TRANSFORMING CARE

Insights from Social Medicine in Opioid Use Disorder Treatment

ESSENTIAL HOSPITALS INSTITUTE

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About America's Essential Hospitals

America's Essential Hospitals is the leading association and champion for hospitals dedicated to high-quality care for all, including those who face social and financial barriers to care. Since 1981, America's Essential Hospitals has advanced policies and programs that promote health and access to health care. We support our more than 350 members with advocacy, policy development, research, education, and leadership development. Communities depend on essential hospitals for care across the continuum, health care workforce training, research, public health, and other services. Supported by Essential Hospitals Institute, the association's research and education arm, essential hospitals innovate and adapt to lead all of health care toward better outcomes and value. Learn more at **EssentialHospitals.org**.

About Essential Hospitals Institute

Essential Hospitals Institute leads research, education, dissemination, and leadership development for America's Essential Hospitals. To advance the quality, safety, and affordability of care at essential hospitals, the Institute identifies promising practices in the field, provides professional development training, promotes practice improvements, and disseminates innovative approaches to care. It does this with an eye toward improving individual and population health through community-integrated health care.

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KEY TERMS

Addiction Specialist: A medical doctor who specializes in diagnosing, treating, evaluating, and preventing addiction.[1]

Case Manager: A health care professional who supports and speaks on behalf of patients and their families, providing guidance and care coordination. Case managers often manage patient communications with other health care team members.[2]

Community-Integrated Health Care: A strategy by which health care providers work with other sectors (e.g., government, social service) in both complementary and collaborative ways to improve health; meet the physical, mental, and social needs of individuals; and improve the structures and conditions that influence those needs.[3]

Harm Reduction: An evidence-based approach to engaging people who use drugs to prevent overdose and disease transmission. Harm reduction focuses on community-driven strategies such as prevention, risk reduction, and health promotion to help people live healthy lives.[4]

Medication-Assisted Treatment (MAT): The combination of medication, counseling, and behavioral therapies for the treatment of substance use disorders.[5]

Medications for Opioid Use Disorder (MOUD): A type of treatment approach that uses Food and Drug Administration–approved medications (buprenorphine, methadone, and naltrexone) to treat people diagnosed with opioid use disorder.[6]

Office-Based Addiction Treatment (OBAT): An outpatient treatment approach that provides medication-assisted treatment, individual and group therapy, education, general medical care, and connections to resources for people diagnosed with opioid use disorder.[7]

Opioid Use Disorder (OUD): The chronic use of opioids that causes significant distress or impairment.[8]

Recovery Specialist: An individual who has experienced and overcome challenges related to substance use or mental illness and has received specialized training to support others in their recovery from similar issues.[9] Also known as a certified recovery specialist or peer recovery specialist.

Social Determinants of Health (SDOH): Nonmedical factors that influence health outcomes, including the conditions in which people are born, grow, work, live, worship, and age.[10] Sometimes referred to as social drivers of health or health-related social needs.

Social Medicine: An approach to health care that investigates and manages the effects of socioeconomic factors on health and disease.[11]

Social Worker: A professional who helps individuals, groups, and families prevent and manage challenges in their lives. A licensed clinical social worker diagnoses and treats mental, behavioral, and emotional conditions.[12]

Substance Use Disorder (SUD): A mental disorder that affects the brain and behavior, causing an uncontrolled use of legal or illegal substances such as drugs, alcohol, or medications.[13]

INTRODUCTION

Challenges Facing Individuals with Opioid Use Disorder

Individuals with substance use disorders such as opioid use disorder (OUD) cite complex reasons for neglecting to seek treatment. Studies show stigma, fear, financial limitations, legal issues, and cultural disconnects are common barriers to treatment.[14]

In seeking health care, including OUD treatment, underserved communities often face complex social factors that influence not only their ability to access care but also their ability to achieve successful outcomes. People in rural areas might have low access to providers, lack of financial resources, and limited knowledge of treatment options.[15] Women report a lack of or limited child care, potential loss of child custody, partner violence, and gender-specific stigma as obstacles to engaging in OUD treatment programs.[16]

Many communities are experiencing a dramatic rise in OUD and overdose deaths but receiving less treatment, largely due to avoidable social and environmental stressors. Gaps in treatment access and outcomes highlight the importance of targeting the social determinants of health (SDOH) that affect a patient's ability to engage meaningfully in care.[17]

By using social medicine in addiction and OUD treatment, essential hospitals can create a stable foundation for patients, improving their chances of long-term recovery.

The Value of Social Medicine

To successfully manage and engage the many kinds of patients in OUD treatment, programs must use a holistic approach that acknowledges the whole person and encompasses challenging aspects of an individual's life.

Social medicine seeks to understand how social, economic, and environmental factors affect health. It aims to improve the way these factors influence overall well-being. Incorporating social medicine into OUD treatment initiatives can increase successful outcomes by treating patients and their complex social needs comprehensively and coordinately.

The Role of Essential Hospitals

Essential hospitals are exceptionally positioned to improve health outcomes for patients disengaged in OUD treatment, as they already have a significant presence and commitment to care in communities most affected by the condition.

Essential hospitals provide care to all, regardless of their economic and social circumstances. Although essential hospitals account for only 5% of all acute-care hospitals in the United States, they provide over 28% of all charitable care.[18] These institutions are on the front lines, providing critical care, economic stability, and community-integrated health care to areas that have experienced long-standing structural barriers and gaps in opportunity. Approximately 75% of patients treated at essential hospitals in 2021 were uninsured or covered by Medicaid or Medicare.[19]

Economic Needs in Essential Communities

13M

PEOPLE IN OUR COMMUNITIES LIVE BELOW THE POVERTY LINE

9.3M

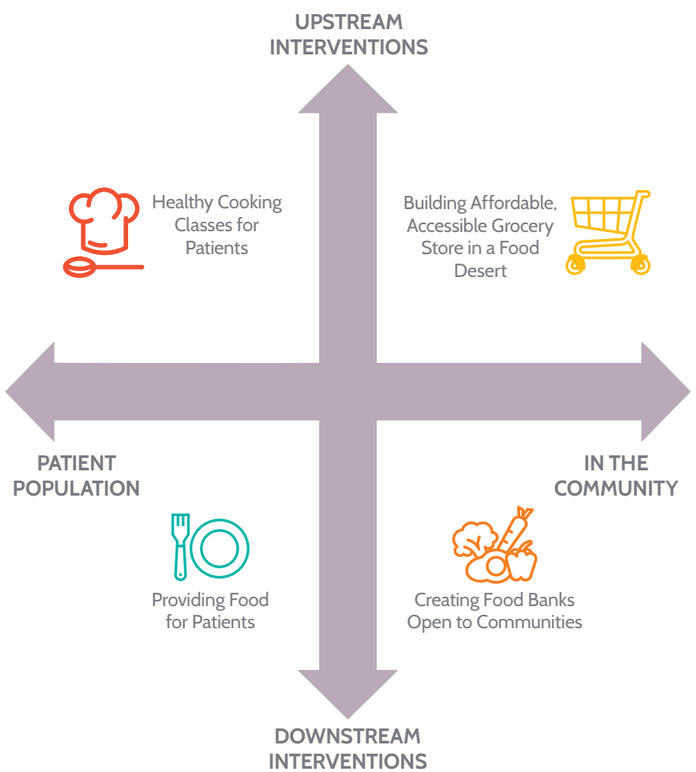
PEOPLE IN OUR COMMUNITIES HAVE NO HEALTH INSURANCE

Source: Miu R, Kelly K, Nelb R. *Essential Data 2024: Our Hospitals, Our Patients–Results of America's Essential Hospitals 2022 Annual Member Characteristics Survey.* America's Essential Hospitals. December 2024. **essentialdata.info**. Accessed Aug. 20, 2025.

Essential hospitals reduce care limitations by meeting patients where they are in the community. They offer treatment through:

- Federally qualified health centers
- Rural health clinics
- Outpatient clinics
- Mobile clinics
- Telehealth services

The Continuum of Community-Integrated Care



The interventions included in the continuum graphic are just examples of myriad interventions that could be implemented at different points of the continuum scale.

Source: America's Essential Hospitals. *Outside the Hospital Walls: An Update on Essential Hospitals' Efforts to Improve the Health of Their Communities*. December 2019. **https://essentialhospitals.org/wp-content/uploads/2020/01/EHI-CIHC-Progress-Report-December-2019.pdf**. Accessed July 21, 2025.

Social Needs in Essential Communities

327,897

PEOPLE ARE EXPERIENCING HOMELESSNESS IN OUR COMMUNITIES

5.9M

PEOPLE SERVED BY ESSENTIAL HOSPITALS HAVE LIMITED ACCESS TO HEALTHY FOOD

Source: Miu R, Kelly K, Nelb R. *Essential Data 2024: Our Hospitals, Our Patients–Results of America's Essential Hospitals 2022 Annual Member Characteristics Survey.* America's Essential Hospitals. December 2024. **essentialdata.info**. Accessed Aug. 20, 2025.

PROJECT DESCRIPTION

From October 2023 to October 2024, Essential Hospitals Institute, in partnership with the CVS Health Foundation, helped nine essential hospitals enhance social medicine efforts within established OUD treatment programs. Each program examines the complex social factors affecting many patients with OUD and makes OUD treatment more consistent for traditionally overlooked communities.

This learning collaborative offered a consistent virtual community for addiction medicine providers, including:

- Emergency medicine physicians
- Behavioral health directors
- Licensed clinical social workers
- Population health nurses
- Chief clinical officers

Together, this cohort learned how different and intersecting social factors limit access to OUD care and gained successful strategies to overcome these barriers.

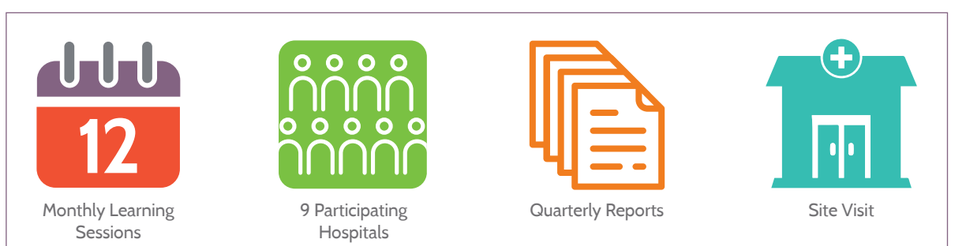
This cohort is the second of three yearlong virtual learning collaboratives under the Improving Opioid Use Disorder Treatment at Essential Hospitals grant. Results from the first learning collaborative, **Transforming Care: Insights from Essential Hospitals Institute's Office-Based Addiction Treatment Initiative**, helped the Institute develop this and the subsequent collaboratives under this grant. The Institute will publish a final report with findings from the third learning collaborative, also focused on social medicine, at the grant's conclusion.

Project Activities

During the learning collaborative, participants engaged in monthly peer-to-peer training facilitated by Rahul Vanjani, MD, medical director of Amos House. Amos House is a nonprofit agency providing food, social services, employment, and job training to people who are unhoused, unemployed, and experiencing poverty in Rhode Island.

Most trainings were virtual. These sessions focused on:

- Managing social needs within clinical operations
- Reducing stigma about OUD care
- Engaging and retaining patients experiencing extreme hardships in care
- Lowering impediments to care and harm reduction
- Gaining organizational support for social medicine interventions within OUD treatment programs



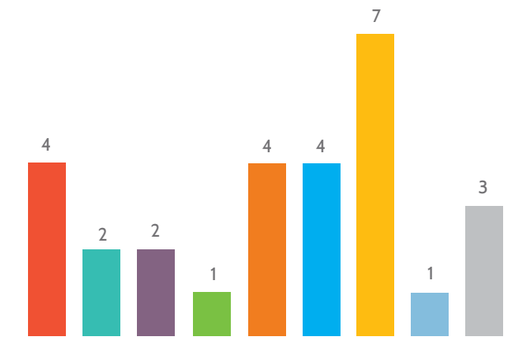
In January 2024, participants attended a full-day, in-person training at Amos House. This training centered on the intersection of justice involvement and OUD care. Participants learned best practices for providing trauma-informed care for justice-involved patients and shared challenges connecting this population to community resources to reduce relapse and recidivism.

Each hospital submitted quarterly reports providing performance data and a qualitative report of how the sessions informed their application. In the final learning collaborative session, the hospitals provided best practices and lessons learned from enhancing their programs, which are detailed in the Findings section of this report.

Overview of OUD Services at Grantees

Our grantees provide comprehensive OUD care to a broad patient population.

NUMBER OF SITES OFFERING OUD TREATMENT DURING THE GRANT PERIOD PER PARTICIPATING MEMBER HOSPITAL



TYPES OF SITES WHERE DELIVERY OF OUD SERVICES/CARE WAS OFFERED DURING THE GRANT PERIOD

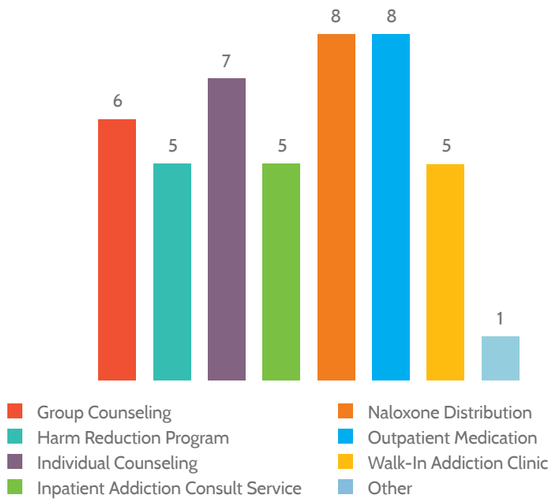
Participating hospitals provided substance use disorder (SUD) services that included:

- Inpatient medication-assisted treatment (MAT)
- Outpatient medications for opioid use disorder (MOUD) treatment
- Walk-in addiction clinic services

Almost all grantees implemented harm reduction interventions, which reduce harm and improve the safety and well-being of people who use drugs. Interventions included naloxone distributions, needle exchange programs, and distribution of fentanyl test strips. One hospital's programming included a mobile suboxone clinic and an office-based opioid therapy clinic to meet patients' complex needs.

Grantees also offered a combination of group counseling, individual counseling, case management, and behavioral health support.

TYPE OF OUD RESOURCES PARTICIPATING HOSPITALS PROVIDED



Number of Patients Who Initiated Treatment

30,409

USING GRANT FUNDING TO MEET SOCIAL NEEDS

Participating hospitals used grant funding to directly improve patients' social determinants of health, including by:

- **Purchasing gift cards from local community vendors to help patients obtain cellphones**
- **Covering the cost of rideshare and public transit vouchers**
- **Purchasing harm reduction medications**
- **Investing in enhanced staff training, education, and resources**
- **Developing and distributing public outreach materials, such as billboards and business cards**
- **Funding temporary placement in recovery beds for patients experiencing homelessness**

PROGRAM SUMMARIES

ALAMEDA HEALTH SYSTEM FOUNDATION, Oakland, California

ALAMEDA HEALTH SYSTEM BRIDGE CLINIC

Alameda Health System (AHS) is a leading public health care provider and training institution serving Alameda County, Calif. The Alameda Health System Bridge Clinic, a partner of the Public Health Institute's California Bridge Program, provides low-barrier outpatient SUD treatment services. It also provides acute care consultation to three acute-care hospitals within AHS.

The clinic serves patients who are overwhelmingly from underserved communities, including a high Black and Hispanic population, pregnant people, people living with HIV/AIDS, and LGBTQ+ people. Almost all patients are on government health insurance, primarily managed by Medi-Cal, California's Medicaid program. Many are victims of trauma and violence, have co-occurring behavioral health conditions, and experience significant obstacles to treatment. To address these needs, the clinic is co-located with an intensive outpatient program and behavioral health services at Highland Hospital, where most AHS patients receive OUD treatment.

The clinic provides services including case management, behavioral health support, and MOUD treatment using a low-threshold harm reduction model. It connects patients to pharmacy and prescription services and offers withdrawal crisis support. A warm-line, available Monday through Friday from 9 am to 5 pm, allows patients to connect with a clinic substance use navigator. The warm-line received over 25,000 calls in the first six months, averaging about 100 calls daily.

To improve OUD treatment access, adherence, and outcomes, the clinic aims to break down structural resource barriers and address the social needs that prevent patients from accessing OUD treatment. As part of this collaboration, the clinic purchased over 500 $20 gift cards from a community vendor to provide patients with phones. This increased patient access to telehealth services and the warm-line. The clinic plans to continue purchasing phones and to provide transportation services.

BERGEN NEW BRIDGE MEDICAL CENTER, Paramus, New Jersey

EVERGREEN SUBSTANCE ABUSE TREATMENT PROGRAM

As a hospital filling a safety net role, Bergen New Bridge Medical Center (BNBMC) provides immediate, barrier-free access to primary care and specialized medical services, regardless of a patient's ability to pay. The Evergreen Substance Abuse Treatment Program, housed under the Center for Comprehensive Addiction Treatment (CCAT) at BNBMC, is a flexible and comprehensive SUD treatment program tailored to patient needs.

BNBMC provides extensive services, including inpatient withdrawal management and short-term residential treatment. BNBMC also provides outpatient services such as MAT and office-based addiction treatment. The program promotes access to inpatient services for New Jersey Medicaid and Medicare patients.

OUD treatment staff work to create a welcoming environment at Bergen New Bridge Medical Center.

CCAT includes a Peer Recovery Center, which provides services for people in recovery made by people in recovery. The Peer Recovery Center provides nonjudgmental peer support in a safe environment. It links patients to social agencies, such as the New Jersey Reentry Corporation, for housing, legal, and employment services.

Targeting individuals aged 18 and older, BNBMC has expanded capacity by hiring a psychiatrist specializing in addiction medicine and by incorporating primary care into outpatient services. These changes improve overall health care delivery and remove stigma. Since increasing services, BNBMC started treating patients with Hepatitis C, sexually transmitted diseases, and diabetes. It now provides medications for HIV and other comorbid medical conditions that were left untreated.

Despite challenges, such as limited space and ongoing stigma about SUD, the program trains clinicians and peer recovery specialists on cultural competency, LGBTQ+ issues, and trauma. This training improves and refines treatment by helping providers better understand how client intersectionality, social barriers, and economic hardship can compound co-occurring problems.

The program also trains clinicians on safe spaces, helping them provide a welcoming and empathetic environment for LGBTQ+ people and patients with legal issues or previous felony charges, who might feel they have limited resources.

CHESAPEAKE REGIONAL MEDICAL CENTER, Chesapeake, Virginia

PREVENTION AND RECOVERY IN OPIOID USE DISORDER (PROUD) PROGRAM

Chesapeake Regional Medical Center's Prevention and Recovery in Opioid Use Disorder (PROUD) program initiates buprenorphine-based MAT in the emergency department (ED) through the Screening, Brief Intervention, and Referral to Treatment model.

PROUD begins when patients are admitted to the ED with clear signs of opioid use. The ED integrates SDOH screening into the patient assessment process. After assessment, patients in the program work with ED physicians to create a treatment plan. This plan might include MAT to help with withdrawal side effects.

To continue treatment, the hospital connects patients to an outpatient community partner, with guaranteed follow-up within 72 hours after ED release. Most PROUD program participants are uninsured and struggle with SDOH, but patients are not turned away due to financial limitations.

To increase awareness of the services offered, Chesapeake placed QR codes on business cards and community billboards. These provide easy access to resources and connect patients with partners offering OUD and SDOH services. SUD treatment resources also are available on the program's website.

In partnership with Eastern Virginia Medical School, the program provides tailored training to ED physicians to reduce stigma and improve best practices. To increase buy-in, Chesapeake offers continuing medical education credits and training reimbursements to all participating clinicians. The program also partners with the hospitalist and emergency medical services teams to provide care through a mobile clinic.

Despite challenges with marketing and staff turnover, the program continues to evolve. Future enhancements aim to reduce reliance on ED visits by expanding partnerships with outpatient clinics and increasing mobile outreach efforts.

PARKLAND HEALTH, Dallas, Texas

JAIL RELEASE PROGRAM

Through its Correctional Health Department, Parkland Health serves as the medical provider for the Dallas County Jail. The health system offers more than 165 outpatient specialty and subspecialty clinics on its main campus, and it operates an extensive mobile health program to care for underserved people and people experiencing homelessness in Dallas County.

The Jail Release Program links MAT patients recently released from the Dallas County Jail to community-based care. Parkland Health collaborates with community-based organizations and the Dallas County Jail correctional health team, which consists of a nurse navigator, a referral coordinator, peer navigators, and social workers. Together, they developed a release workflow and referral hub. This referral hub helps patients transition back to the community by linking them with transitional housing, health insurance, pharmacy assistance, food pantries, career planning and placement, social support networks, and transportation through rideshare companies and bus passes. These services remove roadblocks to reentry into society for individuals who experience social barriers to health.

Parkland Health's medical team on site at the Dallas County Jail screens inmates at intake. Those who are positive for SUD are connected to this program, excluding those with no release date and those who will be transferred to other facilities. The program's relationship with the jail's correctional health team has been key to its success. Parkland Health staff recently were granted access to the jail, allowing direct patient engagement, improved data collection, and targeted needs assessments.

TAMPA GENERAL HOSPITAL, Tampa, Florida

BUILDING RECOVERY INTEGRATION FOR DRUG USERS INTO EMERGENCY MEDICINE (BRIDGE)

Tampa General Hospital's Building Recovery Integration for Drug Users into Emergency Medicine (BRIDGE) program offers a range of services, including a mobile suboxone clinic, an office-based opioid therapy clinic, mental health and substance use counseling, and essential wraparound services. These services improve postdischarge outcomes, decrease readmissions, and shorten the length of hospital stays while providing world-class care to adults with OUD.

The BRIDGE program has a strong community influence. The hospital collaborates with the Hillsborough Housing Authority to help patients find housing stability and works with local food banks to mitigate food insecurity through mobile pantry days. The program also opened Florida's second legal syringe exchange, which treats over 2,000 patients.

Recently, the BRIDGE program engaged a volunteer attorney. The attorney provides free consultations to patients facing legal challenges that can hinder recovery program engagement. The program plans to develop an inpatient addiction consultation service, create a social medicine fellowship with an addiction and toxicology focus, and address the co-occurring mental health needs of both patients and peer recovery specialists to prevent burnout and promote long-term success.

Hospital OUD team members offer naloxone at a community health event.

TEMPLE UNIVERSITY HOSPITAL, Philadelphia, Pennsylvania

A WHOLE-PERSON APPROACH TO TREATING A MARGINALIZED POPULATION

Temple University Hospital provides MAT for addiction patients through the ED and formed a substance use disorder engagement team to ensure proper follow-up of patients after ED discharge. With a focus on quickly getting patients to the appropriate level of care, the hospital created an advanced recovery plan for patients with OUD who are being discharged from emergent settings. Certified recovery specialists (CRSs), who have lived experience with OUD, support patients on their recovery journey. Temple enhanced the CRS role in connecting patients to addiction care and housing–a significant challenge in the hospital's community.

The hospital places CRSs in the ED, where they work with patients to complete a postdischarge advanced recovery plan. CRSs have clear directions on how to prioritize and overcome identified obstacles and how to make appointments for follow-up and assessment of patients' physical health, behavioral health, SDOH, and substance use.

The program integrates individualized recovery plans into the CRS workflow to ensure tailored patient support. It also partners with an external training initiative to offer a residency program that prepares CRSs for their roles by exposing them to the job before they start.

The program increased medium-term patient housing through collaboration with citywide grants, large hospitals, and Project HOME (Housing, Opportunities for Employment, Medical Care, and Education). Temple has also partnered with the city of Philadelphia to secure same-day placement for recovery beds and expanded its network of inpatient rehab partners.

THE METROHEALTH SYSTEM, Cleveland, Ohio

PRIMARY CARE MOUD EXPANSION

The MetroHealth System consists of 21 primary care clinics that provide high-quality service to uninsured, underinsured, and underserved people in Cleveland, one of the poorest large cities in the United States.

MetroHealth has been at the forefront of the opioid crisis. The Office of Opioid Safety recognized MetroHealth for its leadership in overdose prevention. This included internal prevention through opioid stewardship initiatives and external prevention through naloxone distribution and community education and advocacy.

The program increases access to MOUD by integrating MOUD clinics that offer treatments such as suboxone into primary care settings. It operates in three primary care clinics. Two of these primarily serve Hispanic patients, and one serves a high Black patient population, making minority groups a focus for treatment.

To develop an addiction-informed clinic, staff received education on recognizing and screening for addiction, providing a nonjudgmental approach to treatment, and understanding the social challenges that patients with OUD face, particularly in racial and ethnic minority populations. Provider training also included one-on-one training with each primary care provider (PCP) in each clinic. This training supports the PCPs while they are in the clinic to ensure they integrate MOUD care seamlessly during visits.

Providers showed strong interest in MOUD training. MetroHealth trained all its integrated behavioral health staff on the American Society of Addiction Medicine levels of care framework to improve patient access and increase referrals for higher-level treatment when needed. Despite challenges, the program successfully increased the number of patients receiving buprenorphine and other MOUD at all primary care sites.

UMASS MEMORIAL HEALTH, Worcester, Massachusetts

ROAD TO CARE MOBILE ADDICTION SERVICE

As one of the nation's most distinguished academic health care systems, UMass Memorial Health, in Worcester, Mass., provides a wide range of programs. It offers both health care and health-related services to uninsured, Medicaid, and other economically and socially disadvantaged populations regardless of the patient's ability to pay. Services include mental health treatment, inpatient and outpatient substance use disorder treatment, and inpatient and ED access to MOUD.

The UMass Memorial Road to Care Mobile Addiction Service, a state-funded program, is a street medicine program that offers walk-up addiction care in the city of Worcester. It focuses on the needs of patients experiencing homelessness. The program aims to reduce opioid-related morbidity and mortality by offering mobile addiction services, including treatment for OUD. For individuals experiencing housing insecurity, the Mobile Addiction Service provides free care, including prescribing suboxone and distributing naloxone kits in encampments, shelters, and food pantries.

The Mobile Addiction Service can serve up to 30 patients in one afternoon session, ensuring that care reaches all populations where they are. More than 2,000 individuals have accessed the Road to Care Mobile Addiction van in over 11,000 encounters since May 2021. Of the patients treated by the program, 61.1% identify as white, 11.4% identify as Black, and 20% identify as Hispanic.

The program assembled a team of interdisciplinary experts that included professionals in psychiatry, emergency medicine, and hospital medicine, as well as individuals with lived experience. The team developed an overarching strategy to provide compassionate care and withdrawal management to patients experiencing aggressive pain with OUD. This clinical resource toolkit will train providers on initiating and continuing opioid agonist treatment, using adjunct therapies to treat pain, and addressing stigma. Future enhancements include expanding and measuring these educational efforts to improve hospitalwide understanding and treatment of OUD patients.

UVA HEALTH, Charlottesville, Virginia

SOCIAL MEDICINE AND OUTREACH ENHANCEMENT IN UVA'S ADDICTION MEDICINE CLINIC

Serving patients across Virginia without limitations on distance, insurance, age, or substances used, the University of Virginia (UVA) Addiction Medicine Clinic serves individuals with substance use disorders. The multidisciplinary team includes addiction psychiatrists, physicians, social workers, and nurses. It offers recovery services and supports including medication management, therapy, relapse prevention, overdose education, and care coordination. These services address the complex needs of individuals with substance use disorders regardless of race, gender, and socioeconomic status.

In addition to clinical care, the program addresses patients' social needs. It offers sober living housing support and aid with transportation and food. The clinic collaborates with local community organizations to provide additional support, connect individuals to services, or coordinate a higher level of care.

The program has accomplished significant milestones, including increasing addiction treatment staff and launching a street medicine program that provides services for people experiencing homelessness. The street medicine program focuses on social medicine, providing treatment services to individuals where they are in the community.

Challenges have included delays in securing Intensive Outpatient Program (IOP) licensing and pushback from community service boards regarding placing a comprehensive harm reduction vending machine. In addition to putting the vending machine in an ideal community location, future plans focus on enrolling new patients in the IOP and expanding staff to further enhance community outreach, ensuring services reach those in need outside the hospital setting.

Embedded in UVA's health system, the clinic hosts medical students, residents, and fellows from various specialties to teach culturally appropriate levels of OUD care for a broad patient population. The clinic offers onsite training and e-consults to medical providers who request guidance on treating addiction needs in their clinics.

FINDINGS

Screening and Intervention for Social Medicine

Essential hospitals use screening tools, peer support, and coordinated resources to manage the social factors that influence OUD treatment access and retention. Participants reported specific barriers experienced by patients seeking OUD treatment.

Patients Screening Positive for Social Needs

27,187
PATIENTS SCREENED POSITIVE FOR HOUSING INSTABILITY

25,386
PATIENTS SCREENED POSITIVE FOR FOOD INSECURITY

29,204
PATIENTS SCREENED POSITIVE FOR LACK OF ACCESS TO RELIABLE TRANSPORTATION

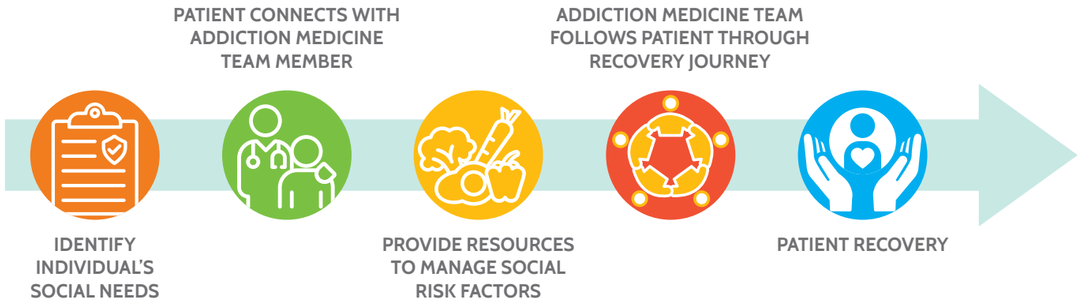
2,581
PATIENTS SCREENED POSITIVE FOR NEED OF LEGAL ASSISTANCE

To identify patients' social needs, all grantees used SDOH screening tools at a patient's first entry point into the hospital or health system. Screening tools included:

- A "social determinants wheel"
- The Screening, Brief Intervention, and Referral to Treatment model
- American Society of Addiction Medicine assessments
- Direct documentation of patient history at initial intake

These tools help program leaders develop individualized treatment plans and connect patients to social support services.

Once a program identifies an individual's social needs, it connects the individual to an addiction medicine team member, such as a care navigator or peer recovery specialist. This team member provides internal and external resources to manage the patient's social risk factors. Addiction medicine team members stay with the patient throughout their recovery journey, providing consistent check-ins and following up with them in their community.



Common Challenges Managing Social Needs for Patients in OUD Treatment

Participants reported several obstacles to managing social factors for patients in OUD treatment.

COMPLEX PATIENTS STRUGGLE TO ENGAGE IN CARE FOR LONG ENOUGH.

Grantees experienced challenges in treatment continuity. They struggled to engage patients in long-term treatment programs, with many patients stopping before the program could tackle their social needs. This delayed or prevented grantees from linking patients to needed social support.

One hospital had trouble establishing and maintaining trust between patients and care providers, especially after the patients left their correctional health program. The hospital reported this was because patients provided incomplete contact information and demonstrated an overarching mistrust of health care providers.

In response, the hospital placed a peer navigator within the correctional facility. Having lived experience with substance use and recovery, the peer navigator engages inmates directly, building trust and rapport before release.

HOSPITALS LACK INFRASTRUCTURE TO SUPPORT COMMUNICATION BETWEEN DEPARTMENTS AND ORGANIZATIONS.

Without strong communication and collaboration between health care providers and external social support teams, such as housing services, patients might disengage from recovery services. This could undermine any stability gained from social support. Poor communication between hospital divisions also disrupts referrals, hindering care continuity.

To solve this, grantees initiated regular communication through monthly virtual meetings or quarterly site visits between divisions and organizations such as:

- Medical service departments
- Community housing partners
- Transportation entities
- Jail release staff

This helped grantees identify when patients needed medical, behavioral health, or mental health intervention or immediate social support. Strong and consistent communication between all medical service teams and social support providers keeps patients engaged in recovery treatment.

> **"Within our organization, [the grant] deepened our interdepartmental collaboration by aligning our team around shared goals for addressing social determinants of health. This alignment fostered more cohesive workflows between clinical staff, mental health providers, and peers, all working together to provide holistic care."**
>
> –Learning collaborative participant

HOSPITALS EXPERIENCE STAFF SHORTAGES.

Insufficient staffing at all levels reduced patient access to necessary support and created long wait times for referral services. One hospital didn't have enough case managers, which hindered its ability to connect patients to social services outside mental health and primary care.

To solve staffing challenges, grantees hired and trained experienced staff at all levels to provide integrated care. Positions included:

- Addiction specialists
- Case managers
- Opioid specialist paramedics
- Social workers
- Other licensed professionals

Grantees also hired recovery specialists with lived experience. These team members build rapport with patients who express apprehension about treatment, and they enable care continuity. Recovery specialists also connect patients to community partners for social support when necessary, alleviating patient wait times.

Strategies for Managing Social Needs for Patients in OUD Treatment

SUCCESSFUL STRATEGIES SOLVE ROOT CAUSES OF TREATMENT AND RECOVERY CHALLENGES.

Grantees used several tools to alleviate food insecurity, transportation instability, housing instability, and the legal needs of patients seeking OUD treatment:

- Grocery store gift cards, referrals to local food banks, connections to food as medicine programs, and food vouchers
  - Access to nutritious food reduces a potential stressor that can hinder sustained recovery.
- Transit vouchers, gas gift cards, partnerships with rideshare companies, and collaborations with local transportation service providers

- Reducing transportation barriers helps patients stay engaged in consistent treatment, aiding in care continuity and retention.

- Partnerships with local housing organizations and connections with housing programs focused on substance use recovery
  - Safe and stable housing is important in recovery. Studies have linked secure living environments such as sober living homes to improved mental health, fewer instances of relapse, and higher patient engagement.[20]
  - One example is funding from the Housing Opportunities for Persons with AIDS program, which provides stable housing options specifically for patients living with HIV. This program recognizes the intersection of stable housing and treatment adherence.

- Partnerships with volunteer lawyers who provide free consultations and assist with housing disputes, custody matters, immigration concerns, and other legal issues
  - Patients with OUD sometimes experience legal and justice needs that can keep them from engaging in continuous care, so some grantees partnered with local legal providers to assist patients requesting this service.

These varying strategies demonstrate our members' commitment to treating OUD in a comprehensive fashion that manages both the addiction and underlying social factors. By providing social resources, essential hospitals reduce roadblocks to treatment success and create a more solid foundation for patients to fully engage in care.

INTERNAL COLLABORATION ENABLES A SOCIAL MEDICINE APPROACH TO OUD CARE.

To align and streamline workflows, internal departments such as behavioral health, nursing, case management, and community outreach must commit to collaboration and a shared goal. For grantees, these commitments have led to improved communication, care transitions, and patient outcomes. Participants also reported that collaboration with internal legal departments can bridge logistical gaps and clarify a program's capabilities and limitations, making intervention more accurate and efficient.

Learning collaborative participants engage patients through street outreach during a site visit in Providence, R.I.

> **"Beyond treatment, we addressed critical social determinants that impact recovery, such as housing support, food security, reliable transportation, and legal assistance. By linking patients to these essential services, the program helped to reduce barriers that often hinder long-term recovery, reinforcing a holistic approach to substance use disorder treatment. Qualitative feedback further supports the program's success. Patients reported improvements in quality of life, access to care, and a sense of support throughout their treatment journey."**
>
> –Learning collaborative participant

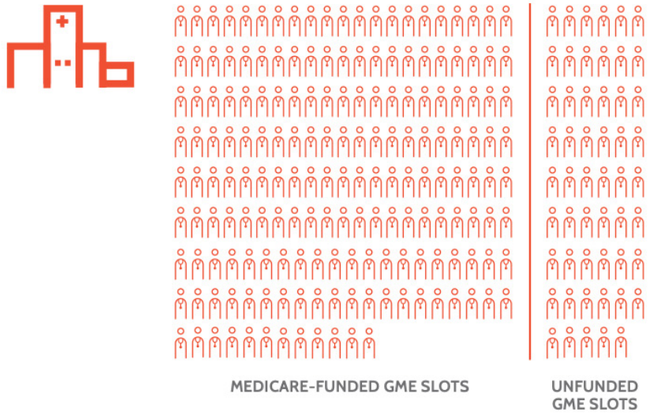
Multidisciplinary teams, including social workers, addiction specialists, case managers, and recovery specialists, are needed to provide integrated OUD care. Each member is vital to creating a healthy recovery environment for all patients.

To create successful multidisciplinary teams, hospitals should hire and recruit staff with lived experience. Training staff on MOUD and ASAM criteria for addiction care gives staff the skills needed to treat patients appropriately.

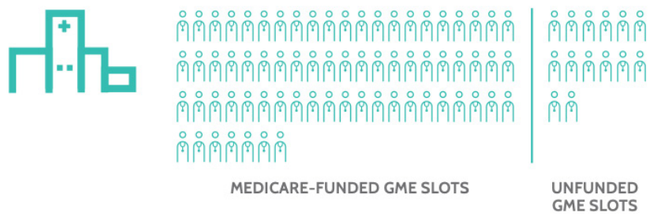
Because essential hospitals administer high-quality care to all, on average they train three times as many physicians as other U.S. teaching hospitals. This helps them meet the needs of underserved populations, including people in rural areas. Many essential hospitals invest resources of their own to cultivate the future workforce.[21]

Number of Trained Physicians

MEMBER TEACHING HOSPITALS TRAINED AN AVERAGE OF 231 PHYSICIANS IN 2022, WHICH WAS 30 PERCENT HIGHER THAN THEIR MEDICARE GRADUATE MEDICAL EDUCATION (GME) FUNDING CAP.



OTHER U.S. TEACHING HOSPITALS TRAINED AN AVERAGE OF 84 PHYSICIANS IN 2022, WHICH WAS 19 PERCENT HIGHER THAN THEIR MEDICARE GME FUNDING CAP.



Source: Miu R, Kelly K, Nelb R. *Essential Data 2024: Our Hospitals, Our Patients–Results of America's Essential Hospitals 2022 Annual Member Characteristics Survey.* America's Essential Hospitals. December 2024. **essentialdata.info**. Accessed Aug. 20, 2025.

COLLABORATING WITH COMMUNITY-BASED ORGANIZATIONS ALLOWS HOSPITALS TO OFFER INTEGRATED CARE.

To manage the dual challenges of addiction and complex medical needs, hospitals should partner with community-based organizations (CBOs) and other external entities to ensure that patients receive integrated care. This structure allows hospitals to effectively manage medical complexities alongside addiction treatment, contributing to better patient outcomes.

> **"Externally, the grant allowed us to build and strengthen relationships with key community partners for housing, food security, and legal aid. … These partnerships have allowed us to provide more comprehensive support and have increased our program's positive impact on patient outcomes, highlighting the value of sustained collaboration for long-term success."**
>
> –Learning collaborative participant

Grantees partnered with CBOs and used internal hospital programs, such as MetroHealth's Institute for H.O.P.E.™, an initiative that tackles the social drivers of health in the Greater Cleveland area. These programs connect patients to various social services, from mental health support to assistance with co-occurring medical conditions.

Some grantees partnered with local vendors to provide patients with essential items such as cellphones, enhancing communication and care coordination. To reduce external stressors, many grantees partnered with local organizations to offer personal care items such as clothing, deodorant, and other hygiene products. These partnerships enhanced grantees' reach and efficacy and expanded the services and resources offered to patients seeking treatment, reducing barriers to care.

By partnering with organizations that handle social determinants of health, hospitals help patients access comprehensive support beyond addiction treatment alone. This combined effort promotes treatment program retention and long-term patient recovery.

MEANINGFUL STAKEHOLDER EDUCATION IS CRITICAL.

To increase community support for local initiatives, hospitals can educate community members on OUD, OUD treatment, and social medicine interventions. Without research-informed knowledge about the benefits and risks of OUD treatment methods, such as harm reduction, community members might hesitate to start such initiatives due to perceived negative effects rooted in possible biases.

Because many patients who need OUD care avoid seeking treatment in hospital settings, harm reduction interventions require community-driven strategies. But communities often lack knowledge on harm reduction and its effect on community well-being, leading to pushback. One participating hospital experienced resistance from community members to expanding OUD treatment interventions, such as placing a **harm reduction vending machine** in a local barbershop and community center.

To solve this obstacle, grantees educate CBOs, local business leaders, and non–addiction medicine hospital staff about harm reduction substance use treatment. They teach what it consists of and how it might affect their communities. Our members also teach front-line staff how to provide compassionate, stigma-free care.

Effectiveness of Social Medicine in OUD Treatment

EVALUATING EFFECTIVENESS REQUIRES PATIENT, PROVIDER, AND COMMUNITY DATA.

Capturing data specific to SDOH-related services can help hospitals understand the challenges and successes experienced when integrating social medicine into addiction treatment. Hospitals can then make informed adjustments to their program models. Grantees assessed the effectiveness of their OUD social medicine interventions through:

- Quantitative data on patient engagement and retention
- Quantitative and qualitative data on linkages to social support resources
- Qualitative feedback from patients, providers, and community partners

> **"When these systems work in harmony, patients can seamlessly transition from inpatient treatment to community-based support, allowing for continuity of care that is essential for long-term recovery."**
>
> –Learning collaborative participant

Quantitative Data

Tracking the number of patients screened for OUD, initiated into OUD treatment, and retained over a specified period can help hospitals understand their programs' reach and retention effectiveness. A high number of patients screened for OUD but a low number initiated or retained could indicate care gaps and areas for improved programming.

Beyond tracking treatment engagement, many grantees recommended collecting data such as:

- Volume of calls to a patient support line
- Number of connections to stable housing post-treatment
- Duration of housing stability post-treatment
- Number of food vouchers requested or used (e.g., grocery gift cards, Supplemental Nutrition Assistance Program registrations, food bags)
- Number of transportation vouchers requested or used (e.g., rideshare company gift cards, bus passes)
- Number of connections made between patients and legal support services

> **"By utilizing a comprehensive mix of quantitative and qualitative measures, we were able to evaluate both the program's outcomes and the patient experience. This approach allowed us to refine our strategies and ensure that our programs continue to effectively meet the needs of those we serve, furthering the integration of social medicine into substance use disorder treatment."**
>
> –Learning collaborative participant

Qualitative Data

To identify strengths and areas for improvement from the patient's perspective, hospitals can conduct regular surveys and interviews to capture patient experiences. Surveys could ask about perceived accessibility, support quality, and treatment effectiveness.

Qualitative insights from staff members, such as recovery specialists and case managers, can help hospitals understand patients' engagement, challenges, and progress during treatment. Many grantees rely on continual feedback from staff and community-based organizations. This feedback helps grantees evaluate the effectiveness of their care coordination, community support, and support for complex medical and social needs. Partner feedback can also strengthen interorganizational relationships and enable new collaborations to support holistic patient recovery.

Along with assessing the program's effectiveness, evaluating data can help secure additional funding from both hospital leadership and external investors. Demonstrating measurable outcomes and their effect on patient health, community health, and hospital processes can justify continued support and future resource allocation.

CONCLUSION

Participants highlighted that managing nonclinical challenges can make OUD treatment more effective. Our members state that participating in the yearlong collaborative gave them an opportunity to engage in meaningful discussions about:

- Initiating difficult conversations with hospital leadership about investment and buy-in
- Overcoming challenges implementing social medicine services
- Creating solutions for effective change in managing complex patient needs

Participants emphasized the value of exchanging knowledge to reevaluate their individual programs and enhance their services. Group sessions encouraged programs to tackle social barriers flexibly, tailoring interventions to patients' needs. Members emphasized combining medical care with social services, mental health support, and community engagement to create comprehensive, patient-centered care models.

The Institute understands the importance of addressing the societal and environmental factors preventing patients, especially populations experiencing disadvantages, from accessing and remaining in OUD treatment. Therefore, the Institute facilitated a third and final learning collaborative to help essential hospitals build and expand their OUD social medicine programming. The final learning collaborative, which launched in October 2024 and will end in October 2025, aims to provide essential hospitals with funding and resources to improve outreach and treatment for patients that face social and financial barriers to care.

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