Oh the Places You'll Go: Coordinating Transitions of Care for Addiction and Pain

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The Pain and Addiction Common Threads Course, April 2023

Disclosure Information

Oh the place you'll go

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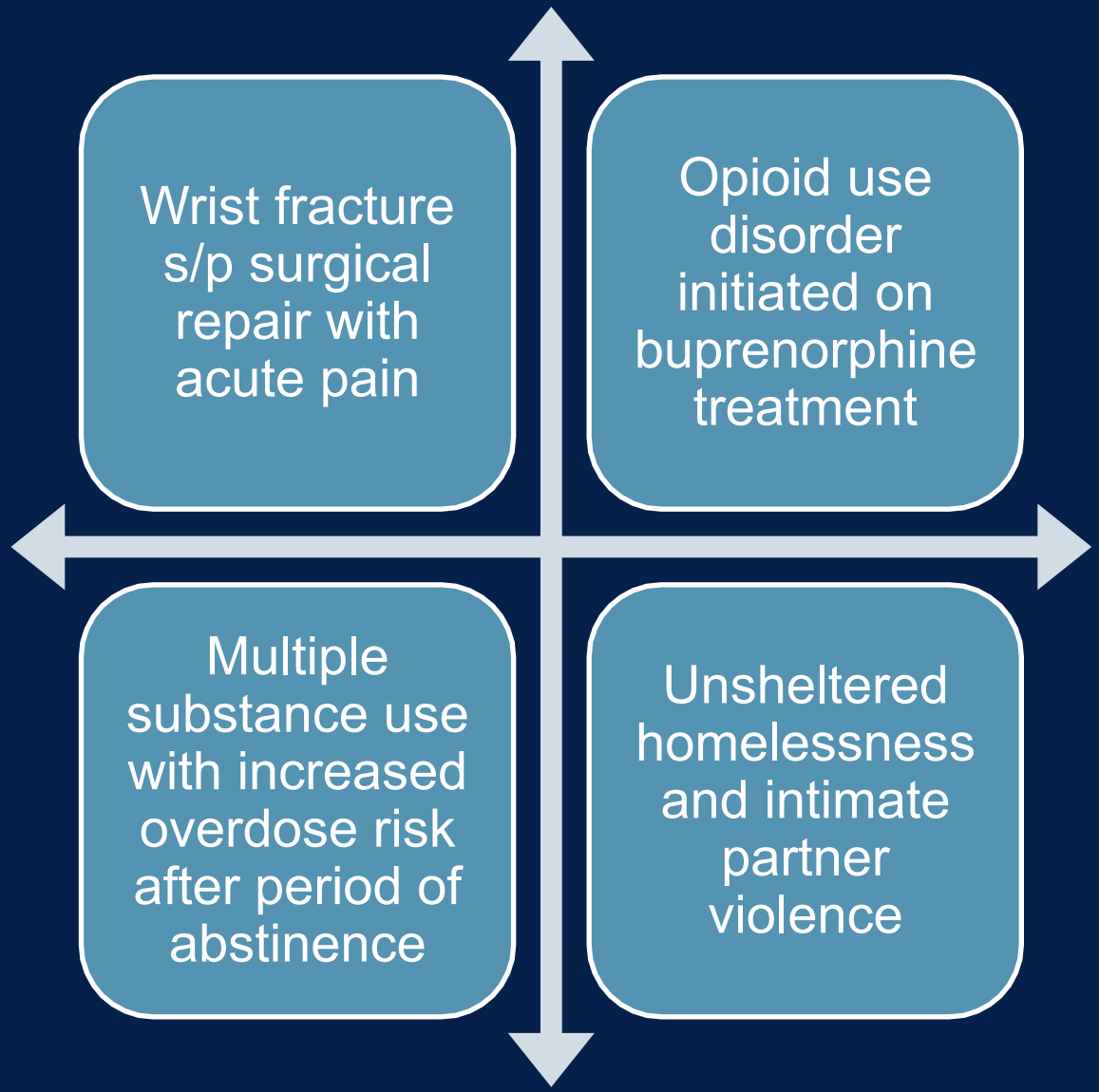
- No disclosures

Learning Objectives

- Identify common barriers that impact transitions of care from hospital to community for patients with OUD and pain
- Examine evidence-based strategies to optimize linkage to post-discharge care for patients with OUD and pain
- Discuss a low-threshold approach when engaging patients with OUD and pain in post-discharge care

Transitions of Care: Where to Start?



Transitions of care can be a vulnerable period for patients with OUD and pain

- Linkage to post-hospitalization OUD treatment among out-of-treatment persons are widely variable (as low as 17%)[1]

Patient Barriers	Clinician Barriers	System Barriers
-Severe medical and psychiatric conditions -Unstable housing -Lack of transportation -Poor social supports	-Discomfort with opioid rx for pain and OUD -Lack of experience with buprenorphine -Unfamiliarity with community-based treatment options	-Lack of protocols for coordinating post-discharge OUD care -Access to buprenorphine vary by pharmacy -Insurance gaps or restrictions

Unplanned discharges as a common barrier

- Patients with SUDs nearly 3x more likely to have unplanned discharges ("against medical advice") than those without SUD
  - 2-12x higher risk of hospital readmission within 30 days
- Unplanned discharges often due to patients' experiences of inadequately treated pain, withdrawal, and stigma

"Anytime that they hear you're a drug addict, they immediately shut down, they don't want to work with you and pain management. They think you're only there to f--- have the painkillers."

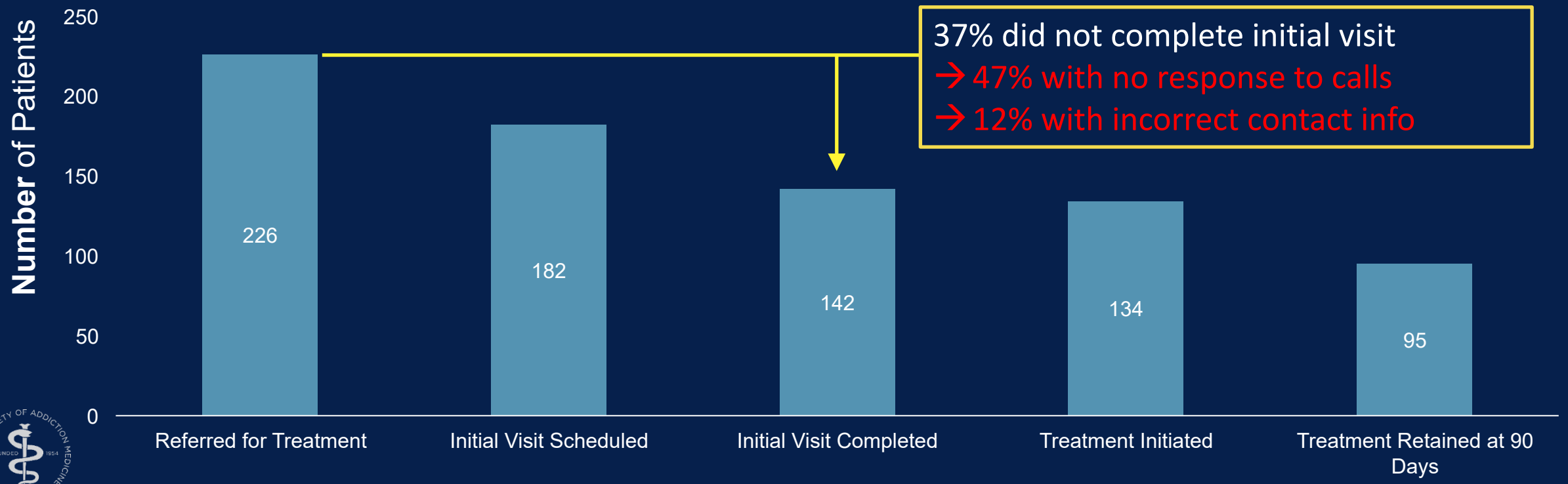
"I left, because I didn't want to sit there and continue suffering…I ended up going to use because I was in so much pain. And doctors don't do nothing for the pain."

Simon et al. Substance Abuse 2020

Attrition between referral and linkage to outpatient treatment

Among 226 pts referred for BUP treatment in Bronx community clinics 2018-19:

- 25% patients were referred from hospital settings
- Referring clinician called/emailed to schedule appts and gave warm handoff



Khalid et al. JSAT 2022.

Optimizing transitions in care from hospital to community for patients with OUD

- Evidence-based interventions:[1]
  - ✓ In-hospital initiation of opioid agonist medications for OUD[2]
  - ✓ Linkage to outpatient treatment via addiction consult services[3-4]
  - ✓ Discharge coordination via patient navigation services or peer recovery coaching[5,6]
  - ✓ Same- or next-day post-discharge appointment[7]

[1]James et al. Drug Alc Dep 2023; [2]Liebschutz et al. JAMA 2014; [3]Wakeman et al. JGIM 2017; [4]Englander et al. JGIM 2019; [5]Nordeck et al. Drug Alc Dep Rep 2022; [6]Byrne et al. Drug Alc Dep 2020; [7]Roy et al. Drug Alc Depend 2021

Initiating OUD treatment during trauma-related hospitalizations may help with linkage to care

Among 197 pts initiated on BUP at Level 1 Trauma Center 2018-19:

- 31% hospitalized for trauma-related injuries
- 63% trauma pts linked to post-discharge care vs 48% non-trauma pts (no significant difference)

Characteristic	OR (95% CI)	p-value	aOR (95% CI)[a]	p-value
Trauma status	1.84 (0.86 - 3.93)	0.100	1.95 (0.75 – 5.11)	0.172
Age	1.04 (1.01 – 1.07)	0.005	1.05 (1.01 - 1.08)	0.008
History of buprenorphine treatment	1.97 (0.99 - 3.92)	0.054	2.89 (1.15 – 6.43)	0.009
History of injection drug use	0.40 (0.16 – 0.99)	0.046	0.26 (0.08 - 0.83)	0.022

→ Trauma hospitalizations = reachable moment to (re-)initiate BUP

Bhatraju et al. Drug Alc Dep 2020 (Table 2: OR of 30-Day Follow-Up Adjusted for Sex, Race/Ethnicity, and Housing Status)

Addiction consult services help with linkage to outpatient treatment

- Interprofessional, hospital-based addiction consult services implemented at academic hospitals associated with:
  - 2x higher odds of post-discharge treatment engagement[1]
  - 60% lower risk for hospital re-admission within 90 days[2]

Initiate medication treatment for SUDs

Formalize referral pathways to post-hospital SUD care

Offer appt at low-threshold post-discharge bridge clinic

[1]Englander et al. JGIM 2019; [2]Wakeman et al. JGIM 2017;

Same- or next-day post-discharge appointments associated with improved linkage

Among 142 pts initiated or recommended for BUP on discharge 2015-17:

- Addiction consult service linked pts to appts at low barrier addiction clinic

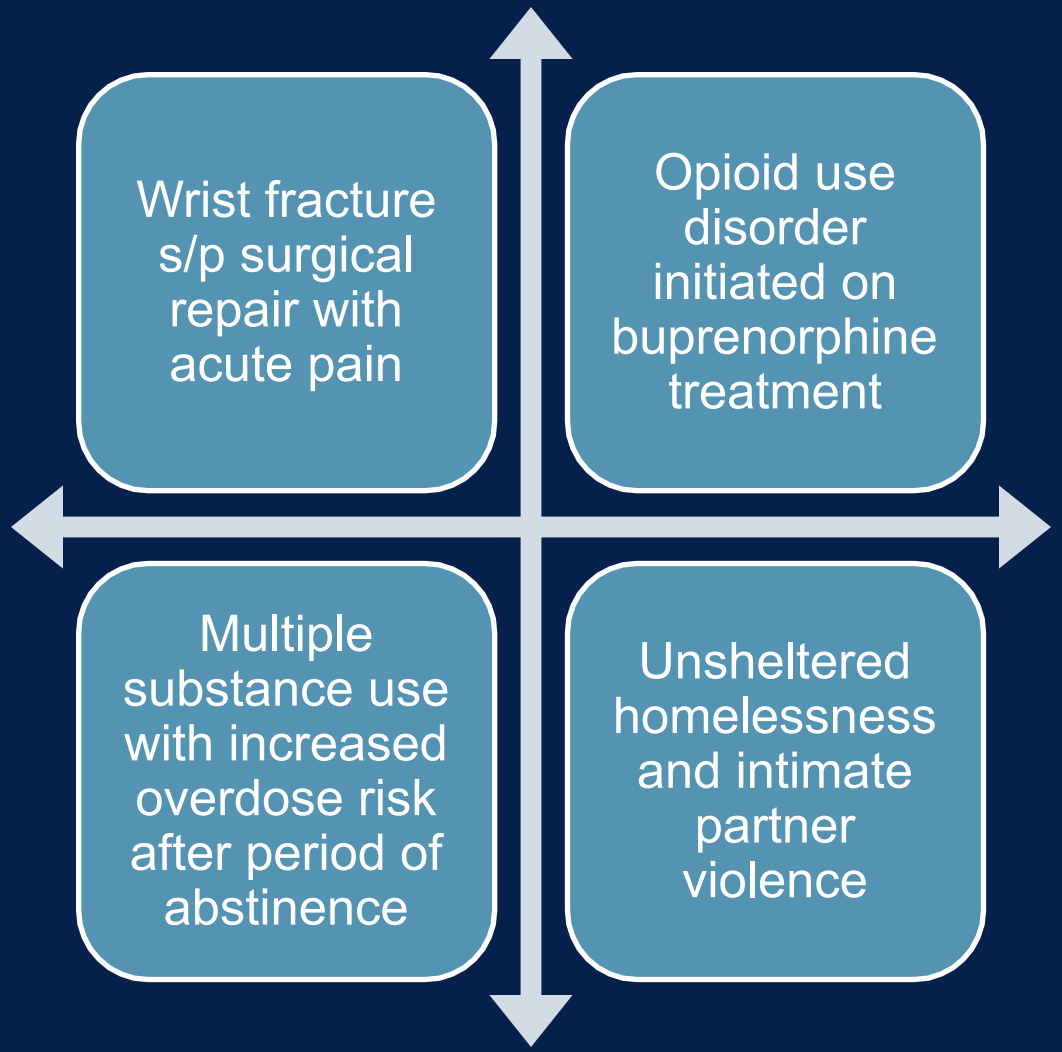
Sample Demographics to a Low Barrier Access Addiction Clinic By Wait-Time.

1a. Sample Demographics	0–1 day N=56	2+ days N = 86	p-values
Arrived % (n)	63 % (35)	42 % (36)	0.02
Male % (n)	73 % (41)	76 % (65)	0.91
Age mean (SD) min, max	43 (11.8) 20, 64	46 (11.0) 22, 67	0.09
Distance from the hospital, in miles mean (SD)	6.0 (9.9)	5.7 (10.9)	0.66
Insurance % (n)			
Medicaid	68 % (38)	67 % (58)	0.13
Medicare	13 % (7)	4% (12)	
Commercial	11 % (6)	13 % (11)	
Other (free care) /Unspecified	9% (5)	6% (5)	
Alcohol use disorder % (n)	13 % (7)	8% (7)	0.39
Discharged with buprenorphine prescription % (n)	75 % (42)	79 % (68)	0.23

Roy et al. Drug Alc Depend 2021

Transitions of Care: Taking Inventory of Discharge Needs

Pain control and post-op follow-up



OUD treatment continuation

Harm reduction education & tools

Housing, social supports and case management

Involve different stakeholders in the hospital system – start with practical strategies and refine into protocols and workflows!

Practical strategies to optimize transitions of care: Facilitate linkage to care

- ✓ Identify post-discharge providers and referral pathways
- ✓ Support primary team to obtain post-discharge appointments with short wait times

-Please include the following information in discharge paperwork for addiction medicine follow-up in the outpatient setting:
{ACSDISCHARGEREFERRAL:35729}

Montefiore Comprehensive Family Care Center (CFCC) Bridge Clinic for addiction medicine treatment: 1621 Eastchester Road, Bronx, NY 10461. (718)-405-8227. Appt: ***
Montefiore Comprehensive Health Care Center- Addiction Medicine Fellow Clinic for primary care and substance use treatment: 305 E 161 St, Bronx, NY 10451. (718) 579-2500. Appt
Montefiore Next Steps North for outpatient substance use treatment program providing counseling and medication treatment: 1510 Waters Place, Bronx, NY 10461. (718) 597-3888. Ap
Montefiore Next Steps South for outpatient substance use treatment program providing counseling and medication treatment: 260 East 161st Street, Bronx, NY 10451. (718) 993-3397.
Montefiore New Directions Recovery Center for outpatient substance use treatment program providing counseling and medication treatment: 2058 Jerome Avenue, Bronx, NY 10453. (9
Montefiore Wakefield Recovery Center for outpatient substance use treatment program providing counseling and medication treatment: 4401 Bronx Blvd, Bronx, NY 10470. (718) 304-7
Montefiore Project Rising Program for outpatient substance use treatment providing counseling and medication treatment for adolescents: 1510 Waters Place, Bronx, NY 10461. (718)
Jacobi Comprehensive Addiction Treatment Center for outpatient substance use treatment program providing counseling and medication treatment: 9th Floor, 9West, Behavioral Health
Lincoln Recovery Center for outpatient substance use treatment program providing counseling and medication treatment: 545 East 142 Street, Lower Level, Bronx, NY 10454 (Between
Montefiore Waters Place Wellness Center for opioid treatment program (methadone clinic): 1510 Waters Place, Bronx, NY 10461. (718) 829-3440. Appt: *** (Walk in: Mon-Th, arrive be
Montefiore Melrose Wellness Center for opioid treatment program (methadone clinic): 260 East 161st Street, Bronx, NY 10451. (718) 993-3397. Appt: ***
Montefiore Port Morris Wellness Center for opioid treatment program (methadone clinic): 804 East 138th Street, Bronx, NY 10454. (718) 665-7500. Appt: ***
Montefiore SATP Unit 1: for opioid treatment program (methadone clinic): 3550 Jerome Avenue, Bronx, NY 10467. (718) 920-4067. Appt: ***
Montefiore SATP Unit 3: for opioid treatment program (methadone clinic): 2058 Jerome Avenue, Bronx, NY 10453. (917) 564-8700. Appt: ***
Montefiore Power Over Pain (POP) Clinic: 3444 Kossuth Ave, Bronx, NY 10467. (718) 920-2273. Appt: ***
NYC-DOH Primary Care Based Buprenorphine Nurse Care Manager Programs: https://www1.nyc.gov/site/doh/health/health-topics/opioid-treatment-medication.page Appt: ***
Montefiore Behavioral Health Clinic for addiction psychiatry care and medication treatment: 2527 Glebe Ave, Bronx, NY 10461. (718) 904-4400. Appt: ***
New York Harm Reduction Educators (NYHRE) for low threshold harm reduction care. 104 -106 E 126th St #1A, New York, NY 10035. (929) 314-1147. Walk in M-F 10-2 for all services
Smoking Cessation: If you are interested in help quitting smoking, you can contact the NY State Smokers' Quitline at 1-866-NY-QUITS (1-866-697-8487) or find resources at becomean
Montefiore Buprenorphine Treatment Network: Call us at 718-405-8227 to get answers to your questions and email bupe@montefiore.org to schedule a confidential intake visit.

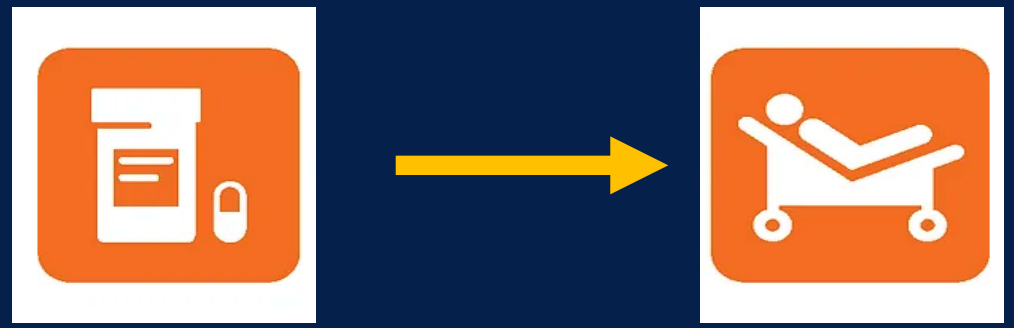
Practical strategies to optimize transitions of care: Facilitate linkage to care

- ✓ Ensure closed loop communication with patients about post-discharge plans
- ✓ Confirm patients' contact information for outreach as needed

Example: Follow-up appt patient flyer

Practical strategies to optimize transitions of care: Facilitate opioid agonist prescribing

- ✓ Optimize buprenorphine dose for OUD/pain
- ✓ Support primary team to prescribe bridge buprenorphine
  - Consider prescription duration of at least 7-14 days
- ✓ Identify pharmacy partners for same-day med dispensing
  - Utilize hospital's meds to beds program if available



Practical strategies to optimize transitions of care: Provide harm reduction education and tools

Image from NC Harm Reduction Coalition

WHY?

- Pain and reduced tolerance during hospitalization = vulnerable time!
- "Meeting people where they are"

BARRIERS?

- Hospital clinicians not typically trained to deliver harm reduction education
- Harm reduction equipment distribution not routinely integrated in hospitals

Practical strategies to optimize transitions of care: Integrating naloxone distribution in hospitals

- Partner with local health department to dispense free naloxone take home kits, if available
- Prescribe naloxone to hospital pharmacy for dispensing at bedside
- Train hospital nurses and pharmacists to provide opioid overdose prevention education

Jakubowski et al. Substance Abuse. 2018

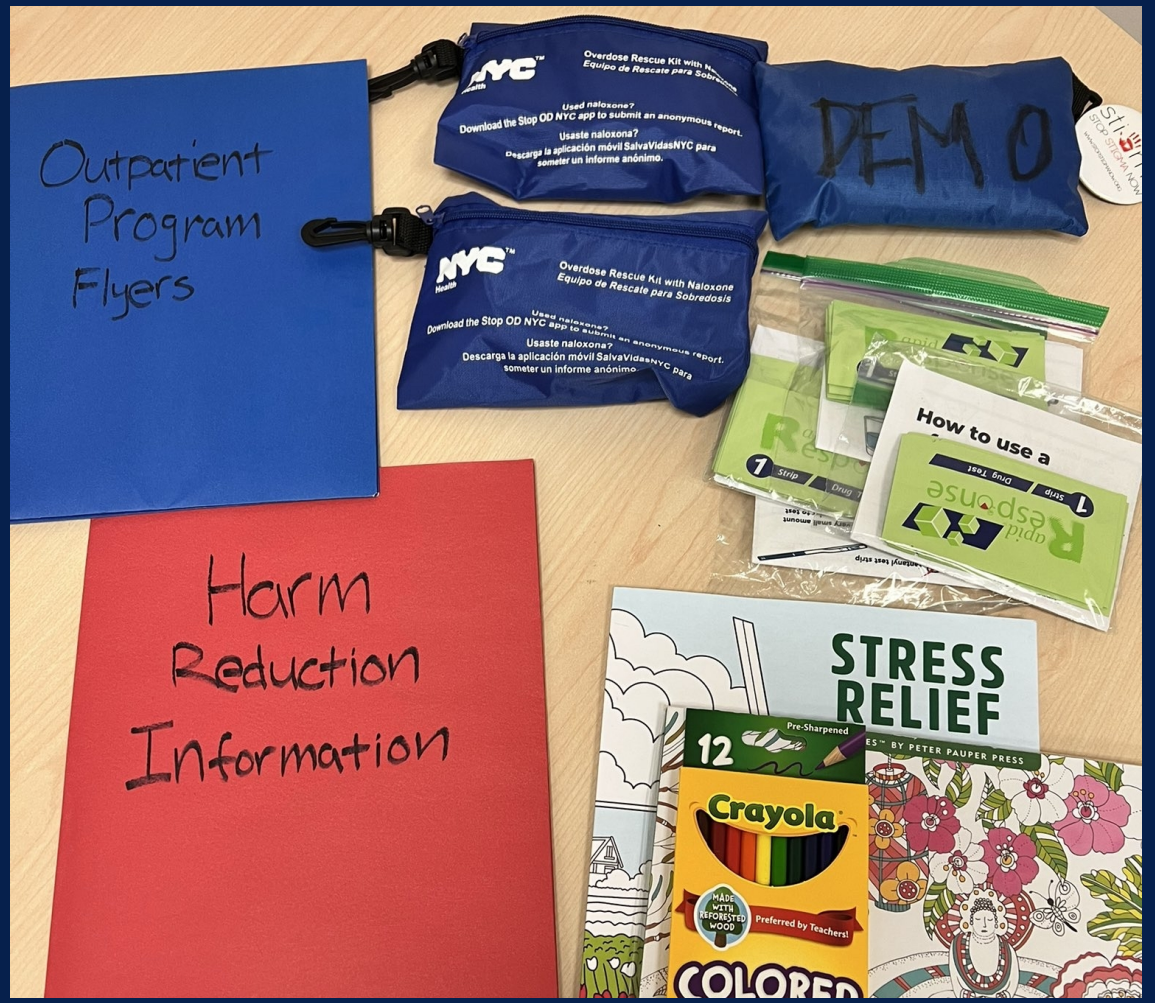
Providing harm reduction education and tools via inpatient Addiction Consult Service

Harm Reduction "Kits":

- ✓ Overdose prevention education
- ✓ Naloxone access
- ✓ Fentanyl test strips and education
- ✓ Never use alone flyer and education
- ✓ Local resources
- ✓ Additional information on safer use of specific substances and routes of use

Perera et al. Harm Reduction Journal 2022

Providing harm reduction education and tools via inpatient Addiction Consult Service



Transitions of Care:
Engaging Patients in the Post-Discharge Visit

- You are now seeing the patient in clinic for post-discharge visit….
- TAKE A MINUTE TO AFFIRM THIS STEP WITH THE PATIENT!

- How do you begin to address OUD, pain, and other needs?

The Need for a Low-Threshold Approach

- Low-threshold buprenorphine treatment defined by:
  - ✓ **Same-day treatment access**
    - ✓ Does not require additional visits before buprenorphine prescribing
    - ✓ Unobserved initiation available
  - ✓ **Harm reduction approach**
    - ✓ Reduction in illicit opioid use is acceptable goal
    - ✓ Use of other substances does not result in treatment cessation
  - ✓ **Flexibility in treatment structure**
    - ✓ Visit frequency reduced based on clinical stability
    - ✓ Intensive counseling offered but not required

Jakubowski and Fox. *J Addict Med*. 2019

Applying a low-threshold approach to transitions of care

Goal	"Bridge Clinic" - Facilitate rapid access to and engagement in care for patients with OUD and co-occurring conditions
Evaluate	OUD treatment goals and stabilization Other substance use patterns and risks Acute medical and mental health concerns Acute psychosocial needs
Offer	Medications for OUD and co-occurring conditions Harm reduction education and tools Referral to counseling, case management, and community services Follow-up until transition to long-term treatment providers

Developing visit templates for post-discharge care

Patient's goals for today's visit: ***

Summary of recent hospitalization course, addiction medicine consults,

Opioid use history:
-When did use start?
-Types of opioid used?
-Route of use?
-Amount used in the last 30 days?
-Days used in the last 30 days?
-Date of last use?
-History of overdose?

Other substance use history:
-Cocaine/crack, methamphetamines:
-Non-rx benzos:
-Alcohol:
-Tobacco:
-Other:

Opioid/substance use treatment history:
-Buprenorphine, methadone or naltrexone?
-Substance use treatment programs?
-Self-help/12-step groups (NA, AA, etc)?
-Longest period of time abstinent?
-What helped the most?

Medical history:
-Active medical concerns:
-HIV/HCV status:
-Current medical care providers:

Mental health history:
-Active mental health concerns:
-Suicidal ideation/attempts:
-Psychiatric hospitalizations:
-Current mental health care providers:

Social History:
-Social supports:
-Housing issues:
-Insurance issues:
-Legal issues:

Low-threshold post-discharge care improves patient experiences

- Among N=29 pts interviewed at a large 'Bridge Clinic', positive experiences reported with: (1) accessible/flexible services, (2) harm reduction emphasis, and (3) patient-provider relationships

"I found out about the clinic six months ago. I overdosed and after that, I was referred to the clinic…I came the very next day…."

"I walk out of here and I feel good about myself…instead of getting chastised for relapsing and feeling bad about it, we actually talked about it…"

"I get a feeling of safety with [my provider] that she's not going to…withhold treatment or make you go somewhere else or force you to do something that you know that you're not going to do and end up not coming back."

Snow et al. JSAT 2019

Final Takeaways

- Transitions of care between hospital and community is a vulnerable time for patients with OUD and pain
- Initiating opioid agonist treatment and facilitating post-discharge care with short wait times are key interventions
- Low-threshold approach to transitions of care, including providing harm reduction education and tools, is essential
- Interprofessional addiction consult services and post-discharge bridge clinics may not be available – start somewhere!!

Questions/Comments

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References Part 1

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