

# An OUD Support Line Improves Opioid Use Disorder Treatment in Hospitalized Patients

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## INTRODUCTION

- Inpatient hospitalization presents an opportunity to engage patients with OUD in treatment.<sup>1</sup>
- Inpatient buprenorphine initiation for OUD improves patient outcomes and quality of care, including:
  - Increased outpatient follow-up<sup>2</sup>
  - Decreased post-discharge opioid overdose<sup>2</sup>
  - Decreased hospital length of stay and readmissions<sup>3</sup>
- Undertreated opioid withdrawal can interfere with inpatient care
- Formal addiction consultation services (ACS) improve MOUD initiation and post-discharge engagement in care.<sup>4</sup>
- Many hospitals—including GWU Hospital (GWUH)—lack access to an ACS, risking suboptimal care.<sup>5</sup>
- ACS implementation not feasible due to stigma or insufficient funding, expertise, or stakeholder buy-in<sup>6</sup>

**Primary Aim:** To evaluate whether an "OUD support" pager role for curbside consultation staffed by outpatient internal medicine physicians with experience in OUD treatment was associated with an increase in inpatient buprenorphine prescribing.

**Secondary aim:** To characterize the types of questions and users of an OUD curbside consultation line for inpatient care.

## METHODS

- GWUH uses a secure texting app for patient care communication.
- Messages can be sent to "roles" staffed by signed-in clinicians.
- February 2023: "Opioid Use Disorder Support" role is launched.
  - Announced at meetings or didactics to clinicians, case managers, nurses, and pharmacists
  - No additional promotion conducted
- Role description: "Contact this role if considering inpatient initiation of buprenorphine for OUD. Mon-Fri 8am-5pm."
- Staffed by two internal medicine physicians with OUD clinical experience and involvement in SUD-related initiatives.
- Any hospital staff can contact the role for advice.
- Role provides real-time education and guidance without direct patient contact; no billing occurs.
- Primary teams retain responsibility for care decisions and documentation.
- Pager call summaries were logged in a shared document for descriptive analysis.

## RESULTS

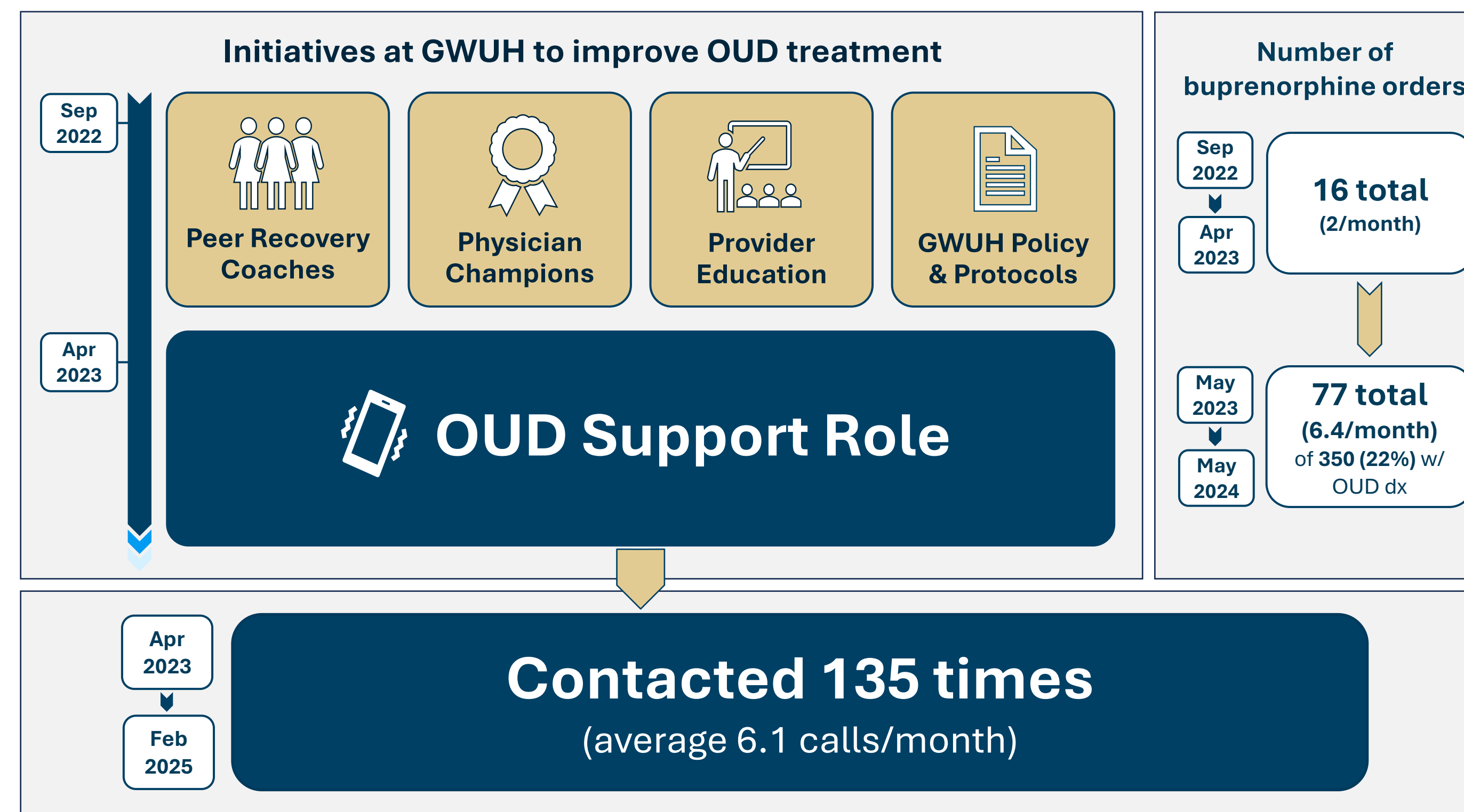


Table 1. Topics discussed in calls.

Topic	# Calls
OUD treatment	82 (61%)
Opioid withdrawal management	27 (20%)
Pain management in patients with OUD	33 (24%)
Planned buprenorphine starts	28 (21%)
Planned methadone starts	10 (7%)
Discharge planning/legal questions	37 (27%)
Other (OUD hx, MOUD in pregnancy, peri-op MOUD, )	25 (19%)

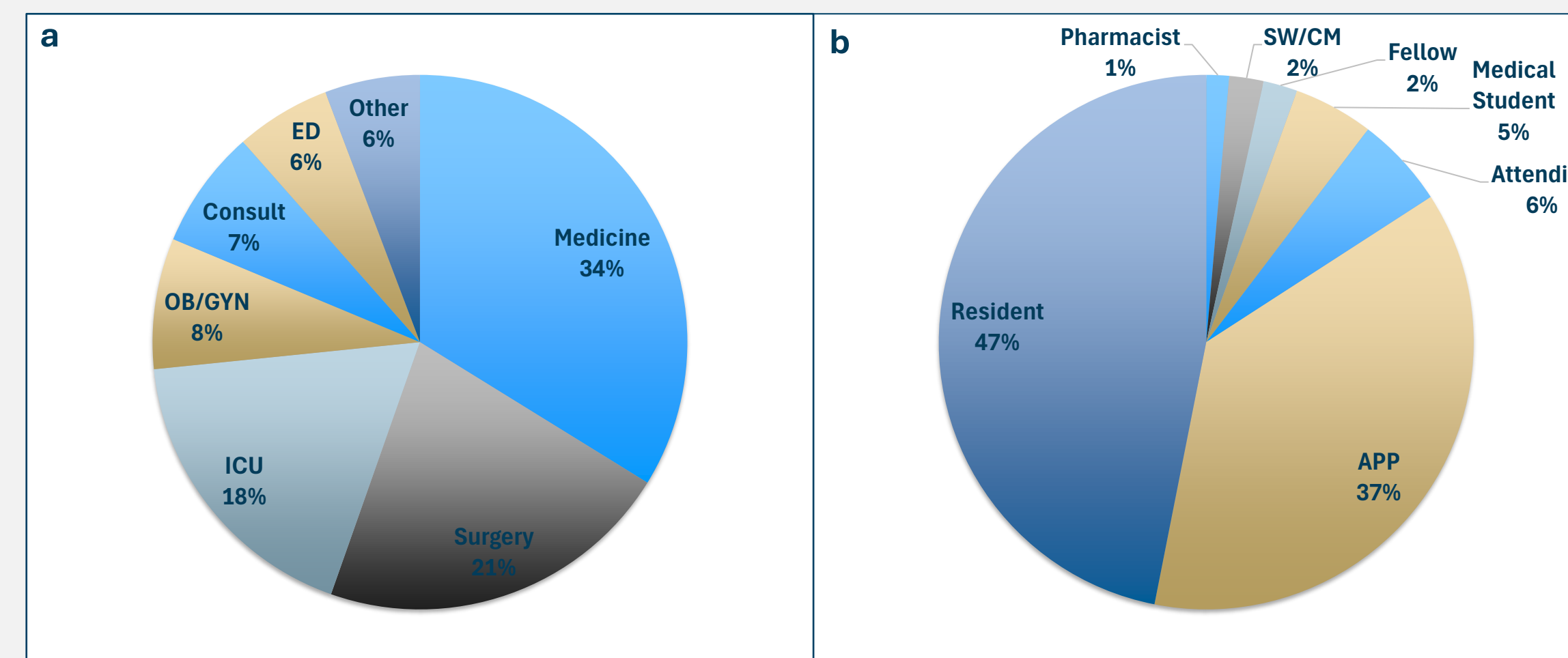


Figure 1. (a) Caller service lines. (b) Caller roles.

## DISCUSSION

- Many clinicians sought real-time advice to improve care for patients with OUD.
- Engagement spanned multiple disciplines and specialties.
- Most calls addressed knowledge gaps or discomfort in prescribing MOUD—known barriers to MOUD prescribing.<sup>6</sup>
- Many calls resulted in plans for MOUD initiation.
- A wide span of topics were addressed, including withdrawal management, pain control, MOUD continuation while inpatient, and discharge planning.

### Limitations:

- Relies on volunteer physician "champions"—a model that may not be sustainable long-term.
- Our physicians have academic/research roles not common at all institutions that allow flexibility to maintain the role.

### Future Directions:

- We hope to use this data to demonstrate need and potentially secure funding/support.
- Additional data collection to better demonstrate impact.

For institutions unable to implement an ACS, a real-time OUD Support role is an effective and lower-barrier alternative that can provide practical education to clinicians, improve care for patients with OUD, and increase access to MOUD for those that need it.

## AUTHORS & DISCLOSURES

The authors have no relevant conflicts of interest to disclose.

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