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Rapid Implementation of Opioid Use Disorder Treatment in the Hospital Nationwide

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

Authors and acknowledgements

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Arianna Campbell, PA-C, Aimee Moulin, MD, Hannah Snyder, MD, Amy Lund Stone, RN, Sarah Windels, Serena Clayton, PhD, Andrew Herring, MD.

Contributors to Source Material

Alicia Mikolaycik Kurtz, MD, Hannah Snyder, MD, Amy Lund Stone, RN, Sarah Windels, Serena Clayton, PhD, Aimee Moulin, MD, Andrew Herring, MD, Arianna Campbell, PA-C, Bharath Chakravarthy, MD, Reb Close, MD, Christian Hailozian, Sky Lee, MD, Vanessa Lara, Josh Luftig, PA, Meghan O'Brien, MD, MBE, Shannon Robinson, MD, Alex Stack, MPH, Tommie Trevino, Rebecca Trotzky-Sirr, MD, Rais Vohra, MD, Jennifer Zhan, MD.

This toolkit was last updated in September 2020 and adapted in January 2022 for use outside of California. Specific policies and regulations surrounding addiction care and medication dispensing and prescribing may have changed since that time. Documents are periodically updated to reflect the most recent evidence-based research and evidence-informed cutting edge care being offered in the community.

These resources are not a substitute for clinical judgment or medical advice. CA Bridge does not have relationships with pharmaceutical companies or third-party vendors.

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Introduction

Substance use disorder (SUD) is a chronic illness, like type 2 diabetes or coronary artery disease. Its etiology is similarly multifactorial, with contributions from genetics, the environment, and human behavior.[1] Medication for addiction treatment (MAT) is evidence based for SUD treatment; a prime example is buprenorphine for the treatment of opioid use disorder (OUD).[2] Randomized controlled trials have shown that initiation of buprenorphine in emergency departments (EDs) prior to community discharge increases rates of linkage to outpatient treatment over brief interventions.[3] Similarly, for patients who are admitted to the hospital, buprenorphine initiation and dose stabilization can control withdrawal symptoms and increase rates of linkage to outpatient treatment.[4] Despite evidence that buprenorphine is associated with decreased illicit opioid usage,[5] improved adherence to addiction treatment programs, and cost-savings,[6] 60-80% of people who use opioids do not have access to this medication.[7]

Since EDs and hospitals provide 24/7 access to healthcare, they offer a unique opportunity to make treatment for SUD universally accessible. Despite strong evidence for the efficacy of 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 increasingly implemented in hospitals throughout California and nationwide. While the details of implementation vary, these sites demonstrate feasibility at large and small, public and private, urban and rural hospitals.

The CA Bridge model is based on three pillars:

1. **Low Barrier Treatment** – Make medication for addiction treatment (MAT) accessible in the emergency department and all hospital departments without complicated restrictions and procedures. Provide rapid, same-day treatment in response to patient needs.
2. **Connection to Care and Community** – Link patients to ongoing care through active support and follow up. Reach out to community organizations and people who use drugs to increase access to care.
3. **Culture of Harm Reduction** – Create a welcoming culture in the hospital that does not stigmatize substance use and does recognize racial disparities in access to care. Promote harm reduction and trauma-informed practices. Build trust through human interactions and lead with respect.

This resource provides step-by-step guidance on how to set up a MAT program in an acute care hospital following the CA Bridge model. Recognizing that not all hospitals will have the resources to implement the full model with navigation, we offer practical alternatives when possible. Implementing your program quickly is key; start in whatever way you can. Once you start treating patients, you can see that treating OUD is simple and effective.

Get in Touch!

CA Bridge is dedicated to advancing treatment for OUD, and ultimately all SUDs, in all hospitals and health systems. We welcome you to become part of the amazing and committed group of clinicians who have found changing their hospital's approach to people who use drugs to be some of the most rewarding work they have done. We want to support you and learn from you! You can join the conversation at www.cabridge.org.

Implementation Checklist

Start treatment

- ❑ Ensure buprenorphine is on formulary and available in the hospital.
- ❑ Share treatment protocols with the ED clinician team, nursing teams, pharmacy teams, and coordination teams (social work, case management, patient navigation) and post in visible locations.
- ❑ Ensure there are no barriers, such as unnecessary diagnostic testing, that delay the start of treatment.

Connect patients to ongoing care

- ❑ Establish informal or formal relationships with at least one clinic or outpatient setting that provides MAT. Consider a standing appointment time for follow up.
- ❑ Develop patient materials, including a list of MAT follow-up options, discharge instructions, home start guidance, and harm reduction guidance.
- ❑ Establish a patient-centered referral process, including workflows for night and weekend follow up.
- ❑ Identify staff who can help navigate patients to treatment.

Change hospital culture

- ❑ Learn about harm reduction and trauma-informed care and integrate them into your clinical practice.
- ❑ Educate providers and staff about the use of non-stigmatizing language through flyers or presentations.
- ❑ Print and hang patient-facing signs in the ED lobby and patient care areas.

Build your program

- ❑ Identify at least one clinician champion and navigator role.
- ❑ Provide easy X-waiver enrollment instructions and establish expectations for the X-waiver.
- ❑ Educate clinicians and hospital staff on the MAT program, treatment protocols, and referrals to ongoing care.

Medication for Addiction Treatment

Start Treatment

This toolkit covers treatment for OUD in acute care hospitals with buprenorphine. Buprenorphine prevents and treats withdrawal, helps control opioid cravings, and is associated with reduced mortality.[8,9,10] ED initiation of buprenorphine is feasible and associated with increased linkage to outpatient care.[3] Patients with untreated withdrawal are at risk for using in an unsafe way that puts them at risk of fatal overdose. This section covers the key components of a treatment program.

Key Steps for Starting Treatment	Resources
Ensure buprenorphine is available in the hospital so that it is easily administered from the ED and inpatient settings.	• Buprenorphine and Pharmacy
Identify and treat OUD using rapid, patient-centered treatment.	• CA Bridge Treatment Protocols • Clinical Opioid Withdrawal Score (COWS) Template • How to Use Your New X-Waiver: Starting and Prescribing Buprenorphine
Remove clinical barriers to treatment so that patients can begin treatment immediately.	• A Patient-Centered, Rapid Access Approach to Substance Use Disorder • Treatment, Culture & Connection (video) • A Caring Culture in Healthcare
Provide medication on discharge to ensure continued access until a connection to outpatient treatment is made.	• Buprenorphine Sample Discharge Instructions • Harm Reduction Sample Discharge Instructions

Ensure buprenorphine is available in the hospital

Buprenorphine must be easy to order in the ED setting and from any other department that will provide MAT. Coordinate with the pharmacy team to put this medication on formulary, if it is not already available, and ensure buprenorphine is available and stocked in the ED (e.g., in Pyxis or Omnicell). Buprenorphine monoproduct and buprenorphine/naloxone are available in 4mg and 8mg tabs or strips for sublingual (SL) administration.

TIP: Work with information technology (IT)

- Coordinate with IT to ensure that buprenorphine can be ordered in the electronic health record (EHR) system, prescribed at discharge (continuation and self-start versions), and that DEA-X is added to prescriber profiles.

Identify and treat OUD

These treatment protocols are designed to be simple resources for providers and include best practices, dosing information, and important reminders for providers prior to initiating treatment.

CA Bridge treatment protocols	Overview
Buprenorphine Hospital Quick Start for Opioid Withdrawal	A patient in the ED or inpatient settings who is experiencing opioid withdrawal can be started on buprenorphine following the "Quick Start" protocol of SL buprenorphine. Patients do not need to commit to ongoing care in order to be started on buprenorphine. A urine drug screen and lab testing are not necessary for treatment. Prolonged monitoring is not required.
Buprenorphine Hospital Quick Start in Pregnancy • Buprenorphine Quick Start in Pregnancy • Medications for Addiction Treatment and Trauma Informed Care: Pregnancy	The American College of Obstetricians and Gynecologists recommends providing MAT for OUD during pregnancy. Detoxification from opioids, without continuation of MAT, is NOT recommended. Buprenorphine and methadone are safe and effective during pregnancy and breastfeeding. Fetal monitoring is not required for MAT starts. In labor, analgesia beyond MAT is required.
Acute Pain Management for Patients on Buprenorphine • Acute Pain Management in Emergency Department and Critical Care • Acute Pain Management in Medical Surgical Units	Patients currently on MAT or who are newly started on buprenorphine in the ED may experience acute pain. **We do not recommend stopping a patient's maintenance of buprenorphine or methadone;** this leads to uncontrolled withdrawal and therefore pain that is difficult to control. Their maintenance dose of buprenorphine or methadone is not sufficient to treat acute pain, so other analgesics must be offered including opioids if needed. **Do not avoid treating pain for people with a substance use disorder.** Untreated pain can lead patients to return to use.
Starting Buprenorphine Immediately After Reversal of Opioid Overdose with Naloxone	Patients who receive naloxone to reverse opioid overdose should be given buprenorphine following the reversal.
Care for Patients with Opioid Use Disorder Who Are in Custody	Many hospitals care for patients who are in custody. In these settings, MAT remains the standard of care. Issues specific to the criminal justice system must be considered.
Buprenorphine Patient Self-Start Options • Gentle Buprenorphine Home Start • Rapid Buprenorphine Home Start	For patients who are not yet in enough withdrawal to start buprenorphine, write a prescription of buprenorphine with instructions for self-starting. We offer two different versions depending on the situation: • Gentle Home Starts are for people with major medical issues/with lower opioid tolerance (for example, using opioid pills). • Rapid Home Starts are for patients familiar with buprenorphine/who have higher opioid tolerance.

Identify Patients Who are Candidates for Buprenorphine

To find patients who may benefit from buprenorphine in your hospital, consider the following:

1. Visible, patient-facing signs in public spaces in the hospital encourage patients to self identify opioid use.
2. Clinicians and navigators should ask about opioid use in patients with opioid withdrawal symptoms or sequelae of injection use.
3. Screening questions can be used but should be interpreted with caution as patients may not self-identify their use disorder if they are concerned about stigma or do not know that they will be offered treatment.

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

What about screening?

Universal screening in triage is not necessary as it can be traumatizing to ask about stigmatized conditions in a busy triage area. Consider ways to universally offer treatment and encourage a safe space for self disclosure.

- Display signs and buttons indicating that the department is a safe space to disclose and that treatment is available. This may make patients more likely to disclose.
- Consider targeted screening by the primary nurse or a member of the care team for patients with common substance use disorder-related chief complaints (i.e. abscess). One approach is to ask, *"Is it ok if I ask you about drug/alcohol use?"*
- Consider screening all admitted patients. You can share with patients that you are asking because you want to make sure that they are comfortable throughout their stay and that they won't have withdrawal. If they disclose that they might enter withdrawal, make a plan to treat withdrawal symptoms during the patient's hospital stay.

Signs & symptoms of opioid withdrawal

Objective signs:

- Tachycardia
- Diaphoresis
- Restlessness/ agitation
- Dilated pupils
- Rhinorrhea/ lacrimation
- Vomiting, diarrhea
- Yawning
- Piloerection *("goose bumps")*

Subjective symptoms:

- Nausea
- Stomach/ abdominal cramps
- Body aches
- Achy bones/joints
- Restlessness
- Hot and cold
- Runny nose

Symptoms may mimic the following conditions:

- Viral gastroenteritis or food poisoning
- Influenza
- Sepsis
- Pancreatitis or other causes of abdominal pain
- Alcohol withdrawal

Ask about pain medication use in patients with:

- Abscesses
- Cellulitis
- Endocarditis
- Acute or chronic hepatitis C
- Human immunodeficiency virus (HIV)
- Positive urine toxicology testing
- Signs of substance use

A Clinical Opioid Withdrawal Score (COWS) can be used to help providers identify when a patient is in opioid withdrawal. The COWS can be checked prior to administering the first dose of buprenorphine if there is concern for insufficient withdrawal. Growing evidence supports patients' self report of withdrawal as sufficient for buprenorphine initiation in the non-facility setting,[11,12] therefore some providers do not conduct formal COWS prior to initiation and instead ask the patient if they have symptoms and look for at least one objective sign.[13] See Clinical Opioid Withdrawal Score (COWS) template.

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 or fentanyl

≥ 48 hours (can be > 72 hours) after methadone

Precipitated withdrawal:

- The sudden onset of severe opioid withdrawal after the administration of a medication that displaces opioids from the mu receptor (e.g., naloxone or buprenorphine).
- Usually time-limited and resolves with supportive care.

TIP: Create order sets

Order sets encourage best practices. They make it easy for providers to use appropriate dosing and ensure that everyone is prescribed naloxone. See Clinical Considerations for Order Sets for recommendations on building order sets. We also offer Example Order Sets and cover this topic in our Buprenorphine In The Hospital: How Do We Do It? (video). Work with your IT department to create discharge prescription options. Examples include:

- **Buprenorphine/naloxone**
  8 mg / 2 mg SL film (OK to substitute SL tablets)
  2 strips under the tongue once a day
  Quantity #14 (7 days)
- **Buprenorphine/naloxone (self start/self titration)**
  8 mg / 2 mg SL film (OK to substitute for SL tablets)
  1/2 strip under the tongue as needed for withdrawal every 2-8 hours up to 32 mg per day
  Quantity #56

Remove clinical barriers to treatment

Patients seeking treatment for SUD routinely encounter barriers, such as long wait times and prolonged intake processes, increasing the risk of continued illicit substance use and premature death.[14] A patient-centered, rapid access model includes welcoming patients with a medication-first approach and including patients' goals in the treatment plan. Do not make treatment contingent on labs, on their abstinence from stimulants, benzodiazepines, or alcohol, nor on their participation in psychosocial support.[15]

Removing barriers is critical to creating equitable access to care, and many of the practices detailed in our Patient-Centered, Rapid Access Approach to Substance Use Disorder are applicable in the hospital setting. More insight on processes in the ED that can remove clinical barriers to treatment is also available in our Treatment, Culture & Connection video.

What about 42 CFR Part 2?

Some hospitals have mistakenly interpreted 42 CFR as a barrier to providing MAT in the ED. ED programs are a part of general medical care and do not fall under 42 CFR Part 2, which guarantees confidentiality for people seeking treatment for substance use disorders from federally assisted programs. More information on 42 CFR Part 2 is available through the Substance Abuse and Mental Health Services' (SAMHSA) Disclosure of Substance Use Disorder Patient Records and Fact Sheet: SAMHSA 42 CFR Part 2 Revised Rule.

What about urine drug screens?

A urine drug screen is not necessary to start a patient on buprenorphine and has disadvantages, including prolonging the emergency department stay, delaying withdrawal treatment, and increasing costs. In most cases, urine drug screen results will not change the management of a patient in opioid withdrawal in the acute care setting. Outside of the hospital, starting buprenorphine without toxicology results is also common.[16] Urine positivity for stimulants, benzodiazepines,[17] or other substances should not prevent buprenorphine treatment. Presence or absence of opioids on the urine drug screen does not make a diagnosis of opioid use disorder. Obtain a urine toxicology test only if it will otherwise help your clinical decision making.

Provide medications on discharge

Any provider may order buprenorphine or methadone for *administration* to admitted or registered patients for the purposes of treating opioid withdrawal, starting MAT, or maintaining MAT. Providers may start ordering and administering buprenorphine as soon as the hospital has it on formulary. Medicaid coverage of buprenorphine prescriptions varies from state to state. Check with your state Medicaid program or local pharmacy program to determine coverage. More information on Medicaid coverage is available at the Medicaid Behavioral Health Services: Buprenorphine for Medication Assisted Treatment (MAT) website.

However, in order to *write a prescription* for buprenorphine for the treatment of OUD for patients being discharged from the hospital or emergency department to fill at an outpatient pharmacy, providers must have a DATA 2000 waiver for their DEA license. This waiver is commonly called the "DEA-X" or "X-waiver." As of April 2021, all prescribers with a valid state license and DEA can register for an X-waiver without mandatory training. For more information regarding obtaining an X-waiver, see How to Apply to Get Your X-Waiver.

For X-waivered providers:

- Prescribe buprenorphine-naloxone combination SL tablets or films.
    - Most patients will require 16-32 mg of buprenorphine per day, daily dosing.
- Prescribe a 7-14 day supply to allow the patient time to follow-up with ongoing outpatient treatment.
    - Check your state's CURES reporting requirements.
    - Patients with OUD that also have chronic pain syndrome or are pregnant in the second and third trimesters can receive split dosing (i.e., BID or TID).
- For electronic prescribing, enter your DEA-X number in comments for the pharmacy. Some pharmacies will not accept the electronic prescription without the X-number.
- For handwritten prescriptions, include your DEA-X number and handwritten date. State the number of prescriptions and refills on the script.
- Provide naloxone directly to the patient (preferred) or by prescription (at minimum) for all patients with SUD.

For non X-waivered providers:

- Refer to an X-waivered colleague to assist with a discharge prescription.
- If an X-waivered colleague is unavailable to assist with a discharge prescription, there are several options:
    - Administer a loading dose of buprenorphine to prevent withdrawal for approximately 48 hours until the patient is able to link to care with an outpatient X-waivered provider. The usual loading dose is 24-32 mg of buprenorphine.
    - Instruct the patient to return to the ED daily for up to 3 days to receive administration of buprenorphine while connection to ongoing care is being arranged.
    - Dose the patient in the ED and arrange next-day follow up with an outpatient X-waivered provider.
- For inpatients, anticipate upcoming discharge and seek support from an X-waivered provider in advance.
- Provide naloxone directly to the patient (preferred) or by prescription (at minimum) for all patients with SUD.

Connect Patients to Ongoing Care

Once a patient has been initiated on buprenorphine in the acute care setting, they need prompt follow-up, ideally within 72 hours. Although EDs should offer patients the opportunity to return for repeat dosing if they experience issues in connection to outpatient services, the goal of the program should be connection to outpatient care. This section describes the key steps needed to ensure effective follow-up outpatient care for the patients you start on treatment in the hospital.

Key steps for connecting patients to ongoing care	Resources
Dedicate staff to linking patients to care through the navigator role or another trained staff position (case manager, social worker, etc).	• Substance Use Navigator FAQ • Substance Use Navigator Job Description template • Hiring a Substance Use Navigator • Substance Use Navigator & Clinician Champion Collaboration
Provide training and support to navigators so that they are equipped to effectively engage and link patients to care.	• Substance Use Navigation Toolkit • Substance Use Navigator Training 101 (video)
Establish connections with outpatient providers to facilitate successful connection to ongoing treatment.	• Options for Ongoing Treatment after Hospital Starts
Conduct patient-centered referrals so that patients have the guidance, support, and resources needed to make it to the next step of their treatment	• Harm Reduction Sample Discharge Instructions • Buprenorphine Start Sample Discharge Instructions • BUP-XR Sample Discharge Instructions • Buprenorphine: What You Need to Know

Dedicate staff to linking patients to care

Linking patients who use drugs with follow-up outpatient treatment requires time and specific skills and is best handled by a staff member who has all, or a significant portion, of their time dedicated to this work. The CA Bridge model fills this function with a full-time navigator as described in the Substance Use Navigator FAQ and Substance Use Navigator Job Description. Other programs use different terms for this position including behavioral health counselor, treatment navigator, peer navigator, patient navigator, care coordinator, etc.

While a dedicated full or part-time navigator is ideal, it may not be feasible for all hospitals. The functions of a navigator can be performed by other hospital staff members. Alternative options include:

- Training care coordination teams (e.g., social workers, case managers) to serve patients with SUD
- Utilizing charge nurses or nurse shift managers to serve this role while on shift
- Training *all* nurses or providers to be able to counsel their patients and refer them to ongoing care
- Recruiting a volunteer from the community (e.g., nearby outpatient clinic patient navigators) to collaborate with and share compilations of patient resources

A navigator is a staff member embedded within an ED or an inpatient setting to engage with patients who use drugs and facilitate treatment for SUD. Navigators become experts on regional treatment resources and conduct extensive community

outreach to improve connection to ongoing care and raise awareness about SUD treatment options. Successful navigators are flexible and creative problem solvers, able to leverage interpersonal skills to build relationships throughout their hospital and with community organizations, law enforcement, EMS, schools and universities, tribal populations and more. Most importantly, a navigator should be able to establish a human connection with people who use drugs.

For guidance on bringing this critical member onto your team, see Hiring a Substance Use Navigator. Your state might have reimbursement mechanisms for peer support. Check your local resources for funding sources for a navigator position.

Provide training and support to navigators

The role of a navigator is complex and requires intentional training and support. One of the keys to success is a strong relationship between the navigator and the medical staff as described in the Substance Use Navigator & Clinician Champion Collaboration resource. The clinician champion will be helpful in determining the chain of command, orienting a navigator to the hospital, bringing navigators to meetings, and introducing them to department heads and nurse leaders.

The CA Bridge Substance Use Navigation Toolkit is a comprehensive resource that we recommend as essential reading for navigators, staff who supervise them, and anyone who will be connecting patients to ongoing care. The Substance Use Navigator 101 Training series features up-to-date information by expert speakers covering best practices for substance use disorder, including MAT and harm reduction techniques. Navigators should:

- **Engage patients:** Navigators play a critical role in establishing human connections with patients. We offer tools to help navigators build these connections in our Substance Use Navigation Toolkit.
- **Understand buprenorphine:** The navigator should know what buprenorphine is for, how to take it, and how to continue a prescription vs. do a "self-start" after leaving the hospital. This knowledge is essential to a navigator's ability to counsel the patient prior to discharge and answer their questions.
- **Link patients to ongoing care:** The navigator should be able to call the patient's desired clinic and facilitate prompt follow up. Navigators should visit the connected outpatient clinics and build relationships with their clinicians and scheduling teams. Ideally, clinics will offer follow-up visits to be scheduled within 72 hours of patient discharge and/or drop-in availability. Prescriptions should be written to last until the first clinic visit.
- **Develop patient-facing materials:** Patients should receive handouts with information on buprenorphine, their follow-up clinic, and home starts as needed. Navigators should review these with patients prior to discharge.
- **Document:** Navigators should document a note in the patient's medical record describing the counseling offered and plan for follow up so other care team members understand the plan and resources provided. Consider developing a template for this.
- **Coordinate care for patients seen on weekends and evenings:** When a patient is discharged in the evening or over the weekend when the navigator is not working, the navigator needs to establish a system for follow-up.
- **Know local community resources:** These resources will include primary care clinics providing MAT, harm reduction services, residential programs, shelters, twelve step support groups, or other resources for people with SUD. Navigators should visit these settings so they can do warm hand-offs and encourage referrals from these providers into the acute care substance use treatment program.

Establish connections with outpatient providers

Every hospital should have at least one option for low barrier outpatient treatment, and having several options is encouraged given variations in patients' insurance coverage. There are a variety of entities that offer outpatient MAT, including federally qualified health centers, narcotic treatment programs, primary care, hospital outpatient clinics, and others. When considering clinics to refer patients, look for accessible, patient-centered care. Specific details to consider are referral process, wait times, insurance accepted, and staff culture as it relates to SUD. In communities with limited access to treatment, telemedicine is an option. For more information, see Options for Ongoing Treatment after Hospital Starts.

Most hospitals following the CA Bridge model do not have formal agreements with outpatient clinics, but agree on a process for referrals and check in over time to ensure the workflow is functioning well. Although not required, some hospitals prefer to have written, formal agreements between their hospital and the follow-up facility that cover agreements such as: guaranteed clinic follow up within a specific number of days (i.e., allocating dedicated intake slots), establishing a process for day-time referrals and a secure voicemail line for after hours referrals, and naming point persons at the hospital and clinic. See Memorandum of Understanding example.

Conduct patient-centered referrals

While practices will vary by hospital and based on community resources, an effective patient-centered referral process should include some of the following elements.

Provide written treatment and follow-up instructions

Develop patient handouts that clearly explain buprenorphine, such as the Buprenorphine: What You Need to Know handout, and instructions for filling and taking prescription medication. We have some templates that can be adapted for this purpose: Buprenorphine Start Sample Discharge Instructions; Harm Reduction Sample Discharge Instructions; BUP-XR Sample Discharge Instructions.

Conduct a warm hand-off

Set up the first appointment with an outpatient provider or assist the patient in using a hospital phone or tablet to do so. Ideally, the navigator has visited the outpatient clinic and formed personal relationships with clinicians and scheduling teams, so they can tell the patient what to expect, how to get to the clinic, and introduce them to a contact there.

Facilitate access

Even with a warm hand-off to an outpatient provider, many patients experience barriers to accessing care. The navigator should work with patients to identify and minimize these barriers through strategies such as: arranging for transportation, providing resources for free phones, identifying local pharmacies that fill buprenorphine prescriptions, helping to obtain the necessary discharge papers from the hospital, etc.

Plan for follow up after evening or weekend starts

When a patient is discharged in the evening or over the weekend, the navigator may not be present and the follow-up clinic may not be open for immediate coordination of care. Create a list of patients for the navigator to contact when they return to work. Consider establishing drop-in slots at outpatient clinics so patients can present if a navigator was unable to set up an appointment. Buprenorphine prescriptions should be written until the patient is able to follow up with the outpatient clinic if next day appointments cannot be arranged. If no X-waivered provider is available, use higher dose buprenorphine for longer effect or arrange for the patient to come back to the ED for re-dosing as needed for up to 72 hours.

Follow up

The navigator should confirm that the patient has made it to their outpatient visit with a follow-up call to either the patient or the treatment provider within seven days. If the patient does not attend the appointment, either the navigator or clinic should reach out.

Stay connected

Provide the patient with a phone number that they can call after discharge to speak directly with the navigator if they encounter obstacles accessing follow-up care. Most navigators distribute their number widely and continue to receive calls from patients when issues arise, often for many months.

Create a back-up plan

If resource constraints do not allow for a full patient-centered referral process, at a minimum, develop a handout with a list of clinics for follow up along with contact information for each, including at least one telehealth option for patients who may have geographic or transportation challenges.

Change Hospital Culture

Stigma in society and in health care settings is the top barrier to evidence-based medical treatment for people experiencing SUD.[18] Health care providers often have unconscious stigmatizing attitudes toward people who use drugs that can result in behaviors that lead to suboptimal health care outcomes for these patients.[19,20] Changing this culture in a hospital is a long-term process that can be started with a few basic steps.

Key Steps for Culture Change	Resources
Promote harm reduction practices that make patients safer if they do continue to use drugs.	• Harm Reduction Strategies for the Hospital Setting
Use non-stigmatizing language that promotes respect for people who use drugs and avoids negative labels.	• Words Matter: Terms to Use and Avoid When Talking About Addiction from the National Institute on Drug Abuse
Post signs inviting patients to seek treatment in the ED and waiting areas.	• Patient-Facing Signage • Treatment Starts Here: Sign of the Times signage examples

Promote harm reduction

According to the National Harm Reduction Coalition, harm reduction encompasses, "*a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users 'where they're at,' addressing conditions of use along with the use itself.*"

The following strategies integrate harm reduction into the hospital setting and are described in greater detail in Harm Reduction Strategies for the Hospital Setting.

- **Use person first language** rather than terms like 'drug addict' or 'user,' which imply someone is something that cannot change. Instead, put the person first and describe behavior as in, 'a person who uses drugs.'
- **Distribute naloxone** and train people who are at risk for overdose and family members in overdose recognition and response. See this Guide to Naloxone Distribution for more information on naloxone and distribution programs. Many states have different regulations around naloxone distribution, check this list for state specific regulations: Characteristics of Statewide Naloxone Distribution Mechanisms.
- **Increase syringe access** by supplying safe consumption kits at discharge or prescribing syringes.[21] Studies consistently demonstrate the effectiveness of syringe access in preventing transmission of infectious disease [22] and skin and soft tissue infections,[23] while also supporting the overall health of people who use drugs[24] through connection to drug treatment,[25,26,27] medical care, housing, overdose prevention, and other vital social services.

What about harm reduction policies in my state?

Legality of syringe services and other harm reduction resources, such as fentanyl test strips, are variable nationally. It is advisable to work with a local harm reduction organization to figure out what is allowable and to advocate for increased access. Check your local state laws for additional guidance. For more information on state specific policies, see NEXT Distro's list of State Policies.

Use non-stigmatizing language

The language we use to discuss SUD has been shown to be associated with outcomes in medical settings.[28,29] Consider using these alternate terms adapted from NIDA Words Matter: Terms to Use and Avoid When Talking About Addiction to decrease stigma in your clinical practice.

Instead of…	Use…	Because…
Addict User Substance/drug abuser Junkie Alcoholic Drunk Former addict Reformed addict	• Person with opioid use disorder (OUD)/substance use disorder (SUD) or person with an 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	• Use person-first language. • The terms to use show 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	• Use person-first language.
Habit Relapse	• Substance use disorder • Drug addiction • Return to use/slip	• The terms to avoid inaccurately imply that a person is choosing to use substances or can choose to stop. • The term '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. • The term 'clean' 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. • The term 'dirty' may decrease the patients' sense of hope and self-efficacy for change.

Post signs inviting patients to seek treatment

Signs offering treatment or asking if people want help with their substance use invite patients to speak openly with providers about their use of substances. Download and print your own signs using our signage template and post them at registration, triage, hallways, bathrooms and any place in the hospital that patients visit. This empowers patients to self identify as having an 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.

Program Launch Strategies

Build Your Acute Care Substance Use Treatment Program

Like any practice change in acute care, implementing a MAT program can be done in a variety of ways based on the resources available. Below are two key steps and tips for scaling these up if you have the capacity.

Identify key players

A single provider (or a champion) who uses buprenorphine to treat opioid withdrawal paired with a person to make referrals to ongoing treatment (a navigator) is the essence of an acute care substance use treatment program.

Clinician champions are critical to the success of any practice change, as clinicians want to learn from their peers. Clinician champions will get X-waivered, start treatment, help ensure adequate education for their team, and serve as a resource on-shift when others have questions.

A clinical champion's scope of work may include assisting the hospital in developing, implementing, and operating the acute care substance use treatment program. The duties of this role may include the following:

- Develop a plan for the Clinical Champion role, including a plan to increase the amount of X-waivered clinicians.
- Provide mentoring, education, and support of other clinicians.
- Attend other department meetings as available and as requested to provide education.
- Assist with inputs to ongoing evaluation of the acute care substance use treatment program.

Ideally, champions should be awarded administrative time or a stipend to conduct this work. Champions should devote as much time to the services required as necessary, at times and locations mutually agreed between the champion and hospital. On average, six hours per month may be sufficient, however, needs will vary from site to site. While these individuals will remain champions for the long term, funded time is helpful in the first year to launch the program.

Navigators are the second critical element of an acute care substance use treatment program. Navigators conduct initial brief assessments, introduce patients to treatment programs, serve as the primary coach for their clients, and maintain ongoing contact with patients. They also link to other services, such as financial counseling, primary care, mental health services, social services, and residential treatment facilities. For guidance on bringing on a navigator, see Hiring a Substance Use Navigator. If a navigator is not available, a case manager, social worker, nurse, or other team members can fill this role.

TIP: Form an acute care substance use program team

A more robust acute care substance use treatment program includes stakeholders from various disciplines including:

- Clinician/Provider Groups (inpatient and ED, physician or PA/NP)
- Nursing
- Pharmacy
- Care Coordination (e.g., Social Work, Case Management)
- Hospital and Health System Administration
- Others, such as Information Technology, Patient Registration, Security, Community Health, and Volunteer Services

Engaging stakeholders early in the process, holding regular team meetings, and designating a team member as a project lead can facilitate the rollout and success of the program. Many sites have found that bringing together champions from different hospital departments is critical to identifying and overcoming obstacles that inevitably arise in implementation.

Educate hospital staff

Proactively educating providers, nurses, social workers, and pharmacists will improve program rollout. Ideas include:

- Placing posters in public spaces like the ED lobby and patient care areas, break areas, and bathrooms.
- Hosting 'lunch and learns' and in-services.
- Joining grand rounds and/or presenting at department meetings.
- Incorporating MAT education into continuing education and onboarding (including locums and travel nurses).
- Inviting a speaker to a hospital wide forum. To request a speaker from CA Bridge, reach out at info@cabridge.org.
- Preparing and uploading patient discharge instructions into the EHR or making paper copies available.

Staff	Suggested Educational Topics
Providers (physicians, PAs, NPs)	• Identifying patients with OUD • Treatment protocols: Quick Start Guides • Legality of buprenorphine administration • Linkage options for ongoing outpatient SUD care • Nursing protocols: MAT Toolkit for Nurses and Nurses Drive Care for Opioid Use Disorder • Stigma reduction: Words Matter
Nurses	
Pharmacists	• Buprenorphine and Pharmacy • Legality of buprenorphine administration • Treatment protocols: CA Bridge Quick Start Guides • Stigma reduction: Words Matter
Social workers and care coordination teams	• Navigator role and connecting with the navigator • Linkage options for ongoing outpatient SUD care • Stigma reduction: Words Matter
Technicians (e.g., ED techs)	• Awareness of the MAT program • Importance of patient-facing signs, training on steps to take if a patient expresses interest • Answers to questions frequently asked by patients • Stigma reduction: Words Matter
Hospital operators and unit clerks	
Patient registration, front desk greeters and security guards	

National Clinician Consultation Center Substance Use Warmline, (855) 300-3595

Any provider seeking support for first-time buprenorphine starts or assistance with complex cases may utilize The National Clinician Consultation Center Substance Use Warmline, which should be posted visibly in areas frequented by clinicians.

The warmline is specialty addiction medicine consultation, regardless of substance, issue, or clinical setting. **It is available Monday-Friday, 6am-5pm PT. Their voicemail is available 24 hours a day, 7 days a week.**

Measure and Communicate Success

As your program launches, you should begin thinking about the data you will need for both quality improvement and sustainability. How will you know if you are meeting your patients' needs? How can you generate evidence of the program's impact to obtain resources to sustain it? This section covers the steps needed to begin data collection and reporting.

Select metrics

Selection of metrics and data collection should be based on a thoughtful assessment of the information you need to generate for specific audiences and purposes (see section below on Plan for Sustainability). As a starting point, CA Bridge recommends consideration of the following metrics:

- # patients served by the navigator/behavioral health counselor or staff performing similar function
- # patient visits with MAT (buprenorphine) administered or prescribed
- # patients with OUD
- # patient visits served with overdose diagnosis
- # patients served on 5150/1799
- # patients who received a referral for ongoing MAT, mental health services, residential treatment, and other support services
- # patients who successfully attended follow-up appointment for outpatient MAT

TIP: Create a data team

Finding allies in clinical leadership, administration, quality improvement, and IT facilitates data collection, review, and reporting. Hospital quality and or clinical informatics teams can pull EHR reports and tap into other relevant data your hospital might already collect, such as community health assessments, patient satisfaction surveys, or readmission information. Anyone engaged in data collection and sharing should be familiar with 42 CFR Part 2. See resources that are helpful to data collection and reporting:

- Fact Sheet: SAMHSA 42 CFR Part 2 Revised Rule from SAMHSA
- Overcoming Data-Sharing Challenges in the Opioid Epidemic from the California Health Foundation (certain sections of this paper focus on California, but are applicable throughout the country)

Identify data sources

Options for gathering data for the program include:

- **EHR and pharmacy reports**. When possible, data collection will be easiest and most accurate if it is pulled from the EHR and pharmacy reports.
- **Navigator records**. If collecting data through the EHR is not an option, the navigator can manually track patients and their care outcomes using a paper or electronic spreadsheet. This method avoids customization or changes to the EHR and allows collection of detailed data that may be of specific interest to the program, but is not included in the EHR. While this method can be effective, it is labor intensive.
- **Follow-up data**. To collect data on follow up, it will likely be necessary to obtain data from outside of the hospital system, either from the patient or follow-up treatment provider. To obtain follow-up information from another provider, you will need a release of information for the patient.
- **Qualitative data.** Patient or provider satisfaction surveys, focus groups, testimonials, or de-identified patient stories can provide valuable data for improving a program or communicating its value to others.

Analyze and report on data

Focused analyses

When resources and capacity allow, we highly encourage hospitals to conduct focused analyses of specific subsets of patients or services for the purpose of answering specific questions. Some examples include:

- Reduction in the number of ED visits by high utilizers who present to the ED with SUD[31,32]
- Reduction in the number of patients with SUD leaving the hospital AMA
- Reduction of SUD-related hospital care
- Reduction in number and length of psychiatric holds in the ED in patients with co-occurring mental illness and SUD
- Regional or statewide data can provide context for these analyses. Resources for publicly available data include:
    - The California Opioid Overdose Dashboard has overdose-related data that can be filtered by year, geographic area, and demographics. Other states may have a similar dashboard.
    - The Healthcare Cost and Utilization Project has opioid-related hospital use statewide and nationally, comparing rates annually and stratifying data by demographics, hospital setting, and expected payer.
    - The Office of Statewide Health Planning and Development has an Emergency Department Report on patients treated at the hospital and county level, with data on demographics, dispositions, and diagnoses.

Measure quality improvement

Implementation can be strengthened by using quality improvement tools. Rapid tests of change help to gain buy-in, understand the strengths and limits of the change you plan to make and determine whether the change will result in the intended outcome. The Institute for Healthcare Improvement offers tools for applying a quality improvement framework to practice change on their webpage, How to Improve.

Plan-Do-Study-Act (PDSA) Cycle

The goal of the following PDSA plan is to initiate buprenorphine (bup) in the ED for >90% of SUD patients eligible for MAT. This plan is based on this PDSA cycle template which can be operationalized using the PDSA cycle worksheet.

Plan			Do	
Description	**Predictions**	**Data Collection**	**Date(s) of test**	**Notes**
Clinician champion educates providers on bup & how to access it in the ED at next department meeting	With education, providers will begin requesting a navigator consult &/or initiating bup in the ED	# of bup initiations for 10 SUD patients	8/31 – 9/4	Complete a chart review for additional details

Study	Act
Results/Key Learning	**What will you do next?**
• 50% (2/4) of eligible patients in the sample that were identified during the day shift received bup while in the ED with navigator and pharmacy support. • 1/6 of SUD patients identified during the night shift received bup. • Not all-night providers and staff knew about the new MAT program and protocol for prescribing bup. • No X-waivered providers were working during the night shift.	• Add MAT program update as an agenda item for the next week. • Educate all clinicians on MAT protocols. • Support at least 1 night shift ED clinician in getting the X-waiver. • Develop a resource binder for the ED providers/staff with info on the MAT program, outpatient contacts, referral forms, etc.

Plan for Sustainability

Many aspects of an acute care substance use treatment program are sustainable once they become part of the standard of care and culture of a hospital. The California Health Care Foundation's How to Pay for It Series offers useful tools for financing an acute care substance use treatment program and related services.

However, a critical component of a robust CA Bridge model is a navigator or other staff member with time dedicated to working with people with SUD. Current financing for navigators through state and federal grants is time limited, and navigator services are not currently reimbursable.

Evaluate options for navigator sustainability

The navigator role will be more sustainable if additional revenue can be generated to support it. We recommend reviewing options while simultaneously assessing the potential for various stakeholders to be critical champions. Key groups to consider are described below.

Hospital administrators

Some acute care substance use treatment programs have been sustained because the hospital became convinced of the value of the program. Demonstrating cost savings or changes in utilization of costly resources can make a compelling case to administrators. In addition, administrators are sensitive to staffing needs and the hospital's reputation, so showing the program's impact on patient, nurse, or provider satisfaction can also be persuasive.

Providers

Some programs are sustained largely on the basis of provider demand. To incentivize ED initiating treatment of OUD, Centers for Medicare & Medicaid Services created a new billing code, G2213. This is a procedure code that is designed to support patient follow up and support the work of a navigator. Additional benefits that accrue to providers may include better ED flow, fewer disruptions, or reduction in psychiatric holds, resulting in less pressure on bed space. Many providers report increased job satisfaction because they have effective treatment for SUD, a problem they previously felt powerless to address. Program sustainability can be enhanced by elevating the positive experiences of providers through data, stories, or quotations that help bring other providers on board. It is also helpful to educate providers about the Medicare billing code G2213. See Documentation Examples for Procedure Code G2213 for additional guidance.

Patients

Community reputation and trust are critical to both the mission and the viability of any hospital. Documenting patient satisfaction can be a valuable component of a sustainability plan. Many who will not be swayed by data will see impact in a single compelling patient story.

Health plans

Health plans are acutely focused on costs and are interested in reduced utilization of high cost services. They also report quality metrics to employers and government agencies, including the proportion of ED visits for members 13 years and older with a principal diagnosis of alcohol or other drug abuse or dependence who received follow-up for substance use disorder within 7 and 30 days of the ED visit. Demonstrating that a hospital substance use treatment program can help improve the plan's performance on this metric may increase the plan's interest in supporting the program. Some hospitals directly pay navigator salaries for these reasons.

Make the navigator's work visible

The sustainability of the navigator position is greatly enhanced by making the navigator, the services they provide, and the outcomes they achieve visible to key stakeholders. Some of the practices that acute care substance use treatment programs have found effective in elevating the visibility of the navigator are described below.

Proactive relationship building

Many navigators make a point of systematically introducing themselves and building relationships with everyone in the ED. This is important because the navigator role is often new and is not automatically understood or appreciated by other staff whose buy-in is important for long-term sustainability.

Modeling collaboration

Champions can greatly enhance the effectiveness of the navigator by actively modeling a strong relationship with the navigator. Other clinicians will see how this position can assist with effective treatment for patients who use drugs and come to rely on them.

Sharing follow-up information

Sending quick emails to providers with patient updates can be extremely effective in letting providers know that their efforts paid off. Many ED providers report that making a difference with patients with OUD, for whom they previously offered no treatment, is some of the most satisfying work they do. When navigator funding is on the line, these provider voices can make a difference.

Public relations

Working together, champions and navigators should seek out opportunities to showcase the program to key stakeholders, such as hospital administrators, medical directors, or community members. Effective strategies include writing up patient success stories, preparing data summaries, or simply describing the program and how it has improved ED workflow.

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Additional Resources

Treatment Protocols

- Buprenorphine Hospital Quick Start
- Buprenorphine Quick Start in Pregnancy
- Frequently Asked Questions Medications for Addiction Treatment and Trauma Informed Care: Pregnancy
- Acute Pain Management in Patients on Buprenorphine Treatment for Opioid Use Disorder Emergency Department/Critical Care
- Acute Pain Management in Patients on Buprenorphine Treatment for Opioid Use Disorder - Medical/Surgical Units
- Buprenorphine Immediately after Reversal of Opioid Overdose with Naloxone
- Care for Patients with Opioid Use Disorder Who Are in Custody
- Gentle Self-Starts
- Rapid Self-Starts

Guides, FAQs, Toolkits

- The CA Bridge Model
- A Patient-Centered, Rapid Access Approach to Substance Use Disorder
- A Caring Culture in Healthcare
- Clinical Considerations for Order Sets
- DATA 2000 X-Waiver for Buprenorphine Prescribing
- MAT Options for Ongoing Treatment After Hospital Starts
- Hiring a Substance Use Navigator
- Substance Use Navigator & Clinician Champion Collaboration
- Substance Use Navigator FAQ
- Harm Reduction Strategies for the Hospital Setting
- Guide to Naloxone Distribution
- Substance Use Navigation Toolkit

SUN Training 101 Series

- Session 1: Getting Started
- Session 2: Substance Use Disorder & Medication Assisted Treatment
- Session 3: Starting Treatment
- Session 4: Connecting Patients to Ongoing Care
- Session 5: Leading Change in Hospital Culture
- Session 6: Strengthening Community Connections
- Session 7: Improving and Sustaining your Program
- Session 8: Self-promotion & CADTP Certification
- Session 9: Behavioral Health Basics
- Session 10: Newest Trends in Harm Reduction

Nursing Resources

- MAT Toolkit for Nurses
- Nursing Resource - Quick Reference
- Discharge Considerations for Nurses
- Best-Practices in Nursing Management of Opioid Use Disorder and Acute Withdrawal (video)

Skills Building Video Series

CME is available for this video series through the UC Davis Office of Continuing Medical Education. For more information on how to obtain CME for this series, see Free Medication for Addiction Treatment Courses for CME Credit.

- Skills building video: Buprenorphine In The Hospital: How Do We Do It?
- Skills building video: Treatment, Culture & Connection
- Skills building video: Substance Use Navigators
- Skills building video: Nurses Drive Care for Opioid Use Disorder

Site Level Examples and Templates

- Treatment Starts Here: Sign of the Times
- Patient-Facing Signage
- Substance Use Navigator Job Description Template
- Example MOU
- Clinical Opioid Withdrawal Score (COWS)
- Buprenorphine Sample Discharge Instructions
- Harm Reduction Discharge Sample Instructions
- Bup XR Sample Discharge Instructions
- Example Order Sets - Zuckerberg San Francisco General hospital
- Starting Buprenorphine with Microdosing and Cross Tapering