CA BRIDGE

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CA Bridge
MAT Toolkit for Nurses

A patient-centered approach to 24/7 access to medication for addiction treatment

About

CA Bridge, a program of the Public Health Institute, works to ensure that all people with substance use disorder receive 24/7 access to high-quality care in every California health system. Addiction treatment should be part of standard medical practice in the emergency department and inpatient settings in order to increase treatment access and save lives.

Authors and Acknowledgments

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Introduction

CA Bridge is a statewide program working to ensure that people with substance use disorder (SUD) receive 24/7 high-quality care in every California health system by 2025. We seek to fully integrate addiction treatment into standard medical practice — increasing access to treatment to save lives.

As of 2019, the CA Bridge Model has been implemented at 52 hospitals across California. Since EDs and hospitals provide around the clock access to healthcare, they offer a unique opportunity to make treatment for SUD universally available. Despite strong evidence for buprenorphine initiation in acute care as well as guidance from emergency medicine societies, many hospitals do not offer this service.

The CA Bridge model is based on three pillars:

1. **TREATMENT:** Provide quick start, low-barrier access to evidence-based medication for addiction treatment for substance use disorder in all hospital departments.

2. **CULTURE:** Create a welcoming, non-stigmatizing hospital culture for people who use drugs that is reflected in patient-facing communications throughout the hospital and an emphasis on human connections that build trust.

3. **CONNECTION:** Establish pathways to link patients to outpatient care through active support and follow-up. We actively promote our services to patients through community outreach.

Nurses play a critical role in all of these elements. This toolkit covers the basics of managing the care of a patient with opioid use disorder (OUD) in the acute care setting in order to empower **nurses to initiate and advocate for best-practice, evidence-based treatment** for patients who use drugs.

Framing Our Perspective: Culture of Care

We begin this discussion about treating OUD by addressing one of the most critical and challenging aspects of this work: considering the culture of healthcare and framing how we think about people who use drugs. Many healthcare providers have developed discriminatory thoughts and behaviors related to all kinds of SUD due to peer influences or prior personal and professional experiences. Some have sustained moral injuries in the past, which created negative emotions toward substance use.

"Moral injury describes the challenge of simultaneously knowing what care patients need but being unable to provide it due to constraints that are beyond our control."[1]

Past moral injuries often affect how we approach situations in the present. This may show up as compassion fatigue, a lack of empathy, or burnout. Unfortunately, this can cause us to lead with judgment, bias, stigma, and discrimination.

When we utilize discriminatory language and behaviors, we actually create barriers to care. If people have felt bias or stigma in the past, they will avoid seeking life-saving healthcare based on prior negative experiences. People with SUD are three times more likely to leave AMA, often due to perceived discrimination.[2] It is vital to be aware of our own perceptions and biases in order to **intentionally reduce stigma** and prioritize excellent patient care.

Photo Credit: Menka Belgal, Marshall Medical Center 2020

Nurses Drive Culture of Care

We, as nurses, need to prioritize patient-centered care. Human connections that build trust are integral to how SUD treatment is provided. When we intentionally foster communication techniques and word choices that **create a culture that does not discriminate**, we encourage patient engagement in treatment and recognize substance use as a disorder, not an identity.

Words Matter

The **language we use heavily impacts the way care is received**. When we use terms such as "addict," "drug seeker," and "junkie," it can be extremely stigmatizing. Instead, refer to patients using **'person first' language** such as a "person who uses drugs." This acknowledges the person first, rather than identifying them by their drug.

> ***"When talking to people with SUD, their loved ones, and your colleagues, use non-stigmatizing language that reflects an accurate, science based understanding of SUD and is consistent with your professional role."[3]***

Words Matter. And our decision to use words that de-stigmatize SUD must be intentional.

INSTEAD OF…	USE…	BECAUSE…
Addict User Substance or drug abuser Junkie Alcoholic Drunk Former addict Reformed addict	• Person with opioid use disorder (OUD)/substance use disorder (SUD) or person with opioid addiction • Patient • Person in recovery or long-term recovery **For heavy alcohol use:** • Unhealthy, harmful, or hazardous alcohol use • Person with alcohol use disorder	• Person-first language. • The change shows that a person "has" a problem, rather than "is" the problem. • The terms to avoid elicit negative associations, punitive attitudes, and individual blame.
IV drug user	• Person who injects drugs	• Person-first language.
Habit Relapse	• Substance use disorder • Drug addiction • Return to use/slip	• Inaccurately implies that a person is choosing to use substances or can choose to stop. • "Habit" may undermine the seriousness of the disease.
Clean	**For toxicology screen results:** • Testing negative **For non-toxicology purposes:** • Being in remission or recovery • Abstinent from drugs • Not drinking or taking drugs • Not currently or actively using drugs	• Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions. • Set an example with your own language when treating patients who might use stigmatizing slang. • Use of such terms may evoke negative and punitive implicit cognitions.
Dirty	**For toxicology screen results:** • Testing positive **For non-toxicology purposes:** • Person who uses drugs	• Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions. • May decrease patients' sense of hope and self-efficacy for change.

(Adapted from NIDA Words Matter: Terms to Use and Avoid When Talking About Addiction)

Medication for Addiction Treatment (MAT)

Medication for Addiction Treatment or "MAT" is treatment for SUD with medications to prevent withdrawal, help control opioid cravings, and increase compliance with treatment which literally saves lives.[4,5,6]

MAT is an evidence-based treatment for OUD, which is **a chronic disease** – like hypertension or diabetes – that **often requires medication for disease management to reduce the risk of morbidity and mortality**. MAT is also safe and recommended during pregnancy.[7]

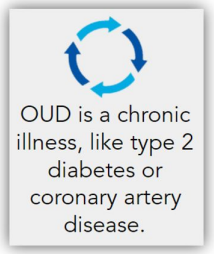
Multiple medications are utilized for MAT, including buprenorphine, methadone, and naltrexone; however, this toolkit will focus mainly on buprenorphine due to its efficacy and low-risk profile. What is most important is that **this approach to treatment works**! This is something we as nurses can get behind! *(video)*

Overview of MAT

	METHADONE	BUPRENORPHINE	NALTREXONE
Mechanism of Action	Full Agonist on Opioid Receptor	Partial Agonist on Opioid Receptor	Antagonist on Opioid Receptor
Dosing	80-100mg (usual dose)	4-32mg (oral)	380mg Depot Injection
Advantages	• Provided in a highly structured supervised setting where additional services can be offered on-site and diversion is unlikely • May be effective for individuals who have not benefited sufficiently from partial agonists or antagonists	• Improved safety due to antagonism • Availability in office-based settings	• No addictive potential or diversion risk • Available in office-based settings • Option for individuals seeking to avoid all opioids

Identifying Opioid Use Disorder (OUD)

Opioid Use Disorder (OUD) can affect anyone - patients, loved ones, peers. Nurses should assess for and recognize both acute opioid withdrawal as well as patients with opioid use disorder who may not be actively experiencing withdrawal. Accurate assessment skills and knowledge of signs and symptoms are essential!



OUD is the chronic use of opioids that causes clinically significant distress or impairment and consists of an overwhelming desire to use opioids, increased opioid tolerance, and withdrawal when discontinued. OUD includes both dependence and addiction. The pattern is similar to other chronic conditions in that signs and symptoms can be severe, and long-term adherence to treatment is often intermittent.[8]

"Drug addiction is a chronic disease characterized by compulsive, or uncontrollable, drug seeking and use despite harmful consequences and changes in the brain, which can be long-lasting."[9]

Current Data Related to Opioid Use

- *Roughly 21 to 29 percent of patients prescribed opioids for chronic pain misuse them.*[10]
- *Between 8 and 12 percent develop an opioid use disorder.*[10]
- *An estimated 4 to 6 percent who misuse prescription opioids transition to heroin.*[10]
- *About 80 percent of people who use heroin first misused prescription opioids.*[10]
- *In the U.S., 67,367 drug overdose deaths were reported in 2018, of which nearly 70% were caused by opioids.*[10]

Acute Opioid Withdrawal

There are a variety of symptoms--physical, emotional, mental--experienced by opioid-dependent patients when they stop using opioids. The typical objective and subjective symptoms of withdrawal are outlined below; however, **the most accurate assessment of the severity of withdrawal is the patient's self-report**.

Onset of Withdrawal Symptoms:

- *> 12 hours after short-acting opioid (some may experience symptoms as early as 8 hours after use)*
- *> 24 hours after long-acting opioid*
- *> 48 hours (can be > 72 hours) after methadone*

Duration of Withdrawal:

- *Initial Phase/Active Symptoms: 7-10 days*[11]
- *Secondary Phase: 26-30 weeks*[11]

SYMPTOMS OF OPIOID WITHDRAWAL

Objective Signs:

- Tachycardia
- Diaphoresis
- Restlessness and/or agitation
- Dilated pupils
- Rhinorrhea or lacrimation
- Vomiting, Diarrhea
- Yawning
- Piloerection (“goose flesh” or “goose bumps”)

Subjective Symptoms:

Patient reports feeling "bad" due to:

- Nausea
- Stomach/abdominal cramps
- Body aches
- Achy bones/joints
- Restlessness
- Hot and cold
- Nasal congestion

Symptoms may mimic the following conditions:

- Viral gastroenteritis or Food Poisoning
- Influenza
- Sepsis
- Pancreatitis or other causes of abdominal pain
- Alcohol withdrawal

Ask about opioid or chronic pain medication use in patients with:

- Abscesses
- Cellulitis
- Endocarditis
- Acute or Chronic Hepatitis C
- Patients with HIV
- Positive urine toxicology testing
- Admitted or signs of alcohol, methamphetamine, or other substance use

Precipitated Withdrawal

This is characterized by the sudden onset of severe opioid withdrawal symptoms following administration of a medication that displaces opioids from the mu receptor, such as naloxone or buprenorphine. This is usually time-limited and resolves with supportive medications, such as administration of additional buprenorphine.

COWS Scale

A **Clinical Opioid Withdrawal Scale or COWS score** can be used to help providers identify when a patient is in opioid withdrawal.[12] While a COWS score ***is not necessary*** to start someone on buprenorphine or methadone, the COWS can be a useful assessment tool, especially for less experienced clinicians, to recognize the common symptoms of withdrawal. It also tends to be utilized more in academic settings in order to standardize treatment. Of note, this scale can be somewhat subjective and also does not account for the cravings a patient may be experiencing.

Although there may be an inclination to use the COWS score to guide MAT initiation and subsequent dosing similarly to how we use the Clinical Institute Withdrawal Assessment for Alcohol (CIWA), we do *not* recommend serial COWS for redosing buprenorphine or methadone as this may be a barrier to care.

Buprenorphine ("Bup")

Subutex, Suboxone, Buprenex, Sublocade, Butrans

Bup Basics

Buprenorphine is a long-acting **partial opioid agonist** that is primarily used to treat acute opioid withdrawal but can also be effectively used to manage pain. It has been shown to **decrease illicit opioid use and increase engagement in treatment**.[13] It is formulated as a monoproduct (buprenorphine alone) or in combination with naloxone. The naloxone component functions as a deterrent that is inert when the tablet is taken sublingually but becomes active if the tablet is injected or snorted.

Because buprenorphine is a partial agonist, it treats cravings and physical withdrawal symptoms but is very **unlikely to cause life-threatening respiratory depression**, does not create euphoria, and **helps to prevent overdose** if a person does use opioids because of its high affinity for opioid receptors.

Adverse Reactions include: sedation, dizziness, headache, insomnia, diaphoresis, nausea, vomiting, abdominal pain, constipation, injection or application site discomfort, or pruritus (for SubQ injection and patch).[14]

Formulations

- Sublingual tablet or film
  - Commonly used for starting OUD treatment
- Extended-release subcutaneous injection
  - Often administered to patients who have already been stabilized on the tablets or strips
- Intravenous or intramuscular solution
  - Can be indicated in cases of severe emesis
  - May be helpful for perioperative use
- Transdermal patch
  - Primarily prescribed for pain management
  - Not approved for OUD treatment

Starting Treatment

Treatment is most effective when provided rapidly at the time when the patient is seeking care. Patients can undergo a Hospital Quick Start or a self-start outside of hospitals/clinics - both are safe and effective options! In order to safely navigate a self-start, patients with a higher opioid tolerance, experience with withdrawal or buprenorphine, and minimal co-morbidities can have a Rapid Start, whereas patients with medical comorbidities, lower opioid tolerance, or who have less experience with withdrawal will do a Gentle Start.

To increase access to treatment and reduce risks and barriers, the CA Bridge Program advocates A Patient-Centered, Rapid Access Approach to Substance Use Disorder. This model allows patients to begin treatment as soon as they seek care by reducing any delays caused by structural barriers as much as possible.

TIPS: Buprenorphine Essentials

- Buprenorphine total dose will generally correlate with how heavy the patient's use is (usually 16-32mg/day).
- Buprenorphine must dissolve/absorb sublingually, NOT swallowed, to be effective (will not be effective and may cause nausea if swallowed).
- Treatment should NOT be started if the patient is not actually in withdrawal as buprenorphine will precipitate a withdrawal (patient will feel WAY worse, not better).
  - Current or recent methadone use may also cause a precipitated withdrawal - switching from methadone to buprenorphine is more complicated and takes time (not usually done in Emergency Departments).
- Okay to treat even if the patient has not continued treatment in the past (the patient is safer while on buprenorphine for however long that is).
  - Each positive treatment experience supports a patient's understanding that OUD is a treatable medical condition.
- Providers do NOT need an X-waiver to order buprenorphine for administration while in the Emergency Department (ED) or inpatient units.
- Urine toxicology or "drug" tests are used to inform care but should NOT be required in the acute care setting and should not exclude a patient from MAT.
- Buprenorphine is often administered in the sublingual formulation (tablet or film) in acute care settings, but can also be administered as a long-acting injection (BUP-XR).

Buprenorphine after Overdose

Buprenorphine can be started after Naloxone Resuscitation which facilitates a straightforward transition into MAT. Of note, this would be contraindicated for patients with co-ingestion or recent methadone use. This is an effective treatment because the buprenorphine displaces the naloxone and then occupies the mu receptors effectively treating the withdrawal symptoms. The two possible "worst-case" scenarios that should be monitored for with this treatment are additive sedation with respiratory depression or a precipitated withdrawal.

Buprenorphine for Pain Management

Buprenorphine is also an excellent option for Pain Management. When buprenorphine is used for analgesia, nurses should anticipate TID dosing and the possibility of adding additional opioids/analgesics or increasing the dose/frequency of the buprenorphine even more if needed. Consider utilizing additional non-pharmacological interventions for pain management, such as a calm environment, a sense of control, mindfulness meditation, and positioning for comfort.

MAT in Pregnancy

Both buprenorphine and methadone are **safe and best practice for treating OUD** during pregnancy and breastfeeding. In pregnant patients, treatment reduces HIV, HCV, and HBV infection, and improves engagement in prenatal care as well as neonatal outcomes.[15] Neither hospital admission nor fetal monitoring is required in order to start treatment with buprenorphine or methadone. Nurses can expect patients to require increased doses or they may need to change to BID/TID/QID dosing due to the increased metabolic rate during pregnancy (Bup Quick Start in Pregnancy).

Neonatal abstinence syndrome (NAS) and neonatal opiate withdrawal syndrome (NOWS) are potential side effects of medications for opioid use disorder, however, **MAT in Pregnancy** is still recommended by the American College of Obstetricians and Gynecologists (ACOG) due to its effectiveness and improved treatment outcomes.

Care for Patients in Custody of Law Enforcement

There are several considerations to make when caring for patients who are in the custody of law enforcement. The first is to remember that law enforcement personnel are not clinical and that medical information should not be shared unless with permission or by court order. It is also essential to educate our patients that, upon release, the clinics and local ED's that are providing treatment for OUD serve as 24/7 safety nets which allows them to access treatment at any time. Lastly, while it is preferable to continue buprenorphine without interruption, **it is always better to start or provide buprenorphine** even when you can not ensure it will be continued. This is because any positive treatment experience, even for just one dose, supports a patient's understanding that OUD is a treatable medical condition and that the healthcare system can provide a positive healing experience.

Many hospitals care for patients who are in custody. In these settings, using MAT remains standard of care, however, issues specific to the criminal justice system must be considered. Care for Patients with Opioid Use Disorder Who Are in Custody addresses these important considerations.

Care Goals

As one of the core concepts of this treatment model is **connection**, nurses should pause to consider how we can collaborate with our patients to establish desired goals. This is why it is so important to build trust, respect, and therapeutic relationships with our patients.

It is also helpful to consider, from a more global perspective, **what are the desired outcomes?** What are we trying to accomplish? Let's consider a few key goals.

Long Term Care

This is a chronic disease with anticipated **long-term management**. We do not expect people with other chronic conditions, such as diabetes or hypertension, to modify their lifestyle and control their disease without prescription medications (even though some may be able to do so). The same is true for treating OUD! It is very helpful to **set this expectation** with patients so that they can accurately anticipate the management of their care.

Access

Access to care with minimal barriers is essential. Encourage patients that **we have treatment options that work** in order to support them seeking help. **Patients who have been on buprenorphine in the past should not be excluded** from care just because they used drugs again. In fact, they should be provided with extra support! Additionally, drug/alcohol test results should not prevent patients from being started on treatment.

Signs create access

Signs offering treatment or asking if people want help with their substance use invites patients to speak openly with their care team about substance use. Download and print your own signs using our *signs template* and post them at registration, triage, hallways, bathrooms, and any place in the hospital patients visit. This empowers patients to self identify as having a SUD, preventing the need for formal screening and urine testing. Coordinating with administration and maintenance is often necessary to ensure that signs are not removed. For examples of how signs are used see *Treatment Starts Here: Sign of the Times*.

If a patient is not interested in treatment now - that's okay - **we are here for them anytime!**

Public Health and Harm Reduction

Due to the high mortality rates associated with OUD,[16] we need to be addressing it from a public health perspective. **MAT works.** When we treat OUD with MAT, we **decrease morbidity and mortality rates** and **enhance quality of life**. We also decrease illicit drug use and disease transmission.[13] What we provide with this model of treatment is a way for patients to feel normal again. This is literally saving lives!

"Harm reduction is incorporating a spectrum of strategies including safer techniques, managed use, and abstinence. [It is also] a framework for understanding structural inequalities (poverty, racism, homophobia, etc). Meeting people "where they're at" but not leaving them there."[17]

Another key, evidence-based measure for caring for people with SUD is harm reduction. By utilizing principles of harm reduction, nurses can positively impact healthcare culture. By treating all patients with respect, we create a space where people who use drugs can and will actively engage in care because they do not fear stigma, judgment, and discrimination, even if they start using drugs again.

Naloxone Distribution

Naloxone Distribution Programs are a vital aspect of harm reduction which empowers various people to provide education on and distribute naloxone to the public. See https://tinyurl.com/CA-Naloxone. Nurses can, and should, advocate for all at-risk patients to receive either naloxone in hand or a co-prescription upon discharge. Naloxone Distribution Project (NDP) is a California statewide program funded at the federal level by the Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by the Department of Healthcare Services (DHCS) to combat opioid overdose-related deaths throughout California. The Guide to Naloxone Distribution offers more information on how to set up naloxone distribution from the hospital.

By promoting harm reduction practices, we help make patients safer if they continue to use drugs. Strategies to integrate harm reduction into the hospital setting are described in greater detail in Harm Reduction Strategies for the Hospital Setting.

Equity

The negative consequences of national drug policy have fallen disproportionately on communities of color. Although the use of illicit drugs is almost identical among white and Black communities, incarceration rates for drug use are two to three times higher for Blacks.[18] Unfortunately, the resulting consequences often include increased childhood trauma, unemployment, and income instability, all of which are risk factors for SUD and other chronic health conditions. In addition, Black patients have very limited access to treatment with buprenorphine compared to white populations.[19] Our goal is to **create anti-racist and socially just treatment options** for substance use. As health care providers, nurses should be striving for equity in our approach to SUD treatment by making treatment **accessible and available to all communities**.

Nursing's Role

Nurses fill many roles and responsibilities in healthcare. First and foremost – we care for people – we ensure high-quality care is provided to each of the patients entrusted to our care. The same should be true for our patients suffering from SUD.

Advocate

We should be empowered to **advocate for best practice treatment** for SUD. There are many situations in which nurses are the first to interact with and assess patients. This gives us an unique opportunity as well as the responsibility to ensure our patients get high quality, evidence-based care for SUD.

Treat with Respect

Establish a therapeutic environment that supports a **culture of respect**. Many of our patients with SUD have negative past healthcare experiences. By creating an environment of care that facilitates information sharing, encourages patients that we have treatment that works, and, most importantly, **treats patients as a person first**, we can actually help people!

Educate

Educate patients on **what to expect** with MAT, care plan goals, and how to utilize resources. Alert patients that though buprenorphine treats physical withdrawal symptoms, they may feel different or have emotions that they have not experienced in a long time. Thorough discharge teaching that includes **harm reduction** information along with follow-up care plans is crucial.

See Nursing Considerations at Discharge and Buprenorphine Patient Info.

For additional education on the nurses' role in caring for patients with opioid use disorder see Nurses Drive Care for Opioid Use Disorder (video).

Collaborate

Collaborate with the interdisciplinary team to effectively manage care. **Connect patients with a Substance Use Navigator** (SUN) when available. SUNs are a vital asset to the team and guide patients through the various aspects of their care. If there is not a SUN at your hospital, nurses, social services, or case management can assist patients in linkage to clinics or outpatient MAT.

Destigmatize

Destigmatize SUD. Utilize patient-centered, person-first language. This is not "replacing one drug for another" or "masking the problem" – it is treating a disease with evidence-based, best practice. It is vital that we, as a team, actively work to stop stigmatizing and **start saving lives!**

TIPS: Take action and destigmatize

(From Harm Reduction Coalition's Respect to Connect: Undoing Stigma)

- Ensure all services are provided in a culture of respect and safety within the workplace
- Review documents and materials to ensure the use of person-first/non-stigmatizing language and change them if necessary
- Emphasize building relationships and trust with people who use drugs as important outcomes
- Consider how past histories of trauma, violence, layers of disadvantage and stigma may affect a person's ability to engage with providers
- Ensure services are grounded in an understanding of how people's health, priorities, and experiences are shaped by the criminalization of drug use

More information can be found at CABridge.org

References

[1] Dean W, Talbot S, Dean A. Reframing clinician distress: Moral injury not burnout. *Fed Pract*. 2019 Sep;36(9): 400-402.

[2] Simon R, Snow R, Wakeman S. Understanding why patients with substance use disorders leave the hospital against medical advice: A qualitative study. *Subst Abus*. 2019 Oct 22;1-7. doi:10.1080/08897077.2019.1671942.

[3] Words Matter - Terms to use and avoid when talking about addiction. National Institute on Drug Abuse. https://www.drugabuse.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction. Published August 27, 2020. Accessed October 22, 2020.

[4] Liebschutz JM, Crooks D, Herman D, et al. Buprenorphine treatment for hospitalized, opioid-dependent patients: a randomized clinical trial. *JAMA Intern Med*. 2014 Aug;174(8): 1369-1376. doi:10.1001/jamainternmed.2014.2556.

[5] Wakeman SE, Larochelle MR, Ameli O, et al. Comparative effectiveness of different treatment pathways for opioid use disorder. *JAMA Netw Open*. 2020;3(2): e1920622. doi: 10.1001/jamanetworkopen.2019.20622.

[6] D'Onofrio G, Chawarski MC, O'Connor PG, et al. Emergency department-initiated buprenorphine for opioid dependence with continuation in primary care: outcomes during and after intervention. *J Gen Intern Med*. 2017 Jun;32(6): 660-666. doi: 10.1007/s11606-017-3993-2.

[7] Committee on Obstetric Practice. Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy. *Obstet Gynecol*. 2017;130(2): e81-e94. doi: 10.1097/AOG.0000000000002235.

[8] Dydyk AM, Jain NK, Gupta M. Opioid Use Disorder. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK553166/. Updated June 22, 2020. Accessed October 14, 2020.

[9] Treatment Approaches for Drug Addiction DrugFacts. National Institute on Drug Abuse. https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction. Published January 17, 2019. Accessed October 8, 2020.

[10] Opioid Overdose Crisis. National Institute on Drug Abuse. https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis. Published June 10, 2020. Accessed October 8, 2020.

[11] Fudin J, Ahmed N, Horlacher R. Opioid Withdrawal: A New Look At Medication Options. *Practical Pain Management*. 2019 Jan 3;15(9).

[12] Tompkins DA, Bigelow GE, Harrison JA, Johnson RE, Fudala PJ, Strain EC. Concurrent validation of the Clinical Opiate Withdrawal Scale (COWS) and single-item indices against the Clinical Institute Narcotic Assessment (CINA) opioid withdrawal instrument. *Drug Alcohol Depend*. 2010 Nov 1;105(1-2): 154–159. https://doi.org/10.1016/j.drugalcdep.2009.07.001.

[13] D'Onofrio G, O'Connor PG, Pantalon MV et al. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. *JAMA*. 2015 Apr 28;313(16): 1636–1644. doi: 10.1001/jama.2015.3474.

[14] Buprenorphine. In: Lexi-Drugs Online. Riverwoods, IL: *Wolters Kluwer Health, Inc.* https://online.lexi.com/. Updated October 14, 2020. Accessed September 24, 2020.

[15] Mozurkewich EL, Rayburn WF. Buprenorphine and methadone for opioid addiction during pregnancy. Obstetrics and Gynecology Clinics. 2014 Jun;41(2):241–253. doi: 10.1016/j.ogc.2014.02.005.

[16] Health Consequences of Drug Misuse: Death. National Institute on Drug Abuse. https://www.drugabuse.gov/drug-topics/health-consequences-drug-misuse/death. Published June, 2020. Accessed October 14, 2020.

[17] Foundations of Harm Reduction. Harm Reduction Coalition. https://harmreduction.org/issues/harm-reduction-basics/foundations-harm-reduction-facts/. Updated October 2, 2020. Accessed October 14, 2020.

[18] Mooney AC, Giannella E, Glymour MM et al. Racial/ethnic disparities in arrests for drug possession after California Proposition 47, 2011–2016. *Am J Public Health*. 2018 Aug;108: 987-993. doi: 10.2105/AJPH.2018.304445.

[19] Lagisetty PA, Ross R, Bohnert A, Clay M, Maust DT. Buprenorphine Treatment Divide by Race/Ethnicity and Payment. *JAMA Psychiatry*. 2019;76(9): 979–981. doi: 10.1001/jamapsychiatry.2019.0876.

Appendix

Treatment Protocols

- *Buprenorphine (Bup) Hospital Quick Start*
- *Rapid Self-Start*
- *Gentle Self-Start*
- *Buprenorphine Immediately after Reversal of Opioid Overdose with Naloxone*
- *Buprenorphine (Bup) Quick Start in Pregnancy*
- *Acute Pain Management in Patients on Buprenorphine (Bup) Treatment for Opioid Use Disorder – Medical/Surgical Units*
- *Acute Pain Management in Patients on Buprenorphine (Bup) Treatment for Opioid Use Disorder Emergency Department / Critical Care*

Guides, FAQs, Toolkits

- *The CA Bridge Model*
- *Words Matter*
- *Patient-Centered, Rapid Access Approach to Substance Use Disorder*
- *FAQ Medications For Addiction Treatment and Trauma-Informed Care: Pregnancy*
- *Care for Patients with Opioid Use Disorder Who Are in Custody*
- *Harm Reduction Strategies for the Hospital Setting*
- *FAQ Substance Use Navigator (SUN)*
- *Buprenorphine: What You Need to Know (Patient Info)*
- *Medicines for Treating Opioid Use Disorder*

Videos

- *Nursing Call to Action Video*
- *Administering Naloxone Video*
- *Nurses Drive Care for Opioid Use Disorder Video*

Additional training on addressing stigma

- Harm Reduction Coalition: Respect to connect: Undoing Stigma
- Resetstigma.org offers free CME focused on decreasing stigma in OUD treatment
- California Health Care Foundation (CHCF) Medication for Opioid Use Disorder: Overcoming Objections
- The National Council Challenging the Myths about Medication Assisted Treatment (MAT) for Opioid Use Disorder
- Addiction Technology and Transfer Center Network:
  - Anti-Stigma Toolkit: A Guide to Reducing Addiction-Related Stigma
  - Healing the stigma of addiction: A guide for treatment professionals