IMPLEMENTING HOSPITAL AND EMERGENCY DEPARTMENT SUBSTANCE USE DISORDER CARE: TRANSLATING ASAM GUIDANCE INTO ACTION

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Outline

1. Background and Rationale (5 minutes)
2. Overview of competencies and implementation guide (15 minutes)
3. Taxonomy (5 minutes)
4. Vignettes/Case Studies
    1. ACS (5-7 minutes)
    2. HBOT (5-7 minutes)
    3. Bridge Clinics (5-7 minutes)
5. Breakout Session (10 minutes)
6. Report Out Session (20 minutes)
7. Q&A (5 minutes)

Scope of the Problem

Substance Use Disorder in U.S. Hospitals and EDs

- 105,000 overdose deaths annually in the U.S.
- 178,000 alcohol-related deaths annually
- 11.9% of inpatient hospitalizations involve SUD
- 9.4% of ED visits involve SUD
- $13 billion in hospital medical costs (2017)
- 12-month mortality:
  - 8% after hospitalization for OUD
  - 6% after fentanyl-positive ED visit

The Implementation Gap

SUD often goes unaddressed in acute care.

- Historic siloing of SUD from medical care
- Effective treatments exist but are not routinely initiated
- Withdrawal management alone is not adequate treatment
- Lack of integration contributes to stigma
- Patients report being dehumanized or having needs minimized
- Lack of treatment associated with premature discharge

Why Hospitals and EDs Matter

Hospitals are universal access points.

- Unique opportunity and responsibility to address SUD
- Initiating treatment during hospitalization improves:
  - Engagement in post-discharge care
  - Readmission rates
  - Clinical outcomes
- Mortality risk peaks in days and weeks after discharge
- ASAM outlines standard capabilities for general hospitals in THE ASAM Criteria (4th Edition)

Purpose of the Guidance

- Delineate the services and competencies needed to meet the ASAM Criteria standards for general hospitals
- Describe care delivery models (e.g., Addiction Consult Services, practice-based models, bridge clinics)
- Provide implementation guidance to hospital administrators and clinician leaders

This guidance supports hospitals and EDs in implementing baseline standards of care for patients with SUD.

How the Standards Were Developed

- Informed by a structured review of the literature
- Task Force reviewed and updated existing standards
- Modified Delphi method used to rate appropriateness
- Independent voting panel (without conflicts of interest) rated each standard (appropriate, uncertain, inappropriate)
- Stakeholder review (August 2025)
- Review by ASAM Quality Improvement Council and Criteria Strategy Steering Committee
- Final approval by ASAM Board of Directors

The 7 Core Competencies

1. Identification and engagement of patients with SUD
2. Intoxication and withdrawal management
3. Overdose and post-overdose care
4. Initiation and continuation of addiction medications
5. Management of co-occurring conditions
6. Linkage to ongoing SUD care
7. Risk reduction

General Implementation Steps

1. Identify stakeholders and obtain buy-in
2. Conduct a focused landscape survey and needs assessment
3. Define and measure success
4. Establish a sustainable funding model
5. Provide education and address stigma

Key Implementation Considerations

- Selection of care delivery model
- Staffing and workforce capacity
- Clinical workflows and order sets
- Billing and sustainable financing
- Community referral partnerships
- Quality metrics and performance monitoring

All US hospitals and EDs should deliver addiction care, but how?

- Various approaches exist.
- Standard model definitions are critical to advancing clinical care, research, policy

Taxonomy

- Scoping review of published literature (Jan 2000-July 2021)
- Key informant interviews across diverse US geographies, hospital settings
- 6 distinct model types, classified as
  - Consult models (interprofessional ACS, psych CL service, individual consultant)
  - Practice-based models (HBOT, HBAT)
  - Community in-reach

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Interprofessional Addiction Consult Service (ACS)

- **Dedicated staff** provide comprehensive addiction care; *by definition* includes:
  - Expert addiction clinician (e.g., MD)
  - Coordinator (e.g., social worker or case manager)
  - Patient engagement staff (e.g., peer)
  - Many include other roles such as nurses and pharmacists
- Designed to manage high SUD, physical, behavioral health complexity
- Platform for system-level education, policy transformation

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Other consult-based models

- Psychiatry Consult Liaison
- Individual Consultant Model

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Hospital-Based Opioid Treatment (HBOT)

- **Generalists** (e.g., hospitalists, ED clinicians) and non-addiction specialists (e.g., ID) integrate meds for OUD as part of standard practice
  - Does not rely on expert addiction consultants
- Often rely on protocols and order sets
- Not designed to manage high SUD complexity or co-occurring medical or behavioral health needs

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In-reach model

- **Community-based clinicians** in primary care or specialty addiction care "reach in" to hospital to offer MOUD, provide remote clinician support, and follow-up.

- Though Bridge Clinics were outside scope of taxonomy, they provide useful example of how in-reach could be implemented.

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Comparing ACS, HBOT and in-reach

- All models rely on:
  - Clinicians who start, continue SUD meds
  - FDA approved meds are available on formulary
  - Care pathways supporting linkage to ongoing SUD care after DC
- Vary by resources/ staffing, expertise, scope
- Can co-exist (e.g. ACS plus HBOT)

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Vignette/Case Study #1 – ACS

Addiction Consultation Service

MD

- Diagnosis
- Medication
- Comorbidity

SW

- Brief interventions
- Discharge planning

Peer

- Engagement
- Recovery support

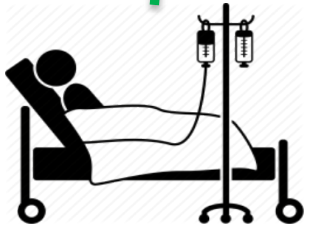
APP

- Implementing protocols
- Monitoring response

PharmD

- Medication optimization
- Harm reduction

Addition Consultation Service
(Staff + Tools)



Hospitalized patient with untreated SUD

Roadblocks:

- Lack of knowledge, training, protocols
- Focus on acute admission; psychosocial issues often deferred
- Poorly coordinated care transitions
- Payer mix and payment models are disincentives
- Stigma

Patient receives evidence-based care:

- Diagnostic Assessment
- Education
- Brief interventions
- Appropriate medications

Improved Outcomes:

- ⬆ Medication Treatment
- ⬆ Linkage to care in community
- ⬆ Health outcomes

Principles of *Collaborative Care* can be applied to ACS

Population-Focused

- Defined target population
- Consultative, flexible, adaptive

Patient-Centered Team

- Trauma Informed: *safety, choice, collaboration, trustworthiness and empowerment*
- Motivational

Evidence-Based

- Utilizes treatments supported by credible research
- MOUD; Standards of Care
- MI; BNI; RED

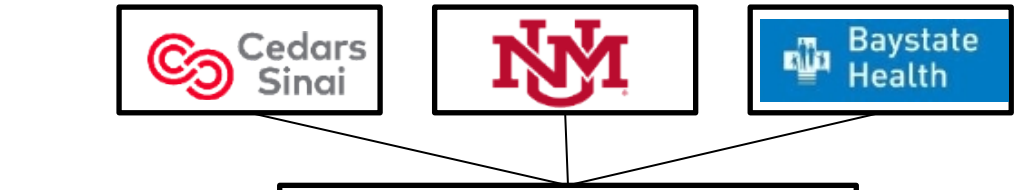
Measurement-Driven

- COWS; CIWA
- Induction protocols
- Pain; Depression
- Care-coordination process

Accountable

- Fidelity
- Utilization outcomes
- Patient outcomes

START for Hospitalized Patients with Opioid Use Disorders:
Translating Evidence into Practice



414 patients randomized, stratified by prior MAT use

START | Usual Care

Inpatient Outcomes
- In-hospital MAT initiation*
- Completed after-hospital care plan

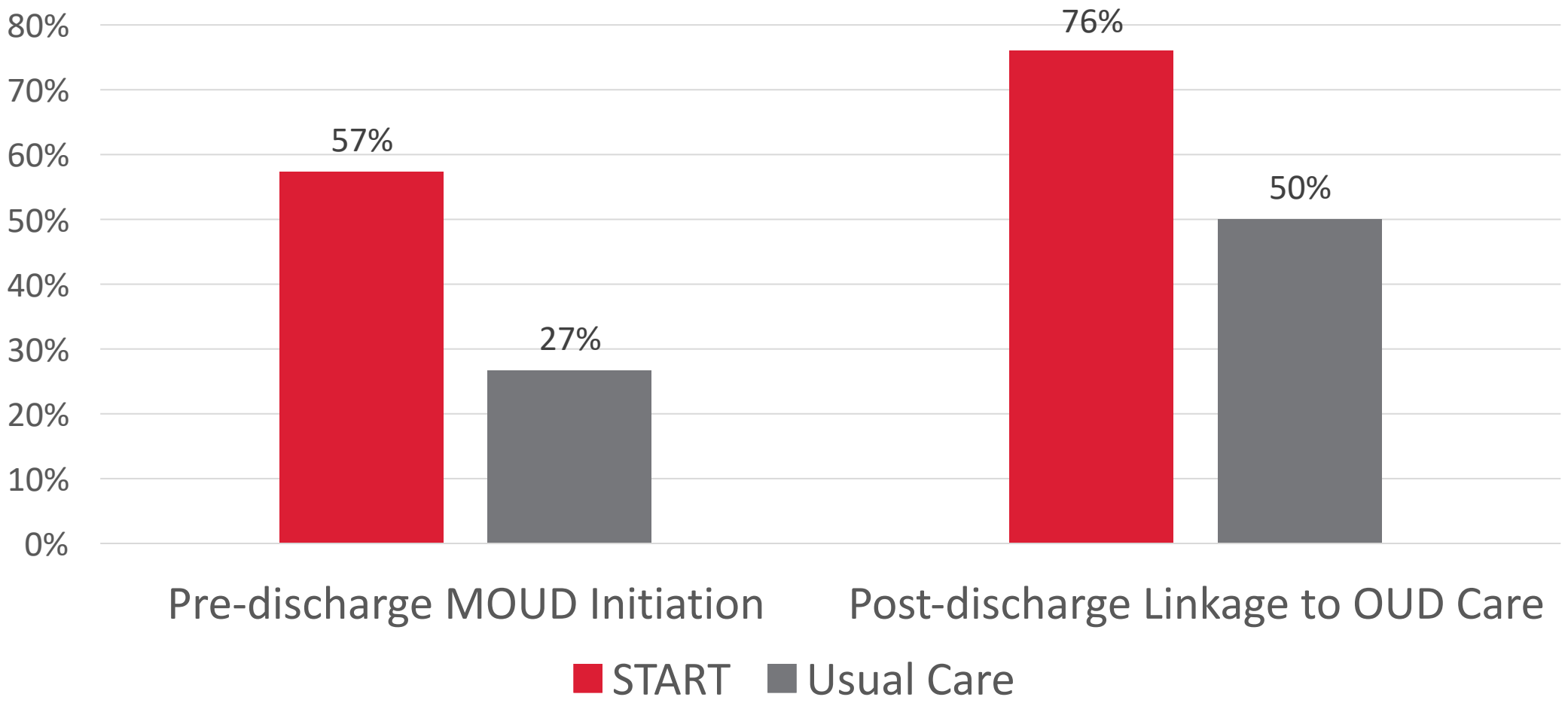
Outpatient Outcomes
- OUD treatment initiation*
- OUD treatment engagement
- MAT initiation / continuation
- Medical treatment follow up
- Readmission/Emergency Department use
- Opioid misuse

***Other outcomes:**
- Local variability, context
- Sustainability of CCT
- Costs

Funded by the National Center for Advancing Translational Sciences (NCATS) and National Institute on Drug Abuse (NIDA) U01 TR002756

ASAM American Society *of* Addiction Medicine

Results from the START Study



MOUD Initiation: aRR=2.10, 97.5% CI: (1.51, 2.91)]

Linkage: aRR=1.46, 97.5% CI: (1.14, 1.88)]

Practical Implementation

Challenges

- Billing limitations
- Staffing positions
- Scope of services (pain; psych; etc...)
- Pro-active vs Re-active
- Aftercare/ SDOH
- Demonstrating ROI

Facilitators

- Leadership Support
- Champions (MD; RN; SW; PharmD...)
- Pipeline (trainees)
- Mission reasoning (service; discovery; education; community)
- Community partners

Case Study # #2 – HBOT: Hospital Based Opioid Treatment

Core Components

- **MOUD:** Offer buprenorphine +/- methadone +/ XR naltrexone
- Typically offer naloxone, overdose education
- Referral to post-hospital OUD care

Focus is patients with high motivation for change, not designed to manage high medical/ behavioral complexity

Less dedicated financial resources

Does not depend on addiction expert on staff

HBOT challenges

- Generalist staff may lack expertise, comfort managing SUD
  - May hold negative attitudes towards people w OUD
- Staff have many competing priorities and high workload
- Systems are often unprepared
  - Formularies lack basic meds
  - Policies can interfere (e.g. belonging searches, off-unit policies)

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Shearer JSAT 2024
Hawk JAMA Open 2020

HBOT facilitators

- Strong clinical champions facilitate:
  - Staff engagement to promote MOUD as evidence-based standard of care
  - Negative experiences/ burnout as motivation for system improvement
- Protocols, order sets, decision-support make care "easy"
- Technology can standardize and streamline care
- Interdisciplinary teams promote high quality care

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Peng JAMA Open 2026
Hawk JAMA Open 2020

Case Study # 3: Bridge Clinics

Core Components of Care

- **Immediate Access:** Walk-in and same-day access, ability to start treatment immediately.
- **Low Threshold:** Flexible schedule which allows for high touch care, drop-in services, and no requirements for or barriers to receiving care.
- **Person-Centered:** Treatment goals are patient-defined and patient-driven.
- **Transitional Care:** Patients receive brief treatment, stabilization, and care coordination with the goal to bridge patients to ongoing care.

Bridge Clinic Model of Care

- **Recruitment and Referral:** Patients referred from the ED, hospital, primary care, word of mouth, and community partners.
- **Connection:** Patient is welcomed into care, seen same day.
- **Treatment Initiation and Stabilization:** Providers offer same day assessment and treatment initiation including medication. Other care team members provide a variety of other supports, which may include recovery coaching, brief therapy, infectious disease screening & treatment, mental health care, and resource finding.
- **Bridge to Ongoing Care Setting:** Once a patient is stabilized, they are transitioned to a long-term, community-based treatment setting.
- **Ongoing access:** A patient may return to Bridge clinic at any time.

The Care Team & Roles:

Primary Roles	Primary Responsibilities
Addiction Specialist Physician*	Assessment, diagnosis, development of a treatment plan, withdrawal management, initiation of pharmacotherapy, and management of SUD-associated medical complications
Bridge Clinic Clinical Therapist	Psychosocial assessment and determination of a psycho-social treatment plan Provides crisis intervention and trauma informed short-term therapy
RN	Triages patients, provides injections, administers medication, provides OBAT RN care
Recovery Coach	Provides peer recovery support services
Practice Manager	Oversees the daily operations at the clinic and supports the clinic with administrative duties such as scheduling appointments, billing, verification of insurance, etc.
Practice Coordinator*	Greets all patients and visitors to the practice in a welcoming and respectful manner. Performs check-in and check-out functions, scheduling follow-up appointments, etc.
Resource Specialist*	Links to services not offered at BC (OTP, ATS, residential, sober living, etc.) Works with patient and clinical team to develop transition plan

*At a minimum, a Bridge Clinic can be staffed with a physician or advanced practice provider with specialty addiction expertise, a patient services staff member, and a care coordinator or resource specialist to link to other care.

Breakout Session

Sharing common wisdom, what is working and what isn't:

1) What is one success you have had in implementing hospital-based SUD services?
2) What is a challenge you have faced in implementing hospital-based SUD services?

Report Out

Each table shares one topic that hasn't yet been discussed

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