Identification, Management, and Transition of Care for Patients With Opioid Use Disorder in the Emergency Department

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Because of a soaring number of opioid-related deaths during the past decade, opioid use disorder has become a prominent issue in both the scientific literature and lay press. Although most of the focus within the emergency medicine community has been on opioid prescribing—specifically, on reducing the incidence of opioid prescribing and examining alternative pain treatment—interest is heightening in identifying and managing patients with opioid use disorder in an effective and evidence-based manner. In this clinical review article, we examine current strategies for identifying patients with opioid use disorder, the treatment of patients with acute opioid withdrawal syndrome, approaches to medication-assisted therapy, and the transition of patients with opioid use disorder from the emergency department to outpatient services. [Ann Emerg Med. 2018;■:1-12.]

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INTRODUCTION

Opioid misuse is a major public health emergency in the United States, affecting communities large and small, urban and rural, affluent and poor.[1,2] The opioid epidemic is unique in its vast reach, and a rapid increase in opioid-related deaths has led to declarations of a national crisis, with urgent calls to focus on evidence-based strategies to curb the epidemic and increase federal funding for treatment programs and opioid abuse–related research.[3]

According to the 2015 National Survey on Drug Use and Health, an estimated 3.8 million individuals, composing 1.4% of the US population aged 12 years and older, were current misusers of pain relievers.[4] An additional 329,000 people aged 12 years and older use heroin. During the same year, more than 2.1 million individuals initiated the inappropriate use of prescription pain medications, and nearly 135,000 became new heroin users.[5] There were 63,632 drug overdose deaths in 2016, representing a 21.4% increase from 2015.[6] Furthermore, 66.4% of drug overdose deaths involved an opioid (illicit, prescription, or both), an increase of 27.7% from 2015.[7] Since 2000, there has been a 200% increase in the rate of opioid overdose deaths, with heroin and synthetic opioids other than methadone considered the primary drivers.[8]

Within the US health care system, emergency departments (EDs) are often at the forefront of the opioid epidemic, treating individuals with opioid overdose, complications from opioid use, or long-term opioid addiction.[7] To date, much of the focus within the emergency medicine community has been on opioid prescribing patterns, addressing concerns that physician prescribing may be an important driver of opioid abuse, dependence, and overdose.[9] Since 2012, the American College of Emergency Physicians (ACEP) has promoted an opioid prescribing policy that encourages the use of nonopioid analgesics to treat pain when appropriate.[10,11] However, ED prescribing reflects less than 5% of total opioid prescribing in terms of the total quantity of opioids in morphine equivalents.[12]

There is significantly less emphasis on establishing best practices for transitioning patients with opioid use disorders from the ED to appropriate longitudinal services and development of evidence-based treatment strategies. Furthermore, the Center for Behavioral Health Statistics and Quality recognizes that many patients with substance use disorders, including opioid use disorder, are not receiving treatment and many of these patients are not seeking treatment in traditional inpatient treatment centers.[4] Expanding the availability of medication-assisted therapy and facilitating entry into appropriate outpatient treatment centers is a critical step in addressing this treatment gap.

This article examines the current body of evidence underpinning the identification of patients at risk for opioid use disorder, ED-based symptomatic treatment of acute opioid withdrawal, medication-assisted treatment of opioid use disorder on discharge from the ED, and transition to outpatient services.

Screening for Opioid Use Disorder in the ED

Emergency physicians require screening tools to identify patients with opioid use disorder, as well as those at risk for opioid-related harms, including overdose and misuse. Screening tools must be accurate, reliable, and easy to administer in the ED environment. They also must be brief and integrate seamlessly into existing ED work flows to promote widespread uptake and use.[13] Competing clinical care priorities, limited time, and staff turnover present significant challenges to screening in a busy ED environment. Although many opioid screening tools have been validated, not all have been examined in the ED environment, and therefore generalizability should be examined before their use in the ED.

Table 1 provides an overview of commonly used screening tools for opioid abuse, misuse, and dependence. The Opioid Risk Tool is a self-report screening tool developed to assess the likelihood of opioid misuse among patients with chronic pain. It was initially tested and validated in patients presenting to a pain management clinic before initiation of prescription opioid therapy.[14] The Current Opioid Misuse Measure and the Addiction Behaviors Checklist were both developed and validated in a pain clinic setting to clarify aberrant drug-related behavior

Table 1. Opioid use disorder screening tools.

Tool	Author	Population	Methods	Screening Tool Characteristics
Opioid Risk Tool (ORT)	Webster (2005)[14]	Newly enrolled adult patients at a pain clinic. Administered before beginning of opioid therapy for pain management.	Brief self-report, 10 questions (yes, no).	Assesses personal and family history of substance abuse, H/O sexual abuse, and psychological disease.
Revised Screener and Opioid Assessment for Patients With Pain (SOAPP-R)	Butler (2008)[17] Reyes-Gibby (2016)[18] Weiner (2015)[19]	Adult patients with chronic noncancer pain treated at pain clinics. Assessed for feasibility in the ED.	Self-report, 24 questions. Likert 5-point scale ("never" to "very often").	Short (95% completed in <5 min), easy to score, assessed in the ED setting. Sensitivity 0.81, specificity 0.68 (using a cutoff score of 18).
Current Opioid Misuse Measure (COMM)	Butler (2008)[15]	Adult noncancer chronic pain patients. Assesses risk for aberrant drug-taking behavior before the initiation of opioid therapy—chronic pain patients.	17 items, patient self-assessment. Likert 5-point scale.	Sensitivity 0.77, specificity 0.68 (using a cutoff score of 9).
Addiction Behaviors Checklist (ABC)	Wu (2006)[16]	Adult patients with chronic pain already prescribed opioids or sedative analgesics.	20 questions (yes, no).	Assesses addictive behaviors exhibited "since the last visit" and "within the current visit." Longitudinal assessment. Sensitivity 0.88, specificity 0.86 (using a cutoff score of 3).
Alcohol Smoking and Substance Involvement Screening Test (ASSIST V 3.0)	WHO (2002)[20]	Adults with no history of substance use, history of use, and history of dependence.	Interviewer-administered pencil-and-paper questionnaire and screens.	Addresses multiple addictive substances, including opioids. Sensitivity and specificity developed for use/abuse and abuse/dependence. Sensitivity 0.75, specificity 0.65 (for abuse/dependence).
NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NIDA-m-ASSiST)	NIDA[21] Blow (2017)[22] Bogenschutz (2014)[23] Macias-Konstantopoulos (2014)[24]	Intended for adults in the primary care setting. Used effectively in the ED.	Patient interview or online self-assessment.	Patients are asked about street opioids, such as heroin, and misuse of prescription opioids separately. Has not been validated.

NIDA, National Institute on Drug Abuse.