Opioid and Other Substance Use Disorders Study Committee
Wednesday, Aug. 30, 2023

Hospital Panel Presentation: CHA Remarks – Richard Bottner

Good morning, Chair deGruy Kennedy and members of the Committee. My name is Rich Bottner and I am the vice president of clinical excellence at the Colorado Hospital Association (CHA). In this role, I collaborate with clinical leaders across Colorado on a multitude of clinical issues. I also convene CHA's Clinical Leadership and Excellence Council, a diverse group of clinical leaders who provide guidance and direction on the association's work to improve clinical outcomes across the state.

The topic of substance use disorders is one of particular passion and experience for me. Prior to joining CHA, I was on faculty at Dell Medical School in Austin, Texas where I led statewide improvement efforts related to addiction care in hospitals. I've personally authored numerous peer-reviewed papers and studies and have given hundreds of lectures nationally on addiction care in hospitals, in addition to completing my doctorate with a dissertation focused entirely on hospital addiction care best practices. If you're having trouble sleeping, I'm happy to forward you a copy.

For today's purposes, the Committee received two documents in advance. One is an article recently published by the American Hospital Association and authored by four Coloradans including myself. It is a paper highlighting the role of hospital board members in addiction care and was delivered through the American Hospital Association to every hospital trustee in the United States.

The second paper is called *Caring for Patients with Substance Use Disorders in Acute Care Hospitals*. All of its authors are from Colorado and have extensive experience in hospital addiction care. Its content was endorsed by the CHA council I mentioned earlier, and it is findings from this report that I'd like to discuss with you today.

Given our limited time here, I've chosen three highlights to focus on:

1) **The opportunity for hospital engagement in SUD care is massive**. Based on Colorado hospital claims data evaluated by CHA, we were able to conclude that 16% of all hospitalized patients have an SUD. This is highly likely an underestimate due to the complexity of billing and coding, but the point is that we're talking about 1 in 5 patients.
    a. This is at a time when we have the highest number of overdose deaths ever recorded. Colorado is in the middle of the pack nationally as we're ranked 25th in overdose deaths.
    b. It is paramount to appreciate that the hospital experience related to SUD is NOT limited to opioid overdoses. Many patients experiencing SUD are hospitalized for co-occurring conditions such as infections and other diagnoses that keep them hospitalized for days, weeks, even sometimes months at a time.
    c. Opioids are not the only SUD. In fact, alcohol and methamphetamine in some ways are more challenging. Colorado ranks 46th in nation for alcohol-related deaths. And where do patients go with severe alcohol withdrawal or with liver failure – they go to the hospital.

2) **The vast majority of people with SUD will be seen in a hospital at some point**. Hospitalization is a reachable moment to meet patients where they are at and to provide the kinds of resources and access

to care that we know reduces harm, saves lives, and is being a good steward of the health care resources that we have.

3) **The breadth and depth of clinical interventions must be expanded.** Starting on page 6 in the whitepaper, we propose the Colorado Hospital Addiction Care Framework, an evidence-based approach to improving addiction care in hospitals. It focuses on multidisciplinary teams, comprehensive clinical and systems interventions, and recognizes that while emergency departments are important areas of the hospital that can address addiction, they are by no means the only one. We need to be inclusive of inpatient medicine, labor and delivery, perioperative services, pediatrics, adolescent medicine, etc. I encourage you to review the proposed interventions on pages 8 and 9 and reach out any time for discussion.

I would also encourage you to read the entire report and I'm happy to discuss any of this in greater detail during Q&A if helpful. But for now, I'll leave you with three key takeaways:

1) Hospitals play a vital role in serving people with substance use disorders, but their impact is limited by stigma, clinical training, and policy.
2) Outcomes can be improved by empowering existing multidisciplinary clinical teams inclusive of people with lived experience and focused on four key areas: prevention, treatment, harm reduction, and recovery – all of which have a place in hospitals.
3) There are dozens of examples of hospitals and health systems around the United States who have done strong work to improve care for people with SUD, and there are numerous examples right here in Colorado. Their work shows promise and hope that we can improve this care together, but doing so requires – demands – that we resource those efforts appropriately.

Thank you for your time this morning and for the opportunity to speak before you on a topic close to me and Colorado's hospitals. I am happy to take any questions.

Contact Information:
Richard Bottner, DHA, PA-C, CPHQ, FACHE
Vice President, Clinical Excellence
Richard.bottner@cha.com

Joshua Ewing, MPA, CAE
Vice President of Government Affairs
Joshua.ewing@cha.com

Caring for Patients with Substance Use Disorders in Acute Care Hospitals:

A Paper from the Colorado Hospital Association's Center for Clinical Leadership and Excellence

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Colorado Hospital Association
Center for Clinical Leadership and Excellence

Authored by:

Richard Bottner, DHA, PA-C, *Vice President, Clinical Excellence, Colorado Hospital Association*
Katie Breen, MPH, *Vice President of Programs, Colorado Perinatal Care Quality Collaborative*
Robert Valuck, *Director, Center for Prescription Drug Abuse Prevention, University of Colorado, Skaggs School of Pharmacy and Pharmaceutical Sciences*
Jose Esquibel, *Associate Director, Center for Prescription Drug Abuse Prevention, University of Colorado, Skaggs School of Pharmacy and Pharmaceutical Sciences*
Susan L. Calcaterra, MD, MPH, MS, *Associate Professor of Medicine, Department of Medicine, Divisions of General Internal Medicine and Hospital Medicine, University of Colorado, Anschutz Medical Campus*
Jenny Koch-Zapfel, MSW, CHoSEN QIC, *Kempe Center for the Prevention and Treatment of Child Abuse and Neglect*
Joshua A. Barocas, MD, *Associate Professor of Medicine, University of Colorado School of Medicine, Divisions of General Internal Medicine and Infectious Diseases*
Don Stader, MD, FACEP, FASAM, *Executive Director, The Naloxone Project*
JK Costello, MD, MPH, *Director of Behavioral Health Consulting, Steadman Group*

Endorsed by the Colorado Hospital Association's Clinical Leadership and Excellence Council:

Brian Murphy, MD *(chair), Chief Executive Officer, Valley View Hospital*
Jackie Attlesey-Pries, MSN, RN, CENP, *Chief Nursing Officer, Boulder Community Health*
Jeff Bacon, DO, *Chief Medical Officer, Banner Health - Western Region*
Kevin Coleman, MD, *Chief Medical Officer, Grand River Health*
Andy French, MD, MBA, *Vice President, Quality Safety, and Clinical Operations, Centura Health*
Kelly Gallegos, RN BSN, *Chief Nursing Officer, UCHealth, Yampa Valley Medical Center*
Karla Hardesty, MA, *Board President, San Luis Valley Health*
Ian Howells, MHA, RN, *Director, Clinical Performance Improvement, Intermountain Health, Peaks Region*
Amy Lavigne, MSN, RN, *Quality Director, Vail Health*
Read Pierce, MD, *Chief Quality Officer, Denver Health*
Rachel Smith, RN, BSN, *Hospital Director of Nursing, Lincoln Health*
Sandeep Vijan, MD, FACS, CPE, *Chief Medical Officer, Spanish Peaks Regional Health Center*

Executive Summary

Across the United States, including in Colorado, substance use disorders (SUD) continue to represent a major public health challenge. Despite increased attention nationally, mortality related to substance use and drug overdose continues to devastate communities. Importantly, while opioids have garnered much of the national attention, additional substances are also major public health concerns, particularly alcohol and stimulants. Hospitalization represents a reachable moment for people with SUD. A tremendous opportunity exists for hospitals to be engaged in systems improvement and for hospitals to be resourced appropriately to provide this vital care. Hospitals are uniquely positioned to integrate robust prevention, treatment, harm reduction, and recovery strategies driven by multidisciplinary teams.

In December 2022, the Colorado Hospital Association convened a group of Colorado-based clinical experts with experience and expertise in hospital addiction care. With guidance from the Association's Clinical Leadership and Excellence Council (CLEC), the group of SUD advisors collaborated to identify best practices, promote evidence-based clinical care, and spotlight innovations. In the following paper, CLEC shares the Colorado Hospital Addiction Care Framework, which outlines systems and clinically based interventions to expand screening, treatment, and care linkage for hospitalized patients with SUD, including integration across all areas of acute care hospitals.

This paper is designed to provide thought leadership around hospital-based addiction care and elevate best practices based on objective review of the scientific literature. While the authors recognize the tremendous opportunity and need to improve fragmented SUD infrastructure in the outpatient setting, the following focuses exclusively on the SUD care continuum within acute care hospitals. This paper should be used as a catalyst for additional conversations and convenings, and as a foundation to guide technical assistance and other implementation support around the included themes. Hospitals should consider which of the following suggestions, if any, are most appropriate given the unique processes and resources of the hospital, which can be reviewed by legal counsel. In addition, specific clinical guidelines and toolkits are not included here, but may be developed as part of future work products.

Introduction

Acute care hospitals are an essential part of the care continuum for patients with SUD. Opportunity exists for hospitals to be fully integrated as meaningful community partners and in the grantmaking processes for systems and clinical innovations. Current limitations to hospital integration exist largely due to hospitals not being promoted as, positioned for, or appropriately resourced to be part of the solution to the SUD crisis. Given the fact that SUDs are life-threatening medical diseases with significant morbidity, mortality, and social costs, the need for hospitals to be appropriately equipped and resourced is urgent. There is an opportunity for hospitals to be key stakeholders in public health innovations related to SUD and to achieve critical funding through federal, state, and foundation programs to improve care delivery.

There are a multitude of interventions that hospitals could utilize in response to the SUD epidemic including screening, prevention, treatment, harm reduction, and elimination of stigma. Hospitals need dedicated education, training, and resources to foster and grow effective, compassionate, and evidence-based care for people with SUD. While the overall support for hospitals as part of the SUD care continuum has been minimal, significant attention has focused on emergency departments (EDs). EDs are a key access point for patients with SUD, however they are only part of a much larger continuum of hospital-based care that includes inpatient care, labor and delivery units, perioperative services, and pediatric and adolescent services – all of which are uniquely positioned to support patients with SUD and their families. The objective for improving SUD care in these practice settings is similar, but the tactics are different based on the clinical context, structure, resources, and distinct clinical workflows of each.

It is critical to recognize that while much of the attention on the SUD epidemic in the United States and in Colorado over the past decade has focused on opioids, including illicit fentanyl and its analogues, additional substances also contribute significantly to hospitalizations, including alcohol, methamphetamine, cocaine, tobacco, and increasingly, cannabis.

The Opportunity

The impact of SUD on communities and the hospitals serving them is staggering. Even with important and impactful efforts around responsible prescribing, drug overdoses and the consequences of unhealthy substance use significantly impact the health of communities across the United States, including those in Colorado:

- Over 107,000 people died of a drug overdose in the United States in 2021, the **highest number ever** recorded and a 15 percent increase from 2020.[1]
- Per the Commonwealth Fund's 2023 Scorecard on State Health System Performance, Colorado **ranks 25th** for drug overdoses and **46th** for alcohol-related deaths.[2]
- Approximately one in 11 ED visits and one in nine hospitalizations is related to SUD, accounting for up to 33 percent of all admissions in safety net settings.[3] Nationally, **up to 15 percent** of patients who present to the ED after an opioid overdose die within one year, a number that far exceeds the number of patients who die from heart attacks.[4]
- According to claims data between 2017 and 2021 analyzed by the Colorado Hospital Association, **16 percent of all patients admitted to hospitals across the state have a SUD diagnosis documented,** with alcohol use disorder being the most dominant. Given known challenges surrounding accurate SUD diagnoses among hospitalized patients, the prevalence is likely significantly higher.
- One in five cases of maternal mortality is a direct result of mental health conditions, primarily related to substance use disorders and overdoses.[5]
- Hospitalizations related to stimulant use, particularly methamphetamine, have drastically increased due to stimulant-induced cardiomyopathies and acute psychiatric diagnoses.[6]
- Presentations to the ED for adverse events related to cannabis use have also continued to rise.[7]

Moving beyond prevention of opioid use disorder: Major strides have been made on responsible prescribing of opioids. Prior work led by the Colorado Hospital Association, Colorado Medical Society, and Colorado Consortium for Prescription Drug Abuse Prevention included a 2019 initiative designed to improve the safety of opioid prescribing: Colorado's Opioid Solution: Clinicians United to Resolve the Epidemic (CO's CURE). CO's CURE brought together diverse clinical specialties committed to resolving the opioid epidemic in Colorado through the development of opioid prescribing and treatment guidelines. Despite development of evidence-based guidelines and improvement of appropriate prescribing practices specific to opioids, massive opportunity for implementation of holistic and comprehensive best practices surrounding SUD remains.

When it comes to hospitalization, it's about more than overdoses: The impact of SUD on hospitals extends beyond the toll of overdose reversals and management of withdrawal. For patients and hospitals alike, SUD can lead to a variety of other serious health care concerns that require significant resources to address.

- Upwards of 70 percent of patients with SUD who are hospitalized are undiagnosed.[8]
- Hospitalizations related to opioid use disorder with and without serious injection-related infections increased significantly between 2002 and 2012. There were further increases between 2016 and 2018 for heart, bone, and skin infections, and sepsis related to substance use.[9]
- Hospitalizations for SUD-related infections may require weeks of intravenous antibiotic therapy.[10]
- Hepatitis C infection, often associated with injection drug use, continues to account for substantial proportions of both hospitalizations for end-stage liver disease and for liver transplantation.[11]
- Xylazine, a central nervous system depressant, is increasingly contaminating the drug supply and resulting in severe systemic and localized infections.[12]

Hospital-based interventions for improving SUD outcomes are proven, but underutilized: Professional society guidelines exist for addressing opioid and substance use disorders, including among hospitalized patients. Such guidelines have been published by the Society of Hospital Medicine, American College of Emergency Physicians, American College of Obstetrics and Gynecology, and the American Society of Addiction Medicine. Despite several decades of robust scientific research, a lack of translation from science to clinical and system-based practice persists primarily due to inadequate technical assistance and implementation resources specifically for hospitals.

Connection to the Hospital Transformation Program: The Hospital Transformation Program (HTP) aims to improve the quality of hospital care provided to members of Colorado's Medicaid program by tying provider fee-funded hospital payments to quality based initiatives. HTP, which is managed by the Colorado Department of Health Care Policy and Financing, includes several measures related to SUD care. These measures are briefly described in the following table.

Select Measures from the Hospital Transformation Program

MEASURE	RELEVANCE TO THE SUD CARE CONTINUUM
SW-RAH1: 30 Day All Cause Risk Adjusted Hospital Readmission	As stated above, hospitalized patients with SUD who are not provided SUD-specific resources are at high-risk for hospital readmission within 30 days.
SW-CP1: Social Needs Screening and Notification	Health related social needs often present a major barrier for people with SUD to receive necessary care.
SW-BH1: Develop and implement a discharge planning and notification process with the Regional Accountable Entity	Post-discharge care coordination is essential for patients to receive evidence-based care in the community. This includes appropriate and accurate diagnosis of SUDs.
SW-BH3: Using Alternatives to Opioids (ALTO) in Hospital Emergency Departments	Use of ALTO when clinically appropriate is part of a comprehensive public health strategy to prevent SUD.
BH1: Screening, Brief Intervention, and Referral to Treatment (SBIRT) in the ED	SBIRT is one well-established approach for identifying patients in need of SUD care and initiating appropriate clinical interventions.
BH2: Initiation of Medication Assisted Treatment (MAT)	Initiating clinically appropriate MAT is part of a comprehensive public health strategy to increase access to SUD treatment.

The Return on Investing in SUD Care

Caring for SUD in the hospital is expensive: A recent analysis by Premier based on input from over 4,000 hospitals nationwide found that opioid use disorder alone costs hospitals $95 billion per year, nearly 8 percent of all hospital expenditures.[13] Alcohol use disorder represents a significant proportion of all hospital costs related to SUD, underscoring the necessity to focus systems and clinical interventions beyond opioids.[14]

Providing evidence-based care reduces costs and improves outcomes: Building models of SUD care in hospitals has been shown to improve mortality, reduce hospitalizations, decrease overdoses in the community, and is cost effective.[15] Pharmacologic and psychosocial interventions implemented around the time of hospital discharge improve engagement in post-acute addiction care and reduce subsequent health care utilization.[16–19] Navigation services reduce costs and readmission and improve post-discharge engagement.[20] Spreading models of SUD care to rural communities has also been shown to be effective.[21]

In the current environment, up to 17 percent of patients with SUD leave the hospital via patient directed discharges (i.e., "against medical advice").[22–25] However, patient-centered interventions that promote evidence-based practice and shared-decision making between the provider and patient reduce the likelihood of a patient self-discharging from the hospital prior to the conclusion of treatment.[26–28] Such interventions include mitigating and treating withdrawal, using patient-first language, providing appropriate multimodal approaches to pain management, among many others.[29–32] Implementing strategies around addiction care re-establishes trust between patients with SUD and hospitals and health systems while also improving patient and staff/clinician satisfaction.[33–35] Patient and staff-centered policies and interventions for in-hospital substance use may improve upon health and racial/ethnic inequities, and reduce incidents of workplace violence.[29] Providing evidence-based addiction care in hospitals supports destigmatization, models compassionate care, and supports reframing SUDs as chronic medical conditions.[36]

Colorado Hospital Addiction Care Framework

Given the opportunity to improve care for hospitalized patients with SUD, CLEC has endorsed the following hospital addiction care framework. The purpose of the framework is to illuminate key areas of focus for hospital leaders, clinicians and staff, communities, state and federal grantmakers, and philanthropic organizations. The framework promotes widely accepted categories of SUD care in all clinical areas of the hospital, encourages engagement of multidisciplinary teams, and puts forth certain foundational elements for hospital SUD care in acute care settings.

CLEC strongly believes that resourcing hospitals appropriately within this framework will result in reduced morbidity and mortality, improved patient and team member experience, and decreased total costs related to SUD care.

Hospital Addiction Care
FRAMEWORK

ESSENTIAL ELEMENTS:

Staff and provider education, evidence-based measures, trauma-informed care, integration of technology, community engagement, and access to real-time data.

Multidisciplinary Teams

PROVIDERS	NURSES	PHARMACISTS
CASE MANAGERS/ SOCIAL WORKERS	PHYSICAL REHABILITATION SPECIALISTS	ADMINISTRATION

Interventions

PREVENTION	TREATMENT
RECOVERY	HARM REDUCTION

Practice Settings

EMERGENCY DEPARTMENT	INPATIENT	LABOR AND DELIVERY
PERIOPERATIVE	PEDIATRICS	

The following section describes components of the hospital addiction care framework in greater detail. Hospitals should consider these suggestions within the context of their own unique processes and resources.

Interventions[37–40]

- **Prevention**
  - Integrate best practice screening protocols, particularly models that include Screening, Brief Intervention, and Referral to Treatment (SBIRT).
  - Support evidence-based and appropriate multimodal pain management. Recognize that in-hospital ordering of opioids for acute pain management among hospitalized patients with SUD is different from prescribing opioids at discharge and requires unique approaches. Patients with a history of opioid use disorder may have higher opioid tolerance and hypersensitivity to pain.
  - Establish standardized approaches to the use of prescription drug monitoring programs.
  - Promote screening for HIV and hepatitis C among vulnerable hospitalized patients.
- **Treatment**
  - Initiate evidence-based pharmacotherapy for SUD. This includes appropriate and adequate medications to effectively treat withdrawal in addition to starting maintenance medications for continuation at discharge, depending on patient preference.
  - Establish electronic health record-integrated protocols for initiation of medications for SUD. Protocols should be specific to the patient population and clinical scenario (e.g., pregnant patients, patients with acute pain, patients undergoing surgical procedures, intubated patients).
  - For patients with opioid use disorder, partner with opioid treatment programs for increased access to methadone treatment services, including mobile services.
  - Link patients to post-discharge care for continued treatment, including streamlined partnerships with substance use disorder programs able to continue medications started in the hospital, such as buprenorphine, methadone, or naltrexone.
- **Recovery**
  - Grow and integrate a peer recovery specialist workforce with specific competencies around hospital-based clinical care and administrative operations.
  - Link patients to outpatient peer recovery groups.
  - Promote recovery-friendly workplaces.
- **Harm Reduction**
  - Implement best practices for naloxone education and distribution for at-risk patient populations per guidelines, including those established by the Food and Drug Administration and CO's CURE.
  - Distribute alcohol swabs, wound care supplies, and fentanyl test strips, and create safe syringe programs. While these interventions are specific to intravenous drug use, they are essential to decreasing morbidity and mortality related to infections.
  - Note that many of the elements in the following section are also related to harm reduction. The spirit of harm reduction is centered on preserving patient-centered care and respecting patient autonomy in a manner that builds trust and ultimately improves outcomes. Harm reduction is an all-encompassing term which promotes appreciation that recovery is an individualized journey that does not always necessitate total abstinence.

Essential Elements and Foundational Guidance

- Promote staff education and hospital-wide campaigns around evidence-based practice and destigmatization (e.g., appropriate language, guideline-based care).
- Engage community members with lived experience and incorporate lessons learned into strategic planning and day-to-day operations.
- Adopt SUD interventions that are measurable, achievable, and specifically designed for hospital care. Examples can be found in the Stem The Tide program from the American Hospital Association.
- Improve infrastructure for real-time data collection, analysis, and monitoring related to the impact of substance use on hospitals.
- Practice trauma-informed care and promote trauma-informed leadership.
- Review internal policies that may inadvertently limit access to SUD care during hospitalization, including clinical and nursing policies, hospital bylaws, and formularies.
- Design and implement tools within the electronic health record that support SUD care and improve efficiencies for care teams.
- Foster community-based organization partnerships, particularly those which can facilitate support around health related social needs.
- Establish care navigation pathways and/or "SUD coordinator" roles that facilitate transitions of care from the acute hospital setting to the community setting.
- Establish comprehensive approaches to gathering and utilizing population health data, including claims data and screening of drug supply and substance use patterns.

Practice Settings and Functions for Targeted Interventions

- **Emergency Departments** – EDs are the primary access point to acute care hospitals for most patients. Patients with SUD may present to the ED for a variety of reasons and EDs should be well-equipped to respond.
- **Inpatient Medicine (including hospitalist-led services)** – Patients with SUD may be admitted to the hospital for days to weeks. Admission may be directly related to the substance use disorder itself, such as withdrawal or infection, or may be related to another organic diagnosis. In either case, hospitalization is a reachable moment to provide whole-person care which includes addressing SUD.
- **Labor and Delivery** – Mental health and SUDs continue to be a major driver of maternal mortality and morbidity during the perinatal period. Many patients do not receive optimal pre-natal care, especially related to SUD. Labor and delivery units are critical parts of the care continuum.
- **Perioperative Services (including anesthesia)** – Surgical procedures, the discontinuation of medications for addiction treatment, and the introduction of anesthetic medications increase the risk of relapse events.
- **Pediatrics** – As the rates of SUD increase among the adolescent population, the need for improved pediatric SUD care is paramount.

Multidisciplinary Teams and Engagement of Interprofessional Stakeholders

- **Hospital administration**
- **Providers (MD/DO, PA, NP)**
- **Nurses**
- **Pharmacists**
- **Case managers**
- **Social workers**
- **Physical rehabilitation specialists**
- **Behavioral health specialists**

Next Steps

As is the case with most chronic medical conditions, acute care hospitals are not the appropriate practice setting for patients to receive longitudinal, long-term maintenance care. However, hospitals are uniquely positioned to address patients and communities in acute crises and to provide comprehensive interventions that can foster recovery. SUDs are life threatening diseases which benefit from high quality, evidence-based care. Significant opportunities exist for hospitals to optimize, streamline, and standardize SUD care if they are resourced appropriately and engaged in the stakeholder process. Next steps include convening additional stakeholders and experts to perform a thorough needs assessment and identify best practices, developing toolkits and step-by-step resources to support implementation, and creating grant programs to support technical assistance and use of implementation science frameworks.

Additional Reading

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Trustee Insights

QUALITY OVERSIGHT

Trustees Play Major Role in Addressing Substance Use Crisis

Board oversight of quality improvement and patient safety has been shown to correlate with improved patient outcomes

BY RICHARD BOTTNER, KARLA HARDESTY, KORREY KLEIN AND BENJAMIN ANDERSON

Across the United States the number of deaths and medical complications from unhealthy substance use continue to skyrocket. Behind the alarming numbers of people impacted are individuals: fathers and mothers, sons and daughters, brothers and sisters and dear friends. Despite significant national attention, the substance use epidemic continues to impact every neighborhood in the country. Rural and urban communities alike continue to struggle with improving care and outcomes for people with substance use disorders and addiction. As the nation continues to identify and implement public health programs to curb this national health crisis, hospitals and health systems have a unique role to play.

According to the Centers for Disease Control and Prevention (CDC), substance use disorders (SUD) are "treatable, chronic diseases characterized by a problematic pattern of use of a substance or substances leading to impairments in health, social function, and control over substance use." While opioids have received much of the national attention around unhealthy substance use, alcohol, stimulants, tobacco and increasing use of cannabis also represent significant public health concerns. The burden of illness across the nation related to these substances is massive — over 40 million people in the U.S. have a substance use disorder, according to the Substance Abuse and Mental Health Services Administration (SAMHSA). Specific to illicit substances, more than 107,000 people died of a drug overdose in the U.S. in 2021, the highest number ever recorded and a 15% increase from 2020, as determined by the National Center for Health Statistics.

This article describes the important role hospitals and their boards can play in supporting the SUD care continuum and improving addiction care in hospitals and health systems and the communities they serve.

Impact of Substance Use Disorders on Hospitals

A recent analysis by Premier based on input from over 4,000 hospitals nationwide found that opioid use disorder alone costs hospitals $95 billion per year, nearly 8% of all hospital expenditures. Between 1998 and

2016, there were over 5.5 million hospitalizations across the U.S., primarily for alcohol use disorder. Nationally, approximately one in 11 visits to the emergency department and one in nine hospitalizations are related to substance use disorder, accounting for up to 33% of all admissions in safety net settings. Contrary to common belief, many hospitalizations are unrelated to overdose or withdrawal specifically. Reasons for hospital admission include infections of the heart, skin or joints which often result in lengthy, complex and expensive hospitalizations.

Patients with SUD may be cautious to engage in medical care because of negative past experiences with the health care system. In fact, up to 30% of patients with SUD self-discharge or leave the hospital "against medical advice" because of stigma, inadequate control of cravings or fear of mistreatment. Patients with SUD are also more likely to be readmitted within 30 days of hospital discharge. These are preventable readmissions. Moreover, when patients are not provided access to resources and pathways to treatment during an acute hospitalization, 80% of patients will return to substance use.

It is critical to appreciate that hospitalization is a reachable moment for patients who may not be engaged in care otherwise. Hospitalization is the ideal time to "meet patients where they are" and provide supportive resources related to SUD. Patients who initiate SUD care during hospitalization are more likely to enter outpatient treatment, stay in treatment longer and have more substance-free days compared to those offered only a referral. Patients with SUD who are linked to outpatient SUD programs post-discharge are also less likely to be readmitted at 30 and 90 days for SUD-related reasons.

What Hospital Boards Can Do

The Institute for Healthcare Improvement promotes a high degree of board engagement in quality improvement and patient safety activity. In fact, board oversight of quality improvement and patient safety has been shown to correlate with higher performance on key quality indicators and improved patient outcomes. According to GovernWell, boards have the responsibility to take four leadership actions, which have been applied to substance use disorders below.

1. **Establish Strategic Intent.** Boards can ensure that mission, values and strategic priorities reflect commitment to improving care and outcomes for patients with substance use disorders.

2. **Lead through Collaboration.** Boards can promote the importance of building community engagement and connections between hospitals and community-based organizations that serve people with substance use disorders. Engaging the vast community networks of trustees can support and solidify this approach.

3. **Reflect, Understand and Learn.** Boards can incorporate and lean on people with lived experience, including past patients of the hospital, to better illuminate opportunities for care improvement. As is the case for all quality improvement and patient safety, a "culture of caring" should be established to promote engagement among providers and staff and encourage disclosure of opportunities to better serve people with substance use disorders.

4. **Ensure Meaningful, Measurable Goals.** Measurement is key to ensuring ongoing clinical and systems improvement for people with substance use disorder. Numerous measures related to the substance use disorder care continuum are available from the American Hospital Association's (AHA) "Stem the Tide" program, American Society for Addiction Medicine, National Quality Forum and the Centers for Medicare & Medicaid Services, among others.

Boards can also look to partner with various local, state and national affiliations for participation in advocacy efforts to address substance use disorders. Boards can promote evidence-based practice through their quality programs, advocate for SUD-related education, and perhaps most importantly, serve as a vital conduit between the hospital's SUD work and the community. Public health messaging is a core function of governance. Boards bring their diverse community perspective to hospitals and are also responsible for communicating hospitals' priorities and programs to the community, including work around mental health and addiction. SAMHSA and AHA have toolkits and resources for board members to learn more about SUD, various community models and advocacy.

What Hospitals Can Do

Hospitals are critical access points along the SUD care continuum, and therefore, must be well equipped to address key areas. Prevention, treat-

ment, harm reduction and recovery are the generally accepted and nationally recognized areas of focus in the SUD care continuum.

Prevention strategies are used to mitigate individuals away from developing a substance use disorder. The most notable prevention strategy in recent history has been the focus on safe and appropriate prescribing of opioids. Prevention is important but insufficient by itself. This is clearly exemplified in recognizing that while we are prescribing far less opioids as a medical community, the number of overdose deaths continues to skyrocket.

Treatment is a critical and vastly underutilized part of the care continuum. The treatment system in the U.S. includes prescribing medications such as buprenorphine and methadone for opioid use disorder, naltrexone for alcohol use disorder, and nicotine replacement therapy for tobacco use disorder — to name a few. Medications are often coupled with behavioral change support, which can include cognitive behavioral therapy and sometimes residential or partial hospitalization programs.

Harm reduction preserves patient autonomy and promotes appreciation that recovery is a patient-centered journey that does not necessitate total abstinence. As defined by SAMHSA, harm reduction is "an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services."

Recovery includes four critical dimensions for patients including: achieving good health, establishing a stable place to live, developing meaning and purpose, and integrating into a community complete with support structures.

There are many opportunities for hospitals to integrate prevention, treatment, harm reduction and recovery strategies *(see "Caring for People with Substance Use Disorders: Hospital-Based Interventions" below)*. Such interventions must

Caring for People with Substance Use Disorders: Hospital-Based Interventions

Prevention	Treatment	Harm Reduction	Recovery
• Integrate robust screening protocols • Establish evidence-based pathways for pain management in the hospital setting • Promote screening for HIV and hepatitis C among hospitalized patients	• Initiate medications for substance use disorder • Establish best practices for acute and chronic pain management • Partner with community-based treatment programs for post-discharge referral	• Distribute naloxone for all at-risk patient populations • Distribute alcohol swabs, wound care supplies and fentanyl test strips • Provide safe syringes	• Integrate peer recovery coaches and people with lived experience into clinical and administrative operations • Link to outpatient peer groups • Promote recovery-friendly workplaces

Foundational and cross-functional strategies that must drive this work include:

- Launching staff education and hospital-wide campaigns promoting de-stigmatization;
- Reviewing policies that may limit access to SUD care in the hospital, including clinical and nursing policies, hospital bylaws and formularies;
- Delivering care with the respectful knowledge that many patients have endured traumatic events and periods in their lives that have inadvertently created mistrust of the health care system;
- Focusing on community-based organization for people with SUD and the necessity to navigate patients to care appropriately after discharge; and
- Ensuring electronic health record support and real-time data collection.

consider the unique operating environments and practice settings within the walls of each hospital, primarily emergency departments, inpatient acute care, labor and delivery, and perioperative services. Regardless of individual department or unique patient populations, certain approaches can be utilized across the enterprise including system-wide education, policy review, data analysis and engagement of SUD-focused community partners.

Summary

Boards can collaborate with their leadership to ensure the above strategies of prevention, treatment, harm reduction and recovery are in place and measured. Unhealthy substance use is a nationally recognized public health problem. Low-barrier access to SUD care in partnership with hospitals is part of the solution. While hospitals are not ideal environments for patients with SUD to receive long-term and maintenance care for addiction, hospitals are care environments equipped to care for people with acute physical and mental health crises. With appropriate interventions in hospitals, the nationwide crisis in treating and reducing substance use disorders can be addressed collectively and yield greater success. Governance engagement and action is a core component to improve care and outcomes for people with SUD.

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Richard Bottner (richard.bottner@cha.com), is vice president, Clinical Excellence, at the Colorado Hospital Association based in Denver. **Karla Hardesty** (kjhardesty@gmail.com) is board chair, San Luis Valley Health in Alamosa, Colo. **Korrey Klein, M.D.** (kklein@fhw.org) is chief executive officer, Family Health West in Fruita, Colo. **Benjamin Anderson** (*Benjamin.anderson@cha.com*) is vice president, Rural Health and Hospitals, at the Colorado Hospital Association based in Denver.

Please note that the views of authors do not always reflect the views of the AHA.

University of Colorado Medicine

uchealth

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Good morning, Chair deGruy Kennedy and members of the Committee. My name is Susan Calcaterra. I am a hospitalist physician with specialty training in addiction medicine. A hospitalist is a physician who cares for patients exclusively in the hospital setting.

I began my medical career in 2007 working at Denver Health, our safety net hospital here in Denver, caring for medically ill, hospitalized patients at a time when treating addiction in the hospital was not the standard of care. The job was challenging and rewarding. Over time, however, I became disillusioned with my work because it felt like there were missed opportunities to help the patients I served with their substance use. For example, I treated patients who had alcohol withdrawal seizures, without having the tools to address their underlying alcohol use disorder. For people who injected drugs, I treated their skin and soft tissue infections, but could not start lifesaving medications for opioid use disorder. Around this time, physicians did not receive training in medical school or residency on how to treat substance use disorders. Practicing on the frontlines of this epidemic, it was devastating to see that the medical system was unprepared to offer any wholistic help for people struggling from addiction.

In 2017, I left Denver Health to complete an addiction medicine fellowship at the University of Colorado. I wanted to learn more about the biology of addiction and how to treat different substance use disorders using evidence-based medications, but I needed training and time to learn this practice.

After completing addiction medicine fellowship training in 2018, I began as faculty at the University of Colorado Hospital. At that time, there remained a large gap to provide evidence-based treatment for substance use disorders among hospitalized patients. This time around, however, I had the skills to do something about it. In 2019, I received grant funding from CU-Medicine and Colorado Medicaid to develop and implement a hospital-based addiction consultation service. To do this, I recruited and trained ten of my hospitalist colleagues in the practice of addiction medicine including how to initiate medications for opioid use disorder and alcohol use disorder, how to manage acute pain among people with opioid use disorder, how to manage acute methamphetamine intoxication, and severe alcohol withdrawal. With the grant funding, we hired two dedicated addiction medicine social workers and a person in recovery from addiction to link patients from the hospital to the community to continue treatment following hospital discharge. In July 2022, our grant funding ended, and I am grateful to the leadership at the University of Colorado Hospital who agreed to continue funding our addiction consultation service.

Providing addiction care in the hospital can be incredibly impactful for patients with severe substance use disorders. From August 2022 to August 2023, our addiction consultation service provided addiction care to over 1,700 hospitalized patients. We enrolled over 100 patients into a methadone program for treatment of opioid use disorder, we started buprenorphine, a

medication treatment for opioid use disorder, more than 200 times. We started naltrexone, a medication used to reduce cravings for alcohol, over 200 times, and we prescribed naloxone, the opioid overdose antidote, over 600 times.

I highlight this to demonstrate what can be done in the hospital setting with leadership support, subject matter expertise, and a strong dedication to serving this patient population. Unfortunately, not providing dedicated addiction treatment remains the standard of care in many Colorado hospitals. This is because physicians describe:

- A lack of comfort with the use of medications used to treat various substance use disorders
- concern for insufficient community resources for post discharge addiction treatment linkage
- A lack of support from hospital leadership to provide this care
- A lack addiction medicine experts to support management of particularly challenging cases
- And feeling overwhelmed to try to provide this care in a busy hospital practice

When we asked physicians what they needed to provide hospital-based substance use disorder treatment they said they needed:

- Protocols that walk clinicians through the process of initiating medications to treat various substance use disorders, like opioid and alcohol use disorders
- Addiction specialist support to help manage particularly challenging cases
- Education to keep clinicians up to date on best practices for substance use disorder treatment
- Clear referral pathways from hospital to outpatient substance use disorder treatment

Making these changes in the hospital does not happen organically. It requires subject matter expertise, hospital leadership support, and accountability of the part of hospital leadership, clinicians, and staff to ensure addiction treatment is offered to hospitalized patients with substance use disorders. We are facing an epidemic in the US – we have highly effective treatments for substance use disorders, but more than 80% of people in the US with a substance use disorder do not receive evidence-based treatments. Hospitals can close this treatment gap—we can do better.

Susan Calcaterra, MD, MPH, MS
Associate Professor of Medicine
Director, Addiction Medicine Consultation Service
Univeristy of Colorado Hospital

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POSITION STATEMENT

Journal of Hospital Medicine | shm Society of Hospital Medicine

Management of opioid use disorder and associated conditions among hospitalized adults: A Consensus Statement from the Society of Hospital Medicine

Susan L. Calcaterra MD, MPH[1] | Marlene Martin MD[2] | Richard Bottner DHA, PA-C[3] | Honora Englander MD[4] | Zoe Weinstein MD[5] | Melissa B. Weimer DO, MCR[6] | Eugene Lambert MD[7] | Shoshana J. Herzig MD, MPH[7,8]

[1]Department of Medicine, Division of General Internal Medicine, Division of Hospital Medicine, University of Colorado, Aurora, Colorado, USA

[2]Department of Medicine, Division of Hospital Medicine, San Francisco General Hospital, University of California San Francisco, San Francisco, California, USA

[3]Department of Internal Medicine, Dell Medical School, The University of Texas, Austin, Texas, USA

[4]Department of Medicine, Section of Addiction Medicine, Division of Hospital Medicine, Oregon Health and Science University, Portland, Oregon, USA

[5]Section of General Internal Medicine, Boston University School of Medicine, Boston, Massachusetts, USA

[6]Department of Medicine, Yale School of Medicine, New Haven, Connecticut, USA

[7]Department of Medicine, Harvard Medical School, Division of General Internal Medicine, Massachusetts General Hospital, Boston, Massachusetts, USA

[8]Department of Medicine, Beth Israel Deaconess Medical Center, Boston, Massachusetts, USA

Correspondence
Susan L. Calcaterra, MD, MPH, Division of General Internal Medicine, University of Colorado School of Medicine, 8th Floor, Academic Office 1, Mailstop B180, 12631 E 17th Ave, Aurora, CO 80045, USA.
Email: susan.calcaterra@cuanschutz.edu;
Twitter: @CalcaterraSusan

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Abstract

Hospital-based clinicians frequently care for patients with opioid withdrawal or opioid use disorder (OUD) and are well-positioned to identify and initiate treatment for these patients. With rising numbers of hospitalizations related to opioid use and opioid-related overdose, the Society of Hospital Medicine convened a working group to develop a Consensus Statement on the management of OUD and associated conditions among hospitalized adults. The guidance statement is intended for clinicians practicing medicine in the inpatient setting (e.g., hospitalists, primary care physicians, family physicians, advanced practice nurses, and physician assistants) and is intended to apply to hospitalized adults at risk for, or diagnosed with, OUD. To develop the Consensus Statement, the working group conducted a systematic review of relevant guidelines and composed a draft statement based on extracted recommendations. Next, the working group obtained feedback on the draft statement from external experts in addiction medicine, SHM members, professional societies, harm reduction organizations and advocacy groups, and peer reviewers. The iterative development process resulted in a final Consensus Statement consisting of 18 recommendations covering the following topics: (1) identification and treatment of OUD and opioid withdrawal, (2) perioperative and acute pain management in patients with OUD, and (3) methods to optimize care transitions at hospital discharge for patients with OUD. Most recommendations in the Consensus Statement were derived from guidelines based on observational studies and expert consensus. Due to the lack of rigorous evidence supporting key aspects of OUD-related care, the working group identified important issues necessitating future research and exploration.

BACKGROUND

Overdose deaths are rising at an unprecedented rate. In 2020, over 100,000 people died of an overdose.[1] Highly effective medications for opioid use disorder (OUD) have the potential to reduce overdose deaths by approximately 30% over a 12-month period,[2,3] yet many people with OUD are unable to access this life-saving treatment.[4–8]

Hospitalizations related to opioid use are also rising.[9] Patients with injection drug use may be hospitalized with skin and soft tissue infections,[10] osteomyelitis,[11] and endocarditis,[11,12] requiring weeks of intravenous antibiotic therapy. Among these patients, initiation of medications for OUD is associated with increased days of antibiotic therapy,[11] decreased risk of recurrent infection,[10] and reduced overdose mortality.[12] Despite these optimistic outcomes, on average, less than 20% of patients in these studies received medications for OUD during their hospitalization.[10–13] This significant treatment gap for hospitalized patients with OUD presents an opportunity for practice improvement among hospital-based clinicians. To our knowledge, there are no existing guidelines for improving and standardizing OUD care for hospitalized adults. Access to clinical recommendations to guide care for hospitalized patients with OUD may facilitate practice change to close the treatment gap.

The Society of Hospital Medicine (SHM) convened a working group to systematically review existing guidelines and develop a Consensus Statement to assist clinicians in the identification and treatment of OUD and opioid withdrawal, perioperative and acute pain management in patients with OUD, and care transitions at discharge for hospitalized adults with, or at risk of, OUD.

CONSENSUS STATEMENT PURPOSE AND SCOPE

The purpose of this Consensus Statement is to present clinical recommendations for OUD treatment, opioid withdrawal management, opioid overdose prevention, and care transitions among hospitalized adults. We developed each of the clinical guidance statements through a synthesis of the key recommendations from existing clinical practice guidelines on OUD management and adapted them for a hospitalist-specific scope of practice. They are intended for clinicians practicing medicine in the inpatient setting (e.g., hospitalists, primary care physicians, family physicians, advanced practice nurses, and physician assistants) and are intended to apply to hospitalized adults at risk for, or diagnosed with, OUD.

CONSENSUS STATEMENT DEVELOPMENT

Our working group included experts in the treatment of OUD in the hospital setting, defined by (1) engagement in the clinical practice of hospital medicine, (2) engagement in the provision of hospital-based substance-related care via an addiction consultation service or a buprenorphine team,[14–18] and (3) involvement in clinical research related to OUD treatment in the hospital setting (see Table S1). SHM provided administrative assistance with the project, but it had no role in formulating the recommendations. The SHM Board of Directors provided approval of the Consensus Statement without modification.

An overview of the sequential steps in the Consensus Statement development process is described below; details of the methods and results can be found in the Supporting Information Materials, eMethods.

Performing the systematic review

The methods and results of the systematic review of existing guidelines on the management of OUD, opioid withdrawal, opioid overdose prevention, and care transitions from which the Consensus Statement is derived are described in a companion article. We extracted recommendations from each guideline related to the topics in Table 1 and used these recommendations to inform the Consensus Statement.

Drafting the Consensus Statement

After performing the systematic review, the working group drafted and iteratively revised a set of recommendations using a variation of the Delphi Method[19] to identify consensus among working group members.

External review

Following agreement on a draft set of recommendations, we obtained feedback from external groups, including (1) members of the SHM Substance Use Disorder Special Interest Group, (2) members of the SHM outside of the Special Interest Group, (3) addiction-trained clinicians in the hospital or outpatient setting, (4) leaders at specialty societies including the American Academy of Addiction Psychiatry, American College

TABLE 1 Topics for which recommendations were extracted from existing guidelines

- Best practices to screen, diagnose, and treat OUD
- Best practices for the treatment of opioid withdrawal
- Best practices to manage perioperative and acute pain in patients with OUD
- Best practices to manage patients whose goal is not complete abstinence
- Best practices to link patients with OUD to addiction treatment

Abbreviation: OUD, opioid use disorder.

of Academic Addiction Medicine, Society of General Internal Medicine, (5) leaders and advocates of people with lived experience at harm reduction agencies and advocacy groups including the National Harm Reduction Coalition and Faces and Voices of Recovery, and (6) peer-reviewers at the *Journal of Hospital Medicine*.

RESULTS

The process described above resulted in 18 recommendations under five content areas (Table 2). These recommendations are intended only as guides and may not be applicable to all patients and clinical situations. Furthermore, these guidelines are not meant to supersede state or local policies pertaining to the treatment of OUD. Clinicians should use their judgment regarding whether and how to apply these recommendations to individual patients. Because the state of knowledge is constantly evolving, this Consensus Statement should be considered automatically withdrawn 5 years after publication, or once an update has been issued.

Nonstigmatizing medical communication and language for people who use opioids

1. *SHM recommends that hospitalists use nonstigmatizing and person-first language*

The majority of people with substance use disorder do not seek treatment and stigma is a barrier to seeking treatment among people who use drugs.[20,21] Language intentionally and unintentionally propagates stigma, which is harmful, distressing, and marginalizing to the people who bear it.[22,23] Person-first language puts the word referring to the individual before the word describing their behavior or condition to highlight that the condition is not their defining characteristic (e.g., person with OUD).[24,25] When referring to hospitalized patients with OUD, do not use stigmatizing language, such as "addict," "opioid abuse," or "IV drug user."[26,27] Instead, use language, such as "person who uses drugs," "person who injects drugs," or "person with OUD" when documenting in the medical record and speaking with patients and healthcare providers.

Assessment of unhealthy opioid use and diagnosis of OUD

2. *SHM recommends that hospitalized patients with unhealthy opioid use be assessed for OUD*

Hospitalization offers an opportunity to identify patients with OUD and provide life-saving treatment. Unhealthy opioid use includes the nonmedical use of prescription opioids, or the use of heroin, fentanyl, or other opioid analogs obtained through illegal drug

TABLE 2 Society of Hospital Medicine key guidance for opioid use disorder assessment, treatment, overdose prevention, and care transitions for hospitalists

Nonstigmatizing medical communication and language for people who use opioids

- Use nonstigmatizing and person-first language.

Assessment of unhealthy opioid use and diagnosis of OUD

- Assess hospitalized patients with unhealthy opioid use for OUD.
- Use the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) criteria to diagnose OUD.
- Offer HIV, hepatitis A, B, and C, syphilis, pregnancy testing, and urine drug analysis to patients who meet DSM-5 criteria for OUD.

OUD medication for DSM-5 confirmed the diagnosis

- Use shared decision-making to initiate medications for OUD.
- Offer buprenorphine or methadone as first-line agents to treat opioid withdrawal and OUD.
- Initiate buprenorphine at 2–4 mg.
- Initiate methadone at 20–30 mg to treat opioid withdrawal and/or OUD.
- If already performed, review an EKG to assess for QTc prolongation as part of a risk-benefit assessment when initiating methadone.
- Prescribe nonopioid adjunctive medications (e.g., clonidine, loperamide, NSAIDs, acetaminophen, ondansetron, hydroxyzine), as appropriate, for opioid withdrawal symptoms in addition to buprenorphine or methadone.
- Offer intramuscular naltrexone if the patient prefers opioid antagonist treatment to methadone or buprenorphine.

Acute pain and/or perioperative pain management in the setting of OUD

- Assess and treat pain in the setting of OUD.
- Continue buprenorphine or methadone during hospitalization, including in the setting of acute pain and the perioperative period.

Care transition at hospital discharge

- Obtain an X-Waiver to prescribe buprenorphine at hospital discharge.
- Link patients to a buprenorphine prescriber or an opioid treatment program when they want to continue buprenorphine or methadone following hospital discharge.
- Link patients to psychosocial support, mental health treatment, mutual support groups, peer recovery supports, harm reduction services, and, if appropriate, resources for access to housing and shelters when they desire these services following hospital discharge.
- Discharge patients on medication for OUD to facilities that will continue these medications when patients require postacute care following hospital discharge.
- Prescribe naloxone at hospital discharge for all patients with OUD.

Abbreviations: EKG, electrocardiogram; HIV, human immunodeficiency virus; NSAID, nonsteroidal anti-inflammatory drug; OUD, opioid use disorder.

markets. Patients with unhealthy opioid use may be hospitalized for conditions related to drug use, including opioid overdose, skin and soft tissue infections, osteomyelitis, and endocarditis. More subtle behaviors associated with unhealthy opioid use include the use of opioids in hazardous situations, an inability to cut down opioid use, cravings to use opioids, or opioid use leading to social, legal, or financial problems, among others.[28] Validated tools to screen for unhealthy opioid use are available (e.g., Single-Question Screening test, NIDA Quick Screen, the WHO 8-item ASSIST, TAPS Tool, SUBS).[29–31] Data from state prescription drug monitoring programs (PDMP) may be used to verify the use of controlled medications.[32]

3. *SHM recommends that hospitalized patients with unhealthy opioid use be assessed for OUD*[33]

The Diagnostic and Statistical Manual (DSM) contains descriptions, symptoms, and other criteria for diagnosing substance use disorder while providing a common language to describe such behaviors and diagnoses. OUD is diagnosed when a person meets two or more of the 11 criteria outlined in the DSM-5 for OUD in a 12-month period. OUD severity is defined by the number of DSM-5 criteria met (mild: 2–3; moderate: 4–5; and severe: ≥6 criteria).[34] Opioid tolerance and opioid withdrawal alone, in the absence of other DSM-5 criteria, are insufficient to diagnose OUD for patients who are prescribed opioids and take the opioids as prescribed. Much of this information can be obtained during a history and physical exam. Making an accurate diagnosis is important when considering treatment for OUD.

4. *For patients who meet DSM-5 criteria for OUD, SHM recommends that hospitalists offer the following tests: HIV, hepatitis A, B, and C, syphilis, pregnancy test, and urine drug analysis*

Recent outbreaks of the human immunodeficiency virus (HIV), hepatitis, and syphilis associated with opioid use have been documented.[35–38] Hospitalization offers an opportunity to diagnose new infectious diseases and link patients to effective and curative treatment.[39–42] The Centers for Disease Control and Prevention (CDC) recommends at least annual HIV screening for people who inject drugs, although the optimal frequency for HIV testing is unknown for this patient population.[43] General informed consent that notifies patients that an HIV test will be performed unless the patient declines should be considered sufficient to encompass informed consent for HIV testing.[43] Among high-risk adults including people who inject drugs or engage in transactional sex work, the CDC recommends routine periodic testing for hepatitis A, B, C, and syphilis, with the administration of the hepatitis A and B vaccination for nonimmune people.[44–47] Pregnancy status should be confirmed as opioids may cause secondary amenorrhea[48] and medication dosing for OUD treatment may differ in pregnancy.[49,50] Explicit informed consent is not required for clinical drug testing;[51] however, clinicians should explain the reason for the test and the intended use of the results prior to sample collection.[52,53] Urine drug analysis may provide data not obtained during the history and physical exam to help inform medical management. Confirmatory testing, when available, should be performed when results are not consistent with information provided by the patient. Hospital policies should outline procedures for protecting the confidentiality of drug testing and results.[52,53]

Medication treatment for DSM-5 confirmed OUD diagnosis

5. *SHM recommends that hospitalists use shared decision-making when discussing the initiation of medications for OUD*

One important aspect of delivering patient-centered care is the active participation of patients in healthcare decisions.[54,55] Buprenorphine, methadone, and intramuscular (IM) naltrexone are the three medications approved by the Food and Drug Administration to treat OUD. High-quality evidence demonstrates that routine use of buprenorphine and methadone reduces opioid-related mortality and all-cause mortality.[3,56] The use of IM naltrexone is non-inferior to buprenorphine for select patients who complete a period of opioid abstinence and successfully initiate IM naltrexone.[57,58] Regardless of the medication used to treat OUD, medication effectiveness is dependent upon patient preference and medication access, including the availability of local opioid treatment programs (required for methadone), office-based opioid treatment programs or primary care practices that offer buprenorphine or IM naltrexone, and cost.[59] This information should be shared with patients so that they can make an informed decision about medication initiation for OUD. Consider partnering with a clinical pharmacist or developing staff expertize so that obtaining this information does not delay the initiation of medication treatment.

6. *SHM recommends that hospitalists offer buprenorphine or methadone as first-line agents of opioid agonist therapy to treat opioid withdrawal and OUD*

Opioid withdrawal symptoms are mitigated with the use of opioid agonists, including buprenorphine and methadone. The use of a validated opioid withdrawal assessment scale such as the Clinical Opiate Withdrawal Scale (COWS)[60] can be used to quantify opioid withdrawal symptoms and direct buprenorphine or methadone treatment initiation. Once a patient has entered mild withdrawal, buprenorphine can usually be safely initiated (i.e., without precipitating further withdrawal). A COWS score of 8–10 indicates mild withdrawal and usually occurs around 6–12 h after the last heroin or short-acting opioid use.[61] Methadone initiation should begin when the patient reports any opioid cravings or withdrawal symptoms. There are no legal or regulatory restrictions around inpatient ordering and titration of methadone or buprenorphine for opioid withdrawal management among patients hospitalized for medical or surgical reasons.[62,63] The 42 Code of Federal Regulations (CFR), Title 21, Section 1306.07 "Administering or dispensing of narcotic drugs" describes federal regulations in detail.[62] A buprenorphine X-Waiver is not required to administer buprenorphine in the hospital.

7. *SHM recommends that when treating patients for opioid withdrawal and OUD, hospitalists initiate buprenorphine at 2–4 mg*

Evidence for buprenorphine dose titration is based on expert opinion and other guidelines, which carry a lower strength of recommendation. One common approach for buprenorphine initiation includes dose increases by 2–4 mg every 2 h until opioid withdrawal symptoms and cravings resolve, or a COWS score of ≤5, for a total dose of 12–16 mg on Day 1. Dose titration should continue on Day 2 to assess for ongoing cravings and withdrawal symptoms. Evidence supports increased treatment retention with buprenorphine doses of 16–24 mg per day.[64,65] Various "low dose" and "high dose" buprenorphine protocols can assist with dosing algorithms for buprenorphine initiation and should be adjusted based upon the patient's anticipated length of hospitalization, reported cravings, and their past experience initiating buprenorphine outside of the hospital setting.[66–70] In areas where the drug supply is contaminated with fentanyl, when patients report regular fentanyl use, or when patients are transitioning from another long-acting opioid to buprenorphine (e.g., methadone), consider the use of a low dose buprenorphine initiation protocol to avoid precipitated withdrawal.[71–74] These recommendations should be applied with caution because buprenorphine initiation and dosing practices are rapidly evolving. Learning about the patient's past experiences with buprenorphine initiation is recommended to inform the timing of buprenorphine initiation and dose titration.

8. *SHM recommends that when treating patients for opioid withdrawal and OUD, hospitalists initiate methadone at 20–30 mg*

Opioid tolerance is difficult to establish by history and the amount of opioid use reported by the patient typically yields only a rough estimate of opioid tolerance.[75] A starting methadone dose between 20 and 30 mg is supported by most guidelines. The dose should be increased by 5–10 mg every 2–3 h to no more than 40 mg on Day 1 for reported withdrawal symptoms. In some cases, (e.g., older age, liver disease, poor respiratory reserve, lower opioid tolerance) consider beginning with 10 mg of methadone.[75] During methadone initiation, patients should be instructed to judge their doses by how they feel during the peak blood concentration period, which is approximately 2–4 h after their dose.[75] If patients request methadone after discharge they must be referred to a local opioid treatment program. Methadone for the treatment of OUD cannot be legally dispensed from an outpatient pharmacy.

9. *If an electrocardiogram has been performed, SHM recommends hospitalists review it to assess for QTc prolongation as part of a risk-benefit assessment when initiating methadone*

Whether to check an electrocardiogram (EKG) in all patients starting on methadone is controversial.[59,76,77] Most guidelines recommend checking an EKG when a patient has risk factors for QTc interval prolongation, including electrolyte abnormalities, such as hypokalemia or hypomagnesemia, impaired liver function, structural heart disease, genetic predisposition, such as congenital prolonged QT syndrome or familial history of prolonged QT syndrome, and use of drugs with QTc-prolonging properties.[78–82] At higher doses, or in combination with other QTc prolonging medications,[83,84] methadone has been associated with QTc prolongation leading to torsades de pointes.[85–87] Because most hospitalized patients will have an EKG performed, reviewing the results to assess for QTc prolongation is recommended. If a patient has a QTc of ≥500 ms, assess for reversible causes, (e.g., correcting electrolyte abnormalities or discontinuing other nonessential QTc prolonging medications). If the QTc remains ≥500 ms, discuss the risks versus benefits of methadone with the patient and consider buprenorphine.

10. *SHM recommends that in addition to buprenorphine or methadone, hospitalists prescribe nonopioid adjunctive medications for opioid withdrawal symptoms as appropriate (e.g., clonidine, loperamide, nonsteroidal anti-inflammatory drugs, acetaminophen, ondansetron, and hydroxyzine)*

These medications are effective complementary agents in the early stages of opioid withdrawal treatment, especially when initiating and therapeutically titrating medications for OUD. Clonidine and lofexidine, both α_2-adrenergic agonists, reduce opioid withdrawal symptoms.[88] Commonly reported opioid withdrawal symptoms include anxiety, diarrhea, nausea, and muscle aches, which can be reduced using the aforementioned medications targeted to specific patient-reported symptoms.[60,89–92]

11. *SHM recommends that hospitalists offer IM naltrexone if the patient prefers opioid antagonist treatment to methadone or buprenorphine*

A period of opioid abstinence is required prior to IM naltrexone initiation. If IM naltrexone is available to be administered in the hospital, initiate IM naltrexone ≥7 days from the last short-acting opioid use and >10 days from the last long-acting opioid use to avoid precipitated withdrawal. Obtain a urine drug analysis to assess for the absence of opioids in the urine prior to IM naltrexone administration. Consider a naloxone challenge before IM naltrexone initiation, especially if given sooner than these timeframes.[93] Counsel the patient on the risk of an opioid overdose when naltrexone wears off. Do not use oral naltrexone for OUD due to its noninferiority over placebo to prevent return to opioid use.[94]

Acute pain and perioperative pain management in the setting of OUD

12. *SHM recommends that hospitalists assess and treat pain in the setting of OUD*

Patients with OUD may have high opioid tolerance and require higher doses of short-acting opioids for acute pain, even when receiving medications for OUD. Multimodal analgesics are also recommended (e.g., neuropathic medications, anti-inflammatory medications, or local/regional anesthesia). Importantly, under- or untreated opioid

withdrawal may exacerbate pain. It is essential to prescribe medications for OUD; however, medications for OUD are insufficient to treat acute pain. Patients receiving buprenorphine or methadone for OUD treatment do not derive sustained analgesia for pain control; the duration of analgesia for methadone and buprenorphine is approximately 4–8 h,[95,96] while their duration to suppress opioid withdrawal is approximately 24–48 h.[97–99] There is no evidence that exposure to opioid analgesia for acute pain control among patients on medications for OUD increases the risk of return to opioid use.[98,100,101]

13. *SHM recommends that hospitalists continue buprenorphine or methadone during hospitalization, including in the setting of acute pain and the perioperative period*[102–108]

Patients with OUD who are prescribed buprenorphine or methadone may present with acute pain or have scheduled elective surgeries. Elective surgeries in patients with OUD require careful planning and interdisciplinary involvement to coordinate care and OUD treatment management.[109] When a patient is admitted to the hospital, confirm the patient's current methadone or buprenorphine dose with the patient's opioid treatment program or through the PDMP, with the last date of dosing, and continue this dose throughout the hospitalization unless there is an acute medical contraindication. Some experts recommend splitting the total daily buprenorphine dose into three times a day to optimize the analgesic activity of buprenorphine.[98,106] Similar dose splitting can be done with methadone to maximize its analgesic effect. In both cases, dose- splitting, should be discussed with the patient prior to making any changes. If methadone doses are split, they should be consolidated to once-daily dosing prior to hospital discharge. Discontinuation of methadone or buprenorphine is not recommended during acute pain or in the perioperative setting and will result in an opioid debt, which may worsen acute pain, make treatment more difficult, and may increase the risk of return to opioid use and opioid overdose.

Care transition at hospital discharge

14. *SHM recommends that every hospitalist obtain an X-Waiver to prescribe buprenorphine at hospital discharge*[110]

Prescribing buprenorphine at discharge requires an X-DEA license, which no longer requires 8+ h of training. Submitting a Notice of Intent application to the Substance Abuse and Mental Health Services Administration allows for the issuance of an X-Waiver license while exempting clinicians from completing the 8+ h training.[111] Free training for buprenorphine is widely accessible.[112]

15. *SHM recommends that when patients want to continue medications for OUD following discharge, every attempt is made to link patients to a buprenorphine prescriber or an opioid treatment program*

A hospitalist with a DEA X-Waiver should prescribe a buprenorphine bridge prescription until the scheduled follow-up appointment. At hospital discharge, methadone for OUD cannot be prescribed through a pharmacy and can only be dispensed through an opioid treatment program. Health systems should develop resource sheets with local buprenorphine prescribers and opioid treatment programs for treatment linkage. Many websites provide resources for addiction treatment services across the United States.[113–115] Telehealth follow-up is an option for patients on buprenorphine.[116–120] Hospital teams should identify treatment linkage; however, lack of follow-up should not preclude the use of methadone or buprenorphine during hospitalization or provision of buprenorphine at discharge.[121]

16. *SHM recommends that every attempt is made to link patients to psychosocial support, mental health treatment, mutual support groups, peer recovery supports, harm reduction services, and resources for access to housing and shelters, as appropriate*

Referrals to psychosocial treatment interventions and community-based supports, including peer support groups and harm reduction agencies, should be offered to patients, in addition to medications for OUD. Examples of psychosocial addiction treatment include individual or group therapy, intensive outpatient treatment, residential treatment, structured counseling, and dedicated mental health treatment. Treatment resources are readily available.[113,115,122] Peer-based support groups are free, widely available, and are a source of additional guidance and support for people with OUD.[123,124] Harm reduction agencies and local recovery community organizations provide naloxone and sterile syringes, partner with people who use drugs to teach naloxone administration and wound care techniques, and advocate for policy reform to increase access to evidence-based harm reduction strategies.[115,125–127] Provision of harm reduction education and supplies can happen during hospitalization,[126,128–130] in the outpatient clinic setting,[131] and in the community.[127,132]

17. *SHM recommends that, when postacute, facility-based care is recommended, patients on medications for OUD are discharged to facilities that will continue these medications*

Continuation of medications for OUD at hospital discharge to post-acute care facilities is paramount for ongoing treatment of OUD. Care facilities such as skilled nursing facilities that prohibit the continuation of medications for OUD are in violation of the Title III of the Americans with Disabilities Act.[133,134]

18. *SHM recommends that hospitalists prescribe naloxone at hospital discharge for all patients with OUD*

Patients with OUD are at a very high risk of overdose-related mortality.[135] High-quality evidence supports the use of naloxone to reverse opioid-related overdose and death.[136–139] The legal risk with prescribing naloxone is no higher than that associated with any other medication.[140,141] Furthermore, laws in a majority of states provide civil immunity to prescribers, dispensers, and administrators of naloxone.[141,142]

DISCUSSION AND AREAS FOR FUTURE RESEARCH

This Consensus Statement reflects a synthesis of the key recommendations from a systematic review of existing guidelines on OUD treatment, opioid withdrawal management, opioid overdose prevention, and care transitions, adapted for the hospital-specific scope of practice. Many of the recommendations made in this Consensus Statement are based on lower-quality evidence, including observational studies and expert consensus. Despite this, several consistent topics emerged across the 19 guidelines included in the accompanying systematic review, which were relevant to the hospital setting. While the Consensus Statement focuses on care provision for OUD, many of the recommendations are applicable to people with other substance use disorders.

Several important issues were raised during the extensive external feedback process undertaken as part of the development of this Consensus Statement. Many of these issues were subsequently incorporated into the Consensus Statement, with consideration of the existing body of evidence identified in the systematic review. Still, several suggestions remained for which we felt the evidence base was insufficient to allow for clear or valid recommendations by the working group.

First, many reviewers expressed concern about initiating buprenorphine or methadone during hospitalization if there were no community clinicians or opioid treatment programs to continue the medication in the outpatient setting. Previous research consistently demonstrates that people with OUD have an increased risk of overdose death during life transitions, whether from prison to community,[143,144] psychiatric hospitalizations to discharge,[145] or when moving in and out of OUD treatment.[146] Thus, it stands to reason that hospitalized patients are at the same risk of opioid overdose after being hospitalized for days to weeks without regular use of opioids. Provision of methadone or buprenorphine for prevention of opioid withdrawal during hospitalization will maintain opioid tolerance, reducing the risk of an opioid-related overdose death following hospital discharge. Furthermore, one observational study demonstrated that people who received medications for OUD during hospitalization were equally likely to seek out ongoing buprenorphine treatment whether or not they were directly linked to a buprenorphine prescriber following discharge.[121] In this Consensus Statement, we included references to websites where local buprenorphine prescribers, telemedicine buprenorphine prescribers, and opioid treatment programs can easily be identified for referral and direct linkage for ongoing addiction treatment post-hospital discharge.[113–115,122]

Next, several external reviewers expressed concern and discomfort about the provision of methadone for the prevention of withdrawal without support from an addiction-trained clinician. This discomfort is likely due to inexperience with the medication and concerns about opioid overdose due to methadone's unique pharmacology, including its long and variable half-life, potential interactions with many medications, and its association with QTc prolongation.[85] Despite these challenges, methadone has been the primary means of treating OUD for the past 30 years. It is safe and effective when taken as prescribed and as directed by this Consensus Statement.[147] One issue raised by reviewers was a recommendation for the inclusion of a ceiling dose for methadone when initiating treatment in the hospital among patients not actively enrolled in an opioid treatment program. As outlined in Title 21 of the 42 CFR section 1306.07C, "there are no federal limitations on a physician or authorized hospital staff to administer or dispense narcotic drugs in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction."[62] The decision to titrate methadone beyond 40 mg should be individualized based on the patient's clinical course and medical status, the clinician's comfort and access to an addiction specialist, and the patient's ability to directly link to an opioid treatment program following hospital discharge. At the least, prescribing up to 40 mg of methadone daily for opioid withdrawal prevention among people who use illicit fentanyl or heroin is safe and should be readily utilized as a treatment modality during hospitalization.

Some reviewers requested clarification on roles and responsibilities when assessing and treating patients with OUD in the hospital setting. The guidelines that informed this Consensus Statement did not identify specific roles and responsibilities directed to a particular healthcare provider type or physician, including assessing patients for unhealthy opioid use with various validated screening tools; conducting and documenting the COWS score for buprenorphine initiation and dosing; verification of the patient's last methadone dose and date; identification of local resources for direct linkage to treatment following hospital discharge; education regarding harm reduction; and advocating for patients to receive medications for OUD when they transition to a postacute care facility. These roles and responsibilities can be completed by nonphysician healthcare workers, including advanced practice providers, nurses, pharmacists, and social workers. Hospitals employ teams of healthcare workers to ensure the efficiency of care. The care of the hospitalized patient with OUD should include support from all team members. Additionally, whenever possible, processes for care should be automated with the use of standardized order sets for buprenorphine and methadone initiation, automatic ordering of naloxone at hospital discharge when a patient is prescribed buprenorphine or methadone, and incorporation of the state PMDP into the electronic health record to reduce workload and time spent on repetitive tasks.

The major limitation of this Consensus Statement is the lower quality of evidence from which these recommendations were made and were primarily based on observational studies and expert opinions and consensus. Additional research is needed before evidence-based recommendations can be made for some of the topics discussed in this Consensus Statement. Some topics identified by the working group that warrant future research include the frequency of screening for HIV and hepatitis C among hospitalized patients who inject drugs; the use of low dose or high dose protocols to initiate buprenorphine among people

who regularly use long-acting opioids like methadone or regular use of fentanyl or fentanyl analogs; practice recommendations regarding the use of short-acting opioids, in addition to methadone or buprenorphine, for opioid withdrawal management in the hospital setting;[148] and importantly, best practices to reduce OUD treatment disparities by race and ethnicity.

This Consensus Statement includes recommendations for the management of OUD and related conditions among hospitalized patients based on the best available evidence. Until more high-quality evidence becomes available, this Consensus Statement may be used as a guide for the care of hospitalized adults with OUD. This Consensus Statement should be used in conjunction with clinical judgment, input from hospital-based providers (social workers, pharmacists, nurses), physicians, patients, and local and state policies or guidelines for OUD treatment to help facilitate consistent high-quality care. In doing so, hospital-based providers and physicians can help close the treatment gap for patients with OUD.

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ORCID

Susan L. Calcaterra http://orcid.org/0000-0002-0584-7783
Marlene Martin http://orcid.org/0000-0001-8727-0289
Shoshana J. Herzig http://orcid.org/0000-0001-8005-4727

TWITTER

Susan L. Calcaterra @CalcaterraSusan

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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08.30.23

Good morning, Chair deGruy Kennedy and members of the Committee. My name is Audrey Reich Loy, and I am the Director of Programs at San Luis Valley Health, located in the southwestern region of our state. I began my career as a social worker in the clinical setting and now take that experience to oversee program operations for San Luis Valley Health, including our significant work on substance use disorders.

San Luis Valley Health is a non-profit comprehensive health care organization serving approximately 46,000 people across a region that is bigger than the state of Connecticut. We are surrounded by mountains in all directions, and our closest, larger healthcare partners are at least 120 miles away. All six counties are designated as Health Professional Shortage Areas and are ranked as having some of the highest opioid-related overdoses in Colorado. We made national news about ten years ago for the exorbitant number of prescriptions for opiates being written and filled locally, making us the epicenter of this crisis.

Despite these incredible barriers, our frontier nature inspires our ability to roll up our sleeves and problem solve with limited resources. Isolated healthcare providers have no choice but to build substance use response services within its service delivery, because we are often the only option for patients and families. For us, this has included screening patients for mental health and substance use, providing care coordination to address linkages to specialty services and social determinants, and staffed teams with behavioral health providers, where available, to respond to higher acuity needs. We have trained providers in Medication Assisted Treatment. And we have maximized our partnerships with local community providers to fill gaps and develop expertise beyond our walls. Our providers spearheaded the grassroots effort in the Valley ten years ago, to develop community-wide processes to respond to the prescribing epidemic, to better manage pain and modify prescribing practices.

However, it's impossible to go far enough with limited resources, and we continue to face extreme barriers, both universal to healthcare providers in Colorado, as well as unique to those serving rural communities.

- Financial hardships – San Luis Valley Health operates at a less than 1% margin. Therefore, we must either prioritize and do without, or get creative in our financial portfolio. Grants have funded much of the work we've done in this space, but as you know, grants require sustainability. And while we participate in many of the latest alternative payment models, the newness and unpredictability of this phase in healthcare doesn't offer the level of sustainability needed to address the massive problems we face in managing this population. Outside of those options, we are limited to our operating margin. As long as insurance billing remains complex and limited to one condition priority at a time, we cannot bill for the services we provide in a medical setting.
- Staffing shortages – Like the nation, San Luis Valley Health faces tremendous obstacles recruiting and retaining healthcare staff. However, rural healthcare providers have faced recruitment challenges long before the COVID pandemic. Recruiting for more specialized roles, such as behavioral health and substance use providers, has only becomes harder. In fact, it can take over a year to fill one of our few Behavioral Health roles.
- Scope of the problem – Our teams do incredible work to support wraparound services, but it is easy to get disillusioned when confronted daily with the scope of the problem. As mentioned previously, our community worked tirelessly to clean up the prescribing practices of the past and made a significant improvement toward addressing the opioid epidemic. However, we continue to see an increase in the use of illicit drugs and crime, thus posing new challenges to providers in our region. Along with our community partners, we have made measurable efforts toward building capacity in partnership with other organizations, but we as a community continue to fall short in having the necessary safety net available to respond to the medical and substance use complexities we are facing.

If I can leave you with nothing else today, as you consider solutions I ask that as you keep in mind:

1. Not all hospital systems are created equal. As such, the goal should be to achieve equitable resourcing, not equal resourcing. As an organization working within a less than 1% margin attempting to serve a complex and high acuity population, our challenges are different than some of our partners across the state, and thus, solutions must look different.
2. Hospitals must be considered within the continuum of care needed to address substance use disorders, and this must include more than Emergency Departments. Emergency Departments not designed to fully respond to this epidemic in a holistic manner, and we leave out the many opportunities we have to reach this population through our inpatient and community-based encounters. We must "strike while the irons hot" by creating "no wrong door" for a patient struggling. This can only happen with a breadth and depth of 24/7 access needed to meaningfully respond to this population.

3. That our workforce shortage is not a one-dimensional problem. Recruiting workforce to rural communities has only become harder since the COVID pandemic. Without robust wraparound resources available and accessible for patients struggling, burnout and migration can only continue, thus leaving our rural communities vulnerable to ongoing adversity.

I fear we are racing to the edge of a cliff as we assess the growing acuity of those struggling with substance use disorders, paired with the continued complexities facing healthcare organizations statewide. Costs are not going down. Reimbursement models are not changing at the rate needed to respond accordingly. The demand on healthcare providers only continues to rise. And rural communities will never stop relying on their local hospitals as their trusted partners in healthcare.

Thank you for your time this morning and for this opportunity to talk with you. I look forward to your questions.

Audrey Reich Loy, LCSW, LAC
San Luis Valley Health
106 Blanca Ave
Alamosa, CO 81101

About Us:

Where we serve:

The San Luis Valley (SLV) is the largest and highest valley in North America, surrounded by three mountain ranges that isolate the Valley from the rest of Colorado. The region spans 8,194 square miles, comprised of six counties covering Alamosa, Conejos, Costilla, Mineral, Rio Grande and Saguache Counties. Three of the six counties are designated rural, and three are frontier. Frontier areas are sparsely populated rural areas, isolated from population centers and services and defined as counties having a population density of six or fewer people per square mile.

Who we serve:

The SLV has a diverse population of more than 46,000, according to information from the 2020 Census. 46% identify as Hispanic, Latino or Spanish. The Valley is predominately agricultural in nature and includes a large population of indigent migrant farmworkers who travel to the region to work from springtime planting through harvest in the fall.

According to the 2020 Census, the SLV is one of the poorest areas in Colorado with **an estimated 17.3% of the population living in poverty, compared to 9.7% statewide.** The **average of the valley's median household incomes (in 2021 dollars) was $45,668, which falls short of the state's comparable income of $80,184. The number of persons in the SLV without health insurance, under age 65 years averages 12.9%, higher than the state's average of 9.3%.**

The SLV faces higher percentages of patients experiencing chronic conditions, including obesity, diabetes, cardiovascular disease, hypertension, chronic obstructive pulmonary disease, and asthma. Over 25% of the population served are over age 65. All six counties of the SLV are ranked as having

some of the highest opioid-related overdoses in Colorado. And behavioral health-related ED visits are higher for Region Four, which includes the SLV, than any other region in the state.

Who we are:

SLVH is a non-profit, 501(c)(3), that provides a continuum of health care services to all SLV residents. SLVH Regional Medical Center (RMC) offers the only Level III Trauma Center that offers 24/7 access to orthopedic and general surgeons and offers the only labor and delivery unit within 121 miles, which means that patients do not have to travel over a mountain pass to deliver their newborns. **RMC is designated a Prospective Payment System (PPS) by the Center for Medicare and Medicaid.**

SLVH Conejos County Hospital (CCH) Emergency Department (ED) uniquely serves residents in two of the state's poorest counties, Conejos and Costilla, and northern New Mexico. Nearing closure, CCH approached SLVH to provide financial and management oversight. CCH fully merged into the organization in 2013. This unique arrangement, not available in most rural areas, prevented a hospital closure in a high-need area. **CCH is a designated Critical Access Hospital (CAH).**

SLVH also includes a physician service practice that provides primary and specialty services, behavioral health, and other ancillary services—**three of its five clinics are designated as Rural Health Clinics and two are designated as Provider-Based.**

SLVH Funding Models:

The fixed costs of providing care in rural communities is an ongoing challenge. Rural hospitals must maintain staff and service availability 24/7 regardless of patient census. Facility maintenance, updates, and medical equipment needs far outpace resources which can negatively impact recruitment and retention of contemporarily trained staff. Regulatory burden, geographic isolation, low patient volumes, limited resources and a challenging payer mix add to daily hardships and threaten the viability of maintaining a rural hospital network.

SLVH operates at a less than 1% margin. An acceptable margin is generally in the 3% range, which offers organizations the opportunity to re-invest in capital, operations, and human resources. Notably, SLVH's percent margin is derived from a significantly lower bottom line number**. Due to SLVH's demographics and regional economics, there is no room to shift costs among the payer mix.** Therefore, when determining priorities, SLVH is faced with agonizing choices.

San Luis Valley Health (SLVH) provides services to all patients regardless of their ability to pay. As of June 2023, **72% of patients were enrolled in Medicare and/or Medicaid attributed to RMC, 80% were enrolled in Medicare and/or Medicaid attributed to CCH, and 64.7% were enrolled in Medicare and/or Medicaid attributed to the clinics, both primary and specialty.** SLVH's payer mix demonstrates a higher Medicaid payer mix due to a high enrollment in Medicaid for pregnant women and children. In addition, **SLV health provided $846,955 in charity care, not including $5,414,882 in bad debt and $4,558,798 in financial assistance and community benefit.**

SLVH participates in a number of alternative payment models in addition to Fee for Service. These provide only a small incentive to cover cost of care, compared to the fee-for-service model primarily utilized at this time. This includes but is not limited to:

- MIPS – Medicare Merit-Based Incentive Payment System
- HQIP – Colorado Medicaid Hospital Quality Incentive Program
- HTP – Colorado Medicaid Hospital Transformation Program
- ACO REACH – Medicare Accountable Care Organization Realizing Equity, Access, and Community Health Model
- Medicaid APM – Medicaid Alternative Payment Model
- RAE PCMP – Regional Accountable Entity Primary Care Medical Provider
- Commercial programs, such as Humana

Additionally, SLVH proactively seeks grant funding to supplement many of the innovations and operations provided. However, grants require sustainability, and outside of a very narrow margin, having a robust sustainability plan is challenging. RMC does not qualify for many state and federal opportunities limited to CAHs.

UCHealth
Behavioral Health Service Line

uchealth.org

August 30, 2023

Good morning Chair deGruy Kennedy and members of the Committee. My name is Angela Swafford and I am a Licensed Clinical Social Worker at UCHealth, where I am a program director for the behavioral health service line. In my role, I oversee and support our behavioral health programs, focused on ensuring we are staying up to date with regulatory and statutory requirements, evidence-based best practices and patient safety needs, including the treatment of patients with substance use disorders.

In 2017, I joined UCHealth as the Social Work Manager for the University of Colorado Hospital's Emergency Department. The UCH ED is the busiest ED in the state of Colorado, and is consistently ranked as one of the top 10 highest volume ED's in the nation with 300-400 unique patients arriving to the ED for care each day. In 2018, our ED was awarded a grant from the former Office of Behavioral Health to expand access to treatment for opioid use disorder in the emergency department. We developed a program to start patients on Suboxone, which is a medication that treats opioid use disorder by controlling withdrawal symptoms and cravings. With Suboxone, many patients are able to return to work or school, re-engage in social settings, and live their lives again.

Before receiving the grant, we only had two full time social workers in the ED, and with the funding received, we were able to hire 2 additional social workers to support the Suboxone program, extending our available hours to nearly 24/7.

As time went on, our program became more well-known, and we had patients actually presenting to our ED asking to be started on Suboxone. We initiated a young woman on the medication, and the next day her father and her uncle presented to the ED to be started on Suboxone after hearing how she was treated and actually helped in our care. After decades of use, the family began an amazing recovery journey together.

After 2 years our grant funding ended, and luckily, we were able to fund the social work positions in the ED given the overwhelming need for support. In the first 15 months of our program, 120 patients were started on Suboxone, with more than 60% following up at their initial outpatient appointment and nearly 40% remaining engaged in treatment at 30 days.

Without the grant funding we received, this program would have been nearly impossible to develop and support. In a post-COVID world, even well-resourced hospitals don't have the budget available to add additional positions, regardless of the need. The vast majority of services social workers provide within hospitals is either not reimbursable or has extremely low reimbursement rates, and without a clear return on investment, it can be tough to justify additional positions even if it is the right thing to do for patients.

While Emergency Departments are a key part of SUD treatment in a hospital setting, other areas such as labor & delivery units are just as important. In Colorado and the United States, suicide & accidental overdose are the top 2 causes of maternal mortality – meaning death during pregnancy, and within 1 year of a pregnancy episode ending. In the perinatal setting, patients are often terrified to tell the truth about their substance use, as hospitals come with mandatory reporters, which inherently creates fear of having your child taken from you simply because you have a substance use disorder.

While the healthcare community has made great strides in better understanding substance use disorders, healthcare is still riddled with stigma that prevents patients from getting the care they need. Many pregnant women with substance use disorders avoid getting any prenatal care because of how they are treated. Instead of being seen as a human with a medical condition deserving of compassion and care, they are treated as a bad person and bad parent with a blatant disregard for their unborn child's welfare. As we move toward education and changing the culture within healthcare settings, hospitals continue to be inundated with new protocols, regulations, and statutory requirements. Turnover rates are at an all-time high, and new initiatives are often viewed as just "one more thing" that staff don't have time for.

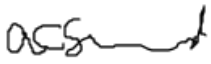
This is why having staff within hospitals dedicated to substance use disorder is key. Staff and providers need education and training in order to buy-in and understand the important role they can play in helping save the lives of individuals and families affected by substance use disorder.

Every hospital is different in terms of patient population, financial resources, and staffing constraints. What may work well at an academic medical center may be impossible to implement in rural hospitals. While we have evidence-based interventions that we know help individuals with substance use disorders, there is not a "one size fits all" solution that could be successfully implemented at every hospital in Colorado.

Peers with lived experience can play an important role within healthcare settings. A peer who has been through what a patient has been through may have a bigger impact than a hospital social worker, nurse, or physician could ever have. Peers can help provide support bridging patients from a hospital until they establish care with an outpatient provider. The number of barriers patients with SUD face are often overwhelming – from transportation, child care, insurance, and phone access to appointment availability and having to take time off of work to establish care. Peers are specially trained to support patients in navigating the system and increase the likelihood that patients will be retained in care.

While we now have highly effective treatments for substance use disorders, it's not as simple as making it the standard of care in every hospital. Hospitals need support and resources to implement best practices, and more often than not this requires additional staff with specialized training to help create

the culture change needed. The opportunity hospitals have to impact patients with substance use disorder is huge, and with the right support, we can impact and help save the lives of so many more Coloradans. Thank you for your time.



Angela Swafford, AM LCSW
Program Director, Behavioral Health
UCHealth System