Choosing a Treatment Plan in Acute Care Settings

December 2025

ScalaNW

Overview

This guide contains example patient scenarios that can help facilitate rapport, trust-building, and engagement in shared decision-making when patients with opioid use disorder (OUD) end up in the hospital or emergency department. Each scenario will suggest clinical protocols that might be appropriate in that situation. For more on shared decision-making, check out this overview, and for additional sample language, check out our conversation guide. For more information on the benefits and limitations of the different types of medications for opioid use disorder (MOUD), take a look at our MOUD treatment options overview.

Patient scenarios

Naloxone precipitated withdrawal

Sample language:

> I know getting Narcan is scary and feels awful. How can I help you get comfortable? Would you like some water?

> I'm glad you're alive, and I'm glad you're here. My priority is to help you feel better.

> Buprenorphine can treat withdrawal and lower your risk of having another overdose. You don't have to decide to stay on it long term, but it's the best way to help you feel better and be safer for now.

Tips:

- Offer buprenorphine and other adjunct medications for withdrawal first. Talk about longer term treatment and discharge planning after the patient feels better.
- Treating opioid withdrawal with buprenorphine can be a lifesaving intervention - it can prevent overdose by blocking other opioids for at least 24 hours after a single dose and can facilitate connection to addiction recovery services.

Protocol: Opioid Withdrawal in Acute Care Settings or Opioid Withdrawal in Pregnancy in Acute Care Settings

Handouts: Post-visit handout

Patient in acute withdrawal

Sample language:

> I want to help you feel better. I can give you a bunch of meds to help, and the cause of your symptoms can be treated best with a few doses of buprenorphine. Later you can decide whether to continue taking it and what you want to happen next.

Tips:

- Offer buprenorphine and other adjunct medications for withdrawal first. Talk about longer term treatment and discharge planning after the patient feels better.
- The COWS score is not perfect, it's a static tool. If your patient has a COWS score of 5 and is in excruciating unmanageable withdrawal, understands the risks and benefits, and wants to treat with buprenorphine, that's okay. Similarly, if your patient is anxious, has an infectious process, or has recently used stimulants, a COWS score of 8 may not reflect only acute withdrawal.
- The timing from last use is likewise variable between patients. Drug type, supply and use pattern are all unknown variables that could lead toward safe earlier buprenorphine dosing. If a patient feels sick AND has objective evidence of withdrawal, there's a good chance they are ready for buprenorphine.
- Consider a motivational interviewing approach if the patient is in a place to carry on a discussion. This technique works best if not in a coercive setting; provide symptom relief before making a plan.

Protocol: Opioid Withdrawal in Acute Care Settings or Opioid Withdrawal in Pregnancy in Acute Care Settings

Handouts: Post-visit handout

Admitted patient

Sample language:

> You're sick enough to be admitted to the hospital, which means it's important you get the care you need. You may have had a bad experience in the past where your withdrawal was not managed. That sounds scary, and I'm sorry it happened. I want to keep you from getting sick while you are here. You don't need to commit to treatment after you leave – I just want you to be comfortable enough to get better.

Tips:

- Get patients started on a protocol as soon as possible to prevent or minimize withdrawal symptoms and improve engagement in care.
- Patients can start, or continue, MOUD while having their pain managed with full agonist opioids.
- Motivational interviewing in the ED or on admission might facilitate MOUD implementation later in the hospitalization.

Protocol: Inpatient Care of OUD with Buprenorphine Uptitration or Inpatient Pain Management for Patients with OUD

Patient with severe and acute pain

Sample language:

> I'm sorry you're hurting, and I know you may have had experiences in the past where doctors didn't believe you about your pain or didn't give you the medications you needed to treat it. I want you to know that I am going to try and treat your pain, and if it's not working, I want to know.

Tips:

- Full agonist analgesics and MOUD can be given at the same time – it is not one or the other.
- Buprenorphine is an effective pain reliever, and doses can be adjusted depending on most needs, including some types of acute pain.
- Patient may need very high doses of full agonist medication. If they are not overly sedated and their vitals are normal, the dose is not too high.

Protocol: Emergency Department Pain Management for Patients with OUD or Inpatient Pain Management for Patients with OUD

Patient with opioid use disorder

Sample language:

> I can see that you are concerned about your health. What questions do you have about it today?

> My goal is to help you feel better and be safer. Is it okay if we talk about your fentanyl use?

> It sounds like you would like to make changes related to your drug use. What steps are you planning on taking?

> Medications for OUD can help prevent withdrawal, reduce your risk of illness and death, and help you feel better. Can I tell you about the options?

> I understand if you are unsure. There could be several reasons to not be interested in MOUD. Will you share a little more about your concerns so I can better understand your preferences?

> You are in control of this process, and I am here to help you meet your goals. If you aren't looking to start medication for OUD today, that's okay. We can talk about other ways to stay safe. Are you interested in a hotline number to call in case you change your mind?

Tips:

- Trusting your patient to be the expert on what is right for them empowers them to take the lead on decision-making and can have better success in the long run.
- Offer accurate and unbiased information; use motivational interviewing to support informed decision-making.

Protocol: Emergency Department Methadone Initiation, Emergency Department Buprenorphine Initiation, Emergency Department Adolescent Buprenorphine Initiation (Ages 13+)

Handouts: Post-visit handout, ADAI shared decision-making brochure

Pregnant patient with opioid use disorder

Sample language:

> We'd like to have you start this medication in the hospital over a few days to carefully avoid withdrawal. Withdrawal is risky during pregnancy; severe withdrawal can harm the fetus. If you're in the hospital, we can work together to avoid withdrawal. Are you okay with that? Do you have any concerns?

> Opioid use, and particularly opioid withdrawal, are high risk during pregnancy. Can we talk about medications that can prevent withdrawal and reduce your risk for complications?

Tips:

- Both methadone and buprenorphine are safe and effective in pregnancy.
- **Severe opioid withdrawal in pregnancy is a medical emergency.** Withdrawal in pregnancy can lead to severe complications, including:
  - Maternal autonomic instability and dehydration
  - Fetal hypoxia and distress; in rare cases, fetal demise
  - Uterine irritability triggering preterm labor
  - Unregulated opioid use that may result in overdose
  - Neonatal opioid withdrawal syndrome
  - Fetal growth restriction
  - Adverse epigenetic changes, potentially affecting long-term neurodevelopmental outcomes

Protocol: Emergency Department Care of OUD in Pregnancy, Emergency Department Methadone Initiation in Pregnancy, or Inpatient Care of OUD with Buprenorphine Uptitration

Handouts: Home initiation in pregnancy handout, Post-visit handout

Patient has severe physical dependence, prior difficulty tolerating buprenorphine, or prefers methadone

Sample language:

> Methadone is a great medication for opioid use disorder. It is the right choice for many people and lowers your risk of death. There are some particulars about it though – can we talk more about the details?

> Can you consistently get to an opioid treatment program (OTP) (also known as a methadone clinic)? At first, you may need to go to the OTP daily.

> Would you mind sharing with me your troubles with buprenorphine? It's not the right medication for some people, but sometimes it works better when we use the right approach to starting it and support you with other medications.

Tips:

- Some patients had bad experiences with buprenorphine because the initial dose was wrong or they were given the dose too early. Sometimes they tried to do it themselves. Usually in a controlled environment, induction is easier.
- Methadone takes some time to titrate up to a therapeutic dose.
- You do not need to wait until moderate withdrawal to start methadone, so it may be more accessible than buprenorphine.
- You can give the first dose of methadone in the ED.
- Patients need a follow-up appointment at an opioid treatment program (OTP) within 24 hours, or up to 72 if take home methadone is dispensed to them (in accordance with 21 CFR 1306.07) on discharge.

Protocol: Emergency Department Methadone Initiation or Emergency Department Methadone Initiation in Pregnancy

Handouts: Post-visit handout

Patient interested in buprenorphine, in sufficient withdrawal

Sample language:

> This is a good time to start buprenorphine because you need to be in withdrawal to take it, and that can be hard to do. Since you are already feeling sick, we can treat your symptoms with buprenorphine, and you can stay on it long-term if it works well for you.

> Medications for OUD can help treat and prevent withdrawal, reduce your risk of illness and death, and help you feel better. Can I tell you about the options?

> Many people have received a dose that was too low or given at the wrong time, and that can cause severe withdrawal – we are going to try and make sure that doesn't happen here.

Tips:

- Offer buprenorphine and other adjunct medications for withdrawal first. Talk about longer term treatment and/or after discharge planning after the patient feels better.
- Motivational interviewing works best if it doesn't feel coercive; offer and give symptom relief early.
- The COWS score is not perfect, it's a static tool. If your patient has a COWS score of 5 and is in excruciating unmanageable withdrawal, understands the risks and benefits, and wants to treat with buprenorphine, that's okay. Similarly, if your patient is anxious, has an infectious process, or has recently used stimulants, a COWS score of 8 may not reflect only acute withdrawal. Patients with one or more opioid-specific withdrawal symptoms like yawning, piloerection and isolated runny nose are more likely to succeed buprenorphine induction.

Protocol: Emergency Department Buprenorphine Initiation or Emergency Department Adolescent Buprenorphine Initiation (Ages 13+)

Handouts: Post-visit handout

Patient interested in buprenorphine, but not yet in sufficient withdrawal

Sample language:

> This medication can cause withdrawal if you take it when you aren't feeling sick yet, but it will also treat withdrawal and make you feel better once you have moderate symptoms. I'm going to send you home with a prescription, so you have it when you need it. Let's talk more about how you will know you are ready to start, and what you can do if you feel worse after the first dose.

Tips:

- Prescribe adjunct medications to help them through the first stages of withdrawal.
- Provide education on what to do if they precipitate withdrawal at home (i.e., more buprenorphine).
- Let them know it might take a little while for them to be ready for the process, and that's okay. It's still worth filling the script right away so when the time comes, they don't miss their window.
- This type of patient is the best person to implement a thorough motivational interviewing approach with.

Protocol: Buprenorphine Home Initiation, Emergency Department Care of OUD in Pregnancy

Handouts: Home initiation handout, Home initiation in pregnancy handout, Post-visit handout

Patient is discharging home

Sample language:

> Can we talk about reducing your risk of overdose from fentanyl?

> Are you interested in a prescription for buprenorphine that you can start at home when you are ready?

Naloxone

> Have you used Narcan before? What do you know about how it works?

> This medication cannot be self-administered. Let other people know where you keep it and how to use it, so they can give it to you if you need it.

> This medication can cause withdrawal. Do you want to talk about a prescription for buprenorphine so you can treat that withdrawal? You can start it any time you are in withdrawal whether it's from waiting it out or after Narcan.

Safer Use

> It's safer to use with other people around who can administer Narcan or get help if you overdose. I know that isn't always possible, but there is a phone number you can text or call where they will call for help if you become unresponsive. The Never Use Alone Hotline number is 1-800-484-3731.

> You are at high risk for a repeat overdose in the next day or two. This is a good time to be around other people.

> Consider using smaller doses at first – start low and go slow to check the strength of a specific batch of drugs.

Support available

> There are a number of syringe services programs that provide safer use supplies and help getting connected to other resources. You can look them up through DOH's syringe services program.

> You can call the Washington Recovery Helpline 24/7 to get support for addiction, information about local services, and information on where to get MOUD. Their phone number is 1-866-789-1511.

Appendix

MOUD Treatment Options

ScalaNW

Use this information to support making shared decisions between methadone or buprenorphine when initiating MOUD.

	Buprenorphine	Methadone
Best for	Patients who would benefit from flexible treatment options	• Patients who would benefit from more structured care • Patients whose symptoms are better managed with a full agonist opioid
Formulation and frequency	Daily sublingual, weekly or monthly injectable	Daily oral
Benefits	• Multiple formulations • Treats cravings and withdrawal • Decreases risk of death by over half • Safe in pregnancy and improves both neonatal and maternal outcomes • Appropriate for ages 13+ Long-acting injectable only: • Helps patients who have difficulty taking or do not want to take daily medication • Gradually tapers, so if a dose is missed, it continues to provide some protection from overdose, and reduces severity of withdrawal symptoms	• Treats cravings and withdrawal • Decreases risk of death by over half • Don't have to be in withdrawal to start • Frequent engagement with provider • Safe in pregnancy and improves both neonatal and maternal outcomes
Limitations	• Patient usually needs to be in mild to moderate withdrawal to start • Small risk of precipitating withdrawal when starting Long-acting injectable only: • Injection site pain • Must be administered by a health care provider	• Can only get methadone from an opioid treatment program (OTP) • Early on, may have to go to an OTP often, perhaps daily; over time, may be able to get more take-home doses • May be inaccessible to those who are far from an OTP or lack transportation • Some OTPs have additional requirements, like counseling • Age restrictions may apply: ages 13+ can legally consent in WA, but OTPs may have their own restrictions
A note on buprenorphine precipitated withdrawal Precipitated withdrawal happens in <1% of cases. What to say if a patient is concerned about buprenorphine-precipitated withdrawal: • *"When patients receive a dose at the wrong time or that is too low, it can cause severe withdrawal. But we're going to take steps to avoid that."* • *"If you do have severe withdrawal, we know how to treat it quickly and effectively with higher doses of buprenorphine and other medications."* • *"It sounds like you may have had bad experiences with buprenorphine in the past. Do you want to talk through it together?"*		

For most patients with opioid use disorder, buprenorphine and methadone will be the preferred medications. However, naltrexone may be appropriate for some patients.

	Naltrexone
Best for	• Patients who are already abstinent from opioids, who want to reduce cravings, and prefer a non-opioid option • Patients who use stimulants and are at risk of accidental opioid overdose from the unregulated drug supply
Dose frequency	Monthly injectable
Benefits	• Helps manage cravings • Helps patients who have difficulty taking or do not want to take daily medication • May prevent opioid overdose in those who are not opioid dependent
Limitations	• Must be abstinent from opioids >7 days to start • No reduction in mortality • Does not treat withdrawal • Injection site pain • Must be administered by a health care provider