RECOMMENDATIONS FOR SAFE OPIOID PRESCRIBING

Version 1.0 (03/01/19)

Important Notes:

- These recommendations were initially developed by Kaiser Permanente and then modified and endorsed by Safe Med LA and on December 12, 2018 by the California Society of Addiction Medicine's (CSAM) Committee on Opioids. They are based on recommendations and guidelines from the Centers for Disease Control and Prevention (CDC), CSAM, and other subject matter experts.
- As with any clinical recommendations, provider judgment should govern considerations involved in high quality and evidence-based patient care.
- **Importantly, these recommendations should not be interpreted to require involuntary and/or rapid tapers, which can be more harmful than they are beneficial by putting patients at risk for poor outcomes such as medical and/or psychiatric decompensation, relapse or illicit drug use, overdose, and self-harm. Tapering decisions must be made based on the individual circumstances of each case, with careful consideration of the risks and benefits.**
- Prescribers need to be aware of additional local, state, and federal laws and regulations involving opioid prescribing that may supersede these recommendations.
- For any prescribing outside of these recommendations, it is highly advised that the reason(s) be documented in the patient's medical record.
- ***These recommendations do NOT pertain to palliative care, end-of-life (hospice), or active cancer treatment.***

FOCUS AREA #1 – SAFE OPIOID PRESCRIBING

FOCUS AREA	RECOMMENDATIONS
Use safer opioid prescribing practices in opioid-naïve patients with severe, acute pain to avoid overprescribing and minimize potential for physical dependence and/or addiction.	**Patients with acute non-surgical pain** 1. If an opioid is needed, offer a non-refillable prescription with a maximum 3-day supply. *Rarely will more tablets be required. However, clinically appropriate exceptions may be considered on a case-by-case basis and in these instances should require additional patient assessment to justify that the benefits outweigh the risks.
	Patients with acute post-procedural and/or post-surgical pain 1. If an opioid is needed, recommend offering a non-refillable prescription with a maximum 5-day supply. *Rarely will more tablets be required. However, clinically appropriate exceptions may be considered on a case-by-case basis and in these instances should require additional patient assessment to justify that the benefits outweigh the risks. 2. If a longer course of opioid therapy is needed to manage severe pain, avoid more than 10–12 days total to decrease the risk of side effects and long-term dependence.
	Additional Risk Mitigation Strategies Goals of Pain Treatment with Opioids and Expectation-Setting 1. Treat with opioids at the lowest effective dose for the shortest duration of therapy necessary for severe pain management, realizing there may be specific situations in which a longer course may be needed. 2. Avoid new dependence/addiction by deferring the use of opioids and employing non-pharmacologic and non-opioid therapies first, reserving opioids for only when necessary.

FOCUS AREA	RECOMMENDATIONS
	3. Consider opioids only when benefits are likely to outweigh risks. Studies show increasing rates of drug dependence after just 3–5 days of opioid prescribing, with potential adverse long-term consequences. 4. Engaging patients in discussions about their pain and setting realistic expectations regarding pain management is critical. Rather than "zero pain," the preferred aim is to achieve "functional pain," whereby pain is controlled to a degree that patients can function. <u>Opioid Formulation and Dosing Considerations</u> 5. Consider non-opioid pharmacotherapy initially o Consider short-acting opioids such as hydrocodone or oxycodone for patients with acute, severe pain when other non-opioid medications, such as acetaminophen and/or ibuprofen, are not sufficient. 6. Avoid combination medication such as Norco® or Vicodin® o Instead, consider opioid monotherapy (e.g., oxycodone or immediate-release morphine), as monotherapy allows for the maximization of non-opioid medications such as acetaminophen or ibuprofen. 7. Avoid tramadol as a first-line opioid therapy for acute pain. o Tramadol's analgesic effects are less than hydrocodone or oxycodone and its onset of action requires several days of therapy for maximal effect. 8. Avoid long-acting opioid prescriptions (including XL, SR and ER formulations, methadone, and fentanyl patches) for patients with acute pain. 9. Avoid range dosing (e.g., "one-two tablets every four to six hours"). Instead, provide more specific dosing directions (e.g., "use 1 tablet every six hours"). 10. When opioids are required for pain management, buprenorphine is FDA-approved for pain and possesses a safer risk profile compared to full agonist opioids as a result of its ceiling effect as a partial agonist at the opioid receptor. In particular, buprenorphine for pain may be considered in the following instances: o Severe acute pain in patients with a history of opioid use disorder (OUD) that requires opioids (e.g., severe trauma in patient with current or historical heroin use in emergency room) o As a safer choice for patients with long-term, high-dose opioid use <u>Reassessing Risks/Benefits</u> 11. Reassess risks and benefits of opioid use periodically with patient to determine if ongoing opioid therapy continues to be advisable. If increases in opioid dosages are needed, update treatment plan accordingly. <u>Prescribing to Minors</u> 12. In accordance with SB 1109, a provider is required to discuss specified information with the minor, the minor's parent or guardian, or another adult authorized to consent to the minor's medical treatment before the first prescription for a minor in a single course of treatment with opioid medication. That information includes the following: o The risks of addiction and overdose associated with the use of opioids. o The increased risk of addiction to an opioid to an individual who is suffering from both mental and substance abuse disorders. o The danger of taking an opioid with a benzodiazepine, alcohol, or another central nervous system depressant. Exceptions to this mandate include emergency care, emergency surgery, or if in the provider's professional judgment,

FOCUS AREA	RECOMMENDATIONS
	fulfilling the requirement would be detrimental to the minor's health or safety or in violation of the minor's legal rights regarding confidentiality. Utilization of CURES 13. Consult CURES (per SB 482) the first time a controlled substance is prescribed. Exemptions include a non-refillable 7-day supply for Emergency Department visits or a non-refillable 5-day supply after a surgical procedure. 14. Consult CURES (per SB 482) every 4 months if opioid medications remain part of the patient's treatment plan. Naloxone 15. Providers MUST offer naloxone to any patient under the following conditions (per AB 2760): ○ > 90 MME/day of prescribed opioids ○ Concurrent prescription of opioids with a benzodiazepine ○ Patient determined to be at increased risk for overdose, including those with a history of a substance use disorder (SUD). 16. Consider other situations when patients on opioids should be prescribed or dispensed naloxone due to increased risk of overdose: ○ ≥ 50 MME/day ○ > 64 years old ○ Patient is exposed to peers with higher potential for misuse, overdose, and/or illicit drug use (e.g., teens, college students) 17. Educate patients and family members on overdose identification and how to use naloxone. Medications for Addiction Treatment (MAT) 18. Ensure individuals with an opioid use disorder (OUD), either directly in primary care/mental health settings or through a facilitated referral to an addiction specialist, are offered MAT (*see Focus Area #5 below for additional details*). Treatment Agreements 19. Although there are varying perspectives on the benefit of Treatment Agreements (aka "Pain Contracts"), they can be useful to initiate and document a conversation with the patient regarding the risks of opioids (links to sample Treatment Agreements can be found in the *References/Resources below*). Urine Drug Screening 20. Recommend monitoring therapeutic adherence and assess for intoxicants with urine drug screening before starting opioids for chronic pain and then on an ongoing basis at a frequency appropriate to the patient's risk factors. Traditional urine toxicology testing does not include fentanyl and buprenorphine. If there is clinical concern for use of these substances, add this testing. Safe Drug Storage and Disposal 21. Advise patients to keep all opioids and other medications in a safe, secure, and non-public location. 22. Urge patients and family members to safely and responsibly dispose of expired, unwanted, and/or unused medications, including opioids (see the *References/Resources* below for additional details on safe drug disposal information).

References/Resources

1. Opioid prescribing resources: BU School of Medicine SCOPE of pain, safe and competent opioid prescribing education: https://www.scopeofpain.com/ & Safe and effective opioid prescribing for chronic pain: https://www.opioidprescribing.com/
2. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. https://dx.doi.org/10.15585/mmwr.rr6501e1
3. Guy GP Jr., Zhang K, Bohm MK, et al. Vital Signs: Changes in opioid prescribing in the United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:697–704. https://dx.doi.org/10.15585/mmwr.mm6626a4
4. CDC Guidelines for Opiates and Chronic Pain: Guidelines at-a-glance https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf & Prescriber Fact Sheet: https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf
5. Shah A, Hayes CJ, Martin BC. Characteristics of initial prescription episodes and likelihood of long-term opioid use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. https://dx.doi.org/10.15585/mmwr.mm6610a1
6. Coffin PO, Behar E, Rowe C, Santos G, Coffa D, Bald M, et al. Nonrandomized intervention study of naloxone coprescription for primary care patients receiving long-term opioid therapy for pain. Ann Intern Med. 2016;165(4):245–252. https://dx.doi.org/10.7326/M15-2771
7. Munzing T. Physician guide to appropriate opioid prescribing for noncancer pain. Perm J 2017;21:16–169. https://dx.doi.org/10.7812/TPP/16-16
8. Controlled substances: CURES database. Cal. S.B. 482 (2015-2016), Chapter 708 (Cal. Stat. 2016). https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB482
9. Prescription drugs: prescribers: naloxone hydrochloride and other FDA-approved drugs. Cal. Assemb. B. 2760 (2018), Chapter 324 (Cal. Stat. 2018). https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2760
10. Prescribe to Prevent. Provide Naloxone, Save a Life-for patients, families, prescribers, pharmacists. www.prescribetoprevent.org
11. Safe Drug Disposal Information, Los Angeles County:
    - https://www.google.com/maps/d/u/0/viewer?mid=1TWtqcLV6nw3Q0BsxiDcoSNUtbUp3mDvJ&ll=34.00666555952027%2C-118.07444166303026&z=10
    - http://dpw.lacounty.gov/epd/HHW/Pharmaceuticals
    - https://takebackday.dea.gov/
12. Sample Patient Treatment Agreements
    - https://www.drugabuse.gov/sites/default/files/files/SamplePatientAgreementForms.pdf
    - https://www.oregonpainguidance.org/app/content/uploads/2016/05/Patient-Treatment-Agreements.pdf

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FOCUS AREA #2 – AVOID ESCALATING OPIOID DOSES

FOCUS AREA	RECOMMENDATIONS
Avoid escalating opioid doses and placing patients at higher risk of overdose and death.	1. The recommended starting dose for acute pain is less than or equal to 20 MME/day, and the maximum suggested dosage of opioids is up to 49 MME/day in opioid-naïve patients.* Avoid increasing the dose of opioids to 50 MME/day or higher. If patients are already on doses 50 MME/day or higher, these recommendations should not be interpreted to require involuntary and/or rapid tapers, which can be more harmful than they are beneficial by putting patients at risk for poor outcomes such as medical and/or psychiatric decompensation, relapse or illicit drug use, overdose, and self-harm. Tapering decisions must be made based on the individual circumstances of each case, with careful consideration of the risks and benefits. 2. Consider using alternative non-pharmacologic and non-opioid therapies to prevent escalation of opioid doses. **There is no evidence to support the use of ever-increasing doses of opioids for non-cancer pain and there is clear evidence that this can lead to harm.** 3. Clinical judgment should govern specific patient conditions or situations. Exceptions should require additional patient assessment to justify that the benefits outweigh the risks. 4. When necessary and possible, consider consultation with a pain or palliative specialist. * Opioid-naïve versus opioid-tolerant Opioid-naïve patients are often defined as patients who have not used any form of opioids (legal or illegal) in the previous 6 months. Opioid-tolerant patients have previous recent use of opioids (legal or illegal) that may result in requiring higher doses of opioids to achieve similar pain-relieving results.

References/Resources

1. Garg RK, Fulton-Kehoe D, Franklin GM. Patterns of opioid use and risk of opioid overdose death among Medicaid patients. Med Care. 2017 Jul;55(7):661–68. https://dx.doi.org/10.1097/MLR.0000000000000738
2. Liang Y, Turner BJ. Assessing risk for drug overdose in a national cohort: role for both daily and total opioid dose?. J Pain. 2015 Apr;16(4):318–25. https://dx.doi.org/10.1016/j.jpain.2014.11.007
3. Dunn KM, Saunders KW, Rutter CM, Banta-Green CJ, Merrill JO, Sullivan MD, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med. 2010 Jan 19;152:85–92. https://dx.doi.org/10.7326/0003-4819-152-2-201001190-00006

FOCUS AREA #3 – AVOID DANGEROUS MEDICATION COMBINATIONS

FOCUS AREA	RECOMMENDATIONS
Avoid medication combinations that place a patient at higher risk of overdose and death.	1. Avoid concurrent prescribing of opioids and benzodiazepines and/or other sedative-hypnotics (e.g., drugs for insomnia, such as zolpidem or eszopiclone, skeletal muscle relaxants, and barbiturates) due to significantly increased risk of opioid overdose and death. Some evidence also suggested increased risk of overdose and death with concurrent prescribing of gabapentin and pregabalin. 2. If a patient is unable to discontinue concurrent use of a benzodiazepine, other sedative-hypnotics, or skeletal muscle relaxant with opioids, the risks and benefits of the combination should be discussed with the patient. Lower starting dosages of opioids are recommended (e.g. 20 MME/day) when concurrently prescribed with benzodiazepines and/or other sedative-hypnotics. Justification for dosage and drug combinations should be documented in the medical record. 3. The CDC recommends urine drug screens should be ordered upon initiation of opioids for chronic painful conditions and then yearly after that to evaluate if the patient is taking legal or illicit drugs and to verify the patient is taking the medications as prescribed. 4. Providers must offer naloxone to any patient under the following conditions (per AB 2760): ○ > 90 MME/day of prescribed opioids ○ Concurrent prescription of opioids with a benzodiazepine ○ Patient determined to be at increased risk for overdose, including those with a history of substance use disorder (SUD)

References/Resources

1. Voshaar RC, Couvée JE, van Balkom AJ, Mulder PG, Zitman FG. Strategies for discontinuing long-term benzodiazepine use: meta-analysis. Br J Psychiatry. 2006 Sep;189:213–20. https://dx.doi.org/10.1192/bjp.189.3.213
2. Jones CM and McAninch JK. Emergency department visits and overdose deaths from combined use of opioids and benzodiazepines. Am J Prev Med. 2015 Oct;49(4):493–501. https://dx.doi.org/10.1016/j.amepre.2015.03.040
3. Bachhuber MA, Hennessy S, Cunningham CO, Starrels JL. Increasing benzodiazepine prescriptions and overdose mortality in the United States, 1996-2013. Am J Public Health. 2016 Apr;106(4):686–88. https://dx.doi.org/10.2105/AJPH.2016.303061
4. Dasgupta N, Funk MJ, Proescholdbell S, Hirsch A, Ribisl KM, Marshall S. Cohort study of the impact of high-dose opioid analgesics on overdose mortality. Pain Med. 2016 Jan;17(1):85–98. Erratum in: Pain Med. 2016 Apr;17(4):797-8. https://dx.doi.org/10.1111/pme.12907
5. Cho J, Spence M, Niu F, Hui R, Gray P, Steinberg S. Risk of opioid overdose with concurrent use of prescription opioids, benzodiazepines, and non-benzodiazepine sedative-hypnotics. Poster presented at: Academy of Managed Care Pharmacy Annual Meeting, April 2018.
6. Prescription drugs: prescribers: naloxone hydrochloride and other FDA-approved drugs. Cal. Assemb. B. 2760 (2018), Chapter 324 (Cal. Stat. 2018). https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2760
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FOCUS AREA #4 – SAFE TAPERING PRACTICES

FOCUS AREA	RECOMMENDATIONS

For chronic pain patients, safely taper down from higher-dose opioids to lower, safer doses.
 	
Excludes palliative, end-of-life (hospice), and active cancer patients.
	Tapering schedules should be individualized, performed safely, minimize symptoms of opioid withdrawal, and maximize pain treatment with non-opioid and non-pharmacologic therapies (*see the References/Resources below for Sample Tapering Guidelines*). Although safely tapering down from higher-dose opioids is recommended, involuntary and/or rapid tapers can lead to more harm than benefit by putting patients at risk for poor outcomes such as medical and/or psychiatric decompensation, relapse or illicit drug use, overdose, and self-harm. Tapering decisions must be made based on the individual circumstances of each case, with careful consideration of the risks and benefits.
	
	1. Rapidity of voluntary tapering should be patient-specific and completed in a safe manner. Tapering may range from 5–10% per week to 5–10% per month or longer when necessary depending on the risk of harm, patient's clinical need, and/or clinical judgment.
	2. During a taper of prescription opioids, the patient should be carefully monitored through clinical visits and urine toxicology testing. Some patients will exhibit symptoms of an opioid use disorder during a taper. For these individuals, they would benefit from transition to buprenorphine-naloxone for pain and OUD.
	3. Decreasing or discontinuing opioids is a high-risk time for patients, and management of withdrawal symptoms is critical to the success of any taper regimen. Management may include slowing the taper, providing as-needed medications for symptoms, or transition to buprenorphine-naloxone for a person with pain and an OUD. Given the pharmacology of buprenorphine and its ceiling effect as a partial agonist at the opioid receptor as opposed to a full agonist, its risk profile makes it a safer alternative compared to full agonists, particularly for patients with long-term, high-dose opioid use. Most importantly for patients, observational evidence indicates that pain control is improved among patients with chronic pain who transition from high-dose opioids to buprenorphine.
	4. The goal is to minimize risk and maximize benefit for individual patients. While striving to taper patients to < 90 MME/day of opioids is reasonable, involuntary and/or rapid tapers can lead to more harm than benefit, particularly when the individual circumstances of each case is not considered. Patients with a long history of high-dose opioids or with medical and/or psychiatric co-morbidities may be unable to be safely maintained at < 90 MME/day of opioids. In these cases, the risk of medical and/or psychiatric decompensation, relapse or illicit drug use, overdose, and self-harm must be considered when determining the best tapering approach and final stabilizing opioid dose.
	5. Patients who are on a combination of benzodiazepines or other sedative-hypnotics along with an opioid medication are at higher risk for an overdose and death. Discussion with the patient and family regarding the ongoing risks and benefits is paramount. Tapering of either the opioid or sedative-hypnotic to the lowest effective dose in a safe, voluntary manner is recommended.
	6. Strongly consider safely tapering down or transitioning patients from full agonist opioids to the partial agonist buprenorphine if the patient:
	  ○ Experiences overdose or another serious adverse event
	  ○ Has or exhibits other risk factors for overdose
	  ○ Has a concomitant opioid use disorder

References/Resources

1. Sample Tapering Guidelines:
   - CDC Pocket Guide: https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf
   - Veteran Affairs (VA) Opioid Taper Decision Tool: https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf
   - Oregon Pain Guidance Tapering Flow Sheet: https://www.oregonpainguidance.org/app/content/uploads/2016/05/Opioid-and-Benzodiazepine-Tapering-flow-sheets.pdf
2. Daitch D, Daitch J, Novinson D, Frey M, Mitnick C, Pergolizzi J Jr. Conversion from high-dose full-opioid agonists to sublingual buprenorphine reduces pain scores and improves quality of life for chronic pain patients. Pain Med. 2014 Dec;15(12):2087–94. https://dx.doi.org/10.1111/pme.12520
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5. Malinoff HL, Barkin RL, Wilson G. Sublingual buprenorphine is effective in the treatment of chronic pain syndrome. Am J Ther. 2005 Sep-Oct;12(5):379–84. https://dx.doi.org/10.1097/01.mjt.0000160935.62883.ff

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FOCUS AREA #5 – CONCURRENT DRUG AND ALCOHOL USE

FOCUS AREA	RECOMMENDATIONS
Avoid combining opioids with drugs and alcohol due to higher risk of overdose and death.	1. Carefully consider the use of opioid medications in individuals with a history of illicit drug, cannabinoids, and/or alcohol use.* The risk of overdose and development of an opioid use disorder (OUD) is higher in these cases, and therefore the provider should carefully evaluate the use of opioids to justify that the benefits outweigh the risks. *Importantly, substance use is not an indication for involuntary and/or rapid taper of a patient with long-term opioid use. 2. While concurrent use of opioids and substances with depressant effects (e.g., alcohol, sedatives, etc.) does result in higher risk for overdose and death, involuntary and/or rapid tapers can also result in similar poor outcomes, and thus clinical decisions in these instances must balance overall risks and benefits in each individual case. Opioids can be offered to individuals who also use cannabinoids, but the concurrent use of cannabis and opioids is associated with cognitive impairment and other risks. 3. The risks, benefits, and alternative therapies for pain should be reviewed with the patient and family. The patient's informed consent should be documented in the medical record.

References/Resources

1. Opioid Risk Tool, Patient Self-Report Screening: https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf
2. Screener and Opioid Assessment for Patients with Pain (SOAPP-SF): https://www.nhms.org/sites/default/files/Pdfs/SOAPP-5.pdf
3. Campbell G, Hall WD, Peacock A, et al. Effect of cannabis use in people with chronic non-cancer pain prescribed opioids: findings from a 4-year prospective cohort study. Lancet Public Health. 2018 Jul;3(7):e341–e350. https://dx.doi.org/10.1016/S2468-2667(18)30110-5
4. Chou R, Fanciullo GJ, Fine PG, et al. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. American Pain Society-American Academy of Pain Medicine Opioids Guidelines Panel. J Pain. 2009 Feb;10(2):113–30. https://dx.doi.org/10.1016/j.jpain.2008.10.008

FOCUS AREA #6 – OPIOID USE DISORDER AND MEDICATIONS FOR ADDICTION TREATMENT

FOCUS AREA	RECOMMENDATIONS
It is important for providers to recognize opioid use disorder. Initiation and/or referral for ongoing treatment is vital.	1. Clinicians should screen for substance use disorders in patients, including opioid use disorder (OUD), when prescribing opioids. The diagnosis of a substance use disorder (SUD) is more likely when aberrant medication taking behaviors and functional and social impairments that result from substance use (including prescription opioids) are present (see the *References/Resources* below for screening and referral resources). 2. Primary care providers should provide patients with medications to treat OUD (e.g., buprenorphine-naloxone, naltrexone) or should refer these patients to a clinician who offers medications for opioid use disorder. Providers can become waivered by the DEA to prescribe buprenorphine-naloxone for opioid use disorder by maintaining a DEA certificate and obtaining X-waiver training (see the *References/Resources* for information on treatment for substance use in primary care settings). 3. Emergency department providers should administer buprenorphine to patients presenting with signs and symptoms of opioid withdrawal, and, if the patient has an opioid use disorder, refer these patients to appropriate community-based substance use treatment (see the *References/Resources* below for information about treatment of opioid use disorders in hospital settings and screening and referral resources). 4. When a patient confirmed to be receiving outpatient methadone or buprenorphine-naloxone maintenance treatment is admitted to a hospital for a non-substance use disorder medical condition, the hospital should continue these maintenance medications. In these instances where methadone or buprenorphine maintenance treatment are continued in a hospital setting, a separate federal license or X-waiver for buprenorphine is not necessary (see the *References/Resources* below for information about treatment of opioid use disorders in hospital settings). 5. When opioids are prescribed to individuals with a history of substance use, employ all appropriate opioid risk mitigation strategies (see *"Additional Risk Mitigation Strategies"* in Focus Area #1 above for more details).

References/Resources

1. Screening for substance use
   - Evidence-based substance use screening tools: https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools
2. Treatment for substance use in primary care settings
   - Buprenorphine X-Waiver certification training: https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training
   - National Council for Behavioral Health: https://www.thenationalcouncil.org/wp-content/uploads/2018/03/021518_NCBH_ASPTReport-FINAL.pdf
   - Agency for Healthcare Research and Quality (AHRQ): http://effectivehealthcare.ahrq.gov/sites/default/files/pdf/opioid-use-disorder_technical-brief.pdf
   - Treating Addiction in the Primary Care Safety Net: https://tapcprogram.com/category/mat-tools/
3. Treatment for substance use in hospital settings
   - Project SHOUT: https://www.projectshout.org/
4. Treatment for substance use in emergency department settings
   - ED-BRIDGE: https://ed-bridge.org/
5. Case consultation for substance use
   - The University of California, San Francisco Clinical Consultation Center is available for free case consultations related to substance use: https://nccc.ucsf.edu/clinician-consultation/substance-use-management/ or (855) 300-3595.

6. Legal information on providing buprenorphine to medically hospitalized inpatients: https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/legislation-regulations-guidelines/special
7. Referrals for substance use treatment
   - Referrals for commercially insured patients – contact relevant health plan or provider group
   - Referrals for publicly funded substance use disorder (SUD) treatment services in Los Angeles County can be made by calling the Substance Abuse Service Helpline (SASH) at (844) 804-7500 or by searching the Service and Bed Availability Tool (SBAT) at http://sapccis.ph.lacounty.gov/sbat/