Overcoming Barriers to Prescribing Buprenorphine in the Emergency Department

Howard S. Kim, MD, MS; Elizabeth A. Samuels, MD, MPH, MHS

Emergency department (ED) visits for opioid overdose and opioid use disorder (OUD) are increasing nationwide. In 2017, there were more than 140,000 ED visits for opioid overdose, an approximate 30% increase from the year prior. In addition, patient outcomes after an ED visit for overdose are poor; more than 5% of patients treated in the ED for nonfatal overdose die within 1 year. Despite clear evidence that opioid agonist medications for OUD (MOUD), such as buprenorphine and methadone, can reduce opioid-related morbidity and mortality, only 20% of the approximately 2 million people with OUD receive MOUD. The ED is a critical opportunity to address this treatment gap. Prescribing buprenorphine to patients in the ED with untreated OUD has been demonstrated to be efficacious; however, implementation of ED-based buprenorphine programs has been limited. The Drug Addiction Treatment Act of 2000 (DATA 2000) "X-waiver" training requirement is a well-known barrier to buprenorphine prescribing; however, other barriers to ED buprenorphine prescribing are incompletely understood.

In JAMA Network Open, Hawk et al assessed organizational readiness for ED buprenorphine prescribing among clinicians at 4 geographically diverse EDs. The authors conducted surveys and focus group discussions with ED physicians and advanced practice clinicians (APCs) to identify barriers and facilitators to buprenorphine prescribing. Primary barriers included (1) lack of training and experience with buprenorphine, (2) availability of outpatient follow-up, and (3) competing needs for clinician time in busy ED clinical environments. Implementation facilitators included (1) receipt of relevant education and training, although the DATA 2000 waiver training was identified as a structural barrier to prescribing; (2) clinical protocols for buprenorphine administration and prescribing; and (3) prescriber-level feedback on care quality, patient experiences, and outcomes.

These findings build on 2 previous implementation assessments of ED buprenorphine prescribing. In a survey of ED clinicians at 2 affiliated academic settings, Lowenstein et al identified patient-level factors that hindered ED buprenorphine use, including social barriers and lack of patient interest in treatment, as well as clinician concerns, such as inability to obtain outpatient follow-up and clinician discomfort administering and prescribing buprenorphine. Martin et al used a behavioral economics approach to address implementation barriers and increase ED buprenorphine prescribing capacity at a single academic ED. They accomplished this by establishing social norms around ED OUD treatment, minimizing barriers to obtaining a DATA 2000 waiver, and increasing awareness of the saliency of treating OUD in the ED setting. Hawk et al extend these earlier findings and specify several priorities to inform future implementation strategies.

Effective strategies to train clinicians to prescribe buprenorphine must address gaps in medical knowledge (eg, buprenorphine pharmacology and clinical indications) and include practice-based knowledge, such as prescribing regulations and local formulary availability. Gaps in medical knowledge among current prescribers can be addressed through in-service education (eg, grand rounds) and formal didactic curricula for clinicians in training, including physicians, APCs, nurses, and pharmacologists. Importantly, most undergraduate and graduate medical education program curricula do not substantively address MOUD, thus forcing clinicians to obtain extracurricular buprenorphine-specific education, which is a known significant barrier to buprenorphine prescribing. Integrating buprenorphine education into medical training nationally would not only better prepare clinicians to successfully care for patients with OUD but also obviate the need for DATA 2000–specific training. Notably, Hawk et al found that enthusiasm for initiating buprenorphine treatment was highest among residents and APCs, suggesting that graduate medical education-focused...
training efforts would be well received. Hospital protocols can also be an effective strategy to address practice-based knowledge gaps and change local standards of care. Standardized care protocols reduce treatment variation, signify support by hospital leadership, and can be used for quality improvement. Importantly, many of the early pioneers of ED-initiated buprenorphine have made their care protocols publicly available (California’s ED Bridge, for example), thus avoiding the need for individual hospitals to reinvent the wheel each time a new program is implemented.

Beyond prescribing, ED buprenorphine protocols must also include linkage to timely outpatient follow-up for continued treatment. Establishing formal relationships with outpatient providers and formalizing clear referral pathways may help allay clinician concerns about outpatient follow-up availability. Although many EDs have established “warm handoff” procedures to improve linkage to outpatient services, a significant portion of ED care occurs during overnight and weekend hours, when outpatient clinics are closed. Follow-up is further affected by many patients’ limited means of reliable communication or transportation. Therefore, outpatient treatment partners would ideally offer dedicated walk-in availability, thereby minimizing barriers to patient entry. Other initiatives to facilitate navigation from ED to outpatient care include use of peer recovery specialists or health promotion advocates. Finally, for patients who present to the ED requesting treatment but who are not in opioid withdrawal, home induction of buprenorphine is a successful prescribing approach that can bridge patients to outpatient treatment with MOUD.

Finally, as Hawk et al discuss, ED clinicians are faced with many competing priorities in a busy care environment and frequently manage multiple complex patients simultaneously. The effects of competing demands on patient care can be addressed by establishing systems to decrease clinicians’ cognitive load, such as automating protocols for buprenorphine prescribing and linkage to outpatient follow-up, providing clinical decision support, and changing social norms and expectations around ED OUD treatment. Obtaining buy-in from clinical staff can be facilitated by the presence of a clinical champion, especially one in a leadership position, and motivation for ED-initiated buprenorphine can be sustained by sharing patient successes, addressing clinician stigma toward patients with OUD and use of MOUD, and establishing departmental quality improvement initiatives for ED OUD treatment.

Prescribing buprenorphine in the ED is a key strategy to address gaps in OUD treatment and improve long-term patient outcomes. The work of Hawk et al highlights the key barriers and facilitators to ED buprenorphine initiation and is critical to developing effective implementation strategies to provide this evidence-based treatment. Importantly, these barriers are likely to be magnified at smaller hospitals, at hospitals with fewer organizational and financial resources, and in regions with limited availability of outpatient treatment, such as rural areas. To truly close gaps in access to MOUD, outpatient buprenorphine treatment capacity must be simultaneously expanded in coordination with efforts to implement ED-based buprenorphine prescribing. Aligning ED and outpatient resources will not only facilitate success of ED buprenorphine initiatives but also promote equitable treatment access and ultimately reduce overdose mortality.
REFERENCES


