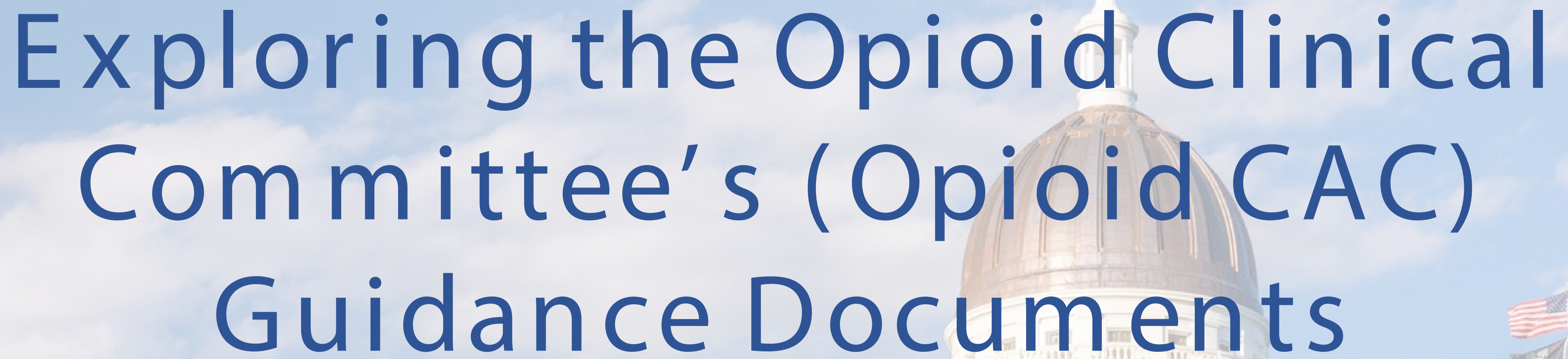
Exploring the Opioid Clinical Committee's (Opioid CAC) Guidance Documents



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On behalf of Maine's Opioid Response Clinical Advisory Committee

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Overview

- What is the Opioid CAC?
- Preview of Upcoming CAC Guidance on Withdrawal Management
- Review of Promoting MOUD in Hospital Settings Guidance Document
- Provider Perspective on Hospital Care for OUD/SUDs

Maine Opioid Response Clinical Advisory Committee

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Upcoming Guidance

Supervised Withdrawal Management in Maine

DRAFT

- **Background:** Need for timely, evidence-based, systemic access to withdrawal management in the subacute and outpatient settings, with focus on opioid use disorder and alcohol use disorder
- **Systems-level Recommendations:**
- Expand systematic access to withdrawal management services by developing ambulatory and sub-acute WM services that meet ASAM Level of Care
- Improve access to WM through same-day and multi-modal access
- Additional recommendations regarding monitoring supply and demand, workforce support, developing quality measures and reimbursement
- **Clinical Guidance:**
- Ambulatory and inpatient alcohol WM, patient education tools, treatment algorithms
- Collaborative decision-making tools for buprenorphine initiation, use of adjuncts, 5 initiation models

Promoting MOUD in Hospital Settings

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, Pt self-directed discharge the day after admission.
- Inpatient Admit (October 2022): Pt admitted with "pain and swelling of right lower arm due to iv drug use for weeks." Completed debridement, 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 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 and unable to leave the floor

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

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

Why Focus on Hospitals?

High risk cohort for 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)

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

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"

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

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

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

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.)

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

The View from the Hospital

- Reflections from a Family Physician/Inpatient SUD Consult Service Attending

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Questions for Table Top Discussion

1. What is working well in my community with regard to ED/Hospital access to MOUD?
2. What are areas where we would really like to see improvement, and what is a reasonable place to start?
3. What support would we need to make these changes (at health system level, at community level, at state level)?
4. What are some great things happening in my community with regard to withdrawal management? What would be a real game-changer for us?