SUMHI Action Update

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

9-14-20

We envision a healthcare 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.

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Welcome

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

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

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SUMHI Action Update - Goals

- Provide updates on work in the D-HH system aimed at improving care of persons with SUDs and MH issues
- Identify opportunities to engage within D-HH and with other communities and improve our work
- Meet the needs of people with SUDs and MH challenges

Session Requests & Info

- Please CHAT message us now with your name, department or organization & email
- Mute, unmute to speak
- Slides will be posted at SUMHI website, will send link
- Presentations will be 7-8 min. 2-3 min questions.
- Submit questions/comments by chat. Or raise hand. Will ask you to unmute and ask/comment. And 20 minutes at the end.

Continuing Education Credits

Activity Code For This Session Only

C7bH

Use This Number to Text Requests For Credit

603-346-4334

Need help? clpd.support@hitchcock.org Signing in on-line? http://www.d-h.org/clpd-account

RSS: Substance Use & Mental Health Initiative **Session Date:** September 14, 2020 **Topic:** DH SUMHI Opioid/SUD Action Update **Session Speakers**: Seddon Savage, Will Torrey, Charlie Brackett, Angie Raymond Leduc, Maureen Gardella, Dave Segal, Colleen Kershaw

Learning Outcome Statement:
Participants will be able to identify and implement clinical strategies to better evaluate and address substance use and mental health disorders throughout the health system.

Conflict of Interest

The RSS Physician Director(s), planning committee member(s), speaker(s), author(s) or anyone in a position to control the content for Substance Use & Mental Health Initiative have reported NO financial interest or relationship* which could be perceived as a real or apparent conflict of interest. There were no individuals in a position to control the content that refused to disclose.

In accordance with the disclosure policy of Dartmouth-Hitchcock/Geisel School of Medicine at Dartmouth as well as standards set forth by the Accreditation Council on Continuing Medical Education and the Nursing Continuing Education Council standards set forth by the American Nurses Credentialing Center Commission on Accreditation, continuing medical education and nursing education activity director(s), planning committee member(s), speaker(s), author(s) or anyone in a position to control the content have been asked to disclose any financial relationship* they have to a commercial interest (any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on patients). Such disclosure is not intended to suggest or condone bias in any presentation, but is elicited to provide participants with information that might be of potential importance to their evaluation of a given activity.

Dartmouth-Hitchcock is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
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DHH Substance Use & Mental Health Initiative (SUMHI) Action Update

Program

5:00-5:05	Welcome	*Sally Kraft & Will Torrey*
5:05-5:15	**Impact of COVID on SUD in NH – Survey results**	*Seddon Savage, facilitator*
5:15-5:25	**DHH Therapeutic Cannabis Guidelines**	*Will Torrey*
5:25-5:35	**Toolkit for Managing OUD in Inpt & ED Hospital Settings**	*Charlie Brackett*
5:35-5:45	**D-H Suicide Prevention Initiative**	*Angie Raymond Leduc* *Maureen Gardella*
5:45-5:55	**D-H Keene Drug Court program**	*Andy Tremblay*
5:55-6:05	**Outpatient IV Antibiotic Tx in Patients with OUD**	*Colleen Kershaw*
6:05-6:10	**Brief Note-other DHH Substance & Mental Health Projects**	
6:10-6:30	Discussion	*Participants & Presenters*

Impact of COVID-19 on Substance Use and Mental Health in NH *Survey*

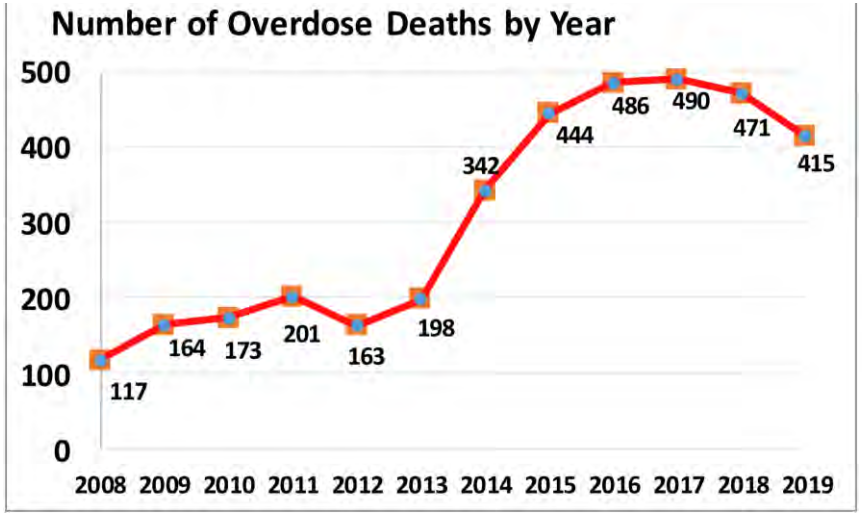
Seddon Savage

Advisor, Dartmouth Hitchcock Substance Use and Mental Health Initiative

Adjunct Associate Professor, Department of Anesthesiology, Geisel School of Medicine

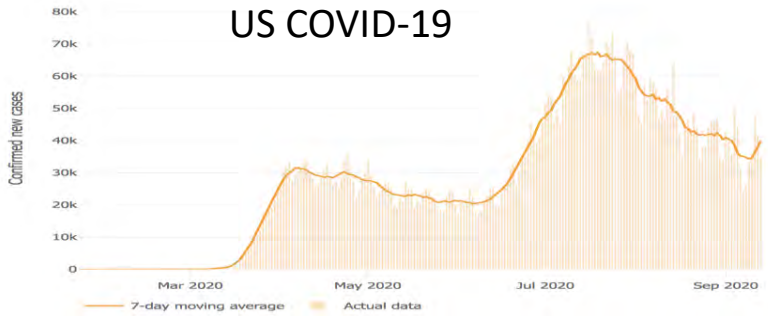
Overdose Epidemic & COVID-19 Pandemic

New Hampshire

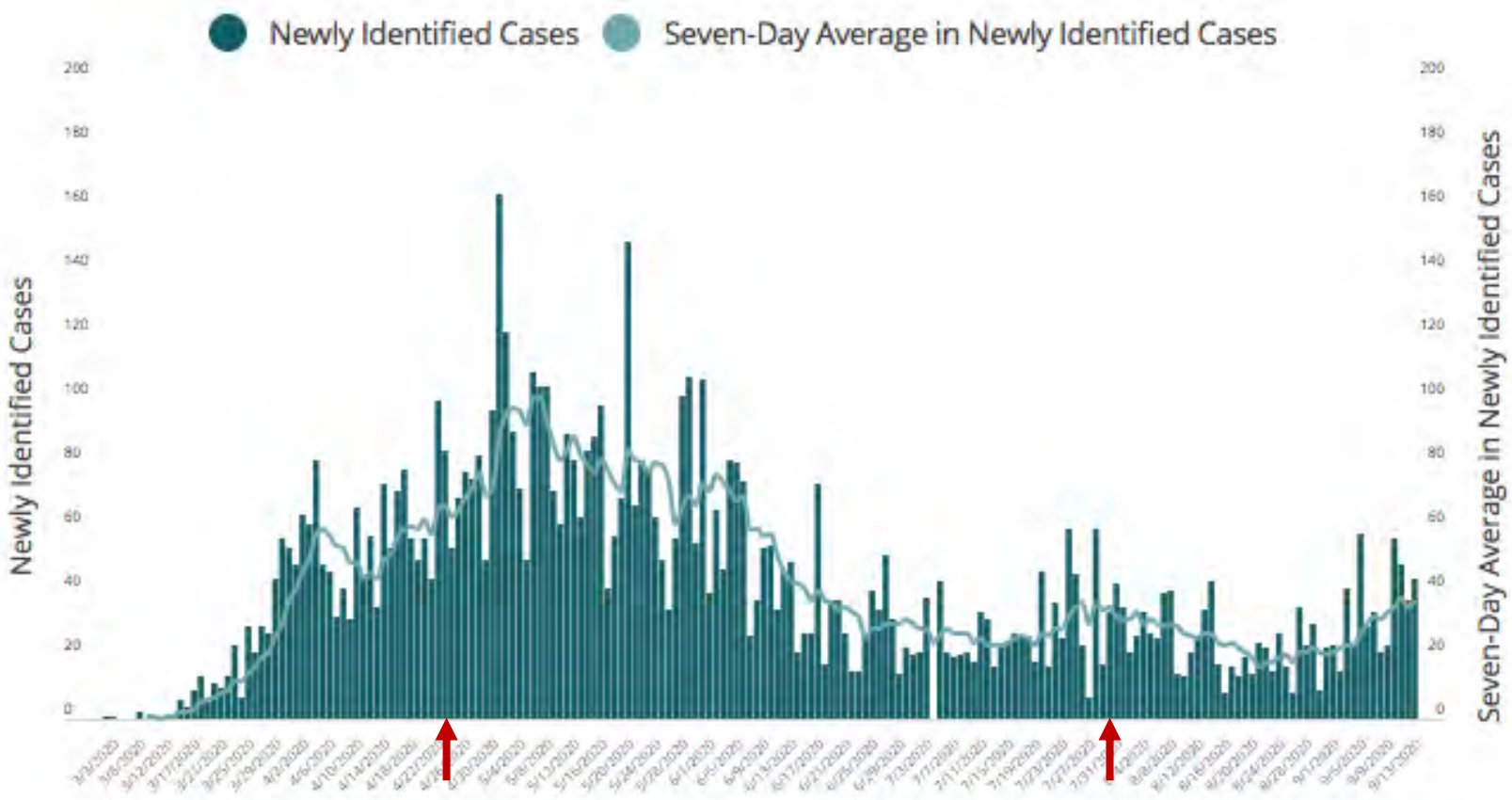


Office of the NH Medical Examiner, 8-18-20

US COVID-19



COVID-19 in New Hampshire



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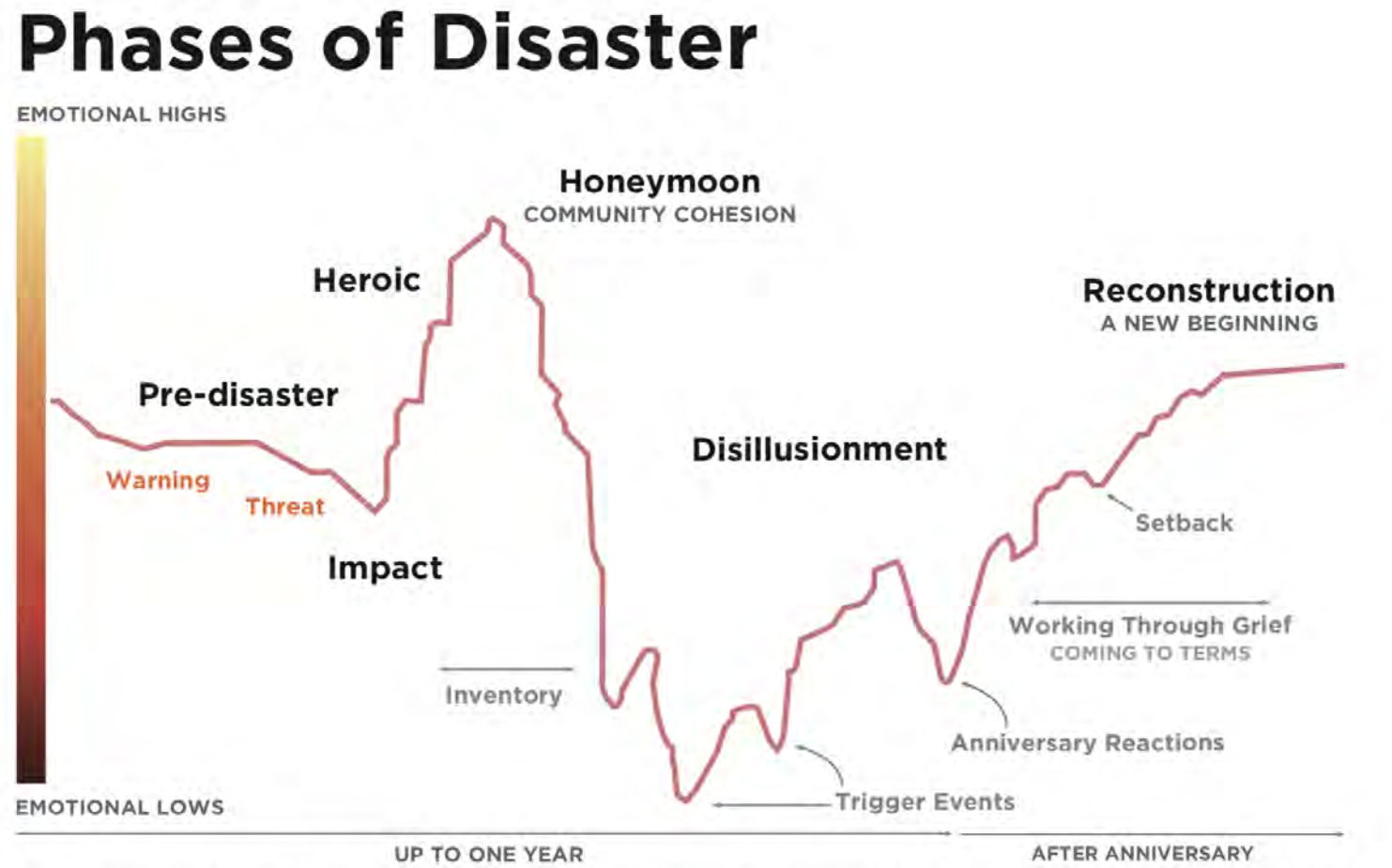
COVID 19 – Potential Timeline of Psychological Impact



Source: Zunin/Meyers, as cited in Training Manual for Mental Health and Human Service Workers in Major Disasters, U.S. Department of Health and Human Services (2000).

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Survey - COVID 19 & Substance Use in NH

- **Objectives**- gather diverse observations regarding
  - Changes in substance use and treatment patterns since COVID
  - Engagement of people who use drugs in COVID safety practices
- **Goal**- To inform clinical and public health responses
- **Methods**

Round	*End of April*	*End of July*
Fixed-response questions	13	18
Open ended responses	3	2
Groups circulated	11 req, ? sent	16 requested, 9 sent
Forward?	Requested	Not requested
Recipients	Uncertain	5830 (w/o EMS 1285)
Responses	339	261
Response rate	Unknown	4.28% (w/o EMS 14.7%)

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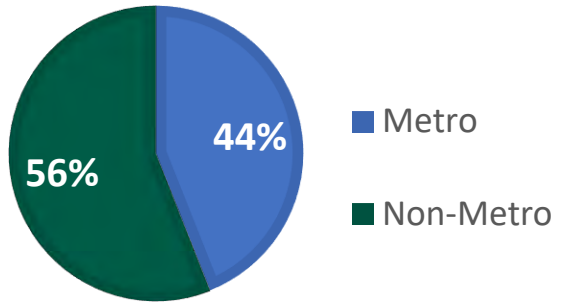
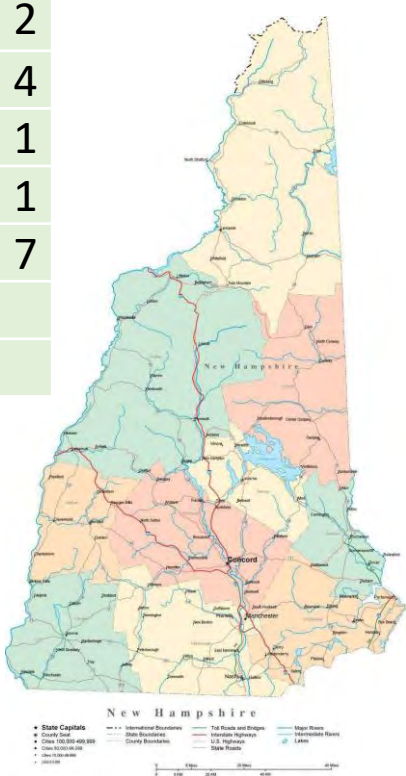
July- Observer Perspective/Role

Category	N	N
Healthcare		**125**
Addiction or mental health treatment	88	
Healthcare provider or staff (not SUD-MH)	37	
First Responders		**61**
Emergency medical service (EMS)	59	
Law enforcement	2	
Legal, policy, justice systems		**17**
Legislative, policy, advocacy	3	
Corrections system	12	
Judicial system	2	
Community based perspectives		**47**
Harm reduction, syringe service or similar	2	
Person with drug use (PDU) or family/friend	2	
Recovery support system	20	
Community-based prevention or intervention	23	
Other	10	**10**
Total Observer Role Responses:		**260**

July- Location of Observation

NH County	% of responses	# resp	Rural Urban Continuum Codes (RUCC)	
Belknap	5%	11	Non-Metro	4
Carroll	2%	4	Non-Metro	6
Cheshire	11%	24	Non-Metro	4
Coos	3%	6	Non-Metro	7
Grafton	18%	38	Non-Metro	5
Hillsborough	24%	50	Metro	2
Merrimack	9%	19	Non-Metro	4
Rockingham	9%	20	Metro	1
Strafford	6%	13	Metro	1
Sullivan	3%	7	Non-Metro	7
Statewide	9%	20		
	100%	**212**		





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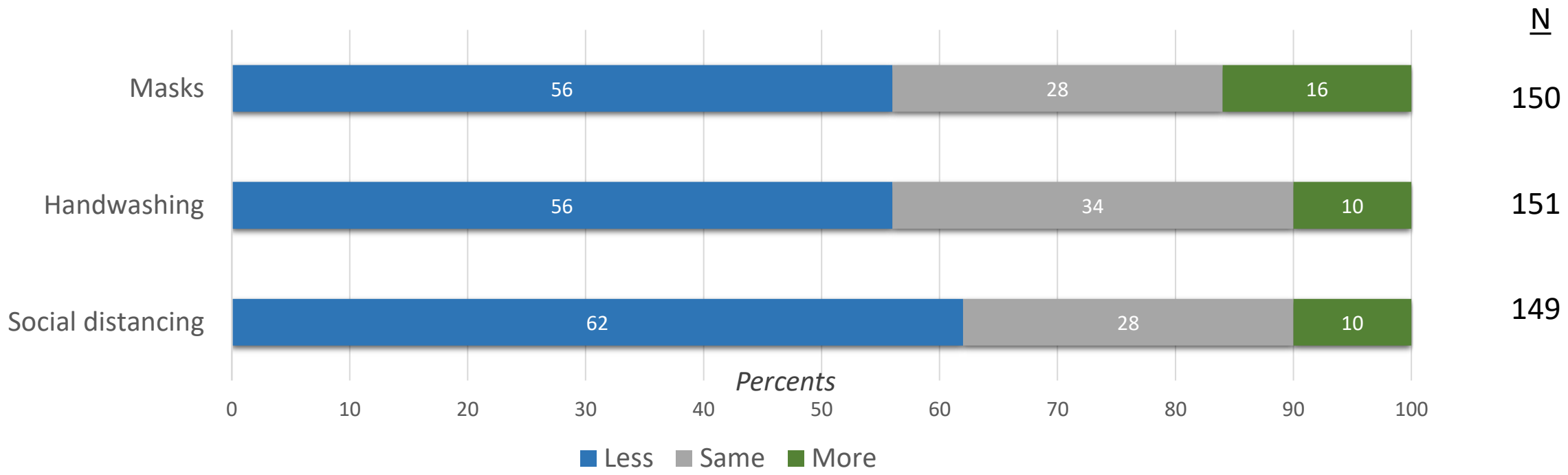
Observations

Extent to which people with SUDs in NH able to engage in the following recommended COVID-19 safety practices compared with people without substance use



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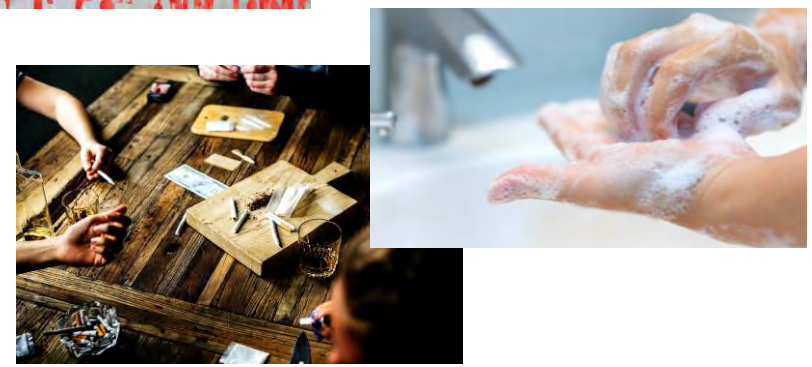
Comments – COVID-19 Safety

"Many pt's jobs don't allow them to socially distance."

"Treatment facilities, jails, shelters, make social distancing impossible/increase likelihood of transmission"

"You can't socially distance in a tent or a shelter, or at least it's a lot more difficult."

"Clients are…not socially distancing due to fear of over-dosing when using alone."



"A lot of times their survival relies on sharing resources, unfortunately that's not always sanitary. "

" Regular makeshift source of hygiene (homeless café, restaurants, libraries, community centers) are all closed.

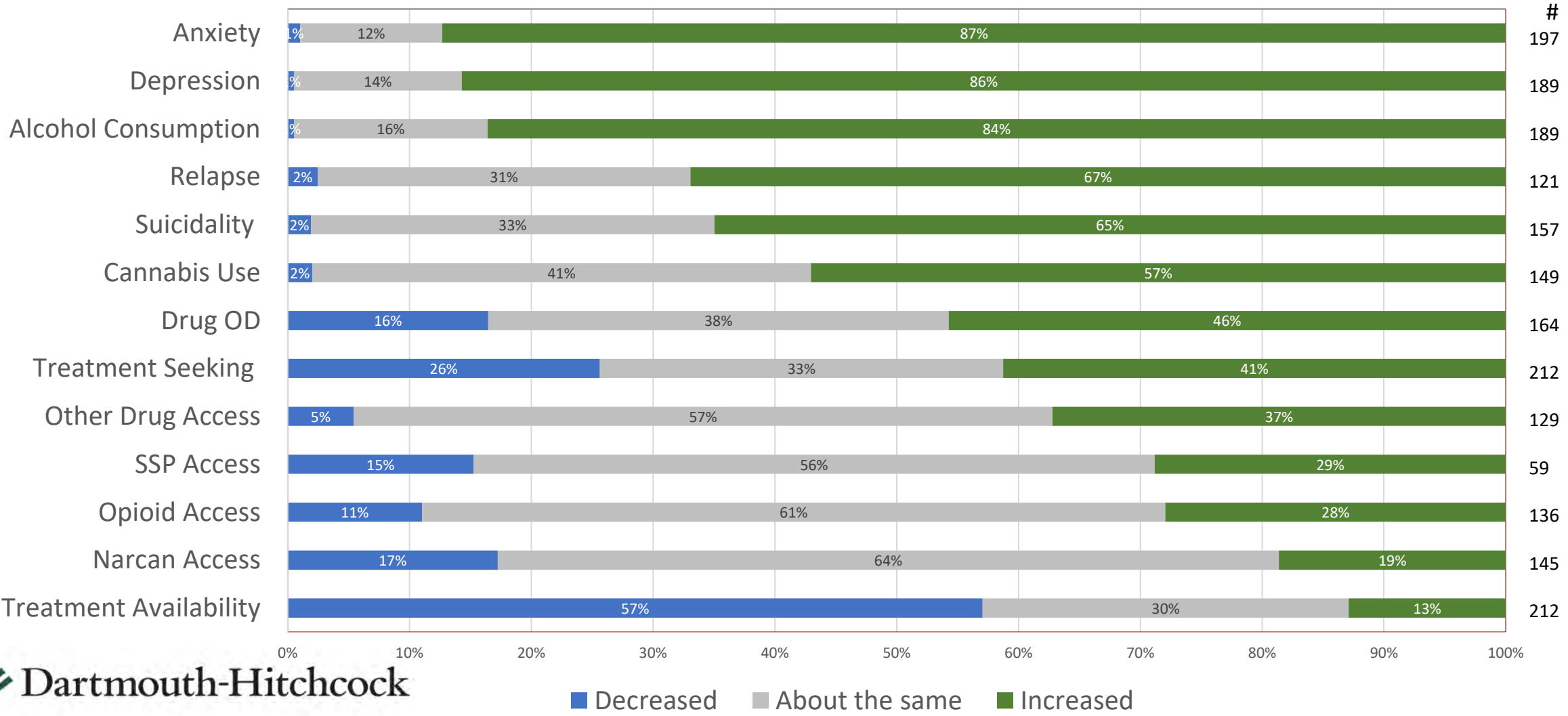
"…work has been done with shelters to improve PPE, hand washing supplies & social space since early April.

"I am struck by [patients] inability to tolerate the discomfort of a mask, difficult to use a mask if you have anxiety issues"

"Many are also loath to wear masks given high proportion of cigarette smokers/vapers"

Observations

Changes in the following, if any, in your community since COVID 19 entered our communities.



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Comments- COVID-19 Changes

"Isolation is very difficult for patient with SUD; more cravings and more possibility to relapse.

"The level of hopelessness has skyrocketed."

"the impact of social isolation is can be much higher in patients with mental health issues

"As the pandemic has dragged on, we are seeing more relapse in people with long term recovery, often starting with alcohol and cannabis."

"We have noticed an incredible increase in cases of alcohol abuse.

Social isolation and increased anxiety…due to COVID has likely played a significant role in everyone's lives, but especially for those with underlying MH and SUD issues.

Increases alcohol consumption, many not working which means less structured time.

it seems like many hospital-based healthcare providers I know report an increase in their drinking since March.

We have had many relapses and several overdoses and a handful of deaths.

Overwhelming need for step down services and/or shelter/programming availability to increase access to care for SUD patients.

Many relapses of folks in both short term and long-term sobriety

The lack of in person contact has increased relapse rates.

"biggest issue we are seeing is lack of access to mental health and substance abuse services which was already limited Pre-covid. "

Quarantining makes accessing needed treatment and recovery services for an already-marginalized population even more challenging"

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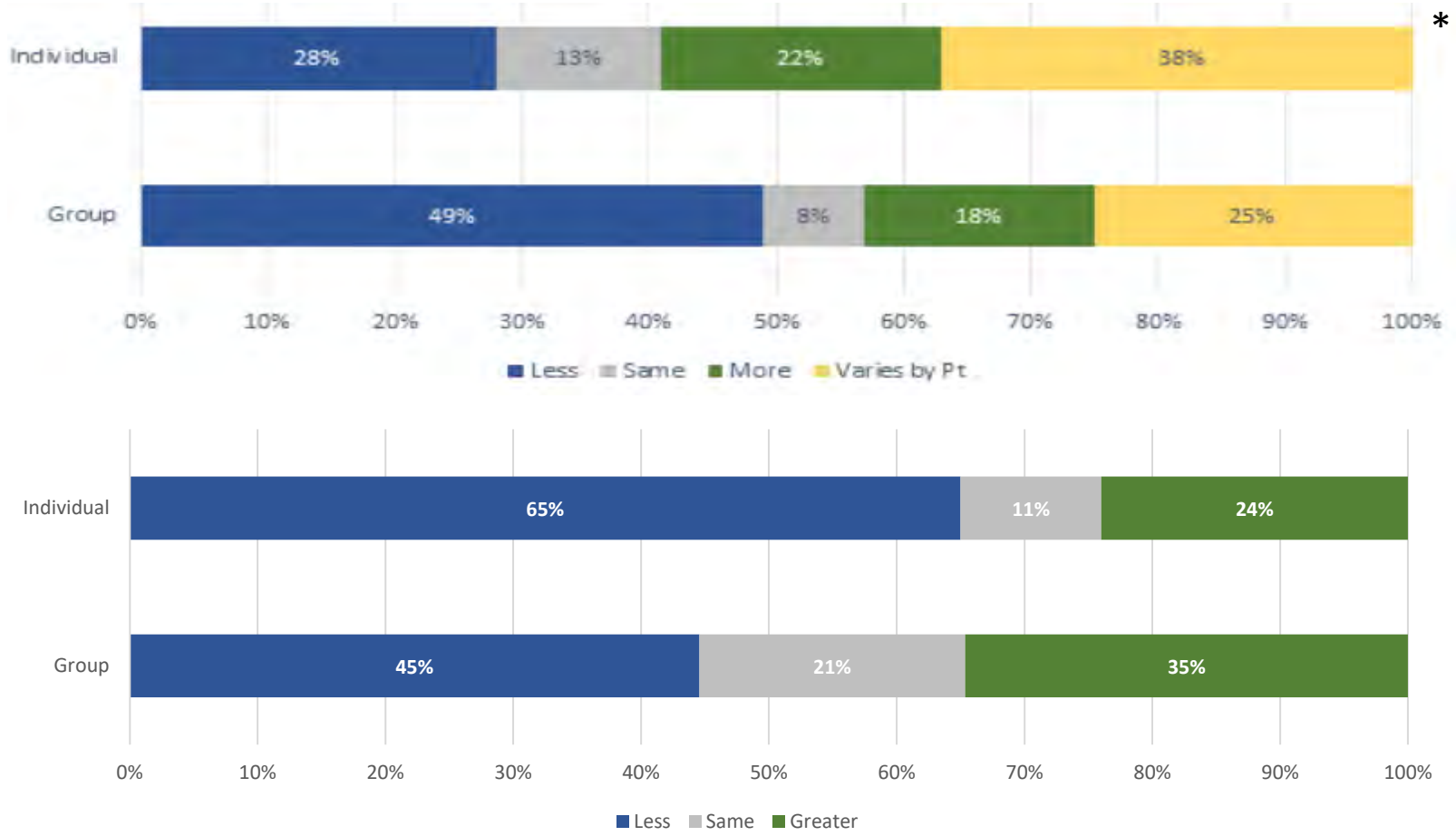
Observations

How telehealth has effected patient engagement in treatment and recovery compared with in person services?



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*Note: this is amended from 9/14/20 presentation based on corrected data

Telehealth – Mixed Experiences

"I have found that some clients seem more willing to share and talk about difficult topics on this [telehealth] venue, and others find it hard to talk at all due to the lack of human connection."

It allows patients to be able to engage in treatment while reducing barriers such as transportation, cost of gas, rides and childcare.

Patients have reported feeling more comfortable sharing information because they are able to be in their own safe spaces.

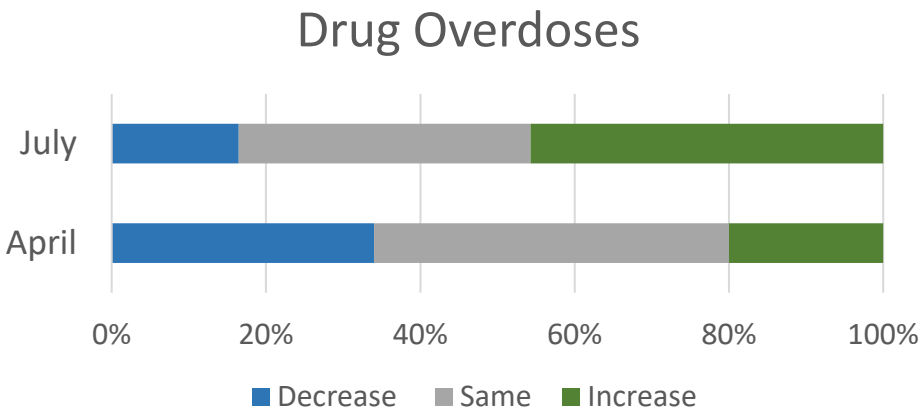
It allowed families to be more engaged in treatment by including family physically in a session with patients or allowing for patients and families to be in different places but connect through the session.

Persons tend to be more engaged with in person treatment including resolving any social detriments that interfere with recovery

Access to technology has become a greater barrier for accessing treatment and support services.

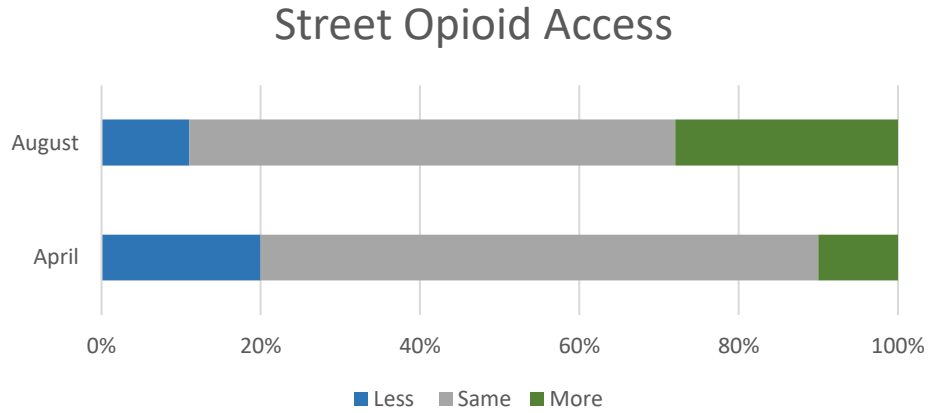
Telehealth does remove the personal contact I feel is necessary in observing S & S of active substance use.

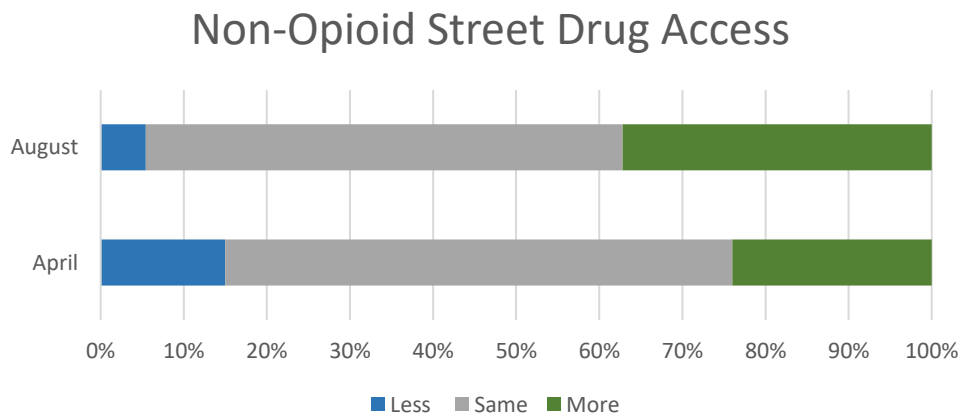
"Many patients do not have access to unlimited cell service. Some don't have video-capable phones and most don't have computers."



*Possible Variations April to July

*Significance not yet assessed





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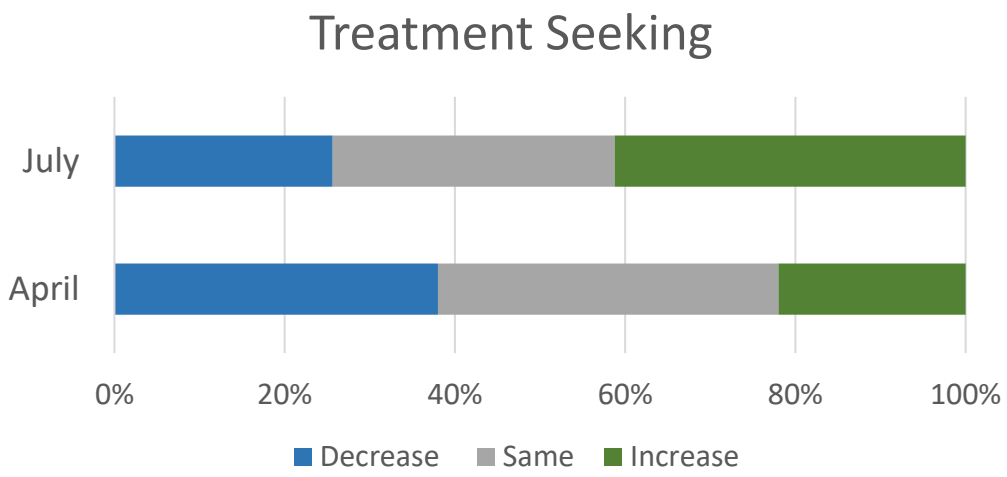

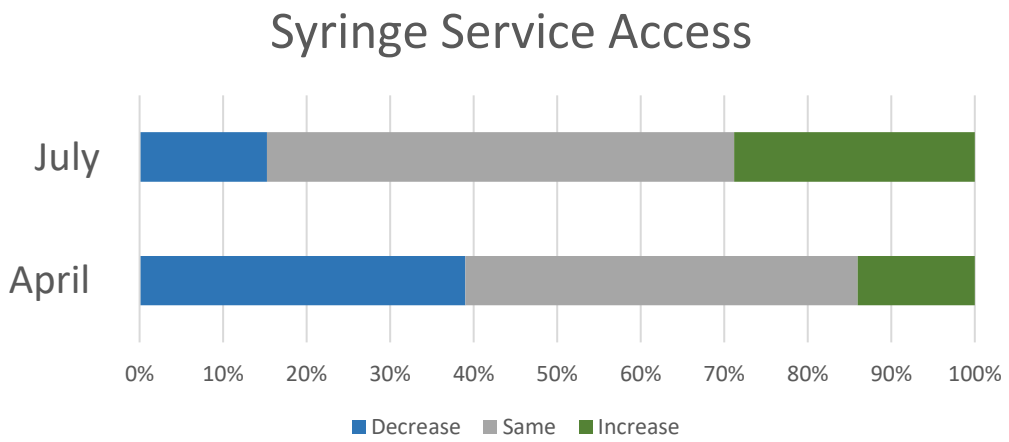

Key Observations

- Anxiety, depression, suicidal ideation are increased.
- Alcohol use is increased. Cannabis use may be.
- Relapses increasing.
- Drug overdoses may be increasing
- Treatment access is changing.
  - More difficult for some
  - Telehealth experiences are mixed.

Next Steps

- Complete analysis of quantitative and qualitative data
- Correlate with hard data (OD, ER visits, drug seizures, etc)
- Prepare paper and presentations to disseminate information
- Evolve strategies to address

Survey Team

Thank you.

Aurora Drew, Elizabeth Saunders, Chantal Lambert-Harris, Charlie Brackett, Luke Archibald, Sally Kraft, Laura Fineberg, Heather Carlos, Ariel Pike, Megan Colgan

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Cannabis Guidance

Will Torrey

September 12, 2020

Guidance purpose

- provide Dartmouth-Hitchcock clinicians with an orientation to state-regulated cannabis use

- offer guidance to improve the care of their patients

Workgroup and review group

Core workgroup

- William Torrey MD (Project Lead, Psychiatry)
- Charles Brackett MD, MPH (Internal Medicine)
- Seddon Savage MD (Pain)
- Luke Archibald MD (Psychiatry, Addictions)
- Erik Shessler MD (Pediatrics)
- Richard Morse MD (Neurology/Pediatrics)
- Matt Wilson MD (Palliative Care/Oncology)
- Andrea Wolffing MD (Surgery, Ethics)
- Jonathan Thyng MD (Family Medicine)
- Alan Budney PhD (Addictions Research)

Administrative Review Workgroup

- Kim Troland (Deputy General Counsel)
- Courtney Tanner (Government Relations)
- Matt Houde (Government Relations)
- Jennifer Gilkie (Communication & Marketing)
- Karen Borgstrom (Communication & Marketing)
- Staci Hermann PharmD MS (Pharmacy)
- Patty Spencer (Medical Staff Services)
- Karen Aframe (Director Employee Relations)
- Karen Chandler (Director QA & Safety)
- Melissa Clary (Risk Management)

Products of the workgroup

- Cannabis Guidance Statement
- Brief guidance for clinicians being asked to certify for therapeutic use of cannabis
- Fact sheet for patients using cannabis to treat symptoms

Cannabis guidance statement content

- Brief general orientation
- Brief introduction to the key constituents of cannabis and recommending specific blends
- D-H position on providers certifying patients as having a qualifying medical condition
- Information about the cannabis certifying process in New Hampshire and Vermont
- Brief summary of current knowledge of the risks of cannabis
- Brief summary of current knowledge of the benefits of cannabis, by qualifying condition
- Workgroup recommendations
- Citations

NH and Vermont laws

- Have been created through a political process
- Have (different) lists of qualifying health conditions
- Allow access to cannabis for individuals who are certified by a physician, an APRN, or a PA as having one or more of the qualifying conditions
- Require that the certifying provider review the potential risks and benefits of cannabis with the patient before certification
- Require follow-up review
- Allow providers to choose whether or not they wish to participate in the certifying process
- Indicate that the role of providers is to certify health conditions, not “prescribe” cannabis.

Ethical considerations

- Healthcare professionals are obligated to promote health (and avoid doing harm) and cannabis carries risk
- Thus, participating in the certification process requires more than making a determination of whether the individual has a legally qualifying condition; it also requires making a case by case determination of whether access to therapeutic cannabis is more likely to promote health than it is to do harm.
- Although physicians/ APRNs/PAs do not “prescribe” cannabis, in certifying a patient, they are taking an action in their role as agents of health that makes cannabis available to the patients and therefore implicitly supports its use.

Risk/benefit determinations challenging

- Cannabis is a plant with numerous biologically active constituents.
- Dispensaries offer a range of cannabis products including variable cannabis species and diverse extract products.
- Many of the health claims for cannabis are anecdotal and not based on scientific studies.
- Scientific evidence supporting the benefits of cannabis is very limited for most of the qualifying health conditions
- In addition to health risks, patients may suffer social risk from cannabis use.
- The overall evidence regarding risks and benefits is complicated and evolving

D-HH Bup Starts ED & Inpatient

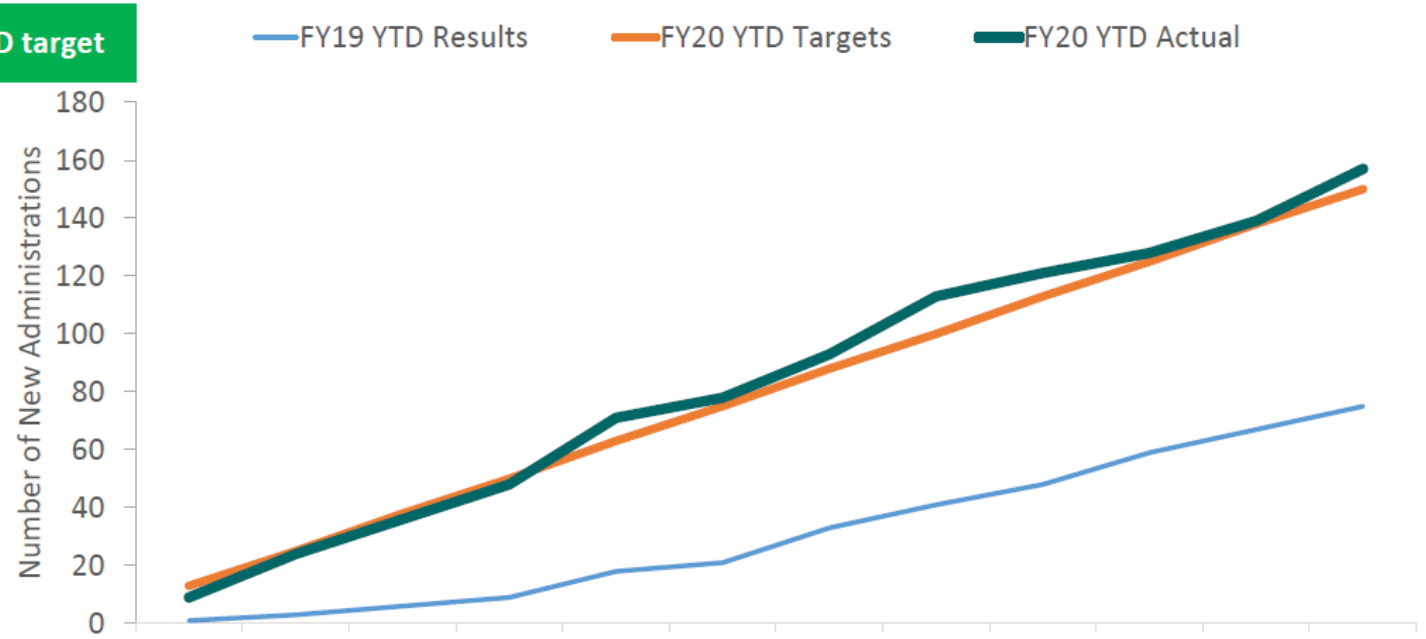
SUMHI Action Update

September 14, 2020

Increase # of Buprenorphine Starts in Inpatient and ED Locations

The total number of patients with a new administration or prescription for buprenorphine in Inpatient and ED Locations. The order or prescription must be new for that encounter.

Better than YTD target



System Results	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
FY20 Monthly Actual	9	15	12	12	23	7	15	20	8	7	11	18
FY20 YTD Actual	9	24	36	48	71	78	93	113	121	128	139	157
FY20 YTD Targets	13	25	38	50	63	75	88	100	113	125	138	150
FY19 YTD Results	1	3	6	9	18	21	33	41	48	59	67	75

Member YTD Results	FY19												
APD	0		0	0	0	0	1	1	2	2	2	2	2	2
CMC/DHK	10		4	7	8	8	13	15	20	26	27	30	31	36
DH DHMC	65		5	17	27	39	54	59	68	82	89	93	103	116
DH CGP														
MAHHC	0		0	0	1	1	3	3	3	3	3	3	3	3
NLH														
VNH														

YTD Results through each month. Colors are based on comparisons to FY20 YTD organization specific targets and FY19 actual performance if available.

Better than FY20 target YTD	Not at FY20 target, better than FY19 actual YTD	Not at FY20 YTD target, worse than FY19 actual

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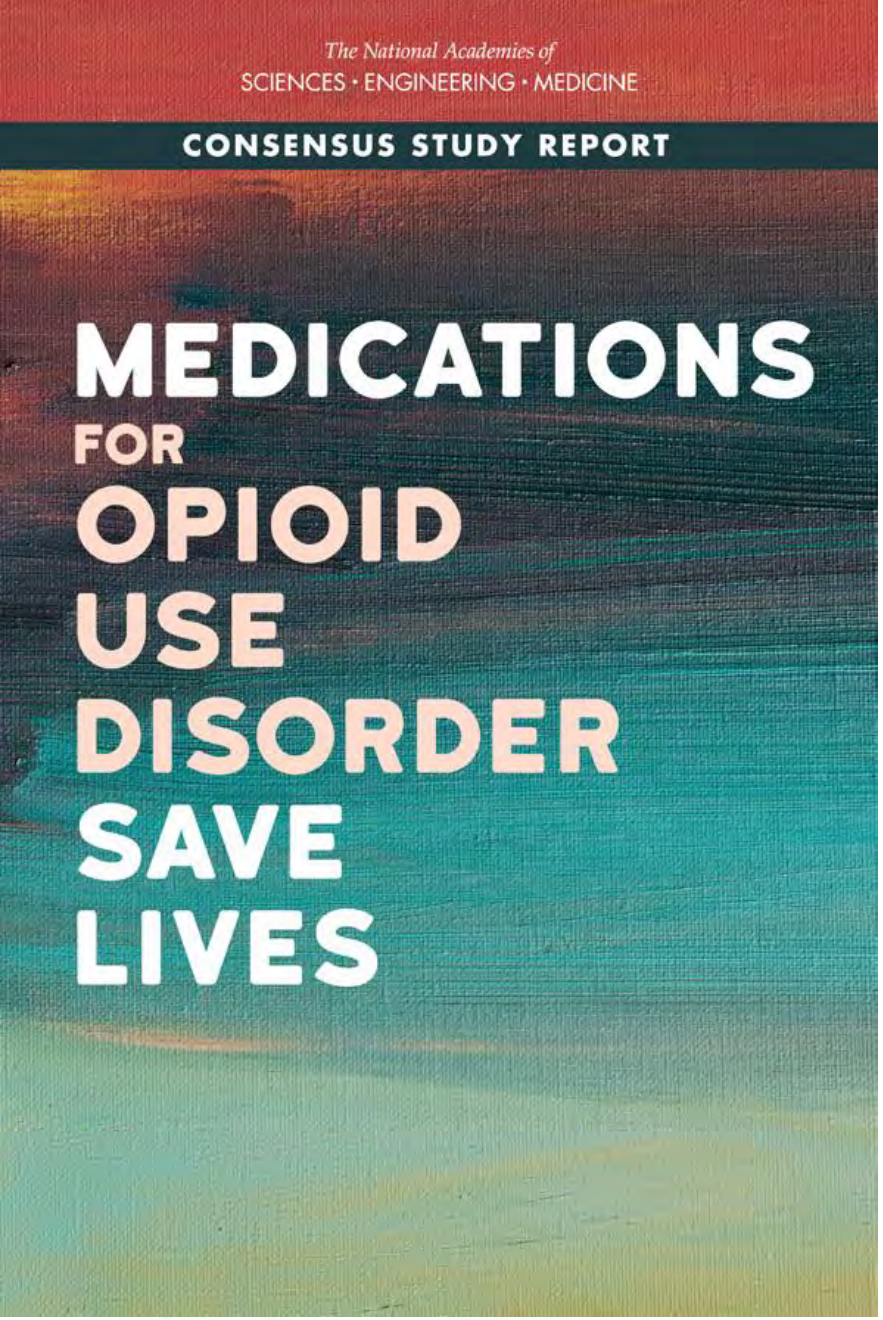

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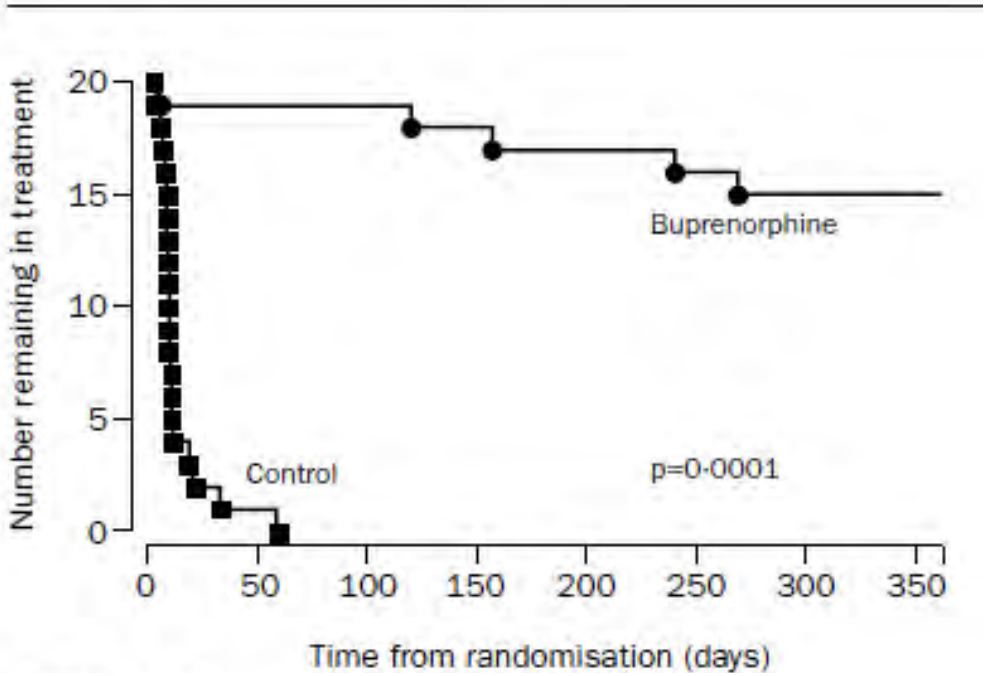

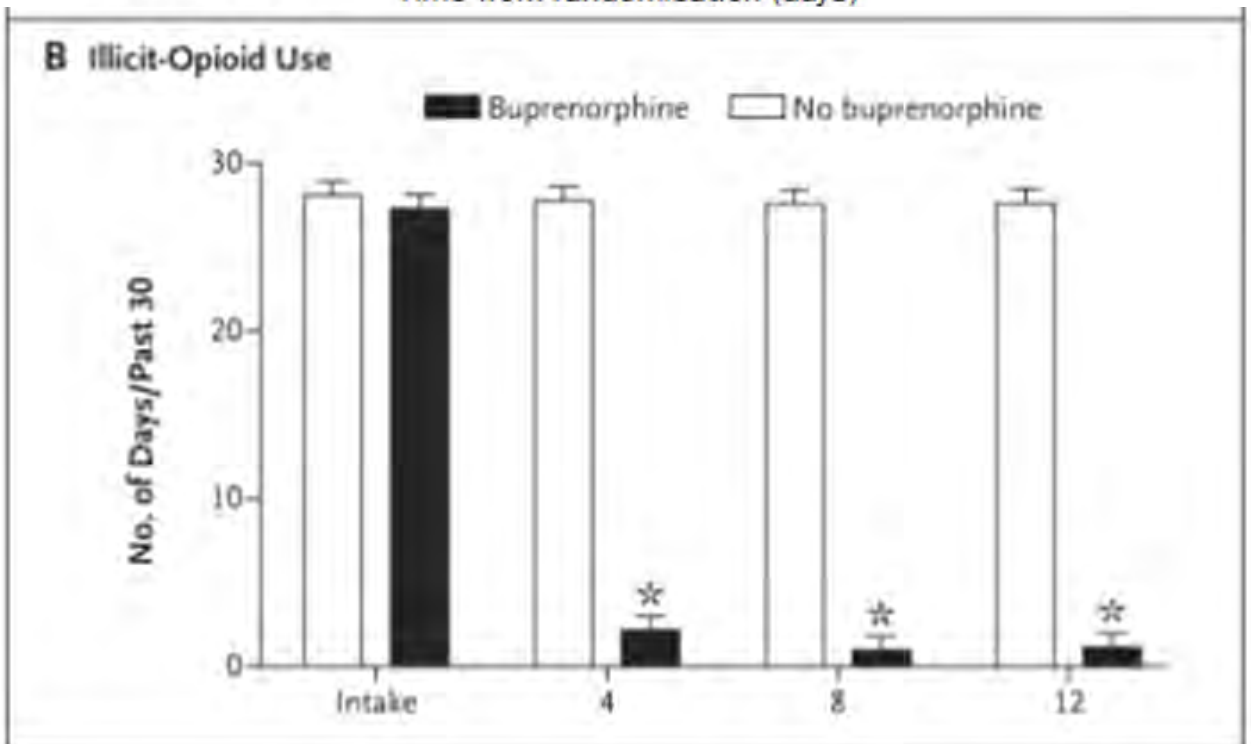

Original Investigation

Buprenorphine Treatment for Hospitalized, Opioid-Dependent Patients
A Randomized Clinical Trial

Jane M. Liebschutz, MD, MPH; Denise Crooks, MPH; Debra Herman, PhD; Bradley Anderson, PhD; Judith Tsui, MD, MPH; Lidia Z. Meshesha, BA; Shernaz Dossabhoy, BA; Michael Stein, MD

- 72.2% in the linkage group vs 11.9% in the detox group entered into outpatient treatment

CONCLUSIONS AND RELEVANCE Compared with an inpatient detoxification protocol, initiation of and linkage to buprenorphine treatment is an effective means for engaging medically hospitalized patients who are not seeking addiction treatment and reduces illicit opioid use 6 months after hospitalization. However, maintaining engagement in treatment remains a challenge.

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Original Investigation

Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence
A Randomized Clinical Trial

Gail D'Onofrio, MD, MS; Patrick G. O'Connor, MD, MPH; Michael V. Pantalon, PhD; Marek C. Chawarski, PhD; Susan H. Busch, PhD; Patricia H. Owens, MS; Steven L. Bernstein, MD; David A. Fiellin, MD

JAMA. 2015;313(16):1636-1644. doi:10.1001/jama.2015.3474

30 day treatment engagement: 78% vs. 37% vs. 45%

CONCLUSIONS AND RELEVANCE Among opioid-dependent patients, ED-initiated buprenorphine treatment vs brief intervention and referral significantly increased engagement in addiction treatment, reduced self-reported illicit opioid use, and decreased use of inpatient addiction treatment services but did not significantly decrease the rates of urine samples that tested positive for opioids or of HIV risk. These findings require replication in other centers before widespread adoption.

Leadership and Teams

D-HH Site:	APD	Mt. Ascutney	New London	SVMC	Cheshire/Keene	SME support at DH
Admin Contact(s)	Lee Ann Bergeron, Prac Dir	Paul Calandrella, COO	Tom Manion, CEO Barbara Mahar, VP EMMA BIDWELL - Admin	Paula Johnson Rachael Trimble, Adm Asst	Shawn LaFrance, VP Pop Hlth	Laura Fineberg, Project support
Leadership	Michael					ckett, MD - Primary Care
Hospitalist Champion	Jose M					ooke, MD - hospitalist ovseth, RN - Director on inpt
Other Inpatient Provider Contact(s)	Daniell					Finn, MD MD
ED Provider Contact(s)	Justin prev. (inter					nter, MD - ED
Other clinical Contact(s)	Sheila Vickie					
Waivered Providers						
Referral Options	Headrest (ambulatory arrangem	CT Valley Recovery Services (Fred Lord);	(Frenklewich) Steve Powell's clinic (Grantham) Counseling associates	SaVida Healthcare (and 2 other less robust spokes)	Doorway, Nelson Hayden Phoenix House (inconsistent) *This is barrier for ED prescribing	Doorway available for all of NH

Toolkit for Addressing OUD in ED and Inpatient Settings: Intro, Tasks, Resources

Tasks to Prepare for Implementation

- ***Assemble a multidisciplinary team***
- ***Consider training all staff on understanding addiction, with the goal of reducing stigma.***
- ***Create a workflow for initiation of buprenorphine for patients in withdrawal.***
- ***Establish a relationship with one or more local addiction treatment providers.***
- ***Clarify who is responsible for arranging outpatient follow-up.***
- ***Clarify who will provide a bridge prescription at discharge.***
  - **Get clinicians waivered to prescribe buprenorphine *(esp in ED)***
- ***Consider standardized screening***
- ***Naloxone education and prescription***

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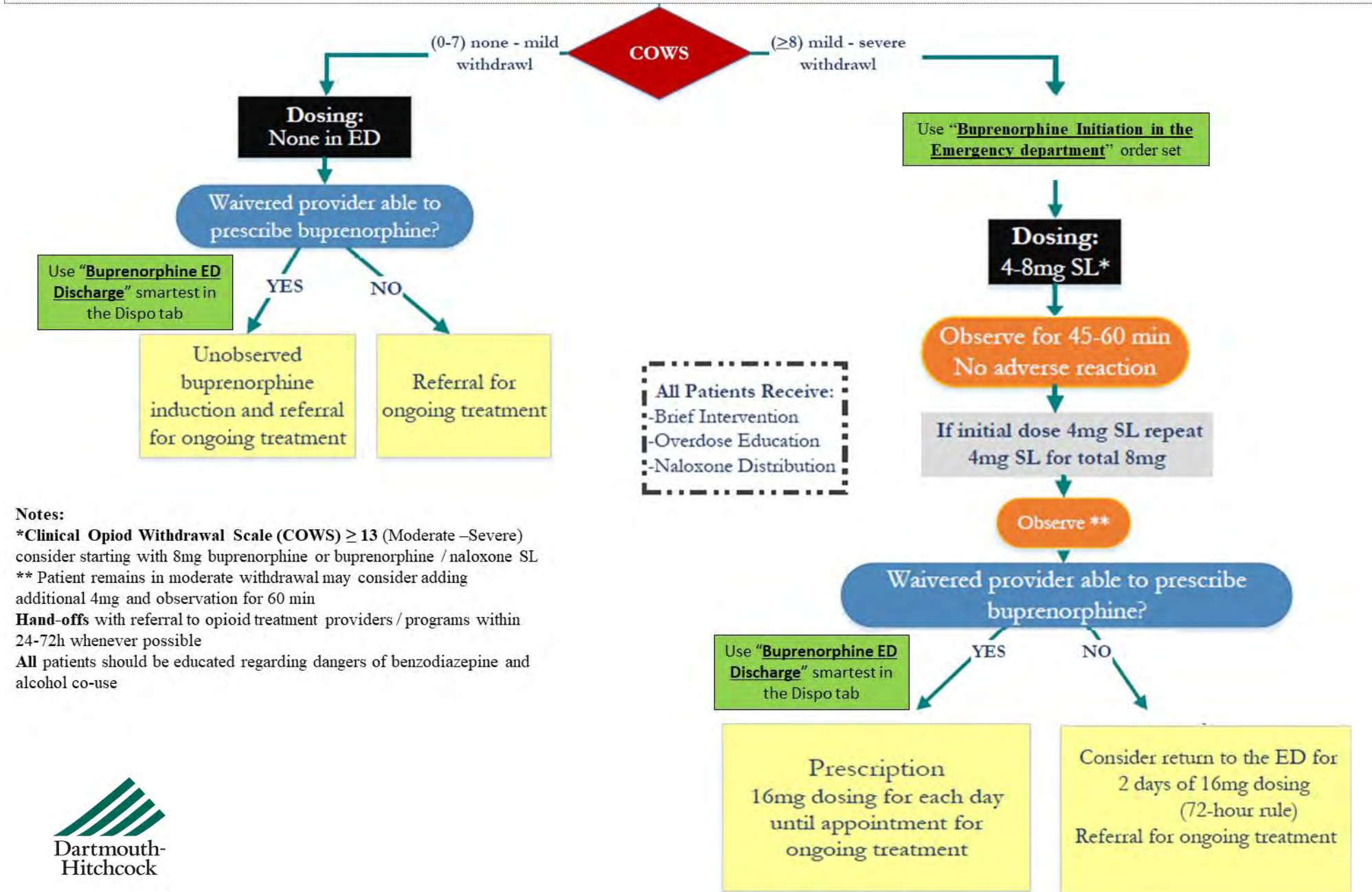
Staff education

-Talks:
All staff: MOUD 101, Science of Addiction, Stigma
Hospitalists: Inpatient Management of OUD
-Academic detailing- 2.5 page summary for hospitalists
-SUMHI Website:
https://med.dartmouth-hitchcock.org/sumhi.html

ED-Initiated Buprenorphine

Diagnosis of Moderate to Severe Opioid Use Disorder
Assess for opioid withdrawal and last use



Notes:

***Clinical Opiod Withdrawal Scale (COWS) ≥ 13** (Moderate –Severe) consider starting with 8mg buprenorphine or buprenorphine / naloxone SL

** Patient remains in moderate withdrawal may consider adding additional 4mg and observation for 60 min

Hand-offs with referral to opioid treatment providers / programs within 24-72h whenever possible

All patients should be educated regarding dangers of benzodiazepine and alcohol co-use

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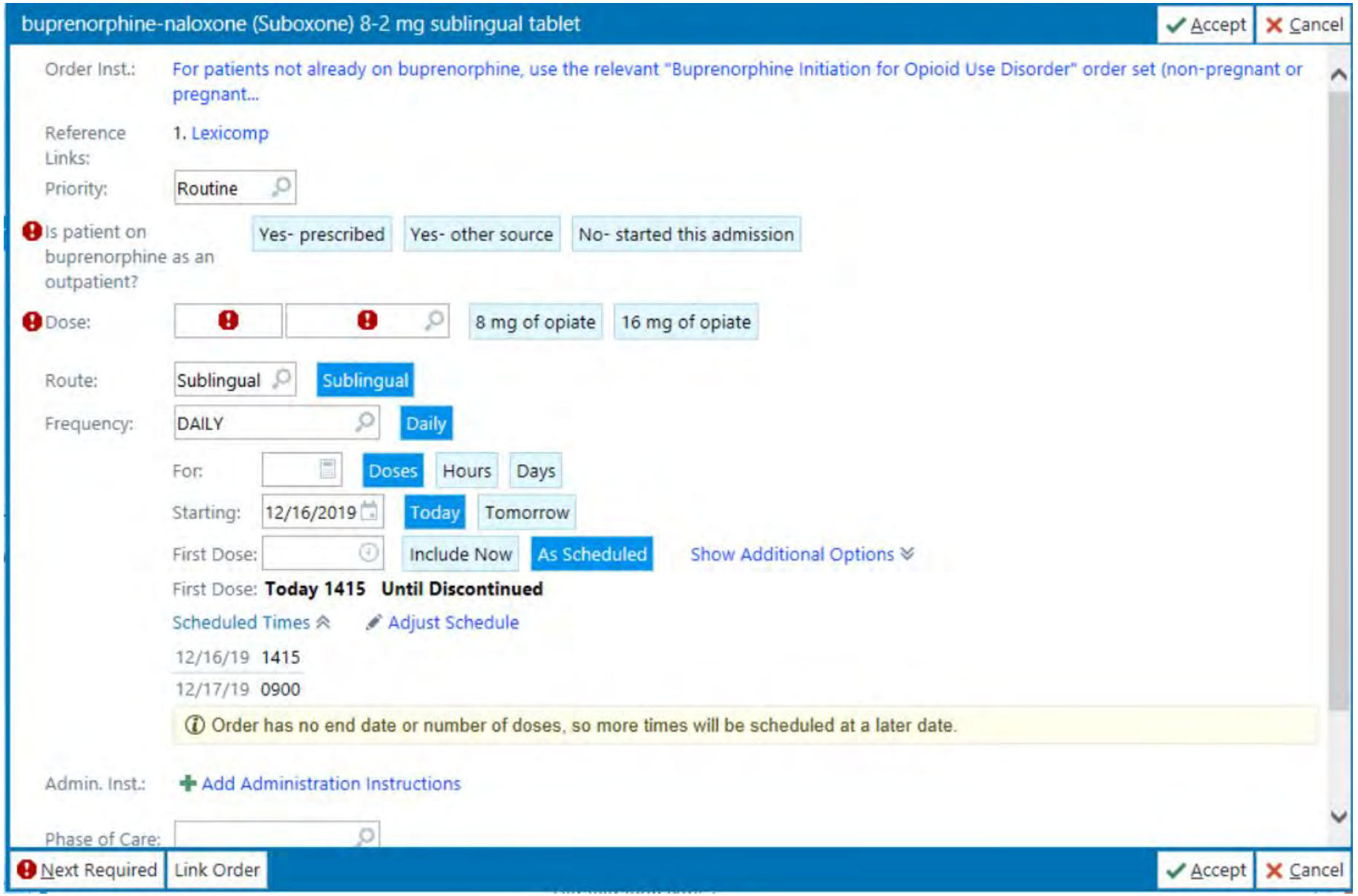
eDH tools

-Adapt existing DHMC inpatient and ED ordersets (And ED discharge smartset) to other eDH users: Cheshire, APD, New London (10/20)
-If not on eDH, create an orderset using local EHR

Outside of Order set (continuing outpatient buprenorphine)



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Initiation Order set

Buprenorphine Initiation for Opioid Use Disorder in Non-Pregnant Adult Inpatients

* Contact the behavioral intervention team (BIT) to evaluate all patients who are being initiated on buprenorphine.
* This order set only covers day 1 loading dose of buprenorphine and PRNs on day 1, 2 and 3 for signs of withdrawal- the morning dose of buprenorphine for day 2 and beyond needs to be ordered separately. For days 2- 3, give the total amount received on the previous day as a single dose at 9 am. A stable ongoing dose can usually be determined by day 3-4.

- Buprenorphine for Opioid Use Disorder in Adult Patients Policy
- Buprenorphine initiation for Opioid Use Disorder in Adult Patients Procedure

Nursing Assessments — Collapse

Nursing assessement / monitoring

- [x] Opiate / Opioid Withdrawal - Assessment:
  Routine, UNTIL DISCONTINUED starting Today at 1625 Until Specified
  Assess patient every 2 hours while awake using the Clinical Opiate Withdrawal Scale (COWS) scoring tool.
- [x] Notify Provider / HERT / Stat Airway
  Routine, UNTIL DISCONTINUED starting Today at 1625 Until Specified
  If Respiratory rate less than 8 breaths per minute or Sp02 less than 90%: Call house officer or Hitchcock Early Response Team (HERT) or Stat Airway Team.

Consults — Collapse

Buprenorphine Initiation Consult Orders

- [x] Consult to Psychiatry
  P Contact the behavioral intervention team (BIT) to evaluate all patients who are being initiated on buprenorphine.
- [x] Consult to Social Work
  P Details
- [x] Consult to Pharmacy
  Pharmacy to review patient meds? No
  P Check for drug interactions? No
  Reason for Consult? Pharmacy managed Buprenorphine

Medications

Nursing Assessments

Nursing assessment / monitoring

- [x] Opiate / Opiod Withdrawl - assessments
  - [x] Opiate / Opioid Withdrawl - Assessment
    Routine, EVERY 4 HOURS WHILE AWAKE, First occurrence today at 1800, for 48 hours
    Reassess patient one hour after Initial and PRN doses of buprenorphine using the COWS scoring tool., Assess and Document per frequency ordered using the Clinical Opiate Withdrawal Scale (COWS) scoring tool.
  - [x] Opiate / Opioid Withdrawl - Assessment
    Routine, EVERY 12 HOURS, First occurrence on Wed 3/11 at 1515, for 24 hours
    Reassess patient one hour after Initial and PRN doses of buprenorphine using the COWS scoring tool., Assess and Document per frequency ordered using the Clinical Opiate Withdrawal Scale (COWS) scoring tool.

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Medications

Collapse

Initiation Medications

- [x] Buprenorphine-Naloxone (SUBOXONE) Panel

  buprenorphine-naloxone (SUBOXONE) 2-0.5 mg sublingual tablet 2 tablet

  2 tablet, Sublingual, ONCE, 1 dose Today at 1645

  DAY 1: To avoid precipitating withdrawal, the first dose of buprenorphine should be started only when objective signs of moderate withdrawal appear. **Patient must score greater than or equal to 12 per the Clinical Opiate Withdrawal Scale (COWS) scoring tool.

  Routine

  Followed by

  buprenorphine-naloxone (SUBOXONE) 2-0.5 mg sublingual tablet 1-2 tablet

  1-2 tablet, Sublingual, EVERY 2 HOURS PRN starting Today at 1645 until Thu 7/19 at 1644, opioid withdrawal - uncomplicated

  Day 1 **1-2 tablet, Sublingual, EVERY 2 HOURS PRN. Per the Clinical Opiate Withdrawal Scale (COWS) scoring tool: **For withdrawal score of 5-12, give 1 (2 mg-0.5 mg) tablet **For withdrawal score of greater than 12, 2 (2 mg-0.5 mg) tablets - Contact provider if patient reaches a total daily dose of 12 mg of buprenorphine on day one of induction and continues to score on the COWS. Day 2 and 3 **1-2 tablet, Sublingual, EVERY 2 HOURS PRN. Unless sedated, give the previous day's total dose of buprenorphine as a single dose at 8 am then: Per the Clinical Opiate Withdrawal Scale (COWS) scoring tool: **For withdrawal score of 5-12, give 1 (2 mg-0.5 mg) tablet **For withdrawal score of greater than 12, give 2 (2 mg-0.5 mg) tablets - Contact provider if patient reaches a total daily dose of 16 mg of buprenorphine on day two of induction and continues to score on the COWS.

  Routine

- [x] Buprenorphine - daily order reminder 1 each

  1 each, Oral, DAILY, First Dose Tomorrow at 0900, For 3 days

  If the daily Buprenorphine order has not been placed, contact the Provider to confirm that the order will be written, the dose is held or discontinued.

Adjunctive Medications

- [ ] cloNIDine (CATAPRES) tablet
  0.1 mg, Oral, EVERY 6 HOURS PRN, for restlessness, sweating, or tremor, Hold if SBP is less than 105 mmHg.
- [ ] dicyclomine (BENTYL) capsule
  20 mg, Oral, EVERY 6 HOURS PRN, Abdominal cramps
- [ ] loperamide (IMMODIUM) capsule
  2 mg, Oral, EVERY 6 HOURS PRN, Diarrhea
- [ ] acetaminophen panel
- [ ] mirtazapine (REMERON) tablet
  15 mg, Oral, NIGHTLY PRN, Sleep
- [ ] hydrOXYzine (ATARAX) tablet
  50 mg, Oral, EVERY 6 HOURS PRN, for itching, anxiety, or insomnia not improved by mirtazapine

Labs

- [x] Buprenorphine Intitiation dose

  buprenorphine-naloxone (Suboxone) 2-0.5 mg disintegrating tablet 2-4 tablet ($)

  2-4 tablet (4-8 mg of opiate), Sublingual, ONCE, 1 dose, today at 1530

  Day 1: COWS score of 8 - 12: give two (2 mg-0.5 mg) tablets; COWS score of 13 or greater: give four (2 mg-0.5 mg) tablets

  To avoid precipitating withdrawal, the first dose of buprenorphine should be started only when objective signs of withdrawal appear.

  Routine

  Followed by

  buprenorphine-naloxone (Suboxone) 2-0.5 mg disintegrating tablet 2 tablet ($)

  2 tablet, Sublingual, EVERY 1 HOUR PRN, starting today at 1530, until Thu 3/12 at 1529, opioid withdrawal - uncomplicated

  Day 1 **For withdrawal score of greater than 5; two (2 mg-0.5 mg) tablets -Contact provider if patient reaches a total daily dose of 16 mg of buprenorphine on day one of induction and continues to score >5 on the COWS. Day 2 and 3 **Unless sedated, give the previous day's total dose of buprenorphine as a single dose at 8 am, then continue to dose PRN per the COWS scoring tool. **For withdrawal score greater than 5, give two (2 mg-0.5 mg) tablets. Contact provider if patient reaches a total daily dose of 16 mg of buprenorphine on day two & three of induction and continues to score on the COWS.

  Routine

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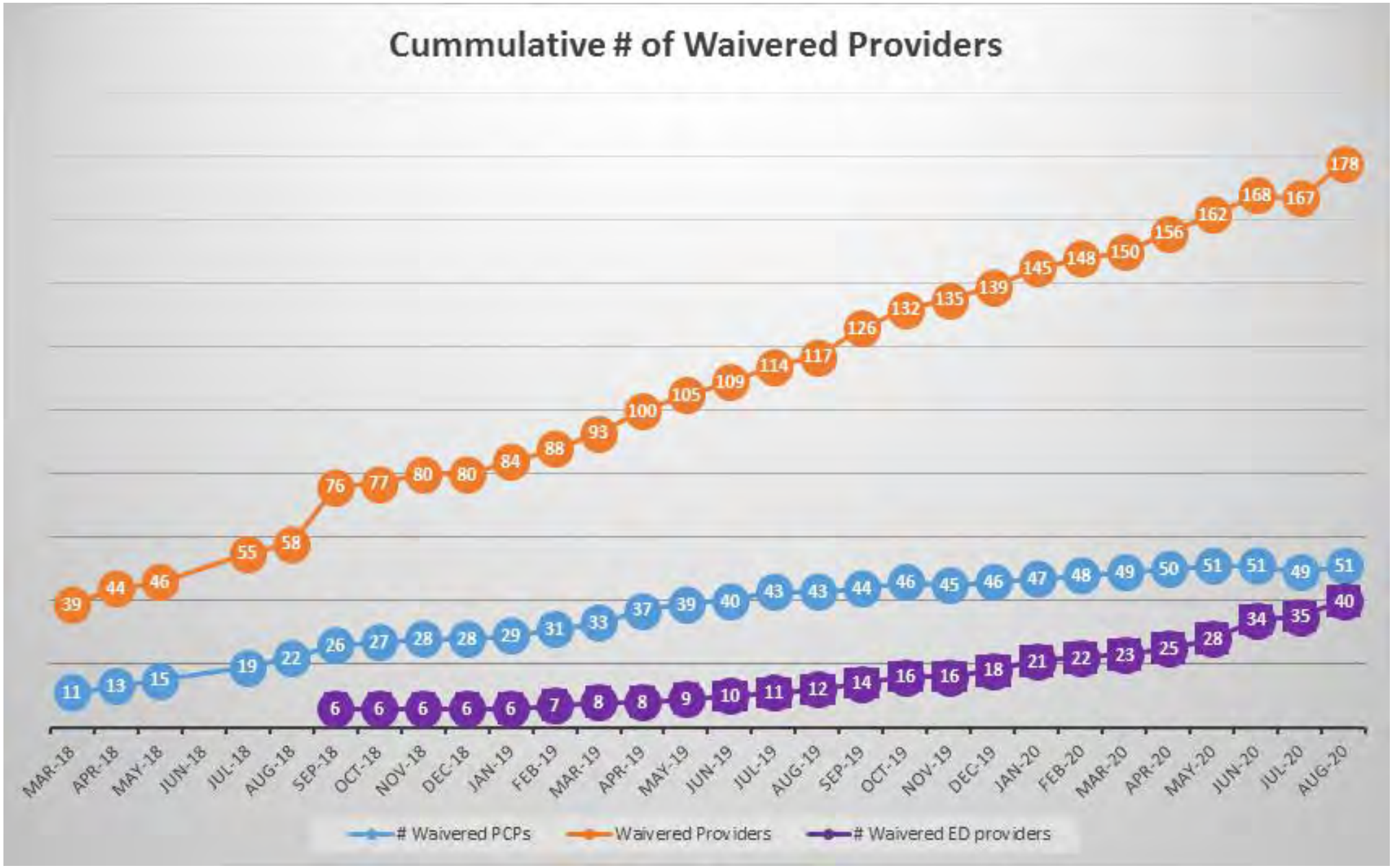
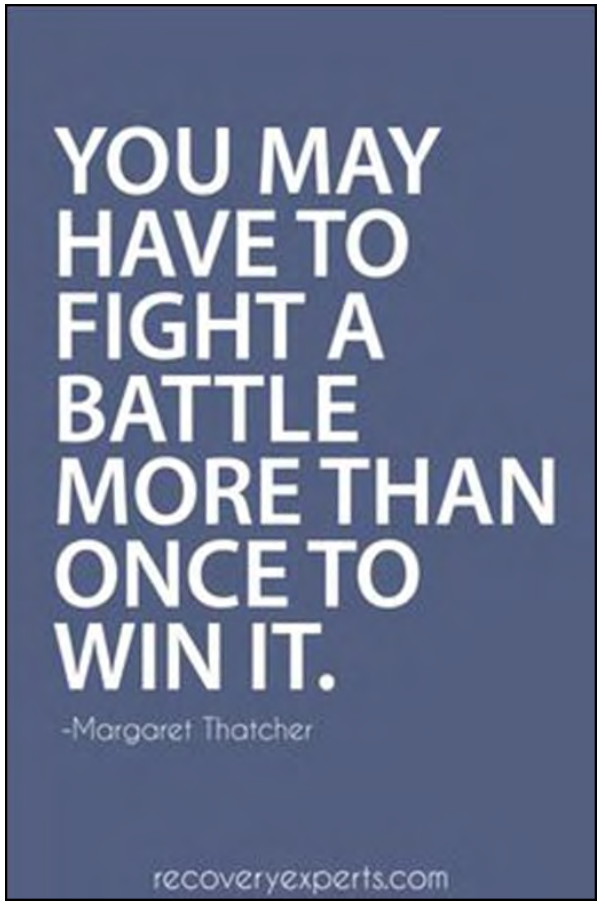
Encourage X-Waiver: in person or online



Overdose Prevention – Naloxone

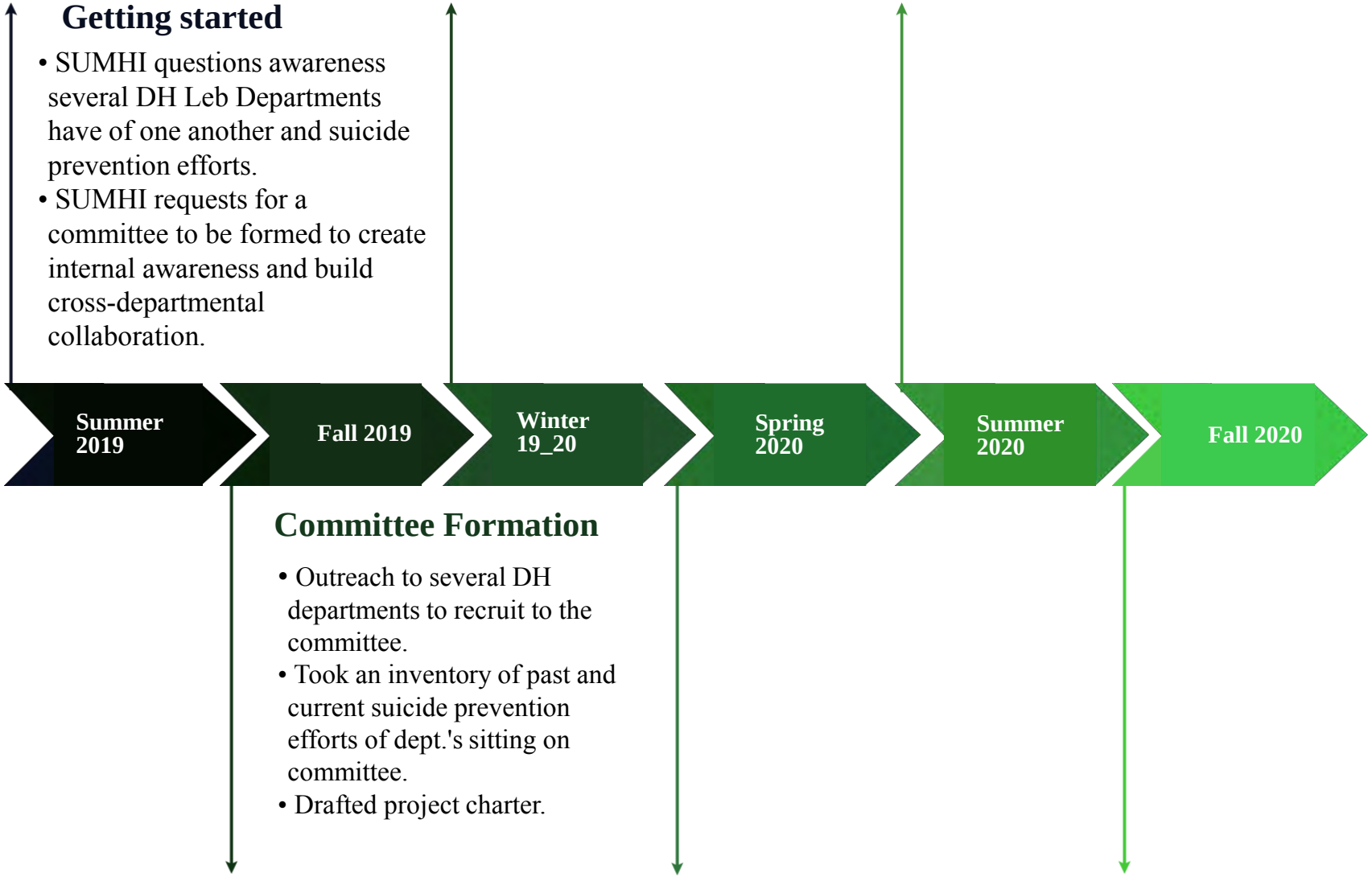
- Risk/Harm reduction education
  - Never use alone
  - Do not lock the door
  - Same dealer
  - Avoid combining sedating substances
  - Test shot
  - Fentanyl test strips
  - Aseptic technique
- Refer to appropriate treatment
- **Naloxone for patient and supports**

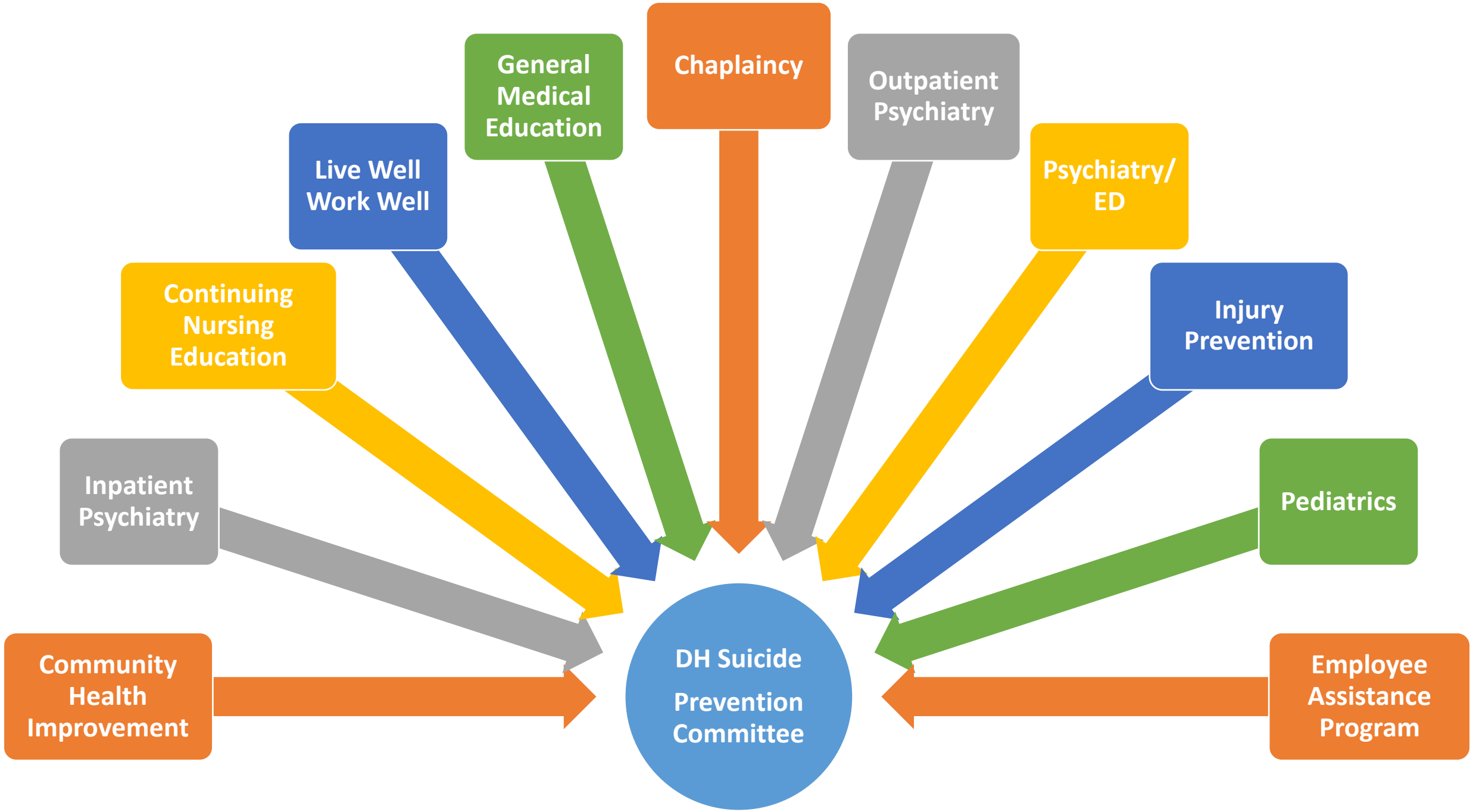


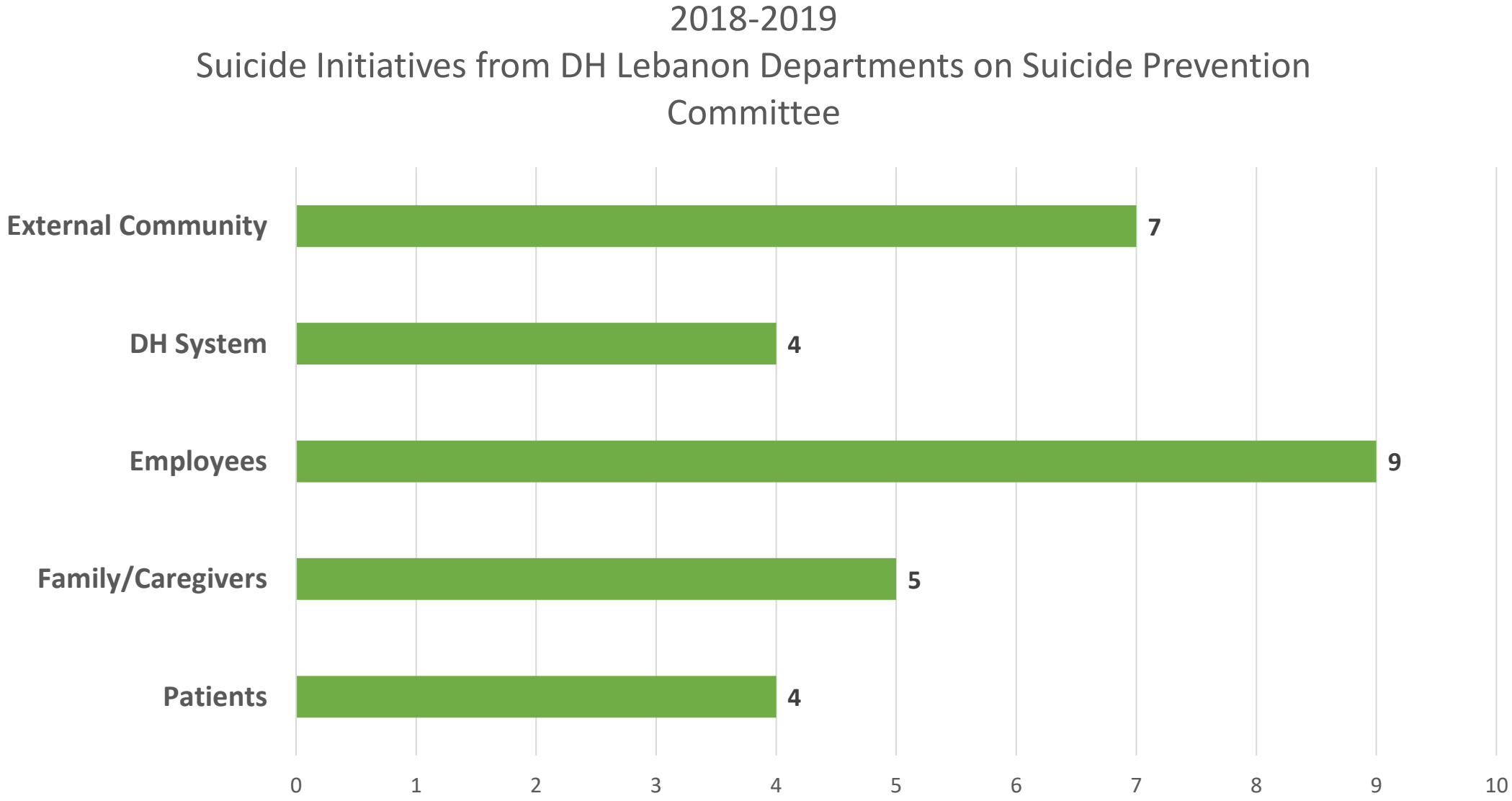
DH Suicide Prevention Initiative SUMHI 9.14

Angie Raymond Leduc and Maureen Gardella

DH Suicide Prevention Committee Formation




General Medical Education
Chaplaincy
Outpatient Psychiatry
Live Well Work Well
Psychiatry/ ED
Continuing Nursing Education
Injury Prevention
Inpatient Psychiatry
Pediatrics
Community Health Improvement
DH Suicide Prevention Committee
Employee Assistance Program


2018-2019
Suicide Initiatives from DH Lebanon Departments on Suicide Prevention Committee
External Community
7
DH System
4
Employees
9
Family/Caregivers
5
Patients
4
0
1
2
3
4
5
6
7
8
9
10

DH Suicide Prevention Committee Efforts

How we started, what we've accomplished and where we hope to go.

Summer 2019

Getting started

- SUMHI questions awareness several DH Leb Departments have of one another and suicide prevention efforts.
- SUMHI requests for a committee to be formed to create internal awareness and build cross-departmental collaboration.

Fall 2019

Committee Formation

- Outreach to several DH departments to recruit to the committee.
- Took an inventory of past and current suicide prevention efforts of dept.'s sitting on committee.
- Drafted project charter.

Winter 19_20

Building momentum

- Developed two working groups.
- Trained the Committee in Connect Suicide Prevention Gatekeeper.
- Planned a Connect Suicide Prevention Training of the Trainer for the spring to train 16+ DH employees as trainers.

Spring 2020

Progress and then Halt

- Interviewed 3 healthcare stakeholders who have implemented the Zero Suicide Framework.
- Applied for CDC Comprehensive Suicide Prevention Grant.
- Connect Training of Trainer : CANCELLED DUE TO COVID19
- Took a break from frequent meetings due to reassignments of roles.

Summer 2020

Regroup & Refocus

- Began virtual meeting schedule.
- Had 15 DH employees review and provide feedback on Connect Suicide Prevention Webinar Trainings for Healthcare and Mental Healthcare
- Focused efforts on next steps to propose DHH undergo the Zero Suicide Organizational Self-Study
- Increase Connect Program Trainings (virtually)

Fall 2020

Motivate & Engage

- Prepare our proposal to leadership.
- Obtain leadership support.
- Recruit more members from DHH system.
- Seek funding opportunities.
- Train more staff in Connect Suicide Prevention
- Find a champion.

Suicide Facts & Figures:
New Hampshire 2020

On average, one person died by suicide every 31 hours in the state.

Almost six times as many people died by suicide in New Hampshire in 2018 than in alcohol related motor vehicle accidents.

The total deaths to suicide reflected a total of 5,199 years of potential life lost (YPLL) before age 65.

Suicide cost New Hampshire a total of **$222,439,000** combined lifetime medical and work loss cost in 2010, or an average of **$1,134,894 per suicide death**.

8th leading cause of death in New Hampshire

2nd leading
cause of death for ages 10-44

4th leading
cause of death for ages 45-54

6th leading
cause of death for ages 55-64

16th leading
cause of death for ages 65+

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
New Hampshire	**279**	**19.27**	**12**
Nationally	48,344	14.21	

CDC, 2018 Fatal Injury Reports (accessed from www.cdc.gov/injury/wisqars/fatal.html on 3/1/2020).

Suicide Facts & Figures:
Vermont 2020

On average, one person died by suicide every three days in the state.

More than eight times as many people died by suicide in Vermont in 2018 than in alcohol related motor vehicle accidents.

The total deaths to suicide reflected a total of 2,290 years of potential life lost (YPLL) before age 65.

Suicide cost Vermont a total of **$117,583,000** combined lifetime medical and work loss cost in 2010, or an average of **$1,109,277 per suicide death**.

8th **leading cause of death in Vermont**

2nd leading
cause of death for ages 10-44

4th leading
cause of death for ages 45-54

5th leading
cause of death for ages 55-64

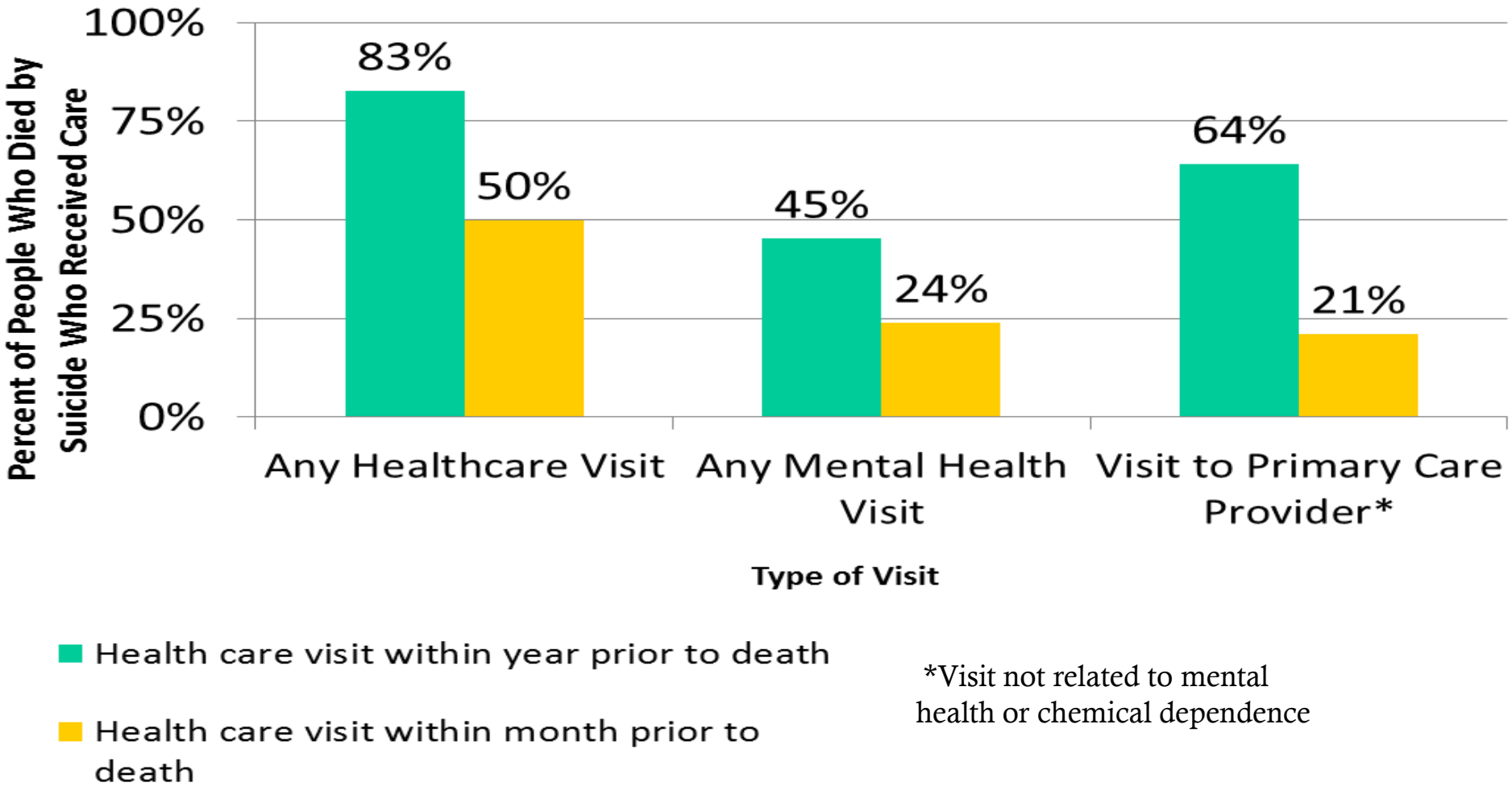
15th leading
cause of death for ages 65+

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
Vermont	**125**	**18.66**	**18**
Nationally	48,344	14.21	

CDC, 2018 Fatal Injury Reports (accessed from www.cdc.gov/injury/wisqars/fatal.html on 3/1/2020).

Health Care and Suicide Deaths



*Visit not related to mental health or chemical dependence

(Ahmedani, 2014)

www.zerosuicide.sprc.org

10.6%

of Employees (During any part of FY 2019) had a Depression Dx

From Claims Data regarding Employees that are members of the Employee Health Plan

Employee Health Plan
Members During Any Part of FY 2019 with a Depression Dx from Claims Data

Member Counts	
Relationship	Depression
Employee	873
Spouse	270
Child	301
Other or N/A	19
Grand Total	**1,463**

% of All Members	
Relationship	Depression
Employee	10.6%
Spouse	8.8%
Child	5.2%
Other or N/A	12.8%
Grand Total	**8.5%**

from file: Chronic Condition Prevalence.xlsx

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Suicide Among Physicians

Physicians have higher rates of burnout, depressive symptoms, and suicide risk than the general population. Physicians and trainees can experience high degrees of mental health distress and are less likely than other members of the public to seek mental health treatment. Physicians report several barriers to seeking mental health care, including time constraints, hesitancy to draw attention to self-perceived weakness, and concerns about reputation and confidentiality. Other facts include:

- Suicide generally is caused by the convergence of multiple risk factors — the most common being untreated or inadequately managed mental health conditions.[1,2]
- Physicians who took their lives were less likely to be receiving mental health treatment compared with nonphysicians who took their lives even though depression was found to be a significant risk factor at approximately the same rate in both groups.[3]
- The suicide rate among male physicians is 1.41 times higher than the general male population. And among female physicians, the relative risk is even more pronounced — 2.27 times greater than the general female population.[2]
- Twenty-eight percent of residents experience a major depressive episode during training versus 7–8 percent of similarly aged individuals in the U.S. general population.[1]

ZERO SUICIDE

The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving patient safety, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care.

LEARN MORE »

ZERO Suicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

https://zerosuicide.edc.org/

QUESTIONS?

CHESHIRE MEDICAL CENTER/DARTMOUTH-HITCHCOCK

MAT Program with Cheshire County Drug Court

Drug Court MAT Program

- Has been operating through Cheshire Medical Center connections for the last 3 ½ years
  - The primary provider here with regards to prescribing is Dave Segal, PA

- Goal is to provide an opportunity for Department of Corrections (DOC) inmates to participate in a court sanctioned MAT Program that provides an alternative to sentencing and serving time in jail

- Program creates a triad of care points including:
  - The Court system (judge, county attorney, public defender, correction officer)
  - The Support System (Drug Court Case Manager, counselors)
  - The Medical Component (prescribing provider)

Drug Court MAT Program-Provider Role

- Responsibilities of provider at Cheshire Medical Center/Dartmouth-Hitchcock
  - Attends every other week meetings.
    - Meetings are 1 hour
    - Provider is allotted time to attend
    - Meetings bring together all the aforementioned participants
  - Advises on all medically-related issues
      - Participants are required to sign release
      - Provider reviews medical record
      - Reports on medically related issues such as ER visits, office visits etc.
  - Prescribes suboxone to participants

Drug Court MAT Program-Process

- Department of Corrections that wish to participate must petition the court
- The petition proceeds through the DOC Case Manager
- The inmate is presented to the Team for review
- Acceptance into the program is confirmed essentially by a vote of members
- Once accepted into the program the inmate is referred to the provider while in jail for induction
  - Induction starts 2 weeks before release from incarceration
  - While incarcerated the inmate attends regular counseling sessions and meetings with DOC case manager, court appointed counselor
  - Participation in these sessions is mandatory to continue with the program while incarcerated

Drug Court MAT Program-Process

- At release, the inmate/client is given a prescription for suboxone to bridge them until first appointment with provider at DH clinic
  - Partnered locally with CVS
- After the inmate has established with the provider, they will follow up with 1 to 2 week appointments and prescriptions until stabilized
- After stabilized, the script will change to 28 days
- Requirements for the inmate/client
  - Receive urine drug screens weekly
  - Must participate in group sessions for substance abuse
  - Must attend individual counseling sessions
  - Must complete a variety of assignments from these sessions
  - Typically will go before the judge weekly with their attorney and DOC case manager to discuss progress

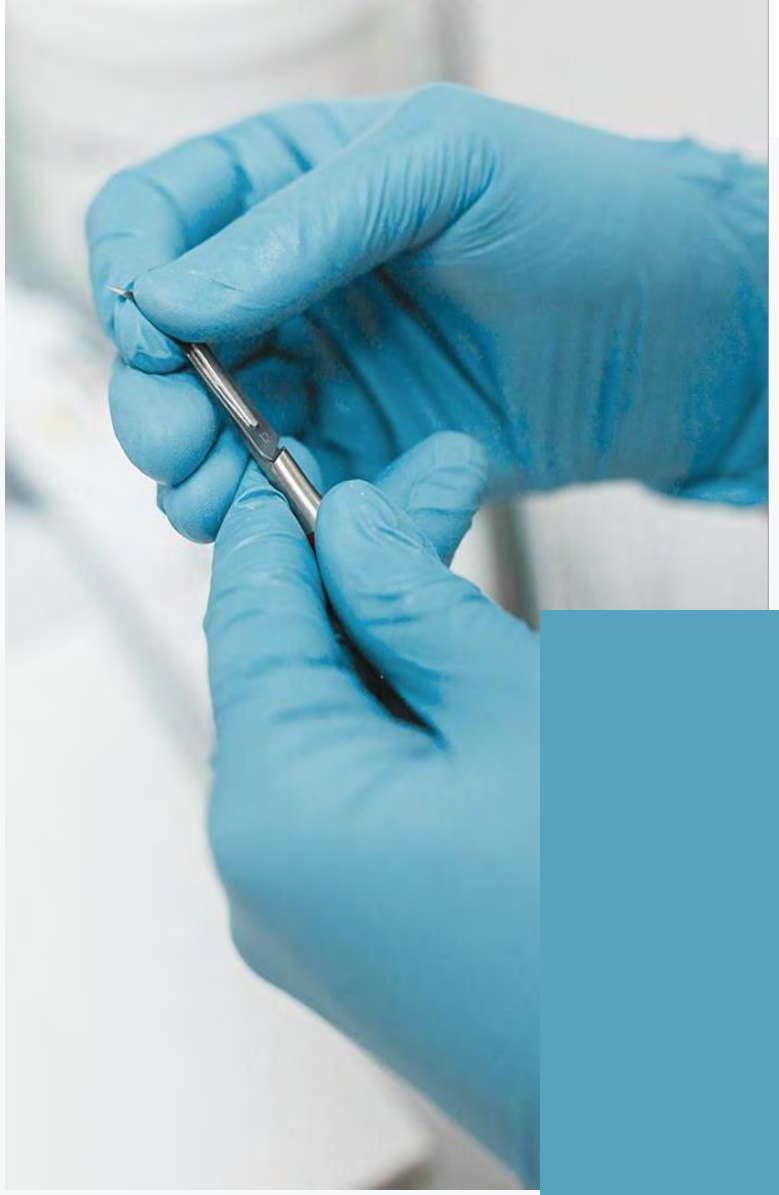
Drug Court MAT Program-Process

- Additionally, the CMC/DH provider may also obtain clients via the drug court who are in another MAT program that need to be switched secondary to distance to other provider or insurance issues

- Successes:
  - "Graduation rate" through our program is 75%
  - Those that graduate remain with our provider provided they are in counseling
  - Some graduates transfer to another clinic

- Consequences
  - Those that do not comply with the Drug Court recommendations (usually after multiple attempts to correct behavior) must serve their time in jail

Redesigning Care for Patients with Serious Infections Due to Injection Drug Use



The Problem

Patients who inject drugs (PWID) are typically excluded from home IV antibiotics and often receive suboptimal treatment regimens, leading to poor outcomes, long hospital stays, frequent readmissions, and missed opportunities to initiate SUD treatment.

The Proposal

Comprehensive treatment plans for integrated infectious disease and addiction care, which prioritize discharge on home IV antibiotics partnered with addiction treatment.

Program Benefits

Patients

- ✓ Universal standard of care
- ✓ Completion of treatment course
- ✓ Reliable dedicated care for addiction, clear path to recovery
- ✓ Care where they prefer it: outside of the hospital
- ✓ Faster return to the community

Health System

- ✓ Decrease in length of stay (estimated 20-day reduction in average LOS)
  - *Predicted direct cost savings @ 85 admissions/yr: $2.4 million*
  - *Revenue opportunity from 1700 additional bed days/yr*
- ✓ Decrease in readmissions
- ✓ Better partnerships with community health agencies
- ✓ Reduced strain on inpatient care team


Jon Lurie
Academic Mentor & Hospital Medicine
Elias Loukas
Hospital Medicine & Care Management
Danielle Pierotti
Visiting Nurse and Hospice
Sarah Mullins
Patient Partner
Colleen Kershaw
Infectious Disease
OUR TEAM
Charlie Brackett
Primary Care
Chris Finn
Psychiatry
Melissa Borrows
NELC
Elizabeth Carpenter-Song
Medical Anthropology

Approach (May 2020 – August 2020)

Stakeholder Interviews

- Patients
- Infectious Disease
- BIT Team
- Cardiac Surgery
- Primary Care
- Hospital Medicine
- Emergency Department
- Care Management
- Risk Management/Legal
- Outpatient Treatment Programs

Literature Review

- 15+ publications
- Benchmarking:
  - Brigham and Women's
  - University of KY

Baseline Data Review

- 22 patients
- 40 admissions
- Partially sampled cohort of admissions between 1/2018-8/2020

Insights

Stakeholder Interviews

- Common recognition of problems
- Enthusiasm for solution
- Acknowledgement of resource constraints
- Significant support for addiction program partnerships

Literature Review

- OPAT is safe and effective in properly selected patients who inject drugs, with low rates of PICC line complications
- Successful programs require participation in addiction treatment

Baseline Data Review

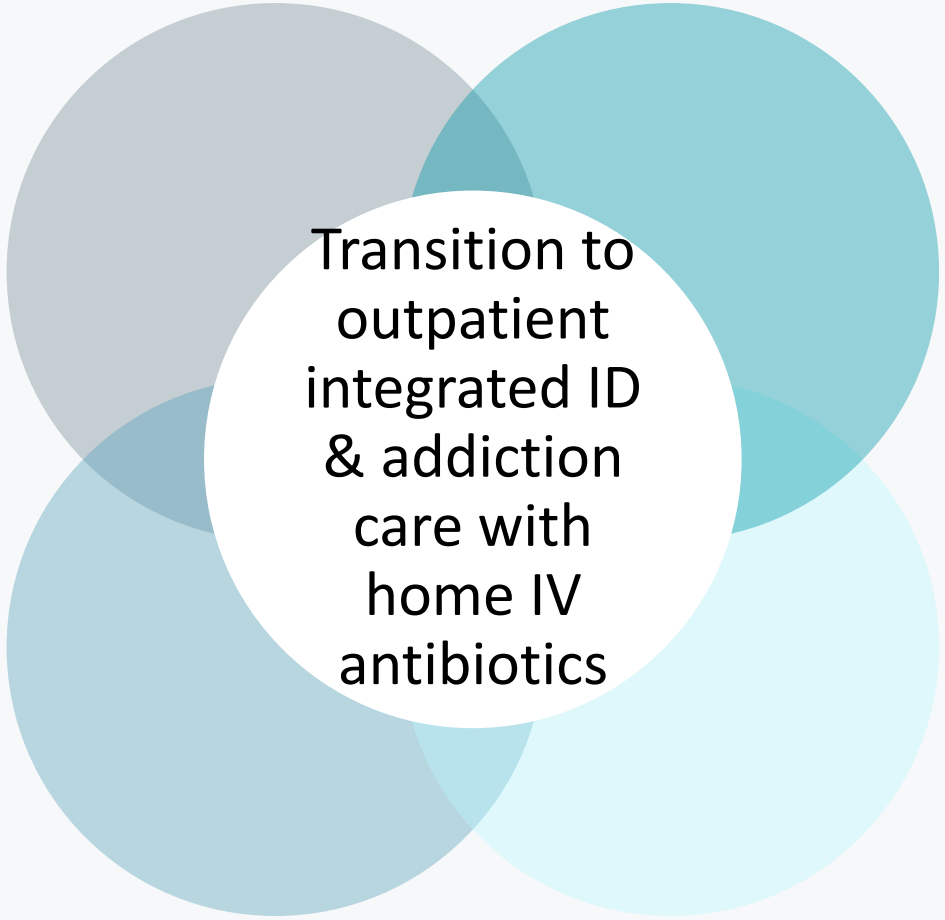
- Mean LOS 15d (range 1-58)
- 29% left AMA
- 47% did not complete course
- Infection cured in only 22%
- 48% were not seen by BIT
- Discharge treatment plan not discussed in 25%
- 50% readmitted within timeframe
- 5 patients discharged with PICC: 4/5 cured, no misuse

*Aware of patient not included in this review who had known adverse outcome with PICC in place

Pilot Program Structure

Clinical Care Pathway

Multi-Disciplinary Team



Recovery Coach/Care Coordinator

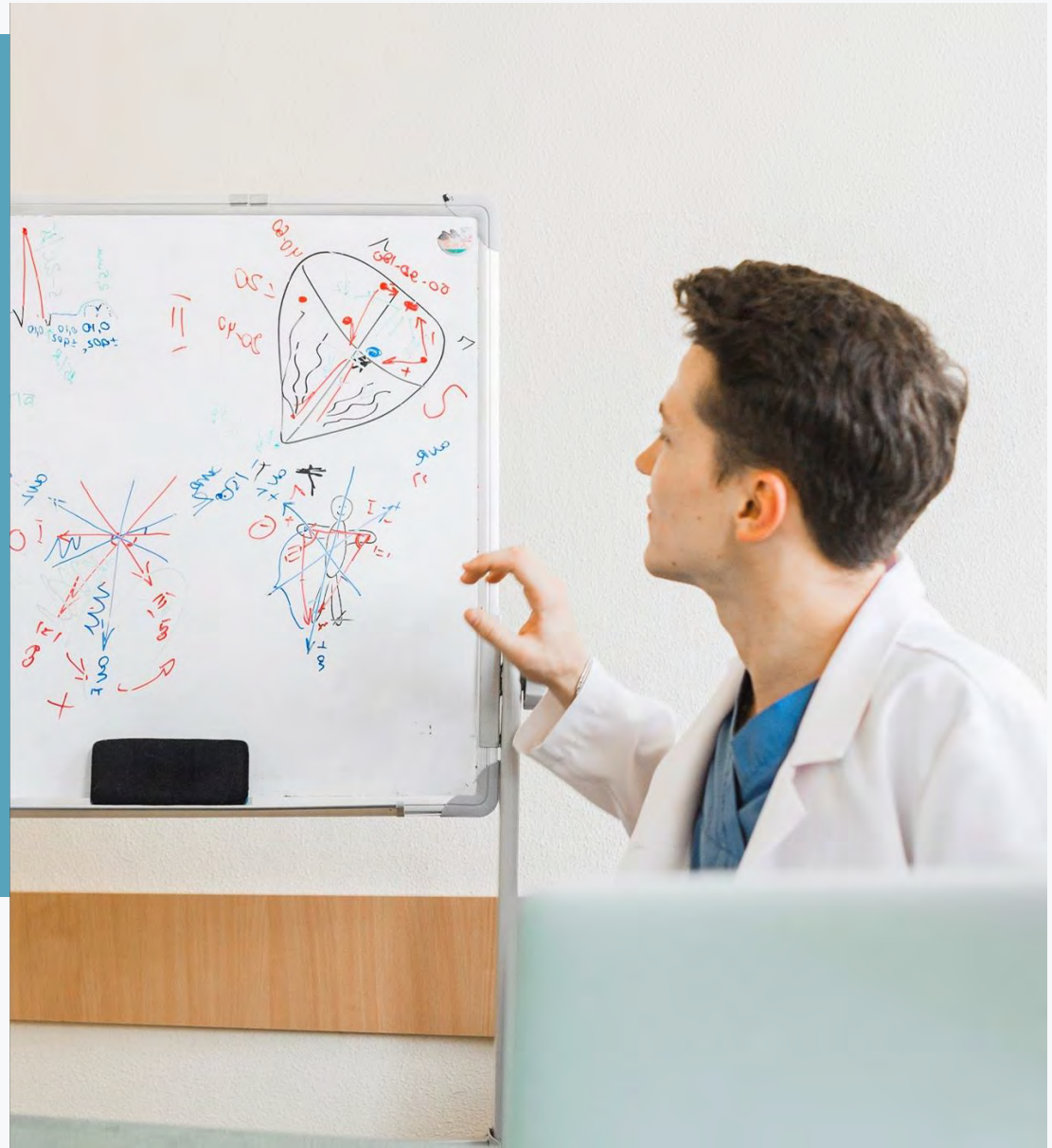
Home Care & Outpatient Addiction Treatment

Anticipated Challenges & Potential Solutions

Barriers	Pilot Solutions
Limited capacity for early identification of substance use	Increase screening and provide patient/ provider education
Limited capacity for recovery coaching/peer recovery	Staff dedicated recovery coach
Prior institutional experience with bad outcomes	Apply lessons learned from RCA
Stigma within the care community	Provide education

Next Steps

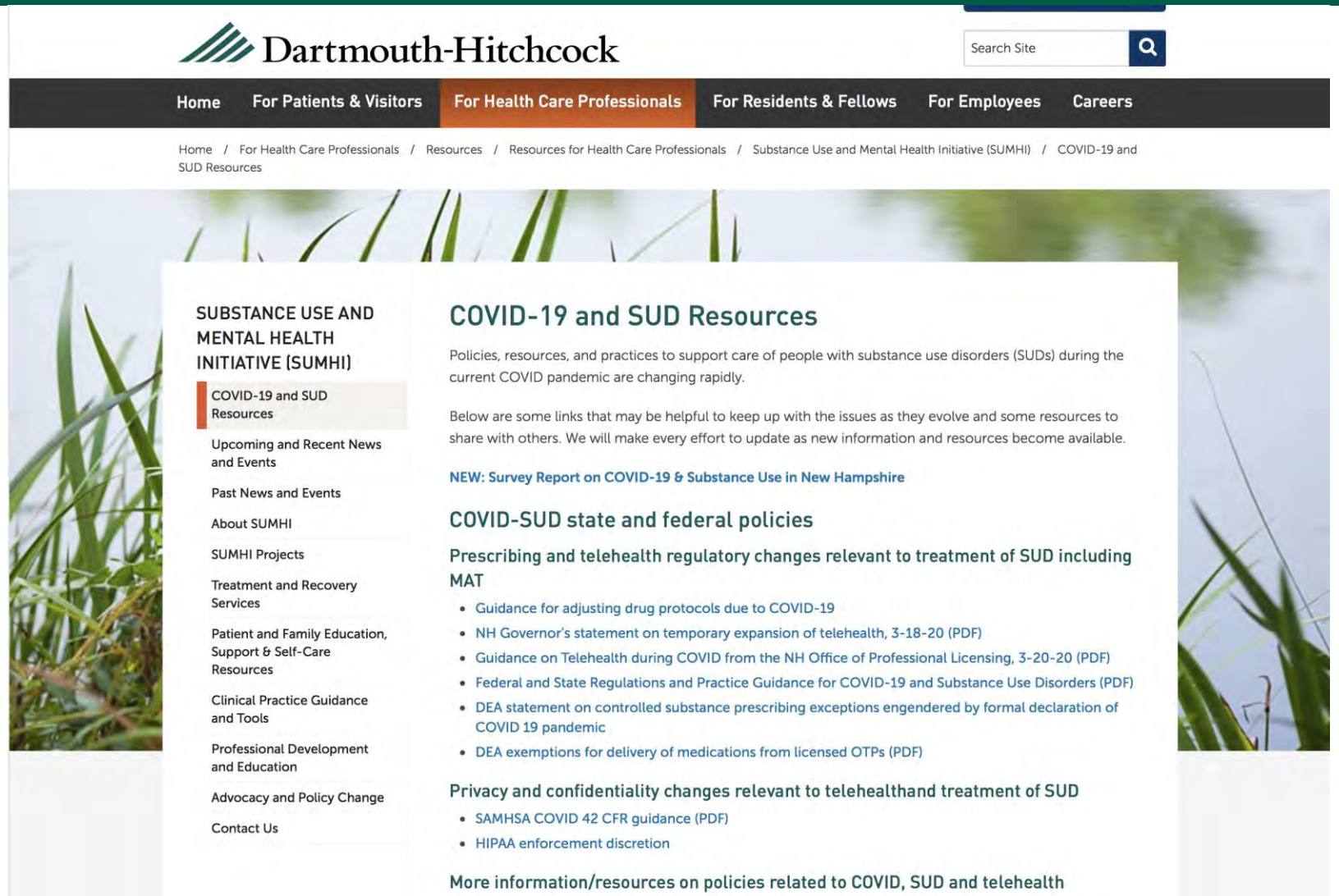
1. Writing protocols and workflows
2. Sharing new care model with stakeholders
3. Finalizing data plan with key metrics to evaluate success
4. Preparing to launch pilot



- Content by Incubator Team
- Presentation template from Slidesgo
- Icons from Flaticon
- Infographics from Freepik
- Images fromFreepik
- Author introduction slide photo from Freepik
- Text & Image slide photo created by Freepik.com

SUMHI COVID-19 Page

https://med.dartmouth-hitchcock.org/sumhi.html



Other D-H Substance Use & Mental Health Initiatives

Dartmouth-Hitchcock

Other D-HH Substance Use Initiatives

Initiative	Link / Contact
The Doorway at D-H	https://thedoorway.nh.gov/doorway-dartmouth-hitchcock
NH Integrated Delivery Networks, Rgn I	http://region1idn.org
BH Integration/Collaborative Care model	Matthew.S.Duncan@hitchcock.org
Center for Addiction Recovery in Pregnancy & Parenting (CARPP)	med.dartmouthhitchcock.org/carpp.html CARPP@hitchcock.org
Project DISCERNNE	David.D.De.Gijsel@hitchcock.org Aurora.L.Drew@dartmouth.edu
S.T.A.R.T Program (Support team for addiction recovery transitions), Recovery Coach in ED	Lauren.E.Chambers@Hitchcock.ORG
Recovery Friendly Pediatrics Program	Holly.A.Gaspar@hitchcock.org
Postsurgery Prescribing Guideline	Richard.J.Barth.Jr@hitchcock.org
OATC – Opioid addiction treatment collaborative	Charles.D.Brackett@hitchcock.org Christine.T.Finn@Hitchcock.org INPATIENT Patricia.L.Lanter@Hitchcock.org ED

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Other D-HH Substance Use Initiatives - con'd

Initiative	Link / Contact
Opioid Risk Assessment in the Oncology Population	*Kathleen.broglio@Hitchcock.org*
All Together – workgroup of the Upper Valley Public Health Council (UVPHC)	*Angie.M.Leduc@hitchcock.org* *Lauren.E.Chambers@Hitchcock.ORG*
Project ECHO at Dartmouth-Hitchcock	*ECHO@hitchcock.org*
Unhealthy Alcohol Use Project	*Luke.J.Archibald@hitchcock.org*
SUMHI Website; Education & Culture workgroup	*https://med.dartmouth-hitchcock.org/sumhi.html*
Needle Exchange Support	*http://www.h2rc.org/contact-us*
Safe Storage/Safe Disposal Rx Medication	*Specialty.Pharmacy@Hitchcock.ORG*

Discussion

Questions ?
Comments?
What more is needed?

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Next SUMHI Action Update

March 2021

Dartmouth-Hitchcock