Substance Use Disorders in People Living with HIV

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I have no disclosures.

Learning Objectives

Participants will be able to:

- Discuss the scope of the current opioid crisis
- Define addiction and substance use disorder (SUD)
- List infectious diseases complications of injection drug use
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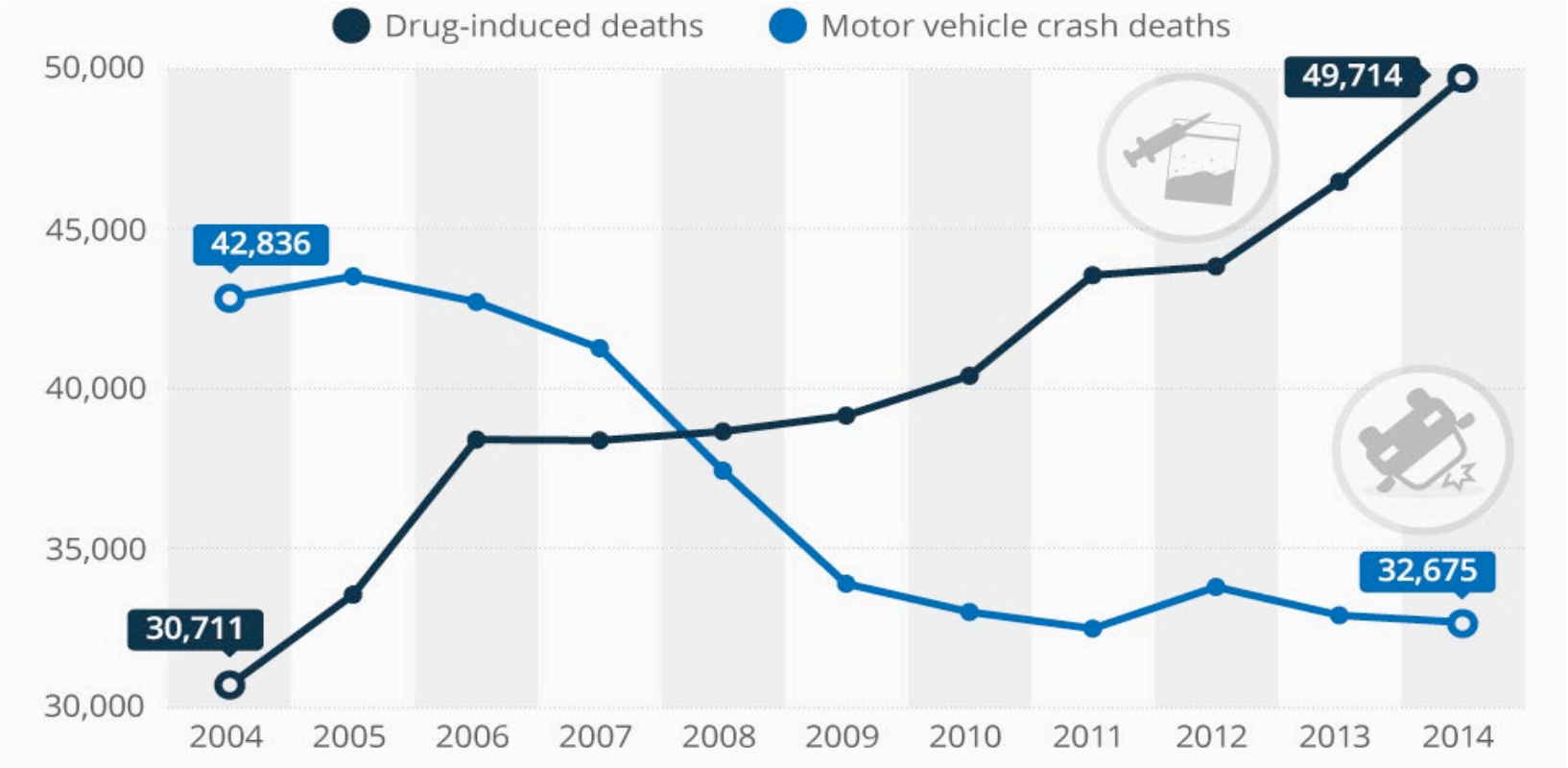
Drug Overdose Is the Leading Cause of Accidental Death in the United States



https://www.statista.com/chart/6805/drugs-are-killing-more-americans-than-road-crashes

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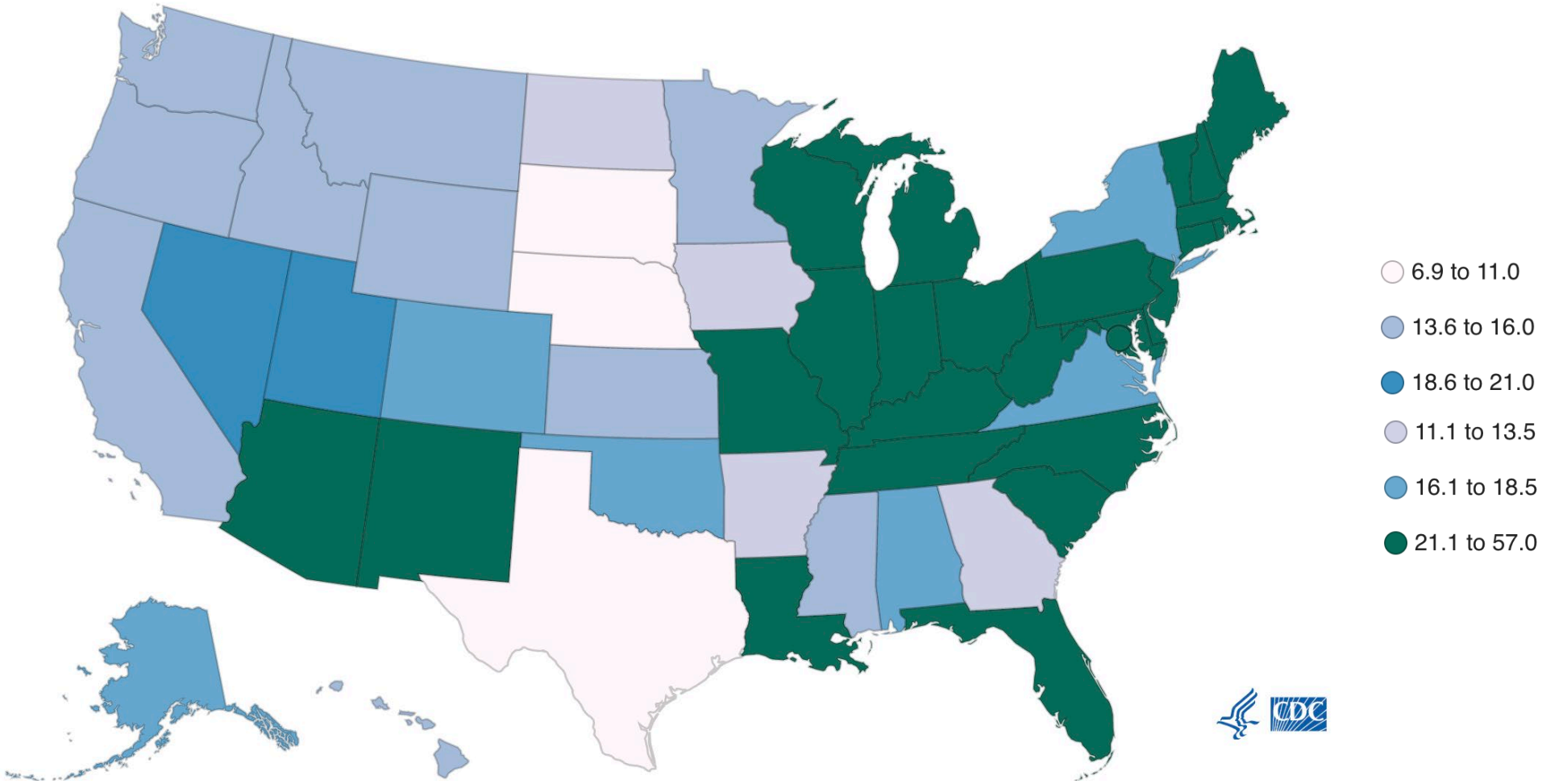
2019 Drug Overdose Death Rates
(per 100,000 people)



https://www.cdc.gov/drugoverdose/deaths/2019.html

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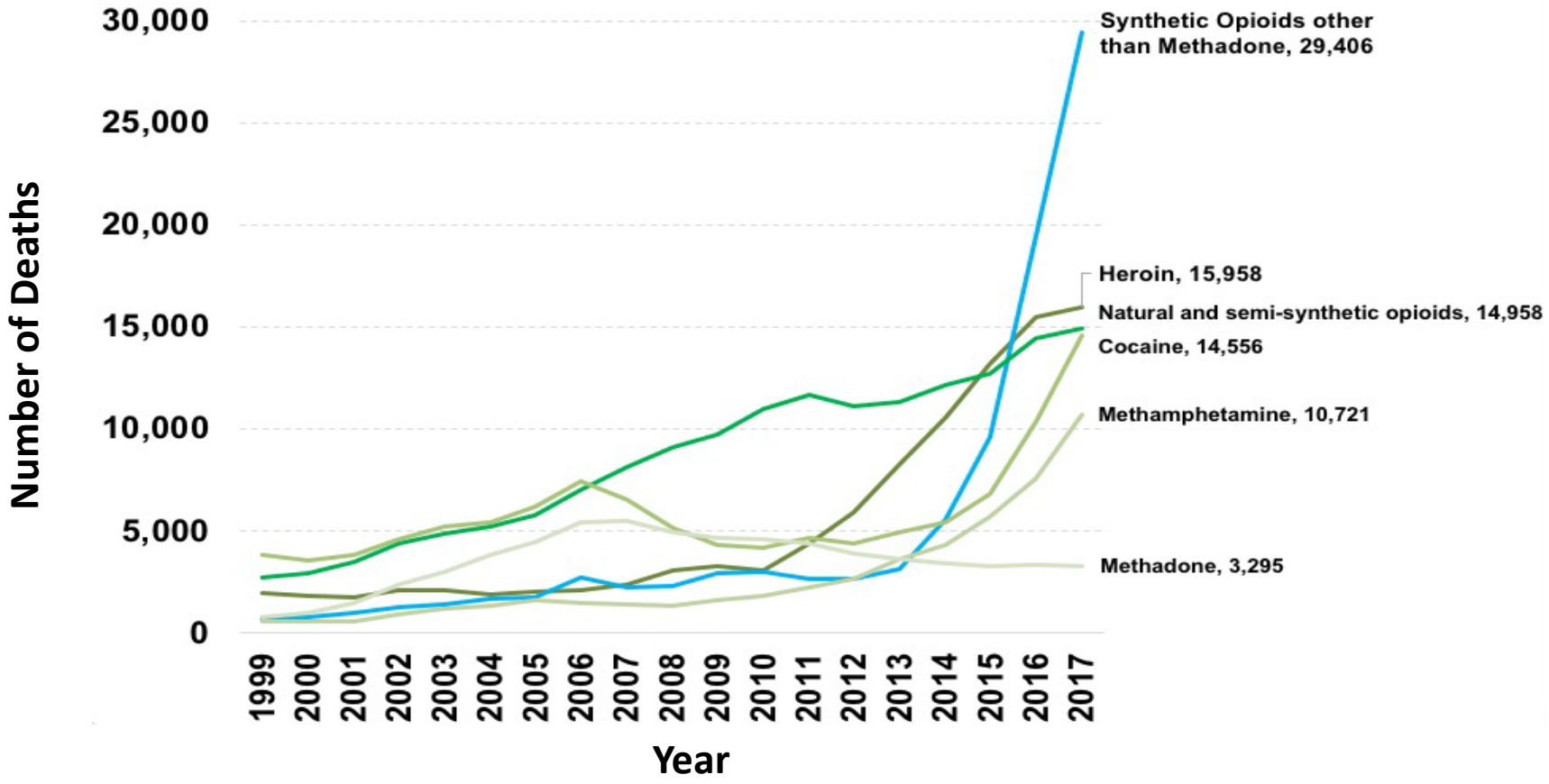
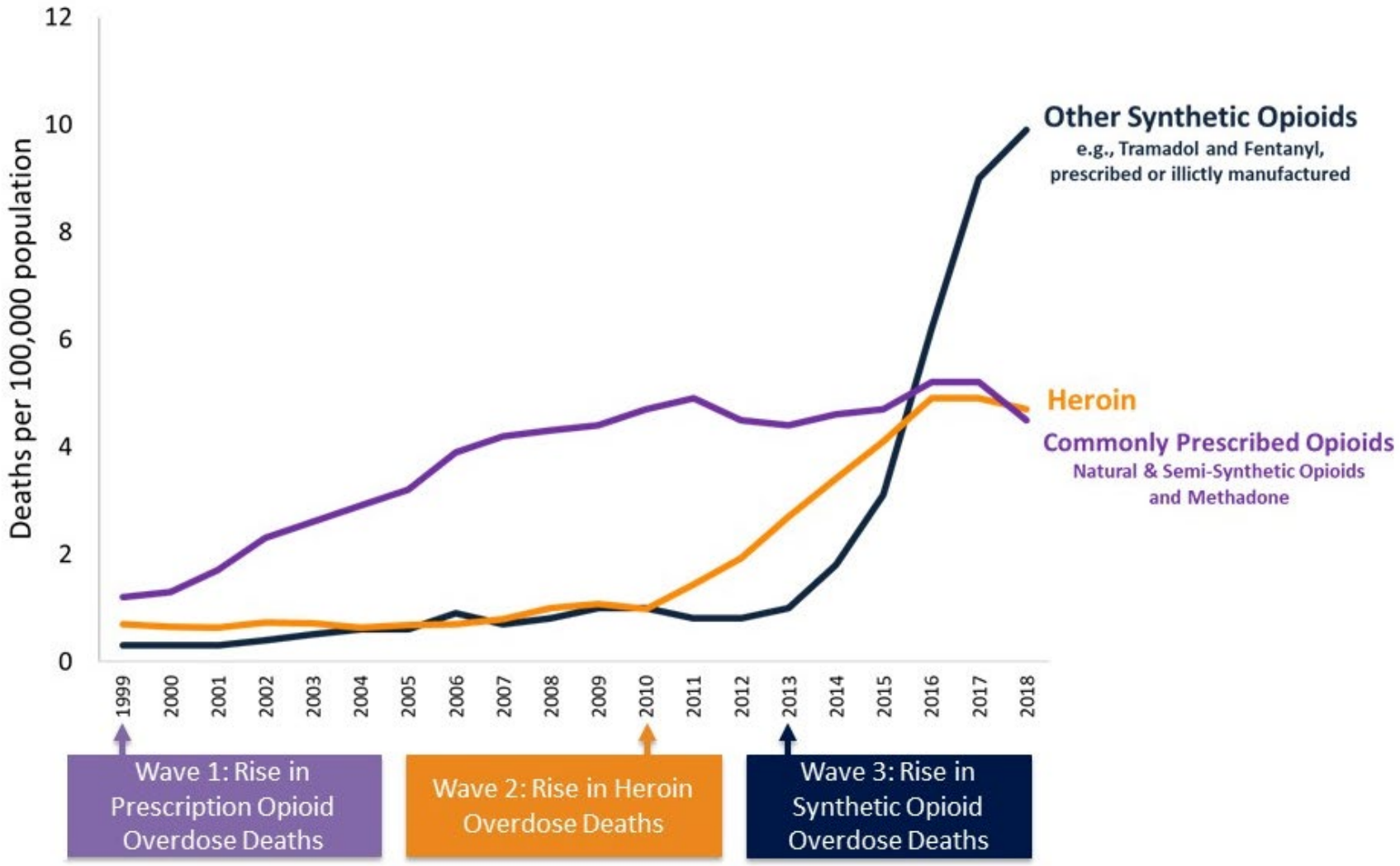
Drugs Involved in U.S. Overdose Deaths

1999 to 2017



World Economic Forum: https://www.weforum.org/agenda/2018/08/what-you-need-to-know-about-the-opioid-epidemic

Three Waves of the Rise in Opioid Overdose Deaths



CDC: https://www.cdc.gov/drugoverdose/epidemic/index.html

Two Milligrams of Fentanyl…a Potentially Lethal Dose

DEA.gov

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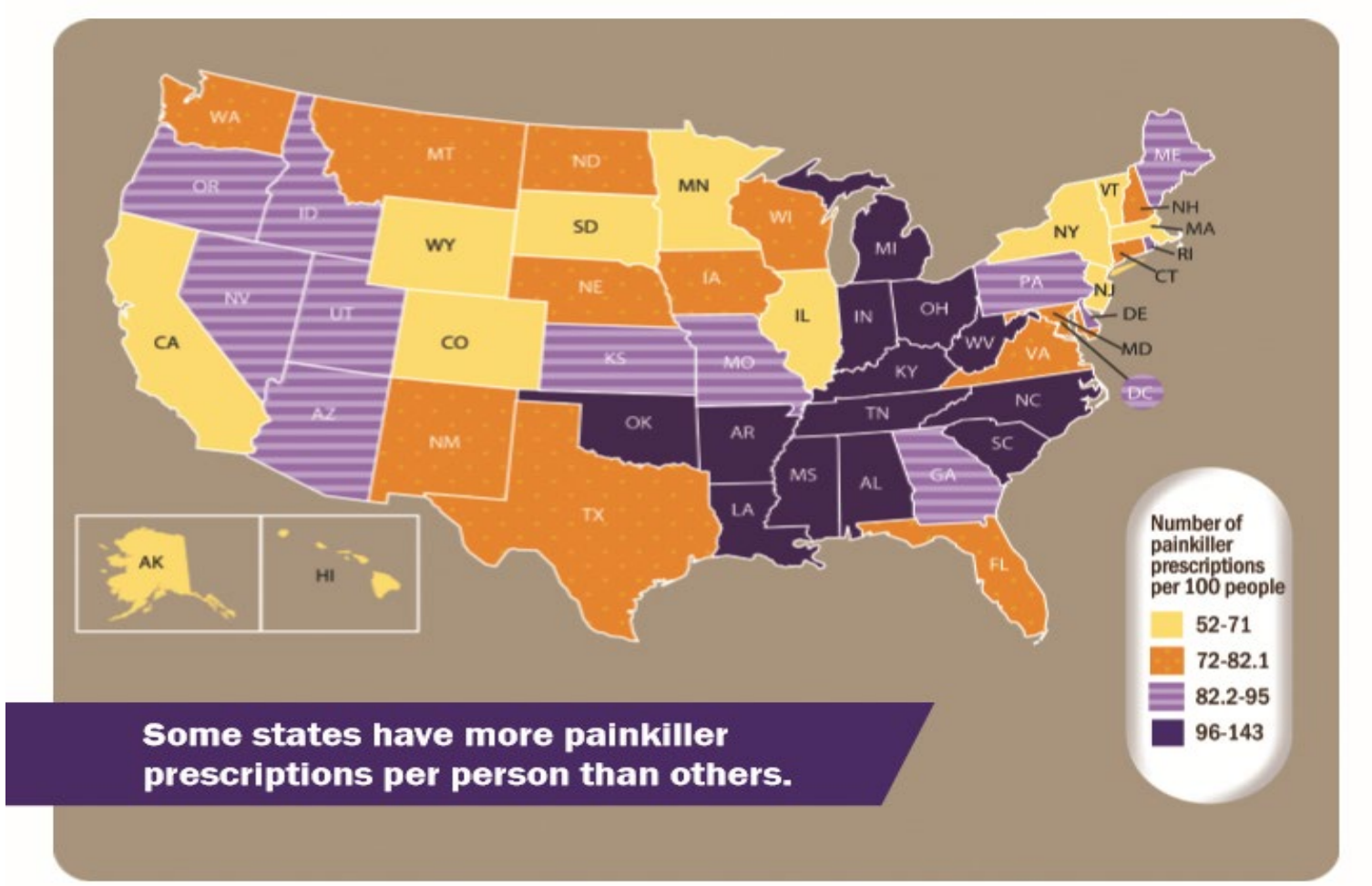
2012: Healthcare Providers Wrote 259 MILLION Prescriptions for Opioid Medications



State of Tennessee:
96-143 opioid prescriptions per 100 people

CDC Vital Signs, July 2014. cdc.gov/vitalsigns

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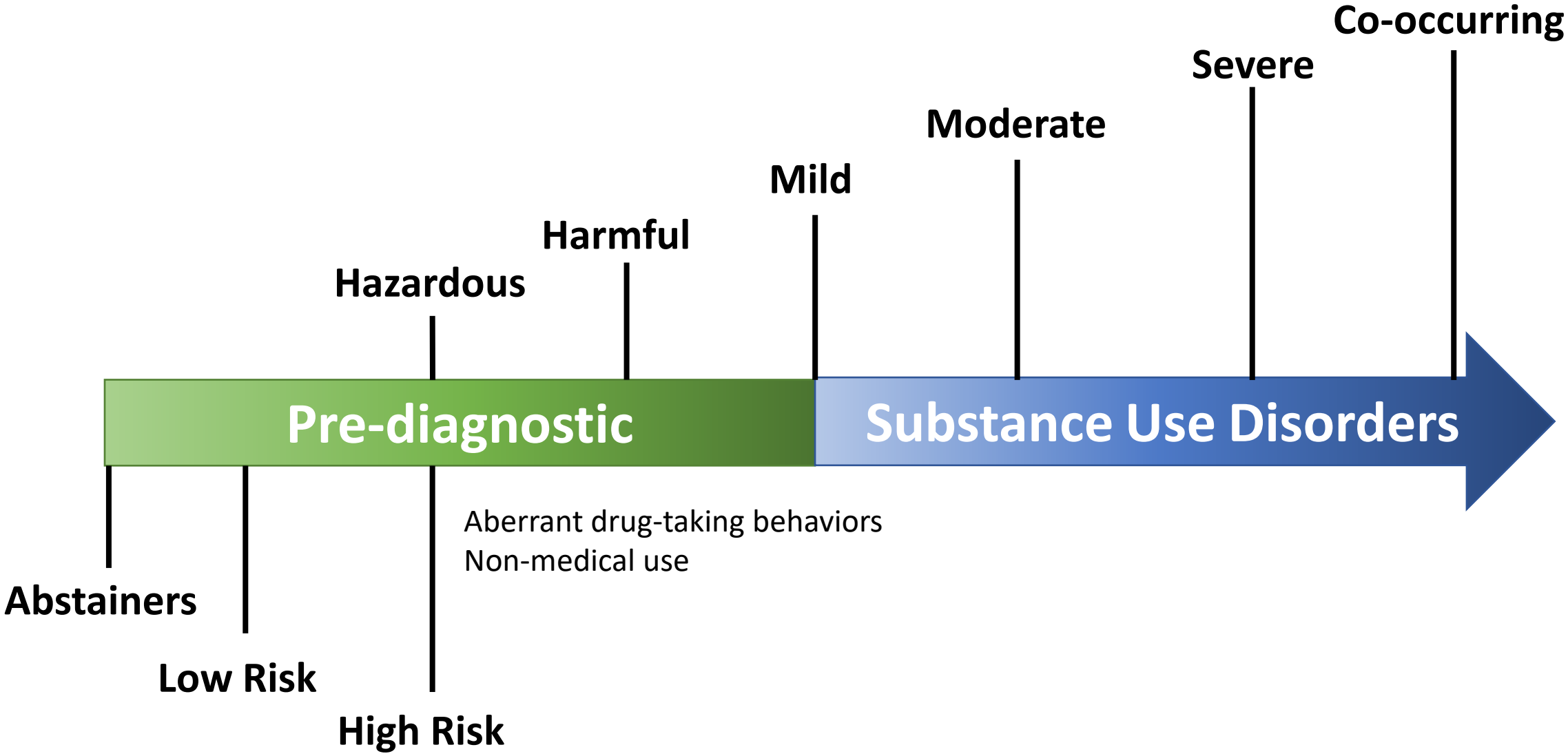
Spectrum of Substance Use



What is Addiction?

American Society of Addiction Medicine:

"Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors."

SMART Recovery:

"Maladaptive behaviors with physiological underpinnings."

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What is Addiction?

DSMV Diagnostic Criteria

- Mild OUD: 2-3 items co-occurring in a 12 month period
- Moderate OUD: 4-5 items co-occurring in a 12 month period
- Severe OUD: 6 or more items co-occurring in a 12 month period

Table 1. Diagnostic Criteria for an Opioid-Use Disorder.*
Use of an opioid in increased amounts or longer than intended
Persistent wish or unsuccessful effort to cut down or control opioid use
Excessive time spent to obtain, use, or recover from opioid use
Strong desire or urge to use an opioid
Interference of opioid use with important obligations
Continued opioid use despite resulting interpersonal problems, social problems (e.g., interference with work), or both
Elimination or reduction of important activities because of opioid use
Use of an opioid in physically hazardous situations (e.g., while driving)
Continued opioid use despite resulting physical problems, psychological problems, or both
Need for increased doses of an opioid for effects, diminished effect per dose, or both†
Withdrawal when dose of an opioid is decreased, use of drug to relieve withdrawal, or both†

Schuckit, M.D.. Treatment of Opioid-Use Disorders. N Engl J Med. 2016; 375(4): 357-68.

What is Addiction?

DSMV Substance-Related and Addictive Disorders

Ten classes of substances included

- Alcohol
- Caffeine
- Cannabis
- Hallucinogens
- Phencyclidine
- Inhalants
- Opioids
- Sedatives/Hypnotics/Anxiolytics
- Stimulants
- Tobacco

Key Features of Addiction

Loss of Control

- Inability (or persistent desire) to stop or reduce substance use

Cravings

- Strong psychological urge to use

Consequences

- Continued use despite knowledge of physical, psychological, and social consequences

What is Addiction?

Addiction is a chronic brain disease that can be effectively prevented and treated.

Heritability of Substance Dependence

JAMA®

Drug Dependence, a Chronic Medical Illness

Implications for Treatment, Insurance, and Outcomes Evaluation

A. Thomas McLellan, PhD
David C. Lewis, MD
Charles P. O'Brien, MD, PhD
Herbert D. Kleber, MD

MANY EXPENSIVE AND DISturbing social problems can be traced directly to drug dependence. Recent studies[1-4] estimated that drug dependence costs the United States approximately $67 billion annually in crime, lost work productivity, foster care, and other social problems.[2-4] These expensive effects of drugs on all social systems have been important in shaping the public view that drug dependence is primarily a social problem that

The effects of drug dependence on social systems has helped shape the generally held view that drug dependence is primarily a social problem, not a health problem. In turn, medical approaches to prevention and treatment are lacking. We examined evidence that drug (including alcohol) dependence is a chronic medical illness. A literature review compared the diagnoses, heritability, etiology (genetic and environmental factors), pathophysiology, and response to treatments (adherence and relapse) of drug dependence vs type 2 diabetes mellitus, hypertension, and asthma. Genetic heritability, personal choice, and environmental factors are comparably involved in the etiology and course of all of these disorders. Drug dependence produces significant and lasting changes in brain chemistry and function. Effective medications are available for treating nicotine, alcohol, and opiate dependence but not stimulant or marijuana dependence. Medication adherence and relapse rates are similar across these illnesses. Drug dependence generally has been treated as if it were an acute illness. Review results suggest that long-term care strategies of medication management and continued monitoring produce lasting benefits. Drug dependence should be insured, treated, and evaluated like other chronic illnesses.

JAMA. 2000;284:1689-1695 www.jama.com

Estimated genetic heritable risk from twin studies:

- Hypertension: 0.25 – 0.50
- Type I Diabetes: 0.30 – 0.50
- Type II Diabetes: 0.80
- Asthma: 0.36 – 0.70
- Substance Dependence:
  - 0.34 for heroin addicted males
  - 0.55 for alcohol addicted males
  - 0.52 for marijuana addicted females

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OUD and Infectious Diseases: “Dueling Epidemics”

People Who Inject Drugs (PWID) are at high risk for:

- Bacterial, viral, and fungal infections
  - Skin and soft tissue infections (SSTI)
  - Infectious endocarditis
  - Bone and joint infections
  - Viral hepatitides (hepatitis A, B and C)
  - HIV

Springer SA, Merluzzi AP, del Rio C. Integrating Responses to the Opioid Use Disorder and Infectious Disease Epidemics: A Report From the National Academies of Sciences, Engineering, and Medicine. *JAMA.* 2020;324(1):37–38. doi:10.1001/jama.2020.2559o

OUD and Infectious Diseases: Serious Infections

National estimates of hospitalizations related to OUD and associated infections 2002 and 2012

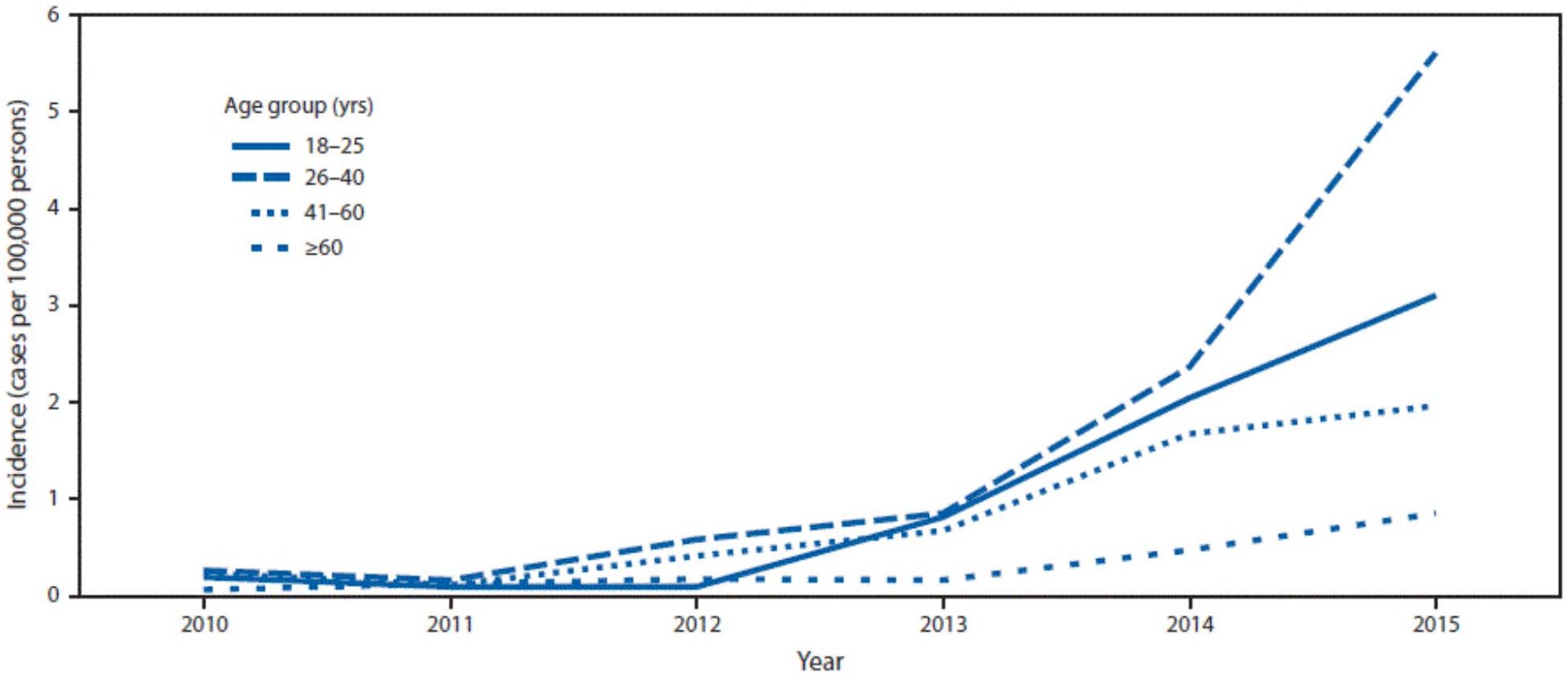
	2002 (N = 36,523,831)	2012 (N = 36,484,846)
	Number	Number
OUD/dependence	301,707	520,275**
OUD/dependence with infection#	3,421	6,535**
Endocarditis	2,077	3,035*
Osteomyelitis	458	985**
Septic arthritis	729	1,940**
Epidural abscess	411	1,085**

#Infection: endocarditis, osteomyelitis, septic arthritis, or epidural abscess
*$p < 0.01$
**$p < 0.001$

Ronan MV, Herzig SJ. Hospitalizations related to opioid abuse/dependence and associated serious infections increased sharply, 2002-12. Health Aff (Millwood) 2016; 35:832–7.

OUD and Infectious Diseases: Infective Endocarditis

Incidence of SUD-associated infective endocarditis



Fleischauer AT, Ruhl L, Rhea S, Barnes E. Hospitalizations for Endocarditis and Associated Health Care Costs Among Persons with Diagnosed Drug Dependence — North Carolina, 2010–2015. MMWR Morb Mortal Wkly Rep 2017;66:569–573. DOI: http://dx.doi.org/10.15585/mmwr.mm6622a1

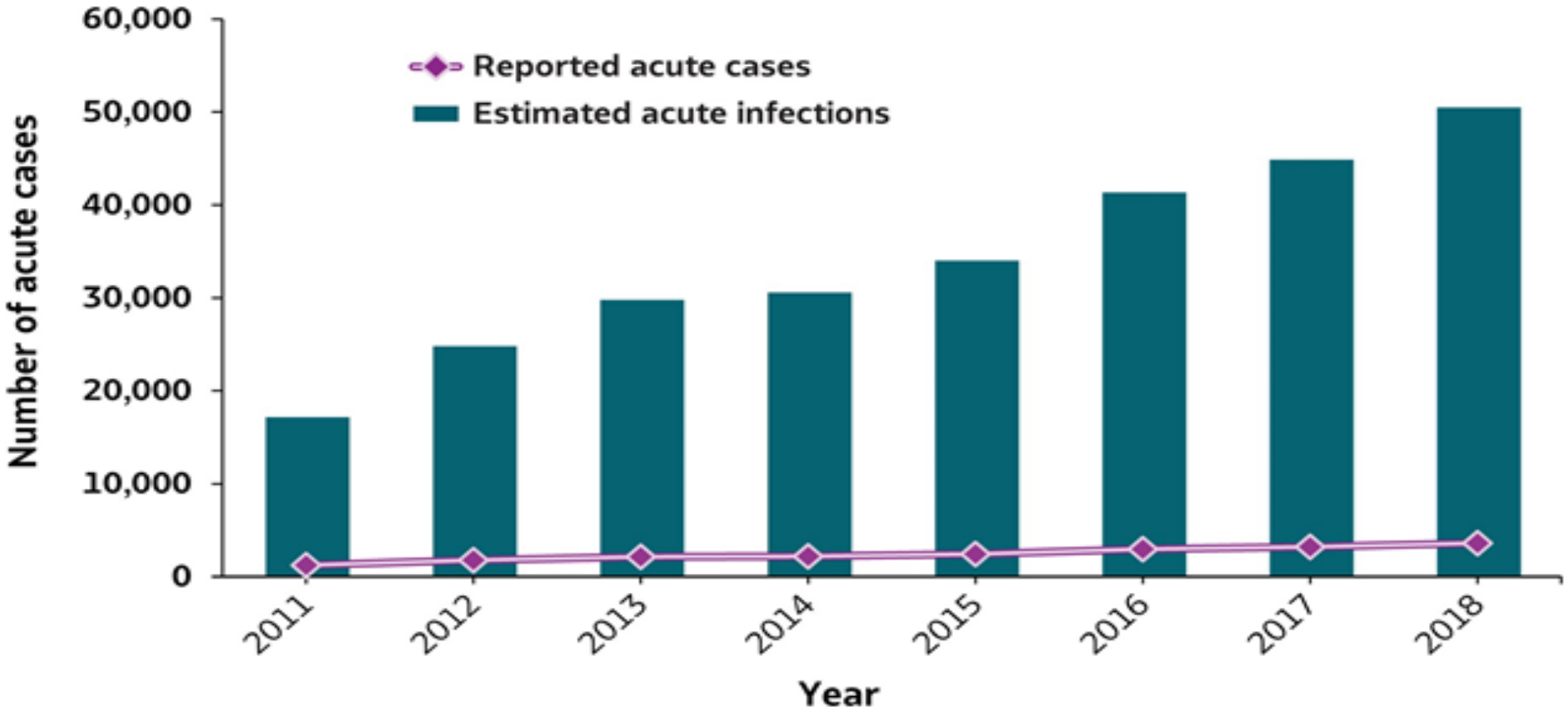
OUD and Infectious Diseases: Hepatitis C Virus

- Hepatitis C virus (HCV) is the most common infection transmitted through drug injection, and a large proportion of new HCV infections are associated with injection-drug use.
- In the United States, the annual incidence rate of acute HCV infection increased more than 2-fold from 2004 to 2014.
- Largest increase in cases among those aged 30-39 years, consistent with age groups most impacted by the nation's opioid crisis.
- Among the reported cases with injection drug use (IDU) information available, *72% report IDU.*
- Of reported acute cases of HCV, IDU is most common risk/exposure identified.

National Notifiable Diseases Surveillance System, Viral Hepatitis: United States. Atlanta: Centers for Disease Control and Prevention. 2018.
Zibbell JE, Asher AK, Patel RC, et al. Increases in acute hepatitis C virus infection related to a growing opioid epidemic and associated injection drug use, United States, 2004 to 2014. *Am J Public Health*. 2018;108(2):175-181.

OUD and Infectious Diseases: Hepatitis C Virus

Number of reported acute hepatitis C cases and estimated infections in the United States 2011 - 2018



CDC: National Notifiable Diseases Surveillance System

OUD and Infectious Diseases: HIV

- HIV incidence and IDU illustrate concomitant other high risk behaviors of people who inject drugs
  - Multiple sex partners, unprotected sex, transactional sex
- 10 % of new HIV diagnoses in the U.S. are attributed to IDU or MSM *and* IDU (in men who report both risk factors)
- In 2016, IDU with opioids responsible for clustered HIV outbreaks in Indiana and Massachusetts
- Sharing syringes is second riskiest behavior for HIV transmission (MSM is the first)

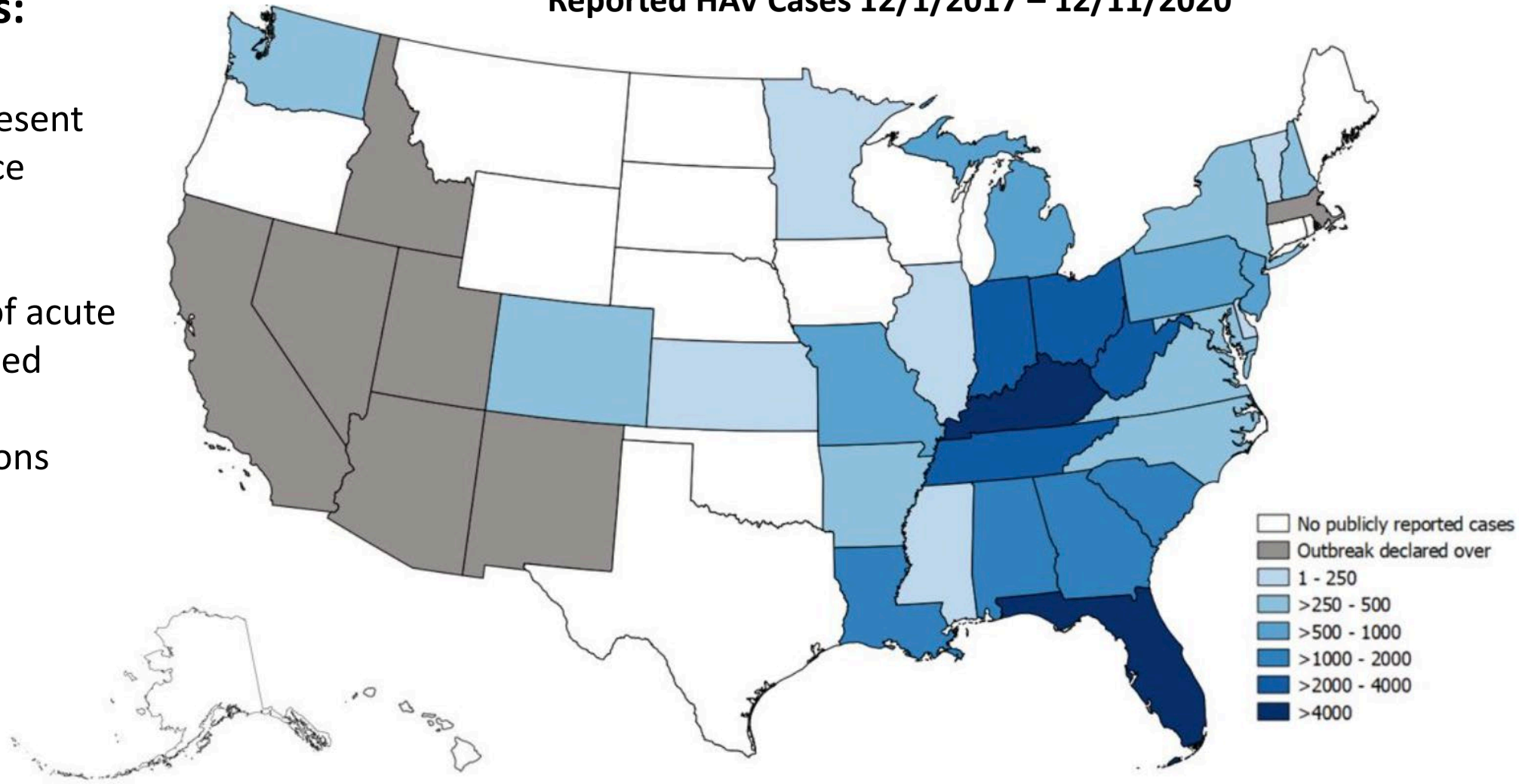
Schwetz K, et al; Opioids and Infectious Diseases: A Converging Public Health Crisis. The Journal of Infectious Diseases 2019; 3: 346–349
Peters P et al. ; Indiana HIV Outbreak Investigation Team. HIV infection linked to injection use of oxymorphone in Indiana, 2014-2015. N Engl J Med 2016; 375:229–39.
Scales A. CDC joins Department of Public Health in investigating HIV cluster among people who inject drugs. 2018. https://www.mass.gov/news/cdc-joins-department-of-public-health-in-investigating-hivcluster-among-people-who-inject.

OUD and Vaccine-Preventable Infectious Diseases

Hepatitis A Virus:

- HAV outbreak present in Tennessee since 12/1/2017
- As of 5/8/2020:
  - 3036 cases of acute HAV diagnosed
  - 1839 hospitalizations (61%)
  - 28 deaths

Reported HAV Cases 12/1/2017 – 12/11/2020



https://www.cdc.gov/hepatitis/outbreaks/2017March-HepatitisA.htm

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SUD Among PLWH

Past year DSM-V dependence	Unadjusted OR (95% CI) (HIV+ vs HIV-)	Adjusted OR* (95% CI) (HIV+ vs HIV-)
Alcohol	1.86 (1.10, 3.12)	1.17 (0.69, 1.99)
Marijuana	3.12 (1.80, 5.41)	2.31 (1.32, 4.06)
Cocaine	14.00 (7.88, 24.86)	6.01 (3.22, 11.21)
Heroin	11.02 (2.97, 40.91)	5.19 (1.39, 19.31)
Hallucinogens	6.23 (2.09, 19.17)	5.74 (1.84, 17.94)
Any illicit drug	6.14 (4.16, 9.07)	4.34 (2.87, 6.57)

*Adjusted for sex, age, race/ethnicity, education, total family income, marital status
Analysis of National Survey on Drug Use and Health (NSDUH) data, 2005-2014.

- **Substance use: is a barrier to optimal engagement in the HIV care continuum, may increase likelihood of risk-taking behaviors, and potential for drug-drug interactions**

Shiau et al., Patterns of Drug Use and HIV Among Adults in a Nationally Representative Sample. Addictive Behaviors 2017; 68: 39-44.

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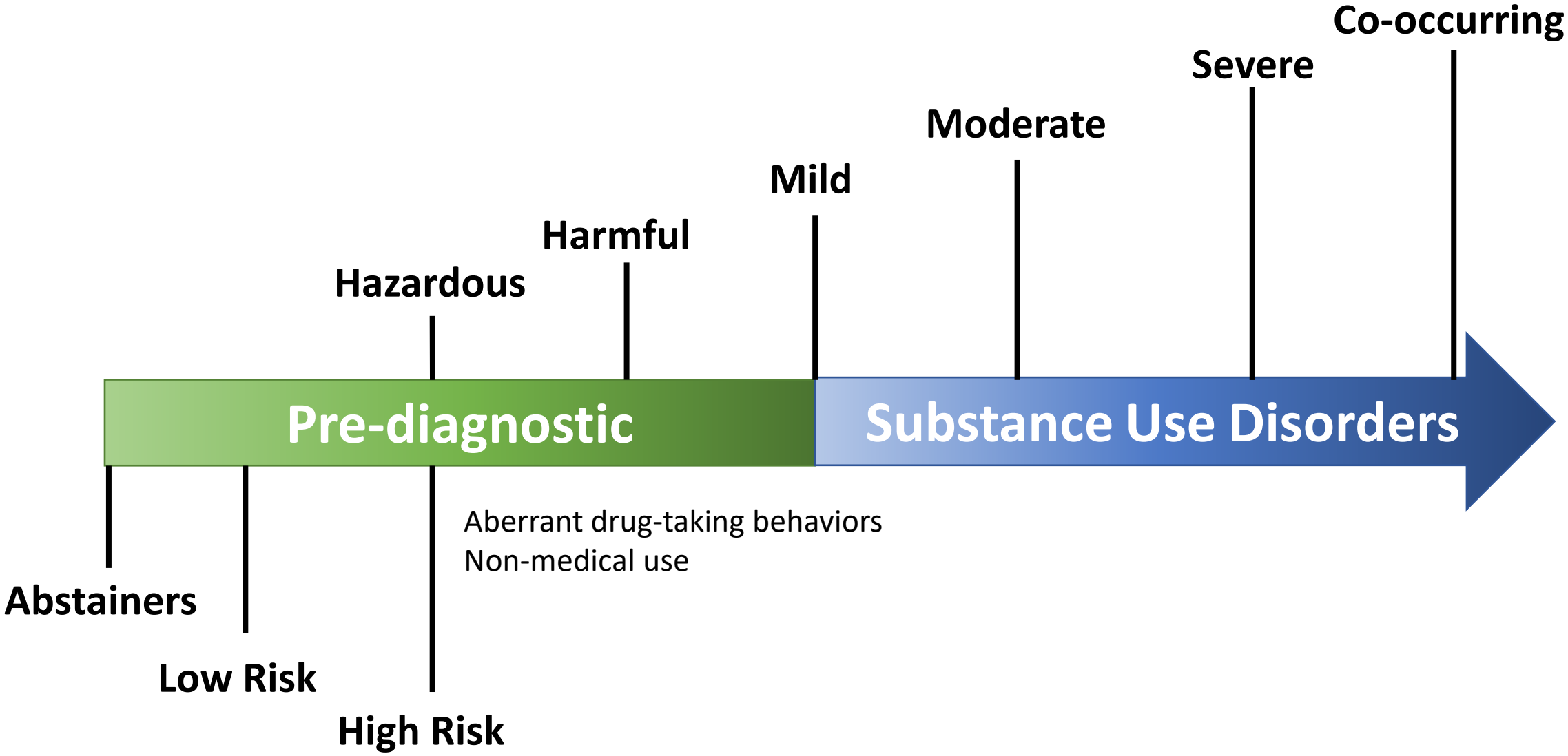
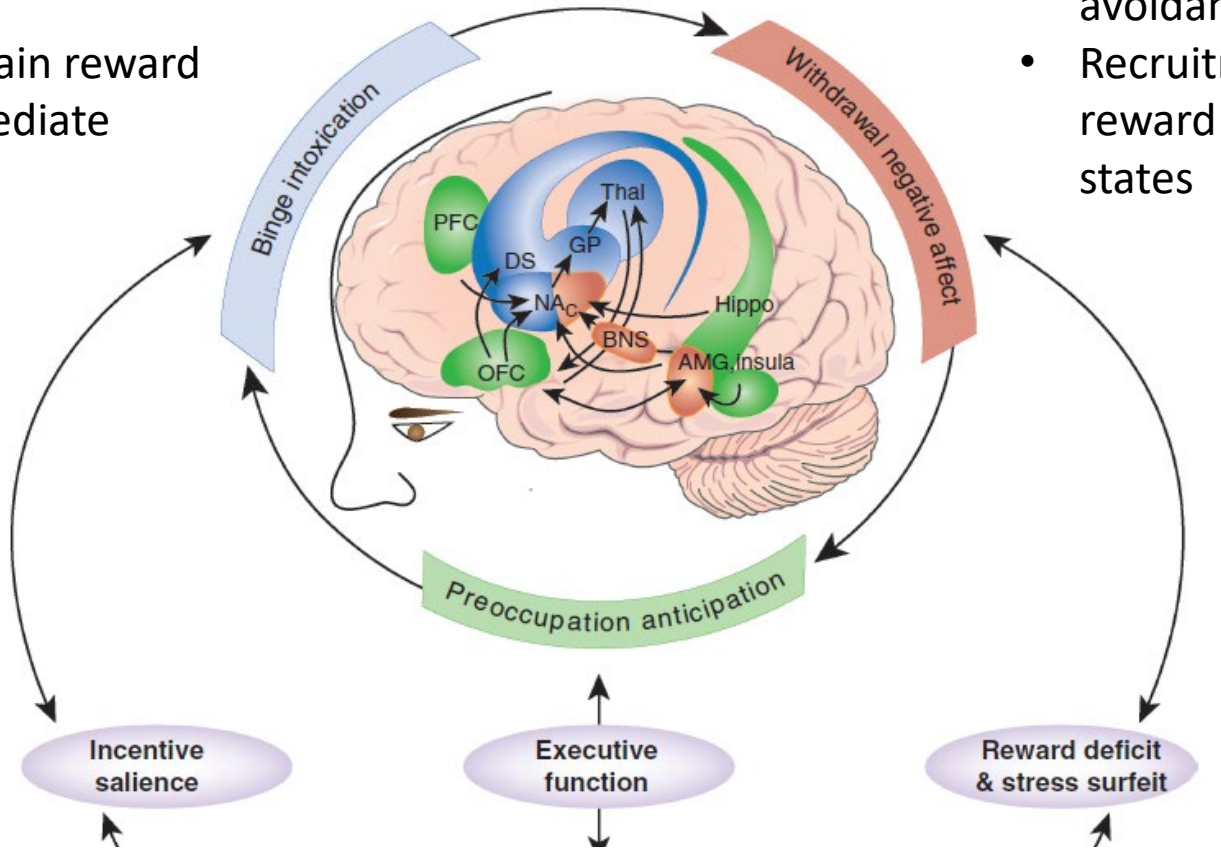
Spectrum of Substance Use



Neuroscience of Addiction

- **Positive reinforcement** leads to initial repeated use
- Decreased function of brain reward systems that normally mediate natural rewards

- **Negative reinforcement** involves avoidance of withdrawal syndromes
- Recruitment of brain stress/anti-reward systems that drive adverse states



Positive and Negative Reinforcement

Wise, RA and Koob, GF. *Neuropsychopharmacology.* 39(2): 254-262. 2014.

How Does Neurobiology Impact Medication Prescribing for Treatment of Addiction?

- Target reward pathways
  - Blocking agents (naltrexone)
  - Opioid agonists (methadone and buprenorphine)
  - Disulfiram (Antabuse)
  - Treat underlying “reward system disruption” i.e. major depression
- Target stress pathways
  - Decrease withdrawal symptoms
    - Opioid agonist treatment for OUD
    - GABA modulators for AUD like benzodiazepines acutely and gabapentin/acamprosate/topiramate
  - Treat underlying comorbid anxiety and other disorders
- Target executive function pathways
  - Treat comorbid ADHD, bipolar disorder, etc.

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Evidence Based Treatments for SUD

Non-pharmacologic	Pharmacologic
Motivational Enhancement Therapy	Treat withdrawal
Cognitive Behavioral Therapy	Medications for Addiction Treatment (MAT)
Community Reinforcement	Treat co-occurring illness
Contingency Management	
12-Step Facilitation	
Some family therapies	

http://www.nrepp.samhsa.gov/
Drake et al., *Schizophrenia bulletin*, 24(4), 589-608. 1998.
Horsfall et al., *Harvard review of psychiatry*, *17*(1), 24-34. 2009.
Donald, et al., *Social science & medicine*, *60*(6), 1371-1383. 2005.

Various Treatments Work for Relapse Prevention

- Stimulant use disorder
- Cannabis use disorder

- Opioid use disorder
- Nicotine use disorder

- **Psychosocial Treatments**
- Medication for Addiction Treatment (MAT)

- **Medication for Addiction Treatment (MAT)**
- Psychosocial Treatments

Alcohol use disorder

Mattick, R. P., Kimber, J., Breen, C., & Davoli, M. (2004). Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database Syst Rev*, *3*(3).
Lima, M. S. D., Soares, B. G. D. O., Reisser, A. A. P., & Farrell, M. (2002). Pharmacological treatment of cocaine dependence: a systematic review. *Addiction*, *97*(8), 931-949.
Wu, P., Wilson, K., Dimoulas, P., & Mills, E. J. (2006). Effectiveness of smoking cessation therapies: a systematic review and meta-analysis. *BMC Public Health*, *6*(1), 300.
Marshall, K., Gowing, L., Ali, R., & Le Foll, B. (2014). Pharmacotherapies for cannabis dependence. *The Cochrane database of systematic reviews*, *12*.

Medication for Opioid Use Disorder (MOUD)

	Methadone	Buprenorphine (Oral)	Naltrexone (IM)
Mechanism of Action	Full Agonist on Opioid Receptor	Partial Agonist on Opioid Receptor	Antagonist on Opioid Receptor
Dosing	80mg-100mg (Usual Dose)	4-32mg	380mg Depot Injection
Advantages	▪ Provided in a highly structured supervised setting where additional services can be provided on-site and diversion is unlikely ▪ Maybe effective for individuals who have not benefited sufficiently from partial agonists or antagonists	▪ Improved safety due to partial agonism ▪ Availability in office-based settings	▪ No addictive potential or diversion risk ▪ Available in office-based settings ▪ Option for individuals seeking to avoid any opioids

Schuckit, M.D.. Treatment of Opioid-Use Disorders. N Engl J Med. 2016; 375(4): 357-68.

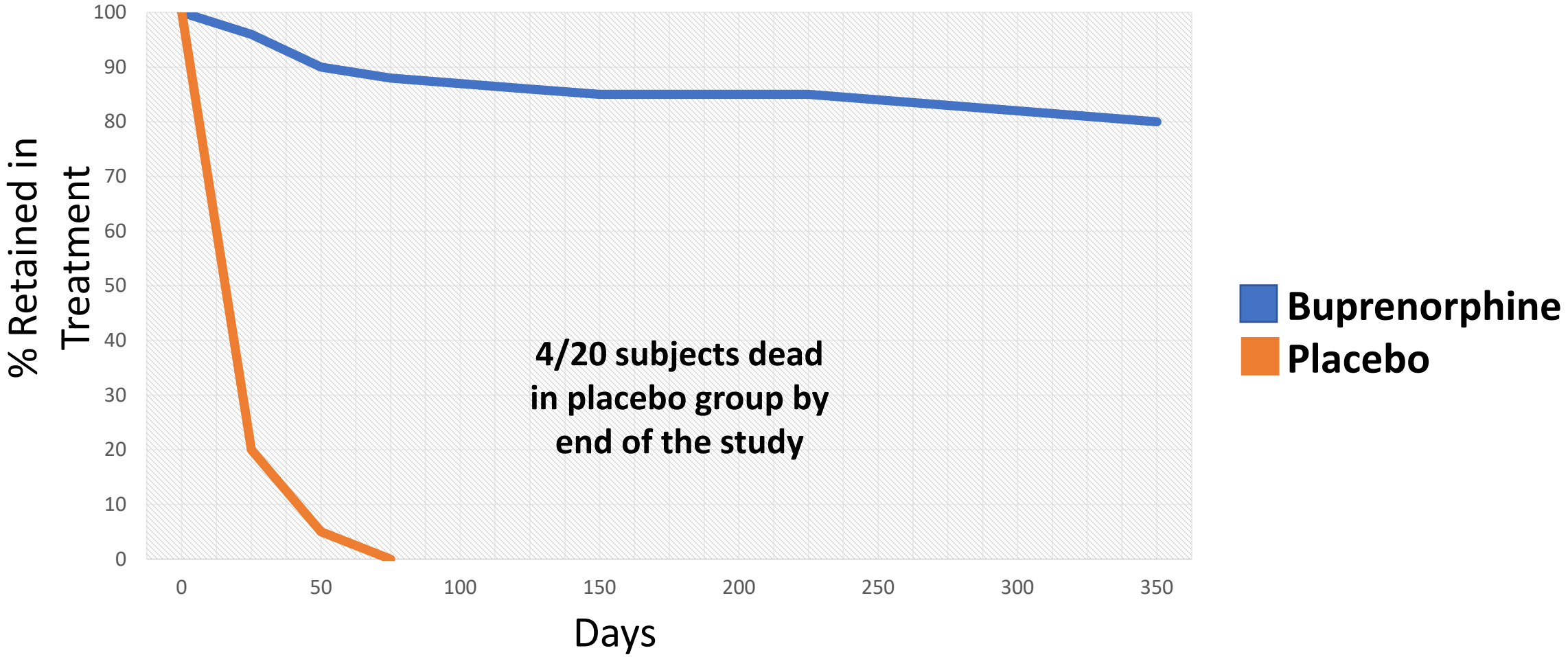
Major Features of Buprenorphine

- **Partial agonist** at mu receptor (semi-synthetic analog of thebaine)
  - Comparatively minimal respiratory suppression and no respiratory arrest when used alone
- **Long acting**
  - Half-life ~ 24-36 hours
- **High affinity** for mu receptor
  - Blocks and displaces other opioids; <u>but can be overcome</u>
- **Slow dissociation** from mu receptor

SAMHSA, 2018.
Orman and Keating, Buprenorphine/Naloxone. *Adis Drug Evaluation* 69: 577-607 2009.
Carroll and Carlezon, Development of Kappa Opioid Receptor Antagonists. *J Med Chem* 56(6): 2178-2195. 2013.

Major Features of Buprenorphine

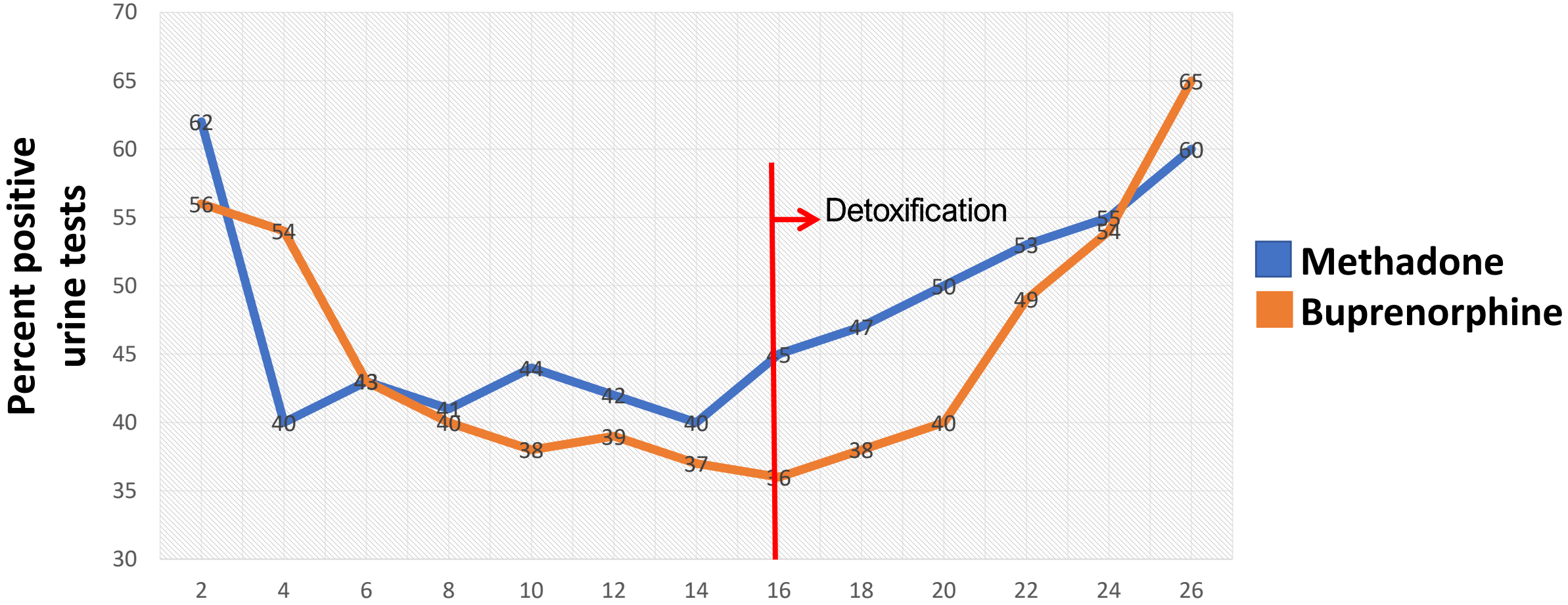
Treatment retention with buprenorphine vs. placebo with intensive psychosocial support



Kakko et al., 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomised, placebo-controlled trial. Lancet 361:662-668. 2003.

Major Features of Buprenorphine

Treatment retention with buprenorphine vs. methadone with intensive psychosocial support

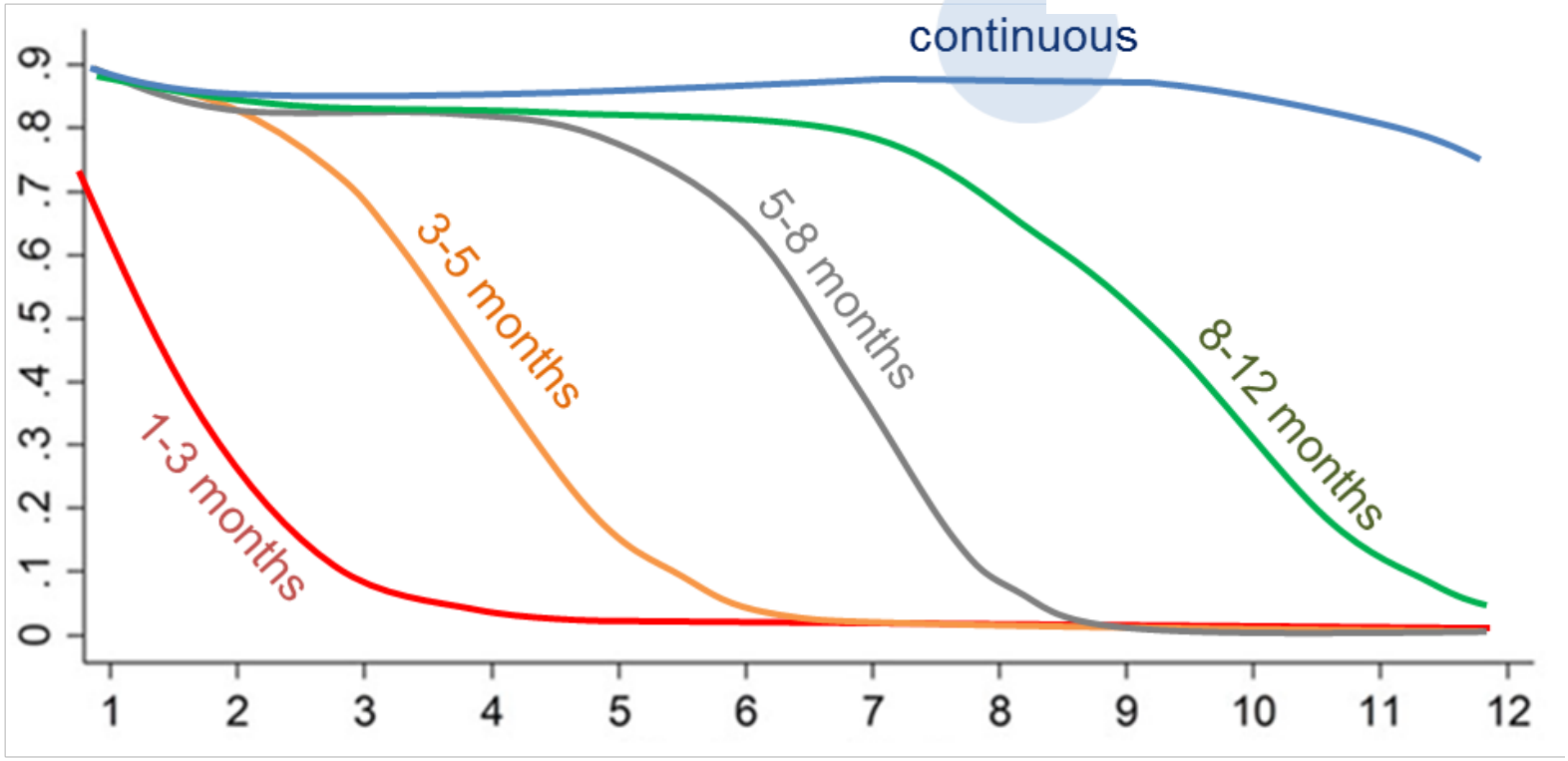


Strain *et al.*, Comparison of Buprenorphine and Methadone in the Treatment of Opioid Dependence. *J Am Psychiatry* 151(7):1025-30. 1994.

Duration of Buprenorphine Treatment

Continuous group had 14% fewer ED visits and 18% fewer admissions than those discontinuing at 3-5 months

Proportion of days when buprenorphine was taken

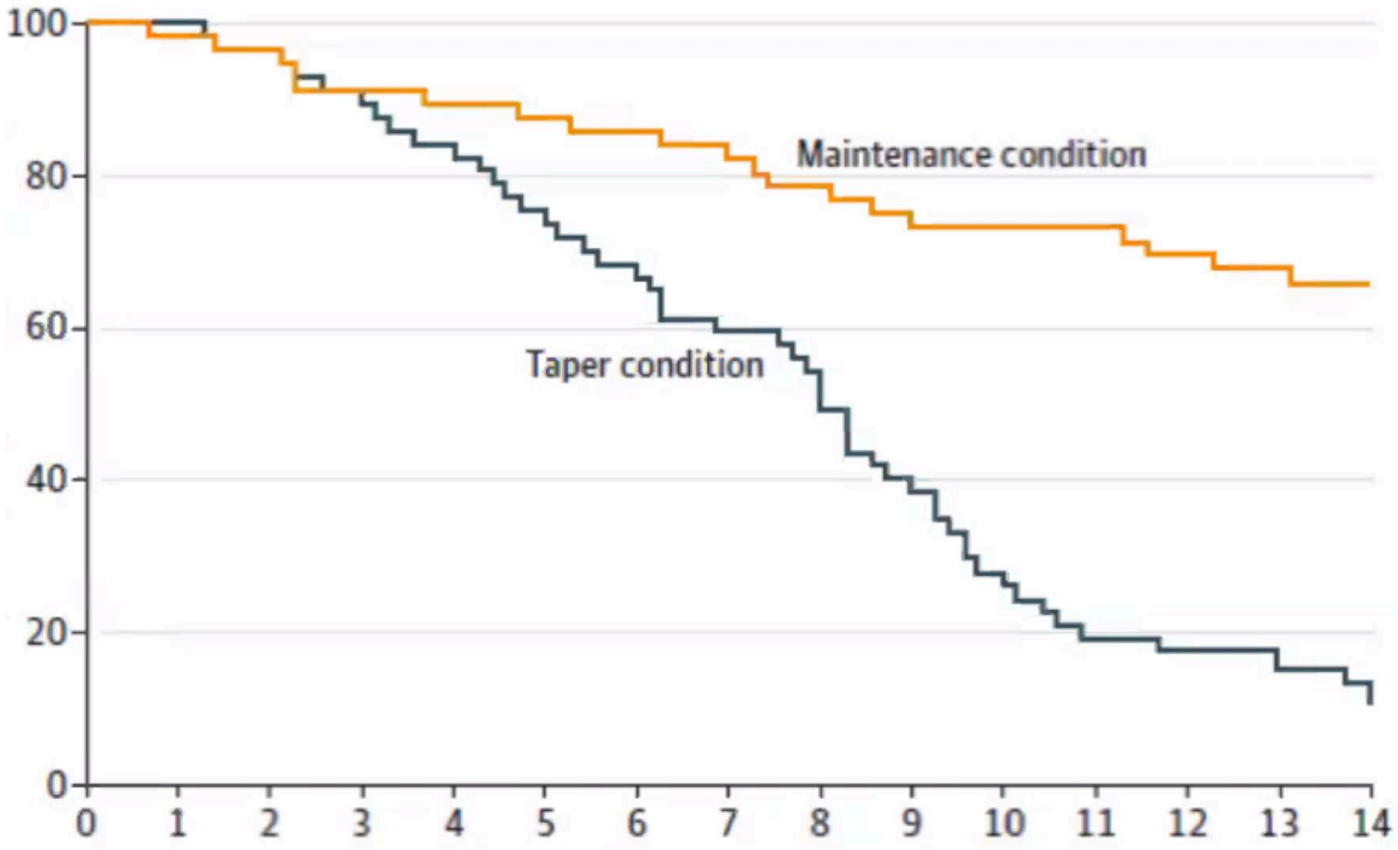


Months since starting treatment

Lo-Ciganic *et al*. Association Between Trajectories of Buprenorphine Treatment and Emergency Department and Inpatient Utilization. *Addiction Res Rep* 111:892-902. 2016.

Duration of Buprenorphine Treatment

Treatment
Retention
(% of patients)



Weeks since starting treatment

Fiellin *et al*. Primary Care-Based Buprenorphine Taper vs Maintenance Therapy for Prescription Opioid Dependence. *JAMA Internal Me 174(12)*:1947-1954. 2014.

Duration of Buprenorphine Treatment

Evidence is variable.

- Studies as long as 16 weeks show high relapse rates with medication withdrawal
- Improved retention rates in treatment with extended buprenorphine maintenance

Continue maintenance as long as patient is benefitting from treatment (decreased substance use; meeting employment, educational, relationship goals).

- Note: provider can have discussions regarding reduction in dose with improving stability or patient preference however, *caution patients about discontinuing medication too early in treatment*

Strain *et al*., Comparison of Buprenorphine and Methadone in the Treatment of Opioid Dependence. *J Am Psychiatry* 151(7):1025-30. 1994.
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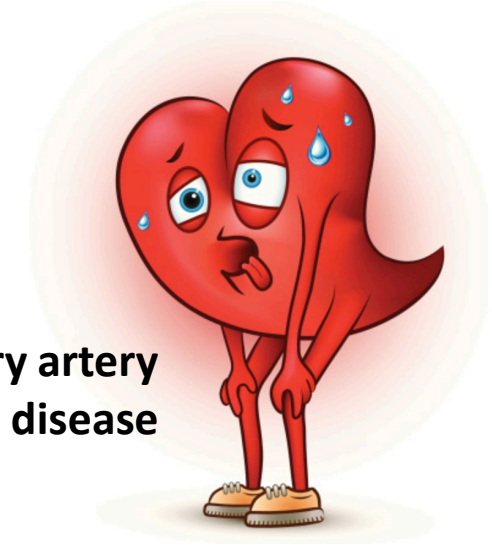
What are the resources do persons with substance use disorder need for successful recovery?

Destigmatizing Substance Use Disorders

Addiction is a chronic brain disease that is preventable and treatable

Coronary artery disease



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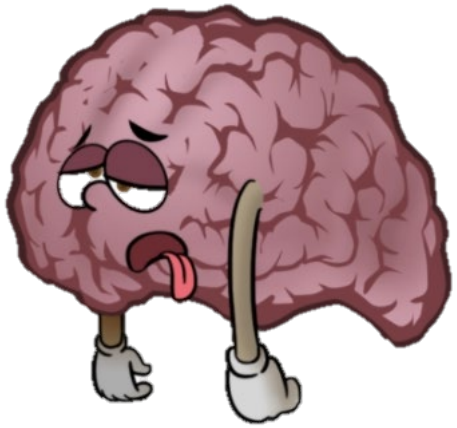


Substance use disorder

- **Prevention:** Routine assessment and early intervention when risk factors present
- **Treatment:** Medical therapies, management of co-occurring diseases, lifestyle modification, and social support

Destigmatizing Substance Use Disorders

Language matters

Commonly Used Term	Preferred Term	Rationale
Addict, abuser, etc.	Person with a substance use disorder	• Focuses on respect, dignity and primacy of personhood
Substance abuse	Substance use disorder	• Avoids implication of willful misconduct • Shift emphasis to chronic disease model
Opioid substitution therapy/replacement therapy	Opioid agonist therapy	• Avoids implication of "switching addiction" • Pharmacologic classification more in line with other medications (i.e., ACEi, SSRI)
Clean	Sober/abstinent	• Avoids value-laden, non-clinical terminology
Dirty or clean urine	Positive or negative urine drug screen	• Avoids value-laden, non-clinical terminology

Brezing and Marcovitz, 2015. https://www.recoveryanswers.org/addiction-ary/

VANDERBILT HEALTH

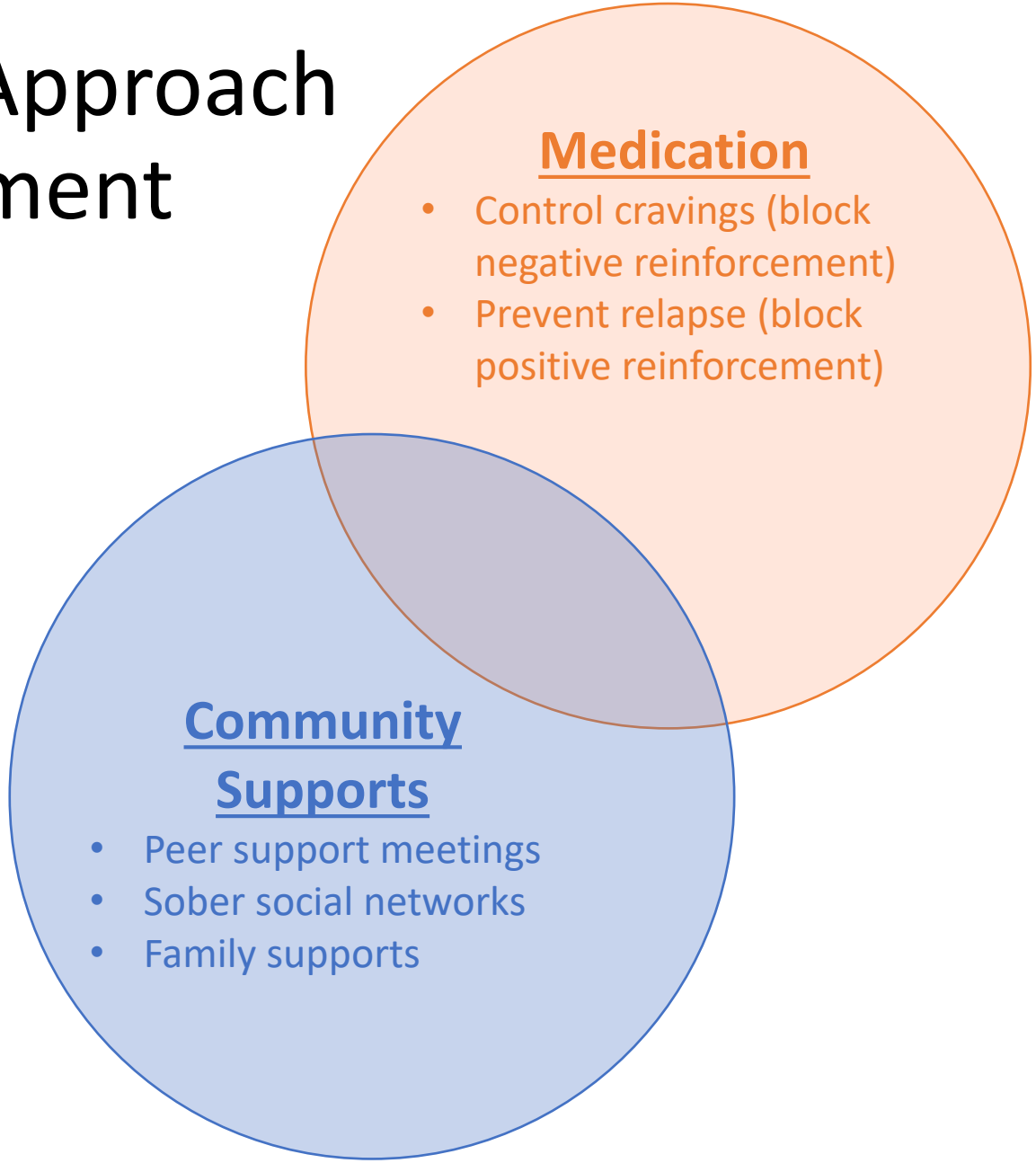
Bio-psycho-social Approach to Addiction Treatment

Medication

- Control cravings (block negative reinforcement)
- Prevent relapse (block positive reinforcement)

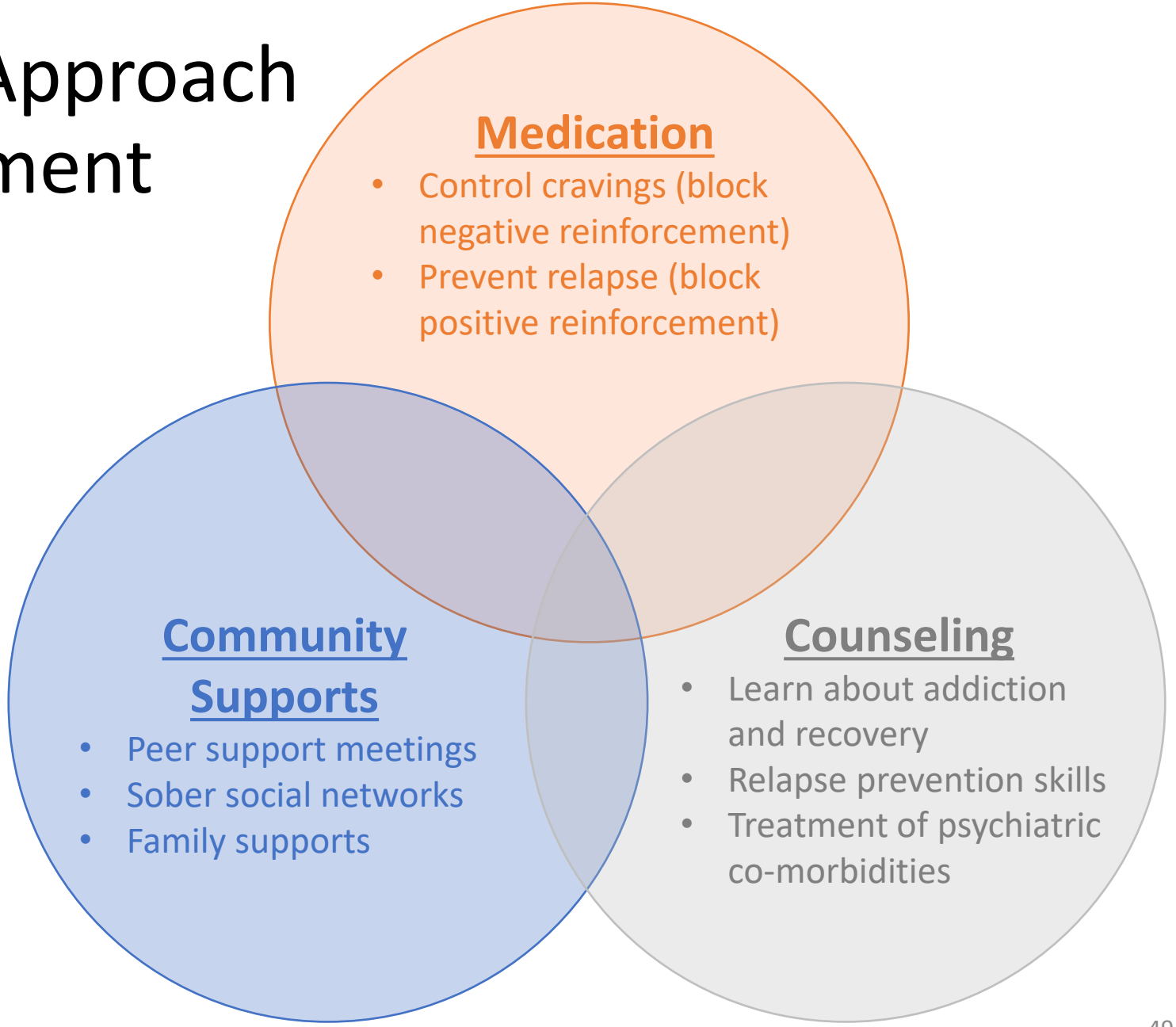
VANDERBILT HEALTH

Bio-psycho-social Approach to Addiction Treatment



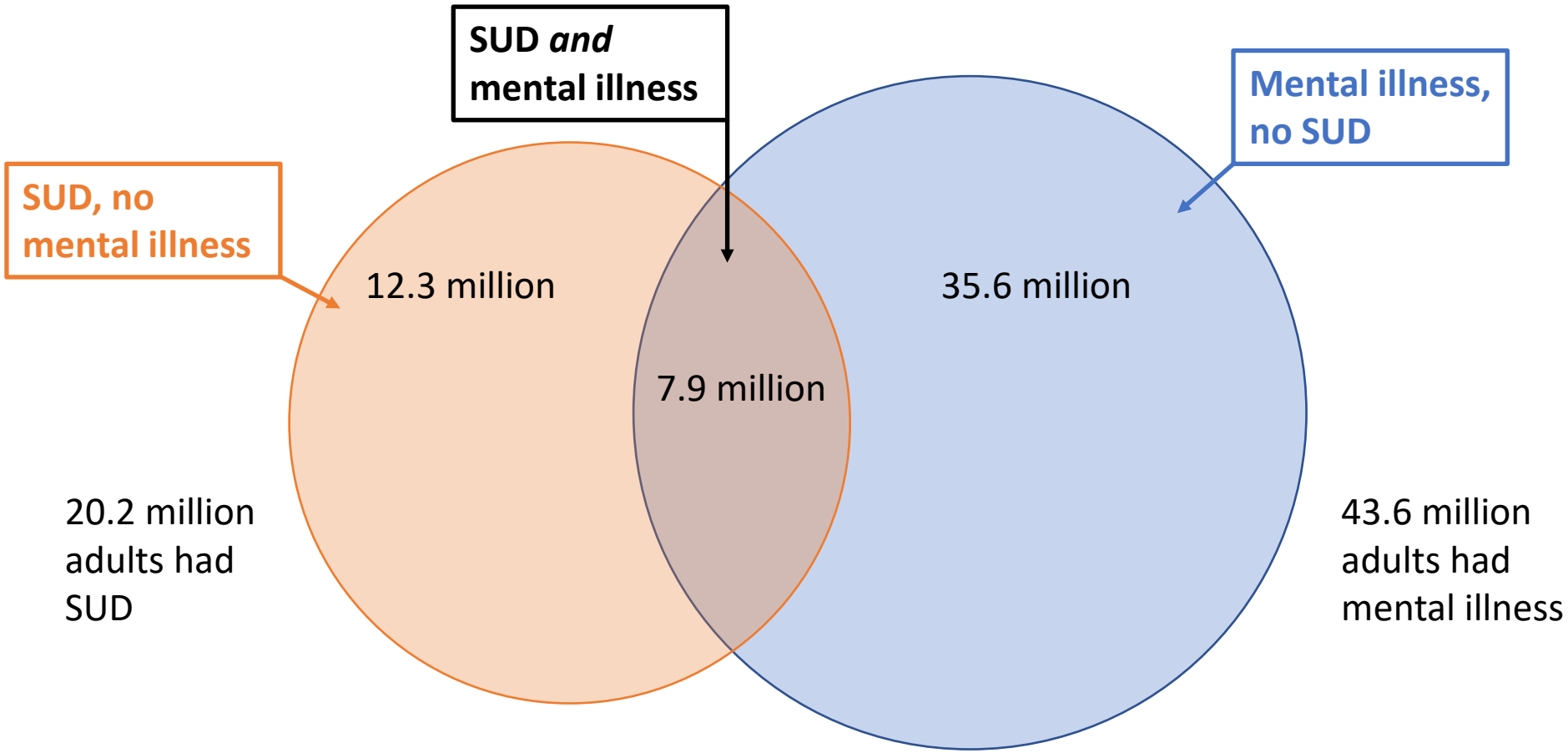
VANDERBILT HEALTH

Bio-psycho-social Approach to Addiction Treatment



Bio-psycho-social Approach to Addiction Treatment

Co-occurring psychiatric disorders



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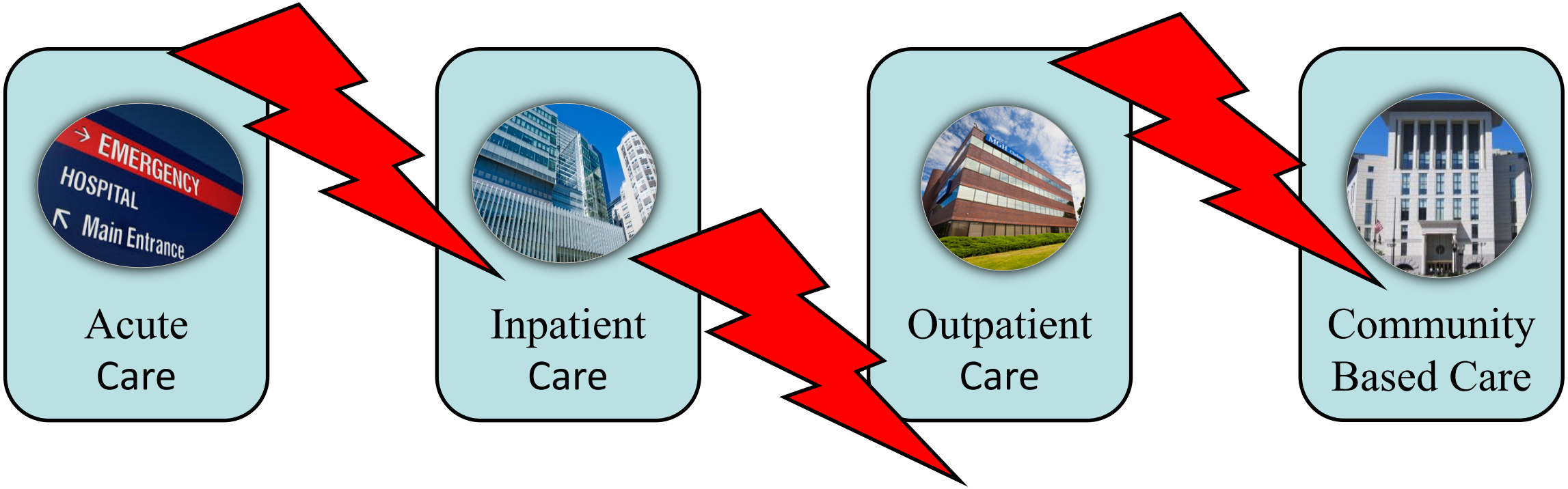
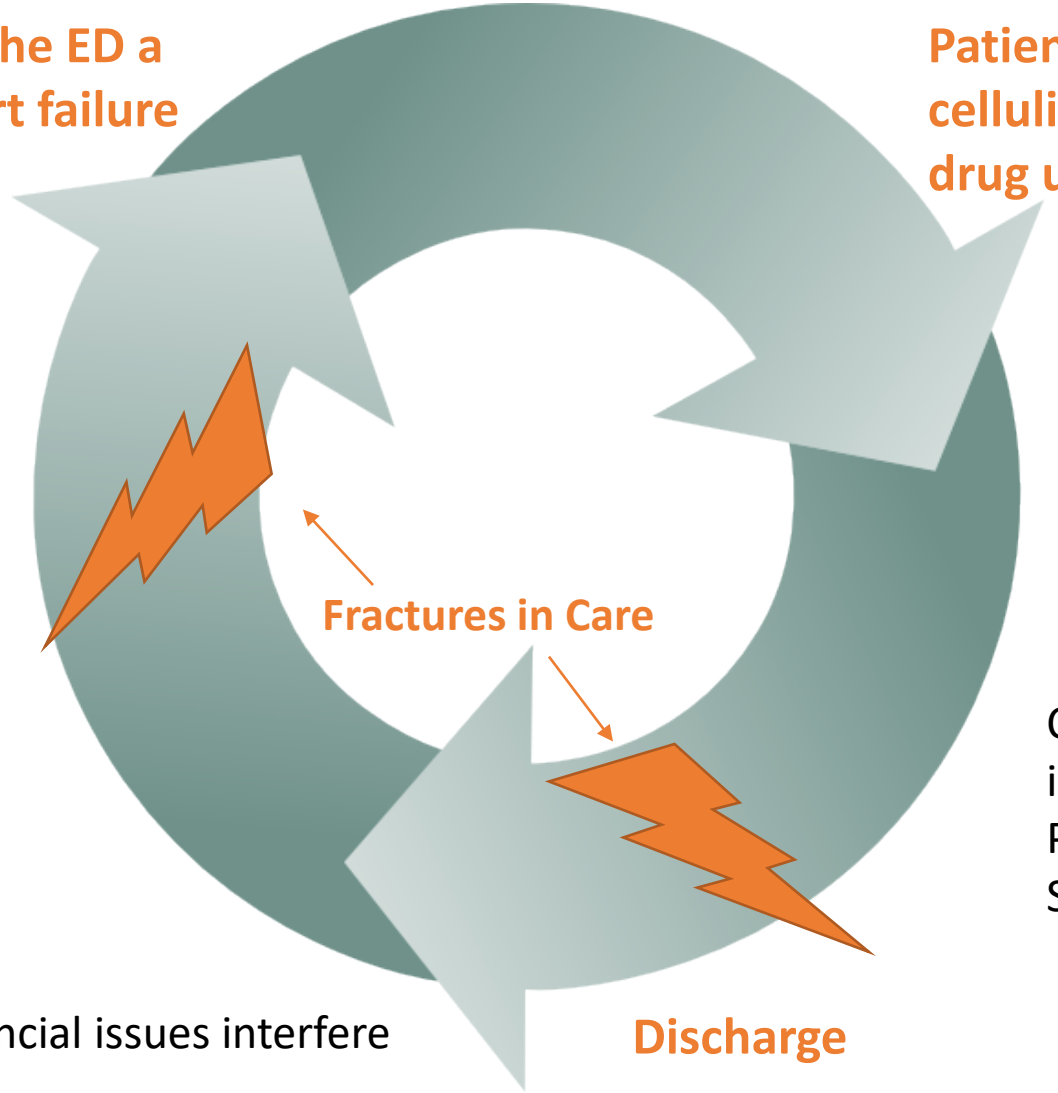
VANDERBILT HEALTH

"Traditional" Model of SUD Care



High risk of fractured care at multiple transition points

"Traditional" Model of SUD Care



Patient presents to the ED a week later with heart failure and fever

No appt made, PCP/health center not involved, patient does not follow through

Patient admitted with cellulitis due to injection drug use

Medical team pages Psychiatry Consult Liaison service

Patient given phone numbers of other programs to call

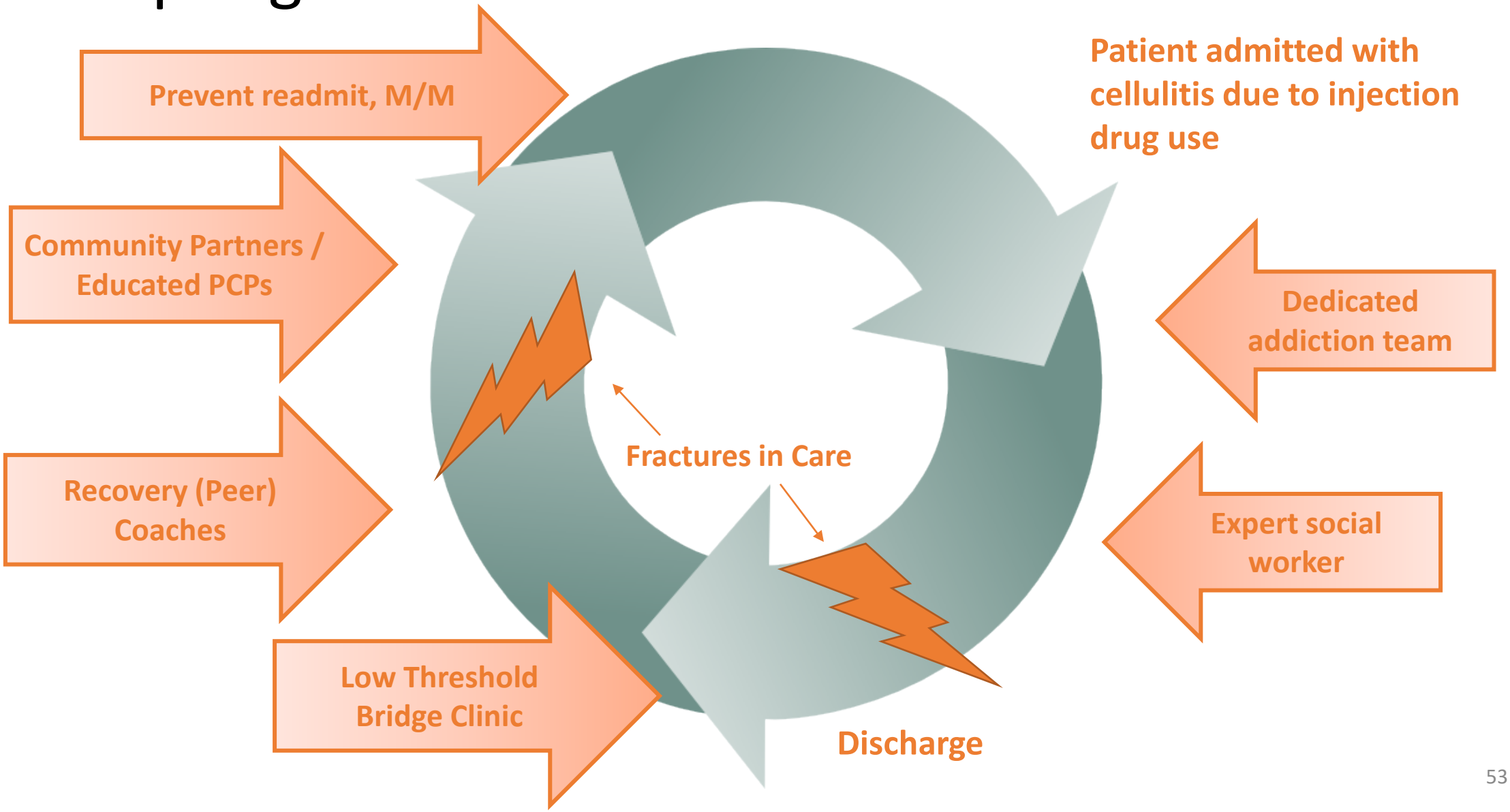
Consult service develops inpatient management plan. Patient referred to outpatient SUD treatment program.

Transportation, financial issues interfere

Discharge

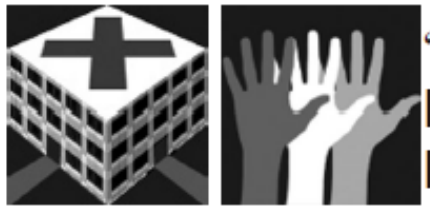
VANDERBILT HEALTH

Interrupting the "Traditional" Model of SUD Care



VANDERBILT HEALTH

Addiction Consult Services: care, connect, coordinate



"It's been an Experience, a Life Learning Experience": A Qualitative Study of Hospitalized Patients with Substance Use Disorders

Christine M. Velez, MSW[1,2], Christina Nicolaidis, MD, MPH[2,3], P. Todd Korthuis, MD, MPH[3], and Honora Englander, MD[1,4]

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BACKGROUND: Individuals with substance use disorders (SUD) have high rates of chronic illness and readmission, yet few are engaged in addiction treatment. Hospitalization may be a reachable moment for initiating and coordinating addiction care, but little is known about motivation for change in the inpatient setting.
OBJECTIVE: To explore the experiences of hospitalized adults with SUD and to better understand patient and system level factors impacting readiness for change.
DESIGN: We performed a qualitative study using individual interviews. The study was nested within a larger mixed-methods needs assessment.

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DOI: 10.1007/s11606-016-3919-4
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INTRODUCTION

Individuals with substance use disorders (SUD) have high rates of chronic illness, hospitalization, and readmission.[1–5] Despite frequent contact with healthcare systems, many people are not engaged in addiction treat-

Addiction Consult Services: care, connect, coordinate

CrossMark

Inpatient Addiction Consultation for Hospitalized Patients Increases Post-Discharge Abstinence and Reduces Addiction Severity

Sarah E. Wakeman, MD[1,2], Joshua P. Metlay, MD, PhD[1,2], Yuchiao Chang, PhD[1,2], Grace E. Herman, BA[3], and Nancy A. Rigotti, MD[1,2]

[1]Division of General Internal Medicine, Massachusetts General Hospital, Boston, MA, USA; [2]Harvard Medical School, Boston, of Psychiatry, Massachusetts General Hospital, Boston, MA, USA.

BACKGROUND: Alcohol and drug use results in substantial morbidity, mortality, and cost. Individuals with alcohol and drug use disorders are overrepresented in general medical settings. Hospital-based interventions offer an opportunity to engage with a vulnerable population that may not otherwise seek treatment.
OBJECTIVE: To determine whether inpatient addiction consultation improves substance use outcomes 1 month after discharge.
DESIGN: Prospective quasi-experimental evaluation comparing 30-day post-discharge outcomes between participants who were and were not seen by an addiction consult team during hospitalization at an urban academic hospital.
PARTICIPANTS: Three hundred ninety-nine hospitalized adults who screened as high risk for having an alcohol or

from baseline severity, the differences
cally significant.
CONCLUSIONS: In a non-randomized
inpatients, addiction consultation red
verity for alcohol and drug use and inc
of days of abstinence in the first mo
discharge.

KEY WORDS: addiction; substance use disorder; hospitalized patients; post-discharge abstinence.
J Gen Intern Med 32(8):909–16
DOI: 10.1007/s11606-017-4077-z
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INTRODUCTION

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Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

ELSEVIER

Regular articles

Addiction consultation services – Linking hospitalized patients to outpatient addiction treatment

CrossMark

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ABSTRACT

Background: Approximately 15% of hospitalized patients have an active substance use disorder (SUD). Starting treatment for SUD, including medications, during acute hospitalizations can engage patients in addiction care. In July 2015, the Boston Medical Center Addiction Consult Service (ACS), began providing inpatient diagnostic, management, and discharge linkage consultations. We describe this implementation.
Methods: The ACS staff recorded SUDs diagnoses and medication recommendations and tracked follow-up data

Wakeman et al, 2017, Trowbridge et al, 2017.

Vanderbilt Model: VISTA

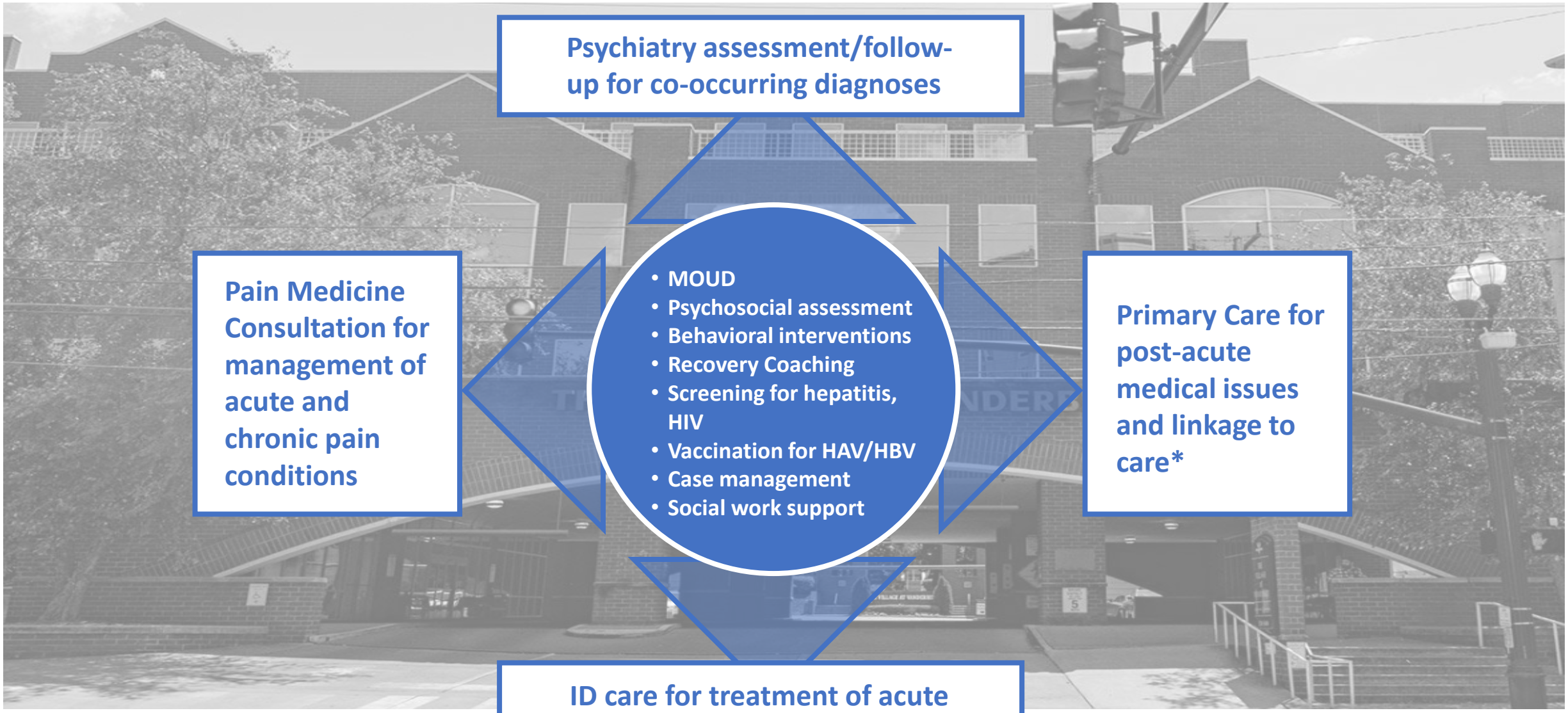
- *mid 17th century: from Italian, literally 'view', from visto 'seen', past participle of vedere 'see', from Latin videre .*

1. a pleasing view, especially one seen through a long, narrow opening
2. Vanderbilt Integrated Services for the Treatment of Addiction

Emergency Department and Psych ED	Addiction Consult Service	Bridge Clinic	Outpatient Addiction Clinic	Inpatient Dual Unit	IOP	ECHO
Buprenorphine-waivered physicians and SUD-focused social worker can triage patients with SUD in the ED and provide assessment, MAT initiation and referral.	Dedicated consultation service within Vanderbilt University Hospital (general hospital) to evaluate, assess, manage and refer any patient with SUD in adult hospital	Three-month multi-specialty outpatient transitional clinic to stabilize appropriate patients with SUD discharging from Vanderbilt Adult Hospital and ED/Psych ED	Outpatient services ranging from MAT and psychiatric care to counseling, case management, group, family and individual therapy. Clinic will eventually have capacity to receive a steady flow of patients from within our system	Inpatient team including psychiatrist, social worker and additional staff providing stabilization, evaluation and management services on a contained unit to complex patients with SUD and co-occurring psychiatric issues	Professional clinic team offering multiple extended outpatient group therapy and psychoeducation visits per week for patients with SUD and co-occurring psychiatric issues	Tele-education platform leveraging the expertise of VUMC faculty to assist statewide efforts to expand addiction treatment capacity

VANDERBILT HEALTH

Vanderbilt Bridge Clinic Clinical Services



Psychiatry assessment/follow-up for co-occurring diagnoses

Pain Medicine Consultation for management of acute and chronic pain conditions

- MOUD
- Psychosocial assessment
- Behavioral interventions
- Recovery Coaching
- Screening for hepatitis, HIV
- Vaccination for HAV/HBV
- Case management
- Social work support

Primary Care for post-acute medical issues and linkage to care*

ID care for treatment of acute infection; initiation of HCV treatment

*Referral for Women's Health Services when needed

The Treatment Team: Wrap-Around Support

- Primary providers
  - Addiction Psychiatry, Internal Medicine, ID, Pain Management
- Intensive Case Management
- Social Work/Brief Interventions
- Peer Recovery Coaches

- Warm handovers at each transition in care
- Encourage patients to engage in recovery community

The Treatment Team: Wrap-Around Support

TN Department of Mental Health & Substance Abuse Services

Go to TN.gov

Search Mental Health & Substance Abuse

Crisis Services | Mental Health Services | Substance Abuse Services | Hospital Services | Licensing | Data | For Providers | Who We Are

NOVEL CORONAVIRUS - COVID-19: INFORMATION FOR COMMUNITY BEHAVIORAL HEALTH PROVIDERS, CONSUMERS, AND FAMILIES

Certified Peer Recovery Specialist Program

- **What is a Certified Peer Recovery Specialist?**
- CPRS Stories
- Certification: Part One
- Certification: Part Two
- Renewing Your Certification
- CPRS Handbook

What is a Certified Peer Recovery Specialist?

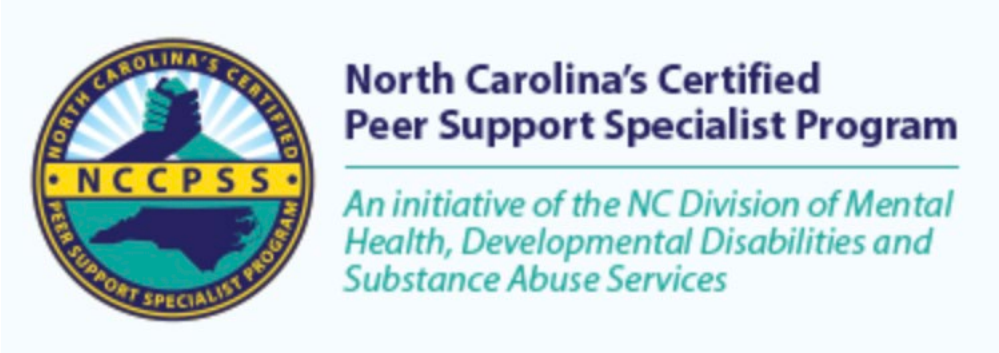
A Certified Peer Recovery Specialist (CPRS) is someone who has self-identified as being in recovery from mental illness, substance abuse, or co-occurring disorders of both mental illness and substance use disorder. To become certified, a CPRS has completed specialized training recognized by the Tennessee Department of Mental Health and Substance Abuse Services on how to provide peer recovery services based on the principles of recovery and resiliency.

Certified Peer Recovery Specialists can provide support to others with mental illness, substance abuse, or co- occurring disorder and help them achieve their personal recovery goals by promoting self-determination, personal responsibility, and the empowerment inherent in self-directed recovery.

The Treatment Team: Wrap-Around Support

Southeastern states with Peer Recovery Specialist certification programs

GEORGIA DEPARTMENT *of*
BEHAVIORAL HEALTH *and* DEVELOPMENTAL DISABILITIES



Working with Patients in the Outpatient Setting

"…immediate abstinence may *not* be a realistic goal for patients early in treatment."

"In the event that a patient's self-reported substance use differs from the results of a drug test, the provider should use the discrepancy as a springboard for therapeutic discussions."

2017 ASAM Consensus Statement

Working with Patients in the Outpatient Setting

ASAM Levels of Care

Cyclical Reassessment

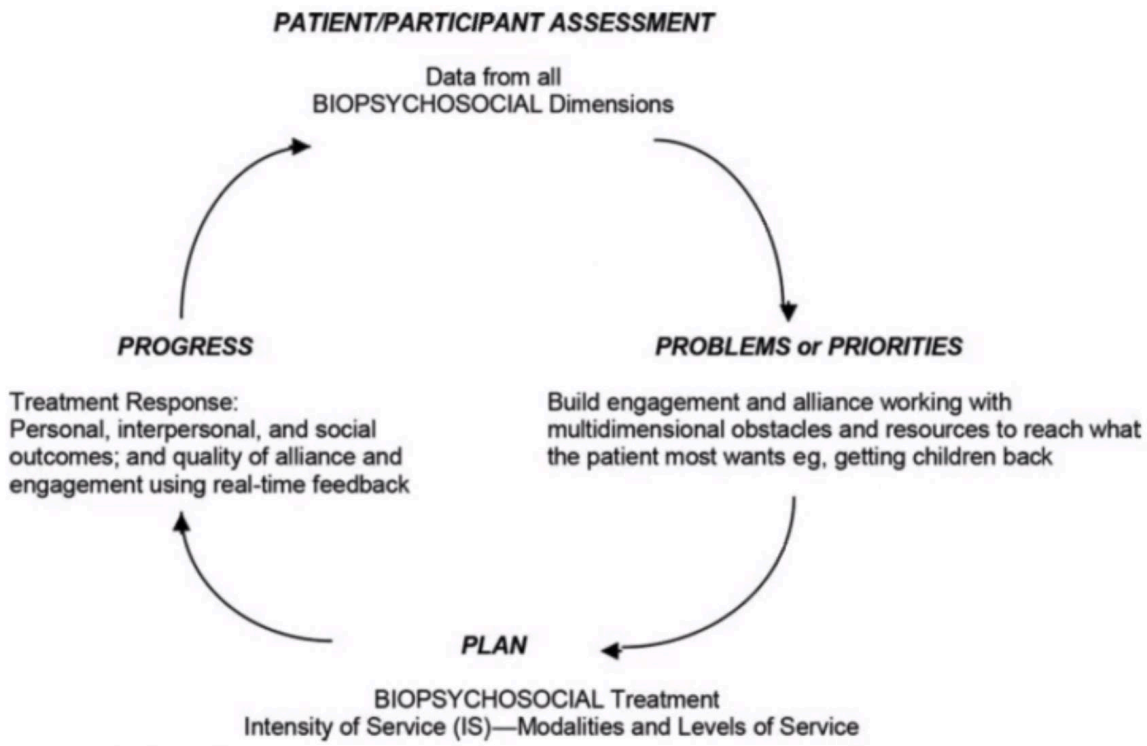


Figure 30.1. Individualized, outcome-driven treatment.

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Vanderbilt Comprehensive Care Clinic

All of our patients