Psychiatric Consultation in the Medical/Surgical Setting

The Art of the Consult

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No conflicts of interest for this presentation

American Board of Medical Specialties – ABMS

Boards of Certification – 24

Approved Specialties – 38

Approved Subspecialties – 89

ONLY ONE WITH FOCUS ON THE PRACTICE OF CONSULTATION WITHIN THE SPECIALTY – CONSULTATION-LIAISON PSYCHIATRY

Why Psychiatric Consultation?

- Most medical and surgical services provide consultation to primary care, Emergency Medicine, and inpatient medical services
- However, virtually no discipline except Psychiatry has a subspecialty focused on providing consultation to other specialties
- Why?
  - Minimal psychiatric training/experience in medical school/residencies
  - Psychiatry has traditionally removed itself from the 'House of Medicine', resulting in decreased exposure to psychiatric patients for many other providers
  - Discomfort with psychiatric symptoms and patients
- Despite specialty expertise, far less than half of general hospitals have a dedicated psychiatric consultation service*
  - Typically provided by psychiatrist who cover inpatient psychiatric unit or outpatient psychiatrists in community with "hospital privileges"

* Ellison et al, Mayo Clin Proc. May 2022

Psychiatric Consultation Assessment: Useful Considerations

- Consult usually called to answer specific question; assessment should be focused on answering that question
- Acute vs. chronic onset of symptoms
- Greater attention to relevant medical history and ROS
- Less focus on early developmental hx
- Consider impact of medical/surgical illness and hospitalization, especially for patients with hx of PTSD, i.e., important to take a Trauma Informed Care approach to consultations

Consultation patient groups

- In general, psychiatric consultants are evaluating patients in one of five (or a combination of) categories :
  - Psychiatric presentation of organic disease (secondary mania in hyperthyroidism)
  - Psychiatric complications of organic disease (depressed mood with Keppra)
  - Psychiatric reactions to organic disease (demoralization with CA illness)
  - Somatic presentation of psychiatric disorders (PNES)
  - Somatic Symptom disorders

Lipowski ZJ; Psychosomatic Medicine

Tenets of Effective Consultation

- **Know who you are serving; medical team, hospital system, patient**

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- **Swift response**

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- **Discussion vs. Interrogation**

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- **Who am I?**

Who am I?

- Inform the patient of who you are
- Identify any other staff (residents, students, social workers, etc) with you
- Briefly describe your general role on the medical floor or ED, particularly your primary function as a consultant to their doctor

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- Who am I?
- **Did they know?**

Ask if they were told

- Check with the patient to see if they were informed that consultation was requested
- Only informed 50 % of time, compared to 80 % of other consultants*
- Increased patient value for consult if informed*

* Gitlin, Worley. *Patient perceptions of consultation*, 2007

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- Who am I?
- Did they know?
- **Why am I here?**

Why am I here?

- After informing the patient of why you have come, ask the patient if they know why their doctors wanted a psychiatrist to see them
- Helps get sense of patient's understanding of the situation and the medical team's concerns
- Can allow the patient to initially set the agenda, which may diminish resistance
- Ultimately, do give the patient your perception of why you were consulted to help them

What do you need?

- End with asking patient what they believe they need
- Emphasizes to patient that their needs and opinions are valued
- Allows assessment of patient insight
- Patient most likely to accept treatment that they feel will help them

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- Who am I?
- Did they know?
- Why am I here?
- **Do something for the patient**

Do Something for the Patient

- Being in the hospital is difficult at best
- Patients often unable to maintain dignity
- Do something the patient can appreciate
  - Get a blanket, glass of water, etc.
  - Help change to more comfortable position
  - Communicate info to nurse or attending
- Can break ice with patient, especially if resistant to consultation

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- Who am I?
- Did they know?
- Why am I here?
- Do something for the patient
- **Sit down!**

Take A Seat

- Sit down as soon as you can
- Get to eye level with the patient; raise head of bed if necessary/possible
- Neutralizes status differences
- Helps diminish anger and agitation
- Changes interview from interrogation to conversation
- Decreases appearance of being hurried

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- **Additional sources of information can be critical**

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- Additional sources of information can be critical
- **Communication is the key to effective consultation**

Consultation Note

- Be Concise
  - Likelihood of note being read by consultee is inversely related to length of note
- Only use relevant information
  - Medical hx only as relates to consult
  - Relevant laboratories
  - Appropriate mental status exam
- Only document what you would want your neighbor to see
- Impression and Recommendation are most important sections

Barriers to effective consultation

- Patients are often severely ill/debilitated, negatively impacting ability to obtain information from patient
- Lack of privacy in hospital/ED rooms
- Patient availability (tests/procedures/other providers)
- Hard to duplicate office setting
- Patient may not “want” to be evaluated

Make Your Service Valuable

Make Your Service Valuable

- Involvement with hospital committees
  - Ethics
  - Safety Committee
  - P&T

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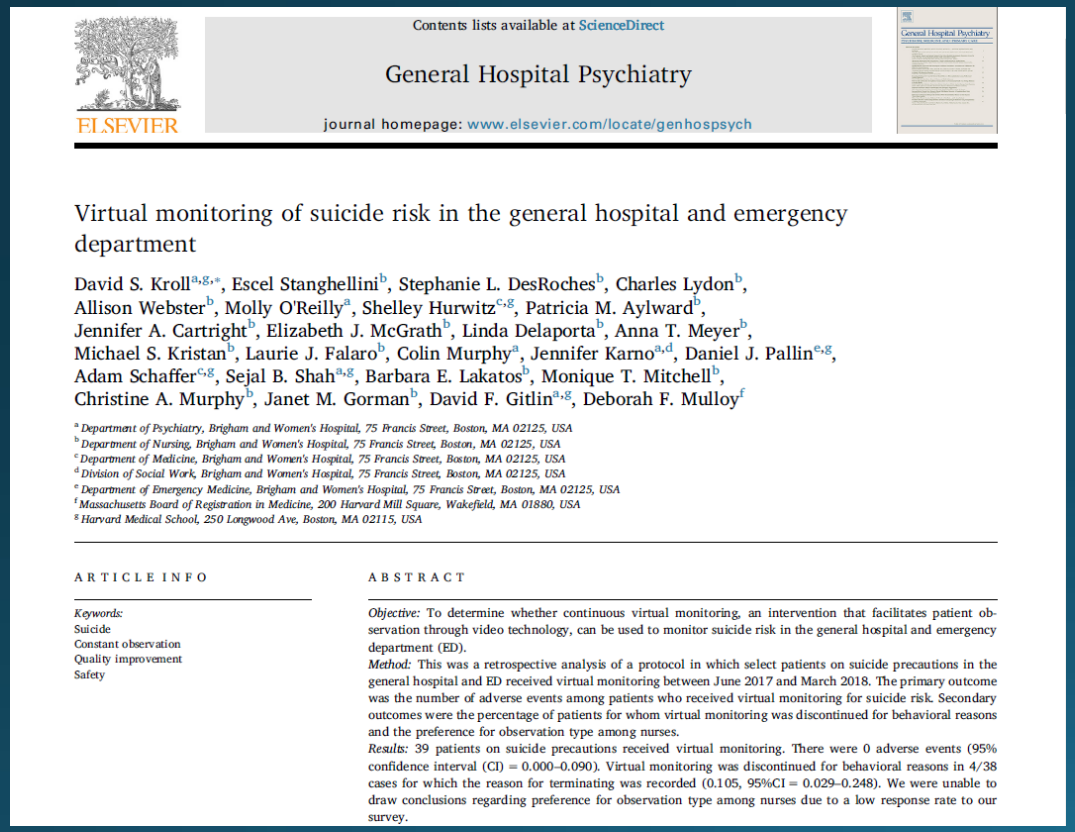
- Identify areas of hospital need/expense
  - Constant Observation

Virtual Monitoring for Suicide Risk



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Virtual monitoring of suicide risk in the general hospital and emergency department

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ARTICLE INFO

Keywords:
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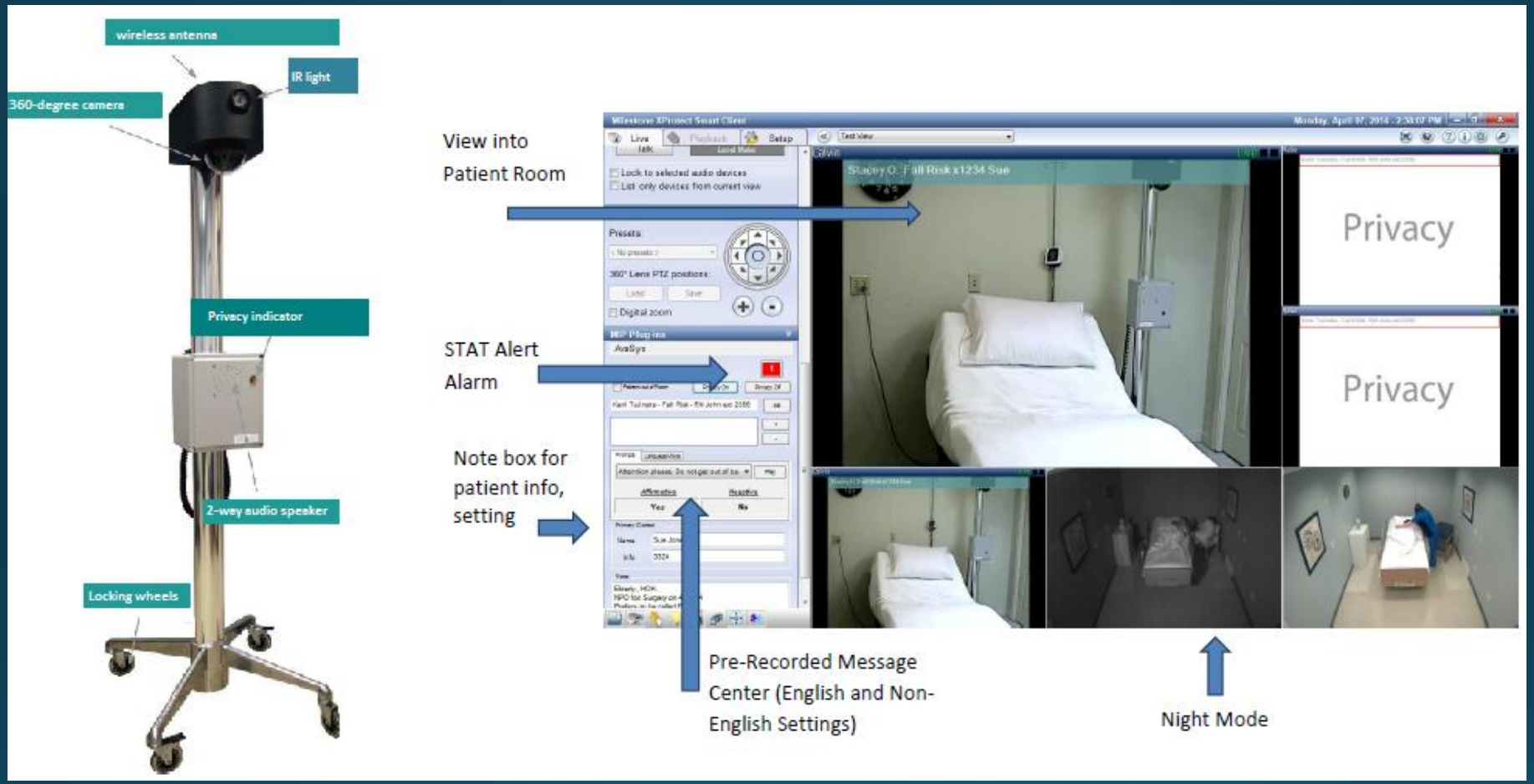
ABSTRACT

Objective: To determine whether continuous virtual monitoring, an intervention that facilitates patient observation through video technology, can be used to monitor suicide risk in the general hospital and emergency department (ED).

Method: This was a retrospective analysis of a protocol in which select patients on suicide precautions in the general hospital and ED received virtual monitoring between June 2017 and March 2018. The primary outcome was the number of adverse events among patients who received virtual monitoring for suicide risk. Secondary outcomes were the percentage of patients for whom virtual monitoring was discontinued for behavioral reasons and the preference for observation type among nurses.

Results: 39 patients on suicide precautions received virtual monitoring. There were 0 adverse events (95% confidence interval (CI) = 0.000–0.090). Virtual monitoring was discontinued for behavioral reasons in 4/38 cases for which the reason for terminating was recorded (0.105, 95%CI = 0.029–0.248). We were unable to draw conclusions regarding preference for observation type among nurses due to a low response rate to our survey.

- Results: 39 patients on suicide precautions received virtual monitoring. There were no adverse events (95% confidence interval (CI)=0.000–0.090).
- Virtual monitoring was discontinued for behavioral reasons in 4/38 cases for which the reason for terminating was recorded (0.105, 95%CI=0.029–0.248).
- Conclusions: Suicide risk can feasibly be monitored virtually in the general hospital or ED when their providers carefully select patients for low impulsivity risk.



WE USED A MOBILE DEVICE THAT SITS IN A PATIENT'S ROOM AND CONNECTS TO A CENTRAL OFFICE


Out of room:
Dialysis

Make Your Service Valuable

- Involvement with hospital committees
  - Ethics
  - Safety Committee
  - P&T
- Identify areas of hospital need/expense
  - Constant Observation
- Standardized guidelines
  - Suicide Assessment

Suicide Assessment Documentation

- Increasingly recognized area of general hospital risk
- JCAHO requirement for assessment in all entry areas, e.g., ED
- JCAHO recommendation for standardized tool
- Standardized tools help with consistency

Suicide Assessment Documentation

R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

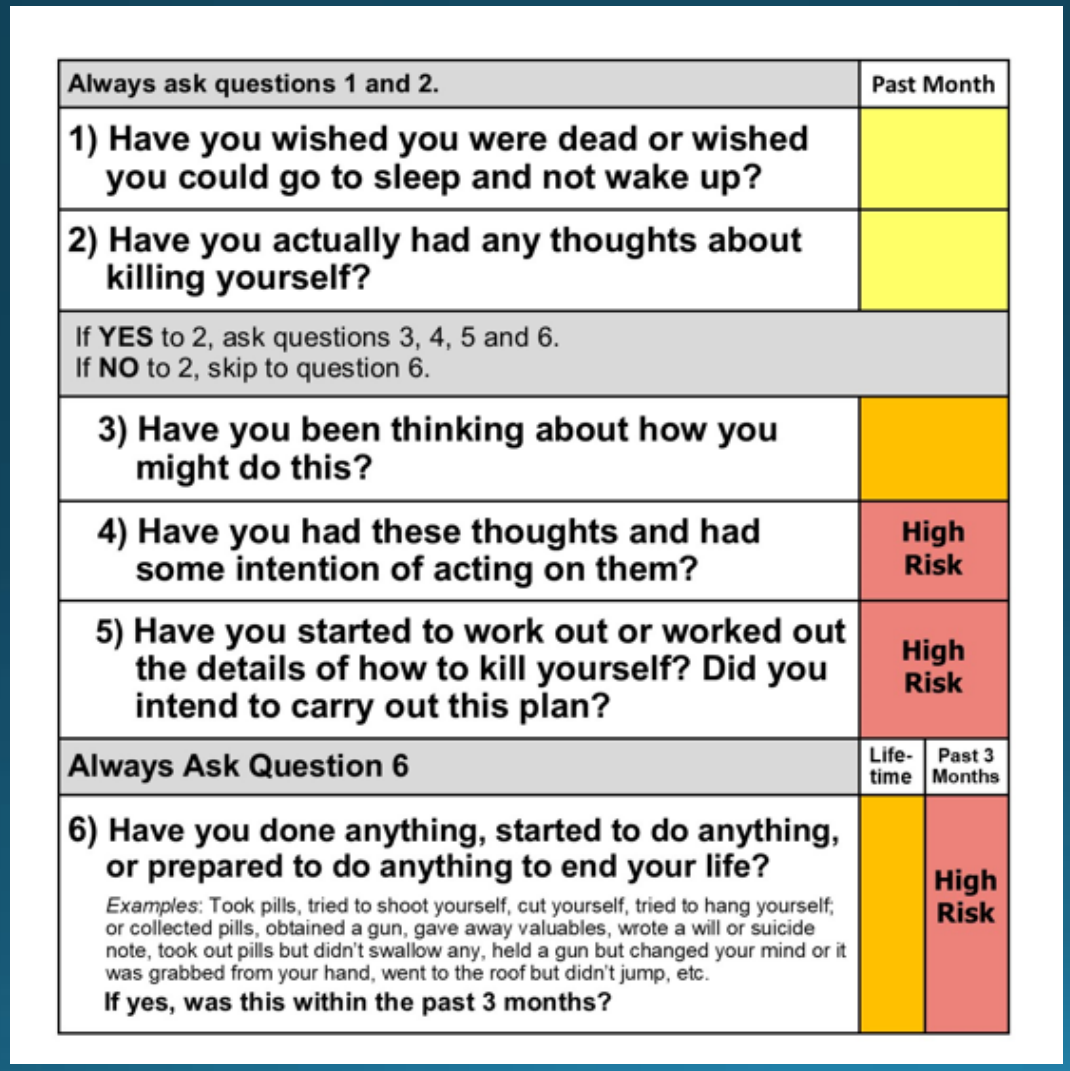
Issue 18, Nov. 27, 2018
UPDATED Nov. 20, 2019

Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

National Patient Safety Goal for suicide prevention

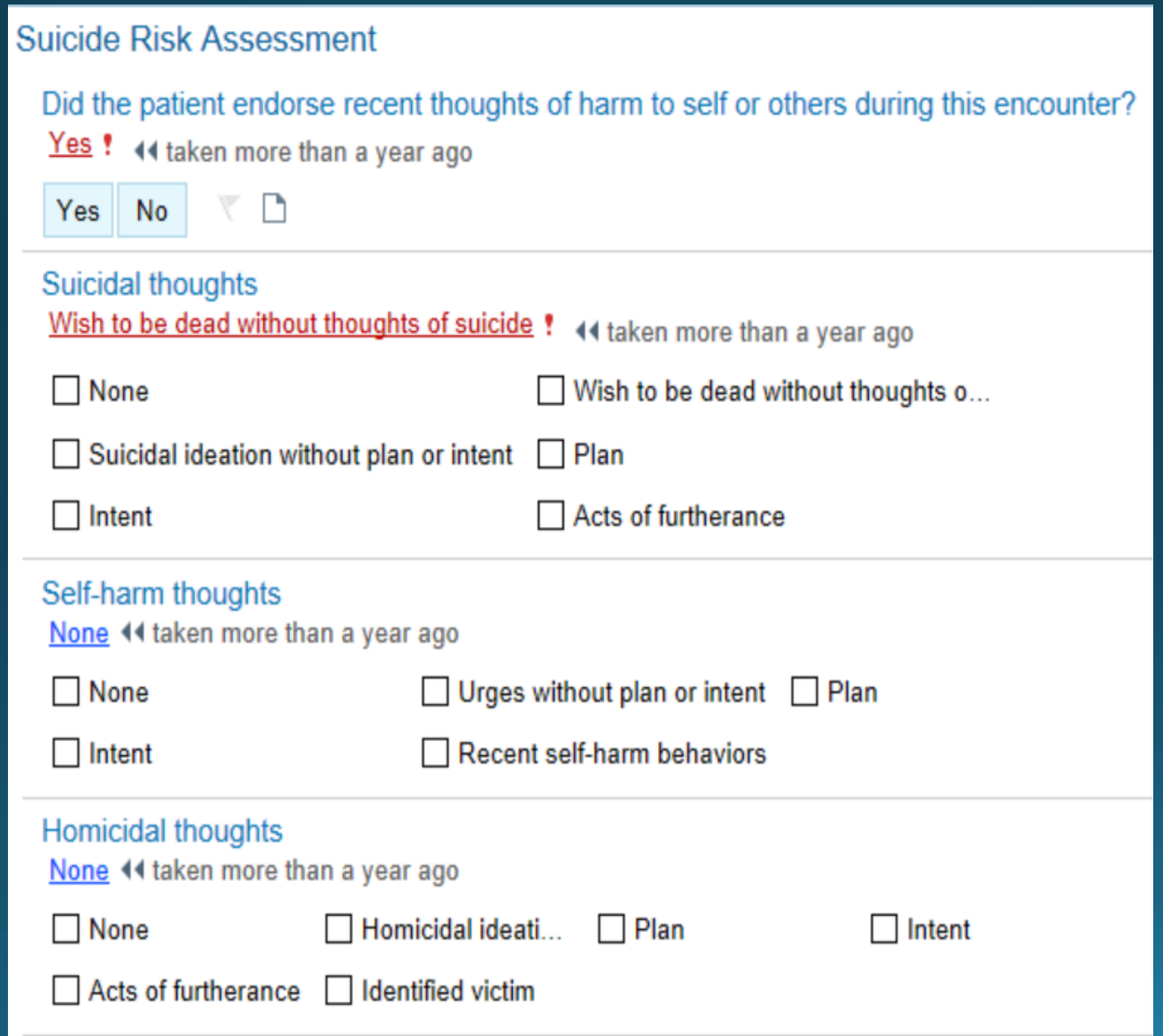
Requirement	NPSG 15.01.01, EP 2: BHC: Screen all individuals served for suicidal ideation using a validated screening tool. Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above. HAP: Screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool.

Columbia Suicide Severity Rating Scale – C-SSRS



Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	High Risk	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself; or collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, etc. **If yes, was this within the past 3 months?**		High Risk

Suicide Risk Assessment



Violent/destructive thoughts

None taken more than a year ago

- [ ] None
- [ ] Urges without plan or intent
- [ ] Plan
- [ ] Intent
- [ ] Recent violent or destruc...

Additional details

Prior suicide behaviors or attempts

Yes ! taken more than a year ago

None | Yes

Static risk factors

Recent/new onset of psychiatric illness taken more than a year ago

Modifiable risk factors

Psychosis taken more than a year ago

Protective factors

Help-seeking behavior taken more than a year ago

What is the patient's current, overall, acute risk of harm to self and/or others?

High ! taken more than a year ago

Minimal | Low | Moderate | High

Actions taken to minimize risk of harm to self and others

Filed a Section 12(a) taken more than a year ago

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- Identify areas of hospital need/expense
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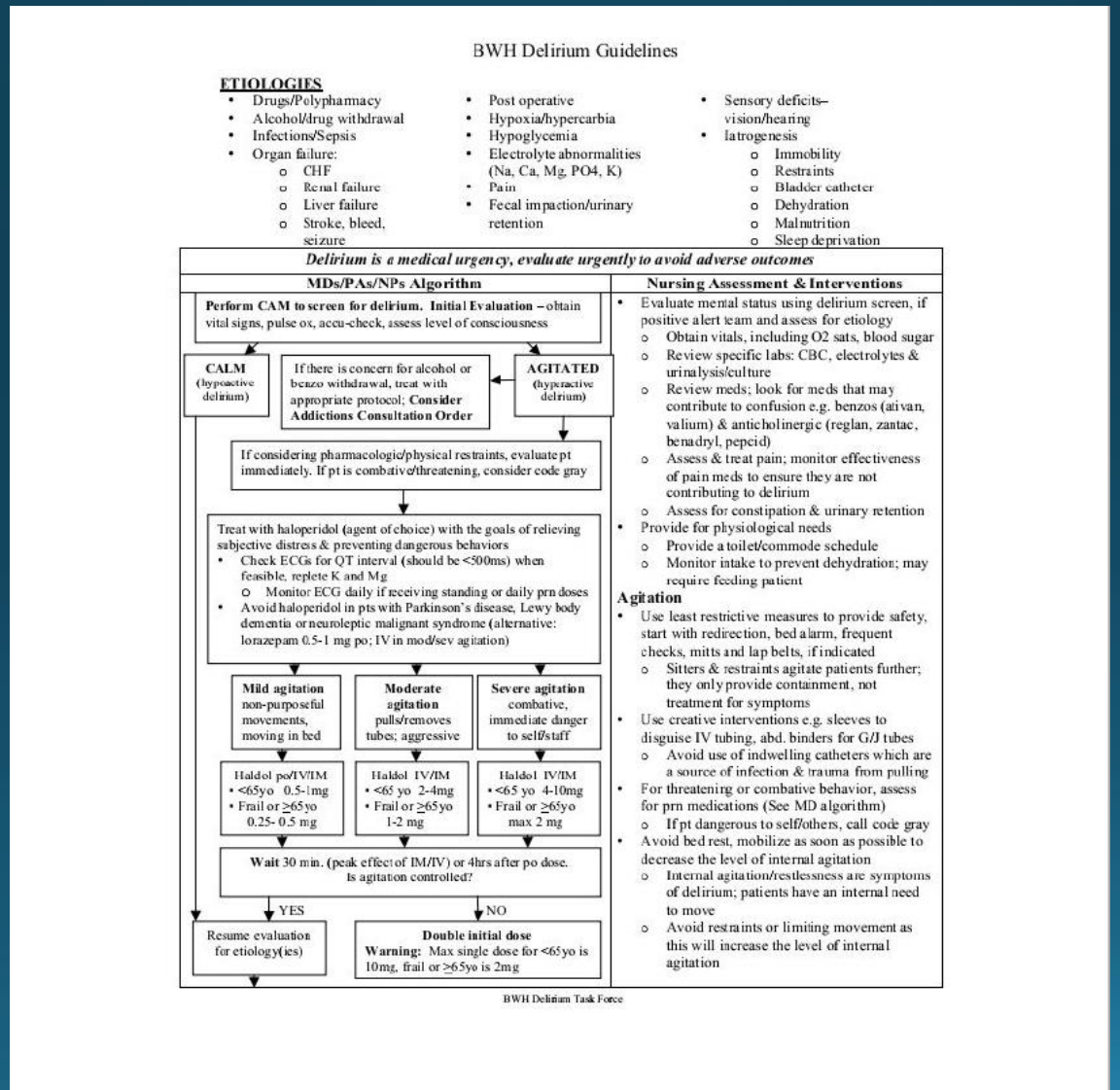
- Standardized guidelines
  - Suicide Assessment
  - Delirium Management

Delirium Management Guidelines



BWH Delirium Guidelines

ETIOLOGIES

- Drugs/Polypharmacy
- Alcohol/drug withdrawal
- Infections/Sepsis
- Organ failure:
  - CHF
  - Renal failure
  - Liver failure
  - Stroke, bleed, seizure
- Post operative
- Hypoxia/hypercarbia
- Hypoglycemia
- Electrolyte abnormalities (Na, Ca, Mg, PO4, K)
- Pain
- Fecal impaction/urinary retention
- Sensory deficits– vision/hearing
- Iatrogenesis
  - Immobility
  - Restraints
  - Bladder catheter
  - Dehydration
  - Malnutrition
  - Sleep deprivation

Delirium is a medical urgency, evaluate urgently to avoid adverse outcomes

MDs/PAs/NPs Algorithm

Perform CAM to screen for delirium. Initial Evaluation – obtain vital signs, pulse ox, accu-check, assess level of consciousness

CALM (hypoactive delirium)

If there is concern for alcohol or benzo withdrawal, treat with appropriate protocol; **Consider Addictions Consultation Order**

AGITATED (hyperactive delirium)

If considering pharmacologic/physical restraints, evaluate pt immediately. If pt is combative/threatening, consider code gray

Treat with haloperidol (agent of choice) with the goals of relieving subjective distress & preventing dangerous behaviors

- Check ECGs for QT interval (should be <500ms) when feasible, replete K and Mg
  - Monitor ECG daily if receiving standing or daily prn doses
- Avoid haloperidol in pts with Parkinson's disease, Lewy body dementia or neuroleptic malignant syndrome (alternative: lorazepam 0.5-1 mg po; IV in mod/sev agitation)

Mild agitation non-purposeful movements, moving in bed	**Moderate agitation** pulls/removes tubes; aggressive	**Severe agitation** combative, immediate danger to self/staff
Haldol po/IV/IM • <65yo 0.5-1mg • Frail or ≥65yo 0.25- 0.5 mg	Haldol IV/IM • <65 yo 2-4mg • Frail or ≥65yo 1-2 mg	Haldol IV/IM • <65 yo 4-10mg • Frail or ≥65yo max 2 mg

Wait 30 min. (peak effect of IM/IV) or 4hrs after po dose. Is agitation controlled?

YES → Resume evaluation for etiology(ies)

NO → **Double initial dose** **Warning:** Max single dose for <65yo is 10mg, frail or ≥65yo is 2mg

Nursing Assessment & Interventions

- Evaluate mental status using delirium screen, if positive alert team and assess for etiology
  - Obtain vitals, including O2 sats, blood sugar
  - Review specific labs: CBC, electrolytes & urinalysis/culture
  - Review meds; look for meds that may contribute to confusion e.g. benzos (ativan, valium) & anticholinergic (reglan, zantac, benadryl, pepcid)
  - Assess & treat pain; monitor effectiveness of pain meds to ensure they are not contributing to delirium
  - Assess for constipation & urinary retention
- Provide for physiological needs
  - Provide a toilet/commode schedule
  - Monitor intake to prevent dehydration; may require feeding patient

Agitation

- Use least restrictive measures to provide safety, start with redirection, bed alarm, frequent checks, mitts and lap belts, if indicated
  - Sitters & restraints agitate patients further; they only provide containment, not treatment for symptoms
- Use creative interventions e.g. sleeves to disguise IV tubing, abd. binders for G/J tubes
  - Avoid use of indwelling catheters which are a source of infection & trauma from pulling
- For threatening or combative behavior, assess for prn medications (See MD algorithm)
  - If pt dangerous to self/others, call code gray
- Avoid bed rest, mobilize as soon as possible to decrease the level of internal agitation
  - Internal agitation/restlessness are symptoms of delirium; patients have an internal need to move
  - Avoid restraints or limiting movement as this will increase the level of internal agitation

BWH Delirium Task Force

Make Your Service Valuable

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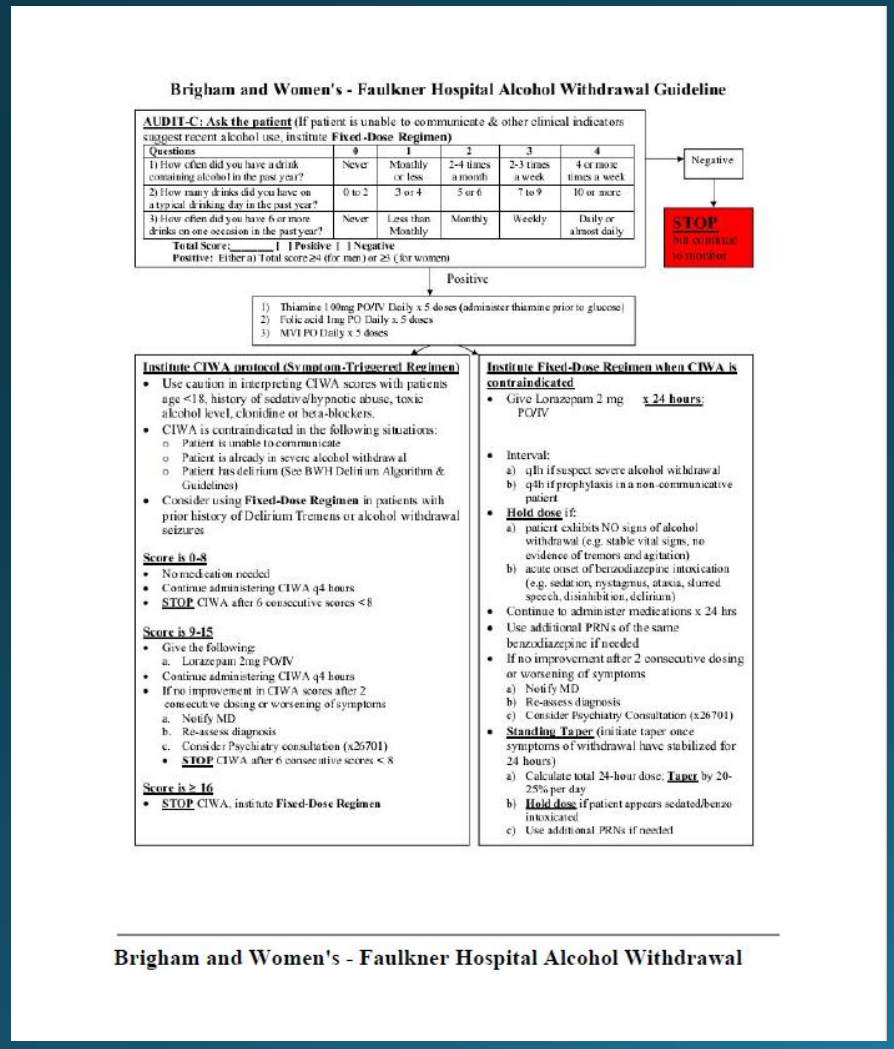
- Standardized guidelines
  - Suicide Assessment
  - Delirium Management
  - Alcohol/Opioid Withdrawal

Alcohol Withdrawal Management Guidelines



Brigham and Women's - Faulkner Hospital Alcohol Withdrawal Guideline

AUDIT-C: Ask the patient (If patient is unable to communicate & other clinical indicators suggest recent alcohol use, institute **Fixed-Dose Regimen**)

Questions	0	1	2	3	4
1) How often did you have a drink containing alcohol in the past year?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2) How many drinks did you have on a typical drinking day in the past year?	0 to 2	3 or 4	5 or 6	7 to 9	10 or more
3) How often did you have 6 or more drinks on one occasion in the past year?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily

Total Score:_____ [ ] Positive [ ] Negative
Positive: Either a) Total score ≥4 (for men) or ≥3 (for women)

Negative → **STOP** but continue to monitor

Positive

1) Thiamine 100mg PO/IV Daily x 5 doses (administer thiamine prior to glucose)
2) Folic acid 1mg PO Daily x 5 doses
3) MVI PO Daily x 5 doses

Institute CIWA protocol (Symptom-Triggered Regimen)

- Use caution in interpreting CIWA scores with patients age <18, history of sedative/hypnotic abuse, toxic alcohol level, clonidine or beta-blockers.
- CIWA is contraindicated in the following situations:
  - Patient is unable to communicate
  - Patient is already in severe alcohol withdrawal
  - Patient has delirium (See BWH Delirium Algorithm & Guidelines)
- Consider using **Fixed-Dose Regimen** in patients with prior history of Delirium Tremens or alcohol withdrawal seizures

Score is 0-8
- No medication needed
- Continue administering CIWA q4 hours
- **STOP** CIWA after 6 consecutive scores <8

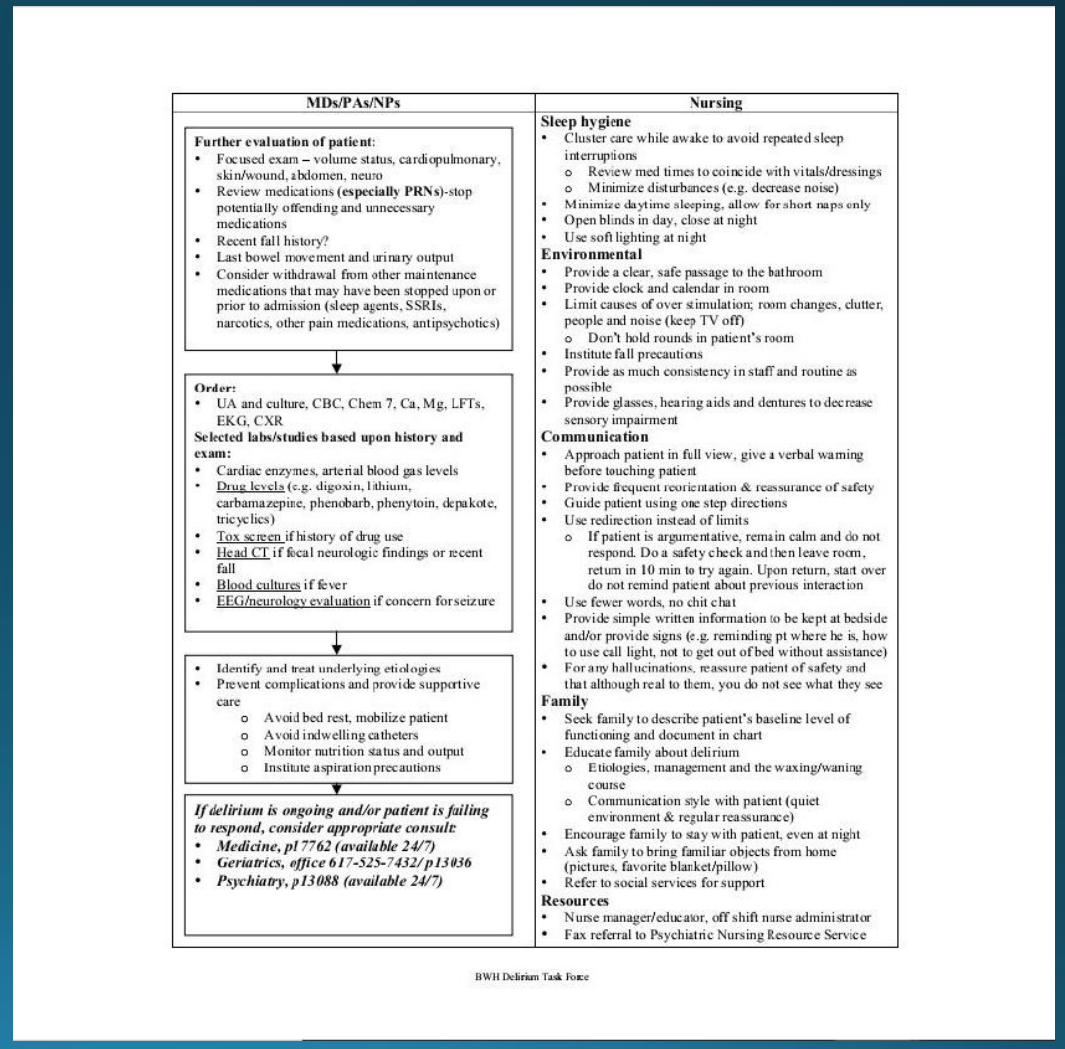
Score is 9-15
- Give the following:
  a. Lorazepam 2mg PO/IV
- Continue administering CIWA q4 hours
- If no improvement in CIWA scores after 2 consecutive dosing or worsening of symptoms
  a. Notify MD
  b. Re-assess diagnosis
  c. Consider Psychiatry consultation (x26701)
  - **STOP** CIWA after 6 consecutive scores < 8

Score is ≥ 16
- **STOP** CIWA, institute **Fixed-Dose Regimen**

Institute Fixed-Dose Regimen when CIWA is contraindicated

- Give Lorazepam 2 mg **x 24 hours**: PO/IV
- Interval:
  a) q1h if suspect severe alcohol withdrawal
  b) q4h if prophylaxis in a non-communicative patient
- **Hold dose** if:
  a) patient exhibits NO signs of alcohol withdrawal (e.g. stable vital signs, no evidence of tremors and agitation)
  b) acute onset of benzodiazepine intoxication (e.g. sedation, nystagmus, ataxia, slurred speech, disinhibition, delirium)
- Continue to administer medications x 24 hrs
- Use additional PRNs of the same benzodiazepine if needed
- If no improvement after 2 consecutive dosing or worsening of symptoms
  a) Notify MD
  b) Re-assess diagnosis
  c) Consider Psychiatry Consultation (x26701)
- **Standing Taper** (initiate taper once symptoms of withdrawal have stabilized for 24 hours)
  a) Calculate total 24-hour dose. **Taper** by 20-25% per day
  b) **Hold dose** if patient appears sedated/benzo intoxicated
  c) Use additional PRNs if needed

Brigham and Women's - Faulkner Hospital Alcohol Withdrawal



MDs/PAs/NPs	Nursing

Further evaluation of patient:
- Focused exam – volume status, cardiopulmonary, skin/wound, abdomen, neuro
- Review medications **(especially PRNs)**-stop potentially offending and unnecessary medications
- Recent fall history?
- Last bowel movement and urinary output
- Consider withdrawal from other maintenance medications that may have been stopped upon or prior to admission (sleep agents, SSRIs, narcotics, other pain medications, antipsychotics)

Order:
- UA and culture, CBC, Chem 7, Ca, Mg, LFTs, EKG, CXR

Selected labs/studies based upon history and exam:
- Cardiac enzymes, arterial blood gas levels
- Drug levels (e.g. digoxin, lithium, carbamazepine, phenobarb, phenytoin, depakote, tricyclics)
- Tox screen if history of drug use
- Head CT if focal neurologic findings or recent fall
- Blood cultures if fever
- EEG/neurology evaluation if concern for seizure

- Identify and treat underlying etiologies
- Prevent complications and provide supportive care
  - Avoid bed rest, mobilize patient
  - Avoid indwelling catheters
  - Monitor nutrition status and output
  - Institute aspiration precautions

If delirium is ongoing and/or patient is failing to respond, consider appropriate consult:
- ***Medicine, p1 7762 (available 24/7)***
- ***Geriatrics, office 617-525-7432/p13036***
- ***Psychiatry, p13088 (available 24/7)***

Sleep hygiene
- Cluster care while awake to avoid repeated sleep interruptions
  - Review med times to coincide with vitals/dressings
  - Minimize disturbances (e.g. decrease noise)
- Minimize daytime sleeping, allow for short naps only
- Open blinds in day, close at night
- Use soft lighting at night

Environmental
- Provide a clear, safe passage to the bathroom
- Provide clock and calendar in room
- Limit causes of over stimulation; room changes, clutter, people and noise (keep TV off)
  - Don't hold rounds in patient's room
- Institute fall precautions
- Provide as much consistency in staff and routine as possible
- Provide glasses, hearing aids and dentures to decrease sensory impairment

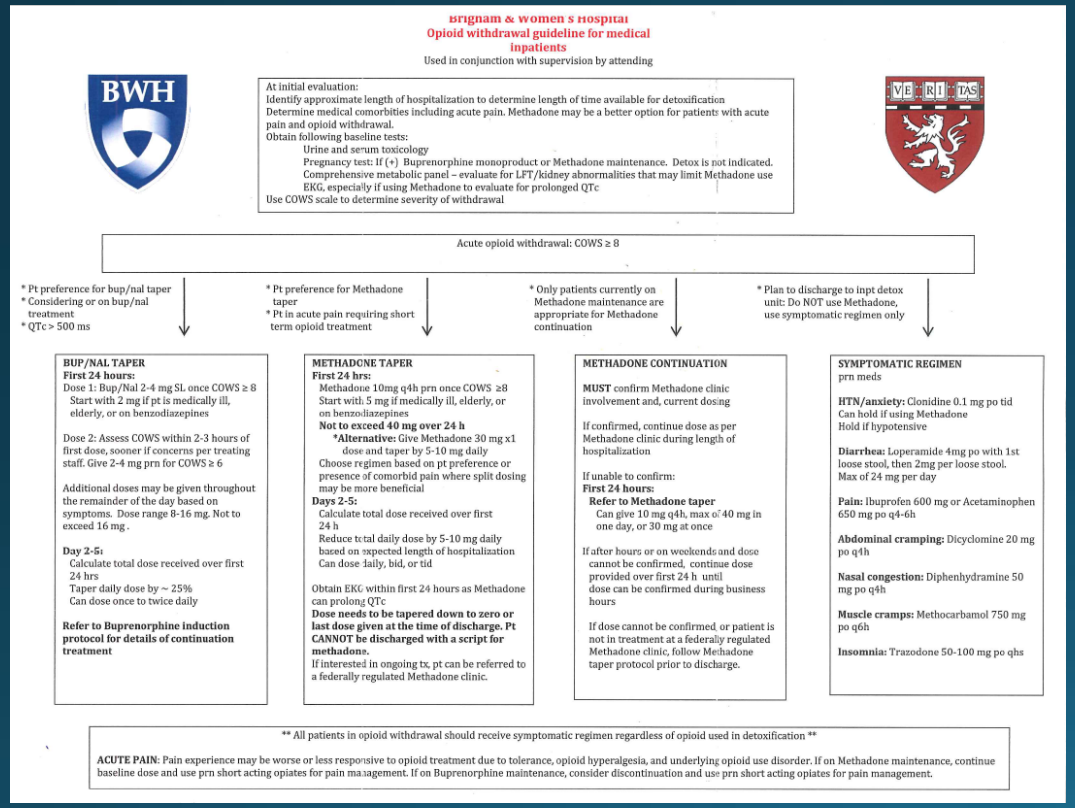
Communication
- Approach patient in full view, give a verbal warning before touching patient
- Provide frequent reorientation & reassurance of safety
- Guide patient using one step directions
- Use redirection instead of limits
  - If patient is argumentative, remain calm and do not respond. Do a safety check and then leave room, return in 10 min to try again. Upon return, start over do not remind patient about previous interaction
- Use fewer words, no chit chat
- Provide simple written information to be kept at bedside and/or provide signs (e.g. reminding pt where he is, how to use call light, not to get out of bed without assistance)
- For any hallucinations, reassure patient of safety and that although real to them, you do not see what they see

Family
- Seek family to describe patient's baseline level of functioning and document in chart
- Educate family about delirium
  - Etiologies, management and the waxing/waning course
  - Communication style with patient (quiet environment & regular reassurance)
- Encourage family to stay with patient, even at night
- Ask family to bring familiar objects from home (pictures, favorite blanket/pillow)
- Refer to social services for support

Resources
- Nurse manager/educator, off shift nurse administrator
- Fax referral to Psychiatric Nursing Resource Service

BWH Delirium Task Force

Opioid Withdrawal and Induction Guidelines



Brigham & Women's Hospital
Opioid withdrawal guideline for medical inpatients
Used in conjunction with supervision by attending

At initial evaluation:
Identify approximate length of hospitalization to determine length of time available for detoxification
Determine medical comorbities including acute pain. Methadone may be a better option for patients with acute pain and opioid withdrawal.
Obtain following baseline tests:
Urine and serum toxicology
Pregnancy test: If (+) Buprenorphine monoproduct or Methadone maintenance. Detox is not indicated.
Comprehensive metabolic panel – evaluate for LFT/kidney abnormalities that may limit Methadone use
EKG, especially if using Methadone to evaluate for prolonged QTc
Use COWS scale to determine severity of withdrawal

Acute opioid withdrawal: COWS ≥ 8

* Pt preference for bup/nal taper
* Considering or on bup/nal treatment
* QTc > 500 ms

BUP/NAL TAPER
First 24 hours:
Dose 1: Bup/Nal 2-4 mg SL once COWS ≥ 8
Start with 2 mg if pt is medically ill, elderly, or on benzodiazepines

Dose 2: Assess COWS within 2-3 hours of first dose, sooner if concerns per treating staff. Give 2-4 mg prn for COWS ≥ 6

Additional doses may be given throughout the remainder of the day based on symptoms. Dose range 8-16 mg. Not to exceed 16 mg.

Day 2-5:
Calculate total dose received over first 24 hrs
Taper daily dose by ~ 25%
Can dose once to twice daily

Refer to Buprenorphine induction protocol for details of continuation treatment

* Pt preference for Methadone taper
* Pt in acute pain requiring short term opioid treatment

METHADONE TAPER
First 24 hrs:
Methadone 10mg q4h prn once COWS ≥8
Start with 5 mg if medically ill, elderly, or on benzodiazepines
Not to exceed 40 mg over 24 h
***Alternative:** Give Methadone 30 mg x1 dose and taper by 5-10 mg daily
Choose regimen based on pt preference or presence of comorbid pain where split dosing may be more beneficial
Days 2-5:
Calculate total dose received over first 24 h
Reduce total daily dose by 5-10 mg daily based on expected length of hospitalization
Can dose daily, bid, or tid

Obtain EKG within first 24 hours as Methadone can prolong QTc
Dose needs to be tapered down to zero or last dose given at the time of discharge. Pt CANNOT be discharged with a script for methadone.
If interested in ongoing tx, pt can be referred to a federally regulated Methadone clinic.

* Only patients currently on Methadone maintenance are appropriate for Methadone continuation

METHADONE CONTINUATION

MUST confirm Methadone clinic involvement and, current dosing

If confirmed, continue dose as per Methadone clinic during length of hospitalization

If unable to confirm:
First 24 hours:
Refer to Methadone taper
Can give 10 mg q4h, max of 40 mg in one day, or 30 mg at once

If after hours or on weekends and dose cannot be confirmed, continue dose provided over first 24 h until dose can be confirmed during business hours

If dose cannot be confirmed, or patient is not in treatment at a federally regulated Methadone clinic, follow Methadone taper protocol prior to discharge.

* Plan to discharge to inpt detox unit: Do NOT use Methadone, use symptomatic regimen only

SYMPTOMATIC REGIMEN
prn meds

HTN/anxiety: Clonidine 0.1 mg po tid
Can hold if using Methadone
Hold if hypotensive

Diarrhea: Loperamide 4mg po with 1st loose stool, then 2mg per loose stool.
Max of 24 mg per day

Pain: Ibuprofen 600 mg or Acetaminophen 650 mg po q4-6h

Abdominal cramping: Dicyclomine 20 mg po q4h

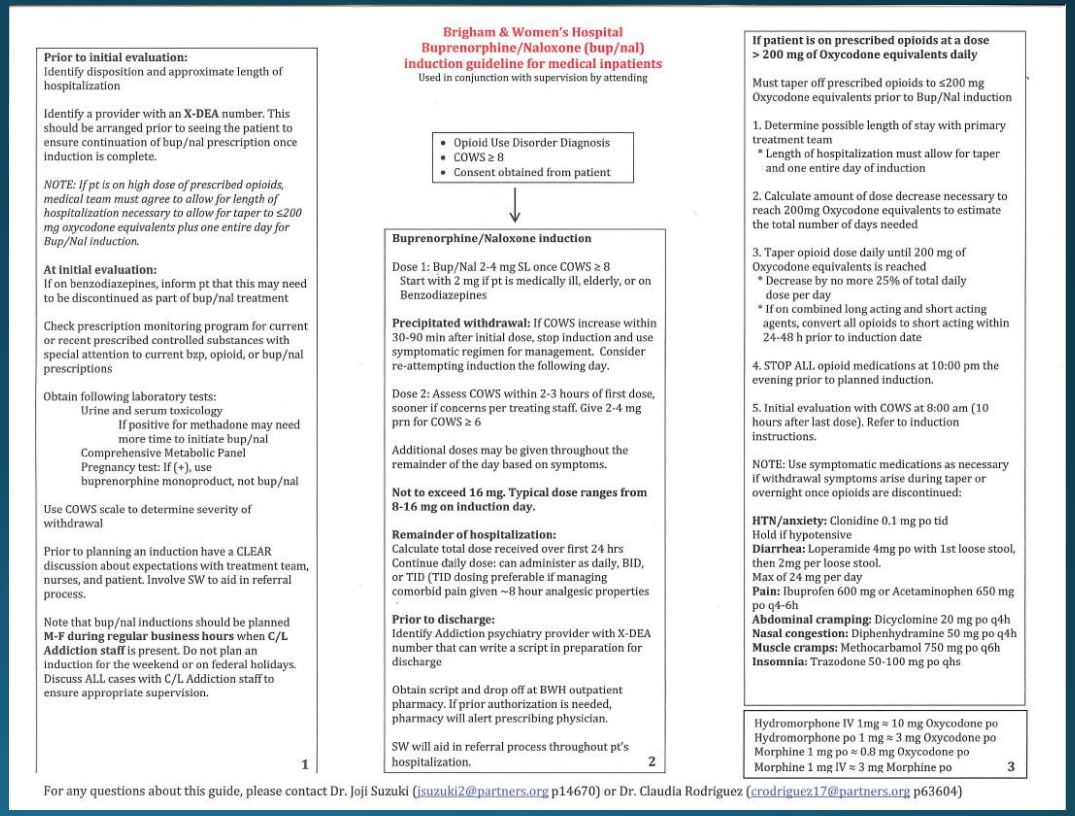
Nasal congestion: Diphenhydramine 50 mg po q4h

Muscle cramps: Methocarbamol 750 mg po q6h

Insomnia: Trazodone 50-100 mg po qhs

** All patients in opioid withdrawal should receive symptomatic regimen regardless of opioid used in detoxification **

ACUTE PAIN: Pain experience may be worse or less responsive to opioid treatment due to tolerance, opioid hyperalgesia, and underlying opioid use disorder. If on Methadone maintenance, continue baseline dose and use prn short acting opiates for pain management. If on Buprenorphine maintenance, consider discontinuation and use prn short acting opiates for pain management.



Brigham & Women's Hospital
Buprenorphine/Naloxone (bup/nal) induction guideline for medical inpatients
Used in conjunction with supervision by attending

Prior to initial evaluation:
Identify disposition and approximate length of hospitalization

Identify a provider with an **X-DEA** number. This should be arranged prior to seeing the patient to ensure continuation of bup/nal prescription once induction is complete.

NOTE: If pt is on high dose of prescribed opioids, medical team must agree to allow for length of hospitalization necessary to allow for taper to ≤200 mg oxycodone equivalents plus one entire day for Bup/Nal induction.

At initial evaluation:
If on benzodiazepines, inform pt that this may need to be discontinued as part of bup/nal treatment

Check prescription monitoring program for current or recent prescribed controlled substances with special attention to current bzp, opioid, or bup/nal prescriptions

Obtain following laboratory tests:
Urine and serum toxicology
If positive for methadone may need more time to initiate bup/nal
Comprehensive Metabolic Panel
Pregnancy test: If (+), use buprenorphine monoproduct, not bup/nal

Use COWS scale to determine severity of withdrawal

Prior to planning an induction have a CLEAR discussion about expectations with treatment team, nurses, and patient. Involve SW to aid in referral process.

Note that bup/nal inductions should be planned **M-F during regular business hours** when **C/L Addiction staff** is present. Do not plan an induction for the weekend or on federal holidays. Discuss ALL cases with C/L Addiction staff to ensure appropriate supervision.

1

- Opioid Use Disorder Diagnosis
- COWS ≥ 8
- Consent obtained from patient

Buprenorphine/Naloxone induction

Dose 1: Bup/Nal 2-4 mg SL once COWS ≥ 8
Start with 2 mg if pt is medically ill, elderly, or on Benzodiazepines

Precipitated withdrawal: If COWS increase within 30-90 min after initial dose, stop induction and use symptomatic regimen for management. Consider re-attempting induction the following day.

Dose 2: Assess COWS within 2-3 hours of first dose, sooner if concerns per treating staff. Give 2-4 mg prn for COWS ≥ 6

Additional doses may be given throughout the remainder of the day based on symptoms.

Not to exceed 16 mg. Typical dose ranges from 8-16 mg on induction day.

Remainder of hospitalization:
Calculate total dose received over first 24 hrs
Continue daily dose: can administer as daily, BID, or TID (TID dosing preferable if managing comorbid pain given ~8 hour analgesic properties

Prior to discharge:
Identify Addiction psychiatry provider with X-DEA number that can write a script in preparation for discharge

Obtain script and drop off at BWH outpatient pharmacy. If prior authorization is needed, pharmacy will alert prescribing physician.

SW will aid in referral process throughout pt's hospitalization.

2

If patient is on prescribed opioids at a dose > 200 mg of Oxycodone equivalents daily

Must taper off prescribed opioids to ≤200 mg Oxycodone equivalents prior to Bup/Nal induction

1. Determine possible length of stay with primary treatment team
   * Length of hospitalization must allow for taper and one entire day of induction

2. Calculate amount of dose decrease necessary to reach 200mg Oxycodone equivalents to estimate the total number of days needed

3. Taper opioid dose daily until 200 mg of Oxycodone equivalents is reached
   * Decrease by no more 25% of total daily dose per day
   * If on combined long acting and short acting agents, convert all opioids to short acting within 24-48 h prior to induction date

4. STOP ALL opioid medications at 10:00 pm the evening prior to planned induction.

5. Initial evaluation with COWS at 8:00 am (10 hours after last dose). Refer to induction instructions.

NOTE: Use symptomatic medications as necessary if withdrawal symptoms arise during taper or overnight once opioids are discontinued:

HTN/anxiety: Clonidine 0.1 mg po tid
Hold if hypotensive
Diarrhea: Loperamide 4mg po with 1st loose stool, then 2mg per loose stool.
Max of 24 mg per day
Pain: Ibuprofen 600 mg or Acetaminophen 650 mg po q4-6h
Abdominal cramping: Dicyclomine 20 mg po q4h
Nasal congestion: Diphenhydramine 50 mg po q4h
Muscle cramps: Methocarbamol 750 mg po q6h
Insomnia: Trazodone 50-100 mg po qhs

Hydromorphone IV 1mg ≈ 10 mg Oxycodone po
Hydromorphone po 1 mg ≈ 3 mg Oxycodone po
Morphine 1 mg po ≈ 0.8 mg Oxycodone po
Morphine 1 mg IV ≈ 3 mg Morphine po

3

For any questions about this guide, please contact Dr. Joji Suzuki (jsuzuki2@partners.org p14670) or Dr. Claudia Rodriguez (crodriguez17@partners.org p63604)

Make Your Service Valuable

- Involvement with hospital committees
  - Ethics
  - Safety Committee
  - P&T
- Identify areas of hospital need/expense
  - Constant Observation
- Standardized guidelines
  - Suicide Assessment
  - Delirium Management
  - Alcohol/Opioid Withdrawal
- Models of Care
  - Integrated Addictions services

Treatment of Opioid Use Disorder in the General Hospital

Margo C. Funk, M.D., M.A., Sara Nash, M.D., Allison Smith, M.D., Kelly Barth, M.D., Joji Suzuki, M.D., James K. Rustad, M.D., Stefania Buonocore, D.O., Abhisek C. Khandai, M.D., M.S., Michael A. Smith, Pharm.D., Shawn Jin, M.D., Karen Drexler, M.D., John A. Renner, Jr., M.D.

In 2022, the APA Joint Reference Committee voted to approve a comprehensive Resource Document jointly sponsored by the APA Councils on Consultation-Liaison Psychiatry and Addiction Psychiatry for psychiatrists involved in the treatment of patients with Opioid Use Disorder (OUD) in the general hospital. The full Resource Document, which includes a comprehensive review of the literature, is available

improved safety profile compared to other opioids, including less euphoria, decreased abuse liability, and a "ceiling effect" on respiratory depression regardless of the ingested amount. The high binding affinity makes it difficult to displace buprenorphine from the MOR and allows buprenorphine to displace other opioid agonists, which can lead to precipitated withdrawal. Unlike buprenorphine, methadone is a full ag-

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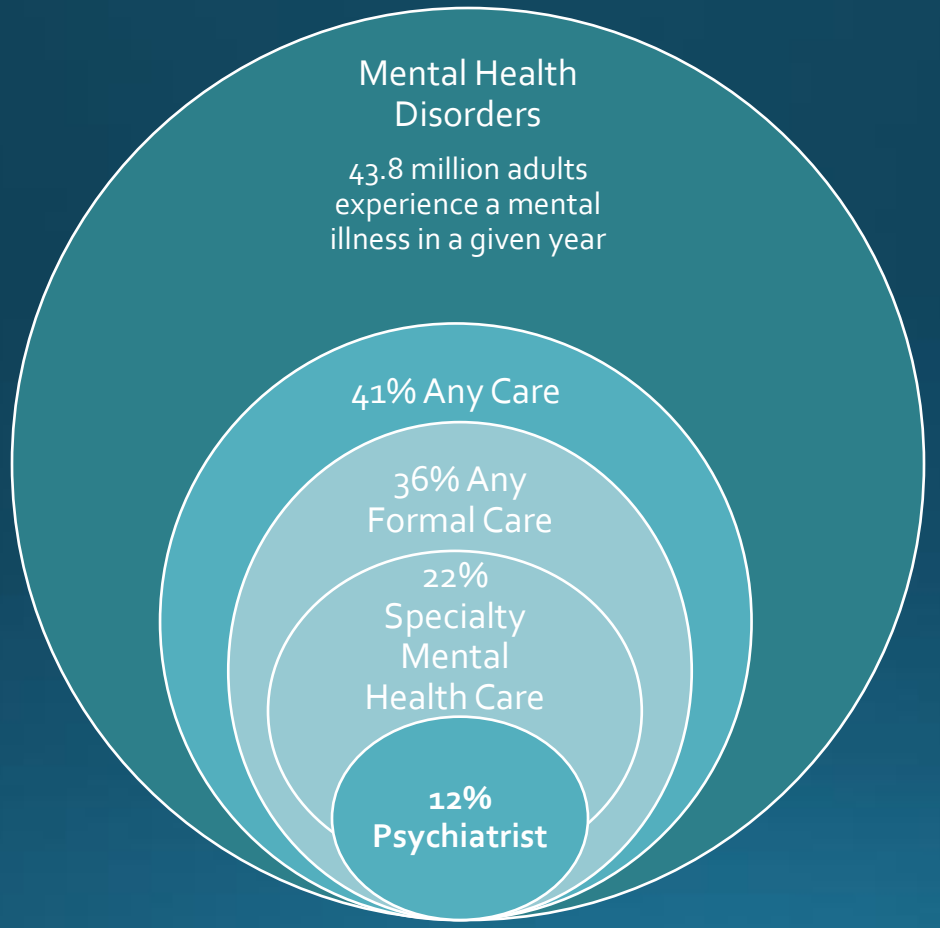
  - Alcohol/Opioid Withdrawal
- Models of Care
  - Integrated Addictions services
  - Collaborative Care – Ambulatory Consultation Model

Treatment for Mental Health Disorders



Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. Arch Gen Psychiatry, 62(6), 629-640.

Any Mental Illness (AMI) Among Adults. (n.d.). Retrieved October 23, 2015, from http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml.

Behavioral Health is a challenge for PCP practices

- Mental illness is commonly treated in primary care:
  - 43–60% of treatment for mental illness occurs in primary care
  - only 17–22% in specialty mental health settings

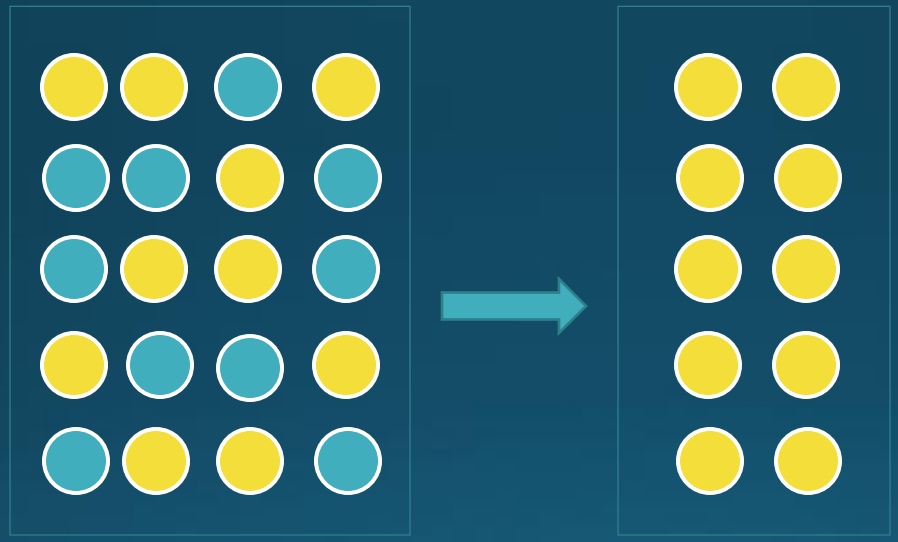
- PCP practices were less likely to have procedures for referrals, communication, and patient scheduling for responding to MH/SU services than for other medical subspecialties
  - (50% compared with 73% for cardiology and 69% for endocrinology).

- Practices reported that **lack of reimbursement, time, separation of MH and health systems, and sufficient knowledge** were obstacles to providing care

NCQA, 2014

Why Not Just Refer?
Patient Factors

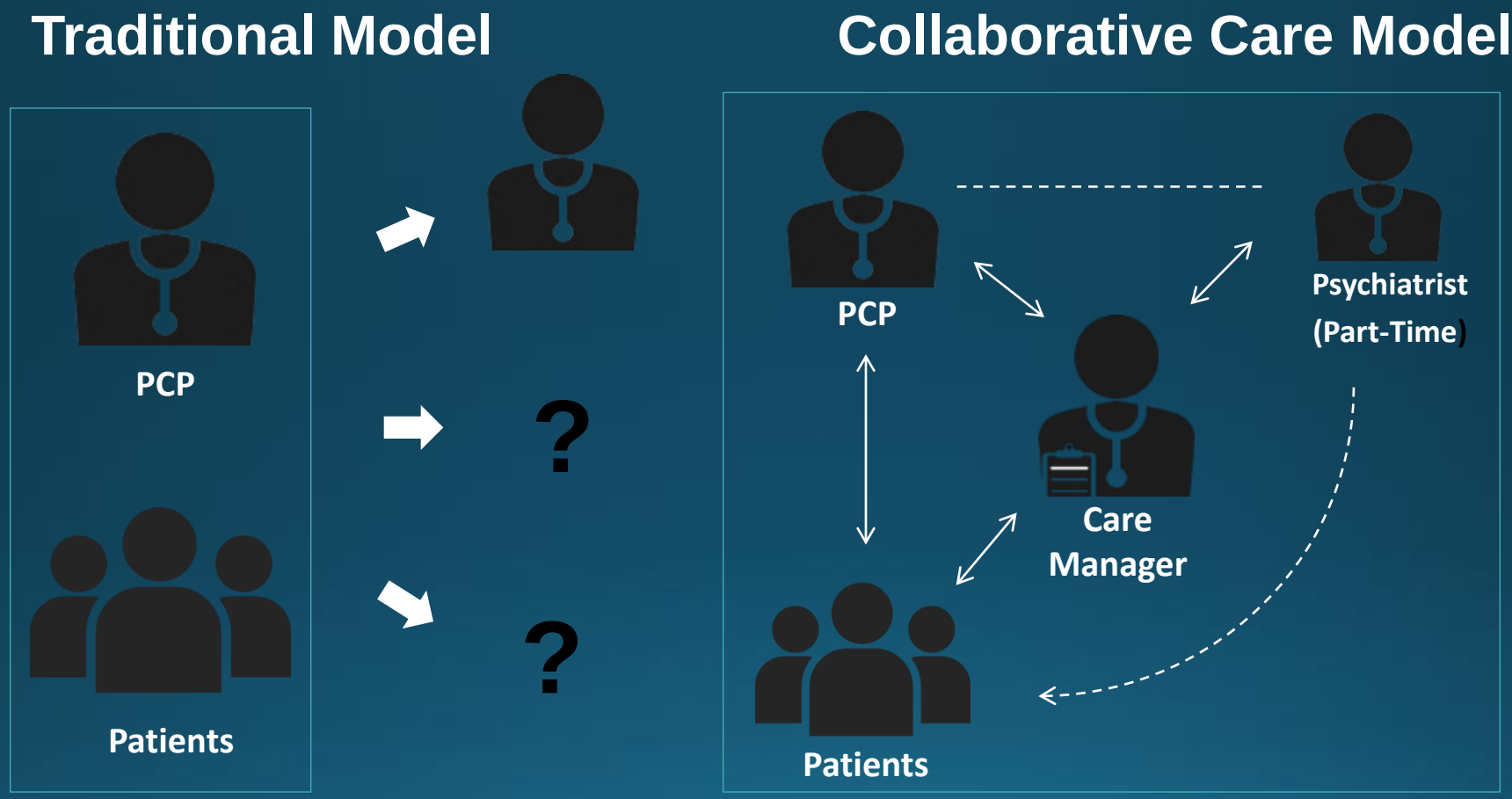
Half of those referred do not follow through.



Mean # of mental health visits = 2

Grembowski, Martin et al., 2002
Simon, Ding et al., 2012

Solution: Collaborative Care is an evidence-based solution that can increase access



Integrated Care offers a solution

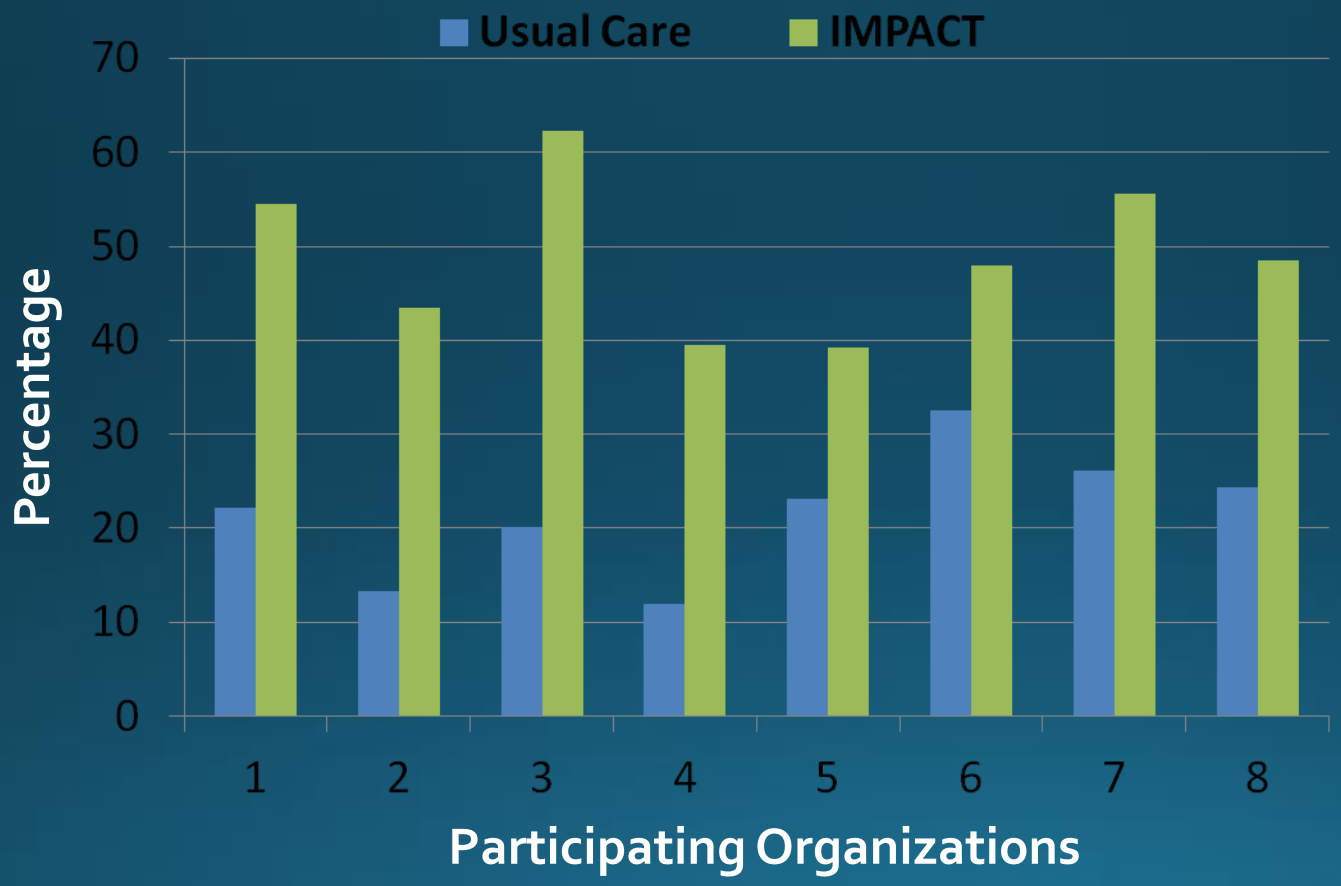
- **Improves access for patients**
  - Nearby primary care clinic
  - More timely appointments
  - Less stigmatizing
  - Lower out-of-pocket costs

- **Increases capacity of mental health providers**
  - Consultation
  - Collaboration
  - Leverages scarce mental health resources

- **2015 Milliman Report : Effective integration has potential to save $50 billion in overall healthcare spending**

Twice as Many People Improve

50 % or greater improvement in depression at 12 months



Unützer et al., 2002, 2004

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- Models of Care
  - Integrated Addictions services
  - Collaborative Care
  - Proactive Psychiatric service

Proactive Psychiatric Consultation

Clinical Trial > Psychosomatics. 2011 Nov-Dec;52(6):513-20. doi: 10.1016/j.psym.2011.06.002.

Proactive psychiatric consultation services reduce length of stay for admissions to an inpatient medical team

Paul H Desan [1], Paula C Zimbrean, Andrea J Weinstein, Janis E Bozzo, William H Sledge

Affiliations + expand

PMID: 22054620 DOI: 10.1016/j.psym.2011.06.002

Abstract

Background: Some studies suggest intensive psychiatric consultation services facilitate medical care and reduce length of stay (LOS) in general hospitals.

Objective: To compare LOS between a consultation-as-usual model and a proactive consultation model involving review of all admissions, rapid consultation, and close follow-up.

Methods: LOS was compared in an ABA design between a 33-day intervention period and 10 similar control periods, 5 before and 5 after the intervention, on an internal medical unit. During the intervention period, a staff psychiatrist met with the medical team each weekday, reviewed all admissions, provided immediate consultation as needed, and followed all cases throughout their hospital stay.

Results

- 50 % med admissions had mental health needs
- 20 % needed psych consultant to facilitate care
- Case review time was brief
- Consult rate 2x control group
- Mean LOS shorter in intervention group
- ROI 4.2

Psychotherapy and Psychosomatics

Regular Article

Psychother Psychosom 2015;84:208–216
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Published online: May 23, 2015

Multidisciplinary P
Consultation Servi
of Stay for Medical

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Biostatistics, Yale School of Public Health, New Haven

General Hospital Psychiatry 71 (2021) 11–19

Contents lists available at ScienceDirect

General Hospital Psychiatry

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Niekerk[a],

Psychosomatics 2019:60:263–270

Original Research Article

Hospital Length of Stay With a Proactive Psychiatric Consultation Model in the Medical Intensive Care Unit: A Prospective Cohort Analysis

Melissa Bui, M.D.[1], Robyn P. Thom, M.D.[1], Shelley Hurwitz, Ph.D., M.A., M.S., Nomi C. Levy-Carrick, M.D., M.Phil., Molly O'Reilly, Dara Wilensky, M.D., Daniel Talmasov, M.D., Bonnie Blanchfield, S.M., Sc.D., Vineeta Vaidya, M.S., Rose Kakoza, M.D., M.P.H., Michael Klompas, M.D., M.P.H., Elizabeth Stanley, M.B.A., R.N, David Gitlin, M.D., Anthony Massaro, M.D.

2022:63:363–371
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rticle

a Proactive
atry Pilot as
Consultation on
Demand for Hospital Medicine

Brian D. Bronson, M.D., Abdulkader Alam, M.D., Teresa Calabrese, M.S., Frances Knapp, B.S.B.A., C.P.A., Joseph E. Schwartz, Ph.D.

ELSEVIER journa

Research paper

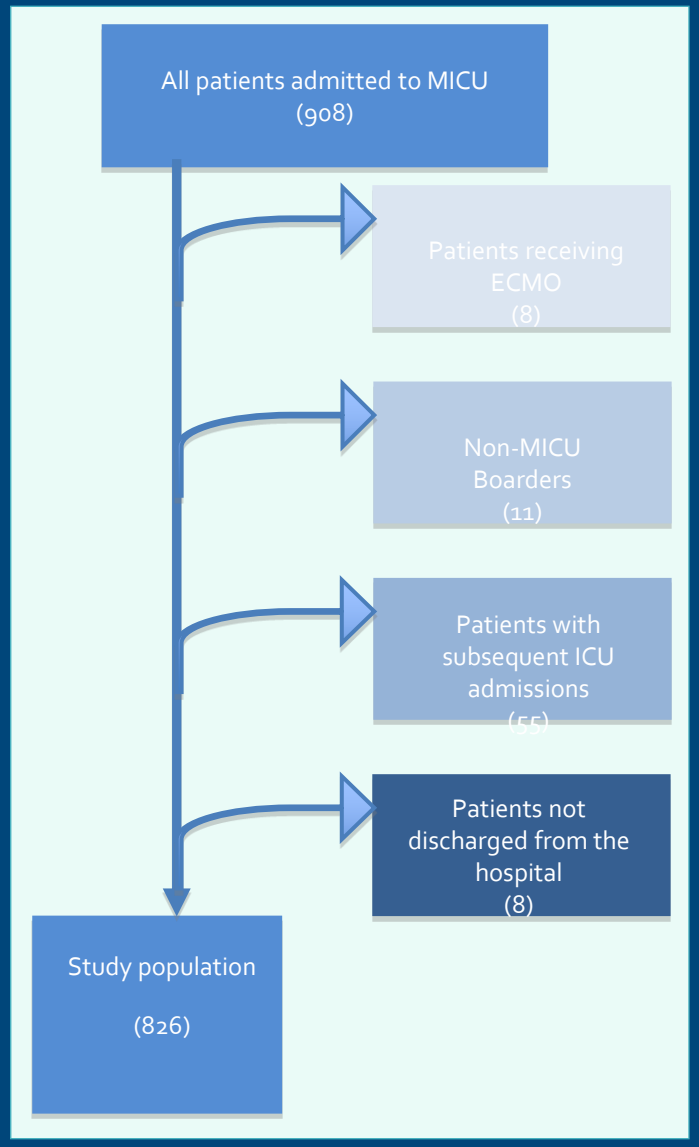
An evaluation of proactive psychiatric consults on general medical units

Patrick Triplett*, C. Patrick Carroll, Ted Avi Gerstenblith, O. Joseph Bienvenu

Johns Hopkins University School of Medicine, United States of America

Proactive Critical Care Psychiatry – Brigham and Women's Hospital

Medical ICU 3B (Intervention)



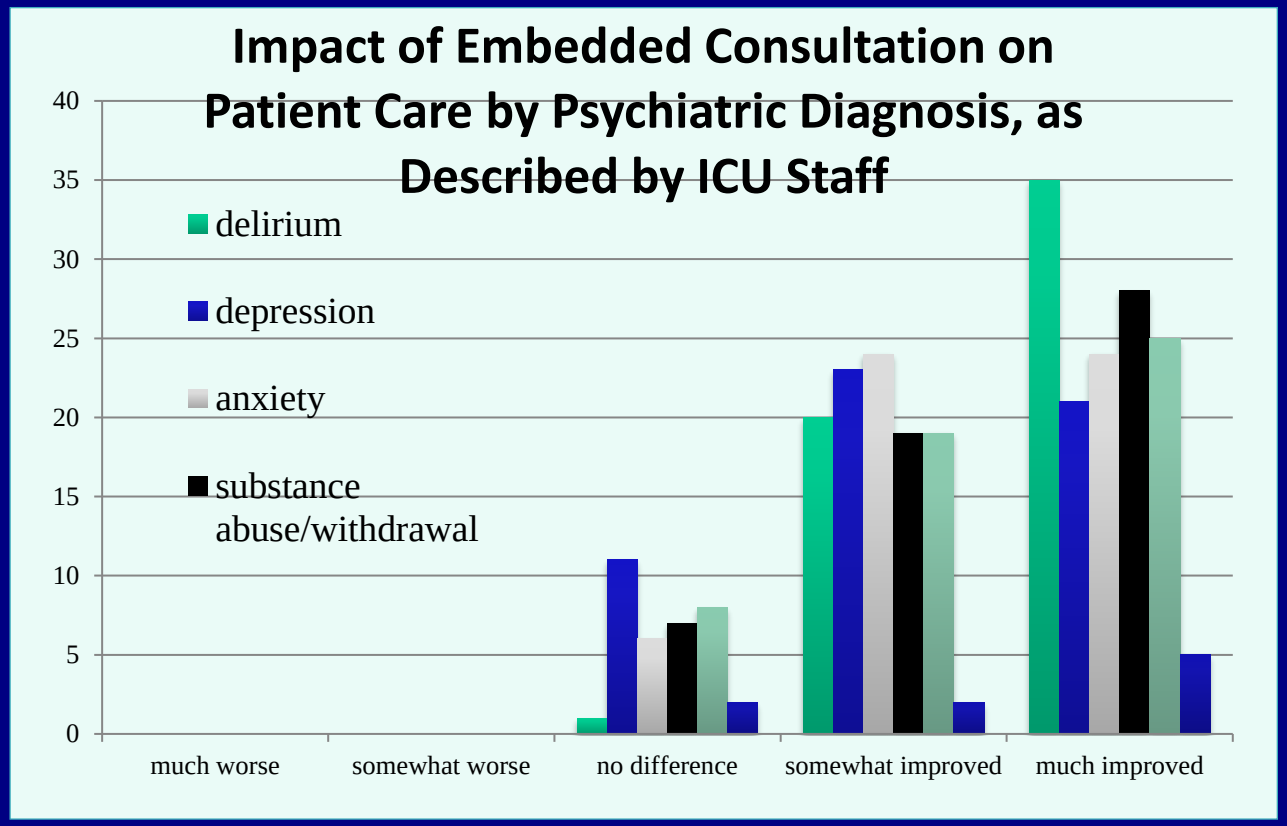
Medical ICU 3C (Control)

Proactive Critical Care Psychiatry – Pilot at Brigham and Women's Hospital

TABLE 4a. Respiratory Failure Subgroup Analysis of Length of Stay ($n = 426$)

	Intervention MICU		Control MICU			
	Mean ± SD	Median (IQR)	Mean ± SD	Median (IQR)	*p* value	Adjusted* *p* value
Hospital LOS (mean days)	13.37 ± 12.55	9.46 (4.95–17.56)	17.70 ± 18.45	12.29 (6.58–21.10)	0.007	0.011
MICU LOS (mean days)	4.99 ± 6.31	2.95 (1.52–5.88)	5.87 ± 7.02	3.22 (1.56–7.74)	0.244	0.447

* Adjusted for age and APACHE II score.



ROI 29.4

Cost savings ~ $2-4 mil over 8 months


THE WALL STREET JOURNAL.

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THE MIDDLE SEAT The Best and Worst Frequent-Flier ...

STYLE & FASHION Summer's New Very Wearable Tanks & Bikinis

Trousers That Solve All Your Problems

A Heyday for New Fashion

LIFE | HEALTH | HEALTH & WELLNESS

Hospitals Test Putting Psychiatrists on Medical Wards

To identify problems early, trials embed mental-health workers on teams of doctors seeing patients

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