



Providers  
Clinical Support  
System

# Emergency Department Initiated MOUD: Practical Tips and Innovations

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Arianna Campbell, DMSc, MPH, PA-C, CAQ-EM, DFAAPA

Founder and Principal Investigator, The Bridge Center

# Housekeeping

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- PCSS-MOUD aims to increase the knowledge and skills of healthcare and counseling professionals about available evidence-based treatment approaches for substance use disorder (SUD) with a particular focus on opioid use disorder (OUD). PCSS-MOUD provides free training and mentoring to practitioners on the use of medications for OUD (MOUD) and the integration of these services into mainstream health care.

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## Presenter(s)

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Founder, Principal Investigator, The Bridge Center at PHI

Arianna Campbell, DMSc, MPH, PA-C, is an Emergency Department and Addiction Medicine PA with over 26 years of experience. She serves on the Executive Leadership Team as M-Principal Investigator for The Bridge Center at PHI, a program which she co-founded. She works clinically in Emergency and Addiction Psychiatry at the VA Medical Center in Sacramento and leads addiction programming at Marshall Medical Center in Placerville, California. Arianna is current President of the California Academy of PAs, a member of ASAM's CE Committee and Associate Member Committee, and a board member for the Society of PAs in Addiction Medicine.

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*All speakers have been advised that any recommendations involving clinical medicine must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in patient care. All scientific research referred to, reported, or used in the presentation must conform to the generally accepted standards of experimental design, data collection, and analysis.*

# Course Contents

- 1 **Background: ED-Initiated MOUD**
- 2 **Initiating MOUD**
- 3 **XR Bup Administration in ED**
- 4 **Care Coordination and Follow Up**

# Educational Objectives

At the conclusion of this activity participants should be able to:

1

Summarize the evidence supporting the initiation of Medications for Opioid Use Disorder (MOUD) within the emergency department (ED) setting, emphasizing a team-based approach.

2

Distinguish among intervention strategies for initiating buprenorphine aimed at recovering opioid sensitivity.

3

Develop a plan for integrating emerging team-based practices in ED-based buprenorphine initiation, including the administration of XR buprenorphine.

# Overdose is Our #1 Public Health Problem

More Americans under age 45  
die from drug overdose  
than from any other cause.



# The Patient Journey



- What steps must a patient, who is actively using fentanyl, follow to access medication treatment in your system?
- Is the system working for the most vulnerable/highest risk patients?

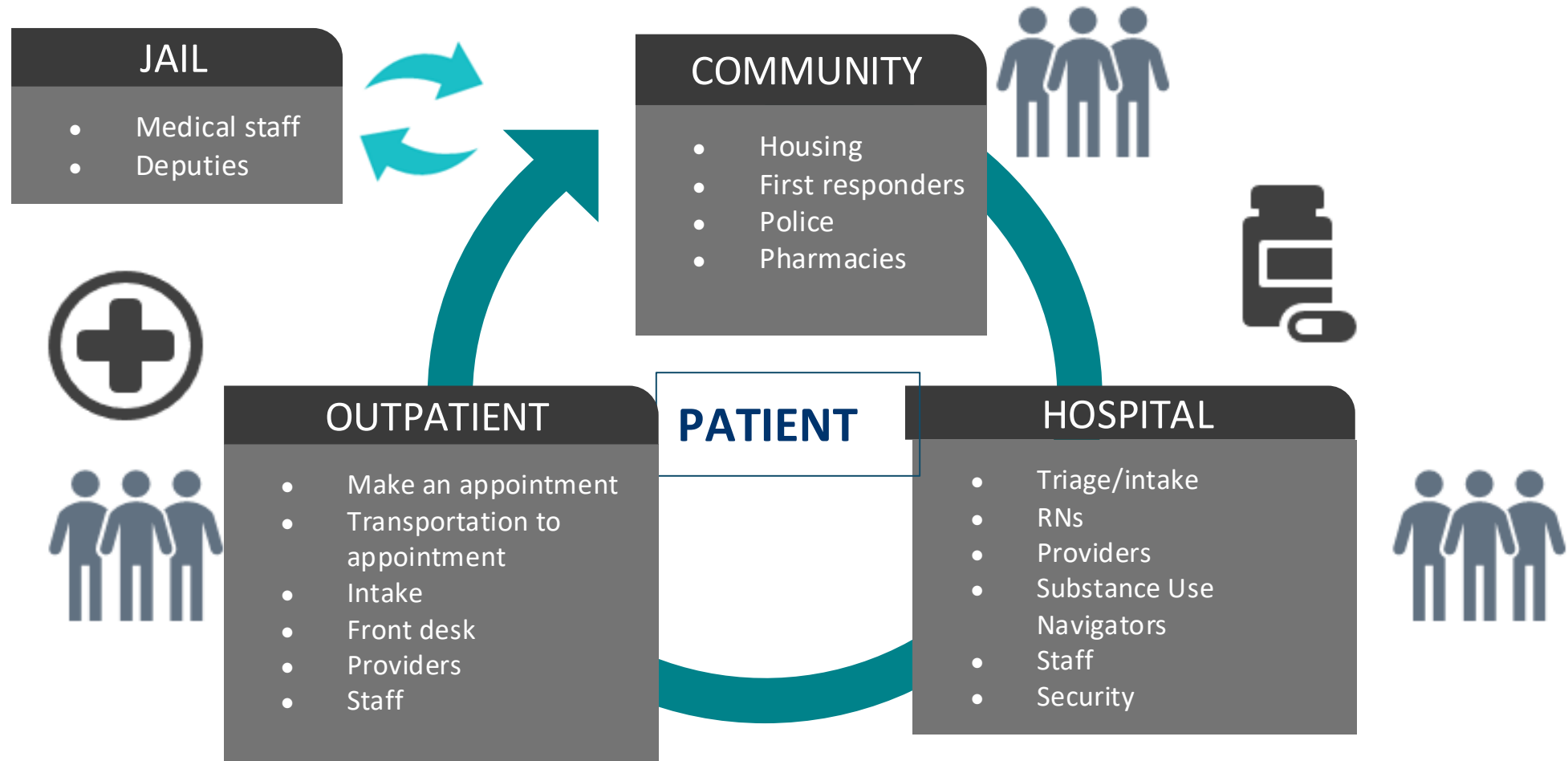
# Goals of Treatment for OUD

| Stage                                                   | Clinical Goal                                                                                         | Effective Tools for Achieving Goal                                              | Time Frame                                                                          |
|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| <b>Protection</b>                                       | Prevention of overdose and infectious diseases                                                        | Medication for OUD (MOUD)                                                       | Immediate and continuing                                                            |
| <b>Remission from OUD</b>                               | Significant, sustained reduction in OUD symptoms                                                      | MOUD<br>Behavioral therapy<br>AA or NA attendance                               | 1–6 mo: Early remission<br>7–12 mo: Sustained remission<br>>12 mo: Stable remission |
| <b>Recovery from All Substance Use Disorders (SUDs)</b> | Significant, sustained reduction in all SUD symptoms and improvement in health and social functioning | MOUD<br>Behavioral therapy<br>Additional medical and social services, as needed | 1–6 mo: Early recovery<br>7–12 mo: Sustained recovery<br>>12 mo: Stable recovery    |

**Proposed Model for the Care of Patients with Opioid Use Disorder (OUD).**

AA denotes Alcoholics Anonymous and NA Narcotics Anonymous.

# Systems of Care



# Case

51yo male named Charles presents to the ED with a chief complaint of knee pain. He is asking for pain relief. You notice he has gooseflesh skin and is yawning several times per minute. Vital signs: BP: 148/90, P: 104, RR: 18, SaO<sub>2</sub>: 96%

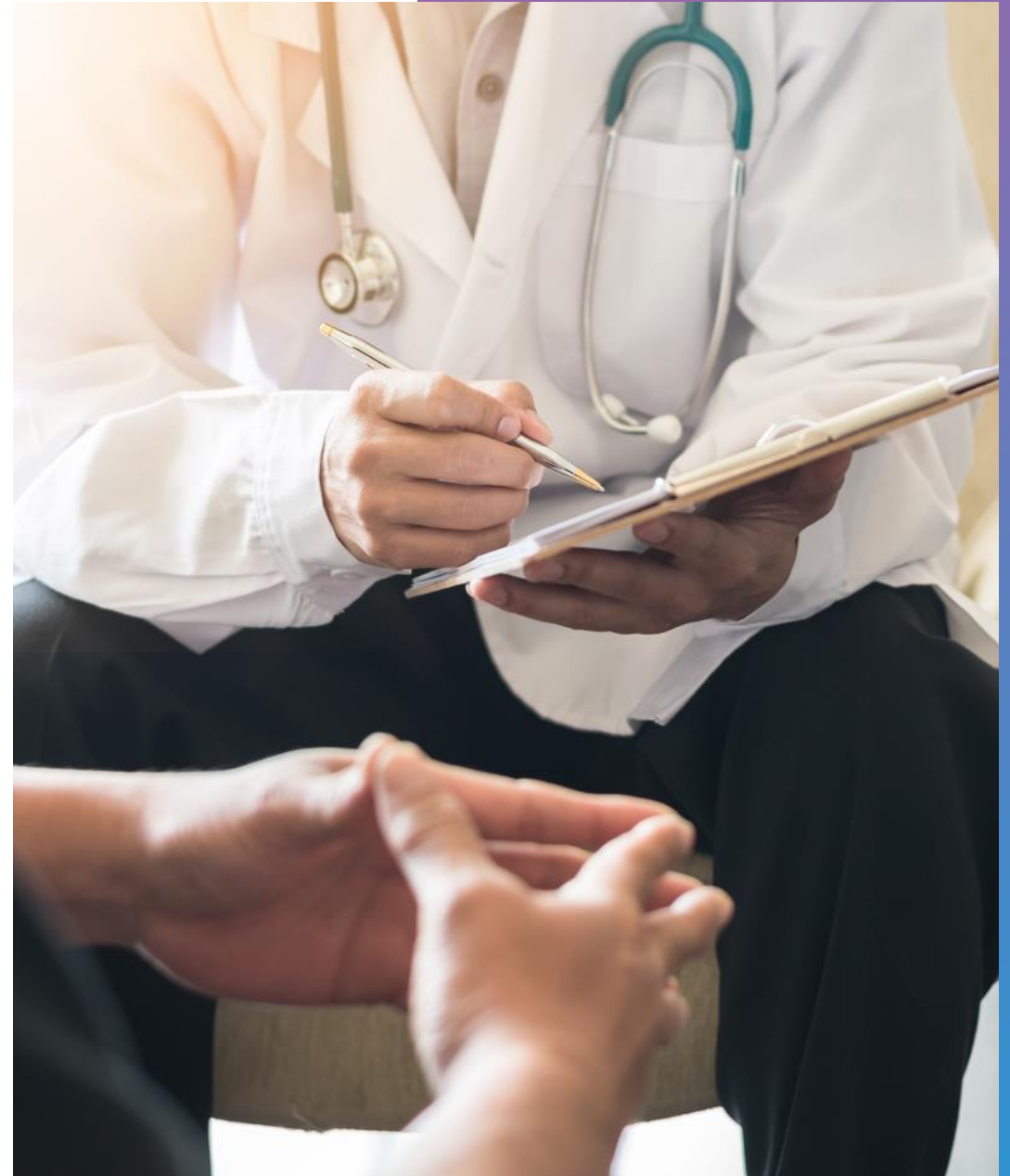
- How do we recognize opioid withdrawal?
- How do we make it safe for Charles to discuss opioid use?

Charles discloses recent overdose – that he “cut off” prescribed opioids when he was found to be using additional off the street. He describes feeling sick, and that his last use was 2 days ago. His COWS score is 13.

# Background

## ED-Initiated MOUD

Summarize the evidence supporting the initiation of Medications for Opioid Use Disorder (MOUD) within the emergency department (ED) setting

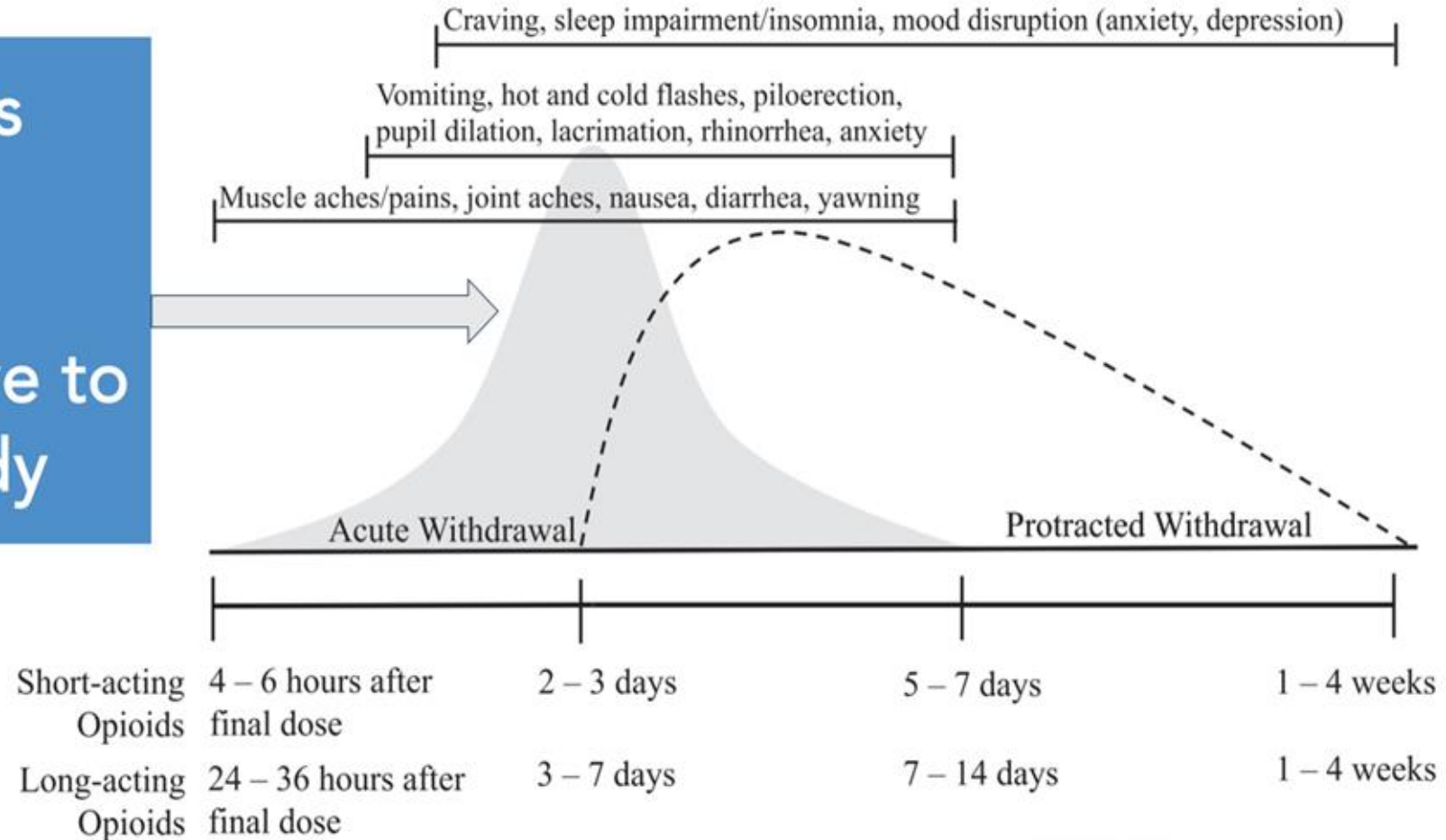


# Managing Overdose and Fentanyl Use

- Fentanyl use is an emergency.
- Withdrawal and use can be deadly.
- Every ED and Healthcare System needs a plan.

Minutes  
matter

We have to  
be ready



# Buprenorphine saves lives

Buprenorphine reduces all-cause mortality by more than 50% over 5 years

Santo et al., 2021

One-year mortality after a non-fatal overdose is similar to STEMI.

Weiner et al., 2019

Starting patients on buprenorphine decreases readmissions and minimizes ED utilization.

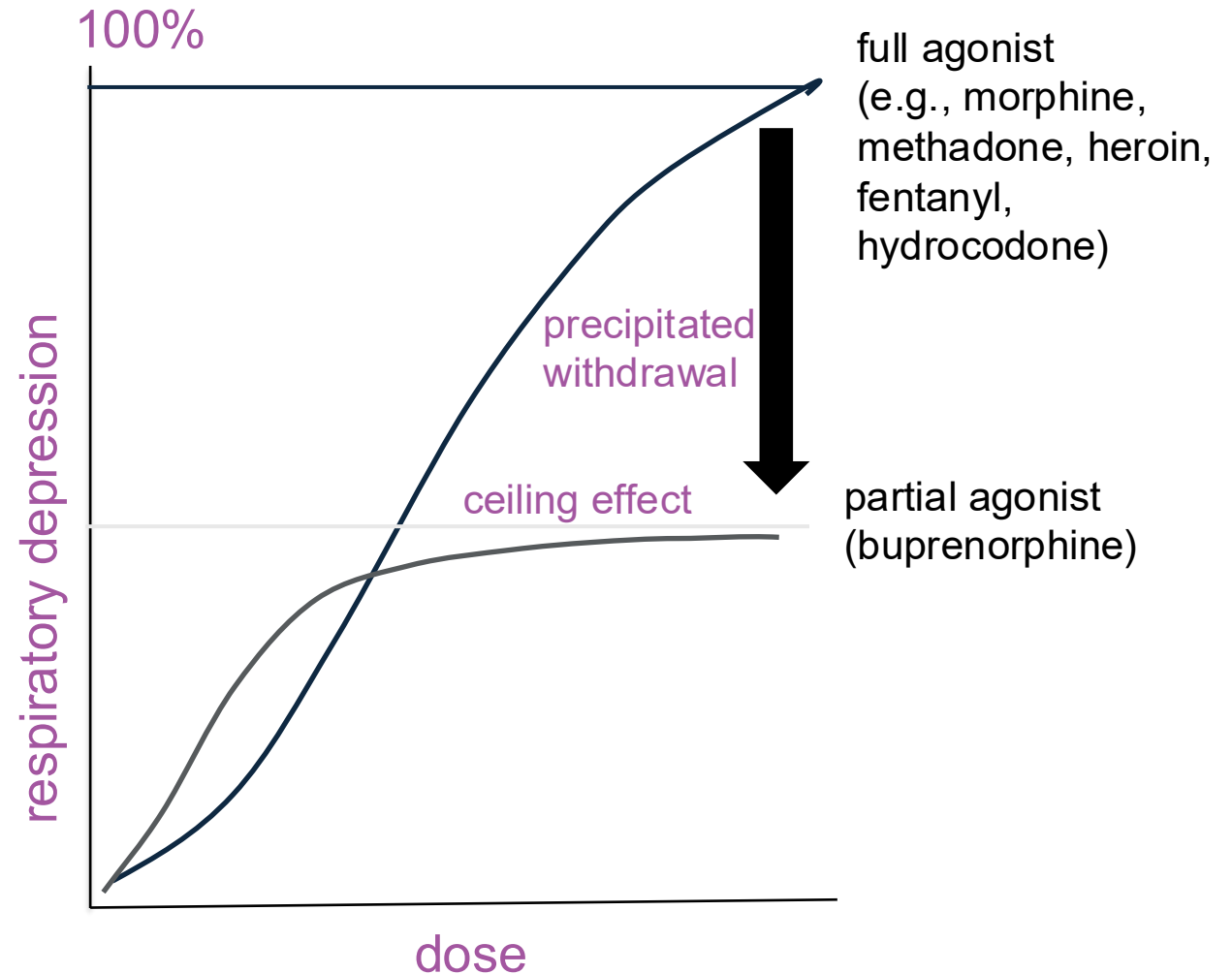
Gryczynski et al., 2021

ED-initiated buprenorphine increases the likelihood of your patient being in treatment in 30 days.

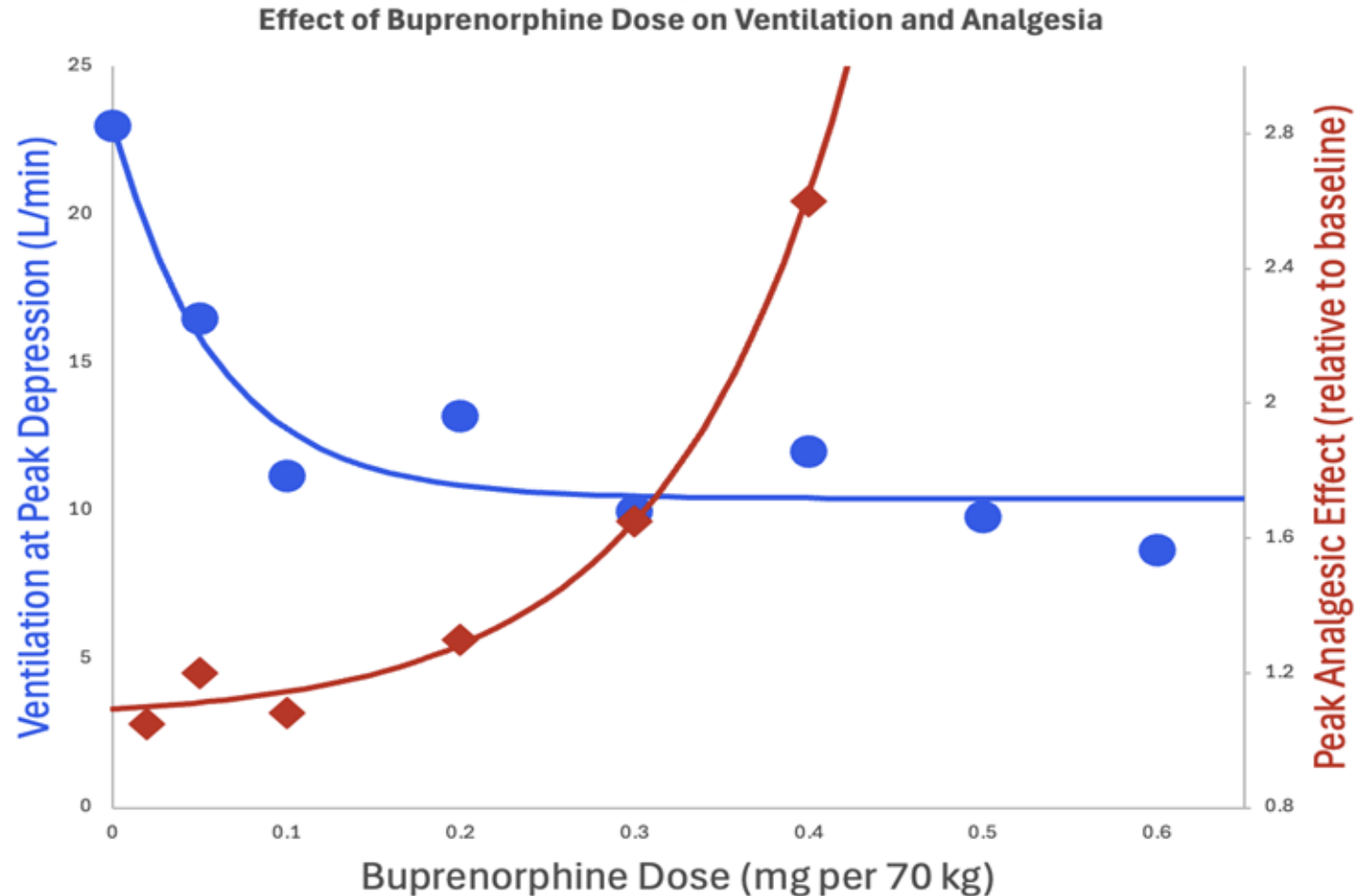
D'Onofrio et al., 2015

# How does Buprenorphine Work?

- ▶ Buprenorphine safely and effectively treats withdrawal, craving, & overdose
- ▶ Partial agonist
  - Ceiling effect:
    - Respiratory depression
    - Sedation
  - No ceiling effect:
    - Analgesia
- ▶ High affinity
  - Blocks other opioids
  - Displaces other opioids
  - Can precipitate withdrawal
- ▶ Long-acting
  - Half-life ~ 24-36 Hours



# Ceiling on Respiratory Depression, Not Analgesia



# Buprenorphine: High Doses are Safe

JAMA  
Network | **Open**

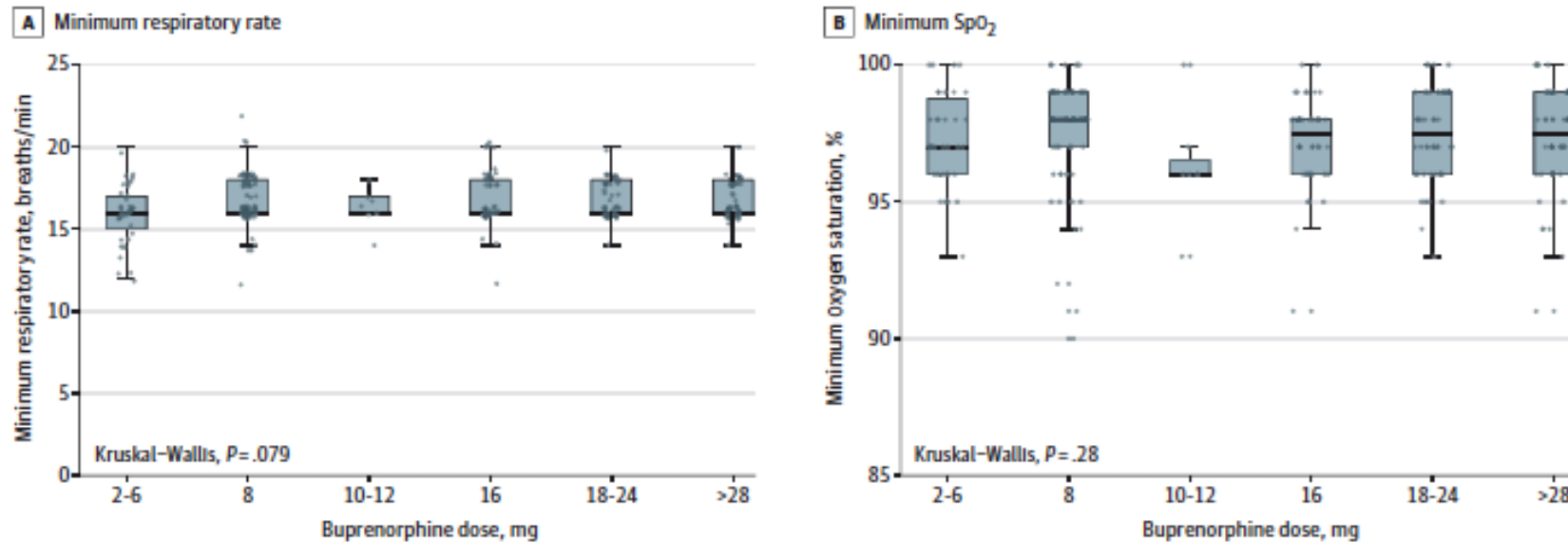


Original Investigation | Substance Use and Addiction

## High-Dose Buprenorphine Induction in the Emergency Department for Treatment of Opioid Use Disorder

Andrew A. Herring, MD; Aidan A. Vosooghi, MS; Joshua Luftig, PA; Erik S. Anderson, MD; Xiwen Zhao, MS; James Dziura, PhD; Kathryn F. Hawk, MD, MHS; Ryan P. McCormack, MD, MS; Andrew Saxon, MD; Gail D'Onofrio, MD, MS

**Figure 2. Minimum Respiratory Rate and Oxygen Saturation (SpO<sub>2</sub>) Following Initial Dose by Buprenorphine Dose**



Boxes correspond to 25th and 75th percentiles, with lines in boxes denoting medians. Dots denote outliers. Error bars denote 95% CIs. Kruskal-Wallis test compares distributions of respiratory rate and oxygen saturation across buprenorphine dose categories.

## Number Needed to Treat (NNT)

|                                      |                                 |
|--------------------------------------|---------------------------------|
| Aspirin in STEMI                     | <b>42</b> to save a life        |
| Warfarin in Afib                     | <b>25</b> to prevent a stroke   |
| Steroids in COPD                     | <b>10</b> to prevent tx failure |
| Defibrillation in Cardiac Arrest     | <b>2.5</b> to save a life       |
| Buprenorphine in Opioid Use Disorder | <b>2</b> to retain in treatment |

# Rationale and Evidence for ED-initiated MOUD

## Reflection

- How do we meet the crisis of withdrawal with a crisis response in the ED?
- Who needs education and training in Crisis SUD care?
- How do we approach our case with Charles to explore opioid use?

# Initiating MOUD

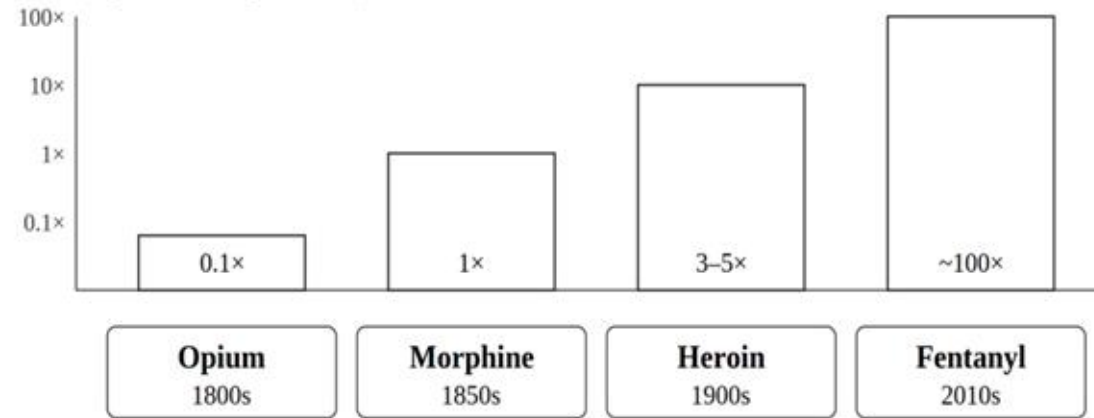
Distinguish among intervention strategies for initiating buprenorphine aimed at recovering opioid sensitivity.



# Problem of Potency

USA 2026

Relative potency (log scale, morphine = 1)

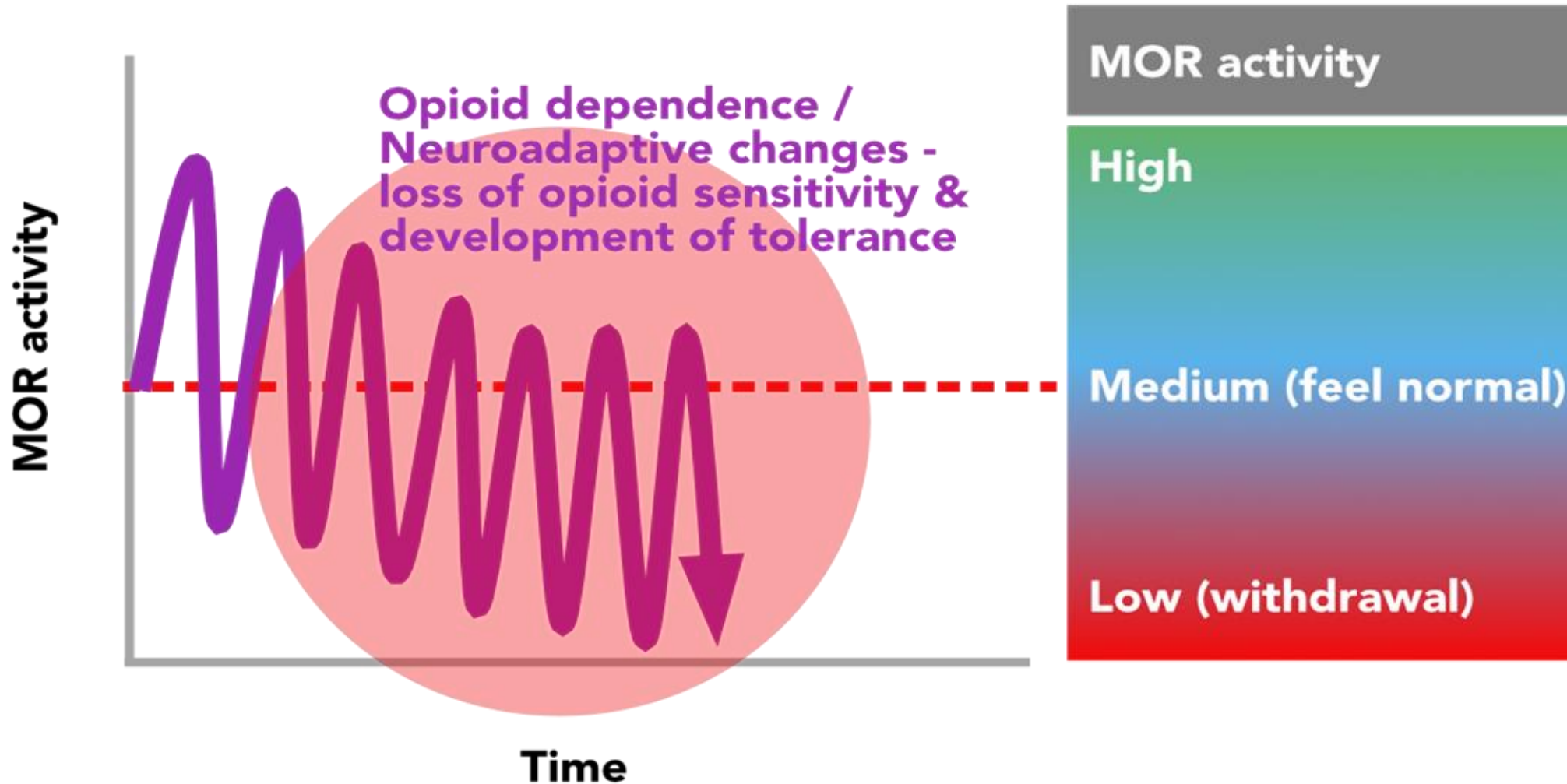


Increasing risk of fatal overdose with return to use after abstinence →

More extensive and more persistent neuroadaptations  
in reward circuitry and stress-tolerance systems



# MOR activity with fentanyl use over time

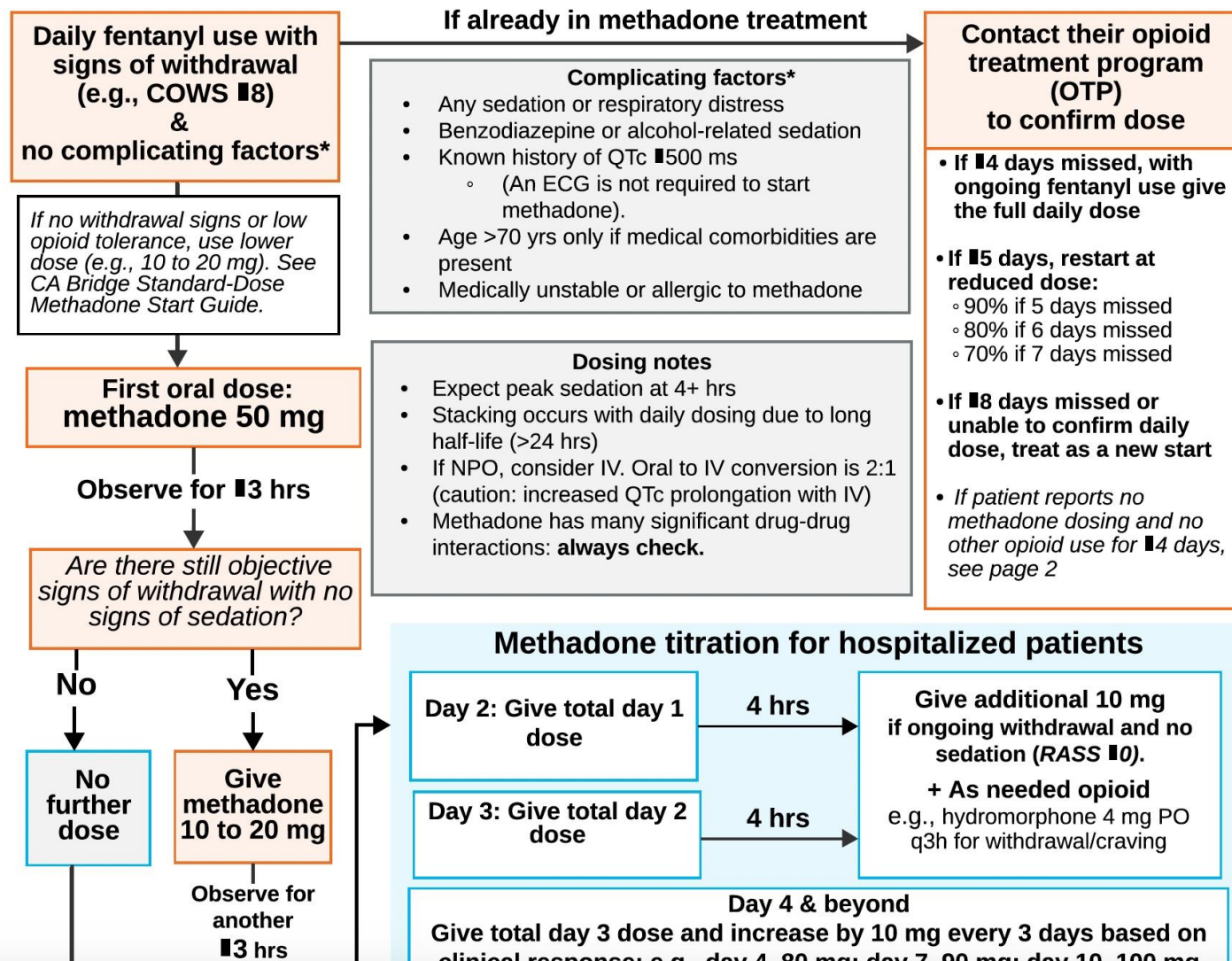


# Medications for OUD

| Methadone                                                                                                                                                             | Buprenorphine ± Naloxone                                                                                                                                                                                                      | Naltrexone                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Full mu (opioid) receptor agonist</b></p>  <p><b>Oral (often solution)</b></p> | <p><b>Partial mu receptor agonist</b></p>  <p><b>Sublingual (tab, film),<br/>IV, IM, subcutaneous injection,<br/>transdermal patch</b></p> | <p><b>Mu receptor <u>ant</u>agonist (blocker)</b></p>  <p><b>Intramuscular injection (extended<br/>release) or oral<br/>Ex: “Vivitrol,” “ReVia”</b></p> |



# High-Dose Methadone Start Guide for Hospital & Emergency Department Patients Using Fentanyl

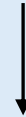


# Interventions to Recover Opioid Sensitivity

- **Abstinence + time**
- Partial agonist + full agonist
- Antagonists
- Potentiators that accelerate tolerance recovery

**Clear withdrawal**

*(e.g. 24 hrs of abstinence with development of  $\geq 2$  objective signs)*



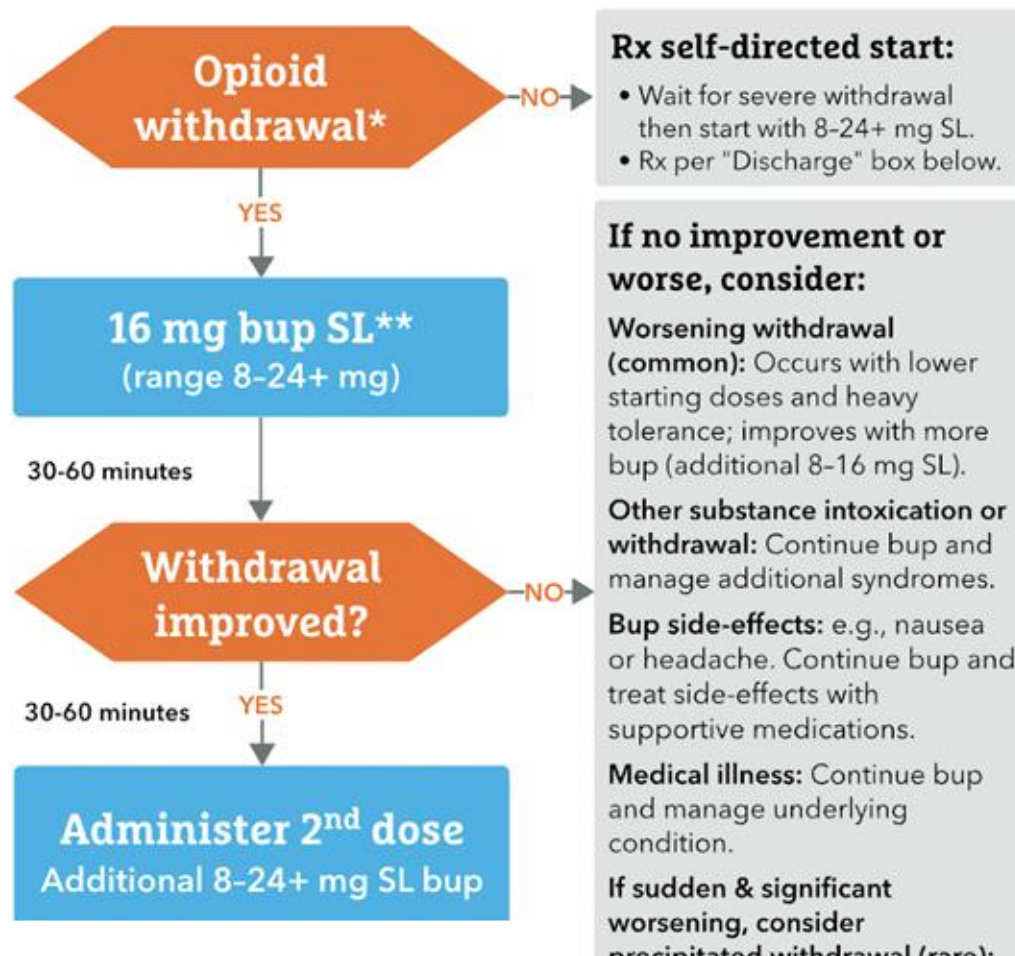
**Rapid High Dose  
Buprenorphine**

Best practice indicates that a provider should be consulted prior to advising self-directed start



## Emergency Department Buprenorphine (Bup) Quick Start

Connect with your patient: Accurate diagnosis and treatment requires trust, collaboration, and shared decision making.



### \*Diagnosis Tips for Opioid Withdrawal:

1. Look for at least two clear objective signs not attributable to something else: large pupils, yawning, runny nose & tearing, sweating, vomiting, diarrhea, gooseflesh/piloerection, tachycardia.
2. Confirm with the patient that they feel 'bad' withdrawal and they feel ready to start bup. If they feel their withdrawal is mild, it is likely too soon.
3. As needed, consider using the **COWS** (clinical opioid withdrawal scale). Start if COWS  $\geq 8$  with  $\geq 2$  objective signs.
4. Withdrawal sufficient to start bup typically occurs 24-36 hrs after decreased/stopped use, but can vary from 6-72 hrs. Methadone withdrawal commonly takes longer.

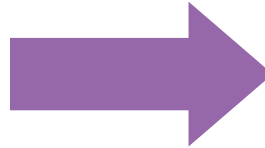
### \*\*Bup Dosing Tips:

1. Respect patient preference. Shared decision making, flexibility, and collaboration are essential.
2. Heavy dependence/tolerance (e.g., fentanyl) may need higher doses of bup.
3. Low dependence/tolerance may do well with lower doses of bup.
4. Starting bup may be delayed or modified if there complicating factors:
  - Altered mental status, delirium, intoxication
  - Severe acute pain, trauma, or planned surgery
  - Severe medical illness
  - Long-term methadone maintenance

# Step 1: Look for 2 Objective Signs

## \*Diagnosis Tips for Opioid Withdrawal:

1. Look for at least two clear objective signs not attributable to something else: large pupils, yawning, runny nose & tearing, sweating, vomiting, diarrhea, gooseflesh/piloerection, tachycardia.
2. Confirm with the patient that they feel 'bad' withdrawal and they feel ready to start bup. If they feel their withdrawal is mild, it is likely too soon.
3. As needed, consider using the COWS (clinical opioid withdrawal scale). Start if COWS  $\geq 8$  with  $\geq 2$  objective signs.
4. Withdrawal sufficient to start bup typically occurs 24–36 hrs after decreased/stopped use, but can vary from 6–72 hrs. Methadone withdrawal commonly takes longer.



## Include 2+ objective signs!

- Dilated pupils
- “Goose bumps”
- Vomiting
- Tachycardia
- Yawning
- Runny nose & eyes

## \*\*Bup Dosing Tips:

1. Respect patient preference. Shared decision making, flexibility, and collaboration are essential.
2. Heavy dependence/tolerance (e.g., fentanyl) may need higher doses of bup.
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  - Altered mental status, delirium, intoxication
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  - Severe medical illness
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# Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

- 1 Plan to take a day off and have a place to rest.
- 2 Stop using and wait until you feel very sick from withdrawals (at least 12 hours is best, if using fentanyl it may take a few days).
- 3 Dose one or two 8mg tablets or strips **UNDER** your tongue (total dose of 8-16mg).
- 4 Repeat dose (another 8mg-16mg) in an hour to feel well.
- 5 The next day, take 16-32mg (2-4 tablets or films) at one time.

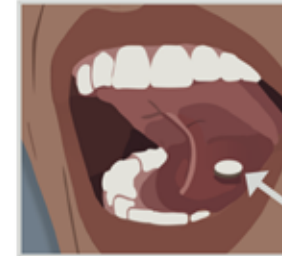
Best practice indicates that a provider should be consulted prior to advising self-directed start

## If you have started bup before:

- If it went well, that's great! Just do that again.
- If it was difficult, talk with your care team to figure out what happened and find ways to make it better this time. You may need a different dosing plan than what is listed here.

## If you have never started bup before:

- Gather your support team and if possible take a "day off."
- You are going to want space to rest. Don't drive.
- Using cocaine, meth, alcohol or pills makes starting bup harder, and mixing in alcohol or benzos can be dangerous.



Place dose under your tongue (sublingual).

## If you have a light habit: (For example, 5 "Norco 10's" a day)

- Consider a low dose: start with 4mg and stop at 8mg total.
- **WARNING:** Withdrawal will continue if you don't take enough bup.

## If you have a heavy habit: (For example, injecting 2g heroin a day or smoking 1g fentanyl a day)

- Consider a high dose: start with a first dose of 16mg.
- For most people, the effects of bup max out at around 24-32mg.
- **WARNING:** Too much bup can make you feel sick and sleepy.

# Interventions to Recover Opioid Sensitivity

- Abstinence + time
- **Partial agonist + full agonist**
- Antagonists
- Potentiators that accelerate tolerance recovery



## Buprenorphine (Bup) Hospital Start: Low-Dose Bup Initiation with Opioid Continuation

### Treatment Bundle Over Three Days<sup>1</sup>

Maximize pain control & withdrawal treatment with opioid analgesics throughout bup initiation

Day 1

Day 2

Day 3

**Opioid  
Continuation**<sup>2</sup>

**Example Regimen:** (see page 2 for alternatives)

1. Morphine ER 30-60 mg PO q8h scheduled
2. Morphine IR 15-30 mg PO q4h PRN
3. Morphine 10-20 mg IV q4h PRN

**Low-Dose Bup  
Initiation (Day 1)**<sup>3</sup>

Bup 0.5 mg SL q3h x 8 doses  
(q4h x 6 doses is OK)<sup>4</sup>

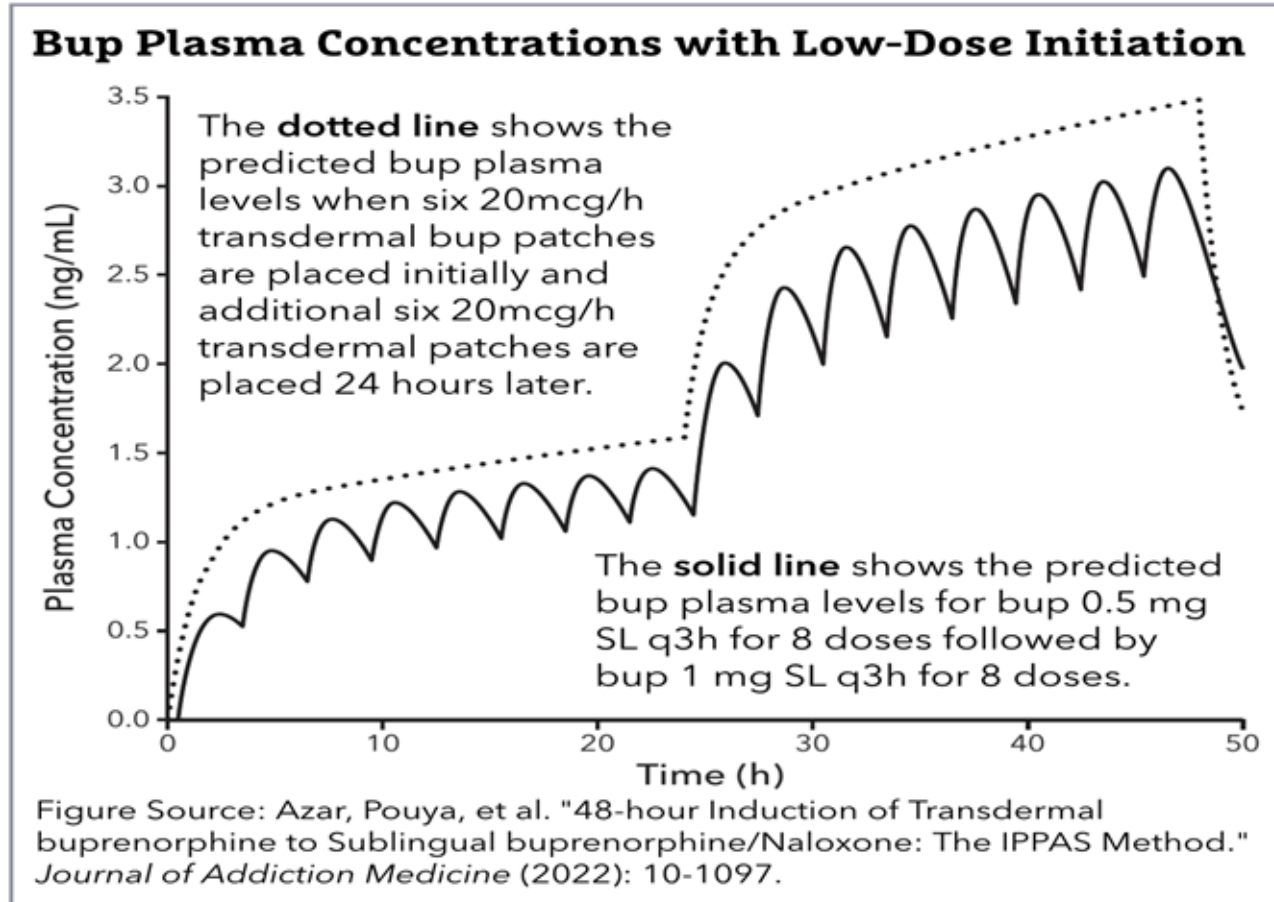
**Low-Dose Bup  
Initiation (Day 2)**

Bup 1 mg SL q3h x 8 doses  
(q4h x 6 doses is OK)<sup>4</sup>

**Low-Dose Bup  
Initiation (Day 3)**

Bup 8 mg SL TID or  
Injectable XR bup  
(e.g., 300 mg SQ)

# Low Dose Initiation with Opioid Continuation



This graph shows the point of steady rise of buprenorphine levels over time with low dose initiation, based on patch technique. In the ED, we try to replicate how the mu receptor is being occupied.

## Case

51yo male named Charles presents to the ED with knee pain. You notice he has gooseflesh skin and is yawning.

- What if Charles has a septic knee and needs admission to the hospital?
- Who on the team can facilitate the right conversation with Charles?
- How does Charles know he can get treated for opioid withdrawal as well?
- Is Charles afraid his pain will not be treated in ED?

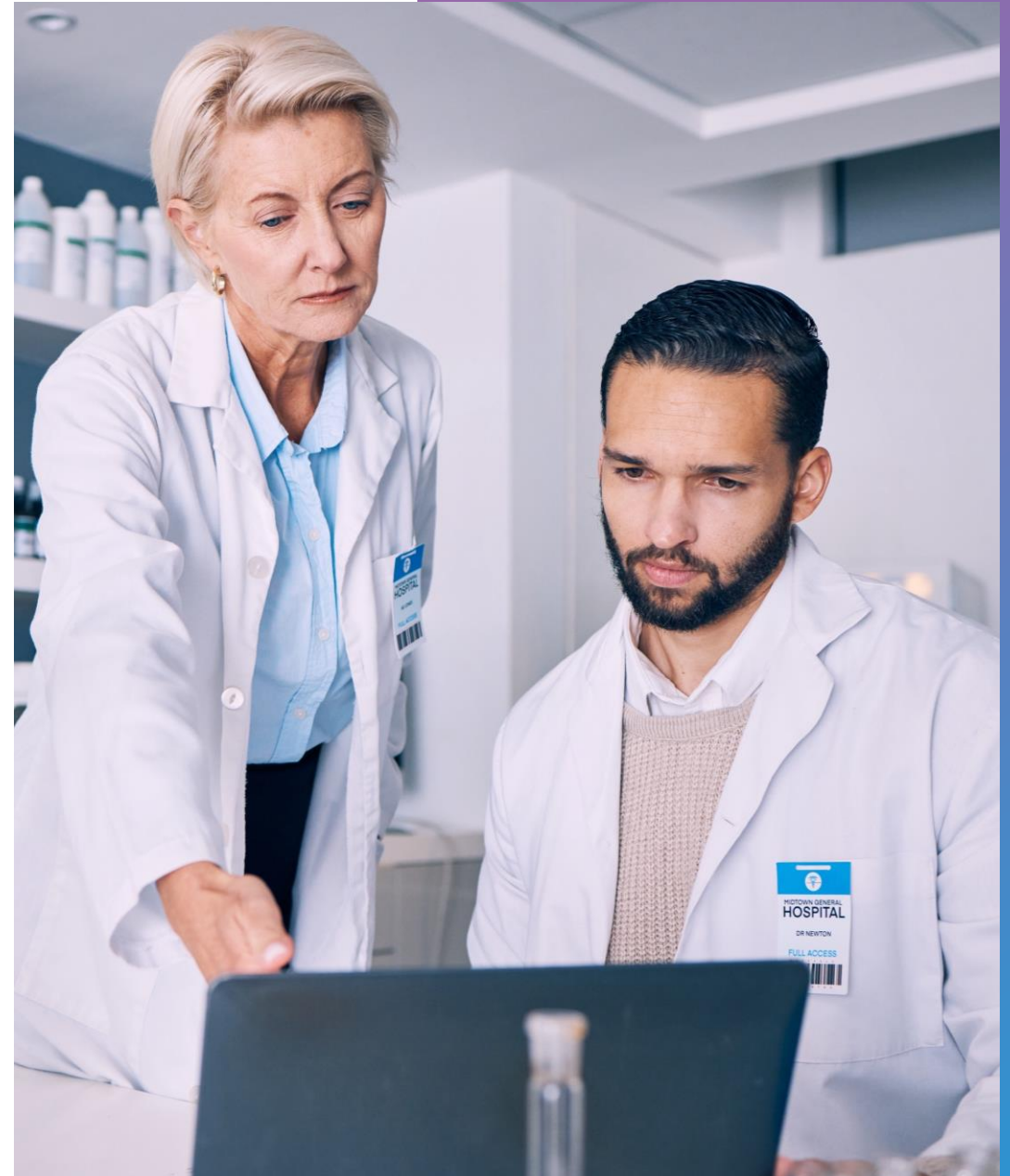
# Initiating MOUD and Recovering Opioid Sensitivity

## Reflection

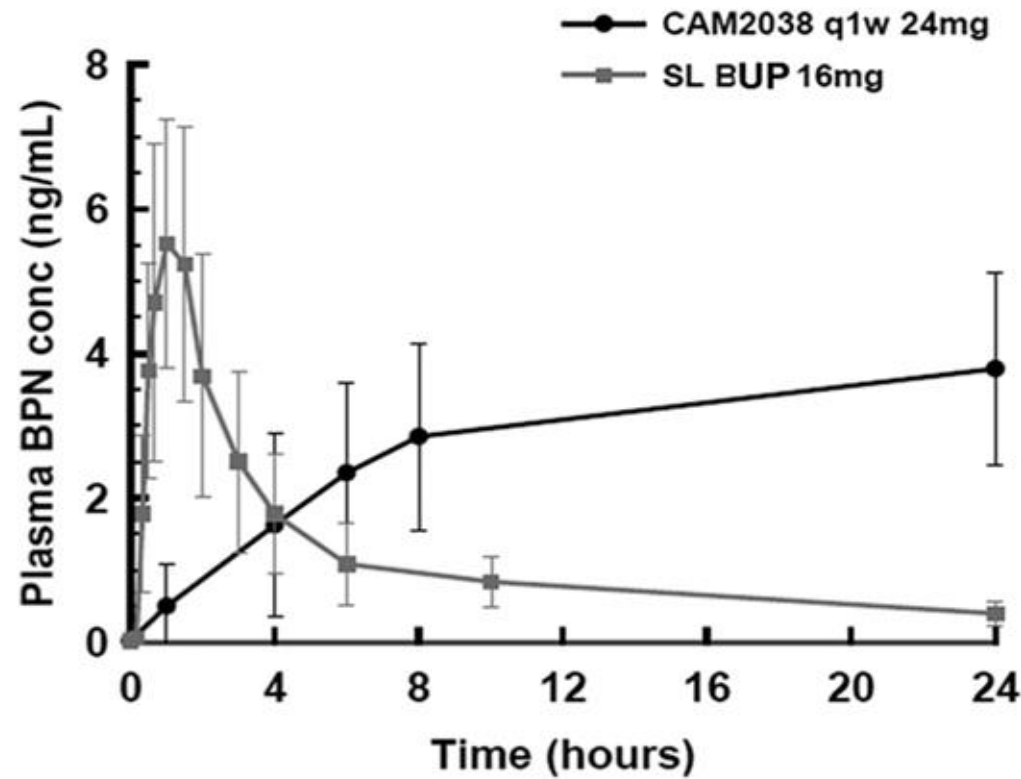
- How can we meet the patient where they are to provide an opportunity to recover opioid sensitivity?
- How do we present options for Charles?
- What if Charles says "I am allergic" to buprenorphine?

# XR Buprenorphine Administration in the ED

Demonstrate understanding of emerging team-based practices in ED-based buprenorphine initiation, including the administration of XR buprenorphine.



# Pharmacokinetics of XR-Bup vs. SL-Bup



This graph shows that XR-Bup is comparable to SL-Bup, but feasible at a lower COWS.

## Available formulations of long acting injectable buprenorphine (XR Bup)

| Generation | Formulation                | US Brand Name   | Dosage Form        | Doses                     | Injection Volumes                  | Median Time to Max Concentration (Tmax) | Mean Half Life (T1/2) |
|------------|----------------------------|-----------------|--------------------|---------------------------|------------------------------------|-----------------------------------------|-----------------------|
| 2nd        | XR Bup weekly (50 mg/mL)   | Brixadi Weekly  | Pre-filled syringe | 8 mg, 16 mg, 24 mg, 32 mg | 0.16 mL, 0.32 mL, 0.48 mL, 0.64 mL | 24 h                                    | 5 d                   |
| 2nd        | XR Bup monthly (356 mg/mL) | Brixadi Monthly | Pre-filled syringe | 64 mg, 96 mg, 128 mg      | 0.18 mL, 0.27 mL, 0.36 mL          | 6-10 h                                  | 19-25 d               |
| 1st        | XR Bup monthly (200 mg/mL) | Sublocade       | Pre-filled syringe | 300 mg, 100 mg            | 1.5 mL, 0.5 mL                     | 24 h                                    | 45-60 d               |

## DTI Potential to Expand Treatment Access

- Can be used in patients with low or no withdrawal
  - Highest-risk patients can struggle to present in withdrawal
- Bup serum levels gradually increase over 24 hours after injection of weekly formulation, decreasing risk of precipitated withdrawal
- Meets patients “where they are at,” at the moment they engage in care
- Can consider giving monthly formulation for quicker onset if patient presents in severe withdrawal and/or unable to return within a week.

## ED DTI Evidence

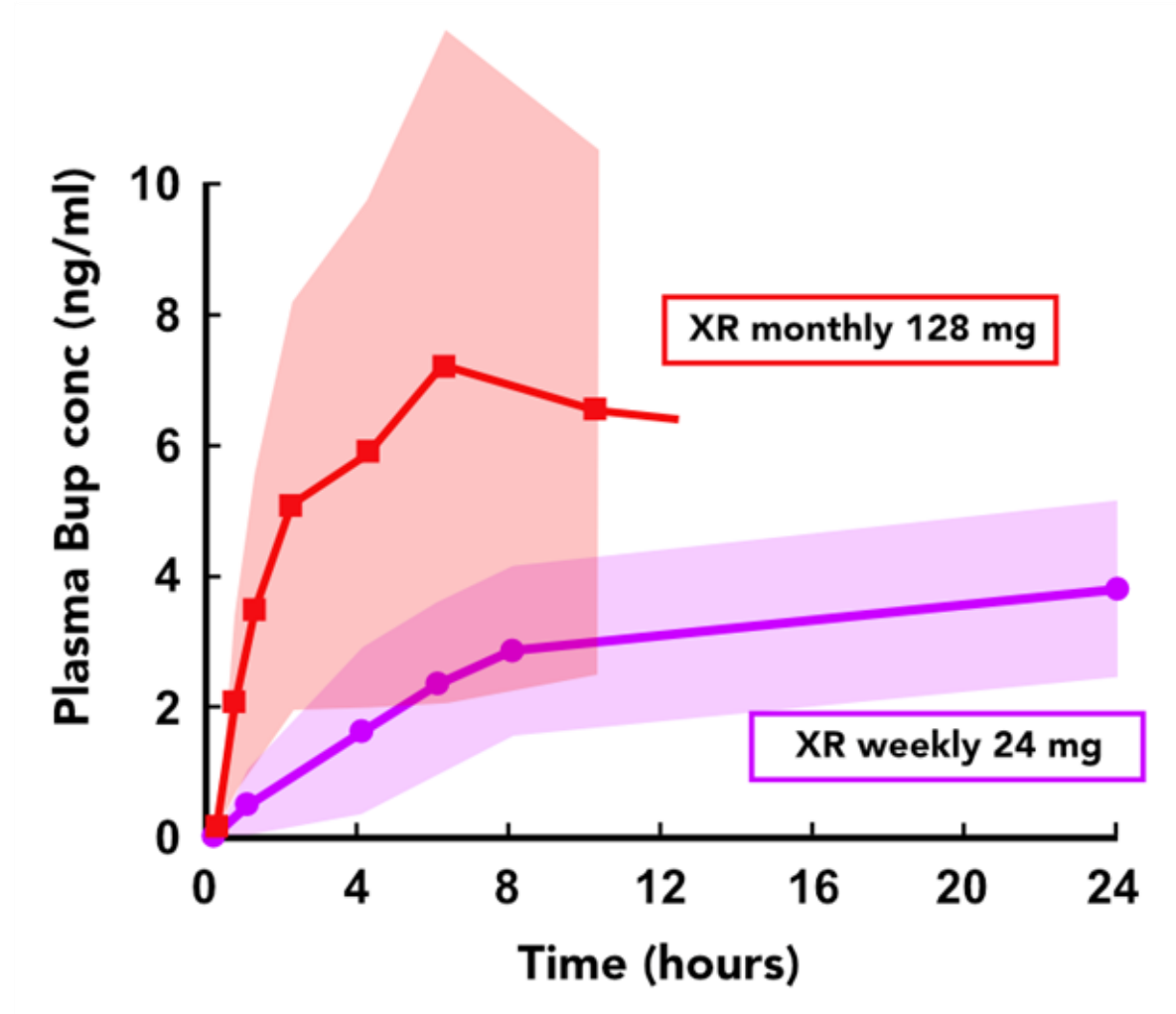
### **Incidence of Precipitated Withdrawal During a Multi-site Emergency Department-Initiated Buprenorphine Clinical Trial in the Era of Fentanyl**

Gail D'Onofrio, MD, MS<sup>1,2,3</sup>; Kathryn F. Hawk, MD, MHS<sup>1,3</sup>; Jeanmarie Perrone, MD<sup>4</sup>; et al

## Precipitated Withdrawal is Uncommon in the ED

- 1994 patients starting buprenorphine from 29 EDs
  - Most patients used fentanyl
- 14 cases of precipitated withdrawal (0.8% of participants with SL bup, 0.6% with XR bup)
- Treated precipitated withdrawal until symptoms resolved
- 40% attended follow-up MAT clinic appointment within 7 days
- Some studies (Kawasaki et al 2026) have shown higher rates of precipitated withdrawal in other practice settings than previously reported.

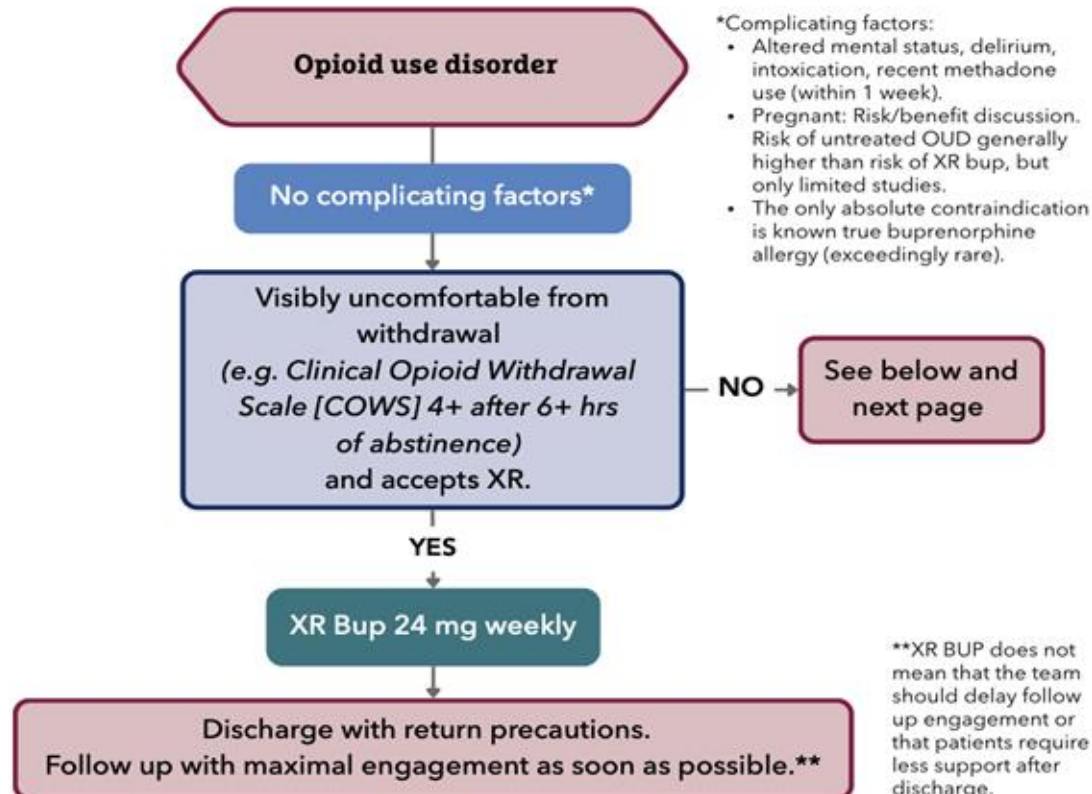
## Time to Max Concentration is Highly Variable



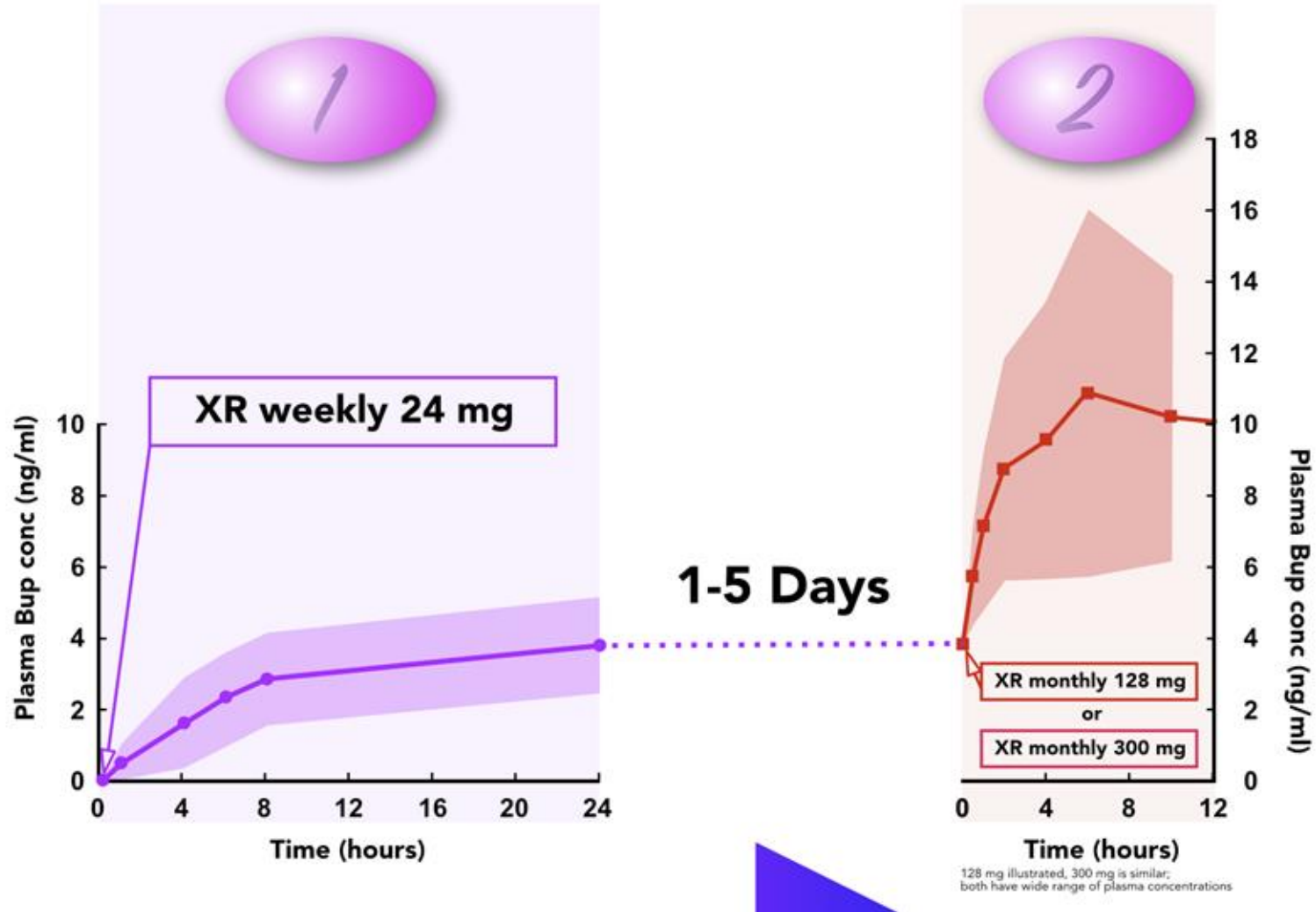
# Emergency Department Direct-to-Inject (DTI) Buprenorphine

September 2025

Starting weekly long acting injectable buprenorphine (XR Bup) without sublingual (SL) lead-in for patients with opioid use disorder (OUD).



Note: DTI is an off-label use for Buprenorphine.



# XR Buprenorphine Administration in the ED

## Reflection

- How can this change help overcome the neuroadaptive hurdle of buprenorphine initiation?
- How can Charles benefit from Direct to Inject (DTI)?
- Who is involved in creating a system of DTI initiations?
- How can we work to get more access to this for our patients?

# Interventions to Recover Opioid Sensitivity

- Abstinence + time
- Partial agonist + full agonist
- **Antagonists**
- Potentiators that accelerate tolerance recovery

# Starting Buprenorphine Immediately after Reversal of Opioid Overdose with Naloxone

Based on Herring, A. A., Schultz, C. W., Yang, E., & Greenwald, M. (2019). Rapid induction onto sublingual buprenorphine after opioid overdose and successful linkage to treatment for opioid use disorder. *The American journal of emergency medicine.*

**Heroin or Fentanyl\* overdose reversed with naloxone**  
\*or other short-acting opioid

## Are any patient exclusion criteria present?

- Benzodiazepine, other sedative or intoxicant suspected
- Altered mental status, depressed level of consciousness, or delirium
- Unable to comprehend potential risks and benefits for any reason
- Severe medical illness such as sepsis, respiratory distress, organ failure present or suspected
- Report of methadone use
- Not a candidate for buprenorphine maintenance treatment for any reason

NO TO ALL

YES TO ANY

Is the patient awake with signs of opioid withdrawal? (i.e. COWS >4)

NO

Provide  
supportive care,  
observe and  
reevaluate

YES

Is the patient agreeable to treatment with buprenorphine?

NO

Provide  
supportive care,  
observe and  
reevaluate

YES

## 16mg SL Buprenorphine

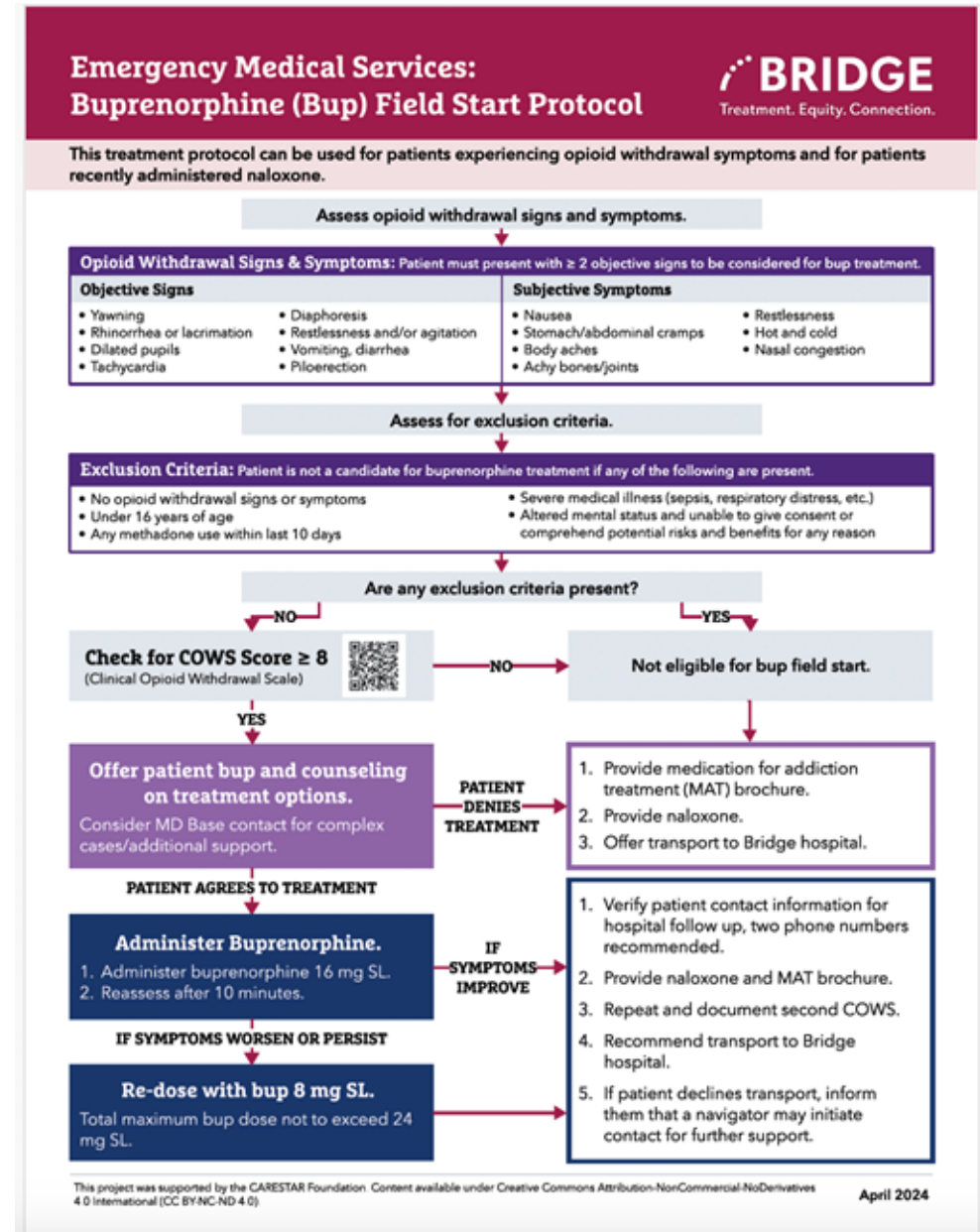
Administered as a single dose or in divided doses over 1-2 hours.  
(Start with 0.3mg IV if unable to tolerate SL.)

**Observe in ED until patient shows no clinical signs of excessive sedation or withdrawal (typically 2 hours).**

OK to administer additional doses of Bup up to 32mg.  
Engage, use motivational interviewing, and link to ongoing care.

# EMS Bridge Field Protocol:

- Patients experiencing opioid withdrawal including after naloxone
- 1,300 paramedics across California use this protocol
- Currently 1/3 of all Californians live in an area where EMS has been trained to provide field buprenorphine



# Annals of Emergency Medicine

*An International Journal*

## Key Findings:

- “Patients who received buprenorphine had a 12-fold increase in being engaged in treatment at 30 days”
- No precipitated withdrawal
- Decrease in Clinical Opioid Withdrawal Scale (COWS) from 9.3 to 2.2
- Increased scene time of 6 minutes

Emergency medical services/original research

## Impact of Administering Buprenorphine to Overdose Survivors Using Emergency Medical Services

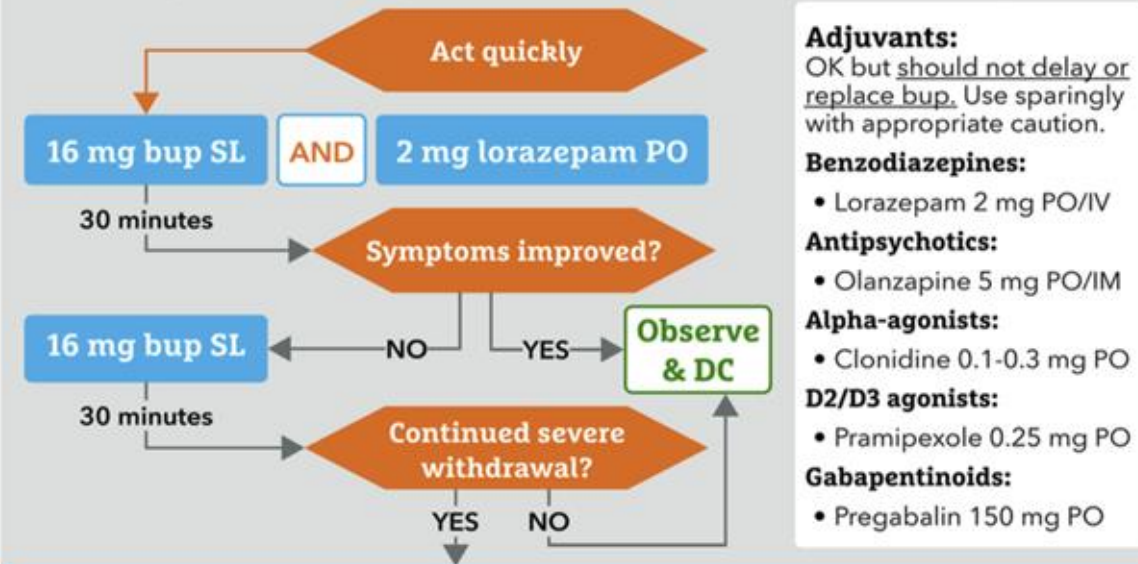
# Interventions to Recover Opioid Sensitivity

- Abstinence + time
- Partial agonist + full agonist
- Antagonists
- **Potentiators that accelerate tolerance recovery**

**In the event of buprenorphine precipitated withdrawal (sudden severe worsening of withdrawal symptoms, e.g., abrupt COWS score increase of >5):**

### **Treatment of bup precipitated withdrawal**

(Sudden, significant worsening of withdrawal soon after bup administration.)



**Escalate level of care to manage potential moderate to deep sedation including cardiac, pulse oximetry, and end tidal CO<sub>2</sub> monitoring:**

1. Ketamine (0.3 mg/kg IV slow push q 15 minutes and/or infusion).
2. Fentanyl 200 mcg IV q10 minutes. Total dose of > 2000 mcg has been reported.

**After clinical resolution, observe and discharge with bup Rx and/or XR-bup**

Source: CA Bridge's "[Emergency Department Buprenorphine Quick Start](#)"

For refractory precipitated withdrawal not responding to bup / fentanyl / ketamine, consider dexmedetomidine. Typically need higher dosing, e.g., starting at 1-1.5 mcg/kg/hr and titrating up as needed.

*This is an algorithm for treatment of buprenorphine precipitated withdrawal created by Bridge, and does not include adulterants or treatment of withdrawal from adulterants/other substances.*

*Treatment may be different if adulterants are present.*

# Care Coordination and Follow Up



## Who are the important players on your team?



## Impact of Substance Use Navigators on Initiation of Treatment for Substance Use Disorders and 30-Day Unplanned Readmission



Arianna Campbell, DMSc, MPH, PA-C, DFAAPA<sup>1,2,10,11</sup> , Allison D. Rosen, PhD<sup>3</sup>, Steven J. Shoptaw, PhD<sup>3,7</sup>, Andrew A. Herring, MD<sup>2,4,5</sup>, David Jay, PhD<sup>9</sup>, Aimee Moulin, MD, MAS<sup>2,8</sup>, Juliet LaMers, MD<sup>11</sup>, Elizabeth A. Samuels, MD, MPH, MHS<sup>2,6</sup>, and Lindsay Gietzen, PhD, PA-C<sup>1</sup>

**Navigators are essential and can reduce readmissions by 64%**

**Need help with  
your drug use?**

**Talk to me.**

## Alternatives to a Dedicated Navigator

**Social Worker**

**Peer**

**Unit Clerk**

**Case  
Manager**

**Scribes**

**RN**

# Getting Started: Potential First Steps

- Identify stakeholders & assign tasks

ED, pharmacy, hospitalist,  
OB, outpatient

- Get buprenorphine on formulary

- Educate ED clinicians

- Designate person responsible for “warm handoff” or linkage to care

Substance Use Navigator  
(SUN), Social Worker, etc

- Establish a referral process with at least 1 MOUD clinic & 1 telehealth provider

- Education plan for everyone

Docs, RNs, pharmacists,  
registration

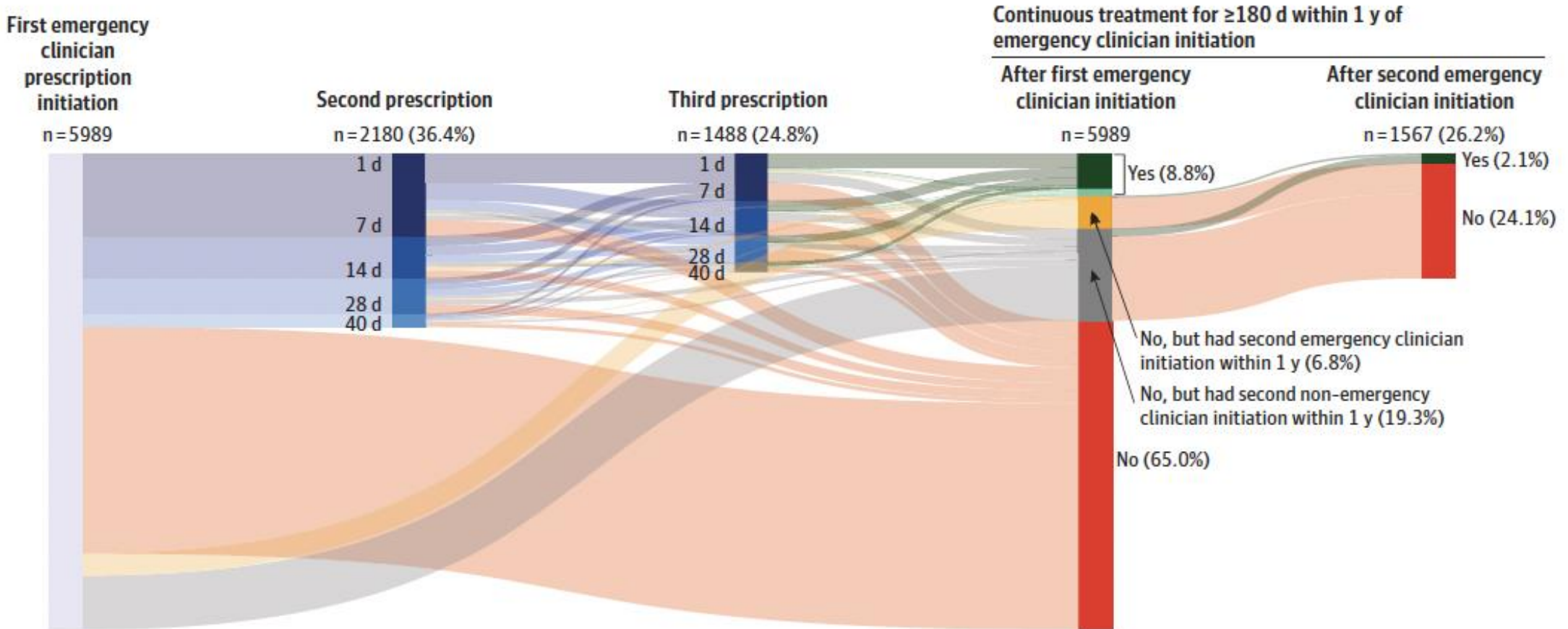
- EHR MOUD orders available (optional)

## Case

51yo male named Charles presents to the ED with knee pain. You notice he has gooseflesh skin and is yawning.

- Do you have a way for Charles to continue buprenorphine?
- What could the role of a Navigator be?
- Do you have a set of expectations from RN upon discharge?
- Do you keep data?

# Recovery Needs More Than the ED



## Ideal Referral Partners

- Low barrier/low threshold
- Standing appointments available
- People can be seen within 48-72 hours
- Medication/appointments not delayed by tox screen or urine test
- Stigma and judgement free zone
- Programs for uninsured/underinsured

## Three Essential Elements of a Behavioral Health Crisis System:

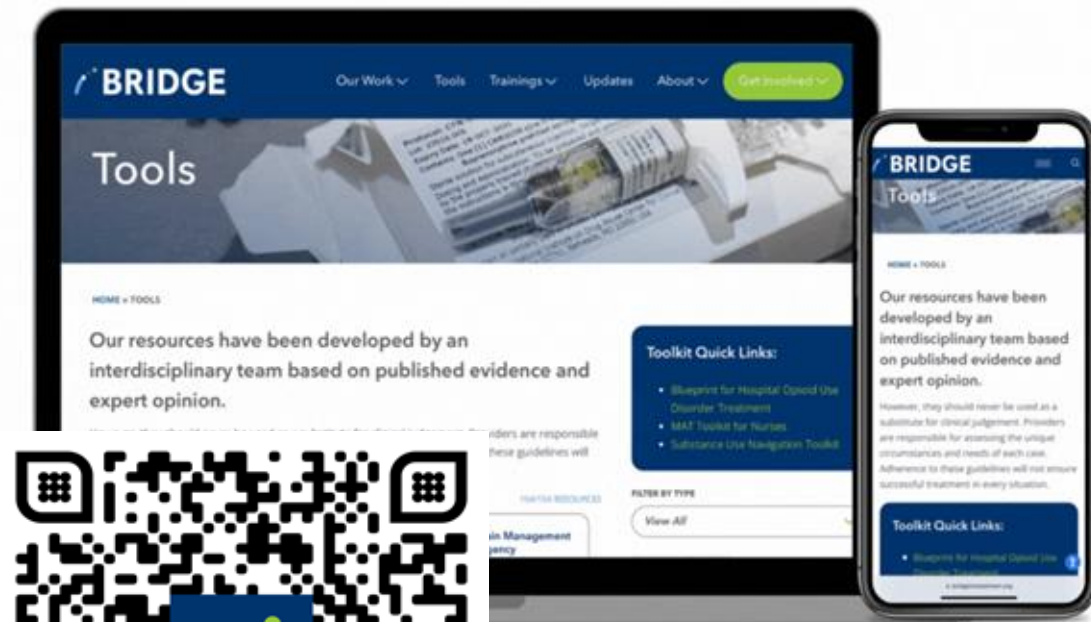
1. Someone to call
2. Someone to respond
3. A safe place to go

# Summary

## Emergency Department Initiated MOUD

- Buprenorphine (bup) treats withdrawal & craving, and protects against overdose
- Mode of buprenorphine initiation depends on presentation and patient needs
- Direct to Inject Buprenorphine is an avenue to provide treatment earlier in withdrawal
- Precipitated withdrawal is rare in ED settings, and treatable.

# Resources



<https://bridgetotreatment.org/>

PCSS  
Medications for Opioid Use Disorders

Providers  
Clinical Support  
System

Search ...

About Education & Training 8-Hour DEA Training Mentoring

**The Providers Clinical Support System-Medications for Opioid Use Disorders (PCSS-MOUD)**

PCSS-MOUD is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to American Academy of Addiction Psychiatry (AAAP) leading a large coalition of national healthcare organizations and created in response to the opioid and stimulant overdose epidemic.

PCSS-MOUD provides multidisciplinary training, educational resources, mentorship, and implementation support at behavioral health professionals to prevent, risk of and with substance use disorders with and stimulant use disorders.

[Learn more about PCSS-MOUD](#)

**Foundational SUD 101 Core Curriculum Courses**

These eight NEW interactive courses feature immersive, case-based learning that review real-world clinical scenarios.

**Course components:**

- Interactive learning: 35-60-minute interactive presentations with knowledge checks and reflection questions.
- Resources: Downloadable slide decks, resource links, references, and mentorship opportunities.
- Facilitation Guides: Tools to support discussion and implementation within clinical teams.
- Accredited CE credits: A certificate following each completed course with continuing education ranging from 0.75 to 1.5 credits.
- Choice of available CE Credit types: AMA PRA Category 1 Credit™, AAPA Category 1 CME, Nursing Contact Hours, Pharmacy CE Credit, Interprofessional Continuing Education (IPCE) Credit.

**Completion:**

After completing each course, learners will receive a CE certificate.

**Digital badge:** Learners who complete all 8 foundational courses can receive an 8-Hour SUD Training Digital Badge. The badge confirms completion of at least 8 hours of training on substance use disorders and fulfills the 8-hour DEA training requirement. It can be shared on social media, added to email signatures, or included in online portfolios and resumes.

**Note:** Learners seeking a certificate verifying 8 hours of training must complete the full 8-course bundle via the PCSS-MOUD website under the 8-Hour DEA Training.

[View Foundational Course Listing](#)

[Review Foundational Tools and Resources](#)

**MUSE**  
CREATIVE AWARDS  
2023  
SILVER  
WINNER

PCSS-MOUD's SUD 101 Foundational Course Series has been awarded the Silver MUSE Award, an international honor recognizing excellence in creativity, design, and innovation.

<https://pcssnow.org/>

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## PCSS-MOUD Steering Committee

- ▶ PCSS-MOUD is led by the American Academy of Addiction Psychiatry (AAAP), in collaboration with a coalition of national professional and healthcare organizations.



Learn more about the Steering Committee and its partner organizations:  
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# PCSS-MOUD Mentoring Program

- ▶ Designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder (MOUD).
- ▶ Supported by a national network of providers with expertise in addictions, pain, and evidence-based treatment, including MOUD.
- ▶ Three mentoring options are available to meet your needs.
- ▶ No cost to participate.



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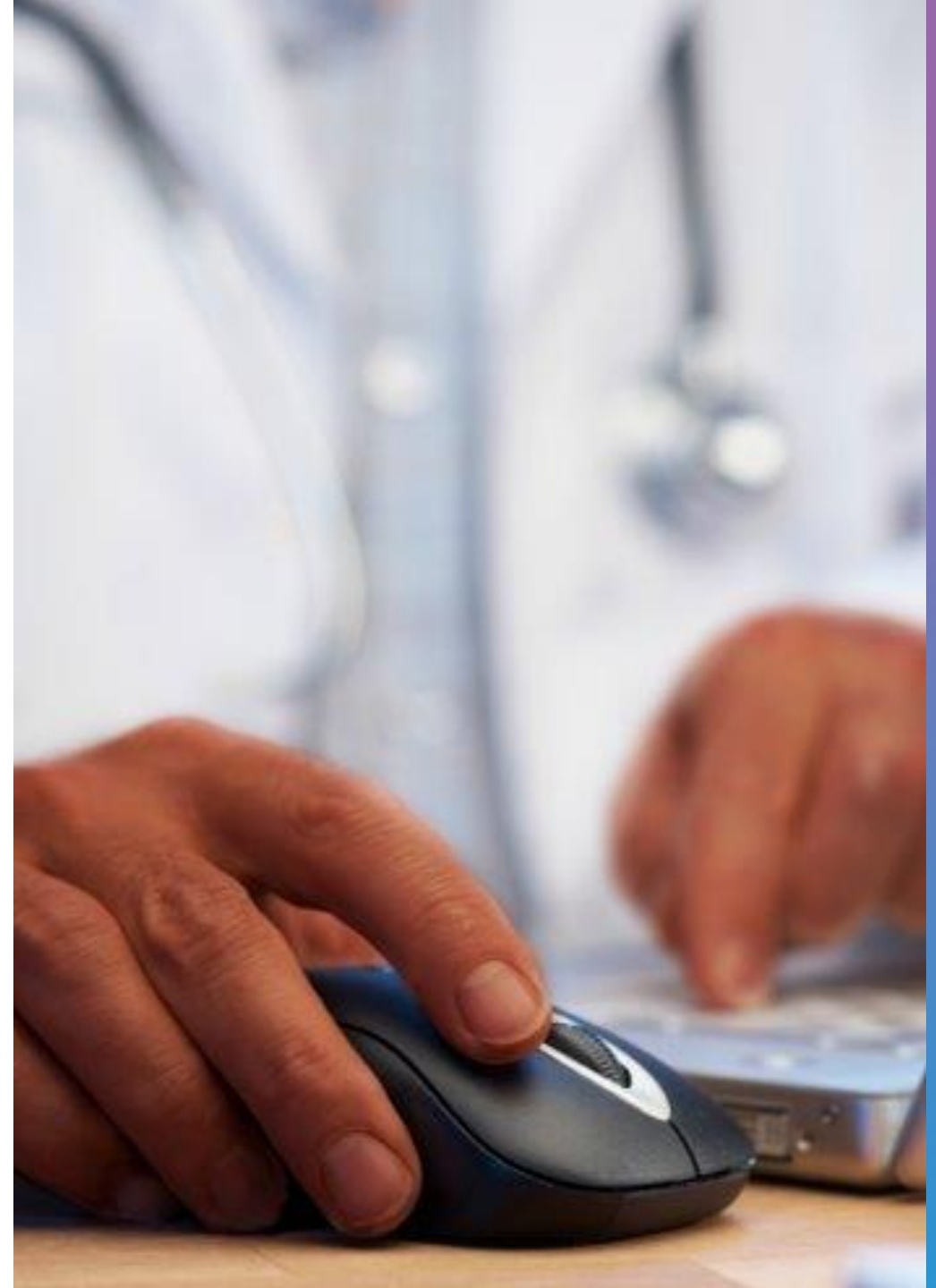
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- ▶ Provides individualized, one-on-one guidance via email, phone, or in-person (if feasible), to discuss specific clinical issues. Members are “matched up” with one of our mentors in their region. This is the most in-depth of the three PCSS-MOUD mentoring tools. Please contact [pcssmentoring@aaap.org](mailto:pcssmentoring@aaap.org) to receive a mentor request form.



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