NORTH CAROLINA
HEALTHCARE FOUNDATION

EMERGENCY DEPARTMENT
Buprenorphine Treatment

> A Toolkit for North Carolina Hospitals

Emergency Department Buprenorphine Treatment

A Toolkit for North Carolina Hospitals

North Carolina, like many other states, is in an overdose epidemic historically driven by prescription opioids and, in more recent years driven by heroin, fentanyl, and fentanyl analogues. This crisis has been further exacerbated by the devastating effects of the COVID-19 pandemic on health systems and communities. From 2000-2020, more than 28,000 North Carolinians lost their lives to drug overdose, and in 2021 alone there were 4,041 overdose deaths—the highest number in a single year on record in the state.[1] Additionally, overdose Emergency Department (ED) visits have increased nearly 58% since 2016, reaching 16,937 in 2022.[2]

An emergency department (ED) visit is a critical point where patients with an opioid use disorder can be introduced to life-saving treatments that serve as a gateway to recovery. Medication assisted treatment (MAT),[3] including opioid agonist (such as methadone) and partial agonist (such as buprenorphine) medications, has been identified as the gold standard for evidence-based treatment of opioid use disorder (OUD)[4] [5] due to its ability to temper the withdrawal symptoms that make it difficult for people with OUD to stop using opioids, and to help protect against overdose. An ED visit can be a prime opportunity to offer and initiate buprenorphine treatment for patients with OUD, provide education and harm reduction resources, and link patients to ongoing community-based treatment.

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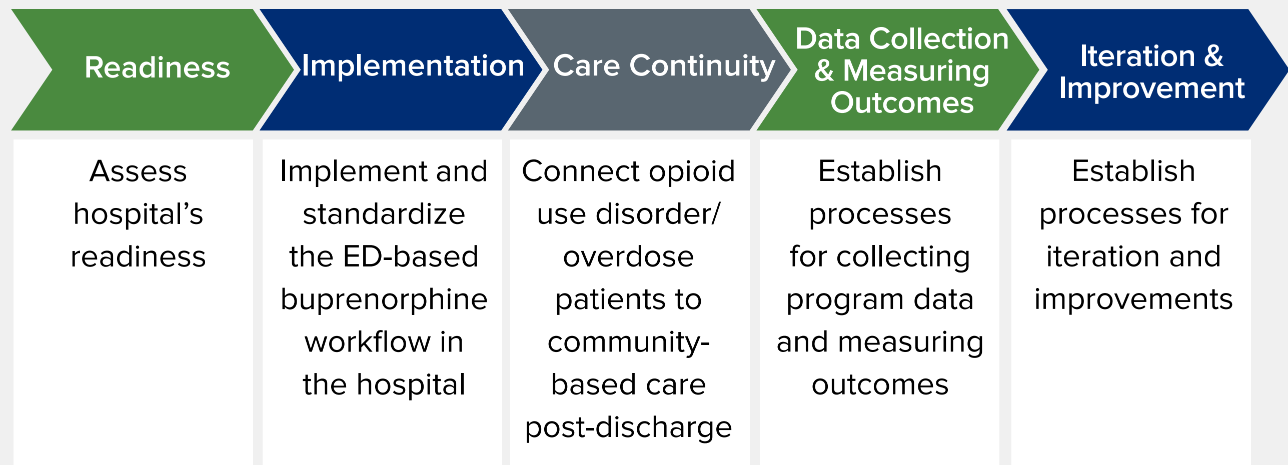
From 2000-2020, more than 28,000 North Carolinians lost their lives to drug overdose, and in 2021 alone there were 4,041 overdose deaths — the highest number in a single year on record in the state. Additionally, overdose Emergency Department (ED) visits have increased nearly 58% since 2016, reaching 16,937 in 2022.

[1] https://www.ncdhhs.gov/news/press-releases/2023/02/21/north-carolina-reports-22-increase-overdose-deaths
[2] https://www.ncdhhs.gov/opioid-and-substance-use-action-plan-data-dashboard
[3] Also known as medications for opioid use disorder (MOUD). "MAT" and "MOUD" are sometimes used interchangeably.
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7194237/
[5] https://pubmed.ncbi.nlm.nih.gov/25747920/



Readiness

How do you know if your facility is ready to pilot ED-based buprenorphine? In general, any facility with an ED can take the necessary steps to implement ED-based buprenorphine. The readiness qualifications most essential for success are having an identified clinical champion or point person within your facility to oversee the program and having a place to refer patients for ongoing MAT in the community. Additionally, having the following "preferred" components in place at the outset can improve your facility's likelihood of success with the program. However, these "preferred" capabilities can also be developed as you implement the program if they are not in place at the beginning.

Table 1 Readiness Assessment

Preferred	Required or Preferred
Identified clinical champion/ point person	Required
Identified community partners/ Medication Assisted Treatment providers for referrals	Required
Buy-in from ED clinicians and hospital administrators	Preferred
Ability to collect and report program data	Preferred
Funding and financial incentives	Preferred
Identified prescribers on ED team	Preferred
Assessed, identified, and secured any additional facility-specific pilot resource needs (if applicable)	Preferred

Readiness Questions

Asking the following readiness questions early on in the planning phase can be a useful starting point to gain an understanding of where your facility is today on the readiness pathway as well as any relevant workflows and protocols that already exist. This will be helpful in scoping out strengths, gaps, and what needs to be done during implementation.

- What is the level of need for this service in our facility and community? What is our volume of ED patients with an OUD diagnosis?
- Does offering buprenorphine treatment align with any existing organizational strategic priorities and/or quality initiatives?
- Who is the staff champion who is passionate about this subject and able to oversee or manage the program?
- Which providers in our ED are currently willing and able to administer and prescribe buprenorphine? If none, which would be willing to learn how to do this and can meet the requirements?[6]
- What is the current referral/linkage to care process for patients with a substance use disorder?
- What outpatient providers in our area can accept referrals for patients' ongoing buprenorphine treatment after they leave the ED? Do we have an existing relationship with those providers and/or have we had conversations with them?
- What harm reduction services (e.g., syringe exchange, naloxone distribution) exist in our area?
- What MAT products does our ED have? Is pharmacy aware of plans for MAT initiation? Will there be 24/7 access?
- Is there an established order set for MAT initiation?
- Are we able to supply naloxone kits to patients as they leave the ED?
- What is the inpatient policy for continuing MAT if a patient needs to be admitted?
- What data or metrics will we collect for monitoring performance, quality improvement, and demonstrating impact?
- What is our plan for sustaining the program?
- What other strengths or barriers do we foresee with starting this program in our ED?
- If we see a significant volume of pregnant patients:
  - Do the outpatient MAT providers that we identified accept pregnant patients?
  - Do the outpatient obstetrical providers where we refer accept MAT patients?
  - If patients are not going to deliver at this facility, where do they deliver? Where is the Neonatal Intensive Care Unit where newborns with severe neonatal opiate withdrawal syndrome would be treated (if not at our facility)?

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[6] The removal of the federal X-Waiver requirement means that all practitioners who have a current DEA registration that includes Schedule III authority may now prescribe buprenorphine for Opioid Use Disorder in their practice if permitted by applicable state law. Learn more and find FAQs from SAMHSA here: https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement.

Implementation & Standardization in Your Facility

There are multiple effective workflows and protocols for initiating buprenorphine in the ED. Though the details vary across models, the common steps are:

1. Screening for OUD and comorbidities/contraindications
2. Assessment of patient readiness for treatment using motivational interviewing
3. Assessment of severity of opiate withdrawal (using the Clinical Opiate Withdrawal Scale)
   - Determines if sufficient opioid withdrawal is present to initiate buprenorphine
4. Administration of sublingual buprenorphine dose
   - Supportive pharmacotherapy as needed for symptoms of withdrawal
5. Re-assessment of withdrawal symptoms
   - Second dose of buprenorphine if withdrawal persists
6. Linkage to community resource for continued care
7. Bridging prescription for OUD
8. Harm reduction education and naloxone provided

A recommended workflow is shown on the next page, which is adapted from multiple sources including a University of North Carolina School of Medicine workflow for buprenorphine-naloxone induction in the ED and the American College of Emergency Physicians (ACEP) buprenorphine use in the ED tool.[7] [8] Though the high-level steps should remain consistent, facilities are encouraged to customize this workflow and develop internal policies and protocols to include important information about facility-specific processes such as documentation instructions, key staff contact information, any differences between daytime and night/weekend protocols, and/or referral instructions.

[7] https://www.med.unc.edu/emergmed/wp-content/uploads/sites/649/2019/07/ED-suboxone-algorithm.pdf

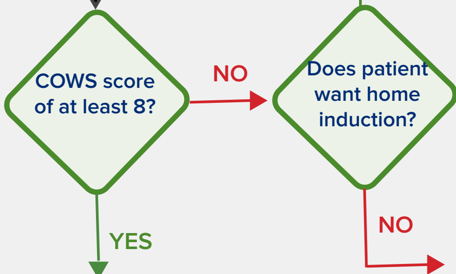
[8] Multiple buprenorphine products are FDA-approved for the treatment of OUD, including buprenorphine combination products and monoproducts. A list of these products can be found here: https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/buprenorphine

ED-Based Buprenorphine Induction Workflow

START

Before considering buprenorphine*

1. Diagnose opioid use disorder (OUD).
2. Last opioid use > 12 hours prior to arrival for short-acting opioids and >48 hours for long-acting opioids (methadone).
3. Evaluate whether the patient wants Medication Assisted Treatment (MAT) such as buprenorphine — proceed only if "yes."
4. Obtain Clinical Opiate Withdrawal Scale (COWS) score. Click here.



Home Induction

Provide handout about home induction. (click here)

Prescribe:
Prescribe buprenorphine for home induction.

Referral:
Ensure patient has MAT clinic appointment secured.

Options

If the patient doesn't have a COWS score of at least 8 and doesn't want home induction you can either:

1. Discharge patient with instructions to return to ED when withdrawal symptoms worsen; or
2. Discharge patient with instructions/ referral to follow up with an outpatient MAT clinic; or
3. Observe patient in ED until COWS score is at least 8, at which point clinician can proceed with ED induction.

ED Induction**

COWS score 8-12:
- Buprenorphine 4mg/1mg tablet/film.

COWS score 13+:
- Buprenorphine 8mg/2mg tablet/film.

Observe for 1 hour.

Reassess

Reassess with COWS score.

If COWS is still 8+, repeat dose 4-8mg and observe again for 1 hour. Repeat reassessment/ dosing each hour until COWS score less than 8. Do not exceed max. cumulative dose of 32 mg.

If COWS is less than 8, proceed to next step.

Prescribe

Write bridging buprenorphine prescription (3-5 days) to last until patient can get to outpatient MAT clinic.

Referral

Refer patient to outpatient MAT clinic for next dose; appointment should be within the next 24-48 hours.

Assess/Review (if possible)

- Did case manager secure MAT appt?
- Does patient have housing?
- Does their housing allow MAT?
- Does patient have transportation for weekly appts?
- Can patient afford MAT (Tx and Rx)?

BEFORE DISCHARGE (All patients)

Referral
Ensure patient has MAT referral list and/ or appointment scheduled. See the Case Management and Referral Process sample questions/checklist on Page 8 of this toolkit.

Harm Reduction
Provide comprehensive harm reduction patient education and tools.
- Naloxone prescription/kit
- Needle exchange info
- Safe injection info

DISCHARGE

AFTER DISCHARGE

Re-dose in Clinic or ED

After initial dose of buprenorphine (whether in the ED or at home), patient should receive re-dose in outpatient clinic within 24-48 hrs.

If clinic follow-up in 24-48 hrs isn't possible, patient to return to ED for re-dosing. (Patient can return for up to 2 additional days for buprenorphine administration and provided daily dosing rather than BID dosing.)

NOTES

* Multiple buprenorphine products are FDA-approved for the treatment of OUD, including buprenorphine combination products such as Suboxone and monoproducts. Learn more at: http://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/buprenorphine

** Note: For patients taking opioids regularly who are NOT in opioid withdrawal or are in early (less than mild) withdrawal -- buprenorphine may precipitate a rapid onset severe withdrawal. The steps to take for buprenoprhine precipitated withdrawal (BPW) can be found here, under "BPW Management": https://www.acep.org/patient-care/bupe/

[9] Sources: UNC School of Medicine, http://www.med.unc.edu/emergmed/wp-content/uploads/sites/649/2019/07/ED-suboxone-algorithm.pdf; ACEP, http://www.acep.org/patient-care/bupe/; Yale School of Medicine, http://medicine.yale.edu/edbup/home_buprenorphine_initiation_338574_5_v1.pdf; Dr. Christopher Griggs, Atrium Health; Dr. Genevieve Verrastro, MAHEC Faculty, Special Projects, and UNC Associate Professor of Medicine

Quick Tips for Implementation

Identify key team members

- Identify the team members across the organization who will need to be involved in various aspects of the planning and implementation process. See the checklist on the following page.

Standardize

- Use the EHR to automate and standardize the workflow as much as possible
  - Standard EPIC scripts are available
  - A Power Plan (a group of orders under a single title in the EHR) can be developed to support standardization in your facility
  - Example order sets: https://bridgetotreatment.org/resource/order-sets/, https://bridgetotreatment.org/resource/clinical-considerations-for-order-sets/ and https://bridgetotreatment.org/resource/nurse-initiated-buprenorphine-sample-order-set/
- This EMBED tool can also be used: https://www.mdcalc.com/emergency-department-initiated-buprenorphine-opioid-use-disorder-embed

Educate providers/ frontline staff

- Incorporate physician-to-physician peer learning and/or learning collaboratives
- Provide information on how MAT works; many training options are available including the following:
  - Introduction to MAT/MOUD: https://mahec.net/home/event/69510
  - Post X-Waiver SUD Training Suite: https://mahec.net/substance-use/post-x-waiver
- Address stigma
- Identify who in the ED will be prescribing buprenorphine. Ensure at least 1 prescriber at all times.

Make sure there is buprenorphine in the ED to administer

- EDs can obtain the buprenorphine by working with the ED/hospital pharmacist to make sure the medication dispensing system (e.g.,Omnicell) in the ED is stocked with buprenorphine.

Make sure there is a place to refer the patient

- The patient should always be referred to the closest treatment center or provider that can manage patient, even if it is at a distance.
- The SAMSHA Buprenorphine Practitioner Locator can help you find the closest provider for referral: https://www.samhsa.gov/resource/dbhis/buprenorphine-practitioner-locator
- See more Care Continuity tips in the next section of this toolkit

Provide discharge instructions and education

- OUD/MAT education
- Local resources, including for uninsured patients
- If indicated, Stanley-Brown Safety Plan or other suicide prevention

Discharge the patient with harm reduction tools and information, such as:

- Naloxone, an opioid antagonist medication that is used to reverse an opioid overdose.
  - Naloxone take home kits
  - Referral to a harm reduction program where they can obtain naloxone, or
  - A prescription for naloxone kits
- Needle exchange resources
- HIV and Hepatitis C testing resources

Implementation Checklist

As you plan to launch buprenorphine treatment in the ED, you can complete this checklist to make sure that all the essential components are in place.

Implementation Checklist	
Internal champions and stakeholders have been identified and engaged: • Administrative champion: • Pharmacy champion: • Nursing champion • Physician champion: • ED provider champion: • IT champion: • Case management champion: • Peer support specialist champion (if applicable):	☐
Are ED clinicians and hospital administrators onboard?	☐
Have you identified any needs/barriers/tasks unique to your facility that will need to be addressed?	☐
Has the ED team received training and education on MAT?	☐
Have you finalized the buprenorphine workflow/protocol that your hospital will use?	☐
Does your facility have buprenorphine products stocked?	☐
Who in the ED will be prescribing buprenorphine? Names:	☐
How will the patient receive naloxone at discharge?	☐
What other harm reduction information/tools will be provided at discharge? *Recommended harm reduction information include: Naloxone, Needle Exchange resources, HIV and Hepatitis C testing resources.*	☐
Have all applicable ED staff been educated on the new workflow/protocol? Do they have access to a point person and informational resources they may need? *Note that multiple/ongoing educational sessions may be needed. These should be led by your champions so that it is specific to your facility.*	☐
Have you started the process of developing EMR order sets with your IT team, if applicable? *Note that developing order sets can be a time consuming process; hospitals can implement the workflow without order sets as long as the ED clinicians have access to the necessary workflow/materials.*	☐
Have you identified community partners where you will make patient referrals for ongoing MOUD treatment? List:	☐
Have you held any meeting(s) with community partners to obtain information on their process, capacity, and their referral coordinator including for after hours?	☐
Have you developed written referral protocol(s)?	☐
Have you developed patient-facing education and referral materials?	☐
What is the anticipated launch date?	☐

Care Continuity

Linking patients to ongoing treatment after an overdose is critical, given the high short-term and one-year mortality rate among patients who present to the ED with an overdose and initially survive.[10] The ED in this model is intended to provide an introduction to buprenorphine and other resources and serve as a bridge to ongoing addiction and recovery treatment in the community. Care continuity and referral to community-based treatment are thus important components of this pilot program.

Quick tips for hospitals to refer patients to community-based treatment after administering buprenorphine:

- Identify and partner with local MAT clinics/treatment providers and establish referral relationships.
- Provide ED staff (including, if applicable, ED case managers or patient navigators) a list of places where they can refer patients, with contact information.
- Provide education and a list of resources to the patient at discharge.
- If possible, engage staff to help the patient navigate follow-up care (for example, a peer support specialist or social worker); these staff may be employed by the hospital, local health department, or other local organization.

CASE MANAGEMENT

Sample Questions/Checklist for Discharge

ED Case Management Point of Contact Name, number, email:

1. Was the follow-up MAT appointment secured?
   - If not, does patient have contact information to the office where they are being referred?
   - Is another attempt to schedule patient with office planned? When?
2. Was the patient given harm reduction tools and patient education?
   - Naloxone kit
   - Information on where to get naloxone
   - Other:
3. Does the patient have housing?
   - If not, have resources and shelter information been given to patient?
4. Does their housing allow MAT?
   - If not, how can we assist them?
5. Does patient have transportation for weekly appointments?
   - If not, how can we assist them?
6. Can the patient afford MAT (treatment and prescription)?
   - Did the prescription go to a pharmacy that helps lower the cost of medications?

REFERRAL PROCESS

Sample Questions/Checklist*

Outpatient MAT Program

1. MAT program/clinic name:
2. Referral Coordinator contact name/ number:
3. Patient received handout with MAT clinic information (phone number, address, hours) (yes/no):
4. Verbal handoff was given to:
5. Referral forms/documentation were sent to:
6. Appointment scheduled for:
7. Referral process completed (yes/no):
8. Other referral notes/ next steps:

*Tip: As you develop your referral process, note that each MAT clinic may have different referral protocols. Contact the clinics where you will refer patients to establish a process and find out who to contact to coordinate referrals.

[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6920606/

Care Continuity: Finding Referral Partners

As you identify referral partners, below are key questions and steps in the process:

- Find out if your organization or the referral partner requires a Memorandum of Understanding or other agreement to be in place.
- Ask about the specific services the partner provides, any applicable criteria that patients must meet for treatment (or exclusions), and what forms of insurance they accept including whether they accept patients with Medicaid, Medicare, or are uninsured.
- If the partner has relevant fliers or educational materials that you can provide to patients, obtain copies to hand out.
- Identify who the primary point person is for referrals and exchange contact information.
- Find out the partner's capacity to accept referrals for buprenorphine treatment and whether there is a maximum number of referrals they can accept.
- Establish the referral process including where and how referral notifications and documentation should be sent. This referral should be a "warm handoff" if possible.[11]
- Find out if the referral process is different on nights and weekends.
- Check in with the partner, especially after the first patients are referred, to make sure the process is working or make any needed adjustments.

Where To Find Referral Partners

Below are links that can help your organization identify places to refer patients for ongoing buprenorphine treatment at discharge.

- SAMHSA's buprenorphine practitioner locator: https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator
- SAMHSA's opioid treatment program directory: https://dpt2.samhsa.gov/treatment/directory.aspx
- Shatterproof Treatment Atlas is searchable database of addiction treatment options: https://treatmentatlas.org/
- The Local Management Entity/Managed Care Organization (LME-MCO) that serves your region may be able to help identify buprenorphine treatment providers in the area: https://www.ncdhhs.gov/providers/lme-mco-directory
- Some Federally Qualified Health Centers offer MAT; you can use the Find a Health Center tool to find local FQHCs: https://findahealthcenter.hrsa.gov/

To gather all of your referral partner information in one place, consider creating a simple internal reference document or grid that lists each partner along with their:

- Locations
- New patient capacity
- Preferred referral mechanism
- Referral phone number/email/online form
- Information needed in the referral
- Whether they accept insured and uninsured patients
- Whether they have peer support services available
- Whether they accept perinatal patients
- Whether telehealth is available
- Whether the patient must establish their primary care at the practice
- Pharmacy information

[11] A facilitated referral or "warm handoff" is when a healthcare team member introduces another team member to the patient, explaining why the other team member can better address a specific issue and also emphasizing the other team member's competence.

Data Collection & Measuring Outcomes

Collecting data and assessing outcomes are important for celebrating successes, identifying areas for improvement, and making the case for sustaining the pilot program. It is recommended that hospitals participating in the pilot create data reports or dashboards to continuously monitor program outcomes. The identified champion can oversee or help with monitoring and providing regular updates to department leads and hospital leadership.

Hospitals are also encouraged to establish facility-specific targets based on your baseline data and improvement goals.

While it is critical to monitor the pilot program outcomes and impact at your facility, hospitals involved in the pilot design indicated that it can also be helpful to reference existing evidence for ED-based buprenorphine from other hospitals and health systems. A few examples are provided below.

What outcomes have already been established?

- **Financial return on investment.** ED-initiated buprenorphine is overall cost-saving, compared to brief intervention or referral[12] and compared with no treatment.[13] One study showed that costs occurring during the enrollment ED visit were low ($8–$83), reflecting the minimal health care resources used in the ED-based component of the intervention.[14]

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5657503/
[13] https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2778020
[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5657503/

Data Extraction Tips

To pull and analyze this data, below are quick tips for data abstraction from the electronic medical record (EMR).

- Identify the data expert for your facility
- Identify what is accessible through your EMR and/or billing data
- Develop a plan for data extraction from the EMR or billing data
- Decide if manual data collection is worthwhile for data that cannot be extracted
- Determine time intervals for data abstraction (monthly or quarterly)
- EPIC users can get some of this data through the EMR's Slicer Dicer data exploration tool

Diagnosis Codes

For evaluating pilot program outcomes, the following opioid-related diagnoses can be used for data extraction from the EMR.

- **Opioid Abuse**: F11.1 , F11.10 ,F11.11, F11.12, F11.120, F11.121, F11.122, F11.129, F11.13, F11.14 , F11.15, F11.150, F11.151, F11.159, F11.18, F11.181, F11.182 , F11.188, F11.19, F11.120-F11.129, F11.220-F11.229, F11.920-F11.929

- **Opioid Overdose/Poisoning**: T40.0X1A-T40.0X4S, T40.1X1A-T40.1X4S, T40.2X1A-T40.2X4S, T40.3X1A-T40.3X4S, T40.411A-T40.414S, T40.421A-T40.424S, T40.491A-T40.494S, T40.601A-T40.604S, T40.691A-T40.694S

- **Opioid use withdrawal**: F11.13, F11.23, F11.93

Data Collection & Measuring Outcomes

- **Clinical return on investment.** The benefits of buprenorphine include decreases in mortality, [15] hospitalizations and ED visits,[16] and improved retention in outpatient treatment.[17]
- **Throughput time.** Patients are generally much more comfortable within 30-45 minutes of being administered buprenorphine in the ED.[18] One analysis of ED patients undergoing buprenorphine induction and referral to outpatient MAT found the median ED length of stay decreased by 40% over the 1.5 year study period.[19]

What does success look like?

Program adoption

- Increase in assessing and identifying patients who meet the medical criteria for buprenorphine treatment
- Increase in buprenorphine administered to OUD patients in the ED
- Increase in buprenorphine prescribed to OUD patients from the ED

Care continuity

- Increase in patients who engage in treatment at community referral sites

Health outcomes

- Decrease in ED visits for OUD/ overdose
- Decrease in patient mortality from OUD/overdose

[15] https://www.nature.com/articles/s41380-018-0094-5
[16] https://pubmed.ncbi.nlm.nih.gov/26662858/
[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6542472/
[18] https://nida.nih.gov/sites/default/files/edbuprenorphinehandout.pdf
[19] https://www.sciencedirect.com/science/article/abs/pii/S0735675719305030?via%3Dihub#section-cited-by

Iteration & Improvement

Hospitals are encouraged to regularly review their outcomes data to identify what is working well and areas that need improvement.

Quick tips:

- Review data/outcomes reports and meet with ED staff regularly to pinpoint (a) what is going well and (b) areas for improvement
- Identify and engage performance improvement capabilities within your health system. Incorporate program metrics into existing quality improvement programs and processes.
- Provide a feedback loop to staff. Share and celebrate successes, particularly patient success stories.
- Share lessons learned and ask for support if needed. Assistance and resources are available through NCHF at https://opioidlibrary.caronova.org/technical-assistance/.

Additional Resources

Settlement Funding

The North Carolina Opioid Settlements can fund local programs that offer MOUD and other evidence-based addiction treatment for people with OUD. More information and resources can be found here: https://ncopioidsettlement.org/resources/evidence-based-addiction-treatment/.

Removal of X-Waiver Requirement

The removal of the federal X-Waiver requirement means that all practitioners who have a current DEA registration that includes Schedule III authority may now prescribe buprenorphine for Opioid Use Disorder in their practice if permitted by applicable state law. Learn more and find FAQs from SAMHSA here: https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement.

Provider Helplines

The workflows and recommendations in this toolkit do not replace the need for providers to assess the unique circumstances and needs of each patient and to exercise clinical judgment. The following provider support lines are available to any provider seeking support for treating patients with MOUD.

National Clinician Consultation Center Substance Use Warmline

M-F 6am-5pm PT. Voicemail 24 hours a day, 7 days a week.
Specialty addiction medicine consultation
855-300-3595

National Poison Helpline

24 hours a day, 7 days a week
1-800-222-1222

Additional Resources

Patient Assessment

The following tools provide information about the COWS screening assessment that should be done before administering buprenorphine as well as conversation tools and strategies.

- Clinical Opiate Withdrawal Scale (COWS): https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf
- Motivating Patient Videos: https://medicine.yale.edu/edbup/treatment/videos/

Patient Education at Discharge

Existing patient education materials are available about opioid use disorder, buprenorphine treatment, and harm reduction. Below are sample materials that your facility can use or adapt.

- CDC Materials for Patients: https://www.cdc.gov/opioids/patients/materials.html
- Patient Education (Bridge): https://bridgetotreatment.org/resources/?cat=patient-education
  - Buprenorphine Discharge Instructions: https://bridgetotreatment.org/resource/buprenorphine-sample-discharge-instructions/
  - How to Use Naloxone: https://bridgetotreatment.org/resource/how-to-use-naloxone-to-reverse-an-overdose/
  - Naloxone: What You Need to Know https://bridgetotreatment.org/resource/naloxone-what-you-need-to-know/
  - Patient-Facing Flyer template: https://bridgetotreatment.org/resource/patient-facing-flyer/
- Home buprenorphine induction instructions
  - A Guide for Patients Beginning Buprenorphine Treatment at Home (Yale): https://medicine.yale.edu/edbup/discharge/home_buprenorphine_initiation_338574_284_42799_v1.pdf
  - Discharge and Treatment Referral (Yale) https://medicine.yale.edu/edbup/discharge/
  - Buprenorphine Self Start (Bridge): https://cabridge.org/resource/rapid-guidance-for-patients-starting-buprenorphine-outside-of-hospitals-or-clinics/

Harm Reduction

Equipping patients with harm reduction information and tools at discharge is critical. Below are several harm reduction resources and information about where your facility can obtain a supply of naloxone.

- Naloxone Saves: https://naloxonesaves.org/where-can-i-get-naloxone/
- North Carolina Drug User Health Resource Guide by Region: https://www.carereachnc.org/images/DrugUserHealthResourceGuide_2.19.20-WEB.pdf

Other

The organizations and websites below provide additional information about ED-based buprenorphine treatment.

- American College of Emergency Physicians: Buprenorphine: https://poctools.acep.org/POCTool/fb2be2eb-a9dc-43eb-b7d6-56cc2901d442
- Yale Department of Emergency Medicine: ED-Initiated Buprenorphine: https://medicine.yale.edu/edbup/
- Bridge: https://bridgetotreatment.org/tools/resources/
- Practice-Based Guidelines: Buprenorphine in the Age of Fentanyl (PCSS): https://pcssnow.org/wp-content/uploads/2023/05/PCSS-Fentanyl-Guidance-FINAL-1.pdf
- NCHA Emergency Department Opioid Treatment Pathway: https://www.ncha.org/ncha-emergency-department-opioid-treatment-pathway/#1603917530413-dd201220-bdf8

www.ncha.org/foundation