Frequently Asked *Questions*

Emergency Department Buprenorphine

NORTH CAROLINA HEALTHCARE FOUNDATION

THE CONVENER OF CHANGE

1

In treating patients with buprenorphine, aren't you just replacing one opioid with another?

Buprenorphine is *fundamentally different* from full opioid agonists like heroin or fentanyl in both its pharmacology and clinical effects. Unlike other opioids, it stabilizes brain chemistry, reduces cravings and withdrawal, and blocks the effects of other opioids, supporting recovery and reducing mortality. All persons require opioid receptor activity from endogenous opioids for normal brain functioning. Those with an opioid use disorder have disordered function of these receptors and robust evidence shows medications like buprenorphine support people with OUD in recovering this brain function over time. While some persons may be on buprenorphine for extended periods of time, long term goals can include weaning the treatment to a point where it is no longer required. It is essential to emphasize, that buprenorphine has a respiratory ceiling effect, meaning overdose and respiratory arrest are *far less likely* when compared to other full opioid agonists.

2

At what point during the withdrawal process is it best to begin buprenorphine induction?

Patients with opioid use disorder who want medication assisted treatment may be ready depending on time since last opioid use and current symptoms. They should only begin buprenorphine induction if it has been more than 12 to 48 hours (for short acting and long-acting opioids, respectively) since last opioid use. Further, patients should have a clinical opiate withdrawal score of 8 or higher, indicating at least mild withdrawal symptoms. [i]

3

Should a provider initiate buprenorphine in the Emergency Department if they do not have a plan of care in place for ongoing treatment in the community?

Yes, buprenorphine both decreases the immediate risk of overdose by decreasing return to illicit opioids and gives persons with OUD an opportunity to seek care, which may be present through both a local clinic or increasingly through telemedicine services. It is appropriate to direct a patient to return to the ED for re-dosing with buprenorphine up to two times if starting treatment in the community within 48 hours is not possible. A 2024 study found getting buprenorphine in the ED *can increase patient engagement in treatment* over the next 30 days. This may mean initial barriers to finding a community treatment provider are easier to surmount once a patient receives buprenorphine in the ED. [ii] [iii]

4

How do providers responsibly discharge patients they've administered buprenorphine to?

Responsible discharge includes two main steps. The first step is getting a patient referred to treatment in the community so they can continue supervised buprenorphine treatment. For more details on what to do if no plan of care can be established with a community provider, see the answer to the prior question. The second step is providing patients with harm reduction education and tools (e.g., naloxone), as well as providing information on needle exchange and safe injection. [iv]

5

Where can a patient or caregiver get Naloxone? Do they need a prescription?

With the statewide standing order, eligible patients do not need a prescription to get naloxone. NC DHHS explains that "if a pharmacist identifies a patient whom the pharmacist believes may be at risk for overdose, the pharmacist may initiate a conversation with the patient to determine whether he or she would like to receive naloxone." As far as where to get it, many local health departments and places with syringe exchange programs offer free or reduced cost naloxone. Visit naloxonesaves-nc.org to find where in your county to get naloxone. [v] [vi]

For more information, view the ED Buprenorphine Toolkit and the sources used in this document.