

2-5-2026

Staff Education to Reduce the Incidence of Bias in Managing Patients with Opioid Use Disorder in a Rehabilitation Center

Almarie Alison McLaren
Walden University

Follow this and additional works at: <https://scholarworks.waldenu.edu/dissertations>



Part of the [Nursing Commons](#)

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Nursing

This is to certify that the doctoral study by

Almarie McLaren

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Barbara Niedz, Committee Chairperson, Nursing Faculty

Dr. Diane Whitehead, Committee Member, Nursing Faculty

Chief Academic Officer and Provost

Sue Subocz, Ph.D.

Walden University

2026

Executive Summary: Staff Education Project

Staff Education to Reduce the Incidence of Bias in Managing Patients with Opioid Use

Disorder in a Rehabilitation Center

by

Almarie McLaren

MS, Walden University, 2020

BS Western Governor University, 2018

Executive Summary Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

February 2026

Summary

This Doctor of Nursing Practice (DNP) project addressed stigma and implicit bias toward individuals with opioid use disorder (OUD) within a rehabilitation subacute care setting. OUD remains a significant public health concern and at the project site, inconsistent staff education was identified as a practice gap requiring intervention.

The purpose of this practice-focused DNP project was to evaluate the impact of a structured staff education intervention on healthcare staff knowledge, attitudes, and confidence in caring for patients with OUD. The project was guided by a thorough evidence search. The project was implemented using brief, unit-based educational sessions delivered to interdisciplinary healthcare staff.

Post-implementation findings demonstrated statistically significant improvements in staff knowledge with an increase in scores from a mean of 66.14 to 87.28 ($t = -23.467$, $p < .001$), a 33% increase in knowledge. More positive attitudes toward patients with OUD were seen with a 1.5 point shift to more positive attitudes pre to post education across five attitudinal questions. Staff reported increased comfort, enhanced stigma recognition, and greater confidence in applying evidence-based OUD care practices.

This project has implications for nursing practice, organizational culture, and health equity by promoting compassionate, patient-centered care for all individuals with OUD. Reducing implicit bias among healthcare staff contributes to more equitable treatment regardless of diagnosis, socioeconomic status, or history of substance use. Inclusive care environments that respect patient dignity and promote fairness in clinical decision-making contribute to positive social change.

Background

Opioid use disorder (OUD) remains a significant public health concern in the United States and continues to negatively affect individuals, families, and healthcare systems. Rising rates of opioid-related morbidity and mortality have increased the demand for evidence-based, compassionate, and equitable care across healthcare settings (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020; Wakeman & Rich, 2018). Despite advances in treatment modalities, patients with OUD frequently experience stigma and implicit bias from healthcare professionals, which can undermine therapeutic relationships, limit access to care, and contribute to poor health outcomes (Livingston et al., 2012; van Boekel et al., 2013). Within clinical environments, these biases often manifest through negative language, reduced empathy, and inconsistent application of evidence-based interventions (Ashford et al., 2019; Brener et al., 2010).

Doctor of Nursing Practice (DNP)-prepared nurses are uniquely positioned to identify and address practice gaps that influence patient outcomes and system performance. Implicit bias toward individuals with substance use disorders remains prevalent in healthcare and often stems from misconceptions about addiction as a moral or behavioral failure rather than a chronic, relapsing medical condition (Livingston et al., 2012; SAMHSA, 2020). These biases may influence clinical judgment, pain management decisions, and communication, resulting in disparities in care delivery (van Boekel et al., 2013; Wakeman & Rich, 2018). Patients with OUD frequently report feeling judged, disrespected, or dismissed by healthcare providers, which discourages care seeking and engagement in treatment (Brener et al., 2010).

At the project site, a rehabilitation subacute setting, formal education addressing OUD, stigma, and bias has been inconsistent. Staff lack foundational knowledge of the neurobiology of addiction, evidence-based treatment options, and trauma-informed approaches to care. Without structured education, negative attitudes may become embedded within organizational culture, perpetuating inequities and undermining quality improvement efforts (Ashford et al., 2019; Livingston et al., 2012; van Boekel et al., 2013). Walden's DNP rubric highlights the importance of identifying system-level contributors to practice gaps, making staff education a logical and necessary intervention.

Rehabilitation and acute care settings present unique challenges for patients with OUD, including complex comorbidities, chronic pain, and psychosocial stressors (Brener et al., 2010; Wakeman & Rich, 2018). When implicit bias influences care, patients may experience delayed treatment, inadequate pain control, or premature discharge (Brener et al., 2010; Wakeman & Rich, 2018). Addressing this gap through education supports ethical practice, improves patient safety, and aligns with national priorities to reduce opioid-related harm.

The purpose of this DNP project was to evaluate the impact of a structured staff education program focused on OUD and implicit bias on healthcare staff knowledge, attitudes, and perceptions toward patients with OUD. The project is designed as a practice-focused staff education initiative. Thus, the guiding project question was as follows: Among healthcare staff in a clinical setting, does a structured educational intervention addressing OUD and implicit bias, improve staff knowledge and attitudes toward patients with OUD? The project sought to enhance staff competence, promote reflective practice, and foster a supportive clinical environment. By increasing awareness

of implicit bias and providing tools to mitigate its impact, the intervention aims to improve patient-provider interactions and support equitable, evidence-based care.

A systematic literature search was conducted to identify current, high-quality evidence related to OUD, healthcare provider stigma, implicit bias, and staff education interventions. Electronic databases including CINAHL, PubMed, MEDLINE, PsycINFO, and Google Scholar were searched using a combination of keywords and Boolean operators. Search terms included *opioid use disorder*, *OUD*, *substance use disorder*, *implicit bias*, *stigma*, *healthcare provider attitudes*, *nurse perceptions*, *addiction education*, *harm reduction*, *trauma-informed care*, and *staff education AND opioid use disorder*. Boolean operators such as AND and OR were used to broaden and refine the search strategy. Inclusion criteria were limited to peer-reviewed journal articles, English-language publications, and studies published within the last 10 years to ensure relevance and alignment with current evidence-based practice standards. Articles were selected if they focused on healthcare professionals, educational interventions, stigma or bias reduction, patient-centered OUD care, or organizational-level practice change.

The selected articles were critically appraised for methodological rigor, relevance to nursing and interdisciplinary practice, and applicability to inpatient, rehabilitation, and long-term care environments using the Johns Hopkins model (Dang et al., 2022). Evidence was analyzed through synthesis of findings to identify recurring themes, effective educational strategies, and best practices related to reducing stigma and improving provider attitudes toward individuals with OUD. This evidence informed the development, implementation, and evaluation of the staff education intervention.

Hooker et al. (2023) conducted a randomized control trial (RCT) with 140 primary care clinicians and found that contact-based online stigma education significantly reduces stigmatizing attitudes and increases readiness to care for individuals with OUD. They also observed that microlearning modules and narrative/lived-experience videos improve provider empathy and care confidence (#6). Finally, they found that skill-focused training improves short-term stigma scores, though booster sessions are needed for long-term retention.

Using a survey process with 181 participants in Midwest counties, Avery et al. (2018) showed significant improvement in provider attitudes toward individuals with SUD following brief online education. Training reduced misconceptions and reinforced addiction as a chronic condition. Findings support brief, scalable education to improve empathy and reduce stigma.

Staff stigma, fear, and discomfort with OUD contribute to care avoidance, resident rejection, and poor engagement (Kimmel et al. 2022). Staff reported lacking adequate training, protocols, and clarity on medication for OUD (MOUD), leading to uncertainty and bias-driven decisions. They also found that increased training exposure predicts more positive attitudes, improved MOUD readiness, and stronger organizational care capacity (Moyo et al., 2024; O'Reilly et al., 2024; Pasman et al., 2022).

National organizations, including the SAMHSA (2025), have emphasized workforce education as a critical component of addressing the opioid crisis. Guidelines recommend ongoing training to reduce stigma, support medication-assisted treatment, and improve access to care. Integrating education into organizational quality

improvement initiatives enhances sustainability and promotes culture change (O'Reilly et al., 2024).

SNFs face persistent stigma and logistic barriers can be mitigated through structured education and policy reinforcement (Parihideh et al., 2024). Case study evidence shows that language campaigns, staff scripts, and stigma-reduction messaging effectively improve provider engagement (Centers for Disease Control and Prevention [CDC], 2022). Expert recommendations stress the need for methadone workflow clarity, safety planning, and leadership involvement to reduce fear-based bias (CDC, 2022).

The integration of higher-level quantitative evidence with supportive qualitative findings ensured that the proposed staff education intervention was grounded in both empirical outcomes and real-world clinical relevance (Corrigan et al., 2019; Stone et al., 2021). This systematic ranking process supports the rigor of the evidence synthesis and aligns with Walden DNP rubric expectations emphasizing evidence-based interventions and measurable practice outcomes. Studies demonstrated that structured education addressing OUD reduce implicit bias and stigma significantly improved healthcare providers' knowledge, attitudes, and confidence in delivering patient-centered, nonjudgmental care (Corrigan et al., 2019; Stone et al., 2021; van Boekel et al., 2013). Several articles reported measurable reductions in stigmatizing beliefs and increased acceptance of evidence-based treatments, including medication for OUD, following educational interventions. Although some studies noted that reinforcement or ongoing education was necessary to sustain long-term attitude change, the overall evidence supported staff education as a feasible and impactful practice change.

Implicit bias and stigma toward patients with OUD represent a persistent and significant gap in healthcare practice at the project site. These biases negatively affect patient experiences, access to care, and clinical outcomes. Addressing this gap through structured staff education aligns with doctoral-level nursing competencies and Walden University's mission to promote social change and health equity. This DNP project leverages strong evidence to support a practice-focused intervention aimed at improving provider knowledge and attitudes. By translating evidence into practice, the project has the potential to enhance quality of care, support ethical nursing practice, and improve outcomes for individuals with OUD.

Staff Education Project Development

The participants for this evidence-based practice project include interdisciplinary healthcare staff working in an inpatient acute-care and affiliated rehabilitation setting within a New Jersey healthcare system. Expected participants included approximately 10–20 staff members per session, consisting of RNs, LPNs, nursing assistants, case managers, social workers, and available providers. Participation was voluntary and focused on staff directly involved in caring for patients with OUD.

The project was developed in response to identified gaps in staff knowledge, attitudes, and confidence related to caring for patients with OUD, particularly surrounding stigma, implicit bias, pain management, and evidence-based treatment approaches. Educational content was informed by national guidelines and evidence demonstrating that stigma reduction and staff education improve patient engagement, safety, and treatment outcomes (Ashford et al., 2019; Livingston et al., 2012; SAMHSA, 2023).

Implementation procedures consist of brief, unit-based “micro-in-service” huddles lasting 15–20 minutes, delivered across day, evening, and night shifts to ensure maximum staff access. Sessions are repeated weekly over a 2-week period to capture staff unable to attend initial offerings. Instructional strategies included short didactic segments, case-based discussion, role-play, teach-back exercises, and workflow reviews. Educational reinforcement is provided through learning management system (LMS) PowerPoint modules and printed pocket cards distributed during the final session to support sustainability and bedside application (see Appendix).

Evidence collection for this project used a pretest–posttest design with manual data collection, administered immediately before the first educational module and following completion of the final module. Data collection focused on changes in staff knowledge, attitudes, confidence, and stigma-related perceptions regarding OUD and pain management. To protect confidentiality, no participant identifiers were collected; results were aggregated by staff role and session attendance only.

The assessment tool consisted of 10 multiple-choice knowledge-based questions aligned with the educational objectives, including pain management in patients with OUD, ethical principles, trauma-informed care, MOUD, and non-stigmatizing communication (see Appendix). In addition, Likert-scale items assess staff confidence and attitudes toward caring for individuals with OUD (see Appendix). This approach aligns with evidence demonstrating that structured pre- and post-education assessments are effective in measuring stigma reduction and learning outcomes (Livingston et al., 2012; Ashford et al., 2019).

The evaluation process was designed to determine the effectiveness of the staff education intervention in improving knowledge, reducing stigma, and enhancing confidence in caring for patients with OUD. Program success is evaluated using predefined outcome benchmarks established in the planning grid. The intervention is considered effective if at least 80% of participants score 5 or higher on the posttest and if the mean posttest score increases by a minimum of 2 points compared to baseline scores.

Results

Postimplementation findings demonstrated a statistically and clinically significant improvement in staff knowledge, attitudes, and confidence related to caring for patients with OUD. Prior to the educational intervention, participants ($N = 100$) had a mean pretest knowledge score of 66.14% ($SD = 7.05$). Following the staff education program, the mean posttest score increased to 87.28% ($SD = 7.31$), reflecting a mean improvement of 21.14 percentage points, a 33% increase. A paired samples t test confirmed that this improvement was statistically significant, $t(99) = -23.47$, $p < .001$, 95% CI $[-22.93, -19.35]$.

In addition to objective knowledge gains, self-reported measures demonstrated meaningful improvements across all attitudinal questions. Participants reported significantly higher levels of comfort caring for patients with OUD, increased ability to identify stigmatizing language and behaviors, greater understanding of evidence-based OUD treatment principles, and improved confidence using non-stigmatizing, person-first language. Mean Likert-scale scores increased from approximately 3.0 (neutral) pre-intervention to 4.5 (agree/strongly agree) postintervention across these domains, with all paired comparisons reaching statistical significance ($p < .001$). These findings indicate

that the intervention was effective not only in improving knowledge but also in shifting staff perceptions and self-efficacy related to OUD care.

The educational intervention had a positive impact on the organization by promoting a more informed, compassionate, and evidence-based approach to caring for patients with OUD. Improved staff knowledge and reduced stigmatizing attitudes support safer clinical interactions, enhanced therapeutic relationships, and alignment with national best-practice recommendations for substance use disorder treatment (Corrigan et al., 2019). Increased staff confidence and comfort may also reduce moral distress, enhance job satisfaction, and support retention among healthcare professionals working with complex patient populations.

From a systems perspective, the project supports organizational goals related to quality improvement, patient safety, and equity in care delivery. Reducing stigma has been shown to improve patient engagement, adherence to treatment, and continuity of care, all of which may positively influence patient outcomes and reduce avoidable healthcare utilization (van Boekel et al., 2013). The project further demonstrated the feasibility of integrating brief, structured education into routine staff development, providing a sustainable model that leadership can replicate across departments or facilities.

Several limitations should be considered when interpreting the project outcomes. First, the project used a single-group pretest–posttest design which limits the ability to attribute observed changes solely to the intervention. External factors, such as prior experience or concurrent organizational initiatives, may have influenced results. Second,

outcomes relied in part on self-reported measures, which are subject to social desirability bias and may overestimate changes in attitudes or confidence.

Additionally, data collection occurred immediately following the educational intervention, limiting insight into the long-term sustainability of knowledge retention and attitude change. Although posttest results were strong, it remains unclear whether improvements will persist over time without reinforcement. Finally, the project was implemented at a single site with a specific staff population, which may limit generalizability to other settings or disciplines.

Despite these limitations, the magnitude of improvement and consistency across multiple outcome measures support the intervention's effectiveness and practical relevance. This project has significance beyond the local practice setting due to the widespread prevalence of OUD and the persistent stigma experienced by affected patients across healthcare systems. Stigmatizing attitudes among healthcare providers have been consistently linked to reduced quality of care, delayed treatment, and poorer patient outcomes (Corrigan et al., 2019). The findings of this project contribute to the growing body of evidence supporting staff education as an effective strategy to address stigma and improve evidence-based OUD care.

Conclusions

The implementation of a structured staff education program addressing OUD and implicit bias had a meaningful and measurable impact on the organization. Postimplementation findings demonstrated significant improvements in staff knowledge, attitudes, and confidence related to caring for patients with OUD. Improved staff competence supports safer clinical decision-making, enhanced therapeutic

communication, and greater consistency in applying evidence-based OUD care practices. These improvements align with organizational goals related to quality improvement, patient safety, and regulatory compliance (Corrigan et al., 2019; SAMHSA, 2020).

From an organizational culture perspective, the reduction in stigmatizing attitudes contributes to a more respectful, patient-centered environment. Stigma within healthcare systems has been associated with reduced patient engagement, delayed treatment, and fragmented care (van Boekel et al., 2013). By increasing awareness of implicit bias and promoting person-first language, the project supports a cultural shift toward viewing OUD as a chronic medical condition rather than a moral failing. This cultural change may enhance patient satisfaction, trust in the healthcare system, and continuity of care while also reducing staff moral distress when caring for complex patient populations (Wakeman & Rich, 2018).

Additionally, the project demonstrated that brief, unit-based education can be feasibly integrated into routine staff development without disrupting workflow. This provides the organization with a scalable and sustainable model for future education initiatives targeting other quality or equity-related priorities.

Several recommendations may be considered to strengthen and sustain the impact of this initiative. First, incorporating OUD stigma-reduction education into mandatory annual competencies or new-employee orientation would reinforce knowledge retention and normalize evidence-based, non-stigmatizing care practices. The literature suggests that ongoing reinforcement is necessary to sustain long-term attitude and behavior change (Corrigan et al., 2019; Stone et al., 2021). Second, expanding the program to include interdisciplinary providers such as physicians, advanced practice providers, pharmacists,

and ancillary staff may further reduce system-wide stigma and promote consistency across care transitions. Third, leadership may consider integrating OUD-related metrics into quality improvement dashboards, such as referrals to MOUD, documentation of person-first language, or patient engagement indicators. Finally, future initiatives could incorporate longitudinal follow-up assessments to evaluate the durability of attitude and behavior changes over time.

This project has important implications for nursing practice at both the individual and systems levels. Nurses frequently serve as the primary point of contact for patients with OUD and play a critical role in pain management, patient advocacy, and care coordination. Improved knowledge and reduced bias enhance nurses' ability to provide ethical, trauma-informed, and evidence-based care, which may improve patient outcomes and safety (Ashford et al., 2019; Livingston et al., 2012).

For DNP-prepared nurses, this project demonstrates the role of nurse leaders in identifying practice gaps, translating evidence into practice, and leading organizational change. The findings support staff education as an effective nursing-led intervention to address stigma, promote reflective practice, and improve care quality for marginalized populations. Embedding such education into routine nursing practice reinforces professional accountability and aligns with national nursing priorities focused on health equity and quality improvement.

The findings of this project support positive social change by addressing structural and interpersonal stigma that disproportionately affects individuals with OUD. Stigma toward people with substance use disorders has been identified as a significant contributor to healthcare inequities, reduced access to care, and poorer health outcomes

By promoting person-first language, bias awareness, and evidence-based care, this project advances principles of diversity, equity, and inclusion within the healthcare setting.

Reducing implicit bias among healthcare staff contributes to more equitable treatment regardless of diagnosis, socioeconomic status, or history of substance use. These changes support Walden University's mission of social change by fostering inclusive care environments that respect patient dignity and promote fairness in clinical decision-making. On a broader scale, widespread adoption of similar educational interventions may help reduce disparities in OUD treatment access and outcomes, contributing to improved population health and social justice (SAMHSA, 2020; Wakeman & Rich, 2018).

References

- Ashford, R. D., Brown, A. M., McDaniel, J., & Curtis, B. (2019). Biased labels: An experimental study of language and stigma among individuals in recovery and health professionals. *Substance Use & Misuse*, 54(8), 1376–1384.
<https://doi.org/10.1080/10826084.2019.1581221>
- Brener, L., von Hippel, W., Kippax, S., & Preacher, K. J. (2010). The role of physician and nurse attitudes in the health care of injecting drug users. *Substance Use & Misuse*, 45(7–8), 1007–1018. <https://doi.org/10.3109/10826080903525687>
- Centers for Disease Control and Prevention. (2022). *Overdose prevention*.
<https://www.cdc.gov/overdose>
- Corrigan, P. W., Nieweglowski, K., & Sayer, J. (2019). The impact of education on mental illness stigma: A meta-analysis. *Psychiatric Services*, 70(9), 781–789.
<https://doi.org/10.1176/appi.ps.201800367>
- Dang, D., Dearholt, S.L., Bissett, K., Ascenzi, J., Whalen, M. (2022) *Johns Hopkins evidence-based practice for nurses and healthcare professionals* (4th ed.). Sigma Theta Tau The International Honor Society of Nursing.
- Knowles, M. S., Holton, E. F., & Swanson, R. A. (2015). *The adult learner* (8th ed.). Routledge.
- Livingston, J. D., Milne, T., Fang, M. L., & Amari, E. (2012). The effectiveness of interventions for reducing stigma related to substance use disorders. *Addiction*, 107(1), 39–50. <https://doi.org/10.1111/j.1360-0443.2011.03601.x>
- Polit, D. F., & Beck, C. T. (2021). *Nursing research* (11th ed.). Wolters Kluwer.

Stone, E. M., Kennedy-Hendricks, A., Barry, C. L., Bachhuber, M. A., & McGinty, E. E.

(2021). The role of stigma in U.S. primary care physicians' treatment of opioid use disorder. *Drug and Alcohol Dependence*, 221, Article 108627.

<https://doi.org/10.1016/j.drugalcdep.2021.108627>

Substance Abuse and Mental Health Services Administration. (2020). *Key substance use and mental health indicators in the United States*. <https://www.samhsa.gov>

Substance Abuse and Mental Health Services Administration. (2023). *Treatment improvement protocol (TIP) 63: Medications for opioid use disorder*.

<https://store.samhsa.gov>

van Boekel, L. C., Brouwers, E. P. M., van Weeghel, J., & Garretsen, H. F. L. (2013).

Stigma among health professionals toward patients with substance use disorders. *Drug and Alcohol Dependence*, 131(1–2), 23–35.

<https://doi.org/10.1016/j.drugalcdep.2013.02.018>

Wakeman, S. E., & Rich, J. D. (2018). Barriers to medications for addiction treatment:

How stigma kills. *Substance Use & Misuse*, 53(2), 330–333.

<https://doi.org/10.1080/10826084.2017.1363238>

Appendix

Staff Education Planning Grid Project Materials

Inpatient acute-care and affiliated rehabilitation setting at NJ hospital. Expected attendees: ~10–20 staff per session (RNs, LPNs, nursing assistants, case management, social work, and providers as available). Delivery: brief live, unit-based huddle “micro-in-services” (15–20 minutes) offered on day, evening and night shifts, repeated weekly for 2 weeks to reach all staff; supplemented with a short LMS/remote module and printed pocket cards.

| <p>Learning Outcome(s):</p> <p>Nursing Professional Development</p> <ul style="list-style-type: none"> • Describe OUD (OUD) as a chronic, treatable disease and identify how stigma and implicit bias affect care. • Apply person-first, trauma-informed communication and de-escalation strategies when caring for patients with OUD. • Demonstrate knowledge of evidence-based OUD treatment pathways (e.g., screening, brief intervention, and referral; MOUD initiation/referral). <p>Patient Outcome</p> <ul style="list-style-type: none"> • Improve patient experience and engagement (reduced hostile interactions; improved therapeutic rapport). • Increase acceptance of treatment options (e.g., naloxone education, MOUD referral/continuation) and reduce AMA/early departure risk. <p>Organizational Outcome</p> <ul style="list-style-type: none"> • Improve staff attitudes and confidence in caring for patients with OUD and standardize referrals/consult triggers. • Reduce safety events related to unmanaged withdrawal/agitation and improve continuity of care across transitions. | | | |
|---|------------|--|--|
| Topical Content Outline | Time frame | References | Teaching method/learner engagement and Evaluation method |
| Introduction: Why stigma and implicit bias matter in OUD care (impact on outcomes, safety, and equity). | 3–4 min | van Boekel et al., 2013; Livingston et al., 2012; SAMHSA, 2023 | Pretest at the start of the huddle Mini-lecture; quick poll (hands up/QR). |

| | | | |
|---|-------|---|---|
| | | | Pretest (5 items). |
| Module 1: OUD basics—neurobiology, withdrawal vs intoxication, pain considerations, and myths. | 4 min | ASAM, 2020; SAMHSA TIP 63, 2021/2023 | Case vignette discussion; “myth vs fact” cards. |
| Module 2: Person-first and trauma-informed communication; avoiding stigmatizing language; motivational interviewing basics. | 4 min | SAMHSA, 2014; Rollnick et al., 2008 | Role play scripts (2-minute pairs); feedback checklist. |
| Module 3: Evidence-based clinical pathway—screening (SBIRT), consult/referral triggers, harm reduction, naloxone education. | 4 min | SAMHSA SBIRT; CDC, 2022; WHO, 2014 | Workflow walk-through; pocket card review. |
| Module 4: Medication for OUD (MOUD)—buprenorphine/methadone/naltrexone overview; continuation during hospitalization; discharge planning. | 5 min | SAMHSA TIP 63; ASAM, 2020 | Teach-back: “what do you do next?” branching scenarios. |
| Module 5: Safety, ethics, and legal considerations—nonjudgmental care, EMTALA/anti-discrimination principles, documentation, de-escalation. | 4 min | ANA Code of Ethics, 2015; Joint Commission, 2018 | Group discussion: ethical dilemmas; debrief. Posttest at the end of the huddle for module #5. |
| Follow-up reinforcement: PowerPoint in learning management system (LMS) and pocket cards distributed in huddles at module 5. | 5 min | Site policy; local referral resources, pocket cards | |

Evaluation Method: Pre and Posttest (manual data collection before module 1 and after module 5).

Pre- and Post-Test Questions (10 – Questions)

Knowledge (Case Study Multiple choice with only one correct answer)

1. Pain Management in a Patient With OUD

Mr. C is an 86-year-old patient with a history of OUD (OUD) who reports severe right knee pain. X-rays show bone-on-bone arthritis. There is no pain management order.

- a. Ignore the complaint because patients with OUD should not receive pain treatment
- b. Order physical therapy only and reassess in several weeks
- c. Assume the patient is exaggerating pain to obtain medications
- d. Speak with the covering provider to request non-opioid pain management options

Correct answer: d

Rationale: A history of OUD does not negate the right to pain management. Non-opioid and multimodal strategies are appropriate and evidence-based.

2. Assessing Pain Objectively

A patient with OUD reports severe postoperative pain, but vital signs are stable and the patient appears calm.

- a. Pain is unlikely because vital signs are normal
- b. Pain is subjective and should be assessed using a standardized pain scale
- c. The patient is likely drug-seeking
- d. Delay pain treatment until objective signs appear

Correct answer: b

3. Language and Stigma

Which statement demonstrates non-stigmatizing communication when caring for a patient with OUD?

- a. "You've abused drugs before, so we need to be careful"
- b. "You're an addict, so pain meds aren't an option"
- c. "You have a history of OUD; let's work together on safe pain control"
- d. "Your pain is probably psychological"

Correct answer: c

4. Acute Pain in Patients on Medication Assisted Treatment (MAT)

A patient on buprenorphine for OUD is admitted with a fractured hip and reports severe pain.

- a. Stop all pain medication due to relapse risk
- b. Continue MAT and collaborate with the provider on acute pain management
- c. Discontinue buprenorphine permanently
- d. Delay pain treatment until discharge

Correct answer: b

5. Bias Recognition

A nurse feels frustrated caring for a patient with OUD who frequently requests pain relief. What is the best first step?

- a. Avoid the patient to reduce conflict
- b. Recognize personal bias and refocus on objective assessment
- c. Label the patient as non-compliant
- d. Report the patient for drug-seeking behavior

Correct answer: b

6. Non-Opioid Pain Strategies

Which intervention is appropriate as part of multimodal pain management for a patient with OUD?

- a. Refusing all analgesics
- b. Only offering reassurance
- c. Acetaminophen, topical agents, ice, and physical therapy
- d. Sedation to avoid pain complaints

Correct answer: c

7. Responding to Pain Complaints

A patient with OUD reports uncontrolled pain despite current orders.

- a. Tell the patient to tolerate the pain
- b. Document the complaint and notify the provider for reassessment
- c. Assume the patient is manipulating staff
- d. Delay action until the next shift

Correct answer: b

8. Ethical Considerations

Which principle supports providing adequate pain relief to patients with OUD?

- a. Justice
- b. Autonomy
- c. Nonmaleficence
- d. All of the above

Correct answer: d

9. Trauma-Informed Care

Which action best reflects trauma-informed care for patients with OUD?

- a. Setting strict limits without explanation
- b. Assuming dishonesty
- c. Involving the patient in shared decision-making
- d. Avoiding discussions about pain

Correct answer: c

10. Documentation and Advocacy

A patient with OUD reports worsening chronic pain and feels dismissed by staff.

- a. Avoid documenting subjective complaints
- b. Document objectively and advocate for reassessment
- c. Remove pain from the care plan
- d. Discourage further reporting

Correct answer: b

Attitudes / Confidence (Likert Scale: Strongly Disagree → Strongly Agree)

- 1. I feel comfortable caring for patients with OUD.
- 2. I can identify stigmatizing language and behaviors in clinical practice.
- 3. I understand evidence-based principles for treating OUD.
- 4. I am confident using non-stigmatizing, person-first language.
- 5. Staff education can reduce stigma and improve care for patients with OUD.

Pocket Cards will be distributed at the final module (5).

- 1. OUD is a chronic medical condition
Treat OUD with the same respect and consistency as other chronic illnesses.
- 2. Use person-first language
Say “person with OUD,” not labels that define the patient by the condition.
- 3. Avoid stigmatizing terms
Words influence attitudes, care decisions, and patient trust.
- 4. Treat pain appropriately
OUD does not eliminate the right to safe, effective pain management.
- 5. Support MOUD when indicated
MOUD is evidence-based and lifesaving.
- 6. Practice trauma-informed care

Assume a history of trauma; prioritize safety, choice, and respect.

7. Listen without judgment

Active listening improves engagement and adherence.

8. Build trust through empathy

Small actions and words shape patient experiences.

9. Recognize implicit bias

Self-awareness helps prevent unequal treatment.

10. Respect supports recovery

Dignity and compassion improve health outcomes.

Pre- and Post-Test Scoring System (OUD Staff Education)

Test Structure

- Number of questions: 10
- Question type: Multiple choice (1 correct answer per question)
- Focus areas:
- Pain management in OUD
- Stigma and implicit bias
- Evidence-based, non-opioid interventions
- Ethical and trauma-informed care

Point Allocation

- Correct answer: 1 point
- Incorrect answer: 0 points

Maximum possible score: 10 points

Score Interpretation

| Score Range | Knowledge Level Interpretation |
|-------------|--|
| 0–3 | Limited knowledge / high stigma risk |
| 4–6 | Moderate knowledge / needs reinforcement |
| 7–8 | Adequate knowledge |
| 9–10 | Strong knowledge / best practice alignment |

Pre- vs Post-Test Comparison

- Individual score change:
- Post-test score – Pre-test score = Knowledge Gain
- Group outcome measure:
- Mean pre-test score vs. mean post-test score
- Target improvement benchmark:
- $\geq 20\text{--}30\%$ increase in mean post-test scores

Program Effectiveness Criteria

The education intervention will be considered effective if:

- $\geq 80\%$ of participants score 7 or higher on the post-test
- Mean post-test score increases by at least 2 points compared to pre-test

Optional Bias-Focused Sub-Scoring

You may also track stigma-related items separately:

- Identify 5 stigma-focused questions
- Score same system (1 = correct, 0 = incorrect)
- Maximum stigma score: 5

Interpretation:

| Score | Interpretation |
|-------|---------------------------------------|
| 0–2 | High stigma risk |
| 3–4 | Moderate stigma awareness |
| 5 | Low stigma / patient-centered mindset |

Data Collection Method

Pre- and post-tests will be administered with manual data collection before module 1 and after module 5. OUD staff education session using a Pre and post testing scores will be manually collected base on staff numbers not name and analyzed to assess changes in knowledge, attitudes, and stigma related to OUD and pain management.

PowerPoint slides were used as a reminder and launched in the learning management system (LMS) at the site.