Transitions of Care for Persons with Opioid Use Disorder: From Hospital to Practice

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Disclosures

- Dr. Dale – none
- Dr. Klein – none

Learning objectives

- Utilize best practices when caring for hospitalized persons with OUD
- Create a comprehensive discharge plan for hospitalized persons with opioid use disorder
- Describe key aspects of successful care transitions for persons with OUD
- Assess the challenges and opportunities within your own organizations to improve care transitions for persons with OUD

OUTLINE

- Acute Pain Service
- Addition Medicine Consult Service
- Transitional Pain Clinic
- After Care Clinic

- Small Group Discussion
- Report out & Wrap Up

CASE

- 27 yo man who is post-op day #1 from an incision and drainage of 7cm x 7cm sized abscess in the left lower extremity
- Admitted to rule out necrotizing soft tissue infection and for IV antibiotics.
- The floor nurse pages requesting additional pain medication as he is rating his pain a 10/10.
- He is currently receiving acetaminophen 1000 mg Q6h, hydromorphone 4 mg PO every 4 hours and IV hydromorphone 2mg q2h.

CASE

On evaluation of the patient, he appears visibly uncomfortable and the nurse confirms that the patient has been struggling with pain control all morning.

What information do you think is important in your assessment of the patient?

ACUTE PAIN SERVICE

- >7,000: # of patients treated by HMC's acute pain service annually
- > 70 %: # with a SUD, mostly involving opioids (OUD)
- No pathway or plan to manage patients with acute pain and OUD
- No guidance in the literature

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HMC SOLUTION

Principles of Care: Pain and Co-morbid OUDs

1. Improve patient safety and healthcare outcomes by treating underlying problem - OUD.
2. Optimize pain treatment by providing multimodal relief
3. **Facilitate access to medication treatment programs upon hospital discharge.**
4. Empower patients and providers by promoting clear, just, and equitable behavioral consequences of active use while hospitalized.
5. Support the individual's plan of needed surgical and medical treatment.
6. **Protect the community by promoting safe discharge opioid prescriptions in high risk patients.**

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HMC SOLUTION

Pathway Assessment

1. Methadone – Safe and effective!
   - High rate of out-patient MAT engagement
   - Successful patients = happy providers
   - Custodians of our communities
2. Buprenorphine – Current QI study underway

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CASE

WQ is irritable, but is alert and answers questions appropriately. He reports injecting $60 worth of heroin daily to help with his back pain. He states he has severe body aches all over, with the worst pain around the wound. You discuss his reported allergy to NSAIDS and determine it is more of an intolerance.

Aside from opioids, what medications or other treatment modalities may be useful to help treat this patient's symptoms?

Multimodal Pharm. Adjuvants

Alpha 2 agonists (clonidine, dexmedetomidine)	*NMDA antagonists (ketamine infusion)*
Local/topical anesthetics (peripheral nerve catheter infusion, IV lidocaine, topical lidocaine, etc.)	*Antidepressants (Duloxetine, venlafaxine, nortriptyline)*
NSAIDS (toradol, ibuprofen, naproxen, etc.)	*Muscle Relaxants (tizanidine, methocarbamol, cyclobenzaprine, baclofen)*
Acetaminophen	*Cannabinoids*
Gabapentinoids (gabapentin, pregabalin)	*Anxiolytics (hydroxyzine, gabapentin)*

MULTIMODAL PAIN CONTROL

Aside from a peripheral nerve catheter other pharmacologic approaches could include:

- Continuation of scheduled acetaminophen. However, dose should be reduced to maximum of 2000mg/day due to patient's history of Hepatitis C
- Addition of scheduled gabapentin (starting dose 300-600mg TID) to help with anxiety/pain/irritability
- Addition of prn or scheduled hydroxyzine (25-50mg q6-q8hr) for anxiety/agitation
- Addition of low-dose ketamine infusion (8-15mg/hr) for pain
- Addition of NSAIDS (ketorolac, naproxen, ibuprofen, etc) for pain
- Addition of clonidine for symptoms of withdrawal
- Addition of ondansetron for nausea/vomiting

MULTIMODAL PAIN CONTROL

Non-Pharmacologic therapies

Group support activities	**Physical therapy**
Rehab psychology	**Acupuncture**
Spiritual Care	**Distraction techniques (music, virtual reality, hospital volunteers)**
Meditation	**TENs Unit**
Sleep hygiene	

CASE

How is opioid use disorder diagnosed?

OPIOID USE DISORDER DIAGNOSIS

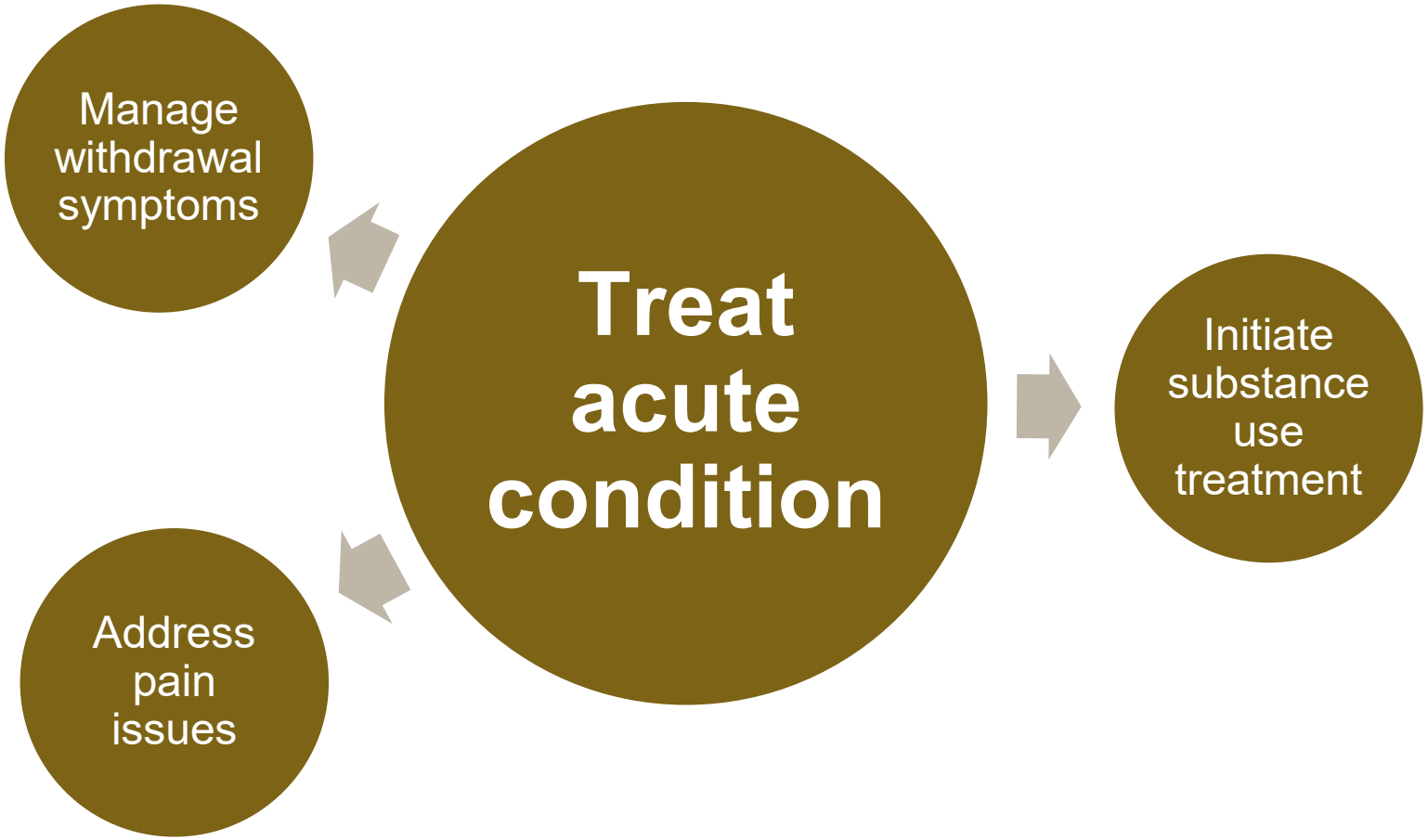
- Larger amounts than intended
- Persistent desire to cut down or quit
- Significant time spent taking, obtaining
- Craving or urge to use
- Failure to fulfill obligations
- Continued use despite negative interpersonal consequences
- Reduced social, recreational activities
- Use in physically hazardous situations
- Use despite knowledge of harms
- Tolerance
- Withdrawal

SEVERITY

No SUD: 0-1
Mild: 2-3
Moderate: 4-5
Severe: >5

Cravings
Negative consequences
Loss of control

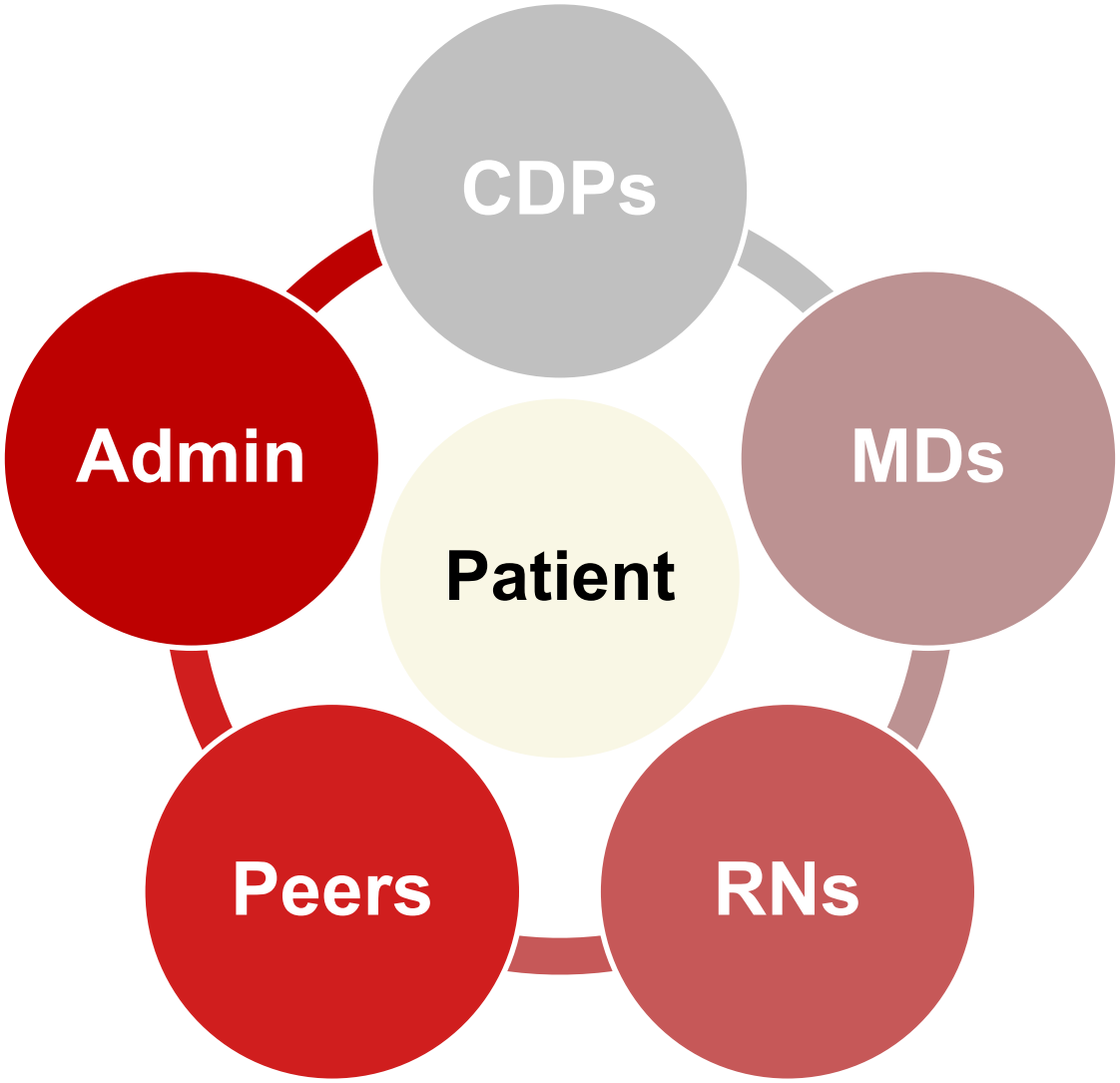
CARING FOR PATIENTS WITH OUD: GOALS



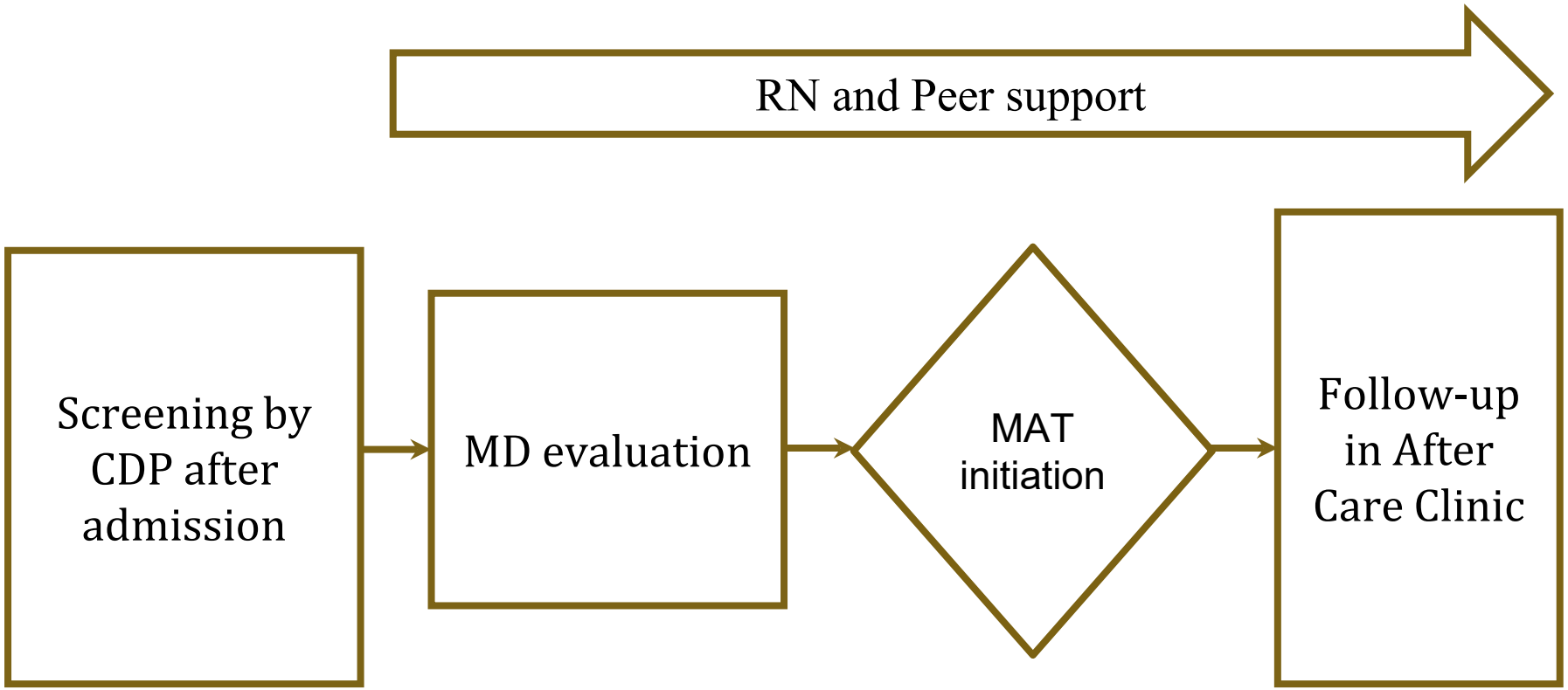
OUD IS A CHRONIC CONDITION

- Withholding opioids during hospitalization will not cure addiction
  - Giving opioids during hospitalization will not worsen addiction
- Anticipate tolerance
- Support safety

ADDICTION MEDICINE CONSULT SERVICE



ADDICTION MEDICINE CONSULT SERVICE



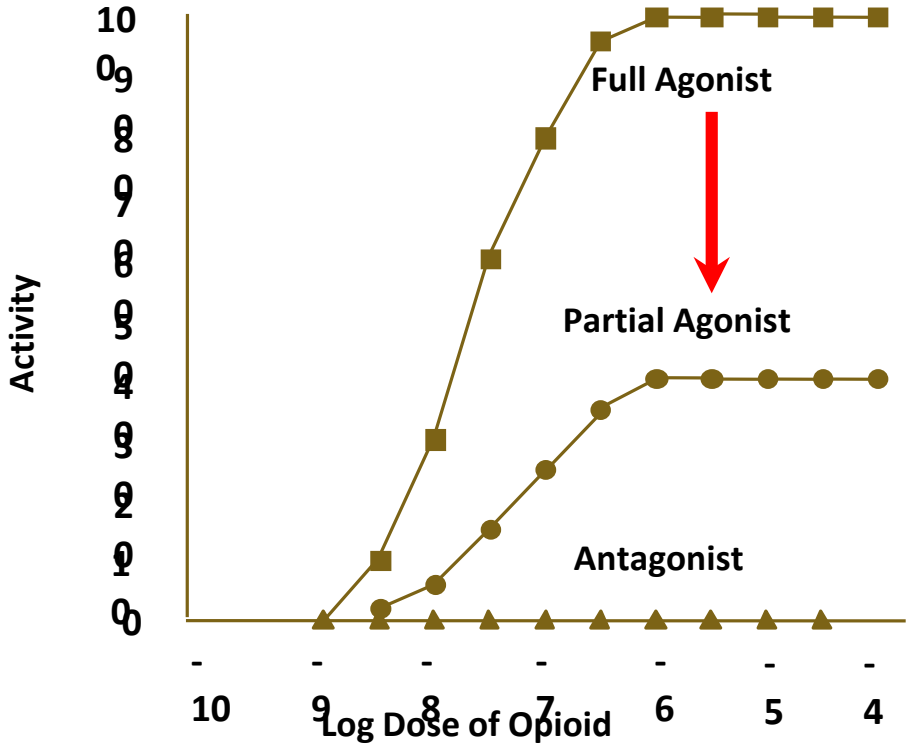
CASE

The patient endorses cravings to use, significant negative consequences of his use and withdrawal symptoms when he doesn't use.

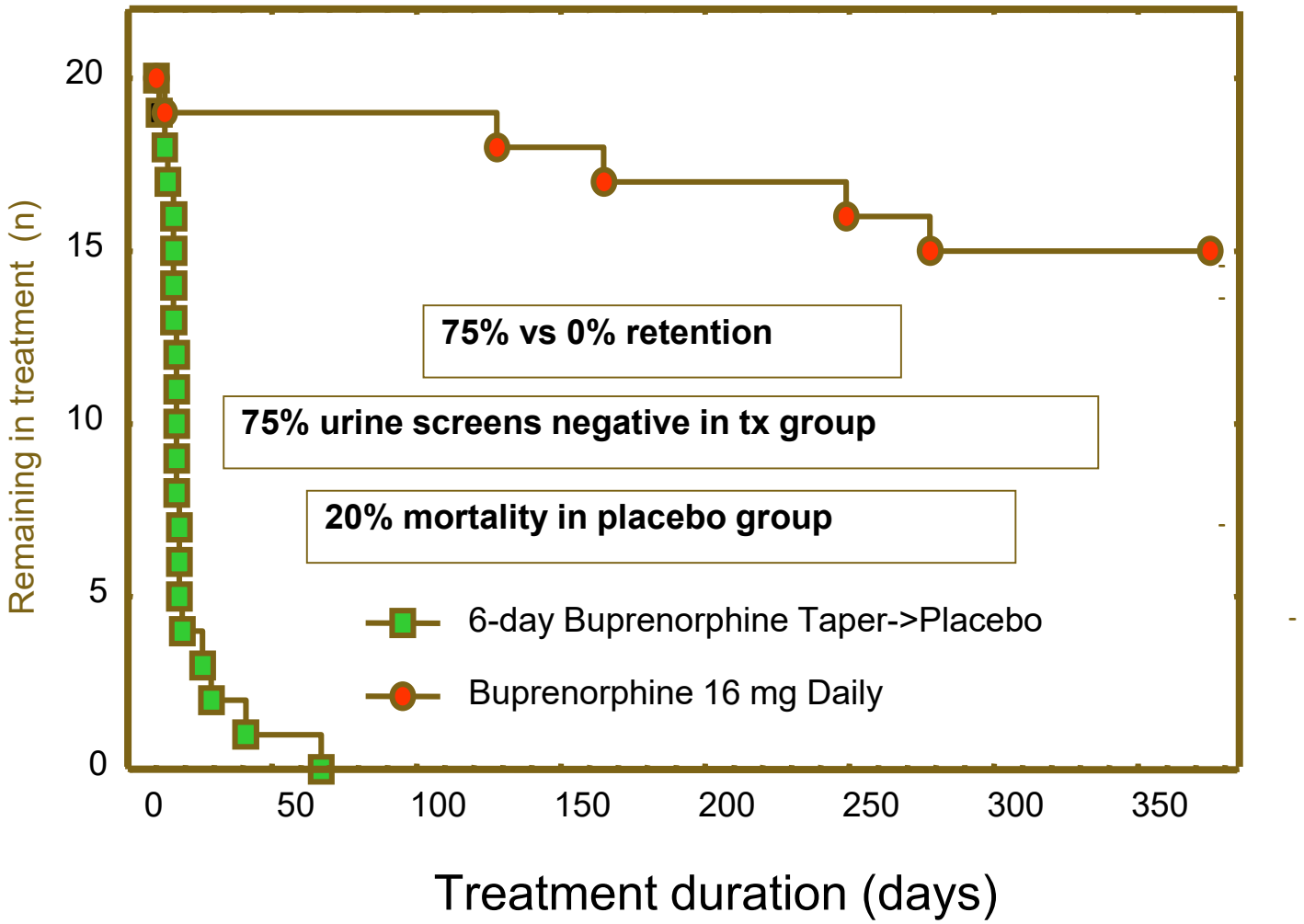
- You diagnose **severe OUD**.

BUPRENORPHINE

- Partial opioid agonist
- Naloxone co-formulation
- Dosing



BUPRENORPHINE

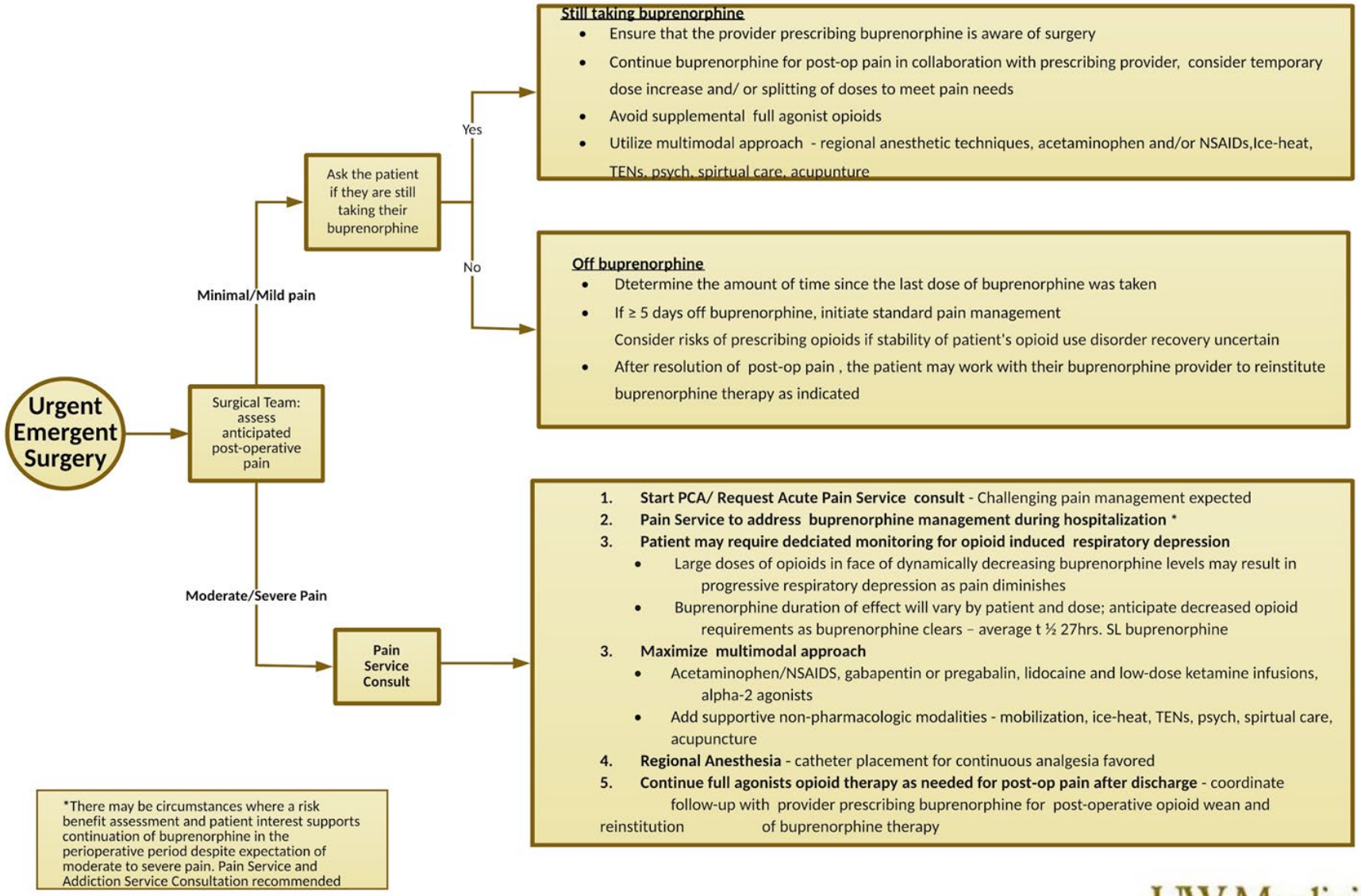


Kakko J et.al. Lancet 2003

BUPRENORPHINE & ACUTE PAIN

- Significant uncertainty
- Options:
  1) Stop buprenorphine, start full mu-agonists
  2) Increase buprenorphine & split the dose
  3) Continue buprenorphine, add full mu-agonists
- Negotiate a plan with the patient

PERI-OP BUPRNEORPHINE MANAGEMENT



*Anderson, T. A., et.al. (2017). To Stop or Not, That Is the Question: Acute Pain Management for the Patient on Chronic Buprenorphine. Anesthesiology, 126(6), 1180–1186

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CASE

He has been in methadone treatment in the past (100mg daily) with good success, however stopped going due to transportation issues. He continues to have withdrawal symtoms:

- Would you start methadone now?
- How much methadone do you order the patient?
- Should methadone be ordered daily or in divided doses?
  - Why? why not?

CASE

Assume you have started WQ on liquid methadone 30 mg daily

Do you continue the hydromorphone 4 mg PO every 4 hours and IV hydromorphone 2mg q2h as ordered?

CASE

You decide to order a morphine PCA at 1 mg every 8 minutes as needed, in addition to acetaminophen, ibuprofen, gabapentin, and a peripheral nerve catheter. You follow up on POD#2 and he is visibly more comfortable and reporting better pain control. However, the patient requests an increase of methadone as he recalls being on much higher doses in the past.

What do you do?

CASE

The surgery team is planning to discharge patient now on POD#3.

In preparation for discharge, how would you proceed?

CASE

- On POD3 the patient is ready for discharge. He believes methadone has been helpful.
- The discharge planner coordinated an intake appointment at the local methadone clinic two days after discharge.
- The surgical service is asking what pain medications they should provide him with at discharge.

CASE

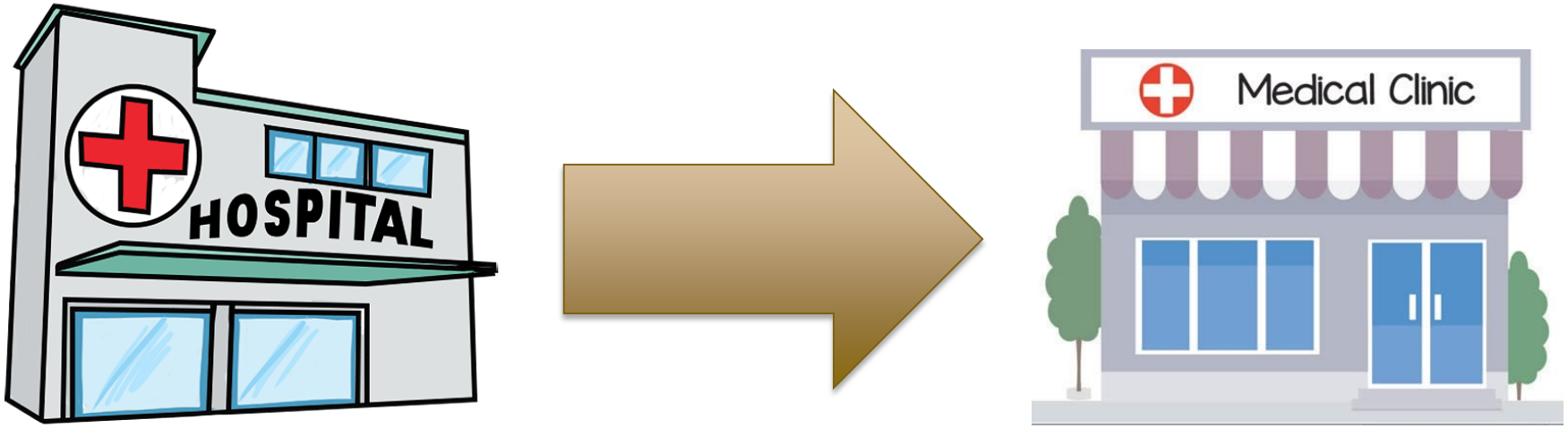
If the patient was not interested in engaging in outpatient methadone treatment, what would your discharge opioid plan be?

Should we still have started methadone while hospitalized?

TRANSITIONAL PAIN CLINIC

- Provides coordinated and structured post-operative pain care
  - Run by our PA and PharmD
  - Addiction support and structured taper
  - Since initiation of this pathway, patient load has dramatically decreased

TRANSITIONAL PRIMARY CARE



TRANSITIONAL PRIMARY CARE

No PCP:

- Homelessness
- Substance use
- Limited English Proficiency
- Recent immigration
- Marginalized

TRANSITIONAL PRIMARY CARE

AFTER CARE CLINIC

- “The safety net for the safety net”
- Founded 2008
- Goal: support medically unaffiliated patients transitioning from ED/inpatient to primary care
- Provides transitional primary care and integrated buprenorphine treatment

AFTER CARE CLINIC

- 5/1/18-4/30/19
  - Unique visits: 2,191
  - Open M-F, 8-5
  - High no show rate

Top Primary Diagnoses	
1	Hypertension
2	Diabetes mellitus
3	Opioid use disorder
4	Dyspepsia

Top Languages Spoken*	% of all Patients
Spanish	17%
Amharic	7.4%
Tigrinia	1.4%
Vietnamese	1.3%

*Overall, 38.9% non-English speaking patients

- Staffed by:
  - RN x3
  - MA x2
  - 1.5 provider FTE
- Integrated OBOT

SMALL GROUP DISCUSSION

- Break into groups of 4-5
- Take about 20 minutes
- Discuss challenges and opportunities to support care transitions for persons with OUD in your organization

WRAP UP

- What was a challenge you identified?
- What was an opportunity that arose?

CARE COORDINATION IS KEY

1. Start discharge planning as soon as the patient is admitted
2. Get to know your local resources
   - Your local MAT clinic medical director
   - UW Pain and Opioid Consult Hotline for Clinicians 1-844-520-PAIN (7246) see handout
   - UW TelePain: Grant funded service for community-practice providers about chronic pain management (see handout)

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