CA BRIDGE

CA Bridge Treatment Protocols

CA BRIDGE

CA Bridge Treatment Protocols Overview

These resources can be accessed using the QR Code or by navigating to our resource directory at cabridge.org/tools/resources.

Buprenorphine Emergency Department Quick Start

A patient in opioid withdrawal can be started on buprenorphine following the 'Quick Start' protocol.

Buprenorphine Immediately after Reversal of Opioid Overdose with Naloxone

Patients who receive naloxone to reverse opioid overdose can be given buprenorphine following the reversal.

Acute Pain Management in Patients on Buprenorphine Treatment for Opioid Use Disorder in Emergency Department/Critical Care and Medical/Surgical Units

Guidance on the importance of continuing buprenorphine or methadone and starting additional medications to treat acute pain.

Buprenorphine Quick Start in Pregnancy

Guidance on buprenorphine initiation in pregnant patients.

Methadone Hospital Quick Start

Methadone may be a better choice for some people. This 'Quick Start' is for people that are not already on methadone for opioid use disorder.

Acute Care Treatment of Alcohol Use Disorder

Treatment for alcohol use disorder in emergency departments and inpatient settings.

Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics.

Medications for Addiction Treatment and Trauma-Informed Care: Pregnancy

Frequently asked questions regarding the management of pregnant and early parenting patients.

Care for Patients with Opioid Use Disorder Who Are in Custody

Many hospitals care for patients who are in custody. In these settings, using MAT remains the standard of care; however, issues specific to the criminal justice system must be considered.

Emergency Department Buprenorphine (Bup) Quick Start

Connect with your patient: Accurate diagnosis and treatment requires trust, collaboration, and shared decision making.

Opioid withdrawal* — NO → **Rx self-directed start:**
- Wait for severe withdrawal then start with 8-24+ mg SL.
- Rx per "Discharge" box below.

YES ↓

16 mg bup SL** (range 8-24+ mg)

30-60 minutes ↓

Withdrawal improved? — NO → **If no improvement or worse, consider:**

Worsening withdrawal (common): Occurs with lower starting doses and heavy tolerance; improves with more bup (additional 8-16 mg SL).

Other substance intoxication or withdrawal: Continue bup and manage additional syndromes.

Bup side-effects: e.g., nausea or headache. Continue bup and treat side-effects with supportive medications.

Medical illness: Continue bup and manage underlying condition.

If sudden & significant worsening, consider precipitated withdrawal (rare): See box below.

30-60 minutes ↓ YES

Administer 2nd dose
Additional 8-24+ mg SL bup

↓

Discharge

- **Prescribe at least a 2 week supply of 16-32 mg SL bup per day.**
- **Example 2 week order:** buprenorphine/ naloxone 8/2 mg film 1 film SL TID #42,1 refill. Notes to pharmacy: OK to substitute tablets or monoproduct. Bill Medicaid FFS, ICD 10 F11.20.
- **Dispense/distribute naloxone** in-hand from the ED.

*Diagnosis Tips for Opioid Withdrawal:

1. **Look for at least two clear objective signs not attributable to something else:** large pupils, yawning, runny nose & tearing, sweating, vomiting, diarrhea, gooseflesh/piloerection, tachycardia.
2. **Confirm with the patient that they feel 'bad' withdrawal** and they **feel ready to start bup.** If they feel their withdrawal is mild, it is likely too soon.
3. **As needed, consider using the COWS (clinical opioid withdrawal scale).** Start if COWS ≥ 8 with ≥ 2 objective signs.
4. Withdrawal sufficient to start bup typically occurs 24-36 hrs after decreased/stopped use, but can vary from 6-72 hrs. Methadone withdrawal commonly takes longer.

**Bup Dosing Tips:

1. Respect patient preference. Shared decision making, flexibility, and collaboration are essential.
2. Heavy dependence/tolerance (e.g., fentanyl) may need higher doses of bup.
3. Low dependence/tolerance may do well with lower doses of bup.
4. Starting bup may be delayed or modified if there complicating factors:
   - Altered mental status, delirium, intoxication
   - Severe acute pain, trauma, or planned surgery
   - Severe medical illness
   - Long-term methadone maintenance

Treatment of bup precipitated withdrawal

(Sudden, significant worsening of withdrawal soon after bup administration.)

Act quickly

16 mg bup SL AND **2 mg lorazepam PO**

30 minutes ↓

Symptoms improved?

NO → **16 mg bup SL**

YES → **Observe & DC**

30 minutes ↓

Continued severe withdrawal?

YES ↓

Escalate level of care to manage potential moderate to deep sedation including cardiac, pulse oximetry, and end tidal CO2 monitoring:

1. Ketamine (0.3 mg/kg IV slow push q 15 minutes and/or infusion).
2. Fentanyl 200 mcg IV q10 minutes. Total dose of > 2000 mcg has been reported.

After clinical resolution, observe and discharge with bup Rx and/or XR-bup

Adjuvants:

OK but should not delay or replace bup. Use sparingly with appropriate caution.

Benzodiazepines:
- Lorazepam 2 mg PO/IV

Antipsychotics:
- Olanzapine 5 mg PO/IM

Alpha-agonists:
- Clonidine 0.1-0.3 mg PO

D2/D3 agonists:
- Pramipexole 0.25 mg PO

Gabapentinoids:
- Pregabalin 150 mg PO

Bup Rx Notes

- The X-waiver program has ended. Only a DEA license is needed to prescribe (schedule III).
- Either bup or bup/nx SL films or tab are OK.
- Bup monoproduct or bup/nx OK in pregnancy.

For pregnancy: Bup in Pregnancy
For post-overdose: Bup Opioid Overdose

For minors: Caring for Youth
For self-directed starts: Bup Self-Start

California **Substance Use Line**
(844) 326-2626

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CORRESPONDING AUTHOR

Andrew Herring, MD

AUTHORS

Erik Anderson, MD, Hannah Snyder, MD, Raul Ayala, MD, Arianna Campbell, PA-C, Bharath Chakravarthy, MD, Reb Close, MD, Alicia Gonzalez, MD, Gene Hern, MD, Andrew Herring, MD, Kevin Jones, MD, Kathy Lesaint, MD, Shahram Lotfipour, MD, Josh Luftig, PA-C, Aimee Moulin, MD, Leslie Mukau, MD, Edward Pillar, MD, Louis Tran, Rebecca Trotzky-Sirr, MD, Monish Ullal, MD, Jennifer Zhan, MD.

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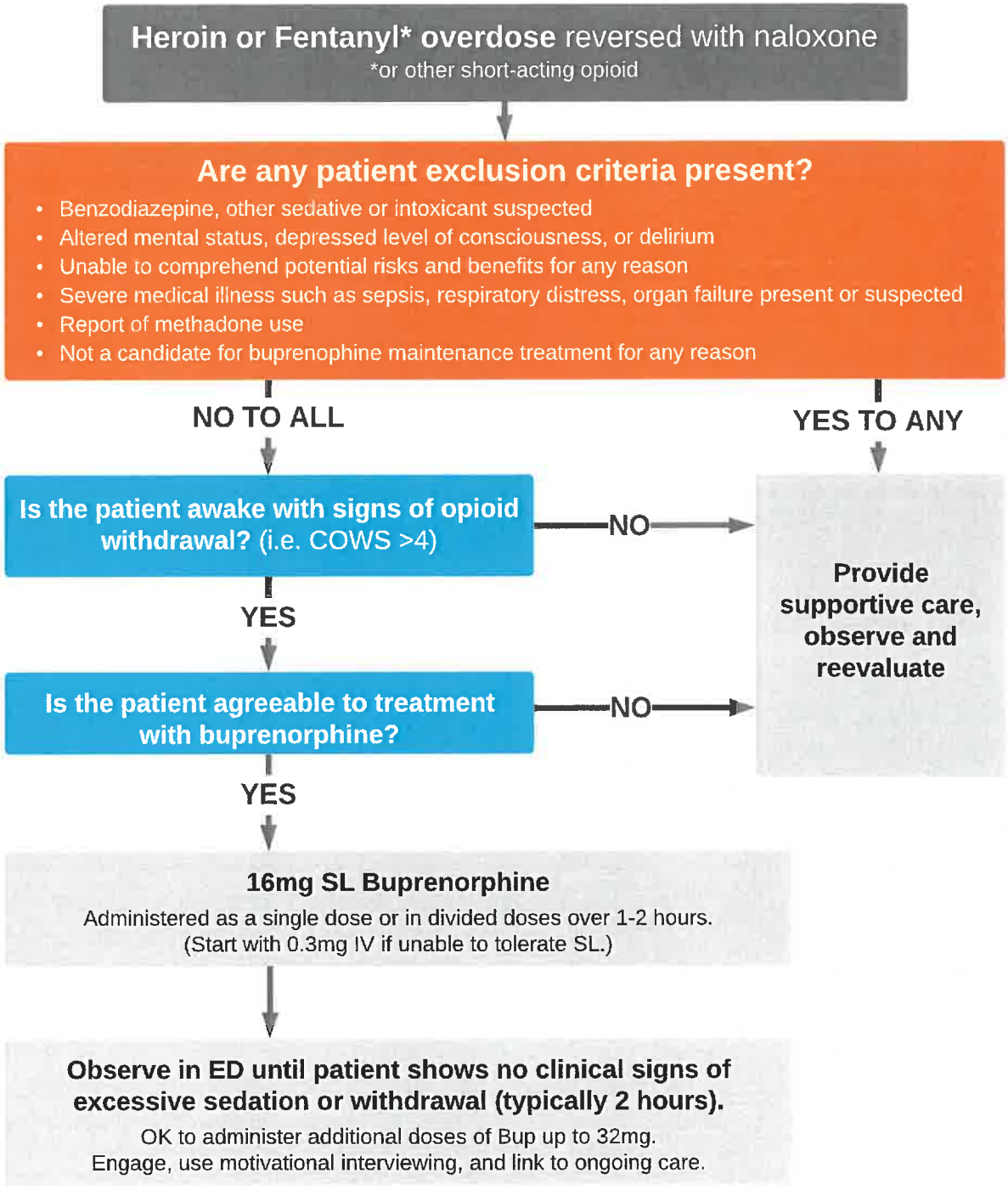
Starting Buprenorphine Immediately after Reversal of Opioid Overdose with Naloxone

Based on Herring, A. A., Schultz, C. W., Yang, E., & Greenwald, M. (2019). Rapid induction onto sublingual buprenorphine after opioid overdose and successful linkage to treatment for opioid use disorder. *The American journal of emergency medicine*.



SEPTEMBER 2020

PROVIDER RESOURCES

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CA Only (24/7)
1-844-326-2626

UCSF Substance Use Warmline
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EXPLAINER

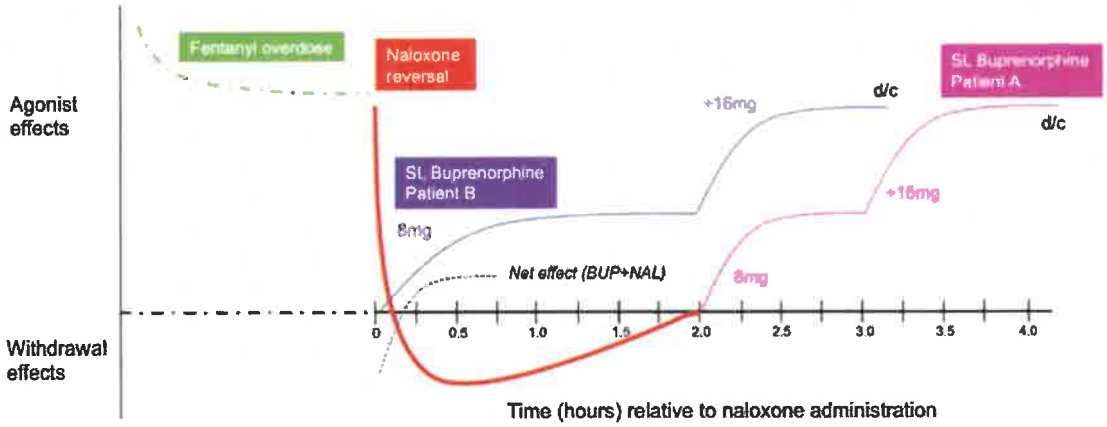
Buprenorphine After Opioid Overdose (ODNaloxoneBup)

The minimum inclusion criteria for ODNaloxoneBup is an otherwise healthy patient with no suspected co-ingestions and no recent methadone use with a normal level of consciousness, normal mental status, and the ability to provide informed consent.

Administration of buprenorphine (Bup) to patients intoxicated with alcohol, benzodiazepines or other sedative can result in potentially dangerous respiratory depression. Patients with acute illness or severe chronic illness such as infection, heart failure, liver failure, respiratory failure or acute renal failure can experience unpredictable sedation and respiratory depression.

Patients with altered mental status are not able to provide a reliable history or adequately consider the risks and benefits to provide informed consent. Patients taking methadone should be supported to continue methadone treatment; overdose is not an indication to switch to buprenorphine and may disrupt care.

Additionally, the interaction with buprenorphine and methadone is not well understood and potentially adverse antagonistic (withdrawal) interactions can occur.



Be prepared

There are two "worst case scenario" adverse events possible with ODNaloxoneBup:

1. Additive sedation with respiratory depression, and
2. Precipitated withdrawal. While neither of these has been reported at this time, any ED should be prepared and willing to adequately manage these potential complications. Reversal of buprenorphine is accomplished with high-dose naloxone (2-3mg IV push followed by 4mg/hr infusion) (9,10). Precipitated withdrawal is treated with empirically titrated with a multimodal approach that may include: benzodiazepines, alpha-2 agonists (clonidine, dexmedetomidine, lofexidine), high affinity full agonist opioids (hydromorphone), ketamine, and dopamine antagonists (e.g. metoclopramide or haldoperidol).

Why this works

Once naloxone has reversed opioid overdose (regardless of whether withdrawal signs/symptoms have been precipitated), initiation of buprenorphine should yield a relative increase in mu-opioid receptor (MOR) agonism and be experienced as stabilization or withdrawal relief. *In vitro (+NaCl),* naloxone exhibits 5-fold higher MOR affinity than morphine and comparable MOR affinity as sufentanil and, under these same physiological conditions, buprenorphine exhibits 6-fold higher MOR affinity than naloxone.

Following naloxone displacement and reversal of opioid overdose, buprenorphine is therefore expected to displace naloxone from available MORs (and residual naloxone effect should wash out rapidly due to its pharmacokinetics; (see figure above). Once bound to MORs, buprenorphine's high-affinity, longer-acting MOR occupancy should effectively prevent return of full agonist toxicity (provide opioid blockade) even if relatively high concentrations of full agonist remain in the circulation.

The positive treatment responses we have observed suggest the possibility that as naloxone is metabolized and/or displaced from MORs a mixed state of buprenorphine partial agonism and full opioid agonism (from the residual opioid that caused the overdose) occur, thereby avoiding an abrupt transition from full to partial agonism that would have been experienced as precipitated withdrawal.

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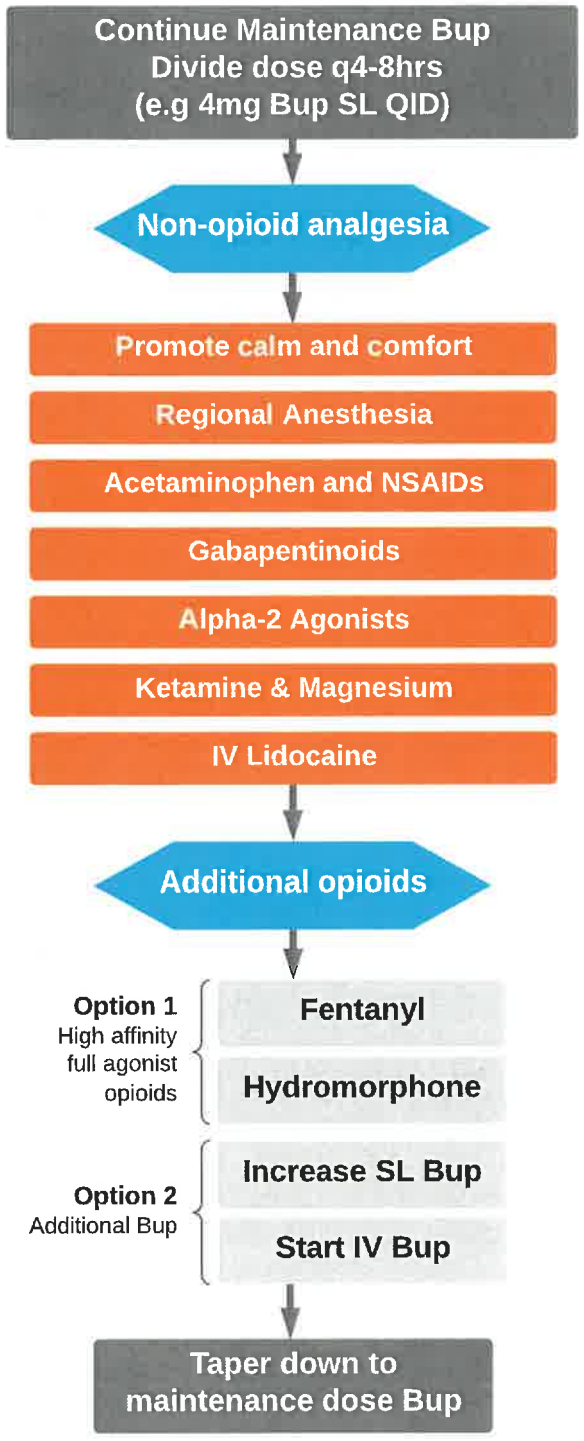
Acute Pain Management in Patients on Buprenorphine (Bup) Treatment for Opioid Use Disorder

Emergency Department / Critical Care



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 contraindicated, 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 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.

SEPTEMBER 2021

PROVIDER RESOURCES	California Substance Use Line	UCSF Substance Use Warmline
	CA Only (24/7) 1-844-326-2626	National (M-F 6am-5pm; Voicemail 24/7) 1-855-300-3595

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Acute Pain Management in Patients on Buprenorphine (Bup)* Treatment for Opioid Use Disorder

Medical/Surgical Units

James Gasper, PharmD, Andrew Herring, MD, Kyle Harrison, MD, Sky Lee, MD, Hannah Snyder, MD

Continue Maintenance Bup+
Split dose q4-8hrs
(e.g for total daily dose of 16mg = 4mg Bup SL QID)

Promote calm and comfort
Anxiety, fear, depression are common: Instill sense of control, provide education on self-management techniques such as mindful meditation. Reduce noise, uncertainty, confusion. Positioning, splinting, and physical comfort should be maximized. Minimize unnecessary NPO status.
Use adjunctive meds to treat symptoms (ie. diphenhydramine, ondansetron, melatonin, baclofen, etc).

Acetaminophen and NSAIDs
Schedule both around the clock if not contraindicated.

Non-opioid analgesia

- Gabapentinoids
- SNRI/TCA
- Regional Anesthesia
- Alpha-2 agonists
- IV Lidocaine
- Ketamine & Magnesium

Additional opioids

Additional Bup
OK to increase dose and frequency for acute pain usual dose 24-32mg/day.

Full agonist Opioids
Can be added to maintenance Bup to provide synergistic analgesia. Titrate to analgesia and side effects. This will NOT precipitate withdrawal.

***Guidelines are for patients on maintenance Bup, however if patient is on maintenance Methadone or Naltrexone:**

- **Methadone:** Confirm maintenance dose. Continue full dose, can split dosing to aid pain control. Use multimodal analgesia. *Do NOT use Bup.*
- **Naltrexone:** If injectable, stop 1 mo prior to elective surgery and switch to PO. Stop PO 72 hours prior to elective surgery for full opioid agonists to be effective.

Gabapentinoids
Calcium channel inhibitors, gabapentin and pregabalin reduce postoperative pain and opioid consumption.

SNRI/TCA
Can help with neuropathic pain as well as anxiety/depression.

Regional Anesthesia
- Peripheral nerve blocks
- Spinal or Epidural anesthesia

Alpha-2 agonists
Clonidine and Dexmedetomidine are anxiolytic and analgesic with significant opioid sparing affects.

IV Lidocaine (Na channel antagonist)
Opioid sparing analgesic.

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Buprenorphine (Bup) Quick Start in Pregnancy

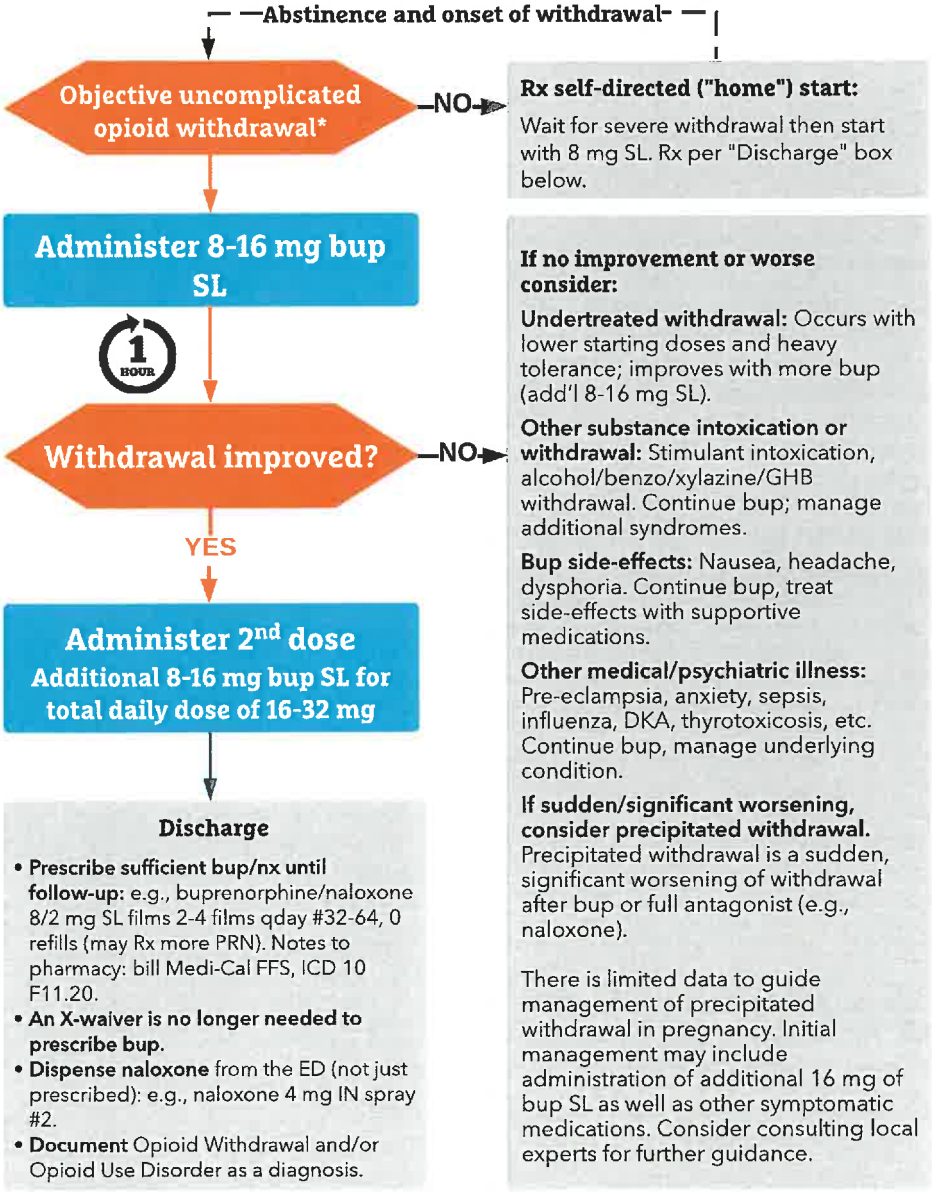
This guidance is for the emergency department (ED). We advocate for continuation & initiation of bup in inpatient and outpatient settings. Algorithms vary based on clinical scenario.

CA BRIDGE

Medication for Addiction Treatment in Pregnancy

- Any prescriber can order bup in the ED/hospital. It can also be prescribed as medication for opioid use disorder by any prescriber with an active Drug Enforcement Agency license that includes schedule III medications.
- Fetal monitoring is not required to start bup in normal pregnancy, regardless of gestational age.
- Admission for observation is NOT required for bup starts.
- Bup monoproduct or bup/naloxone (nx) is OK in pregnancy.
- Bup is a high-affinity partial agonist opioid that is SAFE in pregnancy and highly effective for treating opioid use disorder.
- Split dosing and an increase in total bup dose is often necessary, esp. in later trimesters.
- If patient is stable on methadone or prefers methadone, recommend continuation of methadone as first-line treatment.

We encourage shared decision making with patients for dosing.



Discharge

- **Prescribe sufficient bup/nx until follow-up:** e.g., buprenorphine/naloxone 8/2 mg SL films 2-4 films qday #32-64, 0 refills (may Rx more PRN). Notes to pharmacy: bill Medi-Cal FFS, ICD 10 F11.20.
- **An X-waiver is no longer needed to prescribe bup.**
- **Dispense naloxone** from the ED (not just prescribed): e.g., naloxone 4 mg IN spray #2.
- **Document** Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.

Peripartum (for planned C-Section and/or labor, or acute pain):

- Continue patient's normal bup dose in combination with multimodal analgesia that may include regional anesthesia and opioids.
- Bup is safe for breastfeeding.
- Bup reduces neonatal abstinence syndrome (NAS) severity. Dose does not correlate to NAS severity.

Postpartum:

Bup dose reduction should be gradual and per patient cravings.

Ethical Considerations:

- MAT alone is not justification for contacting Child Protective Services.
- Consent is required for urine drug testing.
- Pregnant patients have the right to determine their treatment plan.
- Delivering quality care is an essential component of reducing mortality for Black birthing people.

* Opioid Withdrawal:

At least one clear objective sign (prefer ≥ 2): Tachycardia, mydriasis, yawning, rhinorrhea, vomiting, diarrhea, piloerection. **Ask the patient if they are in bad withdrawal** and if they feel ready to start bup. If they feel their withdrawal is mild, it is too soon.

If unsure, use COWS (clinical opioid withdrawal scale). Start if COWS ≥ 8 AND objective signs.

Typical withdrawal onset >12 hours after last short acting opioid use (excluding fentanyl); variable after last use of fentanyl or methadone (may be >72 hours).

Start protocol may vary for complicating factors:

- Altered mental status, delirium, intoxication
- Severe acute pain, trauma, or planned large surgery
- Organ failure or other severe medical illness (decompensated heart failure, respiratory distress, hemodynamically unstable, etc.)
- Recent methadone use
- Minimal opioid tolerance (consider lower dosing)

Most people who use fentanyl do well with starts following this guide. For fentanyl specific initiation questions, see Fentanyl FAQ.

If patient has already completed withdrawal (no longer symptomatic withdrawal, often >72 hrs from last use of opioids) and wants to start bup: give bup 8 mg SL q6h PRN cravings, usual dose 16-32mg/day. After first day, consolidate dosing to daily.

Additional Resources:

- Prevent & Treat Opioid Withdrawal in Your Baby
- Opioid Use and Opioid Use Disorder in Pregnancy
- Pregnancy and Substance Use: A Harm Reduction Toolkit

April 2023

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

CA BRIDGE Methadone Quick Start

Follow-up clinic (phone, address, intake hours):

Follow-up clinic (phone, address, intake hours):

Opioid use disorder (OUD) & wants methadone*
No complicating factors**

New start → **Day 1: 30 mg methadone**

In treatment → **Call opioid treatment program to confirm dose*****

Hospitalized Patients

Day 2: 40 mg methadone → **May administer an additional 10 mg methadone 4 hours after daily dose if no sedation.**

Day 3: 50 mg methadone → **May administer an additional 10 mg methadone 4 hours after daily dose if no sedation.**

- **Day 4 and beyond: Increase methadone by 10 mg every 3-5 days.**
- If methadone doses do not control withdrawal, short acting opioid agonists can be administered.
- Methadone can be continued throughout hospitalization. No additional licensing required (X-waiver removed, Jan 2023).

DISCHARGE

- Provide patient with information on how to link to methadone clinic next day, or have them return for doses every 72 hours. Methadone may not be prescribed at discharge for the treatment of OUD.
- Patient should have naloxone 4mg/0.1ml in hand at discharge.

Methadone vs buprenorphine (bup) for patients*

- Methadone ED starts are only suggested when patients are able to follow up in a methadone clinic (OTP) within 72 hours. Work with local clinics to expedite follow up.
- Methadone and bup are both great options that decrease all cause mortality and overdose.
- If a patient is struggling to wait for withdrawal to start bup, methadone may be an option.
- You usually must go to an OTP for daily dosing.
- If methadone dose too high or if mixed with other depressants, may cause sedation.

Complicating Factors**

- RR <10 or sedated
- Low opioid tolerance
- Allergy to methadone
- Known QTc ≥500 (do not need to check EKG to start methadone routinely)
- Recent use of benzodiazepines, alcohol, or other sedatives
- Severe liver disease
- Medically unstable
- Methadone safe in pregnancy & breastfeeding

Patients already in methadone treatment***

- Call clinic to confirm dose amount and when it was last administered.
- If unable to confirm dose, treat as a new start until able to confirm.
- Methadone dispensed from a clinic is never listed in CURES, and some hospitals urine toxicology will not show methadone.
- If 1-2 days missed, administer the full dose.
- If additional days missed, ask the clinic for recommended dosing. Ex: 90% if 3 days missed, 80% if 4 days missed, 70% if 5 days missed, 60% if 6 days missed, 50% if 7 days missed, 40% if 8 days missed.

Regulations

- General acute care hospitals may treat addiction with methadone under their existing license.
- ED may administer methadone for 3 days in a row. If a patient is hospitalized, administer throughout their hospitalization.
- Methadone cannot be prescribed for the treatment of OUD.
- Hospitals can apply to the DEA for a waiver to dispense a 72 hour supply of methadone to help patients connect to a clinic.
- OTPs can only provide methadone if patients have been opioid dependent for at least 6 months.

Pharmacologic notes:

- Can use adjunctive medications for withdrawal symptoms.
- In cases of high tolerance, including fentanyl use, may need additional dose of full opioid agonists to control withdrawal; only while patient is in the hospital.
- Sedation from methadone peaks at 3-4 hours after each dose, patients experiencing sedation should not receive additional doses.
- Half-life of methadone is more than 24 hours, so doses can stack and sedation can occur after multiple days at the same dose.
- Bup should not be given to patients who are currently taking methadone, as this would cause withdrawal.
- Methadone has many significant drug-drug interactions. Before starting new medications, always check the effect on methadone levels to avoid over-sedation or withdrawal.

March 2023

PROVIDER RESOURCES

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

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

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Methadone Quick Start

CORRESPONDING AUTHOR

Hannah Snyder, MD

AUTHORS

Erik Anderson, MD, Raul Ayala, MD, Arianna Campbell, PA-C, Bharath Chakravarthy, MD, Reb Close, MD, Alicia Gonzalez, MD, Gene Hern, MD, Andrew Herring, MD, Kevin Jones, MD, Kathy Lesaint, MD, Shahram Lotfipour, MD, Josh Luftig, PA-C, Aimee Moulin, MD, Leslie Mukau, MD, Edward Pillar, MD, Louis Tran, Rebecca Trotzky-Sirr, MD, Monish Ullal, MD, Jennifer Zhan, MD

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MEDICATION INTERACTIONS

Medications that increase methadone metabolism/decrease methadone effect (INCREASED RISK FOR OPIOID WITHDRAWAL)		
• Phenytoin • Dexamethasone • Ritonavir containing drugs incl: nirmatrelevir/ritonavir (Paxlovid)	• Phenobarbital • Rifampicin/rifabutin • Vitamin C (ascorbic acid)	• Carbamazepine • NNRTIs (efavirenz, nevirapine) • St John's Wort
Medications that decrease methadone metabolism/increase effect (INCREASED SEDATION/CNS DEPRESSION)		
• SSRI Antidepressants • Cimetidine • Chlorpromazine • Azoles	• Fluoroquinolones (increased sedation and prolonged QTc time) • Risperidone • Grapefruit juice	• Diltiazem • Dextromethorphan • Indinavir

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GUIDE

Acute Care Treatment of Alcohol Use Disorder

QUICK REFERENCE

Steps to reduce emergency department visits and help your patient by combining withdrawal treatment with craving reduction:

1. **Treat Acute Withdrawal**

   Use your preferred strategy/hospital standard practice with benzodiazepine and/or phenobarbital to treat acute withdrawal.

2. **At Discharge**

   a. Prescribe Medication for protracted withdrawal.

   Gabapentin 600mg-900 TID, #42

   - Avoid/use with caution in renal disease.
   - If history of severe withdrawal may need additional treatment including with benzodiazepines)

   b. Prescribe Medication to reduce craving and relapse.

   Naltrexone 50mg PO Daily #14;

   Contraindications:

   - Any opioid use--incl. planned surgery/anesthesia, buprenorphine starts, or OUD
   - Acute liver injury with LFTS > 5x normal
   - Decompensated cirrhosis

3. **Contact the SUN (Substance Use Navigator)**

   The SUN will problem solve, motivate and arrange follow up care.

4. **At follow up**

   Offer 30day Naltrexone injection (Vivitrol)

GUIDE

Acute Care Treatment of Alcohol Use Disorder

Eleven million Americans have an alcohol use disorder while two million Americans have an opioid use disorder. Screening, brief intervention, and referral to treatment is proven to decrease risky drinking and alcohol use disorder-related behaviors in acute care settings. Targeting patients presenting for trauma may be particularly effective.

This guidance is for hospitals participating in the California Bridge Program who would like to incorporate treatment for alcohol use disorder into their emergency departments and inpatient settings. This is part of the *Practice Under Development* series presenting information about practices we are piloting and continuing to refine. This guidance does not focus on withdrawal treatment, rather the focus here is on the initiation of medications to decrease cravings and acute care utilization.

Consider screening:

- Men < 65 yo: *How many times in the past year have you had 5 or more drinks in a day?*
- All women, men > 65: *How many times in the past year have you had 4 or more drinks in a day?*

Alcohol withdrawal management:

- Treat per the protocols of your facility
- Consider phenobarbital, benzodiazepines
- Consider gabapentin (ex: gabapentin 600 mg PO TID #42), caution in renal disease, if severe withdrawal may need additional treatment

Offer maintenance treatment:

- First line is naltrexone, which is FDA approved for AUD treatment:
    - **Naltrexone PO:**
        - E.g.: naltrexone 50 mg PO, 1 tab PO qday, dispense #14, 0 refills
    - **Naltrexone IM:**
        - Consider if patients unable to take daily medication, but have tolerated PO naltrexone
        - Naltrexone 380 mg IM x 1 in buttock monthly – consider at least one trial PO dose before injection
        - Covered by MediCal for outpatient treatment, pharmaceutical company may be able to provide acute care doses
    - *Cautions and contraindications:*
        - Avoid if patient has active OUD or opioid dependence or is on buprenorphine (recommend at least 7 days off of opioids if physically dependent)—can consider test dose of naloxone or PO naltrexone to ensure no withdrawal
        - Avoid if planned surgery or anesthesia needed
        - Avoid if AST and ALT >5x upper limit of normal or Childs Pugh class C
    - *Adverse effects:*
        - Headache, GI distress, opioid withdrawal, injection site reaction, transaminitis
- Second line: Multiple agents, select based on comorbidities and patient preference (see table below)

Discharge from acute care with direct linkage to ongoing treatment if possible in clinic, intensive outpatient program, medically assisted withdrawal (detox) facility, residential treatment as fits patient's interest and program availability

Consider the first dose of IM naltrexone in acute care for those who have not been able to successfully connect on prior presentations if possible

Always contact your SUN who can work with the patient to motivate, make shared decisions, and ensure follow up.

	Target population	Efficacy	Contraindications/ADEs	Dosing
Naltrexone (first line)	First line for most people without contraindications	NNT 9 for return to heavy drinking	Opioid use (risk of withdrawal), planned surgery/anesthesia AST and ALT >5x ULN ADEs: HA, GI distress, opioid w/d, injection site rxn, transaminitis	50 mg PO **qday** OR 380 mg IM **qmonth**
Topiramate	Consider if also using cocaine, PTSD, seizure hx, overweight	NNT 7.5 for return to heavy drinking 7.5	Dose reduce in CKD Cognitive slowing, weight loss, paresthesias, altered taste, metabolic acidosis Avoid if hx kidney stones, narrow-angle glaucoma	Goal 150 mg ***BID*** (slowly uptitrate)
Baclofen	Consider if also chronic pain, liver disease	Not effective in meta-analyses	Dose reduce in CKD Somnolence, dizziness	10-20 mg ***TID***
Gabapentin	Consider if neuropathic pain, anxious, EtOH withdrawal Helps when added to naltrexone if naltrexone had some efficacy	Mixed evidence	Dose reduce in CKD Somnolence, dizziness, GI effects, HA Note, some abuse liability and can potentiate opioids	600 mg ***TID***
Acamprosate (FDA approved)	Patients who are already abstaining, prevents relapse, safe in liver disease	NNT 9 to reduce risk of any drinking	Dose reduce in CKD Causes diarrhea, fatigue, GI upset	2x 333 mg tablets ***TID***
Disulfiram (FDA approved)	Patients who are already abstaining, prevents relapse, only effective if observed dosing by family, opioid treatment program	If not directly observed, outcomes similar to placebo	Causes physical illness if return to use, do not start if ongoing EtOH use Causes metallic taste, hepatotoxicity, optic neuritis, peripheral neuropathy	250-500 mg **qday**
Varenicline	Men who are also smokers	Decreased heavy drinking in male smokers	Dose reduce in CKD Caution in depression	2mg **qday** (start with 0.5 qday and uptitrate)

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Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

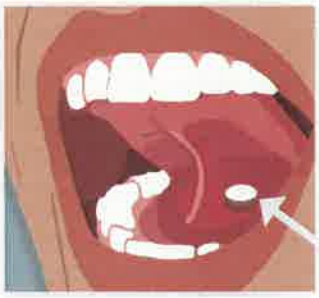
1. Plan to take a day off and have a place to rest.
2. Stop using and wait until you feel very sick from withdrawals (at least 12 hours is best, if using fentanyl it may take a few days).
3. Dose one or two 8mg tablets or strips UNDER your tongue (total dose of 8-16mg).
4. Repeat dose (another 8mg-16mg) in an hour to feel well.
5. The next day, take 16-32mg (2-4 tablets or films) at one time.

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 out what happened and find ways to make it better this time. You may need a different dosing plan than what is listed here.

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 makes starting bup harder, and mixing in alcohol or benzos can be dangerous.



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:** Withdrawal will continue if you don't take enough bup.

If you have a heavy habit: *(For example, injecting 2g heroin a day or smoking 1g fentanyl a day)*

- Consider a high dose: start with a first dose of 16mg.
- For most people, the effects of bup max out at around 24-32mg.
- **WARNING:** Too much bup can make you feel sick and sleepy.

Not going well? Have questions? Contact your Navigator for help!

Call or text your Navigator for help at _____

3.28.22

FREQUENTLY ASKED QUESTIONS

Medications for Addiction Treatment and Trauma-Informed Care: Pregnancy

This fact sheet provides answers to frequently asked questions regarding the use of medications for opioid use disorder during pregnancy. It also covers how to address substance use disorders during pregnancy utilizing principles of trauma-informed care.

Key Points:

- Buprenorphine and methadone are safe and effective during pregnancy and breastfeeding. Both are recommended for treatment for opioid use disorder by ACOG.
- Admission to the hospital or fetal monitoring regardless of gestational age is not required to start buprenorphine or methadone.
- A positive urine drug test does not diagnose a substance use disorder and ACOG requires patient consent.
- Neonatal abstinence syndrome (NAS)/neonatal opiate withdrawal syndrome (NOWS) is a potential side effect of medications for opioid use disorder, independent of dose. Rooming-in and breastfeeding help decrease NAS/NOWS.
- Patient preference and shared decision making is paramount in developing treatment plans for opioid use disorder.

MEDICATION FOR OPIOID USE DISORDER (MOUD)

Are treatments for Opioid Use Disorder (OUD) effective?

Yes. Medications for OUD (buprenorphine, methadone or XRT-naltrexone) are effective, with 60-80% of patients still engaged in care at 1 year,[1,2,3] and a reduction in all-cause mortality by at least 50%.[4] In pregnant patients, treatment reduces HIV, HCV, and HBV infection, and improves engagement in prenatal care as well as neonatal outcomes (i.e., birth weight).[5]

Is detox (medical withdrawal) and abstinence recommended for pregnant patients with OUD?

No. Medical withdrawal is not recommended during pregnancy as recurrence rates are high (59-99%),[6,7] and it is associated with worse maternal outcomes.[6] Some data suggest fetal safety during medically assisted opioid withdrawal in pregnancy.[6,7]

Is treatment with buprenorphine (or buprenorphine/naloxone), methadone or naltrexone safe in pregnancy?

Buprenorphine (the mono-product or the buprenorphine/naloxone combo product) and methadone are safe and effective to use in pregnancy,[8,9] and use of either is the standard of care for pregnant people with opioid use disorders.[10] Most studies of buprenorphine in pregnancy used the mono-product (buprenorphine only), although limited data suggest the combination product (buprenorphine and naloxone) is also safe. Many experts offer either product based on patient preference, availability and diversion concerns.

There is extremely limited data on use of naltrexone in pregnancy. Continuation of naltrexone for people who become pregnant on this medication can be considered on a case-by-case basis. Initiation of naltrexone in pregnancy is not recommended at this time due to limited clinical data.[10]

What about extended release formulations (injectable) buprenorphine?

Extended release buprenorphine (Bup-XR) currently has one formulation on the market (Sublocade). This formulation of Bup-XR contains an excipient (NMP) which has been shown to have adverse fetal effects in animal models.[11] Most experts do not recommend the use of this formulation of Bup-XR during pregnancy. However, there is a clinical trial to study the impact of a new formulation of Bup-XR (CAM2038) in pregnancy, which may offer an extended release option of buprenorphine to pregnant people in future.[12]

STARTING TREATMENT AND COUNSELING

How do I build trust with the pregnant patient with OUD in front of me? How do I offer treatments in a non-stigmatizing, trauma-informed way?

First and foremost, listen to the patient and prioritize their goals. Provide options for treatment (methadone, buprenorphine combo or mono products) and options for how to engage in treatment (home, clinic-based, inpatient inductions). Universal precautions for trauma (trauma-informed care) suggest we should engage with patients assuming that a history of trauma is present without needing to know the specifics, and that simple interactions (examination and interview) can be triggering and counterproductive to treatment goals.

Initial counseling strategies include (1) focusing on strengths, (2) acknowledging the natural progression of substance use disorders as chronic and relapsing, (3) welcoming people back if they return to use or fall out of care, (4) exploring parenting goals rather than making assumptions, and (5) nonjudgmental discussion of prior CPS involvement and patient concerns. Additionally, recognizing that opioid use during pregnancy is common (5.6 per 1000 live births)[13] can normalize this condition and treatment as part of routine care.

Is buprenorphine or methadone better for my pregnant patient with OUD? How should I present treatment options to pregnant people?

The decision to start or choose medication is based on patient preference and should be individualized. Buprenorphine and methadone are both safe and effective options.[10] If the patient is stable on methadone or buprenorphine already, it is not recommended to switch to the other medication as there is an increased risk of withdrawal and subsequent return to use during the transition.[10]

The health care provider's role is to inform patients of their options and support individuals to make decisions that best meet their needs, preferences, and priorities. Methadone has been used for more years and has slightly higher retention in treatment, while buprenorphine has less severe neonatal abstinence syndrome.[9] Practical considerations often drive patient-centered decision making. These should include: frequency of clinic visits (methadone requires daily dosing at a clinic, usually for 3 or more months, before take-home doses are offered); access (where is the nearest methadone clinic or buprenorphine provider?); risk of neonatal withdrawal after birth; and, most importantly, patient preference and engagement with the treatment plan.

How will buprenorphine or methadone affect the fetus? What about the risk of neonatal abstinence syndrome (NAS) or neonatal opiate withdrawal syndrome (NOWS)?

Neonatal abstinence syndrome (NAS) and neonatal opiate withdrawal syndrome (NOWS) refer to the same condition – withdrawal of the newborn in the days and weeks after birth. While concern for NAS/NOWS has been identified as one of many concerns for pregnant people seeking treatment for opioid use disorder,[14] there is no evidence to suggest long-term negative impacts on the child, even if NOWS develops.

Compared to methadone, buprenorphine has been associated with decreased NOWS, shorter hospital duration by 50% and opioid need by 10-fold,[6] decreased likelihood of preterm birth, and increased head circumference.[8,9] Despite these relative benefits of buprenorphine, methadone treatment is still associated with decreased preterm birth, increased birth weight, and increased head circumference when compared to no treatment for OUD. Therefore, methadone continues to be an

important option for pregnant people with OUD. The risk of developing NOWS is not generally considered to be dose dependent for methadone or buprenorphine – higher doses will not increase risk or severity of NOWS.[10, 15]

Importantly, recent studies demonstrate that rooming-in with the mother (ex: Eat Sleep Console protocols) can reduce the use of morphine, length of stay and be cost-effective.[16,17,18] Breastfeeding, in particular, has been shown to reduce NOWS severity.[19,20]

How do I start buprenorphine or methadone? Can I start in the emergency department or outpatient clinic without fetal monitoring or inpatient admission?

Methadone or buprenorphine starts do not generally require admission or fetal monitoring, regardless of gestational age.[10] Many institutions offer admission for induction to increase support particularly for patients experiencing homelessness, other triggering home environments, or for person-centered care. For specific details on dosing please see the CA Bridge Methadone Hospital Quick Start or Buprenorphine Quick Start for Pregnant Patients.

URINE DRUG TESTING

Is performing a urine drug test (UDT) necessary or even required for treatment? Can I order it without asking the patient?

A Urine Drug Test (UDT) is not needed for treatment initiation if a patient demonstrates clinical signs of opioid tolerance and withdrawal with a history consistent with opioid use disorder. Presence of illicit substances on a UDT can have negative unintended consequences so should be weighed carefully and be clinically indicated to drive care. Per the American College of Obstetricians and Gynecologists (ACOG) Guidelines,[10] a UDT requires verbal or written consent and the patient should be informed of any ramifications of a positive test.

UDT can be helpful to determine when to initiate buprenorphine based on the presence or absence of longer-acting opioids (i.e. non-pharmaceutical fentanyl or methadone) which may be intentionally or unintentionally present in street-purchased opioids. Finally, UDT can be offered from a place of strength to demonstrate recovery in the medical record. Some patients appreciate the opportunity to show their recovery; others do not. Talking with patients about why you are offering a UDT is an opportunity to build trust and share decision-making around MOUD-related care.

Most importantly, UDT should be offered when clinically indicated or when requested by the patient. The decision to test should be intentional in avoiding perpetuating stereotypes or motivated by bias.

How do I interpret a UDT?

The substances included in urine drug testing (UDT) at every institution varies. If clarification is needed on interpretation please call the lab at your institution. The most common false positives are from amphetamines; some labs will offer automatic reflex testing, and if not, these must be added on separately. Fentanyl and clonazepam are the most common false negatives and can be evaluated via separate testing or a comprehensive test. Cocaine, when present, is rarely a false positive. When evaluating if prescribed versus illicit benzodiazepines are used, order a comprehensive urine test and specify in the comments what you are looking for. Most importantly, a positive UDT does not indicate a substance use disorder. The diagnosis of a substance use disorder is made via the DSM V criteria.

CARE DURING PREGNANCY, LABOR, AND BIRTH

How does methadone or buprenorphine dosing change during pregnancy?

Metabolism of methadone (and to a lesser degree, buprenorphine) increases during pregnancy. Patients may need to increase the maintenance dose and frequency (usually splitting the dose to BID, TID or QID) to help control cravings.[21]

Should I adjust methadone or buprenorphine for pregnant people who present in labor or for birth?

Both buprenorphine and methadone should be continued peripartum and in the perioperative period for patients previously maintained on these medications. Discontinuing these medications will cause withdrawal and increase pain.

Should I start buprenorphine or methadone during labor, or wait until after birth?

If the patient is not yet on buprenorphine or methadone prior to birth, we recommend starting on admission rather than waiting for the post-partum period (including for cesarean birth). Managing withdrawal during labor can be incredibly challenging for patients and providers; consultation with anesthesia colleagues and the Substance Use Warm Line is strongly recommended.

How do I manage pain during labor/cesarean birth or other acute pain episodes?

Assuming medications for opioid use disorder have been initiated, first line treatment for perioperative pain management should use a multimodal approach. Discussing the pain management plan at an antenatal visit can decrease stress and address concerns. First line treatment includes epidural or spinal anesthesia, non-opioid analgesics, and sometimes full opioid agonists. Adding full agonists for patients already on buprenorphine will not precipitate withdrawal, but higher doses are usually needed due to increased tolerance. Avoid using partial agonist/antagonist medications such as butorphanol, nalbuphine, and pentazocine as these drugs can precipitate withdrawal in patients on buprenorphine.[22,23] Pregnant patients on buprenorphine compared to methadone have been shown to have similar opioid needs, postoperative complications, and length of hospital stay.[24]

POSTPARTUM CONSIDERATIONS

What do I need to know for the postpartum period? Should the dose of buprenorphine or methadone change?

If the dose of buprenorphine or methadone was changed in pregnancy, dose reduction to pre-pregnancy dose (if applicable) may be needed. A reduction postpartum should be based on the patient's cravings and side effects (particularly sedation in the case of methadone treatment). In general, postpartum medication adjustments need not be rushed as there is a large range and variation (days versus months) of when patients need to return to pre-pregnancy dose.[10] However, assessing for sedation in postpartum patients on methadone at peak drug effects, approximately 2-4 hours after dosing, may be prudent while patients are hospitalized.

In addition, frequent check-ins should be offered as the risk of overdose and return to use significantly increases postpartum. Patients should be screened for postpartum depression and offered contraception in a person-centered manner.[10]

Can patients breastfeed while taking buprenorphine or methadone?

Yes. Breastfeeding is recommended by ACOG (2017),[10] American Academy of Breastfeeding Medicine (2015),[25] American Academy of Pediatrics (2013)[26] and Lactmed[27] regardless of maintenance dose. Breastfeeding is safe and only negligible amounts of buprenorphine or methadone are transmitted through breast milk.

Patients should be offered to breastfeed if there are no other contraindications.[10] In general, the only indications to recommend against breastfeeding are in: (1) people who intend to continue using illicit substances, and (2) people with other contraindications to breastfeeding (irrespective of substance use). It is important to support individual choices to breastfeed or not, regardless of context. Even if people are using illicit substances up until birth, some institutions support a pump and dump policy until urine becomes negative for illicit substances, followed by a plan to support recovery and breastfeeding.

What about CPS? What is the legal mandate?

As noted in ACOG guidelines, "It is our ethical obligation to pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed."[28] CPS cannot be called before birth in California. The decision to call CPS should NOT be made in the middle of the night and SHOULD be decided after a multidisciplinary case review including an addiction specialist where possible. Many institutions advocate for a multidisciplinary review of cases prior to calling CPS to reduce discrimination and bias in reporting. Regulations vary by state, and it is important to become familiar with true regulations to differentiate interpretations from requirements. A 2016 review showed that in the US, only 18 states require reporting for suspected prenatal use and 4 require testing if suspected.[29]

HARM REDUCTION STRATEGIES

I am seeing a patient who is not ready to start medications for OUD (MOUD). Is there anything else I can do for this patient today?

Yes! You can discuss methods to reduce harm. Explore if alternate routes of use (other than injection) would be acceptable to the patient, prescribe naloxone, encourage patients to use with others when possible, encourage patients who use alone to call Never Use Alone (1-800-484-3731), and provide information on how to access care regardless of medication use.

Overall mortality from drug use exceeds that of motor vehicle collision in the US,[30] with maternal mortality related to opioid use at 11 to 12-fold increased risk,[31] and high rates of fatal overdose in the first year after delivery.[32] In California, substance use is the second most frequent cause of death in the postpartum period (3.68 per 100,000 person-years).[33] With so much at stake, addressing any level of harm reduction is crucial.

AUTHORS

Jessica Ristau, MD, University of California, San Francisco; Dominika Seidman, MD, MAS, University of California, San Francisco; Hannah Snyder, MD, University of California, San Francisco; Tricia Wright, MD, MS, University of California, San Francisco; Miskha Terplan, MD, MPH, University of California, San Francisco; Sky Lee, MD, University of California, Davis

RESOURCES

Never Use Alone neverusealone.com; 1-800-484-3731

Substance Use Warm Line nccc.ucsf.edu

- *California Substance Use Line 24/7:* 1-844-326-2626
- *National Substance Use Warmline Monday-Friday 6am-5pm PST:* 1-855-300-3595

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GUIDE

Care for Patients with Opioid Use Disorder Who Are in Custody

BACKGROUND

Many community and academic medical centers care for patients who are in custody. In these settings, providers often use evidence-based practices to treat opioid use disorder (OUD), opioid overdose, and opioid withdrawal with medications for opioid use disorder.

People who have been incarcerated are at risk of death from overdose 100 times greater than the general population. Providing Medication for Addiction Treatment (MAT) in correctional facilities decreases the overdose mortality by over 60 percent.[1] It is important to treat OUD, and other substance use disorders, as chronic medical conditions with effective treatment for all patients. Patients in custody have the same right to health care services as all other patients, and there is broad support by national criminal justice and health care organizations for making all forms of MAT available to persons with OUD within the justice system.

Across the country, jails vary in their readiness to implement MAT. In California, more than 30 jails representing over 80 percent of the state population have committed to improvements to the accessibility of MAT. Still, transitions of care between confinement and community settings are critical to ensure rapid identification and treatment of OUD for all patients.

Because most jails do not have methadone licenses or contracts, this document highlights the use of buprenorphine (bup) treatment of OUD. Additionally, some patients, upon release from structured care settings like jail, do not want to connect to daily observed dosing that is required by methadone centers. Bup provides safe, effective, and flexible outpatient care for patients experiencing OUD. However, if a jail has access to methadone, this can be a great option for some patients. Both buprenorphine and methadone save lives, and offering both options is ideal.

Key Messages

- While it is preferable to continue bup without interruption, it is always better to start or provide bup even when you can't ensure it will be continued. Exposure to treatment with bup provides a period of symptom relief, immediate overdose protection, and familiarization with the positive effects of the medication. These benefits occur even when patients are unable to continue treatment while incarcerated.
- Any positive treatment experience, even for just one dose, supports a patient's understanding that OUD is a treatable medical condition and that the healthcare system can provide a positive healing experience.
- Providers should treat patients in custody the same as all other patients: do not share protected health information without your patient's consent or a court order. Sheriffs and police officers are not medical providers: do not share medical information with non-medical personnel of a jail unless given permission or court-ordered.
- Just like hospital to nursing home transfers, it is appropriate and expected to share transition of care information to a medical care team in a custody setting.
- Many patients in jail custody have not been convicted of a crime and are released within a few days or weeks. Therefore, provide all patients with information on connecting to outpatient treatment upon release.
- Remind patients that on release from jail, community Emergency Departments and urgent cares in the CA Bridge Program serve as 24/7 safety nets allowing them access to bup to start or restart treatment at any time.

GUIDING PRINCIPLES

Across the medical care continuum, provide evidence-based treatment for opioid withdrawal and OUD.

Just like any patient population, patients in custody are excellent candidates for treatment of withdrawal and opioid use disorder. Patients in custody may be cared for in any care setting. At some point, nearly all hospitals and emergency departments care for patients in custody – often in the usual care areas of the ED, hospital, specialty clinic, intensive care unit (ICU), or surgical centers. There also may be a special jail ward in the hospital or ED.

It is important to recognize and treat patients for OUD and opioid withdrawal in any and all care settings.

Across the legal continuum, provide treatment for opioid withdrawal and OUD.

Patients may be evaluated for medical care in any stage of the legal process: prior to booking, while awaiting trial, during trial, pre or post-conviction. If a patient is in your care, you can treat OUD and opioid withdrawal across the legal process. Buprenorphine is the first line treatment for OUD and opioid withdrawal for all patients, regardless of their legal status.

Even one dose of buprenorphine supports a patient's recovery.

One dose of bup for a patient in active withdrawal will lessen a patient's withdrawal symptoms. While we strongly recommend continuation of bup in jail, the decision to treat opioid withdrawal or OUD in other institutions will vary.

STEPS TO ENSURE HIGH QUALITY, CONTINUOUS CARE FOR PEOPLE WITH OPIOID USE DISORDER IN CUSTODY

1. **Make a clear diagnosis.**

   Clearly diagnose "OUD, moderate or severe" (ICD-10-CM code F11.21) or "Opioid Overdose" (T40.2X1A) or "Opioid withdrawal" (F11.23) in your EMR to ensure transition of care information is clearly recorded.

2. **Provide treatment.**

   Provide bup dosing while the patient is in your care, for patients with withdrawal, even when you cannot confirm that the patient will be continued on bup later. If you anticipate a one-time only dose to treat withdrawal because your local jail will be unlikely to continue treatment, dose at 24mg or 32mg total daily dose for increased duration of effect. This higher dose may suppress cravings and protect against overdose for 2 days or more.

   - If a patient is outside of the withdrawal window and with clear opioid use diagnosis, starting treatment at 16mg bup daily to prevent relapse is reasonable.
   - If your patient is on MAT previously started in the community, reconcile this treatment as a "home medication." While a patient is in your care, generally continue MAT. On transfer, encourage MAT continuation upon transition to jail.

3. **Advocate for the continuation of MAT.**

   As a healthcare provider, you should strongly advocate for the continuation of MAT for all patients. Hospitals and EDs may be an immediate source of MAT for patients in custody. Reach out to the jail to recommend continuation of bup and discuss how this could occur. Many jails are building the capacity to continue bup started in the community. You may discover that the hospital can send a prescription or several days of medication to cover the jails' need to access continuation medication since many jails are not able to stock this controlled substance.

   - If your patient is pregnant, it is extremely important that the patient is treated for OUD, with bup as the first line medication to support maternal and fetal health. Most facilities will provide bup for pregnant patients.
   - Other special populations that may be supported by jail health services include pediatrics, patients who are co-infected with HIV or Hep C, or have high risk of recurrent overdose while in custody.

4. **Provide clear instructions to the patient.**

   Provide clear verbal and written patient instructions that include diagnosis, treatment plan, and follow-up available in the community. Provide written transition of care information to the accepting medical team in jail. Consider a warm hand-off to the jail's medical team if this will increase your patient's chances of continuing MAT in jail.

5. **Get medication to patients along with options to access care for mixed stages of institutional readiness.**

   When your jail system does not provide treatment for patients with OUD to support post-release care upon re-entry to the community:

   - Send a prescription for naloxone and bup-naloxone (8/2 mg SL films 2-4 films daily or BID #64, 1 refill) to the outpatient pharmacy.
   - Select a pharmacy in your care system at a location near to a patient's anticipated discharge home or near the jail. Prescriptions for controlled substances like bup are active for up to six months. Other medications can be active for up to a year after prescribing. Naloxone rescue is active for a year.
   - Inform your patient that these prescriptions will be available upon release from jail for pick up in the community. Alternatively, provide a printed bup prescription and dispense naloxone from the ED or urgent care during medical clearance to be secured along with the patient's possessions while in custody, then returned to the patient upon release.

6. **Advocate within the jail health team for evidence-based treatment for your patients.**

   Make clear your individualized medical recommendation to jail providers. The general recommendation is to continue treatment of at least 16-24mg SL bup (2-3 tab/film buprenorphine-naloxone 8mg-2mg) daily while your patient is in jail. Clearly state your medical opinion that your patient receives appropriate treatment while in jail. Reinforce that using bup for withdrawal only is not an evidence-based practice, and does nothing to reduce cravings or the risk of relapse. It is ethical and legal to document that you made the appropriate medical decision and attempted to ensure care continuity for all your patients, even when presented with external institutional barriers.

7. **Identify and support modifiable care gaps across institutions.**

   - ***Example:*** *"We don't do buprenorphine."*

     If your jail is currently resistant to providing medical standard of care for treatment of OUD, continue to advocate treatment of each individualized case. You are not alone! Reach out for support on how to build relationships to transform the culture of health on this issue.

8. **Exiting jail, hospital, and ED and returning back to the community is a high-risk time for overdose deaths.**

   You should encourage patients to be started, continued, or restarted on MAT and provide them with naloxone before release into the community. While the medical standard is to continue the stable dose of bup throughout custody without interruption, operational or political barriers often make this impossible. Alternatively, start or restart patients on bup before release into the community. There is no strong evidence for significant central sedation caused by treatment doses of bup; even when restarting, central sedation is far less common than any other opioid such as methadone.

   While there is variability based on local constraints, you should provide a pre-release on-ramp to community treatment. This includes at least 5-7 days of 16-24mg daily sublingual bup immediately before release. In a community setting, there is strong evidence for 16mg bup as a dose that reasonably allows our patients to reach a steady-state therapeutic level before release. Since many people in custody have short stays and unexpected release, focus should be on brisk titration to therapeutic levels.

   Many people with OUD leaving custody settings are opioid non-dependent patients i.e. they are not currently taking bup or other opioids, typically due to facility restrictions on access to MAT.

- **A reasonable rapid bup start or restart prior to release for these patients is:**
    - Day 1: 16mg SL bup daily
    - Day 2 until release: 16-32mg SL bup daily
    - We recommend implementing a protocol that maximizes the number of days patients receive treatment, within local constraints.
- **Other important details to consider upon exiting jail:**
    - Give the patient bup on the day of release or transfer to a new facility, even when that means providing bup earlier than usually scheduled.
    - For patients that are released unexpectedly without prior starts of bup, even one dose of 8mg SL buprenorphine-naloxone on release day will confer some protective effect against opioid overdose death.
- **On release:**
    - Prescribe a bridging supply of bup, at least 16-24 mg SL bup daily (2 tab buprenorphine-naloxone 8mg-2mg) as discharge medication – ideally in hand – for all patients with OUD.

9. Encourage and support the jail team to provide at least a one-month supply of medication for outpatient transition.

Immediate access to treatment with medications in hand is nearly always beneficial regardless of a patient's stated readiness to engage with any other service planning like housing, employment, counseling, or other support programs. Even when a patient states they intend to return to their prior patterns of illicit drug use, it is beneficial to provide MAT in hand. If there is concern for medication diversion or theft, prescribe a one-week supply with 4 refills. If jail facilities are unable to provide treatment in hand upon discharge, we suggest one of the aforementioned strategies above – bup in community pharmacy available upon release, written as a discharge medication from community providers.

10. Returning to the community upon release from jail is a moment of high risk for opioid overdose deaths.

In addition to encouraging the start and continuation of treatment, always provide patients with naloxone in hand when leaving jail.

11. Encourage all patients to return to your follow-up care resource upon release from jail.

Encourage patients to return to their community providers to obtain MAT upon release alongside assistance in navigating barriers such as lack of transportation, lack of insurance, stigma, and cultural barriers.

Even when a care transition to an outpatient clinic is arranged, all patients should be informed that their local ED or urgent care centers within the CA Bridge program are a safety net to access bup and other care at any time. These sites welcome everyone, even after a period of return to substance use. During medical clearance for incarceration and at time of release from incarceration, patients should be clearly and explicitly made aware that CA Bridge sites have the capacity to administer bup on-demand 24 hours a day, 7 days a week, and link to ongoing MAT.

12. Build care connections across the jail experience.

Consider developing a list of patients as a population health management strategy, with the permission of your patients. A care manager, social worker, or community health worker, can support the coordination of care for patients upon release from jail or upon transition back to jail. Most patients benefit from support with their applications for Medi-Cal and engagement to Bup capable primary care services. Transitions Clinic Network (TCN) can be a resource to support building care connections across the jail experience.

AUTHORS

All authors certify that they have no financial or commercial interests associated with the manufacture or sale of the products discussed in this document.

Rebecca Trotzy-Sirr, MD, LAC+USC Jail Health Service; Josh Luftig, PA-C, Alameda Health System Highland Hospital

RESOURCES

Transitions Clinic Network (TCN) transitionsclinic.org

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