BRIDGE TO CARE

Advancing Linkage to and Retention in Care Across Health Care Settings for Patients with Opioid and/or Stimulant Use Disorder

2025

American Hospital Association™
Advancing Health in America

HRET
HEALTH RESEARCH & EDUCATIONAL TRUST

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COMMONLY USED TERMS

For definitions of commonly used terms throughout this toolkit, please visit the CDC's Overdose Prevention Glossary.

ABBREVIATIONS

ACS	Addiction Consult Service
CADC	Certified Alcohol and Drug Counselor
ED	Emergency Department
EHR	Electronic Health Record
IOP	Intensive Outpatient Program
LTACH	Long-Term Acute Care Hospital
MOUD	Medications for Opioid Use Disorder
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PDMP	Prescription Drug Monitoring Program
SNF	Skilled Nursing Facility
StUD	Stimulant Use Disorder
SUD	Substance Use Disorder

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EXECUTIVE SUMMARY

BACKGROUND

For patients living with opioid use disorder and/or stimulant use disorder, transitions between inpatient, primary care and pharmacy settings are pivotal moments that can impact which direction their recovery journey takes. Ensuring that patients are on a healing path is critical, considering the size and scope of the overdose crisis in the United States: Although there was almost a 27% decrease in overdose deaths in 2024 compared to 2023, overdose remains the leading cause of death for U.S. adults aged 18-44.[1] Moreover, OUD is a major financial problem as well as a public health one: The average annual cost associated with each OUD case is nearly $700,000.[2]

In fall 2024, the Centers for Disease Control and Prevention (CDC) awarded the American Hospital Association's (AHA's) Health Research & Educational Trust (HRET) a grant to pursue the following goals:

- Develop three evidence-based and evidence-informed toolkits that detail leading practices for linkage to and retention in OUD and StUD care for inpatient, primary care and pharmacy settings.
- Partner with hospital and health system implementers to incorporate the toolkit strategies into their practice and clinical workflow.
- Track the uptake and use of the toolkits in each clinical setting to refine and improve recommendations based on the implementers' on-the-ground experiences.
- Finalize the toolkits based on feedback from implementers and subject matter experts.

To address the above objectives, AHA/HRET partnered with clinician teams spanning inpatient, primary care and pharmacy settings from three hospital and health system implementers: Oregon Health and Science University Health Care (OHSU), Trinity Health of New England (THONE) and University of Kentucky HealthCare (UK HealthCare). Together, the teams developed the content of this toolkit, using best practices identified through a literature review and the evidence-informed practices being used within their organizations.

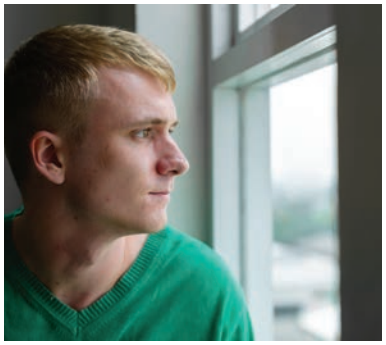
Across work with health system implementers and in the literature, three focus areas consistently emerged as essential to improving linkage to and retention in care: **expanding access to care**, **fostering strong leadership commitment** and **ensuring continuous education and communication** among care teams.

This toolkit offers leading practices as a framework for action across inpatient, primary care and pharmacy settings, with sections provided for each setting. AHA/HRET has identified both challenges and opportunities and detailed them in alignment with the three focus areas for improving linkage to and retention in care. In addition, the toolkit includes questions for teams to reflect on and encourage conversation about local opportunities. Note that due to the interconnected nature of OUD and StUD care, information about both conditions will often look similar across settings throughout the report.

1 CDC National Center for Health Statistics. U.S. Overdose Deaths Decrease Almost 27% in 2024. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2025/20250514.htm

2 Avalere Health. The cost of addiction: Opioid use disorder in the United States.

OVERVIEW OF FINDINGS



Access to Care

Challenges related to access to care are widespread across the United States. Patients who are hospitalized and identified as good candidates for ongoing treatment for OUD or StUD can experience challenges throughout the care delivery system; some patients may experience hardship in accessing MOUD outside of the acute care setting, and some patients may experience barriers related to social drivers of health such as housing, transportation and low health literacy. In addition, patients who may benefit from continued outpatient care may be unable to access services or treatment programs following inpatient discharge, particularly where such services and programs are unavailable, the patient's insurance coverage or financial resources are insufficient, or other barriers to accessing care exist. In primary care, long waitlists, stigma toward patients with OUD and StUD and clinician uncertainty regarding OUD and StUD treatment all contribute to delays and disruptions in ongoing care. Pharmacies face another layer of complexity with patients encountering stock shortages, restrictive insurance policies and stigma, all of which might lead to reduced retention in treatment.

Leadership Commitment

Overcoming these access to care barriers requires broad changes that extend beyond individual patient interactions: Achieving better outcomes requires leadership commitment across organization levels to prioritize OUD and StUD care as a core health care service. Leadership commitment can include allocating resources for clinician training, hiring patient navigators or peer support specialists, integrating psychiatric and substance use disorder treatment into primary and inpatient care, and fostering strong partnerships with community-based providers of SUD care. Leadership can actively sustain these efforts long-term — not only by supporting champions and initiating projects, but by fully integrating OUD and StUD care into their organization's priorities.

Continuous Education and Communication

Continuous education and communication among teams is another key component to enhancing linkage to and retention in care practices. Front-line teams across care settings benefit from a strong understanding of how to screen and diagnose OUD and StUD and prescribe, dispense and counsel patients on OUD and StUD treatments. In addition, given the societal stigma associated with SUD, specific efforts to address communication skills to reduce stigma and engage patients effectively would enhance care delivery. This training could include fostering effective warm handoffs between settings, learning motivational interviewing techniques, understanding insurance navigation and offering trauma-informed care.

PILOT PROGRAMS

These three key focus areas — access to care, leadership commitment and continuous education and communication — emerged from AHA/HRET's partnered work with its three hospital and health system implementers, who each engaged in a pilot program, or "test of change," which aimed to advance linkage to and retention in care across health care settings among OUD and StUD patients. Information gathered from the work of these implementers has helped inform the content of these toolkits.

Oregon Health and Science University Health Care

OHSU is piloting the use of **visible badges** for willing inpatient clinicians that invite patients to engage in discussions about OUD and StUD treatment without fear of judgment. This intervention has built stronger linkages to outpatient and pharmacy follow-up care.

Trinity Health of New England

THONE is embedding **peer support specialists** into discharge workflows, allowing for bedside engagement that strengthens patient trust, addresses barriers early and provides warm handoffs into outpatient treatment.

University of Kentucky HealthCare

UK HealthCare is **integrating educational resources directly into its electronic health record**, helping clinicians to initiate buprenorphine treatment and maintain continuity of care after hospital admission.

Each of these initiatives aligns with this report's core focus areas of assisting patients with accessing care, sustaining change through leadership support and empowering clinicians through continuous education and communication. Lessons learned from these pilots inform each setting-specific toolkit. To read each implementing organizations' case example, go to page 51.

INTRODUCTION

Since the 1990s, the United States has faced a significant crisis related to substance use disorders — particularly OUD as well as StUD.[3] Provisional data show an estimated 80,391 overdose deaths in 2024, according to the CDC.[4] These numbers are an improvement — showing a drop of nearly 27% from the year prior — indicating progress in prevention of substance use, distribution of naloxone and better access to evidence-based treatment for substance use disorders. Still, significant gaps remain in ensuring that patients have access to timely, coordinated and continuous care across settings.

Beyond overdose fatalities, millions of Americans live with the chronic consequences of OUD and StUD, including infectious diseases, impacts on their mental health, unstable housing and economic hardship. While effective treatments exist — such as methadone and buprenorphine for OUD — only a fraction of individuals with OUD and/or StUD receive evidence-based care, and even fewer remain engaged in long-term recovery support. The situation is even more challenging for patients with StUD, as there are currently far fewer resources, treatments and FDA-approved medications available than there are for patients with OUD.

Moreover, many communities lack adequate access to treatment services and behavioral health care resources. Stigma against individuals with OUD and/or StUD creates additional barriers to care by deterring people from seeking help. A lack of strong partnerships and cross-sector collaboration also can lead to more individuals falling through gaps between inpatient care, primary care and ongoing support systems.

On an individual level, fragmented health systems, limited coordination between clinicians and community providers, workforce shortages, and insurance complexities all contribute to missed opportunities to engage patients to seek treatment. Patients discharged from hospitals after overdose events or serious complications related to OUD and/or StUD require support in understanding the next steps in their treatment plan and connecting to ongoing treatment options, and without a strong and supportive linkage to ongoing care, these individuals can face a heightened risk of resumed substance use or even overdose.

3 Avalere Health. The cost of addiction: Opioid use disorder in the United States.

4 Centers for Disease Control and Prevention. Statement from CDC's National Center for Injury Prevention and Control on Provisional 2024 Overdose Death Data. https://www.cdc.gov/media/releases/2025/2025-statement-from-cdcs-national-center-for-injury-prevention-and-control-on-provisional-2024.html

TOOLKIT DEVELOPMENT

To address these urgent challenges, this AHA/HRET report seeks to identify leading practices in three focus areas identified as essential to supporting strong linkage to and retention in care: assisting patients with accessing care, supporting leadership engagement, and fostering continuous education and communication across health care teams.

Three evidence-based and evidence-informed toolkits detail challenges and opportunities for linkage to and retention in OUD and StUD care for inpatient, primary care and pharmacy settings, respectively. Case study examples from AHA/HRET's partnered hospital and health system implementers support leading practices in these three clinical settings. A supplemental literature review provides additional context and research for clinicians and others who wish to deepen their understanding of OUD and StUD care.

This report encourages its readers to approach linkage to and retention in OUD and/or StUD treatment with an open mind and look toward novel approaches that go beyond traditional paradigms to address the substance use crisis. Thought-provoking questions are included to guide clinical and care team discussions, challenging existing procedures in constructive ways.

By focusing on inpatient care, primary care and pharmacy settings, this report aims to equip clinicians, health care leaders and front-line teams across the care continuum with actionable strategies to close the gaps in linkage to and retention in care and, ultimately, to improve outcomes for individuals, strengthen communities and contribute to the broader national effort to address the substance use crisis.

Please note: The content in this toolkit is not official CDC guidance. These resources are offered to help support linkage to and retention in care, and incorporating this toolkit into practice is voluntary.

METHODS

HRET, the research affiliate of the AHA, launched this project to support hospitals and health systems in strengthening linkage to and retention in care for individuals with OUD and/or StUD. The project focused on three clinical settings — inpatient care, primary care and pharmacies — with the goal of developing setting-specific, evidence-based resource toolkits that support integrated care across the continuum.

AHA/HRET recruited clinical implementers from three hospitals — OHSU, UK HealthCare and THONE — to guide this work. Each implementation team included representatives from each of the three clinical settings. Over three phases from November 2024 to July 2025, implementers worked together to identify, test and refine a "theory of change" to evaluate leading practices tailored to their respective settings. Throughout the project, four subject matter experts with clinical expertise (one in each setting and one overall expert) supported them in each phase.

In Phase 1 (November 2024 through February 2025), AHA/HRET hosted a virtual kickoff and convened implementers into setting-specific cohorts. Each cohort met three times to identify leading practices, assess readiness for implementation and surface operational barriers. This report's acknowledgments section lists the subject matter experts who supported these meetings and provided technical assistance. By February, each implementation team selected leading practice strategies to pilot at their sites.

During Phase 2 (March 2025 through May 2025), implementers submitted action plans, attended monthly check-ins and reported progress on implementing their selected leading practice in care transitions using standardized templates. Through these meetings, they exchanged real-time insights, provided peer support and received expert feedback on implementation barriers and potential strategies to assess them.

In Phase 3 (June 2025 through July 2025), implementers reviewed and provided input on the report's draft toolkits. Final revisions to the report's resource toolkits incorporated direct feedback from implementers and individual national experts. AHA/HRET invited select representatives from each implementing hospital/health system to present their findings at the AHA Leadership Summit in July 2025.

Throughout the project, AHA/HRET coordinated communication, encouraged collaboration across clinical settings and developed a technical assistance framework to support long-term implementation at each site. The final resource toolkits — one for each clinical setting — reflect a combination of field-tested strategies, expert insights and practical tools to help clinical teams close care gaps and improve patient outcomes for individuals with OUD and/or StUD.

The Role of Inpatient Care in Advancing Linkage to and Retention in Care for Patients with OUD and/or StUD

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INTRODUCTION

Inpatient care teams that do not specialize in addiction medicine may feel ill-equipped to care for patients with co-occurring OUD or StUD when they are admitted to the hospital for treatment not related to OUD or StUD. Similarly, if OUD or StUD is identified and addressed during the inpatient stay, these teams may lack the resources to help patients transition to continuing care for OUD or StUD at discharge.

Some hospitals and health systems have implemented inpatient addiction consult services "to provide support, effective role modeling, and education about substance use disorder interventions" to both patients and non-addiction medicine clinicians.[5] Although an inpatient addiction consult service can produce positive outcomes for both patients and clinicians, this may not be a viable option for every hospital or health system due to barriers such as cost and availability of qualified clinicians.

Inpatient clinical teams can support patients with OUD and/or StUD in connecting to care as they transition into or from the inpatient setting to other settings — even in the absence of an addiction consult service. This chapter of the toolkit provides ideas to address and discussion of the challenges to accessing and offering OUD and StUD services in inpatient care settings and maintaining linkage to and retention in care upon discharge.

An expert panel — with clinical and nonclinical representatives from each of the three implementing organizations — and the literature review identified three primary factors that can inhibit linkage to and retention in care in the inpatient care setting. The three factors were informed by both evidence-based and evidence-informed practices identified in the literature review, as well as practices employed by the implementing organizations as reported during discussions and surveys.

A successful strategy for improving linkage to and retention in care will incorporate ideas that address all three of the factors that can be barriers to effective linkage and retention for patients with OUD and/or StUD.

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5 Weinstein, Z. M., Wakeman, S. E., & Nolan, S. (2018). Inpatient Addiction Consult Service: Expertise for Hospitalized Patients with Complex Addiction Problems. *Medical Clinics of North America*, 102(4), 587–601. https://doi.org/10.1016/j.mcna.2018.03.001

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FACTOR 1

ACCESS TO CARE

Improving access to OUD/StUD treatment during hospitalization and continuing treatment after discharge

Primary barriers that can inhibit access to OUD/StUD treatment in the inpatient care setting

- Challenges in accessing MOUD in the community setting post-discharge due to lack of available services or appointments, prescribing clinicians and/or medication availability.
- A shortage of resources to address complex social needs that may impede patients from continuing care.
- Lack of referral connection to primary care clinics or other outpatient addiction care services upon discharge.
- Clinician uncertainty in how to initiate OUD/StUD care during hospitalization.
- Internalized societal and health care-associated stigma toward OUD and StUD and treatment modalities, including stigma toward MOUD.

Evidence-informed ideas for improving access to OUD/StUD treatment in the inpatient care setting

These ideas correlate to the barriers identified by the expert panel and the literature review. They can be used to build upon a hospital or health system's efforts to improve linkage to and retention in care and are not meant to serve as a one-size-fits-all approach.

IDEAS to improve internal practices

- Educate all patient-facing members of inpatient care teams about OUD and StUD to reduce the stigma of seeking treatment.
- Empower and support, with consistent and reoccurring education and resources, all DEA-registered inpatient clinicians in administering or prescribing MOUD to patients as appropriate.
- Explore opportunities to employ peer support specialists, financial navigators, substance use care navigators or community health workers to assist patients and families in navigating the complexities of health insurance and/or sliding scale payment opportunities, supporting social needs and helping patients connect with community social services that can increase retention in care.

INNOVATION IN PRACTICE

Preventing discharge delays at UK HealthCare

PROBLEM: Discharging patients can be challenging and it can be costly if their needs are not met, creating delays resulting in longer stays and strain on hospital resources.

IMPLEMENTATION: To avoid discharge delays, the UK HealthCare care team conducts Thursday and Friday discharge plan check-ins to proactively address any barriers such as access to medication, outpatient treatment, methadone dosing hours, transportation and naloxone prescribing.

TAKEAWAY: Proactive planning can help your team ensure that all necessary steps are completed in advance, allowing for a safe and timely discharge.

- Establish formal communication pathways and workflows related to OUD/StUD care retention to better coordinate care plans, including with the ED, primary care, addiction consult service line and pharmacy.

IDEAS for building partnerships

- Connect with and establish referral relationships to community organizations that offer social resources to patients to reduce barriers to engaging with ongoing care. Ensure contact information with these organizations is always current so inpatient care teams can easily refer patients.
- Meet with leaders from community social service agencies on a regular basis to establish referral relationships, improve practices for warm handoffs and coordinate support for the patients and families being served by both parties.
- Connect with leaders from your community's OTPs, treatment centers and community pharmacies to improve referral relationships and coordinate services.

INNOVATION IN PRACTICE

Developing an interdisciplinary addiction medicine consult service

PROBLEM: Patients with OUD and/or StUD often are admitted to the hospital for acute medical or surgical needs related to their substance use, but the underlying substance use disorder is not always addressed during the inpatient stay. These hospitalizations are common and costly and associated with high morbidity and mortality, and not every hospital has access to clinicians trained to treat patients with OUD and/or StUD.

IMPLEMENTATION: Clinicians at OHSU recognized the need to change the status quo, and in 2015, conducted a patient needs assessment and held a series of meetings with diverse hospital and community stakeholders to develop a different approach to caring for patients with SUD in the hospital. This led to the development of the Improving Addiction Care Team (IMPACT) in 2015. IMPACT is among the first interdisciplinary addiction medicine consult services in the U.S. By demonstrating that the hospital was already investing significant money and resources in SUD care and showing the potential to improve the Triple Aim +1, the team secured funding from OHSU and Medicaid payers for IMPACT. IMPACT has demonstrated improvements in care quality, patient and staff experience, and savings including improvements in length of stay. IMPACT also is transforming hospital care and educating the workforce, helping change the standard of care for hospitalized patients with SUD across the state.

TAKEAWAY: Providing evidence-based, high-quality SUD care for hospitalized patients can help achieve the Triple Aim +1. Demonstrating that hospitals and health systems already invest in care for people with OUD and/or StUD can help to gain leadership buy-in and commitment to support efforts that will continue to support patients, families and the workforce. Efforts that build on existing models and research, but are tailored to local needs and incorporate local champions, may be most successful.

KEY TAKEAWAY

Inpatient care teams significantly influence their patients' continuation of care for OUD and/or StUD after discharge. Addressing the challenges and roadblocks that deter inpatient teams from successfully linking and retaining patients out of the inpatient setting and into ongoing care is vital to improving access.

QUESTIONS FOR TEAM REFLECTION

It's not always easy to know where to begin. The questions below focus on guiding the inpatient team through conversations about improving access to OUD/StUD treatment during hospitalization and after discharge. These questions are designed to guide your team in selecting the most relevant and impactful ideas that fit the needs of your organization.

DISCUSS Current state of linkage to and retention in care practices

Potential individuals to include in the conversation: Linkage and retention champion(s), inpatient clinicians, addiction consult service team, social workers, case managers, students/residents/fellows, peer supports, community health workers, patient experience/front desk staff, community clinicians who treat OUD and/or StUD

- How many inpatient clinicians can administer and provide MOUD to patients? What would it take to increase this number?

- How does the hospital or health system educate clinical teams on connection and referral for patients with OUD and/or StUD?

- How do inpatient service line(s) typically handle warm handoffs to primary care clinics or community clinicians/pharmacists?

- How are inpatient service line(s) working to address linkage and retention barriers?

- How does the hospital or health system actively work to reduce stigma against patients with OUD and/or StUD within inpatient service line(s)?

DISCUSS Improving linkage to and retention in care practices for the future

Potential individuals to include in the conversation: Linkage and retention champion(s), inpatient clinicians, addiction consult service team, social workers, case managers, students/residents/fellows, peer supporters, community health workers, patient experience/front desk staff, hospital-based pharmacists, primary care practice managers, IT, risk management, community-based pharmacists, community partners

- Is there an opportunity to add a peer support specialist, financial navigator, substance use care navigator or community health worker to the organization's inpatient team(s) to help address patients' social and/or care reimbursement needs? If yes, what steps are needed to add these individuals to the organization?

- How does the hospital or health system regularly maintain relationships with social service agencies and OTPs in the community?

FACTOR 2

LEADERSHIP COMMITMENT

Gaining sustainable leadership buy-in and commitment for inpatient-focused programs and resources that support linkage to and retention in care

Primary barriers that can lead to insufficient leadership buy-in for OUD and StUD inpatient treatment resources and connection programs that support linkage to and retention in care

- Absence of C-suite leader to serve as a linkage and retention champion.
- Lack of formalized organizational goals for improving linkage and retention outcomes.
- Absence of an inpatient leader to champion linkage and retention efforts.
- Misalignment between best practices for linkage and retention and organizational policies and practices.
- Lack of referral options or limited relationships with primary care clinics, OTPs and other community social service organizations.

Evidence-informed ideas for gaining sustainable leadership buy-in and commitment for inpatient-focused programs and resources that support linkage to and retention in care

These ideas correlate to the barriers identified by the expert panel and the literature review. They can be used to build upon an organization's linkage and retention efforts and are not meant to serve as a one-size-fits-all approach.

IDEAS for gaining leadership commitment

- Understand the priorities of the organization and consider how improving linkage to and retention in care can support those priorities.
- Deepen understanding of change management theory, as well as individual and group dynamics, to engage leaders using evidence-based approaches.
- Create a business case for investing in policies, programs and resources that will improve linkage to and retention in care. Include data, patient case studies and research studies that illustrate the benefits of investing in improved linkage and retention for patients with OUD and/or StUD.
    - Examples can focus on improving patient outcomes, reducing total cost of care, reducing readmissions, reducing the amount of uncompensated care provided by the hospital or health system, improving patient experience, and improving community-level public health metrics like overdose rates and overdose deaths.
- Share examples of organizational policies that can inadvertently get in the way of optimal care delivery and propose changes that will improve linkage and retention.
- Share goals for improving linkage and retention for patients with OUD and/or StUD with leadership on an ongoing basis to reinforce commitment and drive sustained action.

IDEAS for identifying and engaging champions

- Seek out a C-suite leader who is passionate about improving care for patients with OUD and/or StUD. The leader(s) may have training or interest in caring for patients with OUD and/or StUD, have lived experience that informs their passion for OUD and StUD care, and/or recognize the importance of offering high-quality OUD and StUD services to patients and families.
- Present a clear call to action to encourage potential champions to be excited about supporting this work.
- Look for opportunities to engage leaders about linkage and retention in formal and informal conversations.
- Seek out community leaders who are willing to partner to further the work and achieve common goals.

IDEAS for sustainability

- Establish standing meetings with leaders across care settings to share challenges, offer support, discuss priorities and collaborate on solutions.
- Identify and measure metrics for success in linkage and retention that are regularly shared with leaders, the board and other key stakeholders.
- Celebrate wins, accomplishments and examples of exceptional care coordination efforts with leaders and board members. Incorporate patient and family stories to ensure leaders, champions and stakeholders stay engaged with the work.

KEY TAKEAWAY

Successful care transitions for patients with OUD and/or StUD cannot occur sustainably without the support and buy-in from strong leaders willing to champion this work. It is critical that administrative leaders, clinical leaders and community leaders are engaged in ensuring inpatient care clinicians have the time and resources they need to care for patients with OUD and/or StUD.

QUESTIONS FOR TEAM REFLECTION

It's not always easy to know where to begin. The questions below focus on guiding the inpatient team through conversations about gaining buy-in and commitment from leaders and identifying champions. These questions are designed to guide your team in selecting the most relevant and impactful ideas that fit the needs of your organization.

DISCUSS Gaining buy-in and commitment from leaders

Potential individuals to include in the conversation: C-suite leaders, service line leaders, addiction consult service team and/or physicians and advanced practice providers who provide clinical care to patients with OUD/StUD, physician/administrator leadership dyads, medical staff leaders, board of trustees

- Where and when do leaders typically convene to make decisions, and how can improving linkage to and retention in care become a part of their existing conversations?

- Where are the best places in the decision-making pipeline to share the challenges encountered when transitioning OUD and StUD patients to and from the inpatient setting?

- How has the inpatient care team engaged senior leadership on other initiatives in the past? Can the same actions be applied to engage leaders in OUD and StUD initiatives?

- How do we hardwire successful linkage and retention practices into the organization's culture so that they are sustainable?

DISCUSS Identifying and engaging champions

Potential individuals to include in the conversation: C-suite leaders, service line leaders, addiction consult service team and/or physicians and advanced practice providers who provide clinical care to patients with OUD/StUD, physician/administrator leadership dyads, medical staff leaders, board of trustees

- Have newly committed champions received any education, training or communication about the challenges the team faces with care transitions for patients with OUD and/or StUD?

- What tactics have the organization's inpatient service line(s) used to identify and engage champions in the past?

FACTOR 3

COMMUNICATION AND CONNECTION

Enhancing education, communication and connection between inpatient clinical teams and key partners

Primary barriers that can inhibit education, communication and connection between inpatient clinical teams and key partners

- Limited communication between inpatient clinicians and partners (primary care clinics, OTPs, community social service organizations, etc.) can create confusion and barriers to efficient linkage to and retention in care.
- Low inpatient clinician self-efficacy for treating OUD and/or StUD in the inpatient setting due to limited knowledge and education.
- Lack of awareness and/or education among inpatient clinical teams about key partners' workflows and procedures.

Evidence-informed ideas to enhance education, communication and connection between inpatient clinical teams and key partners

These ideas correlate to the barriers identified by the expert panel and the literature review. They can be used or build upon an organization's linkage and retention efforts and are not meant to serve as a one-size-fits-all approach.

IDEAS for educating leaders

- Highlight opportunities for improving care and outcomes, incorporating best practices and changing culture.
- Share early successes and challenges from new interventions and set expectations for what success will look like.
- Educate about the value that improved linkage to and retention in care will bring to the hospital and/or health system and the patients they serve.
- Share patient and caregiver stories to normalize discussion about OUD and StUD and reduce stigma.

IDEAS for educating care teams

- Establish a process for "just-in-time" education during the hospitalization of a patient with OUD and/or StUD to improve self-efficacy for caring for patients with OUD and/or StUD and reducing reliance on addiction consult service.
- Create a FAQ with talking points and key information for the team to use when providing treatment and communicating with patients and families.
- Ensure care teams understand protocols for initiating MOUD during hospitalization and connecting the patient to resources for continuing MOUD.
- Identify a patient with OUD and/or StUD whose discharge was challenging to coordinate due to issues with linkage and retention in care; discuss the case as a team and identify opportunities to improve in the future.

- Embed resource links into order sets in EHR for topics such as MOUD initiation protocols, patient education handouts, instructions for initiating referrals to OTPs and treatment centers, and instructions for initiating referrals to social service organizations.

IDEAS for connecting with partners

- Host training and learning opportunities at the hospital or health system that are free and open to the public to provide community education about OUD and StUD prevention.
- Invite community partners to come to the hospital to meet the inpatient care team and identify opportunities to expand partnerships and referral relationships.
- Participate in community-led events that raise awareness about OUD and StUD.
- Visit OTPs, treatment centers and social service organizations in the community to build relationships with leaders and learn more about their services.

INNOVATION IN PRACTICE

Educating about X-waiver requirements at UK HealthCare

PROBLEM: DEA-registered clinicians who care for OUD patients might be unaware that X-waiver requirements have been removed, creating confusion and missed opportunities to expand access to medication for OUD care.

IMPLEMENTATION: UK HealthCare adopted a dot phrase that is part of the standard addiction medicine note (initial consult and all follow-up notes). This is a visible reminder to all DEA-registered clinicians that they can provide buprenorphine bridge prescriptions at time of discharge without needing specific authorization to help expand access to treatment.

TAKEAWAYS:

- Incorporate the necessary information into the EHR prompts to ensure that everyone is informed and reminded of the change in prescribing restrictions.
- Build a buprenorphine prescription (for anyone who is on buprenorphine as an inpatient) into the EHR as a hard stop at time of discharge to increase the likelihood of buprenorphine being prescribed. Clinicians should opt out of prescribing it if a prescription was inappropriate (for example, if a patient has received a long-acting injection of buprenorphine at time of discharge).

KEY TAKEAWAY

Connecting all stakeholders to facilitate positive linkage to and retention in care for patients requires a multipronged approach that incorporates both internal and external audiences, as well as formal and informal communication approaches.

QUESTIONS FOR TEAM REFLECTION

It's not always easy to know where to begin. The questions below focus on guiding the inpatient team through conversations about education and communication with a variety of important stakeholders. These questions are designed to guide your team in selecting the most relevant and impactful ideas that fit the needs of your organization.

DISCUSS Engaging leadership

Potential individuals to include in the conversation: Service line leaders, addiction consult service team and/or physicians and advanced practice providers who provide clinical care to patients with OUD/StUD, clinical leaders from across the hospital or health system, IT colleagues, marketing colleagues, communications colleagues, OTP leaders, leaders from community treatment centers, leaders from skilled nursing facilities, social service organization leaders

- How robust is the inpatient care team's communication with senior leadership?

- Within the inpatient care team? _____
- With primary care teams? _____
- With the inpatient pharmacy team? _____
- With community partners? _____
- What can be improved? _____
- How can the inpatient care team leverage technology to improve communication and education for partners across the hospital and health system?

- Are there any additional audiences, both inside and outside the organization, that should be considered when communicating about improving care transitions?

The Role of Primary Care in Advancing Linkage to and Retention in Care for Patients with OUD and/or StUD

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INTRODUCTION

According to the Centers for Medicare and Medicaid Services, primary care services cover a wide range of prevention, wellness and treatment services.[6] They provide many routine health care services that may include screening for diseases, providing patient education and coordinating care for patients receiving services from multiple specialists at one time. Primary care teams are experienced in helping patients manage complex, chronic conditions and, given this experience, they can be well suited to manage the long-term, ongoing treatment of OUD and StUD and coordinate the care patients need to improve their health and well-being.

Primary care clinicians, such as physicians and advanced practice providers, and their teams of nurses, social workers, administrators and peer supports play a crucial role in ensuring patients with OUD and/or StUD are linked and retained through the health care system smoothly and continue to receive needed care. They can be a critical resource for patients with OUD and/or StUD who are transitioning out of an inpatient hospitalization and need follow-up care, or they can potentially prevent the need for an inpatient stay altogether by screening, identifying and connecting patients to services and medications.

While methadone for OUD is limited to federally licensed OTPs and extended-release naltrexone is less commonly used in primary care, buprenorphine can now be prescribed by any clinician with a DEA registration. This change followed the 2023 elimination of the federal X-waiver, which had previously required clinicians to complete specialized training and obtain a separate waiver to prescribe buprenorphine.

Primary care providers also play a vital role in caring for patients who receive methadone at OTPs — including managing co-occurring conditions, coordinating with OTPs and supporting continuity of care. Effective treatment for OUD and StUD often depends on this kind of collaborative, whole-person approach that spans care settings.

This chapter highlights challenges in providing OUD and StUD treatment in primary care and the roles that primary care teams can play in gaining organizational commitment for resources that support linkage to and retention in care and strategies for educating key stakeholders on this work. While not all primary care offices and practices may have the resources to undertake all of these approaches, this toolkit will help identify those that make the most sense for the population served and resources available.

An expert panel — with clinical and nonclinical representatives from each of the three implementing organizations — and the literature review identified three primary factors that can inhibit linkage and retention in primary care. The three factors were informed by both evidence-based and evidence-informed practices identified in the literature review, as well as practices employed by the implementing organizations as reported during discussions and surveys.

A successful strategy for improving linkage to and retention in care will incorporate ideas that address all three of the factors that can be barriers to effective linkage and retention for patients with OUD and/or StUD.

6 Centers for Medicare & Medicaid Services. Primary Care. https://www.cms.gov/priorities/innovation/key-concepts/primary-care

The content in this toolkit is not official CDC guidance. These resources are offered to help support linkage to and retention in care, and incorporating this toolkit into practice is voluntary.

FACTOR 1

ACCESS TO CARE

Improving access to evidence-based OUD/StUD treatment in the primary care setting and community

Primary barriers that can inhibit access to OUD/StUD treatment in the primary care setting

- Limited availability of clinicians with training and support to provide OUD and StUD treatment, including prescribing buprenorphine, and providing mental health treatment alongside OUD or StUD treatment.
- Inconsistent communication and information sharing between inpatient clinicians and primary care clinicians after a patient is discharged and needs to establish primary care.
- Complex social needs that may impede patients from accessing or continuing treatment.
- Challenges with connecting patients to OTPs, outpatient substance use treatment, mental health treatment, and social service organizations to continue treatment between primary care appointments.
- Absence of, or inconsistent implementation of, screening for substance use disorders during all primary care appointments.

Evidence-informed ideas for improving access to OUD and StUD treatment and services in the primary care setting

These ideas correlate to the barriers identified by the expert panel and the literature review. They can be used to establish or build upon a primary care practice's linkage to and retention in care efforts and are not meant to serve as a one-size-fits-all approach.

IDEAS to improve care practices

- Screen for unhealthy drug use as a standard operating procedure during physical exams or other primary care visits as appropriate. When a patient screens positive, appropriate care can be offered or referred out. Use validated screening tools[7] during primary care visits to identify patients who may benefit from further assessment and connection to treatment.
- Help patients understand what types of services are covered in their insurance plans and help uninsured patients enroll in coverage.

INNOVATION IN PRACTICE

Bringing OUD and StUD care to rural communities at OHSU

PROBLEM: Patients with OUD and/or StUD may struggle to access addiction care in the community, particularly those living in rural areas.

IMPLEMENTATION: To address this gap, OHSU's Improving Addiction Care Team (IMPACT) and others developed the Harm Reduction and Bridges to Care (HRBR) clinic, a low-barrier telehealth SUD bridge clinic. Patients who are discharged from the hospital are set up with an appointment to be seen by HRBR for treatment of alcohol use disorder (AUD), OUD or StUD. The bridge clinic then connects patients with a provider for ongoing care, including primary care, in their community.

TAKEAWAY: Low-barrier options for follow-up and establishing a linkage to care in the community while patients are in the hospital are essential to continuity of care for patients with OUD and/or StUD.

7 NIH National Institute on Drug Abuse. Screening and Assessment Tools Chart. https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

- If the primary care clinic is part of a health system, collaborate with the health system's billing office to offer OUD and StUD services on a sliding fee schedule or through charity care to help patients receive the services they need.
- Utilize telehealth services in accordance with state and federal law to reach patients who may not be able to reliably access care in person.
- Consider employing a peer support specialist or partnering with a community organization that offers peer support services, which can help patients navigate their care and connect them to needed services.
- Utilize contingency management[8] as a treatment modality for StUD.
- Implement motivational interviewing[9] techniques to empower patients to partner with the care team to address challenges and solve problems related to their health and well-being.

INNOVATION IN PRACTICE

Using peer support services to engage families at THONE

PROBLEM: Family members may not fully understand the pathways for treatment and how best to support their loved ones in seeking recovery options.

IMPLEMENTATION: Implementing family peer support specialists to deliver support and education to families of patients seeking treatment strengthens the patient's recovery support system and assists in addressing unmet emotional needs of the family.

TAKEAWAY: When family members are informed and engaged in their loved ones' OUD or StUD treatment, they are better equipped to cope with the related stressors of the disease and become change agents within their family system. Engaging family peer support specialists is vital in preparing them with education around addiction and recovery and addressing existing emotional needs within the family system.

IDEAS to improve operational practices

- Develop a systematic process, when possible, for ensuring there is a warm handoff between clinicians as a patient transitions to receiving treatment in the primary care or community setting.
- Develop a system to reach out to "lost to follow-up" patients who have been referred to primary care for treatment and who have not yet been seen for an appointment. Assign a member of the care team to reach out to patients to discuss and address their barriers to seeking care.
- Identify ways to support the primary care practice team in building confidence and capacity for OUD/StUD care and MOUD prescribing through training, peer mentorship, clear clinical protocols and implementation support. Partner with hospitals and health systems and use available resources from community groups to gain these skills.
- Set a practice expectation for the standard of care that should be provided for OUD and StUD treatment that all primary care clinicians and other clinicians can follow.
- Educate all members of the care team, including nonclinicians, about OUD and StUD to reduce the stigma around seeking treatment and the potential bias from health care clinicians.
- Consider co-locating or integrating behavioral health clinicians into primary care clinics, in person or virtually, to provide patients with easier access to psychiatric care, therapy and support for social needs.

8 Contingency management is "an evidence-based psychosocial therapy for the treatment of stimulant use disorder, as well as a variety of other SUDs, that is supported by three decades of research. It involves providing incentives to people to reinforce desired behaviors that promote recovery from SUDs, such as abstinence from substance use, SUD treatment attendance, and adherence to medications for SUDs." U.S. Department of Health and Human Services, 2023.

9 Motivational interviewing is "a goal-directed SUD intervention that stems from person-centered counseling and focuses on the collaboration between provider and client. It is a respectful counseling style that raises awareness of a client's internal discrepancies about substance use, focuses on helping clients resolve their ambivalence about SUD, and can promote their motivation to change. Underlying this approach is the principle that a client's motivation to change is essential to bringing about actual change." SAMHSA, 2021.

- Collaborate with other providers to offer OUD and StUD services on a sliding fee schedule or through charity care to help patients receive the services they need.

IDEAS to build partnerships

- Connect with community organizations who can offer social resources to patients to establish referral relationships. Ensure contact information with these organizations is always current so the primary care team can easily refer patients when the need arises.

KEY TAKEAWAY

Removing the barriers to providing and receiving holistic, timely, patient-centered care in the primary care setting can improve retention and linkage outcomes for both patients and care teams.

QUESTIONS FOR TEAM REFLECTION

It's not always easy to know where to begin. The questions below focus on guiding the primary care team through conversations about improving access to OUD/StUD treatment and services in primary care. These questions are designed to guide your team in selecting the most relevant and impactful solutions that best fit the needs of your primary care clinic.

DISCUSS Current state of linkage to and retention in care practices

Potential individuals to include in the conversation: Linkage and retention champion(s), clinicians within the primary care practice, primary care practice managers, social workers, case managers, students/residents/fellows, medical assistants, peer support specialists, community health workers, patient experience/front desk staff, pharmacy leaders

- How many primary care clinicians feel comfortable with treating patients with OUD and/or StUD? What are the barriers for those who do not feel comfortable? How can the barriers be reduced?

- How many primary care clinicians feel comfortable with treating patients with co-occurring mental health disorders? What are the barriers for those who do not feel comfortable? How can the barriers be addressed?

- How many primary care clinicians are able to prescribe buprenorphine? If the number is insufficient, what are the alternatives for meeting the need for services?

- How does the primary care team actively work to reduce stigma against patients with OUD and/or StUD?

- How do primary care clinics help patients with OUD and/or StUD address social needs? What are the missed opportunities to improve this process?

- Has the primary care team implemented any treatment modalities specifically for StUD such as contingency management? If not, are there barriers or concerns that prevent the team from doing so?

DISCUSS Improving linkage to and retention in care practices for the future

Potential individuals to include in the conversation: Linkage and retention champion(s), clinicians within the primary care practice, primary care practice managers, social workers, case managers, students/residents/fellows, medical assistants, patient care technicians, peer supporters, community health workers, hospital-based pharmacists, community-based pharmacists, community partners

- How are primary care clinicians working with local pharmacies to help patients access buprenorphine and other forms of MOUD?

- Do primary care clinicians and team members know where to refer patients for methadone treatment, mental health treatment and help with social needs?

FACTOR 2

LEADERSHIP COMMITMENT

Gaining sustainable leadership buy-in and commitment for primary care-focused programs and resources that support linkage to and retention in care

Primary barriers that can lead to insufficient leadership buy-in for OUD and StUD treatment, programming and resources in primary care

- Absence of a C-suite leader to champion linkage and retention efforts.
- Misalignment between best practices for linkage and retention in primary care and organizational or practice policies and procedures.
- Lack of referral options or limited relationships with OTPs, outpatient substance use treatment centers, mental health treatment centers and other community social service organizations.
- Lack of formalized organizational or practice goals for improving linkage and retention outcomes.

Evidence-informed ideas for gaining sustainable leadership buy-in and commitment for OUD and StUD treatment, programming and resources in primary care

These ideas correlate to the barriers identified by the expert panel and the literature review. They can be used to establish or build upon a hospital or health system's linkage to and retention in care efforts and are not meant to serve as a one-size-fits-all approach.

IDEAS for leadership commitment

- Create a business case for investing in policies, programs and resources that will improve linkage to and retention in care in the primary care setting. Include data, patient case studies and research studies that illustrate the benefits of investing in improved linkage and retention for patients with OUD and/or StUD.
    - Examples can focus on improving patient outcomes, increasing time spent in recovery, improving patient experience, improving workforce satisfaction, and improving community-level public health metrics like overdose rates and overdose deaths.
- Share examples of where practice policies present barriers to providing optimal care and propose changes that will improve linkage to and retention in care.
- Understand the priorities of the practice and consider how improving linkage to and retention in care can support those priorities.

IDEAS for identifying and engaging champions

- Seek out an administrative or clinical leader who is passionate about improving care for patients with OUD and/or StUD to support the work.
- Present a clear call to action that will encourage potential champions to be excited about supporting this work.
- Look for opportunities to engage leaders about linkage and retention in formal and informal conversations.

- Seek out community leaders who are willing to partner to further the work and achieve common goals.
- Seek out member(s) of the primary care team, such as a social worker, a medical assistant or a front desk administrative clerk, who has expressed interest in contributing to improving outcomes for patients with OUD and/or StUD. Engage team member(s) in process improvement and project management work to keep initiatives moving forward.

IDEAS for sustainability

- Establish standing meetings with leaders across care settings — inpatient, primary care and pharmacy — to share challenges, offer support, discuss priorities and collaborate on approaches.
- Identify and measure metrics for success in linkage to and retention in care that are regularly shared with leaders, clinical teams and other key stakeholders.
- Celebrate wins, accomplishments and examples of exceptional care coordination efforts with leaders and the team. Incorporate patient and family stories to ensure stakeholders stay engaged with the work.

KEY TAKEAWAY

Successful care transitions for patients with OUD and/or StUD cannot occur sustainably without the support and buy-in from strong leaders willing to champion this work. It is critical that administrative leaders, clinical leaders and community leaders are engaged in ensuring primary care clinicians have the time, resources and workforce they need to care for patients with OUD and/or StUD.

QUESTIONS FOR TEAM REFLECTION

It's not always easy to know where to begin. The questions below focus on guiding the primary care team through conversations about gaining buy-in and commitment from leaders and identifying champions. These questions are designed to guide your team in addressing challenges that impact patients and families.

DISCUSS Gaining buy-in and commitment from leaders

Potential individuals to include in the conversation: C-suite leaders, service line leaders, linkage and retention champion(s), physicians and advanced practice providers who provide clinical care to patients with OUD/StUD, physician/administrator leadership dyads, medical staff leaders, board of trustees

- Where and when do leaders typically convene to make decisions, and how can improving care transitions become a part of their existing conversations?

- Where are the best places in the decision-making pipeline to share the challenges encountered when transitioning OUD or StUD patients to and from primary care?

- How has the primary care team engaged senior leadership on other initiatives in the past? Can the same actions be applied to engage leaders in OUD and/or StUD initiatives?

- How do we hardwire successful linkage and retention practices into the organization's culture so that they are sustainable?

DISCUSS Identifying and engaging champions

Potential individuals to include in the conversation: C-suite leaders, service line leaders, linkage and retention champion(s), physicians and advanced practice providers who provide clinical care to patients with OUD/StUD, physician/administrator leadership dyads, medical staff leaders, board of trustees

- Have newly committed champions received any education, training or communication about the challenges the team faces with care transitions for patients with OUD or StUD?

- What tactics has the primary care team used to identify and engage champions in the past?

FACTOR 3

COMMUNICATION AND CONNECTION

Enhancing education, communication and connection between primary care teams and key partners

Primary barriers that can inhibit education, communication and connection between primary care teams and key partners

- Limited communication between primary care clinicians and partners (inpatient clinicians, community pharmacists, OTPs, social service organizations, etc.) can create confusion and barriers to care for patients and families.
- Low clinician self-efficacy for treating OUD and/or StUD and co-occurring mental health conditions due to limited knowledge and education.
- Lack of awareness from primary care teams about key partners' workflows and procedures.
- Insufficient clarity from primary care clinicians about referrals for methadone administration, mental health treatment and social support services

Evidence-informed ideas to enhance education, communication and connection between primary care teams and key partners

These ideas correlate to the barriers identified by the expert panel and the literature review. They can be used to build upon a hospital or health system's linkage to and retention in care efforts and are not meant to serve as a one-size-fits-all approach. Although the communications tactics and messages may differ by audience, the goal is to empower others to make clinical and administrative decisions that can contribute to improving how patients move throughout the health care system and continue living in recovery.

IDEAS for engaging leaders

- Highlight opportunities for improving care, incorporating best practices and changing culture.
- Share early successes and challenges from new interventions and set expectations for what success will look like.
- Educate about the value that improved linkage to and retention in care will bring to the hospital and/or health system and the patients they serve.
- Share patient and caregiver stories to normalize discussion about OUD and StUD and reduce stigma.

IDEAS for engaging the care team

- Offer ongoing clinical learning and awareness of referral resources to improve self-efficacy and motivation for caring for patients with OUD and/or StUD, including mental health treatment.
- Create a FAQ with talking points and key information for the team to use when providing treatment and communicating with patients and families.
- Identify a patient with OUD and/or StUD who had trouble accessing MOUD or seeking addiction care;

discuss the case as a team and identify opportunities to improve in the future.

- Embed resource links into order sets in EHR for topics such as buprenorphine initiation protocols, methadone referral protocols, patient education handouts, instructions for initiating referrals to OTPs and SUD treatment centers, and instructions for initiating referrals to social service organizations.
- Offer naloxone training to all primary care team members.

IDEAS for building partnerships

- Participate in training and learning opportunities about OUD and StUD.
- Participate in community-led events that raise awareness about OUD and StUD.
- Visit hospitals, OTPs, SUD treatment centers, pharmacies and social service organizations in the community to strengthen relationships with leaders and learn more about their services.

INNOVATION IN PRACTICE

Scheduling and confirming appointments via text message at OHSU

PROBLEM: Scheduling appointments post-discharge can be a challenge for patients, leading to missed opportunities for continued care.

IMPLEMENTATION: To close that gap and ensure continuity of care for patients, OHSU enabled established patients to schedule and confirm appointments via text message (not permitted for patients who have not yet established care). This simple process made it easier for patients to manage their care needs, increasing engagement and adherence to care plans.

TAKEAWAY: Simplifying the appointment scheduling process can empower patients to take an active role, improving patient engagement and long-term outcomes.

KEY TAKEAWAY

Connecting all stakeholders to facilitate positive care transitions for patients requires a multipronged approach that incorporates both internal and external audiences, as well as formal and informal communication approaches. Primary care providers can play a key role in connecting and communicating with all parties, including patients and families.

QUESTIONS FOR TEAM REFLECTION

It's not always easy to know where to begin. The questions below focus on guiding the primary care team through conversations about education and communication with a variety of important stakeholders. These questions are designed to guide your team in addressing challenges that impact patients and families.

DISCUSS Connecting with leadership and across care settings

Potential individuals to include in the conversation: Linkage and retention champion(s), primary care leaders, leaders from across the hospital or health system, addiction consult service leaders, IT colleagues, marketing colleagues, communications colleagues, OTP leaders, leaders from substance use treatment centers, leaders from mental health treatment centers, social service organization leaders, peer support specialists

- How strong is the primary care team's communication with health system leadership?

- Within the primary care team?
- With inpatient service line teams?
- With community pharmacies?
- With community partners?
- What can be improved?

- How can the primary care team leverage technology to improve communication and education for partners across the hospital, the health system and the community?

- Are there any additional audiences that should be considered when communicating about improving care transitions?

The Role of Pharmacy in Advancing Linkage to and Retention in Care for Patients with OUD and/or StUD

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INTRODUCTION

Pharmacists play a vital role in providing medication, clinical counseling and supportive care services to patients with OUD and/or StUD across the continuum of care. These medications can support patients in achieving their recovery goals, especially when combined with non-pharmacological interventions like therapy and patient education. Despite the effectiveness of MOUD, only 1 in 4 adults[10] (25%) who needed OUD treatment in the U.S. received MOUD in 2022.

Hospital-based pharmacists play a critical role in supporting patients with OUD and/or StUD as they transition through the care delivery system. Hospital pharmacists can educate patients and clinicians about pharmacotherapy options, establish protocols and order sets to initiate and maintain pharmacotherapies for patients during hospitalization, and support patients in accessing pharmacotherapies in the community after discharge. Community pharmacists play a crucial, yet distinct, role in supporting care transitions for patients with OUD and/or StUD. Patients rely on community pharmacists to gain and maintain access to the pharmacotherapies necessary for their continued recovery and treatment. Community pharmacists can play a critical role in identifying patients with or at risk of substance use disorder and referring patients to treatment, and they also can provide preventive services including vaccination, screening and testing for common chronic and acute conditions. This toolkit is focused on the role of hospital-based pharmacy teams in advancing linkage to and retention in care, but it is highly encouraged to engage community pharmacists as partners to further this work.

Although pharmacy plays an important role in linkage to and retention in care for patients with OUD and/or StUD, pharmacists often encounter numerous challenges in helping patients access the medications necessary for treatment and recovery. This chapter of the toolkit highlights some of those challenges and explores potential ideas for addressing these challenges, describes the roles that pharmacy teams can play in gaining leadership buy-in and commitment, and lists strategies for educating key stakeholders to improve care transitions.

An expert panel — with clinical and nonclinical representatives from each of the three implementing organizations — and the literature review identified three primary factors that can inhibit linkage and retention in pharmacy. The three factors were informed by both evidence-based and evidence-informed practices identified in the literature review, as well as practices employed by the implementing organizations as reported during discussions and surveys.

A successful strategy for improving linkage to and retention in care will incorporate ideas that address all three of the factors that can be barriers to effective linkage and retention for patients with OUD and/or StUD within the resources available at the organization.

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10 Centers for Disease Control and Prevention: Treatment for Opioid Use Disorder: Population Estimates — United States, 2022. https://www.cdc.gov/mmwr/volumes/73/wr/mm7325a1.htm#F1_down

The content in this toolkit is not official CDC guidance. These resources are offered to help support linkage to and retention in care, and incorporating this toolkit into practice is voluntary.

FACTOR 1

ACCESS TO CARE

Improving access to evidence-based pharmacotherapies for OUD and promising medications for StUD

Primary barriers that can limit access to evidence-based pharmacotherapies for OUD and promising medications for StUD within the hospital or health system and the community

- Uncertainty from hospital-based pharmacists on how much buprenorphine to keep on hand in the hospital pharmacy due to storage requirements and high cost.
- Delays in care delivery due to need for prior authorization before MOUD can be administered.
- No FDA-approved pharmacotherapy options for StUD.
- Corporate policy restrictions for community pharmacies regarding MOUD.
- Lack of availability of buprenorphine in the community pharmacy setting.
- Limited willingness of community pharmacists to fill buprenorphine prescriptions. Inadequate resources to address complex social needs that may impede patients from accessing buprenorphine.
- Patient, family, clinician and community stigma against using MOUD.

Evidence-informed ideas for improving access to evidence-based pharmacotherapies for OUD and promising medications for StUD

These ideas correlate to the barriers identified by the expert panel and the literature review. They can be used to build upon a pharmacy team's linkage to and retention in care efforts and are not meant to serve as a one-size-fits-all approach.

IDEAS for improving internal practices

- Identify opportunities to improve communication pathways and workflows related to OUD/StUD care retention between hospital-based pharmacy teams and the ED, inpatient service lines, the addiction consult service line, if available, and primary care to better coordinate care plans.
- Use order sets to effectively continue pharmacotherapy for OUD and StUD after inpatient admission.
- Ensure that educational materials for patients who are taking MOUD are at an appropriate reading level and easy to follow. Ensure members of the hospital pharmacy team are available to counsel patients and families on MOUD, either with an in-person visit or by phone.
- Involve clinical pharmacy specialists in bridge clinics to optimize MOUD and minimize risk of readmission.

IDEAS for building partnerships

- Be proactive with discharge planning. Contact community pharmacies in advance to ensure availability of medication. Verify that the order is correct and contains all components of a valid prescription in your state.
- Establish connections between hospital pharmacies and local community pharmacies to enhance relationships and advocate for the importance of access to treatments for patients with OUD and/or StUD.
- Leverage hospital-based pharmacy specialists to support warm handoffs to community pharmacists post-discharge.
- Ensure that prescriptions for pharmacotherapy for OUD and StUD are complete and contain a diagnosis code as well as a phone number that allows the community pharmacists to clarify prescriptions with the prescriber.
- Treat every prescription as a transition in care. Utilize hospital-based pharmacists to educate patients, families and their community pharmacy counterparts about the importance of successful treatment continuation.

INNOVATION IN PRACTICE

Initiating buprenorphine via microdosing or low-dose induction at UK HealthCare

PROBLEM: The inpatient hospital setting provides an opportunity to engage patients with OUD in treatment with MOUD. Buprenorphine, a medication that significantly reduces all-cause mortality, is a desirable treatment option for many patients with OUD. Initiating buprenorphine historically required a patient to be in moderate opioid withdrawal — Clinical Opiate Withdrawal Scale (COWS) score is 8 or higher — to avoid prompting precipitated withdrawal.

IMPLEMENTATION: New techniques to initiate buprenorphine, commonly referred to as "microdosing" or "low dose induction" allow patients to begin buprenorphine without having to experience withdrawal. In fact, patients receiving full agonist opioid medications in the hospital can also begin buprenorphine safely via low dose induction. The new initiation pathway typically requires a set of buprenorphine orders that are specifically timed and increase in dosage over a timed cadence. UK HealthCare's pharmacy team created an order set for two of these newer pathways in the EHR to ensure ordering providers can easily place a safe and accurate initiation pathway.

TAKEAWAY: Buprenorphine induction in the hospital setting is on the rise. An order set that is integrated in the EHR ensures providers that a safe and evidence-based buprenorphine initiation will occur. The EHR can be leveraged to facilitate buprenorphine initiation in the hospital setting.

KEY TAKEAWAY

Pharmacotherapy can be a critical component of a long-term, patient-centered approach to SUD treatment, particularly for OUD. Hospital-based pharmacists play a key role in helping patients access the medications they need for their treatment and recovery, whether in the inpatient setting, in a primary care clinic or in the community.

QUESTIONS FOR TEAM REFLECTION

It's not always easy to know where to begin. The questions below focus on guiding the pharmacy team through conversations about improving access to OUD/StUD treatment options. These questions are designed to guide your team in selecting the most relevant and impactful ideas that fit the needs of your organization.

DISCUSS Current state of linkage to and retention in care practices

Potential individuals to include in the conversation: Linkage and retention champion(s), hospital-based pharmacists, community-based pharmacists, students/residents/fellows, pharmacy technicians

- What's the process for making a member of the hospital pharmacy team available to patients and families for questions and in-person education prior to patient discharge?

- How is the hospital or health system's pharmacy and therapeutics committee addressing the impact and importance of efforts to maintain continuity of pharmacotherapy for OUD at admission?

- Are prescribers including diagnosis codes and a direct phone number on all prescriptions for OUD and/or StUD?

- Does the hospital pharmacy team have a relationship with the community pharmacists who fill prescriptions for patients? If not, how can those relationships be established?

DISCUSS Improving linkage to and retention in care practices for the future

Potential individuals to include in the conversation: Linkage and retention champion(s), hospital-based pharmacists, community-based pharmacists, students/residents/fellows, pharmacy technicians, addiction consult team (when available), and/or physicians and advanced practice providers who provide clinical care to patients with OUD/StUD, social workers, peer supporters

- How can hospital-based pharmacists better provide support to clinicians when they have questions about MOUD?

- How can the hospital pharmacy team support identification and documentation of MOUD in the EHR?

- What additional training may be helpful for the hospital-based pharmacy team?

- How can pharmacists support effective peer-to-peer communication between inpatient pharmacy staff and their community counterparts?

- What strategies can pharmacists use to reduce the stigma of OUD and StUD among pharmacy teams?

FACTOR 2

LEADERSHIP COMMITMENT

Gaining sustainable leadership buy-in and commitment for pharmacy-focused programs and resources that support linkage to and retention in care

Primary barriers that can lead to insufficient leadership buy-in for resources and programs that support the role of hospital- and community-based pharmacies in OUD and StUD treatment

- Absence of C-suite leader with understanding and experience in pharmacy procedures and protocols to serve as a linkage and retention champion.
- Lack of formalized organizational goals for hospital pharmacy being engaged in improving linkage and retention outcomes.
- Absence of a hospital-based pharmacy leader to champion linkage and retention efforts.
- Absence of community-based pharmacy leaders to champion linkage and retention efforts.
- Absence of corporate leadership in community chains with direct dispensing experience.
- Misalignment between best practices for linkage and retention and organizational or corporate pharmacy policies and practices designed to prevent controlled substance diversion.

Evidence-informed ideas for gaining sustainable leadership buy-in and commitment for pharmacy-focused programs and resources that support linkage to and retention in care

These ideas correlate to the barriers identified by the expert panel and the literature review. They can be used to build upon a pharmacy team's linkage to and retention in care efforts and are not meant to serve as a one-size-fits-all approach.

IDEAS for gaining commitment for programming and resources

- Understand the priorities of the organization and consider how improving linkage and retention can support those priorities.
- Deepen understanding of change management theory, as well as individual and group dynamics, to engage leaders using evidence-based approaches.
- Create a business case for investing in policies, programs and resources that will improve linkage and retention for pharmacotherapy. Include data, patient case studies and research studies that illustrate the benefits of investing in improved linkage and retention for patients with OUD and/or StUD.
    - Examples can focus on: improving patient outcomes, reducing total cost of care, reducing readmissions, reducing the amount of uncompensated care provided by the hospital or health system, improving patient experience and improving community-level public health metrics like overdose rates and overdose deaths
- Share examples of organizational policies that can inadvertently get in the way of optimal care delivery and propose changes that will improve linkage and retention.
- Share goals for improving linkage to and retention in care for patients with OUD and/or StUD with leadership on an ongoing basis to reinforce commitment and drive sustained action.

IDEAS for identifying and engaging champions

- Seek out a C-suite leader who is passionate about improving care for patients with OUD and/or StUD. The leader(s) may have training or interest in caring for patients with OUD and StUD, have lived experience that informs their passion for OUD and StUD care, and/or recognize the importance of offering high-quality OUD and StUD services to patients and families.
- Present a clear call to action that will encourage potential champions to be excited about supporting this work.
- Look for opportunities to engage leaders about linkage and retention in formal and informal conversations.
- Seek out community leaders who are willing to partner to further the work and achieve common goals.

IDEAS for ensuring sustainability of programs and resources

- Establish standing meetings with pharmacy staff and leaders across care settings to share challenges, offer support, discuss priorities and collaborate on solutions.
- Celebrate wins, accomplishments and examples of exceptional care coordination efforts with leaders and board members. Incorporate patient and family stories to ensure leaders, champions and stakeholders stay engaged with the work.

INNOVATION IN PRACTICE

Aligning OUD and StUD initiatives with organizational goals at OHSU

PROBLEM: Opioid treatment programs often have long wait times for new patient intake or post-hospitalization assessment. Additionally, patients may be ready to discharge on a weekend when clinics are often not open, requiring patients to extend their hospital stay to prevent withdrawal. The 72-hour rule allows for the administration of methadone while arranging for follow-up, but administration of methadone from an inpatient pharmacy is not standard practice and requires extensive planning, procedure development and leadership buy-in.

IMPLEMENTATION: OHSU leveraged the opportunity afforded by the 72-hour rule change. Led by their addiction consult service pharmacist, OHSU built processes and workflows to administer methadone at hospital discharge. This supports more seamless care transitions and generates significant cost savings through reduced hospital length of stay. OHSU has published[11] their approach to disseminate and spread best practices regionally and nationally.

TAKEAWAY: Framing OUD and StUD care initiatives to align with the financial or strategic goals of leadership can help forge collaboration and secure buy-in to improve access to OUD and StUD treatment.

KEY TAKEAWAY

Successful care transitions for patients with OUD and StUD cannot occur sustainably without the support and buy-in from strong pharmacy leaders willing to champion this work. It is critical that administrative leaders, clinical pharmacy leaders and community leaders are engaged in ensuring hospital-based pharmacists have the time and resources they need to care for patients with OUD and StUD.

11 Skogrand, E., Sharpe, J., & Englander, H. (2024). Dispensing Methadone at Hospital Discharge: One Hospital's Approach to Implementing the "72-hour Rule" Change. *Journal of Addiction Medicine*, 18(1), 71–74. https://doi.org/10.1097/ADM.0000000000001246

QUESTIONS FOR TEAM REFLECTION

It's not always easy to know where to begin. The questions below focus on guiding the pharmacy team through conversations about gaining buy-in and commitment from leaders and identifying champions. These questions are designed to guide your team in selecting the most relevant and impactful ideas that fit the needs of your organization.

DISCUSS Gaining buy-in and commitment from leaders

Potential individuals to include in the conversation: C-suite leaders, hospital-based pharmacy leaders, pharmacy and therapeutics committee, board of trustees

- Where and when do leaders typically convene to make decisions, and how can improving care transitions become a part of their existing conversations?

- Where are the best places in the decision-making pipeline to share pharmacy-related linkage and retention challenges and opportunities to address them?

- How has the pharmacy team engaged senior leadership on other initiatives in the past? Can the same actions be applied to engage leaders in OUD and StUD initiatives?

- How do we hardwire successful linkage and retention practices into the organization's culture so that they are sustainable?

DISCUSS Identifying and engaging champions

Potential individuals to include in the conversation: C-suite leaders, hospital pharmacy leaders, pharmacy and therapeutics committee, board of trustees

- What do we expect the champions to do in their role?_____

- Have newly committed champions received any education, training or communication about the challenges the team faces with care transitions for patients with OUD and StUD? _____

- What tactics have the pharmacy team used to identify and engage champions in the past?

FACTOR 3

COMMUNICATION AND CONNECTION

Enhancing education, communication and connection between pharmacy teams and key partners

Primary factors that can inhibit education, communication and relational connection between hospital-based pharmacy teams and key partners

- Patients may not be accepted into post-acute levels of care if discharged with a prescription for buprenorphine or methadone.
- Inadequate communication between hospital pharmacists and partners (community pharmacists, primary care clinicians, OTPs, etc.) resulting in and barriers to efficient linkage and retention.
- Limited training on pharmacotherapy for OUD and/or StUD in schools and colleges of pharmacy.
- Formulary incompatibilities between sites of care within the community that make it challenging for patients to continue receiving MOUD as they continue care.

Evidence-informed ideas to enhance education, communication and connection between hospital-based pharmacy teams and key partners

These ideas correlate to the barriers identified by the expert panel and the literature review. They can be used to build upon a pharmacy team's linkage to and retention in care efforts and are not meant to serve as a one-size-fits-all approach.

IDEAS for engaging leaders

- Highlight opportunities for improving care, incorporating best practices and changing culture.
- Share early successes and challenges from new interventions and set expectations for what success will look like.
- Educate on the value that improved linkage to and retention in care will bring to the hospital and/or health system.
- Share patient and caregiver stories to normalize discussion about OUD and StUD and reduce stigma.

IDEAS for engaging care teams

- Establish a process for "just-in-time" education to support clinicians in prescribing and administering MOUD in the ED, in the inpatient setting and in primary care.
- Provide training for clinicians on protocols and policies for prescribing buprenorphine and other forms of MOUD.
- Create a FAQ with talking points and key information for the team to use when providing treatment and communicating with patients and families.

- Embed resource links into order sets in EHR for topics such as MOUD initiation protocols, patient education handouts and instructions for sending prescriptions to community pharmacies.
- Identify a patient with OUD and/or StUD whose discharge was challenging to coordinate due to issues with linkage and retention in care; discuss the case as an interdisciplinary team and identify opportunities to improve in the future.

IDEAS to improve connections with community pharmacies

- Invite community pharmacists to the hospital to meet with the inpatient pharmacy team to identify opportunities to build relationships that will support patients in accessing needed medications.
- Participate in community-led events that raise awareness for OUD and StUD.
- Visit community pharmacies to build relationships with leaders and learn more about their services.
- Visit skilled nursing facilities, OTPs, SUD treatment centers, mental health treatment centers and social service organizations to understand their concerns about accepting patients taking MOUD into their care and work to identify solutions together.

INNOVATION IN PRACTICE

Educating clinicians about community MOUD access at THONE

PROBLEM: During an internal needs assessment, THONE learned there was a lack of understanding and knowledge of community-based methadone clinics among some of its physicians. THONE identified an opportunity to provide education, developed by an interdisciplinary team, about enrollment protocols and requirements for connecting patients to MOUD providers.

IMPLEMENTATION: Utilize Grand Rounds as an opportunity to educate clinicians on methadone resources and processes, providing continuing medical educational credits whenever possible.

TAKEAWAY: Education to improve understanding and objective workflows will improve the team's ability to appropriately assess patients for opportunities to connect to community-based MOUD care and reduce stigma when they seek OUD care in the acute hospital space.

KEY TAKEAWAY

Connecting all stakeholders to facilitate positive linkage to and retention in care for patients requires a multipronged approach that incorporates both internal and external audiences, as well as formal and informal communication approaches. Pharmacists can play a key coordinating role by providing education and enhancing communication across all audiences.

QUESTIONS FOR TEAM REFLECTION

It's not always easy to know where to begin. The questions below focus on guiding the pharmacy team through conversations about education and communication with a variety of stakeholders. These questions are designed to guide your team in addressing challenges that can impact patients and families.

DISCUSS Engaging leaders and partners

Potential individuals to include in the conversation: Hospital-based pharmacy leaders, community-based pharmacy leaders, service line leaders, primary care practice managers, clinical leaders from across the hospital, health system, and primary care clinics, IT colleagues, marketing colleagues, communications colleagues, OTP leaders, leaders from community treatment centers, social service organization leaders

- How strong is the pharmacy team's communication with senior leadership? _____
- With community pharmacies? _____
- With primary care teams? _____
- With community partners? _____
- What can be improved? _____

_____

_____

- How can the pharmacy team leverage technology to improve communication and education for partners across the hospital, health system and community? _____

_____

_____

- Are there any additional audiences that should be considered when communicating about improving care transitions?

_____

_____

_____

SUGGESTIONS FOR FUTURE WORK

FOR HOSPITALS AND HEALTH SYSTEMS

- Using the guidance in these toolkits, build or enhance the use of evidence-based and evidence-informed practices that will improve linkage and retention outcomes for both clinicians and patients, across inpatient, primary care and pharmacy settings. Use data to identify groups of patients with OUD or StUD who are most at risk of facing barriers during care transitions, and target interventions specifically for these groups.
- Normalize and publicize conversations about OUD, StUD and other substance use disorders to reduce stigma among clinicians, hospital employees, patients and families.
- Focus on improving linkage and retention outcomes for patients who enter the care delivery system through the ED and consistently share results with C-suite leadership and possibly the organization's board of trustees.

FOR HOSPITAL AND HEALTH CARE ASSOCIATIONS

- As hospitals and health systems continue to improve linkage and retention outcomes for patients with OUD or StUD, associations can convene a multidisciplinary group of champions to share knowledge and concerns, problem solve and co-create tools and resources that are specific to the communities and states they serve.
- Expand awareness of existing evidence-based and evidence-informed practices for improving linkage to and retention in care.
- Raise awareness of the need to improve linkage to and retention in care for patients with OUD or StUD through local and state campaigns and interventions.
- Advocate for policies that would remove barriers for the clinicians and team members who are working to improve linkage to and retention in care for the patients and families they serve.
- Advocate for national and state policies that would increase reimbursement rates for providing care for patients with OUD and StUD.
- Advocate for enhanced resources in the community setting to create multifaceted, sustainable systems of care for patients with OUD and StUD.

FOR RESEARCHERS

- Although promising pharmaceutical options exist to manage and treat StUD, the FDA has not yet approved any medications for this purpose. More research is needed to evaluate the efficacy of existing medications or to develop new medications to treat StUD.
- Research on best practices for linkage to and retention in care transitions specific to StUD is limited in both literature and hospital practices. More studies are needed to identify the most effective methods for treating patients with StUD.
- Prioritize implementation research for high-impact linkage to and retention in care.[12]
- More research is needed for special populations with OUD or StUD:
  - Adolescent patients
  - Incarcerated patients
  - Obstetric patients
  - Pain management patients
  - Unhoused patients
  - Patients with serious and persistent mental illness
- There is a need to broaden research metrics beyond treatment retention to include linkage to housing, recovery supports and patient-defined outcomes.

12 Michael, A., Huebler, S., Szczotka, K., Grant, S., Kertesz, Stefan G., Gordon, A. Expert Panel Consensus on the Effectiveness and Implementation of Models to Support Posthospitalization Care Transitions for People With Substance Use Disorders. *Journal of Addiction Medicine* 18(6):p 696-704, 11/12 2024. https://pubmed.ncbi.nlm.nih.gov/39221815/

CASE EXAMPLES

Oregon Health and Science University Health Care

Challenge

Some patients who visit EDs or are admitted to hospitals do not receive timely initiation of MOUD, when appropriate. Even when they do, there are often barriers to ensuring continued engagement with MOUD care after discharge. Patients commonly avoid disclosing OUD and StuD, and clinicians may be unable to prescribe MOUD. These problems are both a cause and consequence of a lack of clear pathways for MOUD initiation and linkage from the ED.

Without clearer treatment pathways for successful care transitions, individuals with OUD or StUD are at risk of falling through the cracks, leading to worsened health outcomes and increased health care costs. For more than a decade, OHSU has been developing, implementing and evaluating new and innovative methods for addressing these risks. While gaps remain, OHSU has made considerable progress, which includes implementing tests of change as part of this report.

Intervention

To address gaps in ED care transitions, OHSU is engaging a core group of early adopters within its ED and partnering with a team at Asante Rogue Regional Medical Center to develop and reinforce ED-to-community referral pathways and pilot messaging strategies that encourage MOUD initiation while the patient is in the ED. One such strategy is to create buttons that read, "Want buprenorphine? Ask me how" that early adopters can wear to signal their readiness to provide MOUD.

OHSU also is collaborating with pharmacy champions and bridge clinics to simplify referral pathways and identify key resources for successful linkage — for example, making point-of-care flowsheets to guide post-hospital referrals and leveraging existing peer support infrastructure to partner more closely with ED stakeholders. As of May 2025, OHSU is implementing and evaluating at least two of these strategies across inpatient, primary care and pharmacy settings. This builds upon existing work that includes MOUD order sets and protocols, all-staff education efforts, a harm reduction nurse and contingency management interventions to support people with StUD, and decades of change led by an interprofessional addiction consult service.

Impacts and Implications

Through this work, OHSU and Asante anticipate that there will be increased clinician willingness to initiate MOUD in ED settings, resulting in increased treatment access for patients with OUD and/or StUD and reduced structural and individual stigma. Moreover, the use of badges and clear referral pathways can help empower patients to self-identify and seek MOUD without fear of judgment. Enhanced coordination between hospitals, pharmacies and bridge clinics also can improve retention rates, ensuring that more patients transition from emergency care to long-term treatment. By addressing system-level gaps and unclear pathways for MOUD initiation and linkage, OHSU's messaging-focused approach can serve as a model for other organizations looking to improve substance use disorder care and patient retention.

University of Kentucky HealthCare

Challenge

In order for patients with OUD to receive effective and continuous MOUD, it is essential for clinicians to be familiar with both MOUD initiation and follow-up care processes. Yet all too often, many clinicians are unfamiliar with initiating buprenorphine treatment and are uncertain about where to refer patients.

This uncertainty is exacerbated by the fact that many patients on MOUD admitted to inpatient settings experience disruptions in taking MOUD, as their medication is not always automatically continued upon admission due to several barriers. If clinicians do not have access to educational resources for the patient on MOUD and subsequent follow-up care options, their ability to provide effective treatment is at risk. UK HealthCare, an integrated health system, has recognized this issue and is proactively working on educational solutions to address it.

Intervention

To address these challenges, UK HealthCare is implementing a multifaceted plan that focuses on clinician education, workflow integration and digital resource enhancement. The plan includes the creation and distribution of educational flyers in key hospital areas to inform staff about buprenorphine initiation and follow-up care options.

The UK HealthCare team is working with the hospital's IT department to implement an EHR trigger, which will help ensure an automatic continuation of outpatient buprenorphine treatment for admitted patients. A step-by-step guide for how to prescribe MOUD has been made available and integrated into UK HealthCare's EHR system, providing clinicians with a centralized resource for treatment guidelines and referral options; additional MOUD educational resources for providers are in development as well.

These initiatives involve a coordinated effort across inpatient, outpatient and pharmacy settings to ensure that best practices are systematically embedded in patient care workflows.

Impacts and Implications

By implementing these strategies, UK HealthCare aims to increase the number of buprenorphine initiations at all hours (including times when the addiction medicine team is not in-house), ensure that patients continue receiving their MOUD upon hospital admission and improve clinician awareness of follow-up options.

The new EHR care plan integration in particular can facilitate improved communication between inpatient and outpatient clinicians, enhancing coordination for sustained treatment. Furthermore, an educational tab in the EHR can serve as a readily available tool for health care professionals, increasing their knowledge and ability to manage patients with OUD/StUD effectively.

Trinity Health of New England

Challenge

Many patients with OUD and/or StUD struggle to navigate the U.S. health care system's complex treatment landscape, resulting in an increased risk of a return to drug use.

Without a strong linkage to ongoing care and support, patients are at heightened risk of negative health outcomes, including overdose and rehospitalization. However, supportive transition programs that acknowledge and empathize with patients' lived experience offer significant potential to keep patients engaged and actively participating in their treatment program over time. THONE recognizes this and is developing a new program to directly confront this issue.

Intervention

THONE is integrating peer support specialists (PSS) into their patient care protocol to strengthen the connection to care for patients who seek withdrawal management and MOUD services. These specialists, who have lived experience with substance use recovery, will provide education, encouragement and assistance to patients in navigating post-discharge care.

The new process calls for PSS to engage with patients at the bedside within 24 to 48 hours before discharge, allowing time for relationship building between PSS and patients, identifying and addressing health-related social needs such as housing, food insecurity or transportation and ultimately ensuring a smoother handoff to primary care providers or community treatment programs and community-based pharmacies. To promote sustainability and long-term impact, this intervention will be embedded into THONE's organizational policies, strengthening patient retention in care and supporting better health outcomes across the system.

This initiative also is modeled after THONE's successful integration of community health workers (CHWs) and hospital-based violence intervention specialists with lived experience into its care delivery to address health-related social needs. This approach has ensured meaningful post-discharge connections to resources and sustained support. It also has demonstrated effectiveness in reducing recidivism and reinjury among individuals involved, as well as improving outcomes for patients with uncontrolled chronic conditions.

Impacts and Implications

THONE expects the initiative to lead to measurable improvements in patient retention in MOUD treatment post-discharge. By integrating PSS into the discharge process, THONE is working to ensure patients can receive more relatable, personalized support that reduces barriers to continuing care. Strengthening community partnerships can further enhance continuity of care for patients as well by increasing access to treatment resources and reducing the likelihood of return to use.

As a result of these efforts, THONE also anticipates improved patient outcomes, including higher engagement in treatment programs, reduced hospital readmissions, and overall better health and well-being for individuals struggling with OUD and/or StUD.

By integrating PSS into its patient care protocol, THONE is providing clinicians with new ways of engaging with patients with OUD and/or StUD.

RESOURCES

The contents below do not necessarily represent the official views of CDC or the Department of Health and Human Services, and should not be considered an endorsement by the Federal Government.

FOR INPATIENT CARE

Care Delivery Models

- Toward a Consensus on Strategies to Support Opioid Use Disorder Care Transitions Following Hospitalization: A Modified Delphi Process
- Hospital Addiction Consultation Service and Opioid Use Disorder Treatment
- Expert Panel Consensus on the Effectiveness and Implementation of Models to Support Posthospitalization Care Transitions for People With Substance Use Disorders
- Hospital-based opioid treatment: Expanding and sustaining the model in Texas
- The Support Hospital Opioid Use Disorder Treatment (SHOUT) Texas program implementation strategy for expanding treatment for hospitalized adults with opioid use disorder
- Caring for Hospitalized Adults With Opioid Use Disorder in the Era of Fentanyl: A Review
- Hospital Standards of Care for People with Substance Use Disorder
- Caring for Hospitalized Adults with Methamphetamine Use Disorder: A Proposed Clinical Roadmap
- Integrating Hospital-Based Harm Reduction Care-Harnessing the Nursing Model
- "We've Learned It's a Medical Illness, Not a Moral Choice": Qualitative Study of the Effects of a Multicomponent Addiction Intervention on Hospital Providers' Attitudes and Experiences
- Adapting Contingency Management for Hospitalized Patients with Stimulant Use Disorder

MOUD Initiation

- The development and implementation of a "B-Team" (buprenorphine team) to treat hospitalized patients with opioid use disorder
- Hospital Buprenorphine Program for Opioid Use Disorder Is Associated With Increased Inpatient and Outpatient Addiction Treatment
- Low-dose Buprenorphine Initiation in Hospitalized Adults With Opioid Use Disorder: A Retrospective Cohort Analysis
- Rapid Low-dose Buprenorphine Initiation for Hospitalized Patients With Opioid Use Disorder

FOR PRIMARY CARE

- Primary Care–Based Models for the Treatment of Opioid Use Disorder: A Scoping Review
- Post-hospitalization Care Transition Strategies for Patients with Substance Use Disorders: A Narrative Review and Taxonomy
- Contingency Management for Patients Receiving Medication for Opioid Use Disorder: A Systematic Review and Meta-Analysis

FOR PHARMACEUTICAL CARE

- Emergency Clinician Buprenorphine Initiation, Subsequent Prescriptions, and Continuous Prescriptions
- The Pharmacy Access to Resources and Medication for Opioid Use Disorder (PhARM-OUD) Guideline: A Joint Consensus Practice Guideline from the National Association of Boards of Pharmacy and the National Community Pharmacists Association
- Physician-Delegated Unobserved Induction with Buprenorphine in Pharmacies

GENERAL OUD/STUD RESOURCES

- American Hospital Association Opioid Stewardship Hub
- American Society of Addiction Medicine
- Bridge to Treatment: Resource Library
- CA Bridge Substance Use Navigation Toolkit
- CA Bridge Guide: Clinical Considerations For Order Sets, Prescribing Buprenorphine (Bup) in the Acute Care Setting
- CA Bridge Blueprint for Hospital Opioid Use Disorder Treatment
- Support Hospital Opioid Use Disorder Treatment (SHOUT) Texas Resource Library
- SAMHSA: Federal Guidelines for Opioid Treatment Programs – 2024
- SAMHSA: Incorporating Peer Support Into Substance Use Disorder Treatment Services (TIP 64)