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Promoting MOUD in Hospital Settings

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On behalf of Maine's Opioid Response Clinical Advisory Committee

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Why Focus on OUD Treatment?

- Maine & US continue to see increasing epidemic of drug overdose deaths
- Deaths largely fueled by highly lethal illicit fentanyl
- >107,000 individuals died of drug overdose in the US during 2021, a 15% increase from 2020
- Maine saw 716 drug overdose deaths in 2022, a 13.5% increase from 2021

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Why Focus on Hospitals?

Decreased overdose deaths and morbidity:

- 1 in 9 patients in hospital have substance use disorder (SUD), and most are not being treated
- Individuals seeking care at hospitals are at increased risk of drug overdose death:
  - Approximately 17% of Maine fatal overdose decedents had evidence of hospital inpatient stay or emergency department (ED) visit within 30 days prior to their death
  - In Oregon, 7.8% of patients with OUD died within 1 year after hospital discharge (similar mortality to acute MI)

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Why Focus on Hospitals?

Decreased overdose deaths and morbidity:

- Medications for opioid use disorder (MOUD) shown to be highly effective in decreasing overdose deaths
- Patients treated with MOUD in ED less likely to use illicit drugs and more than twice as likely to be in MOUD treatment at 30 day follow up
- Individuals on MOUD on hospital admission have 30 day & 90 day hospital readmission rates 53% and 43% lower than those with untreated OUD

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Why Focus on Hospitals?

Avoid harms of NOT addressing OUD in hospitals include:

- Untreated withdrawal symptoms
- Untreated pain:
  - Reluctance to treat pain adequately for fear it will "exacerbate" opioid use disorder
- Frequent patient-directed discharges
- Moral distress for patients and staff:
  - Chaotic, reactive interactions with patients
  - Variable care quality
  - Feelings of futility by providers

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Why Focus on Hospitals?

Hospitalization as "reachable moment" for patients and staff alike:

- Hospital-based SUD care has been shown to:
  - Improve trust in providers and providers' feelings of preparedness and satisfaction
  - Improve patient experience
  - Increase adoption of evidence-based treatment
  - Increase engagement in post-discharge SUD treatment
  - Reduce SUD severity
  - Reduce death
  - Increase likelihood that *other* hospital care will be trauma-informed and meet comprehensive health needs of people, i.e.. "treatment changes culture"

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Why Focus on Hospitals?

Case Presentation 1:

- ER Visit (May 2022): 28yo female with h/o OUD, PTSD, homelessness presents to ED with abscess, concern from friend about OUD. ED treated pt with IV abx, and notes "we counseled her on hazards of drug abuse. We did throw out her drug paraphernalia in accordance with hospital policy. Patient did become very upset when this was disposed of." Pt was instructed to f/u with PCP
- Inpatient Admit (September 2022): Pt admitted with cough, pleuritic chest pain, daily use of heroin/fentanyl, injected. CXR showed early airspace disease. Pt self-directed discharge the day after admission. Was told to follow up with her PCP regarding pending blood cultures
- Inpatient Admit (October 2022): Pt admitted with "pain and swelling of right lower arm due to iv drug use for weeks." Found to have abscess requiring formal debridement and irrigation in OR. Two days earlier, she had self-directed discharge from another local hospital because they were "mean." Patient completed procedure, then self-directed discharge on post-op day one, to homelessness. Seen one week later by experienced Street Medicine Provider, who provided wound care and initiated MOUD (buprenorphine/naloxone) for patient
- Inpatient Admit (December 2022): Pt admitted with chest pain, shortness of breath, shaking chills, hypotension. Diagnosed with bacteremia, sepsis. Patient and mother advocated strongly that her suboxone be continued while she was an inpatient. The hospital team declined, stating that if she was on MOUD, they could not find evidence of it. Five days passed. Patient's mother worked with outpatient provider, brought prescription for suboxone to patient in hospital, with hope that they would dispense it to her. Hospital team eventually provided her suboxone. Throughout hospitalization, patient "red-flagged" as individual with OUD and must have restricted visitors

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Why Focus on Hospitals?

Case Presentation 2:

- 52yo female with h/o PTSD, bipolar disorder admitted with MRSA bacteremia and pelvic abscess. Was initiated on suboxone during her admission, which was continued by outpatient MOUD provider upon discharge
- Re-admitted one month later with septic arthritis of hip. Received hip resection arthroplasty. Suboxone continued during hospitalization
- Pain management difficult during hospitalization, and team attempted to manage it, documenting risk of recurrence of use on discharge if pain not well-managed
- Discharged to home, still on suboxone, though with limited mobility and lives 2 hours from her outpatient MOUD provider, who was not contacted about her discharge
- After discharge, MOUD provider coordinated with surgeon regarding pain management. Surgeon recommended oxycodone 7.5mg q4 hours prn, saying "this isn't going to touch her pain"
- For ensuing weeks, outpatient team attempted to manage pain and MOUD via telehealth visits, limited by internet connectivity, as well as home health RN who advised patient that suboxone was interfering with her pain medications

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Why Focus on Hospitals?

Case Presentation 3:

- 79yo male, h/o OUD (prescription opioids) stable on 8mg suboxone for 10+ years
- Admitted to hospital in Summer 2022 with hip fracture, s/p ORIF. Suboxone was stopped during hospitalization, discharged to SNF on oxycodone; rationale was that no SNF would accept pt on suboxone. Was in acute withdrawal in SNF; re-started on suboxone by SNF provider
- Once home, became bored, depressed, started drinking heavily
- Early 2023, suffered CVA, again admitted to hospital. Suboxone stopped again, again with rationale that he could not access SNF while on suboxone, and that "his real problem is his alcohol use." He was not offered medications for alcohol use disorder in the hospital
- Presented to SNF in acute withdrawal, but was resistant to re-starting suboxone: "The doctor in the hospital told me I don't need it"
- Attending provider at SNF gradually was able to convince patient to re-start suboxone; also provided medication for alcohol use disorder

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Enhancing Access to MOUD in Hospitals

- Recommendations from Maine Opioid Response Clinical Advisory Committee
- Group of 40+ clinicians with OUD expertise from around state
- Reviewed literature, solicited input from national experts
- Developed guidance document in effort to promote awareness and education with hospital-based clinicians statewide

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Enhancing Access to MOUD in Hospitals

- Propose that all Maine hospitals should provide at least basic level of care to patients with OUD
- Also recognize that some hospitals able to provide more advanced level of care
- Also provided policy recommendations, variety of helpful resources for providers

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MOUD in Hospitals: Basic Level of Care

- Annual training and education about SUDs and stigma for all members of its staff
- Process to identify high risk individuals (both inpatient and in ED) including patients who:
  - Are opioid intoxicated/post-overdose or in opioid withdrawal
  - Have pain that is unusually difficult to manage
  - Have SUD-related complications such as endocarditis, osteomyelitis, sepsis, etc.
  - Request treatment of a SUD
- Toxicology screening that is consistent with substances seen in community and provider knowledge of how to interpret findings

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MOUD in Hospitals: Basic Level of Care

- Buprenorphine available on hospital formulary
- Buprenorphine initiation available in both ED and inpatient hospital setting (X-waiver no longer required)
- Evidence-based best practices for treating patients on MOUD including:
  - MOUD should not be discontinued unless there is clear contraindication to use of MOUD
  - Pain management sensitive to unique needs of patients with OUD
  - Direct linkage to buprenorphine prescriber at hospital discharge including scheduled appointment
  - Referrals to post-acute care facilities (e.g., skilled nursing facilities, nursing homes) that provide ongoing treatment with MOUD
  - Naloxone kit in hand at discharge
- Wrap around services for individuals with OUD as appropriate (e.g., peer support, harm reduction, etc.)

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MOUD in Hospitals: Advanced Level of Care

- Provide Basic Level of care, plus…
- Commitment to educate learners and providers in training about full spectrum of SUD care
- Protocols and resources to utilize extended-release buprenorphine (XRB) in ED and inpatient setting
- Integrated inpatient care management and peer support
- Initiation of MOUD using methadone in inpatient setting

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Common Concerns

- It's illegal to provide MOUD in the hospital, especially methadone
  - Provider may maintain patients on methadone from an OTP; and may initiate methadone and create transition plan to OTP on discharge
- It's dangerous to start/maintain MOUD if there is no plan at discharge
  - Begin discharge planning early, just as you would for another treatable chronic condition
  - Establish referral pathway as "basic" level of care
  - Low-barrier telehealth MOUD treatment options increasingly available

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Common Concerns (cont'd)

- We don't have the clinical expertise
  - Multiple resources in Maine for clinician education (ECHO, ME SUD Learning Community), as well as national resources (e.g. CA Bridge, OHSU Toolkit)
  - Create protocols, pathways and orders sets in Electronic Health Record
  - Build in as provider incentive
  - Access to warm consult/on-call expert?
- We don't have the staff for an addiction consult team:
  - Multiple models exist, from inpatient consult teams to hospitalist-based opioid treatment (see Taxonomy article in References)

Common Concerns (cont'd)

- There isn't a clear financial return on investment
  - Many inpatient consult services don't directly save money
  - Policies that provide incentives for good care delivery do provide an ROI, as do new reimbursement models
- It's too hard to do this on my own as a well-intended clinician
  - Agreed! Health systems need to be part of solution
  - Quality measures could include provision of MOUD, identifying discontinuation of MOUD as a "never event"
  - In other states, larger hospitals build up capacity, then serve as community assets, consultants to other hospitals

Promoting MOUD in Hospital Settings:

Next Steps

- Promote communication of this Opioid Clinical Advisory Comm guidance document
- Encourage clinician conversations, feedback
- Promote use of educational supports and resources – e.g. ME SUD Learning Community

https://mesudlearningcommunity.org/

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Questions & Answers

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