

Dr. Carolyn Chan: Hello. Welcome. Thanks to everybody for tuning in to today's episode. This is ASAM Practice Pearls, a podcast series from the American Society of Addiction Medicine.

I'm Dr. Carolyn Chan, and today I'm joined by my co-host, Dr. Shawn Cohen, and we have an incredible guest lined up for you today. We are here with Dr. Marlene Martin, a true expert in addiction medicine who has extensive experience and many practical pearls today to really help us learn how to navigate the complexity of in-hospital substance use. Dr. Marlene Martin, I was wondering if you could just tell us a little bit about yourself.

Dr. Marlene Martin: Yes, thank you so much for having me here. It's a pleasure to be here with you both today. I'm Marlene Martin, an associate professor at UCSF. My clinical work is based at San Francisco General Hospital, our county hospital, and I trained in internal medicine and practice hospital and addiction medicine.

Since 2019, my focus has really been on improving hospital-based addiction care for people with substance use disorders. I founded and direct the Addiction Care Team, a consultation service that provides compassionate care, treatment, and linkage to people who are hospitalized with substance use disorders.

I really love my role because I'm able to collaborate with hospital and community partners around hospital policies and hospital substance use and do a lot of training with healthcare workers around evidence-based care. And have gotten to develop some nurse liaison program models and work with the community, to train promotores who speak Spanish in substance use, so, lots of different hats that I get to wear in this role.

Dr. Shawn Cohen: Well, I'm Shawn. I'm one of the co-hosts. It is such a pleasure to have you here, Dr. Martin. I will say, fanboying out a little bit, I remember when I first started reading some of your articles in Fellowship, and now definitely have a Google Scholar alert for everything that comes out for you so I can get an early look at it, but as Carolyn and Marlene said, today we're going to dive into hospital-based providers and how they feel about managing in hospital substance use. When patients do feel the need or do have instances where they use substances in the hospital, I think it, creates a lot of challenges we want to obviously help address for them, but also I think challenges to the system and still ensuring that they're able to get the care that they need.

I think this not only requires a lot of skill on our end, but also a thoughtful, measured, and evidence-based stepwise approach that I'm hoping we can talk through. So, let's set the stage with a quick case example.

Dr. Carolyn Chan: Today, we're going to talk about a case that probably feels familiar to many of us who do this work.

We have a fifty-year-old patient with opioid use disorder who's actually currently admitted for chest pain. Currently, they're on methadone 50 milligrams for their opioid use disorder and on their second day of admission, the nurse walks in and finds the patient to be lethargic; they have pinpoint pupils, they're rousable, vitals are stable, but they can't really complete a sentence, you know, they're just falling asleep really quickly in front of the clinician's eyes, so the nursing staff pages the attending, and they're saying, "Hey, we're just really worried that this person used substances in the hospital, and we want to call security to search the belongings."

They had a friend visit them, let's put on some visitor restrictions. The patient is just sort of deferring and refusing to let anyone search his belongings, and they say, "Hey if I have visitor restrictions, I'm just going to leave the hospital."

So, a case scenario that I think a lot of us have experienced and we're really hoping for you to guide us through your approach to navigating these situations.

Dr. Marlene Martin: Yeah, in hospitals, substance use happens really commonly. There's one study that showed that there's rates up to 44% of people, and this was back in 2013, so I wonder how that has changed, especially with the changing drug supply. And then the things that I take really into consideration is a lot of the same way that I approach medicine and addiction care and just being really kind and compassionate when addressing it. It's a hard topic for the people who are using substances and for the people taking care of the patients.

I think I try to remember that the reasons why people use substances are a lot of the same reasons that people with substance use disorders are afraid to come to the hospital in the first place. And the same reasons that they self-discharge, and a lot of those are things that we can do something about.

There's a lot that's in our control and that we can help to do to prevent substance use. Making sure there's not untreated pain or withdrawal, thinking about stigma and the role

that that's playing, and that's sort of a longer-term thing that we address with education and many other interventions. Thinking about hospital restrictions and how those can hurt patients and then realizing that this is somebody with a substance use disorder. The substance use disorder does not go away because somebody is in the hospital. In fact, the hospital is triggering, and people have to cope with all of the feelings they're experiencing, and it's important to keep that in mind as we think about how to approach this. When I respond to these efforts, I try to keep everything rooted in mutual safety for the patient and all of the healthcare workers and keep a harm reduction lens in mind. I share with people, "There's been concerns about use. I'm sharing this concern with you because there's a lot of things we can do about this. We want to make sure you're safe, and everyone who's taking care of you is safe, and also, you don't have to take care of yourself in here. We have lots of medications and tools at our disposal so that you don't have to take care of yourself."

I offer addiction care team services, medications, make sure their withdrawal is really well managed, their pain. There's other things that are very simple, like if there's spiritual services, involving social work, journals. People just sometimes want artwork; other things to do so that they're not bored in the hospital.

And making sure that we're all advocating for people, I think the biggest piece, though, is offering evidence-based treatment. And then we also have a policy where I work on in-hospital substance use, and I share what that policy is, and what might happen if people continue using because I think it's important for people to know that and be transparent because most times people avoid talking about it, and then the substance use will likely continue if we're all walking on eggshells around this, but it's going to continue to cause a lot of harm for the patient and for the staff.

I think the other thing to keep in mind is, sometimes people bring up concerns around in hospital substance use, and I'll go see the patient, and a lot of times, too, it really might be stimulant withdrawal, and people are sleepy and resting because they haven't had that in days. So, really, making sure you're approaching this with open-ended questions the same way we approach a lot of addiction care.

Dr. Shawn Cohen: Yeah, I love the answer of first taking a step back and remembering we're treating a person that has needs here and needs at the hospital, depending on where the hospital you work often is either not very good or sometimes good at addressing those needs in that, whether it's uncontrolled withdrawal, not getting medications for opioid use

disorder, or other needs like entertainment and having a life and feeling like you can be a person in the hospital is kind of step number one, but also keeping that differential broad. It sounds like your hospital, and probably due to a lot of your advocacy on this, has a policy around this that is hopefully more person-centered. But what do you feel like are the best practices for a policy like that? And what are the worst practices that should not be in a policy like that?

Dr. Marlene Martin: I'll start off with policies that I don't recommend people using, because I think that's easier to think about, and I want to acknowledge that people across the U. S., that we're all in locations where regulations might be slightly different. We're practicing under different scenarios where you might have more or less access to certain resources.

I think the biggest thing to avoid is punitive responses as a first-line approach, and by that, what I mean are things such as calling security or the sheriff's department. At our hospital, that was often how people used to respond and we're one of the hospitals where security is provided by a local sheriff's department, and that resulted in harm to a couple of patients in terms of people self-discharging, people having outstanding warrants and things like that. I really think that we should really, really, really avoid [that] unless there's imminent harm to someone. We have made that sort of the last resort: if there's continued substance use and there's imminent harm and a reason to call security. I think other things are really perceived as punitive by patients, such as moving them closer to the nursing station, having a safety attendant at the bedside, because then it feels like somebody's monitoring them. Restricting visitors. And then the other thing that I hear happens is, "You're using substances, so we're not going to give you opioid withdrawal management," potentially. It comes from a place, I think, of concern from staff around: is it safe to continue to treat opioid withdrawal in the setting of in-hospital substance use?

But, generally, people are using because their withdrawal is untreated, so we're trying to do a lot of education around that piece. And then in terms of best practices, I come back to, like, what we're doing at our hospital policy, and just one snapshot, and I think we're all learning what are the best practices to follow and what the evidence base will say, and I'm really excited for more literature to come out around this. We're working on something right now, so I'll be excited to hopefully share that soon.

So, in terms of best practices for hospital policies, I think where there is evidence, especially around medication for substance use disorders, make that the focus. Keep a

harm reduction and equity lens in place. And then really making sure that, if there is a policy, thinking about how can this potentially hurt patients, right?

Because we've had a policy for a while and realized it actually didn't help direct people to who to call first, how to respond, and that left people calling security. So, thinking about let's make sure we standardize the response. Let's make sure that first and foremost, it offers evidence-based addiction treatment, and it provides people who are responding who are often not addiction medicine specialists who are often bedside nurses, right, who are first responding to have some sort of script around this, because I think that's the main thing that has come up. How do we address this with patients and what should we offer? And when this happens at night, is it an emergency? Do we need to do something about it right away, or can we wait until the morning time? And I think, in most cases, you can wait, you can share like, "Hey, this is not supposed to happen. We want to make sure you're getting treated. We want to make sure you're getting the care that you need and you can stay in the hospital, but let's offer you adequate opioid withdrawal management, adequate pain management." I think the policy should also really involve a multidisciplinary response where it doesn't put just one person as the responder. Lots of places do not have addiction consult teams, right?

And so, thinking about how we empower the front-line responders, such as nurses, being able to do something about this. It's important that the policy also involves various partners across the hospital. So, when we developed ours, we worked with the regulatory department with hospital leadership with, MedSurg, the nursing leadership. The city and county's lawyer looked at the policy and reviewed it, and then it went through all the committees that it normally does through the hospital setting. And then I think the last piece of this is it's so important to do training around the policy, like education and implementation piece.

Because there might be a policy, but no one might know what it is. And so, you have to disseminate. That's been the biggest lesson learned for me out of our last policy. We didn't do the best job in terms of educating everyone. So, we're actually already revising our policy and working on a workshop, hopefully, to educate everyone around it.

But this time, we're getting a lot more buy-in from all the different people involved because there were a couple of things missing, so this is a living document that will continue to make better.

Dr. Carolyn Chan: I think that's such a great point that we really need this multidisciplinary component to these policies because I feel like, in my experiences, it really impacts staff and can cause a lot of distress and sort of managing and navigating that can be challenging, so I love that you were able to add all of those layers into your policy. And I'm curious in your policy, as you said, there's a lot of different regulations that I think people have to consider at their own institution, but a pain point that kind of comes up frequently, and that I hear from colleagues is that like, what happens when paraphernalia or drugs are actually discovered on a patient?

You know, a lot of times I hear folks being like, "I don't want to handle it as a clinician" because they worry about the liability of it. Some people say, "Well, we need to call security to dispose of it." So, again, acknowledging that different places will have different regulations at their own institution, and [you] have to think about that.

But in your own policy and in your own lessons, how do you approach or think through what happens when you find substances on somebody?

Dr. Marlene Martin: That's something that we do have guidance on with our policy and that we worked on because that was another piece that people wanted instructions on, like, what do we do next, right? Because if you don't give a standardized approach, people are all going to do different things. And people, I think, are just coming from a place where they want to make sure that the patient's safe, and they also want to make sure that they're safe, and some of the biggest concerns that have come up for us have been people worried about exposure to smoked drugs.

People are worried about their licensing and other things that I didn't necessarily think of at the beginning of this. And so, these are such important things and it's important to acknowledge these feelings and, also, think about there's limits to what we can do in hospital settings in the United States, right? Hospitals are not overdose prevention sites. I wish we had hospitals who had an overdose prevention site attached to them, like in Canada, but we don't have that yet. And so, meeting the patient staff in the hospital where they are and taking that approach and what's going to be the least harmful, what's going to try to keep the patient here in the hospital.

Coming back to your question about when supplies or substances are found, what do we do? What we do at our hospital is we have two options for people. First, if people want to dispose of their substances and substance use supplies, we can do that via hazardous wastes and syringe disposal and such measures.

And then, another option for people is that we treat this as their belongings, right? We don't go through their belongings. We don't throw away their belongings if that's not what they want. In most cases, no one would be happy if somebody got rid of, you know, a book or something else that you brought to the hospital.

This is a very different thing, but our policy states that if people are interested, we'll lock their belongings away in their room, there's a cabinet, and they get their things back at discharge. And patients sometimes are really hoping to not use after they leave the hospital. In most cases, people will share like, "Yes, please get rid of this."

In other cases, people are open to their belongings and the substances, substance use supplies being stored and they understand that we're going to work with them to get evidence-based, adequate substance use disorder treatment so that they're not having to take care of themselves because people come prepared or people visit and they're worried about their family and friends and wanted to make sure that they're taken care of and that's how the substances end up there in the first place.

Dr. Carolyn Chan: Who disposes, like who actually in your policy, I'm curious, is it the physician? Is it a nurse manager? Who does that next step handling of whether it's going to be locked or whether it's going to be destroyed?

Dr. Marlene Martin: Yes. If people are interested in having it disposed, it's put in a hazardous waste bag, and then it's disposed of as all other hazardous waste is disposed in the hospital, and then if there's syringes or other things, we'll handle it the same way that we handle like other syringe disposal. And it's usually whoever's at the bedside doing it. If I'm there, and I'm the one who's taking care of the patient, I'll work with nursing, if the syringes are there and make sure I'm disposing of things appropriately.

But that is a piece that comes up often that people worry about in terms of like that is a big part of it. What do we do, exactly? Do we put it in another bag? All these questions come up and I think it's important to have guidance around that.

Dr. Carolyn Chan: That's why we're asking you the tough questions, Marlene, today. I have questions, but few answers.

Dr. Shawn Cohen: It sounds like your policy is I mean, honestly, really great and very person-centered, harm reduction-oriented, but like, was there a process early on in terms

of how did you engage the other stakeholders that are often at the front-line, like, nurses, medical assistants, one to learn about their concerns, their experiences, and then add in that education piece on this is why we want to do it this certain way, kind of thing?

Dr. Marlene Martin: Yes, initially, we got a group of people together to revise the policy when we noticed some of the harmful outcomes that some of the prior policy was having. And it went through all the hospital committees, and that's how we got it approved. I have to say that, what we're doing now. We're revising it again.

We've taken a different approach where we're getting buy-in department by department because I also found out some places have lockers but maybe some places, like the emergency department, actually don't have a place to lock away patients' belongings, so we're working on making sure there's guidance that is supportive and as similar as possible across the whole hospital from the emergency room, inpatient, our psych emergency services, et cetera., and, especially lots of buy-in and meetings with nursing leadership. That's been a key piece of this. And then we're working with our nurse educators. Once the policy is moved forward to the next few stages on an education and implementation piece. And then we'll go ahead and work with them to do education in smaller groups and in the workshops and things like that.

And we've more recently begun to do this more with some of the other things that we do, like rapid methadone titrations. And when we started doing intravenous buprenorphine for low dose, buprenorphine starts. We've worked with the nursing educators, and that's been, so, so helpful because people are wanting this knowledge. They didn't get it. Many of us didn't get it before, so everyone wants to learn about it.

Dr. Carolyn Chan: What would you say to a physician such as myself, who is interested in doing this in my practice setting, though I'm worried about the overall climate? I've worked in a number of different places with varying levels of comfort with harm reduction philosophies, et cetera, and part of me worries that if there's some formal policy, it could be the worst-case scenario, where the answer is like "arrest the patient," which I think we all agree is not the answer. I think there's definitely complexity around the whole process, but instead of dealing with the complexity of it, being nervous, right? That sometimes raising the question and elevating it up could actually impose more negative consequences. Do you have any thoughts about navigating that?

Dr. Marlene Martin: Yeah, of course, policies can hurt people. Really, right? And then you worry about having something down on paper that actually can cause more harm than

good. But I think that without a policy, there's inconsistent responses, and there's probably a lot of people who potentially change their approach to patients if they are concerned about in-hospital substance use.

Maybe somebody might call in sick because they were worried that they're going to get exposure. Maybe they're going to stop giving the patient opioid withdrawal management or adequate pain management, and so I think putting something down on paper can be helpful when it's going to have the evidence-based focus best practices and avoid the punitive things as a first-line response and also acknowledging the other piece.

That, for hospitals, there's regulations and other things that they have to comply with. And these concerns from healthcare workers around exposure are very real. So, if there's continued substance use, we want to take good care of the patient, but I also have frank discussions with the patient about "we want to continue to take care of you. This can't keep happening. Our new policy will have a patient agreement if there's continued substance use that we might have to offer some of these things, like moving you closer to the nursing station eventually, or having more frequent checks." People don't want that.

Dr. Shawn Cohen: Yeah, it sounds like some of this is just expectation setting, too, and having that policy and being able to say "We want to provide you the best care possible, we want to address this, we want to treat your withdrawal, we want to treat your pain. But if this keeps happening, there are next steps that will eventually have to happen."

Dr. Marlene Martin: I think the other piece is involving the subject matter experts who are going to try to build a policy that's focused on harm reduction and evidence-based care as much as possible. Because if you have someone who is really focused on more of the punitive initial response, it's going to be hard, right? But you also need to acknowledge that that is what some people are thinking, right? And so it's important to also get buy in from those individuals because they're the ones who are going to be able to influence others and educate later and learn about this process. So, working with hospital leadership and also starting somewhere, right?

Because it doesn't have to be perfect at the beginning, but just starting somewhere from a place of at least first-line: let's offer evidence-based addiction treatment. That's not, "Tell the patient we're going to discharge them." It's not called security as a first-line response. Those pieces, right? Whatever you can do, implement one of those and go somewhere from that. And then I think it's really helpful, also, for people to know that this is happening across hospitals in the United States. Everyone's facing in-hospital substance use and overdoses in hospital settings. That's very real. Not only in hospital settings, right? That's

very real, and we can be part of helping to prevent that and offering treatment. And I think coming from that place can help get some leverage around policies and approaching things from a place of not doing harm.

Dr. Carolyn Chan: And that comes to a second pain point, right? So let's say you have implemented your amazing policy, and you have a person who probably has in-hospital substance use, you have a conversation with them, set expectations, really avoid punitive measures, you adjust their pain medications, their methadone dose in this case, and a couple of days later, unfortunately, have an in-hospital overdose. So, now we have a clear adverse outcome, a safety concern within your policy. What happens next? If this happens, what of a second-line?

Dr. Marlene Martin: Continued use and especially an overdose is so hard on both the patients and all of the healthcare workers involved. I continue to approach this from a place of making sure we maximize services, but also acknowledging, "Hey, this can't happen. We've discussed this before." At that point, I would offer a patient agreement that involves not continuing to use substances. And then also just sharing, you know, "I understand, if your cravings are really high, or there's something else going on, and I understand if you might want to continue to use." If people want to leave, use and come back, too, that's another thing. We're always going to be a place for people to come back. I really don't want that to happen, right? I don't want people to leave, especially if they came here for an acute medical condition, and I will do everything that I can. And I don't want them to leave and also go overdose or anything like that, but there's limits of what we can offer. And also, people can make choices. And I want to respect that, too. I don't have the right answer here. I think we're all working on figuring this out.

Dr. Carolyn Chan: It sounds like you guys kind of tailor next steps in your intervention to the context. Because, like you said, I think context matters a lot in these situations. If a patient did end up having a search, do you have any recommended best practices to try and mitigate patient discomfort and the harm if a search has to happen?

Dr. Marlene Martin: Yeah, I think, in terms of searches, our hospital has a policy on searches, too.

But unless people, are like, "Oh, yeah, you can see here, I don't have anything," we don't search admitted patients. But I think, just, being very real with people, being upfront, being direct, and offering as much as we can of different resources.

And if people are denying that they're using substances, yeah, maybe they're not using substances, or maybe there's a reason that they are not wanting to share that with you, right? They've had bad healthcare experiences in the past and, just sharing with them, "That's okay. Let me just share with you what the hospital policy is anyway, so that, you know, so that if there is continued use, people know what might come down the line. Because I think in most cases, when I've been able to have a direct conversation with people, and my colleagues, people don't continue to use.

Dr. Shawn Cohen: Yeah, I mean, I think that's really good to hear. I've, at times, or when I'm seeing patients that I've seen before, and I know they really struggle with withdrawal even when we're trying to like really maximize therapy and they've had prior in-hospital substance use before, I sometimes try to have a conversation up-front of like "If this happens, it does start this cycle of things that happen.

Do you ever have a preventative conversation with people just warning them of, "We're going to do our best, tell us if you're having withdrawal symptoms, but if you do use in the hospital, these things might happen."

Dr. Marlene Martin: Yeah, I've thought about just having that conversation up front. Or, is there a way that the hospital could train everyone to have this conversation with all admitted patients, right?

Dr. Shawn Cohen: Yeah.

Dr. Marlene Martin: Because I think if we let everyone pick and choose who they decide to have that conversation with. People use biased approaches, and so it might be better to just have it as part of admission agreements for patients when they come to hospitals. So, have it as part of that. But the language we use when we discuss this is so important, too. I struggle with should we do this with everyone? Should we have the admitting nurse do this? I think that piece I'm interested in learning a little bit more about, but otherwise I do have that conversation when I see somebody in withdrawal, "We want to take really good care of you. If this dose is not enough, we're going to go up on the dosing, but you need to tell us, right? You need to tell your nurse, we need to get paged, and we're going to come back here and go up on your dosing. That's how I approach that piece. Sounds like very similar to what you do.

Dr. Shawn Cohen: It makes me feel good that I'm doing something similar to you. So, I mean, I guess the other thing that I always think about is the nurses, I think, are the ones

who really bear the brunt of this as [they are] always the front-line people. I think often the people who are seeing someone use in the hospital or seeing the effects of it or being worried about that. Is there anything that you've been able to create that's helped engage nurses more or kind of work more with nurses around what I think is often a little bit of a difficult issue?

Dr. Marlene Martin: Yes, on the education piece around the policy with nurses and with other healthcare workers is really important and then the other thing we've been doing more recently that I'm really excited about is we piloted an addiction care team nurse liaison program in our family birth center with six nurses.

One of the nurse educators there is one of the main people leading it and then our addiction care team nurse practitioner is also co-leading it and doing practicums with people. So, having people come to our addiction consult team rounds and educating them on substance use. What has been so helpful is, we're training people to become nursing champions, and then they're also going to get board-certified in nursing.

And then what has already started to happen is their nurse colleagues are going to them to these six individuals with questions, around, in hospital substance use policy, around, "How do I treat this? Hey, when do I give Clonidine?" And that has been awesome to see.

And I'm really hopeful that as we expand this across the hospital, it's going to continue to have some of that impact. We're launching our second pilot in the new year with our med surge and emergency department colleagues, so we'll hear more about that

Dr. Carolyn Chan: That sounds so cool.

Dr. Shawn Cohen: Yeah, I'm very jealous. I got to learn how to do this too.

Dr. Marlene Martin: The family birth center nurse educator who did this is awesome. It's so cool.

Dr. Carolyn Chan: I can't wait to hear more. I couldn't imagine a train the trainer program that could just spread across the country. That's really cool and super innovative, and [I'm] so glad to hear that people are working on that.

Dr. Marlene Martin: We learned a lot from BNC because they have their addiction nursing fellowship, which is really cool, too. They inspired us for sure.

Dr. Carolyn Chan: Amazing. Well, thank you so much Marlene for coming on and chatting with us. I feel like I learned a ton and have a lot of take homes.

Dr. Marlene Martin: Thank you for having me here.

Dr. Carolyn Chan: So, let's take a moment just to remind everyone of the case we started with. We had a gentleman who was admitted to the hospital with in-hospital substance use, likely opioid or fentanyl use. Based on our conversation, how could this patient's situation be changed or managed differently to sort of improve their outcomes for the patient and entire care team in general?

Dr. Marlene Martin: I have two thoughts here. I think if I'm taking care of the patient early on, I might see that methadone dose and wonder like, "Hey, how are you doing on this?" Because it's kind of a low dose in terms of what I see and think. And so, I might ask about cravings and withdrawal and continued opioid use on that dose and then ask them, "Hey, is it okay if I call your opioid treatment program and get a little bit more information?" to see how their overall methadone dosing has been doing and offer more methadone if that's what the patient would like. That might be one way to help prevent in-hospital substance use.

And then I think we're here, we're worried he may have used substances. So, if I'm involved in responding later, I would consider other in addition to substances about why might he be in this situation right now, right? He came in with chest pain, is something else going on? But making sure I assess him, making sure he continues to be supported. It sounded like he is arousable, so he doesn't need naloxone, but making sure all those pieces are in place.

And then I would not want to call security or do a search or have visitor restrictions as his first line of response. I would ask, "Hey, let's stabilize the patient. Let's talk to them when they're a little bit more awake, and let's maximize our addiction services and see what he says, and then we'll move from there."

So hopefully we can get buy in from the patient's nurse, and then make sure that patient's opiate withdrawal is treated aggressively, and then explore all of the other things that we can do to support the patient, inform them of the policy, and go from there.

Dr. Carolyn Chan: Amazing. And for those of you interested, Marlene has published this policy.

It sounds like you're working on a new iteration, but for folks who are interested in looking it up, the title is In Hospital Substance Use Policies and Opportunity to Advance Equity, Reduce Stigma, and Offer Evidence-Based Addiction Care.

Dr. Shawn Cohen: Well, thank you all for joining us for this episode of ASAM Practice Pearls. And a big thank you to Dr. Marlene Martin for sharing her insights, how they develop the policy and kind of the best practices for policies for managing substance use in hospitalized patients. For more information and resources on this topic, as well as other challenges in addiction, you could check out ASAM's Advanced Buprenorphine Education series, where you'll find additional training opportunities and tools to support your practice.

Dr. Carolyn Chan: And you know what? We would love to hear from you. What challenges have you faced when addressing in-hospital substance use? What strategies have worked for your team?

Be sure to comment and join the conversation. Don't forget to subscribe to the podcast and share this episode with your colleagues.

Thanks for tuning in, and we will see you next time, on ASAM Practice Pearls.