Launching Lean Inpatient Addiction Consult Teams

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Disclosure Information

Abby Sepanski, LISW-CP

- No Disclosures

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- No Disclosures

Trish Melling, CPSS

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Learning Objectives

- Discuss methods to launch an inpatient addiction team utilizing stakeholder engagement, protocol development, IT support, and funding acquisition.
- Describe the roles of each inpatient addiction consult team (IACT) members including nurse practitioner, social worker, peer support specialist, addiction medicine and infectious diseases physicians.
- Conduct a shared decision-making assessment incorporating harm reduction, choice of MOUD, social determinants of health, co-occurring infectious diseases, management of pain and addiction, and collaboration with hospital teams.

Prisma Health System

Prisma Health serves 21 counties and more than 1.2 million unique patients annually with nearly 30,000 team members, 18 acute care and specialty hospitals, 2,984 beds and more than 300 physician practice sites, across the Midlands and Upstate of South Carolina, making it the largest health company in SC.

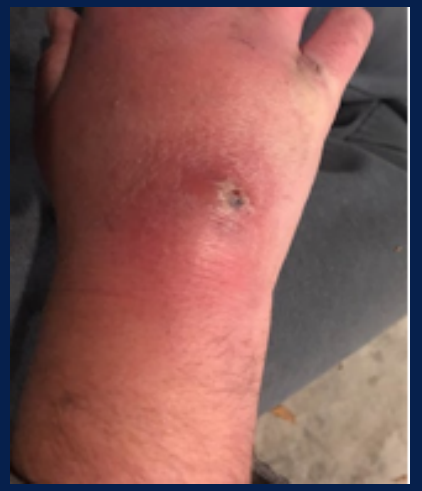
Prisma Health's Greenville Memorial Hospital is a 24-hour Level I Trauma Center, along with the Upstate's only pediatric trauma center. The surrounding campus houses many of the area's top specialty programs and educational facilities.

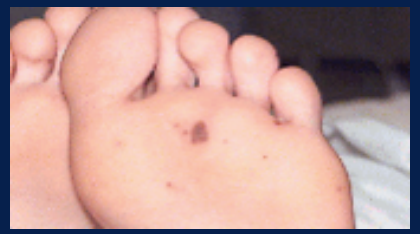
Additional Prisma Facts:

45% of S.C.'s population lives within 15 miles of one of our facilities	2 affiliated medical, 40 affiliated nursing and 70 affiliated allied health schools	775 employee health business partners to ensure a healthy workforce	238,000 patients with Medicaid served

The Beginning

- 2019: No addiction medicine services aside from a social work list of places to go
  - Psychiatry did not address addiction
  - No MOUD was available
  - No syringe service programs available
  - Lots of stigma
- As an infectious disease physician approximately ¼ of my patients had underlying SUD as the cause of the infection



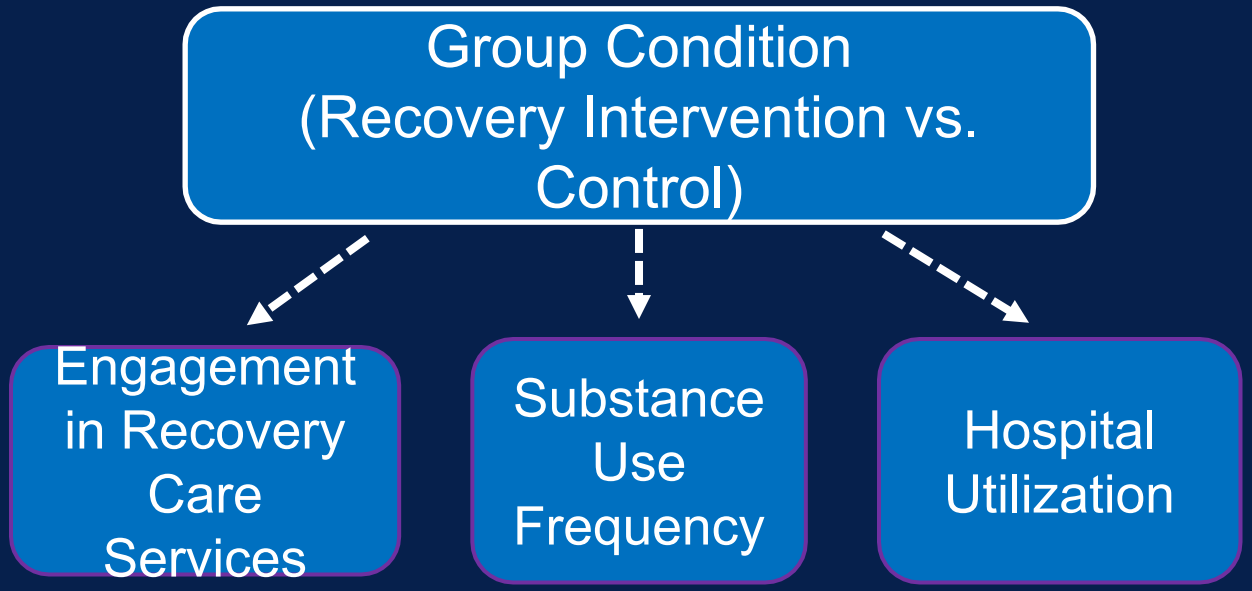


The First Team

- Idea was formed to connect students doing an elective in motivational interviewing with FAVOR (Faces and Voices of Recovery) to inpatients who needed help
- Funding was obtained through a Prisma Health Seed grant of $20,000 for 1 year to do a RCT comparing standard of care to linkage with a peer recovery coach
- Medical students helped and research students volunteered to help with the study
  - 98 patients enrolled in year 1

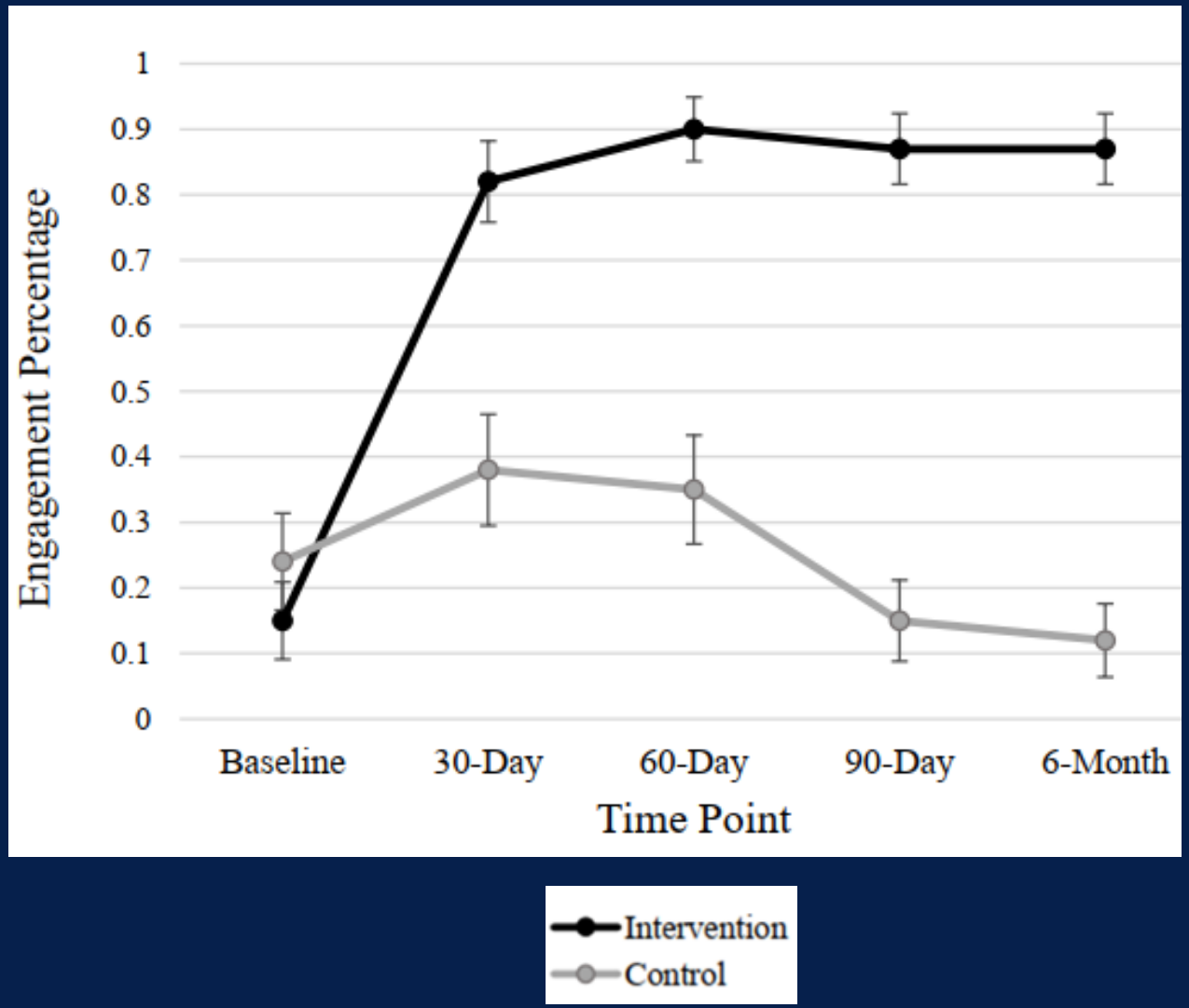
Study Design

- *Participants*: Patients (*N*=98) hospitalized with SUD at Greenville Memorial
- *Study Overview:* Prospective randomized controlled trial
  - Two-arm, 6-month longitudinal study



Study Results

- Compared to the control, those in the intervention condition had:
  1. Greater engagement in recovery services at all post-baseline time points
  2. Diminished alcohol use for those with AUD overall
  3. Decreased substance-related ED visits

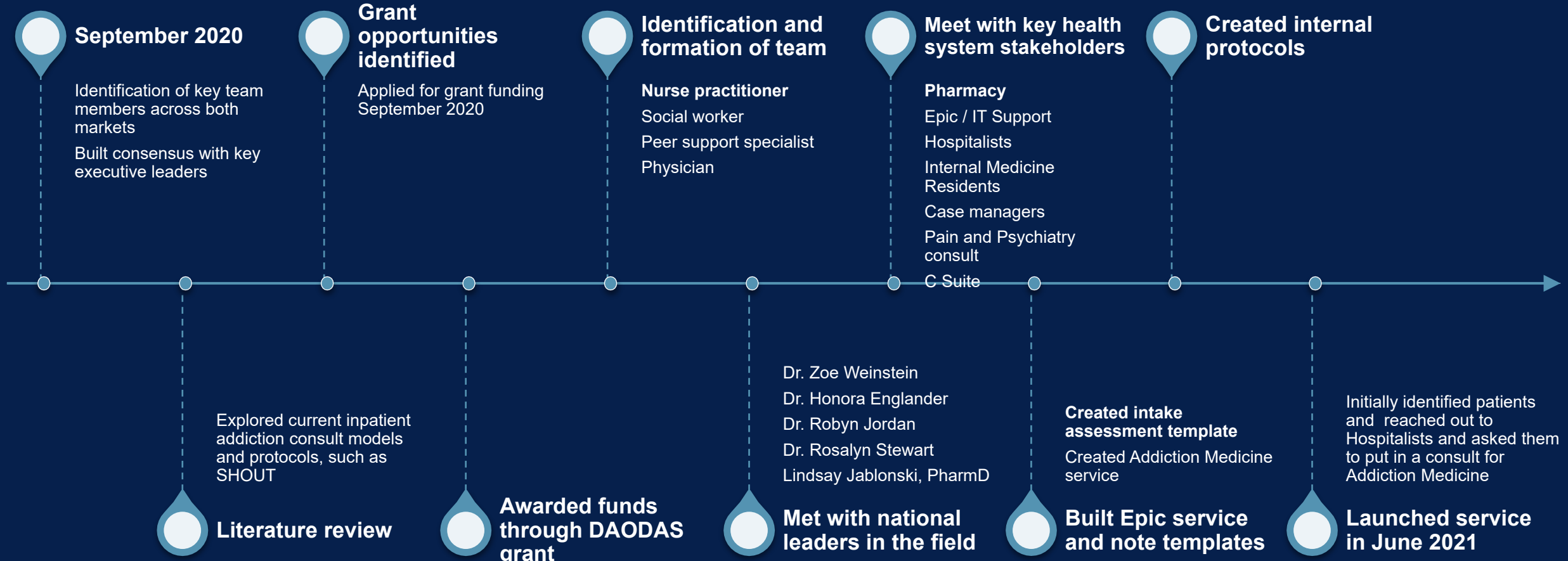


Byrne, K. A., Roth, P. J., et al. (2020). Inpatient link to peer recovery coaching: Results from a pilot randomized control trial. Drug and Alcohol Dependence, 215, 108234.

Poll

Does your hospital system have an inpatient addiction consult team?

Timeline of Launch



Inpatient Addiction Consult Team

MEDICAL

SOCIAL WORK

PEER COACH

IACT General Workflow

Initial Assessment

- Conduct focused H&P related to current and past substance use including:
  - Address any current use of substances or withdrawal in hospital
  - Prior treatment for substance use disorder
  - Relevant co-morbidities: mental health, infectious diseases
  - Current recovery capital

Discharge Planning

- Discharge planning needs to start on day one
- Create substance use treatment plan
- Collaborate with hospital case management and primary team
- Assist patient with outpatient referral process
- Provide harm reduction education

Engagement Follow-up

- Post-discharge, SW and Peers conduct 30-, 60-, and 180-day engagement calls:
  - MOUD continuation
  - Recovery coaching
  - Substance use treatment

Consult Service Objectives

Objective 1. Launch a hospital-based addiction evaluation and treatment team with a primary focus on opioid and stimulant use disorders

Objective 2. Document the cascade of care for patients with opioid use disorder and factors associated with improved outcomes after hospital discharge

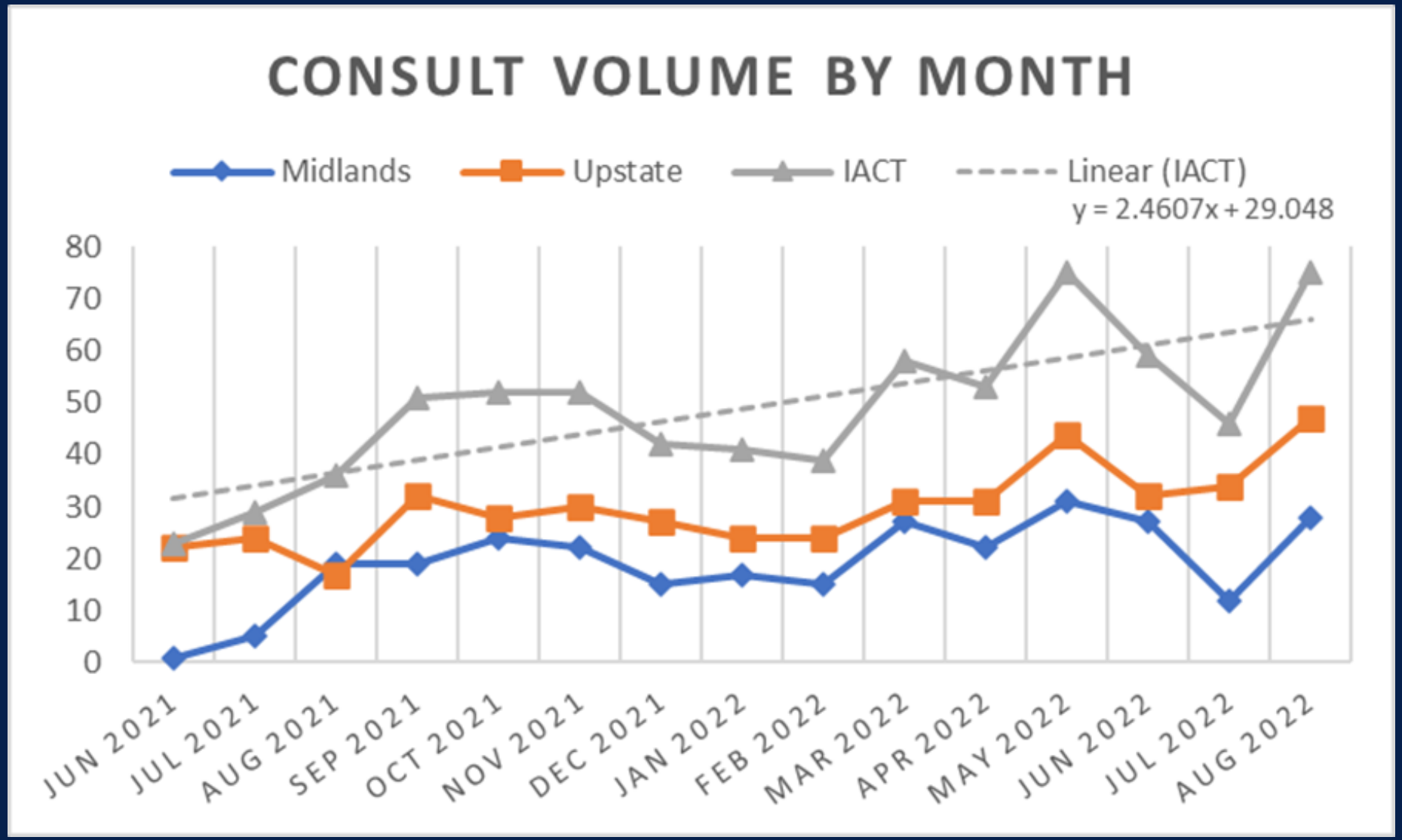
Objective 3. Document healthcare utilization for patients with opioid use disorder and stimulant use disorder

Objective 4. Increase capacity for addiction treatment among hospital clinicians and reduce patient addiction stigma among hospital staff

Year 1 Outcomes

Total Consults Completed	**N=731**	
OUD Diagnoses Only	214	*29.3%*
Stimulant Diagnoses Only	230	*31.5%*
Amphetamine Type Substance	109	
Cocaine	121	
Polysubstance Diagnosis (OUD +StimUD)	139	*19.0%*
Amphetamine Type Substance	110	
Cocaine	29	
Other Substance Use	102	*14.0%*
Did not meet diagnostic criteria	46	*6.3%*
Total Consults not Completed	**N=113**	
Medical complexity preventing consultation	27	*23.9%*
Consult and services declined by patient (defined below)	37	*32.7%*
Discharged prior to being seen	41	*36.3%*
Deceased prior to being seen	8	*7.1%*

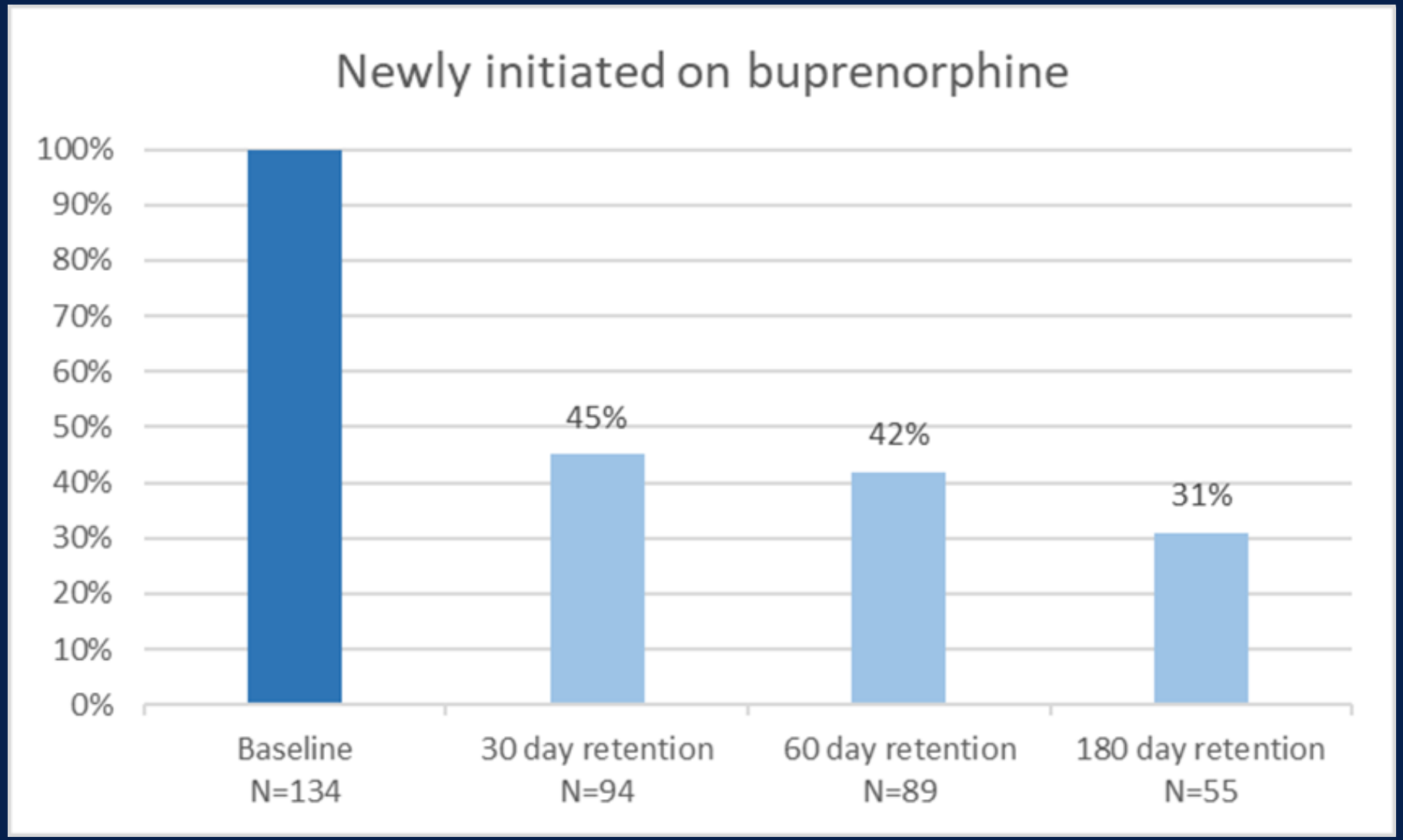
Increase in consults over time



Linkage data

Step 1. Initiate MOUD						
	IACT Total	%	Upstate	%	Midlands	%
OUD consults seen	353		248		105	
Enrolled in MAT Program Prior to Admission	78	22%	56	23%	22	21%
Continued	74	95%	52	93%	22	100%
Buprenorphine	50	68%	40	77%	10	45%
Methadone	24	32%	12	23%	12	55%
Not Continued	4	5%	4	7%	0	0%
Eligible to be Newly Initiated on MOUD	275	78%	192	77%	83	79%
Induction Started	173	63%	115	60%	58	70%
Buprenorphine	134	49%	101	53%	33	40%
Methadone	39	14%	14	7%	25	30%
No interest	102	37%	77	40%	25	30%
Did Not Receive MOUD	106	30%	81	33%	25	24%

Retention in care



Case Study 1:
Medical advocacy and addiction

- AF is 40-year-old woman with PMH significant for opioid/amphetamine use disorders and paravertebral/retropharyngeal abscess complicated by cervical osteomyelitis requiring two spinal fusion surgeries with hardware now hospitalized for MRSA bacteremia
- Posterior paravertebral fluid was drained, and AF was noted to have loose hardware requiring future surgical intervention. She has received vancomycin x 2 weeks and oral rifampin
- Patient verbalized the need to discharge early as she was the primary caregiver of her partner's children

Case Study 1 cont.

- Patient lived with partner in rural SC > 1 hour away with poor access to transportation
- Patient came to buprenorphine program (driven by partner) and was started on outpatient low-dose buprenorphine induction while continuing hydromorphone
- Patient was eager to have neck surgery due to debilitating pain and inability to extend her neck
- After several months, AF separated from partner, became homeless, was unable to drive to our pharmacy or clinic for appointments, returned to injection use and was lost to follow-up

Case Study 1 cont.

- 6 months later, AF was readmitted to our hospital after return of C spine osteomyelitis in setting of daily injection opioid use
- Patient was discharged after 2-month hospitalization
- Addiction medicine physician manages long-term infection with lifelong medication
- AF now makes monthly addiction virtual visits and is adherent with both buprenorphine and antibiotics
- Patient has recently returned to use and has asked to be linked to inpatient substance use treatment

Case Study 2: Shared Decision Making

47 yoM with a history of IVDU who was found to have MRSA bacteremia and lumbar spine extensive epidural abscesses. Was taken to the OR for debridement. Recommended treatment by ID was daptomycin 10mg/kg daily for 6 weeks with patient remaining inpatient for duration – however he did not want to stay.

32 yoM with IVDU admitted with MRSA bacteremia and L foot osteomyelitis, underwent I&D, plan was for 6 weeks of IV vancomycin, however about 1 week in patient had to leave urgently for personal issues.

What would you do?

Case Study 3: Barriers to Care

- KD is a 46 y.o. female with 30-year history of IV drug abuse, HCV, ulcerative colitis, smoker 1 pack/day, who consistently presents to the ED with wounds on right lower leg and lower arms bilaterally
- KD was admitted in May 2022 with abdominal pain
- KD is homeless, does not work, has no social support, and does not own a phone
- KD was started on buprenorphine through a low-dose induction

Case Study 3 - continued

With the plan for KD to stay on buprenorphine after discharge, what are the next steps IACT should take in discharge planning for this patient?

What are the barriers KD faces? How would you overcome them?

Case Study 3: Next steps

KD maintained on buprenorphine 16mg/day and set her up with an appointment at MOUD clinic

IACT referred KD to care coordination team that links patients to HCV treatment

Referred to local shelters and residential treatment

IACT helped KD to obtain a phone

KD made initial visit but was ultimately lost to follow-up due to lack of transportation and loss of phone

Final Takeaways

- It is possible to launch a low-cost and lean addiction consult team
- Hospital admission is a “reachable moment” for life-saving interventions
- Addiction Consult Teams have been associated with
  - Improvement in substance use treatment retention
  - Decreases in hospital readmission and self-discharge rates
- Shared decision making should incorporate social determinants of health
- Efforts are underway to address gaps in linkage and retention in care including mobile health clinics, community paramedic programs, and provision of transportation and phones

Panel Q&A

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