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OPIOID RESPONSE

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To: Substance use treatment providers and pharmacy communities

The Maine Opioid Response Clinical Advisory Committee consists of approximately 30 leaders in substance use disorder prevention, treatment and harm reduction in Maine including both prescribers and pharmacists. As part of our efforts, we have been working on developing clinical recommendations related to the management of patients with substance use disorders, particularly as they encounter barriers within the existing health care delivery system. One common challenge is transferring patients on medications for opioid use disorder (MOUD) from the inpatient setting to post-acute care facilities. We have attached our proposed position on ensuring access to MOUD in post-acute care facilities. These recommendations are intended to enhance your care and should not replace your own clinical judgement. If you have any questions, please do not hesitate to contact us.

Sincerely,
Maine Opioid Response Clinical Advisory Committee

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Maine Opioid Response Clinical Advisory Committee: Proposed Position on Ensuring Access to Medications for Opioid Use Disorder (MOUD) in Post-Acute Care Facilities

Introduction: Maine has been especially affected by the opioid epidemic. The rate of opioid related inpatient hospitalizations and ED visits are 7.6% and 59.3% higher than the national average.[1] Opioid related inpatient hospitalizations are often complications of intravenous drug use (e.g., endocarditis, osteomyelitis) and require lengthy hospital stays. After hospital discharge, many patients require further nursing care for the intravenous administration of antibiotics. Patients with opioid use disorder (OUD) may also require treatment in post-acute care facilities for diagnoses unrelated to their OUD.

Problem Statement: In a recent study, over 80% of referrals to post-acute care facilities for patients on medications for OUD (MOUD) were rejected with substance use and/or MOUD cited as common reasons for rejection.[2] This has a significant impact on increasing healthcare costs as those that are rejected often must remain in the hospital. The inpatient cost per day for a patient with Mainecare is $1,816.17 whereas the cost per day of a post-acute care facility is $251.14.[3] Limited inpatient bed capacity is further restricted when otherwise eligible patients are unable to be placed in a post-acute care facility. Stigma is believed to play a role in rejections of referrals and includes the perceived need to separate patients with OUD from the rest of the population due to their "drug seeking behavior" and "that they will stop at nothing to get what they need."[4,5] It has been suggested that stronger enforcement of the American with Disabilities Act (ADA) might enhance access to post-acute care facilities for patients on MOUD. Unfortunately, the rate of rejection of patients on MOUD did not improve after a related settlement was made by a nursing home in Massachusetts for violating the ADA.[2]

Recommendation for Ensuring Access to MOUD in Post-Acute Settings: Several post-acute care facilities in Maine have been successfully providing care to patients on MOUD. In line with other states, we recommend that all post-acute care facilities in Maine be required to care for patients on MOUD.[6]

Below, we review many of the commonly cited challenges to providing MOUD in post-acute care facilities and make related recommendations for how to address those challenges. We also understand that ongoing education around reducing stigma and providing trauma informed care will be required and we look forward to participating in those efforts.

***Challenge*:** Post-acute care facilities are unable to provide MOUD as they do not have a DEA X-waivered clinician on staff and/or are not a methadone outpatient treatment program (OTP).

> ***Solution:*** Clinicians prescribing buprenorphine as MOUD must have a DEA DATA-2000 X-waiver. However, the US Substance Abuse and Mental Health Services Administration (SAMHSA) recently revised these guidelines to eliminate the previously mandated 8 (or 24) hour training requirements when clinicians are prescribing buprenorphine as MOUD to 30 or fewer patients. Prescribers must still submit and receive approval from SAMHSA of a Notice of Intent (NOI) to prescribe buprenorphine, which is a relatively easy, one

step process.[7] Alternatively, facilities can credential an outside X-waivered clinician to provide these services. Prescriptions for buprenorphine as MOUD can be filled by the facility pharmacy and administered in the same manner as all other prescription medications. Federal regulations also allow patients on methadone as MOUD to continue to receive their medication at a post-acute care facility provided they were in treatment at an OTP prior to admission to the hospital or post-acute care facility.[8,9] Clinicians may need to collaborate with the patient's OTP and/or a local pharmacy to obtain the medication.

Challenge: Providing post-acute care to patients with OUD is prohibitively expensive.

Solutions: MOUD, including both methadone and buprenorphine, are relatively inexpensive medications, especially as buprenorphine is now available generically. The approximate price per unit of buprenorphine/naloxone 8/2 mg sublingual tablets is $2.68, or approximately $161/month when patients are prescribed a 16 mg daily dose.[10]

Providing care for patients on MOUD in the post-acute setting may be considerably less expensive than the cost of caring for the "typical" post-acute patient. For example, patients receiving ongoing antibiotic treatment for endocarditis place less burden on staff as they are less complex, tend to be mobile and are on fewer medications. They are also less likely to be cognitively impaired or require extensive support services.

Challenge: Post-acute care facilities are unable to provide the substance use counseling required by patients on MOUD.

Solutions: The Maine Division of Licensing and Certification has indicated that post-acute care facilities do not need to have on-site nursing or other clinicians with specialized training and credentials in substance use disorder (SUD) treatment. Facilities need to have a patient-centered care plan for behavioral health and/or SUD treatment developed in collaboration with a clinician (provided either via consult or telehealth) who has knowledge and experience in the treatment modalities that meet patient specific needs. Facilities must then ensure that staff who are providing care to the patient understand the care plan and are competent in implementing the care plan (including appropriate non-pharmacological interventions) to ensure that the patient improves, or at least does not deteriorate, while residing in the facility.

Additionally, for patients who require and agree to participate in SUD counseling, the COVID-19 pandemic has made access considerably easier as most post-acute care patients have become familiar with the use of phones, tablets, and other devices to engage with medical specialists and counselors. Most studies suggest that telemedicine interventions for patients with SUD are associated with high patient satisfaction and are an effective alternative, especially when access to treatment is otherwise limited.[11]

Challenge: It is impossible to adequately monitor patients on MOUD in the post-acute setting.

> ***Solution:*** Toxicology testing using either urine or oral fluid is widely available. There are many options to contract with vendors who can receive specimens by mail and are able to assist with laboratory interpretation as needed.

Challenge: Patients on MOUD might overdose.

> ***Solution:*** There are many patients in post-acute care facilities who could potentially be at risk of overdose, such as those on multiple medications, those on opioid analgesics and/or opioids in combination with benzodiazepines, and those receiving MOUD. Buprenorphine's respiratory suppression safety profile is much better than that of full agonist opioids that are routinely prescribed for acute pain. It is essential to have systems in place for routine monitoring, and to have naloxone on site to reverse potential overdose. Post-acute care facilities can develop standing orders for the use of naloxone as part of their institutional practices.[6]

In summary, we believe that if a patient would otherwise be eligible for admission to a post-acute facility, the facility is expected to admit the patient and provide for the administration of MOUD.

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