EMPRN Buprenorphine Prescribing Survey

Demographic of Participants					
Age	**(n)**	**Gender**	**(n)**	**Race/Ethnicity**	**(n)**
30-39	36	Male	150	Asian	7
40-49	57	Female	38	Black or African American	1
50-59	50			Hispanic or Latino	4
60-69	33			White	129
70-79	12			Other	41

Q.1.What is the trauma designation of the hospital where you primarily practice?

Level I	74
Level II	31
Level III	26
No designation	56
No response	2

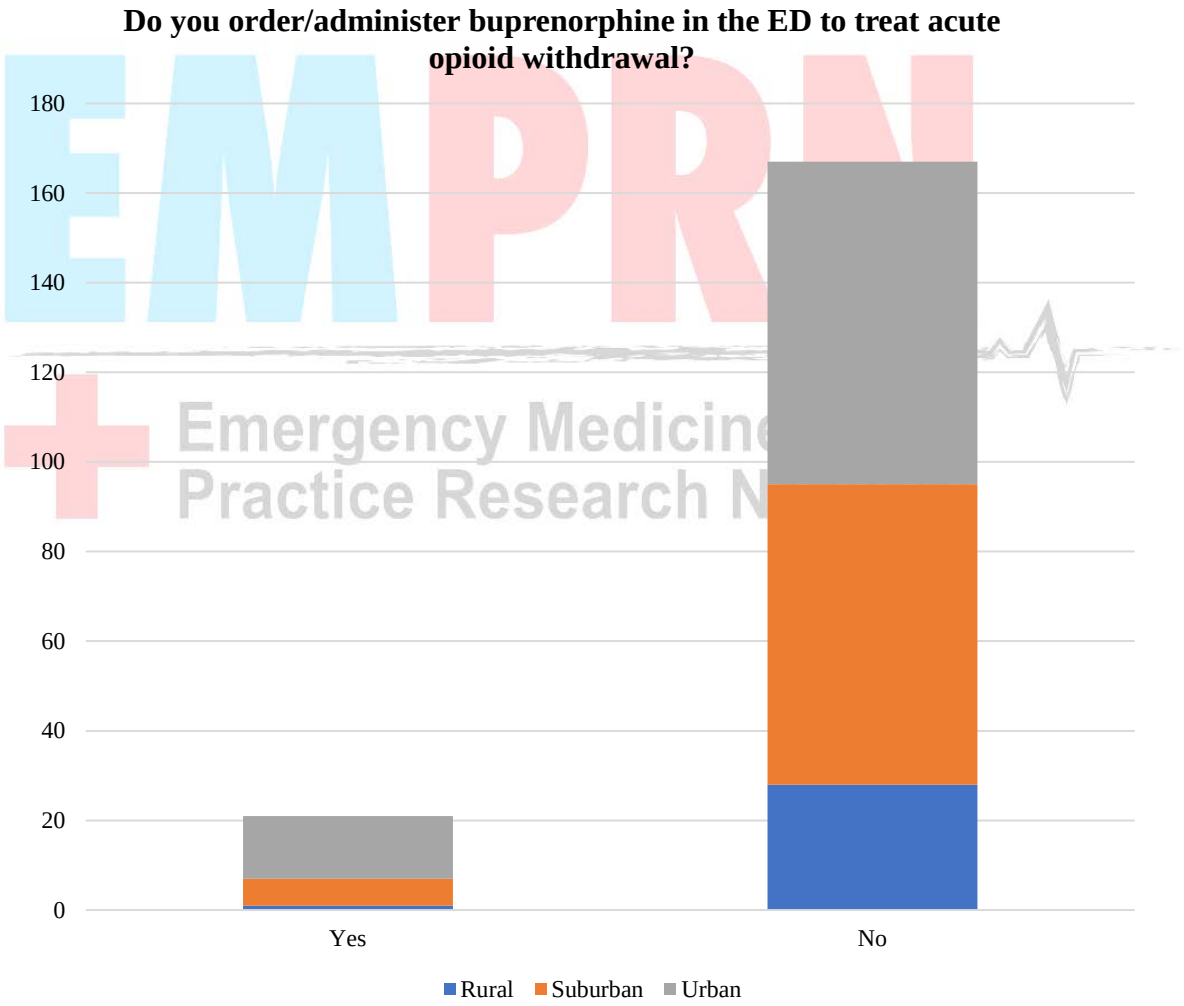
Q.2. What best describes the hospital setting where you primarily practice?

Rural	29
Suburban	73
Urban	86
No response	1

Q.3. Do you order/administer buprenorphine in the ED to treat acute opioid withdrawal (this does not require an X-license/waiver)? Select one.

Yes	21
No	**168**

Yes		**No**	
Rural	1	Rural	28
Urban	14	Urban	72
Suburban	6	Suburban	67
Male	18	Male	133
Female	3	Female	35



Funding for this survey was made (in part) by Indivior Inc.

Q.4. Why do you not order/administer buprenorphine in the ED for withdrawal? Select all that apply.

Response Selected	(n)
Because an X-license/waiver is required to order a dose in the ED	37
I am not familiar with the drug and its side effects/dosing	**76**
I don't believe in treat opioid withdrawal with opioids (including buprenorphine)	26
We don't have buprenorphine on formulary in the ED	66
Other	36
No Response	21

Other Responses Provided

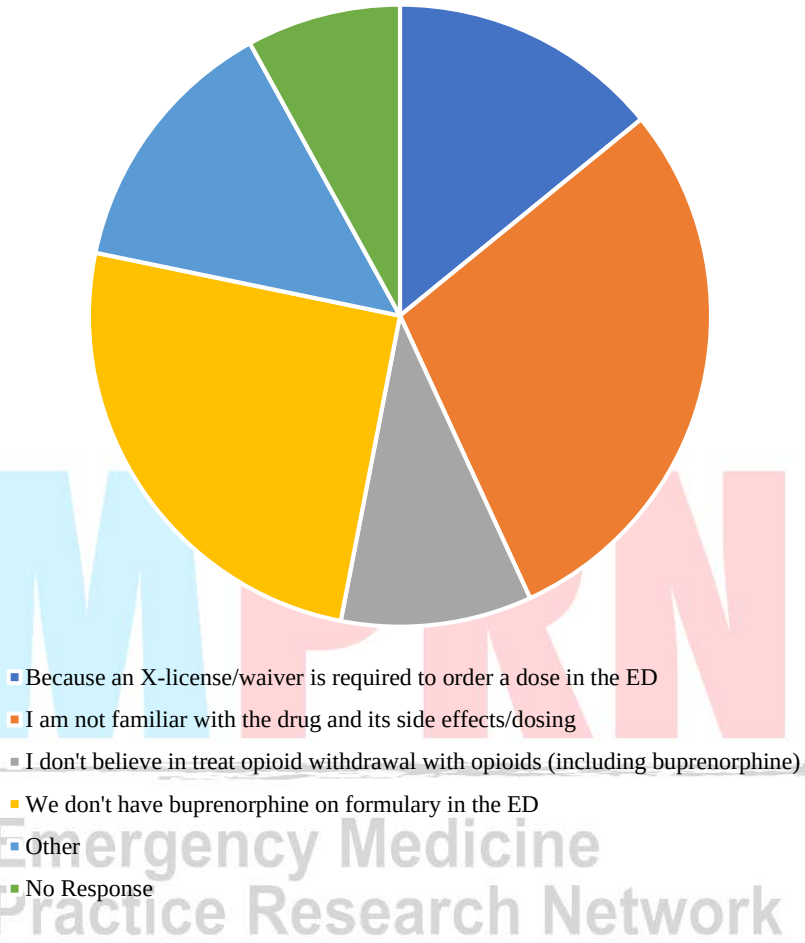
- Acute opiate withdrawal is rarely a medical emergency. Patients can be referred to outpatient substance abuse services.
- Do not stock it in ED
- Due to lack of follow up with the patient, I do not feel it is safe to treat withdrawal with a substance such as suboxone that can be easily abuse as well.
- Emergency physicians can use for pain and continuation of therapy but not initiate therapy without 'pain management' consult.
- For acute withdrawal, I have other choices and I'm not prescribing it long term. If they are already on it and "ran out", I will administer one dose.
- Have not had the opportunity in a patient who wants it.
- Have other options, not impressed with treating opiate addition with an opiate, history has shown the fallacy of that approach.
- I am waivered. We are setting up a hospital bridge clinic to be able to follow patients after ED induction with buprenorphine. That should be up and running in a few weeks, at which point I will begin prescribing.
- I believe that this is appropriate for a monitored detox setting or for outpatient treatment through a CD provider, rather than in the ED.
- I do not have a follow-up system to enter someone into treatment
- I don't have adequate ability to refer for continuing treatment within a short enough time to justify ED treatment of opioid dependence
- Lack of follow up
- My population is horribly non-compliant, and often fail to follow through with the outpatient treatment plan.
- need clear cut institutional guidelines
- No downstream follow up readily available to establish programmatic care.
- No local protocol or specific follow-up.
- No time for "the conversation".
- Not part of group's practice pattern yet.
- Our group has not yet reached consensus on if/how we should move in this direction but it is currently under discussion
- Policy not permitted
- Prefer a more comprehensive approach to opioid dependency treatment. Also, not a fan of substitution therapy without a well formulated, structured plan in place.
- The network is not terribly supportive yet of this practice, we are currently determining pathways by opioid stewardship committee for the network
- Very difficult to get into treatment programs in 3 days
- we are in the process of staring a suboxone clinic. I do not wish to start someone on a drug that they then cannot have continued in our area as an outpatient. It would be futile.
- We are working on a formalized program around this but have not yet implemented it.
- we do not have adequate/timely follow up for these patients after ED discharge.
- We don't yet have an effective plan for follow-up or continuation of treatment.

• I love the idea, but need more education about it. I think it is potentially very beneficial. BUT, one big hesitation is the question of which addicts are truly serious about quitting.... • I might use Suboxone since I have a waiver if they are 48 + hours clean. If less, I think supportive meds to get to Suboxone is better. • I think it is my role. • I treat with nonopioid meds • I use clonidine and antiemetic to treat. • I will give Zofran for nausea and Catapres for withdrawal symptoms. I do not give narcotics to someone who misuses/abuses them. • I work in a pediatric facility and this presentation is quite rare	• We have no follow up program/treatment plan so seems useless. Looking into the Belvue methadone treatment • I'm not aware of using a one-time dose of buprenorphine for withdrawal symptoms. I'd like to initiate in the ED, but have nowhere to send patient afterwards. • It has never been part of my treatment plan. I don't know enough about it to add it to my plan • It has never been part of my treatment plan. I don't know enough about it to add it to my plan • It seems pointless to give one dose when I can't assure outpatient follow up with a prescriber who can prescribe ongoing suboxone and other therapies.

EMPRN
Emergency Medicine
Practice Research Network

Funding for this survey was made (in part) by Indivior Inc.

Why do you not order/administer buprenorphine in the ED for withdrawal?



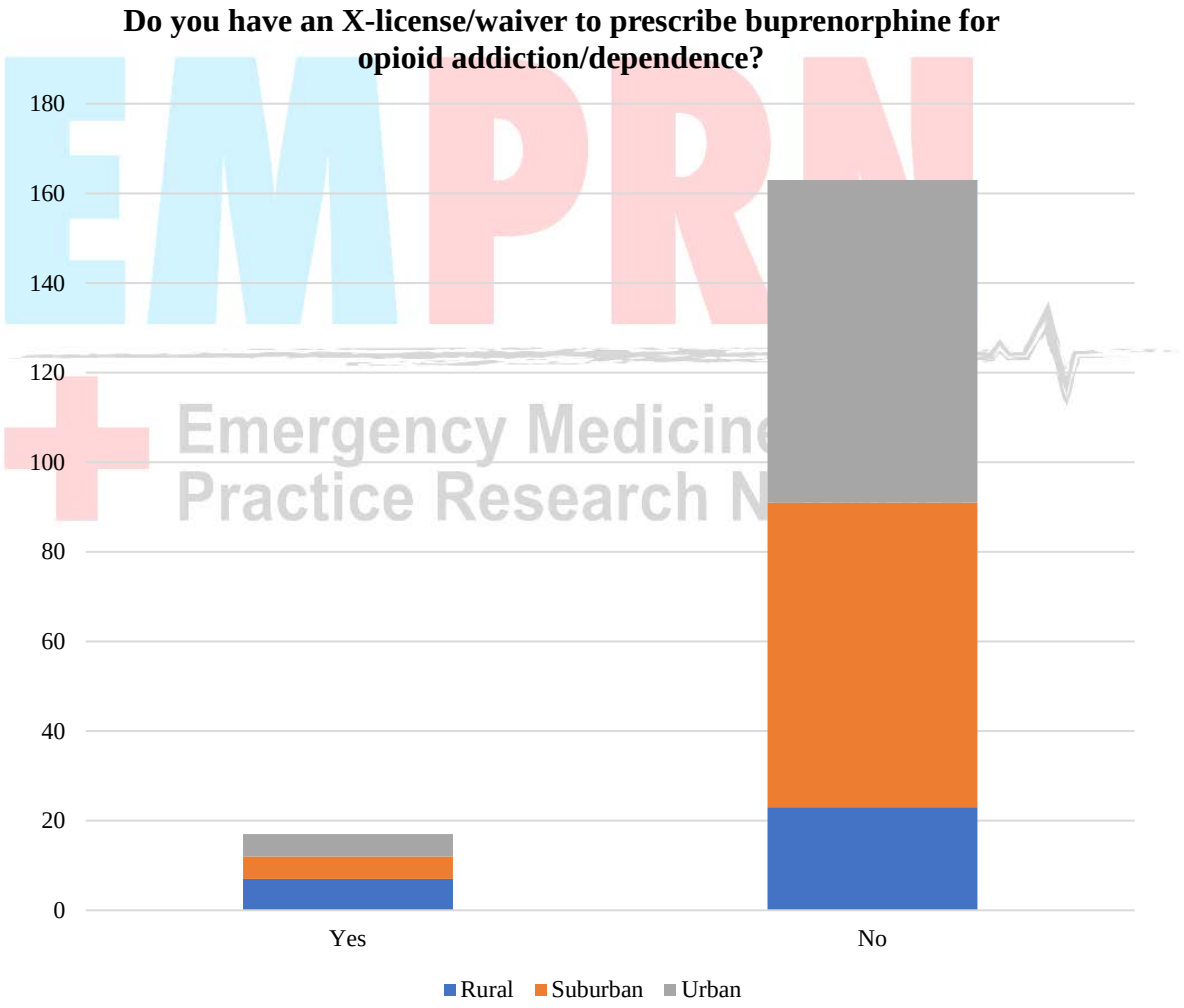
EMPRN
Emergency Medicine
Practice Research Network

Funding for this survey was made (in part) by Indivior Inc.

Q.5. Do you have an X-license/waiver to prescribe buprenorphine for opioid addiction/dependence (Opioid Use Disorder)?

Yes	17
No	**172**

Yes		**No**	
Rural	7	Rural	23
Urban	5	Urban	81
Suburban	5	Suburban	68



Funding for this survey was made (in part) by Indivior Inc.

Q.6. Why have you not gotten an X-license?

Response Selected	(n)
Cost/time to get a license	69
I am unfamiliar with the drug and its side effects	68
I can prescribe what I need by using the 3-day rule	26
I do not think the ED is the right place to start buprenorphine	**78**
I don't see patients with opioid addiction	5
My partner has an X-license	2
Patients can be seen within 24 hours at a nearby clinic	12
We have no outpatient services for our patients	53
Other	15

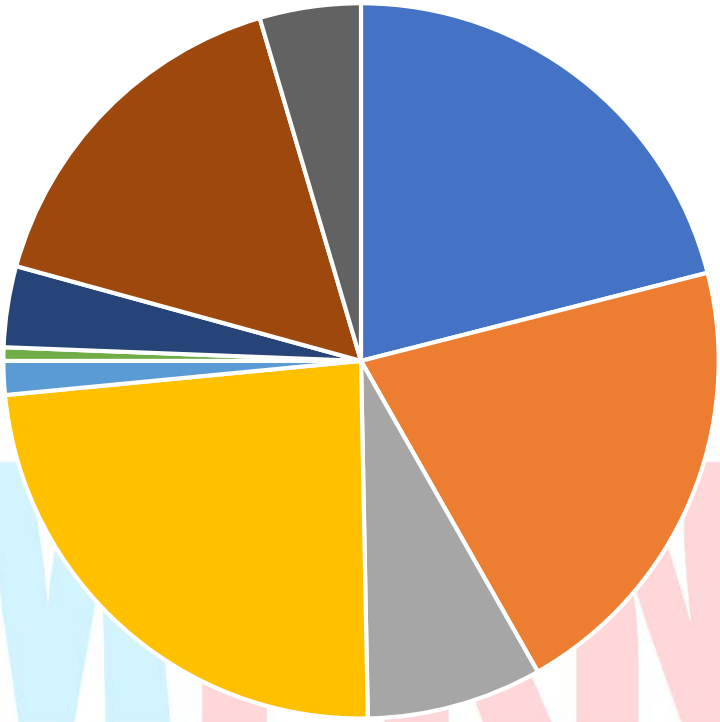
Other Responses Provided

- Addicts swarm on all new licensees.
- Again, very rare that we are seeing patients in withdrawal.
- Don’t know what an x waiver is
- I am at the end of my career and I don't want the hassle of dealing with the regulations. I realize there is evidenced base research that suggests the ED is the place to initiate this care
- I didn't know about it or know if it is available in Oregon.
- I'm on staff at 21 different ED's and none of them are set up to initiate and have immediate follow up with buprenorphine treatment
- I've never thought about it.
- my residency program did not require residents to have this license
- Need better system for follow up after starting meds in ED.
- Previously, we did not have outpatient follow-up available for these patients. Also, we do not have the medication on formulary, so not able to start in the ED.
- We have a toxicology team and addiction clinic
- working on it
- in process of getting waiver
- Didn’t know about it

EMPRN Emergency Medicine Practice Research Network

Funding for this survey was made (in part) by Indivior Inc.

Why have you not gotten an X-license?

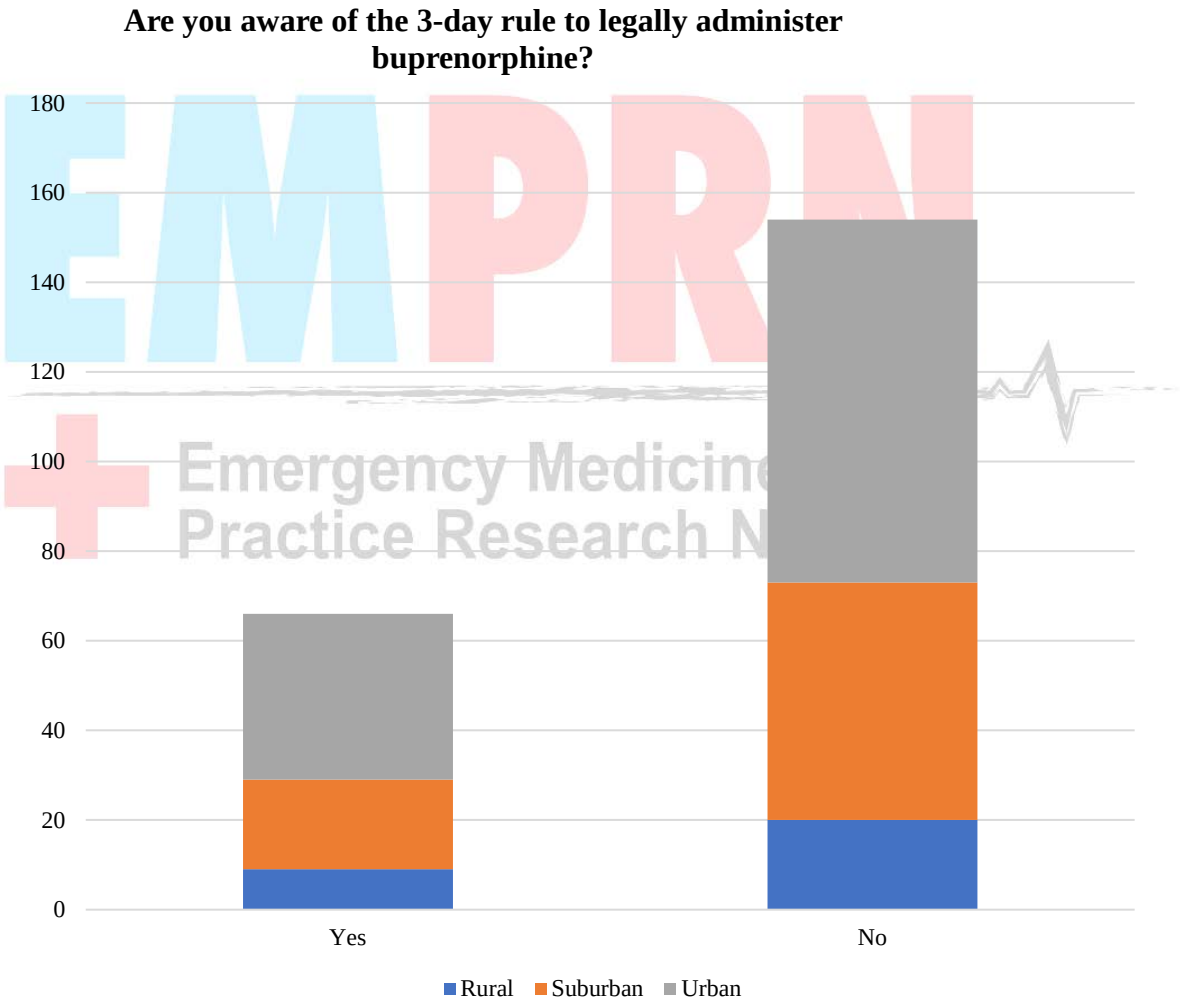


Funding for this survey was made (in part) by Indivior Inc.

Q.7. Are you aware of the 3-day rule to legally administer buprenorphine?

Yes	66
No	122

Yes		**No**	
Rural	9	Rural	20
Urban	37	Urban	49
Suburban	20	Suburban	53



Funding for this survey was made (in part) by Indivior Inc.

Q.8. Do you ever prescribe buprenorphine to treat Opioid Use Disorder (OUD) but officially prescribe it "for pain"?

Yes	3
No	186

Q.9. Do you order/administer buprenorphine in the ED to begin treatment of opioid addiction/dependence (Opioid Use Disorder/OUD)?

Yes	21
No	168

Q.10. Why do you not order/administer buprenorphine in the ED?

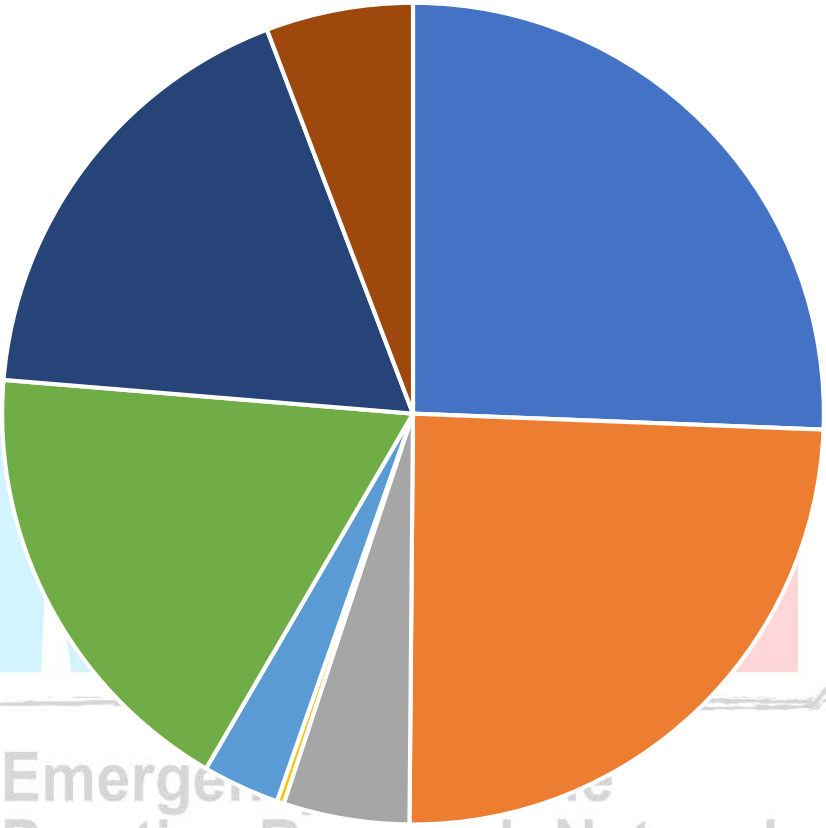
Response Selected	**(n)**
I do not have an X-license	**93**
I don't have local resources for follow-up	89
My institution will not permit use of the 3-day rule	18
My state will not permit use of the 3-day rule	1
Our local clinic will see the patient within 24-48 hours so it is unnecessary	11
Patients will come to the ED just to get buprenorphine	65
The ED is not the right place to start treatment of opioid addiction	65
Other	21

Other Responses Provided

- Who really wants to quit; never been educated about addiction and weaning therapies
- Care is not sufficiently coordinated.
- Don't feel comfortable with buprenorphine
- Don't know if my state has a 3d rule anyway
- haven't had the opportunity yet.
- I have not used opiates or analogues to treat withdrawal. Unless there are mitigating circumstances (pregnancy, etc.) I don't continue opiates in an addiction situation
- I haven't thought too much about this option.
- Indiana prescribing guidelines recommend against.
- Just not part of common use in our ED yet.
- Not aware/familiar of how to do this.
- usually use clonidine and refer to clinic
- Not on formulary
- Outside of my philosophy for treatment of this disease
- There's a paucity of clinics that will see patients on an acute basis; starting it is pointless because they'll get no follow-up.
- Not really faced with this issue due to the patient population in the pediatric facility I work in
- Just don't know much about the drug and how to administer unless the patient is already taking the medication.

Funding for this survey was made (in part) by Indivior Inc.

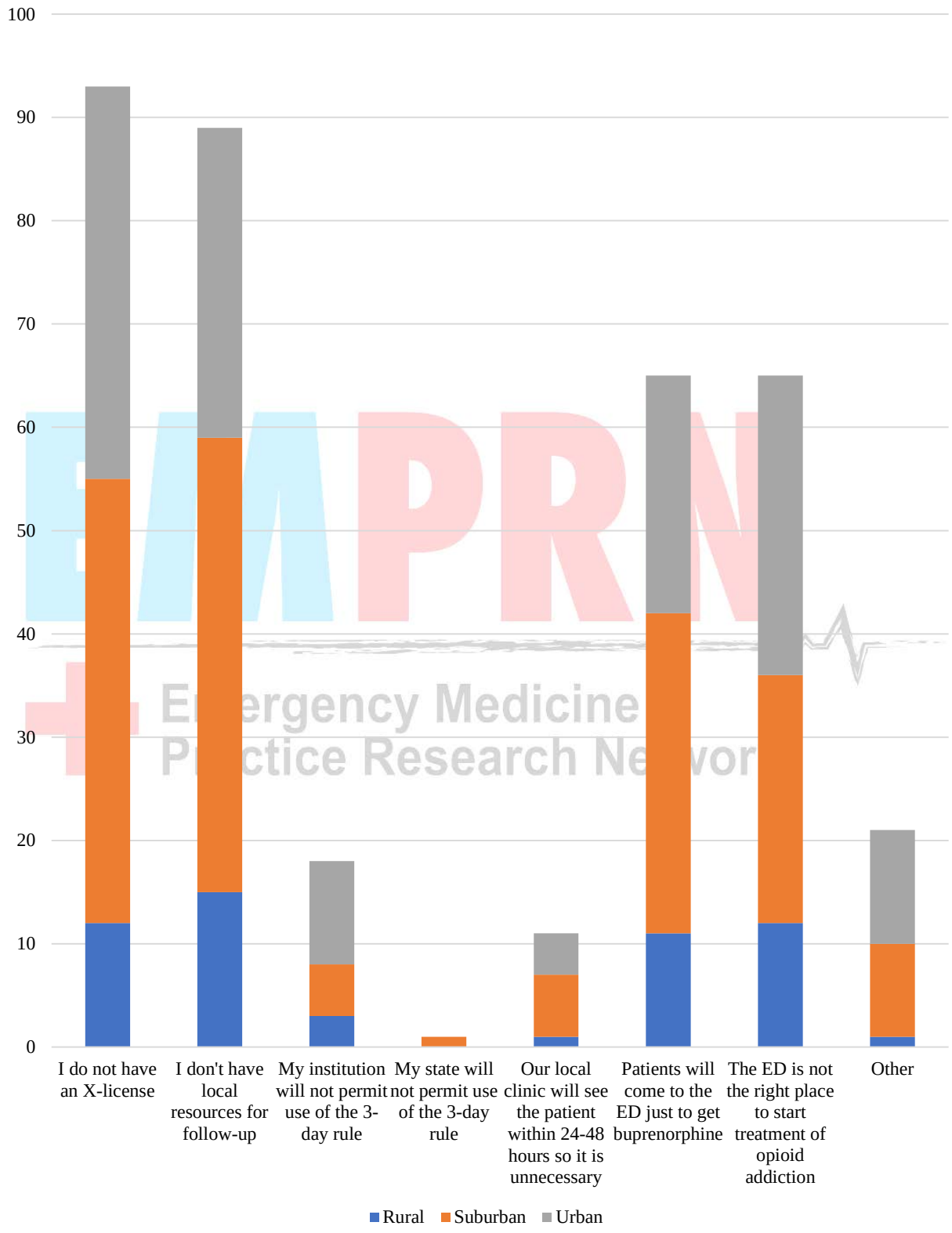
Why do you not order/administer buprenorphine in the ED?



- I do not have an X-license
- I don't have local resources for follow-up
- My institution will not permit use of the 3-day rule
- My state will not permit use of the 3-day rule
- Our local clinic will see the patient within 24-48 hours so it is unnecessary
- Patients will come to the ED just to get buprenorphine
- The ED is not the right place to start treatment of opioid addiction
- Other

Funding for this survey was made (in part) by Indivior Inc.

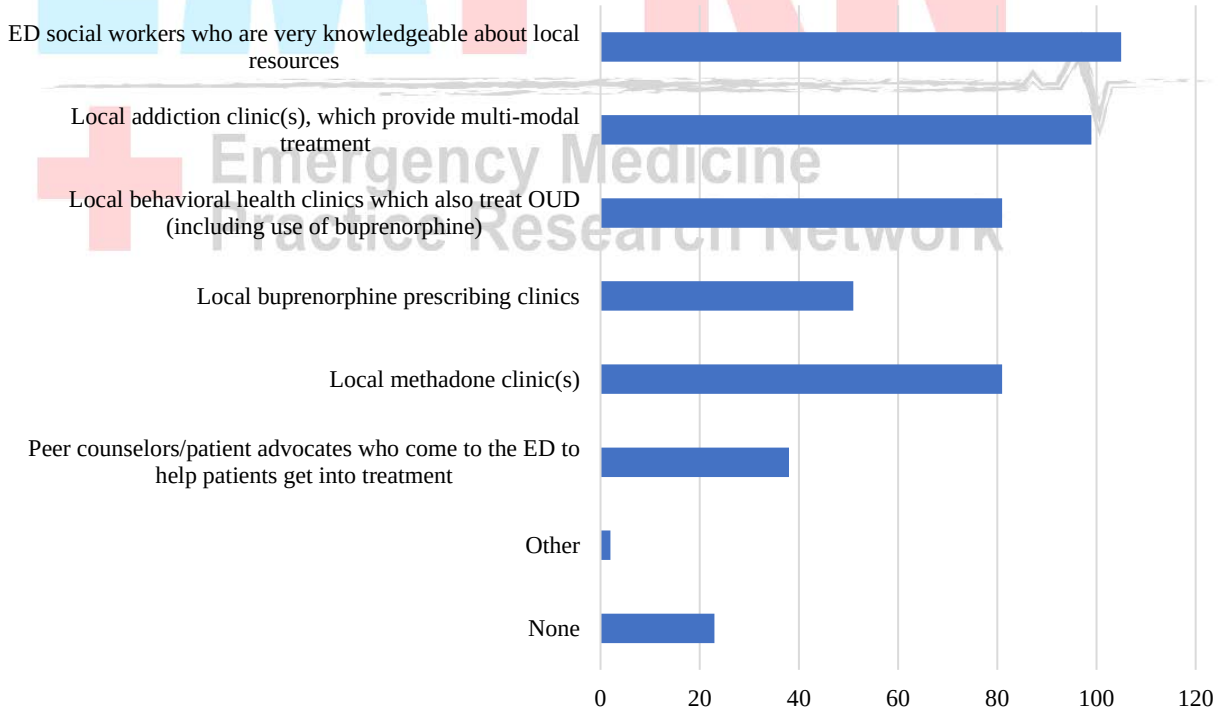
Why do you not order/administer buprenorphine in the ED?



Funding for this survey was made (in part) by Indivior Inc.

Q.11.What resources do you have to help get patients into treatment for OUD from your ED?

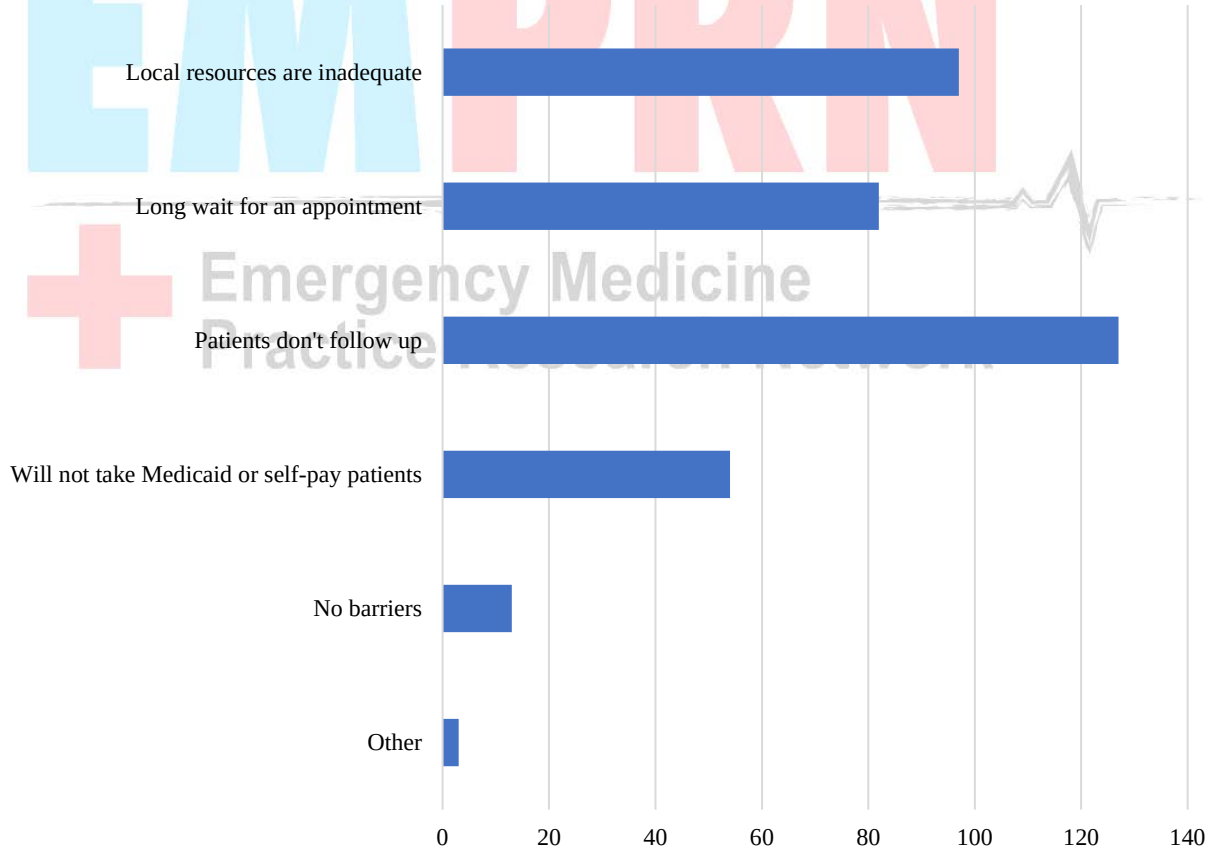
Response Selected	(n)
ED social workers who are very knowledgeable about local resources	**105**
Local addiction clinic(s), which provide multi-modal treatment	99
Local behavioral health clinics which also treat OUD (including use of buprenorphine)	81
Local buprenorphine prescribing clinics	51
Local methadone clinic(s)	81
Peer counselors/patient advocates who come to the ED to help patients get into treatment	38
None	23
Other	2
Other Responses Provided	
• There is an inpatient detox facility at my hospital, which we can admit patients to (until they are full) • Resources just coming on line. Still need more. Social workers in hospital nor helpful regarding addiction. • our local social workers give sheets with referrals; however most local sites want patients to be clean and sober before they take them in. That is why we are starting our own suboxone clinic • I'm on staff at 21 different ED's and none have adequate resources for opiate addiction outpatient or inpatient care.	



Funding for this survey was made (in part) by Indivior Inc.

Q.12.If you have local resources, which of the following are barriers to treatment?

Response Selected	(n)
Local resources are inadequate	97
Long wait for an appointment	82
Patients don't follow up	**127**
Will not take Medicaid or self-pay patients	54
No barriers	13
Other	3
Other Responses Provided	
• Only one of our hospitals are using MAT program. Grant funded. Addiction SW present - referred to a specific FM clinic that treats addiction disorders • many of our patients can't wait for the appts, they have no transportation (are homeless in this rural area) • Don't know. Haven't had feedback on follow ups.	



Funding for this survey was made (in part) by Indivior Inc.