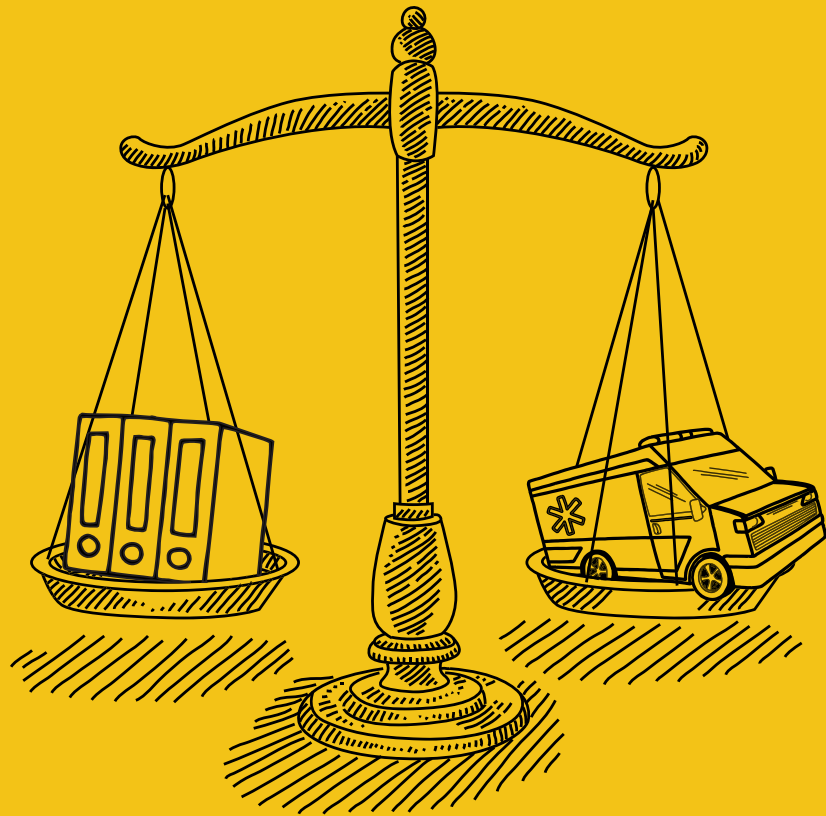


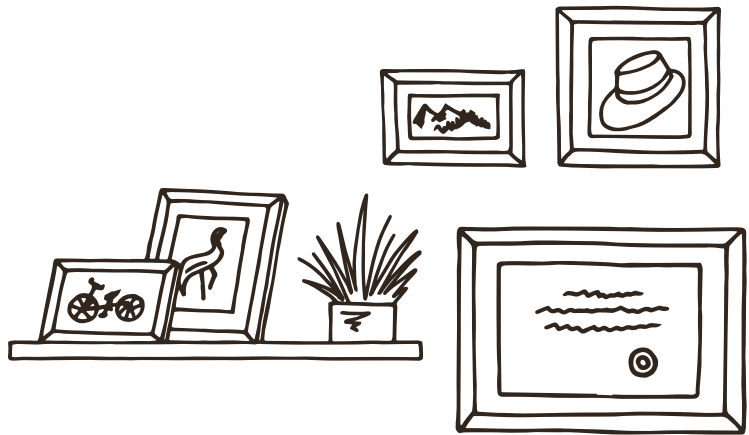
EMERGENCY:

Hospitals are Violating Federal Law by Denying Required Care for Substance Use Disorders in Emergency Departments



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**“Do the best you can until you know better.
Then when you know better, do better.”**

— Maya Angelou

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Executive Summary

Overview

The United States is in the grips of a substance use and overdose epidemic that has escalated in the wake of the COVID-19 pandemic. More than 92,000 individuals died from a drug overdose from December 2019 through December 2020 - an almost 30 percent increase from the previous 12 month period. Over the past two decades, this unprecedented morbidity and mortality have demanded that all healthcare practitioners, institutions, and financing systems improve access to substance use disorder treatment.

Hospital emergency departments have a crucial role in addressing the nation's substance use disorder epidemic. Emergency departments routinely care for patients with drug and alcohol use-related emergencies, and, during the pandemic, the rate of emergency department (ED) visits for drug overdose increased even as the rate of visits dropped for all other medical conditions. Substance use disorder care fits squarely within the emergency department's role in our healthcare delivery system - serving as a primary point of access for medical care, diagnosing and treating medical emergencies and linking patients to definitive care. Many EDs have adopted evidence-based practices to diagnose those with substance use disorder, care for them, and link them to treatment, with promising results. Yet far too many others have not; they fail to identify individuals with life-threatening substance use disorders and discharge them without providing proven life-saving interventions.

This report describes evidence-based practices for substance use disorder care, their successful adoption by many emergency departments, common justifications for not adopting these practices, and how this resistance exacerbates other barriers to care. The report notes the particular implications of inadequate care for Black, Latinx and Indigenous people who have experienced the steepest increases in rates of overdose deaths nationally and, in some communities, the highest overdose rates for some substances.

The report then turns to the law. It provides an in-depth explanation of how hospitals that do not adopt evidence-based practices for patients with substance use disorder can violate federal laws that require ED delivery of certain healthcare services and that bar discrimination based on disability, race, and ethnicity.

Key Factual Findings

Based on extensive research, numerous federal experts and professional medical organizations, including the U.S. Surgeon General, the National Institute on Drug Abuse, Centers for Disease Control, the Substance Abuse and Mental Health Services Administration, and the American College of Emergency Physicians have recommended hospital adoption of **three evidence-based practices for substance use-related emergencies** and have developed protocols to facilitate implementation.

These practices include (1) screening and diagnosis of substance use disorder (including a brief intervention for at-risk alcohol use), (2) offer of opioid agonist medications, as appropriate, for individuals with opioid use disorder, and (3) for individuals with any substance use disorder, facilitated referrals to treatment along with naloxone distribution or prescription for patients who use drugs that can contain opioids (e.g., fentanyl).

(1) Substance use disorder screening and diagnosis enables ED practitioners to determine whether a patient who presents with a substance use-related condition has a substance use disorder that could pose a life-threatening condition: the most fundamental role of the emergency department. Multiple substance use disorder screening tools have been validated for ED use and the Diagnostic and Statistical Manual contains clear diagnostic criteria for substance use disorders that can be incorporated into an emergency department's electronic health record.

(2) The offer to administer opioid agonist medications to patients with opioid use disorder, as appropriate, helps avert or treat opioid withdrawal and suppress opioid cravings. Buprenorphine, the most effective opioid agonist medication for ED use, reduces mortality by 50 percent and protects

patients from opioid overdose. ED initiation of buprenorphine is effective and cost-effective, and hospitals nationwide have adopted protocols for its administration.

(3) Facilitated referral to treatment connects patients with substance use disorder to ongoing care, consistent with the emergency department's role to link patients to definitive care. A facilitated referral addresses common roadblocks to care including insurance status and transportation and language barriers. EDs also make naloxone (an opioid overdose reversal medication) available to patients who use drugs that may include opioids to decrease their likelihood of death post-discharge.

Many hospitals across the country have adopted these evidence-based practices – with support and direction from state and local policymakers, professional association protocols, and federal healthcare financing. In January 2021, the American College of Emergency Physicians approved consensus recommendations that call for EDs to offer to initiate treatment for opioid use disorder with buprenorphine and provide a direct referral to ongoing opioid agonist medication-based treatment to patients with untreated opioid use disorder. Recently issued federal practice guidelines for buprenorphine prescribing remove education and counseling certification requirements for practitioners treating up to 30 patients and will further enhance ED capacity to link patients with opioid use disorder to definitive treatment.

In far too many other hospitals, however, EDs address only the acute symptoms of substance use and fail to conduct diagnostic testing for substance use disorder, offer opioid agonist medications to address a life-threatening opioid use disorder, or link patients to definitive care. The stated rationales for this hospital resistance often center on perceived challenges of this patient population, safety concerns, hospital resources, and the perception that EDs should play a more limited role for substance use disorder care than for other chronic conditions. None of these claims, however, justify failure to offer evidence-based care to patients with substance use disorder. Doing so is good medical practice – and in accordance with the law.

Key Legal Findings

Hospitals could be liable for violations of **the Emergency Medical Treatment and Labor Act (EMTALA), the Americans with Disabilities Act (ADA) and Rehabilitation Act of 1973 (Rehabilitation Act) and Title VI of the Civil Rights Act of 1964 (Title VI)**, when they fail to adopt evidence-based practices, resulting in patient harm.

Required Medical Care for Emergency Department Patients

EMTALA imposes affirmative medical care requirements on most hospitals that see individuals with substance-use related conditions in their ED. Emergency departments must conduct a medical screening examination of *every individual* to identify an emergency medical condition – a condition that, absent immediate medical attention, poses a serious threat to the patient's health. They also must stabilize that condition before the patient's discharge or transfer to another medical facility. EDs violate EMTALA when they do not conduct medical screening examinations to identify life-threatening substance use disorders and stabilize them.

Patients seek ED care for a range of substance use-related conditions that include withdrawal or overdose from opioids or other drugs, alcohol intoxication or poisoning, falls, injuries or infections related to substance use. Many of these conditions constitute an emergency medical condition. If the ED does not conduct a medical screening examination to screen for substance use or diagnose a substance use disorder, and the patient suffers harm as a result, the patient could successfully assert a violation of EMTALA's *medical screening examination* obligation. To conduct that examination, practitioners have standardized screening tools, validated for ED use, that identify substance use not evident from the patient's presenting condition as well as standardized criteria from the Diagnostic and Statistical Manual to diagnose the existence and severity of a patient's substance use disorder.

A patient diagnosed with moderate or severe substance use disorder also could successfully assert an EMTALA *stabilization* violation if the ED does not offer appropriate medications and/or discharge planning which are necessary to ensure, with reasonable medical certainty, that the individual's condition will not

materially deteriorate post-discharge. Because untreated moderate or severe substance use disorders are characterized by compulsive substance use, an ED physician can foresee that a patient will continue to use substances post-discharge with potentially life-threatening consequences absent appropriate stabilization of withdrawal symptoms and cravings for drugs or alcohol. Thus, the failure to offer to administer an opioid agonist medication, such as buprenorphine – one of the most effective medications to avert or treat withdrawal, suppress cravings, and prevent future overdose – to patients with opioid use disorder, as appropriate, could violate EMTALA’s stabilization requirement.

Similarly, most patients with a substance use-related emergency medical condition will require substance use disorder treatment post-discharge for their generally chronic condition. While EMTALA does not require an ED to treat a patient’s underlying medical condition, the ED must help secure such care because it is foreseeable that a patient with moderate or severe substance use disorder will continue to use substances in a life-threatening manner absent treatment. Discharging patients with a list of treatment programs does not meet this EMTALA requirement. Finally, ED failure to make naloxone available at discharge for patients who use drugs that may contain opioids could also give rise to an EMTALA violation, as continued, life-threatening drug use is foreseeable, and naloxone effectively reverses opioid overdose.

Disability-Based Discrimination

Two federal laws prohibit disability-based discrimination – **the ADA and Rehabilitation Act**. Both laws are intended to eliminate discrimination by requiring state and local government programs and “places of public accommodation” – including hospitals – to treat individuals with substance use disorders and other disabilities equally and fairly, based on an objective evaluation of their qualifications for services, rather than outdated stereotypes and myths. Many ED patients who are denied evidence-based practices for substance use disorder could meet the requirements for proving disability-based discrimination: they (1) have a “disability,” (2) are qualified (or eligible) for the services or benefits sought, and (3) were denied those services or benefits because of their disability.

An individual with a substance use disorder who seeks care for a substance use-related emergency has a “disability” (substance use disorder) and is “qualified” for ED services because they have an acute injury or illness – the “essential eligibility requirement” for ED care. Individuals who “currently engage in the illegal use of drugs” do not have a “disability” as defined by the ADA, but EDs may not deny them substance use disorder treatment – or other health services – on the basis of such use. A hospital that denies ED patients evidence-based practices “because of” their substance use disorder or current illegal drug use could be liable for discrimination under two legal theories: disparate treatment and failure to provide a reasonable modification.

Disparate treatment discrimination occurs when an ED denies evidence-based practices for substance use disorder due to generalizations, assumptions, and stereotypes about people with substance use disorder, as opposed to legitimate non-discriminatory reasons. Many patients could show that the reasons they were denied these evidence-based practices are not legitimate, but are instead due to stigma or assumptions about patients with substance use disorder. Additionally, an emergency department’s failure to use evidence-based practices for substance use disorder typically occurs through its “methods of administration,” such as decisions not to stock buprenorphine for opioid use disorder or failure to implement protocols requiring consistent screening and diagnosis and facilitated referrals to treatment. These administrative methods can constitute another form of “disparate treatment” discrimination because they have the purpose and/or effect of discriminating against people with substance use disorder.

Finally, if a patient requests an evidence-based practice, such as a facilitated referral to treatment, which the ED does not provide, the hospital could be liable for *failing to provide a reasonable modification* of its policies or practices, as necessary to avoid discrimination. A hospital’s affirmative defense that providing these services would be an “undue burden” or would “fundamentally alter” the nature of ED services would fail because these services are consistent with an emergency department’s current and essential function of providing life-saving treatment and linkage to definitive care.

Race-Based Discrimination

Title VI bars federally funded entities – including hospitals – from discriminating on the basis of “race, color, or national origin.” Its protections are crucial to remedying ongoing racial disparities in access to healthcare – especially for Black, Latinx, and Indigenous communities that have been disproportionately affected by the substance use epidemic. Hospitals whose EDs deny evidence-based practices for substance use disorder could be liable for “disparate treatment” (intentional) and/or “disparate impact” discrimination.

Disparate treatment discrimination occurs when an ED denies evidence-based practices for substance use disorder because of a patient’s race. Some Black, Latinx, or Indigenous persons could marshal proof of race discrimination, such as ED personnel’s explicit statements of a race-related or race-coded reason for not providing these services, or hospital or public records revealing decisions to offer these evidence-based practices to white people more often than similarly situated Black, Latinx, and/or Indigenous persons. While a hospital likely would provide countervailing, non-discriminatory reasons for its actions, with the right evidence, such a claim could prevail.

Similarly, a hospital could be liable for *disparate impact* discrimination when its denial of these evidence-based practices disparately impacts Black, Latinx, or Indigenous persons. Given the well-documented racial disparities in access to some substance use disorder care, as well as higher overdose death rates for Black, Latinx, and Indigenous persons in some communities, an emergency department’s failure to use evidence-based practices likely will disproportionately impact some of these communities. A combination of hospital data, national, state, and local ED demographics, and other relevant statistics, could reveal this disparate impact. While an ED likely would argue that outside factors – not its practice – caused this disparate impact, the data should be strong enough in some locations to show that this disparate impact was, at least in part, the foreseeable result of ED policies. An ED would need to provide a substantial legitimate justification for failing to provide evidence-based care – which it likely will not be able to do.

Conclusion

Emergency department adoption of evidence-based practices for patients with substance use disorder is essential to addressing the nation’s substance use and overdose epidemic. But stigma and institutional inertia result in too many emergency departments turning a blind eye to the urgent healthcare needs of these patients. These emergency departments miss a key opportunity to improve health outcomes, save lives, and reduce racial disparities. Their failure to adopt evidence-based practices for substance use disorder also can violate the Emergency Medical Treatment and Labor Act and federal civil rights laws prohibiting discrimination based on disability and race.

Introduction

The United States is in the throes of a twenty-year substance use epidemic that has accelerated with the COVID-19 pandemic.¹ In 2019, 19.4 million adults were living with a substance use disorder (SUD) and an additional 10.1 million individuals ages 12 years and older misused opioids.² Overdose death rates have also reached record heights since the pandemic.³

In the year leading up to December 2020, **over 92,000 people died by overdose** - an almost 30 percent increase from the previous 12 month period.⁴

From 2011 through 2015, “excessive drinking” was responsible for an average of 95,158 deaths annually – more than half of which were caused by chronic conditions.⁵ Substance use-related emergency department (ED) visits have similarly increased, particularly for young adults aged 18 to 34 years.⁶ Even in the midst of the COVID-19 pandemic, during which ED visits declined, visits for all drug overdoses increased.⁷ Tragically, many patients with opioid-related emergencies die shortly after discharge or within a year of their ED visit.⁸

EDs are the primary point of access to the healthcare system for many individuals with limited access to medical care and health insurance. EDs have routinely delivered care to individuals with substance use-related conditions – in sizeable numbers. An average of nearly 15,000 individuals sought ED care for a drug overdose every week between January and October 2020.⁹ For alcohol-related ED visits, nearly 3.9 million visits involved alcohol, alcohol intoxication or related conditions from 2001 through 2011.¹⁰ In the midst of the worst addiction epidemic ever, EDs have a critical role in delivering medical care that helps patients survive and enter treatment.

Federal public health agencies, professional medical organizations, state and local policymakers, and many hospitals, have endorsed and adopted **evidence-based SUD practices**¹¹ for ED implementation. These practices differ based on the substance used, recognizing that many individuals use multiple substances.

They include (1) **SUD screening and diagnosis** (including a brief intervention for at-risk alcohol use), (2) **offer of opioid agonist medications**, as appropriate, for individuals with opioid use disorder (OUD), and (3) for individuals with any SUD, **facilitated referrals to SUD treatment** along with a naloxone prescription for patients using drugs that can include opioids (e.g., fentanyl) (hereafter referred to as “evidence-based practices”).

Hospital EDs that have adopted these evidence-based practices approach a patient with a substance use-related emergency as having acute symptoms that could indicate a potentially chronic underlying undiagnosed and/or untreated SUD. They integrate well-established SUD care practices into their medical setting in the same way they deliver care to patients with other chronic conditions, such as diabetes or hypertension.¹²

In contrast, hospitals that treat the patient’s acute symptoms alone – without diagnosing an underlying SUD, administering medications proven to reduce opioid-related death, and identifying viable treatment options post-discharge – miss an “opportunity to identify persons at high risk for death and engage them in treatment.”¹³ Although complete data on the level of ED adoption of evidence-based practices are not available, ED objections to implementing these practices focus on perceived challenges of serving this particular patient population, safety, and limited resources. They also reflect a far more limited ED role for SUD care than for other chronic medical conditions. As a result, individuals with SUD who rely on the ED for emergency care and linkage to treatment suffer tremendous harm.

Patient experiences reveal all too common ED practices and consequences:

- In 2015, Julie took her son Henry to the ED because he was in withdrawal. They sat in the ED for 12 hours and were “turned away” because Henry’s withdrawal was “not bad enough.” They were seeking linkage to SUD care. “Today, he is dead.”¹⁴
- In 2019, Marie accompanied her friend, Sam, to the ED in search of OUD treatment. The treating ED physician described his behavior as “drug-seeking,” strapped him to the bed for four hours, and discharged him with nothing but an “overwhelming packet of papers.” Sam had wanted medications to address his withdrawal and initiate treatment, which he did not receive.¹⁵



ED failure to implement evidence-based practices exacts a particularly harsh toll on Black, Latinx, and Indigenous communities, who historically have received inadequate and unequal medical care.

Black and Hispanic¹⁶ people are more likely to seek ED care than white people because of their more limited access to primary care.¹⁷ The need for quality SUD care in the ED is particularly crucial because Black, Indigenous, and Latinx people are experiencing the highest *increases* in overdose death rates, according to national and some local data. (See *infra* Sec. I.D.). Yet some studies have shown that Black people are more likely than white people to have multiple treat and release ED visits for substance use-related emergencies,¹⁸ and have more limited access to naloxone (an opioid overdose antidote) in the ED¹⁹ and buprenorphine post-discharge.²⁰ As this report discusses, adoption of evidence-based SUD practices in all EDs is consistent with their role, crucial to meet clinical care standards, and necessary to ensure racial equity.

ED failure to incorporate these practices exposes hospitals to legal liability.²¹ The Emergency Medical Treatment and Labor Act (EMTALA) imposes an affirmative obligation on virtually every hospital to provide medical services to individuals who come to the ED with an SUD-related condition. EMTALA requires the ED to medically screen and diagnose these individuals for an “emergency medical condition” – including those related to SUD – and provide stabilization care for any such conditions identified. Use of evidence-based practices satisfies a hospital’s obligations under EMTALA, whereas the failure to do so may violate that law. In addition, hospitals must comply with civil rights standards under the Americans with Disabilities Act (ADA), the Rehabilitation Act of 1973 (R.A.) and Title VI of the Civil Rights Act of 1964 (Title VI). These laws prohibit hospitals from denying these evidence-based practices on the basis of disability (SUD), current illegal drug use, and/or race. Hospitals that do not use evidence-based SUD practices may violate any one or all of these laws.

This report has three goals: (1) to set out the urgent need for effective care of addiction in the ED by implementing evidence-based SUD practices; (2) to identify strategies that will help address the SUD crisis and remedy historical racial health disparities; and (3) to assess the legal liability of hospitals for not doing so. Toward that end, the report (1) identifies the considerable body of research that supports the adoption of evidence-based practices for patients who present with substance use-related emergencies and the endorsement and implementation of those practices by professional organizations and hospitals; and (2) analyzes a hospital’s legal obligation to provide these evidence-based practices under EMTALA and federal civil rights laws.

This report does not examine an ED’s obligations to provide emergency care for *other* conditions of this patient population. For example, a patient with SUD may present at the ED with cardiac arrest, injuries, or mental illness – possibly related to substance use. But the report does not examine whether the ED’s care for *those* conditions separate and apart from the SUD could violate these federal laws. Importantly, however, the non-discrimination principles of the ADA and Title VI apply equally to *any* care for people with SUD. They also apply to *admitted* patients with SUD, another topic beyond the scope of this report, which merits further examination.

I. Landscape of ED Practices for Patients with Substance Use-Related Emergencies

A. Evidence-Based Practices in EDs

Healthcare experts consistently call for the integration of evidence-based practices to identify and treat individuals with SUD in every healthcare setting.²² Such integration is necessary to address the traditional separation of SUD treatment from general healthcare services, which leads to the mistaken notion that SUD care is not “the responsibility of health care systems.” As the U.S. Surgeon General observed in 2016, “[e]ffective integration of prevention, treatment, and recovery services across health care systems is key to addressing substance misuse and its consequences and it represents the most promising way to improve access to and quality of treatment.”²³

Three practices constitute evidence-based practices for SUD in the ED (hereafter “evidence-based practices” or “evidence-based practices for SUD”):

- (1) **SUD screening and diagnosis** (including a brief intervention for at-risk alcohol use),
- (2) **Offer of opioid agonist medications**, as appropriate, for individuals with OUD, and
- (3) For individuals with any SUD – **facilitated referrals** to SUD treatment and access to naloxone (e.g., ED prescription or distribution) for patients using drugs that can include opioids (e.g., fentanyl).

These practices align with the ED’s role as “a universal point of medical access, diagnosis, treatment, and linkage to definitive care”²⁴ and fit into the ED’s workflow.²⁵

National SUD experts and professional medical organizations have endorsed ED adoption of one or more of these practices. These endorsers include the U.S. Surgeon General,²⁶ National Institute on Drug Abuse (NIDA),²⁷ the National Institute on Alcohol Abuse and Alcoholism (NIAAA),²⁸ the Centers for Disease Control and Prevention (CDC),²⁹ the Substance Abuse and Mental Health Services Administration (SAMHSA),³⁰ American College of Emergency Physicians (ACEP),³¹ American College of Medical Toxicology (ACMT),³² American College of Surgeons Committee on Trauma,³³ and American Society of Addiction Medicine.³⁴

Increasingly, hospitals are implementing these evidence-based practices as federal, state, and local policymakers mandate, direct or incentivize their adoption and researchers and professional organizations standardize practice protocols. The imperative to prevent overdose deaths among ED patients has also motivated hospitals to adopt these evidence-based practices.

1. Screening and Diagnosis in EDs

Screening and diagnostic assessment are the **essential first steps** to identify whether an ED patient with an opioid overdose, alcohol intoxication or poisoning, or injuries and infections associated with substance use has an SUD. Screening enables a provider to quickly determine whether a patient’s symptoms are related to substance use or another health condition³⁵ and can be particularly helpful to determine whether an individual who presents with other medical complaints should be assessed for an SUD.³⁶ A number of screening tools have been validated for ED use,³⁷ and treatment experts and medical professionals recommend SUD screening in the ED.³⁸

For some patients, screening is not needed to determine whether their medical condition involves substance use, as the presenting problem itself – a drug overdose, an abscess from drug injection, or alcohol intoxication – reveals substance use.³⁹ A diagnostic assessment is required to determine

whether these patients and those who screen positive on a screening tool have an SUD. An SUD diagnosis is based on a physical examination and medical and substance use history that includes the eleven diagnostic criteria in the Diagnostic and Statistical Manual (DSM-5).⁴⁰ In taking the medical history, an ED practitioner may also learn that the patient has already been diagnosed with an SUD and is or has been in SUD treatment. SUD screening and diagnostic assessment fall squarely within the ED's role as a "center for diagnostic testing...to rule out life-threatening illness...."⁴¹

For alcohol-related emergencies, research supports screening combined with brief intervention for individuals who identify patterns of at-risk alcohol use. The brief intervention engages the patient in a discussion about their alcohol use, ways to reduce risky use, and, as appropriate, interest in treatment.⁴² Implementation of screening and brief intervention in the ED results in decreased quantity and frequency of alcohol consumption and fewer recurrent ED visits in the initial months following the intervention.⁴³ Based on this research, professional medical organizations have disseminated Screening, Brief Intervention, and Referral to Treatment (SBIRT) toolkits to EDs nationwide,⁴⁴ and ACEP recommends EDs implement SBIRT.⁴⁵ Since 2006, the American College of Surgeons Committee on Trauma has recommended alcohol screening in level one and two trauma centers and brief intervention for patients who screen positive.⁴⁶

2. Administration of Opioid Agonist Medication in EDs

The Food and Drug Administration (FDA) has approved three medications to treat opioid use disorder (MOUD);⁴⁷ all constitute evidence-based care.

Buprenorphine and methadone – opioid agonist medications – **effectively address acute opioid withdrawal and reduce mortality by 50 percent**,⁴⁸ a result not achieved for any blood-pressure medication, diabetic agent, or statin.⁴⁹

Research to date has demonstrated that the ED can effectively administer buprenorphine to avert or treat opioid withdrawal, suppress cravings and allow practitioners to engage patients in treatment discussions.⁵⁰

In a 2015 randomized feasibility study, D'Onofrio and colleagues reported that ED patients with OUD who received ED-initiated buprenorphine and a facilitated referral to ten weeks of office-based buprenorphine treatment had much higher rates of treatment engagement, fewer days of self-reported illicit opioid use, and reduced likelihood of entering inpatient addiction treatment as compared to ED patients who received either SBIRT or a referral to treatment.⁵¹ Patients in the buprenorphine group were twice as likely to be engaged in treatment at 30 days following the treatment referral compared to patients who only received a treatment referral.⁵² At two months, those patients continued to participate in treatment at significantly higher rates than the other two patient groups.⁵³ Busch and colleagues found that ED-initiated buprenorphine is "cost-effective" compared to SBIRT or referral – each of which "cost[s] more than ED-initiated buprenorphine, with fewer benefits[.]"⁵⁴

ED-initiated buprenorphine can be effectively integrated into ED practice. ED practitioners can administer buprenorphine for up to three days to relieve a patient's acute opioid withdrawal symptoms, without an X-waiver.⁵⁵ Under new federal guidelines, they also can prescribe buprenorphine for up to 30 patients for their use after discharge without satisfying educational and counseling requirements. D'Onofrio and colleagues have observed that **"buprenorphine is safer and more predictable than many medications used in routine ED practice [and] treatment can be accomplished in less time than an urgent care visit;"**⁵⁶ within the 60 to 90 minute national benchmark.⁵⁷ In practice, D'Onofrio has found buprenorphine superior to typical ED "symptomatic treatment with nonopioid medications [which is] generally ineffective [and results in] patients ... becom[ing] more irritable as their symptoms worsen...."⁵⁸ Love and colleagues have similarly concluded that buprenorphine is likely better in treating acute withdrawal than clonidine – the most commonly used medication for opioid withdrawal symptoms in the ED.⁵⁹ As a long-acting opioid agonist, buprenorphine helps the patient, who otherwise would quickly resume opioid use, prevent the physical pain associated with opioid withdrawal and physiological need for opioids.

Based on this body of research, federal agencies uniformly recommend ED-initiated buprenorphine and have implemented financing mechanisms for its systemwide adoption. According to NIDA Director Nora Volkow, “too few” EDs have standardized initiation of medication for patients with OUD,⁶⁰ resulting in these individuals being “thrown out on the streets when there are medications that can protect them from overdose.”⁶¹

SAMHSA promotes ED-initiated buprenorphine as a “recommended best practice” to “manage the individual’s withdrawal symptoms, cravings and other medical complications of opioid use.”⁶²

And the CDC views the ED as a key player in reducing repeated opioid overdoses through buprenorphine administration and referral to ongoing treatment.⁶³ To remove financial barriers to implementing ED interventions, the Centers for Medicare and Medicaid Services (CMS) has recently instituted Medicare billing codes that reimburse hospitals for costs associated with ED OUD assessment, medication initiation, referral to care, and access to supportive services.⁶⁴

Professional medical organizations have similarly endorsed ED-initiated buprenorphine and offered standardized protocols for implementation. ACMT and ACEP recommend ED-initiated buprenorphine to increase OUD treatment engagement and reduce opioid overdose deaths.⁶⁵ ACEP’s ED toolkit, BUPE, sets out OUD diagnostic criteria, buprenorphine dosing guidelines and other medications for opioid withdrawal management.⁶⁶ The Health Care Advisory Board, recognizing the hospital’s “pivotal” role in addressing the opioid epidemic, has urged providers to “make every effort to administer...[medication-based treatment]” and link patients to ongoing OUD care.⁶⁷

The medical community’s consensus is summed up best in 2019 recommendations to the American Academy of Emergency Medicine: “[a]ll patients with opioid use disorder who are not already in a MAT [(i.e., medication assisted treatment)] program (methadone, buprenorphine, or naltrexone) should be considered for ED-initiated buprenorphine.”⁶⁸

3. Facilitated Referral to Substance Use Disorder Treatment and Naloxone

A facilitated referral (or **warm handoff**) is a streamlined plan that helps a patient receive ongoing care for any SUD promptly after ED discharge.⁶⁹ The adoption of ED facilitated referrals capitalizes on research showing that some populations are more likely to initiate SUD treatment when they receive an initial diagnosis in an ED rather than in a primary care setting.⁷⁰ Facilitated referrals help address “delays in outpatient services, gaps in medication-assisted therapy, and overall worse [patient] outcomes[,]”⁷¹ and, in some cases, have resulted in higher rates of treatment engagement post-ED discharge.

One California hospital found that, of its patients with OUD who received medication and a facilitated referral in 2019, 90 percent showed up for their follow-up appointment and **more than 70 percent remained in treatment one year after their ED encounter.**⁷²

Consistent with the ED’s role in “providing linkage to definitive treatment,”⁷³ this ED practice affords a patient with an SUD the same care opportunities as patients with other chronic conditions, such as insulin-dependent diabetes and hypertension, who are routinely linked to community-based care at discharge.⁷⁴

National accreditation bodies have recently updated quality measures to promote and improve a hospital’s ability to help patients initiate and engage in SUD treatment post-ED discharge. The National Committee for Quality Assurance (NCQA) updated two SUD treatment metrics in its Healthcare Effectiveness Data and Information Set (HEDIS) in 2018 to improve tracking of initiation and engagement in SUD treatment, including medication-based treatment for OUD and alcohol use disorder, and the identification of SUD services.⁷⁵ Additionally, as of January 2018, Joint Commission-accredited hospitals must identify opioid treatment programs (OTP) to which patients with OUD can be referred, making the hospitals responsible for maintaining “readily accessible and accurate information” for patient referrals.⁷⁶

Finally, federal policymakers and professional organizations have taken steps to increase the availability of OUD treatment in the community and have offered guidance to improve ED referral capacity. SAMHSA's recent Practice Guidelines for the Administration of Buprenorphine for Treating OUD, removing education and counseling certification requirements for practitioners treating up to 30 patients should help increase the availability of office-based treatment in the community and expand opportunities for ED referrals.⁷⁷ Additionally, SAMHSA, the American Hospital Association and ACEP recommend that EDs use peer counselors, care managers and social workers to make facilitated referrals and take advantage of telehealth to expand provider capacity.⁷⁸ These strategies have proven effective in practice.⁷⁹

An increasingly common practice at ED discharge includes **facilitating patient access to naloxone**, an opioid antagonist that reverses the toxic effects of opioids – particularly respiratory depression – and prevents fatal opioid overdoses in both children and adults.⁸⁰ Emergency medical services personnel, including EDs, have used naloxone for more than 40 years to reverse opioid overdose⁸¹ and now many EDs provide naloxone to patients who are at risk of opioid overdose. While some EDs distribute naloxone directly to patients, more often, they provide a naloxone prescription at discharge.⁸² Research has shown that ED prescription of naloxone at discharge helps to reduce “opioid related ED visits”⁸³ and overdose deaths.⁸⁴ The CDC⁸⁵ and HHS,⁸⁶ as well as professional organizations, including ACEP,⁸⁷ recommend acute care settings, including EDs, provide naloxone prescriptions to patients who are at risk of opioid overdose including those who present to the ED with an opioid-related emergency or another emergency related to use of a substance that can include opioids.⁸⁸ The hospital's cost for prescribing naloxone is de minimis. Moreover, the patient's cost is covered through most insurance plans (including Medicare and Medicaid) and many states have implemented cost-reduction initiatives.⁸⁹ In short, making naloxone available at discharge is part of a “[p]ublic [h]ealth [a]pproach” to opioid-involved substance use that saves lives.⁹⁰

B. ED Adoption of Evidence-Based Practices

Evidence of effective ED practices has prompted state and local governments and hospital systems to adopt evidence-based practices for SUD care. Most requirements pertain to opioid-related conditions, but several apply to all SUDs. Data show some positive signs of progress with respect to patients with OUD emergencies: between 2002 and 2017, a study found that the rate of ED administration of buprenorphine increased by 300 percent, with a substantial reduction in racially disparate rates of administration from 2016 through 2017.⁹¹

Legislation in a handful of states mandates implementation of one or more evidence-based practice. For example, Florida requires hospitals to develop policies that may require EDs to implement SBIRT and use peers to encourage patients to seek SUD treatment to prevent drug overdoses.⁹² Massachusetts requires acute care hospital EDs to have protocols and the capacity to “dispense, administer, and prescribe opioid agonist medications” for those presenting with an OUD-related overdose.⁹³ New York requires general hospital EDs to develop treatment protocols for administration of buprenorphine as well as protocols that the ED must follow if such administration is not feasible.⁹⁴ See App. A.

State health departments and medical associations have also issued guidelines to standardize ED practices, and others have financially incentivized improvements in ED practices. Rhode Island, for example, has categorized ED services into three levels of care that hospitals must satisfy through adoption of evidence-based SUD practices, including universal SUD screening, medication for OUD (MOUD), and facilitated referrals, along with naloxone prescription or provision.⁹⁵ Colorado's ACEP chapter issued opioid prescribing and OUD treatment guidelines for the ED.⁹⁶ Illinois requires recipients of specific state funds to implement intensive discharge planning for patients with SUD that requires coordination of care with treatment providers,⁹⁷ and Pennsylvania has established a hospital quality improvement program that provides funding for those that implement one or more evidence-based protocols, including buprenorphine initiation and facilitated referrals, to help patients who come to the ED for OUD enter treatment.⁹⁸ Finally, of their own accord, some hospitals have required their EDs to incorporate these services. For instance, the ED at the University of Alabama-Birmingham administers buprenorphine, provides take-home naloxone kits, and links patients to ongoing care.⁹⁹ See App. A for additional examples. All of these state efforts illustrate that evidence-based practices for SUD can be incorporated into ED practice successfully.

C. ED Resistance to Evidence-Based Practices

Despite the myriad calls for adoption of evidence-based practices and evidence that they save lives and reduce repeated ED visits, many hospitals unfortunately fail to implement one or more. Hospital adoption of ED-initiated buprenorphine has been “slow.”¹⁰⁰ One survey of physicians in two urban academic EDs that assessed practitioners’ level of preparation to treat OUD found that physicians reported feeling least prepared to initiate buprenorphine treatment, connect patients to outpatient treatment, and determine the level of care for patients with OUD.¹⁰¹ A second recent survey of practitioners in four urban academic EDs found that only 20.9 percent rated their readiness to initiate buprenorphine in the ED as high.¹⁰² Providing referrals to treatment for ED patients diagnosed with alcohol use disorder was identified in earlier research as “uncommon” as a result of time constraints.¹⁰³ Publicly-stated reasons for this kind of institutional inertia center on perceived challenges in serving this particular patient population, safety, and limited resources. They also reflect a perception that the ED’s role for SUD care is far more limited than for other chronic medical conditions. Clearly, the implementation of evidence-based practices requires hospital planning, protocol implementation, and collaboration with community-based treatment centers.¹⁰⁴ But, according to medical experts, too often the real barriers are stigma, limited availability of community treatment resources, and gaps in provider knowledge and training (contributing to stigma).¹⁰⁵

1. Perceptions of a Limited ED Role and Practitioner Attitudes About Patients with Substance Use Disorder

Many hospital EDs assume a far more limited role for SUD than for other chronic medical conditions.

Generally, the ED serves three important purposes: (1) stabilize and treat time-sensitive conditions; (2) “conduct acute diagnostic testing...to rule out life-threatening illness;” and (3) serve as a “point of access to the health care system” by linking patients to “definitive treatment.”¹⁰⁶

The same is not true for patients with SUD.¹⁰⁷ A common refrain is that the ED’s role is to “sav[e] lives of patients in the midst of an immediate, life-threatening crisis, like a heart attack or traumatic injury, not those with chronic relapsing health conditions like substance use disorders[.]”¹⁰⁸

This narrow perspective has led some EDs to implement protocols that *only* address the *acute symptoms* of patients with a substance-use related emergency. For substance use-related emergencies that are not alcohol-related, EDs prioritize improving patient respiratory function and alleviating pain, discomfort, and/or nausea from withdrawal.¹⁰⁹ For opioid-related emergencies, the ED may provide advanced cardiac life support,¹¹⁰ administer naloxone to reverse an opioid overdose, and administer medications “such as nonsteroidal anti-inflammatory medications, antiemetics, and alpha-2 agonists such as clonidine to treat symptoms of withdrawal[.]” as necessary.¹¹¹ For substance use-related infection, such as cellulitis, the ED will administer antibiotics, as appropriate.¹¹²

Acute care of these emergencies is essential, but the ED often neglects its two other roles – identifying life-threatening illnesses and providing linkage to definitive care – with devastating consequences for patients with SUD.

Many EDs do not screen patients for at-risk substance use, conduct a diagnostic assessment to identify a life-threatening SUD, or effectively refer those patients to treatment in the community.

Often, discharge protocols amount to nothing more than giving the patient a contact list of SUD treatment programs.¹¹³ For patients with an OUD, many EDs also fail to offer buprenorphine to avert or manage opioid withdrawal or suppress cravings and protect patients from opioid overdose. And while some EDs provide a naloxone prescription or kit at discharge to patients who have presented with an opioid-related condition,¹¹⁴ others do not follow that life-saving practice.¹¹⁵

Frequently, this **limited ED role is animated by ED practitioner misperception of SUD** as an acute condition instead of a generally chronic relapsing disorder that can be treated successfully.

Practitioners **often stigmatize and stereotype individuals with SUD** as having a character flaw rather than a disease, lacking interest in treatment, and engaging in drug-seeking behavior.¹¹⁶ One survey of inpatient and outpatient internists at a large urban hospital identified stigmatizing attitudes about patients with SUDs that have been refuted by decades of research: 38 percent of hospitalists and 26 percent of primary care practitioners believed that people who use drugs or alcohol are making a choice and, consequently thought that “SUD is different from other chronic diseases[;]” 18 percent of hospitalists and 11 percent of internists believed that treatment of OUD with an opioid agonist is “simply replacing one addiction with another[;]” and 12 percent of hospitalists believed that “someone who uses drugs is committing a crime and deserves to be punished.”¹¹⁷ Patients who use substances “have traditionally been considered a difficult population for health care providers to care for[;]”¹¹⁸ and provider stigmatization of this already “stigma-vulnerable” patient population negatively impacts patient care and outcomes.¹¹⁹

Ironically, the ED’s limited acute care and discharge regimen may reinforce a common perception that patients with SUD are “uncooperative and difficult to treat.”¹²⁰ A patient with any SUD who is not linked to treatment will invariably resume substance use and likely return to the ED, requiring additional practitioner attention and resources. Patients with OUD who do not receive medication to suppress opioid cravings will become more irritable in the ED as their withdrawal symptoms worsen.¹²¹ Unaware of the ways in which inadequate ED care *contributes* to this scenario, some ED personnel wrongly view a patient’s frequent return to the ED as reason to doubt their interest in long-term treatment and to question the investment of limited time and resources.¹²² For patients with OUD, some fear that initiating buprenorphine will turn the ED into a “Suboxone Clinic[.]”¹²³

For alcohol use-related emergencies, the ED’s acute care depends on the nature and severity of the patient’s condition. Generally, the ED conducts lab screening to determine the level of intoxication, imaging as needed for injuries, and screening under the SBIRT model, if the patient is sufficiently coherent. The level of detail in the screening, diagnosis, and brief intervention processes may vary by practitioner.¹²⁴ For patients with alcohol use disorder, discharge protocols are important because a referral to treatment is the primary and most promising opportunity to receive medications for this condition. Yet, like treatment referrals for other SUDs, the ED too often offers limited assistance in linking the patient to appropriate care.

2. Concerns About Safety and Limited Resources

A second set of ED concerns relates to **perceptions about safety of patients and staff** and the **ED’s insufficient resources** to screen and diagnose patients with SUD, administer buprenorphine for OUD, and conduct facilitated referrals. Most would agree that the ED is a time-pressured environment in which practitioners are frequently interrupted and required to resolve acute medical conditions quickly, often without the patient’s health records or full medical history.¹²⁵ These concerns – while applicable to ED patients with other serious medical conditions – are filtered through practitioner attitudes about SUD, thereby influencing hospital decisions that deprive people with SUD crucial ED care more readily provided to those with other medical conditions.¹²⁶ It also results in the failure of some EDs to require practitioners to gain the skill and comfort level needed to assess patients with OUD and their appropriateness for buprenorphine initiation.¹²⁷ Without this training, ED personnel are more likely to retain generalized (and unjustified) patient safety concerns that make them unwilling to administer buprenorphine. This is particularly true if a patient has multiple medical conditions or has recently received naloxone to reverse an overdose.¹²⁸ Some hospitals also raise questions about the safety risk for other patients if buprenorphine is available in the ED, even though the ED stores medication in a secure, electronic-code protected storage system¹²⁹ and regularly stores other opioid medications on the ED floor. Finally, **some hospitals express concerns that they will not be reimbursed** for these services due to insurance limitations on access to buprenorphine¹³⁰ and reimbursement for injuries sustained while intoxicated,¹³¹ even though these concerns do not justify denying services; **federal law bars hospitals from denying services based on insurance status.** See *infra* Sec. II.

Finally, some EDs cite the **lack of sufficient community-based services** as a significant barrier to providing referrals to “definitive treatment.” Yet experts note that there are often more treatment resources available than providers expect, many of which can be identified through increased collaboration with community treatment programs. Should an ED prioritize this function, a range of hospital staff and peer specialists are equipped to facilitate those referrals.¹³²

Each of these common justifications contributes to widespread ED “neglect in addressing this potentially life-threatening situation.”¹³³ Research and protocol development have put to rest each of these objections. See *supra* Sec. I.A. Moreover, numerous EDs successfully operationalize the three key functions to the benefit of patients with SUD and their loved ones.¹³⁴

D. Racial Disparities in Substance Use Disorder and Access to Related Services

Since 1999, national overdose death rates have risen, culminating in an unprecedented number of deaths during the COVID-19 pandemic. Data illustrate the SUD crisis has disparately impacted specific populations, including youth,¹³⁵ females,¹³⁶ people with multiple health needs,¹³⁷ and individuals with public insurance.¹³⁸ Some of the most striking disparities are racial.



While public attention has focused on opioid overdose rates among white people, **overdose rates have increased faster among Black, Indigenous, and Latinx people** for both opioids and some non-opioids, and these groups experience more overdose deaths than white people in specific geographic areas.

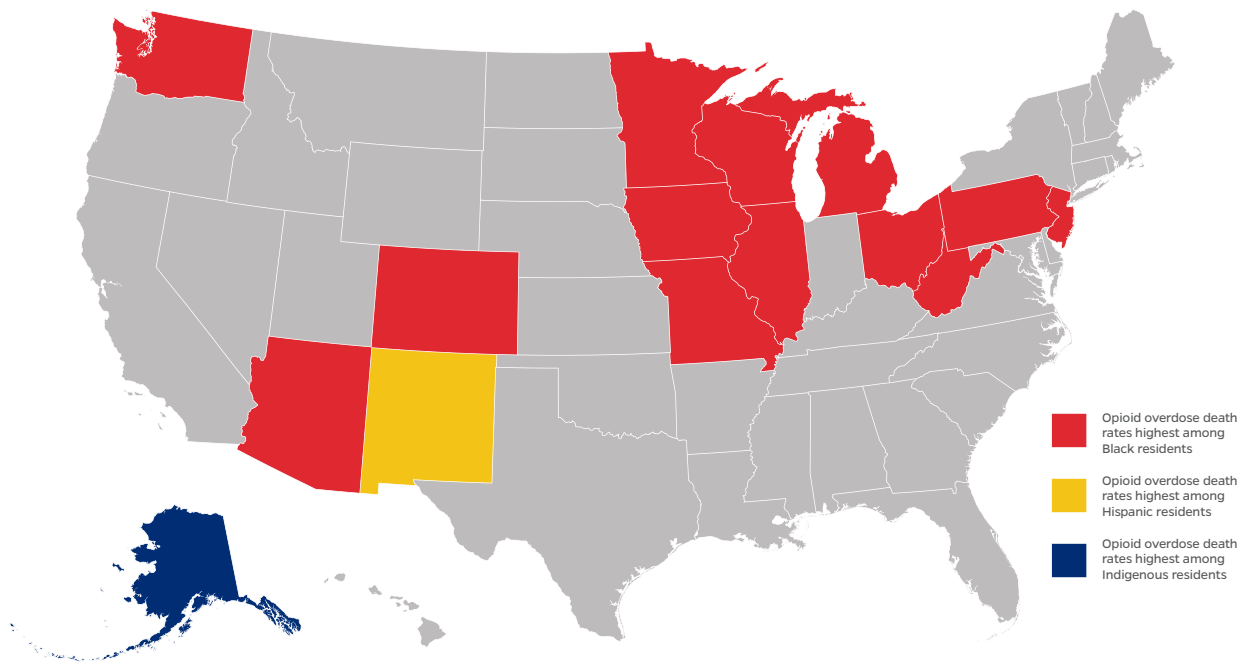
ED adoption of evidence-based SUD practices is particularly important for Black and Latinx populations as national data demonstrate that they are more likely to seek ED care than white people.¹³⁹ State-specific data in Florida also confirm that Black residents in majority-Black communities use EDs for opioid poisoning and OUD at rates that exceed or closely track ED use for white Floridians in majority-white communities.¹⁴⁰ Though publicly-reported race and ethnicity data on ED care for substance use-related conditions are limited,¹⁴¹ existing research compels an examination of the racial impact of ED failure to adopt evidence-based SUD practices. Stigma, insurance limitations, and racism all operate to deny Black, Latinx, and Indigenous communities equitable healthcare. Data suggest that the same is true for SUD care.

1. Race and Related Racial Disparities for Substance Use

National, state, and local data reveal racial disparities in the need for SUD treatment. While national drug overdose death rates are highest for white people,¹⁴² the SUD crisis has had a devastating impact on Black, Hispanic, and Indigenous people, particularly as synthetic opioids (e.g., fentanyl) have dominated the opioid epidemic’s most recent wave.¹⁴³

- **Black Individuals:** From 2011 through 2016, Black individuals had the greatest increase in synthetic opioid-involved overdose death rates, even though their rate of opioid misuse is approximately the same as the general population.¹⁴⁴ In 2018, the rate of cocaine-involved overdose deaths was double that of white people and three times that of Hispanic people.¹⁴⁵
- **Hispanic Individuals:** While opioid overdose death rates are significantly lower for Hispanic individuals compared to Black and white individuals,¹⁴⁶ from 2014 through 2017, death rates involving synthetic opioids increased by 617 percent,¹⁴⁷ second only to the 818 percent increase among Black people.¹⁴⁸
- **Indigenous Individuals:** As of 2019, 10.2 percent of Indigenous individuals were living with an SUD¹⁴⁹ compared to the general population rate of 7.4 percent.¹⁵⁰ In 2018, Indigenous people had the highest prevalence of opioid misuse – 30 percent – compared to the general population rate of 3.7 percent.¹⁵¹ The rate of all drug overdose deaths within this community – 25.7 per 100,000 – fell just short of the rate in the white population (27.5 per 100,000).

Opioid Overdose Death Rates 2019: States in which Rates for Black, Hispanic or Indigenous People Exceed Rates for White People



Some state level data reveal similar or even starker racial disparities. 2019 data indicate that opioid overdose death rates were highest among Black residents in 13 states, among Hispanic residents in one state and among Indigenous residents in one state.¹⁵² For drug overdoses more broadly (not just opioids), in 2019, Indigenous residents in Minnesota were seven times as likely as white Minnesotans to die of a drug overdose and Black residents almost twice as likely,¹⁵³ even though Minnesota has “one of the lowest [overall] drug overdose mortality rates in the U.S.”¹⁵⁴ In Georgia, in 2018, Black residents were 1.5 times more likely to die from a cocaine-involved overdose than white residents while less likely to die from drug overdose involving other stimulants (e.g., amphetamines) and opioids.¹⁵⁵

Local community data show a similar trend in the addiction epidemic’s disproportionate impact on Black, Indigenous, and Latinx communities. For example, in Cook County, Illinois, as of May 2020, Black residents, who comprise less than 25 percent of the population, represented 50 percent of opioid-related overdose deaths.¹⁵⁶ In 2017, the Chicago neighborhoods with the most opioid-related overdose deaths were predominantly Black and/or Hispanic,¹⁵⁷ and, in 2018, these rates were highest among Black Chicagoans.¹⁵⁸ Notably, as of 2017, Chicago had the *lowest* buprenorphine treatment capacity in the Midwest and the *third lowest* capacity among all large U.S. cities.¹⁵⁹ Researchers of Chicago’s opioid epidemic have observed that this “can have a disparate impact on African American communities, especially among those living in poverty[.]”¹⁶⁰

Data show that Indigenous individuals, as a whole, have the highest rate of alcohol use disorder, followed by white, Hispanic, and Black individuals.¹⁶¹ The rate of alcohol-induced deaths in 2015 was highest among Hispanic individuals and increased by 50 percent from 1999 to 2015.¹⁶² Data from several cities also reveal racial disparities. For example, in 2017, alcohol-related ED visit rates in Chicago were highest among certain populations, including Black Chicagoans and persons living in zip codes of high economic hardship.¹⁶³ Similarly, from 2012 through 2016, San Francisco saw the highest “alcohol-abuse” related ED visit rates among Black residents aged 25 to 64 years – more than double that of white San Franciscans.¹⁶⁴ Additional national, state and local data are needed to illustrate the SUD epidemic’s impact on Black, Indigenous, and Latinx communities.

2. Racially Disparate ED Care for Substance Use-Related Conditions and Access to Substance Use Disorder Treatment

Research suggests that to provide equitable care, EDs must adopt evidence-based SUD practices that can mitigate the operation of racial and other bias.¹⁶⁵ This is particularly true for Black and Latinx people with SUD, whose chronic medical condition is too often criminalized.¹⁶⁶ ED adoption of evidence-based practices also could mitigate racially disparate patterns of SUD treatment outside of EDs, as identified in the research.

Racial disparities in OUD care are particularly illuminating, revealing racial disparities similar to those that characterize healthcare delivery more generally.

A 2010 two-state study found that the odds of multiple **treat and release ED visits for substance use-related conditions were 45 percent higher for Black patients** than white patients.¹⁶⁷ A study of two urban hospital EDs in New York between 2009 and 2014 revealed that **Black and Hispanic patients were 48 percent and 25 percent, respectively, less likely than white patients to receive any overdose antidote**, including naloxone, which has standardized administration criteria.¹⁶⁸

A recent review of national data on ED use of buprenorphine for OUD showed a more positive trend: buprenorphine administration increased by 300 percent from 2002 through 2017, and the prevalence of administration was greater for patients of color than white patients in the last reported year, 2016 through 2017.¹⁶⁹ The most recent data reverses an earlier trend that showed, for most years, higher rates of buprenorphine administration for white patients. This could be due to more patients of color seeking ED care,¹⁷⁰ and, **if this trend holds, there is the promise that these patients will receive equitable care.**

Continued tracking of this trend is particularly important due to research that has shown lower rates of ED opioid administration and prescription for Black patients presenting with pain.¹⁷¹

Standardized medication administration and referral practices may also help address the racial and ethnic disparities in treatment that persist beyond ED walls. Nationwide, Black patients with OUD are 77 percent less likely than white patients to receive buprenorphine,¹⁷² and individuals with private insurance or who self-pay are most likely to receive buprenorphine treatment.¹⁷³ Yet, even with private insurance coverage, one study found that Black patients are 50 percent less likely than white patients to receive follow-up treatment (i.e., MOUD, outpatient, or inpatient treatment)¹⁷⁴ after visiting the ED for an opioid overdose *and* less likely to receive buprenorphine or naltrexone post-ED discharge.¹⁷⁵ Studies also show that Black youth with OUD are less likely to be prescribed MOUD than white youth.¹⁷⁶ And 2019 data indicate that fewer Hispanic people who needed alcohol use disorder treatment received it at a specialty facility as compared to Black and white people.¹⁷⁷

A full examination of how race and racism impact patient access to OUD and other SUD treatment is beyond the scope of this report. Yet, in the ED context, **it is clear that the patient's race can affect the care delivered.** Since “non-white race is one of the largest predictor[s]” of patients’ mistrust of providers,¹⁷⁸ **hospitals must work harder to earn the trust of Black, Indigenous, and Latinx patients.** Implementation of evidence-based protocols is one way to do so.

E. Conclusion

The SUD epidemic has devastated all communities, with a particularly harsh impact on Black, Latinx, and Indigenous people in some geographic areas. In this context, federal and state authorities, professional organizations, and hospitals have recommended ED adoption of evidence-based SUD practices, in part, to help mitigate bias and improve quality of care. These healthcare professionals “approach[] substance use disorder as a treatable chronic illness—creating an environment that welcomes disclosure of opioid [and other substance] use, provides rapid evidence-based treatment, and enables patients to enter and remain in treatment.”¹⁷⁹

Hospitals that have not adopted evidence-based practices incur greater costs, lose a key opportunity to address racial disparities and, as discussed in the next section, risk legal liability.

II. A Hospital's Failure to Use Evidence-Based Practices Could Violate the Emergency Medical Treatment and Labor Act

A. Introduction

The Emergency Medical Treatment and Labor Act (EMTALA) imposes affirmative medical care requirements on most hospitals that see individuals with substance use-related medical conditions in their ED. EMTALA requires hospitals¹⁸⁰ to conduct a medical screening examination for these individuals¹⁸¹ to determine **whether an emergency medical condition exists**, and to **stabilize those with such a condition** before discharge or transfer to another medical facility.¹⁸² Not all people seeking ED treatment have an emergency medical condition – the prerequisite for stabilization services.

An individual has an **emergency medical condition** if they have “acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected” to seriously jeopardize their health or seriously impair bodily or organ functions.¹⁸³

Thus, the goal of the medical screening examination is to “determine whether a patient with acute or severe symptoms has a life threatening or serious medical condition.”¹⁸⁴ This requires diagnosing the underlying cause of the acute or severe symptoms. If the ED identifies an emergency medical condition, it is required to provide medical treatment, within its capability, that will “assure within a reasonable medical probability that no material deterioration of the condition is likely to result from or occur during” the patient’s discharge or transfer.¹⁸⁵ To prevail on an EMTALA claim, a patient must demonstrate that they have suffered harm as a direct result of the ED’s screening and/or stabilization violation.¹⁸⁶

Individuals with SUD present to the ED with a range of acute SUD-related symptoms: withdrawal or overdose from opioids or other drugs, alcohol intoxication and poisoning, falls, injuries, as well as organ damage and tissue and other infections related to substance use.¹⁸⁷ A diagnostic assessment for SUD, which includes a history of the patient’s substance use based on the DSM-5 criteria, will determine if the patient’s symptoms stem from an SUD and, if so, if the SUD is sufficiently severe to constitute an emergency medical condition.¹⁸⁸ The failure to provide immediate medical attention could result, for example, in respiratory failure, brain or other organ damage, or death. EMTALA provides an individual who presents to an ED for examination or treatment of a substance use-related condition the right to a medical screening examination for an emergency medical condition and, if identified, stabilizing treatment.

A hospital can violate EMTALA in the following ways:

- **Medical Screening Examination.** This violation occurs when an individual presents with a substance use-related condition and the ED either does not conduct an SUD screening and diagnostic assessment to identify an emergency medical condition or conducts a screening and diagnostic assessment that is not consistent with its practices or protocols for individuals with the same symptoms.
- **Stabilization.** This violation occurs when:
 - The ED identifies a patient with OUD but does not offer to administer buprenorphine to treat withdrawal and suppress opioid cravings or provide a facilitated referral to treatment, along with a naloxone prescription; both are required to prevent the material deterioration of the patient’s condition post-discharge.
 - The ED identifies a patient with non-opioid SUD, including alcohol use disorder, and does not provide a facilitated referral to treatment to prevent the material deterioration of the patient’s condition post-discharge and, as appropriate, a naloxone prescription for patients who use drugs that may include opioids.

In short, EMTALA does not require the ED to treat the patient’s underlying SUD. But it *does* mandate that the hospital identify a patient’s SUD, provide medical care for acute symptoms that pose a serious risk to health, and, like other medical conditions, conduct discharge planning so that a patient can obtain treatment of their condition.

B. A Hospital Could Violate EMTALA if Its ED Does Not Conduct a Medical Screening Examination for an Individual Who Presents with a Substance Use-Related Condition to Diagnose a Substance Use Disorder or Follow the Hospital’s Protocols for This Diagnosis

1. An ED Must Conduct Uniform Medical Screening Examinations to Identify Emergency Medical Conditions

EMTALA requires an ED to conduct a medical screening examination of any individual who comes to the ED or hospital property and requests an examination or treatment for a medical condition or has such a request made on their behalf.¹⁸⁹ Once the hospital is on “notice” of the individual and their medical condition, the ED must provide “an appropriate medical screening examination within...[its] capability... to determine whether or not an emergency medical condition exists....”¹⁹⁰ Courts interpret the “medical screening examination” requirement to **mandate a screening examination of every patient who comes to the ED** and requests examination or treatment.¹⁹¹ Accordingly, every individual who presents to an ED for treatment of a substance use-related condition is entitled to a medical screening examination for an emergency medical condition; i.e. the existence of an SUD that is life-threatening.

The **parameters of an “appropriate” medical screening examination** are determined largely by the hospital under the following legal framework: the screening must be “reasonably calculated to determine whether an EMC [(i.e., emergency medical condition)] exists[,]” and the ED must follow the same procedures for all individuals who present with similar symptoms.¹⁹² Each hospital establishes its own medical screening examination protocols or practices based on the ED’s “capability,” including “ancillary services routinely available” to the ED.¹⁹³ Those ancillary services include resources outside of the ED, such as hospital resources and staff that are available to inpatients for emergency services.¹⁹⁴ Courts generally look to the ED’s policies to determine whether it has provided medical screening within its capability¹⁹⁵ and defer to the hospital’s screening procedures finding that the hospital is in the best “position to determine its own capabilities and limitations.”¹⁹⁶ Depending on the presenting symptoms, a medical screening examination can range from a simple process involving a brief history and physical examination¹⁹⁷ to a more complex process involving laboratory tests, scans, and studies, consistent with the hospital’s staff, resources and specialized services.

Courts generally find an EMTALA medical screening examination violation when an ED has failed to implement its medical screening procedure (even if unwritten) or provide the same “level of screening uniformly to all who present with similar complaints.”¹⁹⁸ Courts generally leave the extent and quality of the medical screening to “the judgment and discretion of the qualified medical personnel” performing it,¹⁹⁹ and will consider the hospital’s “capability” to conduct specific diagnostic tests.²⁰⁰ Thus, some courts have ruled that the only question about the adequacy of the medical screening examination is “*whether the hospital adhered to its own procedures, not whether the procedures were adequate...*”²⁰¹ If the ED has adhered to its medical screening examination protocol and practice, a patient’s claim of misdiagnosis or failure to identify one or more emergency medical conditions is construed as a medical malpractice claim, not an EMTALA medical screening violation.²⁰² Yet importantly, some courts have entertained the possibility that “the hospital’s standard was so low that it amounted to no ‘appropriate medical screening.’”²⁰³

2. A Hospital Violates EMTALA if Its ED Does Not Conduct a Medical Screening Examination for Substance Use Disorder or the Examination is Not Consistent with Its Protocols

While EMTALA provides a hospital with significant latitude in establishing medical screening examination protocols and procedures, **an individual who presents to the ED with a substance use-related condition can likely succeed in asserting an EMTALA medical screening examination violation in two scenarios:** first, if the hospital does not conduct a diagnostic assessment to identify whether an individual who presents with acute symptoms associated with alcohol or drug use has an SUD, and the patient suffers harm as a result; and, second, if the ED does not implement its SUD diagnostic procedures uniformly, resulting in patient harm. Several scenarios illustrate this application of EMTALA.

Sufficient medical screening examination: Ned, a young adult with a cocaine use disorder has experienced multiple overdoses and is brought by his parent to the ED while suffering from severe agitation, chest pain, and hallucinations. The parent requests treatment for Ned's symptoms, fearing that continued cocaine use will result in a fatal cocaine/fentanyl overdose. The ED physician conducts a physical examination and takes a history of Ned's substance use based on the DSM-5 criteria. Relying on Ned's responses, the physician diagnoses Ned with cocaine use disorder and notes possible fentanyl use in his chart.

This satisfies EMTALA's medical screening examination requirement because the ED conducted a DSM-based diagnostic assessment to determine whether Ned has an emergency medical condition – SUD – that requires immediate treatment to prevent serious health consequences.

No medical screening examination: Sophia, a sixteen-year-old, is dropped off at the local ED by friends who were using drugs together and administered naloxone to reverse her opioid overdose. The hospital regularly sees patients with drug overdose, and the ED routinely examines these patients' physical conditions to assess vital signs, respiratory function, and alertness, and treats acute symptoms. The hospital has not implemented a medical screening examination procedure to diagnose whether an individual with these symptoms has an SUD. The ED practitioner follows the examination procedure and, after determining that Sophia is alert and has normal respiratory functions, discharges her.

The hospital's failure to conduct a diagnostic assessment of Sophia for an SUD likely violates the ED's obligation to identify whether she has an emergency medical condition that must be stabilized.²⁰⁴ Courts agree that ED "failure to screen at all" is actionable.²⁰⁵ A hospital ED has a legal obligation to examine every individual who presents with a substance use-related condition for an emergency medical condition and, accordingly, must implement an SUD diagnostic assessment procedure. Courts have rejected the assertion that hospitals need only screen for emergency medical conditions that they know exist, as the very purpose of a medical screening examination is to identify *whether* an emergency medical condition exists in order to prevent serious medical consequences.²⁰⁶

Hospitals that do not screen for SUD would be hard pressed to assert that they do not have the capability to do so: an SUD diagnosis requires a practitioner to conduct a targeted physical examination and take a medical and substance use history that is based on the DSM-5 diagnostic criteria, which can be incorporated into the ED's electronic health record.²⁰⁷ See *supra* Sec. I.A. If Sophia, upon discharge, had used drugs immediately to mitigate withdrawal symptoms and suffered a fatal overdose, the hospital could have been liable for its failure to identify her SUD and stabilize the emergency medical condition.

Cursory medical screening examination: In some jurisdictions, a small variation in Sophia’s scenario could alter the legal balance: if, for example, after Sophia’s medical examination, the ED physician asks whether she uses opioids, other drugs or alcohol, and she says, no, that she tried drugs just this one time. The physician notes this response in her chart and identifies “risky drug use.”

Some courts could construe the ED’s question about Sophia’s drug use to be so cursory as to amount to no SUD diagnostic assessment since it did not track the DSM diagnostic criteria – thereby triggering EMTALA liability for failure to conduct an appropriate medical screening examination. See *supra* Sec.I.A.1. Other courts would defer to the hospital’s medical screening procedure – regardless of how weak– because EMTALA requires no more than the procedure’s consistent application to similar patients.²⁰⁹

Failure to conduct a medical screening examination consistent with hospital procedures:

Cynthia arrives at the ED with a broken leg and other physical injuries following a car crash. Hospital procedure requires the ED to administer the NIAAA quantity and frequency alcohol use disorder screening for all patients presenting after an accident or injury, once alert and able to respond, and do a diagnostic assessment for patients with at-risk alcohol use. After setting her leg and treating the other injuries, the physician asks Cynthia whether she drinks alcohol often, but does not conduct the required screening protocol. She says yes, and, as part of her discharge instructions, the physician tells her to cut back her alcohol use and stop driving after drinking. Cynthia leaves the ED, purchases alcohol, resumes drinking, walks into oncoming traffic, and sustains life-threatening injuries.

A second patient, Jon, presents to the same ED with the same injuries from a fall. The ED nurse administers the required NIAAA screening and determines that a diagnostic assessment for alcohol use disorder is required. The ED physician conducts a diagnostic assessment and additional tests to determine whether Jon requires hospital admission to treat severe alcohol withdrawal symptoms.

Cynthia could successfully assert an EMTALA medical screening examination violation based on the ED’s failure to follow its own procedure for alcohol use disorder screening and diagnostic assessment, which it conducts for other patients (e.g., Jon) with the same presenting symptoms. The ED failed to identify an emergency medical condition – alcohol use disorder – that should have been stabilized prior to discharge. While a *de minimis* deviation from a hospital procedure may not violate EMTALA,²¹⁰ courts penalize hospitals for medical screening examination deviations that harm the patient.²¹¹

In sum, **compliance with EMTALA’s medical screening examination requirement is the linchpin for ED patient care**, as the stabilization obligation is triggered only if the ED identifies an emergency medical condition.²¹² Hospitals cannot avoid their stabilization obligation by setting such a low medical screening examination standard that it constitutes *no* “appropriate screening.”²¹³ The wide availability of ED-validated screening protocols for at-risk substance use and clear DSM-5 diagnostic criteria for SUD allows hospitals both to adopt standardized procedures that satisfy EMTALA medical screening examination requirements and avoid liability by implementing the protocols consistently.

C. A Hospital Could Violate EMTALA’s Stabilization Requirement When Its ED Does Not Offer Buprenorphine to Patients with OUD, as Appropriate, or Provide a Facilitated Referral for Patients with Substance Use Disorder

1. An ED Must Provide Care to Prevent Deterioration of a Patient’s Substance Use Disorder Upon Discharge

Under EMTALA, an ED must stabilize a patient identified with an emergency medical condition before discharging or transferring them to another facility.²¹⁴

EMTALA’s stabilization mandate requires hospitals to do the following: provide such medical treatment of the [emergency medical] condition as may be necessary to assure within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.²¹⁵

Like EMTALA’s screening requirement, the scope of stabilization services is based on the “capabilities of the staff and facilities available at the hospital” and, therefore, will vary by hospital.²¹⁶ Per federal guidance, the facility’s capabilities encompass the “physical space, equipment, supplies, and specialized services that the hospital provides (e.g., surgery, psychiatry, obstetrics, intensive care, pediatrics, trauma.)” Staff capabilities include the “level of care” that hospital personnel “can provide within the training and scope of their professional licenses[,]” including coverage through the hospital’s on-call roster.²¹⁷ The hospital must use “all available resources” to stabilize the patient or provide a transfer, consistent with regulatory standards.²¹⁸

Several principles govern the stabilization requirement. First, **in contrast to EMTALA’s screening requirement, its stabilization mandate requires the ED to treat each patient’s emergency medical condition on an individualized basis.** The plain language of EMTALA does “not allow the Hospital to fulfill its duty to provide stabilizing treatment by simply dispensing uniform treatment. Rather, the Hospital must provide that treatment necessary to prevent material deterioration of *each patient’s* emergency medical condition.”²¹⁹ (emphasis added). Federal guidance instructs hospitals to document “the medically indicated treatment necessary to stabilize the [emergency medical condition], the medications, treatments, surgeries and services rendered, and the effect of the treatment on the individual’s emergency condition....”²²⁰

Second, **EMTALA’s definition of “stable”** differs from the term’s clinical meaning because EMTALA requires the ED to provide medical care that will *prevent material deterioration of the condition* as a result of the individual’s discharge or transfer.²²¹ A patient may be considered stable despite the need for follow-up care,²²² and a hospital need not treat their underlying condition.²²³ According to federal guidance, “[a]n individual will be deemed stabilized if the treating physician or [qualified medical personnel] . . . has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.”²²⁴

Courts will likely find a violation of EMTALA when medical records show that the ED did not resolve the emergency medical condition. For example, the court in *Thomas v. Christ Hosp. & Med. Ctr.*,²²⁵ found that records raised a factual question as to whether a patient who was diagnosed with steroid-induced psychosis was stable when the ED discharged her. The ED physician had discharged her with the instruction to immediately stop taking steroids and make an appointment with the prescribing physician. The physician’s discharge decision conflicted with the hospital’s clinical social worker’s assessment that the patient required hospitalization to prevent her from harming her husband. Three days later, after receiving additional medical care, the patient died when she drove her car into a building. The court, relying on federal guidance regarding stabilization of psychiatric emergencies,²²⁶ found that “there is evidence of facts known and recognized by the Hospital staff *at the time of*

discharge indicating that the patient may very well have been unstable.”²²⁷ In *Burditt v. U.S. Dep’t. of Health & Human Servs.*, the court upheld the federal enforcement agency’s conclusion that the ED did not stabilize a pregnant patient’s severe hypertension by simply administering medication to prevent convulsive seizures during her transfer to another facility. The Court found, based on expert testimony, that the patient’s hypertension put her at high risk of suffering serious complications and that she “entered and exited [the hospital] with an emergency medical condition [(i.e., severe hypertension)].”²²⁸

Third, **assessment of ED compliance with EMTALA’s stabilization requirement must be within the context of the specific case**,²²⁹ generally based on medical expert testimony. As the *Burditt* court noted, stabilization is the “[t]reatment that medical experts agree would prevent the threatening and severe consequence of” the patient’s emergency medical condition at discharge or during transfer to another facility.²³⁰ For example, in *Battle ex. rel. Battle v. Memorial Hospital at Gulfport*, a family alleged that the hospital failed to stabilize their infant son’s seizures when ED physicians twice diagnosed their son as suffering from seizures, prescribed an anticonvulsant after the second ED visit, and yet discharged him without identifying the cause of his seizures (i.e., viral encephalitis). The court agreed, finding that the family had presented sufficient evidence that the hospital knew of the infant’s seizure disorder, as documented in his ED chart, and that, based on the family’s expert testimony, a seizure disorder is an emergency medical condition “because deterioration is likely to occur, and in fact, in this case did occur” as a result of the ED’s treatment.²³¹

Regulatory guidance and caselaw demonstrate that the stabilization mandate requires the ED to treat each patient’s emergency medical condition on an individualized basis with treatment reasonably likely to prevent foreseeable “material deterioration” of this condition. Many patients who present to the ED with an SUD will have acute symptoms that constitute an emergency medical condition, as well as an underlying chronic condition that will involve continued substance use if untreated. In contrast to some emergency medical conditions with less predictable trajectories, moderate and severe SUDs are characterized by compulsive drug seeking and use despite adverse consequences.²³² Consequently, ED physicians know that many, if not most, patients will continue to use substances in a potentially life-threatening manner post-discharge if their withdrawal symptoms and cravings for drugs and/or alcohol are not addressed. Without stabilization care, the risk of another overdose, serious accident, or possible death – all of which constitute a material deterioration of their condition – is foreseeable at discharge. Indeed, EDs increasingly provide naloxone at discharge to “protect” patients who will foreseeably resume opioid use and experience a subsequent life-threatening overdose. See *supra* Sec I.A.3. While EMTALA does not obligate an ED to treat the patient’s underlying SUD, it does require treatment of withdrawal symptoms and cravings with medication, if available and appropriate, and connecting a patient to treatment services to prevent the foreseeable deterioration of their emergency medical condition.

A patient with a substance use-related emergency medical condition likely could succeed in proving that the treating ED has not satisfied EMTALA’s stabilization requirement in the two scenarios: first, for a patient with OUD, the ED fails to offer buprenorphine and/or provide a facilitated referral along with naloxone at discharge; and second, for a patient with SUD, the ED fails to provide a facilitated referral at discharge and naloxone for patients who use drugs that may contain opioids.

a. An ED’s Failure to Offer to Administer Buprenorphine, As Appropriate, Prior to Discharge Could Violate EMTALA’s Stabilization Requirement

Many EDs do not satisfy their stabilization obligation for patients with OUD. They provide a range of medications²³³ to treat a patient’s respiratory depression, pain, discomfort or nausea caused by withdrawal, but do not offer or administer the medication that will suppress cravings or treat withdrawal most effectively. See *supra* Sec. I.C. Medical experts agree that opioid agonist medications suppress opioid cravings, treat or avert opioid withdrawal, and protect patients from opioid overdose. **In the ED, buprenorphine is the most practical opioid agonist medication to administer based on safety, ease of administration, and referral options.** Buprenorphine administration is also within the facility and staff’s capability: it does not require ED staff to be X-waivered; ED practitioners routinely administer opioids for other medical conditions; and standardized ED buprenorphine-initiation protocols are available. See *supra* Sec. I.A. Although research has identified low levels of readiness among ED practitioners to administer buprenorphine, practitioners can be trained sufficiently to implement standardized protocols, as demonstrated in EDs across the country.

Caselaw strongly supports an ED’s obligation to administer buprenorphine for stabilization.²³⁴ Just as the *Burditt* court found that the ED’s administration of one medication was insufficient to stabilize a hypertensive pregnant patient’s condition,²³⁵ a court likely would find, based on expert testimony, that administering non-opioid agonist medications to treat withdrawal symptoms alone is not sufficient stabilization for some patients following an opioid overdose. Such medications do not reduce opioid cravings, which will compel the patient to resume opioid use post-discharge with life-threatening consequences. See *supra* Sec. I.C. Indeed, routine ED treatment with naloxone to restore respiratory function *heightens* the patient’s opioid withdrawal symptoms and cravings. Experts would testify that administering an opioid agonist medication, such as buprenorphine, in appropriate cases, is the only way to suppress cravings, avert withdrawal symptoms and protect patients from overdose.²³⁶

Similarly, an ED’s discharge instruction for patients with OUD to stop using opioids and carry naloxone does not constitute stabilization when the ED does not administer medication to prevent deterioration of an OUD. This situation is analogous to *Thomas*, where the court found that the ED violated EMTALA by directing a patient with steroid-induced psychosis to discontinue steroid use, without providing the medication medical experts agreed was necessary for stabilization.²³⁷ And for a patient who returns to the ED with a second OUD-related emergency immediately after discharge, the hospital, like that in *Battle*, could be liable if it did not provide medication to help suppress the patient’s cravings.

An equally strong case would exist if an individual in opioid withdrawal requests ED initiation of buprenorphine. Federal regulatory guidance makes clear that, if an ED patient requests a medication, the ED must determine whether this individual has an emergency medical condition and requires the medication for stabilization. If so, “the hospital has an EMTALA obligation.”²³⁸ Thus, when a patient presents to the ED and discloses that they have an OUD or communicates to ED staff that they are already in OUD treatment but continue to use opioids, the hospital knows that the patient has an emergency medical condition (i.e., OUD) and, absent any contraindications, must offer to administer buprenorphine to stabilize them.

In sum, an ED’s failure to administer buprenorphine or another opioid agonist to treat the patient’s opioid withdrawal symptoms could result in a stabilization violation, as the practitioner should foresee that their condition would deteriorate post-discharge due to continued opioid use. See *supra* Sec. I.A.2.

In defending against these stabilization claims, a hospital likely would assert that administering buprenorphine in the ED is beyond its capability and, thus, not required. But this assertion does not square with the ED’s existing practice of stocking and administering opioid-based medications to patients experiencing pain related to other health conditions or the availability of protocols for identifying patients who can be medicated safely with buprenorphine and protocols for initiation. This “capability” defense, therefore, should not succeed, particularly if ED resistance is based on decisions grounded in stigma. See *supra* Sec. I.C. (Also see discussion in Sec. III about why failure to stock or administer buprenorphine could constitute disability-based discrimination.)

A hospital may also argue that the community standard of care does not require EDs to administer buprenorphine. But while the standard of care for patients presenting with OUD-related emergency medical conditions is evolving in some jurisdictions, ACEP has now reached consensus that *all* EDs should offer buprenorphine to patients with untreated OUD.²³⁹ Equally important, at least one court has ruled that the standard of care is not the measure of compliance with EMTALA; an ED must satisfy EMTALA’s stabilization requirement regardless of whether the necessary treatment exceeds the “prevailing standard of medical care.”²⁴⁰ Here, administration of buprenorphine is needed for stabilization to address the patient’s cravings and help avert or treat withdrawal and prevent resumed opioid use post-discharge. In this context, the fact that buprenorphine can also be used to treat the underlying OUD is immaterial to the hospital’s EMTALA obligation to offer buprenorphine *to prevent deterioration* of the patient’s condition.

b. An ED’s Failure to Provide a Facilitated Referral to a Patient with a Substance Use Disorder Could Violate EMTALA’s Stabilization Requirement

An ED’s failure to provide a facilitated referral to SUD treatment for patients with a substance use-related emergency medical condition, along with a naloxone prescription, as appropriate for patients

with OUD or other drug use that could include opioids, likely will violate EMTALA. While the statute and regulations do not identify ED discharge procedures as a component of stabilization, **CMS has instructed that a patient is ready for ED discharge (in other words, stabilized) “provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions.”**²⁴¹ CMS expects hospitals “within reason to assist/provide discharged individuals the necessary information to secure the necessary follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital.”²⁴² Because most patients with a substance use-related emergency medical condition require SUD care post-ED discharge,²⁴³ EMTALA requires the ED to assist in securing such care. A hospital can reasonably foresee that a patient with moderate or severe SUD will continue to use substances in a life-threatening manner if not properly linked to ongoing treatment and provided with a naloxone prescription, where appropriate. (See discussion about naloxone *supra* Sec. I.A.3).

A facilitated referral increases the likelihood that ED patients will enroll in SUD treatment, thereby satisfying the hospital’s stabilization obligation.²⁴⁴ Hospital discharge practices that consist of little more than providing contact information for SUD treatment services are by no measure a “plan for appropriate follow-up;” this information is not tailored to treatment appropriateness and availability, insurance coverage, language accessibility, and/or transportation considerations. Absent a facilitated referral, a patient will experience delayed outpatient services, increased risk of continued substance use, and worse outcomes.²⁴⁵ Such practices fall far short of standard ED discharge planning for patients with other chronic conditions who receive direct specialist referrals.²⁴⁶

Hospitals are well aware of quality care measures that include identifying SUD treatment services and assisting with referral. Since 2018, the Joint Commission has required its accredited hospitals to have “readily accessible and accurate information” about OTPs to which patients can be referred.²⁴⁷ The National Committee for Quality Assurance’s HEDIS measures track the portion of patients that initiate and engage in treatment following an SUD diagnosis in an ED and, as of 2018, this measure includes medication-based treatment.²⁴⁸ These national measures demonstrate that hospitals should have, within their capability, staff to identify community-based SUD treatment resources, develop referral relationships with treatment providers, and assist patients with referrals at discharge. Indeed, successful models of ED facilitated referrals exist in many jurisdictions. See *supra* Sec. I.B. and App. A.

Some hospitals may assert that they lack staff capacity to conduct facilitated referrals and do not have enough treatment services for referrals – a problem for which they may claim they cannot be responsible. But professional organizations have identified ED incorporation of non-medical staff as one way to maximize referral capacity. For OUD treatment, the combination of new federal guidelines that remove the buprenorphine training requirements for practitioners treating 30 or fewer patients and increased use of telehealth likely will help address shortages of X-waivered practitioners. See *supra* Sec. I.A. While EMTALA would not impose an obligation on a hospital to make a facilitated referral in the absence of office or community-based treatment resources, the ED’s failure to provide effective referrals commensurate with community resources raises a viable stabilization claim for patients who suffer harm as a result of a non-facilitated referral.

D. Conclusion

A hospital can violate EMTALA when its ED does not conduct a medical screening examination for SUD and stabilize a patient with an SUD emergency medical condition. Specifically, **a hospital can violate EMTALA’s medical screening examination requirement** when a patient presents to its ED with substance use-related symptoms and the ED does not conduct an SUD screening and diagnostic assessment to identify an emergency medical condition or does not conduct an SUD medical screening examination that is comparable to its procedure for patients with similar symptoms. **A hospital can violate its stabilization obligation** if, upon identifying an SUD, the ED does not offer to administer buprenorphine to patients with OUD to treat opioid withdrawal and suppress cravings and/or does not provide a facilitated referral to treatment for any patient with an SUD, which would include a naloxone prescription for a patient who has OUD or uses drugs that may include opioids. Under both circumstances, an ED practitioner can reasonably foresee that the patient’s condition will materially deteriorate post-discharge with continued substance use.

III. A Hospital's Failure to Use Evidence-Based Practices Could Violate the ADA and Rehabilitation Act

A. Introduction

A growing number of EDs have incorporated evidence-based practices for SUD – which are supported by substantial research and are legally mandated in some jurisdictions. Yet many EDs have not adopted them – often because of inaccurate stereotypes and assumptions about people with SUD, a recognized disability under federal law.

Two federal laws **prohibit discrimination on the basis of disability** – the Americans with Disabilities Act (ADA)²⁴⁹ and Rehabilitation Act of 1973 (Rehabilitation Act or R.A.).²⁵⁰ Congress enacted these laws “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.”²⁵¹ Together, they require government-run programs and places of public accommodation – including hospitals – to treat individuals with disabilities equally and fairly, based on an objective evaluation of their qualifications for services, rather than outdated stereotypes and myths. The ADA and R.A. also **require “reasonable modifications”** to enable full and fair participation in services or activities by individuals with disabilities.²⁵²

Jointly, the two laws apply to every level of government as well as private entities serving the public, such as hospitals. Specifically, Title II of the ADA (Title II) applies to state and local governments, including the hospitals they operate,²⁵³ while Title III of the ADA (Title III) applies to places of public accommodation, including private hospitals.²⁵⁴ The R.A. applies to programs and activities operated by the federal government, or receiving federal financial assistance, such as Medicare and Medicaid reimbursement.²⁵⁵

The requirements for proving a violation of the ADA or R.A. are similar. An individual generally must prove they have a “disability,” are qualified (or “eligible”) for the services or benefits sought, and that the entity denied those services or benefits because of their disability. Specifically, **Title II** requires a plaintiff to show that they (1) are an individual with a disability, (2) were denied the benefits, services, programs, or activities of a public entity for which they were qualified or were otherwise discriminated against, and (3) this denial was by reason of their disability.²⁵⁶ **Title III** is similar, and requires showing the defendant operates a public accommodation and denied the plaintiff full and equal enjoyment of the accommodation because of their disability.²⁵⁷ The **R.A.** requires showing that the plaintiff – an individual with a disability – is “otherwise qualified” to participate in or receive the benefits of a federally-operated or assisted program, and was denied those benefits “solely” on the basis of disability.²⁵⁸ Due to their similar statutory purposes and elements, most courts analyze the R.A. and ADA together, and the case law is generally interchangeable.²⁵⁹ For brevity, this report sometimes uses the term “ADA” to refer to both the ADA and R.A.

Discrimination can be shown through (1) disparate treatment (denying a service because of an individual's disability), (2) disparate impact (facially-neutral policy that disproportionately affects individuals with a disability), and (3) failure to make a reasonable modification of policies or procedures for an individual's disability.²⁶⁰ **A hospital that does not use evidence-based practices for an ED patient's substance use-related emergency may be liable under two of these theories:**

(1) Disparate Treatment: Where the denial of any of these evidence-based practices is because of hospital personnel's stereotypes and assumptions about people with SUD, rather than legitimate medical considerations, or where the hospital's administrative methods have the effect or purpose of discriminating against people with SUD.

(2) Failure to Make a Reasonable Modification: Where the hospital denies a patient's request for one or more of these evidence-based practices (for example, for buprenorphine for OUD or for a facilitated referral to treatment for a cocaine use disorder) and cannot demonstrate that providing that service would “fundamentally alter” the ED or pose an “undue burden.”

Importantly, a court could find a violation of the ADA and R.A. without a violation of EMTALA. As long as the hospital's denial of evidence-based practices is because of a patient's disability (SUD), the hospital would be liable under the ADA even if a court concluded that EMTALA did not require that ED to provide that evidence-based practice.

B. The ADA and Rehabilitation Act Protect ED Patients with Substance Use-Related Emergencies

The ADA and R.A. generally protect an individual who seeks ED care for a substance use-related emergency – either because they have a “disability” or because these laws prohibit hospitals from denying health services to a patient due to their current illegal use of drugs. An individual can show that they have a “disability” if they (1) have a physical or mental impairment that substantially limits one or more of their major life activities; (2) have a record of such an impairment; or (3) are regarded as having such an impairment.²⁶¹ The R.A. and ADA regulations explicitly state that drug addiction and alcoholism constitute “impairment[s].”²⁶² Moreover, the case law clearly establishes that drug or alcohol addiction can substantially limit one or more major life activities, such as working, breathing, concentrating, and parenting.²⁶³ An ED patient with a substance use-related emergency, therefore, could establish “disability” in any of these three ways.²⁶⁴ Even someone with a substance use-related emergency but not an SUD could satisfy the “regarded as” test if ED personnel viewed them as having an SUD.²⁶⁵

Individuals who are “currently engaging in the illegal use of drugs” are excluded from many of the R.A. and ADA's protections.²⁶⁶ Nonetheless, these laws make clear that they may not be denied health services (including “services provided in connection with drug rehabilitation”) on the basis of such use if they are otherwise entitled to these services.²⁶⁷

The Title III Technical Assistance Manual specifically applies this provision to EDs, stating that an **“emergency room may not refuse to provide emergency services to an individual because the individual is illegally using drugs.”**²⁶⁸ Thus, while an ED patient whose substance use-related emergency is due to current illegal use of drugs (e.g., overdose or injection-related infection) is not an “individual with a disability,” the ADA provides them equivalent protections under this healthcare provision.

It plainly prohibits hospitals from pointing to their illegal use of drugs as justification for denying the very health services they need to address that use – including evidence-based practices that help initiate SUD treatment in the ED.

C. An ED Patient with a Substance Use-Related Emergency Is Qualified for ED Services

An ED patient with a substance use-related emergency can readily establish that they are “qualified” for ED services (as required by Title II) because they have an acute illness or emergency. They also can satisfy the R.A.'s related requirements and receive the ADA's protections for people denied health services due to current illegal use of drugs.

Title II's non-discrimination provisions apply to a **“qualified individual with a disability.”**²⁶⁹ An individual is “qualified” if they “meet[] *the essential eligibility requirements*” for the public entity's services, programs or activities, with or without reasonable modifications.²⁷⁰ An ED patient with a substance use-related emergency plainly meets this standard. They have an acute injury or illness – which is the “essential eligibility requirement” for ED services.²⁷¹

Likewise, an individual currently engaging in the illegal use of drugs is “otherwise entitled” to ED services, including evidence-based practices for “drug rehabilitation.”²⁷² While the ADA does not define “otherwise entitled,” a court should apply the general ADA framework for “qualified” individuals. Congress excluded these individuals from the definition of “disability” in the context of the “war on drugs,”²⁷³ not due to

a principled determination that a person with active drug addiction is not disabled.²⁷⁴ The statutory protections that the ADA retained for current drug users make clear Congress' intent to preserve the right to challenge the denial of the health and drug rehabilitation services needed to address their addiction.²⁷⁵

The R.A.'s protections apply to an **“otherwise qualified” individual with a disability**²⁷⁶ – a standard that an ED patient with a substance use-related emergency could meet. A plaintiff generally satisfies the “otherwise qualified” requirement when denied medical care solely because of their disability rather than due to a legitimate medical reason,²⁷⁷ or if the defendant could have provided the services with a reasonable accommodation.²⁷⁸ In *Wagner by Wagner v. Fair Acres Geriatric Ctr.*, for example, the defendant nursing home denied admission to a woman with Alzheimer's, saying that it lacked sufficient staffing and services to care for her. The trial court held that the plaintiff was not “otherwise qualified” because she was challenging a “medical treatment decision.”²⁷⁹ The appeals court reversed, holding that staffing decisions are “administrative,” not “medical,” and hence firmly within the R.A.'s ambit.²⁸⁰ The court also held that the plaintiff was “otherwise qualified” for the nursing home's services because the facility could have cared for her with a reasonable accommodation such as additional staff.²⁸¹

In sum, the key issue is whether the denial of services was justified by a legitimate medical rationale (in which case the plaintiff was *not* “otherwise qualified”) or was a pretext for discrimination (in which case the plaintiff was “otherwise qualified”).²⁸² ED patients with substance use-related emergencies often will satisfy the “otherwise qualified” requirement because they will be able to show that the ED failed to use evidence-based practices solely because of their disability or current use of drugs. (See *infra* Sec. D for further discussion of proving discrimination “solely” on the basis of disability.)

D. An ED's Failure to Use Evidence-Based Practices Could Be “Because of” Disability

An ED that denies any of the evidence-based practices for a patient with a substance use-related emergency could be liable for discriminating “because of” disability under two ADA and R.A. legal theories – disparate treatment and failure to provide a reasonable modification. Disparate treatment discrimination exists when the ED does not use these practices because of generalizations, assumptions, and stereotypes about people with SUDs, as opposed to legitimate non-discriminatory reasons. Relatedly, the administrative decisions behind the ED's failure to use these practices can constitute “methods of administration” that have a discriminatory purpose or effect on this patient population.²⁸³ Furthermore, when an ED does not provide an evidence-based practice that a patient requests, the hospital (through the ED) can violate the reasonable modification requirement.

1. The ED's Failure to Use Evidence-Based Practices Could Constitute Disparate Treatment Discrimination

The ADA and R.A. provide numerous ways to demonstrate disparate treatment discrimination, including (1) that the individual with a disability was denied the opportunity to participate in or benefit from a covered entity's services because of their disability,²⁸⁴ and (2) that a covered entity's “methods of administration” have the effect or purpose of discriminating against individuals because of their disability.²⁸⁵ As shown below, people denied evidence-based practices in the ED can prove that in some circumstances, these hospitals engage in both forms of disparate treatment discrimination.

How an individual must prove that their disability was “the “cause” of the discrimination (and not something else) depends on the statutory provision²⁸⁶ and jurisdiction.²⁸⁷ Importantly, none of these standards requires the plaintiff to show that another group of ED patients was treated more favorably than people with SUD.²⁸⁸ Nevertheless, some patients likely could prove that an ED treated people with other medical conditions more favorably than people with SUD, providing additional evidence of discrimination.

a. Denial of Opportunity to Benefit from ED Services

i. The ADA Prohibits Denying Health Services Due to Stereotypes and Assumptions About an Individual's Disability

An ED patient with a substance use-related emergency could show that the ED's failure to provide evidence-based practices denies them the opportunity to participate in or benefit from the ED's services because of their disability (SUD).²⁸⁹ In ADA cases involving the discriminatory denial of health services, courts distinguish between claims for disability-based discrimination, which are within the ADA's scope, and malpractice/negligence cases, which are not.²⁹⁰ In *Kimman v. N.H. Dep't of Corr.*, the court explained that treatment decisions can be either so unreasonable as to constitute discrimination or be facially discriminatory due to reliance on stereotypes:

[A] plaintiff may argue that her physician's decision was so unreasonable – in the sense of being arbitrary and capricious—as to imply that it was a pretext for some discriminatory motive, such as animus, fear, or apathetic attitudes.²⁹¹

There, the court found that the jail's failure to provide the plaintiff's prescribed medication *could* violate the ADA because it was “an outright denial of medical services.”²⁹²

Courts have found discrimination when healthcare providers deny people services due to stereotypes, assumptions, and generalizations rather than individualized, legitimate medical judgments. In *Sumes v. Andres*, for example, a pregnant woman sought prenatal care, but, after learning that she was deaf, the defendant obstetrician, said “all deaf people are high risk[]” and refused to treat her.²⁹³ The court held that this refusal was solely due to the obstetrician's assumptions about the woman's deafness.²⁹⁴

Similarly, jails that deny medication for OUD have been held to likely violate the ADA when acting because of stereotypes about disability, and not individualized, bona fide medical considerations. In *Smith v. Aroostook Cnty.*, Ms. Smith alleged that a jail's no-buprenorphine policy denied her the benefits of its healthcare program because of her OUD. The court found that the defendants likely violated Title II because the jail's policy foreclosed assessment of her medical needs and resulted in an “out-of-hand, unjustified denial” of her necessary medication.²⁹⁵ The court also noted defendant's lack of baseline awareness of OUD – despite serving a population that disproportionately dies of OUD – and staff characterization of MOUD as “giving addicts drugs rather than . . . treatment.” Further, the court emphasized that the state had offered significant funds to start an MOUD program, but the defendants had not taken any steps beyond initial discussions of how to provide the medication. These statements and actions “suggest the kind of ‘apathetic attitude’ towards individuals with disabilities that the ADA intends to remedy.”²⁹⁶

Cost is not a justification to deny healthcare based on impermissible stereotypes. In *Mitchell v. Williams*, the court held that the plaintiff had a viable Title II claim when he alleged that he had “been denied medical treatment for Hepatitis C, which the Department of Corrections provides to inmates with less costly medical condition[s]” and which medical professionals said he needed.²⁹⁷

In contrast, courts have found no R.A. or ADA violation when the defendants made individualized, bona fide medical decisions. In *Lesley v. Hee Man Chie*, for example, the court held that the defendant obstetrician did not violate the R.A. or ADA by referring a patient with HIV to a hospital that administered HIV medication during childbirth.²⁹⁸ The court concluded that the doctor's decision was not based on *assumptions* about the patient's HIV status; he conducted an individualized inquiry by consulting multiple physicians and the hospital pharmacy to determine whether he could safely provide HIV medication during labor and delivery.²⁹⁹

Healthcare providers defending discrimination cases sometimes argue that providing the denied services would pose “a *direct threat* to the health or safety of others[.]”³⁰⁰ But this “direct threat” defense is extremely difficult to satisfy. It requires showing “a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices or procedures, . . .”³⁰¹

The defense fails unless the defendant made an “individualized assessment” relying on “current medical knowledge or on the best available objective evidence” and has assessed: (1) “the nature, duration, and severity of the risk[.]” (2) “probability that the potential injury will actually occur[.]” and (3) “whether reasonable modifications of policies, practices, or procedures . . . will mitigate the risk.”³⁰² Reliance on assumptions, stereotypes, and/or speculation does not satisfy the requirement for rigorous, individualized proof.³⁰³ In *Tamara v. El Camino Hosp.*, the plaintiff sued a hospital for denying her request to bring a service dog to inpatient psychiatric treatment, pursuant to its blanket policy banning dogs because they “might dangerously upset some patients” and their “harness[es] could be used as a weapon[.]”³⁰⁴ The court rejected this defense because the policy was based on “generalized speculation” – not an “individualized assessment as to whether this psychiatric ward, at the time of Tamara’s admittance” had patients whom a dog would upset.³⁰⁵

ii. A Patient Could Prove That a Hospital Did Not Use Evidence-Based Practices Because of Stereotypes and Assumptions About Substance Use Disorder

An ED patient with a substance use-related emergency likely could show that the hospital did not use evidence-based practices because of disability (SUD), rather than legitimate medical considerations.³⁰⁶ Consider, for example, a patient who presents with cellulitis from injecting opioids, receives antibiotics and pain relievers, and is discharged with naloxone but not offered any of the other evidence-based practices. That patient could show that the hospital violated the ADA by proving that its true reasons for withholding these practices were stereotypes and assumptions about people with SUDs. The same would hold true for a patient denied one or more of the evidence-based practices for an emergency related to alcohol use disorder or other non-opioid SUD.

The publicly-stated reasons for ED failure to use evidence-based practices generally fall into the three categories listed below. While some of these justifications may reflect challenges to service implementation, they often are not the true reasons for an ED’s denial of these practices and are not legitimate under the ADA:

(1) Provider Attitudes: ED personnel’s stigmatizing views of people who use substances as a “challenging” patient population are well-documented. Some ED providers and hospital leaders assume patients with any SUD are “uncooperative” and “difficult to treat.” They also fear that if “too many” similar patients come to the ED for evidence-based practices, such as buprenorphine for OUD, they will be inundated. Some have even voiced fears of becoming a “[S]uboxone clinic.” See *supra* Sec. I.C. But these perceptions are rooted in stereotypes and assumptions about SUD – not individualized patient assessment. For example, EDs that initiate buprenorphine have not been overwhelmed by patients seeking this service and have found that it can facilitate patient-provider treatment planning.³⁰⁷ These ED rationales are precisely the type of generalized attitudes that courts have found discriminatory.³⁰⁸

(2) Safety: Studies also show that ED personnel often perceive patients with SUD as “aggressive or violent,” disruptive of the ED milieu, and/or likely to harm providers or other patients. See *supra* Sec. I.C. But the ADA does not countenance denying evidence-based practices to *all* people with SUD because *some* people with SUD may be aggressive and violent, any more than it countenances denying all care to people with dementia because *some* people with dementia are violent.³⁰⁹

EDs cite the concern that buprenorphine for OUD will harm patients recently revived with naloxone, not yet in withdrawal, not physiologically dependent on opioids, and/or living with other medical conditions. See *supra* Sec. I.C. But the ADA and R.A. do not permit an ED to adopt a *blanket policy* of not offering MOUD to *any* patient because the medication *may* be contraindicated in *some*.³¹⁰ The law requires an individualized assessment.³¹¹ Moreover, EDs that *do* adopt evidence-based practices demonstrate that EDs can balance patient safety with clinical efficacy by assessing patients to identify any contraindications, determining MOUD dosage and/or formulation, and providing naloxone at discharge. See *supra* Sec. I.B; App. A. In short, ED “safety” concerns about buprenorphine for OUD and aggressive patients related to substance use are too generalized to satisfy the ADA and R.A.’s strict standards.

(3) Insufficient Resources: Some EDs point to insufficient staff, lack of SUD expertise, limited community-based treatment capacity for post-discharge care, and cost as reasons for not providing evidence-based practices. They may posit that EDs are thinly stretched time-sensitive high-pressure environments. Some dismiss the option of providing facilitated referrals and brief interventions through peers and social workers, noting that these roles are not being staffed around the clock and the “lack of treatment capacity in their surrounding communities.”³¹² Regarding patients with OUD, some argue that they have an insufficient number of X-waivered providers to administer buprenorphine. Other EDs say that they do not stock buprenorphine or will not be reimbursed for MOUD due to state laws that permit insurers to require prior authorization and/or deny reimbursement for injuries sustained while “intoxicated.”³¹³

While insufficient resources often pose challenges in EDs, *none* of these reasons is a sufficient legal justification *not* to adopt evidence-based practices. As a threshold matter, cost is not a justification to discriminate on the basis of disability.³¹⁴ In any case, funding is available to support hospitals’ provision of the service(s) at issue (i.e., Medicare reimbursement for EDs that incorporate any evidence-based practice for patients with OUD and state and federal funding).

Moreover, for patients with OUD, HHS practice guidelines now permit providers to prescribe buprenorphine for up to 30 patients *without* completing an eight or 24-hour training.³¹⁵ This is in addition to the longstanding three-day exemption for buprenorphine administration in the ED. *See supra* Sec. I.A.2. This means an ED provider can help ensure patients with OUD can access buprenorphine while they arrange outpatient treatment and/or navigate wait times for a community’s limited SUD resources. EDs can also work around staffing and capacity limitations through non-physicians’ X-waiver eligibility, buprenorphine bridge clinics, and buprenorphine treatment via telemedicine. *See supra* Sec. I.B. Thus, many ED staffing and cost concerns are overstated and insufficient to justify their failure to use these evidence-based practices.

Some EDs might argue that providing buprenorphine for OUD poses a “direct threat” to others. However, concerns about other patients accessing buprenorphine on ED floors³¹⁶ do not rise to anywhere near the level of “direct threat.” EDs already use Pyxis storage systems to store medications on the ED floor and require electronically-entered codes. And, even if the ED were to prescribe take-home buprenorphine as a bridge to treatment, it is packaged safely and poses no greater risk to children than other common ED medications like opioids for pain relief. *See supra* Sec. I.A.2. EDs also might raise this defense due to fears of “violent” behavior by people with SUD. But this generalized fear also would not meet the rigorous requirements for “direct threat.” The fact that numerous EDs provide these evidence-based practices without these problems underscores why this defense likely would fail.³¹⁷

In sum, many EDs provide these evidence-based practices in a cost-efficient manner without compromising the safety of patients or staff.

See supra Sec. I.B; App. A. The common justifications EDs offer for not providing them reflect bias, stereotypes, and generalizations about people with SUDs or resource concerns that courts have found insufficient. A person who is denied these practices could show that the denial was because of their disability.

b. An ED’s Methods of Administration Could Have the Purpose or Effect of Discriminating Against a Patient with a Substance Use-Related Emergency

An ED patient with a substance use-related emergency also could show that the ED’s failure to use evidence-based practices violates the ADA and R.A. because it results from methods of administration that have the purpose or effect of discriminating on the basis of disability.³¹⁸ Courts have found such violations in cases involving resource allocation and failure to conduct individualized evaluations – similar in key respects to the ED practices at issue here.

In *State of Conn. Office of Protection & Advocacy for Persons with Disabilities v. Conn.*, for example, the plaintiffs alleged that Connecticut violated the ADA and R.A., in part, by failing “to adequately assess and identify” the long-term care needs of individuals who were mentally ill.³¹⁹ The court reasoned that assessment and identification of needs were methods of administration that produced a discriminatory effect – unnecessary segregation of individuals with disabilities.³²⁰ Conversely, courts have held that methods of administration do not violate the ADA and R.A. if they are neutral “level of care” determinations without discriminatory effect.³²¹

A patient who presents to an ED with a substance use-related emergency could prevail on similar claims. Take, for example, an ED patient who presents with psychosis or hallucinations from cocaine or methamphetamine and is discharged without either a facilitated referral for treatment or a naloxone prescription. Two weeks earlier, the same patient was at the ED with an overdose from fentanyl-laced cocaine. The ED’s lack of a protocol requiring a facilitated referral with naloxone prescription is a “method of administration” that could have the effect or purpose of disability-based discrimination.³²² The same would be true if an ED discharged a patient with injection drug-related cellulitis without offering buprenorphine initiation and facilitated referral (with naloxone prescription). The “methods of administration” would be the lack of a protocol requiring an offer of buprenorphine initiation and facilitated referral with naloxone prescription. Or, if the hospital does not stock buprenorphine for OUD, but stocks other opioid medications, such as oxycodone for pain relief, its failure to stock buprenorphine is a method of administration that has the effect of discriminating against patients with OUD. In short, the failure to provide evidence-based practices for SUD is often a result of “methods of administration” that have the purpose or effect of discriminating on the basis of disability.

2. An ED’s Failure to Use Evidence-Based Practices as a “Reasonable Modification” Could Violate the ADA and Rehabilitation Act

A hospital also could be liable under the ADA and R.A. when its ED declines a patient’s request for evidence-based practices as a “reasonable modification” of its policy or practice. Both Titles II and III require “reasonable modifications” of policies, practices, and/or procedures in order to avoid discrimination.³²³

An ED must make a **reasonable modification** unless it would “fundamentally alter” the nature of its services or impose an undue administrative or financial burden (“significant difficulty or expense”) – a showing that is difficult to meet.³²⁴

Courts have required healthcare facilities to provide additional staffing, services, and/or medication as reasonable modifications³²⁵ and likely would require an ED to use evidence-based practices – especially in light of the high mortality associated with opioids, including fentanyl. Take, for example, a patient in opioid withdrawal who requests buprenorphine initiation, or a patient with a stimulant use disorder who is concerned about overdosing on fentanyl and requests a facilitated referral to treatment and naloxone. If the ED implements a policy or practice not to provide these services, then the patient’s request is for a “reasonable modification.”

An ED likely could not justify its denial of evidence-based practices under the “fundamental alteration” and “undue burden” defenses. The ED might cite insufficient staff, but hiring additional staff or relying on non-medical staff (e.g., social workers) for some of these services would not fundamentally alter the ED’s nature or constitute an undue burden, especially because it already provides medical services and likely provides facilitated referrals for other conditions.³²⁶ The same is true for screening patients for at-risk substance use and conducting a diagnostic assessment as needed. The initial screening of patients who present with conditions that may involve substance use can be done by non-medical staff. Telehealth and bridge clinics also enable EDs to connect patients with SUD to ongoing care even if community-based SUD treatment centers are limited. See *supra* Sec. I.A. Moreover, the cost and resource justifications EDs cite for denying these services often are overstated. (See *supra* Sec. D.1.a.).

Regarding the fundamental alteration defense, the ED's provision of opioid agonist medication, naloxone, and other evidence-based practices does not transform it into an "OUD clinic" any more than its provision of insulin and asthma inhalers transforms it into a diabetes or asthma clinic. The fact that other EDs successfully provide these and other evidence-based practices (see Appendix A) is further evidence that they are not a fundamental alteration or an undue burden.³²⁷

E. Conclusion

An ED that does not offer evidence-based practices for substance use-related emergencies could be engaging in discrimination on the basis of disability (SUD) in violation of the ADA and R.A. The ED's actions would constitute disparate treatment discrimination if the ED denied these services because of stereotypes and assumptions about SUD, rather than legitimate medical considerations, or because of administrative methods that discriminate against people with SUDs. When the ED withholds these practices, despite a patient's request for them, it also would fail to provide a reasonable modification in violation of these laws.

IV. A Hospital Could be Liable for Race/ National Origin Discrimination in Violation of Title VI of the Civil Rights Act When It Fails to Use Evidence-Based Practices for Substance Use-Related Emergencies

A. Introduction

Black, Latinx, and Indigenous people historically have been denied equal access to healthcare *and*, in some communities, have been disproportionately affected by the substance use epidemic. They need access to evidence-based practices for SUD. When a hospital's ED denies these services on the basis of race and/or national origin, or offers them in a way that impedes access to these communities, a hospital could incur liability for discrimination based on race and/or national origin. Title VI of the Civil Rights Act of 1964 (Title VI) was enacted to bar entities that receive federal funding from discriminating – explicitly or otherwise – on the basis of “race, color, or national origin.”³²⁸ Because most hospital EDs receive federal funding through Medicare and Medicaid, they must comply with Title VI.

Hospitals violate Title VI when they engage in either “disparate treatment” (intentional) or “disparate impact” discrimination – frameworks similar to those used in the ADA (*see supra* Sec. III).³²⁹ EDs that do not use evidence-based practices for Black, Latinx, and Indigenous³³⁰ people who present with substance use-related emergencies could be illegally engaging in either form of discrimination. The data needed to support a disparate *impact* claim could be marshaled in some instances, even if it is not retained in a single database and/or is not publicly available.³³¹ Research provides solid evidence of racially disparate healthcare.

For example, one study found significant racial-ethnic differences in both ED prescription and administration of opioids to patients with non-definitive conditions (e.g., back and abdominal pain).³³² Another study found that Black and Hispanic patients who presented to two urban hospital EDs after opioid overdose were less likely than white patients to be administered naloxone.³³³

These findings show the need to scrutinize a range of hospital practices for race-based discrimination that violates Title VI.

The failure to use evidence-based practices for an ED patient's substance use-related emergency could result in liability under two Title VI theories:

(1) Disparate Treatment (or “Intentional Discrimination”): Where the patient's race was a substantial and motivating factor for a hospital's denial of these evidence-based practices. A patient could establish discriminatory “intent” through direct evidence, such as explicit statements, or indirect evidence that gives rise to an inference of discrimination for which the hospital cannot provide a legitimate, nondiscriminatory rationale.

(2) Disparate Impact: Where the denial of these services disparately impacts Black, Latinx, or Indigenous persons, there is no substantial legitimate justification for these practices, and less discriminatory alternatives exist.

As with the ADA, a court could find a violation of Title VI even without a violation of EMTALA. As long as the hospital's denial of evidence-based practices is because of – or disparately impacts – a patient's race, the hospital would be liable under Title VI even if a court concluded that EMTALA did not require that ED to provide that evidence-based practice.

B. A Hospital that Does Not Use Evidence-Based Practices for Substance Use-Related Emergencies Could Be Liable for Disparate Treatment Discrimination under Title VI

To prevail on a Title VI disparate treatment claim, a plaintiff must demonstrate that the hospital *intended* to discriminate based on race³³⁴ and that race was a substantial and motivating factor for the defendant's actions.³³⁵ Importantly, "intent" does not require malice or ill will, but only an intentional use of race,³³⁶ and can be proved with direct or indirect (circumstantial) evidence.

In cases against healthcare providers, such as hospitals, courts have identified explicit racial statements and race-based classifications as *direct* evidence of intent. For example, the plaintiff in *Penn v. San Juan Hosp., Inc.*, alleged that a hospital violated Title VI through its explicit policy to transfer some Navajo patients seeking emergency care to a hospital 30 miles away.³³⁷ The plaintiff's evidence included (1) the hospital Board's explicit vote to transfer Navajo patients with non-life-threatening conditions and (2) Board meeting minutes stating that transferring these patients was more profitable than treating them, and revealing the hospital's consistent policy regarding "Indians" as posing a problem separate from other ethnic groups.³³⁸ The hospital presented countervailing evidence, including that 21 percent of ED patients were "Indian" at a given time.³³⁹ The court held that the plaintiff made a "substantial evidentiary showing" of discrimination.³⁴⁰ Similarly, a court found that a white medical provider's sequestration of two patients on the assumption that "this Black girl and her family from Nigeria have Ebola" could violate Title VI.³⁴¹ In contrast, a plaintiff who did not allege *any* evidence of intent did not have a viable claim that a pharmaceutical company's high pricing of hepatitis drugs discriminated against "minorities" because Hepatitis C disproportionately infects Black and Latinx people.³⁴²

Indirect evidence exists when circumstances surrounding defendant's discriminatory conduct "give rise to an inference of discrimination."³⁴³ In "indirect evidence" cases, courts often apply the three-part *McDonnell Douglas* "burden-shifting framework."³⁴⁴ First, the plaintiff must show sufficient indirect evidence of intent.³⁴⁵ The burden then shifts to the defendant to produce "a legitimate, nondiscriminatory rationale for its actions[.]"³⁴⁶ If the defendant produces this rationale, the plaintiff must show that it is a "mere pretext for discrimination."³⁴⁷

A Black, Latinx, or Indigenous person could marshal direct or indirect evidence to prove discriminatory "intent" when denied one or more evidence-based SUD services in the ED. Following are just a few illustrative examples.

- A remark by ED personnel or document indicates that the ED did not want to provide these services because doing so would attract more of "those high-need patients from..." referencing a predominantly Black, Latinx, or Indigenous neighborhood (or some other disparaging or race-coded remark).
- An ED does not offer buprenorphine to a Black patient following an overdose, where ED staff was overheard saying: "they are better in a methadone clinic," "they never follow through after discharge," or "even if he got a prescription in the community, he'd probably sell it." This evidence would be even stronger if the ED had offered buprenorphine to white patients who overdosed.
- A hospital system's records – or public records – document its decision to pilot these evidence-based practices in an ED serving one community rather than another because the former is in a white community that has been particularly hard-hit by the overdose epidemic, and the latter, though similarly hard-hit, is in a predominantly Black, Latinx, and/or Indigenous community.

A court could find these remarks, records, and conduct to be strong evidence of discriminatory intent, similar to the medical provider's sequestration of a Black family from Nigeria on the assumption that they had Ebola, and the hospital's decision to transfer Navajo patients to a different hospital, noting that they were a "problem" group.³⁴⁸

Indirect evidence of discrimination, including ED service data by race and ethnicity, could bolster the direct evidence just described – or stand on its own.³⁴⁹ See *supra* Sec. I.D. For example, a review of demographic data for a specific ED may indicate that its treatment of Black, Latinx, and/or Indigenous patients with substance use-related emergencies differs from that of white patients and may form the basis of a Title VI claim. Also, findings such as an ED being less likely to administer naloxone post-opioid overdose to Black and Latinx patients than to white patients could provide other evidence of intent to discriminate against Black and Latinx patients. See *supra id.* While a hospital is likely to provide countervailing, non-discriminatory reasons for its actions, with the right evidence, such a claim could prevail. Notably, EDs that have implemented standardized protocols requiring evidence-based practices for *all* patients with SUD are *less likely* to engage in such disparate treatment discrimination because standard protocols mitigate bias by minimizing opportunities for subjective decision-making.³⁵⁰

C. A Hospital that Does Not Use Evidence-Based Practices for Substance Use-Related Emergencies Could Be Liable for Disparate Impact Discrimination Under Title VI

Given the well-documented racial disparities in access to SUD care³⁵¹ (see *supra* Sec. I.D.) as well as higher increases in drug overdose death rates for Black and Latinx persons in some states and cities, ED failure to use evidence-based practices likely will disproportionately impact some Black, Latinx, and/or Indigenous communities.

While aggrieved individuals may not bring Title VI disparate impact cases in court,³⁵² they may file complaints with the **Office of Civil Rights (OCR)** of the U.S. Department of Health and Human Services, which can investigate, bring enforcement actions, and enter into settlements.³⁵³ Using a combination of hospital data, national, state, and local ED demographics, and other relevant statistics, OCR could potentially bring a disparate impact claim against an ED whose failure to use one or more evidence-based practices disproportionately impacts Black, Latinx, or Indigenous patients in violation of Title VI regulations.³⁵⁴

To prevail on a Title VI disparate impact claim, OCR would need to (1) identify the specific ED practices or policies being challenged and (2) demonstrate that these practices more likely than not disparately impact the individuals at issue. Proof of “disparate impact” requires a “causal link” between the challenged practice and disparate impact identified.³⁵⁵ The practices or policies being challenged are clear – the ED’s failure to use one or more evidence-based practices. This discussion, therefore, focuses on the second element – disparate impact.

To evaluate disparate impact, courts use the burden-shifting framework similar to other claims under the Civil Rights Act of 1964:

The plaintiff must first show by a preponderance of the evidence that a facially neutral practice has a racially disproportionate effect, whereupon the burden shifts to the defendant to prove a substantial legitimate justification for its practice. The plaintiff then may ultimately prevail by proffering an equally effective alternative practice which results in less racial disproportionality or proof that the legitimate practices are a pretext for discrimination.³⁵⁶

1. Disparate Impact on Black, Latinx, and/or Indigenous Persons

With the assistance of statistical analysts and access to publicly *and* privately-held racial demographic data, OCR may be able to marshal sufficient data to show that an ED’s failure to use these evidence-based practices *causes* a disparate impact on Black, Latinx, and/or Indigenous people. The relevant racial demographic data could include information about individuals who (1) seek ED care for substance-related emergencies, (2) receive any evidence-based practice in the ED, and/or (3) die from substance-related conditions. Courts have significant latitude in evaluating evidence of disparate impact and have found disparate impact based on metrics that are sufficiently representative of the

affected population. For example, in *Groves v. Ala. State Bd. of Educ.*, the plaintiffs alleged that the Board of Education’s use of a minimum ACT score cutoff for college sophomores’ admission to Alabama teacher training programs disparately impacted Black applicants.³⁵⁷ The plaintiff cited the statewide racial disparity in ACT scores for people intending to major in education.³⁵⁸ The Board of Education, on the other hand, pointed to a broader pool of individuals – students otherwise eligible for the teacher training program because of their grade point average and English language proficiency scores.³⁵⁹ The court found that neither side’s figures perfectly captured “the relevant pool[.]” and it would be “infeasible, if not impossible to gather . . . fully accurate statistics on the extent to which the minimum score requirement disproportionately excludes black students”³⁶⁰ Nonetheless, the court concluded that the policy “more likely than not” disparately impacted Black students.³⁶¹

The ED’s policies also would need to “cause” the disparate impact, i.e., be traceable to the disparate impact “in a proximate way.”³⁶² In *Larry P. v. Riles*, for example, the court held that the plaintiff successfully showed that IQ tests used to place students in remedial classes caused a disparate impact on Black students who comprised more than 25 percent of students in remedial classes but less than 10 percent of the California school population.³⁶³ The court held that this racial disparity could not be “explained away solely” by the “nondiscriminatory factors” defendants cited, including an allegedly higher incidence of “mental retardation” and poor nutrition and medical care among Black people.³⁶⁴ Instead, the disparity resulted in part from defendants’ “racially and culturally biased” IQ tests.³⁶⁵ Likewise, a disparate impact challenge to New York City’s decision to close one of 17 hospitals was successful where 98 percent of the patients in that hospital were “minorities,” versus 66 percent in the entire municipal hospital system.³⁶⁶

OCR could employ a range of metrics to demonstrate that an ED’s failure to use one or more evidence-based practices disparately impacts Black, Latinx, and/or Indigenous patients who need these services. Through their subpoena power, they could acquire data such as the following:

- **Data About a Specific ED:** Data from the relevant hospital and/or healthcare systems and local health authorities could reveal racial differences in the numbers of people who needed – but did not receive – evidence-based practices for SUD at a specific ED. Take for example an ED that never provides facilitated referrals to patients with SUD even though hospital claims data and/or other hospital records indicate that a significant portion of patients were diagnosed with SUD. Assuming 80 percent of these patients were Black, 10 percent were white, and 10 percent were other races, these data suggest that the ED’s failure to provide facilitated referrals may disparately impact Black patients.
- **Representative Data:** Other data – not specific to a particular ED – could identify a relevant metric (pool of people who are representative of those who needed but did not receive these services). These data could include information gathered by state and local public health or Medicaid authorities. For example, such data might indicate lower prevalence of ED-initiated buprenorphine for Black, Latinx, and/or Indigenous people, despite national data indicating that EDs did not administer buprenorphine to Black patients at lower rates than white patients in the most recent two-year period.³⁶⁷ Helpful state and local data could also include the racial breakdown of individuals in a community (or larger geographic area) who (1) have SUDs, (2) have untreated SUDs, (3) receive medication for OUD,³⁶⁸ (4) visit EDs (including for substance use-related emergencies),³⁶⁹ (5) have overdosed, and/or (6) have died from overdose. If these data are not retained in a single database or explicitly tracked in privately-held records, OCR may be able to assess health service trends by overlaying data from multiple sources, including census tract data and the National Hospital Ambulatory Medical Care Survey’s data on racial and ethnic composition of ED visits with substance-related primary diagnoses (e.g., alcohol-related disorders, opioid-related disorders, drug overdose).³⁷⁰

Racial disparities may be more apparent in geographical areas where Black, Latinx, and Indigenous persons experience significant disparities in drug overdose death rates (and increases thereof), access to SUD treatment, or ED visits for alcohol-related complaints (see *supra* Sec. I.D.). For example, in Cook County, Illinois, Black residents comprised 50 percent of the county’s opioid overdose related

deaths as of May 2020, but less than 25 percent of its population.³⁷¹ If county ED visit data indicated that Black patients use EDs at higher rates than white patients, OCR could argue that some Chicago and/or Cook County hospitals' failure to incorporate evidence-based practices disparately impacts Black patients.³⁷² Minnesota data also might reveal racial disparities given that drug overdose death rates there are seven times higher for Indigenous people than for white people.³⁷³

A hospital likely would argue that these representative metrics are overinclusive because not all people in these categories visit EDs and need these SUD services. But a court could accept these data as sufficiently representative of those who do need these services. Just as the plaintiffs in *Groves* showed that the group of people who intended to major in education at the time they took the ACT was sufficiently representative of the population that would be harmed by a minimum ACT score for a teacher training program,³⁷⁴ OCR could demonstrate that an ED's patient population is sufficiently representative of the Black, Latinx, and/or Indigenous patients disparately impacted by the ED's failure to adopt evidence-based practices.

OCR also could show that ED practices in some places *caused* this disparate impact. EDs likely will point to a host of contributing outside forces (*see supra* Sec. I.D.), such as the lack of community-based care, poverty, and Black and Latinx communities' historic distrust of healthcare providers.³⁷⁵ Nevertheless, in some cases, the data could be strong enough for OCR to successfully counter that this disparate impact was the foreseeable result of ED policies given that population's heavy reliance on EDs for emergency treatment and, by extension, emergency SUD care as well as historically limited healthcare resources in Black and Latinx communities.³⁷⁶

2. Substantial Legitimate Justification and Alternative Less Discriminatory Means

Once OCR establishes “disparate impact,” the burden would shift to the hospital to prove a “substantial legitimate justification” for failing to adopt evidence-based practices,³⁷⁷ meaning that its policy or practice was necessary to achieve a goal that was “legitimate, important, and integral to the institutional mission.”³⁷⁸ Many hospitals would be unable to meet this burden. Even if they could, OCR likely could demonstrate “that other less discriminatory means would serve the same objective.”³⁷⁹

A hospital's conclusory assertions that its practices serve a substantial legitimate justification generally should fail in most instances. In *Meek v. Martinez*, for example, the court held that Florida failed to provide a substantial legitimate justification for the disparate racial impact that its allocation formula for Older Americans Act (OAA) funds caused. The OAA required states to prioritize these funds for “older individuals with the greatest economic or social needs,” particularly “low-income minority individuals.”³⁸⁰ Yet plaintiffs showed (and the court agreed) that one of Florida's prioritized categories – individuals living alone and over age 65 – did just the opposite. It actually favored people who were *not* “minorities” and individuals with greater income and better health.³⁸¹ Moreover, plaintiffs demonstrated less discriminatory alternatives.³⁸² Conversely, such evidence was lacking in *Elston*, where the court held that the Board of Education's relocation of a school to a predominantly white community had the substantial legitimate justification of “building the school” – which was “integral to the Board's educational mission,” and there was no less discriminatory alternative because no other land was available.³⁸³

A hospital that does not use evidence-based practices could argue that re-allocating resources to these services would undermine their mission of providing acute emergency care. Yet this justification would not be persuasive for the reasons addressed earlier in this report. (*See supra* Sec. I.B-C.).

The clear-cut health benefits of providing these services are central to an ED's mission and legal obligation to stabilize patients with emergency medical conditions, including those with SUD.

Additionally, concerns about insufficient resources, safety, and changing the nature of an ED into an SUD treatment program are overstated and can be addressed through alternative, less discriminatory means (as discussed *supra* Sec. I.B-C.).

An ED also might argue that its decisions are necessary under funding algorithms or formulae determining hospital resource allocation, such as the number of patients served or specialty staffing patterns. An ED might even use these algorithms to justify a new pilot program that adopts evidence-based practices in locations serving a white patient population but not EDs serving predominantly Black, Latinx, and/or Indigenous patients. But these arguments should not succeed because the goals of the federal statutes that provide Medicaid and Medicare funding for hospital services actually support the adoption of these evidence-based practices. CMS has articulated “quality strategy” goals for Medicaid and Medicare services that include preventing or minimizing harm in all healthcare settings and “effective prevention and treatment of chronic diseases” through the elimination of “racial and ethnic disparities.”³⁸⁴

Just like the court in *Meek* held that Florida failed to show a demonstrable relationship between its funding formula and the goals of the Older Americans Act,³⁸⁵ a court could find that a hospital’s formulae do not bear a demonstrable relationship to CMS’ stated goals because they exacerbate, rather than reduce, “racial and ethnic disparities” in ED provision of evidence-based SUD care for Black, Latinx, and/or Indigenous patients. In short, they inhibit and even undermine chronic disease “prevention and treatment” for people in these protected groups. An enforcement authority also could point to alternative, less discriminatory means of allocating scarce resources, such as hospital consideration of the incidence of SUD and/or steep increases in rates of drug overdose deaths among Black, Latinx, and Indigenous persons.³⁸⁶

In sum, a court likely would find that a hospital lacked a “substantial legitimate justification” for denying these evidence-based services, that its reasons for doing so were pretextual, and that the enforcement agency demonstrated alternative, less discriminatory means to achieve the hospital’s overall goals.

D. Conclusion

Hospitals could face liability under Title VI for both disparate treatment and disparate impact discrimination when they do not use evidence-based practices for substance use-related emergencies. A court could find that Black, Latinx, and/or Indigenous individuals presented sufficient evidence of “disparate treatment” discrimination through statements or documents revealing racial motivations for differential treatment, or the hospital’s denial of services that are provided to equally-situated white people. Likewise, a court could find that an ED’s denial of these services disparately impacted one of these protected racial/ethnic groups, that there was no substantial legitimate justification for these practices, and that less discriminatory alternatives existed.

Conclusion

Over the last two decades, researchers and clinicians have made great strides in identifying and advancing effective care for SUD that can help quell the overdose epidemic. For patients with any substance-use related condition, SUD screening and diagnosis (including brief intervention for at-risk alcohol use) are critical to identify life-threatening conditions and a facilitated referral to treatment will help to ensure patients are linked to appropriate follow-up care. For patients with OUD, an ED should also offer to administer opioid agonist medication, as appropriate, to avert or treat withdrawal, suppress cravings and prevent overdose. And, at discharge, EDs save lives when they make naloxone available to individuals who use opioids and/or substances with which opioids can be mixed. But persistent stigma and institutional inertia have resulted in too many EDs continuing to address the acute symptoms of an SUD alone.

Hospitals that fail to adopt evidence-based practices could face legal liability under (1) EMTALA for failure to conduct a medical screening examination and, upon identifying a moderate or severe SUD, failure to stabilize with buprenorphine and/or provide a facilitated referral, along with naloxone as appropriate, (2) the ADA and Rehabilitation Act for engaging in disparate treatment discrimination, and failing to provide a reasonable accommodation, and (3) Title VI where the denial of this care results from the ED's intentional racial discrimination and/or disparately impacts Black, Latinx, or Indigenous people.

There is a powerful **legal case for all EDs to adopt evidence-based SUD practices**. By adopting practices that are **clinically effective, help remedy racial disparities, and save lives**, EDs can help end siloed SUD care and dramatically improve health outcomes.

About Legal Action Center

Founded in 1973, the Legal Action Center (LAC) uses legal and policy strategies to fight discrimination, build health equity, and restore opportunity for people with criminal records, substance use disorders, and HIV or AIDS. To learn more, visit www.lac.org.

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Appendix A

Sample of States with ED Evidence-Based Practices

STATE	ACTIVITY
Colorado	<i>Medical Professional Guidance:</i> treatment practice guidelines recommend EDs incorporate evidence-based practices, including SBIRT, buprenorphine administration, and warm handoffs to continue patients on buprenorphine until they can enroll in an MOUD program. ³⁸⁷
Connecticut	<i>Hospital Practice:</i> Yale New Haven Hospital ED provides screening, medication, as appropriate, and facilitated referral to follow-up care for patients with substance-use related conditions. ³⁸⁸
Delaware	<i>Hospital Practice:</i> Christiana Care Health System EDs embed peers to assist with facilitated referrals to local SUD facilities. ³⁸⁹
District of Columbia	<i>Hospital Practice:</i> EDs at Howard University Hospital, MedStar Washington Hospital Center, and United Medical Center provide MOUD to “recent overdose victims” per D.C. overdose reduction plan. ³⁹⁰
Florida	<i>State Law:</i> H.B. 249 (2017) requires hospitals to develop best-practices and policies (e.g., SBIRT, ED peers) to prevent drug overdoses. ³⁹¹
Georgia	<i>Hospital Practice:</i> Northeast Georgia Medical Center EDs hire peers to liaise between hospital staff and patients, linking the latter to local resources (e.g., people in recovery). ³⁹²
Illinois	<i>State Funding:</i> Hospitals receiving certain funding must provide an intensive discharge planning process, including facilitated referrals and provision of ongoing recovery support for patients with SUD. ³⁹³
Louisiana	<i>State Law:</i> Regulations adopted under HB 210 (2015) require licensed medical practitioners who provide naloxone for opioid overdose to provide substance use education and referral to SUD treatment. ³⁹⁴
Maryland	<p><i>State Law, Medical Professional Guidance and Hospital Practice:</i> HB 1329/ SB 967 (2017) requires hospitals to adopt and implement discharge protocols for patients with SUD and/or treated for overdose. The Maryland Hospital Association adopted consensus recommendations to guide protocols including: (1) universal SUD screening; (2) naloxone dispensing or prescription for patients at risk of OUD or who have overdosed on opioids; (3) facilitated referral for patients with SUD; and (4) peer recovery services. 45 hospitals submitted their ED protocols, including those whose EDs initiate buprenorphine, and identified ED-administered buprenorphine as a best practice if patients have access to a second dose the following day.³⁹⁵</p> <p><i>Baltimore City Health Dept. Guidelines (2018):</i> Baltimore City Health Department categorized ED services into three graduated levels of care:³⁹⁶</p> <p>-Level 3 (the most basic level of care that all Baltimore City hospitals are expected to satisfy) requires universal English/Spanish SUD-screening, naloxone prescription, facilitated referrals to community-based SUD treatment, and offer of at least one FDA-approved MOUD.</p>

STATE	ACTIVITY
	<p>-Level 2: requires all level 3 services and offering peer services to ED patients, and certain services (e.g., naloxone) to admitted patients with OUD and/or at high risk of opioid overdose.</p> <p>-Level 1: requires all levels 2 and 3 services, dispensing naloxone to ED patients, and providing certain services (e.g., offer at least one formulation of each MOUD) to admitted patients with OUD.</p>
Massachusetts	<p><i>State Law and Medical Professional Guidance:</i> H4742 (2018), requires acute care hospital EDs to maintain protocols for and ability to provide evidence-based practices, including administration of buprenorphine and/or methadone to patients who have overdosed.</p> <p>The Massachusetts Health and Hospital Association and Massachusetts chapter of ACEP issued recommendations in 2019 for administering and/or prescribing MOUD in EDs, including: (1) ensuring providers are X-waivered or the ED has a telemedicine option for buprenorphine prescribing; (2) coordinating with local community services (e.g., pharmacies) to facilitate continuity of care; and (3) incorporating recovery coaches and support navigators – both covered benefits under Massachusetts’ Medicaid Managed Care and Children’s Health Insurance Programs – into the ED.³⁹⁷</p>
New Mexico	<p><i>Hospital Practice:</i> The University of New Mexico ED uses COWS to identify patients in opioid withdrawal, administers buprenorphine, and recommends discharging patients with a 14-day buprenorphine prescription and list of local SUD clinics.³⁹⁸</p>
New York	<p><i>State Law, State Funding and Hospital Practices:</i> S1507C (2019), requires general hospitals’ EDs to develop “treatment protocols . . . for the appropriate use of medication-assisted treatment, including buprenorphine, prior to discharge[.]” and protocols for situations where ED-administered MOUD is “not feasible[.]”³⁹⁹</p> <p><i>New York City Relay Program:</i> places wellness advocates (i.e., people with lived experience of SUD) in 13 city EDs to provide naloxone to patients with suspected opioid overdoses and engage them in the ED and 24-48 hours after discharge. For up to 90 days post-discharge, the wellness advocate offers supportive services, including naloxone kits, referrals to medication-based treatment, and assistance in receiving housing, food assistance and insurance coverage. “The vast majority” of these EDs initiate buprenorphine.⁴⁰⁰</p> <p><i>Hospital Practices:</i> BUFFALO Matters EDs administer and prescribe buprenorphine (14-day supply); secure follow-up appointment dates and locations for patients; and provide vouchers for a free 7-day supply of buprenorphine to uninsured patients and Medicaid enrollees.⁴⁰¹</p> <p>Ellenville Regional Hospital ED offers MOUD to every patient revived with naloxone, provides them with buprenorphine for 3 days, and connects them to ongoing treatment.⁴⁰²</p> <p>State University of New York-Upstate ED evaluates all patients for OUD, and, as appropriate, treats for opioid withdrawal and refers patients to the bridge clinic for further treatment, including buprenorphine administration.⁴⁰³</p>

STATE	ACTIVITY
Ohio	<i>Hospital Practices:</i> Summa Health System EDs screen patients for OUD, connect patients believed to have OUD with an Addiction Care Coordinator for a formal COWS assessment, initiate buprenorphine, and provide facilitated referrals to OTPs. ⁴⁰⁴
Pennsylvania	<p><i>State Funding:</i> Beginning in 2019, state provides graduated incentive funding to hospitals that implement: (1) ED-initiated buprenorphine with a warm-handoff to community-based SUD services; (2) direct warm handoff to community services for MOUD or abstinence-based treatment; (3) specialized protocol for women with OUD; and/or (4) a pathway for direct inpatient admission for methadone or observation for buprenorphine induction.⁴⁰⁵ EDs that increase the rate of enrollment of Medicaid enrollees in OUD treatment (excluding subsequent ED visits) within seven days of their initial ED visit receive incentive payments.</p> <p><i>State Policy:</i> EDs must implement “warm handoff” policies for persons who survive overdose.⁴⁰⁶</p>
South Carolina	<i>Hospital Practices:</i> Three EDs in the state perform universal OUD screening, offer SBIRT to individuals with OUD, administer buprenorphine to patients who have OUD and are in withdrawal, and make same-day or next day appointments for these patients to continue MOUD. ⁴⁰⁷
Vermont	<i>State Policy:</i> EDs can refer patients who have overdosed or have injection-related infections to statewide hubs built around existing OTPs. ⁴⁰⁸

Endnotes

- ¹ See Ctrs. for Disease Control and Prevention, Understanding the Epidemic, <https://www.cdc.gov/drugoverdose/epidemic/index.html#:~:text=From%201999%E2%80%932019%2C%20nearly%20500%2C000,outlined%20in%20three%20distinct%20waves> (last reviewed Mar. 17, 2021); Overdose Deaths Accelerating During COVID-19: Expanded Prevention Efforts Needed, Ctrs. for Disease Control and Prevention, <https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html#:~:text=Over%2081%2C000%20drug%20overdose%20deaths,Control%20and%20Prevention%20> (last reviewed Dec. 18, 2020).
- ² Substance Abuse and Mental Health Servs. Admin., The National Survey on Drug Use and Health: 2019 4, 9-10 (Sept. 2020), https://www.samhsa.gov/data/sites/default/files/reports/rpt29392/Assistant-Secretary-nsduh2019_presentation/Assistant-Secretary-nsduh2019_presentation.pdf [hereinafter SAMHSA Drug Use Survey].
- ³ Overdose Deaths Accelerating During COVID-19: Expanded Prevention Efforts Needed, Ctrs. for Disease Control and Prevention, <https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html#:~:text=Over%2081%2C000%20drug%20overdose%20deaths,Control%20and%20Prevention%20> (last reviewed Dec. 18, 2020).
- ⁴ Provisional Drug Overdose Death Counts, Ctrs. for Disease Control and Prevention, <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm> (last reviewed July 14, 2021).
- ⁵ Marissa B. Esser et al., Deaths and Years of Potential Life Lost from Excessive Alcohol Use — United States, 2011–2015, Ctrs. for Disease Control and Prevention (Oct. 2, 2020), <https://www.cdc.gov/mmwr/volumes/69/wr/mm6939a6.htm>.
- ⁶ Ctrs. for Disease Control and Prevention, QuickStats: Number of Emergency Department Visits*,† for Substance Abuse or Dependence§ per 10,000 Persons Aged 18 Years, by Age Group — United States, 2008–2009 and 2016–2017 (Dec. 20, 2019), <https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6850a7-H.pdf>.
- ⁷ Kristin M. Holland et al., Trends in U.S. Emergency Department Visits for Mental Health, Overdose, and Violence Outcomes Before and During the COVID-19 Pandemic, 78 JAMA Psychiatry 4, 374 (Apr. 2021), <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2775991> (finding that, overall, ED visit rates were 1 to 45 percent higher in each week of 2020 compared to the corresponding week in 2019).
- ⁸ See Geoff Jackson et al., Opioid-involved Emergency Department Visits in the National Hospital Care Survey and the National Hospital Ambulatory Medical Care Survey, Ctrs. for Disease Control and Prevention, Nat'l Health Statistics Rept, Number 149, 9 (Dec. 15, 2020), <https://www.cdc.gov/nchs/data/nhsr/nhsr149-508.pdf> (last visited Mar. 16, 2021) (seven percent of ED patients with opioid-related conditions died within a year of discharge and, for 20.6 percent, opioid overdose was the underlying cause of death).
- ⁹ Holland et al., *supra* note 7, at 375 (mean number of ED visits for 41-week period of Dec. 29, 2019 to Oct. 10, 2020).
- ¹⁰ Peter M. Mullins et al., Alcohol-Related Visits to US Emergency Departments, 2001-2011, 52 Alcohol & Alcoholism 1 (2017), 122 (Table 1), <https://academic.oup.com/ajcalc/article/52/1/119/2605785>.
- ¹¹ Throughout this report, SUD includes alcohol and other drug use disorders as described in the Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders (5th ed. 2013) [hereinafter DSM-5].
- ¹² Elizabeth A. Samuels et al., A Quality Framework for Emergency Department Treatment of Opioid Use Disorder, 73 Annals of Emergency Med. 237, 238, 243 (2017).
- ¹³ Marc R. Larochelle et al., Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality: A Cohort Study 9 (Feb. 24, 2019) (author manuscript), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6387681/pdf/nihms-1002372.pdf>.
- ¹⁴ Legal Action Center Consumer Survey (Aug. 2020) (Results of this informal survey are on file with the Legal Action Center. Individual names have been changed).
- ¹⁵ *Id.*
- ¹⁶ Note, throughout this report, we use the terms “Hispanic” and Latinx interchangeably. Where a study refers explicitly to “Hispanic,” we generally retain this terminology.
- ¹⁷ Xingyu Zhang et al., Trends of Racial/Ethnic Differences in Emergency Department Care Outcomes Among Adults in the United States from 2005 to 2016, 7 Frontiers in Med. 1, 2 (2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7330111/> (last visited Mar. 22, 2021).
- ¹⁸ Rosanna Coffey et al., Emergency Department Use for Mental and Substance Use Disorders, Healthcare Cost and Utilization Project 36 (2010), https://www.hcup-us.ahrq.gov/reports/ED_Multivar_Rpt_Revision_Final072010.pdf.
- ¹⁹ Marcee E. Wilder et al., Racial Disparities in the Treatment of Acute Overdose in the Emergency Department, 56 Clinical Toxicology 12, 1173, 1175 (2018), <https://www.tandfonline.com/doi/full/10.1080/15563650.2018.1478425> (last visited Mar. 22, 2021). See also Junwei Jiang et al., Disparity in Naloxone Administration During Emergency Medical Services, NASEMSO, <https://nasemso.org/wp-content/uploads/Disparity-in-Naloxone-Administration-by-EMS-Abstract-2019-Florida.pdf> (last visited June 25, 2021) (noting that review of 2017 through 2018 Florida emergency medical services data found higher “odds of naloxone administration” for white people than Black people).

- ²⁰ Austin S. Kilaru et al., *Incidence of Treatment for Opioid Use Disorder Following Nonfatal Overdose in Commercially Insured Patients*, JAMA Network Open 5 (May 27, 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766239>.
- ²¹ This report does not explore state statutory protections or potential medical malpractice liability for EDs that fail to incorporate evidence-based practices.
- ²² U.S. Dep't. of Health and Human Services, Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, 6-1, 6-2 (2016), <https://store.samhsa.gov/sites/default/files/d7/priv/surgeon-generals-report.pdf>.
- ²³ *Id.* at 6-1. Among the key findings of this report is that the mainstream health system will also benefit from integration of SUD care, as integration “can help address health disparities, reduce health care costs... and improve general health outcomes.” *Id.* at 6-2.
- ²⁴ Samuels et al., *supra* note 12, at 238. See also Kathryn Hawk et al., *Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department*, 78 *Annals of Emergency Med.* 1, 6 (2021) (“Detecting and offering evidence-based treatments for patients with opioid use disorder is aligned with the goals of emergency medicine to intervene on high-mortality disease processes.”) (hereafter, “*ACEP Consensus Recommendations*”).
- ²⁵ Gail D’Onofrio et al., *Emergency Departments – A 24/7/365 Option for Combating the Opioid Crisis*, 379 *New Eng. J. Med.* 2487, 2488–89.
- ²⁶ The Surgeon General’s seminal 2016 report states that “[b]uprenorphine or naloxone treatment for opioid misuse should also be available in emergency departments[]” *supra* note 22, at 4-41.
- ²⁷ See, e.g., Nat’l Inst. on Drug Abuse, *Resource Guide: Screening for Drug Use in General Medical Settings*, <https://archives.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/screen-then-intervene-conducting-brief-intervention> (last visited June 13, 2021).
- ²⁸ See, e.g., Nat’l Inst. on Alcohol Abuse and Alcoholism, *Screening for Alcohol Use & Alcohol Related Problems* (2005), <https://pubs.niaaa.nih.gov/publications/aa65/AA65.htm>.
- ²⁹ See, e.g., Ctrs. for Disease Control And Prevention, *Vital Signs, Opioid Overdoses Treated in Emergency Departments 4* (Mar. 2018), <https://www.cdc.gov/vitalsigns/pdf/2018-03-vitalsigns.pdf>.
- ³⁰ See Substance Abuse and Mental Health Servs. Admin., *Use of Medication-Assisted Treatment in Emergency Departments*, HHS Publication No. PEP21-PL-Guide-F (2021), 12, https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep21-pl-guide-5.pdf (hereafter “*MAT in EDs*”).
- ³¹ See, e.g., Hawk et al., *ACEP Consensus Recommendations*, *supra* note 24; Am. Coll. of Emergency Physicians, *Alcohol Screening and Brief Intervention in the Emergency Department*, https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/publichealth/alcohol-screening/alcohol_screening_kit_overview.pdf; BUPE: Buprenorphine Use in the Emergency Department Tool, AM. COLL. OF EMERGENCY PHYSICIANS, <https://www.acep.org/patient-care/bupe/> (last visited June 21, 2021).
- ³² See *ACMT Position Statement Buprenorphine Administration in the Emergency Department*, *Amer. Coll. of Med. Toxicology* 2 (2019), https://www.acmt.net/Library/Positions/ACMT_PS_Bup_ED_9_2.pdf.
- ³³ See, e.g., Am. Coll. of Surgeons Comm. On Trauma, *Alcohol Screening and Brief Intervention (SBI) for Trauma Patients*, *COT Quick Guide* 3 (Sept. 2007), https://storage.googleapis.com/edcompass/quantum/materials/4228_trauma%20centers%20alcohol%20response.pdf.
- ³⁴ See, e.g., Am. Soc’y of Addiction Med., *Amidst COVID-19 Crisis, ASAM Releases Updated National Practice Guideline for Treating Opioid Use Disorder* (Mar. 20, 2020), <https://www.asam.org/Quality-Science/publications/magazine/read/article/2020/03/20/amidst-covid-19-crisis-asam-releases-updated-national-practice-guideline-for-treating-opioid-use-disorder>. See generally Am. Soc’y of Addiction Med., *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update* (2019), https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2.
- ³⁵ See Nat’l Inst. on Alcohol Abuse and Alcoholism, *supra* note 28; Nat’l Inst. on Drug Abuse, *supra* note 27 (“Screening and brief intervention provides an opportunity for clinicians to intervene early and potentially enhance medical care by increasing awareness of the likely impact of substance use on a patient’s overall health.”); Herbert C. Duber et al., *Identification, Management, and Transition of Care for Patients With Opioid Use Disorder in the Emergency Department*, 421 (Oct. 2018) (author manuscript) (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6613583/pdf/nihms-1035709.pdf>).
- ³⁶ See *Amer. Coll. Med. Toxicology* *supra* note 32; Nat’l Inst. on Alcohol Abuse and Alcoholism, *supra* note 28.
- ³⁷ See Nat’l Inst. of Alcohol Abuse and Alcoholism, *supra* note 28 (CAGE); Kathryn Hawk & Gail D’Onofrio, *Emergency Department Screening and Interventions for Substance Use Disorders*, *Addiction Sci. and Clinical Prac.* (2018) (NIAAA quantity and frequency); and Duber et al., *supra* note 35, at 422–23.
- ³⁸ *Policy Statement*, Am. Coll. of Emergency Physicians, *Alcohol Screening in the Emergency Department*, (Jan. 2017), <https://www.acep.org/globalassets/new-pdfs/policy-statements/alcohol-screening-in-the-emergency-department.pdf>; *Amer. Coll. Med. Toxicology* *supra* note 32; Michael Botticelli et al., *Effective Strategies for Hospitals Responding to the Opioid Crisis*, *Inst. for Healthcare Improvement & The Grayken Ctr. for Addiction at Boston Med. Ctr.*, 6 (2019), <https://bcpsqc.ca/wp-content/uploads/2020/03/IHI-Effective-Strategies-for-Hospitals-Opioid-Crisis.pdf>.

- ³⁹ Telephone Interview with Yngvild Olsen, M.D., Medical Director, Institutes for Behavior Resources Inc./REACH Health Servs. & Shawn A. Ryan, MD, Chief Medical Office, BrightView Health (May 26, 2021).
- ⁴⁰ Deborah S. Hasin, et al., *DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale*, 170 *Am. J. Psychiatry* 8, 834 (Aug. 1, 2013), <https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.2013.12060782>; SUD is classified under the DSM-5 as mild, moderate or severe. Individuals who meet two or three criteria have a “mild” disorder; four or five criteria is considered “moderate;” and six or more symptoms is “severe.” Nat’l Inst. on Drug Abuse, *Media Guide: How to Find What You Need to Know About Drug Use and Addiction* (July 2018), 1–2, https://www.drugabuse.gov/sites/default/files/media_guide.pdf; see also Nat’l Inst. on Drug Abuse, *Questions for Identification of Opioid Use Disorder Based on DSM-5*, <https://www.drugabuse.gov/nidamed-medical-health-professionals/your-discipline/emergency-physicians-first-responders/questions-identification-opioid-use-disorder-based-dsm-5>. See also Hawk et al., *ACEP Consensus Recommendations*, *supra* note 24, at 4 (recommended protocols include asking patients questions derived from the DSM-5 to assess for moderate severe OUD and using the Clinical Opiate Withdrawal Scale to determine the severity of opioid withdrawal); Telephone Interview with Olsen & Ryan, *supra* note 39.
- ⁴¹ Samuels et al., *supra* note 12, at 238.
- ⁴² Suneel M. Agerwala & Elinore F. McCance-Katz, *Integrating Screening, Brief Intervention and Referral to Treatment (SBIRT) into Clinical Practice Settings: A Brief Review*, 1-4 (2012) (author manuscript) (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3801194/pdf/nihms404111.pdf>) (citing to Broadening the Base of Treatment for Alcohol Problems (Nat’l Academy Press 1990)). Research has also identified the potential value of SBIRT in identifying risky drug use. Bertha K. Madras, et al., *Screening, Brief Interventions, Referral to Treatment (SBIRT) for Illicit Drug and Alcohol Use at Multiple Healthcare Sites: Comparison at Intake and Six Months*, 99 *Drug Alcohol Depend* 280 (Jan. 1, 2009), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2760304/pdf/nihms90808.pdf>.
- ⁴³ Pierre M. Déry et al., *Alcohol Screening, Brief Intervention, and Referral to Treatment Conducted by Emergency Nurses: An Impact Evaluation*, 36 *J. Emergency Nursing* 542–43 (2010). See also Robert H. Aseltine Jr., *The Impact of Screening, Brief Intervention and Referral for Treatment in Emergency Department Patients’ Alcohol Use: a 3-, 6- and 12-Month Follow-Up*, 45 *Alcohol and Alcoholism* 6, 514, 517–18 (2010), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3104610/pdf/agq058.pdf>; Constance Weisner et al., *Factors Associated with Healthcare Effectiveness Data and Information Set (HEDIS) Alcohol and Other Drug Measure Performance in 2014–2015*, 40 *Substance Abuse J.* 318, 321 (2019) (finding increased rates of treatment engagement among patients with alcohol and/or other substance use disorders who were identified as such in the ED).
- ⁴⁴ *Id.* at 540.
- ⁴⁵ Am. Coll. of Emergency Physicians, *supra* note 38.
- ⁴⁶ Am. Coll. of Surgeons Comm. on Trauma, *supra* note 33.
- ⁴⁷ Methadone, buprenorphine and extended-release naltrexone are FDA-approved medications for OUD treatment, and naltrexone and acamprosate are FDA-approved for alcohol use disorder treatment. Research on the feasibility of administering naltrexone for persons with alcohol use disorder in the ED is currently underway.
- ⁴⁸ Nat’l Acad. of Sci., Eng’g, and Med., *Medications for Opioid Use Disorder Save Lives* 5, 6 and 39 (2019), https://www.ncbi.nlm.nih.gov/books/NBK538936/pdf/Bookshelf_NBK538936.pdf (“Medication-based treatment for OUD focuses first on managing withdrawal symptoms and then on controlling or eliminating the patient’s compulsive opioid use, most commonly with the agonist medications methadone or buprenorphine.”). See Hawk et al., *ACEP Consensus Recommendations*, *supra* note 24, at 2 (“buprenorphine provides a sufficient agonist effect to ameliorate the [opioid] withdrawal syndrome.”).
- ⁴⁹ Elisabeth Poorman, *The Number Needed to Prescribe – What Would It Take to Expand Access to Buprenorphine?*, 384 *New Eng. J. Med.* 1783, 1784 (May 13, 2021), DOI:10.1056/NEJMp2101298.
- ⁵⁰ See Hawk et al., *ACEP Consensus Recommendations*, *supra* note 24, at 2, 4; D’Onofrio et al., *Emergency Departments — A 24/7/365 Option for Combating the Opioid Crisis*, *supra* note 25, at 2488. Although methadone, a Schedule II opioid agonist medication, has a similar success rate in treating OUD, medical experts have concluded that “the safety, ease of administration and referral options of [buprenorphine] make it a better ED-based medication.” Jennifer S. Love et al., *Should Buprenorphine Be Administered to Patients with Opioid Withdrawal in the Emergency Department?*, 72 *Annals of Emergency Med.* 26, 27 (July 2018), [https://www.annemergmed.com/article/S0196-0644\(17\)31754-7/pdf](https://www.annemergmed.com/article/S0196-0644(17)31754-7/pdf). The third FDA-approved medication for opioid use disorder (MOUD) – extended-release naltrexone – requires opioid abstinence for administration, and, thus, has minimal utility for ED care. See Telephone Interview with Gail D’Onofrio, MD, Physician-in-Chief of Emergency Services, Yale New Haven Hospital (Mar. 9, 2021). Buprenorphine administration in the ED can also initiate OUD treatment and prevent overdose.
- ⁵¹ Gail D’Onofrio et al., *Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial*, 313 *JAMA* 1636, 1642 (2015), <https://jamanetwork.com/journals/jama/fullarticle/2279713>.
- ⁵² *Id.* at 1641; Amy Xiong, *Yale Researchers Lead National Opioid Treatment Study*, *Yale News* (Jan. 31, 2017), <https://yaledailynews.com/blog/2017/01/31/yale-researchers-lead-national-opioid-treatment-study/>.
- ⁵³ Gail D’Onofrio et al., *Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention*, 32 *J. Gen. Internal Med.* 660, 662–63 (2016), <https://pubmed.ncbi.nlm.nih.gov/28194688/>.
- ⁵⁴ See Susan H. Busch et al., *Cost Effectiveness of Emergency Department-Initiated Treatment for Opioid Dependence* 6 (Nov. 2017) (author manuscript) (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5657503/pdf/nihms883890.pdf>).

- ⁵⁵ See 21 C.F.R. §1306.07(b). Under the Continuing Appropriations Act of 2021, the Drug Enforcement Administration must amend the three-day rule to permit the dispensing of a three-day supply of buprenorphine at one time rather than requiring daily administration. Further Continuing Appropriations Act, 2021, and Other Extensions Act §1302 (2020). To prescribe buprenorphine for more than 30 patients, an authorized practitioner must be X-waivered (i.e., satisfy education and patient counseling requirements). 21 U.S.C. §823(g) and U.S. Dep't. of Health and Human Servs., Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder, 86 Fed. Reg. 22439 (April 28, 2021) ("HHS Practice Guidelines"). New federal practice guidelines require practitioners who treat 30 or fewer patients to file a notice of intent to prescribe buprenorphine but have removed the education and counseling certification requirements. Under these guidelines, ED practitioners can prescribe buprenorphine for up to 30 patients, without undergoing the training and facilitating the counseling, previously required.
- ⁵⁶ D'Onofrio et al., *Emergency Departments — A 24/7/365 Option for Combating the Opioid Crisis*, *supra* note 25 at 2489.
- ⁵⁷ *Id.* at 2488.
- ⁵⁸ *Id.*
- ⁵⁹ Love et al., *supra* note 50, at 27 (calculating that treating just four people with buprenorphine as opposed to clonidine will result in one additional patient completing withdrawal treatment).
- ⁶⁰ Nora Volkow, *Emergency Departments Can Help Prevent Opioid Overdoses*, Nat'l Insts. of Health (Aug. 27, 2019), <https://www.drugabuse.gov/about-nida/noras-blog/2019/08/emergency-departments-can-help-prevent-opioid-overdoses>.
- ⁶¹ Interview by Nora Volkow of Gail D'Onofrio, *Emergency Care and SUD During COVID-19*, Nat'l Insts. of Health (June 17, 2020), <https://www.drugabuse.gov/videos/emergency-care-sud-during-covid-19>.
- ⁶² SAMHSA, *MAT in EDs*, *supra* note 30 at 12.
- ⁶³ Ctrs. for Disease Control and Prevention, *supra* note 29, at 4.
- ⁶⁴ CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 85 Fed. Reg. 84472, 84643–44 (Dec. 28, 2020), <https://www.federalregister.gov/documents/2020/12/28/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part>.
- ⁶⁵ See Hawk et al., *ACEP Consensus Recommendations*, *supra* note 24, at 3 (recommending EDs “treat opioid withdrawal and offer buprenorphine with direct linkage to ongoing medication for opioid use disorder treatment for patients with untreated opioid use disorder.”); Am. Coll. Med. Toxicology *supra* note 32 at 2.
- ⁶⁶ Am. Coll. of Emergency Physicians, *supra* note 31. See also Hawk et al., *ACEP Consensus Recommendations*, *supra* note 24, at 5 (“Integrating decision support into the electronic health record is highly effective for streamlining the process of ED-initiated buprenorphine with referral for ongoing treatment and is integral for patient and provider satisfaction.”)
- ⁶⁷ Rebecca Tyrrell, *Confronting the Opioid Epidemic: Nine Imperatives for Hospital and Health System Executives*, Health Care Advisory Bd. 27, 33 (Apr. 10, 2018), <https://www.advisory.com/topics/market-trends/2018/04/confronting-the-opioid-epidemic>; see SAMHSA, *MAT in EDs*, *supra* note 30, at 31–32 (standardized protocols).
- ⁶⁸ Reuben J. Strayer et al., *Management of Opioid Use Disorder in the Emergency Department: A White Paper Prepared for the American Academy of Emergency Medicine*, Am. Acad. of Emergency Med. 17 (2019), <https://www.aaem.org/UserFiles/file/AAEMOUDWhitePaperManuscript.pdf>.
- ⁶⁹ See Duber et al., *supra* note 35, at 426; U.S. Dep't of Veteran Affairs & Dep't of Defense, VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders 49 (2015), <https://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGRevised22216.pdf>.
- ⁷⁰ Weisner et al., *supra* note 43, at 321, 324 (explaining that this difference might be due to the need for primary care providers to receive “[a]dditional support and training” to enhance patient motivation, improve referrals and include behavioral health staff).
- ⁷¹ Duber et al., *supra* note 35, at 426. See Colo. Am. Coll. of Emergency Physicians, 2017 Opioid Prescribing & Treatment Guidelines: Confronting the Opioid Epidemic in Colorado's Emergency Departments 1, 29 (2017), https://coacep.org/docs/COACEP_Opioid_Guidelines-Final.pdf.
- ⁷² *Stem the Tide: Addressing the Opioid Epidemic*, Am. Hosp. Ass'n 13 (2017), <https://www.aha.org/system/files/media/file/2020/07/HIIN-opioid-guide-0520.pdf>.
- ⁷³ Samuels et al., *supra* note 12, at 238.
- ⁷⁴ See D'Onofrio et al., *Emergency Departments — A 24/7/365 Option for Combating the Opioid Crisis*, *supra* note 25, at 2487; Samuels et al., *supra* note 12, at 238–39.
- ⁷⁵ NCQA Updates Quality Measures for HEDIS 2018, Nat'l Comm. For Quality Assurance (July 11, 2017), <https://www.ncqa.org/news/ncqa-updates-quality-measures-for-hedis-2018/>.
- ⁷⁶ R³ Report: Requirement, Rationale, Reference, The Joint Comm'n 3 (Aug. 29, 2017), https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/r3_report_issue_11_pain_assessment_8_25_17_final.pdf?db=web&hash=938C24A464A5B8B5646C8E297C8936C1.

- ⁷⁷ See HHS Practice Guidelines *supra* note 55.
- ⁷⁸ See SAMHSA, *MAT in EDs*, *supra* note 30 at 6; *Stem the Tide: Addressing the Opioid Epidemic*, *supra* note 72, at 12; Am. Coll. Of Emergency Physicians, *supra* note 31; Hawk et al., *ACEP Consensus Recommendations*, *supra* note 24, at 4–5.
- ⁷⁹ See SAMHSA, *MAT in EDs*, *supra* note 30 at 16–23; D’Onofrio et al., *Emergency Departments — A 24/7/365 Option for Combating the Opioid Crisis*, *supra* note 25, at 2489; Gail D’Onofrio & Linda C Degutis, *Integrating Project ASSERT: A Screening, Intervention, and Referral to Treatment Program*, 17 Acad. Emergency Med. 903, 910.
- ⁸⁰ *Naloxone: The Opioid Reversal Drug that Saves Lives*, Dep’t of Health & Human Servs., 1–2, <https://www.hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf> (last visited June 6, 2021); Jason Hack, A Unified Naloxone-Guideline Graph, ACEP Now, July 26, 2019, <https://www.acepnow.com/article/a-unified-naloxone-guideline-graph/>.
- ⁸¹ SAMHSA Opioid Overdose Prevention Toolkit, 2–3, <https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf> (last revised 2018). See Nat’l Ass’n of State EMS Officials, *Naloxone Evidence-Based Guidelines*, <https://nasemso.org/projects/project-archive/naloxone-evidence-based-guidelines/> (last visited June 6, 2021).
- ⁸² Writing a naloxone prescription and providing instructions for use “is low-impact to the health system and can be implemented immediately” in an ED. However, because “there can be barriers associated with patients taking the prescription to pharmacy [sic] including pharmacy availability and patient out-of-pocket costs[,]” ED distribution of naloxone directly to the patient can be more effective. Elizabeth A. Samuels et al., *Emergency Department Naloxone Distribution: Key Considerations and Implementation Strategies*, 7, <https://prescribetoprevent.org/wp2015/wp-content/uploads/TIPSWhitePaper.pdf> (last visited June 22, 2021).
- ⁸³ Maureen Boyle, *Opioid Initiative Wave I – Overdose Prevention & Naloxone Distribution*, Emergency Quality Network & Addiction Policy Forum (July 10, 2018) 17, https://www.acep.org/contentassets/7c78d4de4f174ecb966efb8fd58aab28/webinar_opioidsw1_11oend.pdf.
- ⁸⁴ *Id.* at 12.
- ⁸⁵ Deborah Dowell et al., *CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016*, Ctrs. for Disease Control (Mar. 18, 2016), https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm.
- ⁸⁶ See *generally* Dep’t of Health & Human Servs., *supra* note 80.
- ⁸⁷ Am. Coll. of Emergency Physicians, *supra* note 31; Hawk et al., *ACEP Consensus Recommendations*, *supra* note 24, at 4.
- ⁸⁸ Dep’t of Health & Human Servs., *supra* note 80, at 2.
- ⁸⁹ SAMHSA, *supra* note 81, at 14. See, e.g., N.Y. State Dep’t. of Health, *Availability of Naloxone in Pharmacies*, https://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/directories.htm; Off. of Attn’y Gen. Maura Healy, *Narcan Fund*, <https://www.mass.gov/service-details/narcan-fund>; see also Matt Skoufalos, *CamCo Health Systems Team up to Buy Narcan in Bulk*, NJ PEN (Mar. 22, 2018), <https://www.nipen.com/camco-healthsystems-team-up-to-buy-narcan-in-bulk/>.
- ⁹⁰ Boyle, *supra* note 83 at 15.
- ⁹¹ Taeho Greg Rhee & Gail D’Onofrio, *Trends in the Use of Buprenorphine in US Emergency Departments, 2002-2017*, JAMA Network Open, Oct. 20, 2020, at 1–2, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2771868> (based on National Hospital Ambulatory Medical Care Survey data, EDs administered buprenorphine at a rate of 12.3 per 100,000 ED visits in 2002–2003 and increased to 42.8 per 100,000 ED visits by 2016–2017; racially disparate rates of buprenorphine administration, evident from 2002–2015, were not reported in 2016–2017, with higher rates of administration for people of color (22.7 per 100,000 visits) than non-Hispanic white patients (20.1 per 100,000 visits)); Brita Belli, *Yale-Designed Treatment for Opioid Use Disorder in EDs Gains Widespread Use*, Yale News (Oct. 20, 2020), <https://news.yale.edu/2020/10/20/yale-designed-treatment-opioid-use-disorder-eds-gains-widespread-use>.
- ⁹² Fla. Stat. Ann. §395.1041(6)(b) (West 2020).
- ⁹³ An Act for Prevention and Access to Appropriate Care and Treatment of Addiction, ch. 208, 2018 Mass. Acts, <https://malegislature.gov/Laws/SessionLaws/Acts/2018/Chapter208>.
- ⁹⁴ N.Y. Pub. Health Law § 2803-U(1) (2019).
- ⁹⁵ *Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder*, R.I. Dep’t. of Health 6 (Mar. 2017), <https://health.ri.gov/publications/guides/LevelsOfCareForTreatingOverdoseAndOpioidUseDisorder.pdf>.
- ⁹⁶ Colo. Am. Coll. of Emergency Physicians, *supra* note 71.
- ⁹⁷ 19-444-26-1747-01 NOFO SOR Hospital Screening and Warm Handoff, Ill. Dep’t of Human Servs., <https://www.dhs.state.il.us/page.aspx?item=114010> (last visited June 21, 2021).
- ⁹⁸ See *Hospital Quality Improvement Program: Follow-Up Treatment after ED Visit for Opioid Use Disorder Phase 2*, Pa. Dep’t. of Human Servs. 1 (May 2020), https://www.dhs.pa.gov/providers/Documents/Hospital%20Assessment%20Initiative/c_279176.pdf.
- ⁹⁹ Bob Shepard, *UAB ED Launches Opioid Overdose Program*, Univ. of Ala. at Birmingham (Apr. 4, 2019), <https://www.uab.edu/news/health/item/10346-uab-ed-launches-opioid-overdose-program>.

- ¹⁰⁰ See SAMHSA, *MAT in EDs*, *supra* note 30, at 3.
- ¹⁰¹ Margaret Lowenstein et al., *Barriers and Facilitators for Emergency Department Initiation of Buprenorphine: A Physician Survey*, 37 *Am. J. Emergency Med.* 1787 Author's Manuscript, at 5, Fig. 1 (Sept. 2019), (<https://pubmed.ncbi.nlm.nih.gov/30803850/>) (less than 30 percent of physicians felt "somewhat prepared" or "very prepared" to initiate buprenorphine treatment or connect patients from the ED to outpatient treatment. Less than 40 percent felt somewhat or very prepared to determine the level of care for patients with OUD).
- ¹⁰² Kathryn F. Hawk, et al., *Barriers and Facilitators to Clinician Readiness to Provide Emergency Department-Initiated Buprenorphine*, *Jama Network Open*, 1, 4 (May 11, 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2765704>. Yet, one physician who participated in this study noted the inadequacy of ED care for patients with OUD, noting: "I feel like this is [a] particularly vulnerable patient population that we're just saying: 'Here's a sheet. Call some numbers. Good luck.' That's the way it feels when I discharge these folks." *Id.* at 7.
- ¹⁰³ Academic ED SBIRT Research Collaborative, *The Impact of Screening, Brief Intervention, and Referral for Treatment on Emergency Department Patients' Alcohol Use*, 50 *Annals Emergency Med.* 6, 707 (2007), <https://www.bu.edu/bniart/files/2011/02/SBIRT-emergency-alcohol.pdf>.
- ¹⁰⁴ SAMHSA, *MAT in EDs*, *supra* note 30, at 6–7.
- ¹⁰⁵ Samuels et al., *supra* note 12, at 239. See Hawk et al., *ACEP Consensus Recommendations*, *supra* note 24, at 6 ("Stigma is often unwitting, unrecognized, and unaddressed by physicians, and stigmatizing attitudes, language, and behaviors are often solidified during training."); SAMHSA, *MAT in EDs*, *supra* note 30, at 6–7 and 24–26; and Hawk et al., *supra* note 102, at 8 (barriers to ED-initiated buprenorphine include "a lack of formal training, limitations on time, limited knowledge of local treatment resources, absence of local protocols and referral networks, and perceptions or culture that this falls outside the scope and practice of emergency medicine.") .
- ¹⁰⁶ Samuels et al., *supra* note 12, at 238.
- ¹⁰⁷ Samuels et al., *supra* note 12, at 238–39 (noting that EDs do not have "standardized approaches...[for] the identification of opioid use disorder and treatment of acute opioid withdrawal[,] " needed for acute diagnostic testing. Similarly, "linkage to opioid use disorder treatment has yet to become standard of care in many EDs").
- ¹⁰⁸ Kay Cahill, *Upping the Odds for Addiction Recovery*, *Mass. Gen. Hosp.* (June 17, 2018), <https://giving.massgeneral.org/upping-odds-for-addiction-recovery/>; Hawk et al., *supra* note 102, at 7 (reporting statements by two attending physicians regarding "perceived scope of emergency medicine and competing demands on time[:]" "As an emergency physician, that [buprenorphine initiation in ED] has not been part of our culture to start any kind of long-term therapy." A second attending physician stated, "It's a matter of limited resources in the emergency department. Every minute that I'm writing a suboxone prescription is a minute that I'm not with my critically ill patient").
- ¹⁰⁹ Everett Stephens et al., *Opioid Toxicity*, *Medscape* (June 6, 2020), <https://emedicine.medscape.com/article/815784-print>.
- ¹¹⁰ See Scott G. Weiner et al., *One-Year Mortality of Patients After Emergency Department treatment for Nonfatal Opioid Overdose*, 75 *Annals of Emergency Med.* 13, 17 (Jan. 2020).
- ¹¹¹ D'Onofrio et al., *Emergency Departments — A 24/7/365 Option for Combating the Opioid Crisis*, *supra* note 25, at 2488.
- ¹¹² See *id.* at 2488.
- ¹¹³ Reuben Strayer, *Overcoming Barriers to ED-Initiated Buprenorphine*, *Emergency Physicians Monthly* (Nov. 4, 2019), <https://epmonthly.com/article/overcoming-barriers-to-ed-initiated-buprenorphine/>.
- ¹¹⁴ Stephens et al., *supra* note 109.
- ¹¹⁵ Debra E. Houry et al., *Opportunities for Prevention and Intervention of Opioid Overdose in the Emergency Department*, *Annals of Emergency Med.* 688 (Mar. 6, 2018), [https://www.annemergmed.com/article/S0196-0644\(18\)30079-9/pdf](https://www.annemergmed.com/article/S0196-0644(18)30079-9/pdf).
- ¹¹⁶ D'Onofrio et al., *Emergency Departments — A 24/7/365 Option for Combating the Opioid Crisis*, *supra* note 25, at 2487; *MAT in EDs*, *supra* note 30, at 24–26.
- ¹¹⁷ Sarah E. Wakeman et al., *Attitudes, Practices, and Preparedness to Care for Patients with Substance Use Disorder: Results from a Survey of General Internists*, 37 *Substance Abuse J.* 4 (2016), 635, 637.
- ¹¹⁸ Stuart Henderson et al., *Social Stigma and the Dilemmas of Providing Care to Substance Users in a Safety-Net Emergency Department*, 19 *J. of Health Care for the Poor and Underserved* 4 (2008), 1336. See also Wakeman et al., *supra* note 117, at 637 (97 percent of hospitalists and 95 percent of primary care practitioners found patients with SUD "more challenging [to care for] than the average patient" and over 60 percent of both practitioner types found that caring for patients with SUDs was not "as satisfying as other clinical activities").
- ¹¹⁹ Wakeman et al., *supra* note 117 at 635–36 (stigmatization correlates with decreased provider engagement and is associated with "poor mental and physical health and decreased treatment access."); Leonieke C. van Boekel et al., *Stigma Among Health Professionals Towards Patients with Substance Use Disorders and Its Consequences for Healthcare Delivery: Systematic Review*, 131 *Drug and Alcohol Dependence* (2013), 33 (stigmatization correlates with negative treatment outcomes for patients); Dea L. Biancarelli et al., *Strategies Used by People Who Inject Drugs to Avoid Stigma in Healthcare Settings*, 198 *Drug and Alcohol Dependence* (2019), 82–3 (stigmatization correlates with patient avoidance of treatment); and Henderson et al., *supra* note 118 at 1343 (labeling a patient as "drug seeking" can negatively affect patient care).

- ¹²⁰ Cal. Healthcare Found., *Emergency Care for the Opioid Epidemic: Leaders Discuss Medication Assisted Treatment in the ED 3* (July 2016), <https://www.chcf.org/wp-content/uploads/2017/12/PDF-EmergencyCareOpioid.pdf>.
- ¹²¹ D'Onofrio et al., *Emergency Departments — A 24/7/365 Option for Combating the Opioid Crisis*, *supra* note 25, at 2488.
- ¹²² Henderson et al., *supra* note 118, at 1343–44.
- ¹²³ *Overcoming Barriers to ED-Initiated Buprenorphine*, *supra* note 113; D'Onofrio et al., *Emergency Departments — A 24/7/365 Option for Combating the Opioid Crisis*, *supra* note 25, at 2489.
- ¹²⁴ Telephone Interview with Yngvild Olsen, M.D., Medical Director, Institutes for Behavior Resources Inc./REACH Health Servs. (Jan. 22, 2021).
- ¹²⁵ Coffey et al., *supra* note 18, at 4.
- ¹²⁶ See, e.g., Henderson et al., *supra* note 118, at 1345.
- ¹²⁷ Lowenstein et al., *supra* note 101, at 5 Fig. 1; Hawk et al., *supra* note 102, at 6–7 (although practitioners acknowledged high prevalence of OUD among patients, they identified limited formal training in the treatment of OUD and the need for leadership commitment to change ED practice).
- ¹²⁸ Abby Goodnough, *This E.R. Treats Opioid Addiction on Demand. That's Very Rare.*, N.Y. Times (Aug. 18, 2018), <https://www.nytimes.com/2018/08/18/health/opioid-addiction-treatment.html>; R.I. Dep't. of Health, *supra* note 95, at 15.
- ¹²⁹ Telephone Interview with Suzanne Doyon, MD, Medical Director, Connecticut Poison Control Center (June 30, 2020).
- ¹³⁰ See Letter from Victor E. Friedman, MD, ACEP President, to Brenda Destro, Ph.D., Deputy Assistant Sec'y Planning and Evaluation, Dep't of Health and Human Servs. (Aug. 29, 2019), 1, 3, <https://www.acep.org/globalassets/sites/acep/media/advocacy/federal-advocacy-pdfs/acep-response-to-ensuring-patient-access-and-effective-drug-enforcement-request-for-information.pdf>. Telephone Interview with Marla Oros, RN, Pres., The Mosaic Grp. & Sadie M. Smith, MSW, Chief Program Officer for Behavioral Health, The Mosaic Grp. (June 1, 2020).
- ¹³¹ See Coffey et al., *supra* note 18, at 5 (internal citations omitted).
- ¹³² SAMHSA, *MAT in the ED* *supra* note 30.
- ¹³³ Duber et al., *supra* note 35, at 423.
- ¹³⁴ D'Onofrio et al., *Emergency Departments — A 24/7/365 Option for Combating the Opioid Crisis*, *supra* note 25, at 2489; see App. A.
- ¹³⁵ See, e.g., Scott E. Hadland et al., *Trends in Receipt of Buprenorphine and Naltrexone for Opioid Use Disorder Among Adolescents and Young Adults, 2001-2014*, 171 *JAMA Pediatrics* 747, 749 (2017), <https://jamanetwork.com/journals/jamapediatrics/fullarticle/263243>; Christopher J. Hammond & Kevin M. Gray, *Pharmacotherapy for Substance Use Disorders in Youth*, 25 *J. Child Adolescent Substance Abuse* 292, 298–300 (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5222569/pdf/nihms-806032.pdf>.
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- ¹³⁷ Studies have found a “strong association” between frequent ED visits for severe psychiatric illnesses and an SUD diagnosis, and a link between multi-substance use and increased ED visits. See Aimee Moulin et al., *Substance Use, Homelessness, Mental Illness and Medicaid Coverage: A Set-up for High Emergency Department Utilization*, 19 *W. J. Emergency Med.* 902, 904 (2018); *Public Health and Injury Prevention Committee, After the Emergency Department Visit: The Role of Harm Reduction Programs in Mitigating the Harms Associated with Injection Drug Use An Information Paper*, *Am. Coll. of Emergency Physicians* (June 2019), 1–2, <https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/after-the-ed-visit---the-role-of-harm-reduc-progs-in-mitigating-the-harms-assoc-with-inj-drug-use.pdf>.
- ¹³⁸ See, e.g., Ctrs. for Disease Control and Prevention, *Annual Surveillance Report of Drug-related Risks and Outcomes*, Table 3E at 95 (Nov. 1, 2019), <https://www.cdc.gov/drugoverdose/pdf/pubs/2019-cdc-drug-surveillance-report.pdf> [hereinafter *CDC Surveillance Report*] (in 2016, Medicaid paid for almost 40 percent of ED visits for all drug poisoning).
- ¹³⁹ Zhang et al., *supra* note 17.
- ¹⁴⁰ WeiWei Chen et al., *Racial/Ethnic Disparities in Opioid Use Disorder and Poisoning Emergency Department Visits in Florida*, *J. of Racial and Ethnic Health Disparities*, Published online Nov. 2, 2020 (finding that, in Florida, opioid-related ED visit rates for whites significantly exceeded that for Black and Hispanic individuals when measured on the basis of individual race/ethnicity, but the visit rates for Black and white individuals was similar when patients were grouped by the dominant race of their communities.).
- ¹⁴¹ For example, Indigenous people are often mis-coded as “non-Hispanic white” and many overdose datasets exclude homeless and incarcerated individuals. See Scarlett L. Gomez & Sally L. Glaser, *Misclassification of Race/Ethnicity in a Population-based Cancer Registry (United States)*, 17 *Cancer Causes & Control*, 771–775 (2006), <https://link.springer.com/article/10.1007%2Fs10552-006-0013-y> (last visited Mar. 22, 2021); Telephone Interview with Ayana Jordan, M.D., Asst. Professor of Psychiatry, Yale School of Medicine (Feb. 9, 2021).
- ¹⁴² CDC Surveillance Report, *supra* note 138, at 99.

- ¹⁴³ Christine L. Mattson et al., *Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths – United States, 2013–2019*, Ctrs. for Disease Control and Prevention (Feb. 12, 2021), [https://www.cdc.gov/mmwr/volumes/70/wr/mm7006a4.htm#:~:text=In%202019%2C%20a%20total%20of%2049%2C860%20\(70.6%25\)%20drug%20overdose.in%20the%20West%20\(26.4%25\)](https://www.cdc.gov/mmwr/volumes/70/wr/mm7006a4.htm#:~:text=In%202019%2C%20a%20total%20of%2049%2C860%20(70.6%25)%20drug%20overdose.in%20the%20West%20(26.4%25).). A study of national emergency medical services data found that both Black and Latinx individuals experienced the highest percentage increase in overdose-associated cardiac arrests in 2020 compared to white people: a 50 percent increase versus a 38 percent increase even though white people had the highest rates at baseline. Joseph Friedman et al., *Racial/Ethnic, Social, and Geographic Trends in Overdose-Associated Cardiac Arrests Observed by U.S. Emergency Medical Services During the COVID-19 Pandemic*, *JAMA Psychiatry*, (May 2021), E2, E7, doi:10.1001/jamapsychiatry.2021.0967.
- ¹⁴⁴ Substance Abuse and Mental Health Servs. Admin., *The Opioid Crisis and the Black/African American Population: An Urgent Issue* 3–5 (Apr. 2020), https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf [hereafter “SAMHSA Black/African American Issue Brief”]. See Friedman et al., *supra* note 143, at E7 (“Disproportionate numbers of Black people who use drugs are exposed to fentanyl.”).
- ¹⁴⁵ Holly Hedegaard, *Increase in Drug Overdose Deaths Involving Cocaine: United States, 2009–2018*, Ctrs. for Disease Control & Prevention, NCHS Data Brief 3 (Oct. 2020), <https://www.cdc.gov/nchs/data/databriefs/db384-H.pdf>.
- ¹⁴⁶ Substance Abuse and Mental Health Servs. Admin., *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue* 2–3 (July 2020), <https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Hispanic-Latino-Population-An-Urgent-Issue/PEP20-05-02-002> [hereinafter “SAMHSA Hispanic/Latino Issue Brief”].
- ¹⁴⁷ *Id.* at 4.
- ¹⁴⁸ SAMHSA *Black/African American Issue Brief*, *supra* note 144, at 5.
- ¹⁴⁹ Substance Abuse and Mental Health Servs. Admin., *2019 National Survey on Drug Use and Health: American Indians and Alaska natives (AI/ANs)* 4 (Sept. 2020), <https://www.samhsa.gov/data/sites/default/files/reports/rpt31098/2019NSDUH-AIAN/AIAN%202019%20NSDUH.pdf>.
- ¹⁵⁰ Substance Abuse and Mental Health Servs. Admin., *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* 40 (Sept. 2020), <https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFRRPDFWHTML/2019NSDUHFRR1PDFWO90120.pdf>.
- ¹⁵¹ See CDC Surveillance Report, *supra* note 138, at 80.
- ¹⁵² Kaiser Family Found., *Opioid Overdose Deaths by Race/Ethnicity, Timeframe: 2019*, <https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity/?dataView=2¤tTimeframe=0&selectedDistributions=white-non-hispanic—black-non-hispanic—hispanic&sortModel=%7B%22collid%22:%22Location%22:%22sort%22:%22asc%22%7D> (last visited May 2, 2021). Arizona, Colorado, Illinois, Iowa, Michigan, Minnesota, Missouri, New Jersey, Ohio, Pennsylvania, Washington, West Virginia and Wisconsin had higher overdose death rates for Black residents than white residents. New Mexico had a higher opioid overdose rate among Hispanic individuals than white individuals, and Alaska had a higher overdose rate among Indigenous individuals than white individuals.
- ¹⁵³ Minn. Dep’t of Health, *Differences in Rates of Drug Overdose Deaths by Race* 6 (2020), <https://www.health.state.mn.us/communities/opioids/documents/raceratedisparity2019prelimfinal.pdf>.
- ¹⁵⁴ *Id.* at 1.
- ¹⁵⁵ Ga. Dep’t. of Health, *Stimulant Overdose Surveillance Preliminary Report Georgia 2016–2018* (2018) 9, <https://dph.georgia.gov/document/document/2018-stimulant-overdose-surveillance-preliminary-report/download>.
- ¹⁵⁶ Duaa Eldeib & Melissa Sanchez, *Opioid Overdoses Keep Surging in Chicago, Killing Black People on the West Side*, PROPUBLICA (July 14, 2020, 5:11 PM), <https://www.propublica.org/article/opioid-overdoses-keep-surging-in-chicago-killing-black-people-on-the-west-side>.
- ¹⁵⁷ See Chi. Health Atlas, *Drug Overdose Mortality*, <https://chicagohealthatlas.org/indicators/VRDO?topic=drug-overdose-mortality> (last visited June 21, 2021) for neighborhood demographics.
- ¹⁵⁸ See Chi. Health Atlas, *Drug Overdose Mortality Rate*, <https://chicagohealthatlas.org/indicators/VRDOR?topic=drug-overdose-mortality-rate> (last visited June 21, 2021).
- ¹⁵⁹ Stephanie Schmitz Bechteler & Kathleen Kane-Willis, *Issue Brief: Whitewashed: The African American Opioid Epidemic*, Chi. Urban League 2, 6 (Nov. 2017), https://chiul.org/wp-content/uploads/2019/01/Whitewashed-AA-Opioid-Crisis-11-15-17_EMBARGOED_FINAL.pdf.
- ¹⁶⁰ *Id.* at 2.
- ¹⁶¹ These data are based on a 2012 through 2013 database. Patrice A.C. Vaeth et al., *Drinking, Alcohol Use Disorder, and Treatment Access and Utilization among U.S. Racial/Ethnic Groups*, 41 *Alcoholism Clinical & Experimental Rsch.* 4, Table 2 (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5205547/pdf/nihms828418.pdf>.
- ¹⁶² Betzaida Tejada-Vera, *QuickStats: Age-Adjusted Death Rates* Attributable to Alcohol-Induced Causes, by Race/Ethnicity – United States, 1999–2015*, Ctrs. for Disease Control and Prevention, *Morbidity and Mortality Weekly Rept.* (May 12, 2017), <https://www.cdc.gov/mmwr/volumes/66/wr/mm6618a12.htm>.
- ¹⁶³ See Chi. Dep’t of Pub. Health, *Alcohol Use and Outcomes in Chicago*, 13 (June 2019), https://www.chicago.gov/content/dam/city/depts/cdph/statistics_and_reports/Alcohol%20Epidemiology%20Report%205.24.2019.pdf.

- ¹⁶⁴ See S.F. Health Improvement P'ship, San Francisco Community Health Needs Assessment 2019, 33, https://www.hospitalcouncil.org/sites/main/files/file-attachments/chna_2019_report_052919.pdf?1571263406 (last visited Mar. 26, 2021).
- ¹⁶⁵ Erin Dehon et al., *A Systematic Review of the Impact of Physician Implicit Racial Bias on Clinical Decision Making*, 24 Acad. Emergency Med. 8, 901–02 (2017), <https://pubmed.ncbi.nlm.nih.gov/28472533/> (last visited Mar. 22, 2021) (noting that, despite the prevalence of implicit bias among physicians, most reviewed studies “concluded that physicians’ implicit racial biases do not influence clinical decision making,” although some studies reached a different conclusion. The authors identified the importance of standardized protocols in mitigating bias).
- ¹⁶⁶ Nora D. Volkow, *Addiction Should be Treated, Not Penalized*, Health Affairs Blog, April 27, 2021, <https://www.healthaffairs.org/doi/10.1377/hblog20210421.168499/full/>.
- ¹⁶⁷ Coffey et al., *supra* note 18, at 36.
- ¹⁶⁸ Wilder et al., *supra* note 19, at 1175.
- ¹⁶⁹ Rhee & D’Onofrio, *supra* note 91.
- ¹⁷⁰ Telephone Interview with D’Onofrio, *supra* note 50.
- ¹⁷¹ Astha Singhal et al., *Racial-Ethnic Disparities in Opioid Prescriptions at Emergency Department Visits for Conditions Commonly Associated with Prescription Drug Abuse*, 11 PLoS One 8, 2 (2016), <https://pubmed.ncbi.nlm.nih.gov/27501459/> (last visited Mar. 22, 2021) (study found significant racial-ethnic differences in both opioid prescriptions and administration in the ED for non-definitive conditions of back pain and abdominal pain but not for other conditions of toothache, kidney stones and long-bone fractures); Monika K. Goyal et al., *Racial Disparities in Pain Management of Children with Appendicitis in Emergency Departments*, 169 JAMA Pediatrics 996, 1000 (Nov. 2015), <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2441797> (identified stark racial disparities in administering opioid analgesics for the management of abdominal pain related to appendicitis in black and white children).
- ¹⁷² See Volkow, *supra* note 166, citing Pooja A. Lagisetty et al., *Buprenorphine Treatment Divide by Race/Ethnicity and Payment*, 76 JAMA Psychiatry 9 (Sept. 2019), https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2732871?guestAccessKey=85d2749b-f483-45ae-ad34-513cfa5584a2&utm_source=For.The.Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tf&utm_term=05082019 (reviewing data for outpatient visits that included buprenorphine prescription and were recorded in the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey from 2004 through 2015).
- ¹⁷³ Lagisetty et al., *supra* note 172, at 979.
- ¹⁷⁴ Kilaru et al., *supra* note 20, at 6; see also Weisner et al., *supra* note 43, at 324 (some reviews of ED visits found that certain patient populations, including Black people, face lower odds of treatment initiation and show lower rates of treatment engagement than white patients).
- ¹⁷⁵ Kilaru et al., *supra* note 20, at 5.
- ¹⁷⁶ Volkow, *supra* note 166.
- ¹⁷⁷ Substance Abuse and Mental Health Servs. Admin., Table 5.36B – Classified as Needing Alcohol Use Treatment and Receipt of Alcohol Use Treatment at a Specialty Facility in Past Year among Persons Aged 12 or Older, by Demographic Characteristics: Percentages, 2018 and 2019 (Dec. 20, 2019), <https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect5pe2019.htm>. See also Vaeth et al., *supra* note 161, at 13 (reporting on one study that found Black and Hispanic individuals are less likely to receive treatment for more severe alcohol use disorder while another found “no evidence of differential treatment utilization of alcohol treatment services” for Black and white people).
- ¹⁷⁸ See, e.g., Singhal et al., *supra* note 171, at 2.
- ¹⁷⁹ *Alameda Health System-Highland Hospital Selected for Program to Expand MAT for Opioid Use Disorder*, Alameda Health Sys. (Feb. 13, 2019), <http://www.alamedahealthsystem.org/alameda-health-system-highland-hospital-selected-program-expand-medication-assisted-treatment-opioid-use-disorder/>.
- ¹⁸⁰ A hospital is subject to EMTALA if it satisfies the Social Security Act’s definition of “hospital” (42 U.S.C. § 1395x(e)), has entered into a provider agreement to participate in the Medicare program (42 U.S.C. § 1395dd(e)(2); 42 C.F.R. § 489.24(b)) and has an emergency department. 42 U.S.C. § 13955dd(a); 42 C.F.R. § 489.24(b).
- ¹⁸¹ EMTALA uses the term “individual” to distinguish between those who have rights under EMTALA and “patients” who are not protected under the law. A person who has “begun to receive outpatient services” at the hospital and/or has “been admitted as an inpatient” is a “patient” and is not protected under EMTALA. 42 C.F.R. § 489.24(b) (2020). We use the terms “individual” and “patient” interchangeably to refer to people who receive screening and/or stabilization care in an ED.
- ¹⁸² See 42 U.S.C. § 1395dd(a)–(c).
- ¹⁸³ 42 C.F.R. § 489.24(b).
- ¹⁸⁴ *Baber v. Hospital Corp. of Am.*, 977 F.2d 872, 879 (4th Cir. 1992).
- ¹⁸⁵ 42 U.S.C. § 1395dd(e)(3)(A).

- ¹⁸⁶ 42 U.S.C. § 1395dd(d)(2)(A). A person harmed by an ED’s violation may file a federal court action against the hospital for damages and appropriate equitable relief. *Id.* The Centers for Medicare and Medicaid Services (CMS) enforce EMTALA through administrative investigations and enforcement actions based on individual complaints and complaints from medical facilities. The Department of Health and Human Services (HHS) may levy civil penalties against a hospital and a physician for a negligent violation of EMTALA, 42 U.S.C. § 1395dd(1)(A)–(B), and/or exclude a physician from participation in the Medicare program and other state healthcare programs for repeated violations or a “gross and flagrant” violation. 42 U.S.C. § 1395dd(d)(1)(B)(ii).
- ¹⁸⁷ As noted above (*see supra* Sec. I.A), a screening tool can be used to identify a patient whose substance use contributes to, but may not be evident from, their presenting condition. This “screening” is not commensurate with the EMTALA “medical screening examination,” which, in this case, requires a diagnostic assessment to determine the existence and severity of an SUD. The use of the term “screening” in the EMTALA discussion refers to a “medical screening examination” unless otherwise noted.
- ¹⁸⁸ A patient who is identified as having “mild” SUD may not have an emergency medical condition, as their condition would not be considered a life-threatening or serious medical condition under EMTALA. Some patients with moderate and severe SUD clearly would have an emergency medical condition. *See supra* note 40.
- ¹⁸⁹ 42 C.F.R. § 489.24(b)(1)–(2). Alternatively, an individual is considered to have requested an examination or treatment, if a layperson, upon seeing the individual in the ED or on hospital premises, would believe that the individual needs an examination or treatment based on their appearance or behavior. *Id.*
- ¹⁹⁰ 42 U.S.C. § 1395dd(a).
- ¹⁹¹ *See Summers v. Baptist Med. Ctr. of Arkadelphia*, 91 F.3d 1132, 1139 (8th Cir. 1996). Although EMTALA was enacted to address hospital “dumping” of uninsured persons by either refusing to treat them or transferring them to public hospitals, the law prohibits EDs from failing to screen any individual or stabilize someone with an emergency medical condition for any reason, including, but not limited to, insurance status. Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2009 Rates, 73 Fed. Reg. 48,434, 48,660 (Aug. 19, 2008) (codified at 42 C.F.R. § 412–13, 422, 489) (hereafter “Changes to the Hospital Inpatient Prospective Payment System”) (“[T]he intent of EMTALA was to provide access to emergency care to all individuals who present to an emergency department and are determined to have an emergency medical condition, including the uninsured.”).
- ¹⁹² *See also* Ctrs. for Medicare & Medicaid Servs., State Operations Manual, Appendix V: Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases 36 (July 19, 2019), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf. [hereinafter “State Operations Manual”]
- ¹⁹³ 42 U.S.C. § 1395dd(a) (2011). *Baber*, 977 F.2d at 880.
- ¹⁹⁴ State Operations Manual, *supra* note 192, at 36–37, 40 (noting that the hospital must “utilize[] all of its resources” in conducting screenings).
- ¹⁹⁵ *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994) (“We believe that a hospital defines which procedures are within its capabilities when it establishes a standard screening policy for patients entering the emergency room. Indeed, hospitals, and not reviewing courts, are in the best position to assess their own capabilities.”).
- ¹⁹⁶ *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790, 797 (10th Cir. 2001).
- ¹⁹⁷ *See* Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. 53221, 53236–37 (Sept. 9, 2003) (hereafter “Clarifying Policies re Medicare-Participating Hospitals”)
- ¹⁹⁸ *See, e.g., Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995) (ED violated screening requirement for patient presenting with chest pains and dizziness by not following internal procedures to take vital signs of every patient, record each visit, treat patients with chest pain as critical cases and refer all critical cases immediately to physician); *Power v. Arlington Hosp. Ass’n*, 42 F.3d 851 (4th Cir. 1994) (ED violated screening requirement by not following unwritten, yet typical screening procedure to record patient’s medical history and x-ray results in chart and receive urinalysis results before discharge); *Marshall v. East Carroll Parish Hosp. Serv. Dist.*, 134 F.3d 319, 322 (5th Cir. 1998); *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994); and *Baber*, 977 F.2d at 878, 881.
- ¹⁹⁹ *See* Clarifying Policies re Medicare-Participating Hospitals, 68 Fed. Reg. 53222, 53237.
- ²⁰⁰ *See del Carmen Guadalupe v. Negron Agosto*, 299 F.3d 15, 22 (1st Cir. 2002) (hospital did not violate screening obligation where patient’s assertion that ED should have performed specific diagnostic tests to assess severity of bronchial pneumonia did not consider whether the hospital was capable of performing those tests); *Baker v. Adventist Health, Inc.*, 260 F.3d 987, 991–92 (9th Cir. 2001) (EMTALA did not require hospital to conduct a mental health evaluation because the ED did not have the capability to do so; hospital had no mental health professionals on staff and no mental health services in the ED’s ancillary services policy).
- ²⁰¹ *Repp*, 43 F.3d at 522 n.4 (emphasis added).
- ²⁰² *Power*, 42 F.3d at 859 (explaining that an ED that omits one of three tests under its protocol would violate EMTALA and also could violate the standard of care giving rise to a medical malpractice claim; in contrast, an EMTALA violation would not exist if the practitioner performed all three tests and drew an incorrect conclusion, while a malpractice claim could). *See also Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995) (hospital’s screening for symptoms of drug overdose, but not suicidal condition, did not violate EMTALA where plaintiff did not provide evidence that screening was not comparable to that for patients with similar symptoms or that hospital ignored suicidal condition that manifested in acute or severe symptoms); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991).

- ²⁰³ *Barber*, 977 F.2d at 879 n.7.
- ²⁰⁴ EMTALA requires screening of all patients regardless of age and hospitals need not await the arrival of a guardian to conduct a screening examination. State Operations Manual, *supra* note 192, at 38.
- ²⁰⁵ *Summers*, 91 F.3d at 1139; *Correa*, 69 F.3d at 1190 (a patient “need not prove that she actually suffered from an emergency medical condition when she first came [to the ED]; the failure appropriately to screen, by itself, is sufficient to ground liability...”).
- ²⁰⁶ *Correa*, 69 F.3d at 1190; *Power*, 42 F.3d at 859.
- ²⁰⁷ Telephone Interview with Olsen & Ryan, *supra* note 39.
- ²⁰⁸ *Barber*, 977 F.2d at 879 n.7 (noting that a reliance on the hospital’s procedure to define “appropriate” screening could “theoretically [allow hospitals to] avoid liability by providing very cursory and substandard screenings to all patients, which might enable a doctor to ignore an emergency medical condition.... Our holding...does not foreclose the possibility that a future court faced with such a situation may decide that the hospital’s standard was so low that it amounted to no ‘appropriate medical screening’”). This issue would not arise in states, such as Rhode Island, that require the use of specific protocols. See R.I. Guidelines, *supra* Sec. I.B.
- ²⁰⁹ *Repp*, 43 F.3d at 522 n.4; see *Phillips*, 244 F.3d 790 (ED’s failure to identify patient’s bacterial endocarditis, which resulted in death, did not violate screening obligation; no evidence of inconsistent screening and, with the patient’s denial of drug use, ED likely did not consider whether symptoms were associated with substance use).
- ²¹⁰ *Guzman v. Mem’l Hermann*, 409 F. App’x 769, 775–76 (5th Cir. 2011) (affirming holding that there was no EMTALA medical screening violation where ED nurses took one full set of patient’s vital signs in a two and a half hour time period rather than hourly, as per the ED’s policy, because this was not a “substantial deviation” from ED policy).
- ²¹¹ See *Correa*, 69 F.3d at 1198 (affirming \$700,000 jury award to family of patient who died within hours of hospital ED denying her screening examination consistent with hospital procedure to monitor vital signs, compile written chart and immediate referral of patients with chest pains to in-house physician); *Power*, 42 F.3d at 865 (damages awarded for deviations from screening protocol and failure to conduct a blood test required for an “appropriate” medical screening examination that resulted in patient’s leg amputation, loss of sight in one eye and permanent lung damage).
- ²¹² *Baker*, 260 F.3d at 993; *Urban by and through Urban v. King*, 43 F.3d 523, 525 (10th Cir. 1994).
- ²¹³ *Barber*, 977 F.2d. at 879 n. 7.
- ²¹⁴ EMTALA provides for the transfer of a **non-stabilized patient** to another facility if a patient requests a transfer after being advised of the hospital’s stabilization obligation and risks of transfer and the physician complies with transfer requirements, including certification that the receiving facility has agreed to accept the transfer. See 42 U.S.C. § 1395dd(b)(1)(A)–(B). This analysis assumes that the patient has not requested a transfer and the ED to which they presented provides stabilization care.
- ²¹⁵ 42 U.S.C. § 1395dd(e)(3)(A).
- ²¹⁶ 42 C.F.R. § 489.24(d)(1)(i) (2020).
- ²¹⁷ State Operations Manual, *supra* note 192, at 48. The hospital is expected to use “all available resources” to stabilize the patient or provide a transfer, consistent with regulatory standards.
- ²¹⁸ See Changes to the Hospital Inpatient Prospective Payment System, 73 Fed. Reg. at 48,660.
- ²¹⁹ *In re Baby K*, 16 F.3d 590, 596 (4th Cir. 1994) (provision of respiratory support to an anencephalic infant was required to assure that no material deterioration of the infant’s respiratory distress occurred, even though respiratory treatment is not the standard of care for anencephaly); *Burditt v. U.S. Dep’t. of Health & Human Servs.*, 934 F.2d 1362, 1369 (5th Cir. 1991) (physician who did not provide the treatment medical experts agreed would prevent the “threatening and severe consequences” of a pregnant patient’s severe hypertension violated the stabilization requirement).
- ²²⁰ State Operations Manual, *supra* note 192, at 12.
- ²²¹ See Changes to the Hospital Inpatient Prospective Payment System, 73 Fed. Reg. at 48,659.
- ²²² See Clarifying Policies re Medicare-Participating Hospitals, 68 Fed. Reg. at 53,245.
- ²²³ State Operations Manual, *supra* note 192, at 50.
- ²²⁴ *Id.*
- ²²⁵ 328 F.3d 890 (7th Cir. 2003).
- ²²⁶ *Id.* at 895–96 (finding a psychiatric patient is stabilized only if they are no longer a threat to themselves or others).
- ²²⁷ *Id.* at 895 (emphasis added).
- ²²⁸ 934 F.2d 1362 (5th Cir. 1991).
- ²²⁹ *Cherukuri v. Shalala*, 175 F.3d 446, 449–450, 454 (6th Cir. 2009) (stabilization requirement is “purely contextual” and “requires a flexible standard of reasonableness that depends on the circumstances.”)
- ²³⁰ 934 F.2d at 1369.

- ²³¹ 228 F.3d 544, 559 (5th Cir. 2000). See also *Delaney v. Cade*, 986 F.2d 387 (10th Cir. 1993) (patient, who was treated in an ED for lacerations following an accident and lost feeling in her legs while being transferred to another facility raised fact question as to whether ED stabilized her condition before transfer; additional evidence needed to determine whether loss of feeling in her legs, resulting from an undetected transected aorta, was foreseeable and the type of material deterioration that EMTALA seeks to prevent).
- ²³² Nat'l Inst. on Drug Abuse, Drugs, Brains, and Behavior: The Science of Addiction, 4 (June 2020) <https://www.drugabuse.gov/sites/default/files/soa.pdf>.
- ²³³ Medications may include nonsteroidal anti-inflammatory medications, antiemetics, and alpha-2 agonists such as clonidine to treat symptoms of withdrawal, and antibiotics for SUD-related infections. D'Onofrio et al., *Emergency Departments — A 24/7/365 Option for Combating the Opioid Crisis*, *supra* note 25, at 2488.
- ²³⁴ Although no reported federal appeal court case challenges an ED's failure to stabilize an individual presenting with an SUD-related emergency medical condition, two reported circuit court cases identify stabilization care for patients with SUD. See *Vickers v. Nash General Hosp.*, 78 F.3d 139 (4th Cir. 1996) (ED diagnosed patient, who presented with scalp laceration, as suffering from "laceration and contusions and multiple substance abuse," and referred him to the mental health department for SUD treatment; patient died four days after discharge from an undiagnosed cerebral herniation and epidermal hematoma, which was the basis of the stabilization challenge); *Eberhardt*, 62 F.3d 1253 (ED treated plaintiff's son for a heroin overdose by administering naloxone and advising him to seek follow-up treatment at a methadone treatment program; claim for failure to stabilize suicidal ideation after patient was killed by police 30 hours after discharge in an apparent suicide attempt).
- ²³⁵ *Burditt*, 934 F.2d at 1368.
- ²³⁶ See D'Onofrio et al., *Emergency Departments — A 24/7/365 Option for Combating the Opioid Crisis*, *supra* note 25, at 2488.
- ²³⁷ *Thomas*, 328 F.3d at 896.
- ²³⁸ State Operations Manual, *supra* note 192, at 47.
- ²³⁹ See Hawk et al., *ACEP Consensus Recommendations*, *supra* note 24, at 3. "Common sense and a growing body of research suggest that patients with opioid use disorder (OUD) who receive acute care in an emergency department will be at reduced risk for later overdose if they are initiated on medications to treat their OUD." Volkow, *Emergency Departments Can Help Prevent Opioid Overdoses*, *supra* note 60.
- ²⁴⁰ *In re Baby K*, 16 F.3d at 596.
- ²⁴¹ State Operations Manual, *supra* note 192, at 50.
- ²⁴² *Id.* at 50–51. *Accord Phipps v. Bristol Reg'l Med. Ctr.*, 1997 WL 397200, No. 96-5786 (6th Cir. July 14, 1997) (holding that the hospital stabilized the patient, following a car accident, when it made an appointment for him to see a counselor at the mental health center to address his depression and suicidal thoughts and splinted his broken ankle in advance of surgery).
- ²⁴³ "Potential patients can be lost if treatment is not immediately available or readily accessible . . . Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment." Nat'l Inst. on Drug Abuse, *Principles of Effective Treatment*, Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition) (Sept. 18, 2020), <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment>.
- ²⁴⁴ D'Onofrio & Degutis, *supra* note 79, at 907 (study revealed that individuals who presented to the ED with "unhealthy" drug and/or alcohol use were 30 times more likely to enroll in specialized SUD treatment if they received facilitated (i.e. direct) referrals as compared to those who received standard (i.e. indirect) referrals); Am. Coll. of Emergency Physicians, *supra* note 31 (reporting increased rates of ED patients with direct referrals keeping initial appointment and enrolling in treatment); Weisner et al., *supra* note 43, at 321 (finding that patients are more likely to initiate SUD treatment with an initial diagnosis in an ED or specialty SUD/psychiatry treatment setting than a primary care setting).
- ²⁴⁵ Duber et al., *supra* note 35, at 426.
- ²⁴⁶ D'Onofrio et al., *Emergency Departments — A 24/7/365 Option for Combating the Opioid Crisis*, *supra* note 25, at 2487, 2489.
- ²⁴⁷ Joint Comm'n *supra* note 76, at 3.
- ²⁴⁸ NCQA *supra* note 75; *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)*, Nat'l Comm. for Quality Assurance, <https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/> (last visited Mar. 23, 2021).
- ²⁴⁹ 42 U.S.C. §§ 12101 et seq.
- ²⁵⁰ 29 U.S.C. §§ 701 et seq.
- ²⁵¹ 42 U.S.C. § 12101(b)(1). See 45 C.F.R. § 84.1; 28 C.F.R. § 35.101(b), 36.101(b).
- ²⁵² Individuals may file complaints for R.A. violations with HHS's Office of Civil Rights ("OCR"), see *Discrimination on the Basis of Disability*, Health & Human Servs., <https://www.hhs.gov/civil-rights/for-individuals/disability/index.html> (last reviewed Mar. 11, 2021), and for Title II and III violations, with OCR or the U.S. Department of Justice. See *id.*; *Frequently Asked Questions about Titles II and III of the ADA*, Dep't. of Justice, <https://www.justice.gov/crt/frequently-asked-questions-about-titles-ii-and-iii-ada> (last updated Aug. 6, 2015) ("DOJ FAQs"). The agency may impose penalties and obtain monetary damages for the individual who was harmed. See DOJ FAQs.

- ²⁵³ See 42 U.S.C. §§ 12131(A)–(B).
- ²⁵⁴ *Id.* at §12181(1); 42 U.S.C. § 12181(6)–(7). But, some private hospitals controlled by religious entities are exempt from Title III. 42 U.S.C. § 12187; 28 C.F.R. § 36.102(e). See, e.g., *Reed v. Columbia St. Mary’s Hosp.*, 236 F. Supp. 3d 1091 (E.D. Wisc. 2017). Nevertheless, they generally will be subject to the R.A. due to Medicaid and Medicare reimbursement. See 29 U.S.C. § 794(a)–(b).
- ²⁵⁵ See 29 U.S.C. § 794(a); *United States v. Baylor Univ. Med. Ctr.*, 736 F.2d 1039, 1049 (5th Cir. 1984).
- ²⁵⁶ See *Van Velzor v. City of Burlleson*, 43 F. Supp. 3d 746, 751 (N.D. Tex. 2014) (citing *Melton v. Dallas Area Rapid Transit*, 391 F.3d 669, 671–72 (5th Cir. 2004), *cert. denied*, 544 U.S. 1034 (2005)).
- ²⁵⁷ See *Access Now, Inc. v. S. Fla. Stadium Corp.*, 161 F. Supp. 2d 1357, 1363 (S.D. Fla. 2001); *Parr v. L & L Drive-Inn Rest.*, 96 F. Supp. 2d 1065, 1085 (D. Haw. 2000).
- ²⁵⁸ See *Wilkerson v. Shinseki*, 606 F.3d 1256, 1262 (10th Cir. 2010).
- ²⁵⁹ See *Menkowitz v. Pottstown Mem’l Med. Ctr.*, 154 F.3d 113, 120 (3d Cir. 1998) (citing *Yeskey v. Pa. Dep’t of Corr.*, 118 F.3d 168, 170 (3d Cir. 1997), *aff’d*, 524 U.S. 206 (1998)).
- ²⁶⁰ See *Doe v. Deer Mountain Day Camp*, 682 F. Supp. 2d 324, 343 (S.D.N.Y. 2010) (citing *Tsombanidis v. W. Haven Fire Dep’t*, 352 F.3d 565, 573 (2d Cir. 2003)).
- ²⁶¹ 42 U.S.C. § 12102(1). The R.A. adopts the ADA’s definition. See 29 U.S.C. § 705(20)(B).
- ²⁶² See 28 C.F.R. § 42.540(k)(2)(i) (“physical or mental impairment includes, but is not limited to . . . drug and alcohol abuse”); 28 C.F.R. § 42.540(o) (alcohol abuse includes “alcoholism” and “any misuse of alcohol which demonstrably interferes with a person’s health, interpersonal relations or working”); 28 C.F.R. § 35.108(b)(2), 36.105(b)(1) (“[p]hysical or mental impairment includes . . . drug addiction[] and alcoholism”).
- ²⁶³ See, e.g., *MX Grp., Inc. v. Covington*, 293 F.3d 326, 338 (6th Cir. 2002) (holding that drug addiction necessarily substantially limited the major life activities of “employability, parenting, and functioning in everyday life”). See also 42 U.S.C. § 12102(2)(A) (listing examples of major life activities); 28 C.F.R. § 35.108(c)(1) (listing brain and neurological function as well as caring for oneself as major life activities).
- ²⁶⁴ See, e.g., *MX Grp., Inc.*, 293 F.3d at 339–40 (holding that individuals seeking methadone treatment for OUD satisfied the “record of” test); *Bay Area Addiction Research & Treatment, Inc. v. City of Antioch*, No. C 98–2651 SI, 2000 WL 33716782, at *7 n.17 (N.D. Cal. Mar. 16, 2000) (same).
- ²⁶⁵ 28 CFR § 42.540(k)(2)(iv)(C). See *Bay Area*, 2000 WL 33716782, at *7 (concluding that individuals who received medication for OUD made a strong showing that they were “regarded as” disabled due to defendants’ reliance on stereotypes of people who were receiving methadone as continuing their drug use, “engaging in criminal behavior and [being] unable to control their anger.”); *CRC Health Grp., Inc. v. Town of Warren*, No. 2:11-cv-196-DBH, 2014 WL 2444435, at *10–11 (D. Me. Apr. 1, 2014) (same).
- ²⁶⁶ 29 U.S.C. § 705(20)(C)(i).
- ²⁶⁷ “[A]n individual shall not be denied health services, or services provided in connection with drug rehabilitation, on the basis of the current illegal use of drugs if the individual is otherwise entitled to such services.” 42 U.S.C. § 12210(c) (emphasis added). See also 29 U.S.C. § 705(20)(C)(iii); 28 C.F.R. § 35.131(b), 36.209(b).
- ²⁶⁸ ADA Title III Technical Assistance Manual, § III–3.9000, ADA.Gov <https://www.ada.gov/taman3.html> (last visited May 25, 2021).
- ²⁶⁹ Title II reads, “[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” 42 U.S.C. § 12132 (emphasis added). Note that Title III does not have this requirement. It reads, “No individual shall be discriminated against . . .” *Id.* § 12182(a) (emphasis added).
- ²⁷⁰ 42 U.S.C. § 12131(2) (emphasis added); see also 28 C.F.R. § 35.104.
- ²⁷¹ Coffey et al., *supra* note 18.
- ²⁷² “[A]n individual shall not be denied health services, or services provided in connection with drug rehabilitation, on the basis of the current illegal use of drugs if the individual is otherwise entitled to such services.” 42 U.S.C. § 12210(c) (emphasis added); see also 29 U.S.C. § 705(20)(C)(iii); 28 C.F.R. § 35.131(b), 36.209(b). This provision is in Title IV of the ADA and applies to both Titles II and III.
- ²⁷³ Ellen Weber, *Drugs and Alcohol*, in *Disability Discrimination in Employment Law*, 384 (BNA Books 1995); 135 Cong. Rec. S10,775 (daily ed. Sept. 7, 1989) (Statement of Sen. Helms).
- ²⁷⁴ Congress provided protection for persons with *current alcohol addiction* because alcohol consumption is “legal” for individuals 21 years and older, and people who use alcohol were not the targets of the “war on drugs.”
- ²⁷⁵ “The Committee recognizes that such [health] services are essential to provide for the treatment of, and promote the recovery of, drug dependent persons.” See H.R. Rep. No. 101–485, at 141, (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 424. Moreover, this conclusion is consistent with the R.A.’s original coverage of these individuals. Prior to the ADA, individuals currently using drugs illegally were *protected against discrimination* under the R.A. if qualified for the program sought. The analytical framework of “otherwise qualified” – which applied to these individuals before the adoption of the ADA’s restrictive standard – logically applies when such individuals seek health services under the ADA.

- ²⁷⁶ The R.A. reads, “No *otherwise qualified* individual with a disability in the United States, . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance or . . . conducted by any Executive agency. . . .” 29 U.S.C. § 794(a) (emphasis added).
- ²⁷⁷ *Woolfolk v. Duncan*, 872 F. Supp. 1381, 1388–90, 1389 n.13 (E.D. Pa. 1995) (reasoning that in the medical context, the “otherwise qualified” requirement asks “whether the defendant withheld the benefit solely by reason of the disability, or . . . based upon a *bona fide* medical reason.”) (emphasis in original) (internal quotation marks omitted).
- ²⁷⁸ See *Wagner by Wagner v. Fair Acres Geriatric Ctr.*, 49 F.3d 1002, 1012, 1016 (3d Cir. 1995). Many courts previously had held that “otherwise qualified” required a plaintiff to prove that they were denied medical care “in spite of” their disability. See, e.g., *United States v. Univ. Hosp., State Univ. of N.Y. at Stony Brook*, 729 F.2d 144, 156 (2d Cir. 1984). But, courts ultimately rejected this standard because it “eviscerate[s]” the R.A.’s function of preventing health care discrimination. *Glanz v. Vernick*, 756 F. Supp. 632, 638 (D. Mass. 1991).
- ²⁷⁹ *Wagner*, 49 F.3d at 1012.
- ²⁸⁰ *Id.*
- ²⁸¹ *Id.* at 1018–19.
- ²⁸² *Glanz*, 756 F. Supp. at 638.
- ²⁸³ To obtain monetary damages in a Title II disparate treatment claim, the plaintiff must prove that the defendant acted with discriminatory animus or “deliberate indifference,” depending on the jurisdiction. See, e.g., *Duvall v. Cnty. of Kitsap*, 260 F.3d 1124 (9th Cir. 2001) (noting that most courts require intentional discrimination, but others require deliberate indifference). A plaintiff challenging the ED practices discussed in this report could meet this heightened standard. For example, if a state’s law required these services, and the ED knew about the law yet failed to comply, a court could find deliberate indifference. See *Duvall*, 260 F.3d at 1139. Alternatively, a court could find “discriminatory animus” if the ED did not provide these services due to prejudice toward people with SUD. See *Liese v. Indian River Cnty. Hosp. Dist.*, 701 F.3d 334, 344 (11th Cir. 2012).
- ²⁸⁴ See 42 U.S.C. § 12182(b)(1)(A)(i); 28 C.F.R. § 35.130(b)(1)(i), 36.202(a); 45 C.F.R. § 84.4(b)(1)(i).
- ²⁸⁵ See 42 U.S.C. § 12182(b)(1)(D); 28 C.F.R. § 35.130(b)(3)(i), 36.204; 45 C.F.R. § 84.4(b)(4)(i).
- ²⁸⁶ The statutes use terms such as “by reason of” disability (Title II), 42 U.S.C. § 12132, “on the basis of” disability (Title III), 42 U.S.C. § 12182(a)), and “solely by reason of” disability (the R.A.), 29 U.S.C. § 794(a). The provisions prohibiting denial of health services to current illegal drug users use the phrase “on the basis of that individual’s current illegal use of drugs....” See 42 U.S.C. § 12210(c); 29 U.S.C. § 705(20)(C)(iii); 28 C.F.R. § 35.131(b), 36.209(b).
- ²⁸⁷ For the ADA, most courts use a “but for” standard, meaning the “particular outcome would not have happened ‘but for’ the purported cause.” *Bostock v. Clayton Cnty., Ga.*, 590 U.S. ____ (2020); *Lewis*, 681 F.3d at 317. For the R.A, some courts have interpreted its “solely by reason of” disability requirement to mean that there be no cause for a decision other than the disability. See, e.g., *C.G. v. Pa. Dep’t. of Educ.*, 734 F.3d 229, 236 n.11 (3d Cir. 2013); *Johnson by Johnson v. Thompson*, 971 F.2d 1487, 1493 (10th Cir. 1992); *Soledad v. U.S. Dep’t of Treasury*, 304 F.3d 500, 505 (5th Cir. 2002); *Pinkerton v. Spellings*, 529 F.3d 513, 515–16 (5th Cir. 2008).
- ²⁸⁸ See *Olmstead v. L.C.*, 527 U.S. 581 (1999). Note, also that EDs generally provide screening, medication, and facilitated referral for other acute manifestations of chronic conditions.
- ²⁸⁹ See 42 U.S.C. § 12182(b)(1)(A)(i); 28 C.F.R. § 35.130(b)(1)(i), 36.202(a); 45 C.F.R. § 84.4(b)(1)(i).
- ²⁹⁰ See *S.L. by and through D.L. v. City Hosp., Inc.*, 377 F.Supp.3d 626, 632 (N.D. W.Va. 2019) (“[F]ederal courts have routinely held that ADA claims based on inadequate medical care fail, but ADA claims based upon discriminatory medical care do not.”). As noted *supra* Sec. III.C., cases finding that plaintiffs were “otherwise qualified” under the R.A. also have used this framework to find that denials of healthcare solely because of stereotypes and assumptions (not legitimate medical considerations) could violate the R.A. See *Woolfolk*, 872 F. Supp. 1381; *Glanz*, 756 F. Supp. at 638–39.
- ²⁹¹ 451 F.3d 274, 284–85 (1st Cir. 2006) (emphasis added) (citation omitted). But note that neither an R.A. nor an ADA claim requires a showing of discriminatory animus. See *Helen L. v. DiDario*, 46 F.3d 325, 335 (3d Cir. 1995) (reviewing the legislative history of both acts).
- ²⁹² *Kiman*, 451 F.3d at 287.
- ²⁹³ 938 F. Supp. 9, 10–11 (D.D.C. 1996).
- ²⁹⁴ *Id.* at 12. See also *United States v. Asare*, 15 Civ. 3556 (AT) (OTW), 2018 WL 2465378, *1, *5–*6 (S.D.N.Y. June 1, 2018) (surgeon violated R.A. and ADA because his blanket policy denied a service to *all* individuals on antiretroviral HIV medications due to concerns about possible oversedation in some).
- ²⁹⁵ 376 F. Supp. 3d 146, 159–160 (D. Me. 2019).
- ²⁹⁶ *Id.* at 160 (citing *Kiman*, 451 F.3d at 284). See also *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 46–47 (D. Mass. 2018) (holding that jail’s denial of methadone to incarcerated man likely violated Title II where the jail’s alternative proposed treatment had been documented as ineffective for him, and the jail’s alleged security concerns about people diverting their methadone were not specific to plaintiff or liquid methadone).

- ²⁹⁷ No. 6:15-cv-93, 2016 WL 723038, at *4 (S.D. Ga. Feb. 22, 2016). See also *Tate v. Wexford Health Source Inc* No. 3:16-cv-00092-NJR, 2016 WL 687618, at *1 and *7 (S.D. Ill. Feb. 19, 2016) (declining to dismiss a Title II claim for a prison’s denial of gender affirming surgery where a prison employee said the prison “does not want to waste their money on such treatment.”).
- ²⁹⁸ 250 F.3d 47, 50, 56, 58 (1st Cir. 2001).
- ²⁹⁹ *Id.* at 58. See also *Shelton v. Ark. Dep’t of Human Servs.*, 677 F.3d 837, 843 (8th Cir. 2012) (affirming dismissal of claim that defendant’s removal of the deceased from suicide watch violated the ADA and R.A. where plaintiff failed to allege that defendant was “influenced by anything other than a physician’s judgment[]”).
- ³⁰⁰ See 42 U.S.C. 12182(b)(3); 28 C.F.R. § 35.139(a), § 36.208(a) (emphasis added).
- ³⁰¹ 42 U.S.C. § 12182(b)(3); 28 C.F.R. § 35.104, 36.104.
- ³⁰² 28 C.F.R. § 35.139(b), 36.208(b).
- ³⁰³ See, e.g., *Bragdon v. Abbott*, 524 U.S. 624 (1998) (holding that dentist’s treatment of patients living with HIV did not constitute a direct threat).
- ³⁰⁴ 964 F. Supp. 2d 1077, 1081, 1085–86 (N.D. Cal. 2013).
- ³⁰⁵ *Id. Cf. Rose v. Springfield-Greene Cnty. Health Dep’t*, 668 F. Supp. 2d 1206 (W.D. Mo. 2009) (granting defendants’ motion for summary judgment on plaintiff’s ADA claims where defendants had made an individualized assessment that plaintiff’s “therapy” monkey posed a direct threat to others).
- ³⁰⁶ This report uses “because of” as shorthand for all three causation standards in the ADA and R.A and assumes courts would apply the “but for” standard under the ADA, and either “but for” or “solely” under the R.A.
- ³⁰⁷ D’Onofrio et al., *Emergency Departments — A 24/7/365 Option for Combating the Opioid Crisis*, *supra* note 25, at 2489.
- ³⁰⁸ See, e.g., *Sumes*, 938 F. Supp. at 10–11; *Smith*, 376 F. Supp.3d at 159–60; *Pesce*, 355 F. Supp. 3d at 47.
- ³⁰⁹ See *Wagner*, 49 F.3d 1002, 1007, and 1015–17 (3d Cir. 1995) (finding that woman with Alzheimer’s presented sufficient evidence that nursing home’s exclusion of her because of her “combative and assaultive behavior” violated the R.A. where it could have provided a reasonable accommodation of additional staffing).
- ³¹⁰ See *Lesley Hee Man Chie*, 250 F.3d at 57; *Sumes*, 938 F. Supp. at 11.
- ³¹¹ See *Asare*, 2018 WL 2465378 at *5–*6.
- ³¹² Md. Hosp. Ass’n, *Emergency Discharge Protocols for Patients with Substance Use Disorders and Opioid Overdoses in Maryland’s Hospitals* 3, 11 (Dec. 2018), https://www.mhaonline.org/docs/default-source/resources/behavioral-health/final-ed-discharge-protocol-report.pdf?sfvrsn=fbbbd40d_2. See also *Duber et al.*, *supra* note 35, at 425.
- ³¹³ See *Coffey et al.*, *supra* note 18, at 5 (internal citations omitted); Letter from *Friedman*, *supra* note 130, at 1, 3.
- ³¹⁴ See *Mitchell*, 2016 WL 723038; *Tate*, 2016 WL 687618. Note, additional discussion of cost-reduction strategies, including development of payment structures for buprenorphine, is available at Sec. I.B.
- ³¹⁵ Press Release, Dep’t of Health & Human Servs., *HHS Releases New Buprenorphine Practice Guidelines, Expanding Access to Treatment for Opioid Use Disorder* (Apr. 27, 2021), <https://www.hhs.gov/about/news/2021/04/27/hhs-releases-new-buprenorphine-practice-guidelines-expanding-access-to-treatment-for-opioid-use-disorder.html>.
- ³¹⁶ Telephone Interview with *Doyon*, *supra* note 129.
- ³¹⁷ See *Tamara*, 964 F. Supp. 2d at 1084–85; *Pesce*, 355 F. Supp. 3d at 46; *Smith.*, 376 F. Supp. 3d at 159–60. When an ED patient presents a safety risk to ED staff due to violent behavior, the ED can invoke its safety protocols without violating the ADA and/or RA. However, the ED cannot refuse treatment of *all* patients with SUD and/or substance use-related emergencies because *some* of these patients are violent. An individualized assessment is necessary.
- ³¹⁸ See 45 C.F.R. § 84.4(b)(4)(i); 28 C.F.R. § 35.130(b)(3)(i), 36.204.
- ³¹⁹ 706 F. Supp. 2d 266, 272–73, 278 (D. Conn. 2010).
- ³²⁰ See also *Kathleen S. v. Dep’t of Pub. Welfare of Pa.*, 10 F. Supp. 2d 460, 462 (E.D. Pa. 1998).
- ³²¹ See, e.g., *Tyson v. Access Servs.*, 158 F. Supp. 3d 309 (E.D. Pa. 2016) and *Landrum v. Delta Reg’l Med. Ctr.*, No. 4:13-cv-180-JMV, 2015 WL 1000312 (N.D. Miss. Mar. 6, 2015) (both finding in favor of defendants where plaintiffs did not show that defendants acted because of patients’ disabilities).
- ³²² See also *Kathleen S.*, 10 F. Supp. 2d at 462.
- ³²³ 28 C.F.R. § 35.130(b)(7)(i), 36.302(a). Note, the R.A. incorporates the reasonable modification requirement through its definition of “otherwise qualified.” 29 U.S.C. § 794. See *Wagner*, 49 F.3d at 1014–16.
- ³²⁴ See 42 U.S.C. § 12182(b)(2)(A)(ii); 28 C.F.R. § 35.130(b)(7)(i), 36.302(a). See also 28 C.F.R. § 35.164, 36.303, 36.104. Multiple factors, such as the nature and cost of the accommodation relative to the covered entity’s financial resources, determine whether a burden is undue. See, e.g., *United States v. N. Ill. Special Recreation Ass’n*, 168 F. Supp. 3d 1082, 1092 (N.D. Ill. 2016) (citation omitted).

- ³²⁵ See, e.g., *United States v. Asare*, 2018 WL 2465378, at *6–*7 (holding that a plastic surgeon violated the ADA by denying plaintiff’s requested reasonable modification to hire an anesthesiologist to address defendant’s purported “oversedation” concerns from HIV medication interactions); *Stiner v. Brookdale Senior Living*, 354 F. Supp. 3d 1046 (N.D. Cal. 2019) (partly rev’d on other grounds) (deeming as “reasonable” the requested modifications that an assisted living facility provide additional staffing to help residents with disabilities with daily tasks); *S.L. by and through D.L. v. City Hosp., Inc.*, 377 F.Supp.3d 626 (N.D. W.Va. 2019) (finding as “reasonable” the requested modification that an E.D. give an autistic child a sedative and anesthesia prior to a procedure).
- ³²⁶ See *Asare*, *Stiner*, *S.L. and through D.L.*, *supra*, and *Wagner*, 49 F.3d at 1015–16 (holding that nursing home’s provision of additional medical staff for plaintiff-resident with Alzheimer’s would not fundamentally alter “the essential nature” of the nursing home because it previously had provided additional staffing for other residents); *Smith v. Aroostook Cnty.*, 376 F. Supp. 3d at 160–61 (holding that a jail’s provision of buprenorphine for OUD was not a fundamental alteration of its healthcare services where jail previously provided it to a pregnant woman); *Galusha v. N.Y. State Dep’t of Env’tl. Conservation* 27 F. Supp. 2d 117, 125 (N.D.N.Y. 1998) (holding that plaintiffs’ request to use “limited motorized transport” in an environmentally protected area did not constitute an “undue hardship” because this accommodation simply expanded use of “the same roads currently being used[.]”).
- ³²⁷ *Tamara*, 964 F. Supp. 2d at 1084–85 (holding that allowing patient to bring service dog into psychiatric unit would not fundamentally alter the unit’s services where other hospitals had made such reasonable modifications by shutting ward doors to prevent a dog’s entry).
- ³²⁸ Specifically, Title VI provides: “No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance...” 42 U.S.C.A. § 2000d. Throughout this section of the report, we refer to race-based discrimination as a shorthand for all of the types of discrimination that Title VI prohibits.
- ³²⁹ See *id.*; *Alexander v. Sandoval*, 532 U.S. 275, 280 (2001); 45 C.F.R. § 80.3(b) (2020). People may challenge disparate treatment discrimination under Title VI by bringing a lawsuit, *Alexander*, 532 U.S. at 280, or filing a complaint with the Office for Civil Rights (“OCR”) of the U.S. Department of Health and Human Services. <https://www.hhs.gov/civil-rights/filing-a-complaint/index.html> (last visited May 10, 2021). Non-compliance can result in the termination of federal financial assistance and other measures. 45 C.F.R. § 80.8.
- ³³⁰ This report focuses on Title VI claims by Black, Latinx, and Indigenous people because they can be disproportionately affected by SUD (see *supra* Sec. I.D), but Title VI claims are not necessarily limited to these groups.
- ³³¹ Chen et al., *supra* note 140 (analyzing ED visit data from Florida Agency for Health Care Administration and community demographic and socioeconomic characteristics at zip code level from American Community Survey to identify racial breakdown of ED visits by majority white, Black and Hispanic communities).
- ³³² Singhal et al., *supra* note 171, at 2 (these differences did not persist for other conditions of toothache, kidney stones and long-bone fractures). See also Goyal et al., *supra* note 171, at 996.
- ³³³ Wilder et al., *supra* note 19, at 1175–76.
- ³³⁴ This section sometimes uses “race” as shorthand for “race, color, or national origin,” but is not meant to limit the applicability of the provisions cited.
- ³³⁵ *Stone v. 23rd Chelsea Assocs.*, No. 18-CV-3869 (VSB), 2020 WL 1503671, at *7 (S.D.N.Y. Mar. 30, 2020) (citation omitted).
- ³³⁶ *City of Richmond v. J.A. Croson, Co.*, 488 U.S. 469, 493 (1989). In suits seeking monetary damages, however, proof of intent may require discriminatory “animus” (prejudice, spite or ill will) or “deliberate indifference” (knowing that a harm to a federally protected right was substantially likely and failing to act). See *Southeastern Pa. Transp. Auth. v. Gilead Sciences, Inc.*, 102 F. Supp. 3d 688, 701 (E.D. Pa. 2015) (citations omitted).
- ³³⁷ 528 F.2d 1181, 1184 (10th Cir. 1975).
- ³³⁸ *Id.* at 1184–86.
- ³³⁹ *Id.* at 1186.
- ³⁴⁰ *Id.* at 1186–87.
- ³⁴¹ *Olofinlade v. Atmed Treatment Ctr., Inc.*, No. 19-021-JJM-LDA, 2020 WL 1848084, at *1–2, *4 (D.R.I. Apr. 13, 2020).
- ³⁴² *Southeastern Pa. Transp. Auth.*, 102 F. Supp. 3d at 701–02.
- ³⁴³ *Jackson v. Univ. of New Haven*, 228 F. Supp. 2d 156, 160 (D. Conn. 2002).
- ³⁴⁴ See *id.* at 159–60 (citing *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 802 (1973)).
- ³⁴⁵ To prevail on a claim, a plaintiff must prove that they are a member of a protected group, are eligible for the activities, services or benefits of the recipient entity, and were denied services or otherwise treated adversely, and that someone not in the protected group received better treatment. See e.g., *Brewer v. Bd. of Trs. of Univ. of Ill.*, 479 F.3d 908, 921 (7th Cir. 2007).
- ³⁴⁶ *Id.* at 160 (citing *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 802 (1973)).
- ³⁴⁷ *Chance v. Reed*, 538 F. Supp. 2d 500, 510 (D. Conn. 2008) (internal citations omitted).

- ³⁴⁸ *Olofinlade*, 2020 WL 1848084, at *4, and *Penn v. San Juan Hosp., Inc.*, 528 F.2d 1184–86.
- ³⁴⁹ Data on the racial makeup of an ED’s patient population are also available through sources such as the National Hospital Ambulatory Medical Care Survey. See Jackson et al., *supra* note 8.
- ³⁵⁰ Dehon et al., *supra* note 165, at 901–02 (identifying the importance of standardized protocols in mitigating bias).
- ³⁵¹ See, e.g., Lagisetty et al., *supra* note 172, at 979; Vaeth et al., *supra* note 161, at 13.
- ³⁵² See *Alexander v. Sandoval*, 532 U.S. at 281–82.
- ³⁵³ See U.S. Dep’t of Health & Human Servs., Discrimination on the Basis of Race, Color, or National Origin (Including LEP), <https://www.hhs.gov/civil-rights/for-individuals/race/index.html> (last visited Mar. 28, 2021). Some State Attorneys General also may enforce Title VI. See, e.g., N.Y. Exec. Law § 63(12).
- ³⁵⁴ See 45 C.F.R. § 80.3(b) (2020).
- ³⁵⁵ *Elston*, 997 F.2d at 1407.
- ³⁵⁶ *Meek*, 724 F. Supp. at 908 (citing to *Ga. State Conference of Branches of NAACP v. Ga.*, 775 F.2d 1403, 1417 (11th Cir.1985)).
- ³⁵⁷ 776 F. Supp. 1518, 1522 (M.D. Ala. 1991).
- ³⁵⁸ *Id.* at 1524.
- ³⁵⁹ *Id.*
- ³⁶⁰ *Id.* at 1525–26.
- ³⁶¹ *Id.*
- ³⁶² See *Freeman v. Pitts*, 503 U.S. 467 (1992). Or some courts require a showing that the disparate impact would not have occurred in the absence of the challenged policy or practice (i.e., “but for” causation). See e.g., *Elston*, 997 F.2d at 1407, 1420.
- ³⁶³ See 793 F.2d 969 at 973, 982–83 (9th Cir. 1984).
- ³⁶⁴ *Id.* at 983.
- ³⁶⁵ 495 F. Supp. 926, 988 (N.D. Cal. 1979), *rev’d in part on other grounds*, 793 F.2d 969 (9th Cir. 1984).
- ³⁶⁶ *Bryant v. Koch*, 627 F.2d 612, 616–17 (2d Cir. 1980).
- ³⁶⁷ Note, national data indicate that from 2002 through 2015, the prevalence of buprenorphine use was consistently lower for people who were not “non-Hispanic White,” but the study also shows that that gap had closed from 2016 through 2017. Rhee & D’Onofrio, *supra* note 91.
- ³⁶⁸ Rhee & D’Onofrio., *supra* note 91.
- ³⁶⁹ Chen et al., *supra* note 140.
- ³⁷⁰ Ctrs. for Disease Control & Prevention, Nat’l Ctr. for Health Statistics, National Hospital Ambulatory Medical Care Survey: 2017 Emergency Department Summary Tables, 1, 5 https://www.cdc.gov/nchs/data/nhamcs/web_tables/2017_ed_web_tables-508.pdf (last visited Mar. 15, 2021).
- ³⁷¹ See Eldeib & Sanchez, *supra* note 156.
- ³⁷² “Low treatment capacity can have a disparate impact on African American communities, especially among those living in poverty, who often face multiple barriers to receiving treatment, including transportation and childcare[.]” Bechteler & Kane-Willis, *supra* note 159, at 6.
- ³⁷³ See Minn. Dep’t of Health, *supra* note 153.
- ³⁷⁴ *Groves*, 776 F. Supp. at 1525–26. See also HHS settlement of disparate impact claim challenging a hospital’s closure of one location because of its disparate impact on the predominantly African-American population in the area where the hospital was being closed. U.S. Dep’t of Health & Human Servs., Resolution Agreement 1–2, <https://www.hhs.gov/sites/default/files/ocr/civilrights/activities/agreements/upmcra.pdf>.
- ³⁷⁵ See *supra* Sec. I.D.
- ³⁷⁶ For example, see Resolution Agreement, *supra* note 374.
- ³⁷⁷ *N.Y. Urban League v. New York*, 71 F.3d at 1036.
- ³⁷⁸ See *Elston*, 997 F.2d at 1413.
- ³⁷⁹ *N.Y. Urban League*, 71 F.3d at 1036. See, e.g., *Larry P.*, 793 F.2d at 983.
- ³⁸⁰ 724 F. Supp. 888, 896, 902, 905–06 (S.D. Fla. 1987).
- ³⁸¹ *Id.* at 896.

- ³⁸² *Id.* at 906. See also *Groves v. Ala. State Bd. of Educ.*, 776 F. Supp. 1518 (M.D. Ala. 1991) (holding that plaintiffs, Black students applying to Alabama’s teacher training program, should prevail on their Title VI disparate impact claim, in part, because the defendant state board of education’s selected ACT cut-off score bore “no logical let alone significant relationship to minimal competence as a teacher”).
- ³⁸³ 997 F.2d at 1413.
- ³⁸⁴ Ctrs. for Medicaid & Medicare Servs., CMS’ Quality Strategy, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy> (last modified Nov. 19, 2019).
- ³⁸⁵ 724 F. Supp at 904–06.
- ³⁸⁶ The Title VI regulations give clear examples of disparate impact discrimination involving similar purportedly neutral resource allocation decisions. They prohibit (1) “criteria or methods of administration” that have a racially disparate impact and (2) decisions about “the site or location” of a facility that have “the effect of excluding individuals from” or “denying them the benefits of” the facility. See 45 C.F.R. § 80.3(b)(2)(3).
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- ³⁹⁶ Balt. City Health Dep’t, Levels of Care for Baltimore City Hospitals Responding to the Opioid Epidemic: Guide for Hospitals (Aug. 2018), <https://health.baltimorecity.gov/sites/default/files/Levels%20of%20Care%20-%20Guide.pdf>.
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- ³⁹⁹ N.Y. PUB. HEALTH LAW § 2803-U(1) (2019).
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