SUMHI Action Update

Optimizing care of patients with substance use within the Dartmouth Hitchcock Health System

9-16-19

The D-HH Substance Use & Mental Health Initiative envisions
a health care system where mental health & substance use disorders are treated with the same urgency, respect and seriousness of purpose as other illnesses and where discrimination does not occur.

Welcome

Sally Kraft MD, MPH; V.P. for Population Health D-HH
Will Torrey, MD;   Vice Chair for Clinical Services, D-HH Dept of Psychiatry

Leaders, D-HH Substance Use & Mental Health Initiative (SUMHI)

- Please sign in or send chat message to tell us who is at your webinar site.
- Goals
  - Update D-H staff and others with interest on advances within the D-HH system to improve care of patients with OUD and reduce opioid related harm
  - Identify unidentified or persisting challenges related to substance use
  - Identify opportunities to expand engagement & collaboration
- CME
  - Dartmouth-Hitchcock is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
  - Dartmouth-Hitchcock designates this live activity for a maximum of ***1.5 AMA PRA Category 1 Credits™***. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
  - Quick tips cards are located at the front of the room
  - Activity Code For This Session Only: gftj
    Use This Number to Text Requests For Credit: 603-346-4334
  - There are no conflicts to disclose for this session

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- Evolving Therapeutic Cannabis Guidelines – *Cindy Reuter ND, RD, MPH or Will Torrey MD*
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OATC Update

Opioid Interest Group meeting

9/16/19

Goals of the Opioid Addiction Treatment Collaborative

- Increase understanding that OUD is a treatable chronic disease that should be addressed without judgement or stigma
- Identify inpatients with OUD and encourage initiation of medication and counseling during the admission
- Identify ED patients with OUD and initiate medication
- Develop a referral network of treatment programs and community supports ready to receive patients initiated on medication in a timely fashion
- Mainstream multi-disciplinary treatment of OUD into D-H primary care through expansion of the Collaborative Care Model

Opioid Addiction Treatment Collaborative (OATC) at D-H: Updates

Primary Care Workgroup

> CGP expansion in conjunction w/CoCM and CCSA roll out; as well as Educ & Culture Training support from S. Savage

> Continue to increase # of waivered providers & those prescribing (see metrics slides)

ED Workgroup

> Increased # of bup orders and Rx in ED

> Peer recovery coach is now regular employee, ↑ activation rate

>New Med Dir and 2 new ED providers joining

>Grant CTN99

Inpatient Workgroup

> Inpt screening roll-out on target (4E most recent; next unit 2W)

> AmeriCorps staff joined team, follow-up w pts after d/c

>Met with hospitalists 9/3

>Anesthesiology Grand Rounds 9/13

>Surgery Grand Rounds

>Collaborating with "Improving Care for Pts w/IDU & Infections" Project

Metrics

> Ongoing weekly OATC metrics mtg

> Capturing increasing CGP bup prescribing

> ED report added to OATC Dashboard

> Slow progress: Harvesting data from BITeam notes, BAM results, delays in showing monthly #s, etc.)

Transitions Workgroup

> Current Transitions work under the leadership of Luke Archibald, NH Doorway

D-H Health Quality and Safety Goals FY19 ACTUAL & FY20 PLANNING (as of 08/06/19)

Strategic Imperatives	Key Performance Domains	Performance Goals Within Each Domain FY20 Targets may change when add VNH FY19 Performance	FY18 Actual Baseline	FY19 Proj Actual thru June	FY19 Final Target	FY20 Draft Target	D-HH FY19 Final
OUR PATIENTS	Inpatient Quality	Reduce count of Hospital Acquired Conditions (HACs)/Home Health Acquired Events by 10%	298	300	253	270	
	Ambulatory Quality	Increase preventive screening by 10%	76.1%	76.2%	83.7%	83.8	
	Patient Safety	Standards program adherence at 95% or better	71.5%	93.0%	90.0%	95.0%	
		Reduce count of Serious Safety Events to 16	18	16	16	16	
		Increase count of Near Miss reports by 10%	1,439	2,106	1,583	2,317	
	Patient Experience	Increase "Overall Rating" of Hospital/Home Health Score by 1%	75.9%	76.2%	77.4%	77.0	
		Increase "Overall Rating" of Provider/Hospice Score by 1%	85.8%	86.2%	87.5%	87.1	
OUR PEOPLE	Employee Safety	Reduce OSHA Total Recordable Injury Rate (TRIR) by 10%	4.02	3.45	3.62	3.11	
		Reduce number of Days Away Due to Injury by 5%		3,204		3,044	
OUR COMMUNITY	Population Health	Increase the Number of Ambulatory Patients Screened for Substance Abuse Disorders by 100%					
		Increase number of Inpatient/ED Suboxone Starts for Opioid Use Disorders by 100%					

Key:
- FY19 Actual Better than FY19 Target
- Not at Target, Better than FY18 Baseline
- Not at Target, Worse than FY18 Baseline

Dartmouth-Hitchcock Health

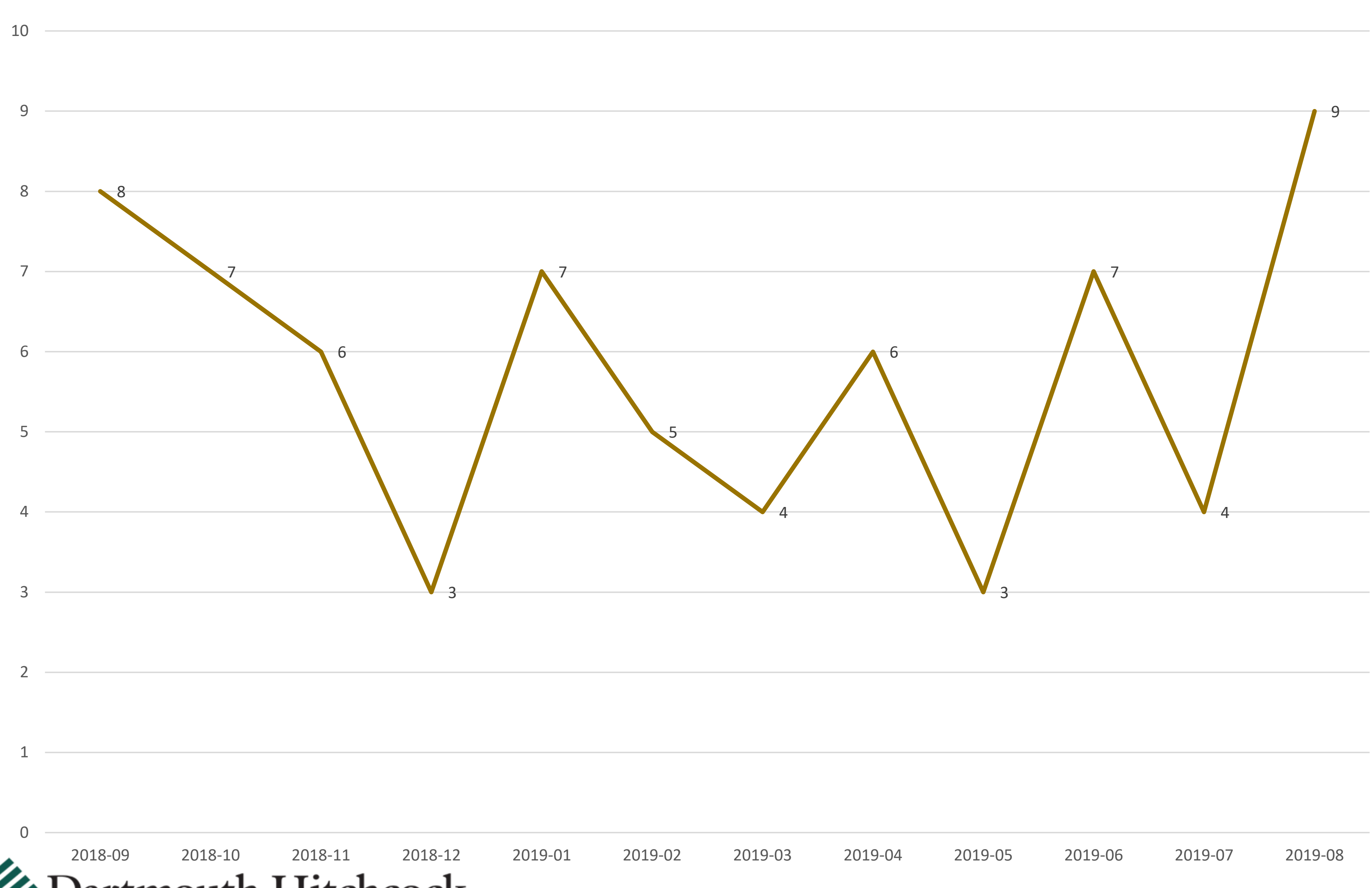
Initiation of buprenorphine on the inpatient service – FY19 & FY20 to date

YRMONTH	ORDSET	DISCH_NEW_MED	QUEST_ANS_THI	TCNT
2018-07	1	2	0	3
2018-08	1	1	0	2
2018-09	1	2	0	3
2018-10	2	2	0	4
2018-11	7	1	0	8
2018-12	2	3	0	5
2019-01	5	1	1	7
2019-02	2	1	1	4
2019-03	4	3	0	7
2019-04	4	4	0	8
2019-05	4	3	0	7
2019-06	2	3	0	5
			TOTAL FY19	63
2019-07	2	3	0	5
2019-08	7	2	1	10
			FY20 thr Aug	15

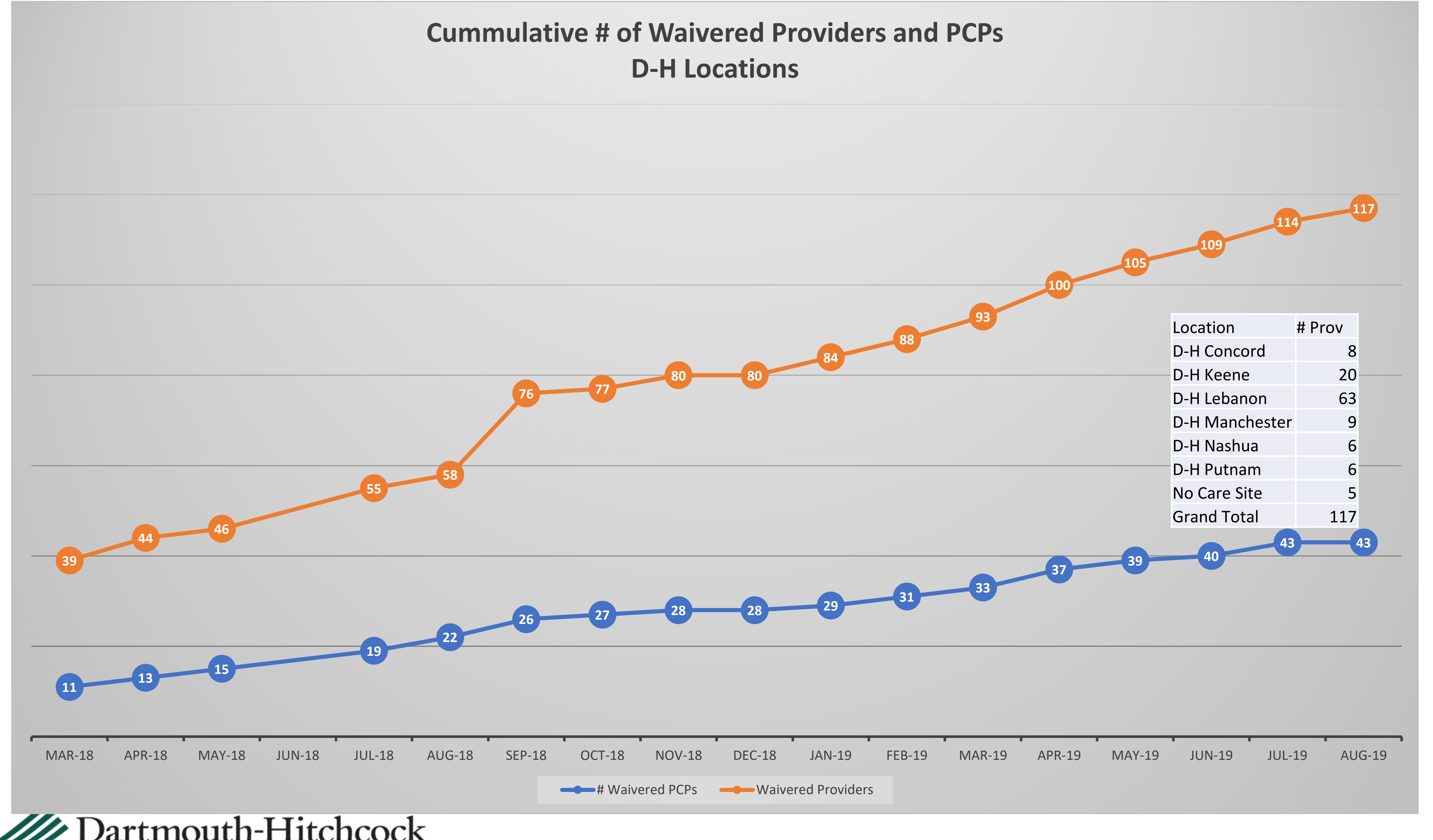
ED Initiation of buprenorphine (past 12 mos)

YRMONTH	ORDSET	ORDERQ_W RESPONSE	OUTPATIENT _MED	TCNT
2018-09	1	0	1	2
2018-10	0	0	1	1
2018-11	1	0	0	1
2018-12	0	0	0	0
2019-01	0	2	1	3
2019-02	0	2	0	2
2019-03	1	1	0	2
2019-04	0	1	1	2
2019-05	0	1	0	1
2019-06	0	2	0	2
2019-07	1	0	0	1
2019-08	0	3	1	4
				22

Patients Initiated on Bup in PC in the past year



Dartmouth-Hitchcock



Location	# Prov
D-H Concord	8
D-H Keene	20
D-H Lebanon	63
D-H Manchester	9
D-H Nashua	6
D-H Putnam	6
No Care Site	5
Grand Total	117

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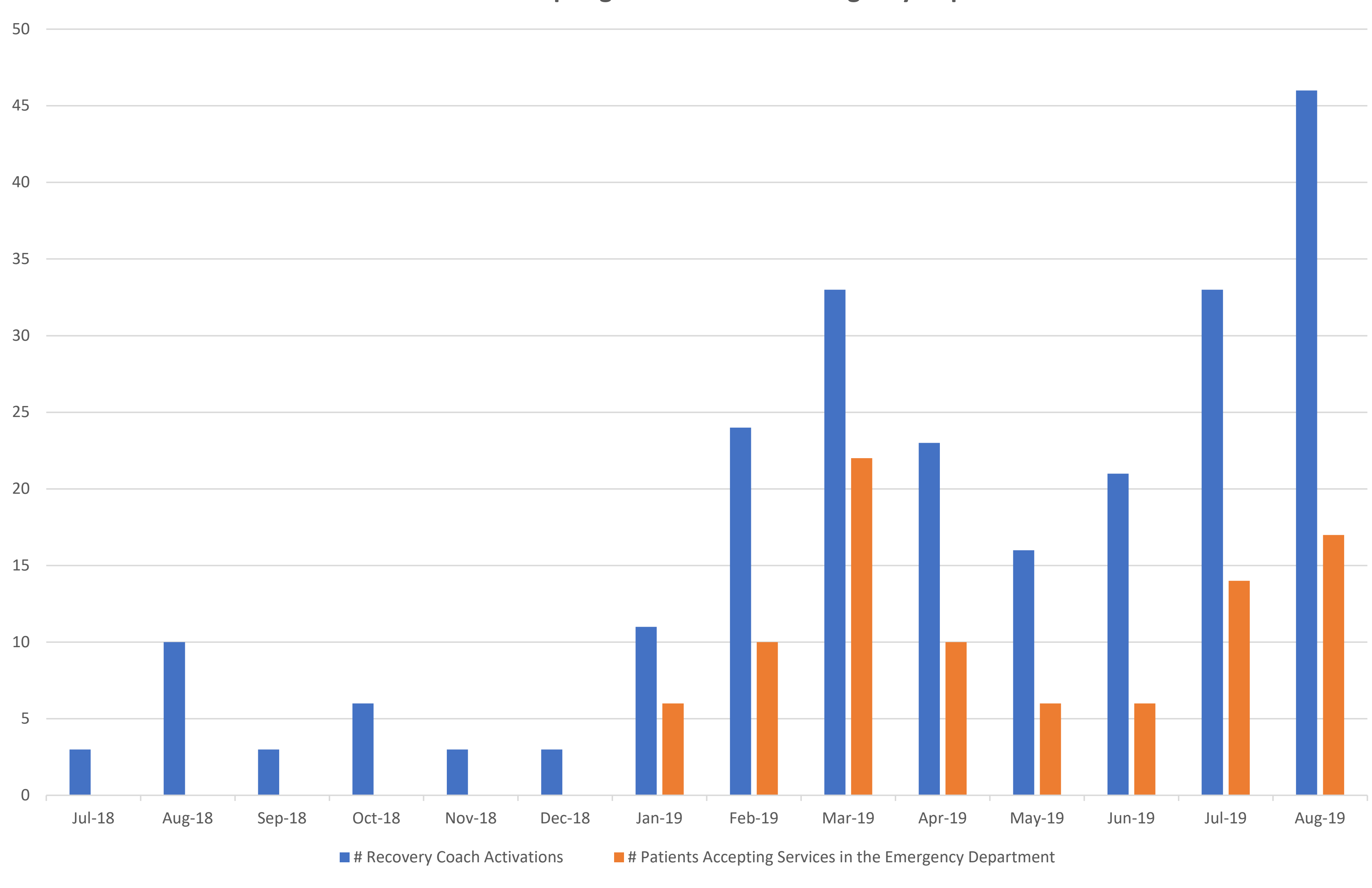
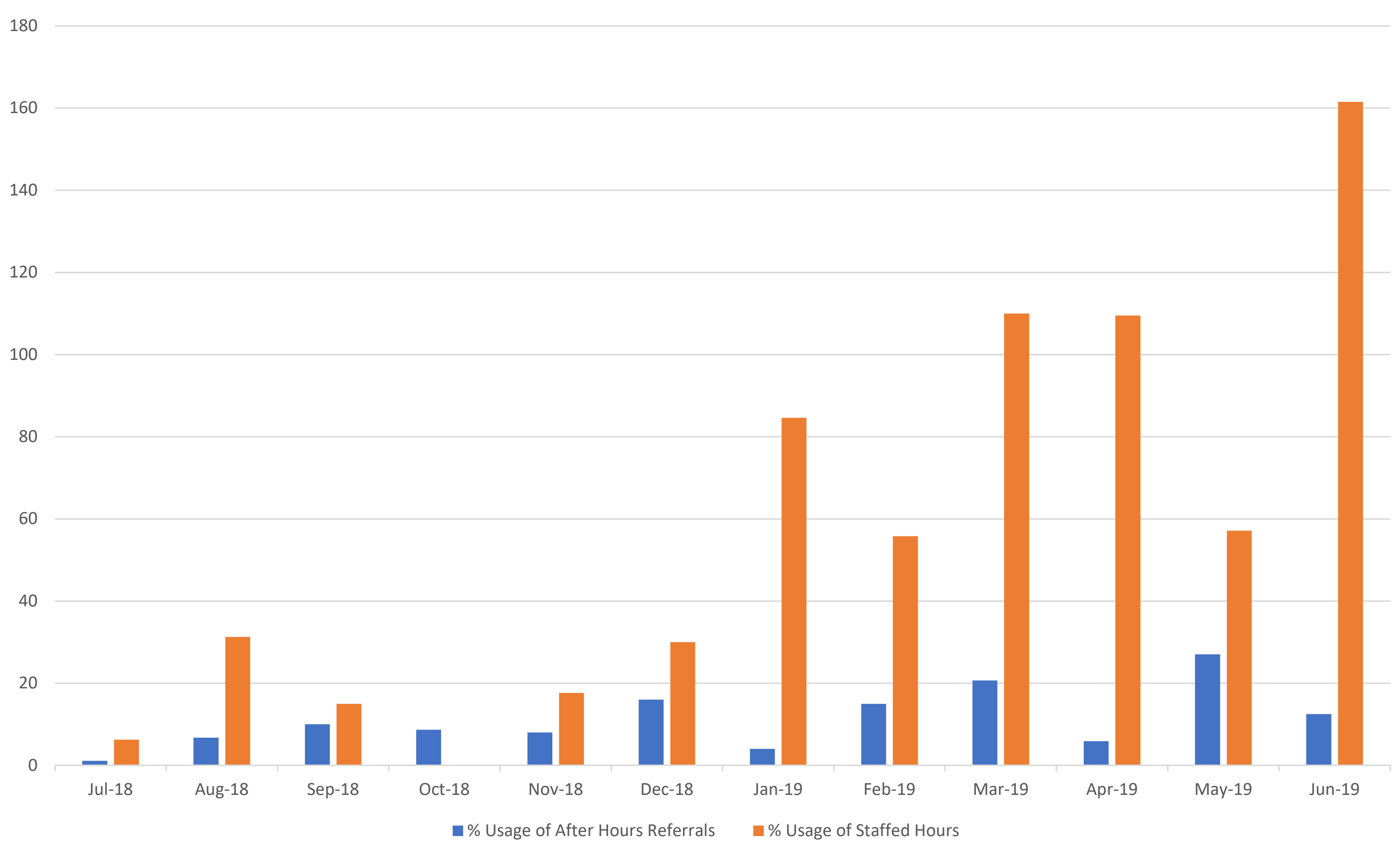
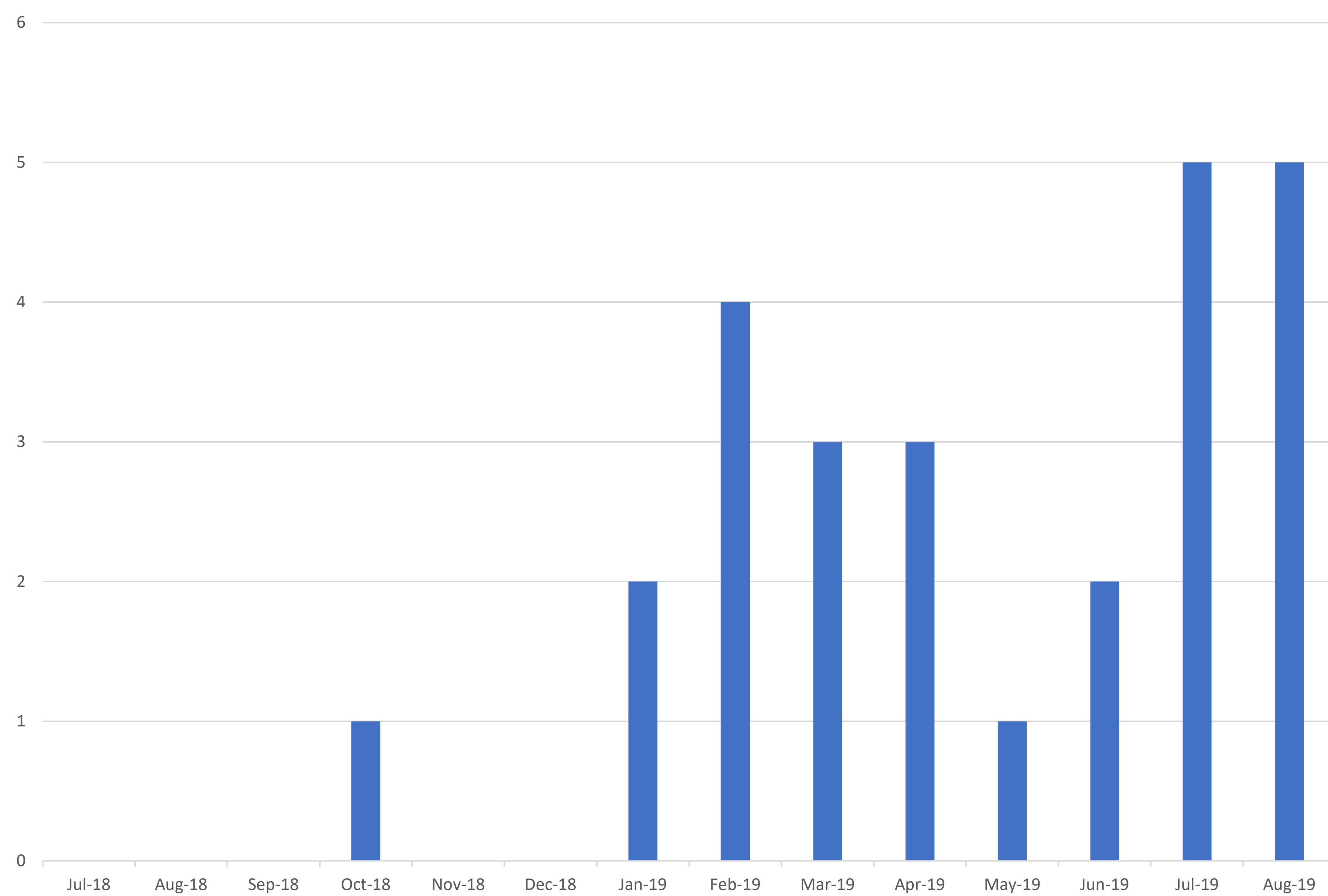


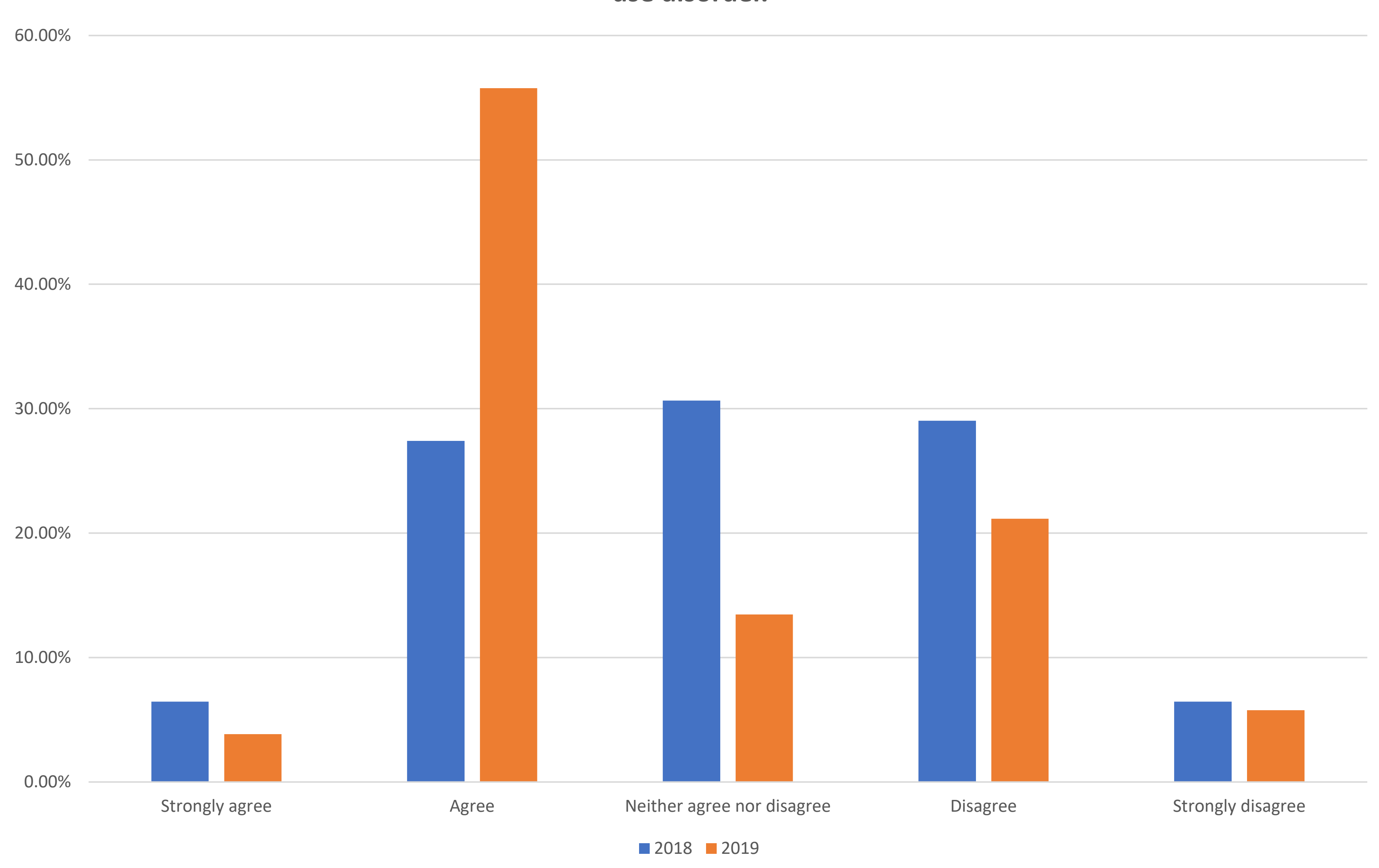
Activations vs. Accepting Services in the Emergency Department
50
45
40
35
30
25
20
15
10
5
0
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Recovery Coach Activations
Patients Accepting Services in the Emergency Department

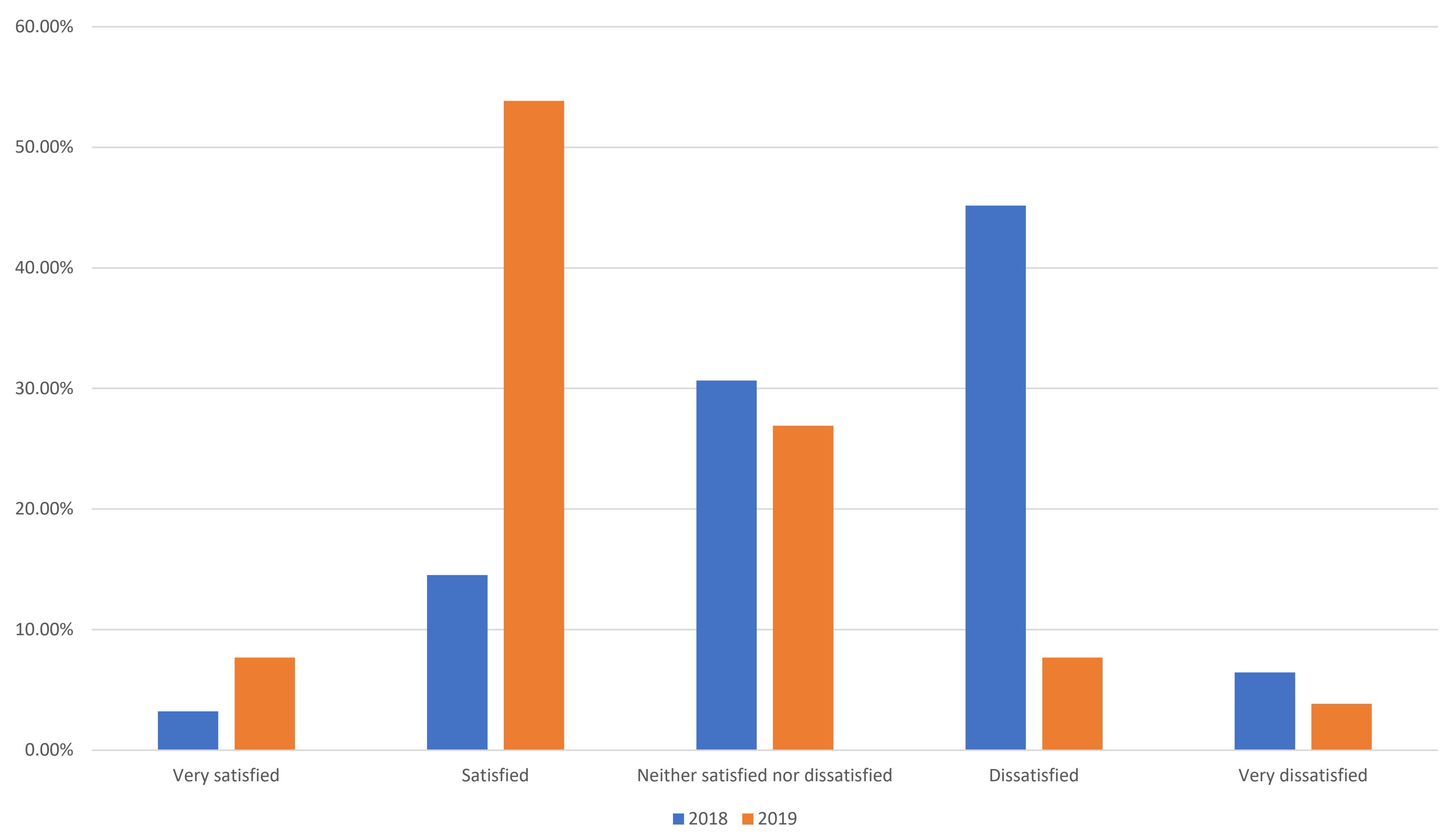


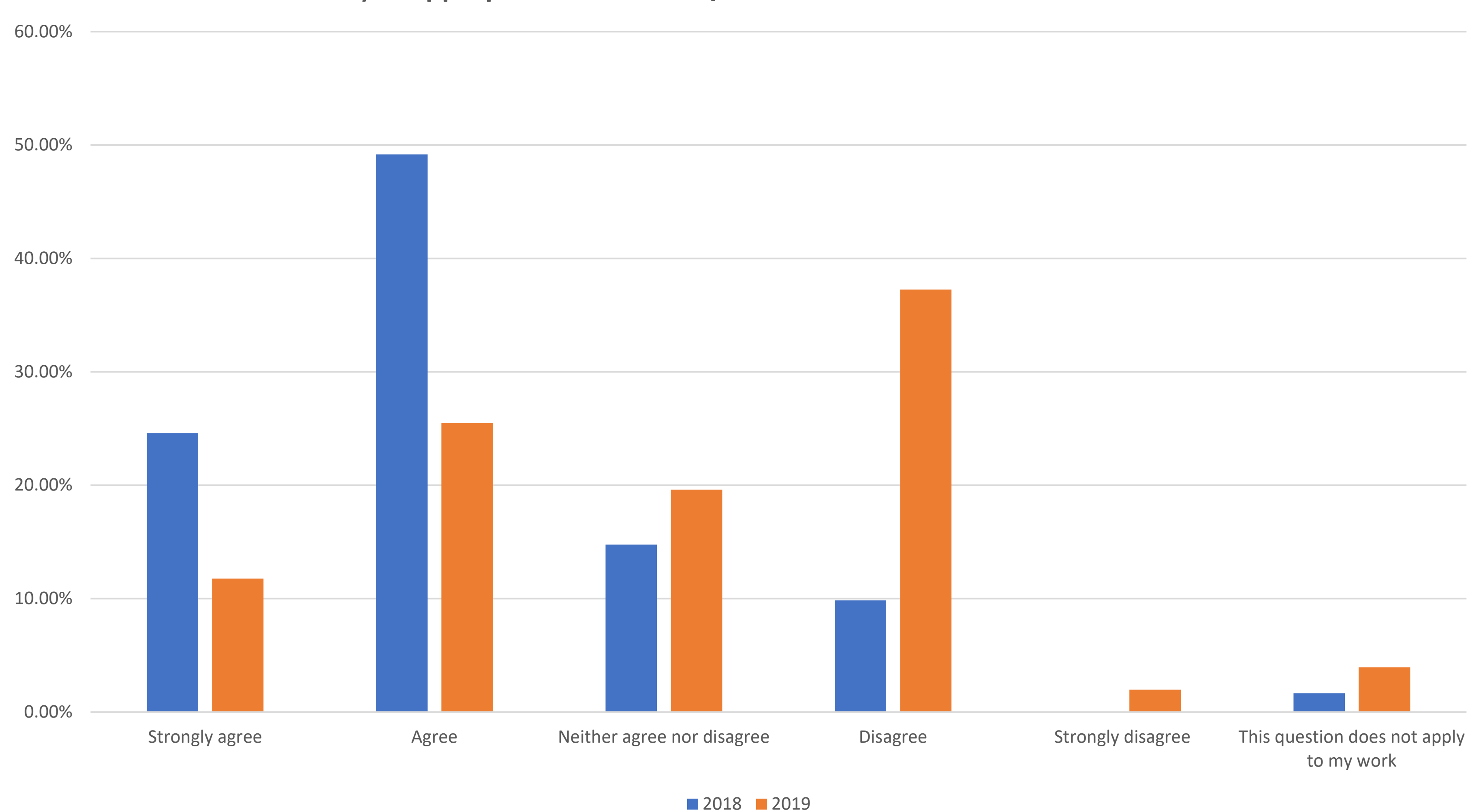
% Utilization of Program Services
180
160
140
120
100
80
60
40
20
0
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
% Usage of After Hours Referrals
% Usage of Staffed Hours



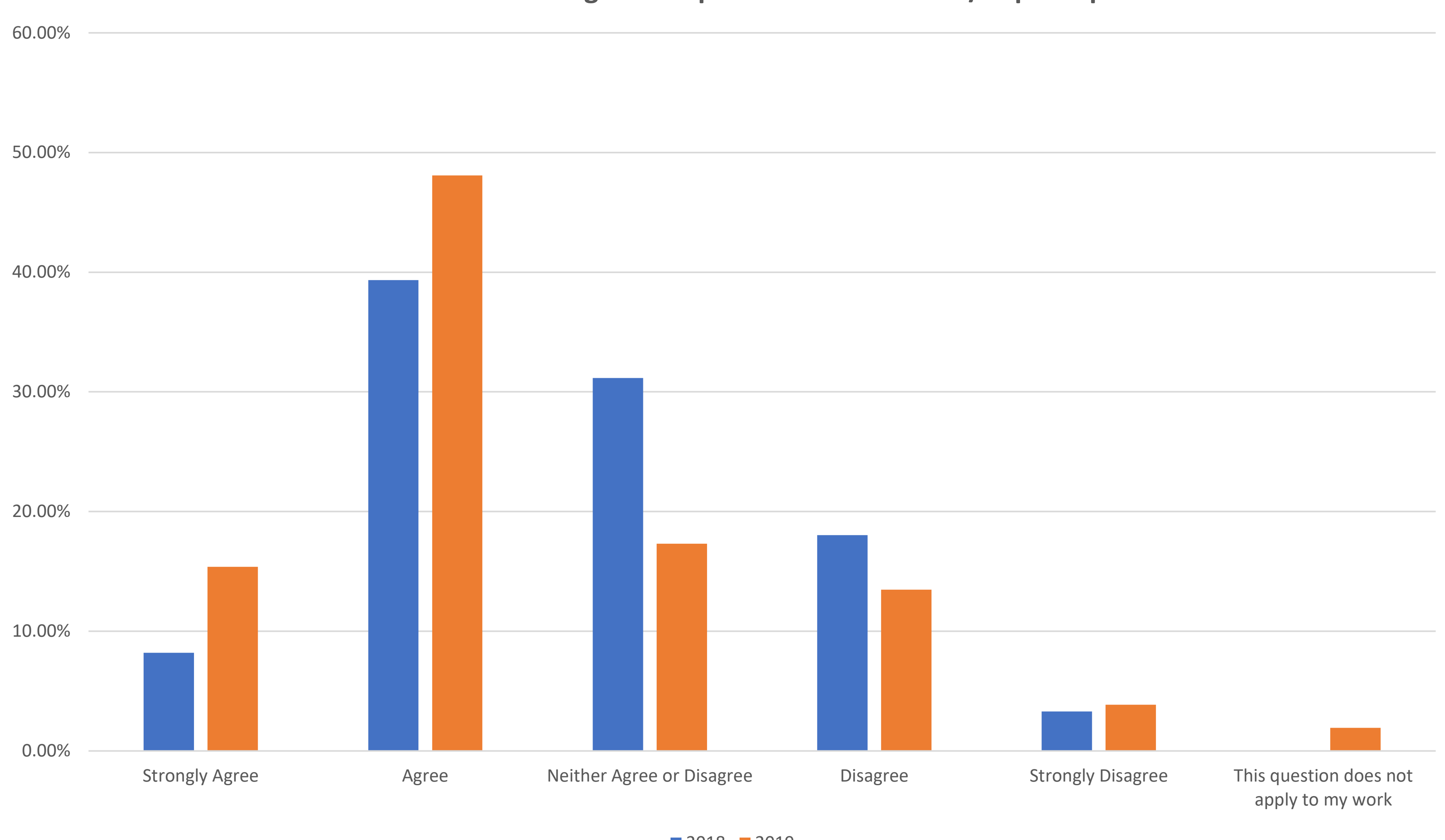
# of Naloxone Kits Dispensed
6
5
4
3
2
1
0
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19


Emergency Department Staff Survey 2018/2019:
“My team is adequately resourced to care for people with substance misuse or substance use disorder.”
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
2018
2019


Emergency Department Staff Survey 2018/2019:
“How satisfied are you with the internal resources currently available to identify and treat ED patients substance use issues (including alcohol, opioids, etc.)?”
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Very satisfied
Satisfied
Neither satisfied nor dissatisfied
Dissatisfied
Very dissatisfied
2018
2019



Emergency Department Staff Survey 2018/2019:
"I find it difficult to refer ED patients with substance use issues (including alcohol, opioids, etc.) to appropriate assessment/treatment due to lack of resources."
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
This question does not apply to my work
2018
2019


Emergency Department Staff Survey 2018/2019:
"I feel comfortable taking care of patients on suboxone/bupenorphine."
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Strongly Agree
Agree
Neither Agree or Disagree
Disagree
Strongly Disagree
This question does not apply to my work
2018
2019

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Syringe Service Programs in the Upper Valley

Laura Bryne, HIV/HCV Resource Center
Ashley Greenfield, DHMC - Population Health

HIV/HCV
Resource Center

What are Syringe Service Programs?

Value of Syringe Service Programs

SSPs Increase Entry Into Substance Use Disorder Treatment:

SSPs **reduce drug use**. People who inject drugs (PWID) are 5 times as likely to enter treatment for substance use disorder and more likely to reduce or stop injecting when they use an SSP.

SSPs Reduce Needlestick Injuries:

SSPs **reduce needlestick injuries** among first responders by providing proper disposal. One in three officers may be stuck with a needle during their career. Increasing safe disposal also protects the public from needlestick injuries. SSPs do not increase local crime in the areas where they are located.

SSPs Reduce Overdose Deaths:

SSPs **reduce overdose deaths** by teaching PWID how to prevent and respond to drug overdose. They also learn how to use naloxone, a medication used to reverse overdose.

3,600 HIV Diagnoses Among PWID In 2015:

SSPs **reduce new HIV and viral hepatitis infections** by decreasing the sharing of syringes and other injection equipment. About 1 in 3 young PWID (aged 18–30) have hepatitis C.

Prevention Saves Money:

SSPs **save health care dollars** by preventing infections. The estimated lifetime cost of treating one person living with HIV is more than $400,000. Testing linked to hepatitis C treatment can save an estimated 320,000 lives.

SSPs DON'T INCREASE DRUG USE OR CRIME.

Source:https://www.cdc.gov/ssp/determination-of-need-for-ssp.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhiv%2Fr

What does H2RC Provide?

- ❑ HIV and Hepatitis C
- ❑ Clean injection equipment
- ❑ Sharps containers
- ❑ Condoms
- ❑ Naloxone nasal spray to reverse opioid overdoses
- ❑ Referrals- medical,social services, drug treatment program
- ❑ Free of charge to residents of Grafton, Sullivan and Coos counties in NH and Windsor and Orange counties in VT.

First H2RC Syringe Service Program opens at Good Neighbor Health Clinic

HIV/HCV Resource Center Founded

March 2017, a second SSP opens at Springfield Health Center in Vermont

May 2019, Claremont SSP opens at Valley Regional Healthcare in New Hampshire

1991	2006	2017	2019	Future

What have we learned?

Questions?

Good Neighbor Health Clinic at 70 North Main Street in White River Junction

Days and hours: Tuesdays and Thursdays from 2:00 to 4:00pm (please arrive by 3:45pm)

Springfield Health Center at 100 River Street in Springfield VT

Days and hours: Wednesdays from 10:00am to noon (please arrive by 11:45am)

Valley Regional Hospital at 243 Elm Street in Claremont NH.
Days and hours: Thursdays from 3:30 to 6:30pm (please arrive by 6:15pm)

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Therapeutic Cannabis Project

9/16/19

TC = Therapeutic *Cannabis*

Agenda

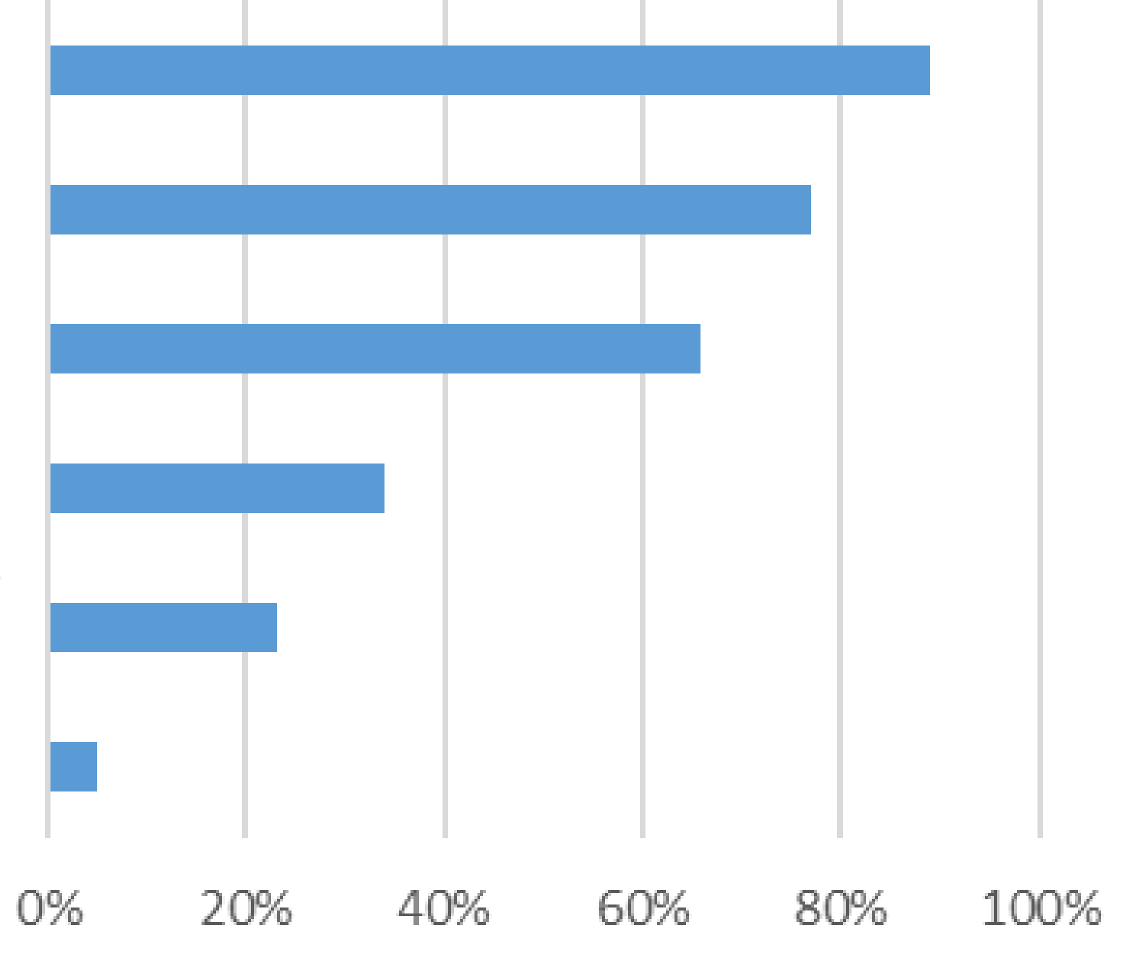
- Cannabis Clinician Survey Results
- Cannabis project deliverables
- Preliminary workgroup recommendations

Cannabis Clinician Survey Highlights

- 207 respondents
- 55% female, 44% male
- 8% PA, 17% APRN, 79% MD/DO
- Responses from all D-H divisions
- Responses from all affiliates except Bennington

D-HH Certifications

- 35% of respondents have certified ≥1 patient for TC (72/207)
- 29 clinicians have certified 1-5 patients
- 19 clinicians have certified 6-10 patients
- 12 clinicians have certified 11-15 patients
- 12 clinicians have certified >16 patients



Agree With This Statement About Therapeutic Cannabis
It has physical risks and/or side effects
It can treat some medical conditions and/or symptoms
It has mental health risks, including for addiction
A therapeutic certification is a tacit recommendation for cannabis use
There are good data for its use in NH/VT qualifying health conditions
The risks outweigh any potential benefits
0%
20%
40%
60%
80%
100%

DISAGREE with this statement about Therapeutic Cannabis

The risks outweigh any potential benefits

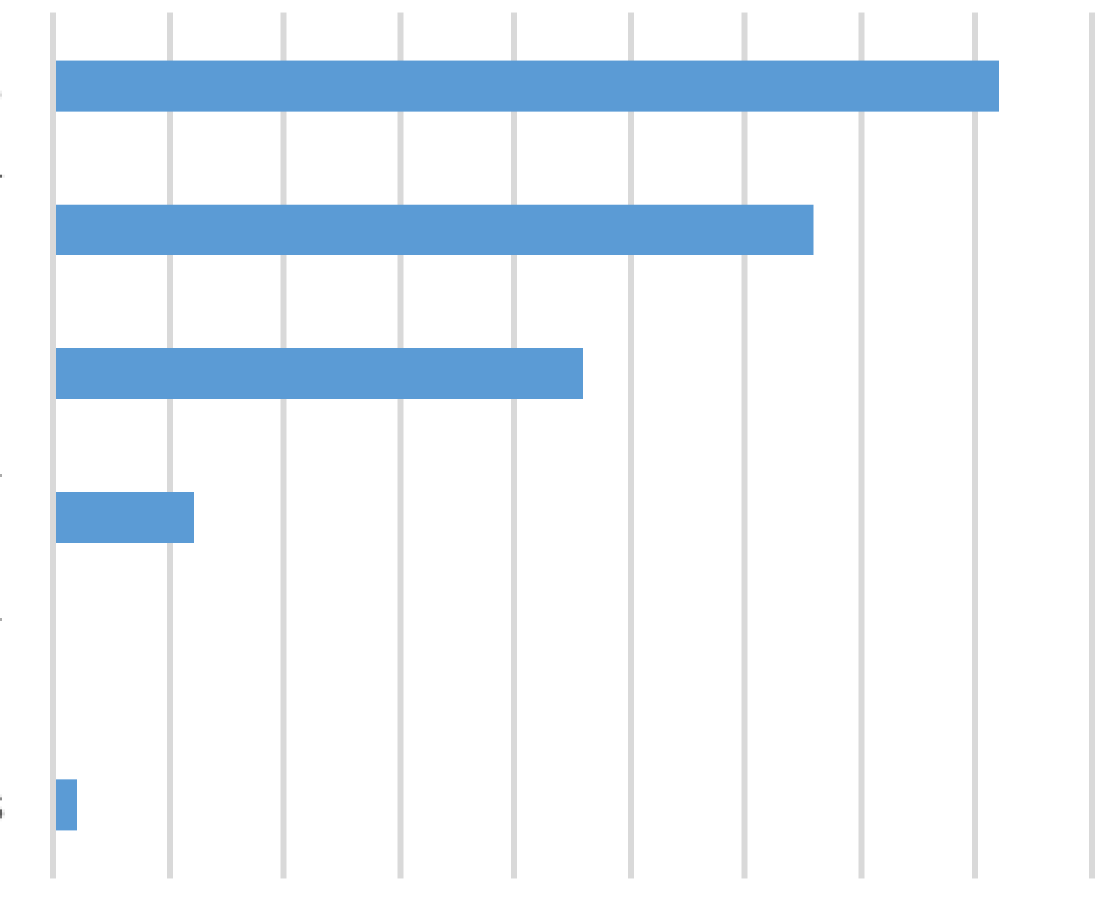
There are good data for its use in NH/VT qualifying health conditions

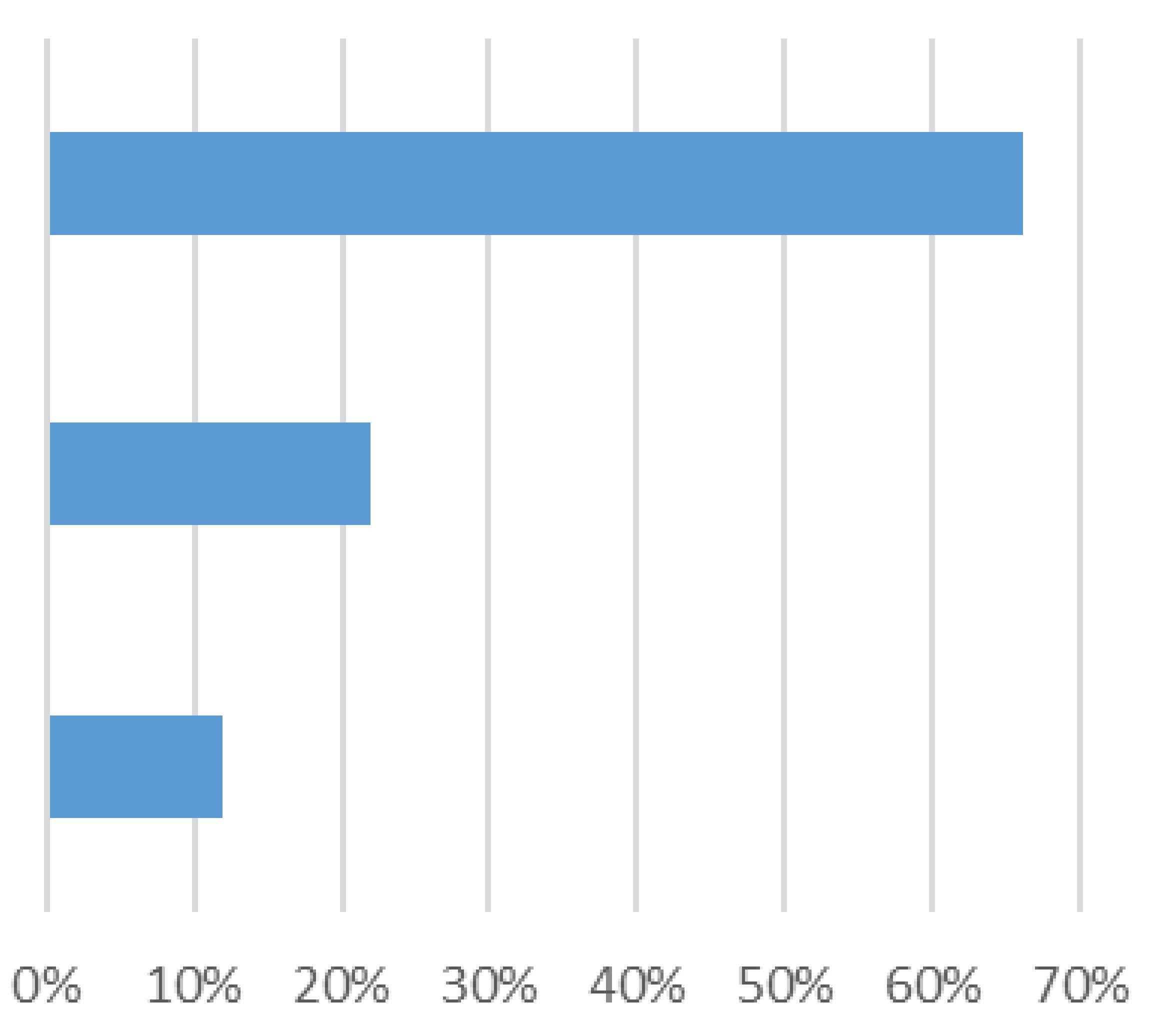
A therapeutic certification is a tacit recommendation for cannabis use

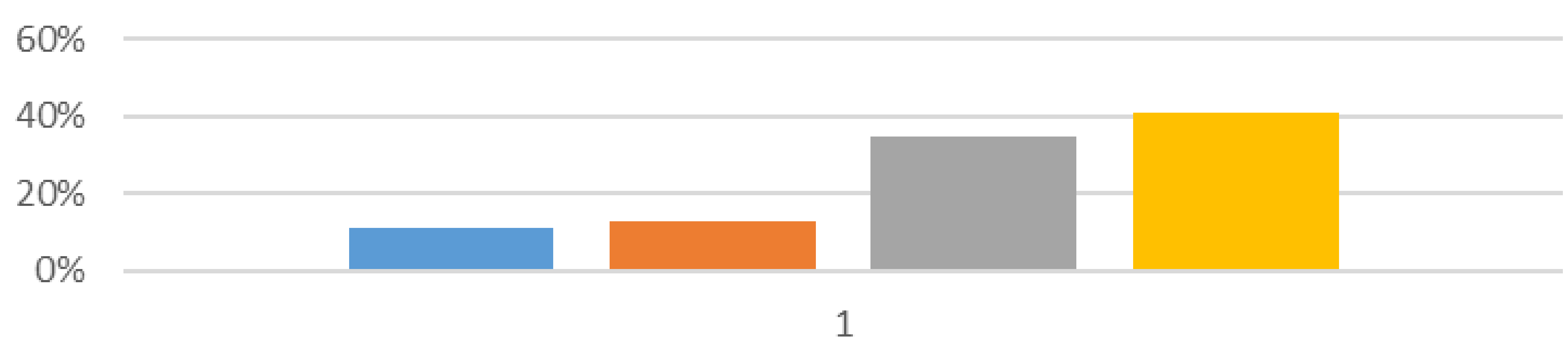
It has mental health risks, including for addiction

It can treat some medical conditions and/or symptoms

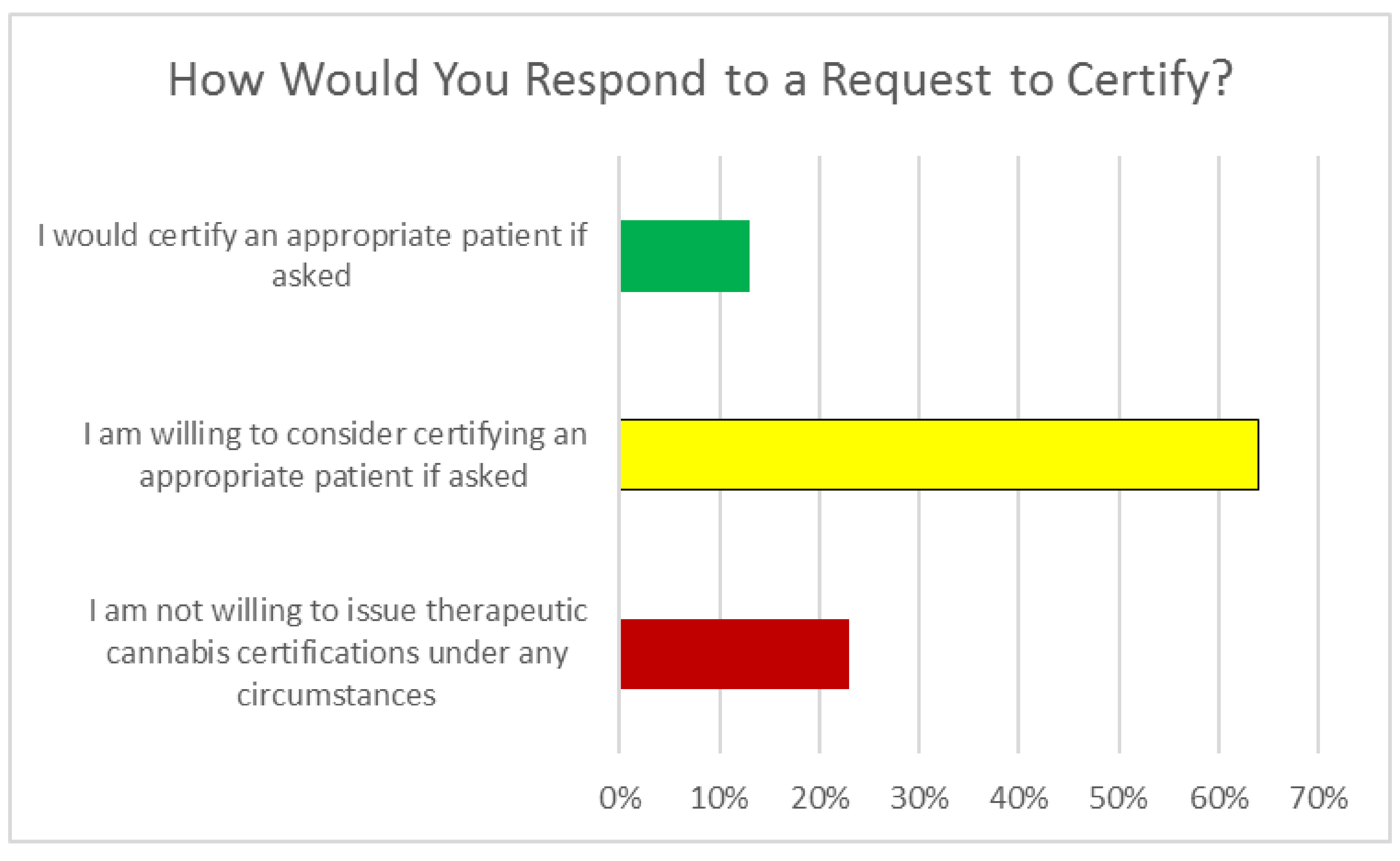
It has physical risks and/or side effects

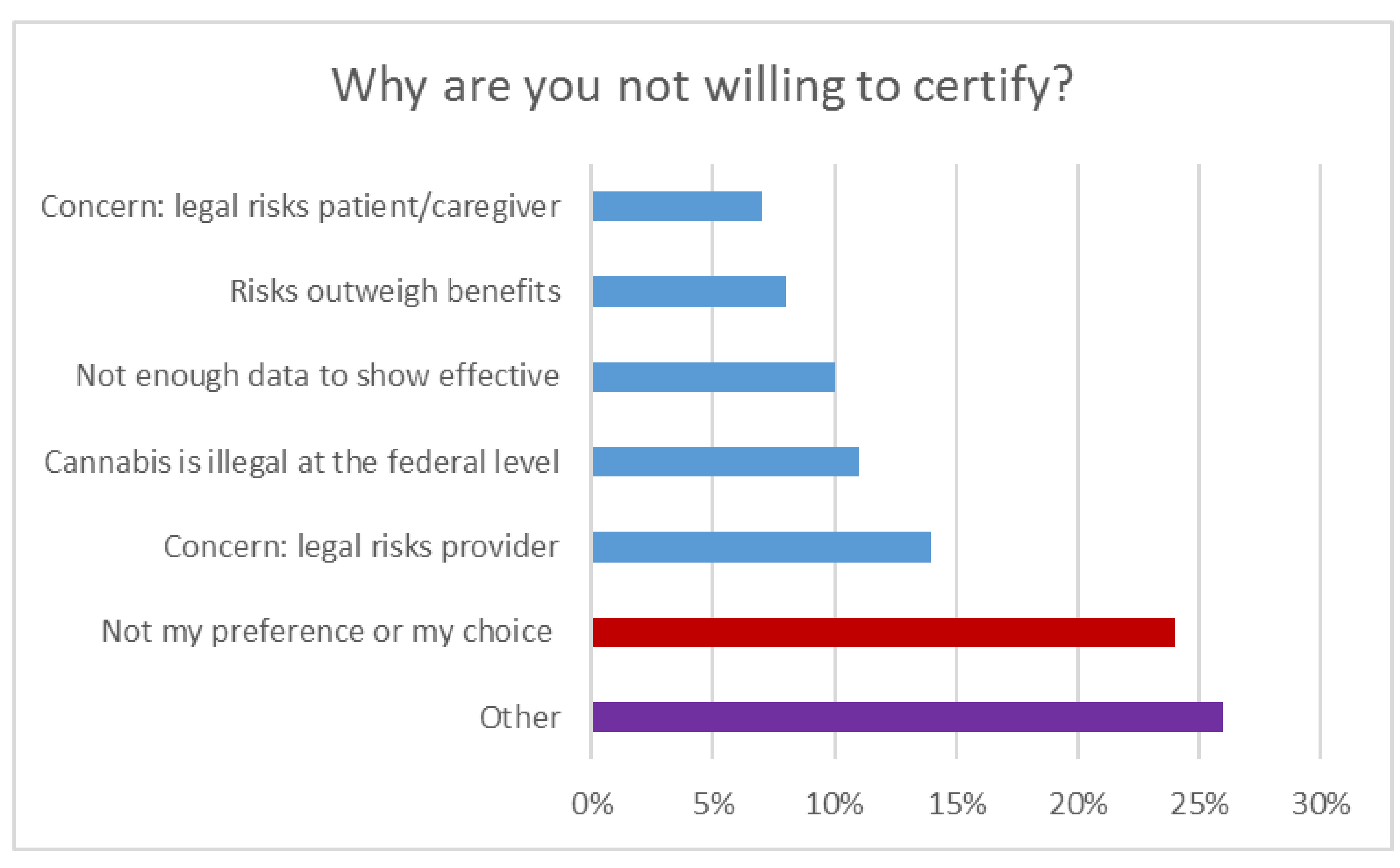



Considering the certifications you have provided....
I am comfortable with the NH/VT state paperwork process for certifying a qualifying condition
I have questions or concerns about the process of completing the state-required paperwork to certify patients and caregivers
I have certified patient(s) even though I do not think cannabis use is in their best interests
0%
10%
20%
30%
40%
50%
60%
70%



- I have been asked, but after discussion with patient/caregiver, we negotiated a different treatment approach
- I have been asked but refused to provide the certification
- Therapeutic cannabis certification is not relevant to my area of practice
- I have not been asked

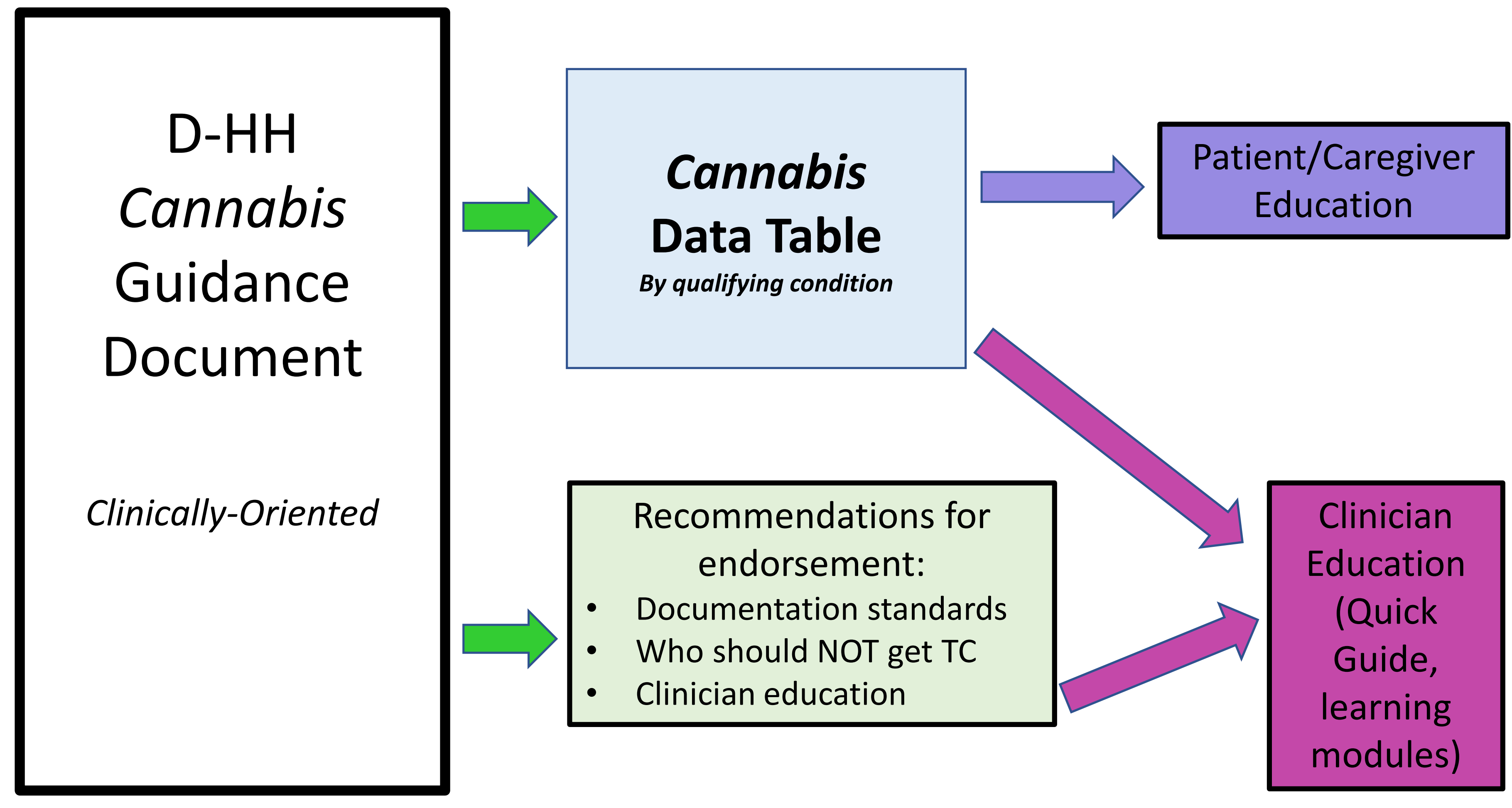

How Would You Respond to a Request to Certify?
I would certify an appropriate patient if asked
I am willing to consider certifying an appropriate patient if asked
I am not willing to issue therapeutic cannabis certifications under any circumstances
0%
10%
20%
30%
40%
50%
60%
70%



Why are you not willing to certify?
Concern: legal risks patient/caregiver
Risks outweigh benefits
Not enough data to show effective
Cannabis is illegal at the federal level
Concern: legal risks provider
Not my preference or my choice
Other
0%
5%
10%
15%
20%
25%
30%

Not Willing to Certify – other

- Not enough knowledge (5 answers)
- I have…too many patients with cannabis adverse effects, often not even recognized by them.
- Unknown compounds/dosing via dispensary
- Referred to an appropriate provider for certification (PCP or oncologist)
- Majority of my patients are pregnant; there are clear harms to cannabis use in pregnancy
- It should be legal like alcohol, certifying is irrelevant


Cannabis Project Deliverables
D-HH
Cannabis
Guidance
Document
Clinically-Oriented
Cannabis
Data Table
By qualifying condition
Patient/Caregiver
Education
Recommendations for
endorsement:
Documentation standards
Who should NOT get TC
Clinician education
Clinician
Education
(Quick
Guide,
learning
modules)

Preliminary Workgroup Recommendations - Under Construction

1. Recommend against providing TC certification to pregnant and breastfeeding women
2. Recommend against providing TC certification (THC products) to patients with cannabis use disorder (CBD probably ok)
3. If opioid use disorder + TC qualifying condition, be clear; use evidence-based therapy for substance use disorder, TC for qualifying conditions
4. Not recommending DH build a system for clinicians to “talk” to dispensaries and make product recommendations
5. DH should provide clinicians with access to professionally-developed, evidence-based cannabis education material (eg webinars)

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Aa

D-H Approach to Unhealthy Alcohol Use

Opioid Interest Group Update

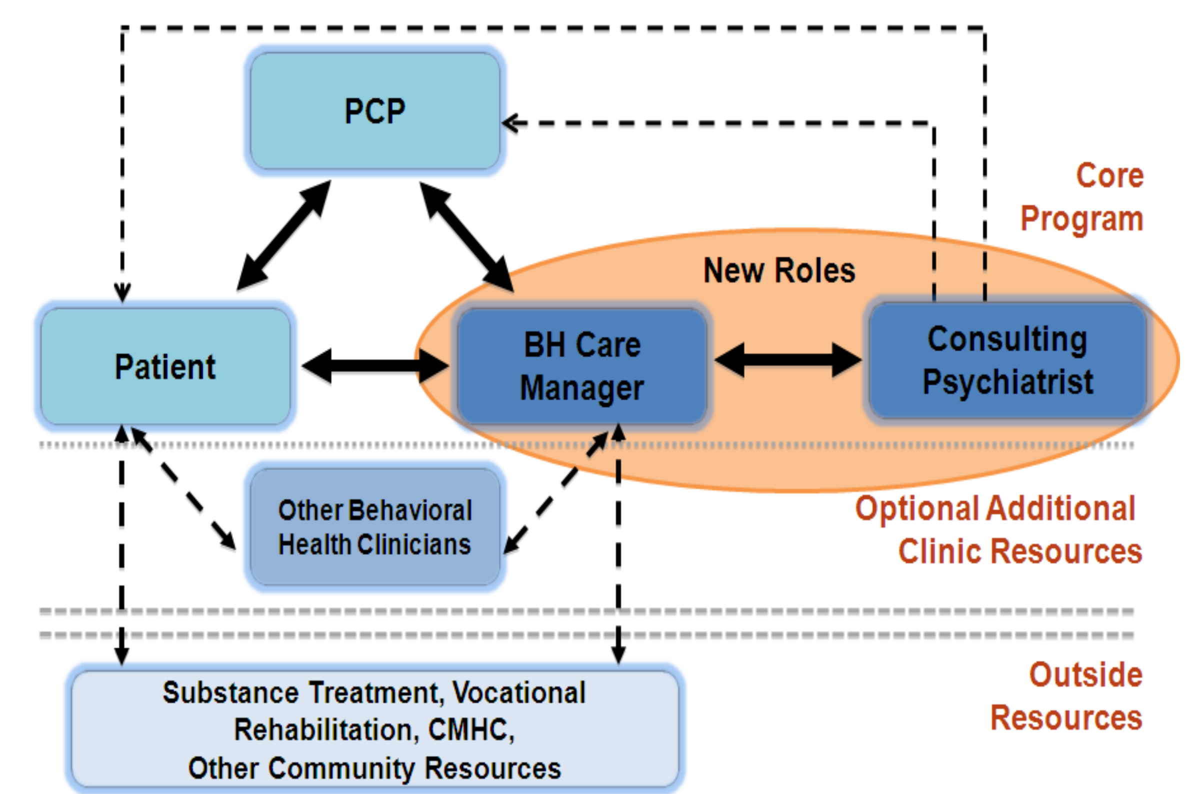
9/16/19

Transitions to ATP meeting 9/9

- Issues
  - No inpatient detox available→
    - Outpatient detox
    - Avoidable admissions
    - Repeat visits to ED
  - Detox in ED/inpatient service not standard of care
  - Confusion about referral process to ATP, waitlists
- Solutions
  - Expedited referrals using eDH referral to ATP->next business day availability
  - Recovery coaches to facilitate transitions
  - Alcohol detox order set (inpatient/ED) and clinician education
  - ? Inpatient detox

D-H Primary Care Clinics

- SUMHI Behavioral Health Integration Project started 2016, Pilot at Nashua FP 9/2017
- Behavioral Health Screening rolling out at all clinics
- Collaborative Care Model
  - Traditional focus on Depression and anxiety
  - Expanded to include Alcohol and opioid use disorders



Unhealthy Alcohol and Drug Use

Adult, Primary Care, Clinical Practice Guideline

Changes for 2018 2
D-H GUIDELINE ENDORSEMENT STATEMENT 3
Introduction 3
Algorithm: Recognizing and Managing Alcohol and Substance Use Disorders in Primary Care 4
Patient Identification 5
Interventions 6
Follow-up/Relapse Prevention 7
References 9
Appendices 11

Guideline Contact:
Charles Brackett, MD, MPH
Email: Charles.D.Brackett@hitchcock.org or knowledge.map@hitchcock.org

Guideline Adoption Statement Sources:

MA-SBIRT (Massachusetts Screening, Brief Intervention and Referral to Treatment) Clinician's Toolkit[3]
Helping Patients Who Drink Too Much: A Clinician's Guide[2]
Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health[1]

D-H Review and Adoption Committee:

Psychiatry:
Matt Duncan, MD (Lebanon)
Will Torrey, MD (Lebanon)
Don West, MD (Lebanon)
Mark McGovern, PhD (Lebanon)

Primary Care:
Andrew Tremblay, MD (Keene)
Timothy Burdick, MD (Manchester)
Virginia Alvord, MD (Lebanon)

Scope:
This guideline is intended to support primary care clinicians and behavioral health clinicians embedded in primary care in their efforts to optimally identify, assess, triage and manage adult patients with unhealthy alcohol and drug use in a Collaborative Care Model in the ambulatory setting and to clarify D-H clinical standards for this work.

Approval Body: D-H Knowledge Map™ **Release Date:** 2017

Algorithm: Recognizing and Managing Alcohol and Substance Use Disorders in Primary Care

Identify

Screening: Questionnaire approach
Initial alcohol question + → AUDIT
Initial drug question + → DAST

Screening: Quick Approach
Initial Drug and alcohol questions + → CAGE-AID

Clinical Suspicion
SUD clinically evident or patient intoxicated or requesting treatment

Scoring

Negative Initial Questions

AUDIT ≤ 14
DAST ≤ 2
CAGE-AID ≤ 1

AUDIT ≥ 15
DAST ≥ 3
CAGE-AID ≥ 2

Assess/Diagnose

No/Low Risk Use
Is patient in recovery from SUD?

Risky Use

Further evaluation
Using DSM-5; # of criteria:

0-1	2-3	4-5	6+
No SUD	Mild	Moderate	Severe

Intervention

No → Reinforce healthy decisions
Yes → Support recovery

Brief Intervention

Treatment Planning

Follow up

Re-screen yearly

Follow-up

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Alcohol BPA triggered by AUDIT≥6

POSITIVE SCREEN FOR UNHEALTHY ALCOHOL USE (risky use or alcohol use disorder). See the attached smartset for support on diagnosis, doing a brief intervention and other management, patient information and resources, medications, referrals and billing. (BPA 1649)

Audit Score	6/28/2017
Audit Final Scores	36 (Severe Risk - Recommend further evaluation and treatment)

Open SmartSet | Do Not Open | Unhealthy Alcohol Use preview

Acknowledge Reason

Intervention done- primary care manageme... | Intervention done- specialty management | Intervention done- no readiness

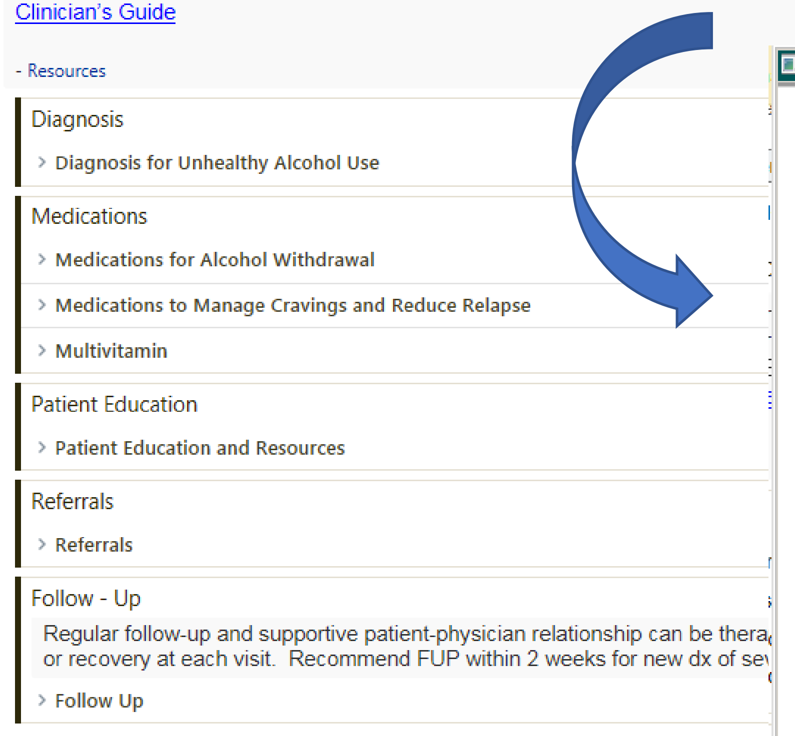
Already in treatment for alcohol | False positive screen | Not addressed today

Apply Selected

Unhealthy Alcohol Use Smartset

Unhealthy Alcohol Use

If diagnosis is uncertain (e.g. Intermediate AUDIT scores: 15-19), use the DSM-5 criteria for alcohol use disorder (AUD) - pull DSM-5 diagnostic checklist into progress note with smartphrase .AUDDSM5. For risky use or mild AUD, a brief intervention is indicated. For moderate to severe AUD, treatment is indicated. Use smartphrase ".RISKYALCOHOLUSE" or ".ALCOHOLUSEDISORDER" to document your assessment and plan. For more information, see KM Unhealthy Alcohol and Drug Use guideline or Helping Patients Who Drink Too Much: A Clinician's Guide



http://sitefinity.hitchcock.org/intranet/docs/default-source/d-h-knowledge-map-documents/brief-intervention-for-risky-alcohol-u...

Brief Intervention for Risky Alcohol Use

A BI is a conversation with a patient using education and motivational interviewing techniques (see p 22-25 MA-SBIRT) to enhance a patient's motivation to change their alcohol use. For risky use or mild AUD, the goal is to reduce (to healthy drinking limits) or eliminate use (for illicit drugs, or consequences from or inability to cut down on alcohol). The Brief Negotiated Interview approach used in MA-SBIRT is summarized here. The NIAAA Clinician's Guide uses a more directive approach.

BI Steps (see p 9-10 and 20-21 MA-SBIRT and these videos for more detail)

1. Understand the patient's views of use
   - Develop discrepancy between patient's goals and values and actual behavior
2. Give information/feedback
   - Ask permission to give feedback. Share AUDIT scores and responses.
   - Explore possible connections to health problems.
   - Review healthy drinking limits (if focus is on risky alcohol use and abstinence is not indicated)
   - Use reflective listening and other motivational interviewing techniques
3. Enhance motivation
   - Ask about pros and cons of alcohol use
   - Ask readiness and confidence for making changes, using 0-10 scale
4. Give advice and negotiate goal
   - Review concerns, summarize pros/cons
   - Ask what the patient is ready to do now
   - Offer clear advice to cut back or eliminate use

Close: Thank patient, offer educational resources (available in smartset: patient instructions), negotiate follow-up

Diagnostic Smartphrase ".AUDDSM5"

DSM-5 defines Alcohol Use Disorder (AUD) as meeting 2 or more of the adapted criteria below.

- ☐ Taking substance more or longer than intended
- ☐ Inability to cut down or stop
- ☐ Spending a lot of time getting/using/recovering
- ☐ Cravings and urges
- ☐ Not meeting responsibilities at home, work, school
- ☐ Continued use despite causing problems in relationships
- ☐ Giving up important social, occupational, recreational activities
- ☐ Recurrent use leading to danger
- ☐ Continued use when causing or worsening a physical or psychological problem
- ☐ Tolerance (needing more to get same effect)
- ☐ Withdrawal symptoms relieved by taking more

Number of criteria:	0-1	2-3	4-5	6+
Interpretation:	No AUD	Mild AUD	Moderate AUD	Severe AUD

Diagnosis

Collapse

Diagnosis for Unhealthy Alcohol Use

- ☐ Alcohol use disorder [F10.99] Details
- ☐ Heavy alcohol use [Z72.89] Details
- ☐ Drug or alcohol risk assessment or counseling [Z71.89] Details

Medications

Collapse

Medications for Alcohol Withdrawal

A minority of patients may require medically managed withdrawal (detoxification). For many patients, this is reasonable as an outpatient with superision of a close friend or family member and close follow-up. Patients with severe symptoms (CIWA-AR>15), past withdrawal seizures or DTs, comorbidities, pregnancy, or lack of social support should be treated inpatient.

- ○ Benzodiazepines
- ○ Non-benzodiazepines Medications

Medications to Manage Cravings and Reduce Relapse

Click here for information on medication options.

- ○ naltrexone (DEPADE) 50 mg Tablet
  Disp-30 tablet, R-5, Normal
- ○ acamprosate (CAMPRAL) 333 mg Tablet, Delayed Release (E.C.)
  Disp-180 tablet, R-5
- ○ baclofen (LIORESAL) 10 mg Tablet
  Disp-90 tablet, R-2, Normal
- ○ gabapentin (NEURONTIN) 300 mg Capsule
  Disp-180 capsule, R-0, Normal

Multivitamin

- ☐ multivitamin (THERAGRAN) Tablet
  Disp-30 tablet, R-0, Normal

http://sitefinity.hitchcock.org/intranet/docs/default-source/d-h-knowledge-map-documents/medication-assisted-treatment-for-a...

Medication Assisted Treatment for Alcohol (FDA approved)
(see NIAAA Guide p13-23 for details

	Naltrexone (Depade®, ReVia®)	Extended Release Injectable Naltrexone (Vivitrol®)	Acamprosate (Campral®)	Disulfiram (Antabuse®)
Action	Blocks opioid receptors, resulting in reduced craving and reduced reward in response to drinking.	Same as oral naltrexone, 30–day duration.	Affects glutamate and GABA neurotransmitter systems, but its alcohol-related action is unclear.	Inhibits intermediate metabolism of alcohol causing a buildup of acetaldehyde and reaction of flushing, sweating, nausea, and tachycardia if a patient drinks alcohol.
Contraindications	Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure.	Same as oral naltrexone, plus inadequate muscle mass for deep intramuscular injection; rash or infection at the inspection site.	Severe renal impairment (CrCl ≤ 30 mL/min).	Concomitant use of alcohol or alcohol-containing preparations or metronidazole; coronary artery disease; severe myocardial disease; hypersensitivity to rubber (thiuram) derivatives.
Precautions	Other hepatic disease; renal impairment; history of suicide attempts or depression. If opioid analgesia is needed, larger doses may be required and respiratory depression may be deeper and more prolonged. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see www.niaaa.nih.gov/guide.	Same as oral naltrexone, plus hemophilia or other bleeding problems.	Moderate renal impairment (dose adjustment for CrCl between 30 and 50mL/min); depression or suicidal ideation and behavior. Pregnancy Category C.	Hepatic cirrhosis or insufficiency; cerebrovascular disease or cerebral damage; psychoses (current or history); diabetes mellitus; epilepsy; hyperthyroidism; renal impairment. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see www.niaaa.nih.gov/guide.
Serious adverse reactions	Will precipitate severe withdrawal if the patient is dependent on opioids; hepatotoxicity (although does not appear to be a hepatotoxin at the recommended doses).	Same as oral naltrexone, plus infection at the injection site; depression; and rare events including allergic pneumonia and suicidal ideation and behavior.	Rare events include suicidal ideation and behavior.	Disulfiram-alcohol reaction, hepatotoxicity, optic neuritis, peripheral neuropathy, psychotic reactions.
Common side effects	Nausea, vomiting, decreased appetite, headache, dizziness, fatigue, somnolence, anxiety.	Same as oral naltrexone, plus a reaction at the injection site; joint pain; muscle aches or cramps.	Diarrhea, somnolence.	Metallic after-taste, dermatitis, transient mild drowsiness.
Examples of drug interactions	Opioid medications (blocks action).	Same as oral naltrexone.	No clinically relevant interactions known.	Anticoagulants such as warfarin; isoniazid; metronidazole; phenytoin; any nonprescription drug containing alcohol.
Usual adult dosage	*Oral dose:* 50 mg daily. *Before prescribing:* Patients must be opioid-free for a minimum of 7 to 10 days before starting. If you feel that there's a risk of precipitating an opioid withdrawal reaction, administer a naloxone challenge test. Evaluation liver function. *Laboratory followup:* Monitor liver function.	*IM dose:* 380 mg given as a deep intramuscular gluteal injection, once monthly. *Before prescribing:* Same as oral naltrexone, plus examine the injection site for adequate muscle mass and skin condition. *Laboratory followup:* Monitor liver function.	*Oral dose:* 666 mg (two 333-mg tablets) three times daily; *or for patients with moderate* renal impairment (CrCl 30 to 50 mL/min), reduce to 333 mg (one tablet) three times daily. *Before prescribing:* Evaluate renal function. Establish abstinence.	*Oral dose:* 250 mg daily (range 125 mg to 500 mg). *Before prescribing:* Evaluate liver function. Warn the patient (1) not to take disulfiram for at least 12 hours after drinking and that a disulfiram–alcohol reaction can occur up to 2 weeks after the last dose and (2) to avoid alcohol in the diet (e.g., sauces and vinegars), over the counter medications (e.g., cough syrups), and toiletries (e.g., cologne, mouthwash). *Laboratory followup:* Monitor liver function.

Medication Assisted Treatment for Alcohol (off label/not FDA approved)

- Baclofen: GABA agonist, decreases withdrawal symptoms,[11] decreases alcohol consumption and craving, and may help anxiety.[12]
  - 10-20mg tid, potentially higher (up to 300mg/day is being studied)

Patient Education

Patient Education

- Patient Education and Resources
  - ☐ Alcohol and Drug Problems (English) Edit
  - ☐ Alcohol Detoxification and Withdrawal (English) Edit
  - ☐ Rethinking Drinking Edit
  - ☐ Treatment and Self-Management Resources Edit

Rethinking Drinking https://www.rethinkingdrinking.niaaa.nih.gov/

Do you enjoy a drink now and then? Many of us do, often when socializing with friends and family. Drinking can be beneficial or harmful, depending on your age and health status, the situation, and, of course, how much you drink. For anyone who drinks, the "Rethinking Drinking" website offers valuable, research-based information on how much alcohol is too much, and can help if you're thinking about making a change. ***What's "low-risk" drinking?*** A major nationwide survey of 43,000 U.S. adults by the National Institutes of Health shows that only about 2 in 100 people who drink within both the "single-day" and weekly limits below have alcoholism or alcohol abuse. How do these "low-risk" levels compare with your drinking pattern?

Mutual Help Groups and Self-Management Resources can help many to achieve their recovery goals, especially together with help from your primary care clinic

- Alcoholics Anonymous: www.aa.org
- Self-Management Addiction Recovery Program: www.smartrecovery.org
- Digital device Applications (Apps)
  - A-CHESS: developed by researchers at the University of Wisconsin as a continuing relapse prevention support for those in recovery from alcoholism and alcohol use disorders, after they leave treatment
  - recoveryBox- for a range of addictions
  - Sober Grid
  - 12 Steps AA Companion

Katharine Bradley- Kaiser

Implementing Care for Alcohol & Other Drug Use in Medical Settings

An Extension of SBIRT

SBIRT Change Guide 1.0

February 2018

Moving beyond stereotypes

Experts no longer view drinking alcohol as a black and white issue, where people are either "alcoholic" or not. Instead, we use the term "alcohol use disorders" to describe a broad range of problems related to drinking.

Experts have also stopped recommending that people drink for their health. Why? Because the health and social problems that drinking can cause far outweigh any potential health benefits.

Did you know

- About 1 in 4 adults drinks more alcohol than is recommended for good health. And about 1 in 12 has an alcohol use disorder.
- People who drink above recommended limits are at risk for a variety of health problems.
- The risk of death increases in women who have more than 7 drinks per week and in men who have more than 14 drinks per week.

Even if you don't want to stop drinking, treatment can still help you cut back. Ask yourself these important questions, then talk with your doctor about your answers.

- ☐ Have you had times when you drank more, or for longer, than you wanted to?
- ☐ Have you wanted to cut back or stop drinking more than once, but found that you couldn't?
- ☐ Do you spend a lot of time drinking or feeling hung-over?
- ☐ Do you feel an urge to drink or a craving for alcohol?
- ☐ Has drinking or feeling hung-over made it harder for you to take care of your responsibilities?
- ☐ Have you continued to drink even when it was causing trouble with your family or friends?
- ☐ Have you stopped doing things you enjoy because of your drinking?
- ☐ Do you ever do dangerous things after drinking, such as drive a car or have unsafe sex?
- ☐ Have you continued to drink even when it made you feel depressed or anxious or caused other health problems?
- ☐ Do you need to drink more than you used to to feel the effect you want?
- ☐ Do you feel like you're not yourself when you don't drink—for example, do you feel irritable, have trouble sleeping, or notice other problems?

A ReThink of the Way we Drink
https://youtu.be/tbKbq2IytC4

KAISER PERMANENTE.

Alcohol and health...

What you should know

KAISER PERMANENTE.

Research

JAMA Internal Medicine | Original Investigation

Alcohol-Related Nurse Care Management in Primary Care
A Randomized Clinical Trial

Katharine A. Bradley, MD; Jennifer F. Bobb, PhD; Evette J. Ludman, PhD; Laura J. Chavez, PhD;
Andrew J. Saxon, MD; Joseph O. Merrill, MD, MPH; Emily C. Williams, PhD, MPH; Eric J. Hawkins, PhD;
Ryan M. Caldeiro, MD; Carol E. Achtmeyer, MN; Diane M. Greenberg, PhD; Gwen T. Lapham, PhD;
Julie E. Richards, MPH; Amy K. Lee, MPH; Daniel R. Kivlahan, PhD

CONCLUSIONS AND RELEVANCE The CHOICE intervention did not decrease heavy drinking or related problems despite increased engagement in alcohol-related care.

Options for people who are thinking about their drinking

Dartmouth-Hitchco

Version 3.1

SUMHI Action Update

- OUD/MAT implementation across D-HH, *Charlie Brackett, MD*
- Recovery Coaches in the DHMC Emergency Department, *Barbara Farnsworth, MS*
- Syringe Service Programs in the Upper Valley – *Ashley Greenfield, MPH*
- Evolving Therapeutic Cannabis Guidelines – *Cindy Reuter ND, RD, MPH or Will Torrey MD*
- Ramping up Unhealthy Alcohol Screening & Care – *Charlie Brackett, MD*
- Outpatient Care for Patients w IDU & Infections – *Colleen Kershaw, MD*
- Inventory of other SUD Projects – *Seddon Savage, MD*

Improving Care for Patients with Acute Infectious Complications of Injection Drug Use

Colleen Kershaw, MD

Dartmouth-Hitchcock

Infection as a 'Symptom' of OUD

- Increasing numbers of complex infections related to injection drug use which require long-term IV antibiotic courses
- Challenging to treat infection:
  - How to administer 6-8 weeks of IV antibiotics?
  - How to keep patient engaged in care
- How can we treat the underlying problem?
  - Inpatient admission for patients with infections is a "reachable opportunity" to engage patients in evidence-based addiction treatment leading to successful treatment of both addiction and infection.

Goals

- Integrate infection and addiction care with a multidisciplinary team
- Improve communication between inpatient care teams
  - Primary team, BIT, Infectious Diseases, Nursing, Care Management
- Create individualized treatment plan for infection and addiction for each patient
  - Evidence-based guidance on choice of treatment for infection (use of long-term IV access vs. other options)
  - Multidisciplinary team discussion and recommendations prior to discharge
  - Ensure addiction treatment plan with MAT is in place prior to discharge
- Outpatient care pathway that addresses both infection and addiction

Current State

- Multidisciplinary team assembled:
  - BIT, GIM, ATP, ID/OPAT, Hospital Medicine
- Community partners engaged:
  - Home infusion services (New England Life Care)
  - Visiting nurse association (Visiting Nurse and Hospice for VT and NH)
- Literature review and benchmarking completed
- Protocols developed
- Considering options for evaluation of new practice/process

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Other D-HH Substance Initiatives
with contacts or links

- The Doorway at D-H https://thedoorway.nh.gov/doorway-dartmouth-hitchcock
  - Component of the NH Doorway System *https://thedoorway.nh.gov/doorway*
- New Hampshire Integrated Delivery Networks Region I http://region1idn.org
- Center for Addiction Recovery in Pregnancy & Parenting (CARPP)

  https://med.dartmouthhitchcock.org/carpp.html
  - Clinical programs: ObGyn SBIRT, Moms in Recovery (outpatient and intensive SUD treatment and supports), Neonatal opioid withdrawal management, others.
  - Provider to Provider Q & A Service. **603-653-1800 or** CARPP@hitchcock.org
- Recovery Friendly Practice Initiative Holly.A.Gaspar@hitchcock.org
- Pediatric SBIRT Steven.H.Chapman@hitchcock.org
- BH Integration/Collaborative Care model Matthew.S.Duncan@hitchcock.org
- Opioid Prescribing Initiatives, post-surgical, Richard.J.Barth.Jr@hitchcock.org

Other D-HH Substance Initiatives
with contacts or links

- Oncology & Palliative Care OUD & pain treatment, Kathleen.broglio@Hitchcock.org
- Stanford Chronic Disease Self-Management for Pain, http://www.snhahec.org
- Clinical naloxone expansion (evolving)
- All Together, community-public health partnership, https://www.uvalltogether.org
- Cheshire-Keene Drug Court Program ATremblay@Cheshire-Med.COM
- 99 Faces, https://www.dartmouth-hitchcock.org/arts/99-faces.html
- ECHOs BH, Employee, School Carolyn.L.Kerrigan@Hitchcock.org ; Megan.M.Colgan@Hitchcock.org
- SUMHI website, Ed & Culture Team, https://med.dartmouth-hitchcock.org/sumhi.html
- NE Node of NIDA Clinical Trials Network, http://www.ctnnortheastnode.org
- Center for Technology and Behavioral Health, https://www.c4tbh.org
- Center for Health Promotion Research, http://www.hprcd.org

Discussion

Any projects missing here?

What more is needed?

How can we grow?

Next SUMHI Action Update

Monday, March 30th

The D-HH Substance Use & Mental Health Initiative envisions
a health care system where mental health & substance use disorders are treated with the same urgency, respect and seriousness of purpose as other illnesses and where discrimination does not occur.