ColoradoMAT

2020 Key Considerations for Hospitalized Patients with Opioid Use Disorder

c|h|a
Colorado Hospital Association

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Executive Summary

Hospitals are on the front lines of the opioid epidemic. Every day, health care systems and their clinicians treat patients suffering from life-threatening complications of opioid use disorder (OUD), but too often they fail to treat the underlying disease responsible for fatal and nonfatal overdoses, endocarditis, osteomyelitis, viral hepatitis, HIV transmission, psychological trauma and the many other common complications of OUD.

OUD is a highly treatable chronic disease. Decades of exhaustive research demonstrates the safety and efficacy of buprenorphine, methadone and naltrexone for the treatment of OUD, and all are approved by the U.S. Food and Drug Administration (FDA) for this purpose. This is one of the tragedies of the current opioid epidemic—nearly 80% of Coloradans who need treatment cannot access it.

Hospitals are uniquely positioned to close this profound treatment gap for OUD. An inpatient hospitalization represents a crucial opportunity to begin treatment for patients with OUD, many of whom avoid contact with health care systems until dire complications necessitate emergent care. All stakeholders benefit when hospital-based clinicians educate patients about their disease, initiate buprenorphine or methadone and ensure that discharge planning includes a warm hand-off to an outpatient provider. Under these circumstances, patients have better health outcomes, clinicians are empowered to provide an evidence-based and cost-effective intervention and hospital systems simultaneously improve quality of care while reducing the cost of caring for patients with OUD.

Backed by the Colorado State Opioid Response Grant, Colorado Hospital Association (CHA) convened a task force of more than 30 multidisciplinary stakeholders from across the state to develop this implementation guide, which seeks to assist hospitals in establishing medication for addiction treatment (MAT) and harm reduction processes for medical inpatients with OUD.

This guide provides a checklist for developing inpatient programs, recognizing that different hospitals and health systems have unique needs and resources. Further, detailed metrics for tracking program success are suggested, as is information concerning laws, regulations and insurance considerations. Users will also find links to treatment locators; guidance in establishing referral relationships with outpatient providers; strategies to address common barriers to program implementation; essential clinical resources; and policy recommendations aimed at facilitating wider access to care for OUD. For readers interested in more in-depth information than is provided in this guide, detailed resources from organizations across the country are linked throughout the document.

Additionally, as part of this initiative, a series of webinars providing further detail on the pharmacologic treatment of OUD; staff training and workflow; and system considerations that may be required when setting up processes for treating patients with OUD will be offered to hospitals and clinicians to ensure every patient with OUD who is treated in a Colorado hospital is offered a path to treatment and recovery.

Background and Epidemiology

The Opioid Epidemic

Opioid overdose remains the leading cause of accidental death for adults under the age of 50 in the United States, claiming an average of 130 lives every day.[1] While official estimates are that approximately two million adults in the United States have OUD, many experts believe this number may be substantially higher.[2] The National Survey on Drug Use and Health reports that in 2018, 3.7% of adults in the United States misused an opioid in the prior year.[2] Estimates of the economic impact of OUD and opioid overdose in the United States vary depending on study design and range from $78.5 billion to $696 billion annually.[3-5]

THE OPIOID EPIDEMIC IN COLORADO

Like many states across the country, Colorado has been deeply impacted by the opioid crisis. In 1999 there were 2.5 deaths per 100,000 Coloradans; by 2017 there were 9.8 deaths per 100,000—a nearly fourfold increase.[6] Opioid-related deaths reached an all-time high in Colorado in 2019, fueled by newly increased availability of fentanyl and other highly potent synthetic opioids.[7] While there is considerable variation from county to county, no community is untouched. Experts predict that the isolation created by the COVID-19 pandemic will exacerbate Colorado's opioid epidemic. Indeed, the Colorado Department of Public Health and Environment recorded 443 overdose deaths in Colorado from January to April 2020—a 35% increase compared to the same time period in 2019.[8] Clearly, efforts are needed to address the continuing crisis of overdose deaths and OUD in Colorado.

Efforts in Colorado to prevent overdose death and broaden access to treatment for OUD have been multifaceted. Colorado has implemented initiatives to limit opioid prescribing by clinicians, encourage use of alternatives to opioids, promote awareness of the importance of safe storage and disposal of opioids and increase the availability of naloxone to Coloradans at risk of overdose. However, prevention efforts do little to help Coloradans with untreated OUD. The treatment gap for OUD remains enormous and persistent. A 2017 report by the Colorado Health Institute found that fewer than 20% of Coloradans with OUD received addiction treatment.[9] In a recent survey, 41% of experts in Colorado identified increased investment in treatment and recovery services as critically important to addressing the opioid epidemic in the state.[10]

TREATMENT OF OUD

Like other chronic medical illnesses such as diabetes and hypertension, OUD is a highly treatable disease. There are three FDA-approved medications for OUD: buprenorphine, methadone and naltrexone. These medications have traditionally been referred to collectively as "medication-assisted treatment" or MAT. However, experts generally find this terminology to be lacking as pharmacotherapy is central—not adjunctive—to effective treatment, and therefore MAT may be more accurately defined at medication for addiction treatment. However, this language is likewise not without debate due to the potential stigma associated with the word "addiction."

Buprenorphine and methadone, in particular, are pertinent to hospital-based practitioners, and will be referred to collectively as MAT henceforth. While buprenorphine will be the first-line agent for most hospitalized patients, methadone is an alternative treatment that may be more efficacious for certain patients. It is important to note that many patients with OUD have other co-occurring substance use disorders (SUD), and that buprenorphine and methadone do not address stimulant, alcohol or tobacco use disorders. However, regardless of other substance use diagnoses, there are few contraindications to treating OUD with pharmacotherapy.

Buprenorphine and methadone are the standards of care for treatment of OUD. Patients receiving buprenorphine or methadone have substantially lower morbidity and mortality, higher treatment retention rates, lower rates of all-cause emergency department (ED) visits and hospital admissions and lower rates of opioid-related readmissions.[11,12] Patients started on buprenorphine during hospitalization are more likely to enter outpatient treatment, stay in treatment and have more drug-free days compared to those offered only a referral.[13] Rates of overdose and overdose death, too, are far lower in patients whose OUD is treated.[14] As important, patients who receive evidence-based care for OUD no longer experience the cravings, compulsions and harmful behaviors associated with addiction.

Background and Epidemiology continued

Both buprenorphine and methadone may be easily and legally **ordered** by any clinician in any hospital setting. However, to **prescribe** buprenorphine at hospital discharge for dispensing at a retail pharmacy, an x-waiver is required, as described in the "Laws, Regulations and Insurance Coverage" section below. Most hospital-based clinicians will not meet the regulatory qualifications for **prescribing** methadone after discharge.

Failing to provide treatment of OUD to patients in need has dire implications for quality of care. Opioid withdrawal, while rarely life-threatening, is profoundly uncomfortable. As many as 30% of patients with SUD leave the hospital against medical advice because of inadequate control of cravings, stigma and fear of mistreatment.[15] For physiologically frail patients, inadequate control of opioid withdrawal may complicate care and prolong hospitalization. Eighty percent of patients who use heroin and are discharged from the hospital will use heroin again within 30 days if not provided access to treatment.[16] Those "detoxed" during hospitalization may lose their tolerance to opioids and are at significantly elevated risk of overdose should they resume use of opioids.[17] Finally, patients whose withdrawal is treated will be better able to learn about their disease and consider entering treatment and recovery following discharge.

HOSPITALS AND THE OPIOID EPIDEMIC

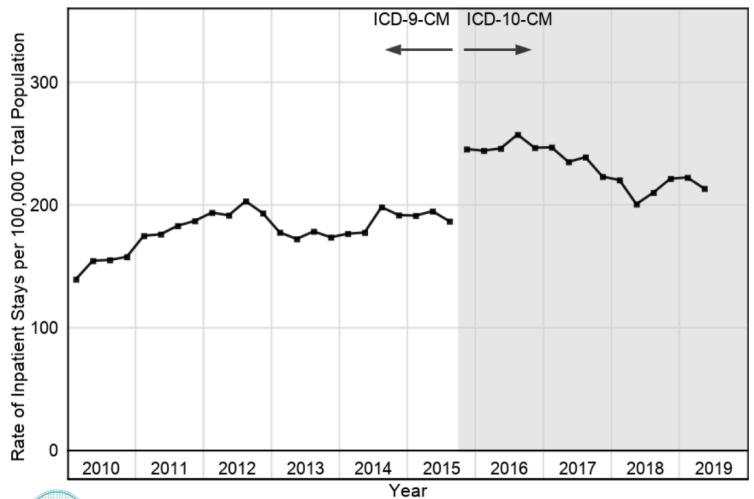
Rates of OUD-related hospitalizations and ED visits have increased dramatically since the turn of the millennium.[18-22] In Colorado the rate of opioid-related hospital admissions increased more than 50% between 2010 and 2019, and nationally rates of ED visits for opioid-related presentations have more than doubled.[23] In communities hard-hit by the epidemic, hospitals bear a significant financial burden of this crisis.[19] Untreated OUD is associated with a wide range of comorbidities, many of which require resource-intensive care. People with OUD who inject drugs are more likely to present with endocarditis, osteomyelitis, epidural abscess, joint infections, cellulitis, necrotizing fasciitis, wound botulism, hepatitis B and C, and HIV/AIDS when compared to those who do not inject drugs.[24,25] Hospitals also care for patients who experience nonfatal opioid overdose: in a sample of 647 hospitals nationwide, opioid overdoses resulted in costs of $1.94 billion, with over 60% being paid for by public programs.[26]

When extrapolated to all hospitals nationwide, costs are estimated at $11.3 billion annually, representing 1% of all hospital expenditures.[26]

Patients, communities and hospitals all benefit when patients receive evidence-based OUD care.

(FIGURE 1)

Colorado: Opioid-Related Hospital Use, Rate of Inpatient Stays



H·CUP HEALTHCARE COST AND UTILIZATION PROJECT

Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID) 2010-2018 and quarterly data for 2019 (all available data as of 01/28/2020). Inpatient stays include those admitted through the emergency department.

SOURCE: HCUP Fast Stats

Background and Epidemiology continued

HOSPITALS: A VITAL LINK TO TREATMENT

Hospitals can play a key role in ensuring that every patient with OUD is offered initiation of MAT and a seamless transition to outpatient care. OUD is a disease characterized by impairment of behavior and decision-making ability, and clinicians and health care systems must be poised to offer care to patients with OUD at every point of contact. By supporting clinicians in consistently providing evidence-based care for OUD, hospitals can alleviate suffering, save lives and provide better, more cost-effective care.

Such efforts also increase clinician engagement and professional satisfaction. Repeated admissions for treatment of OUD-related diseases contributes to a sense of powerlessness on the part of clinicians, eroding their sense of efficacy and—sometimes—their empathy. Health systems that support clinicians in providing evidence-based care for patients with OUD create a new treatment paradigm that benefits both clinicians and patients.

Best Practices and Considerations for Initiating Treatment for Opioid Use Disorder during Hospitalization

Highly effective, evidence-based pharmacotherapies for the treatment of OUD have been available for decades.[27] The stigma surrounding addiction and a lack of clinician training and expertise in the diagnosis and treatment of OUD contribute to a profound treatment gap.[28,29] Hospital-based clinicians are ideally positioned to narrow this gap by offering pharmacotherapy for OUD to every hospitalized patient with OUD. It is recommended that the initiation and maintenance of pharmacotherapy with buprenorphine or methadone be the routine standard of medical care for hospitalized patients with OUD.

The characteristics of programs developed to ensure consistent delivery of pharmacotherapy with buprenorphine or methadone will vary from institution to institution depending on the staffing, size and number of patients with untreated OUD served. At some hospitals, existing staffing and care delivery systems may be adequate. At hospitals with an around-the-clock addiction consult service (ACS), addiction medicine clinicians may directly deliver buprenorphine or methadone. At centers that serve many patients with OUD, a dedicated team may be the best model for care delivery. In some settings, telehealth consults may be an important element to delivering OUD treatment. There are several examples from across the country of each of these care models working to bring effective interventions to some of the most vulnerable patients. The following case studies provide select examples.

CASE STUDIES

CA Bridge

The CA Bridge program combines MAT in acute care hospitals with support from a substance use counselor to help people who use drugs access ongoing substance use treatment. Setting a new standard of care for substance use, CA Bridge equips hospitals with tools for treating people who use drugs and to treat them like any other patient with a life-threatening illness. This work puts California at the forefront of a growing movement to rethink how drug use is treated across health systems and in society at large. The program currently includes more than 50 contracted sites in California, each in various stages of implementation. In total, more than 12,000 individuals have been identified with OUD, and patients have received at least one dose of buprenorphine more than 7,000 times. CA Bridge resources are available HERE.

Dell Seton Medical Center: The B-Team

Dell Seton Medical Center at the University of Texas at Austin, in collaboration with Dell Medical School, launched the Buprenorphine Team (B-Team) in 2017 as an alternative to an ACS. The program is an interprofessional and multidisciplinary effort to screen patients for OUD, initiate buprenorphine for patients who are interested, link patients to OUD-specific care at the time of discharge and work to reduce the stigma surrounding OUD. Composed of members that include physicians, social workers, nurses, pharmacists, chaplains, students and others, the B-Team promotes hospital-wide understanding of OUD and its evidence-based treatment. The model also includes peer recovery specialists and encourages naloxone distribution. Additionally, only a small number of prescribers have x-waivers to facilitate bridge prescriptions at discharge.

The B-Team collaborates with numerous office-based opioid treatment (OBOT) programs in the community. As a measure of the program's effectiveness, the team evaluated over 100 patients at the 200-bed hospital and found that 60% of patients followed up with the outpatient clinic at one-week post discharge.

Best Practices and Considerations for Initiating Treatment for Opioid Use Disorder during Hospitalization continued

CASE STUDIES *continued*

Margaret Mary Health

Margaret Mary Health (MMH), a critical access hospital in Batesville, Ind. has set up a comprehensive pathway for connecting patients with OUD to buprenorphine and behavioral health services by coupling their outpatient services with a telehealth partnership with Indiana University. When patients with OUD present to the ED or are admitted to the hospital, they are connected with either a psychiatrist based at the hospital, or via telehealth to a physician at Indiana University. Through this consultation, patients are initiated on buprenorphine and discharged with a three-day prescription. Once discharged, patients are seen at one of MMH's outpatient clinics or, if appropriate, begin MMH's Intensive Outpatient Treatment Program (IOP). To discourage diversion, patients continue to receive only a three-day prescription as long as they show up for their outpatient appointments. Although a lack of x-waivered physicians remains a barrier, their manager of behavioral health and addiction services and staff psychiatrist have been vocal advocates of MAT, convincing many to support and join these efforts.

University of Colorado Addiction Consult Service

Created in partnership with the Division of Hospital Medicine at the University of Colorado, the Upper Limit Payment Program and University of Colorado Medicine, this hospital-based ACS runs Monday through Friday and is fully staffed by hospitalists trained in addiction medicine and two dedicated addiction medicine social workers. The team focuses on the initiation of medications for alcohol and opioid use disorder treatment, including buprenorphine, methadone, naltrexone and acamprosate. Additional services include the management of complicated alcohol or benzodiazepine withdrawal, initiation of emergency commitments with the state of Colorado, management of complex pain in the setting of OUD and management of acute postoperative pain in patients on buprenorphine or methadone. The program's social workers also link patients to appropriate addiction-based care post hospital discharge, including outpatient addiction clinics, intensive outpatient treatment and residential treatment. From March through December 2019, the service had nearly 1,000 addiction consults and approximately 750 patients started on MAT.

Focus on Rural MAT

Lack of access to treatment for OUD in rural areas poses additional danger to patients. A Centers for Disease Control and Prevention (CDC) study of overdose death rates between 1999 and 2015 found that rates increased 325% in rural areas compared to 198% in urban areas.[30] While efforts to increase the number of outpatient MAT providers in rural areas have made some headway, hospitals in rural areas that initiate patients on pharmacotherapy for OUD during an inpatient stay must forge close partnerships with outpatient providers. Fortunately, the Colorado Office of Behavioral Health has established a mobile health service program using six mobile health units to improve access to MAT in rural and underserved areas of Colorado. In addition to these six units, mobile treatment options are available through pop-ups that offer the same services as the units.

Checklist for Developing Hospital-based MAT Processes

While individual clinicians may commit to providing MAT to their patients with OUD, it is preferable to develop hospital-wide processes that support consistent, efficient and effective care delivery. The following checklist provides guidance on establishing such processes for hospitalized patients with OUD.

(FIGURE 1)

Checklist for Hospital-Based MAT

Infrastructure Development

- ☐ Designate a project lead
- ☐ Engage primary stakeholders
- ☐ Explore similar programs at the local, regional, state or national levels
- ☐ Determine if/how offering MAT as part of hospitalization fits with the department's or organization's vision, mission and/or goals
- ☐ Create milestones for rolling out the program, including metrics to track success
- ☐ Review and update institutional policies related to buprenorphine and methadone administration

Clinical Application

- ☐ Add buprenorphine and methadone to hospital formulary
- ☐ Engage members of the interprofessional team
- ☐ Build order sets where needed to ease ordering of medications
- ☐ Develop guidelines for:
  - Initiating buprenorphine and methadone, including nights and weekends if applicable
  - Notification parameters for nursing orders
  - Under what circumstances, if any, a patient might be transferred to the intensive care unit (ICU)
  - How orders will be entered/saved into the electronic health record (EHR)

Education

- ☐ If applicable, discuss if trainees will be involved. If so, how?
- ☐ Develop or decide on education for buprenorphine, how much is needed and to whom such education should be given (physicians, nursing, pharmacy, social work, etc.)
- ☐ Designate and train those responsible for administering and documenting the Clinical Opiate Withdrawal Scale (COWS) assessment

Revenue Cycle/Costs

- ☐ Determine if it is possible to bill for these services
- ☐ Calculate internal costs that might incur from starting OUD treatment during hospitalization
- ☐ Discuss if a patient cannot afford to pay for bridge buprenorphine whether the hospital pay for it

Harm Reduction

- ☐ Develop a plan for implementing harm reduction strategies
- ☐ Develop a protocol for ensuring that all patients who would benefit from Naloxone leave the hospital with a prescription for it
- ☐ Develop patient education materials

Discharge Planning and Care Coordination

- ☐ Establish protocols for discharge
- ☐ Explore capacity for outpatient MAT treatment in the region
- ☐ Locate resources for reliable transportation to ensure patients can access treatment post discharge
- ☐ Check that local retail pharmacies stock buprenorphine

Laws, Regulations and Insurance Coverage

There are no regulations that restrict administration of buprenorphine or methadone to a hospitalized patient. Any clinician with institutional ordering privileges may initiate treatment for OUD in the inpatient setting without special certification, including the x-waiver. Currently, hospital-based clinicians who wish to prescribe buprenorphine for patients after discharge to be filled at a retail pharmacy must obtain an x-waiver to do so. Browse the American Society of Addiction Medicine (ASAM) advocacy website HERE for information on laws, regulations and advocacy work relating to addiction prevention, treatment, remission and recovery. For Colorado-specific laws and regulations and information about the most recent legislative sessions, access the Colorado Consortium for Prescription Drug Abuse Prevention's legislation website HERE.

BUPRENORPHINE X-WAIVERS

The Drug Addiction Treatment Act of 2000 laid the groundwork for the x-waiver. The law allows physicians to prescribe buprenorphine for the treatment of OUD after completing an eight-hour training. The Comprehensive Addiction and Recovery Act of 2016 provided provisional ability for physician assistants (PAs) and advanced practice nurses (APNs) to prescribe buprenorphine for the treatment of OUD. This was made permanent in 2018 with the signing of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. PAs and APNs are required to complete 24 hours of training. (An x-waiver is not required to prescribe buprenorphine for the treatment of chronic pain.) It is recommended that hospitalist groups incorporate x-waivered providers into their programs to facilitate optimal post-discharge planning and ensure the ability to provide bridge prescriptions. See **APPENDIX 1** for information on the indications for each buprenorphine formulation.

METHADONE

Methadone can be ordered by any clinician in the hospital setting to initiate or continue treatment of OUD. Patients who are initiated on methadone during hospitalization for treatment of OUD cannot be discharged with a prescription for methadone. Methadone can only be dispensed in the outpatient setting at federally regulated, state-licensed opioid treatment programs (OTPs). In most cases, it is recommended that patients receiving methadone from an OTP who are admitted to the hospital be maintained on their existing methadone regimens and the dose be verified when possible.

INSURANCE COVERAGE

Per Colorado House Bill (HB) 18-1007, all Colorado health plans are required to provide coverage for a five-day supply of at least one FDA-approved drug for treatment of opioid dependence without prior authorization. Further, it requires Medicaid reimbursement of at least one FDA-approved ready-to-use overdose reversal drug without prior authorization. It defines prior authorization for MAT as an urgent request. However, many health plans will still require the prior authorization process for buprenorphine. Always check with pharmacy staff to determine what requires prior authorization.

COLORADO MEDICAID AND MEDICARE COVERAGE

When required, prior authorization through Colorado Medicaid typically takes less than five minutes. Suboxone sublingual film is covered as a favored product (following the prior authorization process) along with generic buprenorphine/naloxone sublingual tabs with quantity restrictions of 24 mg/day. All other products necessitate failure of other treatments and/or additional requirements. Prior authorization requirements for Medicare will depend on type of coverage. Typically, prior authorization will be required, and staff should plan accordingly.

Information for X-Waiver Training

X-waiver training is available through Practice Innovation Program Colorado. Click HERE for information on training dates. Training is also offered through a number of national organizations including ASAM and the American Academy of Addiction Psychiatry (AAAP). Training for PAs and APNs can also be accomplished free of charge online through ASAM or AAAP. For access to all online training, click HERE. Providers Clinical Support System offers additional information on waiver training HERE.

Laws, Regulations and Insurance Coverage continued

COLORADO COMMERCIAL HEALTH INSURANCE COVERAGE

For commercial payers, coverage will vary. Typically, combination films (generic versions of Suboxone) are the preferred product in Colorado, however, this often does not preclude the need for prior authorizations. Thus, social workers and discharge planners should coordinate with pharmacy staff to determine if a prior authorization is needed.

COSTS AND FUNDING FOR MAT INDUCTION PROGRAMS

For additional guidance on costs and funding for MAT services at the inpatient level, see the supplemental document, "Business Considerations for Induction of MAT in Hospital Settings."

Metrics and Evaluation

Metrics should capture multiple components of MAT, from screening and treatment to post-discharge follow-up. Tracking the right metrics can aid hospitals in documenting the benefits of MAT and support a return on investment for data-driven, quality care. The following table has been adapted from the American Hospital Association and includes suggested measures to track regarding hospital-based opioid treatment. Hospitals are encouraged to choose those most relevant to their processes and goals, as some of these metrics may not be applicable to every hospital.

For additional details regarding metrics and evaluation, refer to the American Hospital Association's Stem the Tide: Opioid Stewardship Measurement Implementation Guide.[31]

Measure Description/ Measure Concept	Numerator	Denominator	Desired Quality Improvement Trend	Alignment with Federal Quality or Accountability Programs (2020)* and Additional Notes
Naloxone prescribed for opioid overdoses or high-risk patients	Number of naloxone prescriptions	Number of patients presenting with overdose or opioid morphine milligram equivalents (MME) > 50	**Outcome** Increase in naloxone prescriptions	NOTE: this will be challenging to track if a hospital does not have its own retail pharmacy
Screening for OUD/SUD	Number of risk assessments documented in EHR, percentage of patients screened	Number of inpatient admissions	**Process** Increase in number of screens	Merit-Based Incentive Payment System Quality Measure (MIPS QM)
Identification and planning for patients with OUD upon admission	Number of plans documented	Number of patients with OUD diagnosis	**Process** Increase in number of documented plans	Medicaid Adult Core Set (ACS)
Number of referrals for OUD treatment	Number of referrals ordered	Number of patients identified with untreated OUD	**Outcome** Increase in referrals	Medicaid ACS, The Joint Commission (TJC)
Completed/successful referrals for OUD treatment	Number of referrals completed	Number of referrals ordered	**Outcome** Increase in number of completed referrals	Medicaid ACS, TJC
New patient starts for OUD treatment	OUD initiated	Number of patients identified with OUD	**Outcome** Increase in number of new starts	Medicaid ACS
Screening patients with OUD for infectious diseases (e.g., Hepatitis B/C, HIV)	Percentage of patients screened	Number of patients with OUD	**Process** Increase in number of screens	

continued

Metrics and Evaluation continued

continued

Measure Description/ Measure Concept	Numerator	Denominator	Desired Quality Improvement Trend	Alignment with Federal Quality or Accountability Programs (2020)* and Additional Notes
Number of referred patients still in treatment 30 days later	Number of patients still in active treatment program	Number of treatment referrals completed	**Outcome** Increase in number of patients still engaged in treatment	Medicaid ACS
Engagement in outpatient treatment program for 12 months or longer	Number of patients engaged in treatment	Number of treatment referrals	**Outcome** Increase in number of patients engaging in OUD treatment	MIPS QM
Percent readmissions among patients started on MAT	Number of patients admitted for any cause within 90 days after initial inpatient MAT	Number of individuals started on inpatient MAT	**Outcome** Decrease in number of readmitted patients who were started on MAT	NOTE: Reducing readmissions at large and for conditions related to OUD aligns with federal and local quality incentive programs, including the Hospital Transformation Program (HTP) in Colorado.

Addressing Stigma and Barriers

Education around the impact of stigmatizing attitudes toward patients with OUD is crucial. Often due to an experience with stigma on the part of health care professionals, patients with OUD may defer seeking care for medical conditions until such circumstances are serious or life-threatening. Once treatment is sought, patients are likely to downplay their substance use history out of fear that revealing it will impact the quality of care received.[32] Stigmatizing people who use drugs can undermine efforts to treat these patients. A resource guide for overcoming stigma can be found HERE.

Frontline staff play a significant role in supporting their patients by advocating for adequate pain control and limiting the use of stigmatizing language when communicating to other clinicians on shift change or in medical rounds. Having staff, including social workers, case managers, nurses, pharmacists, physicians and others, that better understand the stories of those with OUD can be beneficial. Clinical champions can refer colleagues to Lift the Label to hear some of those stories from Coloradans.

Another resource for dismantling stigma of patients with OUD are the Reducing Stigma Education Tools (ReSET) from Dell Medical School at the University of Texas at Austin. These interactive online modules include original video content of people in recovery and cover several topics related to stigma and actions that can be taken to end it, as well as free continuing education for physicians, nurses, social workers and pharmacists. Visit www.ResetStigma.org for more information.

POTENTIAL BARRIERS

BARRIER 1: Lack of funding and/or support from administration

Hospital administrators and clinical champions should reference the supplemental document "Business Considerations for Induction of MAT in Hospital Settings" for guidance on making a compelling case for starting MAT in the inpatient setting. Further, collecting and reporting data on outcome metrics can be used to demonstrate the potential benefits of setting up a program.

BARRIER 2: Limited connections to treatment networks outside of hospitals[34]

For communities that do not have access to OTPs, hospitalists may be limited to use of buprenorphine when initiating treatment for OUD in patients who cannot travel to an OTP every morning. While access to outpatient treatment with buprenorphine is more widely available, it is critical that discharge planning include a warm hand-off to an OBOT provider. Hospital social workers and recovery specialists, where available, are valuable resources and supports for ensuring seamless transition of care. Hospitals should also consider funding a full-time, part-time or per diem position that supports this work. The CA Bridge program has adopted substance use navigators (SUNs) to fill this role, among others. Consult the program's website for additional information on the roles of SUNs and how hospitals might be able to fund them.

LANGUAGE MATTERS!

Ekaterina Pivovarova and Michael Stein, researchers from the Boston University School of Public Health and the University of Massachusetts Medical School, evaluated the language preferences of over 250 patients in a Massachusetts OTP.[33] The preferred terms for patients to be called by clinical providers or the public were "person who uses drugs," "person with a heroin addiction" and "person with a heroin dependence." For more information on appropriate language and to see examples of hospital pledges to reduce stigmatizing language click HERE and HERE.

Addressing Stigma and Barriers continued

BARRIER 3: Restrictive or outdated institutional opioid policies

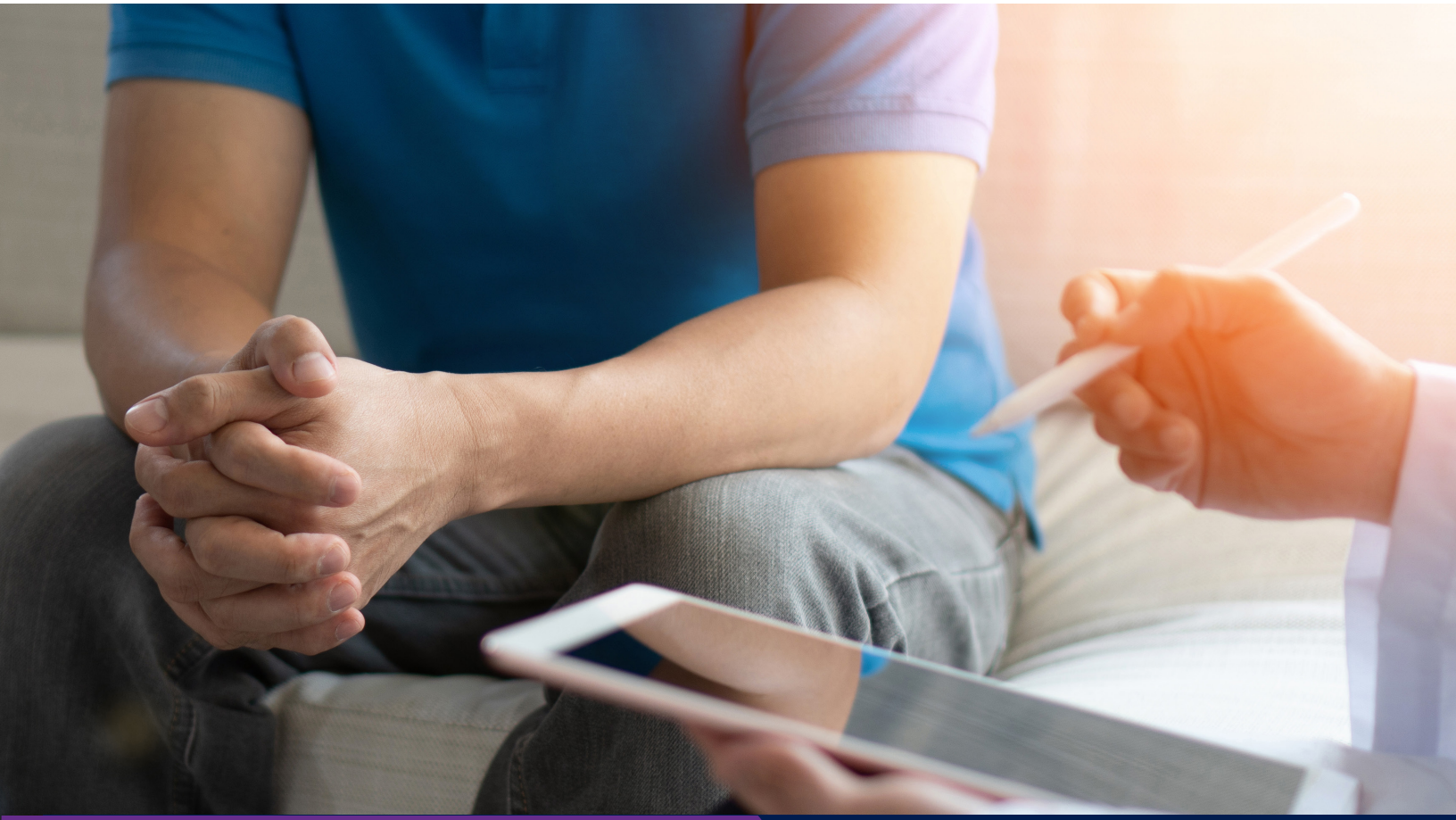
Clinical champions should act as the experts on treatment for OUD, including updating policies and guiding hospital decision-making around MAT.[35]

BARRIER 4: Lack of 24/7 service leads to missing patients in need

Creating a hospital culture that embraces MAT and trains all clinical staff on buprenorphine prescribing can help reduce the number of patients that are missed due to timing of admission. Ultimately, introduction of MAT in the hospital, using patient-first and recovery centered language and promoting harm reduction must be the standard of care in hospitals.

BARRIER 5: Patients have difficulty accessing transportation to MAT treatment after their hospital stays

For patients who are initiated on buprenorphine during their hospital stay, having x-waivered hospitalists is a key step in bridging the gap between discharge and when patients are able to access treatment. If patients are not able to access transportation to treatment over extended periods of time, connecting patients to mobile health units or outpatient treatment via telehealth can also help reduce the need to travel significant distances to treatment. As a result of changes to federal regulations related to the COVID-19 public health emergency, initiation and continuity of treatment for OUD may be conducted without a face-to-face encounter. Whether these changes in regulation will endure is unknown, but utilizing technology to widen access to outpatient treatment for OUD is of clear benefit to patients. Lastly, advocating for local outpatient physicians to obtain x-waivers can allow patients to access treatment at their regular primary care provider's office or any local medical facility.



Prescribing and Monitoring

The American Society of Addiction Medicine released updated guidelines for the treatment of OUD. Refer to these guidelines in addition to the quick start guides in Appendix 2 for information on initiating MAT, as well as on prescribing and monitoring. Hospital pharmacists are an additional source of information and support. Rocky Mountain Poison and Drug Safety offers MAT prescribing support available by phone 24 hours per day, and can be reached at 800.222.1222. Practice Innovation Program Colorado also provides a warm line for consultation on all substances, including alcohol, from addiction medicine-certified physicians, clinical pharmacists and nurses with special expertise in pharmacotherapy options for opioid use, which can be reached at 855.300.3595 (note this line is open Monday-Friday, 7 a.m. to 6 p.m. MST, but voicemail is available 24 hours a day).

MOTIVATIONAL INTERVIEWING

Talking with patients about substance use is a core clinical skill. It is advised that hospital-based clinicians be prepared to effectively interview, counsel, treat and/or refer patients with SUD. The principles and techniques of motivational interviewing can be enormously helpful in conducting fruitful interviews and interventions with patients. More information about motivational interviewing can be accessed HERE.

QUICK START GUIDES TO TREATMENT

Initiating buprenorphine is straightforward and safe. The process begins by utilizing the COWS assessment to evaluate for the presence of opioid withdrawal. When appropriate, as deemed by the numeric score, patients are administered a standardized sublingual or buccal dose of buprenorphine. Additional doses are provided based on ongoing COWS assessments. The process is similar to addressing alcohol withdrawal in the hospital setting in that an objective and subjective scale is employed to assess patients and provide them with evidence-based treatment. More information about initiating buprenorphine is provided in the quick start guide in **APPENDIX 2**, as well as resources for initiating methadone in the hospital setting.

For an example of a nursing quick reference sheet for buprenorphine, see what Dell Medical School is using in **APPENDIX 3**.

PAIN MANAGEMENT

The pain management for hospitalized patients is complex and compounded by a diagnosis of OUD, which can be accompanied by hyperalgesia. It is advised that nonopioid multimodal approaches to acute pain be the first line of treatment. For patients engaged in buprenorphine therapy, for which additional analgesia is needed, split doses or additional doses may be beneficial. For severe pain, the use of full agonist opioids can be considered as well. Detailed recommendations for pain management in patients with OUD can be found in the Treatment of Opioid Use Disorders section of the *2020 Opioid Prescribing and Treatment Guidelines for the Medical Inpatient*, released by the Rocky Mountain Chapter of the Society for Hospital Medicine this summer.

For more information, refer to section 3F of the Substance Abuse and Mental Health Services Administration (SAMHSA) TIP 63: Medications for Opioid Use Disorder treatment improvement protocol.

MAINTAIN PATIENTS USING METHADONE OR BUPRENORPHINE ON THEIR EXISTING REGIMENS

It is advised that patients who present to the ED or are hospitalized that are currently receiving MAT treatment be maintained on their medication in virtually every circumstance, including the settings of acute pain, planned surgical intervention, pregnancy or labor and delivery.[36-39] Clinicians should be aware of important drug interactions between methadone and buprenorphine and other medications.

Harm Reduction

Some patients may not choose to engage in a form of treatment, and their choices should be respected. As mentioned above, motivational interviewing may help start a conversation in a nonjudgmental and supportive way. For patients who do not wish to engage in treatment, encouraging harm reduction techniques is imperative. Harm reduction includes discharging patients with naloxone and providing them with information about syringe exchanges. It is advised that all patients who present with OUD be provided with naloxone. For more information on naloxone and harm reduction, visit Stop the Clock Colorado and Bring Naloxone Home.

Patients with OUD can also benefit from being connected to recovery support services. While some hospitals may have in-house peer specialists who provide support, it may make sense for others to refer patients to peer-delivered services in the community. Such community-based recovery support services include, but are not limited to, recovery community organizations (RCOs), 12-step communities and/or faith-based recovery supports. For more information on RCOs, and to find one nearby, visit the Association of Recovery Community Organization's website.

Connecting to Outpatient Treatment

For patients to receive the treatment they need after they have left the hospital, they must be connected to local outpatient buprenorphine and methadone providers. Patients initiated on buprenorphine must follow up with an outpatient provider that has an x-waiver. By definition, these practices are considered OBOT facilities. Patients initiated on methadone require care from an OTP. Opioid treatment programs may offer more comprehensive care, including counseling, although counseling can sometimes be found in a co-located primary care environment as well. Many patients have positive outcomes in this primary care/OBOT environment; however, some patients require the additional structure and resources of OTPs. For more information on the differences between an OTP and OBOT, see **TABLE 3**. A Treatment Needs Questionnaire has been licensed by Colorado Office of Behavioral Health to aid patients and clinicians in selecting the appropriate level of care. Treatment locators are available at:

- ColoradoMAT Treatment Locator
- SAMHSA Opioid Treatment Program Directory

When developing referral relationships with OBOTs, confirm that the provider has expertise in prescribing buprenorphine. Many outpatient addiction treatment facilities offer only naltrexone or are abstinence-oriented and cannot care for patients initiated on buprenorphine in an inpatient setting. A phone call or visit to potential referral sites by a social worker or hospitalist should confirm that the site offers buprenorphine treatment and facilitates consistent, effective warm hand-offs of care. Discuss the following when connecting with any outpatient treatment facility:

- What medications and services does the outpatient clinic provide?
- What is the typical wait time before the initial appointment?
- What is the best way to connect patients that are being discharged to this outpatient clinic?
- How does the clinic handle the referral process? Do they want clinicals faxed, emailed, etc.?
- What are the requirements of the program and what can the patient expect?
- What forms of insurance does the clinic accept?
- How long is the intake appointment (typically two or more hours)?
- What days and times of day are appointments offered?
- Can patients be referred after hours?

ADDITIONAL CONSIDERATIONS FOR CONNECTING TO OUTPATIENT TREATMENT

Patients with complex medical, behavioral health or social needs may benefit from specialized care or care from a multidisciplinary team. Ideally, patients will be transitioned to co-located outpatient treatment facilities capable of treating OUD and providing care for comorbidities. Additional considerations for special populations include the following:

- INFECTIOUS DISEASE – If a patient also has an infectious disease, it may be in the patient's best interest to be connected with an infectious disease clinic that provides addiction medicine services. Ideally, patients are able to receive all of their treatment in one place.
- PREGNANCY – Some women's clinics may have specialized providers that can treat OUD as well as offer obstetric-gynecologic services.
- BEHAVIORAL HEALTH – Some community behavioral health agencies have MAT capabilities.
- HOMELESSNESS – Some day shelters have drop-in services by MAT clinics that may be convenient for patients.

Refer to **APPENDIX 4** for an example of a MAT follow-up pathway for utilization by social workers, discharge planners or patient navigators.

Connecting to Outpatient Treatment continued

COMPARISON OF OTP AND OBOT CARE FOR OUTPATIENT TREATMENT

(TABLE 3)

OTP and OBOT Characteristics[40,41]

	Opioid Treatment Program (OTP)	Office-Based Opioid Treatment (OBOT)
Description	Specially licensed clinic that provides both pharmacologic and nonpharmacologic services for the treatment of OUD. Staffed by counselors, nurses, a medical director and other professionals. Patients receive a supervised dose of medication daily.	Treatment provided to patients with OUD through a physician's office. Prescribing clinician must have a DEA waiver to prescribe buprenorphine (x-waiver) to outpatients.
Licensing	Colorado Office of Behavioral Health Treatment and Controlled Substance License SAMHSA and DEA Must be accredited by Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission.	Does not require state or SAMHSA licenses or oversight. Prescribers must have completed a course to become x-waivered (eight hours for physicians, 24 hours for PAs and nurse practitioners).
Prescriptions	Patients receive monitored dose in clinic and can advance to take-home dose for self-administration based on duration of adherence to treatment plan.	Patients fill prescriptions through outside pharmacies. Receive weekly or monthly prescriptions based on patient stability.
Medication	Methadone, buprenorphine, buprenorphine/naloxone or naltrexone. (Medications are typically not reported to a prescription drug monitoring program, or PDMP.)	Buprenorphine, buprenorphine/naloxone or naltrexone.
Medical Intake	Comprehensive medical evaluation and history, including baseline laboratory data as appropriate.	Minimal requirements for laboratory medical intake.
Drug Enforcement Administration (DEA)	Must have DEA number.	Must have DEA number and x-waiver.
Behavioral Health Services	Integrated psychosocial and behavioral health services are a legal requirement for OTPs.	Integrated psychosocial and behavioral health services are not a legal requirement for OBOTs, but they must document the ability to refer to behavioral health.

Policy Recommendations

1. **Repeal the x-waiver requirement for prescribing buprenorphine.** The waiver federal requirement, a result of the Drug Addiction Treatment Act (DATA) of 2000, is a barrier to treatment and adds to the stigma surrounding OUD. It is not in the interest of public health to require clinicians to have a waiver to treat patients with OUD, especially when no such waiver is required to prescribe opioids. CHA supports the World Health Organization, the American College of Emergency Physicians, the American Academy of Clinical Toxicology, the National Association of Attorneys General and ASAM in endorsing repeal of the x-waiver requirement.

2. **Eliminate insurer-mandated prior authorization requirements for available formulations of buprenorphine.** Requirements for prior authorization to fill buprenorphine products for the treatment of OUD pose an unnecessary and stigmatizing barrier to treatment. The inability of a patient to fill a prescription for buprenorphine in a timely manner increases the risk of relapse, death and preventable complications. Research shows that when states require payers to eliminate prior authorization requirements, prescription and use of buprenorphine increase and rates of ED visits and hospitalizations decrease.[42] While Colorado HB 18-1007 requires health benefit plans to "provide coverage without prior authorization for a five-day supply of at least one of the federal FDA-approved drugs for the treatment of opioid dependence," in practice, insurers comply with this legislation by covering only naltrexone, a less effective medication. In addition, insurers may deny attempts to provide medication for longer than five days and may deny access to pharmacotherapy for second or subsequent requests for authorization in a one-year period.

3. **Remove insurer-imposed limits on the choice of MAT pharmacotherapy.** It is important that choice of medication for OUD be a shared decision between patient and clinician. Arbitrary limits on the choice of type and formulation of pharmacologic agents imposed by insurers limit the ability of clinicians to provide effective care. While many plans cover at least one formulation of each MAT agent, very few cover the implantable and/or injectable formulations of buprenorphine that are most effective for many patients with OUD. In addition, commercial insurers frequently fail to provide coverage for methadone. While health insurers are not required by the Affordable Care Act to cover MAT agents, the federal government has stated that excluding coverage of methadone for OUD may violate the Mental Health Parity and Addiction Equity Act of 2008.[43] Federal and state regulators are encouraged to ensure that all insurers permit access to all forms of MAT and eliminate requirements for failure of one modality before a trial of another.

4. **Ease regulations around 42 CFR Part 2 to facilitate the sharing of critical health data.** 42 CFR Part 2 requires that patients with SUDs provide explicit permission for a treating provider to share information about their addiction treatment. Lack of clinician access to patient medication information puts patient safety at risk. While the law provided an essential safeguard prior to the enactment of HIPAA (Health Insurance Portability and Accountability Act), subsequently it has created two separate, poorly aligned systems of care. CHA supports the American Medical Association, the American Hospital Association and ASAM in the call to amend further 42 CFR Part 2 to better align SUD treatment with the rest of medicine. While revisions in July 2020 do facilitate better coordination of care, it is recommended that SAMHSA further revise the rule to mandate OTP reporting to PDMPs. Patients should not have to give consent, and OTPs should be required to report medications dispensed to the PDMP.

Policy Recommendations continued

5. **Telemedicine enables efficient, wider delivery of addiction treatment services, and systems for telehealth delivery should be expanded and supported.** Given the enormous potential of telemedicine to improve access to treatment for OUD, every effort should be made to ease restrictions on use of telehealth for initiation and management of treatment with buprenorphine, to support and maintain the technological infrastructure needed to improve telehealth access to OUD treatment and to develop innovative reimbursement mechanisms that support telehealth delivery through the Centers for Medicare and Medicaid Services.

6. **Decrease the regulations surrounding OTPs to reduce barriers to methadone maintenance treatment.** Several current regulations governing the delivery of care at OTPs should be revised or eliminated, including the federal requirement for a documented one-year history of OUD prior to initiation of treatment and the counseling adherence requirements within OTPs. No person should be required to wait one year before accessing treatment for a disease, and while most patients benefit from case management and counseling, patient autonomy is violated by the rigid requirements mandated by state and federal regulations.

7. **Provide subsidies for OTPs in rural areas.** Methadone is the most effective treatment for many patients with OUD; some patients treated with buprenorphine, too, benefit from the structure and support of an OTP. Opioid treatment programs are not financially viable in rural areas because there are too few patients to cover operational expenses. Funding that supports the development of new OTPs in rural areas of the state would help those who live in these currently underserved communities.

8. **Increase local, state and federal funding for MAT services.** The treatment gap for OUD is unacceptably high. An adequate response to this public health crisis requires a substantial investment in a system capable of serving the needs of all patients impacted by the opioid epidemic. Increased federal funding will support grants to states and service providers responding to the opioid epidemic. Greater flexibility for funding to be used to respond to emerging local and regional OUD treatment needs may permit service providers and health care systems to tailor care to meet the needs of their populations. In addition, increased funding to support adjunctive behavioral health, social and recovery support services may improve OUD treatment retention.

Appendices

APPENDIX 1

Buprenorphine Formulations

Buprenorphine Formulations, FDA Approval Status and DEA Data 2000 X-Waiver Requirements

Formulation	Doses Available	Indication	DEA DATA 2000 "X" Waiver Required?
Parenteral (Buprenex)	0.3 mg IV/IM every 30 minutes, duration 6-8 hours Analgesic equivalent = 10 mg IV morphine for opioid naive	Pain	No
Transdermal patch (Butrans)	Buprenorphine: 5, 7.5, 10, 15, and 20 mcg/hour, every 7 days	Pain	No
Low-dose buccal film (Belbuca)	Buprenorphine: 75, 150, 300, 450, 600, 750, 900 mcg, twice daily	Pain	No
High-dose buccal film (Bunavail)	Buprenorphine/naloxone, daily: 2.1 mg/0.3 mg, 4.2 mg/0.7 mg, and 6.3 mg/1 mg	Addiction Off-label for pain	Yes for addiction No for pain or 3-day rule
Sublingual tablets (Subutex, Suboxone, Zubsolv)	Dosed daily for addiction; divided doses for pain Buprenorphine: 2 mg, 8 mg Buprenorphine/naloxone: 2 mg/0.5 mg, 8 mg/2 mg; 1.4 mg/0.36 mg, 2.9 mg/0.71 mg, 5.7 mg/1.4 mg, 8.6 mg/2.1 mg, 11.4 mg/2.9 mg	Addiction Off-label for pain	Yes for addiction No for pain or 3-day rule
Sublingual film (Suboxone)	Buprenorphine/naloxone: 2 mg/0.5 mg, 4 mg/1 mg, 8 mg/2 mg, 12 mg/3 mg	Addiction Off label for pain	Yes for addiction No for pain or 3-day rule
Implant (Probuphine)	80 mg (equivalent to <8 mg sublingual daily)	Addiction Off label for pain	Yes
Compounded	Many options	Pain	No

* Sublocade is an additional formulation not listed above. It is an extended-release injectable for patients with moderate to severe OUD whose withdrawal symptoms are controlled by oral buprenorphine for at least seven days. For more information visit the Sublocade website.

SOURCE: Andrew Herring, California Health Care Foundation

APPENDIX 2
Quick Start Guides for Buprenorphine and Methadone

ColoradoMAT

Buprenorphine (Bup) Hospital Quick Start

- Any prescriber can order Bup in the hospital, even without an x-waiver.
- Bup is a high-affinity, partial agonist opioid that is safe and highly effective for treating opioid use disorder.
- If patient is stable on methadone or prefers methadone, recommend continuation of methadone as first-line treatment.

Uncomplicated* opioid withdrawal?**
- NO → **Start Bup after withdrawal**: Supportive meds prn, stop other opioids
- YES (stop other opioids) → **Administer 8mg Bup SL**
- (one hour) → **Withdrawal symptoms improved?**
  - NO → **No Improvement**
    - **Differential Diagnosis:**
    - **Withdrawal mimic:** Influenza, DKA, sepsis, thyrotoxicosis, etc. Treat underlyling illness.
    - **Incompletely treated withdrawal:** Occurs with lower starting doses; improves with more Bup.
    - **Bup side-effect:** Nausea, headache, dysphoria. Continue Bup, treat symptoms with supportive medications.
    - **Precipitated withdrawal:** Too large a dose started too soon after opioid agonist. No clear evidence regarding treatment of withdrawal, many experts recommend additional Buprenorphine. In complex or severe cases of precipitated withdrawal, OK to give short acting agonist (fentanyl or hydromorphone). Usually time limited, self-resolving with supportive medications.
  - YES → **Administer 2nd dose**
    - **ED:** 8-24mg. Consider discharge with higher loading dose.
    - **Inpatient:** 8mg. Subsequent days, titrate from 16mg with additional 4-8mg prn cravings.
    - **Maintenance Treatment 16 mg Bup SL/day**: Titrate to suppress cravings; Usual total dose 16-32mg/day
    - **Discharge**
      - Document Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.
      - **If no X-waiver:** Use loading dose up to 32mg for long effect and give rapid follow up.
      - **If X-waiver:** Prescribe sufficient Bup/Nx until follow-up. Consider bridging dose of 16mg/day.
    - **Overdose Education Naloxone Kit**: Naloxone 4mg/0.1ml intranasal spray

PROVIDER RESOURCES:

Rocky Mountain Poison Center
Open 24 hours
1-800-222-1222
Specify ED Buprenorphine Induction

Rocky Mountain Crisis Partners
Open 24 hours
1-888-211-7766
Specify Opiate Related Call

Buprenorphine Dosing
- Either Bup or Bup/Nx (buprenorphine/naloxone) films or tab sublingual (SL) are OK.
- If unable to take oral/SL, try Bup 0.3mg IV/IM.
- OK to start with lower initial dose: Bup 2-4mg SL.
- Total initial daily dose above 16mg may increase duration of action beyond 24 hrs.
- Bup SL onset 15 min, peak 1 hr, steady state 7 days
- May dose qday or if co-exisiting chronic pain split dosing TID/QID.

*Complicating Factors
- Altered mental status, delirium, intoxication
- Severe acute pain, trauma or planned large surgeries
- Organ failure or other severe medical illness
- Recent methadone use

**Diagnosing Opioid Withdrawal
Subjective symptoms AND one objective sign

Subjective: Patient reports feeling "bad" due to withdrawal (nausea, stomach cramps, body aches, restlessness, hot and cold, stuffy nose)
Objective: [at least one] restlessness, sweating, rhinorrhea, dilated pupils, watery eyes, tachycardia, yawning, goose bumps, vomiting, diarrhea, tremor
Typical withdrawal onset:
≥ 12 hrs after short acting opioid
≥ 24 hrs after long acting opioid
≥ 48 hrs after methadone (can be >72 hrs)
If unsure, use COWS (clinical opioid withdrawal scale). Start if COWS ≥ 8 AND one objective sign.
If Completed Withdrawal: Typically >72 hrs since last short-acting opioid, may be longer for methadone. Start Bup 4mg q4h prn cravings, usual dose 16-32mg/day. Subsequent days, OK to decrease frequency to qday

Opioid Analgesics
- Pause opioid pain relievers when starting Bup.
- OK to introduce opioid pain relievers after Bup is started for breakthrough pain. Do not use methadone with Bup.

Supportive Medications
- Can be used as needed while waiting for withdrawal or during induction process.

Pregnancy
- Bup monoproduct or Bup/Nx OK in pregnancy.
- Consider referencing buprenorphine in pregnancy guide.

Adapted from California Bridge, a program of the Public Health Institute (www.bridgetotreatment.org)

c|h|a Colorado Hospital Association

APPENDIX 2 *continued*

CA BRIDGE
TREATMENT STARTS HERE

Methadone Hospital Quick Start*

Opioid Use Disoder (OUD) & ready to start methadone treatment

YES

If no sedation give 10-30mg methadone

4 hours

Continued withdrawals/cravings?

YES

If no sedation give 5-10mg methadone

q4 hours

Day 1: Max dose 40mg

DAYS 2 AND 3

If no sedation give total dose from prior 24 hours

4 hours

Continued withdrawals/cravings?

YES

If Ramsay ≤2 give 5-10mg methadone

q4 hours

Day 2: Max 50mg

Day 3: Max 60mg

After initial 72 hours: cont same dose for 5 days, can increase dose by 10mg q5days

DISCHARGE

- Methadone may not be prescribed for OUD. Must be administered in a methadone clinic
- **Naloxone 4mg/0.1ml**

***Quick start is for people not already on methadone for OUD. If a patient is already in a methadone maintenance program:**

- Confirm maintenance dose, give maintenance dose.
- If unable to confirm dose, give methadone 30-40mg and increase to full dose when dose is confirmed. OK to uptitrate per protocol until dose confirmed.
- If patient missed outpatient dosing, strongly recommended to discuss dosing changes with methadone clinic provider.
  - If patient missed dose and dose is confirmed by clinic but clinic provider cannot be reached:
  - If 1-2 days are missed, give patient's regular dose
  - If 3-4 days are missed, give half patient's regular dose
  - If ≥5 days are missed, treat as a new start.

Emergency Department

- May provide methadone up to 72 hours pending linkage. Confirm dose whenever possible.
- If unable to confirm dose, OK to provide methadone 30mg/day.
- Patients may need bridge dose if recent hospitalization, prison or jail discharge, or if they missed a dose at their methadone clinic.

Ramsay sedation score

Some hospitals may define no sedation as Ramsay ≤2

1. Anxious/restless
2. Cooperative/oriented/tranquil
3. Response to commands
4. Brisk response to stimulus
5. Sluggish response to stimulus
6. No response to stimulus

Complicating Factors

- Allergy to methadone
- Respiratory depression
- Ramsay sedation scale ≥3
- QTc ≥500
- Recent use of benzodiazepines, alcohol or other sedatives
- Severe liver disease
- Medically unstable
- If RR <8 or sedated, do not give additional methadone

Initial Dosing

- Patients should be dosed according to tolerance. May use morphine equivalent calculator as a guide. Withdrawal severity is not well correlated with tolerance.
- Can use adjunctive medications for withdrawal symptoms.
- Order naloxone prn sedation/resp depression.

Pregnancy

Methadone is safe in pregnancy and in breastfeeding.

The CA Bridge Program disseminates resources developed by an interdisciplinary team based on published evidence and medical expertise. These resources are not a substitute for clinical judgment or medical advice. Adherence to the guidance in these resources will not ensure successful patient treatments. Current best practices may change. Providers are responsible for assessing the care and needs of individual patients. Documents are periodically updated to reflect most recent evidence-based research.

NOVEMBER 2019

PROVIDER RESOURCES

California Substance Use Line
CA Only (24/7)
1-844-326-2626

UCSF Substance Use Warmline
National (M-F 6am-5pm; Voicemail 24/7)
1-855-300-3595

SOURCE: CA Bridge

APPENDIX 3

Example of Nursing Quick Reference Guide to Buprenorphine

Buprenorphine/Naloxone (Suboxone) Nursing Quick Reference Sheet

B-TEAM
SHOUT TEXAS

The Buprenorphine Team (B-Team) offers patients with Opioid Use Disorder (OUD) the opportunity to be started on buprenorphine while in the hospital. Buprenorphine has been FDA approved to treat OUD since 2000 and is proven to decrease a patient's physical dependency on opioids while increasing self-efficacy and overall quality of life during and after treatment. Primary teams are encouraged to notify the B-Team about any patient who may have a diagnosis of OUD. The B-Team partners with outpatient clinics for continuity of care after the patient is discharged.

Indication	• Moderate to severe OUD and opioid withdrawal (can also be used off-label for pain).
Mechanism	• Buprenorphine – high affinity, partial opioid agonist, binds to opioid receptors and reduces cravings. • Naloxone – opioid antagonist, displaces opioids at receptor sites and prevents IV abuse.
Dose	• Per algorithm. • Starting dose is based on presence of withdrawal symptoms and timing of last use of opioids. • Subsequent dosing is based on assessment of withdrawal symptoms using Clinical Opiate Withdrawal Scale (COWS). • Dosing for tablet versus film are not interchangeable.
Dose Adjustments	• Renal: None. • Hepatic (moderate impairment): Use caution. • Hepatic (severe impairment): Avoid use.
Adverse Effects	• Mild risk for oversedation. • Potential to induce withdrawal. • Hepatic injury (rare).
Drug Interactions	• CYP 3A4 substrate – caution with inducers and inhibitors; additive effects with co-administration of other CNS/respiratory depressing agents. • Recent use of opioid agonists, including heroin, increases the risk of withdrawal upon initiation of buprenorphine.
Ordering Prescribers	• Inpatient: the B-Team provider will typically order, though any provider can order under current regulations. • Outpatient: prescriptions must be prescribed by prescribers who have received an X-waiver certification from the DEA.
Administration	• Buprenorphine-naloxone is administered sublingually and is poorly absorbed by the oral route. • Place one film or tablet under the tongue, close to the base on the left or right side. • If an additional dose is needed (based on COWS score), place film or tablet on the opposite side from the first dose. • Place the film or tablet in a manner to minimize overlapping as much as possible. • Film and tablets should not be chewed, cut, or swallowed. • Films and tablets must be kept under the tongue until completely dissolved. • Moistening the mouth with water prior to administration can help with absorption. • Patients should not eat or drink immediately after administration (~10 minutes).
Monitoring	• COWS is assessed with each dose of buprenorphine-naloxone and reassessed based on level of withdrawal by previous COWS score. • Monitor sedation using validated scales per hospital policy. • LFTs (performed prior to start of induction), urine drug screens (frequency/need determined by MD).
Floor PharmD Action	• Patient counseling. • Just-In-Time education as needed for members of the primary care team. • Ensure patient has adequate medication supply between discharge and follow-up outpatient appointment.
Additional Tips	• If the patient has an acute need for pain medication and is receiving buprenorphine-naloxone, alternative analgesics (ibuprofen, acetaminophen, gabapentin, etc) should be used whenever possible. • Ideally, the patient should not receive any opioids while on buprenorphine-naloxone unless absolutely necessary. • Buprenorphine-naloxone will not compete with benzodiazepine receptors. Although, the combination may cause increased sedation. • If there is any concern for illicit drug use while taking buprenorphine-naloxone, please contact the primary medical team or the B-Team.

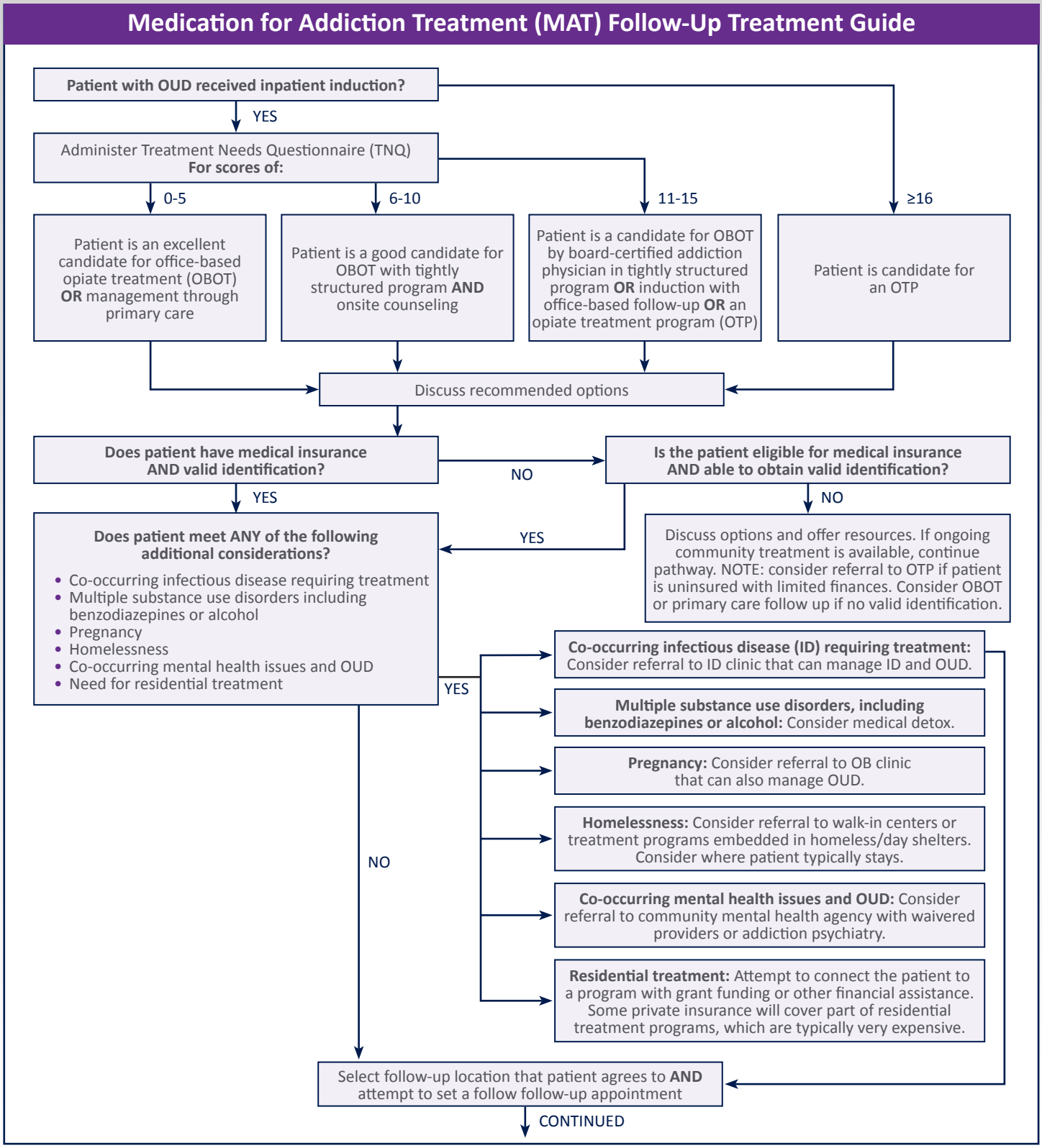
The B-Team is an interdisciplinary group that includes physicians, advanced practice providers, nurses, social workers, case managers, and pharmacists. For questions about the B-Team or for guidance on starting buprenorphine-naloxone **TigerText The Buprenorphine Team.**

The University of Texas at Austin
Dell Medical School

This project is funded by Texas Health & Human Services Texas Targeted Opioid Response.

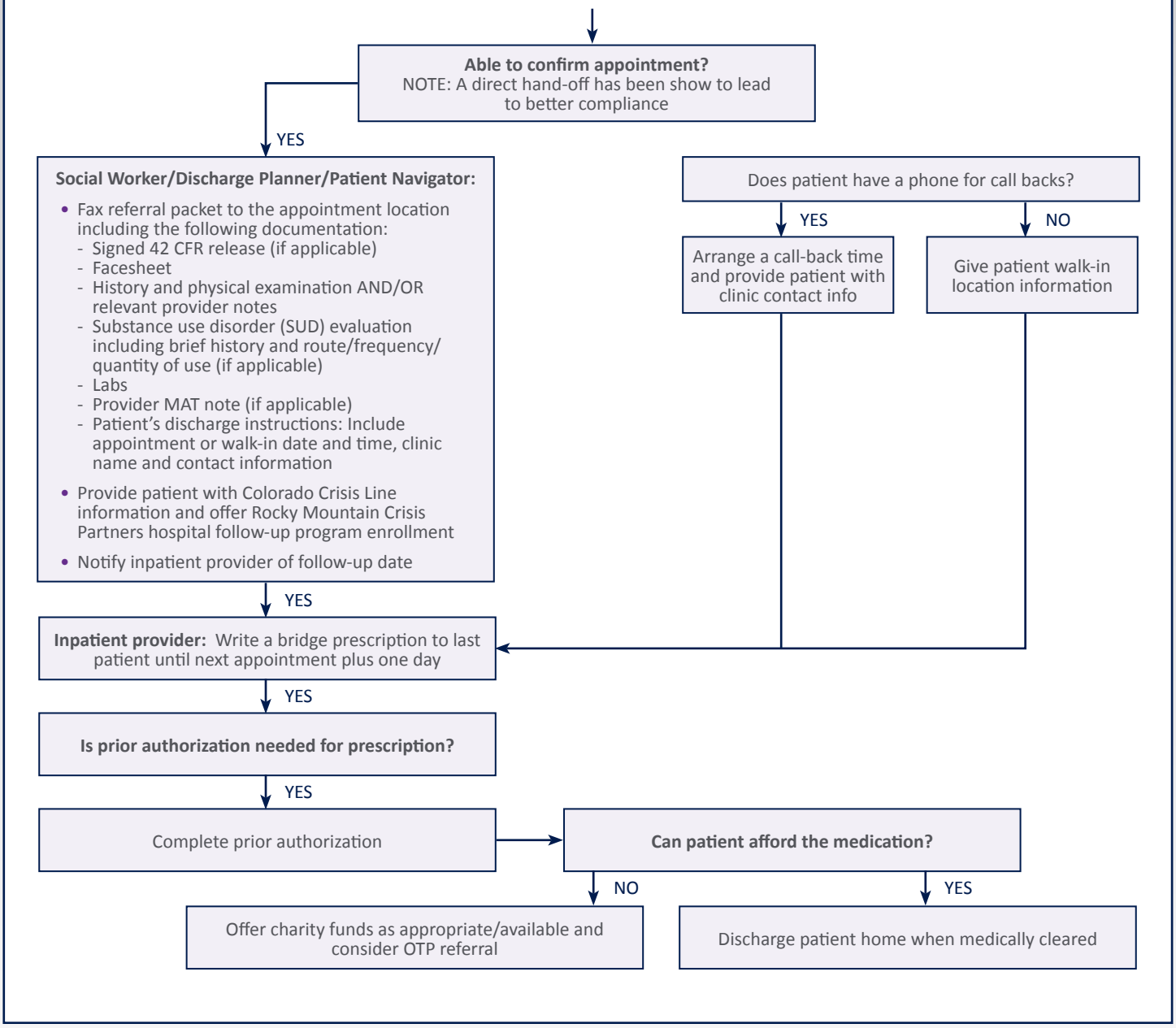
APPENDIX 4

A MAT Follow-Up Pathway for Social Workers, Discharge Planners or Patient Navigators



APPENDIX 4 *continued*

Medication for Addiction Treatment (MAT) Follow-Up Treatment Guide *continued*



Adapted from the University of Colorado Hospital ED MAT Follow-Up Pathway
Special thanks to Angela Khoshnoud

APPENDIX 5
Additional Websites and Resources to Explore

Additional Websites
- Yale School of Medicine: ED-Initiated Buprenorphine
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Center of Excellence for Integrated Health Solutions

Additional Resource Documents
- *AHA Stem the Tide: Opioid Stewardship Measurement Implementation Guide*
- *Colorado's Statewide Strategic Plan for Substance Use Disorder Recovery: 2020-2025*
- *SAMHSA TIP 63: Medications for Opioid Use Disorder*
- *SHM 2020 Opioid Prescribing and Treatment Guidelines for the Medical Inpatient*
- MAT for Pregnant Patients
- MAT in the ED

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