A
ccess to treatment for opioid addiction is a
national health priority — only 10% of patients
who need treatment can get it. Emergency
departments (EDs) can be one effective access point for
patients needing treatment. EDs already see patients
with addiction, but currently have little to offer short of
reversing overdoses and discharging patients, a course
of treatment with high risk for repeated events. Just as
other patients with uncontrolled chronic diseases are
treated and stabilized in the ED, and referred to other
providers for ongoing care, patients with addiction can
be treated with buprenorphine in the ED, and once sta-
bilized, can be transferred to ongoing outpatient care.

Addiction experts and experienced clinicians identified
several common strategies for successful initiation of
medication-assisted treatment (MAT) programs in EDs.
(See Emergency Care for the Opioid Epidemic: Leaders
Discuss Medication-Assisted Treatment in the ED.)

Cultivate Champions
While EDs treat patients with some form of addiction
nearly every day, the concept of treating addiction
with buprenorphine may be new to many ED staff.
Any ED embarking on a MAT program should develop
champions and supporters among physicians, nurses,
pharmacists, social workers, behavioral health staff, and
administrators. Champions help promote a consistent
vision and case for change, build enthusiasm and part-
nerships, address fears and concerns, solve problems,
and overcome barriers. Champions can provide or facil-
itate initial staff training and be an ongoing resource for
staff education and guidance.

Support Emergency Physicians in Obtaining
Buprenorphine (DATA 2000) Waivers
At least two (and preferably several) ED physicians, nurse
practitioners, and physician assistants should have
waivers to prescribe buprenorphine. Because patients
with addiction may present at any time, it is not practical
for any single clinician to cover all needs; multiple cli-
nicians with the capacity to prescribe buprenorphine will
help distribute the workload. Training with other cli-
nicians can promote peer support and build camaraderie
in this challenging work environment, to work through
barriers and to strategize on how to adapt practices.

Partner with Pharmacy Staff
A successful ED MAT program requires working with
both inpatient and outpatient pharmacies to ensure
that formulations of buprenorphine (sublingual, IV, and
transdermal) are on formulary and accessible to ED phy-
sicians. Pharmacy staff may need to be trained on how
to submit Medi-Cal and commercial claims.

DEA audits are inevitable and will require that the ED
produce simple reports of the dates and amounts of
buprenorphine prescribed. In most scenarios, the ED
will not maintain an ongoing caseload of patients
on buprenorphine, and DEA limits on the number of
patients managed by one physician should not be
a concern. It is important, however, for ED staff to
work with the organization’s IT team and pharmacist
to ensure that prompt production of a report on ED
buprenorphine prescribing is possible.

Partner with Outpatient
Buprenorphine Prescribers
The ED is one of the few settings where providers can
reach patients in crisis due to severe withdrawal or near-
overdose and therefore be available when a patient
may be particularly receptive to the idea of addiction
treatment. It is essential to have a close working rela-
tionship with clinic providers interested in taking on new
patients: a buprenorphine induction clinic (for initial sta-
bilization and referral for ongoing treatment), a primary
care physician accepting referrals for buprenorphine,
an opioid treatment program, or a pain clinic. Patients
should not be started on buprenorphine without clear
access to ongoing treatment.

Collaborate with Behavioral Health Service
Providers, Where Available
Behavioral health staff in the ED can help engage
patients and ensure ongoing behavioral health treat-
ment. Depending on community resources, this may
involve on-site or remote (phone or telemedicine)
behavioral health staff, or established connections with
outpatient ongoing treatment. Partnering with 12-step
or other peer-to-peer groups may also help increase
access to support services, as long as those groups are
accepting of MAT.

While support services and addiction counseling are
recommended for long-term treatment success, on-site
behavioral health is uncommon in many EDs, and the
lack of such services should not be considered a barrier
to starting an ED MAT program.

1. Recovery Enhancement for Addiction Treatment Act (TREAT Act),
Cultivate a Team-Based Approach
The ED intersects with virtually all aspects of the health care system; therefore, ED MAT programs may impact a wide range of providers. Early communication and engagement with inpatient and outpatient providers will help promote acceptance of ED MAT programs and help prevent confusion or opposition. Inpatient hospitalist and surgical teams may want to develop protocols for buprenorphine initiation. Outpatient providers will need education on how to appropriately refer patients to the ED for buprenorphine initiation, and may appreciate reassurance that patients will be referred to them through a coordinated hand-off.

The needs of patients new to MAT are diverse and potentially quite complex. A team model enables the ED, inpatient hospital services, and outpatient clinics to provide wraparound, coordinated care. In particular, some patients may benefit from intensive complex care management beyond the scope of ED care. Developing a broad base of partnerships helps meet the needs of ED MAT patients and prevents overburdening ED staff.

Integrate ED MAT with ED Pain Management Initiatives
EDs are undergoing rapid change in the standards of practice around pain assessment and treatment. Partnering with hospital and community-wide efforts to promote safe opioid prescribing may help recruit resources to support an ED MAT program. For ED staff, understanding the limitations of opioid analgesia is a convenient bridge to understanding the fundamental concepts of opioid addiction. In particular, understanding opioid addiction as a cause of physical pain and psychological distress can motivate interest in treating the underlying addiction, versus more superficial symptom management.

Buprenorphine is an effective and underused analgesic that can be used in the ED by any provider with DEA opioid prescribing authority, without a buprenorphine waiver. Increasing the use of buprenorphine for pain may help hesitant or skeptical providers directly witness the effect of buprenorphine on patients before they commit to initiating patients into long-term MAT.

Integrate ED MAT with ED Treatment of Withdrawal and Overdose
EDs treat opioid overdose and opioid withdrawal routinely. Developing a set of interventions that integrate ED initiation of buprenorphine with treatment of overdose and withdrawal is a convenient way to link ED MAT to a well-established role for the ED. Buprenorphine should be viewed as a first-line treatment for opioid withdrawal, as it has significant advantages over alternatives such as morphine or hydromorphone: less euphoria, longer duration of action, and reduced risk of respiratory depression. If ED staff grow accustomed to treating withdrawal with buprenorphine, initiating MAT becomes an easy next step. ED physicians commonly see patients with active or historical addiction present with severe pain or injury; buprenorphine for pain is a safer alternative than other opioids. Finally, a patient with opioid overdose seen in the ED is at extremely high risk for death after discharge. After initial reversal with naloxone, patients can be transitioned onto buprenorphine instead of other potentially more harmful opioids such as morphine, hydromorphone, or illicit opioids.

Develop an Adaptable and Tailored Approach to ED MAT
There are several strategies for integrating MAT into ED care. The simplest approach involves an ED clinician partnering with an outpatient site willing to accept ED-initiated patients. This model is limited in its potential scope of impact but can be a practical first step to get a program up and running in preparation for larger-scale work. In this model, patients are identified and recruited in the ED with a warm hand-off to a buprenorphine clinic within three days. More comprehensive models explore the potential of the ED as a hub and portal for systemwide access to treatment for addiction. Flexibility and creativity in tailoring a program to the opportunities and challenges in a particular community will promote successful, sustainable programs.

Other Resources on Buprenorphine

Buprenorphine: Questions and Answers
Answers to common questions about buprenorphine for addiction and pain: who can prescribe, what formulations, and how to manage inductions
www.chcf.org

UCSF Substance Use Warmline
Free clinical advice on addiction treatment
Monday to Friday, 7 am to 3 pm PST
855.300.3595
nccc.ucsf.edu

Providers Clinical Support System MAT Mentorship Program
Resources and online mentorship for providers new to prescribing buprenorphine
pcssmat.org

Recovery Within Reach: Medication-Assisted Treatment Comes to Primary Care
Discussion of models of integration of buprenorphine into primary care
www.chcf.org

For more information, visit www.chcf.org.
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Improving access to treatment for opioid addiction is a national health priority. Emergency departments (EDs) can be an important access point for patients needing help. Addiction experts and experienced clinicians offer strategies for successful initiation of medication-assisted treatment in EDs.

**Change can start with one ED doctor and one referral clinic.**

**To build a program in the ED:**
- Cultivate **CHAMPIONS** among clinicians, nurses, pharmacists, social workers, behavioral health staff, and administrators.
- Encourage clinicians to get **BUPRENORPHINE TRAINING**.
- Partner with **PHARMACISTS**.
- Build relationships with **CLINICIANS** for ongoing care.
- Collaborate with **BEHAVIORAL HEALTH SERVICES**, where available.
- Develop a **TEAM-BASED APPROACH** involving the ED, inpatient services, and outpatient clinics.
- Integrate buprenorphine into **SAFE PRESCRIBING GUIDELINES** in the ED.
- Connect addiction treatment with **TREATMENT OF WITHDRAWAL AND OVERDOSE**.

For details on these strategies, see the full report: [www.chcf.org/ED-opiod](http://www.chcf.org/ED-opiod)

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