



ASAM Practice Pearls Transcript

Implementing Substance Use Care Across Care Settings: *ED to Ongoing Care*

Dr. Stephen Taylor: Hello, and welcome back to ASAM's Practice Pearls, where we turn clinical expertise into everyday addiction care, one conversation at a time. I'm your host, Dr. Stephen Taylor, and today we have with us the expert that I have been wanting to talk to for a very long time. I got to let you know before I introduce this amazing expert that we at ASAM have recently published a new Implementation Guide for Hospital and Emergency Department Substance Use Disorder Care.

You can find the link to this guide in the show notes. So, who is it that I'm going to speak to? Well, of course, it is our expert whose experience will set the stage for this discussion, Dr. Sarah Wakeman, chair of the presidential task force that helped develop this new implementation guide of hospitals and emergency department SUD care. Dr. Wakeman, please say hello to our listeners.

Dr. Sarah Wakeman: Hello, and thank you for that warm welcome, and I'm so excited to be here today and to talk more with you.

Dr. Stephen Taylor: It's super exciting to have you here with us. Would you please start us off by sharing a little bit about your experience in addiction care?

Dr. Sarah Wakeman: Of course. I'm an addiction medicine doctor by way of internal medicine. I did my medical school and undergraduate training at Brown and then did my residency and chief residency at Mass General Hospital.

I've been at Mass General my entire career doing addiction medicine work, and I currently serve as the senior medical director for substance use disorder across our broader academic health system called Mass General Brigham. As inaugural program director of our addiction medicine fellowship program and the director of what we call our program for substance use and addiction services, which started out as a scrappy little consult team and this idea of something called the Bridge Clinic, and now has become really a robust set of clinical programs across our hospitals, trying to implement a lot of what we're going to talk about today.

Dr. Stephen Taylor: Well, I'm particularly excited to have you here because I'm going to go ahead and mention that two days before we did this recording for this episode, I was literally at the White House with the launch of the nation's drug control strategy. And a major plank in that strategy is to have an addiction medicine consult service in every hospital in America. That is one of the goals of the administration's ONDCP strategy. And needless to say, participating as one of the panelists in one of the panel discussions as part of that launch, I had the opportunity to mention this new implementation guide. So, this is an incredibly timely discussion that we're having, Dr. Wakeman.

First of all, let me start off with my first question. What is the gap between what we know addiction care should look like and what's actually happening in emergency departments and hospitals today, and why does that gap still exist?

Dr. Sarah Wakeman: Yeah. The gap is massive. It is better than it was. So first, you know, I think celebrating progress not perfection is important in this space, and I think back to when I was a trainee in 2009, there weren't hospital-based addiction services. You know, patients would come in with endocarditis or cirrhosis, and we would patch them up and spend a lot of money delivering really high-quality medical care for the symptom and for the sort of acute consequence of why someone was in the hospital, but then we would discharge them without ever addressing their underlying substance use disorder.

And even worse, we would blame them when they would come back, predictably, sicker than when they left the hospital. And I, you know, often think that that would be like treating DKA in someone with diabetes and sort of closing their gap, giving them a little bit of insulin, and then sending them on their way without any treatment for their diabetes or follow-up with endocrinology and expecting them to somehow stay well.

And, you know, as a resident, you're sort of on the front lines, and you have this observer's view to sometimes see what the problems are in how we approach things. And so, I just remember being a young doctor and thinking it really made no sense that we weren't also doing things like starting buprenorphine and starting methadone or starting medications for alcohol use disorder when we had this amazing opportunity that someone's literally in the hospital bed wrestling with the negative consequences of their illness, and we're able to engage with them around that.

And so, I think that implementation gap in some places has narrowed where we see amazing addiction medicine consult services, but they're really still pockets of innovation. This is not the norm yet across the country. These are leaders, many of

whom are ASAM members and ASAM physicians and other leaders who have started these programs and nourished them and nurtured them, but they're often scrambling for funding. They're scrambling for buy-in, and it is far from the expectation that every system has these types of models.

And then I think that it's not just building sort of Cadillac models of specialty care but lifting up the foundation of what is the expectation for any generalist, any hospitalist ED doctor to feel comfortable in engaging with patients, managing intoxication and withdrawal, thinking about starting medications for addiction treatment, and connecting people to care the same way that every frontline hospitalist and ED doctor is comfortable managing coronary artery disease, and yet we also have cardiology specialty teams to help support more complex cases that I think the future is getting to a place where we have a both/and, the sort of, I would say, foundation setting, which ASAM has really put a flag in the ground to say, "This is what should be the standard of care," and that is so important to have a national society like ASAM really say, "This is what patients deserve. This is what we as providers deserve to be doing." And then also to think about what are the implementation models to make that possible.

Dr. Stephen Taylor: That is so important. Given the realities of the healthcare system, such as time pressure, staffing, and of course, limited resources, how do we set realistic and attainable expectations for frontline clinicians who are doing this work?

Dr. Sarah Wakeman: I think that's such an important question, and it's a layered answer. It costs money, no doubt, to start a new consult service or to build a bridge clinic, and that takes investment. I think there are many reasons why it makes good sense, both from a mission standpoint and a patient care standpoint, but also a value standpoint, to make that investment for health systems.

So, on the new resource side, even in a resource-constrained environment, you know, I think just yesterday, Dr. Danovich, who is one of our task force members, his study came out showing the cost-effectiveness of addiction consult service models, which is really important to have that type of data that not only do patients get better, they're more likely to get treatment, they're more likely to get connected to care and stay alive. But also, there's a cost-effectiveness argument that, from a value perspective, this is also the smart thing to do. So, I think there are multiple different arguments for why we should be investing in this space.

But even outside of new investment, this is something we can do a lot more with just in usual care. And a lot of this is about bringing up both the comfort and knowledge base of generalists, but also really setting the expectation that this is not an opt-in thing, that only a certain type of specialist does or only a certain center does, but this is something that should be the expectation of every patient that walks in an emergency department front door or gets admitted to a hospital.

And I often think, you know, about the sort of exceptionalism of how we talk about addiction care versus other medical care. You know that you'll hear so many of the barriers that people list. It's too confusing to learn about a new medication or learn how to start buprenorphine, and yet all of a sudden everyone's prescribing GLP-1s across general medicine, right?

No one knew how to prescribe those, but we're all prescribing them now. Or, you know, it's too hard to learn about a new illness. Take COVID. We all rose to the occasion and learned how to manage COVID when that was a crisis. And so, I think we sort of hold addiction to a different standard, as if we're not charged with the same mission to continue to learn, to continue to develop new skills, and learn how to prescribe new treatments so that we can save more lives and reach more patients.

And so, that's why this idea of standards, I think, is so important, that really saying and naming that this should be an expectation, I think, has a lot of power.

Dr. Stephen Taylor: You're right. And since you made the point about having an expectation and it not necessarily needing to be specialists in the field, let's talk about the non-specialists.

To the non-specialists in the ED or in an inpatient setting, what are the critical elements of care for patients with substance use disorders that should always be in place for those non-specialists?

Dr. Sarah Wakeman: I think it's a great question, and we tried to sort of detail this out in the implementation guide with what we called our seven core competencies.

So, the first was being able to identify and engage with patients with substance use disorder, manage intoxication and withdrawal, manage overdose and post-overdose care, initiate and/or continue addiction medications, manage co-occurring conditions like

psychiatric illness or pain, link to ongoing substance use disorder care, and then think about risk reduction.

And hopefully none of those sound that radical, right? I think a lot of us are doing pieces of those, but to really sort of lay out the full spectrum of what the arc of that care journey in the emergency department or the hospital space should look like, I think is really important. And then to detail out specifically, like what does that actually mean on the front lines, and what are the tools and either clinical models or resources that you can use to get there?

I would say, you know, a lot of the science is out there. The toolkits are out there. It's really sort of an implementation challenge, and that's often uniquely been our work and our gap in addiction medicine. Where, if you think about other public health crises, the HIV epidemic, or again, COVID, we really had to wait for these scientific breakthroughs to understand, you know, what is this illness, what are treatments that are going to work, before we could do anything.

And yet with addiction, I mean, we have clinical trials going back to the 1960s showing us what medical treatments are effective, what type of care models are effective, and so, the work really is getting that to patients, getting that into practice.

And I think you asked this in the first question, I didn't directly address it, but the question is sort of why. Like, why is there this massive gap when we sort of know what's effective and yet most of that doesn't make its way into care? And I think there's lots of layers to that question, but I do think there's been this siloing of addiction care as something separate from the rest of medical or psychiatric care, as if it's sort of treating other health problems or other mental health problems on the one hand, and addiction as something totally separate.

And so, bringing addiction back into the house of medicine and seeing this as something that we all have a role in caring for, and I think giving people the sense of hope and joy that comes from treating addiction. I think that many ED doctors or hospitalists who don't do this work, they hear like, "Oh, caring for the person who's coming in who's been injecting fentanyl," and they sort of feel like a pit in their stomach of like, "Well, that sounds really hard or scary," or, you know, most people don't get better, and that couldn't be further from the truth, right? We know that. Like, we get to see the reward and incredible value in offering addiction treatment. And I always say, you know, there's nothing in medicine that is as rewarding as addiction treatment, where you can see

people go from having this potentially fatal disabling illness to literally just living these amazing resilient lives in recovery, and you get to be a part of that and bear witness to that.

And so, spreading some of that joy and giving people the tools so that they can feel a part of that, too, they can see the impact that they can have even in those brief moments in an emergency room or in a hospital bed, I think can begin to shift that sort of attitude.

Dr. Stephen Taylor: You talk about the attitude shift, and it is a powerful one. And we've talked about that on different podcast episodes on different topics because it's the kind of thing that sort of pervades every discussion about treating folks with substance use disorder. The joy that comes from, you know, marshaling those incredible talents and resourcefulness and creativity and ingenuity that people with SUD have and putting it to work instead of seeking drugs and using drugs and feeling the effects of drugs.

But instead, putting it to work in seeking recovery and starting to regain control over their own health and make decisions that are in their interests health-wise. That is a joy when you see someone do that, and you're able to help them make that conversion.

When we talk about the attitudes, though, the attitudes are part of the puzzle. The other part is the system, the system for delivering care. And I think that's where once folks have that desire to do something, then the question becomes, well, what is the system that I'm going to work within to accomplish it? And that's where the question comes up. What are some of the different systems that can be utilized depending on different resources?

Not everybody has the resources of Mass General or some of the other tertiary care settings that many of our ASAM colleagues work in. How do you decide what's feasible for a particular system that you may be working in as a non-addiction specialist, perhaps?

Dr. Sarah Wakeman: Yeah, it's a great question, and we tried to sort of bucket a few different examples of what people might think about for implementation.

I think the most approachable one is what's called hospital-based opioid treatment or hospital-based alcohol use disorder treatment, which is this idea of making it as easy as possible for generalists to do this work just in their routine practice. And so that can look like, you know, developing order sets or coming up with clinical pathways and protocols,

making sure the right medications are on your formulary so that you can in fact start naltrexone for alcohol use disorder before someone leaves or initiate someone on buprenorphine in the emergency room.

You know, some of that includes just education and awareness building across whatever setting you're working in. If that's a community hospital, if that's a academic medical center, you're sort of bringing people along. And so, the essential elements with HBOD and hospital-based practice, one is having a champion, but if you're already interested in this and if you're listening to this podcast, I would say you're probably a champion, and so that's great.

And don't underestimate the power of a peer champion. People listen to someone that they know actually more than they listen to some person they've never met before saying that this is the right thing to do. And that's often how practice changes the most is you see your colleague doing something, and you realize, A, it's not that scary because they can do it, B, I can ask them for help, and C, oh look, their patient's getting better. Maybe I want to try that out, too. And so, I think a peer champion can go a long way.

But then I do think making it as easy as possible for healthcare providers to take that next step is important, especially given how much people are juggling. So that, much like we do for any other condition where we come up with clinical decision support or ways to help prompt people to take the next best step in clinical management, doing that for addiction, too.

And so those seven competencies you could almost break down into a checklist of thinking about what you want to focus on in your site. So, it might be thinking about screening and identification. You know, are we using the Audit-C when people are coming in, or how are we identifying patients? Or are we putting up signs to just let people know that they can access treatment in the ED or the hospital space?

What do our withdrawal protocols look like? Do we have order sets or pathways that make it easy for frontline providers to do the right thing? How are we responding to people after overdose? And then medications, again, same thing. You can do that via order sets or some systems use things now like smart Rx's, where it really prompts people to sort of be guided towards the right medication choice.

So, approaching this the way we do other illnesses is really helpful because then it really aligns with the mental model that, you know, if your colleagues are sort of taking a

certain approach for ACS management, and they use a certain algorithm, or they have an order set, or they have certain medication tools within the electronic health record, do the same thing for addiction.

Make it sort of easy and simple and aligned with how we think about approaching other health conditions. So, I think that beginning there and starting someplace and recognizing that this is a journey of a lot of steps, and you don't need to revolutionize addiction care in one month or one year, but start where you can and build off of that, and celebrate the wins because I think sometimes it can feel like, oh, we have so far to go, but actually every win is tremendous. Every patient life touched is huge. And I think celebrating those successes back to whoever your stakeholders are in your site, maybe that's your department chair or, you know, the chief nurse or whoever it is that you're talking with about change, really letting them see the successes and humanizing them, I think goes a long way.

And I think the other piece outside of patient satisfaction is actually staff satisfaction, that you can improve staff satisfaction by engaging people in this amazing journey of treatment and recovery, of making it easier for them to take care of patients who are showing up. And so, all of those different, you know, sort of change nuggets I think can help move the system along.

I often joke that these types of system change are like motivational interviewing for a system. You know, it's the same idea. You want to roll with resistance. You want to figure out what the system's goals are. You want to look for that change talk and ignore the sustain talk. And so, taking those same strategies to system change, I think, can be really helpful.

Dr. Stephen Taylor: That's awesome. Okay, listeners, you heard it. If there's one new concept that you need to take from this discussion, it's motivational interviewing for a system. I think that is really elegant. Thank you for that one. I'm going to remember that one. Motivational interviewing for a system. And it's an excellent idea and a very important concept.

But okay, we now have our patient stable, and we've taken care of them. We've done everything we need to do for this patient in the ED. What do we do next? Well, we want to get them onto their next treatment setting, right? You mentioned this is a process of multiple steps. So, let's talk about warm handoffs, which I think is the aspect of this that you've become really most famous for in some respects.

Referrals are crucial, but they can be difficult. So, what does an effective transition to ongoing care look like? And how can systems, once we've engaged those systems in motivational interviewing, build reliable pathways from the ED or hospital to make providing warm handoffs easier?

Dr. Sarah Wakeman: Great question, and that is so important. That sort of linkage to care is the critical step for any chronic condition, not just addiction, you know, when someone leaves the ED, but especially in this case, where there are so many barriers in people's way.

I think in the same way as we think about the different levels of intensity for hospital care, you can think of that linkage piece in a similar model. So, one option is you actually build it. You build a new model of care for people to connect to, and that's what we've done with what we call Bridge Clinics, which we sort of use that term because we literally initially were trying to bridge the hospital and ED continuum back to the community, recognizing that especially back when we were getting started in 2014, 2015, but also still to this day, there's so many hurdles that people have to jump over to access care.

There might be waiting lists, insurance barriers, transportation, or structural barriers. And so, if we can try to really shift from this idea of high-threshold care, where we make it kind of hard for people to get into that next step in care, to low-threshold care, where we make it as easy as possible for people to connect to that next step, that you're going to set people up for success that way.

And so, in our Bridge Clinics, we offer walk-in, drop-in care. I'd say kind of the key elements are that easy-to-access, immediate care so that someone can leave the ED, and best case, they can walk down a hallway and get to a Bridge Clinic, or they can get in a cab and get directly to a Bridge Clinic and be seen that same day and started on ongoing treatment that same day.

The other element of low-threshold care is that it's really centered around the patient, that this is patient-centered, patient-driven care, that, you know, it doesn't really matter why we as doctors think someone should make changes to their substance use. It matters that they think their life is going to get better in some way, and that's actually the fun and the art of this, right, of being curious and partnering with people.

And so, Bridge Clinics are not sort of a one-size-fits-all, everyone's going to do this thing working towards this goal, but really around sort of what is this human being's goal, what's worked for them before, what are some of the challenges they're facing, and how can we partner with them around continuing to engage in treatment?

And then generally, Bridge Clinics are transitional because the way you maintain that sort of walk-in, drop-in model of care is that as people stabilize, you can then connect them to longer-term treatment in the community, which may be primary care integrated treatment. It may be a specialty addiction care setting. You know, that can look different depending on the community and the person's needs. So, that's one option. That's sort of like the addiction consult version on the linkage piece if you actually start something new, and you say, "Okay, we're going to build it, and we're going to build it the way we think patients need it."

Not everyone's going to be able to do that, and so there's lots of other ways to think about this. One is leveraging what resources exist in your community. So, if you have primary care that you're linking people to or at some sites have transitional clinics after ED just generally focused on whatever the person's health needs are. Can you partner with those individuals so that they feel more comfortable receiving that patient who just got started on medications for alcohol use disorder, or medications for opioid use disorder, or who is dealing with stimulant use disorder, and figure out linkage pathways within your existing network?

And then I'd say the third bucket is that there are amazing addiction programs out there, and oftentimes there's just this disconnect or chasm between, like, the emergency department and the hospital and the wealth of community resources that exist out there. And so just creating those linkages, and that doesn't cost anything usually. It's often a matter of getting to know your local ecosystem, forming relationships, meeting with people, sometimes creating a service agreement or a referral pathway so that you can get people seamlessly into care. So, we've done that mostly with methadone because we don't have our own opioid treatment program, but we've created partnerships with all of our regional and local OTPs so that they'll accept direct transfer. So, we can start someone in the hospital on methadone and then connect them directly to an OTP, and that just took kind of working together and understanding the pressures and ecosystem that we were existing in, and then trying to solve problems to make it easier for patients to connect seamlessly.

So, there's lots of different ways of thinking of that, and then lots of different supports for how you enhance those partnerships.

And then the sooner that can happen, the better. We know that the risk of death for patients is highest in the first week after discharge, and so, really trying to make those appointments as quickly as possible so that we can have seamless continuity into treatment. We can make sure people are staying on their medication. We can keep them safe during what often is a very vulnerable time period.

Dr. Stephen Taylor: That is so important. And to your point about the partnerships, it strikes me, having done a little bit of moonlighting very early in my career in the emergency department, I experienced this firsthand, and I know this is a life you're very used to, but emergency department clinicians often don't get to see what happens after a patient is discharged.

And so, when you build that partnership with various resources in the community, the question then becomes, well, how do you get the feedback back from those places? And if you don't get that feedback, how does that impact care that you're delivering in the emergency department? And what are perhaps some effective ways to bring some success stories back? Because, quite frankly, you increase the likelihood of having success stories because of the way that we're approaching it and making sure that people get ongoing care. So how do you get that feedback? How do you get those success stories back?

Dr. Sarah Wakeman: Yeah, I think that is such a great point because you're totally right. People working in the emergency room or inpatient clinicians, nurses, doctors, almost by definition they only see the patients who are continuing to struggle, who come back again and get readmitted, and they don't see the amazing arc of recovery that we get to see in the addiction treatment space of that person who came once to the ED after an overdose, got a buprenorphine script, connected to a bridge clinic, got connected to ongoing care in an OBAT clinic and is doing great. Like, they're never going to hear that journey, and so it is so important to share those stories back.

I think when you make partnerships that having an ongoing opportunity to connect, so often when we form like a new referral pathway or a new partnership, we'll meet monthly to start, just to figure out are there any challenges in the referral pathway? What's it been like on the receiving end? What's it been like on the referring end? And that's a great chance to actually sort of understand what's happening after you refer

someone, because otherwise it feels like a black box to the ED clinician. Like, they did the thing they were told to do, and then they never heard again. They don't know if that person died or if they are doing great or, you know, what happened. And so, getting that, even the anecdotes back, let alone the data, I think is really powerful. And then sharing those stories, and that can be as quick as two minutes at a faculty meeting or an email to say, "Mr. Jones that you saw last week, thank you for writing that prescription. He showed up at our program. We've been seeing him weekly. He's doing awesome, and, like, you made a difference with what you did." So, all of a sudden, that ED doctor feels like they are part of a success story, that their efforts, their clinical intervention actually created meaningful change for this patient in a lasting way, and that's something everyone wants to be a part of.

You know, once you get that feedback, you're like, "Oh, I want to do that again. That was great." So, I think those stories coming back is really important, and it doesn't take a lot of time. You know, again, a quick email, quick conversation, a shout-out at a faculty meeting; you can get that information back to people.

Dr. Stephen Taylor: Absolutely. Well, Dr. Wakeman, I could talk to you and pick your brain for another three hours if I had my druthers, but I don't have that option. So, I'm going to ask you to summarize a little bit for us and tell us what would you say are the main practice pearls that you want our listeners to take away from today's episode? What should they learn?

Dr. Sarah Wakeman: Well, I guess the TLDR, if I had to say one thing, I would steal ASAM's line and say, "Treat addiction, save lives," because that's what we're talking about here. I think the treatments that we have, medication treatments, other interventions, I think we don't frame just how transformative they are for generalists.

Even if you're talking to someone about starting treatment, we often talk in terms of you're going to improve someone's recovery, you know, you're going to connect them to care. But these are literally life-saving, mortality-reducing interventions, and our ED doctors, our hospitals have an opportunity to save lives with the care that they're providing.

And so, empowering them, giving people the tools, creating the referral partnerships and the system structures to make that possible is so important. And everyone goes into medicine because they want to help make people's lives better and save their lives, and

there's arguably no area of medicine where we could do that more than if we were to bring addiction treatment fully back into our medical spaces.

So, look at these competencies. Hopefully, use the implementation guide if it's helpful. There's lots of references, toolkits, and tables with different guidelines. We tried to make it comprehensive, but also to give people direction in terms of seeking out more concrete details. And if you are working on change, bring these to your change leaders at your system and say, "Look, there's now national recommendations around what we should be doing." Because there's also the power of embarrassment. You know, when someone says, "This is what we should be doing," you can help nudge people into place. And so, I hope that you'll use this tool widely, and most importantly, just keep doing the amazing work you're doing on the front lines, and every single life that you touch is a life that's potentially saved.

So, hopefully this was helpful and that these competencies and implementation guide are useful in your practice.

Dr. Stephen Taylor: Well, thank you for that. Dr. Sarah Wakeman, that was awesome. And I'm going to just reiterate as a reminder to everyone, please check out ASAM's new Implementation Guide for Hospital and Emergency Department Substance Use Disorder Care.

That is what Dr. Wakeman was referring to. That is that comprehensive yet user-friendly document that will be very, very useful to you. And I want to thank our expert, Dr. Sarah Wakeman, for sharing her experience in helping bridge care between the ED and addiction treatment. Remember, visit ASAM's e-learning center to claim your CE credits for this episode. I know you learned a lot. I learned a lot. So, let's go ahead and get the credit for it.

Also, make sure to subscribe and share this episode with colleagues who may find this information helpful.

Thanks for listening, and we'll see you next time on ASAM Practice Pearls, where we turn clinical expertise into everyday addiction care, one conversation at a time.