Medication-Assisted Treatment Initiation in the Hospital Setting

OACBHA Ohio’s 2019 Opiate Conference
June 11, 2019
Presenters from OSU Wexner Medical Center

- **Emily Kauffman, DO, MPH**, Clinical Assistant Professor, Departments of Emergency Medicine and Internal Medicine, Assistant Program Director of Emergency Medicine/Internal Medicine Residency
- **Margaret Williams, MD**, Clinical Assistant Professor, Department of Internal Medicine, Division of Hospital Medicine
- **Cara Jordan, MSW, LISW-S**, Psychiatric Counselor, Substance Use Consult Service at East Hospital, Associate Faculty, Department of Psychiatry and Behavioral Health
- **Julie Teater, MD**, Clinical Associate Professor, Department of Psychiatry and Behavioral Health, Medical Director, Talbot Hall at East Hospital, Addiction Medicine Fellowship Director
Introduction

- Panelist Roles
- Case Example:
  - Emergency Medicine Assessment
  - Hospitalist Admission
    • Rationale for early treatment
    • Intervention opportunities
  - Psychiatry Consultation Considerations
  - Social Work Consultation
    • Case examples
  - Addiction Medicine Consultation/Treatment
Emergency Medicine Assessment
Case Presentation

Chief Complaint: Right sided chest pain

History of Present Illness: 26 y/o Caucasian female with past medical history of opioid use disorder (IV use), complicated by blood infection, PTSD, depression, who complains right chest wall pain x 2 days associated with fever; last use of heroin 14 hours ago; left against medical advice from another hospital last month while being treated for her bacterial infection; also complains of anxiety, diarrhea, nausea, vomiting, and restlessness; recently relapsed after an interaction with the father of her children.

Substance Use History: initiation at age 12: alcohol (with blackouts), methamphetamine, cocaine; current daily IV heroin use for “years” (1 gram) with weekly use of meth or cocaine; occasional benzos; multiple overdoses

Exam: anxious, older than stated age, disheveled, pacing the room, diaphoretic
Tachycardic, no murmur
Right chest wall tenderness, indurated; visible track marks
Management

• Suboxone (pain/opioid withdrawal/craving) + non-narcotic
• Antibiotics/Advanced Imaging (Right rib osteomyelitis with fracture)
• Bedside naloxone distribution
• Engagement in peer recovery services
• Admission
  – Barriers to treatment (stigma, craving, poor coping)
  – Benefit of peer coaching
  – Multidisciplinary approach
What can a peer supporter do?

• Transportation
• Facilitate transitions of care for recovery
• Legal Aid
• Social Determinants such as food, shelter, recovery support, ID
• Finding case management
• Engaging bedside during ED/inpatient stay and may follow up to 12 months
ED Initiation of Medication Assisted Treatment

• 30% increased visits in 2017 for non-fatal opioid overdoses
• ED setting most frequently encounters patients with Opioid Use Disorder (OUD) given lack of routine/primary care
• Journal of American Medical Association 2015 Gail D’Onofrio: ED initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial
  – 78% initiated on Suboxone (in ED or home) engaged in treatment at 30 days (compared to 37% for referral only group and 45% of brief intervention group)
  – Urine Drug Screen in prior 7 days more likely to be free of illicit opioids
• Annals of Internal Medicine Aug. 2018: Medication for opioid use disorder after nonfatal opioid overdose and association with mortality: a cohort study
  – Large retrospective study of >17,000 ED visits for nonfatal opioid overdose
  – 4.9% all cause mortality and 2.2% opioid related mortality
  – If started on methadone or Suboxone, lowers to 2.5% for all cause mortality and 1.4% opioid related (no benefit with Vivitrol)
Inpatient Hospitalization
Case Example

- 55 year old male presented to emergency room with back pain, difficulty breathing and swallowing.
- Found to have infection of his vertebrae in his neck and an adjacent neck abscess in danger of compressing his airway. He was put on a ventilator and underwent emergent surgery.
- 20 year history of IV heroin use, also sells heroin. Makes daily 3 hour round trips to pick up supply.
- Lost his fiancé to heroin while he was in jail, has had significant legal troubles.
- After his surgery, pain was managed with oxycodone and Dilaudid.
- Medical team discussed MAT with patient, he was interested stating “I am done [with heroin].”
OSU experience: Starting an inpatient MAT consult team

• Since 2/2018, 32 of our ~100 hospitalist physicians have obtained Suboxone training and waivers

• Hired a social worker dedicated to MAT consults

• Work with consult-liaison psychiatry, palliative medicine, acute and chronic pain, addiction psychiatry, nursing
OSU experience: Starting an inpatient MAT consult team

- Each week, 1 waivered hospitalist is on MAT call. Receives referrals from other hospitalists:
  - Assess patients with OUD hospitalized with medical illness
  - Start Suboxone when appropriate
  - Set up with outpatient MAT follow up and counseling with warm hand-off, often Talbot Hall
  - Provide bridge prescription, ensuring compatibility with insurance and pharmacy
  - SNFs that provide substance use treatment or will permit Suboxone
  - Discharge with Narcan kit or prescription
  - Covering two hospitals
Common Indications for Psychiatry Consultation

1. **Complex withdrawal scenarios**
   - Alcohol + BZDs + opioids
   - Medical comorbidity: safety of withdrawal treatments given drug interactions, hepatic impairment, increased cardiac risk

2. **Complications**
   - Crisis intervention for evolving behavioral emergencies / “difficult patients”
   - Delirium
   - Lethality Risk Assessment
   - Decision Making Capacity / Leaving AMA
   - Malingering
   - Unsafe in-hospital behavior

3. **Comorbidities**
   - “Primary” mental illness treatment
   - Brain injury
   - Dementia

4. **Disposition assistance**
   - Collaborative interventions to remove barriers to safe discharge
OSU MAT consult: Goals moving forward

• Improve discharge against medical advice and readmission rates
• Increase number of OUD patients discharged w/ naloxone rescue kit
• Expand to surgical services when able
• Engage RREACT in the hospital (already seeing ED patients)
• Hire peer recovery coaches
• Provide Narcotics Anonymous and other support meetings in hospital
• Continue to develop expertise on treating severe acute pain in setting of OUD and withdrawal
• Eventually have comprehensive consult service including addiction medicine and comprehensive pain management
Suboptimal Addiction Interventions for Patients Hospitalized with Injection Drug Use-Associated Infective Endocarditis

Elana S. Rosenthal MD a, b, Adolf W. Karchmer MD a, b, Jesse Theisen-Toupal MD b, c, Roger Araujo Castillo MD, MPH a, b, Chris F. Rowley MD, MPH a, b, d

Inpatient Management of Opioid Use Disorder: A Review for Hospitalists

Jessa Theisen-Toupal, MD a, b, c; Matthew V. Ronan, MD d, e; Amber Moore, MD, MPH d, e; Elana S. Rosenthal, MD f

Tools to Support Hospital-Based Addiction Care: Core Components, Values, and Activities of the Improving Addiction Care Team

Honora Englebard, MD, Stacey Mahoney, LCSW, CADC, Kimberly Brandt, FNP-BC, Jessica Brown, LCSW, Claire Dorfman, BA, Alexander Nydahl, PA, Melissa Wiemer, DO, and Jessica Gregg, MD, PhD
Data on inpatient MAT programs

MGH study found decreased 30- and 90-day readmission rates in patients with OUD taking buprenorphine during index hospital admission by 53% and 42% compared with patients with OUD not on buprenorphine.

BMC study found increased entrance into outpatient MAT therapy in patients discharged with buprenorphine and linkage appointment compared with detox and given information to make own appointments (72% vs 12%), improved adherence at 6 months (17% vs 3%).
Case Example (cont.)

- MAT team met with patient on 4/9 (5 days after surgery) and he decided to start Suboxone on 4/13
- Oxycodone, Dilaudid stopped at midnight 4/13
- Started scheduled Suboxone twice a day in morning on 4/13, is doing well
- Staying in the hospital to finish his antibiotic treatment through 5/13
- MAT social worker set up appointment for him at A Renewed Mind within a week of discharge
- Will be given Suboxone script and filled at OSU to bridge from discharge until appointment w/ A Renewed Mind
Substance Use Disorder Social Work Considerations
Social Work Considerations

1. Medical Aftercare

2. Insurance

3. Photo ID

4. Phone

5. Housing
Social Work Considerations

6. Transportation

7. Income

8. Support System

9. Minor Children

10. Legal Involvement
Social Work Considerations

Medical aftercare

*Where will skillable services be provided?

*Specialist appointments.

*Dialysis schedule.

*Lab draws, tests, imaging, etc.
Social Work Considerations

Insurance (Medicaid, Medicare, Commercial Plans, Uninsured)

* Copays.

* In-network providers.

* Financial assistance.

* Verification of coverage (MITS printout, copy of card).
Social Work Considerations

Photo ID

*Intake appointments.

*Pick up controlled substances at pharmacy.

*Printout of ID or patient photo.

*Wear hospital wristband.

*Partner with local pharmacy.
Social Work Considerations

Phone

* Own phone? Shared phone?

* Voicemail.

* Texting.

* Hospital phone number.

* Hospital tablet.
Social Work Considerations

Housing

*Shelter system.

*Need an address for cabs.
Social Work Considerations

Transportation

* Gas money.

* Insurance cabs.

* Transportation provided by agency (case management, van, CPST, peer support coaches).

* Bus passes and cab vouchers.
Social Work Considerations

**Income**

*Time available for treatment.*

*Copays/transportation/etc.*

*Medical leave.*
Social Work Considerations

Support system

*Family, neighborhood, religious community, etc.

*Recovery community.

*Peer support coaches.

*Pastoral Care in the hospital.
Social Work Considerations

Minor children

*Childcare.

*Children’s Services.
Social Work Considerations

Legal involvement

* Probation, Parole, pending charges, etc.

* Restriction to County?
Case Presentation

27 year old male, with Severe OUD (with IV Subutex use), presented originally as a transfer from outside hospital due to an ankle wound and suspected osteomyelitis.

Followed by Infectious Disease and Plastic Surgery. Medical follow-up needed. Given oral oxycodone for pain, and surgical intervention was required.

Admitted to a unit without privileges to leave the unit.

On day 5, he used IV heroin, and left AMA after realizing he might need long-term IV antibiotics at a SNF.
Case Presentation

Family refused to take him home, so he re-presented to the ED.

Admitted again the same day, different unit, with outside privileges.

Started to enter withdrawal 2 days later, and threatened to leave AMA again.

SUD SW consult ordered.

Consult completed, not interested in ongoing treatment, but asking about Suboxone for withdrawal management.
Case Presentation

MAT consult was ordered, and Suboxone was initiated.

Withdrawal adequately managed.

Several days later he started to show symptoms of hypomania.

Psychiatry was consulted, and Depakote was started.
Case Presentation

Hypomania was resolving by time of discharge.

He gained insight, and asked for ongoing treatment.

Needed linkage to Primary Care, Psychiatry, and MAT services.

Ultimately switched to oral antibiotics and discharged home with an outpatient treatment plan.
Case Presentation

Sent with a “bridge script” for several days of Suboxone.

Follow-up visits included Plastic Surgery, Primary Care, Psychiatry, and MAT services.

Kept his Plastic Surgery appointment.

Unknown re: Primary Care and Psychiatry.

Kept MAT intake appointment.
Case Presentation

At MAT intake appointment, assigned a therapist, and prescriber appointment set for several days later.

Was going to run out of Suboxone before prescriber appointment.

Called the hospital asking for another script.

Hospital verified he kept the original appointment, and verified the prescriber appointment.

Second bridge script sent to pharmacy.
Treatment Considerations
Treatment

• Be familiar with options for treatment
  – Provide information on AA/NA Meetings, smoking cessation options, etc.
  – Offer referral to outpatient addiction treatment clinic
  – Suggest inpatient detoxification and/or long-term residential treatment, if indicated.

• There continues to be a large “treatment gap”

• Be familiar with treatment options in your area.

• AA meetings are not treatment; they are mutual aid groups.

• Mutual aid groups vs. treatment; there is a place for and a need for both.

• Proportionately few of the people who need treatment for addictions get it.

• In 2010, an estimated 23.1 million Americans (9.1 percent) needed treatment for a problem related to drugs or alcohol, but only about 2.6 million (<1% of the population & 10% of those needing it) received treatment.
Pharmacological Treatment

Opioid Use Disorders

• Methadone
  – Long acting mu agonist

• Buprenorphine/naloxone (Suboxone)
  – mu partial agonist/antagonist
  – kappa antagonist
  – naloxone is not absorbed in the GI tract

• Naltrexone
  – Mu antagonist

• Long acting injectable naltrexone (Vivitrol)
  – used monthly
Opioid Use Disorder Treatment

• Relapsing condition: RELAPSE RATE IS HIGH
• Best treated as a chronic condition
• Treatment available and indicated
• Acute and maintenance phases of treatment
  – Medical detoxification/stabilization
    • Usually accomplished by tapering that substance itself or by substituting a closely related related substance.
    • Use standardized scales to monitor withdrawal (COWS)
    • Risk of overdose with decrease in tolerance following treatment
  – Minimize relapse risks (maintenance)
    • Relapse rates high (90%) following detoxification with no medication treatment
  – Psychosocial interventions (acute and maintenance)
Suboxone Waivers

• It is currently illegal to prescribe opioids to an opioid addict to treat their addiction, except in a few circumstances
  – Opioid Treatment Programs (OTP): methadone clinics
    • Federally regulated, strict laws- daily dosing initially
  – Providers with a DATA 2000 waiver to prescribe Suboxone in office-based opioid treatment (OBOT):
    • Providers receive a new/second DEA number, typically called an “X number”, because it is your DEA with an X as the first letter
    • Also DEA has rules governing when patients admitted to the hospital for another medical condition, if their withdrawal is complicating treatment
• It is legal, however, to prescribe opioids to an opioid addict for pain, but it must be documented as such
  – Plus, keep in mind they will likely require higher than normal doses for pain
Getting a Suboxone Waiver

• Free and Easy!
  – 8 hour online course for physicians
  – 24 hour online course for NP’s and PA’s (new in 2017!)
  – Ohio also offering reimbursement for your time to get trained

• Providers are limited in how many patients they can treat at a time
  – 30 for the first year
  – 100 after 1 year of prescribing
  – Up to 275 after 2 years of prescribing if in qualified practice settings

• There are laws regarding how often patients need to be seen
  – Monthly for the first year, then can space out
  – Must also be in counseling

https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management
Psychosocial Interventions

• Psychosocial Services
  – Individual and group therapy
  – Family therapy
  – 12 Step, CBT, MI
  – Case Management

• Contingency treatments very useful
  – Take-home medication, limit supply, frequent visits

• Treat comorbid psychiatric issues
  – Depression, PTSD, anxiety

• Treat comorbid medical issues
  – Hepatitis, HIV, skin infections, dental issues

• Consider living situation
  – Access, availability, and proximity to others who use
  – Treatment for family, others surrounding patient
  – Removing supply of excess, outdated prescribed or illicit substances

• Legal issues
  – Drug court, diversionary programs
Treatment Settings

- Inpatient Hospitalization
- Residential Treatment Programs
- Partial Hospitalization
- Outpatient Treatment
  - Intensive Outpatient Programs
  - Outpatient counseling - group and individual
- Medication Assisted Treatment (MAT) can run throughout these levels of care
Length of Treatment

Cocaine Abuse and Brain Glucose Metabolism

- Normal subject
- Cocaine abuser (10 days post)
- Cocaine abuser (100 days post)

Length of Treatment

Dennis et al, Eval Rev, 2007
Thank You!

- Emily Kauffman, DO, MPH
  - Emily.Kauffman@osumc.edu
- Peggy Williams, MD
  - Margaret.Williams2@osumc.edu
- Cara Jordan, MSW, LISW-S
  - Cara.Jordan@osumc.edu
- Julie Teater, MD
  - Julie.Teater@osumc.edu