

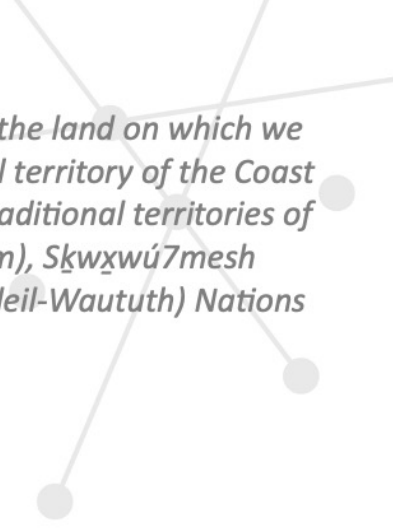


BRITISH COLUMBIA  
CENTRE ON  
**SUBSTANCE USE**  
*Networking researchers, educators & care providers*

## Emergency Department Buprenorphine Basics (3 of 4): Home or Unobserved Induction

Preparatory Module for OUD Webinar Series





*We respectfully acknowledge the land on which we work is the unceded traditional territory of the Coast Salish Peoples, including the traditional territories of x<sup>w</sup>məθkwəyəm (Musqueam), Sḵwxwú7mesh (Squamish), and sə́ilwətał (Tseil-Waututh) Nations*

## Disclaimer

Some of the approaches described in this series of modules have evolved in response to the ongoing opioid crisis due to fentanyl in the illicit drug supply and may not represent current BCCSU Guidelines.

This includes innovative and novel approaches specific to emergency settings that are based on clinical experience and small observational studies. There is still a relative lack of research into the effectiveness of these approaches, therefore clinical judgement is advised.



This caution sign will appear next to recommendations that are off-label and/or differ from current BCCSU guidelines

## Outline

- Considerations for ED-based (emergency department based) home induction
- Preparing the patient for home induction
- Dosing for home induction

## Considerations in the Emergency Department (ED)

- Patient is not in sufficient withdrawal to start buprenorphine in the ED (i.e., Clinical Opiate Withdrawal Score [COWS] <12)
- Patient is eager to leave the ED
- Patient is not yet sure if or when they want to start buprenorphine

Depending on the observation space and patient preference, the patient may be kept in observation until more severe withdrawal develops

## Patient Characteristics

- Consider home induction for patients who have:
  - Prior experience with buprenorphine/naloxone\*
  - A supportive environment and caregivers\*
  - No concurrent alcohol/sedative use
  - No significant anxiety about withdrawal

\*neither prior experience nor stable housing are absolute requirements for home induction

- Note that lack of experience with buprenorphine is not a contraindication, it just may require extra preparation with the patient,
- Likewise, homelessness is not a contraindication to a home induction, but again, may require additional planning
- Some patients may prefer to wait in the emergency department and undergo withdrawal there, while others may prefer to undergo withdrawal outside of the hospital

## Preparation

- General principles identical to emergency department inductions
  - Patients require more instruction
- Plan for managing withdrawal symptoms
- Plan for precipitated withdrawal (if it occurs)
  - Provide medications, suggest returning to the emergency department if needed, presenting to or calling a clinic
  - 1) continue 2) pause, or 3) stop (discussed elsewhere\*)
- Plan follow-up care

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- \*See precipitated withdrawal module in the Buprenorphine Basics module series at: <https://www.bccsu.ca/edcare/>

## Instructions for Patient: Waiting Period

- Do not start buprenorphine until the minimum hours since last opioid use have passed:
  - $\geq 12$ h for heroin, oxycodone, hydromorphone
  - $\geq 24$ h slow-release oral morphine or fentanyl\* (known or possible)
  - 24–72h for methadone

- The same waiting period that is used for emergency department-inductions is used for home inductions
- Advise the patient not to start buprenorphine until the minimum hours since last opioid use have passed:
  - \*Some providers recommend 36 hours after last dose of fentanyl



## Instructions for Patient: Managing Withdrawal Symptoms while waiting to start

- The patient may take the following over-the-counter medications to help manage withdrawal symptoms while they wait to start buprenorphine:
  - Ibuprofen or acetaminophen for body aches,
  - Dimenhydrinate for nausea and vomiting, and
  - Loperamide for diarrhea

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- If diarrhea develops, the patient is often already in sufficient withdrawal to start bup/nlx

## Instructions for Patient: Assessing Withdrawal

- Patients can self-assess withdrawal using the Subjective Opiate Withdrawal Scale (SOWS)
  - The COWS requires clinical observation and is not appropriate for home inductions
- Emergency departments and other community programs often use a basic symptom guide instead of SOWS

- Depending on patient and provider preference and comfort, the patient self-assess withdrawal symptoms using a list of symptoms or the Subjective Opiate Withdrawal Scale (SOWS)
- Multiple different “symptom guides” or criteria lists exist

## Instructions for Patient: SOWS needs to be >17

Item	Symptom	Not at all	A little	Moderately	Quite a bit	Extremely
1	I feel anxious	0	1	2	3	4
2	I feel like yawning	0	1	2	3	4
3	I am perspiring	0	1	2	3	4
4	My eyes are teary	0	1	2	3	4
5	My nose is running	0	1	2	3	4
6	I have goosebumps	0	1	2	3	4
7	I am shaking	0	1	2	3	4
8	I have hot flushes	0	1	2	3	4
9	I have cold flushes	0	1	2	3	4
10	My muscles and bones ache	0	1	2	3	4
11	I feel restless	0	1	2	3	4
12	I feel nauseous	0	1	2	3	4
13	I feel like vomiting	0	1	2	3	4
14	My muscles twitch	0	1	2	3	4
15	I have stomach cramps	0	1	2	3	4
16	I feel like using now	0	1	2	3	4
Total score:						

- If the patient is using the SOWS to assess withdrawal, their SOWS score should be above 17 before they begin buprenorphine

## Instructions for Patient: Symptom Guide

- Patients should not start buprenorphine until they have **3 or more** of the following symptoms:
  - Stomach cramps, nausea, vomiting, or diarrhea
  - Heavy yawning
  - Bad chills or sweating
  - Runny nose and tears in eyes
  - Twitching, tremors, or shaking
  - Feeling anxious or irritable (or both)
  - Enlarged pupils
  - Joint and bone aches
  - Goose bumps
  - Feeling restless/cannot sit still

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- Symptom guide often easier to follow than SOWS
- For either approach, same waiting period applies, e.g.,  $\geq 24$  since last known or possible fentanyl
- The above is an example of a symptom guide used in emergency departments. Patients should not start buprenorphine until they have 3 or more of the symptoms listed

## Buprenorphine Dosing: General Instructions

- Provide patients with a handout to help guide them through home inductions

### Day 1 Starting Suboxone® (buprenorphine/naloxone)

Page 1

Are you in withdrawal? Before starting Suboxone® (buprenorphine/naloxone) you need to be in withdrawal (dope-sick). Use the 'SOWS' withdrawal scale on the back page to determine how bad your withdrawal is. Wait until your withdrawal score is 17 or more to begin.



- Do not take with alcohol or sedatives.
- Do not take more than 12 mg total on Day 1.
- Do not inject. You will be dope-sick if you inject.

My doctor/nurse practitioner and I agree on this treatment plan.

#### Contact Information

Patient Name

Provider Name

Provider Number

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- A patient handout is available on the Government of BC website to guide patients through home inductions

## Buprenorphine Dosing: General Instructions

- Points to emphasize during patient instructions
  - Do not use opioids during initiation to relieve symptoms
  - Do not use sedatives or stimulants\* during initiation
  - Do not give up if symptoms persist after the initial doses
  - Tablet must be put under the tongue and kept there until fully dissolved (10 min). Do not swallow the medication.
  - Do not consume food or drink while the tablet is dissolving. Avoid smoking.
  - Return to care if symptoms of precipitated withdrawal develop or if they are unable to cope

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BCCSU, 2017

- \*Reasons why not to use other drugs during initiation and/or preceding waiting period
  - Opioids: will re-start the clock on the waiting period and/or increase the risk of precipitated withdrawal
  - Sedatives: Risk of respiratory depression, and also make it more difficult for someone to gauge their level of withdrawal (SOWS or symptom list)
  - Stimulants: Some stimulants in street supply contain opioids, increasing the risk of precipitated withdrawal
- Wait one hour after taking the first tablet. If craving or withdrawal symptoms continue, take another tablet and wait another hour. Continue to do this until all tablets are taken or craving or withdrawal symptoms are resolved (next slide)

## Home Induction Buprenorphine Dosing: Day 1

- Wait until:
  - 3 symptoms from list or SOWS is above 17
  - Sufficient amount of time has passed since last opioid use
- Start with 2mg/0.5mg bup/nlx SL tablet.
  - Wait 1–2h
- If cravings & withdrawal symptoms continue:
  - take another 2mg/0.5mg bup/nlx SL tablet
- Stop bup/nlx if symptoms are markedly worse
- If there are no signs of precipitated withdrawal:
  - 2mg/0.5mg q1–2h until symptoms resolve or day 1 maximum is reached (12 to 16 mg buprenorphine\*)

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- \*12 and 16 mg are the most common day 1 maximum doses in guidelines, however, in practice, the day 1 maximum is often 24 mg, and sometimes higher

## Home Induction Buprenorphine Dosing: Day 2

- If there are no withdrawal symptoms since last dose:
  - Take once daily dose (all at once) equal to total day 1 dose
  - If cravings and withdrawal symptoms occur later
    - take 2mg/0.5mg bup/nlx SL 1 or 2 more times as needed
- If withdrawal symptoms are present since last dose:
  - Take dose equal to day 1 dose plus additional 4mg/1mg bup/nlx (all at once)
  - If cravings and withdrawal symptoms occur later
    - take 2mg/0.5mg bup/nlx SL 1 or 2 more times as needed

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- If there are no withdrawal symptoms since last dose, continue once daily dose equal to total day 1 dose, titrating up by 2mg/0.5mg–4mg/1mg bup/nlx to suppress cravings and withdrawal symptoms
- If withdrawal symptoms are present since last dose, administer dose equal to day 1 dose, plus additional 4mg/1mg bup/nlx
- The maximum day 2 dose is 24mg/6mg bup/nlx, but this can be exceeded if withdrawal symptoms and cravings continue



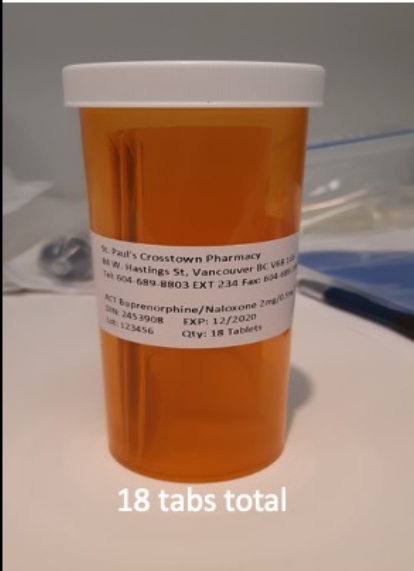
## Home Induction Buprenorphine Dosing: Day 2&3

- The maximum day 2 dose is 24mg/6mg bup/nlx
  - but this can be exceeded if withdrawal symptoms and cravings continue
- Day 3 dosing (taken all at once)
  - Equal to total day 2 total dose

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- If there are no withdrawal symptoms since last dose, continue once daily dose equal to total day 1 dose, titrating up by 2mg/0.5mg–4mg/1mg bup/nlx to suppress cravings and withdrawal symptoms
- The maximum day 2 dose is 24mg/6mg bup/nlx, but this can be exceeded if withdrawal symptoms and cravings continue

## Buprenorphine Home Induction Packs

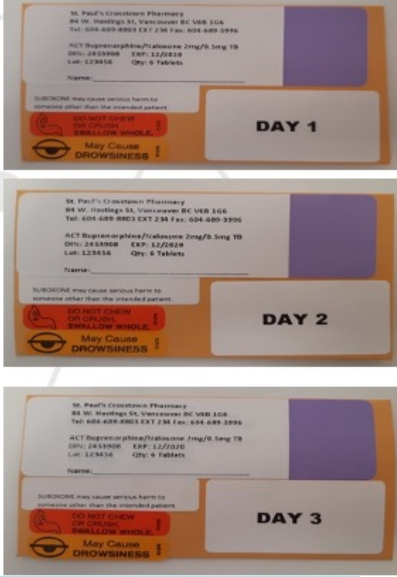


6 x 2mg tab

6 x 2mg tab

6 x 2mg tab

18 tabs total



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- These are St. Paul's home induction packs or "BUP" to go. The containers are childproof .
- Prescribing buprenorphine/naloxone in these home induction packs removes the added barrier of going to the pharmacy
- There is less concern with diversion of buprenorphine/naloxone due to its superior safety profile, including ceiling effect on respiration. Generally, diverted buprenorphine goes to people interested in treatment or who are avoiding dangerous street fentanyl (Cicero 2018)

## Medications to Minimize Withdrawal Symptoms

- The following medications can be prescribed, or ideally can be given as “to-go” packs to manage withdrawal symptoms while waiting to start
  - Clonidine (3 doses)\*
    - 0.1–0.2mg every 4 hours PRN for <12 hours
  - Acetaminophen (4 doses)
    - 325–975mg four times a day PRN
  - Ibuprofen (4 doses)
    - 200–400mg four times a day PRN
  - Dimenhydrinate (4 doses)
    - 50–100mg four times a day PRN
  - Loperamide \*\* (1 dose)
    - 2–4mg once daily PRN

- Clonidine\*
  - Clonidine may lower SOWS score
- Loperamide \*\*
  - Loperamide is only rarely necessary. Diarrhea is typically severe when patient has sufficient withdrawal symptoms and there has been a long enough duration since last opioid use to start buprenorphine
- Some clinicians will provide carry doses of hydromorphone 8mg tabs to help patients deal with precipitated withdrawal, if it occurs
- Ideally, clinicians should provide these medications as “to-go” medications at the same time as dispensing and prescribing buprenorphine

## Discharge Planning

- Discharge checklist:
  - Provide take-home naloxone kit
  - Schedule follow-up appointment for OAT
  - Fax Plan G application form (if applicable)
  - Provide outreach referral
  - Fax OAT/MHSU referral
  - Provide patient education materials
  - Link to community resources
  - Provide medications to minimize withdrawal symptoms

- Discharge planning is nearly identical to starting in the emergency department, except the bridging prescription is usually not necessary and “remaining doses” are not applicable
- Before discharging a patient from the emergency department, consider which of the actions on the discharge checklist above are applicable:
- Be systematic in discharge planning and try to maximize your patient’s success
- Discharge checklist adapted from: [https://bcpsqc.ca/wp-content/uploads/2020/11/F2.0\\_LOUD\\_ED-Clinical-DST.pdf](https://bcpsqc.ca/wp-content/uploads/2020/11/F2.0_LOUD_ED-Clinical-DST.pdf)

## Quiz

Which of the following is true about home inductions:

- A) Patients should calculate COWS score every hr
- B) Maximum Day 1 dose is 8 mg
- C) Different principles of care apply for home inductions than for emergency department starts
- D) Ideal to provide additional medications for withdrawal management as to-go packs

## Quiz

Which of the following is true about home inductions:

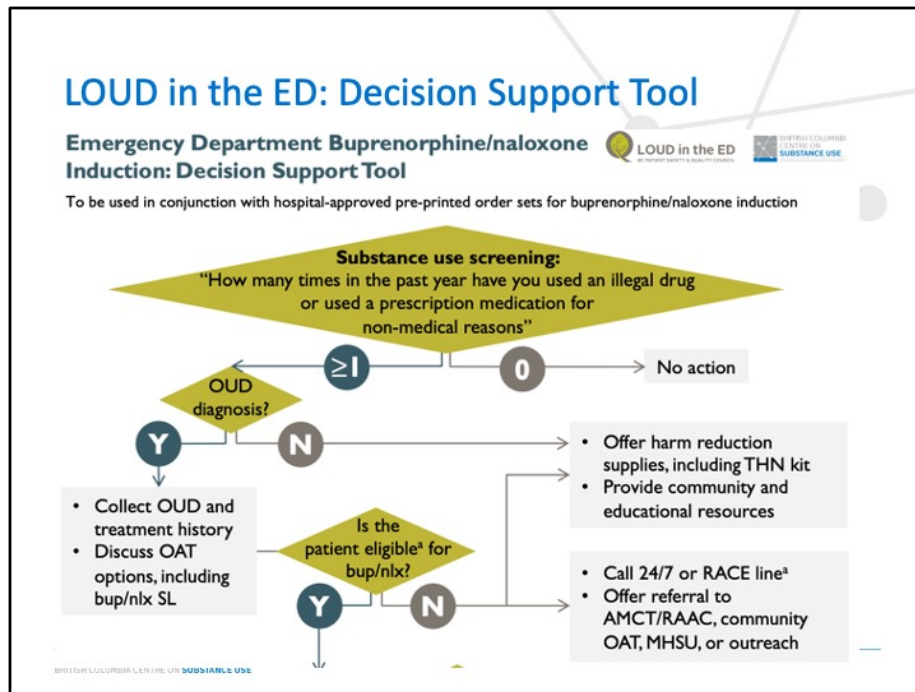
- A) Patients should calculate COWS score every hr
- B) Maximum Day 1 dose is 8mg
- C) Different principles of care apply for home inductions than for emergency department starts
- D) Ideal to provide additional medications for withdrawal management as to-go packs**

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- The correct answer is D, it is ideal to provide additional medications for withdrawal management as to-go packs.
- A is incorrect. The COWS is not appropriate for self-administrations because it involves assessing vital signs. Patients who are doing a home induction should instead use the SOWS to self-assess withdrawal symptoms
- B is incorrect. The maximum day 1 dose in most protocols is 12mg to 16mg of buprenorphine,
  - in practice there is no maximum dose. With PRN doses, some patients will reach 24 mg or beyond on day 1 (disclaimer: this later point is outside of current BCCSU guidelines)
- C is incorrect. The principles of care are the same for both home inductions and emergency department starts.

## Buprenorphine Basics Modules

- You have completed 1 of 4 “Basics” modules:
  - Pharmacology
  - Emergency Department Induction
  - ✓ Home or Unobserved Induction
  - Precipitated Withdrawal
- Please find the remaining modules at:
  - [https://https://www.bccsu.ca/edcare/](https://www.bccsu.ca/edcare/)



- A decision support tool for buprenorphine induction in emergency departments in BC is available through the BC Patient Quality and Safety Council. More resources are available on their website.
- [https://bcpsqc.ca/wp-content/uploads/2020/11/F2.0\\_LOUD\\_ED-Clinical-DST.pdf](https://bcpsqc.ca/wp-content/uploads/2020/11/F2.0_LOUD_ED-Clinical-DST.pdf)



The graphic features a network of grey lines and circles in the background. At the top, the title '24/7 Addiction Medicine Clinician Support Line' is written in blue. Below it is a logo with '24/7' in a blue box, 'ADDICTION MEDICINE' in grey, and 'CLINICIAN SUPPORT LINE' in blue. A paragraph of text describes the service, and a large blue trapezoidal shape at the bottom contains the phone number 'CALL 778-945-7619'. At the very bottom, the text 'BRITISH COLUMBIA CENTRE ON SUBSTANCE USE' is visible.

## 24/7 Addiction Medicine Clinician Support Line

**24/7** ADDICTION MEDICINE  
CLINICIAN SUPPORT LINE

Telephone consultation for physicians, nurse practitioners, nurses, mid-wives, and pharmacists providing addiction and substance use care.

Available 24/7, 365 days a year. More info at [www.bccsu.ca/24-7](http://www.bccsu.ca/24-7).

**CALL 778-945-7619**

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- If you need support managing precipitated withdrawal, inducting a patient on to buprenorphine/naloxone, or providing any other aspect of addiction and substance use care, you can call the 24/7 addiction medicine support line.
- The 24/7 addiction medicine clinician support line provides telephone consultation for physicians, nurse practitioners, nurses, mid-wives, and pharmacists who provide addiction and substance use care. It is available 24/7, 365 days a year. The number to call is 778-945-7619. More information can be found at [www.bccsu.ca/24-7](http://www.bccsu.ca/24-7).



- The Provincial Opioid Addiction Treatment Support Program contains modules with more information on opioid use disorder and opioid agonist treatments, including buprenorphine/naloxone. This program is available online and it is free of charge.

## References

1. Provincial Opioid Addiction Treatment and Support Program. *Module 24: Buprenorphine/naloxone in Acute Care Settings*. Available at: <https://www.bccsu.ca/provincial-opioid-addiction-treatment-support-program/>
2. BC Centre on Substance Use and BC Ministry of Health. Provincial Guideline for the Treatment of Opioid Use Disorder. 2017. Available at: <https://www.bccsu.ca/opioid-use-disorder/>
3. Provincial Opioid Addiction Treatment and Support Program. *Module 12: Home Induction of Buprenorphine/naloxone*. Available at: <https://www.bccsu.ca/provincial-opioid-addiction-treatment-support-program/>
4. Provincial Opioid Addiction Treatment and Support Program. *Module 11: Buprenorphine/naloxone - Induction*. Available at: <https://www.bccsu.ca/provincial-opioid-addiction-treatment-support-program/>
5. BC Patient Safety & Quality Council and BC Centre on Substance Use. 2020. *LOUD in the ED Decision Support Tool*. Available at: <https://bcpsqc.ca/resource/loud/>

