Management of alcohol and opioid problems in hospitals: Current status, best practices

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Disclosure

- None

Alcohol, opioids, and the pandemic

- We are in the midst of the gravest substance-related public health crisis in modern history
- Harms from both alcohol and opioids were increasing in the years preceding the pandemic
- The pandemic has greatly accelerated these trends

Opioid-related morbidity, Ontario

	Jan 2003	Jan 2016	May 2020
ED visits	99	357	1242
Hospitalizations	76	147	179
Deaths	23	77	246

Opioid-related harms (2)

- Estimated 2271 opioid-related deaths in Ontario in 2020, a 50% increase from 2019 (ODPRN 2020)
- Overdose deaths are due to fentanyl which is far more potent than prescription opioids and heroin

Alcohol harms are also increasing

- Between 2003 and 2016, age standardized rates of alcohol-related ED visits increased by 86.5% for women, and 53.2% for men (Myran 2019)
- Mental Health Commission of Canada (2021);
- 24% of Canadians reported increased alcohol consumption vs pre-pandemic
- 8% reported greatly increased consumption

COVID and substance use

- COVID has made things far worse:
  - Social isolation
  - Depression, anxiety, quarantine, loss of income, housing
  - Attendance at addiction and general health care services has declined
    - Weekly ED visits for mental health aged 0-29:
    - 7 days in Feb 2020: 2000 visits
    - 7 days in Feb 2021: 1500 visits

EDs and hospitals: Critical opportunity to intervene

- Study of 1,257 people in Simcoe county who overdosed: 69% had visited the ED at least once in the year prior; 36% had visited 3 or more times (Statistics Canada)
- Patients who attended the ED for an overdose: Risk of fatal overdose in the year following the visit – 5.3% (Leece 2020)
- One-year mortality rate of 5.4% for people who visited the ED two or more times in one year for alcohol-related reasons (Hulme 2020)

ED/ hospital interventions reduce substance-related harms

- Initiating buprenorphine in the ED markedly increases rates of engagement in OAT (D'Onofrio 2015, Srivastava 2019, Busch 2017, Hu 2019)
- Opioid agonist treatment markedly reduces rates of fatal overdose, hospitalizations and ED visits (Moe 2021, Sordo 2017, Lo-Cignac 2016, Pearce 2020)
- Starting injection opioid users on methadone treatment in hospital:
  - Reduces rates of leaving against medical advice, all-cause readmission (Ti 2015, Wang 2020)
  - Improves compliance with antibiotic treatment (Jo 2021)
- OAT reduces risk of being hospitalized for endocarditis, osteomyelitis, septic arthritis (Morin 2020)

Hospitals and EDs are not compliant with HQO standards on substance use disorders

- Quality statement on Opioid Use Disorder: Buprenorphine should be offered on site within two hours to patients in opioid withdrawal
- Survey of 179 Canadian ED physicians: 79.9% reported seeing patients with OUD at least once per week, yet only 7% had dispensed buprenorphine in the ED and 5% had given an outpatient script (Hoyek 2020)

Compliance with HQO standards (2)

- Naltrexone and acamprosate have been shown to improve drinking outcomes and reduce health care utilization (Jonas 2014)
- HQO quality statement: … people with alcohol use disorder have timely access to medications that reduce alcohol consumption…”
- Yet in Ontario, naltrexone was prescribed to 0.35% of hospital inpatients with alcohol use disorder (Spithoff 2017)

How to engage EDs and hospitals in substance use treatment?

- **Roadmap to Wellness outlines the way forward:**
- Develop evidence-based clinical standards that apply to all EDs and hospitals
- Measure compliance with these standards
- Tie standards to funding and accountability agreements
- Ensure that EDs and hospitals have appropriate training and staffing to meet the standards
- Build addiction care pathways between hospitals and community services (eg RAAM clinics, withdrawal management services)

Clinical standards for management of opioid use disorder in the ED and hospital

- Treat withdrawal with buprenorphine
- Initiate opioid agonist treatment with buprenorphine and methadone
- Provide take-home naloxone kits and overdose prevention advice, with information on harm reduction services
- Identify acute psychiatric conditions eg psychosis, depression, suicidal ideation
- Link patients to outpatient OAT - RAAM clinics, community OAT clinics, primary care

Clinical standards for management of alcohol use disorder in EDs and hospitals

- Treat alcohol withdrawal with symptom triggered benzodiazepine protocols using withdrawal severity scales
  - Do not discharge until patient is in minimal withdrawal
- Identify and manage acute psychiatric conditions eg depression, suicidal ideation, psychosis
- Provide brief counselling interventions
- Prescribe anticraving medications eg naltrexone, acamprosate during admission or on discharge
- Link patients to outpatient treatment ie withdrawal management services, RAAM clinics, mental health and addiction services, primary care

Training and resources

- Hospitals would ideally have addiction medicine consult services to:
  - Provide consults on ED and hospital patients
  - Implement treatment protocols eg buprenorphine initiation
  - Train nursing and medical staff
  - Build links with RAAM clinics and outpatient services
- Full services may not be feasible
- Patient navigator can be highly effective

Innovations in Ontario hospitals

- Inpatient addiction medicine services (eg St Joseph's Health Centre)
- Hospital-based RAAM clinics (eg Royal Ottawa)
- Patient navigators (eg Lakeridge Hospital in Oshawa, Health Sciences North in Sudbury)
- Take-home naloxone for ED and hospital patients (eg Health Sciences North)
- Innovative buprenorphine dosing (eg Timmins hospital)
- Prescribing anticraving medications to ED patients (eg Mt Sinai)
- Building addiction care pathways – HSN!

What is needed to build a hospital-based addiction service?

- Three elements:
- At least one committed hospital clinician
- Support from a core hospital department eg Medicine, Emergency Medicine
- Support from senior leadership
- Partnership with RAAM clinics, WMS, other community services

Key messages

- Hospitals and EDs can play a key role in mitigating this public health crisis
- Hospital-based interventions are simple and safe
- Addiction medications can be prescribed by nurse practitioners and physicians without addiction expertise
- Buprenorphine and anticraving medications are remarkably cost-effective compared to virtually any other medication for any condition
- ED and hospital clinicians are deeply concerned about the substance use crisis and very open to change

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