as long as they have not missed more than 3 days of medication
- Confirm last dose with pharmacy
- Send discharge note to treatment provider

PRECAUTIONS
- Patients in naloxone-induced withdrawal after reversal of overdose still need to meet criteria for time from last opioid use to avoid precipitated withdrawal.

CONTRAINDICATIONS
- Allergy or hypersensitivity to buprenorphine or naloxone
- Decreased level of consciousness
- Patient unable to provide informed consent
- Severe liver dysfunction
- Acute intoxication
- Acute severe respiratory distress

- Patients can be monitored and re-dosed in the ED OR discharged with tablets or Rx to maximum 16mg for Day 1
- Write a prescription for daily observed doses (maximum 16mg/day) until planned follow up (max 7 days)
- Dispense naloxone kit, buprenorphine handout, and harm reduction info sheet

SEE BUPRENORPHINE REFERENCE GUIDE FOR FURTHER INFORMATION