Best Practices

Inpatient and order set guidelines for substance use disorders and other co-occurrences

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TREATMENT STARTS HERE

Acute care facilities can each develop site-specific tools for evidence-based treatment for substance use disorders. Below are some recommendations for best practices in inpatient care.

SCREENING		
	PRO	CON
HIV	Many patients may not engage in care outside of acute care. This is a unique opportunity to screen, connect to treatment, and prevent further community transmission.	• Being HIV positive is not a contraindication to initiation buprenorphine (Bup), so should not be a prerequisite to treatment • If patient is a "hard stick" or not otherwise getting labs, this may delay or prevent treatment of opioid withdrawal • Patients may want treatment for their OUD and withdrawal symptoms, but may fear HIV testing due to stigma
HCV	Many patients may not engage in care outside of acute care. This is a unique opportunity to screen, connect to treatment, and prevent further community transmission.	• Being HCV positive is not a contraindication to initiation of Bup, so should not be a prerequisite to treatment • If patient is a "hard stick" or not otherwise getting labs, this may delay or prevent treatment of opioid withdrawal
Urine Tox	• May be useful to identify patient who have recently taken methadone, which may make initiation of buprenorphine more difficult • Some clinics may require a positive tox for opioids in order to continue medications	• **Utox is generally not required.** However, may have a role in some clinical decisions or may be important for helping patients be admitted to outpatient care. • False positives and negatives can occur, will often miss Bup or fentanyl • Most patients will disclose their substance use on history • In the case of pregnancy, positive urine toxes can at times lead to adverse outcomes with child protective services
LFT	May help identify patients at risk for transaminitis after starting buprenorphine	• Evidence does not show any increased risk of hepatotoxicity with appropriate use of Bup[1] • If patient is a "hard stick" or not otherwise getting labs, this may delay or prevent treatment of opioid withdrawal

(Green) Recommended incorporation into new starts

(Yellow) Consider adding to order set, but should not be required for new starts

(Red) Avoid adding to order sets

1. LiverTox: Clinical and Research Information on Drug-Induced Liver Injury [Internet]. Bethesda (MD): National Institute of Diabetes and Digestive and Kidney Diseases; 2012-. Buprenorphine. [Updated 2014 May 20]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK548871/

MEDICATION ADMINISTRATION		
	PRO	CON
Buprenorphine (Bup)	• Treat OUD and withdrawal, save lives! • Cheaper to use mono-product than Buprenorphone-Naloxone	Providers may feel uncomfortable prescribing this medication without prior experience
Stop all other opioids during time of initial doses	• Patients should not be receiving other opioids while being initiated on buprenorphine • After patient is initiated on buprenorphine at a dose that controls symptoms, it is okay to restart additional opioids for pain control	• May make providers think that patients on Bup cannot receive additional opioids for control of their acute pain--this is not true, after the patient is started on Bup full opioid agonists may be utilized • Rarely, a patient may be continued on full opioid agonists during a Bup start, but this should only be done in consultation with an expert
COWS	• May help providers and nurses who are new to diagnosis of opioid withdrawal • May lower risk of precipitated withdrawal	• Not a validated tool for acute care inductions, despite being widely use • Adds barrier to administration, as will need to train RNs or MDs • Inter-provider variability with scoring • Many hospitals do not use COWS and instead start buprenorphine when patient has subjective and objective signs of withdrawal
Narcan PRN RR <8	• May help identify patients with sedation, those at risk include patients on benzodiazepines or with other medical comorbidities that may suppress respiratory drive	• May make providers and RNs think that Bup is more dangerous than it is • Due to the ceiling effect of this partial agonist, there is little risk for respiratory depression
Sedation monitoring (Ramsay or RASS scale)	• May help identify patients at risk for sedation, can be useful in certain subsets (ie those being treated for both opioid withdrawal and alcohol withdrawal with benzodiazepines)	• May make providers and RNs think that Bup is more dangerous than it is • Adds barrier to administration, as will need to train RNs or MDs • Minimal risk of sedation with buprenorphine initiation
COWS reassessment	• May help differentiate precipitated withdrawal from insufficient treatment • May decrease risk of providers undertreating withdrawal symptoms	• Not a validated tool for acute care inductions, despite being widely used • Adds barrier to administration, as will need to train RNs or MDs • Inter-provider variability with scoring • Many hospitals do not use COWS and instead start Bup when patient has subjective and objective signs of withdrawal

Legend:
- (Green) Recommended incorporation into new starts
- (Yellow) Consider adding to order set, but should not be required for new starts
- (Red) Avoid adding to order sets

PREPARATION FOR DISCHARGE		
	PRO	CON
Buprenorphine-naloxone (Suboxone) Rx at discharge	• Initiate MAT for OUD • May increase chances of patient successfully connecting to outpatient clinic	• Requires X-waivered providers • Provider fear about prescribing
Narcan Rx at discharge	• Saves lives if patient overdoses or someone in their community does • State mandated for any patient at increased risk of overdose (in most cases includes patients on chronic opioids, with opioid use disorder, or who use any illicit drugs due to fentanyl contamination	• Requires provider counseling, increasing time demands on providers or team-members
Narcan Counseling	• State mandate with narcan prescribing • Can position patient as a "hero" in the opioid epidemic if they are equipped to save a life of someone in their community	• Requires provider, nurse, or pharmacist time, which may be a deterrent
CURES	State mandate that provider must check CURES when providing a controlled substance	• Providers may not want to take the time to check CURES report • Cumbersome system • Not required if not prescribing controlled substance on discharge, or if patient being discharged from the ED with < 7 day prescription
Information for follow-up or Bridge clinic	Important in getting patient connected to continuity care for OUD	No downsides
HAV, TdAP, HBV Vaccination	Protects people who inject drugs from other health risks, especially in setting of HAV outbreaks in California	• Additional vaccination not directly related to treating OUD or withdrawal may be a barrier • May require serology testing prior to administration or review of prior immunization records

Recommended incorporation into new starts

Consider adding to order set, but should not be required for new starts

Avoid adding to order sets

California Bridge disseminates resources developed by an interdisciplinary team based on published evidence and medical expertise. These resources are not a substitute for clinical judgment or medical advice. Adherence to the guidance in these resources will not ensure successful patient treatments. Current best practices may change. Providers are responsible for assessing the care and needs of individual patients.

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