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Management of opioid use disorders among veterans in subacute rehab: Use of an interdisciplinary task force to address an emerging concern

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Abstract

There is both rapidly growing need, and limited evidence-based guidelines, for the management of opioid use disorders in subacute rehab and other nonaddiction medical settings. Following 2 unintentional opioid overdoses within the Community Living Center (CLC), a VA (Veterans Administration) subacute rehab setting, an interdisciplinary CLC Addictions Task Force was created to address a critical issue: how to best meet the combined neuropsychiatric and medical needs of the opiate use disorder patient through a multifaceted treatment approach. The goals of the task force were to develop and institute educational initiatives for providers; create patient care guidelines; increase safety on the unit; improve provider confidence when caring for this high-risk population; and mitigate the risk of unintentional overdose. The task force divided into 4 working groups to meet these aims. Process and outcomes are discussed. We found that in-services by addiction specialists improved clinician comfort in caring for this high-risk patient group. Specific areas that yielded the greatest clinician satisfaction ratings included didactics on how to identify at-risk patients and techniques on how to manage the patient in a general rehab setting. Utilizing an interdisciplinary approach, and an iterative process, at all stages was critical to the success of the CLC Addictions Task Force, as it improved buy-in and motivation from all disciplines. Improvements have been made to enhance patient safety, improve communication amongst providers, and provide a foundation to improve patient outcomes. Our preliminary work to enhance the identification and management of opioid use disorders at our CLC is an important first step towards a standardized curriculum that could be applied to other VA and non-VA subacute rehab settings.

Keywords

Interdisciplinary; intervention; opioid, rehabilitation

The need to manage opioid use disorders in nonaddictions settings is growing, and there are few evidence-based treatment guidelines for the management these patients in a general rehabilitation setting. One recent study suggests that over 11% of Iraq and Afghanistan veterans received substance use disorder (SUD) diagnoses.¹ The Community Living Center

(CLC), a subacute rehab center associated with the VA (Veterans Administration) Boston Healthcare System, has seen a roughly 3-fold increase in admissions of young (under age 50) veterans with polysubstance use disorders in the past 3 years. This includes an increase in the number of veterans with opioid use disorders admitted following acute hospitalization for medical complications secondary to their substance use. Several of these veterans were actively using intravenous drugs prior to, and during, their admission. Following 2 unintentional opioid overdoses within the CLC, an interdisciplinary CLC Addictions Task Force was created to address this critical issue.

Over 40% of veterans with known SUD have comorbid neuropsychiatric diagnoses such as depression, posttraumatic stress disorder, and traumatic brain injuries that complicate management of their substance use disorder.^{1,2,3} This fact requires a multifaceted treatment approach in the rehab setting to succeed. To this point, the CLC Addiction Task Force was chaired by the Social Work Executive and included representatives from Medicine, Mental Health, Nursing, Social Work, Patient Safety, and Addiction Treatment. Initial meetings focused on consensus building, creating a mission, and setting goals for the group. The stated mission of the task force was to “enhance an environment that supports and promotes motivation for veterans with substance use disorders while in the CLC.” Goals were to develop and institute educational initiatives for nursing and medical providers; to create patient care guidelines to increase safety on the unit; to improve provider confidence when caring for this high-risk population; and to mitigate the risk of unintentional overdose in patients with opioid use disorders. The task force was divided into 4 working groups to meet these aims.

Group 1—Enhancement of unit safety

This group, led by a nurse manager, consisted of representatives from nursing leadership (other nurse managers, assistant nurse managers, and chief nurse executive), addictions treatment (RN, PhD), and patient safety. The primary aim was development of a new patient care memorandum entitled “Enhancing Resident Safety Regarding Use of Illicit Drugs.” Implementation of the final policy is still pending further discussion, however; a summary of the policy to date is as follows:

“Based on the growing prevalence of substance abuse, the provider and nursing staff will identify residents at risk upon admission and thereafter for signs and symptoms of substance abuse. The veteran’s right to treatment under the least restrictive environment will be considered. It is the Medical Center’s position that individuals dealing with substance abuse need treatment, as such, there is a bias against the pursuit of prosecution for infractions. An organized program is designed to assist with safety and reduce risk of harm while preserving the self-esteem and dignity of the veteran. All prudent measures will be used, such as increased monitoring, and testing and observation of veterans who are identified as at risk. Such veterans will be assessed and referred for specialty care as indicated during the inpatient stay and upon discharge.”

Group 2—Identification of at-risk veterans and staff education

This group, led by the CLC psychologist, consisted of consultation-liaison psychiatrists, and addiction experts in psychiatry, psychology, social work, and nursing. The initial aim was to enhance early identification of high-risk veterans in the CLC. A standardized screening process was implemented to identify veterans at high risk of opioid use disorders via the medical provider's history and physical examination and Nursing Admission interview. High-risk veterans are referred to the CLC mental health team for further assessment and treatment. This task was accomplished fairly quickly, so this group volunteered to also address issues of staff education, as a need for education was brought up by several groups.

A needs assessment was conducted via individual and group interviews to determine the learning needs of nurses and medical providers in the CLC. Educational initiatives were then tailored to these reported needs. A series of lectures were offered to medical providers on the following topics: *Alcohol Abuse and Dependence*; *Opioid Abuse and Dependence*; *Identification and Management of the Opioid Dependent Patient in the CLC*; and an *Overview of Stimulants and Uncommon Drugs of Abuse*. Didactics provided a general review of substance use disorders as well as ways to identify and manage these patients on the unit. Separate in-services were tailored to the requests of the nursing staff. Topics included *Common drugs of Abuse*; *The Signs and Symptoms of Drug Abuse*; and *Understanding the Patient with Opioid Use Disorder: Interpersonal Challenges and Barriers to Care*. These trainings were uniformly well received and postdidactic surveys revealed that participants felt more knowledgeable about the topics and more confident managing substance use disorders in a subacute rehab setting.

Group 3—Facilitation of improved referral and access to addictions treatment

This group, led by a social worker, consisted of representatives from social work, hospital leadership, addiction treatment programs, psychology, and nursing. The primary aims of this group were to address gaps in access to addictions treatment while admitted to the CLC and the development of appropriate aftercare plans prior to discharge. Access to addiction treatment while admitted to a VA CLC and after discharge is important but is at times limited by a lack of resources.⁴

Group 3 was able to find practical solutions to gaps in access and availability of addictions treatment by arranging meetings with local VA SUD treatment programs. This allowed more veterans to begin their outpatient SUD treatment while concurrently admitted to the CLC and clarified the process to refer veterans for SUD treatment. Also, with guidance from the consultation-liaison psychiatrists at CLC, outpatient types of treatment for substance use disorders (such as intramuscular [IM] naltrexone) were initiated on a case-by-case basis prior to discharge. Prescriptions for naloxone rescue kits for high-risk veterans were also made available upon discharge. The purpose of such efforts is to reduce the delay to initiation of treatment, to bridge identified treatment gaps, and hopefully to reduce overdoses.

Group 4—Utilization of available resources

This group, led by the Nursing Executive, consisted of nurses and a nurse practitioner. They focused on finding ways to raise awareness and improve utilization of addiction treatment resources already available to staff and patients. A needs assessment revealed opportunities for educational initiatives for nursing staff. These included the topics addressed by Group 3, as well as mock codes before implementing naloxone use on code carts. Ongoing 12-step meetings on campus were identified and advertised through the CLC newsletter and flyers placed in high-visibility areas. Medical escorts were arranged for patients with diminished mobility who wished to attend these meetings. Group 4 also coordinated a grief processing session for staff members, through the Employee Assistance Program, to discuss the fatal overdose of a CLC patient.

Our preliminary work to enhance the identification and management of opioid use disorders at our CLC is an important first step toward a standardized curriculum that could be applied to other VA and non-VA subacute rehab settings. Our work could serve as the basis for a standardized curriculum, which would facilitate more quantitative outcome measurement. This could be accomplished, for example, as an online modular course to provide consistency for learners. The course could incorporate pre- and post-assessments, learning objectives, assigned reading, exercises and activities, and resources for additional study. This could be supplemented by in-service teaching from addiction specialists, focusing on the identification of at-risk patients, and advanced techniques in the management of these patients in a general rehab setting, as per our initiative. Surveys measuring clinician and patient satisfaction, around this process, could be used to measure the success of the interventions and to identify other gaps in knowledge or training for future educational interventions.

One unique aspect of the VA system is the availability of a wide array of medical and mental health services that, while giving veterans diverse residential and outpatient treatment options, can complicate access to these services. Working with the CLC team to ease the transition between subacute rehab and initiation of outpatient addiction treatment by shortening the time to the next appointment and decreasing the opportunity for relapse in the interim has helped to decrease gaps in treatment. Utilizing an interdisciplinary approach and an iterative process at all stages was critical to the success of the CLC Addictions Task Force, as it improved buy-in and motivation from all disciplines. Improvements have been made to enhance patient safety, improve communication amongst providers, and provide a foundation to improve patient outcomes. In addition, creating interventions that preemptively addressed compassion fatigue and caregiver burnout made a significant impact in improving the motivation and confidence of the staff in caring for this patient population. This was the catalyst for implementing the procedural changes the CLC task force created: by supporting staff we were able to provide the scaffold through which significant changes could be made quickly and overall outcomes improved.

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