Addressing Opioid Use Disorder During Acute Hospitalization

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c|h|a
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Word Cloud #1

What one to two words describe the substance use disorder epidemic in your community?

Word Cloud #2

When considering the addiction care continuum in relation to hospitals, what one to two words come to mind?

Main Messages

- Addiction is a chronic, treatable medical disease.
- Pharmacotherapy is the standard of care.
  - Evidence-based
  - Safe
  - Effective
- Yes, totally, 100% hospitalists can and should engage in addiction care during acute hospitalization.

Brief Case

- 42-year-old male with opioid use disorder.
- Mom passed away at age 52 from alcohol and Hep C cirrhosis.
- Spent over 20 years in and out prison related to substance use.
- Admitted to your care for THIRD episode of endocarditis.
- Treatment plan includes six weeks of IV antibiotics.
- Two weeks into hospitalization, found to have used heroin from street.
- Accuses staff of not treating him appropriately / not treating withdrawal.
- Threatens to self-discharge.

What would YOU do?

Contents lists available at ScienceDirect

Healthcare

journal homepage: www.elsevier.com/locate/healthcare

The development and implementation of a "B-Team" (buprenorphine team) to treat hospitalized patients with opioid use disorder

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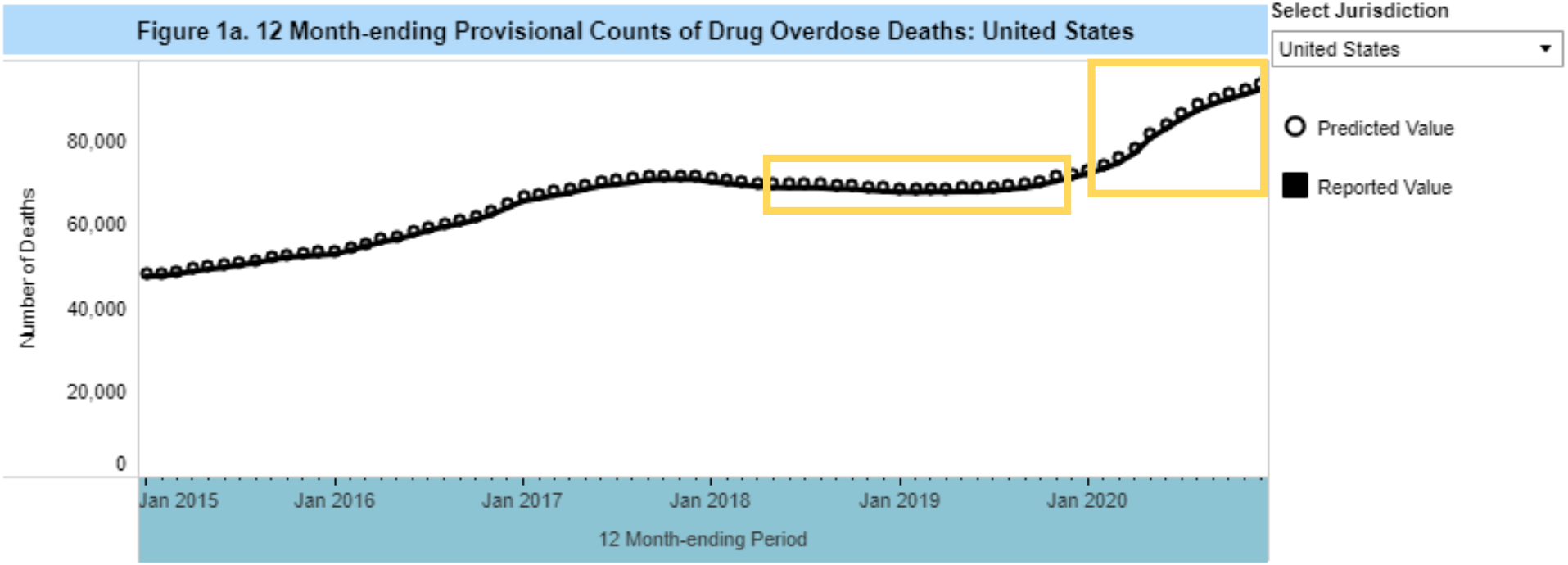
Alarming Data as of July '21

12 Month-ending Provisional Number of Drug Overdose Deaths

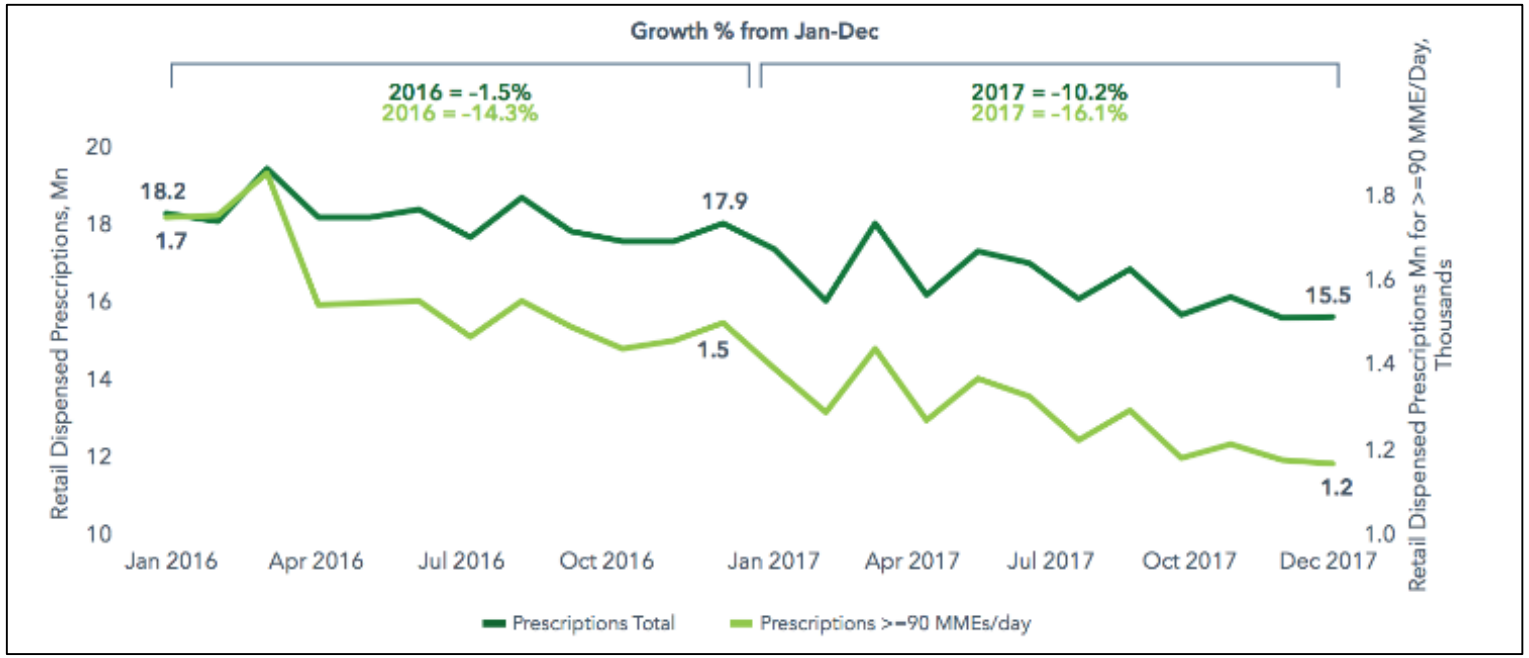
Based on data available for analysis on: 7/4/2021



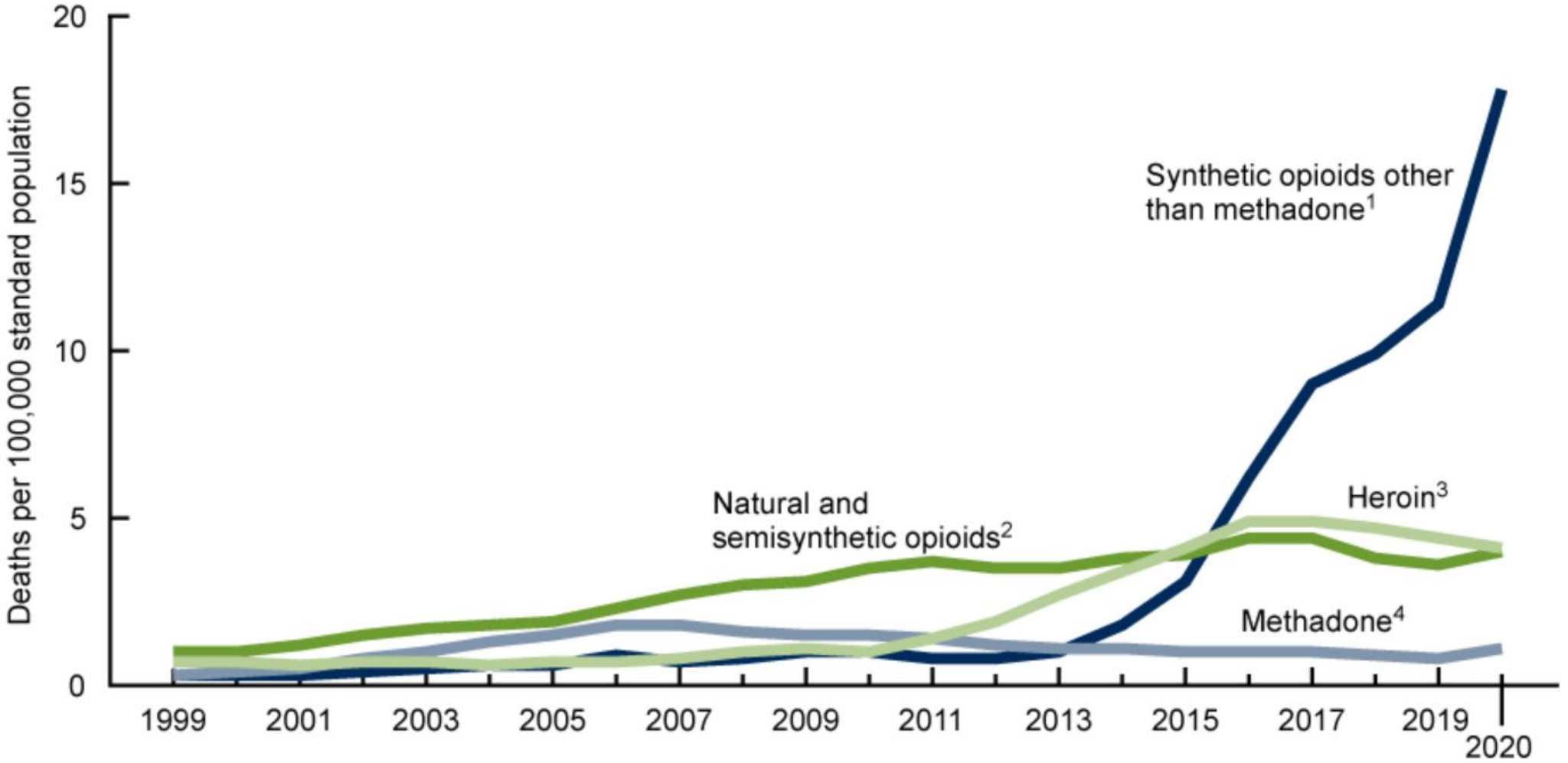
Retail Opioid Prescriptions

- 2017: The decline in the number of retail opioid prescriptions accelerated to 10.2%
- High doses declined by 16.1%

Monthly Retail Opioid Prescriptions and Prescriptions Dispensed at >= 90 MMEs per Day



Age-Adjusted Drug Overdose Death Rates, by Opioid Category - United States, 1999-2020



National Center for Health Statistics. NCHS Data Brief (428). 2021.

Consequences of Drug Use

Withdrawal

Sexually transmitted infections

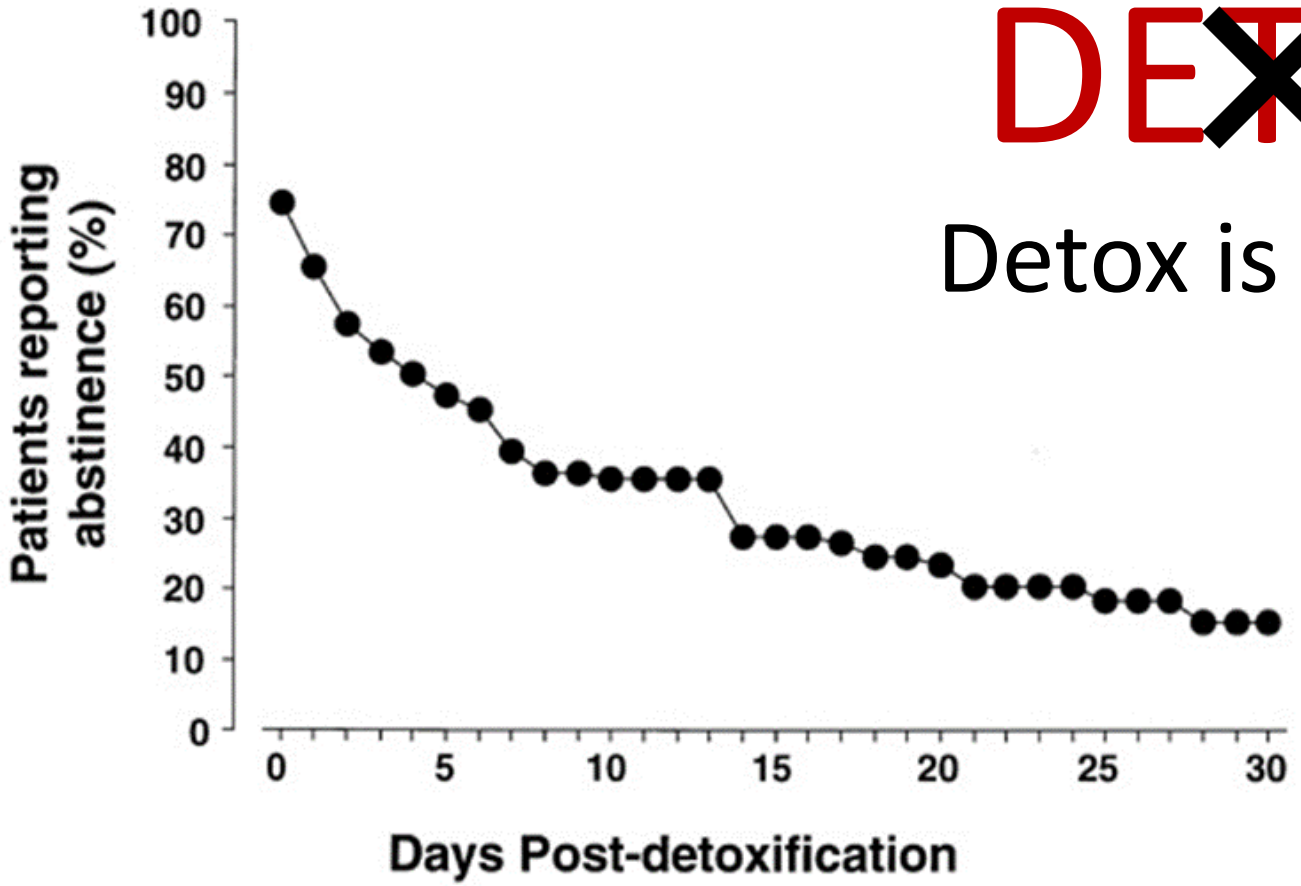
Hepatitis C (133% increase between 2004-2014

Endocarditis (100% increase between 2002-2016, 225% in some areas)

Abscesses/imaging

Kadri, et al., (2019); Meisner, et al., (2019); Zibbell, et al., (2018); Serota, et al., (2020)

Brief Medically Assisted Withdrawal



~~DETOX~~

Detox is ineffective

Chutuape, M et al. One-, three-, and six-month outcomes after brief inpatient opioid detoxification. The American Journal of Drug and Alcohol Abuse. Vol 27:1, 2001.

Hospitalization: An Opportunity

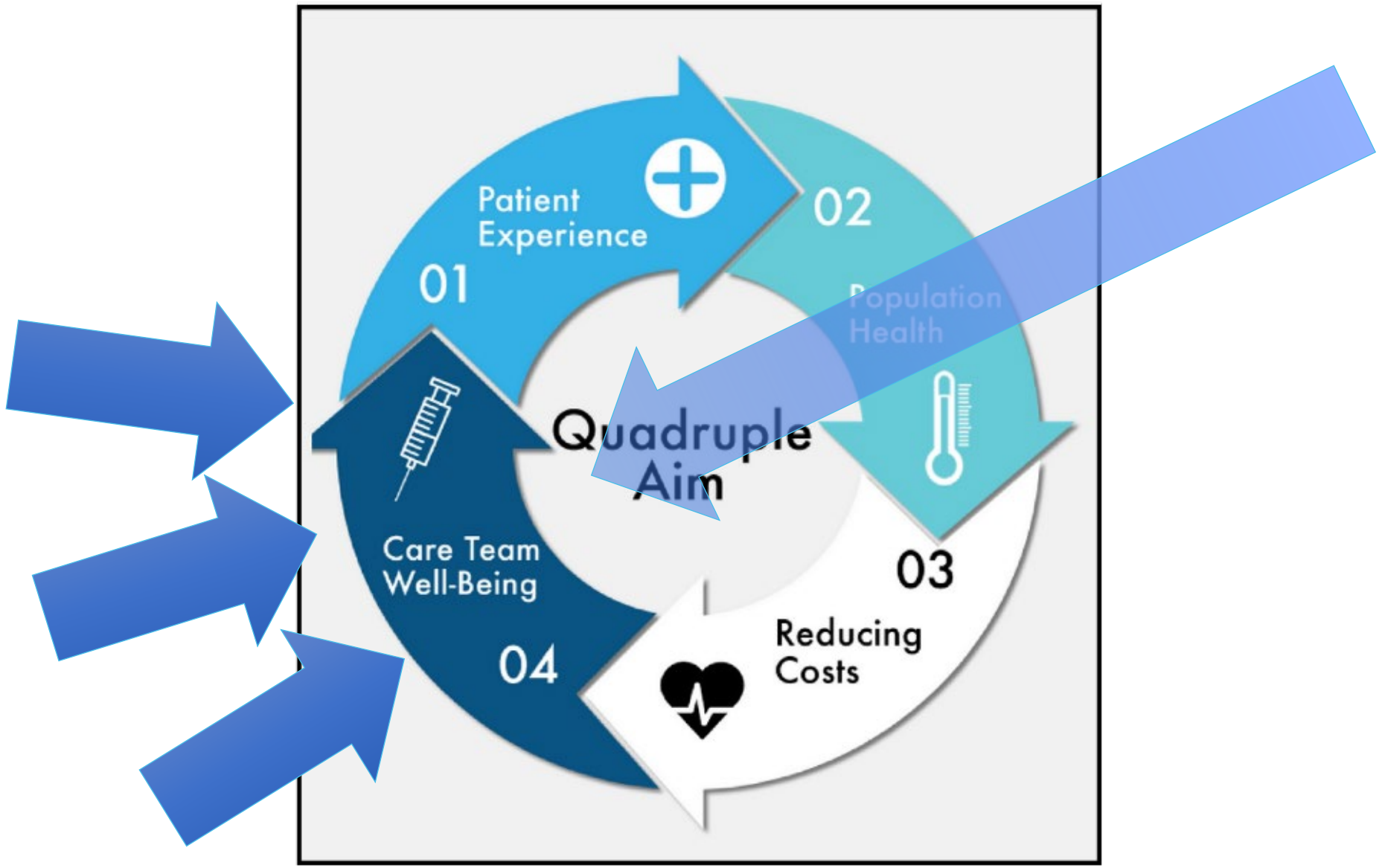
- Patients with OUD are admitted to the hospital for many reasons
- 25-30% of patients leave AMA

Why?

Withdrawal	Motivation for change
Cravings	Away from triggering environment
Fear of mistreatment	Surrounded by supportive staff
Financial and social pressures	

12% of patients who **DON'T** begin treatment in the hospital maintain post-discharge engagement

72% of patients who **DO** begin OUD treatment in the hospital maintain post-discharge engagement


Patient Experience
01
02
Population Health
Quadruple Aim
Care Team Well-Being
04
03
Reducing Costs

Readmission Reduction

Among patients with opioid use disorder taking buprenorphine at the time of hospital admission...

53% reduction

Moreno, Jessica L., PharmD; Wakeman, Sarah E., MD, et al. Predictors for 30-Day and 90-Day Hospital Readmission Among Patients With Opioid Use Disorder. J Addict Med. doi: 10.1097/ADM.0000000000000499

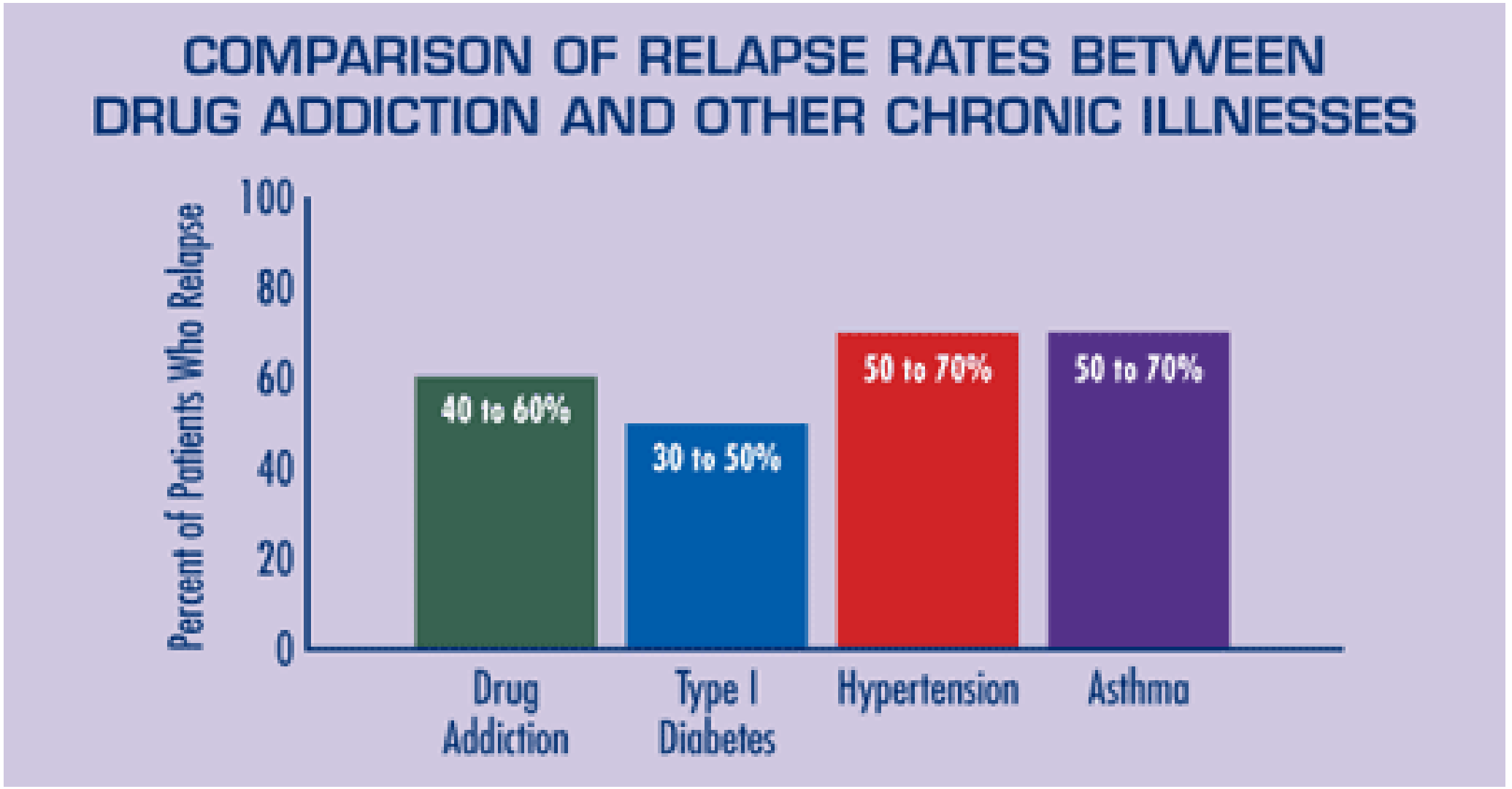
Costs: MOUD Program

Impact of MOUD on Medicaid expenditures and health services utilization rates in Vermont

Table 2
Adjusted average annual expenditures and utilization rates[†].

	MAT group	Non-MAT	Difference[‡]	P-value
Expenditures				
Total expenditures	$14,468	$14,880	−$412	0.07
Total expenditures without treatment	$ 8794	$11,203	−$2409	<0.01
Buprenorphine expenditures	$2708	−$47	$2755	<0.01
Total prescription expenditures	$4461	$2166	$2295	<0.01
Inpatient expenditures	$2132	$3757	−$1625	<0.01
Outpatient expenditures	$345	$604	−$259	<0.01
Professional expenditures	$674	$981	−$307	<0.01
SMS expenditures[*]	$2872	$4160	−$1288	<0.01
Utilization (rate/person)				
Inpatient days	1.54	3.00	−1.46	<0.01
Inpatient discharges	0.30	0.52	−0.22	<0.01
ED visits	1.44	2.48	−1.04	<0.01
Primary care physician visits	15.27	9.81	5.46	<0.01
Advanced imaging	0.29	0.54	−0.25	<0.01
Standard imaging	0.76	1.43	−0.67	<0.01
Colonoscopy	0.01	0.02	−0.01	<0.01
Echography	0.46	0.53	−0.07	0.002
Medical specialist visits	0.49	0.82	−0.33	<0.01
Surgical specialist visits	3.04	1.89	1.15	<0.01

Stigma


COMPARISON OF RELAPSE RATES BETWEEN
DRUG ADDICTION AND OTHER CHRONIC ILLNESSES
Percent of Patients Who Relapse
100
80
60
40
20
0
40 to 60%
30 to 50%
50 to 70%
50 to 70%
Drug Addiction
Type I Diabetes
Hypertension
Asthma

Three Medications

- Buprenorphine
- Methadone
- Extended-release naltrexone (NOT oral Naltrexone)

Buprenorphine 101 – The Basics

- Partial agonist opioid
- Primary activity at mu receptor
- Ceiling effect
- Strong affinity
- Has analgesic properties
- Administered as SL film (patch and IV not for OUD)
- Hepatically cleared
- Side effects primarily headache and GI upset

Acute Pain Strategies

Mild Pain

Pre-op: Continue buprenorphine (consider TID dosing)

Post-op: NSAIDs, APAP, gabapentinoids*, antispasmodics, lidocaine patches

Moderate Pain

Pre-op: Continue buprenorphine (consider TID dosing)

Post-op: NSAIDs, APAP, gabapentinoids*, antispasmodics, lidocaine patches, ketamine, nerve blocks, continuous regional anesthesia techniques (e.g., epidural)

Severe Pain

Pre-op: Continue buprenorphine (consider TID dosing) or lower buprenorphine dose

Post-op: NSAIDs, APAP, gabapentinoids*, antispasmodics, lidocaine patches, ketamine, nerve blocks, continuous regional anesthesia techniques (e.g., epidural)

Naloxone

FDA U.S. FOOD & DRUG ADMINISTRATION

FDA recommends health care professionals discuss naloxone with all patients when prescribing opioid pain relievers or medicines to treat opioid use disorder

Consider prescribing naloxone to those at increased risk of opioid overdose

7-23-2020 Drug Safety Communication

What safety concern is FDA announcing?

To reduce the risk of death from opioid overdose, the U.S. Food and Drug Administration (FDA) is making the following recommendations about the opioid reversal medicine, naloxone:

For all patients who are prescribed opioid pain relievers, health care professionals should discuss the availability of naloxone, and consider prescribing it to patients who are at increased risk of opioid overdose, such as patients who are also using benzodiazepines or other medicines that depress the central nervous system, who have a history of opioid use disorder (OUD), or who have experienced a previous opioid overdose. Health care professionals should also consider prescribing naloxone if the patient has household members, including children, or other close contacts at risk for accidental ingestion or opioid overdose.

Who Is at Risk?

- >50 MME/day
- Chronic resp conditions
- Co-prescribed sedating meds (benzos)
- Substance use disorder
  - Opioid (heroin, fentanyl, misuse of prescription opioids)
    - Receiving OUD treatment
  - Stimulants (may be contaminated with fentanyl)
  - Recent incarceration

X-Waiver and Regulatory

- Buprenorphine vs methadone vs naltrexone
- You no longer need to complete the 8-hour training for the x-waiver! (For up to 30 patients…)

Problem Statement

How can we treat hospitalized patients with opioid use disorder at a hospital without a formal addiction medicine service?

A Solution

Empower existing teams!!

Creation of the buprenorphine team (B-Team)

Conclusion

MOUD is:

- Effective
- Life-saving
- Easy to administer!
- Patient-centered
- Standard of care for hospitals

Word Cloud #3

- What are the facilitators to providing addiction care in your hospitals?
- Discuss as a group at your table. Appoint a note-taker and be prepared to share with the group.

Word Cloud #4

- What are the barriers to providing addiction care in your hospitals?
- Discuss as a group at your table. Appoint a note-taker and be prepared to share with the group.

Group Discussion

- What action will you take today leaving this session?

Questions?

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