The Nuts and Bolts of the Inpatient Substance Use Disorders Consultation

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Financial Disclosures

- Anika Alvanzo
  - Consultant, Emmi Solutions
- Patti Burgee
  - No relationships to disclose

Objectives

- Determine necessary information to gather during the 3 phases of the substance use disorder (SUD) consultation
- Discuss how to match patients to existing resources based upon their unique circumstances
- Identify what aspects can be implemented in own clinical practice setting

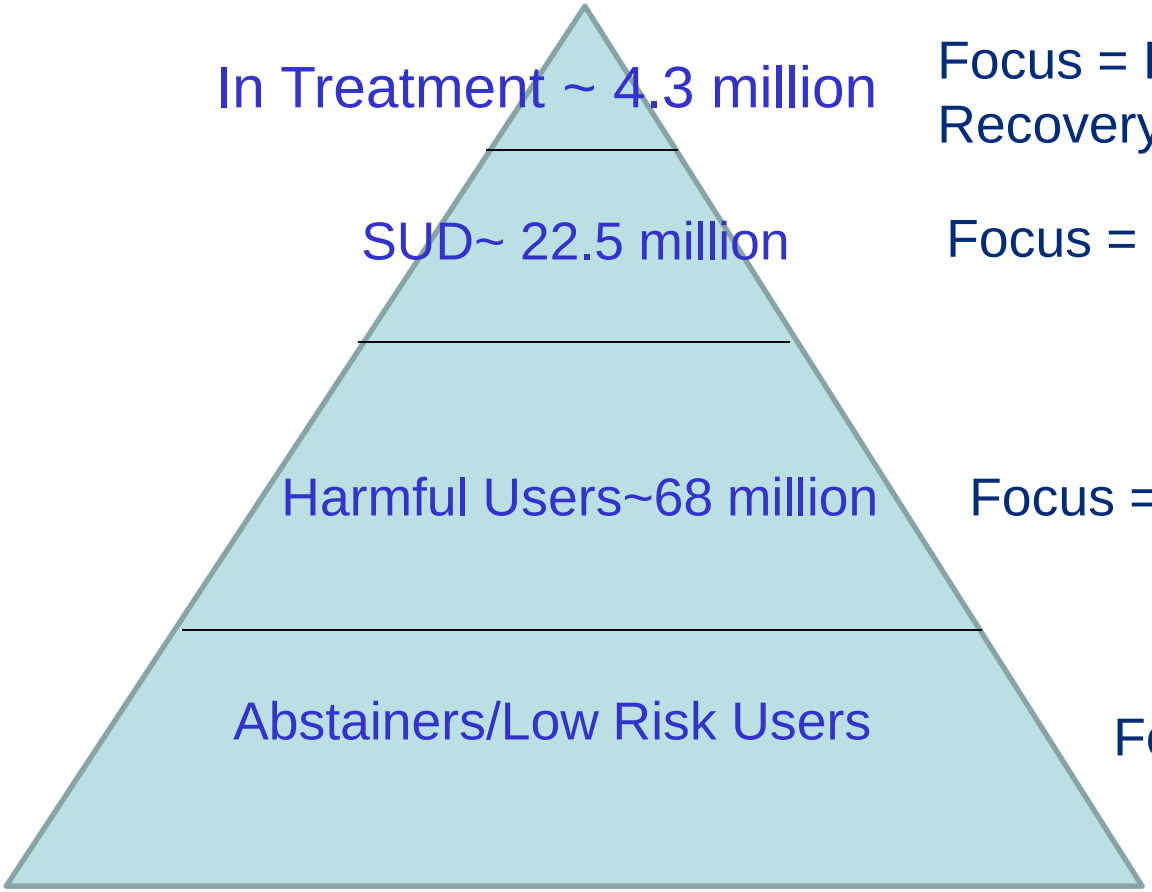
Outline

- Introduction
- Overview of the SUDS
- Phase I: Pre-intervention
- Phase II: Intervention
- Phase III: Post-intervention
- Case Studies

Introduction

- Substance Use & Use Disorders
  - Prevalent
    - >22 million past year alcohol or drug use disorder
  - Costly
    - ~$700 billion annual
  - Comorbidity
  - ↑ Mortality
    - ¼ deaths attributable to tobacco, alcohol or drugs

Pyramid of Substance Use



Focus = Retention, Sustained Recovery

Focus = Treatment

Focus = Early Intervention

Focus = Prevention

Rationale for SUD Consultation Specialty Services

- Hospitalization may be “teachable moment”
- Brief interventions demonstrate reduction in alcohol consumption and death rates
- Provider factors
  - under diagnose
  - under treat
  - lack confidence in treating

McQueen, et al., 2011
Murphy, et al., 2009
Moore, et al., 1989

Historical Perspective

- First Step Day Hospital: 1997 – 2010
  - Departments of Medicine and Psychiatry
  - Ongoing medical care
    - Wound care, IV antibiotics
  - Behavioral health care
    - Group and individual counseling
- Substance Use Disorders Consultation Service (SUDS): 2010 – present

Mission

The Mission of the Johns Hopkins Hospital Substance Use Disorders Consultation Service (SUDS) is to **improve the health and quality of life of patients with substance use disorders** by providing non-judgmental, comprehensive, and patient-centered care and education. The SUDS performs **brief behavioral interventions and counseling** to patients, **facilitates linkage** to hospital and community-based alcohol and drug treatment programs, **provides guidance on the clinical management** on care of patients with substance misuse and use disorders, and **educates** patients, families, healthcare professionals and the community to prevent, identify, and treat persons living with addiction.

SUDS Team

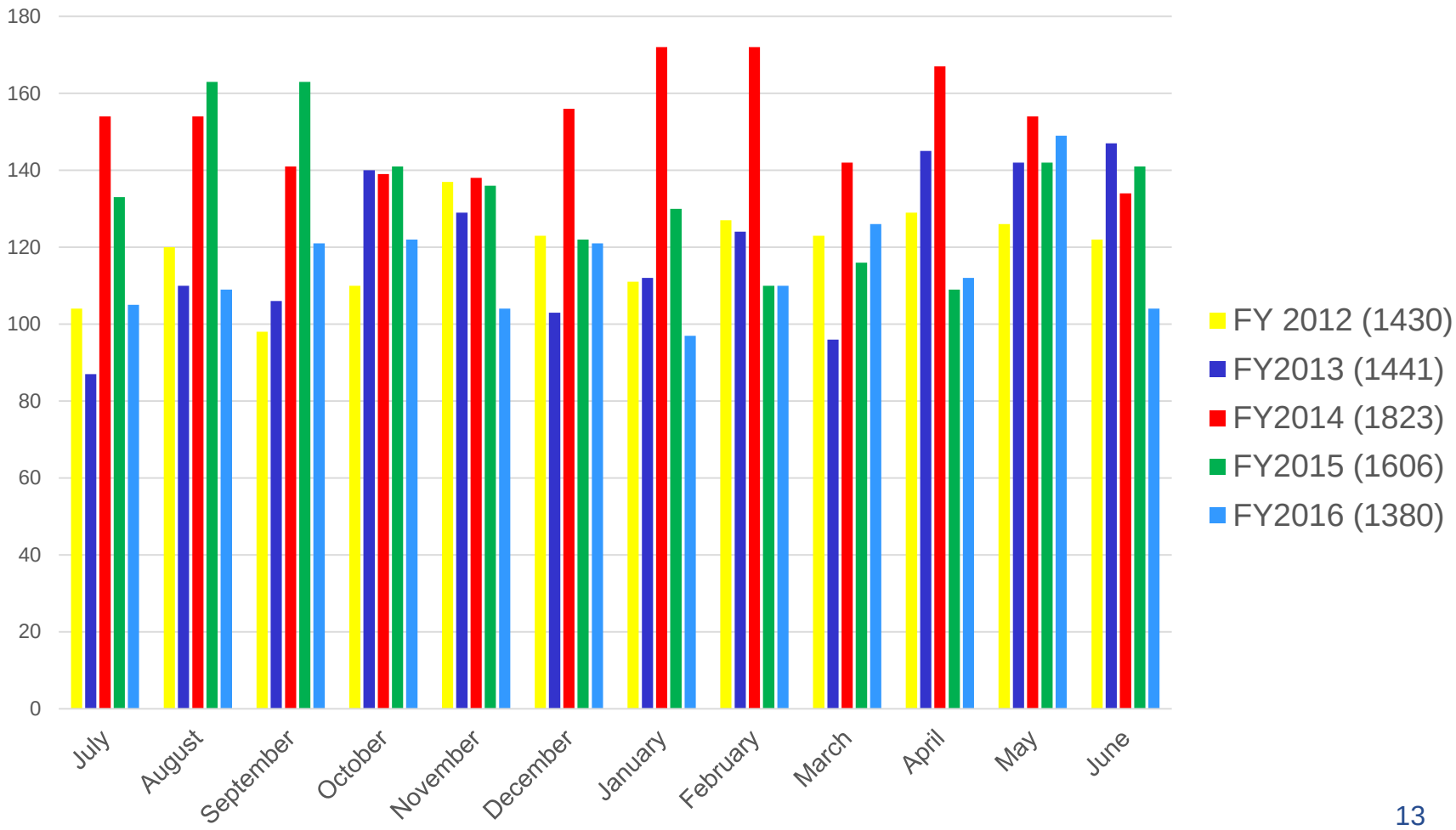
Current Staffing

- Medical Director (25% effort on K23)
  - *Anika Alvanzo, MD, MS, FASAM, FACP*
- Nurse (1FTE)
  - *Patricia Burgee, CARN, MSN, MBA*
- Senior Addictions Therapist (1FTE)
  - *Diane Moses, MSW, M.Ed, LCAD-C*
- Outreach Worker (1FTE)
  - *vacant*

What We Do

- Services
  - Brief Interventions
    - Motivational Interviewing
  - Linkage to Treatment Programs
  - Medical Management
    - Withdrawal syndromes
    - Pain management in patients with opioid use disorders
  - Buprenorphine Bridge
  - Patient, Family and Clinician Education
  - Policy and Order Set Development

Referral Volume: FY12 – FY16



Who We Are Seeing

Jan – Dec 2013 (N =1648)

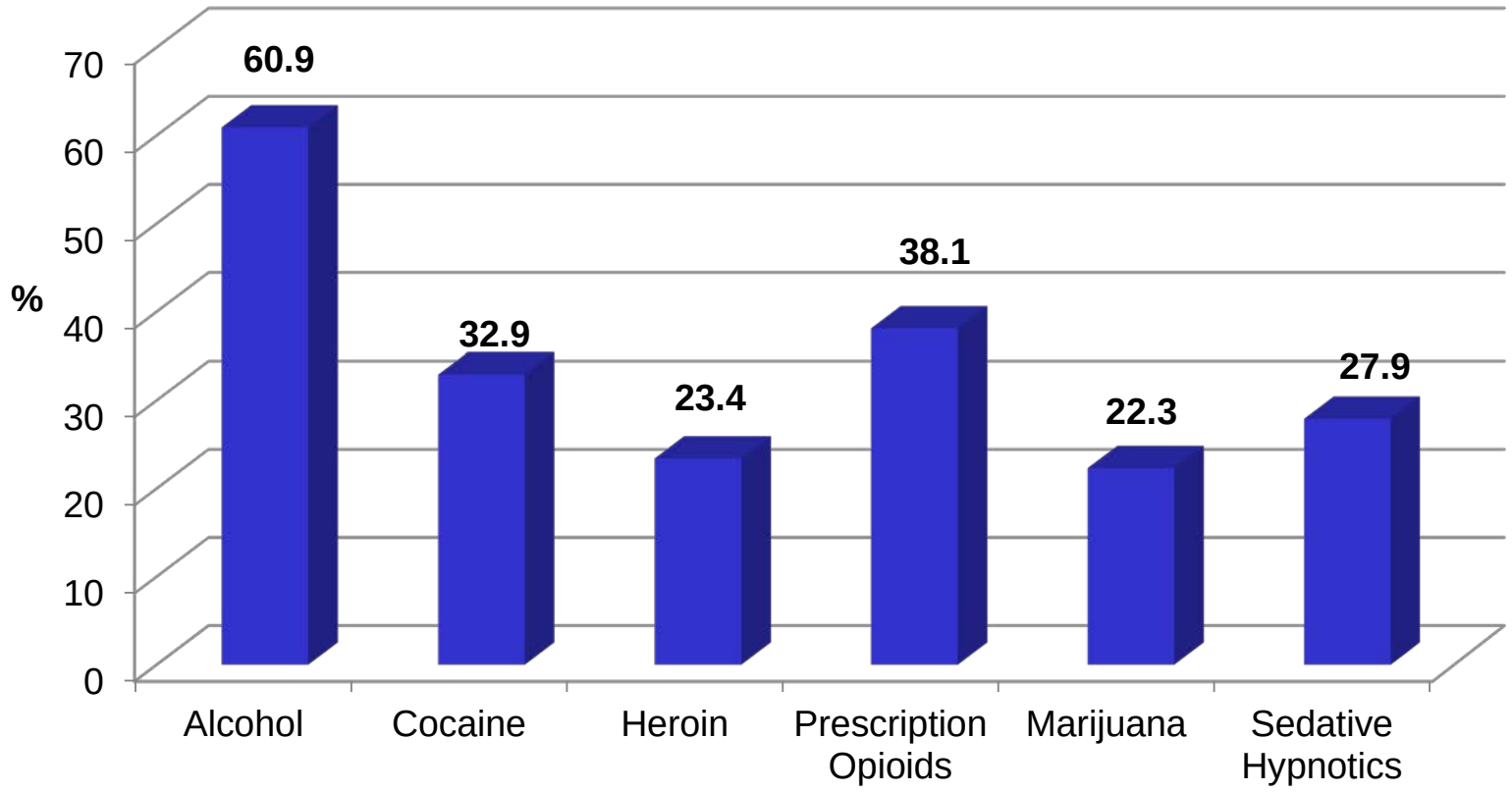
- 49.9 yrs old (SD 11.66)
- 61.8% male
- 73.9% Black, 22.9% White
- 81.6% uninsured or Medicaid* (n = 1082)
- 62.1% alcohol
- 64.9% polysubstance use*

Jan – Dec 2014 (N =1790)

- 50.5 yrs old (SD 12.31)
- 63.7% male
- 67.7% Black, 26.8% White

* January – May 2013

Substances Used: Jan–May ‘13



Accomplishments

- Relationship Building
  - Program Visits
- Electronic Documentation
  - Qualified Service Organization Agreement (QSOA)
- Clinical Database
- Customer Survey
  - 14-item survey using a 5-pt Likert scale (3.1 – 4.8)
- Improving Clinical Care
  - Opioid and alcohol withdrawal protocols

Challenges

- Demonstrating our value
  - Not a revenue generating service
  - Must be able to demonstrate cost savings
    - Readmission, ED visits, LOS, expenditures
    - Treatment entry & engagement

Summary

- Multidisciplinary service
  - Counseling, treatment linkage with bridge, management of withdrawal and pain
- ~ 1400 referrals in last year
- Customers overwhelmingly satisfied
  - Integral role in discharge planning

The Nuts and Bolts…

Pre-Consult Pearls…

- Start building relationships now
- Work out policies on information exchange
- Standardize procedures and documents
- Clinical database
  - Integration with Electronic Medical Record
- Determine outcomes and plan for measurement in advance

Phase I: Pre-Intervention

- Reviewing the placed order
  - Who placed the order?
  - What services requested?
  - Where located?
  - Is patient aware order was placed?

Phase I: Pre-Intervention

- Chart Review
  - History and Physical
    - Admitting Diagnosis, History of Present Illness
  - Past Medical History
    - Medical History
    - Psychiatric History
    - Substance Use History
  - Social History
    - Living Situation

Phase I: Pre-Intervention

- Chart Review
  - Demographics
    - Insurance
  - Medications
    - Withdrawal
    - Pain
  - Labs:
    - Toxicology, BAL
    - Infectious disease testing (HIV, Hep B/C, RPR)

Phase I: Pre-Intervention

- Other Sources
  - Prescription Drug Monitoring Program (PDMP)
  - Judiciary Case Search
- Communication with Team
  - Anticipated Discharge Day
- Pack your bag
  - What resource info do you need to bring?

Phase II: The Intervention

SBIRT as done by SUDS

DIRECT TIME	INDIRECT TIME
Brief Intervention	Chart review
Counseling	Discharge planning with inpatient healthcare team member
Discussion of Treatment Options	Request tablet education, i.e. Emmi smoking cessation module
Education	Authorizations and/or phone calls to SUD programs -back and forth
Family intervention	Complete online Referral form(s)
	ROI – faxing of essential information
	Electronic Medical Record (EMR) charting

SBIRT as done by SUDS

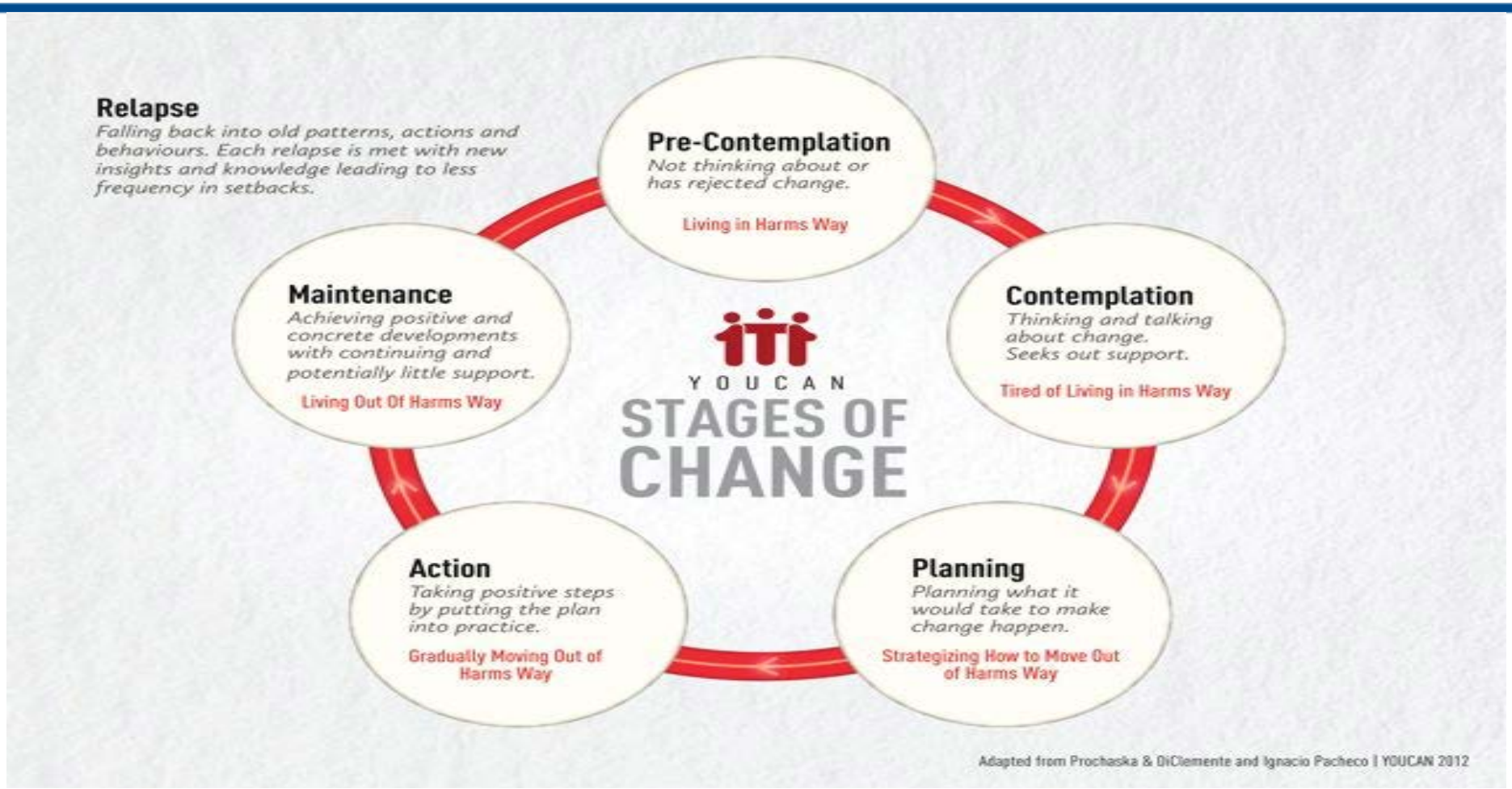
- **S**creening
  - (Patients identified by referring provider)
  - Ask permission to discuss substance use
  - Goal: Patient engagement to capture honest report of current and past substance use
- **B**rief **I**ntervention
  - Goal: Identify the Stage of Change
  - Goal: Reduce the risk of harm from continued substance use
- **R**eferral to **T**reatment
  - Goal: Determine which type of substance use treatment program, (if any) would be most effective and mutually agreeable

SBIRT

- Screening ⇨ Assessment
  - What Substance(s) used/using
    - Age of first use
    - How much, any history of overdose - intentional?
    - How often
    - AUDIT-C
    - ASSIST
  - Any periods of abstinence? Involuntary abstinence (jail)? Use in jail?
  - History of treatment for substance use disorder?
  - 12-step or other support group experience?

SBIRT

- **B**rief **I**ntervention
  - Believe that change is possible
  - Determine patients' Stage of Change
  - Patient-centered and collaborative
  - Motivate patient for change


Relapse
Falling back into old patterns, actions and behaviours. Each relapse is met with new insights and knowledge leading to less frequency in setbacks.
Pre-Contemplation
Not thinking about or has rejected change.
Living in Harms Way
Contemplation
Thinking and talking about change. Seeks out support.
Tired of Living in Harms Way
Planning
Planning what it would take to make change happen.
Strategizing How to Move Out of Harms Way
Action
Taking positive steps by putting the plan into practice.
Gradually Moving Out of Harms Way
Maintenance
Achieving positive and concrete developments with continuing and potentially little support.
Living Out Of Harms Way
YOUCAN
STAGES OF CHANGE
Adapted from Prochaska & DiClemente and Ignacio Pacheco | YOUCAN 2012

Motivational Interviewing (MI)

- Guided interview
- Geared to motivate the patient to think about change
  - Non confrontational
  - Non judgmental
  - Information gathering
  - Exchange of conversation

Motivational Interviewing

- Establish a rapport
  - **OARS** - MI Skills
    - **O**pen-ended questions
    - **A**ffirmations
    - **R**eflection
    - **S**ummarize

Motivational Interviewing

- **Watch the following videos - Which one is most effective**
  - https://www.youtube.com/watch?feature=player_detailpage&v=ZGETDcFcAbI
  - https://www.youtube.com/watch?v=uL8QyJF2wVw&feature=player_detailpage

Phase III: Post-Intervention

SBIRT

- **R**eferral to **T**reatment
  - What elements go into our thought process?

STAGE OF CHANGE

- Remember: the patient is responsible for choosing and carrying out actions for healthy behavior lifestyle change
- **Precontemplative NOT ready for any change, offer harm reduction**
- **For opioid use disorders - No matter what stage of change, always educate about opioid overdose prevention and provide Naloxone prescription**

Referral to Treatment

- **What elements go into our thinking process:**
  - What substance(s) the patient is using
    - Does the patient require further detox?
  - Treatment history (have they failed outpatient treatment in past?)
  - ASAM criteria
  - Insurance coverage, private, commercial OR Medicaid
  - Language ability/cultural competence
  - Living situation
    - Transportation and Location
      - How will the patient gain access to the treatment facility

Referral to Treatment

- **What elements go into our thinking process:**
  - Does the facility offer/support pharmacotherapy for maintenance of abstinence?
  - Does the patient need a facility capable of treating both substance use disorders and mental illness?
  - Does the patient have a picture ID
  - Legal History
  - PT consultation – Ambulation
  - OT consult - Self-care

Referral to Treatment

What elements go into our thinking process:

- What are the medical complications?
  - Wound care
  - IV antibiotics
  - PICC line
- Need to know referral resources in the community and surrounding community
  - Develop relationships, have inservices
  - Visit the programs

Referral to Treatment

- **Maryland Community Services Locator (MDCSL)** http://www.mdcsl.org/search.html

- **AA – on line-** http://www.aa-intergroup.org/

- **NA – on line -** http://www.12stepforums.net/na/

- **Smart Recovery-** http://smartrecovery.org/ **online meetings based on science and disease process**

Referral to Treatment

- Linkage for patient who is already in medication assisted treatment and requires increased level of care

- Linkage for patient who is motivated and ready for buprenorphine medication assisted treatment
  - Involve SUD Medical Director

Buprenorphine Prescribing

- Taper completion
- Short-term script: bridge interval between discharge & intake appt
  - Patient education
    - Risks
  - Clinician education
    - Starting or increasing buprenorphine
  - Communication with treatment provider

Case Studies

Case Study 1: Mr. B.

- 56 year old man
- HCV, CAD, previous admission for heart block
- Polysubstance use
  - Alcohol, cannabis, cocaine, heroin, tobacco
  - On methadone for last 2 weeks, up to 60mg
- Admitted with bradycardia and heart block
- Consult request: need to discontinue methadone secondary to heart block

Case Study 1: Mr. B.

- Methadone held: opioid withdrawal (w/d) and threatening to leave

- Trial of 30mg of methadone for w/d
  - W/d symptoms controlled
  - Recurrent bradycardia and heart block

Pre-Intervention

- What do you want to know?
  - Toxicology results
  - Name of program
    - Verify dose and when last received
  - What options has Cardiology given patient?
    - What does patient want to do?
  - On methadone with previous admission?
  - Is methadone associated with bradycardia and heart block?

Case Study 1: Mr. B.

Methadone
&
Permanent
Pacemaker

No Pacemaker
&
No Methadone

Decision = No Pacemaker

Case Study 1: Mr. B.

- Brief Intervention
  - Patient
    - Contact with methadone program
  - Family member
- Post Intervention
  - Intake appointment for buprenorphine
- Medication management
  - Discontinuation of methadone
  - Buprenorphine induction

Case Study 1: Mr. B.

- Buprenorphine bridge
  - 1-day prescription

- Prologue:
  - Reverted back to heart block
  - Permanent pacemaker placed
  - Discharged to buprenorphine program

Case Study 2: Mr. S.

- 28 year old man
- Endocarditis
- Polysubstance use
  - Alcohol, cannabis, cocaine, heroin, tobacco
- Transferred to Johns Hopkins from outside hospital
- Consult request: Aftercare recommendations and pain management in the patient with an opioid use disorder

Pre-Intervention

- What do you want to know?
  - Toxicology results
  - What happened at outside hospital?
  - What options has Cardiac Surgery given patient?
    - What does patient want to do?

Case Study 2: Mr. S.

Pain management

Full opioid agonists in hospital and SNF

Buprenorphine and discharge to SNF

Decision = find a SNF able to administer Suboxone

Intervention

- What is going to be your approach with this patient?

Case Study 2: Mr. S.

- Admitted to Skilled Nursing Facility for 4 weeks IV antibiotics
- Prologue:
  - Mr. S. called SUDS three times while at SNF to give health updates
  - SUDS kept him motivated for recovery
  - Discharged from skilled nursing to an Intensive IOP with supportive housing

Questions

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