ASAM American Society of Addiction Medicine

Implementation Guide for Hospital and Emergency Department Substance Use Disorder Care

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Introduction

Drug overdose has become the leading cause of death for Americans under age 50. Between 2003 and 2023, the age-adjusted death rate from overdose increased from 8.9 to 31.3 per 100,000, equating to more than 105,000 overdose deaths in the US per year.[1] Excessive alcohol use contributes to an additional 178,000 deaths each year. Beyond mortality, people living with substance use disorder (SUD) experience a high burden of multimorbidity in addition to the chronic sequelae of untreated SUD.[2-5]

SUD is highly prevalent among patients in general hospitals and emergency departments (EDs).[6-8] Between 2014 and 2018, 11.9% of inpatient hospitalizations and 9.4% of ED visits were for patients with SUD.[8] The morbidity, mortality, and cost associated with untreated SUD in hospitals and EDs are substantial. In 2017 alone, the medical costs associated with SUD care in US hospitals and EDs exceeded $13 billion.[9] Mortality rates following hospital and ED encounters are high, with studies demonstrating a 12-month mortality rate of 8% for patients hospitalized with OUD after discharge and 6% for patients with fentanyl use after an ED visit.[9-11]

Because of the historic siloing of SUD care away from the rest of medical care, SUD often goes unaddressed during hospital and ED encounters despite the existence of effective treatments. Lack of SUD treatment is associated with increased rates of premature hospital discharge, emphasizing the importance of effectively addressing SUD to enable patients to get care for their comorbid medical conditions.[12] Lack of training, education, and guidance on how to manage SUD and limited integration of SUD treatment into hospitals and EDs may also contribute to stigma among clinicians. Patients with SUD have reported past experiences of being dehumanized and having their needs minimized in hospital and ED settings, and these experiences lead individuals to avoid or delay seeking needed healthcare services.[10, 13-16] Lack of access to treatment resources also amplifies pessimism among clinicians and enhances stigma.[17,18] When providers do not know how or lack the resources to address SUD, they may feel demoralized and may exhibit more negativity toward patients with SUD. Conversely, access to hospital-based care for patients with SUD reduces stigma and increases providers' willingness to offer treatment.[19,20]

Hospitals routinely provide services that go beyond treating an immediate crisis, initiating treatment for chronic conditions and connecting patients to ongoing care. For example, after stabilizing a patient experiencing a diabetic emergency, hospitals develop a treatment plan including ongoing glycemic management and connection to community care. Initiating treatment at this stage prevents patient harms and reduces hospital readmissions.[21-22] Similarly, initiating SUD treatment during hospitalization represents a critical opportunity not only to mitigate downstream harms such as readmission, recurrent SUD-related morbidity, and mortality, but also to advance the core goals of effective treatment and sustained recovery.[10,23-25]

Treatment of SUD in hospital and ED settings is feasible, rewarding, and improves outcomes, including improved engagement in post-discharge addiction treatment, reduced risk of readmission, and reduced addiction severity (see Appendix C). When hospitals and EDs systematically provide evidence-based care to all patients with SUD, they create an equitable entry point to treatment that can help counteract the structural barriers that often prevent individuals from accessing SUD services. Initiating treatment during hospital stays can help bypass the common disparities in access to care (eg, community referral patterns, lack of insurance coverage).[26] Moreover, establishing clear definitions of the standard of care for SUD services and competencies for SUD care within hospital and ED settings can reduce the impact of provider biases that may contribute to undertreatment of SUD in vulnerable populations.

Addiction consultation and initiation of addiction medications are both associated with reduced hospital readmission.[27] Additionally, as patients in hospital and ED settings generally have other medical and psychiatric conditions co-occurring with SUD, managing these is easier and more likely to be successful when SUD is effectively treated.[28-30]

As universal points of health care access, hospitals and EDs have a unique opportunity to engage people with SUD and reduce related morbidity and mortality. The American Society for Addiction Medicine (ASAM) outlines standard capabilities that all hospitals should meet to effectively care for patients with SUD (summarized in Table 1) in the Fourth Edition of *The ASAM Criteria*, updated in 2025.[31-32] These standards offer one framework for the elements of care that all hospitalized patients with SUD should receive.

Table 1. Core Competencies for Hospital-Based SUD Care Aligned With *The ASAM Criteria**

Core Competencies	Detailed Description
1. Identification and engagement of patients with SUD	Provide a welcoming, patient-centered, and nonstigmatizing environment for individuals with SUD. Hospitals, including EDs, should embed trauma-sensitive practices in all aspects of care.
2. Intoxication and withdrawal management	Assess and manage intoxication and acute withdrawal using evidence-based practices.
3. Overdose and post-overdose care	Manage acute overdose and immediately provide care for the underlying SUD when present.
4. Initiation and continuation of addiction medications	Offer initiation and continuation of medications for SUD for all patients with an SUD for which FDA-approved medications exist, including medications for AUD, OUD, and TUD, and ensure medications are available on formulary.
5. Assessment and management of common co-occurring conditions	Assess and manage common comorbidities, including mental health conditions and pain.
6. Linkage to ongoing SUD care	Link people to ongoing SUD care after discharge from acute care.
7. Risk reduction	Offer interventions to reduce identified risks (eg, overdose prevention interventions, education on safer use practices).

* See Appendix A for a full summary of The ASAM Criteria General Hospital Standards.
ASAM, American Society of Addiction Medicine; AUD, alcohol use disorder; ED, emergency department; FDA, Food and Drug Administration; OUD, opioid use disorder; SUD, substance use disorder; TUD, nicotine/tobacco use disorder

ASAM recognizes that implementing these standards can be challenging for hospitals that are already struggling to meet existing requirements with an overburdened workforce. As such, ASAM convened a Presidential Task Force (hereafter referred to as the Task Force) to develop this *Implementation Guide for Hospital and Emergency Department Substance Use Disorder Care* (hereafter referred to as the Guide) to support hospitals and EDs to implement these standards.

Purpose

Research has demonstrated that touchpoints with EDs and hospitals may offer reachable moments to initiate effective SUD treatment and transform health systems to better meet the needs of people with SUD.[33] Hospital- and ED-based provision of SUD services, including pharmacotherapy, psychosocial services, linkage to ongoing SUD treatment, and services to reduce the risk of overdose and infectious

diseases, has been demonstrated to increase engagement in post-discharge care, reduce hospital readmission, and improve clinical outcomes related to SUD. ASAM developed standards for general hospitals in *The ASAM Criteria*, yet more guidance is needed regarding how hospitals and EDs can meet these standards.

The purpose of this Guide is to:

- Delineate the services and competencies needed to meet SUD care standards for general hospitals
- Describe care delivery models such as addiction consult services (ACS) and bridge clinics that can increase adoption of these care standards
- Provide implementation guidance to hospital administrators and clinician leaders on how to effectively implement baseline standards of care for patients with SUD in hospital and ED settings

Methodology

ASAM convened a Task Force comprised of seven subject matter experts to develop updated standards for general hospitals for *The ASAM Criteria*, Fourth Edition. The detailed methodology and key questions can be found in Supplemental Materials.

The ASAM Criteria, Fourth Edition General Hospital Standards

Development of *The ASAM Criteria* standards for general hospitals was informed by a structured review of the literature.[32] The Task Force reviewed the existing standards in *The ASAM Criteria* and proposed updated standards. A modified Delphi method was used to develop consensus on the standards.. A separate voting panel—comprised of five experts who were not involved in developing the draft standards and without relevant conflicts of interest—voted on the appropriateness of each standard, rating each as appropriate, uncertain, or inappropriate. The Task Force worked with the voting panel to address concerns and modify the standards as needed.

The draft standards were released for invited stakeholder review in August 2025. The Task Force systematically analyzed the feedback and modified the standards before submitting them to *the ASAM Criteria* Strategy Steering Committee and Quality Improvement Council (QIC) for approval.

Implementation Guidance

Development of this Guide was informed by a structured review of the literature (both primary research and gray literature). Twenty field reviewers provided detailed feedback on the full draft document in April 2025. The Task Force reviewed all comments and updated the document to address identified concerns. ASAM's Board of Directors, QIC and Public Policy Coordinating Council provided feedback on the semi-final document in November 2025. The Task Force reviewed all comments and updated the document to address identified concerns. ASAM's Board of Directors approved the final document in December 2025.

A list of Task Force members and field reviewers and their areas of expertise and conflict of interest disclosures are available in Supplemental Materials.

Recommended Competencies

Table 1 delineates the core recommended substance-related competencies outlined in *The ASAM Criteria* standards for general hospitals. The following sections provide a detailed discussion of each of the following core competencies:

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

Competency 1: Identification, Engagement, and Approach to Patient Care

Identifying, engaging, and building an alliance with patients who may benefit from SUD services is an important opportunity in hospital- and ED-based settings. For example, engaging patients presenting with conditions such as intoxication-related falls, injection-related infections, withdrawal, overdose, pancreatitis, and alcohol-related liver disease in SUD care can be highly impactful for longer-term prognosis. Universal screening with a validated instrument is one way of identifying unhealthy substance use (see Appendix E for resources).[7,34] Screening has often been emphasized as a place to begin substance use services in hospital-based settings, is recommended by the Joint Commission, and is a requirement for Level 1 trauma centers. While implementing universal screening may help normalize conversations about substance use, screening alone is insufficient and must lead to clinical interventions when unhealthy use or SUD is identified.[35]

Hospitals implementing universal screening should have services and protocols in place on how to respond to a positive screen. If a patient has been identified through screening to be at high risk for SUD, management of immediate needs and development of an ongoing care plan should happen during the hospitalization. For unhealthy alcohol use, studies have found benefit to delivering a brief intervention in general medical settings, which is a focused conversation rooted in principles of motivational interviewing to provide nonjudgmental feedback about alcohol use.[36-38] Importantly, brief intervention alone has not been shown to be effective for reducing drug use, or for people with severe AUD (see Appendix E for resources).[39]

One way to reframe screening is to think of it as a means of engaging patients in need of care, which requires the care that we offer to be high-quality, welcoming, effective, and appealing. Large implementation projects such as California Bridge have successfully engaged patients into care with a simple strategy of publicly posting the availability of SUD services as part of routine ED care in clinical areas and waiting rooms.[40] This strategy communicates the dual message that services are available and the hospital is committed to providing them on-demand.[41]

Patients who screen positive for unhealthy substance use or present with substance-related health conditions, such as withdrawal, overdose, or drug use-related infections, should be offered assessment for SUD while in the hospital or ED.[42,43] Upon diagnosis, clinicians should communicate screening and assessment results compassionately, initiate evidence-based treatment promptly, and develop a comprehensive discharge care plan effectively. ACS can provide valuable expertise for diagnostic assessments, particularly when the patient has a complex presentation. An accurate diagnosis is particularly important for patients with conditions such as sickle cell disease, where misdiagnoses and stigmatization may contribute to inadequate pain management.[44,45]

Clinicians should approach patient assessments with empathy and offer care that is individualized, nonjudgmental, rooted in autonomy, and pragmatic. Individuals with SUD experience significant stigma, both in day-to-day life and in healthcare systems, which often leads to mistrust. Patient-centered and trauma-informed care principles can facilitate welcoming, nonjudgmental interactions to build trust. Patients who decline addiction treatments or services retain the right to autonomous medical decision-making. They should continue to receive respectful education and engagement efforts that address their concerns and align with their values, as with any other medical condition (see Appendix E for resources).

When addressing substance use risks, hospitals should focus on creating a safe environment for patient care. This may include a review of how institutional policies may inadvertently contribute to stigma or discrimination.[46,47] For example, policies that may be differentially applied in patients with SUD due to broad group stereotypes such as those related to patients leaving the hospital unit; searches of patients and their belongings; allowances for visitors; responses to in-hospital substance use; candidacy for organ transplantation, surgery, or procedures; referral and acceptance to post-acute care facilities; and toxicology and reporting in pregnancy (see Appendix E for resources).

Competency 2: Intoxication and Withdrawal Management

Timely identification and management of intoxication and withdrawal are important initial steps in caring for patients with SUD. Given the prevalence of substance withdrawal among patients in these settings, all hospitals and EDs should be capable of managing diverse withdrawal syndromes.[8,48] Withdrawal management alone (ie, “detoxification”) can increase a patient's risk for substance use related morbidity and mortality due to lost tolerance.[49-53] As such, concurrent initiation of treatment for the underlying SUD should be prioritized. Effectively managing withdrawal is essential for patient safety and helping patients remain comfortable and stay in the hospital. This is particularly true for patients with opioid use disorder (OUD), where the gold standard of care involves ongoing treatment with medication for opioid use disorder (MOUD). Because of the lack of effectiveness of withdrawal management alone, the standard of care for patients experiencing opioid withdrawal in the context of OUD includes both managing withdrawal symptoms and offering MOUD.[54]

Managing intoxication and withdrawal syndromes demands clinical expertise and attention to individual patient presentations. Clinicians must navigate an increasingly complex landscape of SUD and drug supply adulteration. Clinical presentations often interweave conventional and unconventional withdrawal patterns, creating multilayered clinical pictures that require careful assessment and management (eg, xylazine withdrawal co-occurring with opioid withdrawal). Medical and psychiatric comorbidities may intensify withdrawal symptoms and necessitate modifications to standard protocols. Success in managing

complex cases relies on systematic monitoring, clear communication among team members, and regular clinical reassessment. For systems seeing a higher volume of complicated cases, ACS are helpful for supporting complex intoxication and withdrawal management.

Competency 3: Overdose and Post-Overdose Care

Hospitalist and emergency medicine practitioners should be prepared to manage overdoses on site and care for patients in the post-overdose period by providing both initial stabilization and initiation of SUD care. Timely, compassionate care can help prevent self-discharge and reduce hospital readmissions.[21,55-57] This includes offering immediate MOUD initiation for patients with OUD and other services to support engagement and patient wellness. Patients may also experience an overdose in a hospital-based setting. In these circumstances, immediate access to naloxone on code/crash carts and stored with automatic external defibrillators (AEDs) in public spaces can increase the rapidity of the response and resuscitation.

Lower doses of naloxone are often effective and should be encouraged whenever possible to limit the extent of precipitated withdrawal. For patients experiencing opioid withdrawal as a result of resuscitation with naloxone, MOUD can be administered immediately to reverse the opioid withdrawal signs and symptoms.

Given the overlap between overdose and suicide risk, screening for suicide risk is recommended. Any patient who is discharged after experiencing an overdose should be offered naloxone and direct linkage to ongoing SUD care.[58] Clinicians can also consider providing safer use supplies when appropriate and permitted by state law.

Competency 4: Initiation and Continuation of Addiction Medications

Addiction consultation and initiation of addiction medications are both associated with reduced hospital readmission.[27] Evidence-based medication treatment should be on formulary and available for all types of SUD that have FDA-approved treatments. For OUD, the cornerstone of treatment is MOUD. Given the lethality of the illicit opioid supply and the ongoing overdose crisis, timely initiation of MOUD is critical. As such, all hospitals and EDs should be able to support immediate initiation of MOUD when clinically appropriate. Discharge planning should provide referrals to ongoing SUD care and ensure access to MOUD during the transition period.

In addition to MOUD, there are also effective, FDA-approved medications for alcohol use disorder (AUD) and nicotine/tobacco use disorder (TUD) that can be initiated in the hospital setting when clinically appropriate. Voluntary psychosocial treatment referrals, including formal behavioral therapies, should ideally be available but never required as a precondition for medication treatment. For stimulant use disorder (StUD), off-label medications may be utilized, but the cornerstone of treatment is psychosocial treatment, notably contingency management, which may not be feasible to implement in hospital and ED settings.[59]

Competency 5: Assessment and Management of Common Co-occurring Conditions

SUD frequently co-occurs with other mental health conditions, and many patients with SUD have a history of trauma.[60,61] Hospitals and EDs should have staff available with the training and competency to screen, assess, and stabilize co-occurring psychiatric conditions, including suicide risk using trauma-informed principles of care. Mood symptoms, anxiety, and psychosis are common to both SUD and serious mental illness, yet differentiating between primary psychiatric disorders and substance-induced conditions may be challenging. Regardless of etiology, psychiatric symptoms should be treated concurrently with SUD using evidence-based approaches for co-occurring conditions, rather than managed sequentially.[54,59] This is particularly important when serious mental illness is present alongside SUD, as these conditions frequently exacerbate one another. Discharge planning should incorporate mental health follow-up as a core element of SUD care. Coordinated transitions ensure continuity of both psychiatric and SUD treatment, helping to improve outcomes and reduce the risk of return to use or readmission.

Pain is also highly prevalent among patients with SUD, particularly among patients with OUD.[62] Inadequate pain management can lead to high rates of self-discharge. For patients with acute or chronic pain and SUD, pain assessment and management with multimodal pain interventions is generally recommended.[54,63] Patients with active OUD generally have higher opioid tolerance than opioid-naïve patients and may require larger doses of opioid agonists to achieve analgesia in addition to multimodal pain management and continuation of MOUD.[64] Overlapping acute, chronic, or perioperative pain and OUD may be a clinical scenario where involvement of an ACS is helpful, particularly for patients who have illnesses that have been frequently misdiagnosed as SUD, such as sickle cell disease, and have experienced stigma. Addiction specialists can help by clarifying whether a patient has a diagnosis of OUD, guiding multimodal pain management, and joining interprofessional care meetings with other services, including pain consult teams. Conversely, involving addiction specialists in all cases of chronic opioid therapy for pain is not recommended and may reinforce stigma rather than reduce it.

Competency 6: Linkage to Ongoing SUD Care

As with other chronic conditions, SUD treatment requires ongoing engagement in care after hospital discharge. Much like hospitalists might start goal-directed medical therapy for heart failure and then connect a patient to cardiology follow-up once their acute inpatient needs are resolved, it is important that patients initiated on SUD treatment in the hospital or ED are linked directly to ongoing care after discharge.

Continuity of care after hospitalization has been facilitated by expansion of insurance coverage and essential health care benefits. Medicaid is responsible for a significant portion of coverage for SUD treatment and has provided critical access to effective care. Advances in telemedicine and the end of the requirement for a Drug Enforcement Administration (DEA) X-Waiver have increased access to buprenorphine treatment, which supports the feasibility and reach of hospital- and ED-based SUD initiatives.

Establishing referral relationships with opioid treatment programs (OTPs) and community providers who prescribe buprenorphine can help hospitals and EDs support ongoing care when medications are initiated during hospitalization. Whenever possible, linkage to the next step in care should be direct with appointments scheduled prior to discharge.

In addition to formalizing community partnerships, hospitals and EDs should consider developing clinics for post-hospitalization SUD care, such as bridge clinics. In rural settings, telemedicine may help expand the reach of post-discharge SUD care, and telemedicine bridge clinics have been shown to be feasible.[65] **It is important to note that not all SUD treatment programs provide or support MOUD, so verifying that community referral partners provide MOUD is critical.**

The risk of substance-related death reaches its peak in the days and weeks immediately following hospital discharge.[66] Therefore, rapid, low-barrier follow-up is essential. Same or next-day follow-up is ideal, given that both opioid-related mortality and all-cause mortality are significantly increased in the first week after discharge.[67] When this is not feasible, follow-up appointments within 7 days is recommended.[68] Patients should be given a prescription for enough medication to last until their follow-up visit.

A systematic approach to determining the appropriate level of care helps tailor interventions to individual patient needs. *The ASAM Criteria* offers a standardized approach for assessing the needs of patients with SUD across multiple dimensions to match them to a level of care that aligns with their clinical severity and treatment goals. In hospital or ED settings, utilizing a briefer psychosocial and clinical assessment to make a provisional level of care recommendation may be more practical. It is important for staff who conduct these assessments to have the appropriate training and scopes of practice. Immediate treatment initiation should not be delayed for completion of a comprehensive levels of care assessment.

In alignment with *The ASAM Criteria*, identifying an appropriate referral involves shared decision-making with patients to incorporate their unique needs, preferences, and goals into the aftercare plan. Hospitalists and emergency medicine practitioners may benefit from understanding that SUD treatment has historically been built on punitive models, and patients may have elected to not engage in care in the past because it was not welcoming or engaging. Hospitals can build alliances with community SUD treatment programs who provide evidence-based, non-judgmental care for SUD, acknowledge that patients may have had past negative experiences, and communicate their goal of facilitating connections to care that better meets patient needs. Patients can be offered a menu of appropriate options for care, with the recognition that each person is an expert in their own life, and care should ideally be guided by their preferences.

Competency 7: Risk Reduction

Many patients with SUD have experienced stigma and discrimination in health systems, particularly those who are actively using alcohol or other drugs. A person-centered care approach that is nonjudgmental, empathetic, and recognizes the autonomy and dignity of all people who use substances is recommended in all clinical settings, including hospitals and EDs. Patients benefit from being offered a range of services to improve their health and quality of life irrespective, of whether they are able to make changes to their substance use.

A compassionate and pragmatic approach can be helpful. In addition to offering SUD treatment, clinicians can offer interventions to reduce the negative consequences of substance use, such as naloxone and overdose prevention education for patients at risk for overdose and education on safer use

practices and related supplies for patients at risk of substance-related infections, when appropriate and as allowed by state laws.

Implementation Models

There are many possible strategies for meeting general hospital core competencies for SUD care. How hospitals deliver SUD care will vary based on resources, patient and population health needs, and other local and regional factors, including availability of addiction specialists. Hospitals should consider population-specific SUD needs, such as those of pregnant patients, adolescent patients, and people experiencing homelessness. This is similar to how hospitals approach other common health conditions and patient population needs. For example, all hospitals and EDs have protocols for addressing end-of-life care, including being prepared to discuss code status and patient goals and address pain and anxiety, however some deploy palliative care consult services to address these and other more complex needs of their population.

Staffing and Consultation Models

A taxonomy of hospital-based SUD care models describes three main categories (Figure 1)[a]:

- **Addiction consult services (ACS) models**, where addiction specialist teams deliver care in hospitals and EDs
- **Practice-based models**, where generalists provide SUD care as part of routine hospital practice
- **In-reach models**, where community clinicians offer guidance to hospital teams and provide post-hospital follow-up

[a]A summary of resources pertaining to each of the models described is provided in Appendix B.

Figure 1. Comparison of Three Common Hospital-Based SUD Care Models

	Interprofessional Addiction Consult Service (ACS)	Practice-based model (HBOT)	In-reach
Model Description	ACS provide comprehensive care through expert addiction clinicians (eg, MD), dedicated coordinators (eg, social workers or case managers), and patient engagement staff (eg, peers). Teams may also include other roles such as nurses and pharmacists.	General hospital clinicisans (eg, hospitalist, ED clinicians) offers medication for opiod use disorder as part of their standard practice.	Community-based clinician provides remote support to initiate or sustain SUD medications during admission.
Services Delivered by Hospital or ED Staff	**Clinicians start and continue SUD medications**		
	FDA approved medications are available on hospital formulary		
	Care pathways support linkage to ongoing SUD care after discharge		
	Clinicians conduct comprehensive SUD assessments	**Clinicians conduct basic SUD assessments**	
	Provide post-overdose care and distribute naloxone		
	Provide complex withdrawal management	**Provide basic withdrawal management**	
	Review hospital policies with a lens of assessing whether they are causing unintended harms		
	Support management of co-occurring medical (eg, endocarditis, transplant) and psychatric conditions (eg, suicidality, psychosis)		
	Provide dedicated patient engagement support (eg, peers)		
	Provide dedicated patient engagement support (eg, peers)		
	Provide advanced SUD medication management (eg, low dose buprenorphine)		
	Serve as platform for change for transformational SUD improvements and innovation (eg, methadone dispensation via 72 hour rule, developing bridge clinics)		
	Lead interprofessional staff-wide SUD education activities		

Specialized ACS teams offer the most comprehensive model and are best able to provide care for complex clinical cases; however, this model may be more challenging to implement in smaller or rural settings given the requirement for dedicated staffing and workforce specialization. Even with ACS, practice-based models are often still needed to elevate overall care, particularly since ACS may not be available 24/7.

Practice-based models require an upfront investment in training and champions, although they may not require dedicated staffing in the long term. However, they offer less specialized and interprofessional services than ACS and, thus, may not be able to handle the same level of clinical complexity.

In-reach models may be feasible even in rural and less well-resourced settings, but they offer the least amount of support for providers and patients.

Although consult, practice-based, and in-reach models are distinct in their taxonomy and definition, in practice, hospital systems may strategically deploy any or a combination of these model types to effectively meet the population health needs of patients with SUD. For example, a hospital or ED may develop order sets and protocols to ensure patients with OUD are offered methadone or buprenorphine, thus supporting a practice-based model for MOUD. The same hospital system might rely on ACS to support patients with more complex presentations, including those who are withdrawing from multiple substances, have a history of overdose, have unmet withdrawal or pain needs, or require nuanced clinical decision-making related to surgical, obstetrical, or end-of-life care.

This is how specialty medical care is typically organized: generalists are trained to manage common medical conditions, and specialty consult teams exist to provide care for the most complex cases. Taking the example of stroke or acute coronary syndromes, all hospitals and EDs can manage these common, high-risk conditions, and clear accountability measures exist to ensure care meets minimum standards. Many hospitals may also invest in cardiology and neurology teams because they are accepted to be important resources for complex disease management. However, some smaller or more rural hospitals may not have the resources for specialty consult services.

Addiction Consult Models

Consult models include ACS, consultation-liaison psychiatry services, and individual consultants. ACS is the most rigorously studied and provides comprehensive care through expert addiction specialist physicians, coordinators (eg, social workers, case managers), and patient engagement staff (eg, peers, substance use navigators). All consult models have the advantage of dedicated staff with SUD expertise who can deliver direct patient care in the hospital and ED, including addressing complex withdrawal syndromes and other medically complex care (eg, decisions around cardiac valve surgery in patients who inject drugs). ACS also improve hospital systems by educating the workforce; serving as training sites for medical students, residents, and fellows; implementing SUD specific protocols and care pathways; reforming local policies; and advocating for and leading transformational change.[33]

Centers that manage a high volume of patients with complex conditions that frequently co-occur with SUD, such as trauma centers, transplant centers, or cardiac surgery centers, should generally have ACS staffed by addiction specialists to meet their patients' needs during hospitalization.

Practice-Based Models

Practice-based models rely on general hospital and emergency medical staff rather than addiction specialists to deliver evidence-based SUD treatment as part of routine hospital or ED care. Such models include hospital-based opioid treatment (HBOT), hospital-based alcohol treatment (HBAT), and ED-initiated MOUD. Examples of such approaches include hospitalists and emergency clinicians who initiate medications for OUD and AUD with linkage to care after discharge. HBOT clinicians typically

utilize protocols and order sets to spread best practices among clinicians and often rely on local champions to assure system-level preparedness (eg, meeting with local pharmacy committees to work through the process of adding SUD medications to formularies). Unlike ACS, practice-based models do not require on-site addiction medicine specialists or additional staffing, and they can help mainstream SUD care as part of general hospital and ED care. Local, state, and regional resources may support general clinicians through training, mentoring, clinician-to-clinician consultation, and real-time clinician decision-support.[69,70]

In-Reach Models

In-reach models generally involve a community-based addiction specialist providing telephone consultation regarding SUD management for generalists working in hospital or ED settings. This may include facilitating linkage to community-based care after discharge. A more robust in-reach model is the use of an external telemedicine inpatient addiction consult team that offers virtual ACS to hospitalized patients and may serve multiple hospitals concurrently.[71,72]

Linkage to Care Models

Linking people with SUDs to ongoing care after discharge from acute care is critical for reducing morbidity and mortality. Although a range of approaches may help address linkage to care, a primary model for connecting patients to ongoing SUD care is the bridge clinic model.[69]

Bridge Clinics

Bridge clinics offer a model for linking patients with SUD to ongoing treatment and are designed to meet the transitional, time-sensitive needs of those being discharged from hospitals, EDs, or other touchpoints (eg, correctional settings).[69,73,74] These outpatient clinics are defined by their delivery of low-threshold, patient-centered care focused on improving access and engagement for all patients, such as:

- Same-day treatment entry
- Flexible care options (eg, immediate access, walk-in appointments, evening and weekend availability)
- Nonjudgmental care for patients with active SUD

Interprofessional teams in the bridge clinic provide immediate access to and continuation of SUD treatment, including but not limited to MOUD, as well as counseling or care management. Different bridge clinic models include interprofessional outpatient bridge clinics where care is provided in-person by addiction specialists, ED-based bridge clinics where care is delivered by emergency providers, and telemedicine bridge clinics.[73] Regional bridge clinic services, where one bridge clinic serves a number of different regional hospitals, are early in development but offer promising potential for serving patients and hospitals across a broader geographic region.

Implementation Considerations

General Implementation Steps

A growing body of literature delineates key implementation barriers and facilitators in developing hospital-based SUD services, predominantly focused on practice-based care models (Table 2).

Table 2. Common Implementation Barriers and Facilitators for Hospital-Based SUD Services

Barriers	Facilitators
• Clinician hesitance to provide SUD treatment as part of usual care • Stigma within the hospital • Lack of clinician knowledge and comfort with basics of SUD treatment • Lack of funding • Limited referral pathways for ongoing SUD care after discharge • Hospital policies that can negatively impact people with SUD	• Identification of a site champion(s) • Education to promote culture change within the hospital • Development of care pathways and treatment algorithms, including integrating medication order sets and withdrawal assessment tools into electronic health records • Identification of opportunities for billing revenue, grants and philanthropic support, and advocacy for the value of these services (eg, reduced readmissions) • Development of referral partnerships and standard discharge instructions • Creation of patient and provider education materials

Across all care models, the initial steps necessary to begin SUD service expansion include the following:

1. Identifying stakeholders and obtaining buy-in
2. Completing a focused landscape survey and needs assessment
3. Defining and measuring success
4. Establishing a sustainable funding model
5. Providing education and addressing stigma

Step 1: Identify Stakeholders and Obtain Buy-In

The first step in launching new hospital- or ED-based SUD services is to get organizational buy-in. Doing so requires identifying and mobilizing stakeholders and developing a case for the unique institution. This may include creating a summary of the evidence both for the need and the impact of these services,[b] along with a translation of the broad research findings into the local context. The summary should articulate how the proposed changes align with goals that resonate for the institution, hospital leaders, and frontline clinicians.

A key step in obtaining organizational buy-in is to identify champions, sponsors, and stakeholders:

- **Champions** are the individuals who will help drive the implementation and change process forward. These may be clinicians or administrators who are invested in advancing SUD care and can help with implementation and dissemination. Champions are often already doing SUD treatment work in some way or have an interest in SUD care and can be key partners in implementation.
- **Sponsors** are institutional leaders who may not be SUD champions themselves but can provide institutional support and leverage to facilitate implementation. Sponsors may be department chairs or senior leadership of the hospital and may be the individuals to whom the initial case for hospital- or ED-based SUD services is made. They can then help engage other necessary senior leaders to facilitate implementation.

[b]See Appendix C for helpful references.

- **Stakeholders** include the range of staff members who will be touched by this work, including physicians, nurses, pharmacists, social workers, and administrators. These are individuals whose perspectives are important to understand in the early implementation phase to create frontline provider buy-in, identify gaps, and address barriers.

When developing the case for change, some core focus areas may include improving patient safety, care quality, and value, and reducing liability.

Patient safety in hospitals is a critical concern and can serve as a key driver for improving SUD care. Hospitals have made patient safety a core component of delivering effective, equitable care. Omitting SUD services could be classified as contributing to errors of omission, where necessary action in a patient's care is overlooked or not performed, potentially leading to adverse effects and readmissions. Preventing errors of omission requires a multifaceted approach involving change to policies, programs, training, technology, and communication and a strong culture of safety. By prioritizing these elements, hospitals can significantly reduce the incidence of omitted care, ultimately enhancing the safety and quality of patient care. This framework can also be utilized to garner support for new SUD services and guide its implementation.

Value-Based Proposition Examples:

- **Reducing readmission**
- **Reducing length of stay**
- **Improving patient throughput**
- **Improving patient safety**
- **Improving care quality**
- **Better serving the community**
- **Mitigating legal vulnerabilities**
- **Addressing workforce distress**

Mitigating liability and risk may be another motivator for systems to support SUD care implementation: hospitals failing to provide evidence-based care for SUD may violate the Emergency Medical Treatment and Labor Act (EMTALA), the Americans with Disabilities Act (ADA), or the Rehabilitation Act of 1973 (Rehabilitation Act).[75] EMTALA requires identification and stabilization of medical emergencies; not recognizing life-threatening consequences of SUD or discharging patients after an overdose without treatment may violate EMTALA. The ADA prohibits disability-based discrimination in healthcare settings, including denying evidence-based services because of stereotypes, administering healthcare services in a way that has the effect of denying evidence-based services to people who use substances, or failing to offer evidence-based SUD services (eg, not offering MOUD because of assumptions that people with OUD will overwhelm the ED seeking care).[c]

ACS may reduce costly acute care utilization, such as readmission. ACS may also demonstrate financial value through avoided hospital days, for example, by facilitating plans that allow patients to receive intravenous (IV) antibiotics in non-acute care settings.[76,77] However, the financial return on investment extends beyond simple reductions in acute care costs and should be viewed in terms of broader institutional objectives. Hospital-based SUD services align naturally with the shift toward value-based care models and may also positively impact quality metrics and patient satisfaction scores.

[c]This guide by the Legal Action Center can serve as a helpful resource on this topic: Hospital-Administrator-Guide_v3.pdf

Step 2: Focused Landscape Survey and Needs Assessment

A focused landscape survey and needs assessment helps delineate the specific services that do not currently exist and serves as a necessary first step to identify clinical needs and engage stakeholders. This assessment can also explore educational gaps and stigma. A needs assessment may identify where to begin. For example, a hospital that already offers withdrawal management but does not currently initiate medication for OUD or AUD may initially focus on pharmacotherapy initiation and linkage to community care. Utilizing the core substance use services and competencies, a landscape survey checklist may include questions such as those outlined in Table 3.

Competency	Checklist
1. Identification, engagement, and approach to patient care	☐ Does the setting provide welcoming, supportive, patient-centered, and trauma-informed care? ☐ Are clinicians able to identify and diagnose SUD when present? ☐ Are clinicians able to build an alliance with patients by offering nonjudgmental, evidence-based care? ☐ Does the site implement universal screening? ☐ Does the facility have signage about SUD services to engage patients?
2. Intoxication and withdrawal management	☐ Do clinicians know how to assess and manage intoxication and acute withdrawal using evidence-based practices? ☐ Does the site have withdrawal management order sets? ☐ Does the site have access to ACS or an addiction medicine specialist?
3. Overdose and post-overdose care	☐ Do clinicians know how to manage an overdose? ☐ Are clinicians able to provide appropriate post-overdose care? ☐ Are patients offered an SUD care plan? ☐ Is MOUD provided following overdose?
4. Initiation and continuation of addiction medications	☐ Are all types of FDA-approved addiction medications offered to patients for initiation and/or continuation? ☐ Are all addiction medications on formulary? ☐ Does the site have guidelines, protocols, or order sets to support initiation and continuation of addiction medications? ☐ Does the site have access to ACS or an addiction medicine specialist?
5. Assessment and management of common co-occurring conditions	☐ Are clinicians able to assess and manage common comorbidities, including mental health conditions and pain? ☐ Does the site have existing consult services that manage common co-occurring conditions such as psychiatric illness or pain? ☐ Does the site have access to outpatient psychiatric care?
6. Linkage to ongoing SUD care	☐ Are patients provided with direct linkage to ongoing SUD care after discharge? ☐ Do patients have rapid access to a bridge clinic?
7. Risk Reduction	☐ Are all patients who are at risk for overdose offered naloxone and related training? ☐ When indicated, are patients educated on risk reduction strategies (eg, safer use strategies)? ☐ Are current hospital policies on addiction aligned with ADA standards and equitable care principles?

ACS, addiction consult services; ADA, Americans with Disabilities Act; FDA, Food and Drug Administration; MOUD, medication for opioid use disorder; SUD, substance use disorder

Frequently, institutional and clinical policies, procedures, and pathways intersect with this work or may need to be created *de novo*. Examples include protocols or order sets related to the new clinical care being offered (eg, initiation of MOUD, a formulary change to ensure medications are available for OUD and AUD). It may also be helpful to re-examine other seemingly tangential policies that deeply impact the care of people with SUD, such as drug testing and mandatory reporting of substance use in pregnancy, policies around visitors, searches of belongings, or requests to leave the hospital unit. Another important early step in the design and implementation of new SUD services is coordination with clinical services that may already be caring for a high proportion of patients with SUD or could be collaborators in this work, such as psychiatry, social work, and case management.

In addition to identifying stakeholders and partners within the hospital system, a landscape survey can help find community-based referral partners. Accountable referral partners who provide systematic feedback or even closed-loop communication feedback about successful linkage to care can be key facilitators to ensuring consistent and timely follow-up.

When initiating SUD treatment in the hospital setting, it is helpful to identify places to connect patients after discharge for ongoing treatment. For systems that do not have internal places to refer to, such as a bridge clinic, finding community partners and developing formal processes around transitions of care becomes even more important. Partnerships do not necessarily need to be formalized or involve memorandums of understanding. Each hospital and ED should prioritize partnerships based on the unique needs of their community and patient population (Table 4). These may include warm handoffs, clarification around referrals, and bidirectional communication. Regular meeting times to check in on how the referral process is going and troubleshoot any challenging cases are often important for success.

Table 4. Community Partners

Type of Partner	Reason for Partnership	Rationale and Considerations
OTPs	To support initiation of methadone and linkage to ongoing treatment	OTP partnerships promote timely, streamlined linkage to methadone treatment, facilitate optimal dosing, and allow for more rapid methadone initiation strategies as well as care coordination to support complex needs (eg, skilled nursing facilities). However, lack of partnership should not prohibit methadone initiation or continuation.
Outpatient SUD clinics supportive of addiction medication continuation	To support direct referrals for ongoing outpatient SUD care	Outpatient SUD clinics may be able to offer more comprehensive SUD care than a prescriber alone, including therapy, groups, peer support, and care for multiple types of SUD.
Primary care or other office-based addiction medication prescribers	To support direct linkage to continued medication treatment	Hospitals and EDs that do not have bridge clinics will need to link patients to a prescriber for ongoing medication management.
Housing agencies	To support direct linkage to housing supports	Housing instability is common in patients with SUD. Housing agency partnerships are important given the impact of housing insecurity on SUD, but it is often difficult to affect change in the short term.
Post-acute care settings supportive of addiction medication continuation	To support direct referrals for ongoing skilled nursing care	Referral partners for patients who will require ongoing skilled nursing after discharge are helpful. However, it can be difficult to find impactful partnerships in this space.
Recovery community organizations and harm reduction service providers	To support direct referrals for peer support, employment services, and other recovery support needs and provide risk reduction supplies and related education	Community-based recovery supports can allow hospitals and EDs to draw on community expertise and build trust bidirectionally.
Residential SUD treatment supportive of addiction medication continuation	To support direct referrals for ongoing residential SUD care	Residential SUD programs offer more comprehensive care for patients who require high-intensity SUD services and those who require 24-hour structure and support during SUD treatment. Referrals from the hospital and ED may be challenging as residential SUD programs often have wait lists.
Street medicine teams	To support direct linkage to acute care and provide ongoing post-discharge SUD care to people experiencing homelessness	For patients experiencing homelessness, particularly unsheltered homelessness, having a care team who can follow them after discharge can be tremendously helpful. Street medicine teams also act as bidirectional partners by bringing patients who need acute care into hospitals and EDs.

ED, emergency department; OTP, opioid treatment program; SUD, substance use disorder

Step 3: Define and Measure Success

Determining a plan for quality monitoring and improvement, which may include selecting appropriate metrics prior to implementation, is an important early step. This can help ensure essential data elements are captured and support development of a plan for monitoring performance improvement. Utilizing objective process and outcome metrics can promote fidelity, consistency, and accountability and allow leaders to identify the impact of interventions on important clinical outcomes.

Formal clinical quality measures (CQMs) that are thoughtfully defined and rigorously validated and have external benchmarks for systems to target are needed to drive meaningful patient outcome improvement. However, development of CQMs will take years and should not delay needed clinical implementation. Metrics are valuable only if they are used to foster understanding and inspire positive

change. It is important, therefore, that metrics are not only developed, but also presented and discussed on a regular basis, for example, in existing quality governance structures, as part of a clinical service line, or as part of a collaboration between clinical units.

Potential metrics for hospital-based SUD care might include the following measures:

- The percentage of patients with AUD and OUD who receive a discharge prescription for appropriate addiction medication
- The percentage of patients with SUD who are directly referred or linked to care after discharge
- The percentage of patients with SUD who receive timely follow-up care (ie, within 7 days after discharge)
- The percentage of patients with SUD who receive an addiction consult
- The percentage of patients who have naloxone dispensed or prescribed at discharge after an overdose
- The rates of 30-day readmission
- The percentage of patients with AUD and OUD started on pharmacotherapy during hopitalization or ED encounters

Step 4: Establish a Sustainable Funding Model

Making the business case for investing in hospital- and ED-based SUD services may start with demonstrating the existing disproportionate costs and poor outcomes associated with not offering SUD services. While hospitals have an obligation to care for patients' SUD, they must also find sustainable ways to cover costs and deliver services efficiently. Hospitals can show value through improvements in financial metrics, care quality, and staff and patient experiences with enhanced SUD treatment. For example, if hospitals have financial incentives for reducing readmissions or improving insurance contract quality measures related to SUD, a case can be made to invest in SUD services to improve performance and attain financial incentives.

Traditional hospital financial models heavily favor procedural services over cognitive care. Procedures generate higher fee-for-service revenues, carry higher relative value unit (RVU) weights, allow for facility fees related to equipment and infrastructure use, and can be efficiently scheduled and standardized for increased throughput. In contrast, the cognitive-heavy services that underpin SUD care typically receive lower reimbursement rates through evaluation and management (E/M) codes. Furthermore, although medical management services like diagnostics, pharmacotherapy, and treatment planning can be supported through professional billing, care navigation and coordination and psychosocial interventions often face reimbursement obstacles.

The shift toward value-based payment models offers some promise in recognizing the importance of cognitive services in reducing long-term costs and improving patient outcomes; however, these models are not yet widely available. Healthcare systems have developed various creative solutions to financially support SUD service models:

- Developing efficient billing systems to optimize reimbursement, including working with local billing and revenue specialists to code appropriately based on patient complexity which may be underrecognized in SUD care
- Leveraging existing billing codes, such as E/M codes and codes for chronic care management, MOUD, and transitional care
- Incorporating non-billable services (such as peer services) into capitated payment systems or global budgets
- Allocating resources from nonprofit hospitals' community benefit budgets
- Securing grants from foundations, federal agencies, and state health departments

Although the specific care delivery model may ultimately vary based on local resources and circumstances, hospitals have a clear responsibility to provide evidence-based SUD care. Success requires both strategic planning to develop sustainable funding mechanisms and a commitment to delivering effective treatment despite the challenges posed by current reimbursement systems. Alternative approaches, such as case rate billing models, show promise by allowing more time for patient engagement and outreach. As health care continues to evolve, hospitals must advocate for innovative payment models that better support their mission to provide appropriate and medically necessary care, including for SUD, and reimburse the costs of interprofessional care, including the use of certified peer support specialists, patient navigators, and care coordinators.

Step 5: Provide Education and Address Stigma

Proactive and thoughtful planning around educating staff and reducing stigma is key. Developing new SUD services is a powerful way of reducing stigma and burnout among staff. However, some prework to address misconceptions and provide training in trauma-informed care and effective patient engagement is essential.

Education about SUD is often necessary to increase general awareness and begin to combat stigma. Topics may include:

- SUD as a chronic illness
- Efficacy of various evidence-based SUD treatment interventions
- Compassionate withdrawal and overdose prevention strategies

These educational topics can be offered in formal lecture series about SUD to frontline staff or even incorporated into required education as a part of credentialing or annual training. Informal educational formats (eg, brown bag lunch series on inpatient units) can be a powerful way to address educational needs and stigma. In addition, incorporating education on SUD into existing educational series (eg, resident report, conferences, grand rounds) can be useful.

Educational interventions that incorporate content to help reduce stigma are relatively easy to implement, such as:

- Highlighting the importance of using nonstigmatizing, person-first language when discussing patients and in clinical notes
- Incorporating people with personal experience with SUD as trainers or speakers

- Sharing case examples with positive outcomes, as many hospital-based clinicians do not get the opportunity to see patients achieve and sustain recovery following discharge
- Providing basic education about addiction as a disease and highlighting its similarities with other chronic conditions
- Providing basic education on the effectiveness of SUD treatment

It is also important to consider how hospital policies may be stigmatizing and how they can be modified to reduce stigma. For example, some hospitals implement policies that differentially subject patients with SUD to belongings searches or restricted privileges regarding leaving the hospital unit or having visitors; these policies can be stigmatizing and may also be discriminatory.

Developing and posting new signage in clinical areas is another easy intervention that can let patients know that SUD services are available and subtly reduce stigma. In addition, it is important to consider whether artwork and signage in clinical spaces is welcoming and inclusive for a range of patients with SUD.

Implementation Considerations for Addiction Consult Services

When fully implemented, ACS ideally serve patients wherever they are in the hospital, including the ED. Hospitals may consider a phased rollout on a subset of medical units or the ED as they establish and refine processes, assess volume, streamline clinical care, and evaluate staffing needs. Consults should ideally be available in a timely manner, 7 days a week, with after-hours coverage and aligned with consult expectations of other services.

Building relationships across hospital disciplines and roles—for example, identifying champions in nursing, pharmacy, and medical specialties (eg, trauma, cardiac surgery, infectious diseases, hepatology)—can help support innovative practices, like novel approaches to IV antibiotics,[76] cardiac surgery,[78,79] and transplant in patients with SUD and transitions from hospital to skilled nursing facilities.[80,81]

Staffing

ACS traditionally include three team members:

- **A physician** who is ideally board certified in addiction medicine or addiction psychiatry, given their skill set and depth of training related to intoxication and withdrawal management, pharmacotherapy initiation, and other SUD treatment.
- **A care coordinator** who may be a psychologist, licensed mental health counselor, licensed SUD counselor, or unlicensed resource specialist or case manager.
- **A patient engagement specialist** who is ideally a certified peer support specialist or recovery coach, as they bring the strength of their personal experiences.

Hospitals should consider how their policies related to credentialing and privileging (eg, allowing board certified addiction specialists to admit and manage patients with SUD within their hospital system as part of ACS) can best support access to quality SUD care.

Care coordination and patient engagement roles may be combined in some models. Licensed clinicians are generally preferred in the care coordinator role as they can also provide critical bedside therapeutic interventions, including motivational interviewing and brief counseling.

Services

Core services provided by ACS include:

- Diagnostic assessments for SUD
- Management of the spectrum of acute intoxication and withdrawal syndromes
- Post-overdose care
- Treatment formulation for all SUDs
- Initiation and continuation of addiction medications[d]
- Management of medical and psychiatric comorbidities, including pain[e]
- Basic psychosocial services, including:
  - Biopsychosocial assessments
  - Motivational interventions
  - Brief crisis counseling
  - Psychoeducation
  - Distress tolerance support
- Aftercare planning, referral, and direct linkages
- Recovery support services, including risk reduction education and support (eg, naloxone distribution and education, safer injection education)

ACS staff also provide training and support to generalist providers, enabling them to independently manage less complicated substance-related problems.

Billing and Finance

Establishing and sustaining ACS often require funding for new staff. Sources typically include a combination of billing revenue and other internal (eg, hospital general funds) and external (eg, philanthropy, foundations, or grants) sources of funding. Billing generally relies on standard E/M billing codes for physician and advanced practice provider consultation. Services provided by other ACS staff (eg, care coordinators, patient engagement specialists) are typically not reimbursed by payers.

A common challenge occurs when insurers will not reimburse services provided by two physicians of the same specialty on the same day (eg, a hospitalist and an addiction medicine physician providing SUD services, a general psychiatrist and an addiction psychiatrist delivering SUD care). Staffing the ACS team with physicians who have addiction specialization and linking their specialty to their National Provider Identifier (NPI) number can prevent this.

See Establishing a Sustainable Funding Model for additional considerations and recommendations.

[d] Including all FDA- approved medications for OUD (including methadone), AUD, and TUD; off- label medications for other SUDs, including StUD and cannabis use disorder; and medications to manage post- acute withdrawal symptoms.

[e] Independently or in consultation with other specialists.

Other Considerations

Before launching ACS, the team should consider logistical elements that can help support effective workflows, such as:

- Building a consult order into the electronic health record
- Developing and disseminating a workflow for how consults are identified, requested, triaged, and seen
- Developing note templates to support standard clinical practice and documentation[f]
- Modifying or building withdrawal and addiction medication initiation order sets aligned with best clinical practice

Implementation Considerations for Bridge Clinics

Bridge clinics should be accessible from hospitals, EDs, and other primary referral sources. For some settings, the ideal location may be on a hospital campus close to the ED so that patients can be walked directly to the bridge clinic after discharge. For other settings, a community-based location accessible by public transportation from jails, prisons, shelters, or other community referral partners may be ideal.

Staffing

At minimum, bridge clinics should include three team members:

- A physician or advanced practice provider with specialty addiction expertise. A physician with board certification in addiction medicine or addiction psychiatry is recommended given their skill set and depth of training.
- A patient services staff member who can manage the administrative logistics of checking in patients and scheduling follow-up visits.
- A care coordinator or resource specialist who is focused on linking patients to ongoing community treatment from the bridge clinic and connecting patients to any needed services outside of the bridge clinic (eg, psychiatric assessment, primary care, housing services).

In an ideal model, bridge clinics would also be staffed by:

- A nurse who can administer medications; triage patients upon arrival, including walk-in patients; provide assessment and ongoing monitoring for patients undergoing outpatient withdrawal management; and deliver other office-based SUD nursing services.
- A licensed counselor or therapist who is able to provide psychosocial assessments, short-term therapy, and group therapy.
- A certified peer support specialist or recovery coach who can provide recovery support and engagement and bring the strength of their personal experiences.

Larger bridge clinics may also utilize staff with other scopes of practice, like medical assistants or clinical pharmacists.

[f]See Appendix D.

Services

Bridge clinics provide flexible, low-threshold access to ongoing SUD care, including same-day initiation of treatment and walk-in services. Although local resources may be a limiting factor for hours of operation, an ideal bridge clinic model is open for clinical care 7 days a week, with after-hours coverage when the clinic is not physically open.

Core services provided by bridge clinics include:

- Diagnostic assessments for SUD
- Outpatient management of mild to moderate severity intoxication and withdrawal
- Psychosocial services, including:
  - Biopsychosocial assessments
  - Motivational interventions
  - Counseling
  - Psychoeducation
- Treatment formulation for all SUDs
- Immediate initiation, titration, and continuation of addiction medications[g]
- Long-term transitional care planning and linkage to care from the bridge clinic
- Recovery support services, including risk reduction education and support (eg, naloxone distribution and education, safer injection education)
- Referrals for co-occurring mental health needs (eg, psychiatric assessment)

Some bridge clinics also offer infectious disease care, including treatment for human immunodeficiency virus (HIV) and hepatitis C virus (HCV), HIV prevention, and outpatient parenteral antibiotic therapy.

On-site storage of medications, including extended-release formulations, is important to be able to rapidly initiate medications for SUD and support ambulatory withdrawal management. Bridge clinics often utilize the DEA's 72-hour rule to dispense full opioid agonist medications, such as methadone, for the purposes of managing opioid withdrawal and/or initiating MOUD while working on direct linkage to an ongoing care provider, such as an OTP.

Billing and Finance

Establishing and sustaining a bridge clinic often requires multiple funding streams, including fee-for-service billing, institutional funding, and grants. Many of the clinical services delivered in bridge clinics are reimbursable through professional billing (ie, E/M billing codes). Billing specialists can help maximize billing given the complexity of visits. In some cases, there may be opportunities to explore bundled payments or more creative billing models depending on the state and local payer system.

See Establishing a Sustainable Funding Model for additional considerations and recommendations.

[g] Including all FDA- approved medications for OUD (including methadone), AUD, and TUD; off- label medications for other SUDs, including StUD and cannabis use disorder; and medications to manage post- acute withdrawal symptoms.

Other Considerations

Before starting a bridge clinic, the team should consider logistical elements that can help support effective workflows, such as:

- Building a referral order into the electronic health record
- Developing and disseminating a workflow for how referrals are identified, requested, triaged, and seen and how walk-ins and same-day appointments are seen
- Developing note templates to support standard clinical practice and documentation
- Determining which medications and supplies (eg, wound care supplies, safer use supplies) are stored on site at the clinic

Partnerships are critical to the success of bridge clinics, both for building awareness of the bridge clinic and collaborative development of workflows and referral pathways. Within a hospital, important clinical partnerships include the ED, ACS, hospital medicine, and psychiatry. In the community, bridge clinics should prioritize partnerships with:

- Primary care providers, as they are both an important referral source for bridge clinics and important sites to which bridge clinics can refer stabilized patients for care once they are ready to transition
- Community-based SUD treatment programs, including OTPs
- The criminal legal system
- Social service agencies that may help address social determinants of health (eg, housing, transportation, food insecurity)

Implementation Considerations for Practice-Based Models

Staffing

Although practice-based models do not require dedicated staff, champions should be identified by the hospital and funded for the portion of their time spent working on these critical efforts. Champions play several important roles, including:

- Focusing and prioritizing efforts to improve SUD care
- Making policy and protocol changes to support improved SUD care
- Influencing their colleagues by leading, teaching, and making the case for change
- Disseminating new tools and evidence-based clinical practices to raise the bar of what good SUD care looks like in their practice setting

Champions should ideally partner with existing quality improvement teams and committees to ensure that efforts to improve SUD care are supported by data and aligned with system priorities.

Champions' efforts are ideally augmented by patient navigators, who have been demonstrated to increase the engagement of individuals with SUD in outpatient care and reduce acute care utilization and costs.[82,83]

Services

Practice-based models aim to support generalists to provide the following services:

- Diagnostic assessments for SUD
- Management of common intoxication and withdrawal syndromes
- Post-overdose care
- Initiation and continuation of addiction medications[h]
- Aftercare planning and referral

Billing and Finance Practice-Based

Establishing a practice-based model requires funding for a champion's time, which may be supported through institutional funding or grants. In addition, support for electronic health record changes (eg, building new order sets for addiction medication initiation) requires institutional prioritization so that existing resources can be leveraged to complete this work.

Specifically, practice-based models require funding for:

- The champion's time
- Education and training
- Patient navigator services, if utilized
- Digital resources to make changes to the electronic health record and to build order sets

See Establishing a Sustainable Funding Model for additional considerations and recommendations.

Other Considerations

Before launching a practice-based model for SUD care, the team should consider logistical elements that can help support effective workflows, such as:

- Developing and updating protocols and order sets for withdrawal management and addiction medication initiation to help frontline clinicians manage common substance-related concerns
- Building a hospital coalition across disciplines and roles to leverage existing structures for process improvements
- Partnering with the hospital pharmacy formulary committee to ensure FDA-approved medications for SUD are available
- Making training widely available to facilitate changes to clinical practice
- Disseminating information on the availability, importance, and efficacy of SUD care to foster buy-in across the practice setting

Leveraging existing state or national training opportunities like Project ECHO (Extension for Community Healthcare Outcomes); Providers Clinical Support System (PCSS) mentoring programs; or "warm lines" where providers can obtain mentoring, support, and clinical consultation may be helpful in implementing practice-based models.[84] Programs like California Bridge/Bridge to Treatment provide excellent resources for champions that support the implementation of practice-based SUD care, including toolkits, protocols for buprenorphine initiation, and details around making the case for navigator support.

[h] Including all FDA- approved medications for OUD (including methadone), AUD, and TUD; off- label medications for other SUDs, including StUD and cannabis use disorder; and medications to manage post- acute withdrawal symptoms.

A Note to Policymakers

Despite progress, fundamental challenges persist. Policymakers at both the federal and state level play a key role in supporting implementation of hospital- and ED-based SUD services. We recommend that policymakers consider how they can help hospitals and EDs adopt the strategies outlined, with consideration of needs related to the following:

- **Sustainable financing.** The existing fee-for-service payment system reimburses procedural services at higher rates than cognitive services. It does not reimburse many necessary care coordination services and does not sustainably fund ACS or bridge clinic models. In addition, some reimbursement models pose financial barriers to administering long-acting injectable addiction medications by barring hospitals from receiving separate and adequate reimbursement for these medications when administered in an emergency department or inpatient setting. Changes to reimbursement models to pay for hospital- and ED-based SUD care and financial incentives for meeting quality targets are likely needed to drive sustainable improvements in SUD care.

- **Increased access to community-based methadone treatment.** Existing policy hurdles make it hard to do the right thing for patients. Outdated regulations limit community methadone treatment for OUD to OTP settings. This silos an already fractured system and requires patients with this treatable health condition to jump through hoops to get lifesaving treatment. No other patient population is required to overcome such logistical challenges to access care. Logistically, methadone regulations also limit hospital-based SUD care, as hospitals and EDs must create relationships with OTPs and develop direct transfer agreements to be able to seamlessly connect patients to methadone treatment for OUD after discharge. Given limited hours at OTPs, even with partnerships and agreements, it may not be possible for hospital staff to facilitate that connection for a large portion of the hours of the day they are seeing patients, further delaying care transitions and limiting treatment access and efficacy. Allowing methadone to be prescribed for OUD like other Schedule II substances, as is done in Australia and the UK, would increase access tremendously.

- **Coordination across diverse systems of care.** The lack of true integration between medical and psychiatric care and social service systems limits clinicians' abilities to address patients' intersecting needs. Patients who are most vulnerable are often those experiencing severe SUD, medical and psychiatric comorbidities, and homelessness. Patients have needs that go beyond what the hospital or ED can meet on its own, highlighting the need for community partnerships that seek to address the broad range of psychosocial issues a patient may be facing.

- **Training and workforce improvements.** Training programs and consistent education for many roles and durable funding sources for training programs, notably addiction medicine and addiction psychiatry fellowships, are needed. This could be achieved through new funding for slots from the Centers for Medicare & Medicaid Services the way other residency and fellowship programs are paid for. Addressing these barriers will help us move closer to our ultimate goal of a future where hospital- and ED-based care for SUD mirrors other conditions.

- **National CQMs for SUD**. Process and quality measures are needed to drive performance and accountability. Rigorous development of metrics, as with other national quality metrics for common conditions treated in the hospital and ED, is critical to be able to ensure high-quality care and begin to work on performance improvement. Coordinated efforts are needed to fund the development and testing of new CQMs for SUD care in hospital and ED settings.

Future Directions

Despite decades of research demonstrating the effectiveness of SUD treatment, there is a large implementation gap between what is known and what routinely occurs in clinical practice. SUD is a treatable health condition with high morbidity and mortality when untreated, akin to myocardial infarction. Standards and accountability measures for hospitals and EDs consistent with the approach to other high-risk medical conditions are needed. This Guide delineates necessary SUD-related services and competencies, but full adoption will require greater incentivization or mandates.

In the past decade, hospital- and ED-based SUD care has proliferated, yet many questions remain. Future research should use standard definitions to compare and contrast models, evaluate outcomes across multiple settings, and better integrate findings across multiple studies. Appendix E suggests key research questions related to health outcomes, innovation, implementation, financing, and dissemination of best practices in hospital- and ED-based SUD care.

Conclusions

The ASAM Criteria articulates core standards of care to meet the needs of patients with SUD in general hospitals. Specialized models such as ACS, HBOT, and bridge clinics are effective care delivery models to support adoption of these standards and should be paid for and held to the same standards as any other specialty care.

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Appendix A: Summary of *The ASAM Criteria* Core Standards for General Hospitals

Setting

- Hospitals, including EDs, should provide a welcoming, patient-centered, and nonstigmatizing environment for individuals with SUD.
- Trauma-sensitive practices should be embedded in all aspects of care.

Staff

- Physicians with training and competency in using evidence-based practices to initiate and titrate addiction medications, manage acute intoxication and withdrawal, and manage complexities associated with common comorbidities (eg, pain, psychiatric, physical health) should be available on site or via telemedicine/telephone 24 hours a day.
- Hospitals that manage a high volume of patients with complex conditions that frequently co-occur with SUD, such as trauma centers, transplant centers, or cardiac surgery centers doing valve surgery, should have addiction consult services (ACS) available.
- Interprofessional care teams should include clinical staff (eg, psychologists, clinical social workers, SUD and mental health counselors, case managers) trained to assess and treat SUD and co-occurring mental health conditions, including trauma and suicide risk.
- Hospitals are encouraged to identify and incorporate staff who support linkage to ongoing SUD care.

Support Systems

- Hospitals are encouraged to establish relationships with less intensive levels of SUD treatment to support continuity of access to addiction medications and ongoing engagement in SUD care.

Assessment and Treatment Planning

- Assessment should include sufficient biopsychosocial screening and assessments to determine the appropriate level of continuing care and develop individualized care and transition plans that address treatment priorities.
- Clinicians should create treatment plans that reflect:
  - Assessment of addiction medication needs
  - Case management conducted by on-site staff
  - Coordination of SUD treatment, biomedical care (eg, obstetrics and gynecology, infectious diseases, cardiology), and mental health care
  - Shared decision-making with the patient

Services

- General hospitals should have clinicians who are able to:
  - Manage acute intoxication and withdrawal and provide overdose and post-overdose care
  - Offer immediate initiation, titration, and continuation of all FDA-approved addiction medications, including those for alcohol use disorder (AUD), opioid use disorder (OUD), and nicotine/tobacco use disorder (TUD) in alignment with current best practices
  - Provide patient education regarding available addiction medications, including those currently available to treat OUD, AUD, and TUD

  - Manage pain in the context of SUD
  - Adopt emerging evidence-based standards for medical management of SUD
- General hospitals should offer pharmacy services that include all FDA-approved treatments for SUD on their formularies, including methadone, buprenorphine, and naltrexone, as well as medications for AUD and TUD.

Documentation

- Hospitals should document transition plans for patients with SUD that address:
  - Recommendations for follow-up care
  - Reason(s) for any departures from recommendations (if applicable)
  - The program(s) and level(s) of care to which the patient will be transitioning
  - Required medications and how the patient will maintain access to medications during the transition
  - Access to overdose reversal medication, safer use supplies, or drug checking (if applicable)
- Hospital policies and procedures should:
  - Support initiation, titration, and continuation of addiction medications in the hospital and care coordination with addiction medication prescribers in the community
  - Ensure all FDA-approved medications for SUD (eg, buprenorphine, methadone, naltrexone, acamprosate) are on formulary

Appendix B: Resource Guides

Table B.1. Resources on Implementation Models

Model Type	Resource Guides and Toolkits
Interprofessional ACS	• Detailed model descriptions[85-87] • Descriptions of specific model components - Harm reduction[88,89] - Peers[90] • Descriptions of implementation barriers and facilitators - General[19,91] - Harm reduction-focused efforts[92] - Peers[93] • Toolkits and manuals - START manual - CATCH manual[94] - IMPACT toolkit[95] - Proactive Consult-Liaison Psychiatry resource document[96] • Descriptions of ACS change agents and leaders[33]
Practice-based models (eg, HBOT, ED buprenorphine)	• Descriptions of implementation barriers and facilitators - ED practice-based models[97] - Hospital-focused practice-based models[84,98] • Toolkits and manuals - CA Bridge - ACEP Toolkit
Community warmlines	• Pennsylvania's CareConnect • UPMC Toxicology Telemedicine Bridge Clinic

ACEP, American College of Emergency Physicians; ACS, addiction consult services; CA, California; CATCH, Consult for Addiction Care and Treatment in Hospitals; ED, emergency department; HBOT, hospital-based opioid treatment; IMPACT, Improving Addiction Care Team; Penn, University of Pennsylvania; UPMC, University of Pittsburgh Medical Center

Table B.2. General Resources

Topic	Resources
SUD-focused quality improvement	• NIATX
Training resources	• ECHO[99] • PCSS
Clinical guidelines	• SHM clinical consensus guidelines • ACEP guidelines • ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorders • ASAM Clinical Practice Guideline on Alcohol Withdrawal Management • ASAM National Practice Guideline for the Treatment of Opioid Use Disorder
Toolkit for peer recovery coach-led programs for EDs	• NACCHO Emergency Department Based Substance Use Response Toolkit

ACEP, American College of Emergency Physicians; ECHO, Extension for Community Healthcare Outcomes; ED, emergency department; NACCHO, National Association of County and City Health Officials; PCSS, Providers Clinical Support System; SHM, Society of Hospital Medicine

Appendix C: Summary of Evidence Supporting Hospital- and ED-Based SUD Services, ACS, and Bridge Clinics

The table below provides a high-level summary of and reference to key literature on the evidence for ED and hospital-based SUD care, including practice-based care and care provided by ACSs and Bridge Clinics.

Table C.1. Summary of Evidence for Hospital and ED-Based SUD Care

Themes	Key findings
Improving rates of medically necessary services	• ACS improves rates of MOUD and MAUD,[21,67,100-103] and linkage to after-care.[104] • ED models increase MOUD initiation and improve follow-up in SUD care.[105] • Extended-release buprenorphine can be feasibly initiated in ED patients with minimal to mild withdrawal.[106] • Bridge clinics increase rates of MOUD prescribing.[107]
Reducing mortality	• ACS are associated with reduced all-cause mortality.[10,108] • ED-initiated buprenorphine is associated with reduced mortality.[109]
Improving patient experience	• ACS improves patient experience and trust in hospital-based physicians.[93,110] • Bridge clinics improve patient experience of care and trust.[111]
Improving treatment engagement and reducing SUD severity post-discharge	• ACS increase post-hospitalization SUD treatment engagement and reduce SUD severity and days of alcohol and other drug use.[112,113] • ED-initiated buprenorphine improves engagement in SUD care and reduces substance use.[105,114] • Bridge clinics improve engagement and retention in SUD care and reduce SUD-related problems.[115]
Reducing readmissions and acute care utilization	• ACS are associated with reduced 30-day readmission.[21,55] • ED-initiated buprenorphine is associated with lower 30-day ED utilization.[56] • Bridge clinics may reduce ED utilization.[57]
Providing cost-effective care	• Hospital-based SUD care can reduce costs by increasing adoption of cost-effective treatments, which reduce downstream medical expenses by preventing complications of untreated SUD.[116] • Hospital-based SUD care can reduce costly hospital days by supporting patients to receive necessary medical care in lower-acuity ambulatory settings.[76] • ED-initiated buprenorphine treatment is more cost-effective than brief intervention and referral.[42]
Supporting institutional priorities	• Addressing SUD during hospitalizations and ED visits and establishing bridge clinics contribute to broader institutional objectives, such as value-based care, patient satisfaction, and reduced disparities, which can justify investments to hospital administrators.[43]
Reducing staff moral distress and burnout	• ACS can reduce staff moral distress and limit staff fears about workplace harms, which is particularly important given workforce shortages across US hospitals.[13,117]
Reducing stigma and educating the workforce, including trainees, in SUD care	• ACS and other models of hospital- and ED-based SUD care can reduce provider stigma toward patients with SUD and improve staff knowledge and preparedness to provide SUD care.[87,91,118,119]
Driving hospital policy change	• ACS can facilitate hospital policy change around in-hospital substance use.[120] • ACS may address some risk factors for self-discharges.[121,122] • ACS may play a role in guiding change in mandatory reporting policies.[123] • ACS may provide input on hospital policies around leaving the hospital floor.[124]
Driving systems' change	• ACS can develop protocols for rapid methadone initiation among hospitalized patients.[125,126] • ACS and hospital-based SUD care can facilitate improvements in post-acute linkage.[81] • ACS and bridge clinic involvement may facilitate outpatient parenteral antibiotic therapy for people with a history of injection drug use.[127,128] • ACS involvement may elevate other policy arenas where ethical issues related to hospitalized people with SUD exist, such as transplantation and SUD.[129]

ACS, addiction consult services; ED, emergency department; MAUD, medication for alcohol use disorder; MOUD, medication for opioid use disorder; SUD, substance use disorder

Appendix D: Example Consult Note Template

ACS Initial Consultation

Patient Name:
MRN:
Service Date:
Service Time:
Referring Physician:
Location of Consult:
Date of Admission:
Reason for Consult:
HPI:
The patient describes the following substance-related history:

- Substance use first initiated:
- Timeline of use:
- Treatment history:
- Pharmacotherapy tried:
- History of medical complications:
- Overdose history:
- Injection practices:

Interest in or experience with pre-exposure prophylaxis (PrEP) for HIV:
Suicide risk screening:
Past Psychiatric History:
Past Medical/Surgical History:
Current Medications:
Home Medications:
Allergies/Adverse Reactions:
Family SUD History:
Social History:

- Housing:
- Employment:
- Relationship/children:

Medical Review of Systems:
Laboratory Data and Studies:
Vital signs:
Physical Exam:
PDMP reviewed and notable for:
Impression:
Recommendations/Treatment Plan:
Thank you for involving us in this patient's care. I will follow up with you.
Please page with all questions, including overnight and on weekends.

Appendix E: Resources

Screening and Brief Intervention Resources

- Screening, Brief Intervention & Referral to Treatment (SBIRT) | NY OASAS
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) | SAMHSA
- Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) | SAMHSA
- Screening and Assessment Tools Chart | National Institute on Drug Abuse (NIDA)
- Screening and Intervening for Unhealthy Alcohol and Other Drug Use | Massachusetts Department of Public Health
- SBIRT for Medical and Behavioral Health Professionals | National Opinion Research Center (NORC) at the University of Chicago
- Brief Intervention in a Medical Hospital Benefit-Cost Methods | Washington State Institute for Public Policy

Trauma Informed Care

- Trauma-Informed Approaches and Programs | SAMHSA
- What is Trauma-Informed Care? | Trauma-Informed Care Implementation Resource Center
- Trauma Informed Care: Perspectives and Resources | Georgetown University Technical Assistance Center for Children's Mental Health
- Trauma-Informed Care Resources | Institute for Public Health

Countering Stigma and Discrimination

- Structural Stigma in Health-Care Contexts for People with Mental Health and Substance Use Issues | Mental Health Commission of Canada
- Stigma, Prejudice and Discrimination Against People with Mental Illness | American Psychiatric Association
- Stigma from Healthcare Professionals and Care-Limiting Behaviors in Individuals with Substance Use Disorders | The Lancet
- Interventions to Dismantle Mental Health and Substance Use Related Structural Stigma in Healthcare Settings | SSM – Mental Health
- Combatting the Stigma of Addiction – The Need for a Comprehensive Health System Approach | National Academy of Medicine
- Stigma Interventions for Providers Who Treat Patients with Substance Use Disorders | Journal of Substance Use and Addiction Treatment (JSAT)
- Reducing the Stigma of Addiction | Johns Hopkins Medicine

Hospital and Emergency Department Resources

- Care for Substance Use Disorder | American Medical Association
- CA Bridge Treatment Protocols | California Bridge
- Emergency Department Direct-to-Inject (DTI) Buprenorphine | Public Health Institute
- Providers Clinical Support System - Medications for Alcohol Use Disorders | SAMHSA
- Providers Clinical Support System - Medications for Opioid Use Disorders | SAMHSA

Appendix F: Future Research Directions

Table F.1. Future Research Directions

Knowledge Gap	Key Questions	Research Strategy
Outcomes	• What are the effects of hospital-based SUD care?	• Observational and experimental studies that describe outcomes using standard model definitions
Population health and innovation	• How do we improve care models?	• Studies that explore and address health disparities, transitional care gaps, population-specific needs and opportunities (eg, end-of-life care; rural, tribal, and pregnant populations), and specific health conditions (eg, endocarditis, transplant)
Implementation	• How do we implement hospital-based SUD care across diverse settings?	• Mixed-methods studies that explore integration of specific team members (eg, peers), compare different model types and combinations, and explore roles for telehealth/tele-ACS • Studies that explore novel quality measures, alternative payment models, and value-based care
Dissemination	• How do we promote broad adoption and diffusion of innovation?	• Mixed-methods studies that explore clinician, hospital, health system, and policy factors, including metrics and incentives, and engage people with personal experience with SUD in community-based participatory research