

# Treatment for Opioid Addiction Must Be Offered in General Hospitals: But How?

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When people are hospitalized for acute conditions, the focus is necessarily on those conditions that necessitate inpatient care. Infectious endocarditis requires parenteral antibiotics and myocardial infarction requires reperfusion strategies. At hospital discharge, the focus is facilitating completion of the course of antibiotics and treatment with cardioprotective medications, respectively. But what if the patient with endocarditis has newly identified insulin-requiring diabetes? Or if the patient with myocardial infarction has hypercholesterolemia and hypertension? In such cases, those diseases (the diabetes, hypercholesterolemia, and hypertension) are treated, as they are known risk factors for the acute conditions (endocarditis, myocardial infarction) and they are diseases that should be treated in their own right. It would be unimaginable for patients with those conditions known to be present during hospitalization to be discharged without further treatment, or with simply a phone number to call (a referral).

What happens to people with opioid use disorder (OUD) (addiction) hospitalized for endocarditis, cellulitis, and osteomyelitis? Not much in the way of treatment for the OUD. Aside from the fact that there is no rationale to treat OUD differently from other health conditions, there are serious preventable consequences to not treating it. The missed opportunity to begin treatment is associated with preventable emergency department visits and readmissions to the hospital (Walley et al., 2012), morbidity and mortality, including deaths from overdose. Mainstays of addressing the epidemic of opioid overdose deaths include safer opioid prescribing, access to naloxone and expansion of pharmacotherapy. Although applicable in hospital settings, much of the focus of these efforts, necessarily, has been on primary care and specialty treatment settings and clinicians.

Almost 15% of patients in general hospitals have a substance use disorder (Walley et al., 2012). Hospitalizations related to opioid use have been increasing and many of those hospitalizations are because of complications, such as infections (Owens et al., 2014; Wurcel et al., 2016). Starting treatment for OUD in the hospital (during hospitalization and at discharge) is feasible (O'Toole et al., 2006; Shanahan et al., 2010) and medication treatments (eg, methadone, buprenorphine, and naltrexone) are not prevented by regulations (Noska et al., 2015). Treatment at hospital discharge can not only facilitate linkage to outpatient addiction treatment and reduce substance use but also can reduce emergency utilization and increase completion of medical treatments for the acute condition prompting the hospitalization (Liebschutz et al., 2014; Wakeman et al., 2017). Despite increasing prevalence and known efficacious treatments, OUD treatment, even referral for treatment, is uncommon (Naeger et al., 2016; Rosenthal et al., 2016). For example, fewer than 8% of patients with injection drug use-associated endocarditis were discharged with a plan to start medication treatment for OUD (Rosenthal et al., 2016).

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On the basis of what we know, simply issuing an edict or guideline promulgating initiation of OUD treatment when it is identified in general hospital patients would seem to be akin to picking low hanging fruit. But it appears not to be the case. Barriers include lack of expertise and prescribers in hospitals and in outpatient settings to continue care after hospital discharge. To begin to address this care gap, some hospitals are creating addiction medicine consultation services to deliver direct clinical care and to stimulate the creation of care systems for follow-up outpatient care.

Two articles in this issue of the *Journal* address general hospital treatment of OUD. One describes consultation services at institutions that have addiction medicine fellowship training programs. The other describes a well-developed and well-characterized service to improve care for people with addiction in general hospitals at 1 medical center.

Englander et al. (2019) describe best practices of the Improving Addiction Care Team (IMPACT) at the Oregon Health & Science University. In this detailed description, one can see not only how challenging it might be for a hospital with little or no available expertise to provide addiction care but also solutions to such challenges. Authors not only describe their extensive experience with this novel service but also provide detailed guidance, protocols and description of the care delivered. Such detail includes information on financing (from billing, Medicaid, and the hospital itself), staff (medical and social work clinicians, peer recovery mentors), team functions like care coordination (which includes both individual care and program and systems changes), connections to community care delivery programs and systems, and, in supplementary digital material, protocols for pharmacotherapy initiation, withdrawal management, opioid use disorder medication treatment, pain management, mental illness screening and management, harm reduction, and behavioral therapies.

Priest and McCarty (2019) report findings from interviews of key informants at 9 addiction medicine consultation services at hospitals that have addiction medicine fellowships. They report that in addition to providing direct clinical services, these consultants also took on culture change, education, and guidance documents for hospitals. Financial support for these services was precarious.

These 2 articles provide very useful guidance for general hospitals seeking solutions on how to provide care for inpatients with opioid addiction. Materials provided by Englander et al. (2019) can be downloaded, reviewed, and used to design and implement care. However, the articles also point out challenges to be taken on by clinicians and researchers. Getting care to such patients in these settings is not as simple as publishing a practice guideline that cites clinical trial evidence for efficacy. Initiating OUD treatment in hospitals and at hospital discharge will require making the case to healthcare leaders, disseminating expertise through the workforce to where it is needed, attention to financing these services, and improving immediate access to medication treatment postdischarge in outpatient settings. Perhaps as important, clinicians and researchers will need to be creative in better understanding implementation of hospital-based

opioid treatment services. Must they be staffed by addiction medicine physicians? Nurse practitioners? Physician assistants? Nurses? Psychologists? Social workers? Counselors? Peers? Psychiatrists? Case managers? And if so, how much time is needed and what is the distribution of responsibilities? Are all of their efforts needed on site? How much variability can there be in the design of these services and their components? What will it take to make care available at the thousands of acute care hospitals in the United States? These questions should all be answered soon, but without delaying provision of care to all who need it.

It is unacceptable to discharge a patient with insulin-requiring diabetes from an acute care hospital with no prescription for insulin and instead a referral to or phone number of a diabetes treatment program where the patient may be seen some weeks hence. It should be similarly unacceptable to discharge a patient with OUD from an acute care hospital without starting medication known to have efficacy for OUD (assuming the patient has not declined it), and with only a referral to an addiction treatment program. Addiction consultation services offer one way to disseminate access to care in hospitals and the articles in this issue of the *Journal* provide important information relevant to their implementation.

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