

Dr. Elizabeth Salsbury-Afshar: Welcome. This is ASAM Practice Pearls, a podcast series from the American Society of Addiction Medicine. I'm your host, Elizabeth Salsbury-Afshar.

Today's episode is part of a four-part special series highlighting major takeaways from some of the most popular sessions at ASAM's 56th Annual Conference.

In this episode, we're focusing on how to transform hospitals to better care for people with addiction, and we'll hear some key takeaways from the start study. I'm delighted to welcome our esteemed expert, Dr. Itai Danovitch.

Dr. Itai Danovitch: Thank you. It's a pleasure to be here with you.

Dr. Elizabeth Salsbury-Afshar: As an addiction medicine physician, myself and someone who works on an addiction consult team in a hospital, I was so excited to see this START study. Can we start out with you just talking about the background and what made you decide to even start the START study?

Dr. Itai Danovitch: My colleagues and I had long felt that taking care of patients in the hospital who have substance use disorders is critical and that addiction consultation services can help. But we had trouble building support and rationalizing the need for these services and the climate that we're in where you're constantly having to rationalize and prove that things work.

There is and, has been, growing evidence that addiction consultation services are feasible, to do that, patients accept them, the clinicians accept them, but at the time that we set out to do the study, there were no randomized trials that actually compared them to usual care. And we really wanted to generate stronger evidence so that we could build a basis for getting these models adopted more widely, that we could build a basis for getting them paid for more effectively. And that was really why we decided to go down the path of formally studying them.

Dr. Elizabeth Salsbury-Afshar: Thank you so much. I have to say, when I saw this come out, I immediately saved it in my folder titled, "Hospital-Based Addiction Care" because I think so many of us, like you said, are always looking for opportunities to really show the value of our work. We all know it and experience it and hear it from patients and staff, but [it's] more important to have studies to be able to point to that are done in such a rigorous way.

Dr. Itai Danovitch: Well, that's the best feedback because that was the reason we wanted to do it, is to help clinicians like ourselves, like you, have more evidence or more basis to be able to justify offering and scaling these services, which is something that continues to be a challenge.

Dr. Elizabeth Salsbury-Afshar: Absolutely. Can you talk about the study methodology overall and highlight some of your key findings?

Dr. Itai Danovitch: Sure. So, our study was a randomized trial that occurred at three different sites, Cedars-Sinai, University of New Mexico, and Baystate Health. The study was funded by a grant mechanism that was supported by both NIDA and NCATS, and that had a goal of addressing the needs of patients with opioid use disorder in areas that had been hard hit by the opioid epidemic.

And so, we chose those centers to reflect different parts of the US that were to varying degrees. The intervention was essentially a version of an addiction consultation service. We wanted to develop a replicable and well-defined model of an addiction consultation service. There are many different types of addiction consultation services, and there've been some really nice taxonomies and characterizations of the differences.

We developed an addiction consultation service as simply as we could, so we chose the two clinician types that we thought are most available in most hospitals. A physician that is capable to manage substance use disorders and a care manager who is a social worker—doesn't have to be a social worker, it could be a nurse care manager, it could be other clinician types—but those are clinician types that are available in most hospitals.

And then, for each of them, we put together the evidence-based practices that could reflect how each of them could practice at the top of their standard of care for the addiction medicine physician or the addiction—we called it an addiction medicine specialist because we didn't want to limit it to board certification.

But it was knowledge and familiarity with the standards of care for opioid use disorder. And for the care manager, it was using Project Red, which is a manual for facilitating disposition facilitation linkage to aftercare for patients, and then also motivational interviewing, which both were trained on.

So, we assembled all of these practices into a manual. That manual has now been published and is available for anybody to freely download. And we took that intervention and we compared it to usual care at each of these hospitals.

Dr. Elizabeth Salsbury-Afshar: I just want to say how much I appreciate your really practical approach, particularly in the model. Sometimes you see studies and the model is so robust, it's amazing, but it's often hard for people to think about, "Oh gosh, how could I replicate something like that?" And so, I really appreciate how thoughtful you were in thinking about the key pieces and starting there, not with the most Cadillac 10-person consult team, for example. Can you talk about the key findings?

Dr. Itai Danovitch: Our two primary outcomes were, did this service successfully initiate people on medication treatment for opioid use disorder? And did we successfully link people to aftercare? And we found strong effects for each. Those that received the active intervention were substantially more likely to initiate medications in the hospital and to link to aftercare. And this was despite the fact that: A. Usual care had improved at all of our sites, such that pretty significant numbers of individuals in the usual care arms also got initiated on medications and linked to aftercare.

But there was almost twice as many among those that got the interventions, started those. And it was also despite the fact that when we designed the study, we didn't anticipate the degree to which the population that would enroll in the study would also be suffering from many other social determinants of health that create additional challenges.

So over 80% of the population that we studied were covered by a public payer. We had a lot of psychiatric comorbidity, a lot of comorbidity with other substance use disorders, as you'd expect at an academic medical center hospital. These were people that didn't just have substance use disorder, but they had trauma, they had mental health problems, they had other complex medical problems.

So, if there's one population you think about having challenges, following up to get continuity care, that's the group. And yet still 75% of those that got the active intervention actually did link to aftercare.

Dr. Elizabeth Salsbury-Afshar: That's really amazing. Hearing you talk, I'm thinking of all the patients that we see on our consult services and the

challenges, and so 75% is super impressive and, I think, really speaks to the work that you all are doing. I'm curious, as you think about the findings, how do you feel like they inform how we think about hospitals along this addiction continuum and if, you know, we were talking to someone who's in a hospital that doesn't have these services, how might you suggest they use the START study to initiate conversations about the value of adding this to existing service lines?

Dr. Itai Danovitch: To your first question, we view hospitals as a critical juncture to address the health needs of people that are slipping through the cracks. And very often in hospitals, people present with one problem, and it turns out they have another. The example I like to give is diabetic ketoacidosis. Somebody presents in that state, they need to be acutely stabilized. It's not enough to just hydrate them, stabilize their electrolytes, get them on some insulin, and then send them off. They have a chronic illness. They need to have that managed. They need to be on a stable regimen that they could be discharged with, and then they need to be discharged with an aftercare plan; otherwise, they're going to be right back there in a worse shape, which is what we're doing over and over again in opioid use disorder.

We have people routinely across the country that present after an overdose, survive it. We know that they're at very high risk of having the same thing happen within a short span after the hospitalization, and yet we fail to deliver evidence-based treatments that work. We think that this is a model that—certainly it's highly impactful for opioid use disorder. But we think for alcohol use disorder, where we also routinely fail to start people on treatment for their alcohol use disorder after managing the withdrawal.

And then we see them again in the liver clinic when their liver starts to give out and we still fail to address that vulnerability. Same for many other substance use disorders. And we think that this is a model— we actually borrowed this model, there's a lot of principles of collaborative care, which was developed for primary care, mental health integration—and we think that this is a model that can apply for a lot of other behavioral health issues beyond substance use disorders that present to the hospital.

People with psychotic disorders that are presenting in a state of altered mental status after intoxication, they get acutely stabilized and released. Could we do a better job of initiating appropriate therapy for them and linking them to aftercare as well?

Dr. Elizabeth Salsbury-Afshar: I know you mentioned that during the study period or around the study period, care given in the Hospitals of the control group had really progressed, and there were more and more clinicians prescribing. So, I'm curious to hear from you, what do you feel was the secret sauce, if you will, of the intervention?

I don't know if you collected data on that. It's okay if it's more just your gut and your own experience in looking at the data. But I'd love to hear more about how you think that was really impactful in additional ways, or even the curriculum and the training that you gave. Were there pieces of it that seemed to really resonate?

Dr. Itai Danovitch: Yeah, I think that, first, there was a huge effect of the first step of the study, which was identifying people and engaging them, saying, "Hey, we're here to help you with the substance use." And we didn't call it a substance use disorder initially in engaging them. "We have noticed that you are using substances, we've noticed that there may be some consequences. Would you be interested in discussing ways that we may be able to support you?" Patients were very receptive to it. I think once you had patients who were receptive, and once the problem was identified, then it was more conducive to any level of intervention for those patients. So, some of it was the effect of doing a study. And that's part of why we had to compare it to something.

Dr. Elizabeth Salsbury-Afshar: When you think about the intervention, especially if there were already a lot of prescribers, and I know you talked some about social determinants of health, I'm curious if your intervention was specifically touching on social determinants of health in ways that may not have been touched on with usual care.

Dr. Itai Danovitch: So, two pieces to that. One is, I think, the most powerful part of our intervention, in part, was the care manager facilitating the linkage to aftercare. They went beyond what a standard social worker or care manager does in the hospital, which is ideally, assessing and providing some support and referrals.

They also continued to follow the patient for a month after hospitalization to troubleshoot all the things that went wrong, because the best-laid plans fall apart. So that was hugely effective, and the patients that participated both felt cared for after they left the hospital, and we were able to do a lot of recovery

work for the plans that fell apart for all the many reasons they do. So, that was very impactful.

And if I had to isolate one part of the intervention, I would do that over the medication part, maybe, or certainly for other substance use disorders where the medications aren't as effective and as mortality-changing as they are for opioid use disorder. So, that was probably the piece that I think was most critical to it.

Dr. Elizabeth Salsbury-Afshar: I love that you bring up the care management part for a few reasons. One, I feel like they are like the unsung heroes in many of our institutions, right? Often doing work behind the scenes. I also appreciate so much that they followed up for a month.

I think, at least in the institutions where I've worked, it's very much the team in the hospital focuses on you while you're in the hospital, and the minute you're gone, you go to the next place that you're supposed to go. And so, I love that you built that in for that month-long follow-up. And as you said, best-laid plans usually don't pan out exactly as planned.

Dr. Itai Danovitch: And also, none of the hospitals that participated in this had a bridge program. So, bridge programs are certainly another way to support people that are stepping down from acute care to get continued care, and they are phenomenal in doing what they do. But for hospitals like ours that didn't have a bridge program, this was a really key mechanism of bridging the connection to the next level of care until it happened.

Dr. Elizabeth Salsbury-Afshar: Absolutely. So, given all this and the positive findings, what challenges do you see in expanding access to addiction consult services?

Dr. Itai Danovitch: The number one challenge is financing them. Even though we have proven them to be effective, and even though we'll soon be publishing our cost-effectiveness analyses—which I won't give a spoiler alert, but I'll say that they are very encouraging—the cost-effectiveness analysis really look at the benefits from the societal perspective, and the provider, the health system, the program. For them, they don't see the financial benefits as immediate. And yet, they have to financially outlay to support, you know, a care manager who's not able to bill and an addiction consultation provider who can bill, but often not recover all the costs that are involved.

So, that's the biggest challenge. We need to find both more ways of reimbursing for these services and incentivizing them. Also, hospitals do a lot of stuff that they don't recover financially, but they do them because of their mission. We really need to make it clear that this is part of the mission of hospitals.

Just like the question of how they recover costs for taking care of that diabetic, or the person that's presented with heart failure, and that needs post-acute services, is secondary. They have to address heart failure because they're publicly reporting the mortality rates associated with heart failure, publicly reporting mortality rates associated with pneumonia.

We need to do the same thing for opioid use disorder because that's gonna drive them to do what their mission says, which is to care for all the patients that present through their front doors.

Dr. Elizabeth Salsbury-Afshar: So first, I appreciate that you gave us that cliffhanger. We're all going to be waiting for the cost-effectiveness analysis, and again, maybe, hopefully, even more data to be able to work with hospitals and say, "Hey, look, this actually can be really helpful."

I also heard you saying that payment models, in some ways, can get in the way of providing the highest-quality care. So really, this move that we're seeing in many places toward value-based care could be helpful, and also really thinking about the mission and the quality of the care that we know we all wanna provide, and finding alternative ways to do it. With all of that in mind, what suggestions would you have for individuals or teams who are working to start a consult service?

Dr. Itai Danovitch: For a lot of services like this, starting with what you have first—trying not to let the perfect be the enemy of a good enough—is important because you can spend a lot of time petitioning for resources, and we're in a climate that's going to continue to be difficult to get the resources we need to get the Cadillacs of addiction care that we want.

And so, you just have to be willing to roll up the sleeves and start with what you've got. I think that measuring the things that you do, showing the volumes of care that are provided, and the effects of that care build momentum. And they help demonstrate to hospital leadership that what is being done is effective, because a lot of times we do things that we don't do an effective job

of measuring and telling the story, in a way that administrators can get behind, and also recognize how they're contributing to the mission. I think that's how, in most communities and areas, there are experts in addiction and now experts in addiction consultation services that are available to provide support.

We're a very collegial group. And so, I think that at meetings like ASAM and other meetings, you can identify people that have done this, people like ourselves, people like you, and reach out to get guidance, get support, get help amassing the evidence. There's now a pretty robust literature.

We published an integrative review of addiction consultation services that pulls together a lot of the literature in this space, and all of that can help to make a case. So, trying to make a good case, trying to measure, but also jumping in and starting to provide the care for patients is really key. Our experience was for our colleagues in other areas of medicine.

You asked earlier, "Why did we get pretty decent rates of engagement and treatment in the usual care arms?" I think that, as our colleagues in other areas of medicine saw our interventions working, some of them began to offer them themselves as well.

A lot of the interventions that we offer are not that complicated, doesn't mean it's not complicated and challenging to take care of the patients we care for. And experience matters, but there's also just the hurdle of getting comfortable, jumping in, getting comfortable, starting to work with patients, and feeling the incredibly rewarding and reinforcing effects of how grateful patients are, how much they respond, and how effective our interventions are.

Dr. Elizabeth Salsbury-Afshar: Absolutely. As you were talking, you know, one of the things I thought about—and I don't know if you've studied this yet, maybe in the future—is just how much our colleagues often appreciate our services. Because they sometimes feel frustrated or stuck, or like the same people are coming back, or there's a sense that they're maybe not doing everything they could, but not sure how. And with so much focus on burnout, in particular within healthcare, I'm curious if you have any sort of thoughts or experiences related to possibly having addiction consult teams, reducing burdens from other hospital teams, and how that might have overall benefits to the institution as well.

Dr. Itai Danovitch: There's no doubt, and I can speak to it anecdotally more so than having evaluated that specifically, but it really creates a sense of moral distress to be trying to take care of a patient population and not be able to deliver the interventions that really help to address their underlying problems.

And our colleagues feel that our colleagues on the trauma service, that are doing all these surgical repairs of patients, that are presenting for problems related to their substance use, the surgeons feel like they're hitting their heads against the wall. So, they are incredibly appreciative of supports to address the underlying issues. They're some of our biggest advocates.

There's a virtuous spiral of support for this stuff that really makes it a pleasure to do. And I think as stigma has been diminishing, it's certainly still there, but as it's waned, there's also greater and greater support, especially among some of the younger demographics of physicians and clinicians 'cause it's not just physicians, it's the nurses and the social workers and the clinical partners and that whole ecosystem of care providers that are so important in the hospital.

Dr. Elizabeth Salsbury-Afshar: I love that you brought up nurses, too, because I know sometimes our nurses are also our biggest advocates for our team of saying, like, "Oh my gosh, I'm so glad you're here." And being able to talk with them about a plan and making sure we're covering pain and withdrawal can give the nurses a lot of relief because they do a lot of that frontline work much more than our physician colleagues for sure.

Dr. Itai Danovitch: Totally.

Dr. Elizabeth Salsbury-Afshar: I know we've been talking about consult services, you mentioned bridge clinics earlier, I'm curious if someone's working in a hospital and they aren't able maybe, out the gates, to start a consult service, are there other ways people can think about expanding addiction care besides consult liaison services?

Dr. Itai Danovitch: There's a lot of things. There's a continuum of interventions that can help improve care for hospitalized patients with substance use disorders, and that's what we're really trying to do. Consult service is just one mechanism to do it.

And it's part of why, if we figure out how to measure the outcomes we want, which is more patients receiving evidence-based care and more patients

having good outcomes, then we can innovate on different ways to achieve that. So, some of the models that don't rely on addiction consultation services are practice-based models of giving education and tools to hospitalist physicians and other groups of physicians that are willing to start them, to train them.

There are In-Reach models where people for the community can come into the hospital, providers from the community, to provide services, and that's been particularly effective for linking people to aftercare, because if you can achieve a warm handoff of a real connection between a patient and a provider or program that's able to continue to care for them after they leave, they're much more likely to follow up.

And then there's a lot of hybrid versions of that and different versions of consultative models involving different care providers. Nurses, nurse practitioners, PAs, a lot of this has been described nicely, both, in our systematic review and then Honora Englander and also Michael Incze each did taxonomies. She did a taxonomy of addiction consultation services. He did a taxonomy of I think post-acute care, like linkage strategies. And so those are great places to look to identify the full range of options that exist.

And finally, we need a lot of different options because our hospitals were done in academic medical centers that had the benefit of having clinicians with the bandwidth and availability and background and support from their departments to do this. Our 5,000-plus community hospitals that don't have those services really struggle to get the staffing support and also don't necessarily have the volumes to be able to set up addiction consultation services.

And so, being flexible with a model, being open to remote services, I prefer in-person services, but the access that remote services can provide, I think, is also really valuable, and we just need to be open to having as many different pathways as possible to get the outcome.

Dr. Elizabeth Salsbury-Afshar: Yeah, absolutely. I hear you talking about how important knowing local context is, sort of leaning into strengths where they exist, and again, kinda going back to what you started with, don't let perfect be the enemy of good enough, right? There's always room for improvement.

Maybe we can't get whatever the thing is that we need right now, but there are ways that we can still move in that direction of providing high-quality care for the patients that we're seeing and caring for in our institutions. One of the concerns that I sometimes hear come up, as it relates to consult services, is just like, "Wow, you're now telling us that you want to try to address housing insecurity and all of these other social determinants of health." This is going to increase, potentially length of stay, or it may slow down our ability to get the patient out of the hospital.

We know that most hospitals are really pushing for reduced length of stay. And so, I'm curious, how would you answer that question?

Dr. Itai Danovitch: Yeah, thank you. Yeah. We did context work, which we've published on before we launched the study, and in that work, we talked to physicians, and to administrators, and to community providers to try to understand their concerns. What would be facilitators and barriers?

One of the biggest concerns raised, especially by administrators, the biggest barriers was concern that addiction consultation was going to increase length of stay. So, we looked at that specifically, and we found two things. One, we did not increase length of stay. If you look at our active intervention versus usual care group, there was not an increase.

But secondarily, I think that when people get addiction consultations late in a hospital, they sometimes have the perception that they're extending things right when it's the day of discharge, and then suddenly it's, "Oh, we haven't managed the opioid use disorder. Do we want to do that?" It's going to take a moment to transition from the opioids they're on to buprenorphine or methadone. By identifying people earlier in their hospitalization, I think that we were able to head that off and really deliver an intervention that did not interfere with the flow of care. I think it actually promoted and helped the flow of care, and not just in terms of length of stay, but in terms of the hospitalization being a productive, aligned experience where the patient could get the medical services they need, and also get treatment for their substance use disorder.

Dr. Elizabeth Salsbury-Afshar: And what were the ways that you were able to really make sure that the consult happened early during hospitalization instead of, as you said, at the last moment?

Dr. Itai Danovitch: Yeah, that's a big piece too. We both sought referrals to the study. But the most effective way was we designed a tool that basically extracted commonly available terms from the electronic health record to identify people who were likely to have an opioid use disorder. And then, we contacted their hospitalist and said, "Hey, would you be interested in addiction consultation? Would you permit that?" Which the answer was almost always yes. That allowed us to catch people early on, and we did this work before AI tools were widely available. There's groups now, you may know of one.

Dr. Elizabeth Salisbury-Afshar: I do. Yeah. We just published out of the University of Wisconsin, so absolutely. And I think this really proactive approach of trying to make sure we're not missing people.

So, thank you for the tee-up. We just published a paper at the University of Wisconsin. Majid Afshar was the primary author, who is also my husband.

Really using AI tools to sort of scan the chart and proactively prompt the primary team to say, "Hey, you might want to consider an addiction consult." And, similarly, found really positive outcomes associated with it. So...

Dr. Itai Danovitch: I think that is huge.

Dr. Elizabeth Salisbury-Afshar: Yeah, really excited.

Dr. Itai Danovitch: Yeah, because the ability to identify people and then to have an intervention, an action that can actually respond, is really promising.

Dr. Elizabeth Salisbury-Afshar: Yeah. Is there anything else that you want listeners to know?

Dr. Itai Danovitch: One thing that I would highlight is one of the differences in consultation services is that we have some addiction consultation services that are led by addiction medicine and some that are led by addiction psychiatry.

And there's very local reasons for why one or the other is willing or able to take them up. I'm an addiction psychiatrist, and I'll observe that in most areas, it's been addiction medicine that has led the charge on doing this. I think that there's some interesting differences in the training and backgrounds that each bring that allow them to be comfortable addressing some of the other comorbidities, right?

Naturally, those in addiction medicine are going to be more comfortable with the medical comorbidities. Those that have a psychiatric background, more comfortable with the mental health comorbidities and hopefully also with delivering and overseeing some of the psychotherapies that can be really effective, because brief psychotherapeutic interventions can be powerful even in the acute care setting of a hospital. That's one thing that I'm really interested in. How can we leverage these opportunities to deliver brief but effective psychotherapy interventions to engage patients?

Dr. Elizabeth Salsbury-Afshar: Well, that's all the time we have today. Thank you so much for listening to ASAM Practice Pearls. I want to thank our expert Dr. Itai Danovitch, for sharing key insights from his session Hospitals as the Frontline for Addiction Lessons from the START Study. The full recording of Dr. Danovitch's session will be available in ASAM's e-Learning Center starting May 26th. Be sure to check it out. You can also find a link to the START study in today's notes.

Don't forget to subscribe and share this episode with colleagues who may find this information helpful. Thanks for listening, and we'll see you next time on ASAM Practice Pearls.