

DELAWARE OVERDOSE SYSTEM OF CARE

GUIDANCE DOCUMENT ON OPIOID USE DISORDER IN THE EMERGENCY DEPARTMENT

Developed by the OSOC Acute OUD Stabilization Subcommittee

EXECUTIVE SUMMARY

Delaware faces one of the highest opioid overdose rates in the nation, with over 2,000 suspected overdoses presenting to emergency departments (EDs) each year. In response, the Delaware Overdose System of Care (OSOC) developed this *Guidance Document* to establish a consistent, evidence-based approach for identifying and treating opioid use disorder (OUD) in ED settings. The guidance reflects collaboration among Emergency Medicine and Addiction Medicine physicians and clinicians, Emergency Medical Services (EMS), pharmacists, behavioral health professionals, and state leaders, aligning with national recommendations from the American College of Emergency Physicians (ACEP). The goal of this *Guidance Document* is to serve as a framework for health-system policymaking and as a best-practice reference for Emergency Departments in Delaware.

The document outlines standardized best practices, emphasizing five priority areas:

- **Screening:** Implement brief, validated tools integrated into triage or electronic health record (EHR) workflows, supported by staff education and stigma-reduction training.
- **Patient Engagement:** Use trauma-informed, patient-centered communication and expand access to Certified Peer Recovery Specialists and Care Navigators to support consistent, 24/7 engagement.
- **Medication Initiation & Withdrawal Care:** Adopt flexible buprenorphine-naloxone initiation protocols, including high-dose (macro-induction) and home-start options, with built-in EHR order sets for efficiency and safety in starting medication and managing withdrawal.
- **Transitions of Care:** Utilize the Delaware Treatment Referral Network (DTRN) for seamless referrals and warm handoffs to community providers, supported by care navigators and tele-navigation options.
- **Documentation and Billing:** Use specific diagnosis and billing codes (e.g., G2213) to ensure accurate tracking, reimbursement, and program sustainability.

By standardizing OUD management in EDs, these guidelines aim to improve care quality, reduce overdose deaths, streamline ED workflows, and strengthen coordination between hospitals, community providers, and state systems—ultimately supporting recovery and continuity of care for all Delawareans affected by opioid use disorder.

PURPOSE AND BACKGROUND

Delaware ranks in the top three states in the country for opioid overdose deaths, and the state's emergency departments (EDs) encounter an average of 2,062 suspected opioid overdoses every year since 2021[1]. While some national guidelines exist, ED clinicians take varied approaches to patient

[1] Delaware Department of Health and Social Services, Division of Public Health, National Syndromic Surveillance Platform-Electronic Surveillance System for the Early Notification of Community-based Epidemics (NSSP-ESSENCE).

engagement, stabilization, treatment initiation, and continuity of care. Such variation may be due to facility-specific resources and constraints, but the lack of consistency may also hinder quality and trust for patients and at the systems level.

The Delaware Overdose System of Care (OSOC) was established in 2018 by Delaware Legislation and brings together hospitals, EMS, community treatment providers, and state partners to coordinate treatment and care provided to individuals who have overdosed or require acute management of OUD. The work of OSOC is monitored by the Data & Quality Subcommittee using four North Star measures that we developed in collaboration with ED clinicians and other stakeholders:

1. Medications for opioid use disorder (MOUD) prescription at ED discharge.
2. Outpatient engagement in follow-up treatment following ED discharge.
3. MOUD initiated after ED discharge.
4. Sustained engagement in MOUD treatment.

The OSOC Acute OUD Stabilization Subcommittee Co-Chairs and OSOC Medical Advisor jointly proposed a multi-year project to develop referral pathways and a *Guidance Document* that represents OSOC's recommendations for opioid use disorder (OUD) care in the Delaware ED setting. This consensus-driven document summarizes components of standards of care and best practices, including but not limited to:

- Screening and triage
- Patient engagement
- Buprenorphine initiation protocols, including dosing and withdrawal management
- Discharge and transitions of care
- Funding, including coding and billing

The Guidance Document was informed by the OSOC Acute OUD Stabilization Subcommittee Working Group, local and regional ED and EMS experience, and the American College of Emergency Physicians (ACEP) consensus recommendations on the treatment of opioid use disorder in the emergency department[2].

Unlike Stroke or Trauma Systems of Care with regulatory requirements to comply with common standards, the OUD *Guidance Document* does not include a formal compliance structure. However, establishing a standardized approach to care allows for improved consistency in care and benchmarking across the state. Delaware health systems and EDs are encouraged to incorporate the framework and guidelines in this document to guide policymaking and improve standardization of OUD care across Delaware Emergency Departments.

[2] Hawk K, Hoppe J, Ketcham E, et al. Consensus recommendations on the treatment of opioid use disorder in the Emergency Department. *Annals of Emergency Medicine*. 2021;78(3):434-442. doi:10.1016/j.annemergmed.2021.04.023

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VERSION HISTORY

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PATIENT SCREENING

OVERVIEW OF CURRENT STATE (MARCH 2025)

Practices to screen for and identify patients with opioid use disorder (OUD) vary across Delaware emergency departments (EDs). Working group participants noted their EDs often rely on ad hoc or provider-specific practices to identify patients with OUD, rather than a universal or standardized approach. Patients are most commonly identified if they present after an overdose, in withdrawal, or requesting medication for opioid use disorder (MOUD) or opioids, which can result in missing less overt cases. Some hospitals apply SBIRT (universal screening, brief intervention, and referral to treatment) selectively (e.g., for trauma patients). One participating hospital asks questions about substance use during triage and a positive response prompts a referral to a behavioral health nurse. Overall, OUD screening varies by institution and provider, with only a subset regularly initiating conversations about substance use and treatment.

Working group participants queried their colleagues prior to the March 2025 working group meeting to learn what prevents them from screening patients for OUD or initiating conversations about substance use and several themes arose. Clinicians expressed discomfort initiating OUD discussions, and stigma may be a barrier to consistent engagement. One individual noted it is hard to prioritize conversations about substance use when they don't even have enough resources to manage other acute or chronic conditions while working in a busy ED. Additionally, several EDs represented in the working group rely heavily on care navigators for patient engagement, and when navigators are unavailable, screening, engagement, and referrals drop sharply.

Perhaps the largest barriers to screening patients and initiating conversations about substance use are real or perceived gaps in resources and referral pathways. Working group participants noted that the Delaware Treatment Referral Network (DTRN), formerly known as Open Beds referral system is used but is sometimes slow and inefficient, causing long ED stays. Additionally, pathways for outpatient or intermediate care can be unclear or confusing, and many ED providers are unfamiliar with community resources. This knowledge gap and lack of a simple referral resource may be preventing staff from sufficiently screening because they worry about not being able to offer additional support if a patient screens positive.

DELAWARE RECOMMENDATIONS

Any recommendations around implementing substance use or OUD screening must balance the competing priorities and time constraints of busy EDs. The recommendations below are intended to mitigate the barriers to patient screening raised by working group participants. However, as described above, a major reason why ED staff don't screen for substance use or OUD is lack of streamlined, easy to access resources and referral pathways to connect patients to ongoing community care. The recommendation for the State and health system leadership to support simple, streamlined engagement and referral protocols is discussed further in the next section, Patient Engagement.

STAFF TRAINING AND STIGMA REDUCTION

Working group participants' conversations with their colleagues illuminated that some stigma around substance use and OUD remains and may prevent staff from prioritizing OUD screening. Although there has been significant progress in decreasing stigma among healthcare providers, there remains opportunity for growth. Delaware emergency departments are encouraged to implement staff training and stigma reduction in accordance with the following guidelines:

- Establish a culture where SUD and OUD are viewed and approached the same as any other chronic disease.
- Regularly make training available to all ED staff – nurses, physicians, and social workers – on MOUD, trauma-informed care, and stigma reduction.
- Use simulations, case studies, and peer mentoring to build provider confidence and normalize OUD care.

The State and health system leadership can support implementing standardized screening protocols in the following ways:

- Launch a statewide educational campaign to reduce stigma and promote OUD treatment as part of standard emergency care.
- Leverage the OSOC Acute OUD Stabilization Subcommittee to facilitate a statewide collaborative for peer learning, feedback, and shared problem-solving across EDs on topics related to SUD and OUD.

STANDARDIZED SCREENING PROTOCOLS

Working group participants noted that substance use and OUD screenings are typically ad hoc and provider dependent. Standardizing screening protocols for all patients can take the onus off staff to determine if or when to screen a patient and increase the likelihood of identifying patients in need of substance use or OUD support. Delaware emergency departments are encouraged to implement standardized screening protocols in accordance with the following guidelines:

- Implement uniform screening protocols for substance use and OUD, potentially integrated into triage or social history workflows. Several validated screening tools are available, each with their own strengths and weaknesses. The goal is a quick screening tool to help identify at-risk individuals, with the understanding of time constraints in a busy ED. The working group does not endorse one specific screening tool. Rather, we encourage EDs to implement a screening tool that best fits within the workflow of each ED and hospital system.
    - Examples of standardized drug and alcohol use screening tools:
        - CAGE Adapted to Include Drugs (CAGE-AID)
            - Four questions
            - Clinician or self-administered
        - Tobacco, Alcohol, Prescription Medication, and Other Substance Use (TAPS)
            - Four questions (TAPS-1), additional questions depending on responses
            - Clinician or self-administered
        - Two-Item Conjoint Screen (TICS)
            - Two questions
            - Developed for primary care
        - Screening to Brief Intervention (S2BI)
            - Three to seven questions, depending on responses
            - Clinician or self-administered
            - Adolescent-specific
        - Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD)
            - Three to five questions, depending on responses
            - Clinician or self-administered
            - Adolescent-specific
- Develop processes for brief intervention and referral in patients who screen positive.

The State and health system leadership can support implementing standardized screening protocols in the following ways:

- Develop and disseminate statewide evidence-based clinical protocols for substance use and OUD screening and brief interventions, including decision aids and scripts.
- Provide technical and financial resources for integration of screening tools into EHR systems.
- Leverage OSOC resources (including the Data & Quality Subcommittee) to evaluate adherence to protocols and track key metrics (e.g., buprenorphine initiation rates, referral completions, follow-up engagement).
- Positive screen should prompt an action leading to further assessment, diagnosis or treatment.

Resources and Structures to Support SUD Screening

Universal Triage Screening and EHR Nudge – Penn's Perelman School of Medicine

- Implemented 1) triage screening question asked by nurses and 2) automated nudge in EHR to make clinicians aware of patients with OUD.
- Number of OUD assessments doubled and MOUD initiation increased.
- Lowenstein M, McFadden R, Abdel-Rahman D, et al. Redesign of Opioid Use Disorder Screening and Treatment in the ED. *NEJM Catal Innov Care Deliv*. 2022;3(1):10.1056/CAT.21.0297. doi:10.1056/CAT.21.0297. Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10641724/
- Lowenstein M, Perrone J, McFadden R, et al. Impact of universal screening and automated clinical decision support for the treatment of opioid use disorder in emergency departments: A Difference-in-Differences analysis. *Annals of Emergency Medicine*. 2023;82(2):131-144. doi:10.1016/j.annemergmed.2023.03.033. Accessed at: https://www.annemergmed.com/article/S0196-0644(23)00265-2/fulltext

Train All Staff and Standardize Protocols – Cooper University Health Care ED

- Trained all ED physicians and residents in MOUD (buprenorphine and methadone, naltrexone for AUD) and supporting topics (e.g., stigma and language).
- Created protocols for opioid withdrawal assessment, buprenorphine initiation, methadone initiation, naltrexone for AUD, and linkage to community treatment.
- #NDAFW: Emergency Medicine and Hospital-Based Addiction care available at Cooper. eHealth Connection. Published March 27, 2023. Accessed October 13, 2025. https://blogs.cooperhealth.org/ehealth/2023/03/27/ndafw-emergency-medicine-and-hospital-based-addiction-care-available-at-cooper/
- #NDAFW: medications for substance use disorders, increasing access to treatment, and decreasing stigma. eHealth Connection. Published March 22, 2023. Accessed October 13, 2025. https://blogs.cooperhealth.org/ehealth/2023/03/22/ndafw-medications-for-substance-use-disorders-increasing-access-to-treatment-and-decreasing-stigma/

Screen Broadly and Post Signs to Encourage Patients to Seek Care – CA Bridge

- Ask about OUD in patients with:
    - Opioid withdrawal symptoms
    - Sequelae of injection use
    - Skin and soft-tissue infections
    - Endocarditis
    - Flu-like symptoms
    - Nausea, vomiting, and/or diarrhea
    - Acute or chronic hepatitis C or HIV positivity
    - Positive urine toxicology testing
    - Use of alcohol, methamphetamine, or other drugs

- Empower patients to share SUD by posting signs letting them know support is available
- *Blueprint for Hospital Opioid Use Disorder Treatment*. California Department of Health Care Services; 2022. Accessed October 13, 2025. https://bridgetotreatment.org/resource/blueprint-for-hospital-opioid-use-disorder-treatment/

PATIENT ENGAGEMENT

OVERVIEW OF CURRENT STATE (JANUARY 2025)

Strategies for engaging patients with opioid use disorder in Delaware emergency departments vary considerably by provider and by institution. No healthcare system has a standardized protocol for initiating conversations around opioid or substance use, but all participants described their own approaches for beginning the conversation. Strategies shared by working group members include the following:

- Understanding why a patient is in withdrawal in the ED. Sometimes patients come specifically because they want to stop using and want help, and these patients are usually the most open to engaging in a conversation about starting buprenorphine/MOUD.
- Validating patients' discomfort and talking about the best options to make them feel better. This builds rapport and reassures them the ED staff are taking them seriously.
- Talking about withdrawal and understanding the patient's situation and possible reasons for using, which can help calm them down and open the door for a conversation about starting MOUD.
- Asking about past experiences with withdrawal and with trying MOUD.

Working group participants also described several barriers to improving patient engagement around MOUD. A major limitation that prevents ED staff from engaging patients in discussions about MOUD is the lack of a simple, streamlined referral process to transition patients from the ED to ongoing community treatment.

Another barrier is clinician discomfort around initiating conversations about OUD, especially when patients are in acute crisis or are ambivalent about beginning MOUD. ED clinicians are typically not experts on MOUD and may have discomfort answering patients' questions about withdrawal, various medications and their side effects, and long-term treatment options. Relatedly, there remains stigma towards patients with OUD that may be hindering these conversations.

Working group participants also noted it can be difficult to convince their ED physicians to think about OUD like any other medical problem. This challenge seems partly due to an education gap, more so for more senior clinicians. These individuals often did not receive education on OUD or MOUD until recently and even then, often must choose to seek it out. Additionally, ED staff have many competing priorities,

and engaging patients in conversations about MOUD is sometimes seen as optional or secondary, depending on staffing levels and time pressures.

DELAWARE RECOMMENDATIONS

PATIENT-CENTERED AND TRAUMA-INFORMED ENGAGEMENT STRATEGIES

A recurring theme in the discussion of patient engagement was the importance of making patients feel heard, understood, and cared for. Delaware emergency departments are encouraged to implement strategies designed to facilitate engagement with patients with, including the following guidelines:

- Check in with patients regularly throughout their time in the ED to ensure they understand next steps and feel prioritized. Acknowledging ED clinicians have time pressures, these can be very brief check-ins, no more than 1-2 minutes.
- Take a judgement-free, destigmatizing approach to patient interactions, including using person-centered language and avoiding generalizations about people with OUD.
- Believe and validate patients' experiences, symptoms, and concerns about starting MOUD or other OUD treatment.
- Discuss the patient's perspective on their substance use, their desire and motivations for change, hopes/plans, and openness to treatment.

CARE NAVIGATORS, PEERS, AND BEHAVIORAL HEALTH STAFF TO SUPPORT PATIENT ENGAGEMENT

Employing Care Navigators, peers, and increasing ED access to behavioral health support is a top priority among Delaware ED and treatment provider leaders. A peer who has lived experience with MOUD is able to describe the experience of using various medications, share information about recovery process, and help the patient engage in a collaborative relationship with the treatment team. One working group member noted that peers have been "the most impactful thing" they've seen in the ED when it comes to patient engagement. Additionally, peer availability can help ED clinicians balance the time constraints and high patient volumes in a busy ED by providing additional support to the patient. Delaware emergency departments are encouraged to implement peer supports in accordance with the following guidelines:

- Work towards 24/7 access to peer support, either in person or by phone, to support ED clinicians with patient engagement and trust building. Working group participants affirmed that tele-peer support would be a helpful resource and utilized by staff.
- Where peers are not available, consider on-call behavioral health specialists to help facilitate patient engagement around MOUD and care navigators to support follow-up planning.

The State and health system leadership can support implementing the peer and behavioral health staff guidance in the following way:

- Streamline peer access: Consider whether existing State resources (e.g., the Bridge Clinics) can be leveraged to provide 24/7 peer support to EDs. Establish a single phone number or other simple, streamlined process to connect patients with a peer to facilitate engagement and discharge planning.

SIMPLE, STREAMLINED ENGAGEMENT AND REFERRAL PROTOCOLS

Working group participants noted several interconnected barriers to engaging patients in discussions around MOUD. ED clinicians typically are not experts in OUD or MOUD, have limited time and competing priorities, and are often unsure about what resources exist for patients after the ED. All these challenges point to the need for a simple, streamlined process for identifying, engaging, and referring patients (referrals are discussed further in the Transitions of Care section). ED representatives noted a need for a single contact point or phone number they could call to assist with identifying patients' needs, discussing treatment options, and facilitating follow-up.

While emergency departments are encouraged to implement their own engagement protocols and specialized training for ED clinicians, working group members specifically pointed to the need for a single, statewide option. The State and health system leadership can collaborate to help fill this gap in the following way:

- As described above, consider whether existing State resources (e.g., the Bridge Clinics) can be leveraged to provide 24/7 patient engagement and referral support to EDs. ED representatives noted the need for a simple way (e.g., single phone number) to connect patients to an individual who can provide information about treatment options and what might be the best fit, answer their questions, and facilitate a referral and next steps.

FREQUENTLY ASKED QUESTIONS AND RECOMMENDED RESPONSES

There are common questions that often arise when discussing buprenorphine with patients and ED clinicians may be uncomfortable beginning the conversation or answering these questions. To support clinician preparedness, Appendix A contains frequently asked questions, background information on some key concepts, and recommended responses to questions that have been asked by patients.

STARTING MEDICATION FOR OPIOID USE DISORDER (MOUD) IN THE ED

OVERVIEW OF CURRENT STATE (NOVEMBER 2024 MEETING; OCTOBER 2025 UPDATE)

All hospital partners have practices for starting patients on MOUD in the emergency department, though there is some variation in specific protocols for starting buprenorphine or methadone. In general, patient eligibility is determined using the Clinical Opiate Withdrawal Scale (COWS) and other criteria. Eligible patients may be given buprenorphine or methadone, then reassessed. Adjunctive

medications are also typically used to help manage symptoms. Some hospitals offer patients the opportunity to start buprenorphine at home and provide instructions with their discharge materials.

IMPORTANT CONSIDERATIONS

ADULTERANTS IN THE STREET OPIOID SUPPLY

Polysubstance adulterants have become an increasingly larger issue in the management of overdose and withdrawal. Recent adulterants have included xylazine, novel benzodiazepines, and medetomidine. While medetomidine withdrawal is addressed in the "Adjunctive and Supportive Treatments for Withdrawal" section (Appendix B), these guidelines cannot cover all possible adulterants. It is important to recognize the ever-changing landscape of contents in the street drug supply. These changes can cause difficulties in policymaking for health systems. While high-quality research-based evidence is ideal, as novel adulterants rapidly emerge oftentimes the only available evidence for treatments are experience-based expert opinion, case studies, and small retrospective reviews. An understanding of these unique challenges is important. We encourage flexibility in health system policymaking with consideration of benefit versus risk based on available evidence and understanding that highest-quality evidence may be limited. We also recommend monitoring local trends and subscribing to Delaware's Overdose Response Center (ORC) Street Drug Report (email ORC@delaware.gov and ask to be added to the email list) and Health Alert Network (HAN) messages for Delaware, surrounding states, and CDC.

WITHDRAWAL MANAGEMENT ("DETOX") REFERRALS

For patients requesting assistance with entering a withdrawal management ("detox") facility, requests/referrals must be appropriate to the patient-specific factors. For example, a patient with active behavioral/mental health difficulties along with OUD may be appropriate for an "institution for mental diseases" (IMD) facility, however, withdrawal management/detoxification alone would be appropriate for a withdrawal management/detox facility, rather than an IMD. In unclear cases, discussion with an addiction medicine and/or psychiatry/mental health professional can assist with directing post-ED or post-hospital level of care recommendations. Patients should be encouraged to start MOUD at the withdrawal management facility and continue MOUD after discharge from the facility, as the risk of returning to opioid use is very high when not on MOUD. Additionally, with loss of opioid tolerance, there is a very high risk of overdose after "detox" and return to use. This should be considered when discussing withdrawal management ("detox") with patients.

OVERVIEW OF MOUD INITIATION RECOMMENDATIONS

The recommendations below were developed with safety in mind and are intended to be flexible and can be tailored to each individual ED's needs. Health systems are encouraged to implement a formalized program for starting MOUD. The following guidelines may be used to build a standardized program in each facility. The working group recommends the following approach:

1. Evaluate the patient for opioid use disorder (OUD) diagnosis.
2. Assess the patient's Clinical Opiate Withdrawal Scale (COWS) score.
3. Provide opioid withdrawal treatments, including adjunctive and supportive medications.
4. Discuss MOUD.
5. Consider starting MOUD:
    a. Buprenorphine/naloxone (Suboxone) in the ED (if meeting criteria) or at home, OR
    b. Methadone in the ED (Appendix C).
6. Assist with follow-up planning; involve a Care Navigator, Social Worker, or Case Management (if available).
7. Provide prescriptions for Suboxone (if applicable), symptom-control medications, and a naloxone rescue kit (preferred) or prescription for naloxone, and adjunctive/symptomatic medications. Naloxone "Opioid Rescue Kits" are available free of charge from DSAMH. (Discharge checklist available in Appendix D).
8. Integrate this process into the electronic health record (EHR) system, if possible.

Details for these recommendations are below.

EVALUATE FOR OPIOID USE DISORDER (OUD)

While an OUD diagnosis is often clear based on a brief conversation with the patient and review of records, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) includes specific criteria for OUD diagnosis. See Appendix E for an OUD diagnosis checklist.

IDENTIFY AND TREAT OPIOID WITHDRAWAL IN THE ED

Assess withdrawal using the Clinical Opiate Withdrawal Scale (COWS) (Appendix F). Consider the following recommendations for opioid withdrawal treatment in the ED:

ALL ED PATIENTS WITH OPIOID WITHDRAWAL:

- Symptomatic treatments are first-line for opioid withdrawal in the ED (See "Adjunctive and Supportive Medications" [Appendix B])
- Assess criteria for starting buprenorphine/naloxone (Suboxone®) or methadone (See "MOUD" section below).
- Consider and treat co-occurring alcohol, benzodiazepine, or alpha-2-agonist (medetomidine or xylazine) withdrawal.
- Anticipated DISCHARGE: Involve care navigator/case management/social work early (if available) to coordinate follow-up care and ongoing MOUD.
- Anticipated ADMISSION: We recommend coordinated policies between ED and inpatient services to improve transitions of care and post-hospital linkage to care. If available, involving

addiction medicine and/or psychiatry during the hospital stay can assist in care and coordination of post-hospital level of care recommendations.

MILD WITHDRAWAL (COWS ≤12):

- Symptomatic treatments (Appendix B).
- Consider buprenorphine/naloxone (Suboxone) home initiation (Appendix G) or starting methadone (Appendix C).
- Consider checking COWS Q3 hours if at risk for withdrawal or in mild withdrawal.
- Opioid agonists (such as hydromorphone) are *NOT INDICATED* for mild withdrawal.

MODERATE WITHDRAWAL (COWS 13-24):

- Symptomatic treatments (Appendix B).
- Consider starting buprenorphine/naloxone (Suboxone) or methadone in the ED, if meeting criteria. See Emergency Department Buprenorphine Initiation Recommendations or Appendix C for methadone.
- Consider checking COWS Q2 hours while in moderate withdrawal.
- Opioid agonists (such as hydromorphone) are *NOT INDICATED* as an initial treatment but may be considered for worsening or intractable symptoms in the ED.

SEVERE WITHDRAWAL (COWS 25+):

- Symptomatic treatments (Appendix B).
- Consider starting buprenorphine/naloxone (Suboxone) or methadone in the ED, if meeting criteria. See Emergency Department Buprenorphine Initiation Recommendations or Appendix C for methadone.
- Opioid agonists (such as hydromorphone) are often needed to control severe symptoms and pain.
- Consider checking COWS Q1-2 hours while in severe withdrawal.
- Consider and treat polysubstance withdrawal, such as alpha-2-agonist (medetomidine) withdrawal.

DISCUSS MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

Below are key talking points related to MOUD that may be helpful to share with patients. To support clinician preparedness, Appendix A contains frequently asked questions, background information on some key concepts, and recommended responses to questions that have been asked by patients.

DISCUSS BENEFITS AND POTENTIAL RISKS OF MOUD WITH PATIENT

- Significant reduction in risk of overdose or death when stabilized on MOUD.
- Reduction in withdrawal symptoms and cravings.

- Small risk of precipitated withdrawal during buprenorphine initiation.

MOUD OPTIONS

Buprenorphine/Naloxone (Suboxone ®):

- Buprenorphine is an opioid mu-receptor partial agonist with a long half-life.
- The buprenorphine/naloxone combination product (such as Suboxone) is recommended, rather than the buprenorphine mono-product (such as Subutex), due to decreased risk of diversion or unintended methods of use.
- Naloxone is included in the combination product to decrease the likelihood of diversion or unintended methods of use and is essentially inactive when the medication is taken sublingually.
- Buprenorphine/naloxone (Suboxone) may be started in or from the ED.
- Buprenorphine/naloxone (Suboxone) may be prescribed by any physician/prescriber who can prescribe controlled substances with valid DEA/CDS registrations.
- In the past, an X-waiver certificate linked to the standard DEA registration was required–this is no longer needed. In December 2022 the X-waiver requirements were eliminated with the Consolidated Appropriations Act of 2023.
- Guidelines for starting buprenorphine in the ED can be found in Appendix H and at home in Appendix G.

Methadone:

- Methadone is an opioid receptor full agonist with a long half-life.
- Dosing is started low and titrated up over the course of days to weeks.
- Patients wishing to start methadone treatment ED must also be referred to an Opioid Treatment Program (OTP) for ongoing methadone treatment.
- Considerations for starting methadone in the ED can be found in Appendix H.

LABORATORY TESTING

- Bloodwork is not necessary specifically for MOUD initiation.
- Urine toxicology: Urine drug screen, including methadone screen, should be ordered but results are **not** required before starting MOUD.
- Pregnancy test: Females under 55 years of age with possibility of pregnancy.

PATIENTS DECLINING MOUD

For OUD patients not interested in MOUD after discussion of the potentially life-saving benefits of MOUD and very high likelihood of returning to opioid use when not on MOUD, resources for ongoing care and a naloxone rescue kit should be provided. DSAMH provides naloxone “Opioid Rescue Kits” free of charge.

EMERGENCY DEPARTMENT BUPRENORPHINE INITIATION RECOMMENDATIONS

METHODS OF STARTING BUPRENORPHINE

There are several methods of starting buprenorphine, each with potential risks and benefits. Through local and regional experience, the high-dose (macro-induction) method is often most conducive for ED use and will be recommended in these guidelines. Table 1 highlights common methods.

Table 1. Common Buprenorphine Initiation Methods

Method	Standard	High Dose (macro-induction)	Low Dose (micro-induction)
Initial Dose of Buprenorphine	2-4 mg	16 mg	0.25-1 mg
Benefits	• Best for short-acting opioids (e.g., heroin, oxycodone IR). • Note that heroin is *not* frequently found in the Delaware area's street opioid supply.	• Safe and effective for fentanyl withdrawal (if criteria followed), per studies and local/regional ED and EMS use. • One or two large doses given, quick stabilization. • **Typically, most conducive to ED workflow.**	• No waiting period from last use. • Best for use in hospitalized patients with a 3–5-day standardized protocol. • Very low risk of precipitated withdrawal.
Risks	• Requires waiting period from last use and moderate withdrawal. • Higher risk of precipitated withdrawal, especially with prolonged fentanyl use. • Multiple doses over hours, with daily adjustments, less conducive to ED starts.	• Requires waiting period from last use and moderate withdrawal. • Precipitated withdrawal risk if criteria *not* followed.	• Requires cross-tapering with an opioid agonist (continued use of street opioids through harm-reduction approach, or administration of opioid agonist in the hospital). • Often confusing process for patients and clinicians to initiate and maintain.
References	*Buprenorphine Quick Start Guide*. Substance Abuse and Mental Health Services Administration Accessed October 13, 2025. https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf	Weimer MB, Herring AA, Kawasaki SS, Meyer M, Kleykamp BA, Ramsey KS. ASAM Clinical Considerations: Buprenorphine Treatment of Opioid Use Disorder for Individuals Using High-potency Synthetic Opioids. *J Addict Med*. 2023;17(6):632-639. doi:10.1097/ADM.0000000000001202 https://pubmed.ncbi.nlm.nih.gov/37934520/	Suboxone (Buprenorphine-Naloxone) self-guided Micro-Induction Protocol with Cross-Taper. Penn Medicine Center for Addiction Medicine and Policy. Accessed October 13, 2025. https://penncamp.org/wp-content/uploads/2023/11/suboxone-self-guided-micro-induction-protocol-with-cross-taper.pdf *Buprenorphine (Bup) Hospital Start: Low-Dose Bup Initiation with Opioid Continuation*.

		Treat Patients with Substance Use Disorder on Shift. California Department of Health Care Services; 2025. Accessed October 27, 2025. https://bridgetotreatment.org/addiction-treatment/ca-bridge/on-shift/	California Department of Health Care Services; 2024. Accessed October 13, 2025. https://bridgetotreatment.org/resource/low-dose-buprenorphine-initiation-with-opioid-continuation/

EMERGENCY DEPARTMENT STARTS

There are 3 groups of patients that can often start buprenorphine in the ED, with goals of symptom improvement, minimal risk of precipitated withdrawal, and discharge to outpatient follow-up. Instructions for initiating each of these groups can be found in Appendix H.

- Group 1: Opioid withdrawal and meet eligibility criteria below.
- Group 2: Recent naloxone resuscitation after opioid overdose.
- Group 3: No recent opioids but continue to have cravings and risk of use/overdose.

ED START, GROUP 1: OPIOID WITHDRAWAL AND MEET ELIGIBILITY CRITERIA BELOW

Inclusion Criteria: To minimize the likelihood of precipitated withdrawal, **ALL** of the following criteria should be met prior to starting buprenorphine initiation.

1. Has been at least 24-36 hours since the patient's last use of fentanyl, or at least 16 hours since last use of short-acting prescription opioids (such as oxycodone or hydrocodone), AND
2. Patient has not taken methadone in at least 5 days, AND
3. COWS score is 12 or higher, AND
4. Patient subjectively feels very sick from opioid withdrawal and feels ready to start buprenorphine, AND
5. Patient has 2 or more objective signs of withdrawal (e.g., tachycardia, sweating, rhinorrhea, vomiting, diarrhea, enlarged pupils, gooseflesh skin).

Exclusion Criteria

1. Altered mental status: Patient is significantly altered and cannot give history or consent to treatment.
2. Methadone use: If patient has taken methadone within the past 5 days or is receiving methadone from an opioid treatment program (OTP) facility/clinic, buprenorphine should not be started in or from the ED. Note that methadone from an OTP may not show up in the Prescription Monitoring Program (PMP). It is important to ask the patient about any current or recent methadone use. If unclear, results from a urine drug screen for methadone may be used along with history from the patient.

Caution with other sedative use: Alcohol or benzodiazepine use is NOT a contraindication for patients to be started on buprenorphine. However, the patient should be educated about increased risks due to a combination of these substances, such as increased sedation.

If meeting criteria, patient can immediately receive buprenorphine/naloxone 16mg/4mg SL to both treat their withdrawal symptoms and initiate buprenorphine therapy. Additional doses may be needed. See Appendix H for full ED macrodosing algorithm and information about buprenorphine precipitated withdrawal.

ED START, GROUP 2: RECENT NALOXONE RESUSCITATION AFTER OPIOID OVERDOSE

Inclusion Criteria: To minimize the likelihood of precipitated withdrawal, **ALL** of the following criteria should be met prior to starting buprenorphine initiation.

1. Patient has received naloxone in the last ~30-45 minutes, AND
2. Has withdrawal symptoms (COWS 5+), AND
3. Has NOT taken methadone in the last 5 days, AND
4. Patient gives consent to receive buprenorphine, THEN,
5. Patient can immediately receive buprenorphine/naloxone 16mg/4mg SL to both treat their withdrawal symptoms and initiate buprenorphine therapy. See Appendix H for full ED macrodosing algorithm.

Note: This is similar to the successful pre-hospital EMS buprenorphine initiation protocol. The risk of precipitated withdrawal in this group is very low, but there is a time sensitivity to achieve the best outcomes with buprenorphine initiation. While many Group 2 patients will be coming in via EMS, it is recommended to work with triage staff to identify these individuals and expeditiously provide buprenorphine treatment, if indicated.

ED START, GROUP 3: OPIOID ABSTINENCE WITH CRAVINGS

Patients who have been abstinent from opioids and no longer have opioid withdrawal symptoms often continue to have opioid cravings which put them at risk for opioid use and overdose. This is common in post-incarceration or post-detoxification/rehabilitation populations; these patients have high rates of returning to use and overdose mortality. These patients may be started on buprenorphine in the ED and have outpatient follow-up with an MOUD provider arranged.

Note: Lower starting doses (such as 8mg buprenorphine/naloxone SL) may be considered for this group. Vivitrol (naltrexone for extended-release injectable suspension) may also be considered for this group if the patient has been opioid-free for at least 7-10 days.

HOME START

If your patient is in mild withdrawal or recently used opioids and does not fall into the above groups, consider providing instructions on starting buprenorphine/naloxone (Suboxone®) at home. The physician/provider should discuss instructions and the process of starting buprenorphine with the patient. Several methods of starting buprenorphine have been described (see Table 1 above), including at home. We have included instructions for one method being used by a local health system. See the "How to Start Taking Buprenorphine at Home" instruction sheet developed by ChristianaCare. This is available in Appendix G. With this method, it is also important to prescribe and recommend adjunctive and symptomatic medications to assist in the treatment of withdrawal prior to starting buprenorphine.

Caution with other sedative use: Alcohol or benzodiazepine use is NOT a contraindication for patients to start buprenorphine. However, the patient should be educated about increased risks due to a combination of these substances, such as increased sedation.

HOSPITALIZATION NEEDS

If your patient clearly needs hospitalization for a medical reason or severe withdrawal (opioids or polysubstance), we recommend coordination with the hospital admitting team and consider consultation with an Addiction Medicine specialist (if available). Alternative dosing strategies and/or opioid agonist medications are often needed in the hospital to control severe symptoms.

- Prioritize starting and continuing MOUD in the ED or during hospitalization.
- Alternative strategies for starting buprenorphine–such as low-dose (micro-inductions) have been successful in the hospital, with a standardized protocol.
- We recommend coordinated policies between ED and inpatient services to improve transitions of care and post-hospital linkage to care.

SPECIAL POPULATIONS

- Pregnancy: Per American College of Obstetricians and Gynecologists (ACOG), the standard of care for pregnant patients with OUD is buprenorphine or methadone. Consider discussing the case with obstetrician (OB). Withdrawal symptoms in pregnancy are treated the same as in non-pregnant patients.
- Adolescents: FDA guidelines recommend buprenorphine for patients with OUD who are 16 years of age or older. It is best to consult with Addiction Medicine regarding this population. Home buprenorphine initiation may be more challenging.
- Cirrhosis: Patients with severe liver disease may not metabolize buprenorphine at the same rates so starting at lower doses may be appropriate. For patients with a history of liver disease or cirrhosis, discussion with Addiction Medicine consultant or pharmacist is recommended.

- Chronic Pain: For many patients with both chronic pain and OUD, or chronic pain alone, buprenorphine can be an appropriate alternative to full opioid agonists. Twice daily dosing may help with pain control. Consider discussion with Addiction Medicine or Pain Management for patients with OUD treatment complicated by chronic pain.
- Dual Diagnosis Patient: Patients struggling with OUD and psychiatric comorbidity face increased challenges. Buprenorphine is an appropriate medication for OUD in the setting of psychiatric medications with rare medication interactions.

BUPRENORPHINE PRECIPITATED WITHDRAWAL

If sudden and severe worsening of symptoms after buprenorphine administration:

1. Give buprenorphine 16 mg SL once IMMEDIATELY (total of 32 mg).
2. Consider "Adjunctive and Supportive Treatment Options for Opioid Withdrawal" (Appendix B).
3. Consider ketamine administration:
    a. Ketamine can be a helpful adjunct in the treatment of severe opioid withdrawal and buprenorphine precipitated withdrawal.
    b. Initial dose of ketamine 0.3 mg/kg IV slow push over 2 minutes. Alternatively, this dose may be administered IV over 15 minutes to prolong the effects of the medication.
    c. After the initial dose of ketamine, withdrawal symptoms (clinical findings and patient's symptoms or COWS score) should be reassessed within 10-15 minutes. If withdrawal symptoms are not improving, may repeat ketamine dosing at 0.3 mg/kg IV every 15-20 minutes to a maximum dose of 0.9 mg/kg.
    d. For patients without an IV, consider ketamine 0.7-1 mg/kg IM.
4. Reassess in ~30 minutes, consider additional 8-16 mg of SL buprenorphine if not improved (total of up to 48 mg buprenorphine).

Notes and clarifications:

- Buprenorphine precipitated withdrawal (BPW) is often defined as a rapid worsening of opioid withdrawal symptoms and/or increase in COWS of 5+ within 2 hours (but typically within 30 minutes) after taking buprenorphine.
- Gradual increases in withdrawal symptoms and COWS are seen in protracted opioid withdrawal or polysubstance withdrawal and should NOT be labeled as buprenorphine precipitated withdrawal.
- Risk of precipitated withdrawal is higher in frequent users of large amounts of fentanyl, lower risk with other opioids or infrequent use.
- Risk of precipitated withdrawal is minimized by waiting until the patient is in more significant withdrawal and using higher starting doses of buprenorphine (macro-induction). Alternatively, low dose (micro-induction) has a very low risk of BPW (see Table 1 above).

- Consider discussion with Addiction Medicine consultant (if available) in cases of BPW.

MOUD-SPECIFIC REFERENCES:

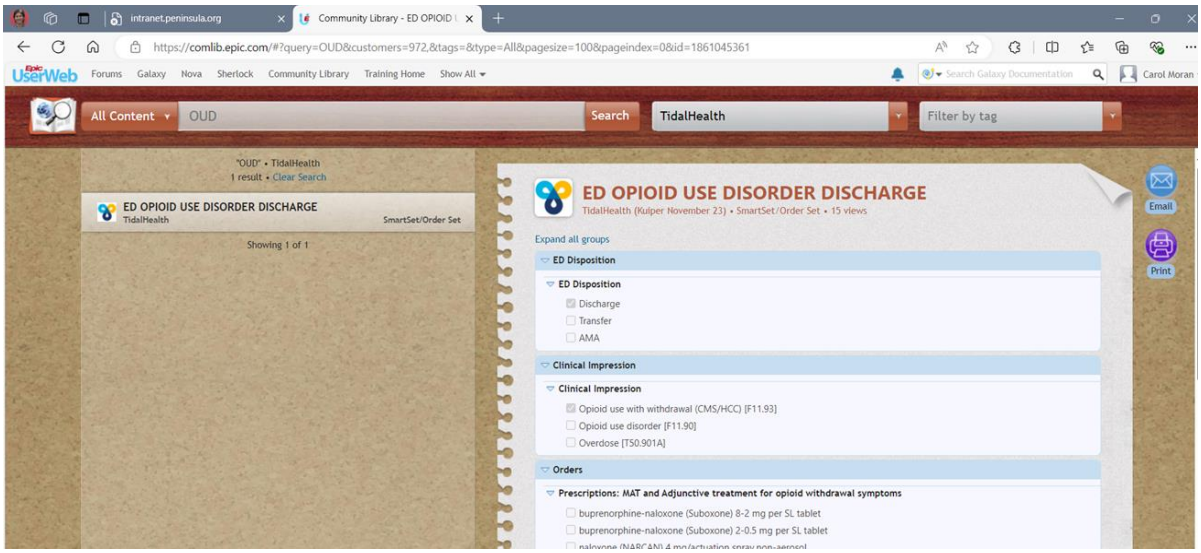
See here.

ELECTRONIC HEALTH RECORD (EHR) INTEGRATION AND SAMPLE EHR OUD DISCHARGE SMARTSET

Integration of policies and guidelines into the EHR is recommended for easy access by clinicians and efficiency of care. Examples of integration include order sets to guide withdrawal care and MOUD initiation, including resources such as the buprenorphine home start instruction sheet (Appendix G) into the EHR discharge workflow, or SmartSets such as the example below.

The SmartSet below was shared by TidalHealth Nanticoke. To access: On the Epic User Web in the Community Library, filter by TidalHealth and search “ED Opioid Use Disorder Discharge”.

Figure 1. TidalHealth ED Opioid Use Disorder Discharge SmartSet



TRANSITIONS OF CARE

OVERVIEW OF CURRENT STATE (SEPTEMBER 2024)

Several hospital partners report using the Delaware Treatment Referral Network (DTRN), formerly known as Open Beds, to refer patients to local substance use treatment providers. Others contact treatment providers directly to coordinate the referral or provide a list of local treatment providers and

resources to patients upon discharge. In some cases, hospitals share information with the treatment provider, including the patient's medical record and medications administered in the ER. However, this information sharing is not standardized or consistent across facilities.

There is some variation among hospitals regarding which staff facilitate referrals and support transitions of care. At one facility, the physician engages the patient to discuss beginning treatment, then a nurse makes the referral in DTRN (typically the charge nurse). Only one hospital has a Peer Navigator team available 24/7; they're physically located at one facility and provide tele-navigation services for the other locations. Hospitals report it is difficult for physicians to make referrals because of time constraints and less familiarity with community resources.

Hospital staff do their best to accommodate patient preferences in terms of treatment provider and location, depending on availability. They encounter some barriers with referral partners, including lack of availability, inconsistent MOUD offerings, and misinformation about MOUD initiation best practices (e.g., primary care providers encouraging urine drug screen prior to buprenorphine initiation).

When discussing gaps related to transitions of care, a major recurring theme is Peer Navigators. Several hospitals report previously having Peer Navigators employed with grant funding, which has since lapsed. For those facilities who do have Peer Navigators or other staff to support referrals, there are lapses in evening and weekend support and a lack of 24/7 coverage was noted as a gap.

Delaware's Overdose System of Care (OSOC) Acute OUD Stabilization Subcommittee has done significant work to establish and strengthen relationships between EDs and community treatment providers to facilitate care transitions. The following OSOC partners have contributed to this foundational work and committed to supporting patients' transitions of care.

Table 2. OSOC Referring and Receiving Partners

Referring Organizations	Receiving Provider Organizations
• Bayhealth • Beebe • ChristianaCare • Kent County EMS • New Castle County EMS • Saint Francis • Sussex County EMS • TidalHealth Nanticoke	• Atlantic Family Physicians/La Red • Brandywine • ChristianaCare Family Medicine • ChristianaCare Project Recovery • CORAS • Lotus Recovery Centers • Westside Family Healthcare

DELAWARE RECOMMENDATIONS

Each ED's internal processes for transitions of care will depend on resources available, such as peer support or navigators, case management, and social work teams. The recommendations below are

intended to be flexible and tailored to each individual ED's needs. Several recommendations rose to the top during the working group's discussion, namely the use of care navigators to facilitate warm handoffs from EDs to outpatient treatment, supporting patient-centered referrals, and broad use of a simple and flexible electronic referral system.

CARE NAVIGATORS AND PEERS TO FACILITATE WARM HANDOFFS

Care Navigators and Peers to support transitions of care are a top priority among Delaware ED and treatment provider leaders. Hospitals need a flexible approach to Care Navigators and Peers. Several hospitals expressed that in an ideal world they would have 24/7 Care Navigator and Peer coverage. Others don't have a large enough patient load to support a full-time Care Navigator or Peer but could greatly benefit from tele-navigation support. Delaware emergency departments are encouraged to implement Care Navigation and Peers in accordance with the following guidelines:

- Care Navigators facilitate referrals from the ED to community treatment for patients with a substance use disorder, especially those who have experienced a nonfatal overdose and/or have been initiated on MOUD in the ED.
- Referrals follow "warm handoff" best practices, including direct communication with referral partner, a bridge prescription, pharmacy access assistance, troubleshooting common barriers to treatment access (e.g., insurance, transportation, childcare, language), and closing the loop with the patient and referral partner to ensure patient attended their appointment.
- Care Navigators develop and implement a discharge and referral checklist and support all care team members in completing their portion. For example, the Care Navigator may facilitate the referral and contact the treatment provider for a warm handoff, remind the physician to write a bridge prescription, remind the nurse to dispense take-home naloxone, and engage a social worker to coordinate benefits enrollment.
- Peers provide support services to patients by identifying hopes, goals and preferences for treatment and care to be received. The relationship between the peer recovery specialist and the client served is the foundation on which peer recovery support services and support are provided. The relationship between the peer and client is respectful, trusting, empathetic, collaborative, and mutual.
- Care Navigator and Peer staffing models are flexible and tailored to the individual needs of each ED. For example, an ED with a high volume of patients with substance use disorder may need a 24/7 in-person Care Navigation or Peer team, while an ED with a lower volume may need 24/7 access to tele-navigation.
- Tele-navigation services are easy to access and supported by necessary technology and infrastructure. For example, EDs have sufficient tablets to allow for video calls between patients and tele-navigators and hospital governing boards support credentialing and other administrative requirements as needed.

- The Delaware Bridge Clinics can be used to fill the tele-navigation gap while hospitals are implementing their own programs. Contact information for all Bridge Clinics is available here: https://www.helpisherede.com/addiction/treatment-and-recovery/bridge-clinics.

- If a warm handoff is not feasible, EDs can provide patients with additional resources to support their transition to community treatment:
  - Delaware Bridge Clinics: https://www.helpisherede.com/addiction/treatment-and-recovery/bridge-clinics.
  - Help is Here DE: https://www.helpisherede.com/.
  - DE Hope Line: 1-833-9-HOPEDE
  - Treatment Connection: https://www.treatmentconnection.com/.

The State and health system leadership can support implementing care navigation and warm handoffs in the following ways:

- Funding: The State may facilitate interim funding, such as grant opportunities. For navigation programs to be sustainable in the long term, health system leadership can allocate ongoing funding for navigator positions.
- Administrative: Health system leadership may help ED teams overcome administrative barriers, for example, implementing a tele-navigation system or ensuring hospital policy allows for hiring people with lived experience.
- Supervision/employing peers: The State can provide training around key considerations and strategies for employing and supervising people with lived experience. Health system leadership can support staff who are supervising people with lived experience (e.g., mentorship, training).
- Stigma: Health system leadership (at all levels) must voice strong support for MOUD as an evidence-based treatment for OUD to fight stigma and misinformation.
- Program development: The State and health system leadership can meaningfully engage people with lived experience (including those who have visited the ED for an OUD-related concern) to provide input on care navigation planning and implementation.

PATIENT-CENTERED REFERRALS

Referrals from the ED to community treatment involve many clinical and non-clinical considerations, including insurance coverage, resources for uninsured patients, pharmacy access, transportation, risk factors, and more. Delaware ED and treatment provider leaders agree these patient-specific factors must be considered when making referrals. Delaware emergency departments are encouraged to implement patient-centered referrals in accordance with the following guidelines:

- ED teams may consider patients' insurance status when arranging referrals to community treatment follow-up availability.

- Refer uninsured patients to providers on DSAMH's list of publicly funded addiction treatment facilities.
- Patients with insurance are referred to providers that accept their insurance. When using DTRN to make a referral, filter providers by "Payments Accepted" to see those that accept patient's insurance. Accepted payments in DTRN are:
  - Federal military insurance
  - Medicaid-AmeriHealth
  - Medicaid-Delaware First Health
  - Medicaid-Highmark
  - Medicare
  - No insurance
  - Private health insurance
  - Self-pay
  - Sliding fee scale
  - Traditional Medicaid

- ED teams and referral partners utilize transportation supports to assist patients in accessing care. As of October 2025, available transportation supports include:

Table 3. Transportation Supports

	Purpose	**Geography**	**How to Use**
DSAMH/Community Partner Support Unit (CPSU) Partnership	For individuals following an interaction with an acute service setting (e.g., ED, EMS) to help access an MOUD appointment.	Statewide	Delaware EDs may refer patients to this transportation resource. To do so, complete a CPSU Transportation Request Form and email it to CPSU. Alternatively, provide the patient with a CPSU Transportation Referral Postcard. The patient is then responsible for calling CPSU to arrange their ride.
DSAMH's DTRN Rideshare (powered by RoundTrip)	For clients receiving behavioral health treatment who require non-emergency transportation.	Sussex County	DSAMH-contracted behavioral health providers can request the service via DTRN.
Medicaid Non-Emergency Medical Transportation (Modivcare)	For Medicaid clients needing non-emergency transport to and from a covered medical service.	Statewide	Eligible Delaware Medicaid clients can request.

- Hospitals work to develop relationships with local pharmacies to facilitate medication access. When possible, ED leadership works with the hospital's outpatient pharmacy to establish a process for patients to get prescriptions filled before they leave the ED.
- ED teams do their best to prioritize patients' language and literacy needs when making referrals, for example providing referral materials at an appropriate reading level and referring to treatment providers with multilingual staff or interpreter services.

The State and health system leadership can support implementing the patient-centered referral guidance in the following ways:

- Funding: The State and health system leadership may explore interim funding for transportation supports, such as grant opportunities. For transportation supports to be sustainable in the long term, the State may consider increasing capacity to expand DTRN Rideshare.
- Pharmacy: Health system leadership can facilitate conversations between ED leadership and hospital pharmacy leadership to improve processes for ED patients to access medication while in the ED or upon discharge. Additionally, leadership can engage in relationship-building with local pharmacies to improve medication access. The State can act as a convener and leverage pharmacy stakeholders to coordinate this relationship-building.

ELECTRONIC REFERRAL SYSTEM

Referring patients from the ED to community treatment can be facilitated by an electronic referral system that is easy to use, flexible, and allows for necessary information to be shared between providers. ED and treatment provider leaders are especially interested in the feedback loop of an electronic referral system. It's helpful for both parties to know whether a patient was successfully connected to care and attended their follow-up appointment.

The Delaware Treatment Referral Network (DTRN), formerly known as Open Beds, is Delaware's automated referral network for behavioral health and substance use disorder treatment. The launch of DTRN360, a care coordination platform, will provide further support and options to providers assisting patients in accessing care.

Delaware emergency departments are encouraged to utilize the DTRN electronic referral system as the first line option for making referrals from the ED to community treatment, with the following considerations:

- DTRN allows receiving providers to set their hours for referral receipt, and some chose not to receive referrals outside business hours. This posed a challenge for EDs, who often need to refer patients to community treatment during evenings and weekends.
- Based on stakeholder input, DSAMH updated the system as follows:
    - Users can access the referral form even if it is outside business hours for the organization/service of interest.

- DTRN will queue these referrals to ensure they only surface in the receiving provider's referral request status page upon the start of their business hours.
- Workflow and "after hours" visual indicators were added to show EDs the provider is not currently open but will receive the referral request upon opening.

- If making a referral through DTRN is not an option, hospitals may do their best to facilitate a warm handoff via other means (e.g., using the referral pathways/forms developed by OSOC, calling the community provider, arranging transportation). See referral pathways described in Transitions of Care, Overview of Current State (September 2024) for more information.

The State and health system leadership can support implementing the electronic referral system guidance in the following ways:

- Awareness and training: The State can continue to raise awareness among relevant ED staff about the full functionality of DTRN (including forthcoming after hours referrals and DTRN360).
- Stakeholder input: The State can continue to collect and be responsive to stakeholder input with regard to DTRN functionality and features.

DOCUMENTATION AND REIMBURSEMENT (CODING AND BILLING)

Accurate documentation is necessary for statewide surveillance and tracking of OUD care and overdoses, and to allow for appropriate reimbursement for care provided. Tracking overdoses and OUD care can assist in the distribution and deployment of public health resources for assistance.

DIAGNOSIS

We recommend using a specific diagnosis reflecting the patient's presentation. Rather than using a nonspecific diagnosis such as "Substance Abuse" or "Intoxication," we recommend applying a more specific diagnosis code. This allows for accurate documentation and assists in public health surveillance and response to the opioid crisis.

For example, in a patient with a history of OUD who presented to the ED with an opioid overdose or opioid withdrawal, a more specific diagnosis would be one (or more) of the following:

- Opioid abuse with intoxication (F11.12)
- Opioid abuse with withdrawal (F11.13)
- Opioid use disorder (F11.90)
- Opioid use with intoxication (F11.929)
- Opioid use with withdrawal (F11.93)
- Opioid overdose (T40.2X1A)

STARTING MOUD IN THE ED

In 2021, a specific billing code (G2213) was introduced to allow for reimbursement of "Medication Assisted Treatment (MAT) in the Emergency Department."

Table 4. G2213 Billing Code Overview

CPT Code	Description	2024 wRVU	2024 Total RVU
G2213	Initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services.	1.3	1.8

This code (G2213) will cover the resource costs involved with initiation of medication for the treatment of opioid use disorder and referral for follow-up care. G2213 is an add-on code that can be assigned in addition to the ED E/M code. It also includes payment for assessment, referral to ongoing care, follow-up after treatment begins, and arranging for access to supportive services. Note that this code is not to be used for giving a patient a dose of naloxone.

Documentation should include:

- Indications for medications for opioid use disorder (MOUD), also referred to as medication assisted treatment (MAT).
- Specific medication employed.
- Follow-up process.
- Diagnosis of opioid use disorder (OUD).

Reference:

- Medication Assisted Treatment (MAT) FAQs. American College of Emergency Physicians. Updated February 2024. Accessed May 2025. Available at: https://www.acep.org/administration/reimbursement/reimbursement-faqs/medication-assisted-treatment-mat-faqs/
- Additional information obtained from the Ventra Health coding team. Consider contacting your facility's coding/billing team for additional recommendations.

REDUCING OVERDOSE RISK, COMPLICATIONS, AND HARM FROM OPIOID USE DISORDER

Even if a patient is not ready to stop using substances, there are ways to minimize the negative health, social, and legal impacts associated with drug use. Stopping the use of drugs and getting into treatment is the safest option, but can be extremely difficult due to withdrawal, cravings, and psychosocial

stressors. The following are recommendations for reducing stigma and "meeting people where they are" if they are not yet ready to stop using.

- Naloxone kits: Naloxone "Opioid Rescue Kits" are available free of charge from DSAMH. Kits include Narcan®, CPR face mask, and referral resources for ongoing treatment.
- Safer injection: Brandywine Counseling & Community Services' syringe services program (SSP) offers safer injection and disease prevention resources.
    - https://brandywinecounseling.com/ssp/
    - 302-588-0452
- Drug checking test strips: Patients may use fentanyl or xylazine test strips to test for the presence of these substances in their drugs.
- OpiRescue Delaware: Free smartphone application that provides individuals and organizations resources to prevent and recognize overdoses, perform overdose reversals, access naloxone, report naloxone use, and more. It's available for download on all Android and Apple devices.
- Never Use Alone: National toll-free hotline for individuals to call when they are using drugs alone. Operators are people with lived experience who collect location and contact information from the caller and contact emergency services in the event of unresponsiveness. Available 24 hours a day, 7 days a week, 365 days a year.
    - www.neverusealone.com
    - 800-484-3731 or 877-696-1996
- Consider sharing safer use tips, such as:
    - Start low, go slow. Use a test shot to determine the strength and effects.
    - Don't use alone, when possible.
        - Take turns using when in a group.
        - If using alone is the only option and a trusted friend or family member is available, ask them to monitor for signs of overdose and respond if necessary. Otherwise, use the Never Use Alone hotline.
    - Use one drug at a time. Using multiple substances at once increases the risk of overdose.
    - Have an overdose plan and keep naloxone nearby and easily accessible.

CONCLUSION

This *Guidance Document* represents a unified, evidence-based framework to strengthen the identification, management, and continuity of care for patients with OUD in Delaware EDs. Developed through collaboration among clinicians, health systems, and state partners, it provides clear, adaptable recommendations to promote standardized practices across screening, patient engagement, medication initiation, and transitions of care. By embedding these approaches into daily ED operations and aligning them with statewide systems and resources, Delaware EDs can ensure every encounter becomes an opportunity for stabilization, connection, and recovery.

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APPENDIX A. BUPRENORPHINE FREQUENTLY ASKED QUESTIONS AND SUGGESTED RESPONSES

MEDICATION EDUCATION

1. **What is buprenorphine?**
   - Buprenorphine [byoo-pruh-nor-feen], sometimes called "bupe/bup", is an opioid receptor partial agonist medication that can help treat opioid use disorder. It has a high receptor affinity, so it can displace opioids (such as fentanyl) from the opioid receptors.
   - Buprenorphine is available as Subutex® (buprenorphine only) and Suboxone® (a combination medication that includes buprenorphine and naloxone).
   - Naloxone is included in Suboxone® to discourage inappropriate use or diversion of the medication. The naloxone is essentially inactive when Suboxone® is taken sublingually.
   - Note that while Suboxone® is sometimes sold on the street, most people who buy it seem to be trying to treat themselves and trying to get off fentanyl. We can help get them into treatment! People don't get "high" from sublingual Suboxone®.

2. **It says "naloxone" on the packaging. Why are you giving me more Narcan®? I thought this was going to help.**
   Response:
   - Suboxone® contains both buprenorphine and naloxone, but the naloxone (Narcan®) isn't active when you take the medicine under your tongue.
   - Naloxone is included as a safeguard to prevent dissolving the strips to inject – the Narcan® will block any euphoric or "high" feelings if someone tried to inject it.

3. **I can't take Suboxone®, it gives me headaches. I can only take Subutex®.**
   Response:
   - We can only give Suboxone® to help treat your opioid use and withdrawal, but I can give you a dose of Tylenol to help if you get a headache.
   - Staying well hydrated and taking over-the-counter medicines like Tylenol or ibuprofen can help with headaches.
   - Sometimes patients do have headaches initially, but the headaches typically get better over time.

4. **What happens if I use again after taking Suboxone®/buprenorphine?**
   Response:
   - If you use again after taking buprenorphine (Suboxone®), the buprenorphine in your system will reduce the effect of opioids (e.g., fentanyl) taken.
   - But the goal of Suboxone® is to treat withdrawal, control your cravings, and help prevent you from feeling the need to use.

5. **I won't be able to drink alcohol if I take Suboxone®.**
   Response:
   - Buprenorphine is not like Antabuse® (disulfiram). You could still drink alcohol, but you may get sleepier if you're on buprenorphine.
   - We recommend being very careful if you're also drinking alcohol or taking other sedating medicines (like benzodiazepines). Don't drive and please talk with your doctor/prescriber about it.

PRECIPITATED WITHDRAWAL

6. **What is precipitated withdrawal?**
   - Precipitated withdrawal (also known as "precip") is a sudden worsening of withdrawal symptoms after being given an opioid antagonist (e.g., naloxone) or partial agonist (e.g., buprenorphine) that displaces a full opioid agonist (e.g., fentanyl or methadone) from the opioid receptors.
   - Buprenorphine precipitated withdrawal occurs because buprenorphine can displace the full agonist (e.g., fentanyl), but can only partially stimulate the opioid receptor.
   - Interestingly, the risk of precipitated withdrawal is low after an opioid overdose and naloxone. There are several theories of why this is the case, including a lower opioid tolerance which caused the overdose.

7. **I/my friend had precipitated withdrawal after taking Suboxone®. I don't want to go into "precip".**
   Response:
   - I understand that precipitated withdrawal feels terrible, and we don't want you going into "precip" either.
   - Over the years we've found new ways to start Suboxone® and avoid precipitated withdrawal.
   - After getting Narcan® for an overdose we have a window of time when you can take Suboxone®, avoid precipitated withdrawal, and start to feel better. We're in that window right now.
   - If you start to feel worse, we can give more Suboxone® and other medications to help you feel better.

INEFFECTIVE MEDICATION

8. **I've taken Suboxone® before, years ago, without success.**
   Response:
   - The dosing of the medication has changed, and we are using a much higher dose to keep you out of withdrawal and to control your cravings.

9. **My significant other/friend had Suboxone® and said it didn't work.**
   Response:
   - The dosing of the medication has changed, and we are using a much higher dose to keep you out of withdrawal and to control your cravings.

STIGMA-RELATED

10. **Isn't Suboxone®/buprenorphine just replacing one drug for another?**
    Response:
    - Suboxone® is a medicine that can be taken at a specific prescribed dose to control withdrawal symptoms and cravings.
    - Suboxone® partially plugs the opioid receptors to help you feel better. It can help you cut down and stop using and help you move toward recovery.
    - Opioid use disorder/addiction is a medical condition/disease—like high blood pressure or diabetes. We give medicine to treat high blood pressure and diabetes—taking Suboxone® to treat opioid use disorder is similar, and it can help treat the medical condition of opioid addiction.

11. **I don't want to be on Suboxone®/buprenorphine forever.**
    Response:
    - Starting Suboxone® now can help you stop using drugs/fentanyl, but you don't have to be on Suboxone® forever.
    - Suboxone® can help treat your withdrawal, control your cravings, and help you move toward recovery.
    - If you start Suboxone® now and you want to stop taking it in the future, your medical provider can help you wean the dose down over time to keep you comfortable.

12. **Denial, e.g., "I didn't take anything" or "I'm not taking that stuff."**
    Response:
    - *Note: Sometimes patients will deny using opioids. If their clinical picture was consistent with an opioid overdose, it was reversed with naloxone, and they're having opioid withdrawal symptoms, you can still offer Suboxone®. Instead of challenging them, consider saying something like the following.*
    - I am really glad you didn't die tonight. I am happy we were able to give you medicine to get you breathing again. A lot of people in your situation don't feel well and I have a medicine that can help you with that. We can get you started on Suboxone® right now, so you don't have to go through this again. Can I give you this medicine to help you start feeling better?
    - *Also remember that many people with opioid use disorder will need to hear this several times before they agree to treatment (research says it takes between 3 and 8 attempts at treatment before recovery). You can help the patient feel better and move toward recovery.*

OTHER CONCERNS

13. **With all the other stuff in street drugs now (medetomidine and sedating adulterants), how can I get started on treatment?**
    Response:
    - Adulterants in the street drugs (such as medetomidine) can make starting treatment more difficult, but treatment is still possible, and we would like to help.
    - With medetomidine, we often see:
        - Overdose: Very sleepy/sedated and low heart rates.
        - Withdrawal: High blood pressure, high heart rates, shaking, and a lot of vomiting.
    - Talk with your doctor/prescriber about giving other medications to help treat your withdrawal symptoms. Examples of medications that could be given are clonidine, tizanidine, and ondansetron.

14. **I'm on probation and this will result in people knowing I violated my probation, and I'll go back to jail.**
    Response:
    - We're here to help, not to get you in trouble. We don't report to probation or parole; it is all confidential patient medical information.

15. **Will I get into trouble if I don't follow up at the clinic?**
    Response:
    - No, you will not get into any trouble if you do not go to the clinic. We're here to help. This is an opportunity for you to get help if and when you want it. We do encourage you to go for follow-up.

16. **Will taking this medication now mess up my intake schedule/appointment at rehab?**
    Response:
    - No this will not change anything with an intake that you already have scheduled. Recovery takes time. Suboxone® can help you feel better until you have your appointment and continue to work on your recovery.

17. **I live out of state and I'm visiting Delaware. How am I going to make it to one of these appointments?**
    Response:
    - If you are still in the area for a few days, go for intake and they can help you to find a clinic near home to continue treatment.
    - You can also visit www.HelpIsHereDE.com or www.FindTreatment.gov, or call 1-800-662-HELP or 988 for assistance in finding substance use treatment near your home.

TRANSPORTATION ISSUES

18. I don't have transportation to get to/from an appointment.

Response:

- See table below for transportation resources.

	Purpose	**Geography**	**How to Use**
DSAMH/Community Partner Support Unit (CPSU) Partnership	For individuals following an interaction with an acute service setting (e.g., ED, EMS) to help access an MOUD appointment.	Statewide	Delaware EDs may refer patients to this transportation resource. To do so, complete a CPSU Transportation Request Form and email it to CPSU. Alternatively, provide the patient with a CPSU Transportation Referral Postcard. The patient is then responsible for calling CPSU to arrange their ride.
DSAMH's DTRN Rideshare (powered by RoundTrip)	For clients receiving behavioral health treatment who require non-emergency transportation.	Sussex County	DSAMH-contracted behavioral health providers can request the service via DTRN.
Medicaid Non-Emergency Medical Transportation (Modivcare)	For Medicaid clients needing non-emergency transport to and from a covered medical service.	Statewide	Eligible Delaware Medicaid clients can request.

19. Should I call 911 if I can't get transportation to the clinic?

Response:

- No – 911 does not provide transportation to clinic or office appointments, it is for medical emergencies only.

INSURANCE/PAYMENT

20. I don't have any insurance.

Response:

- You do not need insurance for the intake appointment. Go to the appointment and the staff will assist you to get the resources that you need.
- If you don't have health insurance, you may be eligible for publicly funded addiction treatment services through DSAMH.
- You can find out more about publicly funded treatment by calling the Delaware Hope Line (1-833-9-HOPEDE) or visiting your local DSAMH Bridge Clinic:

- **Bridge Clinic New Castle County Fernhook Building** - 14 Central Ave., New Castle, DE 19720
  - Hours: Daily, 8:00am to 11:30pm
  - Phone: 302-288-0230
- **Bridge Clinic New Castle County Hope Center** - 365 Airport Rd., New Castle, DE 19720
  - Hours: M-F, 8:00am to 4:30pm and Sat, 8:00am to 4:30pm
  - Phone: 302-544-6815
- **Bridge Clinic Kent County James W. Williams State Service Center** - 805 River Rd., 3rd Floor, Dover, DE 19901
  - Hours: M-F, 8:00am to 4:30pm
  - Phone: 302-857-5060
- **Bridge Clinic Sussex County Thurman Adams State Service Center** - 546 S. Bedford St., Georgetown, DE 19947
  - Hours: M-F, 8:00am to 4:30pm
  - Phone: 302-515-3310

APPENDIX B. ADJUNCTIVE AND SUPPORTIVE TREATMENTS FOR WITHDRAWAL

- **Nausea and Vomiting**
  - **Ondansetron** 4 mg PO/IV every 4-6 hours as needed
  - **ProMETHazine** 25 mg PO every 4-6 hours as needed
  - **ProChLORperazine** 10 mg IM every 6 hours as needed

- **Anxiety and Restlessness**
  - **CloNIDine** 0.2-0.3 mg PO every 6 hours as needed (hold if SBP<110mmHg or HR<55)
    - *Note: Clonidine can mitigate the adrenergic effects of opioid withdrawal and contribute to the control of alpha-2-agonist (medetomidine or xylazine) withdrawal. Higher doses of clonidine (at least 0.3 mg) and more frequent dosing may be needed in patients experiencing medetomidine withdrawal.*
    - *See "Medetomidine (alpha-2-agonist) Withdrawal" section below*
  - **CloNIDine** 0.3 mg/24 hr Transdermal film, extended release
    - *Note: Oral clonidine AND clonidine transdermal film may be ordered in patients experiencing medetomidine withdrawal. Clonidine transdermal film has a prolonged time frame (2+ days) to achieve therapeutic levels.*
    - *See "Medetomidine (alpha-2-agonist) Withdrawal" section below*
  - **HydrOXYzine** 25-50 mg PO every 8 hours as needed
  - **Gabapentin** 300 mg PO every 8 hours as needed
  - **Benzodiazepines** may be considered, if needed, but are considered second-line

- **Pain, Body Aches, or Muscle Spasm**
  - **TiZANidine** 4 mg PO every 6-8 hours as needed for muscle spasm
  - *Note: Tizanidine, an alpha-2-agonist medication, can contribute to the control of medetomidine withdrawal symptoms.*
  - **Ibuprofen** 600 mg PO every 6-8 hrs as needed for pain
  - **Ketorolac** 15 mg IV/IM every 4-6 hrs as needed for pain
  - **Acetaminophen** 650 mg PO every 4-6 hrs as needed for pain
  - **Dicyclomine** 20 mg PO/IM every 6 hours as needed for abdominal cramping
  - **Methocarbamol** 500 mg IV/PO every 8 hours as needed for severe muscle aches

- **Diarrhea**
  - **Loperamide** 2 mg PO every 2 hours as needed (maximum 16 mg in 24 hours)

- **Withdrawal-Associated Akathisia**
  - **Ropinirole** 0.25-1 mg PO every 8 hours as needed

- **Medetomidine (alpha-2-agonist) Withdrawal:**
    - Medetomidine withdrawal often causes significant hypertension and tachycardia, shaking/muscle tremor, nausea/vomiting, and agitation, sometimes with decreased verbal responsiveness and catatonic appearance.
    - Polysubstance withdrawal: Patients should be treated for both medetomidine withdrawal and fentanyl withdrawal (based on prevalence of medetomidine in the community/region).
    - NOTE: Medetomidine withdrawal typically starts earlier than fentanyl withdrawal.
    - As stated above, consider the following alpha-2-agonists early in the course of medetomidine withdrawal: Clonidine (if able to tolerate oral medications) and the clonidine transdermal patch, and tizanidine.
        - Per expert opinion and regional experience: Consider higher doses of clonidine (0.3-0.6 mg PO and transdermal) for medetomidine withdrawal.
    - Some health systems have recommended or considered other alpha-2-agonists, such as guanfacine or sublingual dexmedetomidine.
    - For severe medetomidine withdrawal: Dexmedetomidine (Precedex) infusion with higher starting rates and rapid titration should be considered.
        - Per expert opinion and regional experience: Consider dexmedetomidine starting rates of at least 0.5 mcg/kg/hr. Loading doses (such as 1 mcg/kg over 10+ minutes) may also be considered for severe medetomidine withdrawal.

APPENDIX C. CONSIDERATIONS FOR METHADONE IN THE ED

We encourage hospitals to develop policies allowing for methadone to be started in the ED as a method of MOUD. Examples of policies to consider are included below.

For patients NOT ENROLLED in a certified Opioid Treatment Program (OTP):

- Methadone may be ordered and administered in the ED, but can NOT be prescribed for the treatment of OUD. In the ED:
    - Consider EKG to evaluate for QTc prolongation, especially if the patient is on medications which could potentially prolong the QTc.
    - For patients in opioid withdrawal (COWS 5+) who are interested in starting methadone, up to 30 mg of methadone may be given to help reduce the symptoms of opioid withdrawal.
        - If needed, an additional 10mg of oral methadone may be given for a total of up to 40 mg on day 1.
    - Patients must be referred to an OTP for ongoing methadone treatment; however, if unable to follow-up in a timely manner (such as over a weekend), the patient may receive daily dosing of up to 30 mg of methadone daily in the ED for up to three (3) days.

For patients ENROLLED in a certified Opioid Treatment Program (OTP):

- There are situations in which giving the patient's regular methadone dose may be indicated, examples include:
    - For patients being treated for medical conditions–other than primarily opioid withdrawal–that, as a result, are unable to receive their daily scheduled methadone at their OTP.
    - During declared states of emergency in which the OTP is unable to provide the scheduled dose.
- In these cases, and depending on facility policy, a physician/provider or pharmacist must contact the patient's OTP to verify enrollment in the OTP and the following prior to ordering or dispensing the patient's regular methadone dose:
    - Name, location, and phone number of OTP, and name of verifying OTP staff member.
    - Patient's dose and date of last administered dose.
    - If the last dose was greater than 72 hours prior, then the patient should be referred back to OTP for treatment.
- If verification is unable to be obtained, up to 30 mg of methadone may be ordered and administered.
- Patients presenting solely for missing their OTP dose, outside of a declared state of emergency, should not be provided methadone, and should be referred back to their OTP.

APPENDIX D. ED DISCHARGE CHECKLIST

All of the following should be reviewed or completed by the treating physician/provider.

- ☐ Plan for follow-up with MOUD provider:
  - Involve Care Navigator/Social Work/Case Management (if available) to assist with follow-up planning, OR
  - Use referral pathway to assist with follow-up planning.
  - Provide follow-up appointment information and location in the patient's discharge instructions.

- ☐ Prescription Drug Monitoring Program (PDMP) review:
  - Check PDMP for active opioid or benzodiazepine prescriptions. If found, the patient should be counseled on the increased risks associated with taking several potentially sedating medications. This is NOT a contraindication to prescribing buprenorphine.

- ☐ Provide naloxone rescue kit (preferred) or write prescription for naloxone 4mg/0.1mL nasal spray.

- ☐ For patients starting <u>buprenorphine/naloxone (Suboxone)</u>:
  - Recommended prescription: Buprenorphine/naloxone (Suboxone) 8mg/2mg SL film. Take 1 SL film BID. Dispense # fifteen (15) films. Note: For patients who use large amounts of fentanyl daily, three-times per day dosing (24 mg buprenorphine daily) may be considered to control symptoms and cravings.
  - Home Starts: Physician/provider discusses the process with the patient and provides instruction sheet ("How to Start Taking Buprenorphine at Home").
  - Prescribe or recommend adjunctive and supportive medications for opioid withdrawal, such as ondansetron, clonidine, tizanidine, and ibuprofen.

- ☐ For patients starting <u>methadone</u>:
  - Consider writing prescriptions for adjunctive and supportive treatments for opioid withdrawal, such as ondansetron, clonidine, tizanidine hydroxyzine, loperamide, and ibuprofen.

- ☐ Discharge instructions
  - Include system-specific discharge instructions related to MOUD, treatment locations, opioid use disorder, naloxone use, and/or harm reduction.
  - Patients may continue to have cravings to use opioids. It is helpful to inform patients what they may experience as they get stabilized on their dose, but that they will gradually feel better.

APPENDIX E. CHECKLIST TO EVALUATE FOR OPIOID USE DISORDER (OUD)

While an OUD diagnosis is often clear based on a brief conversation with the patient and review of records, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) includes specific criteria for OUD diagnosis. Select all that apply:

- ☐ Opioids are often taken in larger amounts or over a longer period of time than intended.
- ☐ There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- ☐ A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- ☐ Craving, or a strong desire to use opioids.
- ☐ Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
- ☐ Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- ☐ Important social, occupational or recreational activities are given up or reduced because of opioid use.
- ☐ Recurrent opioid use in situations in which it is physically hazardous.
- ☐ Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
- ☐ Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid. *(Note: This criterion is not considered to be met for individuals taking opioids solely under appropriate medical supervision)*
- ☐ Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms. *(Note: This criterion is not considered to be met for individuals taking opioids solely under appropriate medical supervision)*

Total number of boxes checked: _____

Severity of OUD (# of boxes checked): **Mild = 2-3** **Moderate = 4-5** **Severe = 6+**

APPENDIX F. CLINICAL OPIATE WITHDRAWAL SCALE (COWS)

For each item, circle the number that best describes the patient's signs or symptoms. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient as jogging just prior to assessment, the increased pulse rate would not add to the score.

Resting Pulse Rate*: ___ beats/minute measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**Gastrointestinal Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over last 1/2 hour not accounted for by room temperature or patient activity* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor:** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness: *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning:** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size: 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability:** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint Aches: *if patient was having pain previously, only the additional component attributed to opiate withdrawal is scored* 0 not present	**Gooseflesh Skin:** 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms

1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	5 prominent piloerection
Runny nose or tearing: *Not accounted for by cold - symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	**Total Score : _____** The total score is the sum of all 11 items: ● 5 - 12 = mild ● 13 - 24 = moderate ● 25 - 36 = moderately severe ● > 36 = severe

APPENDIX G: BUPRENORPHINE HOME INITIATION

For patients with mild withdrawal symptoms (COWS < 12) who wish to start buprenorphine:

1. Physician/provider will discuss home initiation with the patient and patient will be instructed to follow the "How to Start Taking Buprenorphine at Home" instruction sheet (following page).
2. Counsel patients regarding the importance of feeling extremely sick before starting, allowing the buprenorphine to be absorbed under their tongue, and not to swallow the buprenorphine.
3. At discharge, review the "ED Discharge Checklist" (Appendix D) to include referral information, instructions, and give the following prescriptions:
    a. Buprenorphine/naloxone (Suboxone®) 8mg/2mg SL film; 1 film SL two times a day (16 mg buprenorphine daily) until follow-up (dispense #15 films). Note: For patients who use large amounts of fentanyl daily, three-times per day dosing (24 mg buprenorphine daily) may be considered.
    b. Naloxone take-home kit (preferred) or prescription: naloxone 4mg/0.1mL nasal spray (dispense # 1).
    c. Adjunctive and Supportive medications to improve withdrawal symptoms during the home initiation process, such as ondansetron, clonidine, acetaminophen, ibuprofen, tizanidine, loperamide.
        i. Alpha-2-agonist (medetomidine) withdrawal: Consider placing a clonidine transdermal patch in the ED and providing prescriptions for oral clonidine and tizanidine to help mitigate the effects of alpha-2-agonist withdrawal (if applicable)
4. Discharge information should include information about medications, risk of overdose, harm reduction resources, MOUD provider information and appointment or appointment time frame, and instructions for home initiation, if applicable.
5. Patients should leave the ED with an appointment or clear appointment time frame established, coordinated with Care Navigator/Social Work/Case Management (if available). Care Navigator/Social Work/Case Management (if available) will provide this information to ED caregivers so it may be added to patient discharge instructions
    a. Appointment for opioid use disorder treatment
        i. ED provider may coordinate with Care Navigator/Social Work/Case Management (if available) to determine outpatient treatment location where patient is being referred.
        ii. Ensure patient's current phone number is on record.

How to Start Taking Buprenorphine at Home

Before you start, you want to feel **very sick** from your withdrawal symptoms.

It should be **at least:**

- 36 to 48 hours since you used **fentanyl.**
- 16 hours since you used **prescription pain pills** (oxycodone or hydrocodone).

AND You should have **at least 5** of these symptoms:

- ❑ Restlessness
- ❑ Runny nose
- ❑ Body aches
- ❑ Bigger pupils
- ❑ Chills/sweating
- ❑ Anxious/irritable
- ❑ Tremors/twitching
- ❑ Nausea/vomiting
- ❑ Diarrhea
- ❑ Cramps
- ❑ Goosebumps
- ❑ Yawning

Day 1

Once you are ready, follow these instructions to start the buprenorphine.
On day 1, you will take a total of 16 to 32 milligrams (mg). Most people feel better after day 1.
Do not drive while starting this medicine.

Step 1

Take 1st dose.

Take **16 mg** (2 of the 8 mg strips).

- Put the strip **under your tongue.**
- Keep it there until it dissolves (15 minutes).
- Do **not** swallow the medicine.
- Do **not** eat or drink during this time.

Step 2

Wait 45 minutes.

Check how you are feeling.

- Feeling better?
  Great! Stop there for today.
- Still feel sick?
  Go to the 2nd dose.

Step 3

Take 2nd dose (if needed).

- If you are only feeling a little better:
  Take 8 mg (1 strip)

OR

- If you feel the same or worse:
  Take 16 mg (2 strips)

Day 2

On day 2, you will take a total of 16 to 24 mg of buprenorphine to keep your symptoms and cravings under control.

- Take 8 mg (1 strip) 2 times a day. If you were using a lot of fentanyl, your provider may recommend 8 mg (1 strip) 3 times a day.
- Repeat this dose every day until your next appointment.



If your symptoms get a lot worse before your next appointment, go to the nearest Emergency Department or call 911.

APPENDIX H. INSTRUCTIONS FOR STARTING BUPRENORPHINE IN THE ED

1. Follow "Buprenorphine Initiation in the ED Algorithm" (following page) and consider "Adjunctive and Supportive Treatment Options for Opioid Withdrawal" (see below).
    a. This method of starting buprenorphine is considered a "macro" or "high dose" initiation. To reduce the risk of precipitated withdrawal, it is important that the patient meet all initiation criteria, including:
        i. At least 24-36 hours since last use of fentanyl (larger reported amounts of daily fentanyl use, such as 1-2+ bundles/day typically require longer waiting times)
        ii. No methadone in at least 5 days
        iii. COWS of at least 12
2. If patient meets criteria, administer buprenorphine/naloxone (Suboxone) 8mg/2mg SL x 2 (total of 16 mg buprenorphine).
3. Wait at least 30 minutes. Does the patient feel subjective improvement in symptoms?
    a. If mild or no improvement, administer an additional dose of buprenorphine/naloxone 16mg/4mg SL (for a total dose of 32 mg buprenorphine).
4. If no response after 32mg consider discussion with Addiction Medicine consultant (if available).
5. Once significant improvement demonstrated:
    a. Coordinate with Care Navigator/Social Work/Case Management (if available) for discharge and follow-up planning.
    b. Complete "ED Discharge Checklist" (below).
    c. Check PMP for active opioid or benzodiazepine prescriptions. If found, the patient should be counseled on the potential risks of combining these medications (such as increased sedation).
6. Provide prescriptions for:
    a. Buprenorphine/naloxone 8mg/2mg SL film; 1 film SL two times a day (16 mg buprenorphine daily) until follow-up (dispense #15 films). Note: For patients who use large amounts of fentanyl daily, three-times per day dosing (24 mg buprenorphine daily) may be considered.
    b. Adjunctive and Supportive medications, such as ondansetron, clonidine, acetaminophen, ibuprofen.
    c. Alpha-2-agonist (medetomidine) withdrawal: Consider placing a clonidine transdermal patch in the ED and providing prescriptions for oral clonidine and tizanidine.
    d. Naloxone take-home rescue kit (preferred) or prescription for naloxone 4mg/0.1mL nasal spray (dispense # 1).

Caution with other sedative use: Alcohol or benzodiazepine use is NOT a contraindication for patients to be started on buprenorphine. However, the patient should be educated about increased risks due to a combination of these substances, such as increased sedation.

ED Buprenorphine Initiation Algorithm

Meets ALL initiation criteria?*

1. **≥ 24 hours since last fentanyl use and NO methadone in 5+ days.**
2. **COWS ≥ 12.**
3. **Pt feels very sick and is ready to start.**
4. **≥ 2 objective signs:**
   Tachycardia, sweating, rhinorrhea, vomiting, diarrhea, large pupils, or gooseflesh skin

NO → *Meets criteria during ED stay?*

1. **Contact** Care Navigator or Case Manager, if available.
2. **Review** the following:
   - ED Discharge Checklist
   - PDMP
3. **Consider starting buprenorphine at home.**
4. **Refer to outpatient treatment and give a naloxone "Opioid Rescue Kit".**

YES

***Post-overdose caveat:**
If pt received **naloxone within the last 45 minutes**, AND has withdrawal symptoms (COWS > 5), AND is **not** on methadone, **THEN** buprenorphine may be started **immediately**.

Buprenorphine/naloxone (Suboxone) dose 16/4 mg SL

Wait ≥ 30 minutes. Improvement in COWS/symptoms?

- **Significant** improvement
- **Mild** improvement
- **No improvement or worsening**

Additional Suboxone 16/4 mg
(total 32 mg of buprenorphine)

Wait 60 minutes. Improvement?

YES

1. **Coordinate** with Care Navigator or Case Manager, if available.
2. **Review** the following:
   - ED Discharge Checklist
   - PDMP
3. **Prescribe buprenorphine (Suboxone) and provide naloxone "Opioid Rescue Kit".**
   Recommended prescription: Buprenorphine/naloxone (Suboxone) 8 mg/2 mg SL film, 2 times daily until follow-up. Consider 3 times daily dosing if using large amounts of fentanyl daily.

NO

Consult Addiction Medicine, if available.

Precipitated Withdrawal:
If sudden/severe worsening of withdrawal after buprenorphine:

1. Give additional 16 mg buprenorphine immediately.
2. See "Adjunctive and Supportive Treatments" section.
3. Consider ketamine 0.3 mg/kg IV slow push over 2 minutes.
4. Consider additional 8-16 mg buprenorphine (total 48 mg).
5. Consult Addiction Medicine, if available.

APPENDIX C: DEFINITIONS AND ROLE CLARIFICATIONS, DEVELOPED BY DSAMH

Title	Scope of Work

Clinician	A Behavioral Health Clinician is a mental health professional who assesses, diagnoses, and/or treats individuals with mental health disorders and behavioral problems using therapeutic interventions. They work with individuals, families, and groups, employing various techniques to help clients manage symptoms, develop coping skills, and improve their overall well-being.
	
	Various levels of license, certification, and other accreditation:
	
	• Licensed/Board certified (may diagnose and/or treat):
	  ○ Psychologist (PsyD)
	  ○ LCSW (Licensed Clinical Social Worker)
	  ○ MSW (Master Social Worker)
	  ○ LPCMH (Licensed Professional Counselor in Mental Health)
	  ○ CDP (Chemical Dependency Professional)
	• Certifications (oftentimes not tied to post-secondary education requirements):
	  ○ CADC
	• College degrees in related field without a license may perform some clinical functions (may not diagnose or treat, but can assist in various parts of care management under guidance/supervision of licensed individual):
	  ○ Master's Level unlicensed
	  ○ Bachelor's Level unlicensed

Case Manager Other titles: • Discharge planner • Care navigator	Case Managers help individuals navigate and access various services and resources to meet their needs. They play a crucial role in coordinating care plans, assessing client needs, and connecting individuals with appropriate support systems. Case managers work in a variety of settings, including healthcare, social services, and legal fields. Often an undergraduate degree or higher is required of the role. Key responsibilities of a Case Manager: • Assessment: Evaluating a person's needs, challenges, and resources. • Planning: Developing individualized care or service plans. • Coordination: Connecting individuals with appropriate resources and services. • Advocacy: Representing clients' interests and advocating for their needs. • Communication: Maintaining open communication with clients, families, and other professionals. • Documentation: Maintaining accurate and comprehensive records of client interactions and progress. The term "social worker" is incorrect for this role.

Peer Other titles: • Certified Peer Recovery Specialist • Certified Family Support • Peer	Principles for Peer Recovery Specialists are: RECOVERY-ORIENTED: Peer Recovery Specialists hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peers help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery. PERSON-CENTERED: Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to specific needs the individuals has identified to the peer worker. VOLUNTARY: Peer Recovery Specialists are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice. RELATIONSHIP-FOCUSED: The relationship between the peer recovery specialist and the client served is the foundation on which peer recovery support services and support are provided. The relationship between the peer and client is respectful, trusting, empathetic, collaborative, and mutual. TRAUMA-INFORMED: Peer recovery support utilizes a strengths-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment. Core competencies of Peer Recovery Specialists: • Engages individuals in caring, collaborative relationships and provides support • Shares their lived experience of recovery • Personalizes peer support (person-centered planning) with focus on individual/personal needs • Supports recovery planning with encouragement and forethought • Helps individuals manage crises • Links individuals to other resources, services, and supports beyond treatment and SDOH • Shares information about health, wellness, and recovery • Values communication and supports teamwork • Promotes leadership and advocacy • Promotes self-growth and development The Peer Recovery Specialist uses their own recovery experience and peer certification training to assist clients with defining their recovery goals, and developing the skills and knowledge needed for their recovery. The Peer Recovery Specialist will interact with many different types

	of behavioral health and medical professionals while remaining true to the mission of peer support. The Peer Recovery Specialist will advocate for clients while being in partnership with other staff members. Peers cannot treat, diagnose, case manage, or coordinate care. The term “Peer Navigator” is considered incorrect.