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

Seamlessly Transitioning Patients on MOUD to Nursing Homes (NHs) Part 1

Friday, November 17, 2023

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.

Learning Objectives

- Describe the discharge planning process to safely transition patients on MOUD to a NH and/or in the community.
- Review the steps of an effective medication reconciliation process.
- Discover effective strategies and interventions to implement a strong partnership with post-acute care facilities and primary care physicians.

Guest Speakers

Aimee Moulin, MD, MAS

Professor of Emergency Medicine with UC Davis Health
Director & Co-Principal Investigator with CA Bridge

Jennifer Miranda, PharmD, BCACP, CPP

Pharmacy Case Management Supervisor with Mountain Pacific Quality Health

Seamless Transitions for Patient on MOUD

Aimee Moulin, MD

California Bridge

Rising Rates of OUD in Older Adults

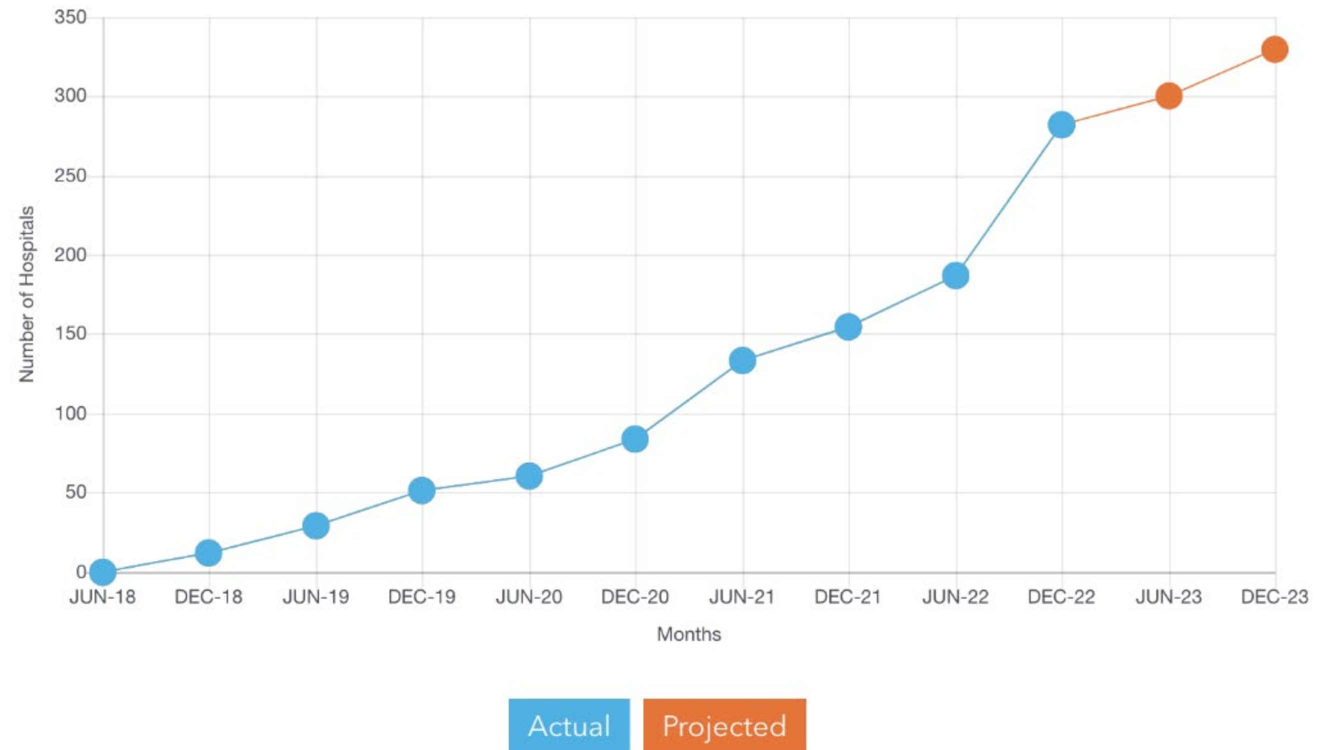
- >1 million adults over the age of 65 with OUD
- Increased prevalence of older adults with substance use disorder (SUD)
  - 35.9% ages 50–59
  - 12% ages 59–69
- Opioid prescriptions disproportionately higher in older adults

Joshi P, Shah NK, Kirane HD. Medication-assisted treatment for opioid use disorder in older adults: an emerging role for the geriatric psychiatrist. *Am J Geriatr Psychiatry*. 2019;27(4):455–457.

Schieber LZ, Guy GP Jr, Seth P, Losby JL. Variation in Adult Outpatient Opioid Prescription Dispensing by Age and Sex - United States, 2008-2018. MMWR Morb Mortal Wkly Rep. 2020 Mar 20;69(11):298-302. doi: 10.15585/mmwr.mm6911a5. PMID: 32191686; PMCID: PMC7739983.

Increasing Hospital Discharges With MOUD

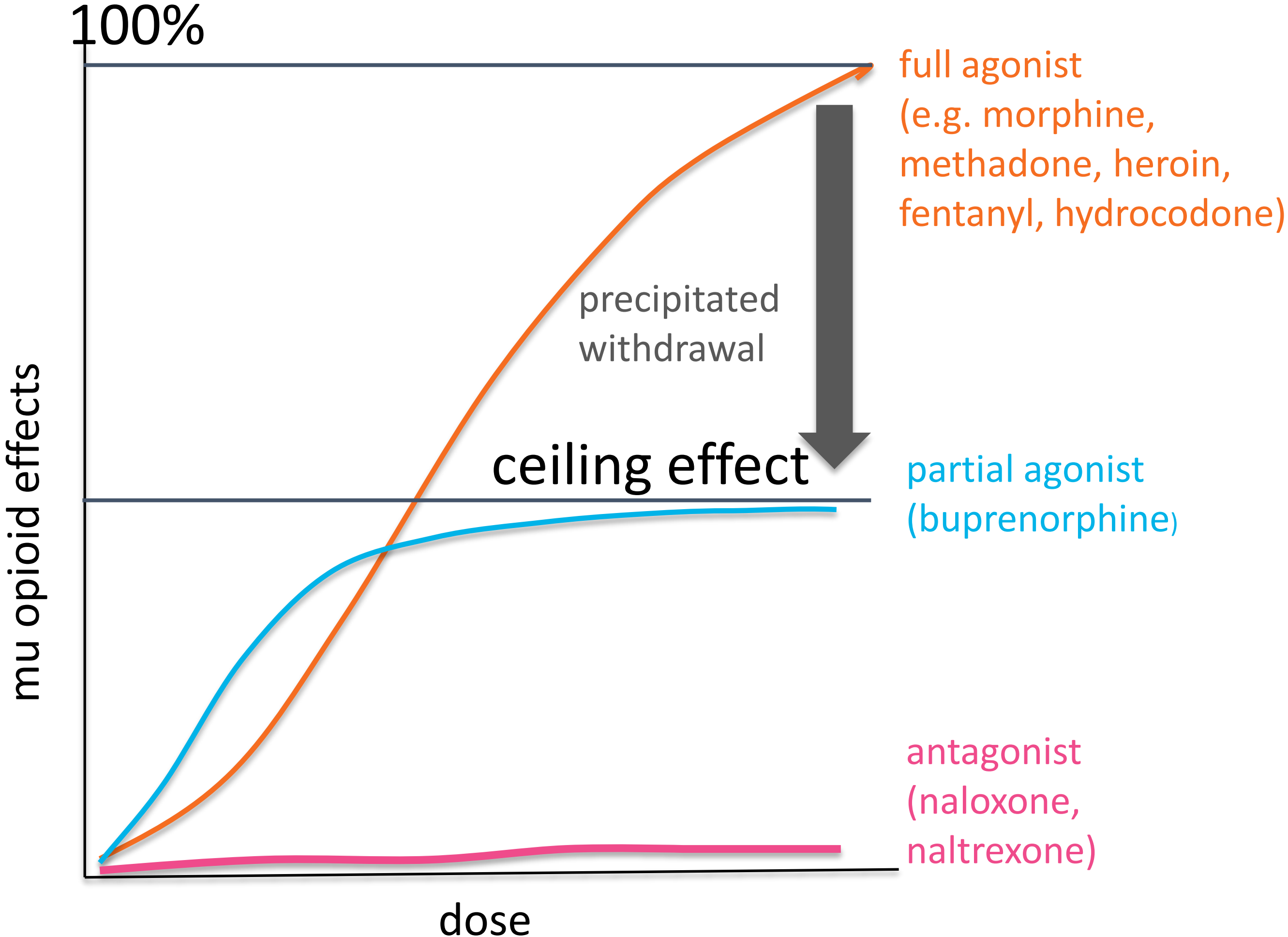
25% of Medicare patients with OUD are discharged to post-acute care facilities.



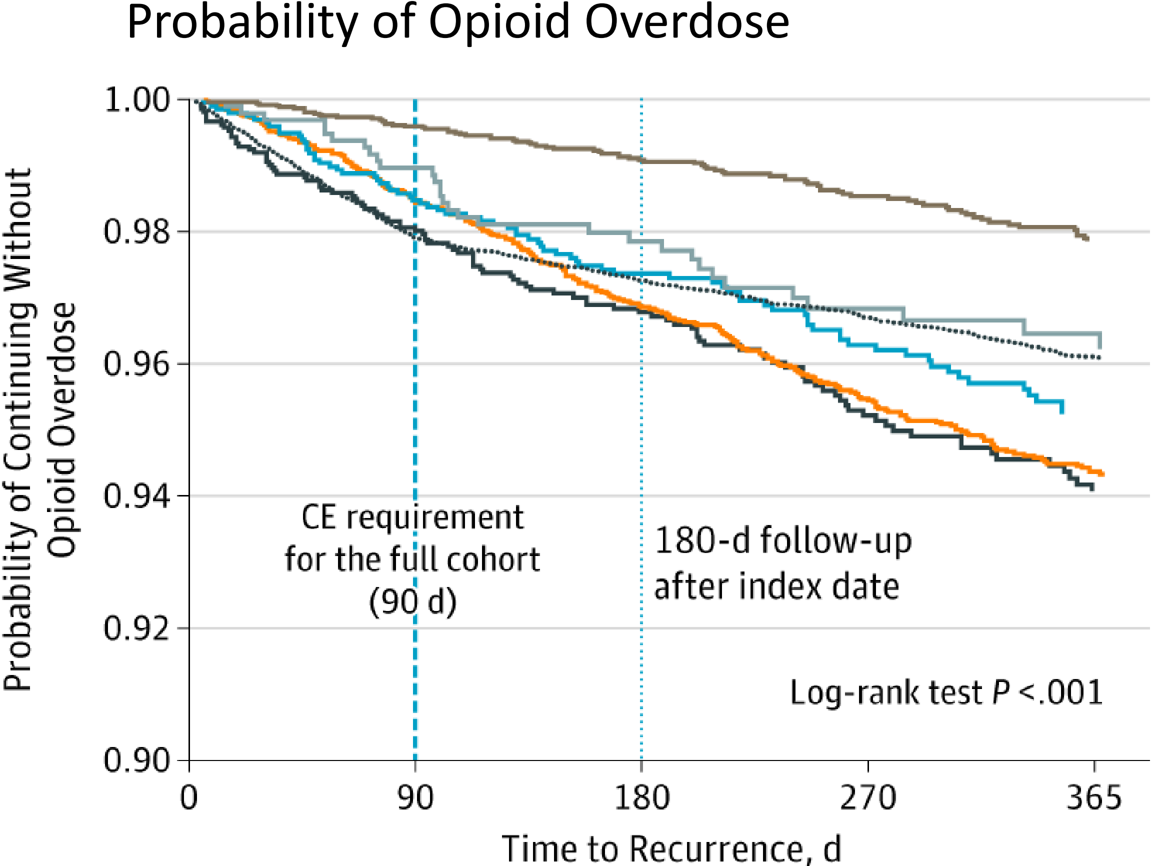
Moyo P, Eliot M, Shah A, Goodyear K, Jutkowitz E, Thomas K, Zullo AR. Discharge locations after hospitalizations involving opioid use disorder among medicare beneficiaries. Addict Sci Clin Pract. 2022 Oct 8;17(1):57. doi: 10.1186/s13722-022-00338-x. PMID: 36209151; PMCID: PMC9548174.

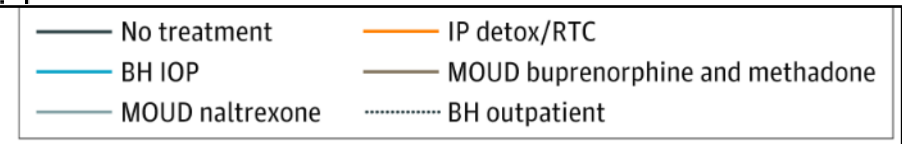
What Is MOUD?

How Does MOUD Work?



Benefits of MOUD in Post-Acute Care





- Improved management of physiologic withdrawal symptoms, cravings
- Improved transitions to outpatient treatment on discharge
- MOUD saves lives

Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder, Sarah E. Wakeman ; Marc R. Larochelle ; Omid Ameli ;
Jama Network February 2020: https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2760032

MOUD Regulations

- Buprenorphine can be prescribed by anyone with a DEA registration number.
- Methadone for OUD can be administered or dispensed but not prescribed.

https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act#:~:text=Do%20providers%20still%20need%20a,in%20which%20they%20deliver%20care
https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/methadone

Methadone Transitions of Care

1. Acute Care Hospital
2. Opioid Treatment Program
3. Post-Acute Care

Acute Care Hospital Strategies for Success

- Maintain contact with opioid treatment program for enrolled patients.
- Dispense 3-day supply on discharge.
- Facilitate intake at opioid treatment program on discharge or during hospitalization via telehealth.

Opioid Treatment Program Strategies

At a Glance: The Six Dimensions of Multidimensional Assessment

Dimension 1 **Acute Intoxication and/or Withdrawal Potential**

- Exploring an individual's past and current experiences of substance use and withdrawal

Dimension 2 **Biomedical Conditions and Complications**

- Exploring an individual's health history and current physical condition

Dimension 3 **Emotional, Behavioral, or Cognitive Conditions and Complications**

- Exploring an individual's thoughts, emotions, and mental health issues

Dimension 4 **Readiness to Change**

- Exploring an individual's readiness and interest in changing

Dimension 5 **Relapse, Continued Use, or Continued Problem Potential**

- Exploring an individual's unique relationship with relapse or continued use or problems

Dimension 6 **Recovery/Living Environment**

- Exploring an individual's recovery or living situation, and the surrounding people, places, and things

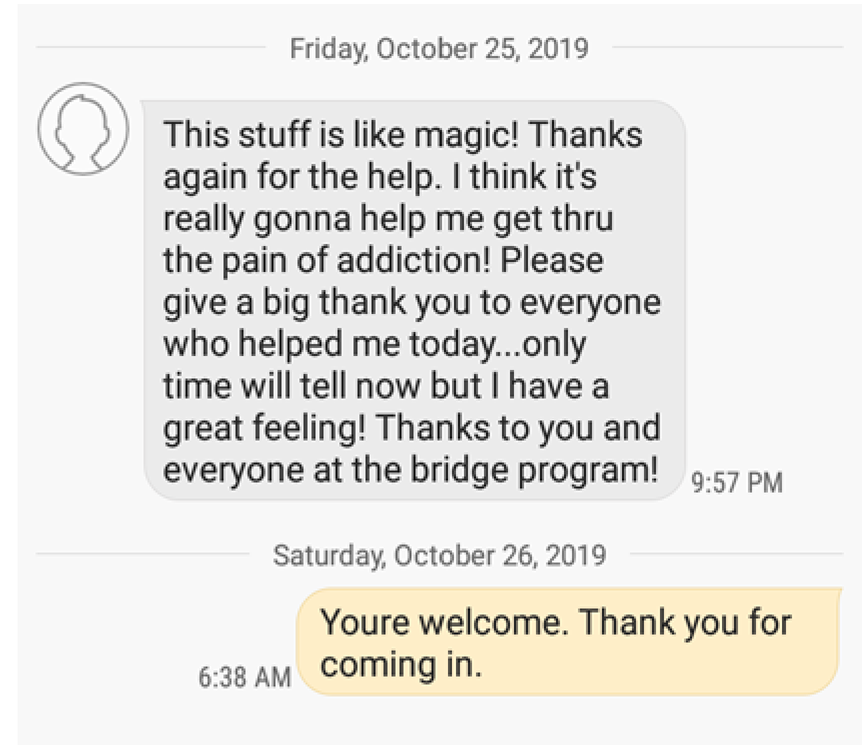
- Facilitate ongoing treatment with telehealth visits and flexible scheduling.
- Dispense methadone to post-acute care facility.

https://www.improvingmipractices.org/resources/encyclopedia/american-society-addiction-medicine-asam-criteria

Post-Acute Care Strategies

- Flexibility in developing new workflows
- Communication, coordination

Questions?



11%

at-risk patients given
Rx for Naloxone

1.6%

patients fill Rx for
Naloxone

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7018930/

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Steps of an Effective Medication Reconciliation Process

Jennifer Miranda, PharmD, BCACP, CPP
Pharmacy Case Management Supervisor
Mountain Pacific

November 17, 2023

Health Care Effectiveness Data and Information Safety (HEDIS®) Measure

- Medication Reconciliation Post-Discharge (MRP)
  - Medications on discharge are reconciled with medications the patient was on prior to being admitted to the hospital.
- **Star measure**
- Requirements for billing:
  - Document in outpatient record, include date MRP was performed
  - Must be performed by registered nurse (RN), physician's assistant (PA), nurse practitioner (NP), physician, certified nurse-midwife (CNM), clinical nurse specialist (CNS)
  - Provider signature
  - Up to 30 days post-hospital discharge and day of discharge (31 days total)

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Transitions of Care
Medication Reconciliation

Hospital to NH or Vice Versa

PURPOSE: Compare new medication orders to medications the patient was taking prior to readmission to the NH.

GOAL: To decrease adverse drug events (ADEs), including death, decrease hospital readmission rates and ensure quality of life.

OUD: What Is It?

- A chronic disease of the brain
- Characterized by persistent use of opioids despite harmful consequences

Time Sensitivity = Improved Outcomes

- Medication reconciliations performed within three to seven days post-discharge have shown decreased hospital readmissions and contribute to cost savings.
- Medication reconciliation for a person with OUD should be prioritized, as inappropriate medication regimens can lead to withdrawal or toxicity.

The Three-Step Medication Reconciliation Process

Verify: Collect and document accurate medication history (names of medications, times, and dose).

Clarify: Is the medication and dose appropriate?

Reconcile: "Match up" medication information; document each change (omissions, changes in dose, additions, etc.).

Unintended Discrepancies

An unintended discrepancy could be described as medications or treatment plans not explained by the patient’s clinic, condition, or medication list.

Tool—Diagnosis Codes:

- Does the medication list match up to the diagnosis codes?
- Is there a diagnosis not being treated that should be?
- Is there a medication listed that does not have a corresponding diagnosis code?

Identify Medication Errors

Omissions

Example: If the patient is on Senna® for constipation prior to admission but not on the medication post-discharge, the patient could end up with a bowel blockage.

Duplications

Examples:

- gabapentin/pregabalin
- zolpidem 5 mg/zolpidem 10 mg
- lorazepam/alprazolam

Dosing

Watch for errors with dosing.

Questions:

- Is the dose the patient was previously taking the same or different?
  - **Follow-up question:** Does the dose make sense?
- If the dose was decreased, do you understand the reason?
- Does the reason make sense?
- If the medication had a counterpart, was its dose also decreased?

The D's of Monitoring

Drug-Drug Interactions: Atazanavir/buprenorphine; monoamine oxidase inhibitors/buprenorphine; hydrocodone/acetaminophen (APAP) with separate Tylenol script, central nervous system (CNS) depressants/buprenorphine/naloxone

Drug-Disease State Interactions: Buprenorphine/naloxone/severe hepatic impairment; hypertension/suboxone; anti-inflammatories (ibuprofen) with kidney disease

Duplications: Watch for generic versus brand name drugs. (Examples: buprenorphine/naloxone, Suboxone®, same as Zubsolv® (not dosed the same), Belbuca® same as Butrans® (both buprenorphine products)

Drug-Drug Interactions

CNS Depressants: Increase the CNS depressant effect of buprenorphine.
Risk D: Consider therapy modification. Examples: sedatives/hypnotics, benzodiazepines.

Moderate CYP3A4 Inducers: Decrease the concentration of buprenorphine.
Risk C: Monitor therapy. Examples: modafinil, St. John's Wart.

Strong CYP3A4 Inducers: Decrease the concentration of buprenorphine.
Risk C: Monitor therapy. Examples: carbamazepine, phenytoin, rifampin.

Moderate CYP3A4 Inhibitors: Increase the concentration of buprenorphine.
Risk C: Monitor therapy. Examples: Erythromycin, diltiazem, verapamil, grapefruit juice.

Strong CYP3A4 Inhibitors: Increase the concentration of buprenorphine.
Risk C: Monitor therapy. Examples: clarithromycin, ketoconazole, itraconazole.

Pertinent Considerations

- Prescriptions needed for treatment of withdrawal that can also have drug interactions with OUD medications include clonidine, hydroxyzine, and ondansetron.
- The patient may not be stable upon admission to the NH.
- Treat MOUD, such as Suboxone®, buprenorphine, and long-acting naltrexone (Vivitrol®) as you would insulin used for diabetes.
- If patient needs methadone, patient must get established with a Federal Opioid Treatment Program (FOTP), aka Methadone Treatment Program.
- Monitor for QT interval prolongation.

Lab Monitoring

Were the appropriate labs ordered upon discharge from the hospital to correspond to the new diagnosis, medications, or changes in medications?

Examples:

- **Liver Function Test's (LFT's): Prior to initiation and during MOUD therapy**
- **Human Immunodeficiency Virus (HIV)/Hepatitis C:** Has patient been tested?
- **New diuretic with buprenorphine:** Was a comprehensive metabolic panel (CMP) or basic metabolic panel (BMP) ordered?

Age Disparities: Elderly; Important Other Concerns

Concern for older age group (65 years or older) based on:

- Chronic conditions
- Polypharmacy
- Need for prescribed opioids increases with age
- Decline in cognitive function
- Decreased saliva
- Anticholinergic medications

Clinical Pearls

- Ensure multiple naloxones in e-kit and readily available
- Ensure standing order for naloxone
- Holiday action plan
- Best to ensure each patient has a script for Narcan

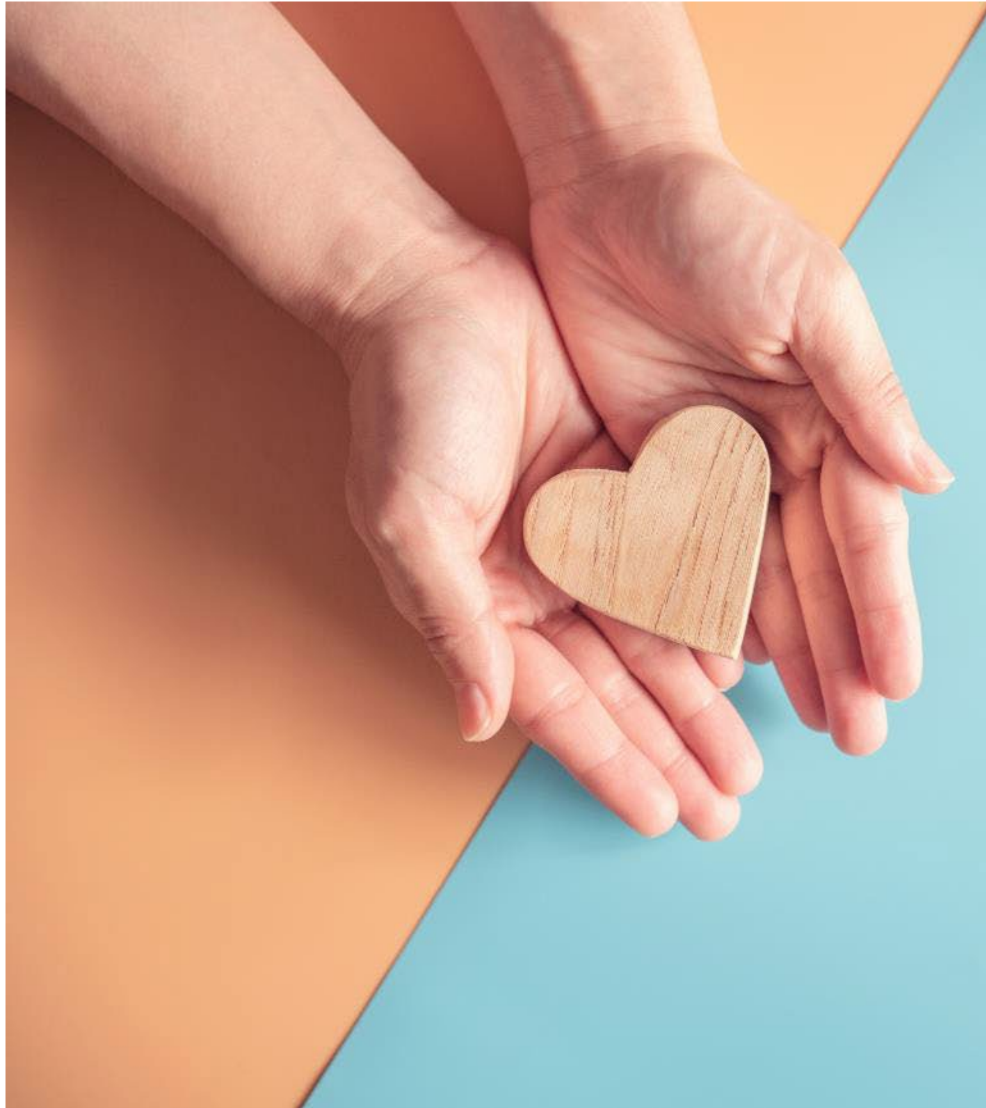
Considerations for MOUD Medication Reconciliation

- Pain Management of acute pain prescription for an opioid. **Example:** post hip surgery
- Increased dose of suboxone
- Suboxone used for pain and for OUD treatment
- Substance use can impact presentation of pain and pain management
- **Naltrexone**: Can decrease risk for respiratory depression with the opioid

What Can We Do?

- Talk to your pharmacist.
- When discharged from a hospital, ensure the patient has been counseled to speak up if they develop cravings for an opioid.
- Care coordination is critical.
- Treat pain, if needed.

Compassion Is Key



"**Love** and **compassion** are **necessities**, not luxuries. Without them, humanity cannot survive."

-Gwalwa Rinpoche,
fourteenth Dalai Lama

Resources

- Accuracy at Every Step: The Challenge of Medication Reconciliation: https://www.ihi.org/resources/Pages/ImprovementStories/AccuracyatEveryStep.aspx
- Develop a Medication Reconciliation Process: https://journals.lww.com/nursingmanagement/Citation/2007/03000/Develop_a_medication_reconciliation_process.6.aspx
- Post Discharge Pharmacist Medication Reconciliation: Impact on Readmission Rates and Financial Savings: https://www.japha.org/article/S1544-3191(15)30291-0/fulltext
- Top 10 Particularly Dangerous Drug Interactions: https://paltc.org/top-10-particularly-dangerous-drug-interactions-paltc
- Value of the Pharmacist in the Medication Reconciliation Process: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4771087/
- Medication History Gathering and Medication Reconciliation Frequently Asked Questions: https://www.oregon.gov/pharmacy/Pages/Medication-Reconciliation.aspx
- Transitional Care Management Services: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf

Resources (cont.)

- A Painful Medication Mishap https://psnet.ahrq.gov/web-mm/painful-medication-reconciliation-mishap
- Acheson, EE. Suboxone: Drug information. In: UpToDate, Post TW (Ed), Wolters Kluwer. https://www.uptodate.com (Accessed on October 29, 2023.)
- Acheson, EE. Buprenorphine: Drug information. In: UpToDate, Post TW (Ed), Wolters Kluwer. https://www.uptodate.com (Accessed on October 29, 2023.)
- Clinical Drug Interaction Studies — Cytochrome P450 Enzyme- and Transporter-Mediated Drug Interactions Guidance for Industry (January 2020) available at: https://www.fda.gov/regulatory-information/search-fda-guidance-documents/clinical-drug-interaction-studies-cytochrome-p450-enzyme-and-transporter-mediated-drug-interactions.
- US Food & Drug Administration. Drug Development and Drug Interactions: Table of Substrates, Inhibitors and Inducers. Available at: FDA.gov website.

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Thank you!

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Guest Panelist

Tanya Vadala, PharmD

Title(s): Senior Pharmacist, Medication Safety & Quality Improvement IPRO

Questions

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What's Next

Join us for the next session on January 12, 2024:
Seamlessly Transitioning Patients on MOUD to NHs—Part 2

bit.ly/MOUDthroughCareContinuumSeries

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

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

https://www.hsag.com/qiocollabopioidseries

Certificate of Attendance

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- 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=f6aceaf2-bc0e-4ce5-8728-084170873815
  - Existing User Link: https://lmc.hshapps.com/test/adduser.aspx?ID=f6aceaf2-bc0e-4ce5-8728-084170873815

Thank You

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HSAG prepared slides 1–4 and 42–44.