ABSTRACT: 2019 ELAM Institutional Action Project

Project Title: Addiction Medicine Clinical Service
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Collaborators and Mentors: Collaborators: Michael Lynch, Priya Gopalan, Janine Then, Mary Viehdeffer, Wendy Romeo, Zachary Lenhart. Mentors: Michael Donahoe, MD, Annmarie Lyons
Topic Category : **Clinical**

Background, Significance: Deaths from addiction related causes (opioid overdose, alcoholic liver disease) along with suicide have been responsible for the decrease in life expectancy of US middle-aged adults. One solution is to expand treatment for addiction into general medical settings, i.e. inpatient, emergency department, and primary care. In 2017, the UMPC hospital-based outpatient clinic started an addiction treatment program (Center for Opioid Recovery-COR), but did not have a presence in other general medical settings despite strong addiction psychiatry specialty programs.
Purpose: The purpose of this project is to initiate or expand clinical addiction medicine in four realms: 1) inpatient (medical/surgical) at UPMC Presbyterian, the flagship teaching hospital of a 40+ hospital system, 2) hospital-based primary care, 3) bridge/transition clinic (low threshold treatment, site of entry) and 4) community based primary care.
Methods: An interdisciplinary team representing internal medicine, toxicology, social work, psychiatry, and pharmacy met regularly to define the inpatient Addiction Medicine consult service's goals, needs, processes, plans and budget which was presented to the hospital administration for resources. Evaluation of hospital discharge data examined numbers of potential patients with addiction diagnoses, readmission rate, and length of stay. A pilot test of the service on limited inpatient medicine floors was started in October 2018 via physician volunteers from internal medicine and toxicology. To expand the COR program, additional location was sought in an outpatient clinical building at an affiliated hospital (UMPC Mercy) with easy access and a political commitment to expand addiction services. Alignment with health system integrated payor (UPMC Health Plan) needs were also negotiated.
Outcomes: The Addiction Medicine consult service obtained financial backing to hire a nurse, social worker and 1.5 FTE peer navigators. It expanded to a full-service program covering the entire hospital March 1, 2019. In the pilot phase, the team performed 18-24 consults per month, whereas in the first 2 weeks of the full service, the team performed 28 consults. Of the total 135 consults performed, 81 were for opiate use, 35 for alcohol, and others for pain or behavior. 99 (73%) patients accepted treatment referral suggestions. The first resident began an elective rotation in March 2019, with more scheduled for the future. Billing collections were 11.9%, less than half that of palliative care or infectious diseases. UPMC Mercy agreed to renovate clinical space and supply clinical administrative staff to host the hospital-based COR program, with future plans to host a bridge/transition clinic.
Discussion/Impact: Addiction Medicine clinical services have begun expansion in general medical settings, with the financial and clinical impact as yet to be determined. Financial challenges for sustainability include low reimbursement, and cost of non-billable staff. Positive impacts could include increased rates of treatment, decreased readmission rates and potential mortality from substance use disorder.

Addiction Medicine Clinical Service

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Background

- Pennsylvania had the highest number of opioid overdose deaths of any state in 2017
- UPMC lacked addiction treatment throughout general medical settings outside of a strong subspecialty psychiatry program
- There is a public health push to expand access for opioid use disorder treatment

Purpose

The purpose of this project is to initiate or expand clinical addiction medicine in four realms over next two years:

1) **Inpatient Addiction Medicine consult service** at UPMC Presbyterian, flagship teaching hospital (topic of this poster)
2) **Center for Opioid Recovery,** embedded within an academic primary care practice, established March 2017
3) **Bridge/transition clinic** (low threshold treatment, site of entry into treatment, after hospital/ED d/c)
4) **Community based primary care.**

Methods

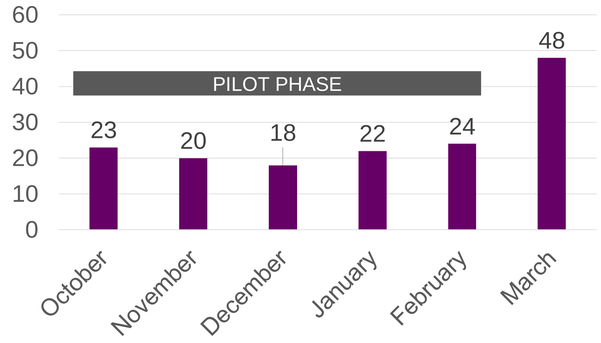
- **Interdisciplinary team** representing internal medicine, toxicology, social work, psychiatry, and pharmacy
- Defined the inpatient Addiction Medicine consult service's **goals, needs, processes, plans and budget** which was **presented to hospital administration**
- **Hospital discharge data** evaluated for patients with addiction diagnoses, readmission rates, and length of stay.
- **Alignment with** the health system **integrated payor** (UPMC Health Plan) was also negotiated.
- **Pilot service** was started in October 2018 in limited inpatient units; **expanded in March 2019** to all inpatient units in UPMC Presbyterian.

Role	Function
Attending Physician	Medical assisted treatment, motivational interviewing, substance withdrawal management, pain management strategies for patients with SUD
Nurse	Coordination with post-discharge treatment providers, motivational interviewing, service coordination
Social Worker	Motivational interviewing, community support
Peer Navigator	Motivational interviewing, community support
Rotating Learner	Exposure to addiction medicine education (MD, RN)

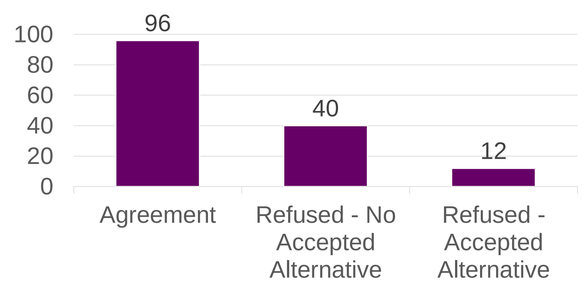
Outcomes and Discussion

- **Pilot phase:** 18-24 consults monthly
- **Expanded phase**: doubled to 48 consults in a month (Fig 1).
- Of the 155 consults performed, 55% were for opiate use**,** 26% were for alcohol use, and 19% for medication management and pain (Fig. 3).
- 62% of patients consulted agree to discharge treatment recommendations (Fig. 2).
- Billing collections at 11.9% were less than half of other consult services.

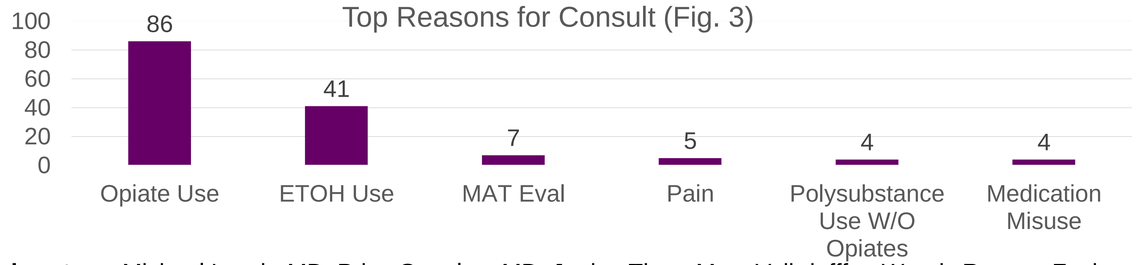
Consult Volume by Month (Fig. 1)



Patient Response (Fig. 2)



Top Reasons for Consult (Fig. 3)



Summary

- The Addiction Medicine Consult service has been established, with increasing use of services
- Financial and clinical impact as yet to be determined; Financial challenges include low reimbursement, and cost of non-billable staff.
- Positive impacts could include increased rates of treatment, decreased readmission rates and decreased mortality from SUD.
- Expansion of other service goals will require a dedicated clinical champion

Collaborators: Michael Lynch, MD; Priya Gopalan, MD; Janine Then; Mary Veihdefffer; Wendy Romeo; Zachary Lenhart, Lisa Book. **Mentors:** Michael Donahoe, MD; Annmarie Lyons. **Data updated through March 30, 2019.**

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