Ensuring Medication for Opioid Use Disorder (MOUD) Treatment through the Care Continuum Webinar Series

Management of Patients on MOUD During the Nursing Home Stay - Part 1

Friday, February 9, 2024

In partnership with all Quality Innovation Network-Quality Improvement Organizations

QIN-QIO Partnership to Address the Opioid Epidemic

This series is a collaboration of all Quality Innovation Networks–Quality Improvement Organizations (QIN-QIOs). National experts across the healthcare continuum provide robust educational content to address the opioid epidemic.

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Learning Objectives

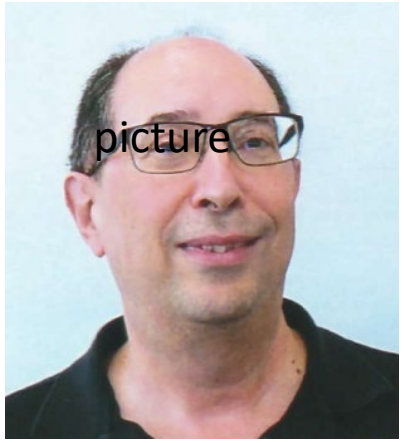
- Describe how to include OUD screening in your admission assessment.
- Review the steps to ensure continuity and/or provide access to treatment for patients with OUD.
- Discuss how to recognize and manage a patient who is overdosing .

Guest Speakers

Jean Storm, DO, CMD, CHCQM

Medical Director

Quality Insights



Rob Accetta, RPh, BCGP, FASCP

Senior Pharmacist

IPRO

Case

A 68-year-old female was admitted to the facility after a hospital stay for cholecystitis. She has a history of chronic pain and has been taking oxycodone 10 mg PO every 8 hours as needed at home for several years.

She arrives to the facility with orders for oxycodone 5mg PO every 8 hours as needed and immediately asks for an increase in her dose. The physician denies the request for dose escalation.

PO= by mouth, orally

Case (Cont.)

One week later, the resident is found unresponsive, apneic, and hypoxic. 911 is called, naloxone is administered, and the resident's condition improves.

After the resident is taken to the emergency department, a nurse finds a foil packet in the resident's bed containing several pill fragments and a powder which appears to be crushed pills.

OUD Definition

"An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders. The behavioral effects of these brain changes may be exhibited in the repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli. These persistent drug effects may benefit from long-term approaches to treatment."

American Psychiatric Association
Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition)
Arlington, VA, American Psychiatric Association, 2013

OUD Among Hospitalized Older Adults

- Of 7,243,208 older Medicare beneficiaries who had an acute inpatient hospitalization in 2016:
  - 75,157 beneficiaries had a diagnosis of OUD listed.
  - Beneficiaries with an OUD-related hospitalization were over twice as likely to have a liver disease diagnosis, had longer hospital lengths of stay, and were more likely to be readmitted to the hospital within 30 days.
  - 26.4% of beneficiaries with OUD were discharged to a skilled nursing facility (SNF) for post-acute care.

Zullo AR, Moyo P, Jutkowitz E, Zhang W, Thomas KS. Opioid Use Disorder Among Hospitalized Older Adults: Prevalence, Characteristics, and Discharge Status. J Am Med Dir Assoc. 2020 Apr;21(4):557-559. doi: 10.1016/j.jamda.2020.01.011. Epub 2020 Feb 18. PMID: 32081682; PMCID: PMC7127932. https://pubmed.ncbi.nlm.nih.gov/32081682/

Screening for OUD Risk

https://www.qualityinsights.org/qin/resources#opioid-risk-assessment-tool-fillable

Opioid Risk Assessment Tool

Resident Name: _____ **Admit Date:** _____

This tool should be administered to patients upon admission and readmission. Score each box as appropriate, or enter "0" if not applicable.

Family History of Substance Abuse	Female	Male	Score
Alcohol	1	3	
Illegal Drugs	2	3	
Prescription Medication	4	4	

Personal History of Substance Abuse	Female	Male	Score
Alcohol	3	3	
Illegal Drugs	4	4	
Prescription Medication	5	5	

Psychological Disease	Female	Male	Score
Attention deficit disorder (ADD), obsessive-compulsive disorder (OCD), bipolar, schizophrenia	2	2	
Depression	1	1	

Other Factors	Female	Male	Score
Currently age 16-45	1	1	
History of preadolescent sexual abuse	3	0	

Total Score	

Current Opioid Orders per Plan of Care:

Total Score Key
≤ 3 = **Low risk** for opioid abuse
4 – 7 = **Moderate risk** for opioid abuse
≥ 8 = **High risk** for opioid abuse

Nurse Completing Risk Assessment: _____ **Date:** _____

Physician Review: _____ **Date:** _____

****Any changes to current plan of care to be addressed in New Orders****

SOURCE: Webster, L.R., & Webster, R. M. (2005). Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool. Pain medicine (Malden, Mass.), 6(6), 432–442. https://doi.org/10.1111/j.1526-4637.2005.00072.x. PMID: 16336480.

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Publication number 12SOW-QI-GEN-110623-CC

Guidance

- **Low risk of opioid abuse:** If opioids are prescribed, utilize standard screening.
- **Moderate risk of opioid abuse:** Consider alternatives to opioids, if opioids are prescribed avoid dose escalation. Monitor behaviors closely along with standard screening.
- **High risk of opioid abuse:** Avoid prescribing opioids. If opioids are prescribed, limit order to a few days and monitor behaviors closely.

Screening for OUD

- **Drug Abuse Screening Test DAST-28 or DAST-10:** Gives "zone" of use and "indicated" action.
- **The Tobacco, Alcohol, Prescription medications, and other Substance Tool TAPS:** Has two components. The first component (TAPS-1) is a 4-item screen for tobacco, alcohol, illicit drugs, and non-medical use of prescription drugs. If an individual screens positive on TAPS-1 (i.e., reports other than "never"), the tool will automatically begin the second component (TAPS-2), which consists of brief substance-specific assessment questions (TAPS-2) to arrive at a risk level for that substance.

DAST-28 - https://integrationacademy.ahrq.gov/sites/default/files/2020-07/DAST.pdf
DAST-10 -https://oasas.ny.gov/system/files/documents/2019/11/drugabusescreeningtest-10_4-24-18.pdf
TAPS - https://nida.nih.gov/taps2/#/

Screening Tools Resources

NIDAMED

Screening and Assessment Tools Chart

Screening tools

Tool	Substance type		Patient age		How tool is administered	
	Alcohol	Drugs	Adults	Adolescents	Self-administered	Clinician-administered
Screening to Brief Intervention (S2BI)	X	X		X	X	X
Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)	X	X		X	X	X
Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)	X	X	X		X	X
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)	X			X		X
Opioid Risk Tool – OUD (ORT-OUD) Chart		X	X		X	

https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

Opioid Use Disorder Treatment Options

Like other chronic diseases, medications are central to the treatment of OUDs. People with OUD benefit from treatment with medication for varying lengths of time, including lifelong treatment. The U.S. Food and Drug Administration (FDA) has approved three types of medication for the treatment of OUD:

- Naltrexone (Vivitrol®)
- Buprenorphine (Subutex®), buprenorphine/naloxone (Suboxone®), buprenorphine extended-release (Subclocade®)
- Methadone

Buprenorphine Initiation

- It is important to understand that individuals have to stop opioids prior to initiating buprenorphine, so they will experience some degree of withdrawal symptoms.
- It may take several dose adjustments to find the appropriate dose for each individual.
- Once an individual is on maintenance buprenorphine, everything should be done to continue this treatment to facilitate successful recovery.

Transitions

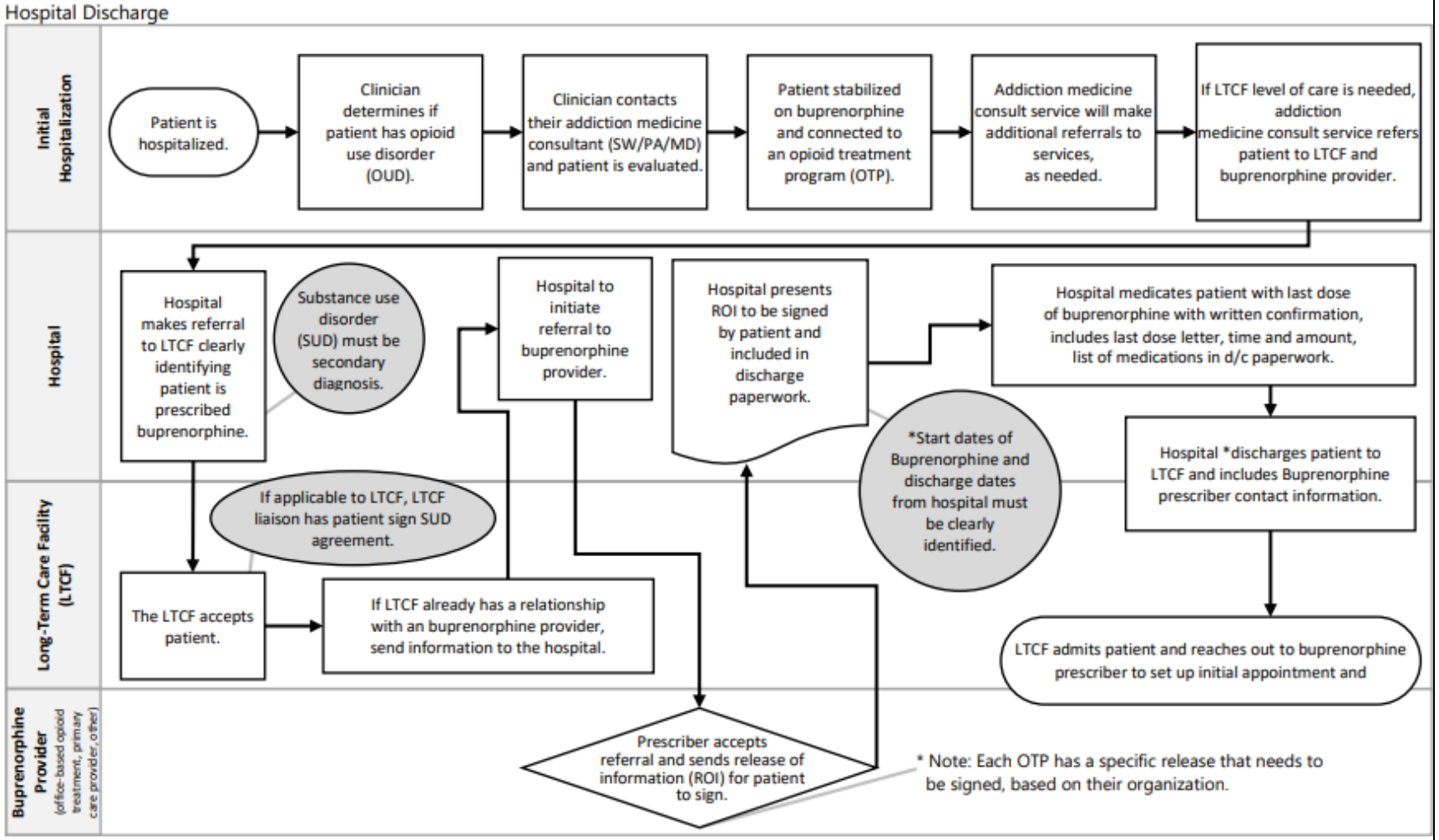
- Communication is essential at all steps.
- A buprenorphine prescriber must be identified prior to discharge from the hospital to the long-term care facility.
- All agreements required by prescriber should be completed prior to discharge from the hospital.
- Start dates should be clearly identified.

The Care of Residents with Opioid and Stimulant Use Disorders in Long-Term Care Settings

Massachusetts Department of Public Health
Bureau of Health Care Safety & Quality
www.mass.gov/dph/bhcsq

Appendix 6: Flow Diagram of Resident on Buprenorphine who is Discharged from the Hospital to a Long-Term Care Facility

Patient is ready for discharge from hospital inpatient stay to long-term care facility (LTCF) (*Only for patients newly inducted or prescribed buprenorphine*)



* Hospital needs to determine appropriateness of buprenorphine and should not be started until there is a plan in place and bridge clinic/prescriber has clearly been identified

https://www.mass.gov/orgs/bureau-of-health-care-safety-and-quality

Staff OUD Education

Older adults with OUD is a knowledge gap for staff in SNFs. An evidence-based curriculum was provided by a geriatrician and all available staff were invited to attend at a pilot facility.

- Topics included:
  - Defining addiction as a medical disease.
  - Describing specific medications for OUD.
  - Incorporating non-stigmatizing language.
  - Recognizing overdose signs/symptoms.

Lau-Ng, R., Kang, S., & Day, H. (2022). Implementation of an Educational Curriculum on Care of Older Adults with Opioid Use Disorder in Long-Term Care. In Journal of the American Medical Directors Association (Vol. 23, Issue 3, pp. B8–B9). Elsevier BV. https://doi.org/10.1016/j.jamda.2022.01.047

Education Opportunities

- Staff orientation training for opioid use disorder toolkit
- About Addiction Science
- Substance use disorder (SUD) for the Healthcare Team
- Medication-Assisted Treatment Improves Outcomes for Patients with OUD

Staff orientation training for opioid use disorder toolkit - https://integrationacademy.ahrq.gov/products/playbooks/opioid-use-disorder/obtain-training-and-support-providers-and-staff/clinicwide-orientation-oud-treatment
About Addiction Science - https://nida.nih.gov/research-topics/addiction-science
SUD for the Healthcare Team - https://pcssnow.org/education-training/sud-for-the-healthcare-team/
Medication-Assisted Treatment Improves Outcomes for Patients with OUD- ts.org/~/media/assets/2016/11/medicationassistedtreatment_v3.pdf

Creating a Culture Without Stigma

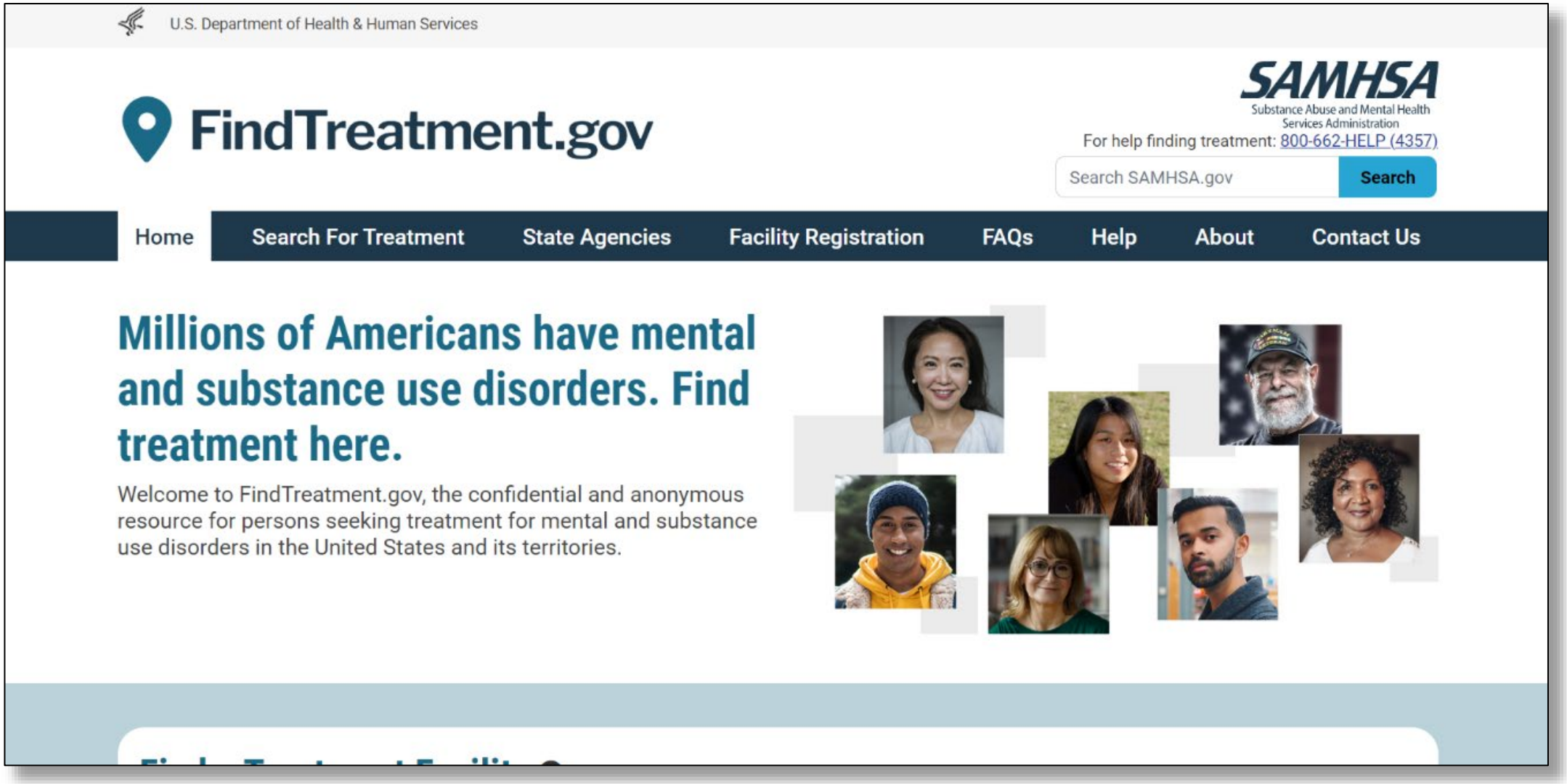
1. Incorporate harm-reduction principles throughout your facility and within your existing policies (National Harm Reduction Coalition).
2. Incorporate a section on OUD into your internal discrimination policy to reduce stigma and foster a positive culture that strives to ensure that staff see addiction as a medical condition.
3. Develop an assessment of staff perceptions of OUD and MOUD.
4. Post anti-stigma posters for staff, residents, and family to view (Words Matter Campaign).

https://www.mass.gov/info-details/the-care-of-residents-with-opioid-stimulant-use-disorders-in-long-term-care-settings-toolkit

Resident Perspectives on SUDs and OUDs in the Nursing Home

- Residents with SUD/OUD admitted into nursing homes generally view their stay as a positive influence on their use disorder.
- Residents' positive experiences may stem from: stable housing, being in an environment removed from daily stressors, and being in an environment where substances are less accessible.
- Areas identified for further improvement include increased access to more counseling services for SUD management.

Yang, Meredith, Kimberly Beiting, and Stacie Levine. "Patient Perspectives on Substance Use Disorders (SUD) and Opioid Use Disorders (OUD) in the Nursing Home." *Journal of the American Medical Directors Association* 23.3 (2022): B19.



https://findtreatment.gov/state-agencies

Case

A 58-year-old with a diagnosis of OUD successfully being treated with buprenorphine/naloxone sublingual film 16mg/4mg per day is admitted to the hospital following a fall with hip fracture. Surgical repair is done, and hydromorphone is added for acute pain control post-operatively and is eventually weaned off.

Recommendations are made for rehab prior to discharge home and accepting physician at skilled nursing facility agrees to prescribe buprenorphine/naloxone for the resident. Nursing facility faxes OUD agreement to hospital for resident to sign and it is returned to facility. Hospital creates flowsheet for buprenorphine/naloxone information (start date, last dose, etc.) and faxes to nursing facility on discharge.

Case (Cont.)

Resident arrives at skilled nursing facility and attending physician arrives to assess resident and write prescription for buprenorphine/naloxone at maintenance dose. Attending physician also writes order for consultation with psychologist for ongoing counseling and support for resident. Pharmacy delivers 2-week supply of buprenorphine/naloxone and the resident continues on therapy during rehab.

The resident discharges home in 2 weeks and is discharged with a prescription for buprenorphine/naloxone with enough supply to last until the resident's appointment with the regular prescriber in 4 days.

Rob Accetta, RPh, BCGP, FASCP

Senior Pharmacist

IPRO

Crisis Affects Patients and Providers

- Nearly 117,000 people experienced a non-fatal opioid overdose requiring an emergency department or hospitalization in 2022, per the Centers for Disease Control and Prevention.
- Beneficiaries requiring a hospital admission diagnosed with an opioid overdose or OUD, or experiencing opioid overdose, once stabilized, need placement options for post-acute or extended care services.
- Patients who have OUD and need the level of care provided by SNF/PALTC facilities face challenges to entry.

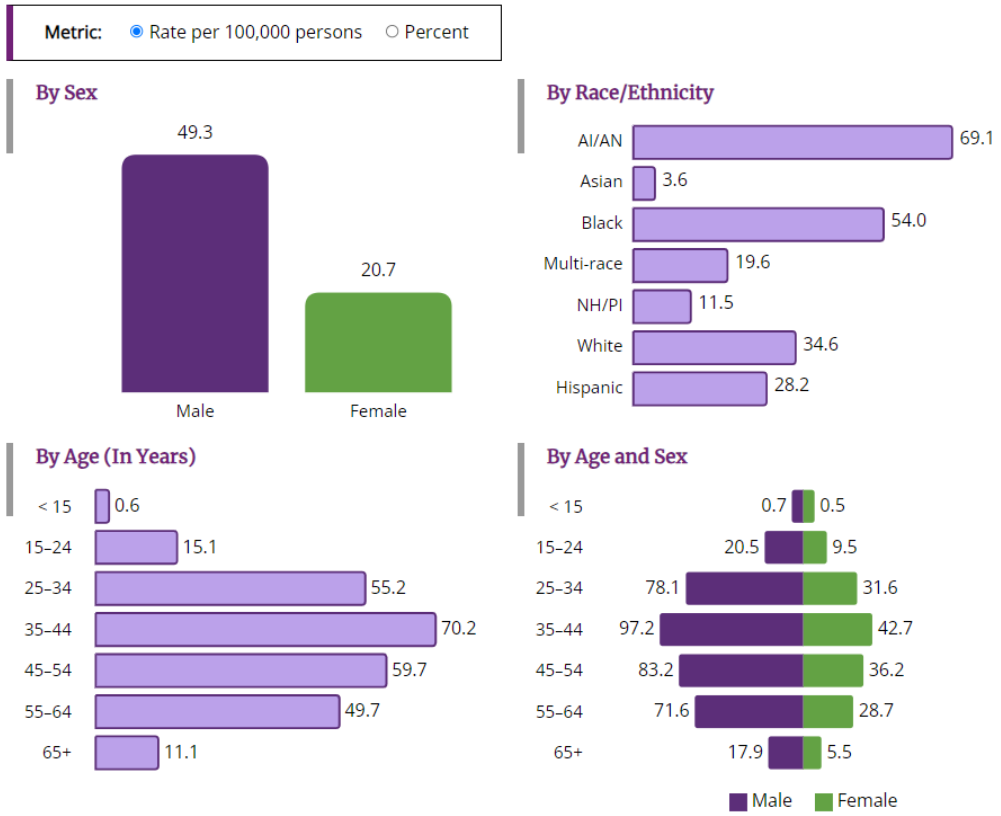
Abbreviations: OUD: Opioid Use Disorder; SNF: Skilled Nursing Facility; PALTC: Post-Acute Long-Term Care

Concerns to be Addressed

- Facilities and clinicians are unfamiliar with providing medications (buprenorphine) or counseling therapy for OUD.
- Facilities have not created relationships with Opioid Treatment Programs (OTPs) which provide methadone for OUD.
- Stigma associated with OUD.
- Access to opioids via external sources.
- Unfamiliarity with emergency protocols to treat suspected opioid overdoses by residents or visitors at facilities.

Data About Overdose Deaths

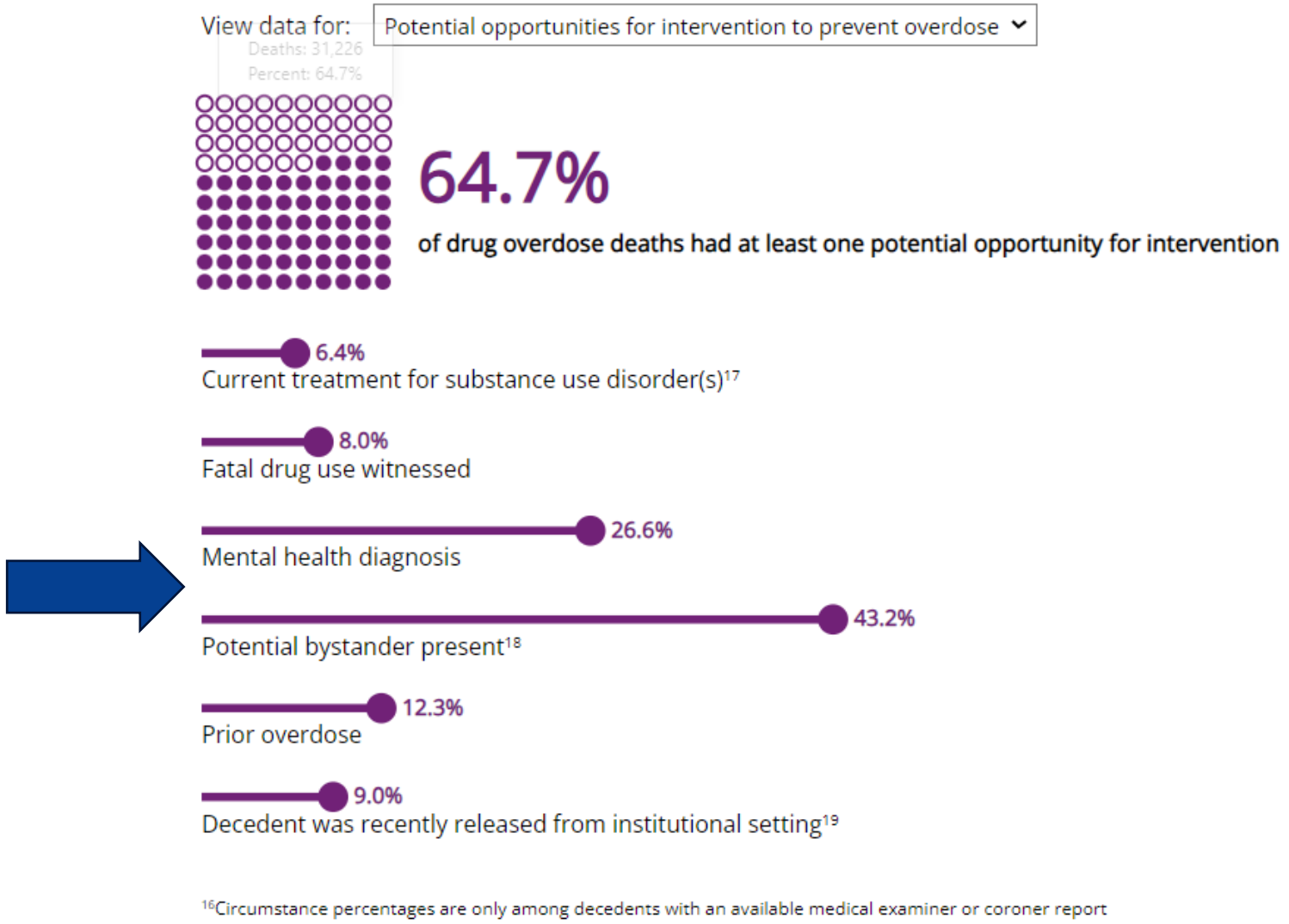
CDC's State Unintentional Drug Overdose Reporting System (SUDORS)



- 70.5% of people who died of a drug overdose were male.
- 26.6% were 35–44 years old.
- 66.2% were White, non-Hispanic.
- The largest percentage of males were aged 35–44.
- The largest percentage of females were aged 35–44.
- American Indian/Alaska Native, non-Hispanic race had the highest overdose death rates.

CDC SUDORS Dashboard - https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html

Potential Interventions

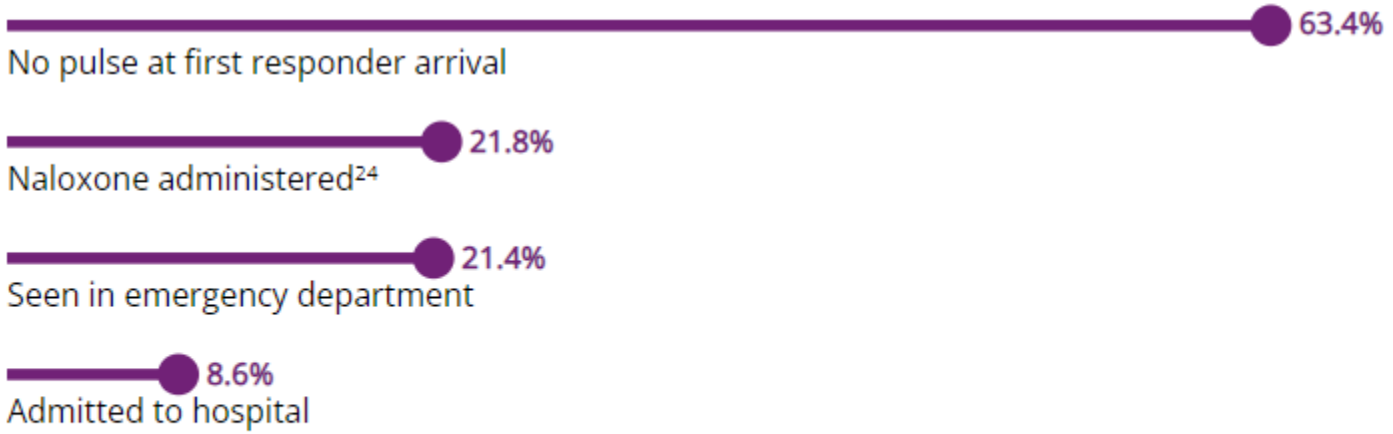


CDC SUDORS Dashboard - https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html

Overdose Response

View data for: Overdose response

These circumstances underscore the need to enhance harm reduction efforts to ensure timely response to overdoses. For example, deaths in which naloxone was administered suggest that naloxone might not have been administered fast enough or at sufficient dosage, or its effectiveness was affected by polydrug use. Presence of a pulse at first responder arrival can affect a person's chances of survival.



[16]Circumstance percentages are only among decedents with an available medical examiner or coroner report

CDC SUDORS Dashboard - https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html

Screening at Admissions

Opioid Use Disorder: Diagnostic Criteria

- ☐ Taking opioids in larger amounts or over a longer period of time than intended
- ☐ Having a persistent desire or unsuccessful attempts to reduce or control opioid use
- ☐ Spending excess time obtaining, using, or recovering from opioids
- ☐ Craving opioids
- ☐ Continued opioid use causing inability to fulfill work, home, or school responsibilities
- ☐ Continuing opioid use despite having persistent social or interpersonal problems
- ☐ Lack of involvement in social, occupational, or recreational activities
- ☐ Using opioids in physically hazardous situations
- ☐ Continuing opioid use in spite of awareness of persistent physical or psychological problems
- ☐ Exhibiting tolerance symptoms, as defined by either of the following:*
  - a. ☐ A need for markedly increased amounts of opioids to achieve intoxication or desired effect, or
  - b. ☐ Markedly diminished effect with continued use of the same amount of an opioid.
- ☐ Exhibiting withdrawal symptoms, as manifested by either of the following:*
  - a. ☐ The characteristic opioid withdrawal syndrome, or
  - b. ☐ Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

Tolerance and withdrawal are not considered to be met for those taking opioids solely under appropriate medical supervision

OUD is manifested by at least 2 out of 11 defined criteria occurring within a year. Severity of OUD is determined based on the number of criteria met.

Severity

Mild: 2-3 criteria
Moderate: 4-5 criteria
Severe: greater than or equal 6 criteria

https://www.cdc.gov/opioids/healthcare-professionals/prescribing/opioid-use-disorder.html

Addressing Overdoses at Facilities

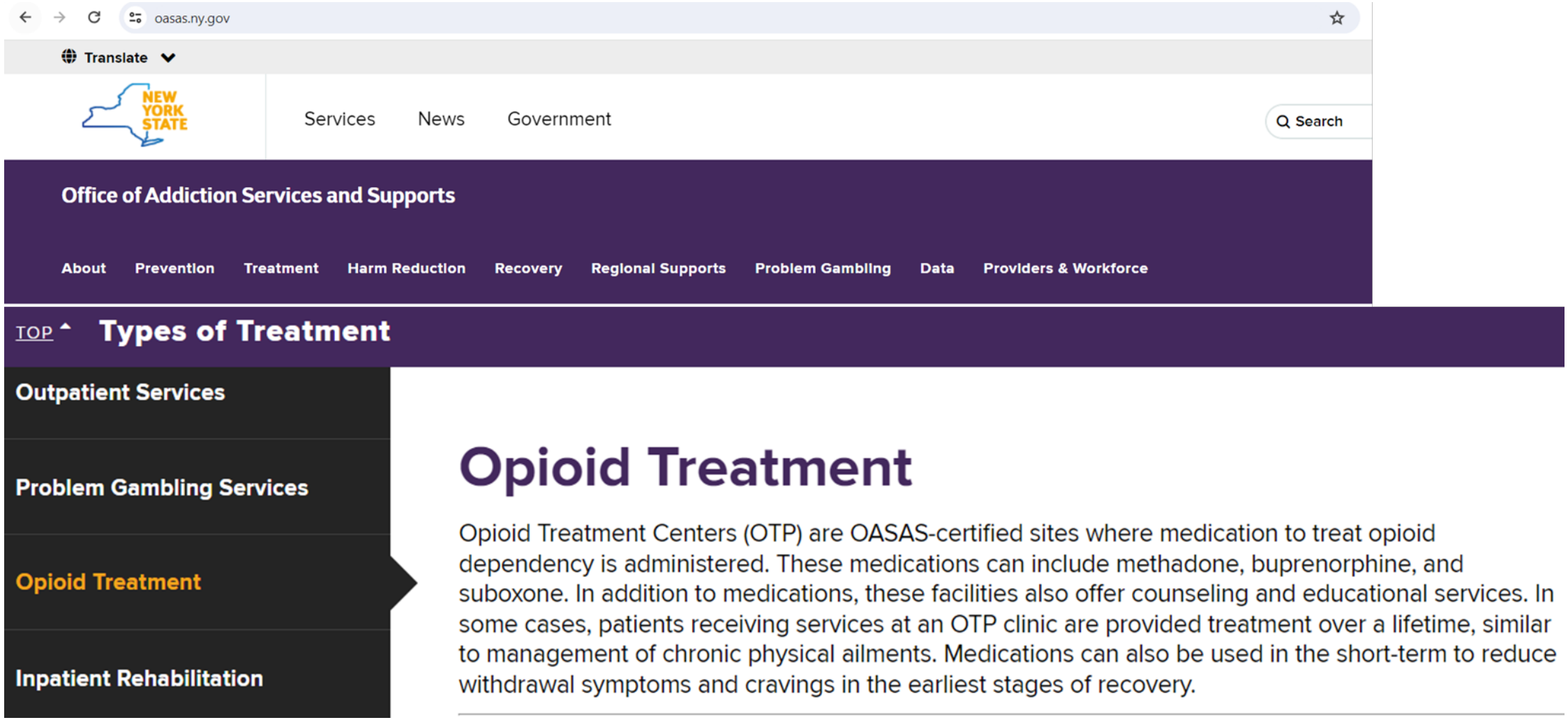
IPRO QIN-QIO Region:

- 29% of nursing homes occasionally, rarely, or never use opioid risk mitigation strategies, including naloxone.
- Nearly 20% of nursing homes did not have naloxone in their emergency medication kits.
- 40% of nursing homes desired education on naloxone.
- Nursing home residents were at increased risk for opioid overdose deaths by both prescription drugs and non-prescribed substances.

Mitigation plans included addressing the following issues:

- Emergency medications kits or Automated Dispensing System laws vary by state.
- Unavailability of naloxone.
- Confusion over multiple naloxone products.
- Lack of policies or protocols.

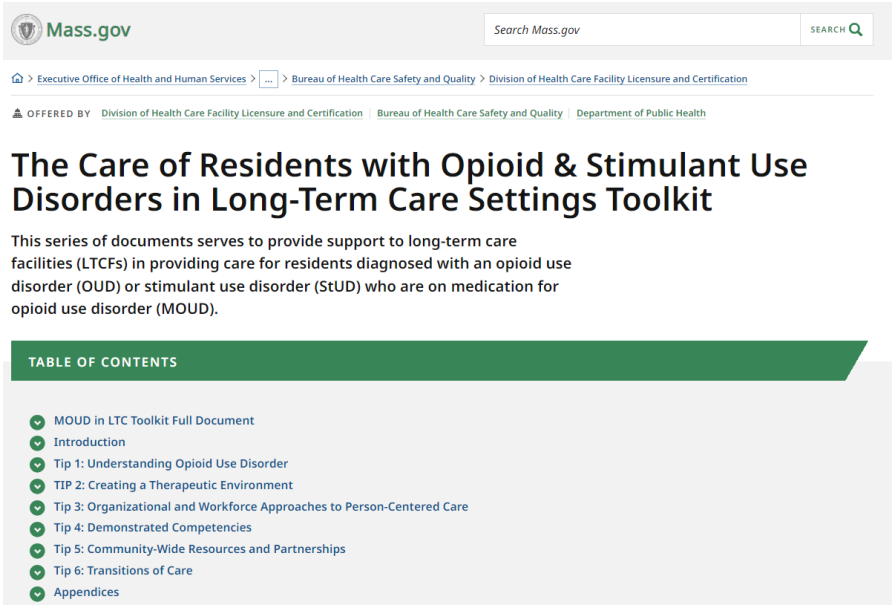
Resources Provided by State Partners



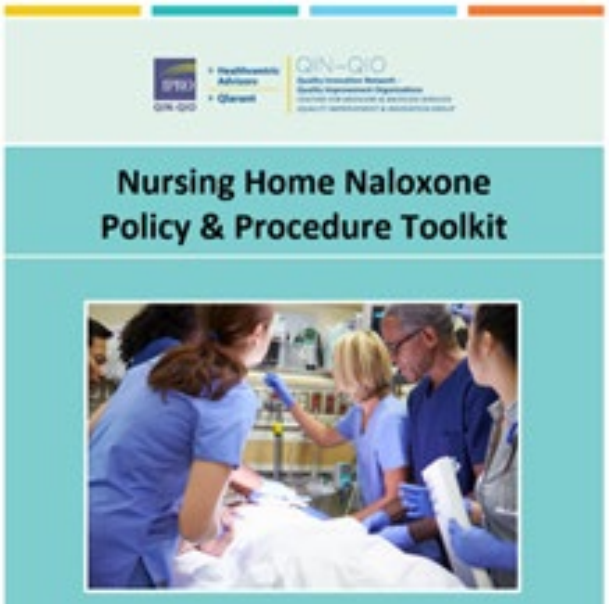
https://oasas.ny.gov/

Best Practice Resources

Resources for providing care for nursing home residents: MOUD and for naloxone advocacy.



https://www.mass.gov/info-details/the-care-of-residents-with-opioid-stimulant-use-disorders-in-long-term-care-settings-toolkit



https://qi-library.ipro.org/2023/01/31/nursing-home-naloxone-policy-and-procedure-toolkit/

Nursing Homes Can Become Proactive

- Knowing about the resources that exist in your community.
- Supporting persons with substance use/substance use disorder with behavioral health strategies and interventions.
- Managing medications including obtaining, storing, administering, and disposition.
  - How methadone is provided to a facility for a resident with OUD.
  - How methadone and buprenorphine are stored in a facility.
- Locating local Opioid Treatment Programs (OTPs).
- Securing delivery services to facilities for methadone supply.
- Opportunities to adopt telemedicine for assessments.

Additional Considerations

- Educating staff about opioid use disorder (SOM, Appendix PP)
- Addressing the stigma associated with an OUD diagnosis.
- Accessing information about medications for OUD.
- Informing about legal and regulatory requirements for admitting persons with SUDs/OUD.
- Providing support or guidance for SNF/LTCFs to care for persons with OUD.
- Removing of barriers to prescribing (X-waiver).
- Planning for addressing illicit substances found in a facility.
- How to respond to an overdose in a facility.

SOM = CMS State Operations Manual

Caring for New or Current Patients

- Care coordination and warm handoff with OUD providers for patients who need continuation of MOUD.
- Role of the admissions coordinator prior to accepting a patient to the facility.
- Transitioning from hospital to the facility and the provision of behavioral health services.
- Prioritizing access to medication when patients are being considered for admission.
- Ensuring access to other services at the facility if the patients have to pick up methadone.
- Nursing administration and medication storage information.

Treating Pain, Harm Reduction

- Screening for patients who may be in need of MOUD.
- Differences between treating chronic pain and MOUD.
- Signs and symptoms of an overdose.
- How to manage active drug or alcohol use in a facility.
- Use of alcohol at social events and interactions with other medications.

Recognizing Signs of an Overdose

- Opioid use can lead to death due to the effects of opioids on the part of the brain which regulates breathing.
- An opioid overdose can be identified by a combination of three signs and symptoms:
  - Pinpoint pupils
  - Unconsciousness
  - Difficulties with breathing

World Health Organization Opioid-Overdose Fact Sheet - https://www.who.int/news-room/fact-sheets/detail/opioid-overdose

Factors Associated with Increased Risks

- Having an opioid use disorder.
- Taking opioids by injection.
- Resumption of opioid use after an extended period of abstinence (e.g., following detoxification, release from justice involvement, cessation of treatment).
- Using prescription opioids (personal supply) without medical supervision.

World Health Organization Opioid-Overdose Fact Sheet - https://www.who.int/news-room/fact-sheets/detail/opioid-overdose

Factors Associated with Increased Risks (Cont.)

- High prescribed dosage of opioids (more than 100 mg of morphine or equivalent daily).
- Using opioids in combination with alcohol and/or other substances or medicines that suppress respiratory function such as benzodiazepines, barbiturates, anesthetics, or some pain medications.
- Having concurrent medical conditions such as HIV, liver or lung diseases, or mental health conditions.

World Health Organization Opioid-Overdose Fact Sheet - https://www.who.int/news-room/fact-sheets/detail/opioid-overdose

Naloxone Policy and Procedure

Policy

- Upon a physician's medication order per resident or facility standing order, naloxone may be administered by a licensed nurse or authorized staff to residents/patients/staff/visitors as indicated for the complete or partial reversal of suspected opioid-induced respiratory depression.
- Identifying suspected opioid-induced respiratory depression:
  - Person with recent inpatient hospitalization for suspected opioid overdose.
  - Person with diagnosis of OUD.
  - Person with history of opioid use or dependence, or diagnosed SUD.
  - Person with current prescribed opioid orders.
  - Person with current prescribed opioid and benzodiazepine orders.
  - Past opioid use and justice involved resident.
  - Person with co-morbid diseases that may adversely affect respiratory status.
  - Current or recent registrant of a methadone maintenance program, or a detox program.
  - Visitor: Friends and family members of the above who may visit the resident and provide illicit or prescription opioids.
  - Resident who frequently attempts to elope or leave the facility premises.

Excerpts from Naloxone Administration Policy and Procedure Toolkit - https://docs.google.com/document/d/1j2_fx8btICBDrs7Yv3bUJMP9VRPCKejZ/edit

Naloxone Procedure (Cont.)

Procedure

FACILITY

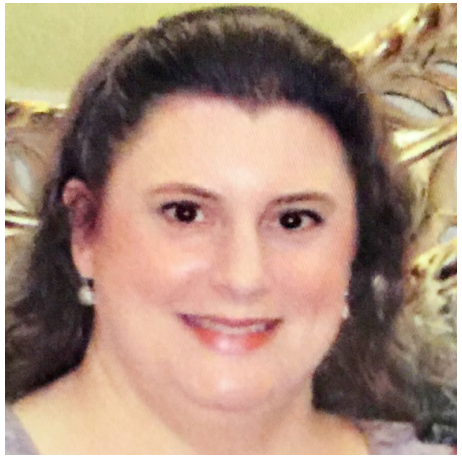
1. Naloxone injectable or intranasal formulation should be stocked in the emergency medication kit or automated dispensing machine (ADM) with at least 2 doses in each emergency medication kit or equivalent in the ADM.
2. All nursing home staff will be educated upon employment orientation and annually on Naloxone Use for Opioid-Induced Respiratory Depression, including participation in response drills, competency evaluations; and applicable Good Samaritan law, federal, state, and local regulations.

Procedures for administration of naloxone (Narcan®) nasal spray

1. Hold the naloxone nasal spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle. Place individual in supine position, do not prime, insert the cone into the nostril, give short vigorous push into nostril.
2. Administer one dose of naloxone intranasally in 1 nostril.
    a. If the individual does not respond in 2 to 3 minutes, or responds and then relapses into respiratory depression, administer additional doses of naloxone nasal spray, using a new nasal spray with each dose.
    b. Additional doses of naloxone nasal spray may be given every 2 to 3 minutes until emergency medical assistance arrives.
3. *See naloxone nasal spray full prescribing information:* Food and Drug Administration. Narcan Nasal Spray 4mg. Full Prescribing Information can be found here https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/208411s001lbl.pdf .

Excerpts from Naloxone Administration Policy and Procedure Toolkit - https://docs.google.com/document/d/1j2_fx8btICBDrs7Yv3bUJMP9VRPCKejZ/edit

Guest Panelist



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Questions

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We want to hear from you!

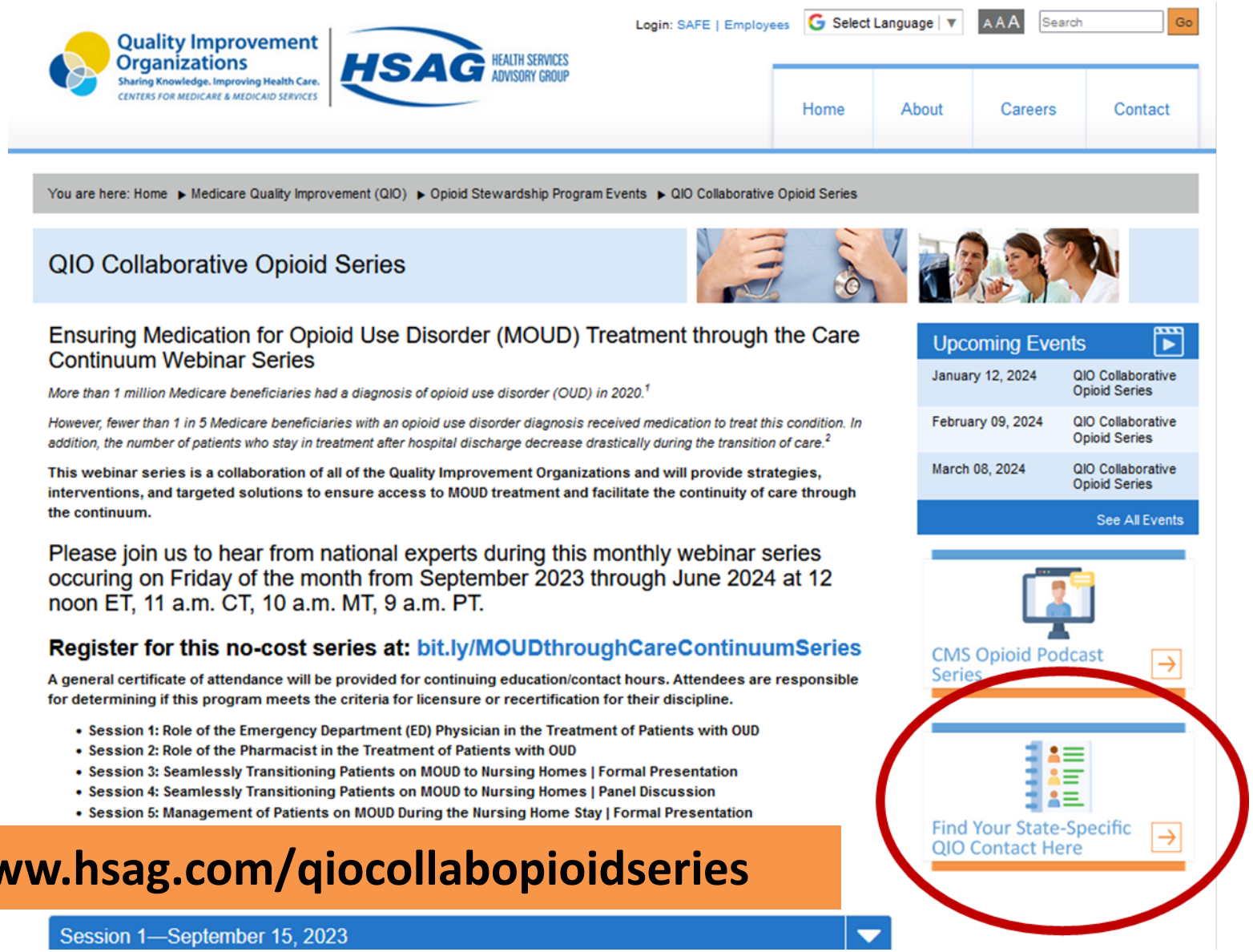
Our common goal:

Improving the management of patients

with opioid use disorder through the care continuum.

- What have you learned through this series?
- What actions have you taken since September 2023?
- What would you like to hear about during our upcoming webinars?

Your State-Specific QIO Point of Contact



https://www.hsag.com/qiocollabopioidseries

What's Next

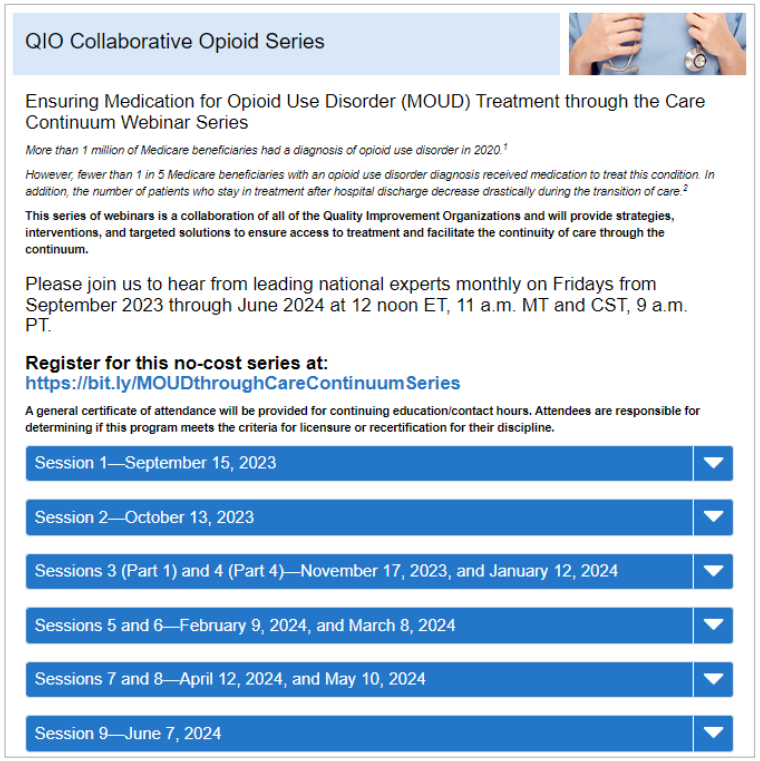
Join us for the next session on March 8, 2024:

Management of Patients on MOUD During the Nursing Home Stay – Part 2

bit.ly/MOUDthroughCareContinuumSeries

Recordings, slides, and resource links are posted for on-demand access 72 hours after every session.

https://www.hsag.com/qiocollabopioidseries



QIO Collaborative Opioid Series

Ensuring Medication for Opioid Use Disorder (MOUD) Treatment through the Care Continuum Webinar Series

More than 1 million of Medicare beneficiaries had a diagnosis of opioid use disorder in 2020.[1]

However, fewer than 1 in 5 Medicare beneficiaries with an opioid use disorder diagnosis received medication to treat this condition. In addition, the number of patients who stay in treatment after hospital discharge decrease drastically during the transition of care.[2]

This series of webinars is a collaboration of all of the Quality Improvement Organizations and will provide strategies, interventions, and targeted solutions to ensure access to treatment and facilitate the continuity of care through the continuum.

Please join us to hear from leading national experts monthly on Fridays from September 2023 through June 2024 at 12 noon ET, 11 a.m. MT and CST, 9 a.m. PT.

Register for this no-cost series at:
https://bit.ly/MOUDthroughCareContinuumSeries

A general certificate of attendance will be provided for continuing education/contact hours. Attendees are responsible for determining if this program meets the criteria for licensure or recertification for their discipline.

Session 1—September 15, 2023

Session 2—October 13, 2023

Sessions 3 (Part 1) and 4 (Part 4)—November 17, 2023, and January 12, 2024

Sessions 5 and 6—February 9, 2024, and March 8, 2024

Sessions 7 and 8—April 12, 2024, and May 10, 2024

Session 9—June 7, 2024

Certificate of Attendance

Continuing Education Credits and Contact Hours for Health Professionals

- This series may meet continuing education requirements for your discipline. You may use this certificate as proof of attendance. It is your responsibility to determine if the series fulfills that requirement.
- The link to request a certificate of attendance is below and will be included in the follow-up email sent directly to you by Webex.

- New User Registration Link: https://lmc.hshapps.com/register/default.aspx?ID=c69fa9fb-a2b3-4b51-bded-b7d72e38d438

- Existing User Link: https://lmc.hshapps.com/test/adduser.aspx?ID=c69fa9fb-a2b3-4b51-bded-b7d72e38d438

Thank You

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