# Buprenorphine:
## Mini X-Waiver Training

LUCINDA GRANDE, MD

WAFP 2021 ANNUAL SCIENTIFIC ASSEMBLY – STUDENT-RESIDENT SESSION

LUCINDA@CRCOLY.ORG 5/8/2021

# Disclosures

- No conflicts of interest to declare.
- This material is condensed from the 4 hour live portion of the approved buprenorphine waiver training course by American Association of Addiction Psychiatry. Slides from that course, labeled "PCSS" are provided with permission from AAAP.
- There is additional material from the CA Bridge website which is clearly labeled.
- Photos of real patients are shown with their written permission.

# Objectives

- Describe the history of treatments for opioid use disorder and the unique features of buprenorphine as a treatment.
- Identify patient characteristics needed to determine an effective treatment plan.
- Formulate a plan to start buprenorphine.
- Apply recent research findings to patient care.

# Overview

- 3 People with OUD
- Background
- Patient Evaluation, Assessment & Treatment Plan
- Induction
- Additional Topics
- Resources

# Chat box:

- Student / Resident / Practicing / Retired
- Waivered? Yes/No
- # of Patients Treated

- Ex: “Resident, yes, 3 patients”
- Ex: “Retired, no”

**April 24, WA State House of Representatives ESB 5476**
https://www.tvw.org/watch/?eventID=2021041259: 56:33

## Ian, 29

Married manager of a nutrition store

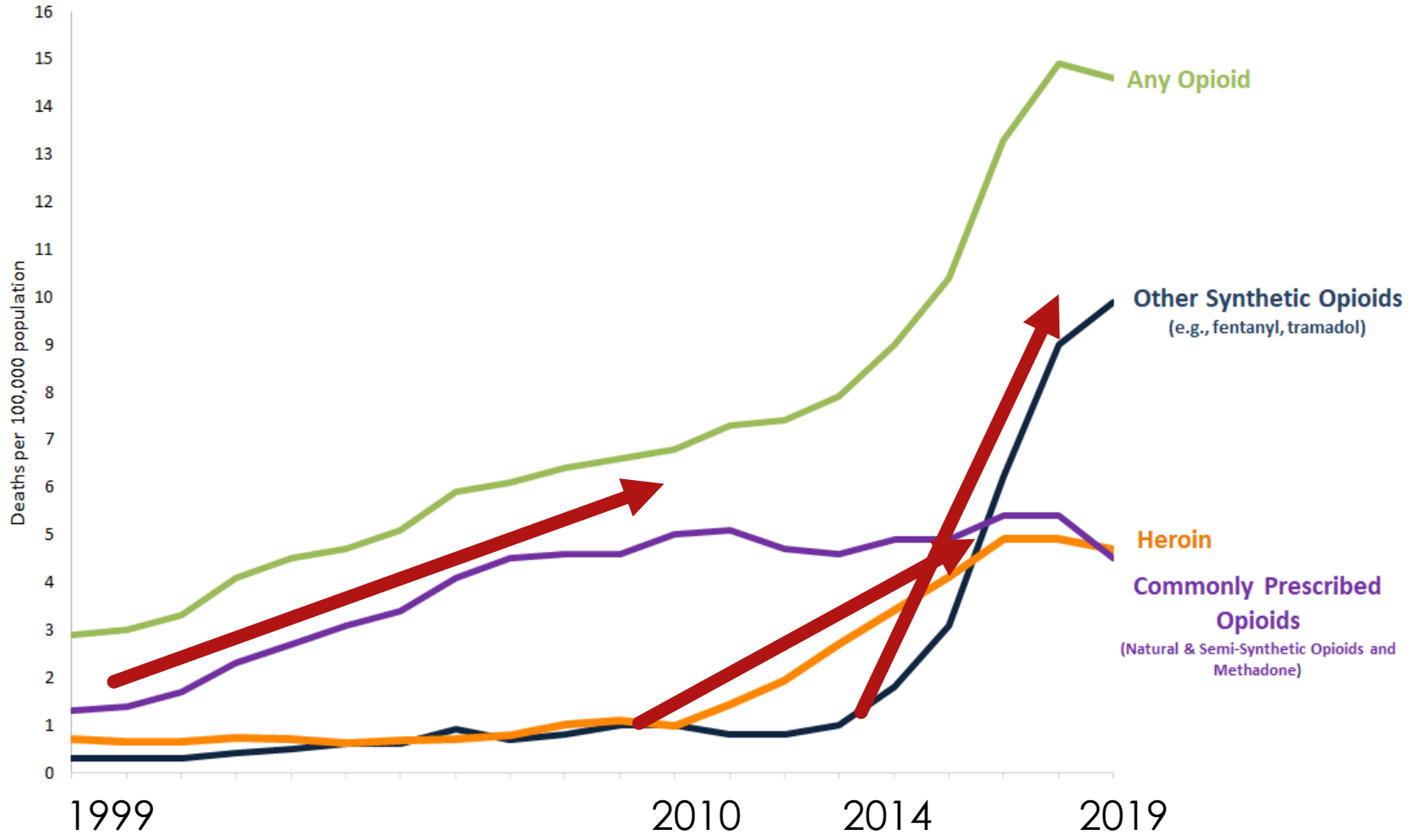
## Terri, 63

Married mother, grandmother

# Background

1853

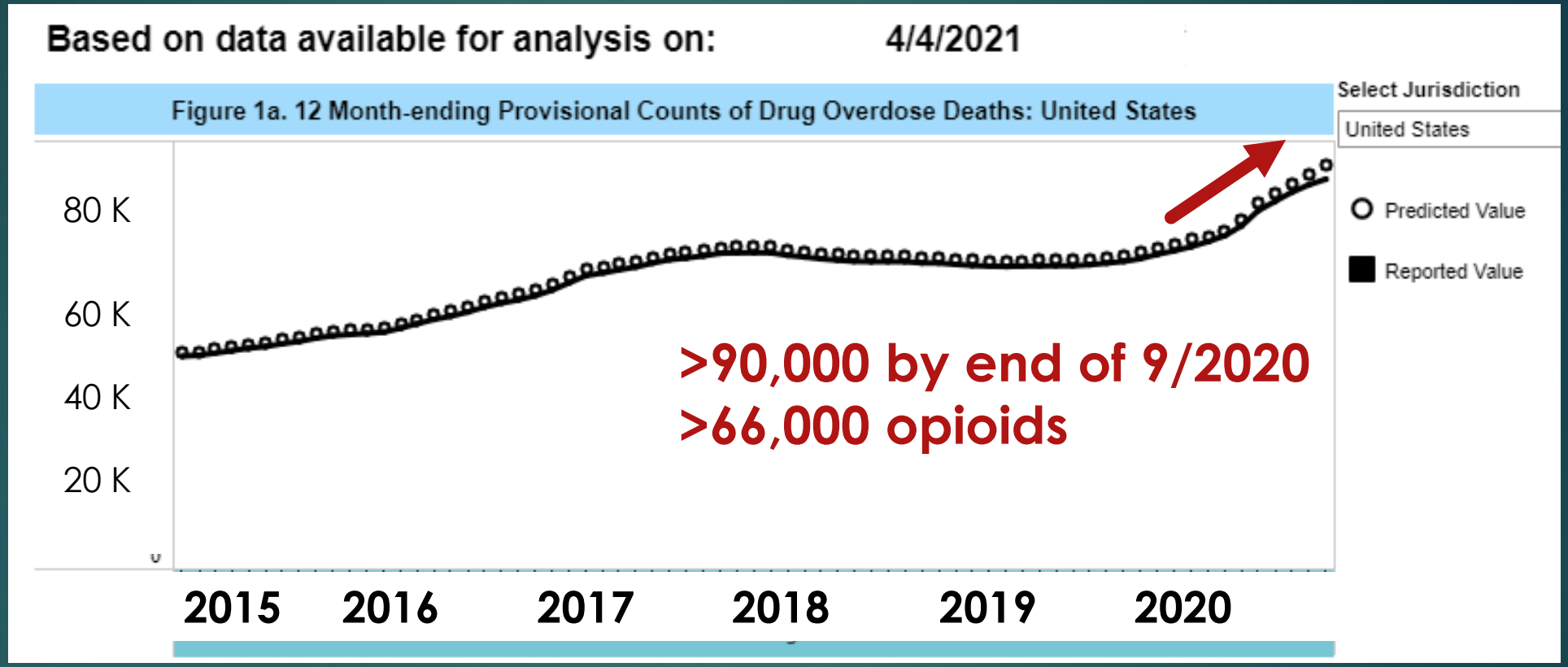
## Overdose Death Rates Involving Opioids, by Type, United States, 1999-2018




SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2020. https://wonder.cdc.gov/.

www.cdc.gov
Your Source for Credible Health Information

# COVID-19




National Vital Statistics System: Vital Statistics Rapid Release

https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

# Medication-Assisted Treatment (MAT)

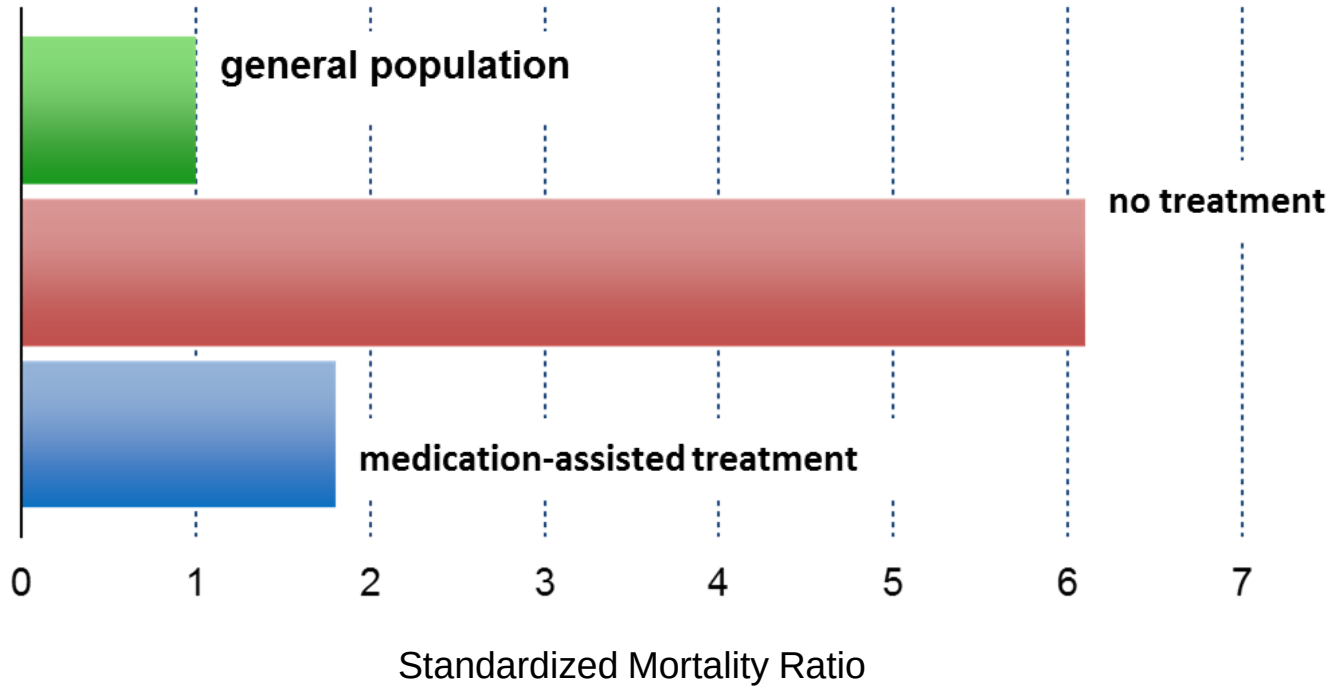
| | Methadone | Buprenorphine (Oral) | Naltrexone (IM) |
|---|---|---|---|
| Mechanism of Action | Full Agonist on Opioid Receptor | Partial Agonist on Opioid Receptor | Antagonist on Opioid Receptor |
| Dosing | 80mg-100mg (Usual Dose) | 4-32mg | 380mg Depot Injection |
| Advantages | ▪ Provided in a highly structured supervised setting where additional services can be provided on-site and diversion is unlikely<br>▪ Maybe effective for individuals who have not benefited sufficiently from partial agonists or antagonists | ▪ Improved safety due to partial agonism<br>▪ Availability in office-based settings | ▪ No addictive potential or diversion risk<br>▪ Available in office-based settings<br>▪ Option for individuals seeking to avoid any opioids |

Schuckit, 2016

PCSS Providers Clinical Support System

# Benefits of MAT: Decreased Mortality

**Death rates:**




Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

PCSS Providers Clinical Support System

# Milestones in Treatment

- **1974:** methadone clinics
- **2000:** DATA 2000 - physicians can prescribe buprenorphine for OUD - with "X-waiver"
- **2010:** Extended-release naltrexone (Vivitrol) approved

# DATA 2000 – Practitioners Requirements

- ✓ Licensed provider with DEA Registration
- ✓ Subspecialty training in addictions or completion of an 8-hour course
- ✓ Registration with SAMHSA and DEA
- ✓ Must affirm the capacity to refer patients for appropriate counseling and ancillary services
- ✓ Must adhere to patient panel size limits
  - 30 during the first year
  - Eligible to apply for increase to 100 after the first year
  - May apply to increase to 275 after being at 100 for a year and meeting specific criteria.

PCSS Providers Clinical Support System

# Milestones in Treatment

- **2016:** ARNPs and PAs can prescribe buprenorphine for OUD
- **4/27/2021:** HHS removes training requirement from X-waiver, if less than 30 patients

# HHS Practice Guidelines 4/27/2021

- "The spike we've seen in opioid involved deaths during the COVID-19 pandemic requires us to do all we can to make treatment more accessible."

  - Tom Coderre, Director of SAMHSA

- "These guidelines provide another tool to help communities respond to the evolving overdose crisis, equipping providers to save lives in their communities."

  - Rachel Levine, MD, HHS Assistant Secretary for Health

# “Notification of Intent”

https://buprenorphine.samhsa.gov/forms/select-practitioner-type.php

SAMHSA
Substance Abuse and Mental Health Services Administration

# Milestones in Treatment

- ***2021?***
- ***Mainstreaming Addiction Treatment (MAT) Act would eliminate the X-waiver entirely***

# Buprenorphine

# Major Features of Buprenorphine

***Partial agonist*** at mu receptor

- Comparatively minimal respiratory suppression and no respiratory arrest when used as prescribed

***Long acting***

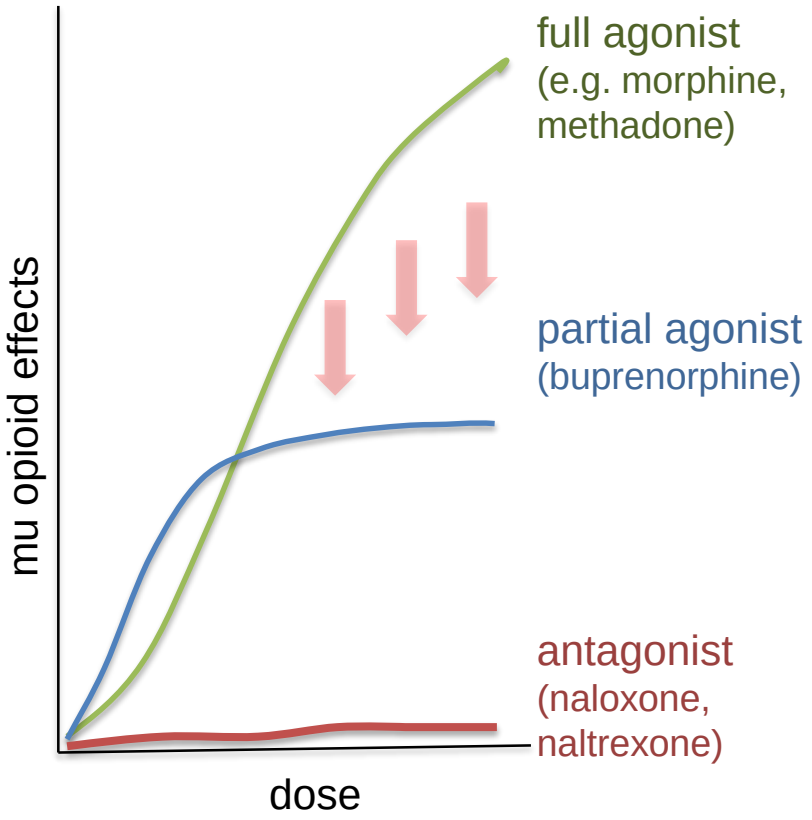
- Half-life ~ 24-36 Hours

***High affinity*** for mu receptor

- *Blocks* other opioids
- *Displaces* other opioids
  - Can precipitate withdrawal

***Slow dissociation*** from mu receptor

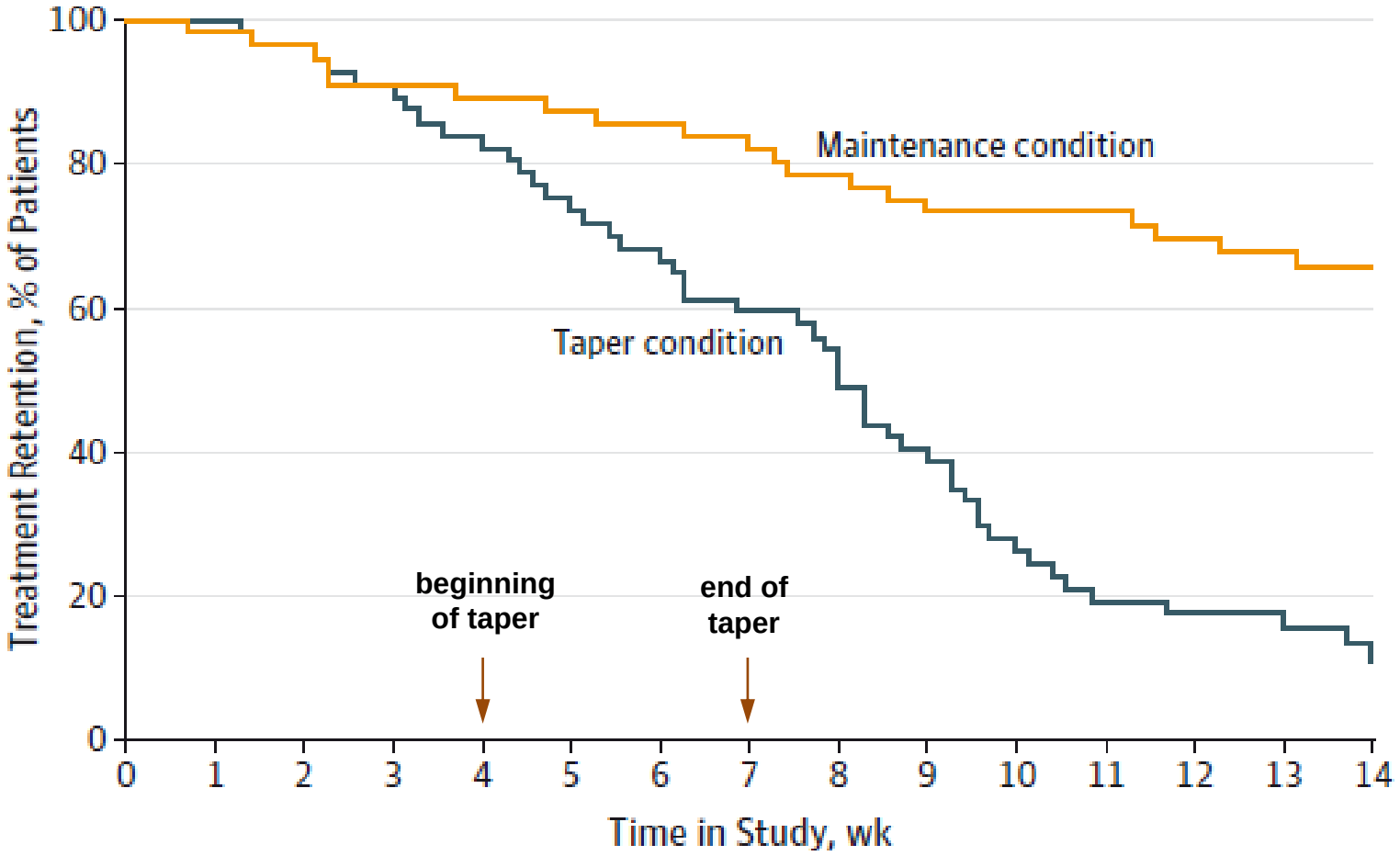
- *Stays on receptor for a long time*




SAMHSA, 2018
Orman & Keating, 2009

PCSS Providers Clinical Support System

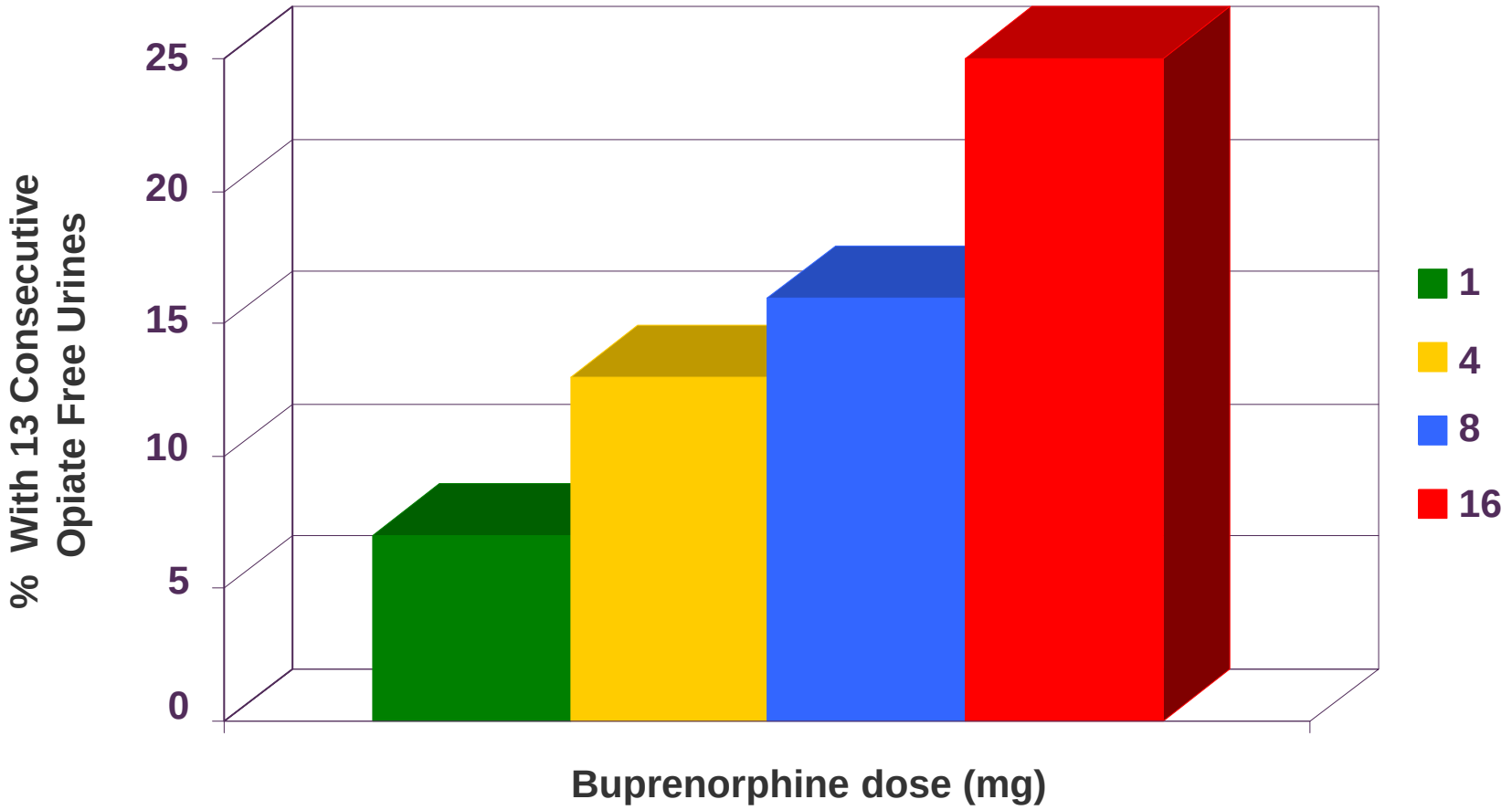
# Buprenorphine: Maintenance vs. Taper




Fiellin et al., 2014

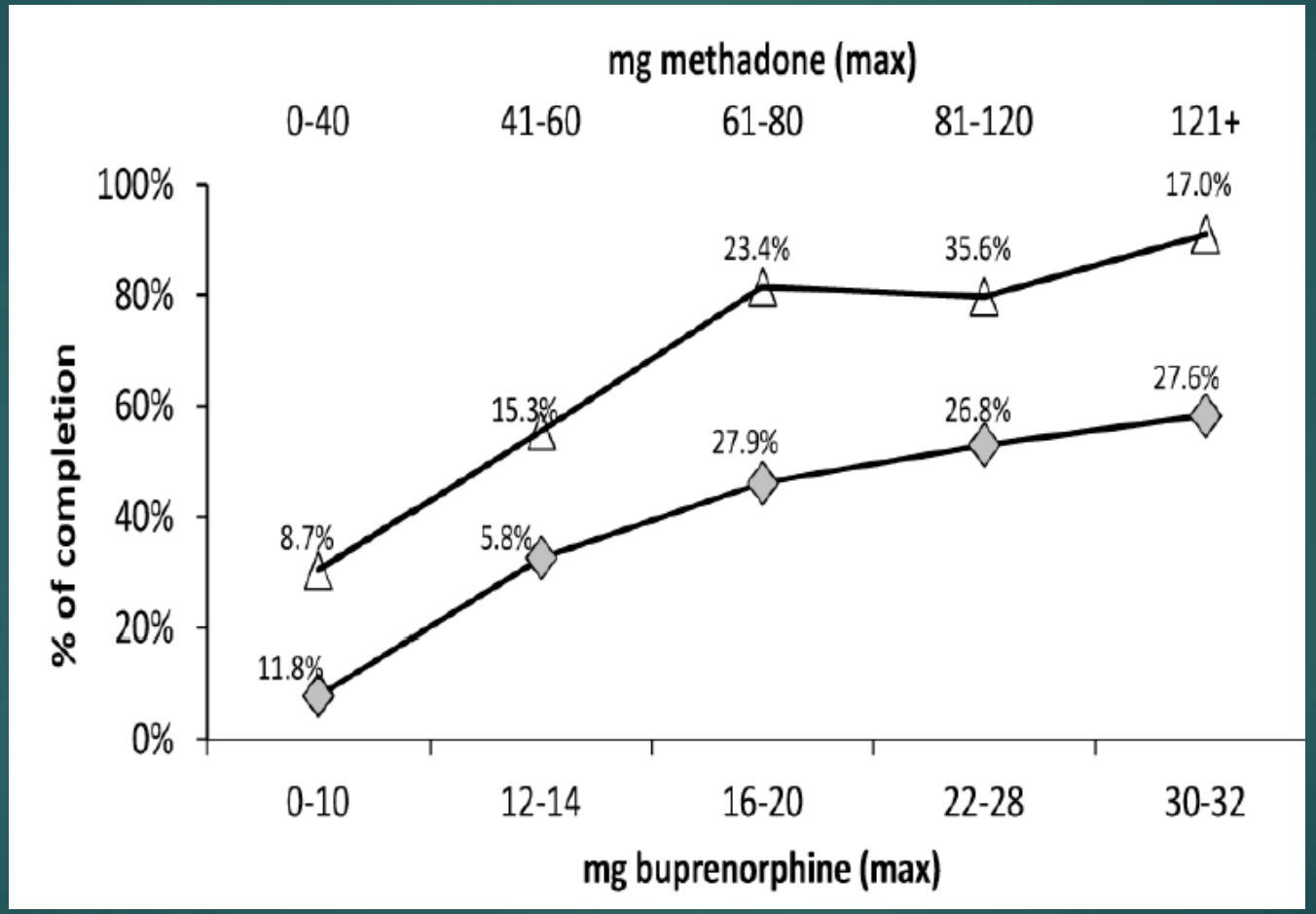
PCSS Providers Clinical Support System

# Buprenorphine Dosing: Efficacy




Ling et al., 1998

# Buprenorphine Dosing: Retention




N=1,267, 24 week trial

Hser et al, 2014

# Higher Dose (24-32 mg) Helpful If…

- High opioid tolerance
- Stress
- Chronic pain

L. Grande, Personal Observations

# Formulations

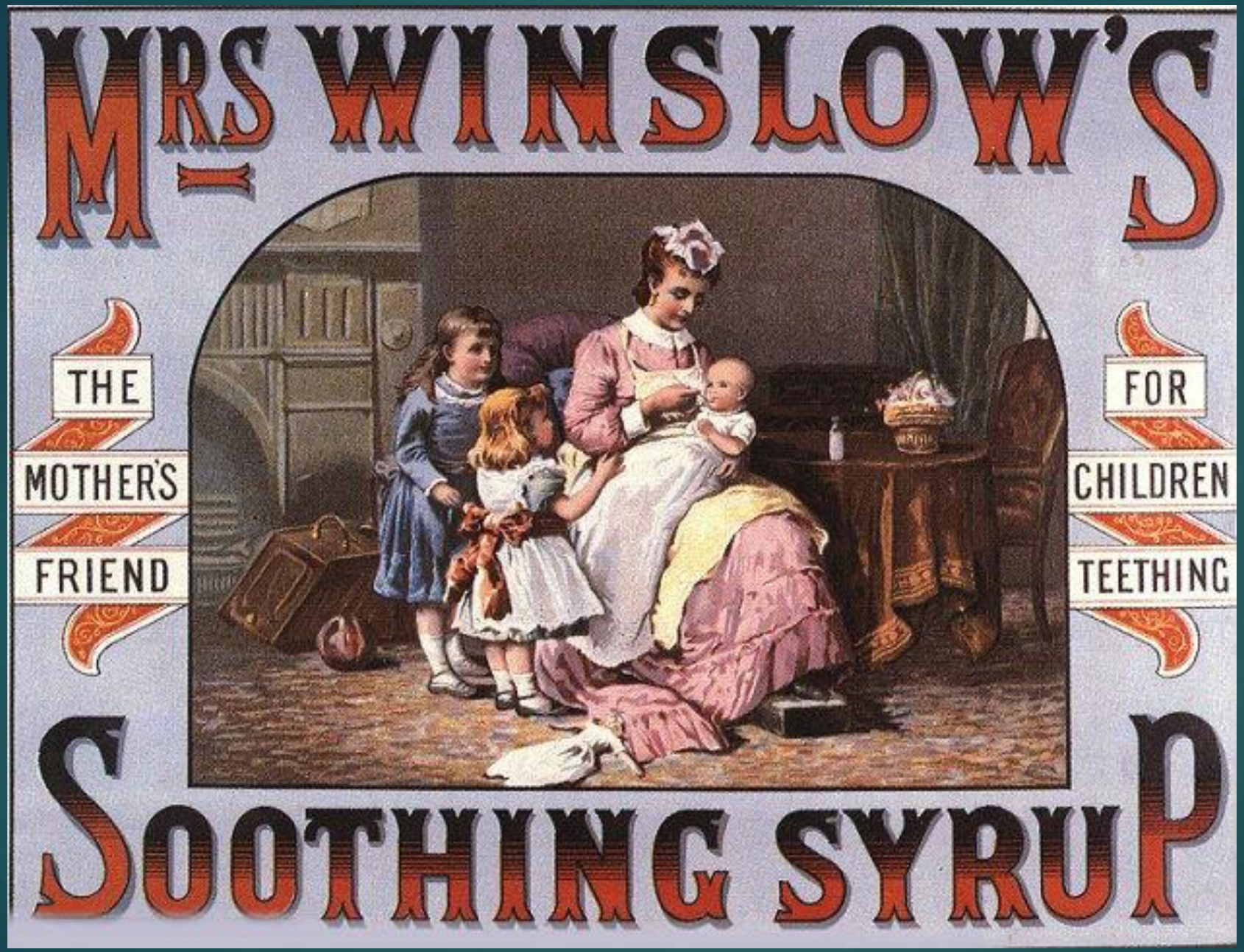
- **Sublingual:**
  - **Bupe/nx: films and tablets, 8-2 mg, 2-0.5 mg (others much less common)**
  - Bupe monoproduct: tablets, 8 mg, 2 mg
- 30-day injection: Sublocade (growing)
- Implant: Probuphine (rare)
- Buccal film: Bunavail (rare)
- FDA-approved for pain, not OUD:
  - Low dose Patch: Butrans
  - High dose IV: Buprenex (1981)

# Rationale for the Combination of Buprenorphine with Naloxone

- When used as prescribed (sublingual or buccal administration), there is minimal bioavailability of naloxone
- Compared to buprenorphine alone, the buprenorphine/naloxone combination:
  - was developed to decrease IV misuse
  - is more likely to precipitate a withdrawal effect if injected by a current opioid user.
  - produces a slowed onset effect when injected or insufflated in those who are physically dependent buprenorphine.
  - per prescription, is less likely to be diverted

Comer et al., 2010
Jones et al., 2015
Stoller et al., 2001

PCSS Providers Clinical Support System

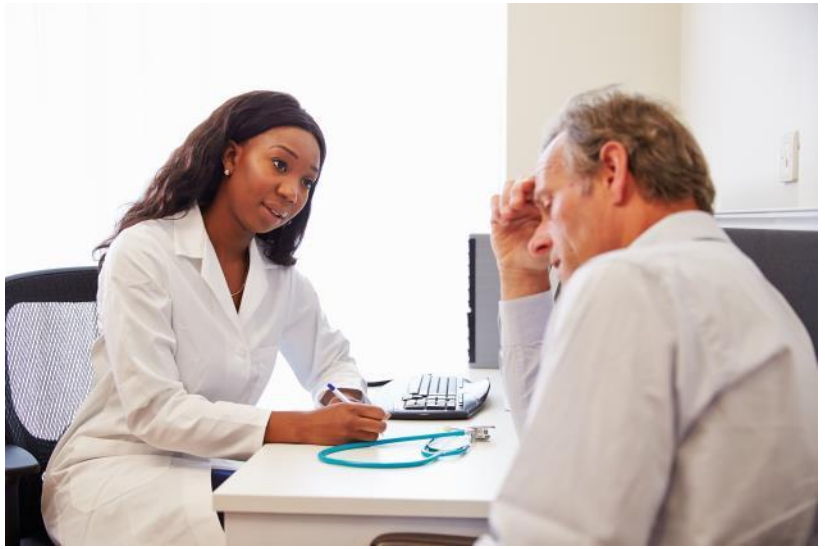

MRS WINSLOW'S
THE MOTHER'S FRIEND
FOR CHILDREN TEETHING
SOOTHING SYRUP

1849

# Patient Evaluation

# Building a Therapeutic Alliance

- Attitude
  - Non-judgmental, curious, empathetic
- Respectful
  - Recognize adversity
  - Recognize strengths
  - Use the non-stigmatizing language
- Honesty
- Shared goals
  - Why is the patient seeking treatment?
  - Provider treatment team concerns



- Reassurance
  - Assure patient your objective is concern for his or her health
  - Confidentiality (with qualifiers)
    - Safety of self, well-being of other (especially children)

Miller WR, Rollnick S, Motivational Interviewing, Guilford Press, NY NY, Third Ed., 2013, page 22.

| TABLE 3. NON-STIGMATIZING LANGUAGE ASSOCIATED WITH SUBSTANCE USE DISORDERS | |
|---|---|
| **Use This** | **Instead of This** |
| Substance use disorder | Drug habit |
| Person with a substance use disorder | Addict, abuser, junkie |
| Person with alcohol use disorder | Alcoholic |
| Person in recovery | Clean, reformed addict |
| Urine that tested positive/negative for a substance | Dirty/clean urine |
| Recurrence; return to use | Relapse |
| Substance use | Substance abuse |
| Medications for opioid use disorder, medication-assisted treatment, medication for addiction treatment, pharmacotherapy | Replacement therapy, substitution therapy |

**National Council for Behavioral Health**
**Medication-Assisted Treatment for Opioid Use Disorder: A Planning and Implementation Toolkit - January 2020**

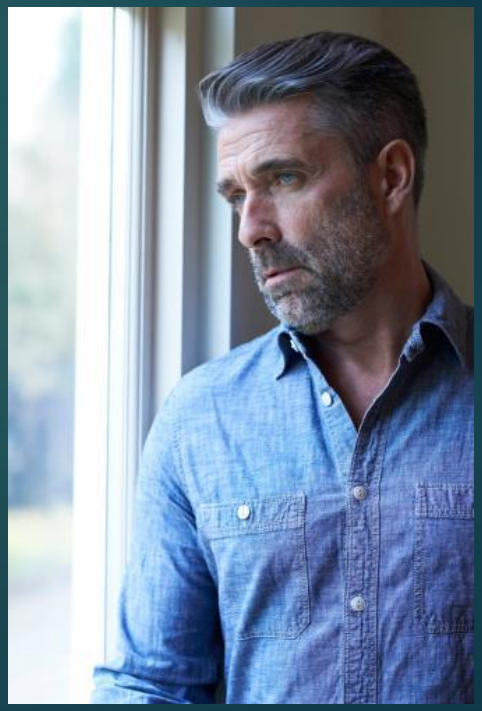
# Medical History

- Medications
- Allergies
- Medical Conditions
- Psychiatric Conditions
- Social History
  - Living situation, family, children, legal issues, jail, employment status
  - Current stressors

- Prescription Monitoring Program Report

# Substance Use History

- Age of first use
- Progression: substance, age, mode of administration
- Opioids:
  - Reason for starting
  - Highest amount, recent amount
  - Injected?
  - Overdosed?
  - Last use
  - Benefits / Consequences
- Treatment – residential, IOP, counseling, 12-step



# Buprenorphine History

- Prescribed or not
- Dose
- Longest duration
- Benefits
- Reason for discontinuing

# Physical Exam

- General: irritable, pressured speech, soiled clothing
- Derm:  track marks, cellulitis/abscess, sores
- ENT: **pupils dilated/constricted**
- Mouth: dentition, abscess
- CV: murmur
- Respiratory: cough, wheeze
- MS: spine/joint tenderness, amputation
- GI:  hepatomegaly

# Clinical Opiate Withdrawal Scale (COWS)

- Resting Pulse
- Sweating
- Restlessness
- GI Upset
- Tremor

- Pupil Size
- Bone or Joint Aches
- Yawning
- Anxiety or Irritability
- Gooseflesh
- Runny Nose
  or Tearing Eyes

Wesson and Ling, 2003

# Labs – optional

- Pregnancy test
- Urine tox screen
- Screening for HIV, Hep A/B/C, STDs
- CBC, CMP

# Establishing Goals

# Range of Treatment Goals

Minimization of harms from ongoing use

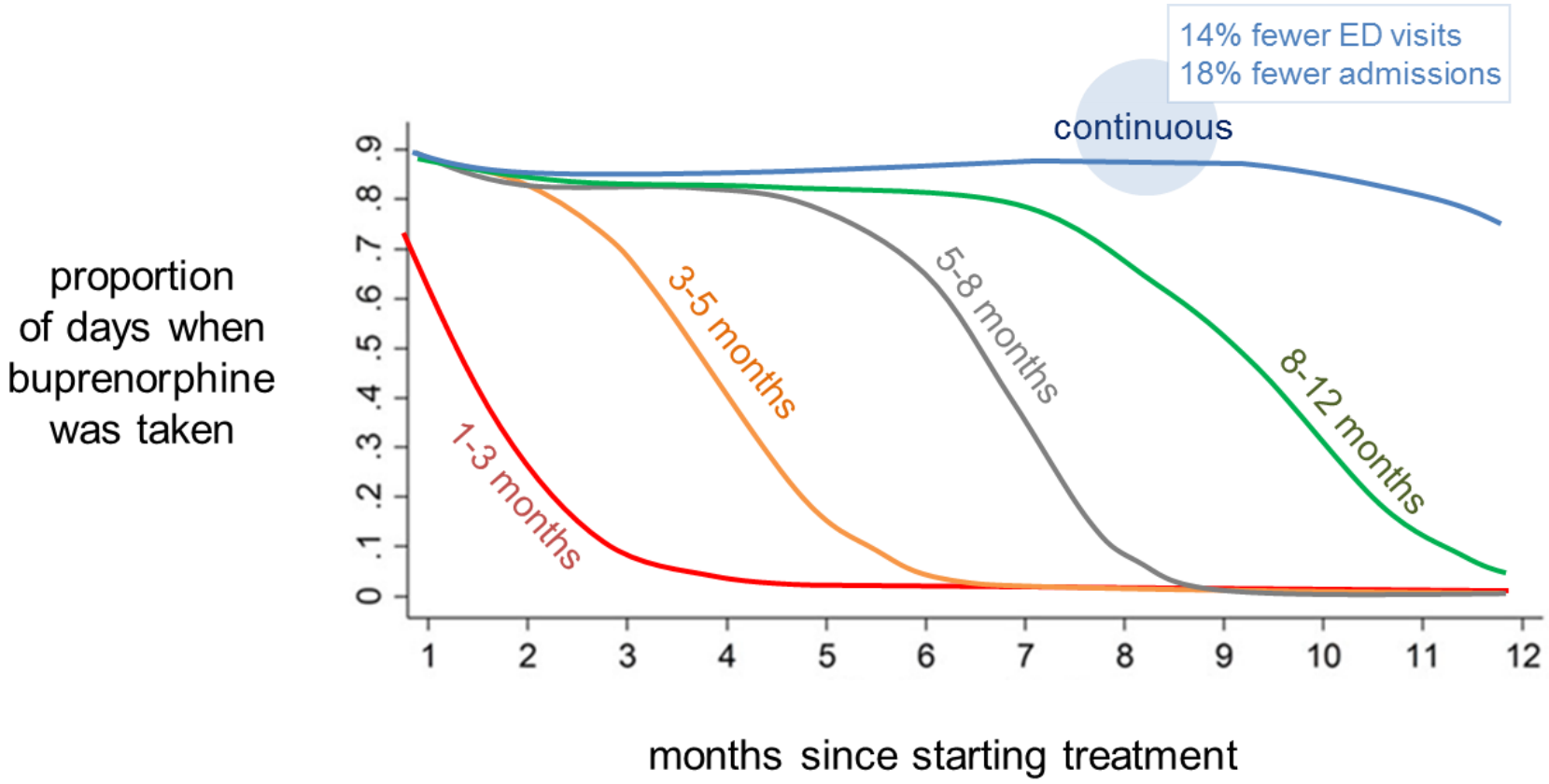
Sustained recovery with abstinence from all substances

# Duration of Use (Patient's Goals)

- Steady use long term, or
- Steady use, then slow taper, or
- Rapid taper, or
- Intermittent use

- "It works for as long as you take it"

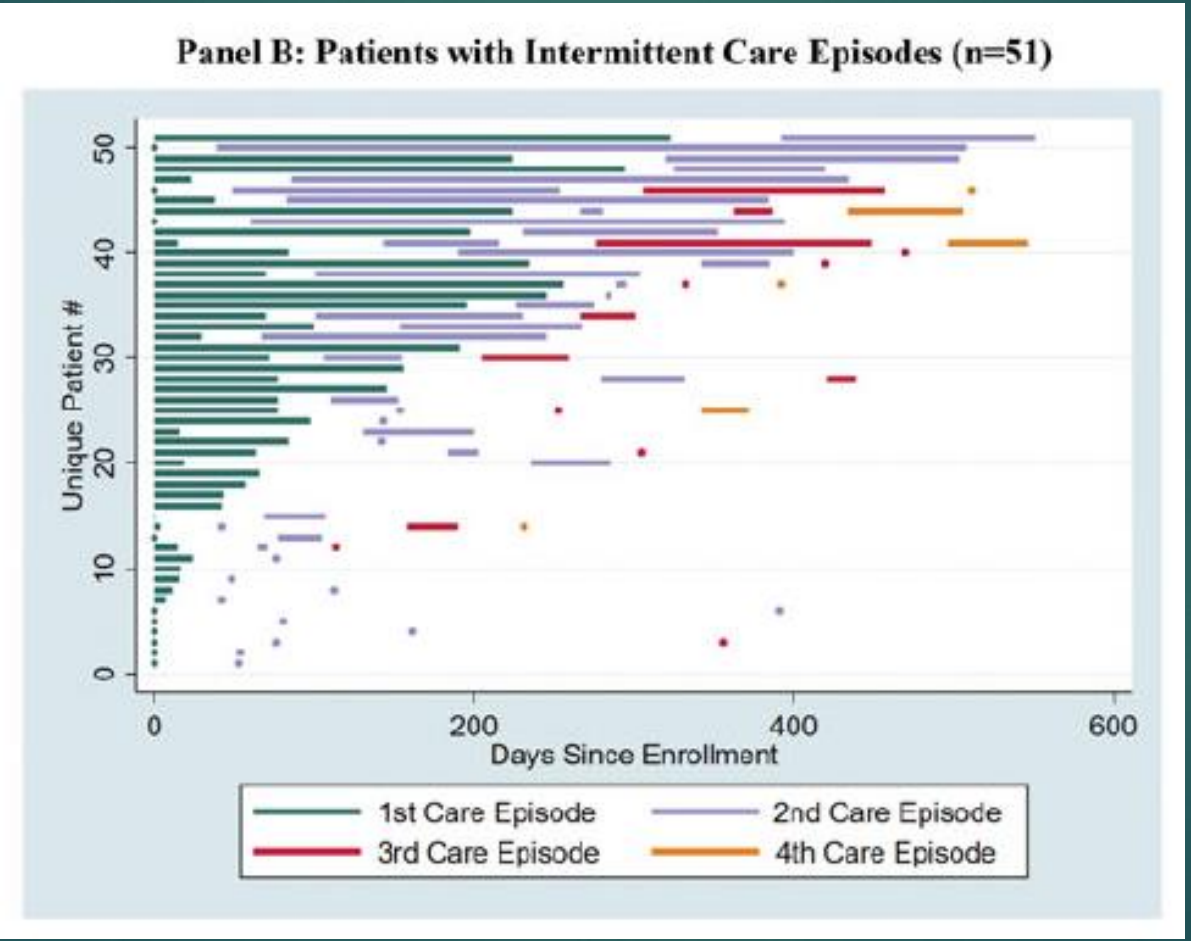
# Optimal Duration of MAT




Lo-Ciganic et al., 2016

PCSS Providers Clinical Support System

# Steady vs. Intermittent Treatment




Care Episode = Visits between gaps of 30+ days

Hood, 2019, Substance Abuse

# Assessment

# DSM V Criteria

- Loss of Control
  - Larger amounts, longer time
  - Inability to cutback
  - More time spent, getting, using, recovering
  - Activities given up to use.
  - Craving
- Physiologic
  - Tolerance
  - Withdrawal
- Consequences
  - Hazardous use
  - Social or interpersonal problems related to use
  - Neglected major roles to use
  - Continued use after significant problems.

- A substance use disorder is defined as having 2 or more of these symptoms in the past year
- Tolerance and withdrawal alone don't necessarily imply a disorder.
- Severity is related by the number of symptoms.

**2-3 = mild**
**4-5 = moderate**
**6+ = severe**

PCSS Providers Clinical Support System

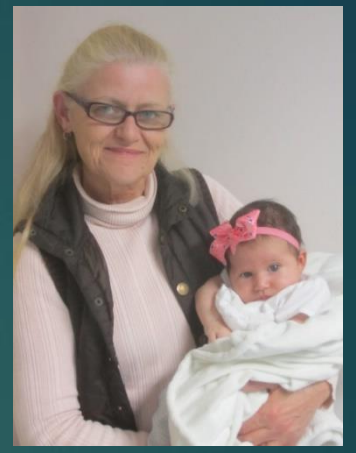
# Terri, 63

- Married mother, grandmother
- Chronic back pain, fibromyalgia
- Hydrocodone Rx 20 mg/day
- Runs out early every month
- Anxiety and depression
- Hypertension

# Chat Box

OUD?  Yes/No

# Assessment



- Diagnosis
- Medical issues
- Psych issues
- Risk of not treating

- OUD
- Abscess
- ADD
- OD, suicide, sepsis

- Pain or OUD
- HTN
- Anxiety, Depression
- Pain, Withdrawal Sx

# Plan

# Higher Dose (24-32 mg) Helpful If…

- High opioid tolerance
  - High lifetime maximum dose (e.g. 2+ grams IV, 120+ MED)
  - Long time use (e.g. 5+ years)
  - Injection
- Stress
  - High ACEs score
  - PTSD
  - Anxiety
  - Current stressors
- Chronic pain

L. Grande, Personal Observations

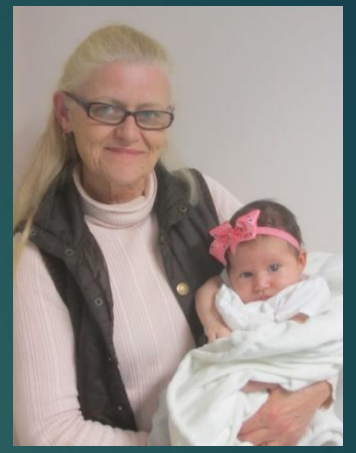
# Ian, 29

- Manager of a nutrition store
- Wife just left him
- Chronic pain from old football injuries
- Previous Oxycontin 800 mg/day
- Injecting heroin 1/2 gram/day
- Large abscess on thigh

# Chat Box

Dose: High or Low?

# Plan



- Dose
- Number of Days
- Medications
- Additional support?

- 24, then 32 mg/day
- 3, 7, 14,  28
- Antibiotics
- Residential, 12-step

- 16 mg/day
- 3, 28
- Fluoxetine, lisinopril
- Family

# Counseling at first visit

- When and how to start: COWS / SOWS
- Plan for missed or early visits
- Safe storage
- Naloxone access
- No sharing or selling

Annals of Internal Medicine

SPECIAL ARTICLE

# The Next Stage of Buprenorphine Care for Opioid Use Disorder

Stephen A. Martin, MD, EdM; Lisa M. Chiodo, PhD; Jordon D. Bosse, MS, RN; and Amanda Wilson, MD

| New Findings and Recommendations |
| --- |
| Home induction is also safe and effective (6). |
| Buprenorphine should not be withheld from patients taking benzodiazepines (5). |
| Relapse indicates the need for additional support and resources rather than cessation of buprenorphine treatment (43). |
| Behavioral treatments and support are provided as desired by the patient (6). |
| Drug testing is a tool to better support recovery and address relapse (56). |
| Buprenorphine treatment does not directly affect other substance use, and such use should be addressed in this context (43). |
| Buprenorphine is prescribed as long as it continues to benefit the patient (6). |

Ann Intern Med 2018 169(9):628-635

# Induction

# Buprenorphine Induction
## Rationale

- Goals of buprenorphine initiation:
  - Identify dose of buprenorphine at which the patient:
    - Discontinues or markedly reduces use of other opioids
    - Significantly decreased or absent withdrawal symptoms
    - Has minimal/no side effects
    - Experiences decreased cravings

SAMHSA, 2004

# Rapid Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

**For people with HIGHER opioid tolerance, experience with withdrawal, or experience with buprenorphine**

1. Plan to take a day off and have a place to rest.
2. Stop using and wait until you feel sick from withdrawals (at least 12 hours is best).
3. Dose an 8mg tablet or strip UNDER your tongue.
4. Repeat dose (another 8mg) in an hour to feel well.
5. Start 16mg per day the next day.

https://cabridge.org/resource/rapid-guidance-for-patients-starting-buprenorphine-outside-of-hospitals-or-clinics/

## If you have started Bup before:

- If it went well, that's great! Just do that again.
- If it was difficult, talk with your care team to figure what happened and find ways to make it better this time.

## If you have never started Bup before:

- Gather your support team and if possible take a "day off."
- You are going to want space to rest. Don't drive.
- Using cocaine, meth, alcohol or pills actually makes starting Bup harder, but that is up to you. Be safe.

*Place dose under your tongue (sublingual).*

## If you have a light habit: *(For example, 5 "Norco 10's" a day)*

- Consider a low dose: start with 4mg and stop at 8mg total.
- **WARNING:** Not enough Bup won't treat your withdrawals.

## If you have a heavy habit: *(For example, injecting 2g heroin a day)*

- Consider a high dose: start with first dose of 16mg.
- The effects of Bup max out at around 24-32mg.
- **WARNING:** Too much Bup can make you feel sick and sleepy.

# Rapid Self-Start

CA BRIDGE

https://cabridge.org/resource/rapid-guidance-for-patients-starting-buprenorphine-outside-of-hospitals-or-clinics/

CA BRIDGE

# Gentle Self-Start

## Guidance for patients starting buprenorphine outside of hospitals or clinics

**For people with LOWER opioid tolerance, major medical issues, or less withdrawal experience**

### Wait, Withdraw, Dose

**If you have started Bup before:**

- If it went well, that's great! Just do that again.
- If it was difficult, talk with your care team to find ways to make it better.

*Place dose under your tongue (sublingual).*

**If this is your first time on Bup:**

- Gather your support team and if possible take a "day off."
- Don't drive.
- Using cocaine, meth, alcohol or pills makes starting Bup harder. Be safe.
- Too little Bup can make you still feel withdrawal.
- Too much Bup can make you feel sick or sleepy.

https://cabridge.org/resource/rapid-guidance-for-patients-starting-buprenorphine-outside-of-hospitals-or-clinics/

## DAY 1

- Plan to take a day off and have a place to rest.
- Stop using and **wait** until you **feel sick** from withdrawals (at least 12 hours is best).
- **Dose ½ of an 8mg tablet or strip (4mg)** under your tongue & let it dissolve.
- If you feel suddenly worse after the first dose, call the Substance Use Navigator or go to the ER.
- **Repeat dose (another 4mg)** in an hour to feel well.
- If you still feel sick, take another 4mg every 6 hours, up to 24 mg.

*Split 8mg film or tablet in half.*

## DAY 2 AND BEYOND

- Take the total amount you needed on day 1 as a single dose in the morning—for example, if you took a total of 16mg, take 2 tablets/films at the same time.
- Later in the day, if you still feel like you're in withdrawal or craving, take 4mg (half-tablet or half-film) more.
- If you're too sleepy, take 4mg less the next day.

**Gentle Self-Start**

CA BRIDGE

https://cabridge.org/resource/rapid-guidance-for-patients-starting-buprenorphine-outside-of-hospitals-or-clinics/

# Buprenorphine Induction
## First Prescription

- Many Logistical Factors/Considerations
  - Review that patient meets induction criteria
  - Insurance
  - Confirm access to pharmacy
  - Confirm access to urine drug testing

- Location
  - Office Induction:
    - Patient given prescription and brings medication to the office
  - Home Induction:
    - Patient goes home with instructions, follow-up appointment, and a prescription for medicine

# Side Effects

- Headache – usually mild
- Nausea - consider spitting out saliva rather than swallowing
- Constipation – Tx: hydration, fiber, laxatives
- Idiopathic – rashes, tongue burning, flank pain, other
- If dose is too high: sedation

# Consider Switching Formulation

- Films instead of tablets
- Tablets instead of films
- Buprenorphine monoproduct
- Depot injection
- Methadone

# General Goals of Drug Testing in Office-Based Treatment

- Important and routine component of treatment
- Urine testing can be viewed as a means for helping the provider to help the patient
- Testing is not meant to "catch" the patient, and a positive test result should not simply lead to discharge from treatment, but an opportunity for reviewing the patient's Recovery Management

# Additional Topics

# Decisions for your practice

- Will you recruit patients? How?
- How will you handle concurrent substance use?
- How will you use urine screening?
- How much time can you spend with each patient?
- Can you tolerate early or missed visits?
- Build a psychosocial referral network

# MAT in Pregnancy

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

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

CA BRIDGE

https://cabridge.org/resource/mat-toolkit-for-nurses/

# Chronic Pain

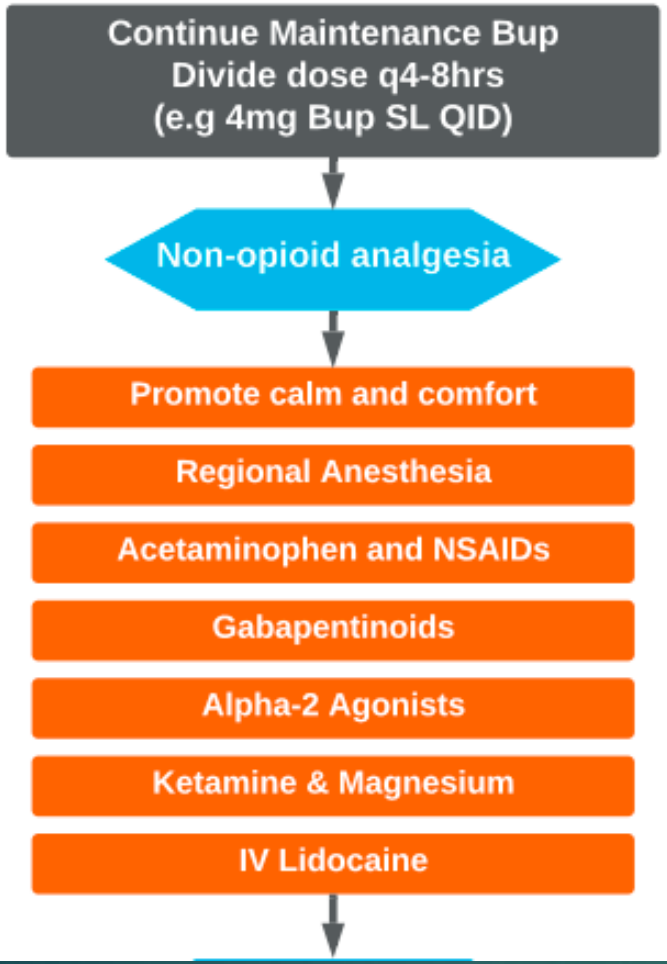
Buprenorphine is also an excellent option for Pain Management. When buprenorphine is used for analgesia, nurses should anticipate TID dosing and the possibility of adding additional opioids/analgesics or increasing the dose/frequency of the buprenorphine even more if needed. Consider utilizing additional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

Up to 32 mg/day

CA BRIDGE

https://cabridge.org/resource/mat-toolkit-for-nurses/

# Acute Pain




## Promote calm and comfort

**Anxiety, fear, depression are common**: Instill sense of control, provide education on self-management techniques such as mindfulness meditation. Reduce noise, uncertainty, confusion.
Positioning, splinting, and physical comfort should be maximized. Minimize unnecessary NPO status.
**TREAT UNPLEASANT SYMPTOMS:**
**Diphenhydramine** 25-50mg PO q8h prn insomnia/anxiety
**Tizanidine** 2-4mg q6h prn muscle spasms
**Ondansetron** 4mg PO q6h prn nausea
**Trazadone** 50mg PO qhs prn insomnia
**Melatonin** 3mg PO qhs prn insomnia
**Lorazepam** 0.5-1mg PO prn anxiety
**Antipsychotics** prn psychotic disorder symptom control
**Nicotine replacement** prn tobacco dependence

## Regional Anesthesia

**Peripheral nerve blocks:** superficial cervical plexus, brachial plexus, radial/median/ulnar, PECS, erratus plane, TAP, femoral, sciatic, posterior tibial.
**Spinal and Epidural anesthesia**

## Acetaminophen and NSAIDs

**Acetaminophen** and **NSAIDs,** when not contrainidicated, should are the foundation of a multimodal analgesic strategy.

## Gabapentinoids

In opioid depenent patients, the calcium channel inhibitors, gabapentin and pregabalin reduce postoperative pain and reduce opioid consumption.
Gabapentin 300-600mg PO TID.

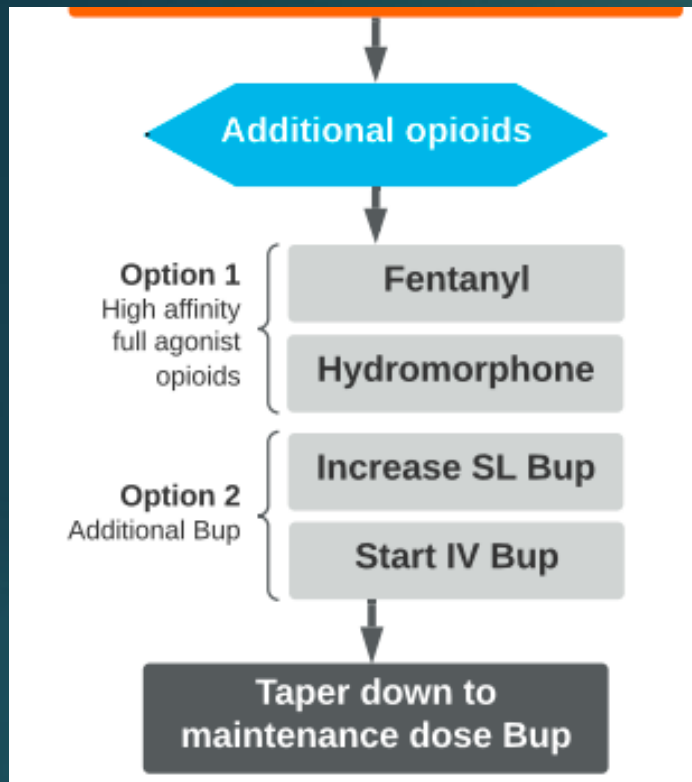
## Alpha-2 agonists

Clonidine and Dexmedetomidine are anxiolytic and analgesic with significant

CA BRIDGE

https://cabridge.org/resource/acute-pain-management-in-patients-on-buprenorphine-ed-critical-care/

# Acute Pain




### Alpha-2 agonists

Clonidine and Dexmedetomidine are anxiolytic and analgesic with significant opioid sparing affects. e.g. **Clonidine** 0.1-0.3mg PO q6-8h prn pain or anxiety (NTE 1.2mg/day, hold if BP <100/70).

### Ketamine & Magnesium (NMDAR antagonists)

**Ketamine** is the most potent non-opioid analgesic for opioid tolerant patients. A brief infusion of 0.3mg/kg IV over 15min is followed by 0.3-1mg/kg/hr as needed.
**Magnesium** is also an NMDAR with analgesic and opioid sparing effect. eg. 30-50mg/kg bolus followed by 10-mg/kg/hr.

### IV Lidocaine (Na channel antagonist)

Opioid sparing analgesic. A bolus of 1-1.5mg/kg is followed by 1.5-3 mg/kg/h. Contraindications include cardiac dysrthymias. Must monitor serum levels after 24hrs.

### High Affinity Full agonist Opioids

Hydromorphone, fentnayl, and sufentanil can be added to maintenance Bup to provide synergistic analgesia. Titrate to analgesia and side effects. This will NOT cause withdrawal.

### Additional Bup

There is no clinical ceiling on Bup analgesia. SL Bup can be given as frequently as q2h. IV Bup is a potent analgesic start at 0.3mg IV and titrate as needed. At higher doses respiratory depression does occur.

Guidelines are options for multimodal analgesic therapy. Use clinical judgement and avoid use if contraindicated.

CA BRIDGE

https://cabridge.org/resource/acute-pain-management-in-patients-on-buprenorphine-ed-critical-care/

# Resources

- Providers Clinical Support System http://www.pcssNOW.org
  - Waiver training schedule, webinars, mentoring
- SAMHSA
  - https://www.samhsa.gov/medication-assisted-treatment/otp-resources
- University of Washington Addictions, Drug and Alcohol Institute (ADAI)
  - https://adai.uw.edu
  - Stopoverdose.org
  - Northwest ATTC Webinar Series
- Washington Recovery Helpline
  - http://www.warecoveryhelpline.org/moud-locator/

CA BRIDGE

# Appendix

## Treatment Protocols

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

https://cabridge.org/resource/mat-toolkit-for-nurses/

CA BRIDGE

# Appendix

## Additional training on addressing stigma

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

https://cabridge.org/resource/mat-toolkit-for-nurses/

# Appendix

## Guides, FAQs, Toolkits

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

## Videos

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

https://cabridge.org/resource/mat-toolkit-for-nurses/